

Version 1
March 17, 2000

BUREAU OF PRIMARY HEALTH CARE

CLINICAL PRACTICE MANAGEMENT INFORMATION SYSTEMS

FUNCTIONAL REQUIREMENTS

COMMUNITY AND MIGRANT HEALTH CENTER

REQUIREMENTS CHECKLISTS

Submitting Vendor:	
Product Name:	
Contact Name:	
Contact Phone:	
Contact E-mail:	
Date Submitted:	

PURPOSE

This document contains a set of functional requirements for clinical practice management information systems used in community and migrant health centers. Community and migrant health centers can use these requirements to measure the ability of commercial vendor products to provide the information processing and management capabilities that they need. The document lists the requirements in checklists organized under the following categories:

<u>Category</u>	<u>Checklist Number</u>
Patient Scheduling	CL-1
Patient Registration	CL-2
Medical/Dental Data	CL-3
Patient Follow-Up Monitoring/Tracking	CL-4
Billing	CL-5
Accounts Receivable	CL-6
Management Support: Reports and Clerical	CL-7
Systems Management	CL-8
Managed Care	CL-9

These checklists are intended to be used by health centers and health care networks to define their requirements for clinical practice management information systems in a Request For Information (RFI) or Request For Proposals (RFP) from vendors. The requirements listed in this standard are identified as minimum (those requirements with X under the MIN column) or optional (those requirements with X under the OPT column) capabilities. Minimum requirements are the basic functions the BPHC recommends that FQHCs should perform in practice management. Optional requirements are desirable or supplementary functions. The minimum/optional classifications are intended as guidance, and may be changed by a health center to best meet its own specific needs.

Instructions for vendors completing these forms can be found at Instructions for Vendor Certification. A Glossary of Terms, used in the checklists, is also provided for reference.

**PATIENT SCHEDULING FUNCTIONAL REQUIREMENTS
(CL-1)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
1. Booking Appointments						
A. The user is able to select an appointment slot on a specified provider's/clinic's schedule by requesting any one of the following:						
• A particular date	X					
• Next available appointment after a particular date	X					
• Next available appointment on a particular day of the week	X					
• Next occurrence of a particular day of the week.		X				
• By time of day. The system will select the next time available.	X					
• By type of visit (e.g., obstetric, well child care, pap smear, dental amalgam restoration, other categories established by the user	X					
• By provider panel	X					
• By case manager or primary provider	X					
• By clinic room or special equipment		X				
B. The user is able to enter a comment when booking an appointment. This comment is printed on all schedule module outputs, if desired by the clinic.		X				
C. The user is able to enter the patient's complaint (60 characters minimum) when scheduling an appointment.	X					
D. The user is able to book one or multiple appointments into an appointment slot. The user can define the multiple/overbooking limits. The system warns the user when the expected maximum number of patients has been appointed to the slot, and allows overbooking.	X					

**PATIENT SCHEDULING FUNCTIONAL REQUIREMENTS
(CL-1)**

Requirements			Vendor Capability			
	MIN	OPT	Yes	Module	Future Vn.	Third Party
E. The user is able to modify an appointment to change the required amount of time allotted. This change affects only the particular day's schedule for the specified provider/clinic.	X					
F. The system informs the user of conflicting appointments on the schedule for the specified patient.	X					
G. The system allows the user to create, modify, or delete types of appointments and to allocate an estimated amount of provider/clinic time needed for each appointment type.	X					
H. The system allows the user to designate timeframes during which individual providers or clinic resources are not available.	X					
I. The system allows the user to book an appointment or generate a reminder for an appointment one year in the future.	X					
J. The system allows the user to view scheduled appointments by scrolling backwards as well as forwards through scheduled appointments.	X					
K. The system assists the user in coordinating appointments with multiple providers addressing multiple problems during one visit.		X				
2. Canceling Appointments						
A. The user is able to cancel a specified appointment that has been booked and to specify a reason for the cancellation. The system makes this appointment slot free for rescheduling immediately upon the cancellation.	X					
B. The user is able to cancel all appointments scheduled for a provider in a selected timeframe and to print a report with contact information for all patients affected by the cancellation.	X					

**PATIENT SCHEDULING FUNCTIONAL REQUIREMENTS
(CL-1)**

Requirements			Vendor Capability				
			MIN	OPT	Yes	Module	Future Vn.
C.	The user is able to generate mailing labels and reminder letters to patients for missed, cancelled, scheduled, or rescheduled appointments.	X					
D.	When a patient misses or cancels the first of a series of appointments, the system allows the user to view, cancel, and reschedule all appointments for the patient.		X				
3. Displaying Patient Appointments							
A.	The user is able to request a display of all future appointments for a given patient or group of patients. For each appointment, this display shows, at a minimum, the following:						
	• Provider/clinic	X					
	• Appointment date	X					
	• Appointment time	X					
	• Appointment duration	X					
	• Appointment comment (30 characters minimum)		X				
	• Patient's complaint		X				
	• Type of visit	X					
	• Special equipment or room required		X				
	• Patient's account balance	X					
	• Patient's insurance plan		X				
4. Displaying or Printing a Provider's/Clinic's Schedule							
A.	The user is able to view a provider's/clinic's schedule either as a display or in hardcopy form. This output shows one day at a time, week-at-a-glance, or month-at-a-glance.	X					
B.	The user is able to view a schedule of clinic resource requirements on demand.		X				
5. Printing a Site's Schedule							
A.	The user is able to print the day's schedule for a specified site, in sequence by appointment time. This output shows at least the following data for each appointment:						
	• Patient name	X					
	• List of names for group visit	X					
	• Patient chart number(s)	X					
	• Guarantor name and relationship	X					
	• Patient(s) phone number(s)	X					
	• Appointment time	X					
	• Type of visit	X					

**PATIENT SCHEDULING FUNCTIONAL REQUIREMENTS
(CL-1)**

Requirements			Vendor Capability			
	MIN	OPT	Yes	Module	Future Vn.	Third Party
• Appointment duration	X					
• Appointment comment		X				
• Patient's complaint	X					
• Provider name(s)	X					
• Patient account status indicator or code		X				
• Patient account balance	X					
• Date of last payment		X				
• New patient indicator		X				
B. A schedule list can be sequenced by Patient Name for a user-selected date range.	X					
C. A schedule list can be sequenced by provider for a user-selected date range.	X					
D. A schedule list can be produced showing new patients with scheduled appointments, walk-ins, and same day appointments for a user-selected date range.		X				
6. Creating a Blank Schedule						
A. For each provider/clinic that will be scheduled, the system manager is able to specify and the system maintain a schedule template which outlines the typical week's available appointment slots and specifies a visit type, duration, and expected maximum number of patients for each slot. Slots are available for same-day visits.	X					
B. The system manager is able to enter and edit a list of holidays in the system and thereby remove these days from all available schedules.	X					
C. The system manager is able to enter and edit a list of leave days during which a particular provider will not be available for appointments.	X					
7. Pull Lists/Routing Slips/Labels						
A. The system has the capability to produce a pull list for each site. The pull list shows the following data, at a minimum, for each appointment:						
• Patient name	X					
• Patient chart number	X					

**PATIENT SCHEDULING FUNCTIONAL REQUIREMENTS
(CL-1)**

Requirements			Vendor Capability			
	MIN	OPT	Yes	Module	Future Vn.	Third Party
• Patient date of birth	X					
• Patient gender		X				
• Appointment date and time	X					
• Patient telephone number and address	X					
• Provider name	X					
B. A follow-up list can be run to list only the patients registered after the first pull list.		X				
C. The system allows the user to design labels for printing patient scheduling and registration information.	X					
D. The system can produce an encounter label or “superbill”/encounter form for scheduled appointments that includes the following information:						
• Patient name	X					
• Patient address	X					
• Patient chart number	X					
• Patient date of birth	X					
• Patient gender	X					
• Patient phone number	X					
• Patient social security number	X					
• Date of service	X					
• Responsible party/guarantor	X					
• Patient account status indicator/flag/code		X				
• Appointment time	X					
• Date label printed		X				
• Migrant/seasonal/other status	X					
• Primary insurance carrier and expiration date	X					
• Secondary insurance carrier	X					
E. The system can produce an encounter form that includes last visit information for disease specific care (see types of data listed below):						
• Patient demographics (name, address, migrant status, homeless status, primary language, date of birth, gender, etc.)		X				
• Problem list (diagnoses, dates of diagnoses)		X				
• Patient assessment (feet, eyes, etc.)		X				
• Patient test results and dates		X				
• Patient referrals and dates		X				

