Document Quick Links:

IMPORTANT REMINDERS FOR SCHEDULING APPOINTMENTS 1
SCHEDULER COLUMNS – WHAT EACH ITEM MEANS 2
STANDARDIZED VISIT CODES 4
VISIT MODE 8
APPOINTMENT STATUS 10

IMPORTANT REMINDERS FOR SCHEDULING APPOINTMENTS

- **Do not pre-block blank lines into the scheduler** – this eliminates the ability to track availability, look for openings, and generate the 3rd next available appointment report.
- Use the time-bar along the top of the Day Book scheduler to see what spaces are available that day or switch to a different view that shows the time along the left-hand side.
- The scheduler is a tool to schedule patients and generally manage a provider's day. Appointments should be added to the patient chart because they are showing that care was planned/provided. Everything entered and linked to a chart in the scheduler will appear in the patient's chart in the Encounter folder.
- Avoid using the scheduler for patient "reminder" calls (e.g. Reception called the patient, no answer), as these will clutter the patient's record – these can be entered in another way.
- Avoid using the schedule for staff communication – use tasks/messages or add a reminder to the relevant patient's chart.
- There are many different types of providers who are accessing the same patient record. The more consistent each person is with scheduling, the more reliable and relevant the information will be to the other providers who need to access the chart or who need to find out what care the patient received or what care the patient is scheduled to receive in the future.
- Care and consideration are required when booking appointments. Tactfully asking what the visit is regarding (i.e. Visit Reason) will help in scheduling the type of appointment, the appropriate provider, the length of the appointment, as well as any room preparations needed.
- A variety of appointments is preferred as opposed to a group of the same types of appointments back to back, especially those that require extra set-up, room prep, and a longer appointment time. For example, it is not recommended to book a large amount of complex visits, procedures, pap smears, and full physicals back to back.
- **Ensure a patient chart is attached** (i.e. you can see the chart number). Patient encounters must be linked to a valid chart.

The following descriptions focus on booking appointments in the Day Book view, however, most elements are available (and should be utilized in the same way) in the other views that are available.

SCHEDULER COLUMNS – WHAT EACH ITEM MEANS

The Day Book view will appear differently based on the option selected for View Type and whether or not any status has been "hidden". Appointments that have been marked as "No-Show", "Rebooked" or "Cancelled" will appear with a line through the text.

View Type: ○ Scheduler ◉ Provider ○ Biller

Hide Status: ☐ No-Show ☐ Rebooked ☐ Cancelled

Provider View – *The order shown in this view has been used for the descriptions below.*

HR	MN	Code	Mode	#	Chart		First Name	Last Name	Visit Reason		Diag. 1		Fee 1		AS	DS	TM	RP	TK	MG	BS	Resource	Room	Payor	M	
00	00	R	DE	3		...				...		...		...		I	-	-	-	-	I					-

Scheduler View

HR	MN	Code	Mode	#	Chart		First Name	Last Name	Visit Reason		Service Location	Resource	Room	AS	TK	MG	Diag. 1		Fee 1		Payor	DS	BS	TM	F
00	00	R	DE	3		...				...					-	-		...		...		I	I	-	

Biller View

HR	MN	Code	Mode	#	Chart		First Name	Last Name	Diag. 1		Fee 1		BS	# Fees	Payor	Visit Reason		Resource	AS	DS	TM	RP	TK	MG	M	
00	00	R	DE	3		...				...		...	I	-			...			I	-	-	-	-		-

HR:MN – The time the booked appointment is scheduled to occur. Use 24-hour clock (e.g. 1400 = 2:00pm)

Code – The Visit Code which identifies the type of appointment that is scheduled. See below for more details and how to determine which code to choose. Use the code that corresponds to what is planned; this requires that more questions are asked prior to booking an appointment.

Mode – The Visit Mode identifies how the visit will be/was carried out – what means of communication and who was involved. See below for more details and how to determine which mode to choose. This can and should be changed if the appointment was not delivered in the same manner that it was scheduled. (E.g. It was to be a "Direct Encounter with the Client Alone", however, was a "Telephone with Third Party Alone" – such as the patient's spouse.)

- This indicates the planned length of the appointment. 1 unit = 5 minutes. This provides a guideline for how many appointments to book in the day and will show blocked time in the time-bar – a useful tool to see gaps for booking the next available appointment. Each Visit Code has a default length of time; this number can be changed to reflect the amount of time needed for the appointment. The actual times (Arrived, In-Room, Seen/Started, Discharged) can be tracked in the Encounter Detail Window, and also link to the Arrival Status.

