

Healthcare Assistant Series for Windows

Version 6.8 Release Notes

December 21, 2009 04:40: PM

Version 6.8.01

Corrections

#2053 Reports: List of On-Hold Claims - Automation Error when attempting to print

ISSUE: For agencies and users running Windows 2000, a "Variable uses an Automation type not supported in Visual Basic" Error would be shown when printing the List of On-Hold Claims report.

RESOLUTION: The report has been corrected to no longer show this error on machines running Windows 2000.

#2054 OASIS: Manifestation Sequencing Error Only does not appear as Warning

ISSUE: When an OASIS record has a "Manifestation Sequencing Only Error", the message does not appear in the error list. The Manifestation Sequencing Only Error is supposed to appear anytime a Manifestation diagnosis code is entered in M1022. Only if there was a "Clinical Domain Error" along with a Manifestation Sequencing Error would the correct messages appear in the error list.

RESOLUTION: The Manifestation Sequencing Only warning now appears correctly.

#2055 OASIS: Making Corrections to Key fields or Non-key fields does not automatically open up the new OASIS-C for editing

ISSUE: When making a correction to either key or non-key fields, the new OASIS does not automatically open up for editing. Instead the user must click on the edit button to make changes.

RESOLUTION: We have modified the application to automatically open the new OASIS record for editing when making corrections to an already submitted OASIS.

#2056 OASIS: Text from Medicare's OASIS-C Questions do not match those in the HealthCare Assistant

ISSUE: A couple questions do not match the text from Medicare's OASIS-C questions. M0032 Resumption of Care on OASIS Report states UK instead of NA - Not Applicable. M1024 Columns 3 and 4 state V- and E-Codes are allowed.

RESOLUTION: The text for these questions now matches the text from Medicare's OASIS-C questions. M0032 Resumption of Care Date now states "NA - Not Applicable" on the OASIS Report. Columns 3 and 4 for M1024 now state "V- or E-Codes NOT Allowed".

Version 6.8.00

Enhancements and Feature Requests

#2050: OASIS-C Released

ENHANCEMENT: This is our initial Release of the new OASIS-C effective 1/1/2010. All Assessments with M0090 (Date Completed) on or after Jan. 1, 2010 must be collected and submitted in the new OASIS-C format. We will be releasing tutorials and how-to videos on the new functionality.

Corrections

#2047 Reports: List of On-Hold Claims - Incorrect Filter by coverage dates of 7/7/09

ISSUE: The List of On-Hold Claims mysteriously chooses a 7/7/09 to 7/7/09 date range when the "Filter by coverage end date" option is checked and ignores the date range entered by the user.

RESOLUTION: The List of On-Hold Claims report options have been fixed to utilize the date range entered by the user when the "Filter by coverage end date" option is checked.

#2048 Reports: PPS Financial Summary by HHRG - Total cost amount is being cut off

ISSUE: The first couple of numbers in the Total Cost column do not show on the report if the amount is \$10,000 or greater.

RESOLUTION: The report was modified to show the whole amount of Total Cost.

#2049 Patient File: Notes Tab - Unable to save changes made if no rights given to view Patient Insurance List

ISSUE: A user is unable to save changes made to patient's notes if the user does not have rights to view the Patient Insurance List.

RESOLUTION: The Patient File - Notes tab was modified so a user is able to save changes made to the notes regardless of whether or not the user has rights to view the Patient Insurance List.

#2051 OASIS: Missing Validations for M1320, M1400 and M2310

ISSUE: OASIS-C Form validates OASIS based on the OASIS-C specifications mandated by CMS. OASIS-C Form is missing validations for M1320, M1400 and M2310.

RESOLUTION: We have modified the validations for OASIS-C to check for valid answers for M1320, M1400 and M2310.

#2052 Patient Insurance: Editing insurance produces an error

ISSUE: If a patient's gender is empty, editing the insurance will produce a "Conversion from Type DBNull to Integer is not valid" error.

RESOLUTION: The Patient Insurance tab was modified to handle editing of insurance with patient's gender being empty.

Version 6.7.00

Enhancements and Feature Requests

#2028 Billing: ERA files download via VisionShare are now automatically imported

ENHANCEMENT: When ERA (835) files are downloaded from the new VisionShare interface, they are automatically imported. The user will need to go to the Payments/EOB/RA option on the Billing menu to view and process these Claim payments.

#2032 Patient List: Add "# of Days Since Last Visit Posted" column

ENHANCEMENT: A "# of Days Since Last Visit Posted" column has been added to Patient List. This column gives the number of days since the last posted visit from the current date. This column can be used to help identify patients that are lacking visit notes or patients who were not discharged in the HealthCare Assistant.

#2034 McKesson Medical Supply Export: Now includes patient phone number

ENHANCEMENT: Per client's request, we have modified the McKesson Medical Supply Export executable to also export patient's home phone number.

#2036 Reports: Patient List by Referral - Add Summary by Non-Admit Reason

ENHANCEMENT: A new summary has been added to the report that gives the count of non-admitted patients by Non-Admit Reason. The Non-Admit Reason is retrieved from the Non-Admit status records in Admissions that fall within the Patient List by Referral reporting options. The new summary will not appear if non-admit patients do not appear in the report.

#2038 Patient: Added Paid column to ledger grid in Patient File

ENHANCEMENT: A Paid column has been added to the Ledger tab in the Patient File. This column shows the date and time a visit was paid via Payroll Processing. The column can be sorted by clicking on the column header. All unpaid visits will be listed on the top if sorted by date paid. Scroll or expand the Patient Info screen to the right to view the new Paid column.

#2041 Communications: Improved loading of Communications in Patient Info

ENHANCEMENT: Some internal modifications have been made when accessing Communications and their Attachments. Users who view patients with large numbers of communications and attachments should notice a significant decrease in loading time.

#2044: CAHPS data available to partners

ENHANCEMENT: CAHPS data is now available to partner vendors for use in producing and distributing the CAHPS surveys. There is no action required on the part of the user as all data comes from the normal process of using the HealthCare Assistant. The partner vendor will be able to grab the data required through their interface with our software.

#2045 Billing: 2010 PPS Pay Rates added

ENHANCEMENT: CMS has released the 2010 PPS pay rates that will become effective in 1 January 2010. These rates have been incorporated into the HealthCare Assistant. There is no user action necessary to begin seeing these new payments for claims that began 3 November 2009 or later.

Corrections

#2030 Medicare Eligibility Log: Sorting some columns causes error

ISSUE: In the Medicare Eligibility Log under the Billing Menu, clicking the headers of the Result Details, MSP Notes and Other Payor Notes columns causes a "sort order cannot be applied" error. All other columns are able to sort by clicking on their respective headers.

RESOLUTION: The loading of the columns for Result Details, MSP Notes and Other Payor Notes in the Medicare Eligibility Log has been corrected to no longer cause such an error when their headers are clicked.

#2031 Billing: CMS-1500 - Patient insurance name is showing in incorrect order

ISSUE: The order of name for primary insurance and secondary insurance is "FirstName MiddleInitial LastName" instead of "LastName, FirstName MiddleInitial".

RESOLUTION: The report was modified to print the primary and secondary insured's name in a "LastName, FirstName MiddleInitial" format.

