Wolf EMR Billing User Guide
for British Columbia

Wolf EMR 2017.1

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TELUS | HEALTH
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The patients, practitioners, and circumstances depicted within this manual are fictitious. Any resemblance of any sample data or screenshots to any actual person, whether living or dead, is purely coincidental and unintentional.

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Chapter 1

Billing overview and setup

You perform most of your billing tasks in the Wolf EMR Billing program. Here, you create and manage all of your MSP, WCB, third party, and patient bills. You can customize some aspects of the Billing program's behaviour to meet your workflow needs. You can also create customized billing alerts, and set notes to print on patient invoices.

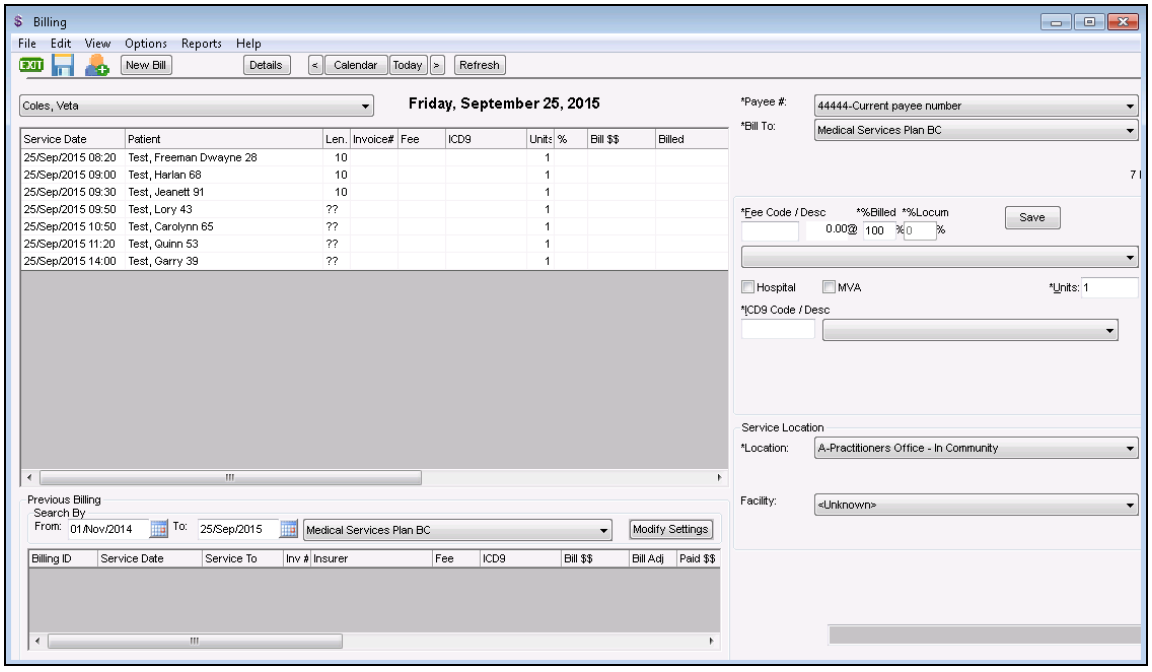
Billing program overview

The Billing program is where you:

- Create bills to MSP, WCB, ICBC and other third-parties, and patients
- Reconcile bills
- Edit, write-off, and resubmit bills
- Record payments for invoices
- Produce accounting reports

Opening and viewing the billing window

To open the Billing program: On the Wolf EMR Launch page, click **Billing** (). The EMR displays the Billing window.



The main area of the window displays the billing list for the selected date and selected practitioner.

If you click a patient in the billing list, the right pane displays the bill entry area. Here, you can enter or modify a bill.

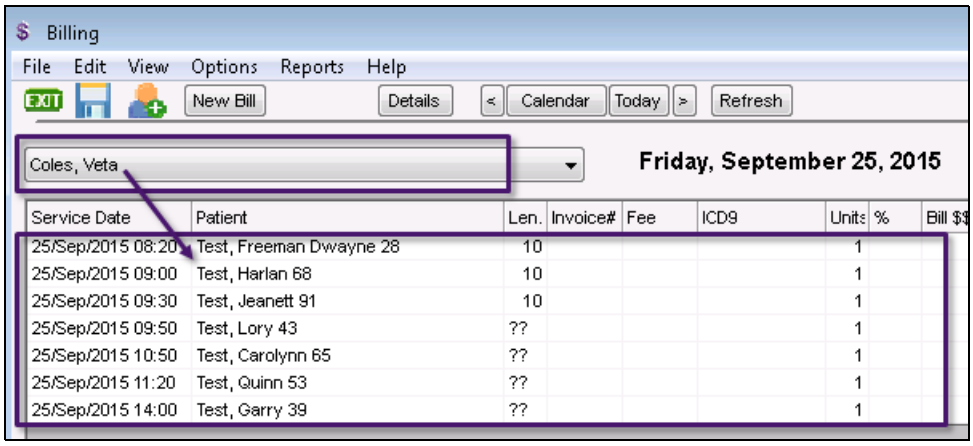
If you have the **Show Patient Previous Billings** screen behaviour enabled, the selected patient's billing history is displayed at the bottom of the window. See "Customizing Billing screen behaviour" on page 4.

Viewing the billing list

The billing list displays patients who need to be billed or have been billed for services. The EMR automatically adds patients to the billing list if they have a booked appointment, unless the appointment is marked as Non Billable or as a No Show. If you create a bill for a patient without a booked appointment, the patient is also added to the billing list.

Steps

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** ( ).
2. In the **Provider** drop-down list, select a practitioner. The EMR displays the selected practitioner's billing list for today.



For patients whose bills have not been created and saved, the billing list displays only the appointment length in the **Len** column.

For patients whose bills have been created and saved, the billing list displays the following information about the bill:

- Invoice # (for third party and patient bills)
- Fee code(s), ICD9 code(s), and Units
- % of fee code billed and total Billed amount
- % of fee code to be paid to a locum (if applicable)
- The date the service was billed
- If the bill was for a motor vehicle accident (MVA)
- Service start and end times (if applicable)
- If the bill is for a consultant referral (**T**)
- If the bill includes a referring practitioner (**B**).
- The Rural Retention code used (if applicable)

Tip: Modifying column widths

You can customize a column's width by clicking and dragging the column border. Columns remain the width you set when you re-open the Billing window.

3. To view the billing list for another service date, click one of the following options:
   - **Calendar**: To select a date from a calendar
   - **View Previous Day** (<): To navigate back one day

- **View Day** (): To navigate forward one day
- **Today**: To navigate back to today's billing list

4. If you have been viewing the billing list for an extended period of time and you want to update the list to include any newly booked and billed patients, click **Refresh**.

Customizing Billing screen behaviour

You can customize the screen behaviour of the Billing program. Some of the options you can customize include:

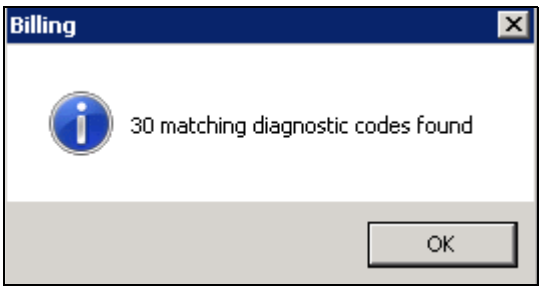
- Options to automatically populate patient bills based on previous bills
- WCB Code Sort Order
- Billing Defaults
- Patient Search Fields
- Notification options
- Billing search options
- Advanced Billing options

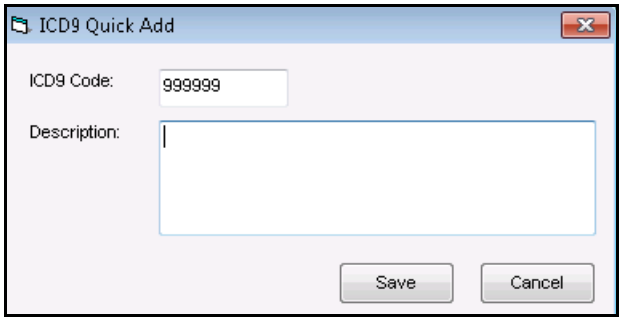
If you change the Billing screen behaviour, the changes apply only to you. Other users are not affected by your selections. You can select and clear options as often as needed to accommodate the type of billing you are performing.

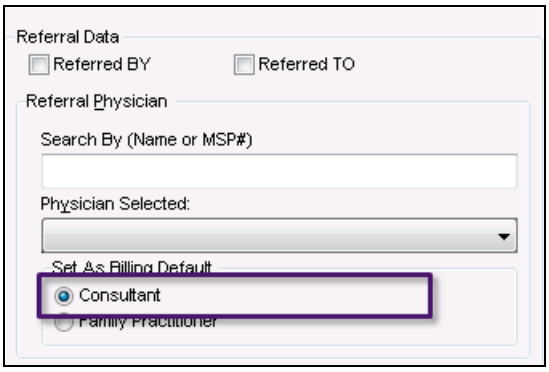
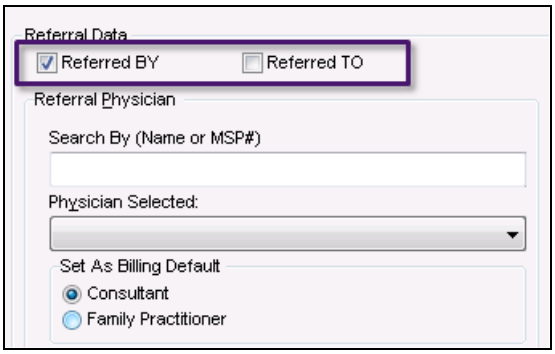
Steps

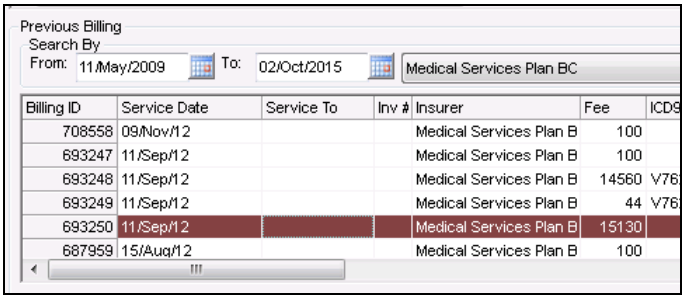
1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** (). The EMR displays the Billing window.
2. On the Billing menu, click **Options** > **Screen Behaviour**. The EMR displays a list of billing screen behaviour options.
3. Using the following table, select or clear an option. Selected options are indicated by a check mark.

Option	Description
Clear Fee Code	When you select a patient to bill, the fee code field is cleared by default.

Option	Description
Clear Submission Code, Notes	The submission code and notes are reset for each bill. This way, if you enter a note for a bill, it does not carry over to the next bill. This option is selected by default. **Tip**: Clear this option if you are in the process of rebilling rejected bills, and must enter the same note for a number of rejected bills. **Note:** When you submit a claim to MSP, the submission code identifies the type of bill. For example, the submission code can identify that a bill is a normal submission, re-submission, duplicate claim, or debit request.
Find Previous Bill	When you select a patient to bill, the EMR populates the fee code(s) and other billing information from the patient's previous bill. **Note:** The ICD9 code(s) from the patient's previous bill do not populate unless you select **Find Previous ICD9s** as well. See below.
Find Previous ICD9s	When you select a patient to bill: ■ The ICD9 codes used in the patient's previous bills display in the **Diag Codes** drop-down list. ■ The EMR populates the **Diag Codes** field(s) with the diagnostic code(s) from the patient's previous bill.
Notify after ICD9 Description Search	When you create a bill, if in the ***ICD9 Code / Desc** field, you enter a search term (for example, "**diabetes**"), the EMR displays a dialog box indicating the number of matching codes.  **Tip**: To save time, clear this option.
Notify after Rebill	A pop-up message is generated each time you rebill a bill. This option is selected by default. To stop receiving rebill pop-up messages, clear this option. **Tip**: To save time, clear this option.

Option	Description
Refresh after Rebill	The EMR removes bills from the Accounts Receivable report as soon as you rebill (edit) them. **Note:** If this option is not selected, if you rebill a bill, the bill remains on your Accounts Receivable report until it has been paid.
ICD9 Quick-Add	If you search for a diagnostic code that has not been entered in ICD9 Code Maintenance, the EMR displays a window enabling you to enter a new diagnostic code. 

Option	Description
Referral Consultants	To specify referral defaults for bills, select one of the following options: ■ **Auto Set Consultant as Billing Default**: When you create a bill, in the Service Detail window, in the **Referral Data** area, **Consultant** is selected as the billing default.  ■ **Always use Prev Bill's 'Referred By' Consultant**: When you create a bill, in the Service Detail window, in the **Referral Data** area, either **Referred By** or **Referred To** is automatically selected based on the selection made in the previous bill. 
WCB Codes Sort Order	To specify the sort order of items in the **Body Part** and **Injury Type** WCB lists, select one of the following options: ■ **by Description**: The EMR sorts the **Body Part** and **Injury Type** lists based on Description. ■ **by Code**: The EMR sorts the **Body Part** and **Injury Type** lists based on the Code.

Option	Description
Show Patient Previous Billings	The EMR displays the **Previous Billing** area at the bottom of the Billing window. When you select a patient in the billing list, the patient's previous bills are listed in the **Previous Billing** area. 
Return billing search screens to today's date	When you view your Receivables, if you perform a billing search, the search date defaults to today. This option is selected by default. **Note:** If this option is not selected, when you perform a billing search, the search date defaults to the date that is displayed in the Billing window.
Patient Search Cursor Position At	To indicate where you want your cursor to be positioned when you search for a bill, select one of the following fields: ■ **PHN** ■ **Last Name** (default) ■ **Chart Number**

Creating billing alerts

Billing alerts are notes that the EMR displays in a pop-up window when you select a patient in the Billing program. You create billing alerts in Patient Maintenance.

Steps

1. Open the Patient Maintenance window for the patient.

> **Tip**: If you are viewing the Billing window, and the patient is listed in the billing area, you can quickly open the Patient Maintenance window:
>
> ■ Click the patient's name and then, on your keyboard, press **F9**.

2. Click the **Notes** tab.

3. In the **Active Notes** area, in the **Display at Billing** field, enter the billing note.
4. Click **Save** () and then click **Exit**.

Chapter 2

Provincial billing

You create provincial bills in the Wolf EMR Billing program. When you open the billing program a billing list displays. The billing list includes all patients who have booked appointments today. To create a provincial bill for a patient, you select the patient from the billing list, and then create a bill using provincial service codes that are available to choose from in Wolf EMR. You can also create a bill for a patient who is not on the billing list.

If after you save a bill, you realize that you made a mistake on the bill, you can modify or delete the bill as long as it has not been sent in a claims file to the province.

Before you send claims to the province you can produce a report of patients who were booked for appointments, but have not yet been billed.

Creating a bill to Medical Services Plan (MSP)

You can create a bill to MSP:

- From the billing list. (These are bills that are automatically generated for patients with booked appointments.) See "Creating a bill from the billing list" on page 11.
- In the Billing program (if the patient is not in the billing list, or if a patient is not in the system). See "Creating a bill for a patient who is not in the billing list" on page 22.
- From a SOAP note (practitioners only). See "Entering bill information from a SOAP note (practitioners only)" on page 26.

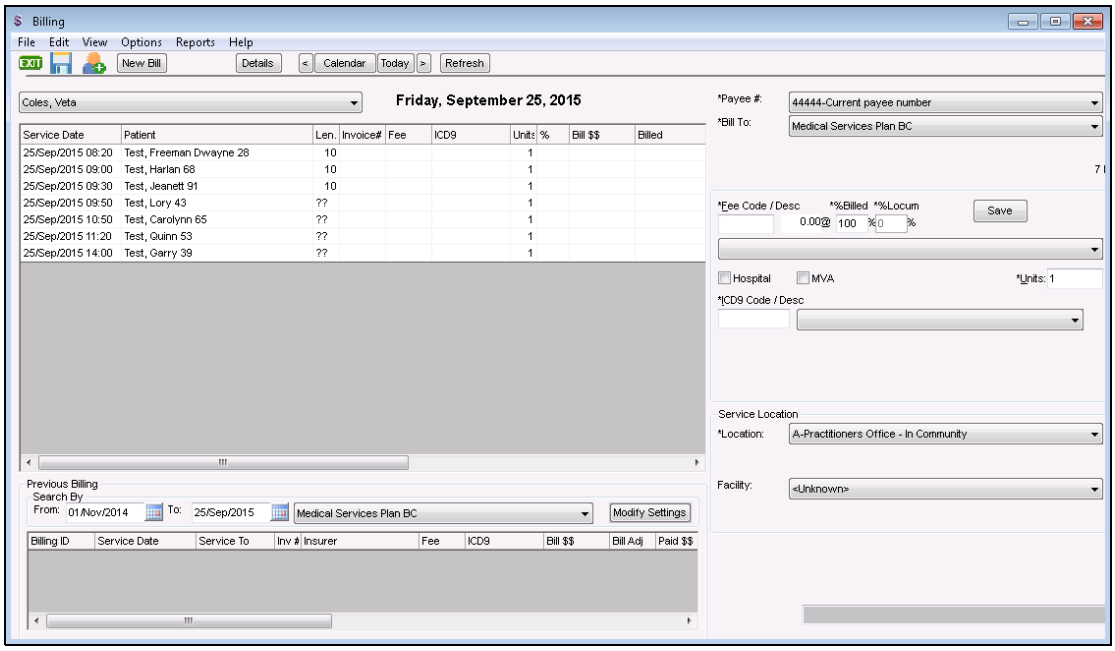
You can also ensure that all appointments have been billed, using the **Incomplete Billing** search feature.

Creating a bill from the billing list

The EMR creates a billing list for each practitioner based on booked appointments. The billing list is visible when you open the Billing program. From the billing list, you can create and save bills.

Steps

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** ( ). The EMR displays the Billing window.



2. In the practitioner drop-down list (located in the top left corner), click a practitioner. The EMR displays the selected practitioner's billing list for today.

> **Note**: If you are the patient's practitioner, your name is selected by default.

3. If you are creating a bill for a day other than today, click **Calendar**, and then click the Service Date. The EMR displays the billing list for the selected date.
4. In the billing list, click a patient. If the patient has not been marked as arrived, the EMR displays a dialog box with the following prompt: "Patient not updated as arrived, cannot bill. Set 'arrive' status?"
   To mark the patient as arrived, click **Yes**.

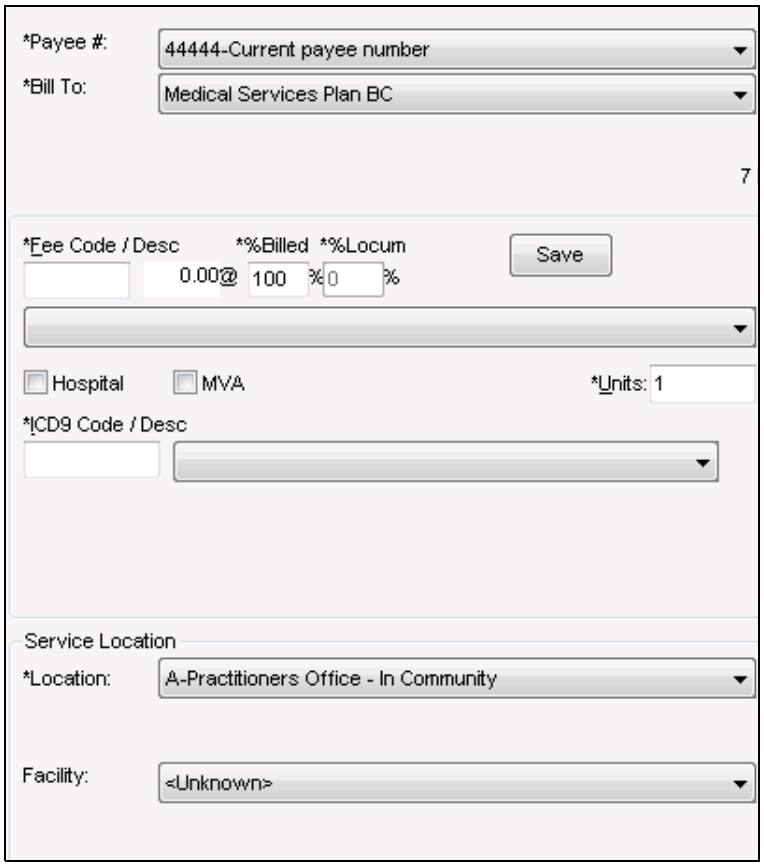
> **Note**: You cannot bill a patient until they have been marked as arrived.

Tips around arrived status

- Question marks **(??)** in the **Len.** (Length of appointment) column means the patient has not been marked as arrived.
- You can click **??** to set the patient status as arrived. The EMR displays the following prompt: "Patient not updated as arrived, cannot bill. Set 'arrived' status?" Click **Yes**.

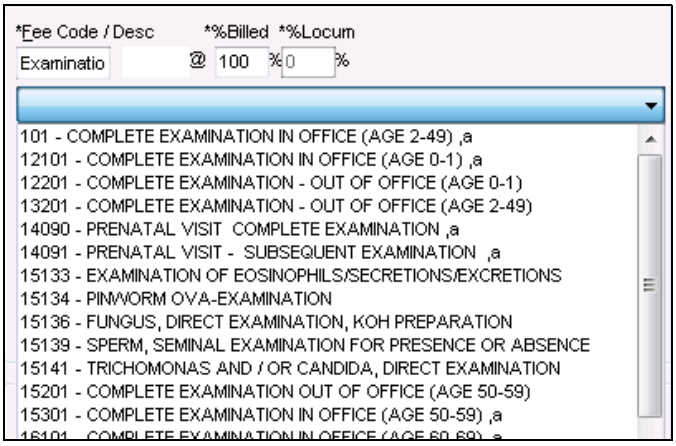
The EMR displays the entry area for the selected bill in the right pane, with:

- The **Bill To** field defaulted to **Medical Services Plan BC**.
- Other bill details (for example, fee code(s) and diagnostic codes) pre-populated. What information populates depends on your billing screen behaviour settings (see "Customizing Billing screen behaviour" on page 4), and on what information the practitioner entered in the patient's visit SOAP note (see "Entering bill information from a SOAP note (practitioners only)" on page 26).

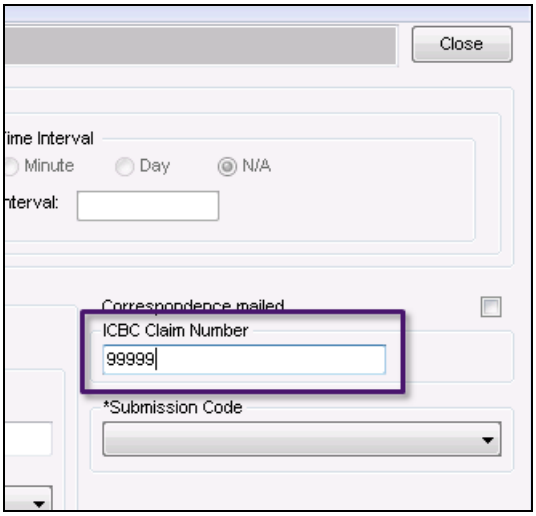


5. Use the following table to enter information for the bill.

Field	Description
Bill To	In the drop-down list, if you are billing MSP, or if you are billing ICBC via MSP, leave **Medical Services Plan BC** selected. **Note:** If a CL-19 ICBC form was completed for an ICBC visit, bill the visit as you do for other third-parties. See "Creating a bill for a third-party" on page 47.
***Payee #**	The EMR populates the practitioner's MSP billing number. If the practitioner has more than one billing number (for example, the practitioner works out of two locations), in the drop-down list, select the billing number you want to bill under.

Field	Description
*** Fee Code/ Desc (required field)**	Enter the fee code or a fee description and then, in the drop-down list below, select a fee code.  **Tips for entering fee codes**: ■ The EMR does not recognize fees that start with '0'. Instead, enter the number that follows the '0'. For example, instead of entering **0100**, enter **100**. ■ If you enter a fee code that differs depending on the patient's age, you can enter the fee code for any age group, and the EMR automatically corrects the code for the patient's age. For example, if you enter **100** (visit in office: age 2-49 years) for a 60 year old, the EMR changes the code to **16100** (visit in office: age 60-69 years). ■ For detailed information on what fee codes you should charge for certain services, and rules behind them, see the MSP website. ■ You can have a fee code populate this field automatically. See the below note on setting default fee codes. ■ If your clinic has a default fee code list set up, you can select a "favourite" fee code from the drop-down list without entering a fee code or description first.

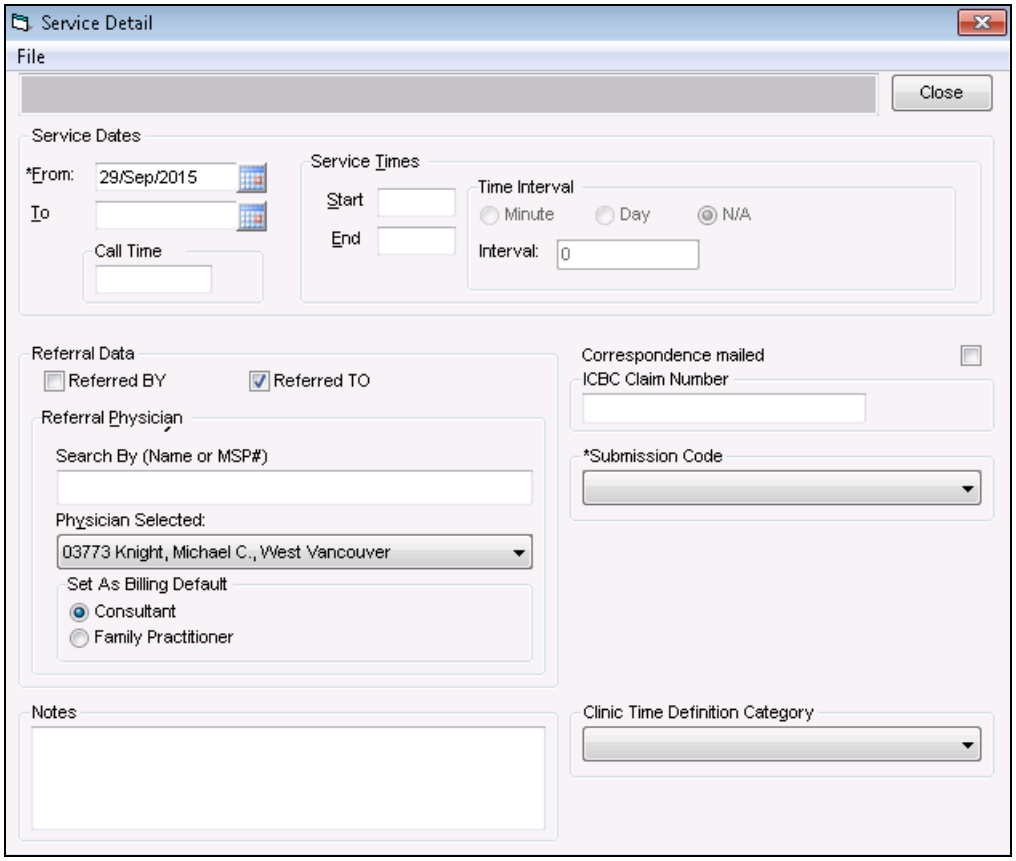
Field	Description
Setting default fee codes The default fee code for a bill is determined by entries and selections made in the following locations. The top-most selection takes precedence over the items below it. ■ **Visit Record:** Uses the fee code entered in the billing area of the visit SOAP note. See "Entering bill information from a SOAP note (practitioners only)" on page 26. ■ **Appointment Reason Default Fee Code:** Uses the fee code entered as the **Default Fee Code** in Appointment Reason Maintenance. You can select the Appointment Reason when creating an appointment. ■ **Find Previous Bill Setting:** Uses the fee code from the previous bill for the selected patient. You can select this option from the Billing Screen Behaviour window. See "Customizing Billing screen behaviour" on page 4. ■ **Fee Code Maintenance Default List**: Populates the fee code drop-down list with selected (favourite) options. Uses the fee codes from Fee Code Maintenance Data tab that have the **Include in default list** check box selected. Up to 50 fee codes can be displayed in the drop-down list. The first fee code in the list is the default unless another fee code is selected from the list at the time of creating the bill. **Tip**: Your favourite fee codes cannot be sorted, enter your most used fee codes first to ensure that they display at the top of the list.	
%Billed	Defaults to 100%. To charge for only a percentage of the normal service fee, enter the percent to be paid. For example, if you are billing a Pap smear and a tray fee with an office visit, enter 50% for the office visit fee code (as per MSP guidelines).
%Locum	If the service was provided by a locum, enter the percentage that is to be paid to the locum.
Hospital	If this bill is related to a hospital stay, select this check box. If you select a Service Location that corresponds to a hospital, the **Hospital** check box is selected by default.

Field	Description
MVA	If this bill is related to a motor vehicle accident: 1. Select the **MVA** check box. The EMR displays the Service Detail window with the following message displayed at the top: "Enter ICBC Claim Number if known". 2. If you know the patient's ICBC claim number, in the **ICBC Claim Number** field, enter the number.  **Note:** Enter only numbers. The bill will be rejected if you include letters. **Note:** If you do not know the ICBC Claim number, and leave this field blank, MSP will forward the claim to the adjudicator for payment. 3. If the service was provided by a Chiropractor, Massage Therapist, or Physiotherapist, in the **Submission Code** drop-down list, select **I ICBC Claim for chiro, massage, physio**. 4. If the bill requires the patient's driver's license details, in the **Notes** area, enter the patient's driver's license number. 5. To close the Service Detail window, click **Close**. In the billing list, the bill displays **YES** in the **MVA** column.
Units	To bill for more than one unit (for example, if you administer multiple injections), enter the number of units. Depending on the insurer and service being billed, units can represent whatever you need to multiply the fee by (for example, days, or number of services).

Field	Description
***ICD9 Code / Desc**	You can enter up to 3 ICD9 codes for a bill. To enter an ICD9 code, in the ***ICD9 Code / Desc** field, complete one of the following actions: ■ If you know the ICD9 code, enter the number. Ensure you enter the ICD9 code without a decimal point. For example, enter **2501** instead of **250.1**. ■ If you do not know the numeric ICD9 code, enter a description and then, in the drop-down list, click an ICD9 code. ICD9 code(s) pre-populate in this field if: ■ A diagnosis was assigned to the visit (in the **ASSESSMENT** area of the visit SOAP note or Consult Letter Examination) ■ You selected the **Find Previous ICD9s** Billing Screen Behavior. If this screen behaviour is enabled, the ICD9 code(s) used in the patient's previous bill populates. Also, if you click the ICD9 drop-down list, all ICD9 codes used in the patient's previous bills are listed. See "Customizing Billing screen behaviour" on page 4. **Tip**: if you are unsure of what ICD9 code to bill, and want to see a list of the patient's current problems, press **F7**. The EMR displays the patient's Medical Summary. **Note:** Although you can enter up to 3 ICD9 codes for a bill, depending on the insurer you are billing, there may be only one, two, or no ICD9 code fields available. If you have administrative authority in Wolf EMR, in Insurer Maintenance, you can set how many ICD9 code fields display on bills to specific insurers.
Location	If the practitioner provides services out of more than one location, click the location where the service was provided.

6. To add more detailed information to the bill (for example, referral physician information, notes to MSP, or service dates and times):

   a) At the top of the Billing window, click **Details**. The EMR displays the Service Detail window.



b) Using the following table, in the Service Detail window, enter additional billing information as needed.

Field	Description
Service Dates area	If the service took place over multiple days: 1. In the * **From** field, enter the service start date, or to select a date from a calendar, click  . 2. In the **To** field enter the service end date, or to select a date from a calendar, click  .

Field	Description
Service Times area	If the fee code requires details on how long the service took to complete: 1. In the **Call Time** field, enter the time of day that the practitioner was called in. 2. In the **Start** field, enter the time of day that the service began. 3. In the **End** field, enter the time of day that the service ended. **Note:** Enter call, start, and end times without a colon (**:**), and using a 24 hour clock. For example, if a service started at 2:00pm, enter **1400**.
Referral Data area	If the fee code requires a referring practitioner: 1. In the **Referral Data** area, select the **Referred BY** check box. 2. In the **Referral Physician** area, in the **Search By** field, enter the practitioner's name or MSP number and then, in the **Physician Selected** drop-down list, select the practitioner's name. **Note:** If the patient has a referring practitioner or consultant entered in Patient Maintenance, and that practitioner is set as the Billing Default, the practitioner's name populates the **Physician Selected** field automatically. If the fee code requires the consultant you are referring the patient to (for example, for a no charge referral - **3333**): 1. In the **Referral Data** area, select the **Referred TO** check box. 2. In the **Referral Physician** area, in the **Search By** field, enter the consultant's name or MSP number and then, in the **Physician Selected** drop-down list, select the consultant's name. **Note:** When you create a referral for a patient, the EMR displays a dialog box with the following prompt: "Send Referral to MSP?". To create a no-charge referral bill for the patient, click **Yes**.
Notes	Enter any additional billing notes for MSP. For example, if you are billing for a delivery, you can enter information about the delivery. **Note:** If you add additional notes to the bill, MSP manually reviews the bill.
Correspondence mailed	If you are sending additional documents in relation to the claim (for example, an operative report), select this check box.

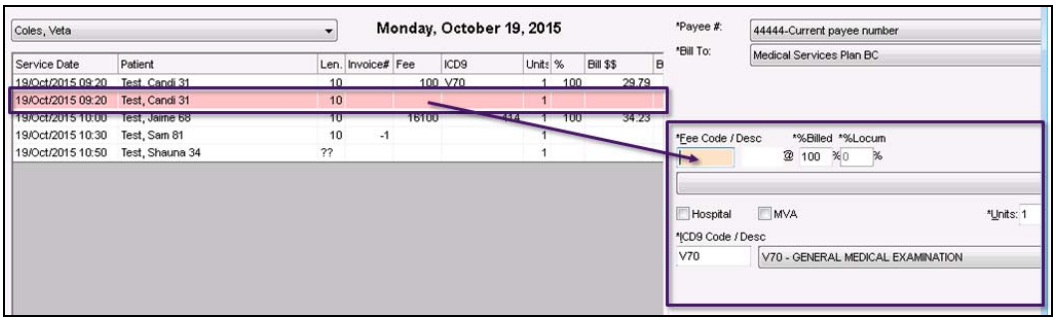
Field	Description
ICBC Claim Number	If the service is related to a motor vehicle accident, and you know the ICBC Claim Number, enter the claim number here. **Note:** If you do not know the ICBC Claim number, MSP will forward the claim to the adjudicator for payment.
Submission Code	If the Submission Code is any code other than **O Normal Submission**, in the drop-down list, select the code you want.

c) When you finish adding your detailed billing information, click **Close**.

3. Perform one of the following actions:

   - To include only the one fee code for this bill, click **Save**.
   - To add other fee codes to this bill:

     a) Click **Save+New**. The EMR inserts another billing list entry for the patient.



b) Enter the **Fee Code** and other billing information as required. See Step 5 and Step 6.

c) Repeat Step a and Step b for each additional fee code.

d) When you finish adding fee codes, click **Save**.

Adding multiple fees to one patient bill

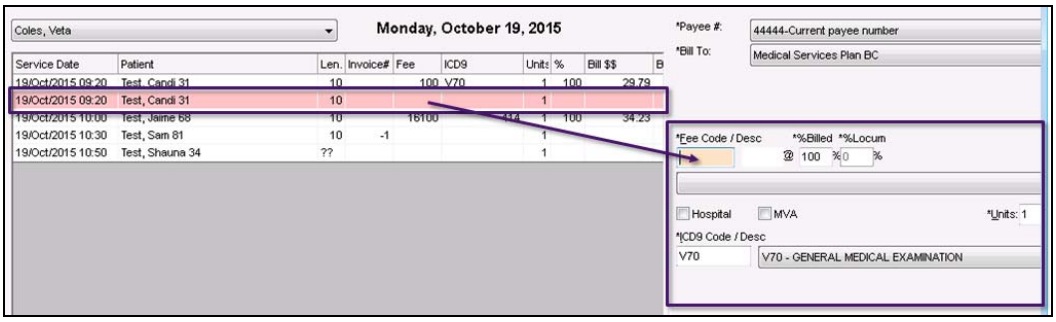
You can add multiple fee codes to one bill. For example, you can include fees for an office visit and a Pap smear on one bill. Each fee code you enter displays as a new line in the billing list with the same patient name.

To add multiple fee codes to a bill, after you enter information for the first fee code, click **Save+New**. If you click **Save** instead of **Save+New**, or if you later realize that you need to add an additional fee code to the bill, you can manually insert a new line to the billing list.

Steps

1. Open the Billing program, and then navigate to the billing list containing the bill. See Step 1 to Step 3 in "Creating a bill from the billing list" on page 11.

a) In the billing list, click the patient you want to add an additional fee code for and then, in the Billing menu, click **Edit** > **Insert Line After** (or press **Ctrl** + **I**). The EMR inserts another billing list entry for the patient and clears the bill entry area.



2. In the bill entry area, enter information for the fee code. See Step 5 to Step 6 in "Creating a bill from the billing list" on page 11.
3. Perform one of the following actions:
   - To finish the bill, click **Save**.
   - To add another fee code to the bill, click **Save+New**.

Creating a bill for a patient who is not in the billing list

Patients with booked appointments display automatically on the Billing window in the billing list. If the patient you want to bill does not have an appointment booked (for example, if you are billing for INR management), the patient's name is not on the billing list. In this case, you perform a search for the patient to bill.

If the patient is not yet in your system, you can add the patient directly from the Billing window.

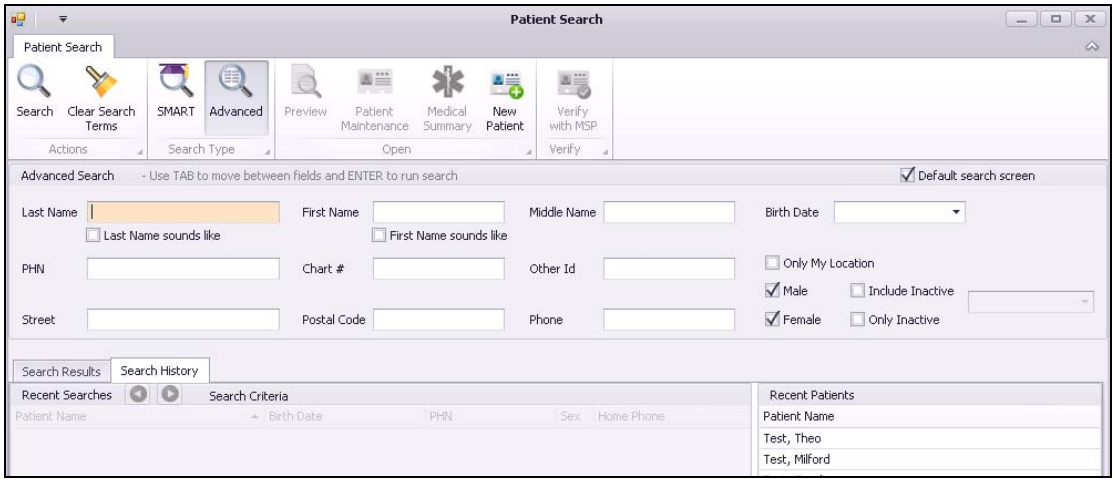
Steps

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** ( ). The EMR displays the Billing window.
2. In the practitioner drop-down list (located in the top left corner), click the patient's practitioner. The EMR displays the selected practitioner's billing list for today.

> **Note**: If you are the patient's practitioner, your name is populated by default.

3. If you are creating a bill for a service date other than today, click **Calendar**, and then click the service date.

4. Click **New Bill**. The EMR displays the Patient Search window.



5. In the **Advanced Search** area, enter your search criteria.

Tips for entering patient search criteria

- If you do not know how to spell a patient's last name, but want to use last name as a search criteria, select the **Last Name sounds like** check box. The EMR includes patients with similar last names (even if the names are spelled differently).
- To include patients who have a status of **Inactive**, select the **Include Inactive** check box.
- If you want to use a more simplified search window, click **SMART** ( ). SMART Search is a single text input search field that works similarly to a web search. When you enter your search criteria in the **Search for** field, the EMR searches the criteria throughout all fields of the patient records.

6. On the **Actions** menu bar, click **Search**, or press **Enter**. The EMR displays the search results in the **Search Results** tab.
7. Complete one of the following actions:
   - If the patient is listed in the **Search Results** area, double-click the patient.

Tip: From the Patient Search window, you can verify the patient's PHN with MSP.

In the list of search results, single-click the patient, and then click **Verify with MSP**.

- If the patient is not found, add the patient to the EMR, and then search for the patient once more:

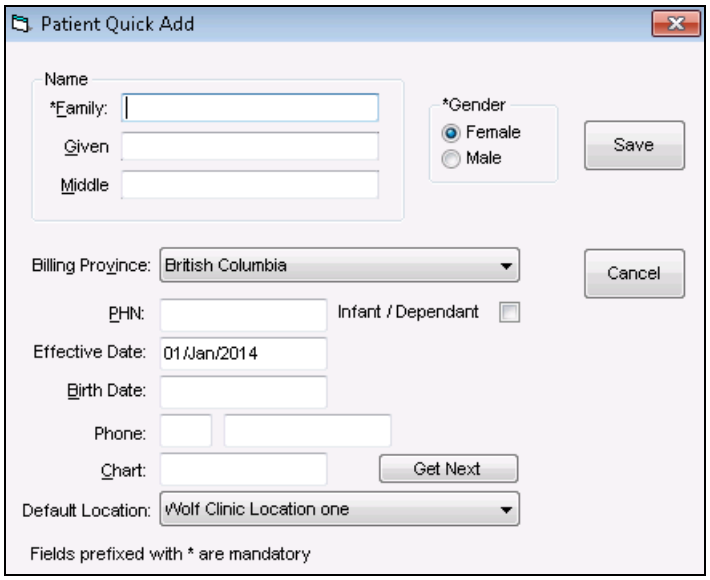
  a) At the top of the Patient Search window, click **New Patient** ( ). The EMR displays the Patient Maintenance window.

  b) Enter the patient's demographic information, including full name, billing province, provincial health number, date of birth, and gender.

  c) Click **Save** ( ), and then click **Close** ( ).

Tips for adding a patient

- To add a patient using a simplified entry window, at the top of the Billing window, click **Add Patient** ( ). The EMR displays the Patient Quick Add window.

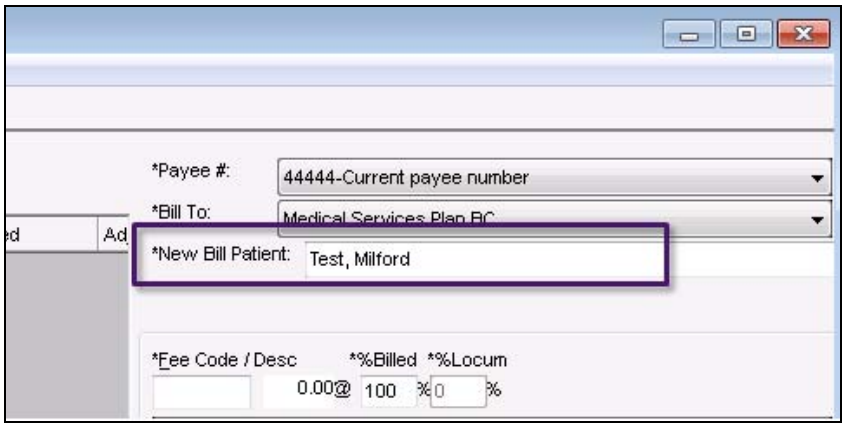


For detailed information on how to enter a patient's demographic information, see the Wolf EMR Front End Staff User Guide.

d) Search for the patient once more. See Step 4 to Step 6.

e) In the **Search Results** area, double-click the patient.

The EMR displays the patient's name in the **New Bill Patient** field.



Best Practice

After you select a patient, do not click the blank area in the left pane.

If you accidentally click on the blank area, the patient name will be lost and you will need to perform Step 4 and Step 7 again.

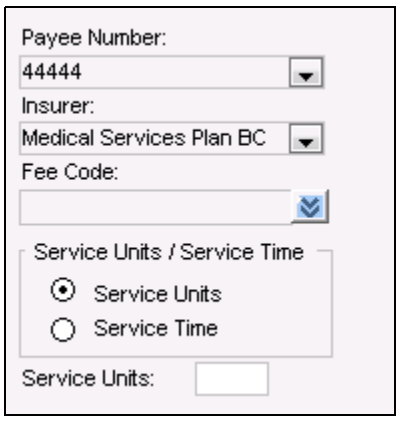
8. Complete and save the bill. See Step 5 to Step 3 in "Creating a bill from the billing list".

Entering bill information from a SOAP note (practitioners only)

If you are a practitioner, you can enter simple bill information from a SOAP note, including:

- Payee Number (if you have more than one Payee Number)
- One fee code
- Service units or service time

The billing area is located on the bottom right corner of the SOAP Note.



If you enter information in the billing area, when you complete and lock the SOAP note, the EMR adds the information to the patient's bill in the Billing program. From the Billing program, you or your billing clerk can modify the bill (for example, add additional fee codes) before saving the bill.

Steps

1. Create a SOAP note for the patient. For information on how to start a SOAP note, see the Wolf EMR Practitioner User Guide.
2. Assign an ICD9 problem code to the visit:
   a) In the **Assessment** field, enter an assessment or problem and then press **Enter**.
   b) In the results list, click a problem.

c) **(Optional)** In the **Qualifier** drop-down list, click a qualifier, if available. A Qualifier is any additional detail about the problem. For example, “Self Managed”.

d) Click **Add to Assessment** (

) to add the assessment to the Visit Record.

3. In the billing area (located on the bottom right of the SOAP note), enter information using the following table as a reference.

Field	Description
Payee Number	If you have more than one Payee number, in the drop-down list select the number you want to bill under. **Note:** Your default Payee number is populated by default.
Insurer	If you want to bill a party other than MSP, in the drop-down list, select the party.
Fee Code	In the field, begin to enter the fee code. As you enter the fee code, the EMR displays a drop-down list of matching fee codes. In the drop-down list, select the fee code you want. **Note:** The services available in the **Fee Code** drop-down list are determined by your clinic. If a fee code you require is not in the list, ask your administrator to add it to the list.
Service Units	To bill for more than one unit (for example, if more than one service was provided): 1. Select **Service Units**. 2. In the **Units** field, enter the number of units. **Note:** Depending on the insurer and service being billed, units can represent whatever you need to multiply the fee by (for example, days, or number of services).

Field	Description
Service Time	To enter a service start and end time: 1. Select **Service Time**. 2. In the **Service Start/End** fields, enter the time of day that the service started and ended. **Note:** Enter times without a colon (**:**), and use a 24 hour clock. For example, if a service started at 2:00pm, enter **1400**. **Note:** The EMR populates the start and end times in the Service Detail window for the bill.

3. When the SOAP form is complete, click **Lock Form** () to save and lock the note. The EMR displays a dialog box with the following prompt: "Lock this record?"
4. Click **Yes**. The bill entry appears in the billing list in the Billing program.
5. In the Billing program, review the bill information and then save the bill. See "Creating a bill from the billing list" on page 11.

Tip: Opening the Billing window from a SOAP Note

If you are entering visit notes for a patient, you can quickly open the Billing window and create a more detailed bill for the patient:

If you have a SOAP note or the Medical Summary open for the patient, on your keyboard, press **Ctrl** + **Shift** + **$**. The EMR opens the Billing window with a bill started for the patient.

Verifying that all appointments have been billed

You can ensure that all appointments have been billed by using the **Incomplete Billing** view. For each practitioner, you can produce a list of appointments that have not yet been billed for. You can then finish and save the bills from the list.

Best Practice

Perform a search for un-billed appointments daily.

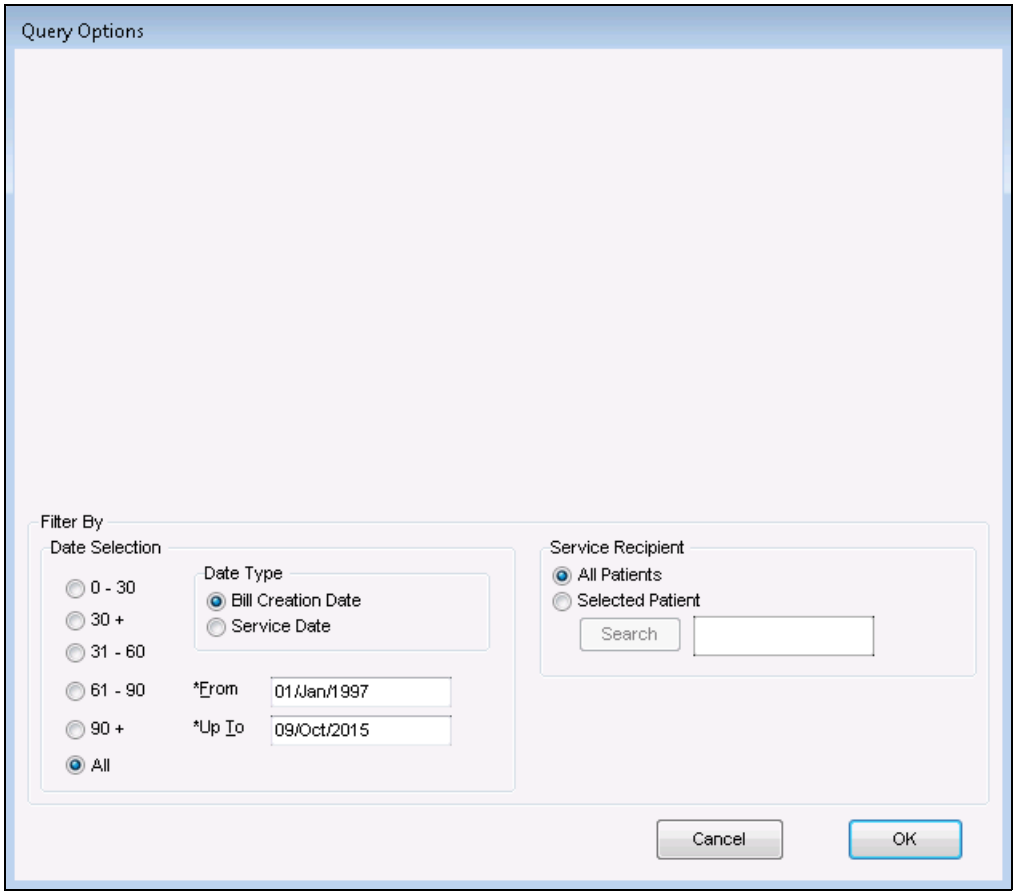
Note: You cannot print the list of appointments without bills.

Steps

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** ( ). The EMR displays the Billing window.
2. In the practitioner drop-down list (located in the top left corner), click the practitioner you want to view missing bills for.

Note: If you are the patient's practitioner, your name is populated by default.

3. On the Billing menu, click **View** > **Incomplete Billing**. The EMR displays the Query Options window.



4. In the **Date Selection** area, perform one of the following actions:
   - Click a date range option. For example, to view missing bills for the past 30 days, select **0 - 30**.

> **Best Practice:**
>
> Select a **Date Selection** of **All**, which produces a list of all appointments with missing bills in the system (with no date range).

   - In the **From** and **Up To** fields, enter a date range by entering a start and end date.
5. In the **Date Type** area, select one of the following options:
   - **Bill Creation Date**: To filter the missing bills by date ranges based on bill creation dates.
   - **Service Date**: To filter the missing bills by date ranges based on bill service dates.
6. If you want to view missing bills for only one patient, in the **Service Recipient** area, select **Selected Patient**, and then click **Search**.
7. Click **OK**. In the Billing List area, the EMR displays any appointments that were not billed. From this list, you can bill the appointments as needed. See "Creating a bill from the billing list" on page 11.

Editing bills before they are sent to the province

> **Note**:
>
> - You can edit MSP Bills that have not been sent via eBill or Private and Third Party bills that have not received payments.
> - **You cannot edit MSP Bills once an eBill submission has been created**. Instead, you must wait until you receive a remittance file. See "Billing reconciliation" on page 67.

You may need to edit a bill after it is created. For example, you may have entered the wrong fee code, or missed information. You can edit the bill before you create an eBill claims submission.

Steps

1. In the practitioner drop-down list, select the practitioner who provided the service.
2. Click **Calendar** and then, in the calendar, select the service date. The EMR displays the billing list for that date.
3. In the billing list, click the bill you want to edit.

4. Edit or enter the bill's information as needed (for example **Bill to**, **Fee Code**, **ICD9 Code**).
5. Click **Save**. The EMR overwrites the bill with the updated information.

Deleting bills

If you create a bill in error, you can delete the bill as long as it has not been sent to the ministry.

Steps

1. In the practitioner drop-down list, select the practitioner who provided the service.
2. Click **Calendar** and then, on the calendar, select the service date. The EMR displays the billing list for the selected date.
3. In the billing list, click the bill you want to delete.
4. On the Billing menu, click **File > Delete Bill** or, on your keyboard, press **Ctrl** + **D**. The EMR displays the following prompt: "Are you sure you want to delete this bill/invoice?".
5. Click **Yes**.

Sending claims to Medical Services Plan

After you create and save your bills in the Billing program, you use the eBill program to create and send your provincial submission file to MSP.

Best Practices:

- Submit your claims to MSP at least once a week.
- Submit your claims to Teleplan prior to 7:00pm on the Close-Off Dates. For information on Close-Off Dates, see MSP Designated Holidays and Close-Off Dates.
- Before each submission, check for any appointments that have not been billed. See "Verifying that all appointments have been billed" on page 28.

Note:

- Claims are processed within 30 days, with a majority being paid within 14 days.
- Remittance reports are sent and Payments are made every two weeks (at the middle and end of each month).

Note: The amount of time it takes for Teleplan to process and pay your claims varies, and depends on the timing of your submissions and the complexity of the claims.

Teleplan password

Your Teleplan password must be changed every 42 days. To ensure that your Teleplan password does not expire, reset your password on the same day of every month from your EMR:

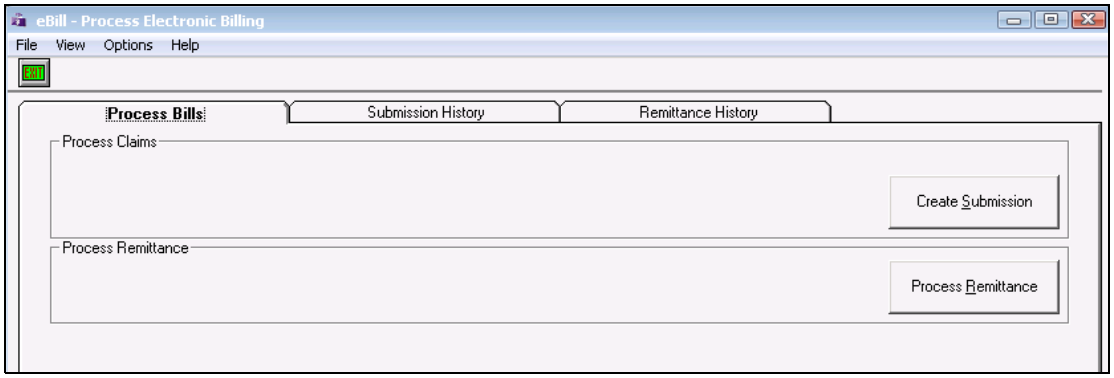
- On the eBill menu, click **Options** > **Change Internet Password**. The EMR displays the Password Change window.

