IMA Desktop

Version 18.0

Release Notes 2.0

Updated: 9/7/2010

Cover Letter

Version 18 is finally being released. The document that follows provides both and index and detail of the many changes that it contains.

In this cover letter I would like to focus your attention on two specifics aspects of this upgrade. I would like to highlight the key enhancements that it includes and I would like to provide some suggestion on the most effective way to go about reviewing this document and planning for the upgrade.

Key Enhancements

Here is a sampling of the key changes contained in this upgrade. When you review the detail you might find some changes which we have already released into some late versions of version 17. We are including them here to make sure all our customers are aware of them.

1. **Fiscal**
   a. Medicaid APG Billing
   b. A new way to organize client self-pay and co-pay amounts.
2. **Admission/Discharge**
   a. Changes to the client and collateral data collection screens/forms
   b. New format for recording client & collateral addresses
   c. Enhanced client group maintenance, tracking and reporting
3. **EMR (Electronic Medical Record)**
   a. ePrescriptions
   b. Expansion of the IMA Forms Catalog
   c. E-signatures including physical signature pads
4. **Misc**
   a. Many new reports and new ways to track services & productivity
   b. Enhanced ad hoc reporting with additional special variables
   c. New Integrated modules for OASAS per Diem, Day Rehab, Waiver HCBC

Planning for the upgrade

A successful upgrade requires that you review your current procedures to identify exactly how and where IMA is being used in your agency. Once you have this information we suggest the following approach.

1. Test Script: Confirm that your current functions all work on the new Release: You need to plan some “test scripts” that you can run on the new version which are a snapshot of the functions you currently use in the IMA Application and prepare to run these in the new version. Typically these test scripts would contain
   a. Create new client

   b. Transfer client between programs
   c. Schedule a visit
   d. Write progress note
   e. Do billing
   f. Post remittance
   g. Run some key reports
2. Notification and Training: Identify what functions will change in the new version. Review the index to find changes that are "auto configured" and that will affect those procedures that you currently perform. Review these changes and decide how to notify all affected staff of this change.
3. For this release you need to pay specific attention to
   a. Client data screens: Identify each client data screen that you use which contains address information and make sure the screens work as expected with the changed address fields
   b. Collaterals: Make sure to review the collateral spreadsheet and make sure that collateral data will convert properly
4. Review what new functionality you might want to implement: Looking at the new features being made available, review which would be applicable to your agency and plan to learn how to implement them soon after the upgrade.

As in the past, we will be providing the following services at no charge to our customers

1. Webinar reviewing the details of all these changes
2. These "Release notes" to document all of the changes
3. Installation service for this upgrade first in your "test system" and then in your production environment.

Also, as in the past, you can also engage us to provide more direct services to your agency to help with the implementation planning as you see fit.

Finally, as in the past, please do not hesitate to contact me directly via email or phone for further details or discussions.

Sincerely,

Barry Samel

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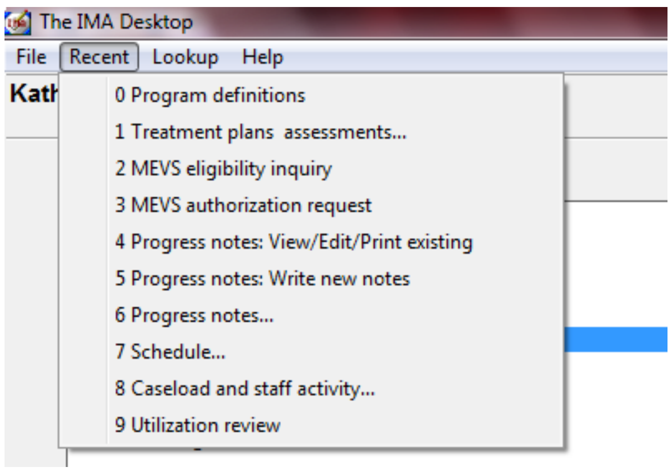
Home Page Main Features

A. Home Page

1. To Do List**-** The To Do list has been expanded by adding quite a few new items your agency can track. See **Appendix 1** for the complete list of To Do options available

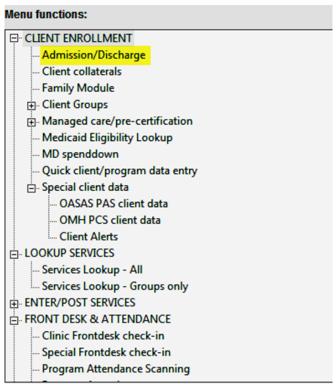
2. New “Recent Items” menu on the home page listing the last 10 modules used allowing quick access back to those modules



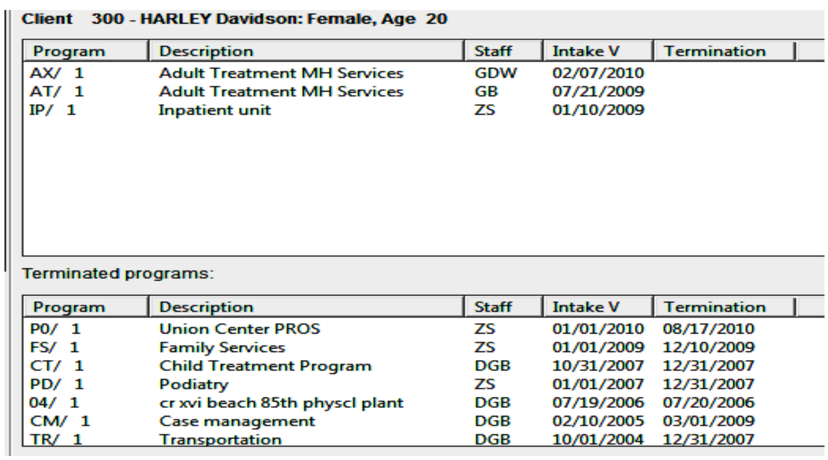
3. Bulletin Board- Some new options were added to the bulletin board allowing a message to be broadcast to a group of staff members and new permissions were added to control who can send what messages.

I. Client Registration/Services/Schedule

A. Admission/Discharge



1. **Screen layout:** On the main registration screen we now display both current and terminated program enrollments, in separate windows for a more comprehensive view of the client's treatment history.



