SEQUELMED

Glossary

Account Number: SequelMed will automatically assign the next unique account number when the user hits the Save button. However, a user can manually assign an account # at the time of entering patient demographics.

Adjustment: An adjustment in SequelMed is used to negate a ledger entry. Please note that if you are going to adjust a ledger entry, you will not be able to modify the amount of money being adjusted off.

Advance Payment: An amount of money paid by a patient that cannot be applied against a charge at the time the payment was made.

Anesthesia Case: The anesthesia case window is used to define the details of the case (i.e. location, date of service, admission date, provider, diagnosis, referring provider). In order to enter the concurrency data, the anesthesia case must be set up first.

Anesthesia Case Admin: The anesthesia case admin window is used to check the concurrency for specific dates of service.

Anesthesia Case Type: The anesthesia case type defines anesthesia case types (i.e. General, MAC, Epidural). This allows you to choose form the various types of anesthesia at the time of entering the case and will calculate the appropriate warning and errors based on the case type at the time of checking concurrency and doing auto charges. The anesthesia case type defines more specific rules based on a case, unlike an anesthesia link that defines specific rules based on the plan.

Anesthesia Cross Walk: The anesthesia crosswalk displays the preloaded table of CPT's mapped to ASA's. Users can also create their own crosswalks to make modifications to the existing table at any time.

Anesthesia Link: The anesthesia link gives a user the ability to define plan specific rules, which can be linked to plan specific naming conventions, attach them to one plan or a number of plans, and then associate specific rules and edits that are cross referenced at the time of running a concurrency check and also at the time of doing auto charges.

Anesthesia Remittal Base Units: Used for expected fees; If you define the expected unit in the procedure profile then you do not need to define this field. However, if you are billing out a higher or lower unit value for a specific payer then you should define this field.

Base Fee: This is the fee that a provider of service charges regardless of the place of service or the plan.

Base Fee Group: A naming convention used in conjunction with a base fee; allows a user to assign a fee schedule to a specific Practice.

Batch Slot Utility: A Scheduling window used to manipulate the status of many slots at one time (i.e. change of location, deletion of slots, blocking of slots).

Budget: A financial plan set up for a patient who is not able to pay an outstanding debt in full.

Call Center Call Type: Allows the end-user to document who specifically they are calling when they hit the Call button within the follow up window (i.e. Insurance Carrier, Patient, Lawyer, Employer). You can also choose to have the calls logged in the patient messages.

Capitation: A method of payment for health services in which the individual provider is paid a fixed per-capita amount for each person served without regard to the number or nature of services provided.

Charge Batch Administration: Charge Batch Administration allows charges to be entered into a specific batch and cross referenced for accuracy. Within the charge batch, a user can cross-reference the # of charges entered, # of dates of service entered, hash counts, co pay's collected, and patient payments collected.

Charge Detail: The charge detail window allows a user to modify information in a previously entered charge (i.e. dos, cpt code, icd-9 code, modifier, fee).

Charge Entry: The charge entry window is used to enter the charges (i.e. date of service, diagnosis, procedures) for procedures performed on a patient.

Charge Listing: The charge listing window is used to view all of the charges associated with a specific patient's account, a practice, a location, and/or a provider. Additionally, you can view the charges in different ways based on the search criteria used (i.e. unpaid charges only, claims on hold, submitted claims only).

Chart Number: A unique number that a user can assign to a patient. However, unlike Account Numbers, SequelMed will leave this field blank if you do not put anything in the field.

Claim: A claim is a request for payment for services and benefits a patient receives. A claim is created in SequelMed once the first charge has been entered.

Claim Editing: The claim editing window allows a user to scrub the claims before they are moved into the appropriate bucket for submission; Based on the parameters set up in the plan edit link and associated with a plan, SequelMed will display any warning, errors, and/or missing information on the claim when the user hits the check edit button. After reviewing a warning, the user can then hit the clear edit button, to override the warning and move the claim into the next bucket. If the claim comes back without any missing information, any

warnings, or any errors, it is considered a clean claim and can be moved into the next bucket by hitting the set edit bucket.

CLIA Number: This is a providers Clinical Laboratory Improvement Amendment number. The Centers for Medicare and Medicaid services regulates all laboratory testing performed on humans in the United States through CLIA.

Coinsurance: A percent of the approved amount that a patient has to pay after they have met there deductible.

Comments: A non-reportable field used to document comments pertaining to the account.

Consolidate: The consolidate button is used to consolidate/merge information. Please note that once you consolidate, the process cannot be reversed.