#2033 Billing: Previewing generated claims from Make Claims window hangs application

ISSUE: Make Claims in the Billing menu, allows the user to preview the generated claims before saving them. The preview of claims opens in Windows Notepad. While Notepad is open, the HealthCare Assistant is unresponsive because it is waiting for Notepad to be closed. If Notepad is closed, the application can resume. But, in some instances where Notepad is left open and the Make Claims window is closed, HealthCare Assistant shows an error and closes.

RESOLUTION: The launching of Notepad has been changed so that when previewing the generated claims, it may be closed or left open and the Make Claims window in HealthCare Assistant remains responsive.

#2035 Reports: Patient List by Referral - Summary does not filter by Office

ISSUE: The Summary Count by Referral does not filter by Office Code if the Report Options filter by an office. However, the rest of the report does filter by office code, therefore the count of patients by referral could appear inflated.

RESOLUTION: The Summary has been fixed to filter by office to properly reflect the rest of the report if a particular office is selected in the report options.

#2037 Reports: Weekly Visit Frequency reported no data to print when multiple supplementals present

ISSUE: The report would report no data to print when one or more patients had multiple supplementals for the reporting period. The report was not able to handle more than one Case Administrator/Nurse to be returned in the data set.

RESOLUTION: The report was corrected to display the most Nurse/Case Administrator selected in the last supplemental for the reporting period.

#2039 Lookup boxes not indicating inactive items in red

ISSUE: A select number of lookup boxes throughout the application had stopped coloring inactive items in red. Items in the libraries can be marked as inactive and will appear in red when editing records throughout the application. Inactive records will not appear in the list when creating a new record unless Show Only Active Entries Upon New Record is selected in the user account (User File Maintenance).

ENHANCEMENT: The lookup boxes throughout the program have been changed for inactive items to appear in red.

#2040 Insurance: Use Patient Address setting does not load properly

ISSUE: When editing a patient insurance on the Patient Insurance screen, the Use Patient Address checkbox was being set by the checked state of Use Patient Info rather than what the user had previously saved for Use Patient Address.

RESOLUTION: The first tab of the Patient Insurance form has been changed so that the Use Patient Info and Use Patient Address are independent of each other and will load correctly regardless of each other's saved and edited state.

#2042 OASIS: Incorrect Validation Error "Item Filler 7 must be blank"

ISSUE: In certain scenarios, upon saving an OASIS record, users would receive an incorrect error "Item Filler 7 must be blank".

RESOLUTION: We have corrected the validations to no longer produce this message.

#2043 OASIS: Validation Rule for M0030 before 7/19/1999 should only apply on RFA 1

ISSUE: An improper validation error appeared for RFA 4 when the M0030 date for Start of Care was before the OASIS Implementation Date of 7/19/1999. There should only be a validation error for RFA 1, when M0030 is before 7/19/1999.

ENHANCEMENT: The OASIS Validation has been corrected to only show the OASIS Implementation Date error when M0030 is before 7/19/1999 for RFA 1.

2046 Correction to New 2010 ICD-9 List in ICD9 Add-In and Diagnosis Library

ISSUE: The DX Codes 209.70, 274.00, 453.50, 488.0, 670.10, 670.20, 670.30, 670.80 and 969.00 were coded incorrectly and the 'Effective From' date for DX Codes 768.7 and 969.7 were also incorrect in ICD-9 Add-In and Diagnosis Library. Furthermore, the new DX Codes 768.70 and 969.70 were not added in the ICD-9 Add-In List.

RESOLUTION: The ICD-9 Add-In and Diagnosis Library have been modified to correct the above issues. A patch named '2010 New ICD9 Codes Patch.exe' was also made to correct the above issues.

Version 6.6.01

Enhancements and Feature Requests

#2015 Billing: Added the ability to submit EMC files to VisionShare

ENHANCEMENT: The HealthCare Assistant is now able to submit the EMC file directly to VisionShare from within the software. A checkbox is present on the Create an EMC file tab and a button on the Manage Files tab of the Electronic Billing form. The check box will automatically submit the EMC file after it is processed or created. The button allows users to select a valid EMC file and submit the file. This feature does require a subscription to this service from VisionShare.

#2016 OASIS Import: Import Patient Code, Admission Source, Referral and Case Admin

ENHANCEMENT: Third-party Vendors can now import the Patient Code, Admission Source, Referral and Case Admin through the new Import API. If a Patient Code, Admission Source, Referral or Case Admin is provided, these fields will automatically be filled in for new Patients and Intakes in the Import Wizard.

Admission and Referring Source tables have been made accessible to those using the import functionality.

#2018 Billing: Eligibility checks admission and episode coverage for previous year

ENHANCEMENT: Eligibility now retrieves the home health patient's admission and episode coverage information for the previous year. The previous year is either one year ago from the current date or from the latest certification start date, if one exists. This will enable agencies to know if the patient has been treated in the past year and the agency that serviced the patient. No user action beyond the checking of the eligibility is required to take advantage of this new feature. Previous information will be displayed in the Patient Insurance form available from the Insurance tab of the Patient File.

#2019 Billing: Added ability to download claim reports and ERA files returned from the Medicare Intermediary

ENHANCEMENT: Users can now download the reports and ERA files resulting from claim submission files uploaded to Medicare via the RHHI. This functionality requires a subscription to VisionShare and allows an agency to eliminate the use of IVANS. The HealthCare Assistant has now integrated the uploading of EMC files, downloading of reports and ERA files as well as DDE all within the application. These features utilize the VisionShare service make the billing process much easier for agencies. This functionality is available from the Billing menu.

#2025 Plan of Care: Epocrates now does medication multiple drug interaction checks

ENHANCEMENT: We have incorporated the new Epocrates functionality to pass multiple drugs to Epocrates to receive the potential interactions with drugs ordered for the patient. Epocrates requires a Premium account to use functionality. Without the Premium account, users will see the Epocrates website, but will not have any medications appear in the web page.

#2026 OASIS: Manifestation coding errors are no longer a validation error

ENHANCEMENT: Diagnosis Manifestation coding errors are no longer marked as validation errors requiring correction prior to being able to lock assessment. Users are still alerted to DX manifestation errors reported by the CMS grouper, but these are now listed as consistency warnings. This means that agencies are now able to lock OASIS assessments with these discrepancies. HealthCare Synergy encourages clients to adhere to correct billing and coding guidelines when submitting OASIS assessments.

#2027 Billing/OASIS: A new CMS Grouper with bug fixes

ENHANCEMENT: A new CMS Grouper has been included that corrects discrepancies affecting billing. The new Grouper also corrects many Java errors users are having.

Corrections

#2017 Interface: Patient List clear filter button does not refresh list

ISSUE: Using the Clear Filter button did not refresh the list contents unless there were Patient Categories selected as a filter.

RESOLUTION: Corrected issue. A popup menu is now presented allowing the user to clear the Filter bar search items and the selected categories or clearing only the filter bar search items and then refresh list.

#2020 Billing: Eligibility Log incorrectly warns user of low Warning level

ISSUE: A Warning Level error message is entered in the Eligibility Log every time the Close button is pressed when viewing the Eligibility Log regardless of how many eligibility checks are remaining. This warning should only be entered when the remaining eligibility checks are at or below the warning level.