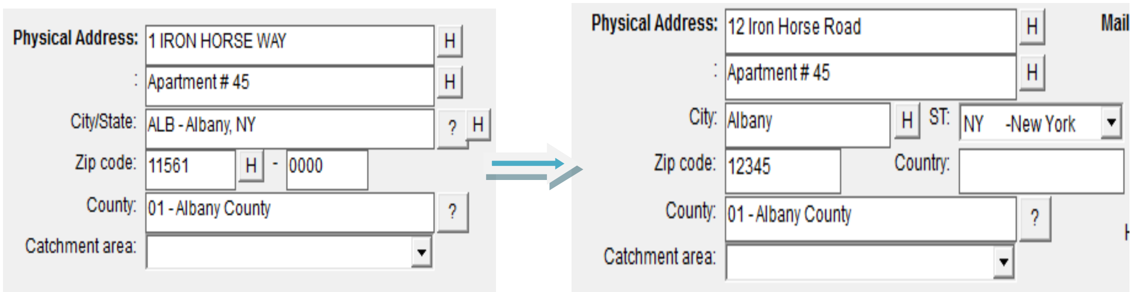
Client 300 - HARLEY Davidson: Female, Age 20

Program	Description	Staff	Intake V	Termination
AX/ 1	Adult Treatment MH Services	GDW	02/07/2010	
AT/ 1	Adult Treatment MH Services	GB	07/21/2009	
IP/ 1	Inpatient unit	ZS	01/10/2009	

Terminated programs:

Program	Description	Staff	Intake V	Termination
P0/ 1	Union Center PROS	ZS	01/01/2010	08/17/2010
FS/ 1	Family Services	ZS	01/01/2009	12/10/2009
CT/ 1	Child Treatment Program	DGB	10/31/2007	12/31/2007
PD/ 1	Podiatry	ZS	01/01/2007	12/31/2007
04/ 1	cr xvi beach 85th physcl plant	DGB	07/19/2006	07/20/2006
CM/ 1	Case management	DGB	02/10/2005	03/01/2009
TR/ 1	Transportation	DGB	10/01/2004	12/31/2007

2. **Client address:** The address fields for clients has been changed to replace the City/State lookup table with type in fields for City and State.
   i. City was changed from a "Table" to a type in
   ii. State was added as a separate field
   iii. Zip and Zip +4 where combined to a single field
   iv. Country was added

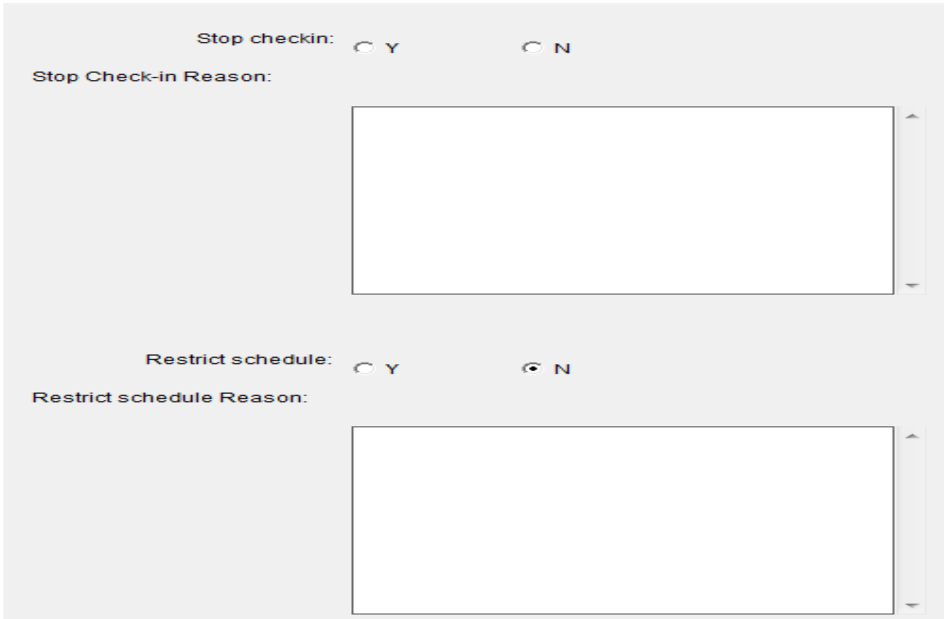


3. **Co-pay Design Change:** An entirely new method is now available to designate client payment amounts (both co-pay and self-pay) using a range of dollar amounts directly instead of fee schedule levels. Different amounts can be associated with different types of services. This is something that should not be implemented during the conversion. Once the new version is installed and stable, you might want to pursue implementing this at your agency. In addition, this new structure also lets you keep track of fee reductions that are offered on a client by client basis.

4. **Private Insurance Plans:** Up to **8** different plans may now be specified in the billing header.

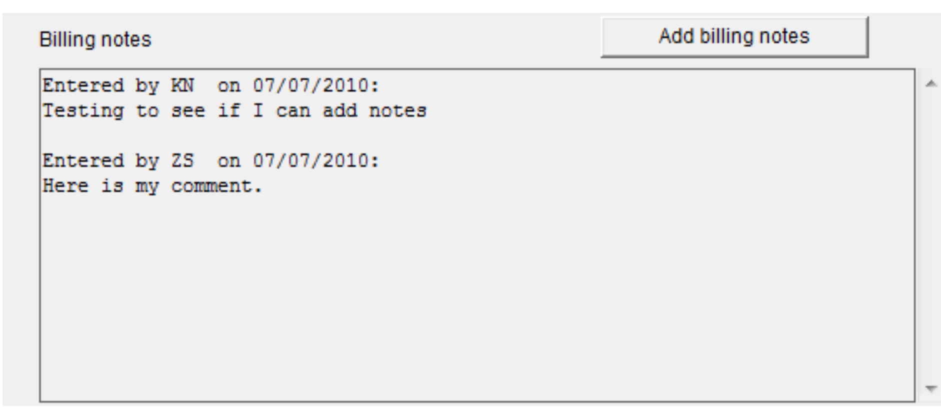
5. **TBI/MR/DD:** A new data field for these indicators is now available in the billing header that will be needed in Article 28 APG Billing.

6. **Restrict schedule flag:** You are now able to "flag" a client record to display a specified warning message every time an appointment is scheduled for that client. This flag may be added in the registration screen along with the specific text of the warning message to display.



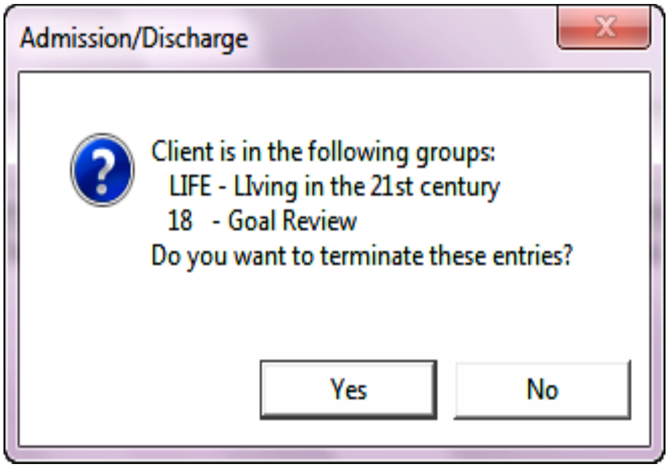
7. **Stop Check in flag:** Similarly, a flag and associated message may be defined for the front desk check-in process.

8. **Auto ID of billing memo notes:** The billing header memo will now automatically identify the date and by whom the text was entered. Entries can only be made via the new Add **billing notes** button. All entries are automatically marked with a date and operator code to keep track of who changed what and when. Direct editing access to this memo area is no longer allowed.



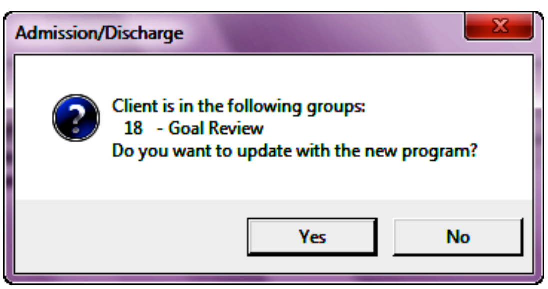
9. **Client transfer/Termination from a program:** A new automatic control function was added to check the enrollment of the client being transferred in any groups or client rosters, and to facilitate updating these as needed. .
(Auto-activated- Y, Affects current Procedures-N, Needs Configuration- N, and Basic)

   a. When a client terminates from all programs we check to see what group rosters the clients is on to see if they should be removed from the rosters as well.



