PATIENT MANAGEMENT USER GUIDE
# OPIE Patient Management

## Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPIE Patient Management</td>
<td>7</td>
</tr>
<tr>
<td>Tasks Tab</td>
<td>7</td>
</tr>
<tr>
<td>Open a Patient File</td>
<td>7</td>
</tr>
<tr>
<td>Pt Info Tab</td>
<td>8</td>
</tr>
<tr>
<td>Branch Quick Switch Button</td>
<td>8</td>
</tr>
<tr>
<td>Order Parts Online</td>
<td>8</td>
</tr>
<tr>
<td>Authentication Failed message trying to Order Parts Online</td>
<td>8</td>
</tr>
<tr>
<td>Files Tab</td>
<td>10</td>
</tr>
<tr>
<td>Financial Tab</td>
<td>11</td>
</tr>
<tr>
<td>Create a New Patient</td>
<td>12</td>
</tr>
<tr>
<td>General Info</td>
<td>12</td>
</tr>
<tr>
<td>Patient Contacts</td>
<td>14</td>
</tr>
<tr>
<td>Insurance Info</td>
<td>14</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>16</td>
</tr>
<tr>
<td>Schedule an appointment directly from Graphic Scheduler</td>
<td>17</td>
</tr>
<tr>
<td>New Patient walk-in or phone call</td>
<td>17</td>
</tr>
<tr>
<td>Existing patient</td>
<td>18</td>
</tr>
<tr>
<td>Schedule an appointment from the List Schedule</td>
<td>18</td>
</tr>
<tr>
<td>Schedule an appointment from the prescription</td>
<td>18</td>
</tr>
<tr>
<td>Appointment Status</td>
<td>18</td>
</tr>
<tr>
<td>Change the appointment status in the List Schedule</td>
<td>19</td>
</tr>
<tr>
<td>Authorization Required Prior to Patient Visit</td>
<td>19</td>
</tr>
<tr>
<td>How to correct if Cancel or reschedule appointment is selected by accident</td>
<td>19</td>
</tr>
<tr>
<td>Cancelled appointment still shows in Compliance Tab</td>
<td>20</td>
</tr>
<tr>
<td>Report a Problem</td>
<td>21</td>
</tr>
<tr>
<td>Workflow</td>
<td>21</td>
</tr>
<tr>
<td>Utilizing the WIP (work in progress)</td>
<td>21</td>
</tr>
<tr>
<td>Administrative Documents</td>
<td>22</td>
</tr>
<tr>
<td>OPIE List of Forms</td>
<td>22</td>
</tr>
<tr>
<td>Clinical Visit folder in OPIE</td>
<td>24</td>
</tr>
</tbody>
</table>

www.opiehelp.com -2- Support: (800) 876-7740, option 3, 3
OPIE Patient Management

- Patient Intake Responsibilities ................................................................. 25
- Rx Summary Screen ..................................................................................... 25
- Practitioner – Patient in Room Process ......................................................... 32
- Patient Checkout Responsibilities ................................................................. 47
- Patient Financial Counseling ......................................................................... 48
- ABN v3.0 (Medicare 2012) ............................................................................ 53
- Insurance Authorization ................................................................................ 54
- Detailed Prescription/Detailed Written Order ................................................ 57
- Diabetic Verification ...................................................................................... 59
- Letter of Medical Necessity (LMN) ............................................................... 61
- Physician Notes ............................................................................................ 62
- Practitioner Delivery Process ........................................................................ 62
- Patient Education .......................................................................................... 64
- Schedule Follow-up Appointment .................................................................. 66
- Patient Complaint Log ................................................................................... 66
- Patient Satisfaction Surveys .......................................................................... 67
- Upgraded Quality Outcomes Accounts ........................................................ 74
- Home Screen .................................................................................................. 75
- Messages ......................................................................................................... 75
- Send a Reminder ............................................................................................ 77
- Patient Schedule/My Patient Schedule .......................................................... 78
- View all appointments for a patient ............................................................... 78
- Note Dictations ............................................................................................... 79
- Compliance/My Compliance Overview ........................................................ 79
- Fab Tracking ................................................................................................... 81
- Delegation of tasks ......................................................................................... 82
- Keep the system up to date ............................................................................ 83
- Scanning Files ................................................................................................ 83
- Direct Scan of Patient ID Images ................................................................... 83
- Add/Save a face image .................................................................................... 83
- Add/Save Pt ID image ..................................................................................... 85

www.opiehelp.com -3- Support: (800) 876-7740, option 3, 3
Scan a Prescription image/Dispensing Order into OPIE ................................................................. 86
Save a Video or Audio File to a Patient’s Record ........................................................................... 87
Support Files ..................................................................................................................................... 87
Scanned Documents ......................................................................................................................... 87
Add Images to a Patient’s Record ....................................................................................................... 88
Make the OPIE Screen Larger ........................................................................................................... 88
Create Note and Letter Writer Templates ......................................................................................... 89
Note/Letter Writer html code ................................................................................................................ 92
Code text to paste into a note or letter writer template .................................................................... 93
Create an Administrative Note .......................................................................................................... 96
Create an Admin Note template with a classification for reuse ....................................................... 96
Scheduler Information ........................................................................................................................ 96
Practitioner who is no longer here is still on the schedule .............................................................. 96
Prevent Inactive Patient Appointments ......................................................................................... 97
Deactivated user appears on the schedule ...................................................................................... 97
Search a Patient in Graphic Scheduler ............................................................................................ 97
Reschedule Appointment Using Graphic Scheduler ........................................................................ 98
Show NC/NS Appointments in Graphic Scheduler .......................................................................... 98
Waiting List ....................................................................................................................................... 98
Room Monitor ................................................................................................................................... 100
View Appointment Modification History ......................................................................................... 101
Opieschedule.com and iCal Sync on iOS Mobile Device ................................................................. 101
View Multiple Days .......................................................................................................................... 101
Delete Appointment ......................................................................................................................... 102
Search by Phone Number ................................................................................................................... 102
Search by Date of Birth ...................................................................................................................... 102
Print Patient Appointment History .................................................................................................. 102
Print Schedule with Patient Phone Numbers .................................................................................... 102
Locked Visit ....................................................................................................................................... 102
Attach a Note to a Prescription ........................................................................................................ 103
Forms ................................................................................................................................................ 103
Tasks Tab

In the Tasks tab in the left pane, users can perform a variety of tasks such as open a patient file, order parts online, return to the Home screen, log out of OPIE, switch branches and access Administrative Tools.

Open a Patient File

Click on Open a Patient File in the Tasks tab of the left pane. From here, users can scroll through the patient list and double click to select the patient or search for the patient by last name or first name.

Search by Last Name

Type the last name in the Search by Last Name field in the Select tab.

Search by First Name
To search for a patient by the first name, type a space and then start typing the first name

**Search for a patient with last and first name**

Users can search for a patient using the full last and first name or a portion of both. For example, if the patient's name is *Jerry Garcia*, type a few letters of the last name, add a space and then type a few letters of the first name, like this:

Gar Je

**Pt Info Tab**

The Pt Info tab in the left pane shows the height and weight from the most recent Medical HX form. It also shows the patient's date of birth, gender, primary and secondary insurances, Prescriptions, Referring Physician and Diagnoses.

**Height/Weight History Form:** This new form will gather a running history of all of the patient's height and/or weight entries, no matter what form they were entered from. It also allows you to put in new entries, so you no longer need to create a new Medical Hx form just to enter a new height and weight. Note that the form only starts gathering entries from the date that you received the update (so older height/weight entries prior to receiving the update will NOT show up in the Height/Weight History).

**Pain Scale Form:** This new form allows you to record pain levels and view a running history of them. It includes a standard pain scale showing faces to indicate the pain levels from 0 to 10.

**Branch Quick Switch Button**

This icon, in the top right corner of the Tasks pane, allows the user to quickly change which branch they are logged in to. Right-click the button to select a branch. The title bar at the very top of the OPIE window will show the branch currently logged in to.

**Order Parts Online**

To order parts online through OPIE Purchasing and Inventory, click on Order Parts Online in the Tasks tab of the left pane. For further instruction on how to order parts, please see the OPIE Purchasing User Guide.

**Authentication Failed message trying to Order Parts Online**

The OPIE Purchasing username is used to link OPIE to the web-based modules of OPIE, such as OPIE Purchasing & Inventory, OPIE Help, OPIE Mobile and the OPIE Online Schedule.

OPIE onsite Administrators will add each user’s Purchasing & Inventory username in Admin Tools via the Add/Edit User option for each user that needs to access Purchasing & Inventory.
Add/Edit User in Administrative Tools will now verify that the username entered for the Purchasing & Inventory user belongs to the facility it is being entered for, thus requiring each user to have a unique login username. If the username is invalid, OPIE will prompt the user with the Authentication Failed message.

The Purchasing username is entered at the bottom left of the Add/Edit User screen in Admin tools. See the screenshot below:
Files Tab

This tab contains all of the files in the patient chart. To access the patient’s chart, click on this tab. The prescription files can be expanded to see further contents by clicking the + buttons to the left of the folders.

A paperclip icon will appear on the left of the form name in the Files tab in the left pane if there is an attachment in a form. See the screenshot below.
Financial Tab

We have added a Financial tab to the left pane of the patient chart. The Financial tab is meant to provide a visual indicator, when viewing the patient chart, of whether the patient owes money. This tab will only appear if a positive account balance exists on any Financial Responsibility form or Patient Responsibility claim exists in a patient chart. If there is a negative account balance, the Financial tab will not appear in the left pane. A permission to enable this functionality is not included. The Financial tab appears in the left pane for all practitioners and clerical users, but will not appear in Technician accounts.

The top frame of the Financial tab contains a chronological list of Financial Responsibility form and Claims at Patient Responsibility information (visit date, balance, Device).

The bottom section of the Financial tab will initially be blank and later populate with details of a selected item from the top portion. If a Financial Responsibility Form item is selected, the bottom portion of the tab will include total payments, last payment amount, last payment date and the current balance.

Clicking the Open Form button at the bottom of the Financial tab will open the Financial Responsibility form that you have selected. Clicking the Refresh button will clear the information so that you can make a different selection. If a Claim at Patient Responsibility item is selected, the bottom portion will include First Statement Date, Total Pt Payments, Last Payment Amt, Last Payment Date, Current Balance and Unapplied Deposits.
If you wish to send a note to your biller about a specific claim, highlight the claim and click the Send OPIE Billing Note button. Clicking the Refresh button will clear the information so that you can make a different selection.

The Financial Tab will disappear after all payments have been entered into the respective Financial Responsibility Forms in OPIE and Claims at Patient Responsibility in OPIE Billing where the balance becomes zero or negative. Then, click the Refresh button on the Financial tab, Save and Close the patient. When the patient is re-opened, the Financial tab will not be there.

**Create a New Patient**
Under the Tasks tab on the left pane, click **Create a New Patient**. The Patient Information tabs will open in the right pane (see screenshot below). This screen will also open as a secondary document to make the information in it easier to access when other forms are being filled out. To open the Patient Information screen as secondary, right click on Patient Information in the left pane and select Open as Secondary Form. When it is opened as secondary, it cannot be edited.

**General Info**
1. **Patient ID**
   OPIE will auto-generate a number for this field. If an alternate numbering scheme is desired, type the number into the Patient ID field.

2. **Entry date**
   This is the date the patient was created.

3. **Active Patient checkbox**
   OPIE automatically checks this box upon creating a new patient. If the patient becomes inactive, uncheck the box. A drop-down box will appear so that a reason may be entered. There are several selections in the drop-down list. If additional reasons are needed, click the blue+ next to this drop-down list and add additional reasons.

4. **Enter identification demographics**
   a. Languages may be added that are not already included in the drop-down list. Click on the blue+ to the right of the drop-down list for Language.
   b. Enter the language in the space provided then click the Add/Edit button.
   c. Click Close.

5. **HIPAA and Billing Signature Date**
   This box will auto-populate when the documents are signed or can be manually updated.

6. **Click Save Patient.**

7. **Patient Phone Numbers**
   a. Click Add, choose the phone number type from the drop-down menu and add the number.
   b. Click ACCEPT.
   c. Multiple phone numbers may be added for the patient. Repeat the process until all contact numbers are entered.

8. **Patient Address**
   OPIE supports international addresses and phone numbers. All country drop-downs contain a full list of country abbreviations. If a country that is not supported in OPIE is selected, the state, postal code and phone number boxes will switch to allow free text entry.
   a. Click Add, choose the address type from the drop-down menu and enter the information.
   b. Click ACCEPT.
   c. Multiple addresses may be added for the patient. Repeat the process until all addresses are entered.

9. **Custom1/Custom2**
   These drop-down lists are for reporting purposes and can include anything needed for tracking such as: how did this patient come to us?, referral from family member, referral from doctor, received marketing letter, etcetera. Patient Custom 1 and 2 fields will appear on the Appointments, Patient Prescriptions and Patients Reports (among others) which are list detailed reports. To show these fields on the reports, click on the Show All Fields button in the upper right corner of the report pane. The Pt. Custom 1 and Pt. Custom 2 fields will appear when the Choose Fields button is clicked and they are selected from the list.

10. **Add/Save a face image**
    Adding a picture of the patient is useful for maintaining a good rapport by being able to identify and acknowledge them by name.
    a. Click Add/save a face image.
    b. Choose select from file.
    c. Navigate to the image file, click on it and choose open.
    d. If the image needs to be rotated, click on the Rotate Left or Rotate Right buttons until the image is in the correct position.
    e. Click ACCEPT.
    f. To view the image, click on the PT Info tab on the left screen.
g. Some patients will have a little head icon to the left of their name if the face image feature is being used.

11. Notes
   Any note can be added to this field. If this notification needs to be highly visible to office staff and/or the practitioner, click the “Create alert from note” checkbox. When the patient record is opened, the note will appear on the screen in a yellow pop-up.

12. Add/Save Pt ID image
   This is where a scanned image of the patients’ DL or ID card should be added.
   a. Click Add/Save Pt ID Image.
   b. Choose Select from File or Direct Scan, whichever is appropriate.
   c. Navigate to the image field.
   d. Double-click on the image or click once and select Open.
   e. Do not change the image compression.
   f. Image Title and Image Description can be added but are not mandatory.
   g. Click ACCEPT.
   h. Click Save Patient.

The General Info section is now complete for this patient.

Patient Contacts

Click on the Patient Contacts tab.

1. Primary Practitioner
   a. Choose the Primary Practitioner using the drop-down list.

2. Primary Branch
   a. Choose the Primary Branch using the drop-down list.

3. Patient Personal Contacts
   a. Click Add Contact
   b. Specify the relationship to the patient.
   c. Fill in the rest of the information and Click ACCEPT.
      i. If the contact is already saved under General Contacts in OPIE Dex, click “Import,” highlight the contact in the list, click Select and then click ACCEPT.
      ii. If multiple contacts need to be added, click add contact and repeat the steps above.

4. Click Save Patient.

The Patient Contacts section is now complete for this patient.

Insurance Info

Click on the Insurance Info tab.

1. Last Authorization complete date
   a. If an authorization form is completed elsewhere in the patient record, this field will auto-populate.

2. Pre-auth
   a. If patient requires pre-authorization from insurance company, check the box.

3. Self-pay
   a. If patient is self-pay, check the box.

4. Worker’s comp case
5. MediPass
   a. Choose yes or no from the drop-down list.

6. Patient Insurance
   a. Click Add Patient Insurance.
   b. If the Insurance Company is not listed in the drop-down list in the left pane next to Name, click the blue Create New Insurance Company button.
   c. Add company and subscriber information.
   d. Click ACCEPT.

7. Click Save Patient.

The Insurance Info section is now complete for this patient.

De-Activate an Insurance Company

Insurance companies and their addresses can be deactivated within the Insurance tab of Patient Information and also within OPIE Dex.

To deactivate an insurance company in the patient’s record:
1. Click on the insurance company to deactivate and click the blue De-Activate Insurance button to the right.
2. The De-activate popup will appear, which asks, “Are you sure you want to make this patient insurance inactive?”
3. Click Ok to deactivate or Cancel to abort.
   a. **Note:** deactivating an insurance company using the blue De-Activate button from within the patient chart will NOT deactivate it for other patients.
   b. **Note:** if an insurance company is deactivated by means of clicking the blue Edit Selected Insurance Company button and then unchecking the Active (Company) checkbox in the Edit popup, it WILL deactivate the company for all patients with this company.

To reactivate an insurance company in the patient’s record:
1. Click on the insurance company to reactivate and click the blue Edit Patient Insurance button.
2. In the left pane, change the Insurance Type to Primary, Secondary, Tertiary or Other.
3. Click Accept

To deactivate an insurance company in OPIE Dex:
1. Click on the Insurance Companies tab.
2. Click on the insurance company to deactivate.
3. Click the blue Edit button.
4. Uncheck the Active (Company) box in the Edit popup.
5. Click the blue Save Changes button.
6. Click Ok and then Done.

To reactivate an insurance company in OPIE Dex:
1. Click on the insurance company to reactivate.
2. Click the blue Edit button.
3. Check the Active (Company) box in the Edit popup.
4. Click the blue Save Changes button.
5. Click Ok and then Done.
   a. **Note:** deactivating an insurance company from within OPIE Dex **WILL** deactivate it for all patients with the same insurance.

### Prescriptions

To make adding the physician’s details easier, there is a View Physician Details button in the Prescriptions tab.

1. Click on the **Prescriptions tab**.
2. Click **Add New**.
3. Click **Eval and Treat**.
4. **Device Type/Filter**
   a. Add the information for the device in the filter fields.
   b. Select the device from the drop-down list.
   c. If the name of the device is not in the list, your onsite OPIE administrator can add it to the drop-down list.
5. **Accident date**
   a. If relevant, include the date of the accident when the injury took place.
6. **Treating practitioner**
   a. The Treating Practitioner at the Rx level is primarily for reporting purposes, so that reports will accurately show which practitioner handled a specific device even if they are not the primary practitioner. This field will also control which practitioner shows up on the WIP screen.
   b. When creating a new prescription, the Treating Practitioner will automatically be set to the Primary Practitioner for the patient, so that it only has to be set if the two are different. There is no real functionality on the Primary Practitioner field on the Patient Contacts tab.
   c. Choose the Treating Practitioner using the drop-down list.
7. **Custom 1/Custom 2**
   a. Both of these fields can be used to create descriptors for the device.
   b. Click the blue+ to add descriptors not in the existing list.
8. **Diagnosis codes**
   If delivery is set to occur on or after October 1, 2015 and the insurance company requires ICD-10 codes to be used from that day forward, users must use the ICD-10 diagnosis code set. If Delivery is set to occur before October 1, 2015, users must select the ICD-9 diagnosis code set. Setup instructions for loading ICD-10 codes into OPIE are included in the OPIE Administrative guide, which is also in the online OPIE User Guides.
   a. Select ICD-9 or ICD-10 code set in the code set drop-down list based on the projected delivery date.
   b. Then, click on the blue Select from Code Set button. Enter a Keyword into the Enter KeyWords or diagnosis code to search field. This allows easier searching by narrowing the results based on the description keyword(s) used.
   c. If an incorrect code is entered, highlight the code and click Remove ICD-9/ICD-10.
9. **Referring Physician**
   a. Select the Referring Physician using the drop-down list.
   b. If the physician is not in the list, click the Add button. Additions will also automatically be added into OPIE Dex from this window.
   c. Edit existing entries by clicking the edit button. The information in OPIE Dex will also automatically be edited from this window.
   d. If the physician is both the referring and the primary care physician, check the Add to Both Referring and Primary Physicians checkbox.

10. **Primary Care Physician**
   a. Select the Primary Care Physician using the drop-down list.
   b. If the physician is not in the list, click the Add button. Additions will also automatically be added into OPIE Dex from this window.
   c. Edit existing entries by clicking the edit button. The information in OPIE Dex will also automatically be edited from this window.
   d. If the physician is both the referring and the primary care physician, check the Add to Both Referring and Primary Physicians checkbox.

11. **Click Save Rx Info**
12. **Click Save Patient**
13. **Height/weight history**
   a. Click on the Pt Info tab in the left pane.
   b. Click on the height and weight history button.
   c. Click Add New.
   d. Fill in information.
   e. Click show ht/wt change button if needed for reporting purposes.
   f. Click Save.

14. **Pain level**
   a. Click Add New
   b. Choose a number between 1 and 10, 1 indicating no pain and 10 indicating a severe level of pain.
   c. Click save and close.

**Schedule an appointment directly from Graphic Scheduler**

**New Patient walk-in or phone call**

The fastest way to add a new patient is to use the Graphic Schedule.

1. Open the Graphic Schedule; double-click on a time slot.
2. At the right of the patient name field, click on the + sign to add a new patient. Fill in the first, middle and last names.
3. Leave the patient ID blank unless the clinic uses a different patient ID numbering scheme than OPIE auto-numbering.
4. Fill in date of birth and gender.
5. Leave the Device Type as unspecified if unknown at the time of scheduling the appointment. This can be edited when the patient prescription is created. If the Device Type is known when scheduling, specify at that time.
6. Select the visit type from the drop-down list and add any alerts (which can be made into a pop-up note by clicking the “Make popup” box).
7. Check the “Add to waiting list” box (if the patient requests) located under visit type.
8. Select the Branch, Room and Location from the drop-down lists on the right of the New Appointment Dialog and add any comments desired.
9. The next few fields (from Created to Pt Phone #) will auto-populate and cannot be manually modified.
10. Add the phone type using the drop-down list.
11. The last field, color, is optional. Colors are self-defined and can be used as visual descriptors, such as: Practitioner X is yellow, Practitioner Y is green, or Location A is blue, Location B is pink, etc.
12. Click Save. The patient will appear on the schedule in the time block accessed.
13. When it comes time to add the rest of the patient information, open the schedule, double click on their appointment block and click “Jump to Patient.” Make sure to save all open information before doing this. Alternatively, go to the Tasks pane in OPIE and click Open a Patient File, and select the patient from the Select List.

Existing patient

1. Double-click in a time slot on the Graphic Schedule to add an appointment.
2. Click the drop-down arrow to select the patient or begin typing the last name to auto-fill the Patient Name field.
3. Fill in the prescription and visit type from the drop-downs and click Save.
4. Double-click on the appointment block to reopen it and then click “Jump to Patient” to open the patient’s record. (Note: If OPIE is minimized, clicking Jump to Patient will maximize it.)