**PATIENT SCHEDULING FUNCTIONAL REQUIREMENTS
(CL-1)**

Requirements			Vendor Capability			
			Yes	Module	Future Vn.	Third Party
	MIN	OPT				
• Objective findings (weight, BP, etc.)		X				
• Patient medications		X				
• Patient health profile		X				
• Patient behavioral and lifestyle issues		X				
• Patient self-management goals		X				
• SOAP notes		X				
• Date of visit		X				
• Responsible party/guarantor		X				
• Migrant/seasonal/other status		X				
• Provider(s) name(s)		X				
• Primary insurance carrier and expiration date		X				
• Tickler information that is appropriate for the patient's age and medical history		X				
F. The system can print order labels/requisitions in the laboratory for scheduled lab tests.	X					
G. The system can generate labels for off-site reference laboratory tests including the following patient related data:						
• Medicare number	X					
• Medicaid number	X					
• Insurance plan and number	X					
• Social security number	X					
• Patient name	X					
• Patient address	X					
• Diagnosis code (ICD9)	X					
• Patient gender	X					
• Patient date of birth	X					
• Chart number	X					
• Appointment date	X					
• Provider number	X					
• Clinic site	X					

**PATIENT SCHEDULING FUNCTIONAL REQUIREMENTS
(CL-1)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
8. Interfaces to Other Modules						
A. The user is able to partially register a patient or change existing registration information for a patient during the process of booking an appointment from the scheduling screen(s). For a new patient registration, the system allows the assignment of a unique temporary record number. Remove after 6 months inactive.		X				
B. The list of patients on the pull list for each site is available to other modules of the system for the printing of selected reports, e.g., patient medical record summaries, for these patients.		X				
9. The system registers attendance for the scheduled appointment when the patient's visit to the clinic is entered.	X					
10. The system can produce follow-up address labels for user-selected patients.	X					
11. The system can produce a report of patients who missed appointments (a "no show" report) in a user-selected date/time period.	X					
12. The system maintains a history of patients that miss and cancel appointments and can produce a report of contact information for these patients including reasons for cancellations.	X					
13. The system can generate letters to patients reminding them of their scheduled appointments.	X					
14. The system can print out a charge ticket (superbill) before the appointment or when the patient arrives and checks in.	X					

**PATIENT SCHEDULING FUNCTIONAL REQUIREMENTS
(CL-1)**

Requirements			Vendor Capability			
	MIN	OPT	Yes	Module	Future Vn.	Third Party
15. The system allows the user to create or edit multiple reminder and/or follow-up letters generated by the scheduling module so that Spanish or English language letters can be produced for selected patients.	X					
16. The system produces a report showing route slips that were printed but had no charges posted.	X					

**PATIENT REGISTRATION FUNCTIONAL REQUIREMENTS
(CL-2)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
1. Registering New Patients						
A. The system maintains a unique patient identification number for each patient.	X					
B. The system is able to automatically assign patient identification numbers in a user-specified format and range, or allows the user to assign a patient identification number to a patient.	X					
C. The system accommodates at least one historical medical record/chart number for tracking back to legacy systems.	X					
D. The user can record the patient's medical record number at registration.	X					
E. The system maintains a master directory or index of patient names.	X					
F. The user is able to record the maiden surname of the patient to help in patient identification and record correlation.	X					
G. The user is able to register individuals by family.	X					
H. Patients associated with a family or guarantor can have surnames and addresses that differ from the head of household or guarantor.	X					
I. The system is able to differentiate between patients and guarantors (patients or non-patients who agree to pay the patient's bill if no one else does).	X					
J. The system allows a patient to have more than one guarantor without requiring the patient to have more than one account.		X				
K. The system supports recording both a permanent and local address for the patient.	X					
L. At registration, the user is able to categorize the patient as migrant, seasonal, or other for Federal reporting.	X					

**PATIENT REGISTRATION FUNCTIONAL REQUIREMENTS
(CL-2)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
M. At registration, the system will establish a patient account status indicator or code that reflects the payment status of the patient's account. This account status indicator or code will change automatically as the account status changes. Users will have the ability to change this account status indicator or code. An account status indicator value or code will be reserved to indicate that no bill should be sent out.	X					
N. The user is able to record information for identifying and locating the patient's employer. The user can print patient registration information by employer.	X					
O. The registration module records geographical information associated with the patient and guarantor's residence (e.g., neighborhood or census track).		X				
P. The system provides a free text comment field associated with the patient's registration record.	X					
Q. For name and address data items that are maintained, the system allows the user to specify "same as patient," or "same as guarantor" or automatically copies previously entered data to reduce the amount of duplicate data entry.	X					
R. Each family can have an unlimited number of insurance policies covering members of the family.		X				
S. The user is able to specify which members in the family are covered by each insurance policy.	X					
T. Subscribers (e.g., employers) may be different than the patient or the guarantor; if so, appropriate demographic data can be collected on the subscribers.	X					

**PATIENT REGISTRATION FUNCTIONAL REQUIREMENTS
(CL-2)**

Requirements			Vendor Capability			
	MIN	OPT	Yes	Module	Future Vn.	Third Party
U. The system records patient's ethnicity using values in a user-defined table.	X					
V. The system allows the user to record chronic diagnoses for the patient and the associated dates of the chronic diagnoses.		X				
W. The user can assign the patient to a sliding fee scale and record an associated date for re-certifying the patient's sliding fee scale eligibility.	X					
X. The system provides at least two free text fields that can be used to categorize the patient for reporting. These fields are accessible via the report writing tool.	X					
Y. The system automatically assigns the city and state based on the zip code.		X				
2. Updating Data on Existing Patients						
A. The user is able to change any user entered data field at any time. Certain data fields can have security protection restricting access to specific users.	X					
B. An on-line data edit function is available.	X					
C. For data items selected by the clinic, the system is able to maintain an audit trail record of the changes made to the data items over time.	X					
D. The system allows the user to change a patient's name or patient registration number without having to re-register the patient.	X					
E. If a patient's registration record is in use, the system identifies which user/workstation has the record locked.		X				
F. The system provides on-line (24x7) access to Medicaid eligibility information. The system will provide the option to update the patient's records based on the eligibility information.		X				

**PATIENT REGISTRATION FUNCTIONAL REQUIREMENTS
(CL-2)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
G. The system maintains an inactive/active status on each patient that can be used for scheduling reminders and reporting.		X				
3. Displaying and Printing Registration Data						
A. The user is able to display the following types of registration data:						
• Family rosters	X					
• All demographic data for each registered family member	X					
• A patient's socio-economic, demographic, and identification number data	X					
• Guarantor's name and patient account number	X					
• Insurance policy and coverage data on each patient	X					
• Patient employer information	X					
• The primary site at which the patient receives care	X					
B. The system displays comments or flags indicating special conditions associated with the patient or his/her account.	X					
C. The system displays account status information (from the Accounts Receivable module) via an account status indicator or code on the patient registration screens.	X					
D. The system allows the user to select subsets of patient information (registration and/or clinical) (e.g., patient age range and gender, patients or guarantors in a geographical area, guarantors of patients in selected age and gender group) to produce mail merge files, print form letters, or generate reports.	X					
4. Global patient identification features are incorporated throughout the modules of the system including the following:						
A. The user is able to uniquely identify a patient by a current or former medical record number.	X					

**PATIENT REGISTRATION FUNCTIONAL REQUIREMENTS
(CL-2)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
B. An alternative method of identifying a patient is entry of the patient's full or partial name.	X					
C. When using the name identifier, the user is able to enter the patient's gender, social security number, and/or date of birth to limit the number of matches found in the system.		X				
D. The full and partial name lookup routines searches for exact matches to the entered spelling and also for phonetic comparables of the entered name or partial name (e.g., soundex).		X				
E. When age or date of birth is entered, the system locates all patients who acceptably match the name (and optionally gender) specified, and whose age is within a specified number of years of the data entered.		X				
F. A patient can be identified by his or her prior name (e.g., maiden name) or alternate name (e.g., alias) previously entered into the system.		X				
G. All patients associated with a given family unit or guarantor can be displayed under the head of household or guarantor.	X					
H. The system allows the user to interrupt an incomplete patient registration process, switch to another module such as scheduling or accounts receivable, perform activities in the active module, and return to the registration module at the point in the registration process when interrupted.		X				
I. The system allows the user to print the registration screen via a screen dump to a local printer.		X				
J. The registration module allows the user to register multiple patients without returning to select a registration menu option between each patient.	X					