   Similarly, when a client terminates from a single program we check to see if the client needs to be removed from the day group roster that is linked to the program.

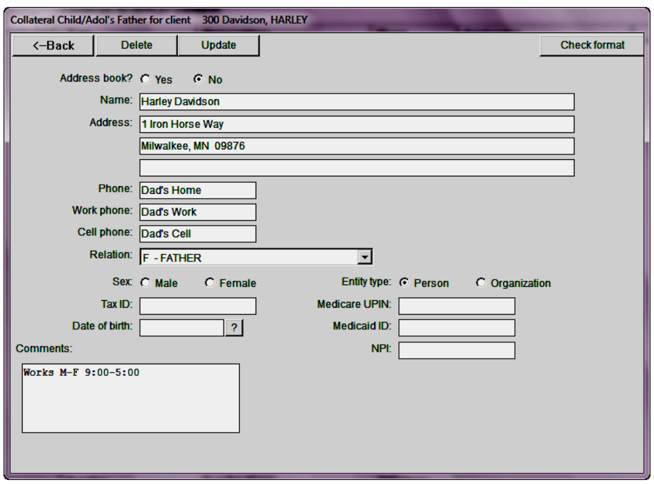
   b. When a client transfers from one program to another, the system checks to see if there should be a transfer from the old program roster to the new one.



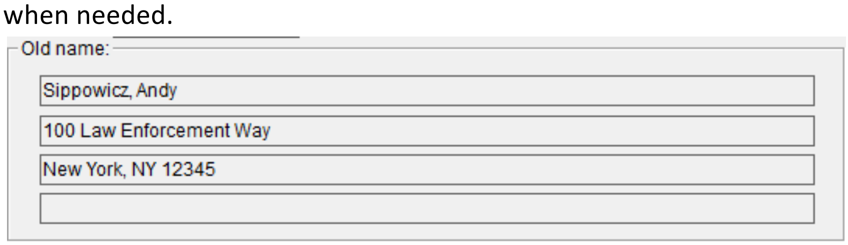
10. New **Forms** button: This allows user easily jump from the Registration screen to forms and back again, making it feasible to utilize Forms Face sheets and other registration related forms.

B. Collaterals

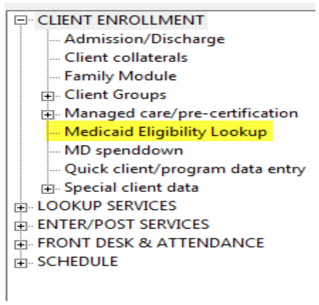
Client Collateral information has been converted into a more structured format. The name and address have been put into separate named fields. The conversion of your data from the old free form address format into the new formatted fields is a challenge. We have put much effort into automatically trying to convert your current data into the new fields and expect all to fit well. We will pre-test your collateral data and send a spreadsheet with the results during the upgrade process for your records.



For those cases where the data does not fit, we have added a history area where the unconverted previous name and address will be saved and can be viewed when needed.

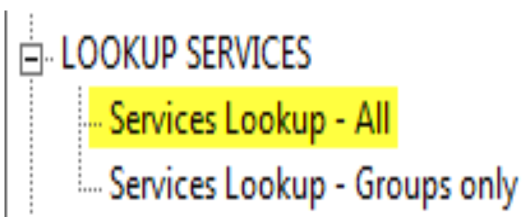


C. Medicaid Eligibility Lookup



This new module gives simple visibility to the Medicaid Eligibility stores in the system for those that use this module. It allows for easy review and ways to spot eligibility problems.

D. Services Lookup



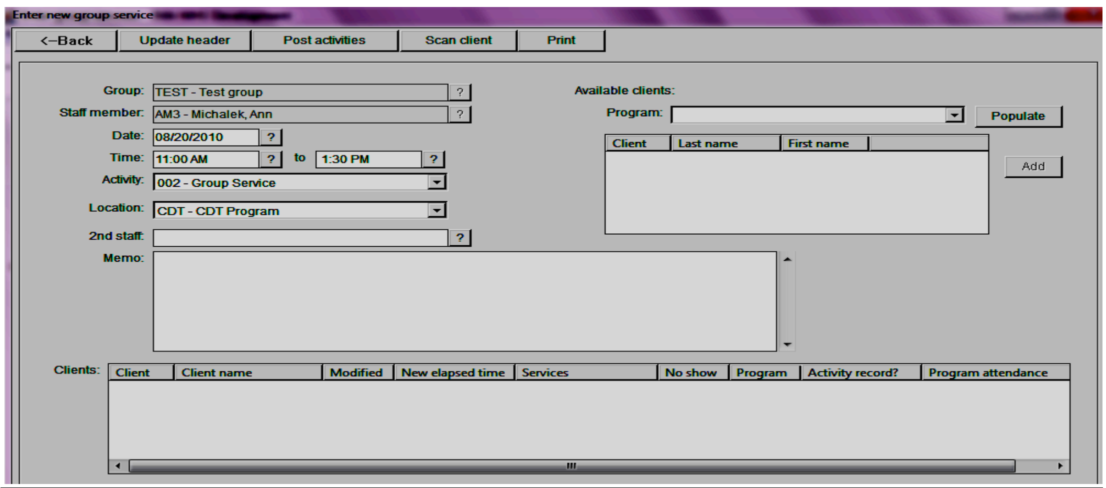
1. An option was added to print the remittance detail on a claim. This was needed for some secondary payers that want details about the primary payer's remittance.
2. The billing history records that are displayed in the payer tabs in the service detail can now be edited, provided the user has Edit permission.
3. Service Specific memos were added to make notes about attempts to get reimbursement on specific claims.
4. A new tab now displays in the invoice detail with some additional data elements that were added for APG billing (i.e. Service modifiers)
5. We have made the Display and Edit buttons more consistent throughout the service lookup. No changes can be made when in display mode.

E. Batch Entry

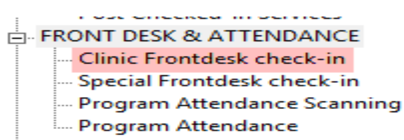
When entering services you can now also add service modifiers. The modifiers available are as listed in the table SRVMDF

F. Enter Group Services

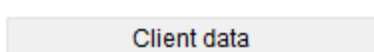
Under Group Services a group memo box is now available for writing a note about the group as a whole.



G. Front Desk & Attendance



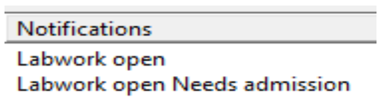
1. **New "Client data" button:** This button will bring the user directly into the client registration screen to allow viewing and editing of demographics without leaving the front desk check in module.



- This button may be configured by the administrator to take the user to the full registration, or the registration screen.
- This option is controlled via the configuration file called WFRDESK.DAT

2. **New "Transfer" button:** This is to enable the receptionist to transfer a client to a preadmission or treatment program if needed, at the time of check in.