Contractual: The difference between the insurance contracted amount and the amount of the charge.

Copayment: The set amount a patient pays for each healthcare service.

Current Procedural Terminology (CPT): A universal coding system created for health care professionals used to describe the services being rendered.

DEA Number: This is a Provider Drug Enforcement Agency number. This field can be found in the Provider table.

Deductible: The amount that a patient or family must pay for health care services before the insurance company will begin making payments. The health insurance policy sets this amount; usually it is due at the beginning of each calendar year.

Denial Batch Administration: Denial Batch Administration allows denials to be entered into a specific batch and cross referenced for accuracy. Within the denial batch, a user can cross-reference the # of denial entered.

Denial Code: The denial code can be linked at the time of entering the payment or at the time of doing follow up. Additionally, the denial code can be linked with a follow up action and reason so that when the denial code is added at the time of working the charge, the user will be advised as to what the next action and reason will be.

Discount: A reduction made on a patient balance.

Dynamic Group: A scheduling dynamic group allows a user to define which providers and/or resources they would like to see in the multiple provider/res daily window at one time.

EDI Report Log: This window is where all of the 977 acknowledgement reports, confirmation reports, and validation reports are downloaded in SequelMed.

Elect EOB: When a user receives an electronic check (835), SequelMed automatically generates an (primary) EOB that can be printed from the application, and attached to the secondary claim form. Additionally, a user can go back to the visit detail window at any time and reprint the EOB as the information is saved historically.

Eligibility: The eligibility feature in SequelMed allows a user to check the status of a patient's insurance on-line, through the application.

Eligibility Inquiry: This window is used to look at all accounts that have an eligibility status that is pending.

Eligibility Response: This window is used to look at all of the accounts that have an eligibility response.

Encounter Form: A multipart form that contains preprinted information such as the name of the provider, ICD-9 codes, CPT codes, modifiers, along with a blank space for the provider's signature.

EOB Payment: EOB payments are

EOD: The EOD process allows a user to lock the financial data for the time period specified and then run reports that correspond with the EOD dates. Additionally, the EOD process can be run in three ways: by practice, by location, or in batch mode which encompasses all of the practices/locations that fall under the entity.

EOD History: The EOD history is a table of all the EOD reports that have been run historically. This allows a user to reference historical information at any time regarding a specific practice and/or location.

Entity: In SequelMed, the Entity represents an independent or separate existence.

Explanation of Benefits: A notice that is sent to the patient after the doctor files a claim. The notice explains what the provider billed for, the approved amount, how much the insurance company will pay, and what the patient is responsible for.

Fee Schedule: A complete listing of fees used by health plans to pay physicians or other providers of service.

Filter: Allows a user to create various filters to modify the way that information is being displayed.

Follow-Up Actions: Naming conventions that allow the end-user to define/document the next Action they will be taken on a claim.

Follow-Up Auto Actions: The next Action that will take place once the first Action is assigned.

Follow-Up Groups: Naming convention that allow the end-user to link a Group to a claim to show proof of and to make sure that the claim is sent back to the same end-user if additional follow up needs to be done on a specific claim.

Follow-Up Letter Printing: A centralized location for all letters to be printed. These letters are created because a specific letter is linked to a Follow-Up Action.

Follow-Up Reasons: Naming conventions that allow the end-user to define the Reason why a claim was not paid.

Guarantor: The person that holds the insurance policy. Please note that the guarantor is not necessarily the responsible party.

HCFA-1500 Form: The form developed and approved by CMS for physicians and suppliers filing medical claims.

History: The History button displays the user's name and a time/date stamp to document when information pertaining to the account has been added/modified.

Hot Keys: All red letters and underlined letters within a search parameter and/or button that can be used in conjunction with the ALT button on a keyboard to maneuver through the application without having to use a mouse.

Insurance: A naming convention that it used in conjunction with a plan.

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM): The specific universal codes used to classify illnesses, injuries, and patient encounters with health care professionals for services rendered.

Inquiry Window: The inquiry window is used to find the table of all existing patients within a practice, and/or location, for a certain provider; Or without any parameters, making the search entity wide.

Ledger: A complete breakdown of patient's charges, payments, submissions, statements and messages.

Ledger Account: Ledger accounts are used for reporting purposes. There are default ledgers that are associated with all transactions (charges, payments, write offs, adjustments) in SequelMed, but additional ledgers can be created in the security application (i.e. bad debt write off ledger, employee discount ledger, deceased write off ledger).

