

# Healthcare Assistant Series for Windows

## Version 6.9 Release Notes

October 20, 2011 04:37: PM

---

### Version 6.9.09

---

#### **Enhancements and Feature Requests**

##### **#2363 Insurance: Billing Units and Minimum Visit Per Insurance**

ENHANCEMENT: Billing Units and Minimum Visit have been moved to now be calculated and editable per Insurance Carrier. Previously, Billing Units and Minimum Visit was at the agency level and insurances that did not match the Medicare standard (15 Minute = 1 Billing Unit, 8 Minutes = Minimum Visit) would require manual entry of units when adding or editing the schedule and ledger.

##### **#2369 Face-to-Face: Report includes patient's birthdate and gender**

ENHANCEMENT: Patient's birthdate and gender has been added in the Patient's Information section of this report.

##### **#2378 Face-to-Face Reports: Date of MD Visits is more visible**

ENHANCEMENT: Per clients' request, Date of MD Visits field was moved down two lines and bolded to make it more visible.

##### **#2387 Claims: Print Admission Source for non-PPS Insurance on Paper Claims**

ENHANCEMENT: The Admission Source is now printed for non-PPS Insurance on the CMS 1450 UB-92 and UB-04 paper claims.

##### **#2388: 5010 Professional**

ENHANCEMENT: Able to generate 5010 Professional EMC

##### **#2389 Claims: CMS 1500 Diagnosis Pointers default to 1**

ENHANCEMENT: Several Insurance companies bill using the CMS 1500 claim form. A requirement of the form is to complete the DX pointers for each visit. Most agencies point the DX pointer to 1, indicating that the visit was performed for the primary DX. To eliminate this manual selection, we have created a default so that when the visit is added it automatically saves with the DX pointer 1. If an agency needs to override a single visit, they can still modify it using the normal process.

#### **#2390 ERA: 005010X221A1 ERA Import**

ENHANCEMENT: ERAs in the 005010X221A1 format are able to be imported into the HealthCare Assistant to post payments and adjustments to claims. The 005010X221A1 format will be required by Medicare intermediaries beginning January 1, 2012.

#### **#2391 Eligibility: 005010X279A1 Eligibility Responses**

ENHANCEMENT: Eligibility Responses in the 005010X279A1 format are able to be read by HealthCare Assistant to update patient insurance eligibility. No change is needed on the user's behalf. When Eligibility is checked on the Patient Insurance screen, the HealthCare Assistant is able to read responses from ABILITY using the current 004010X271A1 format and the upcoming, required 005010X279A1 format taking effect January 1, 2012.

#### **#2393 Patient Insurance: Allow Multiple Medicaid Insurances**

ENHANCEMENT: When adding more than one Medicare or Medicaid insurance to a patient users receive a warning that an active insurance of that type already exists.

We permit multiple Medicaid insurances for a single patient and now present a warning to notify the user that additional Medicaid insurances have already been defined. We do not permit more than one Medicare insurance to be added to a patient though. Users are instructed to either inactivate the existing record or that one of the Medicare insurances must be a Medicare Advantage policy.

#### **#2398 Billing: 5010 billing changes for zip code added with warning.**

ENHANCEMENT: The new 5010 billing format changes require the zip codes to be 9 digit values. The application has been modified to allow for the full 9 digit zip codes in all areas where zip code is entered. A warning will be presented to the user when saving Agency Setup Information without a 9 digit zip code in the Agency address and the Agency Mailing address fields. An EMC Error has been added if the agencies zip code is not 9 digits. An EMC Warning has been added if the patient's address is not 9 digits.

#### **#2400 CMS Grouper Updated for 2012 ICD-9 Codes**

ENHANCEMENT: The CMS Grouper has been updated for the 2012 ICD-9 codes. When these new casemix codes that become effective on October 1, 2011 are used the correct HHRG/HIPPS grouping will be awarded. Be aware the HHRG/HIPPS code will only change if the code is effective when used.

#### **#2401 ICD9: FY 2012 ICD-9 Codes Update**

ENHANCEMENT: The 2012 ICD-9 Codes update has been added to HealthCare Assistant application. This update is incorporated in to PECOS Assisstant so for those clients that are in version 6.9.07 and higher this update will automatically distributed to their machine. There is also a patch named '2012 ICD9 Codes' available for manual updates for those clients that are using version 6.9.06 or lower.

#### **#2408 HOSPICE: Updated HOSPICE Rates for FY 2012**

ENHANCEMENTS: The HOSPICE Payment Rates have been updated to include the new rates for the fiscal year 2012. These rates are included in 6.9.09, however they are also included in the FY 2012 Diagnosis Patch and included in the PECOS Assistant updates.

#### **#2409 Billing: CMS 2012 Grouper**

ENHANCEMENT: The CMS Grouper for OASIS has been updated with the new and expired diagnosis codes for FY 2012. The new Grouper is included in Version 6.9.09, and is available as a patch for Version 6.9.08 as well.

#### **#2411 PECOS: Automatic Download now provides updates**

ENHANCEMENT: The PECOS update utility now provides updates to existing data in the HealthCare Assistant instead of a full download with every update. This means that the updates perform quicker because only the new MD data is added along with the changes to existing MD information.

### **Corrections**

#### **#2361 Reports: Patient Info - Print Status Admission History does not print Case Manager if Primary Diagnosis is empty**

ISSUE: Printing the Status Admission History from Patient Info with a missing primary diagnosis on the intake would cause the case manager to not appear on the report. Printing the Status Admission History from Patient Info with the primary diagnosis entered on the intake would insert the primary diagnosis in parentheses next to the case manager instead of the case manager's code.

RESOLUTION: Corrected the report to print the case manager's code in the parentheses next to the case manager's name. Fixed the issue where the case manager would not appear when the primary diagnosis on intake is empty.

#### **#2367 CAHPS: Manually Exporting When No Patients for the Month Says Successful**

ISSUE: Manually exporting via SHP or Synovate when there are no patients for the month returns a message box that says the submission was successful. The other file formats give a more descriptive message by informing the user that there are no patients to submit for the month.

RESOLUTION: Manually exporting via SHP or Synovate when there are no patients for the month returns a message box that there are no patients to submit for the month instead of the general successful message.

#### **#2368 Plan of Care Defaults: Missing M1230 (Speech and Oral Expression of Language)**

ISSUE: Users were unable to set the default orders and goals for M1230 because it was missing from the list of OASIS Answers.

RESOLUTION: The OASIS Answers was modified to include M1230.

#### **#2370 Intake: Patient Status not Updating on New Intakes for Some Agencies**

ISSUE: On adding a new intake for a patient that was previously Discharged, the patient's status in the Patient List is not being updated from Discharged to Under Eval for some agencies. The patient's status would finally update when a Plan of Care is created or if the patient was marked as a non-admit.

RESOLUTION: Creating an Intake sets the patient status as Under Eval correctly for all agencies in the Patient List.

#### **#2371 CAHPS: Reporting of Unknown Gender to SHP**

ISSUE: Patients whose gender was marked unknown in HealthCare Assistant were being uploaded with a gender code unexpected by SHP.

RESOLUTION: The unknown gender code for CAHPS export has been corrected to meet SHP specifications.

#### **#2372 Diagnosis Library: Fixed Short Description of V15.52**

ISSUE: The Short Description for V15.52 in the ICD-9 Add-In list stated "Hx-milk prod allergy" instead of the correct description of "Hx-traumatic brain injury".

RESOLUTION: The Short Description for V15.52 in the ICD-9 Add-In list and in any imported Diagnoses in the Diagnosis Library with the exact matching Short Description has been updated to state "Hx-traumatic brain injury".

#### **#2374 Billing: Warning 65 incorrectly picks up Recert OASIS that uses the ROC OASIS**

ISSUE: Recerts that reuse the previous Resumption of Care's OASIS are incorrectly marked with the [W65] Validation Warning on the Process Claim Preview screen regardless if they are exported. The [W65] Validation warns if an OASIS for a claim has not yet been submitted to the state.

RESOLUTION: The [W65] Validation Warning has been fixed to correctly discern OASIS that are shared with a Resumption of Care and Recertification.

#### **#2375 ABILITY: Sudden Error Message for some Agencies**

ISSUE: Agencies that may not have completed their registration with ABILITY may be getting an error message when trying to download remittance advices. The generic "No Download File Subscription present. Please Contact ABILITY support." error message recently started appearing when previously the agency was able to download files.

RESOLUTION: Completing ABILITY's registration via website or phone should clear up issues with disallowing viewing, uploading and downloading that was granted before. Also, instead of a generic error message, HealthCare Assistant now presents the user with the error message "Your Download File Subscription cannot be found. Your configuration may not be complete, please contact HealthCare Synergy support at (800) 4 - SYNERG." for better reporting and troubleshooting.

#### **#2376 OASIS: Possible for OBQI Audit Validations to not reflect the OASIS Answers**

ISSUE: While editing an OASIS, if you validated the Oasis, OBQI Audits were being saved even though the OASIS was not, therefore if you exit the OASIS without saving, the OBQI Audits could be an inaccurate result of your OASIS.

RESOLUTION: The OBQI Audits are only saved when the OASIS is saved to ensure accurate reporting on the OASIS Errors Report and for users of the OASIS API.

#### **#2379 SOC Worksheet Report: Only shows physician's NPI if both UPIN and NPI were entered**

ISSUE: The physician's NPI will not show if the UPIN is not entered. It will only show if both UPIN and NPI were entered in the caregiver library.

RESOLUTION: The report was modified to show Physician's NPI even though UPIN is not entered.

**#2380 UB04 Report: Type of Bill should not have leading zero for Non-PPS Claims**

ISSUE: A few clients have requested to remove the leading zero for Type of Bill for Non-PSS claims. The leading zero is required for Medicare Claims.

RESOLUTION: We have modified the report to remove the leading zero in the Type of Bill for Non-PPS claims.

**#2381 OASIS: Cannot create new OASIS for patient if they have two active Medicare insurances**

ISSUE: User receives a "Database error: SELECT returns more than one row" error when creating a new OASIS for patient with two active Medicare insurances. The HealthCare Assistant currently prevents two Medicare insurances from being Active at the same time. However, in the past this rule was not always enforced and agencies may have been able to enter patients with two active Medicare insurances.

RESOLUTION: Entering two active Medicare insurances for a patient is still prevented, however, if a patient has two active Medicare insurances, the HealthCare Assistant will use the top-most insurance in the patient insurance list when creating a new OASIS.

**#2382 ERA: Editing an RA gives a "Run-time error: Subquery cannot return more than one row"**

ISSUE: Editing an RA gives a "Run-time error: Subquery cannot return more than one row" in rare cases when two patients in a Remittance Advice have the same claim number. The application then crashes giving Automation errors.

RESOLUTION: The subquery for editing a remittance advice has been fixed to properly associate the correct claim to the correct patient in the rare cases when patients have claim numbers in common.

**#2383 Plan of Care Import: Users receiving sporadic errors that a certification already exists when there is none shown**

ISSUE: In a few cases, clients received error messages when trying to enter a plan of care stating that an existing plan of care for that period existed even though none was visible.

RESOLUTION: This error was caused by the import process when the user chose to over write the existing plan of care in the system.

HealthCare Assistant requires a "Shell" of a plan of care in order to bill the RAP and also schedule for the cert period. When a completed plan of care comes in from any one of our point of care vendors, users have the option to overwrite the "shell" plan of care. Prior to this fix, the "Shell" still existed and appeared to the system as already entered. We have corrected the import process to overwrite the "Shell" plan of care.

**#2384 OASIS: Creating a new OASIS on a previously Inactivated OASIS gives a "Could not load oasis dll!" message**

ISSUE: Attempting to enter a new OASIS on top of an Inactive, Locked OASIS gives a "Could not load oasis dll!" message and the new OASIS is not created. A workaround is to Unlock and Delete the Inactive OASIS, removing its history in the process.

RESOLUTION: Adding a new OASIS to an Inactive, Locked Oasis has been fixed.

**#2386 Claims: Cannot Preview Process Claims if a claim is missing a required OASIS**

ISSUE: Clicking Find and Preview Claims will crash if one of the claims being included in the list is missing a required OASIS. The check for Warning 65 attempts to load the Oasis Status for an Oasis that does not exist.

RESOLUTION: Warning 65 has been fixed to handle claims with missing, required Oasis.

**#2392 Claims: Medical Supplies are not Automatically Included to CMS 1500 Claims**

ISSUE: When creating a CMS 1500 Claim for a patient, Medical Supplies in the Ledger list were not automatically being included on the claim. If the claim was non-PPS then the Medical Supplies should be included to the claim according to the option for Medical Supplies under Claim Options in Agency Setup.

RESOLUTION: Medical Supplies are automatically included on CMS 1500 Claims for PPS. If the claim is non-PPS then the inclusion of Medical Supplies is dependent on the preference under Claim Options in Agency Setup.

**#2394 Scheduler: Scheduler by Caregiver Posting Corrected**

ISSUE: Visits could not be posted to the patient ledger from the Scheduler by Caregiver.

RESOLUTION: Corrected the issue so that visits can once again be posted to the patient's ledger from the Scheduler by Caregiver.

**#2395 Embedded Home Health Gold Clinical Audits corrected**

ISSUE: Coding audits were incorrectly displaying for discharge and transfer assessments.

RESOLUTION: Prevented coding audits from displaying on discharge and transfer assessments. Some minor grammar issues were also corrected.

**#2396 Billing: Eligibility Checks issue has been resolved**

ISSUE: Eligibility Assistant was not running eligibility checks.

RESOLUTION: The application has been corrected to allow Eligibility Assistant to continue to run eligibility checks.

**#2397 Caregiver Classification is not allowing the usage of a current added Classification**

ISSUE: An added Classification, Language or Ethnicity cannot be used to set a provider's classification, without shutting the program down and restarting

RESOLUTION: Previously the application cached these values when first opening. This functionality has been changed and users can now add a Classification, Language or Ethnicity and immediately start to use it. Also this classification cannot be deleted if it is currently being used for a provider.

#### **#2399 Payroll: Calculated Pay Amount being Summed then Rounded**

ISSUE: Each visit in the Payroll Prooflist and the Payroll Process List is being calculated by rate times time, summed per caregiver, then rounded. Each visit should be calculated as its own transaction therefore the rounding should occur after the pay calculation of each visit. This was apparent on the Payroll Prooflist where the Caregiver subtotal could be a number of cents higher than the total by Employer summary box. The total by Charge would match, however.

RESOLUTION: Each visit in the Payroll Prooflist and the Payroll Process List has been changed to calculate as rate times time first, then rounded, then summed per caregiver.

#### **#2402 OASIS Import: Brand New Agencies Unable to Import Plans of Care**

ISSUE: A new agency database with fewer than 10 Plans of Care total is unable to import a Plan of Care through the OASIS Import. This limit was inadvertently created due to how the HealthCare Assistant assigns the new Plan of Care with a code as well as any error code that is returned during its creation. This limitation does not affect normal Plan of Care creation through the Patient Info, Cases screen.

RESOLUTION: This limitation on creating a Plan of Care has been fixed in the OASIS Import.

#### **#2403 Reports: PPS Financial Summary giving Database Vendor Code: -186 Error**

ISSUE: Attempting to print the PPS Financial Summary gives the error message and does not print the report. The report was incorrectly looking at claim balances to distinguish LUPA claims.

RESOLUTION: The PPS Financial Summary's LUPA check has been fixed to no longer cause the error.

#### **#2405 Electronic Receiver Setup: Unable to Select NPI for Alternate Provider ID**

ISSUE: While very rare, it is not possible to select and save NPI as the Alternate Provider ID for an Intermediary in Electronic Receiver Setup. It would present an error saying "Value is less than the minimum value allowed".

RESOLUTION: It is now possible to select and save the NPI as the Alternate Provider ID for an Intermediary in Electronic Receiver Setup.

#### **#2406 Communication Setup: Unable to add New Communication Actions and Categories**

ISSUE: Introduced in 6.9.09 Beta, users would see a SQL Error message appear when adding a new Action or Category for Communications. Editing an Action or Category was unaffected.

RESOLUTION: Users are able to successfully add a new Action or Category for Communications.

#### **#2407 OASIS: Auto updating of Submitter ID when Agency's Submitter ID changed should only do it to currently logged on Agency**

ISSUE: In the lower version of HealthCare Assistant, a feature that automatically updates the Submitter ID in OASIS B1 string if the Agency's Submitter ID was changed was added. However, a client had found that this feature was updating the Submitter ID in OASIS B1 String for all agencies not for currently logged on Agency.

RESOLUTION: The auto updating of Submitter ID in OASIS B1 string was modified to only update for currently logged on Agency.

