

Family Health Care Manager™ User Guide

FHCM™ Version 1.64

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1. An Important Note About Entering Data

If you're not sure this program is for you, please read this section!

One of the biggest reasons people avoid using a program like FHCM is that they think it will be too much trouble to enter all the data by hand. You may be used to downloading financial data from your bank into whatever program you use to manage your bank accounts – but you undoubtedly have far more financial transactions than medical transactions. In addition, only a couple of insurance companies currently offer the ability to download data, and even if you happen to be using one of those insurance companies, that will only get you information from your Explanation of Benefits statements - - which is only one small part of keeping good medical financial records.

It is easy to think that whatever method you currently use to track your medical conditions and finances (or whatever method you *don't* use), is good enough, and way faster than entering data into FHCM. In all likelihood, you are wrong.

FHCM is a bit different than the average Windows program, and you may find that it takes a little time to get used to the way things are done. But trust me – I (the author) use this program myself all the time, and I've designed it to let me get data in there fast. Once you understand the program, and especially once you learn the keyboard shortcuts, you can enter your data very quickly. It takes me about 3 minutes to enter 12 provider visits. That's not so bad, is it? How much time do you spend looking for information about what you've submitted or need to submit? How much time do you spend trying to figure out if the insurance company processed your claim and how long it's been? (I recently was alerted by FHCM that one of the visits on a recent claim – a very expensive visit – had not been processed, even though the rest of the claim was. Sure enough, when I called, the insurance company somehow had forgotten to key in that particular bill. As a result, it would not have even showed up on an Explanation of Benefits statement because they lost it.) How much time do you spend putting together information to fill out forms for your claims? (FHCM will print out a form to go with your claim to help you fill out your forms.) How much time do you spend tracking billing statements and trying to figure out if they made a mistake and forgot one of your payments? Or billed you twice?

Bet that all takes a lot longer than it would have taken to enter the data. So, get a nice glass of tea, or other beverage of your choice, sit down with this manual (which you can print out in its entirety instead of having to read through a Help system), and get going on becoming the you you've always wanted to be. Or at least on getting your medical expenses organized.

2. Installation

2.1. Hardware and Software Requirements

- Windows 8.1
- Windows 8.1 Pro
- Windows 8
- Windows 8 Pro
- Windows 7 Ultimate
- Windows 7 Professional
- Windows 7 Home Premium
- Minimum Hardware:
 - **CPU:** Intel Pentium 4 / AMD Athlon 64 or newer
 - RAM:** 1 GB
- Recommended Hardware:
 - **CPU:** Intel Pentium 4 / AMD Athlon 64 or newer
 - RAM:** 2 GB

2.2. How to Install and Register

To install FHCM, run the “FHCM Setup.exe” file. FHCM will be installed in your Program Files folder, in the folder “FHCM”. When you install FHCM, it will initially run in Trial Mode. FHCM will be fully functioning – all features are enabled. However, in Trial Mode, the program will stop functioning after 30 days. To register the program, you need to obtain a license.

Please see our web site -- www.familyhealthcaremanager.com – for information, and to obtain a license. Once the program is registered, all data you have entered will be accessible and you can continue where you left off in the trial version. **Note that there are not separate trial and full versions.** If you are not upgrading, there is no need to reinstall or redownload to register. You can have the license autoinjected using the link from Regnow/MyCommerce or type in the license code manually in the Enter License dialog.

However, should you choose not to register (hey – everyone makes mistakes, right?), you should export any data you wish to save before the Trial period expires, as you won’t be able to get it afterwards. I understand how much time managing a family’s medical records can take, and as much as I’d like you to purchase FHCM (which will save you time and reduce the stress of not knowing exactly where you stand) – I would not want you to waste your time or lose your data. (I’m not just the developer, I’m a user, too!)

Look under the File Menu while on a Visit screen and you’ll find an Export to Excel command. This will export your data to two excel spreadsheets, which will be placed in the My Documents\My FHCM folder.

IMPORTANT: Once the program is installed, do not change the names of ANY files, including the database file itself. If you do, FHCM will stop functioning.

2.3. Installing an updated/upgraded version

First, even though your database is automatically backed up regularly, and even though the upgrade installer does its own backup, it never hurts to be extra paranoid. To that end, make a copy somewhere of the fhcm.fhc file, found in the \Program Files\FHCM\ directory. Do this *before* installing the new version.

FHCM's install routine will move your existing fhcm.fhc file to the subdirectory "Previous" when it installs a new file, in preparation for importing into the new version. If for some reason you end up re-running the installer, this will be repeated. In order to avoid over-writing your data, each time the data file is moved, FHCM will rename previous versions (FHCM0.fhc, FHCM1.fhc, etc). It will do this up to 10 times before the data starts getting overwritten, so be careful not to run the installer too many times without importing your data and/or backing up the fhcm.fhc file somewhere else. You should also have multiple backups in the MyDocuments\My FHCM folder as well.

If at any time you need to go back to an earlier version, look in \Program Files\FHCM\previous\ or \Program Files\ (x86)FHCM\previous\ on 64bit systems, and find the file that corresponds to the right date and time and copy/rename it to fhcm.fhc so that it can be imported.

To install an update, run the installer/setup program as above. You'll get a warning that you're installing over a previous version. No problem. Starting with version 1.5, FHCM uses a new database engine that will require your data to be converted before the import. This is taken care of automatically. If the update is not major (ie it is free), you should not need to re-enter any registration code. When you start up the program, you'll see an empty database. Go to the File Menu, and select Import Previous Database. You'll get about 4 warnings implying that you are doing something really bad. Be brave, and say OK to each of them. Then wait a while as the old data gets imported into the new program.

That's it! You're good to go.

2.4. Starting the program

The installer for FHCM will create a shortcut on your desktop and in your Start Menu, in the FHCM folder. You can start the program from either shortcut. If nothing seems to be happening, please be patient. FHCM starts up rather slowly, but once it's running, operation is quite fast; you'll be glad you waited!

2.5. Backing up and recovering damaged files

Power failures, hardware problems, or other factors can damage a database file. When FHCM™ discovers a damaged file, a dialog box may appear and tell you to contact the developer. However, in some cases, files can become corrupted and exhibit erratic behavior without the dialog appearing.

The best way to avoid loss of your data is to backup your database frequently. We here at FHCM have taken a rather paternalistic approach to this and built a mandatory backup feature into FHCM. FHCM will periodically create a backup file in the folder My Documents\My FHCM with the current date added to the name. Under the File menu on the dashboard, you will see a choice called "Preferences". One of the settings under

Preferences is the “Backup Interval”. Backups will be created every time this number of uses has occurred since the last backup. However, only one backup is created on a given day, no matter how many times you open and close the program. You should copy your backup files to a storage medium other than your local hard drive, eg a CD, backup drive, USB stick, etc. It is wise to keep several backups in case a problem develops that was present in a recent backup as well. Not much trouble compared to having to re-enter all your data, right? Given how important your family’s medical records are, we recommend keeping backups in a different location, too – perhaps your desk at work, a relative’s house, slung from a tree, in orbit in a satellite – whatever is most convenient.

Should you experience a problem with your database and wish to use a backup, you need to do two things:

In the FHCM program directory , rename the file FHCM.fhc to something else, eg FHCM.sav.

Copy your backup file to this location and rename it FHCM.fhc (without the date).

If you are having problems that seem to be related to corruption in your file, and somehow you have managed to not have a backup file, please contact FHCM Software. There are ways that we may be able to recover your data – and we’ll give it a try.

2.6. What’s New?

1) Version 1.6

- a) Can now add multiple attachments to Visits, EOBs, Insurance Claims, and FSA claims

2) Version 1.5

- a) - Fixed bug causing wrong Provider Balance to be displayed on Provider report
- b) - Fixed bug causing wrong Provider Balance when using the Visit treatment tab to record medication expenses.
- c) - Changed recording of medication costs. Now - the user must select service "Pharmacy" in order to enter medication costs. Doing so will disable entry of other Provider expenses. Conversely, any service other than "Pharmacy" disables entry of medication expenses. (You can still enter medication details, but no costs).
- d) - New file format and database engine. Data conversion routine added.
- e) - Now fully Windows 8.1 compatible
- f) - No longer compatible with Windows XP or Windows Vista
- g) - Complete overhaul of calculation algorithms for OOP expenses, deductibles, limited expenses.
- h) - Removed limitation of only one insurer being tracked on dashboard for deductibles and OOP.
- i) - Added Insurer Filter to Dashboard and Family Member Screens

- j) - Fixed issue with Provider balance sometimes calculating incorrectly
- k) - Fixed deductible/OOP check boxes on dashboard
- l) - Fixed total OOP expense and insurer cost on Family Member page - now correct. Added insurer drop down.
- m) - Fixed visit list flashing
- n) - Fixed medications counted twice in Tax Report
- o) - Fixed incorrect display of Limited Services on dashboard
- p) - Fixed incorrect operation of dropdowns on dashboard
- q) - Fixed Service listing on Family Member page - appropriate services now list here
- r) - Fixed automatic entry of Insurance copay on visit screen
- s) - Multiple cosmetic improvements

3) Version 1.4

- a) Fixed a problem with the treatment medication list on the Treatment tab of visits. Previously, if a visit was opened in a separate window by clicking the notepad icon, rather than going to detail view, clicking on the list of medications caused a "Table Not Found" error.
- b) Added automatic entry of mileage costs to individual providers. (Distance can be entered on the Provider setup page; cost per mile is entered in Preferences).
- c) Added ability to attach documents to visits, EOBs, FSAs, and Insurance Claims. (Was present in last build of version 1.32 also).
- d) Changed format of medication list on treatment tab. It is now possible to choose medications from the med list and enter the cost of each medication along with treatment/dosing information. Note important caveats about this in Section [Treatment Tab](#).
- e) Starting with version 1.40, the underlying database engine has been updated and should be more stable and robust.

3. Getting Started

The best way to get started with FHCM™ is to take the time to carefully read this user guide to learn how FHCM works. However, if you're like many people (and who isn't?), you want to get started now, right? Sure you do. Okay – here's what you need to do to get going:

a) Open FHCM by double-clicking the desktop shortcut icon labelled “Family Health Care Manager”. The first time you run FHCM it will open to a Getting Started Page, which can also be printed. Once you have gotten FHCM set up, you can turn off this startup page by changing the setting at the bottom of the page. Thereafter, FHCM will open to the Dashboard view (see section 5). Look at the navigation panel on the left. The lower section is labelled “Setup”. Setup is where you enter lists of various kinds of information that can be selected when you enter visits and medical observations. **The order of the following is important. Be sure to create an insurance plan and designate it as “DEFAULT” before creating any providers or services.**

b) **Enter Family Members:** Click the button labelled “Family Members”. Create a new member by clicking the New icon on the top left of the screen. Fill in the information for the first member of your family. Repeat this process for each family member you will be tracking. (Note that in some places Family Members are referred to as Patients – in FHCM these are one and the same).

c) **Create an Insurance Plan:** Go back to the Dashboard (click the house). In Setup, click Insurance Plans. Create a new plan by clicking the “new” icon. Fill in as much financial information as possible, especially deductibles and out of pocket maximums.

