

Software: _____
 Vendor: _____
 Evaluator: _____
 Date: _____

Software Evaluation Checklist (with Detail)

Instructions: Use the following scoresheet when evaluating software products. The scoring is listed below:

- **2 = Software has the identified feature.**
- **1 = Software does not have the identified feature but has a reasonable workaround.**
- **0 = Software does not have the identified feature.**

NOTE: *EW* preceding an item indicates it is related to Classic IVY's Edit Windows.

Module: Demographics

Item	Functionality	Score/Value		Notes
D1.	Can search for a patient by: name, computer account number (IVY number), old medical record number, social security number, relative or other associated person.			Note the ways your practice searches for patient accounts: is the patient's name used when scheduling, is the patient's social security number used when entering the EOB, is the computer-assigned account number used when entering patient payments? Though not supported by Classic IVY, you may want to ask if the system has a searchable prior last name field. Verify that the system you are evaluating meets your practice's needs for patient look up.
D2.	Patient directory displays the same or more information than Classic IVY: patient number, name, age, telephone, address.			The patient directory screen is used to differentiate between patients when they are searched for by their name. When there are multiple people with the same name, additional information is required to select the correct patient.
D3.	Names are upper and lower case automatically.			
D4.	Entering the zip code automatically fills the city and state fields.			If the system you are evaluating supports this functionality, does the vendor provide the zip code table or does the user enter it? If the user enters a zip code that is not in the table, is the user prompted to add it? Can the user override the city and state from those tied to the zip code? Can foreign postal codes be entered?
D5.	Provides four lines for street addresses.			

Item	Functionality	Score/Value	Notes
D6.	Can associate both home address and billing address to a patient.		If the system you are evaluating allows the user to enter primary and secondary addresses for a patient, how does the system identify which address should be used for billing? For example, a patient spends part of the year at a second home and both primary and secondary home addresses are entered into the system. Can the user switch billing locations between primary and secondary homes without having to reenter the address?
D7.	Field for patient's home phone number.		Ensure that there is a field for the patient's home phone number, including area code.
D8.	Field for patient's business phone with extension.		Ensure that there is a field for the patient's business phone number, including area code and extension.
D9.	Phone number field(s) are automatically formatted.		Automatically formatted fields will place the dashes or spaces in the appropriate places.
D10.	Social security number field automatically formatted.		
D11.	Date of birth field automatically formatted.		Does it provide for a four-digit year to meet year 2000 requirements?
D12.	Field for patient's old medical record number.		The old medical record number may reference a chart number or the patient's number from a former computer system. This is a searchable field in Classic IVY.
D13.	Can associate the referring doctor to a patient.		Referring doctor information may be collected in order to compile a referral report or generate referring doctor form letters.
D14.	Can associate non-doctor referral source to a patient.		Does the system you are evaluating allow the user to associate to a patient, non-doctor referral sources such as a Yellow Pages ad or a billboard? This information may be used to generate a referring source report including the number of patients referred by a source and the dollars generated by them.
D15.	Editable choice list for referring source.		Does the office have the ability to add to and delete or archive from the referring doctor list? Can this ability be password protected? If a referring doctor is entered without their UPIN number financials would be effected when the doctor is attached to a Medicare consultant and the charge is denied.
D16.	Patient can have at least 3 active insurance policies. (Dependent on ability to archive insurance companies)		Verify that the system you are evaluating allows the user to associate at least three active insurance policies to a patient if the user can archive inactive policies. If the system does not support archiving patients' insurance policies, verify that a minimum of five active policies can be associated to a patient.

Item	Functionality	Score/Value		Notes
D17.	Patient can have more than one active <u>primary</u> insurance company.			<p>Does the system support associating multiple active <u>primary</u> policies to a patient? Some systems do not provide this functionality and require the user to enter the patient into the system more than one time. Common reasons for having more than one active policy include:</p> <ul style="list-style-type: none"> • A patient has both primary medical and primary vision policies • A patient has both primary medical and primary workers compensation policies • A practice provides services to a patient in more than one location that cross state lines requiring claims be submitted to two different Medicare carriers: an office visit may be performed in one state and the surgery performed in another,
D18.	Can archive (or hide) a patient's inactive insurance policies.			<p>Does the system have the ability to remove insurance policies from the patient's record once the policy is no longer active and all associated balances have been paid? The purpose of archiving is to make it easy to identify the active policies in a patient's account and to avoid accidental posting to an inactive policy. If a patient's policy can be archived, can it also be unarchived?</p>
D19.	Can rebill a patient's archived insurance policies.			<p>If a system allows a patient's inactive insurance policy to be archived, verify that the user is able to rebill charges associated to that policy if necessary.</p>
D20.	Insurance company address is seen when associating a policy to a patient.			<p>Many insurance company names appear in your master list more than once with different addresses (for example, Aetna). The ability to see the company address allows the user to choose the correct company when associating an insurance policy to a patient.</p>

Item	Functionality	Score/Value	Notes
D21.	Insurance company list is editable.		<p>Your practice must have the ability to add to and edit the master list of insurance companies. Verify what level of security can be associated to editing the insurance company list.</p> <p>Also verify whether an insurance company can be added to the patient's list without adding it to the master insurance company list, i.e. Classic IVY's "free text"? IVY's "free-text" ability addressed Classic IVY's limitation of 999 total insurance companies in the master list--many systems do not have this limitation and do not need to allow the user the ability to "free-text."</p> <p>If the system you are verifying supports "free-texting," ask if this feature can be password protected. Also verify how financial reports reflect these "free-texted" companies? In Classic IVY, financial transactions posted to these companies are grouped together into one category on financial reports.</p>
D22.	Insurance company list is editable from within the patient's account.		If the insurance company list can be edited "on the fly" (without leaving the patient's account or record) while entering a patient's demographic information is this functionality password protected?
D23.	Can assign the insurance subscriber's relationship to the patient if other than self.		Classic IVY's subscriber relationships are: self, spouse, patient's child, relative, father, mother, employer and legal representative. When the subscriber is other than the patient, does that name appear in box 4 of the HCFA?
D24.	Field to reflect that patient's signature to release information to insurance is on file.		Box 12 on the HCFA must be populated to reflect that the office has collected the patient's signature.
D25.	Can enter a patient's co-pay information and view when posting a charge and scheduling an appointment.		
D26.	Can enter in referral/authorization information at check-in (prior to posting a charge) and view at the time of posting and scheduling.		Collecting and entering the patient's referral/authorization information at the time of check-in allows the office to ensure that it is available prior to procedures performed. Many practices also check this information when an appointment is scheduled so that the patient can be reminded to obtain a new referral/authorization when necessary.

Item	Functionality	Score/Value	Notes
D27.	Can assign alternate guarantor for patient billing if other than self. (Other demographics)		<p>Assigning an alternate guarantor indicates that someone other than the patient is taking responsibility for the patient-responsible portion of the account. Classic IVY's guarantor choices are: self, spouse, patient's child, relative, father, mother, employer and legal representative.</p> <p>Does the system you are evaluating allow the user to associate more than one guarantor to a patient? For example, the patient is seen for an annual exam for which he is responsible (and is the guarantor) and has also been seen for a foreign body for which his employer is responsible (workers' compensation injury).</p>
D28.	User can add a default doctor and office in demographics (patient registration) that pulls into Financials.		<p>This may speed charge posting but be sure to verify the following:</p> <ul style="list-style-type: none"> • Defaults can be overridden at the time a charge is posted with the appropriate doctor and location • Is the system configurable so that these defaults do not pull into the Financials module if patients in your practice see a variety of doctors and/or are seen at a number of locations?
D29.	User can add a default doctor and office in demographics (patient registration) that pulls into Scheduling.		This may speed appointment booking. Check that the defaults can be overridden at the time an appointment is made.
D30.	Editable choice list for practice doctor.		Does the office have the ability to add to and delete or archive from the practice doctor choice list?
D31.	Editable choice list for location.		Does the office have the ability to add to and delete or archive from the office location list.
D32.	Fields for employer/employment information.		Employer information is used to file worker's compensation claims. Some Medicare carriers require that if an employment status of "retired" is reported the effective date must also be entered.
D33.	User-definable patient classification.		Classic IVY's patient classification displays on the status bar in the patient account with a one or two character user-defined code; this code can also be used in creating patient queries. In the system you are evaluating, patient classification may or may not provide a choice list the user can select from. Practices use classification codes to identify patients for a variety of reasons; examples include: On Collection, Slow Pay, Drug Study Participants.
D34.	Can assign a default diagnosis to a patient.		How does a default diagnosis impact patient financials? If a default diagnosis can be assigned to a patient will it pull into each charge that is posted for the patient and, if so, can it be edited at charge posting? Is it seen at appointment scheduling? Will it impact Medical Records?
D35.	Editable choice list for ethnic background.		

Item	Functionality	Score/Value		Notes
D36.	Able to set user-defined required fields.			<p>Required fields might include the patient's name, date of birth and social security number in patient demographics. Consider the following when evaluating practice management software:</p> <ul style="list-style-type: none"> • Which fields are system-required and which fields can be set up by the user to be required fields? • What prompt is the user given if the required field is not completed? Is the user given a warning but allowed to go past the screen on which the required field is located?

Scoring For Demographics Module

Scoresheet if Using Alcon's Priority Ranking

	Possible Points*	Actual Points	Priority Factor	Score
Score for Priority A questions	9		x 2	
Score for Priority B questions	27		x 1	
Score for Demographics Module				
(Divide By Total Possible Points)				45
Average Score for Demographics Module				

Scoresheet if Using Your Own Priority Ranking

	Possible Points*	Actual Points	Priority Factor	Score
Score for Priority A questions			x 2	
Score for Priority B questions			x 1	
Score for Demographics Module				
(Divide By Total Possible Points)				5
Average Score for Demographics Module				

Based on number of questions ranked as "A" or "B"

Module: Financials

Item	Functionality	Score/Value	Notes
F1.	Line Item (also referred to as Open Item) Accounting. User posts payments and adjustments against a specific line item charge.		In line item (open item) accounting, the user posts payments and adjustments against a specific procedure. This method of accounting allows the user to identify the current balance on each procedure in a patient's account.
F2.	Ability to post charges to a specific doctor.		Many group practices reimburse employee-physicians based on the number, type and dollar amount of procedures performed. Posting charges to a specific doctor (along with the ability to generate financial reports by doctor) will allow the practice to track this information accurately.
F3.	Ability to post charges to a specific office.		Many practices monitor how much revenue is generated for a specific office, particularly when evaluating the cost-effectiveness of maintaining a remote office(s). Posting charges to a specific office (or revenue center), along with the ability to generate financial reports by office will allow the practice to track this information accurately.
F4.	Ability to post a charge to either the patient <u>or</u> to the patient's insurance company at time of posting.		When a patient is seen in a practice, some procedures will be posted as insurance-responsible and some as patient responsible for the same date of service (for example, an office visit posted to Medicare and a refraction posted to the patient). When evaluating practice management systems, verify that procedures can be posted as either patient-and/or insurance-responsible for one date of service.
F5.	Tracks date financial transactions are entered into the system.		In Classic IVY, two dates were associated with posting charges—the date of service and the posting date; payments and adjustments had only a posting date associated to them. The user could change the date of service at the time of charge posting; the posting date was determined by the Classic IVY system date—the date displayed in the lower right hand corner of the status bar. In any practice management system you evaluate, identify which dates are alterable by the user and how end of day reports display financial transactions posted by an operator for that day. Also identify what date the end of day reports are based on—the date the user enters as the posting date or a system-defined date? The flexibility a system allows in altering dates to meet accounting needs must be balanced with audit trails and safeguards to minimize fraud.