#### **#2410 Insurance: Policy Number limits enforced**

ISSUE: The patient's insurance policy number could have invalid characters and be longer than permitted. This caused issues in other areas of the software.

RESOLUTION: Corrected application to limit the number of characters and remove illegal characters to prevent issues with the policy number for a patient's insurance.

---

## **Version 6.9.08**

---

### **Enhancements and Feature Requests**

#### **#2330 Electronic Billing: Added Warnings for PPS Final Claims with missing or unexported OASIS Assessments**

ENHANCEMENT: Added Warnings for PPS Final Claims with missing or unexported OASIS Assessments.

#### **#2331 Agency Info: Added Nickname for the Agency for Internal Use**

ENHANCEMENT: Changed Agency Selection List to display Agency Nickname instead of the exact Agency Name. Also added a column for the Agency City. The Agency Nickname will default to the Agency Name unless changed in the Agency Setup. The Agency Nickname is intended for the immediate user and is never printed or submitted electronically within the HealthCare Assistant.

#### **#2335 CAHPS: Automatically transfer encrypted CAHPS data to Synovate from HealthCareAssistant**

ENHANCEMENT: Automatically transfer encrypted CAHPS data to Synovate from HealthCareAssistant, if Synovate is selected.

#### **#2341 Eligibility: Improved Gender Error Message**

ENHANCEMENT: Messages returned from the Eligibility check regarding gender were sometimes unclear. Messages regarding incorrect patient gender have been improved and suggestions have been added to assist the user with the eligibility feature.

#### **#2342 CAHPS: Improved Auto Submission for Selected CAHPS Vendors**

ENHANCEMENT: Automated uploading of participating patients has been improved for Synovate users. Using a user-defined run date for the month, the service will ensure your monthly CAHPS information is submitted directly and securely to Synovate.

To activate, go to the Configure screen in File...Export...CAHPS Data. Enter in your Activation Code and a Client number for each agency you would like automatically submitted every month. Next, go to any workstation you prefer the service to be run from. It could be a server or any other machine that is used daily. Go to Windows Services, and right-click and enter Properties for the HealthCare Synergy CAHPS Exporter service. Set the startup type to Automatic and click Apply. Finally, click Start.

#### **#2344 Face-to-Face: Able to ignore non-Compliant Face-to-Face on individual intakes**

ENHANCEMENT: A checkbox has been added next to the Face-to-Face date on the Intake/Admission window. The F2F Ignore requirements checkbox, when checked, will cause the non-compliant Face-to-Face date for the intake to be ignored by the Face-to-Face tracking methods on the Dashboard, Dashboard Report and Plan of Care Report. This checkbox should only be used when the agency is fully aware that the Face-to-Face requirement window has passed for a patient's intake.

#### **#2345 Face-to-Face: Face-to-Face Compliance based on Insurance Company**

ENHANCEMENT: An option to set the requirement of the Physician Face-to-Face visit has been added to the insurance company. Checking the 'Check if the insurance requires Face-To-Face document' box on the insurance carrier edit screen will cause any intakes created under that insurance to be tracked via the Face-to-Face Dashboard, Face-to-Face Dashboard Report and Plan of Care Report.

#### **#2349 Schedule: Therapy 13th/19th Reassessment Required**

ENHANCEMENT: Added Warning when saving appointments if a Reassessment has not occurred between the 11-13 and 17-19 Therapy visit. Also added flag to Chart of Accounts to indicate Evaluation or Reassessment. In order to utilize this functionality, users will have to create or change an existing account to indicate it is a "Eval Visit". If this account is used to schedule by the 13th and 19th appointment, the warning will not appear.

If the patient is receiving multiple types of therapy such as occupational and physical, for now the warning will disappear when an Eval Visit for only one of either type of therapy is scheduled. However, be aware that an Eval Visit is required for ALL therapies when their combined count is 11-13 and 17-19.

#### **#2352 Billing: Plain Paper 1500 Form Available**

ENHANCEMENT: A Plain Paper version of the CMS Form 1500 (08-05) is now available within the HealthCare Assistant for printing single claims and batch claim printing.

#### **#2353 Face-to-Face: Language Added to Assist Physician Completion of Form**

ENHANCEMENT: Language has been added to two sections of the Face-to-Face document to assist Physicians in completing the form.

#### **#2359 CAHPS: Updated Fazzi Submission Specifications**

ENHANCEMENT: Specifications have been updated to include the decimal point in diagnosis codes and allow E- and V-Codes.

#### **#2362 Agency Setup: Increase List Size (for Alternate Procedure/Revenue Codes, Fee Schedule, and Certifications)**

ENHANCEMENT: We have increased the above list sizes so users can enter more records into each of the mentioned lists. Several users were reaching the maximum amount the lists allowed.

#### **#2365 Dashboard: Revised Outlier Formula**

ENHANCEMENT: The formula for calculating the Outlier Percentage has been revised. Previously it was calculated as  $(\text{total outlier payments} / (\text{total payments} - \text{total outlier payments}))$ . Now, it is calculated as  $(\text{total outlier payments} / \text{total payments})$ . It was modified to be more approximate as possible.

### **#2366 ABILITY: Select certificate to use if there are more than one**

ENHANCEMENT: Added a Certificate Selection Window if there is more than one ABILITY Certificates in the system.

## **Corrections**

### **#2336 Reports: CA OSHPD Discharges by Reason (Section 3) - Possible incorrect Death discharge count**

ISSUE: Three new reasons for discharge by death were added in 6.5.00. They are "Died at home", "Died in a medical facility", "Place of death unknown". These choices were never added to the calculation for the CA OSHPD Discharges by Reason. So, the total for the Discharges by Reason would always be off by the number of patients who were succumbed by one of the three aforementioned reasons for discharge.

RESOLUTION: The CA OSHPD Discharges by Reason (Section 3) now takes into account the three added reasons for discharge by Death. An ALERTS 2011 patch is also available that fixes this issue for agencies on Versions 6.9.00 to 6.9.06.

### **#2337 Patient Info: Transferred Patient should remain On Hold until a ROC or Discharge is entered**

ISSUE: The status of a transferred patient is changed to On Hold until a resumption of care or DC is entered. Previously, adding any status besides Discharge after the Transfer would change the status of the patient back to Admitted. To resume care of the patient, only entering an ROC should change a transferred patient's status back to Admitted. A patient should remain On Hold if any other non-discharge status is entered.

RESOLUTION: A transferred patient remains On Hold until an ROC or a Discharge is entered.

### **#2339 Dashboard: Face-to-Face Report Displays Error**

ISSUE: When printing the Face-to-Face Compliance Report from the Dashboard, an error appears and the report is not printed. The error occurs when a patient in the report contains an episode with a Supplemental. The report is expecting to retrieve the Physician from either the Intake or Plan of Care, but not a Supplemental.

RESOLUTION: The Face-to-Face Compliance Report has been improved to select the Physician from the Intake or any Care Document and no longer cause an error when printing.

### **#2343 Face-to-Face: Fixed incorrect abbreviations and misspelled words on Report**

ISSUE: In the examples for the Primary Reasons for Ordering Home Care section of this report, "Disease" was abbreviated as "DZ" and "Osteoarthritis" was spelled as "Osteroarthritis".

RESOLUTION: Both reports in Admission and Plan of Care were modified to correct these inconsistencies.

#### **#2346 Patient Info: No warnings for adding status outside a Plan of Care**

ISSUE: Warnings are not being presented to the user when adding a Resumption of Care, Other Follow-up, Transfer or Discharge outside of a Plan of Care.

RESOLUTION: Warnings are now shown to the user when attempting to add a Resumption of Care, Other Follow-up, Transfer or Discharge outside of a Plan of Care.

#### **#2347 Eligibility: Request submission is rejected based on empty Agency Address 2**

ISSUE: Clicking Check Eligibility from the Patient Info's insurance tab performs an immediate eligibility of insurance from CMS through ABILITY. The request for eligibility would fail if the Address2 in Agency Setup contained only a single space. An extra bit of information was being included in the request and causing it to fail.

RESOLUTION: The saving of Address2 as well as the eligibility request generation has been fixed so that saving and reading Agency Address2 works as intended.

#### **#2350 Route Sheet: Unintended Posting with Multiple Route Sheet Windows Open**

ISSUE: Users working with multiple route sheet windows open would sometimes experience route sheets for an unintended caregiver being posted. This would happen when opening one route sheet for editing, leaving it open and then opening and posting another route sheet for the same or different caregiver.

RESOLUTION: Editing of Route Sheet has been changed to only allow one Route Sheet open at a time for editing. To view and edit another now requires to Save and Close the current, viewed Route Sheet.

#### **#2351 OASIS: Validations on M1010 and M1012 check for duplicate codes not working if entered non-sequentially**

ISSUE: If duplicate DX codes were entered in row (a) and row (b) an error will display stating that row (a) DX code cannot be the same as any of the other DX codes, the same error will display for row (b). However, if duplicate DX codes were entered in row (a) and the other one in row (c) the error will not display.

RESOLUTION: The check for duplicate codes for M1010 and M1012 has been corrected so it also works for non-sequential entry of duplicate DX codes.

#### **#2354 PPS Pricer: PEP calculation incorrect when second admission is a non-admit within the first 60-day episode**

ISSUE: In cases where a patient's second intake within the 60-day episode was a "Non-Admit", the system would incorrectly calculate the first admission as PEP.

RESOLUTION: We have corrected the application to not calculate PEP in the scenario above. It will still calculate PEP when the second admission within the same 60-day time period results in admitting the patient.

**#2356 Billing: Warning W65 - EMC Warning incorrectly identifying OASIS as missing when DC OASIS was not collected**

ISSUE: We added a new billing warning in version 6.9.06 to warn users if the claim had associated OASIS that were not yet submitted. This warning also included missing OASIS. The application was incorrectly producing the warning when the user indicated that OASIS was not collected (and not required to be collected).

RESOLUTION: We have corrected the warning to not warn when the user specifies that OASIS was not collected (and not required).

**#2357 Face-to-Face: Spell out Patient on Report**

ISSUE: In the Homebound Reasons section of this report, "Patient" was abbreviated as "PT" which is incorrect.

RESOLUTION: The Face-to-Face Report in Intake/Admission and Plan of Care was modified to spell out "Patient".

**#2358 Face-to-Face: Report from Intake/Admission Produces a run-time error if a Medical Update exists**

ISSUE: If an Intake/Admission includes a Medical Update, attempting to print this report will produce a run-time error.

RESOLUTION: The Face-to-Face report has been modified to handle the above scenario.

**#2360 CAHPS: Error during submission of CAHPS to SHP would show a Successful Message**

ISSUE: Due to incorrect parsing of the response from SHP, the response from any submission would be interpreted as successful and, as such, was presenting the user with a false successful message.

RESOLUTION: Responses from electronic SHP CAHPS submission are now correctly interpreted and displayed for the user.

**#2364 Caregiver: Physicians' Licenses Tab Always Shows Unknown PECOS Enrollment Status**

ISSUE: Viewing the Caregiver List would show the Physicians' Enrollment Status from the most recent PECOS Assistant update. However, opening up the Physician and going to the Licenses tab would always show an Unknown status for PECOS Enrollment.

RESOLUTION: The Physician's Licenses tab has been fixed to show the PECOS Enrollment Status as seen in the PECOS Physician column in the Caregiver List.

**#2373 Electronic Billing: VisionShare button not responding**

ISSUE: When updating VisionShare references in the program to ABILITY, a VisionShare labeled button was not updated and became unresponsive on the third tab of the Electronic Billing form, "Manage EMC File". This was introduced in 6.9.08 Beta.

RESOLUTION: The button's label has been changed to ABILITY and its functionality was returned. This was fixed in the most recent 6.9.08.

### **#2377 Scheduler: Missed Visit and Non-Skilled Counts not appearing**

ISSUE: Changes in 6.9.08 introduced an error where the Missed Visit and Non-Skilled counts no longer appear.

RESOLUTION: In the most recent version of 6.9.08, the Scheduler was fixed to correctly display the Missed Visit and Non-Skilled counts.

### **#2385 HOSPICE: Initial Level of Care Entry does not appear on Printed Claims**

ISSUE: The Level of Care line is no longer printing on the claim. This was introduced in an earlier version of 6.9.08. The error was initial Level of Care statuses were not being picked up by printed claims.

RESOLUTION: The initial Level of Care status has been restored on printed claims in the latest version of 6.9.08.

---

## **Version 6.9.07**

---

### **Corrections**

#### **#2348 Caregiver Library: Certification ID's and expiration dates not saving correctly**

ISSUE: In version 6.9.06 several clients reported certification ID's and expiration Dates getting mixed up upon editing a Caregiver in the caregiver library.

RESOLUTION: We have found and fixed the error so that this problem no longer happens. We will be releasing a future patch that will identify and possibly correct the mixed up ID's.

---

## **Version 6.9.06**

---

### **Enhancements and Feature Requests**

#### **#2287 Eligibility: Checks for all active Medicare Patients where insurance status is active not just where primary Insurance is Medicare**

ENHANCEMENT: In version 6.9.04 and below of HealthCare Assistant, the Eligibility Assistant limits its check to all active patients where the Primary Insurance is Medicare. We have modified the Eligibility Assistant to check for all active Medicare patients where the Insurance status is active which will include MSP situations.

#### **#2288 PECOS: Physician PECOS status automatic update and EMC Warning**

ENHANCEMENT: Physician's PECOS status is automatically updated daily using the most recent list from CMS. Warnings have been added when processing Medicare claims to inform the user whether the Primary Physician is Enrolled in PECOS and if the Physician's name matches their NPI in the PECOS List.

Also, in the Caregiver Library, the PECOS Status for a newly entered Physician will automatically be applied on Save.

#### **#2299 Intake: Face to Face Date captured in Admission/Intake**

ENHANCEMENT: The Physician/Patient Face to Face Encounter date has been added as a data entry field in the Admission/Intake for a patient. Users are able to enter the date of when this encounter occurred. An EMC warning has also been added to the system to warn users when submitting the Final Claim for Medicare claims that a face to face encounter date is missing.

#### **#2304 Dashboard: Face To Face (F2F) with Report**

ENHANCEMENT: We have added a Face To Face (F2F) dashboard and corresponding report to help agencies be compliant with the new CMS regulation. The dashboard and report are designed to alert users about cases that have not met the Face to Face physician requirement. It will also help users identify which cases need attention first according to their SOC date.

#### **#2306 Plan of Care: Removed Warnings for Diagnosis that do not appear on OASIS**

ENHANCEMENT: When saving the Plan of Care, there would be a warning displayed if any of the Diagnosis Codes in rows 7 to 14 did not appear somewhere in M1024 of the OASIS. The warning was removed due to client feedback and the differences of diagnosis reporting between OASIS and Plan of Care.

#### **#2307 Dashboard: Added Previous Year's Outlier Standings**

ENHANCEMENT: The percentage and Outlier Report and corresponding report for the previous year has been added to the Dashboard.

#### **#2308 EMC: Handle HMO ID**

ENHANCEMENT: A field that identifies the HMO ID has been added to the Electronic Receiver Setup. The EMC has been modified also to handle submission of EMC file, given that the HMO ID is entered.

The HMO ID is provided by the Insurance Company to the Agency. Currently, Scan Health requires this field to be entered for billing purposes.

### **#2309 HOSPICE: Improved Claim Calculations and Incorporated CMS' yearly Payment Rates**

ENHANCEMENT: Previously, the services for HOSPICE visits were calculated per day using a flat rate across all visits. The rate per day was locked in using the rates for 2008, and were not wage adjusted. The flat rate was not taking CMS' yearly Final Wage Indexes into consideration. The claim amount of screen would simply contain the values for level of service and not until printing would the claim amount be properly calculated using the level of service rate times the number of days of care.

In 6.9.06, the claim amount is calculated using the rates given for the year per level of service per day for the patient within the claim period. A proper claim amount is show whether or not the claim has been previewed or printed.

### **#2310 Face to Face: Face to Face Worksheet May be Printed in Intake/Admission and Plan of Care**

ENHANCEMENT: In helping our clients maintain compliance with the new Face to Face requirements, we added an option to print the Face to Face Encounter document. The option to print is enabled from Intake/Admission if a Face to Face date is not entered. Furthermore, printing the Plan of Care for the Physician will give the option to print the Face to Face Worksheet as well. The option to print will be enabled if the Plan of Care is for the Start of Care; if a Face to Face date has not been entered into the Admission; and if the Plan of Care is marked as Final (not Draft). The Face to Face worksheet is populated with Agency Contact information as well as the Patient's name, Start of Care date and Medical Record Number.