Schedule an appointment from the List Schedule

1. Click on the Home icon under the OPIE Patient Management Software logo in the top left pane.
2. Click the desired date on the Calendar on the right, click the blue New button.
3. From the left pane, select Patient and click the blue ACCEPT button in the lower right.
4. Choose the practitioner in the “Scheduled For” drop-down list.
5. Choose the location using the drop-down list.
6. Choose the Branch from the drop-down list (it may be auto-populated).
7. Choose the Date, Room, Start Time and End Time using their associated drop-down lists.
8. Choose the Associated Prescription and Visit Type using the drop-down lists.
9. Add comments for the patient or appointment in the designated field.
10. The patient may be labeled as a walk-in or added to the waiting list using the check boxes below the Comments field.
11. Select a color label, if desired, for the appointment from the drop-down list to the right of “Color Label.”

Schedule an appointment from the prescription

1. An appointment can also be scheduled/created when creating/modifying the prescription.
2. From the Prescriptions tab in the right pane, highlight the prescription and click the blue Edit Prescription Info tab on the right.
3. Click the blue Save and Schedule button on the bottom of the right pane.

Appointment Status

1. Before adding forms to the patient record, change the appointment status of the patient to Showed Up.
2. Change the appointment status in the Graphic Schedule:
3. Open the Graphic Schedule.
4. Right-click on the appointment for that patient or double-click to open the appointment and change the Appt. Status from the drop-down list to Showed Up.
5. Click Save.

Change the appointment status in the List Schedule

1. In the List Schedule, click on the patient.
2. Under Appointment Details, change the Sign-In Status to Showed Up.
3. Click the REFRESH DATA button at the bottom of the screen.

Authorization Required Prior to Patient Visit

When an insurance company requires authorization prior to a patient visit, enter the complete patient information into OPIE, including General Info, Contacts, Insurance Info and Prescription. Then, in the left pane under the prescription, select Click to Add a non-clinical event and select Administrative Documentation from the drop-down. Then click the + sign next to the yellow folder for Administrative Documentation and select Click here to add a new form. Click the Browse button and select Lcode Selection from the list of forms. Once the lcode selection form has been saved, go back to the left pane and Click here to add a new form and create the Insurance Authorization form.

How to correct if Cancel or reschedule appointment is selected by accident

Follow the steps below to not actually cancel or reschedule an appointment once you have triggered it.

If Cancel is selected by accident:

1. Click No on the Autonote prompt
2. Click No if it asks you to add to the waiting list
3. Re-open the appointment and select Unspecified in the Appt. Status drop down
4. Click Save

If Reschedule is selected by accident:

There is a Cancel button in Reschedule Mode which appears at the top of the schedule (see below):

1. Click the Cancel button
2. Click No on the Autonote prompt
3. Re-open the appointment and select Unspecified in the Appt. Status drop down
4. Click Save

The end result of these steps should set the appointment back as if you had never selected Cancelled.
Cancelled appointment still shows in Compliance Tab

Best Practice Recommendation for Visit Locks:

The Visit Lock is created if an appointment is Canceled, Rescheduled or No Showed to prevent forms accidentally being saved under a visit that didn’t take place. Whoever changes the status of the appointment to Cancelled/Rescheduled/No Showed should check the Save This Note button on the auto-generated note dialog that appears.

Create Patient Note

![Cancelled appointment dialog]

Otherwise, a compliance note requirement is created on the Practitioner’s Compliance screen. When that happens, the Practitioner should highlight the patient on their Compliance Screen and click the Create Note button to enter a brief note that the appointment was cancelled.
Report a Problem

If it is limited to only one machine, then the Feedback button in the top left of OPIE is the best method. When a feedback is sent, it attaches the error log off of the machine, and we immediately know what type of error is being received. Please include a brief description of the issue, e-mail address, and office location if the practice has multiple branches.

If it is a system wide issue, please call 800-876-7740 option 3, 3 for the support department. If all of the support personnel are on the phone and you have to leave a message, please speak clearly and leave a detailed message of the issue, name, and contact number.

Workflow

Utilizing the WIP (work in progress)

Assigning WIP tasks to specific team members not only helps improve the flow in the office but creates accountability and a routine procedural system to assure that regulations are being met with every patient and that every patient is being processed the exact same way in the practice. The first four tasks (Dispensing Order, HIPAA signatures, Medicare Supplier Standards and Insurance Verification) in the WIP should be assigned to an intake clerk or possibly split specific responsibilities between two administrative staff. These WIP items should be completed before the practitioner sees the patient. Using the WIP will create a more organized, streamlined and paperless process while also meeting auditing requirements.

After a new patient is added into OPIE, the process of completing intake information and authorizations should commence.

Print WIP

The Work-In-Progress (WIP) screen is not printable but if you have access, you can print the Administrative WIP Report from OPIE Reports.

- From the Reports Generator window of OPIE Reports, select Category: Specialty Reports / Report Data: Administrative WIP / Parameters: Active and click the Generate Report button.
- Use the Choose Fields button to limit or expand the fields in view
- Use the Filter icon at the top of the columns to further refine the criteria
- The report can be exported or sent to the Default Printer

Print WIP Column Headers
If clicking the blue Print WIP button doesn't print the column headers, check your printer page setup. Because the headers are actually an image, this must be enabled in the printer Page Setup menu.

- In Print Preview, click the little gear wheel icon to access the page setup menu.
- Check the box to Print Background colors and images.

**Administrative Documents**

As soon as a new patient prescription is added to OPIE and the first appointment has been created and patient has been checked in, two folders will be created under the new RX in the patient’s electronic medical record. The first subfolder is the Administrative Documents folder. This is where ALL administrative documents should be created and housed throughout the care of this patient for this prescription.

Administrative items are added to the patient file under this folder. Selections from the drop-down list may include the following administrative forms: Facility/Patient documents, insurance verification, insurance authorization, service estimate, financial responsibility, scanned documents, detailed prescription, letter writer, delivery receipt and administrative notes. If the required form is not in the drop-down list, click browse and select from the list of available forms.

**OPIE List of Forms**

Below is the list of forms in OPIE that are located in the Browse list of forms. This list will periodically change with additions/deletions.

ABN v2.0
ABN v3.0
Admin Notes
AFO In House Fabrication Workorder
C-Fab Tracking
Custom Knee Brace Verification
Delivery Assessment
Delivery Receipt
Detailed Prescription
Diabetic Verification Form
Facility/Patient Documents
Financial Responsibility
HIPAA Docs & Supplier Standards
Images
Insurance Auth v2.0
Insurance Ver v2.0
Insurance Ver v3.0
Kinetic Fabrication Order
LCode Selection
Letter Writer
LMN Scan
Lower Extremity Initial Evaluation
Lower Limb Consumables v2.0
Medical Hx
Notes
O &P1 CROW Walker Work Order
O &P1 Orthotic Work Order
O &P1 Trans-Femoral Work Order
O &P1 Transtibial Work Order
Orthotic General Lower Limb measurement
Orthotic In House Work Order
Orthotic Work Order
Otto Bock TT Form
Parts Order Form
Patient Complaint Log
Pedorthic Work Order
Physicians Scanned Notes
Scanned Docs
Schedule Appointment
Service Estimate
Shoe Work Order
Spinal Measurement
Support Files
TC2 AFO System
Transfemoral Component Info v2.0
Transfemoral Design OMEGA Tracer
Transfemoral Follow-up
Transfemoral In House Fabrication Work Order
Transfemoral Initial Evaluation v2.0
Transfemoral Measurement
Transfemoral OMEGA Tracer
Transhumeral Fabrication
Transhumeral Initial Evaluation
Transhumeral Measurement v2.0
Transradial Fabrication
Transradial Initial Evaluation
Transradial Measurement v2.0
Transradial Myoelectric Components
Clinical Visit folder in OPIE

The second folder that is automatically created within OPIE after the first appointment has been checked-in is the clinical visit folder. A new clinical visit folder will be created for each subsequent scheduled appointment and this is where the practitioner will create and locate clinically-related documents on the dates that the patient was seen.

Clinical items are added to the patient file in this folder. The practitioner uses this folder at each visit to create and store any forms or processes that are related to that clinical visit. This folder will include items such as: Medical History, Initial Evaluation, Fabrication Work Order, Parts Order Forms, Lower Limb Consumables, Lower limb components (etc), Schedule Appointment, L-Code Selection, L-Code Justification, Delivery Receipts, Patient Education (patient/facility documents) and Notes.

Definition of a Clinical Visit

What constitutes a clinical visit? WIP will auto-complete to green the Lcodes Selected column when Lcodes are selected and Sent to Admin (also if Delivery Receipt is Sent to Bill).

1. Clinical visits are: Consultation, Initial Evaluation, Pre-prosthetic Counseling, Offsite Clinic Visit, Out Of Office Visit, Casting, Measurement, Diagnostic Fitting, Repair, Shape and Cover, Parts Requested, Delivery /Definitive Fitting, Follow-up, Adjustment, Dynamic Alignment, Diagnostic Follow-up, Pre-operative Visit, Post-operative visit, Scanning

Label a Visit

Visits can be labeled by right-clicking on the visit name in the left pane and selecting Add/Edit label. The label created will append to the end of the visit name.
Patient Intake Responsibilities

The patient intake responsibilities, as mentioned above, are the first four tasks in the WIP and should be completed before the practitioner sees the patient. These tasks include obtaining the Dispensing Order from the patient, providing the patient with “new patient documentation” and obtaining appropriate signatures (i.e. HIPAA Signatures & Medicare Supplier Standards) and obtaining Insurance Verification.

Rx Summary Screen

The Rx Summary pulls together the most important patient information related to a particular prescription and displays it on one screen. The main purpose of the Rx Summary is to have all of this information available at-a-glance to minimize the need to search through patient files. The Rx Summary includes basic prescription details, WIP status and WIP status change tracking, fab tracking-parts ordered quick view (with real-time status information pulled from OPIE Purchasing & Inventory), next appointment date and type, WIP Notes (which can be modified from this screen) and WIP Templates (which can be created and applied by the site administrator).

Access the Rx Summary from the following locations in OPIE:
1. Right-click on the prescription or select a visit or document within the prescription and press the "Rx Summary" button that appears in the lower right of the left pane.

2. In the Prescriptions tab, the Rx Summary button appears in the upper right corner.

3. From WIP, either double-click on a WIP entry or select the WIP entry and press the "Rx Summary" button that appears at the top.

4. From the schedule tab on the Administrative Home screen (List Scheduler) you can select an appointment and click the "Rx Summary" button.

Key Points to Know

- While the Rx Summary screen is mainly used for viewing information, there are a couple of functions that can be modified from it.

- Staff members with rights to patient records can add to WIP notes in the upper right-hand corner. Click on the blue Add to Note button, type note in the text field provided and click OK. The new note will appear in the WIP Notes section above any previous notes.

- Administrators can create new WIP Templates within the Rx Summary screen by clicking the blue Create New button in the WIP Templates section, unchecking columns to be marked as N/A, providing a name for the Template and clicking the Save button.

- WIP columns can be marked as complete within the Rx Summary screen if a user has been given the right to do this. This right is usually limited to one or two people at a site, for instance, the biller and a backup. To mark the WIP column complete, check the Complete box beneath the WIP Info box.

- Jump to a Fab item in Fab Tracking directly from the Rx Summary screen. Highlight the fab item in the Fab Tracking box at the bottom of the Rx Summary screen and then click the blue Open Item in Fab Tracking button at the bottom of the screen. Double-clicking on the fab item will also jump to Fab Tracking and select that item.

- In the Insurance tab of the Rx Summary, the Insurance Verification and Authorization forms can now be opened as secondary forms by highlighting the item and then clicking the blue Open As Secondary button beneath the corresponding section.

- In the Codes tab, there is a Selected Codes box that shows the Codes, Quantity and Modifier attributes. This section also shows the Sent to Admin and Delivered dates as well.

- The Rx Summary screen can be refreshed by clicking the Refresh button in the lower right of the screen.

Dispensing Order

The dispensing order is the original written prescription that the patient presents at the O&P office. The Dispensing Order (prescription) must be scanned into the system and all associated information must be entered into OPIE. The critical data that is associated with the Prescription is a copy of the Prescription itself, the Device Type, the appropriate ICD-9, and the referring physician. Once the prescription is scanned into OPIE, the WIP icon will update. The icon will turn yellow with specific icons indicating if the prescription is scanned but the ICD-9 Diagnosis Code or referring physician are missing. When the prescription is scanned and the diagnosis and referring physician are entered correctly,
To add the dispensing order, the basic patient information must already be created in OPIE. When the patient record has been established, go into the Prescriptions tab of the Patient Info screen.

Select the prescription and click on the blue Add New Prescription Image button located toward the upper right of the screen.

Determine if this patient is being seen for a consult only or for an evaluation and treatment.

Select appropriate Device Type of Orthotic or Prosthetic.

Select Lower, Upper, Spinal or N/A.

Select whether or not this is Left, Right, Bilateral or N/A. (Keep in mind that for prosthetic cases, left and right should be entered as separate prescriptions.)

Drop down to select appropriate Device type.

Select Appropriate Treating Practitioner. This is the person who will be associated with the patient in the WIP for accountability purposes.

Enter the date that the Rx was written by the referring physician into the Rx date field.

Track any Prescription specific data that your practice is trying to track with the Custom 1 or Custom 2 fields (i.e. was the patient referred by Cerebral Palsy clinic or scoliosis clinic).

Select appropriate diagnosis code (be certain to be aware of Medicare LCD’s that establish certain guidelines for appropriate ICD-9 usage as linked to reimbursement).

Select Referring Physician or add if new.

Select Primary Care Physician if appropriate since some insurance companies and versions of Medicaid will require prior-authorization be obtained from PCP prior to authorization.

Select Save and Schedule to enter immediately into the scheduler (or) select Save Rx Information to simply save the new prescription into OPIE.
Scan the Dispensing Order into OPIE to complete the first column of the WIP

1. Select the appropriate prescription from the list of prescriptions that were added at the top of the prescription tab.
2. Select the prescription and click on the blue Add/Save Prescription Image. Click on the blue Select From File button in the upper-right of the left pane.
3. Click on the image you want to add.
4. The scanner setting should be set so that the image being scanned is large enough and clear enough to be printed and reproduce a legible copy of the Rx. (Be sure to work with the practice’s IT staff to select the correct settings. TIFFs are NOT appropriate.) Also be sure that the scanner software is set up so that the RX can be cropped in the scanning process so that the entire Rx is visible in the viewer and not just have the Rx scanned as part of a larger blank page.
5. Click open and then click ACCEPT.
6. An image title and description may be added here.
7. Do NOT rotate or change the compression of the image.
8. Click SAVE PATIENT.
9. To verify that everything has been done correctly, open the WIP and check the first column for a green icon next to the appropriate patient name and Prescription. To Open the WIP, select the third icon in the upper left-hand side of the left pane under the OPIE Patient Management Software logo. It looks like a yellow folder with a red check in it.
10. Now that the prescription has been scanned and added to the file, the dispensing order will show that it is completed in the WIP. A green orb indicates a completed procedure.

11. If a yellow icon appears instead, it indicates that an ICD-9 or referring physician is missing. If a red triangle still appears, verify that the scanning process was done correctly.

12. Minimize the WIP. It is unnecessary to close it until the intake processes for the patient are complete. The Refresh button may need to be clicked at the top center of the WIP screen to see recent changes that were made.

PRIOR to being able to complete any additional columns in the WIP, the patient will need to be checked in as either “showed up” or “in-room”. This will activate the prescription within the electronic medical record and automatically create the Administrative Documents folder and first clinical visit folder. All administrative functions and documentation creation will occur within the Administrative Documents folder.

How to Label Prescriptions

When you add a label to a prescription, it will append the label to the end of the prescription name. The label will also appear in the list of prescriptions at the top of the Prescriptions tab, on the top of the Rx Summary screen, and other appropriate locations.

To add a label to a prescription:

1. Right-click on the prescription name in the left pane of the patient chart
2. Select Add/Edit label
3. Click Ok

HIPAA Signatures and Medicare Supplier Standards

This is a very important step in the WIP. Medicare and other insurance companies that base their requirements on Medicare standards are stricter than ever. For auditing purposes, it’s best to meet this step for every patient every time. The WIP icons for HIPAA signatures and Medicare Supplier Standards will turn green when the checkboxes are checked and a digital signature on the HIPAA patient docs and Supplier Standards forms are provided.
1. Under Administrative Documents, click on the “Click to add a new form” link.
2. Click on the blue Browse button.
3. Select HIPAA Docs and Supplier Standards from the list of available forms.
4. Click on the blue Add File button in the right pane.
5. Select the required documents from the list. To add multiple documents, hold down the Ctrl key and click on each document.
6. The practice may include more documents as required documents in this form than just the HIPAA Documents and Supplier Standards.
7. When all required documents are highlighted, click the Add File(s) button.
8. If using the digital signature, select it.
9. Click Start, have the patient sign the digital signature pad and when finished, click the blue Stop button at the bottom of the digital signature window.
10. Click SAVE and then CLOSE.
11. If using paper based signatures, after the files have been added to the list as described above, select Print Patient Receipt at the bottom center of the HIPAA Patient documents and Supplier Standards page.
12. Have patient sign documents then scan into Patient Visit Scan 1 tab and click on the appropriate boxes on the bottom right of the screen to document which documents the patient signed for.
13. Click Refresh Data.
14. Open the WIP to make sure the icons for HIPAA signatures and Medicare Supplier Standards have been updated to green. The green orbs should have yellow lightning bolts in them indicating they were digitally signed, or be green with a paperclip if the documents were printed, signed and scanned.

Insurance Verification
This is the fourth WIP task and, once completed, meets the first set of tasks that have been set as requirements for each patient. Before seeing patient, insurance verification tells us, “Can we see this patient because we accept the patient’s insurance and understand any financial considerations that must be made before treatment”. It is highly recommended that the Insurance Verification process be performed by someone other than the individual responsible for inputting prescription information, scheduling initial appointments, and obtaining HIPAA / Supplier Standards signatures.

1. Under Administrative Documents, click on the “Click to add a new form” link.
2. Click on the blue Browse button.
3. Select Insurance Verification v3.0 from the list of available forms.
4. Click on the blue Select Insurance button located on the right side of the right pane. It will populate the fields with the information already in the Insurance tab of patient information.
5. Add any additional information needed such as contact name, plan type, etc.
6. Under the General Insurance Information section, select yes or no from the drop-down to the right of Current Coverage.
7. Add the Effective Date and Termination Date using the drop-down lists if different from the dates already listed.
8. Pre-auth phone: this is the phone number needed for acquiring pre-authorization for services.
9. The verified by field and date are auto-populated with the name of the person currently logged in.
10. Check the boxes for portions the patient is responsible for.
11. This report can be printed, if needed, by clicking the Print Report button at the bottom of the right pane.
12. Click the Verification Completed checkbox at the bottom right of the right pane. This is an important step. The box must be checked for the WIP icon to update to a green orb, indicating that the task is complete.
13. Open the Specific tab.
14. In the Deductible Information section, enter the appropriate information using the drop-down lists and text fields.
15. In the General Insurance Benefit Information section, enter the appropriate information in the text and checkbox fields.
16. Enter lifetime/annual maximums and any DME limitations, exclusions or provisions in the next section.
17. If yes is chosen for any of these DME questions, additional fields will be activated asking for additional information, such as if the DME is a medical necessity, what types of DME are excluded from coverage and if there are any DME provisions.
18. In the text field next to Required Paperwork, list all paperwork the insurance company requires to pay the claim.
19. If the insurance company requires a waiting period for a pre-existing condition, specify in the drop-down list and provide the start and end dates.
20. In the pre-authorization section, PCP Name refers to the Primary Care Provider. Enter this and other pertinent information using the drop-down lists.
21. If notes are necessary for this section, click on the blue Add to Note button, type the note in the space provided then click the OK button. The note will be added into the field on the form and will show up on the printed page.
22. Click on the Codes tab and choose the claim by clicking on the blue Choose Claim button.
23. Highlight the L-code selection to apply to this claim and click the Select button. If L-codes have not been selected yet, wait until they have been selected by the practitioner before completing this section of the Insurance Verification.
24. Click SAVE.
25. A yellow pop-up will appear asking, “Are you sure you want to mark this Insurance Verification as Complete?”
26. Click the blue Yes box within the yellow pop-up.
27. Click CLOSE and then click REFRESH DATA.
28. Pull the WIP back up and click on the blue Refresh button. The icon under Insurance Verification should be updated to a green orb.

**Practitioner – Patient in Room Process**

**Evaluate and Document the Patient**

In order to create a treatment plan and set goals for a patient, a medical history, initial evaluation and other supporting documents such as fabrication work order, L-Code Selection and Justification and Notes must be documented. In the examples below, AFO Custom (In-house Fabrication) is selected as an example of the Patient-In-Room documentation process. The clinical visit folder located under the administrative folder in patient’s files will appear after the visit type is selected when making the appointment. If the appointment is for an initial evaluation, that is what the folder will be labeled as.

**Medical History**

This is a standardized medical history form and includes items such as general health, activity level, height, weight, any current/past conditions and medications, etc.
Note: Certain fields throughout OPIE forms are added into the Global Data collection. The information in the Global Data fields will automatically populate certain information into other forms where the information would be considered applicable. For example, in the Medical History form, the Height and Weight fields are Global Data fields, so OPIE will auto-populate this information in other forms where the information is required.

1. Click on the Click to add a new form link under the Clinical Visit folder.
2. Select Medical Hx from the drop-down list and click the blue OK button.
3. In the Information tab, check any of the first three items that apply to the patient such as whether the event was an auto accident, work-related accident, or the result of any other type of accident.
4. Checking any of these items will activate new fields asking for additional information regarding the event that caused the injury/condition.
5. Click the drop-down list next to General Health and select from the list the overall health condition of the patient.
6. Click the drop-down list next to Activity and select from the list the level of activity the patient experiences on a day to day basis.
7. If the patient has had an amputation, check the box to the left of Amputation in the field to the right of the Activity drop-down.
8. Enter the height and weight of the patient. If there have been recent changes in weight, check this box to the right of the weight fields. Checking this box will activate fields requesting additional information, such as how much weight was either gained or lost.
9. The following list of check-box fields are for gathering additional health-related conditions the patient has currently or in the past. Check any that apply.
10. The last text field asks the practitioner to “List any other conditions that you feel might affect your treatment (including dates and descriptions of surgeries).”

