

# **User Release Notes**

for RADNET rRIS  
Version 1.0  
Build 28

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## **1. Purpose**

This document describes some of the new features and changes implemented in rRIS as of the end of Sprint 28. This version of rRIS is referred to as Build 1.28.

Only features which can be visually demonstrated to the user will be outlined in this document.

## **2. Intended Audience**

This document is created by the rRIS Development team for the RadNet RIS management team.

## **3. Installing/Accessing the Application**

The installation guide for the rRIS client have been posted to the RadNet Wiki page at <http://mdbal01rdtweb/Wiki/>

Under the RIS menu, click on the rRIS page. The credentials to access the page are:

Username: rRIS

Password: Summerside

*Please note that Build 1.28 is considered a new core release of the application and will require a reinstallation of rRIS. This is accomplished by navigating to the rRIS shared installation drive and running the CoreInstall.bat file (ex: I:\RISDeployment\CoreInstall.bat)*

If you experience difficulties accessing the application, please do not hesitate to contact Darcy Noye with the PEI RIS Development Team.

## 4. New Features and Enhancements

### Adding RVU to Billing Codes

In build 28 the Billing Code table has 2 new columns added to specify RVU values. The columns Technical RVU and Professional RVU are displayed in Figure 4.1 below.

Billing Code	Description	Version	Display Order	Technical Rvu	Profession Rvu	Active
71275	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, CHEST (NONCORONARY), WITH CONTRAST MA...	1	1	1.2	0.75	Y
71551	MAGNETIC RESONANCE (EG, PROTON) IMAGING, CHEST (EG, FOR EVALUATION OF HILAR A...	1	1			Y
71550	MAGNETIC RESONANCE (EG, PROTON) IMAGING, CHEST (EG, FOR EVALUATION OF HILAR A...	1	1			Y
71555	MAGNETIC RESONANCE ANGIOGRAPHY, CHEST (EXCLUDING MYOCARDIUM), WITH OR WIT...	1	1			Y

Figure 4.1 – Billing Code table showing Technical and Professional RVU columns.

### Real Time Alerts

The Alert configuration was introduced in Build 26. In Build 28 the alert will also be real time. Added to the Alert Configuration table patients first or last name has changed and birth date. This is for existing patients if a new patient is being added and one of these fields are changed no alert will display.

For existing patients, if the value for one of these fields are changed and do not match with the value stored in database, the user will automatically receive an alert when the field that was edited is exited. Example: User edits birth date by changing day of birth and tabs out of that field, or selects another area of the form, an alert will pop up.

Also in build 26 the alert for a Patient over the age of 65 and the modality is MR an alert was opened. This alert has been enhanced. The additional conditions must also be met for this alert to fire. In addition to the patient's age and modality type, the patient must have been prescribed Lipitor, lab result has LDL Cholesterol over 100 and have and have heart disease captured in the Problem List.

Alert Configuration Code	Description	Alert Generator	Display Order	Active
DOBChange	Patient's Birth Date has changed. Please ensure the data is correct.	PatientBirthChanged	5	Y
FirstNameChange	Patient's First Name has changed. Please ensure the data is correct.	PatientFirstNameChanged	4	Y
GetLabWork	MR Patients age 65+ with Heart Disease on Lipitor and LDL > 100. Make sure you have up-to-date lab results	MR165PlusHeartDiseaseLipitorAndLDL100Plus	1	Y
LastNameChange	Patient's Last Name has changed. Please ensure the data is correct.	PatientLastNameChanged	3	Y
NoPhone	Patient has no phone number	PatientMissingPhoneInfo	2	Y

Figure 4.2 – Alert Configuration lookup table

The Alert Configuration Code and Description can be entered as the user wishes. The Alert Configuration Code must be a unique value.

The alert generators are hard coded values in the application. The cell under the Alert Generator column is a list box and currently has the following values:

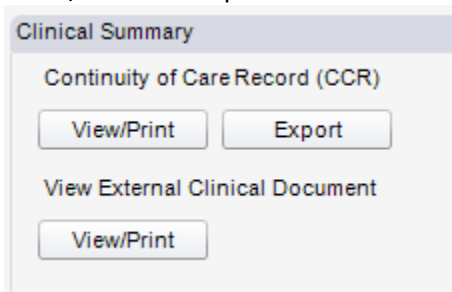
- PatientBirthChanged
- PatientFirstNameChanged
- PatientLastNameChanged
- PatientMissingPhoneInfo
- MRI65PlusHeartDiseaseLipitorAndLDL100Plus

### Clinical Summary – MU Requirement 170.304.i

The generation of the Clinical Summary structured xml file actually satisfies pieces of requirements.