RESOLUTION: Warning Level error messages are now entered only when the remaining eligibility error checks are at or below the warning level specified by the user.

#2021 Reports: Revenue Recovery Section 3 displays only SOC & Recert assessments

ISSUE: Section 3 of the revenue recovery report includes all OASIS assessments. Section 3 lists assessments that have may provide a HIPPS code for billing purpose and pass all of the CMS OASIS validation rules, but still has discrepancies that could affect payment. Some clients have reported no discrepancy with the OASIS reported by this report. We have discovered that this report was incorrectly including all OASIS assessments within an episode.

RESOLUTION: The third section of the revenue recovery report has been modified to include only start of care and recertification episodes. Resumption of care and other follow-up assessments are no longer included as OASIS specification 01.60 no longer allows the billing of SCICs.

#2022 Reports: Single Communication Report - Agency's Address 2 line is printing on incorrect line

ISSUE: The Agency's Address 2 is incorrectly being shown on the City, State and Zip Code line.

RESOLUTION: The report was modified to show Address 2 after Address 1, on the same line.

#2023 OASIS: Therapy Validation Error when M0826 gets Enabled

ISSUE: In certain OASIS RFAs where M0826 is to be skipped, once M0826 is enabled and completed, the OASIS Validation gives a Service, Clinical and Functional domain error. Clearing M0826 and disabling it will not clear the validation error. Only deleting the OASIS and creating a new one without M0826 is being filled in will clear this validation error.

RESOLUTION: M0826 has been fixed to clear out properly in the event M0826 is enabled.

Version 6.6.00

Enhancements and Feature Requests

#2006 OASIS/Billing: Added the new CMS Grouper that includes ICD-9 codes effective October 1

ENHANCEMENT: CMS released a new grouper to correctly calculate the HHRG and HIPPS codes for OASIS assessments that utilize the new ICD-9 codes that will become effective 1 October 2009. We have added this new grouper to our software.

#2012 Billing: Added VisionShare DDE Access

ENHANCEMENT: VisionShare DDE functionality has been added to the HealthCare Assistant. This provides users with the ability to launch DDE from within the Has4Win. Agencies that wish to use this feature will need to sign up for the service with VisionShare to receive the required Certificate to secure the exchanged data. Using this service can replace IVANS DDE software and may represent a cost savings to our clients.

Corrections

#2010 Interface: Dashboard does not correctly select item in associated list

ISSUE: Clicking on some dashboard items would open the associated list with the incorrect filter option. For example, clicking Admitted in the Patient Status Summary would open the patient list with the Discharged filter enabled instead.

RESOLUTION: Corrected the links on the dashboard to launch the appropriate list filter.

#2011 Communications: Ability to save communications when Action or Category contains apostrophes

ISSUE: When trying to save a communication where the desired Action or Category contained apostrophes, the user would be presented with an error and be unable to save the communication.

RESOLUTION: Actions and Categories for Communications that contain apostrophes no longer prevent a Communication from being saved.

#2013 General: 2010 DX codes have corrected effective dates

ISSUE: The 2010 diagnosis codes that were added to the ICD9 Add-In list had an incorrect effective date of 2000-10-01 instead of 2009-10-01.

RESOLUTION: The effective date has been corrected to 2009-10-01 in the Add-In list and any corresponding Diagnosis Library entries that had already been imported by the user from the Add-In list.

#2014 Reports: Patient On Call List - Only Active patients with a current Plan of Care appear

ISSUE: Patients would only appear on the On Call List if they have a current Plan of Care during the period printed. A patient in a Start of Care, Recertification or Follow-up status with no Plan of Care does not appear on the On Call List. Active patients should appear on the On Call List regardless of an available, current Plan of Care.

ENHANCEMENT: The On Call List has been changed to include patients without current Plans of Care, for active with current Start of Care, Recertification or Follow-up statuses.

Version 6.5.04

Enhancements and Feature Requests

#1996 Claims: Claim Amount Settings calculates Outliers

ENHANCEMENT: The Claim Amount Settings feature found on the Claims tab of the Patient File now calculates Outlier Episodes Payments.

#1997 Reports: Revenue Recovery Report ignores amount differences less than \$0.02

ENHANCEMENT: The Revenue Recovery Report includes claims with payments that differ from the calculated amounts. This report now acknowledges differences in amounts of \$0.01 and \$0.02 as insignificant and will no longer display these on the report. This change allows agencies to focus on the large differences in claim amounts.

#1999 Troubleshooter: Include button to connect to HelpDesk

ENHANCEMENT: When attempting to open HealthCare Assistant, a message is shown to help guide the user in troubleshooting a connection or license file error. A button has been added to that message to Connect to HelpDesk, which will prompt for the Tech Number of one of Healthcare Synergy's HelpDesk support crew. This will allow a troubled machine to connect directly to a technician without the need of browsing to the installation folder.

#2000 Coding/Billing: Added the ICD9 codes that will become effective on October 1, 2009

ENHANCEMENT: The ICD-9 Diagnosis and Procedure codes that will become effective on October 1, 2009 have been added to the software; this includes E and V codes. Codes that are expiring on September 30, 2009 have been updated with the expiration date in the Add-In list as well as any codes that appear in the Diagnosis Library for each user. Codes that have the text changed by CMS have also been changed in the Add-In List. Because clients can change the description of the codes in the Diagnosis Library, these descriptions have not been updated to reflect the CMS changes. Users will need to manually modify the Long and Short descriptions of any codes in the Diagnosis Library. Long Descriptions can be found at (http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/04_addendum.asp#TopOfPage) and Short Descriptions can be found at (http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp#TopOfPage).

#2001 Reports: Patient Appointments List - Patient Name shown on following pages indicates continuation

ENHANCEMENT: To improve the readability of the Patient Appointments List, the patient's name along with '(Continued)' is repeated on subsequent pages when their appointments continue beyond the starting page.

#2002 Interface: Patient Insurance does not warn about a missing Part A & Part B date

ENHANCEMENT: When checking Medicare insurance eligibility in the Patient Insurance form the user is no longer warned that they should enter an eligibility date for Part A and Part B coverage. This check has been removed when performing the check using the Check Eligibility button on the Insurance form. The warning will still appear if performing the check from the Insurance tab on the Patient File.

#2003 Interface: Dashboard displays available updates

ENHANCEMENT: A new Dashboard item has been added to notify users of updates. For Agencies that are eligible, BETA versions are also listed.

BETA testers have the benefit of using new features and providing feedback on the functionality of the new features.

#2004 Reports: Communication List includes communication action column

ENHANCEMENT: The Communication Action was added as a column to the Communications List report by user request.

#2005 Interface: Include Intake Communications is automatically checked when viewing the Communications List

ENHANCEMENT: The Include Intake Communications check box found on the Communications tab of the Patient File adds or excludes communications from the list based on whether they have been associated with a specific Intake Episode. Excluding these communications from the list causes some users to believe that their communications have been deleted. This check box is not checked by default.

Corrections

#1998 General: Run-time error handled when using Edit, Delete, Print buttons for Status Records

ISSUE: When attempting to use the Edit, Print, Delete, or Lock buttons with no row selected in the bottom grid of the Case tab on the Patient File, a run-time 13 error would occur. This issue was introduced in a previous version of the HealthCare Assistant that remembered the last record selected after editing or deleting OASIS, POC, Supplementals, etc from this grid.