Item	Functionality	Score/Value		Notes
F6.	Can post a procedure for a specific date of service, including service dates in the past.			<p>Most practice management systems default to the current system date for the date of service when posting charges. The user must be able to enter the actual date that services were rendered.</p> <p>Some systems allow the user to post charges using a future date of service. If the system you are evaluating does not prevent users from posting to the future, verify what safeguards are in place to ensure those charges do not get billed prematurely.</p>
F7.	Ability to overwrite (change) the amount of the charge at the time of posting.			<p>Practices that post procedures with variable dollar amounts typically create a single procedure for \$0. At the time of charge posting, the user overwrites the \$0 charge amount with the appropriate price. For example, many clients create a single procedure, "Frames" for \$0. This avoids the necessity of entering each frame price into their system. This is also applicable to practices that post charges with sales tax.</p>
F8.	Ability to add 5 modifiers.			<p>Practices that operate their own Ambulatory Surgical Center may be required to attach up to five modifiers when posting some surgical procedures. If this impacts your practice, verify the total number of modifiers that can be associated to a single procedure and how many are submitted with the claim.</p>
F9.	Ability to change a charge's associated default place of service (POS) and type of service (TOS) at the time of posting.			<p>Many software programs allow the user to associate a default place of service and type of service to a procedure when creating the master list of procedures. The user must be able to change the default POS and TOS at the time of posting a charge.</p> <p>Not being able to change the POS and/or TOS at the time of posting would mean that a surgery charge that is performed in the hospital or at a surgery center would be entered in the master list twice, each with the appropriate POS code.</p>
F10.	System retains doctor/office/diagnosis when posting multiple charges to one patient so those fields do not have to be reentered for each charge.			<p>Date entry will be more efficient if basic information such as doctor, office, diagnosis, date of service, route slip number and Bill to is retained when posting multiple procedures for a patient.</p>

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F11.	Ability to split charge responsibility between insurance company and patient.			<p>In systems that support split responsibility, a portion of a charge can be made patient responsible and a portion of the same charge can be made insurance responsible. For example, a procedure (office visit) is posted for a patient to Good Health HMO for \$70; the patient has \$10 co-pay. The insurance company would be responsible for \$60, the patient \$10.</p> <p>If the system you are evaluating provides the ability to split responsibility, verify that a statement can be generated for the patient portion of the charge prior to receiving the EOB from the insurance carrier and transferring the balance to the patient. Also verify what amount is billed to the insurance company—the full amount of the charge or just the insurance-responsible portion.</p>
F12.	Ability to add required insurance claim information including facility, referring doctor, authorization number, workers' compensation, accident and UB92 information.			<p>The system must be able to accommodate insurance-specific fields required by your practice's insurance carriers.</p> <p>Verify with the vendor how and when updates are made to the system when an insurance carrier mandates changes relating to claims submission.</p>
F13.	Can create insurance claim information for a patient and reuse or copy that information for procedures posted to multiple dates of service.			<p>Data entry will be more efficient if a user can set up claim information and reuse or copy that information for procedures posted to multiple dates of service. For example, a patient is treated for a work-related injury. The first time the patient is seen, all the required workers comp information (such as accident time and date of injury) is entered for procedures posted that day. The next time the patient is seen, posting will be more efficient and accurate if the original claim information relating to the workers' comp injury can be copied (or reused). Some systems refer to this as Episode or Encounter information.</p>

Item	Functionality	Score/Value		Notes
F14.	Can attach referring or rendering physician and UPIN number at charge posting.			<p>Verify that the user can associate a referring doctor to a specific charge when required for insurance submission (i.e. consults) and that the referring doctor's name and UPIN print in Box 17a and 17b of the HCFA 1500.</p> <p>In many systems, the referring doctor entered into a patient's record in patient registration defaults in charge posting and fills Box 17a & 17b of the HCFA form. If the system you are evaluating has this functionality, ask the following questions:</p> <ul style="list-style-type: none"> • Does the system allow the user to overwrite the default referring doctor when necessary? • Does overwriting the referring doctor when posting a procedure change the referring doctor entered in patient registration or does it only change the referring doctor for that specific procedure? • For charges that do not typically require a referring doctor, does your Medicare carrier (or other large carrier to whom you submit claims) require that the rendering physician's name and UPIN print in Box 17a and 17b. If so, having the referring doctor default at charge posting to the original referring doctor may become cumbersome. • Is the system configurable so the user can decide whether the referring doctor entered in patient registration defaults in charge posting?
F15.	Can create insurance claim information prior to charge posting.			<p>In some practices, the check-in person has responsibility for collecting and entering the referral/authorization information used for claims submissions. If this process is followed in your practice, verify that referral/authorization information can be entered prior to posting a charge and can be retrieved at (or passes through to) charge entry. Also verify the user can select the appropriate referral/authorization if more than one is in the patient's record.</p>

Item	Functionality	Score/Value	Notes
F16.	User can put a claim on hold and can run a report or query to identify all claims that are on hold.		<p>Some practices post charges that are not ready for billing. For example, a surgery may be posted so that it appears in the day's financial records, but is held from the billing process until required operative notes can be attached.</p> <p>If the system you are reviewing allows charges to be held, verify the following:</p> <ul style="list-style-type: none"> • how does the user identify held charges? (i.e. by report or query)? • how are charges released from their hold status and submitted for billing?
F17.	Ability to add line item transaction notes.		<p>Many Classic IVY clients use a \$0 adjustment (and an adjustment note) as a workaround to add line item transaction notes in the patient's account activity. In addition to displaying in the patient's account activity, both the adjustment and the adjustment note print on the patient's statement.</p> <p>For example, when a user is posting an EOB where a patient's claim is denied, the user may post a \$0 adjustment using an adjustment reason, "Claim Denied," add additional information in the adjustment note field and then transfer responsibility to the patient. This creates an audit trail—if a patient calls to discuss why a bill was received, the user can quickly determine what was done to the charge, when it was done and which operator posted the transaction(s).</p> <p>If the system you are evaluating allows the user to add line item transaction notes, verify that these notes print on the patient's statement.</p>
F18.	Can control whether transaction notes are printed on statement.		<p>When posting a charge, an adjustment or a payment, the user is able to add a note in Classic IVY. These notes will always display in the patient's account activity and print on the patient's statement. By putting a hyphen in front of the note, the user can suppress the printing of the note on the patient's statement; the note will still display in the patient's account activity.</p>

Item	Functionality	Score/Value	Notes
F19.	Can post a payment to a charge with a different responsible party (i.e. post a patient co-payment to an insurance responsible charge).		<p>This functionality is vital if your practice treats managed care patients (with co-payments) and/or your practice collects the 20% co-insurance from your Medicare patients at the time service is rendered. Typically, a charge will be posted as insurance responsible; therefore, the system must allow the user to post a patient payment to the co-pay (or co-insurance) portion of an insurance-responsible charge.</p> <p>Additionally, insurance payments are often received from patients' secondary insurance policy prior to receiving payment from the primary payor. The system must allow the user to post an insurance payment from a secondary payor while the primary insurance company is still responsible for the charge.</p>
F20.	Ability to handle surgery deposits as unapplied money without having to post a charge for \$0 and then applying the payment/deposit to the \$0 charge.		<p>In Classic IVY, practices that collect surgery deposits typically post a \$0 charge and then post the patient's deposit/payment to the \$0 charge. This results in a credit balance for the patient. Once the surgery is performed and the procedure posted, the user transfers the payment from the surgery deposit procedure to the surgery procedure using both a positive and negative adjustment. In this way no "unapplied" money is left in the patient's account.</p> <p>If the system you are evaluating supports "unapplied" payments, be sure to ask:</p> <ul style="list-style-type: none"> • How does this unapplied amount display in the patient's account? • How does it show up on the patient's statement? • How does the system report on unapplied money? For example, how is the unapplied amount reflected on the accounts receivable analysis? Can the system generate a report that identifies all patients with unapplied money in their account? • Does the system require the user to post the unapplied money to a specific doctor and/or office? • How does the user access the unapplied amount when applying payment to posted procedures?

Item	Functionality	Score/Value		Notes
F21.	Ability to post an adjustment to a charge at time of charge posting.			Can the system be configured to do an automatic write-off (or prompt the user to make an adjustment) at the time of charge posting? If the system you are evaluating supports this functionality, ask if this feature can be set up selectively (i.e. for a specific insurance company) or is it configured system-wide.
F22.	Ability to post an adjustment to a charge without having to post a payment.			Verify that the system allows the user to post an adjustment to a procedure without posting a payment. For example, the doctor may grant a professional courtesy write-off to another doctor; the procedure would be posted but written off without any payment being applied.
F23.	Ability to post a positive (credit) adjustment.			Practices use a positive adjustment for a variety of situations including: <ul style="list-style-type: none"> • Transferring money from one line item where a credit balance exists to another line item where a debit balance exists • Refunding insurance payments • Refunding patient overpayments • Handling returned checks (NSF checks)
F24.	Ability to post a positive (credit) payment.			Classic IVY supports positive patient payments, which are used for patient refunds. (Classic IVY does not allow for a positive insurance payment.) Some practices prefer to post a positive patient payment when refunding money instead of using a positive adjustment so payments are not overstated in practice management reports, such as the Accounts Receivable Analysis.
F25.	Ability to post multiple adjustments to a specific charge.			Verify that the system does not limit the number of adjustments that can be posted against a specific charge.

Item	Functionality	Score/Value		Notes
F26.	Ability to cancel/edit financial transactions including charges, payments and adjustments.			<p>Identify which financial transactions (charges, payments, adjustments) can be edited, which can be cancelled and when they can be edited and cancelled. Identify what elements of a transaction can be edited and when they can be edited. For example, some systems only allow a charge to be edited after it is posted and before the day or batch is closed. You will want the ability to edit charges that were rejected by the carrier due to a missing modifier or diagnosis code. However, multiple-doctor practices may not want the system to allow a user to edit the doctor and/or office after the charge has been posted.</p> <p>In the system you are evaluating, ask how charges that have been incorrectly entered are handled. Classic IVY allows the user to cancel a charge—there is an audit trail of the cancelled charge but it is not included in practice management reporting. Many systems do not allow a charge to be cancelled and instead require the user to adjust off the charge. If the system you are evaluating handles cancellations in this manner, how are these adjustments reflected in the system's practice management reporting? For example, will charges and adjustments be inflated or can the user configure the system so these are not included in reports?</p>
F27.	Ability to track cancellations/edits.			<p>If the system allows cancellations and/or edits to be made on charges, payments and adjustments, it is important to track what changes have been made, when and by which operator. Identify how the doctor or administrator can monitor changes made in the system to financial transactions. For example, do all cancellations of financial transactions display on the end of day reports (i.e. Daily Journal)?</p> <p>Also, identify what safeguards are in place regarding cancellations/edits. For example, can charges be posted and then cancelled after payment has been applied or must all associated payments and adjustments be cancelled before a charge can be cancelled? Again, verify what audit trails are provided by the system to monitor cancellations of financial transactions.</p>

Item	Functionality	Score/Value		Notes
F28.	Ability to view on-line a patient's accounting history.			<p>Practice management systems handle the display of a patient's accounting history very differently. Classic IVY's default view of a patient's accounting history displays:</p> <ul style="list-style-type: none"> • all charges posted to the patient • all payments and adjustments posted to the charge and any notes associated to those transactions, which are listed below the procedure in date order • basic charge information such as date of service, CPT and modifier(s), procedure description, diagnosis, place of service, type of service, charge amount and current responsible party • which operator posted the transaction (charge, payment or adjustment) • to which doctor and office the charge was posted • billing date(s) for both insurance and patient billing. The account activity displays each time an insurance- responsible charge is billed; patient responsible charges display the last date the patient's charges were itemized on a statement • dates that a charge was edited through "Change Transactions" <p>Prior to evaluating a system, identify which of these features your practice uses most frequently.</p>
F29.	System allows the patient's account history to be viewed several ways: By doctor and/or office, for a specific insurance company, for a specified date range, only open items, charges in newest to oldest order, and view the history of both patient and insurance billings.			Many systems allow the user to determine the format of the patient's account activity screen. Ask if the format can be saved at the operator level, at the workstation level or at the system level.
F30.	Ability to view account status information by patient (displays account information split between aging buckets as well as last billed date and bills pending.)			Classic IVY's account status is a snapshot of the Account Aging Report for a specific patient. When handling a patient's billing questions, it is useful to see the patient's balance broken out and aged by responsible party. It is also useful to see the last billed dates and the last date payment was applied for each responsible party. Some systems include this information in the patient's account history, not as a separate screen.
F31.	System displays total account balance for a patient AND splits the balance out between patient and insurance responsibility.			Note the number of steps required to view the total account balance and the patient and insurance responsible portions.

Item	Functionality	Score/Value		Notes
F32.	Ability to print a route slip (fee ticket) for a specific date.			<p>A route slip may be used:</p> <ul style="list-style-type: none"> • as a tool to collect and enter daily charge information • to aid in identifying patients who had appointments scheduled but were not seen • in the process of balancing the day's financials or a financial batch • as a patient receipt <p>Questions to ask regarding routeslips include:</p> <ul style="list-style-type: none"> • Does the system allow route slips to be printed on plain paper vs. using a pre-printed form? If you have a supply of forms on hand, verify if those forms can be used with the new system. • If the patient has multiple appointments on the same day, does the user have the option to print only one route slip or does the system automatically print one route slip for each appointment the patient has booked? • Can the user choose not to print route slips for a specific resource, i.e. a technician? • Can the user choose not to print route slips for a specific appointment reason, i.e. a visual field?
F33.	Can generate route slips in batch by office.			If your practice has multiple offices, verify that each office will be able to print only its route slips without printing <u>all</u> routeslips.
F34.	Can generate route slips in batch by appointment time.			Verify that a user can print route slips for a group of patients based on appointment date and time, i.e. tomorrow's appointments in appointment time order.
F35.	Ability to print route slip on demand.			Many practices wait until the patient has checked in to print route slips instead of printing them in batch the day before.