### **#2312 Billing: Updated 2011 PPS Rates**

ENHANCEMENT: HealthCare Assistant includes the updated Payment Rates for calendar year 2011 released by CMS on December 10, 2010.

### **#2315 News: Added Mark as Read Button and Multi-Select**

ENHANCEMENT: A Mark as Read button has been added to the News Articles window. Those who read the article's summary in the News window may now mark the article as read without having to open each article in their browser. Multiple articles may also now be selected at the same time for marking as unread, marking as read and deletion. Also, double-clicking an article opens it in a browser for reading just like the Read button.

### **#2320 CAHPS: Manual, Direct SHP CAHPS Export**

ENHANCEMENT: SHP has been added to the list of available formats in the CAHPS Export feature in the File menu. Selecting a vendor will usually generate a file in the preferred location, however, for clients who use SHP as their CAHPS vendor, selecting SHP will send the CAHPS information directly to the SHP website.

### **#2329 Reports: AR by Claim (Detail) Report to work in conjunction with AR Aging Reports**

ENHANCEMENT: In 6.9.04, there were changes to improve the ledger by removing some of the automation of changing claim balances to zero instead of requiring manual adjustments to balance due on claims, particularly PPS claims. Changes were made to the AR by Patient, AR by Claim and AR by Insurance Company reports to reflect this. The AR by Claim (Detail) report has also been updated to improve AR accuracy.

## **Corrections**

**#2289 EMC: Bill To Provider option causes electronic claims to be rejected**

ISSUE: Bill To Provider option adds the address at bottom of EMC file causing rejection.

RESOLUTION: The EMC will no longer generate the wrong address information for Bill To option but will continue to work on Paper Claims.

**#2295 Patient Info: Status Date on Cases Tab Does Not Sort Correctly**

ISSUE: Clicking the header for the Status Date column does not sort the Status Date in chronological order, but rather by numeric order. This sorting is apparent when sorting the column when status records cross from December to January. Sorting ascending will put January on top rather than December because it is comparing 1 and 12 rather than considering the fields as dates.

RESOLUTION: The sorting on the Status Date column for Patient Statuses has been fixed to sort by chronological order.

**#2298 Scheduler: Time does not sort with Date on Details Tab**

ISSUE: Clicking the Time column header will sort the list of appointments by time of day, but does not consider the Appointment Date column.

RESOLUTION: Clicking the headers for Time and Actual Time will result in a sorted list by the header being clicked with the Appointment Date being considered first.

**#2302 Dashboard: Medi-Medi OASIS Summary - Sometimes includes OASIS only from the first agency entered in the database**

ISSUE: The Medi-Medi OASIS Summary in the Dashboard may only return numbers for the first agency entered in the database; other agencies will show empty for Medi-Medi OASIS Summary even though there are OASIS entered.

RESOLUTION: The Dashboard was modified to reflect the correct number of OASIS in the currently logged agency.

**#2303 Reports: Recert Due List - Sort by Cert Start of Missing Cert not working correctly**

ISSUE: The report's print out was listing the details in incorrect order if Cert Start of Missing Cert date is used as the sort order.

RESOLUTION: The report was modified to correct the issue. Patients with the same Cert Start when the report is sorted by Cert Start of Missing Cert will then be sorted by Patient Name then by their SOC Date.

**#2311 Caregiver Payroll: Mileage Reimbursement Rate saving wrong amount**

ISSUE: In version 6.9.05 we introduced an error where the Caregiver's mileage reimbursement was multiplied by 1000, upon entering a new rate.

RESOLUTION: We have found and corrected this issue in version 6.9.06.

### **#2313 OASIS Import: Invalid Use of NULL error in Import Manager**

ISSUE: Some clients were experiencing issues by selecting "Processed" in the filter causing an "Invalid Use of NULL error" and shutting down the program. Some older, imported assessments that did not hold the error code for the translation of the Error Message that appears in the list were the cause of the error.

RESOLUTION: The Import Manager list was changed to be more forgiving when error codes do not exist. This error only happens with older assessments completed in 2006 and earlier.

### **#2314 Caregiver Library: Error when Adding Payroll to New Caregiver**

ISSUE: When entering a new Caregiver, selecting the Payroll tab and adding an Account results in a "There is no row at position 0." error. The payroll is attempting to be added to a caregiver who does not yet exist in the database. This issue was introduced in 6.9.04.

RESOLUTION: On changing tabs for a new Caregiver, their information is saved to the database. If there are errors or missing required information on the first tab, then those have to be addressed before attempting to view any other tabs.

### **#2316 Electronic Billing: Updated EMC Warnings for new G-Codes**

ISSUE: CMS updated the allowable G-Codes that can appear on claims beginning in 2011. These new codes were not yet included in our EMC warnings and agencies are experiencing false warnings about G-Codes, however they are still able to process claims.

RESOLUTION: The updated G-Codes have been included in the EMC Warnings for claims beginning in 2011.

### **#2317 Reports: AR Aging - Reports not Showing Claims that only have Non-Skilled Visits**

ISSUE: Claims with no disciplined visits and only Non-Skilled visits do not show up on the AR Aging by Insurance, by Patient or by Claim reports in the Financial report group.

RESOLUTION: The AR Aging by Insurance, by Patient or by Claim reports have been modified to show claims with or without disciplined visits. Also, the three reports were modified to include the non-skilled visit count in the 'Total Visits' column and show those non-skilled visits when the Show Claim Details (3rd Level) is checked.

### **#2318 User Rights: Error when Creating User Rights Templates**

ISSUE: Selecting a New Template and then saving any time afterwards gives a "Column LoginID in table t\_users cannot be NULL" error. The mouse remains an hourglass, and only the save of the template is disrupted. Clicking Cancel lets the program resume as normal.

RESOLUTION: The saving of new user templates has been fixed.

### **#2319 Plan of Care: Printing a Plan of Care created from Import gives an Invalid Use of NULL error**

ISSUE: In rare cases, trying to print a Plan of Care, imported from the OASIS Import Manager, gives an Invalid Use of NULL error and ceases to print. The error is the program expecting a date or an empty date for the expected OnSet Date for diagnoses, but instead is getting a NULL from the database.

RESOLUTION: The printing of the Plan of Care has been fixed to accept any sort of input for the Onset Diagnosis Date.

**#2321 Caregiver Library: Associated Caregiver not working correctly**

ISSUE: Associated Caregiver functionality on the caregiver's edit screen shows other caregivers associated in all agencies that match the current caregiver's last name, birthday and social security number. Clicking the button was showing an error and was introduced in 6.9.05.

RESOLUTION: The Caregiver edit screen was modified to restore the Associated Caregiver functionality.

**#2322 Patient Statement: Agency's address is inconsistent, Patient's address does not include 'State'**

ISSUE: The report does not show city, state and zipcode if address2 is not entered in the agency's address information. Also, the report does not show the state in the patient's address information.

RESOLUTION: The report was modified to correct the above issues.

**#2323 Ledger: Posting Medical Supplies give a SQL Error when posting by a non-Supervisor**

ISSUE: A non-Supervisor attempting to post Medical Supplies to the Ledger would, in rare cases, receive a SQL Error. The posting is unaffected and the error does not deter the program from normal operation. The error stems from the User Selection List Rights and certain databases returning a cosmetic error. Unchecking the Chart of Accounts right temporarily resolves the problem.

RESOLUTION: Posting's use of the Selection List's Chart of Accounts Right has been fixed to no longer produce an error when a non-Supervisor posts Medical Supplies.

**#2324 Reports: AR Aging Reports - Paid RAPs incorrectly showing on report**

ISSUE: For the three AR Aging reports in Financial Report Group, RAPs with zero balances would appear on the report even though the option for Show Paid Claims is unchecked.

RESOLUTION: Any Paid RAPs in AR Aging reports should now only show if they have a balance or if the Show Paid Claims is checked.

**#2325 Claims: Auto balance not working when remaking a claim**

ISSUE: Remaking a claim with RAP and/or Final Payments posted before today would not auto balance the amount even if the claim balance was within the variance.

RESOLUTION: Remaking a claim with such payments will now auto balance correctly if within the variance.

**#2326 POC: Refresh Diagnosis From OASIS brings in only the first five Diagnosis**

ISSUE: An option in Agency Setup, introduced in 6.9.04, lets agencies forego the import of diagnoses in M1024 in the OASIS into diagnosis 7 - 14 on the Plan of Care and check they match in content not order. Unchecking this box, however, would only import the first five diagnosis from M1020/M1024 instead of the first six as intended.

RESOLUTION: Unchecking the option in Agency Setup now imports the first six diagnosis from M1020/M1024 as originally intended, and checks that their order matches as it did previously.

#### **#2327 Billing: Incorrect 2011 PPS Rural Rates**

ISSUE: The Rural Home Health PPS Rates shared the same amounts as the non-Rural Home Health PPS Rates.

RESOLUTION: The Rural Home Health PPS Rates have been updated. A patch is also available for Versions 6.9.00 to 6.9.05.

#### **#2328 CAHPS: Activation Code resets on Configuration Screen when Organization Id is changed**

ISSUE: On the Configure window when Exporting CAHPS, if the Organization Id is changed, the Activation Code is erased. The form still shows it until the program is closed and reopened. However, the exporting uses the Activation Code in the database and if that is empty then online submissions could fail.

RESOLUTION: The Configure Window for CAHPS has been fixed to never clear the Activation Code unless done by the user explicitly and to always show the CAHPS vendor information as contained in the database.

#### **#2333 Face-to-Face: Intake/Admission Report - Remove Primary Physician's information**

ISSUE: During initial creation of this report, we provided the Primary Physician's information in Intake/Admission and Plan of Care addendums print out. However, a few clients have reported that the Primary Physician is not always the one that will need to sign the Face to Face report and it may cause confusion if the primary physician information is printed on the report.

RESOLUTION: We have removed the Primary Physician's information from the Intake/Admission Face to Face report to allow this report to be sent to any physician. The Face To Face report that can be printed as an addendum to the Plan of Care still includes the Primary Physician's information.

#### **#2334 Billing: Missing CBSA Codes and Rates for 2009, 2010, 2011**

ISSUE: New CBSA Codes added in 2009, 2010 and 2011 were not added to the yearly PPS Rate updates. A few agencies would have patients where the claim amount is \$0 because they live in counties no longer linked to a service area.

RESOLUTION: The missing CBSA Codes and their visit rates for 2009, 2010 and 2011 have been added.

#### **#2338 Communications: Spell Check splash screen warns of unlicense feature**

ISSUE: Opening or creating a Patient Communication displays a small window notifying the user of an unlicensed Spell Check product. Spell check still works as normal and the window is displayed only once each time the HealthCare Assistant is opened.

RESOLUTION: Opening or creating a Patient Communication no longer displays the licensing window for the Spell Check feature.

#### **#2340 Electronic Billing: Face to Face Warnings showing for RAPs**

ISSUE: Claims for Intakes without a Face to Face date or with a Face to Face date too early or too late will provide a warning for users. This warning was unintentionally appearing for RAPs when only Final Claims were intended.

RESOLUTION: The Warnings for Face to Face in Electronic Submission have been fixed to only show for Final Claims.

---

## Version 6.9.05

---

### Corrections

#### **#2297 Scheduler: Correct overlapping checks**

ISSUE: The checks that warn users if an appointment overlaps with other existing appointments were broken.

RESOLUTION: We have corrected the Scheduler by Patients and Scheduler by Caregivers to warn if a appointments overlap with other existing appointments.

#### **#2300 Caregiver Library: Attempting to view Caregiver List produces an error**

ISSUE: Attempting to view the Caregiver List produces an 'Unable to convert Database Records' error.

RESOLUTION: The Caregiver Library has been modified to correct the issue.

#### **#2301 Caregiver Form: Correct saving of Employer for Physician classification**

ISSUE: In version 6.9.03 and below, users were able to save an Employer for Physician classification. This functionality has been removed in version 6.9.04.

RESOLUTION: The Caregiver form was corrected to allow saving of Employer for Physician classification.

#### **#2305 Lists: Patient, OASIS and Library Lists cause error upon opening**

ISSUE: If the Patient, OASIS or a Library (Employers, Facilities, etc.) has no records, the user will receive an error upon trying to open the list. Empty OasisList use of 'Select' will receive an error.

RESOLUTION: We have corrected the issue and an empty list will now load. OasisList 'Select' corrected.

---

## Version 6.9.04

---

### Enhancements and Feature Requests

#### **#2265 485 Import: Third party vendors can now import Onset/Exacerbation codes**

ENHANCEMENT: It is now possible for third party vendors to import the Onset/Exacerbation codes for each diagnosis code used on the 485 into the HealthCare Assistant.

#### **#2268 Caregiver Route Sheets: Added 'Include Posted' check box**

ENHANCEMENT: Some clients were experiencing slowness when loading the initial list of Caregiver Route Sheets due to posted items being included to the list. Thus, we have added the 'Include Posted' check box. By default, the initial list will not show caregivers with items already posted to the ledger. To show caregivers with posted items, a user has to check 'Include Posted'.

#### **#2271 CBSA: 2011 PPS Rates Included and Patch Created for prior versions**

ENHANCEMENT: The Centers for Medicare & Medicaid Services (CMS) issued a final rule to update the Home Health Prospective Payment System (HH PPS) rates for Calendar Year (CY) 2011. We have included the rate changes in this version as well as created a patch for prior versions of HealthCare Assistant.

#### **#2272 Caregiver List: Added Export button**

ENHANCEMENT: We have added a functionality for users to export the Caregiver list to a file. To do this, a user can go to Caregiver Library and click on 'Export' button. File name (in CSV format), can be specified on Caregiver Export.

#### **#2275 Payment Posting: Add Auto Adjust Option for PPS Claims per Insurance Company**

ENHANCEMENT: We made PPS Claims' Auto Adjust to be a customizable option for each Insurance Carrier. Previously, in an effort to reduce the number of required adjustments, upon receiving payment from the Final Claim, the patient balance would be adjusted to match the Final Claim's payment. Now, the patient balance is only adjusted if the Final Claim's payment is within the specified difference per Insurance Company. The default is to Auto Adjust when within \$0.05.

#### **#2276 OASIS Validations: Added Validations for Surgical, Procedure, E and V Codes**

ENHANCEMENT: Added Validations Errors for questions requiring ICD-9 codes. The following questions will show errors based on their respective constraints:

- M1010: No E or V Codes
- M1012: Procedural Codes Only
- M1016: No Surgical, E, or V Codes
- M1020: V Codes Allowed
- M1022: V and E Codes allowed
- M1024: No E or V Codes Allowed

#### **#2279 OASIS: New OASIS-Plan of Care Option for Payment Diagnoses**

ENHANCEMENT: Agency Setup includes a new option that is defaulted to checked, which maintains the current behaviour between Plan of Care Diagnoses 7 to 14 and OASIS M1024 Column 3 and 4. When checked, Payment Diagnoses (Column 3 and 4) are automatically imported into new Plans of Care (Diagnoses 7 to 14) and warnings are shown on mismatch when saving the Plan of Care and OASIS. When unchecked, Payment Diagnoses (Column 3 and 4) are not imported into new Plans of Care (Diagnoses 7 to 14) and warnings are no longer shown when the diagnosis codes do not match.

#### **#2282 Reports: AR Aging Reports - Report Options defaulted to Include Overpayments**

ENHANCEMENT: To prevent any oversight of overpaid claims, the Include Overpayments option on the three Accounts Receivable reports has been defaulted to checked.

#### **#2285 Reports: Revenue Recovery - Added Date Filter**

ENHANCEMENT: The Revenue Recovery Report under the Financial Reports group now includes a date range to filter claims by coverage start by a user-preferred reporting period. The default printing period is within a year from the current date.

#### **#2286 CAHPS: DSS Research will mark Other Payer if no OASIS is entered.**

Enhancement:CAHPS - DSS Research will mark Other Payer if no OASIS is entered.

#### **#2291 Claims: Add Condition Code '06'**

ENHANCEMENT: The Condition Code "06 - End-stage renal disease (ESRD) beneficiary in first 30 months of eligibility/entitlement covered by an employer group health plan (EGHP)" has been added to the list of Condition Codes in the Claim form. This code is used for MSP billing.

### **Corrections**

#### **#2267 Reports: AR Aging Report - Incorrectly including Final Claims with Coverage End after "As of" date**

ISSUE: The AR Aging reports were incorrectly including Final Claims with Coverage End after the "As of" date. The "As of" is designed to give users a snapshot of the Accounts Receivables at a specific date. Typically if you are doing the AR for the prior month, the As of date will be the month end. In this case, if a claim's coverage end occurred after the "As of" date, the Final claim did not yet exist and should not be included to the AR report.