11. If the patient is currently taking medications, click the check-box to the left of this item. A text box will appear so that medications may be listed.

**Stock and Bill**

Below is our recommended process for handling Stock and Bills. Please make sure all of the locations are entered (see step 8) that are used for Stock and Bill in the locations tab in OPIE Dex and Mark them accordingly. This will allow them to appear in the locations options in the drop-down on the pop-up box that appears in step 6 below.

1. Enter all of the patient demographic, insurance and Rx information.
2. Before beginning utilization of the Stock and Bill process, enter all Stock and Bills in the Locations tab in OPIE Dex and be sure to click on the box to mark them as a Stock and Bill location so they appear in the drop-down lists.
3. Go to the left pane and click to create a non-clinical visit under the new Rx they just entered, selecting Stock and Bill as the visit type.
4. Create an L-Code selection under that visit for the Stock and Bill device.
5. Use the new “Deliver on Save” function to go straight to a Delivery Receipt when Save is clicked on the L-Code selection.
6. Immediately save the Delivery Receipt. This is actually not needed, since these devices are delivered by the hospital with their own Delivery Receipt, but this is what sends the device to billing.
7. Saving the Delivery Receipt will trigger the pop-up that asks for Practitioner, Branch and Location, since it is under a non-clinical visit with no appointment to pull that info from. On this pop-up, the Practitioner and Branch should already be defaulted to the practitioner and Branch based on settings that are part of the new version.
8. The third drop-down on that pop-up, Location, will show a special list of locations that are Stock and Bills (because it detects the visit type as Stock and Bill).

**Initial Evaluation Form**

Select the appropriate Initial Evaluation form for the device type.

1. Click on the Click to add a new form link under the Clinical Visit folder.
2. Select the Initial Evaluation form from the drop-down list and click the blue OK button. Since AFO is being used as an example, the Lower Extremity Initial Evaluation form should be selected.
3. In the History tab, Gait Assessment tabs and Lower Extremity Evaluation tabs, fill out the information requested therein to complete the Lower Extremity Initial Evaluation form.
4. If asked for K-Level, include a response on the form only if involving a prosthetic patient (disregard K-level for orthotic cases).
5. This Initial Evaluation form is where the treatment plan will be disclosed. The field for treatment plan is customizable and can be saved for future use.
6. Click SAVE and then click CLOSE.

**L-Code Selection**

The L-Code selection is done by the practitioner during the appointment and, once completed and sent to Admin, the WIP icon will turn green. This is a signal to the Administrative Staff that the information needed for the Insurance Authorization, Patient Financial Responsibility, Detailed Prescription and Letter of Medical Necessity is available.

1. Click on the Click to add a new form link under the Clinical Visit Type folder.
2. Select LCode Selection from the drop-down list and click the blue OK button.
3. Select the L-Code Selection Type from the drop-down list.
   a. If a new L-Code Selection Type is required, click the blue+ to the right of the L-Code Selection Type drop-down list.
   b. Enter the new L-Code Selection Type into the space provided and click Add/Edit.
   c. Click Close.
4. If L-code templates have been created, select a procedure by clicking on the blue “Use a Common Procedure” button in the upper right of the right pane.
5. Choose from one of All, Everyone Else’s or Only My Own lists from the drop-down list to the right of the Search button or search for the L-code by typing some key words into the field to the left of the blue Search button.
   - Example: since AFO has been chosen for device type, AFO or Foot may be typed in the search field to find codes applicable for this device.

6. Common procedures (from the user’s own list only) may be removed or renamed by clicking on the blue Remove or blue Rename buttons at the bottom of the left pane.

7. To see the L-code descriptions, highlight the L-code in the list and click the blue “View Details” button above the list. A pop-up window will appear with the Medicare formal description of the L-code as well as a friendly/simple description and the Medicare and U&C fee schedules for the L-code as well.

8. Select the procedure from the list by double-clicking on the name in the list in the right pane.

9. Check the boxes to the left of each of the L-Codes in the box labeled, “The following L-Codes have been selected for this patient:” Doing this allows the codes to be removed or added to a common procedure and saved for future use.

10. To add modifiers to the L-codes, click the Show Modifiers button. Click the Autopopulate Modifiers button to pull in additional modifiers. This can be aborted by clicking the Cancel button in the popup. Additional modifiers can be added manually by selecting them in the modifier drop-downs. If these should be added to all codes, click the Copy to All button.
11. When satisfied that the correct codes are chosen, click the Send to Admin button at the bottom of the right pane. This will send the L-Code information for authorization.

a. **Send to Admin** is the point at which an L-code selection, which is typically completed by a practitioner, is sent back to the admin staff for authorization, if required, or any other steps that are needed. Pressing the **Send to Admin** button signifies that this L-code selection is ready for the next steps in the process.

There are four things that may happen in OPIE when an L-code selection is **Sent to Admin**:

i. The L-codes Selected column in the WIP screen will turn green (only when the L-code Selection is under the first clinical visit).

ii. The Administrative Compliance screen will show a new entry (with a Sent to Auth date that matches the date it was Sent to Admin).

iii. OPIE Billing & Collections will show a new Authorize/Pre-authorize task (if OPIE Billing & Collections is installed).

iv. The Rx will begin showing up on the Work-in-Progress financial report (with the allowable amount determined by the selected L-codes Sent to Admin).

b. After the L-code Selection has been Sent to Admin, it will show the date it was sent. If changes to the L-code Selection are made, the user will be prompted for a reason for the change. This information is stored and can be viewed in the View Change History screen, which is accessed by clicking on the blue View Change History button located at the top right of the form. When this button is clicked, the...
c. The View Change History button will turn red after a change reason is added. Changes that will trigger a prompt are code additions, removals and quantity changes. If changes are made to the Lcode Selection, we recommend taking the following steps.

   i. **Track L-Code Modifications in WIP**: To help keep track of Lcode selection modifications, the WIP status icon will automate to this icon: 😊. This icon alerts users that the selected codes have changed.

   ii. **View Change History**: Click on the blue View Change History button located at the top right of the form. This allows the user to view all unresolved and resolved changes, the dates changes were made and the user(s) who made the change(s). Click on a specific change to see additional details in the selected change details screen.

   iii. **Update Associated Documents**: After the changes are reviewed and any necessary modifications are made to documents linked to the L-Code selection, the change can be marked Resolved in the Lcode Change History screen by checking the box to the left of the item in the Unresolved Changes box and then clicking the Close button. This will turn the WIP icon back to the green completed status.

   iv. **Does the Detailed Rx Need to be Re-obtained?** One of the documents that typically requires updating when an L-code selection has been changed is the Detailed Rx, especially if it has already been sent to a physician for signature. A new Detailed Rx must be obtained if applicable.

   v. **Save and Notify**: Save any changes to the L-Code Selection form and then use the OPIE Messaging system to send a message to the appropriate person letting them know the L-code Selection has changed and may need to be re-authorized.

   vi. **Note**: The L-Code Selection form will be locked if it has already been delivered or Sent to Bill. The Type label on the L-Code Selection can still be modified, but codes cannot be added or
removed. (The Type label is changed via a drop-down menu at the top of the L-Code Selection form.)

d. After the codes have been Sent to Admin, users will no longer be able to save an empty code selection. (They can still be modified, but the form cannot be saved empty.) If a code selection needs to be blank, then the auth claim needs to be deleted in Billing first.

12. **Reorder L-Codes:** L-Codes can be reordered via the Order box below the Qty field. A code can be clicked on and moved up or down in the list without the need to remove and add. **Note:** The form must first be unlocked to be able to re-order the codes.

**Show Prices/Fees**

For those times when you want a printout with prices and fees for an lcode selection, there are two forms that can be used.

One is the Service Estimate. It will show fees based on the fee schedule selected in the lcode selection. [Click here to learn more information about the Service Estimate form](#)

Another option is the Financial Responsibility Form, which will integrate with the Service Estimate and Ins. Verification v3.0 forms to show the patient’s financial responsibility. [Click here to learn more information about the Financial Responsibility form](#)

**L-Code Justifications**
1. When the L-Code selections have been made, sent to Admin and saved, the L-Code Justification form will be automatically created.

2. Open this form and select the first L-code in the list.

3. Justifications may be chosen from a list of saved justifications by clicking on the blue BROWSE button or they may be typed directly into the field provided to create a new template by clicking the blue SAVE button under Justification Templates.

4. It is occasionally required to list the manufacturer, serial number, model number and/or size on the Delivery Receipt. Add this information into the justification for the code and choose the Print with Justifications option on the Delivery Receipt.

5. OPIE will then ask if the template should be saved under the L-Code selected and will also ask if the template should be saved as a default justification.

6. Repeat this process until justifications have been entered for all L-codes.

7. When the justifications have all been entered, there will be a green orb listed next to the L-code indicating they are complete.

8. L-Code descriptions don’t flow through to OPIE Billing. The Narrative box at the bottom of the L-Code Justifications form is to include information that some payers require. The information added in this box will appear on the claim in OPIE Billing. There is a max allowance of 80 characters for this field.
Schedule Appointment Reminder

Schedule Appointment Reminder does **NOT** add the appointment to the Graphic Schedule. What it does is provide the patient with necessary information regarding the follow-up appointment. It is the responsibility of the Administrative Staff to use the information contained in the Appointment Reminder to schedule the actual appointment.

1. Under the Clinical Visit Type folder, click on the Click here to add a new form link.
2. Select Schedule Appointment from the drop-down list.
3. Click the blue OK button.
4. Using the drop-down lists, select the appropriate parameters for the appointment.
5. The last two fields are where the appointment comments are generated. The larger text field may be typed directly into or pre-defined comments may be generated using the last field on the form.
6. Using the drop-down list, select a pre-defined comment and click the blue Add Comment to this Appointment button. This will add the comment to the larger text field above, which is what appears on the printout.
7. To add pre-defined comments to the drop-down list, click the blue+ to the left of the Commonly used comments field, type it in the space provided, click Add/Edit and then click Close.
Click the Save & Print button to send this document to the appropriate printer will the patient will be checking out. This paper will be given to the patient once the appointment has been scheduled.
Order Parts

The Parts Order Form is used to order specific parts needed for the patient’s prescription. The selection and ordering of parts is typically reserved for after the patient has been checked out. Parts will be selected, documented, and then sent to a shopping cart to be ordered by the individual assigned the responsibility of purchasing supplies.

The Parts Order form is a generic form to be used for orthotic supplies or off-the-shelf supplies. When seeing a prosthetic patient, the Lower Limb Consumables (for liners, shrinkers, etc.), Transtibial and Transfemoral Component firms will be used.

In order for this to work, each user must have a unique username and password for the OPIE Purchasing and Inventory system entered into the system. This will allow parts requested to be sent to the shopping cart for future order placement and tracking.

1. Under the Clinical Visit Type folder, click on the “Click here to add a new form” link.
2. Select Parts Order Form from the drop-down list.
3. Click the blue OK button.
4. Click the blue Add button and fill in the part name, supplier, manufacturer, part number, part type and associated L-code information using the text fields and associated drop-down lists.
5. A label for the part can be retrieved by clicking on the catalog icon * in the center of the screen (the icon to the right of the supplier/manufacturer fields).
6. Catalog Icons will only be available to use when the supplier chosen is an integrated supplier.
7. Properties specific to the item being ordered may be added using the Add Property field. Select the property from the drop-down list and insert a value for that property in the value field below then click the blue Add Property button. The property and associated value will show in the list to the right.
8. When finished adding properties/values, click on the blue Save Part button.
9. Add this item to the shopping cart by clicking on the brown shopping bag icon. A pop-up window will appear.
10. Fill in the date needed, quantity type, category.
11. Check the box to the left of Replenish Inventory if this item is being reordered to replace something that was used from general inventory for a patient.
12. If the part is either high priority or needs to be placed on hold, check the boxes indicating this.
13. Select the shipping method from the list.
14. If any notes to the supplier or internal staff are needed/required, insert these notes in their respective text fields.
15. Click the blue Send to OPIE Lite Shopping Cart to save the order.
16. A part description may be removed by highlighting it in the list under the Parts section on the form and clicking on the blue Remove button.

In-House Fabrication Work Order

1. Under the Clinical Visit Type folder, click on the Click here to add a new form link.
2. Select the appropriate fabrication Work Order from the drop-down list.
3. Click the blue OK button.
4. Fill out the required information using the text fields, check boxes and drop-down lists.
5. Once the form is filled out with all of the necessary information, click the Save and Send for Fab button at the bottom of the form.
6. A pop-up window will appear asking who the job is assigned to, when it is due, the status and any additional notes that can be typed into the field provided.
7. Once sent, the Save and Send for Fab button will disappear and in its place will be the date that the order was sent to Fab.
8. Click SAVE.

C-Fab Tracking

C-Fab Tracking is used for outsourced fabrication. Measurements may be needed in addition to placing the C-Fab Tracking order.
1. Open a measurements form under the Clinical folder.
2. Enter all of the measurements and click SAVE.
3. Print the measurements to PDF using CutePDF or another version of PDF writer and save in a file on the computer.
4. Open a C-Fab tracking form in the Clinical folder and attach the PDF of the measurements in the Scan 1 tab of the C-Fab Tracking form.
5. If filling out a paper form, have the administrative staff scan a copy of the paper form into the Scan 1 tab of the C-fab tracking form for the appropriate patient.
6. In the C-Fab tab, fill in the appropriate information.
7. Click the blue Send to OPIE Lite and Fab Tracking button.
8. A pop-up window will appear. If notification of when the device arrives is desired, check this box. Enter the shipping information and preferred shipping method.
9. Click Send.
10. Print a copy of the C-Fab tracking form so the Purchase Order will be ready and associated with the workorder to be sent to the central fabrication company by fax, phone or email.
11. Click SAVE and CLOSE.

Practitioner Notes

Practitioner Compliance notes are added from the Practitioner Home Screen in the My Compliance Overview Tab.

- In the My Compliance Overview tab of the Practitioner Home screen, any patient that has not had notes entered will have a red triangle to the left of their name.
- Click once on the patient’s name to highlight it and click the blue Create this Note button.
- Enter the notes in the text field provided. The typed note can be saved as a template by clicking the blue Save this note as a template button.
- A note template can be selected by clicking on the Select a note template button.
- Select a template from the Template Title list in the left pane and then click ACCEPT.
- If the note is complete as is, nothing else needs to be done. Click the SAVE button in the lower right corner.
If the note needs to be reviewed, uncheck the Complete box. The Needs Review box will appear. Check this. The following link is a help topic on how to review residents’ notes compliance:
http://www.oandp.com/opie/help/topics/review_residents_notes.asp

Notes can also be created through the use of dictation.

To get started with OPIE’s dictation function to record notes, call us at 800-876-7740, option 3, 3 or email us at opiesupport@oandp.com to have this function added. Headphones or a microphone that plugs into the microphone jack on the computer is needed to be able to record the dictated note.

Instead of typing the note as in the directions above, click on the blue Outsourced Dictation button underneath the section for the written note. Click the blue New Dictation button, and then click Record, the button with the black dot.

Once finished recording the message, click the Stop button, the button with the black square. The recording can be played back, deleted or re-recorded.

Once the recording is satisfactory, click the blue Mark Dictation as ready for upload button. The dictation will be transcribed overnight and uploaded the following day automatically. To see if the file has been uploaded, look at the practitioner compliance screen. A file that has been marked for upload will have a yellow square with a red triangle in the bottom right corner [Marked for Upload]. OPIE will auto-upload the file for transcription (it sends files numerous times a day) and once the file has been uploaded, OPIE will mark the file with a yellow square with a black triangle in the bottom right corner [Uploaded]. Once it has been transcribed and auto-uploaded, OPIE will mark the file with a yellow square with a black triangle in the bottom right and a black R in the center [Imported Needs Review] indicating that the file has been imported and needs review.

Highlight the note and click the blue View this note button. If the file is found to be acceptable, click Save and the file will be marked as complete [Complete]. If the note needs changes, make the changes manually and then mark the file as complete. The note can then be printed and saved.

1. **Note:** To see a short (5-minute) video on using OPIE’s dictation function, access the video tutorial with the following link (Ctrl + click left mouse button to follow link): Demonstration of OPIE Integrated Dictation/Transcription

**Patient Checkout Responsibilities**

**Schedule Patient for Return**
1. When the practitioner is done seeing a patient, the method that will be used to communicate with the check out scheduler at the front office will be the use of the Schedule Appointment reminder form. This form established the time frame needed for the next appointment based upon the clinician’s knowledge. This also establishes a documented list of reminders for the patient to take home. When the form is printed by the clinician, it establishes communication between the practitioner, check-out clerk and patient. This form will advise the amount of time before the next appointment and how long the appointment should take.

2. Double-click in a time slot on the Graphic Schedule to add the appointment.

3. Click the drop-down arrow to select the patient or begin typing the last name to auto-fill the Patient Name field.

4. Fill in the prescription and visit type from the drop-downs and click Save.

5. Double-click on the appointment block to reopen it and then click Jump to Patient to open the patient’s record.

Patient Financial Counseling

When providing financial counseling to patients, it is important to make sure all of the insurance verification information was entered correctly or the patient’s financial responsibility will be incorrect. The L-codes need to be selected as well prior to the creation of the Patient Financial Counseling form. This form pulls information from the Benefits payable, Balance, Out of pocket, Remaining, Annual Max and Annual Remaining fields of the Specific tab in the Insurance Verification and also from the Service Estimate. It is important when working in the Financial Responsibility form that text is not entered into dollar fields (even if pulled from the Insurance Verification form) and that navigating from field to field is done in order (using the tab key).

Service Estimate
• Under Administrative Documents, click on the Click to add a new form link.
• Click on the blue Browse button.
• Select Service Estimate.
• Click the blue OK button.
• Select the desired L-Code selection from the list toward the top of the box (there may be only one selection if there has only been one visit).
• Click the Select button at the bottom of the form.
• The Service Estimate will appear with the selected L-codes listed. Select the ins/Medicare info from the drop-down list.
• Select the physician name from the drop-down list.
• If there is an additional amount, select this from the drop-down towards the bottom left of the form.
• Click the SAVE button at the bottom and click the blue OK button when the yellow pop-up appears.
• Under Administrative Documents, click on the Click to add a new form link.
• Click on the blue Browse button.
• Select Financial Responsibility.
• Click on the blue Import from Svc Estimate / Ins Verification button.

1. **Note:** A user may choose to manually enter all of the information in this form rather than importing from the Service Estimate or Insurance Verification. A user may also choose to import information from only the Service Estimate or only the Insurance Verification. If only one of these is chosen, the user will need to manually enter the rest of the applicable information.

   • A yellow pop-up will appear indicating that selecting this function may overwrite data that is already entered into the Financial Responsibility Form.
   • Click the blue OK button.
   • Another pop-up will appear asking user to choose a Service Estimate to import starting fees.
   • Click on the Service Estimate in the upper portion of the form. This will populate the L-codes into the Selected Codes area.
   • Click on the desired benefit in the next section to import from the insurance verification.
   • Click the Select button.
   • The fields of the Financial Responsibility form will now be populated with information from the Service Estimate and Insurance Verification.
   • If there is any text in these fields rather than dollar amounts, delete the text.
   • Add any notes in the Notes for print-out box on the right of the form and click the blue Save Changes to Note button beneath it.

6. Click the SAVE button at the bottom of the form.

**Financial Responsibility Form**
This form helps you calculate the patient's portion of a device/service, provide a printout to the patient, and capture their signature agreeing to their financial responsibility. It can also be used as a method of tracking payments made by that patient prior to delivery. We strongly recommend that you review this help page to understand what the form is designed to do and how to best use it.

Calculating the patient's financial responsibility:
Once you have filled out all the white boxes in the number column on the form, or checked N/A as appropriate, the form will calculate the patient's portion in the third line from the bottom, and then will split it based on the percentage down and percentage due on delivery (note that you can change the default percentages under Admin Tools). You must have all of the boxes filled in or marked as N/A in order for the form to calculate correctly!

Note:
- Boxes marked as N/A on the form will not show on the printout.
- The Out of Pocket Max and Annual Benefit Limit Fields will only appear on the printout if they actually affect the balance. This keeps the printout as simple as possible so that it is easier for your patients to understand.
- If the Annual Max Benefit is unlimited, the N/A column should be checked. Populating the Annual Max Benefit field with Unlimited will cause the form to not calculate correctly.
Importing data:
Although you can fill in all boxes manually, this form is designed to import the starting value from a Service Estimate, and the other values from the Specific tab on the Insurance Verification 3.0 form. If you fill out these forms in advance and then hit the import button on the Financial Responsibility form and select the appropriate forms, all of the numbers will be filled in automatically and the form will calculate the patient's portion immediately. The document label in the Import selection screen allows the user to verify that the correct verification is being used. View this screenshot of the Specific tab on the Ins Ver 3.0 form to see which fields are imported from that form. If the Annual Max Benefit is unlimited, the N/A checkbox should be checked. Populating the Annual Max Benefit field with Unlimited will cause the form to not calculate correctly. On the Service Estimate, the only value that comes over is the total which is entered in the first box on the Financial Responsibility form.

Self Pay:
Checking this box removes the insurance fields and carries the full balance down to the bottom of the form. This allows you to still use this form to capture a patient’s signature and/or track payments against the balance prior to delivery.

Secondary and supplemental insurances:
Combining benefit information for primary and secondary insurances can be complex, but the form includes several features to try and help with this process so that you can provide an accurate picture of the patient’s financial responsibility. Next to the deductible and coinsurance fields, there are checkboxes that say "Covered by Secondary." If the deductible and/or the coinsurance will be covered by their secondary policy, you can simply check these boxes and the field lower down on the form that displays the secondary insurance contribution will be filled in automatically and locked. If the coverage provided by the secondary insurance is more complex than simply covering the deductible and/or coinsurance, then you can leave these boxes unchecked, calculate the secondary insurance contribution separately, and then simply fill that number into the secondary insurance contribution box manually.

Print the form for the patient to review/sign:
The printout for this form is designed to be given to the patient to help them understand their financial responsibility. As soon as you print the form, the Financial Counseling column on the WIP will turn yellow, and it will turn green when you have either scanned the form back in or captured a digital signature (on the second tab). If your facility opts to not have patients sign this form, you will have to mark the Financial Counseling column green manually (or just leave it at yellow).

