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Version 10.2 Release and Configuration Notes



CREDIBLE

Behavioral Health Software

Confidential & Proprietary

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New Features and Enhancements

General Updates

Signature Capture

Credible has deployed a new, streamlined method for capturing signatures in the software. This enhancement provides the following features:

- works in Internet Explorer®, Firefox®, and Chrome™ on Windows®;
- works in Firefox and Safari® on Mac OS®;
- allows signing on-screen **and** signing using a Topaz® signature pad;
- automatically detects if a Topaz signature pad is attached to the device; and
- permits previewing of the signature before saving it.

This replaces all previous methods for capturing signatures in Credible.

Topaz Users:

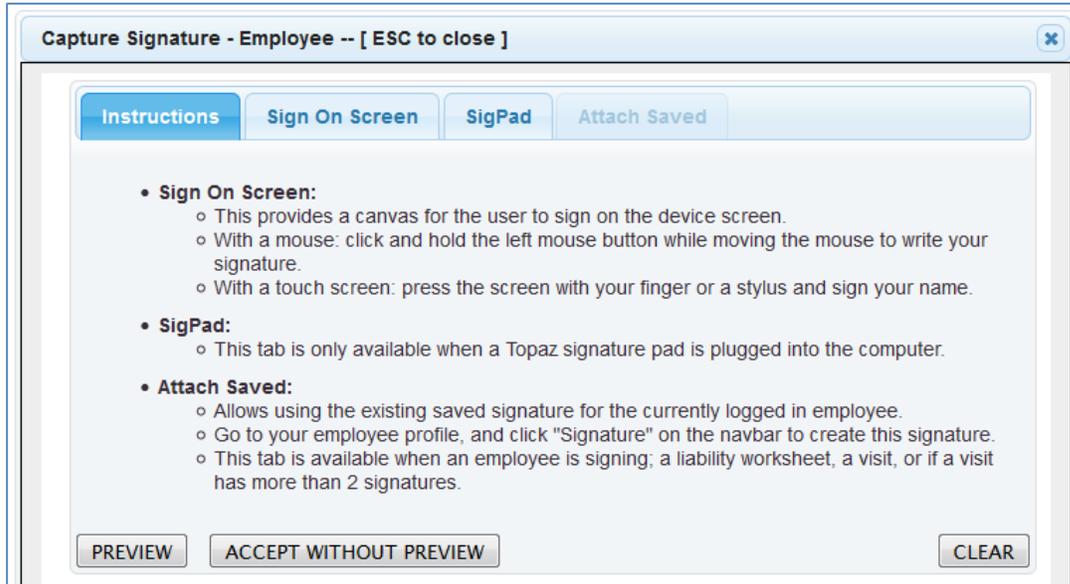
- In order to use this new workflow you must install the plugin from the Topaz website. Please see the instructions at the end of this document.
- Topaz does not currently support Microsoft's Edge browser. Credible is working with Topaz and will release an enhancement when available.
- Google Chrome OS™ and Chromebooks™ are not supported by Topaz.

Standard Usage

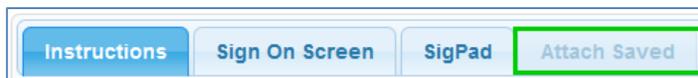
At any point in the software where a signature can be collected, this module will appear. The title will reflect the type of signature being captured (Client Signature, Employee Signature, and so on).



When the **Capture Signature** button is clicked, the **Signature Capture** dialog will appear.



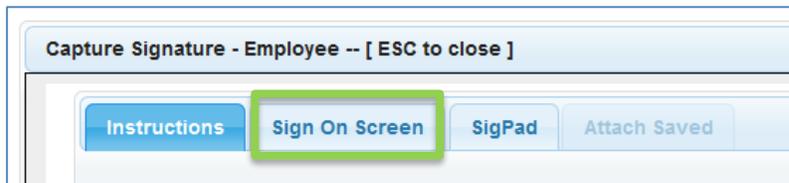
Click on the appropriate tab to start the signature capture process. Tabs that are disabled (greyed-out) are not available for this particular function. In the picture below, the Topaz signature pad has been plugged in, but the use of a saved signature via **Attach Saved** is not available.