RESOLUTION: We exclude any Final claims with coverage end after the "As of" date from the AR aging reports.

#### **#2270 Patient Info: Default Status of Patient should be "Under Evaluation" not "Non Admit"**

ISSUE: Upon creating a patient and not entering the Intake/Referral record, patients default status was "Non Admit". As soon as the Intake/Referral record was entered, the status changed to "Under Eval". The status of the patient prior to entering the Intake/Referral record should be "Under Eval".

RESOLUTION: We modified the application so the default status of a patient is always "Under Eval" regardless if the Intake/Referral record is entered. The only way to change a patient's status to "Non Admit" is to specifically create a "Non Admit" status record for that patient.

#### **#2273 CAHPS: DSS Research - Removed ADL Feed**

ISSUE: Answers for ADL Feed are incorrectly being included in the DSS Research CAHPS Export.

RESOLUTION: Answers for ADL Feed are no longer included in the DSS Research CAHPS Export file.

#### **#2274 Reports: AR Aging Reports - Fixed As of Date**

ISSUE: RAP Cancellations are included into the AR calculations when the cancellation happened after the As of Date.

RESOLUTION: RAP Cancellations have been corrected to not be included in calculations if the cancellation is after the As of Date.

#### **#2277 Route Sheet: Incorrect Unit Type on Schedule when Posting**

ISSUE: Posting from the Route Sheet inserts the visits with their sub accounts into the Scheduler as Posted Appointments. On adding or updating an appointment when posting through the Route Sheet, the appointment's Unit Type is always set as Visits, regardless of the unit type of the Account entered.

RESOLUTION: Appointments posted through the Route Sheet are now added and updated with the Unit Type of the Account being posted.

#### **#2278 CAHPS Export Setting: Saving path incorrectly if it contains "\\n\\"**

ISSUE: The CAHPS Export setting saves path incorrectly if it contains "\\n\\".

RESOLUTION: The CAHPS setting was modified to handle correct saving of path that contain "\\n\\".

#### **#2280 Reports: TAR Status Report - Subquery returns more than one row error**

ISSUE: When printing the TAR Status Report, in some cases a patient for the period could be returning more than one of a diagnosis code when the report and TAR only expect one.

RESOLUTION: The printing of the TAR Status Report has been changed to only return one diagnosis code when retrieving a patient's TAR.

#### **#2281 CAHPS: CAHPS Export is populated with RFA OASIS 1,3 or 4 instead of the Discharge OASIS**

ISSUE: Discharge OASIS were being used to populate patient information, including episode diagnosis information. Discharge OASIS do not particularly include as much information on diagnosis as the previous OASIS for the episode. Patient information should be taken off the most recent OASIS with RFA 1, 3 or 4 instead of the Discharge OASIS.

RESOLUTION: The CAHPS Export now looks at the latest RFA 1, 3 or 4 OASIS for pertinent information for discharged patients. Only the discharge date is taken from the Discharge OASIS.

#### **#2283 Visit Frequency: Subquery cannot return more than one row**

ISSUE: In databases that contain two or more agencies with similar account codes and dissimilar groupings, adding a visit frequency in a Plan of Care will result in a "Subquery cannot return more than one row" error. The group returned was to determine the default week start for the frequency being entered. The error lets the User continue to enter the Visit Frequency.

RESOLUTION: The procedure to attain the Grouping of the Account Code being entered has been changed to only retrieve the Account Code of the current agency to prevent the Subquery error.

#### **#2284 Patient Info: Name not always refreshing when switching patients**

ISSUE: When switching patients without closing the Patient Information form, the name displayed on the form sometimes will show the previous patient's name.

RESOLUTION: The form has been changed to always refresh the patient information when switching patients.

### **#2290 Route Sheet: Notes when Posting Visits from Route Sheet are cleared**

ISSUE: A visit exists in the scheduler and includes notes. When the visit is linked and posted through the Route Sheet, both the original notes from the scheduled visit and the notes added to the Route Sheet's visit are deleted.

RESOLUTION: Posting through the Route Sheet has been fixed to retain the notes from the scheduler side as well as appending any further notes added from the Route Sheet. A note that includes the posting date will help the user determine which notes came from the route sheet visit.

### **#2294 Reports: Communication Report - Saved Report Parameters prints empty Single Communication**

ISSUE: Printing from previously saved Communications Report parameters in the Patient Reports Group prints an empty single communications report as from the Communication tab in Patient Info rather than the expected list of communications.

RESOLUTION: The Communication Report in the Patient Reports Group has been fixed to print the correct report format when selecting previously saved Report Options.

### **#2296 Reports: SOC Worksheet - Right-most Vertical Line not appearing in Print Preview**

ISSUE: The right-most vertical line does not appear when previewing the SOC Worksheet and therefore would not appear when printing the report to PDF. When printing the SOC Worksheet, the right-most line would appear.

RESOLUTION: The SOC Worksheet's right margin has been increased just enough so that the right-most vertical lines will appear on Print Preview as well as printing a hard copy.

---

## **Version 6.9.03**

---

### **Enhancements and Feature Requests**

#### **#2251 Library: Associated Caregiver List**

ENHANCEMENT: Added the ability for the Caregiver Library to recognize the use of the same provider across agencies. Clicking the Associated Providers button when editing a Caregiver from the Caregiver Library will display a list of Caregivers and their specialties across all agencies who have the same, non-empty last name, SSN and birthday.

#### **#2257 Import: Importing Plan of Care Prompts to Update Existing Plan of Care**

ENHANCEMENT: Partners of HealthCare Synergy, Inc. are able to Import OASIS and Plans of Care into the HealthCare Assistant. In the past, if a Plan of Care already exists, the import fails and informs the user that a Plan of Care already exists. The HealthCare Assistant has been improved to allow existing Plan of Care to be replaced. A prompt will ask the user if they would like to replace the existing Plan of Care with the one being imported.

### **Corrections**

#### **#2255 OASIS List: Maximized List shows error after saving an OASIS and returning to List**

ISSUE: Having the OASIS List open and maximized in the HealthCare Assistant produces a "Error 384: Oops! A form can't be moved or sized while minimized or maximized" message box when closing an OASIS C attempts to refresh the OASIS List. The problem is the refresh incorrectly tries to set the width of the OASIS List while the windows is maximized.

RESOLUTION: Setting the width of the OASIS List only occurs when first opened in a non-maximized state, preventing the Error 384 from occurring during the automatic OASIS List refresh after closing an OASIS C.

#### **#2256 Reports: AR by Claim (Detail) - Prints Empty Regardless of Time Period or Options**

ISSUE: Version 6.9 of the HealthCare Assistant introduced a major upgrade to the database infrastructure. Methods relied on by this report were improved causing unexpected results by no data being returned when printing the AR by Claim (Detail).

RESOLUTION: The printing of the AR by Claim (Detail) has been fixed to correctly interact with the new database of Version 6.9.

#### **#2258 Claim 1450: Value Code 61 and G8 Saving and Length Error**

ISSUE: Since Version 6.8.10 and only occurring on some machines, opening a Claim 1450 and saving without touching the MSA/State Code grid, would save back 61 or G8 Value Codes incorrectly. Also, inadvertently entering in values with more than 8 digits for these two value codes would show a invalid procedure call error and crash the HealthCare Assistant.

RESOLUTION: The saving of Values Codes for 61 and G8 have been fixed to no longer save incorrectly when simply editing a 1450 Claim. Also, entering in Value Codes for 61 and G8 no longer gives an error when entering in more than eight digits. However, since the limit for Value Codes is limited to eight digits, it will only accept eight digits from the right.

#### **#2259 OASIS: M2430, M2440 Reasons for Admission Validations**

ISSUE: When M2430 or M2440 are answered, the other answers in each question must be set to zero instead of spaces for submission. This check was missing and affected OASIS imported from outside of the HealthCare Assistant.

RESOLUTION: Validations have been added for M2430 and M2440 to check when at least one answer is selected for either, that all unchecked answers are set as zero to fulfill state submission requirements.

#### **#2260 POC Defaults: Viewing Previous Version via button shows error on some machines**

ISSUE: On operating systems whose My Documents path contains spaces (Windows XP or user-defined paths to My Documents), Viewing Previous Version from the POC Defaults screen will show an unhandled exception error. The previous Plan of Care defaults are then never written and shown from the "My Documents\HealthCareSynergy" folder as intended.

RESOLUTION: The saving and viewing of the Previous Version of the POC Defaults has been fixed to work properly with paths of My Documents that contain spaces.

#### **#2261 Reports: Claims List fails to print data and has To/From dates swapped**

ISSUE: The Claims List does not print data when using the Sent Date or the End of Episode Date filters. The report criteria on the printed page shows that the To and From dates have been swapped and the report has a big label that states "No Data to Print".

RESOLUTION: The report date filter option was broken in 6.9.0 when we added the ability to enter a To/From date for the Date Sent. The report has been corrected to use these date filters correctly.

#### **#2262 Route Sheet: Corrected ability to post multiple visits at one time**

ISSUE: When multiple visits were being posted in a route sheet from a third party vendor, the route sheet would be partially posted with only some visits posted. Users would then have to log into the Has4Win software and manually post the remaining items. This was unintentionally introduced in version 6.9.0 by some code restructuring to allow some upcoming functionality.

RESOLUTION: Corrected application to permit multiple visits to be posted at one time in the route sheet.

#### **#2263 POC: Matching Dx Warning No Longer Shown For Empty M1024**

ISSUE: Functionality was added in 6.9.0 that would automatically place DX codes used in column 3 or 4 for M1024 into the 485 diagnosis grid starting at row 7. This ensured that the codes reported on M1024 would appear on the plan of care to prevent potential survey discrepancies. Because agencies may want to rearrange the order of DX codes this item is presented as a warning. Unfortunately the error is always displaying when the codes placed in rows 7-14 of the 485 don't appear on the OASIS in column 3/4.

RESOLUTION: The application was modified to only show the warning if codes actually are present in OASIS column 3/4 of M1024.

#### **#2264 EMC: Addition of Submission Addresses in Insurance causing Error 5 on EMC Creation**

ISSUE: 6.9.01 introduced the ability to select which addresses were included on claims. Box 1 and 2 on the CMS 1450; and Box 32 and 33 on the CMS 1500 had the ability to be populated per insurance on paper and electronic claims. However, an error for some patient and insurance combinations caused the electronic generation to return two addresses per one address segment.

RESOLUTION: The electronic claim generation has been fixed so that only a single address is found and inserted into an address segment for electronic claims.

#### **#2266 Reports: OASIS-C reports - Incorrect agency address printing at the bottom of the report**

ISSUE: When printing an OASIS-C report, the report footer incorrectly displayed the agency address as 5555 Corporate Ave, Cypress, CA 90630 (which is HealthCare Synergy's corporate office address).

RESOLUTION: We have corrected the program to pull the agency name and address from the Agency Setup module in the HealthCare Assistant application.

---

## **Version 6.9.02**

---

## **Enhancements and Feature Requests**

### **#2240 PECOS: Status can show Enrolled, Not Enrolled and Pending**

ENHANCEMENT: Instead of just showing whether the physician is or is not on the CMS PECOS list, we have changed the PECOS status to be a drop down list containing Not Enrolled, Pending, and Enrolled. This will enable agencies to: indicate Enrolled once they appear on the CMS PECOS list; indicate Pending if the physician states and provides documentation that they are on the list or are in the process of enrolling and are not yet included in the latest CMS PECOS list; or indicate Not Enrolled if the physician is not and does not plan on enrolling for inclusion on the CMS PECOS list.

### **#2242 Library: 2011 ICD-9 codes added**

ENHANCEMENT: The diagnosis and procedure codes that will become effective October 1, 2010 have been added to the software. This also includes updating codes with description changes and codes that will expire on September 30, 2010. These new codes can be seen in the ICD-9 Add-in.

### **#2243 OASIS: POC Dx and OASIS M1024 Comparison Error Changed to Warning**

ENHANCEMENT: When saving OASIS, rows 7 - 14 on the Plan of Care are compared with the M1024 on the OASIS. If they do not match in contents or order, the resulting error message has been changed to a warning message instead. This allows the OASIS to be validated and locked when only the six diagnoses of M1020/M1022 match the first six on the Plan of Care.

### **#2247 PECOS: Automatic Updating of Physicians' PECOS Status**

ENHANCEMENT: When starting the application, HealthCare Assistant will check CMS' website for up-to-date PECOS Enrollment. Physicians entered in each agency, who are currently not enrolled or are pending PECOS Enrollment within HealthCare Assistant, will be updated accordingly so that users will not need to manually check each Physician's PECOS status.

### **#2252 Patient List: Patient Balance Column**

ENHANCEMENT: Patient Balance has been added to the Patient List. Similar to it being viewable on the Classic View Tab, Users with the Rights to view "Patient Balance on Patient List" in User Rights will be able to view it in the Patient List.

### **#2254 Login: Warning Presented for Supervisor Login Using Default Password**

ENHANCEMENT: To assist users with maintaining a high level of security, we have added a warning to have users choose a different password than the default one. To prevent this warning from displaying, it is highly recommended the Supervisor password be updated to a more secure password on the General tab in Agency Setup under the Administration Menu.

## **Corrections**

#### **#2241 OASIS C: M1012 Shows a Disposed Object Error when saving from within a Lookup Box**

ISSUE: When entering a diagnosis code in M1012 and while the down arrows are still visible, right-clicking within the lookup box and selecting Save will save the OASIS C but give an error saying it cannot access a disposed Object called Label. This error only seems to happen on M1012 and on no other diagnosis questions.

RESOLUTION: Closing the OASIS C form after saving has been fixed so that it no longer produces the disposed objects error.

#### **#2245 MSP: RAP Claims are Submitted with Medicare as Primary Insurance**

ISSUE: When a claim is marked as Medicare Secondary Payor (MSP), the RAP is sent with Medicare listed as the secondary payor. This caused problems with the claim because Medicare wants to be listed as the primary payor for RAP claims, but listed as the secondary payor for the final claims.

RESOLUTION: RAP claims list Medicare as the primary payor for MSP claims, but list Medicare as the secondary payor for the final claim.

#### **#2246 Reports: Non-Supervisors Unable to Save Public Report Parameter Template**

ISSUE: On any Report screen in the Reports Module, clicking any assortment of options and clicking Save prompts for a Name and an Access Level. From here the options that were selected may be saved for quick future retrieval for everyone or only the user who created the setting. When saving the report options with a Public Access Level when logged in as a user other than Supervisor, an insufficient rights message appears even though the rights option for Create Global Custom Reports is checked for the User in the User File Maintenance.

RESOLUTION: The checking of user rights for non-Supervisor users has been fixed to allow Public Report Settings to be saved.

#### **#2248: OASIS: Incorrect Effective Warning for Diagnosis Codes**

ISSUE: A Diagnosis Code that is not effective yet has a warning message that indicates it is expired.

RESOLUTION: A Diagnosis Code that is not effective yet has warning message the indicates the code is not effective yet.

#### **#2249: OASIS: Incorrect Expired/Effective Date Warning for Diagnosis Codes**

ISSUE: Diagnosis codes would become expired two days before the expiration date. Diagnosis codes would not become effective until two days after effective date.

RESOLUTION: Fix diagnosis codes to become expired/effective on their corresponding dates.

#### **#2250 Outlier Threshold Calculation incorrectly including Medicare Advantage Claims**

ISSUE: The Outlier Threshold calculation included on the Dashboard and subsequent report was incorrectly including Medicare Advantage claims (Claims with primary insurance categorized as Medicare Advantage in the Insurance Library).

RESOLUTION: The calculation and report have been fixed to not include Medicare Advantage Claims.

## **#2253 Dashboard: Plan of Care Summary Counts including Medical Updates**

ISSUE: The counts of Draft, Sent and Unsent for the POC Summary on the Dashboard are including Medical Updates. Assuming the system has one Draft Plan of Care and one Draft Medical Update, when clicking on the Dashboard POC Summary for Draft where the count is two will open the POC List showing only the Plan of Care, which would appear inconsistent to the user.

RESOLUTION: Since the POC List does not include Medical Updates, the counts of Medical Updates has been removed from the Dashboard's POC Summary.

---

# **Version 6.9.01**

---

## **Enhancements and Feature Requests**

### **#2212 Reports: Claims List - Sent Date filter includes a range**

ENHANCEMENT: Checking Sent, and selecting Sent Filter in the combo box, the Claims List can filter claims sent within a date range instead of a single date.