RESOLUTION: The Edit, Delete and Print buttons are disabled if no status record exists or none are selected in the bottom grid of the Case tab in the Patient File. These buttons are re-enabled when a record is selected in this grid.

#2007 Warning checks for M0090 (Date Completed) are not duplicated in the OASIS Validation form

ISSUE: A check for SOC OASIS with date completed not within the last 5-day window of the episode, and a check for ROC OASIS with date completed not within the last 2-day window of the episode are duplicated in the OASIS Validation form.

RESOLUTION: Both warning messages for M0090 have been modified to only show once in the OASIS Validation form.

#2008 Single Communication Report: Cuts off physician city, state and zip if physician address2 is in used

ISSUE: The physician's city, state and zip code are being cut off from printing if physician's address2 is in used.

RESOLUTION: The physician's address line was modified to always show the city, state and zip code regardless of whether or not the physician's address2 is filled in.

ERA: Final Claim period is incorrect

ISSUE: Importing an ERA file that contains a RAP cancellation and a Final claim payment (in this order) for a particular claim will have an inconsistency. The Final claim period will show the RAP cancellation period, not the Final claim period.

RESOLUTION: The ERA import was modified to display the Final claim period correctly.

Version 6.5.03

Enhancements and Feature Requests

#1981 Reports: Claims List has new options and groupings

ENHANCEMENT: The Claims List now has options to display RAP Claims only, Final Claims only, or Non-PPS Claims only. It is now possible to group these claims by time periods of Day, Week, Month and Year. Each grouping contains a summary followed by a summary for the entire report.

#1988 General: 7 day backup warning implemented

ENHANCEMENT: In an effort to protect client's data, we have implemented a backup warning message. If 7 days have occurred from the last time a database backup was run all users who log into the HealthCare Assistant will be told a backup is due. The backup can be performed from the menu bar within the application or using the command line backup utility. This warning cannot be disabled and cannot be prevented unless users backup every week. This warning will not prevent users from utilizing the software. Detailed information on how to backup both within the software and using the command line utility can be found in the help file.

#1990 Reports: OASIS Case Mix Average report groups by the Episode Start

ENHANCEMENT: The Case Mix Average report was grouping by the Status Date. This has been changed to use the Episode Start date instead.

Corrections

#1982 EMC/Billing: Value Codes with embedded spaces handled

ISSUE: Value codes with spaces caused an error in producing the EMC billing submission file.

RESOLUTION: Value codes are not permitted to have spaces within the value. These codes are now captured when attempting to save the claim and the unwanted spaces are removed prior to saving.

#1983 Scheduling: Cases and Admissions link no longer closes application

ISSUE: Choosing the Cases and Admissions link in the Scheduler for a patient that had Intake/Admission that was Under Evaluation or Non Admit cause an error that would close the application. This was an error that was introduced when the application remembered the last record selected in a grid on the Patient File.

RESOLUTION: The correct status record is now located when using the Cases and Admissions link in the scheduler to quickly display the Patient Cases tab.

#1984 OASIS: OASIS Error Report blank after entering initial OASIS.

ISSUE: If a user entered an OASIS which had validation errors and chose to print the OASIS Error Report from the Validation Errors window the report would be blank the first time it was printed.

RESOLUTION: OASIS Validation Errors were not being saved until after the Validation Errors window was closed. Modified the application to save the OASIS Validation Errors before displaying the Validation Errors window; this ensures the report will correctly display errors shown in the validation window.

#1985 Reports: Patient Appointment List - Date range filter displays on report header

ISSUE: The Date filter that can be selected as a report option when printing the report does not display on the report, thus someone looking at the report will not know the time frame of the visits shown on the report.

RESOLUTION: Added this report option to the report header.

#1987 Reports: Patient On Call List - Scheduled Visit summary no longer shows discipline of caregiver

ISSUE: On the Patient On Call List Report, the breakdown of scheduled visits for each patient no longer shows the discipline of the caregivers' visits being summarized in a consistent manner. This issue was introduced in Version 6.1.

RESOLUTION: The report is now able to better determine the discipline of the visit and caregiver being summarized.

#1989 OASIS Import API: Importing OASIS where many Diagnosis Library Codes exist for one ICD9 gives an HSIUR error

ISSUE: Introduced in Version 6.2.8, when importing OASIS through HealthCare Assistant's HSIOASIS API, a HSIUR error would show when the Diagnosis Selection Screen appears. The Diagnosis Selection screen appears when many Diagnosis Library Codes exist for one ICD-9 code being imported from the B1 string. The HSI User Rights error appears because it is incorrectly expecting a "Show Active Only on New" preference for the logged-in user to determine if matching inactive diagnosis library codes should appear in the Diagnosis Selector, but the API does not set the logged-in user. The error does not affect the import.

RESOLUTION: The OASIS Import API has been changed to no longer look for the Show Active Only on New preference, therefore no longer creating a User Right error.

#1991 General: HealthCare Assistant incorrectly warns for license error

ISSUE: The HealthCare Assistant incorrectly warns that there is a database error when there is really an error opening the license file.

ENHANCEMENT: The HealthCare Assistant has been fixed to report license file errors instead of incorrectly reporting that there is an error connecting to the database.

#1992 Reports: On Call List - Includes empty visits in the patient visit summary

ISSUE: The report is inserting empty visits in the patient summary.

RESOLUTION: The report has been modified to not include empty visits.

#1993 Reports: Cost Report - Worksheet S-3 Part IV correctly includes non-Routine Medical Supplies

ISSUE: Medical Supplies with HCPCS codes were included in Non-Routine Medical supplies while medical supplies without HCPCS codes were included in Other Charges.

ENHANCEMENT: Worksheet S-3 Part IV has been modified to include all medical supplies in the Non-Routine Medical supplies category regardless of whether HCPCS codes are or not.

#1994 OASIS: Importing RFA 3 & 5 incorrectly set as SCIC

ISSUE: Version 6.4.0.2 prevented users from incorrectly selecting SCIC for RFA 3 & 5 when M0090 is greater or equal to 1/1/2008 because CMS no longer allows SCICs to be billed after this date using OASIS 01.60 specifications. This was done for assessments completed through the GUI, but was not done for OASIS imported from third party vendors.

RESOLUTION: Modified the application to correctly disable the SCIC option for RFA 3 & 5 when M0090 is greater or equal to 1/1/2008 regardless of how the assessment is pushed into the HealthCare Assistant.

#1995 Report: Patients List by Referral Source sorting by Referral Source

ISSUE: Summary list of Referral Sources are not in alphabetical order.

RESOLUTION: The summary was modified to sort by Referral Source.

Version 6.5.02

Enhancements and Feature Requests

#1967 Interface: Communication Wizard now allows File Attachments.

ENHANCEMENT: Allows multiple file attachments in addition to scanning from the Communication Wizard.

Simply click on the "Attach" button to link an existing document with the communication.

#1968 OASIS: Improved Third Party ICD9 Import functionality.

