This specification will define the requirements for interfacing a practice management (PM) software package with DocumentPlus. To be effective the practice management software must inform DocumentPlus whenever there is a change to the information associated with patients, doctors, attorneys, and insurance companies. A single file will be used for the one-way communication from the practice management software to DocumentPlus.

There are five record types associated with the DocumentPlus interface. It is not necessary for the PM software to supply all of the five record types. An empty field must be inserted into the record when the PM software does not have data available for a field. Our practice management interface will query the user for any relevant information that is not transferred from the PM software.

The definition of each record type includes:

Field Name - DocumentPlus Internal Field Name

Type - Allowed Characters In Field

- X = any ACSII character (letters, digits, punctuation, or symbols)
- C = character (letters only)
- 9 = numeric (digits and decimal point only)
- D = date(mm/dd/yyyy)
- P = phone number (999) 999-9999 x9999

  Note: A space must appear after the area code's closed parenthesis.
  When the area code is not present the parentheses separated by three spaces is required.
  The extension "x" is only required when an extension number exists.

  Examples: (770) 814-2442, (   ) 814-2442, (770) 814-2442 x1234

Size - Maximum Length Of Field

Note: Trailing spaces should be removed from each field.

Remark

The remark will contain a description of the field's data. Information inside the square brackets [] defines the required codes used by DocumentPlus for the field's data. The allowed codes are separated by a vertical bar "|" in the definition [Code | ... | Code]. For your information a description of some of the codes is provided in the specification using the following format [Code=Description | .... | Code=Description]. Note, the "=Description" is not part of the code sent to DocumentPlus. Only one Code is allowed for the field's data in each record. An empty field must be inserted when the PM software does not contain a field's information. The DocumentPlus codes defined inside square brackets are <u>case sensitive</u>.

Attached you will find the Patient/Doctor/Insurance information requirements for interfacing with DocumentPlus.

Three of the record types are associated with patients. The other two record types are associated with doctors/attorneys and insurance companies. Each patient will have one record containing their Patient Information. A patient may have both a primary and secondary Patient Insurance Information record. A patient may also have numerous Patient Referred To Information records if this information exists in the PM software.

A single file named PM_DATA.TXT containing all the record types will be used to interface DocumentPlus with the PM software. The order of the field's data for each record type must be exactly as defined in the attached specifications. The interface file will be an ASCII text file in which each records ends with a carriage return and line feed. Fields are separated from each other by commas and each field's data delimited by double quotation marks. There can be NO white space between the comma separator and the opening double quotation mark. Fields which have no data for a particular patient, doctor, or insurance company must be included in the records as an empty field, a pair of double quotation marks, (...","","...). Trailing empty fields may be omitted from a record.

WARNING: There can be NO white space between the comma separator and the double quotation marks.

The first two fields of each record are used to identify the record type and status of the data in the record. Below are the record type codes used by DocumentPlus:

PATIINFO	Patient Information
PATIINSR	Patient Insurance Information
PATIREF	Patient Referred To Information
DOCINFO	Doctor Information
INSRINFO	Insurance Company Information

Note, the double "I" in "PATIINFO" and "PATIINSR".

Below are the status codes used by DocumentPlus:

NEW	New patient/doctor/insurance entries
MOD	Modified patient/doctor/insurance entries
DEL	Deleted patient/doctor/insurance entries

A minimum interface may be accomplished with only NEW data records.

The patient records PATIINSR and PATIREF **must** immediately follow a PATIINFO record. Only one PATIINFO record is necessary before a group of PATIINSR and PATIREF records for a patient.

The MS-DOS environment variable DOCPLUS_PMD will contain the path to the directory where the file PM_DATA.TXT will be stored. By default the file will be stored in the directory \DP_DATA_\PM_DATA.

DocumentPlus will lock (open in read/write mode) the interface file temporarily when it detects new data. After moving the data to a work file DocumentPlus will truncate the interface file and release it for access by the PM software. DocumentPlus will inform the user when the interface file is locked by the PM software.

The practice management software will be responsible for creating the interface file when it does not exist. It should always append new information to the interface file. Since this is a shared file it should only be opened (read/write or write) when the data is available for output and closed immediately after writing. As with any shared file the PM software must

make provisions for the interface file being locked.

It would be beneficial to the DocumentPlus users if the practice management software could output all of the existing patient/doctor/insurance information to initialize DocumentPlus' databases.

