

Betasky Manual

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Chapter 1: Sandbox Signup & Initial Access

Chapter Overview

What You'll Learn:

- What is the Sandbox environment and why it matters
- How to create your agency account using the self-service signup
- Understanding Guided Onboarding vs Self-Service Sandbox
- How to log in for the first time
- Navigating the dashboard and understanding key features
- Accessing Agency Settings and reviewing your profile
- Understanding the difference between Sandbox and Production

Who Should Read This: Agency Administrators, anyone setting up a new agency account

1.1 Sandbox Environment Overview

What is the Sandbox Environment?

The **Sandbox** is a safe, isolated testing environment where you can:

- Learn the system without affecting real patient data
- Test workflows and features
- Train your staff
- Experiment with configurations
- Practice documentation before going live
- **Automatically populated with demo data** to help you explore immediately

TIP: Think of Sandbox as your "practice area" - nothing you do here affects real patients or billing.

Sandbox vs Production

Feature	Sandbox	Production
Purpose	Testing & Training	Real Patient Care
Patient Data	Demo/Test Data Only	Real PHI
OASIS Export	Disabled	Enabled
OASIS Submission	Cannot submit to CMS	Can submit to CMS

Feature	Sandbox	Production
Billing	Test claims only	Real claims
CCN Required	Optional	Required
Cost	Free	Subscription Required
Demo Data	Auto-populated	N/A

IMPORTANT: You MUST complete sandbox testing before requesting production access. Production requires a valid CCN (CMS Certification Number) and paid subscription.

NOTE: All Sandbox agencies have demo data pre-loaded with sample patients, care orders, visits, and OASIS assessments so you can explore features immediately.

1.2 Getting Started: Two Onboarding Options

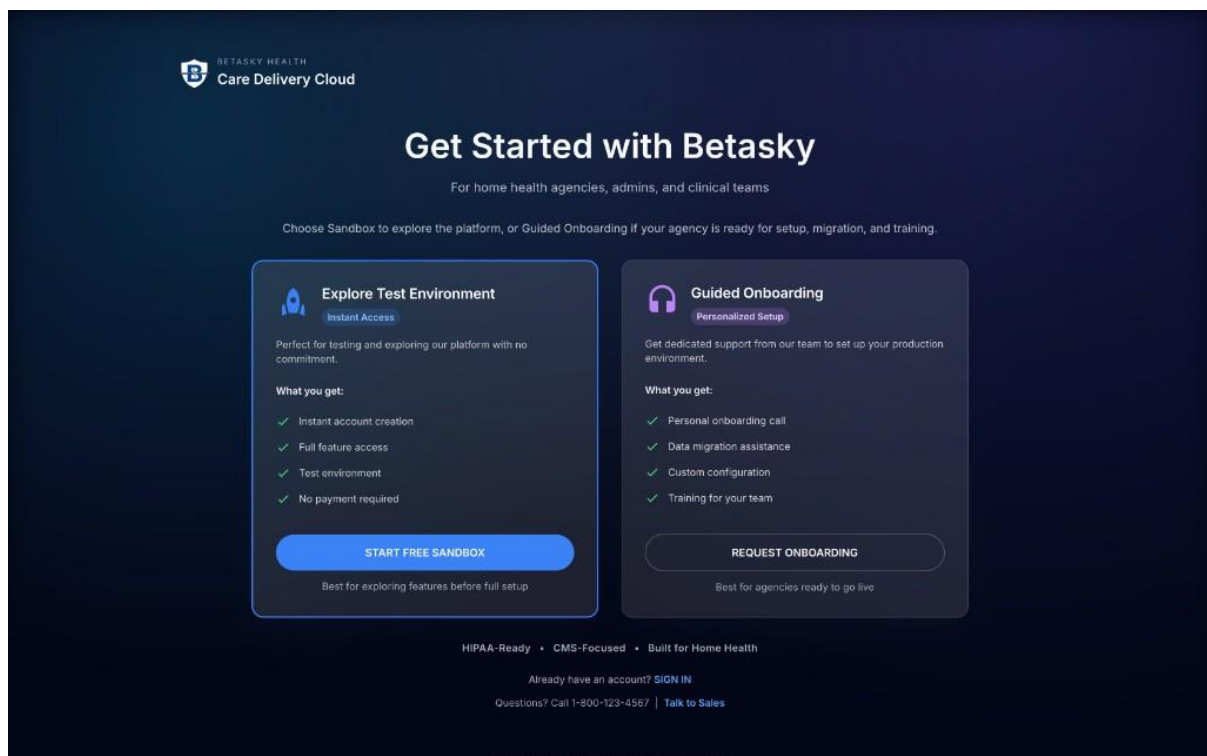
When you visit the Betasky Health platform, you have two ways to get started:

Step 1: Navigate to the Get Started Page

Open your web browser and navigate to: <https://app.betaskyhealth.com/>

You'll see the "Get Started with Betasky" page:

Screenshot 1: Get Started page showing two onboarding options



Understanding Your Two Options

Option 1: Explore Test Environment (Self-Service Sandbox)

Recommended for Quick Start

This is the **instant access** option. Perfect for:

- Testing and exploring the platform with no commitment
- Full feature access immediately
- Test environment (Sandbox mode)
- No payment required
- Demo data automatically populated

What you get:

- Instant account creation
- Full feature access
- Test environment
- No payment required

Best for: Exploring features before full setup

Option 2: Guided Onboarding (Personalized Setup)

This is the **white-glove service** option. Perfect for:

- Agencies ready for production setup
- Need help with data migration
- Want personalized configuration
- Require team training

What you get:

- Personal onboarding call
- Data migration assistance
- Custom configuration
- Training for your team

Best for: Agencies ready to go live

Screenshot 2: Request Guided Onboarding form with agency information fields

The image shows a dark-themed web form titled "Request Guided Onboarding" for Retasky Health Care Delivery Cloud. The form is centered and contains several input fields: "Agency Name *", "Contact Name *", "Email *", "Phone (Optional)" with a format hint "+1(345)7890", "Current EHR System (Optional)" with examples "e.g., Aesop, Workday, etc.", and "Number of Patients (Optional)" with a dropdown arrow. There is also a text area for "Additional Notes (Optional)". Below the form is a blue "Submit Inquiry" button. At the bottom, a small line of text states: "Your information is secure and will only be used to contact you about onboarding."

TIP: For this manual, we'll focus on **Option 1: Self-Service Sandbox** since it gives you immediate access to explore the system.

1.3 Creating Your Sandbox Agency Account (Self-Service)

Prerequisites

Before you begin, make sure you have:

- Agency name (can be anything for testing)
- Agency address
- Valid business email address
- Phone number
- Modern web browser (Chrome, Firefox, Safari, or Edge)

NOTE: For Sandbox testing, you can use placeholder information. For production, accurate information is required.

Step-by-Step Signup Process

Step 1: Click "START FREE SANDBOX"

From the Get Started page (Screenshot 1), click the blue **"START FREE SANDBOX"** button under "Explore Test Environment."

You'll be taken to a 5-step signup wizard.

Step 2: Enter Your Agency Name

Screenshot 3: Step 1 - Agency name entry

The screenshot shows a dark-themed web interface for 'BETASKY HEALTH Care Delivery Cloud'. The main heading is 'Start Your Free Sandbox' with the subtitle 'Basic information about your organization'. A progress bar at the top indicates five steps: 1. Agency (active), 2. Location, 3. Contact & IDs, 4. Administrator, and 5. Review. The main form area is titled 'Your agency' with the instruction 'The name of your home health organization'. It contains a text input field labeled 'Agency name *' with the value 'Sunrise Home Health Agency' and a hint 'e.g. Sunrise Home Health Agency'. Below the input field are two buttons: '← Back' and 'Continue →'. At the bottom, there is a small disclaimer: 'By continuing you agree to our Terms of Service and Privacy Policy.' and a link '← Back to signup options'. The footer states '© 2026 Betasky Home Health. All rights reserved.'

Your agency - The name of your home health organization

1. Agency name* (required)

- Enter your agency's name
- Example: "Sunrise Home Health Agency"
- This will appear throughout the system

2. Click the blue **"Continue"** button to proceed

TIP: You can use any name for sandbox testing. This can be changed later if needed.

PROGRESS INDICATOR: You'll see steps at the top: 1. Agency → 2. Location → 3. Contact & IDs → 4. Administrator → 5. Review

Step 3: Enter Agency Address (Location)

Screenshot 4: Step 2 - Agency physical address

BETASKY HEALTH
Care Delivery Cloud

Start Your Free Sandbox

Your agency's physical address

1. Agency 2. Location 3. Contact & IDs 4. Administrator 5. Review

Agency address

Primary physical location of your agency

Street address *

1200 Medical Center Drive

Suite / floor (optional)

Suite 200

City *

Austin

State *

Texas

Zip code *

78701

← Back Continue →

By continuing you agree to our Terms of Service and Privacy Policy.

← Back to signup options

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Agency address - Primary physical location of your agency

Fill in the following fields:

1. **Street address*** (required)
 - Example: "1200 Medical Center Drive"
2. **Suite / floor (optional)**
 - Example: "Suite 200"
3. **City*** (required)
 - Example: "Austin"
4. **State*** (required)
 - Dropdown selection
 - Example: "Texas"
5. **Zip code*** (required)
 - Example: "78701"
6. Click "**Continue**"

Step 4: Enter Contact Information and Provider Identifiers

Screenshot 5: Step 3 - Contact details and provider identifiers

This screen has two sections:

Section 1: Agency contact

How patients and payers can reach your agency

1. Agency phone* (required)

- Format: (###) ###-####
- Example: "5125550100"
- Note: "Any number works for sandbox"

2. Fax* (required)

- Format: (###) ###-####
- Example: "5125550199"
- Note: "Any number works for sandbox"

3. Agency email* (required)

- Agency general email
- Example: "info@sunrisehomehealth-demo.test"

Section 2: Provider identifiers

Placeholder values are fine for sandbox — update before going live

4. National Provider ID (NPI)* (required)

- 10-digit number issued by CMS
- Example: "1234567989"
- **NOTE:** For sandbox, any 10-digit number works. For production, you need your actual NPI from <https://npiregistry.cms.hhs.gov>

5. CMS Certification Number (CCN) (optional)

- 6-character code (2 letters + 4 digits)
- Example: "HI23456"
- **IMPORTANT:** Optional for sandbox. **REQUIRED** for production and Medicare billing.
- Format: State code (2 letters) + 4 digits (e.g., TX1234, CA5678)

6. Tax ID / EIN (optional)

- Federal Employer Identification Number
- Example: "12-3456789"

7. Click "Continue"

WHAT IS CCN?

The CMS Certification Number proves your agency is certified by Medicare to provide home health services. **Without CCN, you cannot:**

- Go live to production
- Bill Medicare
- Submit OASIS to CMS

You receive your CCN after passing Medicare certification survey. This is **optional in sandbox** but **required for production**.

Step 5: Create Administrator Account

Screenshot 6: Step 4 - Administrator account creation

BETASKY HEALTH
Care Delivery Cloud

Start Your Free Sandbox

The person who will manage this account

✓ Agency ✓ Location ✓ Contact & IDs **4. Administrator** 5. Review

Administrator account

This person gets full admin access. The email and password below are used to sign in.

First name *
Jordan

Last name *
Rivera

Work email *
jo@jo.j

This will be your login username

Administrator phone *
5555555555

Same as agency line is fine for sandbox, you can update later

Password

Must be at least 8 characters with uppercase, lowercase, and a number

Password *
.....

8+ chars Upper & lower Number

Confirm password *
.....

← Back Continue →

Administrator account

This person gets full access. The email and password below are used to sign in.

Personal Information:

1. **First name*** (required)

- Your first name
- Example: "Jordan"

2. **Last name*** (required)

- Your last name
- Example: "Rivera"

3. **Work email*** (required)

- This will be your **login username**
- Must be a valid email you can access
- Example: "jo@jo.j"
- **IMPORTANT:** You'll use this email to log in

4. **Administrator phone*** (required)

- Your phone number
- Example: "555555555"
- Note: "Same as agency line is fine for sandbox; you can update later"

Password Requirements:

5. **Password*** (required)

- Must be at least 8 characters
- Must contain:
 - 8+ characters (green checkmark when met)
 - Upper & lower case letters (green checkmark when met)
 - A number (green checkmark when met)
- Example: "....." (shown as dots)
- **Eye icon:** Click to show/hide password

6. **Confirm password*** (required)

- Re-enter the same password
- Must match exactly

TIP: Use a password manager to generate and store a strong password.

SECURITY: Never share your admin credentials. Each staff member should have their own account.

Password strength indicator:

- Green bar: "Strong" password
- All three requirements checked with green ✓ icons

7. Click "**Continue**"

Step 6: Review and Create Account

Screenshot 7: Step 5 - Review information and create account

RETASKY HEALTH
Care Delivery Cloud

Start Your Free Sandbox

Confirm everything and create your account

✓ Agency ✓ Location ✓ Contact & IDs ✓ Administrator **5. Review**

Review your information

Check everything before creating your account

AGENCY

Name: Sunrise Home Health Agency

ADDRESS

Street: 1200 Medical Center Drive, Suite 200
City / State / Zip: Austin, Texas 78701

CONTACT & IDS

Phone: 5125550100
Fax: 5125550199
Email: info@sunrisehomehealth-demo.test
NPI: 1234567999
CCN: HI23456
Tax ID: 12-3456789

ADMINISTRATOR

Name: Jordan Rivera

Review your information

Check everything before creating your account

This screen shows a summary of all information you entered:

AGENCY

- Name: Sunrise Home Health Agency

ADDRESS

- Street: 1200 Medical Center Drive, Suite 200
- City / State / Zip: Austin, Texas 78701

CONTACT & IDS

- Phone: 5125550100
- Fax: 5125550199
- Email: info@sunrisehomehealth-demo.test
- NPI: 1234567999
- CCN: HI23456
- Tax ID: 12-3456789

ADMINISTRATOR

- Name: Jordan Rivera
- Email: jo@jo.j

- Phone: 5555555555
- Password: (hidden)

Important Option:

Screenshot 8: Review page (scrolled) showing demo data checkbox

At the bottom, you'll see:

Populate with demo data

Adds 4 sample patients with care orders and OASIS visits so you can explore the platform right away.

RECOMMENDED: Leave this checkbox **CHECKED** for sandbox testing. This will:

- Add 4 sample patients
- Create sample care orders
- Add sample visits
- Include sample OASIS assessments
- Help you explore features immediately without manual data entry

Final Steps:

1. Review all information carefully
2. ← **Back** button: Go back to edit any section
3. Ensure "Populate with demo data" is **checked**

4. Click the blue **"Create Sandbox Account"** button

By continuing you agree to our Terms of Service and Privacy Policy

← Back to signup options (link at bottom)

Step 7: Account Created - Redirecting to Dashboard

After clicking "Create Sandbox Account," the system will:

- Create your agency
- Create your administrator account
- Populate demo data (if checked)
- Automatically log you in
- Redirect you to the dashboard

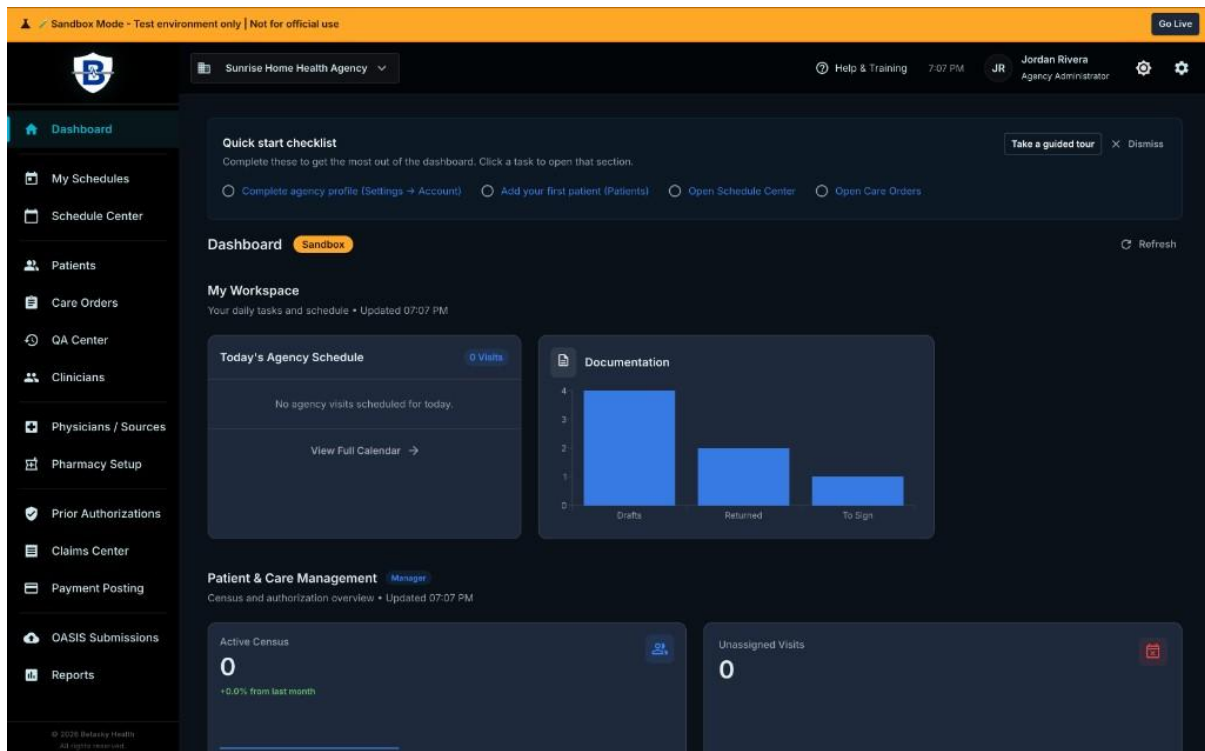
NO EMAIL VERIFICATION REQUIRED - You're logged in immediately!

1.4 First Login - Dashboard Overview

Welcome to Your Dashboard!

After account creation, you'll be automatically logged into your dashboard:

Screenshot 9: Dashboard after first login with Sandbox mode indicator



SUCCESS: You're now logged into your Sandbox agency!

Understanding the Dashboard Layout

Let's explore what you're seeing:

1. Sandbox Mode Banner (Top - Orange Bar)

Screenshot 10: Sandbox Mode banner at the top



"Sandbox Mode - Test environment only | Not for official use"

This orange banner appears on **every page** while you're in Sandbox mode. It reminds you that:

- You're in a test environment
- No data is official
- Claims and OASIS submissions are disabled

"Go Live" button - Click this when you're ready to request production access (covered in the **Going Live (Sandbox → Production)** chapter)

2. Top Navigation Bar

From left to right:

- **Betasky Logo** - Click to return to dashboard
- **Agency Selector** - "Sunrise Home Health Agency" dropdown (for multi-agency users)
- **Help & Training** - Access training resources
- **Time** - Current time (7:02 PM in screenshot)
- **User Info** - "JR" avatar, "Jordan Rivera", "Agency Administrator"
- **Notification Bell** (if applicable)
- **Settings Gear** - Quick settings access
- **System Settings** - Additional settings

3. Left Sidebar Navigation

Your main menu for accessing all system features:

Currently visible sections:

- **Dashboard** (currently selected - blue highlight)
- **My Schedules**
- **Schedule Center**
- **Patients**
- **Care Orders**

- **QA Center**
- **Clinicians**
- **Physicians / Sources**
- **Pharmacy Setup**
- **Prior Authorizations**
- **Claims Center**
- **Payment Posting**
- **OASIS Submissions**
- **Reports**

TIP: We'll explore each of these sections in detail in later chapters.

4. Quick Start Checklist

At the top of the dashboard, you'll see:

"Quick start checklist"

Complete these to get the most out of the dashboard. Click a task to open that section.

This checklist helps you complete essential setup tasks:

- ☐ **Complete agency profile (Settings → Account)**
- ☐ **Add your first patient (Patients)**
- ☐ **Open Schedule Center**
- ☐ **Open Care Orders**

You can:

- **Take a guided tour** - Interactive walkthrough of the system
- **Dismiss** - Hide the checklist

TIP: Even if you dismiss this, you can always access these features from the sidebar.

NOTE: Since "Populate with demo data" was checked during signup, you already have sample patients and care orders! This checklist is optional for sandbox exploration.

5. My Workspace

"Your daily tasks and schedule • Updated 07:07 PM"

This section shows your personal workspace:

Today's Agency Schedule

- Shows: "0 Visits"
- Currently: "No agency visits scheduled for today"
- **View Full Calendar** → button

Documentation

- Bar chart showing:
 - Drafts: 4 (blue bar - tallest)
 - Returned: 2 (blue bar - medium)
 - To Sign: 1 (blue bar - short)

6. Patient & Care Management (Manager Section)

"Census and authorization overview • Updated 07:07 PM"

Active Census

- Shows: **0**
- "+0.0% from last month" (green text)

Unassigned Visits

- Shows: **0**

NOTE: These numbers will update as you explore and add data, or you can view the pre-populated demo data by navigating to the Patients or Schedule Center sections.

Exploring Demo Data

Since you checked "Populate with demo data" during signup, you have:

- 4 sample patients
- Sample care orders
- Sample OASIS visits
- Sample assessments

To view demo data:

1. Click **"Patients"** in the left sidebar
2. Or click **"Open Schedule Center"** from the Quick Start Checklist
3. Or click **"Care Orders"** to see episodes of care

We'll explore these in detail in later chapters!

1.5 Accessing User Menu and Settings

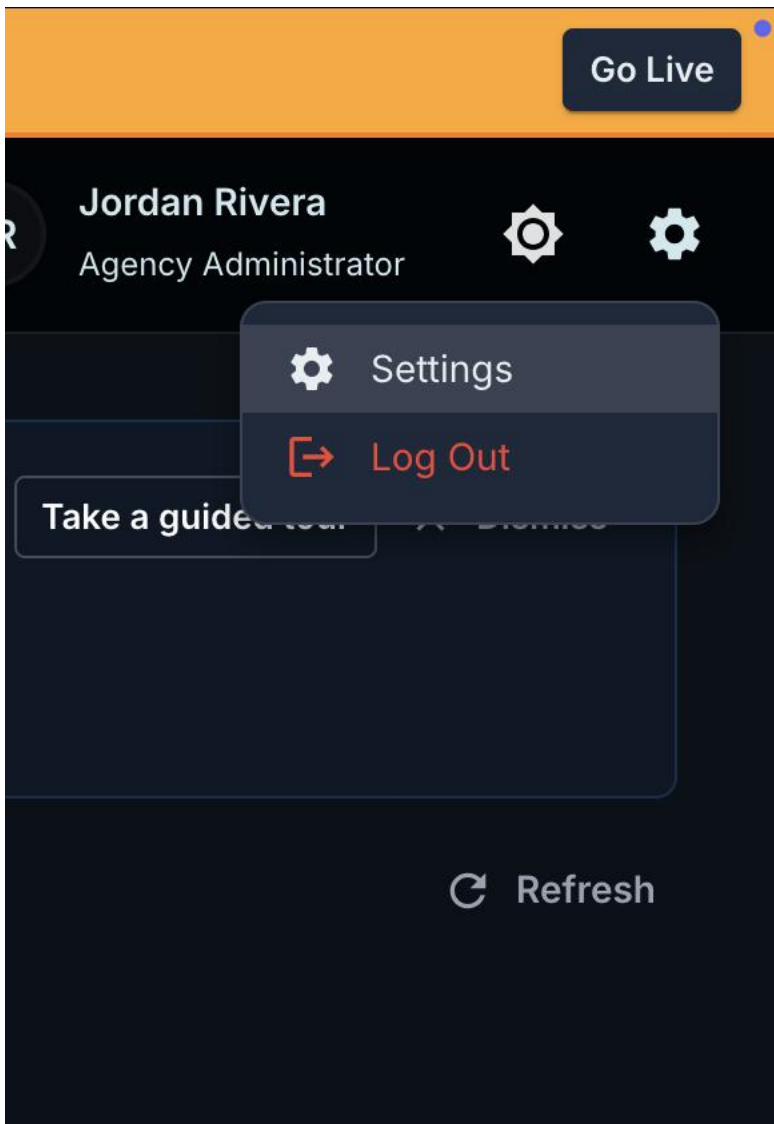
Understanding Your User Account Options

Let's explore the user menu in the top-right corner.

Step 1: Click Your User Info

Click on your name or avatar in the top-right corner:

Screenshot 11: User dropdown menu showing Settings and Log Out options



You'll see a dropdown menu with:

Jordan Rivera

Agency Administrator

Two options:

- **Settings** - Access your account and agency settings
- **Log Out** - Sign out of the system (red text)

TIP: Click **Settings** to access agency information, user management, and system configuration.

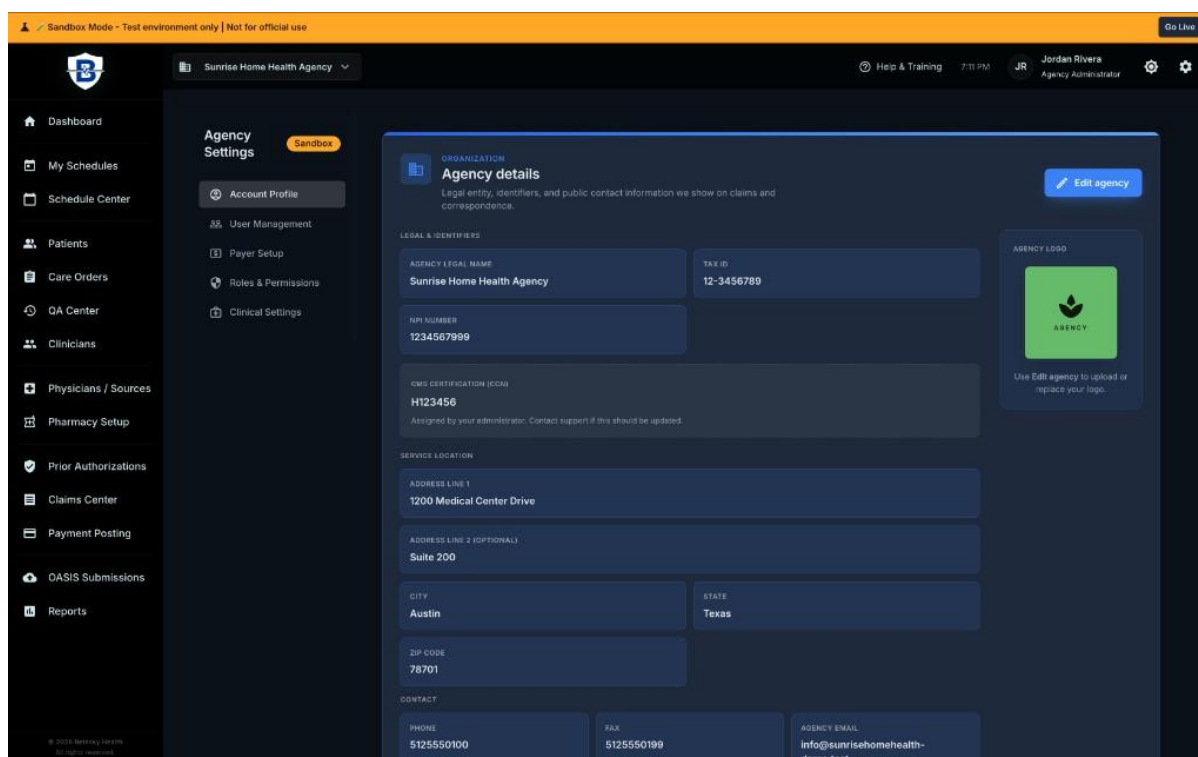
1.6 Agency Settings Overview

Accessing Agency Settings

From the user menu (Screenshot 11), click **Settings**.

You'll be taken to the Agency Settings page:

Screenshot 12: Agency Settings page showing agency details and left sidebar menu



Agency Settings Layout

The Agency Settings area has:

Left Sidebar Menu (Settings Navigation)

- **Account Profile** (currently selected)
- **User Management**
- **Payer Setup**
- **Roles & Permissions**
- **Clinical Settings**

We'll focus on **Account Profile** in this chapter. Other sections are covered in Chapters 4-13.

Reviewing Your Agency Profile

The **Account Profile** page shows all the information you entered during signup.

You'll see a **Sandbox** badge (orange) next to the page title, reminding you you're in test mode.

ORGANIZATION Section

Agency details

Legal entity, identifiers, and public contact information we show on claims and reports

Screenshot 12a: Organization section showing Agency Legal Name, NPI, CCN, Tax ID, and Agency Logo

ORGANIZATION
Agency details
Legal entity, identifiers, and public contact information we show on claims and correspondence.

LEGAL & IDENTIFIERS

AGENCY LEGAL NAME
Coastal Wellness Home Health

TAX ID
638DCSHDVHSDHV873

NPI NUMBER
4567890123

CMS CERTIFICATION (CCN)
789012
Assigned by your administrator. Contact support if this should be updated.

AGENCY LOGO
Use Edit agency to upload or replace your logo.

[Edit agency](#)

LEGAL & IDENTIFIERS

Fields displayed:

- **AGENCY LEGAL NAME:** Sunrise Home Health Agency
- **TAX ID:** 12-3456789
- **NPI NUMBER:** 1234567989
- **CMS CERTIFICATION (CCN):** HI23456
 - Note below: "Assigned by your administrator. Contact support if this should be updated"

AGENCY LOGO (Right side)

- Green placeholder icon showing "AGENCY"
- Text: "Use Edit agency to upload or replace your logo."

Edit agency button (blue) - Click to edit these fields

SERVICE LOCATION Section

Screenshot 12b: Service Location section showing address fields

SERVICE LOCATION

ADDRESS LINE 1
789 Oceanview Parkway

ADDRESS LINE 2 (OPTIONAL)
—

CITY
San Diego

STATE
Massachusetts

ZIP CODE
92101

ADDRESS LINE 1: 1200 Medical Center Drive

ADDRESS LINE 2 (OPTIONAL): Suite 200

CITY: Austin

STATE: Texas (dropdown)

ZIP CODE: 78701

CONTACT Section (Scroll down to see)

Screenshot 13a: Contact section showing Phone, Fax, and Agency Email

CONTACT

PHONE
(555) 123-4568

FAX
(555) 123-4567

AGENCY EMAIL
info@agency.com

PHONE: 5125550100

FAX: 5125550199

AGENCY EMAIL: info@sunrisehomehealth-demo.test

Security Section (Below Contact)

Screenshot 13b: Security section showing Change password button

Security
Protect your login — use a strong, unique password

Change password

Security

Protect your login — use a strong, unique password

Change password button - Click to update your password

Account Section (Bottom)

Screenshot 13c: Account section showing Log out button



Account

End your session on this device

Log out button - Sign out of the system

Editing Agency Information

To update any agency information:

1. Scroll to the section you want to edit
2. Click the **Edit agency** button (blue, top-right)
3. Make your changes
4. Click **Save** (button will appear after editing)

TIP: You can update agency information at any time. Changes take effect immediately.

IMPORTANT: Some fields like CCN may require admin approval before changes are saved.

1.7 Understanding Sandbox vs Production

Now that you're in the system, let's understand the key differences between where you are (Sandbox) and where you'll eventually go (Production).

Current Status: Sandbox Mode

Every page in Sandbox mode displays the orange banner at the top:

Screenshot 10 (repeated): Sandbox Mode banner



Sandbox Mode - Test environment only | Not for official use

Sandbox Environment - What You Have Now

Available Features:

- Full system access for testing

- All core features enabled
- User management
- Patient intake and care orders
- Visit scheduling
- OASIS form completion (but cannot submit to CMS)
- QA review workflows
- Claims generation (test mode only)
- Prior authorization management
- All reports and analytics
- **Demo data pre-populated** (4 patients, care orders, visits)

Limitations (Sandbox Only):

- Cannot export OASIS XML for CMS submission
- Cannot mark OASIS as "Submitted to CMS"
- Claims are test claims only (not real billing)
- No integration with real clearinghouses
- Data is isolated (test data only)

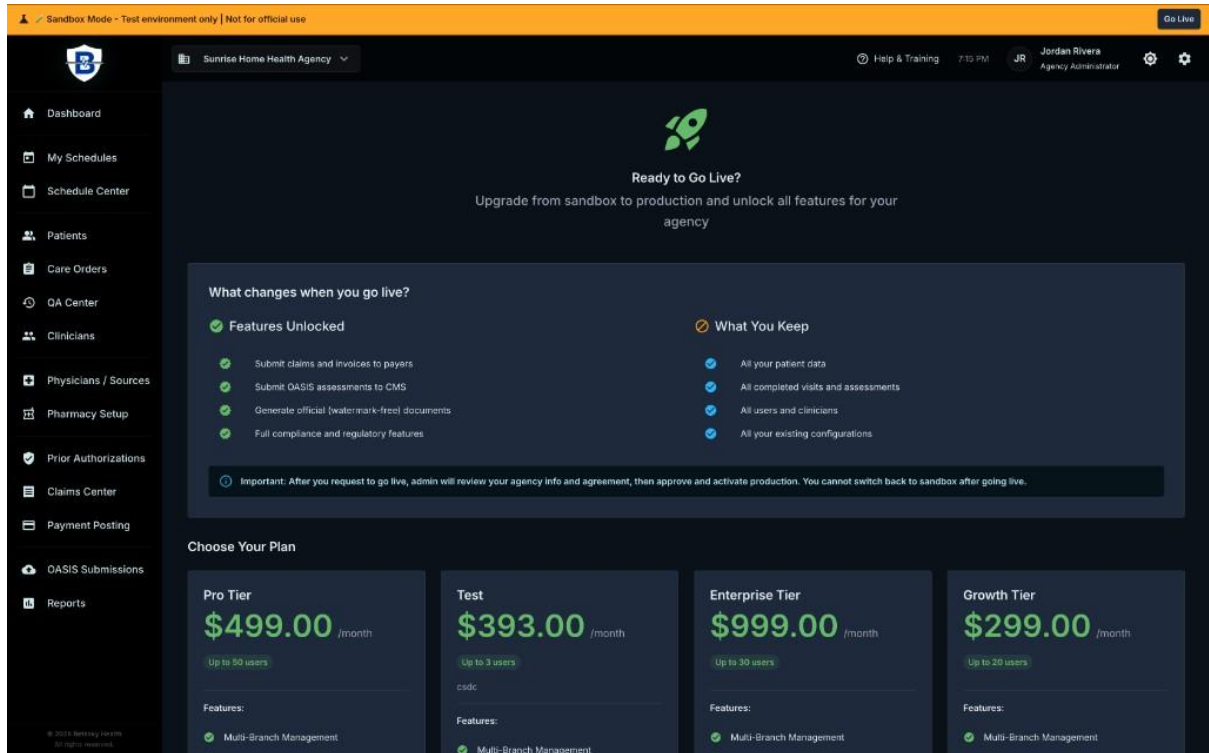
Best Use Cases for Sandbox:

- Train new staff members
- Test workflows before production use
- Practice documentation
- Set up templates and preferences
- Learn the system thoroughly
- Test new features when released

Production Environment - What Comes Next

When you click the **"Go Live"** button in the orange banner, you'll see:

Screenshot 14: Ready to Go Live modal showing features unlocked and plan options



Ready to Go Live?

Upgrade from sandbox to production and unlock all features for your agency

What Changes When You Go Live?

Features Unlocked:

- Submit claims and invoices to payers
- Submit OASIS assessments to CMS
- Generate official watermark-free documents
- Full compliance and regulatory features

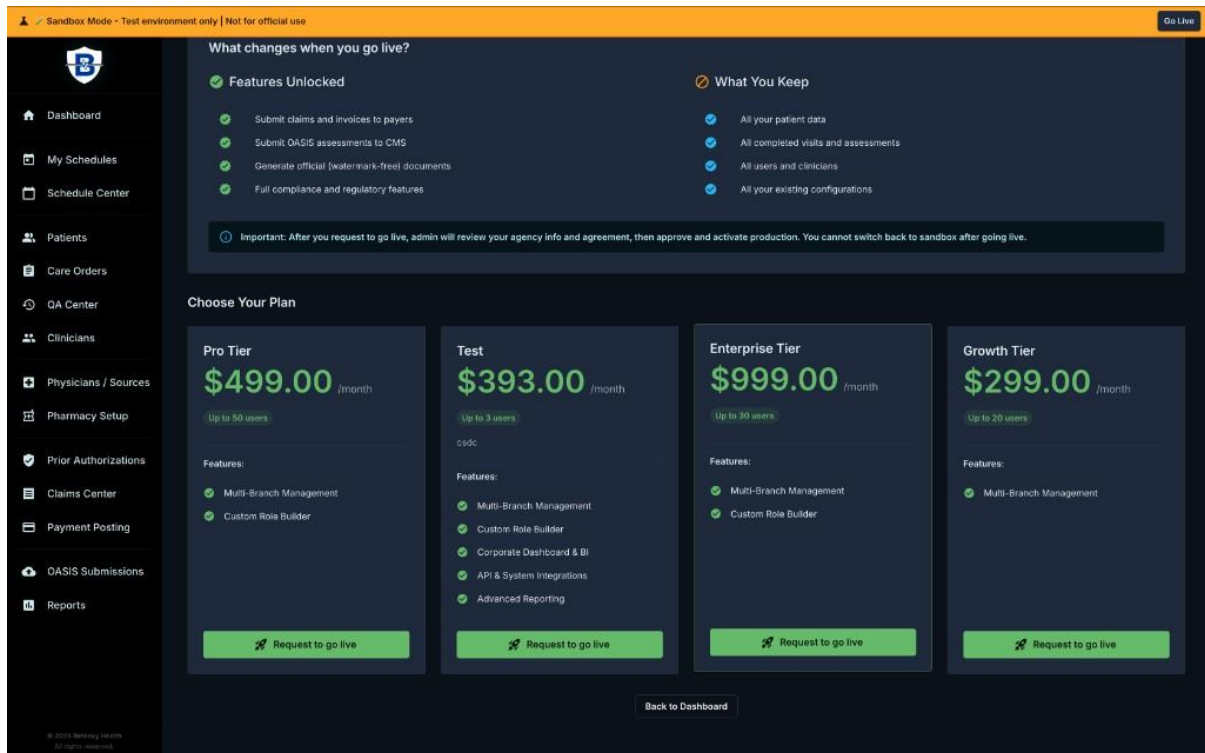
What You Keep:

- All your patient data
- All completed visits and assessments
- All users and clinicians
- All your existing configurations

Important: After you request to go live, admins will review your agency info and agreement, then approve and activate production. You cannot switch back to sandbox after going live.

Choosing Your Subscription Plan

Screenshot 15: Subscription plan options (Pro, Test, Enterprise, Growth Tiers)



Choose Your Plan

Four subscription tiers are available:

1. Pro Tier - \$499.00/month

- Up to 50 users
- Features:
 - Multi-Branch Management
 - Custom Role Builder

2. Test - \$393.00/month

- Up to 3 users
- Code: csdc
- Features:
 - Multi-Branch Management
 - Custom Role Builder
 - Corporate Dashboard & BI
 - API & System Integrations
 - Advanced Reporting

3. Enterprise Tier - \$999.00/month

- Up to 30 users
- Features:

- Multi-Branch Management
- Custom Role Builder

4. **Growth Tier** - \$299.00/month

- Up to 20 users
- Features:
 - Multi-Branch Management

Each plan includes a **Request to go live** button.

At the bottom: **Back to Dashboard** button

When Should You Go Live to Production?

Consider requesting production access when:

Agency Requirements Met:

- Medicare certification complete (CCN received)
- State license active
- Insurance/bonding in place
- Policies and procedures documented

System Training Complete:

- Admin trained on all features
- Clinicians trained on visit documentation
- Schedulers trained on calendar management
- Billers trained on claims process
- QA staff trained on review workflows

Testing Complete:

- Practiced full patient admission workflow
- Completed test OASIS assessments
- Scheduled and documented test visits
- Generated test claims
- Reviewed all reports

Data Ready:

- Payers configured
- Fee schedules set up

- Physicians added
- Pharmacies added
- Visit types configured
- Users created with correct roles

TIP: Most agencies spend 2-4 weeks in Sandbox before going live.

Production Requirements

Production Requirements:

- Valid CCN (CMS Certification Number)
- Medicare certification completed
- Paid subscription plan selected
- Go-Live request approved by admins
- Staff training completed
- Policies and procedures in place

NOTE: See the **Going Live (Sandbox → Production)** chapter for complete details on the go-live process.

1.8 Logging Out and Logging Back In

How to Log Out

You have two ways to log out:

Method 1: From User Menu

1. Click your name in the top-right corner
2. Click **Log Out** (red text)

Method 2: From Agency Settings

1. Navigate to Settings → Account Profile
2. Scroll to the **Account** section at the bottom
3. Click **Log out** button

Logging Back In

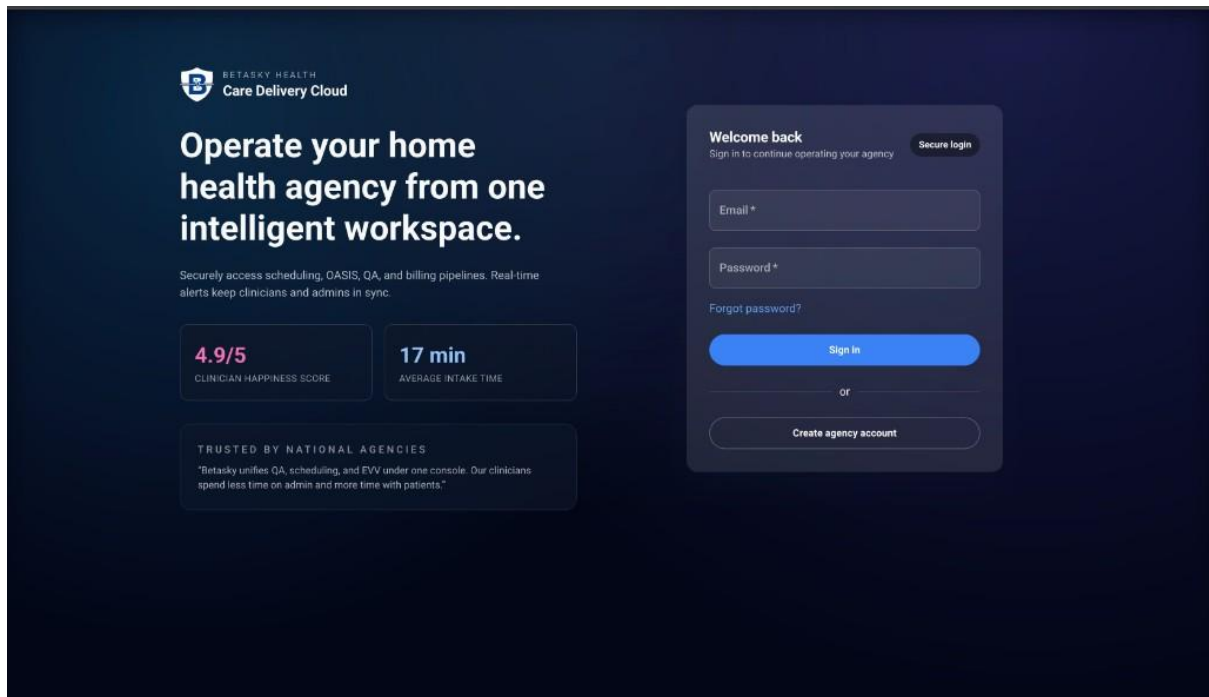
To access your account again:

Step 1: Navigate to Login Page

Go to: <https://app.betaskyhealth.com/>

You'll see the login page:

Screenshot 16: Login page



Step 2: Enter Your Credentials

Welcome back

Sign in to continue operating your agency

On the right side, you'll see the login form:

1. Email* (required)

- Enter the email you used during signup
- Example: "testbetasky@gmail.com" (shown in screenshot)

2. Password* (required)

- Enter your password
- Shown as dots (·····)

Forgot password? link - Click if you need to reset your password

Step 3: Click "Sign In"

Click the blue **"Sign in"** button.

After successful login, you'll be taken back to the dashboard.

Alternative options on login page:

or

Create agency account button - For new users who haven't signed up yet

Left side of login page shows:

- "Operate your home health agency from one intelligent workspace."
- "Securely access scheduling, OASIS, QA, and billing pipelines. Real-time alerts keep clinicians and admins in sync."
- **4.9/5 CLINICIAN HAPPINESS SCORE**
- **17 min AVERAGE INTAKE TIME**
- Trusted by national agencies testimonial

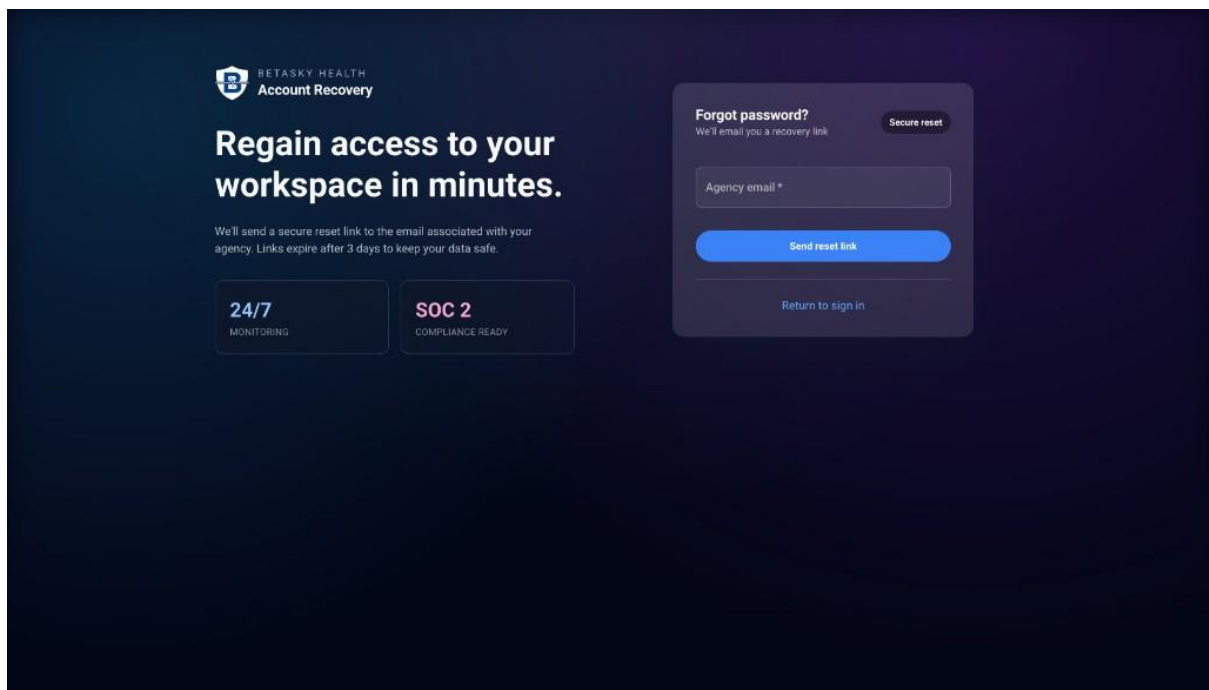
SECURITY:

- Click the eye icon () next to the password field to show/hide your password
- Use "Secure login" tab if available for additional security

Forgot Password?

If you forgot your password:

Screenshot 17: Forgot password page



Forgot password?

We'll email you a recovery link

1. Click "**Forgot password?**" on the login page
2. Enter your **Agency email*** in the field

3. Click the blue **"Send reset link"** button

The system will:

- Send a secure reset link to your email
- Link expires after 3 days to keep your data safe
- Email contains instructions to create a new password

Additional information shown:

- **24/7 MONITORING**
- **SOC 2 COMPLIANCE READY**

Return to sign in link - Go back to the login page

Login Troubleshooting

Common Login Issues:

"Invalid credentials" or "Incorrect email or password"

- Double-check your email spelling
- Verify password (try typing it in a text editor first)
- Check if Caps Lock is on
- Use "Forgot Password?" to reset

"Account not found"

- Verify you're using the correct email
- Check if you completed the signup process
- Contact support if the issue persists

"Account locked" or "Too many attempts"

- Wait 15-30 minutes and try again
- Contact support if issue persists

Browser issues

- Clear browser cache and cookies
- Try a different browser (Chrome, Firefox, Safari, Edge)
- Disable browser extensions temporarily
- Check internet connection

Chapter 2: Dashboard Navigation

Chapter Overview

What You'll Learn:

- Understanding the dashboard layout and main components
- Navigating the left sidebar menu
- Using the header bar and quick actions
- Accessing user profile and settings
- Switching between agencies (multi-agency users)
- Switching between branches (multi-location agencies)
- Understanding system alerts and toast notifications

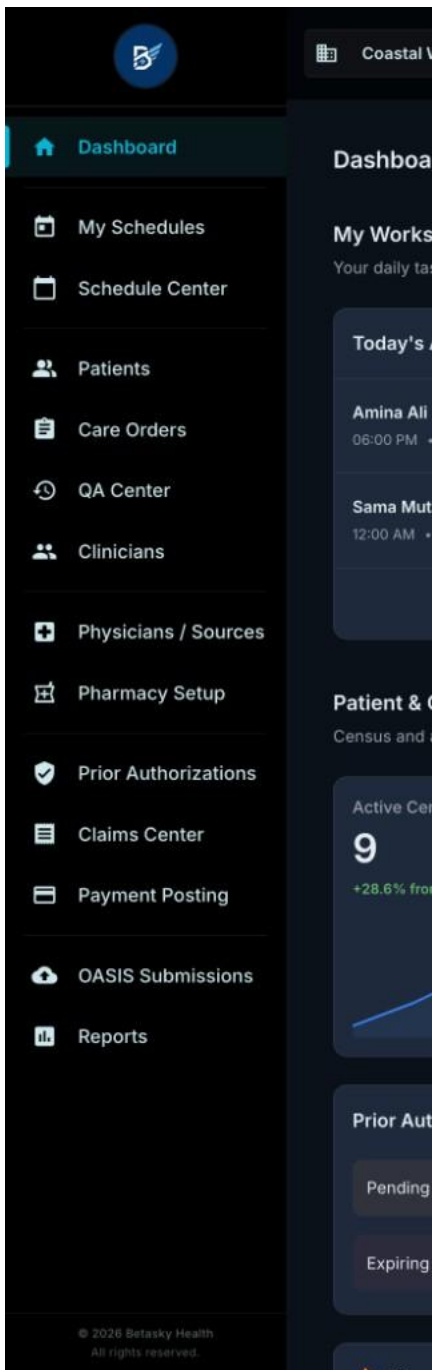
Who Should Read This: All users - this is essential navigation knowledge for using the system

Prerequisites: Complete the **Sandbox Signup** chapter (account created and logged in)

2.1 Dashboard Layout Overview

After logging in, you arrive at the main **Dashboard** - your central hub for all system activities.

Screenshot 1: Complete dashboard showing all major components



Main Components

The dashboard consists of four primary areas:

1. **Left Sidebar** - Main navigation menu (always visible)
2. **Top Header Bar** - Agency selector, user info, quick actions
3. **Main Content Area** - Dashboard widgets and information
4. **Sandbox Banner** (when in sandbox mode) - Orange warning at very top

Let's explore each component in detail.

2.2 Navigation Menu Structure (Left Sidebar)

The left sidebar is your primary navigation tool. It remains visible on all pages for quick access to any feature.

Sidebar Layout

Screenshot 2: Left sidebar showing agency logo and all menu items



Agency Logo

At the top of the sidebar, you'll see:

Custom Agency Logo (if uploaded)

- Your agency's logo appears in a circular icon
- Displays your branding throughout the system
- Click to return to dashboard (home)

Default Betasky Logo (if no logo uploaded)

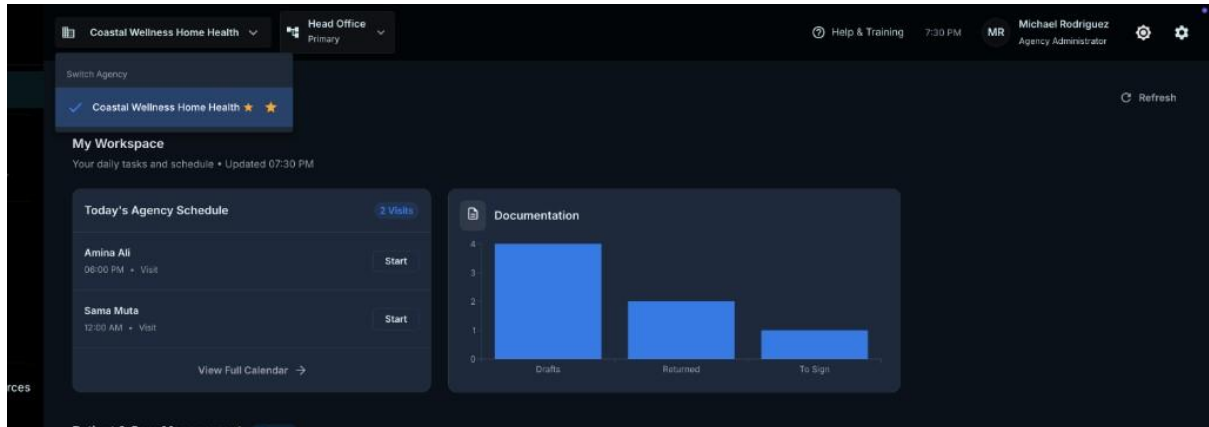
- Shows the Betasky "B" logo
- Indicates no custom logo has been set
- Can upload logo via Settings → Agency Settings

TIP: Upload your agency logo to personalize the interface for your staff. This appears throughout the system and on printed documents.

Complete Menu Structure

The sidebar contains all main navigation items. Let's go through each one:

Screenshot 3: Sidebar with large icons showing all menu items



Primary Navigation Items

1. Dashboard (Blue highlight when selected)

- Your home page
- Shows daily tasks, schedules, and key metrics
- Always the first item

2. My Schedules

- Your personal schedule (clinician view)
- Shows your assigned visits
- Calendar view of your appointments

3. Schedule Center

- Agency-wide scheduling board
- Assign visits to clinicians
- Drag-and-drop scheduling
- View all agency visits

4. Patients

- Patient list and management
- Add new patients
- View patient profiles
- Access intake forms

5. Care Orders

- Episodes of care (60-day periods)
- View all care orders by status

- Create new episodes
- Initiate recertifications

6. QA Center

- Quality assurance review queue
- Review clinical documents
- Approve or return for correction
- Document validation

7. Clinicians

- Staff management
- Add/edit clinician profiles
- Manage user accounts
- Assign roles and permissions

8. Physicians / Sources

- Physician database
- Referral sources
- Facilities (hospitals, SNFs)
- Add/edit physician info

9. Pharmacy Setup

- Pharmacy list
- Add pharmacies
- Manage pharmacy contacts

10. Prior Authorizations

- PA management
- Request authorizations
- Track approved units
- View PA status

11. Claims Center

- Billing and claims
- Ready for billing queue
- Claims tracking

- Denial management

12. Payment Posting

- Post payments to claims
- Remittance processing
- Payment history
- ERA/EOB management

13. OASIS Submissions

- OASIS tracking
- Export OASIS XML (production only)
- Submission status
- CMS submission workflow

14. Reports

- System reports
- Analytics and metrics
- Patient census
- Custom reports

Sidebar Behavior

Always Visible:

- The sidebar stays visible on all pages
- Current page is highlighted in blue
- Scroll to see all menu items

Visual Indicators:

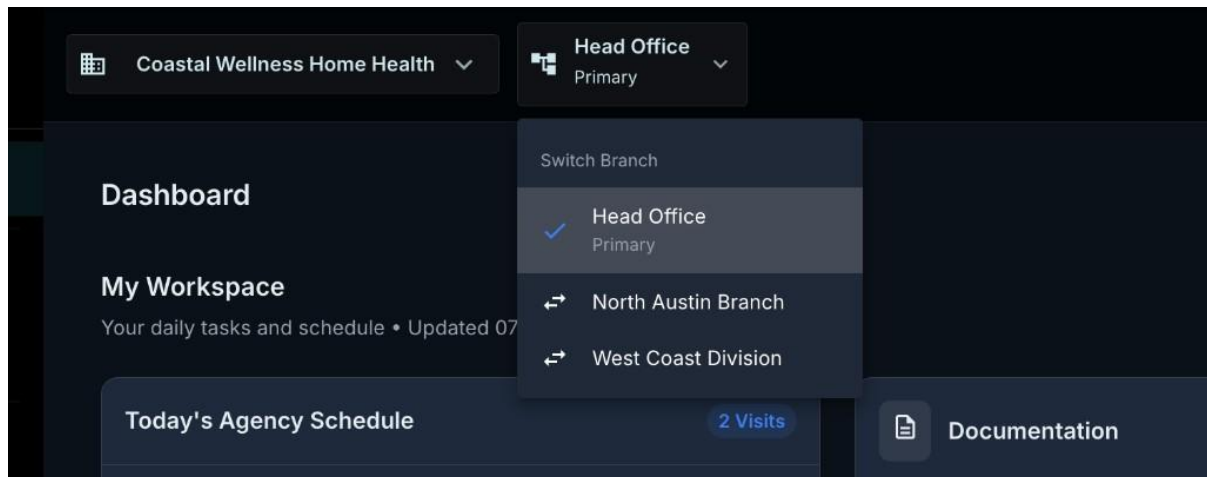
- **Blue background** - Currently selected page
- **White text** - Available menu items
- **Icons** - Visual identification for each section

TIP: Use the sidebar to quickly jump between sections without going back to the dashboard.

2.3 Header Bar & Quick Actions

The top header bar provides global controls and information.

Screenshot 4: Top header bar showing all elements



Header Bar Components (Left to Right)

1. Agency Selector (Left side)

- Shows current agency name
- Dropdown icon (▼) if you have multiple agencies
- Click to switch between agencies

2. Branch Selector (Next to agency)

- Shows current branch name and type
- Example: "Head Office" with "Primary" designation
- Click to switch between branches (multi-location only)
- See Section 2.5 for details

3. Help & Training (Right side)

- Icon with "Help & Training" text
- Access to:
 - User manual
 - Video tutorials
 - Training resources
 - Support documentation

4. Current Time

- Displays current time

- Example: "7:30 PM"
- Useful for time-sensitive tasks

5. User Initials Badge

- Your initials in a circular badge
- Example: "MR" for Michael Rodriguez
- Click to access user menu (see Section 2.4)

6. User Info

- Your full name
- Example: "Michael Rodriguez"
- Your role below name
- Example: "Agency Administrator"

7. Settings Icons (Far right)

- **Settings gear** - Quick settings access
- **System settings** - Additional configuration

Quick Actions from Header

Help & Training:

- Click the  icon to access help resources
- Get training materials
- Watch video tutorials
- Search documentation

User Menu:

- Click your name or initials
- Access Settings, Log Out (covered in the **Sandbox Signup** chapter)

2.4 User Profile & Settings

Clicking your name or initials in the top-right opens the user menu.

[User menu dropdown - same as shown in the Sandbox Signup chapter]

Options Available:

- **Settings** - Access agency settings, user management
- **Log Out** - Sign out of the system (red text)

We covered this in detail in the **Sandbox Signup** chapter.

TIP: Use Settings to access:

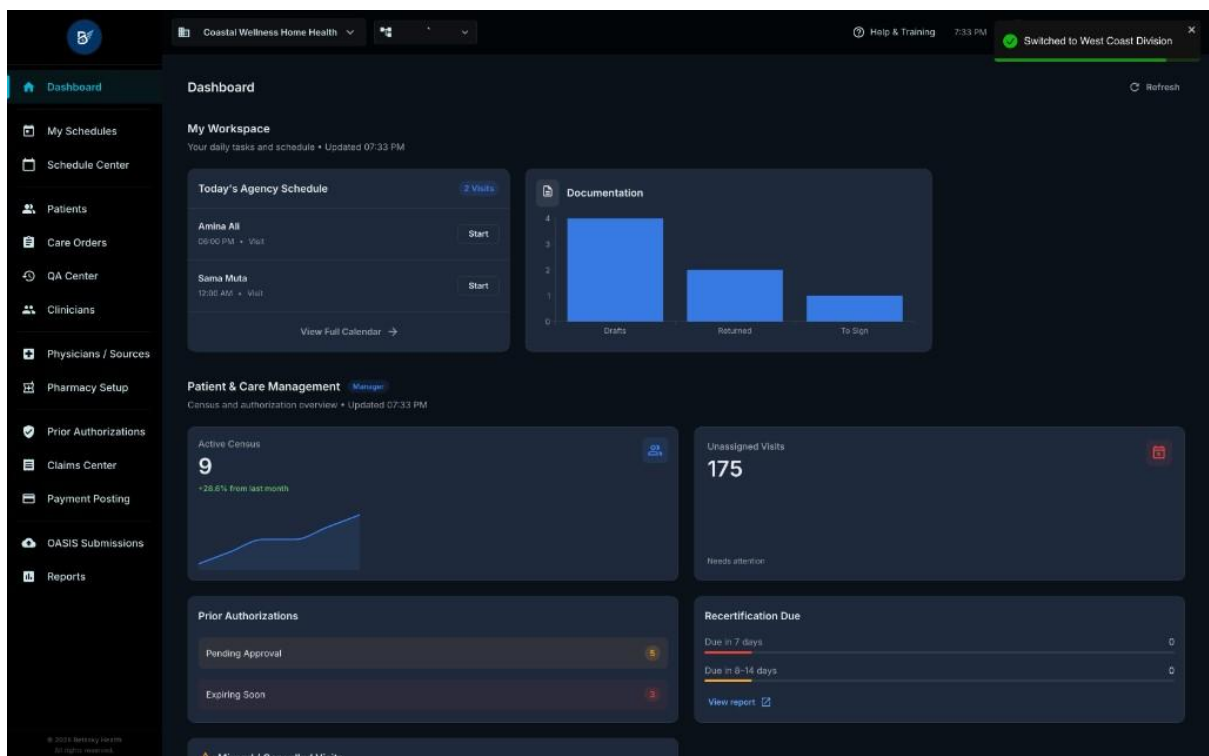
- Account Profile (agency information)
- User Management (add/edit staff)
- Payer Setup (insurance companies)
- Roles & Permissions (user access control)
- Clinical Settings (system configuration)

2.5 Switching Agencies (Multi-Agency Users)

Some users (like Super Administrators or Sales staff) have access to multiple agencies. Here's how to switch between them.

Agency Selector Dropdown

Screenshot 5: Agency selector dropdown showing current agency with checkmark and star



How to Switch Agencies

Step 1: Click on the agency name in the top-left of the header bar

Step 2: You'll see:

- **"Switch Agency"** label at top
- **Current agency** with:
 - **Blue checkmark** - Currently selected
 - **Star icon** - Favorited agency (if applicable)
- **List of other agencies** you have access to

Step 3: Click on any agency name to switch to it

What Happens:

- System switches to the selected agency
- Dashboard refreshes with that agency's data
- All menus and features now show data for selected agency
- Green success notification appears (see Section 2.6)

Agency Selection Details

In the screenshot:

- **"Coastal Wellness Home Health"** is currently selected
- Blue checkmark (✓) indicates active agency
- Gold star (★) indicates this is a favorited/pinned agency

NOTE: If you only have access to one agency, this dropdown will not appear or will show only your agency without the ability to switch.

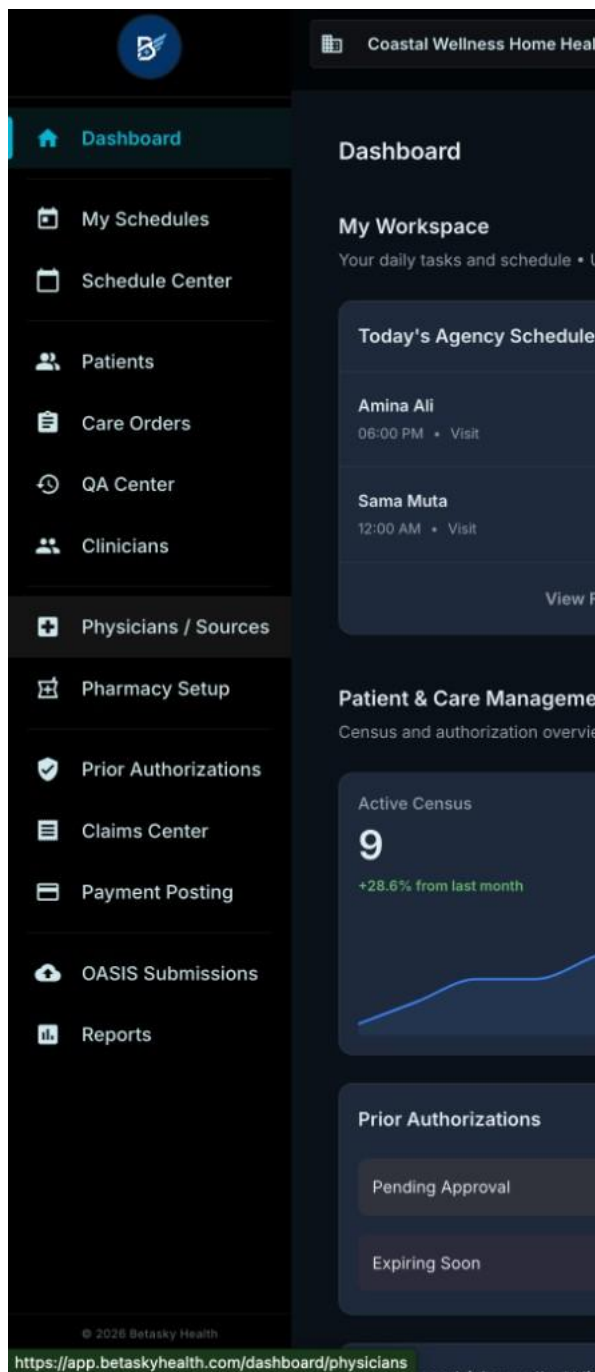
TIP: If you frequently work with specific agencies, you can favorite them (star icon) for quick access.

2.6 Switching Branches (Multi-Location)

For agencies with multiple physical locations (branches), you can easily switch between them.

Branch Selector Dropdown

Screenshot 6: Branch selector showing Head Office and other branches



Understanding Branches

What is a Branch?

- A physical location of your agency
- Example: Main office, satellite offices, regional divisions
- Each branch can have its own:
 - Staff assignments
 - Patient assignments
 - Service territory
 - NPI (optional)

Branch Types:

- **Primary** - Your main/headquarters location
- **Additional Branches** - Satellite offices, regional divisions

How to Switch Branches

Step 1: Click on the branch name in the header bar (next to agency name)

In the screenshot, it shows:

- **"Head Office"**
- **"Primary"** (designation below)

Step 2: Dropdown opens showing:

- **"Switch Branch"** label at top
- **Current branch** with ✓ checkmark
 - "Head Office" with "Primary" designation
- **Other branches** with switch icon (↔)
 - "North Austin Branch"
 - "West Coast Division"

Step 3: Click on any branch to switch to it

What Happens When You Switch

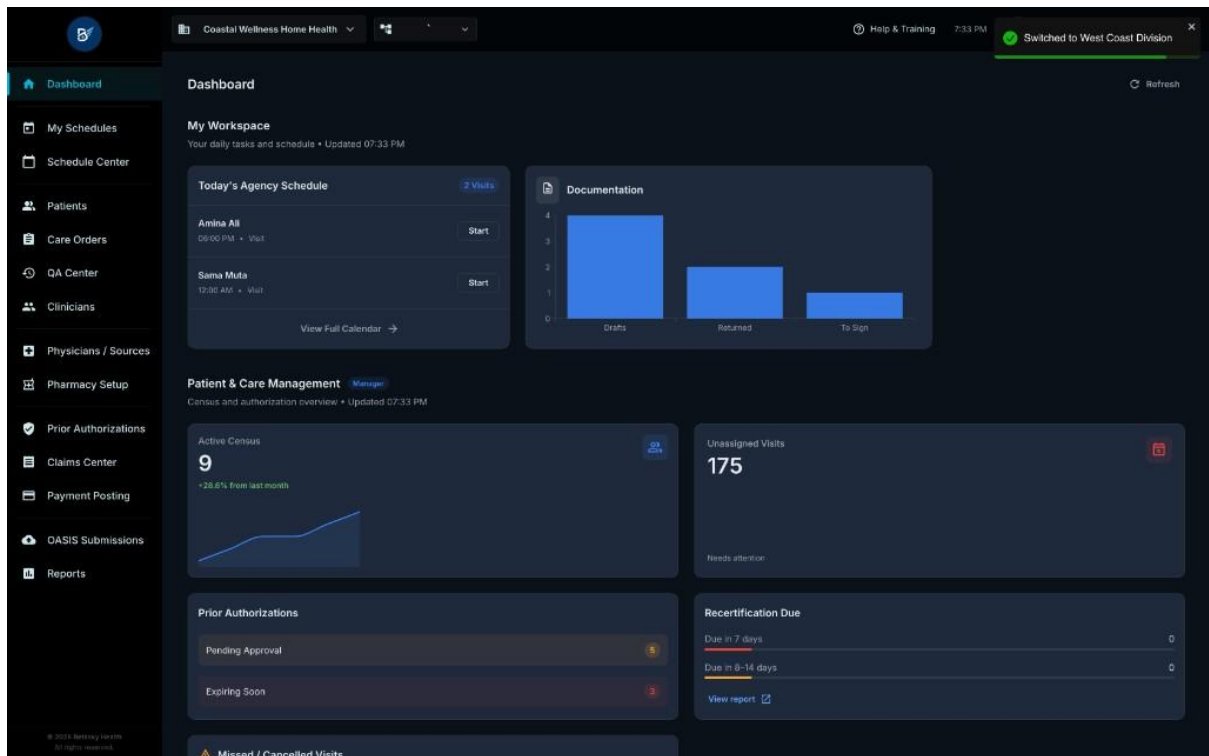
When you select a different branch:

1. Data Filtering Changes

- Dashboard shows data for selected branch
- Patient lists filtered by branch
- Schedule shows branch's clinicians and visits

2. Success Notification Appears

Screenshot 7: Green success notification showing "Switched to West Coast Division"



3. Header Updates

- Branch name changes in header bar
- Shows the branch you switched to

Branch Permissions

IMPORTANT: Branch access depends on your user permissions:

Agency Administrator:

- Can access ALL branches
- Can switch freely between any branch
- Can view agency-wide reports

Branch-Level Staff:

- Limited to assigned branch(es)
- May have access to multiple branches
- Cannot see data from unassigned branches

Single-Branch Users:

- Can only access their primary branch
- Branch selector may not appear
- Or shows only their branch with no switch option

TIP: Branch filtering helps large agencies manage multiple locations efficiently. Each branch can operate semi-independently while rolling up to agency-wide reporting.

Branch Access Types

When users are assigned to branches, they have one of two access types:

ACTIVE Access:

- Can view and edit data for this branch
- Can schedule visits
- Can document visits
- Full operational access

READ_ONLY Access:

- Can view data only
- Cannot schedule or document
- Useful for managers overseeing multiple branches

NOTE: Branch assignment is configured in Settings → User Management when creating or editing users.

2.7 System Alerts & Toast Notifications

The system uses **toast notifications** to provide feedback on your actions.

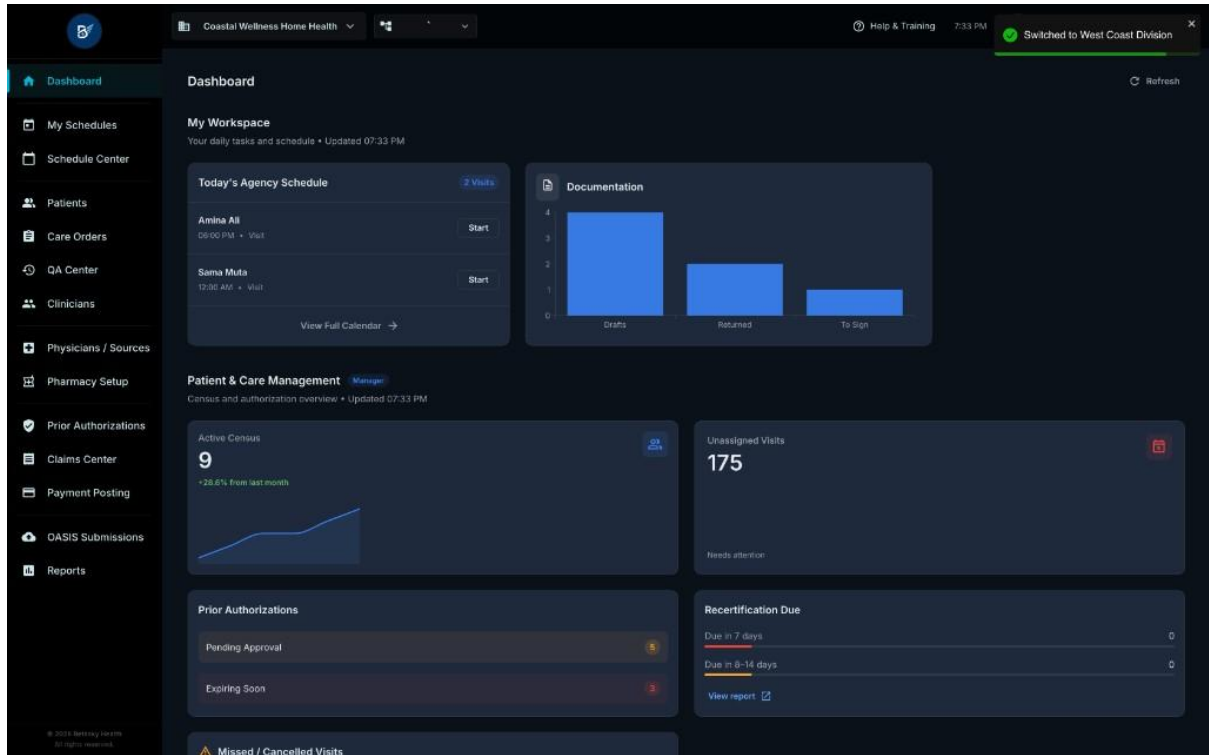
What are Toast Notifications?

Toasts are temporary messages that appear briefly to confirm actions or show errors. They appear in the **top-right corner** of the screen and automatically disappear after a few seconds.

Types of Notifications

1. Success Notifications (Green)

Screenshot 7 (repeated): Success notification example



Appearance:

- Green background
- Checkmark icon
- White text
- Brief message

When You'll See Them:

- Successfully saved changes (agency settings, patient info, etc.)
- Created a new record (patient, care order, visit, etc.)
- Approved a document (QA workflow)
- Switched branches or agencies
- Completed an action (scheduled visit, posted payment, etc.)

Example Messages:

- "Switched to West Coast Division"
- "Agency information updated successfully"
- "Patient created successfully"
- "Visit scheduled"
- "Document approved"

2. Error Notifications (Red)

Appearance:

- **Red background**
- **X icon**
- **White text**
- **Error description**

When You'll See Them:

- Form validation errors
- Required fields missing
- Cannot perform action (permissions, business rules)
- System errors
- Network issues

Example Messages:

- "Required fields are missing"
- "Cannot delete - record has dependencies"
- "Invalid date range"
- "Insufficient permissions"

3. Warning Notifications (Yellow/Orange)

Appearance:

- **Yellow or orange background**
- **Warning icon**
- **Black or dark text**

When You'll See Them:

- Cautions before destructive actions
- Important reminders
- Data quality warnings
- Configuration issues

Example Messages:

- "This action cannot be undone"
- "Care order expires in 5 days"

- "Missing authorization for this visit"

4. Info Notifications (Blue/Gray)

Appearance:

- **i** Blue or gray background
- **Info icon**
- **Informational message**

When You'll See Them:

- General information
- Process updates
- Background task completion
- System updates

Example Messages:

- "Report generation in progress"
- "Data synced successfully"
- "Update available"

Toast Notification Behavior

Duration:

- Success messages: ~3 seconds
- Error messages: ~5 seconds (or until dismissed)
- Warnings: ~5 seconds
- Info: ~3 seconds

Dismissal:

- Auto-dismiss after duration
- Click **X** icon to dismiss immediately
- Click outside notification to dismiss

Location:

- Always appear in **top-right corner**
- Stack vertically if multiple appear
- Most recent on top

Multiple Notifications:

- Multiple toasts can appear simultaneously
- Each dismisses independently
- Maximum usually 3-4 visible at once

Toast Notification Examples by Action

Action	Toast Type	Example Message
Save agency settings	Success	"Agency information updated successfully"
Create patient	Success	"Patient created successfully"
Approve QA document	Success	"Document approved"
Switch branch	Success	"Switched to West Coast Division"
Missing required field	Error	"Email is required"
Permission denied	Error	"You don't have permission to perform this action"
Delete with dependencies	Error	"Cannot delete - patient has active care orders"
Care order expiring soon	Warning	"Care order expires in 3 days - initiate recertification"
Missing authorization	Warning	"Visit exceeds authorized units"
System update available	Info	"System update completed - refresh page"

Best Practices for Toast Notifications

TIP: Pay attention to toast messages - they provide important feedback:

- **Green** = Your action succeeded
- **Red** = Something went wrong, read the message
- **Yellow** = Proceed with caution
- **Blue** = Good to know, but not urgent

IMPORTANT: If you see an error toast, read it carefully. It usually explains exactly what went wrong and how to fix it.

Other Alert Types

In addition to toast notifications, the system uses:

1. Modal Dialogs

- Require user action (OK, Cancel, etc.)
- Block interaction until dismissed
- Used for confirmations and critical decisions

2. Inline Validation

- Red text below form fields
- Shows specific field errors
- Real-time feedback while typing

3. Banner Alerts

- Persistent messages at top of page
- Example: Sandbox Mode banner (orange)
- Remain visible until condition changes

4. Badge Counts

- Number indicators on menu items
- Example: "3" on QA Center = 3 pending reviews
- Shows count of items needing attention

2.8 Dashboard Quick Reference

Now that you understand navigation, here's a quick reference guide:

Essential Navigation Shortcuts

Want to...	Click here...
Go to home/dashboard	Dashboard in sidebar
Add a patient	Patients → Add Patient button
Schedule a visit	Schedule Center
Review documents	QA Center
View claims	Claims Center
Create OASIS	OASIS Submissions
Change settings	Click your name → Settings
Switch branch	Click branch name in header

Want to...	Click here...
Get help	Help & Training in header
Log out	Click your name → Log Out

Menu Item Deep Links

Each menu item takes you to a specific section:

Patient Management:

- **Patients** → Patient list and intake
- **Care Orders** → Episodes of care
- **Schedule Center** → Agency scheduling

Clinical Documentation:

- **My Schedules** → Your personal schedule (clinicians)
- **QA Center** → Document review queue
- **OASIS Submissions** → OASIS tracking

Setup & Configuration:

- **Clinicians** → Staff management
- **Physicians / Sources** → Physician database
- **Pharmacy Setup** → Pharmacy list

Billing & Authorization:

- **Prior Authorizations** → PA management
- **Claims Center** → Claims and billing
- **Payment Posting** → Payment processing

Reporting:

- **Reports** → System reports and analytics

Visual Navigation Cues

Look for these visual indicators:

Blue highlight - Current page in sidebar

Star icon - Favorited agency

Checkmark - Currently selected (agency/branch)

Switch icon - Available to switch to

Blue badge - Notification count

Green toast - Success feedback

Red toast - Error feedback

Chapter 3: User Roles & Permissions

Chapter Overview

What You'll Learn:

- Understanding all standard user roles in the system
- What permissions each role has
- The difference between platform roles and agency roles
- How to use the Custom Role Builder (advanced feature)
- Best practices for assigning roles to staff
- Security considerations for role management

Who Should Read This: Agency Administrators, Clinical Managers, anyone managing staff accounts

Prerequisites: Complete the **Sandbox Signup** and **Dashboard Navigation** chapters

3.1 Understanding User Roles

What are User Roles?

User Roles determine what a user can see and do in the system. Each role has a specific set of **permissions** that control access to features and data.

Key Concepts:

Role = A job function with predefined permissions

- Example: "RN Case Manager" can document visits, create care orders, etc.

Permission = Access to a specific feature or action

- Example: "CREATE_PATIENT" permission allows creating new patient records

User = A person assigned one or more roles

- Example: John Smith is an "RN Case Manager"

Two Types of Roles

The system has two categories of roles:

1. Platform Roles (Super Admin Level)

These are special roles for managing the entire platform:

Role	Purpose	Access Level
Super Administrator	Platform management	ALL agencies, full access
Sales & Onboarding	Agency setup and support	Can create agencies, view all
Support Engineer	Technical support	Read-only access to agencies

SECURITY: Platform roles are assigned by Betasky staff only. Agency administrators cannot create or assign these roles.

NOTE: If you're an agency user, you won't see or interact with platform roles. These are for Betasky internal staff only.

2. Agency Roles (Agency Level)

These are the standard roles for your agency staff:

Role	Typical Job Function
Agency Administrator	Executive Director, Administrator
Clinical Manager	Director of Nursing, Clinical Director
Scheduler	Scheduling Coordinator
Biller	Billing Manager, Revenue Cycle Staff
Intake Coordinator	Admissions Coordinator
RN Case Manager	Registered Nurse, Care Coordinator
LPN / LVN	Licensed Practical Nurse
Therapist	PT, OT, SLP
Home Health Aide	HHA, CNA

Plus: **Custom Roles** (if you have Custom Role Builder feature)

3.2 Standard Agency Roles Explained

Let's explore each standard agency role in detail.

1. Agency Administrator

Who: Executive Director, Administrator, Owner

Access Level: FULL AGENCY ACCESS

What They Can Do:

- Manage all agency settings (NPI, CCN, address, etc.)
- Create, edit, and delete users (all staff)
- Assign roles and permissions
- Set up payers, pharmacies, physicians
- Configure fee schedules and rates
- Access ALL patients and care orders
- View and manage ALL branches (multi-location)
- Schedule visits, document visits
- Perform QA reviews
- Generate and submit claims
- Post payments
- Submit OASIS to CMS (production)
- View all reports and analytics
- Request Go Live to production

Permissions Include:

- Full user management
- Full patient management
- Full clinical documentation
- Full billing access
- Full reporting access
- System configuration

BEST PRACTICE: Limit Agency Administrator role to 1-3 trusted individuals. This role has complete control over the agency's system.

SECURITY: Agency Administrators can delete users, modify sensitive data, and access billing information. Assign carefully.

2. Clinical Manager

Who: Director of Nursing, Clinical Director, Nurse Manager

Access Level: CLINICAL OVERSIGHT

What They Can Do:

- View all patients and care orders
- Create and edit patients
- Manage care orders (create, edit, initiate recertifications)
- Perform QA reviews (approve/return documents)
- Schedule visits for all clinicians
- View and manage compliance tasks
- Access OASIS submissions
- Create and manage physicians
- View reports and analytics
- Document visits (if also a clinician)

What They CANNOT Do:

- Modify agency settings (NPI, CCN, etc.)
- Create or delete users
- Change user roles or permissions
- Set up fee schedules or billing rates
- Generate claims or post payments
- Access Payment Posting module

Use Case:

- Clinical oversight of all patient care
- QA review authority
- Schedule management
- Compliance monitoring
- Staff clinical performance review

BEST PRACTICE: Assign to your Director of Nursing or Clinical Director who oversees care quality but doesn't need billing access.

3. Scheduler

Who: Scheduling Coordinator, Office Manager (scheduling focus)

Access Level: SCHEDULING FOCUSED

What They Can Do:

- Access Schedule Center (full scheduling board)
- Create and schedule visits
- Assign visits to clinicians
- Reschedule and cancel visits
- View patient information (to schedule appropriately)
- View care orders (to schedule within cert period)
- Manage compliance tasks
- View clinician schedules
- Mark visits as missed

What They CANNOT Do:

- Document visits (clinical documentation)
- Perform QA reviews
- Create or edit patients
- Create care orders
- Access billing or claims
- Submit OASIS
- Modify agency settings

Use Case:

- Dedicated scheduling role
- Manages agency calendar
- Coordinates clinician assignments
- Monitors visit completion

BEST PRACTICE: Perfect for non-clinical staff who manage the schedule full-time. They can see patient names and basic info but can't access detailed clinical data.

4. Biller

Who: Billing Manager, Revenue Cycle Specialist, Billing Coordinator

Access Level: BILLING & FINANCIAL FOCUSED

What They Can Do:

- Access Claims Center (all tabs)
- Generate claims from billable visits

- Mark claims as submitted
- Track claim status
- Manage claim denials
- Access Payment Posting
- Post payments to claims
- Process remittance batches (ERA/EOB)
- View patient information (for billing)
- View care orders (for claim grouping)
- Set up and manage fee schedules
- Configure billing rates
- View financial reports

What They CANNOT Do:

- Document visits (clinical documentation)
- Perform QA reviews
- Schedule visits
- Create or edit patients (beyond billing info)
- Submit OASIS to CMS
- Modify agency settings (except fee schedules)

Use Case:

- Revenue cycle management
- Claims submission and tracking
- Payment posting
- Denial management
- Financial reporting

BEST PRACTICE: Billers need access to patient and visit data for claims but don't need clinical documentation access. They focus on the financial workflow.

5. Intake Coordinator

Who: Admissions Coordinator, Intake Specialist, Referral Coordinator

Access Level: PATIENT INTAKE FOCUSED

What They Can Do:

- Create new patients (full intake process)

- Complete all 9 intake tabs (Demographics through Referral Info)
- Edit patient information
- View patient list
- Access intake forms and data
- Create physicians (for referrals)
- View payers (for insurance verification)
- View pharmacies

What They CANNOT Do:

- Create care orders
- Schedule visits
- Document visits
- Perform QA reviews
- Access billing or claims
- Submit OASIS
- View sensitive clinical documentation

Use Case:

- First point of contact for new patients
- Completes intake paperwork
- Verifies insurance
- Gathers referral information
- Hands off to clinical team after intake complete

BEST PRACTICE: Intake Coordinators should complete the patient intake, then clinical staff take over for care orders and visits.

6. RN Case Manager

Who: Registered Nurse, Care Coordinator, Case Manager, RN Clinician

Access Level: FULL CLINICAL ACCESS

What They Can Do:

- View and edit assigned patients
- Create care orders for their patients
- Schedule visits for their patients
- Access My Schedules (personal schedule)
- Document ALL visit types (SN, OASIS, supervisory, etc.)

- Complete OASIS assessments (all types)
- Submit OASIS for QA review
- Create and edit HHA Care Plans
- Initiate recertifications
- Initiate discharge, transfer, death assessments
- Create physician orders
- View care order details
- Access patient clinical data
- View QA feedback on returned documents

What They CANNOT Do:

- Perform QA reviews (can't approve own work)
- Access billing or claims
- Manage users or agency settings
- View patients not assigned to them (unless agency admin grants broader access)

Use Case:

- Primary clinician role
- Manages patient caseload
- Completes SOC visits and OASIS
- Coordinates care team
- Clinical documentation

BEST PRACTICE: RN Case Managers are the backbone of home health. They should be assigned as Case Manager on patient records to have full access to their patients.

7. LPN / LVN

Who: Licensed Practical Nurse, Licensed Vocational Nurse

Access Level: LIMITED CLINICAL ACCESS

What They Can Do:

- View assigned patients
- Access My Schedules
- Document LVN visits (limited visit types)
- View care plans and physician orders
- View patient clinical data (read-only mostly)

What They CANNOT Do:

- Complete OASIS assessments
- Create care orders
- Initiate recertifications or discharges
- Create physician orders
- Schedule visits
- Perform QA reviews
- Access billing

Use Case:

- LPN/LVN field visits
- Follow care plan created by RN
- Document skilled nursing visits (limited scope)
- Report to supervising RN

BEST PRACTICE: LPNs should be supervised by RNs. They can document visits but cannot complete OASIS or manage episodes.

COMPLIANCE: LPN/LVN scope of practice varies by state. System permissions align with typical scope but agency should enforce state-specific rules.

8. Therapist

Who: Physical Therapist (PT), Occupational Therapist (OT), Speech Language Pathologist (SLP)

Access Level: THERAPY-SPECIFIC CLINICAL ACCESS

What They Can Do:

- View assigned patients
- Access My Schedules
- Document therapy visits (PT, OT, SLP visits)
- View care plans and physician orders
- View patient clinical data
- Complete OASIS assessments (if therapy is primary discipline)
- Create care orders (if designated as primary therapist)

What They CANNOT Do:

- Document nursing visits (SN, LVN)

- Document HHA visits
- Perform QA reviews
- Access billing
- Schedule visits (typically)

Use Case:

- Therapy visits and documentation
- Therapy-specific care planning
- OASIS completion when therapy is primary service
- Functional assessment

BEST PRACTICE: Therapists should document their discipline's visits only. They can be case managers if therapy is the primary service.

9. Home Health Aide

Who: Home Health Aide, Certified Nursing Assistant (CNA)

Access Level: RESTRICTED TO HHA DUTIES

What They Can Do:

- View assigned patients (limited info)
- Access My Schedules
- Document HHA visits only
- View HHA Care Plan (their task list)
- Check in and check out of visits

What They CANNOT Do:

- View detailed patient clinical data
- Complete OASIS
- Document any other visit types
- Create or edit care orders
- Schedule visits
- View billing information
- Access QA reviews

Use Case:

- Personal care and ADL assistance
- Follow HHA Care Plan created by RN

- Document task completion
- Report changes to supervising RN

BEST PRACTICE: HHAs have the most restricted access. They see only what they need to complete their visits and follow the care plan.

SECURITY: HHAs should not have access to sensitive patient information beyond what's needed for care tasks.

3.3 Permission Levels by Role - Quick Reference

Here's a comprehensive permission matrix showing what each role can do:

Permission Matrix

Feature / Action	Agency Admin	Clinical Manager	Scheduler	Biller	Intake	RN Case Mgr	LPN /LV N	Therapist	HHA
USER MANAGEMENT									
Create/edit users	✓	✗	✗	✗	✗	✗	✗	✗	✗
Assign roles	✓	✗	✗	✗	✗	✗	✗	✗	✗
View all users	✓	✓	✓	✓	✗	✗	✗	✗	✗
PATIENT MANAGEMENT									
Create patients	✓	✓	✗	✗	✓	✓*	✗	✗	✗
Edit patients	✓	✓	✗	✓**	✓	✓*	✗	✗	✗
View all patients	✓	✓	✓	✓	✓	✗***	✗** *	✗***	✗** **
CARE ORDERS									
Create care orders	✓	✓	✗	✗	✗	✓*	✗	✓*	✗
Initiate recert	✓	✓	✗	✗	✗	✓*	✗	✓*	✗

Feature / Action	Agency Admin	Clinical Manager	Scheduler	Biller	Intake	RN Case Mgr	LPN /LVN	Therapist	HH A
Initiate discharge	✓	✓	✗	✗	✗	✓*	✗	✗	✗
SCHEDULING									
View schedule	✓	✓	✓	✗	✗	✓	✓	✓	✓
Create/schedule visits	✓	✓	✓	✗	✗	✓*	✗	✗	✗
Reschedule visits	✓	✓	✓	✗	✗	✓*	✓**	✓*** **	✗
CLINICAL DOCUMENTATION									
Document SN visits	✓	✓	✗	✗	✗	✓	✗	✗	✗
Document LVN visits	✓	✓	✗	✗	✗	✓	✓	✗	✗
Document PT/OT/SLP	✓	✓	✗	✗	✗	✗	✗	✓	✗
Document HHA visits	✓	✓	✗	✗	✗	✓	✗	✗	✓
Complete OASIS	✓	✓	✗	✗	✗	✓	✗	✓*** **	✗
QA REVIEW									
Perform QA reviews	✓	✓	✗	✗	✗	✗	✗	✗	✗
Approve documents	✓	✓	✗	✗	✗	✗	✗	✗	✗
Return for correction	✓	✓	✗	✗	✗	✗	✗	✗	✗
BILLING & CLAIMS									
Generate claims	✓	✗	✗	✓	✗	✗	✗	✗	✗

Feature / Action	Agency Admin	Clinical Manager	Scheduler	Biller	Intake	RN Case Mgr	LPN /LV N	Therapist	HH A
Post payments	✓	✗	✗	✓	✗	✗	✗	✗	✗
Manage fee schedules	✓	✗	✗	✓	✗	✗	✗	✗	✗
View claims	✓	✗	✗	✓	✗	✗	✗	✗	✗
OASIS SUBMISSION									
Submit OASIS to CMS	✓	✓	✗	✗	✗	✗	✗	✗	✗
Export OASIS XML	✓	✓	✗	✗	✗	✗	✗	✗	✗
REPORTS									
View all reports	✓	✓	✓	✓	✗	✗	✗	✗	✗
SETUP & CONFIGURATION									
Manage payers	✓	✗	✗	✓*** ***	✗	✗	✗	✗	✗
Manage pharmacies	✓	✗	✗	✗	✓	✗	✗	✗	✗
Manage physicians	✓	✓	✗	✗	✓	✓	✗	✗	✗
Agency settings	✓	✗	✗	✗	✗	✗	✗	✗	✗

Legend:

- * = Only for their assigned patients
- = Only for their assigned patients
- ** = Billing information only
- *** = Only assigned patients (determined by caseload)
- **** = Can reschedule own visits only

- ***** = Only when therapy is primary discipline
 - ***** = View only for billing purposes
-

3.4 Custom Role Builder (Advanced Feature)

What is the Custom Role Builder?

The **Custom Role Builder** is an advanced feature available with certain subscription plans (Pro Tier, Test, Enterprise Tier) that allows you to create **custom roles** beyond the standard 9 roles.

Available in:

- Pro Tier subscription
- Test subscription
- Enterprise Tier subscription
- (Not available in Growth Tier)

Why Use Custom Roles?

Standard roles work for most agencies, but you may need custom roles if:

You have unique staff positions not covered by standard roles

- Example: "QA Specialist" who only does QA (not a full Clinical Manager)

You want to restrict access more than standard roles

- Example: "Billing Assistant" who can view claims but not post payments

You want to grant specific combinations of permissions

- Example: "Scheduler + Intake" role that can do both functions

You have specialized departments

- Example: "OASIS Coordinator" who only completes OASIS

How Custom Role Builder Works

Access: Settings → Roles & Permissions → Create Custom Role

Process:

Step 1: Name Your Role

- Enter role name (e.g., "QA Specialist", "OASIS Coordinator")
- Add description explaining the role's purpose

Step 2: Select Permissions

- Browse all available permissions (organized by module)
- Check the permissions you want to grant
- Uncheck permissions you want to deny

Step 3: Preview & Save

- Review selected permissions
- Test the role (optional)
- Save custom role

Step 4: Assign to Users

- Go to User Management
- Assign your custom role to staff members

Permission Categories

When building a custom role, permissions are organized into categories:

1. Patient Management

- VIEW_PATIENTS
- CREATE_PATIENT
- EDIT_PATIENT
- DELETE_PATIENT
- MANAGE_PATIENT_DEMOGRAPHICS
- MANAGE_PATIENT_CLINICAL_DATA

2. Care Order Management

- VIEW_CARE_ORDERS
- CREATE_CARE_ORDER
- EDIT_CARE_ORDER
- INITIATE_RECERTIFICATION
- INITIATE_DISCHARGE
- INITIATE_TRANSFER
- INITIATE_ROC

3. Scheduling

- VIEW_SCHEDULE
- CREATE_VISIT
- EDIT_VISIT

- CANCEL_VISIT
- RESCHEDULE_VISIT
- ASSIGN_CLINICIAN

4. Clinical Documentation

- DOCUMENT_SN_VISIT
- DOCUMENT_LVN_VISIT
- DOCUMENT_PT_VISIT
- DOCUMENT_OT_VISIT
- DOCUMENT_SLP_VISIT
- DOCUMENT_MSW_VISIT
- DOCUMENT_HHA_VISIT
- COMPLETE_OASIS
- CREATE_HHA_CARE_PLAN

5. QA Review

- VIEW_QA_QUEUE
- APPROVE_DOCUMENT
- RETURN_DOCUMENT
- REMOVE_DOCUMENT
- MARK_DOCUMENT_ACTIVE

6. Billing & Claims

- VIEW_CLAIMS
- GENERATE_CLAIM
- SUBMIT_CLAIM
- VOID_CLAIM
- POST_PAYMENT
- MANAGE_FEE_SCHEDULES
- MANAGE_DENIALS

7. OASIS Submission

- VIEW_OASIS_SUBMISSIONS
- EXPORT_OASIS_XML
- MARK_OASIS_SUBMITTED
- MARK_OASIS_ACCEPTED

8. Prior Authorization

- VIEW_PRIOR_AUTHORIZATIONS
- CREATE_PRIOR_AUTHORIZATION
- EDIT_PRIOR_AUTHORIZATION
- APPROVE_PRIOR_AUTHORIZATION

9. Reporting

- VIEW_REPORTS
- EXPORT_REPORTS
- CREATE_CUSTOM_REPORTS

10. Setup & Configuration

- MANAGE_USERS
- MANAGE_PAYERS
- MANAGE_PHYSICIANS
- MANAGE_PHARMACIES
- MANAGE_VISIT_TYPES
- MANAGE_BRANCHES
- MANAGE_AGENCY_SETTINGS

11. Branch Access

- MANAGE_BRANCHES
- VIEW_ALL_BRANCHES
- EDIT_BRANCH_ACCESS

...and many more!

Custom Role Examples

Here are some real-world custom role examples:

Example 1: QA Specialist

Purpose: Dedicated QA reviewer (not full Clinical Manager)

Permissions:

- VIEW_PATIENTS

- VIEW_CARE_ORDERS
- VIEW_QA_QUEUE
- APPROVE_DOCUMENT
- RETURN_DOCUMENT
- VIEW_CLINICAL_DOCUMENTS
- Everything else

Use Case: Staff member who only performs QA reviews, doesn't schedule or create care orders.

Example 2: OASIS Coordinator

Purpose: Specialized OASIS completion role

Permissions:

- VIEW_PATIENTS
- VIEW_CARE_ORDERS
- COMPLETE_OASIS (all types)
- VIEW_OASIS_SUBMISSIONS
- EXPORT_OASIS_XML
- VIEW_REPORTS (OASIS-related)
- Cannot schedule, bill, or perform QA

Use Case: RN dedicated to OASIS completion only, doesn't do field visits.

Example 3: Billing Assistant

Purpose: Junior billing role with limited access

Permissions:

- VIEW_CLAIMS
- VIEW_PATIENTS (billing info only)
- VIEW_CARE_ORDERS
- Cannot generate claims
- Cannot post payments
- Cannot manage fee schedules

Use Case: Assistant who tracks claims but doesn't generate or post payments.

Example 4: Scheduler + Intake

Purpose: Combined role for small agencies

Permissions:

- CREATE_PATIENT (full intake)
- EDIT_PATIENT
- VIEW_SCHEDULE
- CREATE_VISIT
- ASSIGN_CLINICIAN
- RESCHEDULE_VISIT
- Cannot document visits or perform QA

Use Case: Office staff who handles both intake and scheduling.

Custom Role Best Practices

Best Practices:

Start with Standard Roles:

- Use standard roles for 90% of staff
- Only create custom roles when necessary
- Don't over-complicate your role structure

Follow Principle of Least Privilege:

- Grant only the permissions needed for the job
- Don't give "just in case" permissions
- Review and remove unused permissions

Name Roles Clearly:

- Use descriptive names: "QA Specialist" not "Role 1"
- Include department if helpful: "Billing Assistant", "Clinical QA"
- Make it obvious what the role does

Document Your Custom Roles:

- Keep a document explaining each custom role
- List what permissions are included
- Explain when to assign each role

Review Regularly:

- Audit custom roles quarterly
- Remove unused custom roles
- Update permissions as needs change

Test Before Assigning:

- Create a test user with the custom role
- Verify they can access what they need
- Verify they CANNOT access what they shouldn't

Custom Role Limitations**Important Limitations:****Cannot Override System Rules:**

- Custom roles respect system business rules
- Example: Can't approve own documents even with APPROVE_DOCUMENT permission
- Example: Can't schedule visits outside cert period

Cannot Grant Platform-Level Access:

- Custom roles are agency-level only
- Cannot create "super admin" type roles
- Cannot grant cross-agency access

Subscription Required:

- Custom Role Builder requires Pro, Test, or Enterprise plan
- Growth Tier subscribers use standard roles only

Maximum Custom Roles:

- Most plans allow up to 10-20 custom roles
- Check your subscription plan for exact limit

3.5 Role Assignment Best Practices**How to Assign Roles to Staff****When creating a new user:****Step 1:** Identify their primary job function

- What will they do most often?
- What's their job title?

Step 2: Choose the matching standard role

- Start with standard roles
- 90% of staff fit into standard roles

Step 3: Consider custom roles only if needed

- Does a standard role not fit?
- Do they need unusual permission combinations?

Step 4: Assign the role in User Management

- Settings → User Management → Add User
- Select role from dropdown
- Save user

Multiple Roles (Advanced)

Can a user have multiple roles?

The system typically assigns **one primary role** per user. However, there are scenarios where multiple role assignments make sense:

Scenario 1: Dual Function Staff

- RN who also does scheduling: "RN Case Manager" + custom scheduling permissions
- Clinical Manager who also does QA: "Clinical Manager" role (already includes QA)

Scenario 2: Coverage Roles

- Backup billing person: Primary role + limited billing permissions
- Cross-trained staff: Multiple role capabilities

NOTE: Check with your system administrator or support to confirm if your subscription supports multiple role assignments per user.

Role Assignment by Agency Size

Small Agencies (1-10 staff):

- Fewer, broader roles
- Staff wear multiple hats
- Consider combined custom roles
- Example: "Scheduler + Intake Coordinator"

Medium Agencies (11-50 staff):

- Standard roles work well
- Some custom roles for specialists
- Example: Dedicated QA person = "QA Specialist" custom role

Large Agencies (51+ staff):

- Standard roles for most staff
- Custom roles for specialists
- Department-specific roles
- Example: "OASIS Coordinator", "PA Specialist", "QA Specialist"

Security Best Practices

Security Guidelines

1. Least Privilege Principle

- Give users only what they need to do their job
- Don't give "everything" access to avoid future restrictions
- Review permissions during performance reviews

2. Regular Access Reviews

- Quarterly: Review who has what access
- Check for terminated employees (deactivate immediately)
- Remove unnecessary permissions

3. Separation of Duties

- Billing and QA should be different people
- Don't let clinicians approve their own documents
- Agency Admins should be separate from daily operations (when possible)

4. Audit Trail

- System logs all user actions
- Review audit logs for suspicious activity
- Track who approved what, who billed what

5. Offboarding Process

- Immediate: Deactivate user account when employee leaves
- Don't delete - preserve audit trail
- Transfer patient assignments to other staff

Common Role Assignment Mistakes

Mistakes to Avoid:

Mistake 1: Everyone is an Agency Administrator

- Problem: Too many people with full access
- Fix: Only 1-3 Agency Admins, everyone else gets appropriate role

Mistake 2: Using wrong role for job function

- Problem: RN assigned "Therapist" role can't document SN visits
- Fix: Match role to actual job duties

Mistake 3: Not updating roles when duties change

- Problem: Former biller still has billing access after moving to clinical
- Fix: Update role when job function changes

Mistake 4: Creating too many custom roles

- Problem: 20 custom roles, nobody knows what they mean
- Fix: Use standard roles, create custom only when necessary

Mistake 5: Forgetting to deactivate terminated employees

- Problem: Ex-employee still has system access
- Fix: Immediate deactivation on last day of work

3.6 Switching Between Roles (If Applicable)

Can Users Switch Roles?

Typically: NO

Users are assigned one role (or multiple if supported) and **cannot switch between them** on their own. Role assignment is controlled by Agency Administrators only.

Exception: Multi-Agency Users

- Platform-level users (Super Admin, Sales, Support)
- May have different roles in different agencies
- Role applies based on current agency context

Why this restriction?

- Security: Prevents privilege escalation
- Audit trail: Clear accountability for actions
- Compliance: Ensures appropriate access control

Role Changes During Employment

If a staff member's job function changes:

Process:

1. Agency Administrator accesses User Management
2. Edits the user's account
3. Changes the assigned role
4. Saves the change
5. User's permissions update immediately (may need to log out/in)

Example:

- Sarah was "Intake Coordinator"
- She's promoted to "Clinical Manager"
- Admin changes her role to "Clinical Manager"
- Sarah now has Clinical Manager permissions

Chapter 4: Agency Settings

Overview

Agency Settings is where your organization's foundational information is configured and maintained. This chapter covers all aspects of agency profile management, including:

- Agency information and identifiers (NPI, CCN, Tax ID)
- Contact and address details
- Subscription tier management
- Security settings
- Agency branding and logos

Who Should Read This Chapter:

- Agency Administrators
- Super Administrators
- Sales & Onboarding staff (during initial setup)

Prerequisites:

- Completed sandbox signup (Chapter 1)
- Active user account with Agency Administrator or Super Administrator role

4.1 Accessing Agency Settings

Navigation Path

1. **From the Dashboard:** Click the **Settings** icon (gear icon) in the top-right header bar
2. **Select "Agency Settings"** from the dropdown menu
3. The **Edit Agency** modal will open

Alternative Access:

- Super Administrators can access agency settings for any agency in their scope
- Regular Agency Administrators can only edit their own agency

4.2 Agency Information Tab

The **Agency Information** section contains your organization's core business identifiers and contact details. This information appears on official documents, claims, and communications.

4.2.1 Required Fields

Agency Name

- **Purpose:** Your organization's legal or DBA (Doing Business As) name
- **Format:** Text (up to 255 characters)
- **Examples:** "Austin Home Health Services", "Caring Hands Agency"

- **Note:** This name appears on all claims, reports, and patient communications

National Provider Identifier (NPI)

- **Purpose:** Unique 10-digit identification number for healthcare providers
- **Format:** Exactly 10 numeric digits (e.g., 1234567890)
- **Required For:** Medicare/Medicaid billing, claims submission
- **Validation:** Must pass Luhn algorithm check
- **Where to Find:** Obtain from the [NPPES NPI Registry](#)

Common Mistakes:

- Using a 9-digit or 11-digit number
- Including dashes or spaces
- Correct format: 1234567890

CMS Certification Number (CCN)

- **Purpose:** 6-character code certifying your agency to provide Medicare services
- **Format:** 6 alphanumeric characters (e.g., 12345A)
- **Required For:** Going live in production, Medicare billing
- **Validation:** Must be exactly 6 characters
- **Note:** Only certified Home Health Agencies have a CCN

Sandbox vs Production:

- **Sandbox:** CCN is optional (agencies can test without certification)
- **Production:** CCN is **mandatory** for Medicare billing and going live

Related Features:

- Without a CCN, the agency remains in Sandbox mode
- CCN is required to complete the "Go Live" process (see Chapter 13)

Tax Identification Number (Tax ID / EIN)

- **Purpose:** Your organization's federal tax ID (Employer Identification Number)
- **Format:** 9 digits, typically formatted as 12-3456789
- **Required For:** Tax reporting, financial documentation, payer enrollment
- **Where to Find:** Obtained from the IRS during business formation

4.2.2 Contact Information

Primary Contact Person

- **Field:** Full name of the primary point of contact
- **Purpose:** Who to reach for administrative matters
- **Example:** "Sarah Johnson", "Dr. Michael Chen"

Phone Number

- **Format:** (###) ###-####
- **Purpose:** Primary agency phone number
- **Note:** Used for urgent communications, payer contacts, and patient inquiries

Email Address

- **Format:** Valid email address
- **Purpose:** Primary agency email for official communications
- **Note:** System notifications, claim correspondences, and alerts are sent here

Address

Complete physical address including:

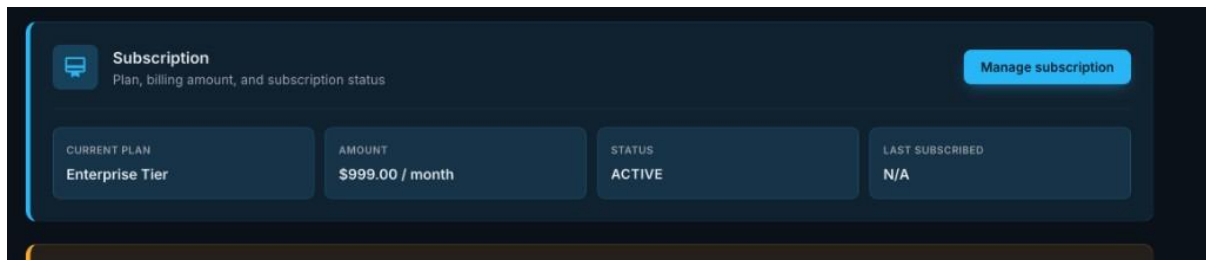
- **Street Address:** Physical location (P.O. boxes generally not accepted for home health)
- **City:** City name
- **State:** Two-letter state abbreviation (e.g., TX, CA, NY)
- **ZIP Code:** 5-digit or 9-digit format (12345 or 12345-6789)

Important:

- This address must match the address on file with CMS and state licensing boards
- Used for official correspondence and regulatory filings

4.3 Subscription & Billing

The Subscription section displays your current plan details and provides access to upgrade options.



Screenshot 5: Subscription section showing current plan, billing amount, and status

4.3.1 Current Subscription Information

You'll see a card displaying:

- **CURRENT PLAN:** Your subscription tier (e.g., "Enterprise Tier")
- **AMOUNT:** Monthly billing amount (e.g., "\$999.00 / month")
- **STATUS:** Subscription status (e.g., "ACTIVE")
- **LAST SUBSCRIBED:** Date of subscription or upgrade (e.g., "N/A" for sandbox)
- **Manage subscription** button to view more details or change plans

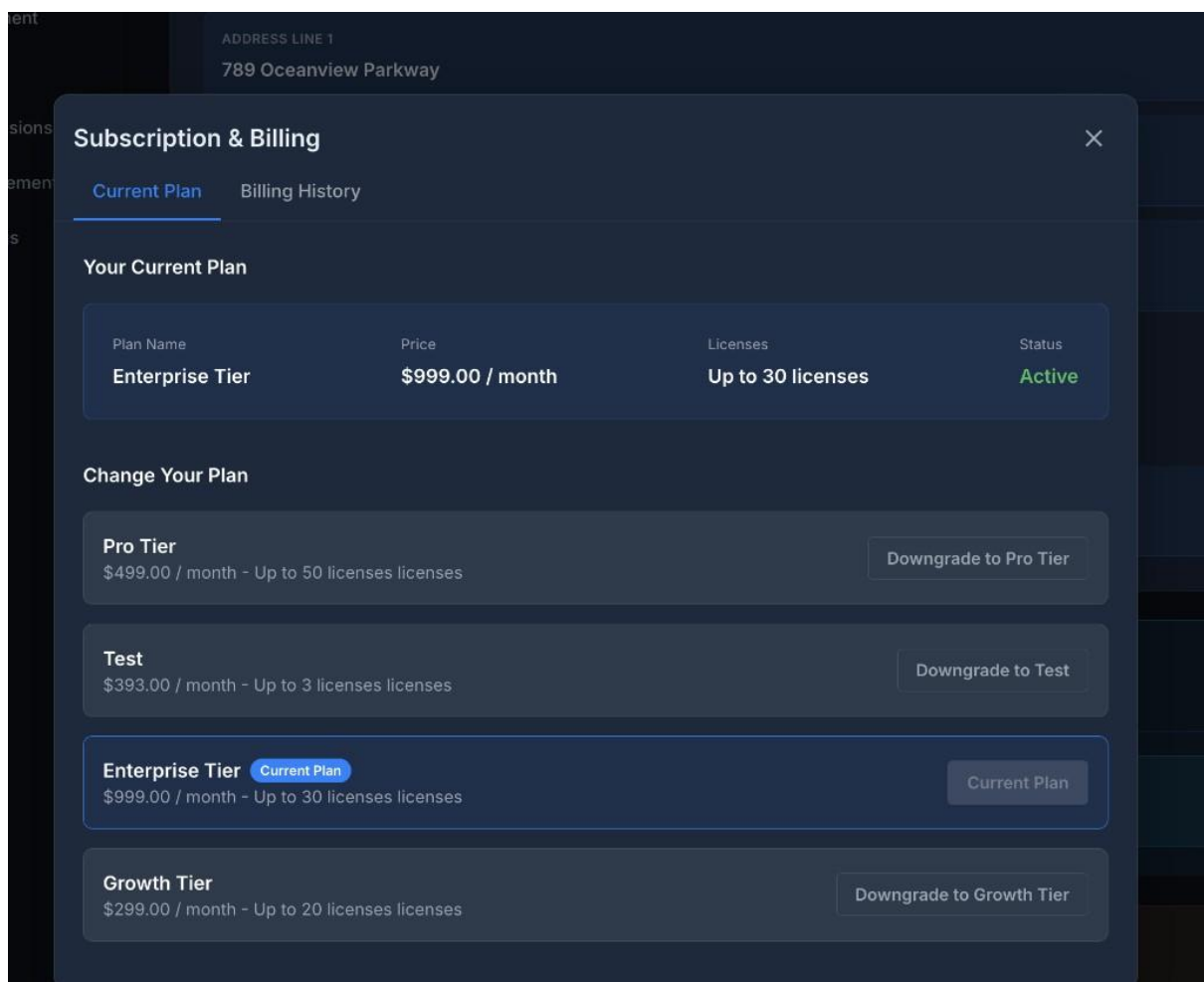
4.3.2 Subscription Tiers

Your agency is assigned one of the following subscription tiers:

Tier	Description	User Limit	Key Features
Sandbox	Free trial environment	Unlimited users	Demo data, full feature access, no billing
Test	Development/testing account	5 users	Full features, no production data
Growth	Small to medium agencies	20 users	Standard features, basic support
Pro	Mid-sized agencies	50 users	Custom Role Builder, priority support
Enterprise	Large multi-branch agencies	Unlimited users	Custom Role Builder, dedicated support, SLA

4.3.3 Managing Your Subscription

Click the **Manage subscription** button to open the Subscription & Billing modal:



Screenshot 6: Subscription & Billing modal showing Current Plan tab and Change Your Plan options

The modal has two tabs:

1. **Current Plan:** View your active subscription details
2. **Billing History:** View past invoices and payment records

Your Current Plan Section:

- **Plan Name:** (e.g., "Enterprise Tier")
- **Price:** Monthly cost
- **Licenses:** Number of user licenses included (e.g., "Up to 30 licenses")
- **Status:** Active/Inactive

Change Your Plan Section:

Available plan options displayed with:

- Plan name and pricing
- Number of licenses
- Upgrade/Downgrade buttons for each tier

To Change Your Plan:

1. Click the **Downgrade to [Plan Name]** or **Upgrade to [Plan Name]** button
2. Confirm your selection
3. Complete billing information if upgrading
4. Your subscription will be updated within 1-2 business days

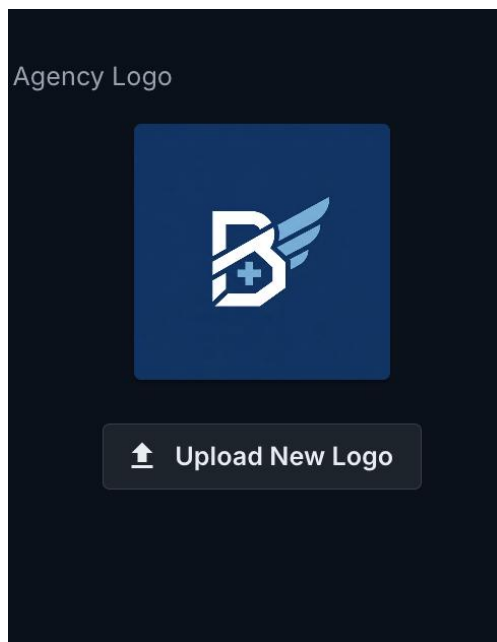
Note: Upgrading from Sandbox to Production requires:

- A valid CCN (CMS Certification Number)
- Paid subscription (Growth, Pro, or Enterprise)
- Completion of the "Go Live" process (see Chapter 13)

4.4 Branding & Logo Upload

4.4.1 Agency Logo

Upload your agency's logo to personalize the system interface:



Screenshot 2: Agency Logo section showing current logo and Upload New Logo button

- **Where It Appears:**

- Left sidebar (replaces default Betasky logo)
- Printed reports and documents
- Patient-facing forms and communications

- **File Requirements:**

- **Format:** PNG, JPG, or SVG
- **Recommended Size:** 200px x 60px (or similar aspect ratio)
- **Max File Size:** 2 MB
- **Background:** Transparent PNG recommended

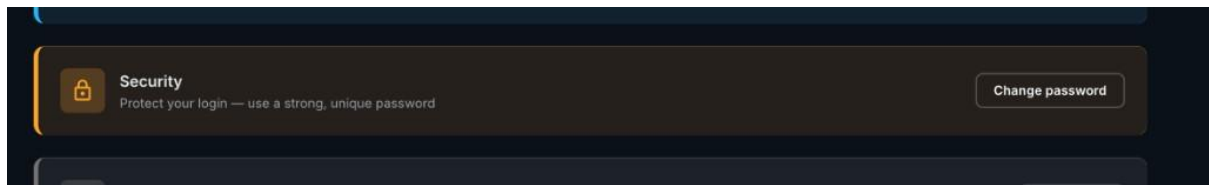
How to Upload:

1. In the **Edit Agency** modal, scroll to the **Branding** section
2. Click **Upload New Logo**
3. Select your image file
4. Preview the logo
5. Click **Save Changes**

Result:

- Your logo will immediately appear in the left sidebar
- If no logo is uploaded, the default Betasky logo is shown

4.5 Security Settings

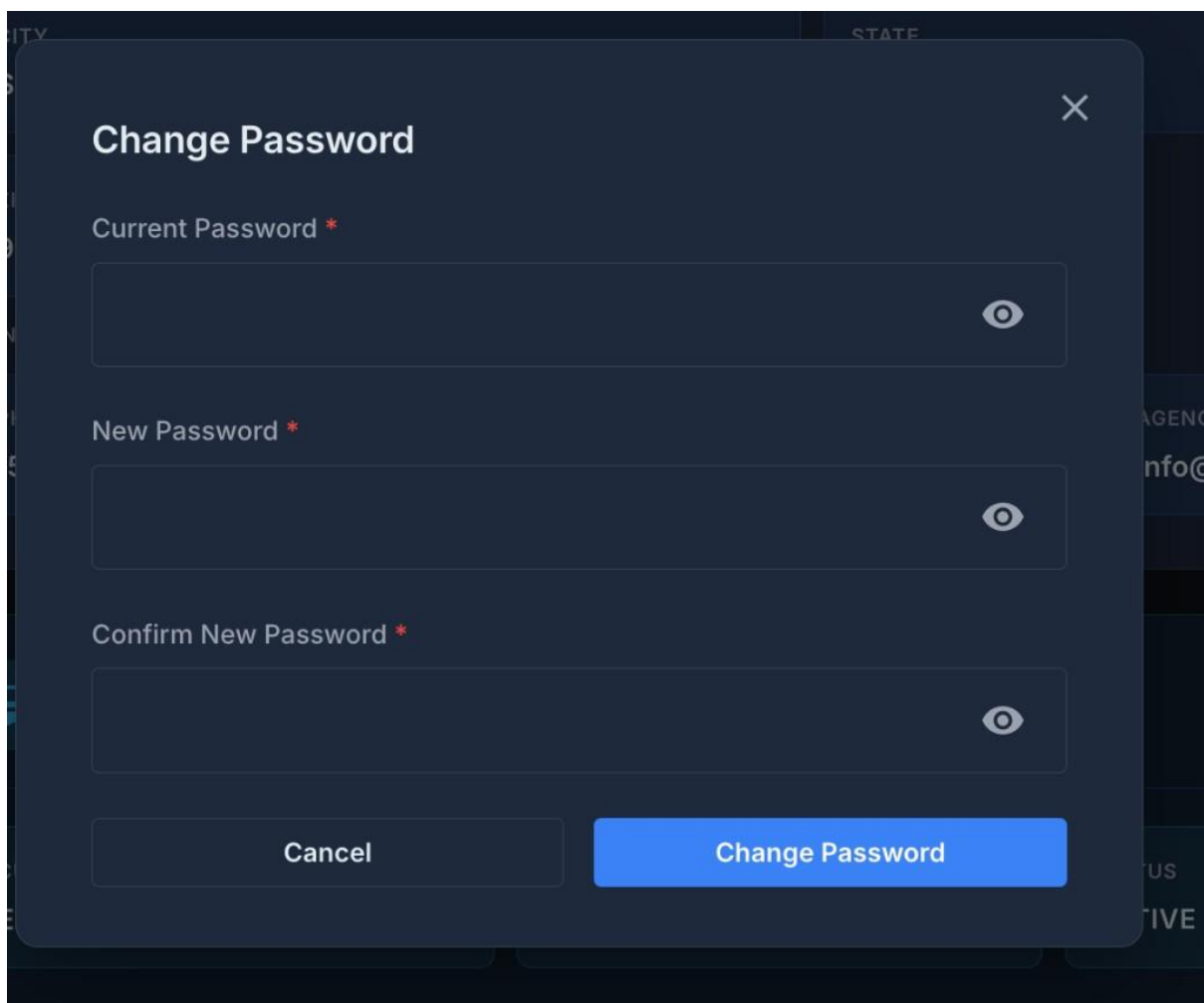


Screenshot 3: Security section with Change password button

4.5.1 Changing Your Password

To update your password:

1. Scroll to the **Security** section
2. Click **Change password** button
3. The **Change Password** modal opens



Screenshot 4: Change Password modal showing current password, new password, and confirm password fields

4. Enter your **Current Password**
5. Enter your **New Password**
6. Confirm the new password in **Confirm New Password** field
7. Click **Change Password** button

Password Requirements:

- Minimum 8 characters
- Must contain uppercase and lowercase letters
- Must contain at least one number
- Must contain at least one special character

4.6 Saving and Canceling Changes

Saving Your Updates

1. After editing any field, click **Save Changes** at the bottom of the modal
2. A **Success** toast notification will confirm: "Agency settings updated successfully"
3. Changes take effect immediately

Canceling Edits

1. Click **Cancel** or the **X** icon in the top-right of the modal
2. All unsaved changes will be discarded
3. No confirmation prompt (you must re-enter changes if needed)

4.7 Troubleshooting Common Issues

Issue 1: "Invalid NPI Format"

Error Message: "NPI must be exactly 10 digits"

Solution:

- Ensure your NPI contains exactly 10 numeric characters
- Remove any dashes, spaces, or special characters
- Example: Use 1234567890 instead of 123-456-7890

Issue 2: "CCN Required for Production"

Error Message: "Cannot go live without a valid CCN"

Solution:

- Obtain your CMS Certification Number from your state survey agency
- Enter the 6-character CCN in the **Agency Information** tab
- Complete the Go Live process (Chapter 13)

Issue 3: "Tax ID Already in Use"

Error Message: "This Tax ID is already registered to another agency"

Solution:

- Each Tax ID can only be used by one agency

- If you're migrating from another system, contact Betasky Support to merge accounts
- If this is an error, verify the correct Tax ID with your business records

Issue 4: Logo Not Appearing

Problem: Uploaded logo doesn't show in the sidebar

Solution:

- Ensure the logo file is under 2 MB
- Use PNG or JPG format (SVG sometimes has rendering issues)
- Clear your browser cache and hard refresh (Ctrl+Shift+R or Cmd+Shift+R)
- Try a different image with a standard aspect ratio (3:1 or 4:1)

Issue 5: "Subscription Limit Reached"

Error Message: "Cannot add more users. Your plan allows a maximum of X users."

