SHARECARE RELEASE NOTES

Version 8.15.0

INTRODUCTION

ShareCare version 8.15.0 contains bug fixes and enhancements.

SAAS CUSTOMERS

Echo support will contact you to determine the best time to install this version.

SELF-HOSTED CUSTOMERS

Do not install this version until 8.14.2 has been installed.

IT IS HIGHLY RECOMMENDED THAT YOU PERFORM AND VERIFY A FULL DATABASE BACKUP PRIOR TO INSTALLING ANY UPGRADES, ENSURING THAT YOUR DATABASE CAN BE RESTORED IF NEEDED.

Please note that users will be unable to access ShareCare while the version is being installed. If you have any questions about this process or about items requiring administration, please contact Echo Technical Support at (510) 238-2727 or email support@echoman.com.

SMA COVERED SHARECARE ENHANCEMENTS

Add Begin and End Dates for ICD-10 Diagnosis Codes

A *Begin Date* and *End Date* has been added to the ICD-10 Diagnosis master table so that a user is able to end date a diagnosis code if mandated by Federal, State or local authority. ****Important**** With this release, a script will be run to set the Begin Date to 10/01/2015 for all ICD-10 Diagnosis Codes unless a *Begin Date* already exists.

Screens and functions have been updated to respect the expiration date of the diagnosis code and the master code date range. These include:

- **Clinical > Clinical Setup > Diagnosis > ICD Codes**
  - Added *Begin Date* and *End Date.*
  - *Begin Date* is required.
  - *End Date* is optional. If left blank, the code will be in effect until an End Date is specified.
  - Using the hyperlink to lookup available ICD-10 codes will only display active ICD-10 codes as of the current date.
  - The selection of ICD-9 Diagnosis Codes for Insert or Update has been disabled.
- **Clinical > Diagnosis >(DSM-5/ICD-10)** and **Access > Consumer > Diagnosis > (DSM-5/ICD-10) –** When inserting a new ICD-10 diagnosis or updating an existing ICD-10 diagnosis, the date range must be within the data boundary of the master ICD-10 Diagnosis Code.
  - The following are examples of exceeding master code's date range:
    - Master code began on 1/1/2019 with no *End Date*. User enters ICD-10 code with *Begin Date* of 7/1/2018.
    - Master code has *Begin Date* of 10/01/2015 and *End Date* of 12/31/2018. User enters ICD-10 code with *Begin Date* of 1/1/2019 with no *End Date.*
    - Master code *Begin Date* of 1/1/2010 and *End Date* of 12/31/2018. User enters ICD-10 code with *Begin Date* of 12/1/2018 and *End Date* of 02/01/2019.
  - In addition, when using the hyperlink to lookup available ICD-10 codes, the screen will only display active ICD-10 codes based on the **DATE RANGE** (mandatory *Begin Date,* optional *End Date)* that the **USER ENTERED.**
- **HIPAA 837 Medi-Cal claims –** The claim program will look up ICD-10 Primary Diagnosis from the ICD-10 master table and compare the *Service Date* with the master ICD-10 code's valid date range. If the master ICD-10 Diagnosis has expired as of the date of service, the claim will be skipped and an error message shown.

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- **Billing Status Report (BSR) –** A new validation has been added to compare the service date with the effective period of Admission's ICD-10 Primary Diagnosis code from the ICD-10 master table. If the Primary Diagnosis code is out of range, an error will display with the master code's effective period. A hyperlink to the DSM-5/ICD-10 screen is provided so that the user may replace the expired code.

Clinician Gateway Diagnosis Upload to ShareCare is Now Automated

A single SQL stored procedure can now be called directly by Clinician's Gateway after uploading a batch of diagnosis records into the "staging table". This eliminates the need to manually process uploaded records by batch via the front-end screen. ShareCare's existing screen that processed diagnosis records manually now uses the new stored procedure. The original upload records will still be deleted from the staging table. New tables however have been created for storing "success" records, DiagnosisStage_com, and "rejected" records, DiagnosisStage_err.