Note: If you let your Teleplan password expire, you must have your password reset. Complete one of the following actions:

- Call the Teleplan support line: **604-456-6950** ext.**3**, ext.**2**
- Go to the Teleplan website: https://teleplan.hnet.bc.ca
  Your Username is **ttut####** (where #### = your data center #)

Steps

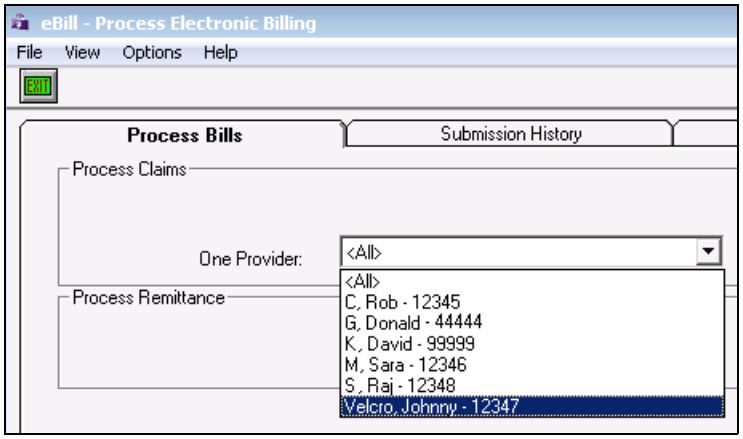
1. Open the eBill program: On the Wolf EMR Launch page, click **eBill** ( ). The EMR displays the eBill - Process Electronic Billing window with the **Process Bills** tab open.



Tip for multi-location clinics:

You can choose to send bills for only one practitioner:

1. On the eBill menu, click **Options** > **Specify Submission Service Provider**. The EMR displays the **One Provider** drop-down list in the **Process Claims** area.
2. In the **One Provider** drop-down list, click a practitioner's name. The EMR will send bills for only this practitioner to MSP.



If this is your first time submitting a claim to MSP through Teleplan

You must set the sending mechanism to "Use Internet" (if it is not selected already):

- On the eBill menu, click **Options** > **Use Internet (NOT Teleplan)**.

2. In the **Process Claims** area, click **Create Submission**.

   A progress bar indicates the progress of the submission process. When complete, the EMR displays a dialog box stating the number of files uploaded and the number of files downloaded.

3. Click **OK**. If a remittance file is downloaded it will start processing. When finished, the EMR displays the following message: "1 Remittance processed."
4. Click **OK**.

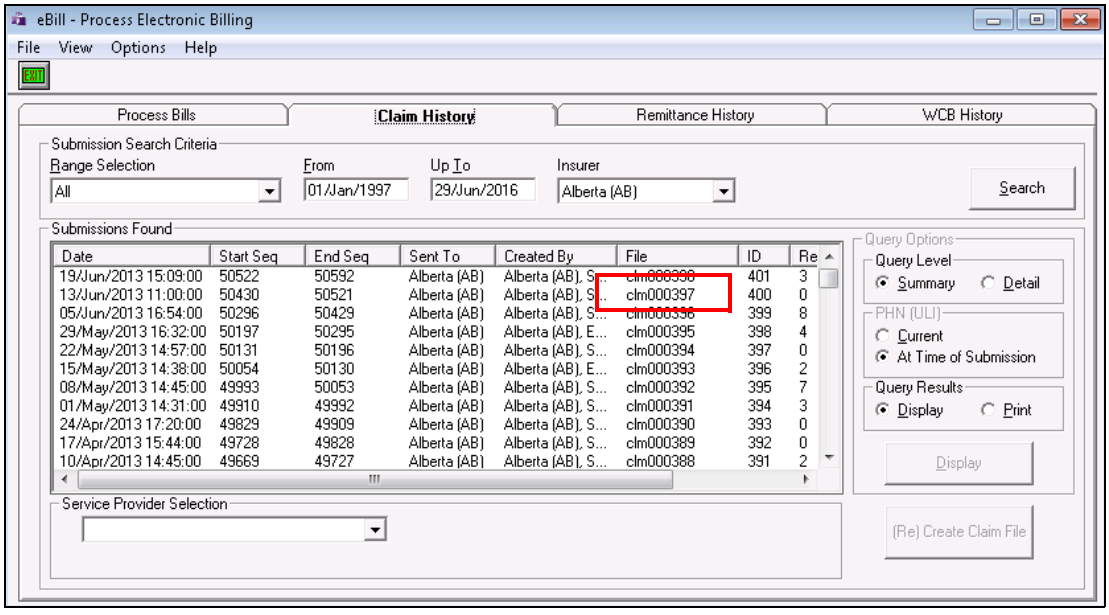
Verifying that received your claims

After you submit claims to Alberta Health you can verify that your claims were received by viewing the Batch Balance report.

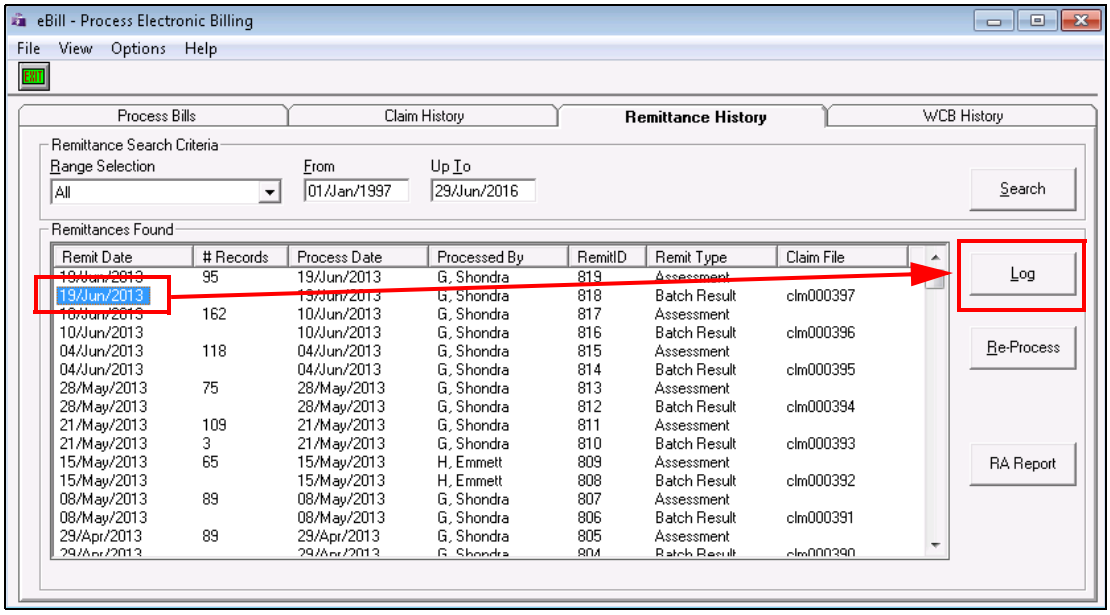
Note: **Batch Balance reports** (also known as BB files) are confirmations from Alberta Health that they received your claims files and will process them for payment. For every claims file that Alberta Health receives, they will send you a corresponding Batch Balance report.

Steps

1. Open the eBill program: On the Wolf EMR launch page, click **eBill** ( ). The EMR opens the eBill - Process Electronic Billing window.
2. On the **Process Bills** tab, click **Process Remittance**.
3. The EMR imports your Batch Balance reports and remittance files from AHC and displays a dialog box indicating the number of files downloaded
4. Click **OK**.
5. Identify the claim number you want to view a Batch Balance report for: Click the **Claim History** tab. The EMR displays a list of claims sent by your clinic, with the **File** column containing the corresponding claim numbers.

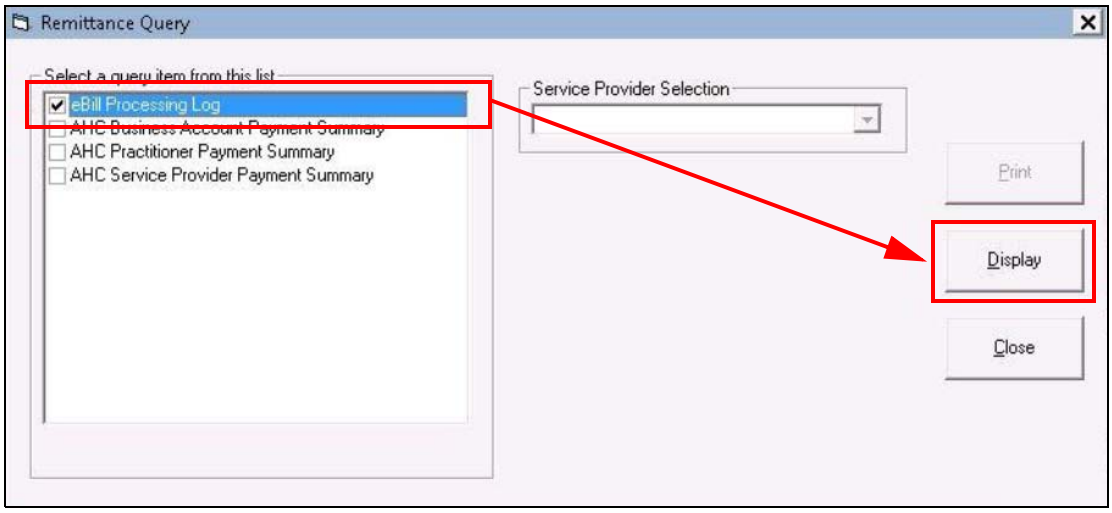


6. Click the **Remittance History** tab. The EMR displays a list of Batch Balance reports and Assessment Results reports received by your clinic.
7. Find the listed Batch Balance report for the claim number you identified in Step 5, click the report's **Remit Date**, and then click Log.

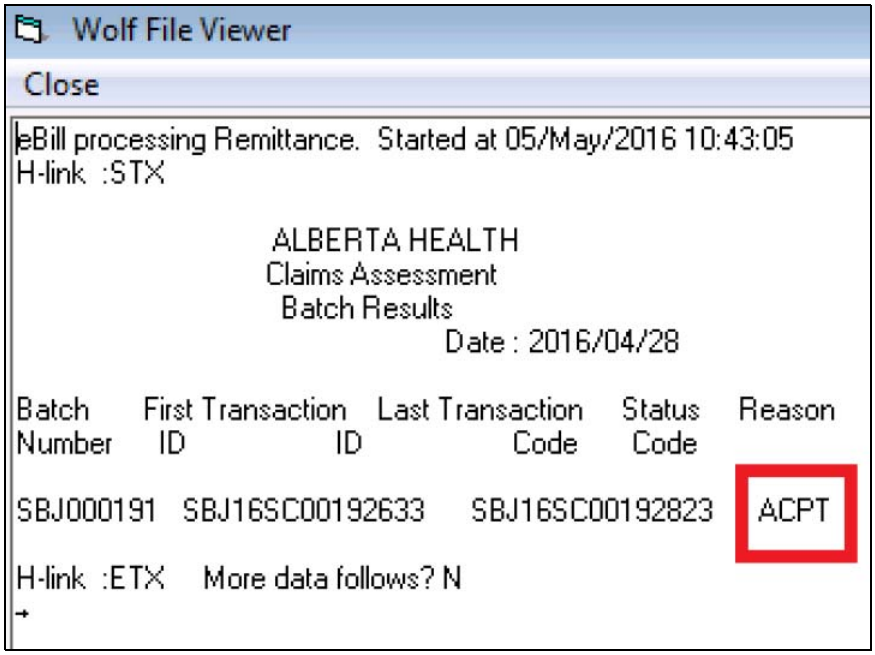


The EMR opens the Remittance Query window.

8. Select the **eBill Processing Log** check box, and then click **Display**.



The EMR displays the Batch Balance report.



Tip: If the **Reason** code is **ACPT**, this indicates that the claims file was received and accepted for payment.

Chapter 3

Patient billing

You bill patients similar to how you bill the province or bill patients.

When you save patient bills, you are automatically prompted to enter payment information for the bill. If the patient will be paying at a later time, you can enter payment information when you receive payment.

If you enter the wrong payment information, you can reverse the payment. If you determine that you will not receive payment for a bill, you can write-off a bill.

Creating a bill for a patient

You start bills for patients similar to how you start bills for MSP. You can start a patient bill:

- From the billing list. See "Creating a bill from the billing list" on page 11.
- For a patient who is not on the billing list. See "Creating a bill for a patient who is not in the billing list" on page 22.
- From a SOAP note. See "Entering bill information from a SOAP note (practitioners only)" on page 26.

The following section describes how to bill a patient who is not on the billing list.

Steps

1. On the Wolf EMR Launch page, click **Billing** (). The EMR displays the Billing window.
2. In the practitioner drop-down list (located in the top left corner), click a practitioner.

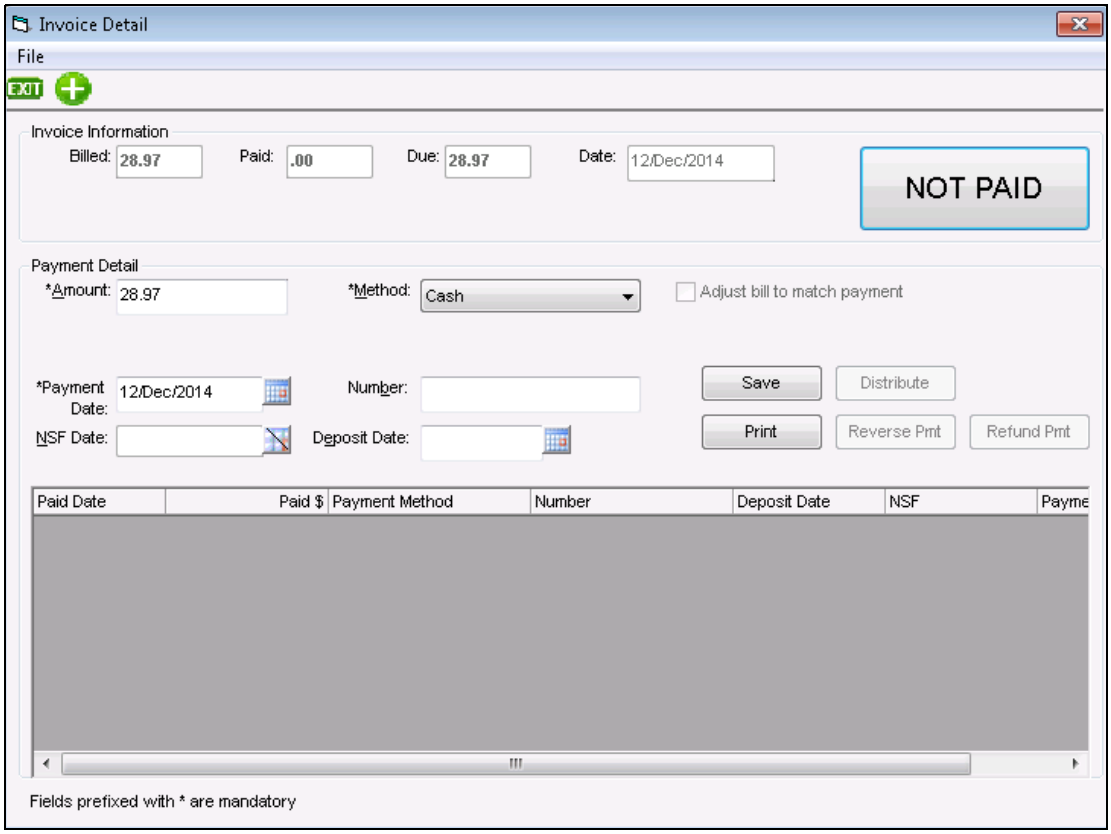
Note: If you are the patient's practitioner, your name is populated by default.

3. If you are creating a bill for a day other than today, click **Calendar**, and then click the Service Date.
4. Click **New Bill**. The EMR displays the Patient Search window.

5. Search for the patient and then double-click the patient's name. The EMR displays the patient's name in the **New Bill Patient** field.
6. Enter bill details similar to how you would for an MSP bill. See Step 5and Step 6in "Creating a bill from the billing list" on page 11. The following table outlines exceptions for bills to patients.

Field	Description
Bill To	In the **Bill To** drop-down list, select **Patient**.
Fee Code/Desc	1. In the **Fee Code/Desc** field, enter the fee code or service description, and then press **Enter**. 2. In the drop-down list below, click a fee code. **Note:** Before you can bill for a service, the service must be entered in Wolf EMR as a fee code. You typically create custom fee codes for services and products you charge to patients. See "Managing service fee codes and fee schedules" on page 175.
Units	Enter the number of services performed or products provided. For example, if the service fee is for vitamins, and the patient is purchasing 3 containers of vitamins, in the **Units** field, enter **3**. The EMR multiplies the Rate by the number of **Units** and displays the total billed amount in the **Bill $$** column in the billing list.
Rate (field to the right of Fee Code/Desc)	If you want to charge a different rate than the default, in the Rate field, modify the amount.

3. Click **Save**. The EMR displays the following prompt: "Are all services entered for this bill?"
4. Perform one of the following actions:
   - If all services are entered for this bill, click **Yes**. The EMR displays the Invoice Detail window.
   - To add more services to the bill, click **No**. The EMR inserts another line into the original bill to allow you to add a second item to same invoice. Repeat Step and Step 3.
5. In the Invoice Detail window, perform one of the following actions:
   - If the patient has paid all or part of the bill at the time of the visit, enter payment information, and then close the window. See "Recording a payment to a patient bill" on page 40.
   - If the patient has not paid the bill, click **NOT PAID**. You can take a payment at a later time and record it in the EMR. See "Recording a payment to a patient bill" on page 40.



The EMR displays a prompt asking if you would like to print the invoice.

6. Perform one of the following actions:

   - If you want to print the invoice or receipt, click **Yes**.
     Note: Another way to print an invoice is to click the bill in the Billing list, and then on the Billing menu click **File > Print Invoice**.
   - If you do not want to print the invoice or receipt, click **No**.

Tip: If you want to print the invoice at a later time, you can print the invoice from the billing list. In the billing list, click the bill, and then on the Billing menu click **File** > **Print Invoice**.

Tip: Customizing patient invoices

For patient invoices, you can customize:

- What information displays on invoice letterheads
- Messages or notes that display on the bottom of invoices

See "Setting invoice preferences" on page 207.

For an individual patient's invoices you can add a customized note. See "Creating personalized notes for patient invoices" on page 45.

Recording a payment to a patient bill

If you do not receive complete payment at the time you bill a patient (for example, if you bill a patient for missing an appointment and send the bill by mail), you can record a partial or complete payment at a later time when you receive payment.

It is important that you always record a payment as soon as you receive it because the EMR cannot report which bills were paid and or not paid unless you record them in the system.

Steps

1. Open the Patient Maintenance window for the patient:

   a) On the Wolf EMR Launch page, click **Scheduling** ( ).

   b) In the **Patient Search** area, in the **Family Name /Portion** field, enter the patient's last name, and then on your keyboard press **Enter**. Your cursor moves to the **Given** (first name) field.

   c) In the **Given** field, enter the patient's first name, and then on your keyboard press **Enter**.

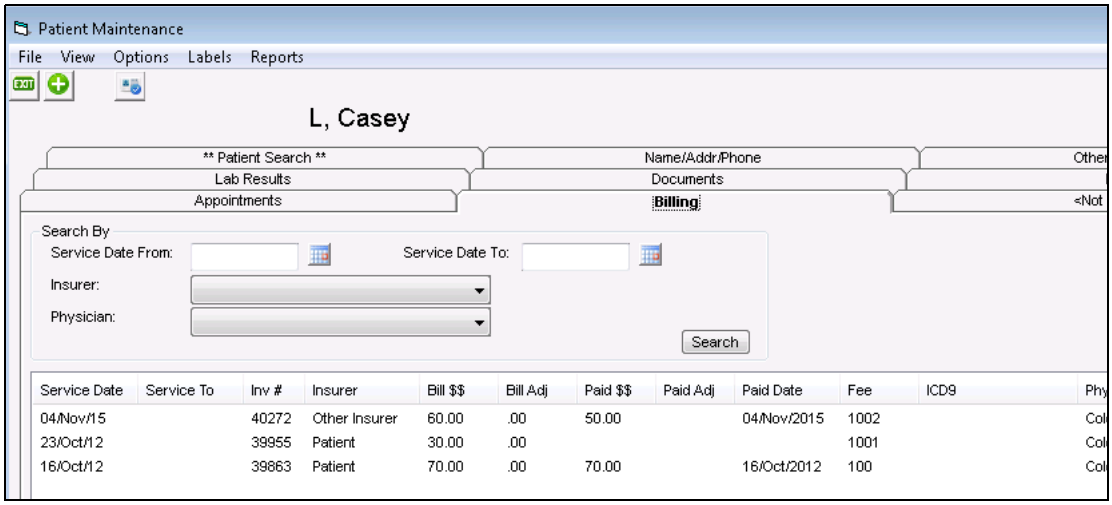
   d) In the search results list, click the patient name, and then, on your keyboard, press **F9**. The EMR displays the Patient Maintenance window.

Tip: You can also access the Patient Maintenance window from your WorkDesk and from Billing:

- **Workdesk**: On your WorkDesk, click **Demographics**.
- **Billing**: On the Billing menu, click **View > Patient Maintenance**.

The EMR displays the Patient Search window.
Search for the patient and then double-click the patient's name.

2. Click the **Billing** tab. The **Billing** tab displays a list of bills created for the patient.

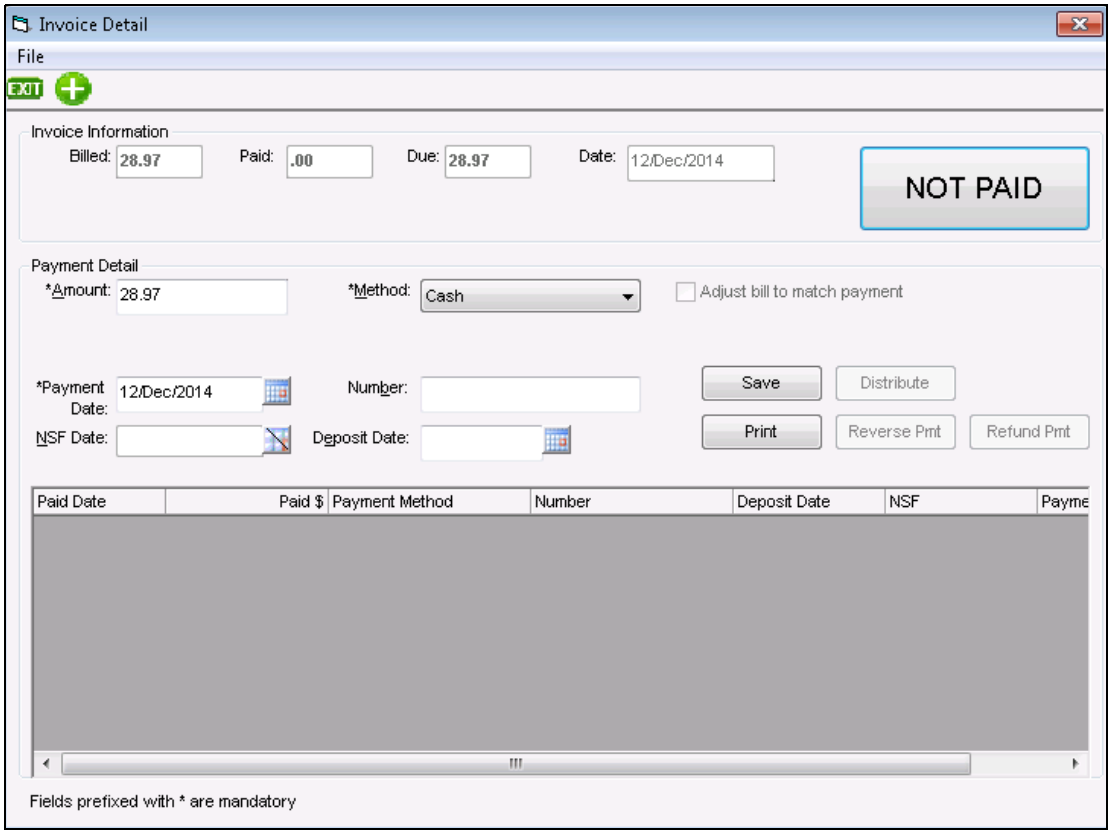


3. Click the service date of the bill to which you want to record a payment.

Tip: If the patient's list of bills is long, and you are having trouble finding the bill, filter the list to display only bills to the patient:

1. In the **Search By** area, in the **Insurer** drop-down list, select **Patient**.
2. Click **Search**.

3. On the Patient Maintenance menu, click **View > Invoice Payment** or, on your keyboard, press **Ctrl** + **P**. The EMR opens The Invoice Detail window.



4. Using the following table, enter payment information.

Field	Description
***Amount**	Ensure the payment amount is correct. If you are entering a partial payment, enter the actual paid amount.
Method	In the drop-down list, select the method of payment. If the method of payment is a cheque, in the **Number** field, you can enter the cheque number for reference.
Payment Date	Enter the date that payment was received, or to select a date from a calendar, click .
Number	If the method of payment is cheque, enter the cheque number.
NSF Date	If you cash the cheque and the cheque is rejected due to insufficient funds, in the **NSF Date** field, enter the date of the rejection, or click to select a date from a calendar.

Field	Description
Deposit Date	Enter the date that the payment was deposited to your bank account, or click  to select a date from a calendar.

5. Click **Save**. The EMR displays the payment in the lower pane of the Invoice Detail window.
6. To print a receipt:
   a) Click **Print**. The EMR displays Print Report window
   b) In the **Copies** field, enter number of copies to print, and then click **Print**.
7. Click **Exit**. The EMR displays the payment in the **Paid$$** column in the billing list.
8. If you received only a partial payment for the bill, but you want to mark the bill as complete (that is, you want to accept the bill as fully paid), write-off the remainder of the billed amount. See "Writing off a patient bill" on page 44.

Reversing a payment

You can reverse a payment to an invoice if a payment was posted against an invoice in error. You reverse a payment from the patient's Invoice Detail window, which you can access from the Billing program, or from the **Billing** tab on the Patient Maintenance window.

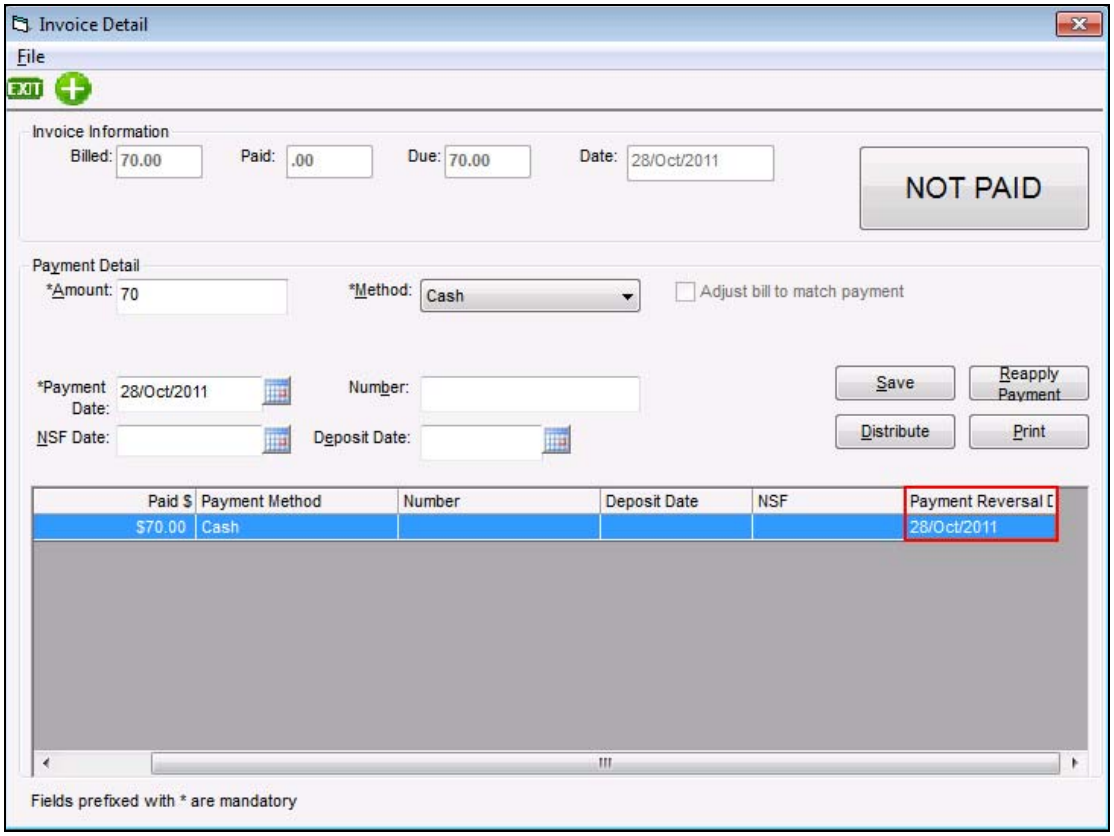
Note: You can reverse a payment only if a deposit has **NOT** been recorded for that bill. If the deposit has been done, you must **refund** the payment.

Steps

1. Perform one of the following actions:
   - If you know the date that the patient was billed, open the Billing program, and then view the billing list for the billed date. See "Viewing the billing list" on page 2.
   - If you do not know the date that the patient was billed, open the Patient Maintenance window, and then click the **Billing** tab. See Step 1 and Step 2 in "Recording a payment to a patient bill" on page 40.
2. Click the bill you want to reverse a payment for.
3. Perform one of the following actions:
   - If you are in the Billing program: On the Billing menu click **File > Enter Invoice Payment** or, on your keyboard, press **Ctrl** + **P**.
   - If you are on the **Billing** tab of the Patient Maintenance window: On the Patient Maintenance menu, click **View** > **Invoice Payment** or, on your keyboard, press **Ctrl** +**P**.

The EMR displays the Invoice Detail window.

4. In the lower pane of the Invoice Detail window, click the payment you want to reverse.
5. Click **Reverse Pmt**. The EMR displays the following prompt: "Are you sure you wish to reverse this payment?"
6. Click **Yes**. If you scroll to the right of the payment row, the **Payment Reversal Date** is displayed for the payment.



7. Click **Exit**.

Writing off a patient bill

You write-off a patient bill if:

- You know you will not receive payment for the bill.
- You receive only a partial payment for a bill, but you want to mark the bill as complete (that is, you want to accept the bill as fully paid).
- You created the bill in error. For example, you created the bill for the wrong patient.

When you write-off a partially paid bill, the EMR notes the unpaid portion as written-off.

Steps

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** (). The EMR displays the Billing window.
2. Search for all outstanding patient bills. See "Searching for unpaid and partially paid patient bills" on page 86.
3.
   -
4. In the list of outstanding patient bills, click the bill you want to write-off and then, on the Billing menu, click **File > Write Off**.
5. Click one of the following options:
   - **This Invoice**: To write-off only the selected bill.
   - **All Bills on Screen**: To write-off all bills currently displayed in the billing window.
6. Click **Yes**.
7. In the WriteOff Reason window, select one of the following options:
   - **Uncollectible**: If you know you will not receive payment for the outstanding bill amount.
   - **Mistake**: If there was an error on the bill or if the bill was created in error.

   The EMR writes off the bill(s), and displays the word **WriteOff** in the **Remitted** column of the billing list.

Creating personalized notes for patient invoices

You can create a personalized note that displays on all invoices printed for a particular patient. You enter the personalized note in Patient Maintenance.

Steps

1. Open the Patient Maintenance window for the patient.

> **Tip**: If you are viewing the Billing window, and the patient is listed in the billing area, you can quickly open the Patient Maintenance window:
>
> - Click the patient's name and then, on your keyboard, press **F9**.

2. Click the **Notes** tab.

3. In the **Active Notes** area, in the **Print on each invoice for this patient** field, enter the invoice note.

4. Click **Save** () and then click **Exit**.

Chapter 4

Third-party billing

You bill third parties similar to how you bill the province or bill patients. When you create a third-party bill, you select the name of the company or person you want to bill to. If the third party is not yet listed in your system, you can add the third-party directly from the bill.

When you save third-party bills, you are prompted to enter payment information for the bill. If the third-party will be paying at a later time, you can enter payment information when you receive payment.

If you enter the wrong payment information, you can reverse the payment. If you determine that you will not receive payment for a bill, you can write-off a bill.

Creating a bill for a third-party

You start bills for third-parties similar to how you start bills for MSP. You can start a third-party bill:

- From the billing list. See "Creating a bill from the billing list" on page 11.
- For a patient who is not on the billing list. See "Creating a bill for a patient who is not in the billing list" on page 22.
- From a SOAP note. See "Entering bill information from a SOAP note (practitioners only)" on page 26.

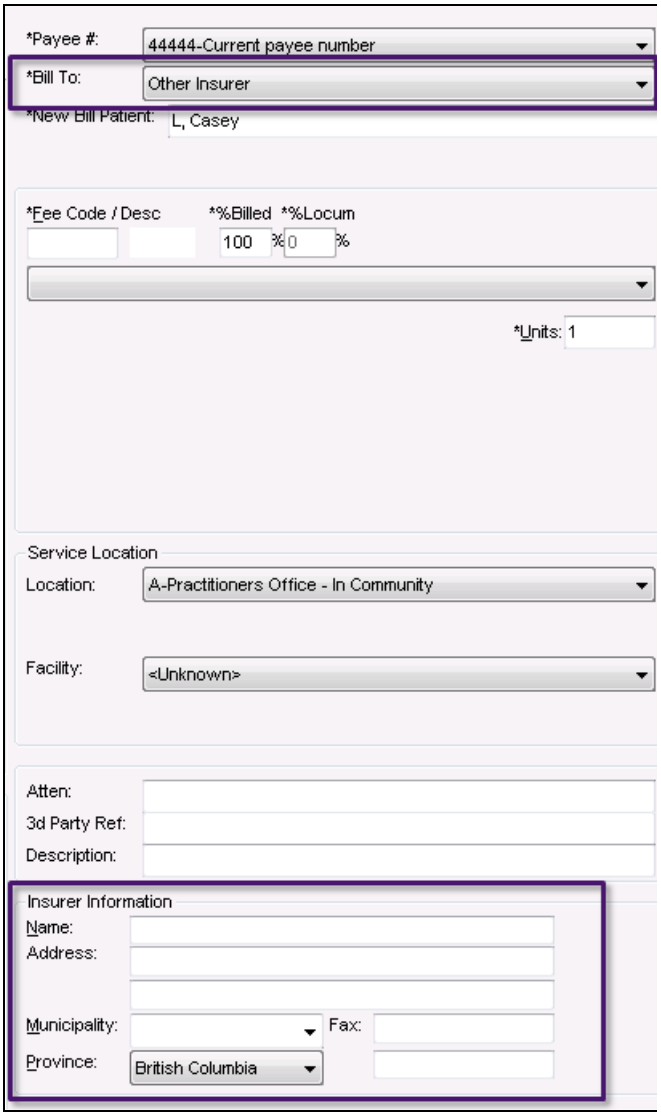
The following section describes how to create a third-party bill for a patient who is not on the billing list.

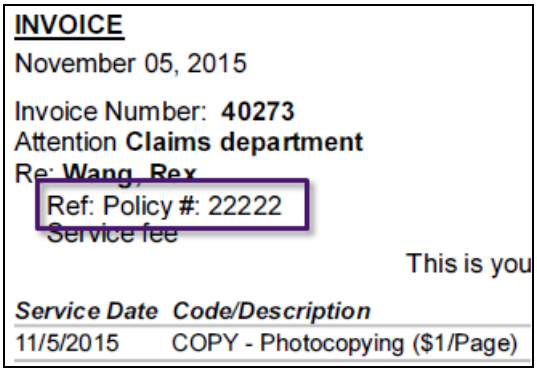
Steps

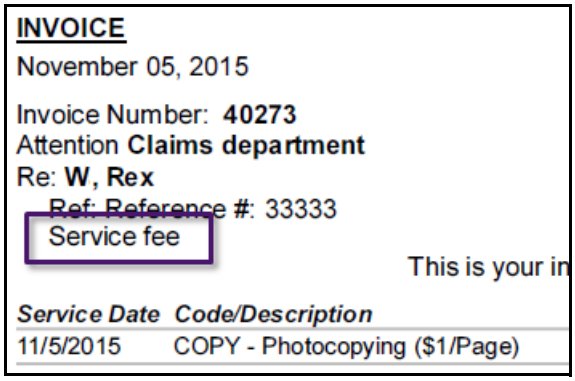
1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** (). The EMR displays the Billing window.
2. In the practitioner drop-down list (located in the top left corner), click a practitioner.

Note: If you are the patient's practitioner, this step is unnecessary; your name is selected in the drop-down list by default.

3. If you are creating a bill for a day other than today, click **Calendar**, and then click the Service Date.
4. Click **New Bill**. The EMR displays the Patient Search window.
5. Search for the patient and then double-click the patient's name. The EMR displays the patient's name in the **New Bill Patient** field.
6. Enter bill details similar to how you would for an MSP bill. See Step 5and Step 6in "Creating a bill from the billing list" on page 11. The following table outlines exceptions for third-party bills.

Field	Description
Bill To	■ In the **Bill To** drop-down list, select the third-party. ■ If the third-party is not in the list, click **Other Insurer** and then, in the **Insurer Information** area, enter the insurer's **Name**, **Address**, **City**, **Province**, and **Fax Number**. 

Field	Description
Fee Code/Desc	1. In the **Fee Code/Desc** field, enter the fee code or service description, and then press **Enter**. 2. In the drop-down list below, click a fee code. **Note:** Before you can bill for a service, the service must be entered in Wolf EMR as a fee code. You typically create custom fee codes for third-party bills. See "Managing service fee codes and fee schedules" on page 175.
Units	Enter the number of services performed or products provided. For example, if the service fee is for photocopying, and you photocopied three pages, in the **Units** field, enter **3**. The EMR multiplies the Rate by the number of **Units** and displays the total billed amount in the **Bill $$** column in the billing list.
Rate (field to the right of **Fee Code/Desc**)	If you want to charge a different rate than the default, in the **Rate** field, modify the amount.
Atten	To address the invoice to a specific department or person, enter the name of the department or individual. **Note:** When you add or modify an insurer you can enter a default name for this field. See "Adding and modifying third-parties (insurers) you bill to" on page 202.
3d Party Ref	If the third-party requires that you include a reference number or description (for example, the patient's policy number or claim number), enter the reference here. The reference you enter displays on the invoice below the **Re** line. 

Field	Description
Description	Enter any additional information required by the third-party. For example, a description of the service, or an indication that "Medical Legal Letter Enclosed as per MVA Jan 1, 2015". The description you enter displays on the invoice below the **Re** line.  **INVOICE** November 05, 2015 Invoice Number: **40273** Attention **Claims department** Re: **W, Rex** Ref: Reference #: 33333 Service fee This is your in *Service Date* *Code/Description* 11/5/2015 COPY - Photocopying ($1/Page)

Tip for billing ICBC

In the **Bill To** drop-down list, avoid selecting the generic **ICBC** insurer. Instead, create customized ICBC insurers for each location you bill to (for example, **ICBC_Richmond**), and then select the appropriate location for each bill. This way you can track what bills were sent to and are outstanding from each location.

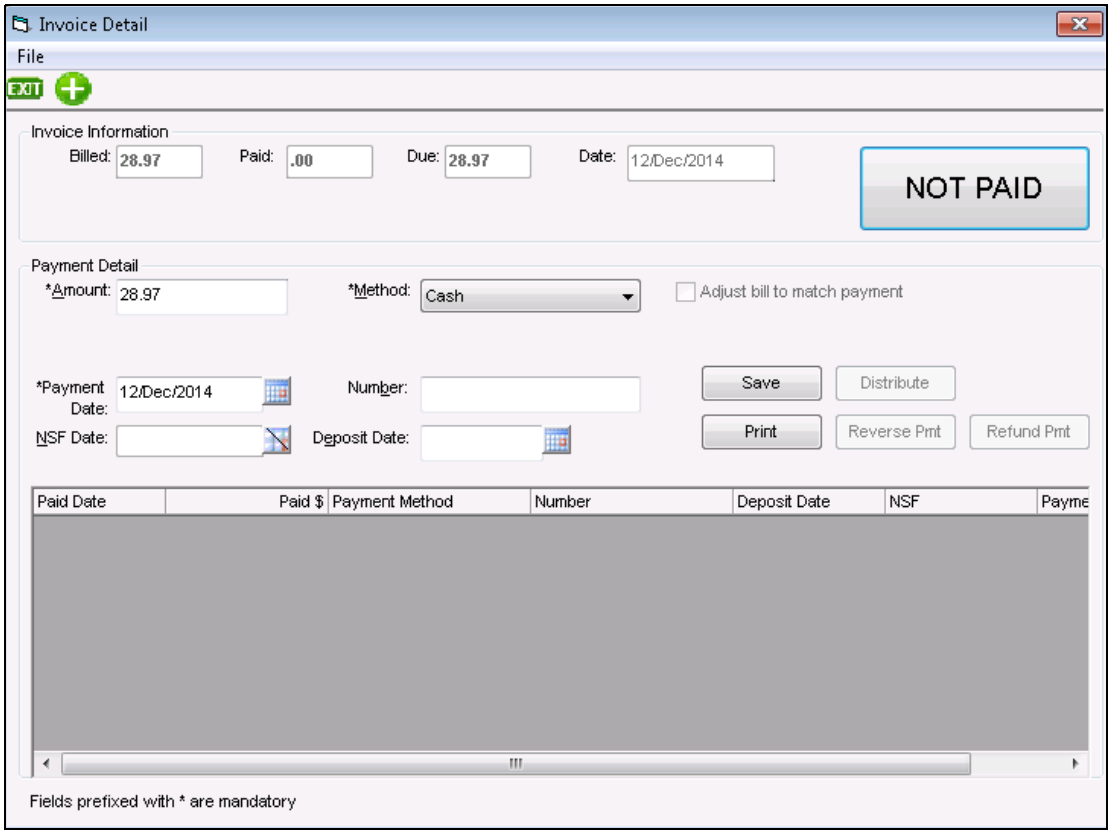
3. Click **Save**.

Note: If you entered information for a new insurer, when you save the bill, the EMR displays the prompt - "Add <insurer name> to Database?". Click **Yes**. The EMR saves the insurer in the database.

When you later create invoices, you can select this insurer from the **Bill To** drop-down list. You can also modify the insurer's information and billing details as needed. See "Adding and modifying third-parties (insurers) you bill to" on page 202.

The EMR displays the following prompt: "Are all services entered for this bill?"

4. Perform one of the following actions:
   - To add more services to the bill, click **No**. The system inserts another line into the original bill to allow you to add a second item to same invoice. Repeat Step 6 to Step 3.
   - If all services are entered for this bill, click **Yes**. The EMR displays the Invoice Detail window.



5. In the Invoice Detail window, perform one of the following actions:

   - If you have received payment for the bill, enter the payment details. See Step 4 to Step 8in "Recording a payment for a third-party bill (when you have the patient's name)" on page 53.
   - If you have not received payment, click **NOT PAID**. You record the payment in the EMR at a later time. See "Recording payments for third-party bills" on page 53.

   The EMR displays a prompt asking if you want to print the invoice.

6. To print the invoice, click **Yes**.

> **Tip**: If you want to print the invoice at a later time, you can print the invoice from the billing list. In the billing list, click the bill, and then on the Billing menu click **File** > **Print Invoice**.

Tip: Customizing third-party invoices

For each third-party insurer, you can customize:

- Information displayed on invoice letterheads
- Messages or notes that display on the bottom of invoices

See "Setting invoice preferences" on page 207.

Recording payments for third-party bills

Best Practice:

Record payments as soon as you receive them.

When you receive a payment record the payment in the Invoice Detail window. This is an important practice to establish because the EMR cannot track which bills were paid or not paid unless you record payments accurately.

The method you use to record payment to a third-party invoice depends on the information that came with the payment:

- If the third party included the patients name with the payment information, access the Invoice Detail window via the **Patient Maintenance window**. See "Recording a payment for a third-party bill (when you have the patient's name)" on page 53.
- If the third party included only the invoice number with the payment information, access the Invoice Detail window via the Billing program. See "Recording a payment for a third-party bill (when you have only the invoice number)" on page 56.

Recording a payment for a third-party bill (when you have the patient's name)

If the third party includes the patient's name with payment information, you can record the payment via the Patient Maintenance window.

Steps

1. Open the Patient Maintenance window for the patient:

   a) On the Wolf EMR Launch page, click **Scheduling** ( ).

   b) In the **Patient Search** area, in the **Family Name /Portion** field, enter the patient's last name, and then on your keyboard press **Enter**. Your cursor moves to the **Given** (first name) field.

c) In the **Given** field, enter the patient's first name, and then on your keyboard press **Enter**.

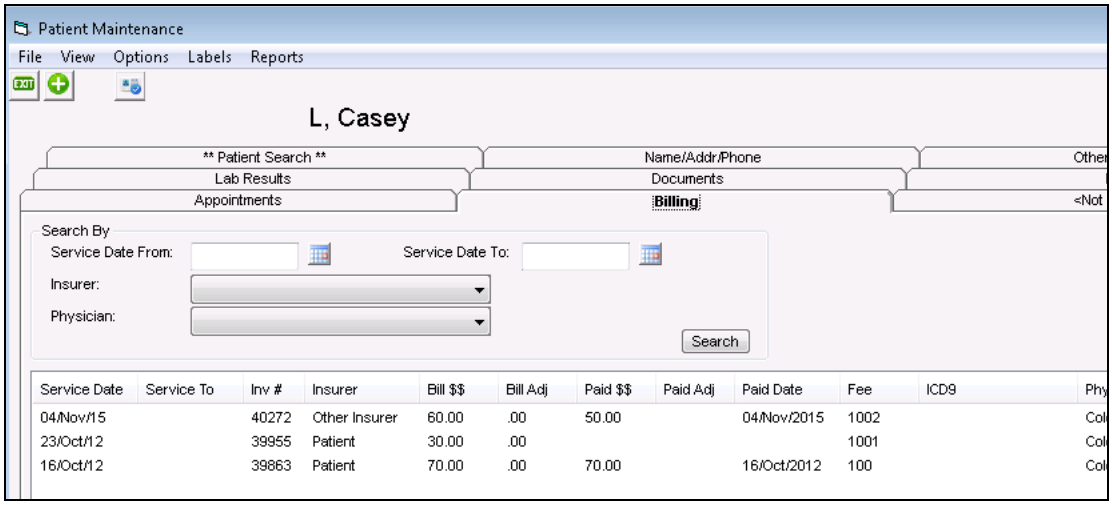
d) In the search results list, click the patient name, and then, on your keyboard, press **F9**. The EMR displays the Patient Maintenance window.

Tip: You can also access the Patient Maintenance window from your WorkDesk and from Billing:

- **Workdesk**: On your WorkDesk, click **Demographics**.
- **Billing**: On the Billing menu, click **View** > **Patient Maintenance**.

The EMR displays the Patient Search window.
Search for the patient and then double-click the patient's name.

2. Click the **Billing** tab. The **Billing** tab displays a list of bills created for the patient.

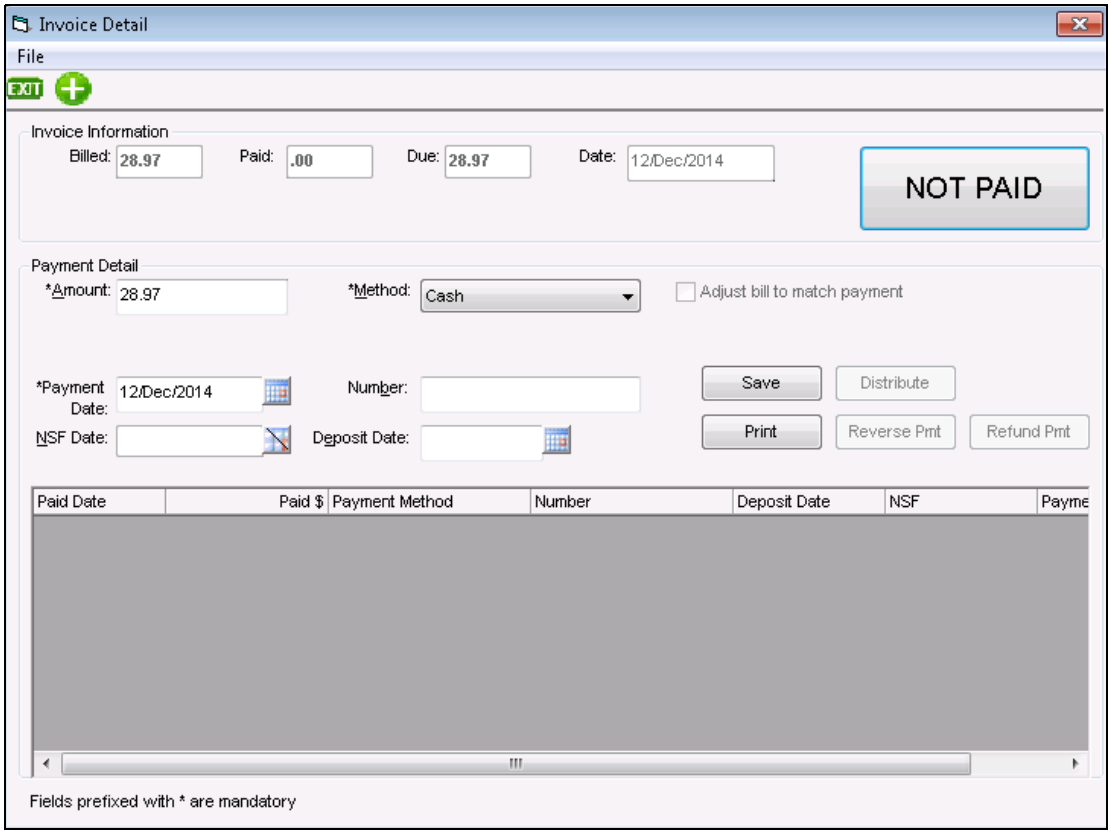


3. Click the service date of the bill to which you want to record a payment.

Tip: If the patient's list of bills is long, and you cannot find the bill, filter the list to display only bills to the third-party:

1. In the **Search By** area, in the **Insurer** drop-down list, select the insurer.
2. Click **Search**.

3. On the Patient Maintenance menu, click **View** > **Invoice Payment** or, on your keyboard, press **Ctrl** + **P**. The EMR opens the Invoice Detail window.



4. If you have previously recorded a payment toward the invoice and are recording another payment, click  .
5. Using the following table, enter payment information.

Field	Description
***Amount**	Ensure the payment amount is correct. If you are entering a partial payment, enter the actual paid amount.
Method	In the drop-down list, select the method of payment.
Payment Date	Enter the date that payment was received, or to select a date from a calendar, click  .
Number	If the method of payment is Cheque, enter the cheque number.
NSF Date	If you cash the cheque and the cheque is rejected due to insufficient funds, in the **NSF Date** field, enter the date of the rejection, or click  to select a date from a calendar.

Field	Description
Deposit Date	Enter the date that the payment was deposited to your bank account, or click  to select a date from a calendar.

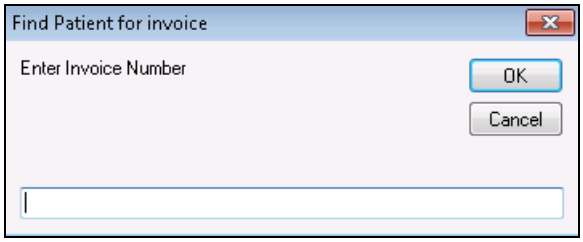
6. Click **Save**. The EMR displays the payment in the lower pane of the Invoice Detail window.
7. To print a receipt:
   a) Click **Print**. The EMR displays the Print Report window.
   b) In the **Copies** field, enter number of copies to print, and then click **Print**.
8. Click **Exit**. The EMR displays the payment in the **Paid$$** column in the billing list.
9. If you received only a partial payment for the bill, but you want to mark the bill as complete (that is, you want to accept the bill as fully paid), write-off the remainder of the billed amount. See "Writing-off third-party bills" on page 58.

Recording a payment for a third-party bill (when you have only the invoice number)

Sometimes the payment information provided by a third-party does not include the patient's name and only includes the Wolf EMR invoice number. If you receive only the invoice number for a payment, record the payment via the Billing program.

Steps

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** (). The EMR displays the Billing window.
2. Find the patient that the invoice is for:
   a) On the Billing menu, click **Options** > **Find Patient for Invoice**. The EMR displays the Find Patient for invoice window.

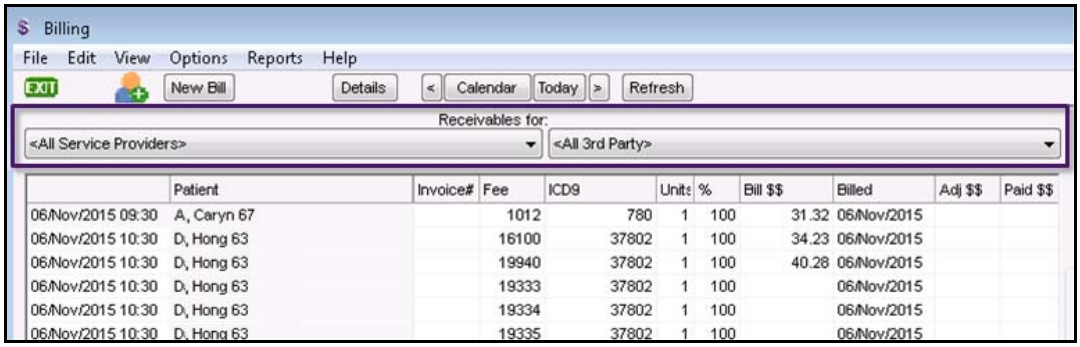


   b) Enter the invoice number, and then click **OK**. The EMR displays the patient's name, Provincial Health Number, and date of birth.
3. Search for outstanding third party bills for the patient:

a) On the Billing menu, click **View** > **Receivables (or 100% Paid)**. At the top of the billing list, the EMR displays two **Receivables for** drop-down lists.

b) In the left drop-down list, select the practitioner you want to view bills for, or to view bills for all practitioners, click **<All Service Providers>**.

c) In the right drop-down list, select the third-party or, to view bills for all third-parties, select **<All 3rd Party>** (located at the bottom of the list).