The notes field in the lower right corner of the first tab will appear on the printout. If you make changes to that notes field after the form is originally saved/printed, those changes will be tracked in the Internal Notes field on the second tab, so that you have a history of what information was provided to the patient on the printout.

Customizing the header and footer:
You can customize the text that appears at the top and bottom of the printout to match your facility's policies. This is done under Administrative Tools > Office Settings > Custom Text Blocks.

Tip:
Home screen indicator for open balances: On the Administrative Home Screen in OPIE (List Scheduler) a new dollar sign
indicator will appear next to any patients who have an open balance on a Financial Responsibility Form. Once the patient is selected, the total balance from all open Financial Responsibility forms will display in the lower right.

**Tracking payments:**
Payment tracking is an optional feature that helps you manage patient payments that you accept prior to the delivery of the device. This is particularly important for practices who use OPIE Billing & Collections, because the claim does not appear in OPIE Billing until delivery and thus there was previously no easy way to track whether a patient had paid their deposit or not from within OPIE. Please note that payment tracking via the Financial Responsibility form is NOT tied to a claim that will later be created in OPIE Billing. The form simply provides a method to track whether payments have been received and whether there is an outstanding balance on the deposit, and then those payments will still have to later be posted to the claim in OPIE Billing.

**Locking the form before entering payments:**
You must lock the form before entering any payments. This will prevent you from changing any of the numbers on the first tab which would interfere with the payment tracking. If you realize after entering payments that the numbers were incorrect, you will need to cancel the form by hitting the "Deactivate" button on the first tab, and then create a new one.

**Entering payments into OPIE Billing & Collections:**
If your facility uses OPIE Billing, you will see an option on the popup for entering a payment that allows you to also copy the payment to OPIE Billing. This is simply a way to avoid the step of separately going into OPIE Billing and entering the payment there. You will still have to later post that payment in OPIE Billing once you have a claim to post it to (after delivery).
Deactivating a form:
The Deactivate button on the first tab will add a "Cancelled" label to the form in the left pane, and will also cause the balance to not be counted in the home screen indicator discussed below. You can deactivate a form that is no longer valid, and you may also choose to deactivate them once the device is delivered, since the claim will be tracked in OPIE Billing & Collections (or an alternative billing system) at that point.

ABN v3.0 (Medicare 2012)

ABN v3.0 is OPIE's newest version of ABN form CMS-R-131, which was issued by CMS in 2011 with a mandatory use date of January 1, 2012. Medicare states that use of any other form than the ABN FORM CMS-R-131 will result in claim rejection. OPIE's ABN v3.0 form generates a PDF file that exactly matches the ABN form CMS-R-131. However, because the new ABN v3.0 exactly matches ABN form CMS-R-131, and does not contain an expanding code/descriptors field, there is a limited amount of space for inputting device codes and descriptors which can cause issues with printing if certain guidelines are not followed. The limitations and guidelines are listed below:

Instructions for ABN v3.0 form:

Note: Only use six codes or less per form. If you use more than six codes per form, it will cause the text to run off the specified block where it is supposed to appear on the printout, and thus will not be CMS compliant.

2. Open the ABN v3.0 form.
3. A pop-up will appear asking the user to pick an L-Code selection to use.
4. Select the L-Code selection the ABN applies to and the associated fee schedule.
5. Enter a short device descriptor. There is a limit of 15 characters for this. This descriptor is what appears in the option boxes in section G that the patient selects from.

6. Check the first code in the list and click the blue Edit Selected Code button.

7. Select a reason Medicare probably will not pay for selected code from the drop-down and click the blue button with three downward-pointing arrows. This will move the reason into the lower frame. If the appropriate reason does not appear in the drop-down list, add a new one by clicking on the blue+ button.

8. Because the CMS limits code descriptions to 30 characters or less, enter a Description for Printout beneath the Estimated Cost field. This appears to the right of the L-Code in section D on the printout.

9. Add any relevant additional information in the bottom text frame (appears in section H on the printout) which might include:
   - A statement advising the beneficiary to notify his/her provider about certain tests that were ordered but not received
   - Information on other insurance coverage for beneficiaries, such as a medigap policy, if applicable
   - An additional dated witness signature; or
   - Other necessary annotations

10. When finished entering information for the selected code, click the blue Update Selected Code button.

11. Repeat the steps above for all codes that the ABN should cover and when finished click Save and click the Print PDF Report button for a printout.

Click here for CMS guidelines on completing an Advance Beneficiary Notice then scroll to page 16 to see the instructions for the ABN.

After much discussion, we have decided to leave the ABN v2.0 form active. This form does not comply with Medicare standards but can be used when submitting to non-Medicare insurance companies. The main reason for this decision is that checking the Print as non-Medicare insurance box on the ABN v3.0 form does not cause the information regarding Medicare to be removed on the printout. The Print as non-Medicare insurance checkbox is checked by default on the ABN v2.0 form. This form is also more user-friendly since the code/descriptors field is expandable and the submitter does not have to worry about space concerns. When browsing through form options for the ABN form, be aware that both the ABN v2.0 and the ABN v3.0 will be options to choose from.

Insurance Authorization
1. Under Administrative Documents, click on the Click here to add a new form link.
2. Click on the blue Browse button.
3. Select Insurance Authorization v2.0 from the list of available forms.
4. A pop-up will appear asking user to pick an L-Code selection to use.
5. Highlight the appropriate L-Codes listed and click the Select button at the bottom of the pop-up.
6. Click the blue Update Form with Current PT Info button on the right side of the right pane.
7. Click the blue Select Insurance button on the right side of the right pane. This will populate the information from the insurance verification form.
8. Only click the blue Update form with current Rx Info button if the prescription information has changed.

9. Once specifics regarding the authorization have been documented on the Ins. Auth tab, check the Auth Complete button on the bottom of the page. This will turn the Insurance Authorization tab in the WIP green.

10. Click the SAVE button at the bottom of the right pane.

Once the insurance authorization is completed, the user will then be able to calculate the patient financial responsibility and begin the patient financial counseling documents.
1. Under Administrative Documents, click on the Click to add a new form link and choose Detailed Prescription from the drop-down list.

2. Click the blue OK button.

3. A pop-up will appear asking user to choose an L-code selection to use.

4. Highlight the appropriate L-code and click the Select button.

5. Choose the appropriate K-level to attach to the L-codes using the drop-down list for that section (this is a Global Data field that is selected at the evaluation stage by the practitioner. It should already be filled in for prosthetic patients and should auto-populate. If it is not auto-populating, the clinician is not selecting a K-level appropriately at the evaluation stage. K-levels are NOT needed for orthotic patients).

6. Select the appropriate Projected Monthly Frequency and Estimated Length of Need using the drop-down lists. If the appropriate response is not listed in these drop-down lists, additional responses may be inserted by clicking the blue+, typing the new response into the space provided, clicking Add/Edit and then Close.

7. The diagnosis and ICD-9 code(s) are automatically populated into this form.

8. The start date is automatically populated as the date the prescription was created but can be changed if necessary.

9. Select the insurance/Medicare info using the drop-down list.
10. Select the physician from the drop-down list. The address/phone information will automatically populate upon selection.

11. In the bottom right corner, there are several printing option selections to choose from. Check appropriate boxes.
   a. The printing option, With Fee/Allowables, will print both the fee and the allowable amount on the Detailed Prescription printout. If the fee/allowable should not print, uncheck this option.
      i. The Allowable (Each) column will be populated by the practice’s default allowable fee schedule.
      ii. The Charge (Each) column will be populated by the practice’s selected default billed fee schedule.
   b. There are three Print Title options: Detailed Product Description, Detailed Written Order and DWO and LMN (Detailed Written Order and Letter of Medical Necessity). See the screenshot below.

12. Click Print to Print the Detailed Prescription. This document may then either be printed for hard copy or electronically faxed (preferred paperless method) to the referring physician.

13. Click SAVE. At this point, the WIP icon for this task will be a yellow square, indicating that the signed detailed prescription has not been received yet.

14. Once the signed Detailed Prescription is received, scan it to a file on your computer.

15. Open the Detailed Prescription and click on the second tab (Signed Detailed Prescription 1).
16. Click on the blue Attach File button, select the file from the computer by double-clicking on it.
17. Click SAVE.
18. This will cause the WIP icon to automatically turn green with a paperclip, indicating the document is attached.

**Diabetic Verification**

This form will need to be filled out if the patient has been diagnosed with Diabetes mellitus and is obtaining diabetic shoes and inserts.
1. Under Administrative Documents, click on the Click to add a new form link.
2. Click on the blue Browse button.
3. Select Diabetic Verification Form from the list of available forms.
4. Under item 2, select all conditions that apply to the patient.
5. Select the insurance/Medicare Info using the drop-down list.
6. Select the physician using the drop-down list.
7. Select the K-Level using the drop-down list.
8. Click the SAVE button.
9. Once the signed Diabetic Verification form is received, scan it to a file on the computer.
Letter of Medical Necessity (LMN)

A Letter of Medical Necessity should come from the patient’s physician and should clearly state the medical reasons for the patient’s need of the orthotic device. The letter should include:

- Practitioner’s name and contact information
- Patient's name, date of birth, evaluation date and diagnosis
- Patient’s functional challenges that are being addressed
- Orthotic type/style and reasons why it was chosen
- Expected functional improvement of patient after treatment and expected duration of improvement
- Practitioner’s signature

1. If an LMN is required for a patient, open the Detailed Prescription form.
2. Under Printing Options, check the With Rx and Med. Necessity Header option.
3. E-fax to the referring physician (follow instructions under Detailed Prescription).
4. Once the signed LMN is received and has been attached to the Patient’s file in OPIE (follow instructions under Detailed Prescription), go into the Clinical Visit Type folder and click on the Click here to add a new form link.
5. Click Browse and select the LMN Scan form.
6. Click the blue Attach File button and select the file to attach and double-click on it.
7. The Document Received box will automatically check when the document is scanned and the WIP icon for LMN will automatically update with a green orb with a paperclip in it, indicating the document was received and attached to the patient’s file.
8. A customized Letter of Medical Necessity may be required for some insurance companies and the Detailed Prescription may not suffice.
9. L-Code Justification also creates a Letter of Medical Necessity.

**Physician Notes**

Physician notes should be added using the Physicians Scanned Notes form.

1. Under the Clinical Visit folder, click on the Click here to add a new form link.
2. Click the blue Browse button and select Physicians Scanned Notes from the list of available forms.
3. Notes Requested is the default selection under Physician Notes Compliance. If the notes satisfy the requirements, click the Satisfies Requirements selection.
4. Any notes about the compliance can be added to the Notes section in this form. To add notes, type them into the text field located at the bottom of the form and then click the blue Add to Note button.
5. To attach a file, click the blue Attach File on the right side of the right pane.
6. Double-click on the file you would like to attach and click SAVE.
7. There are 6 tabs for Scanned Documents and two files can be attached to each tab.
8. To view the document, image or listen to the audio attachment (.docx, .pdf, .jpg and .wav files can be used), click the blue View button.
9. If a file is attached in error, it can be deleted by clicking the blue Delete button.
10. Click Close to exit the form.

**Practitioner Delivery Process**

**Delivery Receipt**

Once the L-Codes and justifications have been added and the patient is fitted with the final prosthesis or orthosis, the delivery receipt is ready to be printed for the patient.
1. Under the Clinical Visit folder, click on the Click here to add a new form link.
2. Click the blue Browse button and select Delivery Receipt from the list of available forms.
3. Highlight the desired L-code selection to add to the delivery receipt and click the Select button.
4. Add any notes to the biller in the text field provided.
5. In the drop-down list under who will sign, choose the person responsible for signing the delivery receipt and include their relationship to the patient in the Relationship field.
6. To select the componentry information to add to the Delivery Receipt, click the Edit/View button to the right of the Component Info button. The popup that appears will list all of the parts added in the current prescription and will allow the user to pull that information into the Delivery Receipt.
   a. To use the Select Components form, either check one or a few of the components or select all of them by clicking the Select All button then click the button with three downward-facing arrows to add them to the Description field and click Ok.
   b. The componentry information also appears on the printout.
7. Print and Save. Select the printer at the check-out window where the patient will be seen by the check-out clerk. This sends the L-Codes to billing and prepares the check-out clerk to obtain a signature for delivery from the patient as they leave the check-out area.

8. The Delivery Location appears on the printout. It defaults to the appointment location; however, the location can be changed by clicking on the Edit/View button to the right of the Delivery Location field. Select the appropriate delivery location and fill out any other pertinent information, then click OK.

9. If the check-out clerk will obtain a digital signature, they should provide the patient with the copy of the paper delivery receipt that was printed by the practitioner as their copy.

10. Click the button next to Digital Signature for the Signature Type.

11. If a digital signature will be collected, the check-out clerk will click the Start button and then either the Patient or Guardian will sign the digital signature pad. Once they have finished their signature, the check-out clerk will hit Stop, and then SAVE in the lower right corner.

12. Check the Print with Justifications box so that the L-code justifications will show on the printout. Print a copy for the patient to keep for their own records. The Treating Practitioner also displays on the printout.

**Patient Education**

The Facility/Patient Documents form is used to provide the Patient Education documents and will include everything from information about their device/treatment plan to facility documents regarding fee payment.

1. Under the Clinical Visit Type folder, click on the Click here to add a new form link.

2. Select Facility/Patient Documents in the drop-down list and click the blue OK button.
3. The Date Provided and Provided By fields will be auto-populated with the current visit information.
4. Select the individual the documents will be provided to using the drop-down list.
5. To add files, click the blue Add File button.
6. Select all pertinent files from the list and click the blue Add Files button. If more than one document is needed from the list, click Ctrl and the left mouse button to select more than one file at a time.
7. If the patient is to sign paper documents rather than digitally sign, click the Add and Open Files(s) to Print button. If paper documents are being signed, we suggest scanning and attaching them to the Patient Visit Scan tabs.
8. Check Digital Signature and click the Stop button after the patient has digitally signed.
9. Click the Print Patient Receipt button at the bottom of the form to print the documents for the patient.
10. Adding a scan, attachment, or checking the document received checkbox on the Physicians Scanned Notes form will automate the Physician Scanned Notes WIP column to yellow.
11. When the "Notes satisfy requirements" checkbox on Physicians Scanned Notes form is checked, the Physician Scanned Notes WIP column will automate to green.
12. Click SAVE and CLOSE.
Schedule Follow-up Appointment

1. Under the Clinical Visit Type folder, click on the Click here to add a new form link.
2. Select Schedule Appointment in the drop-down list and click the blue OK button.
3. Click the blue OK button.
4. Using the drop-down lists, select the appropriate parameters for the appointment.
5. Select Follow-up in the drop-down list for Schedule Appointment For.
6. If the patient will be called for an appointment, select “We will call you” or if the patient is to be seen only as needed, select “As needed (prn).”
7. The last two fields are where the appointment comments are generated. The larger text field may be typed directly into or pre-defined comments may be generated using the last field on the form.
8. Using the drop-down list, select a pre-defined comment and click the blue Add Comment to this Appointment button. This will add the comment to the larger text field above, which is what appears on the printout.
9. To add comments to the drop-down list, click the blue+ to the left of the Commonly used comments field, type it in the space provided, click Add/Edit and then click Close.

Patient Complaint Log
The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services. Service, equipment and billing complaints will be communicated to management and upper management. These complaints will be documented in OPIE’s Medicare Beneficiaries Complaint Log, and completed forms will include the patient’s name, address, telephone number, health insurance claim number, a summary of the complaint, the date it was received, the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint.

All complaints will be handled in a professional manner. All logged complaints will be investigated, acted upon, and responded to in writing or by telephone by a manager within a reasonable amount of time after receipt of the complaint. If there is no satisfactory resolution of the complaint, the next level of management will be notified progressively and up to the president or owner of the company.

The patient will be informed of the complaint resolution protocol at the time of set-up of service.

1. Under Administrative Documents, select the Patient Complaint Log form in the Browse list of forms.
2. Click OK when the Protocol for Resolving Complaints from Medicare Beneficiaries popup appears.
3. Select the appropriate health Insurance Claim Number in the drop-down.
4. Is the patient a Medicare Beneficiary? Select Yes or No.
5. Include a detailed description of the complaint in the Description of Complaint field.
6. Include a detailed description of the complaint in the Action taken to Resolve the Complaint field.

Scan any documents or images pertinent to the complaint directly into OPIE via the Scan tab on the Patient Complaint Log form or attach them if they are already saved in a file on the computer.

Patient Satisfaction Surveys

Patient satisfaction surveys have become an increasingly important factor in accreditation requirements and providing quality care to patients. We have recently upgraded the Quality Outcomes integration to include tools that will better help you manage your surveys and ensure that a survey is provided to every patient you see who has a new prescription containing a qualifying base code in the L-code selection. Below are instructions on how to use the patient satisfaction surveys. If you have any questions about this tool, please send us a feedback through OPIE.

List of HCPCS Codes that Generate Surveys

Patient Satisfaction WIP Automation

There is a fully-automated Patient Satisfaction column in the WIP screen. It turns yellow when Lcodes are delivered and a patient satisfaction survey is created. It turns green if there is an email address for the patient and a survey is created. If the code or print box is checked on the Patient Satisfaction Survey form or if the survey was resent by email, the WIP will turn green.
How Surveys are sent to the Patient

The patient satisfaction survey is sent to the patient either by way of the Send to Bill checkbox on the Delivery Receipt or by clicking the Create Survey button on the Delivery Receipt (this was added for instances where a delivery is not sent to bill but a survey still needs to be sent to the patient). If you would like to default the Send to Bill on Save checkbox to checked, go to Administrative tools → Office Settings → Misc Settings and make sure the “Do not auto-check Send to Bill on Save” setting is unchecked (see screenshot below).

Send a Survey to the patient automatically when the delivery receipt is sent to bill

Below is a screenshot of the Delivery Receipt form. In order for OPIE to automatically send the survey to the patient, the Send to Bill on Save checkbox must be checked.
Please note also that a survey will be sent automatically only when the Send to Bill on Save checkbox is checked on the Delivery Receipt if the prescription is NEW and contains a qualifying base code - OPIE will only send one survey per prescription. When the Delivery Receipt is sent to bill and a Patient Satisfaction Survey is created, the Patient Satisfaction WIP icon will turn yellow.

If a survey is not required, either because a qualifying base code was not present, or a survey was already sent to the patient on that prescription, the software will display an orange orb with a question mark in it next to where it says, “No survey required.” Click on this orb to find out why the survey was not required. OPIE will tell the user that either a survey was already sent to the patient on this prescription or that the L-code selection does not contain a base code.
If the survey was sent to the patient, OPIE will display the date that the survey was provided to the patient.

**Send a Survey to the patient without sending the delivery to bill**

Occasionally, a survey might need to be sent to a patient who received services but the item does not have to be billed. To do this, make sure the Send to Bill on Save checkbox is not checked and click the Create Survey button to send the survey to the patient.
Patient Satisfaction Node

When a survey has been created, a new Patient Satisfaction node will appear in the left pane (see the screenshot below). The number to the right, in this case, a zero, indicates the number of surveys received back from the patient. This does not indicate the number of surveys sent.

For instances where a survey cannot be automatically sent with sending the Delivery Receipt to Bill, i.e. the patient’s email address is not in OPIE, they require a printed survey, etc., this can be done manually by clicking on the survey link.
in the Patient Satisfaction node in the left pane (see screenshot below):

If there is a check in the box at the left of the survey information, it is your indication that the patient response has been recorded in Quality Outcomes.

Survey Sending Options in the Survey Delivery Screen

When the survey link is clicked, the Survey Delivery screen will open. This screen allows other options for providing the survey to the patient and a way to activate the WIP row if the survey cannot be sent to the patient via email. There is also an option to update the patient’s email address on this screen and resend the survey, as below.
Option 1 is where the patient’s email is updated and the survey is resent, if necessary. Note that the screen will show that the survey was emailed. If the patient’s email address is updated and the survey resent, this information will be updated there as well.

Option 2 shows the survey code specific to this prescription. This code can be supplied to the patient and they can enter the code at www.surveycare.com to begin their survey. If this code is provided to the patient, check the Survey code provided to patient box to the right of this option. This is very important! This turns the WIP icon green for the Patient Satisfaction column.

Option 3 provides the option to print the survey for the patient. Just click the Print this Survey button and then check the Printed survey provided to patient box to turn the Patient Satisfaction WIP icon green. When the Print PDF button is clicked, the “Print Survey Provided” will be autochecked.

When you receive the survey back from the patient, enter the results by clicking the Enter Survey Response Now button. Once the survey has been entered and completed, click the Check for Survey Response button.

Send a Patient Satisfaction Survey in Spanish

The Quality Outcomes integration now includes a Spanish version of the Patient Satisfaction Survey. To use this functionality, a patient’s language must be set to Spanish on the Patient Information form. A patient with their language set to Spanish will:

- Receive the survey notification email in Spanish
- Be able to take an online survey in Spanish (or switch it to English via a toggle switch on the survey form)
- Be able to have a printed survey in Spanish

Online surveys can be toggled between English and Spanish when taking the survey. The following surveys are available in Spanish:

- Compression Garment PSS
- Orthotic PSS
- Prosthetic PSS
- PSS Services
- Mastectomy PSS
- Footwear PSS

If a survey is not available in Spanish (or any other language), it will be presented in English.
Upgraded Quality Outcomes Accounts

Upgraded Quality Outcomes accounts contain additional functionality that helps practices monitor their survey scoring and an opportunity to view the patient’s comments/suggestions directly from OPIE (see the screenshot below). On this screen, the Patient Satisfaction Score is available and the comments as well as the score achieved. There is also an option to view all survey responses by clicking the View Survey Response Details button at the bottom of this screen.

Sentry checks for returned surveys multiple times per day, so this process is automated.

In the Patient Satisfaction node in the left pane, the survey percentage achieved appears to the left of the survey information, allowing for easier result tracking.
Home Screen

Click on the Home icon in the OPIE toolbar to go to the Home screen. From this screen, the user will see different tabs based on permissions set by the OPIE onsite Administrator. Based on a user’s permissions, they will be able to send and receive messages through OPIE, view and set Patient Schedule information, see outstanding dictations, view compliance information and manage Fab Tracking.