**PATIENT REGISTRATION FUNCTIONAL REQUIREMENTS
(CL-2)**

Requirements			Vendor Capability			
	MIN	OPT	Yes	Module	Future Vn.	Third Party
K. The registration module allows the user to specify whether updated information (e.g., address changes, new guarantor) is applied to all or individual patients under the guarantor or family account.	X					
L. The registration module records the initials of the data entry operator and the date of changes made to patient registration information.	X					

**MEDICAL/DENTAL DATA FUNCTIONAL REQUIREMENTS
(CL-3)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
1. Input Process						
A. Formatted encounter forms are used for capturing medical and dental data that occurs during an encounter.	X					
B. There are no restrictions on the number of different encounter forms that can be used.	X					
C. It is possible to alter the layout of small portions of an encounter form without having to reprogram the system.	X					
D. The user can design/define data entry screens that are specific to a health care provider or clinical function.	X					
E. It is possible to indicate that a data value previously entered was in error.	X					
F. The system prints a copy of the encounter form(s).	X					
G. The system supports recording specific chronic care diagnosis codes that can be used to establish evidence-based care guidelines for patient scheduling and visits (e.g., diabetes, asthma, etc.). These codes can be used to specify the encounter form to be used with this patient.		X				
H. The system can produce an encounter form that includes past data on the patient (e.g., vitals, observations, special education sessions, co-morbidities, lab results, referrals, etc.).		X				
I. The system supports data entry by optical scanner.	X					
J. The system can display/print care ticklers specific to the patient's chronic disease, age, gender, etc.		X				

**MEDICAL/DENTAL DATA FUNCTIONAL REQUIREMENTS
(CL-3)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
2. There is a capability for an Electronic Medical Record, to store the following information:						
A. Physical examination and assessment data are stored by body system, e.g., eyes, ears, head, etc. Allowable entries for each body system must be, at a minimum, WNL (within normal limits), problem, and problem under management.		X				
B. Vital sign data, i.e., height, weight, blood pressure, and date/time are stored.		X				
C. The dates, and where necessary, the series of each immunization are stored.	X					
D. Coded description of intervention activities, for each relevant data type (e.g., teach, demonstrate, refer, etc.) are stored.		X				
E. Symptom/diagnostic terms are stored. It is possible to amplify the meaning of diagnostic terms by appending a status field to the term. Status field entries are to include, at a minimum, acute and chronic.		X				
F. Additional status fields, such as history of, status post, and rule out, are available.		X				
G. Procedure codes are stored.	X					
H. Laboratory test data are stored. The data indicate both tests ordered, results, and the associated dates.	X					
I. Medication data are stored and sorted by date prescribed. The data indicate when the medication was ordered and for what reason.		X				
J. Referral data are stored. The data indicate to whom the referral was made, the date of the referral, and whether or not the referral visit occurred.		X				
K. Any other medical or non-medical therapy not cited above are stored.		X				
L. Allergies/sensitivities data are stored (including medication allergies).	X					

**MEDICAL/DENTAL DATA FUNCTIONAL REQUIREMENTS
(CL-3)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
M. Unlimited amounts of narrative data can be stored for each physical assessment, diagnostic procedure, and laboratory test.		X				
N. Chronic and acute problem lists are stored.	X					
O. There are no restrictions on the number of encounters that can be stored in a patient's automated medical record.		X				
P. There are no restrictions on the number of terms that can be stored on each visit.		X				
Q. There are no restrictions on the number of terms that can be stored in the patient's automated medical or dental record.		X				
R. Subjective-Objective-Assessment-Plan (SOAP) notes and progress note formats are supported.		X				
S. The system includes a health maintenance feature that compares a patient's history with user-defined and/or industry standard treatment protocols/guidelines and identifies areas needing attention to satisfy protocols.		X				
T. Risk profiles (e.g., tobacco use, alcohol use, illicit drug use) are stored.		X				
3. Outputs						
A. A report that shows all of the data that was captured on one encounter is available.	X					
B. A list of all encounters that have occurred on the patient is available. The following data items appear on each entry on the list: date of encounter, type of visit, provider, and location.	X					
C. The system is able to graph a patient's weight, blood pressure, or laboratory test result, or other numeric material data value over time.	X					

**MEDICAL/DENTAL DATA FUNCTIONAL REQUIREMENTS
(CL-3)**

Requirements			Vendor Capability			
			Yes	Module	Future Vn.	Third Party
D.	It is possible to display as well as print medical and dental reports.	X				
E.	It is possible to create a list of patients for whom medical or dental reports are desired, and to have the system generate the medical or dental reports beginning at a time of day specified by the user.		X			
F.	The header section of medical or dental reports contain the patient's name, address, home and work telephone numbers, age, gender, sliding scale payment category, insurance coverage, and "home" clinic (the clinic where the patient receives most of his or her care).		X			
G.	A summarized medical report is available. It consists of the following sections:					
	• Header	X				
	• Acute problem list	X				
	• Chronic problem list	X				
	• Allergies/sensitivities	X				
	• Immunization summary	X				
	• Physical assessment results		X			
	• Referral history		X			
	• Medication history	X				
	• Procedure history	X				
	• Laboratory test order history	X				
	• Laboratory test results history	X				
	• Other therapies history		X			
H.	A summarized medical record report is available in Subjective, Objective, Assessment, and Plan (SOAP) format.		X			
I.	Flowsheets that show the changes of selected data items from encounter to encounter shall be available for all patients.		X			
J.	The system allows the user to create new flowsheet routines; these routines are stored in a library and invoked under user control.		X			

**MEDICAL/DENTAL DATA FUNCTIONAL REQUIREMENTS
(CL-3)**

Requirements			Vendor Capability				
			MIN	OPT	Yes	Module	Future Vn.
K.	The system allows the user to select medical records for review based on combinations of diagnosis codes and patient demographic information.	X					
L.	The system produces the forms necessary to submit samples and test orders to commercial reference laboratories.	X					
M.	The system is capable of producing an historical perspective report to be given to the patient. At a minimum, it will include past lab results (graphs), vitals, referrals, education, goals, medications (dates and doses).	X					
4. Interface to Other Modules							
A.	Patient identification, demographic and financial data appearing in the header of medical reports is retrieved from data stored by the Patient Registration process.	X					
B.	The medical/dental data module can be linked to external reference databases supporting diagnosis, protocols, drug interactions, physician desk reference information, others.		X				
C.	This medical/dental data module supports industry standard linkages (e.g., Health Level 7) and data integration with off-site laboratory systems.		X				
D.	This module supports electronic data interchange with hospitals, other physician offices, and provider residences.		X				
E.	The data in this module is accessible by third party report writer software.	X					
5. Medical Records Tracking							
A.	The system supports tracking of patient charts using bar code technology.		X				
B.	The system produces labels for patient charts, medications, lab slips, and supplies.	X					

**MEDICAL/DENTAL DATA FUNCTIONAL REQUIREMENTS
(CL-3)**

Requirements			Vendor Capability			
	MIN	OPT	Yes	Module	Future Vn.	Third Party
C. The system supports quality assurance audits against clinic-established protocols.		X				
6. The system suggests patient education materials based on the patient's diagnosis.		X				
7. Disease Management						
A. The system provides the ability to create user developed treatment protocols and to generate disease-specific guidance (e.g., flow charts) that integrates patient-specific data.		X				
B. The system generates prompts for intervention based on the user developed treatment protocols (e.g., appropriate lab tests at indicated intervals, referrals for screening, etc.).		X				
C. The system flags outliers where case management is inconsistent with the indicated disease management protocols.		X				
D. The system supports disease management tracking keyed to patient registries to allow automatic tracking of care specific performance measures.		X				
E. The system provides tools for defining and developing disease-specific patient registries for tracking disease management information (e.g., clinical outcomes, complications, health care utilization, patient satisfaction, patient self-management, adherence to guidelines, percent of patients using self-monitoring, other data elements specific to the disease being managed).		X				
F. The system has the capability to collate, correlate, and report individual and aggregate clinical data over time.		X				