Item	Functionality	Score/Value		Notes
F36.	Ability to associate route slip number at charge posting.			<p>If the system you are evaluating automatically assigns and prints the route slip number, the user should be prompted to use that assigned number at the time of charge posting. If the system does not automatically assign the route slip number, does it still allow the user to input a pre-printed number and then generate a report of charges posted using the route slip number (i.e. the daily balancing reports such as a Daily Journal)</p> <p>Does the routeslip number also display in the patient's account activity? Practices use this number in Classic IVY to reference the route slip associated to a patient's visit in case the route slip needs to be pulled when researching billing questions.</p>
F37.	Ability to print route slip number and track missing route slip.			<p>Some systems assign and print the route slip number instead of requiring a pre-numbered route slip. Some of these systems also track missing route slip numbers—those that have been printed but no associated charge has been posted. If the system you are evaluating provides this functionality, ask the following questions:</p> <ul style="list-style-type: none"> • How does the pre-defined numbering system affect practices with multiple offices? • Can the missing route slip report be run by office? • Can the missing route slip report be run for the past? This will be important if your practice posts charges from a previous day, surgeries for example. • How does this functionality impact practices that do not post \$0 charges (i.e. for post-ops)? • Can a route slip be re-printed with the same number or no number when necessary (i.e. when it doesn't print correctly the first time)? <p>When the system uses pre-numbered route slips, like Classic IVY, ask the following questions:</p> <ul style="list-style-type: none"> • Do you have the ability to track missing route slips? (Classic IVY does not.) This would involve entering the first and last route slip numbers when the report is run.
F38.	Can suppress a patient's statements.			<p>Ask if an individual patient's statements can be suppressed, i.e. for the doctor's mother. Ask if statements can be suppressed for a group of patients, i.e. Medicaid patients.</p>

Item	Functionality	Score/Value		Notes
F39.	Can create payment plan for an individual patient.			<p>If the system you are evaluating allows patient-specific payment plans to be set up (i.e. Mrs. Jones pays \$35.00 a month, Mr. Brown pays \$50.00 a month) ask the following:</p> <ul style="list-style-type: none"> • Will the patient statement display both the total patient balance and the portion currently due as specified by the payment plan? • When payments are current, what dunning message prints on the statement? For example, if the balance is more than 120-days old and the monthly payments have been made as agreed, will the dunning message reflect that payments are current (as Classic IVY's did) or that payments are in arrears? • How does the system handle a patient's balance when payments are not made according to payment arrangements? For example, does the system automatically bill the entire balance on the patient's next statement or combine the previous amount due with the current amount due?
F40.	Can suppress dunning messages by patient.			Many practices choose to suppress the system's default dunning messages for specific patients (i.e. very elderly patients).
F41.	Can accept assignment by patient.			Some practices may elect to accept assignment on a specific patient (i.e. a friend of the doctor), regardless of the patient's insurance carrier.
F42.	Ability to track referrals out of the practice.			<p>Many practices are required, through managed-care contractual agreements, to track referrals from their practice to other practices. Other practices simply monitor this for information purposes. If tracking referrals out is an important part of your practice, identify the following:</p> <ul style="list-style-type: none"> • What monitoring tools are provided by the system (i.e. reports)? • Can the system produce patient referral slips (if required)? • Is the user required to post a financial transaction in order to track outbound referrals?
F43.	System can bill insurance claims electronically.			<p>Verify with the vendor which insurance carriers the user can bill electronically. Does the vendor offer direct carrier billing, a clearinghouse, or a combination (some direct billing, some clearinghouse)? Also verify how clearing house fees are assessed:</p> <ul style="list-style-type: none"> • Flat monthly rate per practice • Flat monthly rate per provider in the practice • Flat monthly rate per office / location. • Per claim charge • Flat rate and per claim charge combined

Item	Functionality	Score/Value	Notes
F44.	Ability to bill claims electronically to YOUR Medicare carrier(s).		Electronic billing may be sent directly to Medicare or sent via a clearinghouse. Alcon developed direct electronic billing programs as needed when sales were made in a state or region. Ask if your Medicare billing program is currently in use by other clients or, if the program is being developed for you, will your practice be the test client for the new product.
F45.	Can generate insurance forms in batch.		Ask if HCFAs can be printed: <ul style="list-style-type: none"> • In batch for all pending claims • In batch for a range of patients • In batch for a specific insurance company • Individually
F46.	System checks for claim errors during the billing process, prior to electronically transmitting the charge or printing the HCFA.		Verify the following when evaluating a system's electronic billing functionality: <ul style="list-style-type: none"> • What specific checks (edits) are in place to check for errors: missing information in demographics, and/or in the charge/procedure itself. • Are these checks (edits) insurance-company specific? • Can errors be corrected prior to transmitting the claims electronically or does the software transmit claims regardless of whether they have errors?
F47.	System provides a printed report(s) listing error claims which identifies the patient and specific error.		Classic IVY provides two reports to identify error claims: the Prepared Claim Status and the Electronic Claim Status reports.
F48.	System processes all error-free charges for a patient for a specific date of service.		Errors found on a patient's individual line item charge should not prevent his other error-free charges, for the same date of service, from being processed. Some software packages hold all charges posted for a patient on a specific date of service until all line items for that patient are error free.
F49.	System allows insurance claims processing to continue even if the batch contains one or more error claims.		Some systems interrupt claims processing until all errors found in that batch are corrected. For example, in a \$50,000 batch of surgery charges, an error is found on a \$15 refraction. The batch could not be sent until the \$15 charge is researched and corrected.
F50.	Can print a UB92 Form.		Offices with surgery centers may require this functionality.
F51.	Ability to print a HFCA on demand.		Some systems allow the user to suppress the printing of HCFAs for insurance companies that medigap or crossover, which helps reduce insurance-processing costs for the practice. If the system you are evaluating provides this functionality, verify the user can still force a HCFA when a claim does not get crossed over to the patient's secondary insurance company.

Item	Functionality	Score/Value		Notes
F52.	System can automatically post an EOB that has been downloaded from the insurance carrier.			<p>In Classic IVY, the ability to automatically post an EOB included the following tasks:</p> <ul style="list-style-type: none"> • Downloading the EOB file from the carrier • Printing the electronic EOB • Posting the EOB to patients' accounts, including automatically posting the selected adjustment and transferring responsibility for the charge to the next responsible party • Printing a report that identified the posting status of each charge on the EOB. <p>When evaluating systems that provide this functionality, ask which insurance carriers participate.</p>
F53.	System interfaces with insurance carrier(s) to provide electronic verification of a patient's insurance eligibility.			Classic IVY does not provide this functionality. If the system you are evaluating offers this feature, ask if the system allows the user to verify a group of patients, i.e. next week's scheduled patients as well as individual patients.
F54.	Ability to generate a HCFA (courtesy claim) form for patient-responsible charges.			Some practices, out of courtesy to their patients, submit a claim to the patient's insurance company, even though the patient has been made responsible for the charge. Non-participating Medicare providers are mandated by law to bill Medicare for a patient's charges even though the patient is responsible. If either of these situations apply to your practice, verify that the system you are considering is able to generate a HCFA for a patient's insurance company even when the charge has been posted to the patient.
F55.	Ability to rebill (resubmit) a claim (i.e. after getting a denial from the insurance company).			Verify that a claim can be resubmitted to an insurance company, for example, when additional information or corrections are required. Note that some programs require the entire charge to be re-posted in order to resubmit the information.

Item	Functionality	Score/Value	Notes
F56.	Ability to rebill a single charge for a patient vs. all charges for a specific date of service.		<p>Verify the user can rebill a single charge (procedure) for a patient regardless of how many charges were posted to the patient on one date of service. For example, two charges are posted for a patient with the same date of service: a 99215 (Comprehensive Visit—Established Patient) and a 92083 (Visual Field). The insurance company pays for the 99215 but denies the 92083 which is missing the rendering physician's name and UPIN in Box 17a & 17b.</p> <p>Some systems do not allow the user to rebill only the 92083. Instead, when a charge on a particular date of service is rebilled, all charges posted for that patient on that date of service are automatically rebilled by the system, creating duplicate claims.</p>
F57.	Can generate patient statements in batch.		<p>If you use cycle billing in your practice, verify that the system allows statements to be generated for a range of patients (i.e., A-E) as well as for all patients. Classic IVY's billing options are listed below; identify which ones are important to your practice and verify with the vendor that the new system supports this functionality:</p> <ul style="list-style-type: none"> • Includes patients in the billing range (if doing cycle billing) who have new charges posted. • Excludes patients with a balance less than a specified amount and those with only an insurance balance. • Can print statements by alpha, zip code or account number. • Can print statements for a specific office or all offices.
F58.	Ability to print a patient statement on demand.		<p>There may be times when you need to print a statement for an individual patient. For example, as a walkout statement or receipt if the system doesn't provide a true receipt, or for a patient who calls and requests a copy of his last statement. If the system you are evaluating has an optional statement service, ask if the user is able to generate a patient statement on demand when necessary.</p>

Item	Functionality	Score/Value		Notes
F59.	EW—Ability to have the same CPT code in the master list with different descriptions.			<p>Some practices with Ambulatory Surgical Centers enter CPT codes into their system twice: one with a description for the professional component and one with a description for the facility fee. Some systems allow this duplicate CPT code by adding a unique identifier to the end of the CPT (66984a). Verify that the unique identifier does not print or transmit when billing the insurance carrier.</p> <p>Also verify how the system's practice management reports handle duplicate CPTs with different descriptions.</p>
F60.	EW—Ability to associate default place of service (POS) & type of service (TOS) codes to procedures.			<p>Associating defaults for POS (where the procedure is commonly performed) and TOS (what type of service is this procedure commonly considered) to procedures increases both the speed and accuracy of charge posting. Not being able to associate defaults requires the user to enter the POS and TOS for each charge posted.</p>
F61.	EW—Ability to associate default modifier(s) to a CPT.			<p>Practices whose office falls under Medicare's Rural Health Clinic reimbursement schedule may want to associate the QB modifier to each CPT so users do not have to remember to input that modifier each time a procedure is posted.</p>
F62.	EW—Ability to create charge groups (i.e. new patient exam).			<p>Creating charge groups allows the user to automate charge posting by linking procedures that are commonly performed in the same visit. For example, a practice's new patient exam always consists of a 99204 (Comprehensive Exam—NP), a 76516 (A-Scan) and a 92015 (Refraction). At charge posting, when the New Patient Exam charge group is selected, the system either automatically posts all charges in the group or prompts the user to post this series of procedures.</p>
F63.	EW—Ability to associate suggested diagnoses to a CPT and warn the user at time of posting.			<p>Does the system allow the user to associate appropriate or suggested diagnoses to a specific procedure and then warn the user at charge posting when one of these diagnoses is not selected? This can aid in reducing the number of posting errors related to invalid/incorrect diagnoses.</p> <p>If the system you are evaluating includes this functionality, verify that the user is not limited in the number of diagnoses that can be associated. Also identify how the user is warned when a diagnosis is selected that is not part of the associated diagnosis group.</p>

Item	Functionality	Score/Value	Notes
F64.	EW—Ability to control printing of charges (Transmit vs. Print)		<p>Insurance carriers, to whom you submit electronically, may require that some procedures be submitted on paper. For example, certain surgical procedures may need to be billed on paper because documentation must be attached to the claim at the time of submission. Identify when / how a charge is indicated to print rather than transmit:</p> <ul style="list-style-type: none"> • At the time the charge is posted • In the charge master choice list • In the charge master choice list associated to a specific insurance company (not supported by Classic IVY)
F65.	EW—Supports multi-statement formats including plain paper.		<p>Verify what statement formats the system supports: plain paper and/or pre-printed forms. Also identify if the user can control what prints on the statement, i.e. insurance filed dates, procedure, diagnoses, tax id number.</p>
F66.	EW—Ability to create a global/default fee schedule.		<p>Verify that the system allows the creation of a default fee schedule that will be used for patient billing and all insurance companies for which a specific fee schedule is not created. Most practices set up a Medicare fee schedule, a “standard” fee schedule and any required capitated fee schedules. The standard fee schedule is used for 99% of the insurance carriers to whom they bill. Creating a separate fee schedule for each insurance carrier in the system would require extensive maintenance work to keep those fee schedules current.</p>
F67.	EW—Ability to create fee schedules by insurance carrier, which is automatically associated to the patient’s insurance policy.		<p>Users may want to create a fee schedule for a specific insurance carrier so the system will automatically use that fee schedule when the insurance carrier is associated to a patient. The most commonly used insurance-specific fee schedules are Medicare, Medicaid and any capitated carriers with whom your practice has contracted.</p> <p>Some systems require the user entering patient demographics to associate an insurance policy AND a financial class/fee schedule to the patient. This user (typically the front-desk/check-in staff) must know what fee schedule should be associated to each insurance carrier. Additionally, the user must remember to change the fee schedule associated to the patient each time the patient’s insurance policy information changes.</p>