The Signature Capture box will default to the **SigPad** tab when:

- the user's *Employee Config* has the *Signature Pad* option checked AND
- the user's device has the appropriate Topaz plugin installed AND
- a signature pad is currently attached to the user's device.

If these criteria are not met, the Signature Capture box will default to the **Sign On Screen** tab.



When capturing using the **Sign On Screen** or **SigPad** methods, the signature will appear in the window.



Clicking the **Preview** button provides a snapshot of the signature which will be saved.



To accept and save the signature into Credible click the **Accept** button. The user can also type their name in the box provided; this will add their printed name to the signature. This typed name is not required, but is recommended. To begin again, click the **Clear** button.

Once you have accepted the signature, the final version will appear in the original Signature Capture window.



Employees that have a saved signature on file can click **Attach Saved** instead of manually adding a new signature. (See the following section for details.)



Attach Saved

Only employees can have saved signatures on file in Credible. Clients must manually sign each time.



If the logged-in employee has a saved signature, the **Attach Saved** tab will be available for:

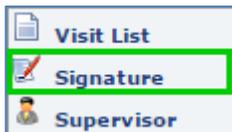
- all signature boxes on the sign and submit screen of a visit EXCEPT the client signature box,
- all signature boxes on a completed visit EXCEPT the client signature box,
- all signature boxes for embedded signatures inside of a form, and
- the employee signature box on the client’s liability worksheet screen.

If the employee has a saved signature, it will be automatically attached to a visit on clicking **Sign & Submit**.

Saved Signatures

To add a saved signature, an employee must:

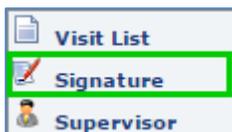
1. log in as themselves,
2. go to their employee record,
3. click the **Signature** button on the navbar.



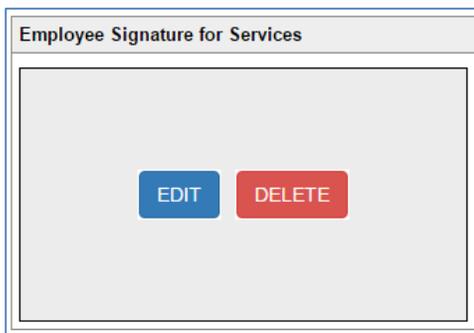
At this point they will follow the steps above to create a saved signature, either on screen or using a signature pad. Note: Creating a saved signature for someone else is no longer allowed.

To edit a saved signature:

1. Go to your employee record and click **Signature** on the navbar.



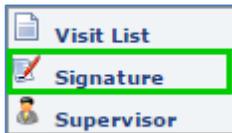
2. Click on the image of your signature. This will reveal the **Edit** and **Delete** buttons.



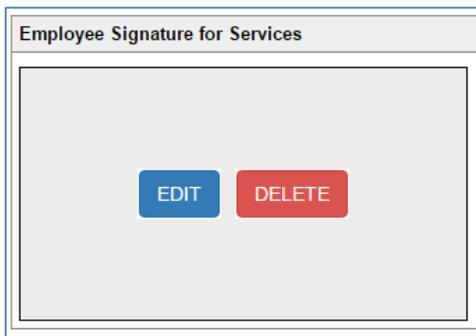
3. Click **Edit**. The Capture Signature window will appear again. Sign as usual, and upon accepting, the new version will be saved.

To delete a saved signature:

1. Go to your employee record and click **Signature** on the navbar.



2. Click on the image of your signature. This will reveal the **Edit** and **Delete** buttons.



3. Click **Delete**, and then confirm the deletion.

Topaz Signature Pad Installation

Credible supports the use of Topaz signature pads on desktops and laptops. Topaz devices do not work with tablets, phones, or Chrome OS devices.

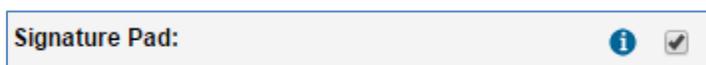
Employee Configuration

Before Credible will recognize a Topaz signature pad your employee profile must be configured for it.

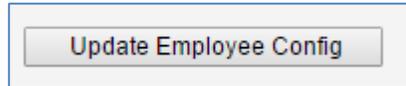
1. From your **Employee** navbar, click the **Config** button.