Solution:

- Upgrade to a higher subscription tier
- Contact sales@betaskyhealth.com
- Or remove inactive users to free up slots (see Chapter 8)

Chapter 5: Branch Management

Overview

Branch Management allows your home health agency to operate multiple physical locations, each with its own address, state license, and Medicare Provider Transaction Access Number (PTAN). This chapter covers:

- Understanding branches and their purpose
- Creating and configuring new branches
- Managing branch-specific settings
- Assigning users to branches
- Switching between branches in the UI

Who Should Read This Chapter:

- Agency Administrators
- Super Administrators
- Multi-location agency owners

Prerequisites:

- Completed agency settings configuration (Chapter 4)
- Understanding of user roles and permissions (Chapter 3)

5.1 What is a Branch?

A **Branch** represents a physical location or service area of your home health agency. Each branch operates semi-independently within your organization.

5.1.1 When to Use Branches

You Should Create Multiple Branches If:

- Your agency has multiple physical office locations (e.g., North Austin Office, South Austin Office)
- You operate in multiple states or regions with different state licenses
- You have separate Medicare Provider Transaction Access Numbers (PTANs) for different locations
- You want to segment operations by geography (e.g., West Coast Division, East Coast Division)
- You need to track performance and billing separately for each location

You Should Use a Single Branch If:

- Your agency operates from one location
- All clinicians report to the same office
- You have one state license and one PTAN

5.1.2 How Branches Work in the System

Data Segregation

- **Patients** are assigned to a specific branch
- **Care Orders, Visits, and OASIS Assessments** are tied to the patient's branch
- **Clinicians** can be assigned to one or multiple branches
- **Claims** are generated per branch (using that branch's NPI and PTAN)

User Access

- Users can have different roles/permissions at different branches (see Chapter 3, Section 3.8)
- The **Branch Selector** in the header bar allows users to switch between branches they have access to
- Users only see data for the currently selected branch (unless they have Super Administrator access)

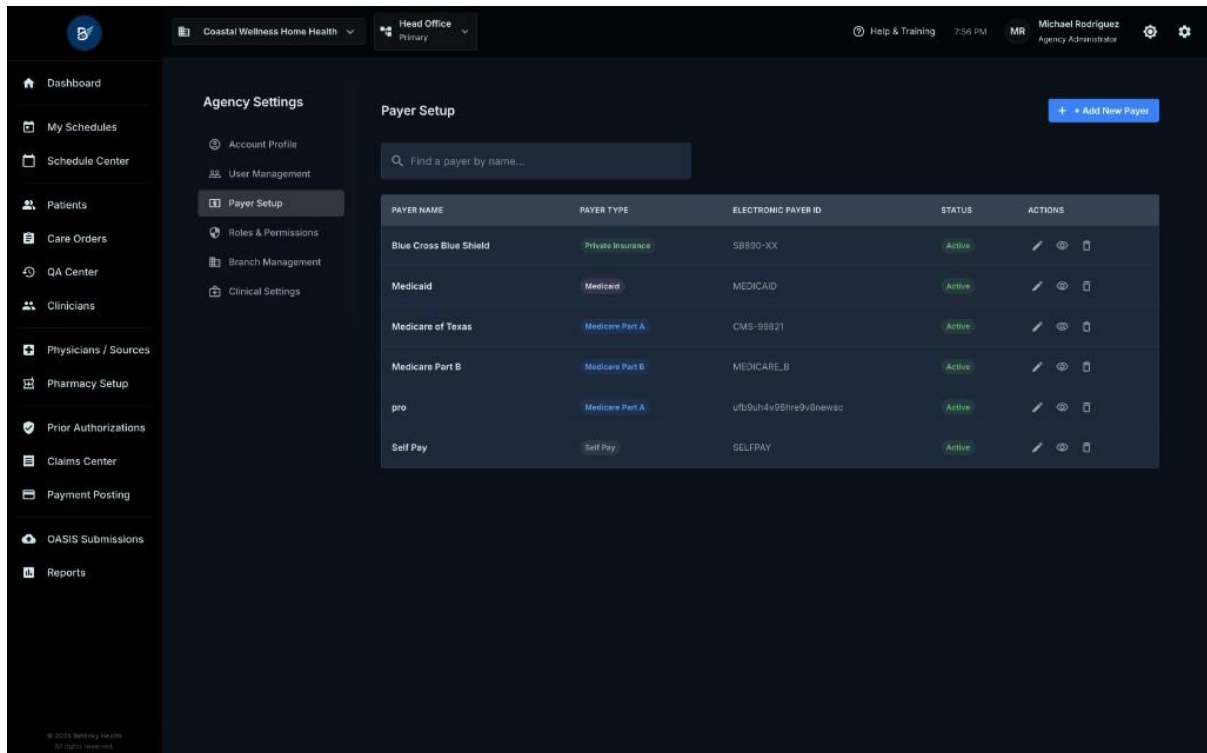
Billing & Reporting

- Each branch can have its own Fee Schedules and HIPPS Rates
- Reports can be filtered by branch
- Claims are submitted using the branch's specific identifiers

5.2 Accessing Branch Management

Navigation Path

1. **From the Dashboard:** Click the **Settings** icon (gear icon) in the top-right header bar
2. Select **"Branch Management"** from the dropdown menu
3. The **Branch Management** page will open, showing all existing branches



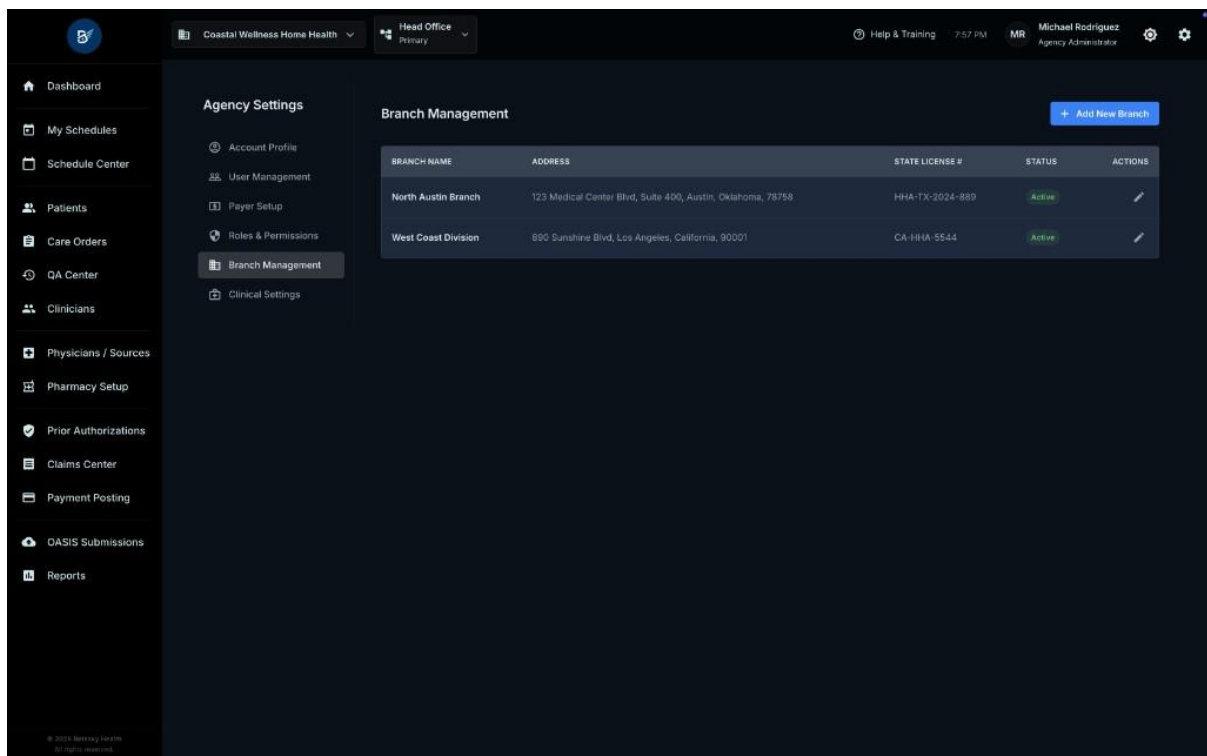
What You'll See:

- List of all branches (if any exist)
- Each branch shows: Branch Name, Address, State License, PTAN (if available)
- **Add New Branch** button in the top-right corner

5.3 Creating a New Branch

5.3.1 Click "Add New Branch"

1. In the Branch Management page, click the **Add New Branch** button (top-right)
2. The **Add Branch** modal will open



5.3.2 Required Branch Information

Branch Name

- **Purpose:** Identifies the branch within your agency
- **Format:** Text (up to 100 characters)
- **Examples:**
 - "Head Office" (default for single-branch agencies)
 - "North Austin Branch"
 - "West Coast Division"
 - "Houston Service Area"

Best Practices:

- Use descriptive names that clearly indicate location or purpose
- Avoid generic names like "Branch 1" or "Location A"
- Include city or region for clarity

Address Information

Complete physical address for this branch location:

- **Street Address:** Physical office location
- **City:** City name
- **State:** Two-letter state abbreviation (e.g., TX, CA, NY)
- **ZIP Code:** 5-digit or 9-digit format

Important:

- This address is used for official communications and regulatory purposes

- It should match the address on your state license for this location
- P.O. boxes are generally not accepted for home health branch offices

State License Number

- **Purpose:** Your state-issued home health license for this specific location
- **Format:** Varies by state (alphanumeric, typically 6-12 characters)
- **Required:** Yes, for production operations
- **Examples:**
 - Texas: HHA000123
 - California: 990000123
 - Florida: HH-123456

Where to Find:

- Issued by your state's Department of Health or equivalent regulatory body
- Separate license required for each state where you operate

Medicare PTAN (Provider Transaction Access Number)

- **Purpose:** Unique identifier assigned by Medicare for billing and claims submission
- **Format:** Alphanumeric (typically 10 characters)
- **Required:** For Medicare billing from this branch
- **Example:** 1AB2C34D5E

Important Notes:

- Each branch location may have a separate PTAN
- Required if this branch submits Medicare claims
- Obtain from your Medicare Administrative Contractor (MAC)
- Different from your NPI (which is agency-wide)

5.3.3 Optional Information

Phone Number

- **Purpose:** Direct contact number for this branch location
- **Format:** (###) ###-####
- **Use Case:** If this branch has a dedicated phone line

Email

- **Purpose:** Branch-specific email address
- **Use Case:** For branch managers or local administrative contacts

5.4 Managing Existing Branches

5.4.1 Editing Branch Information

1. In the **Branch Management** page, locate the branch you want to edit
2. Click the **Edit** icon (pencil icon) next to the branch

3. The **Edit Branch** modal opens with pre-filled information
4. Update any fields as needed
5. Click **Save Changes**

Editable Fields:

- Branch Name
- Address (Street, City, State, ZIP)
- State License Number
- PTAN
- Phone and Email

Non-Editable:

- Branch creation date
- Associated data (patients, visits, claims already tied to this branch)

5.4.2 Deactivating a Branch

When to Deactivate:

- You've closed a physical location
- A branch is no longer in operation
- You're consolidating multiple branches

How to Deactivate:

1. Click the **Deactivate** or **Archive** button next to the branch
2. Confirm the action in the confirmation dialog

Effect of Deactivation:

- The branch no longer appears in the Branch Selector for most users
- Existing patients, visits, and data remain accessible (historical record)
- Users can no longer create new patients or visits for this branch
- Reports can still include historical data from this branch

Important:

- You cannot delete a branch if it has associated data (patients, visits, claims)
- Deactivation is the recommended approach for closed branches

5.5 Assigning Users to Branches

Users can be granted access to one or multiple branches. This is managed in the User Management section (Chapter 8).

5.5.1 Single-Branch Access

Typical Users:

- Clinicians who only work at one location
- Schedulers responsible for one branch

- Branch-specific intake coordinators

How It Works:

- User only sees data for their assigned branch
- They cannot switch branches in the header bar
- All their work (patients, visits, documentation) is tied to that branch

5.5.2 Multi-Branch Access

Typical Users:

- Agency Administrators (access to all branches)
- Clinical Managers overseeing multiple locations
- Super Administrators (Betasky staff)

How It Works:

- User can access multiple branches via the **Branch Selector** in the header bar
- Each branch can have different role assignments (see Chapter 3, Section 3.8)
- Example: User is a "Clinical Manager" at North Austin Branch and a "Scheduler" at West Coast Division

5.6 Using the Branch Selector

5.6.1 Location in the UI

The **Branch Selector** is located in the **top header bar**, next to the Agency Selector (if applicable).

Appearance:

- Dropdown menu showing the currently selected branch name
- Example: "Head Office" or "North Austin Branch"
- Only visible if you have access to multiple branches

5.6.2 Switching Branches

To Change Your Active Branch:

1. Click the **Branch Selector** dropdown in the header bar
2. A list of branches you have access to will appear
3. Click the branch you want to switch to
4. The page will refresh, and all data will now reflect the selected branch

What Changes:

- Patient list (only patients from selected branch)
- Schedule/visits (only visits at selected branch)
- Care orders, OASIS, QA items (scoped to branch)
- Reports and dashboards (filtered by branch)

What Stays the Same:

- Your user profile and settings

- Agency-wide configurations (payers, pharmacies, fee schedules)
- User roles and permissions (though they may differ per branch)

5.6.3 Default Branch

When you log in:

- The system selects your **primary branch** (configured in your user profile)
- If you have access to only one branch, it's automatically selected
- If you have access to multiple branches, your most recently used branch is selected

5.7 Branch-Specific Settings

Certain settings can be configured per branch:

5.7.1 Fee Schedules

- Each branch can have its own billing rates
- Useful for geographic pricing differences or payer contracts

5.7.2 Clinician Assignments

- Clinicians can be assigned to specific branches
- A clinician can work at multiple branches (e.g., traveling therapists)

5.7.3 Reporting & Analytics

- Performance metrics tracked per branch
- Revenue, visit counts, and outcomes can be compared across branches

5.8 Troubleshooting Common Issues

Issue 1: "Branch Selector Not Appearing"

Problem: You don't see the branch selector in the header bar

Solution:

- You may only have access to one branch
- The branch selector only appears for users with multi-branch access
- Contact your Agency Administrator to request access to additional branches

Issue 2: "Cannot Create Patient in This Branch"

Error Message: "You do not have permission to create patients in this branch"

Solution:

- Your user role at the selected branch may not include `CREATE_PATIENT` permission
- Check with your administrator about your role assignment for this branch
- Switch to a branch where you have appropriate permissions

Issue 3: "State License Number Already in Use"

Error Message: "This state license is already assigned to another branch"

Solution:

- Each state license can only be used once in the system
- Verify the license number for accuracy
- If you're setting up a new location in the same state, you need a separate state license
- Contact your state regulatory agency if you're unsure about multi-location licensing

Issue 4: "PTAN Not Accepted"

Problem: System rejects your PTAN entry

Solution:

- Ensure the PTAN is exactly as issued by your Medicare Administrative Contractor (MAC)
- Check for extra spaces or typos
- PTAN format varies, but it's typically alphanumeric (10 characters)
- Contact Betasky Support if the issue persists

Chapter 6: Payer Setup

Overview

Payer Setup is where you configure all insurance companies (payers) that your agency accepts, including Medicare, Medicaid, and private insurance. This chapter covers:

- Understanding payers and their role in billing
- Adding and managing payers
- Configuring Medicare HIPPS rates
- Setting up payer-specific billing rules
- Managing payer contacts and submission details

Who Should Read This Chapter:

- Agency Administrators
- Billing Managers
- Intake Coordinators (to verify insurance eligibility)

Prerequisites:

- Completed agency settings (Chapter 4)
- Understanding of home health billing concepts (PDGM, HIPPS codes)

6.1 What is a Payer?

A **Payer** is an insurance company or government program that reimburses your agency for home health services provided to patients.

6.1.1 Types of Payers

Medicare

- **Description:** Federal health insurance program for individuals 65+ and certain disabled persons
- **Payment Model:** Patient-Driven Groupings Model (PDGM)
- **HIPPS Codes:** 5-character codes determine payment per 30-day period
- **Claim Type:** UB-04 (CMS-1500 for some physicians)

Medicaid

- **Description:** State and federal program for low-income individuals
- **Payment Model:** Varies by state (fee-for-service, managed care)
- **Claim Type:** UB-04

Private Insurance

- **Description:** Commercial insurance companies (e.g., Blue Cross Blue Shield, Aetna, UnitedHealthcare)
- **Payment Model:** Fee-for-service, per-visit, or contracted rates
- **Claim Type:** UB-04 or proprietary electronic claims

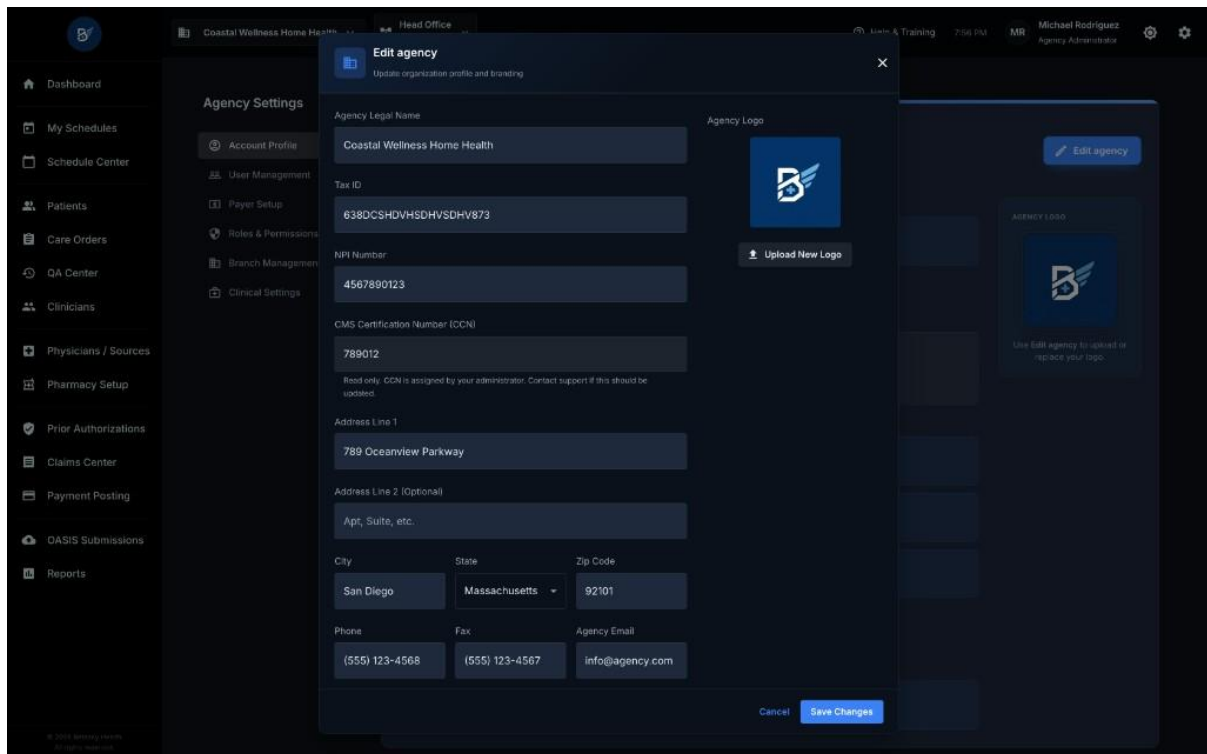
Managed Care Organizations (MCOs)

- **Description:** Health plans that contract with providers to deliver care at reduced costs
- **Examples:** Medicare Advantage, Medicaid Managed Care
- **Payment Model:** Contracted rates, capitation, or per-episode

6.2 Accessing Payer Setup

Navigation Path

1. **From the Dashboard:** Click **Settings** (gear icon) in the top-right header bar
2. **Select "Payer Setup"** from the dropdown menu
3. The **Payer Management** page will open



What You'll See:

- List of all configured payers
- Payer Name, Type (Medicare, Medicaid, Private), and Status (Active/Inactive)
- **Add New Payer** button in the top-right corner
- Search and filter options

6.3 Adding a New Payer

6.3.1 Click "Add New Payer"

1. In the Payer Management page, click the **Add New Payer** button
2. The **Add Payer** modal will open

6.3.2 Required Payer Information

Payer Name

- **Purpose:** Official name of the insurance company or program
- **Format:** Text (up to 255 characters)
- **Examples:**
 - "Medicare - [Your MAC Name]" (e.g., "Medicare - Palmetto GBA")
 - "Medicaid - [State]" (e.g., "Medicaid - Texas")
 - "Blue Cross Blue Shield of Texas"
 - "UnitedHealthcare"

Best Practices:

- Use the payer's official legal name

- Include state or region if the payer operates regionally
- Avoid abbreviations unless they're standard (e.g., "BCBS" for Blue Cross Blue Shield)

Payer Type

- **Purpose:** Categorizes the payer for billing and reporting
- **Options:**
 - **Medicare** - Federal Medicare program
 - **Medicaid** - State Medicaid program
 - **Private Insurance** - Commercial insurance companies
 - **Managed Care** - MCOs, Medicare Advantage, etc.
 - **Other** - Workers' comp, VA, or other non-traditional payers

Payer ID

- **Purpose:** Unique identifier assigned to the payer
- **Format:** Alphanumeric (5-10 characters)
- **Examples:**
 - Medicare: Varies by MAC (e.g., 00510 for Palmetto GBA)
 - Medicaid: Varies by state
 - Private: Payer-assigned ID or national plan ID
- **Where to Find:** Provided by the payer or obtained during enrollment

Status

- **Active:** Payer is currently accepted and can be assigned to new patients
- **Inactive:** Payer is no longer accepted (but historical claims remain accessible)

6.4 Payer Contact Information

6.4.1 Primary Contact

Address

Complete address for claims submission or correspondence:

- **Street Address**
- **City**
- **State**
- **ZIP Code**

Phone Number

- **Purpose:** Main contact number for billing inquiries, claim status checks, and authorizations
- **Format:** (###) ###-####

Email

- **Purpose:** Email for electronic correspondence (e.g., remittance advice, claim inquiries)
- **Format:** Valid email address

Website

- **Purpose:** Payer's portal for eligibility checks, claim submission, and provider resources
- **Example:** <https://www.cms.gov/> (for Medicare)

6.4.2 Claims Submission Details

Claims Submission Address

- **Purpose:** Where to mail paper claims (if applicable)
- **Note:** Most claims are submitted electronically via clearinghouse

Clearinghouse Information

- **Purpose:** Third-party intermediary for electronic claim submission
- **Examples:** Change Healthcare, Availity, Waystar
- **Setup:** Configured in your billing module (not in Payer Setup)

Electronic Payer ID

- **Purpose:** Payer identifier used by the clearinghouse for electronic claims
- **Format:** Varies by clearinghouse
- **Example:** 13551 (Medicare's national payer ID)

6.5 Medicare HIPPS Rates

HIPPS stands for **Health Insurance Prospective Payment System**. Under the Patient-Driven Groupings Model (PDGM), Medicare pays home health agencies based on 5-character HIPPS codes that reflect patient characteristics and resource needs.

6.5.1 Understanding HIPPS Codes

A HIPPS code is structured as follows:

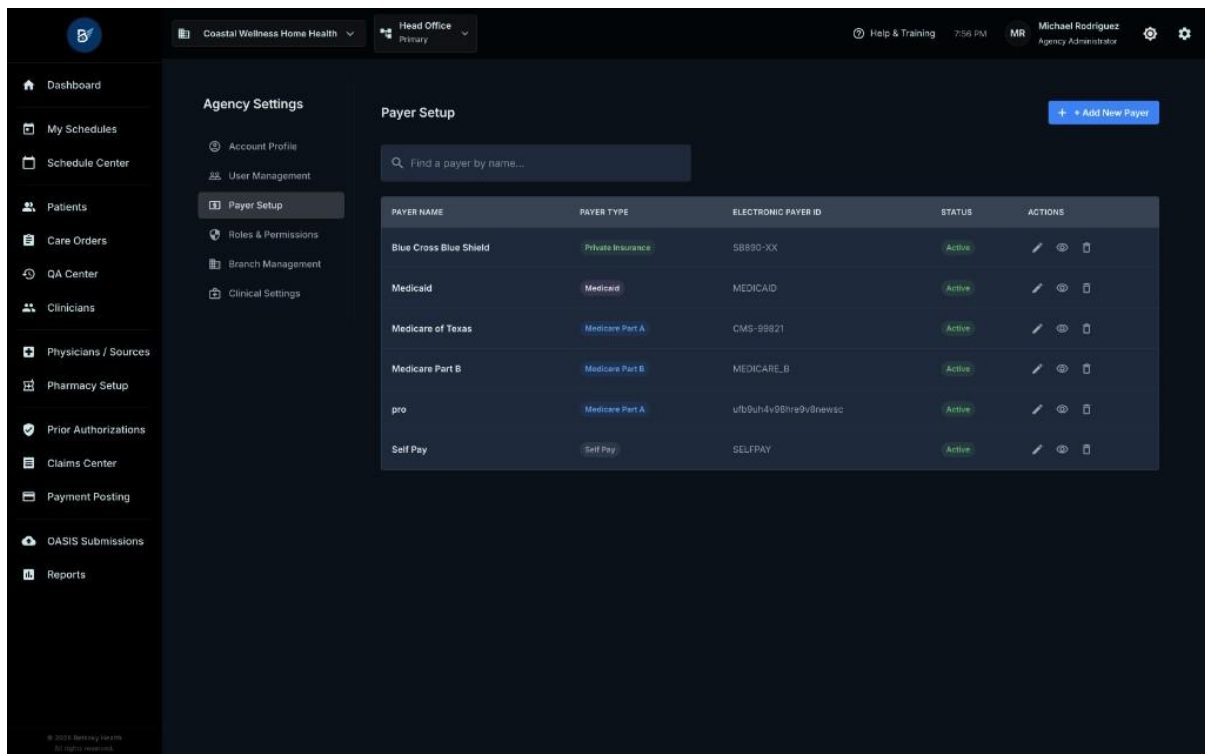
Position	Component	Meaning
1	Admission Source	1 = Community, 2 = Institutional
2	Clinical Grouping	A-L = 12 different clinical categories based on primary diagnosis
3	Functional Impairment	A-C = Low, Medium, High functional impairment
4	Comorbidity	1-3 = None, Low, High comorbidity adjustment
5	Timing	1 = Early (days 1-30), 2 = Late (days 31-60)

Example:

- **1AA11** = Community admission, Behavioral/Neurological, Low function, No comorbidity, Early period
- **2CB32** = Institutional admission, Musculoskeletal, High function, High comorbidity, Late period

6.5.2 Configuring HIPPS Rates

Medicare reimburses home health agencies based on the applicable HIPPS code. These rates are updated annually by CMS and vary by geographic region (wage-adjusted).



To Configure HIPPS Rates:

1. In the **Payer Management** page, click on **Medicare** to view details
2. Navigate to the **HIPPS Rates** tab
3. You will see a table listing all HIPPS codes (there are 432 possible combinations, but only a subset are commonly used)

For Each HIPPS Code:

- **Code:** The 5-character HIPPS code (e.g., 1AA11)
- **Description:** Brief explanation of what the code represents
- **Rate:** Payment amount (in USD) for a 30-day period
- **Effective Date:** When this rate became active
- **End Date:** When this rate expires (if applicable)

6.5.3 Updating HIPPS Rates

HIPPS rates are typically updated by Betasky staff when CMS releases new rates (usually annually in January).

If You Need to Update Manually:

1. Click the **Edit** icon next to the HIPPS code
2. Enter the new **Rate** and **Effective Date**
3. Click **Save**

Important:

- Always use the rates provided by CMS for your region
- Incorrect rates will result in underpayment or overpayment (and potential audits)
- Rates are wage-adjusted based on your agency's geographic location

Where to Find Official HIPPS Rates:

- CMS PDGM webpage: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS>
- Your Medicare Administrative Contractor (MAC) website

6.5.4 HIPPS Code Assignment

Automatic Assignment:

- The system automatically calculates the HIPPS code based on:
 - OASIS assessment data (functional scores, comorbidity)
 - Primary diagnosis (determines clinical grouping)
 - Admission source (community vs institutional)
 - Period timing (early vs late)

Manual Override:

- Agency Administrators can manually adjust the HIPPS code on a claim if needed
- Use this feature with caution (only for corrections, not to inflate billing)

6.6 Payer-Specific Billing Rules

6.6.1 Authorization Requirements

Some payers require prior authorization before services begin.

To Configure:

1. In the payer detail page, navigate to **Billing Rules**
2. Enable **Requires Prior Authorization**
3. Set the **Authorization Duration** (e.g., 30 days, 60 days, entire episode)

Effect:

- When a patient is assigned this payer, the system will prompt for an authorization number during intake
- Prior Authorization Center (Chapter 27) will track authorization expirations

6.6.2 Visit Limits

Per-Day Limits:

- Maximum number of visits allowed per day (e.g., Medicare allows multiple visits if medically necessary)

Per-Episode Limits:

- Total visits allowed in a 60-day episode (common for private payers)

To Configure:

1. Set **Max Visits Per Day** and **Max Visits Per Episode** in the Billing Rules section
2. The system will warn schedulers if limits are exceeded

6.6.3 Co-Pay and Deductible

Co-Pay:

- Fixed amount the patient pays per visit (e.g., \$20 per visit)

Deductible:

- Annual or per-episode deductible the patient must meet before insurance pays

To Configure:

1. Enter the **Co-Pay Amount** (if applicable)
2. Enter the **Annual Deductible** (if applicable)
3. The system will display this information in patient financial records

6.7 Managing Existing Payers

6.7.1 Editing Payer Information

1. In the Payer Management page, click on the payer you want to edit
2. Update any fields (contact info, billing rules, HIPPS rates)
3. Click **Save Changes**

6.7.2 Deactivating a Payer

When to Deactivate:

- Your agency no longer accepts a particular insurance
- A payer has gone out of business or merged with another

How to Deactivate:

1. Click the **Deactivate** button next to the payer
2. Set the **Inactive Date** (date you stopped accepting this payer)
3. Confirm the action

Effect:

- The payer no longer appears in the dropdown for new patients
- Existing patients with this payer retain their insurance assignment (for historical records)
- Claims can still be generated for past service dates

6.7.3 Reactivating a Payer

If you resume accepting a previously inactive payer:

1. Click the **Reactivate** button
2. Update any outdated information (rates, contacts)
3. Click **Save**

6.8 Troubleshooting Common Issues

Issue 1: "HIPPS Rate Not Found"

Problem: When generating a claim, the system cannot find the HIPPS rate

Solution:

- Ensure the HIPPS code is configured in the Medicare payer setup
- Check that the **Effective Date** of the rate covers the claim's service date
- Update HIPPS rates if CMS has released new rates

Issue 2: "Payer ID Already Exists"

Error Message: "A payer with this ID already exists"

Solution:

- Each payer ID must be unique in the system
- Check if the payer is already configured (possibly under a different name)
- Use a modified payer ID if necessary (e.g., 00510-TX for Texas-specific Medicare)

Issue 3: "Authorization Required but Not Provided"

Error Message: "This payer requires prior authorization"

Solution:

- Ensure the authorization number is entered during patient intake (Chapter 14)
- Check the Prior Authorization Center (Chapter 27) for pending or expired authorizations
- Contact the payer to obtain authorization before scheduling visits

Issue 4: "Visit Limit Exceeded"

Warning: "This patient has reached the maximum visits allowed"

Solution:

- Review the payer's visit limits in the billing rules
- Contact the payer to request additional visits (if medically necessary)
- Document medical necessity in the clinical notes

Chapter 7: Pharmacy Setup

Overview

Pharmacy Setup is where you add and manage the pharmacies your agency works with for patient medication needs. This chapter covers:

- Adding pharmacies to your system
- Managing pharmacy contact information
- Coordinating medication orders
- Pharmacy status management

Who Should Read This Chapter:

- Agency Administrators
- Clinical Managers
- Nurses (RN, LPN) who coordinate patient medications

Prerequisites:

- Completed agency settings (Chapter 4)
- Understanding of medication management workflow

7.1 Understanding Pharmacy Management

7.1.1 Why Pharmacies Are Important

In home health care, coordinating patient medications is a critical part of care coordination. The Pharmacy Setup module allows you to:

- **Maintain a Directory:** Keep a list of pharmacies your patients use
- **Streamline Communication:** Quick access to pharmacy contact information for prescription orders
- **Medication Orders:** Reference pharmacies when documenting patient medications
- **Coordination:** Simplify communication between clinicians, patients, and pharmacies

7.1.2 How Pharmacies Are Used in the System

During Patient Intake:

- When admitting a patient, you can select their preferred pharmacy from your agency's list
- This information is saved in the patient's profile

During Care Documentation:

- Clinicians reference the patient's pharmacy when documenting medications
- Medication orders can be linked to the pharmacy for follow-up

For Medication Management:

- The Medication Management module (Chapter 16) uses pharmacy information for tracking prescriptions

- Nurses can quickly contact pharmacies for refills, clarifications, or coordination

In Reports:

- Pharmacy usage reports help identify your most-used pharmacies
- Useful for negotiating contracts or preferred partnerships

7.2 Accessing Pharmacy Setup Navigation Path

1. **From the Dashboard:** Click the **Settings** icon (gear icon) in the top-right header bar
2. **Select "Pharmacy Setup"** from the dropdown menu
3. The **Pharmacy Management** page will open

What You'll See:

- List of all configured pharmacies
- Each pharmacy shows: Name, Address, Phone, Fax, Status (Active/Inactive)
- **Add New Pharmacy** button in the top-right corner
- Search and filter options

7.3 Adding a New Pharmacy

7.3.1 Click "Add New Pharmacy"

1. In the Pharmacy Management page, click the **Add New Pharmacy** button (top-right)
2. The **Add Pharmacy** modal will open

7.3.2 Required Pharmacy Information

Pharmacy Name

- **Required:** Yes
- **Format:** Text (up to 255 characters)
- **Examples:**
 - "CVS Pharmacy #1234"
 - "Walgreens - Main Street"
 - "Austin Compounding Pharmacy"
 - "HEB Pharmacy"

Best Practices:

- Include the pharmacy chain name and location identifier (e.g., store number or street)
- This helps distinguish between multiple locations of the same chain
- Avoid generic names like "Pharmacy 1"

Example Naming Conventions:

- "CVS Pharmacy #5678 - 123 Oak Street, Austin, TX"

- "Walgreens - Downtown Branch"
- "Main Pharmacy" (too generic)

7.3.3 Address Information

Complete physical address for the pharmacy location:

Street Address (Line 1)

- **Required:** Recommended
- **Format:** Text
- **Example:** "123 Main Street"

Street Address (Line 2)

- **Optional**
- **Format:** Text
- **Example:** "Suite 200" or "Building A"

City

- **Required:** Recommended
- **Format:** Text
- **Example:** "Austin"

State

- **Required:** Recommended
- **Format:** Two-letter state abbreviation
- **Example:** TX, CA, NY

ZIP Code

- **Required:** Recommended
- **Format:** 5-digit or 9-digit (12345 or 12345-6789)
- **Example:** 78701 or 78701-1234

Why Address Is Important:

- Helps clinicians and patients locate the pharmacy
- Useful for verifying the correct pharmacy in multi-location scenarios
- Required for certain compliance and documentation purposes

7.3.4 Contact Information

Primary Phone Number

- **Required:** Yes (highly recommended)
- **Format:** (###) ###-####
- **Example:** (512) 555-7890
- **Purpose:** Main phone line for calling in prescriptions or coordinating refills

Fax Number

- **Optional:** But commonly used in healthcare
- **Format:** (###) ###-####
- **Example:** (512) 555-7891
- **Purpose:** Many prescriptions are still faxed to pharmacies for controlled substances or urgent orders

Email Address

- **Optional**
- **Format:** Valid email address
- **Example:** pharmacy@example.com
- **Purpose:** Electronic communication for non-urgent coordination

7.3.5 Pharmacy Contact Person (Optional)

If you have a specific contact at the pharmacy (e.g., a pharmacist or manager who handles your agency's orders), you can enter their name.

Contact First Name

- **Optional**
- **Format:** Text (up to 100 characters)
- **Example:** "Sarah"

Contact Last Name

- **Optional**
- **Format:** Text (up to 100 characters)
- **Example:** "Johnson"

Use Case:

- Your agency has a relationship with a specific pharmacist who handles home health orders
- You want clinicians to know who to ask for when calling the pharmacy
- Useful for pharmacies that provide specialized services (e.g., compounding, IV medications)

7.3.6 Status

Status Field

- **Required:** Yes
- **Format:** Dropdown selection
- **Options:**
 - **ACTIVE** - Pharmacy is currently in use and available for patient assignment
 - **INACTIVE** - Pharmacy is no longer used (closed location, discontinued partnership)

Default: New pharmacies are set to **ACTIVE** by default

7.3.7 Saving the New Pharmacy

After entering all information:

1. Click **Save** or **Add Pharmacy** at the bottom of the modal
2. The system validates:
 - Pharmacy Name is provided
 - At least one contact method (phone or email) is provided
3. If validation passes, the pharmacy is added to your agency's list
4. A **Success** toast notification appears: "Pharmacy added successfully"
5. The new pharmacy appears in the Pharmacy Management list

What Happens Next:

- The pharmacy is now available in patient intake dropdowns
- Clinicians can select this pharmacy when documenting patient medications
- The pharmacy appears in reports and medication management screens

7.4 Editing an Existing Pharmacy

To update pharmacy information:

7.4.1 Open the Edit Modal

1. In the **Pharmacy Management** page, locate the pharmacy you want to edit
2. Click the **Edit** icon (pencil icon) next to the pharmacy's name
3. The **Edit Pharmacy** modal opens with pre-filled information

What You Can Edit:

- Pharmacy name
- Address (street, city, state, ZIP)
- Phone, fax, and email
- Contact person name
- Status (Active/Inactive)

What You Cannot Edit:

- Pharmacy ID (internal system identifier)
- Historical data (patients already assigned to this pharmacy retain the association)

7.4.2 Saving Your Changes

1. Update the necessary fields
2. Click **Save Changes**
3. A **Success** toast notification appears: "Pharmacy updated successfully"

Important:

- Editing a pharmacy does not affect patients who are already assigned to it
- If you update the pharmacy's address or phone number, clinicians will see the updated information immediately

7.5 Deactivating or Reactivating a Pharmacy

7.5.1 When to Deactivate a Pharmacy

Deactivate a pharmacy when:

- The pharmacy location has closed
- Your agency no longer works with that pharmacy
- You want to remove it from patient intake dropdowns but preserve historical data

Effect of Deactivation:

- The pharmacy no longer appears in the dropdown list for new patients
- Existing patients assigned to this pharmacy retain the association (historical record)
- The pharmacy is marked as "INACTIVE" in the pharmacy list

7.5.2 How to Deactivate

Option A: From Pharmacy Management List

1. Locate the pharmacy in the Pharmacy Management page
2. Click the **Deactivate** button (or toggle the status)
3. Confirm the action

Option B: From Edit Pharmacy Modal

1. Open the pharmacy in edit mode
2. Change **Status** from **ACTIVE** to **INACTIVE**
3. Click **Save Changes**

7.5.3 How to Reactivate

If you need to restore a pharmacy (e.g., a partnership is renewed or a location reopens):

1. In the Pharmacy Management page, filter by **Inactive** pharmacies
2. Locate the pharmacy
3. Click **Reactivate** (or edit and change status to **ACTIVE**)
4. The pharmacy becomes available in dropdowns again

7.6 Using Pharmacies in Patient Care

7.6.1 Assigning a Pharmacy During Patient Intake

When admitting a new patient (Chapter 14):

1. In the **Patient Intake** form, navigate to the **Clinical Data** or **Medications** tab
2. Select the patient's **Preferred Pharmacy** from the dropdown
3. The pharmacy's contact information is saved with the patient's profile

If the Pharmacy Isn't Listed:

- Click **Add New Pharmacy** (inline option, if available)
- Or pause intake, add the pharmacy via Settings, then return to intake

7.6.2 Viewing Pharmacy Information in Patient Profile

Once a pharmacy is assigned to a patient:

- The pharmacy name, address, and phone number appear in the patient's **Clinical Overview**
- Clinicians can click on the pharmacy to see full contact details
- Useful for quick reference during home visits or medication coordination

7.6.3 Medication Orders and Coordination

When Documenting Medications:

- Clinicians document patient medications in the **Medication Management** module (Chapter 16)
- Each medication entry can reference the pharmacy where it's filled
- If a refill or clarification is needed, the clinician can quickly access pharmacy contact info

Faxing Prescriptions:

- If a physician provides a new prescription, the nurse can fax it to the pharmacy
- The fax number from the pharmacy setup is readily available

Phone Orders:

- Clinicians can call the pharmacy for refills, status checks, or coordination
- Having the phone number in the system saves time and reduces errors

7.7 Pharmacy List Features

7.7.1 Search and Filter

Search Bar:

- Search by pharmacy name, city, or phone number
- Real-time filtering as you type

Filter Options:

- **Status:** Active or Inactive
- **State:** Filter by state (useful for multi-state agencies)

7.7.2 Sorting

Click on column headers to sort by:

- Pharmacy Name (A-Z, Z-A)
- City
- State
- Status

7.7.3 Bulk Actions (Future Feature)

Future updates may support:

- Export pharmacy list to CSV

- Bulk status updates (e.g., deactivate multiple pharmacies at once)

7.8 Troubleshooting Common Issues

Issue 1: "Pharmacy Not Appearing in Dropdown"

Problem: You added a pharmacy, but it doesn't appear when trying to assign it to a patient

Solution:

1. **Check Status:** Ensure the pharmacy is set to **ACTIVE**
2. **Refresh the Page:** Sometimes the dropdown cache needs to refresh (press F5 or reload)
3. **Verify Agency Association:** Ensure the pharmacy is associated with your agency (if you have multi-agency access)

Issue 2: "Cannot Deactivate Pharmacy"

Error Message: "This pharmacy is assigned to active patients"

Solution:

- Pharmacies assigned to active patients can still be deactivated (historical data is preserved)
- If this error appears, it may be a system protection (contact Betasky Support to clarify)
- Alternatively, edit the pharmacy and set status to **INACTIVE**

Issue 3: "Wrong Pharmacy Selected for Patient"

Problem: A patient was assigned the wrong pharmacy during intake

Solution:

1. Go to the **Patient Profile**
2. Navigate to the **Clinical Data** or **Medications** section
3. Click **Edit** and select the correct pharmacy from the dropdown
4. Click **Save**

Issue 4: "Pharmacy Phone Number Is Incorrect"

Problem: Clinicians are calling an outdated number

Solution:

1. Edit the pharmacy in **Pharmacy Setup**
2. Update the phone number
3. Click **Save Changes**
4. The updated number is immediately reflected system-wide

7.9 Best Practices

Do This:

1. Use Descriptive Pharmacy Names:

- Include store number or location identifier
- Example: "CVS Pharmacy #1234 - Main Street, Austin"

2. Keep Contact Information Current:

- Regularly verify phone and fax numbers (especially after area code changes)
- Update addresses if a pharmacy relocates

3. Assign Pharmacies During Intake:

- Always ask patients for their preferred pharmacy
- If the patient doesn't have a preference, suggest nearby options

4. Maintain Active Partnerships:

- Identify the 3-5 pharmacies your patients use most frequently
- Build relationships with pharmacists at those locations

5. Deactivate Closed Pharmacies Promptly:

- If a pharmacy closes, deactivate it immediately to prevent confusion
- Check annually for outdated entries

6. Add Contact Persons:

- If you have a dedicated pharmacist contact, add their name
- This speeds up coordination for complex medication needs

Avoid This:

1. Don't Use Generic Names:

- "Pharmacy 1", "Pharmacy 2" are confusing as your list grows
- Use specific, identifiable names

2. Don't Leave Contact Info Blank:

- At a minimum, include a phone number
- Fax numbers are highly recommended (still common in healthcare)

3. Don't Forget to Update After Relocations:

- Pharmacies sometimes move to new locations
- Update the address to avoid clinicians going to the wrong location

4. Don't Create Duplicate Entries:

- Before adding a new pharmacy, search to see if it already exists
- Duplicates create confusion and data integrity issues

5. Don't Ignore Inactive Pharmacies:

- Clean up your pharmacy list periodically
- Archive or deactivate pharmacies you no longer use

Chapter 8: User Management

Overview

User Management is where Agency Administrators add, edit, and manage all staff members who will use the Betasky system. This chapter covers:

- Adding new users to your agency
- Assigning roles and permissions
- Managing multi-branch user access
- Configuring per-branch custom permissions
- User status management (Active, Inactive, Pending)
- Subscription user limits

Who Should Read This Chapter:

- Agency Administrators
- Super Administrators
- HR managers responsible for onboarding staff

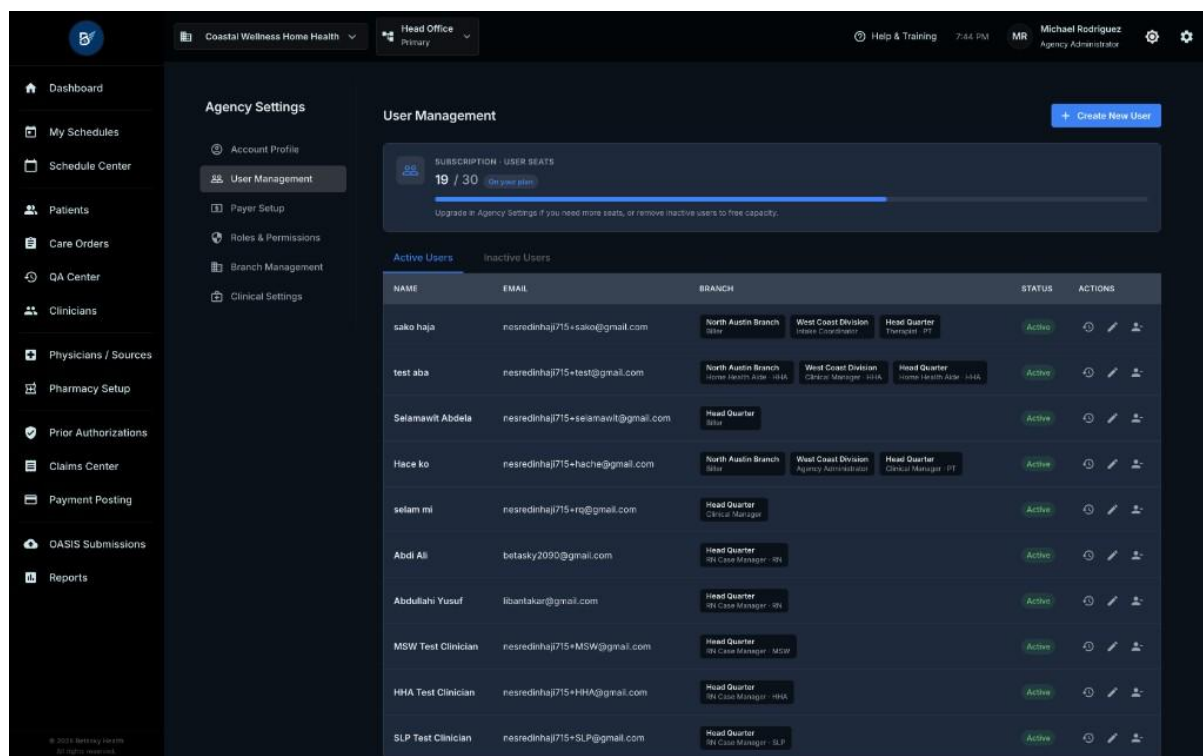
Prerequisites:

- Understanding of user roles and permissions (Chapter 3)
- Completed agency settings (Chapter 4)
- Branch setup (Chapter 5) if your agency has multiple locations

8.1 Accessing User Management

Navigation Path

1. **From the Dashboard:** Click the **Settings** icon (gear icon) in the top-right header bar
2. **Select "User Management"** from the dropdown menu
3. The **User Management** page will open



What You'll See:

- List of all users in your agency
- Each user shows: Name, Email, Role, Branch, Status, Last Login
- **Add New User** button in the top-right corner
- Search, filter, and sorting options

8.2 Understanding User Seat Limits

Your agency's subscription tier determines how many users you can add.

8.2.1 User Limits by Subscription Tier

Subscription Tier	User Limit	Notes
Sandbox	Unlimited	For testing purposes only
Test	5 users	Development accounts
Growth	20 users	Small to medium agencies
Pro	50 users	Mid-sized agencies
Enterprise	Unlimited	Large multi-branch agencies

8.2.2 User Seat Capacity Warning

When Near Limit:

- System displays a warning: "You have used X of Y user seats"
- Administrators receive a notification when 90% capacity is reached

At Capacity:

- Error message: "User seat capacity reached. Please upgrade your subscription or deactivate inactive users."
- **Add New User** button is disabled
- Existing users can still log in and work normally

Solution:

- Upgrade your subscription (contact Betasky Sales)
- Deactivate users who no longer work at your agency
- Set former employees to "INACTIVE" status (they still count toward the limit but cannot log in)

8.3 Adding a New User

Adding a user is a multi-step process that checks for existing users and validates information before granting access.

8.3.1 Step 1: Email Verification

The system first checks if the email address is already in use.

To Begin:

1. Click the **Add New User** button (top-right corner)
2. The **Add User** modal opens at **Step 1: Email Verification**

Enter Email Address:

- **Field:** Email
- **Format:** Valid email address (e.g., john.doe@example.com)
- **Validation:**
 - Must be a valid email format
 - System checks if this email already exists in the database

Three Possible Outcomes:

Outcome A: Email Not Found (New User)

- Message: "Email is available"
- Click **Continue** to proceed to Step 2
- You will enter all user details from scratch

Outcome B: User Exists, Already Has Access to Your Agency

- Warning: "This user already has access to your agency"
- The modal displays the user's current role and branch
- **Action Required:** Click **Close** or **Cancel**
- You cannot add the same user twice (edit the existing user instead)

Outcome C: User Exists in System, But Not in Your Agency

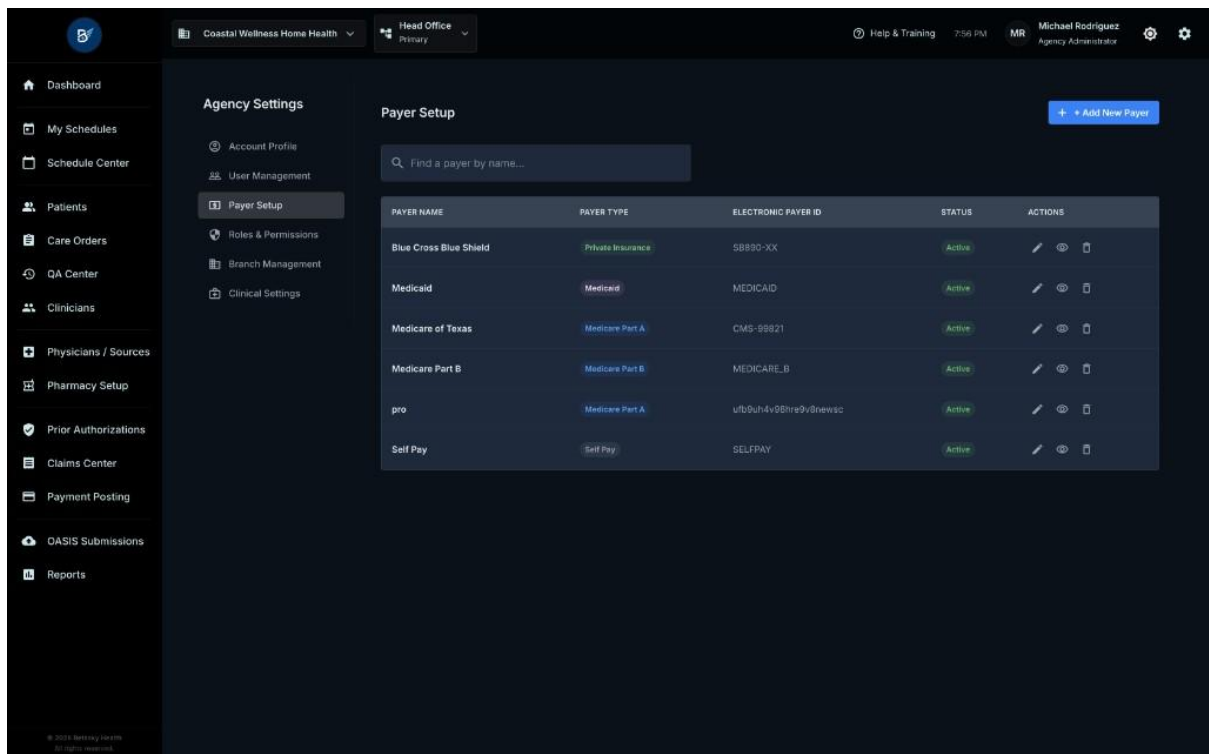
- Info: "User found in the system. Existing profile will be loaded."
- The system pre-fills the user's details (name, phone, discipline, license) from their existing profile
- Click **Continue** to proceed to Step 2
- **Benefit:** Speeds up onboarding for users who already work for another agency or were previously invited

Example:

- Jane Smith worked for "North Austin Home Health"
- She now joins your agency "West Coast Home Care"
- When you enter her email, the system finds her profile
- Her name, phone, and license details auto-fill (you only need to assign her role)

8.3.2 Step 2: User Details

After email verification, you enter (or confirm) the user's personal and professional information.



Personal Information

First Name

- **Required:** Yes
- **Format:** Text (up to 100 characters)
- **Example:** "John"

Last Name

- **Required:** Yes

- **Format:** Text (up to 100 characters)
- **Example:** "Doe"

Phone Number

- **Required:** No (but recommended for clinicians)
- **Format:** (###) ###-#### (automatically formatted as you type)
- **Example:** (512) 555-1234
- **Purpose:** Used for communications, scheduling alerts, and contact purposes

Professional Information (Optional for Non-Clinical Users)

Discipline

- **Required:** For clinical staff (RN, LPN, PT, OT, SLP, HHA, MSW)
- **Format:** Dropdown selection
- **Options:**
 - **RN** - Registered Nurse
 - **LPN / LVN** - Licensed Practical Nurse / Licensed Vocational Nurse
 - **PT** - Physical Therapist
 - **PTA** - Physical Therapist Assistant
 - **OT** - Occupational Therapist
 - **COTA** - Certified Occupational Therapy Assistant
 - **SLP** - Speech-Language Pathologist
 - **MSW** - Medical Social Worker
 - **HHA** - Home Health Aide
 - **(None)** - For non-clinical staff (administrators, schedulers, billers)

Important:

- Discipline is **required** for users who will provide patient care or complete visits
- Non-clinical staff (Agency Administrators, Intake Coordinators, Billers) can leave this blank

License Number

- **Required:** For licensed clinicians only
- **Format:** Alphanumeric (varies by state and discipline)
- **Examples:**
 - Texas RN: RN123456
 - California PT: PT987654
- **Purpose:** Tracked for compliance; required for Medicare/Medicaid billing

License Expiration Date

- **Required:** If License Number is provided
- **Format:** Date picker (MM/DD/YYYY)

- **Purpose:** System alerts administrators when licenses are expiring (90 days, 60 days, 30 days)

Best Practice:

- Keep license information current
- Set up alerts in the Compliance Tasks module (Chapter 32) to track expirations.

8.3.3 Step 3: Role & Branch Assignment

After entering user details, you assign the user's role and branch(es).

Primary Branch

- **Purpose:** The branch the user is primarily assigned to
- **Format:** Dropdown selection
- **Options:**
 - **Head Office** (default if single-branch agency)
 - All active branches (if multi-branch agency)

Single-Branch Agencies:

- If your agency has only one branch, this field auto-selects "Head Office"
- The user has access to all patients and data within that branch

Multi-Branch Agencies:

- The user will have access to this branch by default
- You can grant access to additional branches in the next section

Role

- **Purpose:** Defines the user's permissions (what they can do in the system)
- **Format:** Dropdown selection
- **Options:** All **Agency Roles** (see Chapter 3 for details):
 - Agency Administrator
 - Clinical Manager
 - Scheduler
 - Biller
 - Intake Coordinator
 - RN Case Manager
 - LPN / LVN
 - Therapist (PT / OT / SLP)
 - Home Health Aide
 - Custom Roles (if your subscription includes Custom Role Builder)

Important:

- **Platform Roles** (Super Administrator, Sales & Onboarding, Support Engineer) cannot be assigned by Agency Administrators

- Platform roles are internal Betasky staff roles managed separately

User Status

- **Purpose:** Controls whether the user can log in
- **Format:** Dropdown selection
- **Options:**
 - **ACTIVE** - User can log in and work (default for new users)
 - **INACTIVE** - User cannot log in (for former employees or suspended accounts)
 - **PENDING** - User has been invited but has not completed setup (reserved for future invitation workflows)

Recommendation:

- Always set new users to **ACTIVE** unless you're pre-creating accounts for future employees

8.3.4 Multi-Branch Access (Optional)

If your agency has multiple branches and the user needs access to more than one, you can configure multi-branch assignments.

When to Use:

- Clinical Managers who oversee multiple locations
- Traveling clinicians who work at different branches
- Agency Administrators (who typically need access to all branches)
- Schedulers coordinating visits across multiple regions

How to Add Additional Branches:

1. In the **Add User** modal, scroll to the **Branch Access** section
2. Click **Add Branch**
3. A new row appears with the following fields:
 - **Branch:** Dropdown to select the branch
 - **Role at This Branch:** Dropdown to select the user's role at this specific branch
 - **Discipline at This Branch:** (Optional) Override the primary discipline for this branch

Example:

Branch	Role	Discipline
North Austin Branch	Clinical Manager	RN
West Coast Division	Scheduler	(None)

In this example, the user is a Clinical Manager (with nursing responsibilities) in North Austin but only a Scheduler in the West Coast Division.

Removing a Branch:

- Click the **Delete** icon (trash can) next to the branch row
- The user will lose access to that branch

8.3.5 Custom Permissions (Pro, Test, Enterprise Only)

If your subscription includes the **Custom Role Builder** feature, you can assign **per-branch custom permissions** to further refine access control.

What Are Custom Permissions?

- Granular permissions beyond the standard role (e.g., `CREATE_PATIENT`, `APPROVE_DOCUMENT`, `GENERATE_CLAIM`)
- Can be added or removed on a per-branch basis
- Useful for unique staffing scenarios or temporary elevated access

To Add Custom Permissions:

1. In the **Branch Access** section, click **Customize Permissions** next to a branch
2. An accordion menu expands, showing all available permissions grouped by category:
 - **Patient Management** (e.g., `CREATE_PATIENT`, `UPDATE_PATIENT`, `DELETE_PATIENT`)
 - **Clinical Documentation** (e.g., `CREATE_VISIT`, `APPROVE_OASIS`, `UPDATE_CARE_ORDER`)
 - **Billing & Claims** (e.g., `GENERATE_CLAIM`, `APPROVE_CLAIM`, `POST_PAYMENT`)
 - **Administration** (e.g., `MANAGE_USERS`, `MANAGE_BRANCHES`, `VIEW_AUDIT_LOG`)
 - **Reports** (e.g., `VIEW_REPORTS`, `EXPORT_DATA`)
3. Check or uncheck specific permissions to add or remove them
4. These custom permissions are **additive** (they add to the role's base permissions)

Example Scenario:

- **User:** Sarah, an RN Case Manager at the North Austin Branch
- **Standard Role Permissions:** Can create visits, document care, complete OASIS
- **Custom Permission Added:** `APPROVE_OASIS` (normally only Clinical Managers can approve)
- **Result:** Sarah can now approve OASIS assessments at the North Austin Branch, but not at other branches

Important Notes:

- Custom permissions are only available in **Pro, Test, and Enterprise** subscriptions
- If your subscription does not include Custom Role Builder, this section will not appear
- Custom permissions override role restrictions (use with caution)

8.3.6 Saving the New User

After entering all information:

1. Click **Save** or **Create User** at the bottom of the modal
2. The system validates all fields:
 - All required fields are filled
 - Email is unique within your agency

- License expiration date is in the future (if provided)
 - At least one branch and role are assigned
3. If validation passes, the user is created
 4. A **Success** toast notification appears: "User created successfully"
 5. The new user appears in the User Management list

What Happens Next:

- The user receives an email with their login credentials (if email invitation is enabled)
- They can immediately log in to the system (if status is ACTIVE)
- Their name appears in dropdowns for scheduling, patient assignment, and documentation

8.4 Editing an Existing User

To update a user's information, role, or branch assignments:

8.4.1 Open the Edit Modal

1. In the **User Management** page, locate the user you want to edit
2. Click the **Edit** icon (pencil icon) next to the user's name
3. The **Edit User** modal opens with pre-filled information

What You Can Edit:

- Personal information (name, phone)
- Professional details (discipline, license number, expiration date)
- Role and branch assignments
- User status (Active, Inactive)
- Custom permissions (per branch)

What You Cannot Edit:

- Email address (email is the unique identifier)
- User ID (internal system identifier)

8.4.2 Edit Mode Tabs

The Edit User modal has **two tabs**:

Tab 1: User Details

- Update name, phone, discipline, license information
- Change primary role and branch
- Update user status

Tab 2: Branch & Permissions

- Manage multi-branch access
- Configure per-branch roles and disciplines
- Set custom permissions for each branch (if available)

To Switch Tabs:

- Click the **User Details** or **Branch & Permissions** tab at the top of the modal

8.4.3 Updating Branch Access

In the **Branch & Permissions** tab, you can:

Add a New Branch:

1. Click **Add Branch**
2. Select the branch from the dropdown
3. Assign a role for this branch
4. (Optional) Set a discipline and custom permissions
5. Click **Save**

Edit an Existing Branch Assignment:

1. Locate the branch in the list
2. Click the **Edit** icon next to the branch
3. Update the role, discipline, or custom permissions
4. Click **Save**

Remove Branch Access:

1. Locate the branch in the list
2. Click the **Delete** icon (trash can)
3. Confirm the action
4. The user will no longer have access to this branch

Important:

- Users must have at least one branch assignment
- You cannot remove the user's last branch (deactivate the user instead)

8.4.4 Managing Per-Branch Custom Permissions

For each branch the user has access to, you can configure custom permissions.

To Customize Permissions for a Branch:

1. In the **Branch & Permissions** tab, find the branch
2. Click **Customize Permissions** (or expand the branch accordion)
3. A list of permission categories appears (e.g., Patient Management, Clinical Documentation, Billing)
4. Click on a category to expand it
5. Check or uncheck individual permissions
6. The changes are saved automatically when you click **Save** in the modal

Example:

Branch: North Austin Branch

Role: RN Case Manager

Custom Permissions Added:

- `APPROVE_OASIS` (can approve OASIS assessments)

- **GENERATE_CLAIM** (can generate claims)

Custom Permissions Removed:

- **DELETE_PATIENT** (cannot delete patients even though some Case Managers can)

Result:

- This user has elevated approval rights but restricted deletion rights at this specific branch

8.4.5 Saving Your Changes

After editing:

1. Click **Save Changes** at the bottom of the modal
2. The system validates all fields
3. If validation passes, the user is updated
4. A **Success** toast notification appears: "User updated successfully"

8.5 Deactivating or Reactivating a User

8.5.1 When to Deactivate a User

Deactivate a user when:

- An employee leaves the agency (termination, resignation, retirement)
- A user account is suspended for policy violations
- A temporary employee's contract ends
- You want to preserve historical data but revoke access

Effect of Deactivation:

- User cannot log in
- User still counts toward your subscription's user seat limit (unless permanently deleted)
- Historical data (visits, documentation) remains accessible with the user's name attached

8.5.2 How to Deactivate

Option A: From User Management List

1. Locate the user in the User Management page
2. Click the **Deactivate** button (or status toggle)
3. Confirm the action

Option B: From Edit User Modal

1. Open the user in edit mode
2. Change **Status** from **ACTIVE** to **INACTIVE**
3. Click **Save Changes**

8.5.3 How to Reactivate

If you need to restore access to a previously deactivated user:

1. In the User Management page, filter by **Inactive** users
2. Locate the user

3. Click **Reactivate** (or edit and change status to ACTIVE)
4. The user can immediately log in again

8.6 User List Features

8.6.1 Search and Filter

Search Bar:

- Search by name, email, or role
- Real-time filtering as you type

Filter Options:

- **Status:** Active, Inactive, Pending
- **Role:** Filter by specific role (e.g., show only RN Case Managers)
- **Branch:** Filter by branch (multi-branch agencies only)
- **Discipline:** Filter by clinical discipline

8.6.2 Sorting

Click on column headers to sort by:

- Name (A-Z, Z-A)
- Email
- Role
- Branch
- Last Login (most recent, oldest)
- Status

8.6.3 Bulk Actions (Future Feature)

The system is designed to support bulk actions in future updates:

- Export user list to CSV
- Bulk role reassignment
- Bulk deactivation (e.g., at the end of a contract cycle)

8.7 User Login and Onboarding

8.7.1 How Users Receive Access

Option A: Email Invitation (If Enabled)

- After an administrator creates their account, the user receives an email with:
 - Login instructions
 - Temporary password (or link to set password)
 - System URL: <https://app.betaskyhealth.com/>

Option B: Manual Credential Sharing

- Administrator shares login credentials directly with the user (via phone, in-person, etc.)

8.7.2 First Login

When a user logs in for the first time:

1. They may be prompted to change their password (if using a temporary password)
2. They see a brief onboarding tour (optional, can be skipped)
3. They land on the **Dashboard** with access scoped to their role and branch

8.7.3 User Profile Settings

Users can update their own:

- Profile picture
- Phone number
- Password
- Notification preferences

Users cannot change:

- Their role
- Their branch assignments
- Their permissions (only administrators can modify these)

8.8 Troubleshooting Common Issues

Issue 1: "User Seat Capacity Reached"

Error Message: "Cannot add more users. Your plan allows a maximum of X users."

Solution:

1. **Option A:** Deactivate users who no longer work at your agency
2. **Option B:** Upgrade your subscription:
 - Contact Betasky Sales: sales@betaskyhealth.com
 - Request a tier upgrade (e.g., Growth → Pro)
3. **Temporary Workaround:** Set inactive users to INACTIVE status (they still count toward the limit but cannot log in)

Issue 2: "Email Already Exists"

Error Message: "This email is already in use"

Solution:

- **If the user already works for your agency:** Edit the existing user instead of creating a new one
- **If the user worked for another agency:** The system should detect this and pre-fill their details (see Section 8.3.1, Outcome C)
- **If you believe this is an error:** Contact Betasky Support to investigate

Issue 3: "Cannot Remove Last Branch"

Error Message: "User must have at least one branch assignment"

Solution:

- Users must always have access to at least one branch
- If you want to remove all access, **deactivate the user** instead

Issue 4: "License Expiration Warning"

Warning: "This user's license expires in X days"

Solution:

1. Contact the user to renew their license
2. Update the **License Expiration Date** in the user profile once renewed
3. Set up Compliance Tasks (Chapter 32) to automate license tracking

Issue 5: "Custom Permissions Not Available"

Problem: The "Customize Permissions" option doesn't appear

Solution:

- Custom permissions are only available in **Pro, Test, and Enterprise** subscriptions
- If you need this feature, upgrade your subscription
- Contact Betasky Sales to discuss your needs

Issue 6: "User Cannot See Patients/Data"

Problem: A user logs in but sees no patients or data

Solution:

1. **Check Branch Assignment:** Ensure the user is assigned to the correct branch
2. **Check Role Permissions:** Verify the user's role has the necessary permissions (e.g., `VIEW_PATIENT`)
3. **Check Branch Selector:** Ask the user to check the Branch Selector in the header bar and switch to the correct branch
4. **Verify Status:** Ensure the user status is `ACTIVE` (not `INACTIVE` or `PENDING`)

8.9 Best Practices

Do This:

1. Use Descriptive User Profiles:

- Enter full names (avoid nicknames or abbreviations)
- Include phone numbers for all clinical staff
- Keep license information current

2. Assign Roles Carefully:

- Use the principle of least privilege (give users only the access they need)
- Review roles quarterly to ensure they still match job responsibilities

3. Track License Expirations:

- Enter license numbers and expiration dates for all clinicians
- Set up automated alerts (Compliance Tasks module)
- Review expiring licenses monthly

4. Deactivate Former Employees Immediately:

- When an employee leaves, deactivate their account the same day
- This protects patient data and ensures compliance

5. Use Multi-Branch Access Strategically:

- Only grant multi-branch access to users who truly need it
- Managers and administrators typically need it; field staff usually don't

6. Leverage Custom Permissions (If Available):

- Use custom permissions to handle unique scenarios (e.g., temporary elevated access for training)
- Document why custom permissions were granted (for audit purposes)

7. Train New Users:

- Provide a guided tour of the system after their first login
- Share this user manual with new staff
- Assign a mentor or supervisor for the first week

Avoid This:

1. Don't Share Login Credentials:

- Each staff member should have their own account
- Sharing logins violates compliance and creates audit issues

2. Don't Leave Licenses Blank:

- Even if not immediately required, enter license information for all clinicians
- Missing licenses can block billing and cause claim denials

3. Don't Over-Assign Permissions:

- Not every user needs administrator access
- Excessive permissions create security risks and data integrity issues

4. Don't Forget to Deactivate:

- Inactive accounts are a security vulnerability
- Deactivate users promptly when they leave

5. Don't Ignore User Seat Limits:

- Monitor your user count regularly
- Plan ahead for seasonal staffing increases (e.g., hiring surge in Q1)

6. Don't Create "Generic" Accounts:

- Avoid shared accounts like "scheduler@agency.com" or "nurse1"
- Every user should have a unique, identifiable account

Chapter 9: My Schedules (Clinician View)

Overview

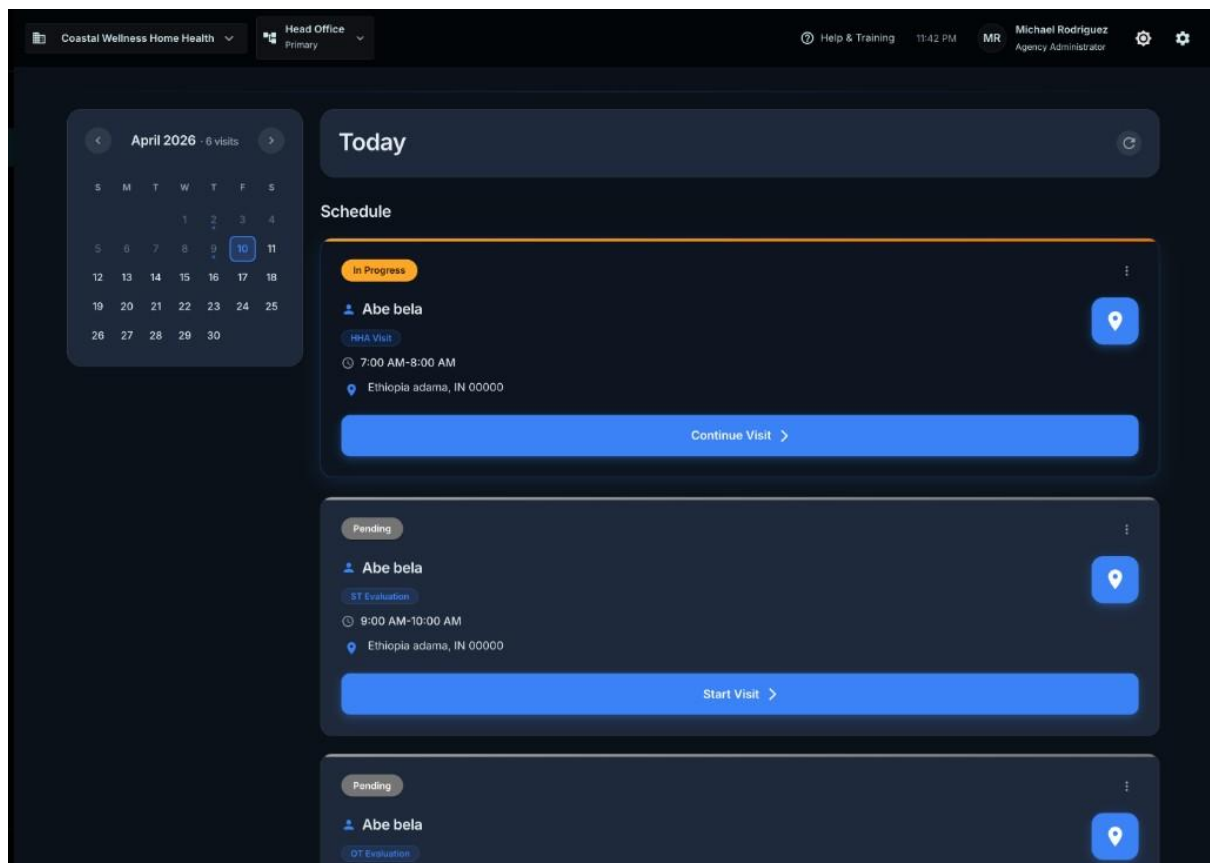
My Schedules (also called "**My Day**") is the clinician-facing schedule view where field staff see their daily visit schedule, start visits, report missed visits, and manage their personal appointments. This is different from the admin **Schedule Center** (Chapter 23), which is used by administrators and schedulers to assign and organize visits across all clinicians.

Key Difference:

- **Schedule Center (Admin)** - Drag-and-drop calendar for scheduling visits across multiple clinicians
- **My Schedules (Clinician)** - Personal day view showing only your own visits

Accessing My Schedules

From Sidebar



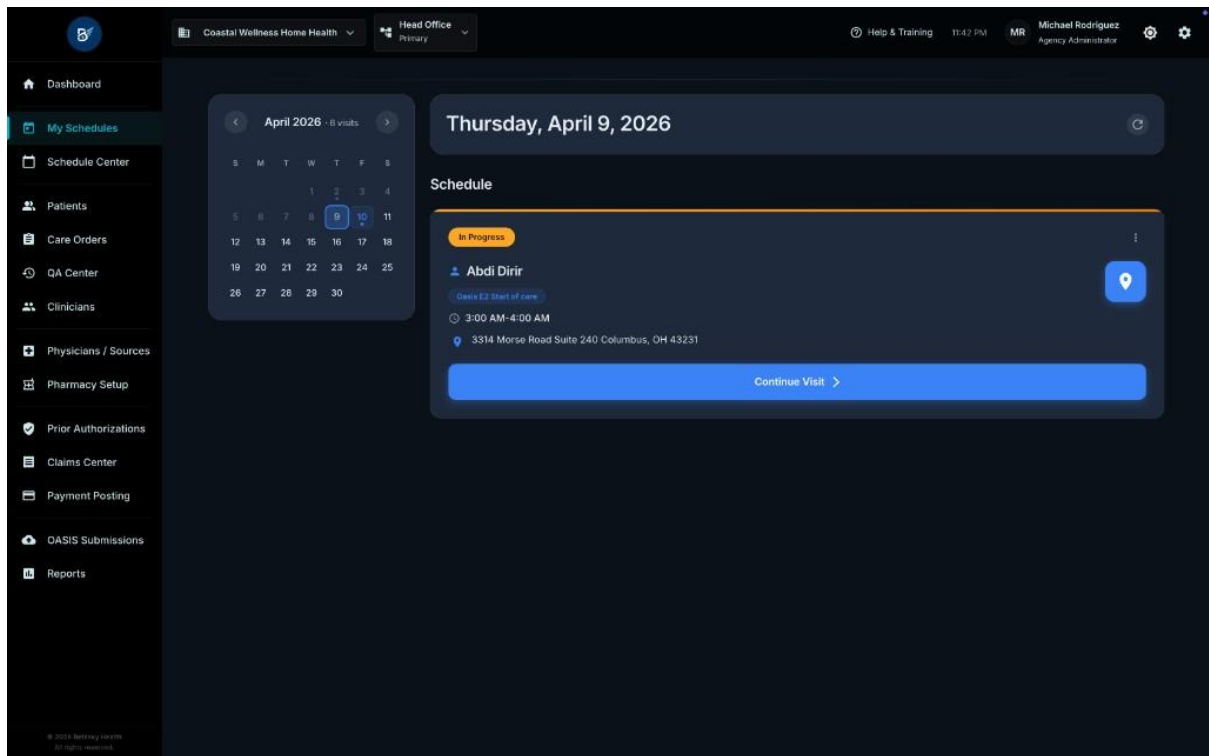
Location: Left sidebar navigation

Menu Item: "My Schedules" (cyan/teal highlight when selected)

Icon: Calendar icon

Click "My Schedules" to open your personal schedule view.

My Schedules Main Screen



Page Layout

The My Schedules page has **three main areas**:

1. Left Sidebar - Mini Calendar (Desktop Only)

- **Month/Year Header:** "April 2026 - 6 visits"
 - Shows current month and total visit count for the month
 - Navigation arrows (< >) to change months
- **Calendar Grid:**
 - Days of the week (S M T W T F S)
 - Date numbers
 - Blue circle highlights today's date (April 10 in the screenshot)
 - Visit counts appear as small indicators on dates with scheduled visits
- **Purpose:** Quick date navigation

2. Main Content Area - Header

- **Title:** "Today" or full date (e.g., "Thursday, April 9, 2026")
 - Shows "Today" if viewing current date
 - Shows full date if viewing a different day
- **Refresh Button:** Circular arrow icon (top right)
 - Click to reload your schedule
 - Useful to see newly assigned visits

3. Main Content Area - Schedule Section

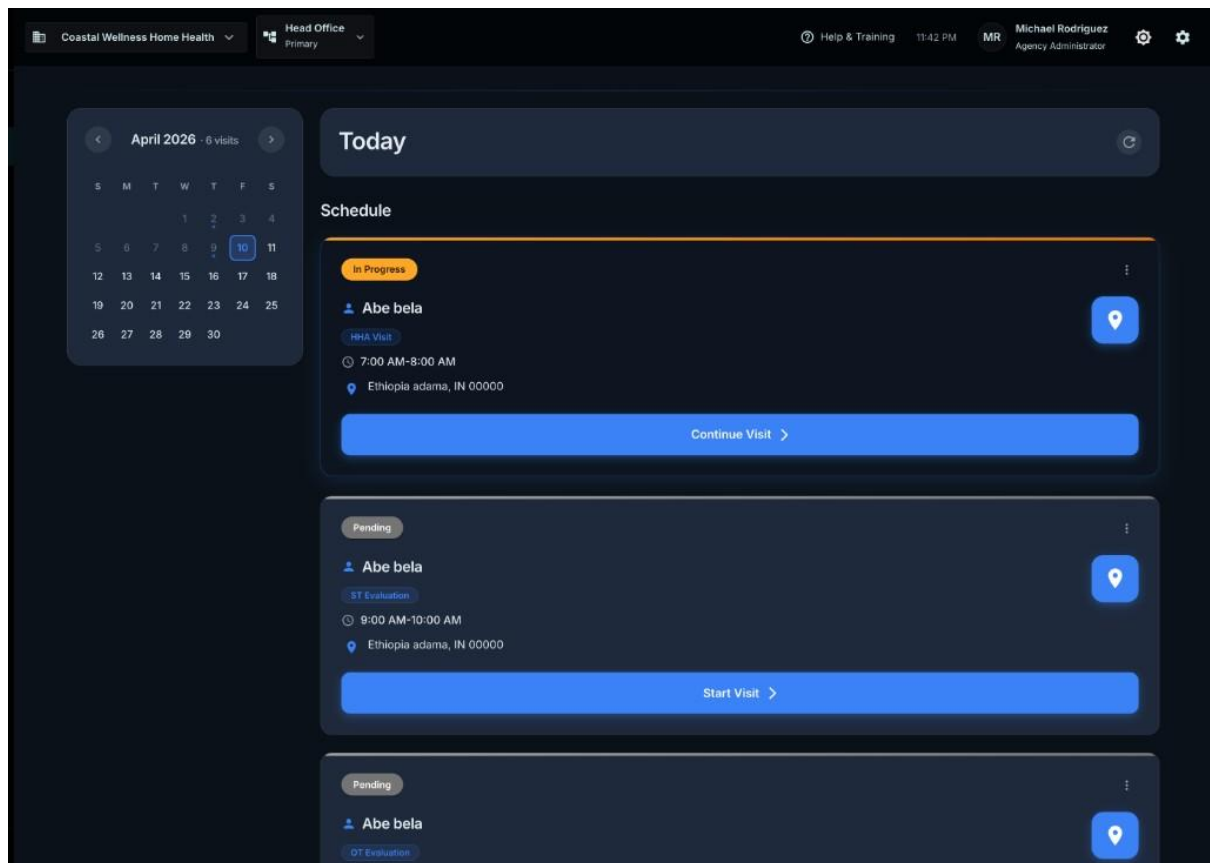
Section Title: "Schedule" (white text)

Orange Progress Bar: Visual separator under the title

Visit Cards

Each visit appears as a card with the following information:

Visit Card Elements



Status Badge (Top Left):

- **"In Progress"** - Orange/yellow badge
 - Visit has been started (you clicked "Start Visit")
 - Shows visit is currently active
- **"Pending"** - Gray badge
 - Visit is scheduled but not yet started
 - Waiting for clinician to begin

Patient Name (Large Blue Text):

- Full patient name (e.g., "Abe bela")
- Person icon () before name

Visit Type Chip (Blue Badge):

- Small badge below patient name

- Shows type of visit (e.g., "SN Visit", "ST Evaluation")
- Example: "SN Visit" in blue

Time Range (Clock Icon):

- Shows scheduled time window
- Format: "H:MM AM-H:MM AM"
- Example: "7:00 AM-8:00 AM", "9:00 AM-10:00 AM"
- Clock icon () before time

Patient Address (Location Pin Icon):

- Full street address
- Format: "Street, City, State ZIP"
- Example: "Ethiopia adama, IN 00000"
- Location pin icon () before address

Action Button (Bottom of Card):

- **Blue button spanning full width**
- **For "In Progress" visits:** "Continue Visit >" button
 - Click to resume documenting the visit
 - Navigates back to visit form
- **For "Pending" visits:** "Start Visit >" button
 - Click to begin the visit
 - Opens visit documentation form

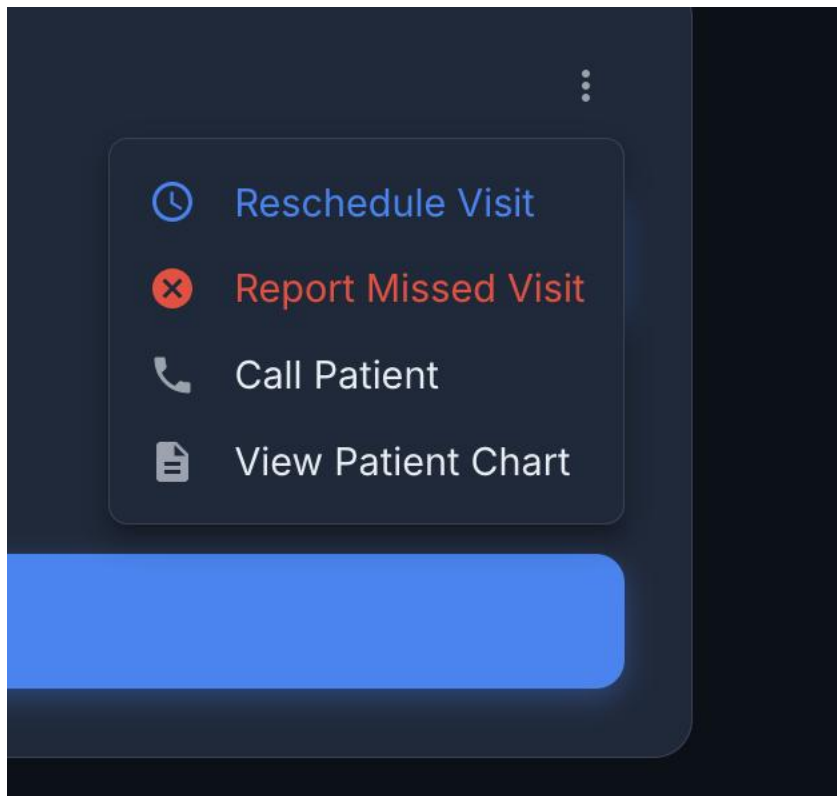
Location Button (Top Right):

- **Blue circular button with location pin icon**
- Opens map/navigation to patient address
- Quick access to driving directions

Three-Dot Menu (Top Right):

- **Three vertical dots (⋮)**
- Opens action menu with additional options
- See "Visit Actions Menu" section below

Visit Actions Menu



How to Open Actions Menu

1. Find the visit card
2. Click the **three-dot menu icon** (⋮) in the top right corner
3. Menu pops up with four options

Menu Options

The actions menu provides four options:

1. Reschedule Visit

- **Icon:** Clock with circular arrow (blue)
- **Label:** "Reschedule Visit" (blue text)
- **Purpose:** Change the visit date/time
- **What Happens:** Opens Reschedule Visit modal

2. Report Missed Visit

- **Icon:** X in circle (red)
- **Label:** "Report Missed Visit" (red text)
- **Purpose:** Document a missed visit with reason
- **What Happens:** Opens Missed Visit Note form
- **When to Use:** Patient not home, refused visit, emergency prevented visit, etc.

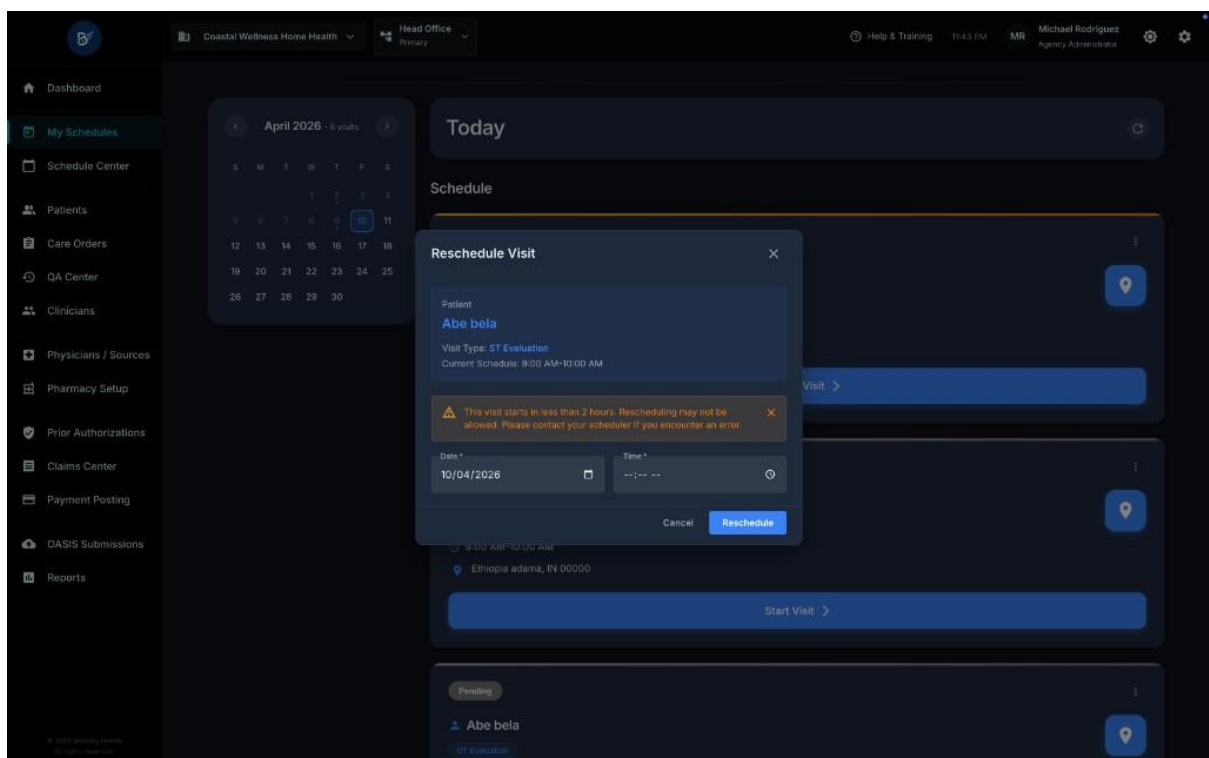
3. Call Patient

- **Icon:** Phone
- **Label:** "Call Patient" (white text)
- **Purpose:** Initiate phone call to patient
- **What Happens:** Opens phone dialer or calls patient number

4. View Patient Chart

- **Icon:** Document/file
- **Label:** "View Patient Chart" (white text)
- **Purpose:** Navigate to full patient profile
- **What Happens:** Opens patient detail page (Chapter 14)

Rescheduling a Visit



When to Reschedule

- Patient calls to change appointment
- You need to adjust your schedule
- Weather or emergency prevents visit
- Patient not available at scheduled time

How to Reschedule

1. Click **three-dot menu** (⋮) on visit card
2. Select **"Reschedule Visit"** (blue option)
3. **Reschedule Visit Modal** opens

Reschedule Visit Modal Elements

Modal Header:

- Clock icon with circular arrow
- Title: "Reschedule Visit"
- X button (top right) to close

Patient Information Section:

- "Patient" label
- **Patient Name:** Full name (e.g., "Abe bela")
- **Visit Type:** Shows visit type (e.g., "ST Evaluation")
- **Current Schedule:** Shows current date/time (e.g., "9:00 AM-10:00 AM")

Warning Alert (Orange Box):

- Icon: Triangle with exclamation mark
- Message: "This visit starts in less than 2 hours. Rescheduling may not be allowed. Please contact your scheduler if you encounter an error."
- **Purpose:** Warns about rescheduling restrictions
- **Rule:** Visits starting within 2 hours cannot be rescheduled by clinicians (must contact scheduler)

Date & Time Fields:

- **Date field:**
 - Label: "Date *" (required)
 - Date picker input
 - Format: MM/DD/YYYY
 - Example: "10/04/2026"
- **Time field:**
 - Label: "Time *" (required)
 - Time picker dropdown
 - Format: HH:MM AM/PM
 - Example: "--:-- --" (select from dropdown)

Action Buttons (Bottom Right):

- **Cancel** button (gray) - Close without saving
- **Reschedule** button (blue) - Save new date/time

Rescheduling Rules

2-Hour Rule:

- You **cannot reschedule** a visit that starts within 2 hours
- Orange warning appears if visit is within 2 hours
- **Why:** Prevents last-minute changes that disrupt scheduling

- **Solution:** Contact your scheduler or administrator

Valid Date/Time:

- Must select a future date/time
- Cannot reschedule to a past date

After Rescheduling

1. Click "**Reschedule**" button
2. Modal closes
3. Visit card updates with new date/time
4. Green toast notification: "Visit rescheduled successfully"
5. Visit moves to the new date in your schedule

Reporting a Missed Visit

The screenshot shows a web application interface for reporting a missed visit. The top navigation bar includes a logo, a dropdown menu for 'Coastal Wellness Home Health', a dropdown for 'Head Office Primary', and user information for 'Michael Rodriguez, Agency Administrator'. The left sidebar contains a menu with options like Dashboard, My Schedules, Schedule Center, Patients, Care Orders, QA Center, Clinicians, Physicians / Sources, Pharmacy Setup, Prior Authorizations, Claims Center, Payment Posting, OASIS Submissions, and Reports. The main content area is titled 'Missed Visit Note' and contains a patient card for 'Abe bela' with details: 'Scheduled: Apr 10, 2026 at 9:00 AM', 'ST Evaluation', and 'Ethiopia, adama, IN 00000'. Below this is a 'Reason for Missed Visit' section with radio button options: Patient Refused Visit, Patient Unavailable/Not Home, Patient Illness, Transportation Issue (highlighted), Weather/Emergency, Clinician Unavailable, and Scheduling Error. At the bottom right is a blue button labeled 'Get Signature & Submit'.

What is a Missed Visit?

A **missed visit** is a scheduled visit that did not occur as planned. This can happen for many reasons:

- Patient not home
- Patient refused visit
- Patient illness (hospitalized, too sick)
- Transportation issue (car broke down, traffic)
- Weather or emergency
- Clinician unavailable
- Scheduling error

Why Documentation is Critical:

- **Compliance:** State and federal regulations require documenting missed visits
- **Quality Assurance:** Tracks patterns and identifies patient issues
- **Billing:** Missed visits cannot be billed; documentation explains why
- **Survey Readiness:** State surveyors review missed visit documentation

When to Report a Missed Visit

Report immediately when:

- You arrive at patient's home and they're not there
- Patient refuses the visit
- Patient is hospitalized/transferred

- Emergency prevents you from completing visit
- Any circumstance where the scheduled visit does not occur

Do NOT report missed visit if:

- You successfully completed the visit (mark as complete in visit form)
- You're running late but will still visit (reschedule instead)

How to Report a Missed Visit

1. Click **three-dot menu** (⋮) on visit card
2. Select **"Report Missed Visit"** (red option)
3. **Missed Visit Note** form opens

Missed Visit Note Form (Deep Dive)

Form Header

Back Arrow (Top Left):

- Click to return to My Schedules without submitting
- Warning: Changes will be lost

Page Title (Red Icon):

- Red cancel icon
- Title: "Missed Visit Note"
- Indicates this is a compliance documentation form

Section 1: Patient & Visit Information

Patient Name (Person Icon):

- Shows patient's full name (e.g., "Abe bela")
- Person icon

Scheduled Date & Time (Clock Icon):

- Format: "Scheduled: MMM DD, YYYY at H:MM AM"
- Example: "Scheduled: Apr 10, 2026 at 9:00 AM"
- Shows original scheduled time

Visit Type Badge:

- Blue chip showing visit type
- Example: "ST Evaluation"

Patient Address (Location Pin Icon):

- Full street address
- Example: "Ethiopia adama, IN 00000"

Section 2: Reason for Missed Visit

Title: "Reason for Missed Visit"

This section has **8 radio button options**. Each option appears in a box that highlights when selected (blue background, blue border when selected).

Option 1: Patient Refused Visit

- **When to Select:** Patient explicitly declined the visit
- **Example:** "I don't want any visitors today"

Option 2: Patient Unavailable/Not Home

- **When to Select:** You arrived but patient wasn't home
- **Example:** Patient out shopping, forgot appointment

Option 3: Patient Illness

- **When to Select:** Patient too sick to receive visit, or hospitalized
- **Example:** Patient admitted to hospital, severe flu

Option 4: Transportation Issue

- **When to Select:** You couldn't reach patient due to transportation problem
- **Example:** Car breakdown, traffic accident, road closure

Option 5: Weather/Emergency

- **When to Select:** Weather or emergency prevented visit
- **Example:** Snowstorm, flood, power outage

Option 6: Clinician Unavailable

- **When to Select:** You couldn't make the visit (illness, emergency)
- **Example:** You got sick, family emergency

Option 7: Scheduling Error

- **When to Select:** Visit was scheduled incorrectly
- **Example:** Patient already received visit this week, double booking

Option 8: Other (specify below)

- **When to Select:** Reason doesn't fit above categories
- **Requires:** Text explanation (see next section)

How to Select:

1. Click the radio button next to the reason
2. The box highlights in blue
3. Blue checkmark appears in radio button

Validation:

- **Required** - Must select one reason
- Red error message appears if you try to submit without selecting

Section 3: Specify Reason (If "Other" Selected)

Appears Only If: You selected "Other (specify below)"

Title: "Specify Reason" (red asterisk for required)

Text Field:

- Multiline textarea (3 rows)
- Placeholder: "Please provide details for this reason"
- Example: "Patient's family member was visiting and requested we reschedule"

Validation:

- **Required** if "Other" was selected
- Red error message: "Please provide details for 'Other' reason"

Section 4: Contact Attempt

Title: "Contact Attempt"

This section documents whether you tried to contact the patient before marking the visit as missed.

Two Radio Button Options:

Option 1: Yes, contact was attempted

- Select if you called, texted, or knocked on door

Option 2: No, contact was not attempted

- Select if you did not attempt contact

If "Yes, contact was attempted" is selected:

Two additional fields appear (indented to the left):

Field 1: Contact Method (Dropdown):

- **Label:** "Contact Method" (red asterisk)
- **Options:**
 - "Select method" (default, placeholder)
 - "Phone Call"
 - "Text Message"
 - "Email"
 - "In Person" (knocked on door)
 - "Voicemail Left"

- **Required** if "Yes" selected

Field 2: Contact Date & Time (Date-Time Picker):

- **Label:** "Contact Date & Time" (red asterisk)
- **Type:** Date-time picker (calendar and clock)
- **Format:** YYYY-MM-DDTHH:MM
- **Example:** "2026-04-10T08:45" (10:45 AM on April 10, 2026)

- **Required** if "Yes" selected

Validation:

- If you select "Yes, contact was attempted" but leave these fields empty, red error messages appear:
 - "Please specify how contact was attempted"
 - "Please specify when contact was attempted"

Section 5: Provider Notes

Title: "Provider Notes" (red asterisk - required)

Text Field:

- Multiline textarea (4 rows)
- Placeholder: "Document any relevant details about the missed visit, patient condition, or circumstances"
- **Required** - You must enter notes
- Example: "Patient's daughter called to say patient was admitted to hospital this morning with chest pain. Visit will be rescheduled once patient is discharged."

Helper Text:

- Gray text below field: "Required field - Document details about the missed visit"
- Turns red if field is empty on submission

Validation:

- **Always Required**
- Red error message: "Provider notes are required"

Best Practices:

- Be specific and factual
- Document what you observed or were told
- Note any safety concerns
- Include follow-up actions taken

Section 6: Follow-up Actions

Title: "Follow-up Actions"

Text Field:

- Multiline textarea (3 rows)
- Placeholder: "Document any follow-up actions taken or planned (e.g., rescheduled visit, notified physician, etc.)"
- **Optional** - Not required

Examples of Follow-Up Actions:

- "Called scheduler to reschedule for tomorrow afternoon"
- "Notified physician of patient's hospitalization"

- "Left voicemail for patient to call back to reschedule"
- "Will attempt visit again tomorrow morning"

Section 7: Reschedule Request

Title: "Reschedule Request"

This section asks whether the patient requested to reschedule the visit.

Two Radio Button Options:

Option 1: Yes, patient requested reschedule

- Select if patient asked to reschedule

Option 2: No reschedule requested

- Select if patient did not ask to reschedule

If "Yes, patient requested reschedule" is selected:

One additional field appears (indented to the left):

Field: Preferred Reschedule Date (Date Picker):

- **Label:** "Preferred Reschedule Date"
- **Type:** Date picker (calendar)
- **Format:** YYYY-MM-DD
- **Optional** - Patient may not have specified a date
- **Example:** "2026-04-12"

Purpose: Helps scheduler know patient's preferred date

Submitting a Missed Visit Note

Submit Button (Bottom of Form)

Location: Bottom right (sticky footer that stays visible)

Button Text: "Get Signature & Submit"

Button Style: Blue, full-width on mobile, fixed-width on desktop

Submission Process

Step 1: Click "Get Signature & Submit"

What Happens:

- Form validates all required fields
- If validation fails:
 - Red error messages appear below problematic fields
 - Red toast notification: "Please complete all required fields"
 - Page scrolls to first error
 - Fix errors and try again
- If validation passes:

- Password Confirmation Modal opens

Step 2: Password Confirmation Modal

Modal Elements:

- **Title:** "Password Confirmation"
- **Description:** "Please enter your password to confirm marking this visit as missed. This action requires password verification for security purposes."
- **Password Field:** Input field (masked with dots)
- **Cancel Button** (gray): Close modal without submitting
- **Submit Button** (blue): "Confirm & Submit"

Why Password is Required:

- **Security:** Ensures only authorized clinician can mark visit as missed
- **Audit Trail:** Creates permanent record of who submitted the missed visit note
- **Compliance:** Meets regulatory requirements for electronic signatures

Step 3: Enter Password and Submit

1. Type your **account password** (the password you use to log in)
2. Click "**Confirm & Submit**" button
3. Button changes to "Submitting..." with loading indicator

Step 4: Backend Processing

What the System Does:

1. Validates your password
2. Marks visit status as "Missed" in database
3. Saves all form data as visit notes
4. Creates audit trail entry
5. Sends notification to scheduler/administrator
6. Updates visit in Missed Visit Report (Chapter 27)

Step 5: Success

Green Toast Notification: "Missed visit note submitted successfully"

Redirect: Automatically returns to My Schedules page

Visit Card Changes:

- Visit card removed from schedule (no longer shows as "Pending" or "In Progress")
- Visit appears in scheduler's Missed Visit Report with your documentation

Common Scenarios

Scenario 1: Patient Not Home

Situation: You arrive at patient's address, but no one answers the door.

Steps:

1. Knock on door
2. Try calling patient phone (if available)
3. Wait 5-10 minutes
4. Open My Schedules → Visit card → Three-dot menu
5. Select **"Report Missed Visit"**
6. Fill out form:
 - Reason: "Patient Unavailable/Not Home"
 - Contact Attempt: "Yes, contact was attempted"
 - Contact Method: "In Person" and "Phone Call"
 - Contact Date & Time: Current time
 - Provider Notes: "Arrived at scheduled time. Knocked on door, no answer. Called patient phone, went to voicemail. Waited 10 minutes, no response. Left voicemail to reschedule."
 - Follow-up Actions: "Will attempt to call patient again this afternoon. Notified scheduler."
 - Reschedule Request: "No reschedule requested"
7. Click **"Get Signature & Submit"**
8. Enter password and confirm

Scenario 2: Patient Refused Visit

Situation: Patient answers door but refuses to let you in for the visit.

Steps:

1. Try to understand reason for refusal
2. Document what patient said
3. Open My Schedules → Visit card → Three-dot menu
4. Select **"Report Missed Visit"**
5. Fill out form:
 - Reason: "Patient Refused Visit"
 - Contact Attempt: "Yes, contact was attempted"
 - Contact Method: "In Person"
 - Contact Date & Time: Current time
 - Provider Notes: "Patient answered door but stated they did not want the visit today. Patient seemed upset about recent hospital bill. No acute distress noted. Patient ambulating independently."
 - Follow-up Actions: "Notified case manager of refusal. Patient education provided on importance of regular visits. Will call tomorrow to reschedule."
 - Reschedule Request: "Yes, patient requested reschedule"
 - Preferred Reschedule Date: Tomorrow (select date)

6. Click **"Get Signature & Submit"**

7. Enter password and confirm

Scenario 3: Patient Hospitalized

Situation: You receive call from patient's family that patient was admitted to hospital.

Steps:

1. Obtain details (which hospital, reason for admission)

2. Open My Schedules → Visit card → Three-dot menu

3. Select **"Report Missed Visit"**

4. Fill out form:

- Reason: "Patient Illness"

- Contact Attempt: "Yes, contact was attempted"

- Contact Method: "Phone Call"

- Contact Date & Time: Time you received call

- Provider Notes: "Patient's daughter called at 8:30 AM to report patient was admitted to Memorial Hospital overnight with chest pain. Patient undergoing cardiac workup. Family will notify us when patient is discharged."

- Follow-up Actions: "Notified physician of hospitalization. Will follow up with family in 2-3 days to check on patient status and reschedule. Marked care order status as ON_HOLD pending discharge."

- Reschedule Request: "No reschedule requested"

5. Click **"Get Signature & Submit"**

6. Enter password and confirm

7. **(Bonus)** Navigate to Care Orders and mark care order as "On Hold" if appropriate

Scenario 4: Transportation Issue (Your Car Broke Down)

Situation: Your car breaks down on the way to the visit, and you cannot reach the patient.

Steps:

1. Call patient to notify them (if possible)

2. Call scheduler to inform them

3. Open My Schedules → Visit card → Three-dot menu

4. Select **"Report Missed Visit"**

5. Fill out form:

- Reason: "Transportation Issue" (or "Clinician Unavailable" if your car made you unavailable)

- Contact Attempt: "Yes, contact was attempted"

- Contact Method: "Phone Call"

- Contact Date & Time: Time you called patient

- Provider Notes: "Car experienced mechanical failure en route to patient's home. Called patient to notify them visit would need to be rescheduled. Patient was understanding. Arranged for tow truck."
- Follow-up Actions: "Notified scheduler immediately. Scheduler reassigned visit to another clinician for today at 2:00 PM. Patient confirmed availability for new time."
- Reschedule Request: "Yes, patient requested reschedule"
 - Preferred Reschedule Date: Today (if reassigned to another clinician) or Tomorrow

6. Click **"Get Signature & Submit"**

7. Enter password and confirm

Best Practices

1. Document Missed Visits Immediately

Why:

- Details are fresh in your memory
- Ensures timely notification to scheduler
- Meets compliance requirements for same-day documentation

How:

- Report missed visit as soon as you determine it's missed
- Do not wait until end of day

2. Always Attempt Contact First

Why:

- Demonstrates reasonable effort
- May resolve situation (patient forgot, is home but didn't hear knock)
- Required for compliance in many states

How:

- Knock on door and wait 5-10 minutes
- Call patient phone
- Try alternative contact (emergency contact if appropriate)
- Document all contact attempts

3. Provide Detailed Provider Notes

Why:

- Supports billing denials
- Protects agency in surveys
- Helps case managers intervene if needed

How:

- Be specific: What did you observe? What did patient/family say?
- Be factual: No assumptions or judgments
- Include safety concerns
- Note patient's condition if you spoke to them

Examples:

- Good: "Patient answered phone, stated she felt too dizzy to walk to door. Patient reported taking blood pressure medication this morning and felt lightheaded. Advised patient to sit down and call 911 if symptoms worsen. Will attempt visit tomorrow."
- Bad: "Patient didn't want visit."

4. Follow Up Promptly

Why:

- Prevents gaps in care
- Shows proactive case management
- Improves patient outcomes

How:

- Call patient within 24 hours
- Notify physician if clinical concern
- Work with scheduler to reschedule ASAP
- Document follow-up actions

Troubleshooting

Issue: Password Confirmation Fails

Symptom:

Red error message: "Incorrect password" when submitting missed visit note.

Possible Causes:

1. Typed password incorrectly
2. Caps Lock is on
3. Password was recently changed and you're using old password

Solution:

- Check Caps Lock
- Retype password carefully
- If still fails, reset your password (top right menu → Change Password)
- Contact IT if password reset doesn't work

Issue: Cannot Find Visit Card

Symptom:

Visit you need to mark as missed is not showing in your schedule.

Possible Causes:

1. Visit was already cancelled by scheduler
2. Visit is on a different date
3. Page needs refresh

Solution:

- Click **Refresh** button (circular arrow, top right)
- Check if you're viewing correct date (use calendar to navigate)
- Check with scheduler - visit may have been reassigned to another clinician

Issue: Form Won't Submit - "Please complete all required fields"**Symptom:**

Red toast notification appears, form doesn't submit.

Possible Causes:

1. Missing required field (Reason, Provider Notes)
2. Selected "Other" but didn't provide details
3. Selected "Yes, contact was attempted" but didn't fill Contact Method or Contact Time

Solution:

- Scroll through form to find red error messages
- Fill in all fields marked with red asterisk (*)
- If you selected "Yes" for contact attempt, ensure both Contact Method and Contact Date & Time are filled
- Try submitting again

Issue: Reschedule Button Disabled**Symptom:**

"Reschedule" button in modal is grayed out, cannot click.

Possible Causes:

1. Date or Time field is empty
2. Selected date/time is in the past
3. Visit starts within 2 hours (rescheduling not allowed)

Solution:

- Ensure both Date and Time fields are filled
- Select a future date/time
- If visit starts in less than 2 hours, close modal and contact your scheduler directly

Permissions and Access Control**Required Permissions**

Action	Required Permission	Notes

Action	Required Permission	Notes
View My Schedules	VIEW_OWN_SCHEDULE or Clinician role	Without this, menu is hidden
Start Visit	COMPLETE_VISITS or Clinician role	Navigate to visit form
Report Missed Visit	REPORT_MISSED_VISITS or Clinician role	Submit missed visit note
Reschedule Visit	RESCHEDULE_OWN_VISITS or Clinician role	Change your own visit date/time (with 2-hour restriction)
View Patient Chart	VIEW_PATIENTS	Navigate to patient profile

Role-Based Access

Clinician (Full Access)

- **Permissions:** All permissions listed above
- **Can:** View own schedule, start visits, report missed visits, reschedule (within rules), view patient charts
- **Cannot:** See other clinicians' schedules, reschedule visits within 2 hours of start time

Administrator (No Access to My Schedules)

- **Permissions:** Does not typically have clinician role
- **Why:** Admins use Schedule Center (Chapter 23) to manage all clinicians' schedules
- **Exception:** If admin is also a clinician, they see My Schedules

Integration with Other Modules

Schedule Center (Chapter 23)

- **Link:** Visits assigned in Schedule Center appear in your My Schedules
- **Impact:** Scheduler assigns visit → You see it in My Schedules → You start/complete or report missed

Visit Forms (Chapter 19)

- **Link:** Clicking "Start Visit" or "Continue Visit" navigates to appropriate visit form
- **Impact:** Must complete visit form and submit to QA to mark visit complete

QA Center (Chapter 21)

- **Link:** After you complete visit form, it goes to QA for approval
- **Impact:** Visit not billable until QA approves your documentation

Missed Visit Report (Chapter 27)

- **Link:** Missed visits you report appear in admin's Missed Visit Report

- **Impact:** Scheduler sees all missed visits and can take action (reschedule, investigate patterns)

Patient Module (Chapter 14)

- **Link:** "View Patient Chart" menu option navigates to patient profile
- **Impact:** Quick access to patient demographics, medications, care orders, documents

Care Orders (Chapter 15)

- **Link:** Visits are created from care orders
- **Impact:** Care order determines visit type, frequency, and authorization

Chapter 10: Clinical Settings

Overview

Clinical Settings is where you configure standards, thresholds, and alerts that guide clinical documentation and quality assurance throughout your agency. This chapter covers:

- Documentation standards and timelines
- Vital sign thresholds and clinical alerts
- QA review time thresholds
- System-wide clinical rules and policies

Who Should Read This Chapter:

- Agency Administrators
- Clinical Managers
- Quality Assurance (QA) staff
- Directors of Nursing

Prerequisites:

- Completed agency settings (Chapter 4)
- Understanding of clinical documentation requirements
- Familiarity with Medicare and state regulatory standards

10.1 Accessing Clinical Settings

Navigation Path

1. **From the Dashboard:** Click the **Settings** icon (gear icon) in the top-right header bar
2. Select **"Clinical Settings"** from the dropdown menu
3. The **Clinical Settings** page will open

What You'll See:

- Three main configuration sections:
 1. **Documentation Standards**
 2. **Clinical Alerts & Triggers (Vital Sign Thresholds)**
 3. **QA Review Thresholds**
- A **Save Changes** button in the top-right corner (saves all sections at once)

10.2 Documentation Standards

Documentation Standards define the timelines and rules for completing clinical documentation across your agency.

The screenshot displays the 'Clinical Settings' configuration page. On the left is a sidebar with 'Agency Settings' and a list of options: Account Profile, User Management, Payer Setup, Roles & Permissions, Branch Management, and Clinical Settings (which is highlighted). The main content area is titled 'Clinical Settings' and includes a 'Save Changes' button in the top right. It is divided into three sections: 'Documentation Standards', 'Clinical Alerts & Triggers', and 'QA Review Thresholds'. The 'Documentation Standards' section has two settings: 'Visit notes must be completed within:' set to '50' with a dropdown for 'Ho...' (Hours), and 'Lock clinical notes from editing after:' set to '7' with a dropdown for 'Days'. The 'Clinical Alerts & Triggers' section contains a table for 'Vital Sign Thresholds' with columns for 'Vital Sign', 'Low Alert', and 'High Alert'. The 'QA Review Thresholds' section includes a description and a 'Normal Visits' subsection with an 'Overdue threshold (hours)' set to '40'.

Vital Sign	Low Alert	High Alert
Systolic BP	9	160
Diastolic BP	60	100
Heart Rate	50	120
Respiration	10	24
Temperature (°F)	96	100.9

10.2.1 Visit Notes Completion Deadline

Visit notes must be completed within:

- **Purpose:** Enforces timely completion of visit notes after a visit is performed
- **Format:** Number + Time Unit (Hours or Days)
- **Default:** 50 Hours
- **Examples:**
 - 24 Hours - Visit notes must be completed within 24 hours of the visit
 - 48 Hours - Visit notes must be completed within 2 days
 - 7 Days - Visit notes must be completed within 1 week

Why This Matters:

- **Medicare Compliance:** CMS requires timely documentation for reimbursement
- **State Regulations:** Many states mandate visit notes within 24-48 hours
- **Quality Assurance:** Timely documentation improves accuracy and care coordination
- **Billing:** Late documentation can delay claim submission

How It Works:

1. A clinician completes a visit in the field
2. The system tracks the visit completion timestamp
3. If the visit note is not completed within the configured timeframe, the system:
 - Flags the visit as **Overdue** in the clinician's dashboard
 - Sends notifications to the clinician and their supervisor (if configured)

- Displays the visit in the QA Center as **Pending Documentation**

Best Practices:

- **Medicare/Medicaid:** Set to **24 Hours** or **48 Hours** to ensure compliance
- **Private Payers:** Verify payer requirements (some allow 7 days)
- **Agency Policy:** Align with your internal policies and state regulations

10.2.2 Lock Clinical Notes After

Lock clinical notes from editing after:

- **Purpose:** Prevents editing of clinical notes after a specified timeframe to ensure documentation integrity
- **Format:** Number + Time Unit (Days)
- **Default:** 7 Days
- **Examples:**
 - 3 Days - Notes are locked 3 days after completion
 - 7 Days - Notes are locked 7 days after completion (default)
 - 14 Days - Notes are locked 14 days after completion

Why This Matters:

- **Audit Protection:** Prevents retroactive changes that could raise compliance concerns
- **Regulatory Compliance:** Many regulators require immutable documentation after a certain period
- **Legal Protection:** Locked notes demonstrate documentation integrity in legal disputes
- **Billing Integrity:** Prevents changes to documentation after claims are submitted

How It Works:

1. A clinician completes and submits a visit note
2. The system tracks the submission timestamp
3. After the configured lock period:
 - The visit note becomes **read-only** for all users (except Super Administrators)
 - An **Edit** button is disabled or hidden
 - A message appears: "This note is locked and cannot be edited (completed on [date])"
4. If edits are needed after locking:
 - **Option A:** Super Administrators can unlock the note (with audit trail)
 - **Option B:** Create an **Addendum** to the note (recommended for compliance)

Best Practices:

- **Standard Setting:** 7 Days is a common industry standard
- **Shorter Periods:** Use 3-5 days if your agency has strict audit requirements
- **Longer Periods:** Use 14 days if clinicians frequently need to make corrections
- **Addendum Policy:** Train staff to use addendums instead of editing locked notes

Important Notes:

- Locking applies to:
 - Visit notes
 - OASIS assessments
 - Care orders
 - Clinical documentation
- Locking does NOT apply to:
 - Administrative corrections (typos in patient demographics)
 - Billing adjustments (managed separately)

10.3 Clinical Alerts & Triggers (Vital Sign Thresholds)

Clinical Alerts & Triggers define the **vital sign thresholds** that generate automatic alerts when patient vital signs fall outside normal ranges during documentation.

The screenshot displays the 'Agency Settings' interface. On the left is a sidebar menu with options: Account Profile, User Management, Payer Setup, Roles & Permissions, Branch Management, and Clinical Settings (which is highlighted). The main content area is divided into two sections. The top section, 'QA Review Thresholds', allows configuration of time thresholds (in hours) for documents in the QA queue. It includes two sub-sections: 'Normal Visits' and 'Compliance Visits'. Each sub-section has input fields for 'Overdue threshold (hours)' and 'Priority threshold (hours)'. The bottom section, 'Visit Types Library', lists 'Standard Visit Types' (noted as system-provided and non-editable) and a table of 'Skilled Nursing (SN)' visit types with their corresponding codes.

Visit Type	Code
Case Conference	
Catheter Care Visit	00299
Diabetic Management Visit	00299
HHA Careplan	
HHA Supervisory Visit	
IV Infusion Visit	00299
LPN Supervisory Visit	00299
LVN Visit	00300
Non-Admit	
Oasis E1 Death At Home	00299
Oasis E1 Discharge	00299

10.3.1 Purpose of Vital Sign Thresholds

What Are Vital Sign Thresholds?

- Pre-configured **normal ranges** for vital signs (blood pressure, heart rate, respiration, temperature)
- When a clinician documents a vital sign **outside the normal range**, the system:
 - Displays an **alert** (warning or critical)
 - Prompts the clinician to acknowledge the abnormal value

- Flags the visit for QA review (if configured)
- Logs the alert in the patient's clinical record

Why Use Thresholds?

- **Patient Safety:** Ensures abnormal vital signs are noticed and addressed
- **Clinical Decision Support:** Alerts clinicians to potential emergencies
- **QA Monitoring:** Tracks patients with unstable vital signs
- **Regulatory Compliance:** Demonstrates proactive monitoring for state surveys and audits

10.3.2 Configuring Vital Sign Thresholds

Each vital sign has two threshold levels:

1. **Low Alert** - Indicates a value below the normal range
2. **High Alert** - Indicates a value above the normal range

Systolic Blood Pressure (BP)

Threshold	Value	Meaning
Low Alert	9 mmHg	Critically low systolic BP (likely data entry error or severe hypotension)
High Alert	160 mmHg	High systolic BP (hypertension concern)

Typical Normal Range: 90-140 mmHg

Clinical Interpretation:

- **Below 90 mmHg:** Hypotension (dizziness, fainting risk)
- **Above 160 mmHg:** Hypertension (stroke or heart attack risk)
- **Above 180 mmHg:** Hypertensive crisis (emergency)

Alert Example:

- Clinician enters systolic BP: **185 mmHg**
- System displays: **"High blood pressure detected. Systolic BP is 185 mmHg (threshold: 160 mmHg). Notify physician if not already aware."**

Diastolic Blood Pressure (BP)

Threshold	Value	Meaning
Low Alert	60 mmHg	Low diastolic BP
High Alert	100 mmHg	High diastolic BP

Typical Normal Range: 60-90 mmHg

Clinical Interpretation:

- **Below 60 mmHg:** Hypotension (possible perfusion issues)

- **Above 100 mmHg:** Hypertension (cardiovascular risk)

Heart Rate (Pulse)

Threshold	Value	Meaning
Low Alert	50 bpm	Bradycardia (slow heart rate)
High Alert	120 bpm	Tachycardia (fast heart rate)

Typical Normal Range: 60-100 bpm

Clinical Interpretation:

- **Below 50 bpm:** Bradycardia (heart block, medication effect, athletic conditioning)
- **Above 120 bpm:** Tachycardia (fever, infection, anxiety, heart condition)
- **Above 150 bpm:** Severe tachycardia (emergency)

Alert Example:

- Clinician enters heart rate: **45 bpm**
- System displays: **"Low heart rate detected. Pulse is 45 bpm (threshold: 50 bpm). Assess patient for dizziness, fatigue, or syncope."**

Respiration Rate

Threshold	Value	Meaning
Low Alert	10 breaths/min	Bradypnea (slow breathing)
High Alert	24 breaths/min	Tachypnea (fast breathing)

Typical Normal Range: 12-20 breaths/min

Clinical Interpretation:

- **Below 10 breaths/min:** Bradypnea (respiratory depression, opioid effect)
- **Above 24 breaths/min:** Tachypnea (respiratory distress, infection, pain)
- **Above 30 breaths/min:** Severe respiratory distress (emergency)

Temperature (°F)

Threshold	Value	Meaning
Low Alert	96°F	Hypothermia
High Alert	100.9°F	Fever

Typical Normal Range: 97.0-99.5°F

Clinical Interpretation:

- **Below 96°F:** Hypothermia (cold exposure, shock, hypothyroidism)

- **Above 100.4°F:** Fever (infection, inflammation)
- **Above 103°F:** High fever (serious infection, emergency)

Alert Example:

- Clinician enters temperature: **102.5°F**
- System displays: **"Fever detected. Temperature is 102.5°F (threshold: 100.9°F). Assess for infection and notify physician."**

10.3.3 Customizing Thresholds

To Update Thresholds:

1. In the **Clinical Alerts & Triggers** section, locate the vital sign you want to modify
2. Enter the new **Low Alert** value (left field)
3. Enter the new **High Alert** value (right field)
4. Click **Save Changes** at the top of the page

Considerations When Customizing:

- **Agency Policy:** Align with your clinical policies and protocols
- **Patient Population:** Consider your typical patient demographics (e.g., elderly patients may have different normal ranges)
- **Physician Input:** Consult with your medical director or clinical advisors
- **Regulatory Standards:** Ensure thresholds meet state and federal guidelines

Example Customization:

- **Geriatric Agency:** Lower systolic BP high alert from 160 to 150 mmHg (more conservative for elderly patients)
- **Cardiac Care Agency:** Lower heart rate alerts to catch arrhythmias earlier

10.3.4 How Alerts Work During Documentation

Scenario: A nurse is completing a visit note for a patient.

