EMR Billing User Guide

Updated December 2024

PEI EMR Program
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To perform billing for any MD on the PEI Provincial EMR (Telus CHR), the Physician must have submitted a valid billing number, their Specialty, and their clinic location to a PEI EMR Program staff to create a standard billing configuration for that Physician. This will ensure that when they create a bill, or anyone else creates a bill on their behalf, the CHR will automatically bring in that information.

We encourage users to update their billing settings (covered in the **Updating your Billing Settings** section) to make billing on the CHR as easy as possible.

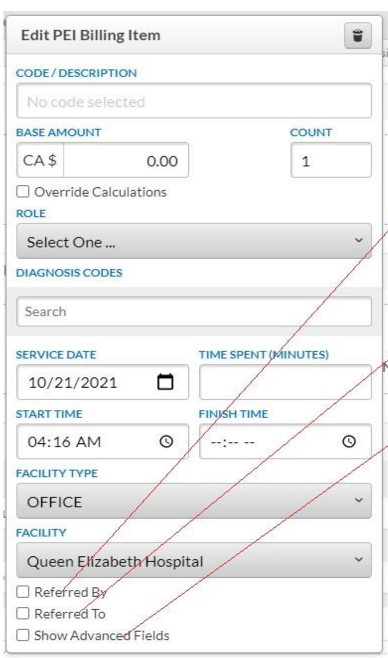
Note: any bills created in the CHR, with a 'Ready' status, will be submitted to Medicare each business day at 6:00pm AST. * If the bill was created as part of an encounter, the encounter must be signed.

In the CHR, you can access billing from four (4) areas:

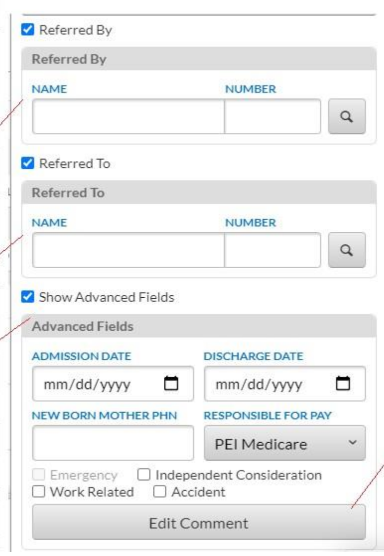
1. The Patient's **Encounter** (For billing by the MD/NP)
2. **Visits** icon on the left-hand menu (For billing by the MOA/billing clerk)
3. Quick Billing – via the **Billing** icon on the left-hand menu (For billing services not on the schedule)
4. The **Patient's Start/Open menu** on the top right when viewing a patient chart (Optional for any of the above)

BILLING VIA AN ENCOUNTER

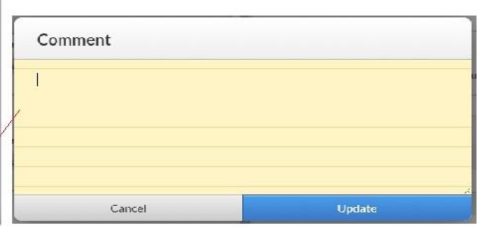
When you select Insured Billing, you will be presented with the following screen.



Billing Screen



Selecting checkboxes



Selecting Edit Comment button

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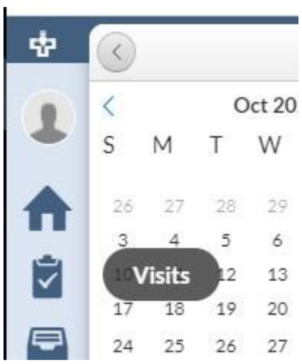
1. **Code/Description** – as you begin typing the code or text, a drop down will appear to select the appropriate code or description. There are two sections here – in the first area, you can use a billing code (e.g. 0113); in the second area, if you cannot recall the code to be used, you can write in the description field what you're trying to bill and it will populate a list of options for you to select from, which will also populate the correct code.
   Note: Once you have found the fee code that you're looking for, you can click the star icon to make it a 'favorite'. Once you have selected any fee codes as 'favorites', that list will automatically be displayed as soon as you click into the Code/Description field.
2. **Base Amount** – this will display the standard dollar amount assigned to that fee code, as outlined in the Master Agreement.
   Note: For time-based codes, the base amount will appear as $0.00, however, the total fee will be displayed in the completed bill that will be sent to Medicare.
   Note: You can manually change the dollar amount in this field, however, you will need to tick the box for 'Override Calculations', and you will also likely need to select the Show Advanced Fields section and tick the box for 'Independent Consideration'. You should also include a comment indicating the rationale for the fee requested. This is applicable only when requesting a fee greater than specified in the Master Agreement.
3. **Role** - Role will populate for the user (if not, it must be selected). Many fee codes will default to Role = 100%, however, for any procedures you will need to set the role %.
4. **Diagnosis Codes** - as you begin typing the code or text, a drop down will appear to select the appropriate code.
5. Bring above to include in step 4 If the diagnosis code was added as part of the encounter, and the bill is linked to that encounter, the diagnosis code will automatically be filled.
6. Still part of 4 Similar to Fee Codes, you can tick the 'star' icon to make a diagnosis code a 'favorite' when entering a diagnosis code in a billing item.
7. **Service Date** will default to the current date – it can be updated if necessary.
8. **Time** - Start Time entered and Time Spent (minutes) entered will populate the Finish Time – depending on the rules, you may be required to enter this. As long as two of the fields are completed for the time (e.g. Start Time + Finish Time, or Finish Time + Time Spent), the third field will be automatically filled. For example, if we put in a start time of 9:00am, and a finish time of 9:30am, the Time Spent field will autofill and display 30 minutes.
9. **Facility Type and Facility** – These will be defaulted for the user based on their billing configuration as submitted to the EMR Program – e.g. Dr. Smith indicated that they work at Boardwalk when they came on to CHR, their Facility Type will default to 'Office' and their Facility will Default to Boardwalk. If the Patient is being seen at another location, the location field will need to be updated. Billing Templates can be enormously helpful for billing regular fee items that were done at other facilities (e.g. surgical procedures at hospital, inpatient care, on-call stipends, etc.).
10. **Show Advanced Fields** - The checkboxes at the bottom of the screen allow users to access additional fields that may be required depending on the Fee Code.
    Options available under the 'Advanced Fields' section include:
    - Responsible for Pay: The default for the Responsible for Pay (RFP) field is PEI Medicare. If left alone, all bills will be sent to Medicare for payment using the standard method as outlined in your contract. **If you are Salaried, and need to submit a bill as Fee For Service (FFS), please change this field to OTHER.** By changing the RFP to Other, Medicare recognizes that the payment modality must be switched to FFS. If your contract with HPEI is set as FFS, there is no need to make any change to this field. PLEASE NOTE: If you are regularly a Salaried

Physician and submitting a bill as FFS, you MUST include the start time and finish time. If the bill requires the evening/weekend/holiday premium, you will need to click the Emergency checkbox to apply the premium.