The Diagnosis Upload workflow is as follows:

- Clinician's Gateway uploads diagnoses to the staging table in ShareCare. Records in each upload are associated with a unique batch ID.
- Clinician's Gateway calls the stored procedure to process this new batch of records by batch ID.
- Clinician's Gateway retrieves error records from *DiagnosisStage_err* for further processing.
- Clinician's Gateway retrieves success records from *DiagnosisStage_com* to confirm the update and retrieve the value in DIAGNOSIS_ICD10_ID column for reference.
    - This is a unique ID associated with the ICD10 diagnosis attached to the consumer.
    - Future updates to this particular diagnosis code require this ID to be submitted in the staging table.
    - If the consumer gets a new diagnosis code, then it will be submitted without the DIAGNOSIS_ICD10_ID.

The following validations are performed on the uploaded Diagnosis staging record:

1. Consumer must have a *consumer* (not pre-consumer) record in ShareCare.
2. Admission must exist and date of diagnosis must be within admission date range.
3. Diagnosed by Provider must be a valid, active Primary Service Provider.
4. Diagnosis codes must be in Diagnosis master table and not marked inactive.
5. If a diagnosis is an update, the system will update the row with the new information. **In this case, the staging record must include DIAGNOSIS_ICD10_ID available in the success record when the diagnosis code was initially inserted in Sharecare.**
6. For new records where there is no existing active diagnosis of the same rank and type, the system will insert the record per the information in the staging table.
7. For new records where there is an existing active diagnosis of the same rank and type (ICD-10), the system will do the following:
    a. If the *Begin Date* (new diagnosis) is before the *Begin Date* (existing diagnosis), insert the new diagnosis with specified *Begin Date*, and end date it as of the day prior to the existing diagnosis.
    b. **If the *Begin Date* (new diagnosis) is after the *Begin Date* (old diagnosis), end date the old diagnosis with the date before the new Diagnosis' *Begin Date*.**

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837 Type Drop-Down for Short-Doyle Medi-Cal

An 837 type drop-down field was added for Short-Doyle Medi-Cal to allow 837I and 837P to be run separately in order to resubmit a claim. The drop-down listing is located to the right of the *Bill Print Name* field as shown in the example below.