1. An OPIE onsite Administrator, who has full rights, will have the following tabs: Messages, Patient Schedule, Note Dictations, Compliance and Fab Tracking.
2. A Practitioner/clerical user who also has full Admin rights will have the following tabs: Messages, Patient Schedule, Note Dictations, Compliance and Fab Tracking.
3. A Practitioner or resident without Admin Rights will have the following tabs: Messages, My Patient Schedule, My Compliance Overview and Fab Tracking.
4. An Administrative/Clerical user who does not have Admin Rights will have the following tabs: Messages, Patient Schedule, Note Dictations and Fab Tracking.
5. A Technician will have the following tabs: Messages, Patient Schedule and Fab Tracking.

Messages

The OPIE Messages system simplifies messaging from practitioners to staff members by giving the practitioner easy access to their entire list of patients and staff instead of having to look this information up and key it into an outside email source. Messages can easily be sent to multiple people or groups and custom groups can be defined within Administrative Tools. Group messages will work separately now so one user reading or filing a message will not affect other users. Messages can also be viewed by patient via an envelope icon on the patient name bar in the left pane.

1. To send a message, click New.
2. If the message is related to a specific patient, click Select a Patient. A drop-down list will appear from which a patient can be selected. The patient’s name can be typed and it will display in the field and from there, press Enter to select the patient.
3. To send a message unrelated to a patient, select None.
4. The body of the message can either be typed manually or pre-defined message text can be selected from the drop-down list beneath the Body of Message text field.
5. To add an attachment to the message, click the Attachment button located in the upper right of the Message form. Double click on the file to attach it. To remove the attachment, click the Remove button, which replaces the Attachment button after the file has been attached.
6. To select pre-defined message text within the drop-down, click on the applicable message to select it then click the blue button with the three upward-facing arrows above it to move the text to the Body of Message field above.
7. To add a pre-defined message to the list, click the blue+ button to the right of this drop-down.
8. The message body can be a combination of contents that are typed manually and selected from drop-down. After selecting a pre-defined message from the drop-down list and adding it to the message body, click inside the text field to begin typing. Be aware that pressing Enter after selecting a pre-defined message text will add the message text again.
9. To add recipients of the message, either type the name of the recipient in the Add Recipients field and press Enter or double-click on their name in the list to add them to the Current Recipients list. To send the message to a group, click Groups and select a group from the list. Message Groups are formed by your site administrator in Administrative Tools.

10. If the practitioner wishes to receive a copy of this message, check the Send to Self box.

11. To send the message to an external email address, check the Send to External Email box. A drop-down will appear with a list of email addresses to choose from. If the email address is not in the list, add it by clicking the blue+ to the right of this drop-down, adding the email address in the space provided and clicking the Add/Edit button. The new email address will appear at the top of the list.

**Tip**

Create a custom group for messaging purposes in Administrative Tools by navigating to the Message Groups tab within Users. Click on the Create a New Group button, check users to add to the group, give the group a name in the Group Name field located at the bottom right and click Save.

Reminders and messages can be delayed to appear in a recipient's message box and e-mail inbox until a specific day by checking the Activation Date box and selecting the date you would like it to appear.

**Key Points to Know**

- OPIE automatically attaches the patient's identification number in the message so that patients with the same name are not confused.
- OPIE Messages will appear in the recipient's Messages tab within OPIE as well as their e-mail inbox.
- OPIE Reminders are messages that are sent to yourself. They are not appointment reminders for patients.

**View Messages by Patient**

Messages can be viewed by patient in chronological order using the instructions below.

1. Click on the Messages by Patient envelope icon located in the patient name bar in the left pane.

2. Then, click the Date column header once or twice, to display the messages in chronological order.
Send a Reminder

OPIE reminders are reminders that are sent to yourself, on which another user can be copied. These are useful for reminding yourself to perform certain any kind of task, patient-related or not. The instructions listed below outline the process of sending a reminder.

1. Open the patient record for which a reminder should be generated.
2. On the OPIE Toolbar, click on the Send Reminder icon (the fourth icon).
3. When the OPIE Reminder function is opened outside of patient files but the reminder is related to a specific patient, the patient will have to be selected.
4. The body of the message can either be typed manually or a pre-defined message text can be selected from the drop-down list beneath the Body of Message text field.
5. To select pre-defined message text within the drop-down, click on the applicable message to select it then click the blue button with the three upward-facing arrows above it to move the text to the Body of Message field above.
6. To add a pre-defined message to the list, click the blue+ button to the right of this drop-down, type the message in the space provided and click Add/Edit.
7. The message body can be a combination of contents that are typed manually and selected from the pre-defined text drop-down. After selecting a pre-defined message from the drop-down list and adding it to the message body, click inside the text field to begin typing. Be aware that pressing Enter after selecting a pre-defined message text will add the message text again.
8. To add recipients of the message, either type the name of the recipient in the Add Recipients field and press Enter or double-click on their name in the list to add them to the Current Recipients list. To send the message to a group, click Groups and select a group from the list. Message Groups are formed by your site administrator in Administrative Tools.
9. If the reminder is for another staff member, check Copy to my Email to receive a copy of the reminder.
10. The reminder can also be sent to an external email address by checking Send to External Email. A drop-down will appear with a list of email addresses to choose from. If the email address is not in the list, add it by clicking the blue+ to the right of this drop-down, adding the email address in the space provided and clicking the Add/Edit button. The new email address will appear at the top of the list.

11. When the message is ready to send, click the Send button at the bottom.

Patient Schedule/My Patient Schedule

Schedule an appointment from the List Schedule

1. Click on the Home icon under the OPIE Patient Management Software logo in the top left pane.
2. Click the desired date on the Calendar on the right, click the blue New button.
3. From the left pane, select Patient and click the blue ACCEPT button in the lower right.
4. Choose the practitioner in the “Scheduled For” drop-down list.
5. Choose the location using the drop-down list.
6. Choose the Branch from the drop-down list (it may be auto-populated).
7. Choose the Date, Room, Start Time and End Time using their associated drop-down lists.
8. Choose the Associated Prescription and Visit Type using the drop-down lists.
9. Add comments for the patient or appointment in the designated field.
10. The patient may be labeled as a walk-in or added to the waiting list using the check boxes below the Comments field.
11. Select a color label, if desired, for the appointment from the drop-down list to the right of “Color Label.”

Cancelled, Rescheduled and NC/NS Appointments in List Scheduler

Users can hide cancelled, rescheduled and NC/NS appointments in the List Scheduler by adding this setting under Change User Settings/Password. The setting for Show Cancelled, Rescheduled and NC/NS Appointments in the List Scheduler will default to match the user’s default setting in the Graphic Scheduler. This setting can be reset by following the instructions below.

1. Click on Change User Settings/Password under Other Tasks in the left pane.
2. Check the Show cancelled, rescheduled and NC/NS appts box.
3. Click Done.

Change the appointment status in the List Schedule

1. In the List Schedule, click on the patient.
2. Under Appointment Details, change the Sign-In Status to Showed Up.
3. Click the REFRESH DATA button at the bottom of the screen.

View all appointments for a patient

1. Highlight the patient in the schedule
2. Click the Show Pt. Appointments button
a. This shows a complete history of appointments for the patient
3. Click the Print Schedule button to print the patient’s appointment history

Print List Schedule

1. Click the Print Schedule button.
2. To include appointment comments on the printout, check the print w/ comments checkbox.
3. To include the patient’s phone number on the printout, check the print w/ phone# checkbox.

Note Dictations

The Note Dictations screen provides a way to view the status of all dictations currently in processing. Dictations can be uploaded from this screen or downloaded and imported.

To view Outsourced dictations, select Outsourced in the drop-down list at the top right corner of the right pane. To view internal dictations, select Internal in the drop-down.

Compliance/My Compliance Overview

L-Code Compliance Overview Screen

On the Administrative Compliance screen, Administrators can view a list of patients that were seen at a specific branch or all branches during a selected timeframe. This screen shows the status of patients with respect to authorization and Sent to Bill. Please note: this screen is a pre-WIP feature and OPIE best practice recommendations are to use the WIP for a more comprehensive visual display of your compliance tasks.

- The branch is selected using the Branch drop-down.
- The applicable date range is selected using the From and To drop-down date pickers.
- To manually update a column, click on a patient name to select it and then make changes as needed using the blue buttons at the bottom of the window.
- The Sent for Auth, Auth Complete and Sent to Bill columns are automated and will show the dates each of these tasks occurred next to the patient name. These dates are added automatically as the functions are completed in the patient’s record. Pressing the Auth Complete button at the bottom of the screen will input the current date. It does not supply a date picker to select a different date.
- The Date Billed, Pmt Posted and Cancelled columns will not show dates automatically because they are not connected to the Billing module and thus are not automated. Updating those columns by pressing the Billed, Payment Posted and Cancelled buttons at the bottom of the screen will only input the current date. Any changes made to these columns cannot be modified or undone.

My Compliance Overview

This screen appears for practitioners and provides a way to manage note compliance and review.
1. Refer to the Compliance symbols to view the status of the notes in the compliance list.
2. If a note needs to be entered, click on the patient to highlight it and click the blue Create Note button. If the note is complete, check the Mark note as Complete checkbox. This causes the compliance symbol to update to a green orb, indicating that it’s complete.
3. If the note is marked as Needs Review (usually because the practitioner who created it is a resident), click the View Note button. Changes can be made to the note, or if it is satisfactory, it can be marked complete and saved.
4. Check the Hide Complete Notes button to hide notes that are already complete.
5. Click the Show Last Name First to display the compliance list by patient last name.
6. If concerned that the patient’s full name is shown on this screen, click the Hide Names checkbox to display the patients’ initials rather than their full name.
7. The Rx Summary screen can be accessed from this screen. Click on the patient’s name to highlight it and then click the Rx Summary button.
8. Highlight the patient and click the Open Patient button to jump directly to their chart.

Set default number of days span in Practitioner Compliance
In the Practitioner Compliance screen, you can manually set the date range to view using the Show Compliance From drop-downs. But you can also set a default range.

1. In the Tasks pane, under Other Tasks, click Change User Settings/Password
2. Under Other Options on the right side of the Change Password window, type in the # days to show Prac Comp field, i.e., 5.
3. Click Done.
4. Practitioner Compliance will now default to a five-day span of time, ending with today.

**Return to Home on Note Save**

If you review a resident's notes, or frequently have several notes to complete in your Compliance, this setting will save some clicks.

1. In the left pane of OPIE, under Other Tasks, click on Change User Settings/Password.
2. Under Other Options, click the checkbox for Return to Home Screen on Note Save and click Done.

**Fab Tracking**

Fab Tracking is a separate screen, similar to the WIP and is accessed from the toolbar. It is the Clipboard icon (the last icon) in the toolbar.

As work-orders are placed, they appear in the Fab Tracking screen for maintenance and delegation.
Delegation of tasks

1. Click on a work order in the list to select it.
2. Click the blue Edit button to make any desired changes. For example, to assign this work order to a particular technician, select their name in the drop-down list under Assigned to.
3. To add notes for the technician, click the blue Add to note button, type note and click the OK button.
4. The status of the order can be updated using the drop-down list beneath Status.
5. To display or print the Fab form information, click the blue Display Fab Form Info button.
6. Assign a priority for the order using the drop-down list beneath Priority.
7. If the project is complete, check the Fab/Parts Complete (WIP) checkbox. This will turn the Fab/Parts icon green in the WIP.
8. Click the blue Save Changes button when finished making changes.

Keep the system up to date

Keeping the Fab Tracking system up to date requires manually changing the status of each order to reflect the current process and the name of the individual responsible for it at that time. Each change is logged at the bottom of the form. When the work order is complete, change the status to Ready to be fit.

Note: The Fab Tracking Auto-Generated Action Notes Field includes the user who made the status change:

Scanning Files

Direct Scan of Patient ID Images

Add/Save a face image
Adding a picture of the patient is useful for maintaining a good rapport with customers by being able to identify and acknowledge them by name. The following instructions are specifically for a direct scan of an ID card using a Canon DR2580C scanner. Patients under the age of 18 may not need a face/ID image scanned in unless one is provided by a parent/guardian or from a provider’s office.

1. On the General Info tab under Patient Information, click Add/Save a face image.
2. Click the blue Direct Scan button in the left pane.
3. Select the source. The name of the scanner being used (Canon DR2580C) will appear in the list. Click on this scanner and click Select.
4. Make sure the settings on the scanner are as follows for scanning an ID card:
   a. Mode: 24-bit color
   b. Page Size: Auto
   c. Dpi: 300
   d. Scanning Side: Simplex
   e. Feeding Option: Standard
   f. Check the Deskew box
g. Scanning Option: Scan ahead
5. Place the ID card in the feeder vertically and face up
6. Click Scan.
7. Once the image is scanned, rotate the image left or right by clicking either the Rotate Left or Rotate Right buttons so that the image will face the correct way.
8. Click ACCEPT.
9. To view the face image, click on the PT Info tab on the left screen.
10. Some patients will have a little head icon to the left of their name if the face image feature is being used.

**Add/Save Pt ID image**

This is where a scanned image of the patient’s Driver’s License or ID card should be added. Patients under the age of 18 should have a parent or guardian’s ID scanned.

1. Click Add/Save Pt ID Image.
2. Click the blue Direct Scan button in the left pane.
3. Select the source. The name of the scanner being used (Canon DR2580C) will appear in the list. Click on this scanner and click Select.
4. Make sure the settings on the scanner are as follows for scanning an ID card:
   a. Mode: 24-bit color
   b. Page Size: Auto
   c. Dpi: 300
   d. Scanning Side: Simplex
   e. Feeding Option: Standard
   f. Check the Deskew box
   g. Scanning Option: Scan ahead
5. Place the ID card in the feeder vertically and face up
6. Click Scan.
7. Once the image is scanned, rotate the image left or right by clicking either the Rotate Left or Rotate Right buttons so that the image will face the correct way.
8. Do not change the image compression.
9. Image Title and Image Description can be added but are not mandatory.
10. Click ACCEPT.

Scan a Prescription image/Dispensing Order into OPIE
1. From the Prescriptions tab in Patient Information, select the appropriate prescription from the list of prescriptions.

2. Click on the blue Add/Save Prescription Image.

3. Click on the blue Direct Scan button in the left pane.

4. Select the source. The name of the scanner being used (Canon DR2580C) will appear in the list. Click on this scanner and click Select.

5. Make sure the settings on the scanner are as follows:
   a. Mode: 24-bit color
   b. Page Size: Auto
   c. Dpi: 300
   d. Scanning Side: Simplex
   e. Feeding Option: Standard
   f. Check the Deskew box
   g. Scanning Option: Scan ahead

6. Place the paper vertically in the feeder and face-up.

7. Click Scan.

8. Click ACCEPT.

9. An image title and description may be added here.

10. Do NOT rotate or change the compression of the image.

11. Click SAVE PATIENT.

**Save a Video or Audio File to a Patient’s Record**
There are forms in OPIE that will allow users to save files of any type, including audio and video files, as well as documents, spreadsheets and image files of any type.

**Support Files**

1. Under the Clinical Visit folder, click on the Click here to add a new form link.

2. Click the blue Browse button and select Support Files from the list of available forms.

3. Click the blue Add File button and select the appropriate document from a file on the computer.

4. Click ACCEPT and then SAVE and CLOSE.

5. As many files as desired may be added to the Support Files using the same directions.

6. The files can be viewed in the Support Files either as a list or as icons. Use the drop-down list at the top of this form next to View to make the selection.

7. Any type of file (video, audio, image) can be added as well following the same directions.

8. To view the files, double-click on the file. They will open in the default external viewer associated with that file type.

**Scanned Documents**

1. Under the Clinical Visit folder, click on the Click here to add a new form link.

2. Click the blue Browse button and select Scanned Documents from the list of available forms.
3. To attach a file, click the blue Attach File on the right side of the right pane.
4. Double-click on the file to attach and click SAVE.
5. There are 6 tabs for Scanned Documents but only one file can be attached to each tab.
6. To view the document, image or listen to the audio attachment (.pdf, .jpg and .wav files can be used), click the blue View button.
7. If a file has been attached in error, it can be deleted by clicking the blue Delete button.
8. Click Close to exit the form.

Add Images to a Patient’s Record
The Images form now allows addition of images with Drag’N’Drop functionality, allowing users to drag one or multiple image files into or out of the Images form. When dragging out, copies of the dragged files can be dropped on the computer desktop or in a folder.

The Save button on this form is disabled until the first image is added to the form.

Make the OPIE Screen Larger
The reason OPIE fills only a portion of most screens is because it is built on a platform meant for a screen resolution of 1024x768 pixels. You can adjust your monitor resolution to 1024x768 pixels and the OPIE screen should fill your monitor screen. To adjust your desktop resolution, follow the instructions below:

1. Minimize any open programs so that your desktop is visible.
2. Right-click on your desktop and select Personalize (you can also get to the Personalization options via the Control Panel).
4. In the resolution section, slide the bar to the low end until you achieve a resolution setting of 1024x768 pixels. (Your display settings screen may look slightly different from the screenshot depicted above, especially if you are using one monitor. I use a dual monitor setup so it shows both of my monitors on this screen.)

5. Click Ok.

6. A popup will appear asking if you would like to keep these display settings. Select Yes.

Create Note and Letter Writer Templates
It’s easier than it looks!

From within a Sample Patient chart, open a Letter Writer form and copy/paste the text below:
<<first name>> was seen today for the fitting of <<his/her>> <<affected side>> Foot Orthoses. The device was fitted to <<his/her>> shoes and <<he/she>> walked in the office for a few minutes to assess the fit.

<<first name>> walked with the new inserts for about 10 minutes with no complaints. <<he/she>> stated that the inserts were comfortable and did not produce any areas of pain or excessive pressure.

Patient was instructed to gradually increase wear time for FO's over the next 2 weeks to attempt to reach full-time wear within that time period. <<He/She caps>> will begin wearing the inserts for periods of 2-4 hours at a time and gradually increase wear time each day.

<<first name>> was scheduled for a 2 week follow up appointment and told to contact us in the event of any problems between now and then. After the next appointment <<he/she>> will schedule a follow up appointment with <<his/her>> referring physician.

Sincerely,

<<primary practitioner full name rx>>

Letter writer in OPIE is a rudimentary text handler. It will not recognize font formatting. Although colors may appear in the display, ultimately, they will be ignored.

1. Select Save This Letter as a Template and in the Template Title field, add a title
2. Click the Save and Close button.
3. Close the Letter Writer form and do not save changes.
4. Open a new Letter Writer form from the left pane of the patient chart.
5. Click Select a Letter Template.
6. In the left pane, select your new template from the list, click the Accept button and the letter autopopulates in the right pane.
7. Add a Classification and click Print and Save.

⇒ If you are an Admin/Clerical user, you will be presented with a Signature dialog pop-up.

Your letter as it will appear in Print Preview:
Paula was seen today for the fitting of her right Foot Orthoses. The device was fitted to her shoes and she walked in the office for a few minutes to assess the fit.

Paula walked with the new inserts for about 10 minutes with no complaints. She stated that the inserts were comfortable and did not produce any areas of pain or excessive pressure.

Patient was instructed to gradually increase wear time for FO’s over the next 2 weeks to attempt to reach full-time wear within that time period. She will begin wearing the inserts for periods of 2-4 hours at a time and gradually increase wear time each day.

Paula was scheduled for a 2 week follow up appointment and told to contact us in the event of any problems between now and then. After the next appointment she will schedule a follow up appointment with her referring physician.

Sincerely,

Paul E Prusakowski, CPO, LPO, FAAOP

Font formatting can be achieved using html codes. Variables are inserted using Tags.

**Note/Letter Writer html code**

non-breaking space - &nbsp;
<br /> Defines a single line break
<i> defines font as italic </i>
<u> defines font as underscored </u>
<b> defines font as bold </b>
<font size="+2">text</font> (= two sizes larger than the default)

Most browsers have their default font size set as 3. The majority of sites will have their text set at around size 2 or 3.

Use **Tags** selected from the Tags drop-down, to create a template that looks something like below. The characters inside the chevrons <> are the **html font formatting codes**. Each one is a toggle — start it and stop it with the <> characters.
The text within the double chevrons << >> are tags – variable information that will pull from data already entered into the patient record.

**Code text to paste into a note or letter writer template**

&lt;first name&gt; was &lt;b&gt;seen&lt;/b&gt; today for the fitting of &lt;his/her&gt; &lt;affected side&gt; Foot Orthoses. The &lt;u&gt;device&lt;/u&gt; was fitted to &lt;his/her&gt; shoes and &lt;he/she&gt; walked in the office for a few minutes to &lt;i&gt;assess&lt;/i&gt; the fit.

&lt;br /&gt;
&lt;br /&gt;
&lt;br /&gt;

&lt;first name&gt; walked with the new inserts for about 10 minutes with no complaints. &lt;he/she&gt; stated that the inserts were comfortable and did not produce any areas of pain or excessive pressure.

&lt;font size="+5"&gt;Patient was instructed to gradually increase wear time for FO's over the next 2 weeks to attempt to reach full time wear within that time period. &lt;He/She caps&gt; will begin wearing the inserts for periods of 2-4 hours at a time and gradually increase wear time each day. &lt;/font&gt;

&lt;first name&gt; was scheduled for a 2 week follow up appointment and told to contact us in the event of any problems between now and then. After the next appointment &lt;he/she&gt; will schedule a follow up appointment with &lt;his/her&gt; referring physician.

Sincerely,
1. Click Translate Tags to see how the letter will behave, then click Translate Tags again to preserve the variables.
2. When satisfied with the template text, Select Save This Letter as a Template and in the Template Title field, add a title.
3. Click the Save and Close button.

What is displayed in OPIE is not what prints:

Paula was seen today for the fitting of her right Foot Orthoses. The device was fitted to her shoes and she walked in the office for a few minutes to assess the fit.

Paula walked with the new inserts for about 10 minutes with no complaints. She stated that the inserts were comfortable and did not produce any areas of pain or excessive pressure.

Patient was instructed to gradually increase wear time for FO’s over the next 2 weeks to attempt to reach full time wear within that time period. She will begin wearing the inserts for periods of 2-4 hours at a time and gradually increase wear time each day.

Paula was scheduled for a 2 week follow up appointment and told to contact us in the event of any problems between now and then. After the next appointment she will schedule a follow up appointment with her referring physician.
This is how the printed letter will appear in print preview:

This is a Sample:

Paula was seen today for the fitting of her right Foot Orthoses. The device was placed in her shoes and she walked in the office for a few minutes to assess the fit.

Paula walked with the new inserts for about 10 minutes with no complaints. She stated that the inserts were comfortable and did not produce any areas of pain or excessive pressure.

