Treatment Plan Settings

Plan Type: Selected at the time of creating the plan. Contributes to the CPT code the system will generate, i.e. if the plan type is Biopsy, do not expect to get a CPT code for shave removal. This cannot be changed once the plan is created.

Impression: The default diagnosis that will populate in the note when this plan is selected. Contributes to the ICD-10 code the system will suggest to you, i.e. if you diagnose neoplasm of uncertain behavior of skin, you will get D48.5, not L57.0 (actinic keratosis). You can use this field when searching your list of treatment plans.

Medical Reference: Can save a link that was used to pull information for the treatment plan. This does not display anywhere on the note and is just for internal reference.

Spoken Phrase: The name of the treatment plan. What would you call this treatment plan if you were to say it out loud? You can use this field when searching your list of treatment plans.

Procedure Tag: If the plan is a procedure, this is what will display on the red tag on the body map. Because it displays on the body map, it is advised to keep this tag short. You can use this field when searching your list of treatment plans.

Morphology: The description of the problem. It will populate in the Physical Exam section of the Progress Note.

DDX: Any differential diagnoses. Will automatically populate under the impression in the Assessment and Plan section of the note as well as on any requisitions.

Disorder Summary: Further detail regarding the diagnosis and treatment plan

Assessment note: Additional information of the plan

Plan note: Additional information of the plan

Plan is a procedure: Toggle this on if the plan is a procedure. If it is not toggled on, no CPT code or procedure note will be generated. Once this is toggled on,

additional fields will display in the treatment plan settings such as Procedure Summary and Procedure Description.

Default selection mode: When this plan is selected, would you like to get a point or area by default when you tap on the body map? Area selection will show count option

Show Action Menu: Will allow a calculator to pop up and you can add the number of procedures performed.

Consent: The consent selected here will populate as an unsigned consent for the visit as soon as the plan is selected. Can be signed from the Physical Exam screen, Progress Note screen, or EZ Check-Out.

Therapies: Prescriptions suggested automatically in the Rx screen of the Progress Note. Prescriptions not added here will need to be added manually in the visit on a patient-by-patient basis.

Laboratory: Lab tests suggested automatically on the Labs screen of the Progress Note. Labs not added here will need to be added manually in the visit on a patient-by-patient basis.

Imaging: Imaging tests suggested automatically on the Imaging screen of the Progress Note. Imaging tests not added here will need to be added manually in the visit on a patient-by-patient basis.

Counseling Note: The information entered here will populate in the Counseling section of the note and can be printed for this patient. It will also automatically be shared with the patient on their patient portal.

Patient Education Link: The website entered here will populate in the Counseling section of the note and can be printed for this patient. It will also automatically be shared with the patient on their patient portal.

Risks and benefits of treatment: Adding risk and benefits of each diagnosis and treatment.

Follow up: Will populate in the Assessment & Plan portion of the Progress Note and will be visible to the front desk when the appointment is opened on the desktop computer.

Procedure Segments: Will populate in the Procedure Note, not the Progress Note. Use these fields to predefine details of a procedure (can be changed during the visit for a specific patient if need be). For a procedure that needs to generate a pathology order like biopsies and excisions, Instructions for Pathologist must be selected or else a requisition will not be generated. For procedures where dimensions affect the CPT code generated, like excisions and repairs, make sure Postoperative Dimensions is selected.

Narrative: Will populate in the Procedure Note, not the Progress Note. Use this field to add a narrative description of the procedure or to add any details about the procedure that cannot be added in Procedure Segments.

Additional Note: Will populate in the Procedure Note, not the Progress Note. Can be used as an additional field to separate out specific information from the Narrative section.

Coding: MDM (Medical Decision Making) comprises the three sections found under Coding (Data Reviewed, Problem Points, and Risk). By pre-defining some or all of these fields in the treatment plan settings, these elements of MDM will be defined as soon as the plan is applied, thus giving you credit toward your E&M code. If these fields are not predefined in the treatment plan settings, it may result in a low office visit code or Undefined code. Below are some references for more information about MDM and each of these fields.

MDM: http://www.emuniversity.com/MedicalDecision-Making.html
Problem points: http://www.emuniversity.com/ProblemPoints.html#Problempoints
Data Reviewed: http://www.emuniversity.com/DataPoints.html#Datapoints
Risk: http://www.emuniversity.com/TableofRisk.html

Grouping: When the plan is a procedure, Grouping determines how the procedure notes will be grouped if multiple procedures are performed. None will separate each procedure out into its own PDF and is good for something like biopsies. All Locations will group all locations of a procedure onto one PDF and is good for

something like AK LN2. All Procedures will group all procedures done on a single location into one PDF and is good for something like Mohs.

Billing: The Simple Charge added here will post to the Financials section of the patient's chart after the note is signed off and can be used in lieu of a CPT code (if the plan is a procedure).

Suggested Products and Services: Simple Charges added here will be suggested in EZ Check-Out and can be added to the patient's Cart. Any products/services added to the patient's Cart will be posted automatically to the patient's Financials regardless of whether or not the note is signed off.