Chart, First Name, Last Name – These 3 columns show the patient who is booked for the appointment, if applicable. When the appointment is not relating to a patient (e.g. an administrative meeting), these columns should be left blank.

Visit Reason – This identifies why the appointment has been scheduled. Whenever possible, select from the drop-down menu. If the reason is not in this list, use consistent wording to identify why this time is blocked on the schedule. More details are noted for each Visit Code below. Write in CAPITALS.

Diag 1 – This is the first diagnostic code associated with the appointment. This is essential for billing purposes and to identify what the visit was actually about. This is not filled out when booking the appointment, but rather is completed as part of the documentation/charting. A maximum of 5 diagnostic codes can be selected for each appointment – the 2nd through 5th must be added within the Encounter Detail Window.

Fee 1 – This is the first fee code associated with the appointment. This is essential for MSP billing purposes for physicians and nurse practitioners. This is not filled out when booking the appointment, but rather is completed as part of the documentation/charting. A maximum of 4 fee codes/NP encounter codes can be selected for each appointment – the 2nd through 4th must be added within the Encounter Detail Window.

AS – This indicates the appointment status. See below for more details and how to determine which status to choose.

DS – This indicates the documentation status for the appointment. If the Progress Note in the Encounter Detail Window is blank, it will show an I = Incomplete, if the Progress Note has content and has been saved, it will show a C = Completed. Any text that is entered into the Progress Note and saved will change this status, even if the provider needs to add more detail.

TM – This indicates the number of templates (Encounter Forms) used for documentation during this visit. Please note: completing and saving a template will not change the documentation status.

RP – This indicates the number of reports created from this appointment. For example, WCB reports.

TK – This indicates the number of tasks created that relate to this appointment, it does not reflect whether or not the tasks are complete.

MG – This indicates the number of messages created that relate to this appointment, it does not reflect whether or not the messages have been reviewed.

BS – This indicates the billing status of the appointment. I = Incomplete, B = Billed. This is triggered to change when the billing submission is complete for the appointment.

Resource – This indicates the resources needed/booked for the appointment. These may differ from location to location. The resource should be reserved at the same time the appointment is booked.

Room – When the patient arrives, this identifies which room number they are in for the appointment.

M – A down arrow in this column identifies that a General Note has been added in the Encounter Detail Window.

Paperclip – A paperclip in this column identifies that an attachment has been linked to this appointment. Attachments may be added prior to an appointment or scanned and linked to the appointment after it has occurred.

Service Location – This field is available in the Scheduler View and is used with inPhonite Voice; it is an automated reminder call system.

Standardized Visit Codes

Unless otherwise stated:

- A patient chart must always be attached to the appointment.
- The mode will default to DE (Direct Encounter with Patient Alone), change as needed.
- If a patient does not show up, the appointment is marked as "No-Show", it is not deleted.
- If an appointment needs to be cancelled or rescheduled (due to provider or patient unavailability), the appointment is marked appropriately, but not deleted.
- A time must be attached to the appointment (i.e. not 00:00, unless noted below).
- The units to indicate the length of the appointment should be changed to reflect the amount of time needed for the appointment.
- Time required to travel to and from an appointment are not to be included with the length of the appointment, but should be recorded separately.
- Payor should always be noted. (E.g. MSP, Patient Pay, WCB, etc.)
- *Location is currently being updated. At this time, please note this as part of the visit reason or in the general notes for that encounter, if necessary.*
- *Service Location is not available to all clinics at this time. It is associated with the automated reminder call system. More details to come.*

Code	Description	Detail	Visit Type
C	Community Visit	Use this code to book patient appointments to occur in any community setting (e.g. grocery store, coffee shop, school). Note time of scheduled appointment. Record Travel time to/from separately with Visit Code TR. Visit Reason - Picklist or appropriate standard free-text from your care area. *Location - This is being updated. Please note the location as part of the visit reason or in the general notes for that encounter at this time.*	Off-Site
Consult	Consultation	Use this code to book patient appointments that will include a comprehensive assessment from the provider's area of expertise with the intention of referring the patient to another member of the interprofessional team. Visit Reason - Picklist or appropriate free-text from your care area.	On-Site
DT	Diagnostic Test	For clinics in a facility only. Use this code to book patient appointments for diagnostic services. Provider - Book under the appropriate generic provider X-Ray, Lab, Echo, etc. Visit Reason - Picklist or appropriate standard free-text from your care area. (e.g. Mantoux, Urine Dip, etc.)	On-Site