- Emergency: The Emergency checkbox is intended to add a 25% premium for Evenings/Weekends/Holidays. See "How to Apply the Evening / Weekend / Holiday Premium" section for details.
- Independent Consideration: This may be used to flag the bill for Medicare review. A comment should be used to ensure that Medicare is provided with context for the review requested.
- Override Rules: This feature allows the biller to submit a bill even where it does not meet all requirements, and if checked prior to selecting a fee code, allows the biller to select fee codes that are not normally available for the Specialty of the biller. A comment would be recommended to provide context for Medicare on the nature of the special request being made.
- Comments: This field may be used to provide necessary information required for a bill. E.g. when billing for meeting time, a comment is required to indicate who was in attendance, and the reason for the meeting.

BILLING VIA THE VISITS ICON



This presents a view of the Day Sheet of Patients that are scheduled for the Provider on a given day. For these patients to show up they must be added to the schedule. Note: if a Provider sees a patient and does not add them to the schedule, they won't show up under the visits sheet.

To access the billing functionality, click on the Insured Column for the Appointment

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When the screen appears, select **Add Insured Payment.**

Complete the form as described using the same billing instructions outlined above in 'Billing via an Encounter'.

QUICK BILL VIA BILLING FEATURE

Steps:

1. In the CHR, please click on the billing icon 
2. Select the feature Quick Bill Entry.

3. This selection will bring up the Patient Search feature. Input the patient details (preferably using ID/MRN).
4. Once the patient information appears, to the right of their name, there are now two options:
   a. **+ Private Billing:** This can be used to create a Quick Bill that is Private pay, for the patient out of pocket / insurance company, etc.
   b. **+ Insured Billing:** This is to create any new bill that will be sent to Medicare for this patient.

Please note: <u>ONLY</u> click on + Private Billing or **+ Insured billing** If you click on the patient's name, it will open the patients chart or bring up the "Access Denied" screen to establish a relationship.

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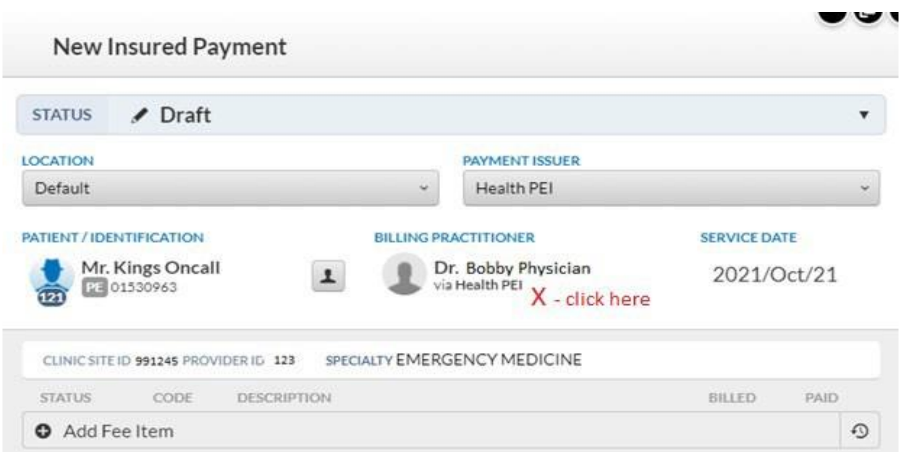
You can now add a new Fee Item and create your bill as normal, without the necessity of:

- Establishing a relationship with the patient
- Entering the patient chart
- Having to click Start/Open
- Clicking on 'Insured Billings'

INSURED BILLING VIA START/OPEN MENU

- Open the patient chart, then click on the Start/Open button)
- From the Start/Open menu select the Insured Billing tab
- The Patients complete list of Insured Payments made via CHR will be displayed

To create a new bill, click on the + New Payment icon



Note: the service date on this screen should remain as is, if needed to edit, change as noted earlier. Select Add Fee Item and you will be presented with the same screen as the Encounter.

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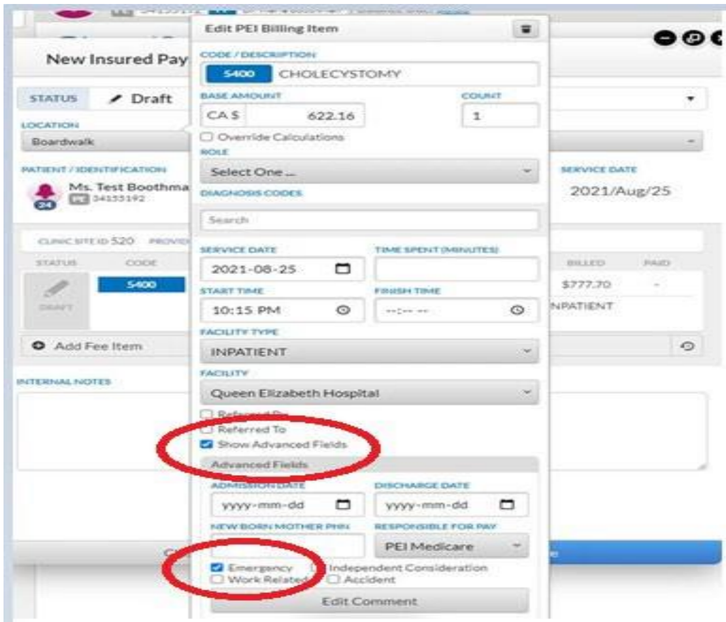
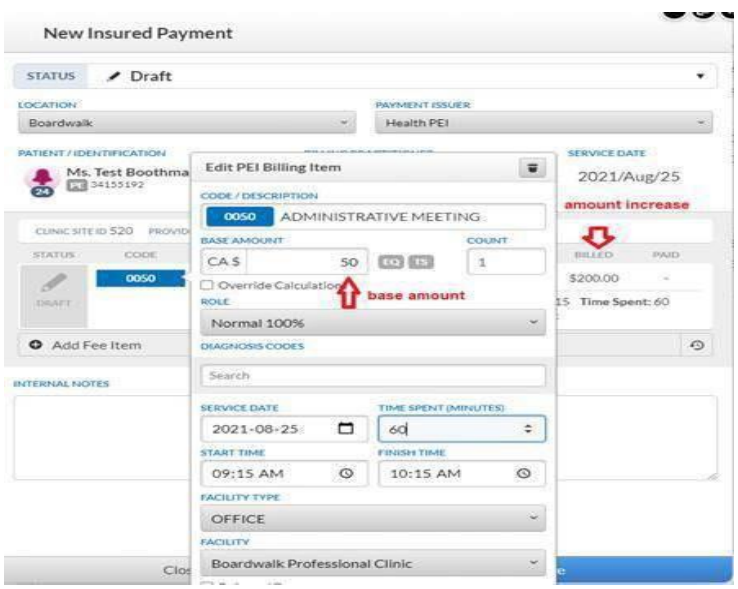
HOW TO APPLY THE EVENING / WEEKEND / HOLIDAY PREMIUM

To apply the fee increase premium for evenings, weekends or holidays, while editing the billing item, select Show Advanced Fields, and then select Emergency. If a comment applies, select Edit Comment and add the appropriate comment.

Note: When billing for an evening/weekend/holiday, please include the Start and Finish Times.