2. Check the **Signature Pad** option.



3. Click the **Update Employee Config** button at the bottom of the page.



This will activate the availability of a Topaz signature pad when it is connected to your device. If the Topaz pad is not currently connected, signature boxes will default to the **Sign On Screen** option.

Additional OQ and YOQ Settings in Partner Config

The following additional OQ and YOQ settings have been made available via Partner Config. For more information on OQ and YOQ, please contact your Partner Relationship Manager.

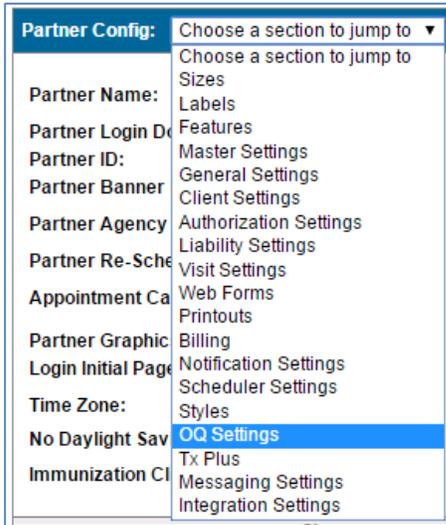
- OQ Sync Web Service
- OQ Username
- OQ Password
- Use Team Prefix
- Use Geo Area
- OQ Medical Record Number

To access these settings:

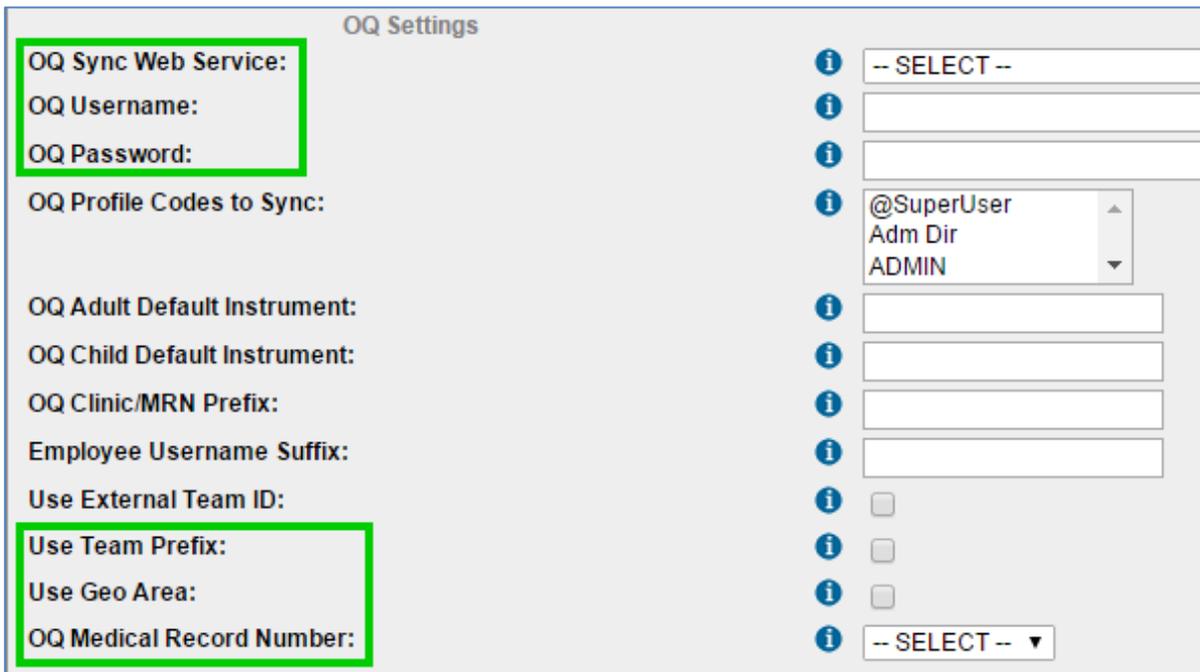
1. Go to **Admin** tab > **Site Configuration** > **Partner Config**.



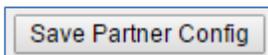
- From the section dropdown, select **OQ Settings**.



- Choose the settings you want to enable.



- Click the **Save Partner Config** button at the bottom of the page.