### **#2215 Reports: SOC Worksheet includes Referral Date**

ENHANCEMENT: This report has been rearranged to be more readable. It includes an improved header and footer to reduce the wasted space. Referral Date has been added to the top left corner of the page. Phone numbers were formatted to include parenthesis around the area code and zip code were modified to include a hyphen between the 5th and 6th digits if required. Additionally the information on the right side of the Patient Information was rearranged to be more readable. The SOC Date was moved to the upper right corner of the report opposite of the Referral Date.

### **#2216 CAHPS: Customized data export for Press Ganey for Kaiser**

ENHANCEMENT: Customized Press Ganey CAHPS data export for Kaiser agencies. Registration code provides access to this feature, so no user action is required to implement this functionality; simply choose Press Ganey from the Export Format options.

### **#2227: Added Oasis Error if M1016 ICD entries are not sequential, Error if M1010 and/or M1012 Procedure Codes are not sequential**

ENHANCEMENT: Added Error indicating that M1016 ICD entries are not sequential if an ICD is left blank and a preceding one has an ICD. Added Error indicating M1010 and/or M1012 Procedure codes are not sequential if a procedure code is left blank and a preceding one has a Procedure Code.

### **#2228 Billing: Claim Form Addresses Selectable per Insurance Company**

ENHANCEMENT: Box 1 and 2 on the CMS 1450 and Box 32 and 33 on the CMS 1500 can be selected via Insurance Carrier settings in the Library. Each box can contain either the Agency Physical Address or the Agency Mailing Address entered on the first tab of Agency Setup. On the CMS 1500, the Patient's address as well as Agency Physical and Mailing addresses may be selected as the Service Facility Address. Address selection from the Insurance Company screen is used on paper printing as well as Electronic Billing.

#### **#2229: SHP CAHPS export no longer requires Client ID**

ENHANCEMENT: Agencies that use the free SHP CAHPS data export to provide to other CAHPS vendors are no longer required to enter a Client ID. SHP still requires the Client ID for submitted CAHPS data; thus if you are submitting data to SHP you will need to enter the Client ID. You can omit the Client ID if you are using the SHP format, but submitting data to any other CAHPS vendor.

#### **#2233 CAHPS: Overall ADL Count will not include ADL for Feeding**

ENHANCEMENT: Changed CAHPS to match HHA change that does not include Feeding in overall ADL count (Change effects only DSS Research)

#### **#2234 CAHPS: Changed Press Ganey Update file to HHCAHPS\_UPDATE\_<sampleMonth><sampleYear>.csv**

ENHANCEMENT: Changed Press Ganey Update file to HHCAHPS\_UPDATE\_<sampleMonth><sampleYear>.csv

#### **#2237 CAHPS: Synovate - Added Russian, Chinese and Vietnamese Languages**

ENHANCEMENT: Russian, Chinese and Vietnamese languages join English and Spanish as exportable languages for Synovate's CAHPS Export. Previously, the three languages would be converted to Other when exporting Synovate CAHPS.

#### **#2244 OASIS: CMS Grouper supports new FY 2011 ICD-9 codes**

ENHANCEMENT: The CMS Grouper was updated to support the new FY 2011 ICD-9 codes that will become effective October 1, 2010. These changes will allow the correct HHRG and HIPPS codes to be calculated and included on claims. Any OASIS assessments entered with an ROC date, Assessment date, Death/Transfer date of Oct 1, 2010 or later will need to be edited and saved after upgrading to this version to receive the correct HIPPS/HHRG codes. Use the Revenue Recovery report to see which OASIS are affected by this new CMS Grouper.

### **Corrections**

#### **#2217 CAHPS: SHP CAHPS data export methods updated for SHP requirements**

ISSUE: SHP revised the data they expect in the CAHPS data.

RESOLUTION: The SHP CAHPS data export has been updated to include the data they now require. No user action is required to use these updates.

#### **#2223 Report: TAR/Pre-Authorization - Error displays with printing if agency has an apostrophe in its name**

ISSUE: Error displays with printing TAR from Patient Claim Info if agency has an apostrophe in its name.

RESOLUTION: Modified the report to allow for apostrophe in agency's name.

**#2224: New Billing Check - Discharge Code '08' will cause EMC Error for PPS Claims**

ISSUE: Using Discharge Code '08' on PPS Claims cause the entire batch of claims to be rejected.

RESOLUTION: The System , marks the claim with an error that has a discharge code '08', preventing the claim from being included in the batch.

**#2225 Licensing: When choosing a Kaiser License, an error would occur even though licensing was successful**

ISSUE: Licensing: When choosing a Kaiser License, an error would occur even though licensing was successful. Users would receive an error message "Authorization Licensing failed - Error Number 1".

RESOLUTION: We corrected the erroneous error so that the licensing functions normally.

**#2226 Reports: Patients Served by Diagnosis - Admitted and Discharged Totals**

ISSUE: The Admitted and Discharged row Totals for any given diagnosis were mimicking the Unduplicated row Total for the Patients Served by Diagnosis report in the Statistical Patient Group.

RESOLUTION: The Admitted and Discharged row Totals for a diagnosis group will show the correct unduplicated patient count for Admitted and Discharged, respectively.

**#2230 Claims: Claims List not viewable by a non-Supervisor**

ISSUE: While logged into HealthCare Assistant with a User Name other than Supervisor, viewing the Claims List from the Billing menu gives an object reference error and the application closes. The Claim List remembers the previous checkbox filters set when the list is closed; however loading the previous filters causes the error.

RESOLUTION: The loading of the user's filter preferences from the previous use has been fixed to load properly. If the user's preferences cannot be loaded correctly, the list will open with all filters checked.

**#2231 Claims: Viewable ledger rights causes error when opening Claim**

ISSUE: Agencies can limit the user rights for types of ledger items that can be viewed. When a user has user right limits on what type of ledger items they can view in the Ledger an error, "Item cannot be found in the collection" is produced when opening a 1450 claim. Clicking OK will let the application continue, but the ledger items are not properly hidden from the user based on their User Rights.

RESOLUTION: Hiding the Ledger items viewable by the User according to User Rights has been corrected when viewing a 1450.

**#2232 Eligibility: Checks failed without SSN entered.**

ISSUE: A change in functionality occurred in 6.8.8 that resulted in a failed eligibility check for patients that do not have a SSN entered.

RESOLUTION: Corrected creation of the Eligibility 270 file so that eligibility can be checked for patients without a SSN.

### **#2235 Reports: Visit Compliance Calendar by Certification and Supplementals corrected**

ISSUE: The Visit Compliance Calendar by Certification report does not show the Weekly Visit Frequency totals for Supplemental POT.

RESOLUTION: The report was modified to include the Visit Frequency totals entered in Supplemental POT with or without the Override checkbox checked. Visit frequency totals now appear in the weekly totals and report summary totals.

### **#2236 Payroll: Paychex - Earnings Code incorrect**

ISSUE: Our system does not store the individual paychex earnings code. We have always defaulted it to "01" hours. We introduced an issue into our program and caused it to incorrectly put in the code "10" which indicates a 1099 paychex earnings code.

RESOLUTION: We have corrected the issue by putting in the correct "Hourly" earnings code of "01".

### **#2238 OASIS/485: Saving a 485 with existing OASIS-C entered in 6.8.10 or earlier was prevented.**

ISSUE: If an OASIS-C Assessment had been entered in 6.8.10 or earlier and not resaved in 6.9 or higher a user would be shown an error message when saving the 485. This message would inform the user that the DX codes and order differed between the OASIS and the 485. This resulted from the addition of the M1024 Column 3 & 4 codes that were added to the 485 to prevent potential survey discrepancies. A conversion was not performed on the existing OASIS-C assessments during the upgrade.

RESOLUTION: Existing OASIS-C assessments are converted to support the new DX structure on upgrade to 6.9.01.

### **#2239 CAHPS: Deyta export data refined**

ISSUE: Deyta has modified their data submission requirements to include date formats, values for missing items or questions not answered.

RESOLUTION: These new data submission requirements have been included in the latest version.

---

## **Version 6.9.00**

---

### **Enhancements and Feature Requests**

#### **#2191 CAHPS: Synovate CAHPS Export Settings**

ENHANCEMENT: From the Tools menu, Agencies can Activate or Deactivate the current machine for Synovate's CAHPS Export. Agencies can also set the export day of the month for those using Synovate to fulfill CAHPS requirements. The default day is the 10th of the month.

#### **#2200 POC/485: Utilize DX Codes from M1024 in the Diagnosis for the care plan**

ENHANCEMENT: When creating a new Plan of Care/485 or refreshing the DX codes from the OASIS any codes used for M1024 in Column 3 or 4 are placed in the Plan of Care diagnosis grid starting at position 7. This new feature helps ensure that DX codes used in M1024 appear on the plan of care to prevent a potential survey discrepancy.

#### **#2201 Medical Supply Export: Patients Under Eval are included in Export**

ENHANCEMENT: Under Eval patients with insurance information entered are now included in the Medical Supply Export.

#### **#2207 MSP: Claim switches PPS and non-PPS based on Primary Insurance Billed**

ENHANCEMENT: Editing an open or on-hold MSP claim will automatically mark claim as PPS or non-PPS based on the primary insurance selected to be billed. In earlier versions, changing an MSP claim from non-PPS to PPS, or vice-versa, required deleting the claim, changing the order of insurance in the Insurance tab and recreating the claim from the Cases tab.

#### **#2209 Library: Physicians now have indicator for PECOS**

ENHANCEMENT: A checkbox has been added to the Physician library on the License tab. This is a manual checkbox that the user can check when the physician has enrolled in PECOS. There is no automatic check performed by the software to see if the physician is enrolled; thus agencies will have to manually check on a physician's enrollment in PECOS. If the agency does not check for PECOS enrollment and mark the physician as appropriate the physician will not show as enrolled.

#### **#2210 Admission: Warn User if Physician is not enrolled in PECOS**

ENHANCEMENT: Upon creating or editing an Admission, a warning is presented if the selected Physician is not enrolled in PECOS. Agencies are able to track PECOS enrollment in HealthCare Assistant by selecting the Physician in the Caregiver Library, going to the License tab and checking "Enrolled in PECOS".

#### **#2211 Route Sheet: Faster Load and Refresh**

ENHANCEMENT: Loading and refreshing the Route Sheet has been significantly sped up.

#### **#2218 Reports: Patients Served by Diagnosis - Reduced Paper usage, Clarify Status Column**

ENHANCEMENT: A footnote has been added at the bottom of each page that explains the intent of the Total column. Changed report title and filter options to a single line in the header. Moved agency information into footer into a single line. Report length may be reduced by as much as half. Modified Status column in the details section to show status description instead of status code.

### **Corrections**

**#2178: Auto-add DX codes with effective From or effective To date missing**

ISSUE: An Unhandle Exception Message would be displayed if you tried to Auto-add DX codes with an effective 'From' and / or effective 'To' not set.

RESOLUTION: System is able to transfer a non-set effective 'From' and / or effective 'To' date to the Diagnosis Library.

**#2198 Payroll: Recall includes processed records that fall on the custom date range start/end**

ISSUE: When recalling processed items in the Payroll module, a processed item would not appear in the list if searching by custom date ranges and the start or end period of the selected range was the same day as the processed items.

RESOLUTION: Corrected selection process to include processed items that fell on start or end of custom date selection range.

**#2199 Reports: Correct title is shown when viewing the Outlier Threshold Report**

ISSUE: Title on Outlier Threshold Report incorrectly displayed OASIS-C Report Viewer when clicking on the Outlier % from the dashboard.

RESOLUTION: Corrected to display Outlier Threshold Report when viewing this report.

**#2202 Ledger: Editing payments attached to claims marked as sent not allowed**

ISSUE: Payments attached to claims marked as sent cannot be edited.

RESOLUTION: Corrected to allow editing of claims regardless of claim status.

**#2203 Eligibility Assistant: Running on 64-bit OS**

ISSUE: Eligibility Assistant will not run on 64-bit versions of Windows OS.

RESOLUTION: Corrected compatibility to run on 64 bit versions of Windows OS.

**#2204 Electronic Billing: After printing prooflist, Preview list did not retain the specific claims checked to be included in the file.**

ISSUE: Checks made on the Preview list prior to printing the prooflist were not kept after printing the prooflist.

RESOLUTION: Claims check on Preview are listed and are maintained even after the prooflist is printed.

**#2205 Route Sheet: Corrected Overflow Error**

ISSUE: Users with a large number of route sheets created in the system can receive an overflow error. This will occur when more than 32767 route sheets have been created.

RESOLUTION: We changed the internal value used to store the route sheet detail number to support millions of route sheets.

#### **#2206 ERA: MSP Claim balance does not consider prior payments or adjustments**

ISSUE: When importing an ERA with a MSP claim, the balance does not consider the prior payments or adjustments.

RESOLUTION: The ERA import has been fixed to correctly calculate the balance for MSP claims.

#### **#2213 CAHPS: Press Ganey - End of Patient Record missing ",\$" per line**

ISSUE: The CAHPS Export within HealthCare Assistant does not append ",\$" to the end of each Patient record in Press Ganey export files. Agencies using Press Ganey would need to manually add a ",\$" to the end of each line.

RESOLUTION: The CAHPS Export in HealthCare Assistant has been fixed to add ",\$" at the end of each Patient record for Press Ganey export files.

#### **#2214 Reports: Patient Count by Age Group and Patient Served by Diagnosis Statistical Reports - Clarify Total column**

ISSUE: A client has reported that the Total columns on these two reports are not adding correctly. After further analysis, a solution was made that the calculation for the Total columns for both reports are correct. Both reports just need to clarify the intent of their respective Total columns.

RESOLUTION: We have added a note at the bottom of each page for each report that explains the intent of its Total column.

#### **#2219 HOSPICE: UB-04 Billing Units and Line Summarizations**

ISSUE: Producing a UB-04 calculates a visit count instead of the number of billing units. The visits are summarized by week.

RESOLUTION: The production of the UB-04 for HOSPICE has been fixed to include the total number of billing units instead of visit count and the line items are no longer summarized by week.

#### **#2220 Claim Submission: Handles correct Source of Admission for Recert claims on or after July 1, 2010**

ISSUE: CMS's recent changes mandate that Recert claims on or after July 1, 2010 must have '1' as the Admission Source or claims will be rejected by Medicare.

RESOLUTION: We have altered the 'Patient Transfer Check Patch Version 6.8.00 to 6.8.10.exe' to be compliant with the CMS changes. Recert claims created on or after July 1, 2010 will have '1' as the Admission Source. The fixed is also included in the later version of HealthCare Assistant.

#### **#2222 Ledger: Invalid Bookmark Error When Changing Patients**

ISSUE: An invalid bookmark error would occur under certain conditions while changing patients when viewing the ledger tab. When multiple ledger entries are selected, then when selecting a patient on the Patient List while the mouse is hovering over the ledger list will sometimes give the bookmark error.

RESOLUTION: The Ledger list has been changed when loading a different patient while multiple ledger items are selected. The ledger will now simply select the last ledger item for the newly selected patient to prevent the invalid bookmark error.

## **#2208 Reports: Patient Visit List and Patient Appointment List - Incorrectly rounding hourly visits to the nearest whole number**

ISSUE: The Patient Visit List and Patient Appointment List are incorrectly rounding hourly visits to the nearest whole number.

RESOLUTION: We modified both reports to now round to the nearest minute.

---

# **Version 6.8.10**

---

## **Enhancements and Feature Requests**

### **#2167 Communications: Added spell check to Notes on Communication Screens**

ENHANCEMENT: We added the spell check to the communication data entry window and communication wizard to restore functionality that was lost in a prior release.

### **#2179 Plan of Care: Default Orders And Goals**

ENHANCEMENT: Updated "Plan of Care" Default Orders And Goals for Oasis C. Oasis B-1 can be view via notepad for transferring of Orders and Goals. Any existing Orders/Goals are automatically transferred from the Pre-OASIS-C to OASIS-C where items matched. Users can use the Previous Version button to see the Pre-OASIS-C Orders/Goals.

### **#2182 Claims: Claims List allows editing and printing of claims list**

ENHANCEMENT: A list of claims has been added to the system and can be accessed from the Billing menu. This list is a resource to quickly edit the claims within the system without the need to navigate down to a specific patient. The list can be sorted just like all other lists in the system. The list can also be printed using the Print List button. The list that is printed utilizes the filters that are applied when printing.

### **#2184 Ledger: Allow selection of multiple items**

ENHANCEMENT: Holding down Shift or Control and left-clicking entries allows for selecting multiple ledger items in the Patient File. This allows users to include to claim; exclude to claim; or delete more than one ledger entry at a time.

