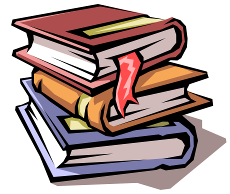
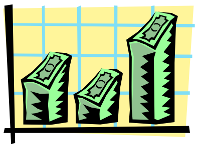
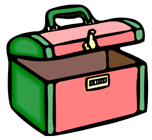
epitomax by psytechsolutions®

Training Manual



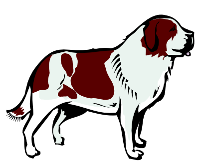


Welcome to Epitomax…..

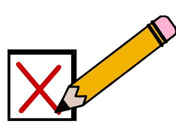
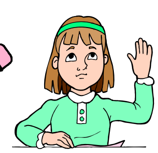
Your Behavioral Health web-based system that integrates Patient Tracking, Scheduling, Service Activity, Billing, Clinical, and Accounts Receivable. This document includes a table of contents, step-by-step processes on how to perform functional activities, end of lesson exercises and graphic screenshots illustrating program activities, notes, tips, and special conditions. This document is meant to assist you in your use of Epitomax.







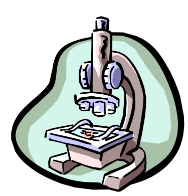


Table Of Contents

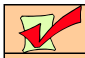
Lesson 1
Getting Started With Epitomax

Objectives

- Using the Courseware
- Using the Mouse
- Using Epitomax Buttons And Links
- Epitomax File Formats
- Epitomax Special Entries
- Important Notes For System Usage
- Logging In
- Logging Out

Using The Courseware

The following terms are used in the courseware to provide supplemental information

	Presents additional information about a topic
Tip	Presents a shortcut way of performing a function

Using The Mouse

The following terms are used to describe functions performed with the mouse

Click	Press and release the left mouse button
Double-Click	Click the left mouse button twice quickly
Right-Click	Press and release the right mouse button
Drag	Move the mouse while holding down the left mouse button
Highlight	Drag the mouse pointer across data, causing the information to appear selected
Point	Position the mouse pointer on the indicated icon

Using Epitomax Buttons & Links

The following describes buttons used to perform functions in Epitomax

Login	Logs Into Epitomax
Page First	First page
Page Prior	Previous Page
Page Next	Next Page
Page Last	Last Page
Search	Searches For Specified Data
Clear	Clears Data
Help	Provides Help On Current Topic
Add	Adds New Data
Update	Updates Existing Data
Expand	Displays More Information
OK	Confirms A Selection
Submit	Submits The Entered Criteria
Deselect	Deselects A Selected Choice
Cancel	Cancels The Function
Delete	Deletes A Selected Option
Back	Goes Back To The Previous Screen
Close	Closes A Window
... (Ellipses)	Presents A Search Box To Select Choices From – used typically when there are over 100 entries from which to choose

(Pick List)	Presents A List of Choices To Select From – used typically when there are less than 100 entries from which to choose
(Check Box)	Activates/Deactivates A Selection
(Radio Button)	Selects A Condition or acts as a Filter for Information
Edit	Makes Changes To Existing Data
Delete	Deletes Data
Logout	Logs Out Of Epitomax
Tabs	Allows Navigation Through Epitomax

Epitomax File Formats

The following describes formats in which results in Epitomax can be viewed

MS-Excel	Views A Page in Microsoft Excel
Text	Views A Page In Notepad
HTML	Views A Page In A Web Browser
Acrobat PDF	Views A Page In Adobe Acrobat

* Browser – The application the Epitomax Program operates in

Epitomax Special Entries

The following describes the ways Birth Dates, Payors and Social Security Numbers need to be entered in Epitomax

Birth Dates	If a patient does not have a birth date, enter "1's" (11/11/1111)
Payors	If a patient no longer uses a Payor, enter the Payor Rank as "99"
Time	Epitomax uses a 24-hour clock. For example, 3:00 in the afternoon could be entered as 15 versus 3:00 pm. Or 8:00 am can be entered as 8.
Searching…	Entering the "%" before letters in a search window will search for any entry that contains those letters

Important Notes Regarding System Usage

! Some functions in Epitomax can only be performed by staff with proper security permissions. If you need assistance, please contact the Help desk or your supervisor.

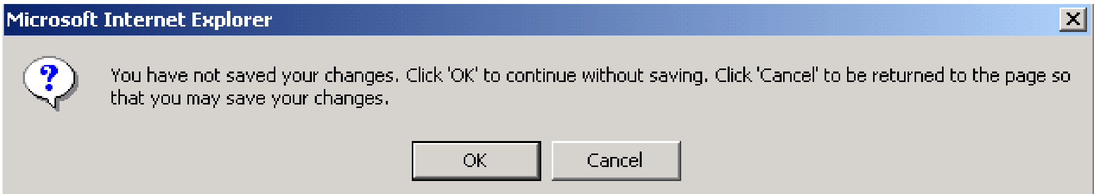
! Please enter as much information as possible to ensure the integrity of the database.

! Some buttons and links are <u>not operational</u> in this version of Epitomax.

! Use sentence structure when entering data instead of <u>all</u> upper or lower case.

! Use the tab key on the keyboard or use the mouse, to move from one field to another <u>instead of the enter key</u>.

! If you make changes and then decide to advance to another function without updating your changes, the following message will be displayed:



If you choose to click **OK**, your changes will not be recorded.

! Some fields in Epitomax are <u>required</u>. This means data has to be entered in the field. Typically you will find these required fields highlighted in light blue.

! Should menu selections need to be added, please contact the Help desk or your supervisor.

! **The exercises in this manual <u>are only to be executed in the Epitomax "Sandbox"</u> not in the "live" database**.

Logging In

To access Epitomax a user will need to login.

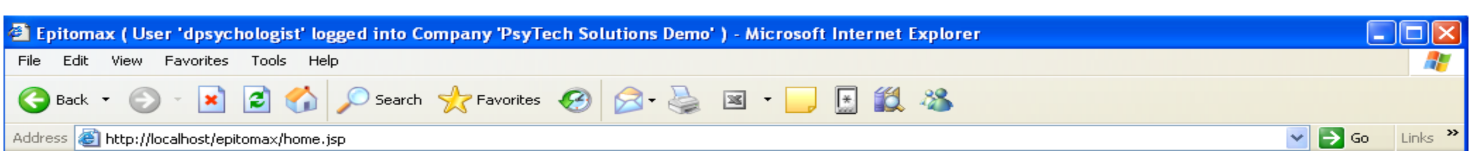
To login

The Login function allows users to Login to the **Epitomax** system.

1. **Double-Click** the **Epitomax**  icon on the desktop

Alert: **If there is no Epitomax Icon on your desktop, please do the following:**

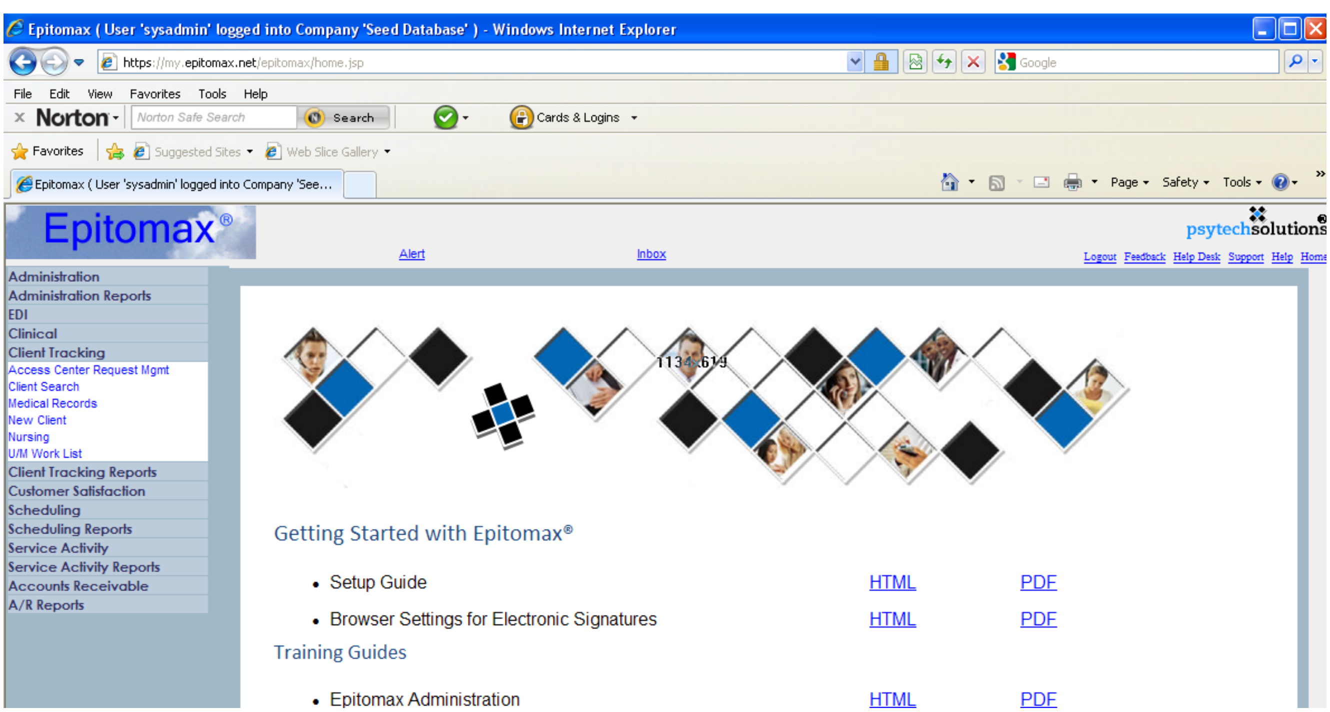
- **Double-Click** the **Internet Explorer**  Icon on the desktop
- **Type** the **Epitomax URL** (Uniform Resource Locator) in the **Internet Explorer Browser Address** field



- **Press** the **Enter** key on the K**eyboard**
  - The **Epitomax** login screen displays

2. **Click** in the **User Name** field
3. **Type** your **Epitomax Login** (Use your “training#” during training class)
4. **Click** in the **Password** field
5. **Type** your **Epitomax Password** (Use your “training#” during training class)
6. **Click Login**

Alert: Your normal Epitomax Username And Password Will Be Used To Login Outside Of Training.



To Expand/Collapse Epitomax menus

Epitomax uses Expandable and Collapsible menus to display and hide Program functions.

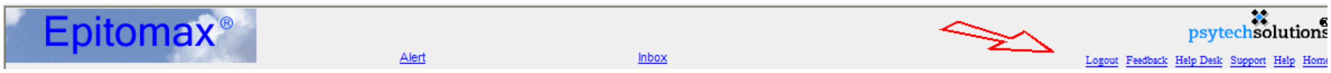
1. **Click Patient Tracking** (The window expands)
2. **Click Patient Tracking** (The window collapses)
3. **Click Service Activity**
4. **Click Scheduling**

Logging Out

The Logout function allows users to Logout of the **Epitomax** system.

To logout

1. **Click** the **Logout** link in the upper right corner



2. **Close Internet Explorer**

Lesson 2
Getting Help

Objectives

- Getting Help Using the Help Button
- Getting Help Using Contents
- Getting Help Using Index
- Getting Help Using Search

Getting Help

To get Help using the Help button

The Help button allows users to receive Help on the current topic.

➡<u>Help Topics</u> may not be available for all functions

To get Help using the <u>Help Link</u>

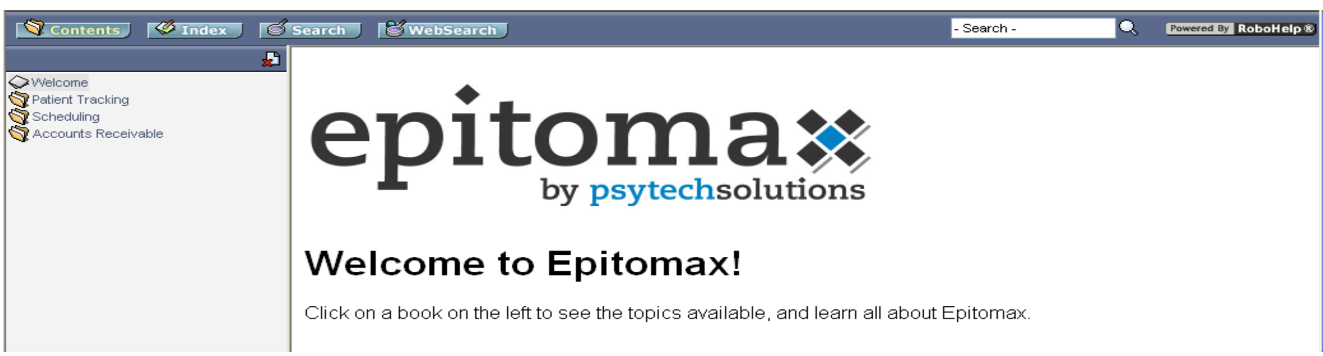
To get Help using contents

The Help Contents function allows users to receive Help by searching through a list of categories.

To get Help on how to create an Alternate Contact, do the following:

1. **Click** on the **Help** link in the upper right corner

   ➡The **Epitomax** Help screen appears



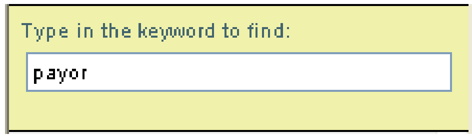
2. **Click** the **Contents** tab (The system defaults to the contents tab)
3. **Click Patient Tracking**
4. **Click Client Search** (The Help topic for Client Search is displayed)
5. **Click Episodes**
6. **Click Create Alternate Contacts** (The Help topic for Alternate Contacts is displayed)
7. **Click Episodes** (Notice the category collapses)
8. **Click Patient Tracking** to close the book
9. **Click Scheduling**
10. **Click Accounts Receivables**
11. **Collapse** all open books

To get Help using index

The Help Index function allows users to receive Help by typing in key words.

To get Help on how to add a Payor, do the following:

1. **Click** the **Index** tab
2. **Type Payor** in the **Keyword** text box



3. **Tap** the **Enter Key** on the **Keyboard**
4. **Select Adding A Payor** from the **Shortcut Menu** to display the Help topic for adding a Payor

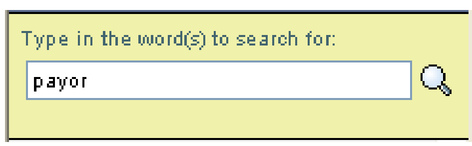
   Tip: Clicking on the keyword will bring up the shortcut menu with associated Help topics

To get Help using search

The Help Search function allows users to receive Help by typing in key words.

To get Help on how to add a Payor, do the following:

1. **Click Search**
2. **Type Payor** in the **Keyword** text box

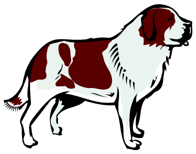


3. **Tap** the **Enter Key** on the **Keyboard** (All results containing “Payor” are displayed)
4. **Click Create Authorization Requirement** (Note “Payor” in the Help detail)
5. **Close** the **Help Browser** window

Lesson 3
Client Records

Objectives

- Client Search
- Client Records
- Payor Information
- Episode History
- Allergies/Medications
- Alerts
- Documents
- Appointments



Client Search

To perform a Client Search

The Client Search function allows users to locate patients that exist within the database. This function is vital in verifying whether or not the Client Record exists and should be the first step in many of your processes.

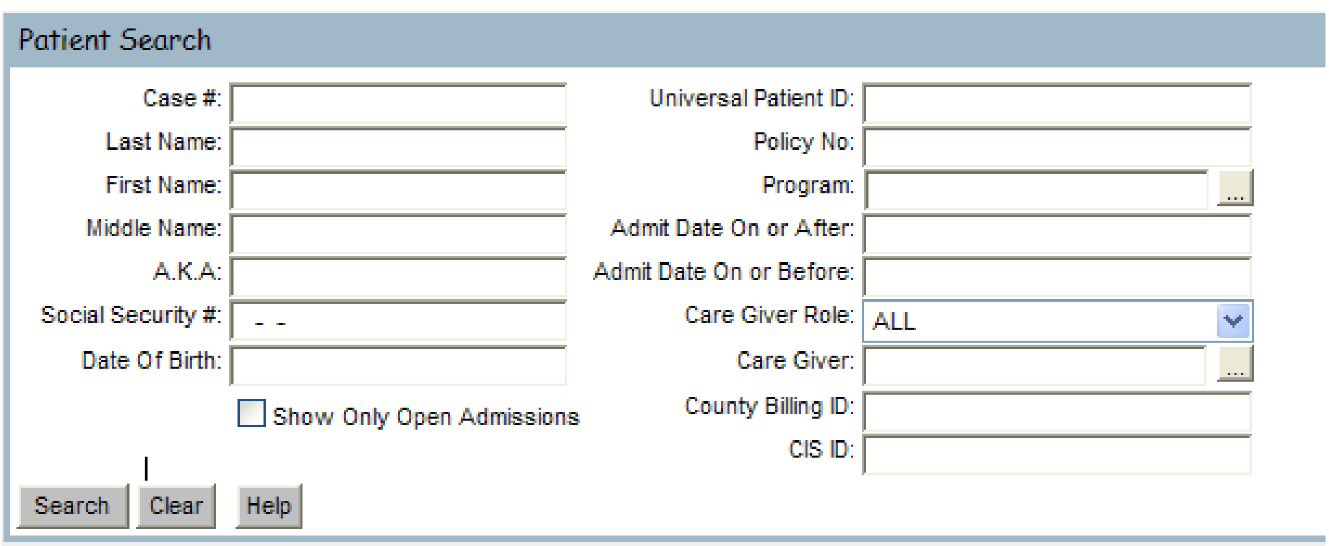
1. **Login** to **Epitomax**:

Username	“training#”
Password	“training#”

2. **Click** the **Patient Tracking** main menu item

Choices listed under the main headings on **Epitomax**’s Main Menu change depending on what screen is active.

3. **Click** on **Client Search** to begin the search for a specific patient.



The **Clear** button Clears the Search Criteria.

Tip: Using the % and the letter, will bring up all results containing that letter(s)

For example: typing in %b will bring up Baker, Barbara, Farber. This feature can be used for all search functions.

Searches can be performed using any of the above fields.

All the fields displayed are free text entry and there are no <u>required</u> fields but criteria must be entered in a least one field to begin a patient search.

It is recommended that a Client Search be performed by first entering a portion of the patient's Last Name, Birth Date or Social Security Number.

The more information provided, the less likely a New Client Record will be a duplicate.

The "Show Only Open Admissions" checkbox narrows down the Client Search to include only those patients with Open Admissions.

To <u>enter a date</u>, user must enter slash marks (**/**/**).

Epitomax remembers the last criteria entered.

If search results are over 100, no results are displayed. Include more criteria to narrow results.

4. **Click Clear**
5. **Type "A"** in the **First Name** field
6. **Click** Search

Alert: No Results Are Displayed Because There Are Over 100 Patients With First Names Beginning With "A".

Search Results — Expand

Case #	Last Name	First Name	Middle Name	Social Security #	Universal Patient ID	Date Of Birth
	** 364 patients foun			- -		
				- -		

Page First | Page Prior | Page Next | Page Last | Help

Rows 1 to 2 of 2 total rows.

7. **Click Clear**
8. **Type Abrams** in the **Last Name** field
9. **Click** Search

The Search Results screen is displayed

Search Results — Expand

Case #	Last Name	First Name	Middle Name	Social Security #	Universal Patient ID	Date Of Birth
46872	Abrams	Aaric		261-95-6119		03/31/1960
147525	Abrams	Ardena	MIXELL	816-91-6286		01/06/1931

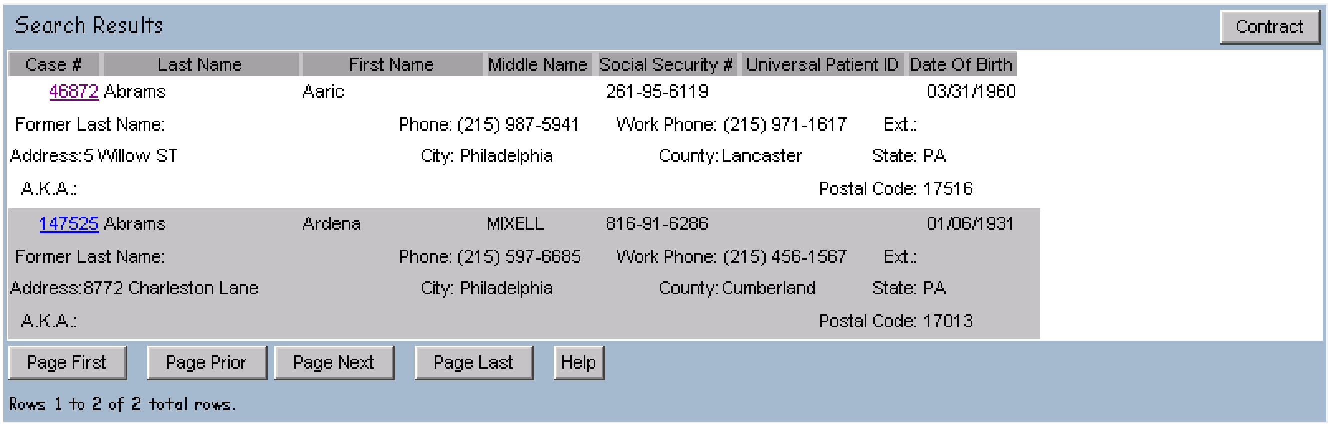
Page First | Page Prior | Page Next | Page Last | Help

Rows 1 to 2 of 2 total rows.

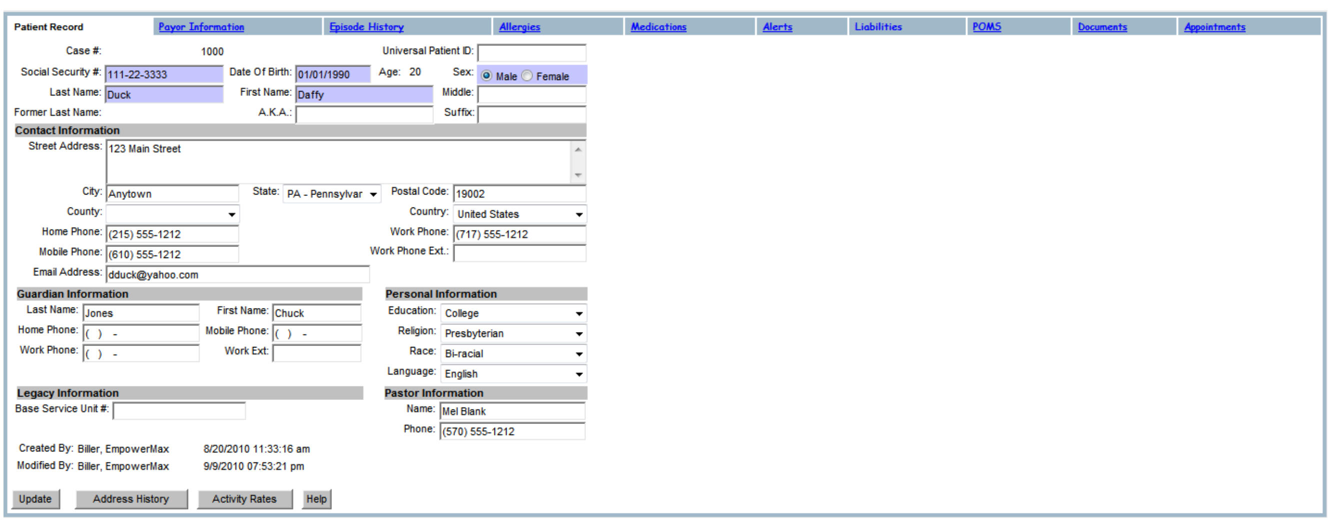
If the patient is not in the Search Results list, then either the Client Record does not match the criteria given or the patient is not in the system. The search criteria may need to be modified, either by adding more complete information or entering only a portion of the Patient's Name, Social Security #, etc., and executing the search again. After these steps have been completed, and the patient is still not displayed, a new Client Record may need to be created.

Entering accurate information and executing additional searches will help to prevent duplicate Client Record entries.

10. **Click** Expand to display more demographic information about the patients listed in the search results



11. **Click Contract** to collapse demographic information about the patient
12. **Click Clear**
13. **Type Duck** in the **Last Name** field
14. **Click Case #: 1000** to display the Client Record for **Duck, Daffy**
15. **Click** OK on the **Alert** message box
16. **Click Alerts** to view, add or edit a patient's Alerts
17. **Click** Help (Note: Help is displayed for viewing Alerts in a new browser window)



18. **Click Payor Information** to view, add or edit patient Payor Information
19. **Click Episode History** to view, add or edit a patient's Episode History
20. **Click on Allergies** which, when you click Add, will take you directly to DrFirst in order to enter any allergies for the patient
21. **Click Medications** to view, add or edit a patient's Medication History via the ePrescribe button, which will redirect you to DrFirst
22. **Click Documents** to view or add documents to a patient's chart, such as an insurance card or information from the referral source
23. **Click Appointments** to view, reschedule or insert a new appointment for the patient

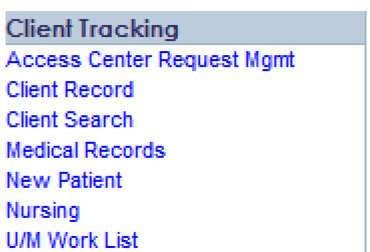
Client Records

The Client Record contains the patient's Demographics, Contact Information, Guardian Information, Legacy Information and the Address History. Additional tabs display the Payor Information, Episode History, Allergies and Medications via DrFirst, any Alerts for the patient, any documents that have been scanned into Epitomax and Scheduled Appointments.

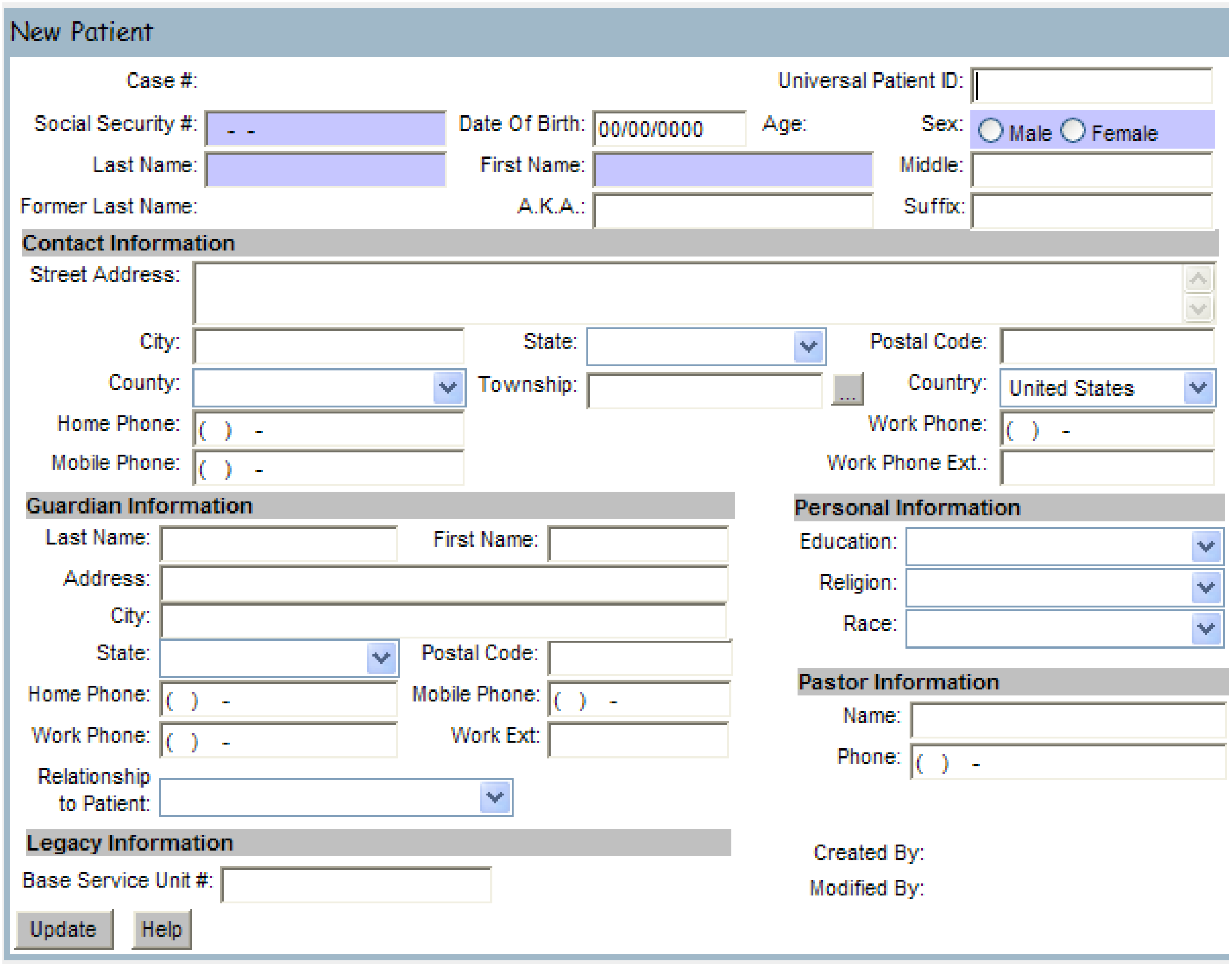
To create a new Client Record

The Create Client Record function allows users to create a New Client in the database.
A New Client Record should be created only after a thorough Client Search in the system has been completed, and the client was not found in the Search Results.

1. **Click** on the **New Client** link on the main menu from the **Client Tracking** option



The New Patient detail screen is displayed.



2. **Enter** the **Following:**

Social Security #	555555555 (no dashes)
Date Of Birth	1/1/1937
Sex	Your Choice
Last Name	Patient
First Name	"Patient#" (Spelled Out – i.e. One)
Street Address	1000 Exton Ave.
City	Anytown
State	PA
Postal Code	10292
County	Select from list
Township	Select from list (County must be selected first)
Home Phone	5555553132 (no dashes)

3. **Click** Update to save the record

➧ The Client Record screen is displayed along with all the associated tabs.

If there is no social security number and it is a <u>required</u> field, you may enter any string of numbers, such as 111111111 or 123456789.

The Last Name and First Name fields are <u>required</u> fields. The system will generate the Case Number, Creation Date and Created By data automatically when the changes are updated.

It is recommended that as much information about the Client as possible be entered. (This information may be received by a telephone call, a walk-in or by an external medical Referral Source, etc.)

To edit a Client Record

The Edit Client Record function allows users to view and update existing patient Demographic Information in addition to Contact, Guardian and Legacy Information.