In v1.5, you no longer need to designate a default insurer. You can have multiple insurers and they will all be tracked (but you still can only have 1 insurer on a given visit)

If you wish to also track a Flexible Spending Account (FSA), you should also set up your FSA (Dashboard → Setup/Flex Spending Acct). FSA contributions are tied to a year, so you need to enter a new FSA for each year.

d) **Enter Medical Providers:** Go back to the Dashboard (click the house). In Setup, click Providers. Create a new provider. Fill in the appropriate information. You don't have to fill in all the information if you don't need it. **At minimum, fill in the name and network status (In or Out of Network).** If you fill in Tax ID, it will be printed on your insurance claim attachment forms. We recommend using last name, first name format, but you can use whatever you like – just be consistent. (Not foolishly consistent – we don't want to create any hobgoblins in your mind).

e) **Enter Services:** Go back to the Dashboard. In Setup, click Services. Create a new service. Fill in the name and **select an insurer.** You *must select the insurer explicitly* to have it properly assigned. If your insurance plan limits your use of this service, click the Limited box, and fill in the limits. Leave the default high values for anything that is not limited. **AGAIN – you must explicitly click on the name of the insurer to link it to the service.** Do this even for the short list of Services that came pre-installed. When you look at the Services in list view, if it shows the linked insurer, you're good.

You have now entered enough information to start entering visits. If you will only use FHCM to track financial data, you will not need to do anything else but enter individual visit and claim information. **If you are also interested in tracking medical history, you will want to setup lists of Medical Conditions, Symptoms, and Medications.**

f) **Enter visits:** Go to the Dashboard, click Visits. Create a new visit. You *must* enter a Provider, Patient (Family Member), Service and the date it occurred. Enter as much financial information as appropriate by selecting the various tabs in the data entry section at the bottom. See the appropriate sections in this user guide for instructions for creating insurance and FSA claims, and entering Explanations of Benefits (EOB).

That's it – you're now organized beyond belief! (Maybe not, but you're heading in the right direction). Read the rest of this manual to understand the many things you can do with FHCM.

4. How FHCM™ Works and How To Use It

Family Health Care Manager™ is designed to work with you as you record your family's medical history, billing, and insurance activities. It is flexible in allowing you to approach record keeping in more than one way – supporting you and facilitating keeping good records, rather than adding additional burden to an often onerous, though necessary task. Are you meticulous – entering every doctor's visit right after it occurs, before you've received a bill or filed a claim? FHCM will work seamlessly with you – see section [15.1](#). Do you wait till it's time to file an insurance claim before you record a medical visit? Then see section [15.2](#). Are most of your insurance claims filed by your provider's office for you? You should review section [15.3](#). Do you need help keeping track of symptoms, treatment, and progress for a complex medical problem? FHCM will help you do this, integrating medical history with provider visits but also allowing you to record your own observations. (See section [15.5](#)).¹

Are you an action oriented kind of person and you just want to get going using FHCM? Then skip the rest of this section (but come back later), and go to section 3 for help entering information quickly. However, you will get the most out of FCHM, and ultimately gain the most efficiency, if you take the time to understand how it works. Read on!

FHCM may seem a bit complicated at first. This is unavoidable due to the amount of power and flexibility it offers. However, if you invest a little bit of time to understand how it works, you will find that it saves you far more time in the long run, and that it actually works intuitively. Being intuitive means that at times it deviates from standard MS Windows behavior – but we think you'll come to appreciate this!

4.1. Key features and Workflow

The following list highlights some of FHCM's key features. These are explained in detail in the sections that follow.

Interface and Documentation

- **Dashboard View** shows the status of your claims, accounts, deductibles, and benefits at a glance
- Flexible, intuitive, hyperlinked interface – navigate by buttons, hyperlinks, or menus.
- Smart links to related data
- Maintain reusable lists of providers, symptoms, conditions, medications, and services
- Popup help tips throughout the program

Medical Expenses

- Filter visit lists by provider, service, patient, dates, and claim status

¹ Future versions of FHCM may add more sophisticated capability to correlate symptoms, treatment, and other events. The current version facilitates quickly scanning all visits and observations associated with a particular condition, and optionally, a specific date of onset for that condition, as well as creating detailed medical history reports.

- Track status of insurance claims, FSA claims, and tax status independently. Identify claim disputes
- Rapidly change the claim status on visits in a list using keyboard shortcuts
- Quickly duplicate visits and easily modify copies in a list
- Calculation of Out of Pocket expenses can be configured according to your insurance company's process
- OOP calculations adjusted for benefits with limited visits or expense
- Track running balances with providers
- Enter payments by visit or directly to provider balances – 3 different ways to enter payments
- Enter multiple installment payments per visit
- Automatically enter standard copay for in-network providers
- Automatically calculate provider write-off

Insurance Claims

- Create insurance claims; automatically find eligible visits and assign by point and click
- Intelligently track and update status of visits assigned to claims, as a group
- Track EOBs; automatically find visits waiting for EOB and intelligently update status
- Track diagnosis codes and procedure codes; optionally associate procedure codes with services
- Print helpful claim summary forms including key information organized to help you fill out your forms and formatted to be attached.

Flexible Spending Account Claims

- Create flexible spending account claims; automatically find eligible visits and assign by point and click
- Intelligent calculation of expense eligibility for FSA reimbursement, adjusted based on previous insurance reimbursement
- Print claim summary forms to attach to your FSA claims
- Dashboard warning lets you know if you are in danger of not using up your yearly FSA contribution in time

Medical History

- Track complete medical history for doctor's visits, including diagnosis, symptoms, lab results, physical exam, treatment, medical instructions, and resolution
- Create medical observations for your family members to help you track progress of their conditions and treatments
- Filter medical history by key clinical characteristics (symptoms, treatment, medical condition, date of onset)
- Tie visits and observations together with a common medical condition, enabling you to quickly find every entry related to that condition
- Track date of onset for recurrent conditions

Reports

- Create financial reports
- Create medical history reports

FHCM™ can track medical provider visits, personal medical observations, insurance claims, explanation of benefit statements (EOBs), symptoms, conditions, medications, services, providers, family members, insurance plans, and flexible spending plans (FSAs). However, FHCM doesn't just keep simple lists of all these things. It ties them together in very flexible and intuitive ways that enable you to find the information you need quickly. It helps you keep track of the most important aspects of your family's medical affairs and associated finances.

FHCM is flexible about adapting to your natural workflow. If it suits your way of working, you can create all your visit entries as they occur, then as you file insurance claims and receive EOBs, you can quickly link those visits to each claim from the claim assignment screen and then assign them to EOBs as they are received (this is the recommended way of working). FHCM knows which visits are waiting to be claimed, or have been claimed and are waiting for an EOB. Do you prefer to wait till you file a claim to record the visits on that claim? Create the claim first, then go back and create visits, and assign them to that claim from the visit entry screen. Are most of your claims filed by your provider for you? Then you might want to wait till the EOB is received and enter all visit details connected to that EOB without tracking individual claims. FHCM gives you the flexibility to use as many of its functions as are helpful to you without forcing you to spend hours entering information that is of no use to you.

Here are a few examples of some of these features:

FSA Claims: Want to submit some uncovered expenses to your Flexible Spending Account (Health FSA)? Go to FSA claims and create a new claim. FHCM will show you a list of all visits that are marked as "To Submit" to your FSA, along with how much of each visit's expense is eligible for FSA reimbursement. Click the assign button next to any visits you want to submit. They are automatically added to the claim, and the total shows how much the claim is for. If you try to assign a claim that is pending insurance reimbursement, FHCM will ask to be sure you want to submit this, since you don't know yet how much will be left after the insurer pays you. You can go ahead and assign it anyway, but it is better to wait. When you're ready to submit, click the printer icon, and FHCM will print a form to attach to your claim. It will help you fill out your FSA form by subtotaling visits by provider and giving you dates of service for each group of visits.

FHCM will automatically change the status of these visits to FSA: Submitted. You will be able to link to them quickly from the dashboard. If a set number of days passes (as set in Preferences) and some of these visits have not been marked reimbursed, FHCM will show you on the dashboard and in the visit list that you have overdue visits. You can quickly link to all overdue visits from the dashboard, too!

In and Out of Network Deductibles: Suppose Dr. Zachariah Smith is out of your insurance network. Enter this in Dr. Smith's provider entry, and all expenses for Dr. Smith will be tracked as out of network, accruing expenses toward your out of network

deductible and out of pocket maximum. FHCM will then let you know when you have met your deductible or your Out of Pocket Max.

Services with Limited Visits: Suppose your insurance plan only allow you 25 visits to a physical therapist. When you create a service called “physical therapy”, you can tell FHCM that it has a 25 visit limit. FHCM will track how many visits have been used for each family member and warn you when you approach and reach the limit. FHCM will continue to track your true out of pocket cost – ie what you really have spent, even though out of pocket cost from the insurer’s point of view will not increase. You can access this information in a tax deductible expenses report, on the Service details screen, or on a Family Member screen.


Medical History: FHCM will also allow you to explore and better understand your family’s medical history. For instance, you can quickly see provider visits and other medical history associated with a particular condition you’ve defined, or when a member of your family experienced a particular symptom. Or you might want to see how often a particular symptom occurs in association with a particular medication. See sections [8](#) and [15.5](#).

4.2. Detail and List Screens

Most of the information tracked in FHCM can be seen from list views and detail views. **You can switch between these views by clicking the familiar detail/list icons shown in the upper left corner of most screens.** The highlight shows you which record is selected; there is also a small vertical black bar at the left of the line. This is the record you’ll see when you switch to detail view. In many cases, you can directly enter or revise some key data from list view without switching to the detail screen. This will allow you to quickly make changes to several visits (for instance, entering the amount paid by insurance on several visits.) Be aware, however, that much more information is usually accessible on the detail screens.

4.3. Flexible Hyperlinking and Navigation

FHCM™ allows you to get to many places and functions by more than one route. On the left of the Dashboard and most detail screens is a navigation panel that allows you to go directly to the key program functions. You can go to the same places via the Activities and Setup menus. Menu navigation is available from any screen, including those which do not have a navigation panel. (A few functions are available only from menus. For instance, the full range of reports for printing is available only via the File menu and changes depending on the context.) In addition, you will find smart hyperlinks throughout the program – these are shown in blue, underlined text. For instance, these could take you directly to the details of a Provider while viewing visits, or allow you to edit the details of a Service, or quickly find the EOB a visit is linked to, etc. There are many such smart-links, designed to work intuitively according to the kinds of information you might need as you work your way through your medical records.