### **#2186 CAHPS: Press Ganey data export**

ENHANCEMENT: The data for a CAHPS survey can now be exported for Press Ganey from within the HealthCare Assistant. Select Press Ganey from the option window displayed when clicking File | Export | CAHPS from the main menu.

### **#2187 CAHPS: DSS Research data export**

ENHANCEMENT: The data for a CAHPS survey can now be exported for DSS Research from within the HealthCare Assistant. Select DSS Research from the option window displayed when clicking File | Export | CAHPS from the main menu.

#### **#2188 CAHPS: Arbor Associates data export**

ENHANCEMENT: The data for a CAHPS survey can now be exported for Arbor Associates from within the HealthCare Assistant. Select Arbor Associates from the option window displayed when clicking File | Export | CAHPS from the main menu.

#### **#2189 CAHPS: Registration codes required for some vendors**

ENHANCEMENT: SHP and Synovate are preferred vendors for CAHPS and are available for free. Other vendors are supported, but require a registration code and an additional fee for ongoing maintenance. A list of supported CAHPS vendors is available in the help file.

#### **#2190 Dashboard: OASIS 5 day submit warning**

ENHANCEMENT: A new item "Submission Required" has been added to the Medicare/Medicaid dashboard. This item is a count of how many OASIS assessments are 25 days or more from the M0090 date. Since all OASIS are supposed to be submitted to DHS on or before 30 days of the M0090 date, these assessments should be resolved and submitted promptly.

#### **#2192 General: Patient code limits special characters**

ENHANCEMENT: Users are limited to alphanumeric and the '-' character when entering a patient code. CMS requires masking of data when entering and submitting private insurance patients. Allowing users to enter characters into the patient code causes DHS to reject submitted OASIS assessments. This occurs because DHS incorrectly interprets these assessments as private pay patients when they see these special characters in the data.

#### **#2193 Dashboard: Outlier Percentage with Outlier Claim Report**

ENHANCEMENT: The percentage of outlier payment compared to the total claim payments has been added to the Dashboard. Clicking on this dashboard item will print out a report of the claims that are included in these outlier payments. This percentage and report will allow agencies to monitor the outliers and see where they stand with the new CMS 10% Outlier payment procedures.

#### **#2194 Claims: Handle CMS changes to Admission Source Codes and Condition Code**

ENHANCEMENT: Beginning July 1, 2010, Medicare will no longer accept the Point of Origin Codes B and C as an Admission Source on new claims. Code C will not be replaced but Code B will be replaced with Condition Code 47 ("Transfer from another Home Health Agency"). These changes have been addressed in the HealthCare Assistant. Admission Source has been renamed to be Point of Origin on the Intake screen and will no longer include codes B or C. A new question has been added on the Intake screen asking if the "Patient was Admitted from Another HHA?". Selecting Yes will automatically put a Condition Code 47 on any Claims generated from within this Admission.

A Billing Warning is shown for any claims that include an Admission Source of B or C when previewing claims to be sent electronically. Claims effective on or after July 1, 2010 that have this warning will be automatically refreshed after selecting a Point of Origin and answering "Patient Admitted from Another HHA?" on the Intake screen of the associated Claim.

#### **#2195: CAHPS: Pinnacle**

ENHANCEMENT: The data for a CAHPS survey can now be exported for Pinnacle from within the HealthCare Assistant. Select Pinnacle from the option window displayed when clicking File | Export | CAHPS from the main menu.

#### **#2197 Manual CAHPS export only exports data from the Currently logged in Agency**

ENHANCEMENT: For certain CAHPS vendors, users must manually create the export file to submit to them. This process will only include patient data from the currently logged into Agency. If users have more than one home health agency in their database, they must log in to each agency and create a separate file.

### **Corrections**

#### **#2180: Communication: Enter/Return key now creates new line in Notes field**

ISSUE: Pressing Enter/Return in the Notes field of the Communication Wizard would Save the Communication. Many users don't know that you can use the Ctrl + Enter key combinations to create a new line in the notes text box.

RESOLUTION: Pressing Enter/Return now produces a new line for 'Notes'. Users must now click on the Save/New or Save/Close button to save the communication.

#### **#2181 Reports: Performance Per Episode By SOC Diagnosis - Total Cost is Incorrect**

ISSUE: The Total Cost calculation in the detail section is incorrect. The amount always shows the first row's Cost amount per diagnosis.

RESOLUTION: The report was modified to show the correct Cost totals.

#### **#2183 Agency Setup: Upon creating new Agency clicking on the Offices Tab produces Type Mismatch Error**

ISSUE: Upon creating a new agency, if the user clicked on the second tab "Offices/Location Setup" a type mismatch error would occur.

RESOLUTION: We have corrected the application so that this error no longer occurs. Users will now be required to enter all required fields on the first tab of setup prior to clicking on other tabs.

#### **#2185 Scheduler: Subscript out of range error when Episode is longer than 10 weeks on Summary Tab**

ISSUE: Clicking on the Summary tab in the Scheduler when the episode is longer than 10 weeks produces a Subscript out of Range error and closes the program. The Week Number column was originally limited to 10 weeks to fulfill the length required for a 60-day PPS Episode.

RESOLUTION: Producing the Week Number column on the Summary Tab has been fixed to display any number of weeks the Episode spans.

#### **#2196 Insurance and Payment Information: Not allowing to save the Primary TAR for Non-PPS Insurance**

ISSUE: Users were not able to save changes made to Primary TAR for Non-PPS Insurance.

RESOLUTION: The form was modified to allow saving of Primary TAR.

---

## Version 6.8.09

---

### **Enhancements and Feature Requests**

#### **#2135 OASIS: M Item numbers have been added to the OASIS validation messages**

ENHANCEMENT: In response to users' feedback, we have added the M Item numbers to the question references within the validation error messages for the OASIS-C. These messages already had the M Item number of the main offending question, but had the question title for other questions referenced in the message. Since many clients are not familiar with the assessment questions, these M Item number should make it easier for clients to locate and verify the answers.

#### **#2144 OASIS: Printing of the OASIS-C assessment forms with populated data added**

ENHANCEMENT: The printing of the OASIS-C assessment forms with the patients name, SOC date, birth date and patient code have been added to the HealthCare Assistant. Because all Pre-OASIS-C assessment forms should have been completed at this point, we have removed the printing of these forms. To print these forms, go to the Case tab on the patient file and select Print button at the top of the form.

#### **#2147 Diagnosis Library: Automatically pull key information from Add-In List**

ENHANCEMENT: In response to user feedback, entering or editing a diagnosis code in the library will automatically pull the ICD9 dates and descriptions from the Add-In, if available. The program will ask before replacing diagnosis information.

#### **#2150 EMC: Modified the Electronic Billing file to handle MSP billing**

ENHANCEMENT: Modified Electronic Billing file creation to handle Medicare as a secondary payer billing.

#### **#2154 Point of Care Tools Interface: Physician's NPI now synchronizes point of care tools**

ENHANCEMENT: If users use any third party point of care tool such as E-Clinical or HealthCare SOS, the physician Library now also synchronizes the physicians NPI as well.

#### **#2155 CAHPS: Support added for Synovate, OCS, and Fazzi**

ENHANCEMENT: Support has been added to produce Export data files for Synovate, OCS, and Fazzi. These third party vendors are the latest options added for patient satisfaction surveys required for the CMS requirement.

#### **#2156 CAHPS: Support added to allow patient to opt out of the survey**

ENHANCEMENT: A check box has been added to the bottom right of the Patient File allowing a patient to opt out of the survey. If this box is checked, the patient data will not be included in the CAHPS export data to any CAHPS vendor.

**#2157 OASIS: Added Oasis Rule to insure M0104 Physician Referral Date is less than 140 years ago**

ENHANCEMENT: Added Oasis Rule to insure M0104 Physician Referral Date is less than 140 years ago. A warning will appear for OASIS-C assessments with a referral date that exceeds 140 years in the past. While this is not a documented CMS rule, a client did receive this warning when submitting OASIS data.

**#2158 CAHPS: Automatic CAHPS Export for Synovate**

ENHANCEMENT: The application now has the ability for Synovate (Preferred CAHPS Vendor) to automatically collect CAHPS information. To sign up with Synovate, please contact Chris.Brown@synovate.com or (800) 279-2602 ext. 24

**#2159 Billing: Added ability to designate billing code for Physician**

ENHANCEMENT: Agencies using Outpatient Rehab and billing on CMS 1500 (X98) needed the ability to bill using the rendering physician code instead of referring physician code. A checkbox was added to the Insurance Company Library to support this functionality. If the Rendering Physician check box is checked, the EMC file will include the Rendering physician code (82) instead of the default Referring Physician code (DN). Home Health bill using the Rendering Physician and thus this checkbox defaults to CHECKED.

**#2160 MSP: Added a second Claim Primary Adjustment, when billing secondary insurance**

ENHANCEMENT: A second primary adjustment section was added to the claim data entry window. This is used when billing Medicare Secondary Payer claims if there are multiple primary adjustments.

**#2161 Billing: Added upcoming CMS changes for admission source**

ENHANCEMENT: Effective July 1, 2010 CMS will no longer allow the use of Admission Source B - Admitted from Home Health Agency or C - Readmitted from same Home Health Agency. Agencies will need to document this type of admission using Condition Code 47. Two new EMC warnings were added to accommodate this change; one warning if B or C is used as admission source on or after 1 July 2010, and one if Condition Code 47 is used prior to 1 July 2010. Condition Code 47 was also added to the software.

**#2162 Eligibility Checks: Request Episode information in the future 4 months**

ENHANCEMENT: In the Eligibility Checks, we have now added the ability to pull down future episode information. In addition to the 12 months of Episode history, we are also including 4 months of future episode information if available from CMS.

**#2163 Reports: 485 and Supplemental Reports include Suffix for Patient**

ENHANCEMENT: If a patient has a suffix, it will now be included in the name when printing on the 485/487. The print order will be Last Suffix, First MI. if all four portions of the name are present. The print order will be Last, First MI. if the suffix is not present. The print order will be Last, First if neither the suffix nor middle initial is missing.

**#2168 Reports: Added Type of Bill (TOB) and Payment Type to Remittance Advice Report**

ENHANCEMENT: Two new columns were added to the detail of this report. Each detail line now includes the TOB or Type of Bill which comes from the RA or the data manually entered and Payment Type which comes from the chart of account selected or the RA.

**#2171 Billing: Added "Received" Subdirectory to intermediary directory for downloaded files**

ENHANCEMENT: In order to keep files downloaded from Visionshare separate from the export files, we added a "Received" subdirectory that will now contain the newly downloaded files.

**#2172 EMC: Combined activity of Finding and Previewing Electronic Billing Claims**

ENHANCEMENT: Combined activity of Finding and Previewing electronic billing claims. Clicking "Find Claims" then clicking "Preview Claims" has been replaced with a "Find and Preview Claims" button.

**#2177 Billing: Added the 3% Rural add-on**

ENHANCEMENT: CMS finally published the 3% add on rates mandated by the recent healthcare reform package. These updated rates have been added to the software. All affected claims are recalculated during the upgrade of the software for version 6.8.0.9.

**Corrections**

**#2137 Route Sheet: Added missing parameters to prevent "Wrong number of parameters" error**

ISSUE: When posting mileage through the route sheet a "Wrong number of parameters" error was displayed to the user.

RESOLUTION: The missing parameters were added to prevent the error when posting visits with mileage.

**#2140 Reports: On Call List corrected to show patients without scheduled visits but suppress ghost visit line**

ISSUE: A change was done in 6.5.04 that would suppress a ghost visit line that showed nothing except 0/0 in the totals portion of the visits for a patient. This change inadvertently also prevented any patients from showing that did not have any scheduled visits.

RESOLUTION: The report has been modified to print patients with no scheduled or posted visits, but also now suppresses the blank line in the visits section where only 0/0 shows in the totals column.

**#2148 EMC Claims File: Rejected because of missing data for claims not covered by a certification**

ISSUE: An entire EMC claims file was rejected by Medicare because of a claim including in the file not covered by a certification period. The application correctly warns the user that the data is missing prior to submission and that the claim may get rejected, but the entire batch should not be rejected.

RESOLUTION: The EMC was modified to prevent rejection of the entire batch of claims file when the scenario above happens. However, a claim within a claims file may be rejected by Medicare if it has a missing data.

**#2149 PPS Pricer by Patient Report: Outlier Payment notification and HIPPS Code Overlaps**

ISSUE: If the report contains outlier payments, printing this report will overlap the Outlier Payment notification and the HIPPS Code in the detail section.

RESOLUTION: The report was modified so "Outlier payment" and HIPPS Code will not overlap.

#### **#2151 Admission: Auto Select Most Recent Admission**

ISSUE: The last admission created will be selected by default, regardless if it was the most recent.

RESOLUTION: The most recent admission is automatically selected when opening a patient and navigating to the Cases tab.

#### **#2152 Electronic Billing: Prooflist Summary file reflects payments posted to existing claims**

ISSUE: When adding functionality to Electronically Bill Medicare Secondary Payer (MSP) claims, we noticed that the Expected payment column on the proof summary report did not reflect any prior payments made to the claim.

RESOLUTION: The Expected payment column on the Proof Summary report now reflects any payments made. The report totals the Reimbursement rate for each charge and then subtracts any insurance payments already made to produce the expected payment.

#### **#2153 Electronic Billing: Creating an electronic file produces error and does not complete when a claim is missing a Value Amount**

ISSUE: Users could not create an electronic claim file for claims that had a value code with no corresponding value amount.

RESOLUTION: We modified the claim file to not error out in the above case. This would still cause the electronic file to be rejected though, so we also prevent the user from saving a claim if they are missing a value amount.

#### **#2164 Scheduler: Corrected Overflow error in Scheduler**

ISSUE: An overflow error was being received by some clients when posting visits in the scheduler with sub accounts. We discovered the error occurred for clients who used the scheduler and had a large number of visits.

RESOLUTION: Increased size of internal value holding the visit information; thereby removing size limitation resulting in overflow error.

#### **#2165 Claims: Medicare Secondary Payer (MSP) claims now include the HIPPS code**

ISSUE: The HIPPS code was not included when billing Medicare as the secondary on claims. This occurs because the original claim billed to private insurance companies does not have a link to the OASIS which generates the HIPPS code.

RESOLUTION: The appropriate OASIS for the claim period is calculated and the HIPPS code is now included in the claim when billing Medicare as secondary payer on claims.

#### **#2169 Reports: On Call List - Handles patients with the same name**

ISSUE: Patients with the same name were listed multiple times in the report if sorted by patient name.

RESOLUTION: The report was modified to correct the issue.

**#2170 Billing: Medicare Secondary Payer (MSP) billing corrects T3 amount**

ISSUE: The T3 amount in the electronic claim file failed to include a \$0.00 when the primary insurance company did not pay on the claim.

RESOLUTION: The T3 segment now includes a \$0.00 in the EMC file for MSP claims when the primary insurance company did not pay on the claim.

**#2173 EMC: Exporting and Submitting to VisionShare perform in correct order**

ISSUE: Processing with both the "Auto Export" and "Auto Submit to Visionshare" options checked exports the processed file and moves its location on the disk so that VisionShare is not able to find and submit it.

RESOLUTION: The order of operation has been changed so that when both the "Auto Export" and "Auto Submit to Visionshare" are checked, the submission to VisionShare is performed first, then the file is moved to the Export folder location.

**#2174 CAHPS Export: Corrected "Total Patient Visit" to be all Patients with visit in the period. Also added patients under 18 years old as an excluding factor**

ISSUE: Total Patients Visited count was including those patients in the CAHPS sample regardless of whether or not a visit was performed. Also, the program was not excluding patients who were under 18 years of age per CAHPS requirements.

RESOLUTION: Total Patient Visit is now all Patients visited within the sample month even those who are not in the sample. The application is now also excluding patients less than 18 years of age.

**#2175 Patient Insurance: Secondary TAR Entry Field is Disabled Appropriately for MSP**

ISSUE: Entering a patient insurance where the Primary Insurance is not Medicare and the Secondary Insurance is Medicare, the Secondary TAR entry field incorrectly remains editable for the user.

ENHANCEMENT: To prevent the suggestion that the Secondary TAR is being saved and used somewhere, if the Secondary Insurance is Medicare, the entry field for the Secondary TAR becomes non-editable.

**#2176 Claims List Report: Not sorted in order when no date grouping is chosen**

ISSUE: Claims list is not sorted in order when No Date Grouping is selected.

RESOLUTION: The report was modified to sort by patient name and patient code when No Date Grouping is selected.