1	RECORDID	C	8	[PATIINFO]
2	MODE	C	3	[NEW | MOD | DEL]
3	IDNO	9	10	Patient's ID number (1234)
4	TNAME	X	4	Patient's Title (Mr., Mrs. Miss ...)
5	FNAME	X	15	Patient's first name
6	MNAME	X	1	Patient's middle initial
7	LNAME	X	40	Patient's last name
8	GREETING	X	40	Greeting used in a letters to patient (Steven, Mr. Steven Sondov, Mr. Sondov)
9	ADDRESS1	X	40	Patient's street address 1
10	ADDRESS2	X	40	Patient's street address 2 (apt, c/o, etc.)
11	CITY	X	24	Patient's city
12	STATE	X	2	Patient's state
13	ZIP	X	10	Patient's zip code
14	TELEH	P	21	Patient's home phone number
15	TELEO	P	21	Patients office phone number
16	FAX	P	21	Patient's FAX number
17	SSN	X	11	Patient's social security number [999-99-9999]
18	BIRTHDATE	D	10	Patient's birth date
19	SEX	C	1	Patient's Sex [M=Male | F=Female]
20	REL2INS	C	6	Patient's relationship to primary insured party [None | Self | Spouse | Child | Other]
21	REL2RESP	C	6	Patient's relationship to responsible party [Self | Spouse | Child | Other]
22	EMPLCOND	C	1	Patient's condition due to a job injury [T | F]
23	AUTOCOND	C	1	Patient's condition due to an auto accident [T | F]
24	PDOC_KEY	X	5	PM Id for doctor treating patient
25	REFDOC_KEY	X	5	PM Id for referred from doctor
26	REFPAT_KEY	9	10	PM Id for referred from patient
27	PERMD_KEY	X	5	PM Id for patient's personal physician
28	ATTY_KEY	X	5	PM Id for patient's attorney
29	FIRSTDATE	D	10	Date patient first entered practice
30	TRTFDATE	D	10	Date of initial examination
31	EXAMDATE	D	10	Date of current examination
32	TRTLDATE	D	10	Date of most recent examination
33	ILLDATE	D	10	Date of accident or injury
34	WORKDATE	D	10	Date patient able to return to work
35	TOTDISDATF	D	10	From date of total disability
36	TOTDISDATT	D	10	To date of total disability
37	PRTDISDATF	D	10	From date of partial disability
38	PRTDISDATT	D	10	To date of partial disability
39	RTNAME	X	4	Responsible party's title

40	RFNAME	X	15	Responsible party's first name
41	RMNAME	X	1	Responsible party's middle initial
42	RLNAME	X	40	Responsible party's last name
43	RADDR1	X	40	Responsible party's street address 1
44	RADDR2	X	40	Responsible party's street address 2
45	RCITY	X	24	Responsible party's city
46	RSTATE	X	2	Responsible party's state
47	RZIP	X	10	Responsible party's zip code
48	RTELEH	P	21	Responsible party's home phone number
49	RTELEO	P	21	Responsible party's office phone number
50	MARITAL	C	1	Martial status [S=Single | M=Married | s=Separated | D=Divorced | W=Widowed] Note: case sensitive S/s
51	LIVEALONE	C	1	Lives alone [T /F]
52	LIVEPARENT	C	1	Lives with parents [T /F]
53	LIVESPOUSE	C	1	Lives with spouse [T /F]
54	LIVECHILDS	C	1	Lives with children [T /F]
55	LIVEOTHER	C	1	Lives with other [T /F]
56	OTHERLIVE	X		Description of other lived with
57	NCHILDS	9	2	Number of children
58	BORNIN	X		Country born in
59	RESDNTYRS	9	2	Years a resident of country doctor practices in
60	HOBBY1	X		Hobby 1 that the patient participates in
61	HOBBY1FREQ	C	1	Frequency of participation in hobby 1 [O=Occasional | F=Frequent | C=Constant]
62	HOBBY2	X		Hobby 2 that the patient participates in
63	HOBBY2FREQ	C	1	Frequency of participation in hobby 2 [O=Occasional | F=Frequent | C=Constant]
64	HOBBY3	X		Hobby 3 that the patient participates in
65	HOBBY3FREQ	C	1	Frequency of participation in hobby 3 [O=Occasional | F=Frequent | C=Constant]
66	SMOKES	X	2	Patient smokes [N=Never | <1=less than 1 pack/day | 12=1-2 packs/day | 23=2-3 packs/day | 34=3-4 packs/day | 5+ =5 or more packs/day]
67	ALCOHOL	X	2	Patient uses alcohol [N=Never, O=Occasionally, 12= 1-2 drinks/day, 23=2-3 drinks/day, 34=3-4 drinks/day, 5+= 5 or more drinks/day]
68	COFFEE	X	2	Patient drinks coffee or tea [N=Never, O=Occasionally, 12=1-2 cups/day, 23=2-3 cups/day, 34=3-4 cups/day, 5+= 5 or more cups/day]
69	DRUGS	C	1	Patient uses recreational drugs [N=Never, O=Occasionally, F=Frequently, C=Constantly]
70	EXERCISE	X	2	Patient exercises [N=Never, O=Occasionally, 12=1-2 days/week, 34=3-4 days/week, 56=5-6 days/week, D=Daily, E=Excessively]
71	SECDEDUC	9	2	Secondary education grade attended
72	COLLEGEYRS	9	2	Number of years of college
73	EDUCOTHER	X		Other education