3. **New "Notifications" section:** In the client check-in screen we now have a combined message area called "Notifications". This list box is located in the upper right hand corner of the screen to the right of the client appointment information.



Here are some typical messages that the user might see in this area:
- Lab work open
- Managed Care OK or Managed Care problem
- Stop Check in Reason
- Pre-admission: Needs admission= **NEW!**

4. **New Alert on number of pre-admission visits:** A new warning message will now alert the receptionist when a client needs to be admitted or transferred to a new program. This is based on the number of visits that a client has had in a specific program exceeding the number allowed as per the program definition (System Administration). Once the message appears the user has the ability to select the new **client transfer** button to make a program transfer.

5. **New Alert at check in to a group when group max is reached:** A maximum number of clients can be set for groups at a specific location (Table SCHLOC). When set, the system will alert the receptionist if the maximum is exceeded by check-ins to a specific group.

H. Scheduling

1. **Auto ID of who/when item was posted:** For scheduled appointments we are now capturing additional information such as the user, date and time the appointment was booked.

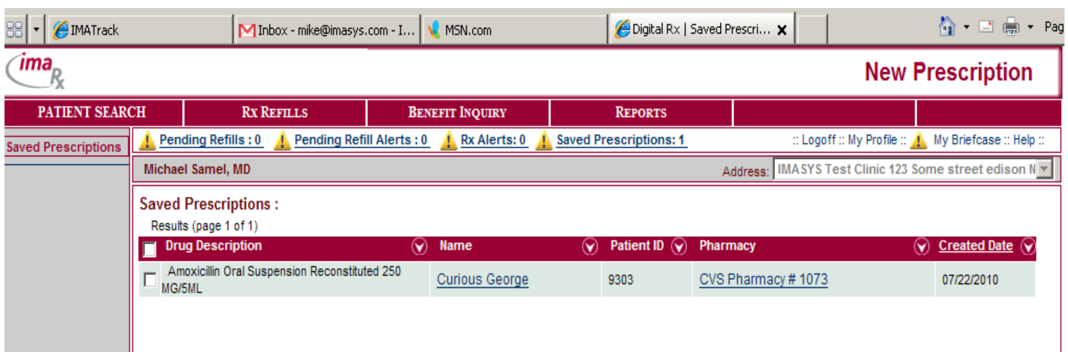
2. **Open slots:** A new feature was added to the calendar to allow the display of "open slots" in a staff person's calendar. Once the available staff hours are

entered (in staff maintenance) for each day of the week, the calendar will display a line for each 30 minute slot that is unscheduled during these times. We are also enhancing this further to allow the administrator to specify if the open slots should be displayed in 15, 30, or 45 minute increments.

II. Electronic Medical Records (EMR)

A. Medication

E-Prescribing: In addition to the standard IMA Medication tracking module, a new option is now available to e-prescribe within it. New buttons have been added to enable the user to access the new **IMA Rx "web based" e-prescribing** function. This module makes available at a glance, the full medication history of this client, the specific medication formulary covered by the insurance plan currently in effect, and drug interactions.



Reporting: In addition to generating and electronically sending new prescriptions to a selected pharmacy, the system also downloads all the information to the IMA database for extensive repowering and monitoring as needed.

This feature needs to be activated and licensed separately. You can do this once this new version is installed.

B. Assessments/forms

The IMA catalog of online clinical forms has been greatly expanded in this release as follows:

1. **Format:** Both PDF and InfoPath formats are available in custom forms.
2. **E-Signatures:** Multiple signatures per form are supported plus the new **Pool** signature wherein a pool of specific staff members may be associated with a specific form and require that someone from that pool signs it.
3. **IMA Catalog:** The standard IMA catalog now includes the following:
   - 10 - OASAS 822 forms based on the TA forms on the OASAS Website
   - 10 - OMH Clinic forms based on common usage & preliminary NYSCRI

C. Progress Notes

1. **Overlap control:** New option to cross check time of the note being entered with other services, to verify that no overlap exists. This is activated by checking this new feature off in program definitions.

2. **IMA-Write:** The IMA-Write utility has been enhanced to allow for more structured data entry, plus direct access to the Goals/Objectives of the treatment plan that in effect for the date of service.

3. **Service Modifiers:** Up to two service modifiers can be added for each billable progress note being written. The initial use for this will be the "Language other Than English" modifier for APG billing.

D. Treatment Plans

1. **Enhanced customization:** Many enhancements were added to expand the available customization features. The printed output integrates the data with any custom PDF layout desired by a customer.

2. **Available stock formats:** A number of stock plans are now available to all Subscriptions licensees that can be implemented quickly with little customization effort. These include:
    a. **OASAS –** This replicates the format published by OASAS on their website as forms TA-7 and TA-8
    b. **PROS –** Per OMH specification and format
    c. **MH Outpatient –** a few models based on formats currently in use at a number of our customers.
    d. **Wiley based –** Model utilizing the Wiley database of treatment planners
    e. **CDT –** A model used in programs with services provided via scheduled CDT group sessions.
    f. **CM -** Designed for Case Management programs

3. **Expanded model specification parameters:** Many new Specifications, Minimum Requirements, and Control parameters are now available in the model definition file. The following are the most important new parameters:
    a. **Addendums –** Signed off plans may now be amended without having to re-issue the whole plan. Parameter <44>

b. **Client e-signature -** It may be specified to be automatically included, required and collected via a Signature pad. Expanded parameter <6>
c. **IMA-Write –** Interactive IMA-Write templates may be specified for all the narrative sections of the paln. Expanded parameter <8>
d. **Expanded Goal narrative section –** The goal narrative may now include three additional sections for each goal to describe specific **Needs, Strengths, Barriers, associated** with each goal.
e. **Default due dates -** Agency selected default dates may be specified for the plan as well as all the Goal, Objectives, and methods as related to the client Intake date as well as each other. Parameters <28> through <34>
f. **Enforce minimum requirements -** Specify acceptable plan date ranges, the minimum number of goals, objectives, and Interventions, or no blank memos, may all be specified & automatically enforced by the system. Parameter <37>
g. **Automatically change plan dates to Psychiatrist signature date –** As a plan is typically not considered in effect prior to the Credentialed signature, you now have an option to enforce this automatically by changing the dates to match the date final signature date. Parameter <36>

4. **Links to progress notes:** Specific goal and objective statements from the plan can now be imported directly into the text of the notes being written at the time when services are provided related to the specific goals established here.

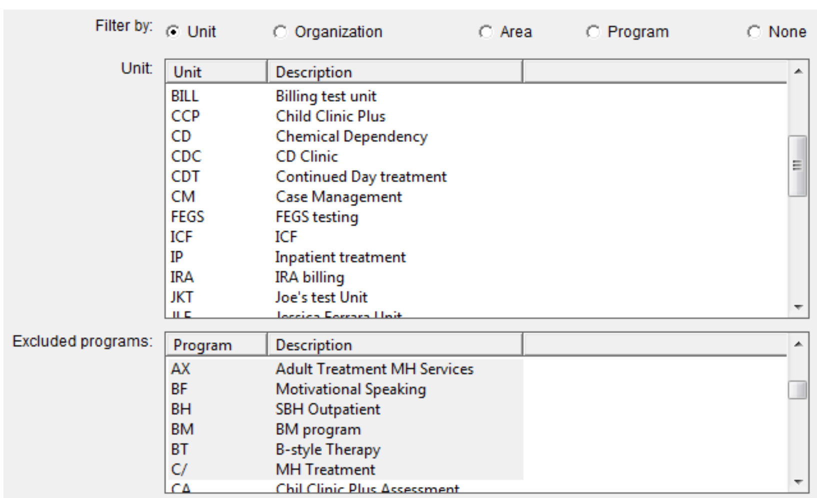
5. **Participants and e-signatures:** Multiple signing and non signing participants may be associated with a plan. Participants may be specific staff members, typed in names of people not necessarily on the staff, or positions such as the Psychiatrist assigned to this patient, the Supervisor of the primary therapist on the plan, or any Psychiatrist from a **Pool** of names setup by the agency.