---

**Version 6.8.08**

---

**Enhancements and Feature Requests**

#### **#2104 HOSPICE: Handles billing of HCPCS codes and Billing Units in 15-minute increments**

ENHANCEMENT: The 2010 requirements for HOSPICE mandate agencies to bill HCPCS Code and Billing Units in 15-minute increments. The HealthCare Assistant application was modified to comply with the new requirements for HOSPICE Agencies.

#### **#2109 Claims: Manual and Batch Claims Entry continues on pressing Enter**

ISSUE: Previously on the Prompts during Make Claims for batch and single non-PPS patient, pressing Enter would continue with the claim generation. While consolidating features for these Prompts, the ability to press Enter to continue was lost.

RESOLUTION: Pressing Enter continues the claim generation when on the Batch Make Claims screen and on the prompt for Make Claims for non-PPS patients. Pressing Escape on these windows will cancel the claim generation.

#### **#2116 OASIS: Saving and Choosing to view Errors or Inconsistencies will automatically select appropriate tab**

ENHANCEMENT: When saving an OASIS C, choosing to view Errors, Warnings or Inconsistencies will automatically select the appropriate tab to instantly view the Errors, Warnings or Inconsistencies.

#### **#2117 OASIS: Added Validation Rule that confirms that only Procedure Codes can be selected for M1012**

ENHANCEMENT: Added Validation Rule that confirms that only Procedure Codes are assigned to M1012

#### **#2122 General: Important Announcements available in HealthCare Assistant via RSS Feed**

ENHANCEMENT: Announcement of new features, solutions, and releases is now available within the HealthCare Assistant through our RSS feed. Important messages sent through email often times is not read by the actual users of the software. This new feature will enable the actual users to receive these announcements.

#### **#2123 OASIS: OASIS-C skip patterns added**

ENHANCEMENT: The OASIS skip patterns have been added for OASIS-C. This feature automatically disables the M item questions that should not be answered based on previously answered questions. Users will no longer need to manually check the Skip Item check box.

#### **#2134 Reports: Open OASIS-C Report and Summary allows interaction with the application**

ENHANCEMENT: Due to user requests, we have changed the OASIS-C Report and Summary to allow access to the HealthCare Assistant while either of these reports are still open. If users click off of these reports, they can be brought back into focus by clicking on them from the task bar or using the Alt-Tab keys. A new report window will be opened each time the report or summary is printed; thus it is possible to have multiple report windows open at the same time.

#### **#2141 OASIS: Data entry window maximized upon opening**

ENHANCEMENT: The OASIS-C data entry window is maximized when opening via a New or Editing an existing OASIS.

## **Corrections**

### **#2085 OASIS: Missing Direction for M1310 - M1314**

ISSUE: CMS provided direction on when to enter the pressure ulcer wound measurements for M1310 - M1314 which was not showing on the assessment data entry form. This was causing users to enter measurements only to be given a validation error stating that these questions must be blank.

RESOLUTION: The CMS provided direction for M1310 - M1314 was added to the OASIS assessment form for SOC/ROC and Discharge.

### **#2107 Eligibility: Error "End Date cannot be null" occurs when patient elects Hospice**

ISSUE: If a patient elected Hospice and a user checked for eligibility the system would produce an error "End Date cannot be null". The eligibility information would be updated correctly though. The system is looking for a beginning and end date for each type of service. Hospice has a start date, but no end date which is the cause of the error.

RESOLUTION: In the above scenario, the eligibility check ignores the Hospice election date and period and continues to only update the Home Health Coverage periods.

### **#2108 Patient Insurance: Electronic Billing produces error if Insured's Address is not entered**

ISSUE: Claims submitted through EMC are being rejected by Medicare Intermediaries because the insured's address included in the claim is empty. This can be caused by in Patient Insurance and not adding the Insured's address. No Error is given when Use Patient Address is unchecked and insured's address is left empty upon save.

RESOLUTION: When attempting to save the Patient Insurance, if Use Patient Address is unchecked and the insured's address is not entered an error will show not allowing to save the changes made until the insured's address is completed.

### **#2110: Missed Translation of MASK VERSION from Oasis B1 V1.6 to Oasis C V2.0**

ISSUE: MASK VERSION was not being translated correctly between Oasis B1 V1.6 to Oasis C V2.0

RESOLUTION: Since Oasis C V2.0 does not use Masking, it will not take the mask version data from Oasis B1 V1.6.

### **#2111: Clear All Inactive M00Questions when Editing Oasis-C (or importing Oasis-C, or from Translating Oasis B1 V1.6 to Oasis-C)**

ISSUE: Some inactive M00 Questions would have Answer set. No way to clear these because inactive M00s are inaccessible.

RESOLUTION: The application clears any inactive M00 Questions prior to editing to prevent reporting errors that questions must be blank, which are not on the assessment.

**#2112: M1012 does not warn when at least one procedure code was given and NA or UK was space filled**

ISSUE: A validation error was not produced when M1012 had one or more procedure code and NA or UK was space filled. If a procedure code is entered then NA and UK must contain a zero (0). It was possible for third party vendors using the HealthCareSynergyOASIS interface to pass in an invalid value for these a nswer combinations, which could not exist when entering an assessment through the OASIS-C GUI.

RESOLUTION: A validation error was added to prevent locking when M1012 contained one or more procedure code and NA or UK was blank or space filled.

**#2113 OASIS: Formatting of M1310 - M1314 validated on import**

ISSUE: M1310 - M1314 values were not being validated to ensure they contain a decimal point when coming in from third party vendors using the HealthCareSynergyOASIS interface. This caused problems opening an OASIS assessment in the HealthCare Assistant.

RESOLUTION: The values for M1310 - M1314 are now validated for correct formatting when passed by third party vendors.

**#2114 OASIS: Submission does not update the Agency Submitter ID in the OASIS when the ID is changed**

ISSUE: The Agency Submitter ID is now stored in the OASIS data at the time the OASIS assessment is created; it used to be added when the submission file was created. If the Agency Submitter ID was changed after the OASIS assessment was entered, the old ID would be submitted to the state DHS and would result in a rejection.

RESOLUTION: The application was modified to update the OASIS submission data when the Agency Submitter ID is changed. The OASIS is updated with the new Agency Submitter ID when the ID is changed for Open, Valid and Locked assessments. Exported OASIS assessments have this ID updated when an individual assessment is Unlocked or an OASIS Submission file is Reset.

**#2115 OASIS: M1845 appearing on OASIS Report for RFA 4 and 5**

ISSUE: Unanswered M1845 incorrectly showing on the OASIS C Report for RFA 4 and 5 followups. M1845 is not a OASIS Followup question.

RESOLUTION: M1845 was removed on the OASIS Reports for RFA 4 and 5.

**#2118: OASIS: Importing B1 into Has4Win was not reporting B1 structure errors.**

ISSUE: Importing B1 into Has4Win was not reporting B1 structure errors.

RESOLUTION: Errors will be reported if the B1 being entered into Has4Win has structural errors.

**#2119 OASIS: OASIS C Report and Summary Does Not Include the Patient's Suffix**

ISSUE: The patient's suffix was never included in the answer to M0040, nor in the patient name in the header and footer.

ENHANCEMENT: The patient's suffix has been included in OASIS Report and OASIS Summary in the answers for M0040, the reports' headers and reports' footers.

### **#2120 OASIS Import: Shows status "Import Successful" but OASIS or Plan of Care was not imported**

ISSUE: If the B1 string being imported has a diagnosis code with invalid ICD-9 code associated with it in the Diagnosis Library, the import process will continue and show an incorrect status of "Import Successful" but the B1 string will not be imported.

RESOLUTION: The OASIS Import Status was corrected to display "Not Imported" and Import Notes were corrected to display "General Oasis Save Error" if the B1 string has diagnosis code with invalid ICD-9 code associated with it.

### **#2121 Reports: Caregiver Appointments List - Show Notes renamed to Show Remarks**

ISSUE: In the options for printing the Caregiver Appointments List, "Show Notes" is an option to print on the report. However, the contents this option prints is actually called Remarks on the appointment screen.

RESOLUTION: To improve distinction between Notes In and Remarks, the options for printing the Caregiver Appointments List now includes "Show Remarks" instead of "Show Notes".

### **#2124 OASIS: Disabled option 3: Edit but keep locked for Exported OASIS-C**

ISSUE: Option 3 for the Unlock OASIS option would unlock the OASIS assessment and display the assessment in the Pre-OASIS-C format regardless of the OASIS type.

RESOLUTION: This feature has been disabled for OASIS-C assessments. A message box will be presented if the user attempts to make edits, but keep the assessment locked when the assessment is in OASIS-C format.

### **#2125 General: Validate ICD9 codes**

ISSUE: There is no validation process that occurs when users enter/modify ICD9 codes in the Diagnosis Library. The application expects users to enter valid ICD9 codes which is then transmitted to the state DHS. If an invalid formatted ICD9 code was entered into the Diagnosis Library and later used in the OASIS or 485 an error would occur.

RESOLUTION: The Diagnosis Library will now perform validation on the ICD9 codes that users enter to ensure they conform to the standard requirements. Upon upgrading to 6.8.08, 1) all existing DX codes have had invalid spaces removed from the beginning and ending of ICD9 codes, 2) a period was added at the end of all 2 and 3 digit ICD9 codes. OASIS-C validation errors have been improved to better handle and report incorrectly formatted ICD9 codes.

### **#2126 OASIS-C: Diagnosis Codes not automatically imported when entering an OASIS-C**

ISSUE: When entering a Pre-OASIS-C, if the ICD9 code entered did not exist in the user's Diagnosis Library, the application would automatically import the code from the ICD9 Add-In List to the Library. With the release of OASIS-C, this functionality was left out due to time constraints. Users would have to close the OASIS, find the code in the ICD9 Add-In List and copy it to the Library.

RESOLUTION: The functionality to auto import ICD9 codes has been added back into the program for OASIS-C. Also, as in previous versions of OASIS, the ability to auto-import may be disabled for certain users via User Rights.

#### **#2127 OASIS: Submitter ID and Medicare ID hyphen causing OASIS rejections**

ISSUE: Many users enter a hyphen when entering the Submitter ID and the Medicare ID. These values are not permitted in the OASIS data by CMS. The OASIS submission file grabs the value entered by the user and adds it to the OASIS data. If hyphens are present in the data the OASIS assessment is rejected by DHS.

RESOLUTION: The application now removes the hyphen if it is present for Submitter ID when creating the OASIS submission file. For Medicare Id, an error will be displayed during addition of an OASIS. This is to allow users to make the correction before submitting the OASIS file to the state. No modification is done to the actual data entered into the Agency Setup and EMC Setup.

#### **#2128 OASIS: Unlocking irregularities corrected**

ISSUE: CMS has setup certain rules on how the OASIS data is to be packaged in the Submission file with different codes being used to indicate whether the assessment is active or inactive in the state databases. We discovered that the OASIS-C assessments were receiving the incorrect code entered when unlocking records. If users unlocked assessments and received these incorrect codes it is possible the state would reject the assessment being submitted.

RESOLUTION: The unlocking process was corrected to use the correct code for active and inactive OASIS-C assessments.

#### **#2129 Reports: Claims List - Group By gives Invalid Group Condition error**

ISSUE: Printing the Claims List when selecting a Group By option of Day, Week, Month or Year gives an Invalid Group Condition error and the report does not print. An enhancement made back in 6.5.03 prevented the Group By from operating correctly in versions since.

RESOLUTION: The Group By for Claims List has been fixed to work as intended.

#### **#2130 OASIS: Certain ID values prevent editing of OASIS with illegal characters**

ISSUE: CMS has defined several values that are not allowed to have dashes in the value; OASIS Submitter ID, Medicare ID, Dr UPIN/NPI. Users who enter a dash in one of these fields in the OASIS or another area of the software that is used as a default for these fields will not be able to edit the OASIS data.

RESOLUTION: The checks for these formatting rules have been moved to validation errors when saving the OASIS data instead of checks when loading the OASIS data for display. This will ensure that users are able to make corrections to the OASIS data when these invalid values have been entered.

#### **#2131 Reports: OSHPD report table 1 visits do not match table 4**

ISSUE: The California state annual reports for the ALIRTS system had a discrepancy where table 1 visit total does not match the table 4 visit total. These visits must match for the reports to balance and be accepted by the state.

RESOLUTION: The table source data collection method was modified to ensure these table visits match.

#### **#2132 OASIS: Date errors moved to warnings**

ISSUE: CMS has timing requirements for the OASIS assessments; meaning certain dates within the assessment are supposed to be within a defined number of days from one another. Agencies don't always adhere to the CMS time frames. In cases where these rules were violated an agency would not be able to lock the assessment.

RESOLUTION: These rules have been moved to warnings instead of errors. This notifies the agencies that they are not completing the OASIS within the CMS requirements, but will also allow them to lock the assessment for submission to the state. Agencies will continue to receive warnings from DHS regarding these timing rules and may incur additional scrutinization from DHS for these violations.

#### **#2133 General: Patient Insurance error could be hidden behind data entry window**

ISSUE: When an error was presented to the user when editing a patient insurance, the error could be hidden behind the insurance form if the user clicked on the insurance form instead of the error message.

RESOLUTION: The method of presenting the error was modified to prevent the error from being hidden behind the insurance form.

#### **#2139 OASIS: OASIS Summary gives object reference not set error when Print Preview is turned off**

ISSUE: Unchecking Print Preview and printing the OASIS Summary for OASIS C presents an "Object reference not set to an instance of an object." error and the Summary does not print.

RESOLUTION: Printing of the OASIS Summary for OASIS C has been fixed to work correctly when printing directly to the printer.

#### **#2142 Reports: OASIS Summary report displays patient name correctly**

ISSUE: Patient name prints as Last, First Middle Initial, instead of printing First Middle Initial Last Suffix as indicated by the labels.

RESOLUTION: Patient Name prints in the order of label on the report (First Middle Initial Last Suffix).

#### **#2143 OASIS: Error due to apostrophes in patient name when sequencing an OASIS-C**

ISSUE: An error occurs when an OASIS-C assessment contains an apostrophe in the patient's name. The error is received when unlocking an assessment that has previously been locked.

RESOLUTION: The apostrophe is now captured and handled to prevent errors when unlocking and editing OASIS-C data.

#### **#2145 OASIS: Inactive/Active conversion incorrectly selects records**

ISSUE: Inactivating or Activating an OASIS assessment would incorrectly modify assessments for the SOC / RFA / Effective Date. Since OASIS retains copies of the assessments when making Key Field changes, Non Key field changes and Inactive records there are multiple records for a single OASIS.

RESOLUTION: The Inactivating/Activating process was changed to select the specific record affected by the change.

### **#2146: Oasis 1.6 Import, indicate success without importing OASIS**

ISSUE: Importing an Oasis 1.6 occasional would report a successful Import, and yet, indicate that the Oasis was not imported.

RESOLUTION: Captured error occurring when importing OASIS 1.6. Reporting it, will now fail Import Wizard with error message.

---

## **Version 6.8.07**

---

### **Enhancements and Feature Requests**

#### **#2093 Added Grouper Point Summary Graph to Oasis-C**

ENHANCEMENT: Added Grouper Point Summary Graph to Oasis-C as a choice view.

#### **#2098 OASIS: M2200 marked NA warns user if patient is Medicare insured**

ENHANCEMENT: Added a warning to alert the user when the patient is insured by Medicare and M2200 has been checked NA. This answer combination will prevent a HIPPS code from being generated. If no therapy is required, the user needs to actively specify no therapy visits by entering "000" in M2200. This is not a CMS validation rule, but a warning that was brought forward from Pre-OASIS-C.

#### **#2100 OASIS: Diagnosis Descriptions Added to OASIS Report**

Enhancement: Descriptions for the diagnosis codes entered in the OASIS now appear on the OASIS Report printed from the Cases Tab in Patient Info.

#### **#2105 OASIS: OASIS Summary Report easier to read**

ENHANCEMENT: The first edition of the OASIS Summary report had the entire question title appearing with the M item. Feedback was that this made it too difficult to see the answers to the questions. The report has been modified to show just the M item number and the selected answer(s).

### **Corrections**

#### **#2089 OASIS: OASIS Status List prints all OASIS-C as Non-Medicare**

ISSUE: OASIS-C assessments show on the OASIS Status list as Non-Medicare regardless of the answers to M0150 for the assessment.

RESOLUTION: This was due to changes in how OASIS-C is stored internally in the database. Corrected the report to correctly pull OASIS-C using the M0150 answers to decide whether an assessment is for Medicare/Medicaid or Non-Medicaid. There is no action required on the user's part to make these OASIS-C assessments show correctly on the report after updating.

