Helper 7 Changes

This document describes the changes that have been introduced in Helper v.7.

Language

Therapist Helper → Helper Software
Session → Encounter
Therapist → Provider
Service → Procedure
Clinic → Facility
Usual and Customary Rate → Allowed Amount
We have made these changes to become more in line with industry standards and to eliminate the use of terms that could be confusing to our users.

Menus

The **Libraries** menu has been moved into the **Setup** menu. We have done this to simplify the layout of the software and to enable the powerful features that are now present in the Library "management console."

Libraries

The libraries are now displayed in a "management console" that shows libraries listed within the left pane and the contents of the library listed in the right pane. The contents of the libraries can now be filtered, sorted and grouped like the patient grid. A library's column display can be customized and the contents of the library can be printed.

Procedure Library

The Procedure Library has changed significantly in Helper v.7:

- The name of the **Services Library** has been changed to **Procedure Library.**
- The **UCR** field has been changed to **Allowed Amount**.
- The Managed Care **Units/Visit** field has been changed to a single field from a ratio. The new field allows the user to enter the amount of managed care units to distribute by a single decimal point.
- There is a new field in the Procedure Library **Charge co-pay for this procedure**. If this field is checked the co-pay amount indicated in the Facesheet > Billing > Who Will Be Billed > **co-pay amount** will be billed to the patient and the co-pay will be subtracted from the total charge for the service. If this checkbox is not checked, then no co-pay will be charged to the patient. The transfer will mark all existing services as "Charge co-pay".

CPT Code Library

The CPT Code Library has changed significantly.

- The CPT Code library is now read only and can only be accessed through the Procedure Library. It contains all of the CPT codes that are published by the AMA (http://www.ama-assn.org/). The CPT code library should now be thought of as a reference library. The CPT Code library is read only so that VantageMed can automatically update the library without overwriting any changes. VantageMed will make updates available to this library.
- You can search, filter, sort, and customize the CPT code library.

- The **Used** column in the CPT Code Library shows which CPT codes are used by the Procedure Library.

When transferring to Helper 7, please keep in mind that the following changes have been made to CPT codes:

1. CPT codes are now drawn from the Procedure Library. There is no longer a field to enter a CPT code in the Defaults section of the Facesheet and there is no longer a field to enter the CPT code information in the Session/Encounter. The Service Name/Procedure Name and the CPT code are now linked.
2. You should specify a CPT code for each procedure in the Procedure Library. If you do not, CPT codes will not flow through the software properly and your billing will not be generated properly.
3. Either before or after you run the transfer to Helper v.7, we strongly recommend that you review your Services/Procedure Library and make sure that you have a CPT code associated with each procedure. You can do this by reviewing the Services Library list in Helper v.6.4 (Libraries > Services) or by reviewing the Procedures Library in Helper v.7 (Setup > Libraries). Once you are viewing the Procedures Library, you can filter the library to show only procedures with blank CPT codes by clicking the dropdown arrow next to the CPT Code header and selecting "(Blanks)".

Diagnosis Codes Library

The Diagnosis Code Library has changed significantly in Helper v.7:

- Like the CPT code library it is now read only and should be thought of as a reference library. This change has been made so that automatic updates can be applied when changes are released by the AMA.
- The new Diagnosis Code Library contains only ICD codes and it contains all of the ICD codes that are published by the AMA (http://www.ama-assn.org/).
- The Diagnosis Code library can now be searched, sorted, filtered, ordered, and customized like the patient list screen.
- By default the Diagnosis Code Library opens so that it is filtered to show only favorites, this is to improve the performance of the software. Diagnosis codes that existed in Helper in versions prior to v.7 will be marked as favorites in the v.7 Diagnosis Codes Library. Because there are now so many diagnosis codes in this library, we recommend that you select a list of favorites when you start using the software, then you can quickly search and select the appropriate diagnosis code.
- If you cannot find the appropriate diagnosis code in the Diagnosis Code Library, you can also simply type the appropriate diagnosis code into the field in question (such as in the Facesheet or Encounter) without selecting the diagnosis code from the library.