**MEDICAL/DENTAL DATA FUNCTIONAL REQUIREMENTS
(CL-3)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
G. The system supports time sensitive, system produced mailers or letters to alert patients of their need for follow-up care.		X				
H. The system tracks over-the-counter and prescribed patient medication including the name of the medication, dosage, route, initial order, and renewal dates.		X				
I. The system maintains patients' medication allergies and displays this information as appropriate.		X				
J. The system supports creation of a "visit day form"/encounter form that:		X				
<ul style="list-style-type: none"> • Can be customized to specific evidence-based care guidelines 		X				
<ul style="list-style-type: none"> • Includes last visit information (test results, provider observations, referral plans and results, lifestyles and self-management data) 		X				
<ul style="list-style-type: none"> • Has space to collect current information on the same categories, demographics, and SOAP notes 		X				
<ul style="list-style-type: none"> • Fits on one page and replaces other documents in the patient chart 		X				
K. The system allows adding and changing chronic care diagnosis codes.		X				
L. The system supports a comprehensive user-defined patient follow-up function generating letters to physicians, clinics, hospitals, etc., for the purpose of collecting disease-specific patient data from external sources.		X				

**PATIENT FOLLOW-UP MONITORING/TRACKING
FUNCTIONAL REQUIREMENTS (CL-4)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
1. Input Process						
A. The user can enter a follow-up date for the patient when entering the patient's encounter data.	X					
B. The user can enter the date of the next compliance protocol issue for any number of wellness and chronic care guidelines when entering patient encounter data.		X				
C. The system calculates the date of the next compliance protocol issue for any number of wellness and chronic care guidelines when entering patient encounter data.		X				
D. The system provides case management features allowing the user to define and track multiple patient registries.		X				
E. The system allows the user to define, track, and report on any data element or combination of data elements associated with patients. This tracking can be over an arbitrary length of time and can be plotted over time.		X				
F. The system allows the user to create data files that supplement patient registration and encounter information and to link these files to the patient's registration record for retrieval and reporting.	X					
G. All patients associated with a specific chronic care condition can be listed and sub-grouped by other identifiers (e.g., last visit date, last lab test results and dates, etc.).		X				
H. The system calculates the date of the next follow-up action based on the date of the last information on file (user-defined).		X				

**PATIENT FOLLOW-UP MONITORING/TRACKING
FUNCTIONAL REQUIREMENTS (CL-4)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
2. Output Reports						
A. Unless otherwise specified, all output reports list patients by home clinic (the clinic where the patient usually receives care).	X					
B. Patients are identified by name and identification number on the reports.	X					
C. The system can produce mailing labels for a user-selected group of patients.	X					
D. The system can produce groupings of patients on any data parameter (and on collections of data parameters) using Boolean logic. Selection is available using the following operators:	X					
• Equals, less than, greater than, greater than or equal, less than or equal, not equal	X					
• Within a range	X					
• First, last occurrence	X					
• Nth occurrence	X					
• NOT, AND, OR, with nesting to five (5) levels	X					
E. On a periodic basis, the system generates a Missed Referral report of all patients who had been referred to another section of the clinic and (n) days after the referred date had not yet been seen by the other section. The user can set the value of "n."	X					
F. The system generates the Missed Referral report per the specifications cited above, but lists the patients by provider or section to which the patient was referred.		X				
G. Under user control, the system generates a report of all patients who are delinquent in any evidence-based care guidelines or standardized wellness procedures (e.g., immunizations, HbA1c tests for diabetics, PAP smears, mammograms, well baby checks). The needed procedures are listed on the report.	X					

**PATIENT FOLLOW-UP MONITORING/TRACKING
FUNCTIONAL REQUIREMENTS (CL-4)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
H. Under user control, the system generates reminder letters for all patients who are delinquent in their scheduled treatments, tests, or consultations (e.g., immunizations, HbA1c test, etc.).	X					
I. The user may edit the reminder letter.	X					
J. If the Scheduling module is not used, on a periodic basis the system generates a Missed Appointment report of all patients who have not returned for a follow-up visit within “n” days or weeks or the visit date. The value of “n” can be set by the user.		X				
K. Under user control, the system generates a report of all patients who have abnormal laboratory results.		X				
L. Under user control, the system generates a report on all patients who have been identified as having a high risk medical condition.		X				
M. The system produces a “report” for the patient to bring them into their own care and to let them know how they are doing. The report includes pertinent test results, referrals, self-management goals, educational sessions, etc.		X				

**BILLING FUNCTIONAL REQUIREMENTS
(CL-5)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
1. Standard Third-Party Billing						
A. The system automatically prints in the provider box of each Medicaid bill the appropriate value for the provider identification number.	X					
B. The Health Insurance Claim Form (AMA Form 1500) can be printed for bills sent to commercial insurance companies.	X					
C. Medicare claims can be processed electronically (electronic submission mandatory, electronic remittance desirable).	X					
D. The standard American Dental Association (ADA) billing claim form can be printed.	X					
E. State Medicaid claims can be submitted and processed electronically.	X					
F. Any of the above bills can be generated at any time during the month.	X					
G. The system can automatically generate third-party bills for all visits identified as billable to third-party carriers that have not yet been billed to these carriers.	X					
H. The system maintains and can print an audit trail of all transactions associated with a patient's bill.	X					
I. The history of patient bills satisfying user-specified selection criteria can be purged at the user's option.	X					
J. The system shall have the capability to transmit claims electronically to all major carriers including, but not limited to, Medicaid and Medicare carriers.	X					

**BILLING FUNCTIONAL REQUIREMENTS
(CL-5)**

Requirements			Vendor Capability			
	MIN	OPT	Yes	Module	Future Vn.	Third Party
K. The system supports automatic translation of entered diagnosis and procedure codes (e.g., revenue codes for Medicaid, ADA codes for dental claims) to alternative state and third-party payer-mandated coding schemes for reimbursement claim forms.		X				
L. The system allows for refiling unpaid claims to third-party carriers based on a carrier code, date of service range, and provider.	X					
M. The system provides the ability to record the payment schedule by procedure code by insurance plan.		X				
2. Split Billing/Proration						
A. The billing function allows for guarantors and third-party payers to be billed at the same time for the same patient visit.	X					
B. The billing function allows the user to suspend billing the guarantor and continue aging the guarantor's balance for a particular visit until such time as a response from the third-party payer has been received. A notation field indicating the reason for the suspension is provided. The account status indicator or code shall be changed by the system or user to indicate suspension of guarantor billing.	X					
3. Transfers/Crossovers						
A. The responsibility for payment on a claim can be transferred from the guarantor to a third-party payer, from a third-party payer to the guarantor, and from one third-party payer to another.	X					

**BILLING FUNCTIONAL REQUIREMENTS
(CL-5)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
B. The system shall have the ability to transfer unpaid balances and co-payments to secondary insurance carriers (including Medicaid) and issue a bill to the secondary carrier detailing all the information necessary for payment.	X					
C. The system shall have the ability to transfer unpaid insurance balances and co-payments to the patient's guarantor after a user-specified period of time.	X					
D. The system shall have the ability to transfer balances remaining after receiving payments from eligible insurance carrier(s) to the patient's account and to issue a bill to the guarantor for this balance.	X					
E. The system shall have the ability to reassign charges previously entered to another carrier. Adjustments must be backed out and reapplied based on the new insurance carrier.	X					
F. The system shall have the ability to merge duplicate patient accounts.	X					
G. The system shall have the ability to split family members and reassign to appropriate accounts (mandatory with family billing).	X					
4. Insurance Forms						
A. The system allows the system manager to initially define all of the possible third party payers that the system will use.	X					
B. This file of payers can be modified over time as deemed necessary by the system manager. "Modified" here involves the user having the ability to add, edit, or delete (within certain limits) third-party payers.	X					