1. Enter Vital Signs:

- Nurse documents: Systolic BP = **185 mmHg**, Diastolic BP = 95 mmHg, Heart Rate = 88 bpm

2. System Checks Thresholds:

- Systolic BP (185) > High Alert Threshold (160) → **Alert Triggered**

3. Alert Display:

- **"High Blood Pressure Alert: Systolic BP is 185 mmHg (threshold: 160 mmHg)."**
- Prompt: "Have you notified the physician? ☐ Yes ☐ No"

4. Nurse Acknowledges:

- Nurse checks: "Yes, physician notified"
- Nurse adds note: "Physician aware. Blood pressure medication adjusted."

5. System Actions:

- Alert is logged in the patient's clinical record

- Visit is flagged for QA review (if configured)
- Alert appears in the patient's **Clinical Overview** and **Alerts** tab

10.3.5 Vital Sign Alert Best Practices

Do This:

1. Set Conservative Thresholds:

- It's better to alert on borderline values than to miss critical changes
- Adjust thresholds based on your patient population

2. Train Clinicians:

- Ensure all clinical staff understand the thresholds
- Teach proper response protocols (notify physician, reassess patient, document interventions)

3. Review Alerts Regularly:

- QA staff should review all vital sign alerts
- Identify patterns (e.g., multiple patients with high BP may indicate a community outbreak or seasonal issue)

4. Document Actions Taken:

- Always document what was done in response to an alert
- Include: Physician notification, interventions, patient response

5. Use Alerts for QA Monitoring:

- Track which clinicians have the most alerts (training opportunity)
- Identify patients with frequent alerts (may need care plan adjustment)

Avoid This:

1. Don't Set Thresholds Too Wide:

- If thresholds are too lenient, you'll miss important clinical changes
- Example: Setting high BP alert to 180 mmHg misses patients in the 160-179 range (stage 2 hypertension)

2. Don't Ignore Alerts:

- Alerts are clinical decision support tools, not just system noise
- Train staff to take every alert seriously

3. Don't Override Alerts Without Documentation:

- If a clinician acknowledges an alert, they must document the reason and action taken

10.4 QA Review Thresholds

QA Review Thresholds define the **time limits** for QA staff to review and approve clinical documentation before it becomes overdue.

Agency Settings Account Profile User Management Payer Setup Roles & Permissions Branch Management Clinical Settings	IV Infusion Visit	00299
	LPN Supervisory Visit	00299
	LVN Visit	00300
	Non-Admit	
	Oasis E1 Death At Home	00299
	Oasis E1 Discharge	00299
	Oasis E1 Recertification	00299
	Oasis E1 Resumption of Care	00299
	Oasis E1 Start of care	00299
	Oasis E1 Transfer	00299
	Oasis E1 Transfer Discharge	
	SN Evaluation	00299
	SN Pediatric Assessment	00299
	SN Pediatric Visit	00299
	SN Re-evaluation	00299
	SN Visit	00299
	Wound Care Visit	00299
	Home Health Aide (HHA)	
	HHA Joint Visit	00156
	HHA Visit	00156
	HHA Visit State Plan	00156
	Medical Social Worker (MSW)	
	MSW Follow-up Visit	00153
	MSW Initial Assessment / Evaluation	00153
	Physical Therapy (PT)	
	Oasis E1 Discharge	00101

10.4.1 Purpose of QA Review Thresholds

What Are QA Review Thresholds?

- Time limits (in hours) for QA staff to review specific types of documentation
- When a document exceeds the threshold without review:
 - It is marked as **Overdue** in the QA Center
 - Notifications are sent to QA staff and supervisors
 - The document appears in the **Overdue** filter in the QA Center

Why Use Thresholds?

- **Timely Billing:** Ensures documentation is reviewed and approved before claim submission deadlines
- **Compliance:** Meets Medicare and payer requirements for timely documentation
- **Accountability:** Tracks QA staff performance and workload
- **Patient Safety:** Identifies delays in care coordination

10.4.2 Configuring QA Review Thresholds

The system has two main threshold categories:

Normal Visits

These are routine skilled nursing, therapy, and HHA visits.

Threshold	Value (Hours)	Meaning

Threshold	Value (Hours)	Meaning
Overdue threshold	40 hours	If not reviewed within 40 hours, marked as overdue
Priority threshold	72 hours	If not reviewed within 72 hours, escalated to priority

Typical Timeline:

1. **0-40 hours:** Normal review period
2. **40-72 hours:** Overdue (QA staff notified)
3. **72+ hours:** Priority escalation (supervisors notified)

Use Case:

- A nurse completes a visit note on **Monday at 9:00 AM**
- QA review is due by **Tuesday at 1:00 PM** (40 hours later)
- If not reviewed by Tuesday 1:00 PM, it becomes **Overdue**
- If still not reviewed by **Thursday at 9:00 AM** (72 hours), it escalates to **Priority**

Compliance Visits

These are OASIS assessments, recertifications, discharges, and other compliance-critical documentation.

Threshold	Value (Hours)	Meaning
Overdue threshold	24 hours	If not reviewed within 24 hours, marked as overdue
Priority threshold	48 hours	If not reviewed within 48 hours, escalated to priority

Why Shorter Thresholds?

- **OASIS Timing:** OASIS assessments must be transmitted to the state within specific timeframes
- **Certification Deadlines:** Care orders and recertifications have strict Medicare deadlines
- **Claim Submission:** Compliance visits directly impact billing and reimbursement

Use Case:

- A nurse completes an **OASIS Start of Care** on **Monday at 9:00 AM**
- QA review is due by **Tuesday at 9:00 AM** (24 hours later)
- If not reviewed by Tuesday 9:00 AM, it becomes **Overdue**
- If still not reviewed by **Wednesday at 9:00 AM** (48 hours), it escalates to **Priority**

10.4.3 How QA Thresholds Work

Scenario: QA staff member reviews the QA Center queue.

1. Visit Note Submitted:

- Nurse completes a visit note on **Monday, 10:00 AM**
- Visit enters the QA queue with status: **Pending Review**

2. Overdue Threshold Reached (40 hours):

- By **Wednesday, 2:00 AM**, if not reviewed, status changes to: **Overdue**
- QA staff see the visit highlighted in red or with an "Overdue" badge
- Email/notification sent to QA staff: "You have 5 overdue visit notes"

3. Priority Threshold Reached (72 hours):

- By **Thursday, 10:00 AM**, if still not reviewed, status changes to: **Priority**
- Visit moves to the top of the QA queue
- Email sent to Clinical Manager: "Priority escalation: Visit note from Monday requires immediate review"

4. QA Review Completed:

- QA staff reviews and approves the visit
- Status changes to: **Approved**
- Visit is cleared from the QA queue

10.4.4 Customizing QA Thresholds

To Update Thresholds:

1. In the **QA Review Thresholds** section, locate the threshold you want to modify
2. Enter the new value (in hours)
3. Click **Save Changes** at the top of the page

Considerations:

- **QA Staffing:** If you have limited QA staff, you may need longer thresholds to be realistic
- **Agency Volume:** High-volume agencies may need shorter thresholds to keep up with claim submission deadlines
- **Payer Requirements:** Some payers require documentation approval within 24-48 hours
- **Medicare Compliance:** Ensure thresholds allow time for timely OASIS transmission (within 5 days of assessment)

Example Customizations:

- **Small Agency (1 QA staff):** Increase Normal Visit overdue threshold to **48 hours** (more realistic)
- **Large Agency (dedicated QA team):** Decrease Normal Visit overdue threshold to **24 hours** (faster turnaround)
- **Strict Compliance Focus:** Keep Compliance Visit thresholds at **24/48 hours** (no exceptions)

10.4.5 QA Threshold Best Practices

Do This:

1. Monitor Overdue Rates:

- Track what percentage of visits become overdue
- If more than 10-15% are overdue, adjust staffing or thresholds
- 2. Prioritize Compliance Visits:**
 - Always review OASIS and recertifications before routine visits
 - Use the QA Center's **Priority** filter to focus on urgent items
- 3. Notify QA Staff Proactively:**
 - Set up email or SMS notifications for overdue items
 - Send daily digests to QA staff: "You have X visits pending review"
- 4. Review Threshold Effectiveness:**
 - Quarterly, review whether thresholds are realistic
 - Adjust based on QA staff feedback and performance data
- 5. Escalate Priority Items:**
 - When priority threshold is reached, assign a supervisor to review immediately
 - Document reasons for delays (e.g., missing physician signature, clinician unavailable for questions)

Avoid This:

- 1. Don't Set Unrealistic Thresholds:**
 - Thresholds that are too short create false urgency and stress
 - QA staff become desensitized to "overdue" alerts if they're always triggered
- 2. Don't Ignore Overdue Notifications:**
 - Overdue items impact billing and compliance
 - Address overdue items before starting new reviews
- 3. Don't Blame QA Staff for Systemic Issues:**
 - If overdue rates are high, investigate root causes:
 - Is documentation quality poor (requiring extensive corrections)?
 - Are clinicians submitting notes late?
 - Is QA staff understaffed?

10.5 Saving Clinical Settings

10.5.1 How to Save

After making any changes to:

- Documentation Standards
- Vital Sign Thresholds
- QA Review Thresholds

Click the "Save Changes" button in the top-right corner of the page.

What Happens:

- All changes are saved immediately

- A **Success** toast notification appears: "Clinical settings updated successfully"
- Changes take effect system-wide for all users

10.5.2 Impact of Changes

Documentation Standards:

- New timelines apply to all **future visits** completed after the change
- Existing visits retain their original timelines (not retroactively changed)

Vital Sign Thresholds:

- New thresholds apply immediately to all **future documentation**
- Existing vital signs are not re-evaluated (alerts are not retroactively triggered)

QA Review Thresholds:

- New thresholds apply to all **future submissions**
- Existing items in the QA queue retain their original due dates

10.6 Troubleshooting Common Issues

Issue 1: "Visit Notes Overdue Alert Too Frequent"

Problem: Clinicians are receiving too many "overdue visit note" alerts

Solution:

1. Review your **Visit notes must be completed within** setting
2. If set to 24 hours and clinicians work varied schedules, consider extending to **48 hours**
3. Train clinicians on the importance of timely documentation
4. Identify clinicians with frequent overdue notes (may need coaching)

Issue 2: "Vital Sign Alerts Are Too Sensitive"

Problem: Clinicians complain that every vital sign triggers an alert

Solution:

1. Review your thresholds in **Clinical Alerts & Triggers**
2. Compare to clinical standards (e.g., American Heart Association guidelines)
3. Consider your patient population (elderly patients may have different normal ranges)
4. Adjust thresholds to be less sensitive (e.g., increase high BP alert from 140 to 160 mmHg)
5. Train clinicians to document accurate vital signs (errors cause false alerts)

Issue 3: "QA Queue Always Overdue"

Problem: Most items in the QA queue are marked as overdue

Solution:

1. **Check QA Staffing:** Do you have enough QA staff for your agency's volume?
2. **Adjust Thresholds:** Increase overdue threshold from 40 to 48 or 72 hours (be realistic)
3. **Prioritize:** Ensure QA staff focus on compliance visits first, then routine visits

4. Review Documentation Quality: Are clinicians submitting complete, accurate notes? Poor quality notes take longer to review.

5. Automate Where Possible: Use soft alerts and auto-approval for low-risk visits (if your subscription allows)

Issue 4: "Cannot Save Clinical Settings"

Error Message: "Failed to save clinical settings"

Solution:

1. Check your internet connection
2. Verify you have **Agency Administrator** role (only admins can change clinical settings)
3. Ensure all fields have valid values (numbers only, no text)
4. Try refreshing the page and re-entering changes
5. Contact Betasky Support if the issue persists

10.7 Best Practices

Do This:

1. Review Settings Quarterly:

- Clinical standards and regulations change
- Review and update thresholds every 3-6 months

2. Align with Agency Policies:

- Ensure settings match your clinical policy manual
- Train staff on the rationale behind each setting

3. Consult Clinical Leadership:

- Involve your Director of Nursing, Medical Director, and QA Manager in setting thresholds
- Get buy-in from clinical staff before implementing changes

4. Monitor Compliance:

- Track how often thresholds are exceeded
- Use data to identify training needs or staffing gaps

5. Document Rationale:

- Keep a record of why you chose specific thresholds
- Useful for state surveys and audits

Avoid This:

1. Don't Set and Forget:

- Settings should be reviewed and adjusted regularly
- Outdated settings can harm compliance and patient safety

2. Don't Ignore Staff Feedback:

- If clinicians or QA staff report issues, investigate and adjust

- Settings should support workflow, not hinder it

3. Don't Copy Another Agency's Settings:

- Each agency has unique patient populations, staffing, and workflows
- What works for another agency may not work for yours

4. Don't Use Extreme Values:

- Setting vital sign thresholds too wide or too narrow defeats their purpose
- Use clinical evidence and guidelines

Chapter 11: Visit Type Setup

Overview

Visit Type Setup is where you view and manage the types of visits your agency provides. The system comes with **Standard Visit Types** for all disciplines, and you can create **Custom Visit Types** for specialized services unique to your agency. This chapter covers:

- Understanding standard vs. custom visit types
- Viewing the Visit Types Library
- Creating custom visit types
- Configuring HCPCS codes for billing
- Task checklists for visit types
- Managing visit type status

Who Should Read This Chapter:

- Agency Administrators
- Clinical Managers
- Billing Managers
- Schedulers

Prerequisites:

- Understanding of home health disciplines (Chapter 3)
- Familiarity with billing and HCPCS codes (basic knowledge)
- Clinical Settings configured (Chapter 10)

11.1 Understanding Visit Types

11.1.1 What is a Visit Type?

A **Visit Type** defines:

- The **discipline** providing the visit (RN, LPN, PT, OT, SLP, HHA, MSW)
- The **purpose** of the visit (evaluation, routine visit, discharge, OASIS assessment)
- The **HCPCS code** for billing (Medicare and insurance billing code)
- The **task checklist** (optional default tasks clinicians should complete)
- The **form templates** associated with the visit (automatically attached documentation)

Examples of Visit Types:

- **SN Visit** - Routine skilled nursing visit
- **PT Evaluation** - Initial physical therapy evaluation
- **OASIS E1 Start of Care** - Start of Care OASIS assessment by RN
- **HHA Visit** - Home health aide personal care visit
- **MSW Initial Assessment** - Medical social worker psychosocial evaluation

11.1.2 Standard Visit Types

What Are Standard Visit Types?

- **Pre-configured visit types** provided by Betasky for all agencies
- Cover the most common visit types across all disciplines
- **Cannot be edited or deleted** (system-protected)
- Available to all agencies by default

Why Standard Visit Types?

- **Medicare Compliance:** Ensures agencies use correct HCPCS codes and visit classifications
- **Consistency:** All agencies use the same terminology and codes
- **Billing Accuracy:** Reduces errors in claim submission
- **Ease of Use:** Agencies don't need to manually create common visit types

Examples of Standard Visit Types:

Skilled Nursing (SN):

- SN Visit
- SN Re-evaluation
- SN Pediatric Visit
- OASIS E1 Start of Care
- OASIS E1 Recertification
- OASIS E1 Discharge
- OASIS E1 Resumption of Care

Home Health Aide (HHA):

- HHA Visit
- HHA Supervisory Visit
- HHA Careplan

Physical Therapy (PT):

- PT Evaluation
- PT Visit (Routine)
- PT Re-evaluation
- OASIS E1 Discharge (PT)

Occupational Therapy (OT):

- OT Evaluation
- OT Visit (Routine)
- OT Re-evaluation

Speech Therapy (SLP/ST):

- ST Evaluation
- ST Visit (Routine)
- ST Re-evaluation

Medical Social Worker (MSW):

- MSW Initial Assessment / Evaluation
- MSW Follow-up Visit

11.1.3 Custom Visit Types

What Are Custom Visit Types?

- **Agency-created visit types** for specialized services not covered by standard types
- Can be **edited, deactivated, or deleted** by the agency
- Allow agencies to tailor the system to their unique service offerings

When to Create Custom Visit Types:

- **Specialized Services:** Wound care specialist visit, diabetic management visit, cardiac monitoring
- **Unique Protocols:** Your agency has specific visit types for certain programs (e.g., CHF monitoring program)
- **Billing Variations:** You need different HCPCS codes for specific payer contracts

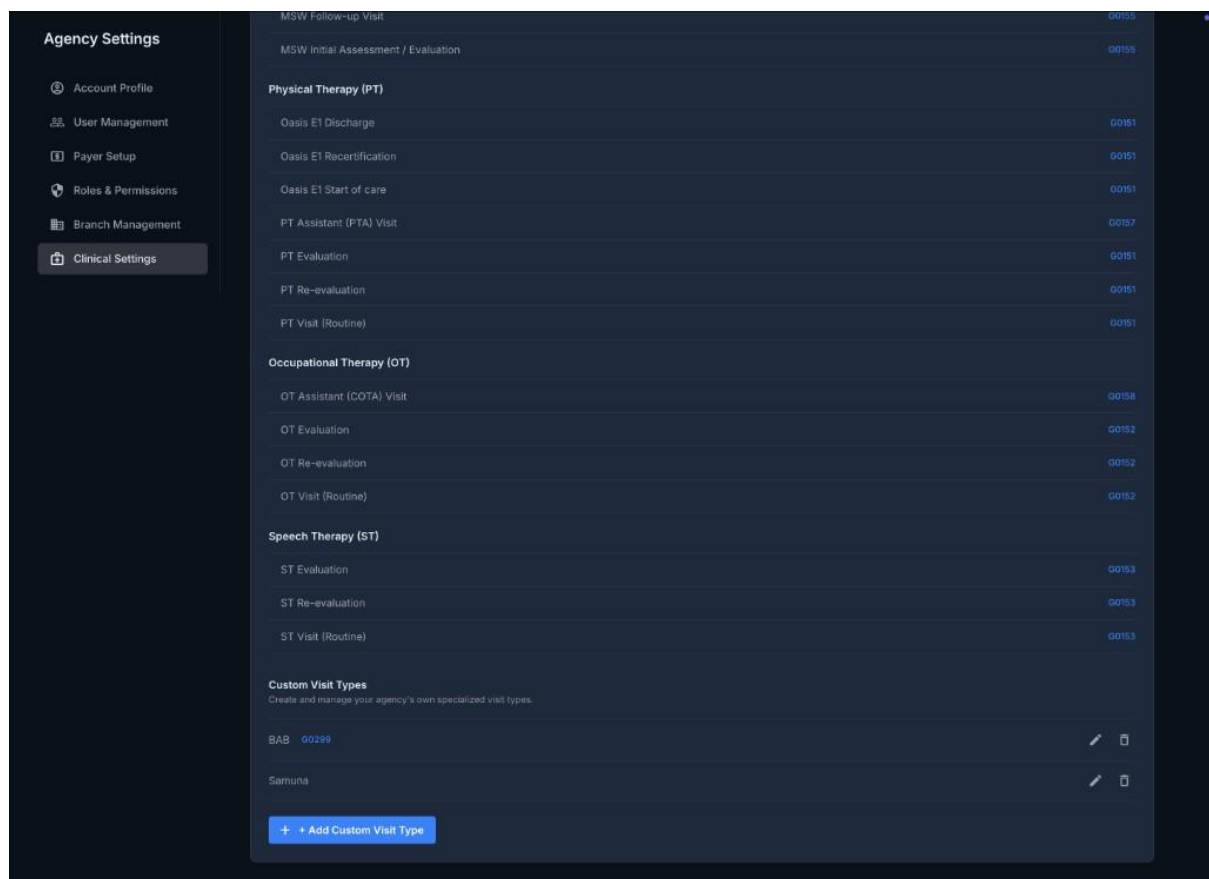
Examples of Custom Visit Types:

- **Wound Care Specialist Visit** (RN with advanced wound care training)
- **Diabetic Management Visit** (RN for insulin education)
- **Cardiac Monitoring Visit** (RN for CHF patients)
- **Behavioral Health Assessment** (specialized MSW or RN)

11.2 Accessing the Visit Types Library

Navigation Path

1. **From the Dashboard:** Click the **Settings** icon (gear icon) in the top-right header bar
2. Select **"Clinical Settings"** from the dropdown menu
3. Scroll down to the **Visit Types Library** section



What You'll See:

- **Standard Visit Types** section (system-provided, cannot be edited)
 - Organized by discipline:
 - **Skilled Nursing (SN)**
 - **Home Health Aide (HHA)**
 - **Medical Social Worker (MSW)**
 - **Physical Therapy (PT)**
 - **Occupational Therapy (OT)**
 - **Speech Therapy (ST)**
- Each visit type shows:
 - **Visit Type Name**
 - **HCPCS Code** (if applicable, displayed in blue on the right)
- **Custom Visit Types** section (agency-created, can be edited)
 - Lists all custom visit types created by your agency
 - Shows **Edit** and **Delete** icons next to each custom visit type
- **+ Add Custom Visit Type** button at the bottom

11.3 Viewing Standard Visit Types

11.3.1 Exploring Standard Visit Types by Discipline

The Visit Types Library organizes standard visit types by discipline. Let's explore what's available:

Skilled Nursing (SN)

The screenshot shows the following standard SN visit types:

Visit Type	HCPCS Code	Purpose
Case Conference	(none shown)	Multi-disciplinary care coordination meeting
Catheter Care Visit	G0299	Catheter insertion, maintenance, or education
Diabetic Management Visit	G0299	Insulin administration, blood sugar monitoring education
HHA Careplan	(none)	Developing or updating HHA care plan
HHA Supervisory Visit	(none)	RN supervisory visit for HHA oversight (Medicare required every 14 days)
IV Infusion Visit	G0299	IV therapy administration or monitoring
LPN Supervisory Visit	G0299	LPN-provided supervisory visit
LVN Visit	G0300	Licensed Vocational Nurse routine visit
Non-Admit	(none)	Visit when admission was attempted but not completed
OASIS E1 Death At Home	G0299	OASIS assessment when patient dies at home
OASIS E1 Discharge	G0299	Discharge OASIS assessment
OASIS E1 Recertification	G0299	Recertification OASIS (every 60 days for Medicare)
OASIS E1 Resumption of Care	G0299	OASIS when patient returns to care after inpatient stay
OASIS E1 Start of care	G0299	Start of Care OASIS assessment (admission)
OASIS E1 Transfer	G0299	Transfer OASIS (patient transfers to another agency)
OASIS E1 Transfer Discharge	(none)	Discharge due to transfer
SN Evaluation	G0299	Initial skilled nursing evaluation
SN Pediatric Assessment	G0299	Pediatric nursing assessment
SN Pediatric Visit	G0398	Routine pediatric nursing visit

Visit Type	HCPCS Code	Purpose
SN Re-evaluation	G0299	Skilled nursing re-evaluation
SN Visit	G0299	Routine skilled nursing visit
Wound Care Visit	G0299	Specialized wound care visit

Home Health Aide (HHA)

Visit Type	HCPCS Code	Purpose
HHA Joint Visit	G0156	HHA visit with another clinician (e.g., RN or therapist)
HHA Visit	G0156	Routine HHA personal care visit
HHA Visit State Plan	G0156	HHA visit under state Medicaid plan

Medical Social Worker (MSW)

Visit Type	HCPCS Code	Purpose
MSW Follow-up Visit	G0155	Routine MSW follow-up visit
MSW Initial Assessment / Evaluation	G0155	Initial psychosocial evaluation

Physical Therapy (PT)

Visit Type	HCPCS Code	Purpose
OASIS E1 Discharge	G0151	PT-conducted discharge OASIS
OASIS E1 Recertification	G0151	PT-conducted recertification OASIS
OASIS E1 Start of care	G0151	PT-conducted Start of Care OASIS
PT Assistant (PTA) Visit	G0157	Physical therapy visit provided by PTA
PT Evaluation	G0151	Initial physical therapy evaluation
PT Re-evaluation	G0151	PT re-evaluation
PT Visit (Routine)	G0151	Routine physical therapy visit

Occupational Therapy (OT)

Visit Type	HCPCS Code	Purpose
OT Assistant (COTA) Visit	G0158	Occupational therapy visit provided by COTA
OT Evaluation	G0152	Initial occupational therapy evaluation
OT Re-evaluation	G0152	OT re-evaluation
OT Visit (Routine)	G0152	Routine occupational therapy visit

Speech Therapy (ST)

Visit Type	HCPCS Code	Purpose
ST Evaluation	G0153	Initial speech-language pathology evaluation
ST Re-evaluation	G0153	Speech therapy re-evaluation
ST Visit (Routine)	G0153	Routine speech therapy visit

11.3.2 HCPCS Codes Explained

What is HCPCS?

- **Healthcare Common Procedure Coding System**
- Standardized codes used for Medicare and Medicaid billing
- Each visit type has a corresponding HCPCS code

Common Home Health HCPCS Codes:

HCPCS Code	Description
G0299	Skilled nursing visit (RN or LPN)
G0300	Skilled nursing visit by LVN/LPN where permitted
G0151	Physical therapy visit
G0152	Occupational therapy visit
G0153	Speech-language pathology visit
G0155	Medical social worker visit
G0156	Home health aide visit
G0157	Physical therapy assistant (PTA) visit
G0158	Occupational therapy assistant (COTA) visit
G0398	Home health setting, each 15 minutes (specialized visit codes)

Why HCPCS Codes Matter:

- **Medicare Billing:** Required on all Medicare claims (UB-04)
- **Reimbursement:** Different codes have different payment rates (though home health is now PDGM, codes still required for claim detail)
- **Documentation:** Helps track what type of service was provided

11.4 Creating Custom Visit Types

11.4.1 When to Create a Custom Visit Type

Create a custom visit type if:

- Your agency provides a specialized service not covered by standard types
- You need to track specific visit types separately for reporting or quality monitoring
- You have unique billing requirements for certain payer contracts

Do NOT create a custom visit type if:

- A standard visit type already exists (use the standard type instead)
- You just want to rename a standard type (standard types should remain as-is for consistency)

11.4.2 Click "+ Add Custom Visit Type"

1. Scroll to the bottom of the **Visit Types Library** section
2. Click the **+ Add Custom Visit Type** button
3. The **Add Custom Visit Type** modal will open

11.4.3 Complete the Custom Visit Type Form

Visit Type Name *

- **Required:** Yes
- **Format:** Text (up to 255 characters)
- **Purpose:** The display name for this visit type
- **Examples:**
 - "Wound Care Specialist Visit"
 - "Cardiac Monitoring Visit"
 - "Diabetic Education Visit"
 - "Behavioral Health Assessment"

Best Practices:

- Use descriptive names that clearly indicate the purpose
- Include the discipline if relevant (e.g., "RN Wound Care Specialist Visit")
- Be consistent with your agency's naming conventions

Placeholder Example (from screenshot):

- "e.g., Wound Care Specialist Visit"

Default Discipline *

- **Required:** Yes

- **Format:** Dropdown selection
- **Purpose:** The primary discipline that provides this visit type
- **Options:**
 - **RN** - Registered Nurse
 - **LPN** - Licensed Practical Nurse
 - **PT** - Physical Therapist
 - **OT** - Occupational Therapist
 - **SLP** - Speech-Language Pathologist
 - **HHA** - Home Health Aide
 - **MSW** - Medical Social Worker
 - **OTHER** - For non-standard disciplines or multi-disciplinary visits

Example:

- For "Wound Care Specialist Visit" → Select **RN**

Associated Form *

- **Required:** Yes
- **Format:** Dropdown selection
- **Purpose:** The documentation form that will be automatically attached when this visit type is selected during scheduling or documentation
- **Options:** (Depends on your agency's configured forms)
 - SN Visit Note
 - PT Visit Note
 - OT Visit Note
 - OASIS Assessment Form
 - HHA Visit Form
 - MSW Visit Note
 - Custom forms created by your agency

Why This Matters:

- When a clinician schedules or completes a visit of this type, the system automatically attaches the associated form
- Ensures correct documentation templates are used
- Streamlines workflow (clinicians don't have to manually select forms)

Example:

- For "Wound Care Specialist Visit" → Select **SN Visit Note** (or a custom "Wound Care Form" if you've created one)

HCPCS Code (Optional)

- **Optional**
- **Format:** Text (up to 10 characters)

- **Purpose:** The Healthcare Common Procedure Coding System code used for billing this visit type
- **Examples:**
 - G0299 (Skilled nursing)
 - G0151 (Physical therapy)
 - G0152 (Occupational therapy)
 - Custom codes for specialized services

Placeholder Example (from screenshot):

- "e.g., G0299"

When to Enter HCPCS Code:

- If this visit type has a specific HCPCS code for billing
- If payers require a unique code for this service
- Leave blank if this visit type doesn't have a specific code (rare)

Where to Find HCPCS Codes:

- [CMS HCPCS Code Search](#)
- Your agency's billing department or billing consultant
- Payer-specific code lists (for private insurance)

Task Checklist (Optional)

- **Optional**
- **Purpose:** Define default tasks that clinicians should complete during this visit type
- **Format:** Add tasks one at a time by typing and clicking + **Add Task**

Why Use Task Checklists:

- **Quality Assurance:** Ensures clinicians don't forget critical steps
- **Training:** Helps new clinicians follow protocols
- **Consistency:** All clinicians complete the same tasks for this visit type
- **Documentation:** Completed checklist is part of the visit record

Example Task Checklist for "Wound Care Specialist Visit":

1. Assess wound size, depth, and drainage
2. Document wound measurements (length, width, depth)
3. Take wound photo (if applicable)
4. Clean wound per protocol
5. Apply appropriate dressing
6. Educate patient/caregiver on wound care
7. Notify physician of any significant changes

How to Add Tasks:

1. Type a task description in the **"Type a task"** field

2. Click + **Add Task** (or press Enter)
3. The task appears in the list
4. Repeat for all tasks
5. Tasks can be reordered (if the UI supports drag-and-drop)

11.4.4 Save the Custom Visit Type

After completing all fields:

1. Click **Save Visit Type** at the bottom of the modal
2. The system validates:
 - Visit Type Name is unique within your agency
 - Default Discipline is selected
 - Associated Form is selected
3. If validation passes, the custom visit type is created
4. A **Success** toast notification appears: "Custom visit type created successfully"
5. The new visit type appears in the **Custom Visit Types** section

What Happens Next:

- The custom visit type is now available in:
 - **Scheduling:** Schedulers can assign this visit type when creating visits
 - **Visit Documentation:** Clinicians can select this visit type when documenting visits
 - **Care Orders:** Can be included in the Plan of Care
 - **Reports:** Tracked separately in visit type reports

11.5 Editing Custom Visit Types

To update a custom visit type:

11.5.1 Locate the Custom Visit Type

1. In the **Visit Types Library**, scroll to the **Custom Visit Types** section
2. Find the custom visit type you want to edit

11.5.2 Click the Edit Icon

1. Click the **Edit** icon (pencil icon) next to the visit type
2. The **Edit Custom Visit Type** modal opens with pre-filled information

What You Can Edit:

- Visit Type Name
- Default Discipline
- Associated Form
- HCPCS Code
- Task Checklist (add, remove, or reorder tasks)

What You Cannot Edit:

- Visit Type ID (internal system identifier)
- Historical visits that used this visit type (they retain the original information)

11.5.3 Save Your Changes

1. Update the necessary fields
2. Click **Save Visit Type**
3. A **Success** toast notification appears: "Custom visit type updated successfully"

Important:

- Editing a custom visit type does NOT affect:
 - **Past visits** that used this type (historical data is preserved)
 - **Scheduled visits** that were already created (they retain the original visit type)
- Editing **ONLY** affects:
 - **New visits** scheduled or documented after the change
 - **Dropdown lists** (updated name appears immediately)

11.6 Deactivating or Deleting Custom Visit Types

11.6.1 Deactivating vs. Deleting

Deactivate:

- The visit type is hidden from dropdowns (cannot be selected for new visits)
- Historical data is preserved (past visits remain visible)
- Can be reactivated later
- **Recommended** if the visit type was used in the past

Delete:

- The visit type is permanently removed from the system
- Historical data **may be affected** (visits may lose their visit type reference)
- Cannot be undone
- **Only use if** the visit type was created by mistake and never used

11.6.2 How to Delete a Custom Visit Type

1. In the **Custom Visit Types** section, locate the visit type
2. Click the **Delete** icon (trash can icon)
3. A confirmation dialog appears: "Are you sure you want to delete this visit type? This action cannot be undone."
4. Click **Delete** to confirm

Warning:

- Do NOT delete a visit type if it has been used in any visits
- Instead, deactivate it (if the system supports deactivation via status field)

11.7 Using Visit Types in Scheduling and Documentation

11.7.1 Scheduling a Visit with a Visit Type

When a scheduler creates a visit (Chapter 20):

1. Open the **Schedule Center** or **My Schedules**
2. Click **Add Visit**
3. Select **Visit Type** from the dropdown
 - All **Active** standard visit types appear
 - All **Active** custom visit types appear
4. Choose the appropriate visit type (e.g., "SN Visit", "PT Evaluation", "Wound Care Specialist Visit")
5. Complete the rest of the visit details (date, time, clinician, patient)
6. Click **Save**

What Happens:

- The visit is created with the selected visit type
- The **associated form** is automatically attached (clinicians see it when they document the visit)
- The **HCPCS code** is auto-populated for billing
- The **task checklist** (if configured) is displayed for the clinician to complete

11.7.2 Documenting a Visit with a Visit Type

When a clinician completes a visit (Chapter 20):

1. Open the visit in their **My Schedules** or **Visit List**
2. Click **Complete Visit** or **Document**
3. The **associated form** opens automatically (based on the visit type)
4. If a **task checklist** is configured:
 - The checklist appears in the documentation screen
 - Clinician checks off each task as completed
5. Clinician completes the visit note
6. Click **Submit**

Result:

- The visit is documented with the correct visit type
- HCPCS code is included for billing
- Task checklist is saved with the visit record
- QA staff see the completed checklist during review

11.8 Troubleshooting Common Issues

Issue 1: "Cannot Find the Visit Type I Need"

Problem: The visit type you need is not in the list

Solution:

1. **Check Standard Visit Types:** Scroll through all disciplines to see if it exists under a different name
2. **Create a Custom Visit Type:** If it doesn't exist, create it using the steps in Section 11.4
3. **Contact Betasky Support:** If you think a standard visit type is missing, report it to support

Issue 2: "Custom Visit Type Not Appearing in Dropdown"

Problem: You created a custom visit type, but it's not appearing when scheduling visits

Solution:

1. **Check Status:** Ensure the visit type is set to **ACTIVE** (if status field is visible)
2. **Refresh the Page:** Sometimes dropdowns are cached; refresh the browser (F5)
3. **Check Associated Form:** Ensure an associated form was selected during creation
4. **Verify Permissions:** Ensure your user role has permission to use custom visit types

Issue 3: "Wrong Form Attached to Visit Type"

Problem: The visit type is attaching the wrong documentation form

Solution:

1. **Edit the Visit Type:** Go to Custom Visit Types and click **Edit**
2. Change the **Associated Form** to the correct form
3. Click **Save Visit Type**
4. The updated form will be attached to all **new visits** created after the change

Issue 4: "Task Checklist Not Displaying During Visit"

Problem: Clinicians don't see the task checklist when documenting visits

Solution:

1. **Verify Task Checklist Was Created:** Edit the visit type and check if tasks are listed
2. **Check Visit Type Selection:** Ensure the visit was scheduled with the correct visit type
3. **Form Compatibility:** Not all forms support task checklists (contact Betasky Support if this is an issue)

Issue 5: "HCPCS Code Incorrect on Claim"

Problem: Claims are rejected because the wrong HCPCS code is on the claim

Solution:

1. **Review Visit Type Configuration:** Check the HCPCS code in the visit type setup
2. **Verify Correct Visit Type Was Used:** Ensure the clinician selected the correct visit type when documenting
3. **Update HCPCS Code:** Edit the visit type and correct the HCPCS code

4. Resubmit Claim: For rejected claims, correct the visit type in the visit record and resubmit

11.9 Best Practices

Do This:

1. Use Standard Visit Types When Possible:

- Standard types are pre-configured with correct HCPCS codes and Medicare compliance
- Only create custom types for truly unique services

2. Name Custom Visit Types Clearly:

- Use descriptive names that indicate purpose and discipline
- Avoid abbreviations that may confuse staff

3. Configure Task Checklists for Complex Visits:

- Use checklists for specialized visits (wound care, IV therapy, etc.)
- Keeps clinicians on track and ensures quality

4. Review Visit Types Quarterly:

- Deactivate visit types that are no longer used
- Update HCPCS codes if Medicare or payers make changes

5. Train Schedulers and Clinicians:

- Ensure staff know which visit type to select for each patient scenario
- Incorrect visit types lead to billing errors and compliance issues

Chapter 12: Fee Schedule Setup

Overview

Fee Schedule Setup is where you configure billing rates for **private payers** (commercial insurance, Medicaid managed care, and other non-Medicare payers). Fee schedules define how much your agency charges for each visit type with each payer. This chapter covers:

- Understanding fee schedules vs. HIPPS rates
- Accessing payer fee schedules
- Adding and managing fee schedule rates
- Effective dates and rate changes
- Status management for fee schedules

Who Should Read This Chapter:

- Agency Administrators
- Billing Managers
- Financial Officers
- Reimbursement specialists

Prerequisites:

- Completed payer setup (Chapter 6)
- Completed visit type setup (Chapter 11)
- Understanding of billing and reimbursement basics

12.1 Understanding Fee Schedules

12.1.1 What is a Fee Schedule?

A **Fee Schedule** defines the **charge amount** (billing rate) for each **visit type** with a specific **payer**.

Components:

- **Payer:** The insurance company or payer (e.g., Blue Cross Blue Shield, Aetna, Medicaid Managed Care)
- **Visit Type:** The type of visit (e.g., SN Visit, PT Evaluation, HHA Visit)
- **Charge Amount:** The dollar amount your agency charges for that visit type
- **Effective Date:** When this rate becomes active
- **End Date:** When this rate expires (optional; if blank, rate is active indefinitely)
- **Status:** Active or Inactive

Example Fee Schedule Entry:

Payer	Visit Type	Charge Amount	Effective Date	End Date	Status
Blue Cross Blue Shield	SN Visit	\$121.00	11/28/2025	-	Active

Payer	Visit Type	Charge Amount	Effective Date	End Date	Status
Blue Cross Blue Shield	HHA Visit	\$300.00	12/14/2025	-	Active
Blue Cross Blue Shield	PT Evaluation	\$3,020.00	12/5/2025	-	Active

12.1.2 Fee Schedules vs. HIPPS Rates

Fee Schedules (This Chapter):

- **For:** Private payers (Blue Cross, Aetna, UnitedHealthcare, Medicaid Managed Care, etc.)
- **Structure:** Per-visit billing (each visit has a specific rate)
- **Configuration:** Set in the **Payer Setup** → **Fee Schedule** tab
- **Example:** SN Visit with Blue Cross = \$121.00 per visit

HIPPS Rates (Chapter 6):

- **For:** Medicare only
- **Structure:** Per-30-day-period billing (paid based on PDGM and HIPPS code)
- **Configuration:** Set in the **Payer Setup** → **HIPPS Rates** tab (for Medicare payer)
- **Example:** HIPPS code 1AA11 = \$2,500.00 per 30-day period

Key Difference:

- **Medicare** → Uses **HIPPS Rates** (not fee schedules)
- **Private Payers** → Use **Fee Schedules** (not HIPPS rates)

12.1.3 Why Fee Schedules Are Important

Accurate Billing:

- Ensures claims are submitted with the correct charge amounts
- Prevents under-billing (lost revenue) or over-billing (audit risk)

Contract Management:

- Tracks negotiated rates with each payer
- Allows you to update rates when contracts are renewed

Financial Reporting:

- Compares expected revenue (based on fee schedules) to actual payments
- Identifies discrepancies (e.g., payer paying less than contracted rate)

Claim Submission:

- Fee schedule rates are automatically used when generating claims for private payers
- Reduces manual entry errors

12.2 Accessing Fee Schedules

Navigation Path

Fee schedules are configured **per payer** (each payer has its own fee schedule).

1. **From the Dashboard:** Click the **Settings** icon (gear icon) in the top-right header bar
2. **Select "Payer Setup"** from the dropdown menu
3. The **Payer Management** page opens, showing all configured payers
4. **Click on a payer** (e.g., "Blue Cross Blue Shield")
5. The **Payer Configuration** page opens
6. Click the **Fee Schedule** tab (next to "Profile & Rules" and "HIPPS Rates" for Medicare)

The screenshot shows the 'Payer Configuration: Blue Cross Blue Shield' page. On the left is a sidebar with 'Agency Settings' and a list of options: Account Profile, User Management, Payer Setup (highlighted), Roles & Permissions, Branch Management, and Clinical Settings. The main content area has a breadcrumb 'Payer Setup / Blue Cross Blue Shield' and a 'Delete Payer' button. Below the title are two tabs: 'Profile & Rules' and 'Fee Schedule' (which is active). Under the 'Fee Schedule' tab, there is a '+ Add Rate' button and a table with the following data:

VISIT TYPE	RATE (\$)	EFFECTIVE DATE	END DATE	STATUS	
Wound Care Visit	\$300.00	12/15/2025	-	Active	
HHA Visit	\$300.00	12/14/2025	-	Active	
OASIS - Discharge	\$3223.00	11/28/2025	-	Active	
SN Visit	\$121.00	11/28/2025	-	Active	
MSW Initial Assessment / Evaluation	\$344.00	11/27/2025	12/8/2025	Active	
IV Infusion Visit	\$499.00	9/30/2025	-	Active	

What You'll See:

- **Payer Name** at the top (e.g., "Payer Configuration: Blue Cross Blue Shield")
- **Fee Schedule** tab (active)
- Table showing all configured fee schedule rates:
 - **Visit Type** (e.g., Wound Care Visit, HHA Visit, OASIS - Discharge)
 - **Rate (\$)** (e.g., 300.00, 3323.00)
 - **Effective Date** (e.g., 12/15/2025)
 - **End Date** (e.g., "-" for no end date, or a specific date like 12/8/2025)
 - **Status** (e.g., Active)
 - **Actions** (Edit and Delete icons)
- **+ Add Rate** button in the top-right corner

12.3 Adding a New Fee Schedule Rate

12.3.1 Click "+ Add Rate"

1. In the **Fee Schedule** tab of a payer, click the **+ Add Rate** button (top-right)

2. The **Add Fee Schedule Rate** modal will open

12.3.2 Complete the Fee Schedule Rate Form Visit Type

- **Required:** Yes
- **Format:** Dropdown selection
- **Purpose:** The visit type for which you're setting a rate
- **Options:** All visit types (standard and custom) from Chapter 11
 - SN Visit
 - PT Evaluation
 - HHA Visit
 - OASIS assessments
 - Custom visit types (if created)

Example:

- Select "SN Visit" to set a rate for skilled nursing visits with this payer

Charge Amount (Rate)

- **Required:** Yes
- **Format:** Dollar amount (up to 2 decimal places)
- **Purpose:** How much your agency charges this payer for the selected visit type
- **Examples:**
 - \$121.00 - Skilled nursing visit
 - \$300.00 - Home health aide visit
 - \$3,020.00 - Physical therapy evaluation

Where to Find Rates:

- **Payer Contracts:** Review your signed contract with the payer
- **Negotiated Rates:** Rates agreed upon during contract negotiations
- **Fee Schedule Documents:** Payers often provide a fee schedule document listing rates for all service codes
- **Your Billing Department:** Your billing manager or financial officer should have this information

Important:

- Enter the **contracted rate** (not your "usual and customary" charge)
- Payers will reimburse based on the contracted rate, so ensure accuracy

Effective Date

- **Required:** Yes
- **Format:** Date picker (MM/DD/YYYY)
- **Purpose:** The date this rate becomes active

- **Examples:**

- 12/15/2025 - Rate is effective starting December 15, 2025
- 01/01/2026 - Rate is effective starting January 1, 2026 (common for annual rate updates)

How It Works:

- Claims for visits on or after this date will use this rate
- If multiple rates exist for the same visit type, the system uses the rate with the most recent effective date

Best Practice:

- Set the effective date to match your contract's start date
- For rate changes, create a new fee schedule entry with the new rate and effective date (don't delete the old rate until after the effective date)

End Date (Optional)

- **Optional**
- **Format:** Date picker (MM/DD/YYYY)
- **Purpose:** The date this rate expires (if applicable)
- **Examples:**
 - Leave blank (-) - Rate is active indefinitely
 - 12/31/2026 - Rate expires on December 31, 2026 (useful for temporary contracts or rate guarantees)

When to Use End Date:

- **Temporary Contracts:** Short-term contracts with expiration dates
- **Pilot Programs:** Special rates for a trial period
- **Rate Guarantees:** Contracted rates that expire after a certain period

What Happens After End Date:

- The rate becomes inactive automatically
- Claims submitted after the end date will **not use this rate** (you must add a new rate for the next period)

Status

- **Required:** Yes
- **Format:** Dropdown selection
- **Options:**
 - **ACTIVE** - Rate is currently in use for billing
 - **INACTIVE** - Rate is not used (archived or superseded)

Default: ACTIVE

When to Set Inactive:

- You've replaced this rate with a new rate

- The payer contract has ended
- You no longer accept this payer

12.3.3 Save the Fee Schedule Rate

After completing all fields:

1. Click **Save** or **Add Rate** at the bottom of the modal
2. The system validates:
 - Visit Type is selected
 - Charge Amount is a valid dollar amount
 - Effective Date is provided
 - No duplicate rate exists for the same payer + visit type + effective date
3. If validation passes, the rate is added
4. A **Success** toast notification appears: "Fee schedule rate added successfully"
5. The new rate appears in the fee schedule table

12.4 Editing an Existing Fee Schedule Rate

To update a fee schedule rate:

12.4.1 Locate the Rate

1. In the **Fee Schedule** tab, locate the rate you want to edit in the table

12.4.2 Click the Edit Icon

1. Click the **Edit** icon (pencil icon) next to the rate
2. The **Edit Fee Schedule Rate** modal opens with pre-filled information

What You Can Edit:

- Visit Type (if no claims have been submitted with this rate)
- Charge Amount (rate)
- Effective Date
- End Date
- Status (Active/Inactive)

What You Cannot Edit:

- Payer (fee schedules are payer-specific)
- Historical claims that used this rate (claims are immutable)

12.4.3 Save Your Changes

1. Update the necessary fields
2. Click **Save** or **Update Rate**
3. A **Success** toast notification appears: "Fee schedule rate updated successfully"

Important:

- Editing a rate **does not affect past claims** (historical data is preserved)

- Editing a rate **affects future claims** generated on or after the effective date

12.5 Deleting a Fee Schedule Rate

12.5.1 When to Delete

Delete a fee schedule rate if:

- The rate was created by mistake and has never been used
- You want to permanently remove it from the system

Do NOT delete a rate if:

- Claims have already been submitted using this rate (set it to INACTIVE instead)
- You're updating rates (create a new rate with a new effective date instead of deleting the old one)

12.5.2 How to Delete

1. In the **Fee Schedule** tab, locate the rate
2. Click the **Delete** icon (trash can icon)
3. A confirmation dialog appears: "Are you sure you want to delete this rate? This action cannot be undone."
4. Click **Delete** to confirm

Warning:

- Deleting a rate can affect claims if they reference this rate
- **Best Practice:** Set the rate to **INACTIVE** instead of deleting

12.6 Managing Rate Changes and Updates

12.6.1 When Payer Rates Change

Payers often update their fee schedules annually or when contracts are renegotiated.

Scenario: Blue Cross Blue Shield notifies you that SN Visit rates will increase from 121.00 to 130.00 effective January 1, 2026.

How to Handle This:

1. **Do NOT edit the existing rate** (preserve historical data)
2. **Add a new rate:**
 - **Visit Type:** SN Visit
 - **Charge Amount:** \$130.00
 - **Effective Date:** 01/01/2026
 - **End Date:** Leave blank (or set based on contract)
 - **Status:** ACTIVE
3. Click **Save**

Result:

- Claims for visits **before January 1, 2026** use the old rate (\$121.00)
- Claims for visits **on or after January 1, 2026** use the new rate (\$130.00)
- Both rates remain in the system for audit and reporting purposes

12.6.2 Overlapping Rates (How the System Chooses)

What if multiple active rates exist for the same visit type?

The system uses the rate with the **most recent effective date** that is **on or before the visit date**.

Example:

Rate	Effective Date	Status	Rate Amount
Rate 1	01/01/2025	Active	\$121.00
Rate 2	01/01/2026	Active	\$130.00

- **Visit on December 15, 2025:** Uses Rate 1 (\$121.00)
- **Visit on January 5, 2026:** Uses Rate 2 (\$130.00)
- **Visit on January 1, 2026:** Uses Rate 2 (\$130.00)

12.7 Viewing Fee Schedules by Payer

12.7.1 Comparing Rates Across Payers

Scenario: You want to see how much different payers reimburse for the same visit type.

How to Do This:

1. Go to **Payer Setup**
2. Click on **Payer A** (e.g., Blue Cross Blue Shield)
3. View **Fee Schedule** tab → Note the rate for "SN Visit" (e.g., \$121.00)
4. Go back to **Payer Setup**
5. Click on **Payer B** (e.g., Aetna)
6. View **Fee Schedule** tab → Note the rate for "SN Visit" (e.g., \$115.00)

Use Case:

- Identify which payers reimburse the highest rates
- Negotiate better rates with low-paying payers
- Prioritize referrals from high-paying payers (if applicable)

12.8 Fee Schedules and Claim Generation

12.8.1 How Fee Schedules Are Used in Billing

When generating a claim for a private payer (Chapter 29):

1. System Identifies the Payer:

- Patient has Blue Cross Blue Shield as their primary insurance

2. System Identifies the Visit Type:

- Nurse completed an "SN Visit" on December 20, 2025

3. System Looks Up the Fee Schedule:

- Finds the active rate for Blue Cross Blue Shield + SN Visit effective on or before December 20, 2025
- Rate: \$121.00

4. System Generates the Claim:

- Claim line includes: Visit Type, HCPCS Code (G0299), Charge Amount (\$121.00)

5. Claim is Submitted:

- Claim is sent to the payer with the correct charge amount

12.8.2 What Happens if No Fee Schedule Exists?

Problem: A visit is completed, but no fee schedule rate exists for that payer + visit type.

System Behavior:

- The claim **cannot be generated** (or generates with a \$0.00 charge, which will be rejected)
- An error appears: "No fee schedule found for [Payer] + [Visit Type]"
- The visit remains in the **Pending Claims** queue

Solution:

1. Add the missing fee schedule rate (Section 12.3)
2. Regenerate the claim
3. Submit the claim

Best Practice:

- Set up fee schedules for all common visit types **before admitting patients** with that payer
- Regularly review the **Pending Claims** queue for missing fee schedules

12.9 Troubleshooting Common Issues

Issue 1: "Fee Schedule Not Found"

Error Message: "No fee schedule found for [Payer] and [Visit Type]"

Solution:

1. Go to **Payer Setup** → Click on the payer
2. Go to **Fee Schedule** tab
3. Check if a rate exists for the visit type
4. If missing, **Add Rate** (Section 12.3)
5. Ensure the effective date is **on or before the visit date**

Issue 2: "Claim Shows Wrong Charge Amount"

Problem: Claim was generated with an incorrect rate (e.g., 100insteadof121)

Solution:

1. Check the **Fee Schedule** for the payer
2. Verify the **Effective Date** of the rate:
 - If the effective date is after the visit date, the system used an older rate
3. If the rate is incorrect:
 - Edit the rate or add a new rate with the correct amount and effective date
4. **Regenerate the claim** (do not submit the incorrect claim)

Issue 3: "Multiple Rates Showing for Same Visit Type"

Problem: Two active rates exist for the same payer + visit type

Solution:

- This is **normal** if rates changed over time (e.g., January 2025 rate vs. January 2026 rate)
- The system automatically uses the correct rate based on the visit date
- If you have duplicate rates with the **same effective date**, delete or inactivate one

Issue 4: "Rate Expired, Claims Not Generating"

Problem: Claims are not generating because the fee schedule rate has an end date in the past

Solution:

1. Check the **End Date** of the rate
2. If the end date has passed, add a **new rate** with a new effective date
3. If the end date was set by mistake, **edit the rate** and remove the end date (set to blank)

Issue 5: "Payer Contract Changed, Need to Update All Rates"

Problem: Your contract with a payer was renegotiated, and all rates changed

Solution:

1. **Do NOT delete old rates** (preserve historical data)
2. **Add new rates** for each visit type:
 - Set **Effective Date** to the contract's new start date
 - Enter new **Charge Amounts** based on the new contract
3. The old rates remain active for past claims; new rates apply to future visits

12.10 Best Practices

Do This:

1. **Set Up Fee Schedules Before Admitting Patients:**
 - Ensure all common visit types have rates configured for each payer
 - Prevents billing delays and claim generation errors

2. Keep Historical Rates:

- Do NOT delete old rates when updating
- Add new rates with new effective dates instead
- Historical rates are needed for audits, reporting, and claim corrections

3. Use Effective Dates Correctly:

- Set effective dates to match contract start dates
- Use end dates for temporary rates or pilot programs

4. Review Fee Schedules Quarterly:

- Compare contracted rates to actual payments received
- Identify discrepancies (e.g., payer underpaying)
- Update rates when contracts are renewed

5. Document Rate Sources:

- Keep a copy of payer contracts and fee schedule documents
- Note where each rate came from (contract section, negotiation date)

6. Train Billing Staff:

- Ensure billing staff know how to add and update rates
- Review the **Pending Claims** queue regularly for missing fee schedules

Avoid This:

1. Don't Delete Historical Rates:

- Deleting rates can break historical claims and reports
- Use **Inactive** status instead

2. Don't Guess Rates:

- Always use the contracted rate from the payer agreement
- Incorrect rates cause underpayment or overpayment issues

3. Don't Use the Same Rate for All Payers:

- Each payer has different negotiated rates
- Set up separate fee schedules for each payer

4. Don't Forget Effective Dates:

- Claims use the rate based on the effective date
- Missing or incorrect effective dates cause billing errors

5. Don't Overlook Visit Types:

- Set up rates for **all visit types** your agency provides, not just common ones
- Missing rates for specialized visits (e.g., IV Infusion, Wound Care) cause claim delays

Chapter 13: Go Live Process

Overview

The Go Live Process is how your agency transitions from **Sandbox Mode** (testing environment with demo data) to **Production Mode** (live environment for real patient care). This chapter covers:

- Understanding the difference between Sandbox and Production
- Requirements for going live
- Submitting a Go Live request
- The admin approval workflow
- Payment and subscription activation
- Post-Go Live considerations

Who Should Read This Chapter:

- Agency Administrators
- Agency owners and executives
- Sales & Onboarding staff (Betasky)
- Super Administrators (Betasky)

Prerequisites:

- Completed all initial setup (Chapters 4-9)
- Valid CMS Certification Number (CCN)
- National Provider Identifier (NPI)
- Decision on subscription tier (Growth, Pro, or Enterprise)

13.1 Understanding Sandbox vs. Production

13.1.1 Sandbox Mode

What Is Sandbox Mode?

- A **testing and training environment** separate from live patient care
- Pre-populated with **demo data** (sample patients, visits, OASIS, care orders)
- **Free and unlimited access** for exploration and staff training
- Clearly labeled with a **blue "Sandbox" banner** at the top of every page

Sandbox Mode Features:

- Full access to all system features
- Unlimited users (no subscription limits)
- Pre-seeded demo data for immediate testing
- No risk to real patient data or billing
- Safe environment for learning workflows

Sandbox Mode Limitations:

- **Cannot submit real Medicare/Medicaid claims** (demo mode only)
- **Cannot process actual patient care** (test data only)
- **No official regulatory compliance** (not for production use)
- **Data is not backed up long-term** (can be reset at any time)

When to Use Sandbox:

- During initial agency setup and configuration
- Training new staff members
- Testing new workflows or features
- Demonstrating the system to prospective clinicians

13.1.2 Production Mode

What Is Production Mode?

- The **live environment** for real patient care
- Used for actual patient admissions, visits, documentation, and billing
- Fully compliant with Medicare, Medicaid, and HIPAA regulations
- Requires a **paid subscription** and **CMS Certification Number (CCN)**

Production Mode Features:

- **Real patient data** with full HIPAA protection and encryption
- **Live claim submission** to Medicare, Medicaid, and private payers
- **Regulatory compliance** for CMS certification and state licensing
- **Data backup and disaster recovery** (daily automated backups)
- **Production-level support** with SLA guarantees (Pro/Enterprise)
- **Audit trail and compliance logging** for regulatory inspections

Production Mode Requirements:

- Valid **CMS Certification Number (CCN)** (6-character code)
- Valid **National Provider Identifier (NPI)** (10-digit number)
- **Paid subscription** (Growth, Pro, or Enterprise tier)
- **Admin approval** from Betasky (to verify credentials and setup)

When to Use Production:

- After initial setup and staff training are complete
- When you're ready to admit real patients and provide care
- For live billing, claim submission, and revenue cycle management

13.1.3 Key Differences

Feature	Sandbox Mode	Production Mode
Purpose	Testing, training, demos	Real patient care
Data	Demo/sample data	Real patient data

Feature	Sandbox Mode	Production Mode
Claims	Cannot submit real claims	Live claim submission
Cost	Free	Paid subscription required
CCN Required	No	Yes (mandatory)
User Limits	Unlimited	Based on subscription tier
Support	Standard support	Priority/SLA support (Pro/Enterprise)
Compliance	Not required	Full HIPAA, Medicare, state regulations
Data Backup	Not guaranteed	Daily automated backups

13.2 Requirements for Going Live

Before submitting a Go Live request, ensure you have completed the following:

13.2.1 Mandatory Requirements

1. CMS Certification Number (CCN)

- **What:** 6-character alphanumeric code issued by CMS
- **Why:** Required for Medicare billing and regulatory compliance
- **Where to Get:** Apply through your state survey agency (part of home health licensure process)
- **Format:** 12345A (6 characters)

Without a CCN:

- You **cannot go live** in production
- Medicare claims will be rejected
- Your agency is not certified for home health services

How to Enter CCN:

1. Go to **Agency Settings** (Chapter 4)
2. Enter your CCN in the **CMS Certification Number** field
3. Save changes

2. National Provider Identifier (NPI)

- **What:** 10-digit unique identifier for healthcare providers
- **Why:** Required for all claims (Medicare, Medicaid, private insurance)
- **Where to Get:** [NPPES NPI Registry](#)
- **Format:** 1234567890 (10 digits)

How to Enter NPI:

1. Go to **Agency Settings** (Chapter 4)

2. Enter your NPI in the **National Provider Identifier** field
3. Save changes

3. Paid Subscription Tier

- **Options:** Growth, Pro, or Enterprise
- **Pricing:** Contact Betasky Sales (sales@betaskyhealth.com)
- **Payment Methods:**
 - **Stripe (Credit Card)** - Automated recurring billing
 - **Manual Payment** - Check, Wire, or ACH (for first payment, then Stripe)

Subscription Tiers:

Tier	User Limit	Monthly Cost	Best For
Growth	20 users	Contact Sales	Small agencies, single location
Pro	50 users	Contact Sales	Mid-sized agencies, Custom Role Builder
Enterprise	Unlimited users	Contact Sales	Large multi-branch agencies, SLA support

13.2.2 Recommended (But Not Mandatory)

Before going live, it's highly recommended to complete:

Agency Setup

- Agency information (name, address, contact) entered (Chapter 4)
- Branches configured (if multi-branch agency) (Chapter 5)
- Payers added (Medicare, Medicaid, private insurance) (Chapter 6)
- Pharmacies added (Chapter 7)

Staff Setup

- Users added with appropriate roles (Chapter 8)
- Physicians and referral sources entered (Chapter 9)

Configuration

- Clinical settings configured (Chapter 10)
- Visit types set up (Chapter 11)
- Fee schedules configured (Chapter 12)

Why This Matters:

- Going live without setup means your staff cannot immediately start working
- You'll need to configure these items in production, delaying patient care

13.3 Submitting a Go Live Request

Once you've met the requirements, you can submit a Go Live request from within the Sandbox environment.

13.3.1 Access the Go Live Option

From the Sandbox Banner:

1. At the top of any page in Sandbox mode, you'll see a **blue banner** that says:
 - "Sandbox Mode - You are in a testing environment"
 - Two buttons: "**Go Live**" and "**View Go Live Status**"
2. Click the "**Go Live**" button

Alternative Path:

- Go to **Settings** → **Agency Settings** → **Go Live** tab

13.3.2 Complete the Go Live Request Form

A modal or page will open with the following fields:

Requested Subscription Tier

- **Purpose:** Choose the subscription plan you want to activate
- **Options:**
 - **Growth** (20 users)
 - **Pro** (50 users, includes Custom Role Builder)
 - **Enterprise** (Unlimited users, SLA support)
- **Note:** Your selection determines pricing and features

Confirm Agency Information

The system will display your current agency settings:

- **Agency Name**
- **NPI** (must be entered)
- **CCN** (must be entered)
- **Tax ID**
- **Address**
- **Contact Information**

Review Carefully:

- Ensure all information is accurate (this will be verified by Betasky staff)
- If anything is incorrect, click **Cancel**, update your agency settings, and resubmit

Acknowledgment and Certification

You must acknowledge:

- I confirm that the information provided is accurate and up-to-date
- I understand that my CCN and NPI will be verified by Betasky staff
- I understand that a paid subscription is required to go live

- I agree to the Betasky Terms of Service and Subscription Agreement

13.3.3 Submit the Request

1. Review all information
2. Click **Submit Go Live Request**
3. A **Success** notification appears: "Your Go Live request has been submitted. You will receive an email when it's reviewed."

What Happens Next:

- Your request enters **PENDING_APPROVAL** status
- Betasky staff will review your request within **1-2 business days**
- You will receive an email notification with the outcome (approved or additional information needed)

13.4 The Admin Approval Workflow

After submission, your Go Live request goes through a multi-stage approval process managed by Betasky staff.

13.4.1 Stage 1: Pending Approval

Status: **PENDING_APPROVAL**

What's Happening:

- Betasky Sales or Onboarding staff review your request
- They verify:
 - CCN is valid (checked against CMS records)
 - NPI is valid (checked against NPPES registry)
 - Agency information is complete and accurate
 - Subscription tier selection is appropriate for your agency size

Timeline: Typically 1-2 business days (faster for urgent requests)

Possible Outcomes:

1. **Approved** → Moves to Stage 2 (Payment)
2. **Additional Information Needed** → You receive an email with clarifications or corrections needed
3. **Rejected** → Rare; typically due to missing CCN or invalid credentials

13.4.2 Stage 2: Pending Payment

Status: **PENDING_PAYMENT**

What's Happening:

- Your request has been approved
- Betasky staff send you a payment link or invoice
- You choose your payment method:
 - **Option A: Stripe (Credit Card)** - Instant activation upon payment

- **Option B: Manual Payment (Check/Wire/ACH)** - First payment processed manually, then recurring billing via Stripe

Payment Method A: Stripe (Credit Card)

1. You receive an email with a **secure payment link** (Stripe-hosted)
2. Click the link and enter your credit card information
3. Payment is processed immediately
4. Upon successful payment, your request is marked **APPROVED**
5. Your agency is converted to Production mode within **minutes**

Payment Method B: Manual First Payment (Check, Wire, ACH)

1. Betasky staff coordinate with you for first payment (via phone or email)
2. You send payment via:
 - **Check:** Mailed to Betasky office
 - **Wire Transfer:** Bank wire to Betasky account
 - **ACH:** Electronic bank transfer
3. Betasky staff confirm receipt and mark your request **APPROVED**
4. Your agency is converted to Production mode
5. **Future billing:** You'll be sent a Stripe link for recurring monthly payments

Timeline:

- **Stripe:** Instant activation after payment
- **Manual:** 1-3 business days (depending on payment method and confirmation)

13.4.3 Stage 3: Approved (Go Live Complete)

Status: APPROVED

What's Happening:

- Payment has been received and confirmed
- Your agency is converted from **Sandbox** to **Production** mode
- You receive a confirmation email: "Congratulations! Your agency is now live."

What Changes Immediately:

- The **blue Sandbox banner** is removed
- Your subscription tier is activated (user limits, features enabled)
- You can now admit **real patients** and provide **live care**
- Claims can be submitted to **real payers** (Medicare, Medicaid, insurance)
- Data is now **production-level protected** with daily backups

13.4.4 Rejection Scenarios (Rare)

Status: REJECTED

Why a Request Might Be Rejected:

- Invalid or expired CCN (not found in CMS records)

- NPI does not match agency name or credentials
- Incomplete agency information
- Outstanding issues from prior sandbox testing (e.g., Terms of Service violations)

What Happens:

- You receive an email explaining the rejection reason
- You can correct the issues and **resubmit** a new Go Live request
- Contact Betasky Support (support@betaskyhealth.com) if you need clarification

13.5 Viewing Your Go Live Request Status

13.5.1 Check Request Status

At any time, you can check the status of your Go Live request:

From the Sandbox Banner:

1. Click the "View Go Live Status" button
2. A modal displays:
 - **Request Status:** PENDING_APPROVAL, PENDING_PAYMENT, APPROVED, or REJECTED
 - **Requested Tier:** Growth, Pro, or Enterprise
 - **Requested Date:** When you submitted the request
 - **Last Updated:** Most recent status change
 - **Admin Notes:** Any comments from Betasky staff (if applicable)

13.6 After Going Live: Post-Production Considerations

13.6.1 Immediate Post-Go Live Tasks

Once your agency is live in Production:

1. Verify System Access

- **Log in again** to confirm access
- Confirm the **Sandbox banner is gone**
- Check that your subscription tier is active (view in Settings → Subscription)

2. Begin Patient Admissions

- Start admitting **real patients** (Chapter 14: Patient Intake)
- Assign **real clinicians** to patients
- Create **live care orders** and schedules

3. Train Staff on Production Workflows

- Remind staff that this is now **live patient data**
- Review data entry accuracy and documentation standards

- Emphasize HIPAA compliance and patient privacy

4. Configure Payer Credentials (If Not Done)

- Ensure all payers are correctly configured (Chapter 6)
- Verify HIPPS rates for Medicare are current
- Test claim submission to clearinghouse (if applicable)

13.6.2 Sandbox Access After Going Live

What Happens to Your Sandbox?

- Your original **Sandbox account remains available** (separate from Production)
- You can still log in to Sandbox for:
 - Staff training and onboarding
 - Testing new features or workflows
 - Demonstrating the system to new hires

How to Switch Between Sandbox and Production:

- Sandbox and Production are **separate environments** with different login URLs (or agency selection)
- Contact Betasky Support if you need help accessing Sandbox after Go Live

13.6.3 Subscription Management

Billing and Payments:

- Your subscription is billed **monthly** via Stripe (or your chosen payment method)
- View invoices and payment history in **Settings → Subscription → Billing**
- Update payment method or subscription tier by contacting Betasky Sales

User Limits:

- Your active user count is monitored against your subscription tier
- If you exceed your limit, you'll be prompted to upgrade
- Contact Sales to upgrade (e.g., Growth → Pro)

13.6.4 Support and Assistance

Production Support:

- **Email:** support@betaskyhealth.com
- **Phone:** (Contact Betasky for phone support number)
- **Response Time:**
 - Growth: Standard support (24-48 hours)
 - Pro: Priority support (12-24 hours)
 - Enterprise: SLA-backed support (4-8 hours, 24/7 critical issues)

What Support Can Help With:

- Technical issues (login problems, bugs, errors)
- Configuration assistance (payers, clinical settings, reports)
- Training and onboarding guidance

- Billing and subscription questions

What Support Cannot Help With:

- Medical or clinical decision-making (contact your clinical manager)
- Legal or compliance advice (consult your agency's legal counsel)
- Third-party issues (e.g., clearinghouse, EVV vendor)

13.7 Troubleshooting Common Issues

Issue 1: "CCN Required to Submit Go Live Request"

Error Message: "You must enter a CMS Certification Number before going live"

Solution:

1. Go to **Settings** → **Agency Settings**
2. Enter your 6-character CCN in the **CMS Certification Number** field
3. Click **Save Changes**
4. Return to the Go Live page and resubmit

Issue 2: "NPI Invalid or Missing"

Error Message: "Your NPI is invalid or not entered"

Solution:

1. Verify your NPI is exactly 10 digits
2. Check for typos (no dashes or spaces)
3. Verify via [NPPES NPI Registry](#)
4. Update in **Settings** → **Agency Settings** and resubmit

Issue 3: "Request Pending for Over 2 Business Days"

Problem: Your Go Live request has been pending for longer than expected

Solution:

1. Check your email (including spam folder) for messages from Betasky
2. Contact Betasky Sales or Support: support@betaskyhealth.com
3. Provide your agency name and request date for follow-up

Issue 4: "Payment Link Expired"

Problem: The Stripe payment link you received has expired

Solution:

1. Contact Betasky Support to request a new payment link
2. Payment links typically expire after 7 days for security reasons
3. A new link will be sent to your email within 24 hours

Issue 5: "Request Rejected - CCN Not Found"

Problem: Your CCN was not found in CMS records

Solution:

1. Verify your CCN with your state survey agency
2. Ensure it's entered correctly (exactly 6 characters)
3. If your CCN is very recent, it may not yet be in CMS systems (contact Betasky for manual verification)
4. Resubmit after correcting the CCN

13.8 Best Practices

Do This:

1. Complete All Setup Before Going Live:

- Add all payers, pharmacies, physicians, and users before submitting your Go Live request
- This ensures your staff can start working immediately after activation

2. Double-Check CCN and NPI:

- Verify these identifiers are correct before submitting
- Incorrect credentials cause delays and rejections

3. Train Staff in Sandbox First:

- Ensure all staff are comfortable with the system before going live
- Use Sandbox for at least 1-2 weeks of training

4. Choose the Right Subscription Tier:

- Consider your current user count and anticipated growth
- Upgrading later is possible, but starting at the right tier avoids interruptions

5. Plan Your Go Live Timeline:

- Submit your request at least 3-5 business days before you need to be live
- Account for payment processing time (especially for manual payments)

6. Communicate with Your Team:

- Notify all staff when the agency goes live
- Emphasize the shift from test data to real patient data

Avoid This:

1. Don't Rush the Go Live Process:

- Going live without proper setup creates confusion and delays care
- Take time to configure everything correctly in Sandbox first

2. Don't Submit Without a CCN:

- You cannot go live without a CMS Certification Number
- Your request will be immediately rejected

3. **Don't Use Incorrect Payment Information:**

- Ensure your billing contact and payment method are accurate
- Failed payments delay your Go Live activation

4. **Don't Ignore Admin Communication:**

- Betasky staff may email you for clarifications or additional information
- Check your email regularly and respond promptly

5. **Don't Assume Instant Activation:**

- Even with Stripe, allow a few minutes for the system to update
- Manual payments take 1-3 business days

13.9 Key Takeaways

- **Sandbox** is for testing and training; **Production** is for real patient care
- **CCN and NPI** are mandatory for going live in Production
- Go Live requires **admin approval** from Betasky staff
- **Payment** activates your subscription (Stripe or manual)
- The process typically takes **1-3 business days** from request to activation
- After going live, you can still access Sandbox for training purposes

Chapter 14: Patient Intake

Overview

Patient Intake is where you admit new patients into your agency's care. This chapter covers everything intake coordinators and administrators need to know about adding patients to the system.

What You'll Learn:

- How to access the patient list
- Adding a new patient step-by-step
- Filling out all intake tabs (Demographics, Payer, Physician, Clinical, etc.)
- Saving drafts vs. completing admission
- Viewing and managing pending admissions
- Viewing patient profiles after admission

Who Should Read This Chapter:

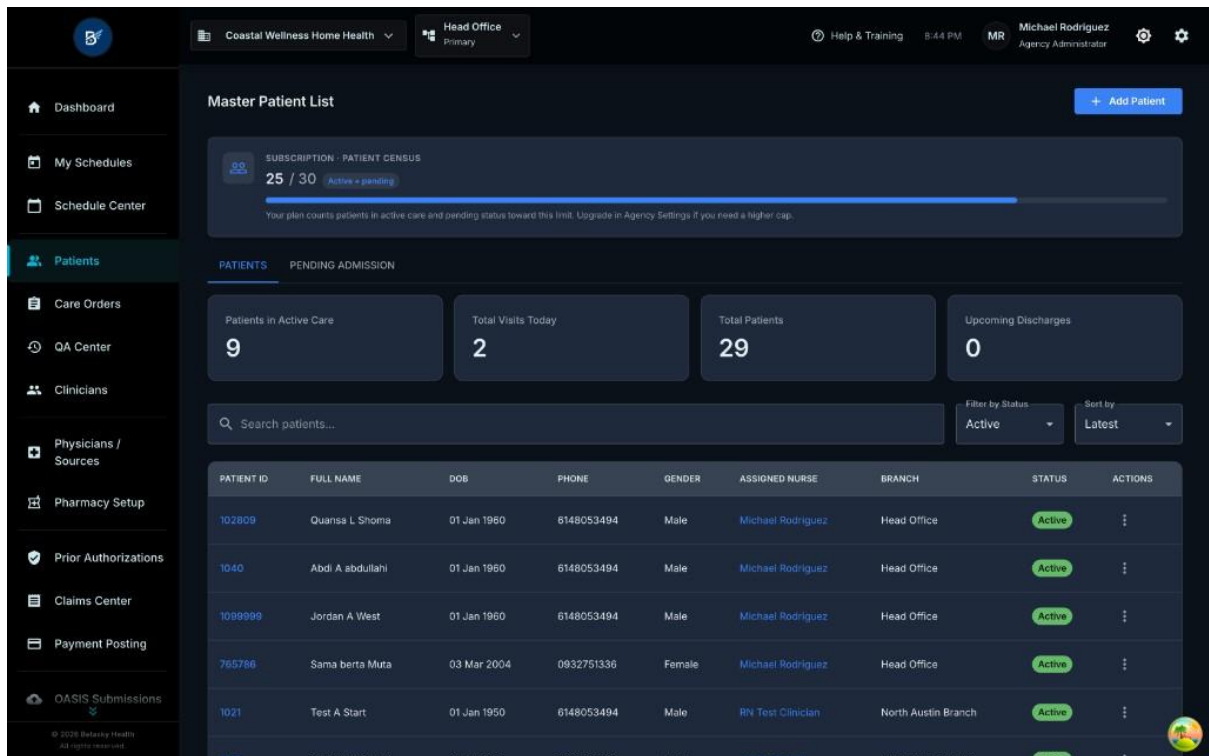
- Intake Coordinators
- Agency Administrators
- Clinical Managers
- Anyone responsible for admitting patients

Prerequisites:

- Completed setup chapters (Payers, Physicians, Pharmacies, Users)
- Understanding of home health admission requirements
- Patient referral information from physician or hospital

14.1 Accessing the Patient List

Where to Find Patients



1. Look at the **left sidebar**
2. Click on **"Patients"** (the icon with two people)
3. The **Master Patient List** page opens

What You'll See on This Screen:

Top Section:

- **Subscription Status Bar** (blue bar)
 - Shows: "25 / 30" (you're using 25 patients out of your 30-patient limit)
 - Text: "Active + pending"
 - Note: "Your plan counts patients in active care and pending status toward this limit. Upgrade to Agency Settings if you need a higher cap."

Two Tabs:

- **PATIENTS** tab (main patient list)
- **PENDING ADMISSION** tab (draft patients not yet admitted)

Dashboard Cards (4 boxes showing quick stats):

- **Patients in Active Care:** 9
- **Total Visits Today:** 2
- **Total Patients:** 29
- **Upcoming Discharges:** 0

Search and Filter:

- **Search bar:** "Search patients..."
- **Filter by Status:** Dropdown showing "Active"
- **Sort by:** Dropdown showing "Latest"

Patient Table:

Shows all patients with columns:

- **PATIENT ID** (e.g., 102809, 1040, 1099999)
- **FULL NAME** (e.g., Quansa L Shoma, Abd A abdullah)
- **DOB** (Date of Birth)
- **PHONE** (Phone number)
- **GENDER** (Male, Female)
- **ASSIGNED NURSE** (the clinician's name in blue)
- **BRANCH** (Head Office, North Austin Branch)
- **STATUS** (green "Active" badges)
- **ACTIONS** (three-dot menu for each patient)

Add Patient Button:

- Blue button in top-right corner: "+ Add Patient"

14.2 Starting a New Patient Admission

Click the "+ Add Patient" Button

1. In the **Master Patient List** page, click the blue "+ Add Patient" button (top-right corner)
2. The **Add Patient** modal opens (large pop-up window)

14.3 The Add Patient Modal (9 Tabs)

The Add Patient modal has **9 tabs** across the top. You'll fill out information in each tab.

The 9 Tabs Are:

1. **DEMOGRAPHIC** - Patient's personal information
2. **PAYER** - Insurance information
3. **PHYSICIAN** - Ordering physician and referral source
4. **CLINICAL / DIAGNOSIS** - Medical conditions and clinical details
5. **PHARMACY** - Patient's preferred pharmacy
6. **CONTACTS** - Emergency contacts and family
7. **EMERGENCY PREPAREDNESS** - Backup plans for emergencies
8. **ADVANCED DIRECTIVES** - DNR, living will, power of attorney
9. **REFERRAL INFORMATION** - How the patient was referred to your agency

Let's go through each tab step-by-step.

14.4 Tab 1: DEMOGRAPHIC

This is where you enter the patient's basic personal information.

Patient Information Section

First Name (required)

- Field code: (M0040)
- Example: "John"
- Enter the patient's legal first name

Middle Name (optional)

- Example: "Michael"

Last Name (required)

- Field code: (M0040)
- Example: "Smith"

Gender (required)

- Field code: (M0069)
- Dropdown options:
 - Male
 - Female
- Select the patient's gender

Date of Birth (required)

- Field code: (M0066)
- Format: MM/DD/YYYY
- Click the calendar icon to pick a date
- Example: "01/15/1950"

Social Security Number (optional)

- Field code: (M0064)
- Format: 9 digits
- Checkbox: "☐ Unknown" (check this if patient doesn't have or won't provide SSN)
- Example: "123-45-6789"
- **Note:** This field is sensitive - handle with care

Marital Status (required)

- Dropdown options:
 - Single
 - Married
 - Divorced
 - Widowed
 - Separated
- Select the patient's current marital status

Primary Address Section**Address line 1** (required)

- Example: "123 Main Street"
- Enter the patient's street address

Address line 2 (optional)

- Example: "Apt 4B"
- Use for apartment, suite, or unit numbers

City (required)

- Example: "Austin"

State (required)

- Field code: (M0050)
- Dropdown showing all U.S. states
- Example: "TX" (Texas)

Zip Code (required)

- Field code: (M0090)
- Format: 5 digits or 9 digits
- Example: "78701" or "78701-1234"

Mailing Address Section

Checkbox: Same as Primary Address

- If checked, the system copies the primary address to mailing address
- If unchecked, you can enter a different mailing address

If mailing address is different:

- **Address line 1** (required)
- **Address line 2** (optional)
- **City** (required)
- **State** (required)
- **Zip Code** (required)

Contact Information Section

Phone Number (required)

- Format: (###) ###-####
- Example: "(512) 555-1234"
- This is the patient's primary phone number

Alternative Phone Number (optional)

- Format: (###) ###-####
- Use for a secondary phone (e.g., cell phone, spouse's phone)

Email Id (optional)

- Format: Valid email address
- Example: "john.smith@email.com"
- Use if patient has email and wants electronic communication

Patient Id / MR Number (optional)

- Field code: (M0020)
- Some agencies use their own patient ID system
- Leave blank if your agency doesn't use this

Clinical Assignment Section

Assigned Clinician (required)

- Dropdown showing all clinicians from your agency
- Select the primary nurse or case manager for this patient
- Example: "Sarah Johnson, RN"

Branch (optional if single branch, required if multi-branch)

- Dropdown showing all branches
- Select which branch this patient belongs to
- Example: "Head Office" or "North Austin Branch"

After Completing Demographic Tab

Do NOT click "Continue" yet!

You have two options:

1. Click "**Continue**" to move to the next tab (Payer)
2. Click "**Save Draft**" to save your progress and come back later (saves to Pending Admissions)

For this tutorial, let's continue to the next tab.

14.5 Tab 2: PAYER

The Payer tab is where you enter the patient's insurance information.

What You'll See:

- A list of insurance types (checkboxes)
- Fields for selecting primary payer, policy numbers, etc.

Insurance Type Checkboxes

Check all that apply to this patient:

- ☐ Inpatient Psychiatric Facility
- ☐ Critical Access Hospital (CAH)
- ☐ Other
- ☐ Medicaid (traditional fee-for-service)
- ☐ Medicaid (HMO/Managed Care)
- ☐ Worker's Compensation
- ☐ Title Programs (e.g., Title III, V, or XX)
- ☐ Other government (e.g., CHAMPUS, VA, etc)
- ☐ Private insurance
- ☐ Private HMO/ managed care
- ☐ Self-pay
- ☐ Unknown
- ☐ Other (Specify)

Most Common:

- Check "**Private insurance**" if patient has Blue Cross, Aetna, etc.
- Check "**Medicaid**" if patient has Medicaid
- Check "**Self-pay**" if patient has no insurance

Episode Timing

Field code: (M0110)

Episode Timing (required)

- Dropdown options:
 - Early - first 30 days of episode
 - Late - days 31-60 of episode
 - UK/NA - Unknown or Not Applicable
- **For new admissions, select "Early"**

Additional Fields (More on PAYER Tab)

Note: The screenshot cuts off here, but typically the Payer tab also includes:

- **Primary Payer** dropdown (select from your configured payers)
- **Policy Number**
- **Group Number**
- **Authorization Number** (if payer requires prior auth)
- **Secondary Payer** (if patient has secondary insurance)

After completing the Payer tab, click "Continue" to go to the Physician tab.

14.6 Tab 3: PHYSICIAN

The Physician tab is where you select the patient's ordering physician and referral source.

What You'll See:

- Dropdown to select **Ordering Physician** (required)
- Field for **Referral Source** (who referred the patient)
- Additional physician-related information

Ordering Physician:

- Dropdown shows all physicians from Chapter 9 (Physician/Source Setup)
- Select the physician who will sign the Plan of Care
- Example: "Dr. Michael Chen"

Referral Source:

- Dropdown shows physicians and referral sources
- Select who referred the patient to your agency
- Example: "Austin Regional Hospital - Discharge Planning"

After completing the Physician tab, click "Continue" to go to Clinical/Diagnosis tab.

14.7 Tab 4: CLINICAL / DIAGNOSIS

Add Patient

☐ Inpatient Psychiatric Facility
☐ Critical Access Hospital (CAH)
☐ Other

(M0110) Episode Timing *

☐ Medicaid (traditional fee-for-service)
☐ Medicaid (HMO/Managed Care)
☐ Worker's Compensation
☐ Title Programs (e.g., Title III, V, or XX)
☐ Other government (e.g., CHAMPUS, VA, etc)
☐ Private insurance
☐ Private HMO/ managed care
☐ Self-pay
☐ Unknown
☐ Other (Specify)

Episode Management

Start of care date * Episode start date *

Create episode & schedule visit after saving
☐ Create episode & schedule OASIS Start of Care visit after saving ☐ Track F2F Documentation

Cancel Save Draft Continue

The Clinical/Diagnosis tab is where you enter the patient's medical conditions and clinical information.

What You'll See on This Screen:

Admission Source Checkboxes

Check where the patient is being admitted from:

- ☐ **Inpatient Psychiatric Facility**
- ☐ **Critical Access Hospital (CAH)**
- ☐ **Other**

(Only check if applicable - most patients are admitted from home or hospital)

Episode Timing Section

Episode Timing (required)

- Field code: (M0110)
- Dropdown showing:
 - Early
 - Late
 - UK/NA
- Select "Early" for new patients

Episode Management Section

Start of care date (required)

- Date picker (calendar icon)
- Enter the date home health services begin
- Example: "04/02/2026"
- **Important:** This date determines the episode start and billing period

Episode start date (required)

- Date picker (calendar icon)
- Usually the same as "Start of care date"
- Example: "04/02/2026"

Checkboxes:

☐ **Create episode & schedule visit after saving**

- Check this if you want the system to automatically create the episode when you finish intake
- **Recommended for most admissions**

☐ **Create episode & schedule OASIS Start of Care visit after saving**

- Check this if you want the system to create the episode AND schedule the initial OASIS visit
- **Recommended if you know the SOC OASIS visit date**

☐ **Track P2P Documentation**

- Check if this patient requires Physician-to-Physician documentation

After Completing Clinical/Diagnosis Tab

Click "Continue" to move to the Pharmacy tab.

14.8 Tab 5: PHARMACY

The Pharmacy tab is where you select the patient's preferred pharmacy.

What You'll See:

- Dropdown showing all pharmacies from Chapter 7 (Pharmacy Setup)
- Select the pharmacy the patient uses for prescriptions

Example: "CVS Pharmacy #1234 - Main Street"

After completing the Pharmacy tab, click "Continue" to go to Contacts tab.

14.9 Tab 6: CONTACTS

The Contacts tab is where you enter emergency contacts and family members.

What You'll See:

- Fields to add emergency contact information:
 - Contact Name
 - Relationship to Patient

- Phone Number
- Address (optional)
- **Add Contact** button to add multiple contacts

Example:

- Name: "Jane Smith"
- Relationship: "Daughter"
- Phone: "(512) 555-6789"

After completing the Contacts tab, click "Continue" to go to Emergency Preparedness tab.

14.10 Tab 7: EMERGENCY PREPAREDNESS

The Emergency Preparedness tab is where you document backup plans for emergencies.

What You'll See:

- Questions about:
 - Does patient have a backup power source?
 - Does patient have emergency contacts?
 - Evacuation plan in place?
- Text area for notes

After completing Emergency Preparedness tab, click "Continue" to go to Advanced Directives tab.

14.11 Tab 8: ADVANCED DIRECTIVES

The Advanced Directives tab is where you document:

- Do Not Resuscitate (DNR) orders
- Living Will
- Healthcare Power of Attorney
- Other advance directives

What You'll See:

- Checkboxes for each type of directive
- Fields to upload documents (if available)
- Date fields for when directives were signed

After completing Advanced Directives tab, click "Continue" to go to the final tab: Referral Information.

14.12 Tab 9: REFERRAL INFORMATION

The Referral Information tab is where you document how the patient was referred to your agency.

What You'll See:

- Dropdown to select referral source
- Fields for referral date
- Notes about the referral

After completing all 9 tabs, you have two options:

1. **Save Draft** - Saves your progress without admitting the patient (goes to Pending Admissions)
2. **Continue** (or **"Save & Admit"**) - Completes the admission and creates the patient in the system

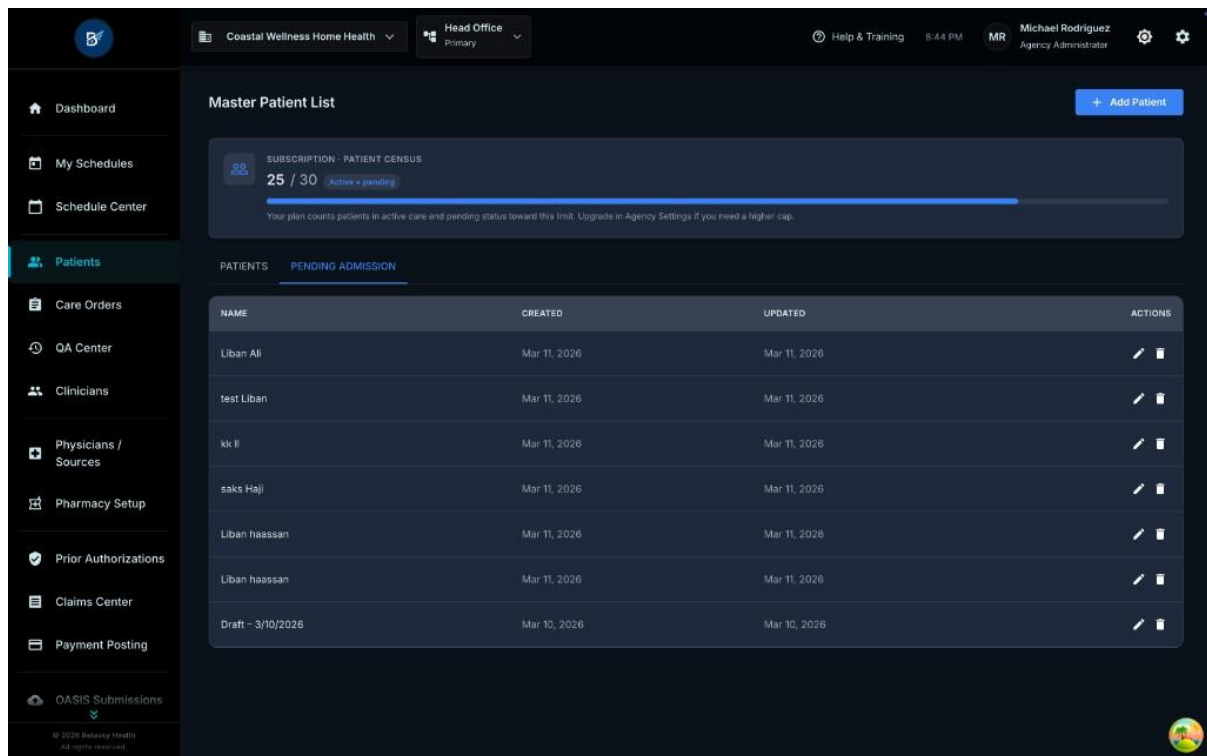
14.13 Saving as Draft (Pending Admissions)

If you're not ready to complete the admission (missing information, waiting for documents, etc.), you can save your progress as a **draft**.

How to Save as Draft

1. At any point while filling out the intake form, click **"Save Draft"** at the bottom of the modal
2. A success message appears: "Patient draft saved successfully"
3. The Add Patient modal closes
4. Your draft is saved in the **PENDING ADMISSION** tab

Viewing Pending Admissions



The screenshot shows the 'Master Patient List' interface. At the top, there's a header with 'Coastal Wellness Home Health', 'Head Office Primary', and user information 'Michael Rodriguez, Agency Administrator'. A sidebar on the left contains navigation links like 'Dashboard', 'My Schedules', 'Schedule Center', 'Patients', 'Care Orders', 'QA Center', 'Clinicians', 'Physicians / Sources', 'Pharmacy Setup', 'Prior Authorizations', 'Claims Center', 'Payment Posting', and 'OASIS Submissions'. The main content area is titled 'Master Patient List' and includes a '+ Add Patient' button. Below this, a 'SUBSCRIPTION: PATIENT CENSUS' section shows '25 / 30' with a progress bar and a note: 'Your plan counts patients in active care and pending status toward this limit. Upgrade in Agency Settings if you need a higher cap.' The 'PENDING ADMISSION' tab is selected, displaying a table of pending admissions.

NAME	CREATED	UPDATED	ACTIONS
Liban Ali	Mar 11, 2026	Mar 11, 2026	 
test Liban	Mar 11, 2026	Mar 11, 2026	 
kk II	Mar 11, 2026	Mar 11, 2026	 
saks Haji	Mar 11, 2026	Mar 11, 2026	 
Liban haassan	Mar 11, 2026	Mar 11, 2026	 
Liban haassan	Mar 11, 2026	Mar 11, 2026	 
Draft - 3/10/2026	Mar 10, 2026	Mar 10, 2026	 

1. In the **Master Patient List** page, click the **"PENDING ADMISSION"** tab (next to "PATIENTS")

2. You'll see a list of all draft patients

What You'll See:

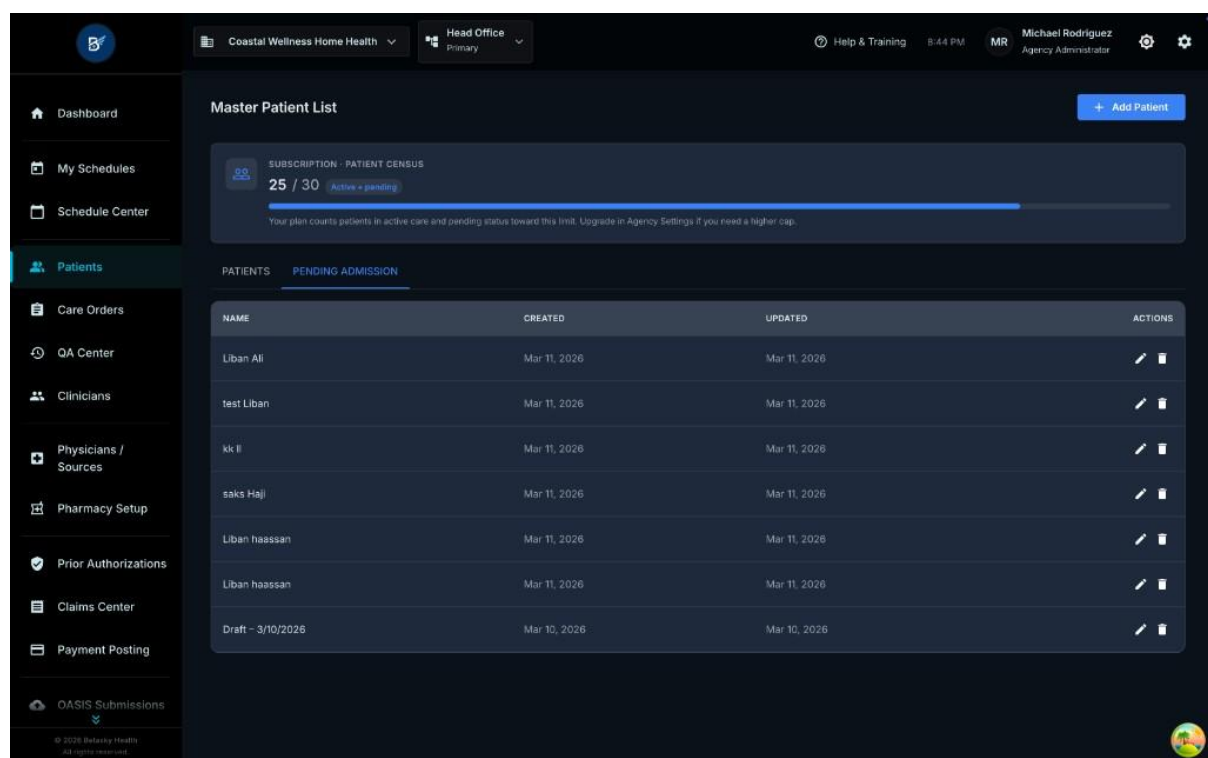
Columns:

- **NAME** (e.g., "Liban Ali", "test Liban", "Draft - 3/10/2026")
- **CREATED** (date the draft was created, e.g., "Mar 11, 2026")
- **UPDATED** (last time the draft was edited, e.g., "Mar 11, 2026")
- **ACTIONS** (two icons for each draft):
 - **Edit** icon (pencil) - continue editing the draft
 - **Delete** icon (trash can) - delete the draft

Editing a Draft Patient

1. Click the **Edit** icon (pencil) next to the draft patient
2. The **Add Patient** modal reopens with all your saved information
3. Continue filling out the tabs where you left off
4. When ready, click "**Continue**" to complete the admission

Deleting a Draft Patient



The screenshot shows the 'Master Patient List' interface. At the top, there's a header with 'Coastal Wellness Home Health', 'Head Office Primary', and user information 'Michael Rodriguez, Agency Administrator'. A sidebar on the left contains navigation links: Dashboard, My Schedules, Schedule Center, Patients (selected), Care Orders, QA Center, Clinicians, Physicians / Sources, Pharmacy Setup, Prior Authorizations, Claims Center, Payment Posting, and OASIS Submissions. The main content area is titled 'Master Patient List' and includes a '+ Add Patient' button. Below this is a 'SUBSCRIPTION - PATIENT CENSUS' section showing '25 / 30' with a progress bar and a note: 'Your plan counts patients in active care and pending status toward this limit. Upgrade in Agency Settings if you need a higher cap.' The 'PATIENTS' tab is selected, displaying a table of draft patients.

NAME	CREATED	UPDATED	ACTIONS
Liban Ali	Mar 11, 2026	Mar 11, 2026	[Edit] [Delete]
test Liban	Mar 11, 2026	Mar 11, 2026	[Edit] [Delete]
kk II	Mar 11, 2026	Mar 11, 2026	[Edit] [Delete]
saks Haji	Mar 11, 2026	Mar 11, 2026	[Edit] [Delete]
Liban haassan	Mar 11, 2026	Mar 11, 2026	[Edit] [Delete]
Liban haassan	Mar 11, 2026	Mar 11, 2026	[Edit] [Delete]
Draft - 3/10/2026	Mar 10, 2026	Mar 10, 2026	[Edit] [Delete]

1. Click the **Delete** icon (trash can) next to the draft patient
2. A confirmation dialog appears:
 - **"Delete inquiry?"**
 - **"This will permanently delete the draft 'Liban Ali'. This cannot be undone."**
3. Click **"Delete"** to confirm, or **"Cancel"** to keep the draft

Warning: Deleting a draft is permanent and cannot be undone!

14.14 Completing the Admission

After filling out all 9 tabs, you're ready to complete the admission.

Final Step: Click "Continue"

1. Review all tabs to ensure all required fields are filled
2. Click "**Continue**" (or "**Save & Admit**") at the bottom of the modal
3. The system validates all fields
4. If everything is correct:
 - A success message appears: "Patient admitted successfully"
 - The Add Patient modal closes
 - The patient is added to the **PATIENTS** tab (main patient list)
 - An episode is created (if you checked the "Create episode" checkbox)

14.15 Viewing the Patient Profile

After admission, you can view the patient's full profile.

The screenshot shows the 'Master Patient List' interface. At the top, there's a header with 'Coastal Wellness Home Health', 'Head Office Primary', and user information 'Michael Rodriguez, Agency Administrator'. A sidebar on the left contains navigation links: Dashboard, My Schedules, Schedule Center, Patients (selected), Care Orders, QA Center, Clinicians, Physicians / Sources, Pharmacy Setup, Prior Authorizations, Claims Center, Payment Posting, and OASIS Submissions. The main content area is titled 'Master Patient List' and includes a '+ Add Patient' button. Below this is a 'SUBSCRIPTION - PATIENT CENSUS' section showing '25 / 30' active patients. A table below lists patients with columns for NAME, CREATED, UPDATED, and ACTIONS. A modal dialog 'Delete inquiry?' is open, asking for confirmation to delete the draft 'Liban Ali'.

NAME	CREATED	UPDATED	ACTIONS
Liban Ali		2026	[Edit] [Delete]
test Liban		2026	[Edit] [Delete]
kk E	Mar 11, 2026	Mar 11, 2026	[Edit] [Delete]
saks Hajj	Mar 11, 2026	Mar 11, 2026	[Edit] [Delete]
Liban haassan	Mar 11, 2026	Mar 11, 2026	[Edit] [Delete]
Liban haassan	Mar 11, 2026	Mar 11, 2026	[Edit] [Delete]
Draft - 3/10/2026	Mar 10, 2026	Mar 10, 2026	[Edit] [Delete]

How to Open a Patient Profile

1. In the **Master Patient List**, find the patient
2. Click anywhere on the patient's row (or click the patient's name)
3. The **Patient Profile** page opens

What You'll See on the Patient Profile

Patient Header (Top Section):

- **Patient Initials Circle** (e.g., "QL" for Quansa L Shoma)
- **Patient Name** (large text: "Quansa L Shoma")
- **Patient Information:**
 - Patient ID/MRN: 102809
 - Age: 66
 - Gender: Male
 - Marital Status: Single
- **Risk Badges** (colored labels):
 - "Fall Risk: Low" (blue)
 - "Hospitalization Risk: Low" (blue)
 - "Infection Risk: High" (red)
- **Status Badge:** "Active" (green)
- **Edit Button** (top-right corner)

Action Buttons:

- **"View Medication Profile"** (blue button)
- **"Show More"** (link) - opens Patient Details modal

Patient Summary Cards (5 boxes):

1. **Primary Payer:** N/A
2. **Primary Physician:** chandra Gowda
3. **Case Manager:** Michael Rodriguez
4. **Start of Care:** Apr 2, 2026
5. **Referral Date:** Mar 3, 2026

Select Episode Section:

Episode Period Dropdown:

- Shows: "04/02/2026 - 05/31/2026"
- Status badge: "Active" (orange)
- Click the dropdown to view other episodes (if patient has multiple)

Episode Details Panel:

Shows current episode information:

- **Episode Period:** 04/02/2026 - 05/31/2026
- **Status:** Active (orange badge)
- **Physician:** chandra Gowda
- **Reason for Care:** New Admission
- **Case Manager:** Michael Rodriguez

Two Tabs:

1. Visits (active tab)
2. Documents

Visits Tab

Coastal Wellness Home Health | Head Office Primary | Help & Training | 6:45 PM | MR | Michael Rodriguez Agency Administrator

Patients / Quansa L Shoma

Quansa L Shoma
Patient ID/MRN: 102809
Age: 66 | Gender: Male | Marital Status: Single
Fall Risk: Low | Hospitalization Risk: Low | Infection Risk: High
Active | Edit | View Medication Profile | Show More

Primary Payer: N/A | Primary Physician: chandra Gowda | Case Manager: Michael Rodriguez | Start of Care: Apr 2, 2026 | Referral Date: Mar 3, 2026

Select Episode
Episode Period: 04/02/2026 - 05/31/2026 | Active

Episode Details
Episode Period: 04/02/2026 - 05/31/2026 | Status: Active | Case Manager: Michael Rodriguez
Physician: chandra Gowda | Reason for Care: New Admission

Visits | Documents

Status | Start Date: dd/mm/yyyy | End Date: dd/mm/yyyy

The Visits tab shows all scheduled and completed visits for this patient.

Filters:

- **Status** dropdown
- **Start Date** (date picker)
- **End Date** (date picker)

Visit Table:

Columns:

- **SCHEDULED DATE** (e.g., "Apr 6, 2026 1:00 PM")
- **VISIT TYPE** (e.g., "HHA Visit", "HHA Supervisory Visit", "SN Visit", "Oasis E2 Start of care")
- **CLINICIAN** (assigned nurse/therapist)
- **STATUS** (green "Completed" badges)
- **CHECK-IN** (date/time clinician checked in, e.g., "Apr 6, 2026 2:45 AM")
- **CHECK-OUT** (date/time clinician checked out, e.g., "Apr 6, 2026 2:47 AM")
- **BILLABLE** ("No" for some visits)
- **ACTIONS** (eye icon to view visit details)

Example Visits Shown:

- Apr 6, 2026 1:00 PM - HHA Visit - Michael Rodriguez - Completed
- Apr 6, 2026 11:00 AM - HHA Supervisory Visit - Michael Rodriguez - Completed
- Apr 6, 2026 10:00 AM - SN Visit - Michael Rodriguez - Completed
- Apr 6, 2026 8:00 AM - HHA Visit - Michael Rodriguez - Completed
- Apr 2, 2026 3:00 AM - Oasis E2 Start of care - Michael Rodriguez - Completed

Show More: Patient Details Modal

Episode Details

Episode Period: 04/02/2026 - 05/31/2026
 Status: Active
 Case Manager: Michael Rodriguez
 Physician: chandra Gowda
 Reason for Care: New Admission

Visits

SCHEDULED DATE	VISIT TYPE	CLINICIAN	STATUS	CHECK-IN	CHECK-OUT	BILLABLE	ACTIONS
Apr 6, 2026 1:00 PM	HHA Visit	Michael Rodriguez	Completed	Apr 6, 2026 2:45 AM	Apr 6, 2026 2:47 AM	No	👁
Apr 6, 2026 11:00 AM	HHA Supervisory Visit	Michael Rodriguez	Completed	Apr 6, 2026 12:40 AM	Apr 6, 2026 12:41 AM	No	👁
Apr 6, 2026 10:00 AM	SN Visit	Michael Rodriguez	Completed	Apr 6, 2026 12:38 AM	Apr 6, 2026 12:39 AM	No	👁
Apr 6, 2026 8:00 AM	HHA Visit	Michael Rodriguez	Completed	Apr 6, 2026 12:36 AM	Apr 6, 2026 12:38 AM	No	👁
Apr 2, 2026 3:00 AM	Oasis E2 Start of care	Michael Rodriguez	Completed	Apr 4, 2026 11:59 PM	Apr 5, 2026 12:15 AM	No	👁

When you click "**Show More**" on the patient profile, a modal opens showing additional patient details.

Patient Details Modal Tabs:

1. Overview (active)
2. Personal Info
3. Clinical Details
4. Coverage
5. Preparedness & Notes
6. Activity

Overview Tab Shows:

"No overview information has been recorded for this patient."

Admission Source:

- (2) Clinic or Physician's Office

Referral Source:

- N/A

Visit Code:

- Elective

Date of Face-to-Face Visit:

- Mar 3, 2026

Selected Face-to-Face Info:

- Date of Face-to-Face Visit

Emergency Triage:

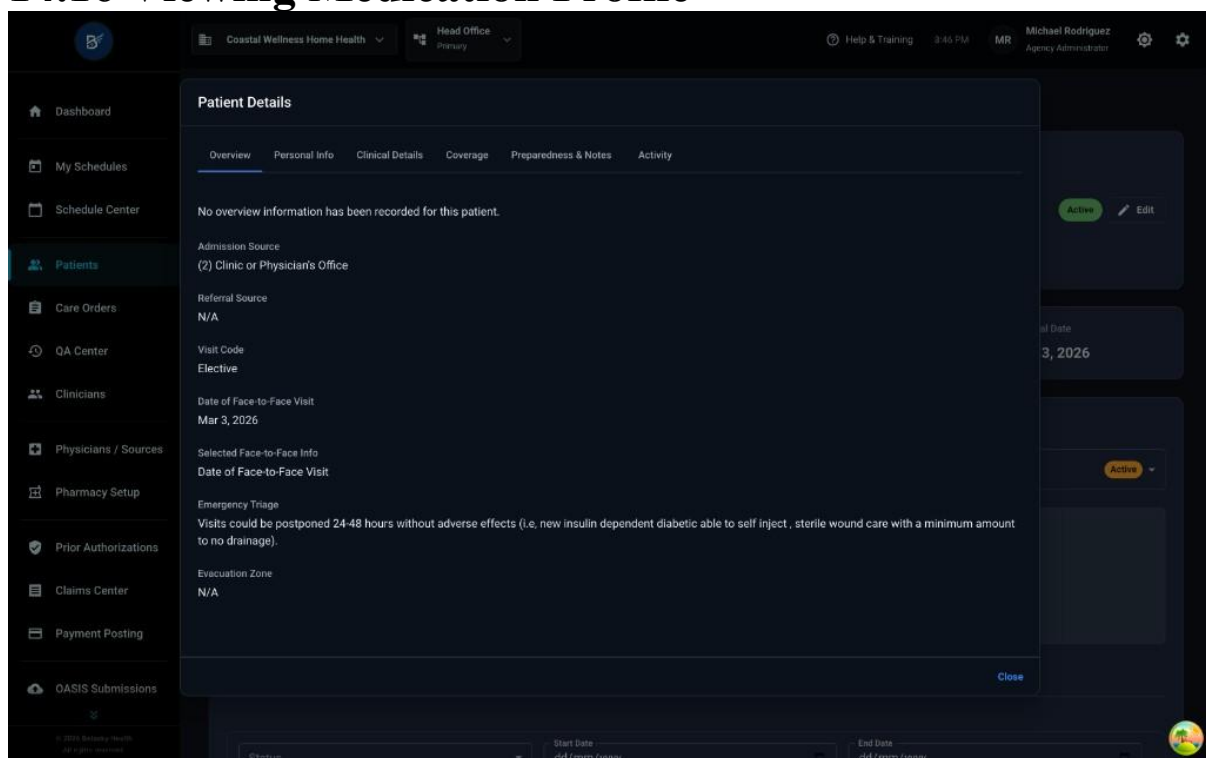
- "Visits could be postponed 24-48 hours without adverse effects (i.e. new insulin dependent diabetic able to self inject, sterile wound care with a minimum amount to no drainage)."

Evacuation Zone:

- N/A

Close Button (bottom-right)

14.16 Viewing Medication Profile



One of the most important parts of patient care is managing medications. Let's see how to view and add medications.

How to Open Medication Profile

1. From the **Patient Profile** page, click the blue button: "**View Medication Profile**"
2. The **Medication Profile** modal opens

What You'll See

Modal Title: "Medication Profile | Quansa Shoma"

Top Section:

- **Pharmacy Name:** CVS Pharmacy #1234
- **Pharmacy Phone:** (212) 555-1234

Action Buttons:

- **Add Medication** (blue button)
- **Import from text** (gray button)
- **Medication Reconciliation** (gray button)
- **Sign Medication Profile** (gray button)
- **Print Medication Profile** (gray button)
- **Drug Interactions** (gray button)
- **Medication History** (gray button)
- **Signed Medication Profiles** (blue button)

Active Medication(s) Table

Shows all current medications for this patient.

Columns:

- Checkbox (to select medication)
- **START DATE**
- **MEDICATION / DOSAGE / FREQ / ROUTE**
- **STATUS** (e.g., "ACTIVE")
- **CLASSIFICATION** (e.g., "Anesthetics for topical use", "Biguanides")
- **PHYSICIAN NAME**
- **D/C THROUGH DATE**
- **ACTION** (Edit and Delete buttons)

Example Medications Shown:

1. **04/02/2026**

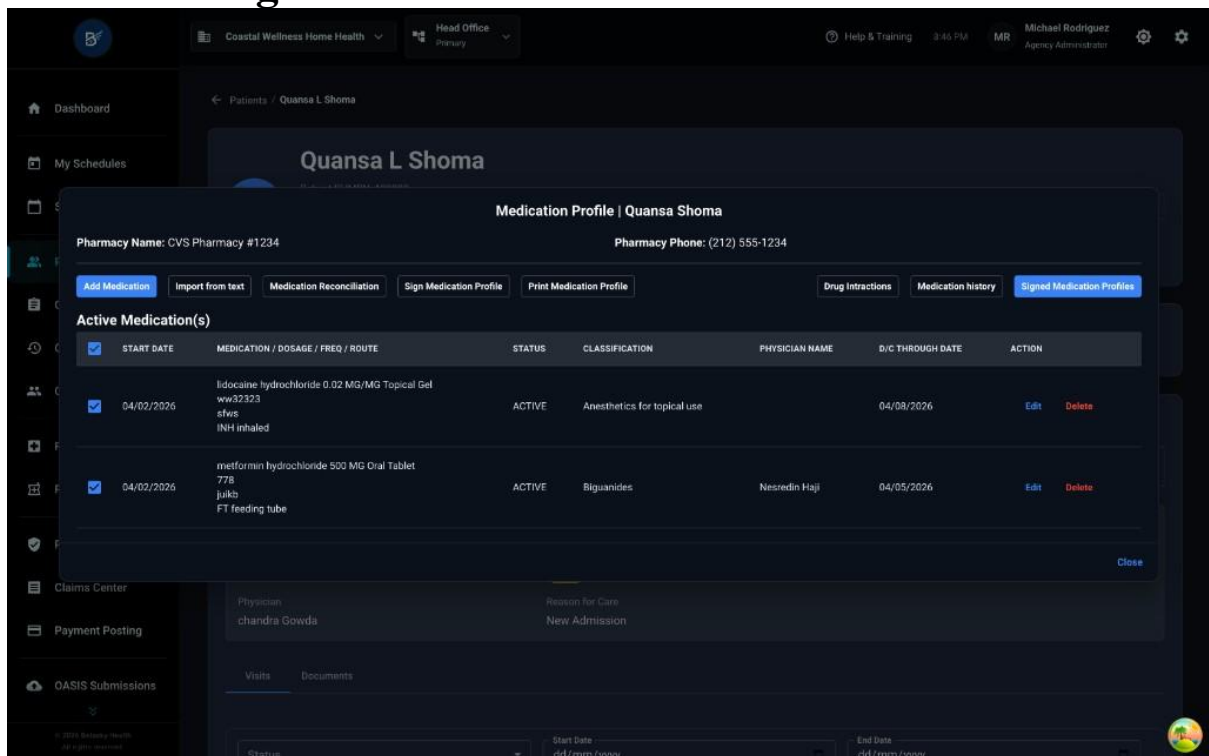
- lidocaine hydrochloride 0.02 MG/MG Topical Gel
- **xw32323**
- efvns
- **INH inhaled**
- **Status:** ACTIVE
- **Classification:** Anesthetics for topical use
- **D/C Through Date:** 04/08/2026
- **Actions:** Edit | Delete

2. **04/02/2026**

- metformin hydrochloride 500 MG Oral Tablet

- **778**
- julkb
- **FT feeding tube**
- **Status:** ACTIVE
- **Classification:** Biguanides
- **Physician:** Nessndin Haji
- **D/C Through Date:** 04/05/2026
- **Actions:** Edit | Delete

14.17 Adding a New Medication



Let's add a new medication to the patient's profile.

Click "Add Medication"

1. In the **Medication Profile** modal, click the blue **"Add Medication"** button
2. The **New Medication** modal opens

What You'll See

Checkbox:

☐ **Long-Standing**

- Check this if the patient has been on this medication long-term (not a new prescription)

Start Date (required)

- Date picker
- Enter when the patient started taking this medication

DC Through Date (optional)

- Date picker
- Enter the discontinuation date if known
- Note: "Medications with a DC Through Date before today will be listed as Discontinued."

Medication and Dosage (required)

- Search field: "Type then click Search or press Enter"
- This is where you search for the medication by name

Searching for a Medication

The screenshot shows a 'New Medication' form in a medical software interface. The form is titled 'New Medication' and includes the following fields and options:

- ☐ Long-Standing
- Start Date * (calendar icon)
- DC Through Date (calendar icon)
- Medications with a DC Through Date before today will be listed as Discontinued.
- Medication and Dosage * (search icon)
- Type then click Search or press Enter
- Amount
- Classification *
- Physician / Referral Source (dropdown)
- Frequency *
- Route * (dropdown)
- Type (dropdown, currently set to 'New')
- ☐ Click here to create an order once the profile is signed
- ☒ Click here if new medications were found in the home and an order is not required
- Buttons: Cancel, Save & Add Another, Save & Exit

The background shows a sidebar with navigation options: Dashboard, My Schedules, Pharmacy Name: CVS Pharmacy #1234, Active Medication(s), Claims Center, Payment Posting, OASIS Submissions, and a list of active medications with columns for Start Date, Medication / Dosage, and Action.

1. In the "**Medication and Dosage**" field, type the medication name (e.g., "lanthanum")
2. Click the **Search** icon or press **Enter**
3. A dropdown list appears with matching medications

Example Search Results:

- erythromycin lactobionate 500 MG Injection
- erythromycin lactobionate 500 MG Injection
- lanthanum carbonate 1000 MG Oral Powder
- lanthanum carbonate 750 MG Oral Powder
- lanthanum carbonate 750 MG Chewable Tablet
- lanthanum carbonate 1000 MG Chewable Tablet
- lanthanum carbonate 500 MG Chewable Tablet
- lanthanum carbonate 250 MG Chewable Tablet
- lanthanum carbonate 500 MG Chewable Tablet

4. Click on the medication you want (e.g., "lanthanum carbonate 750 MG Oral Powder")
5. The medication is selected

Completing the Medication Form

Amount (optional)

- Enter the amount if different from the standard dose

Classification (required)

- Dropdown automatically populated based on the medication selected
- Example: "Biguanides", "Anesthetics for topical use"

Physician / Referral Source (optional)

- Dropdown showing all physicians
- Select the physician who prescribed this medication

Frequency (required)

- Text field
- Enter how often the patient takes this medication
- Examples: "Twice daily", "Once daily at bedtime", "As needed"

Route (required)

- Dropdown showing medication routes:
 - PO (by mouth)
 - IV (intravenous)
 - IM (intramuscular)
 - Topical
 - Inhaled
 - FT (feeding tube)
 - etc.
- Select how the medication is administered

Type dropdown:

- Options: "New", "Continued", etc.
- Select "New" for a new prescription

Checkboxes:

☐ **Click here to create an order once the profile is signed**

- Check this if you want to generate a physician order for this medication

☒ **Click here if new medications were found in the home and an order is not required**

- Check this if the patient already has the medication at home

Action Buttons:

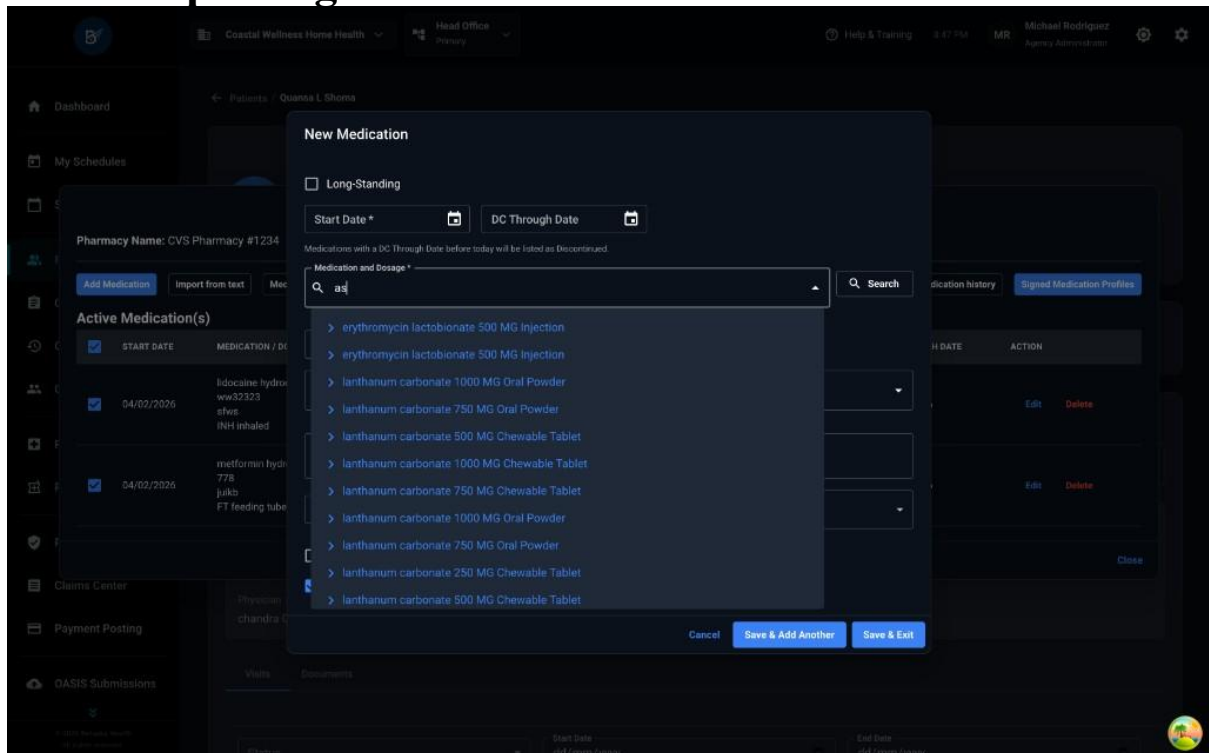
- **Cancel** - Close without saving
- **Save & Add Another** - Save this medication and add another one

- **Save & Exit** - Save this medication and close the modal

Saving the Medication

1. Fill out all required fields
2. Click **"Save & Exit"** (or **"Save & Add Another"** if you have more medications to add)
3. The medication is added to the patient's Active Medication(s) list
4. A success message appears: "Medication added successfully"

14.18 Importing Medications from Text



If you have a medication list from a hospital discharge summary or referral document, you can import medications from text instead of adding them one by one.