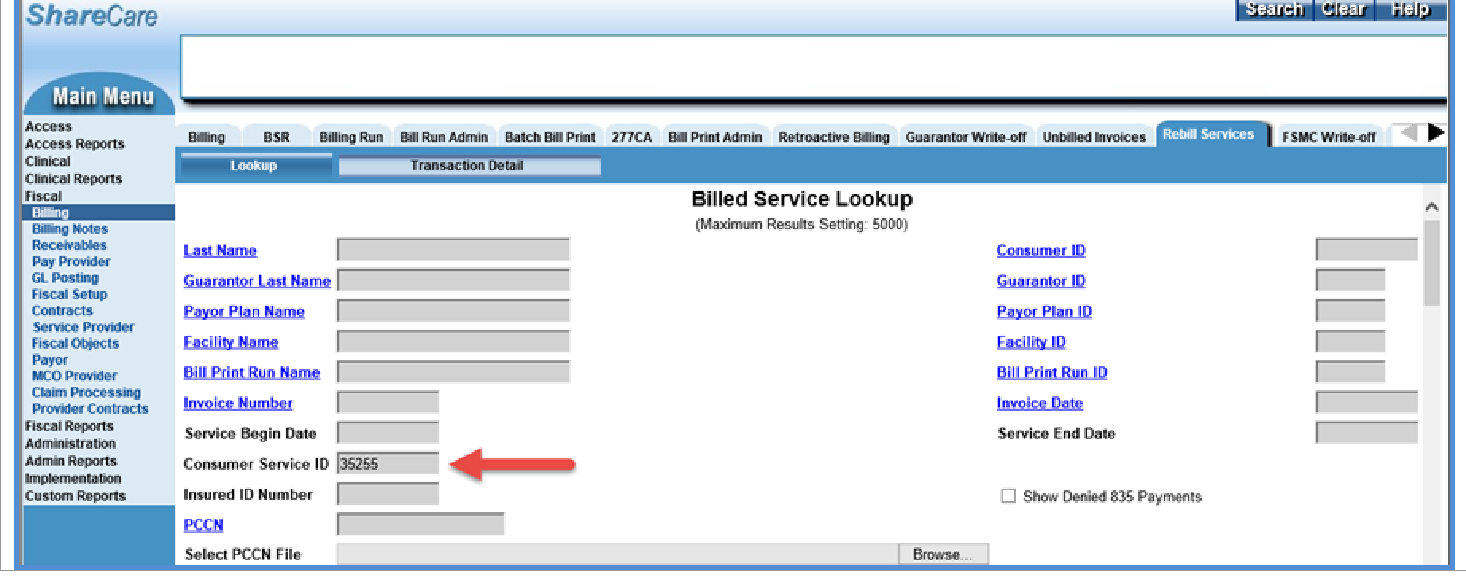
Bill Print Run Lookup

Bill Print Run Name | Bill Print Run ID

Bill Format	Short-Doyle MediCal electronic file	☐ Repay/Void Claims	☐ Re-Billed Claims
System of Care	SELECT SYSTEM OF CARE		
Bill Print Name		837 Type	SELECT
Claim Submission Month	SELECT	Calendar Year	SELECT YEAR
Begin Date	01/01/2020	End Date	01/14/2020
Payor Group		Payor Group ID	
Payor Plan		Payor Plan ID	

Consumer Service ID Lookup Added to Rebill Services Tab

A search parameter field for Consumer Service ID has been added to the rebill Services screen. Clicking the search button goes directly to the detail screen.



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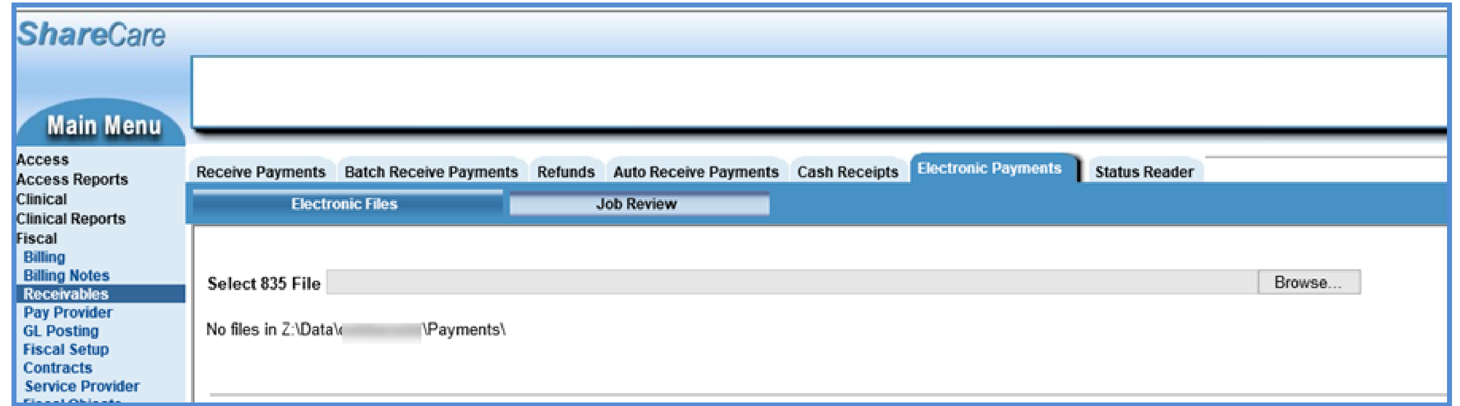
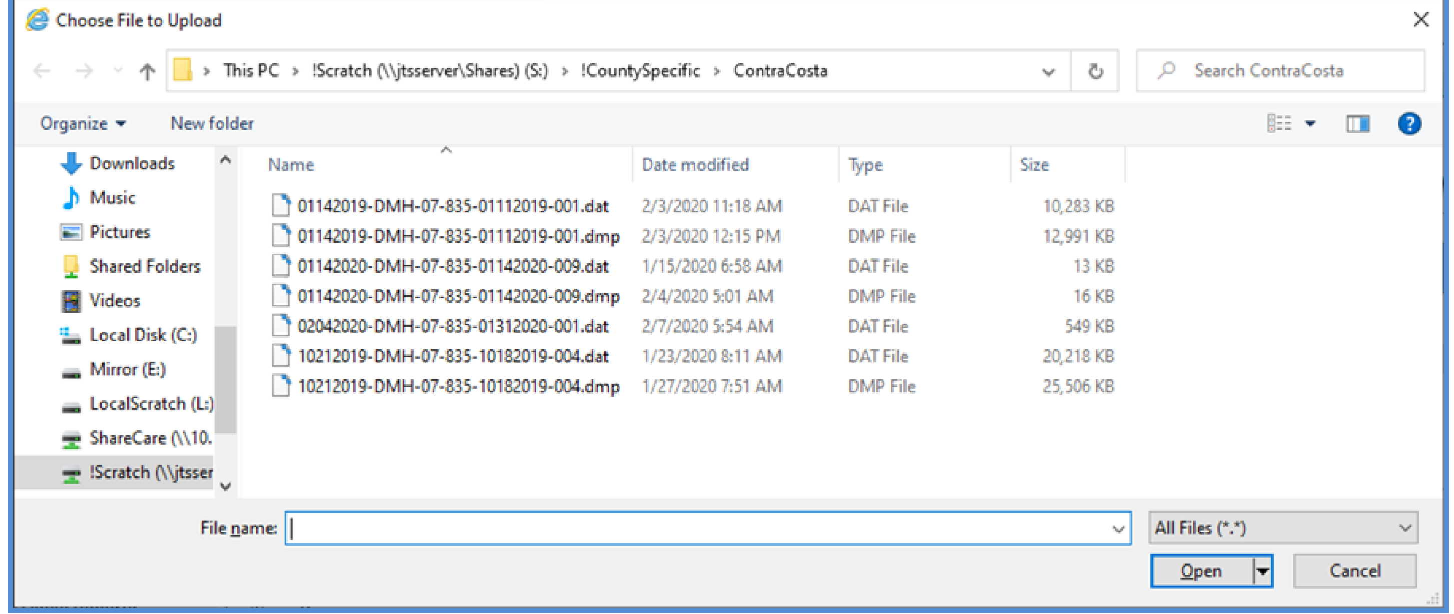
835 Screen Allows 835 Uploads