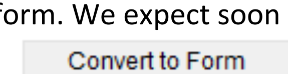
6. **Signature pads:** Physical signature pads are supported for all e-signatures via the Topaz pad (See Appendix IV).

III. Finance (Billing and Remittance)

A. Billing

1. **Medicaid APG billing:**
    a. Implementation details – V18.0 fully supports APG billing and the implementation details are covered in a separate document.
    b. 3M APG Grouper - IMA has entered into a business relationship with 3M (See Appendix IV) allowing us to integrate the 3M APG grouper into the IMA system. This will provide the correct expected reimbursement and weights for each visit on the standard IMA Revenue and Receivable reports.
2. **Billing batches:** New selection criteria were added for creating billing batches. A single “batch” may now include multiple Programs/Units/Orgs/Areas (instead of one or all). In addition, we now also allow “Exclusions” wherein a “batch” may be specified to include a whole organizations or unit, “except” for a specified set of programs.



3. **Electronic 837 claim file conversion to paper:** The data from an Institutional 837 claim file can now be **converted** and printed on the standard paper as a standard UB invoice form. We expect soon to do the same for 837 Professional files onto HCFA forms. 

4. **Combining multiple billing files:** When using clearinghouses, multiple billing files are often needed to be sent to a single receiver. The system will now allow multiple such files to be selected and be concatenated into a single claim file.

5. **New "M" errors:** The following new billing errors are now intercepted and reported as follows:
    - **MB7** - Inconsistent SED setup (Client is marked as SED but also had other insurance active in the billing header)
    - **MB8** - Inconsistent Managed Medicaid setup (Client is marked as Managed Medicaid but does NOT have any Managed Medicaid Insurance plan active in the billing header).

B. Remittance

1. **Better ID of remittance files:** In order to better manage the electronic remittance files from multiple payers, we now display the **Payer description** and **Payer ID** for each file waiting to be processed.

Files waiting to be pre-processed

File ^	Created	Payer	Payer ID
06182003.TXT	Jun 18	EMPIRE MEDICARE SERVICES	
70419.001	Apr 28	NYSDOH	
ALLremitsta12222004.TXT	Dec 22	EMPIRE MEDICARE SERVICES	
ALLtestremt06182003[1].TXT	Jun 18		
ALLtestremt06182003convert.TXT	Jun 18		
CENTRAL.RMT	Mar 26		
Celtknot.TTF	Aug 19		
ERA133530299.20100809.101436.83...	Aug 12	HEALTHFIRST PHSP, INC.	133783732

2. **New APG data fields:** For APG billing we have set the new APG fields so that the system can correctly store the new information that will come back from Medicaid.

IV. Integrated Modules

A. New Modules

Please contact the Helpdesk or Barry for more details on these modules if they are of interest to your agency!

- **OASAS Per Diem (Inpatient)**
- **OASAS Day Rehab**
- **Waiver HCBC (ICC and Subcontractor Billing)**

B. PROS

The following change was made in the internal logic. When calculating a client's eligibility for the PROS Clinic add-on, services during the month will be counted **only** if linked to a Need listed in the client's treatment plan.

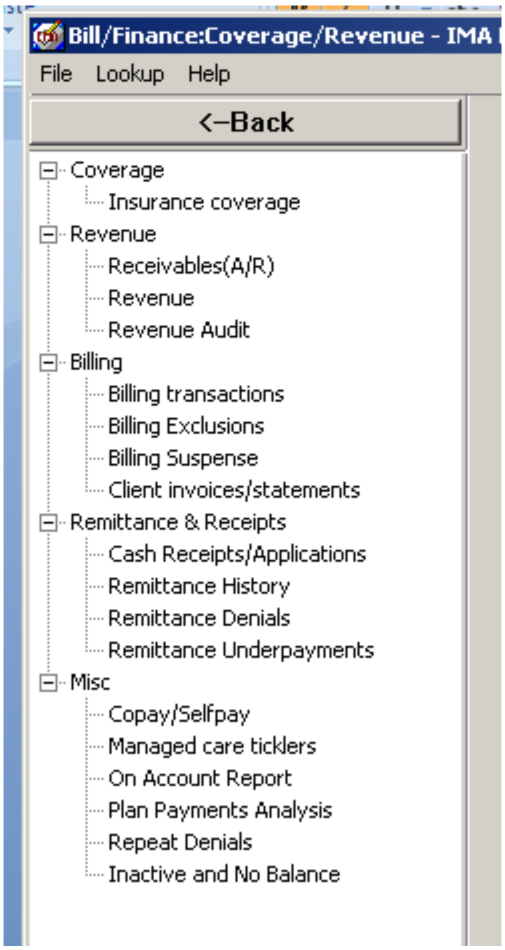
C. Metro-cards

1. This module was updated to conform with the new PTAR system and it's monthly batch billing option.

V. Reports and Performance Tracking

A. Coverage and Revenue

1. **Organization:** The reports under the ***Coverage and Revenue*** title have been re-organizes in a new way and a number of ***new reports*** were added:



1. **Billing Exclusions:** This is a GUI version of the legacy ***C20-EX report***

2. **Copay/selfpay:** This ***new report*** lists co-pay and self-pay amounts due and collected for a particular program and/or date range.

3. **Remittance History:** This ***new report*** allows for the first time the reporting on remittances spread over multiple remittance files. You can now see all remittance posted over a specified date range or from specific payers.

4. **On Account Report:** This ***new report*** was added to show client on account amounts.

5. **Revenue:** Additional data categories were added to this existing report for client self-pay, client co-pay, and a new classification of ***Internal payer*** (a payer that is a division within the organization). This report was previously known as Revenue Forecasting as the reported revenue numbers are based on projections of expected payments rather than actual cash receipts.

6. **Revenue History:** This report is located in the ***Finance (Billing and Remittance)*** menu as **UTILITIES/Revenue History Posting**. Additional data categories were added to this existing report for Client Self-pay, Client Co-pay, Managed Medicaid, and COPS.

B. Medicaid and Medicare

1. **Millen Extract:** This ***new report*** serves as a billing and receivables data export mechanism from the system in a CSV file. This is the format required by the company named Millen needs to follow up on receivables of these claims.

2. **Over 90 Analysis:** This ***new report*** was created to allow the user to report on how many transactions during a period of time were billed out 90 days past the date-of-service for Medicaid claims.

C. Operational Reports

1. **Schedule:** A flexible and easily customizable new reporting structure is now available for this data. In addition to the standard reports available in this submenu, we are now able to easily configure new reports on scheduled appointments selectable by status in flexible format. Setting each up requires

some IMA configuration, but it is now very easy to create schedule reports with almost any layout.