Billing

Additional Client Identifiers for 270 Eligibility Request

In addition to the standard 271 Eligibility Response file, some clearinghouses and payers send an additional file. While this file can be used for importing, matching to the correct client is not possible without a second identifier. Two new *Payer Config* settings have been added to allow sending a second identifier for a client.

1. Go to **Billing** tab > **Billing Config** > **Billing Payer**.

The screenshot shows the TRAINING application interface. At the top, there is a navigation bar with tabs: Home, Client, Employee, Schedule, Visit, Admin, Billing, Reports, and Forms. The 'Billing' tab is highlighted with a green box. Below the navigation bar, the 'Billing Config' section is visible, containing a list of links: Billing Office/Claim Config, Provider Config, Billing Groups Table, and Billing Payer. The 'Billing Payer' link is highlighted with a green box.

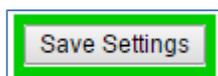
2. Click the **Edit** button beside the payer you want to set.

ID	Name
edit 152	Medicaid
edit 159	Humana
edit 145	PL MCR
edit 123	Medicare

3. Under *Eligibility Override*, select the appropriate values from the dropdowns.
 - 270 Secondary Patient ID is the client profile field which is used to store the ID.
 - 270 Secondary Patient ID Qualifier is what will be sent.

270 Secondary Patient ID:	Client ID (Clients.client_id)
270 Secondary Patient ID Qualifier:	Patient Account Number ▼

4. Click the **Save Settings** button at the bottom of the page.



The qualifier and ID will now be sent automatically when generating the 270 file.

Always Display Episode Forcing Modal

If *Visit Type: Always Display Episode Forcing Modal* is checked, any visit provided of that visit type will always display the **Visit Will Not Attach To Episode** popup on the sign and submit page. This allows the user to always force the visit into the desired episode, regardless of whether or not there is an active episode for the program under which the visit is being signed and submitted.

When the **Sign & Submit** button is clicked on a *Sign & Submit* page, the **Visit Will Not Attach to Episode!** popup will appear.

When the user expands the dropdown, it will show **all** past and current episodes for the program that the visit being signed and submitted under. The active episode will be the last item in the list.

To force the visit to attach to one of the listed episodes:

1. Select the desired episode from the dropdown.

2. Click the **Attach Visit to Selected Episode** button.

Clicking the button will sign and submit the associated with the selected episode.

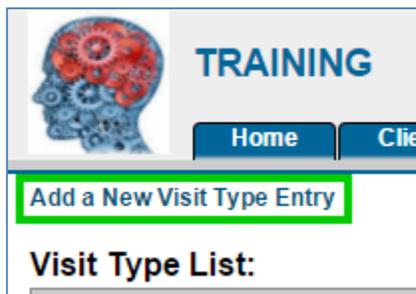
The user may also choose not to attach the visit to an episode by clicking the **Do Not Attach Visit to an Episode** button. The visit will be signed and submitted, but will not be attached to or associated with an episode.

To configure this setting:

1. Go to **Admin** tab > **Billing Configuration** > **Visit Type**.



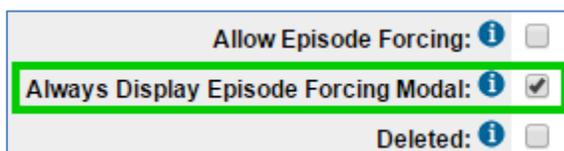
2. To add a new Visit Type, click **Add a New Visit Type Entry**, or click the **Edit** button beside an existing visit type.



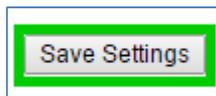
- OR -

ID	Visit Type
edit 505	Individual session
edit 506	Individual Therapy
edit 621	Individual TherapyBL

3. Locate **Always Display Episode Forcing Modal**, and check it.



4. Click the **Save** button at the bottom of the page.



Billing Payer: Send Covered Days in 837I

A new billing payer setting has been added: *Send Covered Days in 837I*. When this setting is checked, **and** the billing payer setting *Send Occurrence Codes, Occurrence Span Codes, and Value Codes* is **also** checked, the system will automatically calculate covered days (value code 80), and send them in the 837I.

The covered days are calculated by taking the difference between the count of days the claim covers and the sum of all non-covered days (value code 80 and 81) that are being sent in the claim.