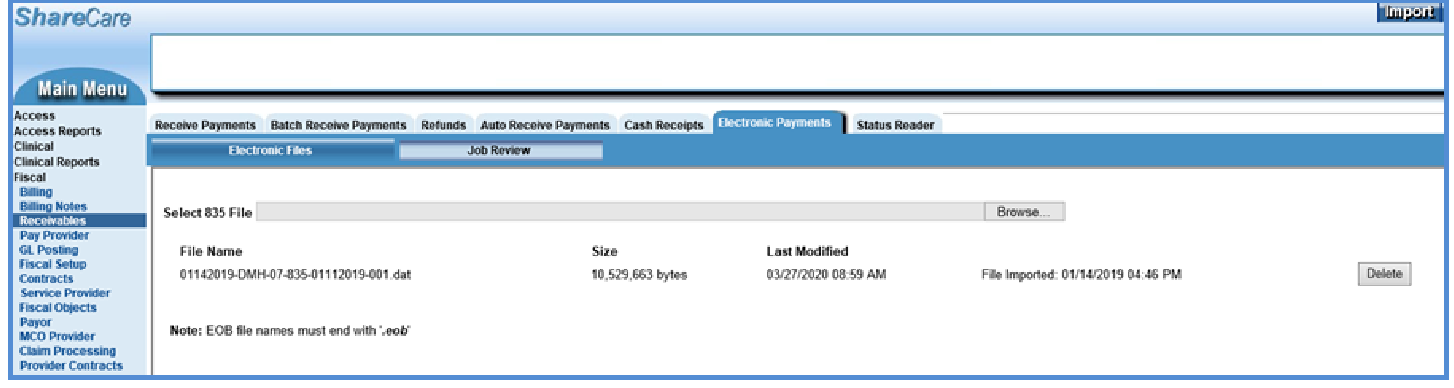
Users now have an option to upload an 835 when viewing the 835 screen. After uploading, the file is moved to the correct location on the Z: drive to be picked up and imported.



An empty 835 screen shows *No files* in the Z:\. Select Browse to open Windows Explorer.