- 170.304(f) Copy of Electronic Health Record
- 170.304(h) Clinical Summaries
- 170.304(i) Exchange Clinical Information / Patient Summary

On the Clinical Summaries section within the Patient Visit 2 buttons were added View /Print and Export.



**Figure 4.3 – Clinical Summary – CCR buttons for View/Print and Export**

Basically you have the option to View the Patient CCR in a browser window. Printing is covered off by using the right click print on the open record.

Exporting the file allows the user to specify where they want the generated XML file saved. From there it can be handled like any file in the Windows environment for printing, copying, emailing and deleting. The preview mode for the CCR looks something like this...

## RADNET, Inc. – rRIS Pre-Release Notes

Continuity of Care Record Sha-1 Hash: 08B9238EF2D85164F9F53DA28690A12070D3F1C5

**Continuity of Care Record**

**Date Created:** 2011-12-12T17:11:42Z  
**From:** Ian G Power  
**To:**  
**Purpose:** Personal Health Record rRIS

**Patient Demographics**

Name	Date of Birth	Gender	Identification Numbers	Address / Phone
Ian G Power	04-04-1978	Undifferentiated	2169	Ians address 1 Ians address 2 Ians City, CA 21244 ian.power@radnet.com  Home: (902) 222-6666 Work: (902) 222-6666

**Alerts**

Type	Date	Code	Description	Reaction	Source
Allergy	--	305 (FDB)	Sulfa (Sulfonamides)	-	Ian G Power
Allergy	--	245 (FDB)	Penicillins	-	Ian G Power

**Problems**

Type	Date	Code	Description	Status	Source
Problem	11-22-2011	10.01 (ICD9CM)	PRIMARY TUBERCULOUS COMPLEX BACTERIOLOGI	Active	Ian G Power
Problem	11-14-2011	952.9 (ICD9CM)	UNSPECIFIED SITE OF SPINAL CORD INJURY W	Resolved	Ian G Power
Problem	12-05-2011	401.9 (ICD9CM)	UNSPECIFIED ESSENTIAL HYPERTENSION	Active	Ian G Power

**Procedures**

Type	Date	Code	Description	Location	Substance	Method	Position	Site	Status	Source
Radiology	12-05-2011		CT 3 Phase [CT13]						Signed1	RadNet rRIS 1.1.28.7842
Radiology	12-05-2011		CT Head W [70460] - Head						Signed1	RadNet rRIS 1.1.28.7842
Radiology	09-03-2011		CT 3 Phase [CT13]						Scheduled	RadNet rRIS 1.1.28.7842
Radiology	10-27-2011		CT Head W & Ear, Orbit, Sella W [CT33] - Head						Cancelled	RadNet rRIS 1.1.28.7842
Radiology	11-24-2011		CT 3 Phase [CT13]						Scheduled	RadNet rRIS 1.1.28.7842
Radiology	12-09-2011		CT 3 Phase [CT13]						Scheduled	RadNet rRIS 1.1.28.7842

Figure 4.4 – Viewing CCR

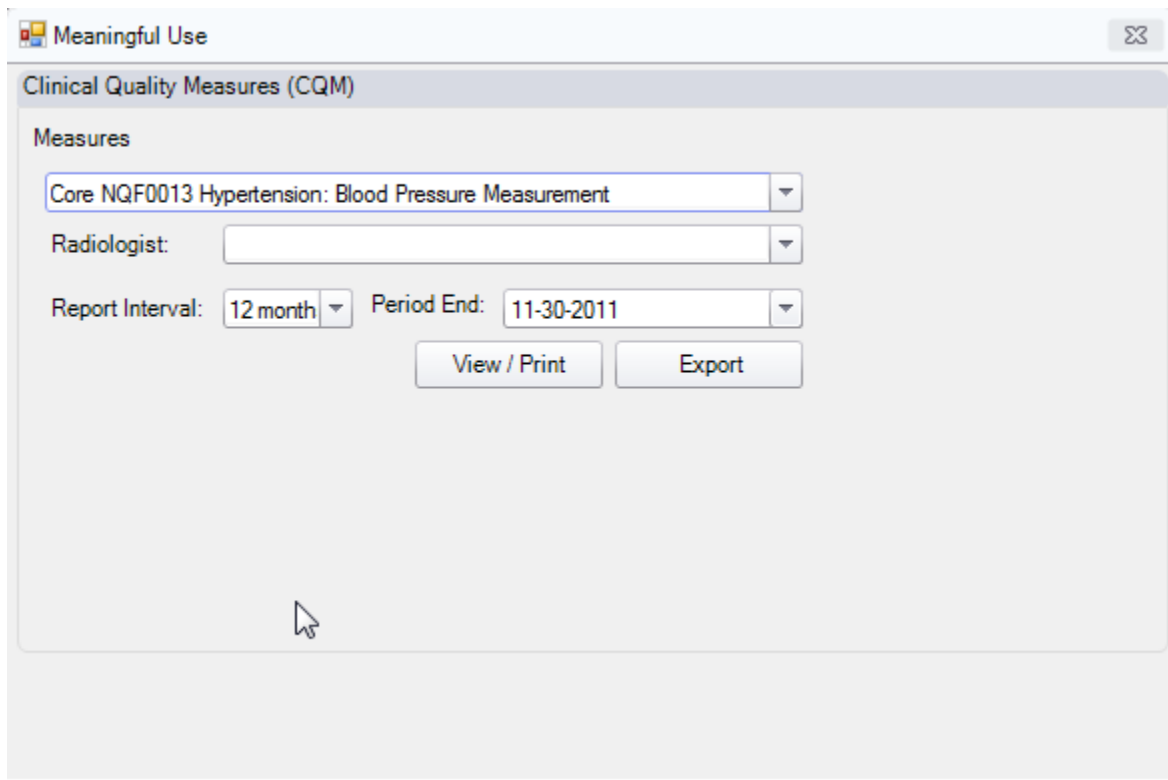
Currently we generate the following sections, but could add others as required.