1. **Click** on **Client Search** to find the **New Client Record**
2. **Click Clear** to clear the last search criteria
3. **Type Patient** in the **Last Name** field
4. **Click** the **Case #** associated with the **New Patient** to display the Client Record

   Tip: Once the patient has been selected, the **"**Client Record" menu item under the Patient Tracking menu may also be used to access the Client Record

5. **Select** the **Street Address** field
6. **Type** 9876 Anytown Lane
7. **Click** Update to **Save** the changes

The Case Number and Former Last Name fields are <u>view only</u>.

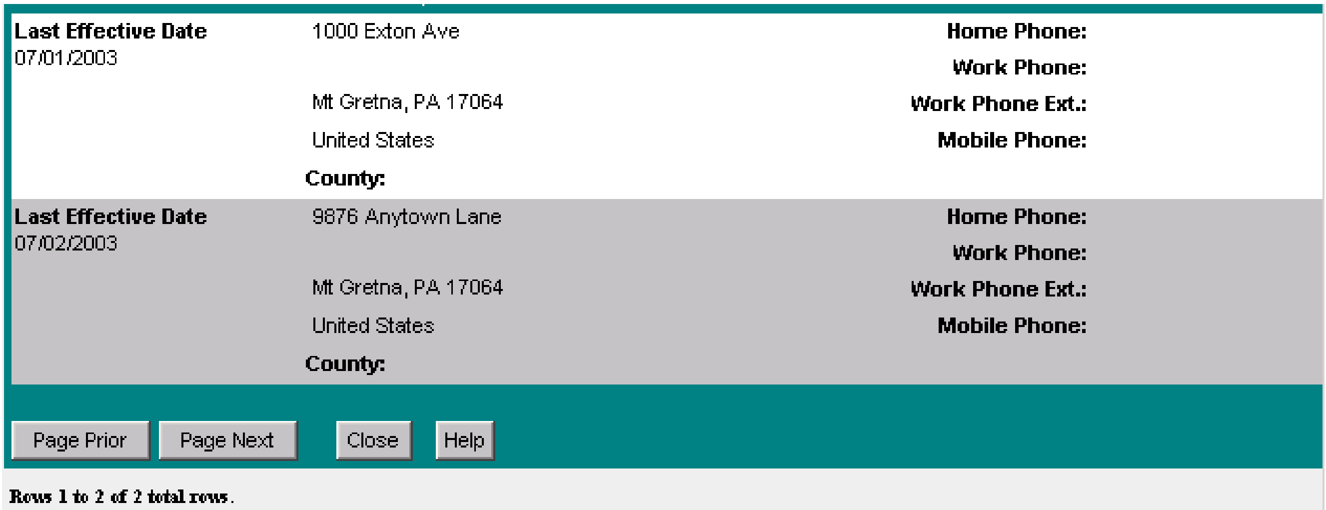
The Last Name and First Name fields are <u>required</u>.

To view the address history

The View Address History function allows users to view all Previous Addresses associated with a Client Record.

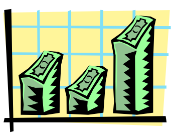
1. **Click** Address History on the Client Record

A new window is launched displaying all addresses associated with this patient.



All fields in this window are view only.

2. **Click** Close



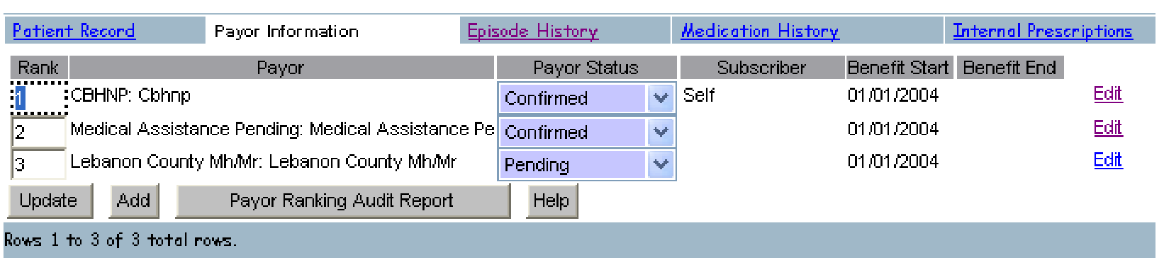
Payor Information

The Payor Information tab allows users to view a summary of the Master Payor Ranking associated with the Client Record. From this summary view, a user (depending on their role) may select to add new Payors and view, update, or inactivate existing Payors.

To view Master Payor Information for a Client Record

The View Payor Information function allows users to view the Master Payor Ranking List for a selected Client Record.

1. **Click** the **Payor Information** tab

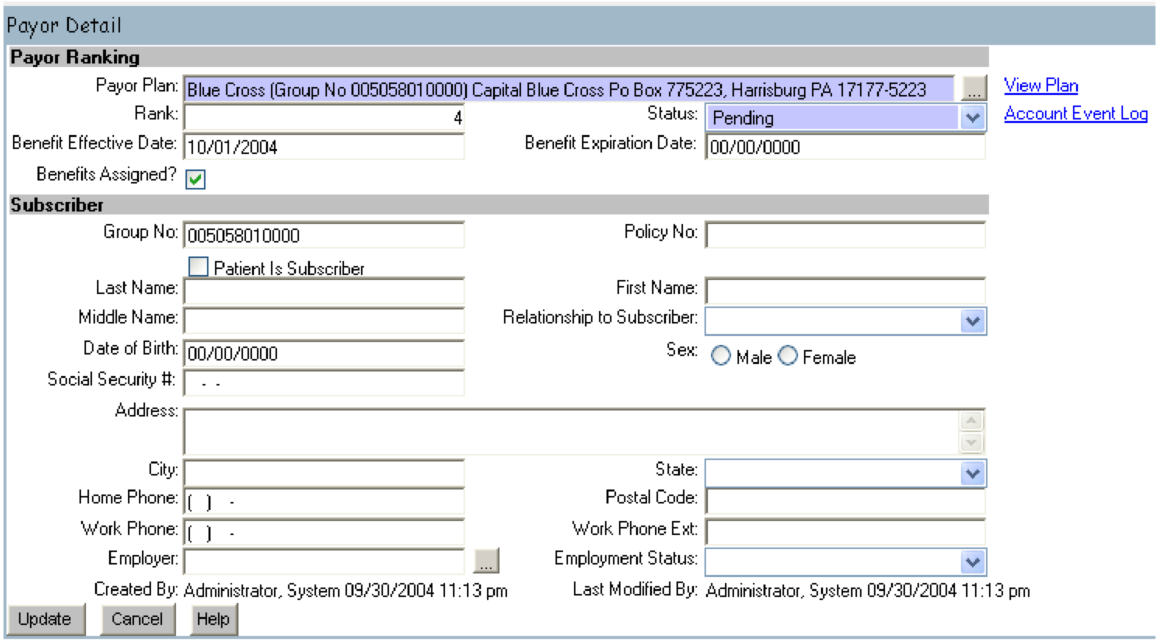


Modifications may be made to the Rank and Payor Status fields only. All other fields are view only.

To add a Payor to a patient record

1. **Click Add**

The required fields are highlighted.



The Payor Plan name and Benefit Effective Date are required fields. If the Benefit Effective Date is not known, an admission date can be used.

If no group number is entered, then the group number (if one exits) is copied from the Payor Plan.

If the patient has multiple Payors, indicate the order of billing preference by entering the Rank of the insurance company in the Rank field as “1” for primary carrier, “2” for secondary, and so on. If the Payor is no longer active, edit the Payor Ranking to “99”. When adding a new payor, the rank order isn’t necessarily a priority at this point. The payor can be added with any rank then re-ranked correctly after all info is entered and the system is updated.

The Payor Status field is view only and will default to “Pending”. To edit the Payor Status, a staff selects the Client Record, displays the Master Payor Ranking from the Payor Information screen and selects the Edit link.

In the Subscriber Information section, selecting the check box “Patient is Subscriber” indicates the patient is the primary subscriber of the insurance company. If this box is checked, then all subscriber information is copied from the Client Record.

If the patient is not the subscriber, complete the Subscriber Information section including the Group and Policy No. and what the relationship is to the patient. This is critical for billing to occur correctly.

Any additions or changes made to the Master Payor Ranking will be logged in the Master Payor Change Report under the Patient Tracking Reports menu

2. Enter data in the editable fields

3. Click Update

To edit Master Payor Information

The Edit Master Payor Information function allows users to modify the Rank or Status of an existing Master Payor Ranking.

Changing the Rank field has no effect on the Episode Payor Rankings on existing episodes. If the user selects the Edit link and changes any Subscriber fields or any of the Benefit Effective Date, Expiration Date, Payor Status or Benefits Assigned fields, then the changes are copied to all patient episodes having this Payor Plan in the Episode Payor Ranking

The system will not allow the patient to have 2 payors with the same rank

The system will not allow the patient not to have a payor with a rank of one.

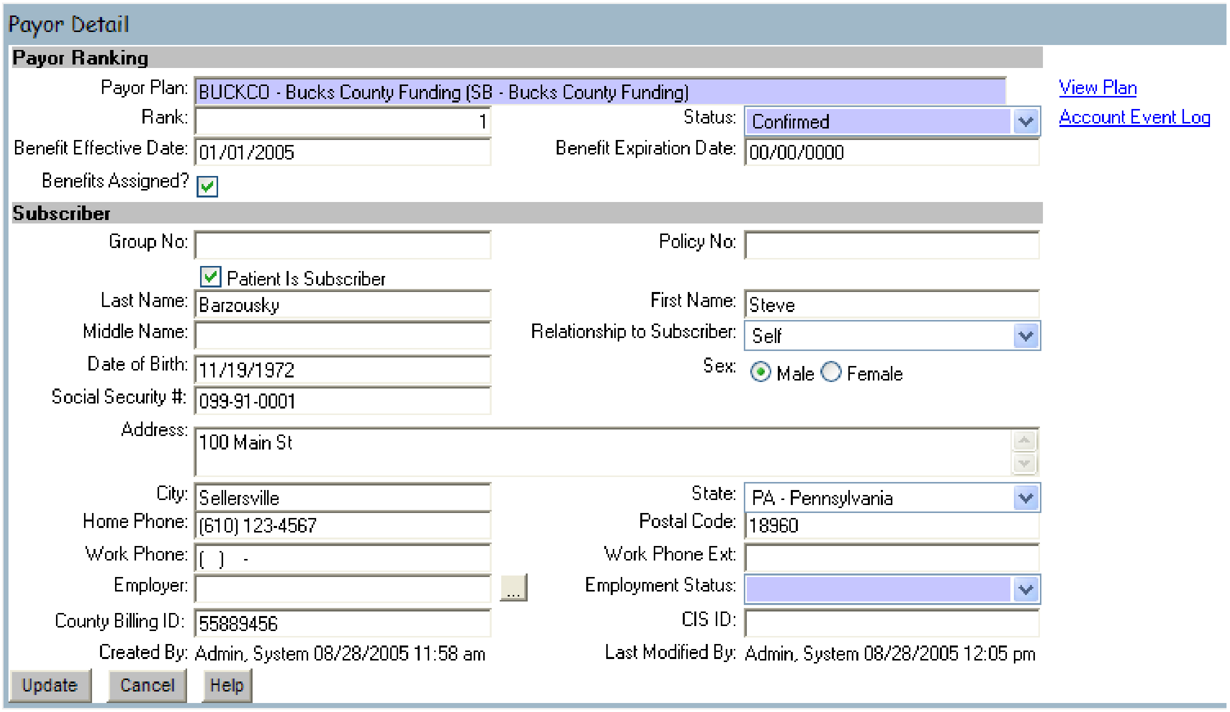
The Payor Status is a required field

To edit Master Payor Subscriber Information

The Edit Payor function allows users to view and edit an existing Payor associated with a Client Record.

1. **Click** on the **Edit** link next to a selected Master Payor.

   The system displays the Payor Detail screen



The Benefit Effective Date is defined as the date the benefits or insurance became effective. This differs from the Rank Effective Date located in the Episode Payor Ranking

The Payor Plan cannot be changed if the same payor exists on any existing episodes. Otherwise, this field is editable and another payor may be selected.

The Payor Plan and the Payor Status fields are required fields

Any changes to the subscriber information will be logged in the Subscriber Change Report under the Patient Tracking Reports menu

Social Security Number, Employer and Employee Status are new fields implemented with Release 2.

If a payor is a county payor, the County Billing ID and CIS ID will be available when editing the payor, for non county payors these fields are not displayed. Refer to Edit Payor Information.

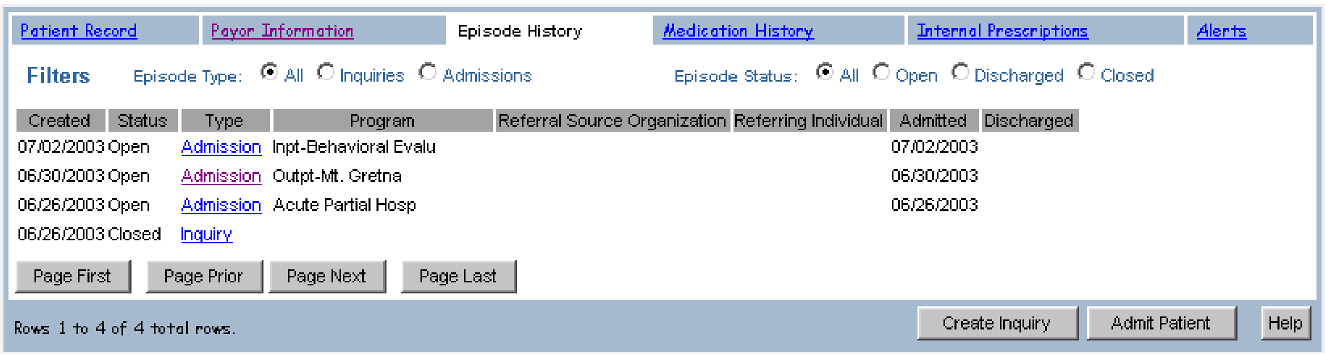
Episode History

The Episode History tab allows users to view and create Admissions and Inquiries associated with the Client Record.

To view an Episode

The View Episode function allows users to view an Episode.

1. **Click** the **Episode History** tab
2. **Select All** for the **Episode Type** (system default)
3. **Select All** for the **Episode Status** (system default)



Patient Record | Payor Information | Episode History | Medication History | Internal Prescriptions | Alerts

Filters Episode Type: All Inquiries Admissions Episode Status: All Open Discharged Closed

Created	Status	Type	Program	Referral Source Organization	Referring Individual	Admitted	Discharged
07/02/2003	Open	Admission	Inpt-Behavioral Evalu			07/02/2003	
06/30/2003	Open	Admission	Outpt-Mt. Gretna			06/30/2003	
06/26/2003	Open	Admission	Acute Partial Hosp			06/26/2003	
06/26/2003	Closed	Inquiry					

Page First Page Prior Page Next Page Last

Rows 1 to 4 of 4 total rows. Create Inquiry Admit Patient Help

All fields on this screen are view only.

An Episode Status of Discharged refers to a patient who has been Discharged from the Program but has not been processed through Medical Records. An Episode Status of Closed has a Discharged date and documentation of all Medical Record's paperwork (admission notes, discharge summaries, progress notes) has been completed. This is only valid for certain types of care (Inpatient, Residential, Partial).

Filters are available to sort the information by Episode Type or Episode Status. (The system defaults to All). For example: If the user only wishes to view Open Admissions, the Episode Type: Admissions is selected and the Episode Status: Open is selected.

Allergies/Medications

Both tabs are currently connected to our e-prescribing partner, DrFirst. In order to add, view or edit a client allergy, click on Add and you will automatically be directed to the DrFirst website.

In order to add, view or edit a client's medication history, or create a new prescription, click on the Medications tab and click on the e-Prescribe button, which will direct you to the DrFirst website.

Alerts

The Alerts tab allows users to view a summary of all Alerts associated with a Client Record. From this summary view, a user may add new Alerts and view or update existing Alerts.

To view an Alert

The View Patient Alert function allows users to view a new Alert associated with a Client Record.

1. **Click** the **Alerts** tab

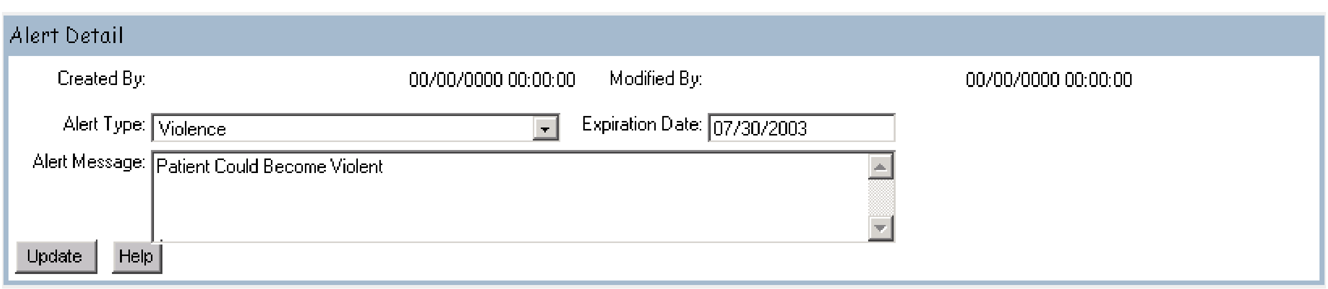
An Alert is a patient condition which staff should be aware of, such as an allergy, a physical condition or substance abuse. This information is normally collected during the assessment of the patient by the Access Center staff.

To add an alert

The Add Patient Alert function allows users to add a new Alert to a Client Record.

1. **Click** Add
2. **Enter** the **Following:**

Alert Type	Violence
Expiration Date	"1 Month From Today"
Alert Message	Patient Could Become Violent

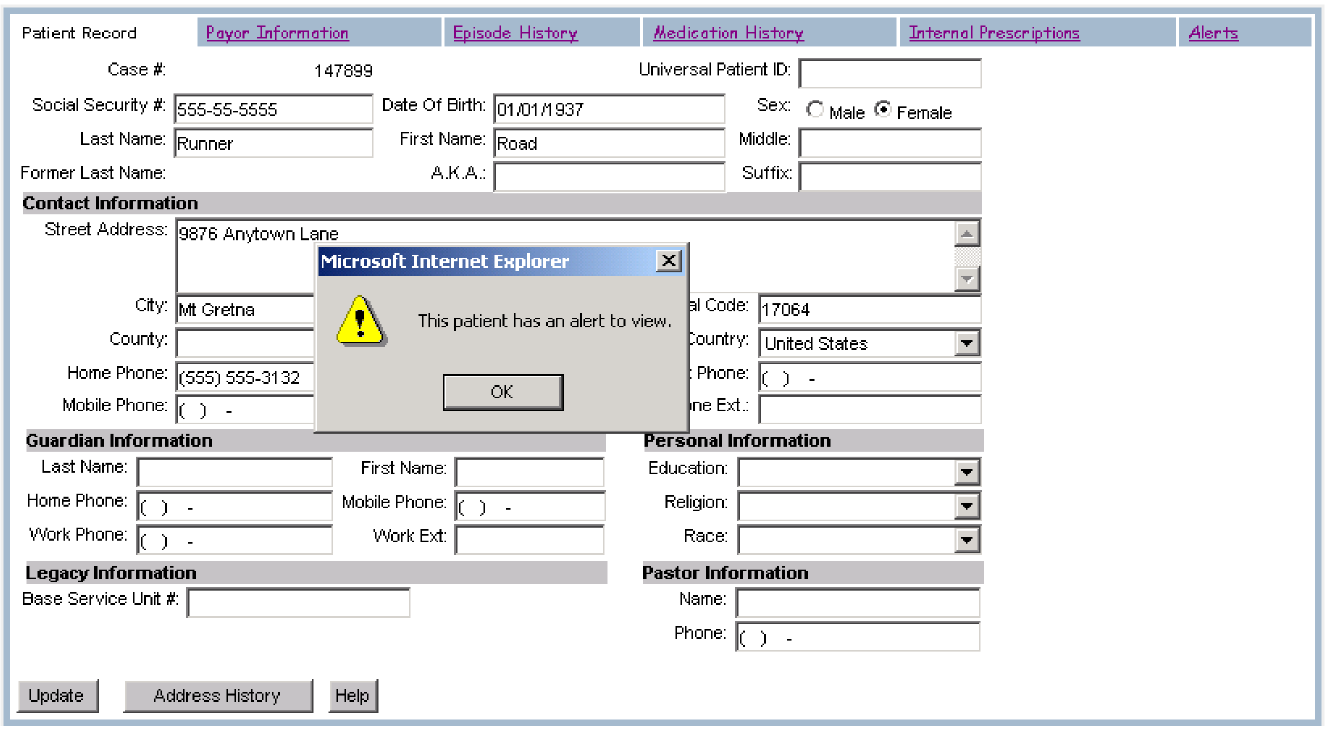


3. **Click** Update

To be notified of the alert

If the patient has an active Alert, the system will notify the user whenever that Patient's Record is accessed. The system will also display a **red** alert box in the upper left hand corner of the Client Record screen. The Alert information can then be viewed by selecting the Alert tab.

1. **Click Client Search**
2. **Type Patient** (Or the last name of your newly created patient) in the **Last Name** field
3. **Click** Search
4. **Click** the **Case #** for the **Newly Created** patient to display the Client Record



5. **Click** OK on the **Alert** message box

To edit an alert

The Edit Patient Alert function allows users to edit an existing Alert for an associated patient.

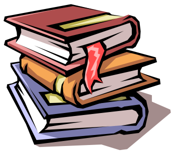
1. **Click** the **Alerts** tab
2. **Click Edit** to the right of the violence alert
3. **Change** the **Following:**

Expiration Date	2 Months From Today

4. **Click** Update

Alerts <u>cannot</u> be deleted. An expiration date can be applied to indicate that the Alert is no longer active.

The Alert Type field is the only <u>required</u> field.

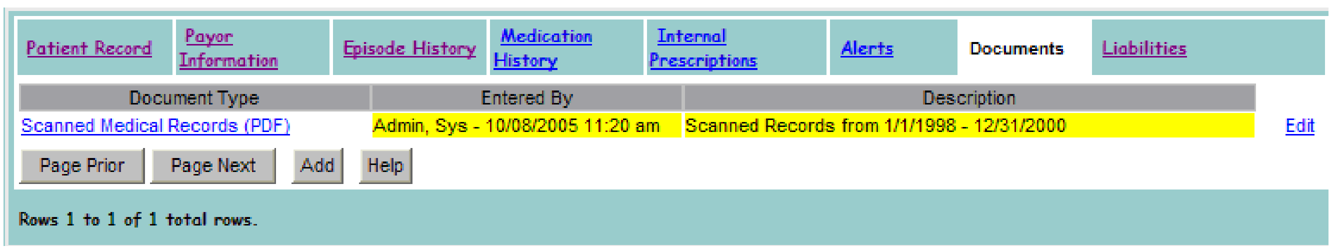


Documents

The Documents tab allows users to add and view external documents related to a patient. These documents can be Word, PDF, Tiff, etc.

To View a Document

1. **Click** the **Documents** tab

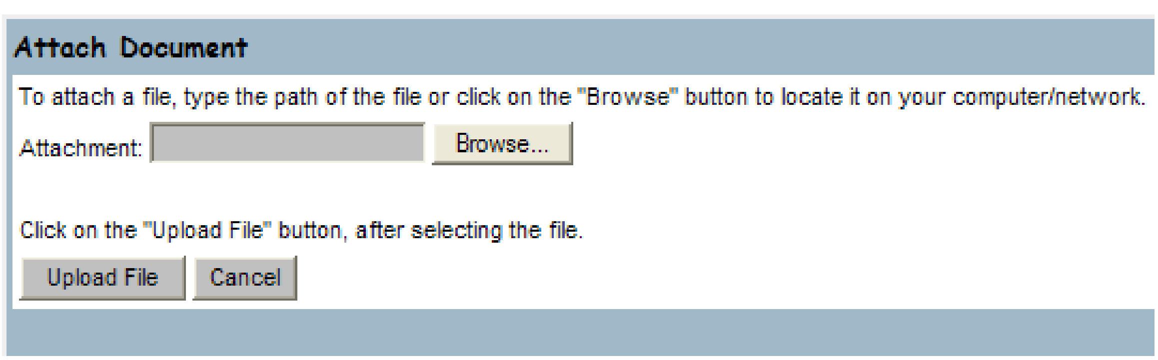


2. **Click** on the link under the Document Type heading for the document you wish to view. The document will then be displayed in the corresponding viewing tool (Word, Acrobat, etc.)

To add a Document

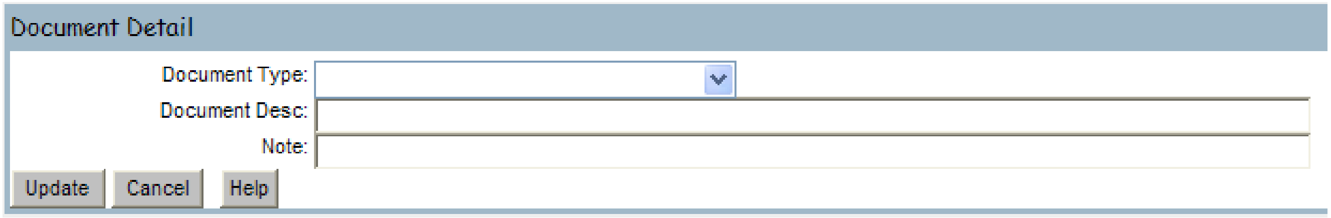
The Add Button allows users to add a new Document to a Client Record.

1. **Click** Add



2. **Click** on the **Browse** button and select the file to attach**.**

3. **Click** on the **Upload File** button.
4. Enter in the Document Detail Information:



Document Type	Scanned Medical Record
Document Desc	Archived Medical Records form 1/1/98 – 12/31/2000
Note	Forms scanned from Archive

5. **Click** the **Update** Button and the document is now attached to the patient

To Edit a Documents properties

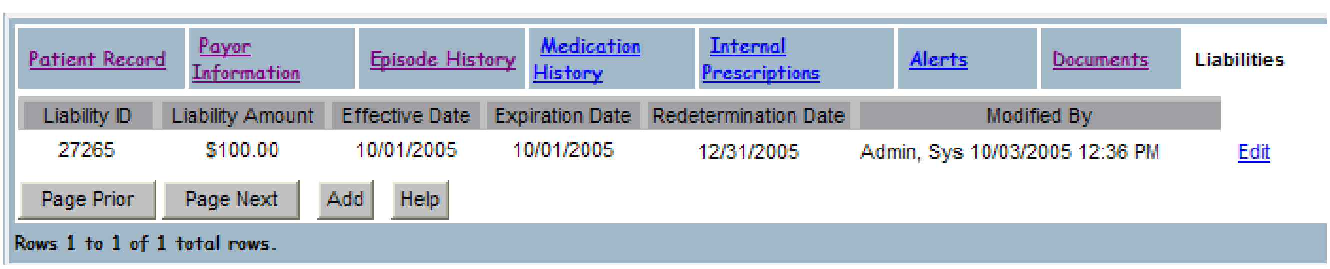
1. **Click** the **Edit** link for the documents properties you would like to edit.
2. Update the Document Details and click the **Update** button to save the changes.

Liabilities

The Liabilities tab allows users to add a liability that can be applied to an Episode Payor that is a county payor.

To View a Liability

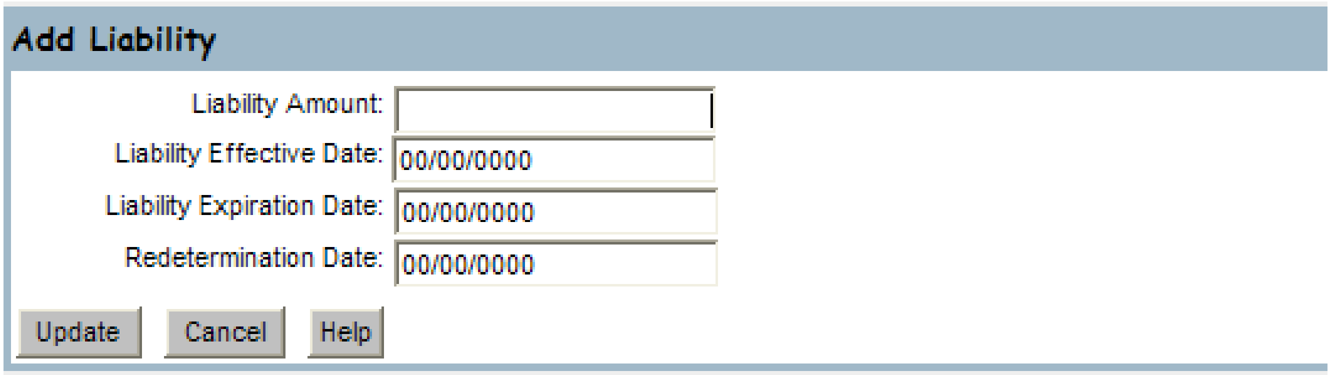
1. **Click** the **Liabilities** tab



To add a Liability

The Add Button allows users to add a new Liability to a Client Record.

6. **Click** 



7. **Enter** the Liability amount effective and redetermination date. If the expiration date is known that can be entered now as well.

Liabilities must be linked to an Episode Payor in order for the system to process them when a charge is generated. Refer to the Attaching a Liability section to see how a liability is attached to an Episode Payor.

Liability Amount	$100
Liability Effective Date	1/1/2005
Liability Expiration Date	
Redetermination Date	12/31/2005

8. **Click** the **Update** Button and the Liability is now created.

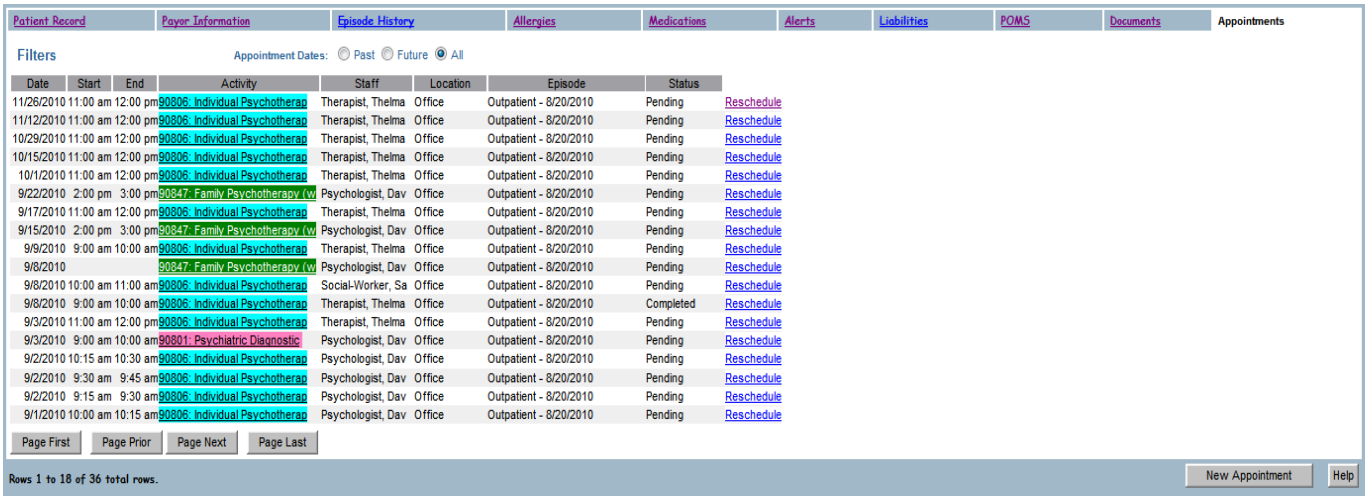
To Edit a Liablity

1. **Click** the **Edit** link for the Liability you would like to edit.
2. Update the Liability information and click the **Update** button to save the changes.