 Note that at this time, FHCM does not have a back button (as it does not work like a browser). However, many links open a secondary window. When you close these windows, you’ll be back where you were before. A fully-featured back and forward navigation system is in the works for a future version.

4.3.1. Editing Visits or Observations from Lists

There are 3 ways to access visit or observation details from the list screens.

Clicking the detail icon at the top left of the screen will switch to the details of whichever record is selected within the same window – that is, the detail view will replace the list view.

Clicking the date hyperlink on any visit, will similarly switch to the detail screen for that visit, even if it was *not* selected, again replacing the list in the same window.

Each line in a list view also has an “edit details” notebook icon on the far left. Clicking this notebook icon will open that visit in a *new* window, allowing you to make changes without losing your place in the visit list.

In addition, although these detail windows do not have navigation buttons, you can actually move through the visits in the current list using the keyboard shortcuts (Ctrl-Up-Arrow, Ctrl-Down Arrow), while remaining in the details window. (Way cool, huh?)

4.4. Menus and Buttons

4.4.1. Menus

File

File Options – is used to set spell checking behavior

Print Setup – Standard Windows printer setup dialog

Print – print the current screen view – not all screens will look good printed.
Use reports for best output.

Print Reports – Available reports change depending on what you are doing in FHCM. The options will be relevant to the current activity.

Preferences:

Backup Interval – how often backup files will be created (days)

Show Getting Started Screen at Startup (yes/no)

Number of days of processing delay before warning (Insurance Claims, FSA Claims): After an insurance or FSA claim has been submitted, FHCM will wait the number of days set here. Any visits that have not been marked as reimbursed by this time, will be shown as overdue in the status column, and noted on the dashboard.

Default Mileage Cost: Cost per mile in dollars of travel to medical visits. If this value is not blank, it will be entered on the Other Expenses tab of Visit Records. Changing this value will only affect new records created after the change. However, you can temporarily change the value used when printing Tax or Travel Expense Reports.

EDIT

Standard editing commands: Copy, Paste, etc

Spelling

RECORDS

Duplicate Current Record (Ctrl-D)

Delete Record (Ctrl-E)

Go To Record (first, last, next, previous) (Also see keyboard shortcuts)

Next Record

Unsort – will remove any current sorting and return records to order they were entered.

Undo Changes – Ctrl Z. **Once you have left a record, you cannot undo changes.** FHCM is a database, so once you change records, changes are permanent. However, if you are in the middle of editing a visit or observation, and realize you've made a mistake, you can undo changes made since the last time you closed this record.

Delete All Records – This will delete *all* records in the current “found set”. That is, if you used filters to find all of Joe’s visits to Dr. Smith, this will delete all of them at once. If all records are showing, all will be deleted. **BE VERY CAREFUL.** There is no way to undo this command. If you delete all – they are GONE. (But of course, you have been saving all those backups FHCM makes for you, so you can recover most of the data you foolishly deleted).

ACTIVITIES

The entries on this menu correspond exactly to the buttons under Activities on the navigation panel:

Provider Visits – view visit list, create visits

Insurance Claims – view claim list, create a claim and assign visits to it.

Insurance EOBs – view EOB list, log an EOB you’ve received and assign visits to it.

FSA Claims – view FSA claim list, create a claim for your flexible spending account and assign visits to it.

FSA Expenses – see a list of all visits that are waiting to be submitted to your FSA or have already been submitted. You can further filter this list by FSA status and other parameters.

Medical Observations – log your own observations of your family’s medical conditions.

Pay A Provider – log a payment to a provider

SETUP

The entries on this menu correspond to the buttons under Setup on the navigation panel – however, they are subdivided for convenience:

Lists – set up medical conditions, services, symptoms, and medications

People – Set up Family Members and Providers (Note that the screens for Providers and Family Members report additional information that will be helpful apart from setup)

Plans – Set up insurance and flexible spending (FSA) plans

ACTIONS

Commands to quickly change insurance claim status and FSA claim status for a visit (as explained in the next section). These are a subset of the status settings available in the status panel, but represent the ones you will want to change most frequently. Although these are available in this menu, their primary value is when used as keyboard shortcuts.

HELP

FHCM User Guide – Open this document

FHCM Website – Go directly to the home of FHCM

About... – a standard about screen, with information on the current version of FHCM

4.4.2. Shortcut Keys

There are a few very helpful shortcut keys that you can use in FHCM to speed up your record keeping work. It's worth learning these – you'll be amazed how fast you can go if you do.



All of these shortcuts work in list view, detail view, and windowed views.

Ctrl-Up Arrow: Move to the previous visit

Ctrl- Down Arrow: Move to the next visit

Ctrl-Shift Up Arrow: Move to the first visit

Ctrl- Shift Down Arrow: Move to the last visit

Ctrl T – Mark insurance claim status “To Submit”

Ctrl-Shift T – Mark FSA claim status “To Submit”

Ctrl S – Mark insurance claim status “Submitted”

Ctrl-Shift S – Mark FSA claim status “Submitted”

Ctrl R – Mark insurance claim status “Reimbursed”

Ctrl-Shift R – Mark FSA claim status “Reimbursed”

Ctrl-D – Duplicate Current Record

Ctrl-E – Delete Current Record

Ctrl-Z – Undo changes (if you have not left the record)

By using the navigation short cuts to move through a list and the status shortcuts to update them, you can rapidly update your records as needed.

4.4.3. General

Common elements of all screens: At the top left of every screen is a house icon that takes you to the home page, ie the Dashboard. Most screens have two gray icons to switch between list and detail views, located to the right of the house. To the right of these is an icon for creating a new record of whatever type you are viewing. On detail screens, you will see a trash can icon to the right of this for deleting a record. On list views, the trash can is located on the far right of each row. On the top left of many screens you will also see right/left arrows and double arrows for moving forward and backward one record, or to the beginning or end of all records that are currently showing. (Remember, you can also use keyboard shortcuts to move through your records).

Several list views have a filter panel at the top where you can choose various parameters and find records that match your search criteria.

4.4.4. Navigation Panel

The navigation panel, found on the left of the dashboard and all detail views, has two main sections – Activities and Setup. Activities are functions related to creating, editing, and claim processing of visits and medical observations. Setup functions relate to creating and maintaining various kinds of lists that you will choose from in entering data about visits and medical history – providers, family members, symptoms, conditions, insurance plans, etc. Although these lists are used for setup, several of these contain valuable information that you may want to consult without changing your setup. For example, the Family Member screens provide information about costs for each member for various services.

Some of the lists are quite simple, containing no additional information (eg symptoms), while others, such as providers and insurance plans, include a considerable amount of supplementary information, some of which affects calculations in other parts of the program. The detailed sections below explain which data are optional and which are important to enter for proper operation of the program.

At the top of the navigation panel are buttons for moving to the first or last record, or moving forward or backward one record at a time. You can also navigate using shortcut keys: CTRL-up or down arrow move one record back or forward, respectively. CTRL-Shift-Up or CTRL-Shift Down arrow move to the first or last record, respectively. You will also see the total number of records (visits), how many visits are in the current filtered set, and the number of the current record in the filtered set.

At the bottom left of this screen and many others, you'll find small buttons that allow you to increase or reduce the magnification.

5. The Dashboard

When you first start FHCM, you will come to the home screen – the Dashboard View (unless you have the Getting Started screen still turned on). You can return here from anywhere in the program by clicking the house icon. The dashboard gives you a quick summary of your pending tasks, pending claims, the status of Deductibles and Out of Pocket Maximums, and any outstanding balances with providers. The screen is divided into 4 panes, as described below.

5.1. Dashboard Panes

5.1.1. Status/Messages/Warnings

The top panel provides a summary of how many visits need to be submitted for insurance reimbursement, how many are pending action by the insurance company, how many need to be submitted to your FSA for reimbursement, and how many are waiting for processing by your FSA administrator. Clicking on the number of visits in each category will take you directly to that set of visits in the visit list. From there, you can review the details, link to the related claims, create new claims, etc. You will also see if any claims in process are overdue, as defined by the settings in Preferences. You can quickly hyperlink to the overdue claims, as well, so you can follow up with your Insurer or FSA administrator to see why they have been delayed. (Usually the answer is something like “Claim? What claim?” Do be sure to keep copies of all your submitted claims. FHCM can help with this – see section 16).

In addition, at certain times of the year, FHCM will check your FSA status and warn you of critical issues. Starting on Dec. 1st of each year, it will check to see if you have incurred enough expenses to use up your contribution for the year. If you have not, it will display a warning, so you can go out and quickly incur some more non-covered expenses! (This is always a good time to get some extra pairs of glasses, try out that new acupuncturist, etc). Between Jan 1st and March 31st, a warning will be displayed if you still have visits from the previous year that are waiting to be submitted to your FSA administrator. (NOTE: most FSA accounts have a March 31st deadline for submission, but be sure to check what your administrator’s deadline is – it could be earlier) Once you have completely exhausted your FSA, be sure to mark remaining visits from that year as N/A for FSA reimbursement.

5.1.2. Provider Balances

The middle pane on the dashboard lists all your providers, in order of decreasing balance due – that is, at the top are the people to whom you owe the most money. This panel shows how much is owed to that provider, as well as the dates of your last visit and your last payment. If these amounts are above a certain limit, FHCM will recommend getting a prescription for an anti-depressant or heading for South America. (Okay, not really, you’ll have to do that on your own).

5.1.3. Limited Services (Out of Network – see below)

On the bottom left of the Dashboard is the Limited Services panel. If you have set up any services which your insurance company limits either by number of visits or amount

of expense, they will show up here if there are any visits. (The dropdowns for year and member change this list; the insurer does not). For each family member, this panel shows how many visits you are allowed, how many you have used, and how much money has been spent. A yellow warning triangle will appear if you are within 10% of your maximum number of visits or dollars. Once you reach the limit, a red warning triangle will appear. (*Note – version 1.5 no longer automatically stops counting OOP Insurer expenses once you reach the limit – however, this will get taken care of once you enter a value of zero for the Insurer Allowed Amount.*) Your true out of pocket costs are still tracked separately and can be seen both in a tax report and on the Services and Family Member detail screens). There is currently no provision for services with a Family limit – most plans set a limit for each member. This panel lists information for your default insurer only.

5.1.4. Deductibles and OOP

The last panel, on the bottom right, shows you how much each family member, and the family as a whole, have spent towards insured services, and whether each has met their in and out of network deductibles and out of pocket maximums. The amount spent shows the total of all costs – both in and out of network, but each kind is still tracked separately; the status is shown by the various checkboxes. (The dropdowns for year and insurer change this list.) Note that the exact way in- and out of network expenses are tracked relative to the out of pocket max and deductible is controlled by a setting in the insurance plan setup screen. See section [6.2.4](#) for more information.