Select the desired file and click Open or double-click on the desired file to upload.



The 835 screen will refresh and the file will appear below the import field.

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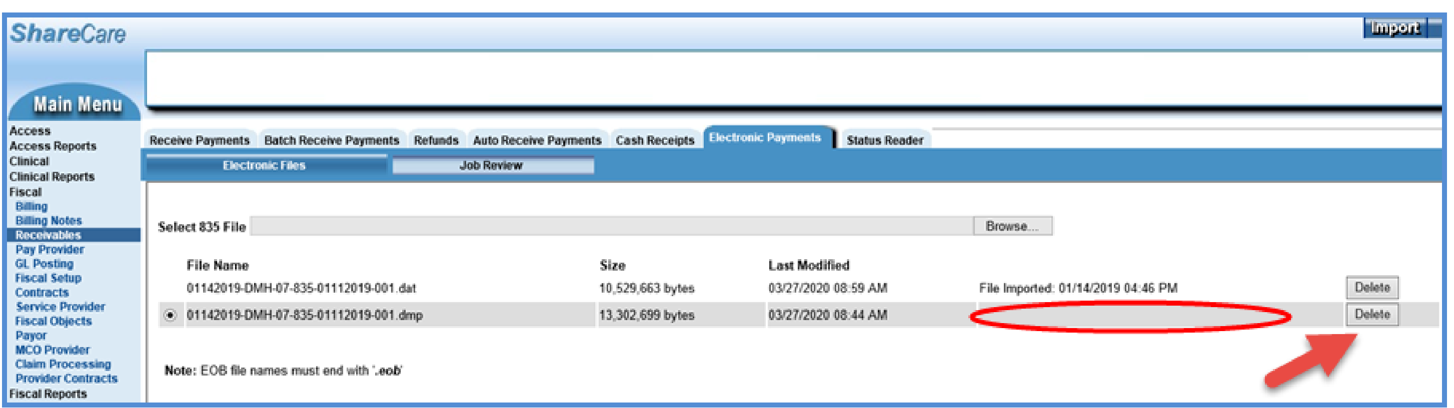
[Job Status]
Elapsed Time: 0 minute(s)

Beginning import.
Import failed in function import835File()- with error: Not ISA Segment
Payments processed but not committed: 0

If the file selected to upload is not an 835 file, an error will display.



Clear the error by cancelling the run on the first screen, deleting the run on the next screen, and then returning to the first screen (shown above) and deleting the file.

CUSTOMER FUNDED SHARECARE ENHANCEMENTS

Diagnosis Expiration Report

The new *Diagnosis Expiration Report* is available under the Clinical/Diagnosis heading in a new tab next to the *Diagnostic Mix Report.* The following user Input parameters are available:

Input parameters:

Entity Name	Entity ID
Organization Name	Organization ID
Facility Name	Facility ID
Program Name	Program ID
Provider Last Name	Provider ID
ICD Code	ICD Code Description
Provider Organization	Provider Organization ID
MCO Provider	MCO Provider ID

Target Expiration Date:

System Of Care SELECT SYSTEM OF CARE

The **ICD Code** and **Target Expiration Date** are required, while all other parameters are optional. This report identifies admissions in which the ICD-10 Primary diagnosis code has already or will be expired based on the ICD Code and Target Date entered. This report outputs the following identifying information:

Consumer ID	Consumer Name	Facility ID	Program ID
Facility/Program Name	Admission ID	Admission Date	