74 EMPLOYER X Employer
75 JOBTITLE X Job title
76 JOBDESCRPT X Job description
77 JOBTYPE C 1 Type of job [F=Full Time | P=Part Time | T=Temporary]
78 WORKHRS 9 2 Number of work hours per day
79 LIFTLIGHT C 1 Light lifting requirement [N=Never | O=Occasionally | F=Frequently | C=Constantly]
80 LIFTMODRAT C 1 Moderate lifting requirement [N=Never | O=Occasionally | F=Frequently | C=Constantly]
81 LIFTHEAVY C 1 Heavy lifting requirement [N=Never | O=Occasionally | F=Frequently | C=Constantly]
82 EMPLOYAS C 3 Employ as [A |. THE]
examples: "employ as a programmer", "employ as the president"
83 EMPLOYYRS 9 2 Years employed
84 EMPLOYMNTH 9 2 Months employed

Example:

“PATIINFO”,”NEW”,”1234”,”Mr.”,”Bob”,”M”,”Jones”,””””,”3700 Westside Rd”,”Apt 21”,”
Atlanta”,”GA”,”30329”,”(770) 395-1925”,”( ) 678-1299”,””””,”111-22-3333”,”
03/12/1956”,”M”,”Self”,”Self”,”F”,””””,”1”,””””,””””,””””,”A121”,”
12/21/1998”,””””,”
M”,””””,”Jones and Smith
Inc.”,””””,””””,””””,””””,””””,””””,””””,””””,””””,””””

1 RECORDID C 8 [PATIINSR]
2 MODEC 3 [NEW | MOD | DEL]
3 IPATI_KEY 9 10 Key to identify patient
4 ITYPE C 1 Type of insurance [P=Primary | S=secondary]
5 IREL2INS C 6 Relationship to insured [Self | Spouse | Child |
Other]
6 ITNAME X 4 Insured party's title
7 IFNAME X 15 Insured party's first name
8 IMNAME X 1 Insured party's middle name
9 ILNAME X 40 Insured party's last name
10 IADDR1 X 40 Insured party's street address 1
11 IADDR2 X 40 Insured party's street address 2
12 ICITY X 24 Insured party's city
13 ISTATE X 2 Insured party's state
14 IZIP X 10 Insured party's zip code
15 ITELEH P 21 Insured party's home phone number
16 ITELEO P 21 Insured party's office phone number
17 IINSCO_KEY X 10 PM Id for insurance company
18 IGROUP X 20 Insured party's group number

19 IINSD_ID X 20 Insured party's insurance id number
20 IMAXCLAIM 9 8 Insured party's maximum claim amount
21 IINSDEDUCT 9 6 Insured party's annual deductible
22 IINSSIG C 1 Insured party's signature is on file [T | F]
23 ICLAIMNO X 20 Current insurance claim number

Examples:

“PATIINSR”,”NEW”,”1234”,”P”,”Self”,”Mr.”,”Bob”,”M”,”Jones”,”3700 Westside Rd”,” Apt 21”,”Atlanta”,”GA”,”30329”,”(770) 395-1925”,”( ) 678-1299”,”IC1”,”AA-123-Z”,” 1298”,””,””,””,””
“PATIINSR”,”NEW”,”1234”,”S”,”Spouse”,”Mrs.”,”Jane”,”L”,”Jones”,”3700 Westside Rd”,”Apt 21”,”Atlanta”,”GA”,”30329”,”(770) 395-1925”,”(404) 328-1685”,”IC2”,”AB-17Z7”,”A589”,””,””,””,””

1 RECORDID C 8 [PATIREF]
2 MODE C 3 [NEW | MOD | DEL]
3 PATI_KEY X 10 PM Id for patient
4 ICONSULT 9 3 Number of this referral
5 DOC_KEY X 5 PM Id for Referred To doctor
6 DATE D 10 Date of referral