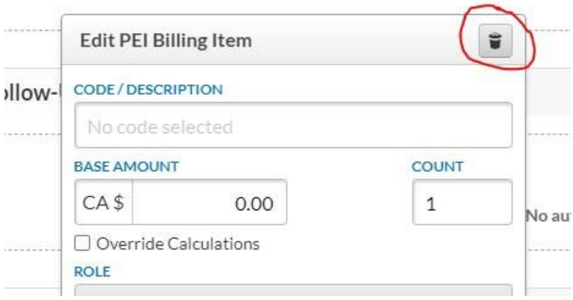


The fee increase should display in the Billed column as shown in the screen shot below.



- Entering comments is accessed by selecting Show Advanced Fields, Edit Comment.
- Once the screens are complete, click outside the form to close it.
- To add another fee item, simply click on the **+Insured Billing** button again.

- To edit or delete the claim, click on the claim and update or click on the garbage can on the top right of the screen. Delete a bill if you created a billing item in error or otherwise need to delete a billing item – so long as the bill has not yet been submitted.



SUBMITTING FOR OUT OF PROVINCE REFERRALS

When submitting a bill for an Out of Province referral, please submit a claim to Medicare using the specified Fee Code for your Specialty: 9401 – 9412 e.g. for Family Medicine, 9401 is the fee code.

The following screen shows how an out of province referral is submitted to Medicare.

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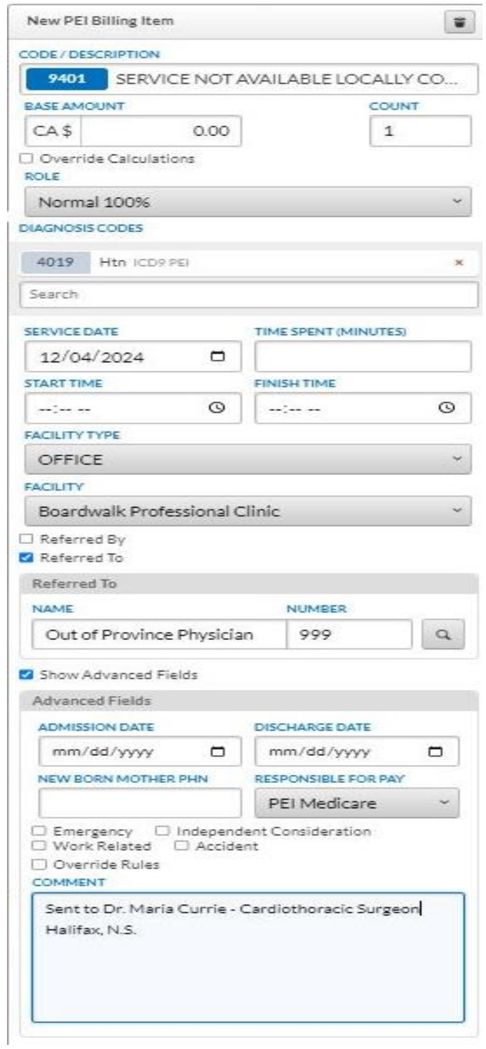


BILLING SETTINGS - MAKING YOUR BILLS DEFAULTED TO READY, AND KEEPING THE PRACTITIONER SELECTED

The following allows any CHR User to customize their Billing settings. This is performed within the Insured Billing section of patient charts, and the settings that you choose will only impact your account.

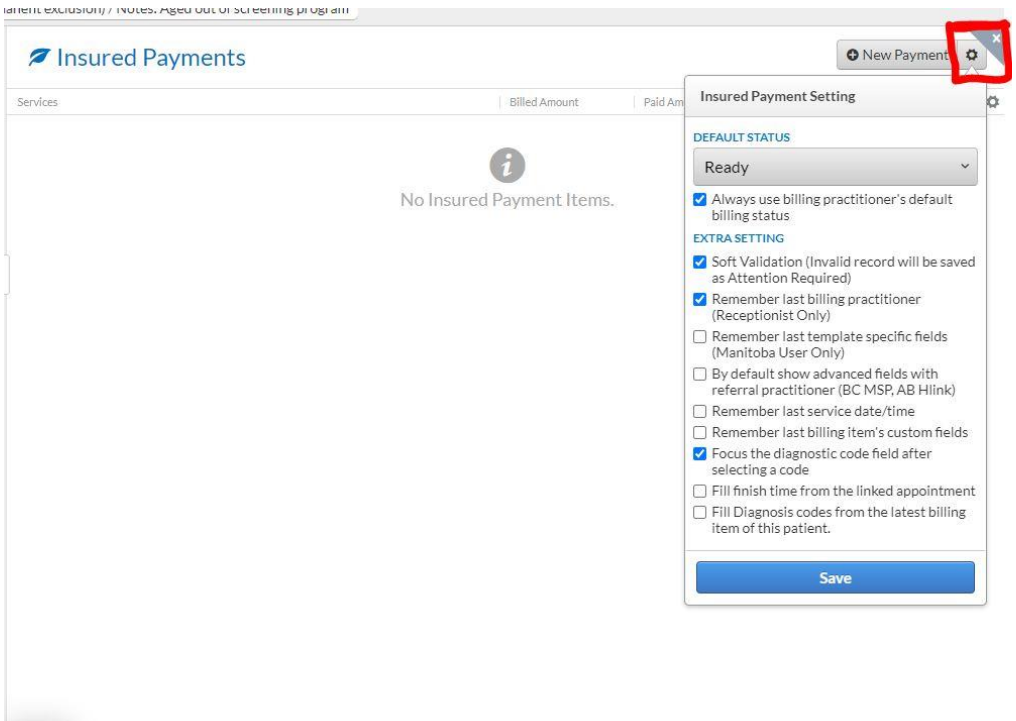
1. From the Patient chart, click **Start/Open**, then select the **Insured Billing** tab**.** The **Insured Payments** section opens.
2. Select the **gear icon** next to +New Payment (see picture below)**.**
3. From here, you have some options – We strongly recommend the following:
    - Default Status: you may elect to set your Default Status for bills to 'Ready to Submit', so that all bills created will be sent to Medicare without any further review. This will reduce the administrative burden of manually switching each bill from 'Draft' to 'Ready to Submit'.
    - Always use billing practitioner's default billing status: If you elect to use the option of "Always use billing practitioner's default billing status' - if you bill for more than

one practitioner and one likes to have their default as Ready, while another prefers Draft, then this will accommodate that.

- Soft Validation: Enabling this feature means that if your bill is missing some requisite information (e.g. forgot to put in a diagnosis code), the bill will automatically be switched to "Attention Required" status, so that you will know it must be repaired, and then reset to 'Ready' status and submitted.
- Remember last billing practitioner: Enabling this feature means that once you select the provider that you are billing for, that provider will remain selected for each subsequent bill you create, until such time that you elect to change the billing provider (if you bill for multiple providers).
- Focus Diagnostic code field after selecting a code: This means that if you have the diagnosis field completed in the encounter that you are billing for, it will auto populate to the bill that you are creating (only if the bill is linked to the encounter).

4. Once you have set your billing settings to the desired options, click the Save button.
5. You may need to hit refresh for the settings to take effect.