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UPDATES

Ticket #	Case #	Description
SC-175	62012	Begin and End dates added for diagnosis codes.
SC-522	67867	Create a Way to Unpackage an 837I and 837P individually to resubmit a claim. 837 Type field added for Short-Doyle Medi-Cal.
SC-523	67805	ADP Sliding Scale billing no longer requires Family ATP record to be created. The record for the Family ATP flag, *Ability to Pay,* still exists but it is no longer required by the sc_calculate_FATP.sql stored procedure to process sliding scale accounts.
SC-546	67546	Enhance MMEF Reports (Partial Match & SOC) – Contra Costa specific report enhancements.
SC-664	70248	The Add button on the Service Provider screen is now disabled after clicking once to prevent multiple entries of the same provider.
SC-671	69006	Add ICN to Bill Print Control File - Santa Barbara
SC-676		Automate Clinician Gateway Diagnosis Upload to Sharecare
SC-699	70935	Enhancement to add consumer_service_ID lookup to Rebill Services tab
SC-730	71271	Medi-Cal claim failure case due to truncation of race.
SC-733	71176	Connection Errors Running Reports
SC-742		GS Link view is corrected so it does not return Transaction_Payment_IDs multiple times.
SC-758		Allow 835 uploads on the 835 screen.
SC-770	72000	BSR gets blank Status Message for some services.
SC-772	71039	Apply authorization not working regression in v8.14 has been resolved in v8.15. **Known Issue – A valid auth number that does not belong to the consumer can be added in edit services and it will save. This will be addressed in the next release.**
SC-784		Cost report displaying blank CDS_Providers (dropped claims).
SC-793		Cost report – added missing total columns to detail report.
SC-796		Added an On or Off Global Variable to turn off Blocking Claims with Pending Payments from being recreated.

BUG FIXES

Ticket #	Case #	Description
SC-117	60758	User with Insert auth cannot create/update UMDAP worksheet elements - User has Insert auth for the Family Ability to Pay module. When trying to add a new UMDAP worksheet to the family, the user gets the “You are not authorized for functionality on this page. Please see your administrator about screen access privileges." error when attempting to add UMDAP Income Source or Asset Allowance elements using the local Add buttons. This error has been fixed.
SC-123		SJ wants to add a one day authorization. Old behavior – Error message: the end date has to be greater than the begin date. This has be resolved so all counties can now do one day authorizations.
SC-284, SC-663		Payor Transaction Report does not filter by Payor Plan ID and includes commas in ID - Example: Fiscal reports > Payor > Payor transaction report and filter by payor plan ID 10 and Facility ID 75 for a date range of 07/01/18 to 7/10/18. The report includes all payor plans beginning with "10" instead of filtering by Medi-Cal payor plan ID 10. The report now filters correctly by PPID and the PPID no longer displays commas

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SC-461, SC-756	66818	When a consumer service had billed to a payor such as Medicare and received payment, if user recreates the invoice and the service does not have valid authorization, payment information is removed, and deposits are unable to be reconciled. Batch Recreate now ignores unauthorized services. Related to SC-771, SC-781
SC-472	66471	CalOMS PNA record reporting when report facility/program is end dated in setup - PNA (provider no activity) record created by CalOMS Report even though the facility/program had been end dated. Resolved by having CalOMS report check for end dates before creating PNA records.
SC-484	67163	Remove CalOms admission restriction on admission dated before 1999 - Annual CalOMS Assessment entered for admission with an admit date in 1994. Annual receives ShareCare CalOMS error message (161) Admission Date year must be a value from 1999 through 2099 and does not make it into the submission file. Resolved by changing CalOMS report to allow annuals and discharges for any admission year.
SC-485	66966	CalOMS Error Report is displaying "(Discharge)" on the error message related to Annual Update Date. Error message now displays: *(167) Annual Update Date is more than 5 years earlier than the Transaction Date:06/23/2004 (AUP-1 Annual Update Date)* The word discharge was removed.
SC-512	67596	CalOMS Annual Update Date is not correct when copying Annual Update Assessment. When copying forward to the current year, the old assessment date was brought forward into the new assessment record. Copying Annual to Annual will now pick up the new assessment date entered instead of holding onto the old assessment date.
SC-557	68377	ShareCare error Variable duplicate_override_ol2 is undefined when adding service. Conditions that caused this error Clinical / Service Entry / Service Entry Enter the values in the top part of the screen (grey boxes) -> Consumer_ID=XXXXXX, Fac/Prgm=129/146, Provider=8262, Service=90792, Begin_Date=08/01/19, Begin_Time=09:00 Set Data: the first row is populated Click on One More record: the second row is populated Click on One More record: Error message Same procedure, but select “Duplicate Service Override” in the first service One More record: the second row is populated, the “Duplicate Service Override” in the second service is grayed out One More record: Error message This has been fixed.
SC-571	68593	Validate EDI Number and EDI PIN to not allow special character entry - The EDI number and the EDI PIN (Fiscal objects>Facility Billing>Payor Specific) are used by the Batch EVC program and the Eligibility verification screen to obtain eligibility information. These fields are usually populated at system setup time and rarely change but need to be entered for new facility programs. The EDI number and EDI Pin come from the state when the facility program is medi-cal certified. **These fields should never contain any special characters.** Resolved by adding a warning about special characters and validating fields to not allow special character entry.
SC-572		Prevent Batch EVC from running when an MMEF eligibility upload is still in process. - Two lines of optional output have been added to the top of the screen and will only appear if needed. 1. "Eligibility Load is still running" will only appear if the latest eligibility load job does not have an end date. 2. "Current Month Begin greater than Repository source file date "mm/dd/yyyy" will only appear if eligibilities from a previous month are being applied. The Batch EVC job can be executed anyway but they'll know they are getting EVCs for old data.
SC-592	68750	Updated the principal_procedure_date in the OSHPD output file to YYYMMDD instead of MMDDYYYY.