To configure this setting:

1. Go to **Billing** tab > **Billing Config** > **Billing Payer**.



2. Click the **Edit** button beside the payer you want to set.

ID	Name
edit 152	Medicaid
edit 159	Humana
edit 145	PL MCR
edit 123	Medicare

3. Check *Send Occurrence Codes, Occurrence Span Codes, and Value Codes* in the **Electronic Claim Overrides** section.

Person Entity for Provider Rendering:	<input type="checkbox"/>
Send Occurrence Codes, Occurrence Span Codes, and Value Codes:	<input checked="" type="checkbox"/>
Send Condition Codes:	<input type="checkbox"/>

- The *Send Covered Days in 837I* setting will now appear. Check it.

Send Condition Codes:	<input type="checkbox"/>
Send Covered Days in 837I:	<input checked="" type="checkbox"/>
Use Rendering:	--N/A-- ▼

- Click the **Save Settings** button at the bottom of the page.

Save Settings

Billing Payer: Send Discharge Hour on Bed Board Claims (837I)

The ability has been added to send the Residential/Inpatient Stay discharge hour in 837Is. If *Billing Payer: Send Discharge Date on Bed Board Claims (837I)* is checked, all visits that are associated with an archived/closed Residential/Inpatient Stay the *Residential/Inpatient Stay Discharge Date* will send in the DTP*096 segment in the 2300 loop.

To activate this setting:

- Go to **Billing** tab > **Billing Config** > **Billing Payer**.

Admin	Billing	Reports	Forms
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Billing Config

- [Billing Office/Claim Config](#)
- [Provider Config](#)
- [Billing Groups Table](#)
- [Billing Payer](#)
- [Billing Payer Types](#)
- [Billing Matrix](#)

- Click the **Edit** button beside the payer you want to set.

	ID	Name
edit	152	Medicaid
edit	159	Humana
edit	145	PL MCR
edit	123	Medicare

3. Locate *Send Discharge Hour on Bed Board Claims (837i)* in the **Electronic Claim Overrides** section.

Do Not Send Discharge Date in 837i:	<input type="checkbox"/>
Send Discharge Hour on Bed Board Claims (837i):	<input checked="" type="checkbox"/>
Use Admission Date for Onset Date in 837P:	<input type="checkbox"/>

4. Check the *Send Discharge Date on Bed Board Claims (837i)* setting.
5. Click the **Save Settings** button at the bottom of the page.

Billing Payer: Use RIS Dates in 837I and CMS 1450

A new billing payer setting has been created: *Use RIS Dates in 837I and CMS 1450*.

1. Go to **Billing** tab > **Billing Config** > **Billing Payer**.

Billing Config

- [Billing Office/Claim Config](#)
- [Provider Config](#)
- [Billing Groups Table](#)
- [Billing Payer](#)
- [Billing Payer Types](#)
- [Billing Matrix](#)

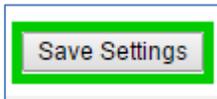
2. Click the **Edit** button beside the payer you want to set.

ID	Name
<input type="button" value="edit"/> 152	Medicaid
<input type="button" value="edit"/> 159	Humana
<input type="button" value="edit"/> 145	PL MCR
<input type="button" value="edit"/> 123	Medicare

3. Locate *Use RIS Dates in 837I and CMS 1450* in the **Electronic Claim Overrides** section and check (enable) the feature.

Use Episodic dates in 837i and CMS 1450:	<input type="checkbox"/>
Use RIS dates in 837i and CMS 1450:	<input checked="" type="checkbox"/>
Use Inpatient Unit of Measurement of DA in 837i:	<input type="checkbox"/>

4. Click the **Save Settings** button at the bottom of the page.



When this setting is enabled (checked), if...

- the visit is associated with a Residential/Inpatient stay, and
- the Residential/Inpatient stay has been closed or archived

...then the statement covers period (*DTP*434 in the 2300 Loop in the 837I or Box 6 in the CMS 1450*) will be populated with the *Residential Inpatient Stay Admission and Discharge* dates.

Note: This billing payer flag supersedes *Billing Payer: Use Episodic Dates in 837I and CMS 1450*, as well as *Billing Matrix: Bill End Date of Roll Group*.

