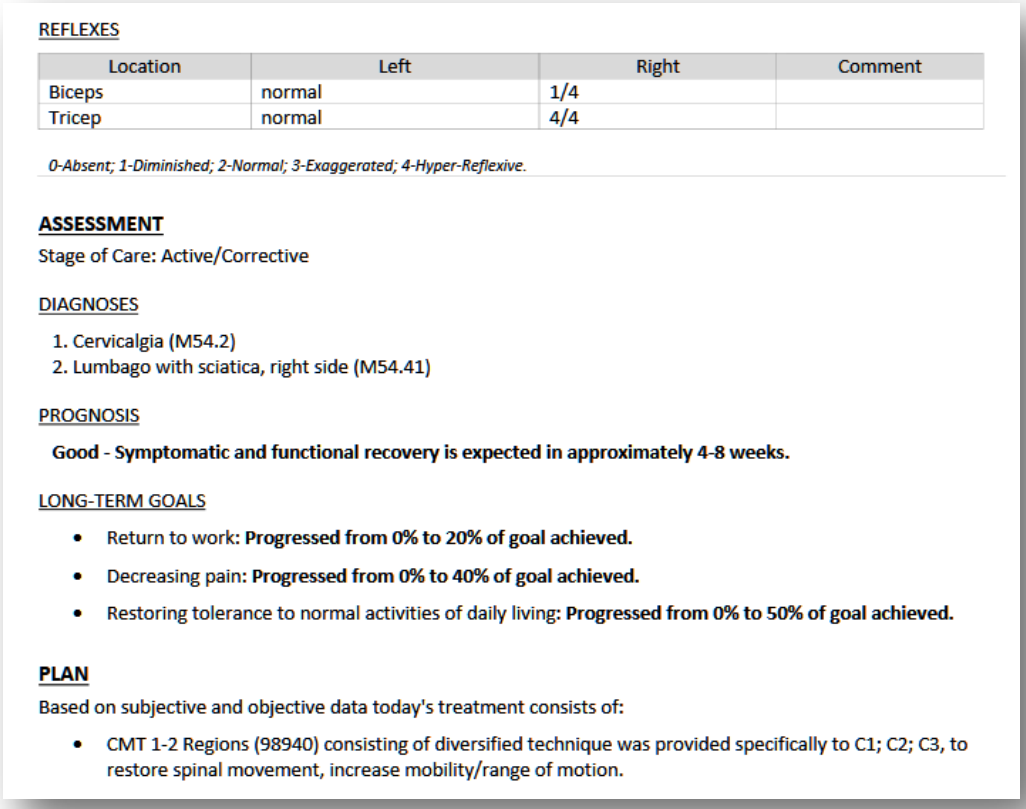
See What's New from PayDC!

Here's what's in this release (November 13, 2018)

This release introduces a lot of changes to the way the SOAP Notes are presented.

Updated Formatting for SOAP Note Narratives

In order to make the SOAP Note Narratives more readable, we have completely overhauled their formatting. They include consistent styles, bullet points, and tables. They also follow a more stream-lined approach that says more by using less extraneous text:



REFLEXES

Location	Left	Right	Comment
Biceps	normal	1/4	
Tricep	normal	4/4	

0-Absent; 1-Diminished; 2-Normal; 3-Exaggerated; 4-Hyper-Reflexive.

ASSESSMENT

Stage of Care: Active/Corrective

DIAGNOSES

1. Cervicalgia (M54.2)
2. Lumbago with sciatica, right side (M54.41)

PROGNOSIS

Good - Symptomatic and functional recovery is expected in approximately 4-8 weeks.

LONG-TERM GOALS

- Return to work: **Progressed from 0% to 20% of goal achieved.**
- Decreasing pain: **Progressed from 0% to 40% of goal achieved.**
- Restoring tolerance to normal activities of daily living: **Progressed from 0% to 50% of goal achieved.**

PLAN

Based on subjective and objective data today's treatment consists of:

- CMT 1-2 Regions (98940) consisting of diversified technique was provided specifically to C1; C2; C3, to restore spinal movement, increase mobility/range of motion.

Archiving Signed Notes

Starting with this release, providers will have the convenience of viewing signed SOAP Notes directly in the application and seeing them exactly as they were signed (i.e. as a Narrative). They will not need to first launch MS Word or hunt around the SOAP Note UI screen.

Note: Any SOAP Note signed prior to this release will be archived using the older formatting. SOAP Notes signed after this release will be archived using the most recent formatting available.