Appointments

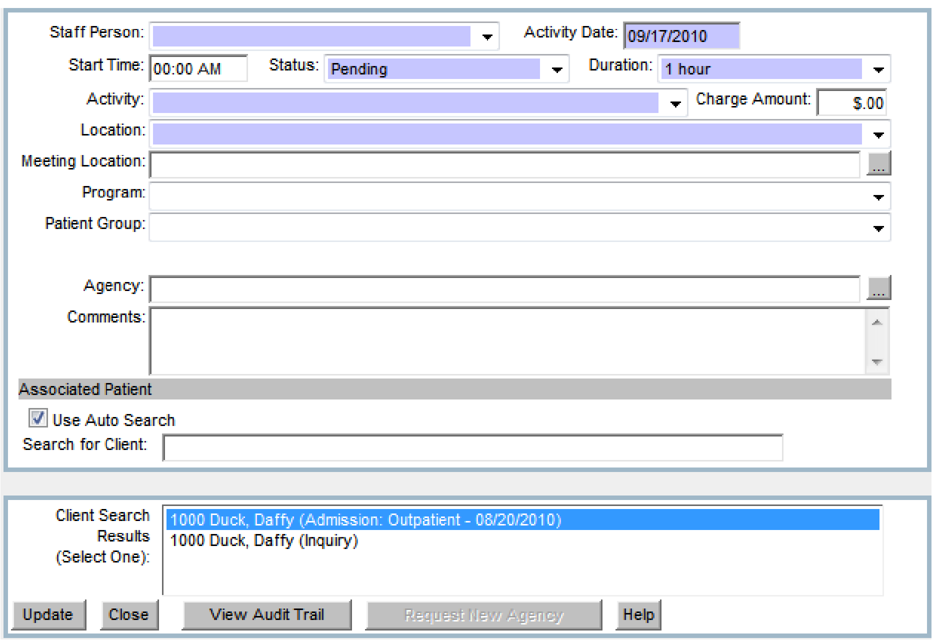
The Appointments tab allows the user to view, reschedule or create new appointments for clients. There are three filters that allow the user to view past, future or all appointments.

1. Click on the Appointment tab.

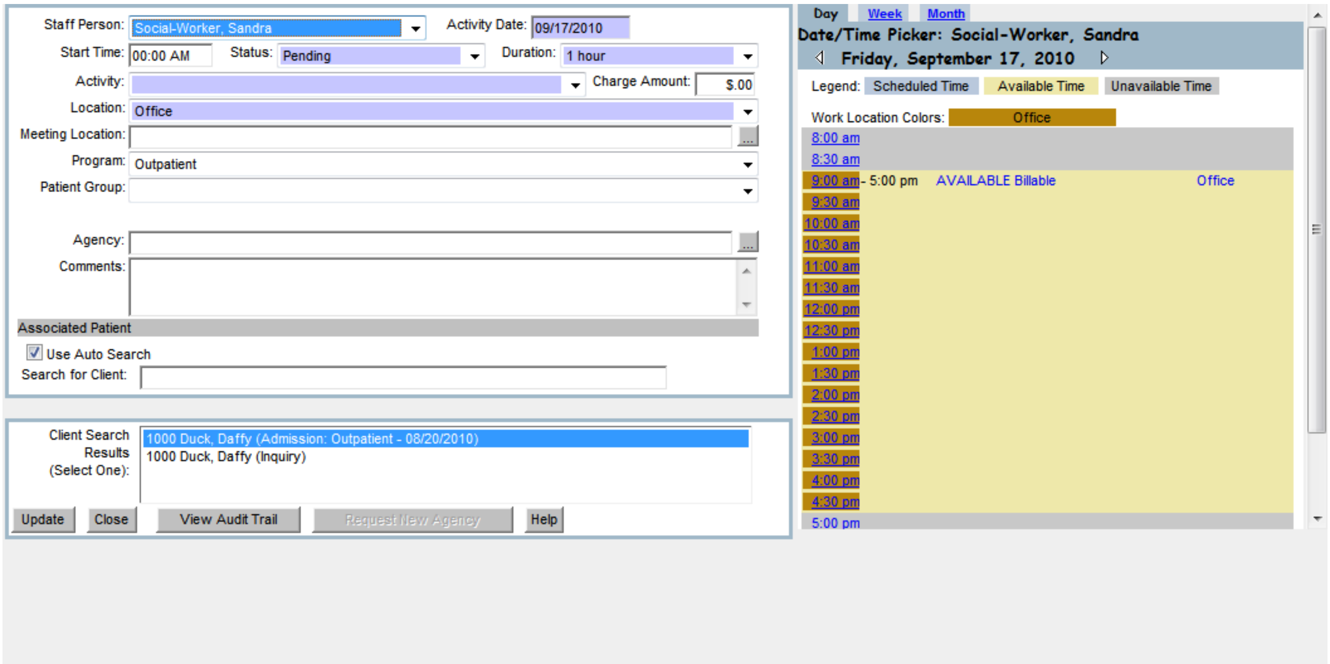


Date	Start	End	Activity	Staff	Location	Episode	Status	
11/26/2010	11:00 am	12:00 pm	90806: Individual Psychotherap	Therapist, Thelma	Office	Outpatient - 8/20/2010	Pending	Reschedule
11/12/2010	11:00 am	12:00 pm	90806: Individual Psychotherap	Therapist, Thelma	Office	Outpatient - 8/20/2010	Pending	Reschedule
10/29/2010	11:00 am	12:00 pm	90806: Individual Psychotherap	Therapist, Thelma	Office	Outpatient - 8/20/2010	Pending	Reschedule
10/15/2010	11:00 am	12:00 pm	90806: Individual Psychotherap	Therapist, Thelma	Office	Outpatient - 8/20/2010	Pending	Reschedule
10/1/2010	11:00 am	12:00 pm	90806: Individual Psychotherap	Therapist, Thelma	Office	Outpatient - 8/20/2010	Pending	Reschedule
9/22/2010	2:00 pm	3:00 pm	90847: Family Psychotherapy (w	Psychologist, Dav	Office	Outpatient - 8/20/2010	Pending	Reschedule
9/17/2010	11:00 am	12:00 pm	90806: Individual Psychotherap	Therapist, Thelma	Office	Outpatient - 8/20/2010	Pending	Reschedule
9/15/2010	2:00 pm	3:00 pm	90847: Family Psychotherapy (w	Psychologist, Dav	Office	Outpatient - 8/20/2010	Pending	Reschedule
9/9/2010	9:00 am	10:00 am	90806: Individual Psychotherap	Therapist, Thelma	Office	Outpatient - 8/20/2010	Pending	Reschedule
9/8/2010			90847: Family Psychotherapy (w	Psychologist, Dav	Office	Outpatient - 8/20/2010	Pending	Reschedule
9/8/2010	10:00 am	11:00 am	90806: Individual Psychotherap	Social-Worker, Sa	Office	Outpatient - 8/20/2010	Pending	Reschedule
9/8/2010	9:00 am	10:00 am	90806: Individual Psychotherap	Therapist, Thelma	Office	Outpatient - 8/20/2010	Completed	Reschedule
9/3/2010	11:00 am	12:00 pm	90806: Individual Psychotherap	Therapist, Thelma	Office	Outpatient - 8/20/2010	Pending	Reschedule
9/3/2010	9:00 am	10:00 am	90801: Psychiatric Diagnostic	Psychologist, Dav	Office	Outpatient - 8/20/2010	Pending	Reschedule
9/2/2010	10:15 am	10:30 am	90806: Individual Psychotherap	Psychologist, Dav	Office	Outpatient - 8/20/2010	Pending	Reschedule
9/2/2010	9:30 am	9:45 am	90806: Individual Psychotherap	Psychologist, Dav	Office	Outpatient - 8/20/2010	Pending	Reschedule
9/2/2010	9:15 am	9:30 am	90806: Individual Psychotherap	Psychologist, Dav	Office	Outpatient - 8/20/2010	Pending	Reschedule
9/1/2010	10:00 am	10:15 am	90806: Individual Psychotherap	Psychologist, Dav	Office	Outpatient - 8/20/2010	Pending	Reschedule

2. If the facility chooses to use color coding for different activities (set up in Activity Maintenance under the Administration menu), each type of appointment will appear in the chosen color.
3. If the user clicks on the **Reschedule** link, a second window will open with that user's calendar, allowing a daily, weekly or monthly view. The rescheduled appointment can be made from that window.
4. If the user needs to make an appointment with another staff member, the user will click on the **New Appointment** button. This will open another window with the appointment screen.



5. Once the original user chooses a new staff person via the drop down menu, that new staff member's calendar will appear on the right side of the screen.

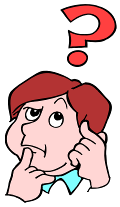


6. From here, the user can either enter the information manually on the right side of the screen or use the selected staff's calendar to find available dates and time slots.
7. The user will then either enter a time manually on the left hand side of the screen (next to Start Time) or choose a time from the calendar.
8. The user will then enter the appropriate time and activity, click on the appropriate episode for the client and click the **Update** button.
9. The window will close after the user clicks on the Update button and the appointment is scheduled for that new staff member.

Lesson 4
Inquiries

Objectives

- Inquiries
- Referral Source
- Instances Of Contact
- Presenting Problems
- Requests
- Authorizations
- Alternate Contacts
- School Info
- Payors
- Forms
- Access Center Request Waiting List



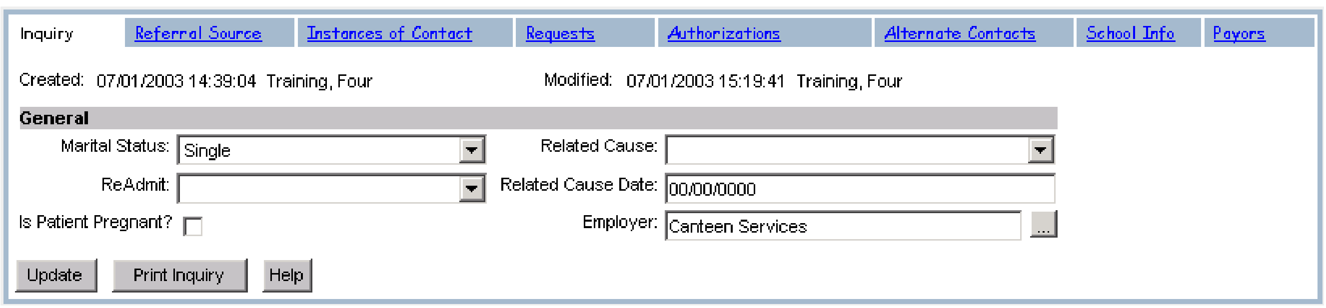
Inquiry

An Inquiry contains patient information such as Marital Status, Employer, any Re-Admit dates and the Related Cause. Additional tabs list the Referral Source, any Instances Of Contact, Requests, Authorizations, Alternate Contacts, School Information, Payors and Forms. An Inquiry is where to enter information about a patient prior to admission.

To view an Inquiry

The Inquiry tab allows users to view and edit an existing Inquiry associated with a Client Record.

1. **Click** on **Client Search** from the **Patient Tracking** menu
2. **Type Duck** in the **Last Name** field
3. **Click** Search
4. **Click** on the **Case #1000**
5. **Click Episode History**
6. **Click** on the **Inquiry** tab (Note: The system defaults to the Instances Of Contact tab)



To create an Inquiry

The Create Inquiry function allows users to create a new Inquiry associated with a Client Record.

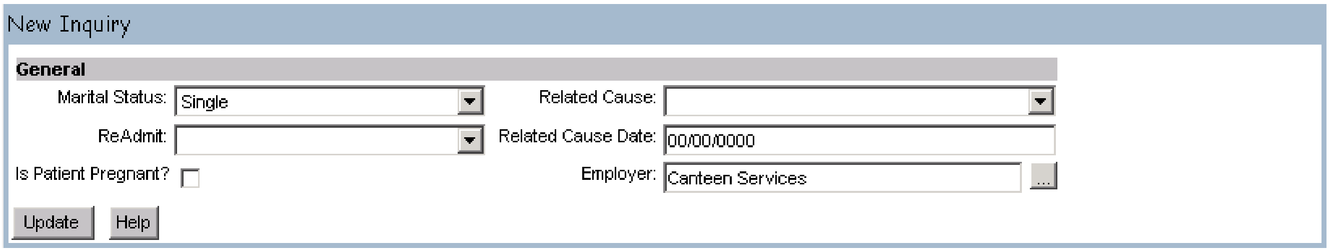
An Inquiry <u>cannot</u> be created if there is already an Inquiry with a Status of "Open".

If a patient is Admitted but the Inquiry Status remains “Open”, the Inquiry has an <u>unfulfilled Request</u> within the system.

1. **Click** on **Client Search** from the **Patient Tracking** menu
2. **Type Patient** in the **Last Name** field
3. **Click** Search
4. **Click** on the **Case #** of the patient
5. **Click Episode History**
6. **Click** Create Inquiry

7. **Enter** the **Following:**

Marital Status	Single
Employer	Canteen Services
Hint*: Use the Ellipses Button to the right of the employer field to search for an employer if there are more than 100 Employers in the system. If there are less than 100 Employers in the system, the employer field will appear as a drop-down box*	



The “Is Patient Pregnant” indicator checkbox indicates that "Yes" the patient is pregnant if checked and "No" the patient is not pregnant if not checked.

8. **Click** Update

To print an Inquiry

The Print Inquiry function first formats and then returns an Inquiry for the staff to view, print or send to various departments. The printed document displays the Client Demographics, Referral Source, any Alerts, Instances Of Contact Information and any Request Information related to the Inquiry.

1. **Click** the **Inquiry** tab
2. **Click Print Inquiry**
3. **Close** the **Print Inquiry** browser window

   Tip: To obtain a printout of this screen, click on the Print button from the Internet Explorer toolbar or select the Print menu item from the File menu.

Referral Source

The Referral Source is the initial contact your staff receives referring a client.
The Referral Source tab can also be utilized as a resource for verifying Referrals and their demographic information. It also allows users to create or update a Referral Source for an Inquiry or Admission.

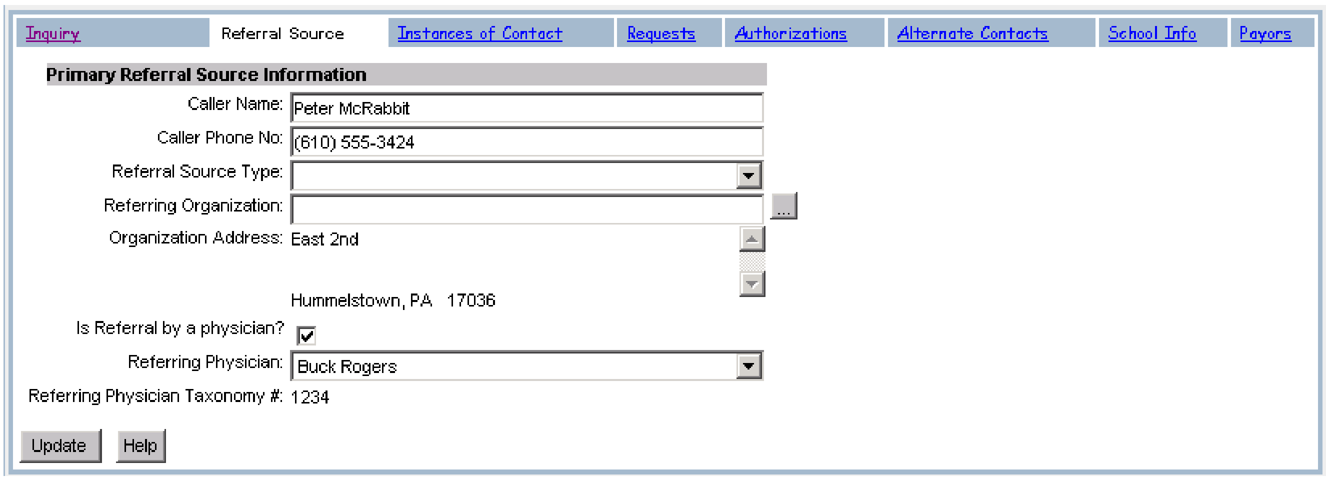
To create a Referral Source

The Create Referral Source function allows users to create a new Referral Source.

1. **Click** the **Referral Source** tab
2. **Enter** the **Following:**

Caller Name	Peter McRabbit
Caller Phone No:	610-555-3424 (no dashes)
Referral Source Type	Employer
Is Referral By A Physician	(checked)
Referring Physician	Buck Rogers

3. **Click** Update



The Organization Address and Referring Physician Taxonomy # fields are view only and cannot be changed.

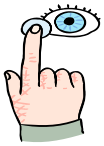
The Referral Source Type is the relationship of the referring person and the patient. Such as clergy, family friend or school.

You may enter a value for Referring Organization only if a value has been entered for Referral Source Type. After the Referral Source Type is entered and the Organization is selected from the pick list, the Organization's address will be displayed.

When a Physician is selected from the pick list, the system automatically checks the "Referral by a Physician" checkbox.

If the desired Referring Physician does not display on the list, contact your supervisor.

The system only allows for one Referral Source. If another Referral Source exists for the selected Episode, the existing Referral Source must be modified with the new information.



Instances Of Contact

An Instance Of Contact allows documentation of information such as the Initial Staff Contact, Classification of Instance Of Contact, Contact/Caller Information, any Chemical Influences and any Presenting Problems associated with an Episode.

To view an Instance Of Contact

The Instance Of Contact tab allows users to view a summary of all Instances Of Contact associated with an Episode. From here the user is able to edit an existing Instance Of Contact or add a new one to the Client Record.

Even though the Instance Of Contact is associated in the system with an open Inquiry, additional Instances Of Contact may be created for other Episodes.

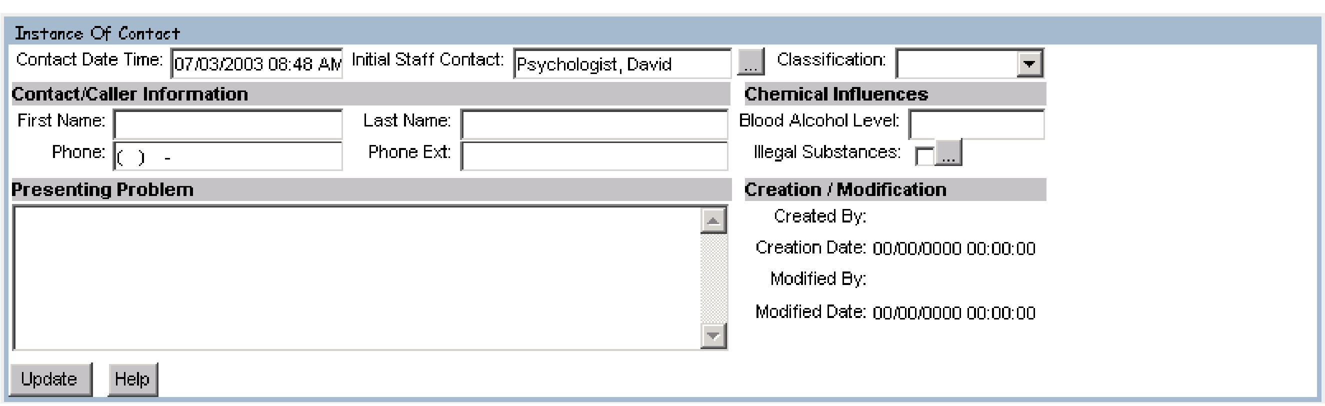
1. **Click** the **Instances Of Contact** tab

To add an Instance Of Contact

The Add Instance Of Contact function allows users to add a new Instance Of Contact for an Episode in the system. The Instance Of Contact tracks correspondence relating to a patient or possible future patient.

When an Inquiry is selected and the Instance Of Contact information is entered or modified, the information will be copied to the associated Admission for that patient.

1. **Click** Add



2. **Enter** the **Following:**

Contact Date Time	Today's Date And Time
Initial Staff Contact	Default
Classification	Phone Call
First Name and Last Name	Roger Rogerio
Phone	555-333-7771 (no dashes)
Phone ext.	2176
Presenting Problem	Physical Instability – Exhibiting Suicidal Thoughts

3. **Click** Update

The Classification is the type of Instance Of Contact, such as a walk-in, telephone call or fax.

Staff may add as many Instances Of Contact as needed.

Contact Date and Time, Contact Last Name, First Name, Phone, Classification and Presenting Problem are all required fields.

Presenting problem does not have to be a diagnosis. It can also include the content of the interaction between the staff and the contact.

To view Presenting Problems

The View Presenting Problem function allows users to view all of the Instance Of Contact's Presenting Problems associated with an Episode.

The system does not allow modification of the Presenting Problem information. If changes are necessary, a new Instance Of Contact will need to be created.

1. **Click** Presenting Problems

The following fields are view only: Contact Date, Initial Staff Contact, and Presenting Problem.

2. **Click** Close

To edit an Instance Of Contact

The Edit Instance Of Contact function allows users to modify an existing Instance Of Contact.

1. **Click** the **Edit** link
2. **Select Illegal Substance**
3. **Click** Add
4. **Enter** the **Following:**

Illegal Substance	Other Hallucinogens
Route Of Administration	Oral
Substance Frequency	Once Per Week

The Illegal Substance information can only be added after an Instance Of Contact has been updated.

The Illegal Substance field is a required field

The following fields are view only: Creation Date, Created By, Modified Date, and Modified By.

5. **Click** Update

Requests

A Request can be created to keep a record of all patients waiting for the next Outpatient Appointment or Program vacancy.

The Access Center maintains a “waiting list” for Child/Adolescent Partial Programs.

The Scheduling department maintains lists for Psychologist Credentialing and Cancellations. Patients requesting to be seen by a non-credentialed Psychologist will be placed on a waiting list until credentialing is approved.

Physicians or Therapists, who have no available Appointments, have their patients placed on the waiting list until the next available Appointment. These patients may also request to be contacted if an Appointment becomes available due to a cancellation.

To view a Request

The Requests tab allows users to view a summary of all Requests associated with an Inquiry. From this summary view, a user may add new Requests and view or update existing Requests. The Access Center Request Waiting List function provides a means for staff to view a list of patients with Requests for your agencies services.

From the Access Center Request Waiting List, the system will display a list of Requests for a selected Type Of Care and Program.

1. **Click** the **Requests** tab

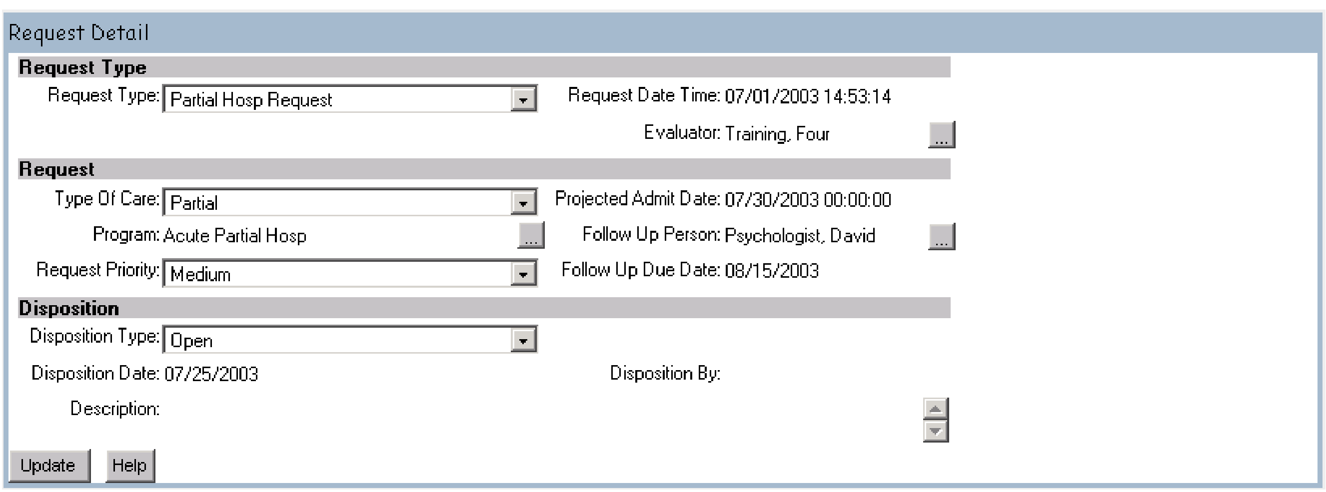
To add a Request

The Add Request function allows users to add a Request for an Inquiry in the system. A search should be performed first, by using the Access Center Request Mgmt. option from the Patient Tracking menu, to verify that a Request for that patient doesn't already exist.

1. **Click** 

2. **Enter** the **Following:**

Request Type	Partial Hosp Request
Evaluator	The name of the person recording the request
Type Of Care	Partial
Program	Acute Partial Hosp
Request Priority	Medium



A Request Type can be an Information Request, Inpatient Request, Outpatient Request, Other or Partial Hospital, etc

It is important to <u>enter the Type Of Care and Program of the Request</u> to ensure both the Request and the Inquiry close if the patient is admitted. The Inquiry and Request will have a Status of "Closed" and "Admitted" respectively, only when the Type Of Care and Program of the new Admission match the Request.

The Request Type and Request Date and Time are required fields. The date and time will default to the current system date and time.

Admitting the patient from the Access Center Request Management screen will allow the user to select a Type Of Care and Program if neither had been previously selected.

3. **Click** Update

To edit a Request

The Edit Request function allows users to edit or view an existing request for an Episode in the system.

1. **Click Edit**
2. **Change** the **Following:**

Request Priority	Low

3. **Click** Update

The Request Priority Status may help to determine the next patient to be admitted from the waiting list for a Program. The Request Priority Status can be edited through the patient's Inquiry or through the Access Center Request Management menu.

The Request Type field is a required field. The Request Date and Time and Disposition By fields are view only.

Authorizations

The Authorizations tab allows users to view a summary of all Authorizations associated with an Inquiry. From this summary view, a user can create, view, and edit Authorizations for an Inquiry.

To view Authorizations

The View Authorizations function allows users to view Authorizations associated with an Inquiry.

1. **Click Authorizations**

The list of authorizations can be sorted by "All", "Current" or "History"

To add an Episode Authorization

The Add Episode Authorization function allows users to add a new Authorization on an Inquiry record.

1. **Click** Add
2. **Select Blue Cross (65 Choice)**
3. **Click** Cancel

Alert: Adding An Authorization Is Done Later In The Course

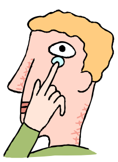
When adding a new Authorization, the system will display a message prompting the user to associate the new Authorization with an existing Payor. After the Payor is selected, Authorization details can be added.

To edit an Episode Authorization

The Edit Episode Authorization function allows users to edit an existing Authorization for an Inquiry in the system.

1. **Click** the **Edit** link next to the **Newly Created** Authorization and make the necessary changes
2. **Click** Cancel

Alert: Editing An Authorization Is Done Later In The Course



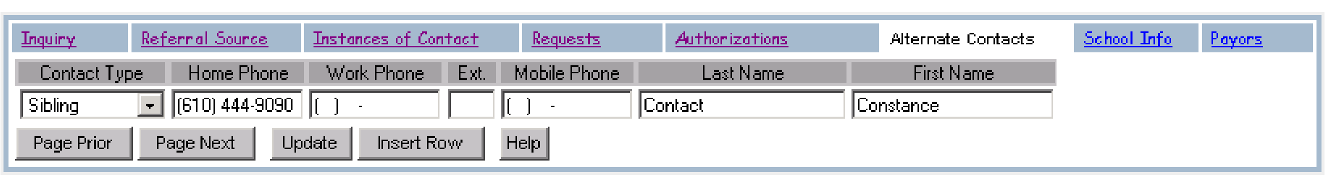
Alternate Contacts

The Alternate Contacts tab contains the Contact Type, such as a psychologist, parent, pastor, etc., Home and Work Phone, and the First and Last Names of the Alternate Contact.

To view an Alternate Contact

The View Alternate Contact function allows users to view a summary of the Alternate Contacts associated with a patient's Episodes.

1. **Click Alternate Contacts**



The following fields are <u>view only</u>: Contact Type, Phone Number, Last Name, First Name, Work Phone Number, Work Phone Extension and Mobile Phone Number.

To add an Alternate Contact

The Add Alternate Contact function allows users to add a new Alternate Contact for an Episode.

1. **Click** Insert Row
2. **Enter** the **Following:**

Contact Type	Sibling
Home Phone	610-777-6666 (no dashes)
Last Name	Contact
First Name	Constance

3. **Click** Update

The Alternate Contact Type, Last Name, First Name and Phone Number are <u>required</u> fields.

The Alternate Contact Type is the relationship between the Alternate Contact and the patient such as family, friend, external caregiver, physician, pastor, etc.

To edit an Alternate Contact

The Edit Alternate Contact function allows users to edit an existing Alternate Contact for an Episode.

1. **Change** the **Following:**

Home Phone	610-987-3445 (no dashes)

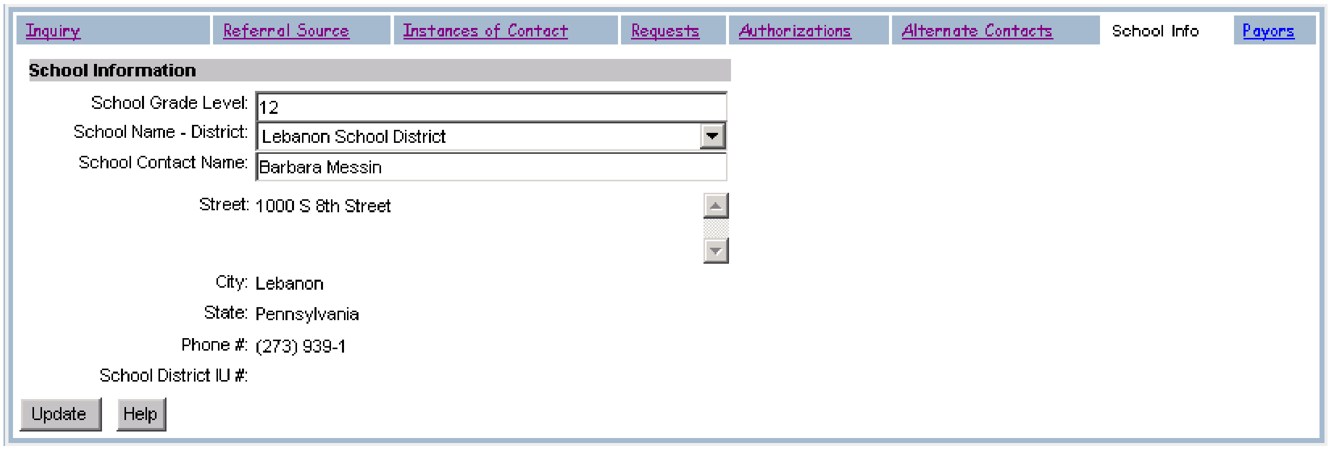
2. **Click** Update

School Information

To view School Information

The view School Info function allows users to view or update School Information associated with an Episode.