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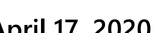

SC-607	68014	AR Aging report Payor Plan displayed services for another payor when drilling down detail from the Summary by Payor Group. Correct services are now being displayed.
SC-609	67039	CLONE - Facility Security User not able to open admission to a program they are authorized for. Error was due to no consumers currently being admitted to that facility/program. This old behavior required the echoadmin user to enter a consumer to that facility/program first. Users with authorization would then be able to add admissions without receiving the error. This has been resolved by not requiring an open admission before a Facility Security User is able to enter an admission to a program for which they have authorization.
SC-612	69096	Enhancement to add Deceased information to Clinical Summary Screen - when the Deceased checkbox on the Consumer Profile Information flag is checked (people.Decsd = 1), a Deceased Label is added to the Clinical Summary Screen with the Date of Death.
SC-613	69020	Cost Report Extract not populating CDS_provider code on the MCO extract - The cost report extract has been updated so that the cds_provider_code for MCO provider organizations pulls the cds_provider_code from the facility_payor.facility_payor_group_number field.
SC-632	69341	Last Day of Service on Clinical Summary Screen and Admission Report showing archived service - Admission Report has been corrected to display the true last service date. Clinical Summary Screen has also been corrected to display the true last service date.
SC-633		Utilization Control Phase III Enhancement – Custom project for San Joaquin
SC-635	68703	Suspended overpayments added to guarantor after commit – original problem is working as designed. This ticket has been replaced with the following 2 tickets: SC-684 Applied overpayments need adjustment SC-685 Make receivables screen show whatever is in transaction_payments and trans_pay_detail.
SC-648	68355	Recreated services are not selected for Cost Report Extract – relates to ticket SC-657. Recreated services that hae been previously claimed will back into the Cost Report.
SC-657	68096	Cost Report Extract doesn't deal with repays correctly – relates to ticket SC-648 The Cost Report Extract is currently including claims that have been voided. The Cost Report Extract has been corrected to exclude claims that have been voided.
SC-665	70256	Medical Claim Submissions rejected by CA State due to missing policy number in OHC loop. Addressed by adding validations to the Bill Print Status Report per 837 Implementation Guide: • OHC policy numbers less than 2 characters • OHC missing subscriber last name • OHC missing subscriber first name If the policy is missing, the claim line will be skipped and an error generated in the Bill Print Status Report: "OHC Policy '?' < 2 characters for 'OHC Company Name". If there is no OHC last name the error message is "missing OHC last name for 'OHC Company Name". If there is no OHC first name the error message is "missing OHC first name for 'OHC Company Name".
SC-667		Sliding Scale amount assigned to each service in an invoice should be Only Monthly. The sliding scale computation has been updated to ignore the current consumer service as it was already being set by the transaction_payment insert trigger. The Monthly Sliding Scale now calculates correctly.
SC-668		San Joaquin includes Admissions not using UC when checking for existing Admissions – this address a customer specific UC module. When setting the length of the original authorization for a new admission the trigger is not excluding admissions that do not require UC.