Item	Functionality	Score/Value	Notes
F68.	EW—Ability to create calculated fee schedules, i.e. a Medicare-type fee schedule.		<p>Medicare is an ophthalmologist's most common calculated fee schedule: Medicare pays 80% of its approved amount, the patient is responsible for 20%.</p> <p>In Classic IVY, when a charge is posted to Medicare, the system displays the charge amount, the 20% patient co-insurance and the write-off amount. Seeing this information at the time of posting allows the user to collect the patient's 20% co-insurance and/or write-off the difference between the charge amount and the approved amount (if it is their practice's policy to do so). If a calculated fee schedule is set up for an insurance carrier, Classic IVY also displays the suggested write-off amount when posting EOB payments, useful for monitoring reimbursements from that company.</p> <p>Verify in the system you are evaluating, how the approved amount, patient's co-insurance and suggested write-off display.</p> <ul style="list-style-type: none"> • Does the user see this information at the time of posting a charge? • Does the user see this information at the time of posting payments and/or making adjustments?
F69.	EW—Ability to create fee schedules by doctor.		<p>Multi-doctor practices may require the ability to set up a unique fee schedule for each doctor or group of doctors. For example, a different fee schedule may need to be set up for MDs vs. ODs. Check to see if the system limits the number of fee schedules that can be created.</p>
F70.	EW—Ability to create fee schedules by office.		<p>Some practices have created different fee schedules in their system based on office. For instance, practices that have rural offices may create two Medicare fee schedules in their system: one for the main office and one for the remote office since the reimbursement rates are different for rural health clinics. Verify the system you are evaluating provides this functionality if this is a requirement for your practice. Also check to see if the system limits the number of fee schedules that can be created.</p>

Item	Functionality	Score/Value	Notes
F71.	EW—Ability to handle capitation fee schedule for charges/payments.		<p>When evaluating a system's ability to handle capitation, review the following areas: charge posting and impact to account receivables, claims submission, applying capitated payments and reporting.</p> <p><i>Charge Posting and Impact to Account Receivables:</i> Some systems require the user to post a charge for the normal amount which the system automatically writes off if the insurance company has been flagged as capitated. In other systems, the user posts a charge for \$0 so a write-off is unnecessary. Verify how the system handles the posting of procedures excluded from capitation but still covered by the plan—can the user bill the UCR amount for those procedures; can the system be set up to flag these excluded procedures? Also, how does the system flag the user that a procedure is not covered by the plan at all and should be posted as patient responsible?</p> <p><i>Claims Submission:</i> Some capitated plans require a HCFA for the UCR amount, some a HCFA for \$0, while other plans accept a report in lieu of a HCFA. Verify the system is able to support the claims submission requirements of your capitated plan. Consider if the system allows flexibility in determining on a plan-by-plan basis how a plan will be billed, i.e. the system supports either billing a HCFA or submitting a report for a specific insurance carrier.</p> <p><i>Applying Capitated Payments:</i> Verify how a lump-sum contract payment is entered into the system. Does the user post capitated payments into the system and how do they impact the account receivables? (The account receivables should not decrease by the lump-sum payment amount since there is no offsetting charge amount.)</p> <p><i>Reporting:</i> Reporting requirements vary by practice but commonly requested reports include utilization and profitability with the ability to groups plans for reporting purposes.</p>

Item	Functionality	Score/Value	Notes
F72.	EW—Ability to set up providers to bill individually or as group.		Depending on your practice's billing needs and how you are enrolled with a specific carrier, verify that the system will allow the user to either bill the insurance carrier individually or as a group. Some multi-doctor practices submit claims as individual providers while others submit claims as a group. Verify that the vendor you are evaluating is able to meet the requirements of your major insurance carriers, such as Medicare, related to group or individual provider billing, including where the rendering physician's name prints on the HCFA.
F73.	EW—Ability to handle multiple coding systems (i.e. CPT, HCPCS).		Even though most insurance carriers use the CPT coding system, a few carriers require a different coding system be used such as HCPCS. If the practice management system cannot handle multiple coding systems, the user would be required to enter a procedure in the master list multiple times. The person responsible for posting a charge would have to remember to select the procedure with the correct code as required by the patient's insurance company, a situation which will likely result in numerous posting errors and denials from the insurance company.
F74.	EW—Ability to track RVU information.		Does your practice track cost information based on the relative value unit of procedures performed? If so, does the system you are evaluating have the capability to associate relative value units to procedures? Does the vendor upgrade HCFA's information annually? If the vendor does not provide an electronic update, does the system allow the user to import updated RVU information into the system? Verify how past history is impacted by updates to the RVU information.
F75.	EW—Has user-definable payment type choice list and can specify which payment types display on the deposit slip.		Some IVY practices have created a variety of payment codes (i.e. Medicare check). Payment codes are displayed separately on Classic IVY's Practice Analysis Report as well as on the deposit slip.
F76.	EW – Has user-definable adjustment choice list.		Verify that the system will allow the user to create practice-specific adjustment reasons.
F77.	EW—Has user-definable dunning messages.		If the system is shipped with pre-defined dunning messages, verify the user is able to edit the dunning messages to make them practice-specific. If required, verify that dunning messages can be created by office or for a group of patients.

Item	Functionality	Score/Value		Notes
F78.	EW—Has user-definable POS tables that support multi-POS codes.			Though most insurance carriers use HCFA's two-digit place of service codes, there are still some insurance carriers that require that their unique place of service codes print on the HCFA. If the system does not allow the user to define carrier-specific place of service codes, the workaround to this is to create duplicate places of service with the carrier-defined codes (i.e. Medical Office – Champus). The person posting charges will have to remember to select the correct POS as required by the patient's insurance company, a situation which will likely result in numerous posting errors and denials from the insurance company.
F79.	EW—Has user-definable TOS tables that support multi-TOS codes.			Though most carriers use HCFA's type of service codes, there are still some insurance carriers that require that their unique type of service codes print on the HCFA. If the system does not allow the user to define carrier-specific type of service codes, the workaround to this is to create duplicate types of service with the carrier-defined codes (i.e. Medical Care – Medicaid). The person posting charges will have to remember to select the correct TOS as required by the patient's insurance company, a situation which will likely result in numerous posting errors and denials from the insurance company.
F80.	EW—Ability to create reporting/query categories for choice lists.			Practices use Classic IVY's display categories for both reporting and query tasks. For example, a category of "Office Surgeries" in the Charges edit window, with all office surgical procedures listed beneath it, will allow the user to run many practice management reports by the "Office Surgeries" category. This will compile information on all procedures listed under that category heading.
F81.	EW—Ability to sort choice lists.			Many Windows-based systems automatically display choice lists in alphabetical order, thus eliminating the possibility that an item (i.e. an insurance company) will be displayed out of alpha order. However, many practices want frequently selected choices (i.e. Medicare) to appear at the top of the choice list. Identify if the system allows the user to manipulate the display order of items in a choice list after the system has completed its automatic ordering.

Item	Functionality	Score/Value		Notes
F82.	EW—Can archive or hide choice list items that are no longer used.			<p>A system's ability to archive or hide choice list items will increase user efficiency and decrease user error by removing inactive items (such as insurance companies no longer used). If the system you are considering has this capability, verify what safeguards are in place when archiving and how archiving impacts reporting.</p> <p>For example, does the system allow an insurance company to be archived if there are open items associated to that insurance company? After that insurance company is archived, how does the system handle that archived item when running queries and practice management reports that display insurance company information? How does the system display archived insurance companies in the patient's account history? Archiving a choice list item may result in missing data in the patient's history or inaccurate/incomplete reporting in some practice management reports. Ask if an item can be unarchived.</p>

Scoring For Financials Module

Scoresheet if Using Alcon's Priority Ranking

	Possible Points*	Actual Points	Priority Factor	Score
Score for Priority A questions	32		x 2	
Score for Priority B questions	50		x 1	
Score for Financials Module				
(Divide By Total Possible Points)				114
Average Score for Financials Module				

Scoresheet if Using Your Own Priority Ranking

	Possible Points*	Actual Points	Priority Factor	Score
Score for Priority A questions			x 2	
Score for Priority B questions			x 1	
Score for Financials Module				
(Divide By Total Possible Points)				
Average Score for Financials Module				

Based on number of questions ranked as "A" or "B"

Module: Scheduling

Item	Functionality	Score/Value	Notes
S1.	Can search for the next available appointment based on specified doctor, office and appointment reason criteria		After the user enters appointment criteria for a patient such as doctor, office and reason, the computer searches for available openings that match. Some systems do not allow the user to search for an available appointment. Instead, the user is required to know which resource is available on a specific date at a specific location in order to book an appointment.
S2.	Can search for the next available appointment without specifying doctor.		<p>Many practices want the ability to search for the first available appointment independent of doctor, particularly when searching for an appointment opening for a new patient exam.</p> <p>If this is important to your practice, verify that the system you are evaluating allows the user to search for the first available appointment based on specified criteria without having to indicate a doctor.</p>
S3.	Can search for the next available appointment across locations.		<p>Many practices want the ability to search for the first available appointment independent of location, particularly when the patient indicates that he is willing to be seen at any of the practice's offices.</p> <p>If this is important to your practice, verify that the system you are evaluating allows the user to search for the first available appointment based on specified criteria without having to indicate a location.</p>
S4.	Can search for synchronized appointments across resources.		Classic IVY's synchronized scheduling allows the user to search for and schedule (simultaneously) multiple appointments for a patient on the same date, same office, typically with different resources. For example, a patient is scheduled for a visual field at 8:30 am with the Technician, an Office Visit with the doctor at 9:15 at the North Office. Classic IVY allows the user to synchronize up to three resources.
S5.	Can search for synchronized appointments across days.		Practices that book surgical procedures may want the ability to synchronize the pre-op exam, the surgery and the one-day post-op. If this is important to your practice, verify that the system you are evaluating allows the user to book synchronized appointments across days.
S6.	Can search for synchronized appointments across locations.		Practices that use synchronized scheduling may want the ability to synchronize appointments at different locations. For example, the patient requires a pre-op appointment at the office (location 1) and then a surgery appointment at the ambulatory surgical center (location 2).

Item	Functionality	Score/Value		Notes
S7.	System allows at least three resources to be synchronized.			Classic IVY allows the user to synchronize up to three resources when booking appointments. If the system you are evaluating provides synchronized scheduling, verify how many resources can be synchronized when booking appointments.
S8.	Can synchronize family appointments.			This feature allows the user to synchronize appointments for multiple family members on or about the same time on the same day. Classic IVY does not support this functionality.
S9.	Can book appointments in the past.			After a walk-in patient is seen, a practice may wish to book an appointment in order to track the patient's visit in the patient's appointment history. If the system you are evaluating supports this functionality, verify when searching for the first available appointment that appointments prior to the current date are excluded (ignored).
S10.	Can block a specific resource's schedule.			If the system you are evaluating supports blocking, verify the following: <ul style="list-style-type: none"> • Can a portion of a resource's day be blocked vs. having to block the whole day? • Can an appointment be scheduled into a block time? • What happens to scheduled appointments when the user blocks? Does the user receive a warning if blocking a time that has previously booked appointments? • How does a block display? i.e. with a unique color? • Are blocked times excluded (ignored) when searching for the first available appointment? • Once a block is assigned, can it be removed?
S11.	Can block multiple resources simultaneously.			Blocking multiple resources simultaneously for holidays and other days when the practice is closed is more efficient than blocking each resource one at a time. If the system you are evaluating supports this functionality, ask if the user can multi-select resources to block. For example, can two of four resources be blocked simultaneously?
S12.	Can block multiple days for multiple resources.			Verify that the system you are evaluating allows the user to multi-select resources and multi-select days to block schedules. Blocking multiple resources on multiple days for holidays and other days when the practice is closed is more efficient than blocking each resource one at a time. For example, the office is closed Thanksgiving and the Friday following Thanksgiving.