1. **Click** on the **School Info** tab



To add School Information

The Add School Info function allows users to add School Information associated with an Episode.

1. **Click** on the **School Info** tab
2. **Enter** the **Following:**

School Grade Level	11
School Name-District	Lebanon School District
School Contact Name	Barbara Messin

3. **Click** 

To edit School Information

The Edit School Info function allows users to view and/or update School Information associated with an Episode.

1. **Click** on the **School Grade Level** ellipses
2. **Change** the **Following:**

School Grade Level	12

3. **Click** 

The following fields are <u>view only</u>: Street Address, City, State, Phone Number, and School District IU #.

Episode Payor Ranking

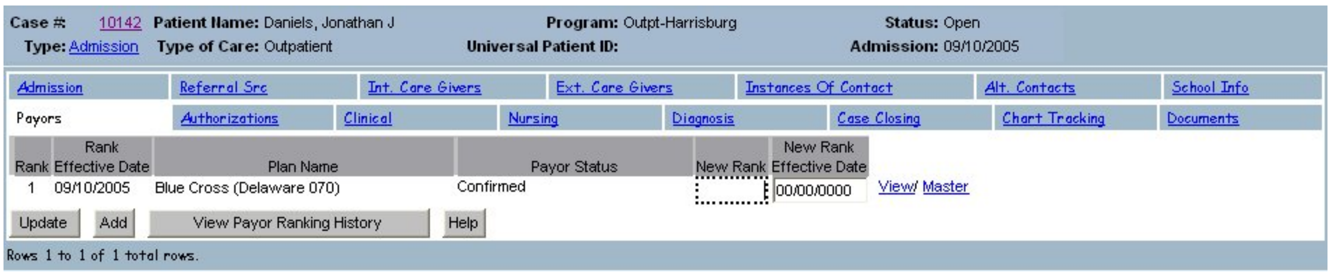
From the Inquiry or Admission screen, the Payors tab allows adding, viewing, updating or deleting existing Payors. From here, staff can select a Payor from the Master Payor List and link it to the selected Episode.

The Master Payor Ranking can be accessed from the episode by selecting the Master link

To view Payor Information associated with an Episode

The View Payor Information function allows users to view existing Payor Information.

1. **Click** the **Payors** tab

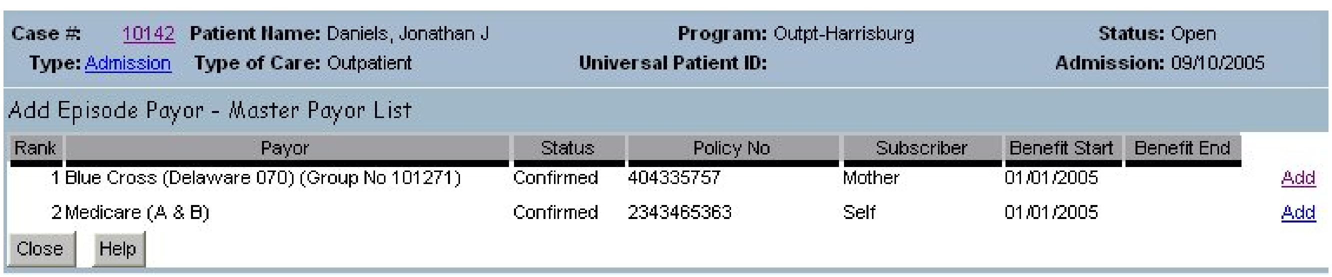


To add a Payor to an Episode

The Add Payor Information function allows staff, based on security permissions, to select an existing payor from the Master Payor Ranking and associate it to the selected episode.

Note: If no Payor Information exists on the Master Payor Ranking in the Client Record screen, a selection of payors will not be available to associate to the episode.

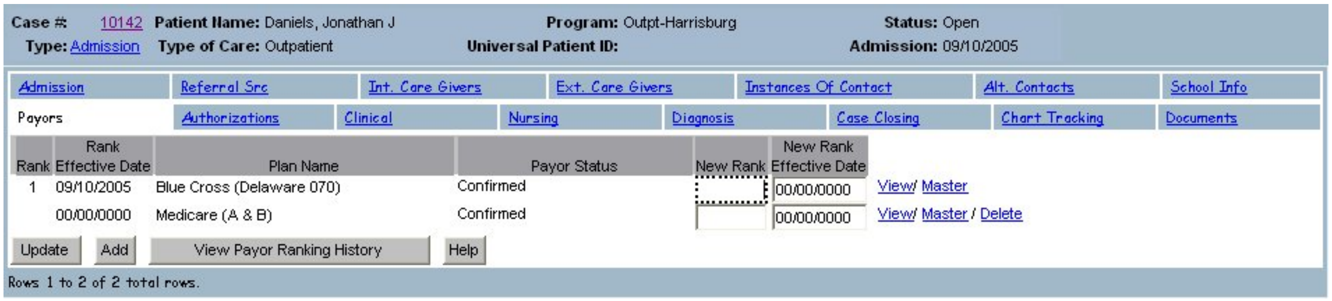
1. **Click** Add



A list of confirmed payors with rank not equal to 99 will be displayed.

Only payors on the Master Payor Ranking with a status of Confirmed can be added to the Episode Payor Ranking. If you aren't seeing any payors to add to the episode, go to the Client Record and add a confirmed payor to the Master Payor Ranking.

2. **Select** the **Add** link next to the payor to be added to the episode.
3. The system adds the selected payor to the Episode Payor Ranking



The Rank, Rank Effective Date, New Rank and New Rank Effective Date fields contain null values.

The New Rank and New Rank Effective Date are the only editable fields. The Payor Status can only be changed from the Master Payor Ranking

The Delete link will remain functional until values are entered in the New Rank and the New Rank Effective Date fields. After selecting Update, the New Rank and New Rank Effective Date values will be copied to the Rank and Rank Effective Date fields.

The View link allows the user to view the selected payor subscriber information. No modifications can be made through this feature.

To edit Payor Information associated with an Episode

The Edit Payor Information function allows the user to modify the New Rank and New Rank Effective Date fields only. All other fields are view only. If other information needs to be entered or modified, such as subscriber information, that must be done from the master payor ranking (accessed from the Payor Information tab on the Client Record).

1. Modify the existing values or add new values in the New Rank and the New Rank Effective Date for the payors listed in the episode ranking

   If the New Rank is entered for an episode payor, the New Rank Effective Date must also be entered. The same applies to entering the New Rank Effective Date.

   The New Rank entered must be a numerical value between 1 and 99

   If a Benefit Effective Date is indicated on the Master Payor Ranking then the New Rank Effective Date must be greater than or equal to the Benefit Effective Date.

   If a Benefit Expiration Date exists on the Master Payor Ranking, the New Rank Effective Date must be less than or equal to the Benefit Expiration Date.

   If the New Rank for an episode payor is less than 99 and the Master Payor Ranking is 99, the system will prevent the New Rank from being saved.

   If a New Rank Effective Date is less than or equal to the current system date, then any charge with it's date of service less than or equal to the current system date has its charge payor ranking modified to reflect the new rank changes for this episode.

If changes are made to the New Rank and New Rank Effective Date on a payor in the episode ranking, modifications must be made to the other payors in the episode ranking so the following conditions are met;

- The system will not allow 2 payors in the ranking with the same Rank on the same date. One of these payors may have a New Rank equal to that of the other payor but the New Rank Effective Date must be set for a date in the future.
- If a New Rank Effective Date is entered that is less than the current system date then all other payor rankings in the episode with a Rank Effective Date must have the same New Rank Effective Date.

To delete Payors associated with an Episode

Payors can only be deleted from an Episode after the payor is added to the Episode Payor Ranking and before the New Rank and New Rank Effective Date fields are entered. After the New Rank and New Rank Effective Date fields have been saved to the database, the Delete link will no longer be available. However, changing the payor rank to 99 will tell the system to ignore that payor.

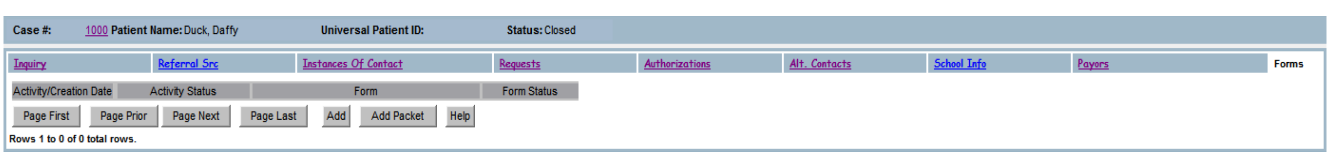
If Payor is not valid at all, make sure the New Rank Effective Date is the same as the Admission Date.

Deleting a Payor from the Episode will only remove it from the Payor list of the patient Episode not from the Master Payor List of the Client Record.

If the Payor has associated Authorizations and you enter a New Rank of 99, the system will display a warning indicating Authorizations exist.

Forms

The Forms tab can be used to add forms to the Inquiry Episode. This differs from the Documents tab discussed earlier in that the Documents tab is useful for scanning in external documents into Epitomax, where they are view only. The Forms tab is useful for documents the facility may want to fill-out prior to admitting a client. For example, agreements regarding dates/times of therapy sessions or evaluations to determine level of care can be added or edited from the Forms tab.



To Add a Form to the Inquiry Episode

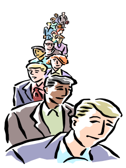
1. Click on the Add button.
2. A second window will pop up with a drop-down box. The user can use the drop-down box to find and select the correct form.

   The user may use the Preview Form button to view the first page of the document in order to ensure the correct form is being chosen prior to adding it to the Inquiry.
3. Once the correct form has been added, staff can use the **Edit** link to complete the form.

To Add a Form Packet to the Inquiry Episode

1. In order to Add a Form Packet, a packet must be created in the Form Packet Maintenance link under the Administration tab (see your System Administrator).
2. Click on the Add Packet button.
3. A second window will pop up with a drop-down box. The user can choose the appropriate Form Packet to add several forms at once.

   Since there are several forms attached, the preview option is not available.
4. Once the correct form packet has been added, staff can use the **Edit** link to complete each form.



Access Center Request Waiting List

The Access Center Request Waiting List function provides a means for the Access Center and other staff to view a list of patients with Requests, edit an existing request or admit a patient.

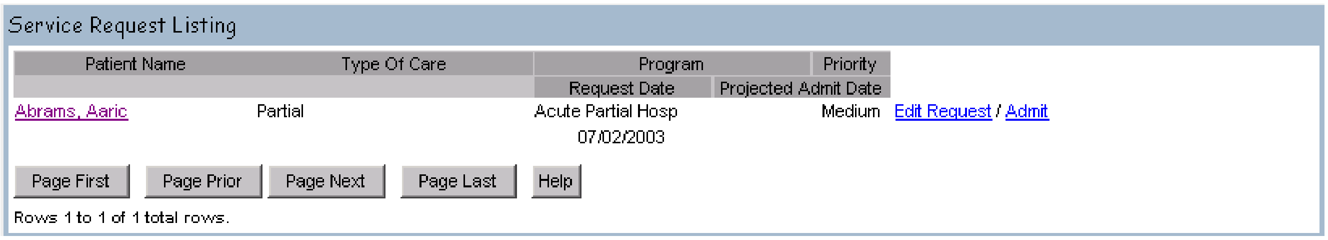
To submit an Access Center request

The Submit Access Center Request function allows users to submit an Access Center request.

1. **Click** the **Access Center Request Mgmt** link from the **Patient Tracking** main menu
2. **Enter** the **Following:**

Type Of Care	Partial
Program	Acute Partial Hosp

3. **Click** Submit



Lesson 5
Admissions

Objectives

- Admissions
- Referral Source
- Internal Care Givers
- External Care Givers
- Instances Of Contact
- Presenting Problems
- Requests
- Alternate Contacts
- School Info
- Payors
- Authorizations
- Nursing
- Diagnosis
- Case Closing
- Chart Tracking

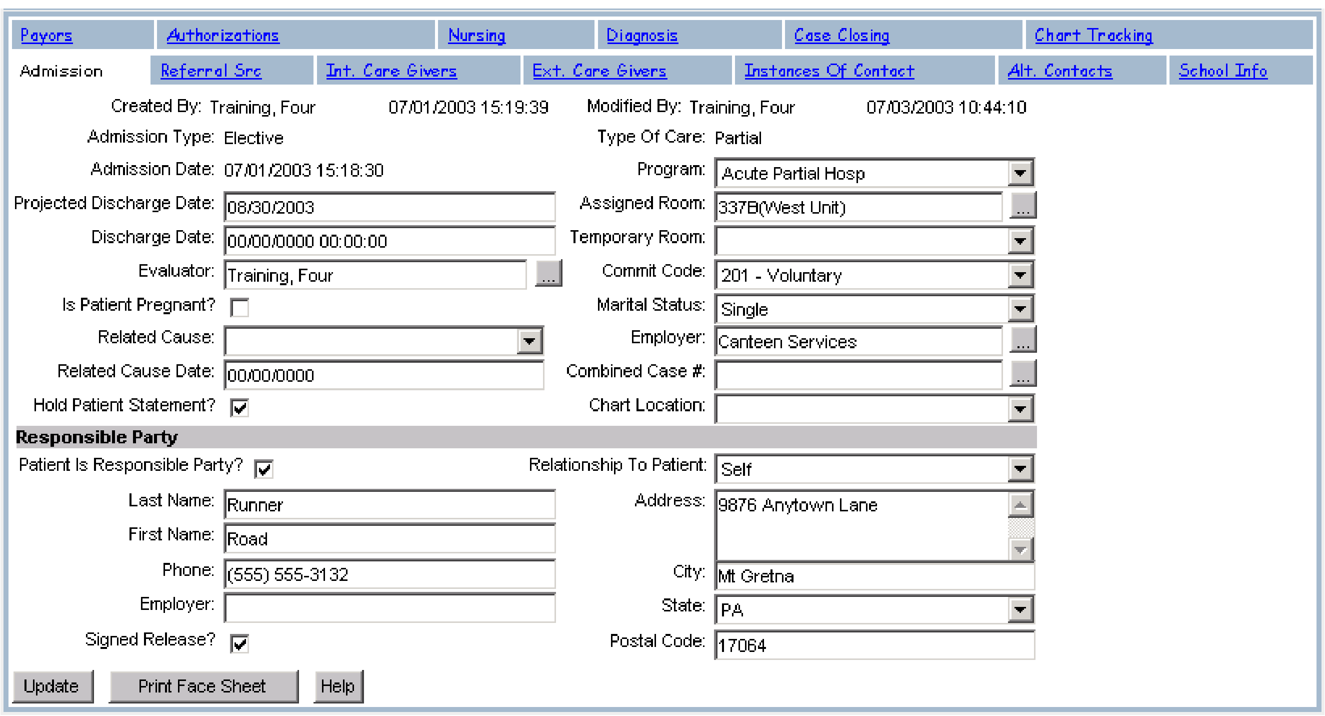
Admissions

An Admission (Inpatient, Outpatient, Partial Hospitalization, etc…) Program displays the Admission Type, Date, Projected Discharge Date, Commit Code and other related information. From here, staff can access the patient's referral information, internal and external caregivers, Instances Of Contact, Alternate Contacts, School Information, Payor Information, Authorizations, Nursing information, Diagnosis data, Case Closing information, and Chart Tracking.

To view an Admission

The View Admission function allows users to view an Admission.

1. **Click** on **Client Search**
2. **Type Runner** in the **Last Name** field
3. **Click** OK on the **Alert** message box
4. **Click Case # 147899** for **Runner, Road**
5. **Click Episode History**
6. **Click Admission… Acute Partial Hosp**



7. **Click** the **Referral Src** through the **Chart Tracking** tab to view associated information
8. **Click** the **Patient Case #** to return to the main Client Record screen
9. **Click** OK on the **Alert** message box

To create an Admission

The Create Admission function allows users to create an Admission.

1. **Perform** a **Client Search** for **Your Patient**
2. **Access** the **Client Record**
3. **Click Episode History**
4. **Click** Admit Patient
5. **Select Outpatient** for the **Type Of Care**
6. **Enter** the **Following:**

Admission Type	Elective
Admission Date	Today's Date
Program	Outpt-Mt. Gretna
Evaluator	Default
Commit Code	Voluntary
Marital Status	Single
Employer	Canteen Services
Patient Is Responsible Party	☑ (Checked)

7. **Click** Update

*** Pretend It is Next Month….And Your Patient Needs To Be Admitted To The Inpt-Behavioral Evaluation Program**

1. **Click Client Record** on the **Patient Tracking** menu
2. **Click** OK on **Alert** message box
3. **Click Episode History**
4. **Click** Admit Patient
5. **Select Inpatient** for the **Type Of Care**
6. **Enter** the **Following**:

Admission Type	Elective
Admission Date	1 Month From Today's Date
Projected Discharge Date	2 Months From Today's Date
Evaluator	Your Staff Member (Default)
Program	Inpt-Behavioral Evaluation
Commit Code	Voluntary
Marital Status	Single
Employer	Canteen Services
Patient Is Responsible Party	☑ (Checked)

7. **Click** Update

*** Pretend It is Next Month….And Your Patient Needs To Be Admitted To The Acute Partial Hospital Program**

8. **Click Client Record** on **Patient Tracking** menu

9. **Click** OK on **Alert** message box
10. **Click Episode History**
11. **Click** Admit Patient
12. **Select Partial** for the **Type Of Care**
13. **Enter** the **Following:**

Admission Type	Elective
Admission Date	2 Months From Today's Date
Projected Discharge Date	3 Months From Today's Date
Evaluator	Your Staff Member (Default)
Program	Acute Partial Hosp
Commit Code	Voluntary
Marital Status	Single
Employer	Canteen Services
Patient Is Responsible Party	☑ (Checked)

14. **Click** Update

When an Admission is created from the Open Inquiry, the Inquiry will be closed.

If an Open Inquiry is used, then the Payor Ranking, Referral Source and School Information is linked to the new Admission.

Alert: Verify that the Acute Partial Hospital Program Admission is being used

To edit an Admission

The Edit Admission function allows users to edit an Admission.

1. **Perform** a **Client Search** for **Your Patient**
2. **Access** the **Client Record**
3. **Click Episode History**
4. **Click** on the **Inpatient Admission**
5. **Change** the **Following:**

Projected Discharge Date	1 Month Later

6. **Click** Update

Case Number, Universal Patient ID, Last Name, First Name, Creation Date, Created By, Modified Date, Modified By, Type Of Care, Admission Type, and Admission Date & Time are view only fields. The Program field is a required field.

If the Discharge Date and Time is set, then the Status of the Admission becomes "Discharged" instead of "Open".

If the Program is changed, then the Internal Care Giver list must be updated to change the Attending Physician.

To print Admission details

The Print Admission function allows users to print an Admission.

1. **Click** [Print Face Sheet] (Prints to new Internet explorer browser window)

07/03/2003

Philhaven

Admission Face Sheet

Case No: **147899**

Runner. Road

Admission Information

Admit Date Time:	7/1/2003 15:18:30		
Readmit:			
Program:	Acute Partial Hosp	Evaluator:	Training, Four
Admission Type:	Elective	Commit Code:	Voluntary

Patient Demographics

Former Last Name:		Alias:	
Social Security No:	555-55-5555		
Street Address:	9876 Anytown Lane		
City:	Mt Gretna	State:	PA
Postal Code:	17064	County:	
Country:	United States		
Home Phone:	(555) 555-3132	Mobile Phone:	

2. **Select File** in **Internet Explorer**
3. **Select Print**
4. **Close Print Face Sheet** browser window

Referral Source

The Referral Source tab allows users to view, create or update a Referral Source for an Admission.

To view a Referral Source

The View Referral Source function allows users to view a Referral Source.

1. **Click** the **Referral Source** tab

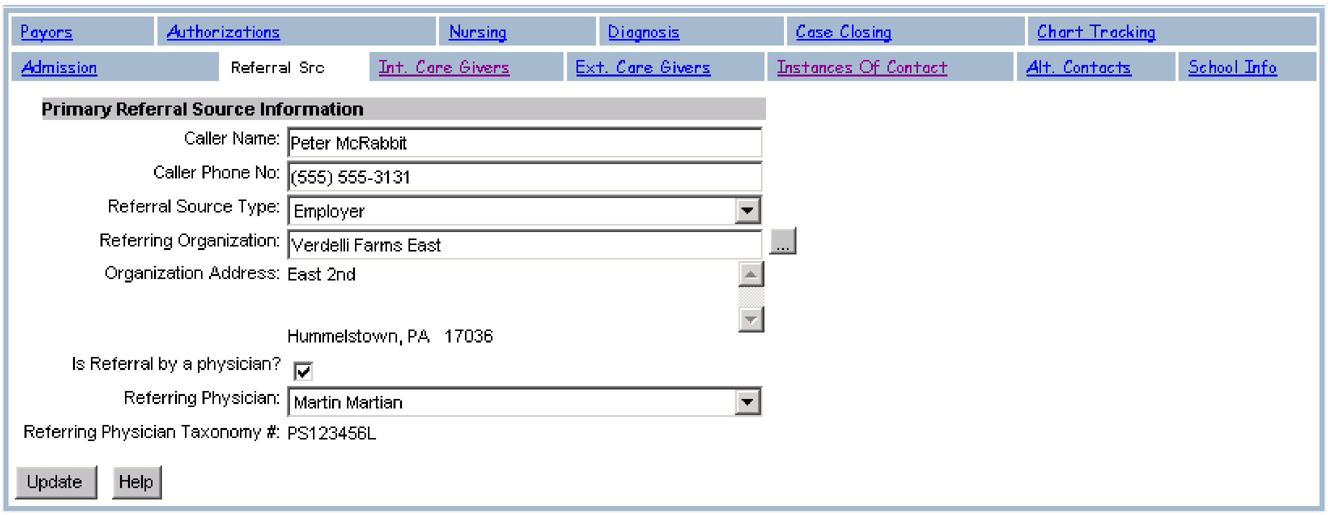
To add/update a Referral Source

The Add/Update Referral Source function allows users to add/update a Referral Source.

1. **Click** the **Referral Source** tab
2. **Enter** the **Following:**

Caller Name	Peter McRabbit
Caller Phone No	555-555-3131 (no dashes)
Is Referred By A Physician	☑ (Checked)
Referring Physician	Martin Martian

3. **Click** Update


Payors | Authorizations | Nursing | Diagnosis | Case Closing | Chart Tracking
Admission | Referral Src | Int. Care Givers | Ext. Care Givers | Instances Of Contact | Alt. Contacts | School Info

Primary Referral Source Information

Caller Name: Peter McRabbit
Caller Phone No: (555) 555-3131
Referral Source Type: Employer
Referring Organization: Verdelli Farms East
Organization Address: East 2nd
Hummelstown, PA 17036
Is Referral by a physician? ☑
Referring Physician: Martin Martian
Referring Physician Taxonomy #: PS123456L

Update | Help

4. **Change** the **Following:**

Caller Phone No	610-555-3137 (no dashes)

5. **Click** Update

The Organization Address and Referring Physician Taxonomy # fields are view only and cannot be changed.

You may enter a value for Referring Organization only if a value has been entered for Referral Source Type.

If a new Referring Physician needs to be added, contact your supervisor.

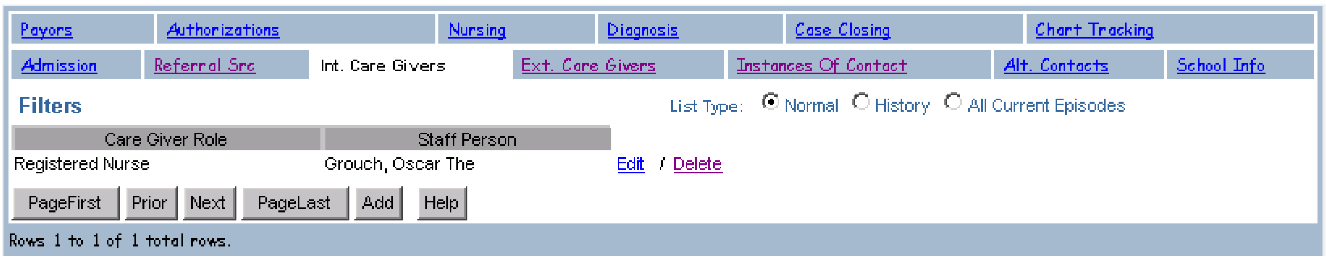
Internal Care Givers

The Int. Care Givers tab allows users to view a summary of the Internal Care Givers associated with an Admission. An Internal Care Giver can be any of your staff with a role of attending physician, care manager or psychologist. From this summary view, a user may select a different Internal Care Giver and view or update existing Internal Care Givers for the selected Admission.

To view Internal Care Givers

The View Internal Care Giver function allows users to view an Internal Care Giver associated with an Admission in the system.

1. **Click** the **Internal Care Givers** tab



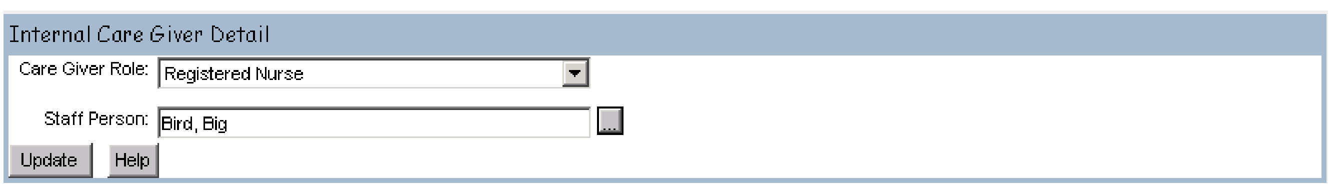
The list of existing Internal Care Givers can be **filtered** by Normal, History or All Current Episodes.

To add an Internal Care Giver

The Add Internal Care Giver function allows users to associate an Internal Care Giver with an Admission.

1. **Click** Add
2. **Enter** the **Following:**

Care Giver Role	Registered Nurse
Staff Person	Big Bird



3. **Click** Update

Care Giver Role and Staff have to be valid combinations. If not, your supervisor may need to be contacted.

If the user chooses to cancel prior to saving changes, then the Internal Care Giver record will not be inserted.

To edit an Internal Care Giver

The Edit Internal Care Giver function allows users to edit an Internal Care Giver associated with an Admission in the system.

1. **Click** the **Edit** link next to the **Newly Created** care giver
2. **Change** the **Following:**

Care Giver Role	Oscar Grouch

3. **Click** Update

To delete an Internal Care Giver

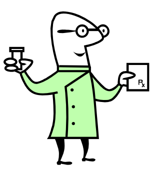
The Delete Internal Care Giver function allows users to delete an Internal Care Giver associated with an Admission.

Alert: For Training Purposes, Do Not Delete Internal Care Giver

1. **Click** the **Delete** link next to the **Newly Created** Internal Care Giver

➡ The "Confirm Delete" screen will be displayed.

2. **Click Delete**



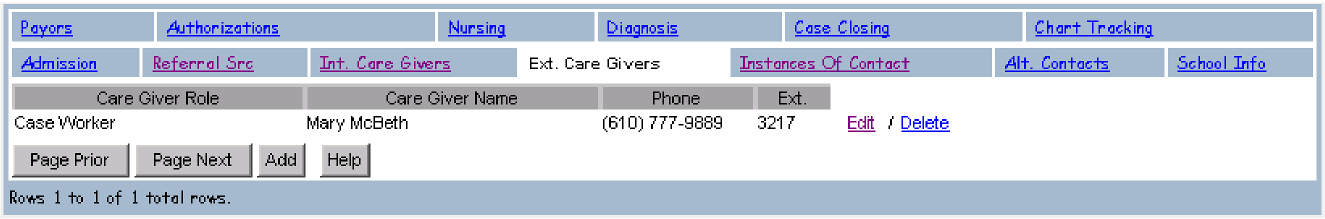
External Care Givers

The Ext. Care Givers tab allows users to view a summary of the External Care Givers associated with a patient. An example of an External Care Giver would be a caseworker or family physician. The user enters the phone #, fax # and address of the External Care Giver.

To view an External Care Giver

The View External Care Giver function allows users to view an External Care Giver associated with an Admission.

1. **Click** the **Ext. Care Givers** tab

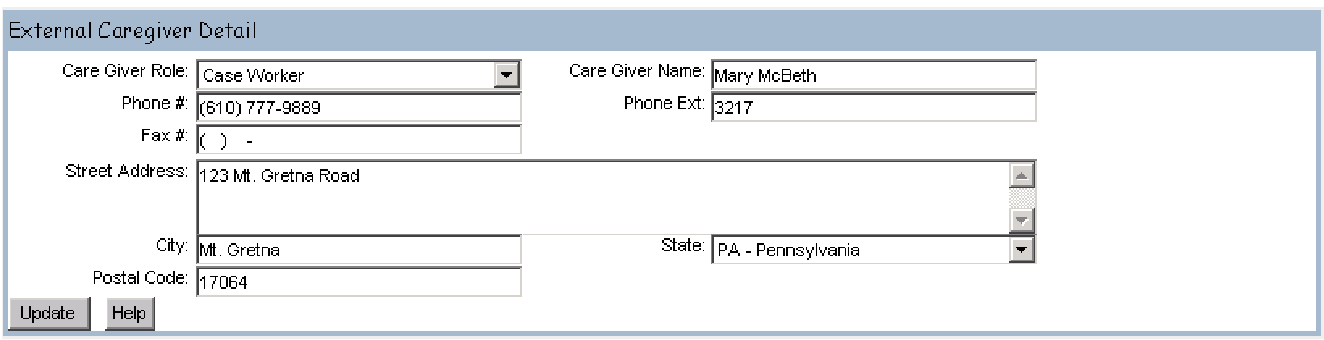


To create an External Care Giver

The Create External Care Giver function allows users to associate an External Care Giver with an Admission in the system.

1. **Click** Add
2. **Enter** the **Following:**

Care Giver Role	Case Worker
Care Giver Name	Mary McBeth
Phone #	610-777-9889 (no dashes)
Phone ext	3212
Street Address	123 Mt. Gretna Rd.
City	Mt. Gretna
State	PA
Postal Code	13216



3. **Click** Update

Care Giver Name, Phone and Role are <u>required</u> fields.