ENHANCEMENT: HealthCare Assistant allows multiple ICD9 Codes in the library. Each is identified with a specific user code and this enhancement allows third party vendors to pass in the user code to ensure accuracy of the ICD9 Code and Description.

#1969 Billing: ERA includes support for longer Document Control Numbers (DCN)

ENHANCEMENT: ERA files being distributed contain a DCN that is longer than what was originally supported in the HealthCare Assistant. The application now supports DCN values up to 30 alpha numeric characters compared to our original length of 15.

#1971 Billing: Created Eligibility List to view and print the log for the Eligibility Checks

ENHANCEMENT: Added an Eligibility Log that is available from the Billing Menu. This lists the results of the eligibility check performed from the automated check that is scheduled through the Windows Scheduler or the manual Check Eligibility performed from the Insurance Tab of the patient. This list can be printed using the Print List button. Both can be filtered by checks performed in the last 3, 7 and 30 days. A new dashboard item has also been added to permit quick access to checks performed in the three ranges.

#1973 Eligibility: Added "Check Eligibility" button inside the Patient's Insurance Screen

ENHANCEMENT: Medicare Eligibility check is now available within the Patient Insurance Screen. This allows users to use the "Check Eligibility" feature right after entering the patient's policy number.

#1976 Billing: Eligibility Checks are managed on a per-click basis

ENHANCEMENT: Eligibility checks can be conducted via the Insurance Record or the Insurance Tab on the Patient File as well as the Eligibility Assistant. Checks can only be run if an existing balance remains. A balance is maintained via a registration code provided to the agency via our Registration department. The Supervisor can monitor the remaining balance, view an audit log of the clicks used as well as enter a warning level limit.

#1977 Interface: Communication setup made easier

ENHANCEMENT: A button was added to the Communications Action List that will load the Communications Category List. A button was also added to the Communications Category List to load the Communications Action List. Although these two items do not have a one to one correlation with each other, it is now easier to define both of these when doing an initial setup to use Communications.

#1980 OASIS Export: Added "Team" patient is assigned to the export data

ENHANCEMENT: We have added a new "Team" patient is assigned to field to the data that is exported via the OASIS Export Module. This module is used by many third party partners that offer OBQI, Point of Care, and Web Documentation systems. In order to use this new feature properly, users must create a custom patient category in HealthCare Assistant, called "Team". They must then create their custom team names and assign each of their patients to an appropriate "Team".

#1972 Eligibility: Show warning message if eligibility has been checked within the last 24 hours

ENHANCEMENT: A warning message is shown if patient eligibility has been checked within the last 24 hours. The message allows user to continue or cancel the current eligibility check request.

Corrections

#1966 Reports: Clicking AR by Claim Details produces a run time error

ISSUE: If an agency does not have any patient categories entered, clicking AR by Claim Details report will produce a run time error.

RESOLUTION: The report was modified to prevent the run time error from happening when clicking AR by Claim Details without patient categories.

#1970 Interface: Patient Insurance grid columns changed from HMO to Other Payor

ISSUE: The insurance grid on the Patient File shows two columns Has HMO and HMO Notes. This was added in a previous version to support the Eligibility checks. This was changed to Has Other Payor and Other Payor Notes prior to release to provide extra clarity for the user. The column names were not change to reflect this which prevented any data from displaying.

RESOLUTION: The columns were updated to reflect the Has Other Payor and Other Payor Notes and correctly populate with data entered by the user or pulled from the Eligibility Check.

#1974 Reports: OASIS Therapy Utilization help file link incorrect

ISSUE: When clicking on the help file link for the OASIS Therapy Utilization report, the user would be taken to the Maintain User Connections help file topic instead of the one for this report.

RESOLUTION: The link between the help file and the application has been fixed. The correct help file topic is now displayed for this report.

#1975 User Rights: Corrected miscellaneous bugs

ISSUE: When a value was typed into the Role drop-down, a run-time error could occur. Accounts with a value in the role drop-down would show this value in the Template column.

RESOLUTION: Corrected multiple issues with Role Templates.

#1978 Electronic Billing: ANSI 837 X098A1 (Professional) including outdated Physician Taxonomy Code

ISSUE: The electronic billing module was incorrectly including an outdated Physician Taxonomy Code (203B00000X) for professional claims (X098A1 OR CMS 1500).

RESOLUTION: We are now including the correct Physician Taxonomy Code (208D00000X) for these claims, if the option is checked in Electronic Submission Setup.

#1979 EMC: Hospice claims not being included to Electronic Billing File version 6.4.02 and up

ISSUE: Beginning with version 6.4.02, Hospice claims were not being included to the electronic billing file, if the receiver was setup under the "Intermediary" section in the receiver setup module.

RESOLUTION: We corrected it so that Hospice claims will now be included to the file regardless of what section the receiver is setup in the electronic receivers' module.

Version 6.5.01

Enhancements and Feature Requests

#1953 Reports: Episode Cost Summary - Added Projected Cost and Margin columns

ENHANCEMENT: Due to request from agencies, Projected Cost and Gross Margin Percentage columns have been added to the report. For a couple of the column titles, the word "Actual" has been replaced with "Completed" for better distinction. The Projected Cost is the sum of all projected visits from the original Plan of Care's Visit Frequency. The Projected Cost is not adjusted for additional or overriding Visit Frequency on subsequent Supplementals in an episode. The Completed Cost remains the sum of costs for all completed (posted) visits in the ledger for the claim.

#1954 Electronic Billing: Mark SOC Final Claims that do not have billable visit on SOC Date as Error

ENHANCEMENT: Billing a Final Claim for the SOC episode that does not have billable visit on the SOC Date will cause a rejection of claim. In the prior version of HealthCare Assistant, we added a check that marks those claims as a warning. However, it is still possible for clients to ignore the warning message and bill the claims.

The check was modified to mark final claims that do not have billable visit on the first day of the episode as an error instead of warning. This change will prevent agencies from billing those claims without correcting the error.

#1955 OASIS: M0470/M0476 Validation error added to prevent loss of income

ENHANCEMENT: A validation has been added to prevent the user from locking and transmitting an OASIS when the agency could lose money. This error is not required by CMS, but due to our concern for the income of our clients we felt it was significant enough to prevent the locking of the OASIS instead of a simple warning. The error is specific to Recertification/Other Follow-Up assessments when M0470 is not answered or is answered 0 and M0476 is answered 2 or 3. Essentially this answer choice is stating there are no Observable Stasis Ulcers, but the Status of the Most Problematic is Early/Partial Granulation or Not Healing. With this combination of answers the agency loses 8 points to the Clinical Domain.

#1957 Interface: Patient and OASIS Lists - Calendar Sort on Date Columns

ENHANCEMENT: Clicking the header of date columns on the Patient and OASIS Lists will sort the column by calendar order not by numeric order. Previously, clicking the header of a date column will bring all the January dates on the top of the list regardless of the year. In 6.4.04, clicking the header of a date column will bring all the earlier dates to the top of the list.

#1958 Patient Info: Selected Claim remains Highlighted

ENHANCEMENT: In the Patient Info, entering the Claims tab will now remember the selected, or highlighted, claim for the duration the Patient Info window is open.