Note: We recommend Un-selecting the option of 'Fill Finish time from the linked appointment', as the provider may only finish the appointment well after the patient has left, which may create a discrepancy in the billings (e.g. the Physician started a skeleton note for a 10:00 a.m. appointment and finished the encounter over their lunch. The patient facing time they are allowed to bill for may have only been 30 minutes, but the bill may fill in that they saw the patient for 2 hours).



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BILLING STATUSES IN CHR

The TELUS Collaborative Health Record (CHR) uses statuses to indicate where in the billing process your claim is currently saved. There are statuses that apply before and after your claim has been submitted to Health PEI, and statuses that appear when a claim is returned from Health PEI.

Below is a summary of the PEI billing statuses for claims and billing items that you can see and use when you create and submit claims.

Claim Status	Description
Draft	The bill is saved in the CHR, and you can still make changes to the bill. When the claim is ready to be submitted to Health PEI, you must manually change the status of the claim to **Ready to Submit**.
Ready To Submit	The bill is complete (ready) and will be automatically submitted to Health PEI at the end of the day at 6pm AST. Any bill in Ready to Submit format will be switched to Submitted after 6 p.m.. **Important:** Your claim will not be submitted to Health PEI until the encounter is signed.
Attention Required	When a bill is saved with status **Ready to Submit**, and the created bill cannot be submitted to Health PEI (e.g due to a missing diagnosis code, the provider is not integrated with Health PEI, the health card number is invalid), the status changes to **Attention Required - Invalid. Bills that are in Attention Required status are missing required information and must be corrected prior to being submitted to Medicare. These cannot be appealed as Medicare has not yet received them.**
Submitted	As soon as your claim is successfully sent to Health PEI, the status changes to **Submitted.** **Note:** You cannot change this status.

Once a claim is submitted to the Health PEI, it comes back with a status of either **Completed, Attention Required**, or **Cancelled**:

Completed - with a **Paid** billing item status	The claim was paid in full by Health PEI.

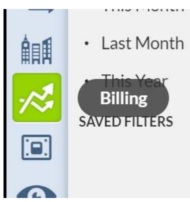
Cancelled - with a **Cancelled** billing item status	The claim was returned and was declined for payment. You cannot make any changes to the bill or the status. You can however appeal this.

HOW TO RUN A BILLING REPORT - FOR BILLING RECORDS KEEPING AND BILLING RECONCILIATION

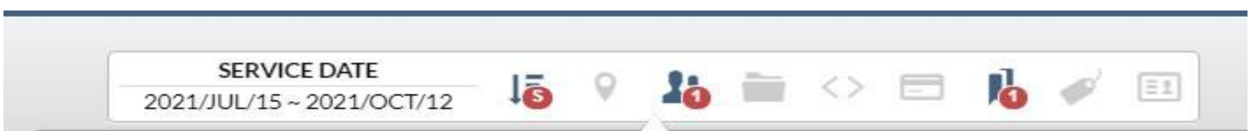
Purpose: The following document details how a user reconciles their billing once they have been submitted and assessed by Medicare. Bills that are submitted to Medicare prior to 6 PM will be available to reconcile the next morning.

Steps:

1. Click on the billing icon



2. Click on the Service date at the top of the screen



3. Select filters:
   - Date to be reconciled – select a start date and end date in the calendars. The search field must be one year of data or less.
   - Billing Practitioner – filter for yourself / the Physician/NP that you are working for
   - Select Insurer (if desired)
     - To search by a specific billing code, you will need to have Health PEI selected under the Insurer field
     - To search for Private Bills (patient pay), select Private Payment under the Insurer field
   - Click on Status filter – can filter by Draft, Ready to Submit, Pending, Submitted, Attention Required, Completed, or Cancelled. You can add or remove a status by clicking on the name. A report can be for one status at a time, or multiples as desired.
   - If you would like to filter in/out any billing items that have had payment tags applied, use the Payment Tags modifiers (With / Without, And/Or), and select the Payment tags desired.
   - Click Apply to run the billing report with the fields selected.

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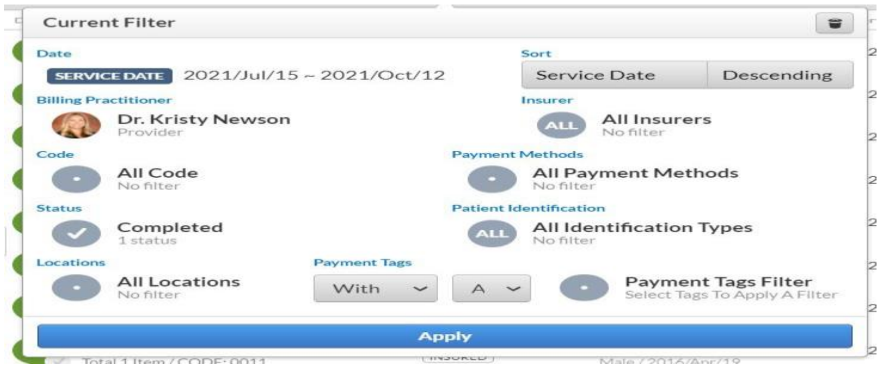
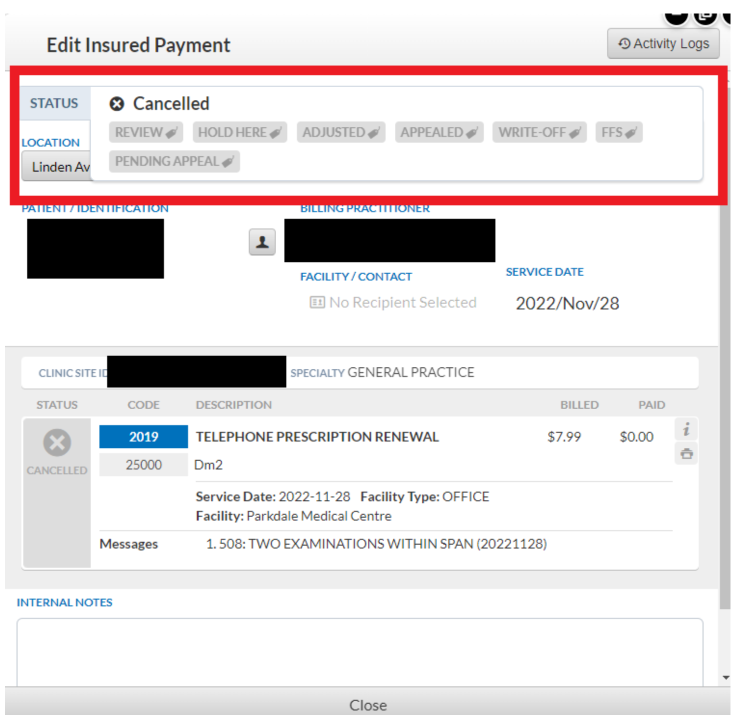


HOW TO APPLY PAYMENT TAGS

When reviewing a bill that has been cancelled, you can apply a payment tag to identify that the bill has been appealed, is pending appeal, has been written off, was adjusted, FFS, etc. By attaching a payment tag, it allows you to filter these in your future reports. For example, when reviewing cancelled bills that you have appealed, apply the payment tag of A**ppealed** to ensure that you do not accidentally appeal it more than once. You can also filter out any appealed bills in your next billing report so that you only see newly cancelled bills that require management.