Item	Functionality	Score/Value	Notes
S13.	Can overbook the daily schedule.		<p>Does the system you are evaluating allow the user to overbook the daily schedule set up for a resource? Some systems do not allow a resource's schedule to be overbooked on-the-fly; it must be defined as part of a daily schedule by creating extra slots. (These extra slots are available for any appointment to be booked not just emergency appointments. This design puts more onus on the user to verify the daily schedule is not overbooked).</p> <p>If the ability to overbook (when necessary) is important to your practice, verify how it is handled in the system you are evaluating. Other questions to ask include:</p> <ul style="list-style-type: none"> • How do overbooked appointments display on the screen? • How do the overbooked appointments print on the schedule? • Can the user book an appointment to a doctor or resource if no schedule has been created for a specific day, specific office? (Typically used for times when the doctor is "on-call".)
S14.	Overbooking can be password protected.		<p>If the system you are evaluating allows the user to overbook, verify that this can be restricted by the practice by requiring users to enter an overbook password or by some other security feature.</p>
S15.	Ability to reschedule an appointment and maintain all associated appointment criteria and notes.		<p>Classic IVY does not provide the ability to reschedule a patient's appointment; the user is required to cancel and reschedule the appointment, including reentering appointment criteria (doctor, location, appointment reason) and appointment notes. If rescheduling is common to your practice, verify that the system you are evaluating allows for rescheduling and maintains all associated appointment criteria and notes.</p> <p>Also ask if the system allows the user to enter in a reschedule reason that displays in the patient's appointment history. This would be helpful in identifying how often a patient reschedules appointments and if it is the practice or the patient that is rescheduling.</p>
S16.	Ability to extend an appointment's length when booking for a specific patient.		<p>At the time a patient's appointment is booked does the user have the ability to extend its length to accommodate special needs of a given patient? For example, a patient in a wheelchair may need additional time allotted for his appointment.</p>

Item	Functionality	Score/Value		Notes
S17.	Standby list automatically schedules appointment.			<p>This functionality allows the user to maintain an on-line waiting list of patients who would like to be seen earlier than their booked appointments. When an appointment becomes available, the user is given the option to insert the next appropriate person from the standby list into the open appointment time. If the system you are evaluating provides this functionality, ask the following:</p> <ul style="list-style-type: none"> • How is a person placed on the standby list? • Does the system display patients on the standby list whose appointment criteria match the cancelled appointment by doctor, location and appointment type/length or do all patients with future appointments display? • Does the system automatically remove patients from the standby list once their scheduled appointment date has past or the patient has been seen? • If the system allows the user to reschedule a patient directly from the standby list, is the patient's original appointment automatically cancelled by the system?
S18.	Patient's appointment history is tracked and is displayed.			<p>The ability to view or print an individual patient's prior appointments and their status, including those which a patient cancelled,—was a no-show and-was seen. Classic IVY's appointment history showed:</p> <ul style="list-style-type: none"> • Future appointments and past appointments including date, time, appointment reason, appointment notes, minutes associated to each appointment, operator who booked the appointment, resource appointment was booked to, office/location appointment was booked at and whether the past appointment was "Seen" or a note indicating why the patient was not seen. • Recalls including the recall date, reason and doctor or resource • Patient scheduling notes <p>When reviewing other practice management systems verify how long the patient's appointment history is maintained. Is it displayed in date order from most current to oldest to make it viewing current appointments easier?</p>

Item	Functionality	Score/Value		Notes
S19.	Patient's appointment history displays which operator booked the appointment and when it was booked.			
S20.	Can view on-line a resource's daily schedules in the past.			Classic IVY does not provide this functionality
S21.	Specify a patient's appointment preferences & save.			The ability to save a patient's scheduling preferences for particular days of the week, time of day, doctor and/or location.
S22.	Can view multiple resources' daily schedules on one screen at the same time.			Can the user go directly to book an appointment from here?
S23.	Can view a resource's weekly schedule on the screen.			
S24.	Can view a resource's monthly schedule on the screen.			
S25.	Enter extended demographic information at the time of booking an appointment.			The ability to enter demographic information when booking an appointment without leaving scheduling to go to patient demographics. This information may include the patient phone number and date of birth.
S26.	Can print the schedule by resource/by office.			The ability to print a resource's schedule for the entire day and/or for a specific office. Also, the ability to print an office's schedule for all resources at that office.
S27.	Can print a chart-pulling list (the schedule in alpha order) by location.			
S28.	Can print a schedule that includes patient balances.			Used by the office to identify accounts with patient balances. Are past due balances flagged?
S29.	Can enter notes for a specific appointment.			The ability to attach notes to a specific appointment when you make that appointment. Determine where these notes can be seen in the system and if they will print on the schedule.
S30.	Can edit patient appointment notes after booking the appointment.			After an appointment has been booked, the ability to edit the attached notes without canceling and rebooking the appointment.
S31.	User receives warning for a patient's expired referrals at the time of booking an appointment.			Referral information is required when the appointment is booked so that the patient can be instructed to obtain a new referral when needed. Ask if the rules for generating referral warnings can be defined by the user. For example, your practice can set the warning to appear when the patient has two or fewer referrals remaining.
S32.	User receives warning when trying to book an appointment with a provider who does not participate in the patient's insurance plan.			A warning, at the time the appointment is made, regarding a non-participating provider allows the user to book the appointment with another provider. Ask if the warning displays which providers are participating?

Item	Functionality	Score/Value	Notes
S33.	Supports recalls.		<p>The ability to set an appointment recall and then print the recall information in a format which can be mailed: a postcard or letter. A recall is not an appointment. It indicates that this patient must be contacted on or around a certain date to make an appointment. It is often used to remind a patient to make an appointment for an annual exam.</p> <p>If the system you are evaluating supports recalls, verify that you have the ability to track patients who have a recall in the past and have not yet made or kept an appointment.</p>
S34.	Supports reminders.		<p>The ability to generate a postcard or letter reminding the patient of a future scheduled appointment.</p>
S35.	Can generate appointment cancellation notices.		<p>The ability to generate, in batch or for an individual patient, a postcard or letter informing the patient that his appointment has been canceled. Classic IVY's cancellation letters included the time, date and appointment reason.</p>
S36.	Has a "bump list" for cancelling and/or rescheduling appointments for a group of patients.		<p>This functionality is not in Classic IVY. Patients on a bump list have had their appointments canceled and need to be rescheduled. The bump list may assist in rebooking appointments. If the system you are evaluating provides this functionality, ask how patients are moved to the bump list.</p>
S37.	Calendar notes can be added by doctor, location, and practice.		<p>Calendar notes are date-specific notes. They may print on the schedule and should be editable. They are not patient specific. For example, "Med student observing Dr. Jones today".</p>
S38.	EW—User can create type-based schedules.		<p>Classic IVY's type-based scheduling specifies particular appointment type(s) at a given time and allows multiple openings at the same time interval. This kind of scheduling allows the user to control the mix of appointments coming in at a given time. For example:</p> <p style="padding-left: 40px;">8:00 AM Long 8:00 AM Short 8:15 AM Short</p>
S39.	EW—System supports rule-based scheduling.		<p>Rule-based scheduling allows the user to define rules for booking appointments on a given day, within a given time interval. Rules may include, which appointment type can be booked at a given time, the maximum number of appointments of a specific type (i.e., new patient exam) which can be booked within a given time, the amount of time associated to each predefined appointment reason.</p> <p>If the system does support rule-based scheduling, how are the rules visually displayed to the user when trying to book an appointment?</p>

Item	Functionality	Score/Value	Notes
S40.	EW—User can create time-based schedules.		<p>A time-based schedule allows the user to book as many appointments as time will allow in a given period. For example, an office may use time-based scheduling to book time with a technician for contact lens instruction and glasses fittings. However, time-based scheduling will not allow for a specific mix of appointment reasons. The technician may be completely booked for contact lens instruction and have no time remaining for glasses fittings.</p> <p>Ask if time increments are assigned at the practice level, the office level or the resource level. Time increments set at the practice level allow consistency among all resources at all locations; time increments set at the location level allow appointment lengths to be set based on factors such as number of rooms or equipment available. The ability to define time increments at the resource level allows the user to tailor appointment lengths for specific resources.</p>
S41.	EW—User can create schedules for different locations.		If your practice has multiple offices can you create and assign separate schedules for each?
S42.	EW—User can assign multiple templates to one day for one resource.		The doctor may have the same schedule each morning of the week but the afternoon schedule varies. Does the system allow the user to create a morning template and assign it for each day of the week and then create and assign separate afternoon templates? Classic IVY does not support this functionality.
S43.	EW—User can specify start and end times of a resource’s daily schedule.		If your practice has multiple providers, does the system allow the user to create specific (and potentially different) start and end times for each resource? If the system does not allow the user to define each resources’ start and end time, how does the user ensure that appointments are not booked before and after the hours the resource will see patients?
S44.	EW—User can create scheduling templates.		<p>A scheduling template is a pattern for the appointment book for a day or portion of a day. When applied to a resource’s appointment book, a template helps control appointment booking. It is created to save the user time.</p> <p>For example, a template is created for Dr. Smith’s “office day” which is then applied to any day that Dr. Smith sees patients in the office. Without the template, the user would have to recreate this schedule over and over each time she wants to use it.</p>

Item	Functionality	Score/Value	Notes
S45.	EW—User can assign different templates on different days for the same provider.		A doctor or other resource may have a different schedule for each day of the week. For example, Dr. Jones schedules surgery appointments on Tuesday and Thursday mornings and schedules office appointments all day Monday, Wednesday and Friday.
S46.	EW—Appointments can be booked at least 13 months in to the future.		Determine how far into the future that the system can book patient appointments. Does this meet your practice's needs? Can the user define how far into the future appointments can be booked? If you can not book appointments at least 13 months into the future, does the system support recalls?
S47.	EW—System displays which template has been assigned on any given day.		If the system supports the use of templates for defining the schedule, does the system display which template has been assigned to a given day?
S48.	EW—User can delete or archive obsolete templates.		Can an obsolete template be deleted or archived if: <ul style="list-style-type: none"> • it has been used? • it is assigned to a day in the future? • it is assigned to a day in the future on which appointments are booked? Also ask if the system allows a template to be deleted or archived without impacting booked appointments?
S49.	EW—User can assign multiple templates to one day for one resource.		The doctor may have the same schedule each morning of the week but the afternoon schedule varies. Does the system allow the user to create a morning template and assign it for each day of the week and then create and assign separate afternoon templates?
S50.	EW—User definable appointment reasons choice list.		Does the system you are evaluating allow the user to create a list of appointment reasons to choose from when booking appointments? Can the user add to this list as necessary? Ask if the user has the ability to define what verbiage prints on patient correspondence for each appointment reason. For example, "CE" may print as "Complete Exam" in a letter to the patient.
S51.	EW—User can delete or hide obsolete reasons with no negative impact to existing appointments.		If an appointment reason is deleted from the master list will all future appointments using this reason be deleted or altered? Will the user receive a warning prior to deleting a reason? Will deleting a reason impact existing templates? How will deleting or hiding obsolete reasons impact the patient's appointment history and scheduling productivity reports?
S52.	EW—User can specify appointment length (duration).		The ability to attach a default length of time to each appointment reason.

Item	Functionality	Score/Value		Notes
S53.	EW—User can specify appointment length (duration) by doctor.			The ability to assign each appointment reason a unique length depending on the doctor scheduled. For example, doctor A may take 30 minutes to do a full exam while doctor B may take 20 minutes.
S54.	EW—User can specify appointment length (duration) by location.			Does the system allow the user to define appointment lengths (duration) by location vs. by doctor? This feature is useful when the same types of appointments are performed at different locations but the length of the appointment varies due to equipment differences.
S55.	EW—User can create schedules for physical resources.			The ability to create schedules for resources other than the doctors, for example, the contact lens fitting room or a piece of equipment like the visual field machine.
S56.	EW—User can create default wait times used when synchronizing appointments.			In Classic IVY, wait times were associated to appointment reasons and were used by the system when searching for consecutive appointment times for synchronized appointment scheduling. For example, a practice's scheduling policy is to wait 30-45 minutes between a patient's visual field and exam. The ability to attach a default wait time to an appointment reason eliminates the need for the user to attach the wait time when the appointment is booked. If the system you are evaluating provides this functionality, verify that the user has the ability to override the default wait time as needed when the appointment is booked.
S57.	EW—User can override (exchange) a day's template with no impact to booked appointments.			Determine what is required to change a day's template and what, if any impact it will have on booked appointments and blocks. Do all appointments have to be deleted and then rebooked? Will appointments be lost if they are not removed before overriding the template? Will blocks be lost?
S58.	EW—User definable recall reasons choice list.			If the system you are evaluating supports recalls (Question S33), verify the system has a user-definable choice list available to the user when selecting the recall reason vs. allowing the user to free-text the reason. This functionality will ensure consistency and provide standardization, which is valuable for querying/reporting purposes.