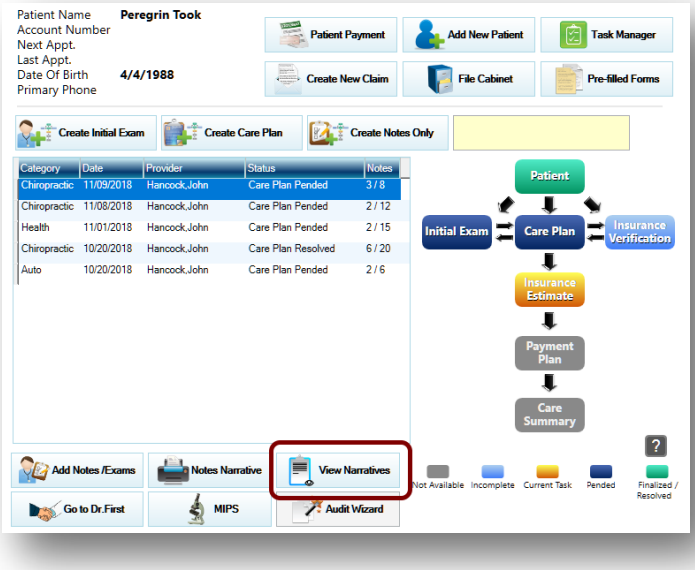
SOAP Note Document Viewer

With this release the SOAP Note Narratives can be viewed in a Document Viewer without needing to first launch MS Word.

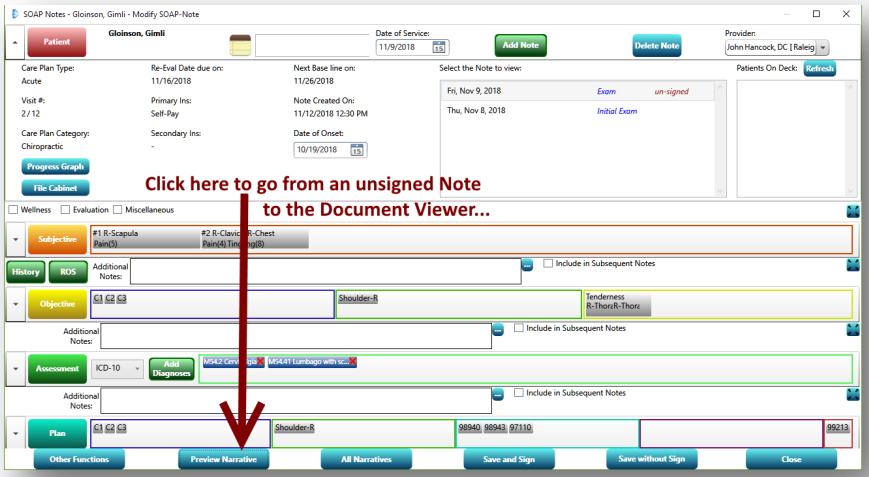
Accessing the SOAP Note Document Viewer

There are three primary ways you can access this viewer:

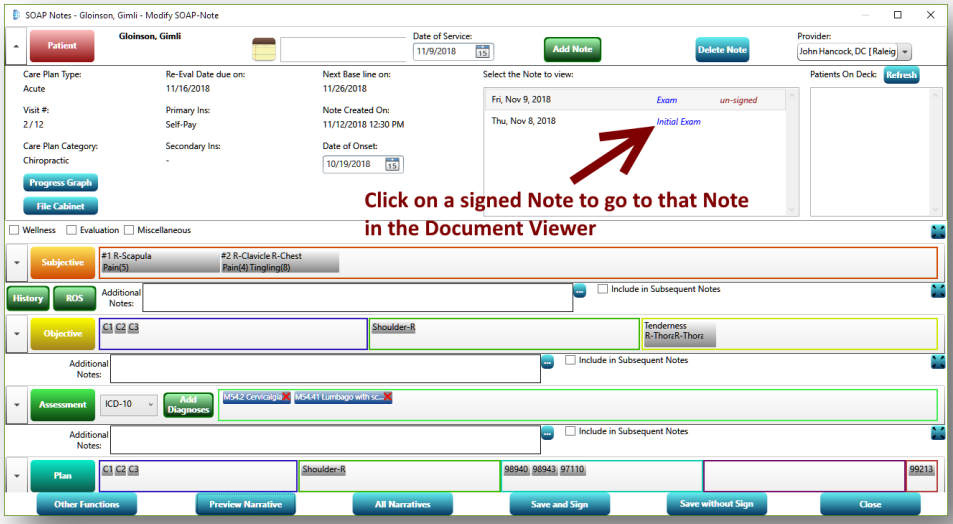
1. When in the Patient Dashboard, click on the new "View Narratives" button:



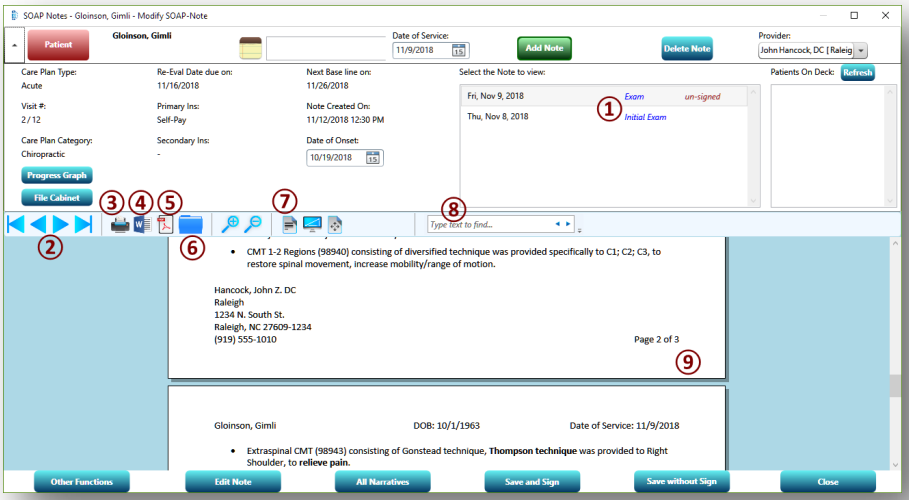
2. When editing an unsigned SOAP Note, click on the "Preview Narrative" button to automatically save all changes and go to the Document Viewer with the narrative of the unsigned SOAP Note in view:



3. When editing an unsigned SOAP Note, click on a signed Note in the Note list window to automatically save all changes and go to the Document Viewer with the narrative of the clicked signed Note in view:

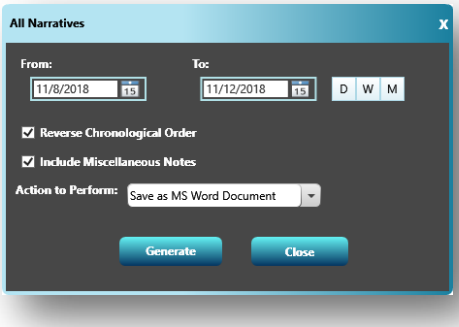


Main Features of the Document Viewer



The Document Viewer includes some of the following features:

1. **Notes List:** Navigate between Notes by clicking on different dates of service.
2. **Navigation buttons:** Navigate from Note to Note, using the following buttons:
   - First Note: Go to the Note with the oldest date of Service
   - Previous Note: Go to the Note with the next older DOS
   - Next Note: Go to the Note with the next more recent DOS
   - Last Note: Go to the Note with the newest date of Service
3. **Print Current Note:** This opens the standard Print dialog and allows you to print directly to your printer the current Note narrative.
4. **Save as a MS Word document:** This will save the current Note to your system's hard drive in the directory "Documents > PayDC Narratives" as a MS Word file (.docx). After being saved, the file will automatically open.
5. **Save as a PDF file:** This will save the current Note to your system's hard drive in the directory "Documents > PayDC Narratives" as an Adobe PDF file. After being saved, the file will automatically open.
6. **Manage All Notes:** This will open the "All Narratives" dialog:



Select a date range using the From: and To: or today ("D"), the past week ("W"),

the past month (“M”).

By default, Notes are presented in Reverse Chronological Order which places the most recent Note first in the document. To have the Notes presented with the oldest first, deselect that option.

Note that you can choose to either send the narratives directly to your printer or save it as a single document in MS Word (.docx) or PDF format.

7. **View buttons:** Use these buttons to:
   - Zoom In
   - Zoom Out
   - Reset the view to Layout width (default)
   - Fit the view to the width of your monitor
   - Fit to the maximum number of pages

8. **Find one or more terms within the current Note.** Type the text you want to search by then hit Enter. Keep hitting enter to step through subsequents instances of the text within the Note.