Insurance Company Library

The **Insurance Company Library** has changed. The **insurance indicator** field has been updated to include a series of new selections and it was converted from a radio button to a drop down box. Validations were added for when the Insurance Company entry is saved: 1) If the Indicator is an N (HMO or PPO claim) or Y (HMO/PPO agreement) then don't let the user select H (Champus) for the Source of Payment. 2) If the Indicator is not N (HMO or PPO claim), Y (HMO/PPO agreement), or Other then the PPO/HMO ID must be entered.

Referring Sources and Referring Physicians Libraries

In Helper v.6.4 or earlier, the Referring Sources Library contained both Referring Physicians/Providers and Referral Sources, such as "Yellow Pages" or "Internet Advertisement" that you would use in the

"Market Analysis" reports to keep track of your business. In Helper v.7, there are now two libraries: Referring Sources and Referring Physicians.

- The Referring Sources Library contains information that you can use to track from which sources business is being driven to your practice. You select from the Referring Source library in the Library Links section of the Facesheet.
- The Referring Physicians Library contains the information that is placed in HCFA Box 17 and 17a.
- The transfer to v.7 takes all of the information that is present in the Referring Sources Library and duplicates it into the Referring Physician Library.
  - If there was First Name, Last Name and Middle Initial information in the EC Fields section of the Referring Sources library before the transfer to v.7, transfer will place these values in the First, Last and Middle fields of the new Referring Physicians Library.
  - If no First, Last, Middle Name entries were present in the EC Fields section o f the Referring Sources library before the transfer to v.7, the transfer will attempt to parse First, Last and Middle names from the library entry.
  - When you start using Helper v.7, you should go into both libraries and clean them up.

Places of Service Library

The places of Service Library has been updated to contain a **Services Rendered At** Field that links to the "Facilities" Library.

- A **Services Rendered At** field has been added to the Place of Service Library.
- This change allows the user to have multiple POS's with the same value and different Services Rendered At values.

Facilities Library

The name of the Clinics Library has been changed to Facilities Library.

Procedure Groups Library

The Procedure Groups Library is a new library that is only available when Helper's medical functionality is unlocked. The Procedure Groups Library allows users to group several procedures together under a single heading. Providers would use this in the case where they have a standard type of encounter, say "annual checkup", that has a standard list of charges associated with is. Users can select a Procedure Group from this library when they are entering an encounter and populate multiple charges into an encounter by selecting a single procedure group.

Facesheet

In Helper v.7, the layout and functionality of the patient facesheet has changed slightly. These changes have been made to streamline and better organize the Facesheet, as well as take advantage of new functionality in Helper. The changes include:

1. The sections of the facesheet in versions prior to v.7 were:
   a. Patient Info,
   b. Additional Responsible Parties,
   c. HCFA Info,
   d. Insurance Co.,
   e. Diagnosis,
   f. Billing,