Scoring For Scheduling Module

Scoresheet if Using Alcon's Priority Ranking

	Possible Points*	Actual Points	Priority Factor	Score
Score for Priority A questions	16		x 2	
Score for Priority B questions	42		x 1	
Score for Scheduling Module				
(Divide By Total Possible Points)				74
Average Score for Scheduling Module				

Scoresheet if Using Your Own Priority Ranking

	Possible Points*	Actual Points	Priority Factor	Score
Score for Priority A questions			x 2	
Score for Priority B questions			x 1	
Score for Scheduling Module				
(Divide By Total Possible Points)				
Average Score for Scheduling Module				

Based on number of questions ranked as "A" or "B"

Module: Reporting and Query Tools

Item	Functionality	Score/Value	Notes
R1.	Practice management reports can be run for a specific office and/or user can specify breakdown by office.		Many practices monitor how much revenue is generated for a specific office, particularly when evaluating the cost-effectiveness of maintaining a remote office(s). If this is important to your practice, verify that the system you are evaluating allows the user to run practice management reports either for a specific office and/or all offices, grouping information by office (revenue center).
R2.	Practice management reports can be run for a specific doctor and/or user can specify breakdown by doctor.		Many group practices reimburse employee-physicians based on the number and type of procedures performed. Many doctors also want to quickly know how many and what type of procedures were done on a given day or within a given time period. Verify that the system you are evaluating allows the user to run practice management reports for a specific doctor, and/or all doctors, with information grouped by doctor
R3.	Daily Journal (or daily transaction report) which includes daily totals of charges, adjustments, payments. Used for balancing.		Classic IVY's Daily Journal includes line item information and totals for the daily charges, patient payments, insurance payments and adjustments. It is used to balance the daily financial transactions posted and a printed copy of the daily journal is maintained in most IVY offices for historical purposes. When evaluating a system request to see their daily balancing procedures. Additionally, consider your need for the following feature: <ul style="list-style-type: none"> • Can the report be generated for a date in the past? Classic IVY's Journal is based on the system date, which is the date displayed on the status line. Ask if the system you are evaluating will allow you to generate a journal for a past date. If not, ask if there is a way to obtain that information.
R4.	Daily Journal – can specify operator.		Ask if the system you are evaluating allows each operator to balance her work. Classic IVY provided this functionality by allowing the Daily Journal to be run by operator. Some systems allow the user to create and then balance her individual batch (group of financial transactions).
R5.	Daily Journal – can specify office/revenue center.		If your practice maintains more than one office/revenue center (i.e. main office and optical shop) verify the software you are evaluating allows you to balance the work posted to each office.

Item	Functionality	Score/Value		Notes
R6.	Daily Journal – can specify doctor.			Verify that the software you are evaluating allows the user to balance for each practice doctor. Balancing by doctor ensures that each doctor's activity on other financial reports is correctly reported which is important for practices that base physician reimbursement on individual productivity.
R7.	Daily Journal – can specify date(s).			When printing the Daily Journal, Classic IVY does not allow the user to specify the Daily Journal date. It prepares and prints the journal for the system date displayed on the status line. When evaluating a system, ask if the user can print the balancing report for a date in the past in the event that the operator fails to print the required report(s).
R8.	Journal Summary that includes previous account receivable totals and current day's totals of charges, adjustments, and payments and displays breakdown by doctor.			<p>Classic IVY's Journal Summary provides a quick overview of the current day's financial transactions for the practice.</p> <p>Other printing options which Classic IVY does not provide but which your practice may wish to consider include:</p> <ul style="list-style-type: none"> • <i>By office</i> (See Question R1) • <i>By doctor</i> (See Question R2) • For a date in the past
R9.	Bank deposit slip – can specify bank account.			Individual offices may maintain their own bank accounts and require the ability to print a bank deposit slip for a specific account.

Item	Functionality	Score/Value		Notes
R10.	Account Aging Report (for all patients) which separates balances by responsible party into aging buckets (i.e. 30, 60, 90, 120 days)			<p>Classic IVY's Account Aging Report is a multi-functional report depending on the criteria selected and can function as an additional backup of the system's outstanding accounts. IVY allows the user to specify report criteria including:</p> <ul style="list-style-type: none"> • <i>Accounts with balances older than a specified number of days.</i> Identifies delinquent accounts based on the practice's collection policy. • <i>Specify a minimum balance.</i> Allows the user to exclude patients with balances too small to make collection efforts cost-effective. • <i>Specify balances less than a given amount.</i> Identifies small balances, which the practice may want to write off. For example, balances less than \$3 and over 120 days old. • <i>Show credit balances</i> • <i>By office</i> (See Question R1) • <i>By doctor</i> (See Question R2) • <i>Patient range by account ID or name.</i> Running the Account Aging report for a specified group of patients allows the user to focus collection efforts on a smaller, more manageable group. It also allows the collection process to proceed with timely information: the report is not printed until it can be worked so that the information at the end of the report is not outdated. • <i>Patient balances only.</i> Ask how outstanding patient accounts are identified in the system you are evaluating. Classic IVY's Account Aging Report displays a patient's detailed billing history, including charges, payments, and adjustments that allows a user to work accounts without requiring access to a computer. • <i>Summary information only.</i> Ask if the Account Aging Report can be run without patient detail in order to see totals only. Classic IVY's Accounts Receivable report shows patient totals, the totals for each insurance company and the practice totals, all broken out in aging buckets.

Item	Functionality	Score/Value	Notes
R11.	Insurance Collection Report for all patients, all companies, grouped by insurance company.		<p>Classic IVY's Insurance Collection Report is used to work outstanding insurance-responsible balances. Grouping outstanding accounts by insurance carrier allows the user to reference multiple accounts when contacting the insurance company. Classic IVY's report includes the patient account number, patient name, subscriber name, policy number, group number, hold status, assignment status, posting date, date of service, days aged and amount due as well as the insurance company's name and phone number.</p> <p>Other options your practice may use include:</p> <ul style="list-style-type: none"> • <i>By insurance company.</i> For example, only Medicare accounts would be printed when it is time to work those accounts. • <i>By category.</i> Can the report be run for a user-defined category or group of insurance companies? For example, you may have several Aetnas with the same claim representative. Classic IVY's report can be run for up to 10 categories. • <i>Run for a range of patients by account ID or name.</i> This allows the collection process to proceed with timely information: a report is not printed until it can be worked so that the information at the end of the report is not outdated. • <i>By office</i> (See Question R1) • <i>By doctor</i> (See Question R2) • <i>Accounts with balances older than a specified number of days by insurance company.</i> This feature allows the report to be run to include patients whose accounts have aged beyond the typical reimbursement period for that company. For example, 14 days for Medicare and 45 days for Medicaid. • <i>Rebill all claims based on the report results.</i> Mass rebilling is helpful only when the charges identified on the report were not received by the carrier. Most practices rebill charges one at a time after making required corrections.

Item	Functionality	Score/Value		Notes
R12.	Practice analysis report (Production Report) for a given date (or date range) which displays count and total dollar amount of charges, patient payments, insurance payments and adjustments.			<p>Classic IVY's report is used to analyze productivity for the practice, monitor patient and insurance reimbursements and adjustments. This report can be run on a daily basis or for a specific date range (i.e. at month end). Other options which might be important to your practice include:</p> <ul style="list-style-type: none"> • <i>By office</i> (See Question R1) • <i>By doctor</i> (See Question R2) • <i>Compares two time periods.</i> Does the system allow the user to compare production data from two time periods? For example, the first quarter of last year compared to the first quarter of this year. Some systems have pre-defined comparisons; verify the system you are evaluating allows the user to define the two periods to compare. • <i>Summarizes procedure information by category.</i> If the system you are evaluating allows the user to categorize procedures (i.e. Office Procedures, Office Surgeries, Hospital Surgeries), ask if this report can be run by category. This option displays count and dollar amount totaled by procedure category instead of just by individual procedure.
R13.	Accounts receivable analysis – specified for a given time period which displays (in separate columns) monthly totals for charges, insurance payments, patient payments, adjustments and net AR.			<p>Classic IVY's Accounts Receivable Analysis report provides an overview of changes in a practice's account receivables and helps identify whether decreases are due to decreased production, increased write-offs or increased collections. Other options which might be important to your practice include:</p> <ul style="list-style-type: none"> • <i>By office</i> (See Question R1) • <i>By doctor</i> (See Question R2) • <i>Display daily account receivables.</i> Ask if the system provides an option to display daily account receivable totals (vs. monthly totals) for a specific time range?
R14.	Profitability Analysis Report - which compares revenue received to cost of procedures provided for a specific insurance carrier for a given date range.			<p>In Classic IVY, this report is used to assess whether participation in a specific insurance plan is profitable for a practice by comparing a practice's reimbursements (including both insurance payments and patient co-pays) to the cost of providing services. The cost of providing services is calculated by multiplying total RVUs by the practice's average cost per RVU for a specified time period. Other options which might be important to your practice include:</p> <ul style="list-style-type: none"> • <i>By office</i> (See Question R1) • <i>By doctor</i> (See Question R2)

Item	Functionality	Score/Value		Notes
R15.	Utilization Report to identify procedure utilization by insurance plan.			<p>Classic IVY's Utilization Report is used to identify procedure utilization by insurance plan for a specified time period. It also identifies the total amount that would have been charged had these procedures been posted using the practice's usual and customary fee schedule.</p> <p>The user can also request patient detail which displays, by patient, the procedures utilized. The report provides the total number of visits and total number of charges by plan. This report may be accepted by capitated plan carriers in lieu of billing the standard HCFA; verify that all the fields required by the carrier are included in the report (i.e. patient name, policy number, date of birth, date of service, diagnosis, CPT).</p> <p>Other options which might be important to your practice include:</p> <ul style="list-style-type: none"> • <i>By office</i> (See Question R1) • <i>By doctor</i> (See Question R2)
R16.	Procedure collection profile which displays, by procedure, all payments and adjustments by responsible party.			<p>In Classic IVY, this report is used to compare average reimbursements and write-offs for a procedure, broken out by payor. It can be run for all procedures, a specific procedure or category of procedures. For example, the doctor is performing a new procedure and wants to compare the reimbursements from all insurance companies for that procedure.</p> <p>In addition to displaying all insurance companies, it can be run for a single insurance company or for insurance company categories. Other options which might be important to your practice include:</p> <ul style="list-style-type: none"> • <i>By office</i> (See Question R1) • <i>By doctor</i> (See Question R2)

Item	Functionality	Score/Value	Notes
R17.	Analysis of referring sources report that displays, by referring source, all charges and associated payments and adjustments.		<p>Classic IVY's Analysis of Referring Sources report is used to identify the number of patients a specific source has referred to your practice and the associated charges, payments and adjustments generated from each source. This information is important in determining how profitable each referring source is to the practice. This report includes non-physician referring sources such as Yellow Pages, radio, television and other patients. (Some systems have the ability to track non-doctor referring sources in addition to the patient's referring physician.)</p> <p>Other options which might be important to your practice include:</p> <ul style="list-style-type: none"> • <i>By office</i> (See Question R1) • <i>By doctor</i> (See Question R2)
R18.	Procedure aging report which displays aging of procedures by responsible party.		<p>In Classic IVY, this report provides aging detail (30, 60, 90, 120 days) for each procedure by responsible party and can be used to identify problem payors and/or potential coding problems. For example, in your practice Medicare typically reimburses within 14 days; however, the 92225 code (Ophthalmoscopy), is aging 30-60 days. The coding of 92225 may be in error or incomplete thus delaying reimbursement of that procedure. Procedure-specific problem areas can be quickly identified by seeing the aging displayed.</p> <p>Other options which might be important to your practice include:</p> <ul style="list-style-type: none"> • <i>By office</i> (See Question R1) • <i>By doctor</i> (See Question R2)

Item	Functionality	Score/Value	Notes
R19.	Adjustment analysis report which displays detail of specific adjustments for a given time period.		<p>Classic IVY's Adjustment Analysis Report provides a detailed listing of all adjustments and displays, by patient, the charge to which each adjustment was posted. This report can be run for a specific adjustment reason and for a specified date range.</p> <p>If specific adjustments have been identified as requiring additional review (usually from the Practice Analysis Report), the adjustment analysis report is used to provide detailed information. This information includes: to which patients and what charge(s) the adjustment was posted, when it was posted and which operator posted it.</p> <p>Other options which might be important to your practice include:</p> <ul style="list-style-type: none"> • <i>By office</i> (See Question R1) • <i>By doctor</i> (See Question R2) • <i>By operator</i>
R20.	Diagnosis report displays the frequency of usage for specific diagnoses.		<p>Classic IVY's Diagnosis Report identifies the frequency of usage for specific diagnoses, divided out between primary and non-primary diagnoses. It can be run for a specific doctor to help identify over-usage of a specific diagnosis code.</p> <p>This report allows the user to display charges associated to specific diagnoses. It is also used to identify diagnoses that have been free-texted at charge posting. Other options which might be important to your practice include:</p> <ul style="list-style-type: none"> • <i>By office</i> (See Question R1) • <i>By doctor</i> (See Question R2)
R21.	Insurance analysis report that displays, by insurance company, all charges, payments, and adjustments, the average billed and the average collected for specified time period.		<p>In Classic IVY, this report is used to identify and compare insurance collection trends for a practice's carriers. This report displays what percentage a given insurance company's charges represent of the total charges posted for a specified time period.</p> <p>This report can be run for all insurance companies, for a single insurance company, or for an insurance category. This report can also be run for all procedures, for a single procedure or for a category of procedures (i.e. Office Procedures, Office Surgeries, Hospital Surgeries).</p> <p>Other options which might be important to your practice include:</p> <ul style="list-style-type: none"> • <i>By office</i> (See Question R1) • <i>By doctor</i> (See Question R2)