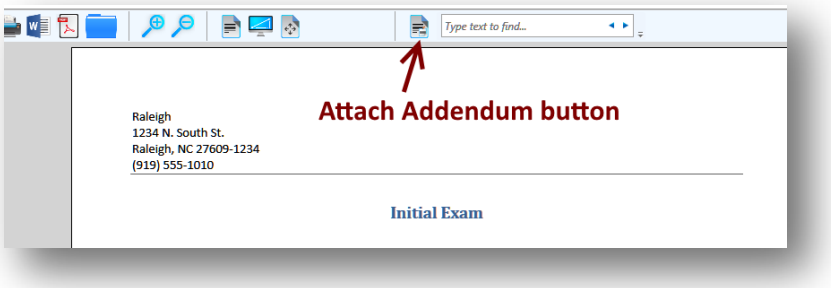
9. Note that the viewer displays one instance of a SOAP Note (i.e. a single encounter) at a time, but can be multiple pages long.

Miscellaneous Notes and Attaching Addenda to Signed Notes

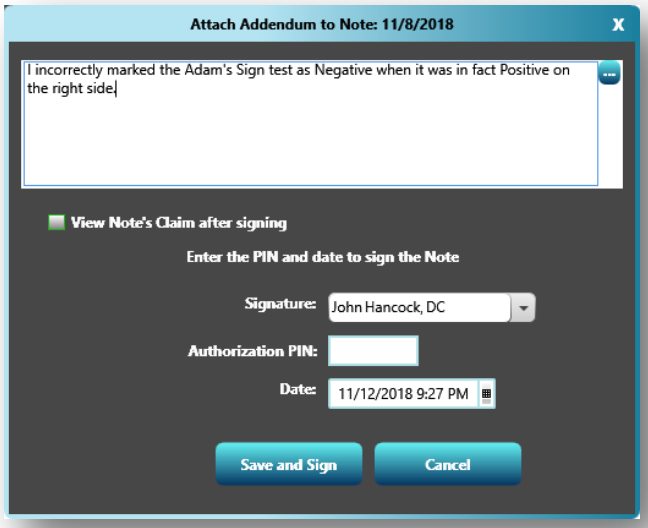
There are times when you as a Provider want to make a change to a signed Note. Prior to this release you could create an Addendum Note, but it was treat like any other independent Note. With this latest release, providers can add addendum text to a previously signed Note.

To add an addendum to a signed SOAP Note:

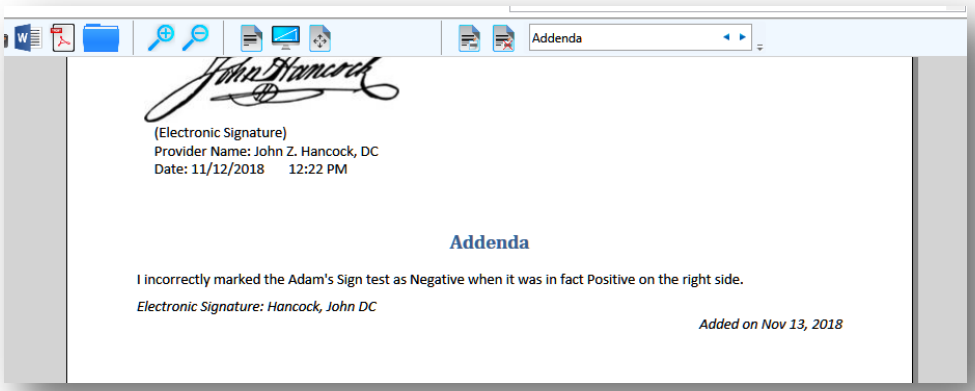
1. In the Document Viewer, note that when a signed Note is in view, there will be in the toolbar a button called “Attach Addendum”:



2. Clicking that button will open the Attach Addendum dialog



3. Add whatever text you need to. Note that macros are enabled for this text box.
4. Sign the addendum just like you would any other SOAP Note. This means that if you normally use a PIN, you will need to include your PIN.
5. Click Save and Sign.
6. That signed Note's Narrative will now have a section after the original signature entitled "Addenda" which will include any addenda added to that Note:



There are some important things to note about Addenda:

- You may add more than one addenda to the same SOAP Note by following the same procedure.

- As a convenience the "Attach Addendum" dialog includes an option labeled "View Note's Claim after signing". If this option is checked, when you Save and Sign the Addendum, the SOAP Note will close and you will be taken automatically to the Claim generated from the original SOAP Note. This may be

useful if the addendum you are adding to the original Note would impact the original claim in some way (i.e. adding/removing a line item).

Note that attaching an addendum does **not** alter the originally generated claim in any way. It is the responsibility of the provider and/or the provider's billing staff to edit the claim to be consistent with the Note.

- Once one or more addenda have been added to a signed Note, a "Remove Addenda" button appears next to the "Attach Addendum" button. To remove an addendum, click the button and follow the prompts.

- Deleting a signed Note will automatically delete any addenda attached to that signed Note.