**BILLING FUNCTIONAL REQUIREMENTS
(CL-5)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
C. Since different payers have different information requirements, the system shall allow the system manager to define all pertinent questions to be asked at the time the patient is registered, at the time the provider and his/her insurance/ID numbers are added to the system, and other questions to be asked in the course of inputting the billable items for a patient visit.	X					
5. Fee Schedule Maintenance						
A. The system maintains fees for all items which the user identifies as billable. This fee schedule has restricted access and can be updated by the system manager when necessary.	X					
B. The system has the ability to identify all procedures which are covered by FQHC rates.	X					
6. Collection Management						
A. The system tracks the status of each outstanding guarantor balance by the age of the balance (in intervals of 30 days up to 150 days) and by whether or not a minimum payment (percentage basis), a full payment, or no payment has been made against the outstanding balance.	X					
B. The system tracks the status of each outstanding third-party payer by the age of the balance due on each account.	X					
C. The system supports the development of budget plans and bills guarantors according to the budget plan agreement.		X				
D. The system provides a "tickler system" for tracking the activities associated with managing collection accounts.	X					
E. The system produces a report of accounts with credit balances.	X					

**BILLING FUNCTIONAL REQUIREMENTS
(CL-5)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
F. The collections module allows the user to flag accounts for follow-up and to add special collection accounts.	X					
G. The system maintains a history of statements mailed to patients (required to file for Medicaid bad debts). The history records the date and type of statement sent.	X					
H. The system has the ability to generate reminder notices to patients with expired sliding fee review dates.	X					
I. The system has the ability to change the sliding fee type of patients with expired sliding fee coverage (temporary category).		X				
7. On-Demand Bill						
A. A demand bill can be generated by the system when the patient's visit is complete.	X					
B. The demand bill includes the following data elements:						
• Patient's name and address	X					
• Patient's account number	X					
• Billing facility's name and address	X					
• Billing facility's taxpayer ID number	X					
• Place of service	X					
• Detail for each line item includes:	X					
– Date of service	X					
– Procedure code(s)	X					
– Service/supply item	X					
– Fee	X					
• Balance prior to this visit	X					
• Total amount due this visit	X					
• Adjustments (discounts, etc.)	X					
• Method of payment	X					
• Amount of payment	X					
• Net balance due	X					

**BILLING FUNCTIONAL REQUIREMENTS
(CL-5)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
C. The system has the ability to print a generic service description for user-selected procedures that may be considered confidential (e.g., STD/AIDS test).	X					
D. Demand bills are generated by a printer associated with the cashier's CRT and capable of printing at least 80 columns.	X					
E. If the patient has been identified as eligible for a certain discount percentage, the demand bills will automatically include the credit adjustment for the discount and the reversing debit adjustment for the discount.	X					
F. If a fixed (minimum) co-payment is specified for the system as a whole or for particular accounts (Medicaid indigents), the demand bill will reflect the associated adjustments.	X					
G. The balance and aging of an account are updated at the time the demand bill is generated and is not delayed until the end of the accounting period.		X				
H. The system tracks the status of each outstanding third-party payer by the age of the balance due on each account.	X					
I. The system supports billing by family where all bills associated with members of a family are summarized in a single family account balance.		X				
J. The system allows the system manager to modify the format of the patient or family statement/bill without vendor intervention.		X				
K. The system automatically determines the sliding fee category based on the family size and income.		X				
L. The system has the ability to reprint a day bill on demand.		X				

**BILLING FUNCTIONAL REQUIREMENTS
(CL-5)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
8. Charge Entry						
A. The system supports both real-time and batch entry of patient service charges.	X					
B. The system defaults the visit diagnosis to the last or the chronic diagnosis based on the preference set by the user.		X				
C. The system shows the primary, secondary, and tertiary insurance for selection during charge entry (defaults to primary) and allows changing insurance assignments as necessary.	X					
D. The system prompts the user with the codes and fees associated with the selected insurance carrier.		X				
E. The system supports splitting global fees into user-defined components.		X				
F. The system prevents users from entering procedures to incorrect sites, departments, or providers (e.g., dental codes cannot be entered in the department of Pediatrics).		X				
9. The system has the ability to print a patient or guarantor's private statement containing a record of patient/guarantor billings, payments on account, insurance filings, and insurance payments received.	X					
10. The system has the ability to print a day-log of all transactions processed by staff member to facilitate cash drawer reconciliation and encounter form tracking.	X					
11. The system allows the user to define at least 100 site-program codes to distinguish revenue categories by clinic site and reimbursement source.	X					

**BILLING FUNCTIONAL REQUIREMENTS
(CL-5)**

Requirements			Vendor Capability			
	MIN	OPT	Yes	Module	Future Vn.	Third Party
12. The system shall issue monthly mailing statements that will conform to the specifications of the U.S. Postal Service including printing of ZIP+4 and bar coding requirements.		X				
13. The system provides the ability to establish and have bills adjust to a center-specific sliding fee scale policy including:		X				
• Minimum fee by procedure code		X				
• Minimum fee by visit		X				
• Minimum fee by department		X				
• Combination of above		X				
• Sliding fee by percentage of full charge		X				
• Ability to identify procedures ineligible for slide		X				

**ACCOUNTS RECEIVABLE (A/R) FUNCTIONAL REQUIREMENTS
(CL-6)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
1. Interfaces with Other Functional Areas						
A. The A/R functions must interface with the Registration functions so that at the initial patient contact the system can display:						
• The account to which the patient belongs	X					
• The sources of payment available to the patient	X					
B. Accounting data (transactions) and medical/nursing data are entered via the same input stream in order to eliminate redundancy and to ensure that services billed match services provided.	X					
C. The system interfaces the A/R function with the Scheduling function so that the status of a patient's account is available:						
• At the time the appointment is made	X					
• When the patient checks in	X					
D. The system interfaces the A/R function with the Registration and Scheduling modules so that comments and an account status indicator/code associated with the patient or his/her account are displayed.		X				
E. All changes to patient registration information are immediately reflected in the A/R data.	X					
2. A/R Account Inquiry						
A. There is an inquiry capability that enables the user to view the following elements of an account:						
• Accounting data (transactions)	X					
• Guarantor's name	X					
• Guarantor's account number	X					
• Guarantor's full billing address	X					
• Guarantor's phone	X					
• Names and Medicaid record numbers of account members	X					
• Patient account status indicator/code	X					
• Guarantor balance with aging in intervals of 30 days up to 150 days	X					

**ACCOUNTS RECEIVABLE (A/R) FUNCTIONAL REQUIREMENTS
(CL-6)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
• Other payers' balances with the following insurance policy information:	X					
– Payer's name	X					
– Policy number	X					
– Group number	X					
– Policy expiration date		X				
– Accept assignment arrangement	X					
– Other user-defined data elements		X				
– Aging in intervals of 30 days up to 150 days		X				
• Detailed transactions are in chronological order by posting date and include:						
– Date of service	X					
– Member of account receiving care	X					
– Posting date	X					
– Provider's name	X					
– Site of service	X					
– Visit line items including:						
♦ Transaction type	X					
♦ Line item description	X					
♦ Dollar amount	X					
♦ If a payment, payment's source	X					
– Aggregation of line items billed via third-party payer claim forms:						
♦ Claim number	X					
♦ Name of payer	X					
♦ Date of service	X					
♦ Status of claim (i.e., "paid" or "not paid")	X					
B. The system provides the ability to sort and print to any printer a patient's account information sorted by pay code (charges, discounts, and payments)		X				
C. A summary report is available that shows the last payment date, last payment amount, and credit balance for a patient's account associated with any payer.		X				

**ACCOUNTS RECEIVABLE (A/R) FUNCTIONAL REQUIREMENTS
(CL-6)**

Requirements			Vendor Capability			
			MIN	OPT	Yes	Module
3. Organization of Account Function/Feature						
A. Accounts are organized by the guarantor of the household (who is clearly identified). Individual family members associated with the account are uniquely identified.	X					
B. Special group accounts are available to handle the situation in which services provided to a large group (100+) of patients are billed to a single third-party payer and should not or cannot be billed to the patient's guarantor.	X					
C. Accounts can be identified by supplying the system with the patient's name, the guarantor's name, or the account number.	X					
D. Accounts can be sorted by guarantor name (in alphabetical order) or by account number (ascending, numeric) on reports.	X					
4. Posting Transactions/Audit Trail						
A. The method of posting transactions is double-entry accounting.		X				
B. In addition to double-entry posting, debit adjustments and credit adjustments are distinguished from debits and credits.	X					
C. Data entry can be either on-line or batched. Batched transactions may be optionally edited on-line (additions, changes, deletions) prior to posting transactions to the accounts.	X					
D. <u>All</u> transactions are associated with the patient, the account, the name of the person who posted the transaction, the posting date, the name of the transaction, the dollar amount of the transaction, and the transaction type.	X					
E. In addition, each charge item includes the following data:						
• Date of service	X					
• Payer	X					
• Provider	X					