To edit an External Care Giver

The Edit External Care Giver function allows users to edit an External Care Giver associated with an Admission.

1. **Click** the **Edit** link next to the **Newly Created** External Care Giver
2. **Change** the **Following:**

Phone Ext.	3217

3. **Click** Update

The Care Giver Name, Phone # and Role fields are required. If the user chooses to cancel prior to saving changes, then the External Care Giver record will not be updated.

To delete an External Care Giver

The Delete External Care Giver function allows users to delete an External Care Giver associated with an Admission.

Alert: For Training Purposes, Do Not Delete External Care Giver

1. **Click** the **Delete** link next to the **Newly Created** care giver

   The "Confirm Delete" screen will be displayed. The user can select another menu item or tab to cancel the Delete function.

Confirm Delete

Care Giver Role: Case Worker
Care Giver Name: Mary McBeth
Phone #: (610) 777-9889
Phone Ext: 3212
Fax #: ( ) -
Street Address: 123 Mt. Gretna Rd
City: Mt. Gretna
State: Pennsylvania
Postal Code: 17064
Delete
Help

2. **Click** Delete

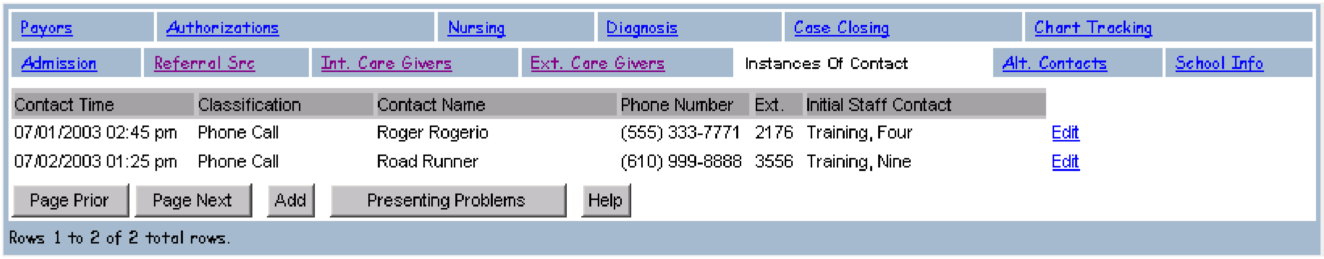
Instances Of Contact

The Instance Of Contact tab allows users to view a summary of all Instances Of Contacts associated with an Episode. An Instance Of Contact provides information about the contact person. From this summary view, a user may add new Instances Of Contacts and view or existing Instances Of Contacts.

To view an Instance Of Contact

The View Instances Of Contact function allows users to view an Instance Of Contact for an Admission.

1. **Click** on the **Instances Of Contact** tab



If the Instances Of Contact tab is accessed from an Admission record, then the Instances Of Contact for the associated Inquiry (if one exists) are displayed along with the Instance Of Contacts created for the Admission.

To create an Instance Of Contact

The Create Instance Of Contact function allows users to create a new Instance Of Contact for an Admission.

1. **Click** Add
2. **Enter** the **Following:**

Contact Date	Today's Date (Default)
Initial Staff Contact	Staff Member
Classification	Phone Call
First Name	Road
Last Name	Runner
Phone	610-999-8888 (no dashes)
Phone Ext.	2345
Presenting Problem	Patient could become violent without much warning

3. **Click** Update

Contact Date and Time, Contact Last Name, First Name, Phone, Classification and Presenting Problem are all <u>required</u> fields.

To edit an Instance Of Contact

The Edit Instance Of Contact function allows users to modify existing contact info for an Admission.

1. **Click** the **Edit** link next to the **Newly Created Instance Of Contact**
2. **Change** the **Following:**

Phone Extension	3556

3. **Click** Update

Contact Last Name, First Name, Phone and Classification are <u>required</u> fields. The Contact Date and Time and Presenting Problem are <u>view only</u> fields.

To view Instance Of Contact Illegal Substance summary

The View Instance Of Contact Illegal Substance Summary function allows users to view a summary of the Illegal Substances associated with an existing Instance Of Contact for an Inquiry or Admission.

1. **Click** the **Edit** link next to the **Newly Created Instance Of Contact**
2. **Click** the **Ellipses** next to **Illegal Substances**

A new browser window is displayed

If the Illegal Substances checkbox is checked, the system returns the Instance Of Contact Illegal Substances screen when the pick list is selected.

To create an Instance Of Contact Illegal Substance

The Create Instance Of Contact Illegal Substance function allows users to create a new Illegal Substance associated with an existing Instance Of Contact record.

The Illegal Substance information can only be added after an Instance Of Contact has been updated.

1. **Click Add** (On the Instance Of Contact Illegal Substances browser window)
2. **Enter** the **Following:**

Illegal Substance	Other Sedatives
Route Of Administration	Oral
Substance Frequency	Once Per Week

3. **Click** Update

The Illegal Substance field is a required field.

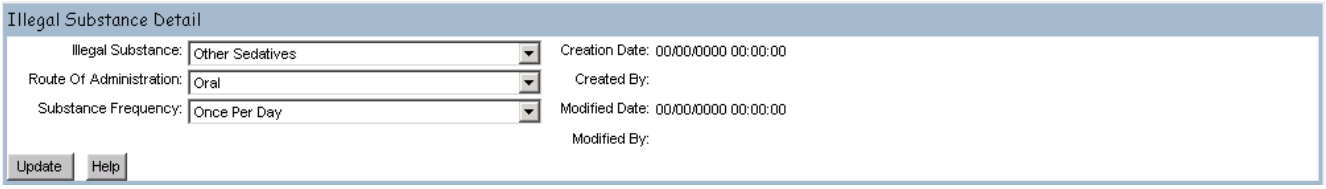
To edit an Instance Of Contact Illegal Substance

The Edit Instance Of Contact Illegal Substance function allows users to edit an existing Illegal Substance associated with the Instance Of Contact.

1. **Click** on the **Edit** link next to the **Newly Created Illegal Substance**
2. **Change** the **Following:**

Substance Frequency	Once Per Day

3. **Click** Update



4. **Click** 

to close the **Illegal Substance** browser window

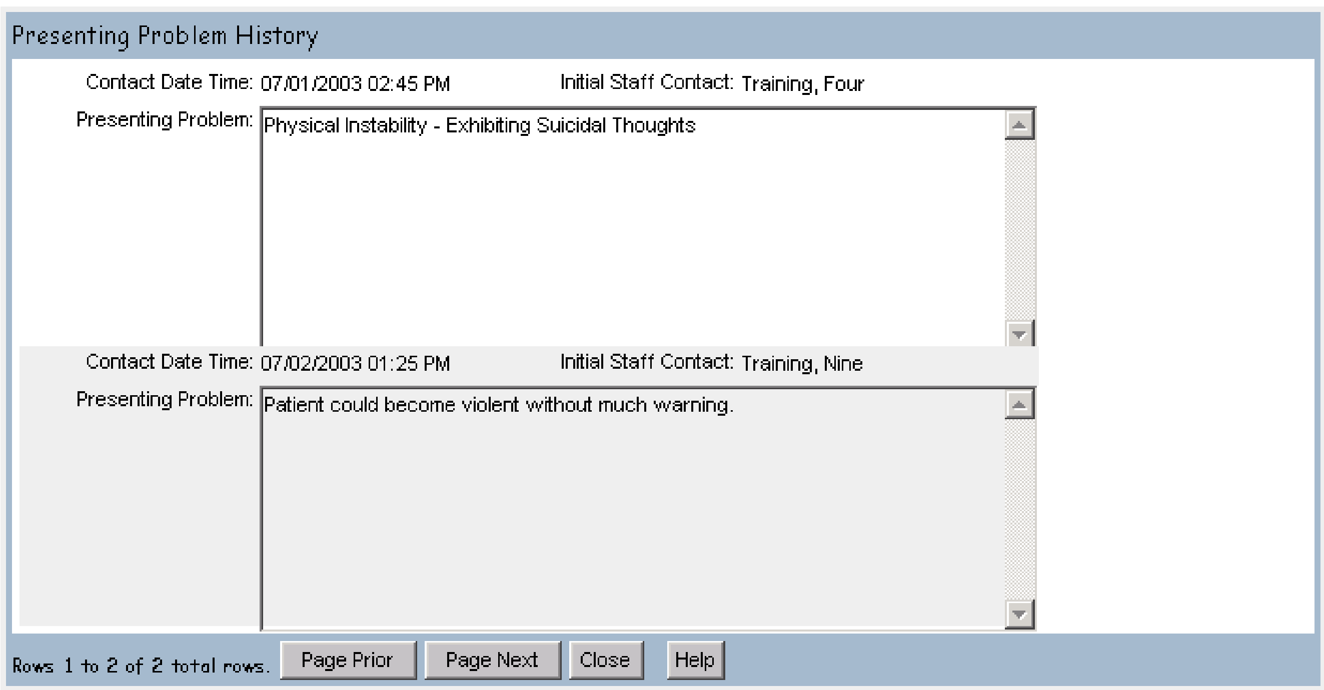
The Illegal Substance field is a <u>required</u> field.

The following fields are <u>view only</u>: Creation Date, Created By, Modified Date, and Modified By.

To view Presenting Problem history

The View Presenting Problem History function allows users to view all Instances Of Contact Presenting Problems associated with an Admission.

1. **Click** 

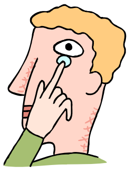


2. **Click** 

to close the **Presenting Problems** browser window

The following fields are <u>view only</u>: Contact Date, Initial Staff Contact, and Presenting Problem.

To scroll through multiple entries, use the Page Prior and Page Next buttons.



Alternate Contacts

The Alternate Contacts tab allows users to view a summary of the Alternate Contacts for a selected patient and associate them to an Admission. From this summary view, a user may create a new Alternate Contact or update existing Alternate Contacts.

To view Alternate Contacts

The View Alternate Contacts function allows users to view an Alternate Contact for an Admission.

1. **Click** the **Alternate Contacts** tab

To create an Alternate Contacts

The Create Alternate Contact function allows users to create a new Alternate Contact for an Admission.

1. **Click** 

2. **Enter** the **Following:**

Contact Type	Power Of Attorney
Home Phone	610-333-2222 (no dashes)
Last Name	Attorney
First Name	Adam

3. **Click** 

The Alternate Contact screen will also list any Alternate Contacts associated with the Inquiry.

The Alternate Contact Type, Last Name, First Name and Phone Number are required fields.

To edit an Alternate Contact

The Edit Alternate Contact function allows users to edit an existing Alternate Contact for an Admission.

1. **Click** in **Newly Created Alternate Contact**
2. **Change** the **Following:**

Home Phone	610-444-9090 (no dashes)

3. **Click** Update

School Information

To view School Information

The View School Information function allows users to view and/or update School Information associated with an Admission.

1. **Click** on the **School Info** tab

   The following fields are view only: Street Address, City, State, Phone Number, and School District IU #.

To add School Information

The add School Information function allows users to add School Information associated with an Admission.

1. **Enter** the **Following:**

School Grade Level	12
School Name – District	Unionville High School
School Contact Name	Barbara Moore

2. **Click** Update

   The School Info tab will list any School Information for the patient associated with the Inquiry.

   If the desired school is not available, contact your supervisor.

To edit School Information

The Edit School Information function allows users to edit School Information associated with an Admission.

1. **Click** in the **School Contact Name** field
2. **Change** the **Following:**

School Contact Name	Barbara Mauer

3. **Click** Update

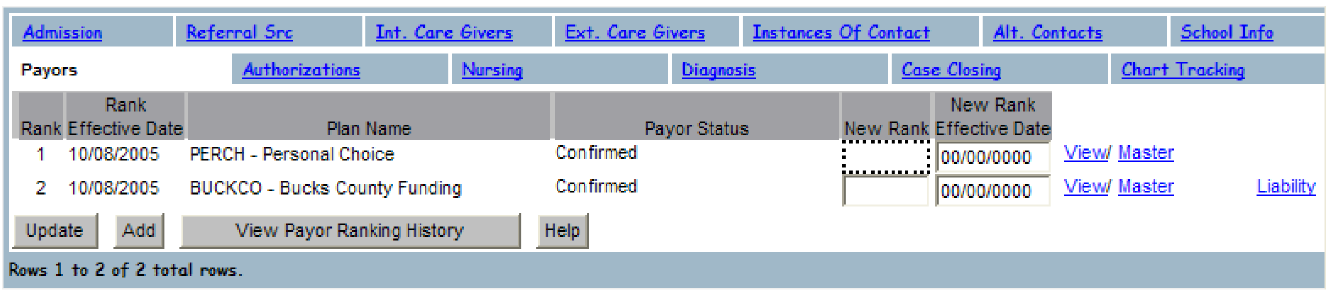
Episode Payor Ranking

The Payors tab allows users to view a summary of the Payor Ranking associated with an Admission. From this summary view, a user can view, edit or create Payor Rankings.

To view and edit Episode Payor Information

The View Payor Information function allows users to view and edit Payor Rankings associated with an Admission.

1. **Click** on the **Payors** tab



Rank	Rank Effective Date	Plan Name	Payor Status	New Rank	New Rank Effective Date		
1	10/08/2005	PERCH - Personal Choice	Confirmed		00/00/0000	View/ Master	
2	10/08/2005	BUCKCO - Bucks County Funding	Confirmed		00/00/0000	View/ Master	Liability

2. **Change** the **Following:**

New Rank	2
New Rank Effective Date	10/01/2005

3. **Click** Update

The New Rank and New Rank Effective Date fields are <u>required.</u> All other fields are read only.

When re-ranking episode payors with a New Rank Effective date that is on or before the current date, all payors must be re-ranked with the same New Rank Effective Date (no exceptions).

No rank, except for 99, can be duplicated.

There must always be a rank 1 payor.

A New Rank Effective Date that is the current date or earlier applies the change immediately. These rank changes are applied to charges associated with the episode.

A New Rank Effective Date in the future will update the payor ranking automatically the night before that date.

A New Rank can not be set to anything other than 99 when the master payor has a rank of 99.

To create Payor Information

The Create Payor Information function allows users to view and/or update Episode Payor Information associated with an Admission.

1. **Select** [Add]
2. **Click** the **Add** link next to the desired Payor
3. **Click** [Update]

The Payor and Rank fields are required and the Payor Status field is view only and will default to 'Pending'.

Only Payors listed on the Master Payor List (Client Record) with a status of 'Confirmed' and Benefit Effective and Expiration Dates valid for the admission will be able to be selected from the drop down menu in the Payor Plan field.

Rank, Current Rank Effective Date, New Rank, and New Rank Effective Date are set to NULL. All other fields from master payor are copied to the episode payor.

To delete Payor Information

Only payors with no values set for the Rank, Rank Effective Date, New Rank, and New Rank Effective Date fields can be deleted.

1. **Click** the **Delete** link next to the desired Payor
2. **Click** [Update]

If a payor is no longer valid, the rank should be changed to '99'.

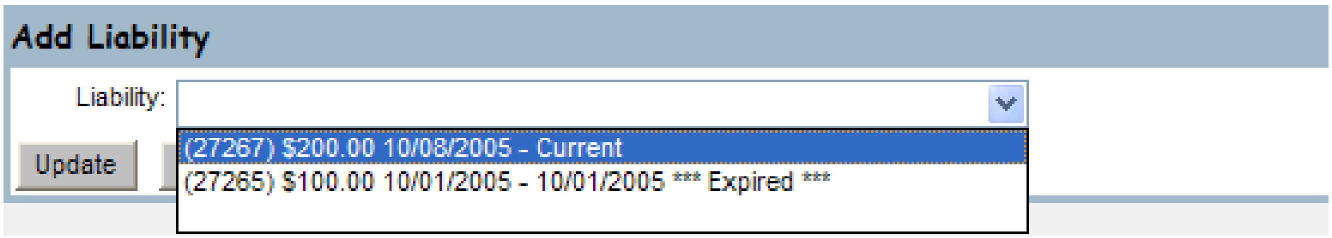
If this Payor has Authorizations associated with it, then the user is prompted to choose another Payor to which the Authorizations will be linked. Any Authorizations, Review Instances, Utilization Review information, and Appeals become linked to the newly selected Payor. If the user does not select another Payor to replace the 99 ranked Payor, **then all Authorizations, Review Instances, Utilization Review information, and Appeals are no longer available**.

To Add a liability to an Episode Payor

Only payors with that are county payors can have Liabilities attached.

1. **Click** the **Liability** link next to the desired Payor

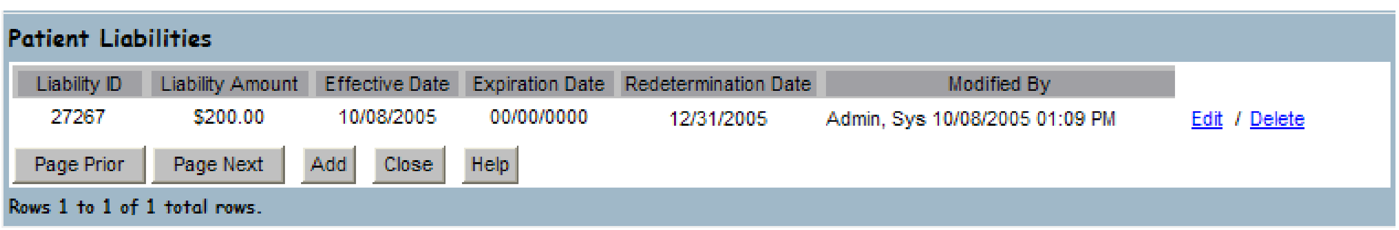
2. Click Add
3. Select a Liability from the selected list. Only liabilities entered on the main liability screen will be displayed in this list.



4. **Click** Update

To Edit a liability

1. **Click** the **Liability** link next to the desired Payor



2. Click on the **Edit** Link next to the liability to edit.
3. Select a new Liability from the selected list. Only liabilities entered on the main liability screen will be displayed in this list.
4. **Click** Update

To Delete a liability

5. **Click** the **Liability** link next to the desired Payor

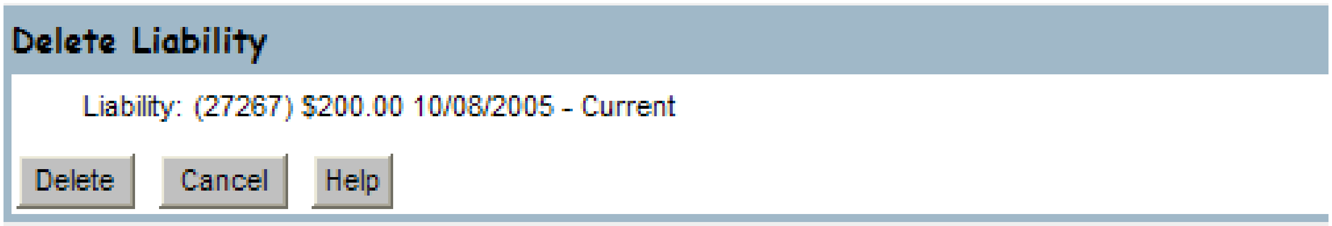
Patient Liabilities

Liability ID	Liability Amount	Effective Date	Expiration Date	Redetermination Date	Modified By	
27267	$200.00	10/08/2005	00/00/0000	12/31/2005	Admin, Sys 10/08/2005 01:09 PM	Edit / Delete

Page Prior Page Next Add Close Help

Rows 1 to 1 of 1 total rows.

6. Click on the **Delete** Link next to the liability to edit.



7. **Click** 

Authorizations

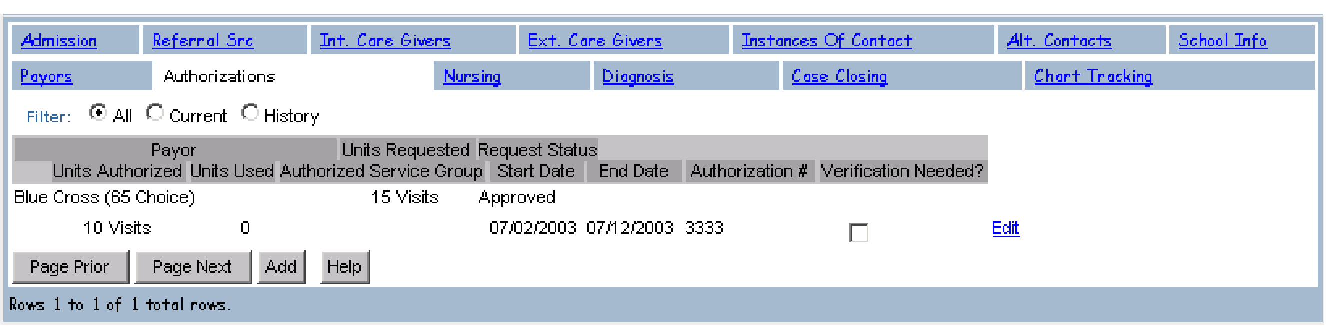
The Authorizations tab allows users to view a summary of all Authorizations associated with an Admission. From this summary view, a user can create, view, and edit Authorizations for an Admission.

To view Authorizations

The View Authorizations function allows users to view Authorizations associated with an Admission.

1. **Click** on the **Authorizations** tab

   The list can be sorted by All, Current or History



Admission | Referral Src | Int. Care Givers | Ext. Care Givers | Instances Of Contact | Alt. Contacts | School Info
Payors | Authorizations | Nursing | Diagnosis | Case Closing | Chart Tracking

Filter: All Current History

Payor			Units Requested	Request Status				
Units Authorized	Units Used	Authorized Service Group	Start Date	End Date	Authorization #	Verification Needed?		
Blue Cross (65 Choice)			15 Visits	Approved				
10 Visits	0		07/02/2003	07/12/2003	3333	☐	Edit	

Page Prior Page Next Add Help

Rows 1 to 1 of 1 total rows.

To create an Episode Authorization

The Create Episode Authorization function allows users to create a new Authorization associated with an Admission record.

If an Authorization was received prior to the patient's Admission, the Authorization can be documented using the Authorization tab on the Inquiry screen.

1. **Click** Add
2. **Select Blue Cross (65 Choice)**
3. **Enter** the **Following:**

Reviewer Name	Bob Psychologist
Reviewer Organization	Value Behavioral Health

4. **Click** Update

The Payor field is a required field. If the Payor exists in the Utilization Review Info table then the system will default to the Reviewer Name, Review Organization, Reviewer Phone No. and Phone Extension.

The system will default to the unchecked Status of "No" for the Verification Needed checkbox.

To edit an Episode Authorization

The Edit Episode Authorization function allows users to edit an existing Authorization for an Admission in the system.

1. **Click** on the **Edit** link next to the **Newly Created Authorization**
2. **Select Blue Cross (65 Choice)**
3. **Enter** the **Following:**

Next Review Date	1 Week From Today's Date
Phone Number	610-555-9999 (no dashes)
Quantity	10
Units	Days
Status	Pending
Status Date	Today's Date

4. **Click Update**

To view Authorization activity

The View Authorization activity function allows users to view Authorization activity associated with an Admission.

1. **Click** on the **Edit** link next to the **Newly Created Authorization**
2. **Click View Activity**
3. **Click** Close to **Close** the **Authorization Activity** browser window
4. **Click** Cancel

Nursing

The Nursing tab allows users to view and/or update Nursing information associated with an Admission record.

To view Nursing activity

The View Nursing Activity function allows users to view Nursing activity associated with an Admission.

1. **Click** on the **Nursing** tab

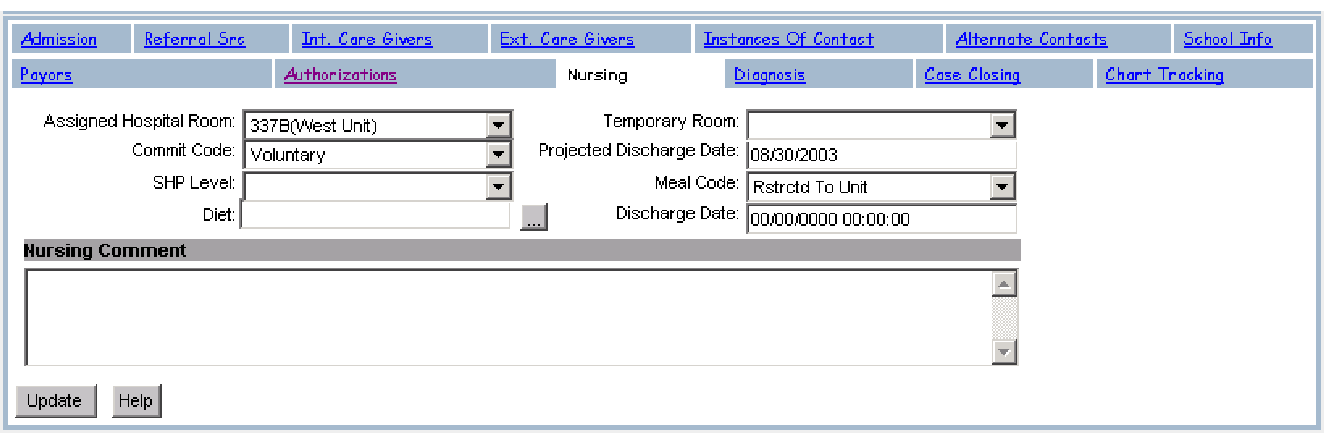
Selecting the Nursing tab from the Patient Tracking menu will also access Nursing Activity.

To add Nursing activity

The Add Nursing Activity function allows users to add Nursing activity associated with an Admission.

1. **Click** on the **Nursing** tab
2. **Enter** the **Following:**

Assigned Hospital Room	337B(West Unit)
Commit Code	Voluntary
Projected Discharge Date	8/30/2003
Meal Code	Rstrctd To Unit



3. **Click** Update

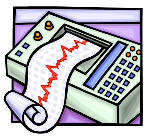
To update Nursing activity

The Update Nursing Activity function allows users to update Nursing activity associated with an Admission.

1. **Click** on the **Nursing** tab
2. **Change** the **Following:**

Nursing Comment	Gave Patient Their Medication

3. **Click Update**



Diagnosis

The Diagnosis tab allows users to view and/or update a Diagnosis associated with an Admission record.

To view a Diagnosis

The View Diagnosis function allows users to view a Diagnosis associated with an Admission.

1. **Click** on the **Diagnosis** tab

To add a Diagnosis

The Add Diagnosis function allows users to add a Diagnosis associated with an Admission.

1. **Click** on the **Diagnosis** tab
2. **Enter** the **Following:**

Diagnosis Status	Admission
IA	290.0 – Senile Dementia
IIA	301.20 – Schizoid Personality Disorder
IIIA	401.9 – Hypertension
Admission	18 - Some Danger Of Hurting Self Or Others

3. **Click** 

The Diagnosis Status identifies the type as the Admission, Preliminary or Discharge Diagnosis.

The staff evaluator establishes the "Admission" Status. The "Preliminary" Status is determined by the attending psychologist and once a Discharge Diagnosis is entered in Axis V, Medical Records assigns a Diagnosis Status as "Discharge".

Axis I is the Preliminary or Drug and Alcohol/Psychiatric Diagnosis. (It is the only Diagnosis required for an Outpatient discharge).

Axis II is the Personality Diagnosis and Mental Retardation.

Axis III is the Medical Diagnosis.

Axis IV lists the Psychosocial and Environmental stressors.

Axis V identifies the GAF. (Global Assessment of Functioning scale) and also contains the Admission and Discharge Diagnosis.

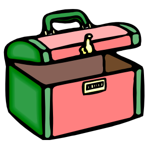
To update a Diagnosis

The Update Diagnosis function allows users to update an existing Diagnosis associated with an Admission.

1. **Click** on the **Diagnosis** tab
2. **Under Axis V, Select** the **Following:**

Admission	82 – Absent or Minimal Symptoms

3. **Click Update**



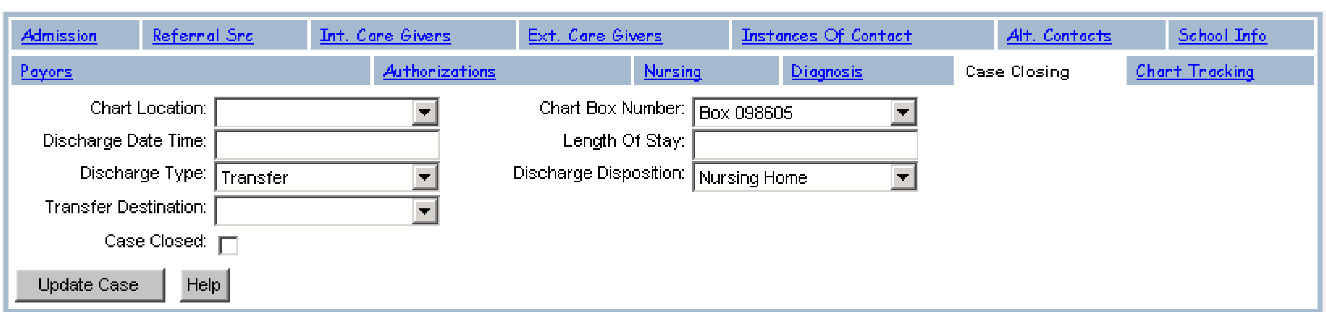
Case Closing

The Case Closing tab allows users to view and/or update Case Closing data associated with an Admission record. In addition, the Case Closing tab allows users to maintain the Discharge Medications for the Admission.

To view Case Closing data

The View Case Closing function allows users to view a Case Closing associated with an Admission.

1. **Click** on the **Case Closing** tab



To add Case Closing data

The Case Closing function allows users to add Case Closing data associated with an Admission.

1. **Click** on the **Case Closing** tab

2. **Enter** the **Following:**

Discharge Type	Transfer
Chart Box Number	Box 098605
Discharge Disposition	Nursing Home

3. **Click Update Case**

 The Case Closed checkbox will default to Unchecked which indicates that "No" the case not closed. If the user (Medical Records staff) checks the Case Closed checkbox, the record will be updated <u>ONLY</u> if the following conditions have been met: A) a Diagnosis record with a Diagnosis Status of 'Discharge' exists; and B) the Discharge Date and Chart Location fields contain information. If these conditions are satisfied, the Update Case process is allowed and the Episode Status is set to 'Closed'.

Discharge Medications

To View Discharge Medications summary

The View Discharge Medications Summary function allows users to view a list of Discharge Medications for a discharged patient.

***Discharge Medications appear below the Case Closing data*.**

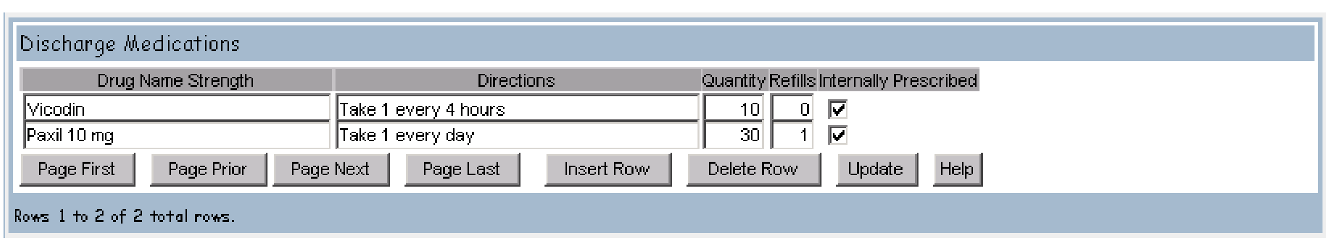
To add Discharge Medication

The Add Discharge Medication function allows users to add a new Discharge Medication to an Admission record.