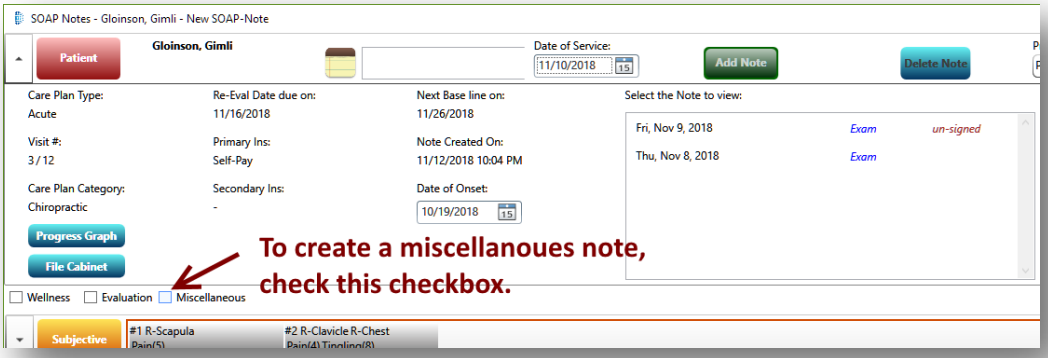
- Information contained in an addendum will not be included in any subsequent Notes nor will it affect any information that might be carried forward from a previous note.

There may be other times in which the provider wants to have a record of some kind of interaction with the patient that doesn't warrant a complete "SOAP"-style Note. For example, the provider may have had a phone conversation with the patient. Or there was an internal staff discussion around a particular course of treatment for a patient. With this release, providers will be able to create a generic "Miscellaneous Note" that is not tied to any particular visit.

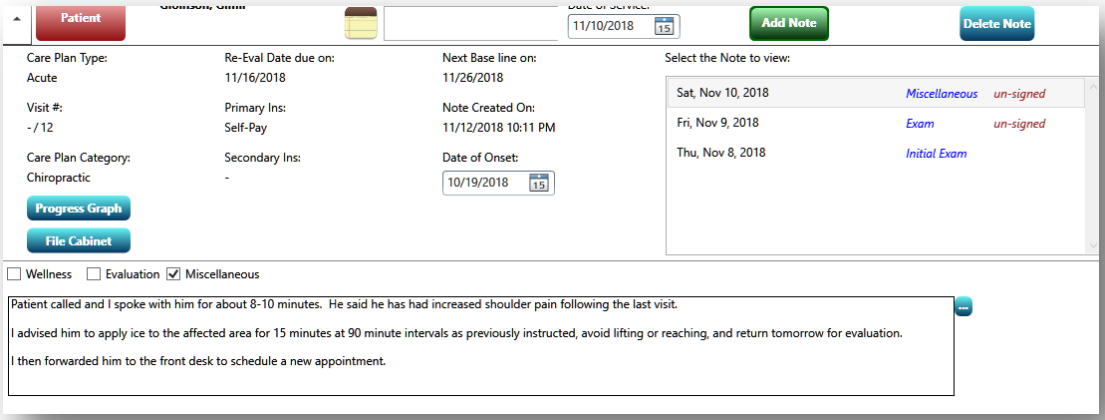
To add a Miscellaneous Note:

1. Add a new Note in the same way you would add a standard SOAP Note. For example, while viewing a note, click the button "Add Note".

2. When the new Note is created, select the checkbox labeled "Miscellaneous"

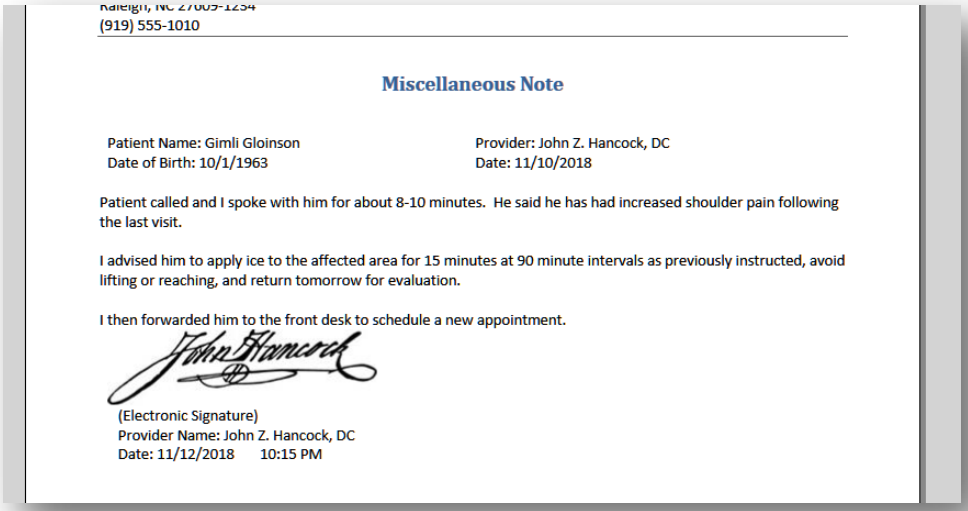


3. Notice that the interface for creating a Miscellaneous Note is much simpler. It only has a single macro-enabled text-box:



4. After filling in the necessary information, click “Save & Sign” and go through the same steps you normally would to sign a Note.

5. Note that a Miscellaneous Note has its own simplified Narrative:


Raleigh, NC 27609-1234
(919) 555-1010

Miscellaneous Note

Patient Name: Gimli Gloinson
Date of Birth: 10/1/1963

Provider: John Z. Hancock, DC
Date: 11/10/2018

Patient called and I spoke with him for about 8-10 minutes. He said he has had increased shoulder pain following the last visit.

I advised him to apply ice to the affected area for 15 minutes at 90 minute intervals as previously instructed, avoid lifting or reaching, and return tomorrow for evaluation.

I then forwarded him to the front desk to schedule a new appointment.

(Electronic Signature)
Provider Name: John Z. Hancock, DC
Date: 11/12/2018 10:15 PM

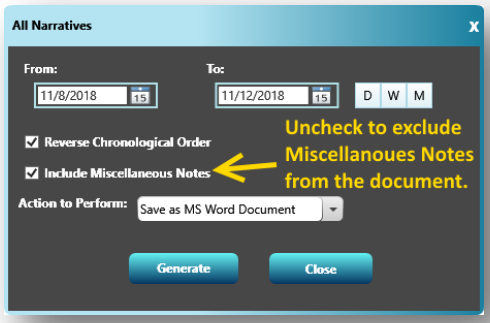
There are some important things to note about Miscellaneous Notes:

- Creating a Miscellaneous Note does **not** generate a claim.
- A Miscellaneous Note will **not** affect the visit count in any way.
- Miscellaneous Notes can be deleted like any other Note.

- A Miscellaneous Note will not affect the flow of information from one Exam/Daily Note to the next. For example, complaints, exam results, goal, etc. will all still be carried forward to the next Note, regardless of how many Miscellaneous Notes appear in between.

- It is possible to add one or more Addenda to a Miscellaneous Note, should the need arise.

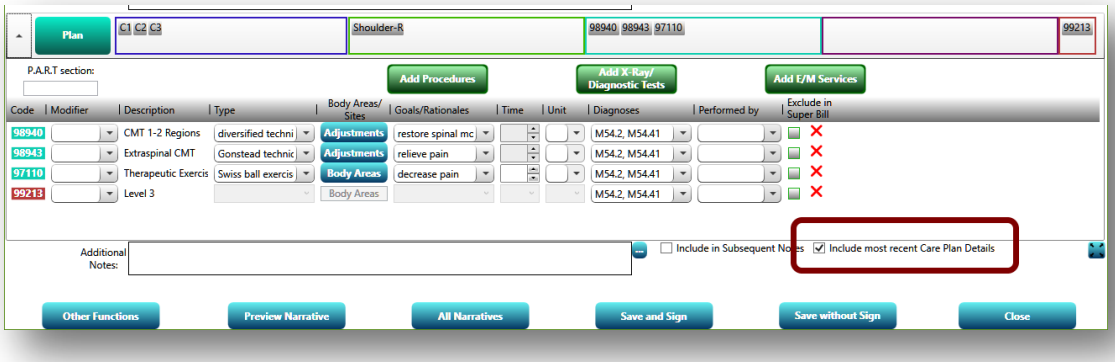
- When printing or creating a Word/PDF document of one or more narratives, you have the option to include or exclude any Miscellaneous Notes:



- Any Notes that were created prior to this release and had selected the "Addendum" checkbox will be automatically treated as a Miscellaneous Note.