**ACCOUNTS RECEIVABLE (A/R) FUNCTIONAL REQUIREMENTS
(CL-6)**

Requirements			Vendor Capability			
	MIN	OPT	Yes	Module	Future Vn.	Third Party
• Department/program	X					
• Procedure code	X					
• Revenue-producing cost center	X					
• Site of service	X					
• Type of service		X				
• A flag identifying a non-standard fee amount (an override fee)		X				
• User-defined comment field		X				
F. Whether or not related to medical/nursing service, each financial transaction is associated with the:						
• Date of the service (mandatory for third-party payer/optional for payments applied to guarantor balance)	X					
• Payer	X					
• Provider	X					
• Department/program	X					
• Revenue-producing cost center	X					
• Charges to which the payment is applied		X				
• If a payment is by check, bank number and check number		X				
G. Each adjustment is associated with the:						
• Date of the service	X					
• Provider	X					
• Department/program	X					
• Revenue-producing cost center	X					
• The type of adjustment, either debit adjustment or credit adjustment	X					
• A comment/notation area		X				
H. Third-party payments can be posted to particular visits designated by the payer as well as to the outstanding balance (as a unit).		X				

**ACCOUNTS RECEIVABLE (A/R) FUNCTIONAL REQUIREMENTS
(CL-6)**

Requirements			Vendor Capability			
	MIN	OPT	Yes	Module	Future Vn.	Third Party
I. The system shall provide a journal entry for the general ledger detailing revenue, adjustments, payments, bad debts, refunds by account number (segmented by site and department). This entry must reflect the exact changes in the AR report by payer category. The GL entry and AR reports can be run at any time after the close of the period and will not have changed.	X					
J. The system shall provide the capability to automatically write-off accounts based on insurance plan, date of service, and threshold balance.	X					
K. The system shall provide the capability to post denials with codes into the system electronically.		X				
L. The system provides a report to reconcile amounts written off to bad debt.		X				
M. The system provides a report to reconcile amounts refunded to patients.		X				
5. Daily Reports						
A. There is a daily transaction log that details all the transactions entered each day.	X					
B. This daily transaction log includes the date and time each transaction is generated.	X					
C. This daily transaction log is organized by patient name in alphabetical order or by account number; the order is user-defined and may be changed from one accounting period to the next.		X				
D. The daily transaction log also includes the following detail within each account:						
• Date of the service	X					
• Posting date	X					
• Provider's name	X					
• Each transaction includes:						
– Transaction description	X					

**ACCOUNTS RECEIVABLE (A/R) FUNCTIONAL REQUIREMENTS
(CL-6)**

Requirements			Vendor Capability			
	MIN	OPT	Yes	Module	Future Vn.	Third Party
– Transaction type (debit, etc.)	X					
– Dollar amount	X					
E. The system generates a bank deposit sheet listing all checks (with bank and check numbers), their dollar amounts, and the total amount for deposit.	X					
F. The system generates a cash receipt log (cash and checks) broken out by facility or by program, and/or by provider.	X					
6. Receivables Management Reports						
A. There is an Aged Trial Balance (ATB) report, provided in alphabetical order by guarantor name that shows all outstanding receivables on all non-zero balance accounts. Aging is presented in 30-day intervals up to 120 days. This report can be run at the user's option in a user-selected date of service range (i.e., not mandatory to run each month).	X					
B. On the ATB, all accounts with charges in suspense show aging of the suspense amounts by insurer and by site.	X					
C. Each account description includes:						
• The guarantor's name	X					
• Account number	X					
• Telephone number(s)	X					
D. The ATB report includes totals for the entire practice by age category for guarantor responsibility and for each third-party payer with suspended amounts.	X					
E. The ATB report can be generated by insurance, days outstanding, sliding fee type, or credit code.	X					
F. There is a monthly Outstanding Third-Party Charges report that shows aged totals for all third-party payers. It includes all claims currently in suspense by account.	X					

**ACCOUNTS RECEIVABLE (A/R) FUNCTIONAL REQUIREMENTS
(CL-6)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
G. The Outstanding Third-Party Charges report can also be broken out by site, by program, and/or by payer.		X				
H. The system produces both detail and summary receivables reports by patient financial status, by age and amount due, by location, by provider, accounts with credit balances, and overdue accounts that are candidates for collection.	X					
I. The A/R Ledger is subdivided into non-zero balance and zero-balance accounts; the non-zero balance accounts are shown with the date and/or number of days since the last payment/activity.		X				
J. The Revenue Analysis report(s) break(s) out revenue or gross charges by:						
• The system as a whole	X					
• Provider	X					
• Site	X					
• Program		X				
• Payer	X					
• Or by any combination of the above	X					
• Cost Center	X					
K. A Detail Revenue Analysis report must show Adjusted Gross Charges by applying contractual adjustments to Gross Charges. Charge Adjustments are subtracted from Adjusted Gross Charges to arrive at Net Billable Amounts. Adjustments to Gross Charges include Reversal of Charges.	X					
L. The Revenue Analysis Report(s), if run on a cash basis, shows the charges, adjustments, and payments at the time the report is run.	X					
M. The Revenue Analysis Report(s), if run on an accrual basis, can be run any time, but the specific accounting period, or range of periods, must be identified.	X					
N. On an accrual basis, the Revenue Analysis Report(s) show(s):						

**ACCOUNTS RECEIVABLE (A/R) FUNCTIONAL REQUIREMENTS
(CL-6)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
• Charges for one or more periods this fiscal year	X					
• Charges for prior periods this fiscal year	X					
• Adjustments posted against dates of service in prior periods this fiscal year	X					
• Net this (or selected) period(s) this fiscal year (charges less adjustments)	X					
• Net prior periods this fiscal year	X					
• Payments posted against dates of service in this (or selected) period(s) this fiscal year	X					
• Payments posted against dates of service in prior periods this fiscal year	X					
O. The system produces a Capitated Patient List that shows insurance information for all patients under capitation.		X				
P. The system produces an Encounters for Patients Without Third Party Coverage report that lists patients' full names, their social security numbers, and all encounters and their associated charges within a user-specified date range for patients that show no insurance coverage on their accounts. This report can be used to check eligibility for Medical reimbursement.		X				

**MANAGEMENT SUPPORT: REPORTS AND CLERICAL
FUNCTIONAL REQUIREMENTS (CL-7)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
1. The system generates the Bureau of Primary Health Care's Uniform Data System (UDS) reports.	X					
A. The system provides the ability to run all or selected UDS tables.	X					
B. The system provides the ability to run UDS reports for all or selected locations (sites).	X					
C. The system provides the ability to run detail data reports to verify the data shown on the UDS tables.	X					
D. The system shall be able to compute and print all UDS reports within 2 hours.	X					
E. The system provides the ability to complete optional fields on the UDS tables.	X					
2. The system generates the Bureau of Primary Health Care's National Goals for Chronic Care Conditions reports.		X				
A. The system provides the ability to run all or selected National Goals.		X				
B. The system provides the ability to run National Goals reports for all or selected locations (sites).		X				
C. The system provides the ability to run detail data reports to verify the data shown on the National Goals reports.		X				
D. The system shall be able to compute and print all National Goals reports within 2 hours.		X				
3. The system will produce a revenue analysis report that summarizes for a user-specified date range, cost center, site, department, and/or provider:						
• Total fees charged	X					
• Total adjustments (by type)	X					
• Total revenue generated	X					
• Total procedures by procedure code	X					
4. The system will produce productivity trend reports including the following ratios by cost center, department, and/or site for a user specified date range:						
• Average charge per visit	X					
• Average charge per diagnosis	X					

