Case Study 5: Josephine L. Carter

Exercise 5.1: Registering the patient with full demographic and insurance information.

1. Open Medware by Sage.
2. Click the Insert Button.
3. On the General Tab, type in the following information in the appropriate fields:
   a. Last Name: <initials> Carter
   b. First Name: Josephine
   c. Middle Initial: L.
   d. Generation: Leave this field blank.
   e. Do not check the box next to “Is the guarantor the legal representative?” (Note: this indicates who will be responsible for paying the bills.)
   f. Social Security number: 303-97-5959
   g. Account number: <initials> 52
   h. Address: 461 Pikes Lane
   i. Zip Code: 32314
   j. Home Phone Number: (901) 333-2828
   k. Provider: Click on the arrow next to this field. Highlight William <initials> Tower. Click Select.
   l. Assistant: Leave blank
   m. Default Referring Physician: Leave blank.
   n. Sex: Female
   o. Date of birth: 12/12/1979
   q. Employment status: None
   r. Fee schedule: Click on Insert. Fee schedule: CHAMP. Description: CHAMPVA. Click OK.
   s. Highlight CHAMPVA and click Select.
   t. Patient Comment: Leave blank.
   u. Click OK.
4. Double click on your newly created patient and it will bring up the demographic screen that was just created. Click on the Insurance Tab.

5. Click on **Insert** to Add Patient Insurance.

6. **Code:** Click on the arrow next to this field; and click **Insert**.
   - Code = **CHAM**
   - Company = **CHAMPVA**
   - Carrier Type = **ChampVA**
   - Address = **CHAMPVA Claim P.O. Box 469064**
   - Zip = Click on Insert button to add a zip code. Type in the City = **Denver**
     - State = **CO**
     - Zip Code = **32168**
   - Click **OK**.
   - Highlight the new entry (Denver) and click **Select**.
   - Contact Person = **Jamie Flick**
   - Phone = **219-876-0909**
   - Click **OK**.
7. CHAMPVA is highlighted, click *Select.*
   - Sequence: Choose *Primary.* Click the box: *Accept Assignment?*
   - Policy Number: *FLCARTER099876A*
   - Group Number: *EP678-02*
   - Deductible: *$50* – Applied: *$0*
   - Type code: *Other*
   - Co-Payment Amount: *$20*
   - Relationship to Insured: Click on the arrow next to this field; highlight #2 *Spouse.*

8. Go the Guarantor section found in the lower, right corner of the screen and click on the box labeled: *Guarantor* and the information will populate for you.
   - DOB: *12/12/1979*
   - Click on *Female.*

9. Click OK.

10. Click OK again and you will be back on the patient claims screen.
Exercise 5.2: Create a claim in MedWare by Sage

1. On the Patient Claims screen, highlight the desired patient.
2. Click Insert on the right hand side of the open box.
3. Claim date: Choose today’s date as the default.
4. Provider = 92, Fee Schedule = CHAMP, and Primary = CHAM should all be filled in for you.
5. Dx 1 – 644.21 – Early onset of delivery

   Important note: A vendor or professional in your organization who is responsible for maintaining the integrity of medical codes would be the proper person to add codes to the database. However, here you may enter them for educational purposes.

6. Dx 2 – Type in 69.96 and click the arrow by this field.
   - Choose to Insert
   - Dx Code: 69.96
   - Description – Removal of cerclage material from cervix
   - Highlight new code and click on Select.
   - Click OK.

Exercise 5.3: Adding an Allergy

1. Open MedWare Chart.
2. Click Charting, and then Patient Chart.
3. Select Josephine <initials> Carter from the patient list and click Edit Chart.
4. Click on the Allergies tab.
5. Click New.
6. Type Shellfish in the Allergy field.
7. Type Rash in the Description field. (Note: Descriptions are a way to document and communicate what kind of reaction the patient is having in regards to their allergy.)
8. Click Save. Shellfish has been added to the allergy list.
Exercise 5.4: Adding Content to a Physical Template

1. Open Medware Chart.
2. Click Charting and choose Patient Charts.
4. Click on the claim for Josephine <initials> Carter and click Edit Chart.
5. On the Chart Tab, click the Select Template icon. Recall that this icon is the yellow icon above the word “Name.”
6. Highlight <initials> Physical and click OK.
7. A template appears on the screen.
8. Type the following text next to each heading. If the headings aren’t there, you may add them in as needed.

**Important note: A physician would normally document the Assessment and Plan for the patient, but here you may enter them for educational purposes.**

CHIEF COMPLAINT. Contractions, 28+ week, cerclage in.