Example:

“PATIREF”,”NEW”,”1234”,”1”,”RT1”,”01/15/1999”

1 RECORDID C 8 [DOCINFO]
2 MODE C 3 [NEW | MOD | DEL]
3 DOC_KEY X 5 PM Id for doctors/attorney [999=In-House | XXXXX=All Other Doctor Types]
4 DTNAME X 4 Doctor's title (Dr.)
5 DFNAME X 15 Doctor's first name
6 DMNAME X 1 Doctor's middle initial
7 DLNAME X 40 Doctor's last name
8 DCREDENT X 40 Doctor's credentials (MD, D.C., etc.)
9 DGREETING X 80 Greeting used in letters address to a doctor
10 DSIGNATURE X 80 In-House doctor - signature on a letter to other doctors and patients; attorney - firm; other doctors - practice
11 DINSSIGN X 80 In-House doctor - signature on insurance letter; attorney and other doctors - attention
12 DADDRESS1 X 40 Doctor's street address 1
13 DADDRESS2 X 40 Doctor's street address 2 (Suite)
14 DCITY X 24 Doctor's city
15 DSTATE X 2 Doctor's state
16 DZIP X 10 Doctor's zip code
17 DTELE1 P 17 Doctor's main phone number

18 DTELE2 P 17 Doctor private phone number
19 DFAX P 17 Doctor's FAX phone number
20 DTELEH P 17 Doctor's home phone number
21 DID_LIC X 40 Doctor's license number / identification number
22 DSSN_TAX X 20 Doctor's tax number or social security number
23 DEMPID X 40 Doctor's employers ID
24 DTYPE C 13 Doctor type [In-House | Referred From |
Referred To | Personal | Attorney)
25 DCONTACT X 80 Contact at doctor's office

Examples:

“DOCINFO”,”NEW”,”1”,”Dr.”,”Alan”,“F”,”Green”,”
DC”,””,””,””,””,””,””,””,””,””,””,””,””,””,””,””,”In-House”
“DOCINFO”,”NEW”,”A1”,”Mr.”,”George”,“R”,”Steele”,”Esq”,””,”Johnson and
Lange”,””,”1516 West Ave”,”Suite 110”,”Atlanta”,”GA”,”30327”,”(770) 677-1980”,””,”
(770) 679-1673”,””,””,””,””,”Attorney”,”Mrs. Nancy Mathews”

1 RECORDID C 8 [INSRINFO]
2 MODEC 3 [NEW | MOD | DEL]
3 INSCO_KEY X 10 PM Id for insurance company
4 ICNAME X 60 Insurance company name
5 ICADDR1 X 40 Insurance company street address 1
6 ICADDR2 X 40 Insurance company street address 2
7 ICCITY X 24 Insurance company city
8 ICSTATE X 2 Insurance company state
9 ICZIP X 10 Insurance company zip code (USA:12345-1234)
10 ICTELEM P 21 Insurance company main phone number
11 ICTELEC P 21 Insurance company contact's phone number
12 ICFAXP 21 Insurance company FAX number
13 ICCONTACT X 60 Insurance company contact's name (full name)

Example:

“INSRINFO”,”NEW”,”IC1”,”American Health and Life”,”100 Lake Drive”,”Suite 200”,”
Norcross”,”GA”,”33701-1234”,”(770) 767-1200”,”(770) 767-1200 x1299”,”(770) 767-
1798”,”Ms Mary Brown”

DocumentPlus Export Specification

This specification will define the requirements for using the export capabilities of DocumentPlus. The export function will send billing information associated with patient treatment to a practice management software package. Once export is enabled DocumentPlus will append patient charge records to a specified ASCII file. The source information for these patient charge records is our Daily Note form version 3 (DN-3). A patient charge record will contain information for a single treatment procedure. A patient's visit can generate multiple charge records.

The name and location of the export file containing the patient charge records can be specified by the user of DocumentPlus on the setup screen. DocumentPlus will create the export file when it does not exist. Access to the export file will be denied to the PM software only while DocumentPlus is writing a patient charge record. It is the responsibility of the PM software to wait when access to the export file is denied. The PM software should minimize the time it keeps this export file open. The PM software should remove patient charge records from the export file after they are processed. The PM software may delete the export file after it processes all the patient charge records. The format of this file is comma/quote delimited. Each record of this file will have the five fields described below:

Field Name	Type	Size	Description
Patient Number	9	10	Primary key to identify patient.
Patient Case Number	9	1	Interger 0 to 5. Identifies which case treatment applies to.
Treatment Date	D	10	Date treatment was preformed.
Doctor Number	N	3	Primary key to identify doctor who authorized treatment.
Procedure Code	X	9	PM Billing code associated with treatment procedure.