Patient was instructed to gradually increase wear for FO's over the next 2 weeks to attempt to reach full time wear within that time period. She will begin wearing the inserts for periods of 2-4 hours at a time and gradually increase wear time each day.

Paula was scheduled for a 2 week follow up appointment and told to contact us if any problems arise. Once the appointment is over, she will schedule a follow up appointment with her referring physician.

Sincerely,

Paul E Prusakowski, CPO, LPO, FAAOP
Get Crafty! Create a Note using multiple templates!

Compiling multiple templates into one form further automates the process. For instance, use the text and tags <<long date>>, <<prim care phys addr>>, Dear Dr. <<prim care phys last name>>, to create a date and address block template named Inside address with date. Create and save another template named Closing and Signature using text and tags Sincerely yours, <<primary practitioner full name rx>>. Insert these templates and the only typing your letter or note now needs is the body text, which, of course, can include tags.

⚠ Don’t expect to get it right the first time; be prepared to make mistakes!

Create an Administrative Note

Admin notes can be created in the same way that letters are created with Letter Writer. Follow the instructions in the Letter Writer Template section above to create Note templates. Created Date and Created By appear in the top of the Administrative Notes form (next to the current fields for Modified By). A “Print with Header” checkbox is also on the form which will add the standard header to the printout which includes the Created Date.

Create an Admin Note template with a classification for reuse

A classification can be added to an Admin Note, which will create a template and automatically add a label to it that will display in the left pane. The template can be reused for future patients. For example, to create a new Classification of “Fax Coverletter” for the note, click on the blue + to the right of the Classification drop-down in the upper left corner of the Admin Note form and create the note template using all relevant tags. When the note is finished, be sure that the “Phone Log” Classification is selected and click the Save This Note As A Template button.

When this note template is used and saved in a patient’s file, it will append, “Fax Coverletter,” (or whatever classification is used) to the end of the form name so that it will be easy to find in the chart.

This process can be used to create other templates with classifications.

Scheduler Information

Practitioner who is no longer here is still on the schedule

Your on-site OPIE Administrator can edit the user's account through Administrative Tools by removing the checkmark in the Can Have Appointments box. However, individual users can modify their Scheduler views as well.

1. In Graphic Scheduler, click on Settings on the top menu bar
2. Click on the Scheduler Sort button
3. Move the inactive practitioner from the left Displayed Users pane to the right Hidden User pane
4. Click OK
Prevent Inactive Patient Appointments

To minimize the possibility of creating appointments for patients who are inactive, hide them.

1. In the Graphic Scheduler, click Settings on the top menu bar
2. Remove the checkmark from Enable INACTIVE Patient appointments

Inactive patients will no longer appear in the Patient Name drop-down list.

Deactivated user appears on the schedule

The on-site OPIE Administrator can go to Administrative Tools / Users / Edit Users, click the Show Inactive checkbox, select the user from the drop-down list and click the blue Edit User button. Then, uncheck the 'Can Have Appointments' security right and click OK. The Inactive user will no longer appear on the scheduler.

Search a Patient in Graphic Scheduler

First Name Search

In addition to last name, a patient search can be done by First Name or Patient ID Number.

1. From the Select Tab, click in the Search by Last Name field
2. To search by First name, type a space immediately followed by the first few letters of, or the entire, patient's first name

OR

1. Enter the patient's ID number into the Search by Last Name field

Search by Phone Number

1. Double-click in any time slot in graphic scheduler, as if creating a new appointment.
2. In the New Appointment dialog, click the ellipsis to the right of the Patient Name field to bring up the Patient Search box, and type the phone number into the Phone field, i.e. 518-672-6821.
3. To move to the patient's record from here, click the Select bar at the bottom of the Search window, then click the Jump to Patient button in the new appointment dialog.

Search by Date of Birth

1. Double-click in any time slot in graphic scheduler, as if creating a new appointment.
2. In the New Appointment dialog, click the ellipsis to the right of the Patient Name field to bring up the Patient Search box, and type the DOB into the DOB field, i.e. 1/2/1996.
3. When the results appear, highlight the correct patient name, click the Select Pt bar at the bottom, then, in the New Appointment dialog, click the Jump to Patient button.

**Show Recent Patient List**

The "Show Recent" button, on the Select/Search patient pane, will show the last ten patients that were opened. To default to viewing the entire patient list and activate the Show Recent list manually when you need it, go to the Tasks pane. Under Other Tasks, click on Change User Settings/Password. In the Other Options box, remove the checkmark from Show Recent by default.

**Reschedule Appointment Using Graphic Scheduler**

The recommended OPIE Best Practice for rescheduling an appointment is:

1. Right-click on the existing appointment
2. Select Rescheduled from the list
3. When the red Reschedule Mode bar appears at the top of the page, go to the day/time you want (you can use View Calendar and select the day you desire if it's not in your scheduler view)
4. Double-click in the time-slot you want the appointment to be
5. Click Save and click Yes at the Confirm Save dialog
6. Enter a note about the reschedule and click Save this Note

When an appointment is rescheduled using the Graphic Scheduler, a Create Patient Note dialog box appears. If a note is entered in this box and saved, it will not appear red, as a note owed, in a Practitioner's compliance.

**Note:** The Rescheduled mode is prevented in appointments with a status of “Showed Up.”

**Show NC/NS Appointments in Graphic Scheduler**

Show cancelled, rescheduled and NC/NS Appointments in the Graphic Scheduler by following the instructions below.

1. Open the Graphic Scheduler.
2. Double-click on Settings in the Scheduler toolbar.
3. Check the Show cancelled, rescheduled and NC/NS appts box.
4. Click Save.

**Waiting List**

The Waiting List was added with the intent of providing an easily accessible list of patients from which to fill cancelled or rescheduled appointments. The Waiting List simplifies this process by having the list of patients available at the click of a button and allowing the user to move appointments without having to go through the process of cancelling the appointments and re-creating them in another time block.

**Graphic Scheduler Setting**
When an appointment is cancelled, the user will be prompted to fill that slot from the Waiting List. If it is preferable to NOT see this prompt, it can be disabled using the "Disable waiting list prompt on cancelled appts" option under the Settings button in the Graphic Scheduler.

**Key Points to Know**

- The Waiting List can be filtered using the "Appointment is for" drop-down list where the user can choose to display patients for a specific practitioner. The Waiting List will display all of the patients for all of the practitioners by selecting the Show All option. The Branch drop-down list is another filter option. It is located in the upper right corner of the Waiting List. Select a specific branch to filter by or select Show All to display patients for all branches.
- To access the Appointment Details screen within the Graphic Scheduler, click on a patient and then click Select. To remove the patient from the Waiting List, uncheck the Waiting List checkbox in the Appointment Details screen.
- The Waiting List has built-in intelligence with regard to practitioner so that, when rescheduling an appointment, the Waiting List will only pull patients scheduled for the practitioner with the available appointment.
- Users can access Patient Information easily within the Waiting list by clicking on a patient and then clicking the Jump to Patient button located in the lower left of the Waiting List.
- When a user fills an appointment from the Waiting List, the list will show only patients for the practitioner they are scheduling for, not all of the patients in the Waiting List.
- When the practitioner is changed on a patient appointment, a warning message pops up letting the user know who the treating practitioner was and if this is a desired change.
- The following are important questions to answer before filling an appointment from the waiting list:
  - Is fabrication complete for the patient? Select the patient from the waiting list. The Appointment Details screen for the patient will open. From this screen you can click on Jump to Patient to access their records to make sure fabrication is complete before continuing.
  - Is the length of time available for the appointment sufficient for this patient's needs?
  - Check to make sure the practitioner is available for this time block.
  - Call the patient to confirm that this appointment time will work for their schedule. The patient's contact number is conveniently accessed within the Waiting List and also within the Appointment Details screen.
  - If it is clear that the practitioner and patient are available for this patient time and fabrication is complete, click Select.

**Tip**

The easiest way to fill an open appointment slot from the waiting list is to right-click on the open space in the schedule, or choose Yes on the waiting list prompt that comes up when you cancel an appointment. Both of these actions will launch the waiting list in a special mode that is specific to the open appointment location. Patients will only be visible for the practitioner or branch associated with the location, and when the appointment is selected to move, the date/time will automatically be changed to new date/time for the slot selected.
How to Fill an Appointment from the Waiting List

1. Right-click in an available appointment block and click Fill from Waiting List. Click on the patient to move to this appointment and click the Select button at the bottom of the Waiting List screen. The Appointment Details screen will pop up for the patient. Note here that the Appointment Date and Start Time are grayed out because the patient’s appointment is being moved to a specific date and start time but the end time of the appointment can be changed, if desired. Note also that the Practitioner box is grayed out as well because the selected patient was already set to see that practitioner. Click Move Appt. once the appointment details are satisfactory.

2. When an appointment is cancelled in the Graphic Scheduler, a pop-up will appear asking, "would you like to fill this time slot from the waiting list?" If yes, click the Yes button. From the Waiting List pop-up, click on the patient to move to this time block and click Select. The Appointment Details box will pop-up. Click the Move Appt. button in the bottom right. The appointment will now show in the selected time block.

3. To make an appointment for a patient from within the Waiting List, click on the Waiting List to open it, click on a patient then click Select. The patient’s Appointment Details screen will pop up allowing the user to make applicable changes and select a new appointment time. Although it is possible to schedule an appointment directly from the Waiting List, it was not intended to be used in this manner. Rescheduling an appointment this way will not mark the appointment as rescheduled and dismisses the tracking process we strongly recommend as an OPIE Best Practice. The intended use of the Waiting List is to move appointments from one block of time to another as they become available by cancellations and reschedules.

Room Monitor

The Room Monitor is a visual representation of available clinic rooms and checked in "showed up" patients and patients with a status of "in room" or "in room with practitioner." The purpose of the Room Monitor is to allow an easily accessible view of the clinic rooms so that clerks will know which rooms are available to assign patients to. Use the Room Monitor and patient status changes to track average appointment times and reduce patient wait time.

Key Points to Know

- Filter the Room Monitor by branch using the drop-down list in the upper right-hand corner.
- To access patient appointment details within the Room Monitor, simply double-click on a patient or click on a patient then click the Open Selected Appt. button located beneath the rooms list.
- Checked in (or showed up) patients are visible in the Room Monitor under the "Other Patients Checked-In" list. Click on a patient in this list and then click the Open Selected Appt. button beneath this list to access their appointment details.

Tip

Refresh the Room Monitor display to reflect added appointments/status changes by clicking the Refresh button in the lower right corner or simply close the Room Monitor and re-open it.
How to use the Room Monitor

1. Assign a patient to a room in the Appointment Details screen, which is accessed by double-clicking an appointment block within the Graphic Scheduler. The Room selection is the second drop-down list on the right side of this screen.
2. Once a patient has been assigned to a room, they must be given a status of "In Room" or "In Room with Practitioner" to be visible in the Room Monitor.
3. To remove a patient from the Room Monitor, change the appointment status to "Checked out."
4. To reflect added appointments or appointment status changes, either click the Refresh button in the lower right corner, or close and re-open the Room Monitor.

View Appointment Modification History

For any new appointment, the user who created the appointment shows in the 'Created By' field. Whenever someone changes that appointment in any way, their Initials and the date and time of modification will be written to the 'Modified By' field.

Opieschedule.com and iCal Sync on iOS Mobile Device

1. On the mobile device navigate to www.opieschedule.com
2. Login with your online (OPIE Purchasing & Inventory (OPIE Lite)) credentials
3. In the drop-down that says "Show all Practitioners" select the initials of the practitioner you want synced to the phone and click Update
4. Review the settings under the "View & iCal settings" link on the left and configure them
5. After the page has refreshed, find the green iCAL link and hold a finger over it until a context menu opens
6. From the pop-up menu, select copy
7. Hit the home button to get back to the main screen
8. Go to the "Settings" icon
9. Select "Mail / Contacts / Calendars"
10. Select "add account"
11. Select "other"
12. Choose "add subscribed calendar"
13. In the box, hold a finger down for a couple seconds and lift it back up. The word "paste" should appear. Touch it.
14. Hit next
15. Wait for it to verify
16. Hit save
17. Hit the home button
18. Open "calendar"

View Multiple Days
Using Graphic Scheduler / View Calendar, you can select an entire week by clicking on the little number to the left of Sunday - that's the week-of-the-year number - and see the entire week. You can also click and drag across multiple days to view a series of days.

**Delete Appointment**

An appointment can be deleted by highlighting it and clicking Delete from the top menu bar of the graphic scheduler. That will remove all traces of the appointment, as if it had never been created.

**Search by Phone Number**

1. Double-click in any time slot in graphic scheduler, as if creating a new appointment.
2. In the New Appointment dialog, click the ellipsis to the right of the Patient Name field to bring up the Patient Search box, and type the phone number into the Phone field, i.e. 518-672-6821.
3. To move to the patient's record from here, click the Select bar at the bottom of the Search window, then click the Jump to Patient button in the new appointment dialog.

**Search by Date of Birth**

1. Double-click in any time slot in graphic scheduler, as if creating a new appointment.
2. In the New Appointment dialog, click the ellipsis to the right of the Patient Name field to bring up the Patient Search box, and type the DOB into the DOB field, i.e. 1/2/1996.
3. When the results appear, highlight the correct patient name, click the Select Pt bar at the bottom, then, in the New Appointment dialog, click the Jump to Patient button.

**Print Patient Appointment History**

1. From the Administrative Home screen, go to the Patient Schedule tab
2. Select the patient for whom to print the report
3. Click the blue Show Pt. Appointments button at the bottom of the screen. The view now shows a list of all appointments for that patient.
4. Click the Print Schedule button.

**Print Schedule with Patient Phone Numbers**

1. From the Home screen, click on the Patient Schedule tab
2. Select the schedule date range you want to print by clicking the date drop-downs at the top of the window
3. On the right side, under the calendar, click the Print w/Phone # checkbox and, if desired, the Print w/Comments checkbox

**Locked Visit**
When a patient appointment is cancelled or no-showed, the visit is locked so forms are not accidentally added to a visit that did not take place. If there is a red triangle in the Practitioner Compliance screen:

- Highlight the entry with the red triangle and click the Create This Note button. A note can then be added.

The OPIE recommended best practice for this situation is for whomever changes the appointment status to Cancelled, to fill in the note and click Save this Note, at the time of the cancellation. That way it doesn't fall into Practitioner Compliance.

**Attach a Note to a Prescription**

The following instructions are for cases where a referring physician gives the dispensing order over the phone. A viable option for attaching a note to a prescription is to type the dispensing order into a phone conversation under non-clinical event.

1. Under Patient Prescriptions, click the Click to add non-clinical event link.
2. Select Phone Conversation from the drop-down list and click Ok. The phone conversation can be done several different ways. To type the message, follow the instructions below. Any number of file types can be attached to the scan tabs. If the practice’s phone system saves voicemails as audio files, this file type can be saved as an attachment and listen to the message within OPIE. Other file types such as Word documents and PDFs can also be successfully attached.
   
   **Note:** Documents that are scanned or attached to a Notes form, changes cannot be tracked in those documents in detail. For compliance reasons, we recommend that all clinical notes still be typed into the notes form (or entered via templates or dictation) so they are fully tracked.
3. Enter the note then click Print.
4. In the Print Preview, click on the print icon in the upper left hand corner and choose the PDF writer (we use CutePDF) and save this document in a folder on the computer.
5. To attach the file to a prescription, go to the Patient Information page and click on the Prescriptions tab.
6. Highlight the prescription to attach the file to and then click the blue Attach File button in the lower left corner of the right pane.
7. Double-click on the file to attach. This file can be viewed easily by clicking the blue View button underneath it or it can be deleted if no longer needed by clicking the blue Delete button underneath it.

**Forms**

<table>
<thead>
<tr>
<th>Transtibial Prosthesis</th>
<th>Transfemoral Prosthesis</th>
<th>Transradial Prosthesis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Evaluation</strong></td>
<td><strong>Initial Evaluation</strong></td>
<td><strong>Initial Evaluation</strong></td>
</tr>
<tr>
<td>- Medical Hx</td>
<td>- Medical Hx</td>
<td>- Medical Hx</td>
</tr>
<tr>
<td>- Transtibial Initial Evaluation</td>
<td>- Transfemoral Initial Evaluation</td>
<td>- Transradial Initial Evaluation</td>
</tr>
<tr>
<td>- Transtibial Measurement (with Images)</td>
<td>- Transfemoral Measurement</td>
<td>- Transradial Measurement (with Images)</td>
</tr>
</tbody>
</table>
- Schedule Appointment
- LCode Selection
- LCode Justification
- Transtibial Fabrication
- Lower Limb Consumables
- Transtibial Component Info
- Notes

**Diagnostic Fitting**
- Schedule Appointment
- Notes

**Drop Off**
- Transtibial Fabrication
- Schedule Appointment
- Notes

**Delivery/Definitive Fitting**
- L-code Selection (to review coding and remove any undelivered codes i.e. cover)
- L-code Justification
- Facility/Patient Documents (education)
- Delivery Receipt
- Schedule Appointment
- Notes

**Follow-up**
- Transtibial Fabrication
- Schedule Appointment
- Notes

**Delivery/Definitive Fitting**
- L-code Selection (for any undelivered codes i.e. cover)
- L-code Justification
- Delivery Receipt
- Schedule Appointment
- Images
- Notes

**Follow-up**
- Transtibial Follow Up
- Notes

(with Images)
- Schedule Appointment
- LCode Selection
- LCode Justification
- Transfemoral In-house Fabrication
- Lower Limb Consumables
- Transfemoral Component Info
- Notes

**Diagnostic Fitting**
- Transfemoral In House Fabrication
- Schedule Appointment
- Notes

**Drop Off**
- Transfemoral In House Fabrication
- Notes

**Delivery/Definitive Fitting**
- Facility/Patient Documents (education)
- Delivery Receipt
- Schedule Appointment
- Images
- Notes

**Follow-up**
- Schedule Appointment
- Notes

**Adjustment**
- Notes
## Transhumeral Prosthesis

**Initial Evaluation**
- Medical Hx
- Transhumeral Initial Evaluation
- Transhumeral Measurement (with Images)
- Schedule Appointment
- LCode Selection
- LCode Justification
- Transhumeral Fabrication
- Parts Order Form
- Notes

**Diagnostic Fitting**
- Transhumeral Fabrication
- C-Fab Tracking
- Schedule Appointment
- Notes

**Delivery/Definitive Fitting**
- Facility/Patient Documents (education)
- Delivery Receipt
- Schedule Appointment
- Images
- Notes

**Follow-up**
- Schedule Appointment
- Notes

## AFO Custom (Central Fabrication)

**Initial Evaluation**
- Medical Hx
- Lower Extremity Initial Evaluation
- AFO In House Fabrication Workorder
- Schedule Appointment
- Support Files (videos)
- LCode Selection
- LCode Justification
- C-Fab Tracking
- Notes

**Delivery/Definitive Fitting**
- Facility/Patient Documents (education)
- Delivery Receipt
- Schedule Appointment
- Images
- Notes

**Follow-up**
- Schedule Appointment
- Notes

## AFO Custom (In-House Fabrication)

**Initial Evaluation**
- Medical Hx
- Lower Extremity Initial Evaluation
- AFO In House Fabrication Workorder
- Schedule Appointment
- LCode Selection
- LCode Justification
- Images
- Notes

**Delivery/Definitive Fitting**
- Facility/Patient Documents (education)
- Delivery Receipt
- Schedule Appointment
- Images
- Notes

**Follow-up**
- Schedule Appointment
- Notes

## Scoliosis TLSO

**Initial Evaluation**
- Medical Hx
- Spinal Measurement (with Images)
- Schedule Appointment
- LCode Selection
- LCode Justification
- C-Fab Tracking
- Notes

**Delivery/Definitive Fitting**
- Facility/Patient Documents (education)

## Bilateral Custom Foot Orthoses

**Initial Evaluation**
- Medical Hx
- Lower Extremity Initial Evaluation
- Orthotic In House Work Order
- Schedule Appointment
- LCode Selection
- LCode Justification
- Images
- Notes

## Walking Boot (OTS Item)

**Evaluation/Delivery (Same Visit)**
- LCode Selection
- LCode Justification
- Facility/Patient Documents (education)
- Delivery Receipt
- Schedule Appointment
- Images
- Notes

- Parts Order Form – document item used and put in P&I for reorder/restock of inventory
- Images
- Notes
Diabetic Shoes
Initial Evaluation
- Medical Hx
- Lower Extremity Initial Evaluation
- Parts Order Form
- Schedule Appointment
- LCode Selection
- LCode Justification
- Orthotic In House Work Order
- Images
- Notes

Delivery/Definitive Fitting
- Facility/Patient Documents (education)
- Delivery Receipt
- Schedule Appointment
- Images
- Notes

Follow-up
- Schedule Appointment
- Notes

Form Unsaved Changes Smart Warnings

If a form is about to close due to the user navigating to another form and the current form contains unsaved changes, OPIE will prompt the user and ask whether OPIE should “Save & Continue,” “Discard Changes” or “Return to Form.”

- **Save & Continue** will trigger the save event prior to closing and navigating to the next document.
- **Discard Changes** will close the form without saving and then navigate to the next document.
- **Return to Form** will leave you on the current form (thus canceling the navigation that was about to happen).

Add a Label to a Form
To help distinguish multiple instances of the same document type (like Primary vs. Secondary Insurance Verifications, multiple Letter Writers, Scanned Docs, etc.) you can add your own label.

1. When viewing a patient chart in the left pane, right-click on any form and select "Add/Edit Label"

### OPIE Forms Print Too Far Left

Page margins can be modified in print preview from the page setup menu.

1. While in Print Preview, click the fourth icon, the one that looks like a gear wheel
2. Set left, right, top and bottom margins to 0.5
3. Click OK
4. Print

### Open One Form While Working In Another

While performing note documentation, you might want to open another form as reference.