☞ Remember also that visits *will not be counted here until they have been marked as reimbursed* (since we can't really know how much the insurance company reimbursed, whether they were allowed, etc until this happens).

6. Entering Resources

Resources are various kinds of lists you will refer to in your visits – doctors, family members, insurance plans, symptoms, conditions, etc. When you first set up FHCM, it is important to enter some resources in a particular order, as discussed in the Getting Started Sections. Please first create your family members, then at least one insurance plan (default), then at least one provider, and then any services you will use. Once you've set up your initial set, you can add additional ones on the fly in any order.

6.1. Family Members

There are three sections to the Family Members set up screen. One of these is a free form notes field. The only other information you actually enter on this screen is the member's name. Note also that all calculated data on this screen are for the year and insurer chosen in the drop downs.

6.1.1. Upper Section

In the upper section with the member's name, FHCM will show you their total out of pocket expenses in two ways.

OOP (Insurer)

This is the out of pocket expense from the insurer's point of view. That is, it sums your coinsurance payments for all *covered* expenses (copays are not included). Specifically, this shows the difference between what the insurer *allows* for a specific expense and what they paid. As an example, if you are billed \$2000 for anesthesia, the insurer allows \$500, and the insurer pays 90% of what they allow (\$450), your OOP (insurer) is \$50. The write-off is not considered out of pocket, even in situations where the provider might expect you to pay the difference. This amount is relevant for knowing when you have met your OOP maximum, after which your insurer may pay 100% of covered amounts (please consult with your insurer to find out what happens after reaching OOP max for your particular plan).

OOP (Patient)

In contrast, OOP (Patient) shows your true expense – what really came out of your pocket. It includes anything you had to pay: coinsurance, copay, travel costs, and any uncovered expenses. So in the example above, if the provider was willing to write off \$1200 dollars of the \$1500 the insurer won't pay, your OOP (Patient) will be \$50 + \$300 = \$350. If the provider would not write off anything, your OOP (Patient) would be \$1550.

This amount is the expense that is relevant for determining your medical expenses for taxes.

6.1.2. Lower Section

The lower section of the Family Member screen shows information for individual services used by that member during the year of interest and covered by the chosen insurer. For each service, you will see both kinds of OOP expense, the number of visits used, and a new cost called Total Cost Insurer. This last number is the amount of money

the insurance plan has paid for this service for this member in the year of interest. This would be particularly relevant if your insurer limits total expenditures for particular services (for example, you're only allowed \$500 of Durable Medical Equipment (DME)).

6.2. Insurance Plans

6.2.1. General Information

The insurance plan screen allows you to enter a variety of identifying information for your insurer and your insurance plan. If you enter a web site for your insurer, you can go directly there by clicking the arrow next to the URL (this is a convenience; FHCM does not interact with the web site in any way). The information in the top section of the screen is primarily for your own record keeping, although your membership ID will be output on the insurance claim attachment form.



The bottom section of the screen is where you enter information about copays, coinsurance, deductibles, and out of pocket maximums, for individuals and for your family, for both in and out of network providers. This information is used in several calculations, so it is important to complete this section.

6.2.2. Copays, Coinsurance

Different insurers define copays and coinsurance differently. FHCM has specific definitions that affect how expenses are tracked. Specifically, copays are fixed amounts that are paid per visit, typically with in-network providers. They do not count towards deductibles or out of pocket maximum. In contrast, coinsurance is generally a percentage of the expense. Out of network expenses (and sometimes in-network expenses) will have a coinsurance payment, but often do not have a copay. Coinsurance counts toward your deductible and your out of pocket maximum. There is a setting in the lower section of the insurance set up screen that controls how in and out of network expenses interact. If you select *Separate*, in and out of network expenses are assumed to be completely independent. Therefore, you need to meet your in-network deductible with in-network expenses and meet your out-of-network deductible with out of network expenses. (The same goes for OOP maximum). Alternatively, if you select *Pooled*, in-network and out of network expenses are combined – all expenses count towards both in and out of network deductibles. The third option, “one-way” works like this: in-network expenses count towards both in and out of network deductibles (and OOP max), but Out of network expenses count only towards out of network deductibles. (If your plan does something even more arcane, let us know and we'll try to add that option.)

6.2.3. Deductibles

FHCM tracks your expenses (according to the options described above), and shows you on the dashboard when you have met your deductibles. No calculations are changed as a result – this is simply to help you know when you've reached this limit, so you can make sure your insurer is properly processing your claims.

6.2.4. Out of Pocket Maximum Amounts

Out of pocket max is similar to deductible – a checkbox on the dashboard allows you to quickly see when you've reached your max. For many insurers, once you've reached

this threshold, you do not have to pay any more coinsurance, but you do still have to pay your copays. (Please check with your insurer for how this works in your particular plan).

6.3. Providers

The Providers section is where you enter physicians, dentists, hospitals, etc, as well as associated contact and address information. If you enter a Tax ID for a provider, it will be printed on the Insurance Claim Attachment report, facilitating filing claims for those services. For physicians affiliated with a group or institution, you may choose to enter either the physician's name (Seuss, Doctor) or it may be convenient to enter the group if all bills come from the latter (Lorax Doctor's Group). In some cases, you may want to enter both a group and the individual physician separately – for instance, you may get billed by your doctor directly for office visits and from a clinic or hospital when you have certain procedures done by that doctor. As long as it makes sense to you, it doesn't matter – but remember that reports and claim attachments will use this information, so try to use whichever will be most useful. (Did I mention being consistent yet?)

Note that this version of FHCM only allows entering one Service, one Insurer and one Provider on a given visit. (Version 2 will allow multiple entries of Service and Insurer, but we don't yet have a committed date for this).

Note that below Provider Address fields, there is a field to enter distance to Provider. If you fill in a distance (miles), this will automatically be entered in the Other Expenses tab of any new visit to this provider. Thus, if you set this value and a default cost per mile for travel (see Preferences), the program will automatically enter and calculate the travel cost for each visit to this provider. (This can always be overridden in a particular record if you need to for any reason).

There is a provision at the bottom of the screen to click a radio button to indicate if the provider is in or out of network. FHCM links services to a particular insurance plan; you will also designate a provider as being in- or out of network for the *service* they provide, even though you won't link them to a particular insurance company. This may seem a bit odd, and that's probably because it is. However, in practice, the majority of services are usually covered by the same insurance plan, so it all works out pretty much the same. Future versions of FHCM will better handle multiple insurers used for the same services (eg secondary plans, Medicare, etc).

Note that even though version 1.5 does not yet allow multiple insurers and services on a visit, the previous limitation of only being able to track deductibles and OOP and limited services for one insurer is gone. You can track many insurance plans simultaneously, just not on the same visit.

The Provider screen also shows the current balance with that provider (upper right section) and a payment history in the bottom section. The payment history lists both payments associated with individual visits and statement payments. You can also add statement payments directly by clicking the link at the top of this section (see section 9). Finally, there is a section for free form notes.

You can enter new Providers on the fly by clicking the plus sign on the visit details screen next to Provider.

6.4. Services

6.4.1. Entering Description and Procedure Codes

When you enter a service, you should at minimum enter the name (description) of the service (eg Physical Therapy), and the insurer that covers it. Whatever insurer is chosen here will be assigned to all future visits that use this service. If you change the insurer, it will not affect any previously recorded Visits.

If the service is a specific procedure that has a CPT procedure code, you can enter that code and the exact CPT description as well. If you enter the code and description, when you assign this service to a visit, the CPT code will automatically be entered on the Treatment tab (see Treatment Tab). However, it is not necessary to enter a CPT code, and in fact, most services will not have just one code associated with them, so for those it is better not to enter the code here – it can always be entered on individual visits if appropriate. If in doubt, leave it out.

You can create a new service on the fly by clicking the plus sign next to Service on the visit details screen.

6.4.2. Entering limited services

For some services, your insurance company may limit either the number of visits or the amount of expense. For instance, you may get only 20 chiropractic visits per year, or you may get only \$1500 of durable medical equipment coverage per year. In this situation, mark the box labelled limited, and then fill in the appropriate in and out of network limits. (You can leave the default high values for those that don't have limits). Note that limits are applied per individual, not per family. FHCM will track your use of limited services on the dashboard, and warn you when you are almost out of coverage. In order to have the values for OOP Insurer accurately track what your insurer calculates, be sure to enter \$0.00 for Insurer Allowed and Insurer Paid amount on visits beyond your maximum. (As discussed above, in this version of FHCM, limits are only tracked for out of network services).

In some cases, your insurer may limit a broad class of services; for instance, you may have 100 visits of rehabilitative therapy per year, and this may include physical therapy, occupational therapy, and speech therapy. In this kind of situation, it is best to define the service as rehabilitative therapy, with a 100 visit limit, and then specify the type of therapy in a notes field or perhaps in Reason for Visit.

6.4.3. Special Treatment for Prescription Coverage

Setting up FHCM to track costs for prescription medications is dependent on what kind of coverage you have for prescriptions. Starting with version 1.5, you must name the service for entering medication costs "Pharmacy". (If you've named it something else, you can easily rename it from the Services screen).

- a) If you have a separate insurance plan that covers your prescriptions, you can simply create an additional insurance plan, set up the deductibles and OOP max, and any limits as appropriate, and assign that insurance plan to the service Pharmacy, and you'll be all set.

- b) If prescriptions are covered by your primary insurer, but do not count towards your deductible or out of pocket expenses, you may want to create a new “virtual” insurance plan for those.
- c) If prescriptions are covered by your primary insurer and do count towards your deductible and OOP, simply set them up as a service called Pharmacy assigned to the same insurer.

Starting with version 1.51, you can no longer enter medication *costs* on the same visit as you enter other provider visit information (you can still record medications here, but not their costs). You can enter multiple medications on the Treatment tab. To record medication costs, you create a “visit” with Service of “Pharmacy”. When you set the service equal to Pharmacy, fields for the cost of medications will appear on the Treatment tab, and fields for Provider visit costs will disappear.

Note also that by associating these medication purchases with a condition, you can determine how much you’re spending for medications related to a particular condition.

6.4.4. Service Costs

The bottom of the screen shows costs for the chosen service for each family member. For an explanation of the different costs, please see Section 6.1.1 . Note that costs will be shown for visits that used whatever insurer is currently assigned to that service. If you need to see costs for other insurers, you can see this on the [Family Member Details Screen](#).

6.5. Medications

The master medication list has three fields: name, type and Rx. The only required one is name. Type is for entering general classes of medication – for instance, NSAID, SSRI, diuretic, etc. If you enter types, when you search medical observations/history, you will be able to find all instances of that type of medication – this may be helpful in trying to understand your family’s medical history. (If you prefer, you could use this column for a generic name if you have no interest in tracking your use of broad classes of medications). Rx is currently only for your reference, but future versions of FHCM will have expanded capabilities for tracking prescriptions.