ER	**Emergency Room**	For clinics in a facility that have an Emergency Room covered by providers from the clinic. Use this code to book Emergency Room visits only. They may be entered retrospectively and may be outside of clinic hours. Visit Reason – Picklist or appropriate standard free-text from your care area. ER trumps other visit codes such as Proc, LA, PN, etc.	On-Site
G	**Group Medical/Education**	Use this code to book patient appointments that will occur in a group setting, on-site. Visit Reason – Picklist or appropriate standard free-text from your care area. All patients attending a group appointment must be booked using Group Booking functionality. Patients who are attending the group virtually (via telephone or videoconference) should be booked into the group with visit code V. Reserve other providers as needed through the Group Booking (creates reservation block). If desired, these times can also be blocked on the provider's schedule using visit code X. G trumps visit codes such as LA, SA, PN; V trumps G.	On-Site
GPS	**GP Specialist**	For clinics only. Use this code to book patient appointments delivered by a Family Physician/General Practitioner doing speciality work, regardless of location. Visit Reason – Use the format "Specialty-Reason" (E.g. Oncology-Consult, Oncology-Chemo). *Location – This is being updated. Please note the location as part of the visit reason at this time.* GPS trumps H, I, O.	On-Site
H	**Home Visit**	Use this code to record patient appointments that occur in at the patient's home (private residence, correctional facility, shelter). Note time of scheduled appointment. Record Travel time to/from separately with Visit Code TR. The patient's home address should be confirmed at time of booking. Visit Reason – Picklist or appropriate standard free-text from your care area. H trumps other visit codes such as LA, SA, Minor, etc.	Off-Site
I	**Inpatient Visit**	Use this code to record patient contacts in a hospital setting. For all patients except those deemed Long Term Care - either waiting for placement or due to no separate LTC facility. Visit Reason – Picklist or appropriate free-text from your care area. Note the difference between an urgent call-out versus rounds using the format "Call-out – *Reason*" or "Rounds".	Off-Site
LA	**Long Assessment**	Use this code to book patient appointments that require an extended amount of time. **First Prenatal** visits are included here as they require a longer appointment time. Visit Reason – Picklist or appropriate standard free-text from your care area. (e.g. Aviation Medical, First Prenatal)	On-Site

Minor	Minor Procedure	Use this code to book patient appointments that require set up for a minor procedure. Visit Reason – Picklist or appropriate standard free-text from your care area. (e.g. Pap, Wedge Resection, Sutures)	On-Site
N	Note, Patient Not Seen	This is not an appointment, but rather a communication note relating to a patient that needs to be documented as part of the patient's medical record. A patient chart is attached. **Time should be 00:00** (to avoid confusion when looking at the day's schedule, to prevent a patient call-out, and for reporting purposes). Visit Reason – Picklist or appropriate standard free-text from your care area. *Exception: Interprofessional Team Care Planning* *Patient-related care planning/review sessions which have more than one provider and no patients should be booked using the Group Booking functionality. Multiple providers can be included. Use the actual time of the meeting. All patients should be added using Visit Code N.*	Other
O	Outreach	Use this code to book patient appointments that occur at an outreach clinic or other outreach location not otherwise defined. NH Primary Care Clinics - this will be used for clinics on reserve Interprofessional Teams - this will be used for Primary Care Home visits when the team is not co-located Visit Reason - Picklist or appropriate standard free-text from your care area.	Off-Site
PN	Prenatal	Use this code to book patient appointments for ongoing prenatal care, *excluding the first prenatal visit*. (First prenatal visits are booked under code LA.) Visit Reason – Use the format "**Prenatal- # weeks**"	On-Site
Proc	Major Procedure	Use this code to book patient appointments that require set up for a major procedure. Reserve the procedure room separately, as needed. Visit Reason – Picklist or appropriate standard free-text from your care area. e.g. Mole Removal, IUD Insertion/Removal, Vasectomy, Incision & Drainage	On-Site
Q	Quick Check	Use this code to book patient appointments for a single symptom, one minor complaint. Visit Reason – Picklist or appropriate standard free-text from your care area.	
R	Routine	Use this code to book patient appointments with any provider who is providing direct patient care for the patient/patient's family, etc. occurring on-site. Note payor as needed (e.g. WCB, Patient Pays). Visit Reason – Picklist or appropriate standard free-text from your care area. Note: "Follow Up" is not sufficient – state what the visit is actually about	On-Site