1. **Click** 

2. **Enter** the **Following:**

Drug Name Strength	Paxil 10mg
Directions	Take 1 Every Day
Quantity	30
Refills	1
Internally Prescribed	☑ (checked)


Discharge Medications

Drug Name Strength	Directions	Quantity	Refills	Internally Prescribed
Vicodin	Take 1 every 4 hours	10	0	☑
Paxil 10 mg	Take 1 every day	30	1	☑

Page First | Page Prior | Page Next | Page Last | Insert Row | Delete Row | Update | Help

Rows 1 to 2 of 2 total rows.

The following fields are <u>required</u>: Drug Name Strength, Directions, Quantity and Refills.

3. **Click** Update

To update Discharge Medication

The Update Discharge Medication function allows users to update an existing Discharge Medication associated with an Admission record.

1. **Click** on the **Case Closing** tab
2. **Click** on the **Newly Created Discharge Medication**
3. **Enter** the **Following:**

Refills	1

4. **Click** Update

To delete Discharge Medication

The Delete Discharge Medication function allows users to delete an existing Discharge Medication associated with an Admission record.

1. **Click** on the **Case Closing** tab
2. **Click** on the **Newly created Discharge Medication**
3. **Click** Delete Row

Chart Tracking

The Chart Tracking tab allows Medical Records to view a list of forms comprising the contents of the chart associated with an Admission record.

To view a chart

The View Chart Tracking function allows users to view a list of forms comprising the contents of the chart associated with an Admission record.

1. **Click** on the **Chart Tracking** tab

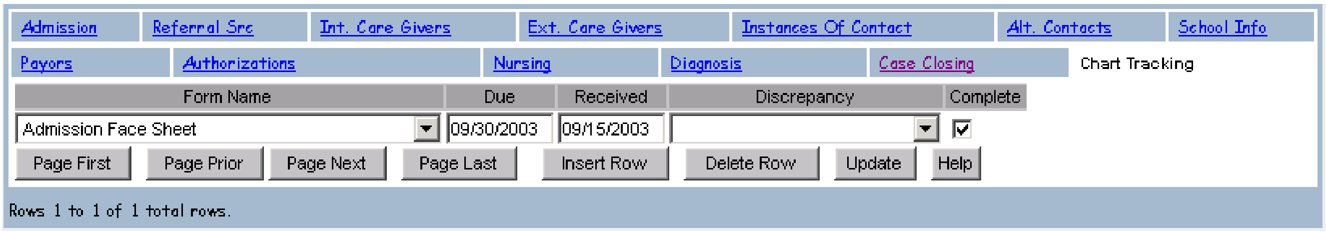
To create a chart form

The Create Chart Form function allows users to create tracking data for a form being tracked for the chart associated with an Admission record.

1. **Click** on the **Chart Tracking** tab
2. **Click** Insert Row

3. **Enter** the **Following:**

Form Name	Admission Face Sheet
Due	9/30/2003
Received	9/15/2003
Complete	☑ (Checked)



The Form Name field is a <u>required</u> field.

When the checkbox for Form Completed field is unchecked, this means that "No" the form is not Completed. The system will default to unchecked.

4. **Click** Update

To edit a chart form

The Edit Chart Form function allows users to edit tracking data for an existing form being tracked for the chart.

1. **Click** on the **Chart Tracking** tab
2. **Click** on the **Newly Created Chart Tracking** form
3. **Change** the **Following:**

Due	9/25/2003

4. **Click** Update

To delete a chart form

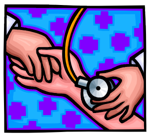
The Delete Chart Form function allows users to delete tracking data for a form being tracked for the patient chart.

1. **Click** on the **Chart Tracking** tab
2. **Click** in the **Newly Created Chart Tracking** form
3. **Click** Delete Row
4. **Click Client Record** from the **Patient Tracking** menu to return to Client Record main screen

Accessing Admission records

The Patient Tracking menu offers three ways to navigate to an Admission in Epitomax. The first method is to perform a Client Search and select an Admission from the Client Record

Episode History tab. A second method is to utilize the Medical Records Work List. The third method is to utilize the Nursing Team Work List through the Nursing menu.



Medical Records Work List

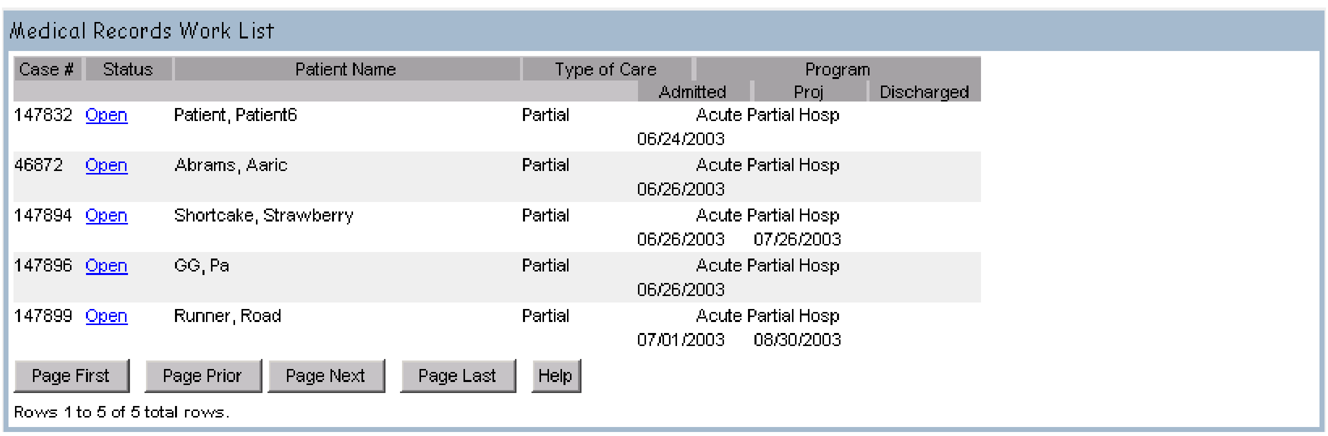
To access Admission records using the Medical Records work list

The Medical Records Work List function provides a means for Medical Records personnel to obtain a list of patient charts.

1. **Click** on the **Medical Records** menu item from the **Patient Tracking** menu
2. **Enter** the **Following:**

Admit Date Between	3 Months prior to Today And Today's Date
Type Of Care	Partial
Program	All

3. **Click** 



Medical Records Work List

Case #	Status	Patient Name	Type of Care	Program		
				Admitted	Proj	Discharged
147832	Open	Patient, Patient6	Partial	Acute Partial Hosp 06/24/2003		
46872	Open	Abrams, Aaric	Partial	Acute Partial Hosp 06/26/2003		
147894	Open	Shortcake, Strawberry	Partial	Acute Partial Hosp 06/26/2003	07/26/2003	
147896	Open	GG, Pa	Partial	Acute Partial Hosp 06/26/2003		
147899	Open	Runner, Road	Partial	Acute Partial Hosp 07/01/2003	08/30/2003	

Page First | Page Prior | Page Next | Page Last | Help

Rows 1 to 5 of 5 total rows.

Medical Records Work List results screen is displayed.

4. **Click** on the **Status Link** to **Open** the **Admission Record**

Admission record opens to the Diagnosis tab

Nursing Team Work List

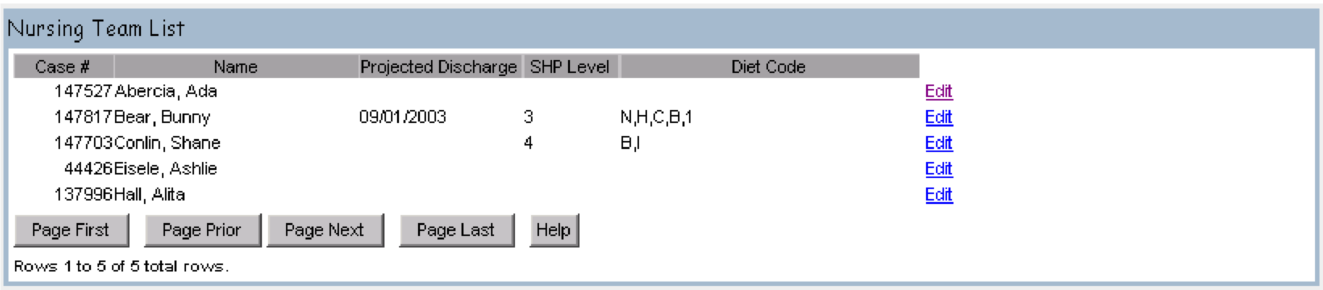
To obtain a list of patients from the Nursing team work list

The Nursing Team Work List function provides a means for Nursing staff to obtain a list of patients to view or update Admission records.

1. **Click** on the **Nursing** menu item from the **Patient Tracking** menu
2. **Enter** the **Following:**

Unit	East Unit
Program	All

3. **Click** Submit



Nursing Team List

Case #	Name	Projected Discharge	SHP Level	Diet Code	
147527	Abercia, Ada				Edit
147817	Bear, Bunny	09/01/2003	3	N,H,C,B,1	Edit
147703	Conlin, Shane		4	B,I	Edit
44426	Eisele, Ashlie				Edit
137996	Hall, Alita				Edit

Page First | Page Prior | Page Next | Page Last | Help

Rows 1 to 5 of 5 total rows.

The system displays the Nursing information for the associated Admission when the Edit link is selected.

Lesson 6
Utilization Management

Objectives

- Utilization Management Records
- Utilization Review
- Review Instances
- Authorizations
- Appeals

Utilization Management

This section describes how to access and maintain Utilization Management records. Utilization Management in Epitomax contains all information regarding Authorizations, Case Reviews with insurance companies, and Appeals for payments denied. This information is maintained on an Admission-Payor basis. For each Payor defined in an Admission's Payor Ranking, Utilization Management data may be maintained.

Accessing Utilization Management Records

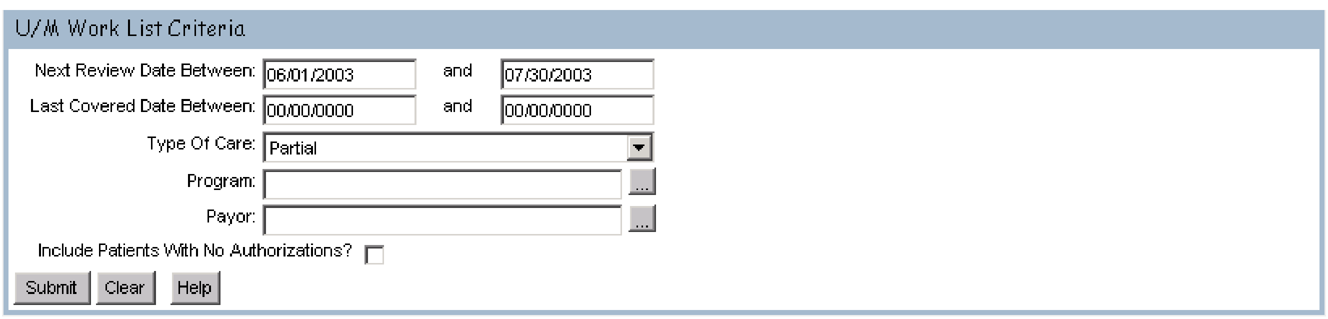
The Patient Tracking menu offers two ways to navigate to Utilization Management in Epitomax. The first method is to open an Admission record for a patient and click on the Utilization Management menu item from the Patient Tracking menu. The second method is to utilize the Utilization Management Worklist.

To create a list of Utilization Management cases

The Utilization Management Work List function allows users to create a list of Utilization Management cases that require attention.

1. **Click** on the **U/M Work List** menu item found in the **Patient Tracking** menu
2. **Enter** the **Following:**

Next Review Date Between	Leave Blank
Type Of Care	Partial
Payor	All



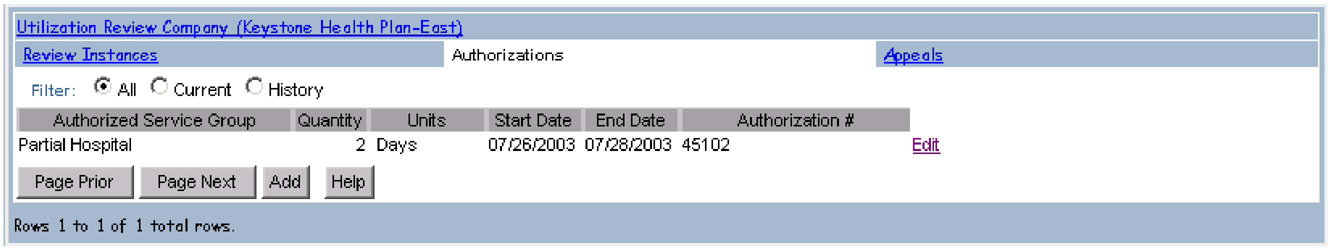
3. **Click** 

To view a Utilization Management record

The View Utilization Management Work List function allows users to view Utilization Management records.

1. **Click** the **Case #** of **Your Patient** to view the Utilization Management record

The list can be filtered by All, Current and History

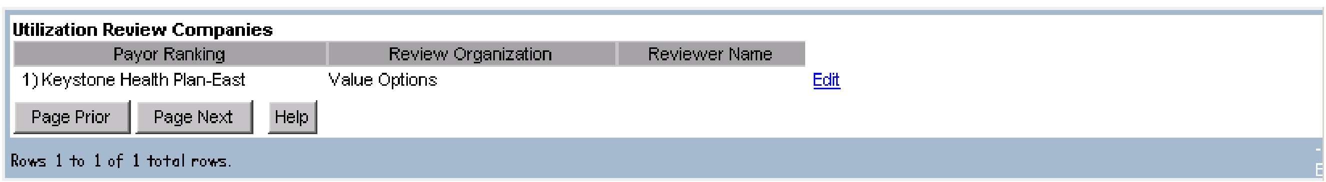


Information on Review Instances, Authorizations and Appeals can be accessed here.

To view a list of Utilization Review companies

The View Utilization Review Company function allows users to view a list of Utilization Review companies or organizations.

1. **Click** on the **Utilization Review Company** link



Only one Utilization Review Company can be associated with a Payor record.

From this screen shown above, the user is able to add or edit an existing Utilization Review Company or Organization.

To create a Utilization Review

The Create Utilization Review Company function allows users to create a new Utilization Review Company associated with a Payor record.

1. **Click Add**
2. **Enter** the **Following:**

Review Organization	Valutrac
Effective Date of Sub Acute Rate	11/15/2003
Reviewer Name	Bert Psychologist
Reviewer Phone No	610-999-9993 (no dashes)
Reviewer Phone Extension	2153

The Review Organization field is a required field.

3. **Click** Update

To edit a Utilization Review

The Edit Utilization Review Company function allows users to edit an existing Utilization Review Company for a Payor associated with the Admission.

1. **Click** the **Edit** link next to the **Newly Created Utilization Review Company (Organization)**
2. **Change** the **Following:**

Reviewer Phone Extension	2176

3. **Click** 

Review Instances, Authorizations and Appeals can be accessed here.

Review Instances

The Review Instances tab allows users to view a summary of all Review Instances associated with a Payor. From this summary view, a user may add new Review Instances or edit existing Review Instances.

To view Review Instances

1. **Click** on the **U/M Work List** menu item found from the **Patient Tracking** menu
2. **Enter** the **Following:**

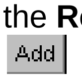
Next Review Date Between	8/1/2003 And 8/1/2003
Type Of Care	Inpatient
Program	Inpt-Behavioral Evaluation
Include Patients With No Authorizations	☑ (Checked)

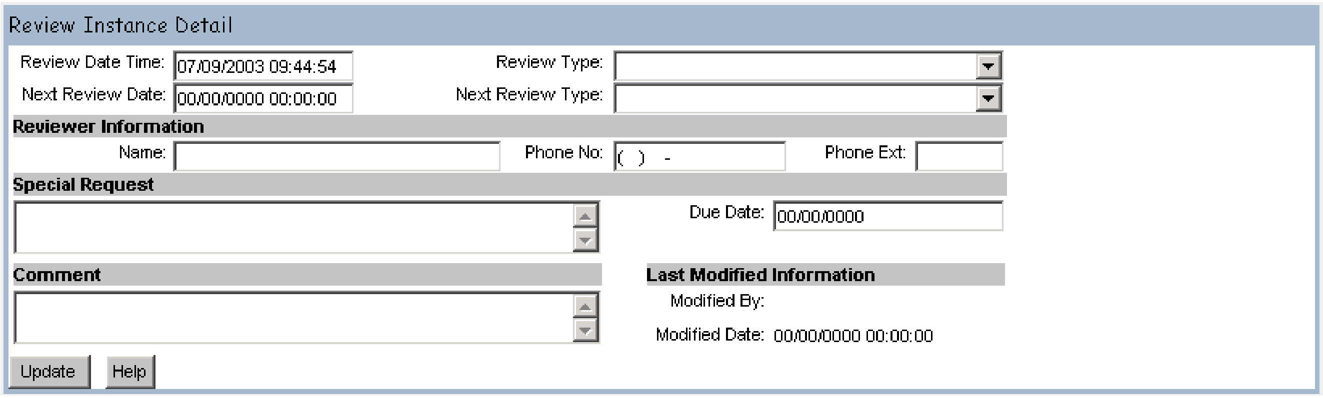
3. **Click** 

, leaving the default criteria
4. Select your patient by clicking on the **case # link**

To add a Review Instance

The Add Review Instance function allows users to add a new Review Instance associated with a Payor Ranking record.

1. **Click** the **Review Instances** link
2. **Click** 



3. **Enter** the **Following:**

Review Date Time	Today's Date
Next Review Date	10/15/2003
Review Type	Normal
Next Review Type	Doc – Doc, Level 1
Name	Abby Psychiatrist
Phone No	610-888-5412 (no dashes)
Phone Ext	7695
Special Request	Patient Needs More Psych Tests

4. **Click** Update

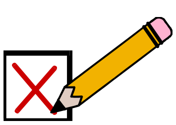
To edit a Review Instance

The Edit Review Instance function allows users to edit an existing Review Instance for a Payor associated with the Admission.

1. **Click** the **Edit** link next to the **Newly Created Review Instance**
2. **Change** the **Following:**

Phone Ext	7824

3. **Click** Update
4. **Click Comments History** to view the list of comments
5. **Click** Close on the **Review Instance History** browser window



Authorizations

The Authorizations tab allows users to view a summary of all Authorizations associated with a Payor. From this summary view, a user may create new Authorizations or edit existing Authorizations.

To view Authorizations

1. **Click** the **Authorizations** link

   Authorizations can be filtered by All, Current or History

To add an Authorization

The Add Authorization function allows users to add a new Authorization associated with a Payor record.

1. **Click** on the **Authorizations** link
2. **Click** Add
3. **Enter** the **Following:**

Quantity	1
Units	Visit
Status	Approved
Status Date	11/15/2003
Start Date	11/30/2003
Quantity Authorized	1
Units	Visit
End Date	12/15/2003
Authorized Service Group	Ind. Therapy Only
Authorization #	3333

5. **Click** Update

To edit an Authorization

The Edit Authorization function allows users to edit an existing request and Authorization for a Payor associated with the Admission.

1. **Click** the **Edit** link next to the **Newly Created Authorization**
2. **Change** the **Following:**

Quantity Authorized	7

3. **Click** Update

Appeals

To view an appeal

The View Appeal Summary function allows users to view a summary of all Appeals associated with a Payor.

1. **Click** the **Appeals** tab

To create an appeal

The Create Appeal function allows users to create a new appeal associated with a Payor record.

1. **Click** the **Appeals** tab
2. **Click** Add
3. **Enter** the **Following:**

Appeal Status	In Progress
Appeal Type	Financial
Appeal Reason	Disputing Bill

4. **Click** Update

To edit an appeal

The Edit Appeal function allows users to edit an existing appeal for a Payor associated with the Admission.

1. **Click** the **Edit** link next to the **Appeal**
2. **Change** the **Following:**

Comment	Chart Request By Reviewer

3. **Click** Update

To generate an appeal letter

A user may generate an Appeal Letter for an existing appeal record from the Edit Appeal function.

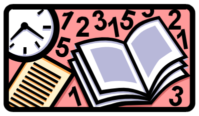
1. **Click** the **Edit** link next to the **Newly Created Appeal**
2. **Click Appeal Letter**
3. **Close** the **Appeal Letter** browser window
4. **Click** the **Patient Case #** to display the main Client Record window

The letter template is displayed in Rich Text Format (RTF). The letter will contain the following fields: Review Organization, Review Organization Street Address, Review Organization City, State and Postal Code, Patient Name and Date of Birth, Admit Date and Discharge Date (if discharged)

Lesson 7
Scheduling

Objectives

- View Schedule
- Appointment Scheduling
- Group Scheduling
- Program Scheduling



Scheduling

The Appointment Scheduling components of Epitomax allow a user to search for available appointment times in the system. Available appointment times are defined for each clinical staff using a Staff Schedule Profile.

View Staff Schedule

Epitomax allows users to view a Staff's scheduled activities for a single Day, for a Week, or for a Month at a time.

To view Staff Daily Schedule

The View Staff Daily Schedule function allows users to view a staff person's scheduled activities for a given Date.

1. **Click** on the **View Staff Schedule** menu item from the **Scheduling** menu
2. **Enter** the **Following:**

Staff Person	Your Staff Person
Date	Today's Date

3. **Click** Submit

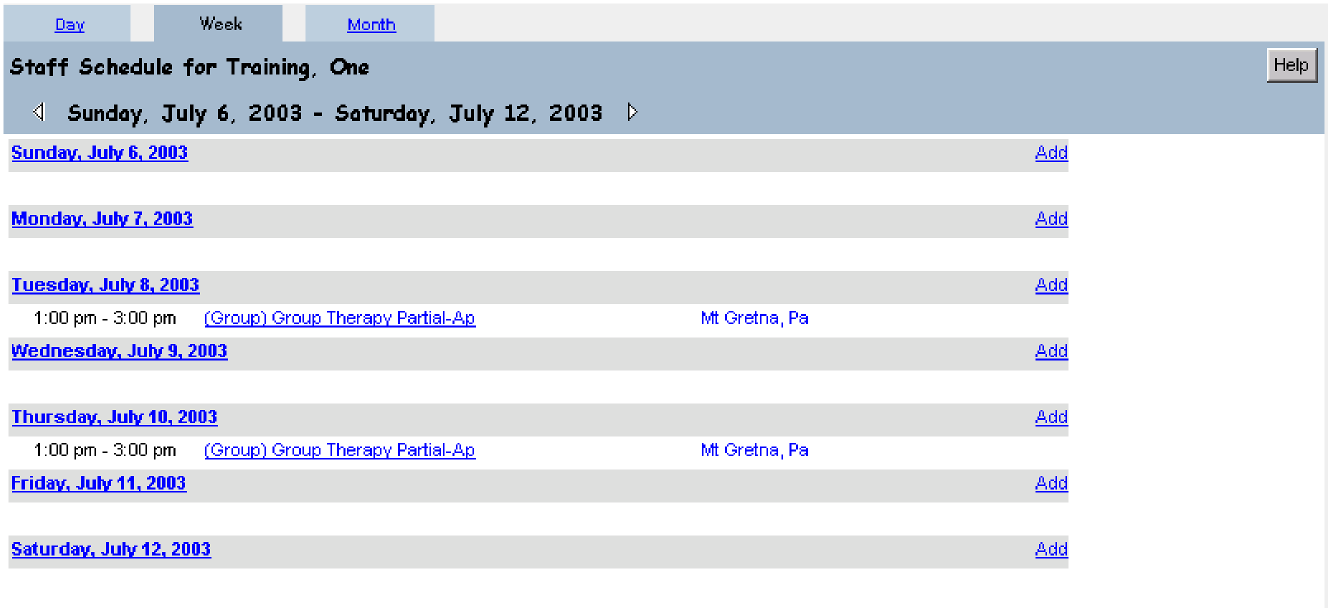
The Staff's Daily Schedule Is Displayed

- The Staff Person and Date fields are required fields.
- These fields are all view only.
- Only scheduled activities with a Status of either 'Pending' or 'Complete' are displayed.
- The View Staff Daily function also displays available time with the following fields: Start Time, End Time, Activity Class Description and Location.
- Three separate background colors are used to differentiate scheduled activity, available time and unavailable time. A legend is displayed indicating which color is used for each. The background color is applied to the entire block of time that an activity spans.

To view Staff Weekly Schedule

The View Staff Weekly Schedule function allows users to view a staff's scheduled activities for the Week of a specified date.

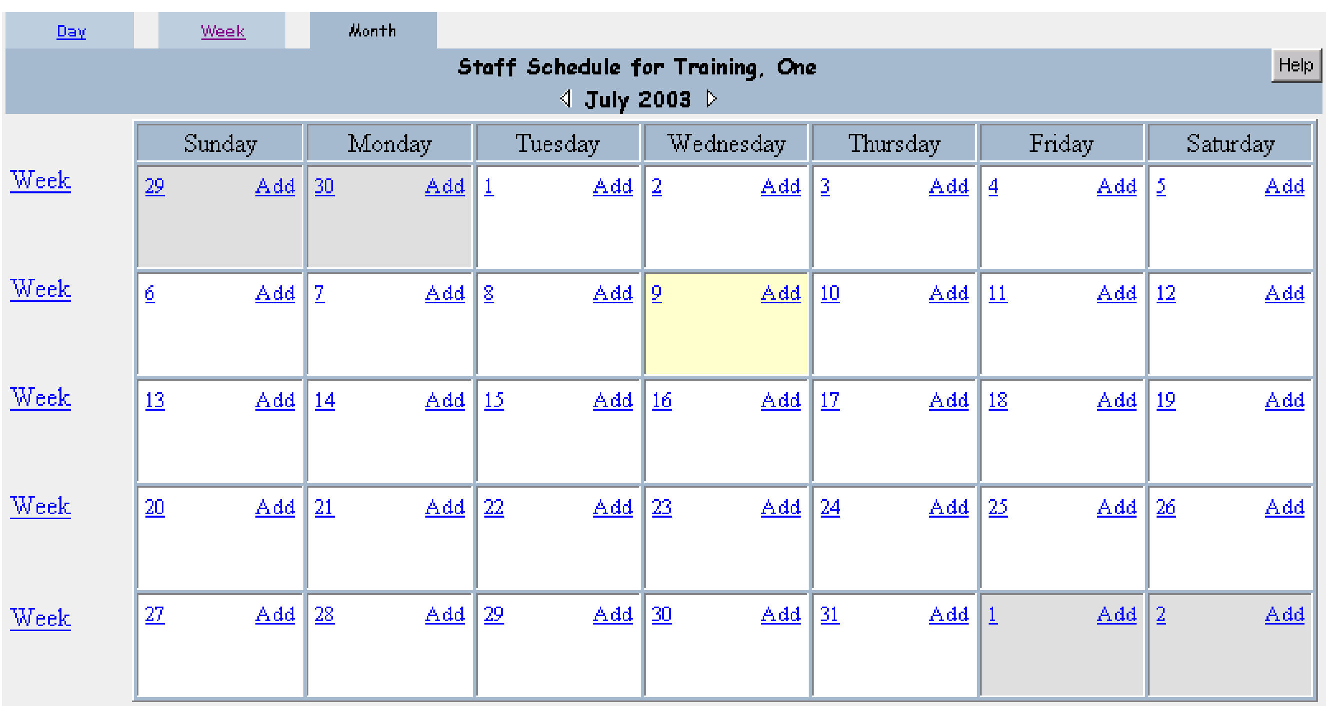
1. **Click** on the **Week** tab



To view Staff Monthly Schedule

The View Staff Monthly Schedule function allows users to view a staff person's scheduled activities for the Month of a specified date.

1. **Click** on the **Month** tab



To access a day within the month

1. **Click** the link for the **Day** of **Your Choice**
2. **Click** the **Month** tab to return to the month view

View Location Schedule

Epitomax allows users to view a Locations scheduled activities.

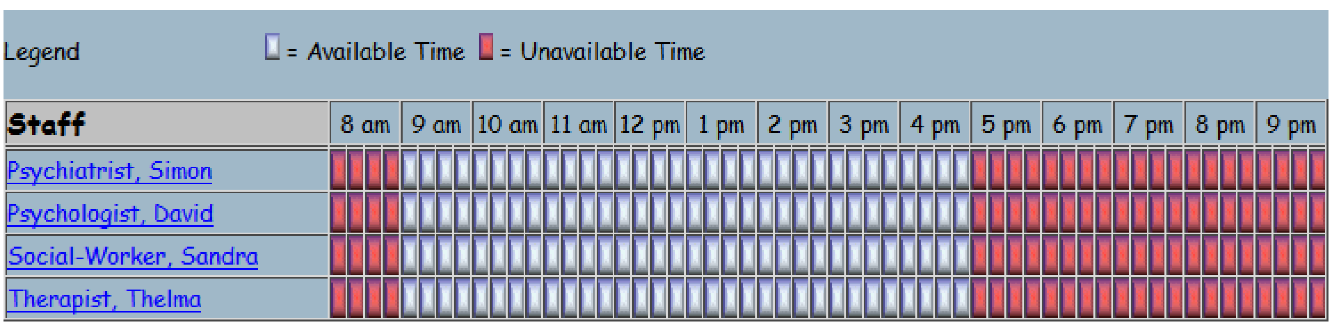
To view Location Schedule

The View Location Daily Schedule allows users to View Scheduled activities for all staff at a location on a given date.

1. **Click** on the **View Location Schedule** menu item from the **Scheduling** menu
2. **Enter** the **Following:**

Location	Use the drop-down box to pick the appropriate location
Date	Today's Date

3. **Click** Submit



Scheduling Appointments

To Schedule a New Client/Existing Client Appointment Using Schedule Appointment Link

Once a new client is created in Epitomax, the user can create an appointment utilizing the Schedule Appointment link under the Scheduling menu.

Alert: This Feature Of Epitomax Will Mainly Be Used By Central Scheduling To Find All Available Outpatient Appointments for Multiple Locations.

1. After the initial Client Record is created, click on the **Schedule Appointment** link under the **Scheduling** menu.
2. If the new client is not auto-filled, click on Clear button and type in the **last name** of the new client in the **Last Name Field**.
3. Click Search.
4. Click on the **Case Number** Link of the new client.
5. Choose either the **Inquiry Episode** or the correct **Admission Episode** if already created.
6. Of the available fields under General, Staff Preferences and Client Availability, choose criteria in order to narrow down the available appointments.