6.6. Conditions

Condition is entered on the Condition tab of visits and observations. This allows you to track different diagnoses, treatments, and observations without losing the unifying thread of the underlying condition as your understanding and medical diagnoses evolve.

The use of “Conditions” is key to getting the most benefit from FHCM in terms of medical issues. This allows you to quickly associate your own medical observations with multiple visits to providers. They are particularly valuable in situations where the official diagnosis may change over time or where different providers give you a different diagnosis. Although the diagnosis may change, the underlying condition may in your understanding be the same.

For instance, suppose your child appears distracted. You visit your pediatrician, who might initially write it off to normal child behavior. You might create a condition called “Distractibility”. You also add your own observations over time, with the unifying condition of “Distractibility”. Later, as you seek more opinions, it might be labelled ADD (Attention Deficit Disorder). If at some point, it becomes clear that it actually is ADD, you can simply edit the condition to ADD, and all the associated visits will now be labelled appropriately. You can quickly search for all the entries marked with this condition (via the Medical Observations screen). That will allow you to view all Medical Observations and all provider visits that were related to this condition, regardless of provider specialty or diagnosis at the time. It also allows you to accurately record the Provider’s diagnosis at any given time, and still keep related entries together.

In addition, you can optionally enter a Date of Onset for a condition. This will be particularly helpful for a condition that had a well-defined beginning, or one that occurs intermittently. You could use this to group entries for a particular episode of a condition. See additional information on entering date of onset in section Diagnosis Tab.

You can create a new condition on the fly by clicking the plus sign next to condition on the visit details screen.

6.7. Symptoms

FHCM comes pre-populated with a list of common symptoms, but you can and should enter or revise those to suit your family’s health and conditions. You can revise the master symptom list either by going directly there from the Setup/Lists menu or from the navigation panel. In addition, you can enter new symptoms on the fly while you are entering or revising visit details, by clicking the plus sign next to the Assign Symptoms section of the Diagnosis tab. This is a simple list with no associated information at present. You can assign multiple symptoms to a visit or medical observation (see Diagnosis Tab. You can search for symptoms from the Medical Observations/History screen, and they are listed on the Medical History report.

6.8. Flexible Spending Accounts

Flexible Spending Accounts (FSA) are tax saving vehicles where you put aside pre-tax dollars to be used for medical expenses. According to IRS rules, you must decide your total year’s contribution at the beginning of the year, and you must use all of it during the year, or else you lose anything unclaimed. This makes it imperative to make sure you have accumulated sufficient expenses that are not reimbursed by your insurance plan to allow you to get your money back out of your FSA. Each year, you should create a new FSA entry with the contribution year and the amount you have contributed. FHCM will keep track of any visits you have marked as FSA eligible. Starting on Dec 1st of each year, FHCM will check to see if you have enough FSA eligible expenses to use up your contribution; if you don’t it will show a warning on the dashboard until the year ends. (In this case, you’ll want to make a lot of visits to your acupuncturist or chiropractor, get some extra pairs of glasses, or do whatever else you can to use up those dollars!). Between Jan 1st and March 31st of each year, FHCM will check to make sure you have submitted claims for all your FSA eligible visits from the year before and warn you on the dashboard if you have not. This is because the IRS requires you to submit those

claims by a specific date (often but not always March 31st) of the year following the year in which the expense was incurred. (A lot of requirements to get back money that was yours to begin with, don't you think? Unfortunately, FHCM can't help with that, but maybe your representative can!). See additional information about submitting claims to your FSA administrator in section 11.

7. Entering Visits

FHCM uses the term visits to refer to any time a member of your family sees any kind of Medical Provider – both individuals and institutions (eg hospitals). Anytime you see someone who expects payment for their services, you should enter a new visit. If you wish to enter information about someone’s medical condition, based on your own observations, you should instead enter a Medical Observation (see section 8). All information available on Medical Observations is also available on Visits, but only Visits have financial information.

7.1. Visit Details Screen

The visit details screen is one of the key elements of FHCM’s data entry. It is divided into three primary areas: the primary visit information at the top, financial/claim status area on the right, and the data entry tabs on the bottom. (And of course the navigation panel on the left).

7.1.1. Primary Visit Information

This is where you enter the name of the patient, the provider, the service, and the date. It is very important that you enter all 4 of these items. If you don’t, some of FHCM’s functions will not work properly with this visit. Services, Providers, and Family Members must be chosen from lists you’ve already set up. You can add a Provider or a Service directly from this section by clicking the plus sign, without having to leave the data entry screen. In addition, you can optionally enter a reason for the visit (eg follow up on sore throat, checkup, etc), a facility where you were seen, and any other notes about the visit. At the top of this area, you will see icons for creating a new visit, switching to the visit list view, and deleting the visit. (Deletions are permanent, so be sure you really want to delete one before doing it!). Note that unlike “Conditions”, Reason for Visit is not used to tie entries together – it is simply a place for you to make notes about what brought you to the doctor that day.

7.1.2. Data Entry Tabs

There are 6 tabs for additional data entry – three for financial information and 3 for medical information. Most tabs have notes areas for entering additional information. Much of this information will be visible on the medical observations/history list, and in the Medical History report.

Financial Tab

This is where you enter information about billing and insurance payments. (Your payments are entered on the Payments tab, but will automatically be shown here). If the provider is in-network, a shortcut for entering your standard copay will be visible; click it to automatically enter a copay on the date of the visit. (You can change the date if it is incorrect).

Provider Billed: how much the provider billed you.

Insurance Allowed: Be sure to enter the amount allowed by your insurance provider, as it is used in some calculations. This value will be shown on your EOB. If you don't know what it is, assume it is the same as the amount billed.

Provider Write-off: If your provider “forgives” or “writes off” some part of the amount not covered by insurance, enter that amount in Provider Write-Off. However, if you are held responsible for anything not covered by insurance, leave Provider Write-Off blank or zero.

FHCM can also *automatically* set Provider Write-off by clicking the Provider Write-off hyperlink. This will toggle between three values:

- the difference between the Provider Billed Amount and the Insurance *Allowed* Amount, ie the provider writes off however much the insurance company won't *allow*, so you pay only your standard copay or coinsurance on what insurance *does* allow.
- the difference between the Provider Billed Amount and the Insurance *Paid* Amount, minus your payments, ie the provider writes off whatever is left after you've entered your coinsurance payment and the insurance company's payment.
- Zero – the provider doesn't write off anything.

If this seems complicated, just click the link a few times after you've entered the other values and see what happens- it'll make a lot more sense. Once you get the hang of it, it will save you a lot of time.

☞ If you have manually entered a value that is different than a, b, or c in the write-off field, clicking the hyperlink will do nothing. FHCM won't overwrite an amount that you entered manually.

☞ If you enter a non-zero amount in Insurance Paid, the insurance status will automatically be set to “Reimbursed”. Be sure to click the radio button to indicate whether the insurance payment went to you or the Provider.

If you've set the service to “Pharmacy” you will instead see a single field for Medication Costs which is calculated from the Treatment tab.

Payments Tab

Enter any payments here. Use copay for a standard, fixed payment that does not count towards deductibles or OOP maximum. Use coinsurance for any other payments. You can enter multiple payments on different dates, along with the type of payment and any other reference information. (If you use the Pay Provider function in FHCM, reference information will be entered automatically). Click the trash can to delete a payment. Payments can be entered in more than one way – see section 9.

Other Expenses

Enter travel, mileage, and parking expenses here, as well as any other miscellaneous expenses. These are included in both OOP-Patient and Tax Deductible Amount (see section 16).

FHCM can automatically enter and calculate your mileage travel expense for visiting providers. To make this work, you need to enter: a) the roundtrip distance to the provider on the provider information screen (bottom right), and b) the default cost per mile to use for calculating expense. If both of these values are present, FHCM will automatically enter both values and calculate the mileage cost for that visit. Note that this happens at the time a visit record is created. Thus, changes to either the mileage cost or distance to a provider will not affect previously created visits – only those that are created going forward. You can also manually override any of these values in an individual visit. In addition, you can temporarily specify a different cost/mile value when printing Tax or Travel Expense Reports.

Medical Information Tabs

The next 3 tabs concern medical/clinical information and are found on Medical Observation records in addition to those for Provider Visits. (In the case of Pharmacy, you will also enter costs here).

Diagnosis Tab

Enter the condition this visit relates to, if applicable. Conditions must be chosen from the list of conditions you have previously set up. (You can add a new one from this tab without having to leave the visit by clicking the plus sign). You can also add a date of onset. If you have previously entered this condition with a date of onset, you will get a drop down list of all previously entered dates of onset for that condition, to help you pick the right one. You do not have to pick from this list, however; you can enter a new date or leave date of onset blank.

If you were given a specific diagnosis and code (ICD-9 or DSM) you can enter the information here. The ICD-9 code and description will be printed on the insurance claim attachment form.

You can assign as many symptoms as you want to the visit. Click the Assign Symptoms hyperlink and you will be taken to a window where you can pick symptoms from your symptom master list. (You can add new symptoms on the fly by clicking the plus sign). You can unassign symptoms by clicking them in the Assigned Symptoms list. Click Done when you are finished.

Finally you can enter any additional condition-related notes here.

Exam Tab

On the exam tab, you can enter any findings from the visit – body weight, height, blood pressure, heart rate, and body temperature. When you pick a method of measuring body temperature (oral, axillary, etc), FHCM will show you the approximate range of normal temperature by this method. However, this is just a rule of thumb; **you should always consult with your physician about any concerns about body temperature or any other medical symptoms; FHCM should not be used in any way to decide on treatment.** There is also a free form area for entering lab findings or any other exam related information.

Treatment Tab

On the treatment tab, you can enter a CPT procedure code, if applicable. If you have previously entered one for the service, it may have already been entered for you. CPT codes are printed on insurance claim forms, to assist you in filing claims.

There are free form areas for entering treatment notes, instructions from your provider, and information about the resolution of the condition related to this visit. None are required. Most of this information will appear on the medical history list view and the medical history report. Finally, you can enter medications prescribed at this visit, along with dose and frequency. Medications must be chosen from your medication list; new medications can be entered from this screen by clicking the plus sign.

You may also enter the costs of medications in this list if the Service is Pharmacy. Note that patient medication costs entered here will be included as Out of Pocket costs, but will NOT be included in tracking of insurance payments.