#1960 Reports: AR By Claim (Detail) -Added ability to group by Patient Category

ENHANCEMENT: This report has a new option allowing the user to select a Patient Category that will be used to group the report details when printed. This is useful when an agency wants to see patient claims grouped by a user defined patient category. This functionality was requested by users to see the claim status (paid, on hold, etc) by marketing staff.

#1962 EMC: Decimal placement in dollar amount formats have been improved

ENHANCEMENT: The formatting of the dollar amounts in the electronic submission file have been improved to adhere to the 837 guidelines for new insurance companies clients are using.

#1965 Eligibility: Healthcare Synergy introduces the Eligibility Assistant

ENHANCEMENT: Healthcare Synergy introduces the Eligibility Assistant. For agencies who register for it, the Eligibility Assistant can be scheduled to be performed nightly (or any other preferred interval) to determine changes in eligibility for active Medicare patients. After the scheduled task is done, the active Medicare patient's changes of eligibility may be viewed in the Medicare's Insurance record in Patient Info.

Corrections

#1956: Reports: Visit Frequency Weekly Compliance - Report does not report any visits even though some exist

ISSUE: On some machines, the Visit Frequency Weekly Compliance Report would incorrectly state there are no records to print.

RESOLUTION: Visit Frequency Weekly Compliance Report now reports scheduled visits.

#1959 Interface: Database Required update message contains a typographical error.

ISSUE: The word "Update" is misspelled in the message prompt presented to the user.

RESOLUTION: Corrected misspelled word.

#1961 Reports: OASIS Status List - Fix Run-time error after printing

ISSUE: The OASIS Status List report was broken in version 6.5.0 and presented a run-time error. The report will print, but an "Object variable not set" message will be shown.

RESOLUTION: The report printing process was changed to correct this error.

#1963 Dashboard: OASIS Dashboard Items incorrectly opening OASIS List with previously saved filter preferences

ISSUE: Clicking on a link within any of the OASIS Dashboard Items opens the OASIS List with previously saved filter preferences instead of the Dashboard link filter that was clicked.

RESOLUTION: The links for the OASIS Dashboard Items have been corrected to open the OASIS List with the appropriate filter settings that are clicked on the Dashboard.

#1964 EMC: Prooflist Report incorrectly calculating the Total Expected Payment, Total Episode Amount and Total Charges

ISSUE: The Total Expected Payment, Total Episode Amount and Total Charges were incorrectly being rounded to the nearest whole number.

RESOLUTION: The Prooflist Report has been modified to correct the calculation of Total Expected Payment, Total Episode Amount and Total Charges.

Version 6.5.00

Enhancements and Feature Requests

#1924 Ledger: Warning Shown When Adding Visit Within Coverage Period of a Sent Final Claim

ENHANCEMENT: When a visit is posted to the ledger through either the Scheduler, Ledger or Routesheet, a warning is shown if the visit falls within the coverage period of a sent final claim. This warning was implemented to let data entry personnel warn the billing personnel that the complete visit details were not submitted with the final claim. The warning will recommended that an adjustment to the claim be sent to the Insurance company.

#1925 General: The HealthCare Assistant introduces the ConnectionExpert Troubleshooter

ENHANCEMENT: The HealthCare Assistant introduces the ConnectionExpert Troubleshooter. This help application will help guide users to resolve connection issues between workstations and the HealthCare Assistant server. Currently, the ConnectionExpert can help with connection problems stemming from the firewall of the AT&T Global Dialer, an application some agencies use to submit OASIS and claims. The knowledge of the Troubleshooter will be expanded upon in future versions. The intent is to put the knowledge of our support desk into this tool so that users can help themselves if a problem arises rather than waiting for help from our support desk.

#1926 Reports: OASIS - Case Mix Weight Analysis

ENHANCEMENT: The Case Mix Weight Analysis Report in the OASIS Group has been added to HealthCare Assistant. Given a date range, this report will display the average case mix by month for the date range given. The purpose of this report is for agencies to see a month-by-month average of their case mix scores to ascertain fluctuations in either: the accuracy in which OASIS are completed, or the severity of patients currently being cared for and admitted.

#1927 General: ConnectionExpert evaluates license file issues

ENHANCEMENT: The ConnectionExpert, which debuted in version 6.4.02, now includes the ability to evaluate license file issues that may occur across network installations. Users are now given suggestions to correct selected network issues that are preventing the software from accessing the license file. An executable program has also been included that can be executed on the server to evaluate potential firewall issues that are preventing workstations from accessing the HealthCare Assistant database.

#1930 Billing: Medicare Eligibility Processing

ENHANCEMENT: It is now possible to check a patient's Medicare eligibility from within the HealthCare Assistant by clicking the "Check Eligibility" button found on the Patient's Insurance screen. An eligibility inquiry is sent electronically to Medicare and the response is processed within a minute. Part A, Part B and the effective dates are updated in the Patient's active insurance record. Users are also informed if this patient is under an HMO or MSP. This feature will assist agencies in quickly checking whether a patient has switched to Medicare Advantage or Medicare as a secondary payer, thus reducing billing errors and lost revenue.

#1931 OASIS: Import wizard requires street address

ENHANCEMENT: The OASIS Import Wizard is used to pull in OASIS assessments from a standard OASIS submission file and third party vendors that push data into the HealthCare Assistant. The patient's street address is now a required entry. If this is not present in the imported data, users will need to enter this information during the import process.

#1933 Billing: MSP and HMO coverage is captured from Medicare eligibility check

ENHANCEMENT: When the eligibility check is made to see if a patient is eligible for Medicare coverage, the patient's HMO and Medicare Secondary Payer information is now captured and displayed to the user on the grid found on the Insurance tab of the Patient File as well as the actual insurance record for the patient. Based on this information agencies are informed of the need to get authorizations for visits as soon as possible and avoid being forced to do free visits.

#1934 Patients: Added the ability to archive former patients

ENHANCEMENT: An Archive checkbox has been placed on the Patient file in the lower right corner allowing agencies to exclude patients that should no longer appear in the Patient List. These will be patients that are deceased, moved out of the area or have NOT been seen by the agency in quite some time. When a patient is marked as Archived, they will no longer be included in the Patient List by default, thus resulting in a much smaller list that will load faster. An agency can check the Include Archived filter box at the top of the Patient List to include previously archived patients if they again receive services through the agency. The Patient Summary Dashboard item has also been updated to display only Active patients; thus all Archived patients are no longer included in the Patient Dashboard summary.

Adding an intake to an archived patient will cause the patient to lose its Archived status.

#1936 Electronic Billing: Check for Medicare claims without Coverage Type

ENHANCEMENT: A Medicare claim may be rejected due to the coverage type not being specified. To prevent this type of rejection, a check was added to the Electronic Billing Claim Preview screen to not allow a claim to be submitted if the Medicare insurance for the patient does not include Part A and/or Part B, implying Medicare ineligibility.

#1937 Patient Insurance: Allow saving of Medicare insurance without Coverage Type

ENHANCEMENT: With the introduction of Medicare Eligibility Processing, a Patient Insurance may now be saved without the Coverage Type. While Part A and Part B must be specified for billing purposes, the user will be warned if attempting to save a Medicare Insurance with neither Part A and/or Part B selected.