1. Document Header
2. Patient Demographics
3. Alerts (Allergies)
4. Problems (ICD codes)
5. Procedures (RIS procedures\_
6. Medications
7. Immunizations
8. Results (Lab Results)
9. People (Patient information)

Information Systems (RadNet rRIS)

## Clinical Quality Measures – MU Requirement 170.304j

Under the Administration menu a new menu item Meaningful Use has been added. This opens the Meaningful Use window (we will change the name of this menu item and window to CQM or Clinical Quality Measures in a later build). The window has a series of list boxes. The first has a list of the CQM options. A radiologist list box, report interval, and the Period Ending for the report.



The screenshot shows a software window titled "Meaningful Use". Inside, there is a section titled "Clinical Quality Measures (CQM)". Below this title, there is a "Measures" label followed by a dropdown menu currently showing "Core NQF0013 Hypertension: Blood Pressure Measurement". Below that is a "Radiologist:" label followed by an empty dropdown menu. Then, there is a "Report Interval:" label with a dropdown menu showing "12 month", and a "Period End:" label with a dropdown menu showing "11-30-2011". At the bottom of this section are two buttons: "View / Print" and "Export".

Figure 4.5 – Medication data pane on MU tab

The following describes each of the CQM requirements to generate the report.

Core

c\_mu\_cqm\_0013\_hypertension –

- a) The patient must be at least **18 years of age or older** at the start of the reporting period and have at least **two encounters** with the Rad during the reporting period.
- b) An active diagnosis of **Hypertension(used icd-9 codes)**.
- c) At least one **blood pressure reading (systolic and diastolic)** should be performed and documented during the reporting period in the Vital Signs chart section.

c\_mu\_cqm\_0028a\_tobacco\_use –

- a) The patient must be at least **18 years of age or older** at the start of the reporting period and have at least **two encounters** with the Rad during the reporting period.
- b) The patient was queried about tobacco use one or more times within 24 months.

c\_mu\_cqm\_0028b\_tobacco\_intervention –

- a) The patient must be at least **18 years of age or older** at the start of the reporting period and have at least **two encounters** with the Rad during the reporting period.
- b) Documentation that the patient is a tobacco user within the last 24 months.
- c) An active diagnosis of Nondependent tobacco use disorder (**used icd-9 codes**).

c\_mu\_cqm\_0421a\_weight\_screening -

- a) The patient must be at least **65 years of age or older** at the start of the reporting period and have at least **one encounter** with the Rad during the reporting period.
- b) The number of patients in the denominator that have a normal BMI (BMI  $\geq 22$  or  $<30$ ) OR an abnormal BMI (BMI  $\geq 30$  or  $<22$ ) recorded in the Vital Signs chart section (BMI must be recorded in the six months prior to the encounter date or during the reporting period);

c\_mu\_cqm\_0421b\_weight\_screening –

- a) The patient must be aged 18 - 64 at the start of the reporting period and have had one encounter with the Rad during the reporting period.
- b) The number of patients in the denominator that have a normal BMI (BMI  $\geq 18.5$  or  $<25$ ) OR an abnormal BMI (BMI  $\geq 25$  or  $<18.5$ ) recorded in the Vital Signs chart section (BMI must be recorded in the six months prior to the encounter date or during the reporting period);

Alternative Core

c\_mu\_cqm\_0024\_child\_weight\_assessment -

- a) The patient must be aged 2 - 17 at the start of the reporting period and have had one encounter with the Rad during the reporting period.
- b) And had BMI percentile documentation (**V85.5, V85.51, V85.52, V85.53, V85.54**), counseling for nutrition (V65.3) and counseling for physical activity (V65.41) during the reporting period. (**used icd-9 codes**).

c\_mu\_cqm\_0038\_childhood\_immunization - missing

c\_mu\_cqm\_0041\_influenza\_immunization -



- a) The patient must be at least **50 years of age or older** at the start of the reporting period and have at least **two encounters** with the Rad during the reporting period.
- b) And had an influenza shot during the flu season(Jan-Feb and Sept –Dec).
- c) And have received influenza vaccine CVX code 111 or 140.