Attachments

You can attach as many documents as you'd like (such as scanned lab results) to each Visit record. The attachment list is located at the bottom of the visit record, below the tabbed sections. There's a new record button at the top of the list. Clicking this will bring up a standard file picker dialog. FHCM will save the *location* of your attachment. The actual document will still be in the same place. This means that if you move FHCM or your documents, FHCM will no longer be able to find them. Therefore, you may want to designate a particular directory to keep your attachments so you can always find them and move them if necessary. You can view the attachment by double-clicking on its name. You can delete an attachment by clicking the trash can to the right of it. (Since FHCM only stores the attachment location, you won't actually be deleting the document – you're just removing it from FHCM's list.). You also have additional fields to store a short description of the attachment (since filenames don't always identify documents well), and a field for more extensive notes. If you hover your cursor over the Notes field, a popup will show you the full contents of that field, even if they don't fit in the box on the line.

Note that if you're editing a visit using the popup window interface (Section 7.2), the attachment interface won't be visible.

7.1.3. Status Area

The status area shows the current balance on this visit and the overall balance with this provider. It also shows whether the expense is considered tax-deductible (assumed yes unless you indicate otherwise), the status of insurance and FSA claims, and if a claim was submitted, whether an EOB has been received. If you have assigned the visit to an FSA claim, Insurance claim, or EOB, the number of that claim or EOB will be shown, and you can jump directly there by clicking the ID number hyperlink. Note that certain functions and calculations are dependent on these settings. For instance, expenses will not affect your deductible unless you indicate that you have submitted a claim and it has been reimbursed. EOBs will show as NA in the visit list (gray X) if you have not filed a claim. If you do not intend to file an insurance claim (eg because the service is not covered), click N/A for claim status.

Note: you can assign visits to claims and EOBs by filling in the numbers in the appropriate fields here or by using the assignment screens. The latter is the preferred method if you file your own claims. However, if you do decide to assign from the Visit Details screen, a drop down of existing claims and EOBs will be shown when you click on those ID fields to help you choose the right one. If you intend to use this method, you should first create a blank claim or EOB, and then return to the visit details screen. Note also – if you assign a visit to an EOB or FSA claim from the assignment window, status will be changed automatically; if you assign from the visit screen, you should set the status yourself. You can quickly change status using keyboard shortcuts (section 4.4.1) or by clicking the appropriate radio buttons.

At the top of the navigation panel, you will also see the navigation buttons for moving to the beginning or end of your visit list, or going to the next or previous visit. (You can also move by shortcuts). You will also see how many visits are in the list. If you have previously filtered the list from the list screen, you will be seeing a subset of all visits here. You can return to seeing the full list by clicking Show All at the top of the screen.

7.2. Visit List

When you first go to Visits from the dashboard or menu, or when you click the list icon from the visit details screen, you will come to the Visit List screen. The visit list shows you all of your visits (or a filtered subset) along with a condensed version of the financial information. Many of the financial parameters can be revised directly here, allowing you to quickly make changes to multiple visits. You can delete a visit by clicking the trash can icon. You can edit a visit in a popup window by clicking the notebook icon on the left. The blue hyperlinks will take you to screens for the related provider or service, or to the visit detail screen in the same window. Many of the column headers allow sorting, and are shown in blue when this is possible. Currently sorting is only possible in one direction. You can duplicate an existing visit by clicking the duplicate icon on the right. (When you duplicate a visit, the date is cleared, and status information is set to default values).

If you need to create a series of similar visits, you can use this method to do so rapidly:

- a) Create the first visit with all appropriate information.
- b) Create the needed number of additional visits by clicking the duplicate icon the appropriate number of times. If you are sorting by date, the visits will sort together at the top since they have no date.
- c) Starting with the first visit, enter a date, and fill in the payment information. Use the keyboard shortcuts to set the claim and FSA status.
- d) Use keyboard shortcuts to move to the next visit. Repeat step c. It will go very fast!

7.2.1. Filtering








At the top of the window is the Visit Filtering area. You can enter date ranges (directly, or via the quick date drop down) or text to search for in most of the key fields.

Text does not have to be an exact match – but if you are not sure if the text begins the field, enter an asterisk before it. If you enter information in more than one field, it will be combined as a logical “AND” – that is, you will only find visits that meet ALL the criteria. When you have entered the information to search for, click the binoculars. To clear all the fields, click the white rectangle icon. To return to showing all the visits, click Show All. You can search by claim status as well. At the far right is the Global Notes search. If you type text in this box and click the magnifying glass, you will see visits that contain the search text in any of the free-text notes fields. This function is independent of the rest of the filters and will ignore anything entered in the other search fields. This is helpful when you remember some text you entered somewhere in a visit (or medical observation), but have no idea where!

7.2.2. Status Icons

At the right of the visit list are icons that quickly show the status of the various claims and EOBs. There are three columns: EOB, Claim (Insurance), and FSA. In addition, there is a flag column. The meanings of these symbols are shown in the table below. Hovering the mouse over the symbols will produce a tool tip that reminds you of the meaning of each symbol. Clicking on the symbols will take you to the EOB or claim related to that visit, if one exists. If there is no claim or EOB, clicking will not do anything. The flag column is there for you to flag a visit for whatever reason you want, apart from any claim issues. Perhaps you’ll use it to mark visits needing more information, or where you need to call the provider. In the flag column, you will also see little sticky note icons. These indicate that the “Status Notes” field has something entered. If you hover the mouse over the icon, the contents of Status Notes will pop-up. (This will work even if you have toggled the flag on).

Table 1 Visit List Status Icons

Symbol	EOB	Insurance Claim or FSA Claim
	N/A – Insurance claim has not been submitted	N/A – Claim will not be filed
	Waiting for EOB (Insurance Claim has been submitted)	To Submit: You need to submit an Insurance Claim or FSA Claim
	EOB Received	Claim has been submitted
	—	Reimbursement has been received
	—	Claim Denied or in Dispute
	—	Claim has been submitted, and is overdue
	—	Pending information or action by provider

8. Entering Medical Observations

Medical observations are used for entering information about a member of your family that is based on your own observations, rather than those of a professional. As such, there will be no financial information associated with these entries. Medical Observations are essentially Visits without the three financial tabs or the Status Panel. (Although you could accomplish the same thing by leaving out all the financial information, the advantage to creating a Medical Observation is that you can later filter for Observations only and not see Provider Visits). They are ideal for tracking symptoms and treatments of an ongoing condition. By choosing the Condition and Date of Onset appropriately, you can keep these easily associated with related Provider Visits, as well. In addition, since Medical Observations include the Treatment Tab, you can use them to track the progress of or reactions to a treatment (eg medication) that was initiated by a Provider. Thus, these are ideal for monitoring effectiveness or side-effects of a particular medication.

The Medical Observation list view, which is also a Medical History view, works similarly to the Visit List view. Since the information in Medical Observations is usually complex, and often lengthy, a somewhat different approach is used to convey this information in a concise format. On the list view you will see a condensed version of most of the clinical/medical information, which will appear truncated since the space is limited. However, **hovering the mouse over the longer fields will produce a popup** that contains the full text of those fields. You can use this to quickly identify entries of particular interest. If you want to further explore a visit, you can select it and switch to detail view (or print a Medical History report).

Like the Visit List, there is a filter section on top that allows you to search for observations meeting certain criteria. There are some differences, not surprisingly, in the specific information you can search for. Text typed in the treatment field will match observations containing the search text in either the medication name or medication type fields. Thus, you could quickly search for all entries using erythromycin, or all entries using antibiotic. (Depending on how you set up your Drugs list).

9. Paying Providers

FHCM provides 3 different ways to record payments to Providers. Depending on the type of insurance plan you have, and your personal habits, you may find any or all of these appropriate. You do not need to stick to any one particular method – just be sure you understand the differences.

9.1. Entering pre-existing balances

If you do not wish to enter all historical data for particular providers, but would like to track your balance correctly, you should create a dummy statement payment, with a date equal to the date that balance existed, and enter a negative number equaling the balance as of that date. You can enter something like Pre-existing Balance in the Reference Info field.

9.2. Payments for one visit

For situations in which each visit is paid separately and you don't run a balance, you can enter your payments directly from the visit details screen. Click the payments tab, and enter one or more payments, along with appropriate amounts, dates, payment type, and any reference information.

For visits to in-network providers who you pay only your standard copay, you can save time by clicking the “Enter Copay” hyperlink on the Financial tab, which will automatically enter your copay as setup in your insurance plan.

This method is ideal since both Visit Balance and Provider Balance will be accurate.

9.3. Statement and Provider Balance payments

In some situations, you may run a balance with a provider, and periodically make payments to your account that are not linked to an individual visit. You have two options for handling this approach. In one case (“Statement Payment”), you enter your payments directly to the Provider account, independent of any particular visit. The Provider Balance will be accurate, but individual visits will continue to show an unpaid balance.

Alternatively, you can have FHCM automatically “spread out” your payment across all visits with unpaid balance, in chronological order. The advantage of this approach is that it will help you check your provider's billing, by making sure that the statement they send you is consistent with the visits you've had. The disadvantage of this approach is that your large payment will appear to be multiple small payments. However, FHCM will assist you in tracking this, by automatically entering reference information so that you can see that those small payments originated in a large payment.

9.3.1. Statement Payments

To enter Statement Payments, click the Pay a Provider button in the navigation panel, or choose “Provider Balance Payment” from the Activities menu. Click Statement Payment on the dialog that comes up. You can now enter a payment to that provider, independent of a visit. The provider balance will be correct, and the payment will be visible on the Provider Details screen. However, individual visits will continue to show unpaid balances.

9.3.2. Distributing Payments Across Visits With Unpaid Balance

If you would like your payments to a running balance to link to visits so that you can see which visits have been covered by each payment, click the Unpaid Visits button when you get the Pay a Provider dialog. This will take you to the Provider Balance Payment screen. Choose the provider you wish to pay, and FHCM will show you a list of all visits that have unpaid balances. Now enter your payment information and click Apply Payment to Visits. FHCM will split your payment up across visits, working chronologically starting with the earliest visit, until there is no more payment left. In this case, it will appear that you have actually made separate payments to each visit, which may make it harder to track your actual payment history. However, FHCM will automatically concatenate the date and the full amount of the payment with any reference information you enter, to make it easier to track the source of those payments. This method is good if you make payments for several visits at once, but primarily have to pay visits off rather than run a balance for billing.

IMPORTANT: If you are going to use the Statement Payments approach with a given provider, do not also use this method. If you do this, the program will assign payments to visits you've already paid for. The overall provider balance will still be correct, but your per visit tracking will be a mess. (It's fine to use different methods with different providers – just try to be consistent with a given provider). Frankly, I created this method because of a provider who had an incompetent billing department, who always told me I had not paid for visits I knew I had paid for, but I was paying in large installments periodically. This made it very easy to see exactly which visits were paid off.