To apply a payment tag, click on the status (e.g. Cancelled, Attention Required, etc.). Once you have clicked on the status, the options for payment tags will appear. Select the desired payment tag(s) that you would like to apply by clicking on them.



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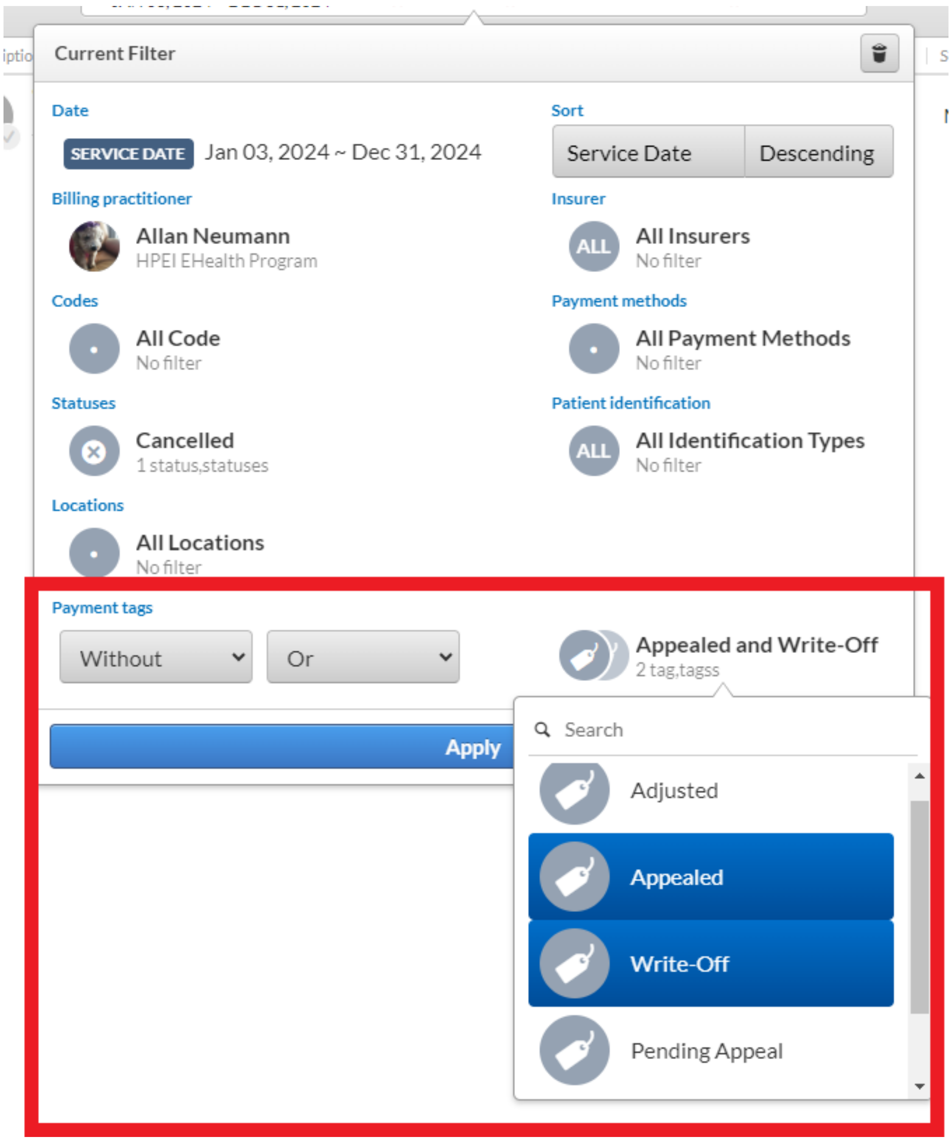
Filtering for **Payment Tags** when running a billing report can be accomplished by using the payment tags modifiers – **With/Without, And/Or**, and then selecting the desired payment tag options from the drop-down list. For example, when running a new billing report, you could set the filter to **Without + Or, Appealed + Written Off**, and the report will only show billing items that do not have a payment tag of **Appealed** or **Written Off**.



HOW TO MANAGE BILLS IN DRAFT FORMAT

Once you have run a report on your billings (see above How to Run a Billing Report), if you have several bills that are in DRAFT format, these should be reviewed to ensure that they are ready to be sent off to Medicare.

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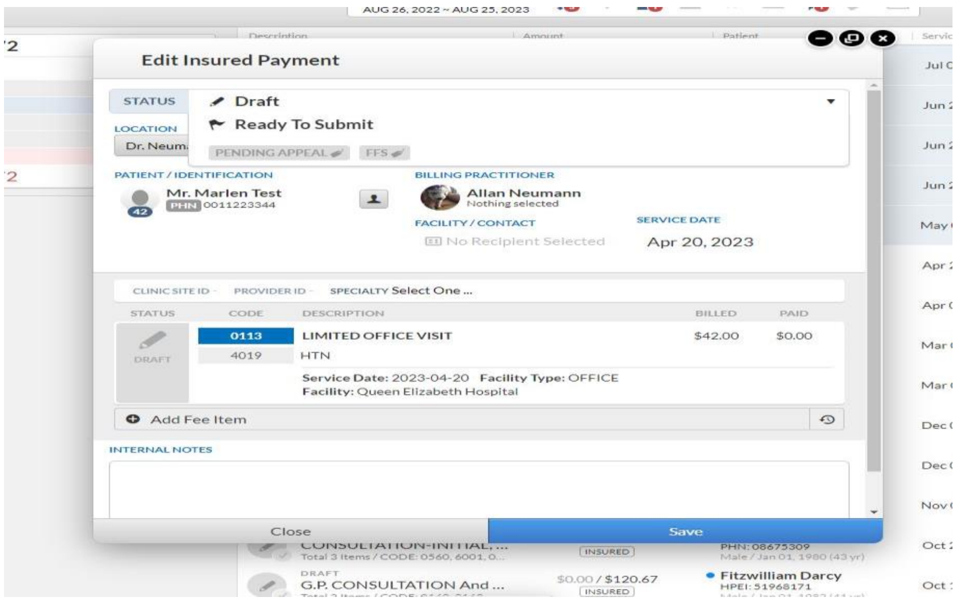
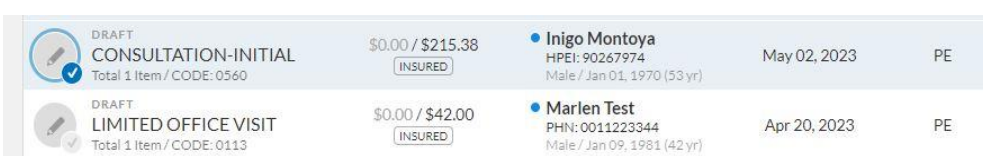
Once you have ensured that all bills are formatted correctly (role selected for procedures, time start/finish for any time-based codes, diagnosis code applied, etc.), you can switch the bill(s) from Draft to Ready to Submit. This can be accomplished in two ways:

1. Switch each bill manually while reviewing the bill:
   - Click at the top of the bill where it indicates the status: **Draft**
   - In the drop-down menu that appears, select **Ready To Submit**
   - Once the status has been changed to **Ready To Submit** format, click **Save**, and now the bill will be sent to Medicare.