Location: The place where the professional is rendering a service. A location can be a hospital, physician's office, lab, etc.

Managed Care: A medical delivery system that manages the quality and cost of medical services.

Mandated (Required) Fields: All fields in SequelMed that are labeled in Blue are considered mandated fields and have to be populated with information before the end-user can save the information. However, the SS# field and the patient DOB field in the patient demographics can be left with all zero's.

Master Index: Allows a user to copy over existing patient information from one practice to another, while still keeping the patient financials separate. SequelMed will flag the user if it recognizes that the SS# already exists.

Medical Record Number: A unique number that a user can assign to a patient. However, unlike an account number, SequelMed will leave this field blank if you do not put anything in the field. The only time that SequelMed will populate this field automatically is if the entity has implemented hospital feeds.

Modifier: A specific grouping of numbers or letters attached to a CPT code.

Negative Ledger: A negative ledger is used to reverse a payment and/or a write off.

Outstanding Days: This field is located in the plan table and is used to determine how many days should transpire (from the date of submission) until the claim is pushed into the follow up bucket.

Panel Billing: A grouping of procedures that can be charged at one time instead of line-item by line-item.

Patient Class: A specific classification that can be attached to a patient for internal reporting purposes.

Patient Follow Up Bucket: All patient balance's that have not been paid in a timely manner are automatically pushed into the patient follow up bucket so that they can be reviewed/worked in one centralized location.

Payment Batch Administration: Payment Batch Administration allows payments to be entered into a specific batch and cross referenced for accuracy. Within the payment batch, a user can cross- reference the amount of monies entered from plan payments, the amount of monies entered from patient payments, and the amount of monies entered from co payments collected.

Payor: A third party entity (commercial or government) that pays a medical claim.

Pending Submit: The pending submit bucket is used when the user who is printing out the paper claims is not sure if they have printed out correctly. The user can hit the pending

submit button and move the claims into the pending submit bucket until he/she has determined if the paper claims have, indeed, printed successfully. If the paper claims need to be reprinted, the user can hit the Submit button to reprint the claim. It the paper claim does not need to be reprinted, then the user can hit the Set Flag button to remove the claim from the pending submit bucket.

Place of Service (POS): Indicates the facility where the services are being rendered, whether it is in a hospital, office, or the patient's home.

Plan: The plan is associated with the insurance

Plan Address: The mailing address that is associated with a plan and will print on the top of a HCFA form when the claim is dropped to paper.

Plan Category: The category associated with a plan

Plan Edit Link: The plan edit link is a naming convention that is created and associated to a plan. The objective in creating a plan edit link is so that at the time of claim editing, SequelMed knows which edits should be associated and cross-referenced against the charges entered.

Plan Fee Group: The plan fee group is a naming convention for a region where the services are being rendered (i.e. Nassau County, Suffolk County, Queens County, Manhattan). This naming convention is associated with a plan and used when creating fee schedules specific to a plan and procedure.

Plan Fee Link: The plan fee link is a naming convention that is associated to a plan when creating a fee schedule specific to the plan.

Plan Follow Up Bucket: All claims that have not been paid in a timely manner (based on the # of outstanding days in the plan profile) from the insurance carrier are automatically pushed into the follow up bucket so that they can be reviewed/worked in one centralized location.

Plan Regulation: This is a naming convention that is used in conjunction with the plan regulation link.

Plan Regulation Link: The plan regulation link is attached in the plan profile and generates edits based on the regulations set (i.e. PAN required, referral required).

Practice: The practice table is used to host/display all of the information specific to the practice (i.e. EIN, practice address, telephone #, fax #).

Predefined Filters: Allows a user to create various filters to modify the way that information is being displayed.

Prior Authorization/Precertification: A formal approval obtained from the primary care physician prior to delivery of specific medical services from a specialist.

Procedure Category: The procedure category is a naming convention associated with a specific procedure for reporting purposes.

Provider: The provider table to used to host/display all of the information specific to the provider (i.e. UPIN #, SS#, DEA #, Qualification, Specialty).

Provider PIN: The Provider pin window is where all of the providers pin #'s should be associated with an insurance, location, and provider. Additionally, you can flag a provider as accepting assignment and document whether they bill to their SS#.

Recalls: SequelMed can automatically generate a recall letter to be sent to a patient when they are due for their scheduled visit; based on the recall definitions.

Recall Definitions: Recall definitions have to be created in order for SequelMed to know when to generate the recall. The recall is defined by the procedure regulation and/or diagnosis regulation associated with the recall.