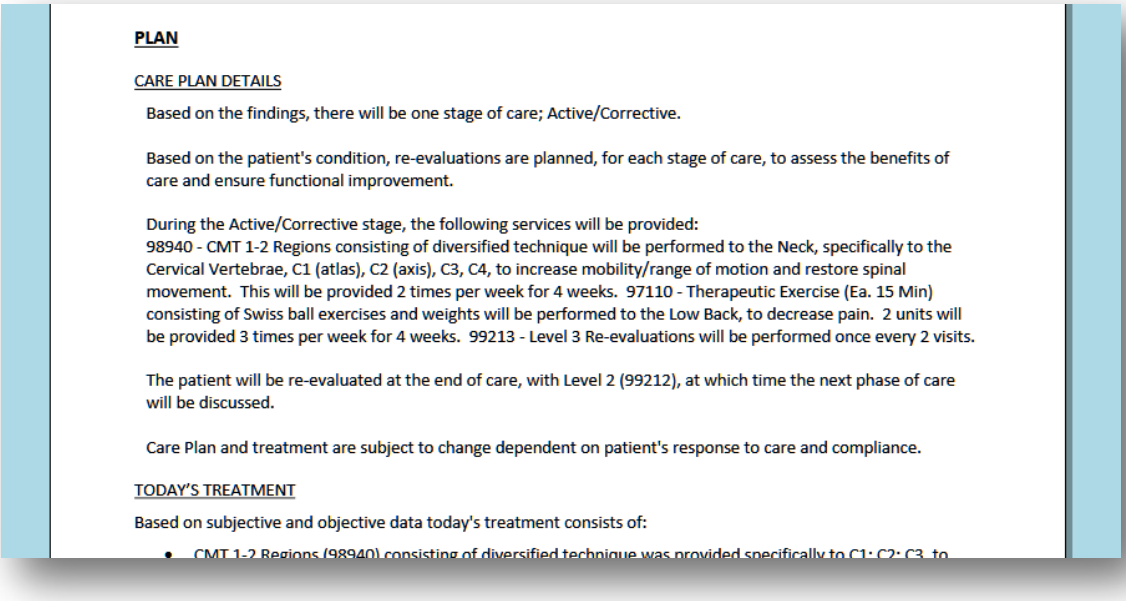
Including Care Plan Details in the SOAP Note Narrative

As of this release, providers will have an option to include in any patient's SOAP Note the details from that patient's most recent Care Plan:



When this option is selected then the Care Plan Details are included in the Plan section

of the SOAP Note:



PLAN

CARE PLAN DETAILS

Based on the findings, there will be one stage of care; Active/Corrective.

Based on the patient's condition, re-evaluations are planned, for each stage of care, to assess the benefits of care and ensure functional improvement.

During the Active/Corrective stage, the following services will be provided:
98940 - CMT 1-2 Regions consisting of diversified technique will be performed to the Neck, specifically to the Cervical Vertebrae, C1 (atlas), C2 (axis), C3, C4, to increase mobility/range of motion and restore spinal movement. This will be provided 2 times per week for 4 weeks. 97110 - Therapeutic Exercise (Ea. 15 Min) consisting of Swiss ball exercises and weights will be performed to the Low Back, to decrease pain. 2 units will be provided 3 times per week for 4 weeks. 99213 - Level 3 Re-evaluations will be performed once every 2 visits.

The patient will be re-evaluated at the end of care, with Level 2 (99212), at which time the next phase of care will be discussed.

Care Plan and treatment are subject to change dependent on patient's response to care and compliance.

TODAY'S TREATMENT

Based on subjective and objective data today's treatment consists of:

- CMT 1-2 Regions (98940) consisting of diversified technique was provided specifically to C1; C2; C3, to

One important point to note about this change. HPI and Examination Findings are no longer going to be available in the Care Plan Wizard or in the Care Plan Narrative. Legacy Care Plans will continue to include that information if it was added to the Care Plan before this release. However, if someone were to edit a legacy Care Plan by running the Care Plan wizard again for that Care Plan, then any HPI or Examination Findings information will be removed from the Care Plan.

Other general enhancements

In addition to all of these changes, there have been many other minor improvements here and there, including:

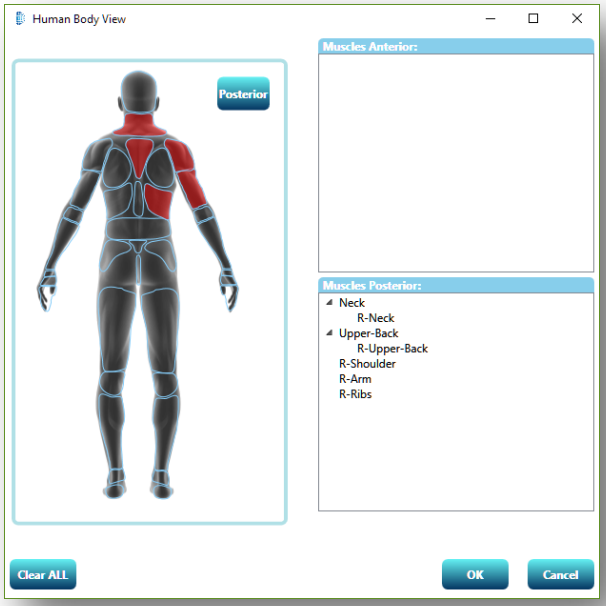
- We removed from the "Save and Sign" dialog the checkbox labeled "Injection Site prepped with Chlorhexidine, Needle removed and tip intact".