RC	**Residential Care**	Use this code to record patient appointments that occur in: Long Term Care (or deemed LTC and in a hospital facility - either waiting for placement or due to no separate LTC facility), Residential Care, Assisted Living, Group Homes. Note time of scheduled appointment. Record Travel time to/from separately with Visit Code TR. The patient's residential care address should be confirmed at time of booking. Visit Reason – Picklist or appropriate standard free-text from your care area. Note the difference between an urgent call-out versus rounds in the using the format "Call-out – Reason" or "Rounds". RC trumps other visit codes such as LA, SA, Minor, etc.	Off-Site
SA	**Short Assessment**	Use this code to book patient appointments that are not routine. May require more time and/or other resources than a routine visit. Visit Reason – Picklist or appropriate standard free-text from your care area. (e.g. Driver's Medical, CDM Annual Visit)	On-Site
TR	**Travel**	This is not an appointment, but rather a way to note travel time for a provider to/from/between off-site appointments, so that the provider might better manage their schedule. (e.g. Travel between home visits, travel to outreach locations, travel to off-site meetings, etc.). **A patient chart is never attached.** Note the time (i.e. do not book under 00:00), change the number of units as necessary. Visit Reason – Use the format "Destination Reason" (i.e. "Home Visit", "Off-site Meeting", "Outreach", etc.)	Other
U	**Urgent**	Use this code to book patient appointments that are required due to being urgent/crisis/unplanned, booked on request by the provider (MD, NP, RN, Allied Health, etc.) or patient-driven (e.g. MH&A crisis) in any location. Visit Reason – Picklist or appropriate standard free-text from your care area. If off-site, include the location as the second part of the visit reason (e.g. "Reason-Home").	On-Site or Off-Site
V	**Virtual**	Use this code to record patient or patient-related appointments that occur in a virtual setting - via telephone, videoconference, telehealth/telemedicine, email. Change the Visit Mode as appropriate. It may be an appointment between patient & remote provider; remote patient & site provider; provider & patient's family/caregiver; provider & other provider/specialists; provider & external party (such as RCMP, school…), etc. A patient chart is attached. Visit Reason – Picklist or appropriate standard free-text from your care area. (e.g. "INR", "Bereavement", "Results", "Glucose Monitoring", "Education") Note the time (i.e. do not book under 00:00), change the number of units as necessary. Note: Do not record attempted calls separately (i.e. 1 entry if called 3x before reaching, enter details in the Encounter Detail Window). A progress note is required for virtual appointments.	Virtual

VS	**Visiting Specialist**	This code is only to be used for appointments with Visiting Specialists that are occurring in the clinic. Time slots may be pre-booked for Visiting Specialists only. Change the number of units to accommodate each specialist's needs/requirements. Provider – Book under the appropriate provider (it may be generic if the providers for that specialty rotate). Visit Reason – Appropriate standard free-text per specialist. (e.g. "Initial", "Follow Up", "1 Year Check", etc.)	On-Site
W	**Walk-In Clinic**	For clinics/facilities that provide a set time for Walk-In Clinic Appointments covered by providers working in the clinic space. (Not simply that the patient "walked in", didn't book ahead, or was seen on the same day.) Visit Reason – Picklist or appropriate standard free-text from your care area. W trumps other codes such as Proc, R, etc.	On-Site
X	**Miscellaneous Time Block**	This is not an appointment, but rather a way to note a miscellaneous time block for a provider, so that the provider might better manage their schedule. (e.g. breaks, meetings, etc.). **A patient chart is never attached.** Note the time (i.e. do not book under 00:00), change the number of units as necessary. Visit Reason – "Break", "Lunch", "Meeting", "Charting", "Do Not Book" Items that follow a pattern should be booked using Reservation blocks - these will only show on the Time Bar, not in the list of appointments for the day. If desired, use this code to block the time set aside using the Reservation Block so that it will show in the list of appointments – this is helpful to avoid double-booking a provider.	Other

Visit Mode

The visit mode defines how the the appointment was carried out and with whom. Not all modes are used at this time.