Item	Functionality	Score/Value		Notes
R22.	Referred out report that displays all patients referred out of practice.			<p>Does the system provide a report to track or monitor patients who have been referred out of the practice including which practice doctor(s) made the referral and to which outside physicians patients have been referred? Other useful information may include:</p> <ul style="list-style-type: none"> • Referral date • Follow-up date • Associated insurance company • Referring diagnosis • Operator who recorded the referral <p>Other options which might be important to your practice include:</p> <ul style="list-style-type: none"> • <i>User-defined date range</i> • <i>By office</i> (See Question R1) • <i>By doctor</i> (See Question R2)
R23.	User can choose to run practice management reports based on date of posting or date of service.			<p>When posting financial transactions, the system typically maintains both the date of service for a charge and the date it was entered into the system. Does the system you are evaluating allow the user to choose either the date of service or the posting date as the basis for generating a practice management report?</p>
R24.	User can choose to include archived patients in practice management reporting.			<p>If the system you are evaluating allows the user to archive patients, verify whether practice management reports exclude the financial data of archived patients. Is the user given the option to include archived patients' financial information at the time a specific report is run?</p>

Item	Functionality	Score/Value		Notes
R25.	User can create queries and save the queries.			<p>Identify what query tools are provided by the system you are evaluating. Does the vendor provide a list of the database field names to enable users to access third party applications, such as MS Query, to create custom queries/reports?</p> <p>If the system you are evaluating has integrated query capabilities, verify the following:</p> <ul style="list-style-type: none"> • Can select multiple query criteria, including criteria from multiple modules (i.e. patient demographics, financials and medical records). For example, the practice wants to invite a specific group of patients to an upcoming educational seminar on the benefits of refractive surgery; mailing labels need to be generated for all patients who are between the ages of 18-45, who have a diagnosis of myopia, who have not had any refractive surgical procedures performed. • Can query on correspondence previously sent to the patient. For example, the practice wants to identify all patients who had 90-day collection letters printed in June. • Can create queries that have multiple conditional statements and uses industry-standard operators such as <i>And, Or, Not, Like, Is Greater Than, Is Less Than, Is Equal To, Does Not Equal</i>.
R26.	Can create custom reports that can be integrated within the system.			<p>Does the system allow the user to create a custom report that can be run from within the practice management system? Or does the system require custom reports be run from the third party application in which they are created? If the system you are evaluating supports running reports from within the system, verify the following:</p> <ul style="list-style-type: none"> • Which report writer is used to create custom reports? • Can the user customize "standard" reports supplied by the vendor. Ask which reports can be customized. Also identify which fields the user can customize.
R27.	Ability to export reports to an ASCII file.			<p>Does the system allow the user to export reports to a format (ASCII or other universally accepted format) that can be imported into other software applications, i.e. Excel?</p>

Scoring For Reporting/Query Tools Module

Scoresheet if Using Alcon's Priority Ranking

	Possible Points*	Actual Points	Priority Factor	Score
Score for Priority A questions	8		x 2	
Score for Priority B questions	19		x 1	
Score for Reporting/Query Tools Module				
(Divide By Total Possible Points)				35
Average Score for Reporting/Query Tools Module				

Scoresheet if Using Your Own Priority Ranking

	Possible Points*	Actual Points	Priority Factor	Score
Score for Priority A questions			x 2	
Score for Priority B questions			x 1	
Score for Reporting/Query Tools Module				
(Divide By Total Possible Points)				
Average Score for Reporting/Query Tools Module				

Based on number of questions ranked as "A" or "B"

Module: Medical Records

Item	Functionality	Score/Value	Notes
M1.	User can specify the attending physician and the physical location for a patient's specific visit.		This information is required for documentation purposes.
M2.	User can edit the attending physician and location that has been previously entered for a patient's visit.		<p>If the physician or location for the patient's visit was entered incorrectly, can that information be edited? If it cannot be edited, what is the workaround suggested by the vendor to ensure the patient's medical record displays the correct doctor/location?</p> <p>An example of a workaround is to delete the visit and re-enter the visit. The user must evaluate how the suggested workaround will function in their practice.</p>
M3.	User can associate a default attending physician and can modify the default attending physician.		<p>There can be multiple ways of attaching a default attending physician to a patient. Based on the system you are evaluating, the default attending physician can be set in the demographic module or in the medical record module.</p> <p>If there is a default attending physician, is it attached to the patient's visit each time a new visit is created? Is the attending physician displayed on the patient's printed medical record?</p>
M4.	User can enter multiple visits for a patient on the same day.		A patient has an appointment for a pressure check at 8:00 am and a second check at 4:00 pm on the same day. This should be documented in the system as two separate visits that occur on the same day. If this is not possible, what is the suggested workaround?
M5.	System tracks the date and time of the patient's visit.		<p>Some systems automatically record the date and time as part of the patient's medical record. In a network environment there are multiple areas the date and time can be stored:</p> <ul style="list-style-type: none"> • Server level – consistent for all workstations • Workstation level – each workstation could have a different date and time • Application level – consistent for all users using the application • User defined application level – each user within the application could have a different date and time <p>If the visit date and time are used from the server, then the date and time information will be consistent for all visits created in your practice. If the date and time are pulled from the workstation level or the user defined application date, it is possible for each user to have an inconsistent date and time – this can be problematic in a large practice.</p>

Item	Functionality	Score/Value		Notes
M6.	User can specify the date and time of the patient's visit.			If the system defaults to the current date and time while entering a new visit, the user must be able to overwrite those defaults to reflect the actual date and time the physician saw the patient.
M7.	System pulls referring physician information previously entered in patient demographics.			This will attach the referring physician information to the patient's visit, which will reduce the amount of duplicate data entry. Can this information be modified for a specific visit?
M8.	The chart (medical record) is accessible/viewable at any point during data entry of the exam.			This feature allows the user to view already-entered visit information to ensure accuracy and to avoid duplication.
M9.	User can view more than one visit at a time for a specific patient.			Can the user view the patient's medical record over a specified date range?
M10.	Ability to copy and verify specific information from a previous exam to the current exam.			Once the patient's allergies or medical history have been entered for a visit, you may want to use that same information for return visits. If the information from a previous visit can be copied, it will be consistent with each exam and it will save both user and patient a considerable amount of time.
M11.	Can generate a subject summary of multiple visits for one patient.			The ability to report on key data for one patient over multiple visits. For example, the doctor wants to review the last five IOP and the last five medication prescriptions for the patient, integrated by date. A subject summary can report on user-defined data elements within the visit.
M12.	Can create a summary on the fly.			Ability to report on portions of a patient's exam without creating a permanent report. Can this report be printed and / or viewed on the screen?
M13.	User can edit a visit after data input.			Ability to make changes to data that has been entered into the patient's medical record. This will allow the user to make necessary corrections after creating the patient's medical record. <ul style="list-style-type: none"> Are there limitations or restrictions to what information (which fields) can be edited?
M14.	System requires visit to be signed off.			Ability to electronically identify that the physician has reviewed the medical chart and agrees with the information contained within the medical record.
M15.	System provides for security for signing off a visit.			In order to protect the integrity of a signing off a visit, available security should prevent an unauthorized operator from signing off a visit. Signing off a visit indicates the physician has reviewed the exam and is satisfied with the recorded information.

Item	Functionality	Score/Value	Notes
M16.	System provides security to protect the patient's data.		<p>Can security be set to:</p> <ul style="list-style-type: none"> deny access to medical records be granted read (view) only to medical records read-write access to medical records sign off authority to medical records <p>Does the operator who opened the medical record have to be the operator to sign off the medical record?</p>
M17.	Ability to edit a previously signed off visit AND system provides audit trail (annotation log) for tracking modifications made to a visit previously signed off.		<p>If an error was made during the data entry phase of a patient's medical record and the visit was signed off; the user must have the ability to edit or append the visit. If a visit can be edited after being signed off, it is extremely important that the system provide an audit trail (i.e., report) that indicates what changes were made to the patient's medical record, which operator made the changes and when the changes were made.</p> <p>If this functionality is not available in the system you are evaluating, have the vendor identify the workaround for the functionality.</p>
M18.	User can search for previous visits based on subjects entered.		<p>This feature is valuable when the user wants to review a portion of the patient's medical record based on the visit type. For example, the patient's past surgery information or the results of the patient's A-Scan from the previous year.</p>
M19.	Can generate referring physician letters for the patient's visit.		<p>Ability to create a letter that automatically prints the patient's referring physician information (Practice Name, Physician Name, Address, City, State and Zip) and the patient's medical record in a document. Also the ability to generate a letter to a physician that includes the patient's complete medical record.</p>
M20.	Can generate referring physician letters for patient visits in batch.		<p>Ability to generate referring physician letters at the end of the day or at the end of the week for all patients seen. If the system you are evaluating provides this functionality, verify the following:</p> <ul style="list-style-type: none"> Can the user specify a date range when generating the letters? Can the letter be generated for a specific referring physician? Can these letters be sorted by referring physicians?
M21.	Can generate a subject summary of multiple visits for one patient.		<p>The ability to report on key data for one patient over multiple visits. For example, the doctor wants to review the last five IOP and the last five medication prescriptions for the patient, integrated by date. A subject summary can report on user-defined data elements within the visit.</p>
M22.	Can create a summary on the fly.		<p>Ability to report on portions of a patient's exam without creating a permanent report. Can this report be printed and / or viewed on the screen?</p>

Item	Functionality	Score/Value	Notes
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M23.	Can generate prescriptions for: Glasses, Contact Lens and Medications.			
M24.	System can track the patient's pharmacy information.			<p>Some systems have the ability to store the patient's pharmacy information (including phone and fax numbers) in the patient's account. This function could help make your office more efficient by creating a simpler prescription process for your patients.</p> <p>If the system you are evaluating provides this functionality, verify the following:</p> <ul style="list-style-type: none"> • Does the system have the ability to fax the prescription to the pharmacy? • Does the system track when a prescription was faxed?
M25.	System provides allergy warnings for medications prescribed to the patient.			<p>Ask how this warning operates in the system you are evaluating. At what point do you see the warning? Does the system document in the patient's medical record that a warning has been issued? If a prescription refill is generated, does the warning appear again?</p>
M26.	Can enter a minimal amount of data for a specific visit.			<p>When a patient's visit consists of picking up contact lenses, the user should not be forced to enter data into every area of the template. Verify how much data is required to record a visit in the patient medical record.</p>
M27.	System tracks which operator created a patient's visit.			
M28.	User can correct visit information entered for the wrong patient.			<p>Verify how corrections are made when medical record information is entered into the wrong patient's record, including the following questions:</p> <ul style="list-style-type: none"> • Does the system allow the user to remove a visit that has been entered in error? • What is stored in the incorrect patient's medical history? • Would the incorrect visit information be included in queries?
M29.	Program supports imaging or drawings.			
M30.	System stores diagrams as part of the patient's medical record.			<p>Some systems only reference a diagram name and file name as part of the medical record, but do not generate the actual diagram when the patient's medical record is printed.</p> <p>If the system has this functionality, what type of security is in place to protect the file that is part of the patient's medical record?</p>
M31.	Can graph components of the patient's visit (i.e., IOP readings).			<p>The ability to view certain pieces of data in a patient's medical record in graph format. An example is the patient's IOP readings.</p>
M32.	Can graph components of multiple visits (i.e., IOP readings).			

Item	Functionality	Score/Value		Notes
M33.	EW – Pre-defined template is included in software.			The template is a format that controls how the data is collected and entered into the computer. Many systems include a 'pre-defined' template instead of requiring the user to create a template "from scratch." If the system you are evaluating provides a pre-defined template, ask to review an ophthalmic template.
M34.	EW- System allows multiple users to edit the template.			Does the system provide security to protect the portion of the template that a user is currently editing? If yes, is there security to prevent more than one user from editing the same area of a template simultaneously?
M35.	EW- Can archive or hide choice list items that are no longer used.			A system's ability to archive or hide choice list items will increase user efficiency and decrease user error by removing inactive items from view (such as medications no longer used). If the system you are considering has this ability, verify what safeguards are in place when archiving and how archiving impacts reporting. For example, does the system allow a medication to be archived if there are open items associated to that medication? After that medication is archived, how does the system handle that archived items when running queries and practice management reports that display medication information? How does the system display archived medication in the patients medical records history? Archiving a choice list item may result in missing data in the patient's history or inaccurate/incomplete reporting in some reports.
M36.	EW – Ability to customize the pre-defined template for a specific procedure.			For practices that have multiple physicians and/or multiple specialties, it may be simpler to link specific portions of a medical record used for a specific specialty or procedure.
M37.	EW – Ability to customize the pre-defined template for a specific physician.			This will allow the user to tailor the template to meet the needs of its practice.
M38.	EW – Can associate a specific template/page(s) to a physician.			This can be helpful for practices that have multiple physicians with different types of exams. It may increase the efficiency of a practice to specify areas of the template to be used for physician 1 and other areas to be used for physician 2. Additionally, there are areas of the template that need to be used by both physician 1 and physician 2. How does the system you are evaluating identify which resources should use certain areas of the template?