Click "Import from text"

1. In the **Medication Profile** modal, click the gray **"Import from text"** button
2. The **Import medications from text** modal opens

What You'll See

Instructions:

"Paste discharge, list, referral, or medication list (one per line). Click Parse to extract medications, then choose source and import."

Example Format Shown:

(e.g. Metformin 500 mg tablet twice daily)

Lisinopril 10 mg once daily

Text Area:

- Large text box where you paste the medication list
- Each medication should be on its own line

Buttons:

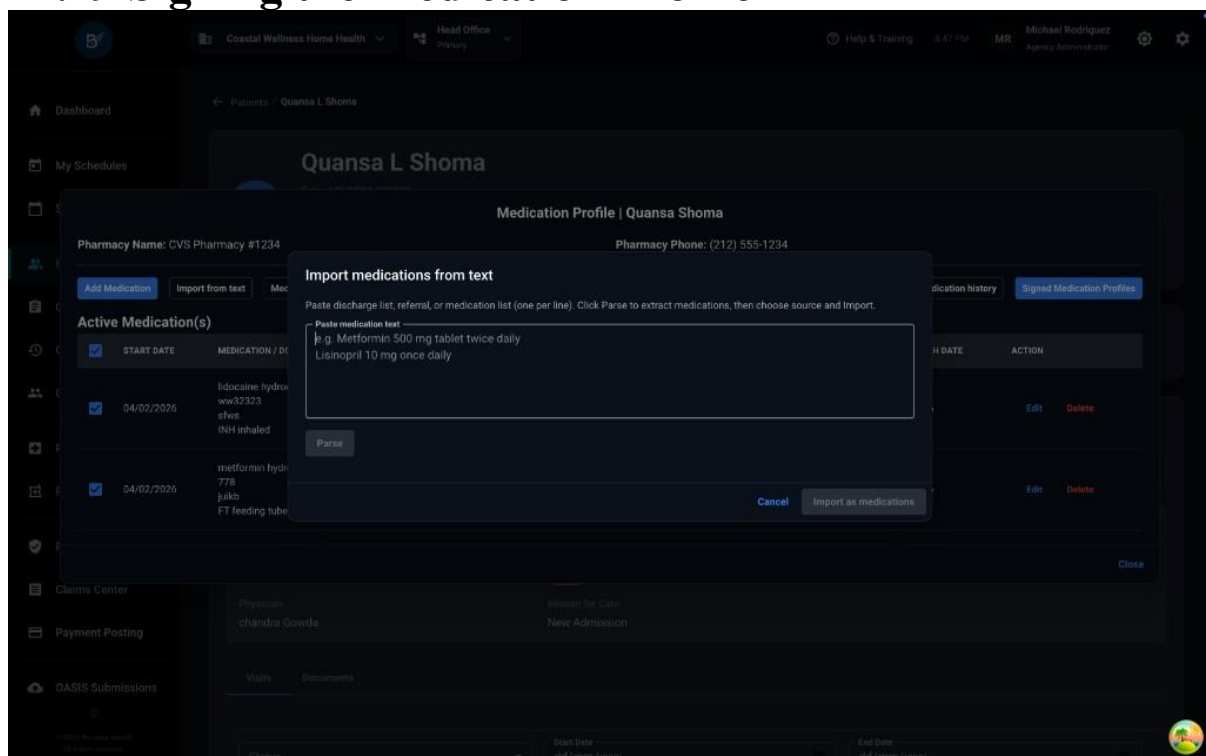
- **Parse** - Click after pasting to extract medications
- **Cancel** - Close without importing
- **Import as medications** - Save the medications to the patient's profile

How to Import Medications

1. Copy the medication list from the discharge summary or referral document
2. Paste it into the text area
3. Click **"Parse"**
4. The system extracts the medication names, dosages, and frequencies
5. Review the parsed medications
6. Click **"Import as medications"**
7. The medications are added to the patient's Active Medication(s) list

This is much faster than adding medications one by one!

14.19 Signing the Medication Profile



After adding all medications, the nurse must sign the medication profile to certify it's accurate.

Click **"Signed Medication Profiles"**

1. In the **Medication Profile** modal, click the blue **"Signed Medication Profiles"** button

2. The **Signed Medication Profiles** modal opens

What You'll See

Table showing all signed medication profiles:

Columns:

- **SIGNATURE DATE** (e.g., "04/05/2025 12:00 AM")
- **SIGNED BY** (e.g., "Michael Rodriguez")
- **MEDICATIONS REVIEWED** (number of medications, e.g., "1")
- **ACTIONS** (Print button)

Example:

- Signature Date: 04/05/2025 12:00 AM
- Signed By: Michael Rodriguez
- Medications Reviewed: 1
- Actions: **Print** (blue link)

How to Sign a Medication Profile

1. Review all medications in the Active Medication(s) list
2. Ensure all medications are accurate and complete
3. Click "**Sign Medication Profile**" (in the main Medication Profile modal)
4. A signature modal opens
5. Enter your name or electronic signature
6. Click "**Sign**"
7. The medication profile is signed and timestamped
8. The signed profile appears in the **Signed Medication Profiles** list

Chapter 15: Care Orders (Plan of Care)

Overview

Care Orders is where you manage each patient's Plan of Care (POC). The Plan of Care tells the physician, clinicians, and Medicare what services the patient will receive during their episode of care.

What You'll Learn:

- How to view all care orders
- Understanding care order status (Active, Pending Assessment, Pending Physician Signature)
- How to view an individual patient's care order
- What the "Authorized Visits" table shows
- How to use the Actions menu (Create Orders, Recertification, Discharge, Transfer, Death)
- How to view visit schedules and documents

Who Should Read This Chapter:

- Agency Administrators
- Clinical Managers
- Case Managers (RN Case Managers)
- Intake Coordinators

Prerequisites:

- Patient has been admitted (Chapter 14)
- Understanding of Medicare home health episodes (60-day periods)

15.1 Accessing Care Orders

Where to Find Care Orders

1. Look at the **left sidebar**
2. Click on "**Care Orders**"
3. The **Care Orders** page opens

15.2 The Care Orders List Page

Care Orders
Manage and track all patient care orders.

Total Active Orders: 7

Pending Assessment: 14

Pending Physician Signature: 2

Nearing Expiration: 0

Search by patient name... Active Filter by Case Manager

PATIENT NAME	CARE ORDER PERIOD	CASE MANAGER (RN)	PHYSICIAN	BRANCH	STATUS	DAYS REMAINING	ACTIONS
Jordan A West	04/02/2026 - 05/31/2026	Michael Rodriguez	Dr. chandra Gowda	Head Office	Active	51	...
Quansa L Shoma	04/02/2026 - 05/31/2026	Michael Rodriguez	Dr. chandra Gowda	Head Office	Active	51	...
Abdi A abdullah	04/01/2026 - 05/30/2026	Michael Rodriguez	Dr. chandra Gowda	Head Office	Active	50	...
Abe b bela	01/20/2026 - 03/20/2026	Abebe Goben	Dr. Nesredin Haji	Head Office	Active	0	...
Test A Start	01/18/2026 - 03/18/2026	RN Test Clinician	Dr. Nesredin Haji	North Austin Branch	Active	0	...
Sema berta Muta	01/14/2026 - 03/14/2026	Michael Rodriguez	Dr. Barn Haji	Head Office	Active	0	...
Realtest A forpdf	01/04/2026 - 03/04/2026	Abebe Goben	Dr. Nesredin Haji	North Austin Branch	Active	0	...

Rows per page: 15 1-7 of 7

When you open Care Orders, you see this main page.

Page Header:

- **Title:** "Care Orders"
- **Subtitle:** "Manage and track all patient care orders."

Dashboard Cards (4 Boxes at the Top)

These four boxes show quick statistics about your care orders:

1. Total Active Orders: 7

- Shows how many care orders are currently active (patients in active care)

2. Pending Assessment: 14

- Shows how many care orders are waiting for an assessment to be completed
- This means the OASIS Start of Care or Recertification hasn't been done yet

3. Pending Physician Signature: 2

- Shows how many care orders are waiting for the physician to sign
- The Plan of Care has been created but the doctor hasn't signed it yet

4. Nearing Expiration: 0

- Shows how many care orders are about to expire (episode ending soon)
- When this number is greater than 0, those patients need recertification

Search and Filters

Below the dashboard cards, you'll see:

Search Box:

- "Search by patient name..."
- Type a patient's name to find their care order quickly

Filter Dropdowns:

1. Status Filter (left dropdown)

- Shows: "Active" (in the screenshot)
- Click to filter by different statuses:
 - Active
 - Pending Assessment
 - Pending Physician Signature
 - Cancelled
 - etc.

2. Case Manager Filter (right dropdown)

- "Filter by Case Manager"
- Click to filter by which case manager is assigned to the care order

Care Orders Table

The table shows all care orders with these columns:

Column	What It Shows
PATIENT NAME	Patient's name (in blue - clickable)
CARE ORDER PERIOD	Episode dates (e.g., "04/02/2026 - 05/31/2026")
CASE MANAGER (RN)	The RN case manager assigned to this patient
PHYSICIAN	The ordering physician
BRANCH	Which branch this patient belongs to
STATUS	Green "Active" badge or other status
DAYS REMAINING	How many days left in the current episode
ACTIONS	Three-dot menu (•••)

Example Rows Shown:

- Jordan A West - 04/02/2026 - 05/31/2026 - Michael Rodriguez - Dr. chandra Gowda - Head Office - Active - 51 days
- Quansa L Shoma - 04/02/2026 - 05/31/2026 - Michael Rodriguez - Dr. chandra Gowda - Head Office - Active - 51 days

How to Open a Care Order

Click on the patient's name (the blue text) to open that patient's care order detail page.

15.3 Filtering Care Orders by Status

PATIENT NAME	CARE ORDER PERIOD	CASE MANAGER (RN)	PHYSICIAN	BRANCH	STATUS	DAYS REMAINING	ACTIONS
Abdi A Dirir	04/09/2026 - 06/07/2026	Michael Rodriguez	Dr. chandra Gowda	Head Office	Pending Assessment	58	...
abi A abayo	04/09/2026 - 06/01/2026	RN Test Clinician	Dr. chandra Gowda	Head Office	Pending Assessment	52	...
Quansa L Shoma	04/02/2026 - 05/31/2026	Michael Rodriguez	Dr. chandra Gowda	Head Office	Active	51	...
Selma A Mas	04/02/2026 - 05/31/2026	Michael Rodriguez	Dr. chandra Gowda	Head Office	Pending Assessment	51	...
Jordan A West	04/02/2026 - 05/31/2026	Michael Rodriguez	Dr. chandra Gowda	Head Office	Active	51	...
Houyo A Houyo	04/02/2026 - 05/31/2026	Michael Rodriguez	Dr. chandra Gowda	Head Office	Pending Physician Signature	51	...
Abdi A abdullahi	04/01/2026 - 05/30/2026	Michael Rodriguez	Dr. chandra Gowda	Head Office	Active	50	...
test A Due	03/27/2026 - 05/25/2026	RN Test Clinician	Dr. chandra Gowda	North Austin Branch	Pending Assessment	45	...
ahmed ahmed	03/13/2026 - 05/11/2026	Michael Rodriguez	Dr. chandra Gowda	Head Office	Pending Assessment	31	...
test A Liban	03/11/2026 - 05/09/2026	Michael Rodriguez	Dr. chandra Gowda	Head Office	Pending Assessment	29	...
Nesredin hbi hj Haji	03/10/2026 - 05/08/2026	Hace ko	Dr. Nesredin Haji	West Coast Division	Pending Assessment	28	...
Amina Ali	03/09/2026 - 05/07/2026	Abebe Goben	Dr. Nesredin Haji	North Austin Branch	Cancelled	27	...

You can filter care orders by status to see specific groups of patients.

In this screenshot, the status filter is changed, and now the table shows different status badges:

Status Badges You'll See:

1. "Pending Assessment" (orange badge)

- Means: The care order exists, but the initial OASIS assessment hasn't been completed yet
- Example patients: Abd A Dirir, abi A abayo, Selma A Mas, etc.

2. "Active" (green badge)

- Means: The care order is active and patient is receiving services
- Example patients: Quansa L Shoma, Abd A abdullahi

3. "Pending Physician Signature" (yellow/orange badge)

- Means: The Plan of Care has been created but waiting for doctor's signature
- Example patient: Houyo A Houyo

4. "Cancelled" (red badge)

- Means: The care order was cancelled (patient didn't start or was declined)
- Example patient: Amina Ali

Days Remaining Column:

- Some show numbers (51, 50, 62, 45, 31, 29, 27)
- Some show "0" in red - This means the episode has expired or ended

15.4 Viewing an Individual Care Order

Click on a patient's name to open their care order detail page.

The screenshot shows a web application interface for viewing a care order. The top navigation bar includes a logo, a dropdown menu for 'Coastal Wellness Home Health', a dropdown for 'Head Office Primary', and user information for 'Michael Rodriguez, Agency Administrator'. The left sidebar contains a list of navigation items: Dashboard, My Schedules, Schedule Center, Patients, Care Orders (highlighted), QA Center, Clinicians, Physicians / Sources, Pharmacy Setup, Prior Authorizations, Claims Center, Payment Posting, and OASIS Submissions. The main content area displays the care order for 'Quansa L Shoma'. It includes a breadcrumb navigation path 'Care Orders / Quansa L Shoma', an 'Active' status badge, and an 'Actions' dropdown button. Below this, the patient's episode dates (04/02/2026 - 05/31/2026), case manager (Michael Rodriguez), physician (Dr. chandra Gowda), and diagnosis (Hypertension (I10)) are listed. A tabbed interface shows 'Overview' as the selected tab, with other tabs for Schedules, Visits, Documents, and History Log. The 'Authorized Visits' section contains a table with columns for Discipline, Authorized, Scheduled, In Progress, Completed, Cancelled, Exceeds Limit, and Missing Auth. The table lists two disciplines: Skilled Nursing (00) and Home Health Aide (00).

DISCIPLINE	AUTHORIZED	SCHEDULED	IN PROGRESS	COMPLETED	CANCELLED	EXCEEDS LIMIT	MISSING AUTH
Skilled Nursing 00	1	0	0	0	0	0	0
Home Health Aide 00	2	0	0	0	0	0	0

Care Order Header (Top Section)

Back Button:

- "← Care Orders / Quansa L Shoma" (breadcrumb navigation)
- Click the back arrow to return to the Care Orders list

Patient Name: "Quansa L Shoma" (large text)

Episode Information:

- **Episode:** 04/02/2026 - 05/31/2026
- **Case Manager:** Michael Rodriguez
- **Physician:** Dr. chandra Gowda
- **Diagnosis:** Hypertension (I10)

Status Badge (Top Right):

- Green "Active" badge
- This shows the care order is currently active

Action Buttons (Top Right):

- **Comment icon** (message bubble) - for notes or comments
- **Blue "Actions" dropdown button** - opens the Actions menu (we'll cover this in detail later)

Five Tabs

Below the header, you'll see **5 tabs**:

1. **Overview** (currently active - blue underline)
2. **Schedules**
3. **Visits**
4. **Documents**
5. **History Log**

Overview Tab: Authorized Visits Table

The Overview tab shows the "**Authorized Visits**" section.

This table shows which disciplines (types of clinicians) are authorized to visit this patient and how many visits have been scheduled, completed, etc.

Table Columns:

Column	What It Means
DISCIPLINE	Type of clinician (Skilled Nursing, Home Health Aide, etc.)
AUTHORIZED	How many visits are authorized in the care order
SCHEDULED	How many visits have been scheduled
IN PROGRESS	How many visits are currently happening (clinician checked in)
COMPLETED	How many visits have been finished
CANCELLED	How many visits were cancelled
EXCEED LIMIT	How many visits exceed the authorized amount (if any)
MISSING AUTH	How many visits are missing authorization (if any)

Example Rows:

1. Skilled Nursing 00

- AUTHORIZED: 1
- SCHEDULED: 0
- IN PROGRESS: 0
- COMPLETED: 0
- CANCELLED: 0
- EXCEED LIMIT: 0
- MISSING AUTH: 0

2. Home Health Aide 00

- AUTHORIZED: 2
- SCHEDULED: 0
- IN PROGRESS: 0
- COMPLETED: 0

- CANCELLED: 0
- EXCEED LIMIT: 0
- MISSING AUTH: 0

What This Tells You:

- The care order authorizes 1 Skilled Nursing visit and 2 Home Health Aide visits
- None of these visits have been scheduled yet (all zeros in SCHEDULED column)
- No visits have been completed yet

15.5 The Actions Menu (Very Important!)

The screenshot shows a patient care interface with a dark blue background. At the top, there are three buttons: 'Active' (green), a chat icon (grey), and 'Actions' (blue) with a dropdown arrow. The 'Actions' menu is open, displaying a list of actions with corresponding icons:

- ⊕ Create Add-On Order
- 📄 Create Physician Order
- 🔄 Initiate Recertification
- 👉 Discharge Patient
- ↔ Initiate Transfer
- ↔ Initiate Transfer Discharge
- ⊖ Initiate Patient Death
- 📞 Log Communication

In the background, a patient record is visible. The 'Diagnosis' field shows 'Hypertens'. Below this, there are two columns: 'CANCELLED' and 'EXCEED'. Each column has two rows of data, all showing '0'.

Click the blue **"Actions"** button (top-right) to see all the actions you can take for this care order.

The Actions Dropdown Shows These Options:

1. **Create Add-On Order** (+ icon)
2. **Create Physician Order** (document icon, green)
3. **Initiate Recertification** (refresh icon, green)
4. **Discharge Patient** (arrow icon, gray)
5. **Initiate Transfer** (transfer icon, orange)
6. **Initiate Transfer Discharge** (transfer icon, orange)
7. **Initiate Patient Death** (minus icon, red)
8. **Log Communication** (phone icon, gray)

Let's go through each one and see what happens when you click them.

Action 1: Create Add-On Order

What It Does: Allows you to add additional services to the existing care order (e.g., add Physical Therapy visits if the patient needs PT in addition to Nursing)

When to Use: When the patient's condition changes and they need additional disciplines or more visits

Note: The screenshot doesn't show what happens after clicking this, but typically a modal would open to add the new discipline and number of visits.

Action 2: Create Physician Order

The screenshot shows a web application interface for a healthcare system. A modal titled "Create Physician Order" is open, overlaying a page for a patient named Quansa L. Shoma. The modal contains the following fields:

- Summary/Comments ***: A text area with a placeholder "Enter the order summary or any comments".
- Clinician Signature Date ***: A date picker with a calendar icon and a placeholder "Select the date when the clinician signed".
- Effective Date ***: A date picker with a calendar icon and a placeholder "Select the date when the order becomes effective".
- Signature Password ***: A password field with a placeholder "Enter your password to verify your signature".
- Enter your password to verify your identity**: A second password field.

At the bottom of the modal are "Cancel" and "Create Order" buttons. The background page shows a sidebar with navigation options like Dashboard, My Schedules, Schedule Center, Patients, Care Orders (selected), QA Center, Clinicians, Physicians / Sources, Pharmacy Setup, Prior Authorizations, Claims Center, Payment Posting, and OASIS Submissions. The top right of the page shows user information for Michael Rodriguez, Agency Administrator.

What It Does: Creates a physician order that needs to be signed by the doctor

When to Use: When you need a new order from the physician (e.g., changing medications, adding a new service, updating care instructions)

What You'll See When You Click It:

A modal opens with the title "**Create Physician Order**"

Fields in the Modal:

1. **Summary/Comments** (required - has asterisk *)
 - Large text box
 - Instructions: "Enter the order summary or any comments"
 - This is where you type what the physician order is about
2. **Clinician Signature Date** (required *)
 - Date picker with calendar icon
 - Instructions: "Select the date when the clinician signed"
 - This is the date the nurse or case manager signs off on creating the order
3. **Effective Date** (required *)
 - Date picker with calendar icon
 - Instructions: "Select the date when the order becomes effective"
 - This is when the order should take effect
4. **Signature Password** (required *)
 - Password field (locked icon)
 - Instructions: "Enter your password to verify your signature"
 - You must enter your password to confirm you're creating this order

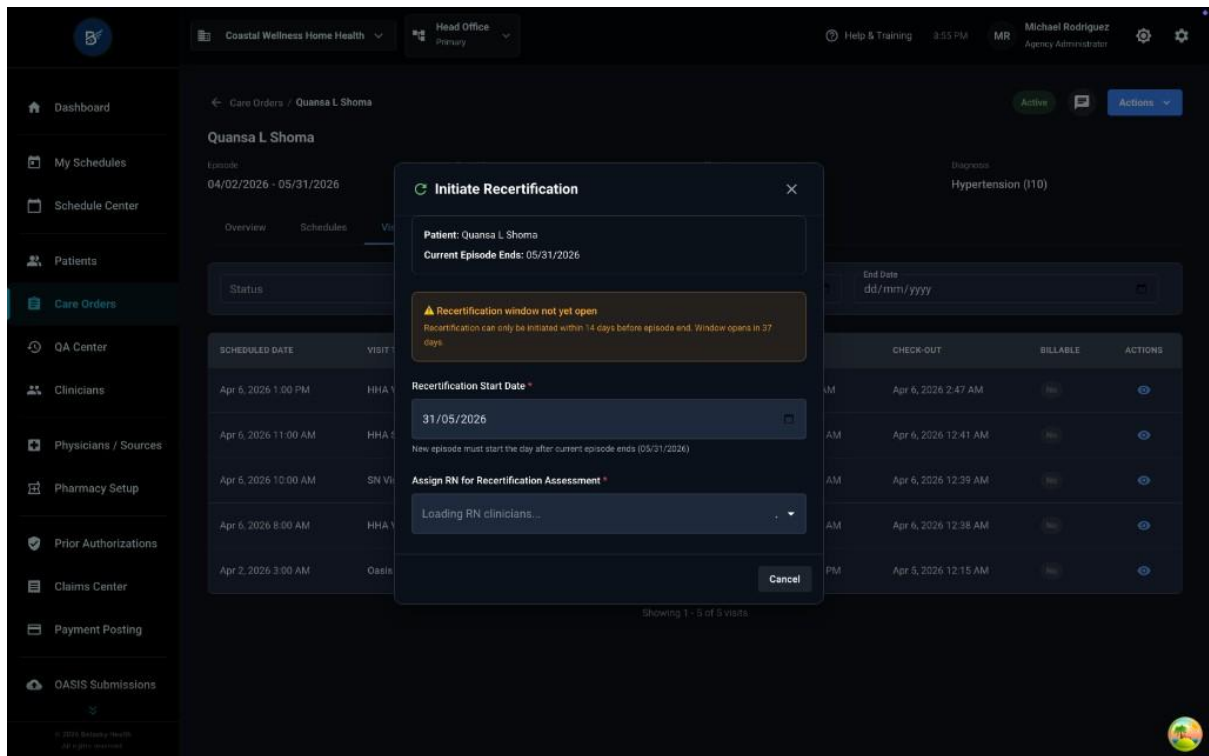
Buttons:

- **Cancel** (gray button) - closes the modal without saving
- **Create Order** (green button) - saves and creates the physician order

What Happens After You Click "Create Order":

- The physician order is created and saved
- The order appears in the Documents tab with status "Pending Review" or "Pending Physician Signature"
- The order needs to be sent to the physician for signature (via fax, electronic signature, etc.)

Action 3: Initiate Recertification



What It Does: Starts the recertification process when a patient's 60-day episode is ending and they need to continue care

When to Use: Around day 55-60 of the episode, when the patient still needs home health services and you want to continue for another 60 days

What You'll See When You Click It:

A modal opens with the title "**Initiate Recertification**"

Information Shown:

- **Patient:** Quansa L Shoma
- **Current Episode Ends:** 05/31/2026

Warning Message (Yellow Box):

" Recertification window not yet open"

"Recertification can only be initiated within 14 days before episode end. Window opens in 37 days"

What This Means:

- You can only start recertification within the last 14 days of the episode
- In this example, the episode ends 05/31/2026, but it's still early (only April 10, 2026)
- The system won't let you start recertification until 14 days before 05/31 (around May 17, 2026)

Fields in the Modal:

1. **Recertification Start Date** (required *)

- Shows: "31/05/2026"
- Note: "New episode must start the day after current episode ends (05/31/2026)"
- The new episode automatically starts the day after the current one ends

2. Assign RN for Recertification Assessment (required *)

- Dropdown showing "Loading RN clinicians..."
- You must select which RN will complete the Recertification OASIS assessment

Button:

- **Cancel** (gray button) - closes the modal without starting recertification

What Happens When the Window Opens (After Day 46):

- The warning goes away
- You can select an RN from the dropdown
- A "Start Recertification" button appears
- Clicking it creates a new 60-day episode and schedules the Recertification OASIS visit

Action 4: Discharge Patient

The screenshot shows a software interface for home health care management. A modal titled "Initiate Patient Discharge" is open, displaying the following fields and options:

- Patient:** Quansa L Shoma
- Discharge Date:** A date picker showing "dd/mm/yyyy". Below it, a note says "Select the official date of discharge."
- Reason for Discharge:** A dropdown menu with "Select a reason" as the current selection.
- Internal Notes for Discharge:** A text area with the placeholder "Add any relevant internal notes..."
- Buttons:** "Cancel" and "Confirm & Initiate Discharge".

The background interface shows a sidebar with navigation options like Dashboard, My Schedules, Schedule Center, Patients, Care Orders, QA Center, Clinicians, Physicians / Sources, Pharmacy Setup, Prior Authorizations, Claims Center, Payment Posting, and OASIS Submissions. The main content area displays patient information for Quansa L Shoma, including an episode date range (04/02/2026 - 05/31/2026) and a table of scheduled visits.

What It Does: Discharges the patient from home health care (patient no longer needs services)

When to Use:

- Patient has met all goals and no longer needs home health
- Patient moved to a facility (hospital, nursing home, assisted living)
- Patient requested to stop services
- Patient is non-compliant with care

What You'll See When You Click It:

A modal opens with the title "Initiate Patient Discharge"

Fields in the Modal:

1. Patient (read-only)

- Shows: "Quansa L Shoma"
- This confirms which patient you're discharging

2. Discharge Date (required *)

- Date picker with calendar icon
- Instructions: "Select the official date of discharge"
- This is the last day the patient was in care

3. Reason for Discharge (required *)

- Dropdown: "Select a reason"
- Common reasons include:
 - Goals met
 - Transferred to hospital
 - Transferred to SNF (nursing home)
 - Patient refused services
 - Non-compliant
 - Deceased (note: use "Initiate Patient Death" action instead)

4. Internal Notes for Discharge (optional)

- Large text box
- Instructions: "Add any relevant internal notes..."
- Use this for internal notes that won't appear on the discharge paperwork

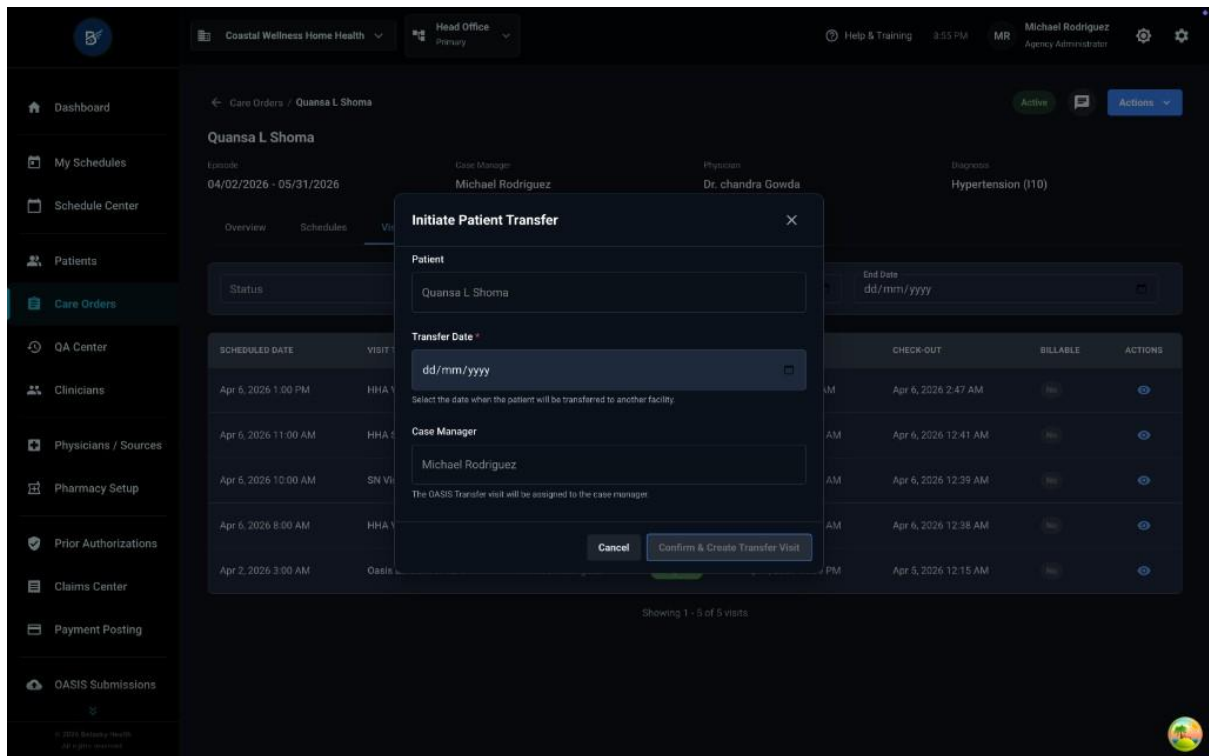
Buttons:

- **Cancel** (gray button) - closes without discharging
- **Confirm & Initiate Discharge** (blue button) - starts the discharge process

What Happens After You Click "Confirm & Initiate Discharge":

- The patient's status changes from "Active" to "Discharged"
- A Discharge OASIS visit is automatically created and assigned to the case manager
- The case manager must complete the Discharge OASIS within 5 days
- The episode closes on the discharge date

Action 5: Initiate Transfer



What It Does: Transfers the patient to another home health agency (patient moves or chooses a different agency)

When to Use:

- Patient moves to a different city/state and needs a local agency
- Patient requests to switch to a different home health agency
- Insurance requires transfer to a specific agency

What You'll See When You Click It:

A modal opens with the title "**Initiate Patient Transfer**"

Fields in the Modal:

1. **Patient** (read-only)
 - Shows: "Quansa L Shoma"
2. **Transfer Date** (required *)
 - Date picker with calendar icon
 - Instructions: "Select the date when the patient will be transferred to another facility"
 - This is the last day your agency provides care
3. **Case Manager** (read-only)
 - Shows: "Michael Rodriguez"
 - Note: "The OASIS Transfer visit will be assigned to the case manager"
 - The current case manager will complete the Transfer OASIS

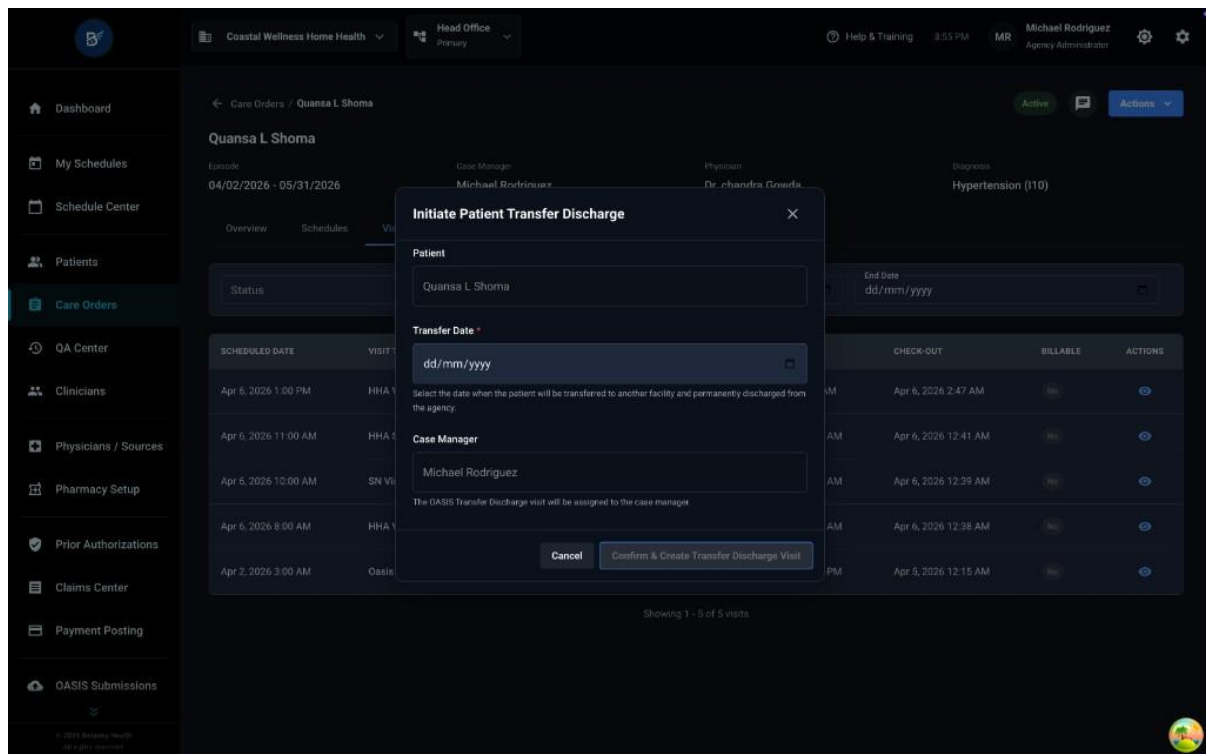
Buttons:

- **Cancel** (gray button)
- **Confirm & Create Transfer Visit** (blue button)

What Happens After You Click "Confirm & Create Transfer Visit":

- A Transfer OASIS visit is created and assigned to the case manager (Michael Rodriguez)
- The case manager must complete the Transfer OASIS on or before the transfer date
- The episode remains open until the Transfer OASIS is completed
- After the Transfer OASIS is done, the episode closes and the patient is no longer in your agency's care

Action 6: Initiate Transfer Discharge



What It Does: Transfers the patient to another facility AND discharges them from home health (e.g., patient goes to hospital, nursing home, etc.)

When to Use:

- Patient is admitted to hospital (acute care)
- Patient goes to skilled nursing facility (SNF)
- Patient moves to assisted living or long-term care
- Any time the patient is transferring AND will no longer receive home health services

What You'll See When You Click It:

A modal opens with the title **"Initiate Patient Transfer Discharge"**

Fields in the Modal:

1. **Patient** (read-only)
 - Shows: "Quansa L Shoma"
2. **Transfer Date** (required *)
 - Date picker with calendar icon

- Instructions: "Select the date when the patient will be transferred to another facility and permanently discharged from the agency"
- This is the date the patient leaves home health care

3. Case Manager (read-only)

- Shows: "Michael Rodriguez"
- Note: "The OASIS Transfer Discharge visit will be assigned to the case manager"
- The case manager will complete the Transfer Discharge OASIS

Buttons:

- **Cancel** (gray button)
- **Confirm & Create Transfer Discharge Visit** (blue button)

What Happens After You Click "Confirm & Create Transfer Discharge Visit":

- A Transfer Discharge OASIS visit is created and assigned to the case manager
- The case manager must complete the Transfer Discharge OASIS within 5 days
- The episode closes
- The patient is discharged from your agency

Difference Between "Transfer" and "Transfer Discharge":

- **Transfer:** Patient going to ANOTHER home health agency (still gets home health)
- **Transfer Discharge:** Patient going to a facility and NO LONGER getting home health

Action 7: Initiate Patient Death

The screenshot shows a software interface for a home health agency. A modal window titled "Initiate Patient Death" is open, displaying the following fields:

- Patient:** Quansha L. Shoma
- Death Date:** A date picker showing "dd/mm/yyyy". Below it, a note says "Select the date of patient death."
- Internal Notes (Optional):** A text area with the placeholder "Add any relevant internal notes..."

At the bottom of the modal are two buttons: "Cancel" and "Confirm & Create Death Visit".

The background interface shows a sidebar with navigation options: Dashboard, My Schedules, Schedule Center, Patients, Care Orders (selected), QA Center, Clinicians, Physicians / Sources, Pharmacy Setup, Prior Authorizations, Claims Center, Payment Posting, and OASIS Submissions. The main area displays the "Care Orders" for Quansha L. Shoma, with a table of visits. The table has columns for SCHEDULED DATE, VISIT, and STATUS. The first visit is on Apr 6, 2026, at 1:00 PM, with a status of HHAY.

What It Does: Documents that the patient has passed away

When to Use: When the patient dies while in home health care

What You'll See When You Click It:

A modal opens with the title **"Initiate Patient Death"**

Fields in the Modal:

1. **Patient** (read-only)
 - Shows: "Quansa L Shoma"
2. **Death Date** (required *)
 - Date picker with calendar icon
 - Instructions: "Select the date of patient death"
 - This is the official date the patient died
3. **Internal Notes (Optional)**
 - Large text box
 - Instructions: "Add any relevant internal notes..."
 - Use for internal documentation (e.g., circumstances, family notifications)

Buttons:

- **Cancel** (gray button)
- **Confirm & Create Death Visit** (blue button)

What Happens After You Click "Confirm & Create Death Visit":

- An "OASIS Death at Home" visit is created and assigned to the case manager
- The case manager must complete the Death at Home OASIS assessment
- The episode closes
- The patient's status changes to "Deceased"
- No more visits can be scheduled for this patient

Action 8: Log Communication

What It Does: Records phone calls, emails, or other communications related to this care order

When to Use:

- After calling the physician's office
- After speaking with family members
- When documenting any important conversation about the patient's care
- For compliance and audit trail purposes

What You'll See When You Click It:

A modal opens with the title "**Log Communication**"

Information Shown:

- **Participant:** Quansa L Shoma
- **Regarding:** Care Order (04/02/2026 - 05/31/2026)

Fields in the Modal:

1. **Type of Communication** (required *)

- Dropdown showing: "Outgoing Call"
- Other options typically include:
 - Incoming Call
 - Email
 - Fax
 - In-Person
 - Voicemail

2. **Spoke With (Name & Title)** (required *)

- Text field
- Placeholder: "e.g., Jessica, Office Receptionist"
- Enter who you spoke with (name and their role)

3. **Date & Time** (required *)

- Date/time picker
- Shows: "04/10/2026 08:56 PM"
- Enter when the communication happened

4. **Category (Optional)**

- Dropdown showing: "None"
- You can categorize the communication (e.g., Care Plan Discussion, Medication Change, Family Update)

5. **Summary** (required *)

- Large text box
- Instructions: "Enter details of the communication..."
- Describe what was discussed or communicated

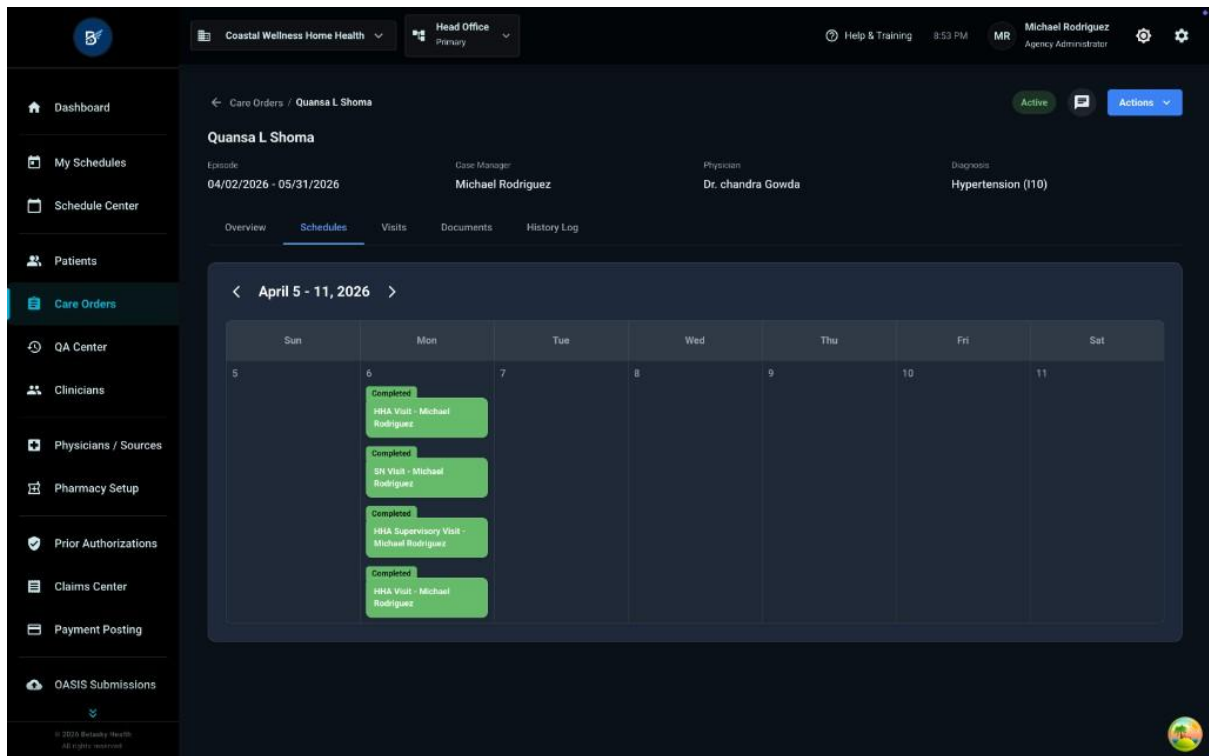
Buttons:

- **Cancel** (gray button) - closes without saving
- **Save Log** (blue button) - saves the communication log

What Happens After You Click "Save Log":

- The communication is recorded in the patient's History Log
- It becomes part of the patient's permanent record
- You can view it later in the History Log tab
- Useful for compliance, audits, and coordinating care

15.6 The Schedules Tab



Click the **"Schedules"** tab to see a calendar view of this patient's visits.

What You'll See:

Calendar Header:

- Date range: "April 5 - 11, 2026"
- Navigation arrows (< >) to move between weeks

Calendar View:

- Shows one week at a time
- Days of the week across the top (Sun, Mon, Tue, Wed, Thu, Fri, Sat)
- Date numbers below each day (5, 6, 7, 8, 9, 10, 11)

Visit Boxes (Green Rectangles):

On **Monday, April 6**, you can see **4 green boxes** stacked vertically:

1. **"Completed - HHA Visit - Michael Rodriguez"**
2. **"Completed - SN Visit - Michael Rodriguez"**
3. **"Completed - HHA Supervisory Visit - Michael Rodriguez"**
4. **"Completed - HHA Visit - Michael Rodriguez"**

What This Tells You:

- All 4 visits on April 6 have been completed (green = completed)
- 2 HHA visits, 1 SN visit, and 1 HHA Supervisory visit
- All were done by Michael Rodriguez

How to Use This View:

- Quickly see which days have visits scheduled
- See if visits are completed, scheduled, or missed
- Click on a visit box to see details

15.7 The Visits Tab

The screenshot shows a web application interface for a healthcare provider. The top navigation bar includes a logo, a dropdown menu for 'Coastal Wellness Home Health', a 'Head Office' dropdown, and user information for 'Michael Rodriguez, Agency Administrator'. The left sidebar contains various navigation options: Dashboard, My Schedules, Schedule Center, Patients, Care Orders (highlighted), QA Center, Clinicians, Physicians / Sources, Pharmacy Setup, Prior Authorizations, Claims Center, Payment Posting, and OASIS Submissions. The main content area displays the 'Visits' tab for a patient named 'Quansa L Shoma'. It includes a filter section with a 'Status' dropdown, 'Start Date' and 'End Date' pickers, and a table of visits. The table has columns for SCHEDULED DATE, VISIT TYPE, CLINICIAN, STATUS, CHECK-IN, CHECK-OUT, BILLABLE, and ACTIONS. The table shows five visits, all with a 'Completed' status. The bottom of the table indicates 'Showing 1 - 5 of 5 visits'.

SCHEDULED DATE	VISIT TYPE	CLINICIAN	STATUS	CHECK-IN	CHECK-OUT	BILLABLE	ACTIONS
Apr 6, 2026 1:00 PM	HHA Visit	Michael Rodriguez	Completed	Apr 6, 2026 2:45 AM	Apr 6, 2026 2:47 AM	No	
Apr 6, 2026 11:00 AM	HHA Supervisory Visit	Michael Rodriguez	Completed	Apr 6, 2026 12:40 AM	Apr 6, 2026 12:41 AM	No	
Apr 6, 2026 10:00 AM	SN Visit	Michael Rodriguez	Completed	Apr 6, 2026 12:38 AM	Apr 6, 2026 12:39 AM	No	
Apr 6, 2026 8:00 AM	HHA Visit	Michael Rodriguez	Completed	Apr 6, 2026 12:36 AM	Apr 6, 2026 12:38 AM	No	
Apr 2, 2026 3:00 AM	Oasis E2 Start of care	Michael Rodriguez	Completed	Apr 4, 2026 11:59 PM	Apr 3, 2026 12:15 AM	No	

Click the "Visits" tab to see a detailed table of all visits for this patient.

What You'll See:

Filter Section (Top):

- **Status** dropdown
- **Start Date** date picker (dd/mm/yyyy)
- **End Date** date picker (dd/mm/yyyy)

Visits Table:

Columns:

- **SCHEDULED DATE** (date and time)
- **VISIT TYPE** (HHA Visit, SN Visit, etc.)
- **CLINICIAN** (who did the visit)
- **STATUS** (green "Completed" badges)
- **CHECK-IN** (date and time clinician checked in)
- **CHECK-OUT** (date and time clinician checked out)
- **BILLABLE** ("No" or "Yes")

- **ACTIONS** (eye icon to view details)

Example Rows:

1. **Apr 6, 2026 1:00 PM** - HHA Visit - Michael Rodriguez - Completed
 - CHECK-IN: Apr 6, 2026 2:45 AM
 - CHECK-OUT: Apr 6, 2026 2:47 AM
 - BILLABLE: No
 - (Eye icon)
2. **Apr 6, 2026 11:00 AM** - HHA Supervisory Visit - Michael Rodriguez - Completed
 - CHECK-IN: Apr 6, 2026 12:40 AM
 - CHECK-OUT: Apr 6, 2026 12:41 AM
 - BILLABLE: No
 - (Eye icon)
3. **Apr 6, 2026 10:00 AM** - SN Visit - Michael Rodriguez - Completed
 - CHECK-IN: Apr 6, 2026 12:38 AM
 - CHECK-OUT: Apr 6, 2026 12:39 AM
 - BILLABLE: No
 - (Eye icon)
4. **Apr 6, 2026 8:00 AM** - HHA Visit - Michael Rodriguez - Completed
 - CHECK-IN: Apr 6, 2026 12:36 AM
 - CHECK-OUT: Apr 6, 2026 12:38 AM
 - BILLABLE: No
 - (Eye icon)
5. **Apr 2, 2026 3:00 AM** - Oasis E2 Start of care - Michael Rodriguez - Completed
 - CHECK-IN: Apr 4, 2026 11:59 PM
 - CHECK-OUT: Apr 5, 2026 12:15 AM
 - BILLABLE: No
 - (Eye icon)

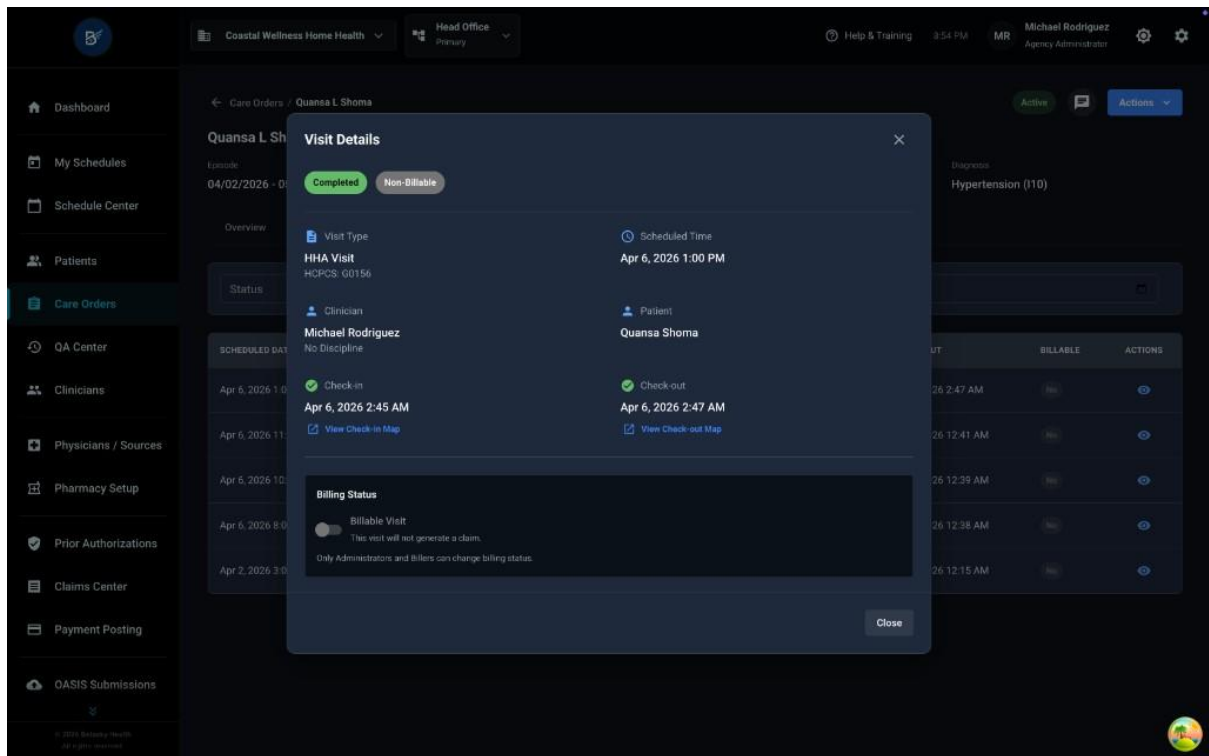
Bottom of Table:

- "Showing 1 - 5 of 5 visits"

How to Use This Tab:

- See all visits at once in a list
- Filter by date range or status
- Click the **eye icon** in the ACTIONS column to view full visit details

15.8 Viewing Visit Details



Click the **eye icon** in the **ACTIONS** column to see details for a specific visit.

What You'll See:

A modal opens with the title **"Visit Details"**

Status Badges (Top):

- **"Completed"** (green badge)
- **"Non-Billable"** (gray badge)

Visit Information (Left Side):

1. Visit Type

- Shows: "HHA Visit"
- HCPCS: G0156

2. Clinician

- Shows: "Michael Rodriguez"
- No Discipline (for this HHA visit)

3. Check-in

- Shows: "Apr 6, 2026 2:45 AM"
- Link: "View Check-in Map" (to see GPS location where clinician checked in)

Visit Information (Right Side):

1. Scheduled Time

- Shows: "Apr 6, 2026 1:00 PM"

2. Patient

- Shows: "Quansa Shoma"

3. Check-out

- Shows: "Apr 6, 2026 2:47 AM"
- Link: "View Check-out Map" (to see GPS location where clinician checked out)

Billing Status Section:

Checkbox: ☐ **Billable Visit**

- Unchecked (gray)
- Note: "This visit will not generate a claim."
- Note: "Only Administrators and Billers can change billing status."

What This Means:

- This particular visit is marked as "Non-Billable"
- It won't be included in claims
- Only admins or billing staff can change this setting

Button:

- **Close** (bottom-right) - closes the modal

15.9 The Documents Tab

The screenshot shows the 'Documents' tab for patient Quansa L. Shoma. The interface includes a sidebar with navigation options like Dashboard, My Schedules, Schedule Center, Patients, Care Orders (selected), QA Center, Clinicians, Physicians / Sources, Pharmacy Setup, Prior Authorizations, Claims Center, Payment Posting, and OASIS Submissions. The main content area displays patient information (Episode: 04/02/2026 - 05/31/2026, Case Manager: Michael Rodriguez, Physician: Dr. chandra Gowda, Diagnosis: Hypertension (I10)) and a list of documents. The documents table has columns for Document, Status, Visit Date, Clinician, and Actions. The documents listed are: Home Health Aide Visit Note (Pending Review), HHA Supervisory Visit (Pending Review), Skilled Nursing Visit Note (Pending Review), Home Health Aide Visit Note (Pending Review), HHA Care Plan (Active), Plan of Care / SOC (Approved), Face to Face Encounter (Approved), and Oasis E2 Start of care (Approved). The status is filtered by 'Status' and the date range is from 'dd/mm/yyyy' to 'dd/mm/yyyy'. The bottom of the screen shows 'Showing 1 - 8 of 8 documents'.

DOCUMENT	STATUS	VISIT DATE	CLINICIAN	ACTIONS
Home Health Aide Visit Note	Pending Review	Apr 6, 2026	Michael Rodriguez	View
HHA Supervisory Visit	Pending Review	Apr 6, 2026	Michael Rodriguez	View
Skilled Nursing Visit Note	Pending Review	Apr 6, 2026	Michael Rodriguez	View
Home Health Aide Visit Note	Pending Review	Apr 6, 2026	Michael Rodriguez	View
HHA Care Plan	Active	Apr 5, 2026	Michael Rodriguez	Download
Plan of Care / SOC	Approved	Apr 4, 2026	Michael Rodriguez	Download, Print
Face to Face Encounter	Approved	Apr 4, 2026	Michael Rodriguez	Download
Oasis E2 Start of care	Approved	Apr 4, 2026	Michael Rodriguez	View, Download

Click the **"Documents"** tab to see all documents related to this care order.

What You'll See:

Filter Section (Top):

- **Status** dropdown

- **Start Date** date picker (dd/mm/yyyy)
- **End Date** date picker (dd/mm/yyyy)

Documents Table:

Columns:

- **DOCUMENT** (type of document with file icon)
- **STATUS** (colored badges)
- **VISIT DATE** (when the document is related to)
- **CLINICIAN** (who created/completed it)
- **ACTIONS** (eye icon to view, download icon, lock icon)

Example Rows:

1. **Home Health Aide Visit Note** - Pending Review (orange) - Apr 6, 2026 - Michael Rodriguez - (Eye icon)
2. **HHA Supervisory Visit** - Pending Review (orange) - Apr 6, 2026 - Michael Rodriguez - (Eye icon)
3. **Skilled Nursing Visit Note** - Pending Review (orange) - Apr 6, 2026 - Michael Rodriguez - (Eye icon)
4. **Home Health Aide Visit Note** - Pending Review (orange) - Apr 6, 2026 - Michael Rodriguez - (Eye icon)
5. **HHA Care Plan** - Approved (green) - Apr 5, 2026 - Michael Rodriguez - (Download icon)
6. **Plan of Care / SOC** - Approved (green) - Apr 4, 2026 - Michael Rodriguez - (Download, Lock icons)
7. **Face to Face Encounter** - Approved (green) - Apr 4, 2026 - Michael Rodriguez - (Download icon)
8. **Oasis E2 Start of care** - Approved (green) - Apr 4, 2026 - Michael Rodriguez - (Eye, Download icons)

Bottom of Table:

- "Showing 1 - 8 of 8 documents"

What the Status Badges Mean:

- **"Pending Review"** (orange) - Document is completed but waiting for QA review
- **"Approved"** (green) - Document has been reviewed and approved by QA

What the Action Icons Mean:

- **Eye icon** - View/read the document
- **Download icon** - Download the document as PDF
- **Lock icon** - Document is locked (cannot be edited)

15.10 Key Takeaways

- Care Orders manage each patient's Plan of Care for their 60-day episode
- The Care Orders list shows all patients with status filters (Active, Pending Assessment, Pending Physician Signature)

- Each care order has an "Authorized Visits" table showing which disciplines are authorized and how many visits
- The **Actions menu** has 8 important options:
 - Create Add-On Order (add services)
 - Create Physician Order (get doctor's orders)
 - Initiate Recertification (continue care after 60 days)
 - Discharge Patient (patient no longer needs care)
 - Initiate Transfer (move to another agency)
 - Initiate Transfer Discharge (move to facility)
 - Initiate Patient Death (document death)
 - Log Communication (record phone calls/emails)
- The **Schedules tab** shows a calendar view of visits
- The **Visits tab** shows a detailed table of all scheduled/completed visits
- The **Documents tab** shows all paperwork (visit notes, OASIS, POC, etc.)

Chapter 16: Medication Management

Overview

Medication Management is where you document, track, and manage all medications for each patient. This chapter covers everything you need to know about working with patient medications.

What You'll Learn:

- How to view a patient's medication profile
- Where medications appear (patient chart and inside visit forms)
- How to add medications one at a time
- How to import medications from text (discharge summaries)
- How to use medication reconciliation
- How to sign medication profiles
- How to view medication history
- How to check drug interactions
- **How medication snapshots work** (frozen copies attached to completed visits)

Who Should Read This Chapter:

- Nurses (RN, LPN)
- Case Managers
- Clinical Managers
- Anyone documenting patient medications

Prerequisites:

- Patient has been admitted (Chapter 14)
- Patient has a preferred pharmacy assigned

16.1 Where You'll See Medications

16.1.1 From Patient Profile Page

The patient profile page is the main place to manage medications:

1. Go to **Patients** in the left sidebar
2. Click on a patient's name to open their profile
3. On the patient profile page, click the blue button: "**View Medication Profile**"
4. The **Medication Profile** modal opens

This is where you **add, edit, and remove medications** for the patient.

16.1.2 Inside Visit Forms

Medications also appear inside many visit forms. You'll see a "**View Medication Profile**" button in these forms:

- **Skilled Nursing (SN) Visit** - Health Management section

- **LPN/LVN Visit** - Assessment section
- **OASIS Start of Care (SOC)** - Medications tab
- **OASIS Resumption of Care (ROC)** - Medications tab
- **OASIS Recertification** - Medications tab
- **OASIS Discharge** - Medications tab
- **OASIS Follow-Up** - Medications tab

What Happens When the Visit is Open (Not Yet Approved):

- You see the **current live medication list** from the patient's chart
- If you click the button and add/edit medications, those changes immediately update the patient's medication profile
- The form itself is just viewing the medications - it doesn't store its own copy yet

What Happens When the Visit is Approved/Completed:

- The system takes a **medication snapshot** - a frozen copy of what the medications were at that exact moment
- This snapshot is permanently attached to that specific visit/document
- If you later open that approved visit to view it, you'll see the medications **as they were when the visit was completed**
- **Important:** Any changes you make to the patient's current medications after the visit is approved will NOT change the snapshot stored with that completed visit

Why Snapshots Matter:

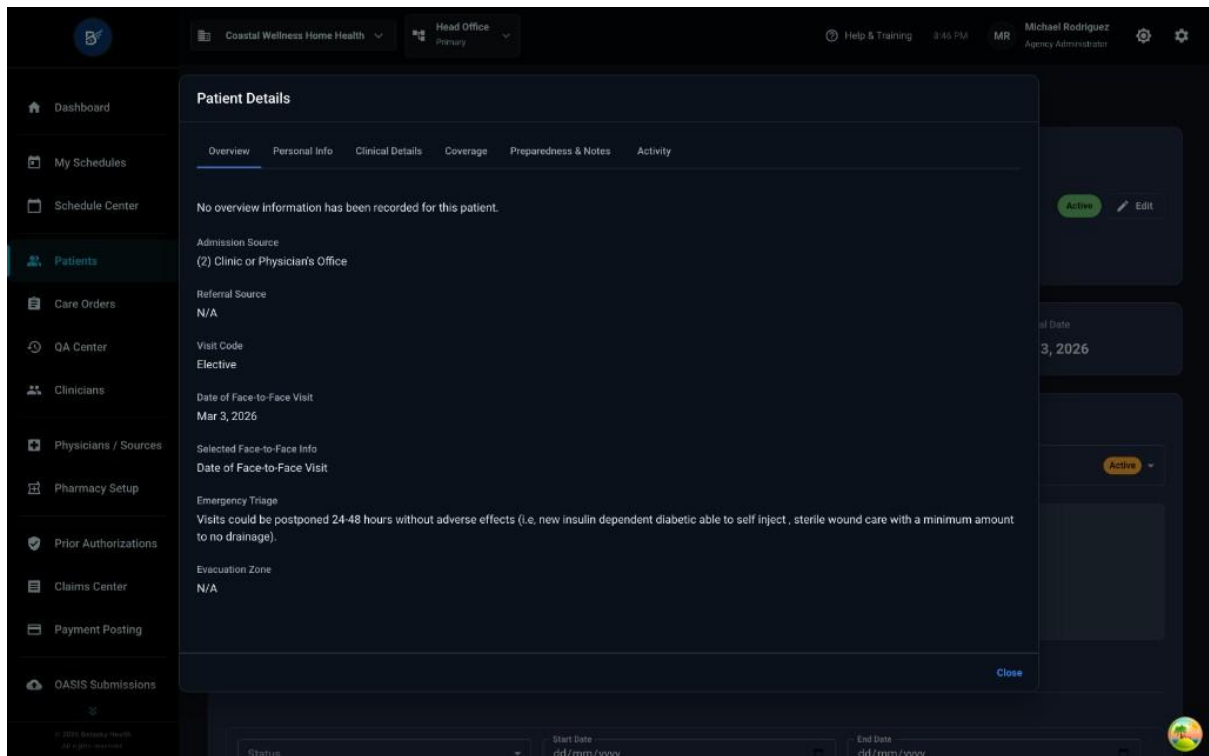
- They preserve what medications the patient was taking at the time of the visit
- They support accurate billing and compliance audits
- They provide a historical record that doesn't change even if you update current medications later

16.1.3 Read-Only View (Approved Forms)

When viewing an approved/completed visit or OASIS form:

- The **"View Medication Profile"** button still appears
- When you click it, you'll see a note: **"Snapshot at document close (read-only)"**
- You **cannot** add, edit, or remove medications from this view
- You're viewing the frozen snapshot, not the live medication list
- The **"Add Medication"**, **"Import from text"**, **"Medication Reconciliation"**, and **"Sign Medication Profile"** buttons are hidden
- The **"Print Medication Profile"** button is also disabled for snapshots

16.2 The Medication Profile Screen



Modal Title: "Medication Profile | Quansa Shoma"

Pharmacy Information (Top):

- **Pharmacy Name:** CVS Pharmacy #1234
- **Pharmacy Phone:** (212) 555-1234

Action Buttons (8 Buttons)

At the top of the modal, you'll see these buttons:

1. **Add Medication** (blue button) - Add a new medication
2. **Import from text** (gray button) - Import medications from discharge summary
3. **Medication Reconciliation** (gray button) - Compare current meds with imported list
4. **Sign Medication Profile** (gray button) - Sign off on the medication list
5. **Print Medication Profile** (gray button) - Print the medication list
6. **Drug Interactions** (gray button) - Check for drug interactions
7. **Medication History** (gray button) - View medication change history
8. **Signed Medication Profiles** (blue button) - View past signed profiles

Active Medication(s) Table

This table shows all current medications the patient is taking.

Table Columns:

- **Checkbox** (to select medications)
- **START DATE** (when patient started this medication)
- **MEDICATION / DOSAGE / FREQ / ROUTE** (medication details)

- **STATUS** (ACTIVE or DISCONTINUED)
- **CLASSIFICATION** (drug class)
- **PHYSICIAN NAME** (who prescribed it)
- **D/C THROUGH DATE** (discontinuation date)
- **ACTION** (Edit and Delete buttons)

Example Medications Shown:

Medication 1:

- ☒ Selected
- **START DATE:** 04/02/2026
- **MEDICATION:** lidocaine hydrochloride 0.02 MG/MG Topical Gel
- **Other info:** xw32323, efvns, INH inhaled
- **STATUS:** ACTIVE
- **CLASSIFICATION:** Anesthetics for topical use
- **D/C THROUGH DATE:** 04/08/2026
- **ACTIONS:** Edit | Delete

Medication 2:

- ☒ Selected
- **START DATE:** 04/02/2026
- **MEDICATION:** metformin hydrochloride 500 MG Oral Tablet
- **Other info:** 778, julkb, FT feeding tube
- **STATUS:** ACTIVE
- **CLASSIFICATION:** Biguanides
- **PHYSICIAN NAME:** Nessndin Haji
- **D/C THROUGH DATE:** 04/05/2026
- **ACTIONS:** Edit | Delete

16.3 Adding a New Medication

(This was already covered in Chapter 14, Section 14.17)

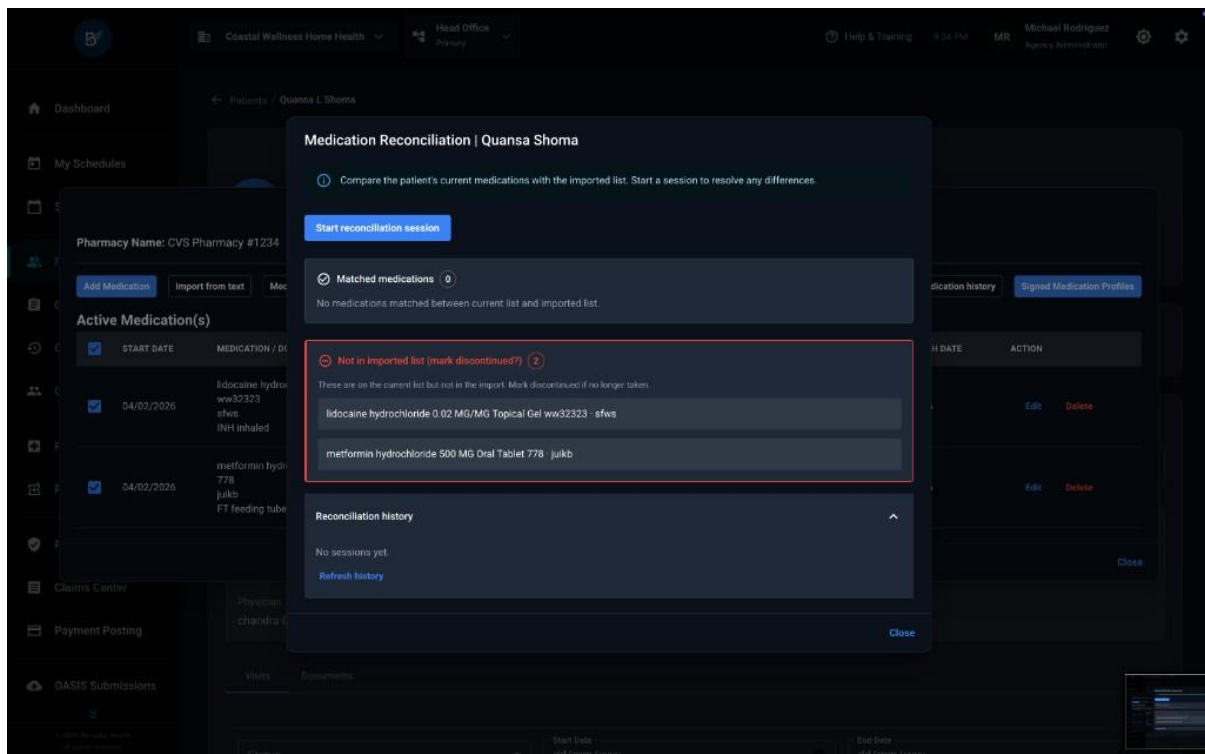
Click "**Add Medication**" → Fill out the form → Search for medication → Enter dosage, frequency, route → Click "Save & Exit"

16.4 Importing Medications from Text

(This was already covered in Chapter 14, Section 14.18)

Click "**Import from text**" → Paste medication list → Click "Parse" → Click "Import as medications"

16.5 Medication Reconciliation



What It Does: Compares the patient's current medications (what's in the system) with a newly imported list (from hospital discharge or new prescription list) to identify differences

When to Use:

- After a patient is discharged from hospital (hospital may have changed medications)
- When a physician provides a new medication list
- During recertification to verify medications are still accurate

How to Use It:

1. First, click **"Import from text"** and import the new medication list (Section 16.4)
2. Then click **"Medication Reconciliation"**
3. The **Medication Reconciliation** modal opens

What You'll See on the Reconciliation Screen

Modal Title: "Medication Reconciliation | Quansa Shoma"

Instructions (Blue Info Box):

"Compare the patient's current medications with the imported list. Start a session to resolve any differences."

Button:

- **"Start reconciliation session"** (blue button)

Reconciliation Results

The screen shows three sections:

Section 1: Matched medications - 0

"No medications matched between current list and imported list."

What This Means:

- The imported list has NO medications that match what's currently in the system
- This could mean:
 - All medications are new
 - The hospital changed all medications
 - The imported list is completely different

Section 2: Not in imported list (mark discontinued?) - 2 (Red Box)

This section shows medications that are currently ACTIVE in the system but are NOT in the imported list.

What This Means:

- These medications might have been discontinued by the hospital or physician
- You need to decide whether to mark them as discontinued

Medications Listed:

1. **lidocaine hydrochloride 0.02 MG/MG Topical Gel (xw32323 - efvns)**
2. **metformin hydrochloride 500 MG Oral Tablet 778 - julkb**

What You Should Do:

- Review these medications
- If the hospital discontinued them, click to mark them as discontinued
- If the hospital forgot to list them but patient is still taking them, keep them active

Section 3: Reconciliation history

Expandable Section (click the arrow to expand)

- Shows: "No sessions yet"
- Link: "Refresh history" (blue link)

What This Means:

- No medication reconciliation has been done yet for this patient
- After you complete a reconciliation session, it will appear here

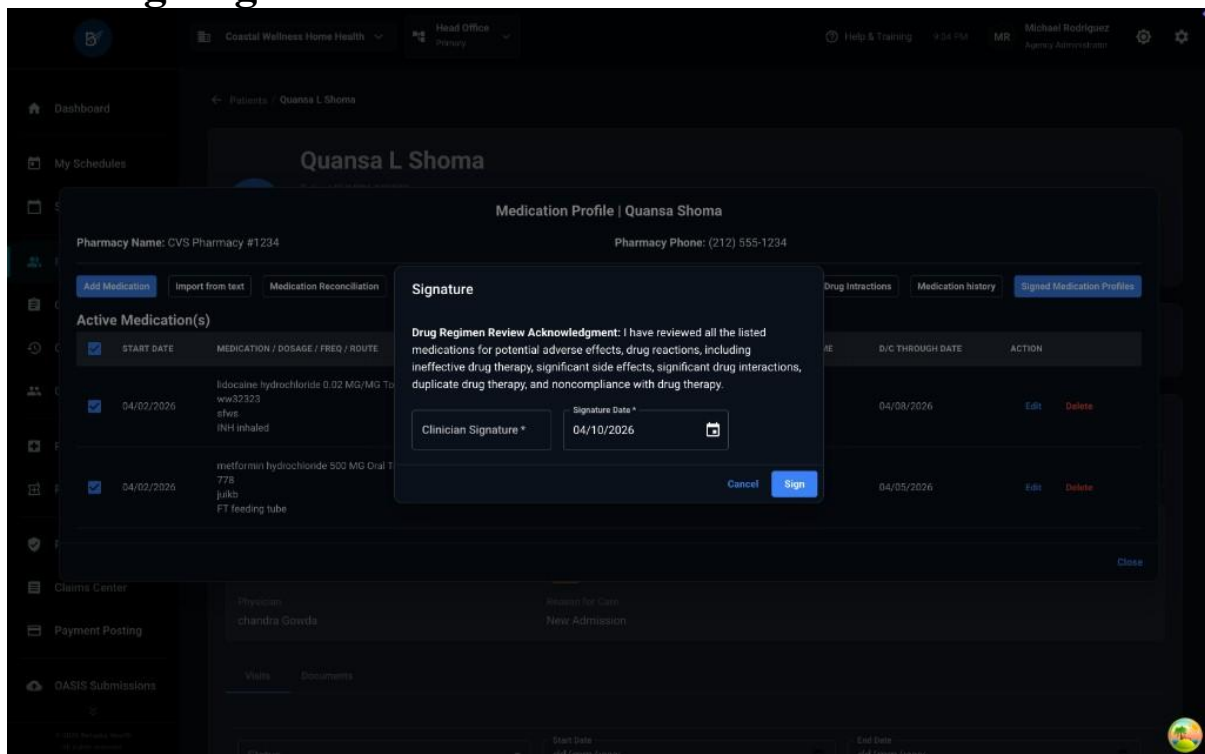
Starting the Reconciliation Session

Click the "Start reconciliation session" button

This will guide you through resolving the differences between the current list and imported list. You'll be able to:

- Mark medications as discontinued
- Add new medications from the imported list
- Keep medications that should remain active

16.6 Signing the Medication Profile



What It Does: Allows the nurse to electronically sign the medication profile, certifying that all medications have been reviewed and are accurate

When to Use:

- After adding all medications during admission
- After completing medication reconciliation
- After making any changes to patient medications
- Medicare requires a signed medication profile

How to Sign:

1. Click the gray button: **"Sign Medication Profile"**
2. The **Signature** modal opens

What You'll See in the Signature Modal

Modal Title: "Signature"

Acknowledgment Text (Drug Regimen Review):

"Drug Regimen Review Acknowledgment: I have reviewed all the listed medications for potential adverse effects, drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug regimen."

Fields:

1. **Clinician Signature** (required *)
 - Text field (currently empty)
 - This is where you type your name to sign electronically

2. Signature Date (required *)

- Date picker with calendar icon
- Shows: "04/10/2026"
- This is the date you're signing the profile

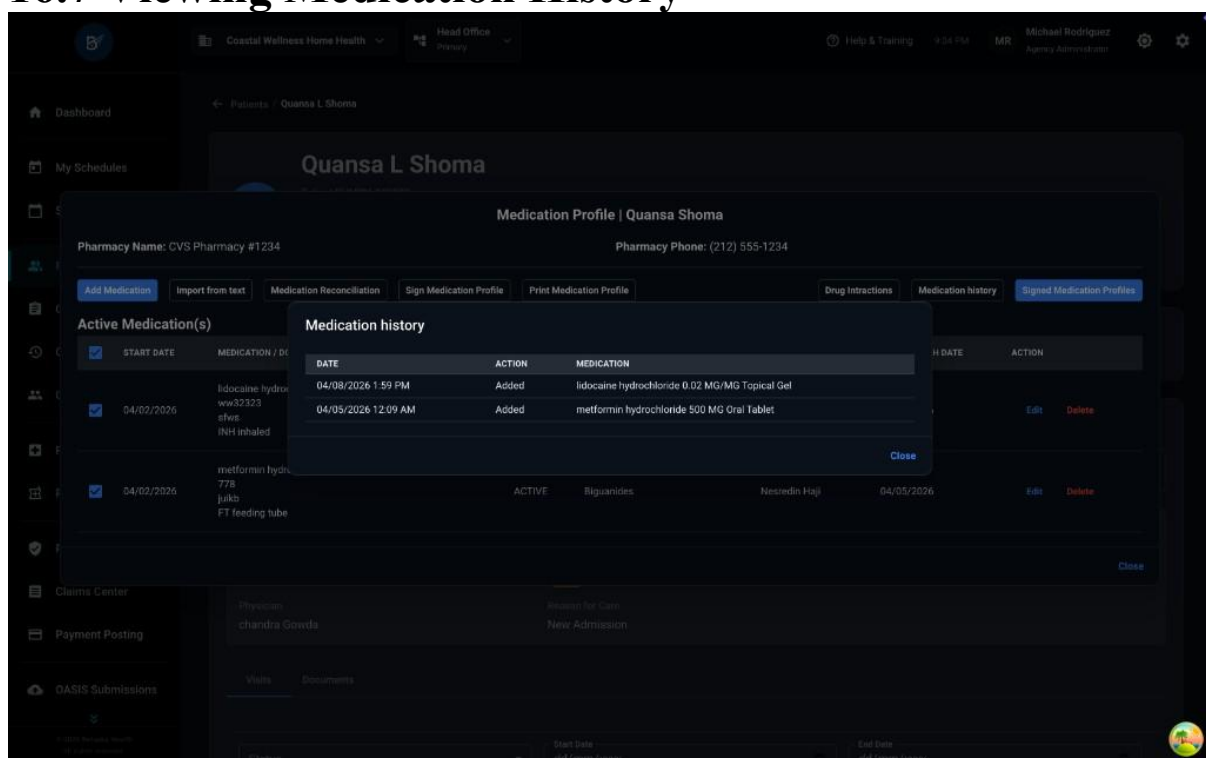
Buttons:

- **Cancel** (gray button) - closes without signing
- **Sign** (blue button) - completes the signature

What Happens After You Click "Sign"

1. The medication profile is officially signed
2. Your name and signature date are recorded
3. The signed profile appears in the "**Signed Medication Profiles**" list
4. A timestamp is created for compliance and audit purposes
5. Success message appears: "Medication profile signed successfully"

16.7 Viewing Medication History



What It Does: Shows a log of all medication changes (additions, edits, discontinuations) for this patient

How to View:

1. In the **Medication Profile** modal, click the gray button: "**Medication History**"
2. The **Medication history** modal opens

What You'll See

Modal Title: "Medication history"

Table Columns:

- **DATE** (when the change was made)
- **ACTION** (what was done)
- **MEDICATION** (which medication was affected)

Example Entries:

1. 04/08/2026 1:59 PM

- **ACTION:** Added
- **MEDICATION:** lidocaine hydrochloride 0.02 MG/MG Topical Gel

2. 04/05/2026 12:09 AM

- **ACTION:** Added
- **MEDICATION:** metformin hydrochloride 500 MG Oral Tablet

What This Tells You:

- On 04/08/2026 at 1:59 PM, someone added lidocaine
- On 04/05/2026 at 12:09 AM, someone added metformin
- This creates an audit trail of all medication changes

Button:

- **Close** (bottom-right) - closes the modal

16.8 Viewing Signed Medication Profiles

(This was covered in Chapter 14, Section 14.19)

Click "**Signed Medication Profiles**" to see all past signed medication profiles with dates, who signed them, and how many medications were reviewed.

16.9 Checking Drug Interactions

What It Does: Checks if any of the patient's current medications interact with each other (can cause side effects or dangerous combinations)

How to Use:

1. In the **Medication Profile** modal, click the gray button: "**Drug Interactions**"
2. The system analyzes all active medications
3. A report shows potential interactions

When to Use:

- After adding new medications
- When patient reports side effects
- During medication reconciliation
- Periodically as part of care review

16.10 Printing the Medication Profile

What It Does: Generates a printable PDF of the patient's current medication list

How to Use:

1. Click the gray button: "**Print Medication Profile**"
2. A PDF opens in a new tab or downloads
3. The PDF shows all active medications with dosages, frequencies, and routes

When to Use:

- Giving a copy to the patient or family
- Sending to physician's office
- Including in patient records for facility transfer
- Compliance documentation

16.11 Understanding Medication Snapshots

What is a Medication Snapshot?

A medication snapshot is a **frozen copy** of all patient medications at the exact moment a visit or OASIS assessment is approved/completed.

When Are Snapshots Created?

The system automatically takes a snapshot when:

- A visit form is **Approved** directly (no physician signature needed)
- A visit form is marked as "**Active**" after physician signature
- An OASIS assessment is **Approved**
- A Plan of Care document is **Approved**
- A Recertification document is **Approved**

Why Snapshots Are Important

Scenario Example:

1. **Monday:** Patient has 5 medications documented in their chart
2. **Tuesday:** Clinician completes an SN Visit and clicks **Submit for Review**
3. **Wednesday:** QA approves the visit → **Snapshot is taken** (those 5 medications are frozen with this visit)
4. **Thursday:** You add 2 new medications to the patient's chart (now they have 7 medications)
5. **Friday:** Someone opens the approved Tuesday visit to view it
 - They see **5 medications** (the snapshot from approval time)
 - They do NOT see the 2 new medications you added Thursday

Why This Matters:

- **Billing Accuracy:** The claim reflects what medications were documented at visit time
- **Compliance:** Auditors see the exact medication list that was present during the visit
- **Historical Record:** You have a permanent record that doesn't change even if current medications are updated

How to Identify a Snapshot View

When you open a completed visit/form and click "**View Medication Profile**":

- You'll see this message at the top: "**Snapshot at document close (read-only)**"
- The medication table title shows: "**Medication(s) at document close**" (instead of "Active Medication(s)")
- All editing buttons are hidden (Add Medication, Import, Reconciliation, Sign Profile)
- Print button is disabled

How to Update Medications for Future Visits

If you need to add/edit medications after a visit is approved:

1. Go to the **Patients** page
2. Open the patient's profile
3. Click "**View Medication Profile**"
4. Make your changes (add, edit, remove medications)
5. These changes will appear in **future** visits, but will NOT change the snapshot attached to past completed visits

16.12 Key Takeaways

- The Medication Profile shows all active medications for a patient
- Medications appear in the patient chart AND inside visit/OASIS forms
- You can **Add Medication** one at a time or **Import from text** for faster entry
- **Medication Reconciliation** compares current medications with a new list to identify changes
- Nurses must **Sign the Medication Profile** to certify they've reviewed all medications
- **Medication History** shows an audit trail of all medication changes
- **Drug Interactions** checks for dangerous medication combinations
- **Print Medication Profile** creates a PDF for patients, physicians, or facilities
- **Medication Snapshots** are created when visits are approved - they freeze the medication list at that moment
- Changes to current medications do NOT affect snapshots from past completed visits

Chapter 17: Wound Care Documentation

Overview

Wound Care Documentation is where you assess, track, and document all patient wounds throughout their care. The system provides comprehensive tools for wound assessment, measurement, photo documentation, and treatment tracking.

What You'll Learn:

- How to access the Wound Care Flowsheet
- How to document multiple wounds for a single patient
- How to measure wounds accurately
- How to upload wound photos
- How to document wound treatment
- Where wound documentation appears in the system

Who Should Read This Chapter:

- Skilled Nurses (RN)
- Licensed Practical Nurses (LPN/LVN)
- Wound Care Specialists
- Clinical Managers
- Anyone documenting wound assessments

Prerequisites:

- Patient has been admitted (Chapter 14)
- Patient has an active care order (Chapter 15)

17.1 Understanding Wound Documentation in the System

Two Ways to Document Wounds

The system provides two distinct methods for wound documentation:

Method 1: Wound Worksheet (Patient-Level)

- **Purpose:** Comprehensive wound assessment flowsheet
- **Storage:** One active worksheet per patient (patient-level, not visit-specific)
- **Access From:**
 - Patient Profile page
 - Inside SN Visit forms (Integumentary section)
 - Inside LPN Visit forms (Assessment section)
 - Inside OASIS forms (Integumentary Status tab)
- **Use Case:** Ongoing wound tracking across multiple visits
- **Capacity:** Up to 5 wounds simultaneously

Method 2: Wound Care Note (Visit-Specific)

- **Purpose:** Standalone visit documentation for wound care visits
- **Storage:** Stored with each specific visit
- **Access From:**
 - Wound Care Note visit type (dedicated visit form)
- **Use Case:** Documenting a dedicated wound care visit
- **Capacity:** Unlimited wounds (add as many as needed per visit)

Key Difference:

- **Wound Worksheet** = Patient's current wound status (one version, updated over time)
- **Wound Care Note** = Documentation of a specific wound care visit (snapshot at that visit)

17.2 Accessing the Wound Care Flowsheet From Patient Profile Page

1. Go to **Patients** in the left sidebar
2. Click on a patient's name to open their profile
3. Scroll down to find the "**View Wound Worksheet**" button
4. Click to open the **Wound Care Flowsheet** modal

From Inside Visit Forms

The "**WOUND WORKSHEET**" button appears in these forms:

Skilled Nursing (SN) Visit:

- Go to the **Integumentary** section
- Click the "**WOUND WORKSHEET**" button at the top

LPN/LVN Visit:

- Go to the **Assessment** section
- Click the "**WOUND WORKSHEET**" button

OASIS Forms (SOC, ROC, Recertification, Discharge):

- Go to the **Integumentary Status** tab
- Click the "**View Wound Worksheet**" button

17.3 The Wound Care Flowsheet Screen

Modal Title: "Wound Care Flowsheet"

Body Diagram (Top Section)

At the top of the screen, you'll see:

- **Front view** (left side) - body diagram showing front of body
- **Back view** (right side) - body diagram showing back of body

Purpose: Visual reference to help identify and document wound locations on the body.

17.4 The Wound Assessment Table

The main section displays a table with **up to 5 wound columns**:

- **Wound One**
- **Wound Two**
- **Wound Three**
- **Wound Four**
- **Wound Five**

Each column represents a separate wound on the patient. If a patient has 3 wounds, you'll fill out columns 1, 2, and 3.

Table Rows (What to Document)

The table has 14 rows for documenting each wound's characteristics:

1. **Upload File**
2. **Location**

3. **Onset Date**
4. **Wound Type**
5. **Pressure Ulcer Stage**
6. **Measurements**
7. **Wound Bed (%)**
8. **Surrounding Tissue**
9. **Drainage**
10. **Drainage Amount**
11. **Odor**
12. **Tunneling**
13. **Undermining**
14. **Device**

Let me explain each row in detail.

17.5 Documenting Each Wound Field

Row 1: Upload File

What It Does: Allows you to upload a photo of the wound

How to Use:

1. In the wound column, find the **Upload File** row
2. Click "**Choose File**" button
3. Select a wound photo from your device
4. The system uploads and attaches it to this specific wound
5. Once uploaded, you'll see the filename and a "**Delete**" button

When to Upload:

- At wound onset (baseline photo)
- Weekly for acute wounds
- Bi-weekly for chronic wounds
- When significant changes occur
- Before discharge

File Format: Images only (JPEG, PNG, etc.)

Row 2: Location

What It Does: Records where on the body the wound is located

How to Use:

1. Click in the **Location** text field for the wound column
2. Type the specific body location

Examples:

- "Left Heel"
- "Right Hip"
- "Sacrum"
- "Left Lower Leg - Lateral"
- "Right Elbow"

Best Practice: Be specific. Instead of "leg," write "right lower leg, medial aspect."

Row 3: Onset Date

What It Does: Records when the wound first appeared

How to Use:

1. Click in the **Onset Date** field
2. Select the date from the calendar picker
3. Format: MM/DD/YYYY

Why It Matters:

- Tracks wound duration
- Helps determine healing progress
- Important for billing and compliance

Row 4: Wound Type

What It Does: Describes the type/cause of the wound

How to Use:

1. Click in the **Wound Type** text field
2. Type the wound type

Common Wound Types:

- Pressure Ulcer
- Surgical Incision
- Diabetic Ulcer
- Venous Stasis Ulcer
- Arterial Ulcer
- Traumatic Wound
- Burn
- Skin Tear
- Abrasion

Row 5: Pressure Ulcer Stage

What It Does: Classifies the depth/severity of pressure ulcers

How to Use:

1. Click the **Pressure Ulcer Stage** dropdown
2. Select the appropriate stage

Options:

- **I** - Intact skin with non-blanchable redness
- **II** - Partial thickness loss (blister, shallow open ulcer)
- **III** - Full thickness tissue loss (fat visible, no bone/tendon/muscle exposed)
- **IV** - Full thickness tissue loss with exposed bone, tendon, or muscle
- **Unstageable** - Full thickness loss, base obscured by slough or eschar

When to Use: Only for pressure ulcers. Leave blank for other wound types.

Row 6: Measurements

What It Does: Records the physical dimensions of the wound in centimeters

How to Use:

Each wound column has 3 measurement fields:

1. **Length (cm)** - Longest dimension (head to toe)
 - Enter number (e.g., "3.5")
2. **Width (cm)** - Widest dimension (side to side)
 - Enter number (e.g., "2.0")
3. **Depth (cm)** - How deep the wound is
 - Enter number (e.g., "0.8")
 - Use a sterile cotton-tipped applicator to measure depth

Measurement Technique:

- Always measure in the same position
- Use a disposable ruler
- Measure length head-to-toe, width side-to-side
- Round to nearest 0.1 cm

Why It Matters:

- Tracks healing or deterioration
- Length × Width = approximate surface area
- Depth indicates tissue involvement

Row 7: Wound Bed (%)

What It Does: Describes the tissue composition visible in the wound bed

How to Use:

Each wound column has 3 percentage fields:

1. **Granulation %** - Healthy pink/red tissue
2. **Slough %** - Yellow/tan devitalized tissue
3. **Eschar %** - Black/brown dead tissue

IMPORTANT: The three percentages **must total 100%**

Examples:

- Healing wound: 80% Granulation, 15% Slough, 5% Eschar
- Infected wound: 30% Granulation, 60% Slough, 10% Eschar
- Necrotic wound: 10% Granulation, 20% Slough, 70% Eschar

What Each Means:

- **Granulation:** Good! This is healing tissue with new blood vessels
- **Slough:** Needs debridement - dead tissue that's separating
- **Eschar:** Needs debridement - hard, dry dead tissue (stable heel eschar may be left intact)

Row 8: Surrounding Tissue

What It Does: Describes the condition of the skin around the wound

How to Use:

1. Click the **Surrounding Tissue** dropdown
2. Select the option that best describes the tissue

Options:

- **Redness** - Inflamed, may indicate infection
- **Pink** - Normal healing color
- **Dry** - Lacks moisture
- **Pale** - Possible poor circulation
- **Moist** - Appropriate moisture balance
- **Excoriated** - Damaged from moisture/friction
- **Calloused** - Thickened, hardened skin
- **Normal** - Healthy surrounding tissue

Row 9: Drainage

What It Does: Describes the type of fluid coming from the wound

How to Use:

1. Click the **Drainage** dropdown
2. Select the type

Options:

- **Serous** - Clear, watery fluid (normal)
- **Serosanguineous** - Clear with pink tinge (blood-tinged, often normal)
- **Purulent** - Thick, cloudy, pus (indicates infection)
- **None** - No drainage present

Clinical Significance:

- Serous/Serosanguineous = Usually normal healing

- Purulent = Infection - notify MD

Row 10: Drainage Amount

What It Does: Quantifies how much drainage is present

How to Use:

1. Click the **Drainage Amount** dropdown
2. Select the amount

Options:

- **None** - No drainage
- **Minimal** - Small amount (dressing slightly damp)
- **Moderate** - Medium amount (dressing 25-75% saturated)
- **Heavy** - Large amount (dressing saturated, may strike through)

Row 11: Odor

What It Does: Records any smell from the wound

How to Use:

1. Click in the **Odor** text field
2. Type the description

Common Descriptions:

- "None"
- "Foul" (may indicate infection or necrotic tissue)
- "Musty"
- "Sweet" (may indicate Pseudomonas infection)

Best Practice: Assess odor after cleaning the wound, not before.

Row 12: Tunneling

What It Does: Documents channels that extend from the wound bed under intact skin

How to Use:

Each wound column has 2 tunneling fields:

1. **Length (cm)** - How deep the tunnel goes
 - Use a sterile cotton-tipped applicator to measure
 - Enter number (e.g., "2.5")
2. **Time (o'clock)** - Direction of the tunnel
 - Use clock face method (patient's head = 12 o'clock)
 - Select from dropdown: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12

Example: "3.0 cm at 2 o'clock" means a tunnel 3 cm deep extending toward the patient's right side.

Why It Matters:

- Tunneling can hide infection
- Prevents healing from the inside out
- Requires packing to heal properly

Row 13: Undermining

What It Does: Documents tissue destruction under intact wound edges (erosion under the skin)

How to Use:

Each wound column has 3 undermining fields:

1. **Length (cm)** - How far the undermining extends
 - Enter number (e.g., "1.5")
2. **From (o'clock)** - Starting position
 - Select from dropdown: 1-12
3. **To (o'clock)** - Ending position
 - Select from dropdown: 1-12

Example: "1.5 cm from 10 to 2 o'clock" means undermining extends 1.5 cm deep from 10 o'clock position around to 2 o'clock position.

Clock Face Reference:

- Patient's head = 12 o'clock
- Patient's feet = 6 o'clock
- Patient's right side = 3 o'clock
- Patient's left side = 9 o'clock

Row 14: Device

What It Does: Documents any devices applied to the wound (e.g., negative pressure wound therapy)

How to Use:

Each wound column has 2 device fields:

1. **Type** - What device is being used
 - Enter text (e.g., "VAC Therapy," "Wound VAC," "Negative Pressure")
2. **Setting** - Device settings/parameters
 - Enter text (e.g., "125 mmHg continuous," "100 mmHg intermittent")

When to Use:

- Only if a wound therapy device is in use
- Leave blank if no device

Common Devices:

- VAC (Vacuum-Assisted Closure)
- Negative Pressure Wound Therapy
- NPWT

- Pulsed Lavage

17.6 Treatment Performed Section

Location: Below the wound assessment table

What It Does: Free-text area to describe the treatment you provided during this visit

How to Use:

1. Click in the "**Treatment Performed**" text box
2. Type a detailed description of the wound care provided

What to Include:

- Wound cleaning method (e.g., "Cleansed with normal saline")
- Debridement performed (e.g., "Sharp debridement of loose slough")
- Products applied (e.g., "Applied silver alginate dressing")
- Packing method (e.g., "Loosely packed tunnel with moistened gauze")
- Secondary dressing (e.g., "Covered with ABD pad and secured with tape")
- Skin protection (e.g., "Applied barrier cream to periwound skin")

Example Entry:

Cleansed wound with normal saline. Performed sharp debridement of loose yellow slough from wound bed. Loosely packed wound with saline-moistened gauze. Applied foam dressing and secured with transparent film. Applied barrier cream to surrounding skin to protect from moisture. Patient tolerated procedure well.

17.7 Narrative Section

Location: Below the Treatment Performed section

What It Does: Free-text area for clinical narrative and patient response

How to Use:

1. Click in the "**Narrative**" text box
2. Type your clinical notes and patient response

What to Include:

- Patient's response to treatment
- Pain level during/after care
- Patient/caregiver education provided
- Patient/caregiver understanding demonstrated
- Signs of infection (or absence thereof)
- Healing progress observations
- Plan for next visit

Example Entry:

Patient reports pain level 3/10 during dressing change, improved from 5/10 last visit. Wound showing signs of improvement with increased granulation tissue and decreased slough. No signs of infection noted - surrounding tissue pink, drainage serous, no foul odor. Educated patient on importance of offloading pressure and keeping

heel elevated. Patient verbalized understanding and demonstrated correct positioning. Continue current treatment plan. Will reassess in 3 days.

17.8 Saving the Wound Worksheet

How to Save:

1. After documenting all wounds, click the blue **"Save"** button at the bottom right
2. Success message appears: "Wound worksheet saved successfully" or "Wound worksheet updated successfully"
3. Click **"Cancel"** to close the modal without saving (you'll lose unsaved changes)

Important Notes:

- The system maintains **one active wound worksheet** per patient
- When you save, it updates the patient's current wound worksheet
- All forms and the patient profile access this same worksheet
- If you close the modal without saving, changes are lost

17.9 Viewing Wound Photos

After Upload:

- The filename appears in the Upload File row
- Click the filename to view the full image
- Click **"Delete"** to remove the photo if needed

Photo Tips:

- Take photos from the same angle each time
- Include a ruler in the photo for scale
- Ensure good lighting
- Take photos after cleaning the wound
- Document photo date in your system

17.10 Common Wound Care Scenarios

Scenario 1: New Pressure Ulcer on Admission

Steps:

1. Open the patient's Wound Worksheet
2. Use **Wound One** column
3. Fill in:
 - **Location:** "Sacrum"
 - **Onset Date:** Date discovered
 - **Wound Type:** "Pressure Ulcer"

- **Pressure Ulcer Stage:** "II" (if partial thickness)
 - **Measurements:** Length, Width, Depth
 - **Wound Bed:** Percentages (e.g., 70% Granulation, 30% Slough, 0% Eschar)
 - **Surrounding Tissue:** "Redness"
 - **Drainage:** "Serous"
 - **Drainage Amount:** "Minimal"
 - **Odor:** "None"
 - Upload baseline photo
4. Document treatment in **Treatment Performed**
 5. Document assessment in **Narrative**
 6. Click "Save"

Scenario 2: Patient Has 3 Active Wounds

Steps:

1. Use columns **Wound One, Wound Two, Wound Three**
2. Fill out complete assessment for each wound separately
3. Example:
 - **Wound One:** Sacral pressure ulcer
 - **Wound Two:** Left heel pressure ulcer
 - **Wound Three:** Right lower leg venous ulcer
4. Upload photos for each wound
5. Document treatment for all wounds in **Treatment Performed**
6. Click "Save"

Scenario 3: Wound Healed - Removing from Worksheet

What Happens:

- When a wound heals, you typically leave it documented with final measurements showing 0 × 0 × 0 cm
- Update the **Wound Bed** to show 100% Granulation
- Document "Wound healed, epithelialized" in **Treatment Performed**
- Take final photo
- For your next visit, you can clear that column and reuse it for a new wound if needed

Best Practice: Document the healed wound in your visit note narrative for that visit before clearing the column.

17.11 Wound Worksheet vs. Visit Forms

When You Update the Wound Worksheet

The Changes Apply To:

- Patient's current wound status
- Any future visit forms that open the worksheet
- The patient profile

The Changes DO NOT Apply To:

- Past completed visits (those have their own snapshots)
- Past OASIS assessments (those are locked once approved)

Example Timeline:

1. **Monday:** You document 3 wounds in the Wound Worksheet during an SN Visit
2. **Wednesday:** You update measurements showing improvement
3. **Friday:** QA approves Monday's visit
4. **Next Monday:** You open the Wound Worksheet again
 - You'll see Wednesday's updated measurements (current status)
 - If you view Monday's approved visit, it shows Monday's measurements (snapshot)

Key Point: The Wound Worksheet shows the **current** state. Past visits show **historical** snapshots.

17.12 Best Practices

Measurement Accuracy

- Use the same measuring technique each time
- Measure with patient in same position
- Use a disposable ruler
- Round to nearest 0.1 cm
- Don't estimate - always measure

Documentation Frequency

- **Acute wounds:** Weekly measurements minimum
- **Chronic wounds:** Bi-weekly measurements minimum
- **Rapidly changing wounds:** Every visit
- **Stable wounds:** Weekly minimum

Photo Documentation

- Take at admission (baseline)
- Weekly for first month
- Bi-weekly thereafter if stable
- Whenever significant changes occur
- Before discharge (final photo)
- Don't take photos before cleaning the wound

Wound Bed Percentages

- Always total 100%
- Reassess each visit
- Use to track healing progress
- Example: Week 1: 40% granulation → Week 2: 60% granulation = Improving!

Clinical Indicators to Report to MD

- Purulent drainage (infection)
- Foul odor (infection or necrosis)
- Increased redness around wound (cellulitis)
- Wound size increasing
- Exposed bone, tendon, or muscle (Stage IV)
- Patient fever with wound present
- Severe pain at wound site

17.13 Troubleshooting

Problem: "Wound bed percentages must total 100%"

Solution: Check your granulation, slough, and eschar percentages. They must add up to exactly 100.

- Example: $70\% + 20\% + 10\% = 100\%$ ✓
- Example: $60\% + 30\% + 5\% = 95\%$ ✗

Problem: Can't upload wound photo

Possible Causes:

1. File is too large (try smaller file size)
2. File format not supported (use JPEG or PNG)
3. No internet connection

Solution:

- Compress the image
- Convert to JPEG or PNG format
- Check your connection and try again

Problem: Don't see my updated wound measurements in last week's visit

Explanation: This is normal! Past completed visits show a snapshot of the wounds **at that time**. Current measurements appear in:

- Today's visit forms

- The patient's Wound Worksheet (current status)
- Future visits

17.14 Key Takeaways

- The Wound Worksheet tracks **up to 5 wounds simultaneously** for one patient
- The worksheet is **patient-level** (one active version per patient)
- Access from **patient profile, SN visits, LPN visits, and OASIS forms**
- **14 assessment fields** per wound (location, measurements, photos, etc.)
- **Wound bed percentages must total 100%**
- Use **clock face method** for tunneling and undermining (head = 12 o'clock)
- **Upload photos** for visual tracking
- Document **treatment performed** and **patient response**
- Changes to the worksheet update the **current status** only
- Past completed visits retain their **historical snapshots**

Chapter 18: HHA Care Plans

Overview

The HHA Care Plan is a comprehensive document that guides Home Health Aides (HHAs) during their visits. It outlines the specific tasks they need to perform, safety parameters to monitor, and important precautions to follow for each patient. This chapter covers when and how to create HHA Care Plans, what information to include, and how the care plan integrates with your workflow.

What You'll Learn

- When HHA Care Plans are required
- Where to create and manage HHA Care Plans
- How to build a care plan using the task library
- Setting vital sign safety parameters
- Adding safety precautions and functional limitations
- How care plans appear in patient documents
- Understanding care plan versions and updates

18.1 When HHA Care Plans Are Required

Automatic Requirement During OASIS Assessments

The system automatically determines when an HHA Care Plan is required:

1. During OASIS Start of Care (SOC):

- If you enter HHA frequency > 0 in the assessment
- The "Create HHA Care Plan" button appears
- You MUST create the plan before completing the assessment

2. During OASIS Resumption of Care (ROC):

- Same rules apply if HHA services are ordered
- Required before finalizing the ROC assessment

3. During OASIS Re-Certification:

- If HHA services continue in the new certification period
- Must be created or updated before completing the recert

For HHA Visits

Before an HHA can complete a visit note, an **Active** HHA Care Plan must exist for the patient. The system blocks completion if no active plan is found.

Important: The care plan requirement is tied to HHA frequency in the Plan of Care. If no HHA visits are ordered, you won't see the option to create a care plan.

18.2 Where to Access HHA Care Plans From OASIS Assessment Forms

The screenshot displays the OASIS Assessment form interface. On the left is a sidebar with a list of assessment sections: 'P - Behavioral, Cognitive, and Psychiatric Symptoms', 'Prior Functioning (0010)', 'GG - Functional Abilities and Goals', 'M - Pain Interference', '4. Nutrition / Elimination / Skin', '5. Medications / Treatments', '6. Care Preferences / Follow-Up', and 'Summary'. The '6. Care Preferences / Follow-Up' section is currently selected, showing sub-items 'Q - Participation and Care Preferences' and 'Aide Care Plan'. The main content area on the right contains several checkboxes for wound care: 'Wounds are healed:', 'Caregiver demonstrates ability to manage wounds:', 'Caregiver identified to instruct and demonstrate:', and 'Other:'. Below these is a section for 'Enter Discipline Frequency and Duration' with input fields for SN, ST, PT, MSW, OT, and HHA frequencies. The HHA Frequency field is set to '1 Week for 1 weeks'. At the top right of the main content area, there are three buttons: 'Save Section' (blue), 'Create HHA Care Plan' (red with a red border), and 'Check for Errors' (blue with a checkmark icon).

While completing an OASIS SOC, ROC, or Recertification form:

1. Look for the **"Create HHA Care Plan"** button in the top action bar
2. The button appears only if HHA frequency > 0
3. Button colors indicate status:
 - **Red border:** No active care plan exists (action required)
 - **Green checkmark:** Active care plan exists

Visual Indicator:

- "Create HHA Care Plan" (red) = You need to create one
- "✓ HHA Care Plan Created" (green) = Already created

From Care Order Documents Tab

Overview	Schedules	Visits	Documents	History Log

Status	Start Date dd/mm/yyyy	End Date dd/mm/yyyy

DOCUMENT	STATUS	VISIT DATE	CLINICIAN	ACTIONS
Home Health Aide Visit Note	Pending Review	Apr 6, 2026	Michael Rodriguez	
HHA Supervisory Visit	Pending Review	Apr 6, 2026	Michael Rodriguez	
Skilled Nursing Visit Note	Pending Review	Apr 6, 2026	Michael Rodriguez	
Home Health Aide Visit Note	Pending Review	Apr 6, 2026	Michael Rodriguez	
HHA Care Plan	Active	Apr 5, 2026	Michael Rodriguez	
Plan of Care / SOC	Approved	Apr 4, 2026	Michael Rodriguez	
Face to Face Encounter	Approved	Apr 4, 2026	Michael Rodriguez	
Oasis E2 Start of care	Approved	Apr 4, 2026	Michael Rodriguez	

After a care plan is created, it appears in the Care Order's **Documents** tab:

1. Navigate to **Care Orders** → Select the patient's care order
2. Click the **Documents** tab
3. Look for "HHA Care Plan" in the document list
4. **Status** shows "Active" for current plans
5. Click the **download icon** to view the care plan PDF

From HHA Supervisory Visit Forms

When conducting an HHA supervisory visit, you can also access and review the active HHA Care Plan directly from the visit form.

18.3 Creating a New HHA Care Plan

Step 1: Opening the Care Plan Editor

1. Click "**Create HHA Care Plan**" from an OASIS form
2. The "Create HHA Care Plan" modal opens
3. You'll see the **Requirements Checklist** at the top:
 - "At least 5 tasks (0/5)" - **Required**
 - "Vital sign parameters filled (0/15)" - Optional

Step 2: Understanding the Modal Layout

The modal has three main sections:

1. **Requirements Checklist** (top):
 - Shows completion percentage
 - Tracks required vs. optional fields
 - Expands/collapses for a cleaner view
2. **Task Library & Care Plan Tasks** (middle):
 - Left side: Browse tasks by category

- Right side: Your selected tasks (Care Plan Tasks)

3. Vital Sign Parameters & Additional Sections (bottom):

- Vital sign safety ranges
- Safety precautions
- Functional limitations
- Activities permitted
- Comments field

18.4 Adding Tasks to the Care Plan

Understanding the Task Library

The screenshot displays the 'Edit HHA Care Plan' window. At the top, a progress bar indicates 'Requirements to Save Care Plan' are '100% Complete'. Below this, two status items are shown: 'At least 5 tasks (8/5)' with a green checkmark and 'Vital sign parameters filled (0/15) - Optional' with an information icon. The main area is divided into two columns. The left column, titled 'Task Library', shows a 'Category' dropdown set to 'Housekeeping'. Below it, four tasks are listed: 'Change bed linens', 'Launder patient's personal items', 'Light housekeeping in patient's immediate environment', and 'Maintain clean and safe patient environment'. Each task has a blue selection button. Below the list is an 'Add Custom Task' section with a 'Task Description' field, a 'Category' dropdown, and an '+ Add Custom Task' button. The right column, titled 'Care Plan Tasks (8)', shows the same four tasks selected. Each task entry includes a 'Housekeeping' tag, a frequency selector (radio buttons for 'Daily' and 'Weekly'), and edit/delete icons. At the bottom of the window, there are 'Cancel' and 'Save & Activate Care Plan' buttons. The footer shows 'M - Pain Interference', 'Patient's Home/Residence (Q5001)', and the date range '4/2/2026 - 5/31/2026'.

The **Task Library** on the left contains pre-defined care tasks organized by category:

Available Categories:

- **Housekeeping:** Change bed linens, launder items, light housekeeping, maintain environment
- **Personal Care:** Bathing, grooming, dressing, toileting assistance

- **Nutrition:** Meal preparation, feeding assistance, hydration monitoring
- **Mobility:** Transfer assistance, ambulation support, exercise
- **Safety:** Fall prevention, medication reminders, emergency response
- And more...

Adding Tasks from the Library

1. Select a Category:

- Use the dropdown at the top of the Task Library
- The list updates to show tasks in that category

2. Add a Task:

- Click the "+" (**plus icon**) next to any task
- The task moves to "Care Plan Tasks (8)" on the right
- A **checkmark** replaces the plus icon (task already added)

3. Set Task Frequency:

- Each task shows "Frequency:" with radio buttons
- Choose **Daily** or **Weekly**
- Daily is selected by default

4. Review Your Tasks:

- The count updates in real-time: "Care Plan Tasks (8)"
- Each task shows:
 - Task description
 - Category badge (blue)
 - Frequency selection (Daily/Weekly)
 - Edit and delete icons

Adding Custom Tasks

If the task you need isn't in the library:

1. Scroll to "**Add Custom Task**" at the bottom of the Task Library
2. Enter the **Task Description** (multiline text field)
3. Select a **Category** from the dropdown
4. Click "**Add Custom Task**"
5. The custom task appears with a "**Custom**" badge (yellow)

Editing and Removing Tasks

To Edit a Task:

1. Click the **pencil icon** next to the task
2. The description becomes editable
3. Make your changes

4. Click the **checkmark** to save or **X** to cancel

To Remove a Task:

1. Click the **trash icon** next to the task
2. The task is removed immediately (no confirmation)

Minimum Requirement: You must have **at least 5 tasks** before you can save the care plan. The requirements section shows progress: "At least 5 tasks (8/5)" with a green checkmark when met.

18.5 Setting Vital Sign Parameters (Optional)

Edit HHA Care Plan

Vital Sign Parameters

Set safety rails (min/max ranges) for vital signs. These will be displayed to aides during visits. (Optional - fill as needed)

Blood Pressure	Pulse (bpm)	Respiration (/min)
Systolic Min	Min	Min
Systolic Max	Max	Max
Diastolic Min		
Diastolic Max		

Temperature (°F)	O2 Saturation (%)	Blood Glucose (mg/dL)
Min	Min (Alert if below)	Min
Max		Max

Weight (lbs)
Gain Per Day
Gain Per Week

Additional Sections

These sections will be displayed as read-only information to HHA during visits.

Cancel **Save & Activate Care Plan**

M - Pain Interference Patient's Home/Residence (Q5001) 4/2/2026 - 5/31/2026

Vital sign parameters are **optional** but highly recommended. They provide HHAs with safety ranges to watch for during visits.

Why Set Vital Sign Parameters?

- **Alerts HHAs** if a reading falls outside the safe range
- **Supports compliance** with physician orders
- **Documents care standards** for the patient
- **Helps HHAs** know when to escalate concerns

Available Vital Sign Fields

The system provides 7 vital sign categories:

1. Blood Pressure

- **Systolic Min** (e.g., 100)
- **Systolic Max** (e.g., 140)
- **Diastolic Min** (e.g., 60)
- **Diastolic Max** (e.g., 90)

2. Pulse (bpm)

- **Min** (e.g., 60)
- **Max** (e.g., 100)

3. Respiration (/min)

- **Min** (e.g., 12)
- **Max** (e.g., 20)

4. Temperature (°F)

- **Min** (e.g., 97.0)
- **Max** (e.g., 99.5)

5. O2 Saturation (%)

- **Min (Alert if below)** (e.g., 92)
- Single field for minimum threshold

6. Blood Glucose (mg/dL)

- **Min** (e.g., 70)
- **Max** (e.g., 180)

7. Weight (lbs)

- **Gain Per Day** (e.g., 2)
- **Gain Per Week** (e.g., 5)
- Monitors for fluid retention or other concerns

How to Fill Out Vital Sign Parameters

1. Scroll down to the **"Vital Sign Parameters"** section
2. You'll see a grid layout with all 7 categories
3. Enter values in the fields that are relevant to the patient
4. Leave fields blank if not applicable
5. The system tracks completion: "Vital sign parameters filled (12/15) - Optional"

Example Scenario:

- Patient has CHF (Congestive Heart Failure)
- Set strict weight gain limits (2 lbs/day, 5 lbs/week)
- Set O2 Saturation min at 92%

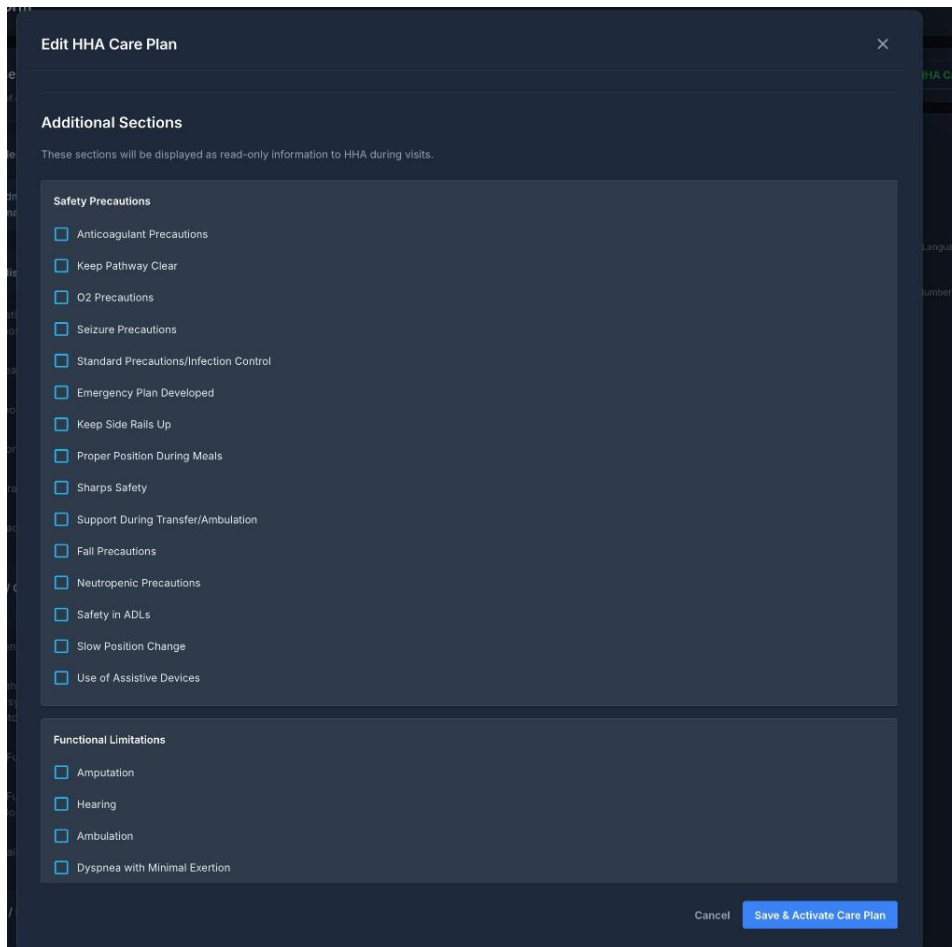
- HHA will see an alert if weight increases too quickly or O2 drops below 92%

Remember: These are safety rails shown to HHAs during visits. If you don't set them, HHAs can still record vital signs, but they won't have predefined alerts.

18.6 Additional Sections (Optional)

These sections provide read-only information to HHAs during their visits. They appear on the printed care plan and in the HHA's visit interface.

Safety Precautions



Edit HHA Care Plan [Close]

Additional Sections

These sections will be displayed as read-only information to HHA during visits.

Safety Precautions

- ☐ Anticoagulant Precautions
- ☐ Keep Pathway Clear
- ☐ O2 Precautions
- ☐ Seizure Precautions
- ☐ Standard Precautions/Infection Control
- ☐ Emergency Plan Developed
- ☐ Keep Side Rails Up
- ☐ Proper Position During Meals
- ☐ Sharps Safety
- ☐ Support During Transfer/Ambulation
- ☐ Fall Precautions
- ☐ Neutropenic Precautions
- ☐ Safety in ADLs
- ☐ Slow Position Change
- ☐ Use of Assistive Devices

Functional Limitations

- ☐ Amputation
- ☐ Hearing
- ☐ Ambulation
- ☐ Dyspnea with Minimal Exertion

[Cancel] [Save & Activate Care Plan]

Check all precautions that apply to the patient:

- Anticoagulant Precautions
- Keep Pathway Clear
- O2 Precautions
- Seizure Precautions
- Standard Precautions/Infection Control
- Emergency Plan Developed
- Keep Side Rails Up

- Proper Position During Meals
- Sharps Safety
- Support During Transfer/Ambulation
- Fall Precautions
- Neutropenic Precautions
- Safety in ADLs
- Slow Position Change
- Use of Assistive Device

Example: For a patient on blood thinners, check "Anticoagulant Precautions" and "Sharps Safety."

Functional Limitations

Identify the patient's physical or sensory limitations:

- Amputation
- Hearing
- Ambulation
- Dyspnea with Minimal Exertion
- Bowel/Bladder Incontinence
- Paralysis
- Speech
- Contracture
- Endurance
- Legally Blind
- Other

Example: Patient with COPD → Check "Dyspnea with Minimal Exertion" and "Endurance."

Activities Permitted

The screenshot shows a medical form with two main sections: 'Functional Limitations' and 'Activities Permitted'. Both sections contain a list of items, each with an unchecked checkbox. The 'Functional Limitations' section lists: Amputation, Hearing, Ambulation, Dyspnea with Minimal Exertion, Bowel/Bladder Incontinence, Paralysis, Speech, Contracture, Endurance, Legally Blind, and Other. The 'Activities Permitted' section lists: Complete bed rest, Bed rest with BRP, Up as tolerated, Transfer bed-chair, Exercise prescribed, Partial weight bearing, Independent at home, Crutches, Wheelchair, and Walker. At the bottom right of the form, there are two buttons: 'Cancel' and 'Save & Activate Care Plan'.

Functional Limitations

- ☐ Amputation
- ☐ Hearing
- ☐ Ambulation
- ☐ Dyspnea with Minimal Exertion
- ☐ Bowel/Bladder Incontinence
- ☐ Paralysis
- ☐ Speech
- ☐ Contracture
- ☐ Endurance
- ☐ Legally Blind
- ☐ Other

Activities Permitted

- ☐ Complete bed rest
- ☐ Bed rest with BRP
- ☐ Up as tolerated
- ☐ Transfer bed-chair
- ☐ Exercise prescribed
- ☐ Partial weight bearing
- ☐ Independent at home
- ☐ Crutches
- ☐ Wheelchair
- ☐ Walker

Cancel Save & Activate Care Plan

Select what the patient is allowed to do:

- Complete bed rest
- Bed rest with BRP (Bathroom Privileges)
- Up as tolerated
- Transfer bed-chair
- Exercise prescribed
- Partial weight bearing
- Independent at home
- Crutches
- Wheelchair
- Walker
- Cane
- Other

Example: Post-surgery patient → Check "Up as tolerated," "Walker," and "Partial weight bearing."

Comments / Additional Instructions

Use this free-text field for any special instructions that don't fit the checkboxes:

Examples:

- "Patient prefers shower in the morning"
- "Always use gait belt for transfers"
- "Check medication box during each visit"
- "Patient's daughter calls daily at 2 PM for updates"

18.7 Saving and Activating the Care Plan Final Review

Before saving:

1. Check the **Requirements Checklist**:

- Must show "100% Complete"
- "At least 5 tasks" must have a green checkmark
- Vital signs are optional (blue info icon)

2. Review the **progress bar**:

- Should be fully filled (green)

3. Ensure all **required fields** are complete

Save and Activate

1. Click "**Save & Activate Care Plan**" at the bottom right

2. The system:

- Saves all tasks, vital sign parameters, and additional sections
- Sets status to **ACTIVE**
- Creates a document entry in the Care Order
- Allows HHAs to access the plan during visits

3. Success message appears: "HHA Care Plan created and activated successfully"

4. The modal closes

5. The button text changes to "**✓ HHA Care Plan Created**" (green)

What Happens Next:

- The care plan is immediately available to HHAs
- It appears in the Care Order Documents tab as "HHA Care Plan" with "Active" status
- You can now complete the OASIS assessment (if that's where you created it)
- HHAs can complete visit notes for this patient

18.8 Editing an Existing Care Plan

When to Edit

You might need to update a care plan when:

- Patient's condition changes
- Physician orders new tasks or vital sign parameters
- HHA reports tasks are no longer needed
- New safety precautions are required

How to Edit

1. Click the "**✓ HHA Care Plan Created**" button (now green)
2. The modal opens in **Edit Mode**
3. All existing tasks and settings are pre-filled
4. Make your changes:
 - Add or remove tasks
 - Adjust vital sign parameters
 - Update additional sections
5. Click "**Save & Activate Care Plan**"

What Happens When You Edit

The system uses a **versioning system**:

1. The current **ACTIVE** plan is moved to **ARCHIVED** status
2. A new plan is created with **version number incremented** (e.g., v1 → v2)
3. The new plan becomes **ACTIVE**
4. The previous version is linked for history tracking

Result: HHAs always see the most current version. Past versions are retained for compliance and auditing.