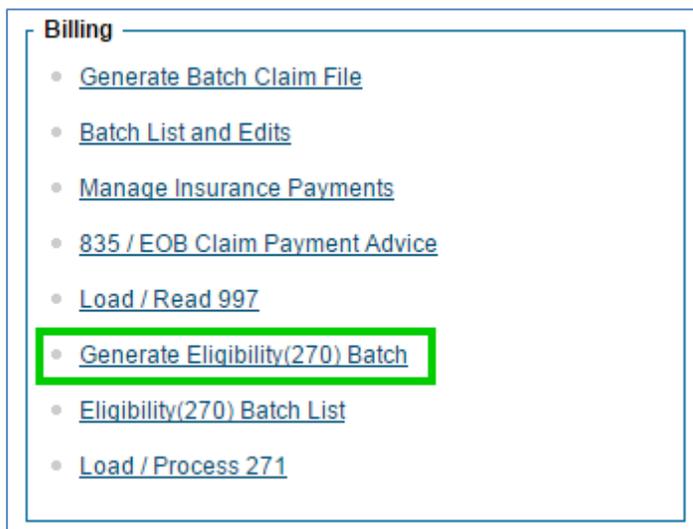
Unduplicated Same Day Clients in 270

When using the schedule options to generate a 270, clients that have more than one appointment appear multiple times. This can cause redundant information to be received in the 271 response.

Credible has added *Unduplicated Same Day* as a new option to *Generate Eligibility (270) Batch*. This option lists all the clients for the selected payer that have an appointment scheduled for the current date. Each client will only appear once in the 270, and the received 271 results will attach to the client's insurance record. When using the *Unduplicated Same Day* option on the same day for multiple payers, a client will only appear once across **all** files generated. This approach is designed for Partners that send all 270s to a single payer (typically Medicaid), and need to receive one response per client.

To use this setting:

1. Go to **Billing** tab > **Billing** section.
2. Click **Generate Eligibility (270) Batch**.



- From the **Scheduled Clients** dropdown, choose *Unduplicated Same Day*.

For the Previous 3 Days	<input type="checkbox"/>
For the Previous 7 Days	<input type="checkbox"/>
Unscheduled Check	<input type="checkbox"/>
Unduplicated Same Day	<input checked="" type="checkbox"/>

- Click the **Build 270 File** button.

Build 270 File

Do Not Send Visit Date in Institutional Claims

Two new billing payer settings have been added for institutional billing.

- When *Billing Payer: Do Not Send Service Date in 837I* is checked, the 2400 Loop DTP*472 segment (Service Date) will not be sent in an 837I file.

No CPT on 837i and CMS 1450:	<input type="checkbox"/>
Do Not Send Service Date in 837I	<input checked="" type="checkbox"/>
Suppress Leading Zeros on CAS L2430 837:	<input type="checkbox"/>

- When *Billing Payer: Box 45 Blank* is checked, Box 45 (Serv. Date) will be left blank on the CMS 1450.

Box 42 Line 23 Count of Revenue Codes:	<input type="checkbox"/>
Box 45 Blank	<input checked="" type="checkbox"/>
Box 51 Health Plan ID:	<input type="checkbox"/>

Use Primary Claim Grouping For Secondary Claims

Credible has created a new, highly specialized, billing payer flag — *Billing Payer: Use Primary Claim Grouping For Secondary Claims*. The following conditions must be met:

- Billing Payer: Use Primary Claim Grouping For Secondary Claims* is checked for the billing payer that is being used as a secondary payer on a visit;
- And either:
 - Billing Payer: Multiple Services Per Claim (837P)* is checked; OR
 - Billing Payer: Multiple Services Per Claim (837I)* is checked.

When those conditions have been met, every visit that was in the primary payer's batch claim file, regardless of its status, will be included in the secondary payer's batch claim file, and in the same claim grouping.

Please note: This is a very specialized billing payer setting that should only be used if the billing payer requires multi-service claims to contain the exact same services sent to a primary payer.

To set the *Use Primary Claim Grouping For Secondary Claims* for a payer:

1. Go to **Billing** tab > **Billing Config** > **Billing Payer**.



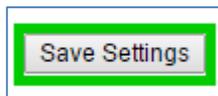
2. Click the **Edit** button for the payer you want to configure.