Referral Management: Referral management allows a user to associate how many visits were allowed when the referral was issued and how many visits have been posted/used in SequelMed. Additionally, when the referral has expired, SequelMed will generate a warning at the time of entering charges and at the time of scheduling the patient.

Refund: Any monies returned in order to balance a patient's account.

Refund Processing: This function allows a user to generate a refund and print out the refund check from the application.

Report Batch Processing: This function allows a user to set up a group and associate reports to that group. This way there can be a set of reports that are run consistently for the client, whether it is daily, weekly, or monthly.

Resource: A resource (i.e. medical assistant, x-ray room, mri room) is considered a non-billable provider of service. Primarily, resources allow users to schedule patient appointments under the resource slot so that the provider does not have to block his/her slot if they are not actually spending all of their time with the patient.

Responsible Party: The responsible party is linked to the patient in the patient demographics window. Additionally, the responsible party will be the one who receives any statements that are sent to obtain the patients outstanding balance. Also note that the responsible party is not considered the guarantor.

Resubmit: Used to send the claim back to the appropriate bucket for submission. Additionally, once you have resubmitted a claim, the information within the claim can be modified.

Scheduling Groups: Scheduling groups allow a user to define a group and link providers and/or resources to the group so that the group can be viewed in the scheduler.

Scheduling Reasons: Scheduling reasons are used at the time of creating/booking a patient appointment. Additionally, the reason is the only mandated field needed in order to save/book the appointment.

Scripts: SequelMed scripts were created in follow up

Self-Pay: A patient who has no insurance or the policy of the practice is not to accept assignment of insurance.

Set Flag: The set flag button allows a user to remove a claim or statement from a pending bucket. If you set flag a claim or statement, SequelMed will remove the claim/statement from the bucket and time/date stamp the claim/statement as being submitted.

Split: Allows a user to split a visit; SequelMed will assign the next unique visit # to the charges that have been split.

Sort: Allows a user to sort information using the parameters available.

Statement Groups: A statement group is a naming convention that has dunning messages associated. These statement groups are linked to practice profiles so that at the time of statement printing, SequelMed knows which dunning message(s) to pick up. The statement group is also where you define the Outstanding Days, # of Statements, and Cycle Days.

Statement Messages: Statement messages allow you to define what the messages will print out as the statement ages.

Statement Pending: Statements move into the pending bucket at the time of statement printing if/when the end-user hits the pending button. Additionally, statements will move into the pending bucket if the end-user is sending the statements electronically to a third party vendor.

Statements: A breakdown of the indebtedness mailed to the responsible party in a weekly, biweekly or monthly time frame.

Submit Log: A log used to keep track of submitted claims in the form of a batch.

Summary Window: The summary window is used to see a snap-shot of the patient's information (i.e. scheduled appointments, last visit date, patients address, last statement date, patient balance).

Ticket Charge Entry: The ticket charge entry window is used to enter hospital charges for procedures performed on a patient. If you were to enter hospital charges in the charge entry window, SequelMed would generate a separate HCFA form for each date of service. Whereas, if you were to use ticket charge entry to enter hospital charges, SequelMed will generate one HCFA form with the date range on it. Additionally, ticket charge entry can be used to add a procedure to an existing visit.

Title Bar: The title bar is used to display the patient that is currently being worked on, along with their account #, date of birth, and any charge or payment batch that is being used at that moment.

Transcription: The transcription functionality allows a provider of service to dictate visit information to a transcriptionist. In turn, the transcription company returns that dictation in the form of an electronic document, which then can be reviewed by the provider, signed electronically, and attached to a patients record.

Type of Service (TOS): Classifies the specific type of service being rendered, whether it is an x-ray, laboratory exam, or surgery.

UPIN: This is a Universal Provider Identification Number. This field can be found in the Provider table and in the Referring Provider table.

View Submit: Allows a user to view the HCFA form and provides a short cut to the profile tables.

Visit #: A unique, sequential number automatically assigned when charges are entered for a patient. This number encompasses all charges for one date of service.

Visit Detail: The visit detail window allows a user to modify information that was previously entered in the charge (i.e., provider, location, referring provider).

Workers Comp/No Fault: Used to define information pertaining to the wc/nf case (i.e. provider, practice, location). Additionally, SequelMed assigned a unique case # and allows the user to associate certain visits to the case.

Write Off: The amount of money you are contractually obligated to write off when you have applied the payment against a charge and there is a balance remaining.

Write Off 2: A field used in the Payment window to document an additional write off (i.e. Bad Debt W/Off, Collections W/Off).