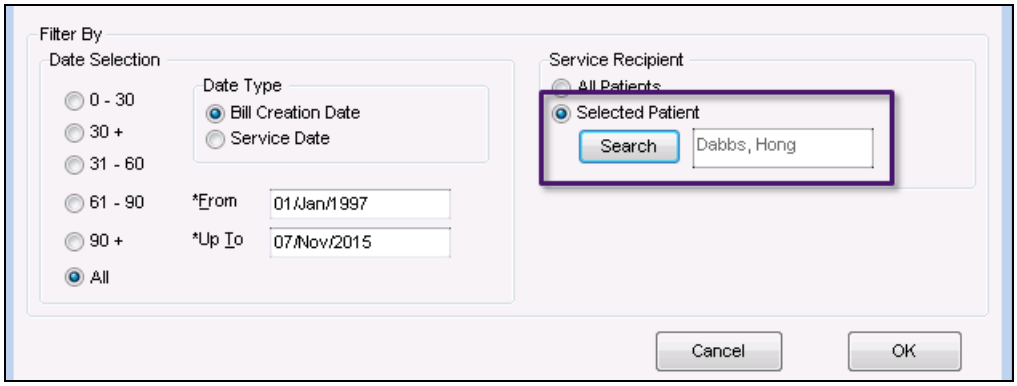


The EMR displays the Query Options window.

d) In the **Date Selection** area, click **All**.

e) In the **Service Recipient** area, click **Selected Patient**, and then click **Search**.

f) In the Patient Search window, search for and select the patient. The EMR inserts the patient's name in the field below **Selected Patient**.



g) Click **OK**. The EMR lists the patient's outstanding third-party bills in the billing list area of the Billing window.

4. Click the bill and then, on the Billing menu, click **File** > **Enter Invoice Payment** or, on your keyboard, press **Ctrl** + **P**. The EMR opens The Invoice Detail window.

5. Enter the payment information for the bill. See Step 4 to Step 8in "Recording a payment for a third-party bill (when you have the patient's name)" on page 53.
6. If you received only a partial payment for the bill, but you want to mark the bill as complete (that is, you want to accept the bill as fully paid), write-off the remainder of the billed amount. See "Writing-off third-party bills" on page 58.

Writing-off third-party bills

You write-off a third-party bill if:

- You know you will not receive payment for the bill.
- You receive only a partial payment for a bill, but you want to mark the bill as complete (that is, you want to accept the bill as fully paid).
- The bill was rejected by the third-party because there is a mistake or incomplete information on the bill.
- You created the bill in error. For example, you created the bill for the wrong practitioner.

When you write-off a partially paid bill, the EMR notes the unpaid portion as written-off.

Steps

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** (). The EMR displays the Billing window.
2. Search for all outstanding bills to the third-party. See "Searching for unpaid and partially paid third party bills" on page 89.
3. In the list of outstanding third-party bills, click the bill you want to write-off and then, on the Billing menu, click **File > Write Off**.
4. Click one of the following options:
   - **This Invoice**: To write-off only the selected bill.
   - **All Bills on Screen**: To write-off all bills currently displayed in the billing window.
5. Click **Yes**.
6. In the WriteOff Reason window, select one of the following options:
   - **Uncollectible**: If you know you will not receive payment for the outstanding bill amount.
   - **Mistake**: If there was an error on the bill or if the bill was created in error.

   The EMR writes off the bill(s), and displays the word **WriteOff** in the **Remitted** column of the billing list.

Chapter 5

WCB billing

When you create a WCB report and send it to the Billing program, Wolf EMR automatically creates five unsaved WCB bill entries. You then review and save the WCB bills.

Saved WCB bills are sent to WCB when you process and send your next MSP claim.

It is essential that all WCB reports are complete before you process and send claims to WCB. You are unable to electronically bill to WCB if the report is incomplete.

Be timely with your WCB submissions!

- You receive a greater payment rate if you submit and bill Form 8 and Form 11 reports within 1-3 days of the service date.
- You will not receive payment for any Form 8 or Form 11 reports that are submitted and billed 7 or more business days following the service date.

Verifying all WCB reports are complete

Make sure all WCB reports are complete before you produce and send claims to WCB through MSP. You can view a list of incomplete WCB reports from the **Incomplete Reports** tab of the WCB Report Manager.

Depending on your role, you may complete the WCB reports yourself, or ask someone else to complete the report. A WCB report is complete when all required fields are populated, the report is saved, and sent to the Billing program.

Note: After you send the WCB report to the Billing program, you can review the WCB bill's information, and then modify and save the bills if needed. See "Reviewing, editing, and saving WCB bills for which reports were created" on page 61.

Steps

1. Open the WorkDesk: On the Wolf EMR Launch page, click **WorkDesk** ( ).

2. Open the **Incomplete Reports** tab of the clinic-wide WCB Report Manager. How you access the clinic-wide WCB Report Manager depends on whether you are a front end staff member, or a provider:

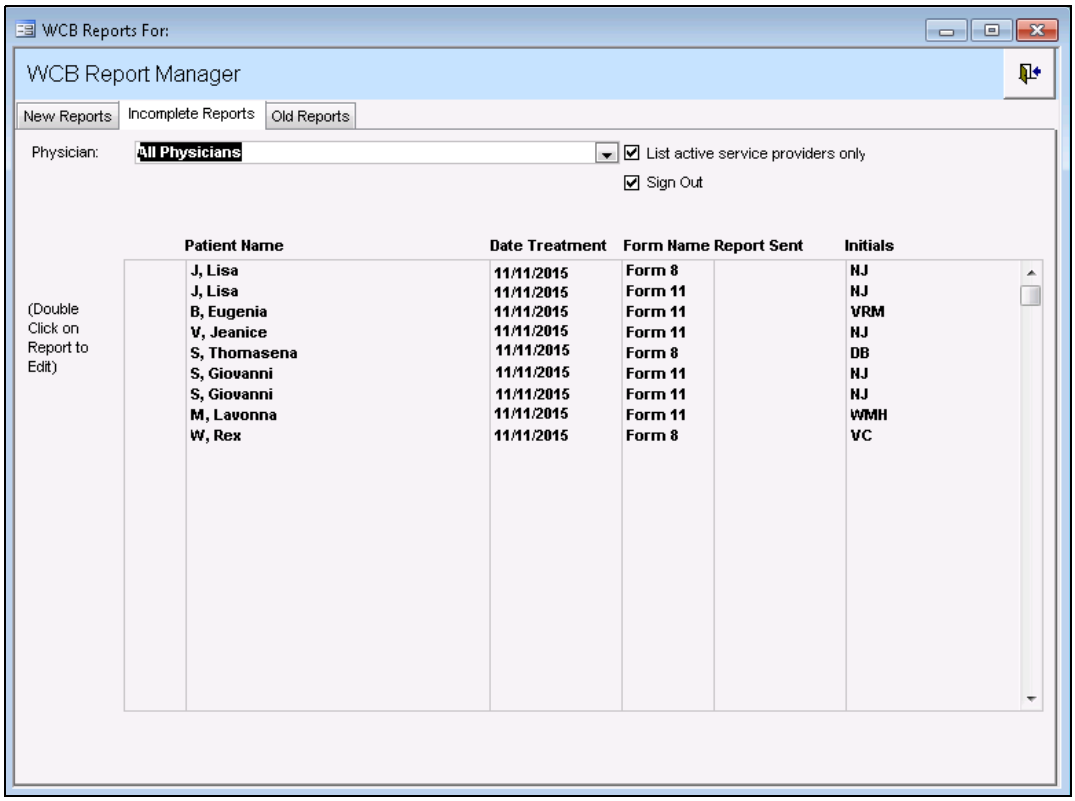
   - If you are a front end staff member:

     a) In the **Data Entry** area, click **WCB e-Forms**. The EMR displays the following prompt: "Select WCB E-form for an Individual Patient?"

     b) Click **No**. The EMR displays the WCB Report Manager window with the **Incomplete Reports** tab open. The Incomplete Reports tab lists all incomplete WCB reports for every patient in your clinic.

   - If you are a provider:

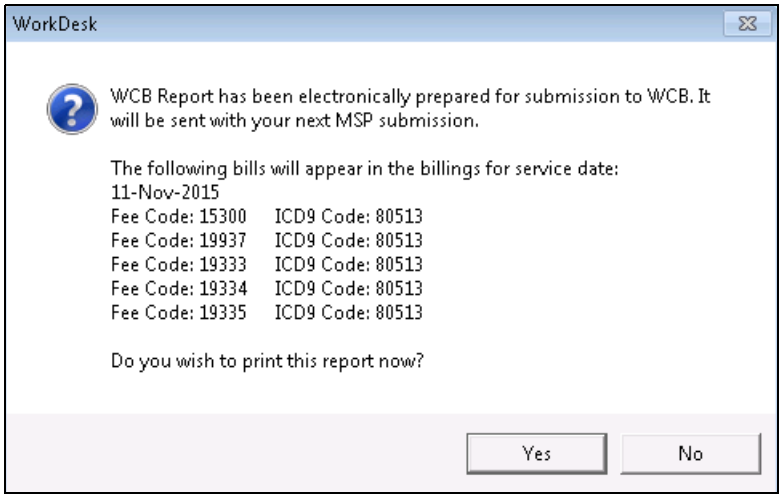
     a) On the **Tasks** area of your Workdesk, click **# Incomplete WCB Reports** (where # = the number of WCB Reports marked as incomplete). The EMR displays the WCB Report Manager window with the **Incomplete Reports** tab open.



3. In the **Physician** drop-down list, click the provider you want to view incomplete reports for, or to view incomplete WCB reports for all providers, select **All Physicians**.

Note: If you are a provider; your name is selected in the **Physician** drop-down list by default.

4. To modify or complete an incomplete WCB report, in the list of incomplete reports, double-click the report. The EMR opens the WCB Electronic Forms window.
5. Enter or modify information in each of the tabs as needed, and then click **Close and Save** (). The EMR displays a dialogue box with the following prompt: "Is this report complete and ready to be sent to WCB?"
6. To send the WCB claim to the Billing program, click **Yes**. The EMR sends the report to the Billing program, and creates and saves 5 bills: 1 office visit, 1 form, and 3 no charge fees. The EMR displays a prompt similar to the following:



Click **Yes** if you want to print the report now. Click **No** if you do not want to print the report.

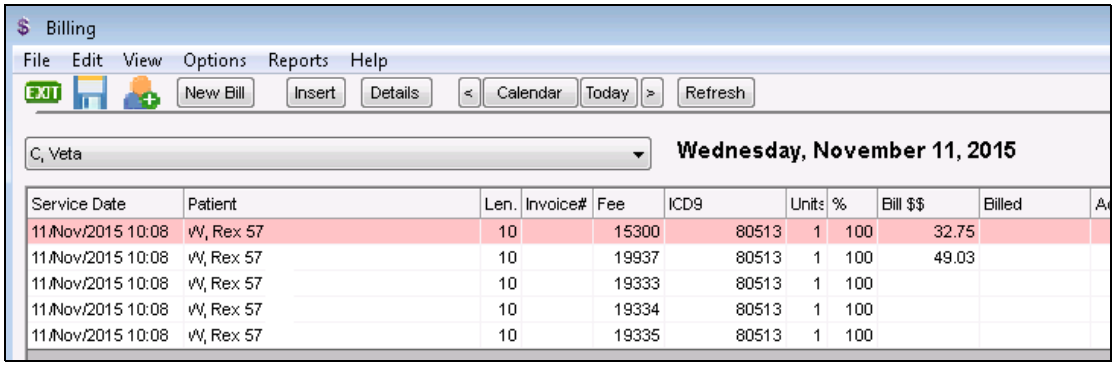
Reviewing, editing, and saving WCB bills for which reports were created

After you ensure all WCB reports are complete and sent to the Billing program, you can review the WCB bills in the Billing program, and then modify and save the bills if needed. WCB bills are auto-saved when they are sent to the Billing program from WCB reports, so you are not required to click save for each bill.

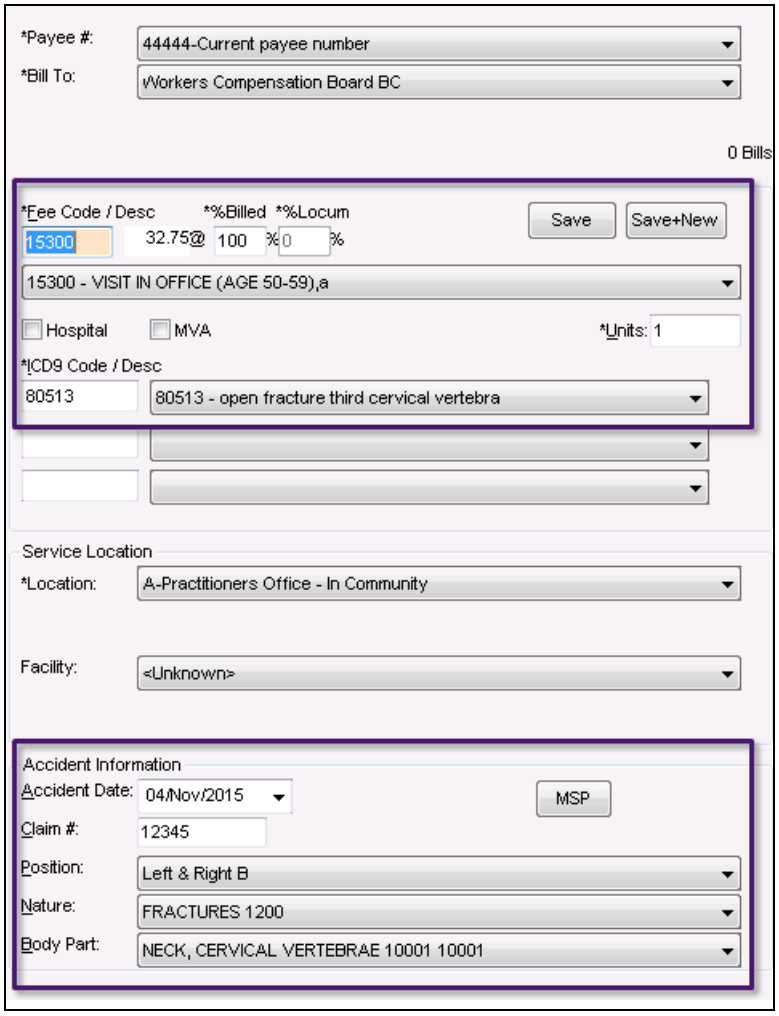
Steps

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** ( ). The EMR displays the Billing window.
2. In the **Physician** drop-down list, select the provider you want to review and save WCB bills for.
3. If you are reviewing and saving WCB bills that were billed on a day other than today, click **Calendar**, and then select the service date.

   The EMR displays a complete list of bills, including WCB bills, for the selected provider on the selected service date. Each WCB claim has 5 bills associated; 1 office visit, 1 form, and 3 no charge fees.



4. In the list of bills, click a WCB bill. The EMR displays the billing information on the right side of the window, with:
   - **Workers Compensation Board BC** populated in the **Bill To** field.
   - The fee code(s) and diagnosis code(s) from the WCB eForm populated in the **Service Fee** area and **Diagnostic Codes** area.
   - The **Accident Information** area populated from the WCB eForm.



5. Enter or modify bill details as needed, similar to how you enter details for MSP Bills. See Step 5and Step 6in "Creating a bill from the billing list" on page 11.

   The following table describes additional fields that are available in the **Accident Information** area on WCB bills.

> **Note**: Fields in the **Accident Information** area are automatically populated based on information you entered in the WCB Report.

Field	Description
Accident Date	Enter the date that the accident occurred.
Claim #	Enter the WCB claim number.

Field	Description
Position	In the drop-down list, select the side of the body where the injury occurred.
Nature	In the drop-down list, select the primary nature of the injury.
Body Part	In the drop-down list, select the primary body part affected by the injury.

Note: You can not modify no charge bills, you can only view them in the Billing program.

6. (Optional) To send the claim to MSP, in the **Accident Information** area, click the **MSP** button.
7. Perform one of the following actions:
   - To save any edits you made to the bill, click **Save**.
   - To save any edits you made to the bill and to add another fee code to the bill, click **Save+New**.

Billing WCB for patient visits where a report was not produced

When you perform a WCB service for a patient which does not require a WCB report, a WCB billing entry is not automatically recorded in the Billing program. Instead, you start a bill similar to how you start bills for MSP. You can start a WCB bill:

- From the billing list. See "Creating a bill from the billing list" on page 11.
- For a patient who is not on the billing list. See "Creating a bill for a patient who is not in the billing list" on page 22.
- From a SOAP note. See "Entering bill information from a SOAP note (practitioners only)" on page 26.

The following section describes how to create a WCB bill for a patient who is on the billing list.

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** ( ). The EMR displays the Billing window.
2. In the **Physician** drop-down list, select the practitioner you want to bill WCB or.
3. If you are creating a bill for a service performed on a day other than today, click **Calendar**, and then select the service date. The EMR displays the practitioner's billing list for the selected date.

4. In the billing list, click the patient you want to create a WCB bill for.
5. In the **Bill To** drop-down list, select **Workers Compensation Board BC.**

   Enter bill details similar to how you would for an MSP bill. See Step 5and Step 6in "Creating a bill from the billing list" on page 11. The following table describes additional fields that are available in the **Accident Information** area on WCB bills.

Field	Description
Accident Date	Enter the date that the accident occurred.
Claim #	Enter the WCB claim number.
Position	In the drop-down list, select the side of the body where the injury occurred.
Nature	In the drop-down list, select the primary nature of the injury.
Body Part	In the drop-down list, select the primary body part affected by the injury.

6. To send the claim to MSP, in the **Accident Information** area, click the **MSP** button.
7. Perform one of the following actions:
   - To save the bill, click **Save**.
   - To save the bill and add another fee code to the bill, click **Save+New**.

Sending claims to WCB

After WCB bills are saved in the billing program, when you create and send a claims file to MSP, the WCB claims are sent with the MSP claims. See "Sending claims to Medical Services Plan" on page 31.

Chapter 6

Billing reconciliation

You can reconcile provincial bills only if you have imported and processed your remittance files. To reconcile all of your clinics bills, you begin by performing a search for bills that are:

- Refused
- Partially paid
- Overpaid
- Held
- Submitted, but have not yet received a response

From the search list, you can then manage the bills (for example, you can edit and resubmit, or write-off bills). How you search for and manage bills differ depending on if the bills are for:

- The province
- WCB
- A patient
- A third party

Reconciling provincial bills

To reconcile your provincial bills, you complete three actions:

Process the provincial remittance file

(**eBill** )

Search for bills that have been refused, underpaid, or overpaid and determine why they were not paid as billed.

(**Billing** $)

Manage refused, underpaid, and overpaid bills

(**Billing** $)

The following sections describe how to complete each of these processes.

Processing provincial remittance files

When you process remittance files from the ministry, the EMR automatically enters bill payments, and updates the status of each bill. You do not manually enter payments on MSP and WCB bills.

When you send your claims to MSP using eBill, the EMR automatically imports and processes any remittance files available from MSP. See "Sending claims to Medical Services Plan" on page 31. You can also import and process remittance files at any time without sending claims to MSP.

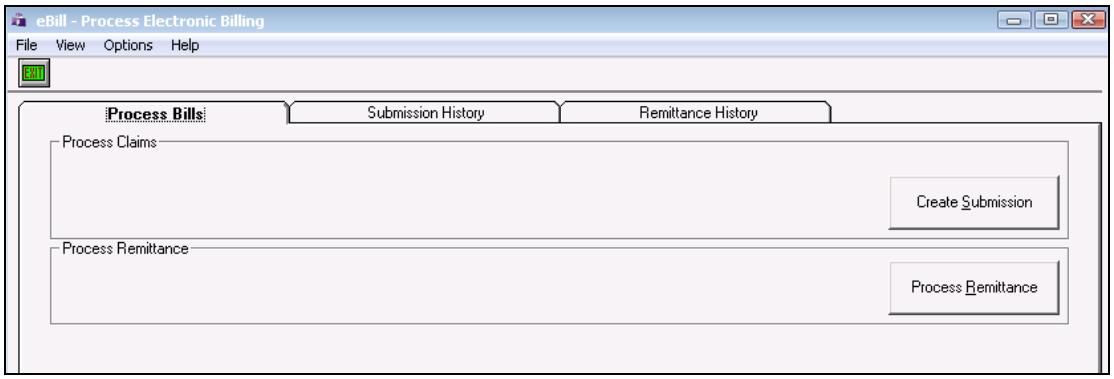
Note:

- You receive smaller remittances for each claim you send (usually on a daily basis). These smaller remittances indicate any bills that were "pre-rejected" by the MSP computer system (usually due to invalid Personal Health Numbers or inaccurate patient demographic information).
- You receive larger remittances, containing responses to all other bills, every two weeks.
- Payments are made every two weeks (at the middle and end of each month).

Note: The amount of time it takes for MSP to process and pay your claims varies, and depends on the timing of your submissions and the complexity of the claims.

Steps

1. Open the eBill program: On the Wolf EMR Launch page, click **eBill** ( ). The EMR displays the eBill - Process Electronic Billing window with the **Process Bills** tab open.



2. Click **Process Remittance**.

   The EMR displays a dialog box indicating the number of files downloaded from MSP.

3. Click **OK**.

Viewing past remittances and remittance reports

In the eBill program you can view a history of your clinic's past remittance imports from MSP. You can also reprocess remittance files, and print previous remittance reports. See "Viewing remittance history" on page 96.

Viewing refused, underpaid, and overpaid MSP and WCB bills

After you process remittances from MSP, you can view lists of bills that were:

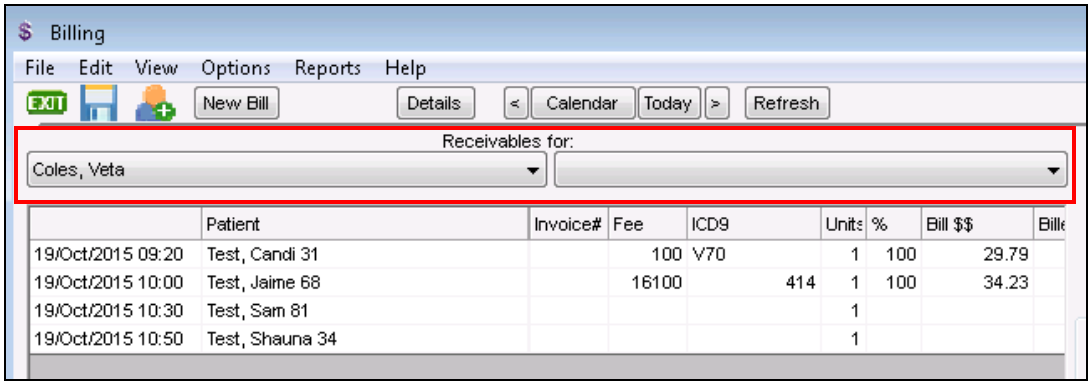
- Refused
- Partially paid
- Overpaid
- Held
- Submitted, but have not yet received a response from MSP or WCB
- Prepared, but have not been submitted

You produce each list for MSP and WCB individually, and at different frequencies. For example, you view and manage your refused MSP and WCB bills each time you receive a remittance file; while you view and address your held bills on a monthly basis. From each list you can manage the associated bills.

You can also produce a complete list of all bills that were refused, underpaid, or not paid. You produce this list monthly so you can balance your accounts at the end of the month.

Steps

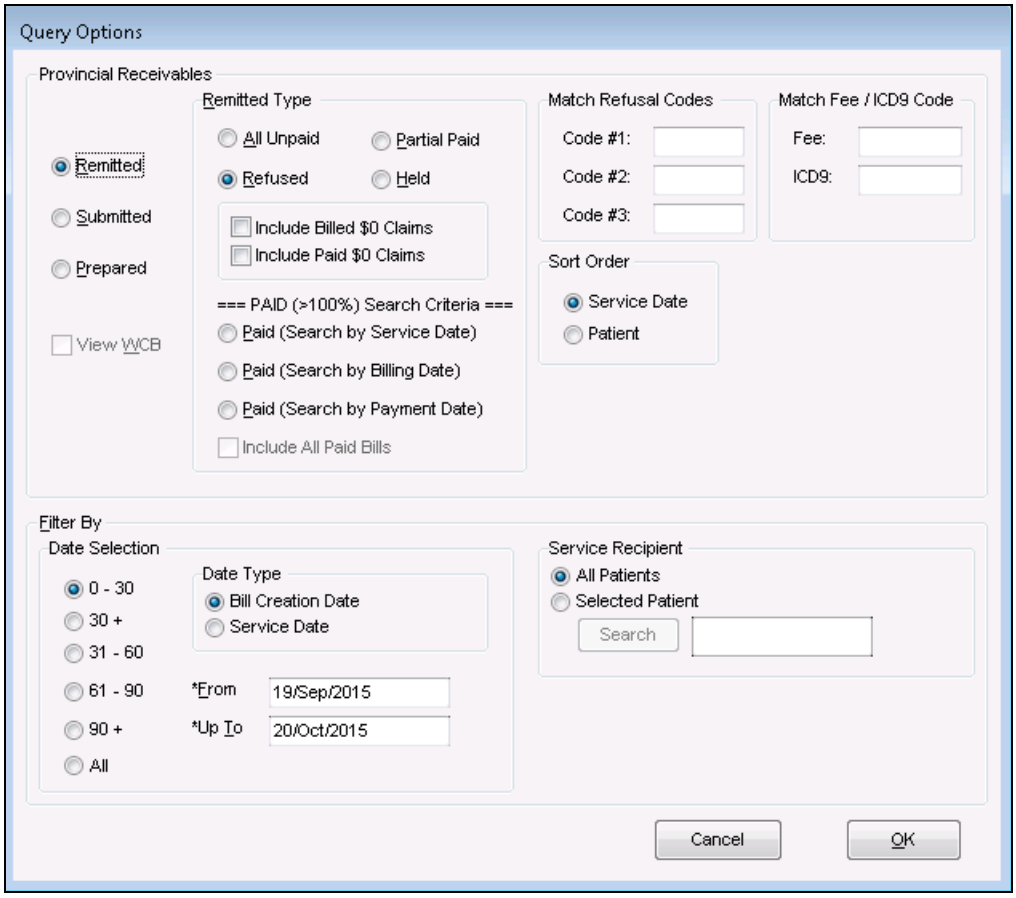
1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** ( ). The EMR displays the Billing window.
2. On the Billing menu, click **View** > **Receivables (or 100% Paid)**. At the top of the billing list, the EMR displays two **Receivables for** drop-down lists.



3. In the left drop-down list, select the practitioner you want to view bills for, or to view bills for all practitioners, click **<All Service Providers>**.
4. In the right drop-down list, select one of the following options:
   - **Medical Services Plan BC**: If you are viewing MSP bills
   - **Workers Compensation Board BC**: If you are viewing WCB bills

> **Note**: You cannot view bills for both MSP and WCB at the same time. You must produce separate lists for each.

The EMR displays the Query Options window.



5. In the **Filter By** area, in the **Date Selection** area, click **All**.

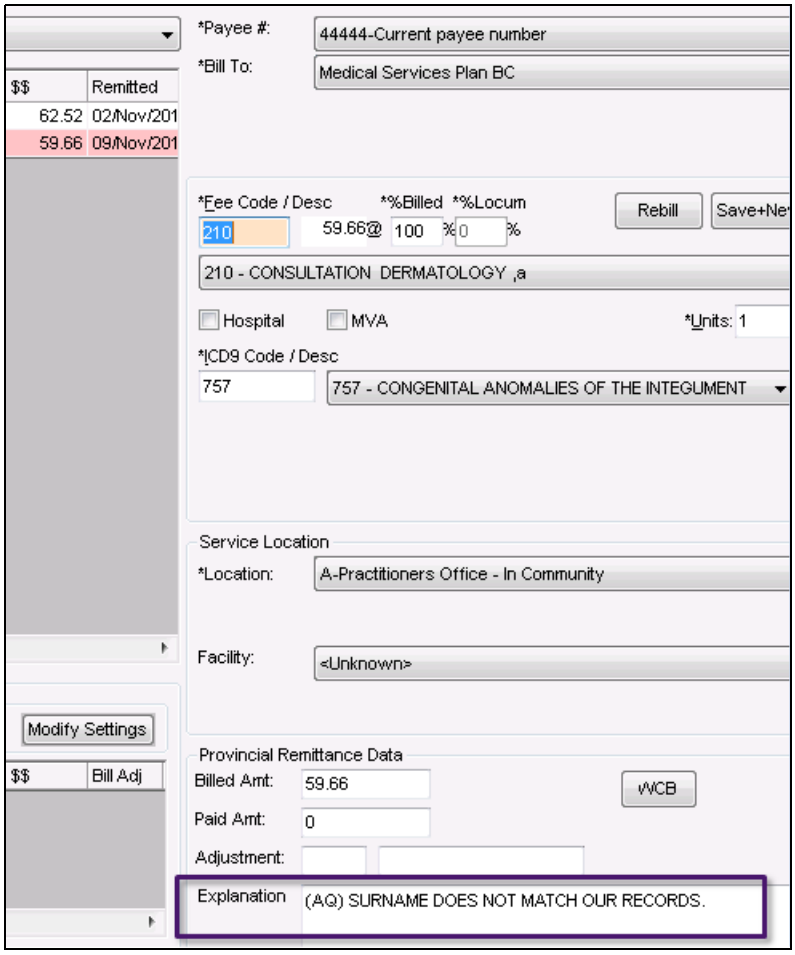
> **Best Practice**
>
> You should always select **All** as the date selection. This way, you are less likely to miss out on billing opportunities.

6. Depending on the list you want to view, enter information in the remainder of the Query Options window. Use the following table as a reference.

To produce the following list...	Recommended frequency	Select the following Query Options...
Refused bills	Each time you receive a remittance.	■ Click **Remitted**. ■ In the **Remitted Type** area, click **Refused**, and then select the **Include Paid $0 Claims** check box.

To produce the following list...	Recommended frequency	Select the following Query Options...
Partially paid bills	Each time you receive a remittance.	■ Click **Remitted**. ■ In the **Remitted Type** area, click **Partial Paid**.
Overpaid bills	Monthly	■ Click **Remitted**. ■ In the **Remitted Type** area, under *****PAID (<100%) Search Criteria*****, click **Paid** (Search by Service Date).
Held bills	Monthly	■ Click **Remitted**. ■ In the **Remitted Type** area, click **Held**.
Submitted bills with no response (To ensure you have not missed receiving a remittance file)	Monthly	■ Click **Submitted**.
Prepared bills that have not been submitted (To ensure you have not missed submitting a group of bills)	Monthly	■ Click **Prepared**.

7. Click **OK**. The EMR displays the matching bills in the billing list area of the Billing window.
8. To view a bill's details, including reasons for refusal or underpayment, click the bill. See "Determining why MSP and WCB bills are refused or underpaid" on page 74.



9. From the produced list, manage the refused, partially paid, and overpaid bills as needed. See "Managing rejected, underpaid, and overpaid MSP and WCB bills" on page 76.

If you are viewing your Submitted with no response bills:

- You can ignore bills that you have not yet received remittances for (usually for services that were provided in the last two weeks).
- If you see an entire group of bills that are abnormally old, your clinic may have missed receiving the remittance file from MSP. Contact MSP to have them reload the remittance for the missing date range. You can then download the remittance.

To contact MSP call **604-456-6950**, extension **3**.

Tip: To return to a view of the regular billing list, on the Billing menu, click **View**, and then clear the **Receivables (or 100% Paid)** check mark.

Determining why MSP and WCB bills are refused or underpaid

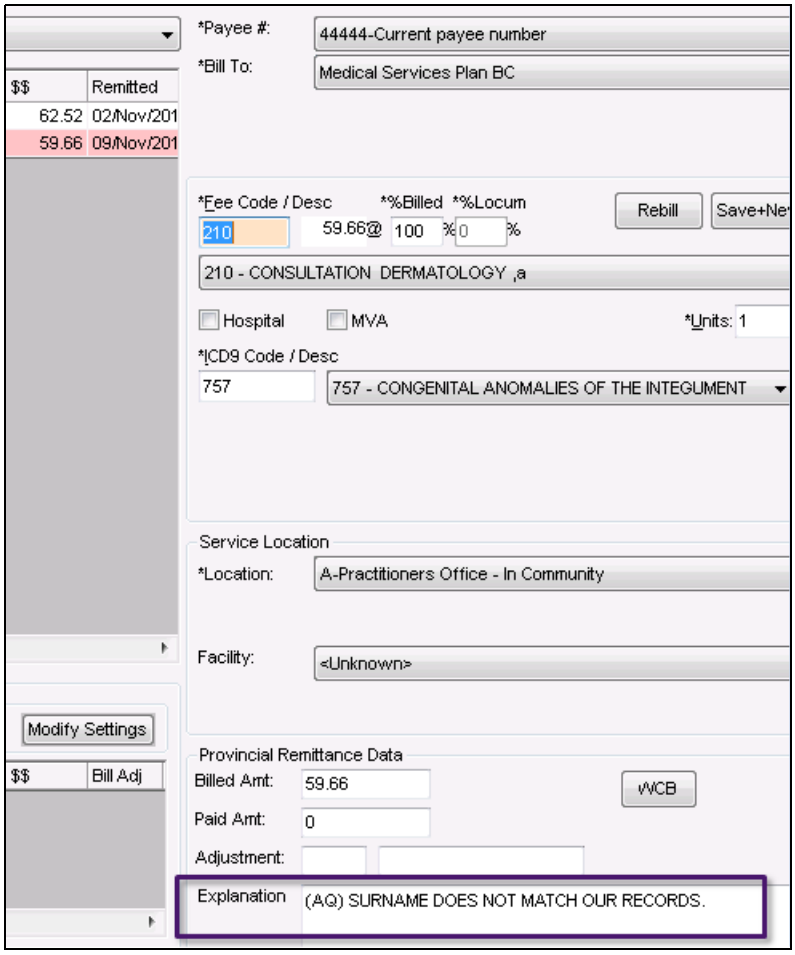
After you search for refused or partially paid bills, you must determine why the bill was refused or partially paid. You can then edit and rebill, write-off, or adjust the bill as indicated.

One way to determine why a bill was refused or partially paid, is to review the bill information to check for errors. For example, you billed the wrong service code for the patient visit.

You can also look at the explanatory codes to determine why a bill was refused. For example, if the explanatory code was "(AQ) SURNAME DOES NOT MATCH OUR RECORDS", in Patient Maintenance you would correct the patient's surname, and then rebill.

Steps

1. View the list of refused or partially paid bills. See "Viewing refused, underpaid, and overpaid MSP and WCB bills" on page 69.
2. In the list of refused or partially paid bills, click the bill.
3. In the right pane, review the bill's information and the Explanatory Code(s). The **Explanation** field is in the lower right-hand corner of the Billing window.



Tip: You can view a patient's billing history to help troubleshoot rejections:

a) In the list, click the bill you want to troubleshoot.

b) In the **Previous Billing** area (located at the bottom of the Billing window), search for and view the patient's recent bills.

Note: If the **Previous Billing** area is not available, enable the **Show Patient Previous Billings** screen behaviour. See "Customizing Billing screen behaviour" on page 4.

4. After you determine why a bill was refused or partially paid, you can edit and rebill, write-off, or adjust the bill as needed. See "Managing rejected, underpaid, and overpaid MSP and WCB bills" on page 76.

Managing rejected, underpaid, and overpaid MSP and WCB bills

If a bill is rejected, underpaid, or overpaid you have several options for reconciling the bill in Wolf EMR. You can:

- Adjust the bill: See "Adjusting a bill" on page 76
- Edit and resubmit the bill: See "Editing and resubmitting a bill" on page 77
- Write-off the bill: See "Writing-off a bill" on page 80
- Create a debit request: See "Submitting debit requests to MSP" on page 81

Note: If a provincial bill has been refused, underpaid, or overpaid, you have only 90 days to re-submit the bill with a correction, otherwise you will not be paid for the difference. There are a few exceptions to this rule, see Step 3 in "Editing and resubmitting a bill" on page 77.

Adjusting a bill

You adjust a bill when you want to:

- Adjust the billed amount to match the actual paid amount (for example, if a bill is underpaid or overpaid and you want to accept the actual paid amount as complete)
- Update the bill as a memo appointment (that is, you want to define the visit as non-billable)

Note: You cannot adjust billed amounts to paid amounts for Patient or Third-Party (Including ICBC) Bills. This feature is available only for MSP and WCB bills.

If a third-party or patient bill is partially paid, and you do not expect to receive the outstanding amount, record the partial payment and then write-off the bill.

Steps

1. Search for bills you want to adjust. See "Viewing refused, underpaid, and overpaid MSP and WCB bills" on page 69.
2. In the list of bills, click a bill you want to adjust.
3. Determine why the bill was only partially paid. See "Determining why MSP and WCB bills are refused or underpaid" on page 74.
4. On the Billing menu, click **File > Adjust Bill**.
5. Select the type of adjustment. The following table describes the types of adjustments.

Type of adjustment	Description
Update Bill as Paid	Defines the selected bill as **Paid**.
Update Bill as Not Paid	Defines the selected bill as **Not paid**.
Adjust BILLED Amt to Paid Amt	Changes the billed amount to the actual paid amount. Use this option to reconcile overpaid or underpaid bills if you want to accept the paid amount as complete.
Update as MEMO	If the bill is for an appointment that should not have been billed (for example, if the appointment is a pre-op or post-op appointment that is covered as part of a surgical service), select this option. Memo bills do not appear in accounting reportsand are not sent to MSP.

6. If you selected **Adjust Billing Amt to Paid Amt**, or **Update as Memo**, select one of the following options:
   - **This Bill**: To adjust only the selected bill.
   - **All Bills on Screen**: To adjust all listed bills at once.

CAUTION!
Ensure that you carefully review all of the bills on the screen before you select to adjust **All Bills on Screen**. You cannot undo this action.

Editing and resubmitting a bill

You can edit and resubmit a bill if the bill has been refused. The most common reasons for a bill to be refused is missing or incorrect patient demographic information (for example, an incorrect provincial health number), or missing or incorrect bill information (for example, you enter the wrong service code). To "fix" bills with missing or incorrect information, you edit the patient demographic information (in Patient Maintenance) and/or the billing information, and then rebill.

Note: You cannot rebill to a different insurer for claims with a Partial Payment. If you sent a bill to the wrong insurer and received a partial payment, send a debit request, and then create a new bill for the correct insurer. See "Submitting debit requests to MSP" on page 81.

Steps

1. Search for bills you can rebill. See "Viewing refused, underpaid, and overpaid MSP and WCB bills" on page 69.

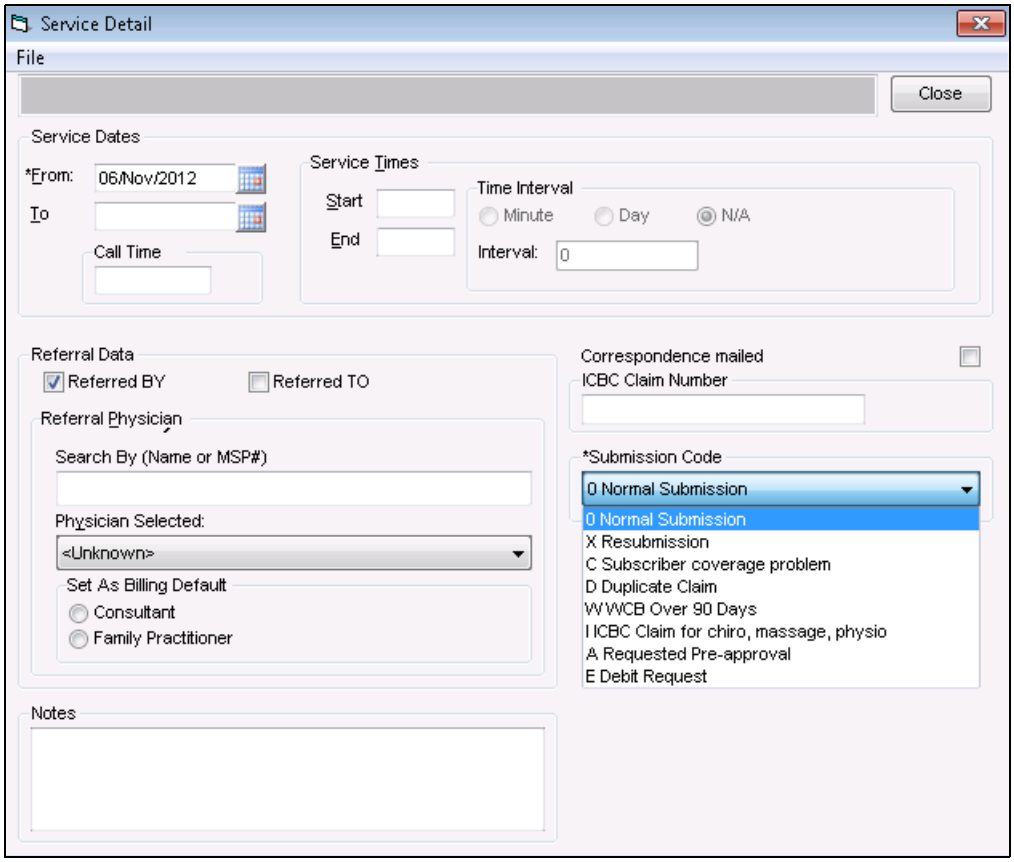
2. In the list of bills, click a bill. The EMR displays the bill details in the right pane.
3. Determine why the bill was refused. See "Determining why MSP and WCB bills are refused or underpaid" on page 74.
4. Using the following table, modify the indicated bill information or patient's demographic information as needed.

To edit or add the following...	Do this...
Patient demographic information (including PHN, name, or DOB)	1. On your keyboard, press **F9**. The EMR opens the Patient Maintenance window. 2. Edit the patient's information as needed. 3. Click **Save**(), and then click **Exit**. The EMR closes the Patient Maintenance and returns to the Billing window.
General bill information (for example, the service fee code or diagnostic code)	In the right pane, modify the bill information as needed.
Notes to MSP	1. At the top of the Billing window, click **Details**. The EMR displays the Service Detail window. 2. In the **Notes** area, enter your bill notes.
Referring practitioner	1. At the top of the Billing window, click **Details**. The EMR displays the Service Detail window. 2. In the **Referral Physician** area, modify or add the referring practitioner.
More detailed bill information (for example, service time)	1. At the top of the Billing window, click **Details**. The EMR displays the Service Detail window. 2. Modify or add to the bill information as needed.

3. If it has been more then 90 days since the original claim was submitted, but you still want to resubmit the bill:

   a) At the top of the Billing window, click **Details**. The Service Detail window opens.

   b) Using the following table, in the **Submission Code** drop-down list, select an option.



Submission Code	Select if...
X Resubmission	The claim is over 90 days old but you disagree with the adjudication of the claim. **Note**: ■ In the **Notes** area, include any additional information required to re-adjudicate the claim ■ Resubmit claim within 90 days from the remittance date of the original claim
C Subscriber Coverage problem	The patient did not have coverage at the time the service was rendered. The claim ins now over 90 days old and the coverage has been reinstated. **Note**: ■ In the **Notes** area, enter the following text: "coverage reinstated"

Submission Code	Select if...
W WCB Over 90 Days	The claim is over 90 days old but since originally submitted, has been either refused or accepted by WorkSafe BC (WSBC). **Note**: Claims must be submitted within 90 days of being advised of WSBC decision
I ICBC Claim for chiro, massage, physio	The claim is over 90 days old but since originally submitted, has been either refused or accepted by ICBC. **Note**: Claims must be submitted within 90 days of being advised of ICBC decision
A Requested Pre-approval	A claim does not meet the criteria for C, X, I, and W, but was pre-approved by MSP to be submitted. **Note**: ■ Written request is required ■ Requests include detailed explanation for late submission, and date range of claims, number of claims, value of claims, and the fee items involved. ■ Administrative issues (eg. staffing problems, clerical errors, lost/forgotten claims, system or service bureau problems) do not qualify for exemption

c) Click **Close**.

4. Click **Rebill**. The EMR displays a Save Bill dialog box with the following message: "Rebill transaction created".
5. Click **OK**. The EMR sends the bill with the next claim file you submit.

Writing-off a bill

After you submit your claims, you can write-off a bill if it is a mistake or is uncollectible. For example, you may have billed to the wrong insurer and submitted your claims file. To correct this error, you can write-off the refused bill as a mistake and then create a new bill.

You can also write-off appointments that are listed in the billing window but have not yet been billed.

Steps

1. Search for the bill that you want to write-off. See "Viewing refused, underpaid, and overpaid MSP and WCB bills" on page 69.
2. In the list of bills, click the bill you want to write-off.
3. On the Billing menu, click **File** > **Write Off**.

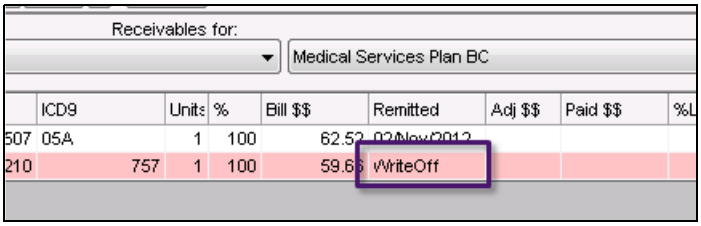
4. Click one of the following options:
   - **This Bill**: To write-off only the selected bill.
   - **All Bills on Screen**: To write-off all bills currently displayed in the billing window.
   - **All UN-Billed Appointments on Screen**: To write-off all unbilled appointments currently displayed in the billing window.

> **CAUTION**!
> Ensure that you carefully review all of the bills on the screen before you select to adjust **All Bills on Screen** or **All Un-Billed Appointments on Screen**. You cannot undo these actions.

   If you are writing off a bill that has been submitted in a claims file, the EMR displays a dialog box with the following prompt: "Claim has been Submitted. Write off this claim?"

   If you are writing off a billing list for appointments that have not yet been billed, the EMR displays a dialog box with the following prompt: "You are about to write off all unbilled appointment(s) displayed on screen - there is NO UNDO for this command. Click YES to continue write off or click NO to abort".

5. Click **Yes**. The EMR displays the WriteOff Reason window.
6. Click your reason for writing off the bill(s). Your options are **Uncollectible** or **Mistake**. The EMR writes off the bill(s), and displays the word **WriteOff** in the **Remitted** column of the billing list.



Submitting debit requests to MSP

You submit a debit request to debit a claim billed in error, whether the claim is being processed or has been paid in full. When you successfully submit a debit request, MSP refuses the in-process claim or debits the paid claim.

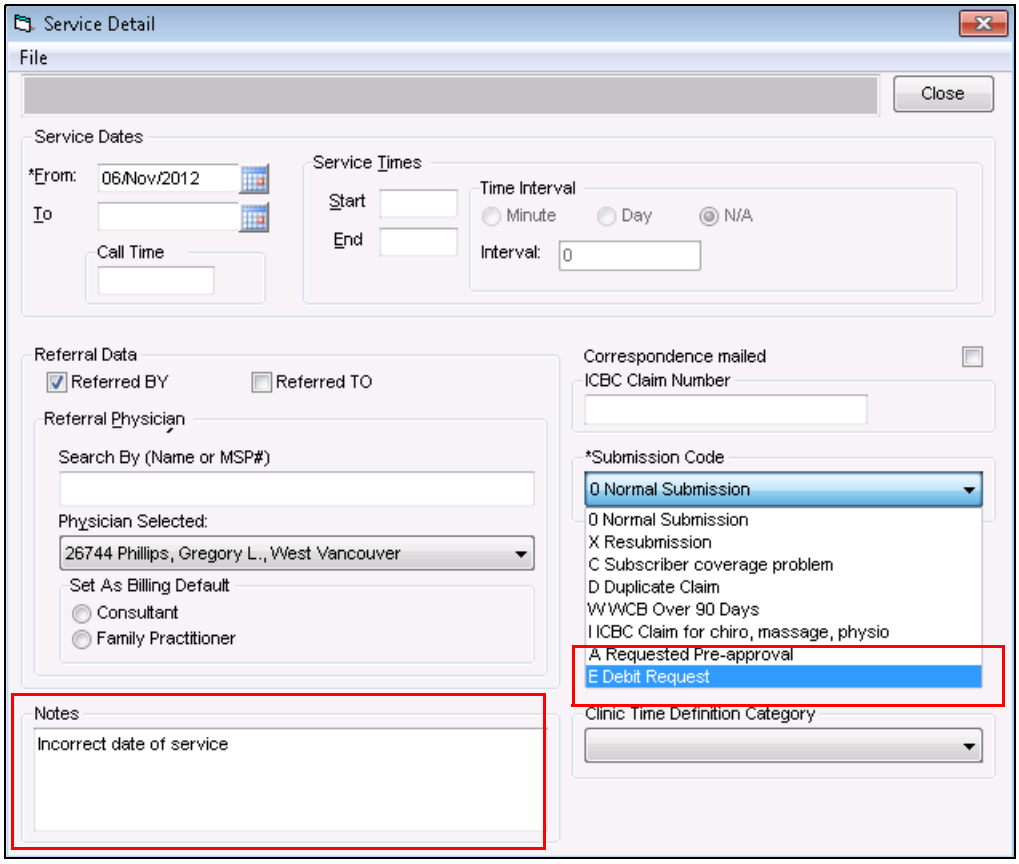
The submission of a debit request record is actually a re-submission of the original claim, with the submission code E.

Note:

- You must include a note on the bill indicating why you are debiting the bill (for example, “Incorrect date of service”)
- If you are re-billing the claim, but the service date is outside the 90 day limit, use submission code X and then, in the bill **Notes** field, indicate “Re-submission with matching Debit Request Record”
- Do not submit a debit request if you disagree with MSP’s adjudication of a claim. Instead, submit a new claim with additional information in the Notes area, and the claim will be re-assessed

Steps

1. Find the bill you want to submit a debit request for. See “Viewing refused, underpaid, and overpaid MSP and WCB bills” on page 69.
2. In the list of bills, click the bill you want to delete.
3. At the top of the Billing window, click **Details**. The Service Detail window opens.
4. In the **Notes** field, indicate your reason for submitting the debit request.
5. In the **Submission Code** drop-down list, choose **E Debit Request**.



6. Close the Service Detail window, and then click **Rebill**. The EMR displays a Save Bill dialog box with the following message: "Rebill transaction created".
7. Click **OK**. The EMR sends the debit request with the next claim file you submit.
8. If needed, create a new bill for the original service. See "Creating a bill to Medical Services Plan (MSP)" on page 11.

Editing and resubmitting WCB bills that are rejected due to missing information in the WCB report

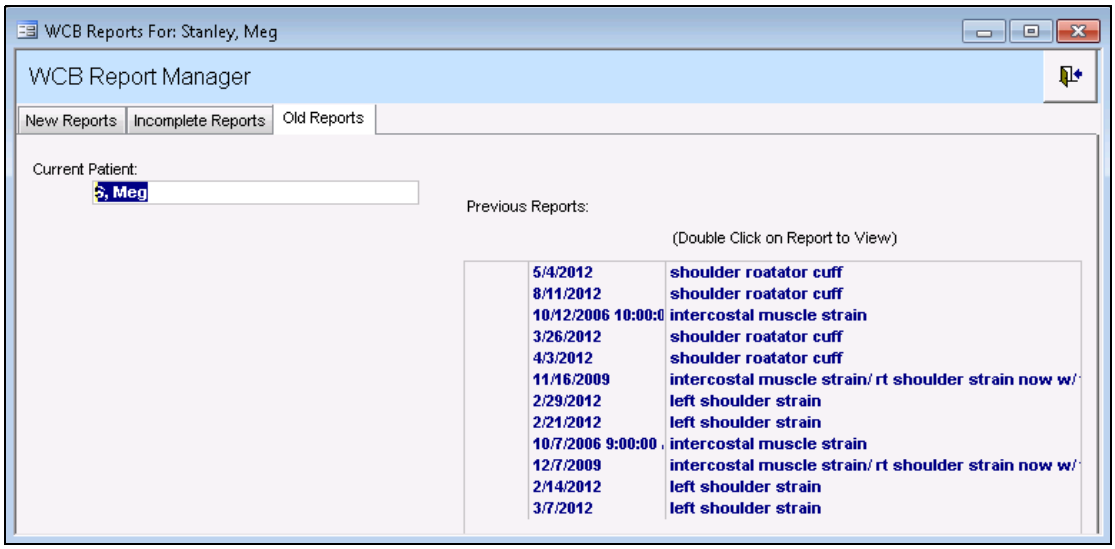
If a WCB bill is rejected due to missing or inaccurate information in the WCB report, you must edit the original WCB report, and then rebill WCB for the service.

Steps

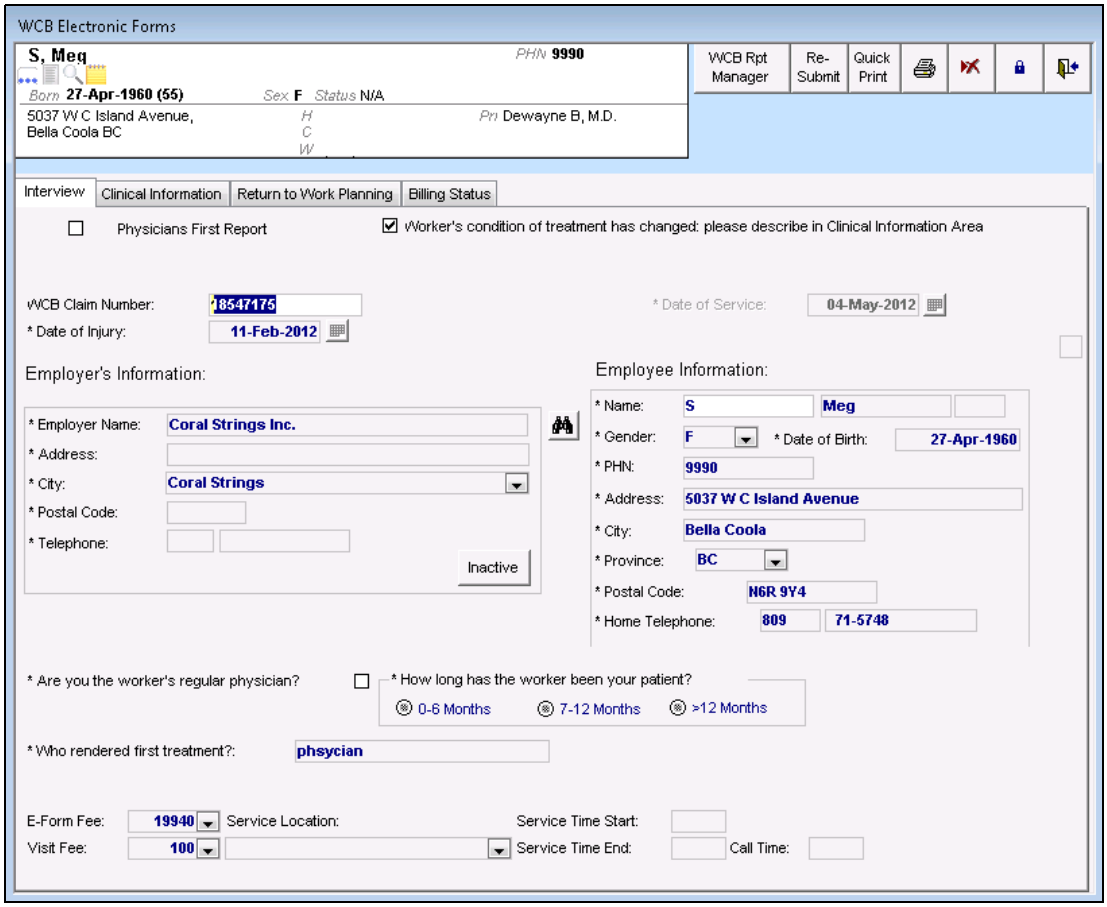
1. From your Workdesk, open the patient's WCB Report Manager:
   a) Open the patient's Medical Summary: On the Workdesk, click **Medical Summary**, and then search for and select the patient.

b) On the Medical Summary window, right-click, and then in the SMART menu, click **View WCB Reports**. The EMR displays the WCB Report Manager window for the patient.