Where:

Type
- 9 - Numeric digits only
- D - Date (99/99/9999)
- N - Letters and digits only
- X - Any character

Size

Maximum size allowed by DocumentPlus

Procedures

In DocumentPlus the user can define a unique code associated with each procedure on the Daily Note form. A list of these treatment procedures can be found in Appendix 1 of this document.

There are eight procedure codes associated with the use of a modality or rehab therapy. Four of the codes apply when the modality or rehab therapy is attended. Four separate codes apply when the modality or rehab therapy is unattended. There is a unique attend and unattended code associated with the length of time the modality or rehab therapy is used. The four time intervals available for the use of a modality or rehab therapy are: 15 minutes, 30 minutes, 45 minutes, and 60 minutes.

There are five level (Level I - Level V) codes associated with each exam category.

When a code in DocumentPlus is not defined for a procedure on the Daily Note form, **no** patient charge record will be stored in the export file when that procedure is marked on the form.

Example:

"1234","0","11/17/1997","2","98943-25"

After DocumentPlus completes its export function it will broadcast a DDE notification message that the export file contains new data. DocumentPlus uses the DDE_Initiate function to perform this notification. It is not necessary for the PM software to actually initiate a DDE session. If a channel is opened by the PM software, DocumentPlus will immediately terminate the session. The user must enter on the, DocumentPlus setup screen, both a DDE service name and DDE topic name supplied by the PM software vendor.

In order to use the export function the user must be running DocumentPlus version **3.617** or greater.

Appendix 1 - Treatment Procedures

Exams (Level I - Level V)
- New Patient Exam
- Established Patient Exam
- Established Patient Exam With Treatment
- Consultation

Home Care Instructions

Modalities (15, 30, 45, or 60 minutes attended/unattended)
- Cryotherapy
- Diathermy
- High Volt Galvanic
- Hydrotherapy
- Ischemic Compression
- Joint Mobilization
- Low Volt Galvanic
- Mechanical Traction
- Moist Heat
- Motorized Intersegmental Traction
- Myofascial Release
- Programmed Interferential Current
- Russian Stimulation
- Ultrasound
- User Defined
- Vibratory Massage Or Massage Therapy

Rehab Therapy (15, 30, 45, or 60 minutes attended/unattended)
- Abdominal
- Bike
- Cervical
- Elbow
- Exercise Ball
- Exercise Tubing
- Knee
- Low Back
- Multipelvic Hip
- Shoulder
- Wrist
- Treadmill
- User Defined 1
- User Defined 2

Adjustments
- One Or Two Spinal Regions (98940)

- Three Or Four Spinal Regions (98941)
- Five Spinal Regions (98942)
- At least One Extraspinal Region (98943)
- At least One Spinal And One Extraspinal Region (98943-25)

Pillows
- Type 1
- Type 2
- Type 3

Supports
- Cervical
- Lumbar
- Extremities

Ice Pack

Orthotics

X-Rays
- Cervical A-P Lateral
- Cervical Complete
- Cervical Davis Series
- Full Spine A-P
- Lumbar A-P Lateral
- Lumbar Complete
- Side View 10x12
- Side View 14x17
- Thoracic A-P Lateral
- User Defined

DocumentPlus Export Specifications for FormSmith with ChiroQuick Charts

The charges.imp file is created by ChiroQuick Charts and it should be located in:

\Dp_data\export\charges.imp

It should be an ascii comma deliminted file with 5 elements per record re:

PRN$, dxTreated$, txDate$, doc$, TXCD$

PRN$ = patient's record number of 5 characters (Usually digits)

dxTreated$ = list of diagnoses seperated by commas for which the service was performed

txDate$ = treatment date. Format: mm/dd/ccyy

doc$ = doctor's initials

TXCD$ = treatment code (FormSmith 3 digit quick code)

Example:

"00747","R51, M99.00, M50.320, M99.01, M99.02, M53.87, M99.03, M99.04, M99.05","09/20/2023","1","104"

FormSmith will take the list of diagnoses in dxTreated$

"R51, M99.00, M50.320, M99.01, M99.02, M53.87, M99.03, M99.04, M99.05"

and cross reference it with the patient's diagnoses. Pointers are then created that point the treatment to the diagnoses.

The number of diagnosis pointers created is limited to 4. This is true for the HCFA 1500 and also for the electronic claim form.