#1946 Interface: Highlighted row's font color changed to white for new drop down lists

ENHANCEMENT: In the new drop-down lists throughout the program, the font color for highlighted rows has been changed from black to white to improve readability. The new drop down lists are used in the Edit Patient Demographics, Patient Insurance and Payroll Processing screens.

#1947 Reports: Statistical - Patient Census Report includes option to include Under Eval Patients

ENHANCEMENT: Due to client requests, a new option has been added to the Patient Census report in the Statistics Report Group. The new option is called "Include Patients Under Evaluation" and is checked by default. With the option checked, the report will retain its prior functionality, which was to include Under Eval Patients. However, unchecking the option will now force the report to not include Under Eval patients in any of its content.

Also, the report was modified to not include non-admitted patients.

#1948 Communications Scanning Tool - Prompt for file name

ENHANCEMENT: In the prior version of HealthCare Assistant, scanned documents were automatically given a random file name. To be more user friendly, we have altered this tool. Users will now be prompted to enter the file name of the document before starting to scan. For a document with multiple pages, each page will have [file name + '_p' + incrementing number] as the file name.

#1951 General: Eligibility functionality has been linked to a registration code

ENHANCEMENT: The ability to check the eligibility for patients has been added to the HealthCare Assistant software and is available on the Insurance tab of the Patient File. In order to successfully check eligibility an agency will need to contact us at 800 479-6374 to receive a registration code. This functionality will enable users to individually check a patient's eligibility for Medicare insurance coverage as well as receive secondary payor and HMO coverage information that are in the CMS system.

#1952 Report: Revenue Recovery Report - Modified to now check for historical OASIS that potentially have grouper errors

ENHANCEMENT: The Revenue Recovery report is used to identify episodes that potentially have errors or mistakes that the agency may be able to recoup money if the errors are corrected. We have now added a new check to this report that will analyze all OASIS entered since January 1, 2008 under the new PPS payment method. The new check will identify those OASIS that have errors in the HIPPS calculation that could potentially lead to higher payments. Once identified users should use the error message provided to correct the error. If the HIPPS code changes, the episode should be re-billed to recoup the higher payment due.

Corrections

#1928 OASIS: M0900 Validation checks improved

ISSUE: When third party vendors pass OASIS Assessments into the HealthCare Assistant a validation process is performed on the assessment for possible issues that would invalidate the OASIS and make it ineligible to submit to the state DHS. M0900 was not being validated correctly when a vendor passed in all zeros for the answer. Since the OASIS was not being marked as INVALID, it was possible to submit this to the state and receive a rejection.

RESOLUTION: The M0900 validation rules were improved to capture this potential invalid response and change the status of the OASIS Assessment to INVALID, requiring the user to validate the assessment before submitting to the state DHS.

#1929 Route Sheet: Detail List not refreshing after posting

ISSUE: The list does not automatically refresh after posting visits in the Route Sheet Detail. Posting successive visits thereafter while on the same screen would cause duplicate visits to appear in the ledger.

RESOLUTION: After posting visits, the Route Sheet Detail list is automatically refreshed.

#1932 Dashboard: Insufficient User Rights messages not being displayed

ISSUE: If a user does not have permissions to view OASIS dashboard summaries, no message was displayed informing the user the reason these summaries were not shown.

RESOLUTION: The error has been corrected that prevented insufficient user rights messages from being displayed to the user.

#1935 Reports: Supplemental POT DX dates cutting off last two digits of the year

ISSUE: The last two digits of the year were being cut off for diagnosis onset dates when printing or displaying on the screen. This prevented the correct display of the dates and showed only the month, day and century.

RESOLUTION: The onset date field has been widened to allow printing of the full year.

#1938 CMS 1500 Report: Balance Due does not reflect adjustments

ISSUE: The CMS 1500 report incorrectly calculates the Balance Due when adjustments are included to the claim.

RESOLUTION: The report was modified to correctly calculate the Balance Due for claims with adjustments.

#1939 Reports: Revenue Recovery - Incorrectly calculates the LUPA Amount

ISSUE: A few clients have reported that this report is incorrectly doubling the Expected Payment amounts for episodes with LUPA.

RESOLUTION: The report has been modified to show the correct Expected Payment amounts for LUPA episodes.

#1940 EMC: Physician Taxonomy Code not being included in Electronic billing file

ISSUE: Certain Insurance companies require the physician Taxonomy code to be included in the electronic billing file. In HealthCare Assistant, users have the option to indicate in the Electronic Receiver Setup module that the billing file should include the physician taxonomy code. Unfortunately, the system was including the correct indicator for the physician taxonomy, but without the actual taxonomy code.

RESOLUTION: We have modified the electronic billing module to correctly include the physician taxonomy code if indicated in the Electronic Receiver Setup.

#1941 ERA: Medi-Cal ERAs not displaying default payment values correctly

ISSUE: When a user processed a Medi-Cal ERA file and processed multiple payments per claim, after the first payment the amounts would not default correctly.

RESOLUTION: We corrected the Medi-Cal ERA processing to correctly default the values when processing multiple payments for the same Medi-Cal Claim.

#1942 Electronic Billing Checks: W14 incorrectly checking for Medical Supplies with zero Billing Units

ISSUE: The Electronic Billing Module contains system warnings and errors to prevent claims from being rejected. Warning 14 (Check for Zero Billing units) was incorrectly modified to check Medical supplies included to Medicare claims to make sure they do not have zero Billing Units. Medical supplies do not use billing units, but instead use the quantity field.

RESOLUTION: We modified this particular check to continue to check billing units for Visits, but not Medical Supplies.

#1943 Reports: Payroll Process List has inaccurate totals

ISSUE: The Report Summary grids at the end of the report had incorrect summary formulas so that the Caregiver Total was showing the caregivers hourly wage instead of totaling all visits the caregiver performed. The Charge Total was also incorrect showing the last caregiver payroll amount instead of the total of all visits per charge type. However, the Total Payroll amounts for each of these categories was correct.

RESOLUTION: Corrected summary total formulas for the affected reporting totals.

#1944 Reports: Medication Library Report failed to print

ISSUE: The Medication Library report would fail to print regardless of the options selected by the user. No indication was presented to the user indicating why the report would not print.

RESOLUTION: Corrected the issue that prevented the report from printing.

#1945 Interface: Charge Lookup Boxes not loading all accounts on some databases

ISSUE: Introduced in 6.1.36, some databases were negatively affected by how Medical Supplies accounts were added to the Charge lookup boxes throughout HealthCare Assistant. If the Charge lookup boxes include Medical Supplies, then the lookup box would cease to load any account codes.

RESOLUTION: The way Medical Supply accounts are added to the Lookup Boxes for Charges have been fixed to work on the databases that experienced this error.

#1949 Hospice: Added 40, 41, 42 Discharge Reason Codes

ISSUE: In 6.2.02, the codes 40, 41 and 42 were removed from the list of possible Discharge Reason Codes on the Discharge Status Record. Removing the codes was correct for Home Health Medicare patients, but these codes are required for Hospice claims.

RESOLUTION: The 40, 41 and 42 Discharge Reason Codes have been restored in the list of possible Discharge Reason Codes on the Discharge Status Record for Hospice agencies.