Optional

c\_mu\_cqm\_0031\_breast\_screening -

- a) The patient must be female aged 40 - 69 at the start of the reporting period and have had one encounter with the Rad during the reporting period.
- b) At least one procedure should be a mammo type(Screening).

c\_mu\_cqm\_0043\_pneumonia\_vaccination -

- a) The patient must be aged 65 at the start of the reporting period and have had one encounter with the Rad during the reporting period.
- b) And have ever received a pneumococcal vaccine CVX code 100 or 133.

c\_mu\_cqm\_0061\_diabetes\_blood\_pressure –

- a) The patient must be aged 18 - 74 at the start of the reporting period and have had one encounter with the Rad during the reporting period.
- b) And had a diagnosis of Diabetes recorded(used icd-9 codes): 250, 250.0, 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.4, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.7, 250.70, 250.71, 250.72, 250.73, 250.8, 250.80, 250.81, 250.82, 250.83, 250.9, 250.90, 250.91, 250.92, 250.93, 357.2, 362.0, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.0, 648.00, 648.01, 648.02, 648.03, 648.04

Patient in the reporting period last blood pressure reading must be <140/90 during the reporting period.

## 5. Resolved Defects

Bugs, Suggested Features and Support Issues resolved in build 1.28. The extract is taken from Redmine bug tracking system and only displays defects resolved in 1.28.

#	Status	Tracker	Priority	Subject	Category	Target version	Resolved Version
752	Closed	Bug	High	Created a Business Hours Availability Template and error returned	Admin Tools	1.27	1.28
749	Closed	Bug	High	Perform Exam > Abort > Study is not sent to Orders to Schedule	Thick Client GUI	1.27	1.28
738	Closed	Bug	High	Create outside read without insurance policy will throw error from Billing Exception	Thick Client GUI	1.27	1.28
747	Closed	Bug	Normal	Walk-In - If the room is selected when the system time is greater than the Scheduled date field, buttons are disabled	Thick Client GUI	1.27	1.28
744	Closed	Bug	Normal	Errors in Edit Billing	Thick Client GUI	1.27	1.28

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737	Closed	Bug	Normal	Add outside read patient search from enter key not initiated	Thick Client GUI	1.26	1.28
736	Closed	Bug	Normal	DB Version in help about is not updated	Web Services/DB	1.27	1.28
720	Closed	Bug	Normal	Carrier Search needs a unique ICON	Thick Client GUI	1.26	1.28
698	Closed	Bug	Normal	Organization - Couple of issues when adding sites	Admin Tools	1.25	1.28
649	Resolved	Bug	Normal	System menu location error	Thick Client GUI		1.28

## 6. Known Limitations

The following are Bugs, Suggested Features, and Support Issues found in build 1.28. This build is the current QE build and testing is ongoing. The list may increase in size. This document will not be updated or re-released.

#	Status	Subject	Category	Target version
760	New	Edit Send To report is not defaulted correctly	Thick Client GUI	1.28
761	New	Closing the Report History will through series of messages	Thick Client GUI	1.28
762	New	Seen this error when closing Report Drafted	Thick Client GUI	1.28
763	New	Report History data nugget throws error on Send To button	Thick Client GUI	1.28
764	Resolved	Walk-In Error thrown after completing required fields.	Thick Client GUI	1.28
765	Resolved	Cannot open 2 instances of Edit Patient	Thick Client GUI	1.28
766	New	Exiting application with data window open keeps record locked	Thick Client GUI	1.28
767	New	Logging off application with data window open can cause error	Thick Client GUI	1.28
768	New	CQM window > Report Interval fields need to be longer	Thick Client GUI	1.28
769	New	Drug Allergies Row Error	Thick Client GUI	1.28
771	New	CQM 00043 Pneumonia Vaccination Status for Older Adults returns error	Thick Client GUI	1.28
772	Resolved	Clinical Summary > Continuity of Care Record needs "Scheduled Study Date"	Thick Client GUI	1.28
773	Resolved	Clinical Summary > Continuity of Care Record Throws error if patient folder is missing procedures	Thick Client GUI	1.28
774	New	Patient search column for "DataNug" gone after search	Thick Client GUI	1.28
775	New	Spelling error for RVU column	Admin Tools	1.28