18.9 How HHA Care Plans Appear in Documents

Viewing in the Documents Tab

Overview	Schedules	Visits	Documents	History Log

Status	Start Date dd/mm/yyyy	End Date dd/mm/yyyy

DOCUMENT	STATUS	VISIT DATE	CLINICIAN	ACTIONS
Home Health Aide Visit Note	Pending Review	Apr 6, 2026	Michael Rodriguez	
HHA Supervisory Visit	Pending Review	Apr 6, 2026	Michael Rodriguez	
Skilled Nursing Visit Note	Pending Review	Apr 6, 2026	Michael Rodriguez	
Home Health Aide Visit Note	Pending Review	Apr 6, 2026	Michael Rodriguez	
HHA Care Plan	Active	Apr 5, 2026	Michael Rodriguez	
Plan of Care / SOC	Approved	Apr 4, 2026	Michael Rodriguez	
Face to Face Encounter	Approved	Apr 4, 2026	Michael Rodriguez	
Oasis E2 Start of care	Approved	Apr 4, 2026	Michael Rodriguez	

Once created, the HHA Care Plan appears in the Care Order's **Documents** tab:

Document Entry Shows:

- **Document Name:** "HHA Care Plan"
- **Status:** "Active" (green chip)
- **Visit Date:** Date the care plan was created
- **Clinician:** Name of the person who created it (e.g., "Michael Rodriguez")
- **Actions:** View (eye icon) and Download (download icon)

Viewing the Care Plan PDF

1. Click the **download icon** next to "HHA Care Plan"
2. The system generates a PDF on the fly
3. A PDF viewer modal opens showing:
 - Patient demographics
 - All tasks organized by category with frequency
 - Vital sign parameters (if set)
 - Safety precautions (if selected)
 - Functional limitations (if selected)
 - Activities permitted (if selected)
 - Comments (if entered)
4. You can **download** or **print** the PDF from the viewer

Filtering Documents

You can filter the documents list to find the care plan:

1. Use the **Status filter** → Select "Active"
2. The HHA Care Plan will appear if it exists

3. Use date filters to narrow down by creation date

18.10 Understanding Care Plan Statuses

The HHA Care Plan has three possible statuses:

1. Active (Green)

- **Meaning:** This is the current, in-use care plan
- **Who Sees It:** HHAs see this plan during visits
- **In Documents Tab:** Shows as "Active" with green chip
- **Action Required:** None - plan is ready to use

2. Draft (Yellow/Orange)

- **Meaning:** Plan created by non-RN staff, pending RN approval
- **Who Can Create Drafts:** LPNs, HHAs, or other non-RN clinicians
- **Who Can Approve:** Only RNs can approve and activate
- **In Documents Tab:** Shows as "Draft" with yellow chip
- **What Happens:**
 - Draft plans are NOT available to HHAs during visits
 - RN must review and approve before use
 - Approval converts Draft → Active

3. Archived

- **Meaning:** Previous version of the care plan
- **When This Happens:** When you edit an active plan, the old version is archived
- **In Documents Tab:** Archived plans do not appear in the documents list
- **Access:** Historical versions are retained in the database for compliance

Note: In practice, most agencies use RN-level staff to create care plans, so they go directly to "Active" status. The "Draft" workflow is available for agencies that want non-RN staff to propose care plans for RN review.

18.11 Best Practices

Task Selection

1. **Be Specific:** Choose tasks that clearly describe what the HHA should do
2. **Set Realistic Frequency:** Daily for essential tasks, Weekly for less frequent needs
3. **Use Custom Tasks Sparingly:** Most needs are covered by the library
4. **Review with Patient/Family:** Ensure tasks align with patient preferences

Vital Sign Parameters

1. **Follow Physician Orders:** Always align with what the doctor prescribed
2. **Consider Comorbidities:** Set tighter ranges for high-risk patients (CHF, COPD, diabetes)
3. **Don't Skip Weight Monitoring:** Critical for CHF patients
4. **Document Rationale:** Use comments to explain why certain parameters are set

Additional Sections

1. **Don't Overload:** Only check precautions that truly apply
2. **Keep Comments Concise:** HHAs need quick, scannable info
3. **Update Regularly:** Remove precautions that are no longer needed
4. **Think "What Would I Want to Know?":** Put yourself in the HHA's shoes

Timing

1. **Create During OASIS:** Don't wait until after the assessment is complete
2. **Have Info Ready:** Review physician orders and patient needs before starting
3. **Coordinate with Team:** Check with RN case manager if unsure about tasks or parameters
4. **Update Promptly:** When patient conditions change, update the care plan ASAP

18.12 Common Scenarios

Scenario 1: New Start of Care with HHA Services

Situation: You're completing an OASIS SOC. Physician orders 3x/week HHA visits for personal care and homemaking.

Steps:

1. Complete the OASIS assessment as usual
2. Enter HHA frequency: 3 visits/week for 8 weeks
3. Click "Create HHA Care Plan"
4. Add tasks:
 - Bathing assistance (Daily)
 - Dressing assistance (Daily)
 - Light housekeeping (Weekly)
 - Launder patient's personal items (Weekly)
 - Change bed linens (Weekly)
5. Set vital sign parameters (BP, Pulse, Respiration, O2 Sat)
6. Add safety precautions: "Fall Precautions," "Support During Transfer"
7. Save & Activate
8. Complete and submit the OASIS assessment

Result: HHA Care Plan is active. HHAs can now complete visit notes.

Scenario 2: Mid-Certification Update

Situation: Patient's condition has improved. Physician reduces HHA visits and removes some tasks.

Steps:

1. Navigate to the patient's Care Order
2. Go to Documents tab
3. Click the "Create HHA Care Plan" button (it now says "✓ HHA Care Plan Created")
4. The modal opens with current tasks pre-filled
5. Remove tasks no longer needed (e.g., remove "Bathing assistance" if patient is now independent)
6. Keep essential tasks (e.g., "Light housekeeping," "Check medication box")
7. Update comments: "Patient is now independent with bathing and dressing"
8. Save & Activate

Result: A new version (v2) is created and becomes active. The old version is archived.

Scenario 3: Re-Certification with Continuing HHA Services

Situation: Patient's 60-day certification period is ending. You're completing an OASIS Recert. HHA services will continue.

Steps:

1. Start the OASIS Recertification form
2. Enter HHA frequency for the new period
3. Click "✓ HHA Care Plan Created" (green button - plan already exists)
4. Review all tasks:
 - Are they still appropriate?
 - Do frequencies need adjustment?
5. Review vital sign parameters:
 - Have physician orders changed?
 - Does patient need tighter monitoring?
6. Update additional sections if needed
7. Save & Activate

Result: Care plan is updated for the new certification period.

Scenario 4: HHA Reports a Problem

Situation: HHA calls to say the patient can no longer tolerate daily showers (gets too fatigued).

Steps:

1. Open the HHA Care Plan
2. Find "Bathing assistance" task
3. Click the pencil icon to edit

4. Change description: "Bathing assistance - Shower 3x/week (Mon, Wed, Fri), bed bath other days"
5. Or adjust frequency to "Weekly" and add a custom task for bed baths
6. Add to comments: "Patient prefers showers Mon/Wed/Fri. Bed bath on other days due to fatigue."
7. Save & Activate

Result: HHAs now have clear, updated instructions that match patient's current needs.

18.13 Troubleshooting

Problem: Can't Find "Create HHA Care Plan" Button

Possible Causes:

1. **No HHA Frequency Entered:** The button only appears if HHA visits are ordered
2. **Wrong Form Type:** Button appears in OASIS SOC, ROC, Recert, Discharge, and HHA Supervisory Visit forms
3. **Assessment Already Completed:** Button may not appear after the assessment is finalized

Solution:

- Go back to the OASIS form's "Summary of Care" section
- Check the HHA frequency field
- If it's 0 or blank, enter the correct frequency
- Save the section
- The button should now appear

Problem: "Cannot Complete Assessment - HHA Care Plan Required"

Error Message: "HHA services are ordered. You must create the HHA Care Plan before finalizing this assessment."

Cause: You entered HHA frequency > 0 but haven't created the care plan yet.

Solution:

1. Click the red "Create HHA Care Plan" button
2. Add at least 5 tasks
3. Save & Activate the care plan
4. The button turns green: "✓ HHA Care Plan Created"
5. Now you can complete the assessment

Problem: Can't Save Care Plan - Not Enough Tasks

Error Message: "Please add at least 5 tasks (currently 3)"

Cause: You have fewer than 5 tasks in the care plan.

Solution:

- Add more tasks from the task library
- Or create custom tasks
- The count updates in real-time
- Once you reach 5 tasks, the requirement turns green
- The "Save & Activate Care Plan" button becomes enabled

Problem: Care Plan Not Appearing in Documents Tab

Possible Causes:

1. **Wrong Status Filter:** You filtered by "Approved" but care plans show as "Active"
2. **Still in Draft Status:** If created by non-RN, it's pending approval
3. **Archived:** If you created a new version, old one is archived

Solution:

- Clear all filters or set Status filter to "Active"
- Check if you have the necessary role to see drafts
- If you just edited the plan, the new version replaced the old one (expected behavior)

Problem: HHA Says They Can't See the Care Plan During Visit

Possible Causes:

1. **Care Plan is Draft:** Only Active care plans are available during visits
2. **Wrong Patient:** HHA opened a different patient's visit
3. **No Active Plan:** Care plan was archived or deleted

Solution:

- Check the Documents tab - is the care plan showing "Active" status?
- If it shows "Draft," approve it (if you're an RN)
- Verify the HHA is accessing the correct patient's visit
- If no care plan exists, create one

18.14 Integration with Other Features

HHA Visit Notes

When an HHA completes a visit note:

1. **Care Plan is Loaded:** All tasks from the active care plan appear
2. **Task Completion:** HHA checks off each task as completed
3. **Vital Signs:** HHA records vital signs and sees alerts if outside parameters
4. **Safety Info:** HHA can view safety precautions and functional limitations
5. **System Blocks Completion:** If no active care plan exists, HHA cannot complete the visit

HHA Supervisory Visits

During RN supervisory visits with HHAs:

1. **Care Plan Review:** RN can access and review the current care plan
2. **Task Assessment:** RN verifies HHA is performing tasks correctly
3. **Plan Updates:** RN can update the care plan if needed after supervisory observation

OASIS Assessments

HHA Care Plans are tightly integrated with OASIS forms:

- **SOC:** Create care plan during initial assessment
- **ROC:** Update care plan when patient returns to service
- **Recert:** Review and update care plan for new certification period
- **Discharge:** Care plan remains in documents for historical record

Billing and Compliance

- **Active care plan required** for HHA visit claims
- **PDF documentation** supports audit requirements
- **Version history** tracks changes over time for compliance
- **Physician order alignment** ensures care matches prescribed services

Chapter 19: Visit Forms

Overview

Visit forms are the clinical documentation tools that clinicians use to record what happened during each patient visit. Each discipline (Skilled Nursing, LPN/LVN, HHA, PT, OT, SLP, MSW) has its own specialized form tailored to the services they provide. This chapter explains how visit forms are accessed, completed, and what makes HHA visits unique.

What You'll Learn

- How visit forms are created from scheduled visits
- Overview of all visit form types by discipline
- Detailed explanation of HHA Visit Notes (requires active HHA Care Plan)
- Detailed explanation of HHA Supervisory Visits
- Common workflow for completing and reviewing visits
- Integration with QA review process

19.1 How Visit Forms Are Created From Scheduled Visits

Visit forms don't exist in isolation - they're always connected to a scheduled visit:

1. **Visits Are Scheduled** in the Schedule Center or Care Order
2. **Clinician Opens the Visit** from My Day or My Schedules
3. **Form Opens** based on the visit type (SN Visit, HHA Visit, PT Visit, etc.)
4. **Clinician Completes Documentation** during or after the visit
5. **Form Is Saved and Submitted** for QA review

Visit Type Determines Form Type

When a visit is scheduled, the system automatically determines which form to use based on:

- **Discipline** (RN, LPN, HHA, PT, OT, SLP, MSW)
- **Visit Type** configured in Visit Type Setup
- **Form Template** associated with that visit type

Example:

- Schedule a "Skilled Nursing Visit" → Opens SN Visit Note form
- Schedule an "HHA Visit" → Opens HHA Visit Note form
- Schedule a "Physical Therapy Visit" → Opens PT Visit Note form

19.2 Overview of Visit Form Types

The system provides specialized forms for each discipline:

Skilled Nursing Visit Note

- **Used By:** RN (Registered Nurse)
- **Purpose:** Document skilled nursing interventions, assessments, treatments
- **Key Sections:** Visit Info, Systems Assessment, Medications, Wound Care, Vital Signs, Clinical Narrative
- **Typical Duration:** 30-60 minutes per visit

LPN/LVN Visit Note

- **Used By:** LPN (Licensed Practical Nurse) or LVN (Licensed Vocational Nurse)
- **Purpose:** Document licensed nursing care under RN supervision
- **Key Sections:** Similar to SN but may have restricted sections based on state scope
- **Typical Duration:** 30-45 minutes per visit

Physical Therapy Visit Note

- **Used By:** PT (Physical Therapist)
- **Purpose:** Document therapy interventions, progress toward goals, exercise programs
- **Key Sections:** Visit Info, Functional Assessment, Interventions, Progress Notes, Home Exercise Program
- **Typical Duration:** 45-60 minutes per visit

Occupational Therapy Visit Note

- **Used By:** OT (Occupational Therapist)
- **Purpose:** Document ADL training, adaptive equipment, cognitive/perceptual interventions
- **Key Sections:** Visit Info, ADL Assessment, Interventions, Equipment/Modifications, Progress Notes
- **Typical Duration:** 45-60 minutes per visit

Speech Language Pathology Visit Note

- **Used By:** SLP (Speech Language Pathologist)
- **Purpose:** Document speech, language, swallowing, cognitive-communication interventions
- **Key Sections:** Visit Info, Communication Assessment, Swallowing Assessment, Interventions, Progress Notes
- **Typical Duration:** 45-60 minutes per visit

Medical Social Worker Visit Note

- **Used By:** MSW (Medical Social Worker)
- **Purpose:** Document psychosocial assessments, counseling, resource coordination
- **Key Sections:** Visit Info, Psychosocial Assessment, Interventions, Resources/Referrals, Progress Notes

- **Typical Duration:** 30-60 minutes per visit

Home Health Aide Visit Note ★

- **Used By:** HHA (Home Health Aide)
- **Purpose:** Document personal care, homemaking, and task completion from HHA Care Plan
- **Key Sections:** Visit Info, Care Plan Tasks, Vital Signs, Visit Narrative
- **Special Requirement:** **Active HHA Care Plan MUST exist** before HHA can complete visit
- **Typical Duration:** 30-120 minutes per visit (varies by care plan)
- **Detailed Documentation:** See Section 19.3 below

HHA Supervisory Visit ★

- **Used By:** RN or LPN conducting supervisory oversight of HHA
- **Purpose:** Evaluate HHA competency, assess care quality, review care plan adherence
- **Key Sections:** HHA Selection, Competency Evaluation, Performance Checklist, Supervisory Narrative
- **Regulatory Requirement:** Required every 2 weeks by Medicare
- **Detailed Documentation:** See Section 19.4 below

19.3 HHA Visit Note (Detailed)

Understanding HHA Visits

HHA (Home Health Aide) visits are unique because they're **task-driven** rather than assessment-driven. HHAs provide personal care and light homemaking services based on a pre-defined care plan.

Critical Requirement: Active HHA Care Plan

Before an HHA can complete any visit, an Active HHA Care Plan MUST exist for that patient's care order.

Why This Matters:

- HHA visits are guided by the active care plan's task list
- The system loads tasks from the care plan into the visit form
- Without a care plan, the HHA has no defined scope of work
- The visit form will block completion if no active care plan exists

What You'll See:

- If no active care plan exists, the form displays: "No active HHA Care Plan found for this patient. Please create a care plan in the OASIS assessment."
- All action buttons (Save, Review, Complete) are disabled until a care plan is available

How HHA Visits Load Tasks from Care Plan

When an HHA opens the visit note:

1. **System Fetches Active Care Plan:** Automatically retrieves the active HHA Care Plan for the patient's care order
2. **Tasks Are Loaded:** All tasks from the care plan appear in the "Today's Care Plan" section
3. **Vital Sign Parameters Are Loaded:** If the care plan includes vital sign safety ranges, they're displayed
4. **Additional Sections Are Loaded:** Safety precautions, functional limitations, and activities permitted are shown as read-only reference

Example:

- Care Plan has 8 tasks (5 Daily, 3 Weekly)
- HHA opens visit on Monday
- All 8 tasks appear in the visit form
- HHA marks each task as "Completed," "Not Done," or "Refused"

HHA Visit Note Sections

1. Visit Information

- **Visit Date:** Date of the visit
- **Travel Start/End Time:** For mileage tracking
- **Associated Mileage:** Distance traveled to/from patient home
- **Surcharge:** Any additional charges (e.g., weekend, after hours)
- **Last BM Date:** Important for monitoring bowel patterns

2. Today's Care Plan (Task Completion)

This is the **core section** where HHAs document what they did.

For Each Task:

- **Task Description:** Loaded from the care plan (e.g., "Bathing assistance")
- **Category:** Task category (e.g., "Personal Care")
- **Frequency:** Daily or Weekly (informational)
- **Status:** HHA selects one:
 - **Completed:** Task was done successfully
 - **Not Done:** Task was not performed (HHA should explain why in narrative)
 - **Refused:** Patient refused the task

Task Status Colors:

- **Completed:** Green chip
- **Not Done:** Gray chip
- **Refused:** Orange chip

Best Practice: HHAs should complete ALL tasks unless there's a valid reason. If "Not Done" or "Refused," explain in the Visit Narrative.

3. Vital Signs (Optional)

If the care plan includes vital sign parameters, they appear here:

Available Fields:

- Temperature (°F)
- Pulse (bpm)
- Respiration (per min)
- Blood Pressure (Systolic/Diastolic)
- O2 Saturation (%)
- Blood Glucose (mg/dL)
- Weight (lbs)

Safety Alerts:

- If the care plan has parameters set (e.g., BP 100-140/60-90)
- AND the HHA enters a value outside that range
- The system may show a warning (depending on agency settings)
- HHAs should note out-of-range vitals in the narrative and notify the RN

4. Visit Narrative

Free-text field for HHAs to document:

- **General Observations:** How the patient looked, mood, behavior
- **Task Details:** Specific notes about tasks performed
- **Patient Statements:** Any concerns or complaints from patient/family
- **Issues or Changes:** Falls, skin changes, appetite changes, confusion, etc.
- **Communication:** What was communicated to family or RN

Example Narrative:

Patient alert and oriented. Assisted with shower - patient steady with grab bars.

Changed bed linens and laundered 2 loads. Patient ate well at breakfast.

Noted small reddened area on left heel - informed RN via text. Patient's daughter called and I updated her on visit. Patient in good spirits today

5. Additional Sections (Read-Only Reference)

These sections are loaded from the care plan for the HHA's reference:

- **Safety Precautions:** Reminders (e.g., "Fall Precautions," "O2 Precautions")
- **Functional Limitations:** Patient's limitations (e.g., "Hearing," "Ambulation")
- **Activities Permitted:** What patient can do (e.g., "Walker," "Up as tolerated")
- **Comments:** Any special instructions from the care plan

HHAs can view these but cannot edit them - they're informational only.

Completing the HHA Visit

1. Fill Out All Required Fields:

- Visit date and times
 - Mark status for ALL tasks
 - Enter vital signs (if required by agency or care plan)
 - Write a narrative
2. **Click "Save Document":**
- Saves progress as Draft
 - Can return later to continue
3. **Click "REVIEW":**
- Puts form in read-only review mode
 - HHA can double-check all entries
 - Click "CANCEL REVIEW" to edit again
4. **Click "COMPLETE VISIT":**
- Opens signature modal
 - HHA enters password to sign
 - Visit is submitted for QA review
 - Status changes to "Pending Review"

What Happens After Completion

- Visit document is created with status "Pending Review"
- Appears in QA Center for RN review
- RN can approve, return for correction, or request changes
- Once approved, visit is locked and counts toward billing

19.4 HHA Supervisory Visit (Detailed)

Understanding HHA Supervisory Visits

HHA Supervisory Visits are **regulatory-required visits** where an RN or LPN evaluates the HHA's performance and competency. These are NOT the same as regular HHA visits - they're oversight visits.

Regulatory Requirement

Medicare Requires:

- **First Supervisory Visit:** Within first 2 weeks of patient admission
- **Ongoing Supervisory Visits:** At least once every 2 weeks while HHA services continue
- **Annual On-Site Supervisory Visit:** At least once per year, conducted in person at patient's home

Who Conducts: RN or LPN (depending on state regulations)

Purpose:

- Ensure HHA is following the care plan

- Assess HHA competency in required skills
- Evaluate HHA's interaction with patient/family
- Review and update care plan if needed

HHA Supervisory Visit Sections

1. Supervision Details

Select HHA(s) Being Supervised:

- Dropdown list of all HHAs assigned to the agency
- Can select multiple HHAs if supervising more than one during the visit
- System may auto-populate based on who's been visiting the patient

Why Multiple HHAs?: If the patient has multiple HHAs rotating visits, you might supervise more than one during a single supervisory visit.

2. Visit Information

- **Aide Present:** Yes or No (Was the HHA present during the supervisory visit?)
 - **Yes:** RN observed HHA working with patient (preferred for annual visit)
 - **No:** RN visited without HHA present (common for routine checks)
- **Visit Date:** Date of the supervisory visit
- **Associated Mileage:** Travel distance
- **Annual On-Site Supervisory Visit Date:** If this is the annual in-person visit, enter the date

Note on "Aide Present":

- Most routine supervisory visits are conducted **WITHOUT** the HHA present
- The annual visit **MUST** be conducted **WITH** the HHA present (observed performing tasks)
- If "No," RN evaluates based on patient/family feedback and documentation review

3. Competency Evaluation

This section assesses the HHA's skills across 10 competency areas:

Competency Areas:

1. Personal Care (Bathing, Grooming, Dressing)
2. Mobility Assistance (Transferring, Ambulation)
3. Medication Reminders
4. Vital Signs Measurement
5. Wound Care
6. Nutrition and Meal Preparation
7. Home Safety
8. Infection Control
9. Documentation

10. Communication with Patient/Family

Rating Options (for each area):

- **Satisfactory:** HHA demonstrates competency
- **Needs Improvement:** HHA needs additional training or supervision
- **N/A (Not Applicable):** Skill not required for this patient's care plan

How to Rate:

- If HHA was **present:** RN observes directly and rates based on performance
- If HHA was **not present:** RN rates based on:
 - Patient/family feedback
 - Review of HHA's documentation
 - Observation of patient's condition and environment

4. Performance Criteria

This section uses a **9-item checklist** to evaluate the HHA's overall performance:

Checklist Items (Yes/No for each):

1. Employee follows and implements the care plan.
2. Employee maintains and implements Standard Precaution per agency policy.
3. Employee is prompt, stays required length of time and is reliable.
4. Employee appears competent in the delivery of service.
5. Employee performs tasks as requested by the client within job description.
6. Employee relates well with the client/family.
7. Employee adheres to the dress code.
8. Employee reports complications and problems to case manager/supervisor.
9. Employee is caring and sympathetic to the client's needs.

Answering:

- Select **Yes** if the criterion is met
- Select **No** if the criterion is NOT met
- Leave blank if unable to assess

If "No" Answers: RN should address issues in the Supervisory Narrative and provide feedback/training to the HHA.

5. Plan of Supervision

This section uses a **3-question checklist** to assess the care plan and service needs:

Questions (Yes/No for each):

1. Is the agency admitting folder readily available?
2. Does the client have a continued need for services?
3. Has the employee's care plan been updated as required?

Purpose:

- Ensures administrative documentation is complete and accessible
- Confirms patient still needs HHA services
- Verifies care plan is current and reflects patient's actual needs

6. Supervisory Narrative

Free-text field for the RN/LPN to document:

- **Summary of Visit:** What was observed or discussed
- **HHA Performance:** Detailed notes on competency and performance
- **Patient/Family Feedback:** What patient or family said about the HHA
- **Care Plan Review:** Any changes needed to the care plan
- **Issues Identified:** Any concerns or areas needing improvement
- **Follow-Up Actions:** What will be done (e.g., retrain HHA on infection control)

Example Narrative:

Conducted supervisory visit with patient and family. HHA was not present. Patient reports HHA arrives on time, stays full visit, and is very kind. Home is clean and well-maintained. Patient's personal care needs are being met - patient is clean, hair brushed, nails trimmed. Patient's daughter states HHA communicates well and follows instructions. Care plan was reviewed with family - no changes needed at this time. Patient continues to need assistance with bathing, dressing, and light housekeeping. Overall, HHA performance is satisfactory. Will continue biweekly supervisory visits.

Completing the HHA Supervisory Visit

1. Fill Out All Sections:

- Select HHA(s) being supervised
- Enter visit information
- Rate all competency areas
- Complete performance checklist
- Answer plan of supervision questions
- Write supervisory narrative

2. Save and Review:

- Click "Save Document" to save progress
- Click "REVIEW" to double-check entries

3. Complete Visit:

- Click "COMPLETE VISIT"
- Enter password to sign
- Visit is submitted for QA review (if required by agency)

Integration with HHA Care Plan

During the supervisory visit, the RN can:

- **View the Active HHA Care Plan:** Button available to open the care plan PDF

- **Update the Care Plan:** If needed, RN can open the care plan editor and make changes
- **Create New Care Plan:** If no care plan exists, RN can create one

This integration ensures the care plan stays current based on supervisory observations.

19.5 Common Workflow for All Visit Forms

While each visit form is unique to its discipline, they all follow a similar workflow:

1. Opening the Visit

- Navigate to **My Day** or **My Schedules**
- Find the scheduled visit
- Click to open the visit form

2. Documenting the Visit

- Fill out visit information (date, times, mileage)
- Complete discipline-specific assessments or tasks
- Record vital signs (if applicable)
- Write clinical narrative
- Save progress frequently

3. Reviewing the Visit

- Click "REVIEW" button
- Form becomes read-only
- Verify all information is accurate
- Click "CANCEL REVIEW" to edit if needed

4. Completing the Visit

- Click "COMPLETE VISIT"
- Enter password in signature modal
- Confirm completion
- Visit is submitted to QA Center

5. QA Review (If Required)

- RN or QA reviewer opens the visit from QA Center
- Reviews for completeness, accuracy, clinical appropriateness
- Can approve, return for correction, or add comments
- Once approved, visit is locked

19.6 Best Practices for Visit Documentation

For All Clinicians

1. **Document Timely:** Complete visits within 24 hours while details are fresh
2. **Be Specific:** Use objective, measurable terms (e.g., "Wound measures 3cm x 2cm" vs. "wound looks better")
3. **Include Patient Response:** How did patient respond to interventions?
4. **Note Changes:** Document any changes in condition, new symptoms, or concerns
5. **Communicate:** Note any calls or communications with physician, family, or team members

For HHAs

1. **Check Care Plan First:** Always review the active care plan before starting the visit
2. **Complete All Tasks:** Mark status for every task - don't leave any blank
3. **Explain "Not Done" or "Refused":** If task wasn't completed, explain why in narrative
4. **Report Issues Immediately:** Don't wait - call RN if patient has concerning symptoms
5. **Be Professional:** Remember your documentation may be read by patient, family, auditors, or attorneys

For RN/LPN Supervisors

1. **Conduct Visits On Schedule:** Don't miss the 2-week supervisory visit requirement
2. **Be Fair and Objective:** Rate HHAs based on actual performance, not personal feelings
3. **Provide Feedback:** Share competency ratings and performance observations with HHAs
4. **Update Care Plans:** Use supervisory visits as an opportunity to review and update care plans
5. **Document Follow-Up:** If issues are identified, document what actions will be taken

19.7 Troubleshooting

Problem: Cannot Open HHA Visit - "No Active Care Plan"

Cause: No active HHA Care Plan exists for the patient's care order.

Solution:

1. Navigate to the patient's OASIS assessment (SOC, ROC, or Recert)
2. Click "Create HHA Care Plan"
3. Add at least 5 tasks
4. Save & Activate the care plan
5. Return to the HHA visit - form should now load tasks

Problem: Cannot Complete HHA Visit - Button is Disabled

Cause: One of these required conditions is not met:

- No active HHA Care Plan exists

- Clinical document hasn't been saved yet
- Required fields are not completed

Solution:

1. Check for "No active HHA Care Plan" message - create care plan if needed
2. Click "Save Document" first before attempting to complete
3. Review form for empty required fields (red asterisks or error messages)

Problem: Tasks Aren't Loading in HHA Visit

Cause:

- Care plan exists but has no tasks
- Care plan is in "Draft" status (not activated)
- Connection error when fetching care plan

Solution:

1. Verify care plan is "Active" (check Care Order Documents tab)
2. Open care plan and ensure it has at least 5 tasks
3. If care plan is "Draft," it needs RN approval
4. Refresh the page and try again

Problem: HHA Supervisory Visit - Can't Find HHA in Dropdown

Cause:

- HHA user doesn't exist in the system
- HHA is not assigned to your branch
- HHA account is inactive

Solution:

1. Go to **Settings** → **User Management**
2. Search for the HHA
3. Verify they have "HHA" role
4. Check they're assigned to the correct branch
5. Ensure their account status is "Active"

19.8 Integration with Other Features

QA Review

All visit forms integrate with the QA Review workflow:

- **Pending Review:** After completion, visits appear in QA Center
- **Soft Alerts:** System checks for common documentation issues
- **Hard Errors:** System blocks approval if critical fields are missing
- **Return for Correction:** QA can send visits back to clinician for edits

- **Approval:** Once approved, visit is locked and counts toward billing

Billing

Completed and approved visits trigger billing:

- **PDGM Grouping:** SN/PT/OT/SLP visits contribute to PDGM scoring
- **HHA Visit Units:** Each HHA visit counts as 1 unit for billing purposes
- **Mileage Tracking:** Travel miles are used for reimbursement calculations
- **Visit Frequency:** System tracks if visits match authorized frequency

Medication Management

Some visit forms (SN, LPN, HHA) include medication documentation:

- **Medication Reconciliation:** Update patient's medication list during visit
- **Medication Profile:** Can view/edit patient medications from within visit form
- **Medication Snapshots:** When visit is approved, medication list is captured

Wound Care

SN and LPN visit forms integrate with wound documentation:

- **Wound Worksheet:** Can open patient's wound worksheet from visit form
- **Wound Care Note:** Dedicated form for wound care visits
- **Photo Upload:** Document wound photos directly in visit form

Chapter 20: OASIS Assessments

Overview

OASIS (Outcome and Assessment Information Set) assessments are **federally-mandated** clinical evaluations required by Medicare and many other payers for home health patients. These assessments determine patient eligibility, establish care plans, calculate payment rates, and measure quality outcomes. This chapter covers all OASIS assessment types, when to use each one, how to complete them, and what happens after approval.

What You'll Learn

- What OASIS is and why it's required
- All 7 OASIS assessment types and when to use each
- How to complete OASIS Start of Care (SOC) - most common first assessment
- How to complete OASIS Recertification - required every 60 days
- How to complete OASIS Resumption of Care (ROC) - after hospital transfer
- Brief overview of Transfer, Discharge, Transfer-Discharge, and Death assessments
- What happens after each OASIS type is approved
- Physician signature requirements
- OASIS submission to CMS workflow

20.1 What is OASIS?

Definition

OASIS stands for **Outcome and Assessment Information Set**. It's a standardized data collection tool developed by the Centers for Medicare & Medicaid Services (CMS) specifically for home health agencies.

Purpose

OASIS assessments serve multiple critical functions:

1. **Patient Eligibility:** Confirms patient meets criteria for home health services
2. **Care Planning:** Establishes the baseline for creating the Plan of Care
3. **Payment Calculation:** Used to calculate PDGM (Patient-Driven Groupings Model) payment rates
4. **Quality Measurement:** Tracks patient outcomes for CMS quality reporting
5. **Regulatory Compliance:** Required by law for Medicare-certified home health agencies

Who Completes OASIS

Only certain disciplines can complete OASIS assessments:

- **RN (Registered Nurse)** - Can complete ALL OASIS types
- **PT (Physical Therapist)** - Can complete SOC and Recert (if PT is primary discipline)

- **SLP (Speech Language Pathologist)** - Can complete SOC and Recert (if SLP is primary discipline)
- **OT (Occupational Therapist)** - Can complete SOC and Recert (if OT is primary discipline)

Important: LPNs, HHAs, and MSWs **CANNOT** complete OASIS assessments.

20.2 OASIS Assessment Types

There are **7 types** of OASIS assessments, each used in specific circumstances:

1. Start of Care (SOC)

- **When:** Patient is admitted to home health for the first time or after a break in service
- **Triggers:** New Admission, New care order
- **Creates:** Initial Plan of Care, establishes baseline
- **Physician Signature: Required**

2. Recertification (Recert)

- **When:** Every 60 days to continue services into a new certification period
- **Triggers:** Approaching end of current 60-day episode
- **Creates:** New 60-day episode, updated Plan of Care
- **Physician Signature: Required**

3. Resumption of Care (ROC)

- **When:** Patient returns to home health after a hospital stay (following an approved Transfer OASIS)
- **Triggers:** After Transfer OASIS is approved and patient returns home
- **Reactivates:** Previously ON_HOLD care order
- **Physician Signature: Required**

4. Transfer

- **When:** Patient is transferred to a hospital, SNF, or another facility (but NOT permanently discharged from home health)
- **Purpose:** Pauses services while patient is away
- **Effect:** Puts care order ON_HOLD, cancels future visits
- **Physician Signature: NOT Required**

5. Discharge

- **When:** Patient no longer needs home health services and is being permanently discharged
- **Purpose:** Officially closes the episode of care
- **Effect:** Closes care order, cancels future visits, closes prior authorizations
- **Physician Signature: NOT Required**

6. Transfer-Discharge

- **When:** Patient is transferred to another facility AND permanently discharged from home health at the same time
- **Purpose:** Combines Transfer + Discharge into one assessment
- **Effect:** Closes ALL care orders, cancels ALL visits, updates patient to DISCHARGED
- **Physician Signature: NOT Required**

7. Death at Home

- **When:** Patient dies at home while receiving home health services
- **Purpose:** Documents circumstances of death for regulatory compliance
- **Effect:** Closes care order, cancels future visits, updates patient to DECEASED
- **Physician Signature: NOT Required**

20.3 OASIS Start of Care (SOC) - Detailed

The screenshot displays the 'Oasis E2 Start of care Note' interface. On the left is a sidebar menu with options: Dashboard, My Schedules, Schedule Center, Patients, Care Orders, QA Center, Clinicians, Physicians / Sources, Pharmacy Setup, Prior Authorizations, Claims Center, Payment Posting, OASIS Submissions, and Reports. The main content area is titled 'Salma Mas' with a 'In Progress' status. It shows patient details: MRN: 10280, Episode Period: 04/02/2026 - 05/31/2026, Scheduled: Apr 2, 2026, 3:00 AM, and Address: 3314 Morse Road Suite 201, Columbus, OH 43231. Below this is the 'OASIS Assessment' section, which includes a list of assessment areas: 1. Intake / Identity (with a sub-item 'A - Administrative Information' marked as complete), 2. Clinical History (with sub-items 'D - Patient History and Diagnoses', 'J - Health Conditions', 'Prognosis', 'Supportive Assistance', 'Respiratory', and 'Cardiac' all marked as complete), and 3. Sensory / Cognitive / Functional. To the right of the assessment list is a 'Basic Profile' section containing fields for: (MO340) First Name (Salma), Middle Name (A), Last Name (Mas), (MO360) Sex (Male), (MO380) Date of Birth (01/01/1960), Phone Number (6148053494), Alternative Phone (N/A), Email (Ll.takar@gmail.com), Address Line 1 (3314 Morse Road Suite 201), Address Line 2 (N/A), City (Columbus), (MO050) State (Ohio), (MO060) Zip Code (43231), Country (Franklin County), Marital Status (Single), (A110A) Primary Language (English), and Medical Record Number (10280). At the top right of the assessment area are buttons for 'Previous', 'Next', 'Save Section', 'D/T review', 'HHA Care Plan Created', and 'Check for Errors'.

When to Complete OASIS SOC

OASIS SOC is completed when a patient is:

- **Newly admitted** to your home health agency
- Starting their **first episode** of care
- Has a care order with reason "New Admission"

Accessing OASIS SOC

1. Navigate to **Care Orders** → Select the patient's care order
2. Click **Schedules** tab
3. Find the OASIS SOC visit (automatically created with the care order)
4. Click to open the visit
5. The OASIS E2 Start of Care Note form opens

OASIS SOC Layout

The form is organized into **6 major workflow groups** with multiple sections:

Left Sidebar shows all sections with completion indicators:

- Green checkmark = Section complete
- Number badges = Number of items in that section

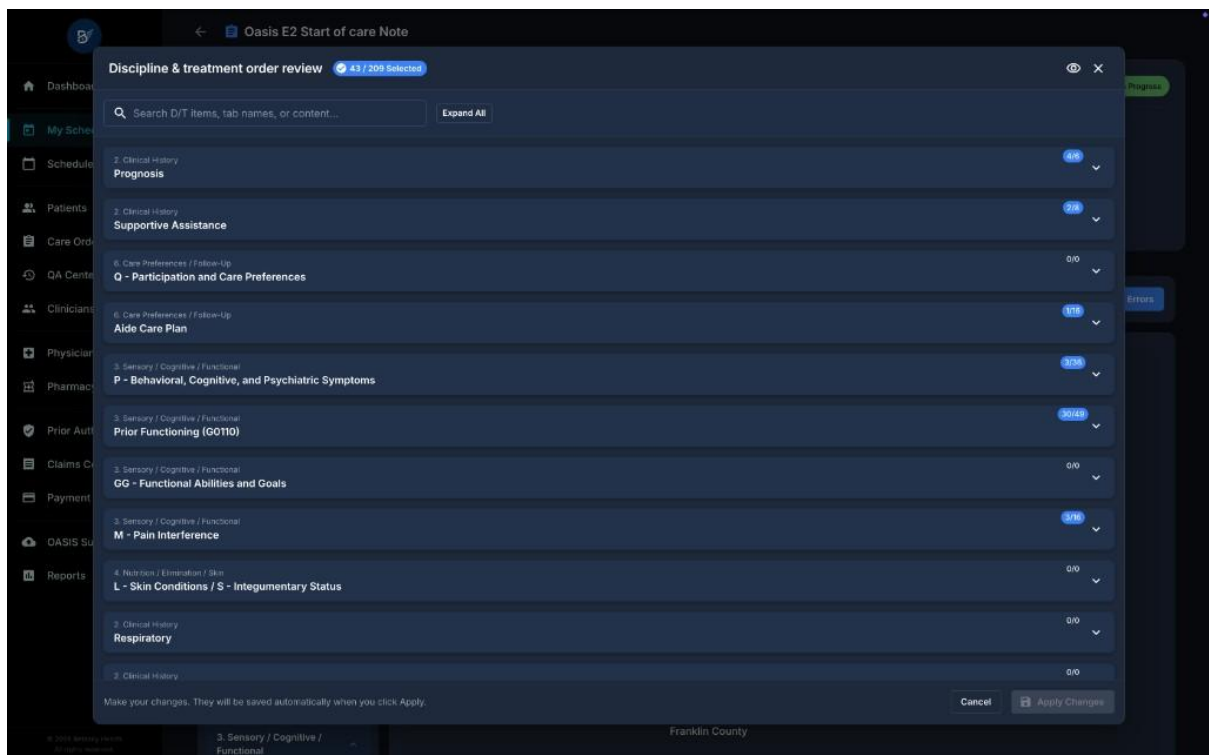
Main Content Area shows the current section's fields

Top Action Bar includes:

- **Previous / Next** buttons (navigate between sections)
- **Save Section** button (blue)
- **D/T Review** button (unique to SOC)
- **✓ HHA Care Plan Created** button (if HHA frequency > 0)
- **Check for Errors** button (blue)

Unique Features of OASIS SOC

1. D/T Review Button



D/T stands for **Discipline & Treatment Order Review**. This button is **unique to SOC** (and Recert).

What It Does:

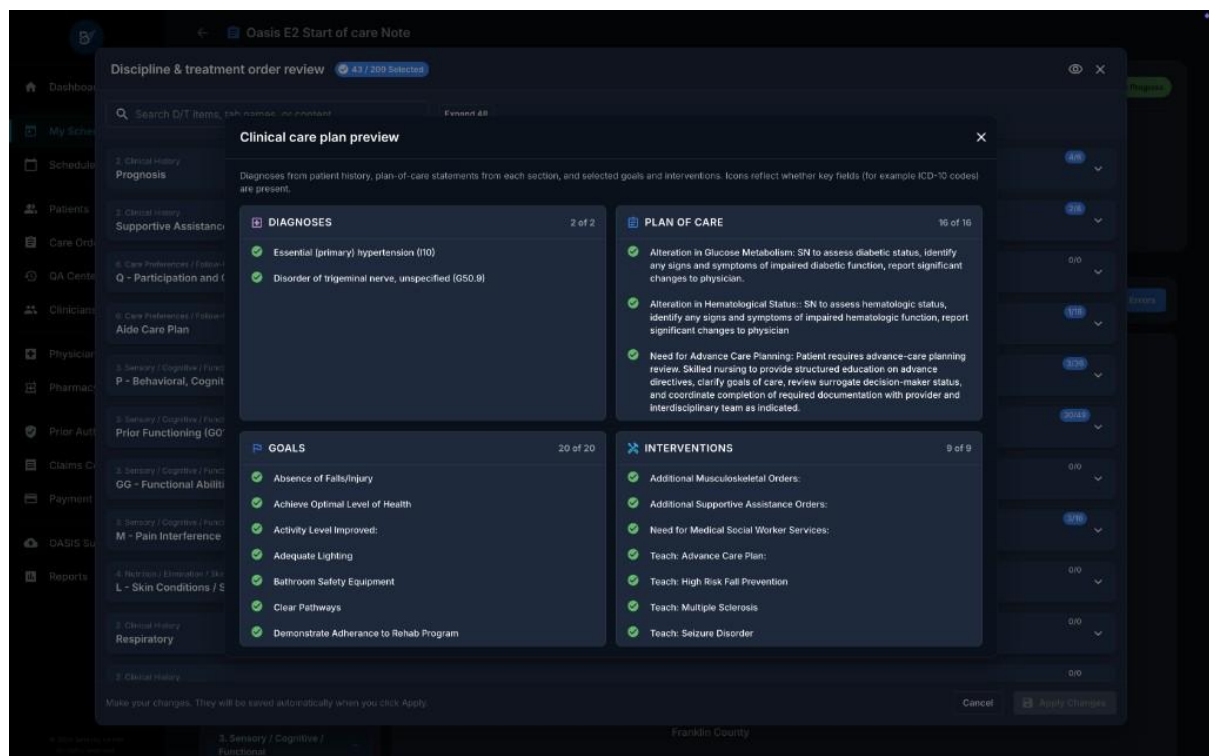
- Opens a modal showing a **searchable list** of all OASIS sections
- Shows completion counts (e.g., "4/4" means 4 out of 4 items completed)
- Clicking on any section scrolls directly to that section in the form
- Helps you quickly navigate large OASIS forms

When to Use It:

- When you need to find a specific section quickly
- When checking which sections are incomplete
- When returning to edit specific items

How It Works:

1. Click "D/T review" button
2. Modal opens with complete section list
3. Use search bar to find sections (e.g., type "respiratory")
4. Click section name or "Expand All" to see all subsections
5. Click "Apply Changes" to close modal



The modal also shows a **Clinical care plan preview** which displays:

- **Diagnoses:** 2 diagnoses from patient history
- **Plan of Care:** Summary of discipline orders
- **Goals:** Selected goals from the assessment
- **Interventions:** Selected interventions (9 of 9 shown in screenshot)

This preview helps you verify that key clinical information is captured before completing the assessment.

2. NO "Plan of Care Profile" Modal

OASIS SOC does **NOT** have a "Plan of Care Profile" button because:

- This is the **first** assessment for this care order
- There is **no previous Plan of Care** to reference
- The SOC creates the initial Plan of Care

Other OASIS types (Recert, ROC, Discharge) **WILL** have a "Plan of Care Profile" button to view/edit the existing Plan of Care.

3. HHA Care Plan Button

If HHA services are ordered (HHA frequency > 0), you'll see:

- "Create HHA Care Plan" button (red) - if no care plan exists
- "✓ HHA Care Plan Created" button (green) - if care plan already exists

Requirement: You **MUST** create the HHA Care Plan before completing the SOC if HHA frequency > 0.

OASIS SOC Sections Summary

The SOC form contains **hundreds of items** organized into these major groups:

1. Intake / Identity:

- Administrative Information (M0010-M0090)
- Patient Demographics
- Current Residence & Living Situation

2. Clinical History:

- Patient History and Diagnoses (M1000-M1051)
- Inpatient Facility Discharge
- Prognosis
- Supportive Assistance
- Respiratory Status
- Cardiac Status

3. Sensory / Cognitive / Functional:

- Sensory Status (Vision, Hearing, Speech)
- Behavioral, Cognitive, and Psychiatric Symptoms
- Prior Functioning (ADL/IADL) - M items
- GG Functional Abilities and Goals - GG codes

4. Skin / Integumentary:

- Skin Conditions
- Pressure Ulcer/Injury Risk Assessment

- Wounds (Number and Status)

5. Medications / Treatments:

- Drug Regimen Review (M2000-M2020)
- Medication Management
- Endocrine (if applicable)
- Supplies / DME

6. Summary of Care:

- Pain (M2200-M2250)
- Care Preferences
- **Summary of Care** - This is where you enter:
 - Discipline frequencies (SN, HHA, PT, OT, SLP, MSW)
 - Treatment frequencies
 - Problems/Diagnoses list
 - Goals
 - Interventions

Completing OASIS SOC Step-by-Step

1. Start with Section 1 (Administrative Information):

- Most fields pre-fill from patient intake
- Verify MRN, demographics, dates
- Move through sections in order

2. Complete Clinical Sections (Sections 2-5):

- Answer all required items (marked with red asterisks)
- Use clinical judgment for assessments
- Reference physician orders and intake data

3. Enter Summary of Care (Section 6):

- Enter discipline frequencies (e.g., SN 2x/week for 8 weeks)
- Enter treatment frequencies (e.g., Wound Care 3x/week)
- Select primary diagnoses
- Enter goals (e.g., "Improve mobility")
- Select interventions (e.g., "Medication management")

4. Create HHA Care Plan (if HHA frequency > 0):

- Click "Create HHA Care Plan" button
- Add minimum 5 tasks
- Set vital sign parameters (optional)
- Save & Activate

5. Check for Errors:

- Click "Check for Errors" button
- System validates all required fields
- Shows any CMS validation errors (Fatal, Warning, Info)
- Shows soft alerts (clinical plausibility checks)
- Fix any Fatal errors before proceeding

6. Complete Visit:

- Click "Complete Visit" button
- Enter password to sign
- Visit is submitted to QA Center
- Document status = "Pending Review"

What Happens After OASIS SOC is Approved

When QA approves the SOC:

1. **Document Status** → "Pending Physician Signature"
2. **Plan of Care is Created** with all discipline frequencies, goals, interventions
3. **OASIS Submission Entry Created** with status "READY_TO_SUBMIT"
4. **Medication Snapshot Taken** (frozen copy of medications at time of approval)
5. **Care Order Awaits Physician Signature** before becoming Active

After Physician Signs the Plan of Care

1. **Care Order Status** → "Active"
2. **Patient Status** → "ACTIVE"
3. **HIPPS Code Calculated** (for Medicare patients - determines payment)
4. **Prior Authorizations Updated** (remaining visits calculated)
5. **Clinicians Can Complete Visits** for this care order

20.4 OASIS Recertification (Recert) - Detailed

When to Complete OASIS Recertification

OASIS Recert is required to extend services into a new 60-day certification period.

Timing Requirements:

- Must be completed **within 14 days BEFORE** the current certification end date
- Must be completed **at least 40 days AFTER** the episode start date
- Initial episode OASIS must be complete and approved

Example:

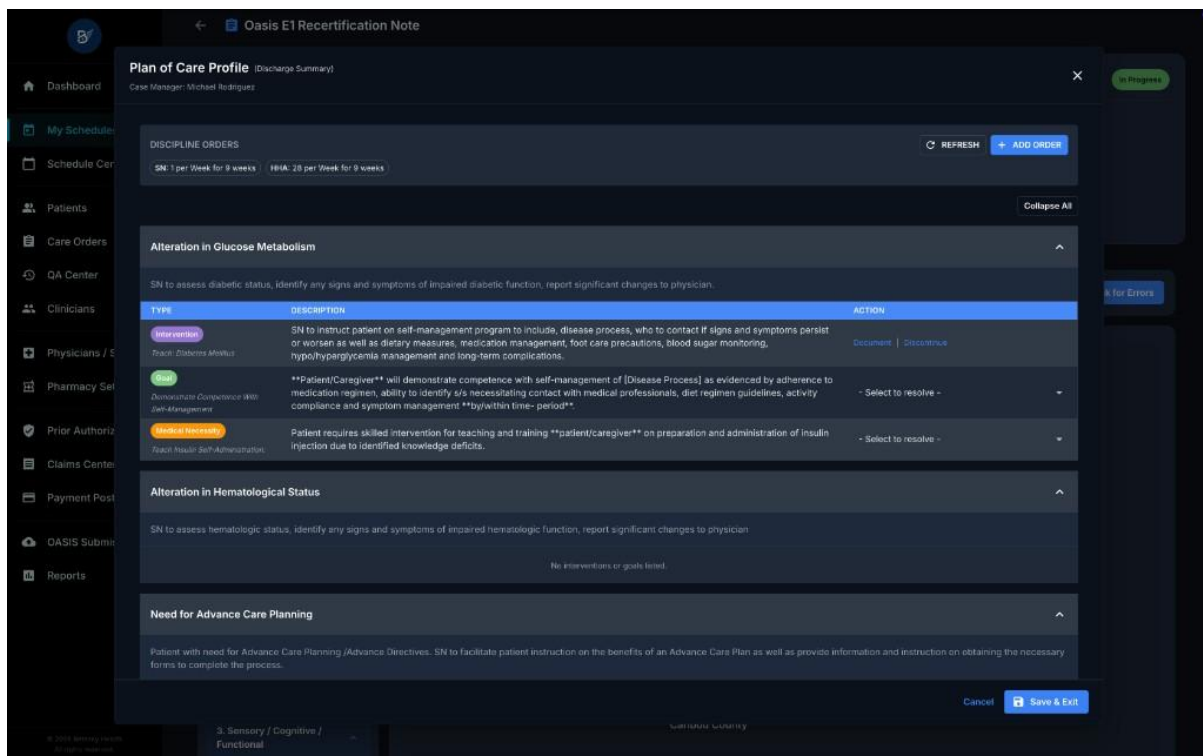
- Episode 1: April 1 - May 30 (60 days)
- Recert Window: May 16 - May 30 (last 14 days)
- Must complete Recert during this window to avoid gap in services

Accessing OASIS Recertification

1. Navigate to **Care Orders** → Select the patient's care order
2. Click **Actions** dropdown (three dots)
3. Select **"Recertification"**
4. System creates a Recert visit
5. Open the Recert visit from Schedules tab
6. The OASIS E1 Recertification Note form opens

Key Differences from SOC

1. Has "Plan of Care Profile" Modal



This is the MAIN difference from SOC!

The "Plan of Care Profile" button allows you to:

- View the current active Plan of Care from the previous period
- Edit discipline frequencies for the new certification period
- Review the Discharge Summary if available
- See current discipline orders (e.g., "SN: 1 pr Week for 8 weeks")
- Refresh the POC to pull latest changes
- Add new orders (e.g., add PT if condition worsened)

Why This Exists:

- During Recert, you're **continuing services** into a new 60-day period
- You need to **review the previous period's plan** and adjust for the new period
- You can increase/decrease frequencies based on patient progress
- You can add/remove disciplines as needs change

How to Use It:

1. Click "Plan of Care Profile" button (in top action bar)
2. Modal opens showing current discipline orders
3. Click "Collapse All" or expand specific sections
4. Review Alteration in Glucose Metabolism, Alteration in Hematological Status, etc.
5. See all interventions and goals from previous period
6. Click "Save & Exit" when done reviewing

2. Has D/T Review Button

Same as SOC - helps navigate the form quickly.

3. Has HHA Care Plan Button

If HHA services continue in the new period:

- Button appears to view/edit the HHA Care Plan
- Can update tasks, vital sign parameters, etc.
- Creates new version of care plan for new period

Recert Sections Summary

Recertification includes **similar sections to SOC** but with some differences:

- **Clinical items focus on CHANGES** since the last assessment
- **Functional items compare** current status to admission status
- **Goals and Interventions** are carried forward but can be updated
- **New diagnoses** can be added if patient's condition changed

Completing OASIS Recertification Step-by-Step

1. Review Previous Plan of Care:

- Click "Plan of Care Profile" to see current orders
- Note discipline frequencies, goals, interventions

2. Complete All Sections:

- Work through sections 1-6 in order
- Update clinical status based on current assessment
- Compare functional status to admission baseline

3. Update Summary of Care:

- Enter new discipline frequencies for the next 60 days
- Adjust frequencies based on patient progress
- Update goals if previous goals were met
- Add/remove interventions as needed

4. Update HHA Care Plan (if applicable):

- Click "✓ HHA Care Plan Created" button
- Review and update tasks
- Save & Activate new version

5. Check for Errors and Complete:

- Click "Check for Errors"
- Fix any Fatal errors
- Acknowledge/resolve soft alerts
- Click "Complete Visit"
- Sign and submit to QA

What Happens After OASIS Recert is Approved

When QA approves the Recert:

1. **Document Status** → "Pending Physician Signature"
2. **NEW 60-Day Episode is Created:**
 - Old episode end date = Day before new start date
 - Old care order status → "Discharged"
 - New care order created with status "Pending Physician Signature"
3. **New Plan of Care Created** with updated frequencies
4. **OASIS Submission Entry Created** for the new episode
5. **Medication Snapshot Taken**
6. **Awaits Physician Signature**

After Physician Signs the Recert Plan of Care

1. **New Care Order Status** → "Active"
2. **Patient Continues** as "ACTIVE"
3. **HIPPS Code Recalculated** for new episode
4. **Prior Authorizations Updated** with new frequencies
5. **Services Continue** seamlessly into new 60-day period

20.5 OASIS Resumption of Care (ROC) - Detailed When to Complete OASIS ROC

ROC is used when a patient **returns home** after being temporarily transferred to a hospital or facility.

Prerequisites:

- A **Transfer OASIS** must have been approved previously
- Patient status must be "TRANSFERRED"
- Care order status must be "ON_HOLD"

Example Scenario:

1. Patient receiving home health services
2. Falls and is hospitalized for 5 days
3. You complete and approve **Transfer OASIS** (puts care on hold)
4. Patient is discharged from hospital and returns home
5. You complete **ROC (Resumption of Care)** to restart services

Similarities to SOC/Recert

ROC form structure is **very similar** to SOC and Recert:

- Same section organization (Intake, Clinical History, Functional, etc.)
- Has "Plan of Care Profile" button (like Recert)
- Has "D/T Review" button
- Has "HHA Care Plan" button (if HHA services continue)

Key Differences

1. Clinical Assessment Focus:

- ROC focuses on **post-hospital condition**
- Documents any changes from the hospitalization
- May show decline or improvement in function

2. Timing:

- Must be completed **within timeframe** after patient returns
- Check with your agency's clinical manager for specific policies

3. Plan of Care Updates:

- Can adjust discipline frequencies based on post-hospital needs
- May add new disciplines (e.g., add PT if patient is now weaker)
- May remove disciplines if no longer needed

What Happens After OASIS ROC is Approved

When QA approves the ROC:

1. **Patient Status** → "ACTIVE" (reactivated)
2. **Care Order Status** → "Pending Physician Signature"
3. **HHA Care Plan Updated** (if tasks were modified in ROC)
4. **OASIS Submission Entry Created**
5. **Awaits Physician Signature**

After Physician Signs the ROC Plan of Care

1. **Care Order Status** → "Active" (services resume)
2. **HIPPS Code Recalculated** (using post-hospital ROC data)
3. **Prior Authorizations Updated** with remaining visits
4. **Visits Can Be Scheduled** and completed again

20.6 OASIS Transfer - Brief Overview

When to Use Transfer

Use Transfer OASIS when a patient is:

- Going to the **hospital** for acute care
- Moving to a **SNF** (Skilled Nursing Facility) temporarily

- Moving to **inpatient rehab** temporarily
- **NOT permanently discharged** - expected to return

Do NOT use Transfer if:

- Patient is permanently leaving home health
- Patient is going to long-term care with no plan to return
- Patient is being discharged entirely

(In those cases, use Discharge or Transfer-Discharge instead)

Transfer Form Structure

Transfer form is **similar to other OASIS forms** with these sections:

- Patient Demographics
- Transfer Information (M0906 Transfer Date - **Required**)
- Clinical status at time of transfer
- Discharge planning items

No D/T Review button - Transfer is a simpler form focused on discharge items.

What Happens After Transfer is Approved

Immediate Effects (this is called the "Safety Sweep"):

1. **Patient Status** → "TRANSFERRED"
2. **Current Care Order** → "ON_HOLD" (services paused)
3. **Future Care Orders** → "CANCELLED" (if any exist)
4. **Future Visits Cancelled** (all visits scheduled after transfer date)
5. **Prior Authorizations Remain Open** (not closed - patient may return)
6. **Document Status** → "Approved" (NO physician signature required)

Result: Services are paused. Patient is expected to return and will need ROC to resume.

20.7 OASIS Discharge - Brief Overview

When to Use Discharge

Use Discharge OASIS when a patient is:

- **Goals met** - no longer needs home health
- **Max benefit achieved** - not progressing further
- **Moving to long-term care** permanently
- **No longer homebound**
- **Refusing services**

Discharge Form Structure

Discharge form includes:

- Discharge Date (M0906 - **Required**)
- Discharge Disposition (where patient is going)
- Clinical status at discharge
- Discharge planning items
- Emergency department use
- Hospitalizations since SOC or last assessment

What Happens After Discharge is Approved

Immediate Effects:

1. **Patient Status** → "DISCHARGED"
 2. **Care Order Status** → "Discharged" (permanently closed)
 3. **Future Visits Cancelled** (all visits after discharge date)
 4. **Prior Authorizations Closed** (status → "closed")
 5. **Compliance Tasks Cancelled**
 6. **Document Status** → "Approved" (NO physician signature required)
- Result:** Episode is permanently closed. Patient is no longer active in home health.

20.8 OASIS Transfer-Discharge - Brief Overview

When to Use Transfer-Discharge

Use Transfer-Discharge when:

- Patient is transferring to another facility **AND**
- Will **NOT be returning** to home health

Example:

- Patient moves to nursing home permanently
- Patient moves to hospice care
- Patient transfers to another home health agency

What Happens After Transfer-Discharge is Approved

Immediate Effects (even more comprehensive than regular Discharge):

1. **Patient Status** → "DISCHARGED"
2. **ALL Care Orders** → "Discharged" (not just current - ALL episodes)
3. **ALL Future Visits Cancelled** (across all care orders)
4. **ALL Prior Authorizations Closed**
5. **ALL Compliance Tasks Cancelled**
6. **Document Status** → "Approved" (NO physician signature required)

Result: Complete closure of patient from home health. Most final OASIS type.

20.9 OASIS Death at Home - Brief Overview

When to Use Death OASIS

Use Death at Home OASIS when:

- Patient dies **at home** while receiving home health services
- Patient dies **in home setting** (not in hospital or facility)

Do NOT use Death OASIS if:

- Patient died in hospital
- Patient died in SNF or other facility

(In those cases, use regular Discharge OASIS)

Death OASIS Form Structure

Death form includes:

- Date of Death (**Required**)
- Clinical status prior to death
- Circumstances of death
- Hospice election (if applicable)
- Discharge planning items

What Happens After Death OASIS is Approved

Immediate Effects:

1. **Patient Status** → "DECEASED"
2. **Care Order Status** → "Discharged"
3. **Future Visits Cancelled**
4. **Prior Authorizations Closed**
5. **Compliance Tasks Cancelled**
6. **Document Status** → "Approved" (NO physician signature required)

Result: Episode is closed. Patient record is marked as deceased for compliance.

20.10 Physician Signature Requirements

Which OASIS Types Require Physician Signature?

Require Signature (3 types):

1. **Start of Care (SOC)** - Establishes initial Plan of Care
2. **Recertification (Recert)** - Establishes new 60-day Plan of Care
3. **Resumption of Care (ROC)** - Updates Plan of Care after hospital return

Do NOT Require Signature (4 types):

4. Transfer - Just pauses services
5. Discharge - Closes episode
6. Transfer-Discharge - Closes all episodes
7. Death at Home - Documents death

What Happens While Waiting for Signature

Document Status: "Pending Physician Signature"

Care Order Status: "Pending Physician Signature"

During This Time:

- Visits **cannot be scheduled** for the new episode (for Recert)
- Services **cannot resume** (for ROC)
- Patient **cannot access care** until signature is obtained

How Long It Takes:

- Depends on physician responsiveness
- Most agencies get signatures within 24-72 hours
- Some use electronic signature systems for faster turnaround

Getting the Physician Signature

The typical workflow:

1. RN prints or emails the Plan of Care to the physician
2. Physician reviews and signs the Plan of Care
3. Agency uploads signed POC or marks as signed in system
4. Care Order is activated
5. Services begin

20.11 QA Review and Approval Workflow From Clinician to QA

1. Clinician Completes OASIS:

- Fills out all sections
- Checks for errors
- Signs and submits
- Document status → "Pending Review"

2. Document Appears in QA Center:

- QA reviewer sees it in their queue
- Can filter by document type, clinician, date
- Opens document for review

3. QA Reviews Document:

- Checks for completeness
- Validates clinical accuracy
- Reviews soft alerts
- Verifies consistency with patient condition

4. QA Takes Action:

- **Approve:** Document moves to next step (signature or final approval)
- **Return for Correction:** Sends back to clinician with notes
- Can add review notes for either action

Three Possible Outcomes

Outcome 1: Approved (Requires Physician Signature)

- For SOC, Recert, ROC
- Status → "Pending Physician Signature"
- Awaits physician signature on Plan of Care
- After signature → Care Order becomes "Active"

Outcome 2: Approved (No Signature Required)

- For Transfer, Discharge, Transfer-Discharge, Death
- Status → "Approved" (final)
- Immediate effects take place (patient status updates, visits cancelled, etc.)

Outcome 3: Returned for Correction

- Status → "Returned for Correction"
- Clinician sees it in their queue with QA notes
- Clinician makes corrections
- Resubmits to QA
- QA reviews again

20.12 OASIS Submission to CMS

After OASIS assessments are approved (and signed if required), they must be submitted to CMS.

OASIS Submission Statuses

1. READY_TO_SUBMIT:

- OASIS is approved and signed (if required)
- Ready to be exported and submitted to CMS
- Appears in "Ready to Submit" tab

2. SUBMITTED:

- Agency has exported the OASIS XML
- Agency has submitted to CMS via their clearinghouse

- Waiting for CMS response

3. **ACCEPTED:**

- CMS has accepted the OASIS submission
- **Care Order becomes "Active"** (if it was Pending Physician Signature)
- This is the final step before billing can proceed

4. **REJECTED:**

- CMS found errors in the OASIS data
- Agency must correct and resubmit
- Common reasons: Invalid dates, missing required items, logic errors

5. **PENDING_CORRECTION:**

- CMS notified agency of needed corrections
- Agency is working on fixes
- Will resubmit after corrections

OASIS Submissions Page

Navigate to **OASIS Submissions** in the sidebar to:

- View all OASIS submissions across all tabs
- Export OASIS XML files
- Mark submissions as "Submitted" after sending to CMS
- Mark as "Accepted" or "Rejected" based on CMS response
- Track submission history

Sandbox Restriction: Export and "Mark Submitted" buttons are disabled in sandbox mode. Go Live agencies can export and submit to CMS.

20.13 Summary Table: All OASIS Types

OASIS Type	When to Use	Physician Signature Required	Patient Status After Approval	Care Order Status After Approval	Future Visits
SOC	New admission	Yes	ACTIVE (after signature)	Pending Physician Signature → Active	Scheduled after activation
Recert	Every 60 days	Yes	ACTIVE (after signature)	New episode: Pending Physician Signature → Active	New episode visits scheduled
ROC	Return after	Yes	ACTIVE	Pending	Scheduled

OASIS Type	When to Use	Physician Signature Required	Patient Status After Approval	Care Order Status After Approval	Future Visits
	transfer		(after signature)	Physician Signature → Active	after reactivation
Transfer	To hospital/facility (temporary)	No	TRANSFER RED	ON_HOLD	Cancelled (after transfer date)
Discharge	Permanently leaving home health	No	DISCHARGED	Discharged	Cancelled (after discharge date)
Transfer-Discharge	Transfer + permanent discharge	No	DISCHARGED	Discharged (ALL orders)	Cancelled (ALL visits)
Death at Home	Patient dies at home	No	DECEASED	Discharged	Cancelled

20.14 Best Practices for OASIS Completion Timing

1. **SOC:** Complete within **5 days of start of care** (or per agency policy)
2. **Recert:** Complete **within 14-day window** before cert end date (don't wait until last day!)
3. **ROC:** Complete **promptly after patient returns** home (same day or next day)
4. **Transfer/Discharge/Death:** Complete **as soon as event occurs** or is known

Accuracy

1. **Use Objective Measures:** Base answers on actual observations and measurements
2. **Be Consistent:** Answers should align with clinical notes and patient condition
3. **Don't Skip Items:** All required items must be completed
4. **Review Before Submitting:** Use D/T Review to double-check sections

Documentation

1. **Support Your Answers:** Clinical notes should support OASIS responses
2. **Explain Declines:** If function worsened, document why (e.g., hospitalization, new diagnosis)
3. **Document Improvements:** If function improved, document interventions that helped
4. **Note Barriers:** Document any barriers to care or goal achievement

Communication

1. **Coordinate with Team:** Discuss patient status with all disciplines before completing
2. **Review with Physician:** Confirm diagnoses and orders match OASIS
3. **Notify QA:** Alert QA if rush approval needed (e.g., patient needs urgent services)
4. **Plan Ahead:** For Recerts, don't wait until the last minute - plan 2-3 weeks in advance

20.15 Common Scenarios

Scenario 1: New Patient Admission (SOC)

Situation: Patient referred from hospital. Discharged 2 days ago. Needs wound care and PT.

Steps:

1. Complete patient intake
2. Create care order (reason: "New Admission")
3. Open OASIS SOC visit
4. Complete all sections (may take 45-90 minutes)
5. Enter Summary of Care:
 - SN: 3x/week for 8 weeks (wound care)
 - PT: 3x/week for 6 weeks (gait training)
6. Check for errors
7. Submit to QA
8. QA approves → Status: "Pending Physician Signature"
9. Get physician signature
10. Care order becomes "Active"
11. Submit OASIS to CMS
12. CMS accepts → Ready to bill

Timeline: 3-7 days from admission to active status

Scenario 2: Continuing Services (Recert)

Situation: Patient's 60-day episode ends May 30. Patient still needs home health.

Steps:

1. Around May 16 (14 days before end), initiate Recertification from care order
2. Open OASIS Recert visit
3. Click "Plan of Care Profile" to review current orders
4. Complete all sections (reassess patient)
5. Update Summary of Care for new period:
 - SN: 2x/week for 8 weeks (reduced from 3x - patient improving)
 - PT: Discharge (goals met)

- Add HHA: 3x/week for 8 weeks (patient now needs personal care assistance)
- 6. Create HHA Care Plan (since adding HHA services)
- 7. Check for errors
- 8. Submit to QA
- 9. QA approves → New episode created
- 10. Get physician signature
- 11. New 60-day period starts June 1

Result: Seamless transition from episode 1 to episode 2.

Scenario 3: Hospital Transfer and Return (Transfer → ROC)

Situation: Patient falls, hospitalized for 3 days, then returns home.

Steps:

Part 1: Transfer OASIS

1. Patient goes to hospital on May 10
2. Complete OASIS Transfer
3. Enter Transfer Date: May 10
4. Submit to QA
5. QA approves → Patient status: "TRANSFERRED", Care order: "ON_HOLD"
6. All visits after May 10 are cancelled

Part 2: ROC OASIS

7. Patient discharged from hospital May 13
8. Patient returns home May 13
9. Complete OASIS ROC
10. Assess post-hospital condition
11. Update Plan of Care if needed (may need more SN visits now)
12. Submit to QA
13. QA approves → Status: "Pending Physician Signature"
14. Get physician signature
15. Care order status: "Active" (services resumed)

Timeline: Services paused May 10-13, resumed May 14+

Scenario 4: Patient Discharge (Discharge)

Situation: Patient's goals met. MD agrees to discharge. Patient no longer needs home health.

Steps:

1. From care order, click Actions → "Discharge"
2. Complete OASIS Discharge
3. Enter Discharge Date (e.g., May 20)
4. Document reason (e.g., "Goals achieved, patient independent")
5. Complete discharge planning items
6. Submit to QA
7. QA approves → Immediate effects:
 - Patient status: "DISCHARGED"
 - Care order: "Discharged"
 - Future visits cancelled
 - Prior authorizations closed
8. Submit OASIS to CMS

Result: Episode permanently closed. Patient successfully discharged.

20.16 Troubleshooting

Problem: Cannot Complete OASIS SOC - "Must Create HHA Care Plan"

Error: "HHA services are ordered. You must create the HHA Care Plan before finalizing this assessment."

Cause: You entered HHA frequency > 0 but haven't created the care plan.

Solution:

1. Check Summary of Care section - confirm HHA frequency is > 0
2. Click the red "Create HHA Care Plan" button
3. Add at least 5 tasks
4. Save & Activate
5. Button turns green: "✓ HHA Care Plan Created"
6. Now you can complete the assessment

Problem: Cannot Submit OASIS - Fatal CMS Errors

Error: "1 Fatal error(s) found. Please fix before completing."

Cause: CMS validation found errors that BLOCK completion.

Solution:

1. Click "Check for Errors" to see full error list
2. Errors show:
 - **Item Number** (e.g., M1800)
 - **Description** of the error

- **Severity** (Fatal = must fix)
- 3. Click on error to navigate to that item
- 4. Fix the issue (e.g., enter missing value, fix invalid date)
- 5. Run "Check for Errors" again
- 6. Repeat until no Fatal errors remain

Problem: OASIS Recert Window Missed

Situation: It's now June 3. Certification ended May 30. You forgot to do Recert.

Cause: Recert must be completed BEFORE cert end date (within last 14 days).

Solution:

- **If gap is small (1-5 days):**

- Contact your clinical manager or agency administrator
- May be able to backdate the Recert visit date (check agency policy)
- Complete Recert with visit date within the window

- **If gap is large (>5 days):**

- Patient may need to be **discharged and re-admitted**
- Complete Discharge OASIS for old episode
- Complete new SOC for new episode
- This is a compliance issue - document reason for late documentation

Prevention: Set up compliance tasks or calendar reminders 21 days before cert end.

Problem: Transfer OASIS Already Approved, But Patient Didn't Actually Transfer

Situation: You completed Transfer OASIS, but patient's hospital stay was cancelled or they refused to go.

Issue: Care order is now ON_HOLD and visits are cancelled.

Solution:

1. Contact your agency administrator or clinical manager
2. This requires **manual database fix** (system doesn't have "undo transfer" feature)
3. Alternative: Complete ROC immediately to reactivate services
4. Document the situation thoroughly in activity log

Prevention: Only complete Transfer OASIS AFTER patient has actually transferred (not before).

Problem: QA Returned OASIS for Correction

Status: "Returned for Correction"

What to Do:

1. Open the OASIS visit from your task list or My Day

2. Read QA's review notes (displayed at top of form or in modal)
3. Make the requested corrections
4. Click "Save Section" for each section you edit
5. Click "Complete Visit" to resubmit
6. Sign again
7. Document goes back to QA queue

Note: You can communicate with QA via the Communication Center if you have questions about their feedback.

Chapter 21: QA Center & Review Workflow

Overview

The **QA (Quality Assurance) Center** is the centralized hub where agency managers and QA reviewers approve, return, or remove clinical documents before they are finalized. Every completed visit form and OASIS assessment must pass through QA review to ensure accuracy, compliance, and quality before being submitted to payers or CMS.

What You'll Learn:

- How documents enter the QA queue and what the dashboard shows
- Understanding the queue table columns (Alerts, Time in Queue, Priority)
- How to run validation checks for OASIS assessments
- Understanding CMS Fatal Errors, Warnings, and Clinical Alerts (Soft Alerts)
- How to approve, return, or remove documents
- Special workflows for documents awaiting physician signature

21.1 Understanding the QA Center Dashboard

When Documents Enter the QA Queue

Documents automatically appear in the QA Center when:

- **Visit Forms:** A clinician completes a visit note (SN, LPN, HHA, PT, OT, SLP, MSW, Supervisory, Wound Care, etc.)
- **OASIS Assessments:** A clinician completes an OASIS SOC, Recert, ROC, Transfer, Discharge, Transfer-Discharge, or Death assessment
- **Status:** The document's status is **"Pending Review"** or **"Pending Physician Signature"**

The screenshot displays the QA Center dashboard for Coastal Wellness Home Health. The top navigation bar includes the agency name, user profile (Michael Rodriguez), and system settings. The left sidebar lists various dashboard sections, with 'QA Center' currently selected. The main content area is divided into two parts: a summary section and a detailed 'Documents Queue' table.

QA Center Summary:

- All Pending Items: 5
- OASIS Pending: 1
- Notes Pending: 4
- Avg. Approval Time: 14 hours

Documents Queue Table:

PATIENT NAME	VISIT DATE	DOCUMENT TYPE	STATUS	ALERTS	CLINICIAN	TIME IN QUEUE	PRIORITY	ACTIONS
Realtax ford	Jan 13, 2026	OASIS - E1 Resumption of Care	Pending Review	3	Abebe Goben	751 hours	High	Review
Ibrahim Omar	Mar 03, 2026	OASIS - E1 Start of care	Pending Physician Signature	4	Michael Rodriguez	609 hours	High	Review
Hosyo Hosyo	Apr 02, 2026	OASIS - E2 Start of care	Pending Physician Signature	1	Michael Rodriguez	188 hours	High	Review
Quanaa Shoma	Apr 06, 2026	HHA Note	Pending Review	—	Michael Rodriguez	117 hours	High	Review
Quanaa Shoma	Apr 06, 2026	SN Note	Pending Review	—	Michael Rodriguez	117 hours	High	Review
Quanaa Shoma	Apr 06, 2026	HHA Supervisory Visit	Pending Review	—	Michael Rodriguez	117 hours	High	Review
Quanaa Shoma	Apr 06, 2026	HHA Note	Pending Review	—	Michael Rodriguez	115 hours	High	Review

Showing 1 - 7 of 7 documents

Key Elements on This Screen:

1. Statistics Cards (Top Row):

- **All Pending Items:** Total number of documents waiting for QA review across all types
- **OASIS Pending:** Number of OASIS assessments (SOC, Recert, ROC, Transfer, Discharge, etc.) in the queue
- **Notes Pending:** Number of visit notes (SN, LPN, HHA, PT, OT, SLP, MSW, etc.) in the queue
- **Avg. Approval Time:** Average time it takes for documents to be reviewed and approved (measured in hours). This helps agencies track QA efficiency.

2. **Documents Queue Table:** A detailed list of all pending documents with powerful filtering and search capabilities

21.2 The Documents Queue Table (Deep Dive)

The queue table is where you manage all pending documents. Each column serves a specific purpose:

Columns Explained in Detail

1. Patient Name

- Displays the patient's first and last name as a clickable link
- Clicking the name takes you directly to the document review page
- **Warning Icon:** If you see a yellow warning icon next to the name, this is a **Missed Visit** document. The clinician documented a visit that was marked as "Missed" in the system.

2. Visit Date

- The scheduled date of the visit or assessment (format: MMM dd, yyyy, e.g., "Jan 13, 2026")
- For OASIS assessments, this is the date the assessment was performed
- Use the **Visit Date filter** above the table to narrow down documents by a specific date

3. Document Type

- Shows the type of clinical document:
 - **OASIS Forms:** "OASIS - E1 Resumption of Care," "OASIS - E2 Start of care," "OASIS - E1 Recertification," etc.
 - **Visit Notes:** "SN Note," "HHA Note," "HHA Supervisory Visit," "PT Visit," "Wound Care Note," etc.
- **"Missed" Chip:** If a visit was marked as "Missed" by the system, you'll see a yellow "Missed" chip next to the document type
- Use the **Document Type dropdown filter** to show only specific types (e.g., "All Document Types," "OASIS," "SN," "HHA")

4. Status

- The current review status of the document:
 - **Pending Review** (Blue chip): The document is ready for QA to review and approve or return
 - **Pending Physician Signature** (Orange/Warning chip): The document has been approved by QA but is waiting for the physician to sign it (applies only to OASIS SOC, Recert, and ROC). Once the physician signs, the Care Order becomes "Active."

5. Alerts (Critical Column)

- **What This Shows:** The total number of validation issues found the **last time QA clicked "QA Review" (Check for Errors)** on this document
- **Alert Count = CMS Fatal Errors + CMS Warnings + Clinical Alerts (Soft Alerts)**
- **Display:**
 - **Number in Orange:** If there are alerts (e.g., "3"), they are shown in bold orange, indicating issues to review
 - **"—" (Dash):** QA has not yet clicked "QA Review" for this document, so no validation has been run
 - **"0":** QA ran validation, and no issues were found

Important: This alert count is **cached from the last QA Review scan**. If the clinician edits the document after QA initially reviewed it, the alert count won't automatically update. QA must click "QA Review" again to refresh the count.

Why This Matters:

- You can prioritize high-alert documents first
- If a document shows "5" alerts, you know to expect validation issues when you review it
- If alerts are "—", you should run "QA Review" before approving to catch any issues

6. Clinician

- The name of the clinician who completed the document (e.g., "Michael Rodriguez, RN" or "Abebe Geben, PT")
- If the clinician is unassigned or unknown, it shows "Unassigned" or "Unknown"

7. Time in Queue (Critical Column)

- **What This Shows:** How long the document has been waiting for QA review since it was submitted
- **Calculation:** Time is measured from the `submittedAt` timestamp (when the clinician completed the form) to the current time, displayed in hours (e.g., "751 hours," "800 hours," "117 hours")
- **Color Indicators:**
 - **Red Text (Bold):** The document is **Overdue** (exceeds the agency's overdue threshold). For most documents, this is after 72 hours (3 days). For compliance documents, it may be 24 hours.
 - **Black Text (Normal):** The document is within the normal timeframe

How Time Thresholds Work (Behind the Scenes):

- Your agency has two types of documents:
 - **Normal Documents** (visit notes, non-compliance OASIS): Overdue threshold is typically 72 hours
 - **Compliance Documents** (OASIS SOC, Discharge, Transfer, Death): Overdue threshold is typically 24 hours (stricter timeline due to regulatory deadlines)
- These thresholds are configurable in **Clinical Settings** by your administrator

Why This Matters:

- Red, overdue documents should be reviewed immediately to avoid delays in billing or regulatory submissions
- Sorting by "Time in Queue" helps you tackle the oldest documents first

8. Priority (Critical Column)

- **What This Shows:** A **red alert icon** appears if the document has been in the queue for a critically long time
- **How It Works:**
 - Normal documents: Priority icon appears after ~48 hours (agency-configurable)
 - Compliance documents: Priority icon appears after ~12 hours (stricter)
- **Display:**
 - **Red Circle Icon with "!"**: Document is flagged as **Priority** and needs immediate attention
 - **Empty**: Document is not yet priority

Why This Matters:

- Priority flags help you identify documents that are at risk of missing deadlines
- You can quickly scan the queue for red icons and tackle those first
- Combined with "Time in Queue," this ensures critical documents don't get lost in the queue

9. Actions

- **Review Button (Blue):** Clicking this takes you to the detailed document review page where you can:
 - View the complete clinical form
 - Run validation checks (for OASIS)
 - Approve, return, or remove the document

21.3 Filtering and Searching the Queue

The QA Center provides powerful filters to help you manage large volumes of documents:

Search by Patient Name

- Type any part of the patient's first or last name in the "**Search by patient name...**" box
- The table updates instantly to show only matching patients

- Example: Typing "Real" will show "Realtest Forpdf"

Filter by Visit Date

- Click the **Visit Date** calendar picker
- Select a specific date to show only documents from that day
- This is useful when reviewing documents from a specific day's schedule

Filter by Document Type

- Click the **Document Type** dropdown
- Options include:
 - **All Document Types:** Show everything
 - **OASIS:** Show only OASIS assessments (SOC, Recert, ROC, Transfer, Discharge, etc.)
 - **SN, HHA, PT, OT, SLP, MSW, etc.:** Show only specific visit note types
- The system automatically extracts unique document types from your queue

Pro Tip: Use filters together. For example, filter by "OASIS" + a specific date to review all assessments from that day.

21.4 Reviewing a Document

When you click the **"Review"** button for any document, you're taken to the **Document Review Page**.

The screenshot shows the 'Document Review Page' for a document titled 'Realtest forpdf'. The page is divided into several sections:

- Header:** Includes the user's name 'Michael Rodriguez' and the agency 'Coastal Wellness Home Health'.
- Document Information:** Displays the patient's name 'Realtest forpdf', age '55y 3m', gender 'Male', MRN '1018', and DOB 'Jan 01, 1970'. It also shows risk levels: 'Fall Risk: Low', 'Hospitalization Risk: Low', and 'Infection Risk: Moderate'.
- Document Details:** Shows the status 'Pending Review', the submission date 'Mar 10, 2026', and the return count '3 times'.
- Return History:** Lists three previous returns:
 - Return #3 (Resubmitted):** Returned Jan 27, 2026 + Resubmitted Mar 10, 2026. By: Michael Rodriguez. Note: Patient is still active pls make sure the patient is transferred.
 - Return #2 (Resubmitted):** Returned Jan 19, 2026 + Resubmitted Jan 18, 2026. By: Michael Rodriguez. Status: Returned.
 - Return #1 (Resubmitted):** Returned Jan 14, 2026 + Resubmitted Jan 14, 2026. By: Michael Rodriguez. Note: check it is not allowing to approve.
- Internal Comments:** A section for adding comments, currently showing 'No comments yet'.
- Footer:** Includes a 'Clinical Form' link and a 'QA Review' button.

What You See:

1. Top Bar:

- **Back Arrow:** Returns to the QA Center queue
- **Patient Name & Basic Info:** Patient's name, age, gender, MRN, DOB, risk indicators (Fall Risk, Hospitalization Risk, etc.)
- **Status Badge:** "Pending Review" or "Pending Physician Signature"
- **"Pending Review" Status Indicator (Top Right):** Shows the current workflow state
- **Actions Dropdown:** "Approve," "Return," "Remove" (we'll cover these in detail below)

2. Left Side (Document Information & Return History):

- **Visit Date:** When the visit or assessment occurred
- **Time in Queue:** How long it's been since submission
- **Clinician:** Who completed the document
- **Document Type:** Full document name (e.g., "OASIS - E1 Resumption of Care")
- **Return History (If Applicable):** If this document has been returned to the clinician before, you'll see a list of all previous returns with:
 - Return date and time
 - Reviewer who returned it
 - Reason for return (review notes)

3. Right Side (Internal Comments):

- **Comments Area:** QA team members can leave internal notes for each other about this document
- **Add a Comment:** Type a note and click "Send" to add it
- **Delete Comment:** If you authored a comment, you can delete it
- **Use Cases:**
 - "Spoke with clinician about missing medication review - will update by EOD"
 - "Flagged for follow-up on wound measurement discrepancy"
 - "Waiting for physician callback to verify diagnosis code"

4. Clinical Form Section (Bottom):

- **"QA Review" Button (Blue, For OASIS Only):** Clicking this runs a comprehensive validation check on the OASIS assessment. We'll cover this in the next section.
- **Form Content:** The actual clinical document is displayed in read-only mode. You can scroll through all sections to review the clinician's documentation.

21.5 Running "QA Review" (Validation Check for OASIS)

For **OASIS assessments only**, the system provides a powerful "QA Review" button that scans the entire form for errors and clinical inconsistencies.

What Happens When You Click "QA Review":

1. The Button Changes:

- Button text changes to "**Scanning...**" with a spinning loader
- The system is now checking the OASIS assessment against **three types of validation:**

2. Three Validation Checks Run Simultaneously:**a. Agency Required Fields Check:**b. CMS Validation Check (Fatal & Warnings):****c. Clinical Plausibility Alerts (Soft Alerts):****

- The system checks if all fields marked as "required" by your agency's internal policy are filled in
- These are fields your agency has designated as mandatory beyond what CMS requires
- Example: Your agency may require a detailed social history note for all SOC assessments
- **Fatal Errors:** CMS edit rules that **MUST** be fixed before the assessment can be submitted to CMS. If any fatal errors exist, the document cannot be finalized.
- **Warnings:** CMS edit rules that flag potential issues but **do not block** submission. These are advisory and should be reviewed, but you can proceed if the clinician has a valid reason.
- Examples of CMS errors:
 - "Use sequence error: Info Completed Date (M0090/M0100) cannot be before Start of Care Date (M0030/M0032)"
 - "Date of Birth (M0066) – Year of Birth must be within 5 days of Start of Care Date (M0030)"
 - "Height Out of Expected Range (SA.SOC.NUTR.048): Patient height (Weight: 8lbs) is outside expected range (80-64 inches). Verify measurement."
- The system runs **soft alerts**, which are non-CMS, clinical plausibility checks to flag unusual or inconsistent documentation
- These are **INFO** or **WARN** level alerts, not errors. They are advisory and meant to help QA catch potential mistakes or prompt clinician clarification.
- Examples:
 - **Grooming vs Dressing Inconsistency (SA.SOC.FUNC.001):** "Patient needs assistance with grooming (M1810=1) but is independent with dressing (M1830=0, M1840=0). This is clinically unusual."
 - **Bowel Incontinence Toileting Independence (SA.SOC.ELIM.038):** "Patient has severe transfer limitations (M1850=3) but no pressure ulcer documented. High-risk population."
 - **No Signed Medication Review (SA.SOC.MEDS.074B):** "Patient is on hypoglycemic medications but no signed medication review is documented. Review medication profile for drug interaction check."

3. Validation Results Modal Opens:

What You See in This Modal:

- **Modal Title: "Validation Results"**
- **Chips at the Top (Summary):**
 - **"1 Clinical Alert" (Blue Chip):** Shows the count of soft alerts
 - If there were fatal errors: **"X CMS Fatal" (Red Chip)**
 - If there were warnings: **"X Warnings" (Orange Chip)**
 - If there were agency required field issues: **"X Required Fields" (Red Chip)**
- **Minimize Button (Top Right, "—" icon):** Clicking this minimizes the modal to a small draggable box in the corner. This allows you to review the form and navigate to specific fields while keeping the validation results visible. Click the minimized box to expand it again.
- **Close Button (Top Right, "X" icon):** Closes the modal entirely

21.6 Understanding Validation Error Types (In-Depth)

When you run "QA Review," the modal displays errors in **sections** by severity. Let's break down each type:

Section 1: Agency Required Fields (Red Alert Box)

What This Means:

- These fields are **mandatory by your agency's policy**, even if CMS doesn't require them
- **Must be completed** before you can approve the document

- Example message: "Agency Required: Social History narrative is missing (Intake > Demographics). Complete this section before approval."

What You Do:

- Click "Close & Fix Errors"
- The modal closes, and you can see the form below
- Scroll to the section mentioned (or use the navigation if provided)
- **Return the document** to the clinician with a clear note explaining what's missing

Section 2: HHA Care Plan Required (Red Alert Box)

What This Means:

- For OASIS SOC and ROC assessments, if the Plan of Care includes HHA (Home Health Aide) orders with frequency > 0, the clinician **MUST** create an active HHA Care Plan before completing the assessment
- This is a system-enforced rule to ensure HHAs have documented instructions

Example Message:

- "HHA services are ordered. You must create the HHA Care Plan before finalizing this assessment."

What You Do:

- Return the document to the clinician with a note: "HHA Care Plan is missing. Please create the HHA Care Plan from the 'HHA Care Plan' button on the OASIS form before resubmitting."

Section 3: CMS Fatal Errors (Red Alert Box)

Remove this document [X]

This document will be marked as removed and will no longer appear in the QA queue. Provide a reason for audit purposes.

Episode already closed (Deceased/Discharged)

Common reasons:

Episode already closed (Deceased/Discharged) Duplicate document Wrong patient or visit Submitted in error

Other

Cancel Remove document

What This Means:

- These are **CMS edit rule violations** that will cause the OASIS assessment to be **rejected by CMS** if submitted
- **Must be fixed** before finalizing the document
- Each error shows:
 - **Error Message:** Human-readable description of the issue
 - **CMS Edit ID:** The official CMS edit code (e.g., "CMS Edit -3060," "SA.SOC.FUNC.001")
 - **Item Code:** The OASIS item that failed (e.g., "M0100," "M1810," "GG0130A")
 - **"(Click to fix)" Link:** If available, clicking this link navigates directly to the problematic field in the form (only works when the modal is minimized or closed)

Examples of CMS Fatal Errors:

1. Date Sequence Error:

- Message: "Use sequence error: Info Completed Date (M0090/M0100) cannot be before Start of Care Date (M0030/M0032)."
- Meaning: The clinician entered an assessment completion date that is earlier than the start of care date. This is logically impossible.
- What to do: Return the document with a note: "Please correct the dates. The assessment completion date (M0100) must be on or after the Start of Care date (M0030)."

2. Grooming vs Dressing Inconsistency:

- Message: "Grooming vs Dressing Inconsistency (SA.SOC.FUNC.001): Patient needs assistance with grooming (M1810=1) but is independent with dressing (M1830=0, M1840=0). This is clinically unusual."
- Meaning: It's rare for a patient to need help with grooming but be fully independent with dressing. This may indicate a documentation error.
- What to do: Return with a note: "Please review functional status documentation. It's unusual for a patient to need grooming assistance but be independent with dressing. Verify these values."

3. Weight Out of Expected Range:

- Message: "Weight Out of Expected Range (SA.SOC.NUTR.048): Patient weight (Weight: 8lbs) is outside expected range (80-200 lbs). Verify measurement."
- Meaning: The entered weight is implausibly low (8 lbs for an adult is clearly a typo).
- What to do: Return with a note: "Patient weight is entered as 8 lbs, which is incorrect. Please verify and update the weight measurement."

What You Do:

- Read each fatal error carefully
- If you can see the form below (or minimize the modal), navigate to the problematic field to understand the issue
- **Return the document** to the clinician with a clear, specific note for each error

Section 4: Warnings (Orange Alert Box)

Help & Training 10:08 PM

Document removed from QA successfully.

Avg. Approval Time

14 hours

Visit Date dd/mm/yyyy

Document Type All Document Types

CLINICIAN	TIME IN QUEUE	PRIORITY	ACTIONS
Michael Rodriguez	609 hours	!	Review
Michael Rodriguez	186 hours	!	Review

What This Means:

- These are **CMS warnings**, not fatal errors
- They **do not block submission** to CMS, but they flag potential issues
- You can approve the document even if warnings exist, but you should review them

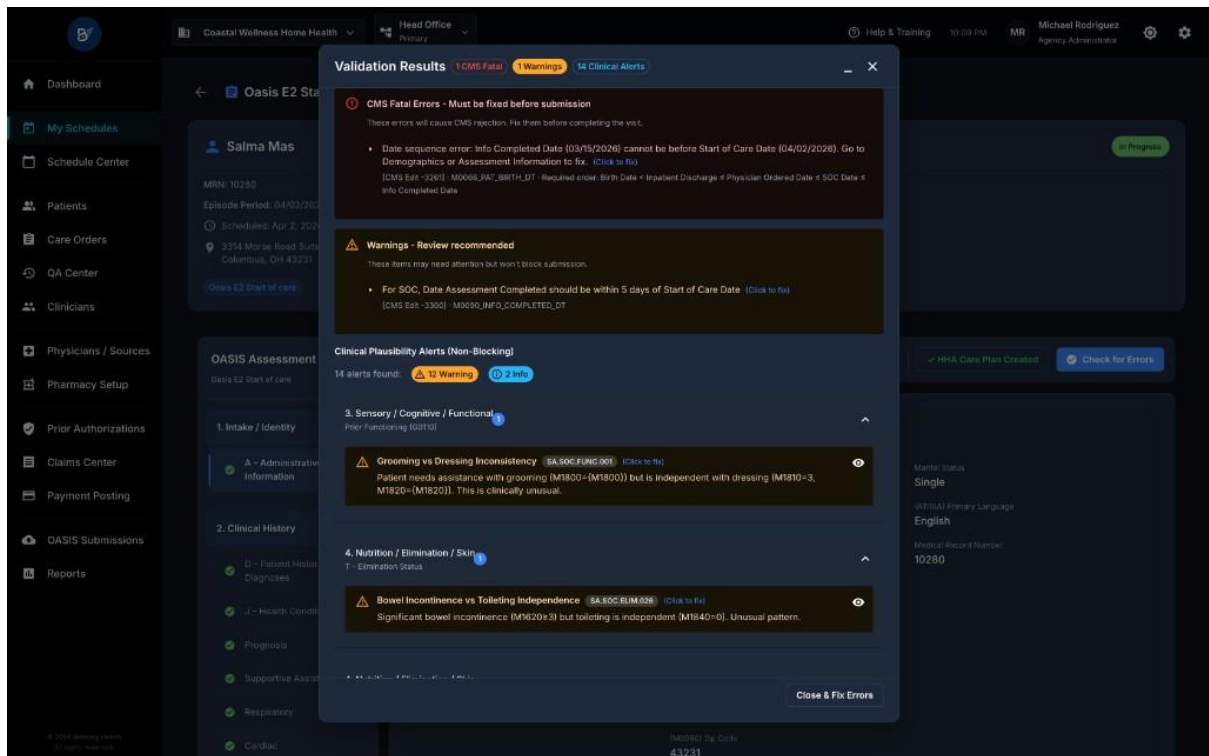
Example Warning:

- Message: "For SOC, Date Assessment Completed should be within 5 days of Start of Care Date (M0030). Current gap: 14 days."
- Meaning: CMS recommends completing the SOC assessment within 5 days of the start of care date. This assessment was completed 14 days later. CMS will accept it, but it's outside the recommended timeframe.

What You Do:

- Review the warning and decide:
 - **If it's explainable:** (e.g., the patient was hospitalized during that window, delaying the assessment), you can approve with an internal comment noting the reason
 - **If it seems wrong:** Return to the clinician with a note: "Assessment was completed 14 days after SOC. Please verify the completion date or provide a note explaining the delay."

Section 5: Clinical Plausibility Alerts (Soft Alerts) (Blue Info Box)



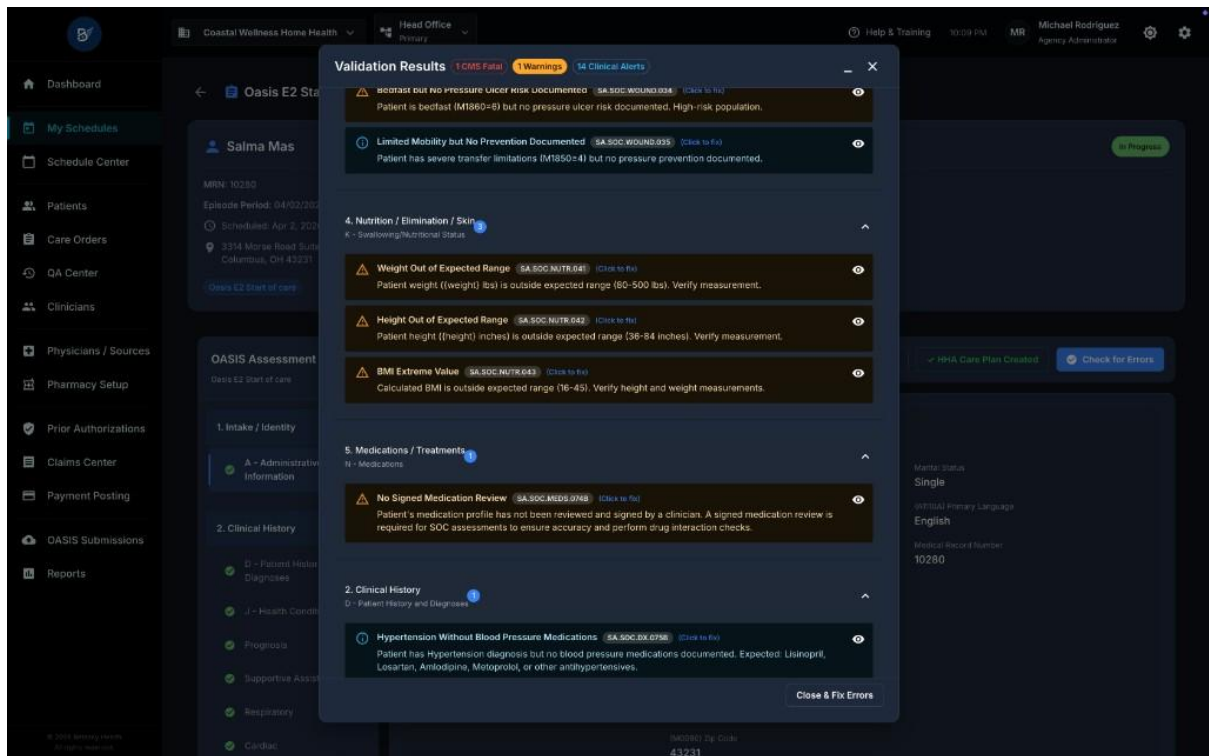
What This Means:

- These are **non-CMS, clinical plausibility checks** designed to catch unusual or inconsistent documentation
- They are **informational or warning level** and **do not block approval**
- Soft alerts are grouped into **packs** (categories) like:
 - **FUNC** (Functional Status)
 - **NEURO** (Neuro/Cognition)
 - **GG** (GG Functional Abilities)
 - **ELIM** (Elimination Status)
 - **WOUND** (Wound/Integumentary)
 - **NUTR** (Nutrition)
 - **MEDS** (Medications)
 - **SUPP** (Supportive Assistance)
 - **DX** (Diagnosis)

- **CROSS** (Cross-Module Checks)

How Soft Alerts Are Displayed:

- The modal shows a collapsible section titled "**Clinical Plausibility Alerts (Non-Blocking)**"
- Each pack (e.g., "FUNC," "MEDS") has a header showing the number of alerts in that category
- Click the header to expand and see individual alerts



Example Soft Alerts:

1. Grooming vs Dressing Inconsistency (FUNC Pack, SA.SOC.FUNC.001):

- **Severity:** INFO
- **Message:** "Patient needs assistance with grooming (M1810=1) but is independent with dressing (M1830=0, M1840=0). This is clinically unusual."
- **Evidence:** Shows the exact OASIS items and their values (e.g., "M1810: Current Ability to Dress Upper Body Safely = 1 - Requires minimal assistance")
- **Recommended Actions:**
 - "Review functional status assessment with clinician"
 - "Verify patient is truly independent with dressing if grooming requires assistance"
 - "Consider if grooming includes specialized tasks (e.g., oral care) that may explain the discrepancy"

2. Diabetes Diagnosis but No Hypoglycemic Medication (MEDS Pack, SA.SOC.MEDS.075A):

- **Severity:** WARN

- **Message:** "Patient has Diabetes diagnosis (ICD-10: E11.9) but no hypoglycemic medications documented. Review medication list."
- **Evidence:** Shows the diagnosis code and the absence of hypoglycemic medication classes in the patient's medication profile
- **Recommended Actions:**
 - "Verify patient is not on insulin or oral hypoglycemic agents"
 - "If patient is diet-controlled, document this in the clinical notes"
 - "Review with clinician if medication list is incomplete"

3. No Signed Medication Review (MEDS Pack, SA.SOC.MEDS.074B):

- **Severity:** WARN
- **Message:** "Patient is on hypoglycemic medications but no signed medication review is documented. Review medication profile for drug interaction check."
- **Evidence:** Shows that the patient is on medications requiring interaction checks, but no signed medication review exists in the system
- **Recommended Actions:**
 - "Complete a signed medication review in the Medication Profile"
 - "Perform drug interaction check (required for SOC per CMS guidance)"
 - "Document any identified interactions or contraindications"

What You Do with Soft Alerts:

- **Review them carefully** to understand if they flag real issues or are explainable
- **INFO Alerts:** These are minor inconsistencies. If they seem reasonable, you can approve without action. If they seem wrong, return to the clinician with a note.
- **WARN Alerts:** These are more significant clinical concerns. You should either:
 - Verify the clinician's documentation is correct (e.g., call the clinician to discuss)
 - Return the document with a note asking for clarification or correction
 - Add an internal comment documenting why you're approving despite the alert

Pro Tip: Soft alerts are **learning tools**. Over time, they help clinicians improve documentation quality and catch mistakes before they become billing or compliance issues.

21.7 Approving, Returning, or Removing Documents

After reviewing the document and (for OASIS) running validation checks, you have three actions:

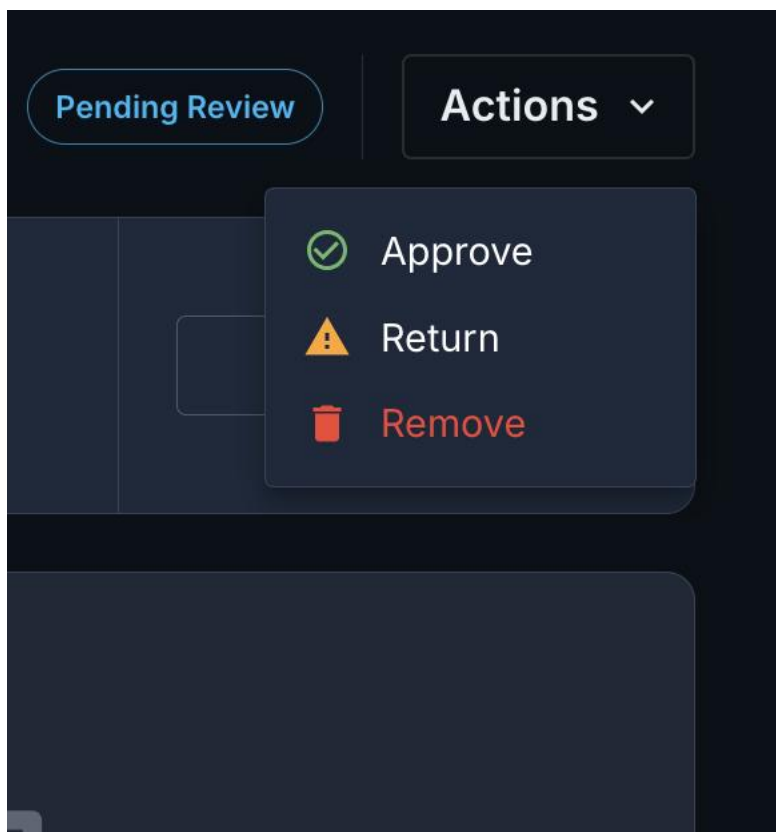
Action 1: Approve

When to Use:

- The document is complete, accurate, and meets all requirements
- For OASIS: No fatal errors exist (warnings and soft alerts are acceptable if explainable)
- The clinician's documentation is clear and clinically sound

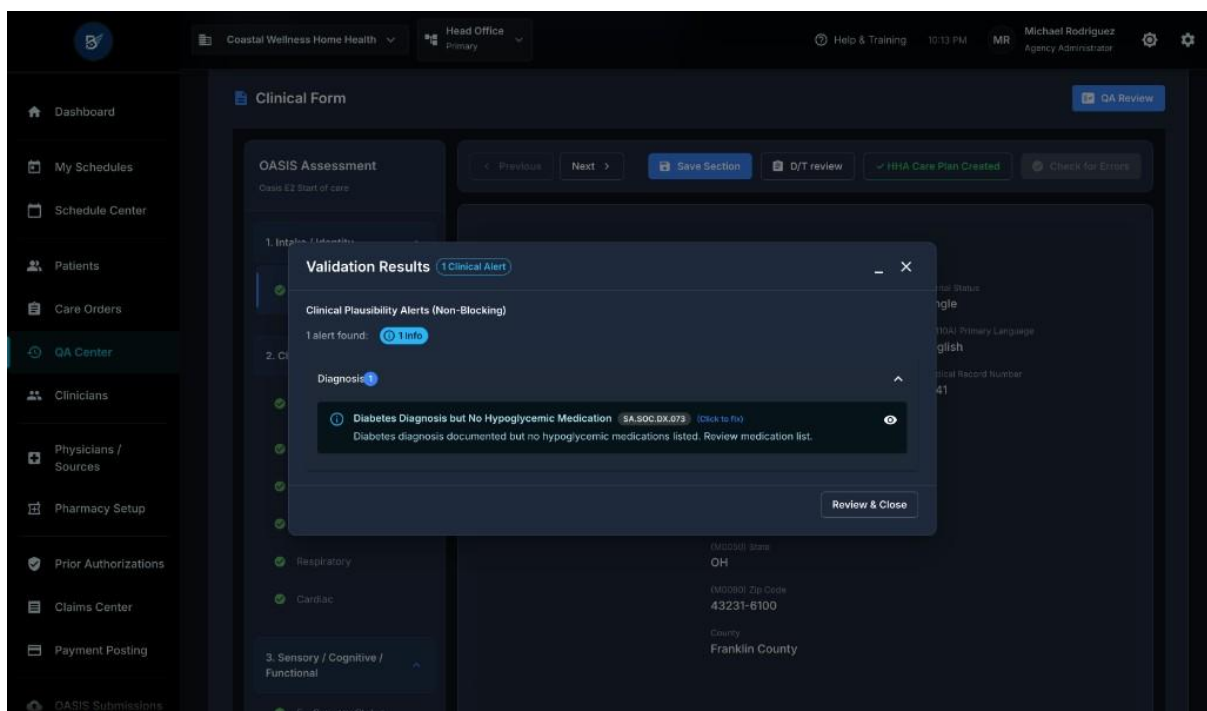
How to Do It:

1. Click the **"Actions"** dropdown (top right of the review page)



2. Select **"Approve"**

3. The **"Approve & Finalize"** modal appears:



What You See:

- **Modal Title: "Approve & Finalize"**

- **Message:** "You are about to approve this document. Once approved, it will be locked and sent to the physician for signature." (This message varies depending on the document type. For non-OASIS documents, it may say "locked and finalized.")
- **Certifying Physician Info (For OASIS SOC/Recert/ROC):** Shows the physician name, facility, and NPI number who will need to sign the document
- **Optional Internal Note Field:** You can add a note for the care order record (e.g., "Approved after clinician corrected medication list")
- **Cancel Button:** Returns to the review page without approving
- **"Confirm Approval" Button (Green):** Completes the approval

4. Click "Confirm Approval"

What Happens After Approval:

- **For OASIS SOC, Recert, ROC:**
 - Status changes to **"Pending Physician Signature"**
 - The document is locked (clinician and QA cannot edit it)
 - A notification is sent to the certifying physician to sign the document electronically
 - Once the physician signs, the Care Order status changes to **"Active"** (for SOC) or a new 60-day episode begins (for Recert)
 - The document moves out of the QA queue
- **For OASIS Transfer, Discharge, Transfer-Discharge, Death:**
 - Status changes to **"Approved"** (final status, no physician signature required)
 - The document is locked
 - **"Safety Sweep" Actions Occur Automatically:**
 - **Transfer:** Care Order status changes to **"ON_HOLD"**, all scheduled visits are canceled, prior authorizations are paused
 - **Discharge:** Care Order status changes to **"CLOSED"**, all scheduled visits are canceled, prior authorizations are closed
 - **Death:** Patient status changes to **"DECEASED"**, Care Order closes, all visits/PAs canceled
 - The document moves out of the QA queue
- **For Visit Notes (SN, LPN, HHA, PT, OT, SLP, MSW, etc.):**
 - Status changes to **"Approved"**
 - The document is locked (no further edits)
 - A **medication snapshot** is taken (a frozen copy of the patient's medication list at the time of approval, for billing and compliance)
 - The visit is marked as **"Completed"** in the schedule
 - The document moves out of the QA queue

Action 2: Return for Correction

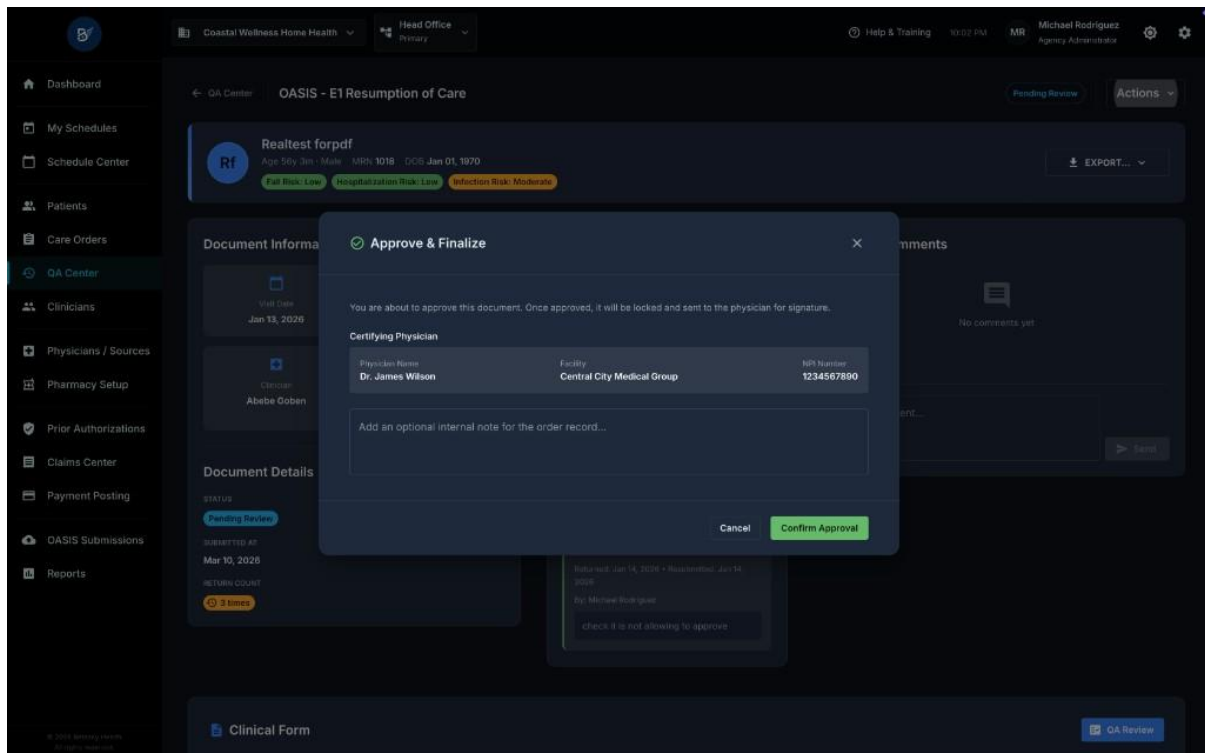
When to Use:

- The document has errors that the clinician needs to fix

- Documentation is incomplete or unclear
- You have questions that require clinician clarification

How to Do It:

1. Click the "Actions" dropdown
2. Select "Return"
3. The "Return for Correction" modal appears:



What You See:

- **Modal Title:** "Return for Correction"
 - **Message:** "Please provide a clear and specific reason for returning this document. This comment will be sent to the clinician."
 - **Reason Text Area:** A large text box where you type your feedback
 - **Common Reason Chips (Shortcuts):** Pre-written reasons you can click to auto-fill:
 - "Inconsistent Vitals"
 - "Missing Signature"
 - "Typographical Error"
 - **"Or, select a common reason:" Section:** Quick-select buttons for common issues
 - **Cancel Button:** Returns to the review page without returning the document
 - **"Send to Clinician" Button (Orange):** Completes the return
4. **Type a Clear, Specific Reason:**
 - **Bad Example:** "Fix errors"
 - **Good Example:** "Please correct the following errors:"

1. Patient weight is entered as 8 lbs (M1060) – verify and update.
2. Assessment completion date (M0100) is before the Start of Care date (M0030) – adjust dates.
3. HHA Care Plan is missing – create the care plan from the OASIS form before resubmitting."

5. Click **"Send to Clinician"**

What Happens After Returning:

- **Status changes to "Returned for Correction"**
- **The clinician receives a notification** (email and/or in-app alert) that the document was returned
- **The document leaves the QA queue** temporarily
- **The clinician can edit the document** to fix the issues
- **Return count increments:** The system tracks how many times a document has been returned (shown in the "Return History" section on the review page)
- **When the clinician resubmits, the document re-enters the QA queue** with status "Pending Review"

Pro Tip: Be specific and kind in your return notes. Clear feedback helps clinicians learn and reduces the number of re-returns.

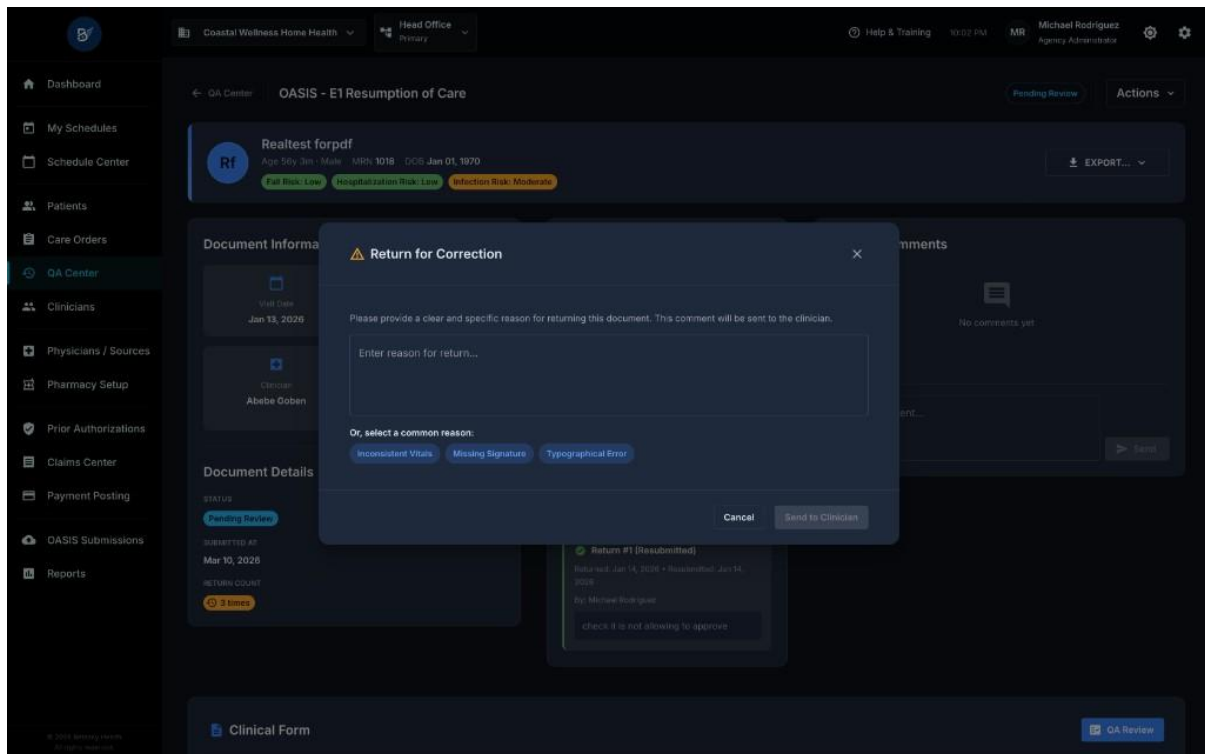
Action 3: Remove from QA

When to Use (Rare):

- The document should not have been submitted to QA in the first place
- The episode or care order has been closed, discharged, or deceased, making the document obsolete
- The document is a duplicate
- The visit was entered in error and should be deleted

How to Do It:

1. Click the **"Actions"** dropdown
2. Select **"Remove"**
3. The **"Remove this document"** modal appears:



What You See:

- **Modal Title:** "Remove this document"
- **Warning Message:** "This document will be marked as removed and will no longer appear in the QA queue. Provide a reason for audit purposes."
- **Reason Text Area:** Type the reason for removal
- **Common Reasons (Chips):**
 - "Episode already closed (Deceased/Discharged)"
 - "Duplicate document"
 - "Wrong patient or visit"
 - "Submitted in error"
 - "Other"
- **Cancel Button:** Returns to the review page without removing
- **"Remove document" Button (Red):** Completes the removal

4. Type a Clear Reason for Audit Purposes

5. Click "Remove document"

What Happens After Removal:

- **Status changes to "Removed"**
- **The document is marked as removed** (not deleted, for audit trail)
- **The document leaves the QA queue permanently**
- **The clinician is NOT notified** (unlike a return, removal is a QA-only action)
- **The removal reason is logged** for compliance and audit purposes

Important: Removing a document does **not** delete the visit or reverse any clinical data. It only removes the document from the QA workflow. If the visit should not exist, coordinate with the clinician or administrator to delete or reschedule it.

21.8 Special Case: Pending Physician Signature

For OASIS SOC, Recertification, and ROC assessments, after QA approval, the document enters a "Pending Physician Signature" state.

The screenshot shows a web application interface for managing OASIS documents. The top navigation bar includes a logo, agency name 'Coastal Wellness Home Health', user role 'Head Office Primary', and user name 'Michael Rodriguez'. A sidebar on the left lists various functions like Dashboard, My Schedules, Schedule Center, Patients, Care Orders, QA Center (highlighted), Clinicians, Physicians / Sources, Pharmacy Setup, Prior Authorizations, Claims Center, Payment Posting, OASIS Submissions, and Reports. The main content area is titled 'OASIS - E2 Start of care' and features a patient profile for 'Hooyo Hooyo' (Age 95y 0m, Male, MCH 1041, DOB Apr 02, 1950). Below the profile, 'Document Information' shows the visit date as 'Apr 02, 2026' and time to complete as '188 hours'. The clinician is listed as 'Michael Rodriguez' and the document type is 'OASIS - E2 Start of care'. The 'Document Details' section shows the status as 'Pending Physician Signature' (highlighted in orange) and the submission date as 'Apr 03, 2026'. To the right, an 'Internal Comments' section is empty. At the bottom, the 'Clinical Form' is partially visible, showing the 'OASIS Assessment' section with '1. Intake / Identity' and 'A - Administrative Information' sub-sections. The form includes navigation buttons like 'Previous', 'Next', 'Save Section', 'DVT review', 'HHA Care Plan Created', and 'Check for Errors'.

What This Means:

- The document has been approved by QA
- The certifying physician **must sign the Plan of Care electronically** to activate the care order
- The document remains in this state until the physician signs

Who Can See These Documents:

- These documents stay in the QA queue with status "**Pending Physician Signature**" (orange/warning chip) so QA can track them
- You can also view them in the **Care Order Details > Documents** tab

How the Physician Signs:

- The physician logs into the system (or uses a physician portal)
- They navigate to "**Documents Awaiting Signature**" or receive a notification
- They review the Plan of Care (CMS-485) and OASIS assessment
- They click "**Sign**" and enter their electronic signature

What Happens After Physician Signs:

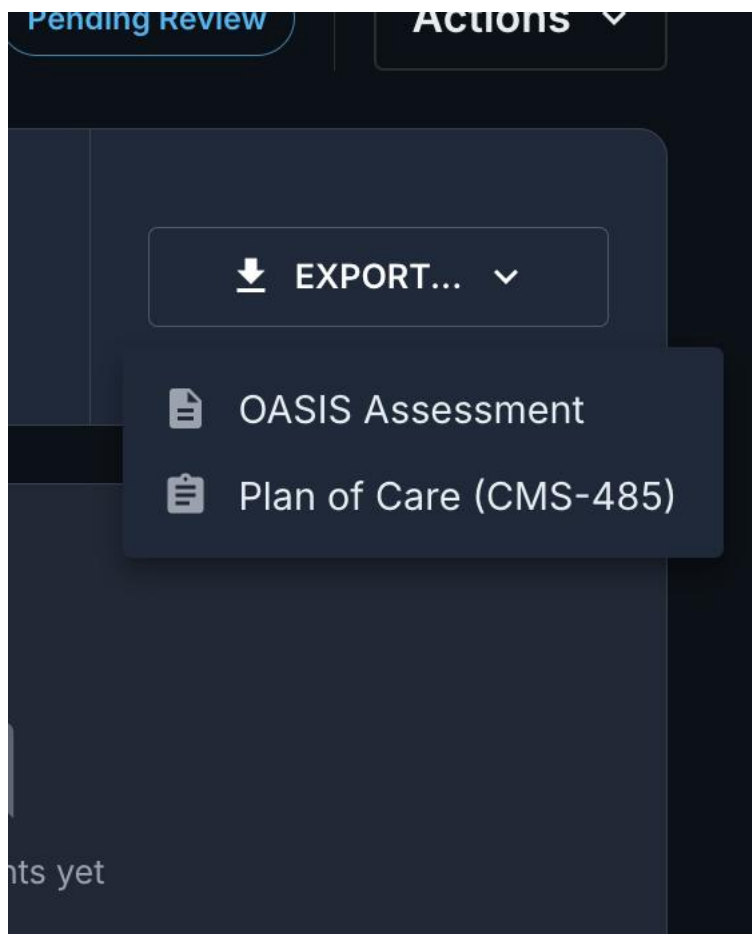
- **For SOC:** The Care Order status changes from "PENDING_POC_SIGNATURE" to "ACTIVE". Home health services can now begin.
- **For Recertification:** A new 60-day episode is created, and the Care Order remains "ACTIVE" for the new period.
- **For ROC:** The Care Order returns to "ACTIVE" status after a hospitalization or interruption.
- **The document status changes to "Approved"** (final status)
- **The document leaves the QA queue**

QA Role in This Phase:

- You can monitor these documents to ensure physicians sign them promptly
- If a physician is delayed, you can follow up directly or use the system's notification features
- Some agencies have a **"Mark as Active"** button (visible to administrators) that allows manually activating a care order without physician signature in emergency situations (e.g., physician is unavailable, but services must start). This should be used sparingly and only with proper authorization.

21.9 Export Options (For OASIS Assessments)

For OASIS assessments, you have the option to **export the assessment as a PDF** for printing, emailing, or archiving.