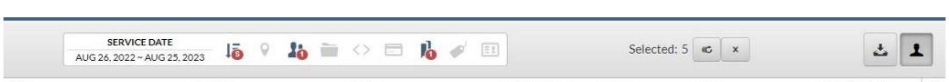


2. Use the Mass Action Manager function to switch multiple bills from **Draft** to Ready To Submit.

   - For each bill in **Draft** format, you'll see that there is a checkmark icon available (see picture below).
   - Click on the checkmark for each bill that you want to switch over to **Ready To Submit.**



   - Once you have each bill selected, you'll see that there is now a mass action manager function that is displayed just to the right of the filters applied at the top of the billing screen, indicating: Selected (Number of selected bills)



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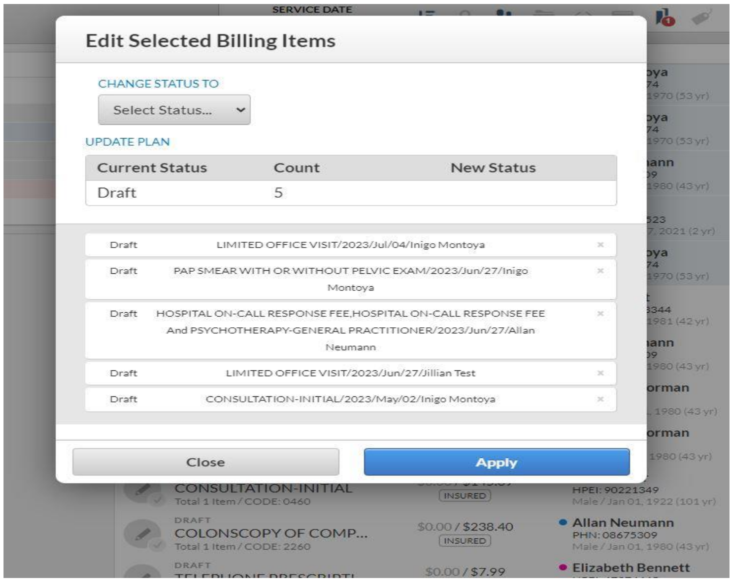
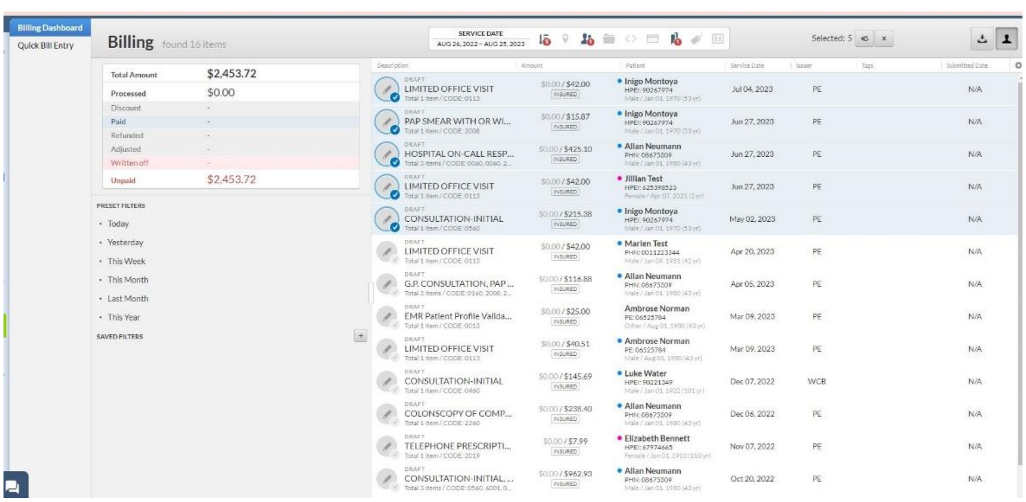
- Click on the action icon: 
- This will bring up a menu: Edit Selected Billing Items. From here, at the top you'll see that it offers you the chance to Change Status To. Click on the icon listed as 'Select Status…' and you can mass switch your bills from Draft to Ready to Submit (or other status, as the case may be).



- Once you have selected the correct status that you want for the bills, click **Apply**.
- You will be prompted to confirm that you want to continue. Click **Okay** to continue.
- Once the changes have taken place, you'll see a green bar at the bottom of the '**Edit Selected Billing Items**' screen indicating '**Update Successful**!'.
- Click '**Close'** and you'll see the changes will have taken place.
- To Un-Click the selected items, click on the 'X' next to the mass action manager.



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HOW TO MANAGE BILLS IN ATTENTION REQUIRED FORMAT

Once you have run a report on your billings (see above   How to Run a Billing Report), if you have several bills that are in **ATTENTION REQUIRED** format, these should be reviewed and corrected to ensure that they are ready to be sent off to Medicare.

Note: If a bill is in status Attention Required – this means that there is either some information missing, or patient information is incorrect.

Any bill that is in status ‘Attention Required’ has NOT been submitted to Medicare – and CANNOT be appealed – these bills must be corrected with either the missing or correct information.

Once the bill has been corrected, click on the banner that indicates ‘Attention Required’, and you will see a drop-down menu appear. Select ‘Ready to Submit’ and then ‘Save’, and the bill will be sent to Medicare.

HOW TO MANAGE ERROR MESSAGES

For any message that has been categorized as Attention Required, there will be an error message displayed which may offer some guidance on how to correct the bill.

In any situation where the patient demographics are causing the issue:

- Patient information mismatch (name, DOB, or other key identifier is incorrect);
- Identification value is invalid (MRN is incorrect);
- Resident covered by another province (need their HCN for home province);
- Check Eligibility for PEI (need their PEI MRN);
- Resident number not on file (temp MRN likely – need to obtain their MRN and re-submit)
- Resident surname mismatch (last name is incorrect);
- Eligibility – suspended health act (their Health card is expired);
- Etc.

These types of issues can be resolved via the bill in many instances by updating the patient demographics within the bill. This can be accessed by clicking on the patient’s name under the heading Patient Identification.