2. **Quality assurance reports:**
   i. **Billing Header Exception:** This ***new report*** was designed to allow the user to see in detail client billing headers that are inconsistent. This report can be run as a CSV or regular report on screen or paper.
   ii. **Managed Care Visit Audit**: This ***new report*** was designed to check the managed care visits used against the actual posted services amounts to ensure accuracy.

D. *Ad Hoc*

The following new features were added to the ad-hoc reporting system:

1. **Additional Special Fields:** A number of new **SPECIAL-FIELDS** that perform various logical and mathematical operations on the data, have been made available for ad hoc reporting during the last year. Please see **Appendix II** for a full current list that includes more than 50 such special functions.

2. **The "*" symbol:** This symbol is now available for use in sorting fields to denote fields that are not real database fields ("special fields")

3. **Easy switch between screens:** A new button is now available to allow switching between the report layout creation screen, and the report generation screen.

4. **Date & Time:** Better formatting was added for the printing of dates and times in report headers.

VI. System Administration

A. *Activity Code Definition* – *New data fields:*

1. On the **Statistics** Tab:
    - **Default activity duration:** In addition to the minimum activity duration (enforced when posting services) this new "default duration" is now available to be used when scheduling the service and writing progress notes.
2. On the **Billing** Tab:
    - **Unit type, Unit source and Unit** value**:** To be used for services which are billed with a number of units other than 1. This replaces the configuration file MED-OUTUNIT.DAT
    - **Complex care: (Y/N)** Indication if this service represents "complex care" and therefore needs to be related to another service in order to be billable. Support for this field has not yet been added to the application.
    - **Ask for Diagnosis: (Y/N)** To indicate that user should be prompted for a service specific diagnosis when posting (i.e. Medical services): Support for this field has not yet been added to the application.
    - **Medicaid APG Billing: (Y/N)**
    - **APG Rate code:** (selected from MDRATE table)
    - **TBI/MR/DD rate code:** To be used when this service is performed to TBI/MR/DD patient in an Article 28 clinic
    - **SED Rate code:** Used for APG billing for SED clients

B. *Program Definition*

New fields in program definition are:

1. On the **General** Tab:
    - **Scheduling location:** Link a program to a scheduling location
2. On the **Billing** Tab:
    - **Allow claim forwarding: (Y/N)** Used when claims to one e-payer are forwarded to other payers. This replaces admindata configuration file (REMIT-FORWARD-SETUP.DAT)

- **Exclusive billing :(Y/N)** Do not allow billing in other programs when a client is enrolled in this program. Replaced configuration file EXCLUSIVE.DAT and used in conjunction with OASAS Inpatient billing.
- **Check for activity overlap: (Y/N)** Controls if system should check for time overlaps between services when writing progress notes.
- **APG Billing: (Y/N)**
- **APG Start date:**
- **Maximum visits:** This field is used to monitor how many visits a client is allowed to have in the program before being transferred. Typical use would be to set to "zero" for referral programs and "3" for pre-admission programs.

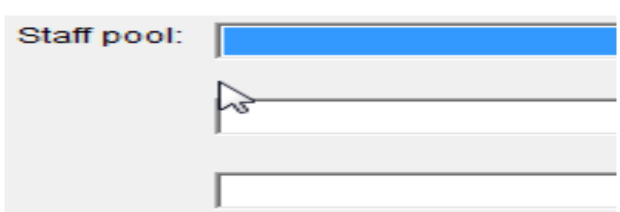
C. Staff Definition

1. **Authorization for e-Prescription:** A new special button is now available on the upper right hand corner of the Staff Definitions/Maintenance screen. It may have one of the following two labels:

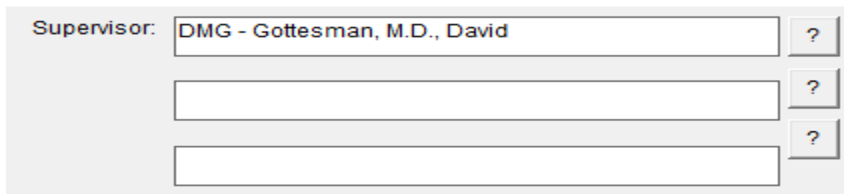
   Create Digital Rx - This indicates that this staff person is NOT currently authorized to prescribe. It can be used to initiate the process of registering and obtaining authorization, after the system verifies the staff credentials and other requirements such as being listed in the Doctor table.

   Update Digital Rx – To update credentials for an authorized prescriber

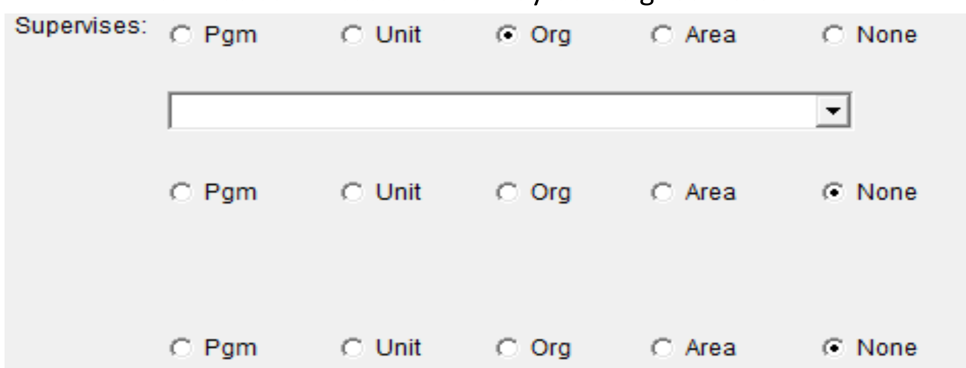
2. New fields in staff definition:
   - On the **Demographics** Tab:
     - **Middle name:**
   - On the **Agency assignment** Tab:
     - **Student? (Y/N)**
     - **Staff pool:** Table selection for up to 3 signature pool names that may be assigned to clinical documents. Any staff member within the pool is then authorized to sign that document.



- **Prescribing? (Y/N)** This is no longer used as it is replaced by e-prescribing described previously.
- **Empty time slots? (Y/N)** Determines if open time slots should be displayed in the schedule
- **Slot duration:** When displaying open slots, this determines the size of each (15, 30, or 45 minutes)
- **Supervisor** Facility to add up to 3 supervisors for each staff record. This allows a person to report to several people if needed. Future development will make use of this.



- **Supervises:** Facility to link a staff code to an organizational unit. Up to three such associations may be assigned here.



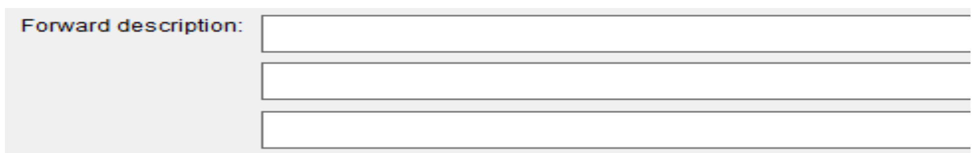
D. Operator Definition

1. Many special permission setting are now available. See the full list in ***Appendix III*** at the end of this document.