    g. Access Times & Outcomes.
2. In Helper v.7, the facesheet sections are:
    a. Patient Info,
    b. Additional Responsible Parties,
    c. HCFA Info,
    d. Insurance Co.,
    e. Defaults,
    f. Billing,
    g. Access Times & Outcomes.
3. Box 17 “Referring Physician” has moved to the Defaults > General tab of the facesheet. In previous version, “Referring Physician” was in the HCFA Information Screen.
4. The Default Diagnosis information has moved from the Diagnosis Section of the Facesheet to the “Defaults” section of the Facesheet.
    a. The Diagnosis Pointers fields have moved from the Billing > Session Defaults tab to the Defaults > General tab of the facesheet.
    b. The Billing Memo field has moved from the Billing > Session Defaults tab to the Defaults > General tab of the facesheet.
    c. The Comments Field has moved from the Billing > Session Defaults tab to the Defaults > General tab of the facesheet.
5. The Session Defaults tab of the Billing section has moved to the Procedure tab of the Defaults section of the facesheet.
    a. The default fee amount now includes the option to use the fee schedule associated with the default procedure. To use the fee schedule check the **Use the Fee Schedule** check box.
    b. In Helper v.6.x, there were two separate fields for Place of Service and Services Rendered At in the Billing > Sessions Defaults screen. Because there is now a link to the Facilities Library in the Places Of Service Library, the Rendered At field in the Procedure Defaults section of the Facesheet is no longer required. The Services Rendered At field that is populated by default in the Encounter is the Rendered At value that is specified in the Place of Service field in the Facesheet > Defaults > Procedure screen.
    c. The transfer to Helper 7 creates a record in the Place of Service library for every Place of Service and Services Rendered At combination in the Patient Facesheet.
    d. In Helper v.6.x, Service and CPT code were two separate fields in the Billing > Session Defaults section of the Facesheet. In Helper v.7, each service is linked to a CPT code. Because of this, the CPT code field has been removed from the Defaults > Procedure section of the Facesheet. The Procedure field now contains the CPT code for a procedure as well as the Procedure name. If a CPT code is associated with a procedure, the Procedure field will show the CPT code, then a comma, and then the Procedure Name.
    e. Primary Units/Session renamed Units/Visit and is now a decimal ratio rather than a fraction.
    f. Users with the “Medical” unlock of Helper can choose to show or hide the Procedure Defaults tab in Setup > Preferences > Screens & Sounds > Display Default Procedure Options in the Facesheet.
6. The Adjustment Defaults tab of the Billing section has moved to the Adjustment Defaults tab of the Defaults section of the facesheet.
7. The Billing > Who Will Be Billed section of the Facesheet has changed slightly.
    a. In Method 1, you can now select to use the Fee Schedule amount as the amount to bill the Primary Insurance Company. This is new.

   b. In Method 1, you can no longer select to bill the Secondary Insurance Company a percent of the UCR/Allowed Amount.

Encounter

The layout of the Add-Edit Encounter screen has changed significantly, however the functionality of this screen is largely the same. The changes include:

1. In version 6.x, the Session screen had four tabs:
   a. General Info.;
   b. HCFA Info.;
   c. Billing Info.;
   d. Authorizations.
2. In version 7.0, the names of the tabs have changed slightly and are now:
   a. General;
   b. Other;
   c. Billing;
   d. Authorizations.
3. Changes in the General Screen include:
   a. Each encounter now has a reference number that appears in the Transaction Ledger. It is for reference only and does not appear in any billing or insurance claims.
   b. You can now enter a "To" and a "From" value for Date of Service. If your date of service is only a single day, you only need to enter a value in the "To" field. If you only enter a value in the "To" field, Helper will work the same as it always has.
   c. Procedure (24D) has now taken the place of the Service Name field. The information that is listed in this field should be a CPT code followed by a comma and then by the Procedure Name. If a CPT code does not appear in this field, a CPT code is not associated with the Procedure. You should do so in the Library of Procedures.
   d. The CPT Code Modifiers have been moved from the HCFA Info Tab to the General Tab.
   e. The "Units" field (24G) has moved to the General tab from the HCFA tab. The value in the units field is used to multiply the new "Per Unit Charge" field to arrive at the "Total Charge" for the procedure.
   f. The "Per Unit Charge" field is new. It is the Fee for the Procedure. The Per Unit Charge is multiplied by the value in Units to arrive at the Total Charge for an Encounter/Procedure.
   g. All four diagnoses now appear in the encounter. The diagnoses can be changed to be different from the diagnoses shown on the Facesheet.
   h. The Diagnosis Pointer fields have been moved from the HCFA tab to the General tab.
   i. To have Diagnosis appear on Patient Billing, the Procedure in an Encounter must have a pointer checked.
   j. Place of Service has been moved from the HCFA tab to the General tab.
4. Changes in the Other/HCFA screen include:
   a. The name of the HCFA tab has been changed to Other.
   b. Many of the changes described in the General tab apply to the changes that were made to the Other tab.
   c. Referring Physician now appears on the Other screen and can be set on the Encounter level.
   d. CPT code has been incorporated into the Procedure field on the General tab.
   e. The Program Type, Account Type, Billing Memo, and Comments fields have been moved from the General tab to the Other tab.