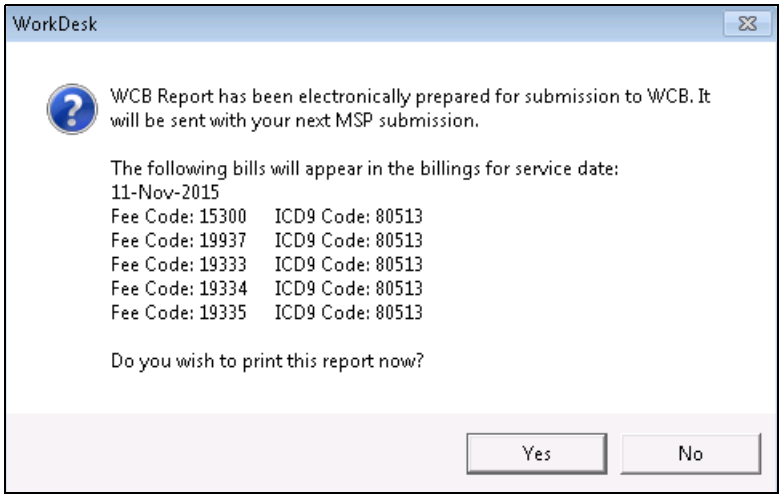
2. Click the **Old Reports** tab. The EMR displays a list of the patient's completed WCB reports.



3. Double-click the WCB report you want to edit. The EMR opens the report in the WCB Electronic Forms window.



4. At the top of the window, click **Unlock Form** (). The EMR enables editing to the form.
5. Add or modify information on the form as needed, and then click **Re-Submit**. The EMR displays a dialog box with the following prompt: Is this report complete and ready to be re-submitted to WCB?
6. Click **Yes**. The EMR sends the report to the Billing program, and creates and saves 5 bills: 1 office visit, 1 form, and 3 no charge fees. The EMR displays a prompt similar to the following:



Click **Yes** if you want to print the report now. Click **No** if you do not want to print the report.

7. Open the Billing program and review and save the WCB bills. See "Reviewing, editing, and saving WCB bills for which reports were created" on page 61.

Reconciling patient bills

> **Best Practice**
>
> Reconcile your patient bills at least once per month.

Each time you receive a payment from a patient for a bill, you should record the payment immediately. This way you can track outstanding payments. See "Recording a payment to a patient bill" on page 40.

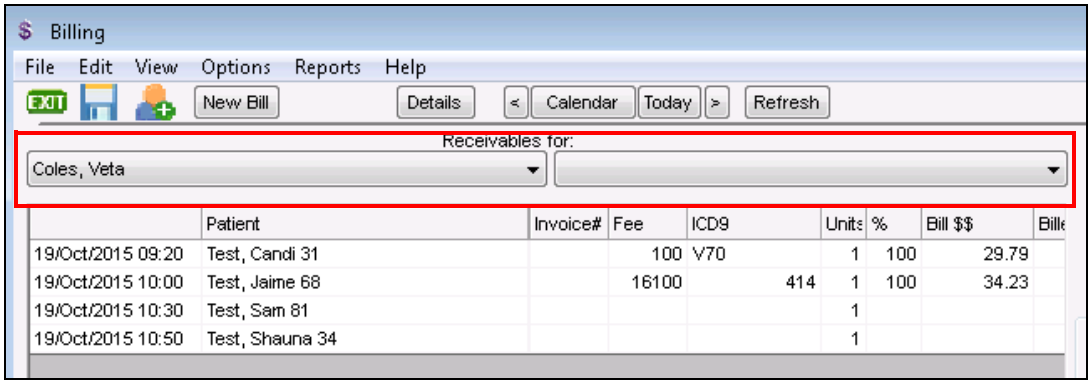
To reconcile patient bills, you search for patient bills that are unpaid, or only partially paid. From the resulting list of bills, you record payments, write-off outstanding amounts, or contact patients regarding outstanding payments.

Searching for unpaid and partially paid patient bills

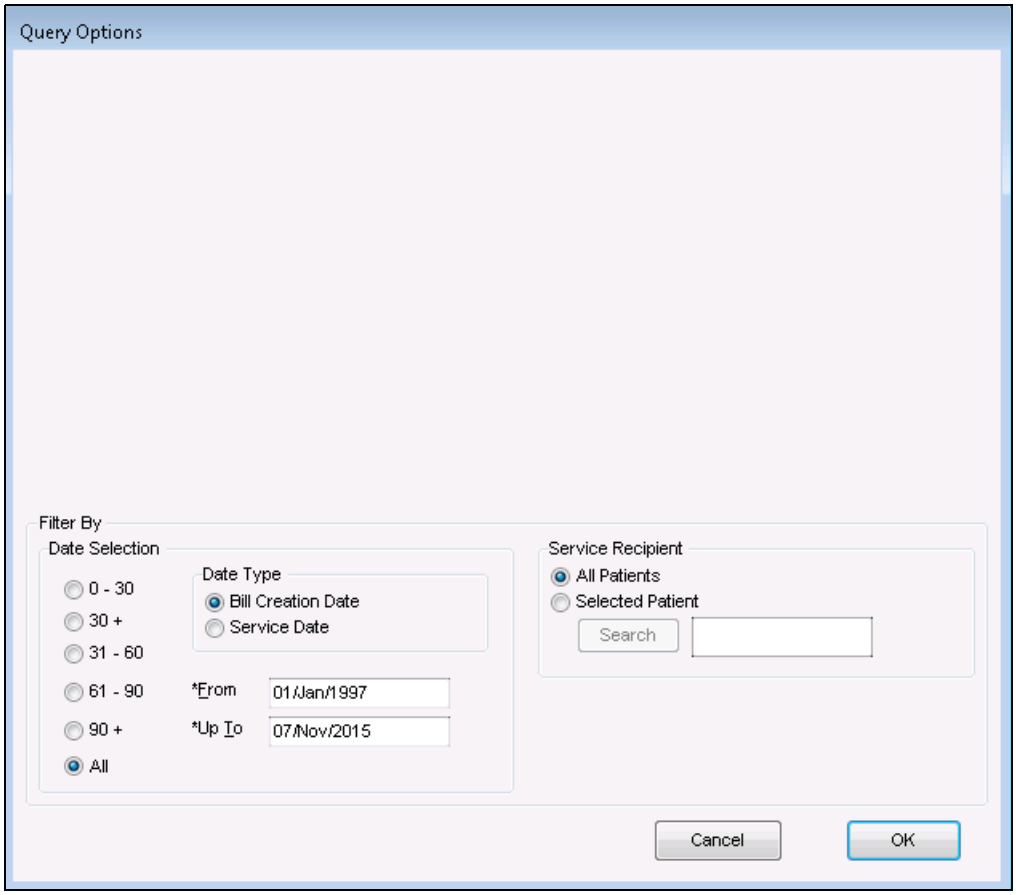
You can produce a list of your unpaid and partially paid patient bills from the Billing program. The list can be specific to one provider, or can show outstanding bills for all providers. You can also choose to view outstanding bills for only a specific patient.

Steps

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** ( ). The EMR displays the Billing window.
2. On the billing menu, click **View** > **Receivables (or 100% Paid)**. At the top of the billing list, the EMR displays two **Receivables for** drop-down lists.



3. In the left drop-down list, select the practitioner you want to view bills for, or to view bills for all practitioners, click **<All Service Providers>**.
4. In the right drop-down list, select **Patient**. The EMR displays the Query Options window.



5. In the **Date Selection** area, click **All**.
6. Click **OK**. The EMR displays all unpaid and partially paid patient bills in the billing list area of the Billing window.

Managing unpaid and partially paid patient bills

For patient bills that are unpaid or partially paid, you have several options for reconciling. You can:

- Apply a payment to the bill: If you have received payment. See "Recording a payment to a patient bill" on page 40.
- Write-off the bill: If you know you will not receive payment, or if you want to accept a partially paid bill as complete. See "Writing off a patient bill" on page 44.

Note: You cannot adjust billed amounts to paid amounts for patient bills. This feature is available only for MSP and WCB bills.

If a patient bill is partially paid, and you do not expect to receive the outstanding amount, record the partial payment and then write-off the remainder of the bill.

Reconciling ICBC and other third party bills

Best Practice

Reconcile your third-party bills at least once per month.

Each time you receive a payment for a third-party bill, you should record the payment immediately. This way you can track outstanding payments. See "Recording payments for third-party bills" on page 53.

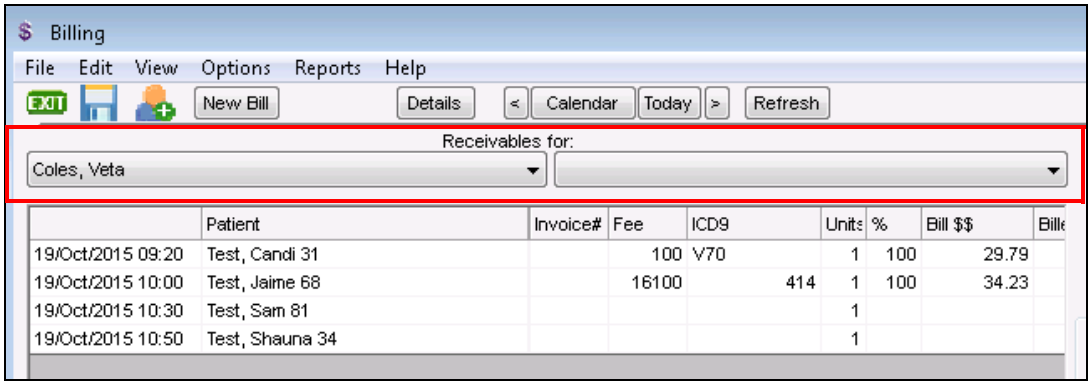
To reconcile third-party bills, you search for third-party bills that are unpaid or partially paid. From the resulting list of bills, you record payments, write-off outstanding amounts, or contact the third-party to inquire about the payment status.

Searching for unpaid and partially paid third party bills

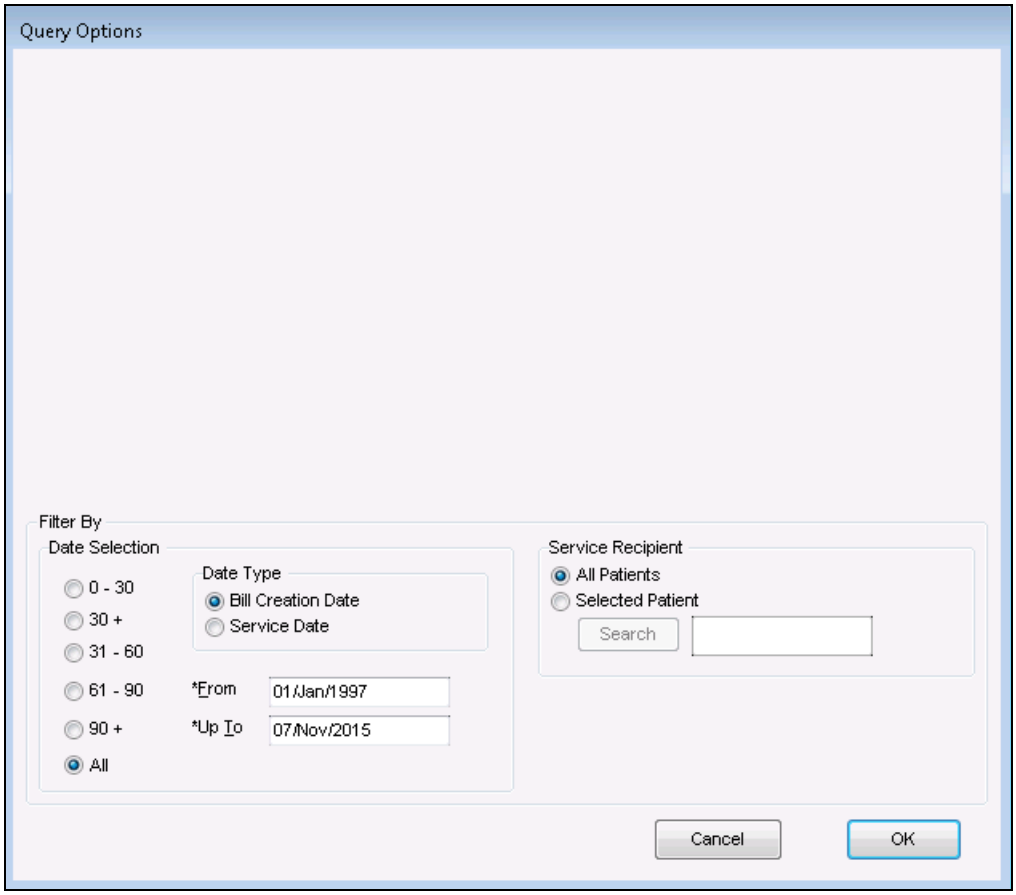
You can produce a list of your unpaid and partially paid third party bills from the Billing program. The list can be specific to one provider, or can show outstanding bills for all providers. You can also choose to view outstanding bills for only a specific third party.

Steps

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** (). The EMR displays the Billing window.
2. On the billing menu, click **View** > **Receivables (or 100% Paid)**. At the top of the billing list, the EMR displays two **Receivables for** drop-down lists.



3. In the left drop-down list, select the practitioner you want to view bills for, or to view bills for all practitioners, click **<All Service Providers>**.
4. In the right drop-down list, select the third-party you want to view outstanding bills for, or to view outstanding bills for all third-parties, select **<All 3rd Party>** (located at the bottom of the list). The EMR displays the Query Options window.



5. In the **Date Selection** area, click **All**.
6. Click **OK**. The EMR displays all unpaid and partially paid third-party bills in the billing list area of the Billing window.

Managing unpaid and partially paid third-party bills

For third-party bills that are unpaid, or only partially paid, you have several options for reconciling in Wolf EMR. You can:

- Apply a payment to the bill (if you have received payment). See "Recording payments for third-party bills" on page 53.
- Write-off bills (if you know you will not receive payment, or if you want to accept a partially paid bill as complete). See "Writing-off third-party bills" on page 58.

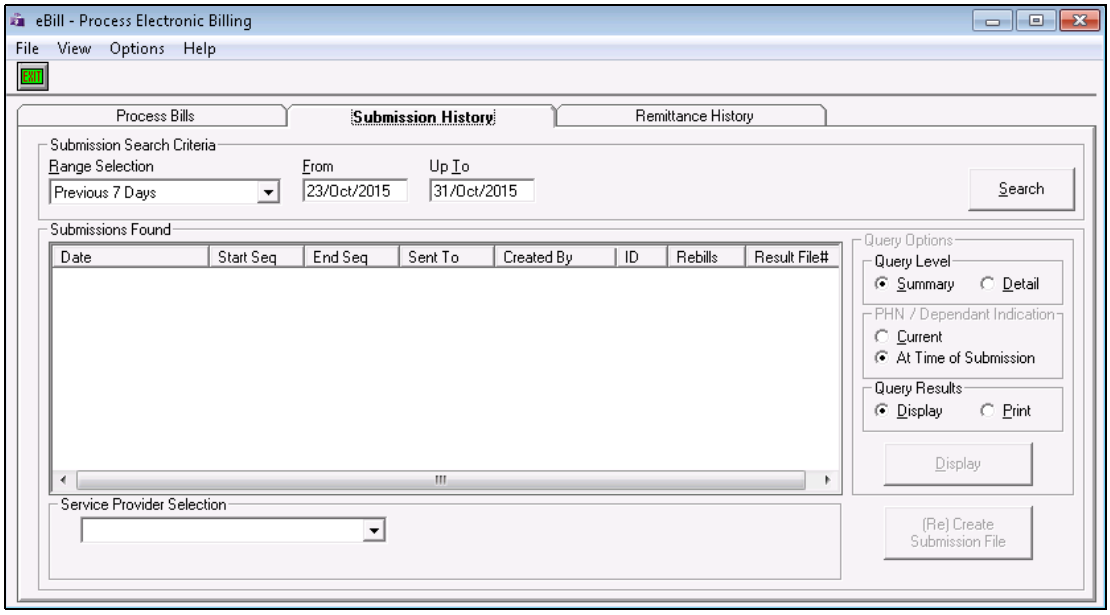
> **Note**: You cannot adjust billed amounts to paid amounts for third-party Billing. This feature is available only for MSP or WCB bills.
>
> If a third-party bill is partially paid, and you do not expect to receive the outstanding amount, record the partial payment and then write-off the bill.

Viewing claim submission history in eBill

You use the **Claim History** tab in eBill to search for MSP claim submission information. After the EMR displays a list of submissions found, you can display or print a summary or detailed version of the information. You can also re-submit a claim file.

Steps

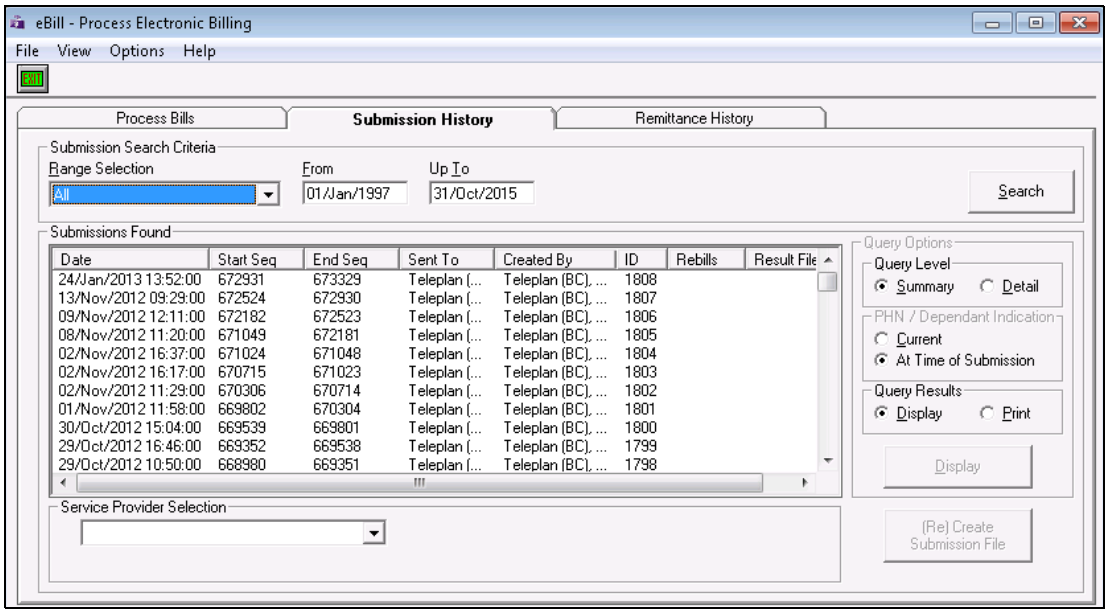
1. Open the eBill program: On the Wolf EMR Launch page, click **eBill** ( ). The EMR displays the eBill - Process Electronic Billing window.
2. Click the **Submission History** tab.



3. In the **Submission Search Criteria** area, perform one of the following actions:
   - To select a pre-defined date range: In **Range Selection** drop down list, click a date range.
   - To specify a date range: In the **From** field, enter the start date for the search criteria and in the **Up To** field, enter the end date for the search criteria.

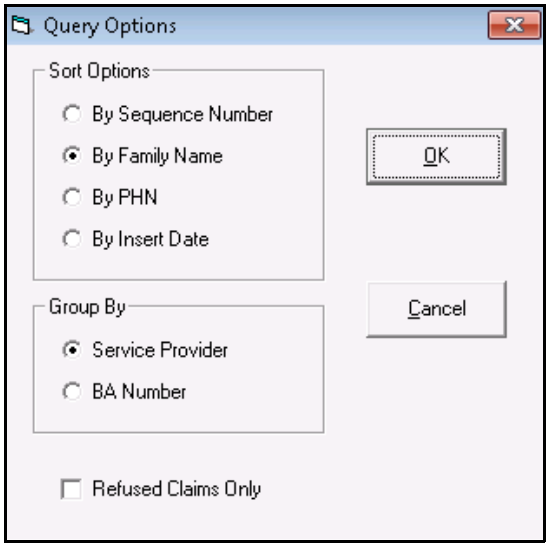
> **Note**: The **Up To** date entered is **NOT** included in the calculation. For example, to search the entire month of April 2015 insert the following information: **From 01/Apr/2015**; **Up To 01/May/2015**.

4. Click **Search**. The EMR lists all submissions found in the **Submissions Found** area.

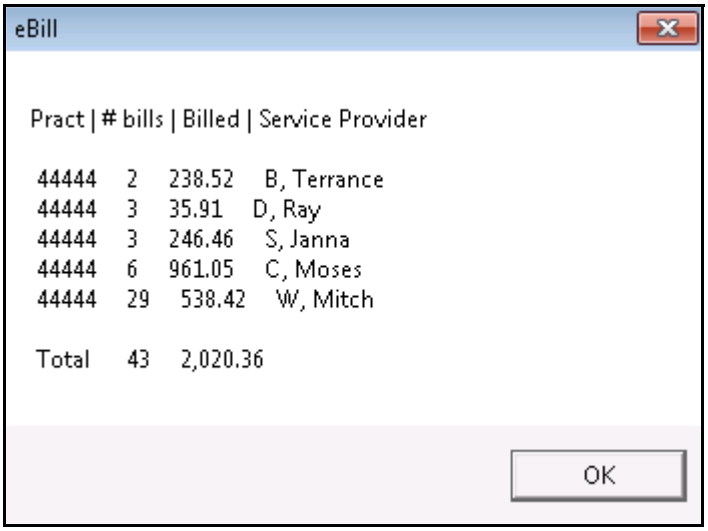


5. To view claims for only a specific practitioner, in the **Service Provider Selection** drop-down list, click the practitioner. Otherwise, the EMR displays information for all practitioners.
6. To view detailed information for a claim:
   a) In the **Submissions Found** list, click a submission. The EMR enables the **Query Options** area.
   b) Use the following table to enter information in the **Query Options** area.

To produce the following claim query result...	Make the following selections...
Summary of the number of bills, and total amount billed for each practitioner	1. In the **Query Level** area, click **Summary**. 2. In the **Query Results** area, select to **Display** or **Print** the query results. 3. To display the query results, click **Display** (Display).

To produce the following claim query result...	Make the following selections...
A complete list of bills.	1. In the **Query Level** area, click **Detail**. 2. In the **PHN (ULI)** area, specify if you want to include the patients' **Current** PHN or the patients' PHN **At Time of Submission** in the query results. 3. In the **Query Results** area, select to **Display** or **Print** the query results. 4. To display the query results, click **Display** (Display). The EMR displays the Query Options window.  5. In the **Sort Options** area, select how you want to sort the query results. 6. In the **Group By** area, select how you want to group the query results. 7. If you want the query results to include only refused claims, select the **Refused Claims Only** check box. 8. Click **OK**. The EMR displays the query results in the Wolf File Viewer window.

- If you chose **Summary** as the **Query level**, the EMR displays the eBill window with a summary of the number of bills and total amount billed for each practitioner.



- If you chose **Detail** as the **Query Level**, the EMR displays a complete list of bills in the Wolf File Viewer window.

Printing query results

If in the **Query Results** area, you select **Print**, the EMR changes the **Display** button to a **Print** button and displays a pre-selected **Page per Service Provider** check box:

1. If you do not want to print a page per practitioner, clear this check box.
2. Click **Print** (Print). The EMR displays the Printer Options window.
3. In the **Copies** field, enter the number of copies you want to make and in the **Printer** drop-down list, click the printer you want to use, the click **OK**.

4. If you want to re-send a claim file to MSP:
   a) In the **Submissions Found** list, click a claim.
   b) Click **(Re) Create Submission File**. The EMR displays a dialog box asking you to confirm that you want to recreate the claim file.
   c) Click **Yes**.

Viewing remittance history

From the **Remittance History** tab in eBill, you can view a history of your clinic's remittance imports from MSP. After the EMR displays a list of remittances, you can do the following:

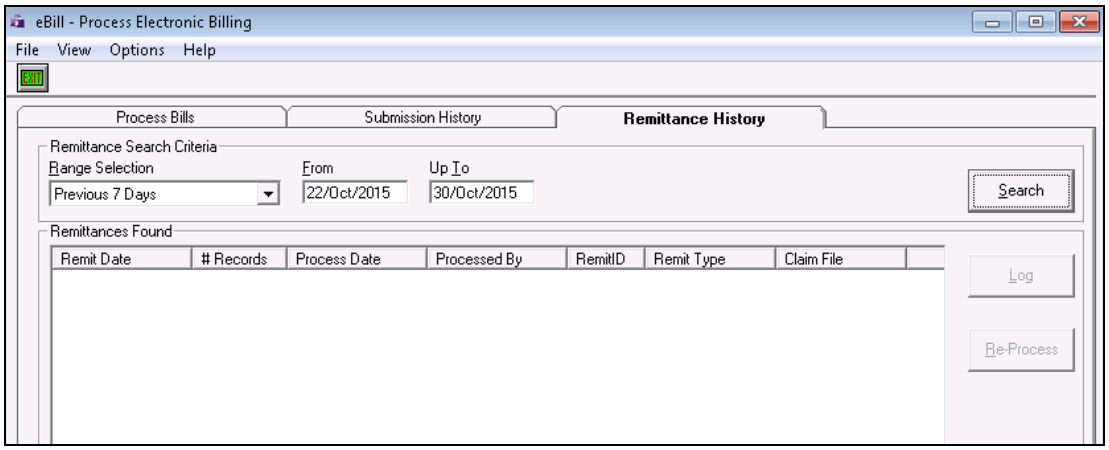
- Query remittance information.
- Re-process the remittance.
- Preview and print past RA Reports.

Remittance reports contain:

- A summary of a physician's paid claims and adjustments (such as interest payments and Rural Retention Premium) for the given payment period
- Broadcast messages sent from MSP
- WorkSafe BC claim numbers

Steps

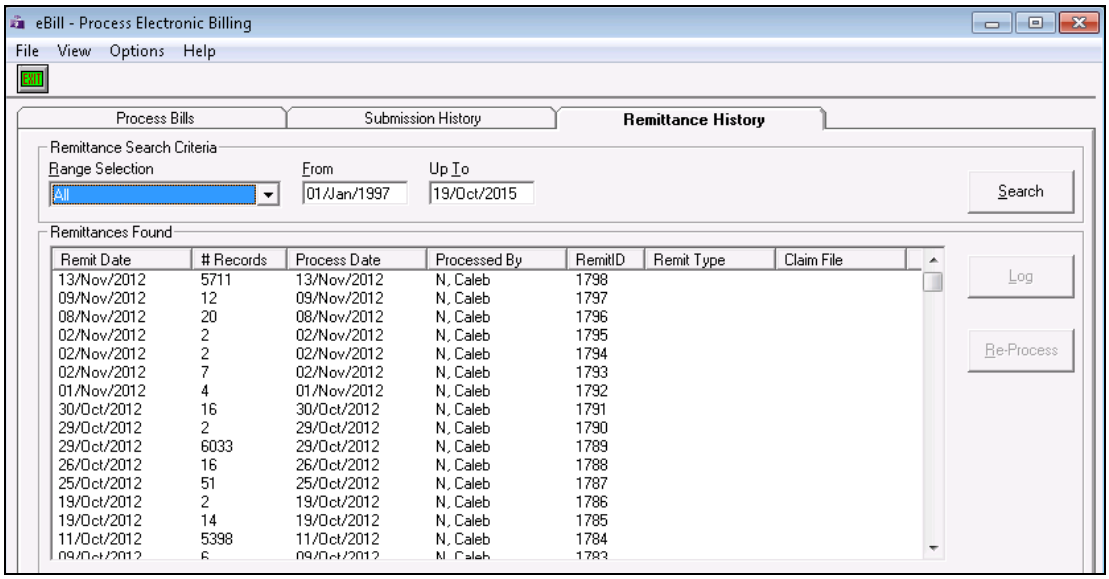
1. Open the eBill program: On the Wolf EMR Launch page, click **eBill** ( ). The EMR displays the eBill - Process Electronic Billing window.
2. Click the **Remittance History** tab. The EMR displays the **Remittance History** tab.



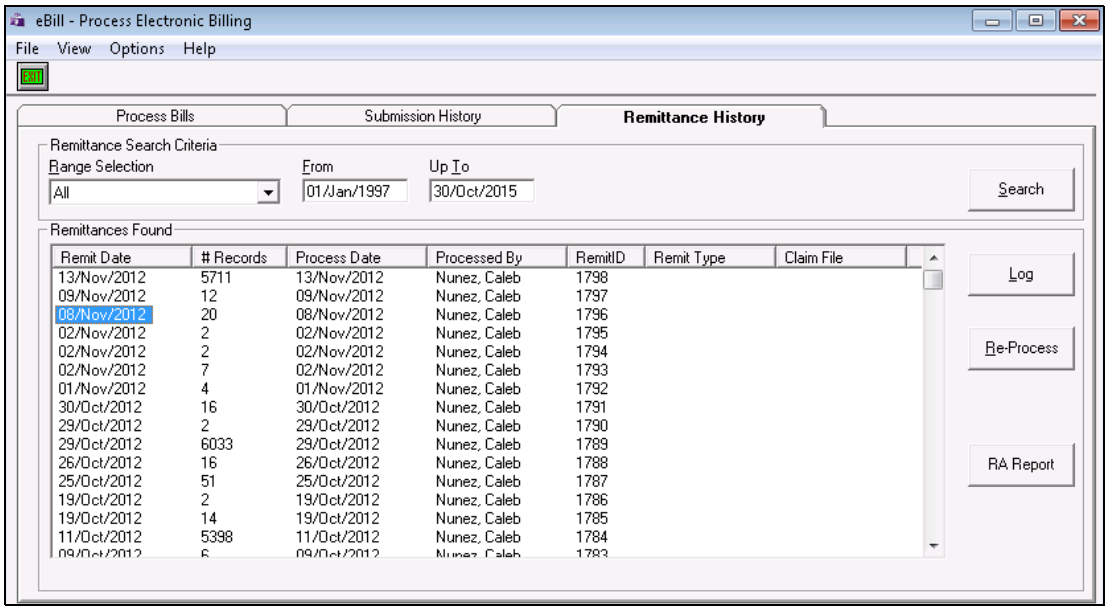
3. In the **Remittance Search Criteria** area, perform one of the following actions:
   - To select a pre-defined date range: In **Range Selection** drop down list, click a search date range.
   - To specify your own date range: In the **From** field, enter the start date, and then in the **Up To** field, enter the end date for the search criteria.

Note: The **Up To** date entered is **NOT** included in the calculation. For example, to search the entire month of April 2015 insert the following information: **From 01/Apr/2015**; **Up To 01/May/2015**.

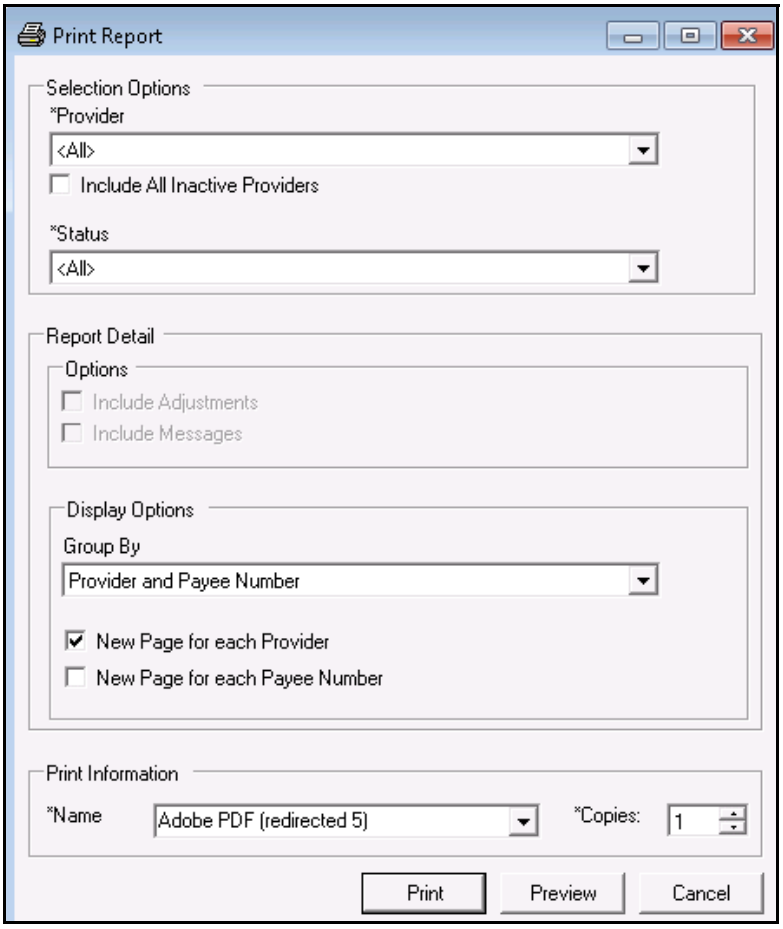
4. Click **Search**. The EMR lists all remittances found in the **Remittances Found** area.



5. In the **Remittances Found** list, click a remittance. The **Log**, **Re-Process**, and **RA Report** buttons are now available.



6. To query remittance information:
   a) Click **Log**. The EMR opens the Remittance Query window:
   a) In the **Select a query item from the list** area, select an item to query.
   b) If applicable, in the **Service Provider Selection** drop-down list, click a practitioner's name.
   c) Perform one of the following actions:
      - Click **Print** to print the query item.
      - Click **Display** to display the query item.
      - Click **Close** to close the Remittance Query window and return to the Remittance History tab.
7. To reprocess the remittance:
   a) Click **Reprocess**. The EMR displays a dialog box asking you if you are sure you want to reprocess the remittances.
   b) Click **Yes**.
8. To preview or print an RA Report:
   a) Click **RA Report**. The EMR opens the Print Report window.



b) In the **Provider** drop-down list, click a practitioner, or to print an RA Report for all practitioners, click **<All>**.

c) In the **Status** drop-down list, click an option to include **All** reports, or reports with the status of **Refused**, **On Hold**, **Paid With Adjustment**, or **Paid as Billed**.

d) To include information on bill adjustments and ministry notifications, in the **Report Detail** area, in the **Options** area, select one or both of the following options:

- **Include Adjustments**: To include information on adjustments made to bills.
- **Include Messages**: To include notifications sent from MSP.

e) To specify how listed items are to be grouped, in the **Group By** drop-down list, select one of the following options:

- **Provider and Payee Number**
- **Payee Number and Provider**

f) To not have a new page for each practitioner, in the **Display Options** area, clear the **New Page for each Provider** check box; otherwise each practitioner's claims are displayed on a separate page.

g) To have a new page for each BA number, select the **New Page for each Payee Number** check box.

h) Perform one of the following actions:

- To print the report, in the **Print Information** area, in the **Name** drop-down list select the printer you want to print to, and then click **Print**.
- To view a PDF version of the report, click **Preview**.

Tip: If you want to preview the information before printing:

1. Click **Preview**. The EMR displays the Print Preview window.
2. When you finish previewing the information, click **Print Report** ().

Chapter 7

Managing provincial incentive billing

In British Columbia, the General Practice Services Committee (GPSC) compensates family physicians for the additional work, beyond the office visit, of providing guideline informed care for:

- Patients who have certain chronic diseases (see "Chronic disease management provincial billing incentives" on page 101)
- Patients who require complex care (see "Complex care provincial billing incentives" on page 103)
- Patients who receive full-service family practice services from the family physician (i.e. are "attached" to the physician) (see "Attachment provincial billing incentives" on page 108)
- Patients who have mental illness and addictions (see "Mental health provincial billing incentives" on page 109)
- Patients who receive other specialized services (see "Other provincial billing incentives" on page 109)

Note: For more information on incentive billing opportunities in British Columbia, see the online General Practice Services Committee Incentive Billing Guides: www.gpscbc.ca/what-we-do/longitudinal-care/billing-guides

Using practice search and other billing management tools, in Wolf EMR you can keep on top of your provincial billing incentive payments. See "Managing provincial incentive billing in Wolf EMR" on page 111.

Chronic disease management provincial billing incentives

Family physicians who manage patients with chronic diseases can receive additional yearly payments, in addition to what they receive for regular patient visits. You can claim payment following a year of patient chronic disease management, provided that you also develop a disease-specific care plan for the patient.

Tip: For complete information on the GPSC Chronic Disease Management Incentive program in BC, go to: www.gpscbc.ca/family-practice-incentive/chronic-disease-management

The following table summarizes the chronic diseases eligible for incentive billing, and the associated billing codes:

Chronic disease	Code	Code if visits were provided while working under salary, service contract, or sessional arrangement
Diabetes	14050	14250
Heart failure	14051	14251
Hypertension	14052	14252
COPD	14053	14253

Notes on patient eligibility for CDM incentive billing

- To bill a patient for an incentive code, the patient must have been billed for at least two visits in the past 12 months, only one of which can be a Telephone visit (14076) or a Group Medical Visit (13763-13781).
- You can bill only once per diagnosis, per patient, per year.
- You cannot bill for 14052 (hypertension), if you have billed 14050 (diabetes mellitus) or 14051 (heart failure) in the preceding year. This is because management of hypertension is included in the guideline for diabetes and heart failure management.
- Visits provided by a locum for a GP are included; however, an electronic note indicating this must be submitted with the claim.
- Patients must be insured by MSP. CDM incentive payments are not available to patients from out-of-province.
- Patients in long-term care facilities are eligible.
- Patients are no longer eligible as soon as the Palliative Planning Incentive (14063) has been billed.
- When a GP assumes the practice of another GP who has been providing care to patients with eligible chronic conditions, the CDM fees are billable on fee anniversary dates provided the new GP has continued to provide care to these patients.

Complex care provincial billing incentives

Family physicians who manage complex care patients can receive yearly payments (in addition to what they receive for regular patient visits), when patients meet the complex care criteria, and the family physician produces a Complex Care Plan with the patients on an annual basis.

Unlike chronic disease management fees, you can claim payment for complex care management **at the beginning** of one year of patient management (assuming that the patient meets the defined criteria). By billing one of these fees, you accept this responsibility for the ensuing calendar year.

Tip: For complete information on the GPSC Complex Care Incentives program in BC, go to: www.gpscbc.ca/family-practice-incentive/complex-care-initiative

Qualifying conditions include:

- Diabetes mellitus (type 1 and 2)
- Chronic renal failure with eGFR values consistently less than 60
- Congestive heart failure
- Chronic respiratory condition (asthma, COPD, emphysema, chronic bronchitis, bronchiectasis, pulmonary fibrosis, fibrosing alveolitis, cystic fibrosis, etc.)
- Cerebrovascular disease
- Ischemic heart disease, excluding the acute phase of myocardial infarct
- Chronic neurodegenerative diseases (multiple sclerosis, amyotrophic lateral sclerosis, Parkinson's disease, Alzheimer's disease, stroke or other brain injury with a permanent neurological deficit, paraplegia, or quadriplegia, etc.)
- Chronic liver disease with evidence of hepatic dysfunction

The following table summarizes the complex care incentive billing codes. You can bill only one of the two codes per patient per calendar year. If a patient has qualified under 14033 there is no need or benefit to change to 14075.

Code	Description
14033	Advance payment for the complex work of caring for patients with **two** of the eligible conditions (listed above). This code is payable upon the completion and documentation of a Complex Care Plan that includes Advance Care Planning when appropriate. **Note:** When you bill a 14033, you must use the diagnostic code that represents the two conditions creating the most complexity. See "Diagnostic codes for multiple chronic conditions (used for 14033 bills)" on page 105. **Note:** 14016 or 14077 are payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for 14033. **Note:** 14050, 14051, 14052, and 14053 are payable on same day for same patient, if all other criteria met.
14075	Advance payment for the complex work of caring for patients with: ■ At least one of the eligible conditions (listed above), and ■ Documentation of a confirmed diagnosis of Moderately Frail (level 6) or Severely Frail (Level 7) as defined by a Canadian Study of Health and Aging (CSHA) Clinical Frailty Scale. See "Determining if a patient's level of fragility is sufficient for billing 14075" on page 107. This code is payable upon the completion and documentation of the Complex Care Plan that includes Advance Care Planning when appropriate. **Note:** Claim must include the diagnostic code **V15**.

Notes on patient eligibility for complex care billing

- The patient's co-morbidities should be of sufficient severity and complexity to cause interference in activities of daily living and warrant the development of a management plan.
- Patients must be Community Based (that is, they must be living at home or in assisted living). Patients are excluded if they live in Residential or Long Term Care facility where 24 hour nursing care is available.
- Complex care incentives are payable once per calendar year per patient upon the completion and documentation of the Complex Care Plan for the patient.
- A visit (office or home visit) or CPX fee must be billed on the same day as the incentive code to indicate that a face-to-face interaction with the patient occurred.
- A minimum of 30 minutes must be spent with the patient (or patient representative) developing and presenting a care plan. Although you are not required to submit start and end times with the claim, you are required to document, in the patient chart, the total time spent in planning and reviewing the care plan (combined time spent with and without the patient).
- Patients must be insured by MSP. Complex care incentive payments are not available to patients from out-of-province.
- Patients are no longer eligible as soon as the Palliative Planning Incentive (14063) has been billed.
- A maximum daily total of 5 of any combination of 14033 complex care, 14075 Attachment Complex Care or 14074 GP unattached complex/high needs patient attachment fees can be billed per physician. You should book appointments accordingly.

Diagnostic codes for multiple chronic conditions (used for 14033 bills)

When you bill for the complex care incentive you must use the diagnostic code that represents the **two** conditions creating the most complexity. Diagnostic codes have been developed to cover all combinations of any two of the chronic condition categories covered under the 14033 complex care fee. Use these diagnostic codes when billing a 14033.

The following table lists diagnostic codes for multiple chronic conditions.

Diagnostic Code	Condition One	Condition Two
N519	Chronic Neurodegenerative Disorder	Chronic Respiratory Condition
N414	Chronic Neurodegenerative Disorder	Ischemic Heart Disease
N428	Chronic Neurodegenerative Disorder	Heart Failure
N250	Chronic Neurodegenerative Disorder	Diabetes
N430	Chronic Neurodegenerative Disorder	Cerebrovascular Disease
N585	Chronic Neurodegenerative Disorder	Chronic Kidney Disease
N573	Chronic Neurodegenerative Disorder	Chronic Liver Disease (Hepatic Dysfunction)
R414	Chronic Respiratory Condition	Ischemic Heart Disease
R428	Chronic Respiratory Condition	Heart Failure
R250	Chronic Respiratory Condition	Diabetes
R430	Chronic Respiratory Condition	Cerebrovascular Disease
R585	Chronic Respiratory Condition	Chronic Kidney Disease
R573	Chronic Respiratory Condition	Chronic Liver Disease (Hepatic Dysfunction)
I428	Ischemic Heart Disease	Heart Failure
I250	Ischemic Heart Disease	Diabetes
I430	Ischemic Heart Disease	Cerebrovascular Disease
I585	Ischemic Heart Disease	Chronic Kidney Disease
I573	Ischemic Heart Disease	Chronic Liver Disease (Hepatic Dysfunction)
H250	Heart Failure	Diabetes
H430	Heart Failure	Cerebrovascular Disease
H585	Heart Failure	Chronic Kidney Disease
H573	Heart Failure	Chronic Liver Disease (Hepatic Dysfunction)
D430	Diabetes	Cerebrovascular Disease
D585	Diabetes	Chronic Kidney Disease

Diagnostic Code	Condition One	Condition Two
D573	Diabetes	Chronic Liver Disease (Hepatic Dysfunction)
C585	Cerebrovascular Disease	Chronic Kidney Disease
C573	Cerebrovascular Disease	Chronic Liver Disease (Hepatic Dysfunction)
K573	Chronic Kidney Disease	Chronic Liver Disease (Hepatic Dysfunction)

Determining if a patient's level of fragility is sufficient for billing 14075

You can bill a 14075 code only if a patient is documented to have a confirmed diagnosis of Moderately Frail (level 6) or Severely Frail (Level 7) as defined by a Canadian Study of Health and Aging (CSHA) Clinical Frailty Scale.

You can use the following table to determine a patient's level of frailty.

Frailty level	Definition	Description
1	Very fit	Robust, active, energetic, well-motivated and fit; these people commonly exercise regularly and are in the most fit group for their age.
2	Well	Without active disease, but less fit than people in level 1.
3	Well, with treated comorbid disease	Symptoms are well controlled compared to those in level 4.
4	Apparently Vulnerable	Although not frankly dependent, these people commonly complain of being "slowed up" or have disease symptoms.
5	Mildly Frail	With limited dependence on others for instrumental activities of daily living.
6	Moderately Frail	Help is needed with both instrumental and non-instrumental activities of daily living.
7	Severely Frail	Completely dependent on others for the activities of daily living, or terminally ill.

The above table is from GPAC "Frailty in Older Adults – Early Identification and Management", Revised January 18, 2012

www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines

Attachment provincial billing incentives

If you provide full-service family practice services to your patients, you can receive extra payment for managing attached patients.

The following table summarizes the attachment fee codes.

Fee Code	When you can use	Amount billed
G14070 (GP attachment participant code)	Bill this code at the beginning of the calendar year to indicate that you are committed to participating in the attachment program for the next year. You can then bill attachment incentive fees for the remainder of the year.	**$0.00**
G14071 (Locum attachment participant code)	If you locum for a family practice that participates in the attachment program, bill this code at the beginning of the calendar year to indicate that you are providing full-service family practice services to the patients of the host physician. You can then bill attachment incentive fees for all patient's attached to the host physician for the remainder of the year.	**$0.00**
G14074 (Complex/High-needs unattached patient attachment fee)	Billed when you integrate **a new patient** (who is not currently being managed by another physician) with higher needs into your family practice. **Note:** Ensure the patient meets the eligibility requirements, and that the appropriate documentation is completed.	**$200**
G14075 (Attachment complex care management incentive)	Billed when you commit to managing a patient with eligible condition(s) for the next year and you complete and document a Complex Care Plan/ Advance Care Plan (ACP) **Note:** This is an expansion of the GPSC complex care incentive to include diagnosis of "Frailty" (V15) when not covered under dual-diagnosis. You can bill only one of14033 or 14075 in one calendar year for a patient.	**$315**
G14076 (Attachment telephone management fee)	Billed when you conduct telephone 'visits' (providing clinical management advice or follow-up) for attached patients.	**$15**

Fee Code	When you can use	Amount billed
G14077 (GP Attachment patient conference fee)	Billed when you conduct a care conference with other health care providers regarding one of your patients. **Note:** This code replaces **G14015**, **G14016**, & **G14017**.	**$40/15min**

Mental health provincial billing incentives

If you assess and manage community-based patients with mental illness and addictions, you can receive extra payment for documenting the management of these patients.

Tip: Use the Wolf EMR mental health SMART exams to document mental health planning and management visits.

Fee Code	When you can use	Amount billed
G14043 (GP mental health planing fee)	Billed when you develop and document a patient's Mental health Plan. Patients must have a confirmed Axis I diagnosis of sufficient severity and acuity to warrant the development of a management plan.	**$100.00**
G14044 - G14048 (GP mental health management fees)	Billed when you conduct prolonged counselling visits (minimum time **20min**) with patients on whom a **G14043** fee has been successfully billed. **Note:** Fee code is age dependant.	**$100.00**

Other provincial billing incentives

Worried that you may be missing out on other billing opportunities? Following are some other commonly missed billing incentives to be aware of.

Fee Code	When you can use	Amount billed
G14063 (Palliative care planning fee)	Billed when you develop and document an Advance (Palliative) Care Plan for patients who have reached the palliative stag of a life-limiting disease or illness. **Note:** Patients must be living at home or in assisted living.	**$100.00**
G14066 (Personal health risk assessment)	Billed when you undertake a Personal Health Risk Assessment with a patient in one of the designated target populations (obese, smoker, physically inactive, unhealthy eating), and develop a plan for preventative actions.	**$50.00**
Conferencing and telephone management incentives		
G14015 (Facility patient conference fee)	Billed when you are requested by the facility in which the patient is residing (permanently or temporarily) to review ongoing management of the patient in that facility or to determine whether the patient with complex supportive care needs can safely return to the community or transition to a supportive care or long-term care facility. **Note:** If you participate in the Attachment program, bill **G14077** instead.	**$40.00/15min**
G14016 (Community patient conferencing fee)	Billed when you conduct two-way collaborative conferencing, with at least one other allied care provider, about the care of a community-based patient with more complex needs. **Note:** If you participate in the Attachment program, bill **G14077** instead.	**$40.00/15min**
G14017 (Acute care discharge planning conferencing fee)	Billed when you participate in a Discharge Planning conference regarding one of your patients with complex supportive care needs, for review of condition(s) and planning for safe transition to the community or to a different facility. **Note:** If you participate in the Attachment program, bill **G14077** instead.	**$40.00/15min**

Fee Code	When you can use	Amount billed
G14018 (General practice urgent telephone conference with a specialist)	Billed when you participate in an **urgent** telephone conference (within 2hrs of request) with a specialist, followed by the creation, documentation, and implementation of a clinical action plan for the care of a patient with **acute** needs.	**$40.00**
G14019 (GP - Advice to a Nurse Practitioner)	Billed when you provide advice (by telephone or in person) to an independent practice Nurse Practitioner, at the request of the Nurse Practitioner, regarding patients for whom the NP has accepted the responsibility of being the Most Responsible Provider for that patient's community care.	**$40.00**
G14021 (GP with specialty training telephone advice)	If you are a GP with specialty training, bill this code when you provide telephone advice to a GP or Specialist, at the request of the GP or Specialist, for the purpose of improving patient care. You must respond within 2hrs of the request.	**$60.00**
G14022 (GP with specialty training telephone patient management)	If you are a GP with specialty training, bill this code when you participate in two-way communication with a GP, Specialist, or Allied Care Provider, regarding the assessment and management of a patient. You must respond within 7 days of the request.	**$40.00/15min**
G14023 (GP with specialty training telephone patient management/ Follow-up)	If you are a GP with specialty training, bill this code when you participate in two-way telephone communication with a patient on a clinical level.	**$20.00/15min**

Managing provincial incentive billing in Wolf EMR

Using Wolf EMR practice search, you can manage your chronic disease and complex care management incentive billing:

- On a daily basis, using practice search rules to prompt you to book appointments and bill for patients who are due for their annual chronic disease or complex care management billing.
- On a less regular basis, using practice search reports to summarize patients who are due for their annual chronic disease or complex care management billing.

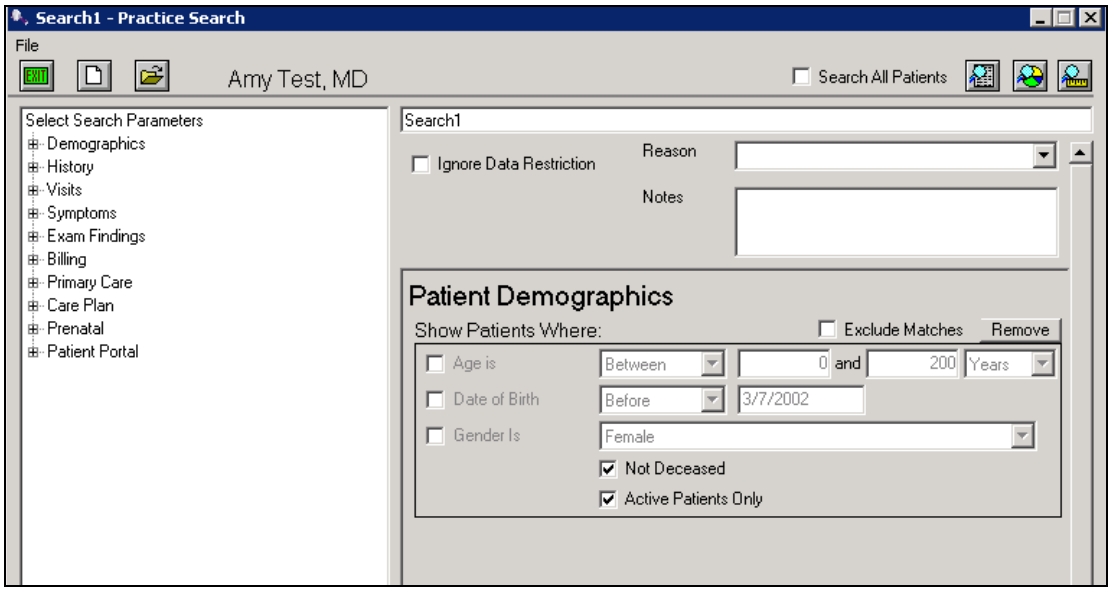
Creating a practice search

Before you can produce a report of patients or create a rule to flag patients who have a specific condition, you must first create a practice search. A practice search defines what parameters patients must meet to be displayed on a report or to be flagged by a rule. You can use the eligibility criteria set by the GPSC to define appropriate parameters for billing-related practice searches. For example, you can create practice searches for:

- Complex care patients who have been billed with a diagnosis code of H250, and have not been billed for a 14033 in over 1 year.
- Chronic disease patients who have a diagnosis of Diabetes (250, or any variant such as 250.1) in their problem list, and have not been billed for a 14050 in over 1 year.