How to Do It:

1. On the document review page, click the **"EXPORT..."** dropdown (top right, next to the Actions dropdown)
2. Select from the available options:
 - **"OASIS Assessment"**: Exports the full OASIS assessment as a PDF with all sections, questions, and answers
 - **"Plan of Care (CMS-485)"**: Exports the Plan of Care (CMS-485 form) as a PDF, which includes the physician orders, disciplines, frequencies, and goals

What Happens:

- The system generates a PDF document
- Your browser downloads the file automatically
- You can now print it, email it to the physician, or save it to the patient's chart

Use Cases:

- Sending a copy to the physician for review before they sign electronically
- Printing for a paper chart (if your agency maintains both digital and paper records)
- Providing a copy to the patient or family (with appropriate redactions if needed)
- Archiving for compliance or audit purposes

21.10 Best Practices for QA Reviewers

1. Prioritize by Time in Queue and Priority Icon

- Review overdue documents (red text) first
- Tackle priority-flagged documents (red icon) before others
- Use the "Time in Queue" column to sort the queue and work oldest-first

2. Always Run "QA Review" for OASIS Before Approving

- Never approve an OASIS assessment without clicking "QA Review" and reviewing the validation results
- Even if the alert count shows "0," run it yourself to ensure nothing changed since the last scan

3. Be Specific in Return Notes

- Don't just say "fix errors." List each error with its location and what needs to be corrected.
- Example: "1. Correct weight (8 lbs is incorrect - verify). 2. Adjust M0100 date to be after M0030. 3. Create HHA Care Plan."

4. Use Internal Comments for Team Collaboration

- If you're unsure about a document, leave a comment for another QA reviewer: "Can someone else review the wound measurements on this? They seem inconsistent."
- Document decisions: "Approved with soft alert for diabetes medication because patient is diet-controlled (verified with clinician)."

5. Educate Clinicians on Common Errors

- If you see the same errors repeatedly from a clinician (e.g., date sequence errors, missing HHA care plans), schedule a brief training session
- Share examples of good vs. poor documentation

6. Track Your Approval Time

- Use the statistics card ("Avg. Approval Time") to monitor how long documents stay in the queue
- Set agency goals (e.g., "All documents reviewed within 24 hours") and work toward them

7. Don't Rush Soft Alerts

- Soft alerts are non-blocking, but they often flag real clinical issues
- Take a moment to review them and decide if they warrant clinician follow-up
- If you approve with a soft alert, document why in an internal comment

8. Coordinate with Physicians for Pending Signature Documents

- If documents are stuck in "Pending Physician Signature" for more than 48 hours, follow up with the physician's office
- Ensure physicians have access to the system and understand how to sign electronically

21.11 Common Scenarios & How to Handle Them

Scenario 1: Document Shows "5 Alerts" But Clinician Says They Fixed Everything

- **What's Happening:** The alert count is cached from the last "QA Review" scan. If the clinician edited the document after you initially reviewed it, the alert count won't auto-update.
- **What to Do:**
 1. Open the document review page
 2. Click "QA Review" again to refresh the validation
 3. If alerts are now "0," proceed with approval
 4. If alerts still exist, return the document with specific notes

Scenario 2: OASIS SOC Has a Soft Alert for "No Signed Medication Review"

- **What's Happening:** The system detected that the patient is on medications requiring interaction checks (e.g., hypoglycemic drugs, anticoagulants), but no signed medication review exists in the Medication Profile.
- **What to Do:**
 1. Check if the medication review is truly missing (navigate to the patient's Medication Profile)
 2. If missing: Return the document with a note: "Please complete a signed medication review in the Medication Profile. CMS requires drug interaction checks for SOC assessments."

3. If the review exists but wasn't detected: This is a timing issue (review was signed after the OASIS was completed). You can approve with an internal comment: "Medication review completed 1/15/26 - approved."

Scenario 3: Clinician Asks Why Their Document Was Returned When It "Looks Fine"

- **What's Happening:** The clinician may not understand CMS validation rules or soft alert logic.
- **What to Do:**
 1. Schedule a brief call or send a detailed email explaining each error
 2. Use the exact error messages from the validation modal (including CMS Edit IDs)
 3. Provide examples of correct documentation
 4. Offer to review a test document with them to prevent future returns

Scenario 4: Document Has Only Soft Alerts (No Fatal Errors), But Something Feels "Off"

- **What's Happening:** Soft alerts are designed to catch unusual patterns. Trust your clinical judgment.
- **What to Do:**
 1. Review the specific alerts carefully
 2. If they raise legitimate concerns, call the clinician to discuss
 3. If the clinician can explain the documentation (e.g., "Patient has upper extremity amputations, so grooming is harder than dressing"), approve with an internal comment documenting the explanation
 4. If the clinician agrees it's an error, return the document

Scenario 5: Transfer OASIS Is Approved, But Visits Were NOT Canceled

- **What's Happening:** The "Safety Sweep" (automatic visit/PA cancellation) should happen immediately upon Transfer approval. If it didn't, there's a system issue.
- **What to Do:**
 1. Check the Care Order status - it should be "ON_HOLD"
 2. If visits are still showing as "Scheduled" after approval, contact your system administrator or IT support
 3. Manually cancel visits if necessary to prevent clinicians from attempting to complete them

21.12 Troubleshooting

Issue: "QA Review" Button Is Not Showing

- **Cause:** The "QA Review" button only appears for OASIS assessments (SOC, Recert, ROC, Transfer, Discharge, Transfer-Discharge, Death). It does **not** appear for visit notes (SN, HHA, PT, etc.).

- **Solution:** For visit notes, you review the form manually without validation checks. No action needed.

Issue: Document Shows "—" in the Alerts Column

- **Cause:** QA has not yet clicked "QA Review" for this document, so no validation has been run.
- **Solution:** This is normal for new documents. Click "Review" and then "QA Review" to run validation.

Issue: "Approve" Button Is Grayed Out

- **Cause:** You may not have permission to approve this document type (some agencies restrict approvals to specific roles), or the document is already approved.
- **Solution:** Check your user role and permissions with your administrator. If the document status is already "Approved," no action is needed.

Issue: Clinician Says They Never Received the Return Notification

- **Cause:** The clinician's email address may be incorrect, or email notifications are not configured in the system.
- **Solution:**
 1. Verify the clinician's email in their user profile
 2. Check the system's notification settings with your administrator
 3. As a workaround, call or text the clinician directly to notify them of the return

Issue: Physician Signature Is Delayed for 48+ Hours

- **Cause:** The physician may not have received the notification, or they don't have access to the system.
- **Solution:**
 1. Check the physician's contact info in the Physicians/Sources module
 2. Call or email the physician's office to follow up
 3. Provide the physician with a PDF export (see Section 21.9) if they prefer to review it before signing electronically
 4. If the physician is unavailable and services must start, consult with your agency administrator about the "Mark as Active" emergency procedure

Issue: Document Is Returned, But It's Not Showing in the Clinician's Queue

- **Cause:** The clinician may be filtering their visit list and not seeing "Returned for Correction" status.
- **Solution:** Have the clinician check their **My Schedules** or **My Day** page and look for documents with status "Returned for Correction" (usually shown with a yellow/orange chip).

Chapter 22: OASIS Submission to CMS

Overview

After OASIS assessments are approved by QA and (if required) signed by the physician, they must be submitted to the **Centers for Medicare & Medicaid Services (CMS)** through the OASIS system. This chapter explains how to manage the entire submission lifecycle, from exporting XML files to tracking acceptance or rejection by CMS.

What You'll Learn:

- Understanding the 5 OASIS submission statuses and their meaning
- How to export OASIS assessments as XML files for CMS submission
- How to mark assessments as submitted and track CMS submission IDs
- How to record CMS acceptance or rejection responses
- How to handle rejected submissions and notify clinicians for corrections
- The relationship between OASIS submission status and billing eligibility

22.1 Understanding OASIS Submission Statuses

Every OASIS assessment that has been approved goes through a submission lifecycle with **5 distinct statuses**:

Status 1: Ready to Submit

- **What It Means:** The OASIS assessment has been **approved by QA** and (if required) **signed by the physician**. It is now ready to be exported as an XML file and submitted to CMS.
- **What Happens at This Stage:** The agency's billing team or OASIS coordinator exports the assessment as an XML file and submits it to CMS through the state's OASIS portal or direct submission system.
- **Care Order Status:** For SOC, Recert, and ROC, the Care Order is still waiting for CMS acceptance before billing can begin.

Status 2: Submitted (& Pending Validation)

- **What It Means:** The OASIS assessment has been **exported and submitted to CMS**. The agency is now waiting for CMS to validate the file and respond with acceptance or rejection.
- **What Happens at This Stage:** CMS runs automated validation checks on the submitted XML file (e.g., correct format, valid item codes, complete data). This typically takes 1-3 business days but can take longer during high-volume periods.
- **What You Track:** The **CMS Submission ID** (a unique ID assigned by CMS when you upload the file through their portal) and **time since submission** (to monitor if CMS is taking too long to respond).

Status 3: Accepted

- **What It Means:** CMS has **validated and accepted** the OASIS assessment. The data is now officially recorded in CMS's system and counts toward quality measures, payment calculations, and compliance reporting.
- **What Happens at This Stage:**
 - **Billing is enabled:** For SOC, Recert, and ROC, the Care Order status automatically changes to "**Active**," allowing visits from this episode to appear in the Claims Center for billing.
 - The assessment is permanently logged in CMS's records.
 - The agency can now bill for visits completed during this episode (for SOC/Recert) or after resumption (for ROC).
- **When to Move Here:** After you receive a **CMS Acceptance Report** (usually via email or portal download) confirming the submission was successful.

Status 4: Rejected

- **What It Means:** CMS has **rejected** the OASIS assessment due to validation errors. The data was not accepted, and the agency must correct the errors and resubmit.
- **What Happens at This Stage:**
 - CMS provides a **Rejection Report** (or "Validation Report") listing specific errors (e.g., "M0100 date is invalid," "M1800 value out of range," "Missing required item M0230").
 - The agency must review the rejection reason, correct the errors in the OASIS form, and resubmit.
 - **Billing is blocked:** The Care Order remains in its current status (e.g., "PENDING_POC_SIGNATURE" or "Active" from a previous episode), but new billing for this episode cannot proceed until CMS accepts the resubmitted assessment.
- **When to Move Here:** After you receive a **CMS Rejection Report** from the portal.

Status 5: Pending Correction

- **What It Means:** The agency has **notified the clinical team** that the OASIS assessment was rejected by CMS and needs corrections. The clinician or RN supervisor is now responsible for fixing the errors and resubmitting the assessment for QA approval.
- **What Happens at This Stage:**
 - The assigned clinician or case manager receives a notification (email and/or in-app alert) with the rejection reason.
 - They edit the OASIS assessment to fix the errors.
 - The corrected assessment goes back through QA review and physician signature (if needed).
 - Once re-approved, the assessment returns to "Ready to Submit" status for a second submission attempt.
- **When to Move Here:** After you click "**Notify for Correction**" in the Rejected tab (or from any other tab if you discover an issue).

22.2 The OASIS Submissions Page

Navigate to **OASIS Submissions** from the left sidebar to access the main submission management page.

PATIENT NAME	ASSESSMENT TYPE	COMPLETION DATE	INSURANCE	ACTIONS
Quansa Shoma	E1 Start of care	2026-04-04	Unknown / To Be Verified	
Hooyo Hooyo	E1 Start of care	2026-04-03	Blue Cross Blue Shield	
Abdi abdullah	E1 Start of care	2026-04-01	Blue Cross Blue Shield	
Jordan West	E1 Start of care	2026-04-01	Blue Cross Blue Shield	
Farah Omar	E1 Start of care	2026-03-16	Blue Cross Blue Shield	
Test Start	E1 Resumption of Care	2026-01-18	Blue Cross Blue Shield	
Sama Mula	E1 Start of care	2026-03-05	Medicare of Texas	
John Doe	E1 Transfer	2025-12-29	Blue Cross Blue Shield	
Test Start	E1 Transfer	2026-01-18	Blue Cross Blue Shield	
John Doe	E1 Transfer Discharge	2026-01-19	Blue Cross Blue Shield	

What You See:

1. **Page Title:** "OASIS Submissions" with a "Last 30 Days" date filter dropdown (allows filtering by date range in future versions) and a **"Refresh Statuses"** button to manually refresh all tab counts

2. **Tab Bar with Status Counts:** Five tabs, each showing the current count of assessments in that status:

- **Ready to Submit (23):** 23 assessments ready for export and submission
- **Submitted (5):** 5 assessments currently pending CMS validation
- **Accepted (3):** 3 assessments accepted by CMS
- **Rejected (1):** 1 assessment rejected by CMS
- **Pending Correction (0):** 0 assessments awaiting clinician corrections

2. **Active Tab Content:** The table below shows all assessments for the currently selected tab (in this example, "Ready to Submit")

22.3 Ready to Submit Tab (Export & Submit to CMS)

The **Ready to Submit** tab shows all OASIS assessments that have been approved and signed (if required) and are now ready for submission to CMS.

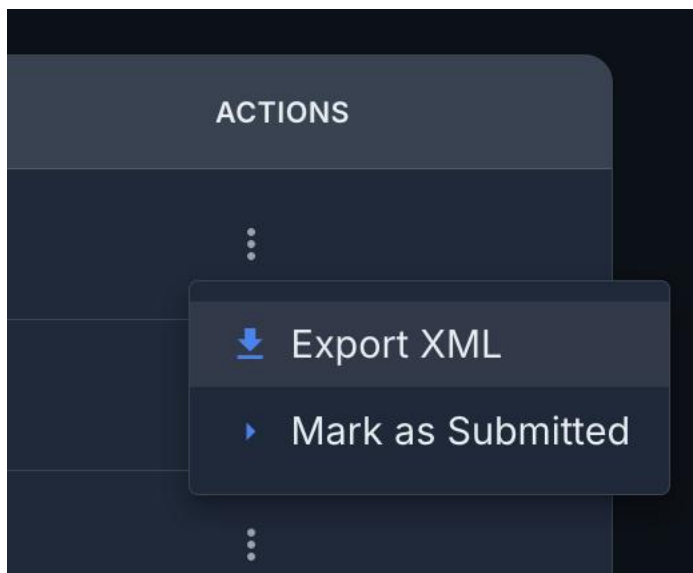
Table Columns Explained:

- **Patient Name:** The patient's full name as a clickable link (clicking opens the patient's profile or care order details)
- **Assessment Type:** The type of OASIS assessment (e.g., "E1 Start of care," "E1 Resumption of Care," "E1 Recertification," "E1 Transfer," "E1 Transfer Discharge")
- **Completion Date:** The date the assessment was completed by the clinician (format: YYYY-MM-DD)
- **Insurance:** The patient's primary payer (e.g., "Blue Cross Blue Shield," "Medicare of Texas," "Unknown / To Be Verified")
- **Actions:** A three-dot menu with options for this assessment

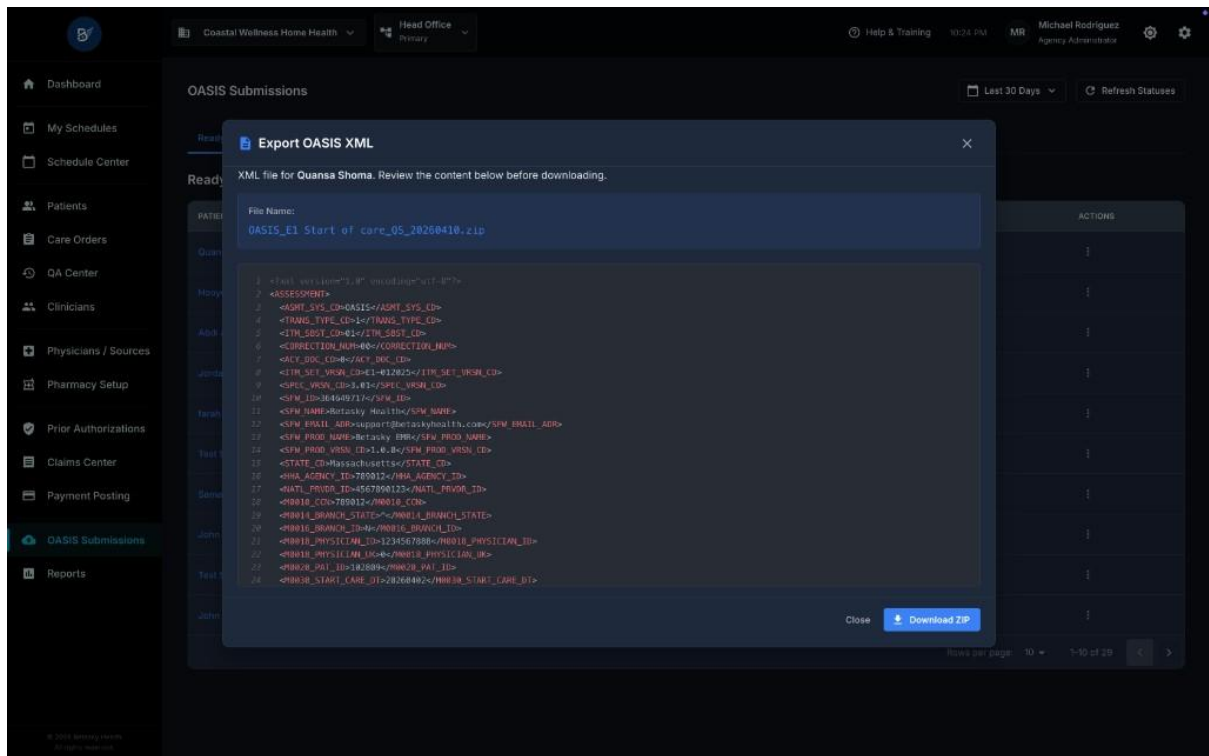
How to Submit an Assessment to CMS:

Step 1: Export the OASIS Assessment as XML

1. Click the **three-dot menu** (Actions) for the assessment you want to submit



2. Select "**Export XML**"
3. The "**Export OASIS XML**" modal appears:



What You See in This Modal:

- **Modal Title:** "Export OASIS XML"
- **Message:** "XML file for [Patient Name]. Review the content below before downloading."
- **File Name:** The auto-generated filename (e.g., OASIS_E1_Start_of_care_05_20260410.zip)
- **XML Preview Window:** A large text area showing the actual XML content (first 20-30 lines visible, scrollable)
 - You can review the XML to verify it contains the correct patient info, assessment type, and OASIS item codes
 - The XML is formatted in CMS-compliant structure with tags like `<ASSESSMENT>`, `<OASI_INFO_COMPLETE_DT>`, `<TRANS_TYPE_CD>`, `<INPATIENT_FACILITY_IND>`, etc.
- **"Close" Button:** Closes the modal without downloading
- **"Download ZIP" Button (Blue):** Downloads the XML file as a .zip archive to your computer

4. Click "Download ZIP"

- Your browser downloads the file (typically to your Downloads folder)
- The filename format is:
OASIS_[Version]_[AssessmentType]_[Sequence]_[YYYYMMDD].zip
- Example: OASIS_E1_Start_of_care_05_20260410.zip

Step 2: Submit the XML File to CMS

5. Go to Your State's OASIS Submission Portal (outside this system)

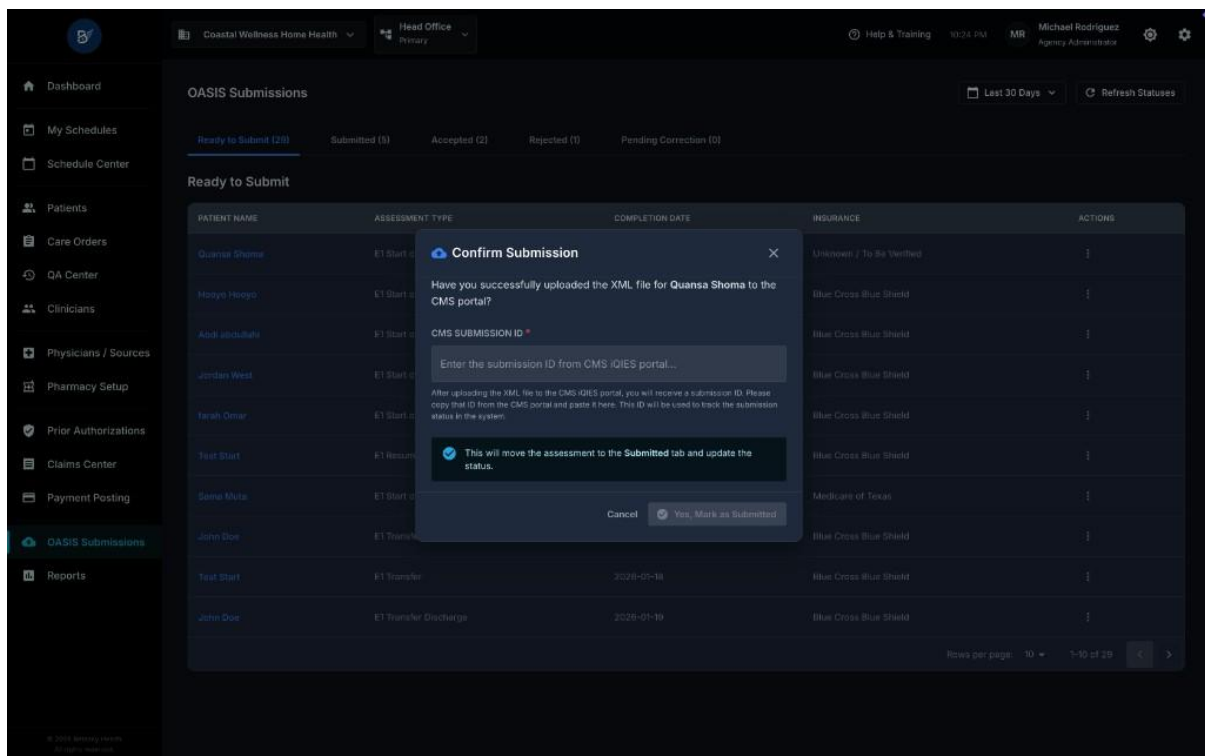
- Each state has its own CMS OASIS submission portal (e.g., Texas uses the "Texas OASIS Portal," California uses "CASPER," etc.)
- Log in with your agency's credentials
- Navigate to the "Submit OASIS" or "Upload OASIS File" section

6. Upload the ZIP File

- Select the downloaded .zip file
- Submit it through the portal
- **CMS assigns a Submission ID** (a unique tracking number, e.g., "3232323," "SZdF4xSu0du7N")
- Copy this Submission ID - you'll need it in the next step

Step 3: Mark the Assessment as Submitted in the System

7. Return to the **OASIS Submissions > Ready to Submit** tab
8. Click the **three-dot menu (Actions)** for the same assessment
9. Select **"Mark as Submitted"**
10. The **"Confirm Submission"** modal appears:



What You See in This Modal:

- **Modal Title:** "Confirm Submission"
- **Message:** "Have you successfully uploaded the XML file for [Patient Name] to the CMS portal?"
- **CMS Submission ID Field:** A text input box labeled "CMS SUBMISSION ID *"
 - **What to Enter:** Paste the Submission ID that CMS assigned when you uploaded the file (e.g., "3232323")

- **Why This Matters:** This ID allows you to track the submission in CMS's portal and link it back to this assessment in your system
- **Helper Text:** "After uploading the XML file to the CMS OASIS portal, you will receive a submission ID. Please copy that ID from the CMS portal and paste it here. This ID will be used to track the submission status in your system."
- **Checkbox:** "This will move the assessment to the Submitted tab and update the status."
- **"Cancel" Button:** Closes the modal without changing the status
- **"Yes, Mark as Submitted" Button (Blue):** Confirms the action

11. Paste the CMS Submission ID into the field

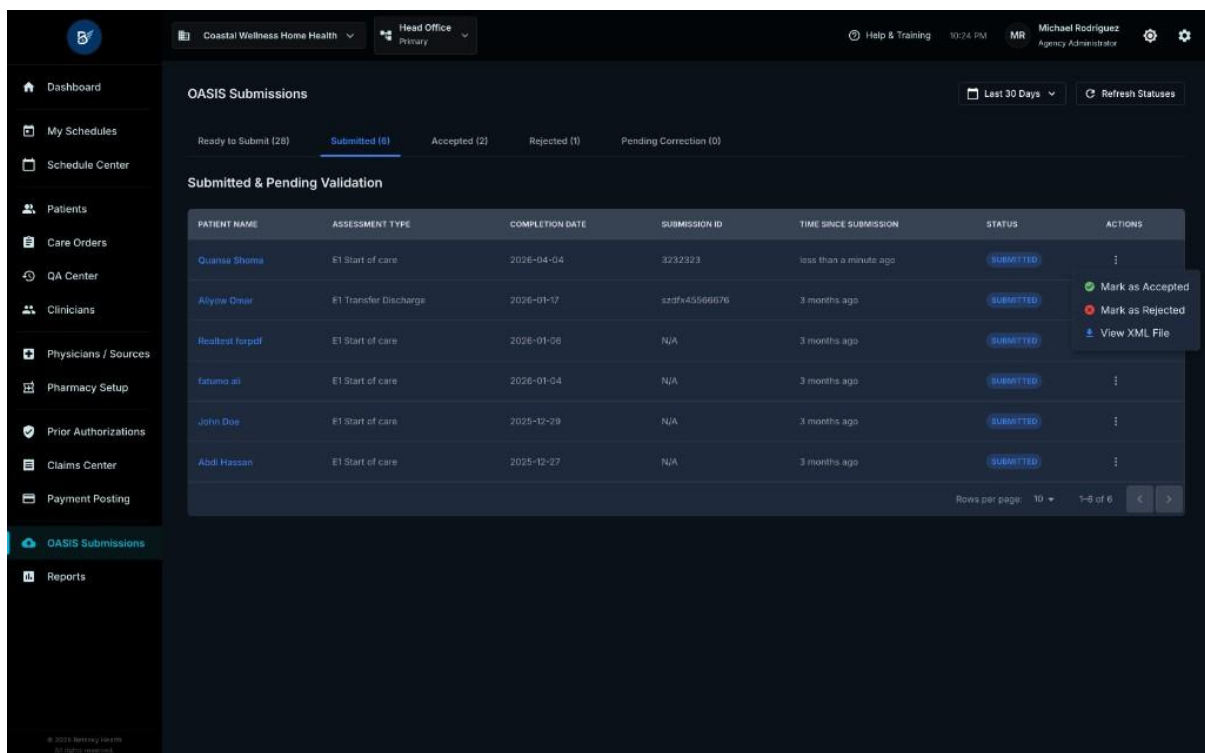
12. Click "Yes, Mark as Submitted"

What Happens Next:

- The assessment **moves from the "Ready to Submit" tab to the "Submitted" tab**
- The status changes to **"SUBMITTED"**
- The **submitted timestamp** is recorded (when you marked it as submitted in this system)
- The **CMS Submission ID** is saved for reference
- **Tab counts update automatically:** "Ready to Submit" count decreases by 1, "Submitted" count increases by 1

22.4 Submitted Tab (Pending CMS Validation)

The **Submitted** tab shows all assessments that have been submitted to CMS and are awaiting validation responses (acceptance or rejection).



The screenshot shows the 'OASIS Submissions' interface. At the top, there are tabs for 'Ready to Submit (28)', 'Submitted (6)', 'Accepted (2)', 'Rejected (1)', and 'Pending Correction (0)'. The 'Submitted (6)' tab is selected. Below the tabs, there is a table titled 'Submitted & Pending Validation'. The table has columns: 'PATIENT NAME', 'ASSESSMENT TYPE', 'COMPLETION DATE', 'SUBMISSION ID', 'TIME SINCE SUBMISSION', 'STATUS', and 'ACTIONS'. The table contains 6 rows of data. The 'ACTIONS' column for the first row shows a dropdown menu with options: 'Mark as Accepted', 'Mark as Rejected', and 'View XML File'.

PATIENT NAME	ASSESSMENT TYPE	COMPLETION DATE	SUBMISSION ID	TIME SINCE SUBMISSION	STATUS	ACTIONS
Quanae Shoma	E1 Start of care	2026-04-04	3232323	less than a minute ago	SUBMITTED	⋮
Alyow Omer	E1 Transfer Discharge	2026-01-17	szdfx4566676	3 months ago	SUBMITTED	⋮
Healtest forpdf	E1 Start of care	2026-01-06	N/A	3 months ago	SUBMITTED	⋮
fatuma ali	E1 Start of care	2026-01-04	N/A	3 months ago	SUBMITTED	⋮
John Doe	E1 Start of care	2025-12-29	N/A	3 months ago	SUBMITTED	⋮
Abdi Hassan	E1 Start of care	2025-12-27	N/A	3 months ago	SUBMITTED	⋮

Table Columns Explained:

- **Patient Name:** The patient's full name
- **Assessment Type:** The OASIS assessment type (e.g., "E1 Start of care," "E1 Transfer Discharge")
- **Completion Date:** The date the clinician completed the assessment
- **Submission ID:** The **CMS Submission ID** you entered when marking it as submitted (e.g., "3232323," "SZdF4xSu0du7N")
 - This is the tracking number CMS assigned
 - Use this ID to look up the submission status in the CMS portal
- **Time Since Submission:** How long ago the assessment was submitted (e.g., "less than a minute ago," "3 months ago")
 - **Why This Matters:** If submissions sit in "Submitted" status for more than 5-7 business days, you should check the CMS portal for a response or contact CMS support
- **Status:** Shows "SUBMITTED" (blue chip)
- **Actions:** A dropdown menu with options:
 - **"Update Status":** Manually change the status (to Accepted, Rejected, or back to Ready to Submit if needed)
 - **"Export":** Re-download the XML file if you need to resubmit or review it

What to Do While Assessments Are in This Tab:

1. Monitor for CMS Responses

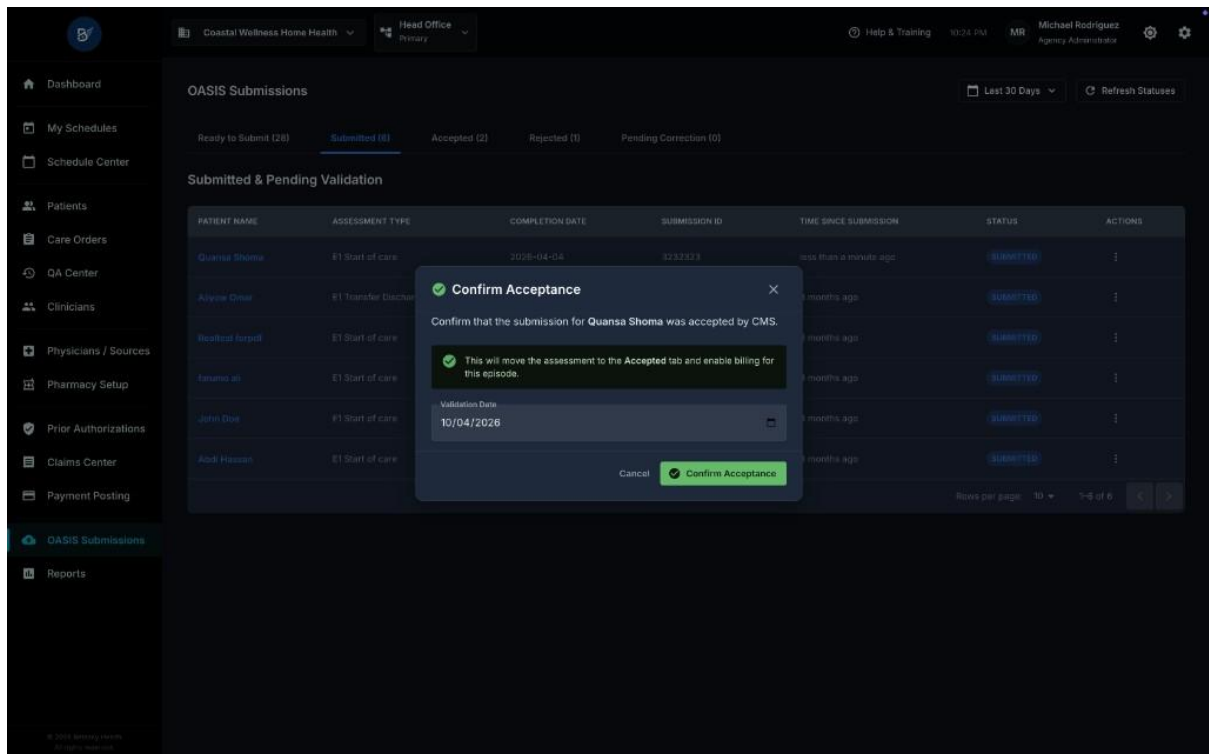
- Check your **CMS portal** daily (or enable email notifications if your state portal supports it)
- Look for **Acceptance Reports** or **Rejection Reports** for your submitted assessments
- **Typical Timeline:**
 - Most submissions are validated within **1-3 business days**
 - Some may take up to **5-7 business days** during peak periods (e.g., end of month, end of quarter)
 - If no response after **7 days**, contact your state's OASIS support team

2. Update Status Based on CMS Response

When you receive a CMS response, update the status in this system:

If CMS Accepted the Submission:

1. Click the **Actions dropdown** for the assessment



2. Select "Update Status"

3. Choose "Mark as Accepted"

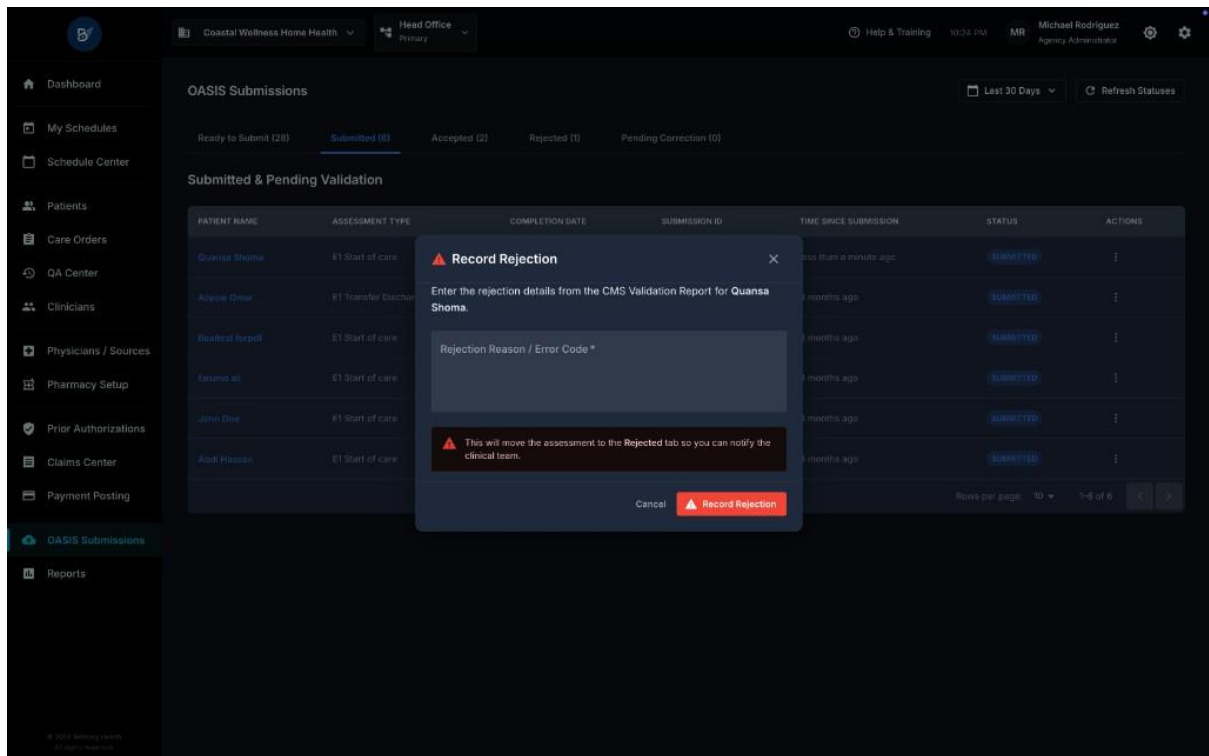
4. The "Confirm Acceptance" modal appears:

What You See:

- **Modal Title:** "Confirm Acceptance"
- **Message:** "Confirm that the submission for [Patient Name] was accepted by CMS."
- **Green Info Box:** "This will move the assessment to the Accepted tab and enable billing for this episode."
- **Validation Date Field:** A date picker to enter the date CMS accepted the submission (default: today's date)
 - **Why This Field Exists:** CMS acceptance dates are important for billing cycles and reporting. If CMS accepted it yesterday but you're recording it today, you can backdate it to match the CMS acceptance report.
- **"Cancel" Button**
- **"Confirm Acceptance" Button (Green)**

5. Enter the acceptance date (or leave it as today if that's correct)

6. Click "Confirm Acceptance"

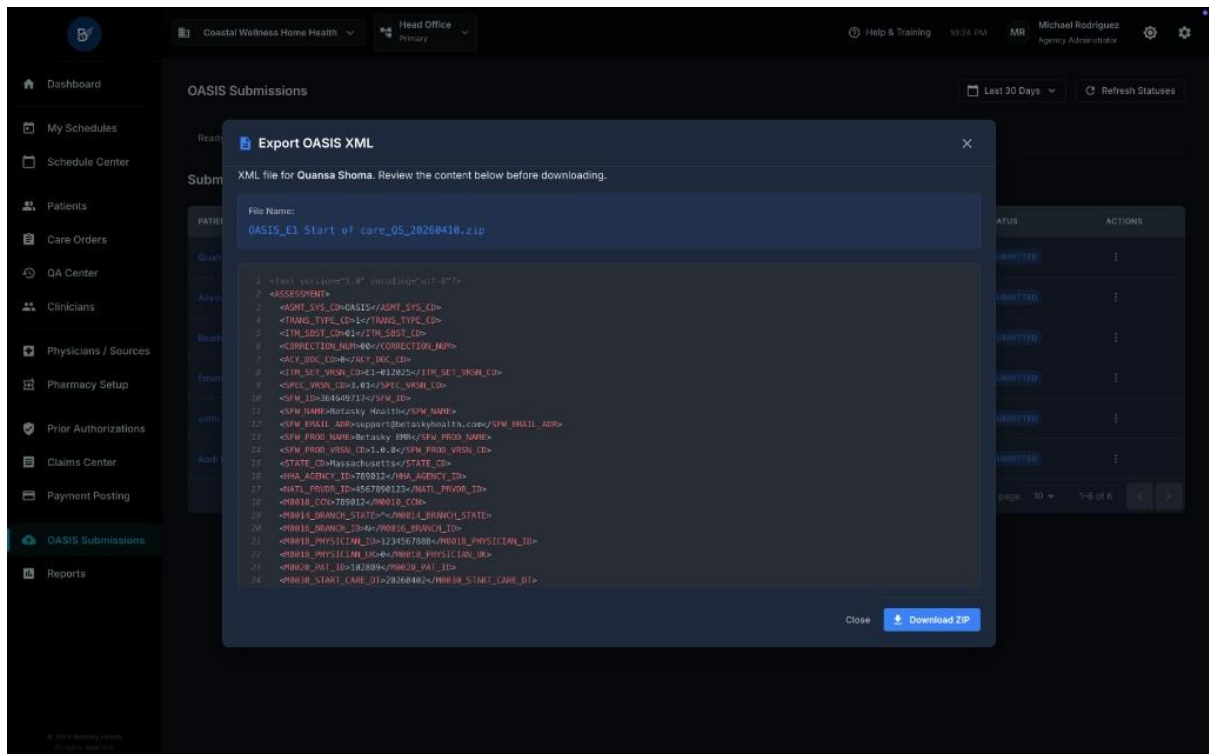


What Happens Next:

- The assessment **moves to the "Accepted" tab**
- The status changes to **"ACCEPTED"**
- The **acceptance timestamp** is recorded
- **CRITICAL FOR BILLING:** The Care Order status automatically changes to **"Active"** (if it wasn't already). This enables visits from this episode to be billed in the Claims Center.
- **Tab counts update:** "Submitted" count decreases by 1, "Accepted" count increases by 1

If CMS Rejected the Submission:

1. Click the **Actions dropdown** for the assessment
2. Select **"Update Status"**
3. Choose **"Mark as Rejected"**
4. The **"Record Rejection"** modal appears:



What You See:

- **Modal Title:** "Record Rejection"
- **Message:** "Enter the rejection details from the CMS Validation Report for [Patient Name]."
- **Rejection Reason / Error Code Field:** A large text area to paste or type the rejection reason
 - **What to Enter:** Copy the **exact error messages** from the CMS Rejection Report
 - Example: "CRITICAL [con-invalid-lineside-jod1-non-lineside-lineside-jod2-non-lineside-lineside-jod2-con-lineside-lineside-jod1-con-lineside-lineside-jod2-con-lineside-lineside]"
 - Or a more readable format: "M0100 (Assessment Completion Date) is before M0030 (Start of Care Date). Invalid date sequence."
- **Red Warning Box:** "This will move the assessment to the Rejected tab so you can notify the clinical team for corrections."
- **"Cancel" Button**
- **"Record Rejection" Button (Red)**

5. Paste or type the rejection reason from the CMS report

6. Click "Record Rejection"

What Happens Next:

- The assessment **moves to the "Rejected" tab**
- The status changes to **"REJECTED"**
- The **rejection timestamp** is recorded
- The **rejection reason** is saved for the clinical team to review

- **Tab counts update:** "Submitted" count decreases by 1, "Rejected" count increases by 1

22.5 Accepted Tab (Successfully Submitted to CMS)

The **Accepted** tab shows all assessments that have been successfully accepted by CMS.

PATIENT NAME	ASSESSMENT TYPE	COMPLETION DATE	SUBMISSION ID	REJECTION REASON	ACTIONS
Neesedin Haji	E1 Start of care	2025-12-17		CRITICAL issue: cannot find patient in system	- View XML File - Notify for Correction - Mark as Accepted

Table Columns Explained:

- **Patient Name:** The patient's full name
- **Assessment Type:** The OASIS assessment type
- **Completion Date:** The date the assessment was completed
- **Submission ID:** The CMS Submission ID (if recorded)
- **Date Accepted:** The date and time CMS accepted the submission (format: MM/DD/YYYY, HH:MM AM/PM)
 - Example: "04/10/2026, 07:25 PM"
- **Status:** Shows "ACCEPTED" (green chip)
- **Actions:** A dropdown with options:
 - **"Export":** Download the XML file again if needed (for records or audits)
 - **"Update Status"** (rarely used): Manually change status if there was a mistake (e.g., move back to Submitted or Rejected)

What This Means for Billing:

Critical Concept: When an OASIS assessment reaches "Accepted" status, the system automatically enables billing for that episode.

For OASIS SOC (Start of Care):

- The Care Order status changes from "PENDING_POC_SIGNATURE" (or whatever it was) to **"Active"**
- All visits completed under this Care Order can now be billed in the Claims Center
- The patient's episode begins officially from CMS's perspective

For OASIS Recertification:

- The Care Order remains "Active" (it was already active from the previous episode)
- A **new 60-day episode** is created
- Visits from the new episode can now be billed (using the new episode's dates)

For OASIS ROC (Resumption of Care):

- The Care Order status changes from "ON_HOLD" back to **"Active"**
- Visits completed after the resumption date can now be billed

For OASIS Transfer, Discharge, Transfer-Discharge, Death:

- These do not require CMS acceptance for billing purposes (the Care Order was already closed or on hold when they were approved)
- Acceptance here is mainly for **compliance and reporting** to ensure CMS has accurate records

Best Practice:

- **Archive or export these records periodically** for compliance audits
- CMS may request proof of submission/acceptance during audits - the data in this tab serves as your audit trail

22.6 Rejected Tab (CMS Validation Errors)

The **Rejected** tab shows all assessments that were rejected by CMS due to validation errors.

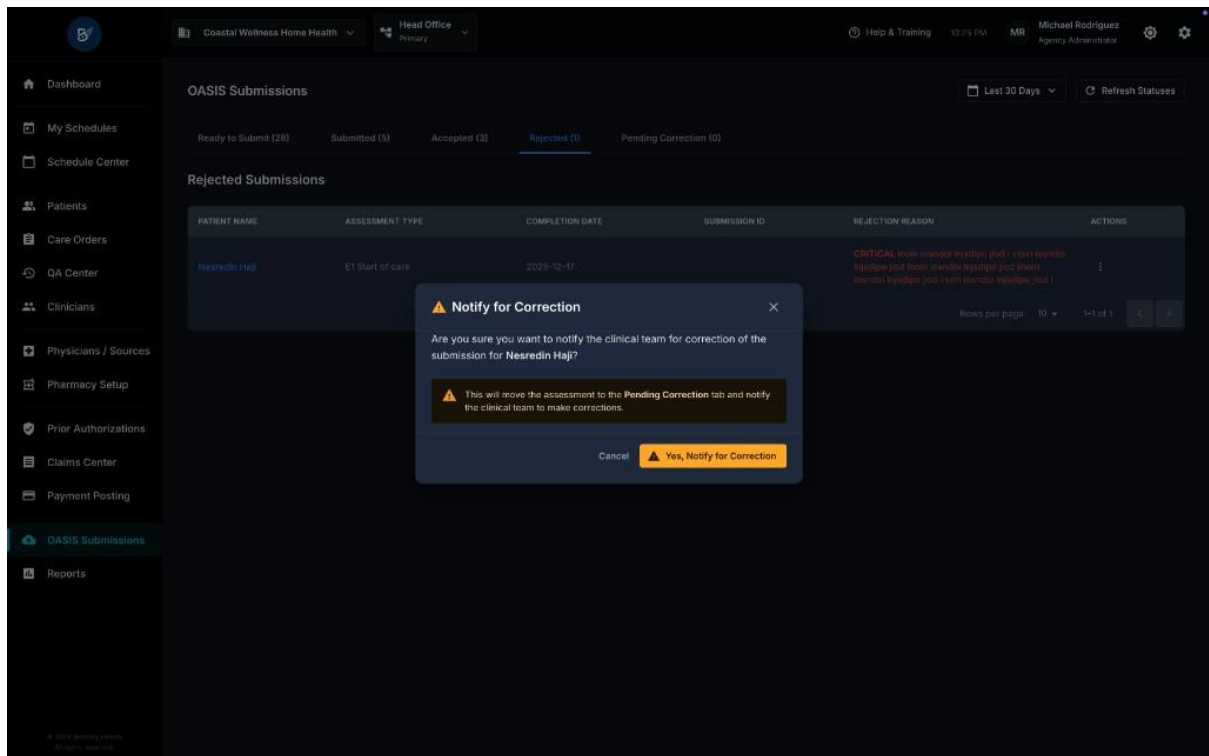


Table Columns Explained:

- **Patient Name:** The patient's full name
- **Assessment Type:** The OASIS assessment type
- **Completion Date:** The date the assessment was completed
- **Submission ID:** The CMS Submission ID (if recorded)
- **Rejection Reason:** The exact error message(s) from CMS
 - This is displayed in **red text** for visibility
 - Example (from screenshot): "CRITICAL [con-invalid-lineside-jod1-non-lineside-lineside-jod2-non-lineside-lineside-jod2-con-lineside-lineside-jod1-con-lineside-lineside-jod2-con-lineside-lineside-jod1-con-lineside-lineside]"
 - This is the raw error code from CMS. In practice, you'll also receive a human-readable report from CMS explaining what these codes mean.
- **Actions:** A dropdown menu with three key options:
 - **"View XML File":** Opens the exported XML to review the data that was submitted
 - **"Notify for Correction":** Sends the rejection reason to the clinical team so they can fix the errors
 - **"Mark as Accepted"** (rarely used): If CMS accepted it on a second review or you made a manual correction in the portal, you can manually mark it as accepted

How to Handle a Rejected Assessment:

Step 1: Review the Rejection Reason

1. Read the **Rejection Reason** column carefully

2. If the error code is cryptic (like the example above), refer to the **CMS Validation Report** you downloaded from the CMS portal for a detailed explanation

3. Common rejection reasons include:

- **Date sequence errors:** "M0100 (Assessment Completion Date) cannot be before M0030 (Start of Care Date)"
- **Invalid values:** "M1800 (Grooming) value '5' is out of range. Valid values are 0-3."
- **Missing required items:** "M0230 (Primary Diagnosis ICD-10 Code) is required but missing."
- **Format errors:** "M0066 (Date of Birth) format is invalid. Expected YYYYMMDD, received YYYY-MM-DD."

Step 2: Notify the Clinical Team for Correction

4. Click the **Actions dropdown** for the rejected assessment

5. Select **"Notify for Correction"**

6. The **"Notify for Correction"** modal appears:

! [Notify for Correction Modal - not provided in screenshots, but inferred from system design]

What You See:

- **Modal Title:** "Notify for Correction"
- **Message:** "Are you sure you want to notify the clinical team for correction of the submission for [Patient Name]?"
- **Warning Box:** "This will move the assessment to the Pending Correction tab and notify the clinical team to make corrections."
- **"Cancel" Button**
- **"Yes, Notify for Correction" Button (Orange)**

7. Click **"Yes, Notify for Correction"**

What Happens Next:

- The assessment **moves to the "Pending Correction" tab**
- The status changes to **"PENDING_CORRECTION"**
- **A notification is sent** to the assigned clinician or case manager (email and/or in-app alert)
- The notification includes:
 - Patient name
 - Assessment type
 - Rejection reason (the full error message from CMS)
 - Instructions to edit the OASIS form, fix the errors, and resubmit for QA approval
- **Tab counts update:** "Rejected" count decreases by 1, "Pending Correction" count increases by 1

Step 3: Clinician Fixes the Errors (Workflow Outside This Page)

8. The clinician receives the notification

9. They navigate to the **OASIS form** (from My Schedules, Patient Profile, or Care Order Details)

10. They **edit the OASIS assessment** to fix the errors listed in the rejection reason
11. They **resubmit the assessment** (it goes back to "Pending Review" status in the QA Center)
12. The QA team **re-reviews and re-approves** the corrected assessment
13. If physician signature is required, the physician **signs again** (or the existing signature may be reused, depending on agency policy)
14. The assessment returns to the **"Ready to Submit"** tab for a second submission attempt

Step 4: Resubmit to CMS

15. Once back in "Ready to Submit," **follow the same export and submission process** (Steps 1-3 from Section 22.3)
16. Monitor the "Submitted" tab for CMS's second response
17. Ideally, the corrected assessment will be **accepted this time**

22.7 Pending Correction Tab (Awaiting Clinician Fixes)

The **Pending Correction** tab shows all assessments that have been notified to the clinical team for corrections but have not yet been corrected and resubmitted.

Table Columns Explained (typical, not shown in screenshots):

- **Patient Name**
- **Assessment Type**
- **Completion Date**
- **Date Notified:** When the clinician was notified to make corrections
- **Days Pending:** How many days the assessment has been waiting for corrections (e.g., "3 days," "14 days")
 - **Why This Matters:** If assessments sit here for more than 7 days, follow up with the clinician to ensure they've seen the notification and are working on the corrections
- **Rejection Reason:** The error message from CMS (or the reason it needs corrections)
- **Notified User:** The clinician or case manager who was notified
- **Actions:**
 - **"Resend Notification":** If the clinician didn't see the first notification, you can resend it
 - **"Force Status Change"** (admin only): Manually move the assessment to a different status (e.g., back to Rejected, or to Ready to Submit if corrections were made outside the normal workflow)
 - **"View XML File":** Review the original submission

What to Do with Assessments in This Tab:

1. Monitor Days Pending

- If **Days Pending > 7 days**, contact the clinician directly:
 - "Did you receive the rejection notification for Patient X's OASIS SOC?"

- "Do you need help understanding the CMS error message?"
- "When can you complete the corrections?"

2. Resend Notification if Needed

- If the clinician says they never got the notification, click **Actions > Resend Notification**

3. Wait for Clinician to Correct and Resubmit

- Once the clinician corrects the assessment and resubmits it through QA, **the assessment will automatically move out of this tab** and return to "Ready to Submit" (after QA re-approval)
- The "Pending Correction" count will decrease by 1

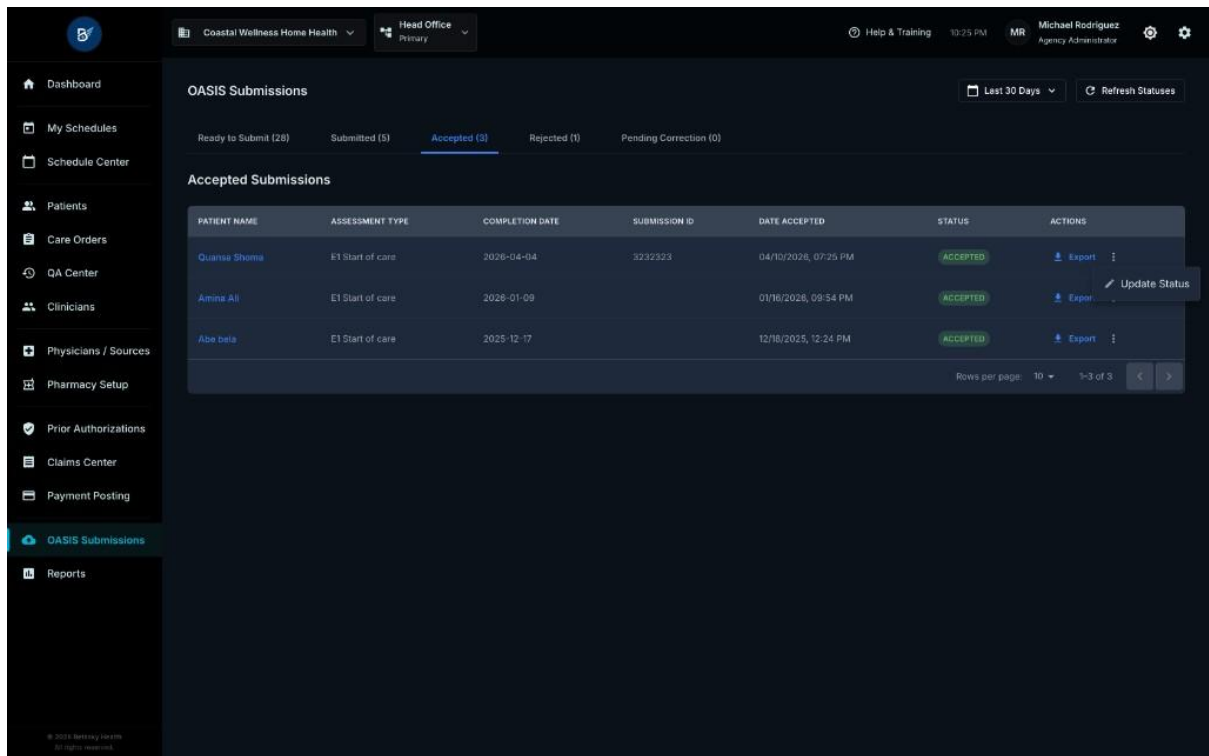
22.8 Exporting XML from Any Tab

You can **re-export the XML file** for any assessment, even after it's been submitted, accepted, or rejected. This is useful for:

- **Record-keeping:** Saving a copy for your files
- **Audits:** CMS or state auditors may request proof of submission
- **Resubmission:** If you need to resubmit a rejected assessment (after corrections), you can export a fresh XML

How to Export from Submitted, Accepted, or Rejected Tabs:

1. Navigate to the tab where the assessment is located (e.g., Submitted, Accepted, Rejected)
2. Click the **Actions dropdown** for the assessment
3. Select **"Export"** (or "View XML File" in Rejected tab)
4. The **"Export OASIS XML"** modal appears (same as in Ready to Submit):



5. Review the XML if needed

6. Click "**Download ZIP**" to download the file again

22.9 The Relationship Between OASIS Submission Status and Billing

Critical Concept for Agency Administrators and Billing Coordinators:

The OASIS submission status **directly impacts billing eligibility** for Medicare home health episodes.

For OASIS SOC (Start of Care):

OASIS Submission Status	Care Order Status	Can Bill Visits?
Ready to Submit	PENDING_POC_SIGNATURE	No
Submitted	PENDING_POC_SIGNATURE	No
Accepted	Active	Yes
Rejected	PENDING_POC_SIGNATURE	No (until resubmitted and accepted)
Pending Correction	PENDING_POC_SIGNATURE	No

Why This Matters:

- You cannot bill Medicare for SOC visits until CMS accepts the SOC assessment
- Delays in OASIS submission = delays in billing = cash flow issues

- **Best Practice:** Submit SOC assessments within 5 days of the start of care date to avoid billing delays

For OASIS Recertification:

OASIS Submission Status	Care Order Status	Can Bill New Episode Visits?
Ready to Submit	Active (from previous episode)	No (for new episode)
Submitted	Active (from previous episode)	No (for new episode)
Accepted	Active (new 60-day episode created)	Yes
Rejected	Active (from previous episode)	No (for new episode)
Pending Correction	Active (from previous episode)	No (for new episode)

Why This Matters:

- You can still bill visits from the **previous episode** (up to the end of the previous 60-day period)
- But you **cannot bill visits from the new episode** until the Recert is accepted by CMS
- **Best Practice:** Submit Recert assessments at least 7-10 days before the previous episode ends to ensure acceptance before the new episode starts

For OASIS ROC (Resumption of Care):

OASIS Submission Status	Care Order Status	Can Bill Visits?
Ready to Submit	ON_HOLD	No
Submitted	ON_HOLD	No
Accepted	Active	Yes (for visits after resumption)
Rejected	ON_HOLD	No
Pending Correction	ON_HOLD	No

Why This Matters:

- After a patient is hospitalized or transferred (triggering an ON_HOLD status), you cannot bill visits until the ROC is accepted
- **Best Practice:** Submit ROC assessments immediately after the patient returns to home health services

For OASIS Transfer, Discharge, Transfer-Discharge, Death:

OASIS Submission Status	Impact on Billing
Ready to Submit	No impact - billing for the episode was already closed or blocked
Submitted	No impact

OASIS Submission Status	Impact on Billing
Accepted	No impact - CMS acceptance is for compliance/reporting only
Rejected	Must resubmit for compliance, but doesn't block past billing
Pending Correction	Must resubmit for compliance

Why This Matters:

- These assessments don't enable future billing (since the episode is ending or has ended)
- But they **must still be submitted and accepted** for CMS compliance and quality reporting
- Rejected Transfer/Discharge/Death assessments won't block billing for past visits, but they **will** cause compliance issues and may trigger audits if not corrected

22.10 Best Practices for OASIS Submission Management

1. Establish a Submission Schedule

- **Daily Submission Routine:** Designate a specific time each day (e.g., 10 AM) to export and submit all "Ready to Submit" assessments
- **Assign Responsibility:** Have a dedicated OASIS Coordinator or Billing Manager responsible for this task
- **Don't Let Assessments Sit:** Delays in submission = delays in billing = cash flow problems

2. Monitor the "Submitted" Tab Daily

- Check the **Time Since Submission** column
- If any submission is **> 5 business days** without a response, log into the CMS portal to check for responses manually
- If **> 7 business days**, contact your state's OASIS support line

3. Prioritize Rejections

- When an assessment is rejected, **notify the clinical team immediately** (don't wait days)
- Set a goal: **All rejections corrected and resubmitted within 3 business days**
- Track rejection reasons to identify patterns (e.g., if the same clinician makes the same error repeatedly, provide targeted training)

4. Use the CMS Submission ID for Tracking

- **Always** paste the CMS Submission ID when marking an assessment as submitted
- This allows you to quickly look up the submission in the CMS portal if there's a question or delay
- Without the ID, you'll have to search by patient name and date, which is much slower

5. Document Everything

- Keep a **log** (spreadsheet or notes) of:
 - Submission dates
 - CMS Submission IDs
 - Acceptance/Rejection dates
 - Rejection reasons
- This log is invaluable during audits or if CMS disputes a submission

6. Train Clinicians on Common Rejection Reasons

- Review the "Rejected" tab monthly and identify the **top 3-5 rejection reasons**
- Provide targeted training to clinicians:
 - "We've had 10 rejections this month for 'M0100 date before M0030' - remember, the assessment completion date must be on or after the SOC date"
 - "We've had 5 rejections for 'M1800 value out of range' - review the allowed values for each functional status item"

7. Set Up Email Alerts (If Your CMS Portal Supports It)

- Many state CMS portals allow you to enable email notifications for submission responses
- If available, enable this so you're notified immediately when CMS accepts or rejects a submission (instead of checking manually each day)

8. Coordinate with Billing Team

- **Weekly Meeting:** Have a brief weekly sync between the OASIS Coordinator and Billing team
- **Discuss:**
 - How many assessments were accepted this week (billing can now proceed for those episodes)
 - How many rejections are outstanding (billing is blocked for those episodes)
 - Expected timeline for resubmissions

22.11 Common Scenarios & Troubleshooting

Scenario 1: Assessment Stuck in "Submitted" for 10+ Days

What's Happening:

- You submitted the assessment to CMS 10 days ago, but still no response (no acceptance or rejection)

What to Do:

1. Log into your state's CMS OASIS portal
2. Look up the submission using the **CMS Submission ID** or patient name/date
3. Check the status in the portal:
 - **If accepted:** Manually mark it as "Accepted" in your system (CMS may have sent a response that you missed)
 - **If rejected:** Download the rejection report and mark it as "Rejected" in your system

- **If still pending:** Contact your state's OASIS support line (they can investigate if there's a system issue)

Scenario 2: Clinician Says They Fixed the Errors, But Assessment Still in "Pending Correction"

What's Happening:

- The clinician corrected the OASIS form and resubmitted it, but it's still showing in the "Pending Correction" tab

What to Do:

1. Check the **QA Center** - the corrected assessment should be in the QA queue as "Pending Review"
2. If it's in QA, approve it (assuming the errors are fixed)
3. Once approved and signed (if needed), the assessment will automatically move from "Pending Correction" back to "Ready to Submit"
4. If the clinician says they submitted it but it's not in QA:
 - The clinician may have saved the form but not **completed** it (they need to click "Complete Visit" or "Finalize Assessment" to send it to QA)
 - Contact the clinician to verify

Scenario 3: CMS Accepted the Assessment, But Care Order Is Still Not "Active"

What's Happening:

- You marked the OASIS SOC as "Accepted," but the Care Order status didn't automatically change to "Active"

What to Do:

1. **Verify the assessment type:** The auto-activation only happens for **SOC, Recert, and ROC** (not Transfer, Discharge, Death)
2. **Check the Care Order manually:** Navigate to Care Orders > [Patient's Care Order] > Details
 - If the status is still "PENDING_POC_SIGNATURE," there may be a system issue
3. **Manual Override (Admin Only):** If needed, an administrator can manually change the Care Order status to "Active" from the Care Order Details page
4. **Contact IT Support:** If the issue persists, report it as a bug

Scenario 4: Accidentally Marked Assessment as "Submitted" Before Actually Submitting to CMS

What's Happening:

- You clicked "Mark as Submitted" too early (before uploading to the CMS portal), and now the assessment is in the "Submitted" tab but hasn't actually been submitted

What to Do:

1. Navigate to the **Submitted** tab

2. Find the assessment
3. Click **Actions > Update Status**
4. Select **"Force Status Change" (if available)** or **"Mark as Ready to Submit"**
5. This moves the assessment back to "Ready to Submit"
6. Now, follow the proper workflow: Export XML → Submit to CMS → Mark as Submitted (with the real CMS Submission ID)

Scenario 5: CMS Rejection Reason Is Unclear or Cryptic

What's Happening:

- The rejection reason shows a cryptic code like "CRITICAL [con-invalid-lineside-jod1-non-lineside...]" and you don't understand what it means

What to Do:

1. **Download the CMS Validation Report** from the CMS portal - this report usually includes a more detailed explanation of each error code
2. **Common Rejection Code Translations:**
 - con-invalid-lineside-jodX often means a **consistency rule violation** (e.g., two items with conflicting values)
 - format-error means a **data format issue** (e.g., date in wrong format, value out of range)
 - missing-required means a **required item is blank**
3. **Contact CMS Support:** If the validation report is still unclear, call your state's OASIS support line and ask them to explain the specific error code
4. **Notify the clinical team with as much detail as possible:** Even if you don't fully understand the error, paste the entire rejection reason into the notification so the clinician can review the OASIS form and identify the issue

Scenario 6: Resubmitted Assessment Was Rejected Again for the Same Reason

What's Happening:

- The clinician corrected the assessment and resubmitted it, but CMS rejected it again for the same error

What to Do:

1. **Review the correction:** Ask the clinician to show you exactly what they changed
2. **Compare the old and new XML files:** Export both versions and compare them side-by-side to verify the change was actually saved
3. **Common Causes:**
 - The clinician made the change in the wrong section (e.g., changed M0100 but the error was about M0090)
 - The clinician saved the change locally but didn't **resubmit** the form through QA, so the old version was used

- The error message was misinterpreted (e.g., "M0100 must be on or after M0030" means $M0100 \geq M0030$, but the clinician made it $M0100 < M0030$)

4. Provide hands-on training: If the clinician is struggling with the correction, schedule a screen-share session to walk them through it

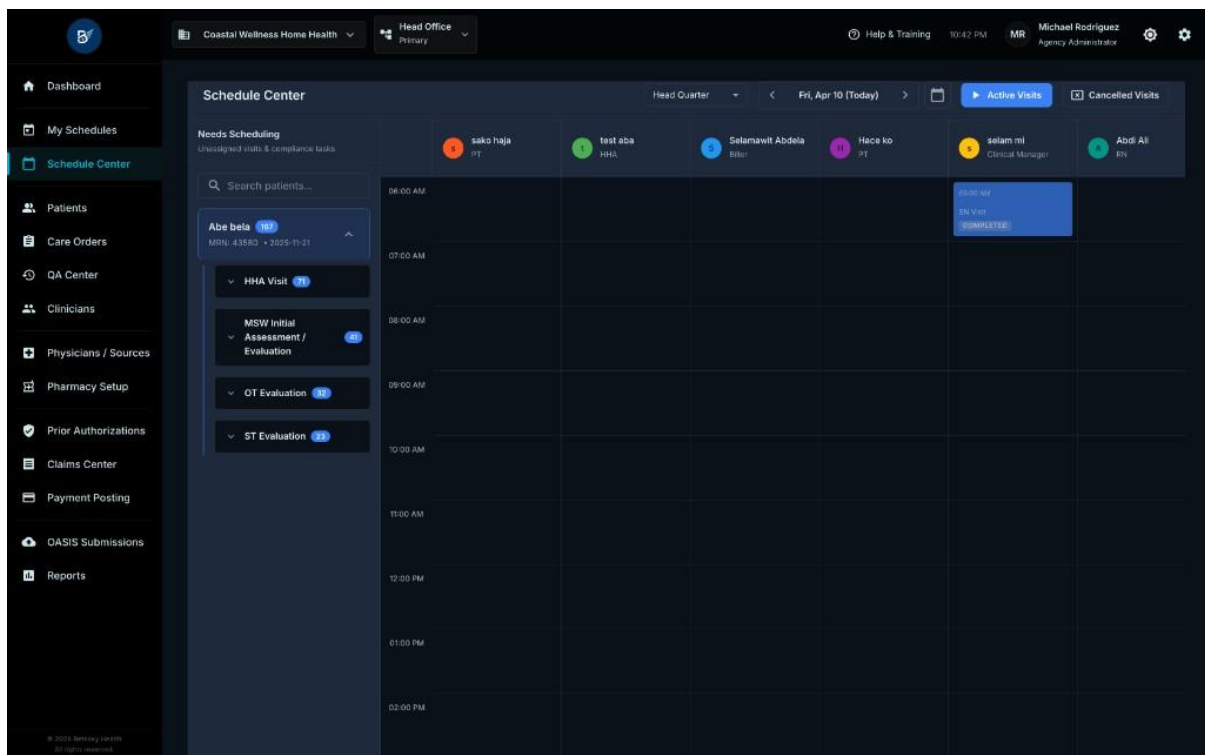
Chapter 23: Schedule Center & Calendar Management

Overview

The **Schedule Center** is the central hub for managing all clinical visits, staff assignments, and time scheduling across your agency. This powerful drag-and-drop calendar interface combines traditional scheduling with intelligent compliance task management, ensuring that both routine visits and regulatory requirements are properly scheduled and completed.

Understanding the Interface

Main Screen Layout



The Schedule Center consists of four main areas:

1. Left Sidebar: Needs Scheduling

This panel displays patients who have unscheduled visits or compliance tasks that need to be assigned to clinicians. It shows:

- **Patient search bar** - Filter patients by name or MRN
- **Patient cards** - Each card shows:

- Patient name
- Number badge indicating total unscheduled items
- **Red "compliance" chip** - Appears when the patient has pending compliance tasks (e.g., "2 compliance" means 2 compliance tasks need scheduling)
- MRN (Medical Record Number)
- Earliest visit date
- Branch name (if multi-branch feature is enabled)

When you click a patient card, it expands to show all unscheduled visits and compliance tasks for that patient.

2. Top Header Bar

- **Branch Selector** (for users with "branch:manage" permission) - Switch between Head Quarter and specific branches to view different scheduling contexts
- **Date Navigator** - Left/right arrows to move between days
- **Date Display** - Shows the currently selected date (e.g., "Fri, Apr 10 (Today)")
- **Calendar Icon** - Opens a date picker modal to jump to any specific date
- **Active Visits Button** - Opens a drawer showing all visits currently "In Progress" or ready to check in
- **Cancelled Visits Button** - Opens a drawer showing recently cancelled visits that can be rescheduled

3. Center: Calendar Grid

The main calendar displays time slots from **6:00 AM to 10:00 PM** in one-hour increments. Each column represents a clinician (staff member) showing:

- **Clinician name and role/discipline** (e.g., "Michael Rodriguez - Skilled Nursing")
- **Visit cards** on the timeline - Each card shows:
 - Patient name
 - Visit type (e.g., "HHA Visit", "OASIS SOC", "PT Evaluation")
 - Time slot placement on the timeline

4. Right Panel: Clinician Details (appears when you click a clinician column)

Shows detailed information about the selected clinician including their scheduled visits for the day.

Understanding Visit Types vs. Compliance Tasks

The Schedule Center handles **two distinct types of scheduling items**, each with different behaviors:

Regular Visits

- Created through Care Orders, Plan of Care, or manually via "Create Manual Visit"
- May or may not have a pre-assigned clinician

- If unassigned, they appear in the left sidebar as **draggable items** that can be assigned to any qualified clinician
- Once assigned, they appear on the calendar

Compliance Tasks

Compliance tasks are **automatically generated by the system** when specific conditions occur. They ensure regulatory requirements are met. They appear in the left sidebar with special visual indicators.

Types of Compliance Tasks

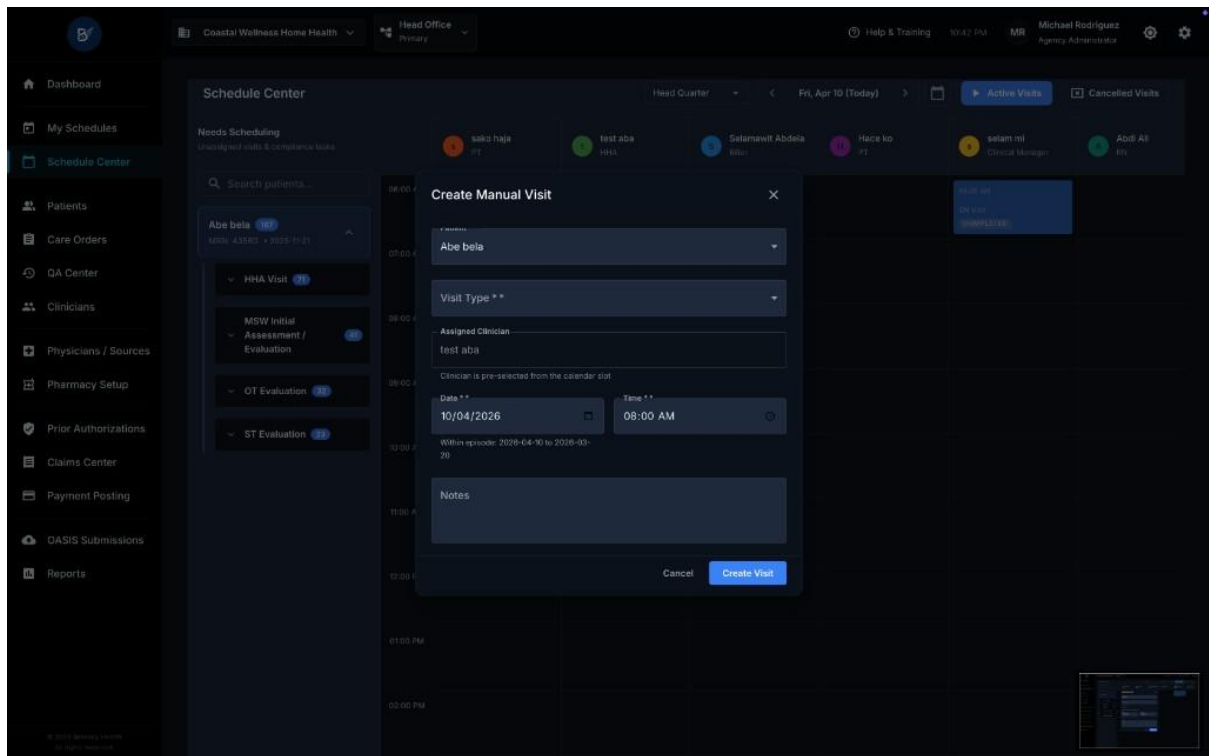
Task Type	When Created	Due Date	Description
OASIS_ASSESSMENT	New patient admission (SOC) created	5 days after SOC date	Complete Start of Care OASIS assessment
OASIS_RECERTIFICATION	Recertification episode is initiated	Episode end date	Complete Recertification OASIS before episode expires
OASIS_DISCHARGE	Discharge process is initiated	As specified	Complete Discharge OASIS assessment
OASIS_DEATH	Death at Home process is initiated	As specified	Complete Death at Home OASIS assessment
HHA_SUPERVISORY_VISIT	First HHA visit is completed OR a supervisory visit is completed	14 days after triggering visit	Conduct HHA supervisory visit (every 14 days)
LPN_SUPERVISORY_VISIT	First LPN/LVN visit is completed	30 days after triggering visit	Conduct LPN supervisory visit by RN case manager
PHYSICIAN_SIGNATURE	Document requires physician approval	As specified	Obtain physician signature on clinical document
RENEW_AUTHORIZATION	Authorization is expiring	Before expiration	Renew prior authorization with payer
UNSIGNED_DOCUMENT	Document pending signature	As specified	Complete document signature requirement

How Compliance Tasks Work in Schedule Center

1. **Automatic Creation:** Compliance tasks are created automatically by backend logic when trigger conditions are met (e.g., first HHA visit completed → creates HHA_SUPERVISORY_VISIT task due in 14 days)

2. **Assignment:** Most compliance tasks are automatically assigned to the **Case Manager** of the care order. Some tasks (like HHA/LPN supervisory visits) must be performed by clinicians with specific disciplines (e.g., RN for LPN supervisory).
3. **Visibility:** Compliance tasks appear in the left sidebar with:
- **Red "compliance" chip** on the patient card
 - Special visual styling when the patient is expanded
 - Due date display ("Today", "Tomorrow", or specific date)
 - Task description from the system
4. **Scheduling Process:** When you drag a compliance task to the calendar:
- The system **creates a new visit** linked to the compliance task
 - The visit type is automatically determined based on the task type (e.g., HHA_SUPERVISORY_VISIT → creates an HHA Supervisory Visit)
 - The system validates that the selected clinician has the correct discipline to perform this task
 - Once scheduled, the compliance task status changes from **PENDING** to **SCHEDULED**
 - The task remains linked to the visit throughout its lifecycle
5. **Completion:** When the visit is checked in, completed, and the visit note is approved:
- The compliance task status changes to **COMPLETE**
 - If it's a recurring task type (like HHA supervisory visits), a new compliance task is automatically created with the next due date
6. **Discipline Restrictions:** Some compliance tasks can only be performed by clinicians with specific disciplines:
- **OASIS Assessments** → RN or PT (depending on agency configuration)
 - **HHA Supervisory Visit** → RN case manager or qualified RN
 - **LPN Supervisory Visit** → RN only (cannot be assigned to the LPN being supervised)

Creating Visits Manually



When to Create Manual Visits

You should create manual visits when:

- A patient needs an ad-hoc visit outside the Plan of Care
- A clinician reports the need for an additional assessment
- You need to schedule a communication note or coordination visit

How to Create a Manual Visit

Step 1: Open the Modal

- Click the **blue "+"** button in the top-right corner of any clinician column in the calendar
- Or click an empty time slot on the calendar

Step 2: Fill in Visit Details

The modal shows the following fields:

Field	Description	Required ?
Patient	Select the patient for this visit. The dropdown shows all active patients with their current care order dates displayed in parentheses (e.g., "Abe bela (MRN: 43829 • 2025-11-01 → 2026-01-30)").	Yes
Visit Type	Select the type of visit. Only visit types appropriate for the selected patient's care order are shown. Note: OASIS visit types (SOC, Recert, Discharge, Transfer, Death) are NOT available here because they must be created through proper care order	Yes

Field	Description	Required ?
	workflows to ensure regulatory compliance.	
Date	The date for the visit. Must be within the patient's current care order period. Cannot be in the past.	Yes
Time	Select a time slot from 6:00 AM to 10:00 PM in one-hour increments.	Yes
Clinician	Select the clinician to assign this visit to. Only clinicians whose discipline matches the selected visit type are shown (e.g., if you select "PT Evaluation", only Physical Therapists appear in the list).	Yes
Notes	Optional internal notes about this visit (not shown to the patient).	No

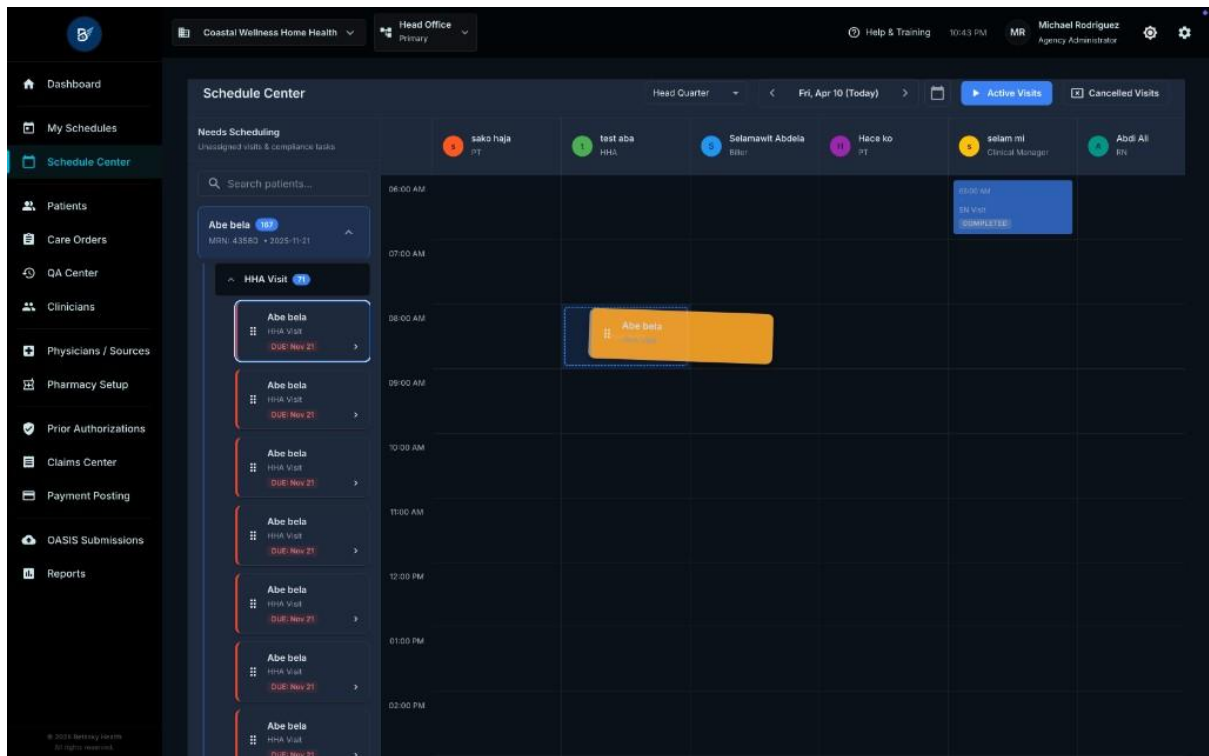
Step 3: Validate and Create

- The modal validates that the selected date falls within the care order's certification period
- If the selected time slot is already occupied by another visit for that clinician, you'll see an error
- Click "**Create Visit**" to schedule the visit

What Happens After Creation:

1. The visit is created with status **Scheduled**
2. It immediately appears on the calendar at the specified time and clinician column
3. The clinician is notified (if notifications are enabled)
4. The visit appears in the clinician's mobile app schedule
5. The patient list in the left sidebar updates to reflect the new visit count

Scheduling Compliance Tasks



Compliance tasks have a special scheduling flow that differs from regular visits.

How to Schedule a Compliance Task

Step 1: Find the Task

- Click on a patient card in the left sidebar to expand their unscheduled items
- Compliance tasks are visually distinct and show the task description (e.g., "HHA Supervisory Visit required for patient. First HHA visit completed.")

Step 2: Choose How to Schedule

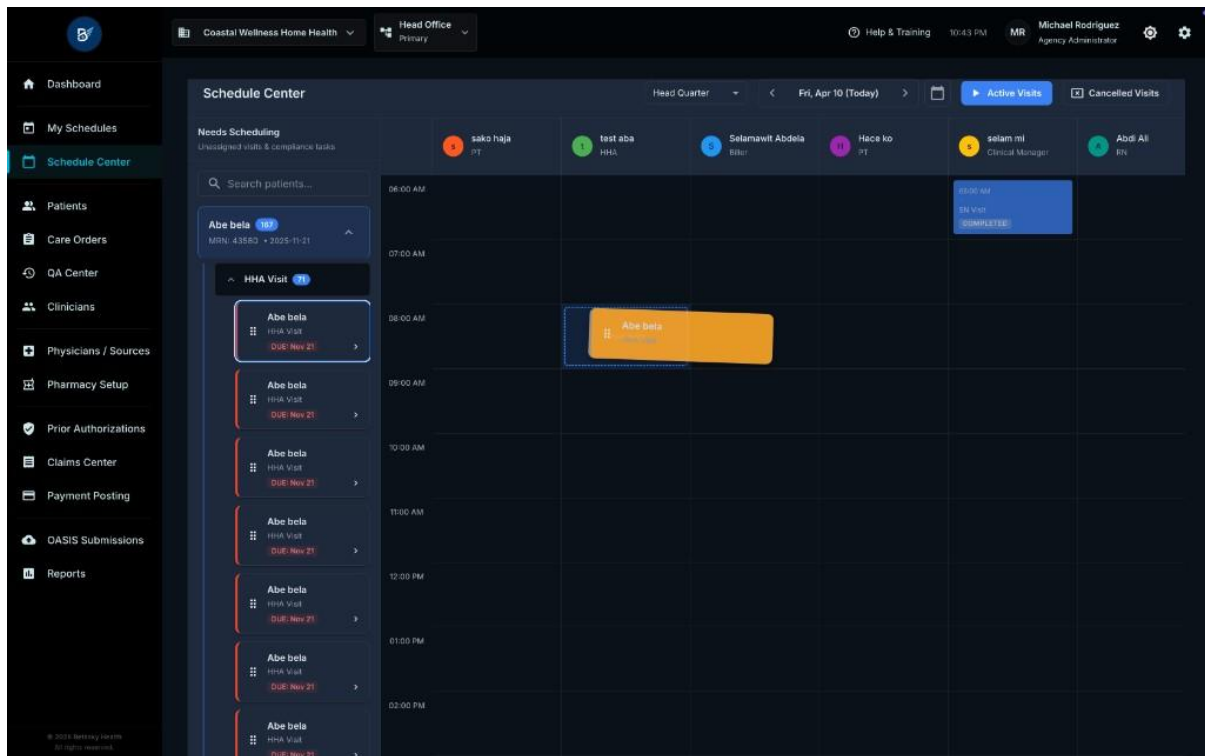
You have **two options** to schedule a compliance task:

Option A: Drag and Drop

- Click and drag the compliance task card from the sidebar
- Drop it onto a time slot in a clinician's column on the calendar
- The system validates discipline restrictions and shows an error if the clinician is not qualified

Option B: Click to Schedule

- Click the **"Schedule"** button on the compliance task card
- A modal opens showing:



Field	Description	Restrictions
Patient & task	Read-only display showing patient name and task description	Cannot be changed
Date	Date picker for the visit. Defaults to the current selected date on the calendar.	Cannot be in the past
Time	Dropdown with time slots from 6:00 AM to 10:00 PM	-
Clinician	Dropdown showing only clinicians who are qualified to perform this task type. The system automatically filters based on discipline requirements.	Critical: If a compliance task requires a specific clinician (e.g., assigned case manager), only that clinician appears in the list. For discipline-specific tasks (e.g., LPN Supervisory Visit), only RNs are shown.

Step 3: Validation

The system performs several validations when you schedule a compliance task:

- 1. Discipline Check:** Ensures the selected clinician has the correct discipline
 - Example: HHA Supervisory Visit can only be assigned to RNs
 - Example: OASIS assessments can only be assigned to RNs or PTs (depending on settings)
- 2. Visit Type Mapping Check:** The system automatically determines which visit form template to use based on the compliance task type:

- OASIS_ASSESSMENT → oasis-soc form
- OASIS_RECERTIFICATION → oasis-recert form
- HHA_SUPERVISORY_VISIT → hha-supervisory-visit form
- etc.

3. **Slot Availability:** Confirms the time slot is not already occupied

4. **Care Order Status:** Verifies the patient's care order is in the correct status for this task

Step 4: System Actions

When you click "**Schedule**", the following happens:

1. **Visit Creation:** A new visit record is created with:

- status: "Scheduled"
- scheduledAt: The date and time you specified
- clinicianId: The selected clinician
- complianceTaskId: Linked to the compliance task
- visitTypeMappingId: Automatically determined based on task type and clinician discipline

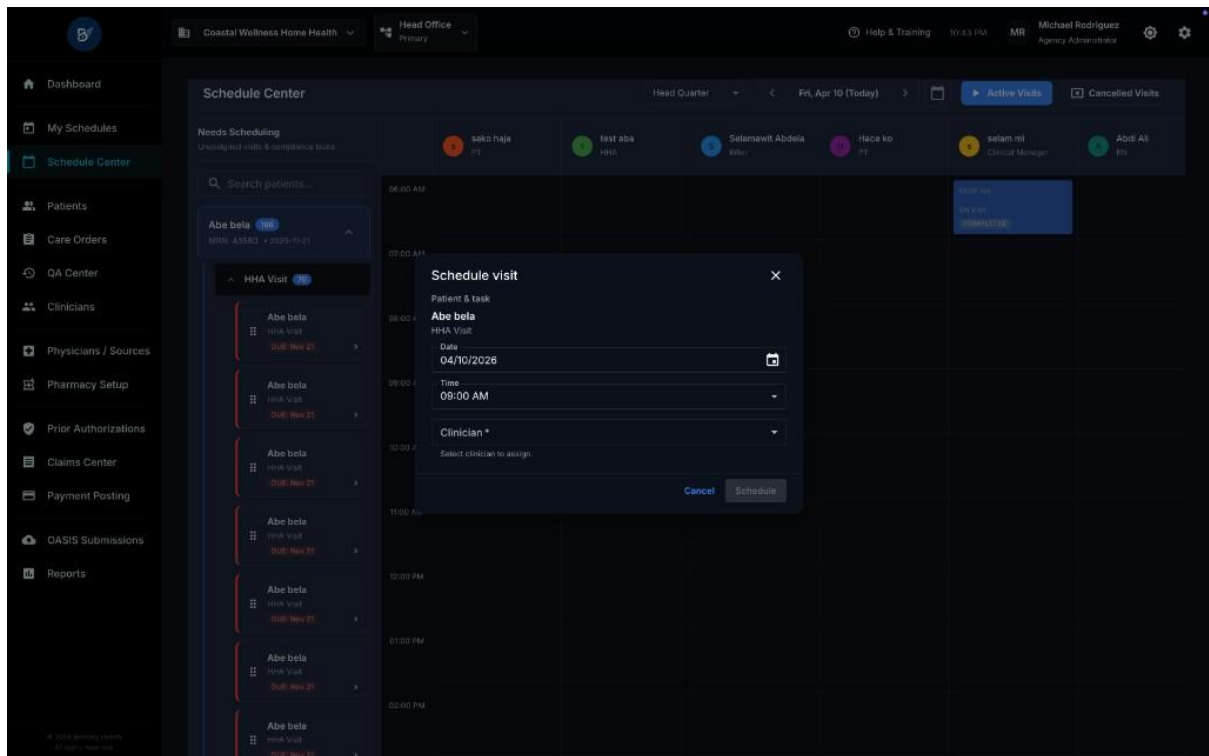
2. **Compliance Task Update:** The compliance task record is updated:

- status: Changes from PENDING to SCHEDULED
- visitId: Set to the newly created visit ID
- This linkage ensures the task and visit stay connected throughout the workflow

3. **Calendar Update:** The visit immediately appears on the calendar at the scheduled time

4. **Sidebar Update:** The compliance task is removed from the "Needs Scheduling" sidebar since it's now scheduled

Understanding the Patient List in Detail



Patient Card Information

When you expand a patient card in the left sidebar, you see:

Visit Cards (Regular Unassigned Visits)

- **Visit type** as the header (e.g., "HHA Visit", "RN Evaluation")
- **Due date** - Shows "Today", "Tomorrow", or the specific date
- **Status indicator** - Color-coded:
 - **Red border** = Urgent (due today or tomorrow)
 - **Normal** = Due in the future
- **Draggable** - Can be dragged to any clinician column (system validates discipline match)

Compliance Task Cards

- **Special visual styling** - Distinct from regular visits
- **Task description** - Auto-generated by the system (e.g., "Complete New Admission OASIS for patient")
- **Due date** with urgency indicator
- **Schedule button** - Opens the schedule modal
- **Cancel button** (X icon) - Allows cancelling the task if it's no longer needed
- **Cannot be manually edited** - Description and due date are system-controlled

Grouping by Visit Type

When a patient has multiple visits of the same type, they're grouped together:

- Click the expand/collapse arrow to show/hide visits of that type

- The count badge shows how many visits of that type exist
- Helpful for patients with recurring visits (e.g., 5 HHA Visits scheduled over the next two weeks)

Patient Card Badges

Badge	Color	Meaning
Number badge (e.g., "5")	Blue	Total count of unscheduled visits + compliance tasks
"X compliance" (e.g., "2 compliance")	Red	Number of compliance tasks needing scheduling

Search Functionality

- Type in the search bar at the top of the patient list
- Searches by **patient name** and **MRN**
- Results update in real-time as you type
- Matching patients remain visible, others are filtered out

Drag-and-Drop Scheduling

How Drag-and-Drop Works

Step 1: Select an Item

- Click and hold on a visit card or compliance task card in the left sidebar
- The item becomes highlighted and follows your cursor
- A semi-transparent preview appears

Step 2: Drag to Calendar

- Move your cursor over the calendar grid
- The calendar shows valid drop zones (time slots for each clinician)
- **Time slots that are already occupied** are visually indicated (you cannot drop on them)

Step 3: Drop on a Time Slot

- Release the mouse button to drop the item
- The system immediately performs validation:
 - **Slot Availability Check:** Is this time slot already taken?
 - **Discipline Check:** Does this clinician have the right qualification for this visit type?
 - **Compliance Check:** If it's a compliance task with a required assignee, does the drop target match?
 - **Date Check:** Is the drop date within the patient's care order period?

Step 4: Validation Results

If validation **passes**:

- The visit card appears on the calendar at the dropped location with a loading spinner
- An API call is made to assign/create the visit
- The loading spinner disappears once confirmed
- The item is removed from the "Needs Scheduling" sidebar

If validation **fails**:

- An error modal appears explaining why (e.g., "This time slot is already occupied")
- The item returns to the sidebar
- No changes are made

Rescheduling Existing Visits

You can also drag **already-scheduled visits** on the calendar to reschedule them:

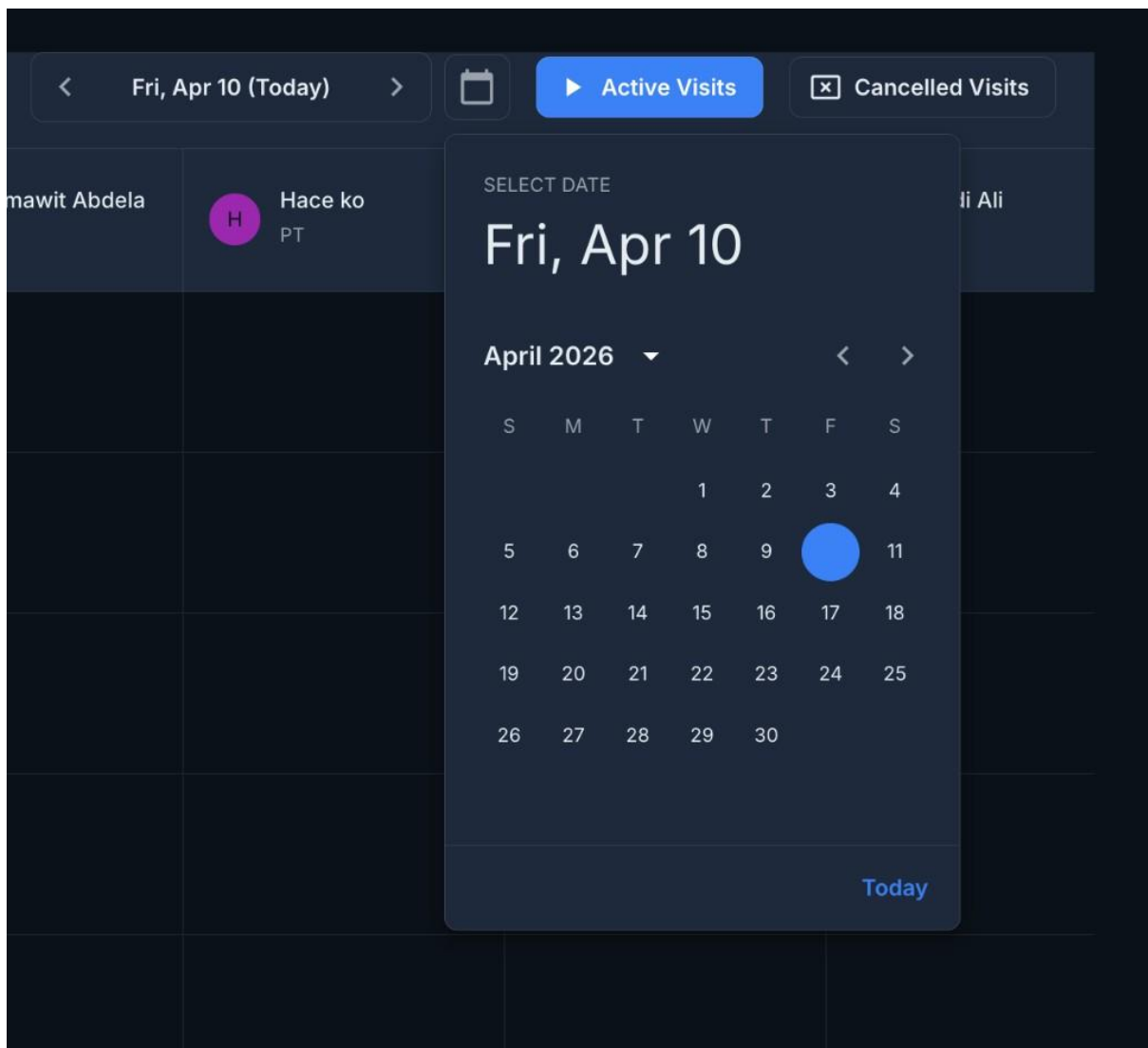
When You Can Reschedule:

- The visit status is **Scheduled** (not **In Progress**, **Completed**, **Missed**, or **Cancelled**)
- The visit is not starting within the next 2 hours (to prevent late cancellations)
- You have the **EDIT_VISIT** permission

How to Reschedule:

1. Click and drag the visit card on the calendar
2. Drop it on a new time slot (can be a different clinician or different time)
3. The system validates:
 - **2-Hour Rule**: Cannot reschedule a visit starting in less than 2 hours (shows "Late Cancellation" error)
 - **Slot availability**: Destination time slot must be empty
 - **Discipline match**: If moving to a different clinician, they must be qualified for this visit type
4. If valid, the visit immediately moves to the new location and the backend is updated

Using the Date Picker



Opening the Date Picker

Click the **calendar icon** in the top header bar.

Date Picker Features

The modal displays a standard calendar view with:

Element	Description
Month/Year Selector	Dropdown to quickly jump to a different month
Previous/Next Arrows	Navigate month by month
Today Highlight	Current date is highlighted in blue
Selected Date	The currently viewed date on the schedule is shown with a filled blue circle
"Today" Button	Quickly jump back to today's date

Selecting a Date

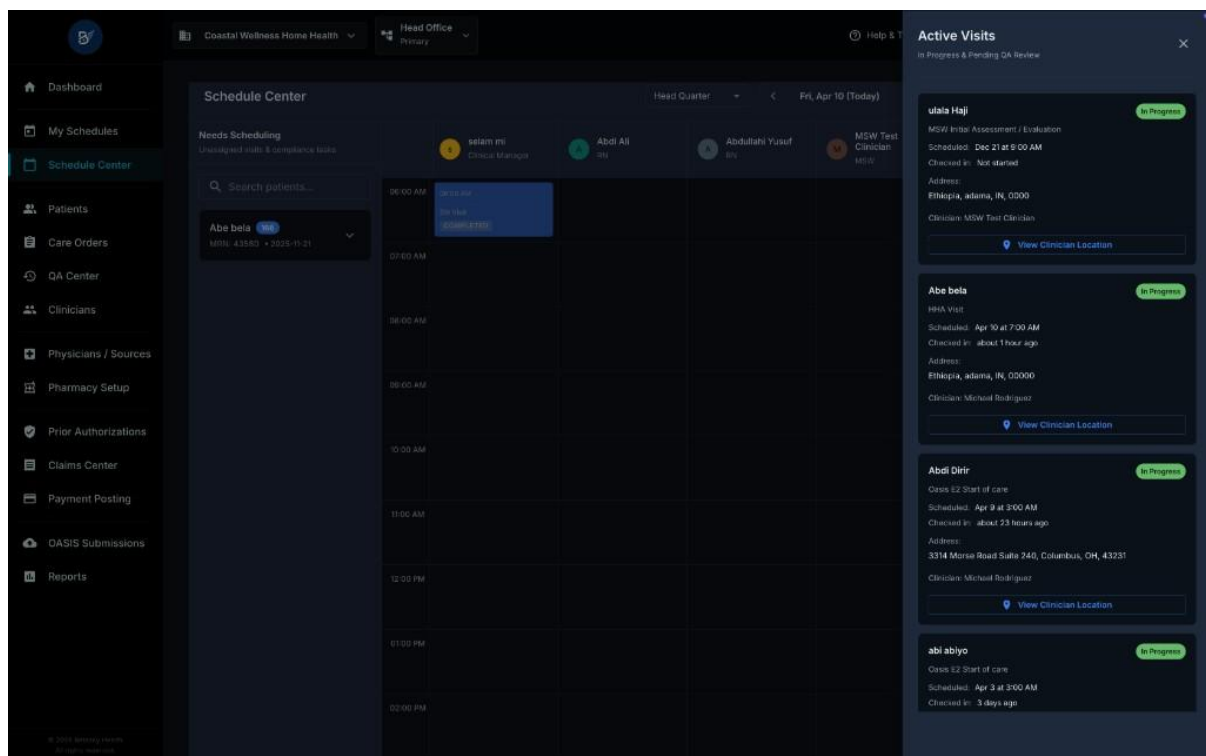
- Click any date on the calendar
- The Schedule Center immediately loads that day's schedule
- The date picker closes automatically
- The "Needs Scheduling" sidebar stays the same (it shows all unscheduled items, not date-specific)

Past Dates

You can view past dates to see historical schedules, but:

- You **cannot** create new visits on past dates
- You **cannot** drag and drop to past dates
- Scheduled visits on past dates are read-only

Active Visits Drawer



What Are Active Visits?

Active visits are visits that are:

- **Status: `In Progress`** - The clinician has checked in and is currently with the patient
- **Ready to check in** - The visit is scheduled for today or earlier and the clinician hasn't checked in yet

Opening the Drawer

Click the "Active Visits" button (with play icon) in the top header bar.

Drawer Contents

The drawer opens from the right side and displays:

Visit Cards

Each card shows:

- **Patient Name** in bold
- **Visit Type** (e.g., "HHA Visit", "MSW Initial Assessment / Evaluation")
- **Status Badge** - Color-coded:
 - **Green "In Progress"** - Clinician is currently with the patient
- **Scheduled Time** - When the visit was scheduled to start (e.g., "Scheduled: Dec 21 at 9:00 AM")
- **Checked In Time** - When the clinician actually checked in (e.g., "Checked in: Morning started")
- **Clinician Name** - Who is performing the visit (e.g., "Clinician: MSW Test Clinician")
- **Patient Address** - Full address where the visit is taking place
- **"View Clinician Location" Button** - Opens a map showing the clinician's real-time GPS location (if they've shared location in the mobile app)

Sorting

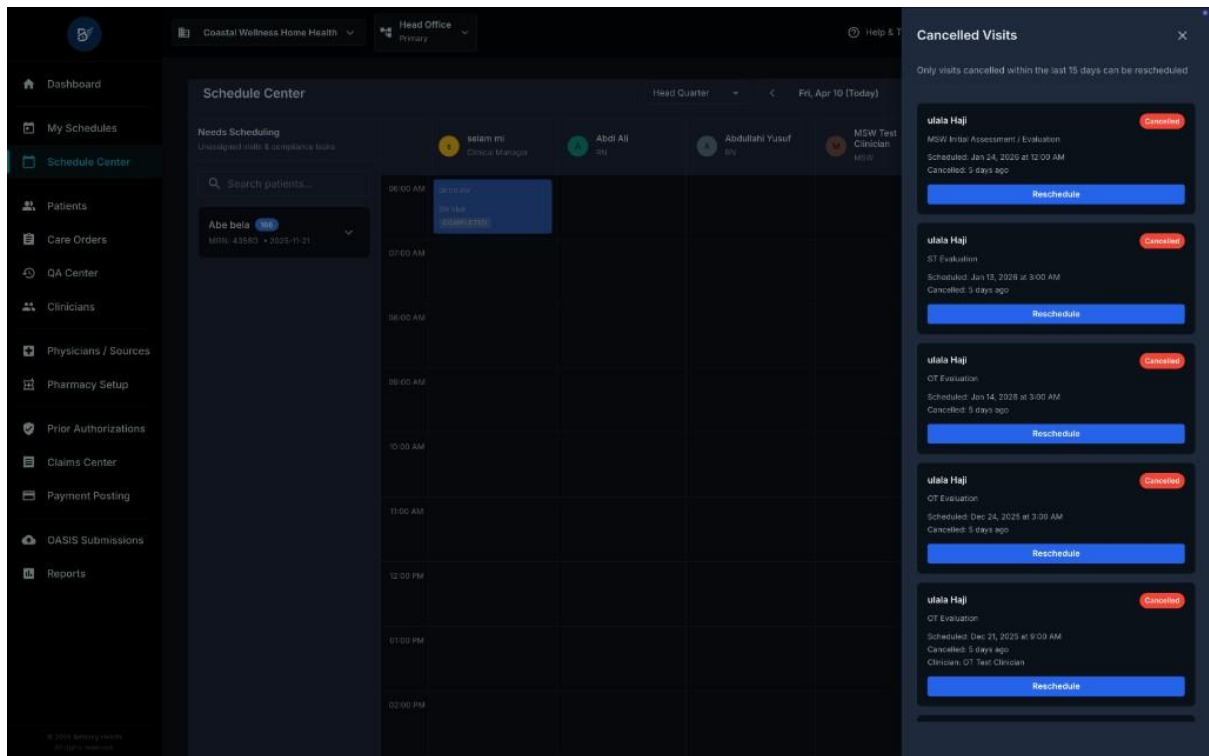
Active visits are sorted by:

1. Status (In Progress visits appear first)
2. Scheduled time (earliest first)

Use Cases for Active Visits Drawer

Scenario	Action
Track field staff	See which clinicians are currently with patients
Monitor late check-ins	Identify visits that should have started but haven't
Coordinate emergency coverage	Quickly see who is in the field and where
Verify location	Use "View Clinician Location" to ensure clinician is at the correct address
Respond to patient calls	Check if the clinician has arrived or is running late

Cancelled Visits Drawer



What Are Cancelled Visits?

Cancelled visits are visits with status: "Cancelled" that were cancelled within the past **15 days**. The system keeps these visible for a short period to allow easy rescheduling if the cancellation was temporary.

Opening the Drawer

Click the "Cancelled Visits" button (with cancel icon) in the top header bar.

Drawer Contents

Each cancelled visit card shows:

Field	Description
Status Badge	Red "Cancelled" badge
Patient Name	Patient for whom the visit was scheduled
Visit Type	Type of visit that was cancelled
Original Scheduled Time	When the visit was originally scheduled (e.g., "Scheduled: Jan 13, 2026 at 3:00 AM")
Cancellation Time	How long ago it was cancelled (e.g., "Cancelled: 3 days ago")
Clinician (if assigned)	Who was assigned to perform the visit
Reschedule Button	Blue button to quickly reschedule this visit

Rescheduling a Cancelled Visit

Step 1: Click "Reschedule"

The schedule modal opens with:

- Patient pre-selected
- Visit type pre-selected
- Date/time fields empty (you choose the new date/time)
- Clinician pre-selected if the original clinician is still available

Step 2: Select New Date/Time

- Choose a new date (must be within the patient's care order period)
- Choose a new time slot
- Optionally change the assigned clinician

Step 3: Confirm

- Click "Schedule"
- The system **creates a new visit** with status: "Scheduled"
- The old cancelled visit remains in the history (it is not modified)
- The new visit appears on the calendar at the specified time

Why Cancelled Visits Are Useful

Reason	Benefit
Patient called in sick	Easily reschedule for later in the week
Clinician had emergency	Reassign to another qualified clinician
Wrong time entered	Cancel and reschedule with correct time
Patient wasn't home	Reschedule for next day
Accidental cancellation	Quickly restore the visit

Automatic Cleanup

Cancelled visits **automatically disappear** from this drawer after 15 days. They remain in the system's permanent records but are no longer shown in the "Cancelled Visits" list.

Branch-Specific Scheduling (Multi-Branch Feature)

If your agency has the **Multi-Branch** feature enabled:

Branch Selector

- Located in the top header bar
- Dropdown showing all branches plus "Head Quarter"
- Selecting a branch changes the entire schedule view to show:
 - **Only clinicians assigned to that branch**

- Only patients assigned to that branch
- Only visits for that branch context

Branch Permissions

Permission Level	What You See
User assigned to a specific branch	Can only view and schedule for your own branch. The branch selector is hidden or locked to your branch.
User with `branch:manage` permission	Can switch between all branches and Head Quarter. Full scheduling access across the entire agency.

Branch Indicators

- Patient cards in the sidebar show "**Branch: [Branch Name]**" if multi-branch is enabled
- Helps you identify which patients belong to which branch when viewing Head Quarter

Compliance Task Lifecycle: Deep Dive

Understanding how compliance tasks flow through the system helps you manage them effectively.

Phase 1: Automatic Creation

Compliance tasks are created by **backend triggers** when specific events occur:

Example 1: HHA Supervisory Visit Task

Trigger Event: A Home Health Aide (HHA) completes their first visit for a patient.

What Happens:

1. Clinician completes the HHA Visit Note in their mobile app
2. The visit status changes to Completed
3. Backend service (complianceTask.service.ts) detects this is the first completed HHA visit for this care order
4. A new compliance task is automatically created:
 - type: "HHA_SUPERVISORY_VISIT"
 - status: "PENDING"
 - dueDate: 14 days from the completion date
 - description: "HHA Supervisory Visit required for patient. First HHA visit completed."
 - patientId: The patient's ID
 - careOrderId: The care order's ID
 - assignedToId: The case manager's user ID (automatically assigned)

Why 14 Days?

CMS regulations require RN supervisory visits for HHAs every 14 days to ensure quality of care and compliance with the Plan of Care.

Example 2: OASIS Recertification Task

Trigger Event: Agency admin clicks "Initiate Recertification" on a care order approaching its end date.

What Happens:

1. Admin clicks the "Initiate Recertification" button (see Care Orders chapter)
2. Backend validates:
 - The current episode has been active for at least 14 days
 - The initial OASIS for this episode is completed
 - No other recertification is already in progress
3. A new compliance task is automatically created:
 - type: "OASIS_RECERTIFICATION"
 - status: "PENDING"
 - dueDate: The care order's certification end date (must be done before episode expires)
 - description: "Complete OASIS Recertification for patient. Episode ends on [date]."
 - assignedToId: The case manager or the selected RN clinician

Why This Matters:

The recertification OASIS must be completed and approved before the episode end date, or the care order will close and billing will stop. The compliance task ensures this critical deadline doesn't get missed.

Phase 2: PENDING Status

When a compliance task is in **PENDING** status:

- **Visibility:** Appears in the Schedule Center left sidebar under the patient's card
- **Visual Indicator:** Patient card shows a red "X compliance" badge
- **Due Date Urgency:** Changes color/style as it approaches:
 - **Normal** (more than 1 day out) - Standard styling
 - **Urgent** (today or tomorrow) - Red highlighting
 - **Overdue** (past due date) - May show additional warning indicators
- **Assignment:** Most tasks are assigned to the case manager, but some (like LPN Supervisory Visit) require specific disciplines
- **Actions Available:**
 - **Schedule** - Opens the schedule modal to assign the task to a clinician and time slot
 - **Cancel** - If the task is no longer needed (e.g., patient was discharged), you can cancel it

Phase 3: Scheduling (Creating the Visit)

When you schedule a compliance task:

Backend Actions:

1. **Visit Creation:** A new visit record is created with:
 - The appropriate `visitTypeMappingId` based on the task type and clinician's discipline

- `scheduledAt` set to the date/time you selected
- `clinicianId` set to the assigned clinician
- `complianceTaskId` linking it to the compliance task
- `status`: "Scheduled"

2. Compliance Task Update:

- `status` changes from `PENDING` to `SCHEDULED`
- `visitId` is set to the newly created visit ID
- This bidirectional link ensures the task and visit stay connected

What You See:

- The visit appears on the calendar
- The compliance task disappears from the "Needs Scheduling" sidebar
- The patient's badge count decreases

Phase 4: SCHEDULED Status

When a compliance task is in `SCHEDULED` status:

- **Visibility:** It's no longer in the "Needs Scheduling" sidebar (because it has a scheduled visit)
- **Linked Visit:** The visit appears on the calendar at the scheduled time
- **Mobile App:** The clinician sees this visit in their schedule in the mobile app
- **Rescheduling:** If you need to change the date/time:
 - Drag the visit card on the calendar to a new slot, OR
 - Click the visit card and edit the scheduled time
 - The compliance task remains in `SCHEDULED` status, and its `visitId` link is maintained
- **Cancellation:** If you cancel the scheduled visit:
 - The visit status becomes `Cancelled`
 - The compliance task status reverts to `PENDING`
 - The task reappears in the "Needs Scheduling" sidebar
 - You must reschedule it

Phase 5: IN_PROGRESS Status

When the clinician checks in to the visit using the mobile app:

- **Visit Status:** Changes from `Scheduled` to `In Progress`
- **Compliance Task Status:** Automatically changes from `SCHEDULED` to `IN_PROGRESS`
- **Active Visits Drawer:** The visit appears in the Active Visits drawer
- **Real-time Tracking:** If the clinician shares their location, administrators can see their GPS position

Phase 6: COMPLETE Status

When the clinician completes the visit and the visit note is approved:

Trigger: The clinical document (visit note) for this visit is approved in the QA Center.

Backend Actions:

1. **Visit Status:** Changes to **Completed**
2. **Compliance Task Status:** Changes from **IN_PROGRESS** to **COMPLETE**
3. **Recurring Task Creation** (if applicable):
 - For **HHA Supervisory Visits:** A new **HHA_SUPERVISORY_VISIT** task is automatically created with **dueDate** = 14 days from completion
 - This creates a continuous cycle ensuring supervisory visits happen every 14 days as long as the patient receives HHA care

What You See:

- The visit shows as completed on the calendar
- The compliance task no longer appears in the Schedule Center (it's complete)
- If it's a recurring type, a new task appears in the sidebar for the next cycle

Phase 7: CANCELLED or OVERDUE Status

CANCELLED Status

If a compliance task is manually cancelled:

- **How:** Click the "X" button on the task card in the sidebar
- **Confirmation:** A modal asks for confirmation
- **Effect:**
 - Task status becomes **CANCELLED**
 - If a visit was scheduled, it's unlinked (**visitId** set to null)
 - The visit itself is NOT automatically cancelled (you must cancel it separately if needed)
 - The task disappears from the sidebar

When to Cancel:

- Patient was discharged and the task is no longer relevant
- The task was created in error
- The requirement changed (e.g., patient no longer receives HHA services)

OVERDUE Status

- Compliance tasks automatically become **OVERDUE** if the due date passes and they're still in **PENDING** or **SCHEDULED** status
- Overdue tasks may trigger alerts or notifications (depending on agency settings)
- They remain in the sidebar and can still be scheduled

Discipline-Based Filtering for Compliance Tasks

When you schedule a compliance task, the system automatically restricts which clinicians can be assigned based on **discipline requirements**. This ensures regulatory compliance and proper skill matching.

How Discipline Filtering Works

Step 1: Task Type Determines Required Form

The compliance task's type field maps to a specific visit form template:

Task Type	Form Template Key	Discipline Requirement
HHA_SUPERVISORY_VISIT	hha-supervisory-visit	RN only
LPN_SUPERVISORY_VISIT	lpn-supervisory-visit	RN only
OASIS_ASSESSMENT	oasis-soc	RN or PT (agency setting)
OASIS_RECERTIFICATION	oasis-recert	RN or PT (agency setting)
OASIS_DISCHARGE	oasis-discharge	RN or PT (agency setting)
PHYSICIAN_SIGNATURE	communication-note	Any (usually RN/case manager)

Step 2: System Queries Visit Type Mappings

The backend looks up the visitTypeMapping table to find a mapping that matches:

- The required form template key (e.g., hha-supervisory-visit)
- The clinician's discipline (e.g., RN)

Example:

Query: formTemplateKey = "hha-supervisory-visit" AND discipline = "RN"

Result: VisitTypeMapping { id: "abc123", visitType: "HHA Supervisory Visit", discipline: "RN" }

If no mapping exists, an error is shown: "No visit type mapping found for [discipline] with form [form key]. Please configure visit types in Clinical Settings."

Step 3: Clinician Dropdown Filtered

When the schedule modal opens, only clinicians with the matching discipline appear in the dropdown:

Example for HHA Supervisory Visit:

- **Shown:** All clinicians with discipline: "RN"
- **Hidden:** PT, OT, SLP, HHA, MSW, LPN (even if they're active clinicians)

Special Case: Assigned Clinician Restriction

Some compliance tasks are **hard-assigned** to a specific clinician and cannot be reassigned:

Example: LPN Supervisory Visit

- When an LPN completes a visit, the task is created and assigned to the **RN case manager** of that patient

- In the schedule modal, **only that case manager** appears in the clinician dropdown
- You cannot assign it to a different RN
- This ensures continuity of care and proper supervision chain

How to Tell:

- If the compliance task has `assignedToId` set, the schedule modal will only show that clinician
- If `assignedToId` is null, the modal shows all clinicians with the required discipline

Conflict Detection and Error Handling

The Schedule Center includes robust validation to prevent scheduling conflicts and errors.

Time Slot Collision Detection

What's Checked:

- When you drag/drop or manually schedule a visit, the system checks if another visit already exists at that time for that clinician

Validation Logic:

Is there any existing visit where:

- `clinicianId` matches the target clinician
- `scheduledAt` time slot matches the target time
- date matches the target date
- status is "Scheduled" or "In Progress" (not "Cancelled" or "Completed")

Error Message:

"This time slot is already occupied."

Resolution:

- Choose a different time slot, OR
- Choose a different clinician

2-Hour Late Cancellation Rule

What's Checked:

- When you try to reschedule an **already-scheduled visit** by dragging it on the calendar

Rule:

If the visit is scheduled to start within the next 2 hours, it cannot be rescheduled without cancelling first.

Why This Exists:

- Clinicians may already be en route to the visit
- Late rescheduling disrupts the patient's expectations
- CMS considers rescheduling within 2 hours as a late cancellation, which can affect agency metrics

Error Message:

"Late Cancellation: Cannot reschedule a visit starting in less than 2 hours."

Resolution:

- Cancel the visit through the proper cancellation flow (which logs it as a late cancellation)
- Create a new visit for the rescheduled time

Care Order Date Validation

What's Checked:

- The selected visit date must fall within the patient's care order certification period

Example:

- Care Order: Jan 1, 2026 → Feb 29, 2026
- Valid visit date: Jan 15, 2026
- Invalid visit date: Mar 5, 2026

Error Message:

"Visit date must be within the care order period."

Resolution:

- Choose a date within the care order period, OR
- Extend the care order period (requires initiating recertification or resuming from hold)

Visit Status Restrictions

What's Checked:

- Visits can only be rescheduled or edited if they're in **Scheduled** status

Rule:

- **In Progress** - Cannot reschedule (clinician has already checked in)
- **Completed** - Cannot reschedule (visit is done)
- **Missed** - Cannot reschedule (must create a new visit)
- **Cancelled** - Use the "Reschedule" button in the Cancelled Visits drawer

Error Message:

"This visit is [status] and cannot be edited."

Resolution:

- For In Progress: Wait for the clinician to complete the visit, then create a follow-up visit if needed
- For Completed: This is a historical record; create a new visit if needed
- For Cancelled: Use the reschedule function in the Cancelled Visits drawer

Discipline Mismatch

What's Checked:

- When assigning a visit (regular or compliance task), the selected clinician's discipline must match the visit type's discipline requirement

Example:

- Visit Type: "PT Evaluation" (requires discipline = "PT")
- Selected Clinician: RN

- Result: Error

Error Message:

"No visit type mapping found for [RN] with form [pt-evaluation]. Please configure visit types in Clinical Settings."

OR (for compliance tasks):

"Compliance Violation: This task must be performed by [required discipline name]."

Resolution:

- Select a clinician with the correct discipline, OR
- If no clinicians with that discipline exist, onboard a new clinician or configure visit type mappings in Clinical Settings

Best Practices for Effective Scheduling

1. Monitor Compliance Task Due Dates Daily

Why:

Compliance tasks have regulatory implications. Overdue OASIS assessments can prevent billing. Overdue HHA supervisory visits can result in CMS deficiencies.

How:

- Check the "Needs Scheduling" sidebar each morning
- Look for patients with red "compliance" badges
- Prioritize tasks marked as "Today" or "Tomorrow"
- Schedule OASIS tasks well before their due dates to allow time for completion, QA review, and corrections

2. Balance Clinician Workloads

Why:

Overloaded clinicians may rush visits, leading to poor documentation or patient dissatisfaction. Underutilized clinicians waste agency resources.

How:

- Review the calendar daily to see how many visits each clinician has
- Aim for 6-8 visits per day per field clinician (adjust based on visit types and travel distance)
- Use the drag-and-drop feature to move visits between clinicians if one is overbooked
- Consider travel distance: assign patients in the same geographic area to the same clinician on the same day

3. Schedule High-Priority Visits Early in the Day

Why:

If a clinician encounters delays or emergencies, later visits may get missed. Critical visits (OASIS assessments, supervisory visits) should happen when the clinician is fresh and has buffer time.

How:

- Schedule OASIS assessments in the 9:00 AM - 12:00 PM time slots

- Reserve afternoon slots for routine visits or follow-ups
- Avoid scheduling compliance tasks at 10:00 PM (late slots are for emergencies only)

4. Use the Active Visits Drawer for Real-Time Coordination

Why:

Patient emergencies, clinician no-shows, or unexpected issues require quick response.

How:

- Keep the Active Visits drawer open during peak field hours (9 AM - 3 PM)
- If a visit shows as "In Progress" for longer than expected, call the clinician to check in
- If a clinician hasn't checked in 15 minutes after scheduled start time, contact them
- Use "View Clinician Location" to verify they're at the correct address (helps catch incorrect patient address issues)

5. Review Cancelled Visits Weekly

Why:

Cancelled visits represent lost revenue and may indicate problems (frequent cancellations by a patient, clinician reliability issues, incorrect scheduling).

How:

- Check the Cancelled Visits drawer every Friday
- Identify patterns: Are specific patients cancelling frequently? Is one clinician cancelling more than others?
- Reschedule any cancelled visits that were temporary (patient was sick, clinician had emergency)
- For persistent cancellers, contact the patient to discuss barriers to care

6. Plan Ahead for Recertifications

Why:

Recertification compliance tasks often have tight deadlines (must be done before episode end date). If delayed, the care order closes and billing stops.