1. In the left pane, right-click on the form you need to refer to
2. Choose Open as Secondary Form

### Fabrication

To facilitate the use and tracking of any practice or manufacturer-specific forms, scan tabs are located on the following fabrication and work order forms:

- Transtibial Fabrication
- AFO Fabrication Workorder
- Orthotic In house workorder
- Orthotic Work Order
- Transfemoral Fabrication
- O&P1 Transtibial Work Order
- O&P1 Transfemoral Work Order
- O&P1 Orthotic Work Order
- O&P1 Crow Work Order
- Transradial Fabrication
- Transhumeral Fabrication
- Shoe Work Order
- Parts Order Form

### Sample Alternate Fabrication workflow for in-house fabrication with PRE-Authorization for all fabrication
1. Patient is checked in by administrative staff
2. Clinician sees patient in exam room
3. Clinician fills out fabrication work order
4. Clinician sends work order to Administrative staff for fabrication and assigns appropriate due date
5. Clinician writes patient ID # on cast and puts cast in designated location for technician
6. Administrative staff changes status to On Hold for Authorization
7. Administrative staff releases fabrication project and assigns to Technician and changes status to Authorization complete
8. Technician prints out work orders for individual projects that have been approved
9. Technician goes to shelf with new casts and matches ID # with approved projects
10. Technician prioritizes work based upon due dates
11. Technician assigns projects to correct personnel and changes status
12. End of the day technician updates status on all fabrication projects and assigns to Scheduling person if ready for fitting
13. Scheduling person reviews fabrication tracking when reviewing schedule and makes sure that all projects are ready for scheduled patients
14. Scheduling person makes sure that fabrication projects ready for fitting are scheduled appropriately
15. Scheduling person changes status to “scheduled” and assigns to appropriate clinician
16. When fitting has been completed, Scheduling person makes fabrication to complete to remove project from active list

Identify problems at weekly staff meetings, i.e.:

- who is not entering work orders into system regularly
- who is choosing wrong due dates
- who is not changing statuses, etc.
- Work to continually improve the process. It takes time and consistency.

Sample Fabrication workflow for in-house fabrication

1. Patient is checked in by administrative staff
2. Clinician sees patient in exam room
3. Clinician fills out fabrication work order
4. Clinician sends work order to Technician for fabrication and assigns appropriate due date
5. Clinician writes patient ID # on cast and puts cast in designated location for technician
6. Technician goes to shelf with new casts
7. Technician matches casts with workorders in OPIE
8. Technician prints out workorders for individual casts
9. Technician prioritizes work based upon due dates
10. Technician assigns projects to correct personnel and changes status
11. End of the day technician updates status on all fabrication projects and assigns to Scheduling person if ready for fitting

12. **Scheduling person** reviews fabrication tracking when reviewing schedule and makes sure that all projects are ready for scheduled patients

13. **Scheduling person** makes sure that fabrication projects ready for fitting are scheduled appropriately

14. **Scheduling person** changes status to “scheduled” and assigns to appropriate clinician

15. When fitting has been completed, **Scheduling person** makes fabrication to complete to remove project from active list

**Identify problems at weekly staff meetings, i.e.:**

- who is not entering work orders into system regularly
- who is choosing wrong due dates
- who is not changing statuses, etc.
- Work to continually improve the process. It takes time and consistency.

**Sample Workflow for In-house C-Fab**

1. Patient is checked in by **administrative staff**
2. **Clinician** sees patient in exam room
3. **Clinician** fills out fabrication work order
4. **Clinician** prints fabrication workorder
5. **Clinician** Selects C-Fab Tracking form and generates Purchase Order, selects fabrication company
6. **Clinician** prints C-Fab tracking form selects Generate Notification Email button
7. **Administrative staff** scans fabrication workorder into scan tab on C-Fab tracking form
8. Alternately **Clinician** creates PDF of fabrication workorder and attaches to C-Fab Tracking scan tab
9. **Clinician** writes patient ID # on cast and puts cast in designated location for outgoing C-Fab- obtains paperwork and includes C-Fab Tracking form and Workorder with casts
10. **Shipping person** boxes cast and paperwork and goes to [www.ups.com](http://www.ups.com) to generate mailing label.
11. **GOAL**: Casts go out to C-Fab the same day they are taken
12. **Receiving person** opens box from UPS and checks in completed project in OPIE Purchasing and Inventory (OPIE Lite)
13. **Receiving person** goes to Fabrication tracking tab in OPIE and selects C-Fab button and finds project-deselects C-Fab button
14. **Receiving person** clicks out of CFab view and changes status of project to “Ready To Be Fit” or “Ready to Schedule” and assigns to **Scheduling Person**
15. **Scheduling person** makes sure that fabrication projects ready for fitting are scheduled appropriately
16. **Scheduling person** reviews fabrication tracking when reviewing schedule and makes sure that all projects are ready for scheduled patients
17. **Scheduling person** changes status to “Scheduled” and assigns to appropriate clinician
18. When fitting has been completed, *Scheduling person* marks fabrication to “Complete” to remove project from active list

Be sure to set up the online UPS account to simplify outgoing shipping.

*If CAD is used, generate the C-Fab Tracking form to create a Purchase Order*

**Identify problems at weekly staff meetings, i.e.:**

- who is not entering work orders into system correctly?
- who is not changing statuses, etc.
- where are the delays?
- How long did it take to send out C-Fab project?
- How long did completed device sit on shelf before patient was fit?
- Work to continually improve the process. It takes time and consistency.

**Add/Edit ICD-9 Codes**

ICD-9 codes can be added/edited either through a patient's record or OPIE Dex.

1. From within the patient's record, click on the Prescriptions tab, highlight the Prescription and click the blue Edit Prescription Info button.
2. If an incorrect diagnosis was previously added, click on the diagnosis needing removal and click the blue Remove ICD_9 button under the Diagnosis Code window.
3. Click the blue Select ICD-9 button beneath the Diagnosis Code window.
4. The user can either enter keywords into the search field or scroll through the list of codes to select the appropriate diagnosis.
5. Click on the appropriate diagnosis and click the blue Accept button.
6. Click the blue Save Rx Information button.

**OR**

1. Click the OPIE Dex icon on the OPIE toolbar
2. Click the ICD-9 tab
3. If a diagnosis needs to be edited, select the code in the list and click the blue Edit Dx button.
4. The user can edit the name of the diagnosis or uncheck the Active Diagnosis box which removes the diagnosis from the active list.
5. To view inactive diagnoses, click the blue Show Inactive Dx’s button at the bottom left. The code can be re-activated by selecting it, clicking the blue Edit Dx button and re-checking the Active Diagnosis box.
6. A pop-up will appear to let the user know that duplicate codes are not allowed and will ask if the user wants to update the description. Selecting Yes will make the code active and update the description. Selecting No will make the code active but keep the old description. Selecting Cancel will leave the code inactive.

7. To add a new ICD-9 code, click the blue Add New Dx button.

8. Type the new Diagnosis Name and ICD-9 code in the appropriate fields and click Save.

**ICD-10 & OPIE**

CMS has set the implementation date for ICD-10 at October 1, 2015. This transition is a very big deal for physicians and other providers who are responsible for diagnosing patients and recording those diagnoses, because they will have to learn an entirely new coding system for doing so. For this reason, CMS is regularly talking about ICD-10 and many general medical software systems are investing significantly in tools that assist with the coding/cross walking process. From an O&P/OPIE standpoint, the situation is much simpler, because our responsibility is not to actually determine and code the diagnosis, but rather to obtain the diagnosis code(s) from the physician, document it in our electronic chart, and include it on claims and other relevant documents. In this way, OPIE is already ICD-10 compliant, because the ICD-10 codes can be loaded into OPIE in the same way as ICD-9 codes are. The bigger question from an O&P standpoint is how to manage the transition process, since it will be an abrupt one. Claims with a Date of Service prior to October 1, 2015 will need to use ICD-9 codes, while claims with a Date of Service after this date will need ICD-10 codes. This document outlines how OPIE plans to make this transition as painless as possible for our users.

**What will change in OPIE?**

**Selecting Codes**

In OPIE, ICD-9 codes are selected on the prescription, and then carried through to the appropriate output, including printed documents and claims. There is a default list of ICD-9 codes loaded into the software that represents many of the common diagnoses seen by O&P providers, as well as the ability to add additional codes on the fly as needed. To accommodate ICD-10 and the transition, OPIE will maintain a separate list of ICD-10 codes, and allow the user to switch between selecting from the ICD-9 list and the ICD-10 list.

The resulting selected code will go into the same database field as the existing ICD-9 codes, and thus will be output by the software in exactly the same way. However, OPIE will keep track of which list the code was selected from, so that the software knows where you are using an ICD-9 or 10 code.

**Important notes**

It will not be possible to select both an ICD-9 and ICD-10 into the same field. The user will need to make their best determination as to which is appropriate based on the expected date of service for the claim, and then adjust if that date of services changes in such a way that the other type of code is required. OPIE will, however, provide a notification at the time of delivery if the wrong type of code has been selected based on the date of service determined by the delivery date.
The determination of the subset of ICD-10 codes that will be provided by OPIE by default has not yet been made, and may not be made until close to the transition date. For any customers who wish to test the functionality well prior to the transition date, it will be possible to do so either by loading in sample ICD-10 codes one by one, or by providing a list to OPIE Support that will be loaded into your OPIE database.

Managing the Transition

As the transition date (Oct 1, 2015) approaches, O&P practices will need to prepare by considering whether a device that they are working on is likely to be delivered before or after the delivery date. If before, they will request an ICD-9 code from the referring physician, and if after, they will request an ICD-10 code. In some cases, it may be intelligent to simply request both and record one of them in a separate location in case it is needed.

Upon delivering a device, the OPIE delivery receipt will have a diagnosis code check built in that compares the delivery date (DOS) to the diagnosis code type, and produces a warning if there is a mismatch. For example, if a practice believes that a device will be delivered after Oct 1, 2015 and thus records an ICD-10 code when taking the referral, but then delivers the device early before the transition date, OPIE would, at the time of delivery, warn the user that the code
selected is an ICD-10 code and will need to be changed to an ICD-9. Similarly, if a user records an ICD-9, believing that a device will be delivered before the transition date, and then the delivery is delayed beyond the transition date, OPIE will warn the user that an ICD-9 was selected and they will need to go back and obtain the correct ICD-10 code.

The OPIE Delivery Receipt, which will show a warning prompt in the case that there is a mismatch between the delivery date and the type of diagnosis code selected on the prescription.

Timeline for Delivery of the OPIE ICD-10 Functionality

OPIE intends to deliver ICD-10 functionality described here on a limited basis to select clients that require testing far in advance of the October 1, 2015 deadline. The majority of OPIE clients will of course not need to perform these tests so far in advance, and thus the functionality may not be delivered to all OPIE users until it’s required. If a facility requires advanced testing prior to a certain date, please contact the OPIE support team to make arrangements to deliver the functionality to the OPIE system prior to the target date.

Please note that in a basic sense, OPIE is already ICD-10 compliant, because the user can load ICD-10 codes into the existing ICD-9 system and they will carry through to the appropriate output just as an ICD-9 would. Therefore, it is only the new functionality being put in place to help ease the transition that will be delivered on the above schedule, and if necessary, it is possible to test OPIE's ICD-10 readiness prior to receiving the new functionality described here.
Review Resident Notes
When a resident creates a clinical note for a patient, it must be reviewed by a Practitioner. There are some setup steps that can make this easier.

For the Resident

1. In Administrative Tools, go to the Users tab, click the Edit User tab, select the user to edit from the dropdown, and click the blue Edit User button.
2. Under Security Rights / Patient Info Form, check the boxes for View / Edit, and Any Patient Medical docs, check the boxes for View / Edit / Create New.
3. Review the other Security Rights and mark as appropriate.
4. Check the box for Mark Notes as Needs Review. Click OK.

Any clinical note the resident creates will automatically have a checkmark in the Needs Review box at the bottom.

For the Practitioner

1. In Administrative Tools, go to the Users tab, click the Edit User tab, select the user to edit from the dropdown, and click the blue Edit User button.
2. Verify the Classification field shows Practitioner & Clerical and there is a checkmark in the View Other' Compliance checkbox. Click OK.

This will enable the practitioner drop-down field on the My Compliance Overview screen so the practitioner can select to view the resident's compliance and see which notes are ready for review.

An additional step to further automate the process: in Administrative Tools / Office Settings / Misc Settings check the box for Mark notes as digitally signed on save. When the note is completed and saved, having this setting active will enter the text string "digitally signed by XXX XXX XXXXX, CPO, LPO on CURRENTDATE at CURRENTTIME." This is a system-wide setting and will apply to all clinical notes.

Send L-Codes to Admin

Send to Admin is the point at which an L-code selection, which is typically completed by a practitioner, is sent back to the admin staff for authorization (if required) or any other steps that are needed. Pressing the Send to Admin button signifies that this L-code selection is ready for the next steps in the process.

There are four things that may happen in OPIE when an L-code selection is Sent to Admin:

1. The L-codes Selected column in the WIP screen will turn green (only when the L-code Selection is under the first clinical visit)
2. The Administrative Compliance screen will show a new entry (with a Sent to Auth date that matches the date it was Sent to Admin)
3. OPIE Billing & Collections will show a new Authorize/Pre-authorize task (if OPIE Billing & Collections is installed)
4. The Rx will begin showing up on the Work-in-Progress financial report (with the allowable amount determined by the selected L-codes Sent to Admin)

After the L-code Selection has been Sent to Admin, it will show the date it was sent and it cannot be resent. If changes need to be made to the L-code Selection and the admin staff need notification, we recommend one of these two procedures:

1. Make the changes to the L-code Selection, save them, and then use the OPIE Messaging system to send a message to the appropriate person letting them know the L-code Selection has changed and may need to be re-authorized.
2. Mark this L-code Selection as Cancelled (using the Category drop down or by right clicking the form in the left pane and adding a label). Next, create a new L-code Selection, import codes from previous selection and make changes. Once complete, send the new L-code Selection to Admin.

** Note: When changing an L-code selection, please be aware that this can affect a Detailed Rx if already sent to a physician for signature. Independent of which step is chosen above, when changing an L-code selection, be sure to notify the appropriate person to obtain a new Detailed Rx if applicable.

Starred Documents
Starred Documents is a feature of OPIE that allows a user to easily locate frequently-used documents in a patient record. When a document is starred, it moves a copy of the document to the top of the patient chart. Both the copy and the original document are updated simultaneously. This feature can be used on as many documents as necessary within a patient record. When finished working with a document, it can be unstarred which will remove the copy from the upper portion of the patient chart.

1. Open a patient record and navigate to the document being frequently accessed.
2. Right-click on the document and select Star/Unstar Document from the list.
3. Look at the top of the patient chart and notice that there is a blue Starred Documents in the list with a (1) to the right of it. The (1) signifies that there is one document within Starred Documents. As documents are starred/unstarred, this number will change accordingly.
4. Double-click on Starred Documents and the list of documents will appear beneath it. Double-click on the document to open it.
5. To unstar the document, right-click on it and select Star/Unstar document and it will be removed from Starred Documents.
Treating vs. Primary Practitioner

Treating Practitioner at the Rx level: the Treating Practitioner field appears in the lower left of the prescription information screen so that it can be changed for each prescription. This is primarily for reporting purposes, so that reports will accurately show which practitioner handled a specific device even if they are not the primary practitioner. This field will also control which practitioner shows up on the WIP screen, and there is a tag for use in templates.

When creating a new prescription, the Treating Practitioner will automatically be set to the Primary Practitioner for the patient, so that a user only has to set it if the two are different. There is no real functionality on the Primary Practitioner field on the Patient Contacts tab.

Any reports that contain a "Practitioner" column will pull that value from the Prescription-level Treating Practitioner. This was a change, based on concerns expressed during an OPIE Reports training, regarding patients who have one primary practitioner but who have certain devices created/fitted by another practitioner. By assigning this at the prescription level, it can be ensured that the correct practitioner is credited with the device in the reports.

The Provider, that is, the practitioner who appears on the delivery appointment, is the name that appears on the HCFA form in Box 31. However, users have the ability to change Box 31 so that it can print the name and credentials of the primary practitioner or the practice name. What is selected in that box depends on who signed the original documents when you became an authorized provider for that payer.

The Delivery Receipt automatically defaults to display the treating practitioner on the printout.

WIP Information

Work-In-Progress (WIP) Icons & Automation

Learn about WIP icons by clicking on the Learn about WIP icons button in the bottom left corner of your WIP. This will launch the WIP Icons and Automation Help topic, which is continually updated as WIP icons and automation functionality changes in OPIE.
### Legend of WIP Icons

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>✗</td>
<td>Not Started</td>
</tr>
<tr>
<td>⏳</td>
<td>Pending/Waiting</td>
</tr>
<tr>
<td>✅</td>
<td>Completed</td>
</tr>
<tr>
<td>⚫</td>
<td>Completed with Scan or Attachment</td>
</tr>
<tr>
<td>⚫</td>
<td>Completed with Digital Signature</td>
</tr>
<tr>
<td>❌</td>
<td>Authorization completed but denied</td>
</tr>
<tr>
<td>🍀</td>
<td>Rx scanned, diagnosis code missing</td>
</tr>
<tr>
<td>🍀</td>
<td>Rx scanned, referring physician missing</td>
</tr>
<tr>
<td>🍀</td>
<td>Rx scanned, dx code &amp; ref. phys. missing</td>
</tr>
<tr>
<td>🍀</td>
<td>Delivery receipt signed but not sent to bill</td>
</tr>
</tbody>
</table>

### WIP Column

<table>
<thead>
<tr>
<th>WIP Column</th>
<th>Turns Yellow When...</th>
<th>Turns Green When...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispensing Order</td>
<td>Rx Scanned but Dx or REF missing</td>
<td>Rx Scanned, Dx and REF entered</td>
</tr>
<tr>
<td>HIPAA Signatures</td>
<td></td>
<td>HIPAA Checkbox/Digital Signature on HIPAA Patient Docs &amp; Supplier Standards form</td>
</tr>
<tr>
<td>Medicare Supplier Standards</td>
<td></td>
<td>MSS Checkbox/Digital Signature on HIPAA Patient Docs &amp; Supplier Standards form</td>
</tr>
<tr>
<td>Insurance Verification</td>
<td></td>
<td>Insurance Verification form saved with complete checkbox</td>
</tr>
<tr>
<td>LCodes Selected <em>NEW automation</em></td>
<td>L-codes are selected and saved but not send to Admin</td>
<td>Will turn green when L-codes have been selected and sent for authorization, will also turn green if the Delivery Receipt is Sent to Bill. Turns green with a red exclamation if the selection has been modified.</td>
</tr>
<tr>
<td>Pt Financial Counseling</td>
<td>Financial Responsibility form is printed</td>
<td>Scan/Attachment/Digital Signature on Financial Responsibility form</td>
</tr>
<tr>
<td>ABN</td>
<td></td>
<td>Checkbox/Scan/Attachment* on ABN form</td>
</tr>
<tr>
<td>Authorization <em>NEW automation</em></td>
<td>Auth form saved with status pending</td>
<td>Will turn green when the Auth form is saved with a status of Complete and the Auth Complete box is checked. Will turn green with a red X if complete but denied. Will show a decremental green icon if 45 days or less from expiration. Will show a red triangle with an E if Auth is expired.</td>
</tr>
<tr>
<td>Detailed Rx</td>
<td>Detailed Rx form is printed</td>
<td>Checkbox/Scan/Attachment on Detailed Rx form</td>
</tr>
<tr>
<td>Diabetic Verification</td>
<td>Diabetic Verification form is printed</td>
<td>Checkbox/Scan/Attachment on Diabetic Verification form</td>
</tr>
<tr>
<td>LMN</td>
<td></td>
<td>Checkbox/Scan/Attachment on LMN Scan form</td>
</tr>
<tr>
<td>Physicians Notes <em>NEW automation</em></td>
<td>Turns yellow when a scan or attachment is added, or checking the document received checkbox on the Physicians Scanned Notes form. Will turn yellow with a black R if the notes are awaiting review. Will turn yellow with red X if the</td>
<td>The &quot;Notes satisfy requirements&quot; checkbox on Physicians Scanned Notes form is checked</td>
</tr>
</tbody>
</table>
notes do NOT satisfy requirements.

<table>
<thead>
<tr>
<th>Feature</th>
<th>Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fab/Parts (Used to track whether the parts are all in and whether fabrication is completed such that the delivery can be scheduled.)</td>
<td>Turns yellow in any of the three following scenarios: 1. At least one part has been requested (shopping cart or inventory), 2. A fab form has been sent to Fab Tracking, or 3. A C-fab form has been recorded.</td>
<td>In Fab Tracking, a new checkbox option was added &quot;Fab/Parts Complete WIP.&quot; (Note: this checkbox is indicating that ALL fab items and parts are ready, and once checked, will turn WIP icon green.)</td>
</tr>
<tr>
<td>Pt Education</td>
<td>Checkbox/Scan/Attachment/Digital Signature on Facility/Patient Docs form</td>
<td></td>
</tr>
<tr>
<td>Delivery Receipt</td>
<td>It turns yellow when printed and will turn yellow with a black dollar sign when it is digitally signed but not sent to bill.</td>
<td>Sent to Bill. It will turn green with paperclip when image (scan or attachment) is present.</td>
</tr>
<tr>
<td>Patient Satisfaction (Automated if Quality Outcomes integration is enabled. Otherwise manual.)</td>
<td>L-codes are delivered and a Patient Satisfaction survey is created</td>
<td>If there is an email address for the patient, or a survey code is provided to the patient or the survey was printed for the patient</td>
</tr>
<tr>
<td>Physician Follow up</td>
<td>Not automated. Intended as manual check that the physician was followed up with after the patient was delivered.</td>
<td></td>
</tr>
<tr>
<td>Paperwork Complete</td>
<td>Not automated. Intended as manual check that everything is in order.</td>
<td></td>
</tr>
<tr>
<td>Delivered</td>
<td>Not automated. Intended as manual confirmation of actual delivery.</td>
<td></td>
</tr>
</tbody>
</table>

*Checkbox/Scan/Attachment means that the columns will turn green as follows:
  - Green circle if the Document Received checkbox on the scan tab of the appropriate form is checked
  - Green circle with a paperclip if a scan or attachment is present on that form

**Multiple Users in WIP**

Multiple users can work simultaneously in WIP and the Rx Summary without overwriting data. If OPIE detects a conflicting status change, the user will be alerted about the conflict and allowed to either continue with the selection or overwrite and pull in the latest data.

**Status Tracking in WIP**

To view status changes in WIP, right click on the WIP row and select View Status Change.
Here is an example of the status tracking log:

<table>
<thead>
<tr>
<th>Status Change Tracking For: LCodes Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>-- Status Change: Opie Auto Completed :: 09/05/2012 09:03 am, JS</td>
</tr>
<tr>
<td>-- Status Change: Opie Auto Completed :: 04/04/2012 04:21 pm, PS</td>
</tr>
<tr>
<td>-- Status Change: Opie Auto Completed :: 04/04/2012 04:21 pm, PS</td>
</tr>
<tr>
<td>-- Status Change: Opie Auto Completed :: 04/04/2012 04:07 pm, DJ</td>
</tr>
</tbody>
</table>

To close the WIP Status Tracking log, click the “X” button in the upper right corner.