ID	Name
edit 152	Medicaid
edit 159	Humana
edit 145	PL MCR
edit 123	Medicare

3. Check the *Use Primary Claim Grouping For Secondary Claims* setting.

Multiple services per Claim (837I):	<input checked="" type="checkbox"/>
Use Primary Claim Grouping for Secondary Claims:	<input checked="" type="checkbox"/>
Send Multi Service Rendering at 2310:	<input type="checkbox"/>

4. Click the **Save Settings** button at the bottom of the page.



Clinical

Ability to Set Admitting Diagnosis for an Episode

The ability has been added to specify an admitting diagnosis for a client's episode.

Note: The *admitting_diagnosis* dropdown only permits selection of a diagnosis which is active during the episode. For a diagnosis to be considered active, it must belong to a Multi-axial or Problem List diagnostic assessment having an *Effective Date* between the episode's *Admission* and *Discharge* dates.

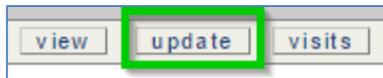
The **Episode: Admitting Diagnosis** will be sent in the **HI*(A)BJ** segment in the 2300 loop in the 837I, and **Box 69** in the CMS 1450. If no *admitting_diagnosis* has been set on an episode, visits will continue to be billed using the visit's diagnosis as the admitting diagnosis.

To set an Admitting Diagnosis for an episode:

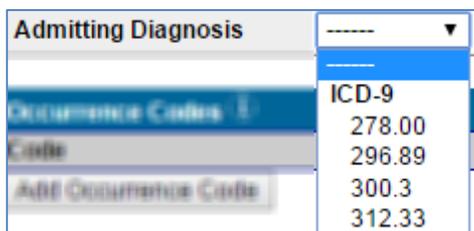
1. On the client navbar, click **Episodes**.



2. Click the **Update** button on the desired episode.



3. Select a diagnosis from the *admitting_diagnosis* dropdown.



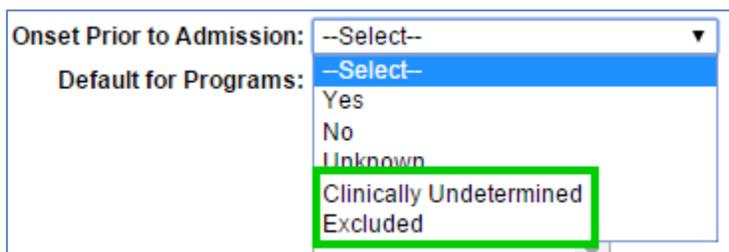
4. Click the **Update Episode** button.



To enable this functionality add the *admitting_diagnosis* field to the *Client Episode* table in *Data Dictionary*.

Diagnosis *Onset Prior To Admission* Dropdown Additions

Two new items were added to the *Onset Prior To Admission* dropdown on the *Diagnosis* page: *Clinically Undetermined* and *Excluded*.



When *Billing Payer: Send Onset Prior To Admission Flag (873I and CMS 1450)* is checked, these new items are transmitted as a 'U' code in institutional claims that are associated with the specific diagnosis.

To enable these items:

1. Go to **Billing** tab > **Billing Config** > **Billing Payer**;



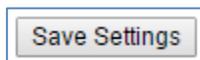
2. Click the **Edit** button for the appropriate payer;

ID	Name
<input type="button" value="edit"/> 52	Medicaid
<input type="button" value="edit"/> 159	Humana

3. Check *Send Onset Prior To Admission Flag (873I and CMS 1450)*.

Send Additional Dx When Present :	<input type="checkbox"/>
Send Onset Prior to Admission Flag (837i and CMS 1450) :	<input checked="" type="checkbox"/>
Send Occurrence Information 837i:	<input type="checkbox"/>

4. Save the change by clicking the **Save Settings** button.



New Logic Used to Determine Default Provider on Physician Orders Page

Credible has updated the logic used to determine the default provider on the physician orders page. The default provider shown will be selected based on the criteria below.

1. If the logged in user is a doctor (the employee profile field *is_doctor* is YES; *employees.is_doctor* = 1), then the **Provider** dropdown will always default to the user.

Provider:

2. If the logged in user is **not** a doctor (the employee profile field *is_doctor* is NO; *employees.is_doctor* = 0), then the **Provider** dropdown will always default to **---Select---**.