#1950 OASIS: M0470/M0476 not presenting a validation error

ISSUE: CMS does not provide a validation error for when M0470 is not answered but M0476 is answered. OASIS is submitted to DHS without errors, when this occurs. While this is a valid answer combination, it will deny the agency clinical points in the Grouper and possibly a lower reimbursement.

RESOLUTION: We have presented a validation error that prevents the OASIS from being locked, thus preventing an agency from losing revenue. If an assessment has M0476 answered, it is now required to answer M0470 before the OASIS is considered Valid.

Version 6.4.02

Enhancements and Feature Requests

#1911 Reports: Added HIC Policy Number to Revenue Recovery Report

ENHANCEMENT: The patient's HIC policy number was added to the first section of the revenue recovery report, thus making it easier to use when interacting with DDE and making changes to the HIPPS code and recovering lost money.

#1913 OASIS: Upgraded to the latest Home Health Gold Clinical Audits

ENHANCEMENT: The latest release of the Home Health Gold Clinical Audits tool has been included. A registration code is still required to access this functionality and is available by calling (800) 479-6374. The latest DLL corrects/updates some inconsistencies that have been reported by clients and adds the ability for adverse events which will be implemented in a future release of the HealthCare Assistant.

#1916 Reports: New Therapy Utilization Report added

ENHANCEMENT: A new report has been added to track the M0826 question that is part of the OASIS 01.60 specification. This report will allow agencies to view the therapy differential between what was entered as the frequency, scheduled and posted when compared with the M0826 value. This new report is found in the OASIS category of the Reports.

#1917 OASIS: Added the ability to print prefilled OASIS assessment forms.

ENHANCEMENT: It is now possible to print OASIS assessment forms (SOC/ROC, Recertification/Other Follow-Up, Transfer, Discharge) from within HealthCare Assistant and have some data (SOC Date, Birth Date, Patient Name and Patient ID Number) printed on the assessment form. The Patient Name and Medical Record Number also appear at the bottom of each page. These assessment forms can be printed from the Print button in the Admission/Intake portion of the Case tab for each patient. These forms can be used by any agency, but will be especially useful with the Nomadic OASIS Scanning add-on.

#1918 Report: Supplemental now includes Signature applies to all pages statement

ENHANCEMENT: A statement now appears in box 9 of the CMS 487 Supplemental Plan of Care that reads "Signature applies to all pages" if there is more than one page that prints for the 487. This allows the physician to sign any one of the pages instead of all pages and still count as a legally binding document.

#1919 Claims: Include SCIC Option removed for 2008 PPS Payment

ENHANCEMENT: 2008 PPS Reimbursement no longer allows the inclusion of significant change of conditions (SCIC) to be included in the claim. Unfortunately, many clients continue to select this option when entering the status record and the result is the claim is rejected. If a user has selected the SCIC check box, we remove it if the status date (ROC/Other Follow Up) is January 1, 2008 or higher as well as hiding the check box to prevent its inclusion in the future. This check box is still present for use when working with assessments that occurred prior to January 1, 2008.

#1920 Reports: RAP Expiration List - Sort by Expiration Date

ENHANCEMENT: A new sort option has been added to the RAP Expiration List report. It is now possible to sort ascending and descending using the Expiration Date field in addition to the existing sort for the Patient Code and Patient Name. When the Expiration Date sort is selected, the report data is sorted on the expiration date and then on the patient name.

#1922 Reports: OSHPD Visits Not Covered Identified

ENHANCEMENT: The OSHPD or ALIRTS is a report required by California and is applicable for many other states. It identifies patients by visit type, age range, diagnosis, etc. Some agencies have a habit of posting visits that are outside the plan of treatment or after a discharge which throws off the totaling of this report. The report has been modified to identify visits that are entered outside of these time periods for the agency to quickly identify and fix.

Corrections

#1909 Electronic RA: No claims are shown in drop down list if multiple patients have same claim code number.

ISSUE: A runtime error "Query returns more than one row" occurs when multiple patients have the same claim number. In early installations of HealthCare Assistance users could manually enter the claim code and it was possible to use the same code for more than one patient. Users are no longer able to manually enter the claim code, so very few clients will see this issue.

RESOLUTION: The drop down list now takes into account situation where multiple patients with the same claim code exist.

#1910 OASIS: M0210 fails to refresh other diagnosis listings after auto-import of DX code from reference list.

ISSUE: Version 6.2.05 added functionality to refresh the DX listings of the OASIS data entry forms when a user chose to automatically import a DX code from the reference list. Prior to this functionality change, users would receive an automation error if they attempted to use the same code just imported in another DX listing. Users have reported that this automation error is still received when auto-importing DX codes.

RESOLUTION: A typographical error was found that prevented M0210 from refreshing the other diagnosis listings in the OASIS form when an auto-import occurred. This error has been corrected so that all diagnosis listings are updated on the OASIS when an auto-import occurs.

#1912 Claims: CMS 1500 - Four digit diagnosis codes not being printed correctly

ISSUE: Diagnosis codes containing four or more digits would not be completely printed on the CMS1500 (08-05). For example, a diagnosis code of "E888.9" would be printed on the CMS-1500 (08-05) as "E88_9", where "_" represents a space.

RESOLUTION: The CMS-1500 (08-05) has been fixed to print the complete diagnosis code regardless of length.

#1914 Report: Weekly Schedule View 1 causes "Object not Set" error when printed from the Appointment Group

ISSUE: Report: Weekly Schedule View 1 causes "Object not Set" error when printed from the Appointment Group but not when printed from the Caregiver group. Found that the issue was introduced when we added new functionality to the report when printed from the caregiver group of which 3 categories to print on the report. We did not add this same functionality to where it is printed from the Appointment Group.

RESOLUTION: Corrected the report so that it does not cause the error when printed from the Appointment Group. We did not add the category printout functionality to the Appointment group and only left it available in the Caregiver report group.

#1915 Communication Wizard: When a Patient is selected, Certification Periods are not populated

ISSUE: For a Plan of Treatment communication, the communication wizard does not populate the Certification Period combo box when a patient is selected. This issue was introduced in 6.3.00 when a new lookup box was placed on the communication wizard.

RESOLUTION: The Certification Period combo box is now populated when a patient is selected.

#1921 ERA: Import process revised to import files and present a message when multiple Transaction Segments are present

ISSUE: In 6.4.0.0 changes were made to strip out informational transaction segments due to changes from CMS ERA file contents. Unfortunately CMS changes included claim payment information in these informational transaction segments. This change prevented users from being able to successfully import claim cancellations contained in ERA files if no actual payment was provided in the ERA file.

RESOLUTION: The removal of the informational transaction segments was removed and a warning message is now presented to the user if multiple transaction segments are present in the ERA file. Users now have the ability to import files with only informational transaction segments.

#1923 Billing: Document Control Number only populated for Final Claims from ERA Import Process

ISSUE: In an earlier version of the HealthCare Assistant the Document Control Number (DCN) was pulled from the ERA file and entered into the Claim when posted. We have since discovered that each phase of the claim has a DCN number, which had the incorrect functionality of recording an inaccurate DCN depending on the ERA file imported.

SOLUTION: The DCN in the claim is only populated by the Final Claim Payment. While a DCN is present for RAPS and Cancellations this is ignored to ensure the correct DCN is populated in the claims for future submissions.