10. Tracking Insurance Claims

This is one of FHCM's most innovative and helpful features. To track insurance claims in FHCM, you create a Claim in the program that corresponds to the actual claim you submitted – in other words, an electronic version of the paper form. If you create your claim in FHCM *first*, it will do a lot of the work for you and make it much easier to fill out your paper form. You can print an insurance claim attachment form that will provide most of the information you need to fill out your insurance company's form (described in more detail at the end of this section). FHCM will group visits by Provider, calculate subtotals, numbers of visits and dates of service for each provider, as well as total claim amount and number of visits for the entire claim. It will also show Provider Tax IDs, treatment codes, and diagnosis codes if you have entered this information.

To create your claim, click the Insurance Claims button or use the Activities Menu. This will take you to the Claims List screen. To create a new Claim, click the new claim icon at the top. When you create a new claim, FHCM will automatically assign a claim ID. You should enter the date of the claim on it, and select the insurance company you are filing the claim with. You also must select a patient since most insurance companies require a separate claim for each patient. (If yours does not require this, you'll need to enter them as if they were separate claims – or Once you have filled in this information, you can assign visits to the claim in one of two ways.

When you first create a new claim, you are automatically taken to the claim entry/editing screen. The top pane shows visits that are currently assigned to the claim. The bottom pane shows all visits eligible to be claimed for the selected patient (and not yet claimed). (Eligible visits are those for the selected patient that have been marked "To Submit", and not yet submitted. Visits that are marked "N/A" for claim status will not appear). Click the assign icon (up arrow on a pile of circles) on the right of the visit to move it to the assigned visits pane. Click the unassign icon (down arrow on a pile of circles) to remove a visit from the claim and send it back to the bottom pane. The fields at the top will update to show you how many visits are on the claim and the total amount claimed. When you are done, click the "Done Assigning" button and you will see the finished claim. You can revise the claim by clicking the notebook icon to return to the assign visits screen. You will also see the notebook icon next to each visit to take you to the visit details screen for that visit.

When a visit is assigned to a claim via this screen, FHCM automatically enters the claim id on the visit and marks its status "Submitted". (FHCM does not know if you actually mail the claim of course – so if you leave it sitting on your desk, don't blame us. Procrastination tracking is not currently on the To Do list).

Alternatively, you can assign visits to a claim from the Visit Details screen. You must have previously created the claim and given it a date, but need not have assigned visits to it. In the Visit Details screen, click in the Claim field in the Status Pane; you will see a drop down list of existing claim IDs with their dates. You can select the appropriate one to link the visit to that claim. In this case, you should manually set the status to Submitted. You may find in certain instances that this method is more convenient, especially if you are creating visits at the time you submit the claim, rather than as they occur.

You can see a list of all existing claims by clicking Insurance claims in the Navigation pane or selecting it from the Activities menu. If the list is long, you can filter it by date range and/or patient. Select a claim and click the Details icon to see the details of that claim and edit it if necessary.

At the bottom of the Claim screen, you'll see a space for notes about the claim as a whole, which is also visible in the list view. You can attach multiple documents to the Claim. See the section on Visit Attachments for more information.

You can print a very helpful claim attachment report by clicking the printer icon or via the File menu. The form will group visits by provider, providing subtotals of number and cost of visits for each provider, and providing provider tax id number if available. In addition, if you have entered diagnoses or procedure codes for any visits, these will also be shown on the claim list. This form will make it much easier to fill out your insurance company's claim form, and you may find it helpful to attach it to your claim. If nothing else, your insurance administrator will be impressed with your organizational skills!

11. Tracking Explanation of Benefit (EOB) Statements

This screen works in much the same way as the Insurance Claim screen.

To create your EOB, click the EOBs button or use the Activities Menu. This will take you to the EOBs List screen. To create a new EOB, click the new EOB icon at the top. When you create a new EOB, FHCM will automatically assign an EOB ID. You can enter the date of the EOB on it, and select the insurance company that issued the EOB. You also must select a patient since claims and their corresponding EOBs are specific to each patient. There is also a place to enter any kind of identifying information on the form, such as a check number. Once you have filled in this information, you can assign visits to the EOB in one of two ways.

When you first create a new EOB, you are automatically taken to the EOB entry/editing screen. The top pane shows visits that are currently assigned to the EOB. The bottom pane shows all visits waiting for an EOB for the selected patient. Click the assign icon (up arrow on a pile of circles) on the right of the visit to move it to the assigned visits pane. Click the unassign icon (down arrow on a pile of circles) to remove a visit from the EOB and send it back to the bottom pane. The fields at the top will update to show you how many visits are on the EOB and the total amount paid. When you are done, click the “Done Assigning” button and you will see the finished EOB. You can revise the EOB by clicking the notebook icon to return to the assign visits screen. You will also see the notebook icon next to each visit to take you to the visit details screen for that visit.

When a visit is assigned to an EOB via this screen, FHCM automatically enters the EOB id on the visit and marks its status “Received”.

Alternatively, you can assign visits to an EOB from the Visit Details screen. You must have previously created the EOB and given it a date, but need not have assigned visits to it. In the Visit Details screen, click in the EOB field in the Status Pane; you will see a drop down list of existing EOB IDs with their dates. You can select the appropriate one to link the visit to that EOB. In this case, you should manually set the status to Received. You may find in certain instances that this method is more convenient, especially if you are creating visits at the time you receive the EOB, rather than as they occur. If your provider submits claims for you, and the first notice you get of the claim is when you receive the EOB, you also may prefer this method.

You can see a list of all existing EOBs by clicking EOBs in the Navigation pane or selecting it from the Activities menu. If the list is long, you can filter it by date range and/or patient. Select an EOB and click the Details icon to see the details of that EOB and edit it if necessary.

At the bottom of the EOB screen, you’ll see a space for notes about the EOB as a whole, which is also visible in the list view. You can attach multiple documents to the EOB. See the section Visit Attachments for more information.

12. Tracking Flexible Spending Account Claims

Tracking flexible spending accounts works the same way as tracking insurance claims. You can assign visits to FSA claims via the same two methods – from the Assign Visits screen or from the Visit Details screen. Unlike insurance claims, FSA claims are not limited to one patient; any visit with FSA status “To Submit” will be considered eligible. You should read section 10 for more information on using claims.

From the FSA list, you can navigate to the FSA claim details via the Details icon, similarly to the Insurance Claim screen. However, there is a third icon visible in the upper left – “Visits by FSA Status”. This icon will take you to a list of all visits whose FSA status is not “N/A”. You can further filter the list by FSA status, patient, provider, service or date. Note that you will be able to see visits for the current year or the previous year only since older visits will no longer be eligible for FSA claims. This screen is helpful for quickly assessing how much of your contribution you have used, and how many visits you have left to claim.

The FSA claim details screen has additional information not shown on the Insurance claim screen. If a visit on the claim was also submitted for insurance reimbursement and an EOB was received, the EOB number is shown. You can open that EOB in a new window by clicking on the EOB ID. Click Done to close the EOB popup window. At the far right of each visit are 3 icons: the last one is the standard notebook to edit the details of the visit. The first icon is a status icon which shows the same information as the FSA status icon in the visit list. The middle icon is a button with a \$ sign; clicking this button will mark the visit as having been reimbursed by the FSA administrator. FHCM will assume it was reimbursed for the full amount claimed – you can edit the amount if this is not correct. If you need to mark the status in any other way (for example to mark a dispute), you should click the revise visit icon and change the status in the visit details window. Finally, note there is a text field for entering general notes about the claim at the bottom of the screen. These comments will be visible in the FSA Claim list view.

At the bottom of the FSA Claim screen, you’ll see a space for notes about the claim as a whole, which is also visible in the list view. You can attach multiple documents to the Claim. See the section on Visit Attachments for more information.

You can print an FSA claim form attachment by clicking the printer icon or from the File menu. The FSA attachment form is similar to the Insurance Claim form. See section 10 on insurance claims for additional information.

13. Viewing FSA-Eligible Expenses and FSA Account Balance

On the navigation bar, you'll see a button for FSA expenses. There is also a button at the top of the FSA claim screens, right next to the List/Details buttons. Clicking this button will take you to a specially filtered visit list screen. This screen shows visits that are eligible for FSA reimbursement (ie the FSA status is NOT set to N/A). A drop down at the top allows you to select either the current year or the previous year (which may be of visit between Jan 1st and March 31st of the subsequent year). This screen also allows you to see how much you have submitted for FSA reimbursement, how much has been paid, and how much remains in your FSA account for the selected year. (Each visit also shows how much of the charge is eligible for FSA reimbursement). You can also filter the primary visit list for particular FSA status. However, the FSA expense screen – unlike the Visit list – focuses on a particular year and corresponds to the contribution you made to your FSA account that year. Thus this is the best place to figure out how much remains in your account, and decide what visits you would like to submit claims for.

14. Reports/Printing

14.1. List of Formatted Reports

The following reports are available via the File Menu for the related screens. Note that all reports will reflect the currently filtered entries shown on screen. Choose Print Records Being Browsed to print out all records in the current list. Many screens also have a printer icon on the top right which is a shortcut to produce the report you are most likely to want at that screen. Use the menu to see the full set of choices.

Reports Available From Visit Related Screens

- Visit Details – formatted print out of most of the detailed information entered in visits
- Visit List Grouped by Provider
- Visit List Grouped by both Patient and Provider
- Provider Expense Summary - subtotals of costs for each provider without individual visits
- FSA Expense List – list of visits eligible for FSA claims
- Tax Report – list of all tax deductible expenses grouped by Tax Year
- Travel Expense Report – list of all travel expenses grouped by Tax Year
 - For both the Tax Report and Travel Expense Report, FHCM gives you the option to override the cost/mile value entered in individual visits with a new value at Print Time. This will not change the values entered in the visits.

Reports Available From FSA Claim Screen

- FSA Claim Attachment Form (facilitates filling out your claim form)

Reports Available From Insurance Claim Screen

- Insurance Claim Attachment Form (facilitates filling out your claim form)

Reports Available From Medical Observations Screen

- Observation List – summary list of medical observations
- Medical History - detail views of currently filtered medical observations

14.2. Printing screens

In addition to formatted reports, many screens can be printed “as is”. In some cases the formatting of the print out may not be optimal. Use File – Print to print out screens of interest.

15. Workflow Examples

15.1. Scenario 1: Entering all visits and claims as they occur

This approach will produce the maximal benefit from FHCM, but is also requires the most disciplined data entry. If you have many expenses that you submit for claims yourself (especially with out of network providers), and many expenses that are eligible for both insurance and FSA reimbursement, you will probably find this approach worth the effort. Families or individuals with complex medical problems, who see many providers outside their insurer's network, or who pay for medical services that are not covered at all should consider this approach, as well as anyone who just likes to know exactly what's going on with their medical expenses.