**Remove an Rx from WIP**

An Rx can be moved from the WIP Active display by clicking the box in the left margin. Click the Refresh button at the top of the page and that entry will move to the Completed WIP display.

**How to Clean Out WIP**

This can be done relatively quickly by anyone at your site who has permission to complete WIP items.

1. Click the rectangle beneath the Rx Date column header twice to sort the WIP by oldest to newest Rx Date.
2. Check the box to the left of the first WIP row you wish to mark as completed.
3. Press the arrow down key on your keyboard.
4. Press the Space bar on your keyboard.
5. Press the arrow down key on your keyboard.
6. Press the Space bar on your keyboard.
7. Continue this process until you have checked all WIP rows you wish to move out of your active WIP display.
8. Click the blue Refresh button and all of the WIP rows that were checked will no longer appear in your active WIP display; they will be in the Completed WIP display instead.

**Print WIP**

The Work-In-Progress (WIP) screen is not printable the Administrative WIP Report can be printed from OPIE Reports.

1. From the Reports Generator window of OPIE Reports, select Category: Specialty Reports / Report Data: Administrative WIP / Parameters: Active and click the Generate Report button.
2. Use the Choose Fields button to limit or expand the fields in view.
3. Use the Filter icon at the top of the columns to further refine the criteria.
4. The report can be exported or Sent to the Default Printer.

**Print WIP Column Headers**
If clicking the blue Print WIP button doesn't print the column headers, check the printer page setup. Because the headers are actually an image, this must be enabled in the printer Page Setup menu.

1. In Print Preview, click the little gear wheel icon to access the page setup menu.
2. Check the box to Print Background colors and images.

**WIP Form Jump**

Double-click on a WIP icon to jump directly to the form in the patient’s chart. If OPIE detects multiple forms related to the icon, the user will have the option to select the document to open. If no document exists, the user will be prompted to see if they want to create that document. **Note:** The last 3 columns do not have the ability to create/view forms since these columns are not automated by OPIE. Patient Satisfaction column cannot create a form from the icon but can open the existing form for viewing.

**WIP Fab Tracking Jump**

Double-click on the Fab/Parts icon to jump to the Fab Tracking screen, which will show all details for all fabrication items for that prescription.

**WIP Authorization Tracking**

The WIP will now indicate that authorizations are about to expire with icons that change decrementally as the expiration date approaches.

- At 45 days until expiration, the WIP status will automate to a 3/4 green orb.
- At 30 days until expiration, the WIP status will automate to a 1/2 green orb.
- At 15 days until expiration, the WIP status will automate to a 1/4 green orb.
- On expiration, the WIP status will automate to a Red Triangle with an E.
  - **Note:** The expiring authorization icons will only change states up until the delivery column goes to green. At that point the auth column expiration will stop counting down
  - In this version, the icons will only be triggered and updated by the authorization forms. In a future version, OPIE Sentry will auto-update WIP by looking through all authorizations on a timed basis.

**Lcode Modification Tracking in WIP**

The WIP status icon for the LCodes column will automate to an orange orb inside a green orb with an exclamation point in it to alert users that the selected codes have changed.

**Physician Scanned Notes Requirement Tracking in WIP**

- Upon adding a Scan or an Attachment, the WIP status will change to "Awaiting Review," which is a yellow square with a black R in it.
The state can then be changed to "Satisfies Requirements," (green orb) or to "Does Not Satisfy Requirements." (a yellow square with a red X in it).

When the form is saved, the WIP status will be updated.

**WIP Filters**

The Visit Type and Appointment Date filters will enable users to limit the WIP display to view selected visit types during a specified date range. WIP will also respect location changes if an appointment location is modified.

**Key Points to Know**

- The WIP is prescription-based and the filters are appointment-based. This means filtering the WIP by a particular visit type will show all of the prescriptions entered under that visit type.
- The Appointment Date component, if checked, will show all or selected visit types during a specified date range.
- The Appointment Date filter is defaulted to display seven days (the current day and seven days beyond) but can be changed manually using the drop-down fields for the initial date and ending date.

**Setting**

The number of days defaulted to display for the appointment date range is a user setting that can be modified. Go to Change User Settings/Password under Other Tasks. Under Other Options, change the number of days for WIP appt date filter by typing the desired number into the text box on the right. Then log out and exit OPIE and log back in to see this change in effect.

**Tip**

To view a list of deliveries scheduled for the current week, select Delivery/Definitive Fitting in the Visit Type filter, check the Appt Date box and enter the date parameters. To display the normal WIP view, uncheck the Appt Date box and reset the Visit Type to Show All.

**How to use WIP Filters**

1. Select the visit type to display in the drop-down list in the upper right-hand corner of the WIP.
2. The WIP is defaulted to display seven days (the current day and seven days beyond, unless changed in Change User Settings/Password). To modify the view for a different date range, check the Appt Date box and add the applicable date parameters.
3. To change the WIP view back to view all prescriptions, uncheck the Appt Date box and reset the Visit Type to Show All.

**WIP Templates**
Site administrators now have the ability to create WIP templates with selected columns to be preset with a value of N/A. This functionality was created to provide a time-saving feature that allows users to select templates for patients where inapplicable columns are already marked as N/A.

**Key Points to Know**

- Choose the correct WIP template for each patient because once a template has been applied to a patient, the columns can be re-designated manually if they are incorrect but the template cannot be re-selected.
- N/A is the only value designation available in the creation of WIP Templates.
- WIP templates can only be created by a site Administrator.

**Tip**

Create a template name that is obvious to other users what type of patient it is for.

Open a patient in the WIP by double-clicking on the patient or highlighting the patient and clicking the Rx Summary button.

**How to Create a WIP Template**

Site administrators can create WIP templates in two ways. See the instructions below on both methods:

1. From the Main Menu of Administrative Tools, click the Edit WIP templates button. Click on the Create a New Template button and uncheck any items that should be marked as N/A. For example, a patient who is not diabetic will not need diabetic verification, so when creating a WIP template for a non-diabetic patient, uncheck Diabetic Verification. Name the template in the text field at the top left of this form. A WIP template will apply to a certain type of patient so the template name should make it obvious to other users what type of patient it is for. For example, an obvious name for a non-diabetic patient template might be "Non-diabetic Patient." After giving the template a name, click Save. This template will now be available in the Templates list.

2. Open a patient in the WIP by double-clicking the WIP row for that patient. In the right-hand side of the Rx Summary is a WIP Templates section where a template can be chosen or created for the current patient. To create a new template, click Create New and uncheck any items that should be marked N/A. Give the template a name, click Save and then Close. After choosing a WIP template, click the Refresh button in the WIP so that the change is visible.

**Tag List**

All date tags should now translate into the same short date format (unless the tag is specified as a long date format). **Note:** some of the new tags do not currently work in OPIE Mobile; however, they will be added into a future OPIE Mobile update soon.

<table>
<thead>
<tr>
<th>Tag Name</th>
<th>Full Name with description</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;&lt;referring phys last name&gt;&gt;</td>
<td>Referring Physician Last Name</td>
</tr>
<tr>
<td>Tag</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>&lt;&lt;Accident Date&gt;&gt;</td>
<td>Patient Accident Date (from global data)</td>
</tr>
<tr>
<td>&lt;&lt;activity level&gt;&gt;</td>
<td>Patient Activity Level (from global data)</td>
</tr>
<tr>
<td>&lt;&lt;affected side&gt;&gt;</td>
<td>Affected Side (from Prescription - right, left, bilateral)</td>
</tr>
<tr>
<td>&lt;&lt;afo&gt;&gt;</td>
<td>ankle foot orthosis</td>
</tr>
<tr>
<td>&lt;&lt;age&gt;&gt;</td>
<td>Patient Age</td>
</tr>
<tr>
<td>&lt;&lt;Amputation Date&gt;&gt;</td>
<td>Patient Amputation Date (from global data)</td>
</tr>
<tr>
<td>&lt;&lt;branch patient (primary)&gt;&gt;</td>
<td>Patient’s Primary Branch Name</td>
</tr>
<tr>
<td>&lt;&lt;check out time&gt;&gt;</td>
<td>From the appointment - the time recorded when the patient was marked checked out</td>
</tr>
<tr>
<td>&lt;&lt;codes/justifications&gt;&gt;</td>
<td>Pulls from the latest LCodes that have been marked as “Final” in the Rx</td>
</tr>
<tr>
<td>&lt;&lt;current user full name&gt;&gt;</td>
<td>Logged in user name (first middle last)</td>
</tr>
<tr>
<td>&lt;&lt;Rx Date&gt;&gt;</td>
<td>Current Prescription Date</td>
</tr>
<tr>
<td>&lt;&lt;device type&gt;&gt;</td>
<td>Device Type Name (from Prescription)</td>
</tr>
<tr>
<td>&lt;&lt;df&gt;&gt;</td>
<td>definitive</td>
</tr>
<tr>
<td>&lt;&lt;diagnosis code primary&gt;&gt;</td>
<td>The old versions of these tags will continue to translate correctly - &gt; Same description as the old tag: “&lt;&lt;ICD9 primary&gt;&gt;”</td>
</tr>
<tr>
<td>&lt;&lt;diagnosis code secondary&gt;&gt;</td>
<td>The old versions of these tags will continue to translate correctly - &gt; Same description as the old tag: “&lt;&lt;ICD9 secondary&gt;&gt;”</td>
</tr>
<tr>
<td>&lt;&lt;diagnosis secondary&gt;&gt;</td>
<td>Second diagnosis entered into the Prescription</td>
</tr>
<tr>
<td>&lt;&lt;diagnosis&gt;&gt;</td>
<td>First Diagnosis entered into the Prescription</td>
</tr>
<tr>
<td>&lt;&lt;dob&gt;&gt;</td>
<td>Patient Date of Birth</td>
</tr>
<tr>
<td>&lt;&lt;first name&gt;&gt;</td>
<td>Patient First Name</td>
</tr>
<tr>
<td>&lt;&lt;first/last name&gt;&gt;</td>
<td>Patient First and Last Name (no Middle)</td>
</tr>
<tr>
<td>&lt;&lt;full name&gt;&gt;</td>
<td>Patient Full Name (First Middle Last)</td>
</tr>
<tr>
<td>&lt;&lt;He/She caps&gt;&gt;</td>
<td>He or She based on patient gender</td>
</tr>
<tr>
<td>&lt;&lt;he/she&gt;&gt;</td>
<td>he or she based on patient gender</td>
</tr>
<tr>
<td>&lt;&lt;height&gt;&gt;</td>
<td>Patient Height (from global data)</td>
</tr>
<tr>
<td>&lt;&lt;height date&gt;&gt;</td>
<td>The most recent date in which the height was measured</td>
</tr>
<tr>
<td>&lt;&lt;him/her&gt;&gt;</td>
<td>him or her based on patient gender</td>
</tr>
<tr>
<td>&lt;&lt;His/Her caps&gt;&gt;</td>
<td>His or Her based on patient gender</td>
</tr>
<tr>
<td>&lt;&lt;his/her&gt;&gt;</td>
<td>his or her based on patient gender</td>
</tr>
<tr>
<td>&lt;&lt;in room time&gt;&gt;</td>
<td>From the appointment - the time recorded when the patient was marked in room</td>
</tr>
<tr>
<td>&lt;&lt;insurance address primary&gt;&gt;</td>
<td>Primary Insurance Address</td>
</tr>
<tr>
<td>&lt;&lt;insurance address primary formal&gt;&gt;</td>
<td>Primary Insurance Address formatted on multiple lines</td>
</tr>
<tr>
<td>&lt;&lt;insurance address secondary&gt;&gt;</td>
<td>Secondary Insurance Address</td>
</tr>
<tr>
<td>Tag</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><code>&lt;&lt;insurance address secondary formal&gt;&gt;</code></td>
<td>Secondary Insurance Address formatted on multiple lines</td>
</tr>
<tr>
<td><code>&lt;&lt;insurance primary id&gt;&gt;</code></td>
<td>Primary insurance ID number</td>
</tr>
<tr>
<td><code>&lt;&lt;insurance primary&gt;&gt;</code></td>
<td>Primary insurance Name</td>
</tr>
<tr>
<td><code>&lt;&lt;insurance secondary id&gt;&gt;</code></td>
<td>Secondary insurance ID number</td>
</tr>
<tr>
<td><code>&lt;&lt;insurance secondary&gt;&gt;</code></td>
<td>Secondary insurance Name</td>
</tr>
<tr>
<td><code>&lt;&lt;insurance subscriber name primary&gt;&gt;</code></td>
<td>Primary Insurance Subscriber Name</td>
</tr>
<tr>
<td><code>&lt;&lt;insurance subscriber dob primary&gt;&gt;</code></td>
<td>Primary Insurance Date of Birth</td>
</tr>
<tr>
<td><code>&lt;&lt;k-level&gt;&gt;</code></td>
<td>The full K-Level with description from global data (ex. “K2 Functional Level 2. The patient has the ability…..”)</td>
</tr>
<tr>
<td><code>&lt;&lt;last name&gt;&gt;</code></td>
<td>Patient Last Name</td>
</tr>
<tr>
<td><code>&lt;&lt;last visit date&gt;&gt;</code></td>
<td>The most recent Date of the visit within the prescription</td>
</tr>
<tr>
<td><code>&lt;&lt;last visit type&gt;&gt;</code></td>
<td>The most recent Visit Type within the Prescription</td>
</tr>
<tr>
<td><code>&lt;&lt;long date&gt;&gt;</code></td>
<td>Current Long Date format as May 25, 2010</td>
</tr>
<tr>
<td><code>&lt;&lt;next appt date this Rx&gt;&gt;</code></td>
<td>The next appointment within the current prescription occurring after this appointment</td>
</tr>
<tr>
<td><code>&lt;&lt;next visit type this Rx&gt;&gt;</code></td>
<td>The next visit type within the current prescription occurring after this visit</td>
</tr>
<tr>
<td><code>&lt;&lt;patient addr formal&gt;&gt;</code></td>
<td>Patient Formal Address (multiple lines)</td>
</tr>
<tr>
<td><code>&lt;&lt;patient addr&gt;&gt;</code></td>
<td>Patient Address (all on one line)</td>
</tr>
<tr>
<td><code>&lt;&lt;patient phone&gt;&gt;</code></td>
<td>Patient Home Phone</td>
</tr>
<tr>
<td><code>&lt;&lt;phys therapist addr formal&gt;&gt;</code></td>
<td>Physical Therapist Formal Address (multiple Lines)</td>
</tr>
<tr>
<td><code>&lt;&lt;phys therapist addr&gt;&gt;</code></td>
<td>Physical Therapist Address (all on one line)</td>
</tr>
<tr>
<td><code>&lt;&lt;phys therapist fax&gt;&gt;</code></td>
<td>Physical Therapist Fax</td>
</tr>
<tr>
<td><code>&lt;&lt;phys therapist phone&gt;&gt;</code></td>
<td>Physical Therapist Phone 1</td>
</tr>
<tr>
<td><code>&lt;&lt;phys therapist&gt;&gt;</code></td>
<td>Physical Therapist Name (from Patient Contacts)</td>
</tr>
<tr>
<td><code>&lt;&lt;physical condition&gt;&gt;</code></td>
<td>Patient Physical Condition (from global data)</td>
</tr>
<tr>
<td><code>&lt;&lt;practitioner (appt)&gt;&gt;</code></td>
<td>The name of the Practitioner to be scheduled for the current appointment/visit.</td>
</tr>
<tr>
<td><code>&lt;&lt;practitioner (Primary)&gt;&gt;</code></td>
<td>The old versions of these tags will continue to translate correctly - Same description as the old tag: “&lt;&lt;primary practitioner full name rx&gt;&gt;”</td>
</tr>
<tr>
<td><code>&lt;&lt;practitioner (Treating)&gt;&gt;</code></td>
<td>The old versions of these tags will continue to translate correctly - Same description as the old tag: “&lt;&lt;primary practitioner full name rx&gt;&gt;”</td>
</tr>
<tr>
<td><code>&lt;&lt;prim care phys addr formal&gt;&gt;</code></td>
<td>Primary Care Physician Formal Address (multiple lines)</td>
</tr>
<tr>
<td><code>&lt;&lt;prim care phys addr&gt;&gt;</code></td>
<td>Primary Care Physician Address (all on one line)</td>
</tr>
<tr>
<td><code>&lt;&lt;prim care phys fax&gt;&gt;</code></td>
<td>Primary Care Physician Fax</td>
</tr>
<tr>
<td>Tag</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><code>&lt;&lt;prim care phys last name&gt;&gt;</code></td>
<td>Primary Care Physician Last Name</td>
</tr>
<tr>
<td><code>&lt;&lt;prim care phys NPI&gt;&gt;</code></td>
<td>Primary Care Physician NPI</td>
</tr>
<tr>
<td><code>&lt;&lt;prim care phys phone&gt;&gt;</code></td>
<td>Primary Care Physician Phone 1</td>
</tr>
<tr>
<td><code>&lt;&lt;prim care phys for current Rx&gt;&gt;</code></td>
<td>Primary Care Physician for current Rx</td>
</tr>
<tr>
<td><code>&lt;&lt;primary practitioner full name&gt;&gt;</code></td>
<td>Patient Default Primary Practitioner full name</td>
</tr>
<tr>
<td><code>&lt;&lt;py&gt;&gt;</code></td>
<td>preparatory</td>
</tr>
<tr>
<td><code>&lt;&lt;race&gt;&gt;</code></td>
<td>Patient race (from global data)</td>
</tr>
<tr>
<td><code>&lt;&lt;referring phys addr formal&gt;&gt;</code></td>
<td>Referring Physician Formal Address (multiple lines)</td>
</tr>
<tr>
<td><code>&lt;&lt;referring phys addr&gt;&gt;</code></td>
<td>Referring Physician Address (all on one line)</td>
</tr>
<tr>
<td><code>&lt;&lt;referring phys fax&gt;&gt;</code></td>
<td>Referring Physician Fax</td>
</tr>
<tr>
<td><code>&lt;&lt;referring phys NPI&gt;&gt;</code></td>
<td>Referring Physician NPI</td>
</tr>
<tr>
<td><code>&lt;&lt;referring phys phone&gt;&gt;</code></td>
<td>Referring Physician Phone 1</td>
</tr>
<tr>
<td><code>&lt;&lt;referring phys UPIN&gt;&gt;</code></td>
<td>Referring Physician UPIN</td>
</tr>
<tr>
<td><code>&lt;&lt;referring phys for current Rx&gt;&gt;</code></td>
<td>Referring Physician for current Rx</td>
</tr>
<tr>
<td><code>&lt;&lt;sex&gt;&gt;</code></td>
<td>Patient Gender (male or female)</td>
</tr>
<tr>
<td><code>&lt;&lt;short date&gt;&gt;</code></td>
<td>Current Short Date format as 05/25/2010</td>
</tr>
<tr>
<td><code>&lt;&lt;showed up time&gt;&gt;</code></td>
<td>From the appointment - the time recorded when the patient was marked showed up</td>
</tr>
<tr>
<td><code>&lt;&lt;tf_txplan&gt;&gt;</code></td>
<td>Treatment Plan from the Transfemoral Initial Eval form under this prescription</td>
</tr>
<tr>
<td><code>&lt;&lt;tf&gt;&gt;</code></td>
<td>transfemoral</td>
</tr>
<tr>
<td><code>&lt;&lt;time&gt;&gt;</code></td>
<td>Current Time format as 03:01 PM</td>
</tr>
<tr>
<td><code>&lt;&lt;tt_txplan&gt;&gt;</code></td>
<td>Treatment Plan from the Transtibial Initial Eval form under this prescription</td>
</tr>
<tr>
<td><code>&lt;&lt;tt&gt;&gt;</code></td>
<td>transtibial</td>
</tr>
<tr>
<td><code>&lt;&lt;visit date&gt;&gt;</code></td>
<td>Date of current visit</td>
</tr>
<tr>
<td><code>&lt;&lt;visit location&gt;&gt;</code></td>
<td>Location of current visit (normally transfers to visit from appointment and location = home office, etc). If the location is ‘In Office,’ it will show the Branch Name.</td>
</tr>
<tr>
<td><code>&lt;&lt;visit type&gt;&gt;</code></td>
<td>Type of current visit</td>
</tr>
<tr>
<td><code>&lt;&lt;weight&gt;&gt;</code></td>
<td>Patient Weight (from global data)</td>
</tr>
<tr>
<td><code>&lt;&lt;weight date&gt;&gt;</code></td>
<td>The most recent date in which the weight was measured</td>
</tr>
<tr>
<td><code>&lt;&lt;date time&gt;&gt;</code></td>
<td>Current Date\Time</td>
</tr>
<tr>
<td><code>&lt;&lt;treatment plan - tf&gt;&gt;</code></td>
<td>TF Treatment Plan from current Rx</td>
</tr>
<tr>
<td><code>&lt;&lt;treatment plan - tt&gt;&gt;</code></td>
<td>TT Treatment Plan from current Rx</td>
</tr>
<tr>
<td><code>&lt;&lt;treatment plan - le&gt;&gt;</code></td>
<td>Lower Extremity Treatment Plan from current Rx</td>
</tr>
<tr>
<td><code>&lt;&lt;treatment plan - th (primary)&gt;&gt;</code></td>
<td>Trans Humeral Treatment Plan (Primary) from current Rx</td>
</tr>
<tr>
<td><code>&lt;&lt;treatment plan - th (secondary)&gt;&gt;</code></td>
<td>Trans Humeral Treatment Plan (Secondary) from current Rx</td>
</tr>
<tr>
<td>Treatment Plan Description</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Trans Humeral Treatment Plan (Tertiary) from current Rx</td>
<td></td>
</tr>
<tr>
<td>Trans Radial Treatment Plan (Primary) from current Rx</td>
<td></td>
</tr>
<tr>
<td>Trans Radial Treatment Plan (Secondary) from current Rx</td>
<td></td>
</tr>
<tr>
<td>Trans Radial Treatment Plan (Tertiary) from current Rx</td>
<td></td>
</tr>
</tbody>
</table>