HISTORY OF PRESENT ILLNESS: The patient is a 29-year-old gravida four, para 2-1-0-2 at 28 and 1/7 weeks gestation with cerclage in secondary to previous history of possible incompetent cervix. She is heterozygous for Factor Leiden V mutation and methyltetrahydrofolate reductase deficiency, on heparin and baby aspirin, who presented to Happy Hospital with leakage of fluid and increasing contractions starting yesterday evening, 12/13/04. No bleeding, baby moving. Upon presentation today, it was verified initially that she is indeed ruptured with positive Nitrazine and positive ferning. She denies any history of bleeding. Leakage of fluid since last night. Contractions increasing and decreasing during the trip here, no decreasing. Here, she is presenting.

PAST MEDICAL HISTORY: Significant for Factor Leiden V Mutation, heterozygous, and methyltetrahydrofolate reductase deficiency.

PAST SURGICAL HISTORY: C-section times two.

OB HISTORY: First two deliveries were C-section secondary to fetal indications. Third pregnancy complicated by possible incompetent cervix and preterm delivery at 20 weeks, stillborn.

GYN HISTORY: No abnormal pap smears. No cervical surgery. Did have a cerclage placed this pregnancy.

ALLERGIES: No known drug allergies.

MEDICATIONS: Aspirin 81 mg q.d., heparin 5,000 subcue b.i.d., prenatal vitamins.

FAMILY HISTORY: No diabetes, no mental retardation, spina bifida in parents, paternal grandmother, offspring, and cannot locate a triple screen on the patient’s records.

SOCIAL HISTORY: Denies tobacco use, alcohol use, illicit drug use, herbal drug use.
REVIEW OF SYSTEMS: There is no bleeding. Contractions decreasing at present. No fever, nausea, vomiting, chills. No GI symptoms. No symptoms associated with UTI to include dysuria, urgency hesitancy, frequency.

PHYSICAL EXAMINATION:

VITAL SIGNS: Her vitals are stable. She is afebrile.

HEART: Regular rate and rhythm.

LUNGS: Clear to auscultation.


SVE: 2, 90, bag starting to bulge. No bleeding. No rubor. Sterile spec exam - positive Nitrazine, positive ferning. Fetal heart tones are in the 160s with good accelerations. No decels are noted.

LABS: Hemoglobin 12.7, white blood cell 22, 243 platelets. Rubella immune, O positive, antibody negative. Cannot locate triple screen or quad screen or AP again. Will ask patient if these have been obtained.

ASSESSMENT: 29-year-old gravida four, para 2-1-0-1, cerclage placed with pregnancy secondary to history of questionable incompetent cervix. She is at 28 and 1/7 gestational age with PPROM and contractions, currently decreasing. She has a history of Factor Leiden V heterozygous mutation and also MTHFR deficiency, on heparin and aspirin. Currently not bleeding. C-section is planned for delivery secondary to history of two previous C-sections. The patient has been counseled. That has been the previously established plan.

PLAN: N.P.O., C-section If increasing contractions, removal of cerclage at time of C-section, tocolytics until second dose of betamethasone is given at 4:00 p.m. today, 12/14/04, first dose given 12/13 at 4:00 p.m., tocolytics, mag sulfate 6 gm load was given 2 an hour and indomethacin 100 p.o. and then 25 q.6. Unasyn started IV secondary to PPROM in hopes of extending latency period. Betamethasone ordered second dose, today at 4:00 p.m. Continue heparin 5,000 subcu b.i.d. and baby aspirin 81 mg q.d. If increasing contractions or bleeding, C-section and removal of cerclage at the time of C-section. The patient is currently n.p.o., will remain so for now. Continuous monitoring and NICU consult today. If patient remains stable, I have ordered an ultrasound for growth and AFI.

9. Click Save when you are finished documenting the <initials> Physical.
**Chief Complaint**
Patient complains of Contractions, 28+ week, cerclage in.

**History of Present Illness**
The patient is a 29-year-old gravida four, para 2-1-0-2 at 28 and 1/7 weeks gestation with cerclage in secondary to previous history of possible incompetent cervix. She is heterozygous for Factor Leiden V mutation and methylytetrahydrofolate reductase deficiency, on heparin and baby aspirin, who presented to Happy Hospital with leakage of fluid and increasing contractions starting yesterday evening, 12/13/04. No bleeding, baby moving. Upon presentation today, it was verified initially that she is indeed ruptured with positive Nitrazine and positive ferning. She denies any history of bleeding. Leakage of fluid since last night. Contractions increasing and decreasing during the trip here, no decreasing. Here, she is presenting.

**Past Medical and Surgical History**