In this case, enter each visit as soon as possible after it occurs, capturing at least the primary financial data, as well as any other information that is of value to you. Each time you submit an insurance or FSA claim, create the claim by going to the FSA or insurance claim list and clicking the "New" button. Then assign the visits you plan to submit from that screen (you will have previously entered them). Print out the claim attachment form and use it to fill out your actual claim form. Your visits will now automatically be linked to the appropriate claim and be marked as having been submitted. When you receive an EOB, create a new EOB in FHCM, and then assign visits to it. You will be able to choose from visits that have been submitted but not yet reimbursed for that insurance company.

15.2. Scenario 2: Entering visits at the time a claim is submitted

If you are primarily interested in tracking status of visits submitted for claims but do not have as much need for other information, or if you just don't have the time or inclination to enter data methodically each time a visit occurs, you can create visits as needed for claims. For this approach, when you are ready to submit a claim, first go to the Claim (or FSA) list and create a new claim. Fill out the appropriate information on top. Now go back to the visit list and create new visits corresponding to those you will submit on your claim. As you are filling in the visit details, go to the FSA or Claim fields in the status pane and choose the claim you just created from the drop down list. Be sure to set the claim or FSA status to "Submitted" when you do this. You can now go back to the Claim Details screen and print an attachment form to help you fill out your Claim Form.

15.3. Scenario 3: Entering visits after an EOB is received

This approach requires the least data entry but also provides somewhat less benefit to you. However, if most or all of your claims are submitted for you by Providers this approach may make the most sense for you. In this case, you will not track claims at all, since you don't know when they are submitted. Instead, when you receive an EOB for a claim your provider submitted, you will create the EOB first and fill out identifying information on top. Then go to Visits and create new visits for all those listed on the EOB. Mark the claim status as Reimbursed (or Denied/Dispute, if appropriate), since you have already received the EOB. Choose the EOB you just created from the EOB ID drop-down list in the status pane. Mark the status manually to EOB Received. The field

for claim number will remain blank as you will not be tracking the actual claim submission. Enter the amounts allowed and paid by the insurance company (or FSA administrator), as well as any provider write-off. The primary value of this method is making sure that all visits you are being billed for have been submitted to your insurance carrier, that the Insurer has processed them correctly, and that your provider is not billing you for expenses that were paid for by your insurer.

15.4. Scenario 4: Tracking doctor's visits without expenses (HMO)

Perhaps you are not interested in tracking expenses at all. If you get all your medical services from an HMO, and never pay anything except a copay, it probably isn't worth the time to try to track medical finances. However, you may still want to keep a history of your medical visits, treatments, etc. In this case, you will be using only the top area of the visit form, and the last 3 data entry tabs. You will not use the Status Pane at all. With this strategy, you will be using Visits similarly to Medical History, but you will also enter information about the provider, the date of the visit, the reason for the visit, etc.

15.5. Tracking medical history and following medical conditions

FHCM allows you to track medical history seamlessly, both via provider visits (as above) and via your own medical observations. The key to using FHCM for this purpose is the use of "Conditions". Conditions in FHCM are more fluid and adaptable than diagnoses. A diagnosis is a formal description of a disease or condition established by a medical professional. It is often required by an Insurer before they will pay. In contrast, a condition is your description of something medical going on with a member of your family. It may be as simple as a sinus infection or as complex as diabetes or cancer. By assigning a condition to related provider visits and your own observation entries, you will be able to tie them together and quickly retrieve a history of all entries related to that condition via the medical observations screen and medical history report. Over time, your understanding of the condition may change; perhaps you start with "facial pain" and eventually determine it to be "chronic sinus infection". Or perhaps you start with "thoracic pain" and eventually find out it's due to a "hiatal hernia". The key to using conditions is understanding that once you create a condition, you can revise its description (name) without losing the assignments you've made. In other words, if you have 2 visits and 3 observations assigned to "facial pain", and you later revise that condition to read "sinus infection", those 2 visits and 3 observations will now be associated with "sinus infection". As your understanding of a condition changes over time, you can keep your records accurate without losing the common thread that ties them together. At the same time, you can maintain notes on your understanding at each point in time by use of the many free text notes fields available throughout FHCM.

16. Suggested Filing Schemes

While FHCM does not relieve you of the need to keep paper files, it can make your filing more efficient, and help you find things easily. You may struggle with figuring out the best way to file the many papers you accumulate. Should you file statements by provider? Chronologically? By family member? Should you have separate copies of bills filed by claim? Where do you put the EOBs? With the claims? In a separate folder? With providers? How should you track EOBs so you can go back and find information when you realize that your insurer never paid for something you submitted a year ago? How do you connect all this to your FSAs? (Is your head spinning? We can relate.)

Here's a suggested scheme that the author of FHCM has found very helpful. As you receive medical statements that you know you will need to submit to your insurer, put them in a folder called INSURER-To Submit– Year (for instance, "Blue Cross – To Submit – 2008"). When you are ready to submit a claim, create the claim first in FHCM and print the attachment form. Write the Claim ID FHCM assigns to it on the top of the application form. Attach all the statements as your insurer requires, along with the form FHCM prints for you, and *file a copy of the entire packet exactly as it was submitted* in a folder called Blue Cross-Submitted - 2008, *ordering by Claim ID*. You don't need to file separate copies by provider, since you can easily find your way back to these by looking the visit up in FHCM and determining which claim it was attached to. However, if you would prefer to be able to find all of Dr. X's statements in one folder, you may wish to file separate copies of those. (I generally don't do this, but for a couple particular providers, I keep additional copies of the statements in a folder for that provider).

When you receive EOB's, log them in FHCM, and file them by the EOB ID that FHCM assigns in their own folder: EOBs 2008.

If you have visits you will not submit for any claims, you may want to have a separate file for those. (Medical Statements: Not for Submitting)

Use a similar approach with FSA claims – two folders each year: FSA-To Submit 2008 and FSA – Submitted 2008. Attach statements to the FSA application, along with FHCM's attachment form. Label the top page with the FHCM FSA Claim ID. File the packets in order by FSA Claim ID. If you are submitting claims that were previously submitted to your insurer, and you are filing to the FSA for the amount insurance did not cover, you will want to use a copy of the EOB as evidence for the amount not reimbursed. In this case, you may want to make an extra copy of the EOB to attach to the FSA claim. (So I have one folder with all EOBs in it [that I've logged in FHCM], and then if I used any of those EOBs to submit an FSA claim, I'll have additional copies of just those particular EOBs, stapled inside my FSA claim copy). It sounds like a lot of work but once it becomes automatic, it will save you so much time later when your insurer conveniently forgets to process a claim and can't find any record that you submitted it.

As long as you have correctly entered claims in FHCM, you will be able to find any needed statement with just a few clicks. At the same time, you will be able to quickly see what was submitted at any one time, and whether the insurer missed any visits or perhaps lost an entire claim. Again – this may sound like a lot of work, but honestly, this system

has saved me a lot of time, a lot of stress, and a lot of money when the insurer insists that half the visits I submitted were not on a claim.

You may also find it helpful to scan statements as received. I've found Fujitsu's Scansnap line helpful. They're fairly fast and small enough to keep next to you as you're working (but not inexpensive unfortunately). There's also some helpful information on moving towards a paperless workflow at Brooks Duncan's website, www.documentsnap.com. Lucion makes a very helpful (but also not inexpensive) document management program called Filecenter.

17. Calculated Values

17.1. OOP – Insurer

The difference between the Insurance Allowed Amount and the Insurance Paid Amount.

17.2. OOP – Patient

The total of all amounts you are responsible to pay: Provider Billed Amount – Provider Write-off - Insurance Paid Amount – FSA Paid Amount + Travel/Miscellaneous Expenses.

17.3. Tax Deductible Amount

Patient Paid Amount – FSA Paid Amount + Travel/Misc Expenses. For the purpose of calculating this value, it is assumed that payments were made in the same year as the visit. If you made your payment in a different year than the visit occurred, you may need to manually adjust your tax deduction. Unlike the FSA eligible amount, this calculation is dependent on your actual payments entered, rather than the amount you are supposed to have paid. Consult your accountant about any tax-related questions.

18. Frequently Asked Questions (FAQ)

18.1. I have entered a lot of expenses, including payments, but FHCM still says my OOP costs are zero, or much less than they should be.

The value for OOP-Insurer (which is the value shown on the dashboard) is based on the insurer's understanding of what you have paid. This value will remain zero until the insurance status is marked *Reimbursed* since the program doesn't know how much insurance paid until the claim has been processed. Check to make sure all the relevant visits are marked *Reimbursed* (or *Denied/Dispute*).

18.2. Okay, but even after I mark the visit *Reimbursed* the OOP-Insurer value still seems too small.

From the Insurer's point of view, OOP cost is based on the difference between what they allow and what they actually pay. Therefore, if the amount allowed for a service is less than what was billed, OOP-Insurer may well be less than what you actually are responsible for. On the other hand, OOP-Patient (not shown on dashboard, but shown on both Service and Family Member detail screens), is based on what you actually are responsible for paying. (Note – it is not based on what you actually *did* pay – the assumption is that you did or will pay as much as you owe. If you don't, that's between you, your provider, and your provider's collection agency. Not that I've ever heard from a Collection Agency myself. I've just heard stories from other people. Really.)

18.3. Is there any way to see how much I actually *paid* within a given period of time?

Yup. The Tax Deduction report is based on your actual payments rather than what you are responsible to pay, since tax deductions are usually dependent on when the payment occurs. (At least we think that's true – but don't complain to us if the IRS doesn't agree. We're not tax experts, and we don't even play them on TV. Consult your accountant and let us know if we don't know what we're talking about)

18.4. When I try to edit something in a separate window, I get a message saying I can't change it because it's being edited in another window.

It's not possible to edit the same thing (eg same visit) in two places at once. Normally this should not happen as FHCM goes to great lengths to prevent you from doing this. However, should you somehow manage to do this, go back to the first window and click out of whatever field you were in. Then you should be able to make changes in the secondary window.

18.5. Sometimes when I change a value, totals don't seem to immediately change.

Most calculated values update instantly, however in some instances, a calculated value may not update until you click somewhere outside that field,

on a part of the screen that does not contain data. Click on a blank area to trigger a refresh and recalculation of data.

18.6. Why don't I see the attachments area at the bottom of my Visit Details screen?

You may have the visit open in a windowed view. If you view visits by clicking on the notebook icon from a list of visits, claims, EOBs, etc, the visit will open in a floating window. This window does not have the full contents of the Visit Details screen. It is intended for quick changes to a visit without losing your place in a list. To see the attachment area, click the Visit Details button at the top of the list window.

18.7. How have I managed to live without FHCM up until now?

Some things must forever remain mysteries

18.8. FHCM has changed my life. I'd like to donate a large sum of money to FHCM Software.

Just e-mail us at miracles@FHCM.com.

Unless you're serious. In which case, use our real e-mail address.