**MANAGEMENT SUPPORT: REPORTS AND CLERICAL
FUNCTIONAL REQUIREMENTS (CL-7)**

Requirements			Vendor Capability			
	MIN	OPT	Yes	Module	Future Vn.	Third Party
• Average charge per procedure	X					
• Average revenue per visit	X					
• Average cost per visit		X				
• Number of encounters per diagnosis and procedure		X				
• Collection ratios	X					
• Accounts receivable ratios	X					
• Net worth, current ratio	X					
5. A report generator is integrated with the other system modules so that the user need not be concerned about job control language.	X					
6. Subsets of patient, encounters, clinical, or account records can be selected using Boolean logic. The logic can be applied to any and all data fields in a patient's record (e.g., laboratory results, health profile status, medications, and other objective findings, lifestyle issues, financial/billing/accounts receivable information, etc.). Selection can be composed of the following operators:						
A. Equals, less than, greater than, greater than or equal, less than or equal, not equal	X					
B. Within a range	X					
C. First, last occurrence	X					
D. nth occurrence	X					
E. NOT, AND, OR, with nesting to five (5) levels	X					
7. Up to ten (10) fields from each selected record can be listed.	X					
8. Two (2) dimensional tables from the selected records can be generated.	X					
9. The user is able to store report programs in a report library, and execute these programs under user control.	X					
10. The user is able to edit the parameters of a report program, and refile the revised parameters into the program library.	X					
11. The system manager is able to queue report programs that are to be executed, and to request that the system execute the programs when the computer is unattended.	X					
12. Report files created by the report generator can be analyzed and presented via a statistical package. The following capabilities are desired:						
A. Frequency counts	X					
B. Mean	X					
C. Median	X					

**MANAGEMENT SUPPORT: REPORTS AND CLERICAL
FUNCTIONAL REQUIREMENTS (CL-7)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
D. Standard deviation		X				
E. Cross tabulation		X				
F. Histograms		X				
G. Scatterplot		X				
H. Chi-square		X				
I. Random sample		X				
J. Run plots of patient data (and aggregated patient data—counts, averages, etc.) over time. The timeframe can be set by the user.		X				
13. The system provides a capability to chart both raw and summarized data.		X				
14. The charting capability allows multiple graphs (up to 5) per page aligned by their X-axis.		X				
15. The user is able to create new data fields and data files that supplement the patient registration and encounter records in the system.	X					
16. User-created supplemental data fields and files can be linked to patient registration and encounter data. Data in these supplemental data fields and files can be used in patient data inquiries and reports.	X					
17. The system includes indexed key fields that reduce the time required to generate reports. Indexed fields include:	X					
• Date of service	X					
• Account number	X					
• Date of posting	X					
• Date of deposit	X					
• Appointment date	X					
• Provider	X					
• Site	X					
• Department	X					
• Insurance Plan	X					
18. The system includes electronic mail capabilities (both internal and Internet).	X					
19. The system allows the user to use third party report writing tools to access the data.		X				

**MANAGEMENT SUPPORT: REPORTS AND CLERICAL
FUNCTIONAL REQUIREMENTS (CL-7)**

Requirements			Vendor Capability			
	MIN	OPT	Yes	Module	Future Vn.	Third Party
20. The system provides a data warehouse in a Standardized Query Language (SQL) environment.		X				
21. The system provides the capability to export all data as comma-delimited text, in MS Excel spreadsheet format, or in open database compliant (ODBC) databases.	X					
22. The system is certified for the Physician Services Practice Analysis (PSPA) program.		X				
23. The system provides query capabilities that allow “drill down” capabilities (e.g., user can view the detailed data supporting a summary down to an individual record).		X				

**SYSTEMS MANAGEMENT
FUNCTIONAL REQUIREMENTS (CL-8)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
1. Security features are incorporated within the system. These shall provide for:						
A. Positive identification of authorized users and terminals.	X					
B. Control of the functions authorized for a user or category of users (e.g., registration, cashier, biller, etc.).	X					
C. Control of the menu options authorized for a user or category of users.	X					
D. Ability to drop inactive users off the system after a specified interval of inactivity.		X				
E. Ability to clear automatically the screens of video display terminals after a specified interval of inactivity.		X				
F. The system allows at least 99 groups or categories of users to be defined for security.	X					
G. The system provides the ability to restrict user access to files by read, write, and modify categories.		X				
2. The system can provide context sensitive on-line help messages for each data prompt at the request of the user, or automatically if an erroneous response is entered and the help facility is enable by the user.		X				
3. The system manager is able to change help messages or add new messages.	X					
4. Selection of functions of the system is through the use of menus, via graphical user interface mouse selections, or via typed commands available as “shortcuts” to traversing menu trees or mouse clicks.	X					
5. The system is designed to protect against simultaneous update of the same data field(s) by more than one user.	X					
6. The system will have means for recovering systems data from an earlier version of the master files.	X					
A. Data is stored on mirrored disk drives.		X				

**SYSTEMS MANAGEMENT
FUNCTIONAL REQUIREMENTS (CL-8)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
B. Data can be backed up on an incremental basis.	X					
C. Data backup operations can be scheduled for off-hours and will operate unattended.	X					
7. Data entry is on-line. The system checks data items upon entry for validity and consistency with other data and warns the user of erroneous entries in time for the user to correct the data before it is filed in the database.	X					
8. The user is able to edit any data item as soon as the error is detected.	X					
9. The system contains a master directory of all terms that will be input as part of the patient registration, encounter data entry, and accounts receivable/billing data entry process.	X					
10. The system manager is able to add, delete, or modify entries in the master directory without programmer intervention.	X					
11. Numerous users can simultaneously use each module, (i.e., a multi-user system). The system will ensure data integrity in the multi-user environment.	X					
12. Large volume updates to static files, e.g., fee changes, can be scheduled for a given effective date.		X				
13. System can be configured to support mirrored or striped disk drives to improve fault tolerance and system recovery.	X					
14. System error messages are clearly explained on the user's screen.	X					
15. Significant system error messages are logged to a file for later review.	X					
16. A list of all error messages with clear explanation and recommended response is documented in an operator's manual.	X					
17. The system allows archiving of inactive patient records (e.g., patients with no accounting activity for two years) onto disk or tape and purging these records from the active patient data files.	X					

**SYSTEMS MANAGEMENT
FUNCTIONAL REQUIREMENTS (CL-8)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
18. The system has a restore capability to recall inactive patient data from the archive and transfer this data back into the active files.	X					
19. Zero balance charges can be periodically purged.	X					
20. The system provides system status reports that indicate the utilization of computer resources (e.g., disk space used/remaining, date/time of last full system backup, terminal/user activity).	X					
21. The system maintains a detailed audit trail that includes user number, date changed, old and new value for all registration and transaction fields. Users must be able to easily generate reports to research audit issues.		X				
22. The software system supports at least 999 system printers.	X					
23. The software system supports at least the minimum numbers of items listed in the following fields:	X					
• Account number -- 999,999						
• Insurance plans – 999						
• Locations – 999						
• Departments – 99						
• Providers – 999						
• Dependents – 99						
• Medical record number – 999999999999 (12 digits or characters)						
• Visit number – 9,999,999						
24. The software system must be Year 2000 compliant.	X					
25. The system supports running reports in the background while allowing the user to perform other tasks.		X				

**SYSTEMS MANAGEMENT
FUNCTIONAL REQUIREMENTS (CL-8)**

Requirements			Vendor Capability			
	MIN	OPT	Yes	Module	Future Vn.	Third Party
26. The system has the ability to manage multiple organizations with multiple sites on a single or set of networked servers (integrated delivery system model).	X					
27. The system supports standards for interfacing to other laboratory, clinical, and business data systems (e.g., Health Level 7 coding, Electronic Data Interchange messages).		X				

**MANAGED CARE
FUNCTIONAL REQUIREMENTS (CL-9)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
1. Enrollment, Eligibility, and Benefits						
A. The system supports entry and management of managed care plan membership lists with member demographics, benefits eligibility, allowed services, and effective dates.	X					
B. The system supports electronic downloading of managed care plan eligibility rosters via direct connection to managed care plan computer systems.	X					
C. The system supports electronic downloading of managed care plan eligibility rosters via diskette or magnetic tape.		X				
D. The system maintains a history of the eligibility of patients associated with managed care plans showing patient demographics and effective dates of enrollment or disenrollment.	X					
E. The system clearly identifies and provides a report of new members that have enrolled in the managed care plan with patient demographics and effective dates.	X					
F. The system provides a report that matches clinic patients with managed care plan membership rolls.	X					
G. Registration of managed care plan members is integrated into the normal patient registration process (e.g., registration of managed care plan members as patients does not require entry in a separate, stand-alone microcomputer system).		X				
H. The system offers on-line eligibility checking via electronic data interchange or demand dial to managed care plan computer systems.		X				