Provider:

Bug Fixes

Bed Board 2.0

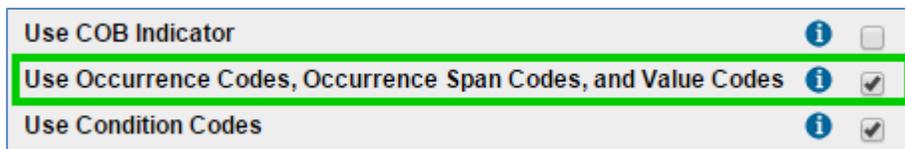
Timeout Error When Generating Bed Board Billing Visits

Resolved an issue where generating bed board billing visits would sometimes time out.

Billing

CMS 1450 Value Codes Missing

When using the *Partner Config* setting *Use Occurrence Codes, Occurrence Span Codes, and Value Codes*, only two-character codes are present even though longer codes are valid. The length of this field was increased to 30 characters, the maximum allowed in an 837I. CMS 1450 claims will use up to the first three characters.



For assistance in adding new *Occurrence*, *Occurrence Span*, and *Value Codes*, please submit a task ticket.

ICD-10 Diagnosis Codes Not Always Pulling Into Claims

Corrected an issue where ICD-10 codes were not always used in 837P claims if *Billing Payer: Multiple Services Per Claim (837P)* was checked.

Payer Amount Paid Incorrect When Sending Multiple Services per Claim

An issue was resolved where the *payer paid amount (AMT*D)* was not always the total of all payer paid amounts for all visits in the claim.

837P/837I Diagnosis Fix

An issue was corrected where sometimes claims for services after October 1, 2015 would use ICD-9 coding instead of ICD-10.

Visits Unmerge on Episode Update

Billing Matrix: Rollup Episode uses the admission and discharge dates of the episode to determine which visits to merge together. Changing the admission or discharge date changed the merging period which then caused visits to recalculate rates. This has been corrected so that batched and paid visits no longer recalculate when changing the episode.

Clinical

Syntax Error with Problem List Form Mapping

Problem Lists would display an error when the saving a form visit apostrophes in the diagnosis description. For example, when adding "(307.23/F95.2) Tourette's disorder" in a form, the error **Incorrect syntax near 's** would appear when saving the visit. Problem List form mapping now correctly handles apostrophes in the diagnosis description.

Tx Plus Fails to Expand Inside of a Visit

Occasionally, Tx Plus would not expand when viewed inside a form. This has been corrected.

eFax

Boxes Appear Unchecked When Sending PDF templates via eFax

Corrected an issue where checkboxes in PDF templates would display and print correctly but would appear unchecked when sending via eFax.

eRx

Medication Eligibility Fails

Corrected an issue where Medication Eligibility would return a **Subscriber/Insured Not Found** error even though the client does have coverage with the insurance.

Wrong Medication Refilled When Refilling a Prescription Order

When two users were simultaneously updating Physician's Orders for the same client, occasionally the wrong order would be updated. The correct physician's order is now updated, even if another user is updating an order for the same client at the same time.

Mobile

Credible Care App: Injected Diagnosis Missing Information

Corrected an issue for injected diagnosis questions where *Last Updated*, *Date Resolved*, and *Date Updated* fields did not appear in the Credible Care app.

NextGen Mobile Visits Missing ICD-10 Coding

When NextGen Mobile visits only contain ICD-9 codes, but the client's record has both ICD-9 and ICD-10 codes, the visit must be manually updated to receive the ICD-10 code. An issue was corrected wherein visits uploaded from NextGen Mobile were not being properly coded to ICD-10, even though the client had a diagnosis containing an ICD-10 code.

Visits uploaded via the Credible Care App have both ICD-9 and ICD-10 codes, and were unaffected by this issue.

No ICD-10 Diagnosis for Visits Uploaded via MobileForm

As issue was corrected where visits created and uploaded via MobileForm would not display ICD-10 diagnosis codes.

Reporting

Reports Tab Logout

An issue was corrected where users would sometimes be logged out on clicking the Reports tab.

Security

Credible BI Access Issues

An issue was corrected with Credible BI that caused the “You have previously logged in as...” message to display. Users can now re-access Credible BI without having to close their browser.