Steps

1. On the Wolf EMR Launch Page, click **Practice Search** ( ). The EMR displays the Practice Search window.

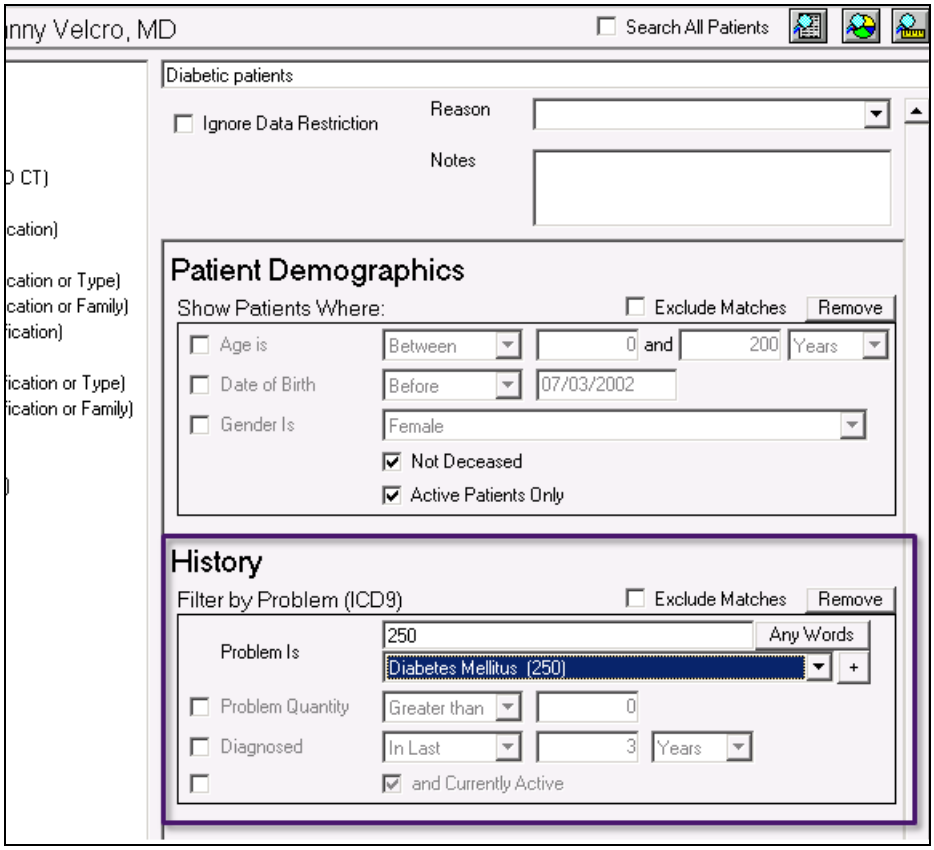


2. Click **Make a New Search** ( ). The EMR displays a dialog box with the following prompt: "Are you sure that you want to clear the Current Search? This Operation cannot be undone."
3. Click **Yes**.
4. In the top field, enter a descriptive name for your search.
5. Enter a search parameter:
   a) In the **Select Search Parameters** list, expand the appropriate parameter category (for example, **History**).
   b) In the expanded list, click the parameter you want (for example, **Problem (ICD9)**). The EMR displays a new area for the parameter on the right side of the window.

Tips for selecting a search parameter

- For chronic disease management practice searches, you typically search for patients based on **Problem (ICD9)**. If you select an ICD9 code without a decimal (for example, 250), the search includes all decimal points for that number (for example, 250.1).
- To view a complete list of available parameters and parameter descriptions, in Wolf online help, see the "Practice Search Parameters" help topic.

c) In the parameter area, enter parameter details.



6. If patients matching the parameter you set are to be excluded from the practice search, select the **Exclude Matches** check box. For example, you can exclude diabetic patients who have been billed for 14050 less than a year ago.
7. To add additional parameters to the practice search, repeat Step 5.
8. To remove a parameter, in the parameter area on the right side of the window, click **Remove**.

9. When you finish entering parameters, click **Save Current Search** (). The EMR displays the Save Current Search As window.

10. Perform one of the following actions:

    - To define the practice search as a rule, enter properties for the rule, and then click **Save as New**. See Step 4in "Creating rules" on page 116.
    - To define the practice search as a search, click **Save as New**. You can now produce a search report. See "Using search reports" on page 122.

Tips for creating a practice search

- Once you save a practice search as a search (that is, you save it without selecting the **Save Item as Rule** check box), you cannot later change the search to a rule.
- In the **Select Search Parameters** area:
    - Most parameters based on Medical Summary information (for example, **Problem**, and **Lab Results**) are available in the **History** category.
    - Parameters based on patient last and next appointments (**Last Visit**, and **Next Visit**) are available in the **Demographics** category.
- In a practice search, you can define only parameters that all patients must meet. You cannot set a group of parameters where patients need to match only one parameter. For example, for a diabetic practice search you cannot find patients that have:
    - An ICD9 diagnosis code of 250 in the problem list, OR
    - Have had a Hemoglobin A1C value > 6.5, OR
    - Have been billed for the diagnosis code of 250

  Ensure all patients who are chronic disease or complex care patients have the correct problem code in their problem list. This way, you can search for those patients using only one parameter.

Using rules

Rules are patient searches that "flag" patients if they match the associated practice search criteria. Patients are automatically "un-flagged" as soon as they no longer match a rule's parameters.

> **Note**: If you want to exclude a patient from being flagged by a rule, you can exempt the patient from the rule for a defined period of time.

Using the eligibility criteria set by the GPSC, you can create and activate practice search rules that flag patients who are due for their annual chronic disease or complex care management billing.

> **Note**: Wolf EMR also comes with a number of pre-configured rules that flag patients who are due for chronic disease or complex care management incentive billing.

Each day, the clinical staff can review rule matches and:

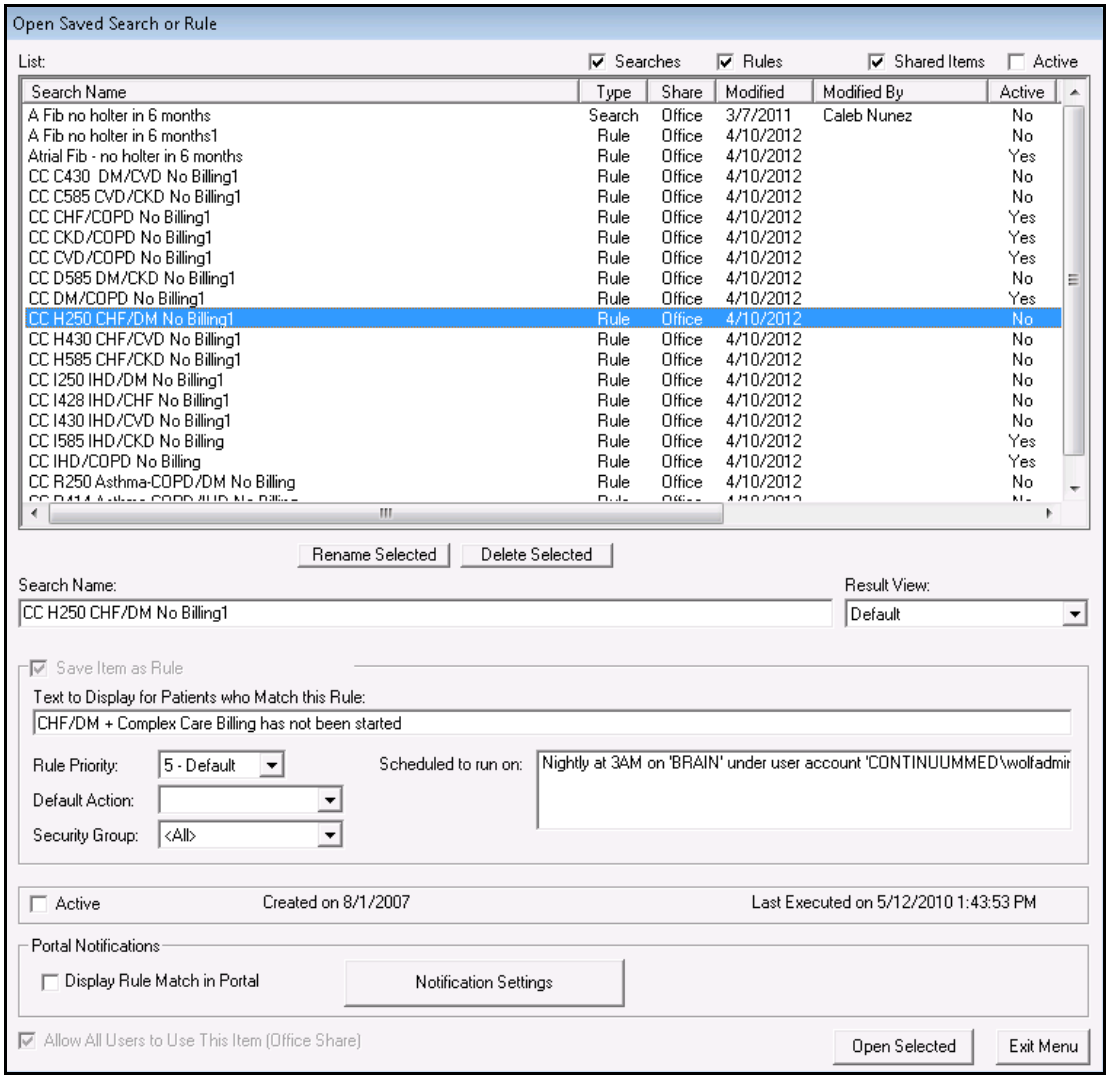
- Bill patients flagged for chronic disease management billing.
- Book patients who are due for their annual Complex Care Plan appointment (enabling you to bill for their annual complex care fee).

Creating rules

You create a rule by producing or selecting a practice search that defines what criteria patients must meet to be flagged by the rule. You then choose to make the practice search a rule, and define the rule's properties. When the rule is complete, by default the EMR executes the rule (that is, the EMR searches for and flags matching patients) every evening.

Steps

1. On the Wolf EMR Launch page, click **Practice Search** (). The EMR displays the Practice Search window.
2. Perform one of the following actions:
   - To create a new rule, produce a practice search that defines the parameters patients must meet to be flagged by the rule. See "Creating a practice search" on page 112.
   - To use a pre-configured rule, click **Open a Previously Saved Search** (). The EMR displays the Open Saved Search or Rule window, with a list of searches and rules. Click the rule you want to use.



Note: Wolf EMR comes with a number of pre-configured rules for chronic disease and complex care management. In your list of practice searches, you can easily identify these rules, as they start with **CDM** (for example, "CDM DM Billing Incomplete"), or **CC** (for example, CC H250 DM/CVD No Billing).

Note: You may have to modify the parameters set for pre-configured rules to take in account your clinic's workflow.

Tip: Modifying pre-configured rules

You can modify the search parameters set for pre-configured rules as needed. To modify a pre-configured rule:

1. In the Open Saved Search or Rule window, click the rule.
2. At the bottom of the window, click **Open Selected**. The EMR displays the Practice Search window for the rule.
3. Enter, remove, or modify parameters as needed. See "Creating a practice search" on page 112.

4. In the Save Current Search As window (if you created a new rule) or in the Open Saved Search or Rule window (if you are using a pre-configured rule), using the following table, enter or modify the rule's properties.

Field	Description
Save Item as Rule	To make the practice search a rule, select this check box.
Text to display for patients who match this rule	Enter a prompt to display for patients who are flagged by this rule. **Note:** The prompt you enter displays as the **Rule Text** in the Rule Matches window. See "Viewing and managing rule matches" on page 120.
Rule Priority	Select a priority for the rule. The range is between **1** and **9**, with 1 being the highest priority. **Note:** When you later view rule matches, you can filter the list based on priority level. For example, you can choose to view only Priority 1 rules.
Default Action	To set an action to be selected by default in the Rule Matches window, in the drop-down list, click the action.

Field	Description
Security Group	To assign a specific role or team to address the rule matches, in the drop-down list, click the role or team. **Note:** A role or team displays in the **Security Group** drop-down list only if a security group has been created for the role or team. **Tip**: If a group of billing staff manage CDM and/or Complex Care billing, create a specific security group for these staff members (for example, a security group called "Billing"). When you create a CDM billing rule, you can then assign "Billing" as the Role for the rule. When the billing staff view the clinic's rule matches, they can filter the list to display only rule matches assigned to "Billing".
Scheduled to run on	Displays the time and frequency the EMR will search for and identify patients who match the rule. **Note:** You cannot edit information displayed in this field. All rules run nightly.
Active	To activate the rule, select this check box. **Note:** The rule will execute on a nightly basis until you clear this check box.
Portal Notifications (This area displays only if the Patient Portal is enabled for your clinic)	If you use the Patient Portal, and you want patients who match the rule to receive a notification on the Patient Portal: 1. In the **Portal Notifications** area, select the **Display Rule Match in Portal** check box. 2. Click **Notification Settings**. The EMR displays the Portal Notification Settings window. 3. In the text area, enter the notification message that patients will see in the Patient Portal. 4. If you want patients to receive an email indicating that a notification is present in the Patient Portal, select the **Send Email Alert** check box. 5. Click **Save**.

6. Perform one of the following actions:
   - If you are creating a new rule, click **Save as New**.
   - If you are modifying and/or activating a pre-configured rule, click **Exit Menu**.

After the rule is activated, it executes (that is, produces a list of rule matches) on a nightly basis after clinic hours. The rules does not automatically execute as soon as you save it.

Tips for creating and activating rules

- You can manually run a rule (that is, produce a list of rule matches) at any time. In the Open Saved Search or Rule window, select the rule you want to run, and then click **Open Selected**. In the Practice Search window, click **Execute the Rule Engine** ().

Note: When you execute a rule, it can take a long time to complete, and as the rule is being executed, Wolf EMR may slow down for you and other clinic users. For this reason, it is recommended that you execute rules after clinic hours.

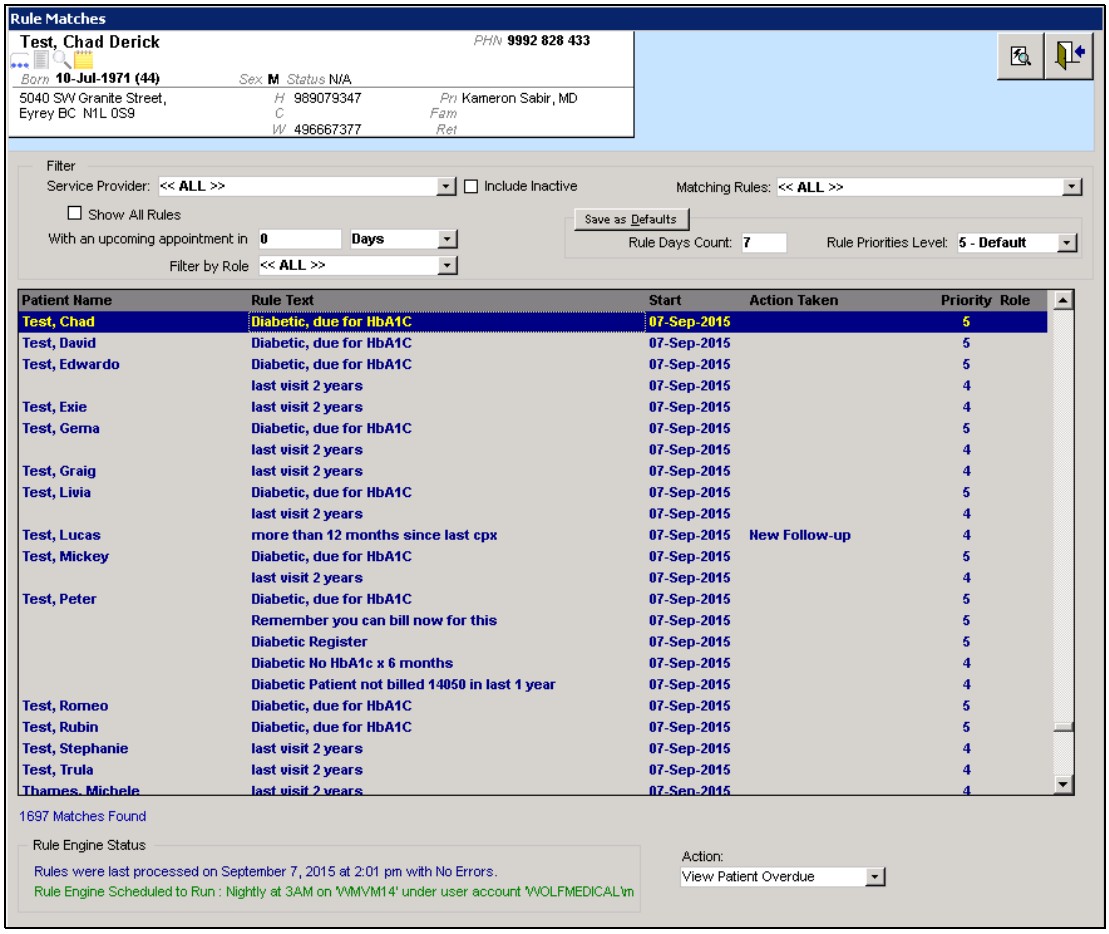
Viewing and managing rule matches

You view and manage patients who are flagged by a rule in the Rule Matches window. Here, you can:

- Create bills for patients who are due for incentive payments
- Create follow-up tasks or to-come-in tasks for patients who are due for visits or annual reviews (required for incentive payments)
- Exempt patients who should not be flagged by a rule

Steps

1. Perform one of the following actions:
   - If you are a practitioner, in the **Tasks** area of the WorkDesk, in the **Investigation Results** area, click **# Rule Matches (level 5) found in last x days**. The EMR displays the Rule Matches window, with a list of your patients flagged by rules.
   - If you are a front end staff, in the **Clinical Queues** area of the WorkDesk, click **# Rule Matches Found...** The EMR displays the Rule Matches window, with a list of patients flagged by rules.



2. Using the options available in the **Filter** area, filter the list as needed. For example, to view only rule matches that are assigned to the Billing security group, in the **Filter by Role** drop-down list, click **Billing**.
3. Click the rule match you want to respond to.
4. To bill a patient directly from the rule matches window, click the patient's name, and then press **Ctrl** + **Shift** + **$**. The EMR opens the billing window for the patient.
5. To create a follow up task, or a patient to come in (TCI) task for the patient (for example, if you want to contact the patient to come in for their Complex Care annual plan review), in the **Action** drop-down list, select **Create New Follow-up**.
6. To exempt the patient from the rule for a defined period of time, in the **Action** drop-down list, select **Create Rule Exemption**.

Note: After you select an action to perform on a patient, the action is noted in the Rule Matches list in the **Action Taken** column.

The patient remains on the Rule Matches list until they no longer match the rule parameters, or until you create a rule exemption.

Note: If a patient no longer matches the rules parameters, the EMR removes them from the list only when the rule is next run (rules run on a nightly basis).

7. When you finish managing rule matches, click  .

Using search reports

If you have not addressed your chronic disease and complex care management billing for a prolonged period of time, you can produce a search report of patients who are due to be billed for chronic disease or complex care management. From the search report, you can:

- Add columns to display billing data and appointment dates for the displayed patients
- Print the report, or export the report (to open in a spreadsheet application)
- Bill patients
- Perform other actions on listed patients (for example, you can create follow-up tasks to book patients for a complex care plan annual review)

To produce a report of patients, you first create a customized practice search that defines parameters patients must meet to display on the report. You can then produce a search report from the defined practice search.

You can also produce a search report using a pre-configured practice search that comes with Wolf EMR.

Producing a search report

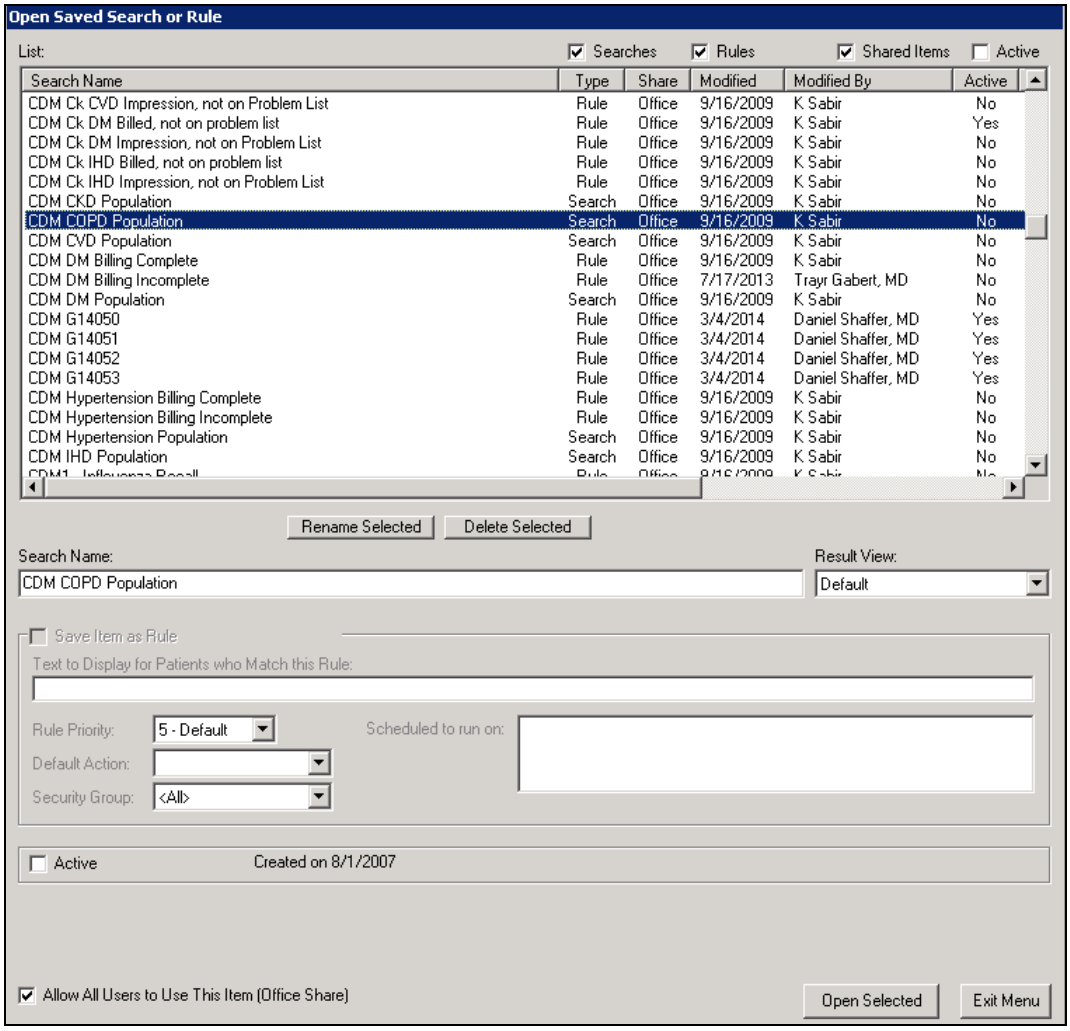
After you create a practice search, you can produce a printable report of patients matching the parameters you set in the practice search. You can also produce a report based on any of the Wolf EMR pre-configured practice searches for common groups of chronic disease or complex care patients, including:

- DM (diabetes)
- Hypertension
- COPD
- CHF (congestive heart failure)

If the search parameters for a pre-configured practice search do not meet your needs, you can modify the search parameters before you produce a report.

Steps

1. On the Wolf EMR Launch page, click **Practice Search** ( ).
2. Complete one of the following actions:
   - To create a search, produce a practice search that defines the parameters patients must meet to display on the report. See "Creating a practice search" on page 112.
   - To use a pre-configured search:
     a) Click **Open a Previously Saved Search** ( ). The EMR displays the Open Saved Search or Rule window, with a list of available searches.



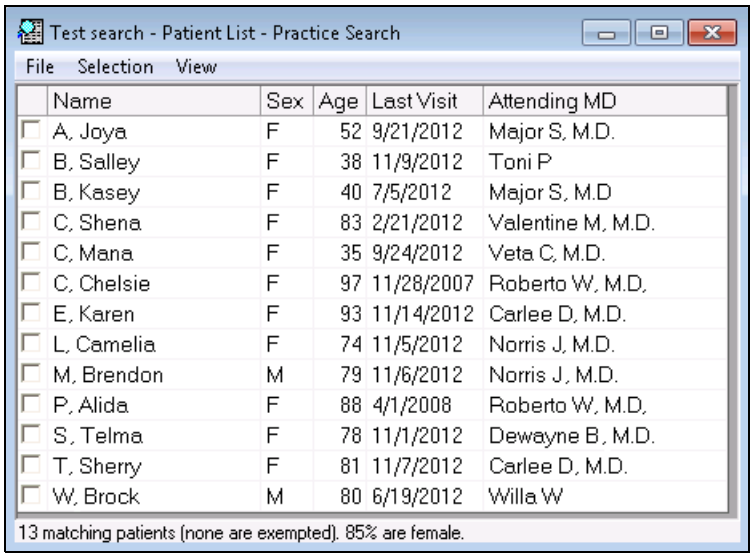
b) Click the search you want to use, and then click **Open Selected**. The EMR displays the Practice Search window for the selected search.

> **Note**: If you are using a TELUS Health-provided practice search that is configured to pull groups of chronic disease or complex care patients, look for practice searches that start with "**CDM**" (for example, "CDM Hypertension Population"), or "**CC**".

c) Modify the practice search parameters as needed. See Step 5to Step 8in "Creating a practice search" on page 112.

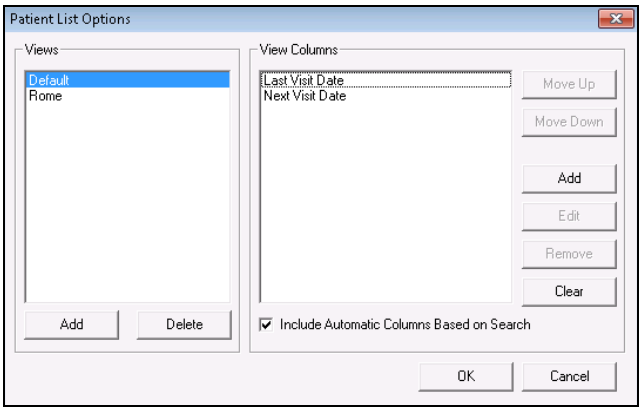
3. To produce a search report for all practitioners, at the top of the Practice Search window, select the **Search All Patients** check box.

4. Click **Show Search Results as a Patient List** (). The EMR displays the Patient List - Practice Search window with a list of patients meeting the parameters set by the practice search.



5. Using the following table, manage the patients on the list.

To do this...	Perform the following action
Bill a patient	Click the patient's name and then, on your keyboard, press **Ctrl** + **Shift** + **$**. The EMR opens the billing window for the patient.

To do this...	Perform the following action
Create a follow-up task or to-come-in task For example, you want to contact the patient to come in for their annual complex care plan review	1. Select the check box beside the patient(s) name, or to select all patients, click **Selection** > **Select all**. 2. Click **Selection** > **Add to Followup List**.
Add a column to the list For example, you want to view the date of the patients' next appointment.	1. Click **View** > **Column Options**. The EMR displays the Patient List Options window.  2. In the **View Columns** area, click **Add**. 3. In the **What to Display** drop-down list, select a data option. 4. Click **OK**.
Print the list For example, you are using the list as a call list.	Click **File** > **Print All**.

Chapter 8

Billing reports

Wolf EMR is equipped with a number of pre-configured reports to help your clinic with billing reconciliation and other accounting tasks. You can produce a number of:

- Accounting reports (See "Accounting reports" on page 128)
- Other billing reports (See "Other billing reports" on page 154)

Setting up report options

You can specify whether the EMR displays a message to indicate that a label or report has been sent to the printer.

Steps

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** (). The EMR displays the Billing window.
2. On the Billing menu, click **Reports** > **Report Options**, and then select or clear the following check boxes:
   - If you want the EMR to display a message after a label has been sent to the printer, select the **Notify after Label Print** check box.
   - If you do not want the EMR to display a message after a label has been sent to the printer, clear the **Notify after Label Print** check box.
   - If you want the EMR to display a message after a report has been sent to the printer, select the **Notify after Report Print** check box.
   - If you do not want the EMR to display a message after a report has been sent to the printer, clear the **Notify after Report Print** check box.

Accounting reports

The following table summarizes the accounting reports available in Wolf EMR.

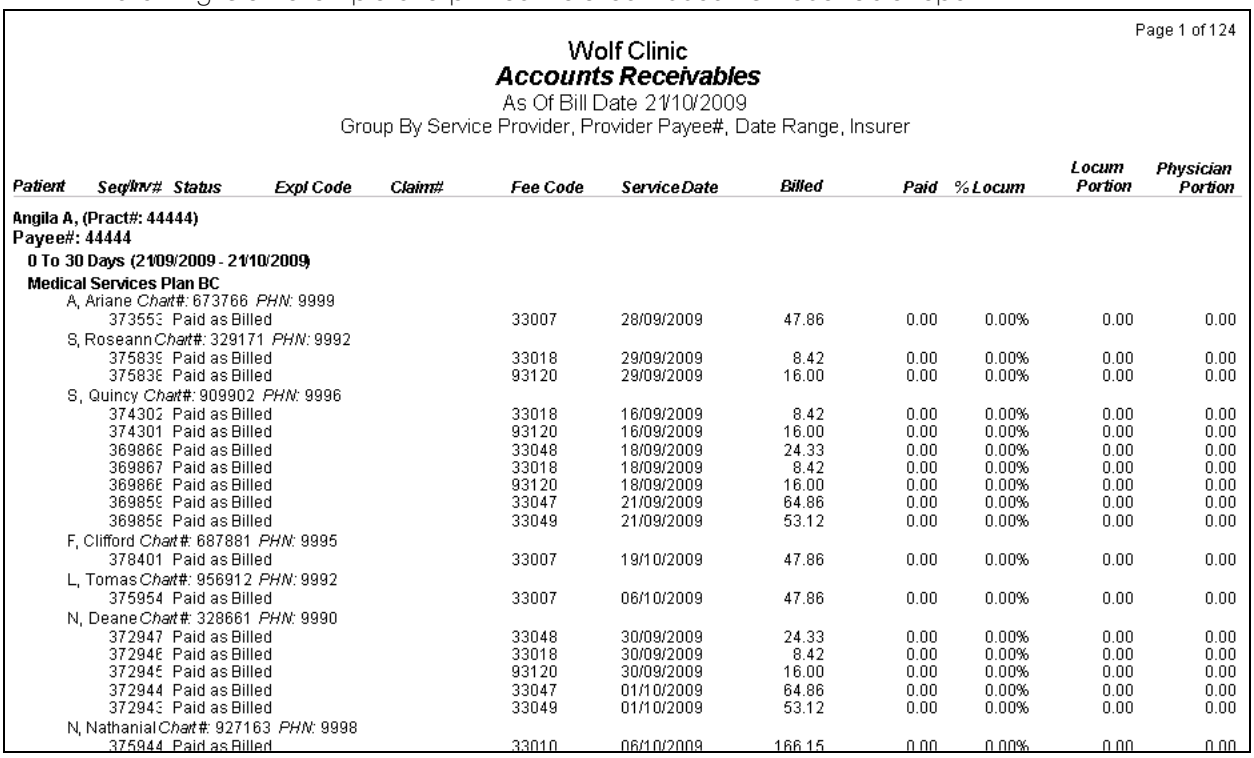
Report name	Information displayed on report	
Accounts Receivable Report of outstanding bills as of a specified date. See "Running an Accounts Receivable report" on page 129.	**Detailed report** For each practitioner, displays a list of outstanding bills. For each bill listed, you see: ■ Patient name, PHN ■ Bill Status, explanation codes, claim number ■ Bill fee code, service date ■ Billed amount, paid amount ■ % Paid to locum, locum portion, physician portion	**Summary Report** For each practitioner, displays: ■ Total amount billed and paid for outstanding bills for each insurer. ■ Total amount billed and paid for outstanding bills billed by each Payee#
Account Summary For all bills, no matter the status, summarizes total amount paid, total amount billed, and total amount outstanding. See "Running an Accounting Summary report" on page 134	**Detailed report** For each practitioner, displays a complete list of insurers billed, and for each insurer, details: ■ A complete list of bills ■ Net billed ■ Net paid ■ Amount owed (Net billed minus Net paid) ■ Net Written off, rebilled, adjusted, deleted, overpaid, and/or paid by cheque that bounced	**Summary Report** For each practitioner, displays the total amount: ■ Billed ■ Billed by locum ■ Debited ■ Adjusted ■ Written off (w/o) ■ Paid ■ Paid by cheque that bounced ■ Paid to locum

Report name	Information displayed on report	
Billing Summary For all bills, no matter the status, summarizes the total amount billed and total amount paid. Includes information on fee codes. See "Running a Billing Summary report" on page 139.	**Detailed report** Includes the same information as the Account Summary report (described above), but the report but also includes a breakdown of total amount billed and paid for each fee code.	**Summary Report** For each practitioner, displays the total amount: ■ Billed ■ Rebilled ■ Adjusted ■ Written off ■ Paid ■ Paid by cheque that bounced
Paid Summary Report For paid bills, summarizes the total quantity and amount paid for each fee code or diagnosis code. See "Running a Paid Summary report" on page 145.	For each practitioner, displays a list of insurers billed, and for each insurer, details: ■ A list of fee codes or ICD9 codes billed to and paid by the insurer. ■ For each fee code or ICD9 code, lists the number of times the fee code or ICD9 code was billed and the total amount billed.	
Paid Detail Report Provides a list of bills paid by each insurer. See "Running a Paid Detail report" on page 150.	For each practitioner, displays a list of insurers billed, and for each insurer, details: ■ A list of bills paid by the insurer. ■ For each bill, includes the patient Name, claim #, service date, fee code(s), transaction date, billed amount, paid amount, and payment method.	

Running an Accounts Receivable report

The Accounts Receivable Report provides outstanding bills as of a specified date. This is an important report for your month end reporting. You should run an Accounts receivable report at the end of every month to keep track of what you have not been paid for. You can run the report for just the province-specific payors or for all payors. You can preview or print the report in a detail or summary format. You can also export the report to a variety of file types.

Following is an example of a printed Detailed Accounts Receivable report.



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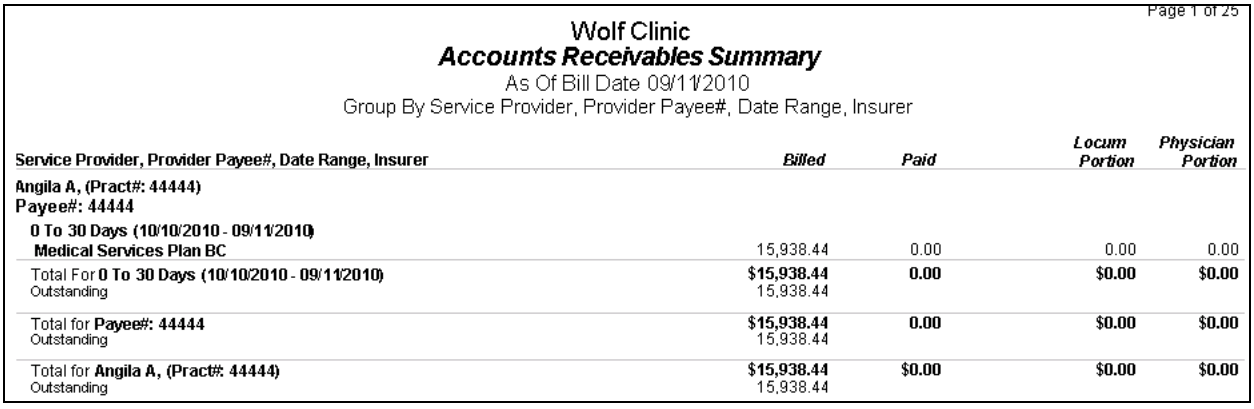
Wolf Clinic
Accounts Receivables
As Of Bill Date 21/10/2009
Group By Service Provider, Provider Payee#, Date Range, Insurer

Patient	Seq/Inv#	Status	Expl Code	Claim#	Fee Code	Service Date	Billed	Paid	% Locum	Locum Portion	Physician Portion
Angila A, (Pract#: 44444)											
Payee#: 44444											
0 To 30 Days (21/09/2009 - 21/10/2009)											
Medical Services Plan BC											
A, Ariane *Chart#*: 673766 *PHN*: 9999											
	373553	Paid as Billed			33007	28/09/2009	47.86	0.00	0.00%	0.00	0.00
S, Roseann *Chart#*: 329171 *PHN*: 9992											
	375839	Paid as Billed			33018	29/09/2009	8.42	0.00	0.00%	0.00	0.00
	375838	Paid as Billed			93120	29/09/2009	16.00	0.00	0.00%	0.00	0.00
S, Quincy *Chart#*: 909902 *PHN*: 9996											
	374302	Paid as Billed			33018	16/09/2009	8.42	0.00	0.00%	0.00	0.00
	374301	Paid as Billed			93120	16/09/2009	16.00	0.00	0.00%	0.00	0.00
	369868	Paid as Billed			33048	18/09/2009	24.33	0.00	0.00%	0.00	0.00
	369867	Paid as Billed			33018	18/09/2009	8.42	0.00	0.00%	0.00	0.00
	369866	Paid as Billed			93120	18/09/2009	16.00	0.00	0.00%	0.00	0.00
	369859	Paid as Billed			33047	21/09/2009	64.86	0.00	0.00%	0.00	0.00
	369858	Paid as Billed			33049	21/09/2009	53.12	0.00	0.00%	0.00	0.00
F, Clifford *Chart#*: 687881 *PHN*: 9995											
	378401	Paid as Billed			33007	19/10/2009	47.86	0.00	0.00%	0.00	0.00
L, Tomas *Chart#*: 956912 *PHN*: 9992											
	375954	Paid as Billed			33007	06/10/2009	47.86	0.00	0.00%	0.00	0.00
N, Deane *Chart#*: 328661 *PHN*: 9990											
	372947	Paid as Billed			33048	30/09/2009	24.33	0.00	0.00%	0.00	0.00
	372946	Paid as Billed			33018	30/09/2009	8.42	0.00	0.00%	0.00	0.00
	372945	Paid as Billed			93120	30/09/2009	16.00	0.00	0.00%	0.00	0.00
	372944	Paid as Billed			33047	01/10/2009	64.86	0.00	0.00%	0.00	0.00
	372943	Paid as Billed			33049	01/10/2009	53.12	0.00	0.00%	0.00	0.00
N, Nathanial *Chart#*: 927163 *PHN*: 9998											
	375944	Paid as Billed			33010	06/10/2009	166.15	0.00	0.00%	0.00	0.00

Following is an example of a printed Summary Accounts Receivable report.



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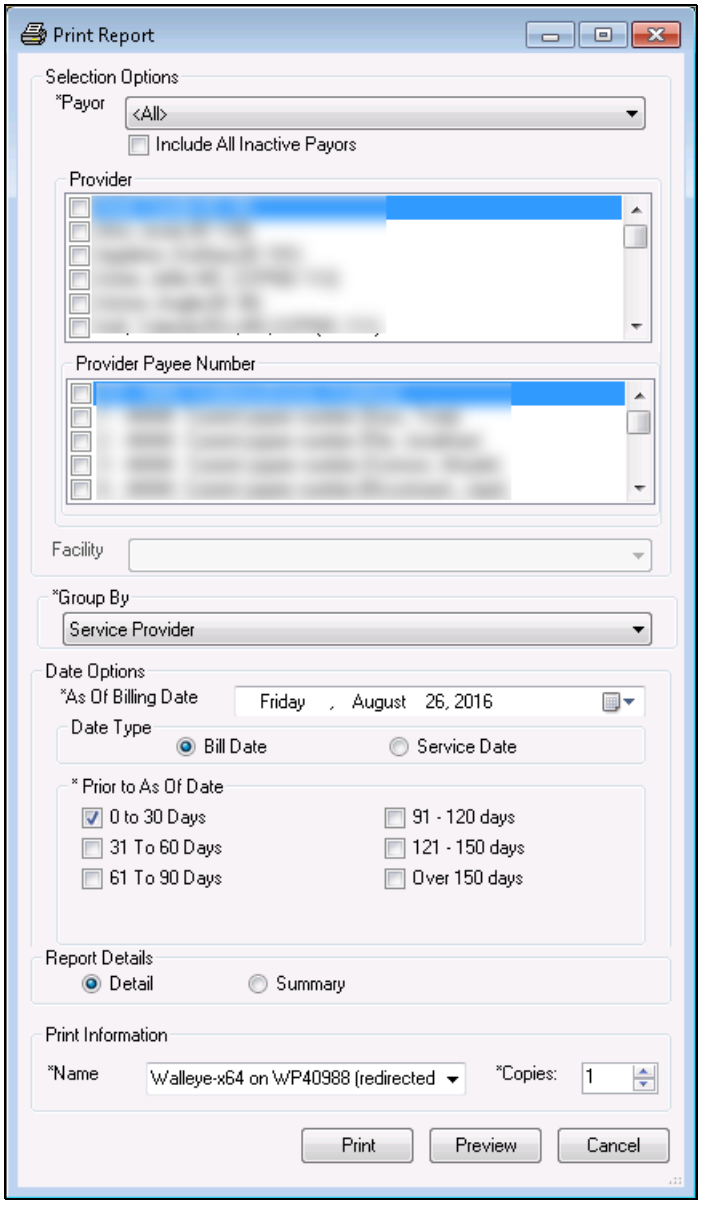
Wolf Clinic
Accounts Receivables Summary
As Of Bill Date 09/11/2010
Group By Service Provider, Provider Payee#, Date Range, Insurer

Service Provider, Provider Payee#, Date Range, Insurer	Billed	Paid	Locum Portion	Physician Portion
Angila A, (Pract#: 44444)				
Payee#: 44444				
0 To 30 Days (10/10/2010 - 09/11/2010)				
Medical Services Plan BC	15,938.44	0.00	0.00	0.00
Total For **0 To 30 Days (10/10/2010 - 09/11/2010)**	**$15,938.44**	**0.00**	**$0.00**	**$0.00**
Outstanding	15,938.44			
Total for **Payee#: 44444**	**$15,938.44**	**0.00**	**$0.00**	**$0.00**
Outstanding	15,938.44			
Total for **Angila A, (Pract#: 44444)**	**$15,938.44**	**$0.00**	**$0.00**	**$0.00**
Outstanding	15,938.44			

Steps

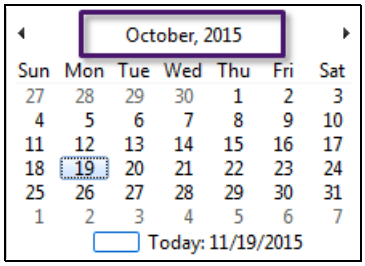
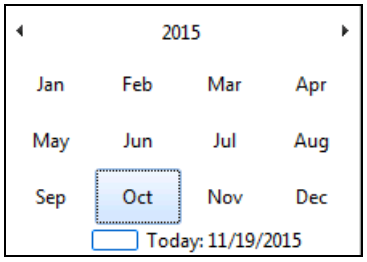
1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** ( ). The EMR displays the Billing window.
2. On the Billing menu, click **Reports** > **Accounting Reports** > **Accounts Receivable**. The **Print Report** window opens.



3. Use the following table to enter your report criteria.

Field	Description
Payor	In the drop-down list, select the insurer you want to produce a report for. **ALL** is selected by default; this includes Medical Services Plan BC, WCB e-Submission, Patient and 3rd Party insurers. The report groups and subtotals the various insurers.

Field	Description
Include All Inactive Payors	Select this check box to include all inactive payors in the report. Inactive payors are insurers whose Service Limit "Up To" date is in the past.
Provider	To view receivables for only specific practitioners, select the check boxes beside the practitioners you want to include. To view receivables for all practitioners, leave all check boxes cleared. **Note:** If your clinic has set up security around Billing, **(<All> Allowed by Security)** displays above the Provider list, and only the providers that you have access to are listed. See "Setting security around billing" on page 209.
Provider Payee Number	To view receivables for only specific payee numbers, select the check boxes beside the payee numbers you want to include. To view receivables for all payee numbers, leave all check boxes cleared. The option is here for practitioners who have more than one active payee number or use shared or group payee numbers.
Group By	The default for the report is to group by **Service Provider**. You can also click an option in the **Group By** drop-down list to group the report by **Payee Number** or **Insurer**.

Field	Description
As of Billing Date	Defaults to today. You can change to any date you want. To select a different date, click the down arrow and then click a date on the calendar. **Tip**: To quickly navigate to a different year or month, at the top of the calendar, click the month or year.  The EMR displays months instead of days. 
Date Type	The **Date Type** defaults to **Bill Date**. You can also select to use the **Service Date** for outstanding billing. If you provide Accounts Receivable reports to an accountant, always use **Bill Date** rather than **Service Date**. The date option search criteria take into account the **As of Date**, and **Bill Date** or **Service Date** selection and compare billing status against this criteria. The report takes into consideration if the bill has since been Paid, Written Off, Adjusted, Debited, Change Transaction, NSF etc. during the **As of Date** and **Bill Date** or **Service Date** specified.
Prior To As of Date	Select which time range to generate outstanding billing information from.

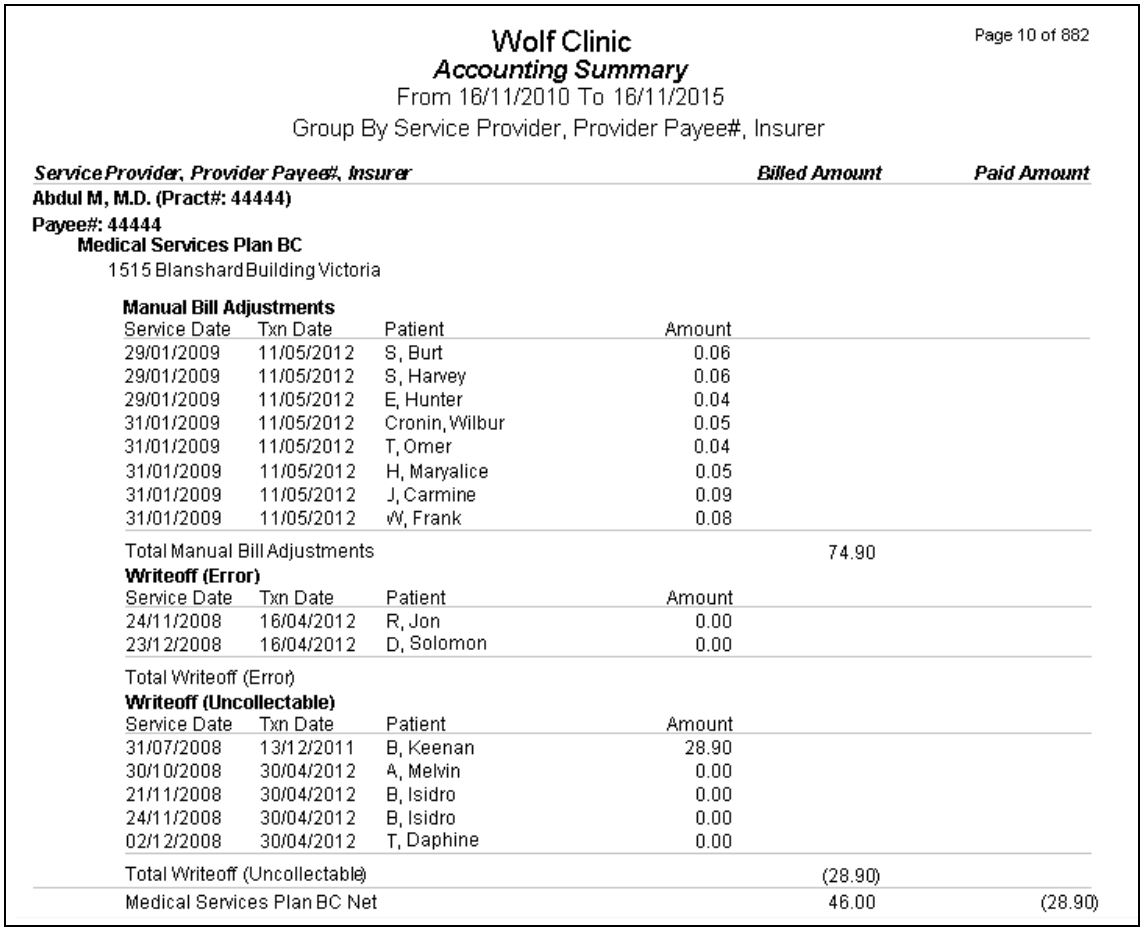
Field	Description
Report Details	Select to include information at a **Detail** or **Summary** level. ■ **Detail**: This is the default view. The detailed report displays Insurer, Patient Name, Sequence Numbers, Status, Explanatory Codes, Claim#, Fee Code, Service Date, Billed Amount, Paid Amount, %Locum, Physician Portion, Chart #, PHN. ■ **Summary**: The summary report displays Insurer, Billed Amount, Paid Amount, %Locum, and Physician Portion. **Note:** For information on what each report includes, see the summary table in "Accounting reports" on page 128.
Print Information	In the **Name** drop-down list, click the printer you want to use. In the **Copies** field, enter the number of copies you want to make.

4. Perform one of the following actions:
   - To print the report, click **Print**.
   - To preview the report before printing, click **Preview**. When you finish previewing, click **Print Report** ( ).
   - To export the report, click **Preview** and then, on the Print Preview menu bar, click **Export Report** ( ). Save the file as one of the following types: Crystal Reports (*.rpt), Adobe Acrobat (*.pdf), Microsoft Excel (*.xls), Microsoft Word (*.doc), or Rich Text Format (*.rtf).

Running an Accounting Summary report

The Accounting Summary report pulls a report of all billed and paid items during the specified date range. You can run the Accounting Summary report and then compare the data to your general ledger in your accounting program. You can preview or print the Accounting Summary report in detail or clinic summary format. You can also export the report to a variety of file types. You can produce two versions of the Accounting Summary report: a detailed Account Summary report or a summarized version of the Account Summary report.

Following is an example of a detailed Accounting Summary report.



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Wolf Clinic

Accounting Summary

From 16/11/2010 To 16/11/2015

Group By Service Provider, Provider Payee#, Insurer

Service Provider, Provider Payee#, Insurer	*Billed Amount*	*Paid Amount*
Abdul M, M.D. (Pract#: 44444)		
Payee#: 44444		
Medical Services Plan BC		
1515 Blanshard Building Victoria		

Manual Bill Adjustments

Service Date	Txn Date	Patient	Amount
29/01/2009	11/05/2012	S, Burt	0.06
29/01/2009	11/05/2012	S, Harvey	0.06
29/01/2009	11/05/2012	E, Hunter	0.04
31/01/2009	11/05/2012	Cronin, Wilbur	0.05
31/01/2009	11/05/2012	T, Omer	0.04
31/01/2009	11/05/2012	H, Maryalice	0.05
31/01/2009	11/05/2012	J, Carmine	0.09
31/01/2009	11/05/2012	W, Frank	0.08

Total Manual Bill Adjustments 74.90

Writeoff (Error)

Service Date	Txn Date	Patient	Amount
24/11/2008	16/04/2012	R, Jon	0.00
23/12/2008	16/04/2012	D, Solomon	0.00

Total Writeoff (Error)

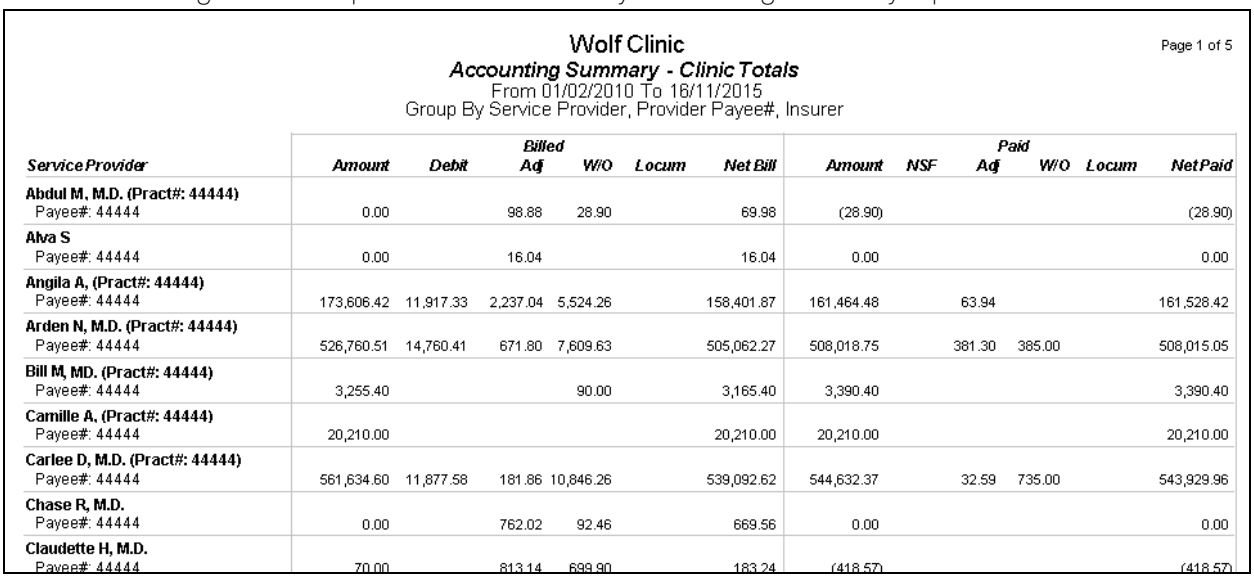
Writeoff (Uncollectable)

Service Date	Txn Date	Patient	Amount
31/07/2008	13/12/2011	B, Keenan	28.90
30/10/2008	30/04/2012	A, Melvin	0.00
21/11/2008	30/04/2012	B, Isidro	0.00
24/11/2008	30/04/2012	B, Isidro	0.00
02/12/2008	30/04/2012	T, Daphine	0.00

Total Writeoff (Uncollectable) (28.90)

Medical Services Plan BC Net 46.00 (28.90)

Following is an example of a clinic summary Accounting Summary report.