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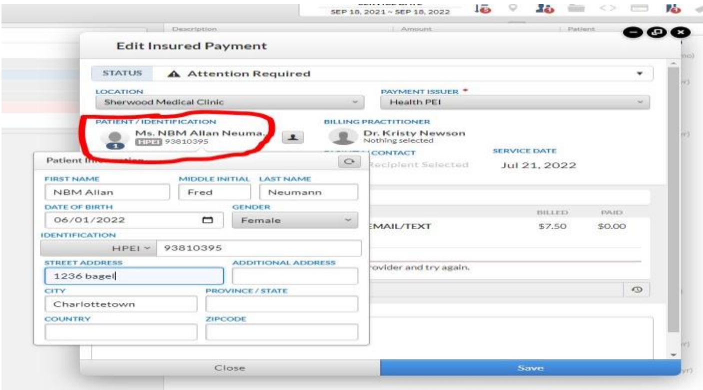
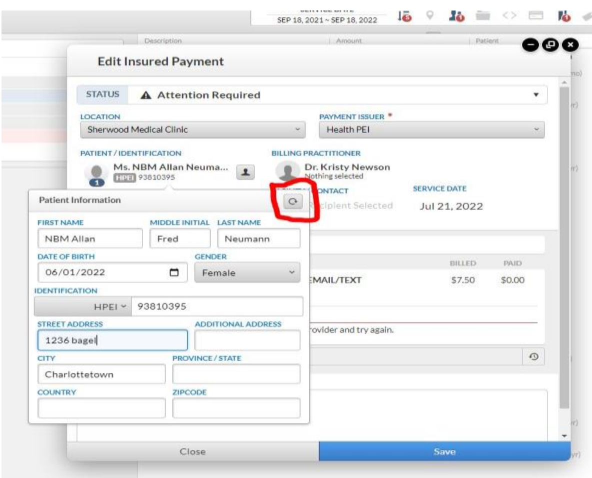
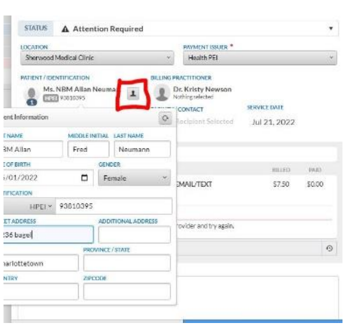


From here you can manually update the patient demographics with any new info (e.g. change the PHN/MRN, Province/Territory and number, or last name, etc.).

You can also update the bill by refreshing the patient data using the internal refresh button in the bill. This will update the bill with any changes that were made to the patient demographics since the bill was created. E.g. a bill for a newborn was marked Attention Required as you didn't have all the information at the first visit, and since the child was seen again and their chart has been updated with accurate name, MRN, etc. The refresh option will update the initial bill with the current up to date information.



You can also check the patient chart for a better review of their demographics available by clicking on the patient icon within the bill.



If you do not have the information that you require available, e.g. after refreshing, and/or checking the chart, it may be time to contact the patient and ask for their information directly or ask that they visit Access PEI to have their health card updated.

MANAGING OTHER ERROR MESSAGES

In many instances, the bill may be missing information which is why it is flagged as Attention Required. Traditionally, these are due to Medicare rules outlined in the Master Agreement, and where not all elements of the billing rules have been satisfied.

The Error messages received may include:

- Service Invalid
- Start Time Required
- Role Required
- Comment Field Required
- Etc.

The most common examples of solutions to correct these errors are:

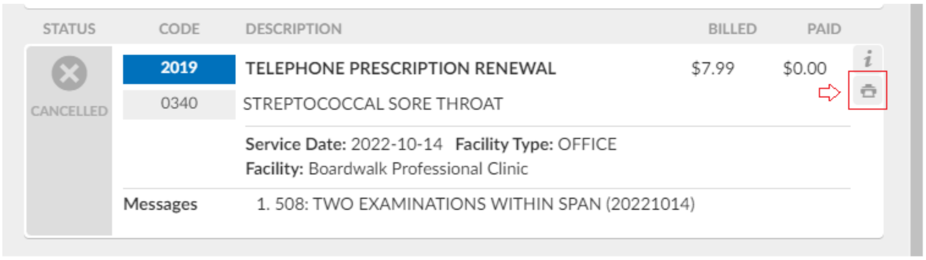
- For procedures and many time-based codes, the role must be set to 100% (or appropriate)
- Diagnosis code is missing
- If a Start time is indicated, either a total or finish time must also be included
- If a comment is required
- The referring provider or referred to was not completed
- Etc.

Once you have reviewed the bill and updated all required fields, switch the bill from Attention Required to Ready to Submit, and then Save.

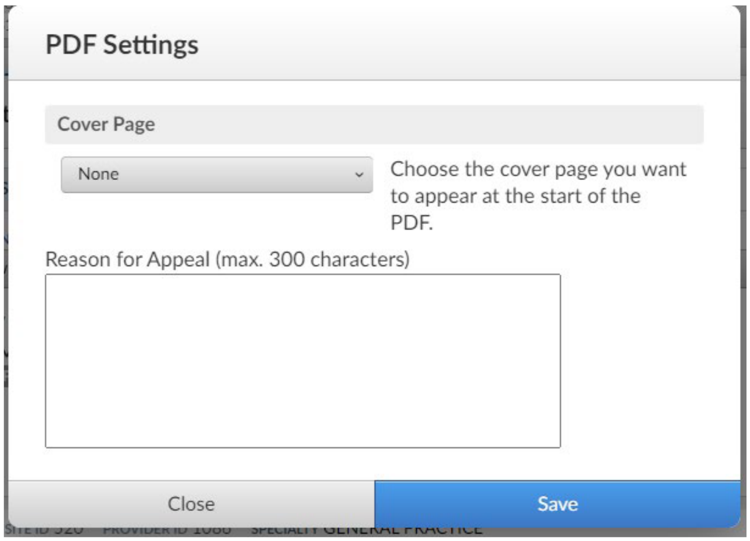
SUBMITTING APPEALS FOR CANCELLED BILLING ITEMS

For any claims that need to be appealed because they have been cancelled or any claims that need to be adjusted, please use the appeal process. Do not re-bill a claim unless instructed to do so by a Medicare assessor. To submit an appeal to Medicare please complete the following steps:

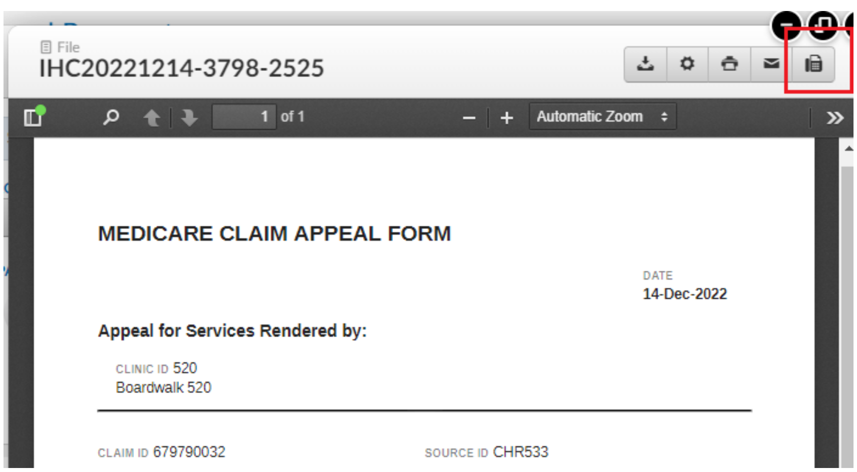
1. Navigate to the claim either through the Billing Icon or the Patient chart.
2. If a claim can be appealed a printer icon will appear. If the printer icon does not appear, the claim cannot be appealed in the status.



3. Once the printer is selected, a message box appears to enter a reason why the appeal is being submitted. Every appeal requires a reason to be entered.