E. Insurance Plan Definitions

New fields on **Billing** Tab of the Insurance Plan definitions are

- **Health Plus?** *(Family, Child orNone)* Indicate if this plan is a health plus plan and the type of plan.
- **SNIP? (Y/N)** To indicate that this plan is a special needs plan
- **Passthru? (Y/N)** To indicate that this plan is not a real insurance company and is just being used to pass claims through it.
- **Internal payer? (Y/N)** To indicate that this plan represents charges to a different division within the same agency.
- **Forward Description:** Three lines of text to identify the plan to be forwarded to. This replaces the configuration file REMIT-FORWARD-SETUP. The forwarded claim will be linked to the insurance plan by matching the description.



F. *Electronic Billing – Payer Records*

New fields in the payer record are:

- **Claim based billing: (Y/N**) Set to “Y for APG billing
- **Start date:** used for APG billing selected above
- **Claim grouping:** Table selection to indicate APG based claim grouping
- **Allow voids/adjustments: (Y/N)** For future support of voids and adjustments to payers other than Medicaid
- **Send statement start/end dates(Y/N)** For Institutional claims, always provide send start and end dates, even when statement is for one day.

G. Fee Schedules

1. Up to 10 Medicare and Medicaid rates (with effective and expiration dates) can now be kept online at once.

Activity ^	Description	Program	Rate code	Payment	Effective	?	Expires	?
000	Intake/Initial Eval	Default	4301	78.05	01/01/1990		12/31/2002	
				75.18	01/01/2003		10/01/2006	
				80.00	10/01/2006		03/31/2008	
				82.50	04/01/2008		12/31/2008	
				91.00	01/01/2009			
				0.00				
				0.00				
				0.00				
				0.00				
				0.00				

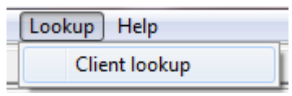
H. Table Definition

The following tables were created or modified:

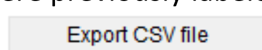
- **MDRATE:** ***New*** table for listing Medicaid Rate codes. Also, a new indicator was added for APG (Y/N)
- **SRVMDF:** ***New*** table for listing service modifiers that are now needed for Medicaid billing.
- **SCHLOC:** A field was added to the Schedule location table to indicate the maximum group capacity for the location. This replaces the configuration file WFRDESK-CAPACITY.DAT and is used with the new check in group max alert.
- **STFPOL:** ***New*** table to define signature pools. Individual staff can then be attached to one or more signature pools of their choice.

General – Changes not related to a specific function/option

1. ***Client Lookup***
   A new lookup feature is now available on every menu bar which gives a user the ability to search for and view any client record, without leaving the current screen. This feature is available via the ***Lookup*** button on the menu bar right next to the Help button. The availability of this feature is controlled by a special permission that needs to be assigned on an operator-by-operator basis (Late 17.1 add on)

2. ***Print, Inport*** and ***Export*** buttons
   Several buttons in the system have been renamed utilizing either one of the two labels above, for consistency as follows:
   - Buttons that were previously labeled "Generate Report" have been changed to 

   - Buttons that were previously labeled "Generate CSV" have been changed to 

   - Buttons that were previously labeled "Transfer" have been changed to also reflect the type of transfer involved. The replacing new labels are: **"Import File" or "Export File"**

3. ***Behind the scene –*** Technical changes not directly visible to the end user
   - **Registration screen configuration files.**
     a. **Location:** The screen configuration files have been moved into a different directory to allow them to be more organized. The new directory name is "registration" and this is where all of these screen files reside.
     b. **Naming convention:** Now the standard file no longer requires the inclusion of the customer name. This will allow for a cleaner file directory in the future and will allow IMA to make changes to the base file as needed, without causing an issue with customization. The system now utilizes the following sequence when searching for a registration file name:
        i. **1st** check for the name with the .[CUSTOM] extension
        ii. **2nd** check for this name with .[agency] extension
        iii. **Finally,** This is **New,** check for this name with NO extension (i.e. XAD-GUI.DEF) **

   - **TX2-VALID.DAT -** The layout of this file, that controls due date alerts, has been changed to a more manageable format.

   - In the **Eligibility response** file, the insurance plan codes have been expanded to 10 characters.

   - **User preferences** - This has been expanded to keep a record also of file transfer locations and recently used modules.

   - **Client On-account** This data field was moved from where it was previously stored in the billing header, to a new free standing file that contains the client ID, amount, date, and comment. A new "On account" report is now available to list these on account values.

Appendices

Appendix I: To Do Options

- **Managed Care Pre-Certifications** (AUTH) - Allows the agency to track the amount of people who need managed care pre-certifications done.

- **View the Staff Caseload** (CLOAD-STAFF) –Allows the agency to track the caseload based on the provider service type in this case the staff caseload.

- **View Case Manager Load** (CLOAD-CM) –Allows the agency to track the caseload based on the provider service type in this case the Case Manager caseload.

- **View Psych Caseload** (CLOAD-PSYCH)–Allows the agency to track the caseload based on the provider service type in this case the psychiatrist caseload.

- **Case Management** (CMANG)-

- **View Missing/Deferred Primary Diagnosis** (DIAG) - Allows the agency to track the amount of clients that have no primary billing diagnosis associated.

- **View EMAIL Unread** (Email) - Allows the agency to track who has unread email within IMA (works with IMA email module)

- **View Clients with Hospitalizations/Incidents** (EVENTS) - Allows the agency to track the events that occurring with their clients

- **View Family Caseload** (FAMILY) - Allows the agency to track the family caseload (used with the family system)

- **View patients who need Follow up appointments** (FOLLOW-UP)- Monitor active clients who do not have upcoming appointments scheduled with either a Social Worker or a Doctor.

- **View Number of Functional Assessments Due** (FASM) - Allows the agency to track how many functional assessments are due

- **View Number of Assessments and Forms are Due** (FORMS) - Allows the agency to track the number of assessment forms that are due to be completed

- **Show MEVS Eligibility Statistics Percentage** (MEVS,- Shows the Agency Mevs eligibility statistics (works with the eligibility module)

- **View the number of clients who need Admission to a program** (NEED-ADM) - Allows the agency to track the number of clients that need admissions into programs.

- **View the NO Show Clients for the Agency** (NOSHOW) –Allows the agency to track the no show clients

- **View Number of Overall Forms due to be completed** (OTH-FORMS) - Allows the agency to track the number of overall forms due to be completed for that members caseload

- **View the number of treatment plans due to be completed** (OTXPLANS) - Allows the agency to track the number of Other treatment plans that are due to be completed

- **View the number of Progress notes due to be completed** (PNOTES) - Allows the agency to track the number of progress notes that are due to be completed

- **View the number of Review Notes due** (RVNOTE) - Allows the agency to track the number of review notes that are due to be completed

- **View number of Appointments on the schedule** (SCH) - Allows the agency to track the number of appointments that are on the schedule

- **View the number of plans needing signature** (SIGN) - Allows the agency to track the number of plans or notes that require signature

- **View the number of forms due for terminated clients** (TERM-FORM)- Allows the agency to track the number of forms that are due to be completed for terminated clients of the agency

- **View the number of ticklers due** (TICK) - Allows the agency to track the number of ticklers that require follow up

- **View the Number of treatment plans due** (TXPLANS)- Allows the agency to track the number of treatment plans that are due to be completed

- **View the Number of UT Authorizations due** (UT-COUNT)- Allows the agency to track the number of UT authorizations that will be due for the agency

Appendix II Special Fields

Allow for selecting, sorting and printing of calculated information.