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Wolf Clinic

Accounting Summary - Clinic Totals

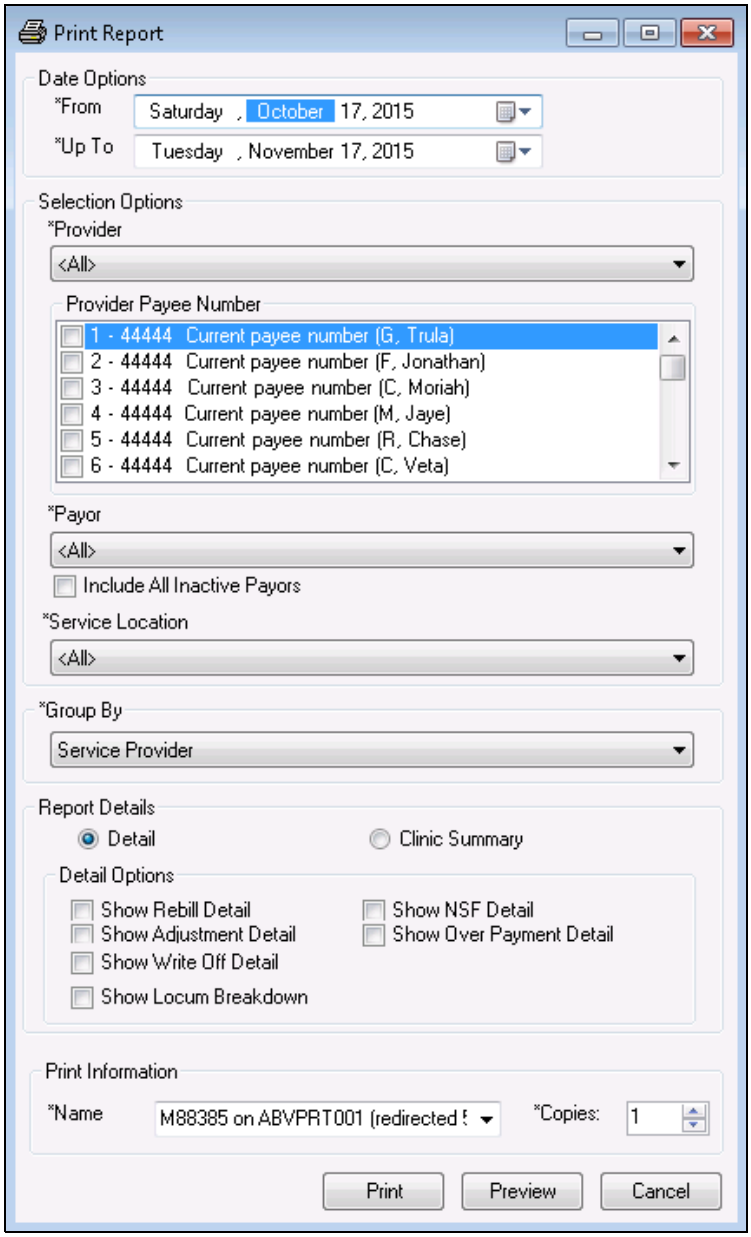
From 01/02/2010 To 16/11/2015

Group By Service Provider, Provider Payee#, Insurer

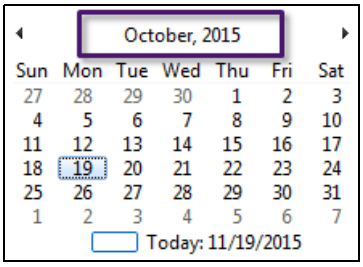
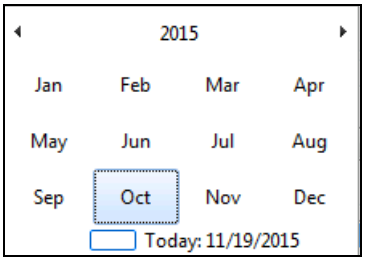
	Billed						*Paid*					
Service Provider	*Amount*	*Debit*	*Adj*	*W/O*	*Locum*	*Net Bill*	*Amount*	*NSF*	*Adj*	*W/O*	*Locum*	*Net Paid*
Abdul M, M.D. (Pract#: 44444) Payee#: 44444	0.00		98.88	28.90		69.98	(28.90)					(28.90)
Alva S Payee#: 44444	0.00		16.04			16.04	0.00					0.00
Angila A, (Pract#: 44444) Payee#: 44444	173,606.42	11,917.33	2,237.04	5,524.26		158,401.87	161,464.48		63.94			161,528.42
Arden N, M.D. (Pract#: 44444) Payee#: 44444	526,760.51	14,760.41	671.80	7,609.63		505,062.27	508,018.75		381.30	385.00		508,015.05
Bill M, MD. (Pract#: 44444) Payee#: 44444	3,255.40			90.00		3,165.40	3,390.40					3,390.40
Camille A, (Pract#: 44444) Payee#: 44444	20,210.00					20,210.00	20,210.00					20,210.00
Carlee D, M.D. (Pract#: 44444) Payee#: 44444	561,634.60	11,877.58	181.86	10,846.26		539,092.62	544,632.37		32.59	735.00		543,929.96
Chase R, M.D. Payee#: 44444	0.00		762.02	92.46		669.56	0.00					0.00
Claudette H, M.D. Payee#: 44444	70.00		813.14	699.90		183.24	(418.57)					(418.57)

Steps

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** ( ). The EMR displays the Billing window.
2. On the Billing menu, click **Reports** > **Accounting Reports** > **Accounting Summary**. The EMR displays the Print Report window.



3. Use the following table to enter your report criteria.

Field	Description
From	Defaults to 30 days before today. To select a different date, click the down arrow and then click a date on the calendar. **Tip**: To quickly navigate to a different year or month, at the top of the calendar, click the month or year.  The EMR displays months instead of days. 
Up To	Defaults to today's date. To select a different date, click the down arrow and then click a date on the calendar. **Note:** The **Up To** date entered is **NOT** included in the calculation. For example, to include the entire month of April 2015, enter the following information: From 01/Apr/2015; Up To 01/May/2015.
Provider	Defaults to **All**. To view a report for a specific practitioner, in the drop-down list, select the practitioner. If your clinic has set up security around billing reports, **(<All> Allowed by Security)** is displayed above the Provider list, and only the practitioners that you have access to are listed. See "Setting security around billing" on page 209.

Field	Description
Provider Payee Number	To run a report for only specific Payee numbers, select the check boxes beside the Payee numbers you want to include. To view receivables for all Payee numbers, leave all check boxes cleared. **Note:** The option is here for practitioners who have more than one active Payee number or use Shared or Group Payee numbers.
Payor	In the drop-down list, select the insurer you want to produce a report for. **ALL** is selected by default; this includes Medical Services Plan BC, WCB e-Submission, Patient and 3rd Party insurers. The report groups and subtotals the various insurers.
Include all Inactive Payors	Select this check box to include All Inactive Payors in the report. Inactive Payors are Insurers whose Service Limit "Up To" date is in the past.
Service Location	The **Service Location** field defaults to **All** service locations. To produce a report for services provided out of a specific service location in the **Service Location** drop-down list, select the service location.
Group By	The default for the report is to group by **Service Provider**. You can also click an option in the **Group By** drop-down list to group the report by **Payee Number** or **Insurer**.
Report Details	Select one of the following options: ■ **Detail**: To view a detailed report. ■ **Clinic Summary**: To view a clinic summary of the report. **Note:** For information on what each report includes, see the summary table in "Accounting reports" on page 128.

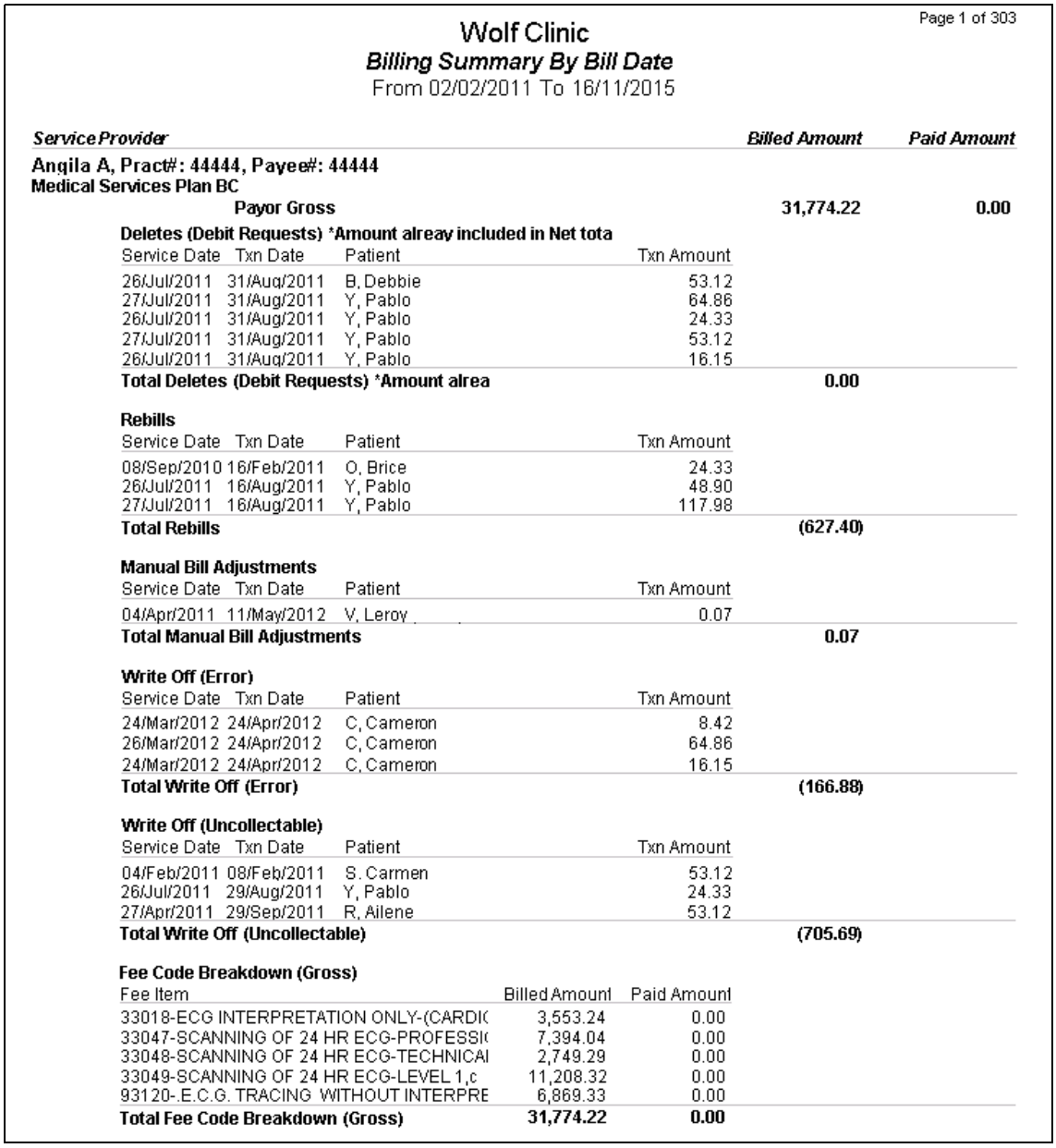
Field	Description
Detail Options	If you selected **Detail** in the **Report Details** section, you can specify which details to include. Select one or more of the following check boxes: ■ **Show Rebill Detail** ■ **Show Adjustment Detail** ■ **Show Write Off Detail** (indicates if the write off is an **error** or **uncollectible**) ■ **Show Locum Breakdown** ■ **Show NSF Detail** ■ **Show Over Payment Detail** ■ **Show Deletes**
Print Information	In the **Name** drop-down list, click the printer you want to use. In the **Copies** field, enter the number of copies you want to make.

4. Perform one of the following actions:
   - To print the report, click **Print**.
   - To preview the report before printing, click **Preview**. When you finish previewing, click **Print Report** ( ).
   - To export the report, click **Preview** and then, on the Print Preview menu bar, click **Export Report** ( ). Save the file as one of the following types: Crystal Reports (*.rpt), Adobe Acrobat (*.pdf), Microsoft Excel (*.xls), Microsoft Word (*.doc), or Rich Text Format (*.rtf).

Running a Billing Summary report

The Billing Summary report pulls all billed amounts and paid amounts during the specified date range. You can choose to include details such as a fee code breakdown of the billed and paid amounts. Some practitioners run this report to see how many of their claims have been billed within a certain time frame or to see which type of procedure codes they billed within a certain time frame. You can preview or print the report in detail or clinic summary format. You can also export the report to a variety of file types.

Following is an example of a detailed Billing Summary report.



Wolf Clinic

Billing Summary By Bill Date

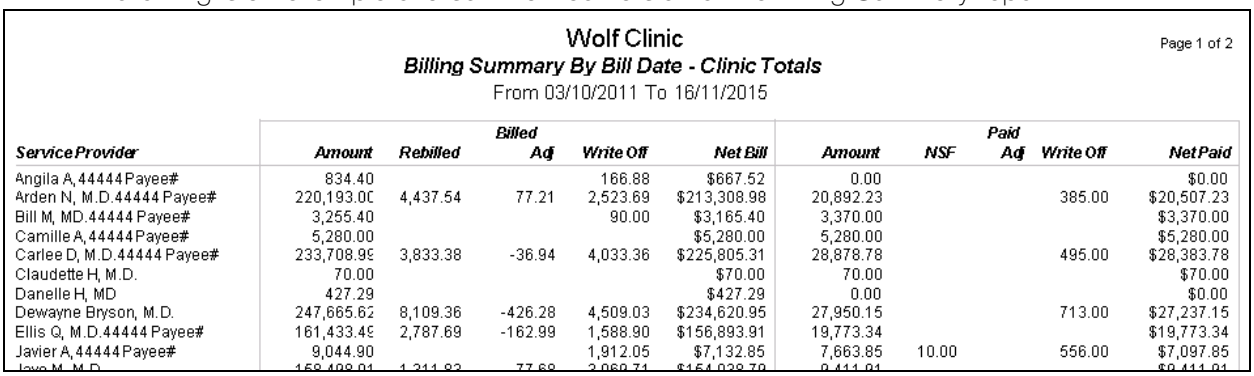
From 02/02/2011 To 16/11/2015

Service Provider				*Billed Amount*	*Paid Amount*
Angila A, Pract#: 44444, Payee#: 44444					
Medical Services Plan BC					
Payor Gross				**31,774.22**	**0.00**
Deletes (Debit Requests) *Amount alreay included in Net tota					
Service Date	Txn Date	Patient	Txn Amount		
26/Jul/2011	31/Aug/2011	B, Debbie	53.12		
27/Jul/2011	31/Aug/2011	Y, Pablo	64.86		
26/Jul/2011	31/Aug/2011	Y, Pablo	24.33		
27/Jul/2011	31/Aug/2011	Y, Pablo	53.12		
26/Jul/2011	31/Aug/2011	Y, Pablo	16.15		
Total Deletes (Debit Requests) *Amount alrea				**0.00**	
Rebills					
Service Date	Txn Date	Patient	Txn Amount		
08/Sep/2010	16/Feb/2011	O, Brice	24.33		
26/Jul/2011	16/Aug/2011	Y, Pablo	48.90		
27/Jul/2011	16/Aug/2011	Y, Pablo	117.98		
Total Rebills				**(627.40)**	
Manual Bill Adjustments					
Service Date	Txn Date	Patient	Txn Amount		
04/Apr/2011	11/May/2012	V, Leroy	0.07		
Total Manual Bill Adjustments				**0.07**	
Write Off (Error)					
Service Date	Txn Date	Patient	Txn Amount		
24/Mar/2012	24/Apr/2012	C, Cameron	8.42		
26/Mar/2012	24/Apr/2012	C, Cameron	64.86		
24/Mar/2012	24/Apr/2012	C, Cameron	16.15		
Total Write Off (Error)				**(166.88)**	
Write Off (Uncollectable)					
Service Date	Txn Date	Patient	Txn Amount		
04/Feb/2011	08/Feb/2011	S, Carmen	53.12		
26/Jul/2011	29/Aug/2011	Y, Pablo	24.33		
27/Apr/2011	29/Sep/2011	R, Ailene	53.12		
Total Write Off (Uncollectable)				**(705.69)**	

Fee Code Breakdown (Gross)

Fee Item	Billed Amount	Paid Amount
33018-ECG INTERPRETATION ONLY-(CARDIC	3,553.24	0.00
33047-SCANNING OF 24 HR ECG-PROFESSIC	7,394.04	0.00
33048-SCANNING OF 24 HR ECG-TECHNICAI	2,749.29	0.00
33049-SCANNING OF 24 HR ECG-LEVEL 1,c	11,208.32	0.00
93120-.E.C.G. TRACING WITHOUT INTERPRE	6,869.33	0.00
Total Fee Code Breakdown (Gross)	**31,774.22**	**0.00**

Following is an example of a summarized version of the Billing Summary report.



Wolf Clinic

Billing Summary By Bill Date - Clinic Totals

From 03/10/2011 To 16/11/2015

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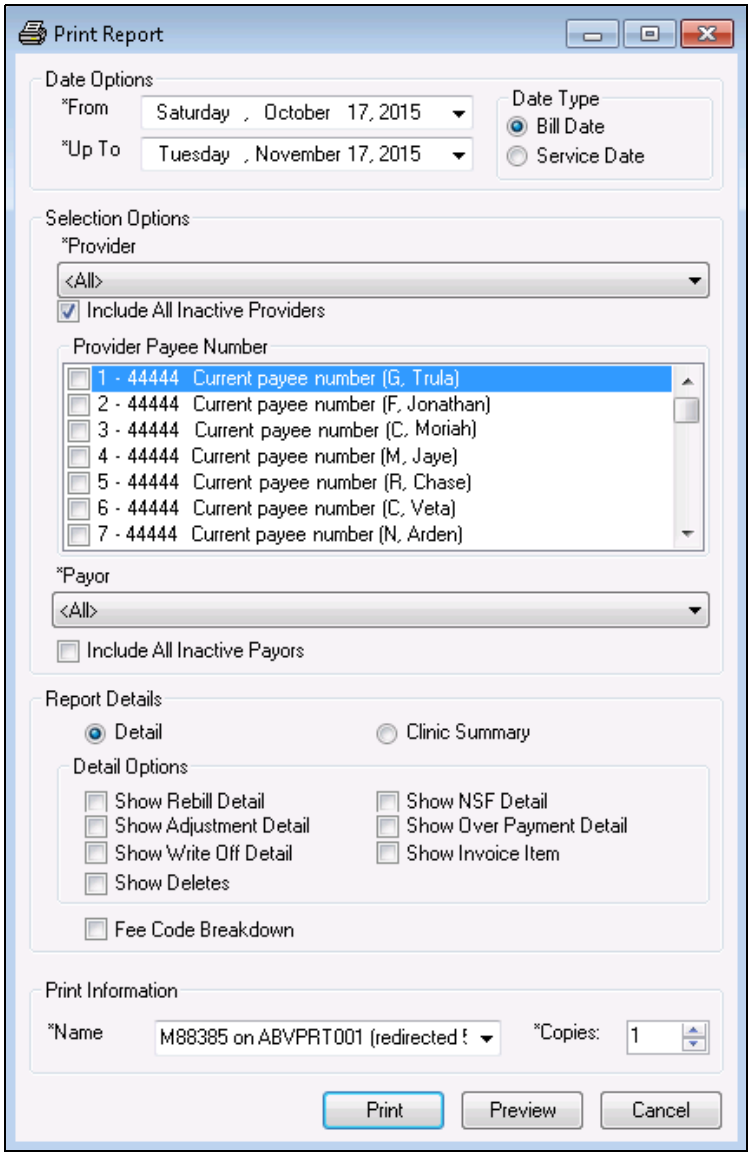
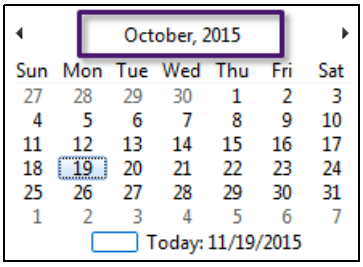
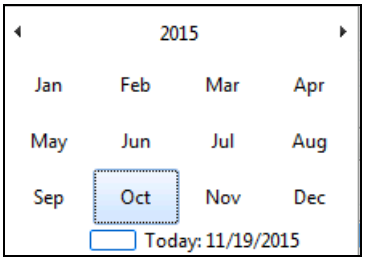
Service Provider	Billed Amount	Rebilled	Adj	Write Off	Net Bill	Paid Amount	NSF	Adj	Write Off	Net Paid
Angila A, 44444 Payee#	834.40			166.88	$667.52	0.00				$0.00
Arden N, M.D.44444 Payee#	220,193.0(	4,437.54	77.21	2,523.69	$213,308.98	20,892.23			385.00	$20,507.23
Bill M, MD.44444 Payee#	3,255.40			90.00	$3,165.40	3,370.00				$3,370.00
Camille A, 44444 Payee#	5,280.00				$5,280.00	5,280.00				$5,280.00
Carlee D, M.D.44444 Payee#	233,708.9(	3,833.38	-36.94	4,033.36	$225,805.31	28,878.78			495.00	$28,383.78
Claudette H, M.D.	70.00				$70.00	70.00				$70.00
Danelle H, MD	427.29				$427.29	0.00				$0.00
Dewayne Bryson, M.D.	247,665.62	8,109.36	-426.28	4,509.03	$234,620.95	27,950.15			713.00	$27,237.15
Ellis Q, M.D.44444 Payee#	161,433.4(	2,787.69	-162.99	1,588.90	$156,893.91	19,773.34				$19,773.34
Javier A, 44444 Payee#	9,044.90			1,912.05	$7,132.85	7,663.85	10.00		556.00	$7,097.85
Jaye M, M.D.	158,488.01	1,211.83	77.68	3,060.71	$154,038.79	9,411.01				$9,411.01

Steps

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** ( ). The EMR displays the Billing window.
2. On the Billing menu, click **Reports** > **Accounting Reports** > **Billing Summary**. The EMR displays the Print Report window.



3. Use the following table to enter your report criteria.

Field	Description
From	Defaults to 30 days before today. To select a different date, click the down arrow and then click a date on the calendar. **Tip**: To quickly navigate to a different year or month, at the top of the calendar, click the month or year.  The EMR displays months instead of days. 
Up To	Defaults to today. To select a different date, click the down arrow and then click a date on the calendar. **Note:** The **Up To** date entered is **NOT** included in the calculation. For example, to include the entire month of April 2015, enter the following information: From 01/Apr/2015; Up To 01/May/2015.
Date Type	Defaults to **Bill Date**. You can also select to use the **Service Date**. - **Service Date**: Regardless of the time the bill was entered or submitted, only bills with Service Dates that fall between the specified date options are displayed. - **Bill Date**: Only bills that were stamped with a billed date during the specified date options are displayed.

Field	Description
Provider	Defaults to **All**. To view a report for a specific practitioner, in the drop-down list, select the practitioner. If your clinic has set up security around billing reports, **(<All> Allowed by Security)** is displayed above the Provider list, and only the practitioners that you have access to are listed. See "Setting security around billing" on page 209.
Include All Inactive Providers	Select this check box to include All Inactive Providers in the report.
Provider Payee Number	To run a report for only specific Payee numbers, select the check boxes beside the Payee numbers you want to include. To view receivables for all Payee numbers, leave all check boxes cleared. **Note:** The option is here for practitioners who have more than one active Payee number or use Shared or Group Payee numbers.
Payor	In the drop-down list, select the insurer you want to produce a report for. **ALL** is selected by default; this includes Medical Services Plan BC, WCB e-Submission, Patient and 3rd Party insurers. The report groups and subtotals the various insurers.
Include all Inactive Payors	Select this check box to include All Inactive Payors in the report. Inactive Payors are Insurers whose Service Limit "Up To" date is in the past.
Report Details	Select one of the following options: ■ **Detail**: To view a detailed report. ■ **Clinic Summary**: To view a clinic summary of the report. **Note:** For information on what each report includes, see the summary table in "Accounting reports" on page 128.

Field	Description
Detail Options	If you selected **Detail** in the **Report Details** section, you can specify which details to include. Select one or more of the following check boxes: ■ **Show Rebill Detail** ■ **Show Adjustment Detail** ■ **Show Write Off Detail** (indicates if the write off is an **error** or **uncollectible**) ■ **Show Deletes** ■ **Show NSF Detail** ■ **Show Over Payment Detail** ■ **Show Invoice Item** ■ **Show Fee Code Breakdown**
Print Information	In the **Name** drop-down list, click the printer you want to use. In the **Copies** field, enter the number of copies you want to make.

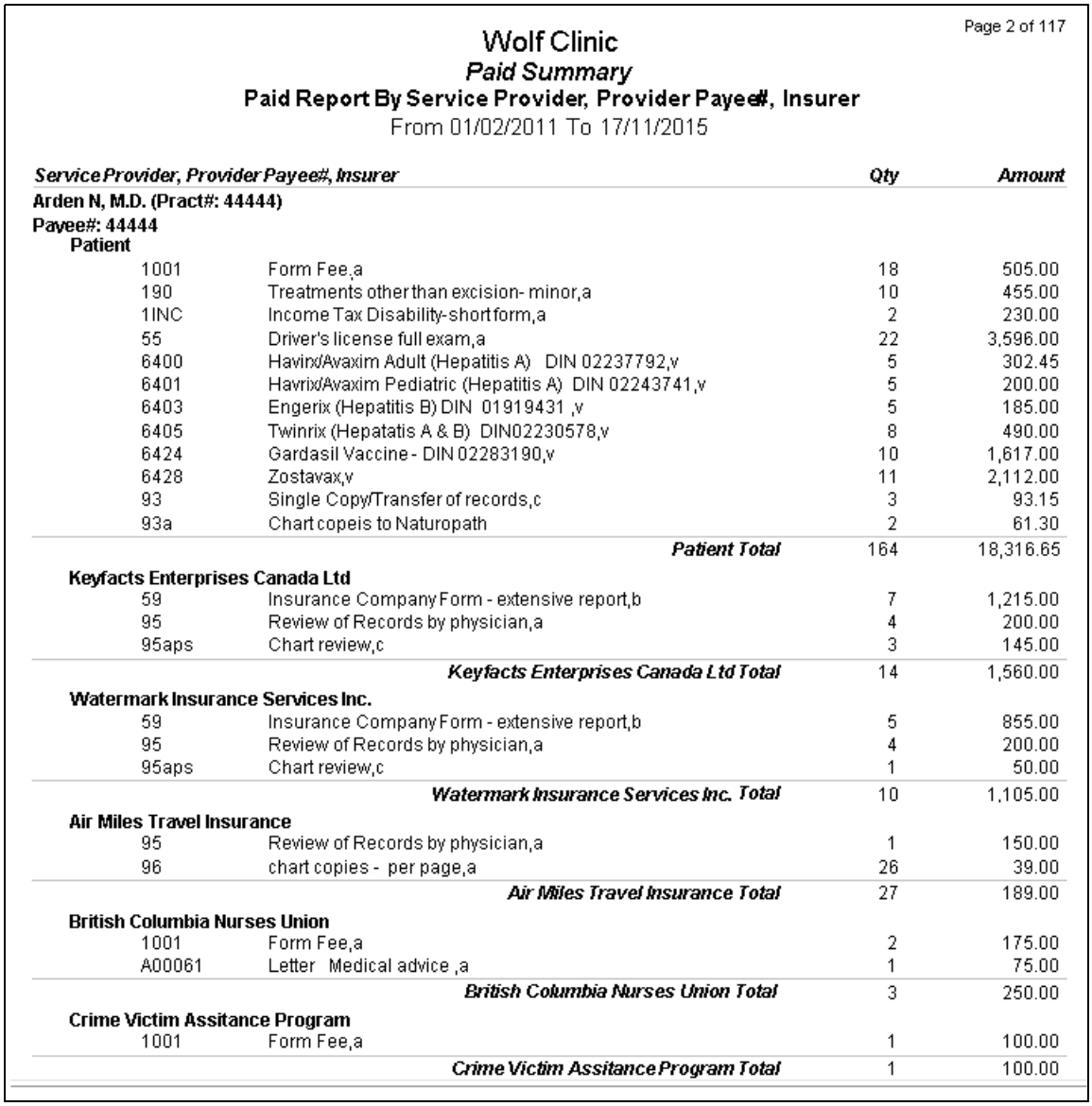
4. Perform one of the following actions:
   - To print the report, click **Print**.
   - To preview the report before printing, click **Preview**. When you finish previewing, click **Print Report** ( ).
   - To export the report, click **Preview**. On the Print Preview menu bar, click **Export Report** ( ). Save the file as one of the following types: Crystal Reports (*.rpt), Adobe Acrobat (*.pdf), Microsoft Excel (*.xls), Microsoft Word (*.doc), or Rich Text Format (*.rtf).

Running a Paid Summary report

The Paid Summary Report pulls paid fee codes based on the “paid date” of all bills paid during the specified date range. You can run a Paid Summary report for a specific fee code or diagnostic code, and produce a separate “Tray Fee Report”, if required. You can preview or print the report. You can also export the report to a variety of file types.

An example of when you would run a paid summary report on a fee code would be if the clinic is billing complex care fee codes. You can find out the total amount paid for a specific complex care fee code. Then, if practitioners are not getting paid for this fee code, they may choose to spend their time on certain procedures over others. For example, some practitioners choose not to bill or see prenatal or WCB patients, because of the time it takes to work on these type of procedures.

Following is an example of a Paid Summary report.



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Wolf Clinic

Paid Summary

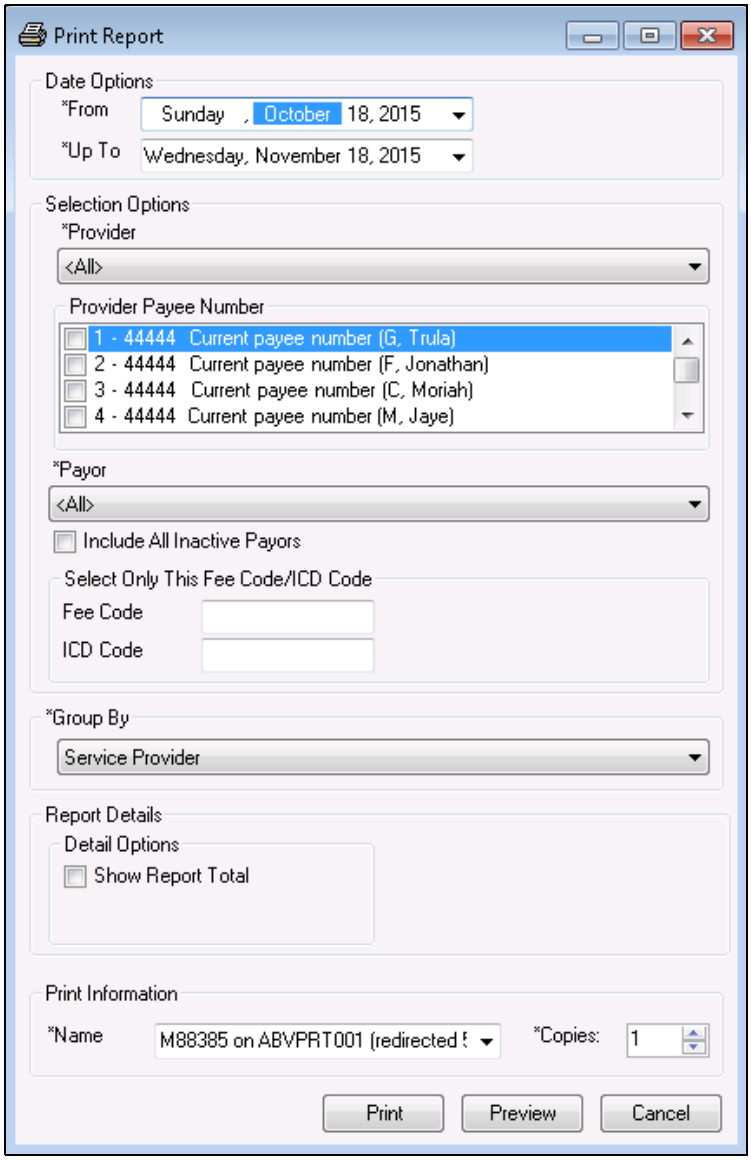
Paid Report By Service Provider, Provider Payee#, Insurer

From 01/02/2011 To 17/11/2015

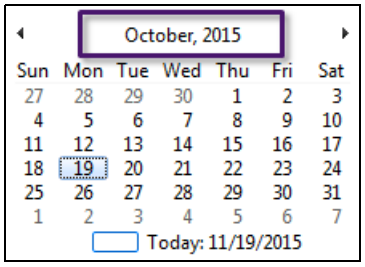
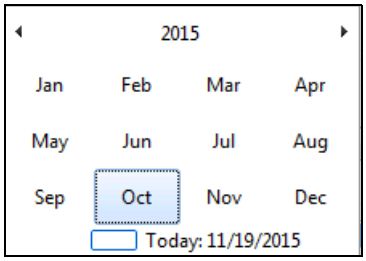
Service Provider, Provider Payee#, Insurer		*Qty*	*Amount*
Arden N, M.D. (Pract#: 44444)			
Payee#: 44444			
Patient			
1001	Form Fee,a	18	505.00
190	Treatments other than excision- minor,a	10	455.00
1INC	Income Tax Disability-short form,a	2	230.00
55	Driver's license full exam,a	22	3,596.00
6400	Havirx/Avaxim Adult (Hepatitis A) DIN 02237792,v	5	302.45
6401	Havrix/Avaxim Pediatric (Hepatitis A) DIN 02243741,v	5	200.00
6403	Engerix (Hepatitis B) DIN 01919431 ,v	5	185.00
6405	Twinrix (Hepatatis A & B) DIN02230578,v	8	490.00
6424	Gardasil Vaccine - DIN 02283190,v	10	1,617.00
6428	Zostavax,v	11	2,112.00
93	Single Copy/Transfer of records,c	3	93.15
93a	Chart copeis to Naturopath	2	61.30
	Patient Total	164	18,316.65
Keyfacts Enterprises Canada Ltd			
59	Insurance Company Form - extensive report,b	7	1,215.00
95	Review of Records by physician,a	4	200.00
95aps	Chart review,c	3	145.00
	Keyfacts Enterprises Canada Ltd Total	14	1,560.00
Watermark Insurance Services Inc.			
59	Insurance Company Form - extensive report,b	5	855.00
95	Review of Records by physician,a	4	200.00
95aps	Chart review,c	1	50.00
	Watermark Insurance Services Inc. Total	10	1,105.00
Air Miles Travel Insurance			
95	Review of Records by physician,a	1	150.00
96	chart copies - per page,a	26	39.00
	Air Miles Travel Insurance Total	27	189.00
British Columbia Nurses Union			
1001	Form Fee,a	2	175.00
A00061	Letter Medical advice ,a	1	75.00
	British Columbia Nurses Union Total	3	250.00
Crime Victim Assitance Program			
1001	Form Fee,a	1	100.00
	Crime Victim Assitance Program Total	1	100.00

Steps

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** ( ). The EMR displays the Billing window.
2. On the Billing menu, click **Reports** > **Accounting Reports** > **Paid Summary**. The EMR displays the Print Report window.



3. Use the following table to enter your report criteria.

Field	Description
From	Defaults to 30 days before today. To select a different date, click the down arrow and then click a date on the calendar. **Tip**: To quickly navigate to a different year or month, at the top of the calendar, click the month or year.  The EMR displays months instead of days. 
Up To	Defaults to today. To select a different date, click the down arrow and then click a date on the calendar. **Note:** The **Up To** date entered is **NOT** included in the calculation. For example, to include the entire month of April 2015, enter the following information: From 01/Apr/2015; Up To 01/May/2015.
Provider	Defaults to **All**. To view a report for a specific practitioner, in the drop-down list, select the practitioner. If your clinic has set up security around billing reports, **(<All> Allowed by Security)** is displayed above the Provider list, and only the practitioners that you have access to are listed. See "Setting security around billing" on page 209.

Field	Description
Provider Payee Number	To run a report for only specific Payee numbers, select the check boxes beside the Payee numbers you want to include. To view receivables for all Payee numbers, leave all check boxes cleared. **Note:** The option is here for practitioners who have more than one active Payee number or use Shared or Group Payee numbers.
Payor	In the drop-down list, select the insurer you want to produce a report for. **ALL** is selected by default; this includes Medical Services Plan BC, WCB e-Submission, Patient and 3rd Party insurers. The report groups and subtotals the various insurers.
Include all Inactive Payors	Select this check box to include All Inactive Payors in the report. Inactive Payors are Insurers whose Service Limit "Up To" date is in the past.
Select Only This Fee Code/ ICD Code	The Paid Summary default displays Fee Code and Quantity for the date option specified. ■ **Fee Code**: If a Paid Summary report is required for only one Fee Code for the date options specified, enter this information here prior to print or preview. The Paid Summary report displays only paid billing information with that Fee Code. ■ **ICD9 Code**: If a Paid Summary report is required for only one Diagnostic Code for the date options specified, enter this information here prior to print/preview. The Paid Summary report displays only paid billing information with that ICD Code
Group By	The default for the report is to group by **Service Provider**. You can also select an option in the **Group By** drop-down list to group the report by **Payee Number** or **Insurer**.
Report Details	Select one or more of the following check boxes: ■ **Show Report Total**: The "Show Report Total" option breaks down grand totals per provider and into sections of paid total, delete total, and tray fee total. ■ **Include in Report**: The default is to include "tray fees" in the Paid Summary report for the specified date options. ■ **Tray Fee Report Only**: Prints only those bills paid during specified date options that are tray fees.

Field	Description
Print Information	In the **Name** drop-down list, click the printer you want to use. In the **Copies** field, enter the number of copies you want to make.

4. Perform one of the following actions:
   - To print the report, click **Print**.
   - To preview the report before printing, click **Preview**. When you finish previewing, click **Print Report** ( ).
   - To export the report, click **Preview** and then, on the Print Preview menu bar, click **Export Report** ( ). Save the file as one of the following types: Crystal Reports (*.rpt), Adobe Acrobat (*.pdf), Microsoft Excel (*.xls), Microsoft Word (*.doc), or Rich Text Format (*.rtf).

Running a Paid Detail report

The Paid Detail Report provides the same information as the Paid Summary Report, but with more detail. The Paid Detail Report displays bills that were paid during the specified date range. The report provides a list of bills paid by each insurer, and for each bill includes the patient Name, claim#, service date, fee code(s), transaction date, billed amount, paid amount, and payment method. You can preview or print the report. You can also export the report to a variety of file types.

Following is an example of a Paid Detail report.

Wolf Clinic

Paid Detail

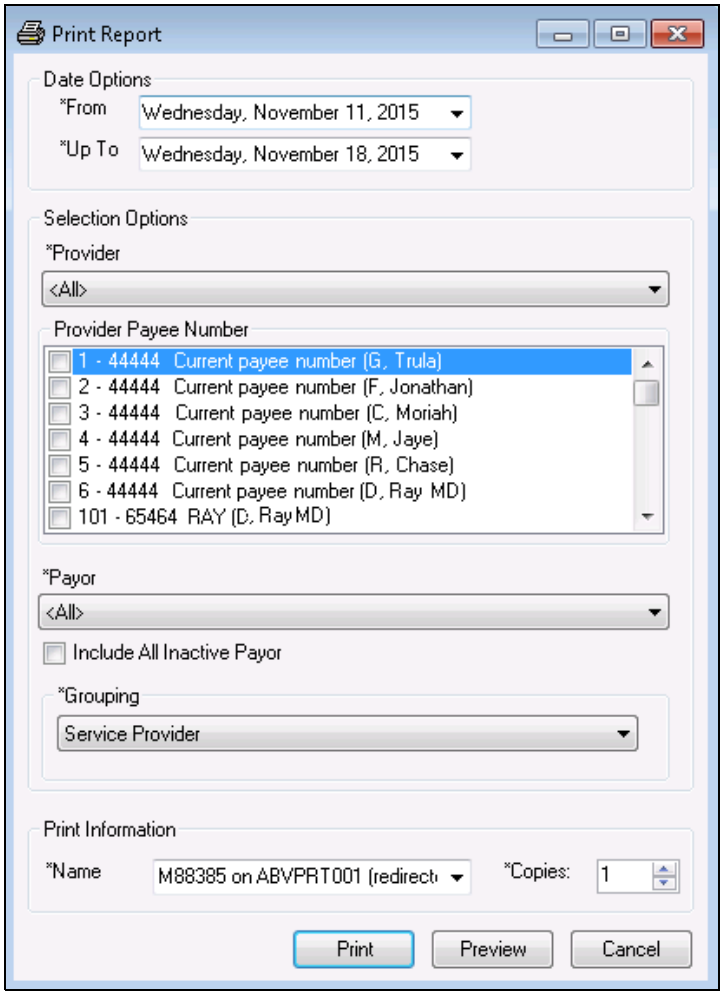
From 01/02/2011 To 17/11/2015

For Provider **Arden N, M.D.**

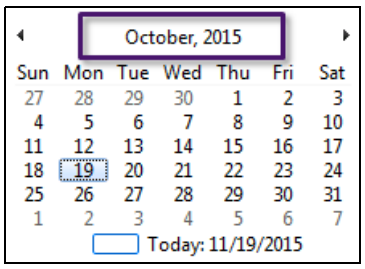
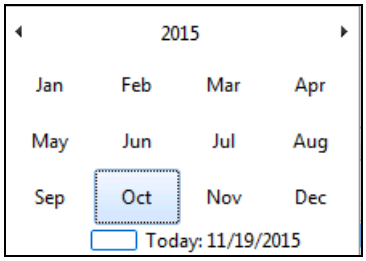
Payor/Patient	*Service Date*	*Service Code*	*Txn Date*	*Billed Amount*	*Paid Amount*	*Payment Method*
Payee#: 44444 **Keyfacts Enterprises Canada Ltd**						
B, Kip						
	Inv#:	38928				
Bill Detail	07/16/2012	59	07/20/2012	175.00		
Bill Detail	07/16/2012	95aps	07/20/2012	45.00		
Payment Detail			07/20/2012		220.00	Cheque
	Total			220.00	220.00	
	Inv#:	39146				
Bill Detail	08/08/2012	59	08/14/2012	175.00		
Bill Detail	08/08/2012	95	08/14/2012	50.00		
Payment Detail			08/20/2012		225.00	Cheque
	Total			225.00	225.00	
C, Jerald						
	Inv#:	40038				
Bill Detail	10/30/2012	59	10/30/2012	175.00		
Bill Detail	10/30/2012	95	10/30/2012	50.00		
Payment Detail			11/14/2012		225.00	Cheque
	Total			225.00	225.00	
K, Noemi						
	Inv#:	33739				
Bill Detail	04/20/2011	59	04/20/2011	170.00		
Bill Detail	04/20/2011	95	04/20/2011	50.00		
Payment Detail			05/02/2011		220.00	Cheque
	Total			220.00	220.00	
M, Carina						
	Inv#:	38692				
Bill Detail	06/27/2012	59	06/27/2012	175.00		
Bill Detail	06/27/2012	95aps	06/27/2012	50.00		
Payment Detail			06/28/2012		225.00	Cheque
	Total			225.00	225.00	
R, Murray						
	Inv#:	39563				
Bill Detail	09/20/2012	59	09/20/2012	175.00		
Bill Detail	09/20/2012	95aps	09/20/2012	50.00		
Payment Detail			09/25/2012		225.00	Cheque
	Total			225.00	225.00	

Steps

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** (). The EMR displays the Billing window.
2. On the Billing menu, click **Reports** > **Accounting Reports** > **Paid Detail**. The EMR displays the Print Report window.



3. Use the following table to enter your report criteria.

Field	Description
From	Defaults to 7 days before today. To select a different date, click the down arrow and then click a date on the calendar. **Tip**: To quickly navigate to a different year or month, at the top of the calendar, click the month or year.  The EMR displays months instead of days. 
Up To	Defaults to today. To select a different date, click the down arrow and then click a date on the calendar. **Note:** The **Up To** date entered is **NOT** included in the calculation. For example, to include the entire month of April 2015, enter the following information: From 01/Apr/2015; Up To 01/May/2015.
Provider	Defaults to **All**. To view a report for a specific practitioner, in the drop-down list, select the practitioner. If your clinic has set up security around billing reports, **(<All> Allowed by Security)** is displayed above the Provider list, and only the practitioners that you have access to are listed. See "Setting security around billing" on page 209.

Field	Description
Provider Payee Number	To run a report for only specific Payee numbers, select the check boxes beside the Payee numbers you want to include. To view receivables for all Payee numbers, leave all check boxes cleared. **Note:** The option is here for practitioners who have more than one active Payee number or use Shared or Group Payee numbers.
Payor	In the drop-down list, select the insurer you want to produce a report for, or to produce a report for all insurers, select **All**. **ALL** is selected by default; this includes Medical Services Plan BC, WCB e-Submission, Patient and 3rd Party insurers. The report groups and subtotals the various insurers.
Include all Inactive Payors	Select this check box to include All Inactive Payors in the report. Inactive Payors are Insurers whose Service Limit "Up To" date is in the past.
Grouping	The default for the report is to group by **Service Provider**. You can also click **Payee Number** in the **Grouping** drop-down list to group the report by BA Number.
Print Information	In the **Name** drop-down list, click the printer you want to use. In the **Copies** field, enter the number of copies you want to make.

4. Perform one of the following actions:
   - To print the report, click **Print**.
   - To preview the report before printing, click **Preview**. When you finish previewing the information, click **Print Report** ( ).
   - To export the report, click **Preview** and then, on the Print Preview menu bar, click **Export Report** ( ). Save the file as one of the following types: Crystal Reports (*.rpt), Adobe Acrobat (*.pdf), Microsoft Excel (*.xls), Microsoft Word (*.doc), or Rich Text Format (*.rtf).

Other billing reports

The following table summarizes other billing reports available in Wolf EMR.

Report name	Information displayed on report
All Bills on Screen See"Running an All bills on screen report" on page 155.	If you perform a search for bills using the Query Options window, this report includes resulting bills listed in the Billing window.
Billing Detail See "Running a Billing Detail report" on page 157.	For each insurer, generate a list of bills created during a specified date range. You can view written-off, deleted, and/or memo bills for each insurer. The report includes billing information only; it does not include payment details.
Service Summary See "Running a Service Summary report" on page 162.	For each insurer billed, produces a list of all fee codes billed and paid for in the specified date range. For each fee code, the report details: ■ Quantity billed ■ Total paid amount ■ Adjustments applied
Third-Party Statements See "Running a Third Party Statements report" on page 166.	You can produce: ■ A list of services billed to a patient over a specified time range ■ A list of services billed to a specific third party over a specified time range
Work Coverage See "Running a Work Coverage report" on page 171.	If practitioners cover for each other, you can produce: ■ A list of services a practitioner has provided to patients who do not belong to them (that is, services provided to other practitioners' patients). ■ A list of services that have been provided to a practitioner's patients by other practitioners in the clinic.

Running an All bills on screen report

If you perform a search for bills using the Query Options window, you can print the resulting bills listed in the Billing window. For example, you can search for all refused bills and then print the refused bills. The report also includes a total for amount billed and amount paid.

The All bills on screen report displays for each bill:

- Patient Name, PHN, Date Of Birth, and Home Phone / Work Phone
- Fee Code and ICD9 Code
- Sequence Number
- Service Date
- Quantity
- Bill Amount
- Paid Amount

Wolf Clinic
Receivables for: Medical Services Plan BC
<All Service Providers> (Remitted)

PHN / DOB	Patient / Phone	Fee	ICD9	Seq/Inv/Service	Qty	%	Bill	Paid
9993	M, Shon 42	15301	7292	649866	1	100	72.83	32.75
15/Dec/1962	Home: (336) 652-2855			26/Jun/2012				
HC	THIS CLAIM HAS BEEN PAID UNDER THE INDICATED FEE ITEM.							
KC	REPEAT COMPLETE PHYSICALS WITHIN 6 MONTHS REQUIRE AN EXPLANATION OF MEDICAL NECESSITY.							
XD	INVALID OR INSUFFICIENT INFORMATION PROVIDED. (IN NOTE OR CLAIM COMMENT FIELD/DESCRIPTION A							
9993	M, Shon 42	15300	244	664815	1	100	32.75	0.00
				26/Jun/2012				
BH	THIS CLAIM WILL BE PROCESSED ON A FUTURE REMITTANCE STATEMENT. PLEASE DO NOT REBILL.							
9990	B, Gayla 42	6007	7332	666232	1	100	24.94	0.00
21/Feb/1928	Home: (273) 786-9092			19/Jul/2012				
BH	THIS CLAIM WILL BE PROCESSED ON A FUTURE REMITTANCE STATEMENT. PLEASE DO NOT REBILL.							
9991	H, Arlinda 42	210	704	668975	1	100	59.66	22.55
09/Oct/1931	Home: (867) 203-3842 Work: (32) 451-2718 ext 093			21/Aug/2012				
BH	THIS CLAIM WILL BE PROCESSED ON A FUTURE REMITTANCE STATEMENT. PLEASE DO NOT REBILL.							
9995	V, Coreen 42	120	311	665540	1	100	51.84	0.00
12/Oct/1968	Home: (854) 372-2648			29/Aug/2012				
BH	THIS CLAIM WILL BE PROCESSED ON A FUTURE REMITTANCE STATEMENT. PLEASE DO NOT REBILL.							

Steps

1. Open the Billing program: On the Wolf EMR Launch page, bar, click **Billing** ( ). The EMR displays the Billing window.
2. Search for the bills you want to print. For example, you can search for:
   - Refused, underpaid, and overpaid bills to MSP or WCB. See "Viewing refused, underpaid, and overpaid MSP and WCB bills" on page 69.
   - Underpaid or unpaid patient bills. See "Searching for unpaid and partially paid patient bills" on page 86.

- Underpaid or unpaid third party bills. See "Searching for unpaid and partially paid third party bills" on page 89.

> **Note**: The All Bills on Screen report does not include listed appointments for which bills have not been saved.

3. On the Billing menu, click **Reports** > **Other Reports** > **All bills on screen**. The EMR displays the Printer Options window.
4. In the **Copies** field, enter the number of copies you want to print.
5. In the **Printer** drop-down list, select the printer you want to use.
6. Click **OK**.

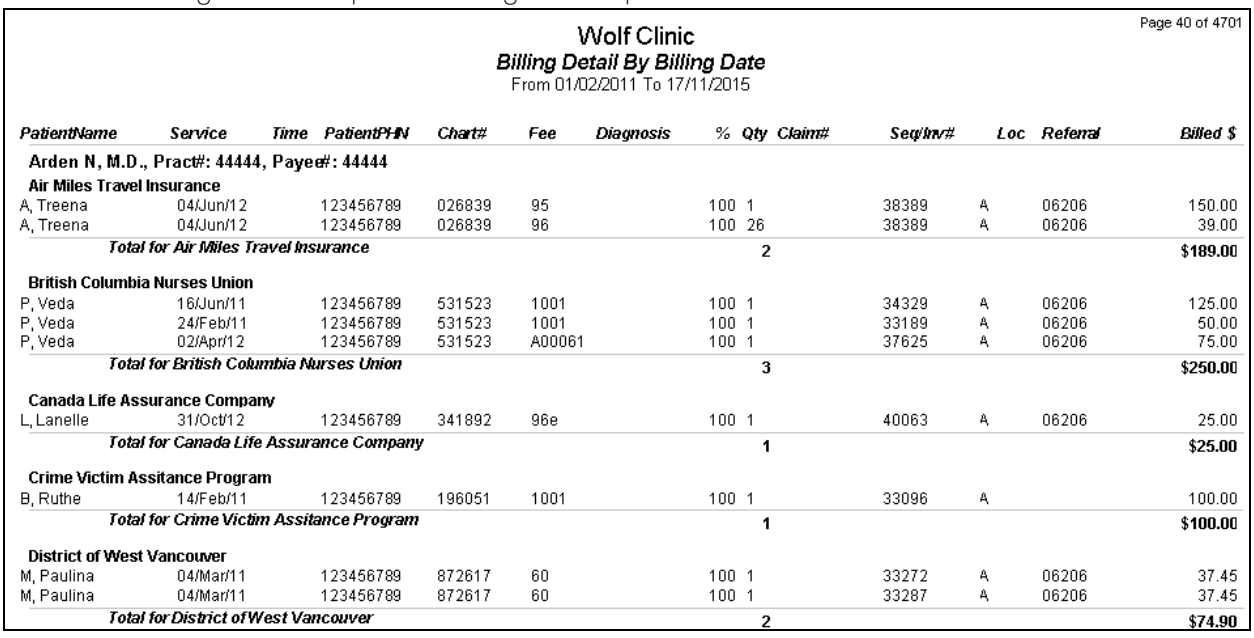
Running a Billing Detail report

Using the Billing Detail report, you can:

- Generate a list of bills created for each insurer during a specified date range.
- View written-off, deleted, and/or memo bills for each insurer.

The Billing Detail report includes only billing details; it does not include payment information. You can run the report based on billed/submitted/created date or service date of the bill. You can preview or print the report. You can also export the report to a variety of file types.

Following is an example of a Billing Detail report.



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Wolf Clinic

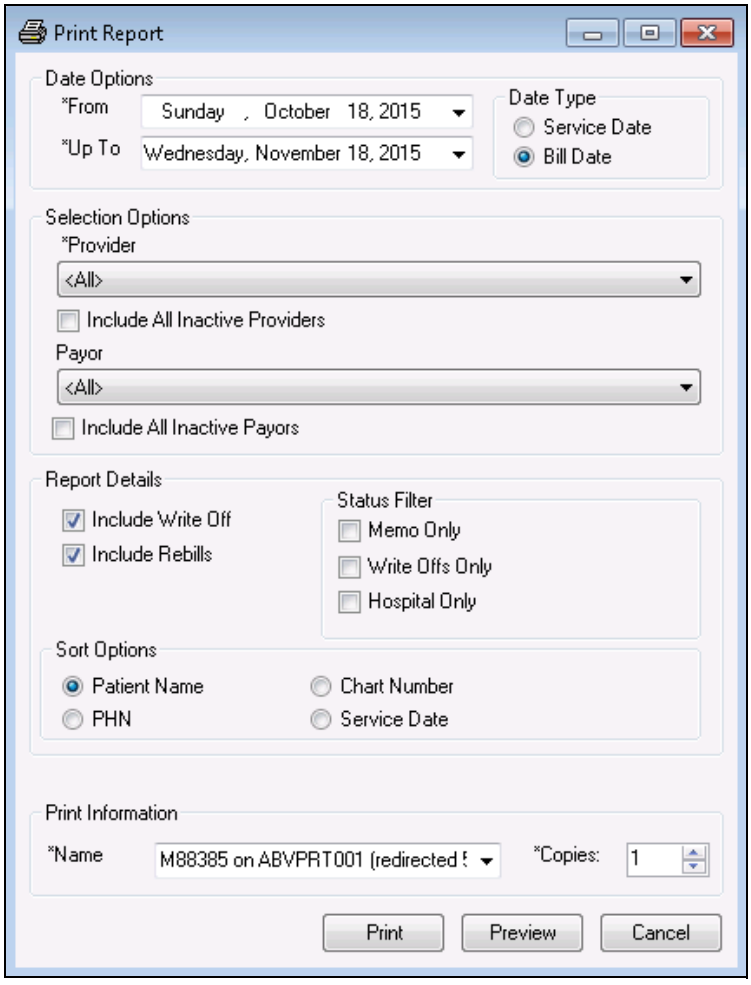
Billing Detail By Billing Date

From 01/02/2011 To 17/11/2015

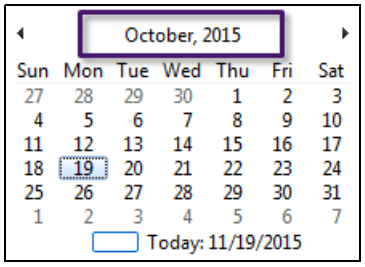
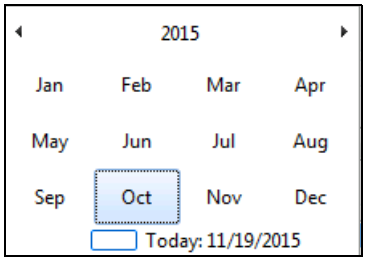
PatientName	Service	Time	PatientPHN	Chart#	Fee	Diagnosis	%	Qty	Claim#	Seq/Inv#	Loc	Referral	Billed $
Arden N, M.D., Pract#: 44444, Payee#: 44444													
Air Miles Travel Insurance													
A, Treena	04/Jun/12		123456789	026839	95		100	1		38389	A	06206	150.00
A, Treena	04/Jun/12		123456789	026839	96		100	26		38389	A	06206	39.00
Total for Air Miles Travel Insurance								**2**					**$189.00**
British Columbia Nurses Union													
P, Veda	16/Jun/11		123456789	531523	1001		100	1		34329	A	06206	125.00
P, Veda	24/Feb/11		123456789	531523	1001		100	1		33189	A	06206	50.00
P, Veda	02/Apr/12		123456789	531523	A00061		100	1		37625	A	06206	75.00
Total for British Columbia Nurses Union								**3**					**$250.00**
Canada Life Assurance Company													
L, Lanelle	31/Oct/12		123456789	341892	96e		100	1		40063	A	06206	25.00
Total for Canada Life Assurance Company								**1**					**$25.00**
Crime Victim Assitance Program													
B, Ruthe	14/Feb/11		123456789	196051	1001		100	1		33096	A		100.00
Total for Crime Victim Assitance Program								**1**					**$100.00**
District of West Vancouver													
M, Paulina	04/Mar/11		123456789	872617	60		100	1		33272	A	06206	37.45
M, Paulina	04/Mar/11		123456789	872617	60		100	1		33287	A	06206	37.45
Total for District of West Vancouver								**2**					**$74.90**

Steps

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** ( ). The EMR displays the Billing window.
2. On the Billing menu, click **Reports** > **Other Reports** > **Billing Detail**. The EMR displays the Print Report window.