Mode	Description	Details
CP	*Client Portal with Client Alone*	*Not used at this time.*
CP	*Client Portal with Client and Third Party*	*Not used at this time.*
CP	*Client Portal with Client in Group*	*Not used at this time.*
CP	*Client Portal with Third Party Alone*	*Not used at this time.*
DE	Direct Encounter with Client Alone	Patient appointment that occurs in person, regardless of location.
DE	Direct Encounter with Client and Third Party	Patient appointment that occurs in person, regardless of location.
DE	Direct Encounter with Client in Group	Patient appointment that occurs in person, regardless of location.
DE	Direct Encounter with Third Party Alone	Patient-related appointment that occurs in person, regardless of location.
EM	Email with Client Alone	

EM	Email with Client and Third Party	
EM	Email with Client in Group	
EM	Email with Third Party Alone	
HL	*Help Line with Client Alone*	*Not used at this time.*
HL	*Help Line with Client and Third Party*	*Not used at this time.*
HL	*Help Line with Client in Group*	*Not used at this time.*
HL	*Help Line with Third Party Alone*	*Not used at this time.*
MM	*Mobile Messaging with Client Alone*	*Not used at this time.*
MM	*Mobile Messaging with Client and Third Party*	*Not used at this time.*
MM	*Mobile Messaging with Client in Group*	*Not used at this time.*
MM	*Mobile Messaging with Third Party Alone*	*Not used at this time.*
OCA	*Online Call with Client Alone*	*Not used at this time.*
OCA	*Online Call with Client and Third Party*	*Not used at this time.*
OCA	*Online Call with Client in Group*	*Not used at this time.*
OCA	*Online Call with Third Party Alone*	*Not used at this time.*
OCA	*Online Call with Video with Client Alone*	Videoconference patient appointment with virtual visit code.
OCA	*Online Call with Video with Client and Third Party*	Videoconference patient appointment with virtual visit code.
OCA	*Online Call with Video with Client in Group*	Videoconference patient appointment with virtual visit code.
OCA	*Online Call with Video with Third Party Alone*	Videoconference patient-related appointment with virtual visit code.
OCH	*Online Chat with Client Alone*	*Not used at this time.*
OCH	*Online Chat with Client and Third Party*	*Not used at this time.*
OCH	*Online Chat with Client in Group*	*Not used at this time.*
OCH	*Online Chat with Third Party Alone*	*Not used at this time.*
OCL	*Other Computer Link with Client Alone*	*Not used at this time.*
OCL	*Other Computer Link with Client and Third Party*	*Not used at this time.*
OCL	*Other Computer Link with Client in Group*	*Not used at this time.*
OCL	*Other Computer Link with Third Party Alone*	*Not used at this time.*
PP	*Provider Portal with Client Alone*	*Not used at this time.*
PP	*Provider Portal with Client and Third Party*	*Not used at this time.*
PP	*Provider Portal with Client in Group*	*Not used at this time.*
PP	*Provider Portal with Third Party Alone*	*Not used at this time.*
TL	Telephone with Client Alone	Patient appointment with virtual visit code.
TL	Telephone with Client and Third Party	Patient appointment with virtual visit code.
TL	Telephone with Client in Group	Patient appointment with virtual visit code.
TL	Telephone with Third Party Alone	Patient-related appointment with virtual visit code.
TM	Telemedicine with Client Alone	Telehealth/telemedicine patient appointment with virtual visit code.
TM	Telemedicine with Client and Third Party	Telehealth/telemedicine patient appointment with virtual visit code.
TM	Telemedicine with Client in Group	Telehealth/telemedicine patient appointment with virtual visit code.
TM	Telemedicine with Third Party Alone	Telehealth/telemedicine patient-related appointment with virtual visit code.

Appointment Status

The appointment status is a useful prompt for providers and staff. Using these codes:

- Lets the provider know that a patient has arrived or has been put into an examination/treatment room.
- Lets the Receptionist or Primary Care Assistant (PCA) know that the provider has started the appointment.
- Lets the PCA know when the appointment is complete.
- Shows if the appointment was rebooked or cancelled.
- Shows if the patient did not show up for their appointment (or was unavailable when the provider went to meet them off-site).
- Records the cycle time of patient visits – including waiting time and length of appointment.
- Can be helpful for increasing office efficiencies.
- *Note: Appointment Status is not relevant to some Visit Codes such as "N" (Note, Patient Not Seen) and "TR" (Travel).*
  - *For "Note, Patient Not Seen", a provider may use the S (Start) and D (Discharged) if they wish to record the length of time spent on that note/task. This is not required.*

Code	Description	Detail
A	Arrived	Use to mark the time the patient arrived for their appointment.
I	In Room	Use to mark the time the patient was put into an examination/treatment room.
S	Seen/Start	Use to mark the time the provider starts the appointment.
D	Discharged	Use to mark the time the patient appointment is complete/finished.
N	No Show	Use to identify that the patient did not show up for their appointment on-site, or was unavailable when the provider went to meet them off-site.
R	Rebooked	Use to identify that the appointment has been rebooked and will no longer occur on this date.
C	Cancelled	Use to identify that the appointment has been cancelled – either by the patient or provider.