The Number of Bookings is displayed in parenthesis beside a staff person's name for staff that allow multiple bookings and for whom other Appointments have been scheduled.

If a Program is specified, then the search retrieves only staff available time when the activity and/or the location is related to the Program. If staff available times exist that have no activity and no location, those available times are also returned in the results.

If any hospital Location is specified, then the search retrieves only staff available time where the activity is related to Programs that are related to the location entered. If staff available times exist that have no activity and have no location, then those available times are returned in the results addition to those matching the location criteria.

If an Activity Code is selected, then the system displays only staff available time where the Activity Class matches the Activity Code or where the staff person's discipline is the selected activity.

If any insurance plans are specified, then the search first verifies whether or not any of the selected insurance plans require credentialing. For those insurance plans that require staff to be credentialed, the search only retrieves staff available time for staff that has valid credentialing for the plan.

If a specific staff person, gender or staff specialty is specified, then the search retrieves only staff available time for any staff satisfying the criteria.

If a staff discipline is specified, then the search retrieves only staff available time for staff with the discipline selected and where the Activity Class has activities based on the discipline.

- If no Available Date From is specified or the Available Date From is less than the current system date, then the search retrieves only staff available time for dates that fall on or after the current system date.

- If an available Date From is specified, then the search retrieves only staff available time for dates that fall on or after the selected date.

- If an available Date To is specified, then the search retrieves only staff available time for dates that fall on or before the selected date. The search will ignore the specified Date To if it falls before the current system date.

- If a day is checked and a Start Time is specified, then the search retrieves only staff available time for dates that fall on the specified day and where 1) the available Start Time is on or after the specified Start Time, or 2) the available End Time is after the specified Start Time.

- If a day is checked and an End Time is specified, then the search retrieves only staff available time for dates that fall on the specified day and where 1) the available End Time is on or before the specified End Time, or 2) the available Start Time is before the specified End Time.

7. **Click** Submit

Appointment Search Results

Available Date	Day Of Week	From	To	Staff Person	Hospital Location			
09/20/2010	Monday	9:00 am	5:00 pm	Psychiatrist, Simon	Office	Add	Staff Schedule	Staff Preferences
09/20/2010	Monday	9:00 am	5:00 pm	Psychologist, David	Office	Add	Staff Schedule	Staff Preferences
09/20/2010	Monday	9:00 am	5:00 pm	Social-Worker, Sandra	Office	Add	Staff Schedule	Staff Preferences
09/20/2010	Monday	9:00 am	5:00 pm	Therapist, Thelma	Office	Add	Staff Schedule	Staff Preferences
09/21/2010	Tuesday	9:00 am	5:00 pm	Psychiatrist, Simon	Office	Add	Staff Schedule	Staff Preferences
09/21/2010	Tuesday	9:00 am	5:00 pm	Psychologist, David	Office	Add	Staff Schedule	Staff Preferences
09/21/2010	Tuesday	9:00 am	5:00 pm	Social-Worker, Sandra	Office	Add	Staff Schedule	Staff Preferences
09/21/2010	Tuesday	9:00 am	5:00 pm	Therapist, Thelma	Office	Add	Staff Schedule	Staff Preferences
09/22/2010	Wednesday	9:00 am	5:00 pm	Psychiatrist, Simon	Office	Add	Staff Schedule	Staff Preferences
09/22/2010	Wednesday	9:00 am	2:00 pm	Psychologist, David	Office	Add	Staff Schedule	Staff Preferences
09/22/2010	Wednesday	9:00 am	5:00 pm	Social-Worker, Sandra	Office	Add	Staff Schedule	Staff Preferences
09/22/2010	Wednesday	9:00 am	5:00 pm	Therapist, Thelma	Office	Add	Staff Schedule	Staff Preferences
09/22/2010	Wednesday	3:00 pm	5:00 pm	Psychologist, David	Office	Add	Staff Schedule	Staff Preferences
09/23/2010	Thursday	9:00 am	5:00 pm	Psychiatrist, Simon	Office	Add	Staff Schedule	Staff Preferences
09/23/2010	Thursday	9:00 am	5:00 pm	Psychologist, David	Office	Add	Staff Schedule	Staff Preferences
09/23/2010	Thursday	9:00 am	5:00 pm	Social-Worker, Sandra	Office	Add	Staff Schedule	Staff Preferences
09/23/2010	Thursday	9:00 am	5:00 pm	Therapist, Thelma	Office	Add	Staff Schedule	Staff Preferences
09/24/2010	Friday	9:00 am	5:00 pm	Psychiatrist, Simon	Office	Add	Staff Schedule	Staff Preferences
09/24/2010	Friday	9:00 am	5:00 pm	Social-Worker, Sandra	Office	Add	Staff Schedule	Staff Preferences
09/24/2010	Friday	9:00 am	5:00 pm	Therapist, Thelma	Office	Add	Staff Schedule	Staff Preferences

Page First | Page Prior | Page Next | Page Last | Help

Rows 1 to 20 of 47 total rows.

8. Peruse the days, times and staff available.
9. **Click** the **Add** link next to **Your Staff Person**
10. **Enter** the **Following:**

Start Time	Defaults to the earliest available time for the chosen staff person and day – the start time remembering Epitomax uses military time
Duration	Using the drop-down box
Activity Code	Using the drop-down box
Program	Using the drop-down box
Comments	Optional

11. Click on the Update button.

Central Scheduling creates an Inquiry for all New Outpatient Appointments.

The following fields are required fields: Activity Code, Start Time and Duration.

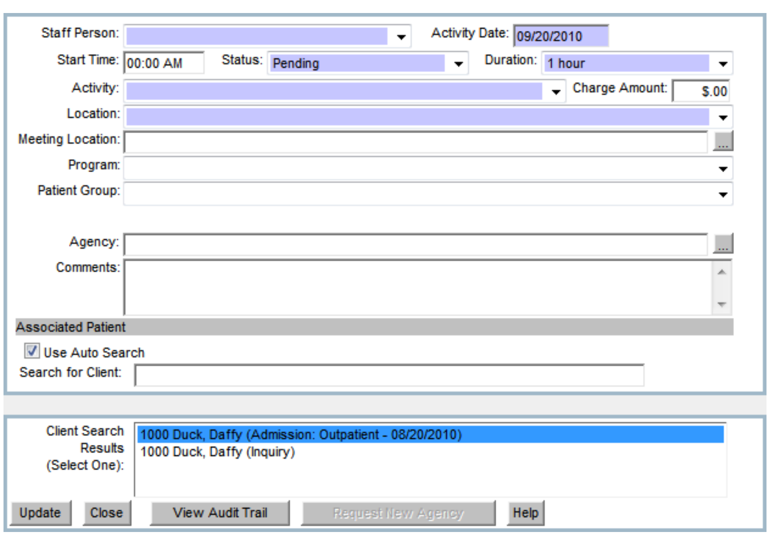
The following fields are view only fields: Activity Status, Staff Person, Activity Date and Location.

If the Start Time and End Time do not fall within staff available time for the selected date, then the Appointment is not created unless the staff person allows double bookings.

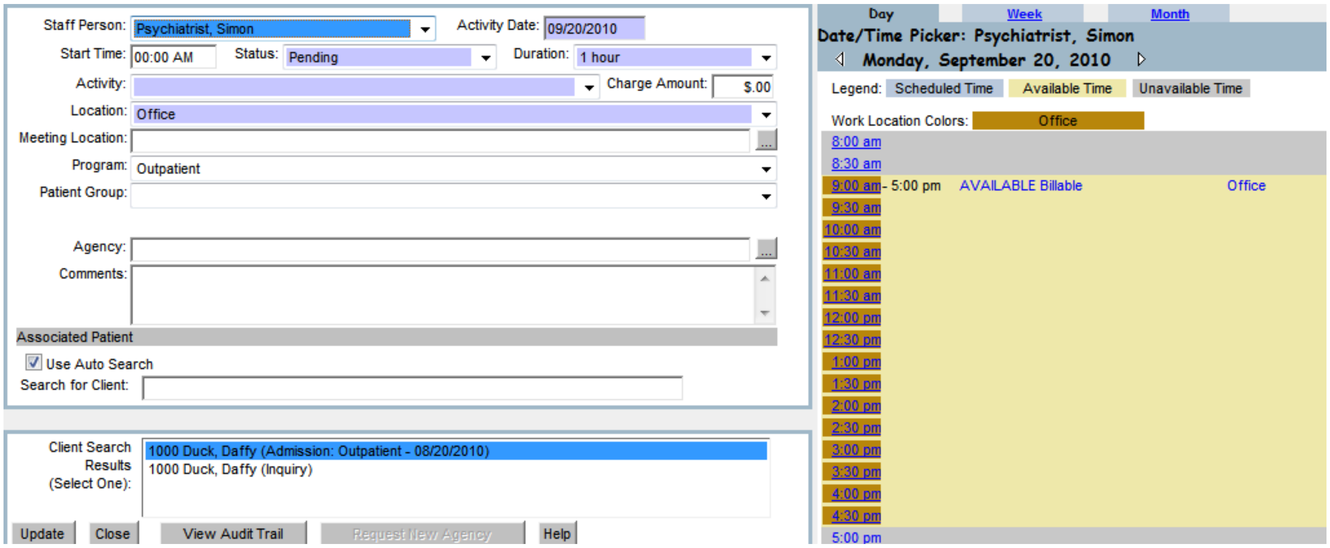
If the staff person allows double bookings and an Appointment is added at a time that overlaps another Appointment, the new Appointment is created and the user is notified of the conflict.

To Schedule a New Client/Existing Client Appointment Using the Appointments Tab

1. After the initial Client Record is created, click on the **Appointments** tab**.**
2. Click on the New Appointment button.



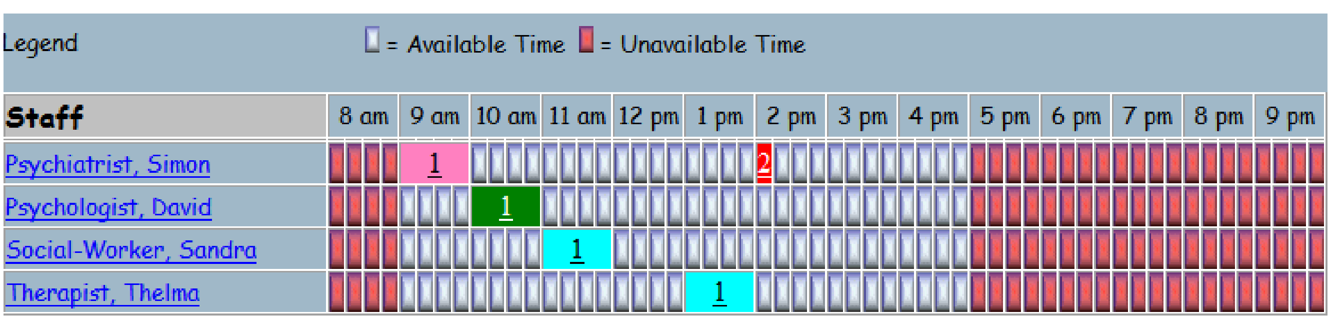
3. Choose a **staff person** by using the **drop-down box** next to the **Staff Person field**.



4. Once a staff member has been chosen from the drop-down box, his or her schedule will appear on the right hand side of the screen, where the user can choose to **view** the chosen staff person's schedule from a **Daily** view, **Weekly** view or **Monthly** view.
5. Either manually **input an activity date and time** or **click on a date and time** to utilize the staff person's calendar to select a date and time.
6. Fill in the **Duration**, **Activity**, **Program** and any optional comments.
7. **Highlight** the **Episode** (Inquiry or Admission) connected to the activity.
8. Click Update.
9. The window will close and the new appointment has been scheduled.

To Schedule a New Client/Existing Client Appointment Using the View Location Link

1. After the initial Client Record is created in Epitomax, **click** on **View Location Schedule** link under the **Scheduling** menu.
2. **Choose** the appropriate **Location** from the drop-down box and enter the correct **Date**.
3. Click Submit



Each hour on the display is divided into 15-minute increments. Staff can select the first 15 minutes of the hour, the second 15 minutes of the hour and so on, by clicking on one of the four associated sections.

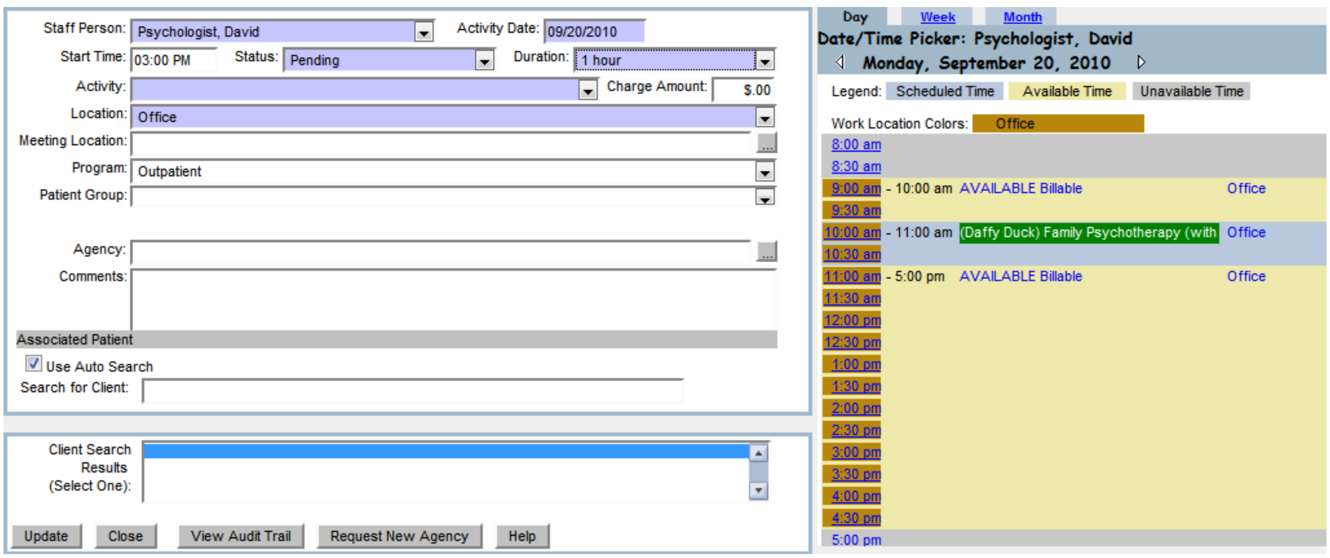
Colors for different **Activities** can be set by the system administrator in **Activity Maintenance** under the **Administration** menu.

The **number** in the Appointment box is the number of **scheduled appointments** for that time frame.

The **details** of the Scheduled Appointment (name, time and activity) can be **viewed by hovering** the cursor over the number.

If staff selects a time slot labeled as unavailable, the system displays a message indicating the time selected as unavailable and another time slot should be selected.

4. Click on one of the blocks next to the correct staff member to open the Appointment screen.



The Staff Person, Date, Time, Location will auto-fill; however each can be manually changed by the user.

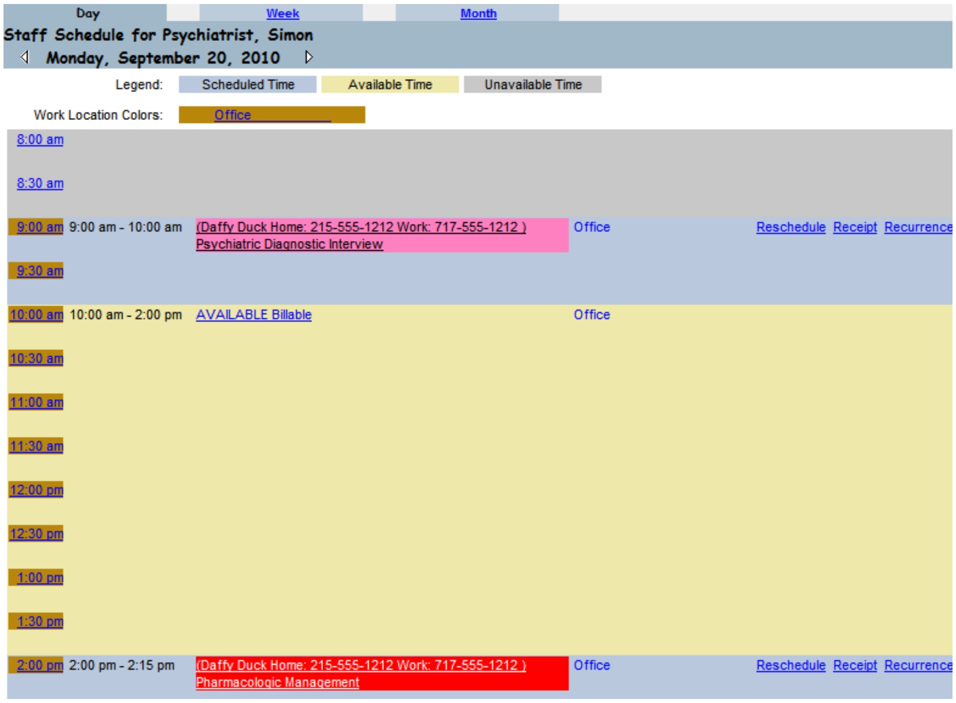
The duration defaults to 1 hour and can be changed by the user.

5. Choose the correct activity using the drop-down box next to Activity.
6. Under Associated Patient, manually enter either the full last name or the first few letters of the client's last name.
7. Highlight the correct Client and Episode under the Client Search
8. Click Update

To Schedule a New Client Appointment/Existing Client Using the View Staff Schedule Link

1. After the initial Client Record is created in Epitomax, **click** on **View Staff Schedule** link under the **Scheduling** menu.

2. **Choose** the appropriate **Staff Person** from the drop-down box and enter the correct **Date**.
3. Click Submit



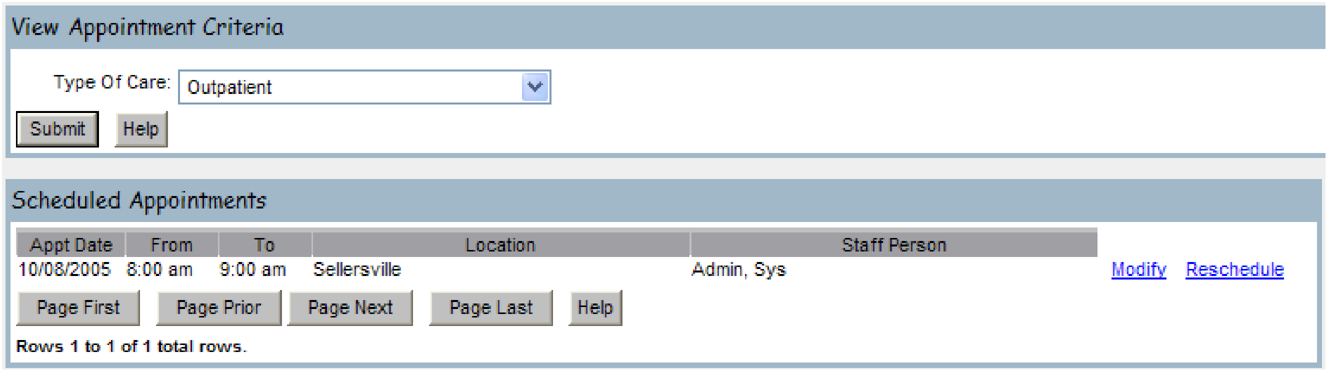
4. Click on a Time link (10:00am, 1:00pm, etc.) to open an Appointment.
5. Enter an **Activity** using the drop-down box
6. **Enter** the **last name** or first few letters of the last name of the client
7. **Highlight** the appropriate Client and Episode
8. **Click** Update

To Modify an Existing Appointment for an Existing Client

The Modify Appointments function allows users to modify Appointments with regards to Canceling, Rescheduled, Pending, etc...

Alert: Modify Appointment Can Be Used To Identify Who A Patient Is Scheduled To See As Well As View Staff Schedule.

1. **Click** on the **Modify Appointment** link on the **Scheduling** main menu
2. **Select Outpatient**
3. **Click** Submit



View Appointment Criteria

Type Of Care: Outpatient

Submit Help

Scheduled Appointments

Appt Date	From	To	Location	Staff Person	
10/08/2005	8:00 am	9:00 am	Sellersville	Admin, Sys	Modify Reschedule

Page First Page Prior Page Next Page Last Help

Rows 1 to 1 of 1 total rows.

4. **Click** on the **Modify** link next to the first Appointment
5. **Click** Cancel

The system will change the Appointment both on the patient and staff records.

The Activity Status field is a required field.

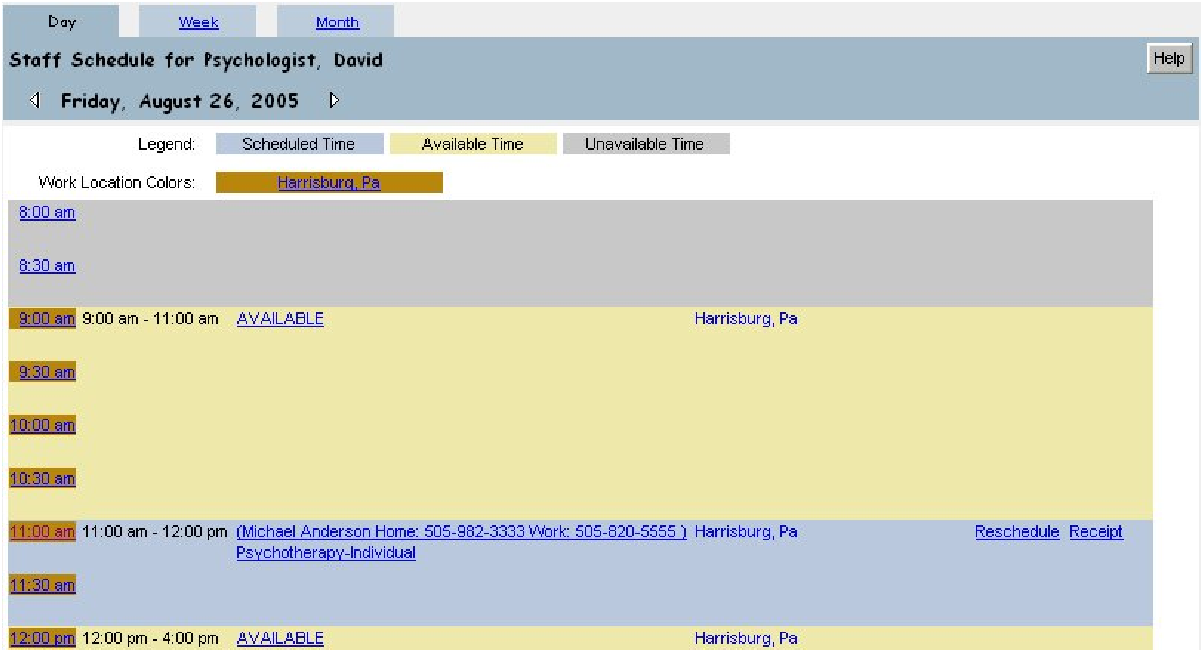
The following fields are view only: Activity Code, Program, Staff Person, Activity Date, Hospital Location, Start Time and End Time.

Status indicators are defined as follows:

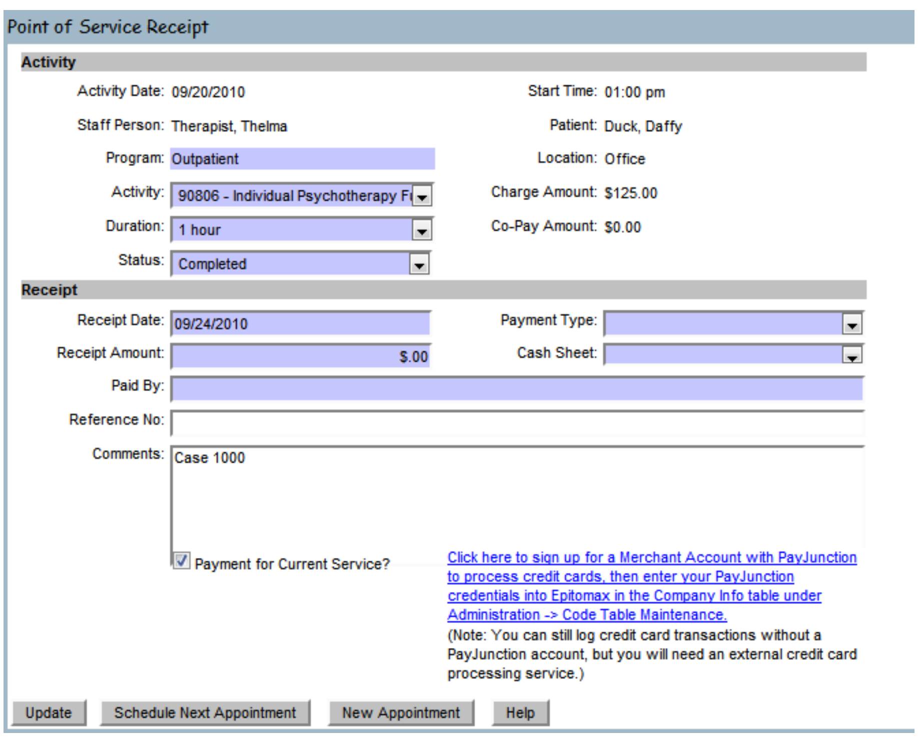
- **Completed As Planned** - To indicate staff activity has been completed. Changes can be made as long as charges have not been generated.
- **Completed With Changes -** To indicate staff activity has been completed and changes were made. Additional changes can be made as long as charges have not yet been generated.
- **Staff Cancelled** -To indicate that a staff has cancelled an Appointment. This option is available under staff activity view.
- **Patient Cancelled** - To indicate that a staff has cancelled an Appointment. This option is available under Associated Patients view.
- **No Show No Charge** – To indicate a patient will not be charged for an Appointment they did not attend.
- **Rescheduled** - To indicate that a patient or staff has rescheduled an Appointment.
- **Incorrect Entry** – To indicate that an Appointment has been incorrectly entered.
- **No Show** – To indicate that a patient did not show up for an appointment they were scheduled for, but are responsible for charges incurred.
- **Did Not Attend** – To indicate staff was not able to attend Appointment.
- **Unplanned Event** - To indicate Appointment was unplanned but still held.

To Receipt a Existing Client including Scheduling Next Appointments

In Epitomax, you can receipt a co-pay and complete the appointment at the same time.



1. **Click** on the **Receipt** link to the right of the appointment. The following page is displayed.



2. **Enter** the **following** information:

Duration	Duration of the appointment
Status	Completed
Payment Type	Check
Receipt Amount	$20
Cash Sheet	Choose the correct cash sheet
Payment for Current Service	Check this box only if the payment is for this service only.

3. If another appointment is going to be scheduled with the same staff member, click on the **Schedule Next Appointment** button now. If a next appointment is scheduled it will print on the receipt.

4. If another appointment is going to be scheduled with a different staff member, click on the **New Appointment** button, choose the staff member, date, time and activity. If an appointment is scheduled with another staff member, it will print on the receipt.

If the payment received is for <u>today's session only</u> – the Payment for Current Service box must be checked. **This payment will automatically apply against today's service.**

If payment received is for <u>today's session and a previous session</u> – the Payment for Current Service box must be unchecked. It would be helpful if the Comments would be entered indicating payment includes a previous session. This payment will be applied to the appropriate services by non-clinical staff.

If payment received is for a <u>previous session only</u> – the Payment for Current Service box must be unchecked. It would be helpful if the Comments would be entered indicating payment is for a previous session.

To Reschedule an Appointment for an Existing Client

1. **Click** the **Modify Appointment** under the **Scheduling** main menu
2. **Select** a type of care
3. **Click** Submit
4. **Click** on the **Reschedule** link next to the Appointment
5. **Select** the new Date and Time by navigating through the staff schedule.
6. **Once** a new date and time have been selected click on the update button and the appointment will be rescheduled for that date and time

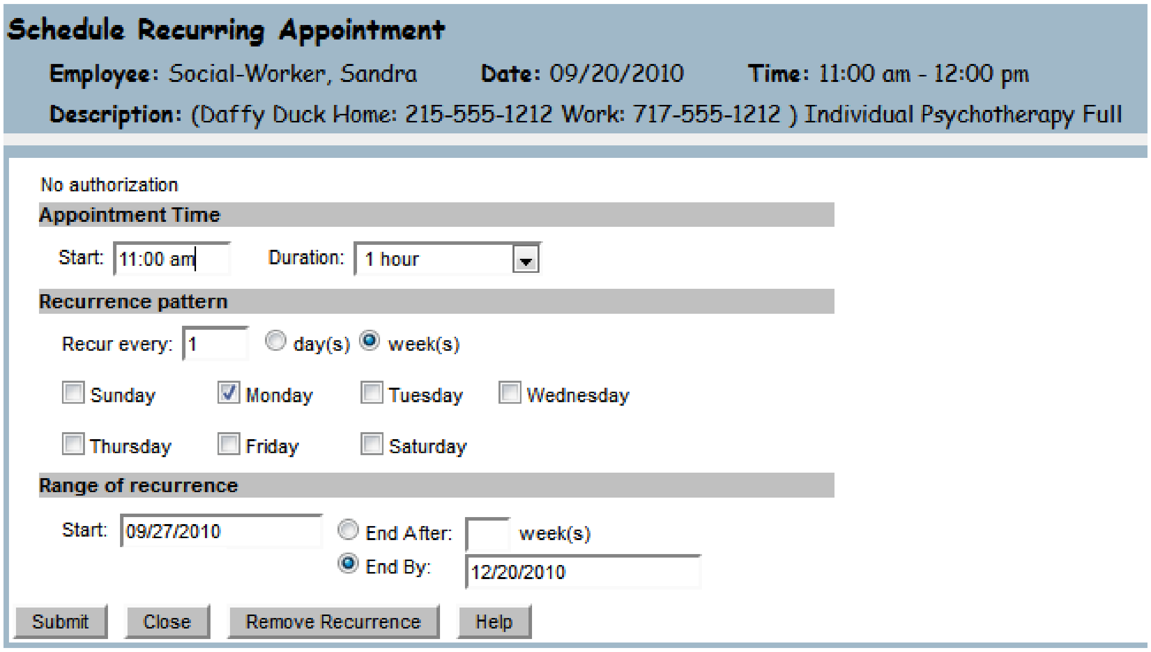
OR

1. From the staff's daily schedule view, click on the **Reschedule** link.
2. Using the daily, weekly or monthly view, find an available time and click on the hour (2:00pm, 8:00am).
3. Review the Appointment information and click Update.

To Set a Recurring Appointment with an Existing Client

In Epitomax, it is possible to set up an appointment to recur into the future. It is possible to recur any individual-type appointment; groups will recur automatically.