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		If a consumer has only non UC admission(s) then receives a UC admission the authorization will be set to 30 days rather than 60 days. The check now ignores facility programs that do not use UC.
SC-669	70417	Scheduler Lookup is not allowing user to look up others' schedules – A method name was replaced in lookups. The scheduler has its own tag that creates lookups that was still using the old method name. Updated the method name used by the scheduler to resolve this issue.
SC-674	70466	Deleting a guarantor statement does not release the services. This behavior has been corrected. Deleting the billing run will release the services back into the billing pool.
SC-678	70472	CSI Assessment is not saving the consumer ID to the assessment record The CSI Assessment was not saving the consumer id to the assessment record UNLESS the consumer was first opened on Access/Consumer/Profile. This behavior has been fixed. The consumer no longer needs to be in focus before adding assessment.
SC-679	70312	CSI Assessment saves the wrong consumer ID to the assessment record If the user tried to do two assessments in a row for two different consumers but did not go back to the access/consumer/profile in between, the consumer id is the same for both even though the screening ids are different. This behavior has been fixed.
SC-684		Applied over payments need to include adjustments. Payments Committed from the Electronic Payments Summary Screen should include any adjustments from their respective 835 adjudications. Overpayments to Medi-Cal will now automatically generate SMA Adjustments to balance Medi-Cal to zero. These SMA Adjustments will waterfall to the guarantor when appropriate.
SC-685		Make receivables screen show everything in the transaction_payment and trans_pay_detail tables. After the 8.15 update – services that are repaid or rebilled will show multiple debit lines to Medi-Cal for balancing purposes and so user can see everything.
SC-688	70638	Unusual Medi-Cal rebilling activity can produce the wrong PCCN on subsequent rebills. The error was caused by out-of-sequence billing activity. When Medi-Cal claim is submitted for a service, user may not further "repay" or "rebill" Medi-Cal claim on the same service until 835 for this outstanding claim is processed, which provides the PCCN for next billing cycle. Changes have been made so that the most recent PCCN given by the state will be selected on any rebill.
SC-700		Authorization doesn't default to Initial
SC-703	70556	Service that violates an authorization could not be invoiced after service was edited. Now editing and/or rerunning the billing resets the violated_authorization flag.
SC-710	71176	Length of Stay now filters by facility.
SC-726	70638	Drug Medi-Cal is using 835 Loop/Segment:2100|MOA03 to pass information about unidentifiable PCCN instead of 2110|LQ02 used in Mental Health. Echo has enhanced 835 process to read this information in both segments. See SC-688 for the cause of such issue.
SC-731	71216	This was a county specific, data driven issue in which a small number of electronic payment records were missing identification information. Scripts have been provided to the county that had this issue to fix the incorrectly mapped payments.
SC-744	71597	Repays or Rebills after recreates produce error: "Can't determine unique ID for REF*6R"
SC-751	71841	Medi-Cal claim was rejected with error message "Element NM103 Missing". The cause of the problem was that Consumer's "Default" Name had been archived. After reinstating the "Default" Name, the claim file was accepted. A check was added in Medi-Cal billing to alert user if Consumer name is missing.
SC-771	72098	Recreate or void is no longer allowed over claim lines that have been sent but not paid or adjusted. These now show as *****Open Claim.*** The Void and Recreate is disallowed and the Batch Recreate will skip services with open claims.

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SC-776		Medi-Cal 837s does not account for OHC payor refunds when creating COB loops.
SC-777	72244	User was not able to complete Medi-Cal 835 upload. A technical review determined this was a unique, data-driven issue. One specific 835 could not post to the claim because consumer had an incomplete Medi-Cal payor plan record. Echo helped to move aside this 835 record and payment processing completed. Problem handling in 835 upload has been improved so that similar situation will not crash the process.
SC-778	70347	CalOMS –remove error 373 –Discharge Date is more than 5 years earlier than Transaction Date This should help in the process of cleaning up errors in the ShareCare Caloms Error report.
SC-785	72469	Receivables Screen FindInvoices query is locking PaymentCreation835, BillPrint runs, etc. - A technical review determined the cause of slowness was due to a unique way of searching records in Receivable screen, in which the “Tab” key was pressed (instead of using the “Search” button). This generated multiple search queries blocking each other and thus slowed down the system. The issue had nothing to do with the 835 process and has been addressed.

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