How:

- When a recertification task is created, schedule the OASIS assessment **immediately** (don't wait)
- Schedule it at least 10 days before the episode end date to allow time for:
 - Clinician to complete the visit
 - QA review of the OASIS
 - Corrections if QA returns it
 - Physician signature if required
 - CMS submission
- Communicate with the case manager: "Recert OASIS for [patient name] is due by [date]. Please complete by [date]."

7. Coordinate HHA Supervisory Visits

Why:

HHA supervisory visits must occur every 14 days while the patient receives HHA care. Missing this requirement is a CMS compliance violation.

How:

- As soon as the HHA_SUPERVISORY_VISIT task appears, schedule it for a date within the next 14 days (don't wait until day 14)
- Schedule it for a day when the case manager RN is already seeing nearby patients (reduces travel time)
- When the supervisory visit is completed, a new task is auto-created—schedule it immediately
- Track the cycle: HHA visit → 14 days → supervisory visit → 14 days → supervisory visit → ongoing

8. Use Filters and Search Effectively

Why:

Large agencies may have hundreds of unscheduled visits. Finding the right patient quickly saves time.

How:

- Use the patient search bar to find specific patients by name or MRN
- Sort patients by earliest visit date to see who needs scheduling soonest
- If multi-branch is enabled, switch branch context to focus on one branch at a time
- Collapse visit type groups you're not working on to reduce clutter

Common Scenarios and Solutions

Scenario 1: Compliance Task Shows "No Eligible Clinicians"

Symptom:

You open the schedule modal for a compliance task, and the clinician dropdown says "No eligible clinicians."

Cause:

No clinicians in the system have the required discipline for this task type.

Example:

- Task: HHA Supervisory Visit (requires RN)
- Your clinicians: 3 HHAs, 2 PTs, 1 MSW
- No RNs exist in the system

Solution:

1. Onboard an RN clinician through the Clinicians module
2. Ensure their discipline field is set to "RN" (not "Skilled Nursing" or other variations)
3. Once the RN is added, return to the Schedule Center and try again

4. The RN should now appear in the dropdown

Scenario 2: Dragging a Compliance Task Shows "Compliance Violation" Error

Symptom:

You drag a compliance task to a clinician's column, and an error appears: "Compliance Violation: This task must be performed by [clinician name]."

Cause:

This compliance task is hard-assigned to a specific clinician (usually the case manager) and cannot be reassigned.

Example:

- Task: LPN Supervisory Visit (assigned to RN case manager "Jane Doe")
- You try to assign it to a different RN ("John Smith")
- Error appears

Solution:

- Only assign this task to the designated clinician (Jane Doe in this example)
- Drag it to Jane Doe's column, or use the schedule modal and select Jane Doe
- If Jane Doe is unavailable (on vacation, resigned), you must:
 1. Go to the patient's Care Order
 2. Change the case manager to a different RN
 3. The compliance task will automatically reassign to the new case manager
 4. Return to Schedule Center and assign it

Scenario 3: Cannot Schedule Visit on a Specific Date

Symptom:

When you try to schedule a visit on a specific date, the date picker shows that date as disabled (grayed out).

Cause:

The selected date is outside the patient's care order certification period, or it's in the past.

Solution:

1. Check the care order dates:
 - Go to Care Orders → select the patient → view certification start and end dates
2. Choose a date within the certification period
3. If the episode is about to end and you need to schedule beyond the end date:
 - Initiate a recertification (see Care Orders chapter)
 - The new episode extends the certification period
4. If the date is in the past:
 - You cannot create visits on past dates (to prevent backdating)
 - Create the visit for a current or future date

Scenario 4: Drag-and-Drop Shows "Time Slot Already Occupied"

Symptom:

You drag a visit to a clinician's time slot, and an error appears: "This time slot is already occupied."

Cause:

Another visit is already scheduled for that clinician at that time.

Solution:

1. Choose a different time slot for the same clinician
2. OR choose a different clinician (if they're qualified for this visit type)
3. If the existing visit in that slot is no longer needed, cancel it first, then reschedule the new visit

Scenario 5: Compliance Task Doesn't Disappear After Scheduling

Symptom:

You schedule a compliance task (the visit appears on the calendar), but the task card remains in the "Needs Scheduling" sidebar.

Cause:

- The backend successfully created the visit but failed to update the compliance task status to SCHEDULED
- Or there's a frontend caching issue

Solution:

1. Refresh the page (F5 or Ctrl+R)
2. If the task still appears, check the backend logs:
 - Look for errors related to `complianceTask.update` in the server logs
 - Common issue: Transaction rollback due to validation failure
3. If the issue persists, contact your system administrator
4. As a workaround, manually cancel the task (click the X button) since it's effectively scheduled

Scenario 6: Clinician Has Too Many Visits in One Day

Symptom:

A clinician's column shows 12 visits scheduled for a single day, which is not feasible.

Cause:

- Multiple users scheduled visits to this clinician simultaneously
- Automatic scheduling (via integrations) didn't check workload limits
- The clinician is the default assignee for all tasks of a certain type

Solution:

1. Identify which visits can be rescheduled:
 - Look for non-urgent visits (not compliance tasks, not today/tomorrow)

- Check for visits that can be performed by other qualified clinicians
- 2. Drag visits to other clinicians' columns to balance the workload
- 3. For compliance tasks assigned to this clinician, check if they can be reassigned:
 - If the task allows any RN, reassign it
 - If it's hard-assigned to this clinician, you must reschedule to a different day
- 4. Communication: Let the clinician know about the schedule change

Scenario 7: Visit Appears on Calendar but Clinician Says They Don't See It

Symptom:

You scheduled a visit and it appears on the Schedule Center calendar, but the clinician reports it doesn't show in their mobile app.

Cause:

- Mobile app hasn't synced yet (mobile apps sync every 5-15 minutes)
- The clinician is logged into a different account
- The visit is assigned to a different clinician than expected
- The clinician has filtered their view (e.g., showing only "Today" visits, but the visit is tomorrow)

Solution:

1. Ask the clinician to pull-to-refresh in the mobile app
2. Verify the visit is assigned to the correct clinician:
 - Click the visit card on the calendar
 - Check the "Clinician" field
 - If wrong, reassign it
3. Check the visit date:
 - Mobile app may only show "Today" by default
 - Ask clinician to change the date filter
4. If still not showing, log out and log back in on the mobile app
5. Last resort: Contact technical support (possible sync issue)

Permissions and Access Control

Different user roles have different capabilities in the Schedule Center.

Required Permissions

Action	Required Permission	Notes
View Schedule Center	VIEW_SCHEDULE	Without this, the Schedule Center menu item is hidden
View clinician list	VIEW_USER	Without this, no clinician columns appear on the calendar

Action	Required Permission	Notes
Create manual visits	CREATE_VISIT	"+" button is hidden if user lacks this permission
Assign unassigned visits	EDIT_VISIT	Cannot drag visits from sidebar to calendar without this
Reschedule visits	EDIT_VISIT	Cannot drag visits on the calendar to new time slots
Cancel visits	CANCEL_VISIT	Cannot access the cancel visit function
Schedule compliance tasks	EDIT_COMPLIANCE_TASKS	Without this, compliance task "Schedule" buttons are hidden
Cancel compliance tasks	EDIT_COMPLIANCE_TASKS	Cannot click the X button on compliance task cards
Switch branches	branch:manage	Branch selector is hidden for users assigned to a specific branch

Role-Based Access Examples

Agency Administrator (Full Access)

- **Permissions:** All permissions
- **Can Do:**
 - View entire agency schedule across all branches
 - Create, assign, reschedule, and cancel visits
 - Manage compliance tasks
 - Switch between branches
 - View active and cancelled visits

Branch Manager (Branch-Specific)

- **Permissions:** All permissions except branch:manage
- **Can Do:**
 - View schedule for their assigned branch only
 - Create, assign, reschedule, and cancel visits within their branch
 - Manage compliance tasks for their branch patients
 - View active and cancelled visits for their branch

Office Coordinator (Limited)

- **Permissions:** VIEW_SCHEDULE, VIEW_USER, CREATE_VISIT
- **Can Do:**
 - View the schedule
 - Create new manual visits

- **Cannot Do:**

- Assign unassigned visits
- Reschedule existing visits
- Cancel visits
- Manage compliance tasks

Clinician (Read-Only)

- **Permissions:** VIEW_SCHEDULE, VIEW_USER

- **Can Do:**

- View the schedule to see their assignments
- See which patients other clinicians are visiting

- **Cannot Do:**

- Create, edit, or cancel visits
- Manage compliance tasks
- Note: Clinicians typically manage their schedule through the mobile app, not the Schedule Center

Troubleshooting Common Issues

Issue: Calendar is Empty / No Clinicians Showing

Possible Causes:

1. No clinicians are onboarded in the system
2. User lacks VIEW_USER permission
3. Selected date has no scheduled visits
4. Branch filter is excluding all clinicians

Solutions:

- Check Clinicians module to ensure clinicians exist and are active
- Verify user permissions in User Roles & Permissions
- Try selecting a different date (use the date picker)
- If multi-branch: switch to "Head Quarter" to see all clinicians

Issue: Patient Has Compliance Task But Can't Schedule It

Possible Causes:

1. User lacks EDIT_COMPLIANCE_TASKS permission
2. No clinicians with required discipline exist
3. Backend validation error (e.g., care order is closed)

Solutions:

- Verify user permissions
- Check if clinicians with the required discipline are onboarded

- Check the patient's care order status (must be Active or ON_HOLD, not Closed)
- Check browser console for error messages

Issue: Compliance Task Keeps Reappearing After Completion

Possible Causes:

1. For HHA/LPN supervisory visits: New tasks are auto-created after completion (this is intentional)
2. Backend failed to mark task as complete

Solutions:

- If it's a supervisory visit, this is expected behavior—a new task is created for the next cycle
- If it's a one-time task (like OASIS), check if the visit note was actually approved in QA Center
- Verify the compliance task's **status** in the database (should be **COMPLETE**)

Issue: Visit Shows in Schedule Center But Not in Mobile App

Possible Causes:

1. Mobile app hasn't synced
2. Visit is assigned to wrong clinician
3. Visit date filter in mobile app

Solutions:

- Pull to refresh in mobile app
- Verify clinician assignment in Schedule Center
- Check date filter in mobile app (expand to see more days)
- Log out and log back in on mobile app

Integration with Other Modules

The Schedule Center is tightly integrated with other parts of the system:

Care Orders Module

- **Link:** Visits are always linked to a care order
- **Impact:** When a care order is closed (discharged), all scheduled visits are automatically cancelled
- **Flow:** Initiating recertification or discharge in Care Orders creates compliance tasks that appear in Schedule Center

QA Center Module

- **Link:** When a visit note is approved in QA Center, the linked compliance task (if any) is marked as complete
- **Impact:** OASIS assessments scheduled via compliance tasks won't be considered "complete" until the OASIS document is approved in QA

Clinicians Module

- **Link:** Clinicians must be onboarded and have the correct discipline field set
- **Impact:** If a clinician's discipline changes, they may lose eligibility for certain compliance tasks they were previously assigned to

Patient Module

- **Link:** Patients must have an active care order to have visits scheduled
- **Impact:** If a patient's care order is On Hold, you can only schedule OASIS ROC (Resumption of Care) visits

Mobile App

- **Link:** All visits scheduled in Schedule Center sync to the mobile app for clinicians
- **Impact:** Clinicians check in, complete visit notes, and mark visits complete via mobile app, which updates the Schedule Center in real-time

Performance Tips for Large Agencies

If your agency has 50+ clinicians and 500+ active patients, the Schedule Center can feel slow. Use these tips to improve performance:

1. Use Branch Filtering

- If multi-branch is enabled, switch to a specific branch instead of viewing "Head Quarter" (which loads all clinicians and patients)

2. Navigate by Date, Not Range

- The Schedule Center loads data for a single day at a time
- Don't try to view multiple days simultaneously (use the date picker to jump between days)

3. Collapse Unused Visit Type Groups

- When a patient card is expanded, collapse visit type groups you're not currently scheduling
- This reduces the number of DOM elements rendered

4. Use Patient Search

- Instead of scrolling through hundreds of patients in the sidebar, use the search bar to filter

5. Schedule in Batches

- Assign all visits for one patient before moving to the next
- This reduces sidebar refreshes

Chapter 24: Prior Authorizations

Overview

Prior Authorizations (PAs) are insurance approvals required before providing home health services to patients. The Prior Authorization Center helps you request, track, and manage these authorizations efficiently, ensuring visits are covered by insurance and preventing claim denials.

This chapter covers the complete PA lifecycle: automatic creation from OASIS assessments, insurance approval tracking, visit generation, and automatic status management based on usage and expiration dates.

Understanding Prior Authorizations

What is a Prior Authorization?

A Prior Authorization is:

- **Pre-approval from an insurance payer** to provide a specific number of visits for a patient
- **Required by most private insurance companies** and some Medicaid plans before services begin
- **Not required for Medicare** (Medicare uses a different authorization system through OASIS assessments)
- **Time-bound** with a specific effective period (start date → end date)
- **Discipline-specific** (separate approvals for RN, PT, OT, HHA, etc.)

Example:

Your patient has Blue Cross insurance. Before you can start PT visits, Blue Cross requires you to call them and get pre-authorization. They approve 10 PT visits valid from Apr 1 - June 30, 2026. This approval is recorded as a Prior Authorization in the system.

Why Prior Authorizations Matter

Reason	Impact
Claim Payment	Without a valid PA, insurance will deny claims and you won't get paid
Visit Planning	PAs define how many visits are approved, helping you schedule appropriately
Compliance	Exceeding approved units without renewal can result in audits or contract termination
Patient Communication	Ensures patients know their insurance coverage status before services begin

How Prior Authorizations Are Created

Prior Authorizations are **automatically generated** when an OASIS assessment (SOC, ROC, or Recertification) is approved in the QA Center. The system reads the treatment frequency from the OASIS Plan of Care and creates a PA with requested units.

Automatic Creation Process

Step 1: OASIS Assessment Approved

- Clinician completes an OASIS (SOC, ROC, or Recert)
- QA reviews and approves the OASIS
- OASIS status changes to **Approved**

Step 2: System Reads Treatment Frequency

The approved OASIS includes the Plan of Care with treatment frequency for each discipline:

- Skilled Nursing: 2x/week for 2 weeks, then 1x/week for 6 weeks = **10 visits**
- Physical Therapy: 3x/week for 4 weeks = **12 visits**
- Occupational Therapy: 2x/week for 3 weeks = **6 visits**
- Home Health Aide: 3x/week for 8 weeks = **24 visits**

Step 3: Prior Authorization Created

The system automatically creates a Prior Authorization record with:

- **Patient** - Linked to the patient from the OASIS
- **Care Order** - Linked to the care order
- **Payer** - Automatically linked to the patient's **primary insurance payer**
- **Source Document** - The OASIS assessment that triggered the PA
- **Effective Dates** - From the care order's certification period (e.g., Apr 1 - June 29, 2026)
- **Status** - Pending (needs insurance approval)
- **Line Items** - One line per discipline with requested units:
 - Skilled Nursing (SN): Requested = 10, Approved = 0
 - Physical Therapy (PT): Requested = 12, Approved = 0
 - Occupational Therapy (OT): Requested = 6, Approved = 0
 - Home Health Aide (HHA): Requested = 24, Approved = 0

What If There's No Primary Payer?

- If the patient has no primary payer configured (self-pay or pre-CCN agencies), the PA is still created but with **payerId: NULL**
- These "non-billable PAs" can be approved without an authorization number
- Useful for tracking visits internally even if insurance billing doesn't apply

Prior Authorization Statuses

Prior Authorizations move through several statuses during their lifecycle:

Status Definitions

Status	Color	Meaning	Can Edit?	Can Generate Visits?
Pending	Orange	Awaiting insurance review. You've submitted the request but haven't received approval yet.	Yes	No
In Progress	Blue	Insurance is actively reviewing your request.	Yes	No
Approved	Green	Insurance has approved all requested units. Visits can be generated.	Yes	Yes
Partial	Yellow	Insurance approved some, but not all, requested units. Visits can be generated for approved disciplines.	Yes	Yes
Denied	Red	Insurance denied the entire request. Services cannot be provided without appeal or new PA.	No	No
Expired	Gray	The effective end date has passed. No longer valid for new visits.	No	No
Exhausted	Purple	All approved units have been used. No remaining visits available.	Yes (can extend units)	No
Revoked	Red	Insurance revoked a previously approved PA (rare, usually due to eligibility loss).	No	No

Auto-Managed Statuses

Two statuses are **automatically updated** by a daily cron job (runs at 1:00 AM every day):

1. Expired Status

- **Trigger:** Today's date > PA end date
- **Auto-Update:** Any PA with status **Approved** or **Partial** automatically becomes **Expired** when the end date passes
- **Example:** PA effective Apr 1 - June 30, 2026. On July 1, 2026, it automatically changes to **Expired**

2. Exhausted Status

- **Trigger:** For each discipline line, $\text{usedUnits} \geq \text{approvedUnits}$ (all approved units have been used)
- **Auto-Update:**
 - If **all discipline lines** are exhausted and PA is **Approved** → becomes **Exhausted**

- If PA is Exhausted and you increase approved units (extend the authorization) → automatically reverts to Approved
- **Example:** PT line has 10 approved units. After 10 PT visits are completed, usedUnits = 10, so the PT line is exhausted. If PT is the only discipline, the entire PA becomes Exhausted.

Navigating the Prior Authorization Center

Prior Authorizations
Manage insurance authorizations and track approved units

Statistics:

- Total PAs: 19
- Pending Approval: 5
- Approved: 4
- Expired/Exhausted: 3
- Denied/Revoked: 3
- Total Units: 748 (55 used + 693 rem)

Search by patient, auth number, or payer... | Status: All Statuses | Patient: All Patients

PATIENT	PAYER	AUTH #	EFFECTIVE DATES	UNITS	STATUS	ACTIONS
Quansa Shoma	No primary payer	Not assigned	Apr 02, 2026 - Jun 01, 2026	3 / 3 Used Exhausted	Exhausted	View Edit
Abdi abdullahi	Blue Cross Blue Shield	Not assigned	Apr 01, 2026 - May 31, 2026	0 / 0 Used	Pending	View Edit
Jordan West	Blue Cross Blue Shield	Not assigned	Apr 02, 2026 - Jun 01, 2026	0 / 0 Used	Pending	View Edit
Sama Mula	Medicare of Texas	Unrevoked	Mar 03, 2026 - May 02, 2026	11 / 11 Used Exhausted	Exhausted	View Edit
Test Start	Blue Cross Blue Shield	12344567	Jan 18, 2026 - Mar 19, 2026	0 / 13 Used 13 remaining	Partial	View Edit
Aliyow Omar	Blue Cross Blue Shield	jk bl b	Jan 11, 2026 - Mar 12, 2026	0 / 6 Used 6 remaining	Approved	View Edit
Amina Ali	Blue Cross Blue Shield	FH7HF435453	Mar 09, 2026 - May 07, 2026	1 / 8 Used 7 remaining	Revoked	View Edit
Amina Ali	Blue Cross Blue Shield	Not assigned	Jan 08, 2026 - Mar 09, 2026	0 / 0 Used	Closed	View Edit
Abe Isale	Medicare of Texas	Not assigned	Jan 20, 2026 - Mar 20, 2026	2 / 5 Used 3 remaining	Approved	View Edit
Realtest forgot	Blue Cross Blue Shield	Not assigned	Jan 04, 2026 - Mar 05, 2026	0 / 0 Used	Pending	View Edit

Dashboard Statistics

At the top of the PA Center, six statistics cards provide a quick overview:

Card	Description	Calculation
Total PAs	Total number of PAs in the system	Count of all PA records
Pending Approval	PAs awaiting insurance decision	Status = Pending or In Progress
Approved	PAs currently active and usable	Status = Approved
Expired/Exhausted	PAs that are no longer valid	Status = Expired or Exhausted
Denied/Revoked	PAs that were not approved or were cancelled	Status = Denied or Revoked
Total Units	Total approved visit units across all PAs	Sum of all approvedUnits from all lines, showing used vs remaining (e.g., "748 Used / 486 left")

Search and Filters

Search Bar:

- Search by patient name, authorization number (auth #), or payer name
- Updates results in real-time as you type

Filter Dropdowns:

1. **Status Filter** - Show PAs by status (All, Pending, Approved, Expired, etc.)
2. **Patient Filter** - Show PAs for a specific patient (useful for multi-episode patients)

Prior Authorization Table

The main table displays all PAs with the following columns:

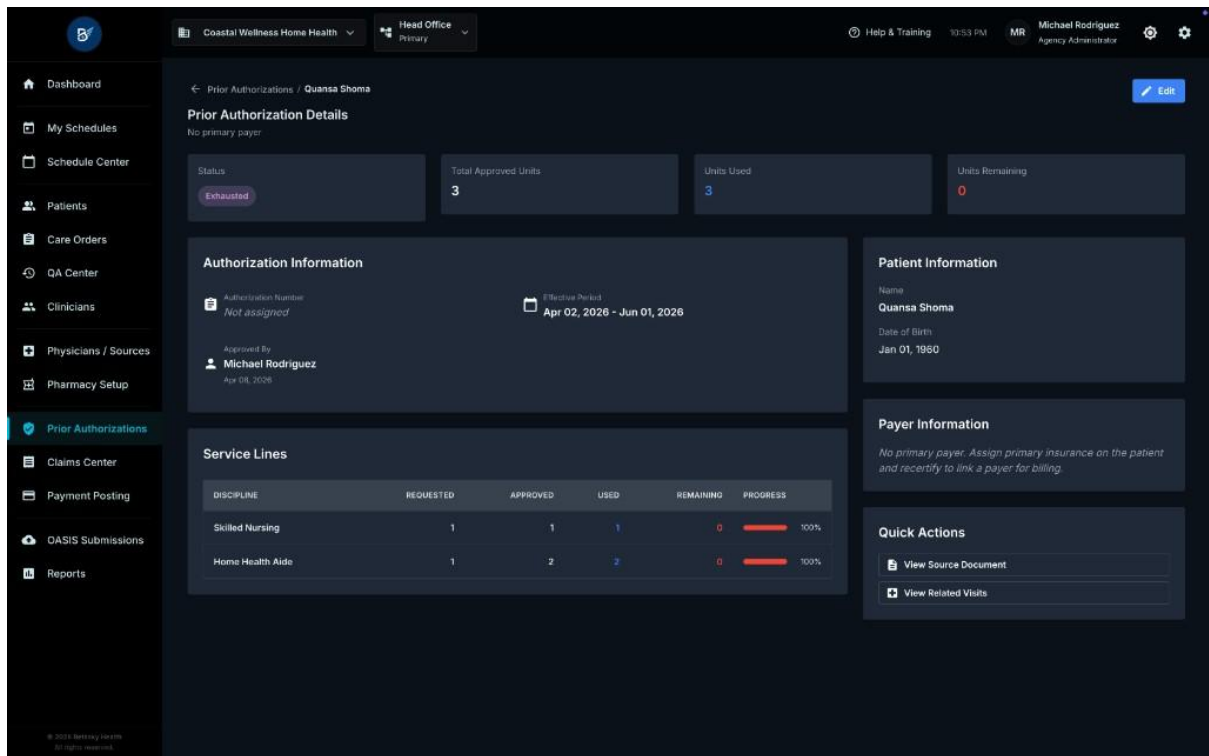
Column	Description
Patient	Patient name (blue text = clickable link to patient profile)
Payer	Primary insurance payer name. Shows "No primary payer" if patient has no payer configured (non-billable PA).
Auth #	Authorization number provided by insurance. Shows "Not assigned" if insurance hasn't approved yet or if it's a non-billable PA.
Effective Dates	Start date → End date (e.g., "Apr 02, 2026 - Jun 01, 2026")
Units	Summary of approved units usage. Format: X / Y Used where X = units used, Y = units approved. Second line shows remaining units (e.g., "3 / 3 Used, Exhausted" or "0 / 0 Used, 11 remaining").
Status	Color-coded status badge (see status table above)
Actions	Two icon buttons: Eye icon (view details) and Pencil icon (edit/update)

Row Colors and Indicators

- **No special highlighting** - Standard PA in normal status
- **Red "X" units text** (e.g., "3 / 3 Used, **Exhausted**") - All units have been used
- **Status badge colors** - Instant visual identification of PA state

Viewing Prior Authorization Details

Click the **eye icon** in the Actions column or click the patient name to open the PA Details page.



Summary Cards (Top Section)

Four summary cards provide at-a-glance information:

Card	Data Shown	Description
Status	Current PA status badge	Color-coded status (e.g., Green "Approved", Purple "Exhausted")
Total Approved Units	Total number of visits approved across all disciplines	Example: "3" means 3 total visits approved (could be 1 SN + 2 HHA, etc.)
Units Used	Total number of visits completed so far	Example: "3" means all 3 approved visits have been completed
Units Remaining	How many visits are left to use	Formula: Approved - Used. Example: "0" means fully exhausted.

Authorization Information Section

Field	Description
Authorization Number	The insurance-provided authorization number. Shows "Not assigned" if pending approval or if it's a non-billable PA.
Effective Period	Date range the authorization is valid (e.g., "Apr 02, 2026 - Jun 01, 2026")

Field	Description
Authorized By	Name of the agency staff member who recorded the approval (e.g., "Michael Rodriguez") and the date (e.g., "Apr 08, 2026")

Patient Information Section

- **Name** - Patient's full name
- **Date of Birth** - Patient's DOB (e.g., "Jan 01, 1950")

Payer Information Section

Shows the primary insurance payer name and type:

- Example: "Blue Cross Blue Shield" - Type: "Private Insurance"
- If no payer: "No primary payer. Assign primary insurance on this patient and recertify to link a payer for billing."

Service Lines Table

This is the most important section, showing the breakdown by discipline:

The screenshot displays the 'Prior Authorizations' section for a patient named Aliyow Omar. The interface is dark-themed. On the left is a sidebar with navigation icons. The main area shows the following details:

- Prior Authorization Details:** Status: Approved (green pill), Total Approved Units: 6, Units Used: 1, Units Remaining: 5.
- Authorization Information:** Authorization Number: jk bl b, Effective Period: Jan 11, 2026 - Mar 12, 2026, Approved By: Michael Rodriguez (Jan 28, 2026).
- Patient Information:** Name: Aliyow Omar, Date of Birth: Jan 01, 1950.
- Payer Information:** Payer Name: Blue Cross Blue Shield, Payer Type: Private Insurance.
- Service Lines Table:**

DISCIPLINE	REQUESTED	APPROVED	USED	REMAINING	PROGRESS	GENERATION STATUS	ACTION
Home Health Aide	1020	4	0	4	0%	Generated: 0 / 4 Approved	Generate 4 Missing Visits
Skilled Nursing	9	2	1	1	50%	Generated: 1 / 2 Approved	Generate 1 Missing Visit
- Quick Actions:** View Source Document, View Related Visits.

Column	Description
Discipline	Type of service (Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Medical Social Worker, Home Health Aide)
Requested	Number of visits requested from insurance (pulled from OASIS Plan of Care)

Column	Description
Approved	Number of visits insurance approved (manually entered after insurance call)
Used	Number of visits completed so far (automatically tracked as visits are completed)
Remaining	Visits left to use (Formula: Approved - Used)
Progress	Visual progress bar showing usage percentage. Color-coded: - Red bar at 100% = All units used - Green/Blue bar = Units still available
Generation Status	Shows if visits have been generated from this PA. Text: "Generated: 0 / 4 Approved". Formula: X / Y where X = visits already created, Y = approved units.
Action	"Generate X Missing Visit" button - Creates unassigned visits for disciplines with unused approved units (only appears for Approved or Partial PAs)

Understanding the "Generate Missing Visit" Button

When It Appears:

- PA status is **Approved** or **Partial**
- The discipline has **approvedUnits > 0**
- The discipline has remaining units (approved - used > 0)

What It Does:

- Creates **unassigned visits** (no clinician assigned) for the remaining units
- These visits appear in the Schedule Center's "Needs Scheduling" sidebar
- Visits are automatically linked to the PA, so when they're completed, the **usedUnits** increments

Example:

- PT line: Requested = 12, Approved = 10, Used = 4, Remaining = 6
- Click "Generate 6 Missing Visits"
- System creates 6 unassigned PT visits for this patient
- Now when you complete 1 PT visit, Used becomes 5, Remaining becomes 5

Why This Is Useful:

- Eliminates manual visit creation
- Ensures visits are properly linked to the PA for tracking
- Prevents over-scheduling (can't generate more than approved units)

Quick Actions Section

Two buttons for navigation:

Button	Action
View Source Document	Opens the OASIS assessment that created this PA (in QA Review view)
View Related Visits	Opens the Schedule Center filtered to show this patient's visits

Updating Prior Authorizations

When you receive approval from insurance, you need to update the PA to record the authorization number and approved units.

Step 1: Open the Update Modal

Click the **pencil icon** in the Actions column on the PA list, or click the **Edit** button on the PA details page.

Update Prior Authorization

Quansa Shoma

Authorization Number (Optional)

Non-billable PA (no primary payer). Auth number is optional.

Status: Exhausted

Non-billable PA - can be approved without authorization number

Update Approved Units

Update the approved units for each discipline. Used units are tracked automatically and cannot be edited.

DISCIPLINE	REQUESTED	CURRENT APPROVED	USED	NEW APPROVED
Home Health Aide	1	2	2	2
Skilled Nursing	1	1	1	1

Cancel Save Changes

Insurance Provider	Authorization Number	Start Date	End Date	Units Used	Status	Actions
Blue Cross Blue Shield	FHFHF435453	Mar 09, 2026	May 07, 2026	1 / 8 Used 7 remaining	Exhausted	View Edit
Blue Cross Blue Shield	Not assigned	Jan 06, 2026	Mar 09, 2026	0 / 0 Used	Expired	View Edit
Medicare of Texas	Not assigned	Jan 20, 2026	Mar 20, 2026	2 / 5 Used 3 remaining	Approved	View Edit
Blue Cross Blue Shield	Not assigned	Jan 04, 2026	Mar 05, 2026	0 / 0 Used	Pending	View Edit

Step 2: Fill in Approval Information

The **Update Prior Authorization** modal shows:

Top Section: Patient Info

- Patient name displayed (e.g., "Quansa Shoma")

Authorization Number Field

For Billable PAs (with a payer):

- Label: "Authorization Number"
- **Required** to change status to **Approved** or **Partial**
- Placeholder: "Enter authorization number from insurance"
- Example: "123456789" (format varies by payer)

For Non-Billable PAs (no payer):

- Label: "Authorization Number (Optional)"
- Optional - can approve without entering a number
- Helper text: "Non-billable PA (no primary payer). Auth number is optional."

Why Auth Number Is Required for Billable PAs:

- Insurance companies require this number on claims
- Without it, claims will be denied even if the PA is "approved" in your system
- Acts as proof of authorization during audits

Status Dropdown

Select the new status:

Option	When to Use	Requirements
Pending	Still awaiting insurance decision	None
In Progress	Insurance is actively reviewing	None
Approved	Insurance approved all requested units	Requires authorization number (for billable PAs)
Partial	Insurance approved some but not all requested units	Requires authorization number (for billable PAs)
Denied	Insurance denied the request	Requires reason (must explain why it was denied)
Revoked	Insurance revoked a previously approved PA	Requires reason (must explain why it was revoked)
Exhausted	Disabled (auto-managed by system)	Cannot manually set

Note: If you try to select **Approved** or **Partial** without entering an authorization number (for billable PAs), the option is disabled with a note: **(Requires Auth #)**.

Reason Field (Conditional)

Only appears when status is **Denied** or **Revoked**:

- **Required** field

- Multiline text area
- Placeholder: "Enter reason for revocation or denial"
- Example: "Insurance denied due to lack of medical necessity documentation."

Why Reason Is Required:

- Provides an audit trail for denied/revoked PAs
- Helps case managers understand what went wrong
- Useful for appeals or future PA requests

Update Approved Units Table

This table allows you to enter the approved units for each discipline:

Column	Description	Editable?
Discipline	Service type (e.g., "Skilled Nursing", "Home Health Aide")	No
Requested	Units requested from insurance (from OASIS)	No
Current Approved	Units currently approved in the system	No (read-only)
Used	Units already used (completed visits)	No (auto-tracked)
New Approved	Editable number field to enter the approved units	Yes - This is what you update

How to Fill This Section:

1. Call the insurance company with the PA request
2. Insurance tells you what they approved for each discipline
3. Enter those numbers in the **New Approved** column

Example Conversation:

- **You:** "I'm requesting 10 SN visits and 24 HHA visits."
- **Insurance:** "We approve 10 SN visits, but only 20 HHA visits."
- **You:** Enter 10 in the SN "New Approved" field and 20 in the HHA "New Approved" field
- **Status:** Change status to Partial (because not all disciplines were fully approved: HHA got 20 instead of 24)

Special Case: Extending Approved Units

If a PA is already Approved or Exhausted, you can increase the approved units later:

- Example: PT was approved for 10 visits. Patient needs 5 more sessions.
- Call insurance to request extension
- Insurance approves 5 additional visits
- Update PA: Change PT "New Approved" from 10 to 15
- System automatically recalculates remaining units

- If PA was Exhausted, status automatically changes back to Approved

Step 3: Save Changes

Click "Save Changes" button at the bottom of the modal.

What Happens:

1. PA record is updated in the database
2. If status changed to Approved or Partial:
 - approvedAt timestamp is recorded
 - approvedByUserId is set to the current user
 - **Alert appears:** "Changing status to 'Approved' will automatically generate unassigned visits for all approved units."
3. If approved units increased for a previously Exhausted PA, status automatically changes to Approved
4. PA list cache is invalidated (list refreshes to show updated data)
5. Success toast: "Prior authorization updated successfully"

Common Update Scenarios

Scenario 1: Full Approval

Situation: Insurance approved all requested units.

Steps:

1. Open PA update modal
2. Enter authorization number (e.g., "AUTH-987654")
3. Change status to Approved
4. For each discipline, enter approved units = requested units:
 - SN: Requested = 10 → New Approved = 10
 - HHA: Requested = 24 → New Approved = 24
5. Save

Result: PA status = Approved, all disciplines have full units available for visit generation.

Scenario 2: Partial Approval

Situation: Insurance approved some disciplines but not others, or approved fewer units than requested.

Steps:

1. Open PA update modal
2. Enter authorization number
3. Change status to Partial
4. Enter approved units:
 - SN: Requested = 10 → New Approved = 10 (fully approved)
 - PT: Requested = 12 → New Approved = 8 (partially approved)

- HHA: Requested = 24 → New Approved = 0 (denied)

5. Save

Result: PA status = Partial, SN and PT lines can generate visits, HHA line has 0 approved so no visits can be generated.

Scenario 3: Denial

Situation: Insurance denied the entire PA request.

Steps:

1. Open PA update modal
2. Change status to Denied
3. Enter reason in the text area (e.g., "Insurance requires face-to-face physician visit within 30 days before services. Patient last saw doctor 45 days ago.")
4. Leave all approved units at 0 (or don't change them)
5. Save

Result: PA status = Denied, no visits can be generated. Case manager must either appeal or create a new care order after addressing the denial reason.

Scenario 4: Extension (Adding Units)

Situation: Patient is progressing well and needs more visits. Insurance approves additional units.

Steps:

1. Open PA update modal for an existing Approved or Exhausted PA
2. For the discipline needing extension:
 - Current Approved = 10
 - Used = 10 (fully exhausted)
 - New Approved = 15 (adding 5 more visits)
3. Save

Result: Status automatically changes from Exhausted to Approved (because remaining units > 0), 5 additional visits can be generated.

Visit Generation and Tracking

Automatic Visit Generation (On Approval)

When you change a PA status to Approved or Partial for the first time, the system **automatically creates unassigned visits** for all approved units.

What Gets Created:

- One unassigned visit per approved unit for each discipline
- Visits are linked to the PA via priorAuthorizationId
- Visits appear in the Schedule Center "Needs Scheduling" sidebar
- Visit type is determined by the discipline code (e.g., SN → "Skilled Nursing Visit")

Example:

- PA approved with:
 - SN: 10 units
 - HHA: 20 units
- System creates:
 - 10 unassigned SN visits
 - 20 unassigned HHA visits
- Total: 30 visits appear in Schedule Center

Manual Visit Generation (Per Discipline)

If you need to generate additional visits later (e.g., after extending approved units), use the **"Generate X Missing Visit"** button on the PA Details page.

Step 1: Identify Disciplines With Remaining Units

- Look at the Service Lines table on PA Details
- Find disciplines where Remaining > 0

Step 2: Click "Generate Missing Visit" Button

- Button text shows how many visits will be created (e.g., "Generate 4 Missing Visits")
- Clicking it triggers visit creation

Step 3: System Creates Visits

- Unassigned visits are created for that discipline
- Success toast: "Visits generated successfully for [Discipline Name]!"
- PA Details page refreshes to show updated generation status

Visit Tracking

As clinicians complete visits, the PA automatically tracks usage:

When a Visit Is Completed:

1. Clinician checks in to visit via mobile app
2. Clinician completes the visit note and marks visit as complete
3. Visit note is reviewed and approved in QA Center
4. Backend increments the PA line's usedUnits by 1
5. System recalculates remaining units
6. If all units are exhausted, PA status automatically changes to Exhausted

Example Timeline:

- Day 1: PA approved - SN: 0 used / 10 remaining
- Day 3: RN completes visit 1 - SN: 1 used / 9 remaining
- Day 7: RN completes visit 2 - SN: 2 used / 8 remaining
- ...
- Day 45: RN completes visit 10 - SN: 10 used / 0 remaining

- System auto-updates: PA status changes to Exhausted

Authorization Alerts on Visits

If you try to create a visit for a patient with an expired, exhausted, or denied PA, the system shows alerts:

Alert Types:

- **MISSING_AUTH** - Patient has no valid PA, or PA is expired/exhausted/denied
- **EXCEEDS_LIMIT** - Visit would exceed approved units (shouldn't happen if visits were generated correctly, but possible if manually created)

Where Alerts Appear:

- Visit card on the Schedule Center (icon indicator)
- Visit details page (alert banner at the top)

What to Do:

- Review the PA status
- If expired, request a renewal/extension from insurance
- If exhausted, request additional units
- If denied, address the denial reason and resubmit

Permissions and Access Control

Required Permissions

Action	Required Permission	Notes
View Prior Authorizations	VIEW_PRIOR_AUTHORIZATIONS	Without this, PA Center menu is hidden
Create Prior Authorizations	System-controlled	PAs are auto-created from OASIS approval (no manual creation permission needed)
Edit/Update PAs	EDIT_PRIOR_AUTHORIZATIONS	Required to open update modal and save changes
View PA Details	VIEW_PRIOR_AUTHORIZATIONS	Can view details page but cannot edit
Generate Visits from PA	CREATE_VISIT + EDIT_PRIOR_AUTHORIZATIONS	Both permissions needed to use "Generate Missing Visit" button

Role-Based Access Examples

Office Manager (Full PA Access)

- **Permissions:** All PA and visit permissions

- **Can Do:**

- View all PAs
- Update PA status and approved units
- Generate visits from approved PAs
- Track authorization usage

Billing Specialist (View Only)

- **Permissions:** VIEW_PRIOR_AUTHORIZATIONS only

- **Can Do:**

- View PA list and details
- Check authorization numbers for claim submission
- Track usage and remaining units

- **Cannot Do:**

- Update PA status or approved units
- Generate visits

Clinician (No Access)

- **Permissions:** None (or only VIEW_SCHEDULE)

- **Cannot Access:** Prior Authorization Center

- **Why:** Clinicians don't need PA access; they just complete visits that were already authorized and scheduled

Best Practices

1. Update PAs Immediately After Insurance Approval

Why:

- Insurance approval phone calls happen in real-time
- Details are fresh in your mind
- Prevents forgetting to record approval

How:

- Keep the PA Center open during insurance calls
- As the insurance rep tells you approved units, enter them directly into the update modal
- Record the authorization number exactly as stated (don't abbreviate or modify)

2. Always Request Authorization Numbers for Billable PAs

Why:

- Required for claim submission
- Insurance may reject claims without a valid auth number
- Acts as proof during audits

How:

- During the insurance call, explicitly ask: "What is the authorization number for this approval?"
- If they don't provide one, ask if they'll send it via email or their portal
- Don't change status to **Approved** until you have the auth number

3. Monitor PAs Approaching Expiration

Why:

- Services must stop when PA expires (unless renewed)
- Last-minute renewal requests are harder to get approved
- Gaps in service affect patient care continuity

How:

- Check the PA list weekly
- Filter by **Approved** status
- Sort by end date (soonest first)
- For PAs expiring in next 10-14 days:
 - Contact insurance to request extension or new PA
 - Update the PA with the new end date or create a new PA

4. Generate Visits Immediately After Approval

Why:

- Visits appear in Schedule Center so coordinators can assign clinicians
- Prevents delays in starting patient care
- Ensures visits are properly linked to the PA for tracking

How:

- As soon as you change PA status to **Approved**, visits are auto-generated
- OR manually click "Generate Missing Visit" buttons for each discipline
- Then go to Schedule Center and assign those visits to clinicians

5. Track Remaining Units Proactively

Why:

- Prevents over-scheduling (trying to provide more visits than approved)
- Alerts you when units are running low so you can request extensions
- Ensures you maximize approved units before they expire

How:

- Check the Service Lines table on PA details regularly
- When remaining units reach 25% of approved (e.g., 2 out of 10 left):
 - Assess if patient needs more visits
 - If yes, call insurance to request extension before units run out

- Don't wait until Exhausted to request more units

6. Document Denial Reasons Thoroughly

Why:

- Helps with appeal preparation
- Prevents repeating the same mistakes on future PAs
- Provides audit trail for compliance

How:

- When entering a denial reason, include:
 - Specific reason stated by insurance
 - Date of denial call
 - Name of insurance rep (if provided)
 - Any instructions for resubmission or appeal
- Example: "Denied on 4/10/26 by rep Sarah. Reason: Requires peer-to-peer review between our MD and insurance MD. Contact insurance at 1-800-XXX-XXXX to schedule review."

7. Use Partial Status Appropriately

Why:

- Accurately reflects mixed approvals (some disciplines approved, others not)
- Prevents confusion about which services are authorized
- Helps billing team know which disciplines to bill

How:

- Use Partial when:
 - Some disciplines are fully approved, others are denied
 - All disciplines are approved, but with fewer units than requested
- Use Approved only when all requested disciplines and units are fully approved

8. Link Non-Billable PAs to Visits Anyway

Why:

- Even if the patient is self-pay or your agency is pre-CCN (not billing yet), tracking visits against a PA helps with:
 - Internal visit planning
 - Future billing setup (when you get your CCN)
 - Reporting and analytics

How:

- When creating a PA for a patient with no payer:
 - Leave authorization number blank (it's optional for non-billable PAs)
 - Change status to Approved even without an auth number
 - Generate visits as normal

- Track usage to understand service delivery patterns

Common Scenarios and Solutions

Scenario 1: PA Created but Insurance Hasn't Responded Yet

Situation: OASIS was approved 3 days ago, PA was auto-created with Pending status, but you're still waiting for insurance to call back.

Actions:

1. Check the PA list - Status should be Pending
2. Follow up with insurance if it's been more than 48 hours
3. If insurance is slow, you can change status to In Progress to indicate active follow-up
4. Once approved, update with auth number and approved units

Note: Don't start visits until PA is approved (unless patient agrees to self-pay if insurance denies).

Scenario 2: Insurance Approved Fewer Units Than Requested

Situation: You requested 12 PT visits, but insurance only approved 8.

Actions:

1. Update PA status to Partial
2. Enter auth number
3. Set PT approved units to 8 (not 12)
4. Generate visits - only 8 PT visits will be created
5. After 8 visits are complete, reassess patient's needs:
 - If patient still needs PT, call insurance to request additional units
 - If patient no longer needs PT, PA remains Exhausted for PT line

Best Practice: Don't schedule all 8 visits immediately. Schedule in increments (e.g., first 4 visits), then reassess and schedule next 4 as patient progresses.

Scenario 3: PA Expires Before All Units Are Used

Situation: PA was approved for 20 HHA visits from Apr 1 - June 30. By June 30, only 15 visits were completed. PA status changes to Expired.

Actions:

1. PA status auto-updates to Expired on July 1
2. Remaining 5 units become invalid
3. You have two options:
 - **Option A: Request Extension** - Call insurance before June 30 to extend the end date
 - **Option B: New Authorization** - If already expired, request a new PA covering the next period

Prevention: Monitor end dates proactively. Don't wait until the last week to request extensions.

Scenario 4: Patient's Insurance Changes Mid-Episode

Situation: Patient was on Blue Cross, PA was approved. Now patient switched to Medicaid (new payer).

Actions:

1. Update patient's primary payer to Medicaid (in Patient Intake module)
2. **Critical:** The existing PA remains linked to Blue Cross (can't change payer on existing PA)
3. Create a new care order (or initiate recertification) to generate a new PA linked to Medicaid
4. Old PA with Blue Cross should be marked Revoked or Closed (use update modal, enter reason: "Patient changed insurance to Medicaid")
5. New PA will be created from the recertification OASIS, linked to Medicaid

Why You Can't Change Payer on Existing PA:

- Authorization numbers and approved units are specific to the original payer
- Billing claims will reference the original payer's auth number
- Changing mid-stream creates billing confusion

Scenario 5: All Units Exhausted but Patient Needs More Care

Situation: PT PA approved for 10 visits, all 10 completed, status changed to Exhausted, but patient still needs PT.

Actions:

1. Assess if patient needs more PT (clinician evaluation)
2. Call insurance to request additional units:
 - Provide update on patient's progress
 - Explain why more visits are medically necessary
 - Request specific number of additional visits
3. If insurance approves:
 - Update the PA: Increase PT approved units from 10 to (e.g.) 15
 - Status automatically changes back to Approved
 - Generate 5 additional PT visits
4. If insurance denies:
 - Patient can self-pay for additional visits (not linked to PA)
 - OR appeal the denial
 - OR discontinue PT services

Best Practice: Request extensions before exhausting all units (e.g., when 2 visits remaining).

Scenario 6: Authorization Number is Wrong

Situation: You entered auth number "123456" but insurance says their records show "789012". Claims are being denied.

Actions:

1. Open PA update modal
2. Correct the authorization number field
3. Save changes
4. Resubmit any denied claims with the corrected auth number
5. Alert billing team about the correction

Prevention: Double-check auth numbers during the insurance call. Repeat it back to the rep for confirmation.

Scenario 7: Insurance Revokes a Previously Approved PA

Situation: PA was approved 2 months ago, 5 visits completed, then insurance calls to say patient lost eligibility and PA is revoked retroactively.

Actions:

1. Update PA status to **Revoked**
2. Enter reason: "Insurance revoked due to patient losing eligibility effective [date]. Called by [rep name] on [date]."
3. System will prevent new visits from being completed against this PA
4. Billing team must:
 - Review claims already submitted for the 5 completed visits
 - Expect denials or clawbacks
 - Work with patient to resolve payment (self-pay or appeal)

Note: This is rare and usually happens due to patient eligibility issues (e.g., insurance lapsed, patient didn't pay premiums).

Scenario 8: PA Automatically Created with No Payer (Non-Billable)

Situation: Patient intake was completed without assigning a primary payer. OASIS approved, PA created with **payerId: NULL**.

Actions:

1. If patient does have insurance:
 - Go to Patient Intake, assign the primary payer
 - Update PA: Change status to **Approved** (no auth number needed for now, but you should get one for billing)
 - OR initiate a new recertification to create a new PA linked to the payer
2. If patient is truly self-pay:
 - Leave PA as-is with **payerId: NULL**
 - Change status to **Approved** (no auth number required)
 - Generate visits and proceed with self-pay billing workflow

Why This Happens:

- Patient intake allows proceeding without payer assignment (useful for pre-CCN agencies)
- OASIS PA creation logic doesn't block on missing payer; it just sets `payerId: NULL`

Troubleshooting

Issue: PA Was Not Auto-Created After OASIS Approval

Possible Causes:

1. OASIS was not actually approved (still in `Pending Review` or `Returned for Correction`)
2. Backend service failed during PA creation (check server logs)
3. Care order had no treatment frequency in Plan of Care (all disciplines = 0 visits)

Solutions:

- Verify OASIS status is `Approved` in QA Center
- Check server logs for errors containing "PriorAuthorization"
- If OASIS has 0 frequency for all disciplines, no PA is needed (no visits to authorize)
- If PA should exist but doesn't, manually check database or contact technical support

Issue: "Generate Missing Visit" Button Doesn't Work

Possible Causes:

1. User lacks `CREATE_VISIT` or `EDIT_PRIOR_AUTHORIZATIONS` permission
2. PA status is not `Approved` or `Partial`
3. Discipline line has 0 approved units
4. All approved units are already generated (generation status shows "Generated: X / X")

Solutions:

- Verify user permissions in User Roles & Permissions module
- Check PA status - button only works for `Approved` or `Partial` PAs
- Verify approved units > 0 for that discipline
- Check generation status - if visits are already generated, button may be disabled or show "All visits generated"

Issue: PA Shows "Exhausted" but Units Remaining > 0

Possible Causes:

- Cron job ran before recent visit completion was processed
- Database inconsistency between PA lines and actual visit counts

Solutions:

1. Refresh the PA details page (F5)
2. Check Service Lines table to confirm used vs approved units
3. If inconsistency persists, contact technical support to reconcile visit counts
4. As a workaround, increase approved units by 1, then decrease back (this triggers status recalculation)

Issue: Cannot Edit PA (Pencil Icon Disabled)

Possible Causes:

1. User lacks `EDIT_PRIOR_AUTHORIZATIONS` permission
2. PA status is `Revoked` or `Denied` (cannot edit these statuses)

Solutions:

- Verify user permissions
- If PA is revoked/denied and you need to change it, you must create a new PA (usually via a new care order/recertification)
- Revoked/denied PAs are intentionally locked to preserve audit trail

Issue: PA Effective Dates Don't Match Care Order Dates

Possible Causes:

- Care order certification period was updated after PA was created
- PA was created from an older OASIS when care order had different dates

Solutions:

- PA dates are set at creation time and don't auto-update if care order dates change
- If PA dates are wrong, you have two options:
 - **Option A:** Manually adjust via database (requires technical support)
 - **Option B:** Create a new PA by initiating a new recertification with correct dates
- Best practice: Ensure care order dates are correct before approving the OASIS that creates the PA

Integration with Other Modules

OASIS Assessments (Source)

- **Link:** PAs are auto-created when OASIS is approved
- **Impact:** OASIS Plan of Care frequencies determine requested units for each discipline
- **Field Mapping:**
 - OASIS SN frequency (e.g., 2x/week for 8 weeks = 16) → PA SN line requested units = 16
 - OASIS effective dates → PA start/end dates

QA Center

- **Link:** PA creation is triggered in the QA approval workflow
- **Impact:** If OASIS is returned for correction, PA creation is delayed until re-approval

Schedule Center

- **Link:** Visits generated from PAs appear in Schedule Center "Needs Scheduling" sidebar
- **Impact:** When visits are completed, PA `usedUnits` is incremented

- **Authorization Alerts:** Visits show MISSING_AUTH or EXCEEDS_LIMIT alerts if PA is invalid

Claims Center

- **Link:** Authorization number from PA is required on CMS-1500 claim forms (Box 23)
- **Impact:** Claims without valid auth numbers will be denied by insurance

Patient Module

- **Link:** PA's payer is populated from patient's primary insurance
- **Impact:** If patient has no primary payer, PA is created with payerId: NULL (non-billable)

Care Orders Module

- **Link:** PA is linked to the care order that generated the OASIS
- **Impact:** If care order is closed, PA should be marked Closed or Revoked

Chapter 25: Claims Center & Billing

Overview

The **Claims Center** is where completed patient visits are converted into billable insurance claims. This module manages the entire billing lifecycle from visit eligibility through claim generation, submission, payment posting, and denial management. Understanding how claims work is essential for maintaining healthy revenue cycles and ensuring your agency gets paid for services provided.

Understanding Claims and Billing

What is a Claim?

A **claim** is a formal request for payment submitted to an insurance payer (Medicare, Medicaid, or private insurance) for home health services provided to a patient. Each claim contains:

- **Patient information** (name, DOB, insurance details)
- **Service details** (visits performed, dates of service, clinicians)
- **Billing codes** (HCPCS codes for services, HIPPS codes for Medicare)
- **Charged amounts** (based on payer rate schedules or Medicare PDGM rates)

Medicare vs Private Insurance Billing

The system handles two fundamentally different billing models:

Medicare/Medicaid (PDGM - Patient-Driven Groupings Model)

- **Billing Period:** 30-day periods (Period 1 = Days 1-30, Period 2 = Days 31-60)
- **Reimbursement:** Based on **HIPPS code** (single rate regardless of number of visits)
- **Claim Timing:** One claim per 30-day period per episode
- **Visit Rates:** Individual visits show \$0.00 (informational only)
- **Total Claim Amount:** HIPPS rate (e.g., \$3,500 for the 30-day period)
- **Prerequisite:** OASIS must be submitted to CMS and status = **ACCEPTED** before billing

Example:

- Patient has Medicare
- Episode: Jan 1 - Feb 29, 2026
- HIPPS code: **1CABA** (determined from OASIS assessment)
- Period 1 (Days 1-30): 8 visits performed → Claim amount = \$3,200 (HIPPS rate)
- Period 2 (Days 31-60): 5 visits performed → Claim amount = \$3,200 (same HIPPS rate)

Private Insurance / Managed Care (Fee-for-Service)

- **Billing Period:** Flexible (bill whenever visits accumulate, no 30-day requirement)
- **Reimbursement:** Based on **Fee Schedule** (per-visit rates configured for each payer and visit type)

- **Claim Timing:** Can bill immediately after visits complete, or batch multiple visits into one claim
- **Visit Rates:** Each visit has its own rate (e.g., SN Visit = 150,PTVisit=180)
- **Total Claim Amount:** Sum of all visit rates
- **Prerequisite:** Prior Authorization (PA) must be approved (for payers requiring PA)

Example:

- Patient has Blue Cross Blue Shield
- 3 visits performed: 2 SN visits (150each),1PTvisit(180)
- Total claim amount = 150+150 + 180=480

Visit Eligibility for Billing

Not all completed visits can be billed. The system applies strict eligibility rules to ensure only valid visits appear in the Claims Center.

Required Conditions (All Must Be Met)

Condition	Description	Why It Matters
Visit Status = `Completed`	Clinician has checked out of the visit	Incomplete visits cannot be billed
Visit Note Status = `Approved`	The clinical document (visit note) passed QA review and is approved	Unapproved documentation doesn't meet insurance standards
Care Order Status = `Active` or `Discharged`	The patient's episode is active or recently discharged	Closed or On Hold episodes are not billable
Visit marked as `isBillable = true`	The visit hasn't been marked as non-billable	Some visits are non-billable (e.g., courtesy visits, training)
Visit NOT already on a claim (claimId = null)	The visit hasn't been billed yet	Prevents double-billing
Patient has Primary Payer	Patient has an insurance payer assigned	Cannot bill without knowing who to bill

Additional Filters for Specific Payers

Medicare-Specific Rules

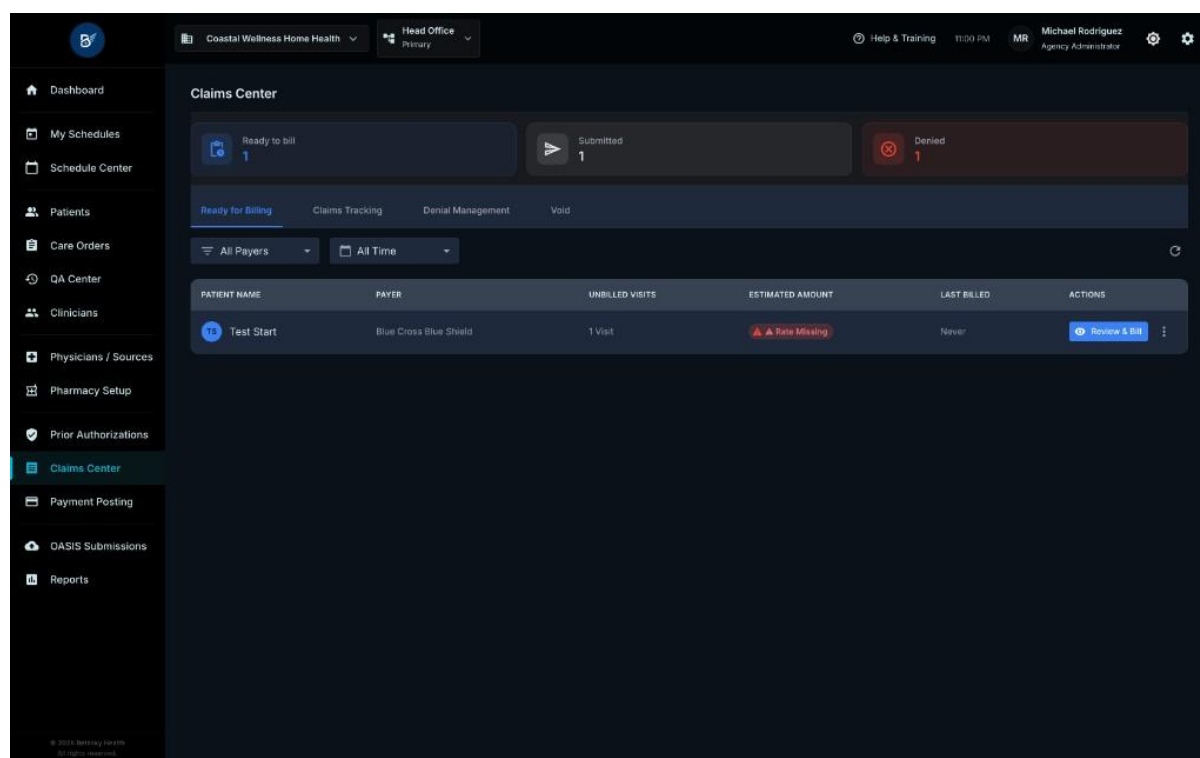
Rule	Description
OASIS Submitted and Accepted	The OASIS assessment for this episode must be submitted to CMS and status = ACCEPTED

Rule	Description
SOC/Recert/ROC Visits Excluded	OASIS visit types (Start of Care, Recertification, Resumption of Care) cannot be billed separately
Post-Discharge Visits Excluded	Visits that occurred after the discharge date (M0906 from Discharge OASIS) are automatically filtered out

Private Insurance Rules

Rule	Description
Prior Authorization (if required by payer)	PA must be approved and have remaining units
Fee Schedule	Rate must be configured for (payer + visit type) combination

Claims Center Interface



Dashboard Statistics Cards (Top Section)

Three KPI cards provide a real-time overview of your billing status:

Card	Color	Meaning	Calculation

Card	Color	Meaning	Calculation
Ready to bill	Blue	Number of completed visits eligible for billing but not yet on a claim	Count of visits meeting all eligibility conditions
Submitted	Gray	Number of claims submitted to insurance and awaiting payment	Claims with status = Submitted
Denied	Red	Number of claims denied by insurance	Claims with status = Denied

These stats are **cached for 90 seconds** and refresh automatically when you generate, submit, or update claims.

Four Main Tabs

The Claims Center is organized into four tabs, each representing a stage in the billing workflow:

1. Ready for Billing Tab

- Shows patients who have unbilled completed visits
- Grouped by patient (one row per patient showing how many visits and estimated amount)
- Primary action: "Review & Bill" button to generate claims

2. Claims Tracking Tab

- Shows all generated claims organized by status
- Sub-tabs:
 - **Ready to Submit** - Claims generated but not yet sent to insurance
 - **Submitted** - Claims sent to insurance, awaiting payment
 - **Partially Paid** - Claims where insurance paid part but not full amount
 - **Paid** - Fully paid claims (balance = \$0)
- Primary actions: Mark as Submitted, Export 837, Post Payment

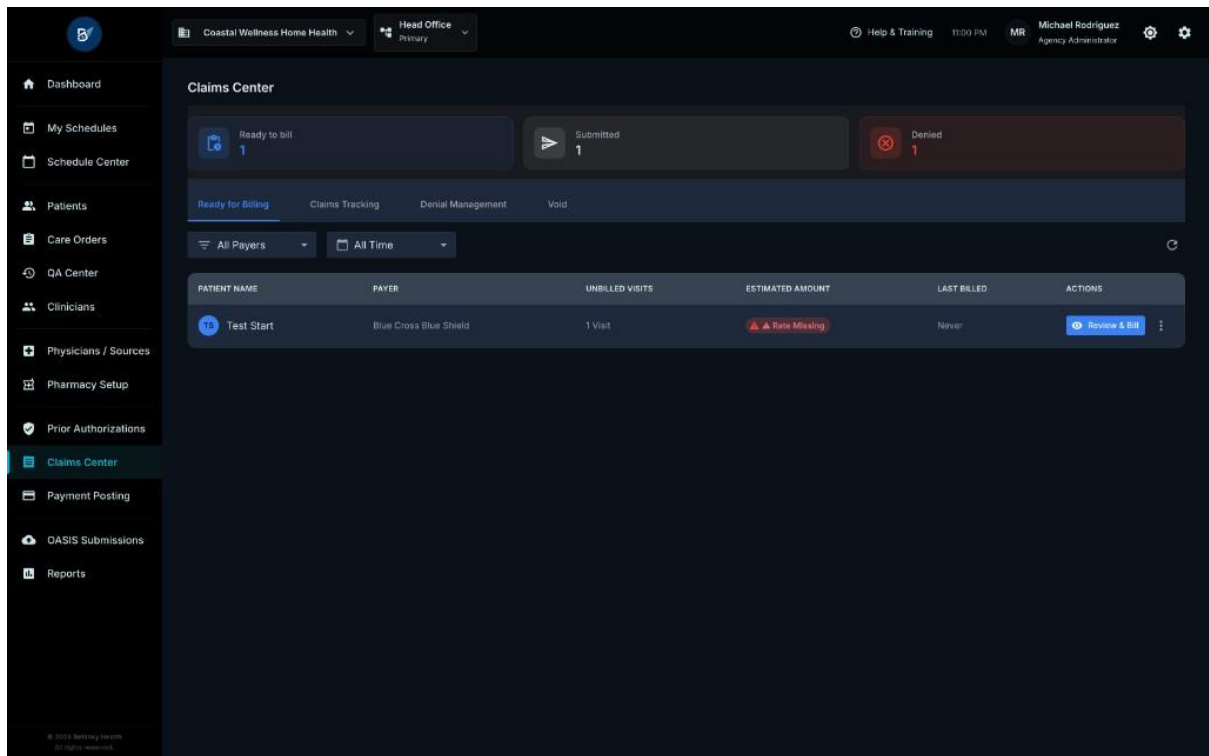
3. Denial Management Tab

- Shows all denied claims requiring investigation and resolution
- Helps you identify patterns (which payer denies most, what reasons)
- Primary actions: Resubmit (after correction), Write Off (if unrecoverable)

4. Void Tab

- Shows voided claims (cancelled before or after submission)
- Claims voided to release visits back to "Ready for Billing"
- Read-only (voided claims cannot be edited)

Ready for Billing Tab: Detailed Walkthrough



Patient List Table

The table shows patients grouped by unbilled visits:

Column	Description
Patient Name	Patient's full name. Shown with an avatar containing initials.
Payer	Primary insurance payer name (e.g., "Blue Cross Blue Shield").
Unbilled Visits	Number of completed, approved visits that haven't been billed yet (e.g., "1 Visit").
Estimated Amount	Projected claim amount. Shows "⚠ Rate Missing" if Fee Schedule rates are not configured. For Medicare, shows the HIPPS rate.
Last Billed	Date of the most recent claim for this patient. Shows "Never" if patient has never been billed.
Actions	"Review & Bill" button - Opens the billing modal to select visits and generate a claim.

Filters (Top of Table)

Payer Filter:

- Dropdown showing "All Payers" or specific payer names
- Filters the patient list to show only patients with selected payer
- Useful for batch-submitting claims to one insurance company

Date Range Filter:

- Options: "All Time", "Last 7 Days", "Last 30 Days", "This Month"
- Filters based on last billed date
- Helps identify patients who haven't been billed recently

Refresh Button:

- Icon button (circular arrow) on the right
- Reloads the Ready for Billing list
- Use after visits are completed/approved to see updated counts

Interpreting "Estimated Amount"

The Estimated Amount column shows different things based on payer type:

Medicare Patients

- Shows the **HIPPS rate** for the current billing period
- Example: "\$3,500.00"
- If HIPPS code is missing or rate not configured: "⚠ Rate Missing"

Private Insurance Patients

- Shows the **sum of individual visit rates** from Fee Schedules
- Example: 3 visits → 2 SN (150*each*)+1PT(180) = "\$480.00"
- If any visit type lacks a rate: "⚠ Rate Missing"

Warning: "Rate Missing"

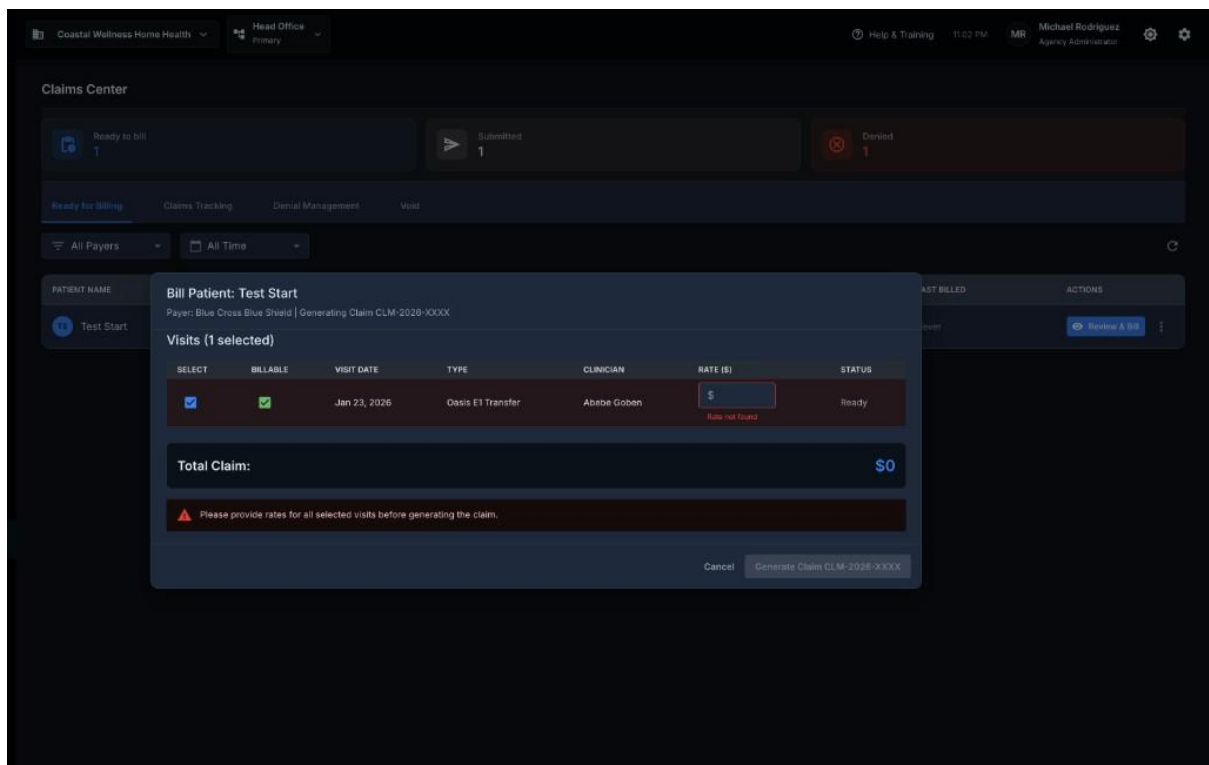
- One or more visits cannot be billed because the rate is not configured
- You must either:
 - Configure the missing rate in Fee Schedule Setup (for private insurance)
 - Configure the missing HIPPS rate in Payer Setup (for Medicare)
 - Manually enter a rate when generating the claim (override)

Generating Claims: Step-by-Step**Step 1: Click "Review & Bill"**

Click the blue "Review & Bill" button for a patient in the Ready for Billing table.

Step 2: Review Patient and Visits

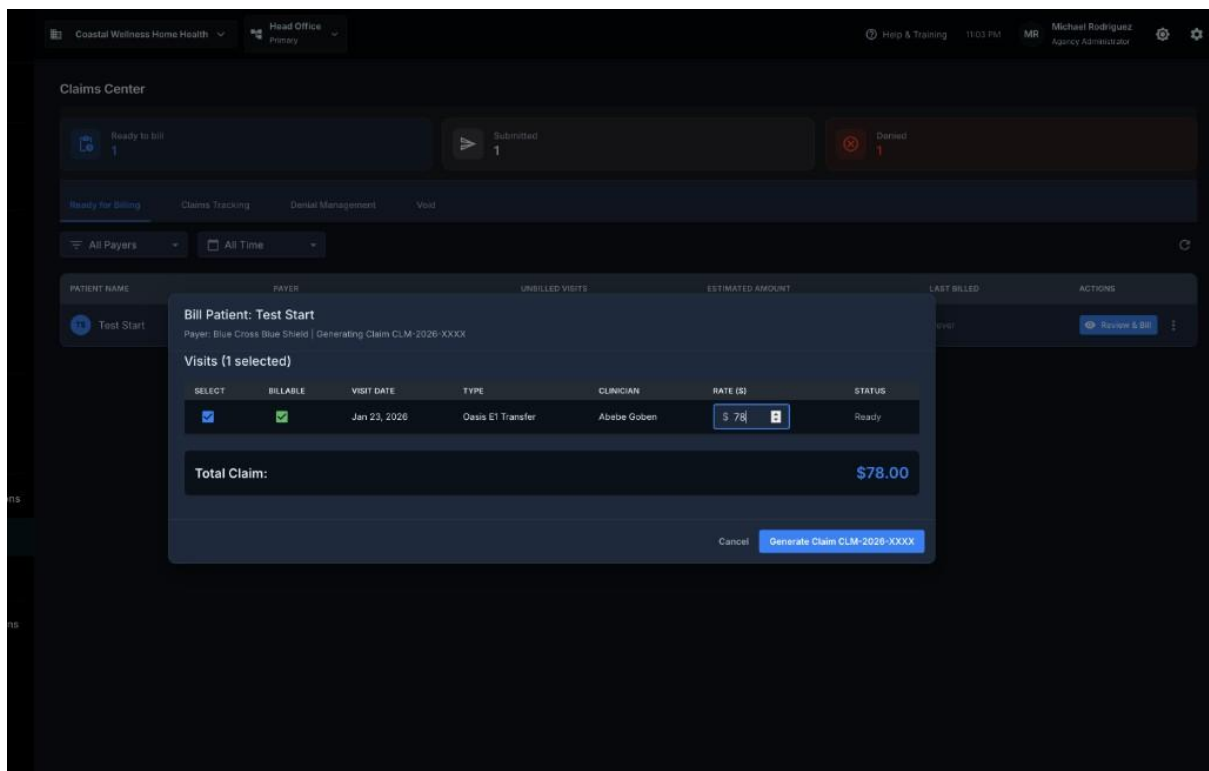
The **Bill Patient** modal opens:



Modal Header:

- **Title:** "Bill Patient: [Patient Name]"
- **Subtitle:** "Payer: [Payer Name] | Generating Claim [Claim Number Preview]"
 - Claim number preview format: CLM-YYYY-XXXX (actual number assigned by backend)

For Medicare Patients:



The modal shows a **Medicare HIPPS Information** section at the top:

Field	Description	Editable?
Detected HIPPS Code	HIPPS code from the approved OASIS assessment (stored in Care Order). Example: 1CABA.	No (read-only chip)
Reimbursement Rate	The rate for this HIPPS code. Automatically looked up from Payer Settings. If missing, field is red with error message.	Yes - You can override the rate if needed

Validation Alert:

If the HIPPS rate is missing:

- Field shows error styling (red border)
- Helper text: "Rate for HIPPS code not found in Payer Settings. Please enter manually."
- You **must** enter a rate before generating the claim

For Private Insurance Patients:

No HIPPS section. Rates are shown per visit in the visits table.

Step 3: Select Visits to Bill

The modal displays a **Visits Table** with the following columns:

Column	Description
Select	Checkbox to include this visit on the claim. Auto-selected by default unless visit has authorization alerts.
Billable	Checkbox showing if visit is marked as billable. You can toggle this to mark visits as non-billable (removes from billing queue).
Visit Date	Date the visit was performed (e.g., "Jan 23, 2026").
Type	Visit type (e.g., "OASIS E1 Transfer", "HHA Visit", "PT Evaluation"). May show authorization alert icons.
Clinician	Name of the clinician who performed the visit (e.g., "Abeble Godeen").
Rate (\$)	For Medicare: Shows "\$0.00" (visits are informational only). For Private Insurance: Shows the rate from Fee Schedule or allows manual entry if rate is missing.
Status	Shows "Ready" or authorization alert chips ("No Authorization", "Exceeds Limit").

Visit Selection Logic

Auto-Selected Visits:

- Have no authorization alerts
- Are marked as billable (isBillable = true)

Disabled Visits (Cannot Select):

- Have authorization alerts:
 - "No Authorization" (MISSING_AUTH) - Critical error, shown with red error icon
 - "Exceeds Limit" (EXCEEDS_LIMIT) - Warning, shown with yellow warning icon

Authorization Alerts Explained:

Alert Type	Icon	Meaning	Action Required
MISSING_AUTH	Red exclamation mark	Visit has no valid Prior Authorization. PA is either missing, expired, exhausted, or denied.	Go to Prior Authorizations module, create or update PA to approve units for this discipline. Then click "Re-Validate" button.
EXCEEDS_LIMIT	Yellow warning triangle	Visit would exceed the approved PA units. Example: PA approved 10 visits, but 11 visits were completed.	Go to Prior Authorizations module, request extension from insurance to approve additional units. Then click "Re-Validate" button.

Re-Validate Button:

- Appears next to authorization alert chips
- Clicking it re-checks the PA status for this visit
- If PA has been updated (e.g., more units approved), alert clears and visit becomes selectable
- Shows loading spinner while validating

Rate Overrides (Private Insurance Only)

For private insurance visits:

- If Fee Schedule rate exists, it's auto-populated
- If missing, the rate field is **empty with red error styling**
- You can **manually enter a rate** to override
- Example: Rate configured = 150, *but you want to bill 160* for this specific visit → Enter \$160 in the rate field

Step 4: Review Total and Generate Claim

Total Claim Section (bottom of modal):

- Shows the calculated total claim amount
- Formula:
 - **Medicare:** Total = HIPPS rate (regardless of number of visits)
 - **Private Insurance:** Total = Sum of (selected visit rates)

Validation Errors:

The "**Generate Claim**" button is disabled if:

- No visits are selected
- Any selected visit has a missing rate (and no override entered)
- For Medicare: HIPPS rate is missing (and no override entered)

Error Messages:

- **If no visits selected and all have authorization alerts:** "Cannot generate claim: X visit(s) have authorization errors and cannot be billed. Please resolve authorization issues first."
- **If missing rates:** "Please provide rates for all selected visits before generating the claim."
- **Red alert banner at bottom:** "Please provide rates for all selected visits before generating the claim."

Step 5: Claim Generation Process

When you click "**Generate Claim CLM-2026-XXXX**":

Backend Actions:

1. **Validation:** Re-checks all visit eligibility conditions
2. **Rate Lookup:**
 - **Medicare:** Looks up HIPPS rate from Payer Settings (or uses override)
 - **Private:** Looks up Fee Schedule rates for each visit (or uses overrides)

3. 30-Day Period Validation (Medicare Only):

- Ensures all visits are in the same 30-day period
- Error if visits span Period 1 and Period 2: "Medicare claims cannot span payment periods. 3 visit(s) are in Period 1 (Days 1-30) and 2 visit(s) are in Period 2 (Days 31-60). Please select visits only from Days 1-30 or Days 31-60."

4. Claim Number Generation: Assigns unique claim number (format: CLM-YYYY-####)

5. Claim Record Created:

- Status = Ready to Submit
- totalAmount = calculated total
- balanceDue = totalAmount (initially unpaid)
- claimStartDate = earliest visit date
- claimEndDate = latest visit date

6. Line Items Created: One line item per visit with:

- chargeAmount = visit rate (or \$0.00 for Medicare)
- visitId = linked to visit
- serviceCode = HCPCS code from visit type

7. Visits Updated: Each visit's claimId field is set to the new claim ID (marks them as billed)

8. Cache Invalidation: "Ready to Bill" count decreases, claim list refreshes

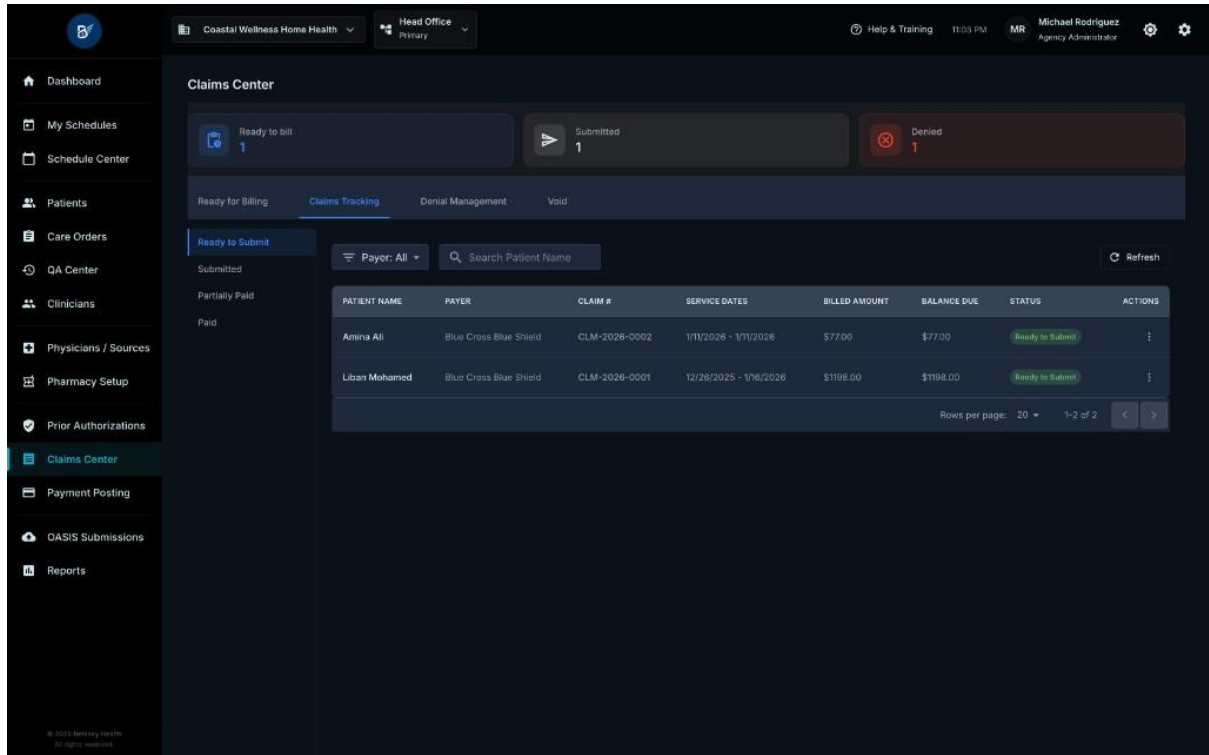
Success Message:

"Successfully generated claim CLM-2026-0002!"

Result:

- Modal closes
- Patient disappears from "Ready for Billing" table
- Claim appears in "Claims Tracking" tab → "Ready to Submit" sub-tab

Claims Tracking Tab: Managing Generated Claims

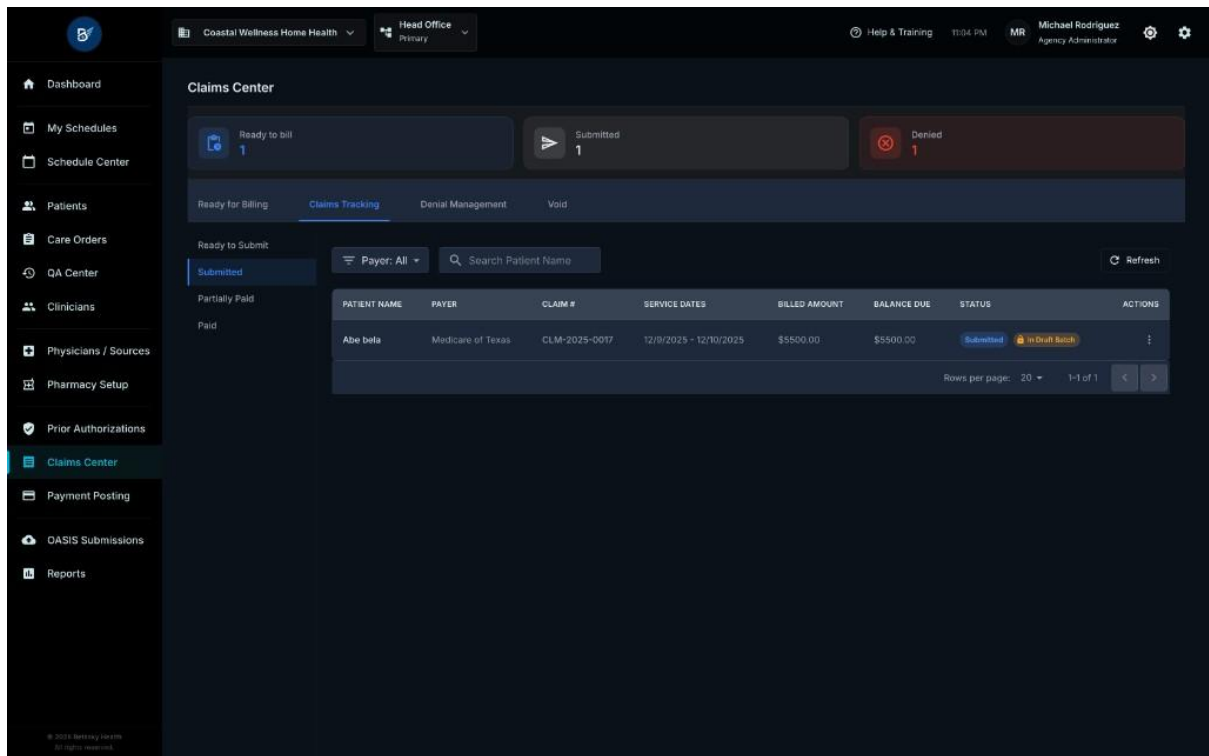


Sub-Tab Structure

The Claims Tracking tab uses a **left sidebar navigation** with four sub-tabs:

Sub-Tab	Status Filter	Description
Ready to Submit	status = "Ready to Submit"	Claims generated but not yet sent to insurance
Submitted	status = "Submitted"	Claims sent to insurance, awaiting response
Partially Paid	status = "Partially Paid"	Claims where insurance paid part but not full amount
Paid	status = "Paid"	Fully paid claims with balance = \$0

Claims Table (All Sub-Tabs)



The table displays claims with the following columns:

Column	Description
Patient Name	Patient's full name. Clickable link opens patient profile.
Payer	Insurance company name (e.g., "Blue Cross Blue Shield", "Medicare of Texas").
Claim #	Unique claim identifier (e.g., "CLM-2026-0002").
Service Dates	Start → End date of services on this claim (e.g., "1/11/2026 - 1/11/2026" for single-visit claim, or "12/1/2025 - 12/30/2025" for monthly billing period).
Billed Amount	Total amount billed to insurance (e.g., "77.00" for private insurance, "3,500.00" for Medicare HIPPS).
Balance Due	Remaining unpaid amount. Initially equals Billed Amount. Decreases as payments are posted. Shows "\$0.00" when fully paid.
Status	Color-coded status badge: - Blue "Ready to Submit" - Gray "Submitted" - Green "Paid" - Yellow "Partially Paid"
Actions	Two icon buttons: - Eye icon (View Details) - Three-dot menu (More Actions)

Filters and Search (Top of Table)

Payer Filter:

- Dropdown showing "All" or specific payer names

- Filters claims by payer

Search Bar:

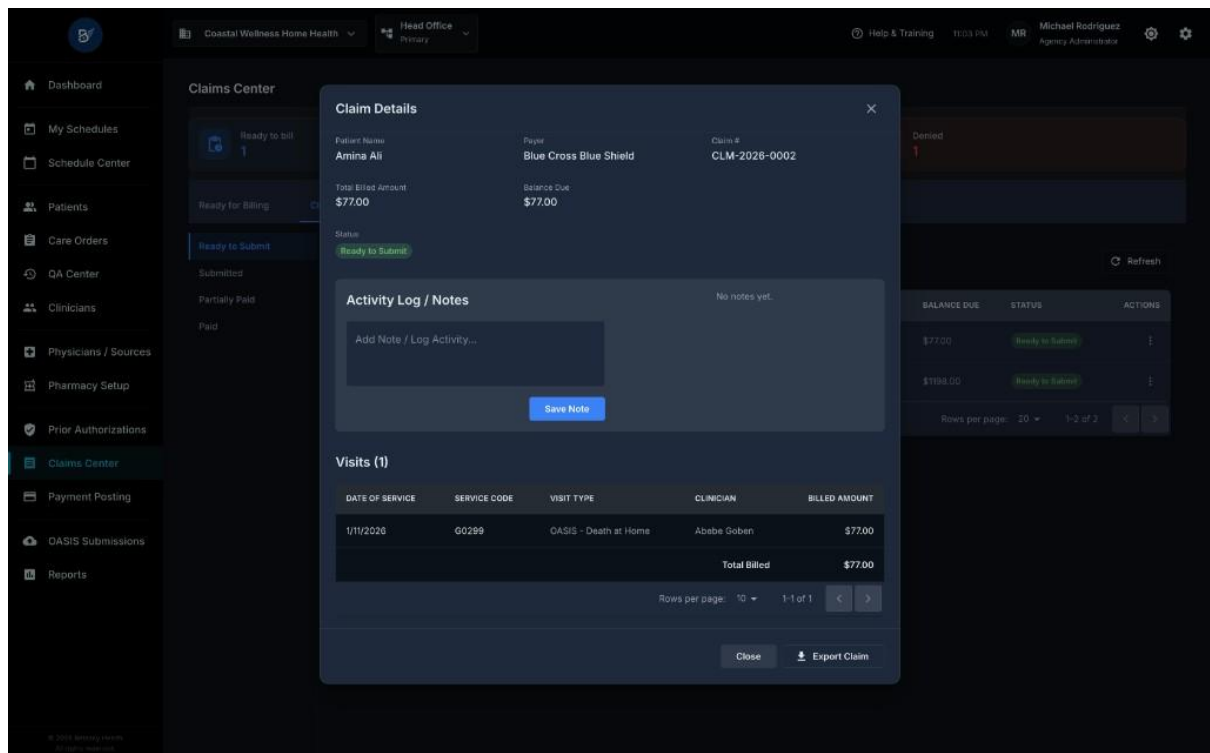
- Search by patient name or claim number
- Real-time filtering as you type

Refresh Button:

- Reloads claims list
- Use after submitting claims externally or receiving payment notifications

Claim Details Modal

Click the eye icon or patient name to open the claim details modal.



Header Section

Field	Description
Patient Name	Full patient name (e.g., "Test Start")
Payer	Insurance company (e.g., "Blue Cross Blue Shield")
Claim #	Unique identifier (e.g., "CLM-2020-XXXX")
Total Billed Amount	Total charged to insurance (e.g., "\$77.00")
Balance Due	Unpaid amount remaining (e.g., "\$77.00" if no payments posted)
Status	Color-coded badge (Green "Ready to Submit")

Activity Log / Notes Section

- Text area to add notes or log activity about this claim
- Example: "Called insurance on 4/10/26 - representative confirmed authorization is valid"
- Click **"Save Note"** to save
- Notes appear with timestamp and user name
- Useful for tracking follow-ups, appeal status, or special instructions

Visits Table

Shows all visits included on this claim:

Column	Description
Date of Service	Date the visit was performed (e.g., "1/11/2026")
Service Code	HCPCS code for the service (e.g., "G0299" for RN visit, "G0156" for HHA visit)
Visit Type	Description of the visit (e.g., "OASIS - Death at Home", "HHA Visit")
Clinician	Name of clinician who performed the visit (e.g., "Abeble Godeen")
Billed Amount	Amount billed for this specific visit. For Medicare: always "0.00"(informationalonly).ForPrivateInsurance:individualvisitrates(e.g.,"77.00") .

Total Billed Row:

- Bottom row shows sum of all visit amounts
- For Medicare: Shows the HIPPS rate here (since individual visits are \$0)
- For Private Insurance: Sum of all visit rates

Action Buttons (Bottom of Modal)

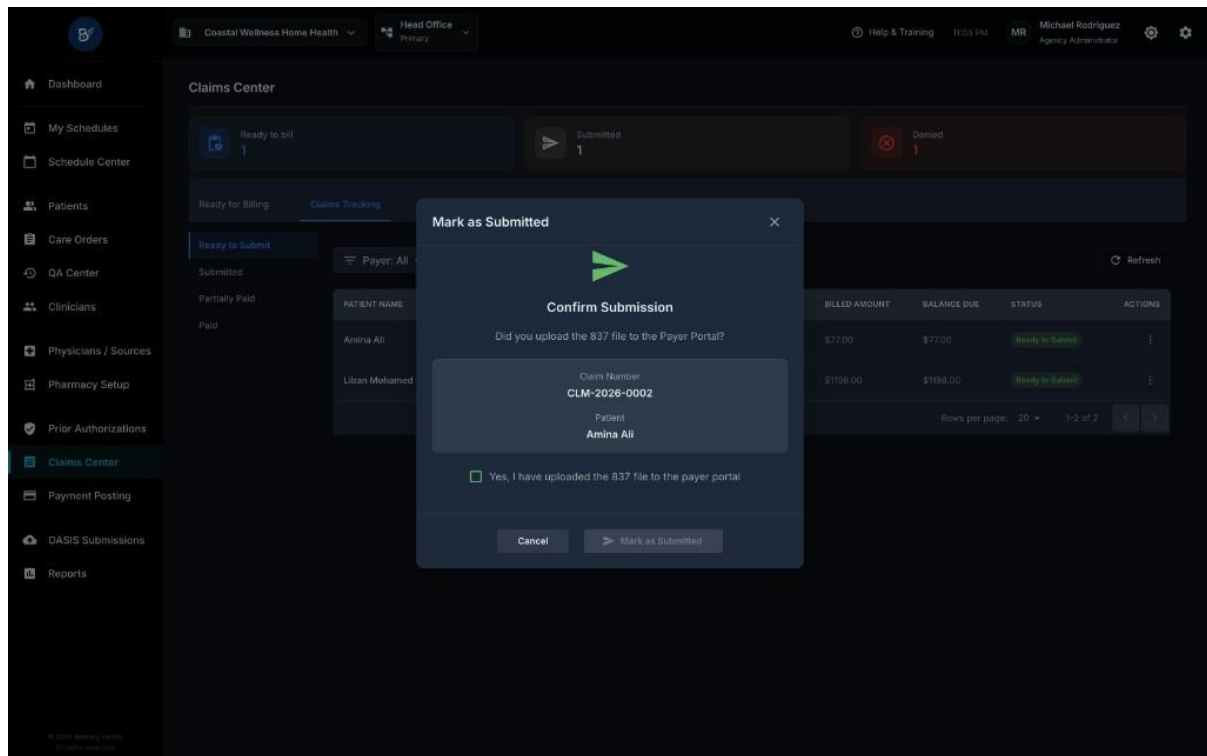
Button	Availability	Action
Close	Always	Closes the modal
Export Claim	Always	Downloads a CMS-1500 PDF or 837 EDI file for this claim (see Export section below)

Marking Claims as Submitted

After you export a claim and submit it to insurance (via clearinghouse, payer portal, or mail), you must mark it as submitted to track its status.

Step 1: Open Mark as Submitted Modal

From the **Ready to Submit** sub-tab, click the three-dot menu icon → **"Mark as Submitted"** (or use the bulk action button if multiple claims selected).



Step 2: Confirm Submission

The **"Mark as Submitted"** modal displays:

Header:

- **Title:** "Confirm Submission"
- **Question:** "Did you upload the 837 file to the Payer Portal?"

Claim Information Box:

- **Claim Number** (e.g., "CLM-2026-0002")
- **Patient** name (e.g., "Amina Ali")

Confirmation Checkbox:

- **Text:** "Yes, I have uploaded the 837 file to the payer portal"
- **Must be checked** to enable the submit button

Action Buttons:

- **Cancel** - Closes modal without changes
- **Mark as Submitted** - Changes claim status to Submitted

Step 3: Claim Status Changes

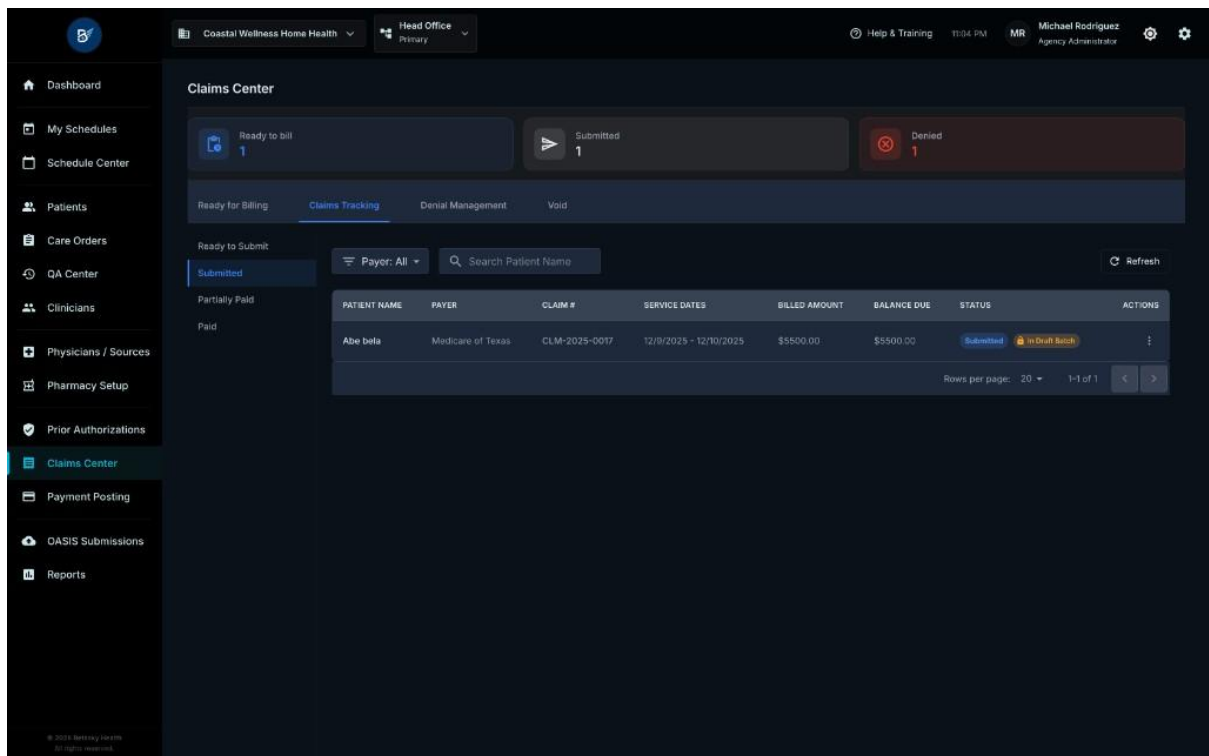
When you click **"Mark as Submitted"**:

Backend Actions:

1. Claim status changes from Ready to Submit → Submitted
2. exportedAt timestamp is recorded (if not already set)
3. Claim moves to the "Submitted" sub-tab

What This Means:

- Claim is now "in flight" with the insurance company
- You're waiting for payment or denial response
- Claim disappears from "Ready to Submit" sub-tab
- Claim appears in "Submitted" sub-tab



Posting Payments to Claims

When insurance sends payment (via check, EFT, or ERA), you must record it in the system.

Step 1: Open Post Payment Modal

From the **Submitted** sub-tab, click the three-dot menu icon for a claim → **"Post Payment"**.

Step 2: Fill in Payment Details

The **Post Payment** modal includes:

Field	Description	Required?
Payment Amount	Amount insurance paid (can be less than, equal to, or more than billed amount)	Yes

Field	Description	Required?
Payment Date	Date the payment was received (from check date or EFT transaction date)	Yes
Check Number	Check number (if paid by check)	No (but recommended)
Payment Method	Dropdown: "Check", "EFT" (Electronic Funds Transfer), "Credit", "Other"	Yes
Notes	Optional note about this payment (e.g., "ERA ID: 12345", "Adjustment reason code: 50")	No

Example:

- Billed Amount: \$480.00
- Insurance Paid: \$420.00
- Payment Date: April 5, 2026
- Check Number: 789456
- Payment Method: Check
- Notes: "Paid in full per contracted rate. Patient responsibility: \$60 co-pay."

Step 3: Payment is Posted

When you click **"Post Payment"**:

Backend Actions:

1. **Payment Record Created** in the payments table with all entered details
2. **Balance Recalculated:**
 - Formula: $\text{balanceDue} = \text{totalAmount} - \text{SUM}(\text{all payments})$
 - Example: $480_{\text{billed}} - 420_{\text{paid}} = \$60_{\text{remaining}}$
3. **Claim Status Auto-Updated:**
 - If balance = \$0 → Status changes to **Paid**
 - If balance > \$0 and < total → Status changes to **Partially Paid**
 - If balance = total (no payment yet) → Status remains **Submitted**

Result:

- Claim moves to **"Paid"** sub-tab (if fully paid) or **"Partially Paid"** sub-tab (if partial)
- Balance Due column updates to show remaining amount

PATIENT NAME	PAYER	CLAIM #	SERVICE DATES	BILLED AMOUNT	BALANCE DUE	STATUS	ACTIONS
ulala Haj	Blue Cross Blue Shield	CLM-2025-0023	12/22/2025 - 12/22/2025	\$799.00	\$0.00	Paid	Batch: CHS-98754788
ulala Haj	Blue Cross Blue Shield	CLM-2025-0022	12/16/2025 - 12/16/2025	\$9900.00	\$0.00	Paid	
ulala Haj	Blue Cross Blue Shield	CLM-2025-0021	12/16/2025 - 12/16/2025	\$3100.00	\$0.00	Paid	
ulala Haj	Blue Cross Blue Shield	CLM-2025-0020	12/16/2025 - 12/16/2025	\$8118.00	\$0.00	Paid	Batch: CHS-987694834
ulala Haj	Blue Cross Blue Shield	CLM-2025-0018	12/16/2025 - 12/16/2025	\$882.00	\$0.00	Paid	Batch: CHS-987694834
ulala Haj	Blue Cross Blue Shield	CLM-2025-0016	12/9/2025 - 12/15/2025	\$801.00	\$0.00	Paid	
Abe dela	Medicare of Texas	CLM-2025-0015	12/11/2025 - 12/11/2025	\$5500.00	\$0.00	Paid	
ulala Haj	Blue Cross Blue Shield	CLM-2025-0011	12/14/2025 - 12/14/2025	\$200.00	\$0.00	Paid	
ulala Haj	Blue Cross Blue Shield	CLM-2025-0009	12/14/2025 - 12/14/2025	\$200.00	\$0.00	Paid	
ulala Haj	Blue Cross Blue Shield	CLM-2025-0008	12/7/2025 - 12/14/2025	\$351.00	\$0.00	Paid	

Posting Multiple Payments

If insurance pays in multiple installments:

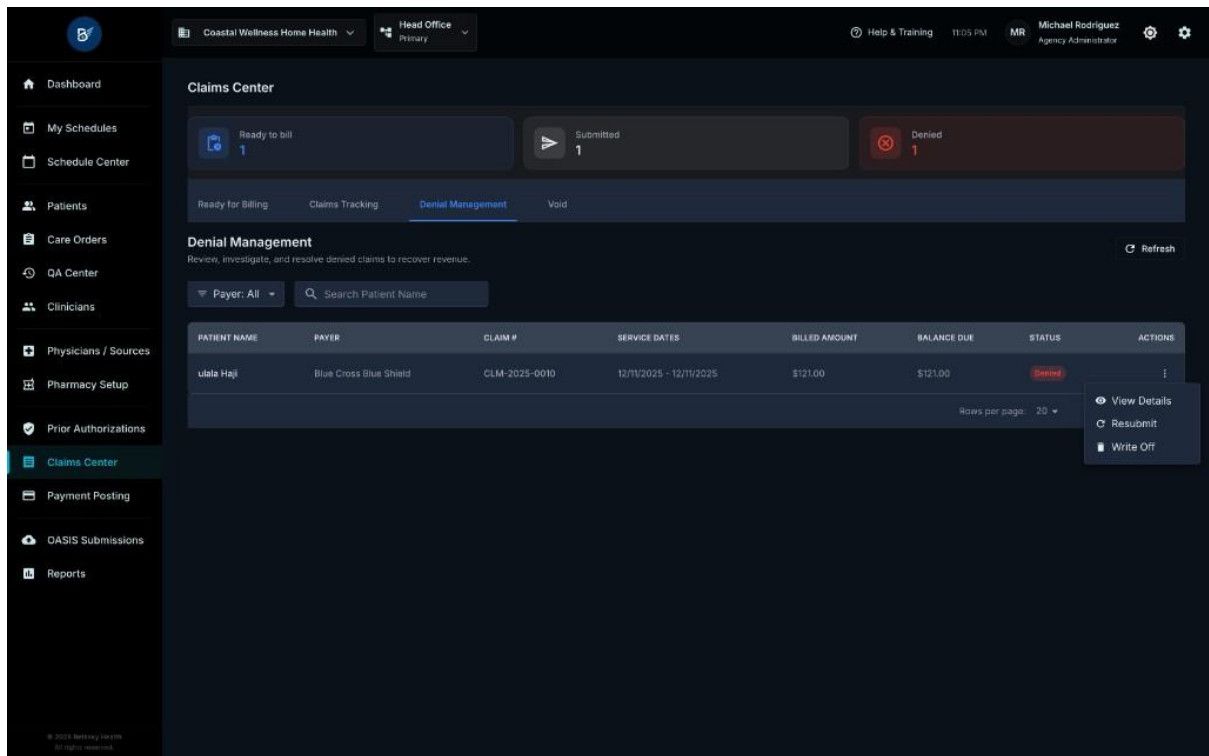
1. Post first payment (e.g., \$200) → Status becomes **Partially Paid**, balance = \$280
2. Post second payment (e.g., \$280) → Status becomes **Paid**, balance = \$0

Overpayment Handling

If insurance pays more than billed:

- Example: Billed 480, insurance paid 500
- Balance becomes -\$20 (negative balance = credit)
- Status becomes **Paid**
- The \$20 credit can be applied to future claims or refunded to insurance

Denial Management Tab



When insurance denies a claim, it moves to the **Denial Management** tab for investigation and resolution.

How Claims Become Denied

Path 1: Mark as Denied (Manual)

1. You receive a denial letter or ERA from insurance
2. Go to Claims Tracking → Submitted sub-tab
3. Click three-dot menu for the claim → "Mark as Denied"
4. Modal opens to confirm denial (similar to mark as submitted)
5. Claim status changes to Denied
6. Claim moves to Denial Management tab

Path 2: Post Payment with Full Denial

- Insurance pays \$0 with denial codes
- You post payment amount = \$0
- Claim status becomes Denied (because balance = total amount, indicating no payment)

Denial Management Table

Same columns as Claims Tracking, but filtered to show only status = "Denied" claims.

Column	Value Example
Patient Name	"ulala Haji"
Payer	"Blue Cross Blue Shield"
Claim #	"CLM-2025-0010"

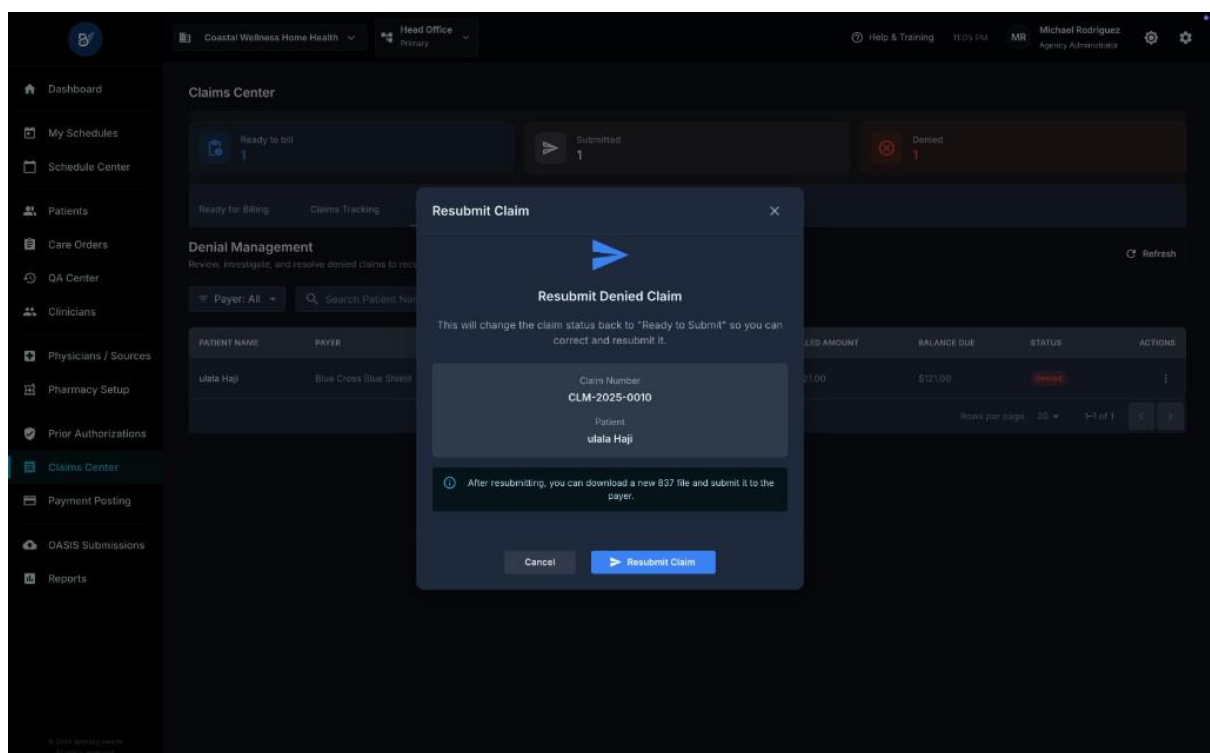
Column	Value Example
Service Dates	"12/11/2025 - 12/11/2025"
Billed Amount	"\$121.00"
Balance Due	"\$121.00" (full amount unpaid)
Status	Red "Denied" badge
Actions	Eye icon (View Details), Three-dot menu (Resubmit, Write Off)

Actions for Denied Claims

Click the three-dot menu for a denied claim:

Action	Description
View Details	Opens claim details modal to see visits and add notes
Resubmit	Corrects the claim and changes status back to Ready to Submit for resubmission
Write Off	Marks claim as uncollectible, sets balance to \$0 (does not change status to Paid - remains Denied)

Resubmitting Denied Claims



When to Resubmit

Resubmit a claim when:

- Denial was due to correctable error (wrong code, missing authorization number, incorrect date)
- You've obtained additional documentation insurance requested
- You've appealed and insurance approved the appeal

Do NOT resubmit if:

- Denial is final and insurance won't reconsider
- Claim is not worth the effort (low amount, high collection cost)
- Patient is responsible for the balance (co-pay, out-of-pocket)

Resubmit Process

Step 1: Open Resubmit Modal

- Go to Denial Management tab
- Click three-dot menu for the denied claim
- Select **"Resubmit"**

Step 2: Review Claim Information

The modal shows:

- **Title:** "Resubmit Denied Claim"
- **Description:** "This will change the claim status back to 'Ready to Submit' so you can correct and resubmit it."
- **Claim Number** (e.g., "CLM-2025-0010")
- **Patient** name (e.g., "ulala Haji")
- **Info Note:** "After resubmitting, you can download a new 837 file and submit it to the payer."

Step 3: Confirm Resubmit

Click the blue **"Resubmit Claim"** button.

Backend Actions:

1. Claim status changes from Denied → Ready to Submit
2. Claim moves from Denial Management tab to Claims Tracking → Ready to Submit sub-tab
3. Cache invalidated (stats updated)

What Happens Next:

- Go to Claims Tracking → Ready to Submit
- Find the resubmitted claim
- Export a new 837 file or CMS-1500 PDF
- Submit it to insurance (via clearinghouse or payer portal)

- Mark as Submitted again

Note: Resubmitting does NOT change the visits, line items, or amounts. It only resets the claim status to allow another submission attempt.

Writing Off Uncollectible Claims

If a denied claim cannot be collected, you can **write it off** to remove it from your accounts receivable.

When to Write Off

Scenario	Action
Insurance final denial	After appeal period expires, write off the claim
Patient unresponsive	Patient owes co-pay but hasn't paid after multiple attempts
Small balance	Amount is too small to justify collection efforts (e.g., \$5 balance)
Bankruptcy	Patient filed bankruptcy and balance is discharged
Death	Patient deceased and estate won't pay (no balance transfer to responsible party)

Write Off Process

Step 1: Open Write Off Modal

- Go to Denial Management tab
- Click three-dot menu for the denied claim
- Select "Write Off"

Step 2: Confirm Write Off

The modal shows:

- **Warning:** Writing off a claim sets the balance to \$0 but keeps status as Denied
- **Claim details** (patient, payer, amount)
- **Checkbox:** "I confirm this balance is uncollectible and should be written off"

Step 3: Execute Write Off

Click "Write Off" button.

Backend Actions:

1. Claim's balanceDue is set to \$0.00
2. Claim status **remains** Denied (to preserve audit trail showing it was never paid by insurance)
3. A write-off record may be created (depending on accounting configuration)

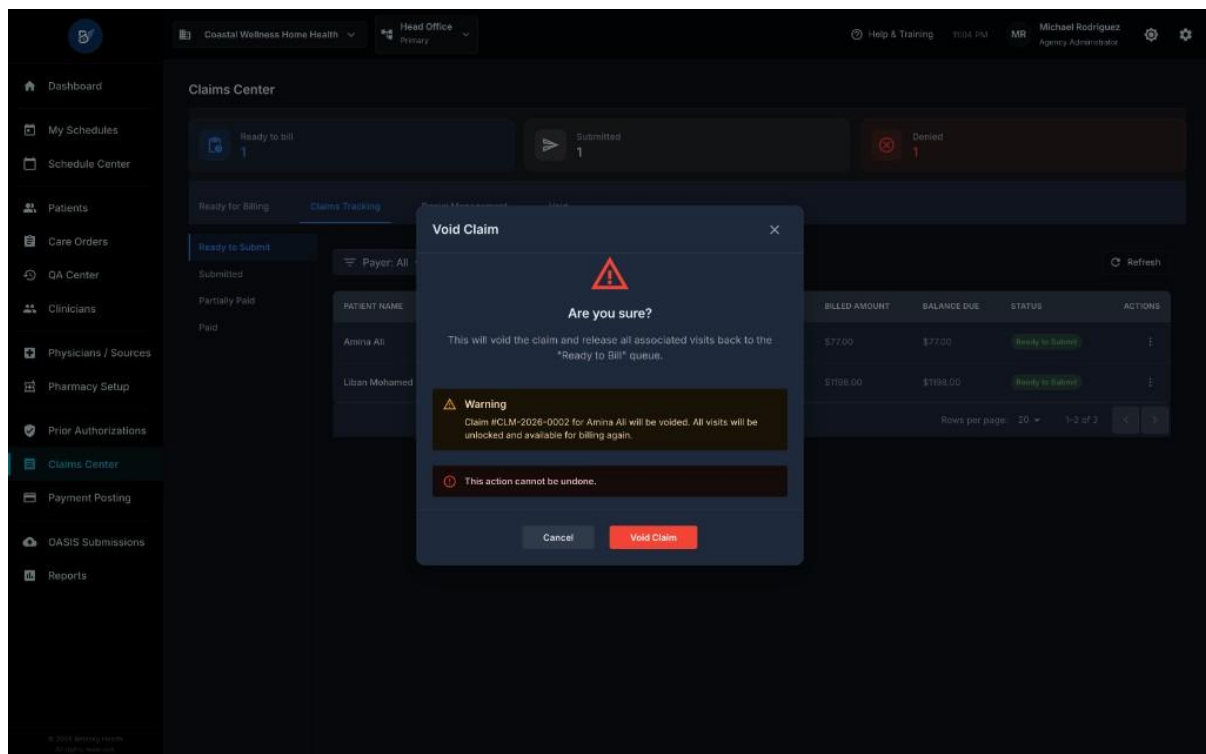
Result:

- Claim shows balance = "\$0.00"
- Claim remains in Denial Management tab (status is still Denied, not Paid)
- Financial reports show this as a write-off, not revenue

Important Distinction:

- **Paid Claim:** Insurance or patient paid the full amount → status = Paid
- **Written Off Claim:** No one paid, agency absorbed the loss → status = Denied, balance = \$0

Voiding Claims



What is Voiding?

Voiding a claim **permanently cancels** it and releases all associated visits back to the "Ready for Billing" queue. This is useful when:

- Claim was generated in error (wrong patient, wrong payer, wrong visits)
- You need to regenerate the claim with different visits
- Claim was submitted to wrong insurance company

When You Can Void

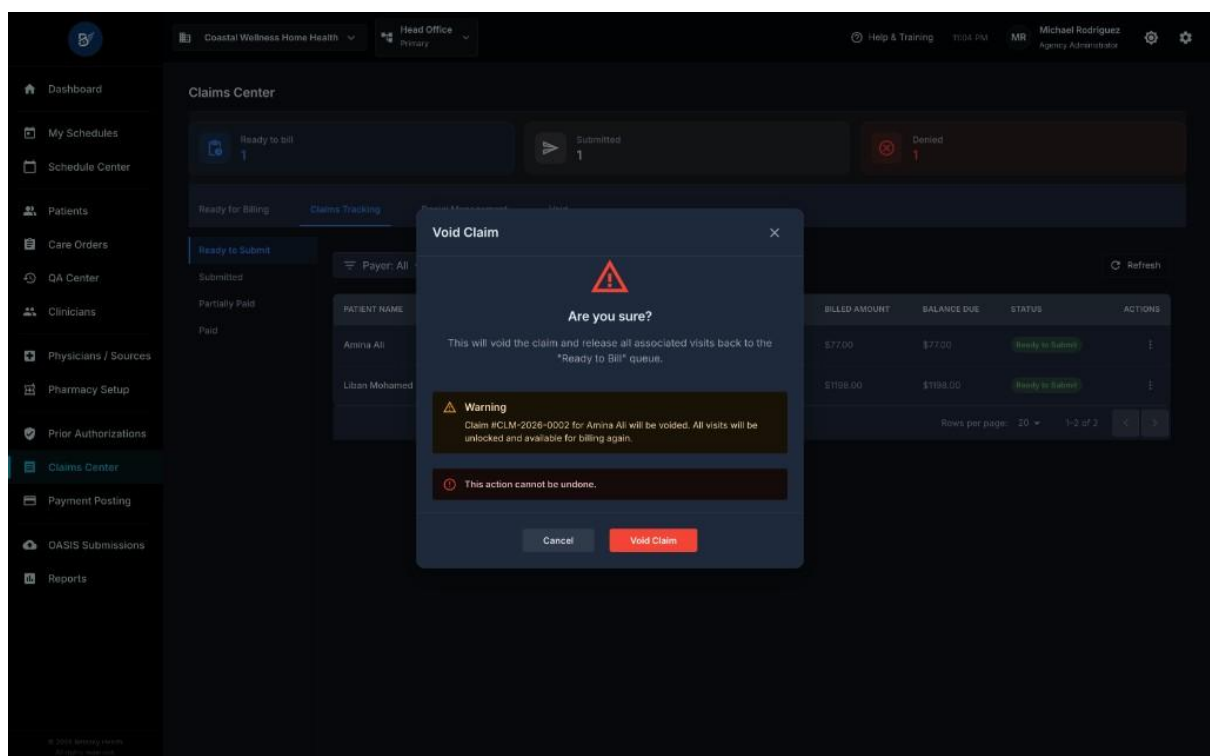
Claim Status	Can Void?	Why?
Ready to Submit	Yes	Claim hasn't been submitted yet - safe to cancel
Submitted	Yes	Claim was submitted but you discovered an error - void it before insurance processes
Denied	Yes	Claim was denied and you want to recreate it

Claim Status	Can Void?	Why?
		differently
Partially Paid	Yes	Rare, but possible if you want to cancel the claim and refund the partial payment
Paid	NO	Cannot void paid claims - financial integrity rule. Paid claims are locked.
Void	No	Already voided

Voiding Process

Step 1: Open Void Modal

- From any Claims Tracking sub-tab (except Paid), click three-dot menu → **"Void"**
- Or right-click the claim row and select Void



Step 2: Review Warnings

The **"Void Claim"** modal shows:

Header:

- **Title:** "Are you sure?"
- **Triangle warning icon** (red)

Main Warning:

"This will void the claim and release all associated visits back to the 'Ready to bill' queue."

Important Notices:

- **Yellow Warning Box:** "Claim [Claim Number] for [Patient Name] will be voided. All visits will be unlocked and available for billing again."
- **Red Error Box:** "This action cannot be undone."

Step 3: Confirm Void

Click the red **"Void Claim"** button.

Backend Actions:

1. Claim status changes to Void
2. **CRITICAL:** All visits' claimId field is set to NULL
 - This "releases" the visits so they're no longer linked to any claim
3. Visits reappear in **"Ready for Billing"** tab
4. You can now generate a new claim with those visits (with corrections)

Result:

- Claim moves to **"Void"** tab
- Patient reappears in "Ready for Billing" with those visits
- You can regenerate the claim correctly

Use Cases for Voiding

Use Case 1: Wrong Payer Selected

Problem: You generated a claim billing Medicare, but the patient's primary payer is actually Blue Cross.

Solution:

1. Void the Medicare claim
2. Visits return to "Ready for Billing"
3. Update patient's primary payer to Blue Cross (in Patient module)
4. Generate a new claim (now correctly billing Blue Cross)

Use Case 2: Included Wrong Visits

Problem: Claim includes 5 visits, but 2 of them belong to a different care order (different episode).

Solution:

1. Void the claim
2. Visits return to "Ready for Billing"
3. Review & Bill again, selecting only the correct 3 visits for Episode 1
4. Generate a separate claim for the 2 visits from Episode 2

Use Case 3: Submitted to Wrong Clearinghouse

Problem: You accidentally uploaded the 837 file to the wrong clearinghouse.

Solution:

1. Void the claim in the system
2. Delete the file from the wrong clearinghouse (if possible)
3. Generate the claim again
4. Export and submit to the correct clearinghouse
5. Mark as Submitted

Void Tab: Viewing Voided Claims

The screenshot shows the 'Claims Center' interface with the 'Void' tab selected. At the top, there are filters for 'Ready to bill' (1), 'Submitted' (1), and 'Denied' (1). Below these are tabs for 'Ready for Billing', 'Claims Tracking', 'Denial Management', and 'Void'. A search bar for 'Payer: All' and 'Search Patient Name' is present, along with a 'Refresh' button. The main table displays a list of voided claims with columns: PATIENT NAME, PAYER, CLAIM #, SERVICE DATES, BILLED AMOUNT, BALANCE DUE, STATUS, and ACTIONS. The table contains 5 rows of data, all with a 'Void' status. At the bottom right, there is a pagination control showing 'Rows per page: 20' and '1-5 of 5'.

PATIENT NAME	PAYER	CLAIM #	SERVICE DATES	BILLED AMOUNT	BALANCE DUE	STATUS	ACTIONS
ulala Haji	Blue Cross Blue Shield	CLM-2025-0019	12/18/2025 - 12/18/2025	\$5100.00	\$5100.00	Void	
Abe bela	Medicare of Texas	CLM-2025-0014	12/10/2025 - 12/10/2025	\$2500.00	\$2500.00	Void	
Abe bela	Medicare of Texas	CLM-2025-0013	12/7/2025 - 12/9/2025	\$2500.00	\$2500.00	Void	
ulala Haji	Blue Cross Blue Shield	CLM-2025-0012	12/9/2025 - 12/9/2025	\$200.00	\$200.00	Void	
ulala Haji	Blue Cross Blue Shield	CLM-2025-0003	12/7/2025 - 12/14/2025	\$242.00	\$242.00	Void	

What's in the Void Tab?

The Void tab shows all claims with status = "Void".

Table Columns:

- Same as Claims Tracking tabs (Patient, Payer, Claim #, Service Dates, Billed Amount, Balance Due, Status, Actions)
- Status column shows red **"Void"** badge
- Balance Due shows the original balance (voided claims keep financial totals for audit trail)

Actions Available:

- **View Details** - See the claim details and visits (read-only)
- **No other actions** - Voided claims cannot be edited, resubmitted, or unvoided

Why Keep Voided Claims?