Item	Functionality	Score/Value	Notes
M39.	EW – User can specify order of exam to meet the practice's needs (data entry and reporting)		This is important for the user completing the data entry. Data entry should follow the flow of the exam, decreasing time searching for the next area in which to enter the information.
M40.	EW – User can specify data entry options when creating template (i.e., checkboxes, drop down lists, note fields)		<p>There can be many different formats for collecting the information. Each format has its own rules that define how that format 'control' can be used.</p> <p>For example: radio button – this type of control forces the user to make a selection, but allows only one selection for that group.</p> <p>List box – a box that will allow the user to make a selection from a pre-defined list. Some list boxes may allow multiple selections within the list box.</p>
M41.	EW – Template can be built to handle multiple eyes.		The user must be able to enter medical information related to a specific eye; the system must be able to accommodate different information being entered for each eye for the same portion of the exam. For example, the patient has a chief complaint of burning in the right eye, blurring in the left eye and cloudiness in both eyes. This would require the user to associate each complaint to a specific eye. Some systems do not have the ability to handle this functionality.
M42.	EW – User can specify required data entry fields.		<p>This functionality will allow the user to define which fields the user is required to complete before leaving the screen or saving the medical record.</p> <p>If the software comes with a pre-defined template, verify which database fields are required for each visit.</p> <p>Also check to see if required fields can be set at a page (or section) level or set at the visit level. For example, if the required fields are set at the page level, the user must enter Review of Systems fields only when the Review of Systems page has been activated. If the Review of Systems has required fields set at the visit level, the user must enter the Review of Systems information each time a visit is created, regardless of the reason for visit, i.e. Post-Op.</p>
M43.	EW--User can associate report text to chosen items within the patient's medical record.		This feature allows the user to define how a selected item displays in the medical record. For example, the user selects an item "NKA" which is reported as "No Known Allergies" in the patient's medical record.
M44.	EW – User can specify default values for certain data entry fields.		For example: Which eye – some practices default the database field 'which eye' to OU. This forces the user to make a change if the 'which eye' should be anything but OU.

Item	Functionality	Score/Value	Notes
M45.	EW – No limit on the maximum number of subjects (if subjects required to create templates.)		<p>The subject is a category of related exam information. Subjects group information into units in the medical record.</p> <p>For example: Commonly used subjects are Visual Field and Chief Complaint.</p>
M46.	EW – User can create pre-defined subject summaries.		<p>Subject summaries are used to provide the physician an overview of the patient's record. Pre-defined subject summaries allows the practice to create commonly used subject summaries for viewing the patient's medical record. A subject summary could include a report of the patient's previous five IOP checks and the previous three prescribed medications.</p>
M47.	EW – No limit on the maximum number of subject summaries.		<p>A subject summary provides a quick view of selected portions of the patient's medical record. Depending on your practice, you may need the ability to have an unlimited number of subject summaries. Verify that the system you are evaluating does not limit the number of pre-defined subject summaries. This will be particularly important in large multi-specialty practices.</p>
M48.	EW – System supports display logic— items displayed on the template for user selection are based on data entry choices made.		<p>Display logic is the ability to pre-define the information seen by the data entry user based on the user's previous selection.</p> <p>For example, the user indicates the patient does not wear glasses. The data elements related to glasses information does not display. These data entry choices are only available to the user when the previous selection indicated the patient wears glasses.</p>
M49.	Medical record module is integrated into the practice management system.		<p>There are many systems that do not have an integrated system that includes scheduling, financial, reporting and medical records modules. The alternative is to have a medical records system interface with your practice management system.</p> <p>An advantage of having an integrated system means your practice is working with one software vendor. An advantage of having an interfaced system is the level of functionality of the medical records system.</p>
M50.	Medical records module can interface with a practice management system.		<p>An interface is a program that allows the medical records system to communicate with the practice management system.</p> <p>Does the design of the interface allow your practice to maintain one patient database? Demographic changes to one database would be updated in the other database through the interface.</p>

Item	Functionality	Score/Value		Notes
M51.	The medical records system is interfaced with the practice management system; the user can generate reports that include information from both systems.			Based on the reporting needs of your practice, verify what information can be retrieved from both systems.
M52.	Medical record information flows through to other areas within the practice management system.			<p>Some practices will want the medical records system to transfer the patient's procedure and diagnosis to other areas of the system; for example, into the financials module. An office can be more efficient if you have the ability to post charges by receiving the information required from the medical records system.</p> <p>If the system you are evaluating has this functionality, ask if the user has the option/ability to change the procedure or diagnosis prior to or during the posting of charges.</p>
M53.	System interfaces with a medication program.			<p>Identify how you can display the list of medications in the system so your most common medications are easy to locate. Other questions to ask include:</p> <ul style="list-style-type: none"> • Most medication programs include all types of medications. Can you remove the medications that you do not or no longer prescribe? • How is this medication list maintained? How often does the program get updated? • Does the medication program use the patient's allergy information in determining the drug interaction? A reason that a system may require the allergy information collected in a specific format is so the allergies can be used for an interaction check when prescribing medication for the patient.
M54.	System interfaces with ophthalmic equipment.			<p>An Auto-Refractor is a good example of ophthalmic equipment that may be interfaced with a medical records system. If there is an interface, how does the system store the data received from the ophthalmic equipment?</p> <p>Other questions to ask include:</p> <ul style="list-style-type: none"> • How does the system report on the data received from the ophthalmic equipment? • Does the medical records vendor provide upgrades for other ophthalmic equipment?

Item	Functionality	Score/Value		Notes
M55.	EW – The medical record data is stored in a format that can be queried on.			<p>Most practices implement medical records systems for detailed reporting abilities. If your practice is part of this group, it is important to understand how the patient's data is stored. When evaluating a medical records module, ask the following:</p> <ul style="list-style-type: none"> • How can you extract the information stored in your database? • What reporting tools are available through the vendor? • What are the system limitations for extracting the patient's medical records data? There might be some information within the medical record that may not be reported on. • Are all data elements reportable/queriable?

Scoring For Medical Records Module

Scoresheet if Using Alcon's Priority Ranking

	Possible Points*	Actual Points	Priority Factor	Score
Score for Priority A questions	11		x 2	
Score for Priority B questions	44		x 1	
Score for Medical Records Module				
(Divide By Total Possible Points)				66
Average Score for Medical Records Module				

Scoresheet if Using Your Own Priority Ranking

	Possible Points*	Actual Points	Priority Factor	Score
Score for Priority A questions			x 2	
Score for Priority B questions			x 1	
Score for Medical Records Module				
(Divide By Total Possible Points)				
Average Score for Medical Records Module				

Based on number of questions ranked as "A" or "B"

Module: General

Item	Functionality	Score/Value		Notes
G1.	System is Year 2000 compliant.			The system will allow all functionality beyond the year 1999. This includes making appointments, setting recalls, entering birth dates and other dates for the year 2000 and beyond.
G2.	EW—No size limitations on EW choice lists (buffer or number).			The ability to add an unlimited number of choices in the master/choice lists. This is particularly important for the insurance company and referring physician choice lists.
G3.	Ability to add more than one doctor.			Some systems only allow the user to enter one doctor into the system. Verify that the system you are evaluating allows multiple doctors, including multiple doctors with the same last name.
G4.	Ability to create offices/revenue centers.			<p>In Classic IVY, the revenue center is created in Edit Windows as an "Office"; at charge posting, the user selects an office to which the charge should be posted. The ability to post to an office (revenue center) allows the practice to obtain both financial and scheduling productivity reports for a specific office. In the system you are evaluating, verify how an office is created and how financial and scheduling information is tracked for each office.</p> <p>In some systems, a charge is posted to a revenue center, in others the charge is posted to a facility.</p>
G5.	Can create security groups with specific security rights and assign operators to each group.			<p>This functionality allows the user to create security groups and assign security rights to that group; users are then added to the appropriate security group based on job function. This can help speed up the process of assigning security rights for offices with large numbers of users since security rights are not assigned to individual operators. For example, the security group "Front Desk" may allow access to view and enter patient demographic and scheduling information but not access to reports. When a staff member changes jobs within a practice, she is moved to another group with the appropriate security rights.</p> <p>Are there any limitations when creating security groups? For example, Classic IVY had seven pre-defined security levels (0-6) but allowed the user to customize the security level defined for specific menu options.</p>

Item	Functionality	Score/Value	Notes
G6.	Ability to create customized security options for specific users.		
G7.	Audit trail for tracking changes made within the system.		An audit trail tracks which operator input information into the system and may include which operator booked an appointment, canceled an appointment, posted a charge, payment or adjustment. It may also track any modifications made to financial and scheduling transactions and when that modification was made. The audit trail is important in combating fraud in a practice.
G8.	Ability to create user-definable short cuts.		Does the system allow the user to create user-defined short cuts within the system which may include: <ul style="list-style-type: none"> • Determining flow of patient registration screens • Scheduling reports to run at a certain time (i.e. overnight)
G9.	Patient correspondence has mail merge capabilities.		This functionality allows the user to generate individual and batch mail merge correspondence for patients and is typically used in conjunction with the system's query tools. Correspondence/reports may include name and address labels, recall cards and collection letters.
G10.	Patient correspondence files are customizable.		Does the system you are evaluating allow the user to alter the correspondence files provided by the system; can the user create new correspondence files? Verify the following when considering a practice management system: <ul style="list-style-type: none"> • What correspondence files/reports are provided by the vendor as "standard" reports. For instance, does the system provide a chart label? • Does the output of the report meet the requirements of your practice? For example, does the chart label provide the information your practice relies on when pulling, filing and reading charts? • What program is used to edit and create correspondence files? Is it provided with the system?
G11.	System tracks patient correspondence and is viewable on-line.		Does the system record which correspondence files have been printed, when they were printed and which operator printed them? Can this information be viewed from within the patient's account? A practice may use this information to track collection letters sent to a patient.

Item	Functionality	Score/Value		Notes
G12.	Includes a Patient Information Sheet viewable on-line or through printed copy.			Classic IVY's Patient Information Sheet allowed the user to view the patient's demographic information, balance and appointment information in one location. Some IVY users printed the Patient Information Sheet and kept a current copy in the patient chart.
G13.	Ability to archive patient accounts/records.			<p>If the system you are evaluating allows the user to archive patients, determine which patient accounts can be archived. Verify the following:</p> <ul style="list-style-type: none"> • Does the system allow only patient accounts with no financial information attached to be archived? • Does the system prohibit patient accounts with open financial items from being archived? Check that an account with debits and credits, which result in a zero balance, cannot be archived. • Does the system exclude archived patients from practice management reports? (See Question R24) • Does the system prohibit patient accounts with future appointments and/or future recalls from being archived? • Does the system allow a patient who has been archived to be retrieved from its archived status? • Does the system allow the archive function to be password protected?
G14.	Supports use of mouse and/or keyboard.			<p>When evaluating practice management software, identify where the system allows the user to select either the mouse or the keyboard and where the user must use one or the other. Other considerations to keep in mind include:</p> <ul style="list-style-type: none"> • Does the financials module of the system support the use of the 10-key pad on the keyboard, which can increase the efficiency of charge posting? • For routine tasks (posting a charge, booking an appointment and entering a new patient) verify how many times the user must switch between keyboard entry and mousing to complete the task.

Scoring For General Module

Scoresheet if Using Alcon's Priority Ranking

	Possible Points*	Actual Points	Priority Factor	Score
Score for Priority A questions	4		x 2	
Score for Priority B questions	10		x 1	
Score for General Module				
(Divide By Total Possible Points)				18
Average Score for General Module				

Scoresheet if Using Your Own Priority Ranking

	Possible Points*	Actual Points	Priority Factor	Score
Score for Priority A questions			x 2	
Score for Priority B questions			x 1	
Score for General Module				
(Divide By Total Possible Points)				3
Average Score for General Module				

Based on number of questions ranked as "A" or "B"

Software: _____
Vendor: _____
Evaluator: _____
Date: _____

Software Evaluation Score Totals

Module	Average Score
Demographics	
Financials	
Scheduling	
Reporting & Query Tools	
Medical Records	
General	

Additional Vendor Information:

1. Where is the vendor located?
2. How many installations have been completed with the evaluated product by state?
3. What is the total number of support staff, Insurance, Software, Hardware, Development?
4. What is the total number of training and implementation staff?
5. How long is the typical sales cycle time?
6. How long is the implementation cycle?
7. From the time you close the sale, how long will it typically take before a practice is fully functional on your system?
8. What data is typically converted from the existing system?
9. What additional services are available? (i.e. Statement service, electronic remittance, etc.)
10. What are the hours of Customer support?
11. Is there a toll free number available for customer support?
12. Does the vendor triage the support calls? (If your system is down, will you get priority?)
13. What is the average response time?
14. Is after hour support available for emergencies?
15. What are the recommended hardware requirements?
16. Do you provide hardware services?
17. What type of network does the system require?
18. Software Pricing: _____By User _____By Workstation

# of Seats	Cost / seat	Software Support Costs %
1 – 5		
6 – 10		
11 – 20		
21 – 30		
31 – 50		
51 – Up		

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19. What type of database does the system support?