- We added a user-level setting for disabling the "untimely Date of Service" warning. By default it is configured for all users to continue to get this warning if they attempt to edit or save a Note that is dated too far in the past.

  To remove this warning, go to the user profile in Advanced Settings > Subscriber Profile > Users. At the very bottom is a section called "SOAP Note" which now has a checkbox called "Warn of Untimely Entries"

- SOAP Notes > Subjective > Complaint > Pain > Radiating: A recent change made it difficult to "deselect" one or more body areas for radiating pain in a subsequent Note. The interaction with this control has been improved. To deselect or select different body areas, click on "Radiating" and click the body areas to get the appropriate items. To "deselect" Radiating as an option for that

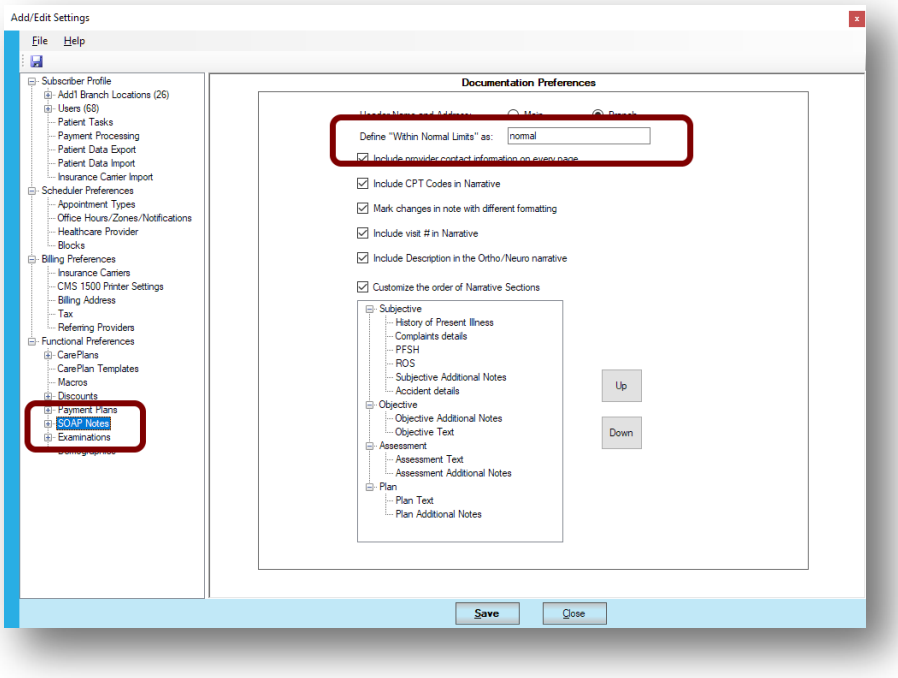
patient, either manually “deselect” each highlighted body area or click the new “Clear ALL” button:



- Billing > Claims > Print Paper Claims: When printing out the SOAP Notes related to a paper claim, the Narrative(s) will go directly to the printer and will be in the styles available when the Note was signed.

- To keep current, we renamed a Patient Dashboard button from “Meaningful Use” to “MIPS”. The content is still the same for this calendar year.

- Advanced Settings > Functional Preferences > SOAP Notes now has a new setting called “Define ‘Within Normal Limits’ as:”



The text entered in this textbox will be used throughout the SOAP Note Narrative whenever a finding is “within normal limits”. As this is a subscription-level setting we recommend coordinating among your providers to determine the best term for your practice (Normal, WNL, Within Normal Limits, etc.) Please note that whatever capitalization is specified will appear in the narrative as entered.

Thank you!

PayDC/APS Development Team

Questions? You can always contact the Service Desk.

- If you are a PayDC customer, the phone number is (888) 306-1257; please choose option 4 for Service Desk.
- If you are an Advanced Provider Solutions customer, the phone number is (855) 283-4940; please choose option 4 for Service Desk.
- If you would like to contact the Service Desk via e-mail, please use the Contact Us form on our website. Please note: the Contact Us form is now secure, so you can include PHI in your description.