1. Upon completing the first appointment, view the staff's daily schedule and click on the **Recurrence** link.

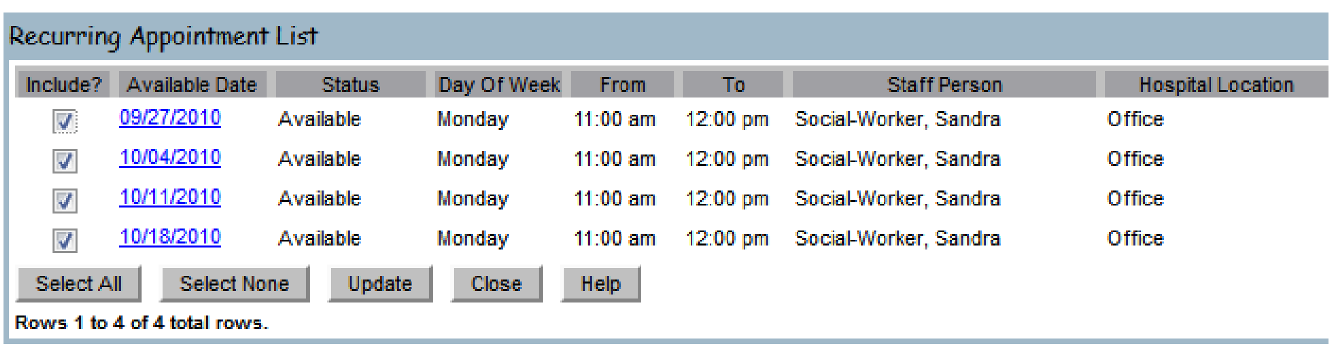


2. Staff is able to change the **Start Time**, **Duration**, **Recurrence Pattern** and **Number of Sessions** or **End Date**.

Staff is unable to change the type of Activity.

It is recommended that a recurrence not extend beyond 4 to 6 sessions.

3. Click Submit



Recurring Appointment List

Include?	Available Date	Status	Day Of Week	From	To	Staff Person	Hospital Location
☑	09/27/2010	Available	Monday	11:00 am	12:00 pm	Social-Worker, Sandra	Office
☑	10/04/2010	Available	Monday	11:00 am	12:00 pm	Social-Worker, Sandra	Office
☑	10/11/2010	Available	Monday	11:00 am	12:00 pm	Social-Worker, Sandra	Office
☑	10/18/2010	Available	Monday	11:00 am	12:00 pm	Social-Worker, Sandra	Office

Select All | Select None | Update | Close | Help

Rows 1 to 4 of 4 total rows.

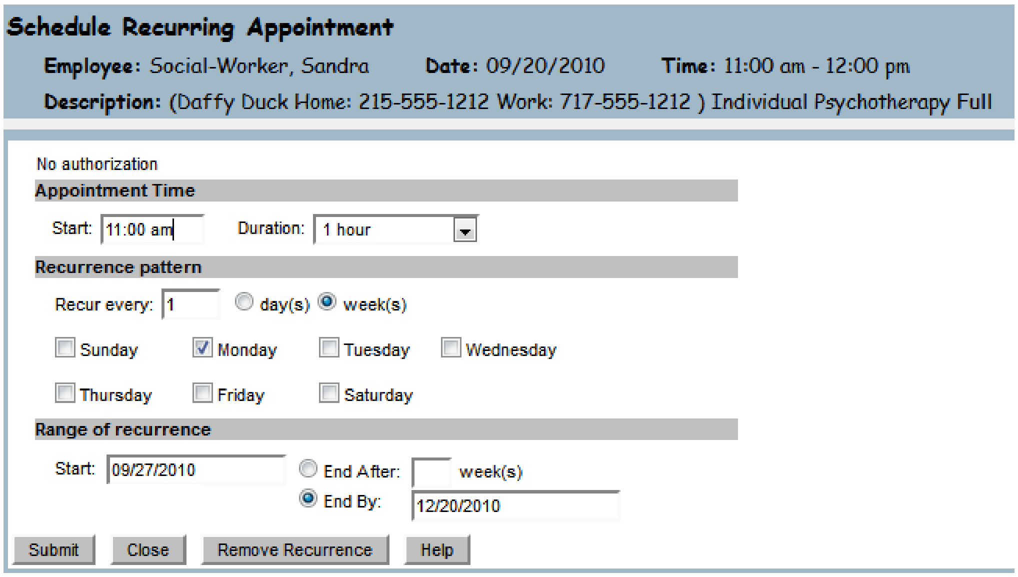
If a time or date is already booked or otherwise not available, the **Status** will appear in RED and state **Unavailable**.

Staff can choose to remove one of the occurrences by clicking the **Include?** checkbox, making it inactive.

4. Click Update

To Remove a Recurring Appointment with an Existing Client

1. View the staff's daily schedule and click on the **Recurrence** link.


Schedule Recurring Appointment

Employee: Social-Worker, Sandra **Date:** 09/20/2010 **Time:** 11:00 am - 12:00 pm

Description: (Daffy Duck Home: 215-555-1212 Work: 717-555-1212) Individual Psychotherapy Full

No authorization

Appointment Time

Start: 11:00 am Duration: 1 hour

Recurrence pattern

Recur every: 1 day(s) week(s)

Sunday Monday Tuesday Wednesday

Thursday Friday Saturday

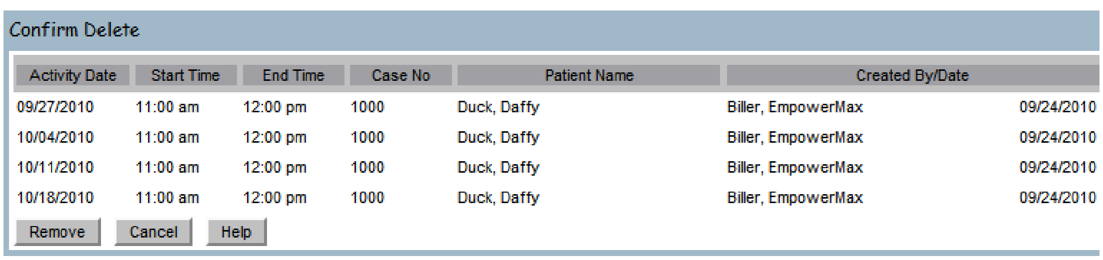
Range of recurrence

Start: 09/27/2010 End After: week(s)

End By: 12/20/2010

Submit Close Remove Recurrence Help

2. Click on Remove Recurrence


Confirm Delete

Activity Date	Start Time	End Time	Case No	Patient Name	Created By/Date	
09/27/2010	11:00 am	12:00 pm	1000	Duck, Daffy	Biller, EmpowerMax	09/24/2010
10/04/2010	11:00 am	12:00 pm	1000	Duck, Daffy	Biller, EmpowerMax	09/24/2010
10/11/2010	11:00 am	12:00 pm	1000	Duck, Daffy	Biller, EmpowerMax	09/24/2010
10/18/2010	11:00 am	12:00 pm	1000	Duck, Daffy	Biller, EmpowerMax	09/24/2010

Remove Cancel Help

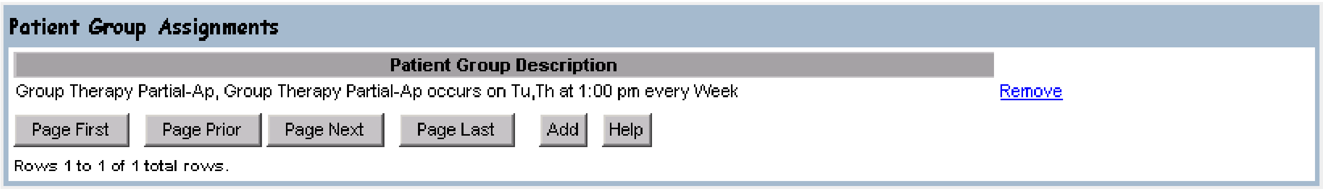
3. Click Remove

Group Scheduling

To view patient Group Assignments

The View Patient Group Assignments function allows users to view recurring group activities associated with the selected patient Admission.

1. **Click** on **Patient Groups Assignments** menu item from the **Scheduling** menu

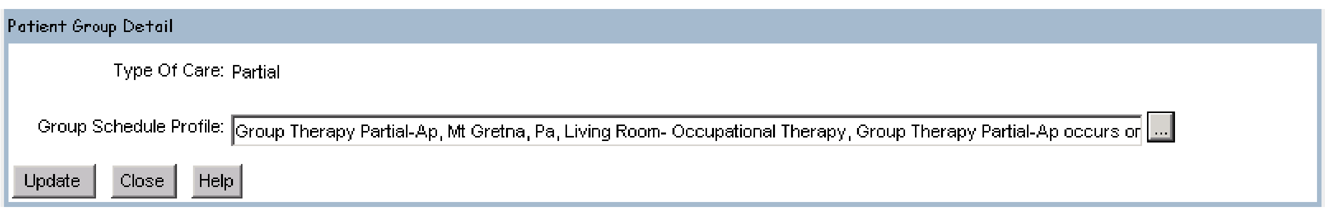


The Patient Group Assignment menu item will only be accessible after an Episode has been selected.

To add a patient Group Assignment

The Add Patient Group Assignment function allows users to add the selected patient Admission to a group activity.

1. **Click Client Record**
2. **Click Episode History**
3. **Select Acute Partial Hosp Admission**
4. **Click Patient Group Assignments** from the **Scheduling** menu
5. **Click** Add
6. **Select Group Therapy Partial-Ap, Mt Gretna, Pa,……..**



7. **Click** Update

After the patient has been associated with the group, the group is added to the patient's schedule on the dates and times defined by the group's recurrence until discharged.

To remove a patient Group Assignment

The Remove Patient Group Assignment function allows users to remove a patient Admission associated to a group schedule profile.

Alert: For Training Purposes Do Not Remove Group Assignment

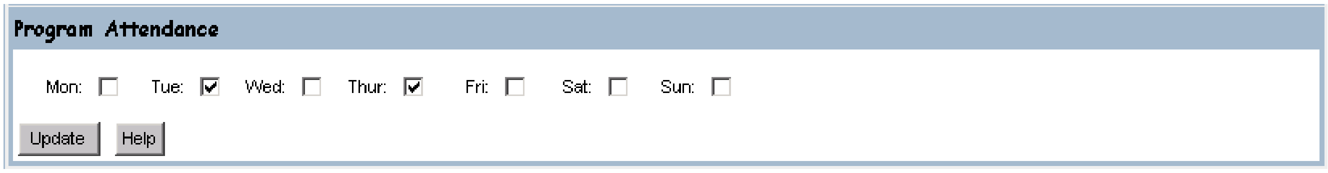
1. **Click** on the **Remove** link next to the first assignment
2. **Click Confirm Delete**

Clicking the Confirm Delete button removes the Patient from the group and removes all occurrences of the group from the patient's schedule (except for dates that occurred in the past) where the Status of the activity for the patient is 'Pending'.

To update Program Attendance Days

The Update Program Attendance Days function allows users to specify which days of the week a patient is to attend the Program to which they have been admitted.

1. **Click** on the **Program Attendance** menu item from the **Scheduling** menu.

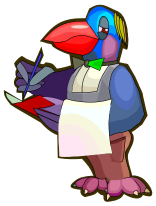


2. **Select Tue, Thru**
3. **Click** 

Lesson 8
Service Activity

Objectives

- Service Activity Entry
- Patient Activity Inquiry
- Program Activity Completion



Service Activity

Service Activity tracking in Epitomax is used to record all activities performed by Staff (both billable and non-billable activities). A day of Service Activity can be Completed after all activities have been resolved (i.e., Statuses set to something other than Pending) for that day. Once a day of activity is “Completed” for a Staff Person, then Charges for any billable services will be processed for billing purposes and the Completed day will be available for payroll processing.

To view incomplete Service Activity

The View Incomplete Service Activity function allows users to view a list of incomplete days of Service Activity for the selected staff person.

1. **Click** on the **Service Activity Entry** menu item from the **Service Activity** menu
2. **Select** the **Staff Person** from the **Search box by using the Ellipsis**
3. **Click** OK
4. **Click** Submit

Incomplete Days

Activity Date	Status	Total Hours	Complete The Day With No Activity
06/17/2003	Complete	0.00	
06/18/2003	Complete	2.00	
06/19/2003	Incomplete	0.00	☐

Page First | Page Prior | Page Next | Page Last | Update | Help

Rows 1 to 3 of 3 total rows.

The Incomplete Days summary screen is displayed. This is the view screen for the list of Service Activity entries that have not been “Completed” in the system.

Clicking Update completes the day for any date having the Complete the Day With No Activity checkbox checked.

The list of Incomplete Days includes all records for the chosen staff between the current system date minus 100 days and the current system date plus 21 days. It also includes any Completed Days where Payroll and Charges have not been generated.

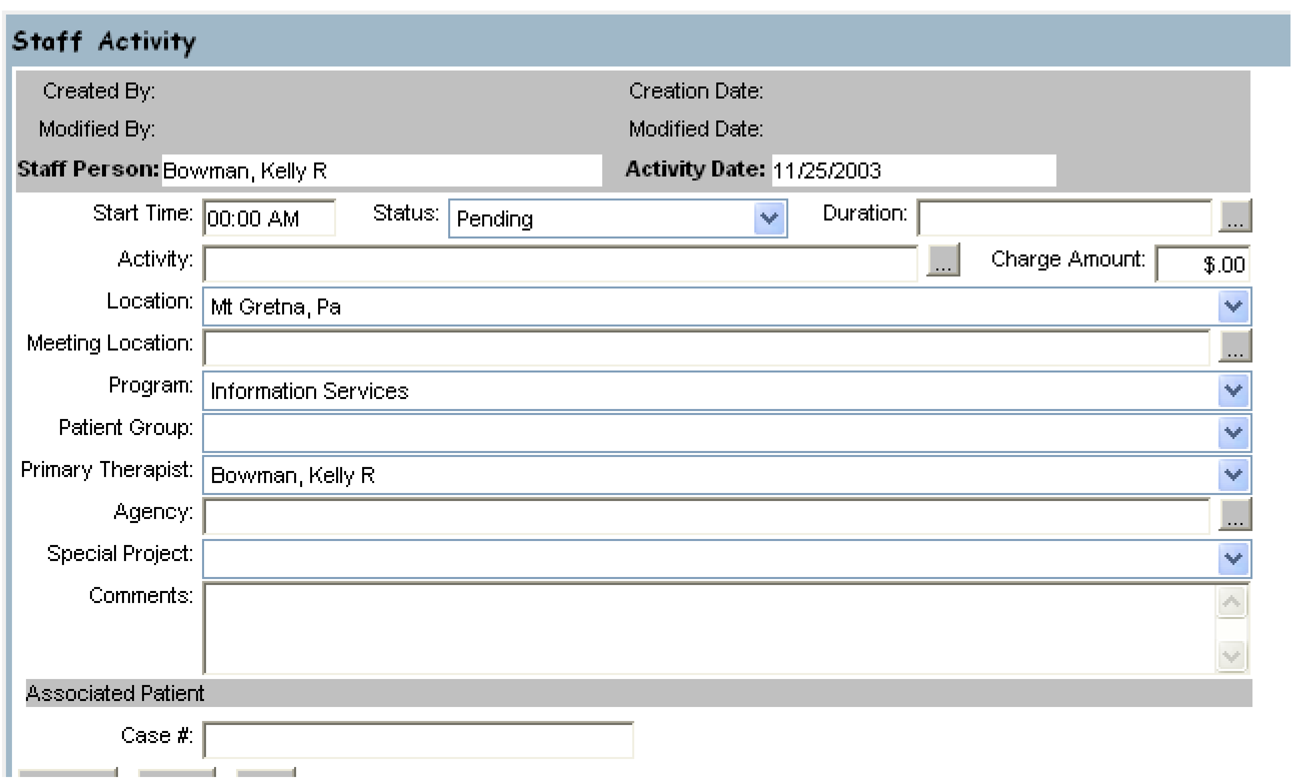
The Complete The Day With No Activity checkbox only displays for days where the Total Hours column equals zero and the activity date is less than or equal to the current date.

To add Service Activity-Benefit Time

The Add Service Activity function allows users to associate benefit time with the selected staff person and activity date.

1. **Click** an **Incomplete** Status date link
2. **Click the Quick Add button**

3. **Enter** the **required information**
    a. **Status** of benefit time is "completed as planned", even for future dates.
    b. **Duration** -Entering the duration in minutes or searching for the number of hours by using the Ellipsis indicates duration.
    c. **Activity -**Search for the Activity by using the Ellipsis or by entering the Activity code in the Activity field. Use the % to search in the search window
        i.e. 9011 is the activity code for Vacation time
    d. **Location** (defaults to staff's primary location)
    e. **Program** (defaults to staff's primary program)
    f. **Primary Therapist** (defaults to staff selected)



4. Click **Update**

- If the code is a billable code, an Associated Patient is required and the system will display the Client Search screen. If you know the Case # of the associated client, enter it in the Case # field at the bottom of the Staff activity screen.
- The following fields are required fields: Status, Activity and Duration.
- The following fields are view only: Staff Person and Activity Date.
- If the user does not enter a Charge Amount, the system will attempt to assign a charge amount by using the highest rate for the Staff's Discipline(s) and the Activity. If the system cannot find a charge for the associated staff person, the default rate in the Activity table is used.
- The Total Hours and Completed Hours for the Staff Person's day are re-calculated when the new activity is saved.
- The End Time is computed by the system based on the Start Time (if a time is entered) and the activity Duration.
- If the Add Service Activity function is accessed through the Scheduling function, the Start Time defaults to the time selected on the Staff Schedule screen.

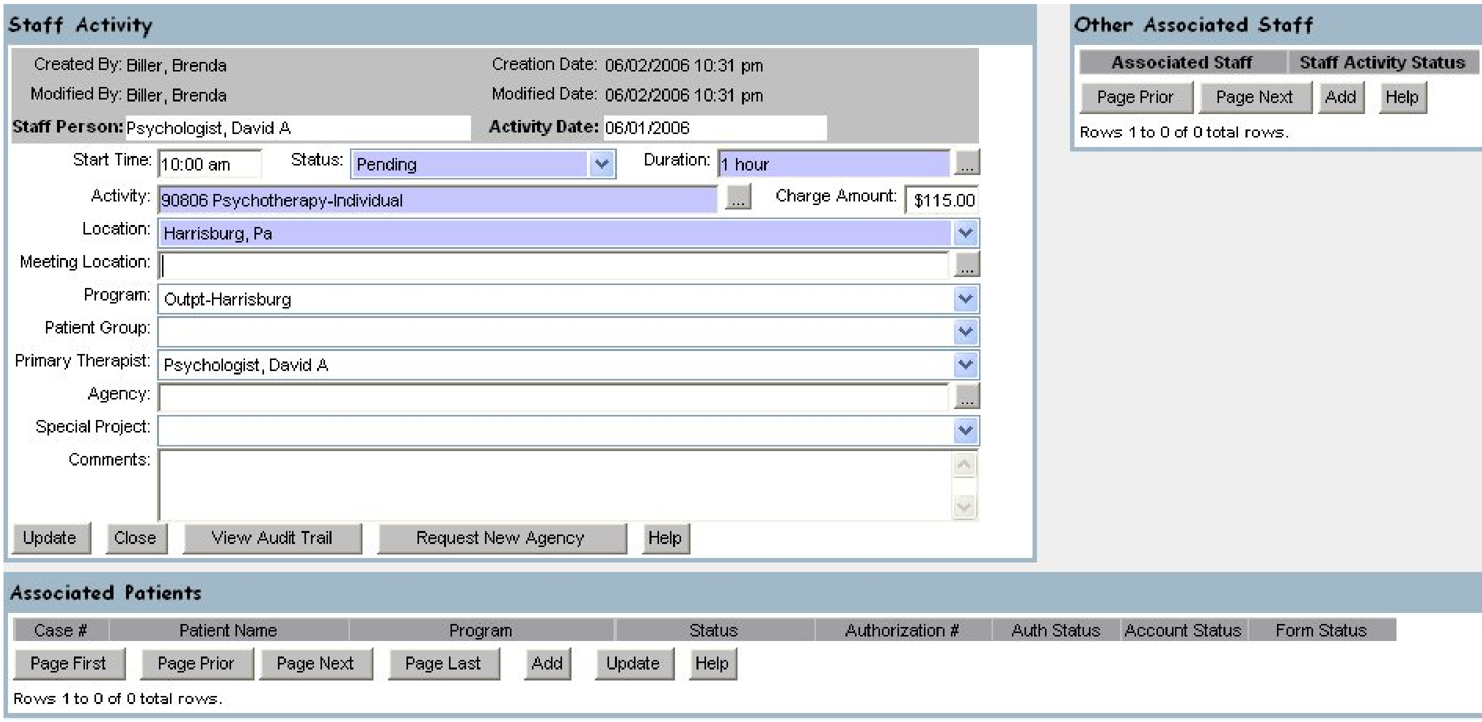
To add Service Activity

The Add Service Activity function allows users to associate a new Service Activity record with the selected staff person and activity date.

5. **Click** an **Incomplete** Status link
6. **Click** Add
7. **Enter** the **Following:**

Start Time	10:00 am
Status	Pending
Duration	1 Hour
Activity	90806 Psychotherapy-Individual
Location	Mt. Gretna, PA
Program	Outpt-Mt. Gretna

8. **Click** Update



- If the code is a billable code, an Associated Patient is required and the system will display the Client Search screen.

- The following fields are required fields: Status, Activity and Duration.

- The following fields are view only: Staff Person, Activity Date and Primary Therapist.

- If the user does not enter a Charge Amount, the system will attempt to assign a charge amount by using the highest rate for the Staff's Discipline(s) and the Activity. If the system cannot find a charge for the associated staff person, the default rate in the Activity table is used.

- The Total Hours and Completed Hours for the Staff Person's day are re-calculated when the new activity is saved.

- The End Time is computed by the system based on the Start Time and the activity Duration.

- The Program will default to the staff person's primary Program.

- If the Add Service Activity function is accessed from the View Staff Daily Schedule function, the Start Time defaults to the time selected on the View Staff Daily Schedule screen.

To add Service Activity for an Agency or EAP Company

1. **Click Service Activity Entry**
2. **Enter** the **Following**:

Staff Person	Your Staff Person

3. **Click** Submit
4. **Click** an **Incomplete** Status link
5. **Click** Add
6. **Enter** the **Following:**

Start Time	10:00 am
Status	Completed As Planned
Duration	4 Hours
Activity	20100 EAP Seminar
Location	Community Location-Unspecified
Program	Employee Assistance Program
Primary Therapist	Your Staff Member
Agency	B.R. Kreider & Son, (Eap) (Group No)

7. **Click** Update

To edit Service Activity

The Edit Service Activity function allows users to edit existing Service Activity records associated with the selected staff person and activity date.

1. **Change** the **Following:**

Start Time	11:00 am

The following fields are <u>required</u> fields: Status, Activity and Duration.

The following fields are <u>view only</u>: Created By, Creation Date, Modified By, Modified Date, Staff Person and Activity Date, Case #, Patient Name, Program, Combined Case, Authorization Number, Associated Staff and Staff Activity Status.

If the Status is being changed then a value must also be set for the Program field.

The End Time is computed by the system, based on the Start Time and the activity Duration.

If the user changes the activity (Activity Code), the system will <u>re-assign</u> the Authorization(s) for each Payor Ranking associated with each Patient Activity record.

If the Patient Activity Status is changed from either 'Pending' or 'Complete' to any other Status, <u>the system will remove all Authorizations</u> associated with the Patient Activity.

If the Patient Activity Status is changed from any Status other than 'Pending' or 'Complete' to 'Pending' or 'Complete', for each Payor associated with the Patient Activity an Authorization will be assigned if a valid one exists.

You can now edit Service Activity after you complete the day. You cannot modify after charges or payroll has been generated. Once charges or payroll have been generated, you must contact the Help Desk for additional corrections to be made.

Benefit time can now be Completed before the time is taken.

To associate a patient

The Add Patient Activity function allows users to associate a patient Admission to an activity record.

The Client Search window will display depending on the activity selection.

1. **Enter** the **Following:**

Last Name	Your Patient

2. **Click** Search
3. **Click** on **Your Patient's Case #**
4. **Select** the **Outpt Mt.-Gretna Admission**
5. **Click** Update

Note: To add other Associated Patients, do the following:

8. **Under** the **Associated Patients** heading, **Click** Add
9. **Select the associated admission for the patient**
10. **Click** Update

To associate another staff

The Associate Another Staff function allows users to associate another staff to the activity.

1. **Click Add** under the **Other Associated Staff Heading**

2. **Type "Training"** *(for training purposes)* in the **Search For Items Containing** text box
3. **Click** Search
4. **Select** the **Next Training Number** *(for training purposes)* **Up From Yours**

Alert: For Example, If You Are "Training, One" Then Select "Training, Two"

5. **Click** OK
6. **Close** the **Staff Activity, Associated Patients, Other Associated Staff Window** to return to **Staff Daily Activity Entry**

Completing the Day

Make sure all activities for the day have a status of Completed

You will not be able to Complete the Day if any activity has a status of anything other than completed.

If no activity occurred, check the check box "Complete the Day with No Activity" and click on Update. This will complete the day with no activity.

Patient Activity Inquiry

To view Patient Activity

The View Patient Activity Inquiry function allows a user to view the selected patients scheduled Appointments.

1. **Click** Client Record
2. **Click** Patient Activity Inquiry from the Service Activity menu
3. **Enter the Following:**

Episode	Outpatient, Outpt-Mt. Gretna

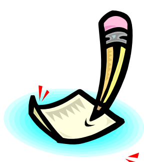
4. Click Submit

Report Criteria
Patient: Carter, Cary B (Case# 10071)
Episode: 10/3/2005 - Outpatient
Sort By: Activity Date

Love Behavioral Health, Inc.
Patient Activity Listing
Report Date: 6/2/2006

Activity Date	Staff	Time	Activity Status	Location	Activity	Program	Duration	Charge Amt.
10/03/2005	Psychiatrist, James	09:00 am	Completed	Mt Gretna, Pa	90801 Psychiatric Evaluation-Full	Outpatient	1 hour	$250.00
Comments:								
10/03/2005		12:00 am	Completed	Community Based	PREPAY Prepay utility charge	Outpatient	1 minute	$0.00
Comments:								
10/10/2005	Psychologist, David A	10:00 am	Completed	Harrisburg, Pa	90806 Psychotherapy-Individual	Outpatient	1 hour	$115.00
Comments:								
10/17/2005	Psychologist, David A	10:00 am	Completed	Harrisburg, Pa	90806 Psychotherapy-Individual	Outpatient	1 hour	$115.00
Comments:								
10/24/2005	Psychologist, David A	09:00 am	Completed	Harrisburg, Pa	90806 Psychotherapy-Individual	Outpatient	1 hour	$115.00
Comments:								
12/19/2005	Psychologist, David A	10:00 am	Pending	Harrisburg, Pa	90806 Psychotherapy-Individual	Outpatient	1 hour	$115.00
Comments:								
12/26/2005	Psychologist, David A	10:00 am	Pending	Harrisburg, Pa	90806 Psychotherapy-Individual	Outpatient	1 hour	$115.00
Comments:								
01/26/2006	Psychologist, David A	11:00 am	Pending	Harrisburg, Pa	90806 Psychotherapy-Individual	Outpatient	1 hour	$115.00
Comments:								
05/31/2006	Psychologist, David A	12:00 pm	Completed	Harrisburg, Pa	90806 Psychotherapy-Individual	Outpatient	1 hour	$115.00
Comments:								
06/01/2006	Psychologist, David A	11:00 am	Completed	Harrisburg, Pa	90806 Psychotherapy-Individual	Outpatient	1 hour	$115.00
Comments:								
06/06/2006	Psychologist, David A	10:00 am	Pending	Harrisburg, Pa	90806 Psychotherapy-Individual	Outpatient	1 hour	$115.00
Comments:								
06/07/2006	Psychologist, David A	11:00 am	Pending	Harrisburg, Pa	90806 Psychotherapy-Individual	Outpatient	1 hour	$115.00
Comments:								
							11 hours 1 min.	$1,400.00

5. In the **Patient Activity Listing** browser window, **Select File**
6. **Click** Close

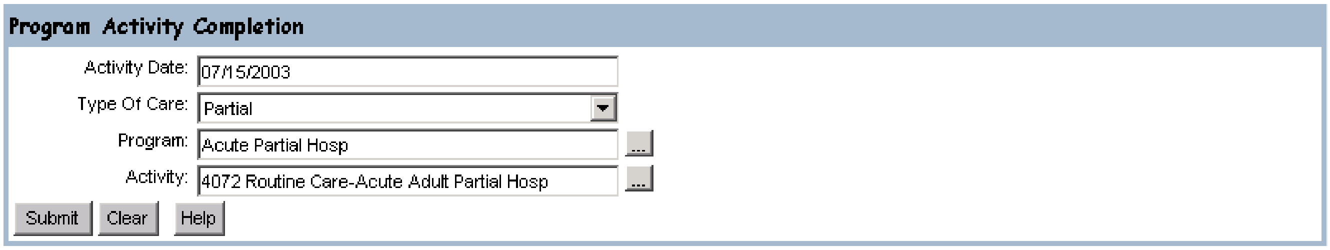


Program Activity Completion

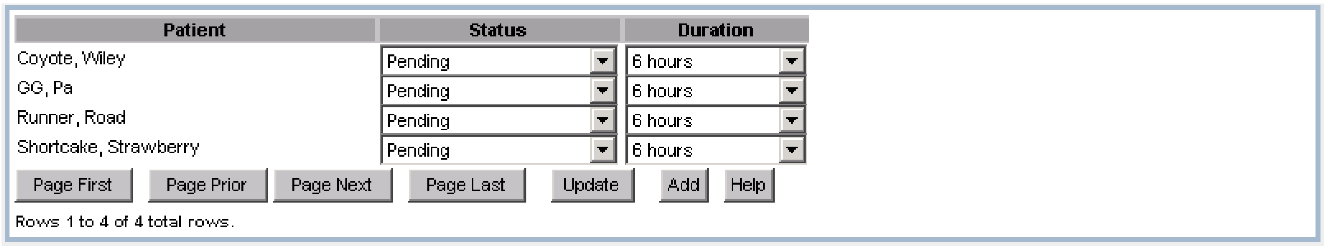
The View Program Activity Completion function allows users to view a list of the routine Program based activity records for an Activity Date, Type Of Care, Program and Activity.

1. **Click** on the **Program Activity Completion** from the **Service Activity** main menu
2. **Enter** the **Following:**

Activity Date	7/15/2003
Type Of Care	Partial
Program	Acute Partial Hosp
Activity	4072 Routine Care-Acute Adult Partial Hosp



3. **Click** Submit



4. **Click** Add
5. **Enter** the **Following:**

Patient	Your Patient
Patient Activity Status	Pending
Duration	6 Hours

6. **Click** Update
7. **Change** the **Following**:

Status	Completed

8. **Click** Update

A user is also able to access the following functions: Create Program Activity function and the Edit Program Activity function.