5. On the Billing Tab, the Expected Amount is now shown next to the Total Charge field as a read only informational field. The expected amount is derived from the “Allowed Amount” field in the Procedure Library if there is no Fee Schedule associated with the procedure. If there is a Fee Schedule associated with the Procedure, the Expected Amount is derived from the Expected Amount field in the Fee Schedule.
6. The Authorizations tab has changed slightly, the changes include:
    a. The grid in the Authorizations tab has been expanded and enhanced.
    b. The Units/Session field has been incorporated into the grid.
    c. The “is this session attached” checkbox has been incorporated into the grid.

Multiple Procedures Per Encounter

The “Medical” unlock of Helper 7 contains the functionality to associate and bill multiple procedures with a single encounter. Only “Medical” unlocks of Helper have this functionality. To add multiple procedures to an encounter:

1. Add an encounter through the Transaction Ledger or through the Patient List screen.
2. Notice the **Select a Procedure** panel on the left hand side of the screen.
    a. The grid shows the CPT code for the procedure followed by the charge for the procedure.
    b. If multiple procedures are added to the encounter, there will be multiple CPT codes listed in this grid.
    c. If “NA” appears in the **Procedure** column in the Multiple Procedure grid, it indicates that a CPT code is not associated with the procedure you have selected.
3. To add an additional procedure to an encounter, click the **Add Procedure** button.
4. To delete a procedure from an encounter, click the **Delete Procedure** button.
5. To add multiple procedures to an encounter simultaneously, click the **Add Procedure Group** button and select a procedure group from the Procedure Group Library. All of the procedures associated with that group will populate the encounter.
6. Except for three, all of the fields in the Encounter screen can be different for each procedure in an encounter. The only fields that must be the same for an encounter are:
    a. Encounter Reference Code
    b. Date(s) of Service
    c. Diagnosis (21, not 24E)
7. The Procedure Summary tab shows all of the Procedures associated with an Encounter.

CPT Payment Posting

The Payment Tracking screen when posting payments in Helper has changed. It now includes the CPT code and Procedure name for each charge.

Fee Schedule

The Fee Schedule is a major enhancement for Helper 7 and is available in both the Behavioral and Medical unlocks. Fee Schedules allow you to associate a set of fees with a CPT code based on the Insurance Company, Provider, and / or Facility associated with the Procedure.

1. There is a new Fee Schedule Ledger. You can access the Fee Schedule Ledger from the Procedure, Insurance Company, Provider or Facility Libraries.
    a. When you access the Fee Schedule Ledger from the Procedure Library, you see all Fee Schedules associated with the Procedure you are editing.
    b. When you access the Fee Schedule Ledger from the Insurance Company Library, you see all Fee Schedules associated with the Insurance Company you are editing.

   c. When you access the Fee Schedule Ledger from the Provider Library, you see all Fee Schedules associated with the Provider you are editing.
   d. When you access the Fee Schedule Ledger from the Facility Library, you see all Fee Schedules associated with the Facility you are editing.
2. The fee schedule allows you to specify the following fields:
   a. Insurance Company – The insurance company that the fee schedule is associated with.
   b. Provider – The provider that the fee schedule is associated with.
   c. Facility – The facility that the fee schedule is associated with.
   d. Fee – The fee to charge for this Procedure.
   e. Allowed Amount – The allowed amount for this procedure.
   f. Write Off – if a write off should be automatically generated based on the difference between the fee and the allowed amount.
   g. Expected Amount – the amount expected from the payer.
   h. Activate On – The date that the fee schedule begins to be active. Leaving this field empty makes the fee schedule open ended in the “start” direction.
   i. Terminate On – The date that the fee schedule ends. Leaving this field empty makes the fee schedule not terminate.
3. You may not enter more than one fee schedule for a Procedure with the same Insurance Company, Provider, and Facility with overlapping activity dates.
4. You can copy a fee schedule by clicking the **Copy** button.
5. To determine which fee schedule to use for a Procedure with multiple Fee Schedules, Helper uses the following precedence:
   a. Procedure
   b. Insurance Company
   c. Provider
   d. Facility.