- **Audit Trail:** Shows what claims were generated and then cancelled
- **Financial Reporting:** Voided claims are excluded from revenue calculations

- **Compliance:** Demonstrates you're not double-billing (visit was released and re-billed on a different claim)

Voided Claim Details:

When you click "View Details" on a voided claim:

- Shows all original information (visits, dates, amounts)
- Shows "Void" status badge
- No action buttons (read-only)
- Visits table may show empty if visits were re-billed on a different claim

Exporting Claims (837 EDI and CMS-1500)

Claims can be exported in two formats for submission to insurance:

Format 1: 837P EDI File (Electronic)

What is 837P?

- **837P** = HIPAA-compliant electronic claim format (P = Professional claims)
- Plain text file with standardized segments (ISA, GS, ST, NM1, etc.)
- Required by most clearinghouses and payer electronic portals

When to Use:

- Submitting to a clearinghouse (e.g., Change Healthcare, Waystar)
- Uploading to payer electronic portal (e.g., Availity)
- Most efficient for bulk claims

How to Export:

1. Click "**Export Claim**" button on claim details modal, OR
2. From Claims Tracking → Ready to Submit, select multiple claims and click bulk "Download 837"
3. System generates the 837P file
4. File downloads automatically (filename: 837P_BATCH_[timestamp].txt)

File Structure Example:

```
ISA*00*      *00*      *ZZ*AGENCY123   *ZZ*PAYER456
*260410*1200*^*00501*000000001*0*P*::~~
  GS*HC*AGENCY123*PAYER456*20260410*1200*1*X*005010X222A1~
  ST*837*0001*005010X222A1~
  BHT*0019*00*CLM-2026-0002*20260410*1200*CH~
...
```

Format 2: CMS-1500 PDF (Paper)

What is CMS-1500?

- Standard paper claim form (red-outlined boxes)
- Used for mailing claims or uploading scanned copies

When to Use:

- Submitting to payers that don't accept electronic claims

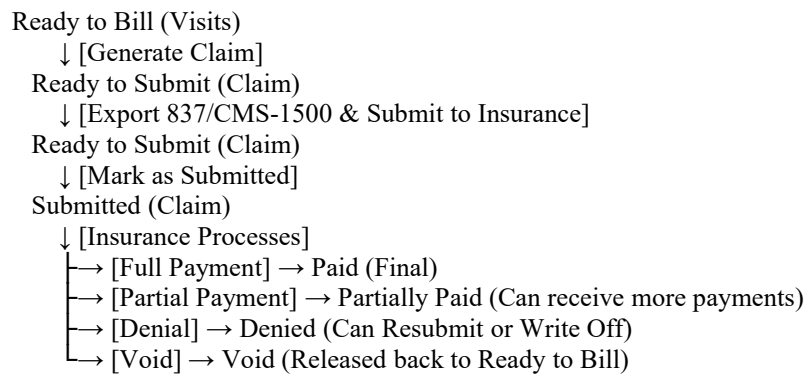
- Printing for patient records or audits
- Small volume of claims

How to Export:

1. Click "Export Claim" → Choose "CMS-1500 PDF"
2. System generates a filled PDF form
3. PDF downloads with patient info, services, codes, and amounts

Understanding Claim Statuses: Complete Lifecycle

Status Flow Chart



Status Definitions in Detail

Status	Color	Description	Actions Available	Next Steps
Ready to Submit	Blue	Claim generated, includes selected visits, has claim number, ready to export and send to insurance	Export 837, Export CMS-1500, Edit, Void	Export and submit to insurance, then mark as submitted
Submitted	Gray	Claim sent to insurance, awaiting response (payment or denial)	Post Payment, Mark as Denied, Void	Wait for ERA/EOB from insurance, then post payment or mark as denied
Paid	Green	Insurance paid full amount, balance = \$0, claim is closed	View Details, Export (read-only)	None - claim is complete
Partially Paid	Yellow	Insurance paid some but not all, balance > \$0	Post Additional Payment, Mark as Denied (remaining balance), Write Off (remaining balance)	Follow up with insurance for remaining balance, or collect from patient
Denied	Red	Insurance denied claim, balance = full amount	View Details, Resubmit (correct and	Investigate denial reason, correct error,

Status	Color	Description	Actions Available	Next Steps
			resubmit), Write Off (if uncollectible)	and resubmit, or write off if not worth pursuing
Void	Red	Claim cancelled, visits released back to billing queue	View Details (read-only)	Visits are now available to bill on a new claim

Medicare-Specific Billing Rules

Medicare billing has unique requirements that differ from private insurance.

1. OASIS Acceptance Requirement

Rule:

For Medicare care orders, the OASIS assessment must be **submitted to CMS** and status must be **'ACCEPTED'** before you can generate claims for visits in that episode.

Why:

Medicare ties payment to OASIS assessments. Without an accepted OASIS, Medicare has no basis to determine the HIPPS code or approve payment.

Error If Not Met:

When trying to generate a claim: "Cannot generate Medicare claim: OASIS submission status is 'READY_TO_SUBMIT'. OASIS must be submitted and accepted before billing Medicare. Please check the OASIS Submissions workspace."

Solution:

1. Go to OASIS Submissions module
2. Export the OASIS XML
3. Submit to CMS via QIES system
4. Mark as Submitted in the system
5. Wait for CMS response (usually 24-48 hours)
6. Mark as Accepted once CMS confirms
7. Return to Claims Center - visits now appear in Ready for Billing

2. 30-Day Period Validation

Rule:

All visits on a Medicare claim must fall within the same 30-day billing period.

Period Definitions:

- **Period 1:** Days 1-30 of the episode (Day 1 = certification start date, Day 30 = start date + 29 days)
- **Period 2:** Days 31-60 of the episode (Day 31 = start date + 30 days, Day 60 = start date + 59 days)

Example:

- Episode starts Jan 1, 2026
- Period 1: Jan 1 - Jan 30, 2026
- Period 2: Jan 31 - Mar 1, 2026

Validation Error:

If you try to bill visits from both periods on the same claim: "Medicare claims cannot span payment periods. 4 visit(s) are in Period 1 (Days 1-30) and 2 visit(s) are in Period 2 (Days 31-60). Please select visits only from Days 1-30 or Days 31-60."

Solution:

- Generate two separate claims:
 - Claim 1: Include only Period 1 visits (4 visits)
 - Claim 2: Include only Period 2 visits (2 visits)
- Both claims will have the same HIPPS rate (e.g., \$3,200 each)

3. HIPPS Code and Rate Lookup

Process:

1. System retrieves HIPPS code from the Care Order (stored when OASIS was approved)
2. System looks up the HIPPS rate from Payer Settings (based on HIPPS code and effective date)
3. If rate is missing, you must manually enter it in the billing modal

Rate Lookup Logic:

- Finds rate with HIPPS code matching AND effective date $\leq$ earliest visit date
- If multiple rates exist, uses the most recent one (by effective date DESC)

Why Effective Date Matters:

HIPPS rates change annually (January 1 each year). A visit on Jan 15, 2026 uses the 2026 rate, but a visit on Dec 20, 2025 uses the 2025 rate.

4. Medicare Does Not Use Line Item Rates

In Medicare claims:

- **Individual visit amounts** = \$0.00 (informational only, not billed separately)
- **Total claim amount** = HIPPS rate (flat rate for the 30-day period)
- **Visits are listed** on the claim to document services provided, but payment is based on HIPPS, not visit count

Why This Matters:

If you provide 3 visits or 15 visits in a 30-day period, Medicare pays the same HIPPS rate. The payment is based on patient acuity and clinical characteristics (captured in OASIS), not visit frequency.

Private Insurance-Specific Billing Rules

1. Fee Schedule Requirement

Rule:

For private insurance and Medicaid Managed Care, each visit type must have a configured rate in the Fee Schedule.

How Rates Are Looked Up:

- System finds Fee Schedule entry where:
 - payerId = patient's primary payer
 - visitTypeId = visit type being billed
 - effectiveDate <= visit date
- If multiple rates exist, uses the most recent one (by effective date DESC)

Missing Rate Handling:

- If rate is missing, visit shows "Rate not found" error in the billing modal
- You can manually enter a rate override
- Better solution: Go to Fee Schedule Setup and configure the rate for future claims

2. Prior Authorization Validation

Rule:

If the payer requires prior authorization, the visit must be linked to an approved PA with remaining units.

Authorization Alerts:

- **MISSING_AUTH:** Visit has no valid PA (PA is expired, exhausted, denied, or doesn't exist)
- **EXCEEDS_LIMIT:** Visit exceeds approved PA units

Error Prevention:

- Visits with authorization alerts are automatically **unselected** in the billing modal
- Checkbox is disabled (cannot include them on the claim)
- Must resolve the PA issue first, then click "Re-Validate" to clear the alert

3. Multiple Claims Per Patient

Unlike Medicare (which requires one claim per 30-day period), private insurance allows flexibility:

- **Option A:** Generate one claim with all unbilled visits (monthly billing)
- **Option B:** Generate separate claims for each visit (immediate billing)
- **Option C:** Group visits by week or other custom period

Recommendation:

Bill weekly or bi-weekly for private insurance to improve cash flow and reduce risk of large denials.

Best Practices for Claims Management

1. Bill Medicare Period 1 Claims Immediately

Why:

- Period 1 claims can be submitted as soon as Day 1 visits are complete (don't need to wait for Day 30)
- Faster billing = faster payment = better cash flow
- CMS allows submitting RAP (Request for Anticipated Payment) after first visit

How:

- As soon as OASIS is accepted and first few visits are complete, generate Period 1 claim
- Even if only 2 visits are complete out of 10 planned, you can bill
- Medicare pays based on HIPPS, not visit count

2. Verify Rates Before Mass Billing

Why:

- Missing rates cause claim generation to fail
- Entering rates manually for every visit is time-consuming
- Consistent rates ensure predictable revenue

How:

- Before running monthly billing, spot-check a few patients:
 - Click "Review & Bill"
 - Check if any visits show "Rate not found"
 - If rates are missing, go to Fee Schedule Setup and configure them
- Once rates are confirmed, proceed with bulk billing

3. Resolve Authorization Alerts Immediately

Why:

- Visits with authorization alerts cannot be billed
- They remain stuck in "Ready for Billing" until PA is fixed
- Delays in PA renewal delay claims and revenue

How:

- In the billing modal, if you see visits with "No Authorization" or "Exceeds Limit":
 - Pause billing for that patient
 - Go to Prior Authorizations module
 - Update the PA (approve units, extend dates, or create new PA)
 - Return to Claims Center and click "Re-Validate" button
 - Alert should clear, visit becomes billable

4. Add Notes to Claims

Why:

- Notes serve as communication log between billing staff

- Helps with follow-ups ("Called insurance on 4/10, waiting for response")
- Provides context for appeals or disputes

How:

- Open claim details modal
- Use the "Activity Log / Notes" text area
- Save note
- Notes are timestamped and attributed to your user account

5. Monitor Denial Patterns

Why:

- Recurring denials from the same payer indicate systemic issues
- Common denial reasons can often be prevented

How:

- Weekly review of Denial Management tab
- Track denial reasons (manually in notes, or use denial codes if system supports)
- Identify patterns:
 - Is one clinician's visits frequently denied? (documentation quality issue)
 - Is one payer denying more than others? (authorization or rate issue)
 - Are specific visit types denied? (incorrect HCPCS code or medical necessity issue)
- Address root causes instead of resubmitting repeatedly

6. Don't Let Claims Sit in "Ready to Submit" Too Long

Why:

- Delayed billing extends your cash conversion cycle
- Timely filing limits (insurance may deny claims submitted more than 90 days after service date)
- Increases risk of missing information (clinician may forget visit details)

How:

- Set a target: Export and submit claims within 5 business days of generation
- Use a weekly billing schedule:
 - Monday: Generate claims for last week's visits
 - Tuesday: Export 837 files and submit to clearinghouse
 - Wednesday: Mark all as Submitted
- Automate where possible (EDI integrations)

7. Post Payments Promptly

Why:

- Accurate balance tracking
- Identify payment shortfalls early (under-payments, incorrect adjustments)
- Timely follow-up on remaining balances

How:

- When ERA (Electronic Remittance Advice) arrives:
 - Post payment within 1-2 business days
 - Record exact amount, check number, and date
 - Add note with ERA reference number
- If payment differs from billed amount, note the reason in the payment notes (e.g., "Adjusted to contracted rate per fee schedule")

8. Use Write-Offs Judiciously

Why:

- Write-offs reduce revenue (permanently)
- Premature write-offs = lost recovery opportunity
- Audit trail requirement

How:

- Establish a write-off policy:
 - Balances < \$10: Write off after 60 days
 - Balances 10–100: Attempt collection for 90 days, then write off
 - Balances > \$100: Pursue aggressively, appeal, or send to collections
- Document reason for each write-off
- Get supervisor approval for write-offs > \$500

Common Scenarios and Solutions

Scenario 1: Visit is Complete But Not Showing in "Ready for Billing"

Possible Causes:

1. Visit note is not approved yet (still in QA)
2. Patient has no primary payer assigned
3. Visit is marked as non-billable
4. For Medicare: OASIS not submitted or not accepted
5. Care order status is "Closed" or "On Hold"

Solutions:

- **Check QA Center:** Is the visit note approved?

- **Check Patient Payer:** Go to Patient module → Insurance tab → Verify primary payer is assigned
- **Check Visit:** Go to Schedule Center → Find the visit → Verify isBillable = true
- **For Medicare:** Check OASIS Submissions → Status should be ACCEPTED
- **Check Care Order:** Care order must be "Active" or "Discharged" (not "Closed")

Scenario 2: Cannot Generate Claim Due to HIPPS Rate Missing

Error Message:

"HIPPS rate not found for code 1CABA. Please configure the rate in Payer Setup for payer [Medicare] with an effective date on or before 2026-01-15, or provide a rate override."

Solution:

1. Option A: Configure Missing Rate

- Go to Payer Setup → Select Medicare payer
- Go to HIPPS Rates section
- Add rate for HIPPS code 1CABA
- Set effective date to Jan 1, 2026 (or earlier)
- Set rate amount (e.g., \$3,200)
- Save
- Return to Claims Center and try again

2. Option B: Manual Override (Temporary Fix)

- In the billing modal, manually enter the rate in the "Reimbursement Rate" field
- Generate the claim
- Note: This only fixes this one claim; configure the rate in Payer Setup for future claims

Scenario 3: Claim Generated for Wrong Billing Period (Medicare)

Problem:

You selected 6 visits: 4 from Period 1 (Jan 1-30) and 2 from Period 2 (Jan 31 - Feb 28). System shows error.

Solution:

1. Deselect the 2 Period 2 visits in the modal
2. Generate claim with only the 4 Period 1 visits
3. Close modal
4. Immediately click "Review & Bill" again for the same patient
5. Generate a second claim with the 2 Period 2 visits
6. Result: Two claims created (one per period, as required by Medicare)

Scenario 4: Insurance Paid Less Than Billed

Situation:

- Billed: \$480.00

- Paid: \$420.00
- Difference: \$60.00

Actions:

1. Post the \$420 payment → Claim status becomes Partially Paid, balance = \$60
2. Review the ERA (Explanation of Benefits) to understand why:
 - **Reason: Contractual Adjustment** → \$60 was adjusted to meet contracted rate (common, usually non-collectible from patient)
 - **Reason: Deductible** → \$60 is patient's responsibility (bill patient separately)
 - **Reason: Co-insurance** → Patient owes 20% co-pay (bill patient)
 - **Reason: Denied Line Item** → One visit was denied on the claim (investigate and appeal or write off)
3. If patient-responsible:
 - Generate patient statement (separate workflow)
 - Attempt to collect
4. If contractual adjustment:
 - Write off the \$60 (not collectible)
 - Claim status remains Partially Paid with balance = \$0 after write-off

Scenario 5: Need to Bill Visits from Multiple Episodes

Problem:

Patient had two care orders (episodes) in the same month:

- Episode 1: Jan 1 - Feb 29 (5 visits)
- Episode 2 (Recert): Mar 1 - Apr 29 (3 visits)

All 8 visits are complete and ready to bill.

Solution:

Critical Rule: You **MUST** generate separate claims for each episode.

Why:

Each episode has a different HIPPS code (from different OASIS assessments). Medicare will deny a claim that mixes HIPPS codes.

Steps:

1. In billing modal, look at visit dates
2. Identify which visits belong to Episode 1 (Jan 1 - Feb 29)
3. Select only Episode 1 visits
4. Generate Claim 1
5. Return to Ready for Billing
6. Click "Review & Bill" for the same patient again
7. Select only Episode 2 visits (Mar 1 - Apr 29)
8. Generate Claim 2

Scenario 6: Claim Submitted But Insurance Says They Never Received It

Problem:

You marked claim as "Submitted" 30 days ago, but insurance has no record of it.

Cause:

- 837 file was not actually uploaded to clearinghouse or payer portal
- File upload failed (network error, format error)
- Submitted to wrong payer ID

Solution:

1. Check if you have a confirmation from the clearinghouse (submission receipt, transaction ID)
2. If no confirmation exists, claim was never sent
3. Go to Claims Tracking → Submitted tab
4. Find the claim
5. Export a fresh 837 file
6. Submit to clearinghouse/payer portal (verify payer ID is correct)
7. Confirm submission (wait for receipt/confirmation email)
8. If insurance still says they don't have it after confirmed submission, escalate with clearinghouse support

Scenario 7: Want to Add More Visits to an Existing Claim

Problem:

You generated a claim with 3 visits. Now 2 more visits for the same patient are complete, and you want to add them to the existing claim.

Solution:

You cannot add visits to an existing claim. Claims are immutable once generated.

Workaround:

1. If claim is still Ready to Submit (not yet sent to insurance):
 - Void the claim
 - Visits return to Ready for Billing (now 5 total)
 - Generate a new claim including all 5 visits
2. If claim is already Submitted:
 - Leave the original claim as-is
 - Generate a **second claim** with the 2 new visits
 - Result: Two claims for the same patient (this is acceptable)

Scenario 8: Patient Changed Insurance Mid-Episode

Problem:

- Jan 1-15: Patient had Blue Cross (5 visits completed)

- Jan 16: Patient switched to Medicaid (3 visits completed after switch)

All 8 visits are ready to bill, but patient's primary payer is now Medicaid.

Solution:

You **must** generate two separate claims:

1. **Temporarily change patient's primary payer** back to Blue Cross (or create a manual claim override - if supported)
2. Generate claim for the 5 visits (Jan 1-15) → Bills Blue Cross
3. Change patient's primary payer back to Medicaid
4. Generate claim for the 3 visits (Jan 16+) → Bills Medicaid

Better Approach:

- In patient module, assign **secondary payer** (Blue Cross) in addition to primary payer (Medicaid)
- When generating claims, system can intelligently bill based on effective dates of each payer
- Consult with your billing specialist if this scenario occurs frequently

Troubleshooting

Issue: "Ready to Bill" Count Doesn't Match Actual Patients

Symptom:

Dashboard says "Ready to bill: 5" but only 3 patients appear in the table.

Possible Causes:

1. Cache is stale (stats cached for 90 seconds)
2. Branch filter is applied (multi-branch feature)
3. Payer filter is hiding some patients

Solutions:

- Wait 90 seconds for cache to refresh, or click Refresh button
- Check branch selector (top of page) - are you viewing Head Quarter or a specific branch?
- Check payer filter - change to "All Payers"

Issue: Cannot Generate Claim Due to Missing Document Approval

Error Message:

"One or more provided visits are not in a billable state..." or visit doesn't appear in Ready for Billing at all.

Cause:

Visit note is not approved in QA Center yet.

Solution:

1. Go to QA Center
2. Find the visit note for this visit (search by patient name or date)

3. Review and approve the visit note
4. Return to Claims Center after 2-3 minutes (give backend time to process)
5. Visit should now appear in Ready for Billing

Issue: Medicare Claim Shows "OASIS Not Accepted" Error

Error Message:

"Cannot generate Medicare claim: OASIS submission status is '[status]'. OASIS must be submitted and accepted before billing Medicare."

Cause:

OASIS for this episode is not yet submitted to CMS, or CMS rejected it.

Solution:

1. Go to OASIS Submissions module
2. Find the OASIS for this patient's care order
3. Check status:
 - **READY_TO_SUBMIT** → Export XML, submit to QIES, mark as Submitted
 - **SUBMITTED** → Wait for CMS response (usually 24-48 hours)
 - **REJECTED** → Fix the errors CMS reported, resubmit
 - **PENDING_CORRECTION** → Notify clinician to make corrections, re-approve in QA, resubmit
4. Once status is ACCEPTED, return to Claims Center
5. Visits should now be billable

Issue: Claim Generated But Visits Still Show in "Ready for Billing"

Symptom:

You generated a claim for patient John Doe, but John Doe still appears in the Ready for Billing table with the same visits.

Possible Causes:

1. Claim generation failed partway through (database transaction rolled back)
2. Frontend didn't refresh after claim generation
3. Those are different visits (not the ones you billed)

Solutions:

- Refresh the page (F5)
- Go to Claims Tracking → Ready to Submit → Verify the claim exists
- If claim doesn't exist, generation failed - check browser console for errors
- If claim exists, those may be new visits completed after you generated the first claim

Issue: Voided Claim Visits Don't Reappear in "Ready for Billing"

Symptom:

You voided a claim, but the visits don't show up in the Ready for Billing table.

Possible Causes:

1. Visits are no longer eligible (care order closed, visit note un-approved, etc.)
2. Frontend cache hasn't refreshed
3. Visits were re-billed on another claim already

Solutions:

- Click Refresh button
- Verify visit eligibility:
 - Go to Schedule Center → Find the visits
 - Check visit status = Completed and visit note status = Approved
 - Check care order status = Active or Discharged
- If visits were re-billed on another claim, they won't reappear (already claimed)

Permissions and Access Control

Required Permissions

Action	Required Permission	Notes
View Claims Center	VIEW_CLAIMS	Without this, Claims Center menu is hidden
Generate Claims	CREATE_CLAIM	"Review & Bill" button hidden without this permission
Mark as Submitted	EDIT_CLAIM	Cannot change claim status without this
Post Payments	POST_PAYMENT	Cannot record insurance payments without this
Void Claims	VOID_CLAIM	Cannot cancel claims without this
Resubmit Denied Claims	EDIT_CLAIM	Resubmit button hidden without this
Write Off	WRITE_OFF_CLAIM or POST_PAYMENT	Cannot write off balances without this

Role-Based Access Examples

Billing Manager (Full Access)

- **Permissions:** All claims permissions
- **Can Do:**
 - Generate claims
 - Export 837 and CMS-1500

- Mark as submitted
- Post payments
- Manage denials (resubmit, write off)
- Void claims

Billing Specialist (Limited)

- **Permissions:** VIEW_CLAIMS, CREATE_CLAIM, EDIT_CLAIM
- **Can Do:**
 - View claims
 - Generate claims
 - Export claims
 - Mark as submitted
- **Cannot Do:**
 - Post payments (requires manager approval)
 - Void claims
 - Write off claims

Finance Director (Read-Only)

- **Permissions:** VIEW_CLAIMS only
- **Can Do:**
 - View all claims and their statuses
 - Run reports on revenue and denials
 - Export claim data for analysis
- **Cannot Do:**
 - Generate, edit, or void claims
 - Post payments

Clinician (No Access)

- **Permissions:** None
- **Cannot Access:** Claims Center
- **Why:** Clinicians focus on patient care, not billing. Their visit notes feed into claims, but they don't manage the billing process.

Integration with Other Modules

Visit Forms / Schedule Center

- **Link:** Completed visits feed into Claims Center
- **Impact:** Visit status and visit note approval determine billing eligibility
- **Flow:** Clinician completes visit → QA approves note → Visit appears in Ready for Billing

QA Center

- **Link:** Visit note must be approved before visit can be billed
- **Impact:** QA bottlenecks delay billing
- **Recommendation:** Prioritize QA review of visits approaching timely filing limits

OASIS Submissions (Medicare Only)

- **Link:** OASIS acceptance is a prerequisite for Medicare billing
- **Impact:** Cannot bill Medicare visits until OASIS status = **ACCEPTED**
- **Timeline:** OASIS approval → CMS submission → 24-48 hour wait → Acceptance → Visits become billable

Prior Authorizations (Private Insurance)

- **Link:** PA approval and remaining units determine visit eligibility
- **Impact:** Expired/exhausted PAs block billing with MISSING_AUTH alert
- **Flow:** PA approved → Visits generated → Visits completed → Appear in Ready for Billing (if PA still valid)

Care Orders

- **Link:** Care order status and dates affect billing eligibility
- **Impact:** Closed care orders block billing, discharged care orders filter post-discharge visits
- **Rule:** Care order must be "Active" or "Discharged" to bill

Payer Setup

- **Link:** Fee Schedules (private insurance) and HIPPS Rates (Medicare) determine claim amounts
- **Impact:** Missing rates prevent claim generation
- **Recommendation:** Configure all rates during payer setup, before seeing patients

Payment Posting

- **Link:** Posted payments update claim balance and status
- **Impact:** Claims transition from Submitted → Partially Paid → Paid based on payments received

Chapter 28: Physicians/Sources Management

Overview

The **Referral Sources** module (also called **Physicians/Sources Management**) manages your network of **referring physicians** and **referral source facilities** (hospitals, SNFs, clinics). These contacts are essential for documenting referral sources, ordering physicians, and tracking patient origins.

Referral Sources Main Page

The screenshot displays the 'Referral Sources' main page. The top navigation bar includes the system logo, organization name 'Coastal Wellness Home Health', user role 'Head Office Primary', and user information 'Michael Rodriguez, Agency Administrator'. The left sidebar contains a menu with items like Dashboard, My Schedules, Schedule Center, Patients, Care Orders, QA Center, Clinicians, **Physicians / Sources** (highlighted), Pharmacy Setup, Prior Authorizations, Claims Center, Payment Posting, OASIS Submissions, and Reports. The main content area is titled 'Referral Sources' and features a search bar 'Search by name or NPI...' and a dropdown menu set to 'Physician'. Below this is a table with the following data:

SOURCE NAME	CONTACT PERSON	PHONE	FAX	NPI	STATUS	ACTIONS
Dr. Setale dera	Dr. Setale dera	0943101449	0943101449995	0876542104	Active	
Dr. chandra Gowda	Dr. chandra Gowda	6148054490	6148405800	1234567888	Active	
Dr. Barn Haji	Dr. Barn Haji	0932751339	878677423424	2345678903	Active	
Dr. Nesredin Haji	Dr. Nesredin Haji	0932751336	N/A	1234567893	Active	

Page Header

Title: "Referral Sources"

Add Button (Blue):

- Label: "+ Add Referral Source"
- Opens the Add modal (Physician or Facility)
- Always visible (no need to select type first)

Verify from CMS Button (Blue, Outlined):

- Icon: Shield with checkmark (VerifiedUserIcon)
- Label: "Verify from CMS"
- Opens CMS physician lookup modal
- Allows you to search the CMS National Provider Identifier (NPI) registry and import verified physician data
- Only works for physicians (not facilities)

Filters Section

Filter	Type	Options
Search	Text input	Search by physician name, facility name, or NPI
Type	Toggle Buttons	"Physician" (left, blue when selected) or "Facility" (right, blue when selected)

How Type Filter Works:

- **Default:** "Physician" is selected (shows only physicians)
- Click "Facility" to switch to facilities
- Data table updates automatically to show only the selected type

Data Table

The table displays either physicians or facilities depending on the Type filter:

When Type = Physician

Column	Description	Example
Name	Physician full name (clickable link to detail view)	"Muud abebc", "Nesredin Haji", "Barn Haji"
NPI	National Provider Identifier (10 digits)	"9955779966", "1518405697"
Phone	Physician's primary phone number	"+37267-245-8809", "+372 (123) 456-7..."
Email	Physician's email address	" ghj@gmail.com ", " b@b.com "
State	Practice location state (abbreviated)	"FL", "MO"
Status	Badge showing Active/Inactive	Green "Active", Gray "Inactive"
Actions	Icon buttons (View, Edit, Delete)	Eye icon, Pencil icon, Trash icon

When Type = Facility

Column	Description	Example
Facility Name	Name of facility (clickable link)	"St. Mary's Hospital", "Pine Grove Nursing Home"
Type	Facility type	"Hospital", "SNF", "Clinic", "Other"
Contact	Primary contact person	"John Smith, Administrator", "—" (none)
Phone	Main facility phone	"(555) 123-4567"

Column	Description	Example
City, State	Facility location	"Austin, TX", "Miami, FL"
Status	Badge showing Active/Inactive	Green "Active", Gray "Inactive"
Actions	Icon buttons (View, Edit, Delete)	Eye icon, Pencil icon, Trash icon

Action Buttons

Each row has three icon buttons on the right:

Icon	Name	Color	Function
Eye	View	Blue	Opens detail view modal (read-only)
Pencil	Edit	Blue	Opens edit modal (all fields editable)
Trash	Delete	Red	Opens delete confirmation dialog

Pagination

Bottom of table shows page controls:

- Total items count
- Current page number
- Navigation arrows
- Page selector

Adding a Physician (Manual Entry)

How to Add Manually

1. Click "+ Add Referral Source" button
2. Modal opens with toggle at top: **"Physician"** (selected) or "Facility"
3. Fill in required and optional fields
4. Click **"Save"**

Add Physician Modal Fields

Type Toggle (Top)

- **Physician** (blue button, selected)
- **Facility** (gray button, inactive)
- Can toggle between types before saving

Required Fields (marked with red asterisk)

Field	Description	Validation
First Name	Physician's first name	Required, text
Last Name	Physician's last name	Required, text

Optional Fields

Field	Description	Validation	Example
NPI	National Provider	10 digits, numbers only	"1518405697"

Field	Description	Validation	Example
	Identifier		
Phone Number	Primary phone	Phone format	" +1 (555) 123-4567"
Fax Number	Fax number	Phone format	" +1 (555) 123-4568"
Email	Email address	Valid email format	" doctor@clinic.com "
Address Line 1	Street address	Text	"123 Medical Plaza"
Address Line 2	Apt/Suite	Text	"Suite 200"
City	City	Text	"Austin"
State	State dropdown	Select from list	"Texas"
ZIP Code	Postal code	Text	"78701"
Status	Active/Inactive	Dropdown: "ACTIVE" (default) or "INACTIVE"	"ACTIVE"
PECOS Certified	Checkbox	Checked = Yes, Unchecked = No	☒ Checked

PECOS Certified Field Explanation:

- PECOS = Provider Enrollment, Chain, and Ownership System (CMS registry)
- Check this box if the physician is PECOS-certified (required for Medicare orders)
- Leave unchecked for physicians who don't need Medicare certification

Saving

1. Click **"Save"** button (blue, bottom right)
2. System validates:
 - First Name and Last Name are required
 - NPI (if provided) must be exactly 10 digits
 - Email (if provided) must be valid format
3. If validation fails, red error messages appear below fields
4. If successful:
 - Modal closes
 - Green toast: "Physician added successfully"
 - New physician appears in table

Cancel

Click **"Cancel"** (gray button) or **"X"** (top right) to close without saving.

Adding a Facility

Add New Referral Source

Add a new physician or facility to the directory.

Source Type

Physician Facility

Facility Name * Enter facility name

Facility Type Select facility type

Primary Contact at Facility

Contact First Name Enter first name

Contact Last Name Enter last name

Contact Title e.g. Case Manager

Contact Phone Number (000) 000-0000

Contact Email Address Enter email address

Facility Information

NPI Number Enter NPI number (Optional, must be 10 digits if provided)

Main Phone Number (000) 000-0000

Fax Number Enter fax number

Address Line 1 Enter facility address

Address Line 2 (Optional) Apartment, suite, etc.

Cancel Save Source

NPI	STATUS	ACTIONS
0676542104	Active	View Edit Delete
1234567890	Active	View Edit Delete
2345678901	Active	View Edit Delete
1234567893	Active	View Edit Delete

How to Add Facility

1. Click **"+ Add Referral Source"** button
2. Modal opens
3. Click **"Facility"** toggle button at top
4. Form switches to facility fields
5. Fill in required and optional fields
6. Click **"Save"**

Add Facility Modal Fields

Type Toggle (Top)

- **Physician** (gray button, inactive)
- **Facility** (blue button, selected)

Required Fields (marked with red asterisk)

Field	Description	Validation
Facility Name	Full name of facility	Required, text
Facility Type	Type of facility	Required, dropdown: "Hospital", "SNF",

Field	Description	Validation
		"Clinic", "Other"

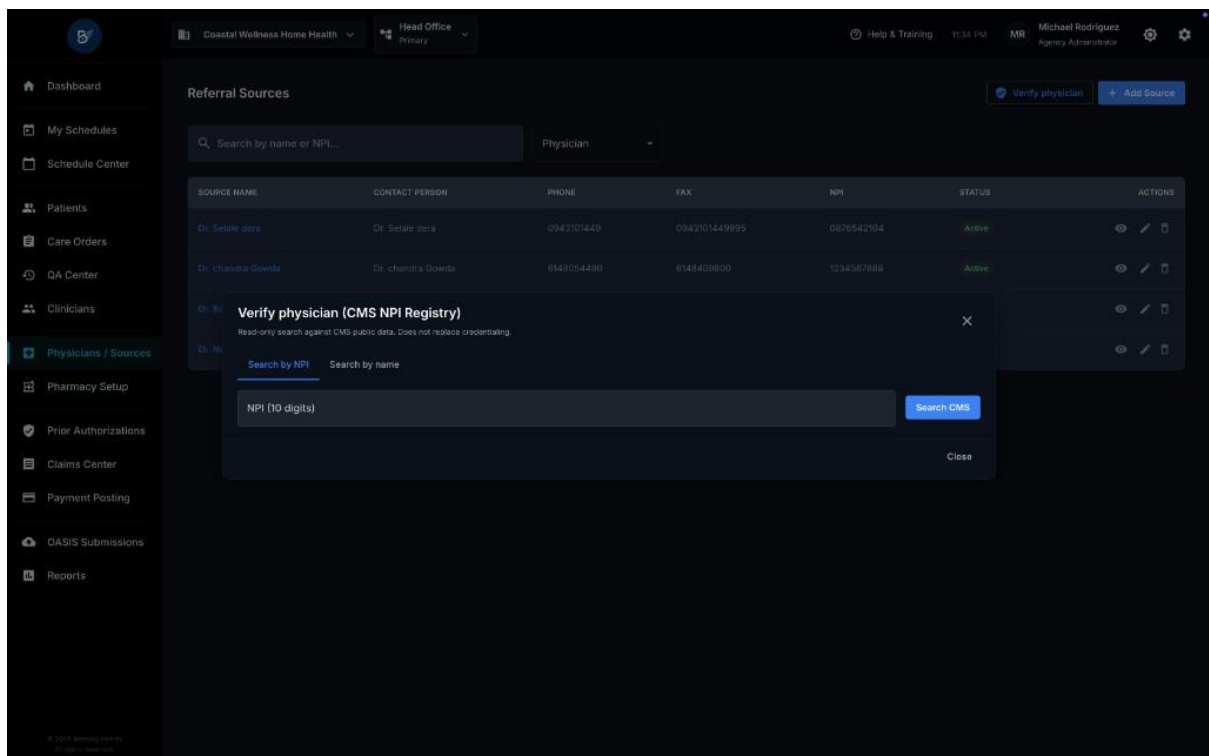
Optional Fields

Field	Description	Validation	Example
NPI	Facility's NPI (if any)	10 digits	"1234567890"
Main Phone	Facility's main phone	Phone format	"+1 (555) 123-4567"
Fax Number	Facility's fax	Phone format	"+1 (555) 123-4568"
Contact First Name	Primary contact's first name	Text	"John"
Contact Last Name	Primary contact's last name	Text	"Smith"
Contact Title	Primary contact's job title	Text	"Administrator"
Contact Phone	Contact person's direct phone	Phone format	"+1 (555) 123-4569"
Contact Email	Contact person's email	Valid email	" john.smith@hospital.com "
Address Line 1	Street address	Text	"456 Hospital Drive"
Address Line 2	Apt/Suite	Text	"Building A"
City	City	Text	"Houston"
State	State dropdown	Select from list	"Texas"
ZIP Code	Postal code	Text	"77001"
Status	Active/Inactive	Dropdown: "ACTIVE" (default) or "INACTIVE"	"ACTIVE"

Saving

Same validation and toast notification as Physician

Verifying a Physician from CMS



What is CMS Verification?

The "Verify from CMS" button allows you to search the **CMS National Provider Identifier (NPI) registry** to:

- **Verify physician credentials** before adding them
- **Auto-populate physician details** (name, NPI, address, phone) from official CMS data
- **Ensure accuracy** by importing verified information instead of manual entry

How to Use CMS Verification

1. Click "Verify from CMS" button (blue, outlined, shield icon)
2. Modal opens with two tabs: "NPI" and "Name & State"

Tab 1: Search by NPI

Use Case: You have the physician's 10-digit NPI.

Fields:

- **NPI** - Text input (10 digits)
- Example: "1518405697"

How to Search:

1. Enter the 10-digit NPI
2. Click "Search" button
3. Results appear in table below (if found)

Tab 2: Search by Name & State

Use Case: You don't have the NPI, but you know the physician's name and practice location.

Fields:

- **Last Name** (required) - At least 2 characters
- **First Name** (optional)
- **State** (required) - Dropdown selector

How to Search:

1. Enter Last Name (e.g., "Haji")
2. (Optional) Enter First Name (e.g., "Barn")
3. Select State (e.g., "Missouri")
4. Click **"Search"** button
5. Results appear in table below

Understanding CMS Search Results

The results table shows:

Column	Description	Example
Name	Physician full name	"Barn Haji"
NPI	10-digit NPI	"1518405697"
Primary Taxonomy	Medical specialty	"Nurse Practitioner"
Phone	Phone number from CMS	"+1 (573) 761-3333"
Address	Full address from CMS	"COLUMBIA, MO 65201-5275"
Actions	"Select" button	Blue button

Empty Cell Indicators:

- "—" (em dash) means no data available in CMS registry

Selecting a Physician from Results

1. Review the results table
2. Find the correct physician
3. Click the blue **"Select"** button in their row
4. CMS Verification modal closes
5. Add Referral Source modal opens automatically
6. **All fields are pre-filled** with CMS data:
 - First Name, Last Name
 - NPI
 - Phone Number

- Address (Line 1, City, State, ZIP)

7. Review the pre-filled data

8. (Optional) Edit any fields

9. Click "**Save**" to add the physician

Note: You can still edit any field before saving. CMS data is a starting point, not locked in.

Why Use CMS Verification?

Accuracy - Data comes directly from official CMS registry

Speed - No need to manually type name, NPI, address

Compliance - Ensures NPI is valid and associated with correct provider

PECOS Status - Can verify if physician is PECOS-certified

Troubleshooting CMS Search

Issue: "No results from CMS for this NPI"

- **Cause:** NPI not found in CMS registry
- **Solution:** Double-check the NPI, or search by name instead

Issue: "No individual providers matched in CMS."

- **Cause:** Name/state combination didn't match any individual providers
- **Solution:** Try with Last Name only (remove First Name), or verify the spelling

Issue: "This NPI is an organization."

- **Cause:** The NPI belongs to a facility/organization, not an individual physician
- **Solution:** Add it manually as a Facility, not a Physician

Viewing Physician Details

Referral Sources / Dr. Nesredin Haji

Dr. Nesredin Haji Edit

Total Referrals (All Time) **16**

Referrals (YTD) **11**

Admission Rate (%) **38%**

Physician Information

NPI: 1234567893

Status: **ACTIVE**

PECOS Certified: **No**

Address

Ethiopia
adama
Louisiana
0000

Contacts

Dr. Nesredin Haji
Physician
📞 0932751336
✉ nesredinhaji75@gmail.com

Referral History Filter

PATIENT NAME	DATE RECEIVED	STATUS	ASSIGNED NURSE
Nesredin Haji	2026-03-10	Admitted	Hace ko
Nuur Abdi	2026-02-23	Admitted	RN Test Clinician
Test Start	2026-01-18	Admitted	RN Test Clinician
Alyow Omar	2026-01-18	Admitted	Abebe Goben
Alyow Omar	2026-01-11	Not Admitted	Abebe Goben
Amina Ali	2026-01-11	Not Admitted	Abebe Goben
Amina Ali	2026-01-08	Not Admitted	Abebe Goben
Abe bea	2026-01-07	Admitted	Abebe Goben
Realtest forpdf	2026-01-04	Admitted	Abebe Goben
John Doe	2026-01-03	Not Admitted	RN Test Clinician

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How to View Details

1. Find the physician in the table
2. Click the **Eye icon** (View button) in the Actions column
3. Detail view modal opens

Detail View Modal

Mode: Read-only (all fields are grayed out, cannot be edited)

Purpose: Quickly view all physician information without opening edit mode

Fields Displayed:

- All physician fields (name, NPI, phone, email, address, status, PECOS certification)
- Each field shows "—" if empty

Actions:

- **Close** button (bottom right)
- **X** button (top right)
- Click outside modal to close

To Edit from Detail View:

1. Close detail view
2. Click the **Pencil icon** (Edit button) instead

Editing a Physician or Facility

How to Edit

1. Find the physician/facility in the table
2. Click the **Pencil icon** (Edit button) in the Actions column
3. Edit modal opens with all current data pre-filled
4. Modify fields as needed
5. Click "Save"

What Can Be Edited

All fields can be edited except:

- Type (Physician vs Facility) - cannot change type after creation
- ID (internal system field)

Editing Best Practices

Updating NPI:

- If you update NPI, verify it's correct (10 digits, valid)
- Use "Verify from CMS" to confirm

Changing Status to Inactive:

- Set Status = "INACTIVE" if the physician retires, leaves practice, or is no longer accepting referrals
- Inactive physicians remain in the system but are hidden from dropdown selectors

Updating Address:

- Update address if physician moves to new practice location
- Ensure state and ZIP code match

Deleting a Physician or Facility

How to Delete

1. Find the physician/facility in the table
2. Click the **Trash icon** (Delete button) in the Actions column
3. Confirmation dialog opens:
 - Title: "Confirm Delete"
 - Message: "Are you sure you want to delete [Physician Name]? This action cannot be undone."
 - Buttons: "Cancel" (gray), "Delete" (red)
4. Click "**Delete**" to confirm
5. Physician/facility is permanently removed

When to Delete

Safe to Delete:

- Duplicate entry (added by mistake)

- Test record from sandbox setup
- Never used in any patient records

NOT Recommended:

- Physician has been used as ordering physician on care orders
- Facility has been used as referral source on patient records
- Historical records need this data

Better Alternative:

Instead of deleting, set Status = "INACTIVE". This:

- Preserves historical data integrity
- Hides from dropdown selectors
- Allows you to reactivate later if needed

Common Scenarios

Scenario 1: Add Physician Who Referred a New Patient

Goal: Add Dr. Maria Rodriguez, who just called with a patient referral.

Solution:

1. Click "+ Add Referral Source"
2. Ensure "Physician" is selected (default)
3. Fill in:
 - First Name: Maria
 - Last Name: Rodriguez
 - Phone Number: (get from her office)
 - (Optional) Ask for NPI and verify from CMS
4. Click "Save"
5. Now available in Patient Admission → Ordering Physician dropdown

Scenario 2: Verify Physician Credentials Before Adding

Goal: Hospital gave you physician's NPI (1234567890). Verify credentials before adding.

Solution:

1. Click "Verify from CMS"
2. Tab: NPI
3. Enter: 1234567890
4. Click "Search"
5. Review results:
 - Name matches expected physician ✓
 - Primary Taxonomy matches specialty ✓
 - Address is correct ✓

6. Click **"Select"**
7. Review pre-filled data
8. Click **"Save"**

Scenario 3: Add Referral Source Facility (Hospital)

Goal: Add St. Mary's Hospital as a referral source.

Solution:

1. Click **" + Add Referral Source "**
2. Click **"Facility"** toggle button
3. Fill in:
 - Facility Name: St. Mary's Hospital
 - Facility Type: Hospital
 - Main Phone: (get from hospital)
 - Address: (hospital address)
 - Contact First Name: John
 - Contact Last Name: Smith
 - Contact Title: Discharge Planner
 - Contact Phone: (direct line)
 - Contact Email: john.smith@stmarys.org
4. Click **"Save"**
5. Now available in Patient Admission → Referral Source dropdown

Scenario 4: Physician Retired, Change to Inactive

Goal: Dr. John Green retired. Stop showing him in dropdowns but keep historical records intact.

Solution:

1. Search for "John Green" in Referral Sources
2. Click **Pencil icon** (Edit)
3. Change Status = "INACTIVE"
4. Click **"Save"**
5. Dr. Green:
 - No longer appears in Ordering Physician dropdowns for new patients
 - Remains visible in historical patient records (existing care orders)
 - Can still be viewed/edited in Referral Sources list (filter will show inactive)

Best Practices

1. Always Use CMS Verification for New Physicians

Why:

- Ensures NPI is valid and matches correct physician
- Auto-populates accurate data
- Saves time

How:

- For every new physician referral, search CMS first
- Only add manually if physician is not found in CMS (rare)

2. Mark Inactive Physicians Instead of Deleting

Why:

- Preserves historical data
- Allows reactivation if physician returns to practice
- Maintains compliance records

How:

- When physician retires/leaves: Edit → Status = "INACTIVE"
- Never delete unless it's a duplicate or test record

3. Add Contact Information for Facilities

Why:

- Facilitates communication with discharge planners, case managers
- Speeds up referral processing

How:

- When adding facility, always fill in:
 - Contact First Name / Last Name
 - Contact Title
 - Contact Phone / Email

4. Verify PECOS Certification for Medicare Patients

Why:

- Medicare requires ordering physician to be PECOS-certified
- Non-PECOS physicians cannot order Medicare home health

How:

- When adding physician who will order Medicare patients:
 - Check "PECOS Certified" checkbox
 - Verify via CMS or ask physician's office

5. Keep Address and Phone Current

Why:

- Fax orders, send reports, coordinate care

How:

- Update physician/facility address if they move
- Update phone/fax if office changes numbers
- Review and update quarterly

Troubleshooting

Issue: Physician Not Appearing in Dropdown

Symptom:

You added a physician, but they don't appear in the "Ordering Physician" dropdown when admitting a patient.

Possible Causes:

1. Status is set to "INACTIVE"
2. Search filter in dropdown is too restrictive
3. Cache issue

Solution:

- Go to Referral Sources → search for physician
- Verify Status = "ACTIVE"
- If inactive, edit and change to ACTIVE
- If active but still not appearing, refresh the page

Issue: CMS Search Returns No Results

Symptom:

Searching by NPI or name returns "No results from CMS."

Possible Causes:

1. NPI is incorrect (typo, wrong number)
2. Name is misspelled
3. Physician is not in CMS registry (rare for US physicians)

Solution:

- Double-check NPI or name spelling
- Try searching by Last Name only (remove First Name)
- Try different state if physician practiced in multiple states
- If still no results, add manually (physician may not be CMS-registered)

Issue: Cannot Delete Physician

Symptom:

Delete button doesn't work, or error message appears.

Possible Causes:

1. Physician is referenced in existing care orders
2. Permission issue (user lacks delete permission)

Solution:

- Instead of deleting, set Status = "INACTIVE"
- If you must delete (duplicate/test record), contact administrator

Issue: Validation Error When Saving**Symptom:**

"First name is required" or "NPI must be 10 digits" error appears.

Possible Causes:

1. Required field is empty
2. Field format is incorrect (e.g., NPI has letters)

Solution:

- Red error message appears below the problematic field
- Fill in or correct the field as indicated
- Retry saving

Permissions and Access Control**Required Permissions**

Action	Required Permission	Notes
View Referral Sources List	VIEW_REFERRAL_SOURCES or similar	Without this, menu is hidden
Add Physician/Facility	MANAGE_REFERRAL_SOURCES	Protected button
Edit Physician/Facility	MANAGE_REFERRAL_SOURCES	Protected button
Delete Physician/Facility	MANAGE_REFERRAL_SOURCES or DELETE_REFERRAL_SOURCES	Protected button
Verify from CMS	MANAGE_REFERRAL_SOURCES	Protected button

Role-Based Access Examples**Agency Administrator (Full Access)**

- **Permissions:** All referral source permissions

- **Can:** View, add, edit, delete, verify from CMS
- **Use Case:** Maintain referral source database

Admissions Coordinator (View + Add)

- **Permissions:** VIEW_REFERRAL_SOURCES, MANAGE_REFERRAL_SOURCES
- **Can:** View, add new physicians/facilities when admitting patients
- **Cannot:** Delete
- **Use Case:** Add physicians during patient intake

Clinician (View Only)

- **Permissions:** VIEW_REFERRAL_SOURCES
- **Can:** View physician/facility details
- **Cannot:** Add, edit, delete
- **Use Case:** Reference ordering physician info when completing OASIS or visit notes

Integration with Other Modules

Patient Admission (Chapter 14)

- **Link:** Ordering physician selected from Referral Sources list
- **Impact:** Must add physician to Referral Sources before assigning to patient

Care Orders (Chapter 15)

- **Link:** Care Order displays ordering physician and referral source
- **Impact:** Accurate physician info ensures proper care coordination

OASIS Assessments (Chapter 20)

- **Link:** OASIS forms include ordering physician (pre-filled from care order)
- **Impact:** Physician signature workflow depends on accurate physician contact info

Dashboard Widgets (Chapter 2)

- **Link:** "Pending Physician Signature" widget counts OASIS awaiting physician approval
- **Impact:** Physician contact info used to send signature requests

Chapter 29: Clinicians & Aides Management

Overview

The **Clinicians & Aides** module (also called "**Clinicians**") is where administrators view and manage the agency's clinical staff. This includes registered nurses (RNs), licensed practical nurses (LPNs), physical therapists (PTs), occupational therapists (OTs), speech therapists (SLPs), medical social workers (MSWs), and home health aides (HHAs).

Important Concept: In this system, "**clinician**" is **NOT** a role - it's a functional designation. Any user can be a clinician if they meet **at least one** of these criteria:

How the System Defines a Clinician

The Clinician Definition Logic

Based on the backend code (`findAllClinicians` in `user.service.ts`), the system identifies a user as a **clinician** if they meet **ANY** of these conditions:

Condition 1: User Has Visit-Related Permissions

A user whose role includes **ANY** of these permissions:

- `visit:create` - Can create visits
- `schedule:view-my` - Can view their own schedule
- `visit:edit` - Can edit visits
- `visit:assign` - Can assign visits

Example: An Agency Administrator who has `visit:create` permission can appear in the clinicians list and be assigned visits.

Condition 2: User Has a Discipline Set

A user who has a **discipline** field set in their user profile (in `UserBranchAccess`):

- RN (Registered Nurse)
- LPN/LVN (Licensed Practical Nurse)
- PT (Physical Therapist)
- PTA (Physical Therapist Assistant)
- OT (Occupational Therapist)
- COTA (Certified Occupational Therapy Assistant)
- SLP (Speech Language Pathologist)
- MSW (Medical Social Worker)
- HHA (Home Health Aide)

Example: A user with role "Clinician" and discipline "RN" will appear in the clinicians list.

Why This Matters

Key Insight: Agency Administrators or other non-clinical roles can function as clinicians if they have the right permissions. This flexibility allows:

1. **Small Agencies:** Admin can also work as a clinician
2. **Emergency Coverage:** Administrative staff with clinical licenses can pick up visits
3. **Training/Oversight:** Managers can complete visits for training or quality purposes
4. **Multi-Hat Roles:** A person can be both an administrator and a clinician

Example Scenario:

- Jane is an Agency Administrator
- Jane is also a licensed RN
- Jane's user account has:
 - Role: "Agency Administrator" (with `visit:create` permission)
 - Discipline: "RN"
- Result: Jane appears in both:
 - **User Management** (as an administrator)
 - **Clinicians & Aides** (as a clinician who can take visits)
 - Jane can schedule visits for herself in the Schedule Center
 - Jane sees "My Schedules" in her sidebar
 - Jane can complete visit forms and OASIS assessments

Accessing Clinicians & Aides

From Sidebar

The screenshot shows the 'Clinicians & Aides' management page. The left sidebar has a navigation menu with 'Clinicians' selected. The main content area features a table with the following data:

NAME	BRANCH	PHONE NUMBER	STATUS	ACTIONS
Isako Naja	North Austin Branch Therapist - PT	0932751336	Active	...
Isak alba	North Austin Branch Home Health Aide - HHA West Coast Division Clinical Manager - HHA Head Quarter Home Health Aide - HHA	343534535	Active	...
Selamawit Abdela	Head Quarter Rider	5078655767545676	Active	...
Hace ko	North Austin Branch Rider West Coast Division Agency Administrator Head Quarter Clinical Manager - PT	0932751339	Active	...
salami ml	Head Quarter Clinical Manager	765457897	Active	...
Abdi As	Head Quarter RN Case Manager - RN	N/A	Active	...
Abdullahi Yusuf	Head Quarter RN Case Manager - RN	6145419025	Active	...
MSW Test Clinician	Head Quarter RN Case Manager - MSW	555-MSW-0000	Active	...
HHA Test Clinician	Head Quarter RN Case Manager - HHA	555-HHA-0000	Active	...
SLP Test Clinician	Head Quarter RN Case Manager - SLP	555-SLP-0000	Active	...

Location: Left sidebar navigation

Menu Item: "Clinicians" (cyan/teal highlight when selected)

Icon: People/group icon

Click "Clinicians" to open the clinicians management page.

Clinicians List Page

NAME	BRANCH	PHONE NUMBER	STATUS	ACTIONS
sako raja	North Austin Branch Head Quarter Therapist - PT	0832751336	Active	...
test aba	North Austin Branch Home Health Admin - HHA West Coast Division Clinical Manager - SLP Head Quarter Home Health Admin - HHA	343534535	Active	...
Selamawit Abdela	Head Quarter Rider	5078655767545676	Active	...
Hace ko	North Austin Branch Rider West Coast Division Agency Administrator Head Quarter Clinical Manager - PT	0832751339	Active	...
selam m	Head Quarter Clinical Manager	765457397	Active	...
Abdi As	Head Quarter RN Case Manager - RN	N/A	Active	...
Abdullah Yusuf	Head Quarter RN Case Manager - RN	6145419025	Active	...
MSW Test Clinician	Head Quarter RN Case Manager - MSW	555-MSW-0000	Active	...
HHA Test Clinician	Head Quarter RN Case Manager - HHA	555-HHA-0000	Active	...
SLP Test Clinician	Head Quarter RN Case Manager - SLP	555-SLP-0000	Active	...

Page Header

Title: "Clinicians & Aides"

Create Button (Top Right):

- Blue button: "+ Create"
- Click to add a new clinician
- Opens User Management creation flow (Chapter 8)
- **Note:** This is the same as adding a user in User Management, but pre-filtered to require visit permissions or discipline

Search Bar:

- Placeholder: "Search by name..."
- Searches clinician names and emails
- Real-time filtering

Status Filter Dropdown:

- Label: "Status: All" (default)
- Dropdown arrow icon
- Options: "All", "Active", "Inactive"
- Filters clinicians by active/inactive status

Clinicians Table

The table displays all clinicians with the following columns:

Column 1: NAME

- **Clinician Full Name** (Blue clickable link)
- Examples: "kako haja", "test aba", "3esamawi Abdelai"
- Click name to open clinician detail view

Column 2: BRANCH

- Shows **all branches** the clinician has access to
- **Multiple branch chips** displayed:
 - Example: "North Austin Branch" + "Head Quarter" + "HHA"
 - Each branch is a separate chip (badge)
 - Branch role shown in smaller text below branch name
 - "Branch Manager - HHA" (role - discipline)
 - "RN Care Manager - RN" (role - discipline)
- **Branch Colors:**
 - Dark gray chips for branch assignments
 - Each chip shows: Branch Name on top, Role + Discipline below

Understanding Branch Chips:

- **First Chip:** "North Austin Branch" with "Branch Manager - HHA"
 - Clinician has access to North Austin Branch
 - Role at that branch: Branch Manager
 - Discipline: HHA
- **Second Chip:** "West Coast Division" with "RN Care Manager - RN"
 - Same clinician also has access to West Coast Division
 - Role at that branch: RN Care Manager
 - Discipline: RN
- **Third Chip:** "Head Quarter" with "RN Care Manager - RN"
 - Clinician also has access to Head Quarter branch
 - Role: RN Care Manager
 - Discipline: RN

Multi-Branch Example: User "test aba" has 3 branch chips showing they work across 3 branches with different roles at each.

Column 3: PHONE NUMBER

- Clinician's phone number
- Format varies: "09327513348", "34353443535", "56789557767545676"
- Shows "N/A" if no phone number

Column 4: STATUS

- **Green "Active"** badge - Clinician is active, can be assigned visits
- **Gray "Inactive"** badge - Clinician inactive, cannot be assigned visits (not shown in screenshot but exists)

Column 5: ACTIONS

- **Three-dot menu icon** (⋮) on right side
- Click to open actions dropdown
- Options likely include:
 - View Details
 - Edit
 - Deactivate/Activate
 - View Schedule
 - View Caseload

Pagination

Bottom of table shows:

- Page numbers: 1 (highlighted in blue), 2, Next arrow (>)
- Current page highlighted
- Click page number to navigate
- Click arrows to go to previous/next page

Clinician Detail View

The screenshot displays the 'Clinician Detail View' for a user named 'test aba'. The interface is dark-themed. On the left is a sidebar with navigation links: Dashboard, My Schedules, Schedule Center, Patients, Care Orders, QA Center, Clinicians (selected), Physicians / Sources, Pharmacy Setup, Prior Authorizations, Claims Center, Payment Posting, OASIS Submissions, and Reports. The top header shows the organization 'Coastal Wellness Home Health' and the user's role 'Head Office Primary'. The main content area shows the clinician's profile with a green 'Active' badge and an 'Edit' button. Below the profile are tabs for 'SCHEDULE & AVAILABILITY', 'CASELOAD', 'PROFILE', and 'ACTIVITY LOG'. The 'SCHEDULE & AVAILABILITY' tab is selected, showing a calendar for April 5-11, 2026. A scheduled visit is shown on Friday, April 10, labeled 'Scheduled' and 'Abu belis - HHA Visit'.

How to Open Detail View

1. Click **clinician name** (blue link) in the Clinicians table
2. Detail page opens

Detail Page Header

Back Arrow (Top Left):

- Breadcrumb: "< Clinicians / Test Aba"
- Click to return to Clinicians list

Clinician Name & Info (Top Section):

- **Name:** "test aba" (large text)
- **Discipline:** "Home Health Aide" (gray text)
- **Contact:** Phone number + Email
 - Example: "3435344535 | neuraldthrapr76+test@gmail.com"

Branches Section (Below Name):

- Label: "Branches"
- Shows all branch chips again (same as table)
 - "West Coast Division"
 - "North Austin Branch"
 - "Head Quarter"

Status Badge (Top Right):

- **Green "Active"** badge
- Indicates clinician is active

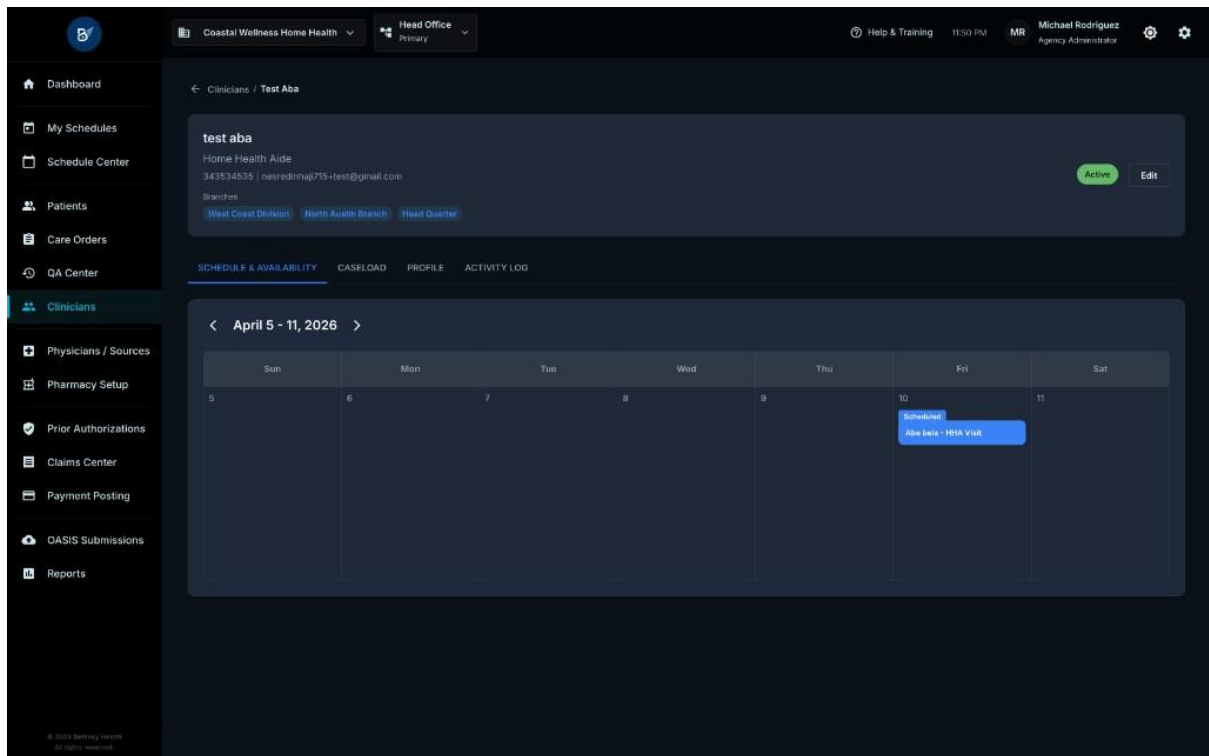
Edit Button (Top Right):

- Gray button: "Edit"
- Click to edit clinician profile (User Management edit flow)

Four Tabs

The clinician detail view has **4 tabs**:

Tab 1: SCHEDULE & AVAILABILITY



- Selected by default (blue underline)
- Shows clinician's schedule and availability calendar

Tab 2: CASELOAD

- Shows assigned patients and visit schedule

Tab 3: PROFILE

- Shows clinician's personal information, license details, contact info

Tab 4: ACTIVITY LOG

- Shows clinician's system activity (logins, visits completed, documents submitted)

Tab 1: Schedule & Availability

Calendar View

Month Navigation:

- **Left Arrow (<):** Previous week
- **Month/Year Display:** "April 5 - 11, 2026"
- **Right Arrow (>):** Next week

Week Grid:

- Columns: Sun, Mon, Tue, Wed, Thu, Fri, Sat
- Dates shown at top of each column
- Example: "5" (Sunday), "6" (Monday), "7" (Tuesday), etc.

Visit Cards on Calendar:

- **Blue card** (Friday, April 10):
 - Label: "Scheduled"
 - Patient: "Abe bela - HHA Visit"
 - Scheduled visit for this clinician

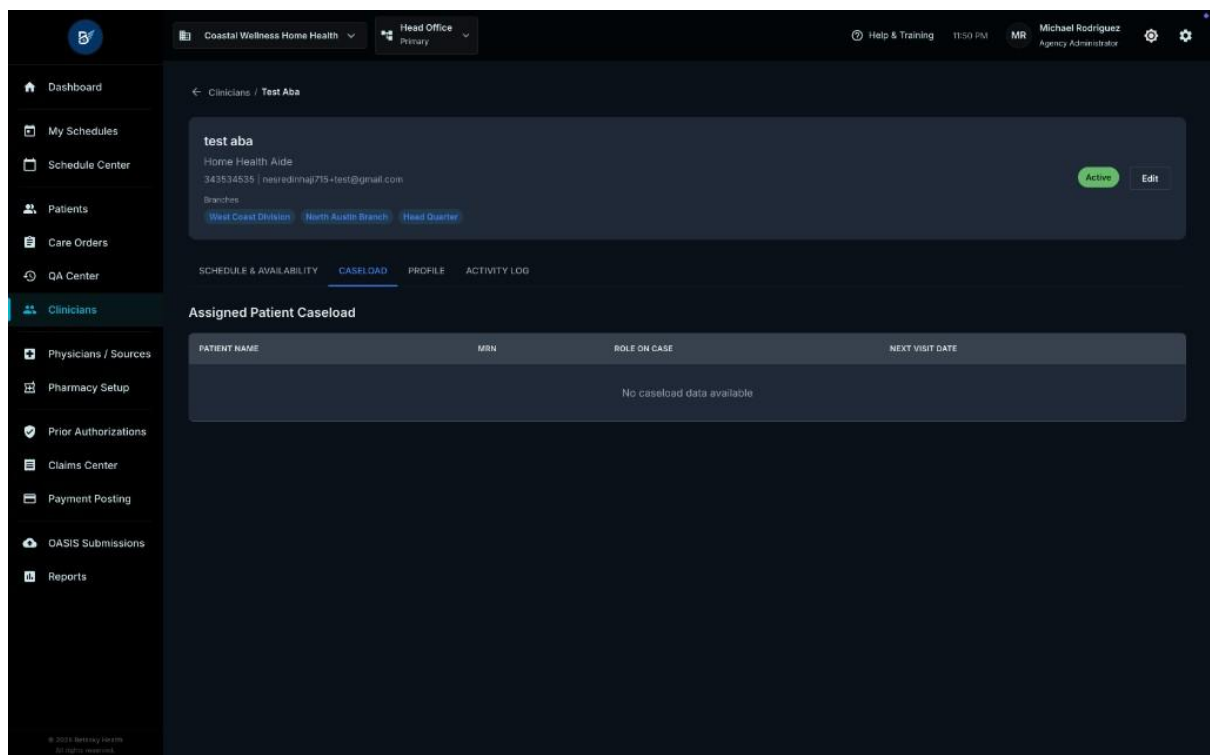
Purpose:

- View clinician's weekly schedule
- See what days/times they're booked
- Identify available slots for assigning new visits
- Check for scheduling conflicts

Use Case:

- Scheduler wants to assign a new visit to this clinician
- Opens Schedule & Availability tab
- Sees clinician is free Monday-Thursday and Saturday
- Friday has one visit already scheduled
- Scheduler assigns new visit to an open day

Tab 2: Caseload



Assigned Patient Caseload Section

Title: "Assigned Patient Caseload"

Table Columns:

Column	Description	Example

Column	Description	Example
PATIENT NAME	Full patient name	"Abe bela", "Matthew Harris"
MRN	Medical Record Number	"1025", "1043"
ROLE ON CASE	Clinician's role for this patient	"Primary Clinician", "Case Manager", "Supervising RN"
NEXT VISIT DATE	Date of next scheduled visit	"2026-04-12", "—" (none scheduled)

Example Rows (from screenshot):

Row 1: (Empty in screenshot)

- Shows "No caseload data available" if clinician has no assigned patients

Purpose

What is Caseload?

- **Caseload** = The list of patients assigned to this specific clinician
- Each clinician has a caseload of patients they're responsible for
- Used for:
 - Case management
 - Visit scheduling
 - Workload balancing
 - Quality tracking

Use Cases:

- **Review Clinician Workload:** See how many patients assigned to clinician
- **Identify Next Visit Dates:** Ensure all patients have upcoming visits scheduled
- **Case Management:** Track which patients this clinician manages
- **Workload Balancing:** If caseload is too high, reassign patients to other clinicians

Note: Caseload is different from "visits assigned":

- **Caseload** = Ongoing patient assignments (long-term)
- **Visits** = Individual visit appointments (can be assigned to different clinicians)

Tab 3: Profile

The screenshot displays a user interface for managing clinician profiles. The top navigation bar includes a logo, a dropdown menu for 'Coastal Wellness Home Health', a 'Head Office' dropdown, and a user profile for 'Michael Rodriguez'. The left sidebar contains a list of navigation options: Dashboard, My Schedules, Schedule Center, Patients, Care Orders, QA Center, Clinicians (selected), Physicians / Sources, Pharmacy Setup, Prior Authorizations, Claims Center, Payment Posting, OASIS Submissions, and Reports. The main content area shows the profile for 'test aba', a Home Health Aide. The profile is divided into three sections: Personal Information, Contact Information, and License Information. The Personal Information section includes fields for Full Name, Discipline, and Status. The Contact Information section includes fields for Email Address, Phone Number, and Branches. The License Information section includes fields for License Number, Expiration Date, and Days Until Expiration.

Personal Information Section

Title: "Personal Information"

Field	Description	Example
Full Name	Clinician's full legal name	"test aba"
Discipline	Primary clinical discipline	"HHA" (Home Health Aide)
Status	Active or Inactive	"Active" (dropdown)

Contact Information Section

Title: "Contact Information"

Field	Description	Example
Email Address	Primary email	" neuraldthrapr76+test@gmail.com "
Phone Number	Primary phone	"3435344535"

Branches (Below Phone):

- Shows branch chips again
- "West Coast Division", "North Austin Branch", "Head Quarter"

License Information Section

Title: "License Information"

Field	Description	Example
License Number	State license number	"hyuabv7t9u"
Expiration Date	License expiration date	"10/16/2026" (format: MM/DD/YYYY)
Days Until Expiration	Countdown to expiration	"1649 days"

Purpose:

- Track license expiration
- Ensure compliance (clinicians with expired licenses cannot work)
- Alert administrators when license is expiring soon

Days Until Expiration Color Coding (typical):

- **Green** or neutral: > 90 days until expiration
- **Yellow/Orange**: 30-90 days (renew soon)
- **Red**: < 30 days or expired (critical)

Tab 4: Activity Log

TIMESTAMP	ACTION	ENTITY	DESCRIPTION	IP ADDRESS
3/2/2026, 10:16:58 AM about 1 month ago	AGENCY SWITCH	Agency ID: 56a0355a...	Switched to agency: Coastal Wellness Home Health	N/A
3/2/2026, 3:31:23 PM about 1 month ago	LOGIN	N/A	User logged in	127.0.0.1
2/28/2026, 10:16:49 PM about 1 month ago	VIEW PATIENT	Patient ID: 24192092...	VIEW PATIENT - Patient Robert Williams	127.0.0.1
2/28/2026, 6:37:23 PM about 1 month ago	VIEW PATIENT	Patient ID: 24192092...	VIEW PATIENT - Patient Robert Williams	127.0.0.1
2/28/2026, 6:12:11 PM about 1 month ago	VIEW PATIENT	Patient ID: 24192092...	VIEW PATIENT - Patient Robert Williams	127.0.0.1
2/28/2026, 6:12:08 PM about 1 month ago	UPDATE VISIT	Visit ID: 44030e62...	OASIS demographics updated for soc.	127.0.0.1
2/28/2026, 6:11:42 PM about 1 month ago	VIEW PATIENT	Patient ID: 24192092...	VIEW PATIENT - Patient Robert Williams	127.0.0.1
2/28/2026, 6:11:40 PM about 1 month ago	VIEW CARE ORDER	CareOrder ID: 600a0eca...	VIEW CARE_ORDER - Care Order Patient: Robert Williams	127.0.0.1
2/28/2026, 4:50:22 PM		Patient		

Activity Log Table

Title: "Activity Log"

Purpose: Track all system actions performed by this clinician for audit, compliance, and performance monitoring.

Table Columns:

Column	Description	Example
TIMESTAMP	Date and time of action	"3/2/2026, 10:30:58 AM"
ACTION	Type of action performed	"AGENCY_SWITCH", "LOGIN", "VIEW PATIENT", "UPDATE_VISIT"
ENTITY	What was acted upon	"Agency", "Patient", "Visit", "CareOrder"
DESCRIPTION	Detailed description of action	"Switched to agency: Coastal Wellness Home Health", "User logged in", "VIEW_PATIENT - Patient Robert Williams"
IP ADDRESS	IP address of user	"127.0.0.1" (localhost), "192.168.1.100"

Example Rows (from screenshot):**Row 1:**

- **Timestamp:** 3/2/2026, 10:30:58 AM (about 1 month ago)
- **Action:** AGENCY_SWITCH (gray badge)
- **Entity:** Agency (ID: 7b6fb68c...)
- **Description:** "Switched to agency: Coastal Wellness Home Health"
- **IP:** N/A

Row 2:

- **Timestamp:** 3/2/2026, 3:31:23 PM (about 1 month ago)
- **Action:** LOGIN (gray badge)
- **Entity:** N/A
- **Description:** "User logged in"
- **IP:** 127.0.0.1

Row 3-7: Multiple "VIEW PATIENT" actions

- **Timestamp:** 2/28/2026, 10:16:49 PM to 8:11:40 PM (about 1 month ago)
- **Action:** VIEW PATIENT (gray badge)
- **Entity:** Patient (with patient ID)
- **Description:** "VIEW_PATIENT - Patient Robert Williams"
- **IP:** 127.0.0.1

Row 8:

- **Timestamp:** 2/28/2026, 8:11:42 PM
- **Action:** UPDATE_VISIT (gray badge)
- **Entity:** Visit (with visit ID)

- **Description:** "OASIS demographic updated for soc"
- **IP:** 127.0.0.1

Row 9:

- **Timestamp:** 2/28/2026, 8:11:40 PM
- **Action:** VIEW CARE ORDER (gray badge)
- **Entity:** CareOrder (with care order ID)
- **Description:** "VIEW_CARE_ORDER - Care Order Patient: Robert Williams"
- **IP:** 127.0.0.1

Action Badge Colors

Actions appear in gray badges in the screenshot. Typical action types include:

- **LOGIN** - User logged into system
- **LOGOUT** - User logged out
- **AGENCY_SWITCH** - Changed active agency
- **VIEW_PATIENT** - Opened patient chart
- **CREATE_VISIT** - Created new visit
- **UPDATE_VISIT** - Edited visit or clinical document
- **SUBMIT_DOCUMENT** - Submitted visit form or OASIS to QA
- **VIEW_CARE_ORDER** - Viewed care order

Use Cases for Activity Log

1. Compliance Audits:

- Verify clinician accessed patient chart before visit
- Confirm timely documentation (visit completed and documented same day)

2. Security Investigations:

- Track unusual login times or locations (IP addresses)
- Identify unauthorized access attempts

3. Performance Monitoring:

- Count how many visits clinician completed this month
- Track how many patients they viewed
- Measure documentation speed (time between visit and submission)

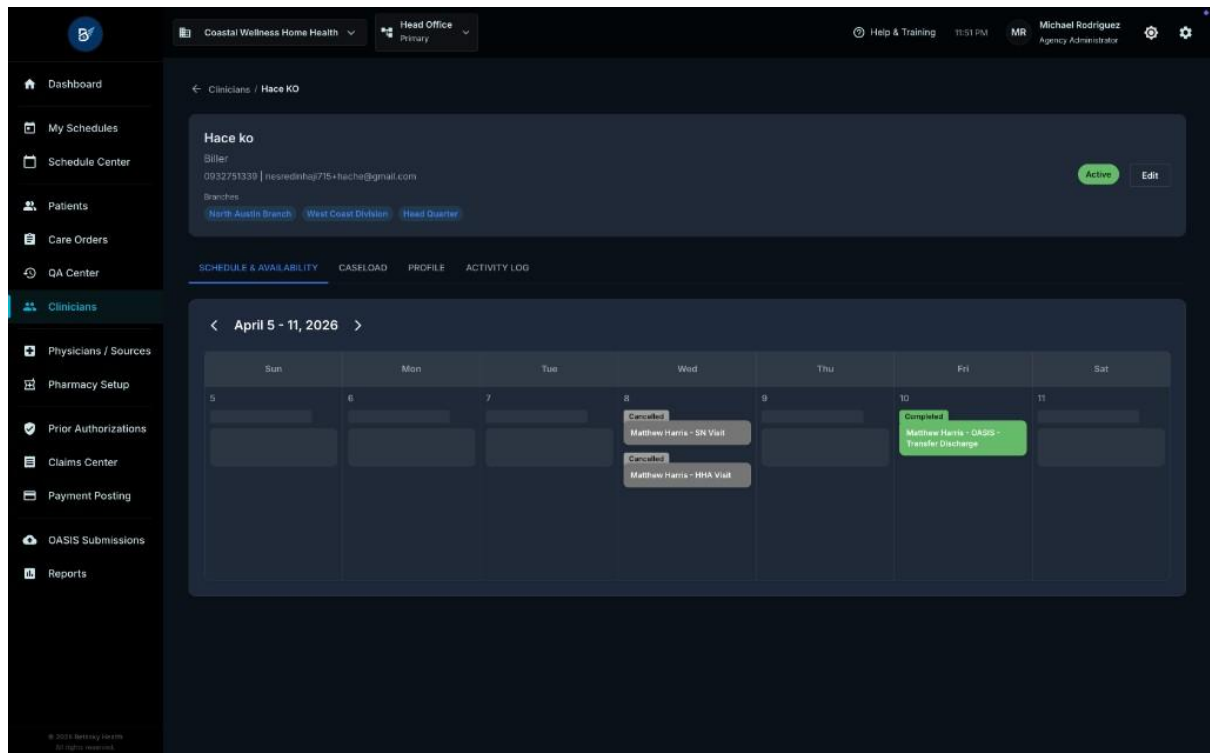
4. Troubleshooting:

- If clinician reports issue, review their activity log to see what actions they took
- Identify when problem occurred

5. Training & Quality:

- Review new clinician's activity to ensure they're using system correctly
- Check if clinician is documenting visits promptly

Tab 5: Schedule & Availability (Another View with Completed Visits)



Another Calendar Example

This screenshot shows the same "Schedule & Availability" tab but with different data.

Week Display: "April 5 - 11, 2026"

Visit Cards:

Wednesday, April 8:

- **Gray card (top):** "Cancelled" status
 - Patient: "Matthew Harris - SN Visit"
 - Visit was cancelled
- **Gray card (bottom):** "Cancelled" status
 - Patient: "Matthew Harris - HHA Visit"
 - Another cancelled visit

Friday, April 10:

- **Green card:** "Completed" status
 - Patient: "Matthew Harris - OASIS Transfer Discharge"
 - Visit completed successfully

Visit Status Color Coding

Status	Card Color	Meaning

Status	Card Color	Meaning
Scheduled	Blue	Visit scheduled, not yet started
In Progress	Orange/Yellow	Clinician started visit, not yet completed
Completed	Green	Visit completed and documented
Cancelled	Gray	Visit cancelled (reason documented)
Missed	Red (typically)	Visit missed (reason documented)

How Calendar Updates

Real-Time Sync:

- Calendar reflects visit statuses from Schedule Center
- When clinician completes visit → Changes from Blue (Scheduled) to Green (Completed)
- When admin cancels visit → Changes to Gray (Cancelled)
- When clinician reports missed visit → Changes to Red (Missed)

Purpose:

- **Visual Workload:** See clinician's week at a glance
- **Completed vs Pending:** Identify what's done vs what's upcoming
- **Cancellation Patterns:** If many visits are cancelled, investigate why (patient issues, clinician availability)

Creating a New Clinician

How to Add a Clinician

1. Click "+ Create" button (top right)
2. System redirects to **User Management** (Chapter 8)
3. **Add User Modal** opens
4. Fill in user details:
 - Email
 - Name
 - Phone
 - **IMPORTANT: Set Discipline** (RN, LPN, PT, HHA, etc.)
 - **IMPORTANT: Assign Role with Visit Permissions** or set discipline
5. Assign to branch(es)
6. Set permissions (must include visit-related permissions)
7. Click "Create User"

Result:

- New user appears in **User Management** (Chapter 8)

- New user also appears in **Clinicians & Aides** (this chapter) because they have discipline or visit permissions
- User can now be assigned visits in Schedule Center

Alternative: Convert Existing User to Clinician

If a user already exists but is NOT a clinician:

Option 1: Add Discipline

1. Go to User Management (Chapter 8)
2. Edit the user
3. Set their **Discipline** field (e.g., "RN", "PT")
4. Save
5. User now appears in Clinicians list

Option 2: Add Visit Permissions

1. Go to User Management (Chapter 8)
2. Edit the user's role
3. Add permissions: `visit:create`, `schedule:view-my`, `visit:edit`, or `visit:assign`
4. Save
5. User now appears in Clinicians list

Understanding Clinician Filtering

Backend Logic Recap

When the Clinicians list loads, the backend (`findAllClinicians`) queries for users where:

```
WHERE (
  UserBranchAccess.roleId IN (roles with visit permissions)
  OR
  UserBranchAccess.discipline IS NOT NULL
)
AND UserAgencyAccess.agencyId = [your agency]
AND UserAgencyAccess.status = 'ACTIVE'
```

Translation:

1. Find all users who have a role with visit permissions (`visit:create`, `schedule:view-my`, `visit:edit`, `visit:assign`)
2. OR find all users who have a discipline set (RN, LPN, PT, HHA, etc.)
3. AND they must have active access to your agency
4. AND their agency access must be ACTIVE status

Result: A user can appear in the Clinicians list without being a "Clinician" role. They just need visit permissions OR a discipline.

Branch-Specific Clinician Filtering

Multi-Branch Scenario

Example: Your agency has 3 branches:

- Head Quarter
- North Austin Branch
- West Coast Division

Clinician: Test Aba has access to all 3 branches:

- Head Quarter: Role = "RN Care Manager", Discipline = "RN"
- North Austin Branch: Role = "Branch Manager", Discipline = "HHA"
- West Coast Division: Role = "RN Care Manager", Discipline = "RN"

Filtering by Branch

In Schedule Center (Chapter 23):

- When scheduling visits, you can filter clinicians by branch
- If you select "North Austin Branch", only clinicians with access to that branch appear
- Test Aba would appear because they have North Austin Branch access

In Patient Intake (Chapter 14):

- When assigning a primary clinician to a patient, the dropdown filters by patient's branch
- If patient is at "Head Quarter", only clinicians with Head Quarter access show in dropdown

In Clinicians List:

- Shows ALL clinicians across all branches (no filter applied)
- To see clinicians for specific branch only, use the backend API with `branchId` parameter

Common Scenarios

Scenario 1: Administrator Also Works as Clinician

Situation: Jane is Agency Administrator and licensed RN. She needs to complete visits when short-staffed.

Setup:

1. Jane's user account has:
 - Role: "Agency Administrator"
 - Discipline: "RN" (set in User Management → Edit User → Discipline field)
 - Permissions: Includes `visit:create` (from Administrator role)
2. Jane appears in:
 - **User Management** (as administrator)
 - **Clinicians & Aides** (as RN clinician)
3. Jane can:
 - Perform all admin tasks

- Be assigned visits in Schedule Center
- Complete visit forms and OASIS assessments
- See "My Schedules" in her sidebar

Result: Jane wears two hats - administrator and clinician.

Scenario 2: Branch Manager Also Completes Visits

Situation: Mike is Branch Manager at North Austin Branch and licensed LPN. He helps with LPN visits when needed.

Setup:

1. Mike's user account:
 - Role: "Branch Manager" (has visit permissions)
 - Discipline: "LPN"
 - Branch: North Austin Branch

2. Mike appears in Clinicians list

3. Scheduler can assign LPN visits to Mike

Result: Mike manages the branch AND completes visits.

Scenario 3: QA Reviewer is NOT a Clinician

Situation: Sarah is QA Reviewer, not a licensed clinician. She reviews documents but doesn't complete visits.

Setup:

1. Sarah's user account:
 - Role: "QA Reviewer"
 - Discipline: (empty/null)
 - Permissions: qa:review, qa:approve, but NO visit permissions
2. Sarah does NOT appear in Clinicians list (no discipline, no visit permissions)
3. Sarah can review documents in QA Center but cannot be assigned visits

Result: Sarah is a user but NOT a clinician.

Scenario 4: Track Clinician Performance

Situation: Administrator wants to see how many visits a clinician completed this month.

Steps:

1. Go to **Clinicians & Aides**
2. Click clinician name (e.g., "Hace ko")
3. Open **Activity Log** tab
4. Filter actions by "UPDATE_VISIT" or "SUBMIT_DOCUMENT"
5. Count entries for current month
6. **(Future Feature):** Run performance report (Chapter 27 - Reports module)

Best Practices

1. Set Discipline for All Clinicians

Why:

- Discipline determines which visit types they can complete
- Schedule Center filters by discipline (RN for OASIS, PT for PT visits, etc.)
- Ensures proper skill mix and compliance

How:

- When creating clinician user, always set Discipline field
- If user can perform multiple disciplines, use their primary/highest license

2. Track License Expiration Dates

Why:

- Clinicians with expired licenses cannot legally provide care
- State surveys check license status
- Billing denials occur if clinician license expired during visit

How:

- Set License Number and Expiration Date in Profile tab
- Review Clinicians list monthly for upcoming expirations
- Set reminders 60 days before expiration
- Require clinicians to upload renewed license immediately

3. Review Caseload Regularly

Why:

- Prevents clinician burnout (too many patients)
- Ensures balanced workload across team
- Identifies clinicians with capacity for new admits

How:

- Weekly: Review each clinician's Caseload tab
- Count patients assigned to each clinician
- If caseload > 30 patients (or agency threshold), reassign some patients
- When new patient admitted, assign to clinician with lowest caseload

4. Use Activity Log for Compliance

Why:

- State surveys require documentation access audit trails
- Proves clinician viewed patient chart before visit
- Tracks timely documentation

How:

- If surveyor asks "How do you verify clinicians review patient chart before visits?":
 - Open clinician's Activity Log
 - Show "VIEW_PATIENT" action timestamp before visit
 - Show "UPDATE_VISIT" action timestamp after visit (same-day documentation)

Troubleshooting

Issue: User Not Appearing in Clinicians List

Symptom:

Created a new user, but they don't appear in Clinicians & Aides module.

Possible Causes:

1. User has no discipline set
2. User's role lacks visit permissions
3. User status is Inactive
4. User has no active agency access

Solution:

1. Go to **User Management** (Chapter 8)
2. Search for the user
3. Click **Edit**
4. **Check Discipline field** - Set to appropriate discipline (RN, PT, HHA, etc.)
5. **Check Role** - Ensure role includes `visit:create`, `schedule:view-my`, `visit:edit`, or `visit:assign` permissions
6. **Check Status** - Ensure status is "Active"
7. **Check Agency Access** - Ensure user has active access to your agency
8. Save changes
9. Refresh Clinicians list

Issue: Cannot Assign Visit to Clinician

Symptom:

Clinician appears in Clinicians list, but not in Schedule Center when trying to assign visit.

Possible Causes:

1. Clinician's discipline doesn't match visit type (trying to assign PT visit to RN)
2. Clinician doesn't have access to patient's branch
3. Clinician marked as Inactive
4. Time slot conflict (clinician already has visit at that time)

Solution:**1. Check Discipline Match:**

- Visit type = "PT Evaluation" requires clinician with discipline = "PT" or "PTA"

- Solution: Select clinician with correct discipline

2. Check Branch Access:

- Patient is at "North Austin Branch"
- Clinician must have access to "North Austin Branch"
- Solution: Go to User Management → Edit User → Add North Austin Branch access

3. Check Status: Clinician Profile tab → Ensure Status = "Active"

4. Check Time Conflict: Schedule & Availability tab → Verify no existing visit at that time

Issue: Activity Log Shows Suspicious Activity

Symptom:

Clinician's Activity Log shows logins from unfamiliar IP address or at unusual times (3:00 AM).

Possible Causes:

1. Account compromised (someone else using clinician's credentials)
2. Clinician working remotely from different location
3. Clinician documenting visits late at night

Solution:

1. Verify with Clinician:

- Call clinician: "Did you log in from IP 192.168.50.100 at 3:15 AM on March 2nd?"
- If NO → Account compromised, reset password immediately
- If YES → Document legitimate reason (working late, from home)

2. Reset Password: User Management → Edit User → Reset Password

3. Enable Two-Factor Authentication (if available)

4. Review Actions: Check what actions were performed during suspicious login

Permissions and Access Control

Required Permissions

Action	Required Permission	Notes
View Clinicians List	LIST_USERS	Same permission as User Management
View Clinician Detail	VIEW_USER	Can view individual clinician profile
Create Clinician	CREATE_USER + must set discipline or visit permissions	Redirects to User Management
Edit Clinician	EDIT_USER	Edit profile, license, discipline
Deactivate Clinician	EDIT_USER	Change status to Inactive

Action	Required Permission	Notes
View Activity Log	VIEW_USER or admin role	Audit trail access
View Caseload	VIEW_USER	See assigned patients
View Schedule	VIEW_USER or schedule:view-all	See clinician's calendar

Role-Based Access

Agency Administrator (Full Access)

- **Permissions:** All clinician management permissions
- **Can:** View all clinicians, edit profiles, view activity logs, manage caseloads
- **Cannot:** (None - full access)

Branch Manager (Branch-Specific)

- **Permissions:** LIST_USERS, VIEW_USER (limited to own branch)
- **Can:** View clinicians assigned to their branch, view schedules
- **Cannot:** View clinicians from other branches (unless multi-branch access granted)

Scheduler (Limited Access)

- **Permissions:** schedule:view-all, schedule:assign
- **Can:** View clinician schedules, assign visits
- **Cannot:** Edit clinician profiles, view activity logs

Clinician (Self Access Only)

- **Permissions:** None specific (can view own profile)
- **Can:** View their own schedule (My Schedules), edit own profile
- **Cannot:** View other clinicians' information

Integration with Other Modules

User Management (Chapter 8)

- **Link:** Creating clinicians redirects to User Management
- **Impact:** Any user with discipline or visit permissions automatically appears in Clinicians list

Schedule Center (Chapter 23)

- **Link:** Schedulers assign visits to clinicians from Clinicians list
- **Impact:** Clinician discipline determines which visit types they can be assigned

My Schedules (Chapter 9)

- **Link:** Clinicians see their personal schedule in My Schedules

- **Impact:** Calendar in Clinician Detail matches what clinician sees in My Schedules

Visit Forms (Chapter 19)

- **Link:** Clinicians complete visit forms assigned to them
- **Impact:** Completed visits appear as "Completed" in Clinician Schedule

QA Center (Chapter 21)

- **Link:** After clinician submits visit form, it goes to QA
- **Impact:** Activity Log shows "SUBMIT_DOCUMENT" action

Reports (Chapter 27)

- **Link:** Performance reports show visits per clinician, missed visits by clinician
- **Impact:** Caseload data used for workload reports

Chapter 30: Complete Patient Journey Workflow Overview

This chapter walks you through the **complete lifecycle of a patient** in the system, from the moment they're admitted to your agency until final payment is received. This end-to-end workflow demonstrates how all modules work together to deliver care and ensure proper reimbursement.

Purpose: Show the complete patient journey based on how the system ACTUALLY works, not assumptions.

The Patient Journey: Maria's Story

Let's follow **Maria Rodriguez**, a 72-year-old Medicare patient with diabetes and hypertension, through her entire home health episode.

Phase 1: Referral & Setup (Before Admission)

Step 1: Add Referring Physician (Physicians/Sources Management)

What Happens:

- Dr. Smith's office calls with a referral for Maria
- Administrator adds Dr. Smith to the system

In the System:

- Go to: **Physicians/Sources Management** (Chapter 28)
- Click: + **Add Physician**
- Can search CMS NPI registry and import his data automatically
- Or manually enter: Name, NPI, address, phone
- **Save**

Result: Dr. Smith is now in the system and can be selected as certifying physician.

Phase 2: Patient Admission (Day 1)

Step 2: Complete Patient Admission Form (Patient Intake)

What Happens:

- Admissions coordinator opens patient admission form
- Fills out ALL 9 tabs of information
- System automatically creates Care Order, Plan of Care, and OASIS SOC visit

In the System (Patient Intake - Chapter 14):

Click: **Patients** → + **Add Patient**

Tab 1: Demographics

- First Name: Maria
- Last Name: Rodriguez
- Date of Birth: 05/15/1952
- Gender: Female
- SSN: 123-45-6789
- Phone: (512) 555-1234
- Address: 123 Oak Street, Austin, TX 78701
- **Start of Care Date: 02/10/2026** ★ (CRITICAL - triggers auto-creation)
- **Assigned Clinician: Sarah Johnson, RN** ★ (CRITICAL - becomes case manager)

Tab 2: Payer Information

- Primary Payer: Medicare of Texas
- Medicare Number: 123456789A

Tab 3: Physician Information

- Ordering Physician: Dr. John Smith (from dropdown)

Tab 4: Clinical/Diagnosis

- Primary: E11.9 - Type 2 diabetes mellitus
- Secondary: I10 - Hypertension

Tab 5: Pharmacy

- Preferred Pharmacy: CVS Pharmacy

Tabs 6-8: Complete Emergency Contacts, Emergency Preparedness, Advanced Directives

Tab 9: Referral Information

- Referral Source: Memorial Hospital
- **Certifying Physician: Dr. John Smith** ★ (CRITICAL - triggers auto-creation)
- Referral Date: 02/08/2026

Click: Complete Admission

What the System Does AUTOMATICALLY (behind the scenes):

1. **Creates Patient record** (status: "PENDING")
2. **Creates IntakeData record** (stores all 9 tabs)
3. **BECAUSE** we provided startOfCareDate (02/10/2026) + certifyingPhysicianId (Dr. Smith) + caseManagerId (Sarah Johnson):
 - **Auto-creates Care Order**
 - Patient: Maria Rodriguez
 - Physician: Dr. John Smith
 - Case Manager: Sarah Johnson, RN
 - Start Date: 02/10/2026
 - End Date: 04/10/2026 (60 days)

- Reason: "New Admission"
- Status: "Pending Assessment"
- Auto-creates Plan of Care
 - Care Order: (linked to above)
 - Status: "DRAFT"
- Auto-creates OASIS SOC Compliance Task
 - Type: "OASIS_ASSESSMENT"
 - Due Date: 02/15/2026 (5 days from start)
 - Assigned To: Sarah Johnson, RN
 - Status: "PENDING"
- Auto-creates OASIS SOC Visit
 - Patient: Maria Rodriguez
 - Visit Type: OASIS Start of Care
 - Scheduled Date: 02/10/2026
 - Assigned To: Sarah Johnson, RN
 - Status: "Scheduled"
 - Linked to compliance task
- Updates Compliance Task
 - Status: "PENDING" → "SCHEDULED"
 - Links to visit

Result: Patient is admitted! Care Order, Plan of Care, and OASIS SOC visit are all created automatically. Sarah sees the OASIS visit in her schedule.

Phase 3: OASIS Start of Care Assessment (Days 1-3)

Step 3: Clinician Completes OASIS SOC (My Schedules)

What Happens:

- Sarah visits Maria at home on Day 3 (02/12/2026)
- Completes comprehensive OASIS assessment
- Documents medications, diagnoses, functional status, and Plan of Care frequencies

In the System:

Sarah's Workflow (My Schedules - Chapter 9):

1. Opens: **My Schedules** on her tablet
2. Sees: "Maria Rodriguez - OASIS Start of Care, 10:00 AM"
3. Clicks: **Start Visit** (checks in)
4. Fills out OASIS form (Chapter 20) - all sections:
 - Patient demographics and payer info
 - Diagnoses, medications, therapies

- Functional status (ADLs, mobility, etc.)
- **Plan of Care section (CRITICAL):**
 - SN (Skilled Nursing): 3x/week x 4 weeks, then 2x/week x 4 weeks
 - HHA (Home Health Aide): 3x/week x 8 weeks
- **Medication Profile:**
 - Metformin 500mg BID
 - Lisinopril 10mg daily
 - Aspirin 81mg daily

5. Before submitting, clicks: Check for Errors (QA Review button)

- System runs CMS validation
- Shows any CMS Fatal Errors (must fix)
- Shows CMS Warnings (advisory)
- Shows Clinical Plausibility Alerts (soft alerts)

6. Reviews results:

- Fixes any CMS Fatal Errors (blocks submission if present)
- Reviews soft alerts, fixes if needed (doesn't block submission)

7. Clicks: Submit to QA

Result: OASIS status → "Pending Review". QA team receives notification.

Phase 4: QA Review & Approval (Days 4-5)

Step 4: QA Reviews OASIS (QA Center)

What Happens:

- QA Reviewer checks OASIS for errors
- Runs CMS validation
- Approves if no fatal errors

In the System (QA Center - Chapter 21):

1. Go to: **QA Center**
2. See: Maria Rodriguez - OASIS SOC - Pending Review
3. Click: **Review**
4. Click: **Check for Errors** (runs CMS validation)
 - System checks for CMS Fatal Errors (block submission)
 - System checks for CMS Warnings (advisory)
 - System runs Clinical Plausibility Alerts (soft alerts)
5. Review results: 1 warning (acceptable - wound documented as healing)
6. Add note: "Wound healing well, RN monitoring"
7. Click: **Approve**

What the System Does:

- OASIS SOC status → "Pending Physician Signature" (because SOC requires signature)
- Plan of Care status → "PENDING_SIGNATURE"
- Care Order status → "Pending Physician Signature"
- **OASIS Submission created** (status: "READY_TO_SUBMIT")

Result: OASIS waiting for physician signature.

Phase 5: Physician Signature & Activation (Day 6)

Step 5: Physician Signs Plan of Care

What Happens:

- Dr. Smith receives email notification
- Reviews and signs Plan of Care electronically

In the System:

- Dr. Smith receives secure email link
- Logs in to physician portal
- Reviews Maria's OASIS Plan of Care
- Enters password
- Clicks: **Sign**

Result: Physician signature captured. Now administrator can mark as active.

Step 6: Administrator Marks OASIS as Active (Critical Step!)

What Happens:

- Administrator sees OASIS with physician signature
- Clicks "Mark as Active"
- **THIS IS WHERE THE MAGIC HAPPENS** - system creates PA, activates episode

In the System (QA Center):

1. Go to: **QA Center** → **Pending Physician Signature** tab
2. See: Maria Rodriguez - OASIS SOC - Signed by Dr. Smith
3. Click: **Mark as Active**
4. Confirm

What the System Does AUTOMATICALLY (the big activation moment):

1. **Creates Prior Authorization** (from OASIS frequencies):
 - Patient: Maria Rodriguez
 - Payer: Medicare of Texas
 - Care Order: (linked)
 - Source Document: OASIS SOC
 - Start Date: 02/10/2026
 - End Date: 04/10/2026

- **Lines:**
 - SN: 20 requested units ($3 \times 4 + 2 \times 4 = 20$ visits)
 - HHA: 24 requested units ($3 \times 8 = 24$ visits)
 - **Status: "pending"**
 - 2. **IF Medicare** (Maria is Medicare):
 - **Auto-approves PA:**
 - Status: "pending" → **"approved"**
 - Approved units = Requested units (SN: 20, HHA: 24)
 - **Calculates HIPPS code** (Medicare billing code):
 - Uses OASIS answers to calculate HIPPS
 - Stores on Care Order: 1CBFD (example)
 - 3. **Updates statuses:**
 - OASIS document status → **"Approved"**
 - Care Order status → **"Active"** ★
 - Plan of Care status → **"ACTIVE"** ★
 - Patient status → **"ACTIVE"** ★
 - 4. **Creates Medication Snapshot** (frozen copy of meds at this moment)
 - 5. **Completes compliance task** (OASIS_ASSESSMENT → "COMPLETE")
- Result:** Episode is NOW officially open and billable! PA is approved. Maria is active patient.
- IMPORTANT:** Visits are NOT auto-generated at this stage. They must be created manually (next step).

Phase 6: Generate Visits from PA (Day 6)

Step 7: Generate Visits from Approved PA (Prior Authorizations)

CRITICAL UNDERSTANDING: This is where the workflow differs significantly based on payer type. Understanding this section is key to knowing why visits appear or don't appear in your schedule.

What Happens:

- **FOR MEDICARE:** PA is auto-approved when marked active → can generate visits immediately
- **FOR PRIVATE INSURANCE:** PA created with status "pending" → administrator must manually call insurance, get approval, update PA in system, THEN generate visits
- **FOR PATIENTS WITHOUT INSURANCE:** Warning shown, PA created with NULL payer → visits created as non-billable (cannot bill for them)

Why This Matters:

- Medicare trusts agencies to bill correctly, so they approve automatically
- Private insurance requires pre-approval before authorizing visits
- Patients without insurance can still receive care, but agency cannot bill for services

SCENARIO A: MEDICARE PATIENT (like Maria)

Context: Medicare operates on a trust-based system. When you mark an OASIS SOC as active, Medicare automatically approves all requested units because they trust your clinical judgment. You'll bill them later using HIPPS codes based on the patient's clinical grouping.

What System Does When Marked Active (Phase 5, Step 6):

- Creates PA from OASIS Plan of Care frequencies
- **Auto-approves immediately** (no insurance call needed):
 - Status: "pending" → "**approved**"
 - Authorization number: Auto-generated (system-generated ID)
 - Approved units = Requested units (exactly what you asked for)
 - SN: Requested 20 → Approved 20 ✓
 - HHA: Requested 24 → Approved 24 ✓
- Calculates HIPPS code for billing (e.g., 1CBFD)
- Care Order → "Active"
- Patient → "ACTIVE"

Administrator Generates Visits (same day, immediately):

In the System (Prior Authorizations - Chapter 24):

1. Go to: **Prior Authorizations**
2. Click: Maria Rodriguez's PA
3. See **Status: "approved"** ✓ (auto-approved by system for Medicare)
4. See **Authorization Number:** PA-2026-00123 (auto-generated)
5. See **Service Lines** table with ALL units approved:
6. Click: **Generate 20 Missing Visits** (for SN)
 - System creates 20 SN visits
 - All unassigned (no clinician yet)
 - Spread evenly across 60 days (certification period)
 - All marked as billable
7. Click: **Generate 24 Missing Visits** (for HHA)
 - System creates 24 HHA visits
 - All unassigned
 - Spread evenly across 60 days
 - All marked as billable

Result: 44 total visits created (20 SN + 24 HHA). All visits appear in Schedule Center's "Needs Scheduling" sidebar, ready to be assigned to clinicians.

Key Point: For Medicare, this is a **same-day process**. No waiting for insurance approval. Mark as active → immediately generate visits → schedule them.

SCENARIO B: PRIVATE INSURANCE PATIENT (Blue Cross Blue Shield)

Context: Private insurance companies want to control costs, so they require pre-authorization before allowing visits. This is a multi-day process involving phone calls, faxes, and back-and-forth with insurance. The insurance company may approve fewer visits than you requested to save money.

If Maria had Blue Cross Blue Shield (private insurance) instead of Medicare:

What System Does When Marked Active (Phase 5, Step 6):

- Creates PA from OASIS Plan of Care frequencies
- **Does NOT auto-approve** (private insurance must approve manually)
- Status: **"pending"** ⚠ (waiting for insurance review)
- Approved units: **0** for all lines (insurance hasn't approved anything yet)
- Care Order → "Active" (patient can receive care)
- Patient → "ACTIVE" (episode is open)

Administrator Checks PA (Day 6 - immediately after marking active):

In the System (Prior Authorizations - Chapter 24):

1. Go to: **Prior Authorizations**
2. Click: Maria Rodriguez's PA
3. See **Status: "pending"** ⚠ (waiting for insurance approval - this is NORMAL for private insurance)
4. See **Authorization Number:** (blank - insurance hasn't provided one yet)
5. See **Service Lines** table with NO approved units:
6. **Cannot generate visits yet** - "Generate Missing Visits" buttons are disabled or will create 0 visits (no approved units to generate from)

Administrator's Real-World Process (Days 6-10 - this takes time!):

Day 6 - Submit to Insurance:

1. Administrator calls Blue Cross Blue Shield prior authorization department
2. Provides patient info, diagnosis, OASIS assessment findings
3. Reads Plan of Care frequencies:
 - "We're requesting 20 skilled nursing visits over 60 days"
 - "We're requesting 24 home health aide visits over 60 days"
4. Insurance says: "We'll review and call back in 3-5 business days"

Day 7-9 - Waiting:

- Insurance company reviews medical necessity
- May call doctor's office for records
- May request additional clinical documentation

- Administrator checks daily for update

Day 10 - Insurance Approves (with reductions):

- Insurance calls back with decision
- **Authorization Number:** AUTH-BCBS-123456
- **SN: Approved 15 visits ✕** (Denied 5 visits - insurance says "15 is medically necessary, 20 is excessive")
- **HHA: Approved 20 visits ✕** (Denied 4 visits - insurance says "20 is sufficient")

Administrator Updates PA with Insurance Approval (Day 10):

In the System (still on PA detail page):

7. Click: **Edit PA** (pencil icon at top right)
8. **Edit Prior Authorization Modal** opens:

Main Section:

- **Status:** "pending" → **"approved"** ✓ (MUST change this)
- **Authorization Number:** AUTH-BCBS-123456 (REQUIRED - system won't let you save "approved" status without this)

Service Lines Section (table with each discipline):

Discipline	Requested	Approved Units (Edit)	Reason
SN	20	15 (enter what insurance approved)	Insurance approved 15, denied 5
HHA	24	20 (enter what insurance approved)	Insurance approved 20, denied 4

9. Click: **Save**

What System Does Automatically (behind the scenes):

- Updates PA status to "approved"
- Saves authorization number
- Updates approved units for each discipline line
- **Auto-links any existing unlinked visits** (if any visits were already created before approval, system now links them to this PA)
- **Recalculates authorization alerts** (checks if existing visits are within limits)
- Triggers notification that PA is approved

Administrator Generates Visits (Day 10 - now that PA is approved):

In the System (refresh or navigate back to PA):

10. Refresh page or click back to PA detail
11. See **Status: "approved"** ✓ (changed from "pending")
12. See **Authorization Number:** AUTH-BCBS-123456 (saved)
13. See updated **Service Lines** table with insurance-approved units:

Discipline	Requested	Approved	Used	Remaining
SN	20	**15**	0	15
HHA	24	**20**	0	20

14. Click: **Generate 15 Missing Visits** (for SN - notice it's 15, not 20!)

- System creates only 15 SN visits (what insurance approved)
- All unassigned
- Spread across 60 days
- All marked as billable

15. Click: **Generate 20 Missing Visits** (for HHA - notice it's 20, not 24!)

- System creates only 20 HHA visits (what insurance approved)
- All unassigned
- Spread across 60 days
- All marked as billable

Result: 35 visits created (15 SN + 20 HHA) - **based on what insurance approved, not what was requested.**

Key Differences vs Medicare:

1. **Time:** Medicare = same day, Private = 3-10 days waiting
2. **Approved Amount:** Medicare = 100% approved, Private = often reduced (in this case, only 79% approved: 35/44 visits)
3. **Manual Work:** Medicare = automatic, Private = requires phone calls, documentation, updates
4. **Risk:** With Medicare you get what you ask for; with private insurance you might need to re-request if patient needs more visits later

What If Insurance Denied Completely?

- Administrator would update status to "denied" instead of "approved"
- Add denial reason (e.g., "Insurance says home health not medically necessary")
- Cannot generate any visits
- Would need to appeal or patient pays out-of-pocket

SCENARIO C: PATIENT WITHOUT INSURANCE (Self-Pay)

Context: Some patients don't have insurance (uninsured, waiting for Medicare eligibility, dropped coverage, etc.). Your agency can still provide care for compassionate or business reasons, but you cannot bill anyone for these visits. These visits are tracked but marked as non-billable.

If Maria had NO primary insurance (no Medicare, no private insurance):

What System Does When Marked Active (Phase 5, Step 6):

BEFORE marking active, system shows **WARNING:**

Patient Has No Primary Insurance
This patient has no primary insurance assigned. If you continue: • Prior Authorization will be created with no payer • All visits will be marked as non-billable • Visits will NOT appear in Claims Center • No Medicare/Medicaid billing possible • Agency will not be reimbursed for services You can update patient insurance later and do a Recertification to create a new billable episode. [Cancel] [Continue Anyway] ← Requires confirmation

- Administrator reads warning
- Understands agency won't be paid for these visits
- Clicks: **Continue Anyway** (maybe patient will get insurance later, or agency provides charity care)

System Proceeds (after confirmation):

- Creates PA from OASIS frequencies
- **Creates with NULL payerId** (no payer attached to this PA)
- Status: "pending" (will stay pending - cannot be approved without payer)
- Approved units: 0 (no insurance to approve)
- **All future visits from this PA will be flagged as isBillable: false**
- Care Order → "Active"
- Patient → "ACTIVE"

Administrator Generates Visits (Day 6):

In the System (Prior Authorizations - Chapter 24):

1. Go to: **Prior Authorizations**
2. Click: Maria Rodriguez's PA
3. See **Status: "pending"** (will stay pending forever without insurance)
4. See **Payer: (None)** - no payer assigned to this authorization
5. See **Authorization Number:** (blank - no insurance to provide one)
6. See **Service Lines** table:
7. **Special Case:** System allows generating visits even though PA is not approved (normally blocked, but exception for NULL payer):
 - Click: **Generate 20 Missing Visits** (SN)
 - Click: **Generate 24 Missing Visits** (HHA)
8. **All 44 visits created BUT marked as NON-BILLABLE:**
 - SN: 20 visits created, **isBillable: false**
 - HHA: 24 visits created, **isBillable: false**

- Visits appear in Schedule Center (can be scheduled normally)
- Clinicians can complete visits normally
- QA can approve visits normally
- **BUT:** These visits will NEVER appear in Claims Center
- **AND:** These visits CANNOT be added to any claim

Result: 44 visits created but all non-billable. Maria can receive full care, but agency will not receive any reimbursement. Clinicians won't see any difference (visits look normal to them), but billing team will never see these visits.

What Clinicians See (no difference for them):

- Visits appear in their schedule normally
- They complete visits normally
- They submit to QA normally
- **They don't know these are non-billable** (that's a billing department concern)

What Billing Department Sees:

- These visits do NOT appear in "Ready for Billing" list
- Cannot add to claims
- Cannot bill for them
- Shows \$0.00 revenue potential

If Insurance Is Added Later (e.g., Day 30, Maria gets Medicare):

1. Administrator updates patient's primary payer to Medicare
2. **Must complete new OASIS Recertification** to create new billable episode
3. Old episode (Days 1-30) remains non-billable forever (cannot retroactively bill)
4. New episode (Days 31-90) will be billable with new PA
5. Agency loses revenue for first 30 days but can bill for remaining days

When Would You Do This?

- Patient promises insurance is "in process"
- Compassionate care for terminally ill patient
- Charity care program
- Patient will pay out-of-pocket (tracks visits but doesn't bill insurance)
- Emergency situation, can't wait for insurance

Result: 44 visits created but all non-billable. Patient can receive care but agency cannot bill for it.

If Insurance Added Later:

- Administrator can update patient's primary payer
- Must complete OASIS Recertification to create new billable episode
- Old episode remains non-billable

Phase 7: Schedule Visits (Days 6-60)

Step 8: Scheduler Assigns Visits (Schedule Center)

What Happens:

- Scheduler opens Schedule Center
- Drags unassigned visits from sidebar to calendar
- Assigns to clinicians

In the System (Schedule Center - Chapter 23):

1. Go to: **Schedule Center**
2. See left sidebar: "Needs Scheduling"
 - Maria Rodriguez - 20 SN visits (unassigned)
 - Maria Rodriguez - 24 HHA visits (unassigned)
3. Drag visits from sidebar to calendar:
 - **Week 1-4 (SN 3x/week):**
 - Monday 10:00 AM → Sarah Johnson, RN
 - Wednesday 10:00 AM → Sarah Johnson, RN
 - Friday 10:00 AM → Sarah Johnson, RN
 - **Week 1-8 (HHA 3x/week):**
 - Monday 2:00 PM → Linda Martinez, HHA
 - Wednesday 2:00 PM → Linda Martinez, HHA
 - Friday 2:00 PM → Linda Martinez, HHA

Result: All visits scheduled and assigned. Sarah and Linda see visits in their schedules.

Phase 8: Clinicians Complete Visits (Days 7-60)

Step 9: Clinicians Document Visits (Visit Forms)

What Happens:

- Each week, Sarah and Linda visit Maria
- Document each visit
- Submit to QA

Example: Sarah's SN Visit (Week 1, Monday):

In My Schedules (Chapter 9):

1. Sarah opens: **My Schedules**
2. Clicks: **Start Visit** on Maria's card
3. Performs nursing assessment:
 - Takes vitals: BP 138/82, Glucose 145, Pulse 78
 - Educates on diabetes management
 - Reviews medications
4. Opens: **SN Visit Note** form (Chapter 19)

5. Documents:

- Vital signs
- Assessment: "Patient ambulating well, no SOB"
- Skilled interventions: "Diabetes education, insulin training"
- Plan: "Continue 3x/week per POC"

6. Clicks: **Submit to QA**

Example: Linda's HHA Visit (Week 1, Monday afternoon):

1. Linda opens: **My Schedules**

2. Clicks: **Start Visit**

3. Assists Maria with:

- Bathing and grooming
- Meal preparation
- Light housekeeping
- Medication reminders

4. Opens: **HHA Visit Note** (Chapter 19)

- System loads HHA Care Plan tasks automatically
- Linda checks off completed tasks

5. Documents narrative

6. Clicks: **Submit to QA**

Result: Visit notes submitted to QA.

Step 10: QA Approves Visit Notes (QA Center)

What Happens:

- QA reviews each visit note
- Approves for billing

In the System (QA Center - Chapter 21):

1. Go to: **QA Center**

2. Review Sarah's SN Visit and Linda's HHA Visit

3. No errors found

4. Click: **Approve Both**

Result: Visits status → "Approved" (now billable). This continues for 8 weeks.

Phase 9: Billing - Period 1 Claims (After Day 30)

Step 11: Generate Claim for Period 1 (Claims Center)

What Happens:

- After Day 30, administrator generates claim for Days 1-30
- Medicare PDGM: 30-day billing periods

In the System (Claims Center - Chapter 25):

1. Go to: **Claims Center** → **Ready for Billing** tab
2. See: Maria Rodriguez - Medicare - 12 visits (Days 1-30)
 - Estimated: \$3,200 (Medicare HIPPS flat rate)
3. Click: **Bill Patient**
4. **Bill Patient Modal** opens:
 - Patient: Maria Rodriguez
 - Payer: Medicare of Texas
 - Billing Period: Days 1-30
 - **HIPPS Code**: 1CBFD (from Care Order)
 - **HIPPS Rate**: \$3,200.00
 - Visits: 12 visits listed (8 SN + 4 HHA)
 - Authorization: No alerts (Medicare doesn't need PA approval)

5. Click: **Generate Claim**

Result: Claim created!

- Claim Number: CLM-20260315-001
- Total: \$3,200.00
- Status: "Ready to Submit"
- All 12 visits now "locked" to this claim (can't be billed again)

Step 12: Submit Claim to Medicare (Claims Center)

What Happens:

- Administrator exports claim as 837 EDI file
- Submits to Medicare clearinghouse
- Marks as submitted in system

In the System:

1. Go to: **Claims Center** → **Claims Tracking** → **Ready to Submit**
2. Click: Maria's claim
3. Click: **Export** → **837P EDI**
 - Downloads electronic file
4. Submit file to Medicare clearinghouse (external system)
5. Return to system
6. Click: **Mark as Submitted**

Result: Claim status → "Submitted". Now wait 30-45 days for payment.

Phase 10: Payment Posting (45 days later)

Step 13: Receive Payment & Post to System (Payment Posting)

What Happens:

- Medicare sends EFT for \$3,200
- Administrator posts payment to system

In the System (Payment Posting - Chapter 26):

Create Batch:

1. Go to: **Payment Posting**
2. Click: **+ Create Batch**
3. Fill:
 - Payer: Medicare of Texas
 - Payment Date: 04/25/2026
 - Method: EFT
 - Check Number: EFT123456
 - Total Amount: \$3,200.00

4. Click: **Create**

Add Claim:

5. Click: **Select Claims**
6. Filter: Medicare, Status = "Submitted"
7. Check: Maria Rodriguez - CLM-20260315-001 - \$3,200.00
8. Click: **Add Selected Claims**

Review Batch:

9. See **Balance Counter** (top right):

- Total to Apply: \$3,200.00
- Applied: \$3,200.00
- Remaining: **\$0.00** ✓ (Balanced!)

10. Review claim in table:

- Payment: \$3,200.00
- Adjustment: \$0.00
- Action: Pay

Post Batch:

11. Click: **Post Batch**
12. Confirm: "Are you sure? Cannot be undone."
13. Click: **Confirm Post**

What the System Does:

- Batch status: "Draft" → **"Posted"** (immutable)
- Claim status: "Submitted" → **"Paid"**
- Claim balance: 3,200→0
- Payment record created
- Batch locked permanently

Result: Period 1 claim PAID! Revenue received.

Phase 11: Continue Care (Days 31-60)

Same process repeats:

- Generate Period 2 claim (Days 31-60)
- Submit to Medicare
- Receive payment (\$2,900 typical for Period 2)
- Post payment

Total for First 60 Days: 6,100(3,200 + \$2,900)

Phase 12: Recertification (Days 55-60)

Step 14: Complete OASIS Recertification

What Happens:

- System auto-creates compliance task: "OASIS Recertification due"
- Sarah completes recert assessment
- Updates Plan of Care with new frequencies for next 60 days

Process (same as SOC):

1. Scheduler assigns recert visit to Sarah (from compliance task)
2. Sarah completes OASIS Recertification
3. QA approves
4. Dr. Smith signs
5. Admin marks as active
6. System creates NEW Care Order (Days 61-120)
7. System creates NEW PA with new frequencies
8. Auto-approves if Medicare
9. Generate visits from PA
10. Schedule visits

Result: Episode extended for another 60 days. Old Care Order expires automatically when Day 60 ends.

Phase 13: Discharge (Day 120)

Step 15: Complete OASIS Discharge

What Happens:

- Maria has improved and is ready for discharge
- Sarah completes OASIS Discharge assessment

In the System:

1. Sarah completes OASIS Discharge form
 - Documents Maria's final status

- Discharge disposition: "Discharged to community"

2. QA approves (no physician signature needed for discharge)

What the System Does AUTOMATICALLY:

- Care Order status → "**Closed**"
- Patient status → "**Discharged**"
- All future scheduled visits automatically **cancelled**
- Prior Authorizations automatically **closed**
- Episode officially ended

Result: Maria's episode complete! She's discharged.

Complete Revenue Summary

Maria's full 120-day episode generated:

Period	Days	HIPPS Rate	Revenue
1st Cert - Period 1	1-30	\$3,200	\$3,200
1st Cert - Period 2	31-60	\$2,900	\$2,900
2nd Cert - Period 1	61-90	\$3,000	\$3,000
2nd Cert - Period 2	91-120	\$2,700	\$2,700
TOTAL			\$11,800

All claims submitted and paid. Episode complete.

Journey Complete!

Maria successfully completed her home health episode:

- ✓ **Admitted** with auto-created Care Order and OASIS visit
- ✓ **OASIS SOC** completed, approved, and marked active
- ✓ **PA auto-created and auto-approved** (Medicare)
- ✓ **Visits generated** from PA and scheduled
- ✓ **92 visits completed** (44 SN + 48 HHA) over 120 days
- ✓ **Recertified** for second 60-day period
- ✓ **4 claims generated and paid** (\$11,800 total)
- ✓ **Discharged** successfully, all future visits cancelled

Summary: The ACTUAL System Workflow

Here's what ACTUALLY happens (not assumptions):

Patient Admission (Chapter 14)

- Fill out 9-tab admission form
- **IF** form has startOfCareDate + certifyingPhysician + caseManager:

- Care Order auto-created (status: "Pending Assessment")
- Plan of Care auto-created (status: "DRAFT")
- OASIS SOC compliance task auto-created (status: "PENDING")
- OASIS SOC visit auto-created (status: "Scheduled")
- Task updated to "SCHEDULED" (linked to visit)

OASIS SOC Completion (Chapters 9, 19, 20)

- Clinician completes OASIS form
- Submits to QA

QA Approval (Chapter 21)

- QA reviews, runs validation
- Approves → status: "Pending Physician Signature"
- OASIS Submission created (status: "READY_TO_SUBMIT")

Physician Signature & Mark as Active (Chapter 21)

- Physician signs electronically
- Admin clicks "Mark as Active"
- **THIS IS THE BIG MOMENT:**
 - PA created from OASIS frequencies
 - IF Medicare: PA auto-approved, HIPPS calculated
 - Care Order → "Active"
 - Patient → "ACTIVE"
 - Medication snapshot created
 - Visits NOT auto-generated (must be manual)

Visit Generation (Chapter 24)

- Go to PA detail page
- Click "Generate X Missing Visits" for each discipline
- Visits created as "unassigned"

Visit Scheduling (Chapter 23)

- Drag unassigned visits from sidebar to calendar
- Assign to clinicians

Visit Documentation (Chapters 9, 19)

- Clinicians complete visits
- Submit to QA
- QA approves → visits billable

Claims Generation (Chapter 25)

- After 30 days, go to Claims Center
- Click "Bill Patient"
- System creates claim with HIPPS rate (Medicare) or fee schedule (private)
- Export 837 EDI or CMS-1500 PDF
- Submit to payer
- Mark as submitted

Payment Posting (Chapter 26)

- Receive payment (check/EFT)
- Create remittance batch
- Add claims to batch
- Balance counter shows \$0 remaining
- Post batch → claims marked "Paid"

Recertification (Chapter 20)

- System auto-creates compliance task
- Complete OASIS Recert
- QA approves, physician signs, mark as active
- System creates NEW Care Order for next 60 days
- Repeat visit generation/scheduling/billing

Discharge (Chapter 20)

- Complete OASIS Discharge
- QA approves
- System closes Care Order, patient status, cancels future visits