CLIENT,**CLIENT-NAME**,29

CLIENT,**LENGTH-STAY**,4

CLIENT,**CLIENT-AGE**,3

CLIENT,**LAST-TXPLAN**,10

CLIENT,**AGE-SERVICE-DATE**,3

CLIENT,**FAMILY-STATUS**,6

CLIENT,**FAMILY-RELATIONSHIP**,30

PROGRM,**UNIT**,4

PROGRM,**ORGANIZATION**,4

PROGRM,**ORGANIZATION-DESCRIPTION**,30

PROGRM,**AREA**,4

PROGRM,**DEPARTMENT**,4

STFACT,**FIRST-SERV-DATE**,10

STFACT,**FIRST-SERV-CODE**,3

STFACT,**LAST-SERV-DATE**,10

STFACT,**LAST-SERV-CODE**,3

ACTCOD,**ACTIVITY-GROUP**,3

ACTCOD,**ACTIVITY-GROUP-DESC**,30

ACTCOD,**MEDICAID-RATE-CODE**,8

ACTCOD,**ACTIVITY-CPT-CODE**,8

PROGRM,**ENROLL-DATE**,10

PROGRM,**LOS-ENROLL-DATE**,4

STFACT,**DEFAULT-DURATION**,5

STFACT,**TIME-SPENT-HHMM**,5

BILHDR,**FEE-,8

BILHDR,**CURR-BILL-ORDER**,12

BILHDR,**EFF-BILL-ORDER**,12

BILHDR,**CURR-FEE-SCHED**,2

BILHDR,**CURR-FEE-SCHED-DESC**,30

BILHDR,**CURR-FEE-LEVEL**,1

BILHDR,**MD-ANNIV-MONTH**,9

BILHDR,**MD-BENEFIT-END**,10

BILHDR,**FIRST-PI-CODE**,4

BILHDR,**FIRST-PI-DESC**,30

BILHDR,**FIRST-PI-ID**,19

BILHDR,**FIRST-PI-EFF-DATE**,10
BILHDR,**SECOND-PI-CODE**,4
BILHDR,**SECOND-PI-DESC**,30
BILHDR,**SECOND-PI-ID**,19
BILHDR,**SECOND-PI-EFF-DATE**,10
BILHDR,**THIRD-PI-CODE**,4
BILHDR,**THIRD-PI-DESC**,30
BILHDR,**THIRD-PI-ID**,19
BILHDR,**THIRD-PI-EFF-DATE**,10
BILHDR,**CURR-MC-ID**,12
BILHDR,**CURR-MC-EFF-DATE**,10
BILHDR,**CURR-MD-ID**,12
BILHDR,**CURR-MD-EFF-DATE**,10
BILTRN,**MD-PAID**,8
BILTRN,**MD-EXPECTED**,8
BILTRN,**MD-LOCATOR**,3

Appendix III-Special Permissions

????? - All options

A4 RO - allow user to only view the calendar w/out any editing (WSTFCAL)

BLALL - allow adding bulletin board messages for all (WMENU)

BLGRP - allow adding bulletin board messages for groups (WMENU)

BLLOC - allow adding bulletin board messages for locations (WMENU)

BLOPR - allow adding bulletin board messages for other operators (WMENU)

CHGID - allow changing of client ID (WPREREG)

CSTRN - allow changes to the transactions in client ledger (WCASHREC)

DELCA - allows the user to be able to delete cash receipts (WRECRPT)

DELS - allow the user to be able to delete billing transactions in services (W[GRP]SRVREC)

ELOOK - This excludes the user from using client lookup

FDOVC - This allows the front desk the ability to override coverage problems (WFRDESK)

GSADM - This allows the user administrator options in group services (WGRPSRV)

GSEXC - This allows the user to have no limits in group services (WGRPSRV)

HIDFN - This hide financial data in services from the user (W[GRP]SRVREC)

MEN - Legacy Main Menu

NOADD - This option does not allow them to add clients (WPREREG)

NOBIL - This option does not allow user to create or edit billing (WGENBIL)

PNOTE - This allows the user to view progress notes in services (W[GRP]SRVREC)

PSIGN -This allows the user the ability to sign service plans (SPRMNT)

RW - allows user to ONLY edit their calendar (WMENU)

RW<OPR> - allows the user to edit the calendar of the operator listed (WMENU)

SNOTE - This allows the ability to sign notes (WCLTNOT)

STFLD - This allows the display of only the staff member's caseload (WNTXPLAN)

SUPER - Gives the user supervisor permissions (MULTIPLE)

TEAM - Gives the user team billing limits (WTEAMBIL)

TODO - This allows the user to change the staff in menu (WMENU)

TRANS - This allows the user to view billing transactions in services (W[GRP]SRVREC)

Appendix IV

Digital RX is a product developed by H2H Solutions, Inc. H2H Solutions Inc. can be contacted at 49197 Wixom Tech Drive, Wixom, MI 48393. For more information, please visit www.h2hsolutions.com

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Change History

1. EMR
    i. Treatment plans
        1. Remove list of plan needing signature from the main window and add this functionality to the plan lookup window
    ii. Medication
        1. Report: Expand option and add support for eprescribed medications.
        2. Change titling of columns from "frequency" to sig"
    iii. Progress notes: Allow specific activity codes to be excluded from "checkin" requirement via a config file
    iv. Client home page: Button to view full progress note for notes that do not fit into the "grid"
2. Front desk checkin
    i. Allow notes to be added to the billing header memo
    ii. Do not allow checkin for inactive activity code
    iii. Add support for tracking return of "client pass"
3. Adhoc reports
    i. Add access to the new billing transaction extension file
4. Images Module: Significant enhancements to allow for scanning and viewing of documents
5. Behind the scene
    i. Separate BILHIS into separate file one for Billing history and the other for remittance history.
    ii. Images and Photo IDs: Make much better use of the imaging capabilities and separate client photos from all other images
6. New reports
    i. Print client's billing memos
    ii. Time to Service
    iii. Billing Exception report: Add selection by Medicaid only and error code (to find Medicaid M15 errors) and add CSV output option for detail
7. Inactive activity codes: Do not allow posting of inactive activity codes in schedule, progress notes and batch billing
8. Calendar open slots: use staff setting to determine if slots should be displayed and in what intervals
9. Child Clinic Plus Statistics
    i. Support skipping certain activity codes
    ii. Count all children up to 19^{th} birthday
10. Remittance Processing
    i. Electronic Remittance from Commercial Payers
        1. Plans need to be linked to plan groups

2. The plan group has to have at least one of the payer IDs that will be on the remittance

11. Billing
    i. Only bill as SED up to client's 19^{th} Birthday
    ii. Allow the G/L report to print for preliminary batches
    iii. Option to "Always include statement start and end date" for institutional billing
    iv. Option to use client Axis I diagnosis in billing instead of program primary and secondary diagnosis.
    v. New APG Billing grouper and batch option
12. New Fee For Service report and "to do list" item.
13. Staff Maintenance: New report on unlicensed and staff with expiring licenses.