3. Use the following table to enter your report criteria.

Field	Description
From	Defaults to 30 days from today. To select a different date, click the down arrow and then click a date on the calendar. **Tip**: To quickly navigate to a different year or month, at the top of the calendar, click the month or year.  The EMR displays months instead of days. 
Up To	Defaults to today. To select a different date, click the down arrow and then click a date on the calendar. **Note:** The **Up To** date entered is **NOT** included in the calculation. For example, to include the entire month of April 2015, enter the following information: From 01/Apr/2015; Up To 01/May/2015.

Field	Description
Date Type	Select one of the following options: ■ **Service Date**: Regardless of the time the bill was entered or submitted, only bills with a Service Date that falls between the specified dates are displayed. ■ **Billed Date**: Only bills that were stamped with a billed date during the specified dates are displayed. **Note: Billed Date for Electronic bills**: Medical Services Plan BC and WCB billed date is the date when the eBill "Create Claim file" is created. **Note: Billed Date for Patient and 3rd Party (Other Insurer) bills**: Patient and 3rd Party bills have, as the billed date, the date the bill is entered/created.
Provider	Defaults to **All**. To view a report for a specific practitioner, in the drop-down list, select the practitioner. If your clinic has set up security around billing reports, **(<All> Allowed by Security)** is displayed above the Provider list, and only the practitioners that you have access to are listed. See "Setting security around billing" on page 209.
Include All Inactive Providers	Select this check box to include All Inactive Providers in the report.
Payor	In the drop-down list, select the insurer you want to produce a report for, or to produce a report for all insurers, select **All**. **ALL** is selected by default; this includes Medical Services Plan BC, WCB e-Submission, Patient and 3rd Party insurers. The report groups and subtotals the various insurers.
Include all Inactive Payors	Select this check box to include All Inactive Payors in the report. Inactive Payors are Insurers whose Service Limit "Up To" date is in the past.

Field	Description
Report Details	Select one or both of the following check boxes: ■ **Include Write Off**: To include written off bills in the overall Billing Detail report amount. Written off bills are flagged in the Claim# column as **W/O**. ■ **Include Rebills**: To include rebills in the overall Billed Detail report amount. Rebills are flagged beside the sequence # column as **R**. Select one of the following **Status Filter** options ■ **Memo Only**: To include only Memo bills (that is, bills that are billed at $0). These are bills that have been marked **Memo** from the billing program. ■ **Write Offs Only**: To include only bills with a Write off status. These are bills that have been written off from the billing program. Appointment Write Off is not considered in this search. ■ **Hospital Only**: To include only bills that are tagged with a Service Location of **E-Hospital - ER**, **G-Hospital - Day Care**, **I-Hospital - Inpatient**, or **P-Hospital - Outpatient**.
Sort Options	Select how you want to sort the report. You can sort the report by: ■ **Patient Name** ■ **PHN** ■ **Chart Number** ■ **Service Date**
Print Information	If you are printing the report, in the **Name** drop-down list, click the printer you want to use. In the **Copies** field, enter the number of copies you want to make.

4. Perform one of the following actions:
   - To print the report, click **Print**.
   - To preview the report before printing, click **Preview**. When you finish previewing, click **Print Report** ( ).
   - To export the report, click **Preview** and then, on the Print Preview menu bar, click **Export Report** ( ). Save the file as one of the following types: Crystal Reports (*.rpt), Adobe Acrobat (*.pdf), Microsoft Excel (*.xls), Microsoft Word (*.doc), or Rich Text Format (*.rtf).

Running a Service Summary report

Using the Service Summary Report, for each insurer, you can produce:

- A list of all fee codes billed and paid for in the specified date range. For each fee code, the report includes the quantity billed, the total paid amount, and the adjustments applied.
- For bills with a specific diagnosis code, a list of all fee codes billed and paid in the specified date range.
- Billed and paid information for a specific fee code.

The report provides subtotals per Insurer and defines the amount owing with an overall total per practitioner. The Service Summary also reports adjustment amounts per insurer.

You can run the report based on the billed date or service date and you can include or exclude write-offs as required.

The report does not split out results for each Payee Number.

Note: You cannot export or preview this report; you can only print.

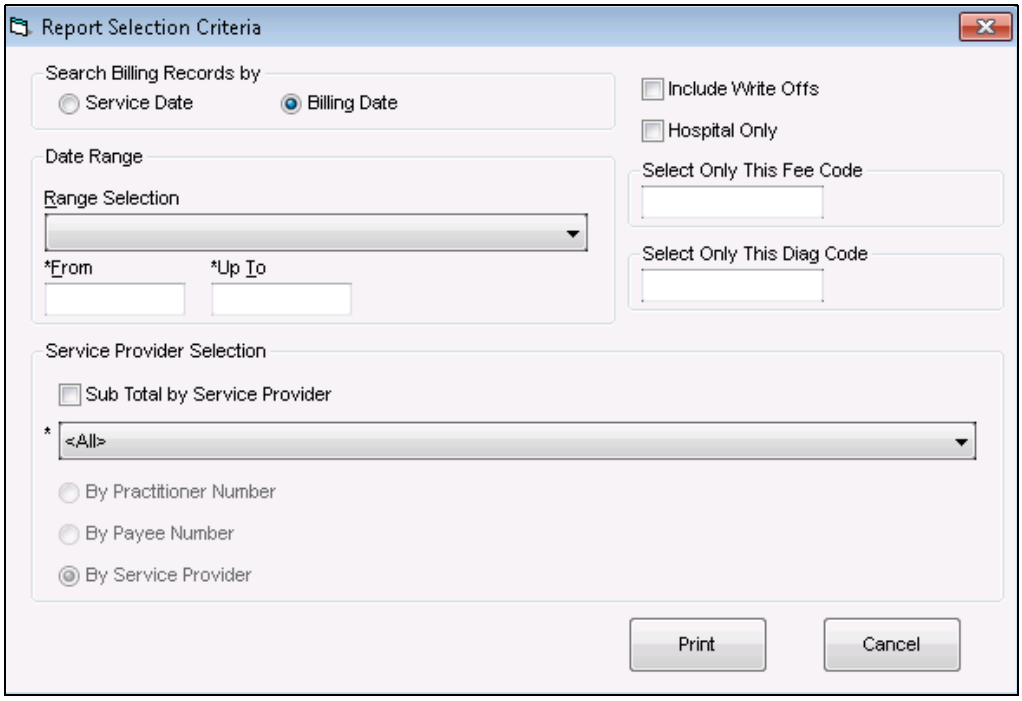
Following is an example of a Service Summary report.

Wolf Clinic **Page: 2**
Service Summary Report by Billing Date
01/Jan/1997 through 31/Dec/2996

		Qty	Billed	Paid
G, Trula (44444)				
Medical Services Plan BC				
10	INJECTION INTRAMUSCULAR ,a	162	1,433.73	1,357.27
100	VISIT IN OFFICE (AGE 2 - 49) ,a	9043	253,730.37	252,152.50
10010	IMMUNIZATION-PATIENT < 19 YRS-DTAP-P ,a	3	11.14	11.14
10011	IMMUNIZATION-PATIENT < 19 YRS-DTAP-P-HIB ,a	10	32.16	32.16
10017	IMMUNIZATION-PATIENT <19 YRS-HB(HEPATITIS B)	5	17.14	17.14
10020	IMMUNIZATION-PATIENT <19 YRS-MEN-C-C(MENINGOCOCCAL ,a	3	9.00	9.00
10021	IMMUNIZATION-PATIENT < 19 YRS-MEN-C-ACYW135(MENING ,a	2	6.00	6.00
10022	IMMUNIZATION-PATIENT < 19 YRS-MMR(MEASLES MUMPS,a	10	32.18	32.18
10023	IMMUNIZATION-PATIENT <19 YRS-PNEU-C-13 PNEUMOCOCAL ,a	13	43.32	43.32
10024	IMMUNIZATION-PATIENT < 19 YRS-PNEU-P-23,a	1	3.00	0.00
10026	IMMUNIZATION - PATIENT < 19 YRS - VAR (VARICELLA) ,a	9	27.00	27.00
101	COMPLETE EXAMINATION IN OFFICE (AGE 2-49) ,a	128	8,035.15	7,938.47
103	HOME VISIT - CALL PLACED BETWEEN 0800 AND 2300HRS ,b	11	1,010.49	1,011.03
108	HOSPITAL VISIT ,b	88	2,755.28	2,661.35
109	ACUTE CARE HOSPITAL ADMISSION VISIT ,b	1	74.23	30.69
11302	ASPIRATION - BURSA/TENDON SHEATH - DIAGNOSTIC	2	45.44	22.72
114	VISIT NURSING HOME ONE OR MULTIPLE PATIENTS ,b	1	21.74	21.74
11402	ASPIRATION - BURSA/SYNOVIAL SHEATH ,a	1	22.72	22.72
115	NURSING HOME VISIT - 1 PATIENT WHEN SPECIALLY CALL ,b	3	236.99	236.99
11600	ARTHROSCOPY - KNEE JOINT	1	209.04	209.04
117	ECG INTERPRETATION ONLY G.P. ,a	3	29.06	29.06
119	NEWBORN CARE, ROUTINE, IN HOSPITAL	1	61.41	61.41
96501	MHR FORM PERSON WITH DISABILITIES DESIGNATION ,a	11	1,430.00	1,430.00
96502	MHR SECTION 3 ASSESSOR REPORT ,a	1	75.00	75.00
96503	MHR MED RPRT - PERSONS WITH PERSIST MULTI BARRIERS ,a	1	50.00	50.00
96504	MHR MEDICAL REPORT EMPLOYABILITY FORM ,a	1	25.00	25.00
	** Insurer total	26123	878,080.68	861,868.72
	** Insurer owes		16,211.96	
Workers Compensation Board BC				
100	VISIT IN OFFICE (AGE 2 - 49) ,a	272	7,721.19	5,024.14
14	INJECTION INTRA-ARTICULAR - HIP ,a	1	19.84	19.84
15130	URINALYSIS - SCREENING ,a	1	1.96	0.00
15300	VISIT IN OFFICE (AGE 50-59) ,a	36	1,164.44	942.31

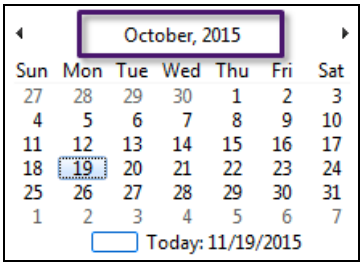
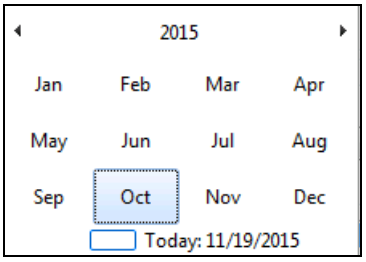
Steps

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** (). The EMR displays the Billing window.
2. On the Billing menu, click **Reports** > **Other Reports** > **Service Summary**. The EMR displays the Report Selection Criteria window.



3. Use the following table to enter your report criteria.

Field	Description
Search Billing Records by	The default setting for the Service Summary report is to search billing records by **Billing Date**. You can also select to use the **Service Date**. ■ **Service Date**: Regardless of the time the bill was entered or submitted, only bills with Service Dates that fall between the specified date options are displayed. ■ **Billed Date**: Only bills that were stamped with a billed date during the specified date options are displayed.
Range Selection	In the drop down list, click a date range.

Field	Description
From	Defaults to 30 days from today. To select a different date, click the down arrow and then click a date on the calendar. **Tip**: To quickly navigate to a different year or month, at the top of the calendar, click the month or year.  The EMR displays months instead of days. 
Up To	Defaults to today. To select a different date, click the down arrow and then click a date on the calendar. **Note:** The **Up To** date entered is **NOT** included in the calculation. For example, to include the entire month of April 2015, enter the following information: From 01/Apr/2015; Up To 01/May/2015.
Sub Total by Service Provider	Select this check box to list sub-totals by service provider.
Service Provider Selection	Defaults to **All**. To view a report for a specific practitioner, in the drop-down list, select the practitioner. If your clinic has set up security around billing reports, **(<All> Allowed by Security)** is displayed above the Provider list, and only the practitioners that you have access to are listed. See "Setting security around billing" on page 209.

Field	Description
Include Write Offs	When you select this check box, the report subtracts the billed and paid amounts from those fee codes affected by write-offs. This decreases the overall total of billed and paid amounts. Write-offs do not show as a separate line item on this report.
Select Only This Fee Code	By default, the report displays paid billing information for each fee code that was billed during the date range specified. To view paid billing information for only one Fee Code, enter the fee code.
Select Only This Diag Code	To view paid billing information for only one diagnostic code, enter the diagnostic code.

4. Click **Print**. The EMR displays the Printer Options window.
5. In the **Copies** field, enter the number of copies you want to print.
6. In the **Printer** drop-down list, click the printer you want to use.
7. Click **OK**.

Running a Third Party Statements report

Using the Third Party Statement report, you can produce a list of services billed to:

- A patient over a specified time range
- A specific third party over a specified time range

A report can include only unpaid invoices, only paid invoices, or both paid and unpaid invoices. You can run the report based on service date or billed date, and you can preview the report before printing. You can also export the report to a variety of file types. The report has an option to print all bills for an insurer on one page or start a new page for each invoice.

Following is an example of a Third Party Statements report.

C Medical Care
6970 H Street
Agassiz, BC

Account Statement

Acclaim Ability Management
200 10 S Way

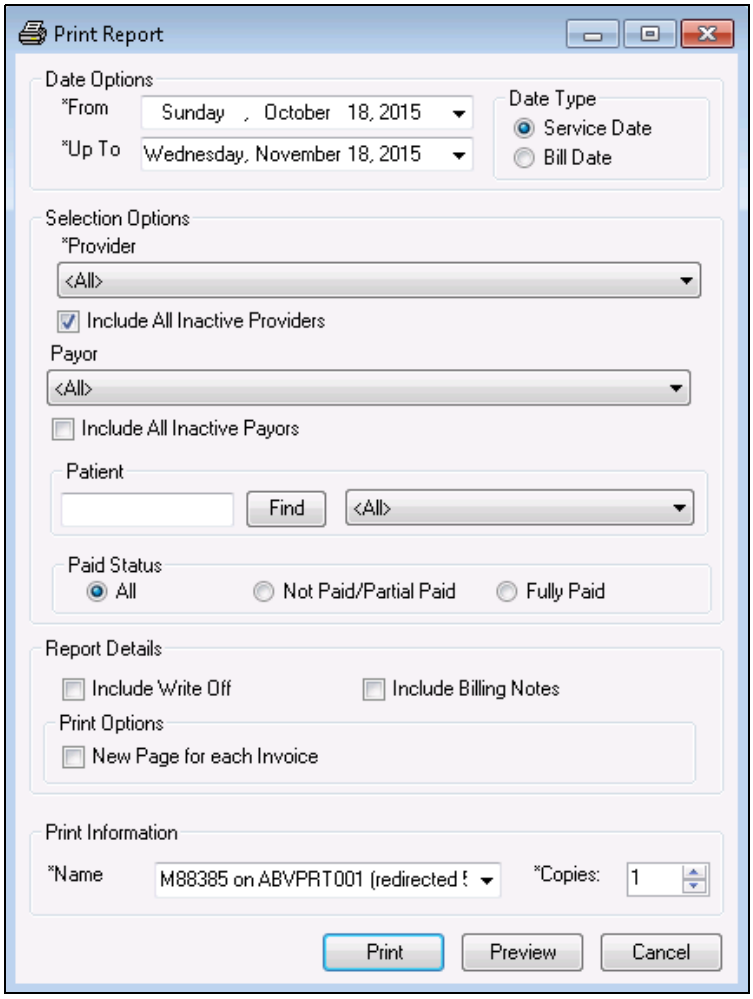
Richmond, BC

Statement Period: From 01/02/2010 To 18/11/2015

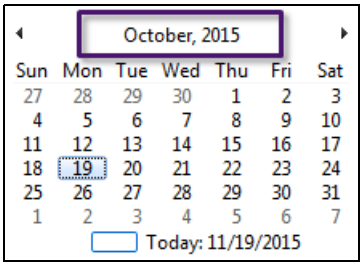
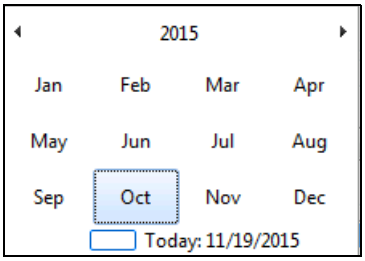
Service Date	Inv #	Patient	Service Provider	Billed	Paid	Balance
13/May/2011	33974	D, Kristofer	N Joe, M.D.			
		A00069 - Insurance Company Form - short repo		120.00	120.00	0.00
Invoice Total				**$120.00**	**$120.00**	**$0.00**
20/Jan/2012	36804	B, Shanika	Roberto S, MD			
		95 - Review of Records by physician,a		50.00	50.00	0.00
		59 - Insurance Company Form - extensive repor		170.00	170.00	0.00
Invoice Total				**$220.00**	**$220.00**	**$0.00**
30/Jan/2012	36877	B, Shanika	Roberto S, MD			
		94529 - Occupational Health Assessment		149.00	149.00	0.00
Invoice Total				**$149.00**	**$149.00**	**$0.00**
27/Jun/2012	38695	W, Denae	Roberto S, MD			
		59 - Insurance Company Form - extensive repor		175.00	175.00	0.00
		95aps - Chart review,c		50.00	50.00	0.00
Invoice Total				**$225.00**	**$225.00**	**$0.00**
31/Jul/2012	39028	W, Denae	Roberto S, MD			
		1001 - Form Fee,a		50.00	50.00	0.00
Invoice Total				**$50.00**	**$50.00**	**$0.00**
22/Aug/2012	39222	W, Denae	Roberto S, MD			
		1001 - Form Fee,a		75.00	75.00	0.00
Invoice Total				**$75.00**	**$75.00**	**$0.00**
Payor Total				**$839.00**	**$839.00**	**$0.00**

Steps

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** ( ). The EMR displays the Billing window.
2. On the Billing menu, click **Reports** > **Other Reports** > **Third Party Statements**. The EMR displays the Print Report window.



3. Use the following table to enter your report criteria.

Field	Description
From	Defaults to 30 days from today. To select a different date, click the down arrow and then click a date on the calendar. **Tip**: To quickly navigate to a different year or month, at the top of the calendar, click the month or year.  The EMR displays months instead of days. 
Up To	Defaults to today. To select a different date, click the down arrow and then click a date on the calendar. **Note:** The **Up To** date entered is **NOT** included in the calculation. For example, to include the entire month of April 2015, enter the following information: From 01/Apr/2015; Up To 01/May/2015.
Date Type	The **Date Type** defaults to **Service Date**. You can also select to use the **Bill Date**. ■ **Service Date**: Regardless of the time the bill was entered or submitted, only bills with Service Dates that fall between the specified date options are displayed. ■ **Bill Date**: Only bills that were stamped with a billed date during the specified date options are displayed.

Field	Description
Provider	Defaults to **All**. To view a report for a specific practitioner, in the drop-down list, select the practitioner. If your clinic has set up security around billing reports, **(<All> Allowed by Security)** is displayed above the Provider list, and only the practitioners that you have access to are listed. See "Setting security around billing" on page 209.
Include All Inactive Providers	Select this check box to include inactive providers in the report.
Payor	In the drop-down list, select the insurer you want to produce a report for, or to produce a report for all insurers, select **All**. **ALL** is selected by default; this includes Medical Services Plan BC, WCB e-Submission, Patient and 3rd Party insurers. The report groups and subtotals the various insurers.
Include all Inactive Payors	Select this check box to include All Inactive Payors in the report. Inactive Payors are Insurers whose Service Limit "Up To" date is in the past.
Patient	If you want to produce a report for a specific patient (for example, if you want to produce a statement of bills billed directly to a patient): 1. In the **Patient** field, enter the patient's last name. 2. Click **Find**. 3. In the drop-down list, click the patient's name.
Paid Status	Select to include bills with one of the following statuses: ■ **All**: All bills regardless of Paid Status (Paid, Partially Paid, Outstanding) ■ **Not Paid/Partial Paid**: Outstanding bills and Partially Paid bills ■ **Fully Paid**: Paid bills NOT including Partially Paid bills

Field	Description
Report Details	Select one or both of the following check boxes to specify the details you want to include in the report: ■ **Include Write Off**: Includes invoices that have been written off. **Note:** The invoice is not flagged as a write off, but is merely added to the Third Party Statement preview and print out. ■ **Include Billing Notes**: Includes notes entered via the Detail/Notes area of the invoice.
Print Options	If you want each invoice to start on a new page, select the **New Page for each Invoice** check box.
Print Information	In the **Name** drop-down list, click the printer you want to use. In the **Copies** field, enter the number of copies you want to print.

4. Perform one of the following actions:
   - To print the report, click **Print**.
   - To preview the report before printing, click **Preview**. When you finish previewing, click **Print Report** ( ).
   - To export the report, click **Preview** and then, on the Print Preview menu bar, click **Export Report** ( ). Save the file as one of the following types: Crystal Reports (*.rpt), Adobe Acrobat (*.pdf), Microsoft Excel (*.xls), Microsoft Word (*.doc), or Rich Text Format (*.rtf).

Running a Work Coverage report

The Work Coverage report details one of the following for a selected date range:

- A list of services a practitioner has provided to patients who do not belong to them (that is, services provided to other practitioners' patients).
- A list of services that have been provided to a practitioner's patients by other practitioners in the clinic.

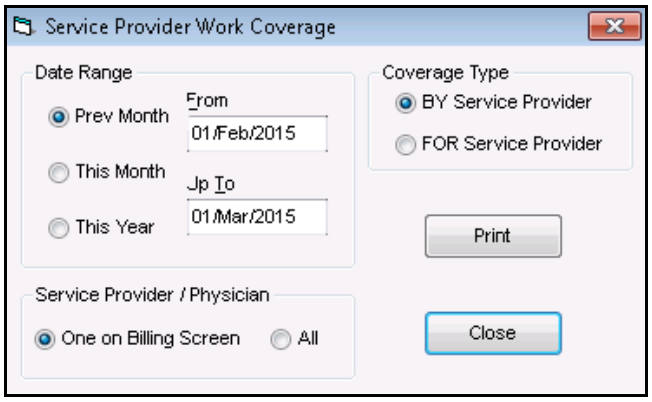
Following is an example of a Work Coverage report.

Wolf Clinic
Other Service Provider's patients seen by: A, Javier
From 01/Oct/2010 through 31/Oct/2015

For Provider	Date	Payor	Patient	PHN	Chart	Fee	ICD9	Billed	Paid
M, Shona	20/Oct/2010	Medical Services Plan BC	M, Dung	123456789		33049	427	53.12	
M, Shona	20/Oct/2010	Medical Services Plan BC	M, Dung	123456789		33047	427	64.86	
M, Shona	20/Oct/2010	Medical Services Plan BC	M, Dung	123456789		33047	427	64.86	
M, Shona	20/Oct/2010	Medical Services Plan BC	M, Dung	123456789		33049	427	53.12	
W, Roberto	24/Jan/2013	Medical Services Plan BC	E, Tai	9996		18100	780	44.67	
W, Thad	24/Jan/2013	Medical Services Plan BC	H, Hunter	9995		15300	780	32.75	
W, Thad	24/Jan/2013	Medical Services Plan BC	H, Hunter	9995		1011	780	20.48	
N, Arden	24/Jan/2013	Medical Services Plan BC	P, Patsy	9998		1011	780	20.48	
C, Shaquita	24/Jan/2013	Medical Services Plan BC	D, Donnie	9993		120	5646	51.84	
				Payor Total				406.18	0.00
N, Scott	13/Sep/2011	Workers Compensation Boar	G, Lemuel	123456789		19904	727	40.80	
C, Lucrecia	24/Jan/2013	Workers Compensation Boar	D, Marci	9990		15300	37803	32.75	
C, Lucrecia	24/Jan/2013	Workers Compensation Boar	D, Marci	9990		19940	37803	40.28	
C, Lucrecia	24/Jan/2013	Workers Compensation Boar	D, Marci	9990		19333	37803	0.00	
C, Lucrecia	24/Jan/2013	Workers Compensation Boar	D, Marci	9990		19334	37803	0.00	
C, Lucrecia	24/Jan/2013	Workers Compensation Boar	D, Marci	9990		19335	37803	0.00	

Steps

1. Open the Billing program: On the Wolf EMR Launch page, click **Billing** ( ). The EMR displays the Billing window.
2. On the Billing menu, click **Reports** > **Other Reports** > **Work Coverage**. The EMR displays the Service Provider Work Coverage window.



3. Use the following table to enter your report criteria.

Field	Description
Date Range	Select one of the following date range options: ■ **Prev Month** ■ **This Month** ■ **This Year** You can also manually enter dates in the **From** and **Up To** fields. **Note:** The **Up To** date entered is **NOT** included in the calculation. For example, to include the entire month of April 2015, enter the following information: From 01/Apr/2015; Up To 01/May/2015.
Service Provider /Physician	Select one of the following options: ■ **One on Billing Screen**: To create a work coverage report for the selected Physician ■ **All**: To create a work coverage report for all Physicians
Coverage Type	Select one of the following coverage type options: ■ **BY Service Provider**: To create a work coverage report to display how many patients were seen by the selected Physician(s) for other service providers in the clinic ■ **FOR Service Provider**: To create a work coverage report to display how many patients of the selected Physician(s) were seen by other service providers in the clinic

4. Click **Print**. The EMR displays the Printer Options window.
5. In the **Copies** field, enter the number of copies you want to print.
6. In the **Printer** drop-down list, click the printer you want to use.
7. Click **OK**.

Chapter 9

Managing service fees, and other billing preferences (Administrators)

If you are a user with administrator authority in Wolf EMR, you can customize and manage a number of features around billing, including:

- Service fee codes and fee schedules (see "Managing service fee codes and fee schedules" on page 175)
- Insurers and other third parties you bill to (see "Managing third-party and patient billing" on page 202)
- Service facilities and functional centres (see "Setting security around billing" on page 209)
- Billing security (see "Setting security around billing" on page 209)
- ICD9 diagnostic codes (see "Managing ICD9 diagnostic codes" on page 210)

Managing service fee codes and fee schedules

If you have administrative authority in Wolf EMR you can update and customize service fee codes used for billing. You can:

- Update your clinic's provincial fee codes each time the province releases fee updates (see "Updating your provincial fee code files" on page 176)
- Add and modify service fee codes (see "Adding and modifying service fee codes" on page 177)
- Define rates for fee codes ("Defining rates for fee codes" on page 184)
- Print a list of your clinic's fees ("Printing a list of fees" on page 187)
- Assign fee codes to your clinic's default (favourites) list (see "Assigning fee codes to your clinic's default (favourite) list" on page 189)
- Remove fee codes (see "Removing fee codes" on page 190)
- Set service limits to restrict how often a fee code can be billed ("Restricting how often a fee code can be billed (service limits)" on page 192)

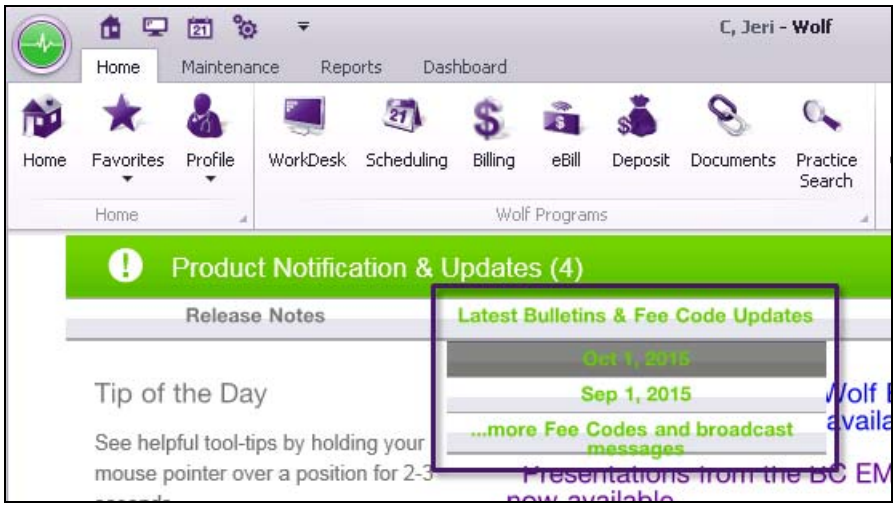
- Apply rules and restrictions around a group of fees (see "Applying rules and restrictions to a group of fees" on page 195)

Updating your provincial fee code files

When a provincial fee update is available, you are informed on the Wolf EMR Launch page. Updated fee codes are typically released around the beginning of every month.

Steps

1. On the Wolf EMR Launch page, click **Latest Bulletins & Fee Code Updates**, and then select the fee code release date you want.



The EMR displays the **BC Fee Schedule Update and Broadcast Message web page**, detailing:

- A link to download the fee update.
- Detailed instructions on how to update your provincial fee codes.

Before you start the update process:

- Inform your staff to refrain from performing any billing-related activities and to close the Wolf EMR Billing and eBill applications. (**Note**: You can resume billing activities as soon as the update is complete).
- Read all supplemental documentation provided with the update to understand the fee code changes.

2. Read and complete the instructions on the **BC Fee Schedule Update and Broadcast Message** web page.

Adding and modifying service fee codes

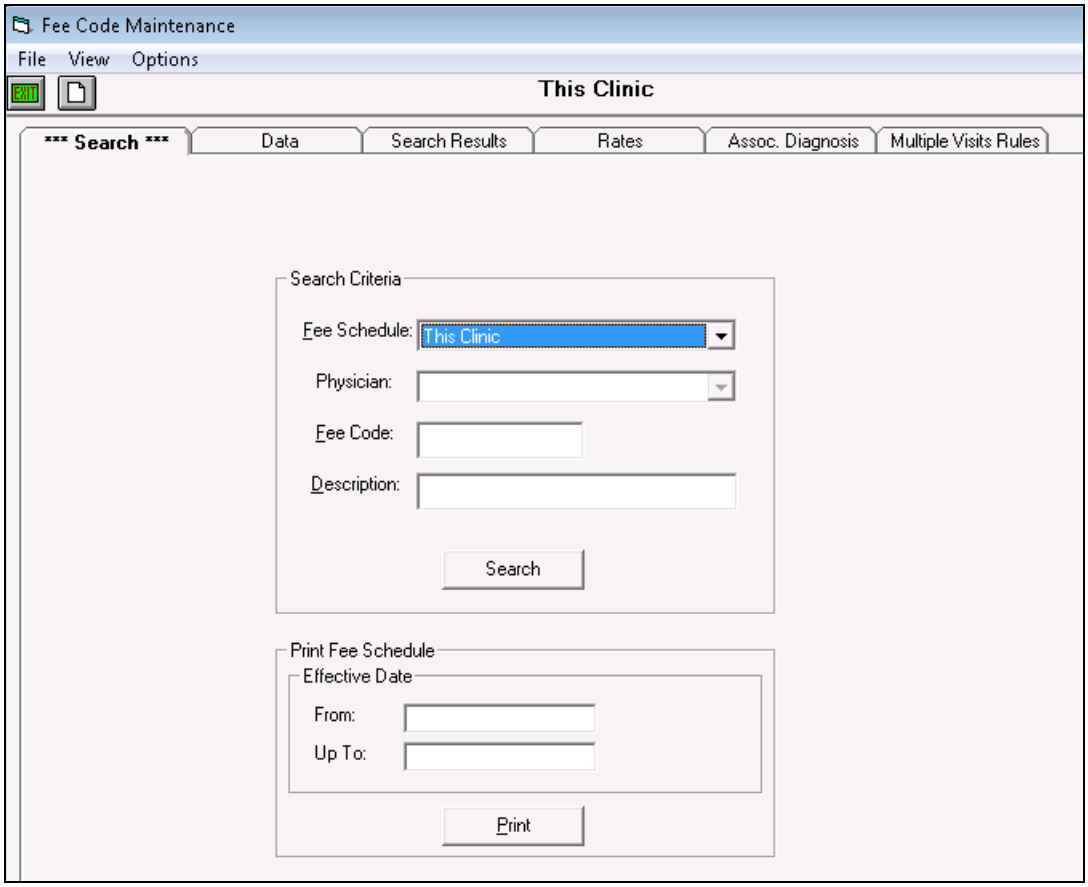
Wolf EMR comes with a compete set of provincial fee codes; however, to bill patients for un-insured services, such as motor vehicle medical examinations, you must create custom fee codes for your clinic. You must also create custom fee codes for services you bill to third parties such as insurance and law companies. You can create as many custom service fee codes as you need.

If necessary, you can also modify provincial service fee codes.

> **Note**: Any modifications you make to provincial service fee codes are overwritten when the provincial fee codes are updated.

Steps

1. On the Wolf EMR Launch page, click **Configuration** ( ). The Configuration window opens.
2. On the Configuration menu, click **View** > **Insurers, Payors (Gov't, Private) and Codes** > **Fee Codes**. The EMR displays the Fee Code Maintenance window.



3. Perform one of the following actions:

   - To add a fee code:

     a) In the **Search** tab, in the **Fee Schedule** drop-down list, select the fee schedule (fee list) you want to add the fee code to.

> **Tip**: To add a fee code to your clinic's custom fee code list, select **This Clinic**. To add a provincial fee code, click **Medical Services Plan (BC)**.
>
> **Note:** If **This Clinic** is not available in the Fee Schedule drop-down list, create a fee schedule called **This Clinic**. See "Creating fee schedules (fee lists)" on page 200.

     b) Click  .

   - To edit a fee code, search for and select the fee code you want to edit:

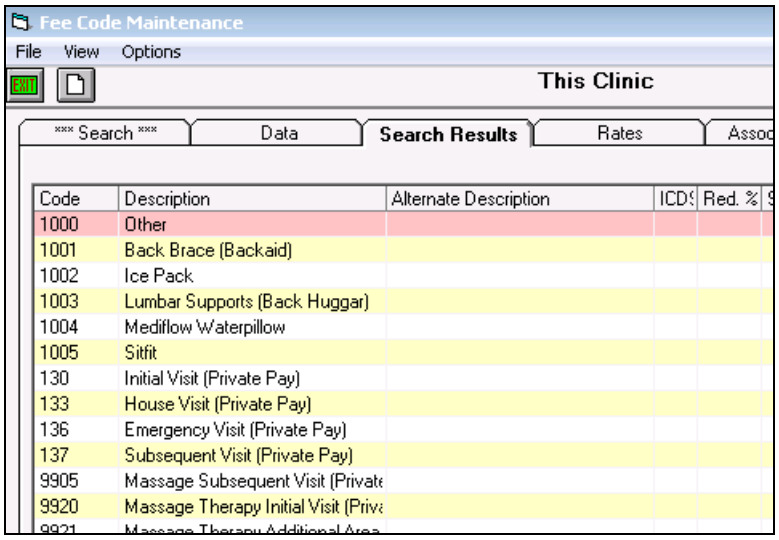
a) In the **Search** tab, in the **Fee Schedule** drop-down list, select the fee schedule (fee list) the fee code is listed under.

> **Tip**: To find one of your clinic's custom fee codes, click **This Clinic**. To find a provincial fee code, click **Medical Services Plan (BC)**.

b) If you know the fee code, in the **Fee Code** field, enter part or all of the fee code. If you don't know the fee code, in the **Description** field, enter a description for the fee code.

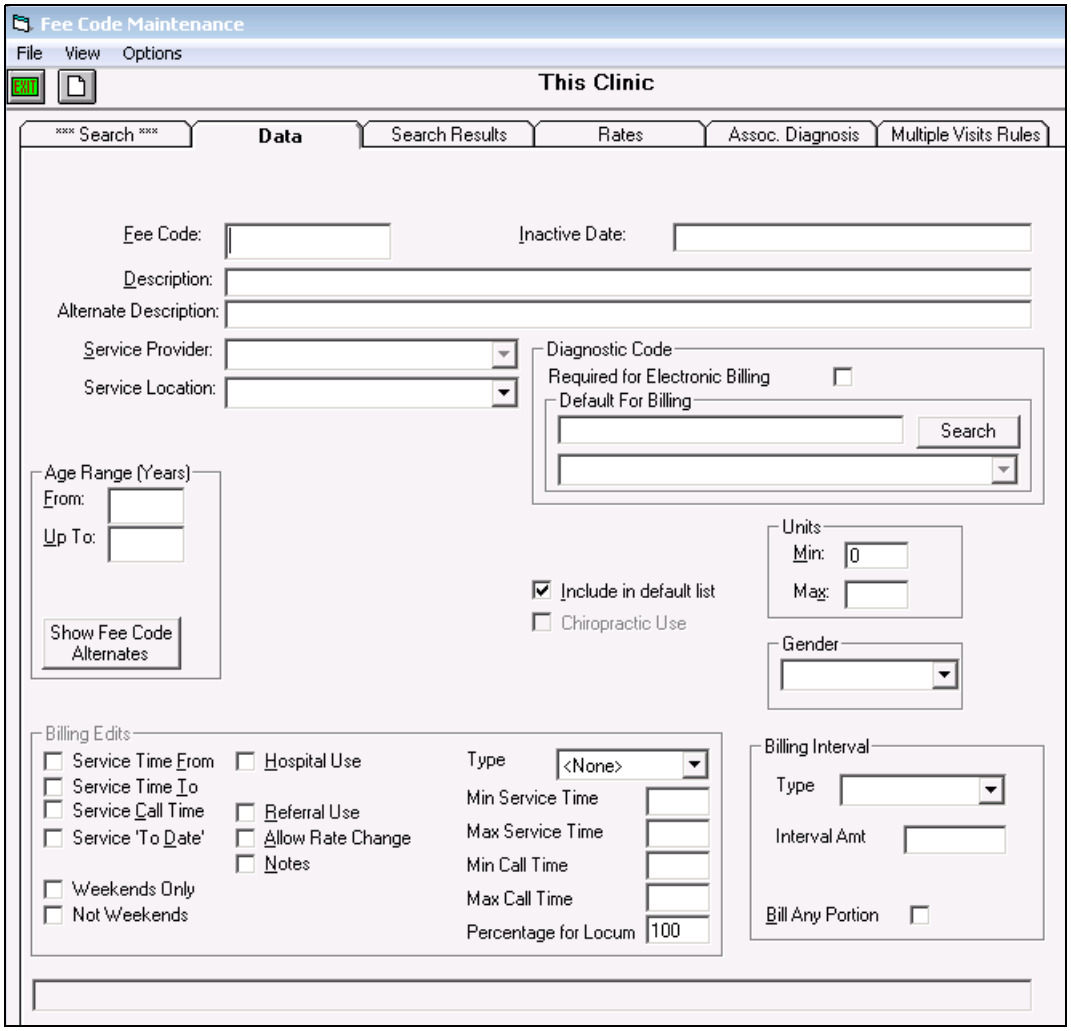
> **Tip**: To view a complete list of fee codes for the selected fee schedule, leave the **Fee Code** and **Description** fields blank.

c) Click **Search**. The EMR displays the **Search Results** tab with a list of matching fee codes.



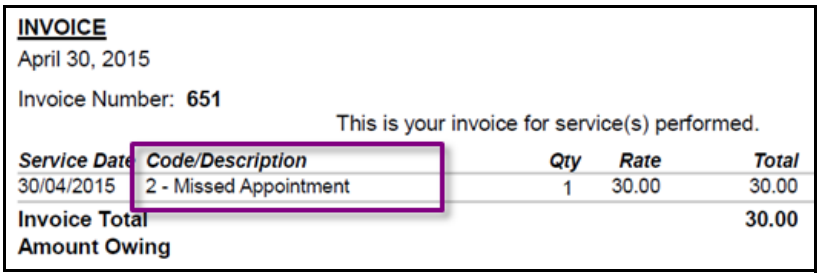
d) In the list of fee codes, double-click the code.

The EMR displays the **Data** tab for the selected or new fee code.



4. On the **Data** tab, enter or edit information using the following table as a reference.

Note: You can ignore fields that are not described in the table.

Field	Description
Fee Code	Enter a code to represent a service. You can use numbers, letters, or a combination of the two. **Note:** You are restricted to 10 characters. The code must contain at least one number. **Note:** On an invoice, the Fee code is printed beside the description, so you do not have to be very descriptive with the code. A simple number looks best. **View on invoice:**  INVOICE April 30, 2015 Invoice Number: **651** This is your invoice for service(s) performed. Service Date / Code/Description / Qty / Rate / Total 30/04/2015 / 2 - Missed Appointment / 1 / 30.00 / 30.00 **Invoice Total** 30.00 **Amount Owing**
Inactive Date	If you want the code to become inactive on a certain date, enter the date here; otherwise, leave this field blank. **Note:** Use the following date format: **dd/mmm/yyyy.**
Description	Enter the service description. **Note:** The description displays in the invoice beside the fee code.
Alternate Description	If the service has an alternate description, enter it here. **Note:** Alternate descriptions help billers search for fee codes. When a biller enters a search term into the **Fee Code/ Desc** area on a bill, the EMR includes fee codes with matching alternate descriptions.
Service Provider	If this code is to be used for only one practitioner, in the drop-down list, click the practitioner's name.
Service Location	If your practitioner(s) bill for services conducted out of multiple Service Locations, and this service is typically billed from only one Service location, in the drop-down list, click the Service Location. **Note:** This field is applicable only for MSP fee codes. **Note:** When you create a bill using this fee code, the **Location** drop-down list defaults to the service location you select here.

Field	Description
Diagnostic Code area	■ **Required for Electronic Billing**: If a diagnostic code is required to bill the fee code, select this check box. **Note:** If you select the **Required for Electronic Billing** check box, billers receive a prompt to enter a diagnosis code if no code is assigned to the bill. ■ **Default for Billing**: To specify a default ICD9 code for bills using this fee code: 1. in the **Default For Billing** field, enter all or part of the ICD9 code or description, and then click **Search**. 2. In the drop-down list, click the ICD9 code you want.
Age Range (Years) area	If the fee code is to be used only for patients in a certain age range, enter the minimum and/or maximum age (in years) in the **From** and **Up to** fields. For example, if the fee code is for patients 65 years and older, enter **65** in the **From** field, and then leave the **Up to** field blank.
Include in default list	To include the fee code in your clinic's default fee code list, select this check box. **Note:** You can assign up to 50 fee codes to your default list.
Units area	To define the number of units a patient or third party can be billed for: ■ In the **Min** field, enter the minimum number of units. ■ In the **Max** field, enter the maximum number of units.
Gender	If the fee code is to be used only for patients of a certain gender, in the drop-down list, click the gender.
Billing Edits area	
In the **Billing Edits** area, you can customize the billing workflow/process for bills with this fee code. You can: ■ Force billers to enter information in certain fields on a bill. ■ Restrict what values billers can enter in certain fields on a bill. ■ Enable billers to edit values that are not normally editable on a bill. ■ Enable a code to be billed only on a weekday or only on a weekend. The following rows describe how each selection affects the bill when you bill the fee code. **Note:** Ignore all options that are not described below.	

Field	Description
Service Time From	When you bill the fee code, the EMR forces you to enter a service **Start** time in the **Service Detail** window, in the **Service Times** area.
Service Time To	When you bill the fee code, the EMR forces you to enter a service **End** time in the **Service Detail** window, in the **Service Times** area.
Service Call Time	When you bill the fee code, the EMR forces you to enter a service **Call Time** in the Service Detail window, in the **Service Dates** area.
Service 'To Date'	When you bill the fee code, the EMR forces you to enter a service end date in the Service Detail window, in the **Service Dates** area, in the **To** field.
Hospital Use	When you bill the fee code, **Hospital** check box is selected by default.
Referral Req'd	When you bill the fee code, the EMR forces you to enter a referring practitioner in the Service Detail window, in the **Referral Data** area.
Allow Rate Change	When you bill the fee code, the EMR enables you to edit the rate. **Note:** If you do not select this check box, you cannot edit the rate.
Notes	When you bill the fee code, the EMR forces you to enter notes in the Service Detail window, in the **Notes** field.
Weekends Only	The EMR allows you to bill this fee code only if the service date falls on a weekend.
Not Weekends	The EMR does not allow you to bill this fee code if the service date falls on a weekend.
Type	Depending on the **Type** selected in the drop-down list, the EMR forces you to enter a service **Start Time**, an **End Time**, both Start and End Time, or either a Start or End Time.
Min Call Time	If you enter a **Call Time** in the Service Detail window, the EMR forces you to enter the **Min Call Time**.
Max Call Time	If you enter a **Call Time** in the Service Detail window, the EMR restricts you from entering a time later than the **Max Call Time**.
Billing Interval area	
If the fee is for a service that is billed based on time (in minutes), in the **Billing Interval** area, you can define how intervals of billed time are charged.	

Field	Description
Type	In the drop-down list, click one of the following options: ■ **Day**: To bill based on intervals of days ■ **Minute**: To bill based on intervals of minutes
Interval amount	Enter the amount that constitutes one interval.

5. When you finish entering information on the **Data** tab, click **Save** ().
6. You can now:
   - Set rates for the fee code. See "Defining rates for fee codes" on page 184.
   - Set restrictions on how often the fee code can be billed. See "Restricting how often a fee code can be billed (service limits)" on page 192.

Defining rates for fee codes

When you create a custom fee code, you must define the rates for the service. There are two types of rates you can apply to a fee code:

- **Base rates**: The standard (default) fees for a service.
- **Special rates**: Over-ride the standard base rates for a short period of time. For example, when you have a "sale" on an aesthetics service.

You can also modify rates for MSP fee codes if needed.

Note: Any modifications you make to **provincial** rates are replaced when MSP fee codes are updated.

Adding or modifying base rates for fee codes

A base rate is the standard rate you charge for a service or product.

In Wolf EMR, you can define multiple base rates for one fee code. For example:

- You can charge different rates for patients in different age groups.
- If you sell products, such as vitamins, you can charge a different rate when a patient purchases a bulk amount of a product (units).

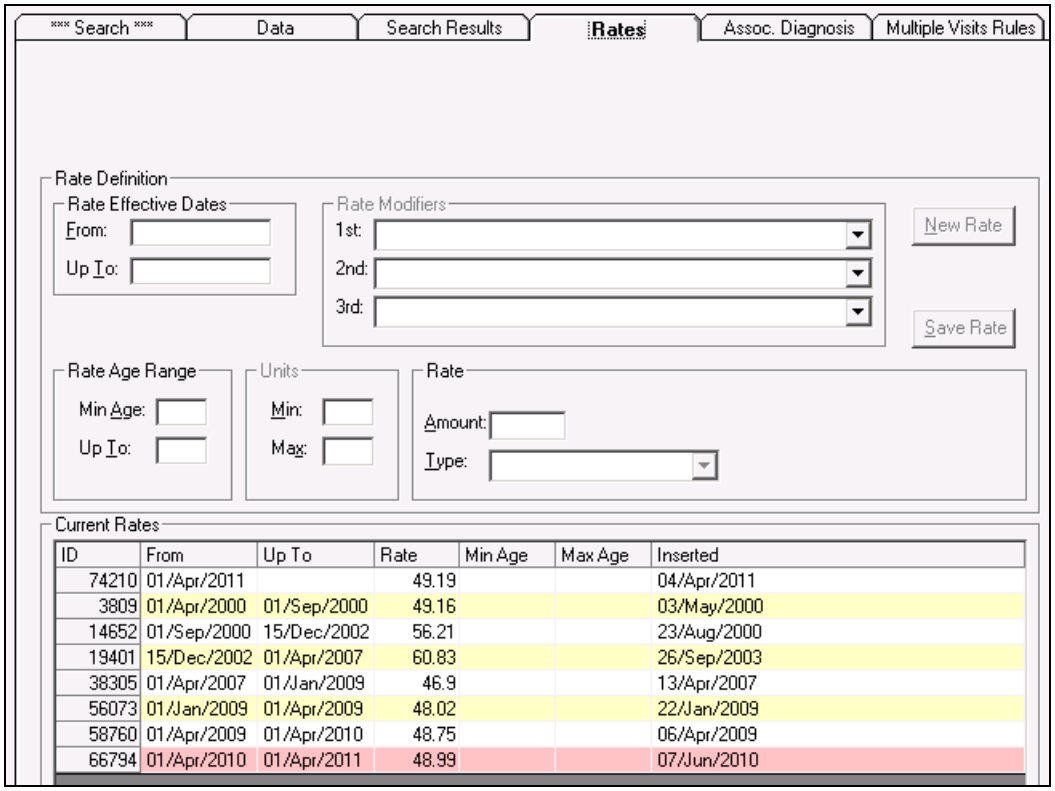
Best practice: Tracking rate changes (or modifications)

When you need to modify a rate, add a new rate, and then deactivate the old rate. Avoid modifying a current rate.

This way, you have a record of all your rate changes.

Steps

1. Search for and select the fee code you want add or modify the base rate for. See Step 1to Step 3in "Adding and modifying service fee codes" on page 177.
2. Click the **Rates** tab. The EMR displays:
   - The **Rate Definition** area, where you enter information for a new rate.
   - The **Current Rates** list, where you can view a history of the fee code's current and past rates.



3. Click **New Rate**.
4. Enter information in the **Rate Definition** area, using the following table as a reference.

Field	Description
Rate Effective Dates	■ **From**: Enter the date that the base rate will take effect. **Note:** If you are editing a current base rate, enter the date you want the changes you are making to take effect. The old base rate will be applied to bills until the **From** date is reached. At that time, the old base rate will discontinue automatically. ■ **Up To**: To have the rate continue indefinitely (until you manually change or discontinue the rate), leave this field blank. **Note:** Use the following date format: **dd/mmm/yyyy**
Rate Age Range	To specify an age range for the rate to apply: 1. In the **MinAge** field, enter the minimum patient age. 2. In the **Up To** field, enter the maximum patient age. **Tip**: If you charge different rates for patients in different age groups, you can program the rate to change automatically based on the age of the patient: 1. Add a rate for each age group. For example: ■ Rate 1: $25 (for patients under the age of 60) ■ Rate 2: $20 (for patients over the age of 60) 2. In the **Rate Age Range** area, define the age group for the rate. For example: ■ For Rate 1, in the **Rate Age Range** area, leave the **Min** field blank, and then enter **59** in the **Max** field. ■ For Rate 2, in the **Rate Age Range** area, enter **60** in the **Min** field, and then leave the **Max** field blank.
Rate	■ **Amount**: Enter the base rate in dollars and cents. For example, 17.2 (for $17.20).

3. Click **Save Rate**. The EMR adds the rate on the **Current Rates** list.
4. If you want the rate you just added to replace a current rate, deactivate the current rate:
   a) In the **Current Rates** list, click the rate you want to deactivate. The EMR displays the information for the rate in the **Rate Definition** area.
   b) In the **Rate Definition** area, in the **Up To** field, enter the date the rate is to become inactive on (the date that the new rate takes effect).
   c) Click **Save Rate**.

Adding special rates for fee codes

You can add a rate that overrides the normal base rate(s) for a specified date range. For example, if an aesthetics clinic has a sale on laser hair removal treatments for a one-week period, they can add the special rate of $35 to replace the normal rate of $40 for that week only. When the end of the week is reached, the EMR resumes the original base rate automatically.

Steps

1. Search for, and then double-click the fee code. See Step 1to Step 3in "Adding and modifying service fee codes" on page 177.
2. Click the **Rates** tab.
3. Click **New Rate**.
4. In the **Rate Definition** area, enter information similar to the normal base rate for the service. See Step 4in "Adding or modifying base rates for fee codes" on page 184.

   The following exceptions apply to special rates:

   a) In the **Rate Effective Dates** area, in the **From** and **Up To** fields, enter the start and end date for the special rate to be in effect.

   b) In the **Rate** area, in the **Amount** field, enter the special rate amount in dollars and cents. For example, $52.50.
5. Click **Save Rate**.

Printing a list of fees

If you want a list of your clinic's patient and third party fees, you can print your clinic's custom fee codes. If you created different fee schedules for different categories of services, you can print more specific lists of fee codes. For example, if a multi-disciplinary clinic creates a fee schedule for physiotherapy services and another fee schedule for Sports Medicine services, they can print a list containing only their physiotherapy services. See "Creating fee schedules (fee lists)" on page 200.

The printed fee list looks similar to the following example.