**#2094 Insurance: Eligibility Log is stopping Patient Insurance from being deleted**

ISSUE: Eligibility Log is stopping Patient Insurance from being deleted which is in turn preventing a patient record from being deleted.

RESOLUTION: Allowed Patient Insurance to be deleted without destroying Eligibility Log

**#2095 OASIS: No error when M0102 and M0104 are not answered**

ISSUE: Validating OASIS does not give Validation Error when Physician Referral Date (M0104) is left unanswered when Physician Ordered SOC/ROC Date (M0102) is NA.

RESOLUTION: Validating OASIS will now give a Validation Error when Physician Referral Date (M0104) and Physician Ordered SOC/ROC Date are left unanswered.

**#2096 OASIS: Missing validation for M1000 or M1016 and M1018 combination**

ISSUE: If M1000 is discharged to any Inpatient Facilities OR M1016 is NA - Not Applicable (no medication or treatment regimen changes within the past 14 days) AND M1018 is NA - No inpatient facility discharge and no change in medical or treatment regimen is past 14 days, then a validation error must be present.

RESOLUTION: The validation error "If the Patient is indicated as Discharged from a facility within the last 14 days OR has had a Regimen Change in the last 14 days, then 'No Change' cannot be selected for Prior Condition." will show if the above scenario is met.

**#2097 OASIS 01.60: OASIS fails to validate and lock when M0855 is answered 3 and M0900 Respite is answered**

ISSUE: Validating OASIS gives a Validation Error when Admitted Inpatient Facility (M0855) is Nursing Home (3) and Reason(s) Patient was Admitted to Nursing Home (M0900) is answered as Respite. This prevents the OASIS from being locked even though this answer combination is not a CMS violation.

RESOLUTION: The validation check now includes the Respite checkbox in determining whether a violation has occurred, thus validating OASIS no longer gives a Validation Error when Admitted Inpatient Facility (M0855) is answered Nursing Home (3) and Reason(s) Patient was Admitted to Nursing Home (M0900) is answered as Respite.

**#2099 OASIS: Patient First and Last Name reversed on OASIS Report**

ISSUE: The first name and last name of the patient is reversed when printing the OASIS Report from the Cases Tab in Patient Info.

RESOLUTION: The order of the first and last name has been fixed to match M0040's captions.

**#2102 OASIS: OASIS Report Shows Incorrect Answer for M1000**

ISSUE: The OASIS Report shows '1' as the answer for M1000 when '2' was selected as the answer for M1000 in the OASIS, and vice versa.

RESOLUTION: The report was modified to show the correct answer for M1000.

#### **#2106 Eligibility: Workers Comp is now included as Medicare Secondary Payer status**

ISSUE: Workers Comp insurance was being included in the Other Insurance category when present in the Eligibility check from Vision Share. We have since learned that Workers Comp should be included in the Medicare Secondary Payer category instead of Other Insurance.

RESOLUTION: Included Workers Comp in MSP category.

#### **#2101: OASIS Validation: Expired DX Warning not working when User Diagnosis Code does not exactly match ICD9Code**

CORRECTION: The Diagnosis Expiration warnings now work correctly where the User Diagnosis Code does not exactly match the ICD9 Code.

---

## **Version 6.8.06**

---

### **Enhancements and Feature Requests**

#### **#2076 OASIS: Added HHRG Calculator for OASIS-C**

ENHANCEMENT: Added the HHRG for the new OASIS-C assessments. The calculator is utilized from within the OASIS-C assessment. The point summary and the groups are always available when editing the OASIS-C data. If the user would like to see only the questions that affect the HHRG calculation, then a checkbox in the lower right, "Only Show Casemix M00s", by the Save button must be checked.

#### **#2086 OASIS: Questions accept 2-digit years**

ENHANCEMENT: Entering a 2-digit year, such as, "01/01/10", are now accepted as dates on the OASIS-C entry screen. The boxes for entering dates have been changed to accept 2-digit years for the OASIS Validation. When leaving a question set and returning, the date entered as a 2-digit year will then be shown with its full 4-digit year.

#### **#2087 Support: Added a link to the Synergy Support Forum to the help menu**

ENHANCEMENT: Added a link to the HealthCare Synergy Support Forum ([support.healthcaresynergy.com](http://support.healthcaresynergy.com)) to the help menu. This is a quick way to get information about the HealthCare Assistant and answers to your questions.

### **Corrections**

#### **#2077 Reports: Claims List Report Has No Observable Sorting Order**

ISSUE: The detailed section of the report is not sorted in any useful order.

RESOLUTION: The report was modified to sort by patient last name, first name and start date of claim.

#### **#2078 Patient Info: Missing OASIS Option During Some Login Scenarios**

ISSUE: The OASIS option would be missing from the bottom button menu choices of the CASES tab if an agency logged into a HOSPICE agency and then logged into a home health agency without closing the HealthCare Assistant. If a user closed the application after leaving a HOSPICE agency and then reopened logging into a home health agency, no issue was noted.

RESOLUTION: The application was removing the OASIS option from a HOSPICE agency because no OASIS is collected in these agencies, but the OASIS option was not being restored to these button menus when a user logged into a home health agency. The OASIS menu option is now present when logging into a home health agency regardless of whether the application has been restarted or not.

#### **#2079 OASIS: Validation incorrectly produces error that DX Codes do not match the Plan of Care**

ISSUE: Some users are getting "The Diagnosis Codes do not match the corresponding codes in the Plan of Care." error even though they do match when attempting to validate an OASIS. This scenario happens if a user uses a Diagnosis Code where in the Diagnosis library, the User Code is different than the ICD9 Code. For Example, if you had a User Code of 428.0A and an ICD9 Code of 428.0.

RESOLUTION: The OASIS-C's Validation was modified to prevent this error from happening and is fixed in version 6.8.06.

Workaround: Create another Diagnosis Entry where the User Code and ICD9 Code are the same (for example: a User Code of 428.0 and an ICD9 Code of 428.0).

#### **#2080 OASIS: Validation does not check for unanswered M1324**

ISSUE: The Validation for OASIS C in the HealthCare Assistant does not give an error for an unanswered M1324 for RFAs 1,3,4,5 and 9. The rule was included in the Errata Sheet for OASIS-C Version 2.00 Specifications in November 2009.

RESOLUTION: The OASIS C Validation for M1324 will now give an error for M1324 under RFAs 1,3,4,5 and 9 that are not answered.

#### **#2081 OASIS: M1310, M1312, M1314 do not display 00.0 on Edit**

ISSUE: Saving the following questions M1310, M1312, M1314 with a value of 00.0 does not display 00.0 when the same OASIS is edited later. The questions will display empty boxes with single decimals inside, instead of showing the originally saved value of 00.0.

RESOLUTION: The boxes that display the values for M1310, M1312, M1314 have been fixed to format zero correctly as 00.0 so the OASIS may Validate.

#### **#2082 Insurance: Patient Insurance checks Use Patient Info**

ISSUE: When the patient insurance form was opened, the Use Patient Info and Use Patient Address would be checked even if the information entered was different than the patient information. Discovered that the order of checking these boxes was changing due the order of loading information when the form was displayed.

RESOLUTION: Corrected order of checking/un-checking these check boxes during the load process.

**#2083 Diagnosis: Corrected long descriptions for V58.61 and V58.62 in Add-In**

ISSUE: V58.61 and V58.62 have the words "Encounter for" at the beginning of the long description. Diagnosis Code manuals include "Encounter for" at the beginning of the description for V58, but this is not present for the more specific codes.

RESOLUTION: The long descriptions for V58.61 and V58.62 have been corrected in the Add-In. The long descriptions were also updated in the Diagnosis Library only if the Long Description was not previously modified by the agency.

**#2804 General: Intermittent Cannot Connect to Database message when posting visits corrected**

ISSUE: Users would periodically receive a "Cannot Connect to Database" message when posting caregiver visits. This was occurring when a new check was being made to potentially warn users of visits posted to a claim that had already been billed.

RESOLUTION: The process was changed to ensure the connection to the database is kept after such activity.

**#2088 OASIS: OASIS Summary Report Added for OASIS-C**

ISSUE: The OASIS Summary report shows Pre-OASIS-C questions with no data when printing for the OASIS-C assessments.

RESOLUTION: This report was not modified to handle OASIS-C before the release of 6.8. The OASIS Summary report will now print with data for OASIS-C Assessments.

**#2090 OASIS: OASIS Error Report - Patient Name in Header doesn't print for OASIS C**

ISSUE: Printing the OASIS Error Report in Patient Info does not show the Patient's Name on the report for OASIS C.

ENHANCEMENT: The report has been fixed to show the Patient's Name on the top of the report as seen when printing the Error Report for a previous version of OASIS.

**#2091 Patient Info: Financial Summary does not give Episode Amount until OASIS is Validated**

ISSUE: The process of saving the new OASIS format changed how the Episode Amount was calculated. The calculation for the Episode with an OASIS C would not occur until a claim is generated for the episode. HealthCare Assistant's saving of previous versions of OASIS was performing the Episode Amount calculation as soon as a HIPPS code was generated from the latest episode's OASIS.

RESOLUTION: Saving an OASIS C now calculates the Episode Amount when a HIPPS code has been generated. A claim no longer has to be made in order for an episode with an OASIS C to show an Episode Amount in the Financial Summary.

**#2092 OASIS: Oasis-C Grouper reporting warnings using Oasis B1 V1.60 M00 Values**

ISSUE: Oasis-C Grouper reports warnings using Oasis B1 V1.60 M00 Values.

RESOLUTION: Oasis-C Grouper reports warnings are now using Oasis-C M00 Values.

## Version 6.8.05

---

### Enhancements and Feature Requests

#### **#2068 OASIS: Oasis-C Validation adds Warnings for Expired Dx Codes**

ENHANCEMENT: The OASIS-C Validation will now warn users when expired Diagnosis codes are entered.

#### **#2071 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 between the Oasis 1.60 and the latest Oasis 2.00 Question Numbers.

### Corrections

#### **#2067 OASIS: OASIS Report has multiple issues for questions M1034 and M1330**

ISSUE: Report does not show checkbox for M1034 when "Unknown" is answered. Report's text for M1330 for answers 01 and 02 are still for draft version of Oasis C. Report is missing Answer 03 for M1330.

RESOLUTION: The Report's questions M1034 and M1330 have been fixed to reflect the correct answers and text as when entering the OASIS C.

#### **#2069 Auto Update: Addresses Windows security rights on file management and other auto update issues**

ISSUES: Unable to move files to server if user didn't have rights to the client distribution folder. When user had permission to copy files Windows security prevented running installation.

RESOLUTION: Before allowing the user to download updates, we ensure the user has permission to write to the client distribution site. Files are copied with target windows access permission, allowing all users to run the installation once successfully downloaded. There were several additional update issues that were addressed which should ease the update process.

#### **#2070 OASIS: Validation errors incorrectly state that M1615 cannot be blank when M1610 is '01' and the RFA is 4 or 5**

ISSUE: When entering an OASIS-C with an RFA as 4 or 5 and M1610 = '01', the OASIS incorrectly displays a Validation Error indicating that if patient is incontinent then M1615 must be answered ('When does UI Occur?'). M1615 is not included in these RFAs.

RESOLUTION: We have corrected the validation rule to no longer give an error for RFA 4 and 5 as M1615 is not supposed to be answered for these RFAs.

#### **#2072 Eligibility Checks: All Eligibility Checks Error out if checked on or after 01/01/2010**

ISSUE: Any eligibility checks performed after 01/01/2010 will result in a data error indicating that it was a bad eligibility request. The user is incorrectly instructed to verify the patient information even though the patient information is correct.

RESOLUTION: The issue was caused by a incorrectly formatted Group Control Number in the eligibility request. The Group Control Number has been corrected as well as any erroneous errors will be credited towards the agencies total available eligibility checks.

#### **#2073 OASIS C: Private Insurance only for M0150 prevents Validation and Locking**

ISSUE: Medicare's validation rules for OASIS C states that answering M0150 as Private Insurance only is an error. However, this prevents the validation and locking of the OASIS in HealthCare Assistant. The error states "M0150: The patient's care is not paid by Medicare or Medicaid and the assessment will be rejected if it is submitted."

RESOLUTION: The rule pertains to Medicare's change of no longer accepting submissions of OASIS whose payment source is exclusively private insurance. In our application, we realize that this rule is not consistent with the needs of the user and have changed the error to be a warning. Changing the error to a warning will allow agencies to validate and lock the OASIS like in the previous versions of OASIS.

#### **#2074 OASIS/Billing: RAP displays incorrect claim amount for high therapy episodes**

ISSUE: Episodes with high therapy projections would have a claim with amount as if the therapy was projected as low. This resulted from a change in how the OASIS data was stored in the application between Pre-OASIS-C assessments and the new storage technique for OASIS-C.

RESOLUTION: Corrected the HealthCare Assistant PPS Pricer to correctly calculate the claim amount regardless of the therapy amount projection for OASIS-C assessments. The affected claims are recalculated when upgrading to 6.8.05 to reflect the amount. Agencies may want to re-bill the RAPS for these affected claims if submitted prior to upgrading to 6.8.0.5.

---

## **Version 6.8.04**

---

### **Corrections**

#### **#2066 OASIS: Editing 1.60 OASIS receives error during the 1.6 to OASIS-C conversion Process**

RESOLUTION: Version 6.8.03 was not released forcing us to correct the issue and release version 6.8.04.

---

## **Version 6.8.03**

---

### **Enhancements and Feature Requests**

## **#2060 OASIS: Translate OASIS-B1 V1.6 to OASIS-C V2.0**

ENHANCEMENT: Translate OASIS-B1 V1.6 that has an M0090 Information Date later than January 1, 2010 to OASIS-C V2.00.

## **Corrections**

### **#2061 Installation: Report Engine Installations incomplete for 64-Bit OS Machines**

ISSUE: When upgrading to 6.8.02 or higher on 64-Bit OS machines, the report engine installations did not complete. When running the HealthCare Assistant, it would continuously prompt the user to run the Report Engine Installations and not allow them into the application.

RESOLUTION: We have modified the Report Engine installations to now properly install on 64-Bit OS machines.

### **#2062 HealthCare SOS Compatibility with version 6.8.03 and higher**

ISSUE: The new OASIS-C functionality added to version 6.8.02 was not compatible with the HealthCare SOS interface.

RESOLUTION: We have found the issue and have corrected the compatibility with the HealthCare SOS interface.

### **#2063 OASIS: Saving OASIS, shows "System could not connect to database." Error**

ISSUE: After Saving an OASIS, users receive a "System could not connect to database." message.

RESOLUTION: Users should no longer receive this error upon saving OASIS.

### **#2064 OASIS: M1630 Incorrectly showing for RFA 9**

ISSUE: For RFA 9 on OASIS-C, M1630 (Ostomy) was incorrectly showing on the screen. Users received the correct validation error when answering though.

RESOLUTION: M1630 (Ostomy) is no longer shown on RFA 9 for OASIS-C

### **#2065 OASIS: Switching RFA on Discharge OASIS sometimes causes application to crash**

ISSUE: Editing, then validating or saving an OASIS C for a Discharge after changing M0100 to 7,8,9 sometimes will cause the application to crash. A "Healthcare Assistant for Windows executable" message then displays warning of potentially lost information.

RESOLUTION: The generating of the OASIS Questions for the newly selected Assessment Reason has been fixed to no longer cause the application to crash.

---

## **Version 6.8.02**

---

## **Corrections**

### **#2058 OASIS: Users without rights to View or Edit OASIS can view or edit an OASIS C**

ISSUE: If a user does not have rights to View or Edit an OASIS in the User File, they are still able to open, edit and save an OASIS C.

RESOLUTION: The process for opening and editing an OASIS C has been changed to adhere to the Rights of the User.

### **#2059 Installation: Auto Distribution from Network not installing Report Components causing "Automation Error" when printing**

ISSUE: When the update is installed after a user is prompted to update, the new report components do not correctly install. If the user directly runs the setup.exe to install the application the report components do get installed correctly.

RESOLUTION: The install correctly installs the report components when the installation is run after the user is prompted to update.

---

## **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".

### **#2057 Patient Info: Circumstance where Phone Numbers and SSN are not updated when switching between patients**

ISSUE: This condition occurs upon creating a new patient then selecting an existing patient from the Patient List. A prompt displays asking to save the new patient. Clicking "Yes" will save the new patient and load the patient selected from the Patient List. However, the phone numbers and SSN from the newly added patient will be still displayed on the patient that was just loaded.

RESOLUTION: Selecting an existing patient while saving a new patient now loads the correct phone numbers and SSN of the patient last selected.

---

## **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.