4. Select save, a PDF will generate containing all the information for the appeal.
5. Select Fax



6. Search for the Contact “Medicare Appeals” or enter 902-838-0940 and select Send.

EMR Billing

HOW TO CREATE BILLING TEMPLATES:

Steps:

1. From the main menu, click **Settings** > **Templates** > **Billing**. A list of all of the current billing templates appears. Note: The billing templates displayed include all templates created by other Physicians/billers on CHR. Please do not archive / delete any of these, as they are still in use.
2. To create a new template, click the **Add Template** button. You will be prompted to give your template a name. Make yourself the billing practitioner, and if necessary, you can update the specialty as well.
3. Add the Fee Items as required – we recommend leaving the diagnosis and service date fields blank – to be filled in at time of use. Note: You can have multiple fee items included in a template making procedures easier to bill. Role can be defaulted, and you can also have comments included as part of the template. Once the initial fee item is completed, click the +Add Fee Item button to add another fee item to the template.
4. You can set the Responsible for Pay field as Other if the bill is to be prepared as Fee For Service (FFS) for a normally salaried/contract Physician.
5. Facility Type and Facility can be set as part of the billing template as well, which can be helpful for submitting consistent bills for fee items at locations other than the standard office location, e.g. LTC homes, hospital, etc.

Note: To archive a billing template, click the eye icon to the right of its name. **PLEASE DO NOT ARCHIVE BILLING TEMPLATES CREATED BY OTHER USERS.**

6. If you wish to copy an existing billing template, click the copy icon to the right of its name. The duplicate template appears at the bottom of the list with the word **copy** at the end of its name. Please rename it and edit it as necessary.

Once you have created your billing templates, we recommend adding them to a folder for ease of use.

HOW TO USE BILLING TEMPLATES

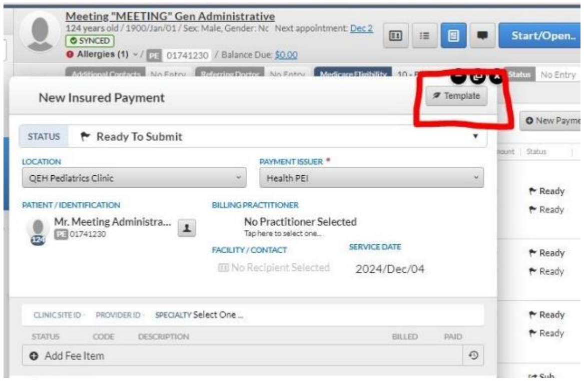
At present time, billing templates can be used when creating bills from:

1. Visits page
2. Quick Billing
3. Insured Billings tab (within the patient chart).

Unfortunately, Billing Templates are NOT currently available for use while billing from within an Encounter.

Once you have opened a new billing item, you'll see the option for Template at the top right of the Insured Payment screen (see picture below).

EMR Billing



Once you click on Template, you will be offered either the full list of billing templates, or if you have created a folder for your billing templates, a list of the folders (either All Templates, or your folder(s)).

Select the template you would like to use and click Apply.

From here, you'll need to update the diagnosis code and service date fields. Update any other areas as appropriate.

Submit the bill as normal – using Ready to Submit format and click Save.

ENTERING A SERVICE DATE IN CHR BILLING

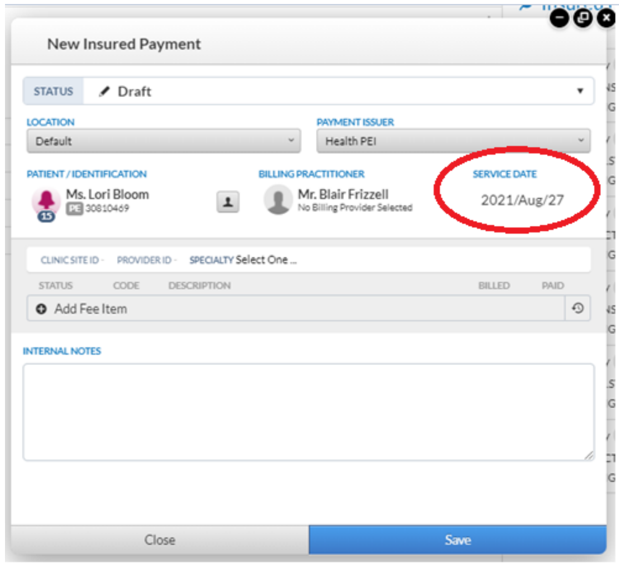
Purpose: The following information details how to enter the service date in CHR when completing billing from the Quick Billing or Start/Open > Insured Billing screen. This does not apply when completing a bill from the Encounter, or via the Visits page – as the service date will default to the calendar date associated with the encounter/bill.

There are two (2) areas where the term '**Service Date**' is used – and they act in different ways – so this is important information to be mindful of.

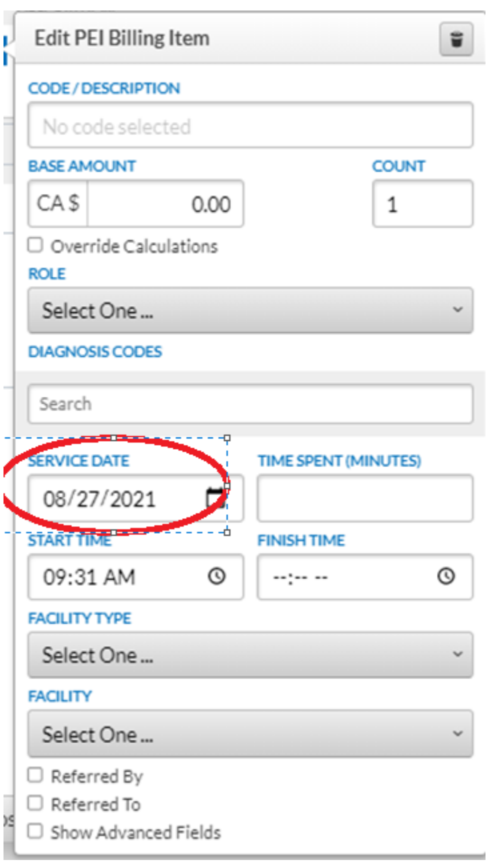
1. The first area where you may see the term Service Date occurs when the following screen is displayed when creating a bill from Quick Billing or the Insured Billing tab in the patient chart. This service date refers to the date that you are creating the bill. If you change the service date from here, it will make every bill created set to that one service date. This can be very helpful if you are creating several bills for a patient that were rendered on the same day in the past.

   A word of caution – if you have created several bills – e.g. inpatient bills spanning multiple dates (Saturday-Thursday for example), if you were to alter the service date in this section, it would change the service date for ALL of the bills created.

EMR Billing



2. The second time you will see the term 'Service Date' occurs after selecting Add Fee Code, when you are presented with the following screen. You'll notice a Service Date on the Add Fee Item screen. **__In this field, Service Date refers to the date on which medical services were provided to the patient.__** If the Service Date needs to be edited, it is to be edited here. The Service Date on this form is submitted to Medicare as part of the claim.



EMR Billing

A few things to note on the two Service dates:

1. When searching for claims in the billing dashboard, the Service Date on the first screen is used
2. If you update the Service Date on the first screen in error and there is a claim already created, the service date is updated on the Claim automatically