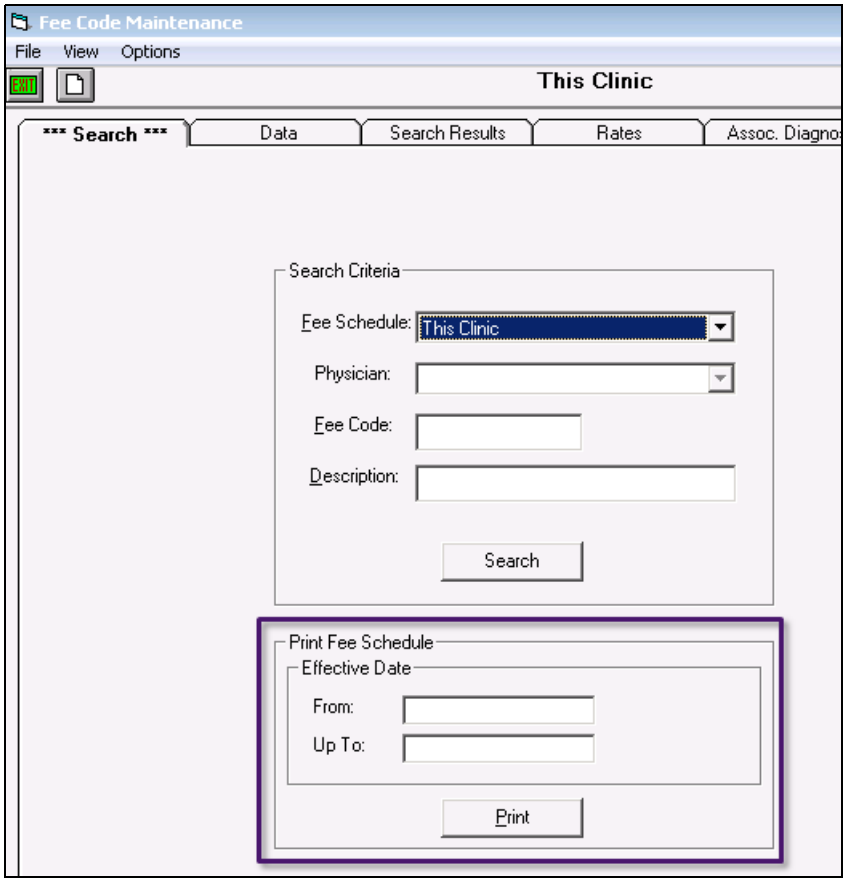
Wolf Clinic 22/Apr/2015

This Clinic Fee Schedule Between 22/Apr/2015 And 23/Apr/2015

Code	Description	Fee Rate	Effective From	Effective To
1	Letter	$50.00	01/Jun/2005	
2	Missed Appointment	$30.00	01/Jun/2005	
3	Uninsured Service	$75.00	01/Jun/2005	
4	APS	$100.00	01/Jun/2005	
5	complete exam No AHC	$70.00	05/Aug/2005	
1DLM	DLM	$50.00	22/Jun/2005	
1Report	Medical Legal Report	$.00	22/Jun/2005	
1Visit	03.03A - Follow Up Visit	$28.97	22/Jun/2005	

Steps

1. On the Wolf EMR Launch page, click **Configuration** (). The Configuration window opens.
2. On the Configuration menu, click **View** > **Insurers, Payors (Gov't, Private) and Codes** > **Fee Codes**. The Fee Code Maintenance window opens, with the **Print Fee Schedule** area displayed at the bottom of the window.



3. In the **Fee Schedule** drop-down list, click the fee schedule you want to print.
4. In the **Print Fee Schedule** area, click **Print**. The EMR displays the Print Label window.

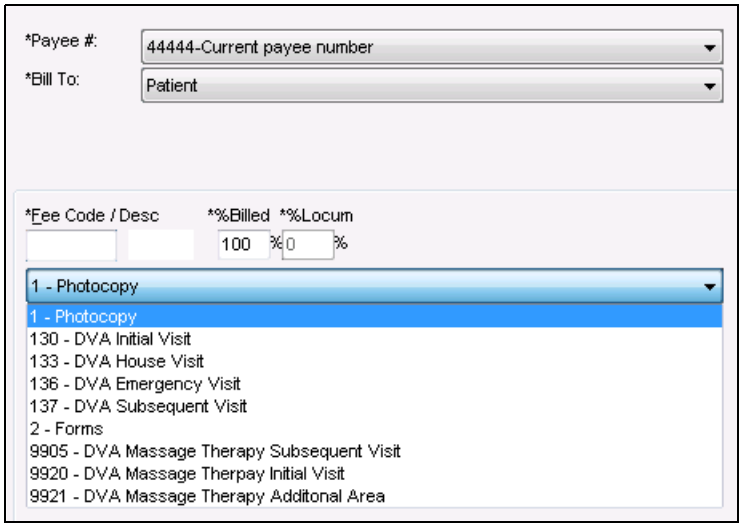
> **Note**: If you want to print a list of all your currently active fee codes, in the **Effective Date** area, leave the **From** and **Up To** fields blank.

5. In the **Printer** drop-down list, click the printer you want, and then click **OK**.

Assigning fee codes to your clinic's default (favourite) list

If your billers frequently use certain fee codes when they bill MSP, a patient, or a third party, you can assign these fee codes to your clinic's default fee code list. If you have default fee codes set, when you create a bill, after you select an option in the **Bill To** drop down list, you can click the **Fee Code** drop-down list to view the default codes associated with the **Bill To** party.

For example, if you start a bill and then, in the **Bill To** drop-down list, click **Patient**, you can select a fee from a list of common fees your clinic bills to patients directly.



Steps

1. In the Fee Code Maintenance window, search for and select the fee code. See Step 1to Step 3in "Adding and modifying service fee codes" on page 177.
2. On the **Data** tab, select the **Include in default list** check box.
3. Click **Save** ( ).

Note: To remove a fee code from your default list, clear the **Include in default list** check box.

Removing fee codes

The method you use to remove a fee code depends on whether the fee code has ever been used on a bill:

- If the fee code has not yet been applied to a bill, for example, if you created a code in error and want to remove it, you can delete the code. The EMR removes deleted fee codes from your fee schedule list. You cannot reactivate a deleted fee code. See "Deleting fee codes" on page 191.
- If a fee code has been applied to a bill, you can only deactivate the fee code. Billers cannot see or use deactivated fee codes; however, deactivated fee codes remain on your fee schedule list indefinitely. You can reactivate a deactivated fee code, if necessary. See "Deactivating fee codes" on page 191.

Deleting fee codes

You delete a fee code only if you want to permanently remove the code from your EMR. You cannot delete a fee code if the code has been applied to a bill. Once you delete a fee code, you cannot reactivate it.

Steps

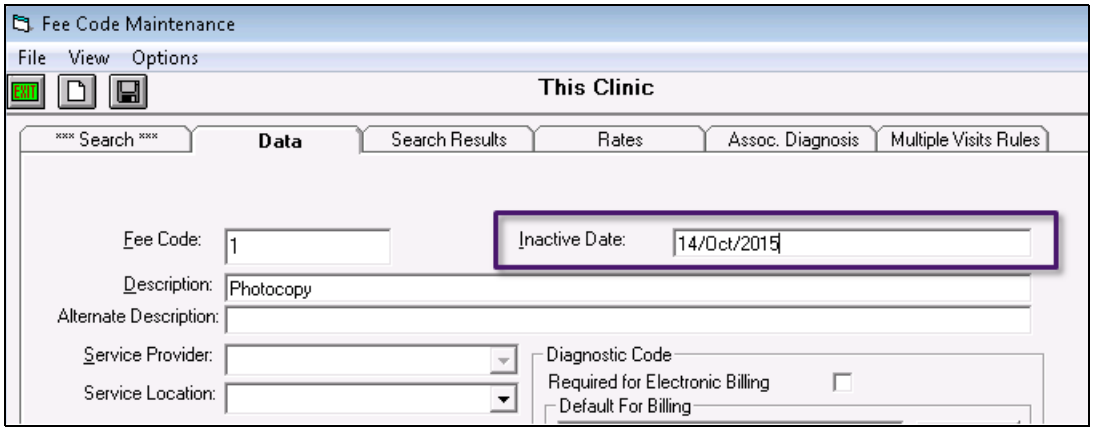
1. In the Fee Code Maintenance window, search for and select the fee code. See Step 1 to Step 3 in "Adding and modifying service fee codes" on page 177.
2. On the Fee Code Maintenance menu, click **File** > **Delete Fee Code**. The EMR displays a dialogue box with the following prompt: "Delete this Fee Code".
3. Click **Yes**.

> **Tip**: If you can still see the fee code on the fee schedule **Search Results** tab in the Fee Code Maintenance window, close the Fee Code Maintenance window, and then open it again. The fee code is now removed.

Deactivating fee codes

You deactivate a fee code if you want to make the code unavailable for billers to use, but the fee code has been applied to bills in the past. If needed, you can reactivate the code.

1. In the Fee Code Maintenance window, search for and select the fee code. See Step 1 to Step 3 in "Adding and modifying service fee codes" on page 177.
2. On the **Data** tab, in the **Inactive Date** field, enter the date you want the fee code to become inactive.



3. Click **Save** (). The EMR maintains the inactive fee code as an item in the fee schedule; however, billers can no longer see or use the fee code.

Note: You can reactivate the fee code by clearing the **Inactive Date** field on the **Data** tab.

Restricting how often a fee code can be billed (service limits)

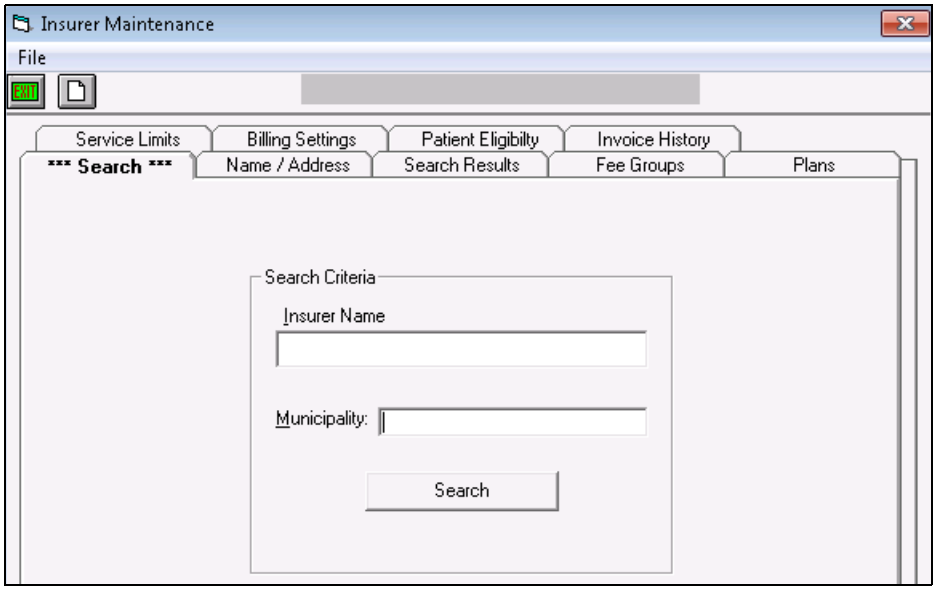
To restrict the number of times that a service can be billed for a patient within a given time period, you must define Service Limits for a particular insurer.

Note: If the service limit is reached, billers are warned when they bill the fee code or fee group to the insurer.

Tip: You can create a service limit for an individual fee code or for a group of fee codes. For more information on fee groups, see "Applying rules and restrictions to a group of fees" on page 195.

Steps

1. On the Wolf EMR Launch page, click **Configuration** ( ). The Configuration window opens.
2. On the Configuration menu, click **View** > **Insurers, Payors (Gov't, Private) and Codes** > **Insurers, Payors**. The EMR displays the Insurer Maintenance window.



3. Find the insurer you want to set service limits for:

   a) In the **Search** tab, in the **Insurer Name** field, enter all or part of the insurer's name.

   b) In the **Municipality** field, enter the insurer's municipality.

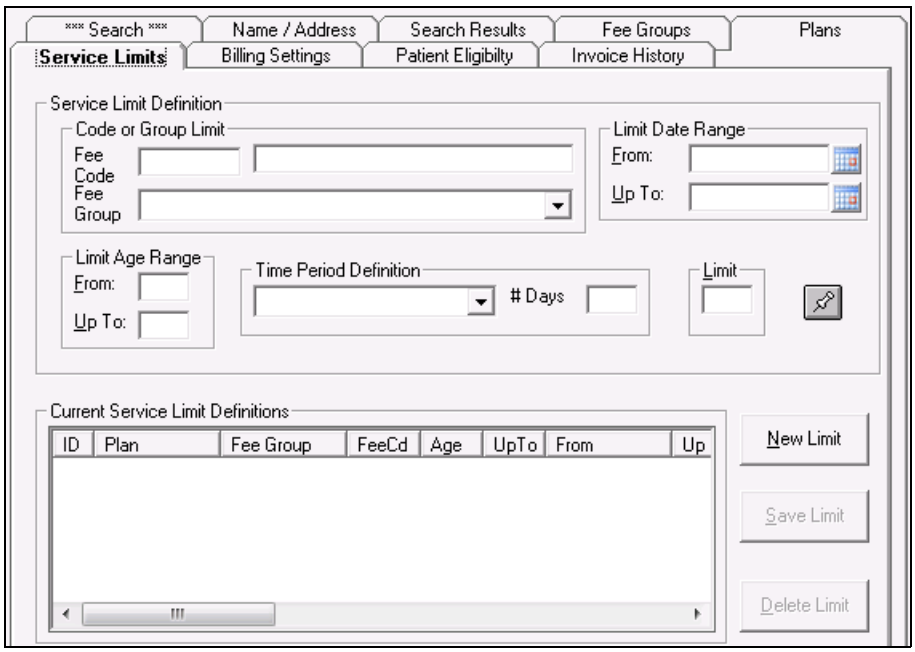
> **Tip**: To view a complete list of all insurers you bill to, leave the **Insurer Name** and **Municipality** fields blank.

   c) Click **Search**. The EMR displays a list of matching insurers.

   d) In the list of insurers, click the insurer.

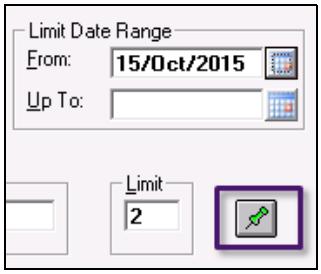
> **Note**:
>
> - To create a service limit for a fee billed to MSP, select **Medical Services Plan BC**.
> - To create a service limit for a fee billed directly to patients, select **Patient**.
> - If the insurer you want is not in the list of insurers, you can add insurers as needed. See "Adding and modifying third-parties (insurers) you bill to" on page 202.

4. Click the **Service Limits** tab. The EMR displays a list of your current service limit definitions for the insurer in the **Current Service Limit Definitions** area.



5. Perform one of the following actions:
   - To enter a new service limit, click **New Limit**.
   - To modify a service limit, in **Current Service Limit Definitions** list, click the ID for the limit.
6. In the **Service Limit Definition** area, enter or modify information using the following table as a reference.

Field	Description
Code or Group Limit	Perform one of the following actions: ■ To set a service limit for an individual fee code, in the **Fee Code** field, enter the fee code, and then press **Enter**. ■ To set a service limit for a group of fees, in the **Fee Group** drop-down list, click the fee group.
Limit Date Range	■ **From**: (Required) Enter the effective date for the service limit. ■ **To**: If the service limit is to be effective only until a certain date, enter the end date here; otherwise leave this field blank.
Limit Age Range	If the service limit applies only to patients in a specific age range: ■ **From**: Enter the minimum age. ■ **Up To**: Enter the maximum age.
Time Period Definition	In the drop-down list, select one of the following options: ■ **In Total**: To set the service limit for the total number of services since a patient first enrolled in the clinic. ■ **Each Calendar Year**: To set the service limit for a calendar year. ■ **Between visits**: To set the service limit for a specified number of days between services. In the **# Days** field, enter the number of days allowed between services within a given time period. ■ **Each Calendar Month**: To set the service limit per calendar month.
Limit	Enter the number of services allowed, for the period defined in the **Time Period Definition** area.

Field	Description
	Click this icon to enter notes regarding the service limit. This information is for your clinic's reference only. You can view these notes only from the **Service Limits** tab. **Note:** After you enter a note and close the Notes window, the Note icon turns green. 

7. Click **Save Limits**. The EMR adds or modifies the limit on the **Current Service Limit Definitions** list.
8. Click **Save** ().

Applying rules and restrictions to a group of fees

You can define groups of fees for a particular insurer, and then apply rules and restrictions to a group of fees as a whole. You use fee groups if you:

- Bill a number of different services to an insurer, but can bill only a certain number of total services to that insurer for any one patient over a defined period of time.
- Charge a fee directly to the patient every time you bill a particular fee to an insurer. For example, a chiropractor can bill patients a portion of a service that is also billed to the province.
- Want to remind billers to bill additional fee codes when they bill a specific fee code. For example, billers can receive a notification to add a tray fee when they bill a fee code that commonly includes a tray fee.

To apply rules and restrictions to a group of fees, you:

1. Add a fee group. See "Adding and modifying fee groups" on page 196
2. Link fee codes to the fee group. See "Linking fee codes to fee groups" on page 198.
3. Apply restrictions to the fee group. See "Restricting how often a fee code can be billed (service limits)" on page 192.

Adding and modifying fee groups

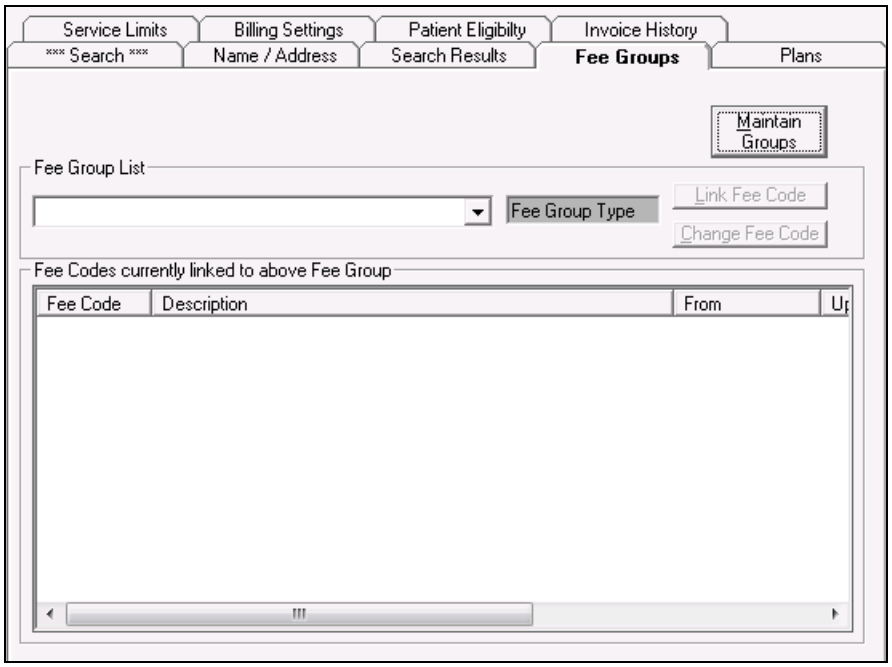
You must create a fee group if you want to apply rules and restrictions to a group of fees. Fee groups are created for each insurer (Bill To) individually. If needed, you can create multiple fee groups for an insurer. Once you create a fee group, you can define what fees belong to the fee group by linking the fees to the group (see "Linking fee codes to fee groups" on page 198)

Steps

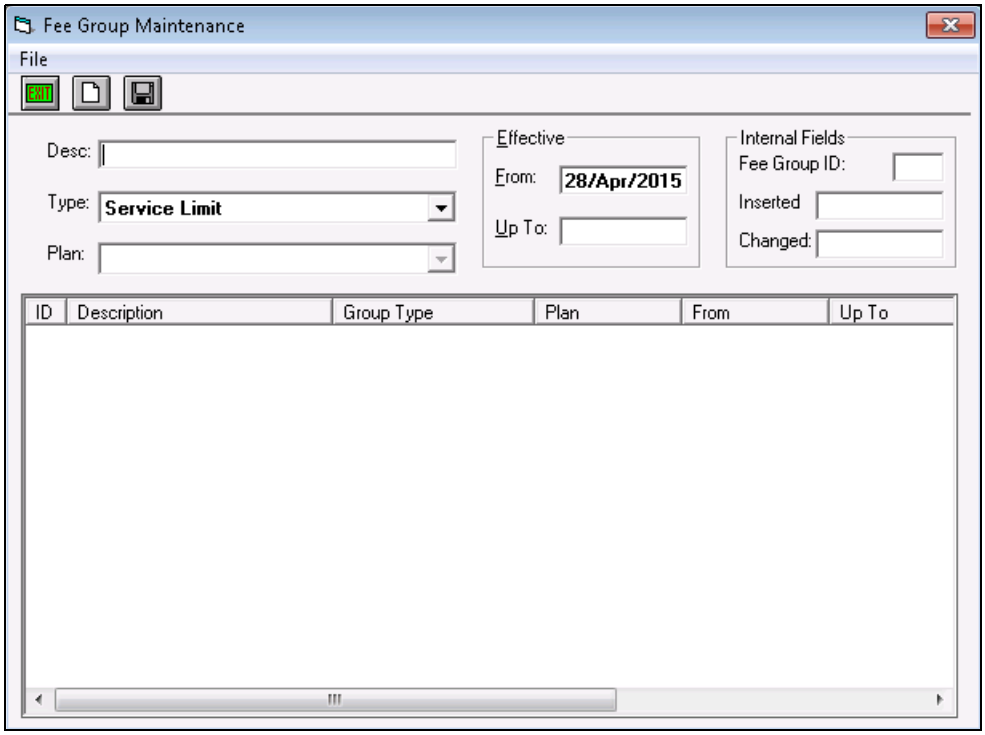
1. In the Insurer Maintenance window, search for and select the insurer you want to add or modify a fee group for. See Step 1to Step 3in "Restricting how often a fee code can be billed (service limits)" on page 192.

> **Note**:
>
> - To create a fee group for fees billed to MSP, click **Medical Services Plan BC**.
> - To create a fee group for fees billed directly to patients, click **Patient**.
> - If the insurer you want is not available, you can add insurers as needed. See "Adding and modifying third-parties (insurers) you bill to" on page 202.

2. Click the **Fee Groups** tab. The **Fee Codes currently linked to above Fee Group** area lists the fee codes linked to the selected fee group.



3. Click **Maintain Groups**. The EMR displays the Fee Group Maintenance window.



4. Perform one of the following actions:

   - To add a fee group, click  .
   - To modify a fee group, in the list of fee groups, click the ID for the fee group.

5. Using the following table, enter or modify the fee group's information.

Field	Description
Desc	Enter a name or description for the fee group.

Field	Description
Type	In the drop-down list, select one of the following options: **Note:** The fee group type you select defines how the fee group will be used. ■ **Service Limit**: To restrict the number of times that services from this group can be billed to an insurer within a given time period. ■ **Additional Charge**: To automatically charge a patient an additional amount when a service from this group is billed to an insurer. For example, a chiropractor can bill patients a portion of a service that is also billed to the province, or insurance company. ■ **Reminder**: To notify a biller to consider billing another service when a certain service from this group is initially billed. For example, billers can receive notifications to consider adding a tray fee when they create a bill for a fee code that typically includes a tray fee.
Plan	■ **Effective From**: Enter the date the fee group takes effect. ■ **Effective Up To**: (Optional) Enter an expiry date for the fee group. **Note:** Use the format **dd/mmm/yyyy**.

6. Click **Save** (). The EMR adds the fee group to the **Fee Group** drop-down list on the **Fee Groups** tab.
7. Link and unlink fee codes to the fee group as needed. See "Linking fee codes to fee groups" on page 198 and "Unlinking fee codes from fee groups" on page 199.
8. Apply rules or restrictions to the fee group. See "Restricting how often a fee code can be billed (service limits)" on page 192.
9. When you finish adding groups, click **Close** ().

Linking fee codes to fee groups

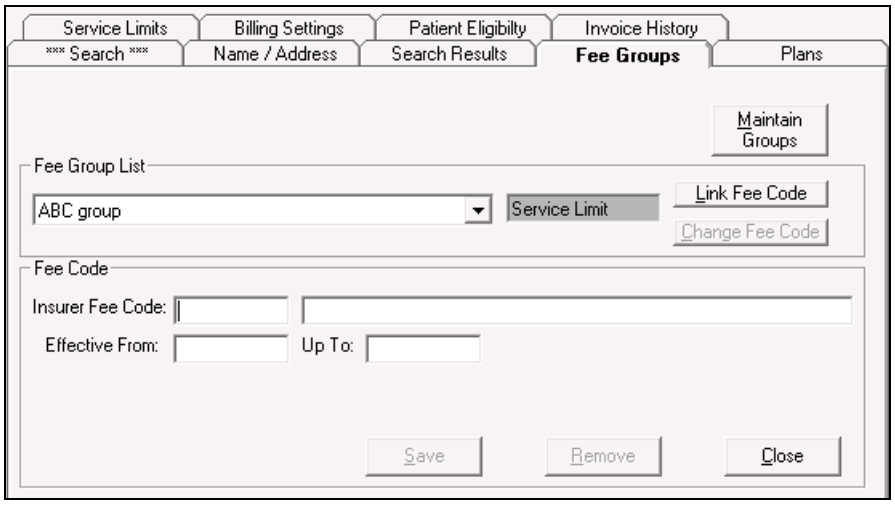
After you create a fee group, you can define what fees belong to that group by linking fees to the fee group.

Steps

1. In the Insurer Maintenance window, open the **Fee Groups** tab for the insurer you want to modify a fee group for. See Step 1 to Step 2 in "Adding and modifying fee groups" on page 196.
2. In the **Fee Group List** drop-down list, click the fee group you want to link the fee to. The EMR displays the fee group type to the right of the selected fee group.

Note: If the fee group you want is not in the list, create the fee group. See "Adding and modifying service fee codes" on page 177.

3. Click **Link Fee Code**. The EMR displays the **Fee Code** area.



4. Perform one of the following actions:
   - If the selected fee group is a Service Limit group, in the **Insurer Fee Code** field, enter the fee code, and then press **Enter**. In the **Effective From** and (optionally) **Up To** fields enter the start and end dates.
   - If the selected fee group is an Additional Charge group, in the **Insurer Fee Code** field, enter the fee code to the insurer, and then in the **Clinic Fee Code** field, enter the fee code to the patient.
   - If the selected fee group is a Reminder group, in the **Insurer Fee Code** field, enter the fee code that initiates the reminder, and then in the **Reminder Code** field, enter the fee code that billers are to be reminded to bill.
5. Click **Save**. The EMR displays a dialog box with the following message: "Insurer Fee Code Linked to Group".
6. Click **OK**, and then click **Close**.

Unlinking fee codes from fee groups

If you no longer want a fee code to be linked to a fee group, or if you linked a fee code to a fee group in error, you can unlink the code.

Steps

1. In the Insurer Maintenance window, open the **Fee Groups** tab for the insurer you want to modify a fee group for. See Step 1to Step 2in "Adding and modifying fee groups" on page 196.
2. In the **Fee Group List** drop-down list, click the fee group you want to unlink a fee code from. The EMR displays the Fee Group's linked fee codes in the **Fee Codes currently linked to above Fee Group** area.
3. In the list of linked fee codes, click the fee code you want to unlink.

4. Click **Change Fee Code**. The EMR displays the **Fee Code** area.
5. Perform one of the following actions:
   - If the associated fee group is a Service Limit fee group, click **Remove**.
   - If the associated fee group is an Additional Charge or Reminder fee group, click both fee code numbers (insurer fee and patient fee), and then click **Remove**.

   The EMR displays a dialog box with the following prompt: "Remove Fee Code from Fee Group?"
6. Click **Yes**. The EMR displays a dialog box with the following message: "Fee Code removed from Group".
7. Click **OK**, and then click **Close**.

Creating fee schedules (fee lists)

If your clinic is multi-disciplinary or offers several groups of services or products, you can create a fee schedule (fee list) for each group of services or products. When you create multiple fee schedules, you can:

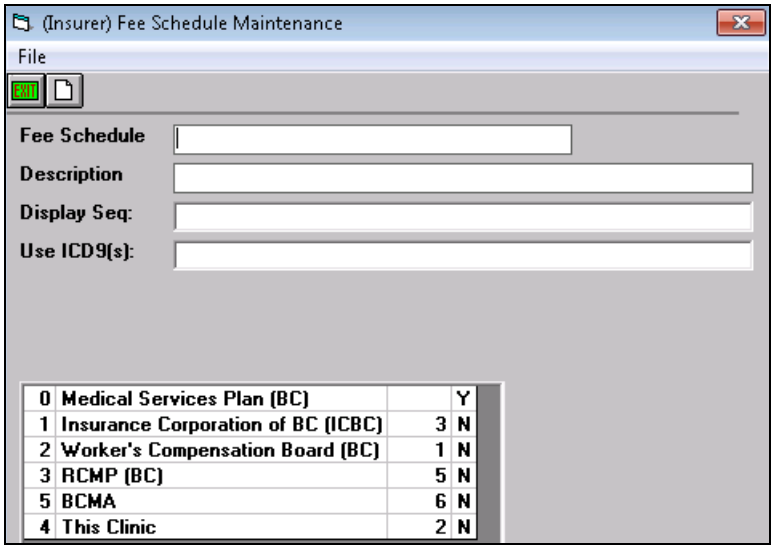
- Manage fee codes for each fee schedule individually.
- Print a unique list of fee codes for each fee schedule.

- Assign specific fee schedules to insurers or other third parties you bill to.

> **Note**: You can assign only one fee schedule to each insurer. If you create multiple fee schedules that can be charged to patients directly (for example, you have a fee schedule for physiotherapy services, and a fee schedule for chiropractic services), you must create multiple patient "insurers" (for example, "Physio patients" and "Chiro patients").
>
> For information on how to assign a fee schedule to an insurer, see "Adding and modifying third-parties (insurers) you bill to" on page 202.

Steps

1. On the Wolf EMR Launch page, click **Configuration** ( ). The Configuration window opens.
2. On the Configuration menu, click **View** > **Insurers, Payors (Gov't, Private) and Codes** > **Fee Schedules**. The EMR displays the (Insurer) Fee Schedule Maintenance window, with a list of your current fee schedules displayed on the lower half of the window.



3. Perform one of the following actions:
   - To add a fee schedule, click ( ).
   - To modify a fee schedule, in the list of Fee Schedules, click the fee schedule.
4. Enter or modify information for the fee schedule using the following table as a reference.

Field	Description
Fee Schedule	Enter a unique number for the fee schedule.
Description	Enter a title or description for the fee schedule.
Display Seq	Enter a number representing the place in the fee schedule list (in the Fee Code Maintenance window) the fee schedule is to be located. **Tip**: The lower the number, the higher the fee schedule displays in the fee schedule list.
Use ICD9(s)	■ To hide the ICD9 diagnosis code area when you bill fee codes from this fee schedule, enter **N**. ■ To display the ICD9 diagnosis code area when you bill fee codes from this fee schedule, enter **Y**.

5. Click **Save** ().
6. Add fee codes to the fee schedule as needed. See "Adding and modifying service fee codes" on page 177.
7. Assign the fee schedule to the appropriate insurers. See "Adding and modifying third-parties (insurers) you bill to" on page 202.

Managing third-party and patient billing

As a user with administrative authority in Wolf EMR, you can customize and manage several features around third-party and patient billing, including:

- Third-parties (insurers) your clinic bills to (see "Adding and modifying third-parties (insurers) you bill to" on page 202)
- Invoice format and preferences (see "Setting invoice preferences" on page 207)

Adding and modifying third-parties (insurers) you bill to

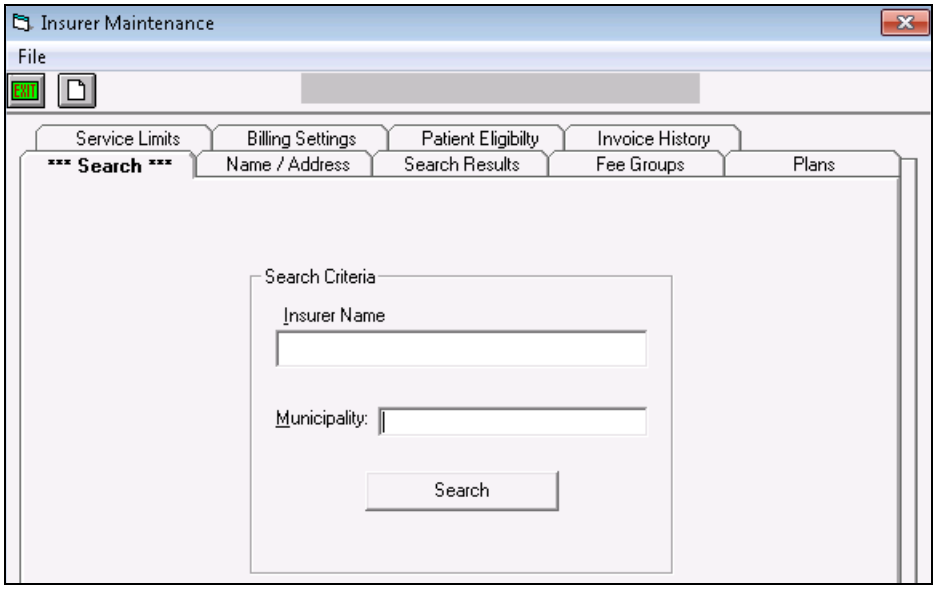
Before you bill a third-party for a service, you can enter the third-party into Wolf EMR as an insurer. If you don't add a third-party as an insurer, you will have to enter the third-party's contact information when you create a bill for the third-party. Also, when you add an insurer you can specify:

- Whether the insurer's invoices are to be sent via fax or mail
- Whether ICD9 diagnostic codes can be included on bills for the insurer
- Notes on how to invoice the insurer

- How many days following a service the insurer can still be billed
- What fee schedule is to be used for the insurer
- What department or individual to address invoices to

Steps

1. On the Wolf EMR Launch page, click **Configuration** ( ). The Configuration window opens.
2. On the Configuration menu, click **View** > **Insurers, Payors (Gov't, Private) and Codes** > **Insurers, Payors**. The Insurer Maintenance window opens, with the **Search** tab selected.

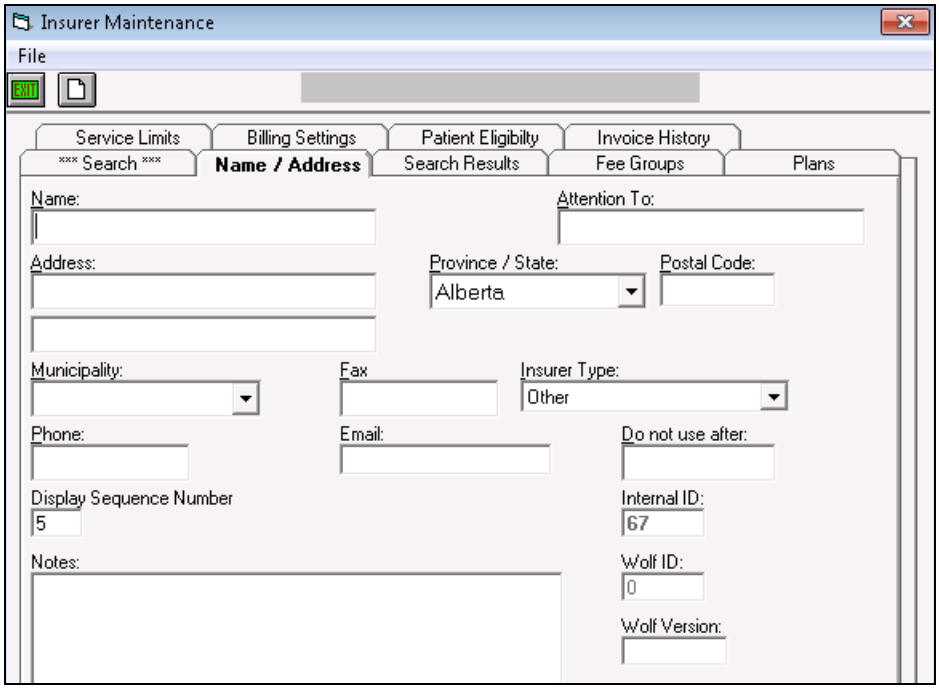


3. Perform one of the following actions:
   - To add an insurer, click ( ).
   - To modify an insurer, search for an select the insurer:
     a) In the **Insurer Name** field, enter all or part of the insurer's name.
     b) In the **Municipality** field, enter the insurer's municipality.

> **Note**: To view a complete list of all insurers you bill to, leave the **Insurer Name** and **Municipality** fields blank.

     c) Click **Search**. The EMR displays a list of matching insurers.
     d) In the list of insurers, click the insurer.

The EMR displays the insurer **Name / Address** tab.



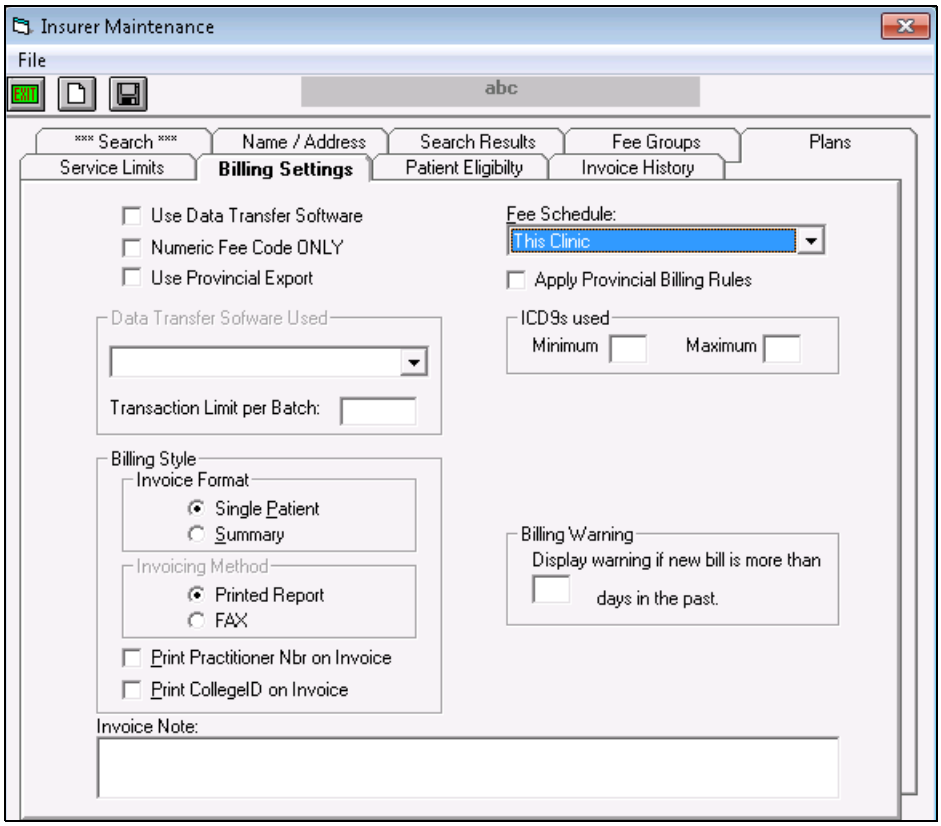
4. In the **Name / Address** tab, enter or modify the insurer's information using the following table as a reference.

Note: You can ignore fields that are not described in the following table.

Field	Description
Name	Enter the name of the insurer. For example "ABC Law practice" or "ABC Insurance".
Attention To	Enter the name of a contact person or department for invoices to be addressed to. **Note:** The **Attention To** name displays on invoices.
Address	Enter the insurer's address. **Note:** The insurer's address displays on labels and invoices.
Province / State	Enter the insurer's province or state. **Note:** The insurer's province or state displays on labels and invoices.

Field	Description
Postal Code	Enter the insurer's postal code. **Note:** The insurers postal code displays on labels and invoices.
Municipality	Enter the insurer's city. **Note:** The Insurer's city displays on labels and invoices.
Fax	Enter the insurer's fax number. **Note:** If you fax invoices to this insurer, the fax number entered here is used by default.
Insurer Type	In the drop-down list, select one of the following options: ■ **Patient**: If bills are to be charged to the patient. ■ **Other**: If bills are to be charged to a third party. **Note:** The **Patient** option is typically used for only the generic **Patient** insurer. However, if you want patient bills to be grouped in your system based on services provided, you can create multiple patient insurers. For example, if you are a multi-disciplinary clinic, you can create a "Physiotherapy patient" insurer and a "Chiropractic patients" insurer. **Note:** Your selection determines invoice format and fields displayed when billing.
Phone	Enter the insurer's phone number (for your reference).
Email	Enter the insurer's email address (for your reference).
Display Sequence Number	Enter a number to specify how high on the **Insurer** list in the Billing window the insurer should display. (The **Display Sequence Number** determines sort order) **Note:** The lower the number, the higher on the list the insurer displays.
Notes	Enter any notes regarding the insurer. For example, "Call for approval before sending invoice".

5. Click **Save** ().
6. Click the **Billing Settings** tab, and then enter billing details for the insurer using the following table as a reference.



Note: You can ignore fields that are not described in the following table.

Field	Description
Billing Style **Invoicing Method**	Select if bills are to be printed/mailed, or faxed ■ **Printed Report**: An individual Invoice is printed for each bill. ■ **Fax**: An invoice is faxed to the fax number entered in the **Name/Address** tab. **Note:** If there is no fax number entered in the **Name/Address** tab for the insurer, **Fax** is not available as an option.
Print Practitioner Nbr on Invoice	Select this check box to display the practitioner's Prac ID on invoices created for the insurer.

Field	Description
Fee Schedule	In the drop-down list, select the fee schedule containing the fee codes you bill to the insurer. **Note:** The most common selection is **This Clinic**. **Note:** You can create a unique Fee Schedule (list of fees) for an insurer. See "Creating fee schedules (fee lists)" on page 200.
ICD9s used	Enter the **Minimum** and **Maximum** number of ICD9 diagnostic codes you can add to bills for this insurer. For example, if you want to be able to enter up to three diagnostic codes on a bill, but not be required to enter a diagnostic code, enter **0** in the **Minimum** field, and then enter **3** in the **Maximum** field. **Note:** The largest number of diagnosis codes you can enable is 3. **Note:** This area is available only if, in the **Fee Schedule** drop-down list, you select a fee schedule that has ICD9 diagnostic codes enabled.
Billing Warning	Enter the number of days past the service date before you receive a warning from the EMR when you bill the insurer. If you create a bill to the insurer for a service provided more than the entered number of days in the past, a warning is generated before the bill is saved. For example, if the insurer requires that clinics add a note to a bill if the service date is 90 days or older, you would enter **90** in the **Bill Warning** area. If the service date is 90 days or older, billers receive the warning to add a note to the bill.
Invoice Note	Enter any notes or instructions on how to invoice the insurer. This information is for your reference only.

7. At the top of the window, click **Save** ().

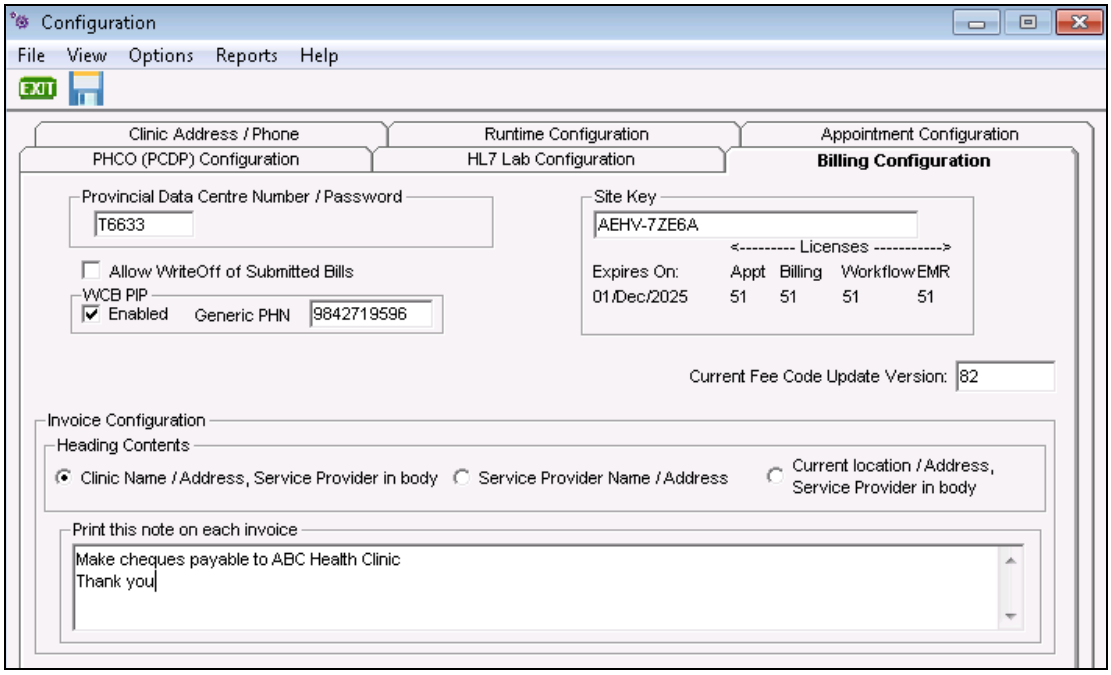
Setting invoice preferences

For your clinic's printed invoices, you can choose:

- What information displays on invoice letterheads.
- Messages or notes that display on the bottom of invoices.

Steps

1. On the Wolf EMR Launch page, click **Configuration** ( ). The Configuration window opens.
2. Click the **Billing Configuration** tab.



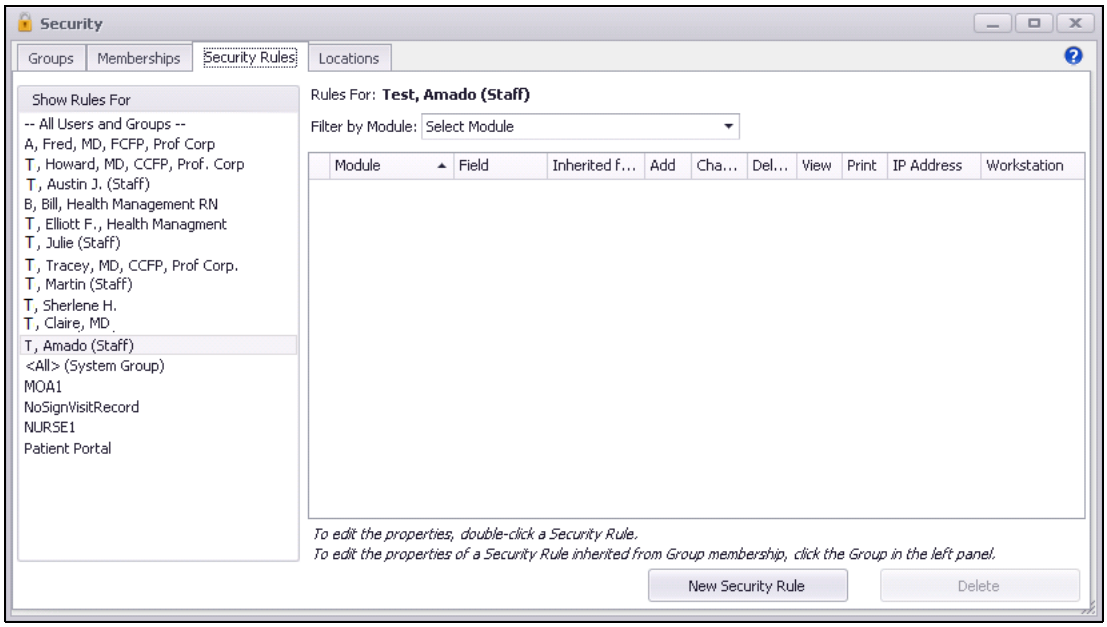
3. To modify the contents on your invoice header, in the **Invoice Configuration** area, in the **Heading Contents** area, select one of the following options:
   - **Clinic Name / Address, Service Provider in Body**: Invoice headers include the clinic name, clinic address and the practitioner's name.
   - **Service Provider Name / Address**: Invoices include only the practitioner's name and clinic address.
   - **Current location / Address, Service Provider in body**: Select this option if your clinic has multiple clinic locations. Invoices include the location's clinic address, location name, and practitioner name.
4. To add a message to the bottom of your invoices, in the **Print this note on each invoice** field, enter the message.
5. Click **Save** ( ).

Setting security around billing

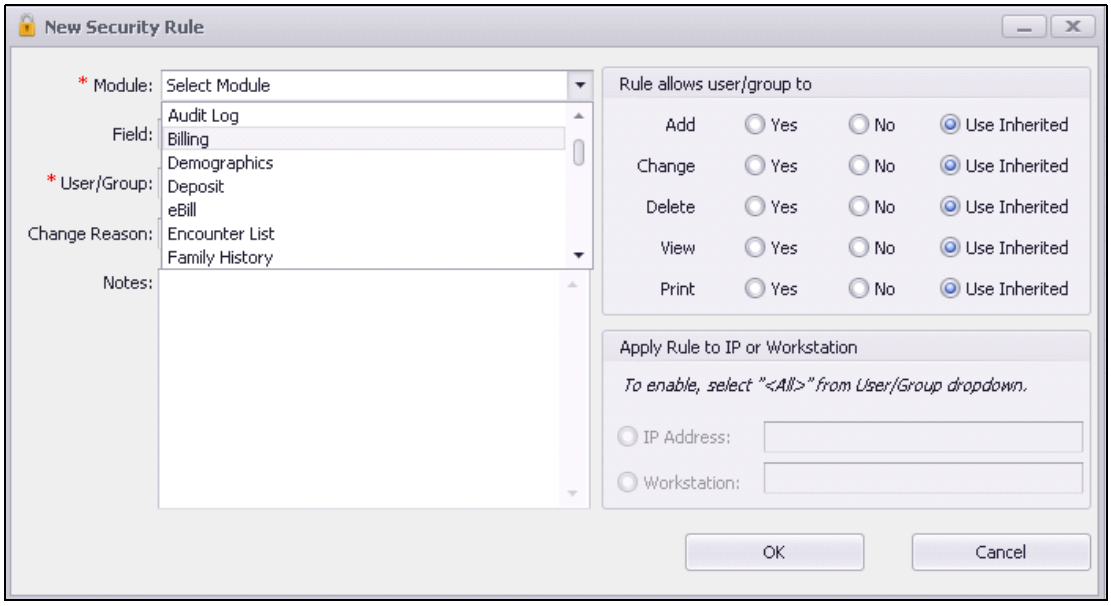
If you want to prevent certain users from accessing the **Billing**, **eBill**, and/or **Deposit** applications of Wolf EMR, you can restrict access to these applications using Security Rules.

Steps

1. On the Wolf EMR Launch page, click **Configuration** ( ). The Configuration window opens.
2. On the Configuration menu, click **View** > **Security** > **Security Rules**. The EMR displays the Security window with the **Security Rules** tab displayed.



3. In the **Show Rules For** area, click the user or group you want to restrict access to.
4. Click **New Security Rule**.
5. On the New Security Rule window, in the **Module** drop-down list, click one of the following options:
   - **Billing**
   - **Deposit**
   - **eBill**



6. In the **Change Reason** drop-down list, select **Other** and then, in the **Notes** field, enter your reason for creating the Security Rule.
7. In the **Rule allows user/group to area**, select one of the following options for Add, Change, Delete, View, and Print:
   - **Yes**: To enable the user or group to perform this action.
   - **No**: To restrict the user or group from performing this action.
   - **Use Inherited**: To use inherited permissions based on the user's role or group.
8. To set security around another billing module, repeat Step 5to Step 7.
9. When you finish, click **OK**. The EMR displays the security rule in the **Security Rules** tab, in the **Rules For <user or group name>** area.

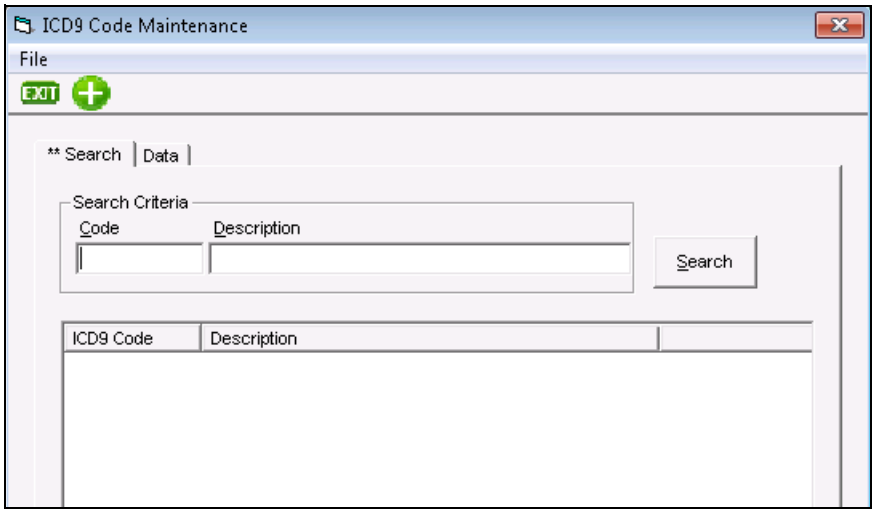
Managing ICD9 diagnostic codes

Your Wolf EMR comes with a complete set of ICD9 diagnostic codes to use in bills; however, you can add, modify, or delete ICD9 codes if necessary.

The most common modifications made to ICD9 codes are to their description. Customizing descriptions can make ICD9 codes easier to find.

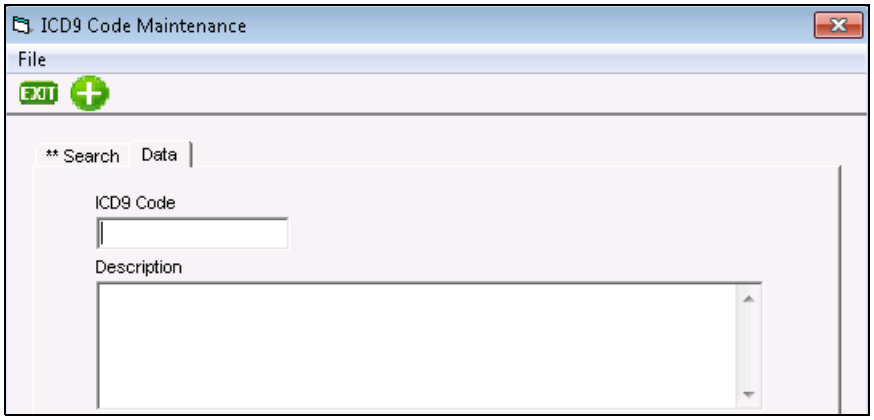
Steps

1. On the Wolf EMR Launch page, click **Configuration** ( ). The Configuration window opens.
2. On the Configuration menu, click **View** > **Insurers, Payors (Gov't, Private) and Codes** > **ICD9 Codes**. The EMR displays the ICD9 Code Maintenance window.



3. Perform one of the following actions:
   - If you are modifying or deleting an ICD9 code, search for and select the code:
     a) In the **Code** field, enter all or part of the ICD9 code.
     b) If you do not know the code, in the **Description** field, enter a description for the ICD9 Code.
     c) Click **Search**. The EMR displays a list of matching ICD9 codes.
   - If you are adding a new ICD9 code, click .

   The EMR displays the **Data** tab.



4. In the **ICD9 Code** field, enter or modify the ICD9 code.
5. If you want to delete the ICD9 code, in the menu, click **File** > **Delete**.
6. In the **Description** field, enter or modify the name or description for the ICD9 code.

> **Tip**: If different staff members tend to use different search terms to find this ICD9 code, enter as many search term variations as you can fit in the **Description** field.

7. Click **Save** ( ).

Questions?

WolfEMR.Support@telus.com

1-866-879-9653 (Option 1)

Wolf EMR Community Portal at
https://telushealthcommunity.force.com/wolfcommunity

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