**MANAGED CARE
FUNCTIONAL REQUIREMENTS (CL-9)**

Requirements			Vendor Capability			
	MIN	OPT	Yes	Module	Future Vn.	Third Party
I. The system provides on-line descriptions of the benefits, service limits, deductibles, and co-payments associated with each managed care contract.		X				
J. The system provides member profile reports that show cumulative member months, prior period members, member additions, and member termination's for a user-selected reporting period. The report includes actual, budgeted, and variance statistics.	X					
K.. The system provides reports that profile the demographics of managed care plan members by age, gender, geographical location, Medicaid eligibility, Medicare eligibility, benefit program, and insurance coverage.	X					
2. Primary Care Physician (PCP) Tracking						
A. The system tracks the assignment of patients to primary care providers and the transfer of patients between primary care providers by date.		X				
B. The system is able to track all services, including those provided by referral providers, to the patient's PCP.	X					
3. Referral Tracking						
A. The system tracks the authorization, diagnosis, visit limits, payment liability, patient stop loss balance, authorizing PCP, referral provider, and payment status of referrals to outside health care providers.	X					
B. The system supports on-line authorization of referrals for managed care plan members.		X				

**MANAGED CARE
FUNCTIONAL REQUIREMENTS (CL-9)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
C. For hospital admissions, the system tracks precertification information, the authorization, the patient, the authorizing PCP, the admitting physician, the attending physician, the health care institution, the admission date, the bed type (i.e., private, semi-private), the approved limits on service, the estimated discharge date, the diagnoses, the procedures, other insurance coverage, the actual discharge date, and the discharge outcome.		X				
D. The system maintains licensing and credentialing information on referral providers.		X				
E. The system integrates referral tracking information (e.g., referral number, plan, authorization code, referring physician, number of visits, maximum charge limits, service period, diagnosis, and comments) with the scheduling module for patients referred into the clinic.		X				
F. The system prints referral forms.		X				
G. The system provides referral analysis reports including referring provider, referral provider, referral voucher number, maximum number of visits authorized, reason for referral, diagnosis, pending referrals, completed referrals, costs for referrals to outside providers, authorized reimbursement rates, and cost variance.	X					
H. The system provides a report of Incurred But Not Reported (IBNR) liabilities for referrals to outside providers if the clinic is at risk for these payments.	X					
I. The system produces a patient limits summary report that shows the status of patient dollar and visit limits so that PCPs are aware of referrals that exceed established thresholds.	X					

**MANAGED CARE
FUNCTIONAL REQUIREMENTS (CL-9)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
J. The system produces a list of referrals to specialists that will expire within a user-selected number of days so that the patients can be contacted for follow-up.		X				
4. Utilization Management						
A. The system provides inpatient utilization reports by plan, hospital, provider, diagnosis, patient, and procedure. The report includes length of stay, member months per year, actuals, budget, and prior year statistics.	X					
B. The system provides utilization reports by physician, department, clinic site, patient, plan for a user-entered date range.	X					
C. The system highlights large case management cases and tracks the utilization management coordinator assigned.	X					
D. The system provides utilization reports showing the number of referral visits and costs by specialty, the average cost per visit, and the per member per month cost by specialty.	X					
E. The system provides utilization reports showing the cost per referral by PCP, the plan average, and specialty.	X					
F. The system provides utilization reports showing the referral rate per 1,000 members per year.	X					
5. Billing and Accounts Receivable						
A. The system automatically distributes the costs associated with the services rendered during a visit and calculates the co-payment required from the patient.	X					
B. For billing, the system automatically separates services allowed under the managed care plan from those not covered.	X					

**MANAGED CARE
FUNCTIONAL REQUIREMENTS (CL-9)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
C. The system automatically tracks changes, adjustments, co-payments, coordination of benefits, units of service, diagnosis codes, procedure codes, modifier codes, place of service, and dates of service.	X					
D. The system produces a Stop Loss report for cases exceeding a user-established maximum cost or user-entered percentage of the maximum cost threshold for a user-entered data range.	X					
E. The system produces a detailed Stop Loss report that lists all the services performed under capitation for patients that exceed the user-established maximum cost or a user-entered percentage of that maximum cost threshold.	X					
6. Management Reports						
A. The system produces the critical performance measures reports described in <i>Community and Migrant Health Centers, Critical Performance Measures for Prepayment</i> , U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Health Care Delivery and Assistance, Rockville, MD, June 1989.	X					
B. The system produces health services performance reports that show actual, budgeted, and variance statistics for primary care including visits per member per year (PMPY), cost per visit, cost per member per month (PMPM), capitation PMPM and gain/loss PMPM.	X					

**MANAGED CARE
FUNCTIONAL REQUIREMENTS (CL-9)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
C. The system produces health services performance reports that show actual, budgeted, and variance statistics for specialty care including referrals PMPY, services per referral, cost per service, cost per referral, cost PMPM, capitation PMPM, and gain/loss PMPM.	X					
D. The system produces health services performance reports that show actual, budgeted, and variance statistics for ancillary care including visits per member per year, cost per visit, cost PMPM, capitation PMPM, and gain/loss PMPM.	X					
E. The system produces health services performance reports that show actual, budgeted, and variance statistics for inpatient care including days per 1,000 per year, admissions per 1,000 per year, average length of stay, cost per day, cost per admission, cost PMPM, capitation PMPM, and gain/loss PMPM.	X					
F. The system produces financial analysis reports that show actual, budgeted, and variance statistics for capitation revenue PMPM, co-payment revenue PMPM, other member revenue PMPM, administration costs PMPM, health services costs PMPM, and gain/loss PMPM.	X					
G. The system is able to present management summary statistics as bar, pie, or run charts.		X				
H. The system produces productivity analysis reports for non-capitated plans and fee for service plans that price services using the Medicare Resource Based Relative Value Scale and the McGraw-Hill Relative Value Scale.	X					

**MANAGED CARE
FUNCTIONAL REQUIREMENTS (CL-9)**

Requirements	Vendor Capability					
	MIN	OPT	Yes	Module	Future Vn.	Third Party
I. The system produces an Analysis of Visits report that provides a profile of managed care plan patients seen by the practice for a user-selected period of time. This report profiles patients by geographic area, financial class, age, gender, primary diagnosis, primary care physician (PCP), and referral providers. It provides a count of patients and visits for each category with percentages of the totals.	X					
J. The system produces a Fee Comparison report that enables the practice to compare its reimbursements from insurance carriers for service procedures to Medicare and McGraw-Hill relative value units. This report allows the practice to evaluate the profitability of participation in the managed care plan.		X				
K. The system produces a Services Summary report that lists service procedures performed in a user-selected date range by site, provider, and plan. The report calculates the expected payments based on the Medicare Resource Based Relative Value Units and the count of service procedures.		X				
L. The system produces a Capitation analysis report by doctor and plan summarized by month for the current fiscal year. The report shows total members seen per month, total visits by patient per month, the standard fee, the average fee per visit, the co-pay amounts paid by patients, the capitation payment, the total payment, the average net revenue per visit, the collection rate, the average number of visits per member, and the year-to-date average for each category.	X					

**MANAGED CARE
FUNCTIONAL REQUIREMENTS (CL-9)**

Requirements			Vendor Capability			
	MIN	OPT	Yes	Module	Future Vn.	Third Party
M. The system produces a Capitation Payment by Provider Report that shows the income expected from a plan based on the number of members enrolled in the plan assigned to the provider and the capitation rate.	X					
N. The system produces a Capitation Plan Analysis report that compares standard charges for service procedures against co-pay charges and payments and billable charges, payments, and adjustments in a user-specified visit date range. The report is selectable by plan, site, and doctor and lists patients, their visit dates and procedures, the service procedure standard charge, the co-payment, the co-payment paid by the patient, the amount charged to the plan, the amount the plan paid, and any adjustments.		X				