

My most recent writing was the online help for Opala's APIs. The public-facing portion of that help can be found here:

<https://docs.opala.com/hubfs/pub/Provider-Directory/providerDirectory.html?hsLang=en>

-Steven Gurr

# NetSolutions

## **NetSolutions HL7 Trigger Events & Message Definitions**

Reference

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HEALTH

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# Trigger Events

These are the events that will trigger a message and the message code.

Event	Event Code
Admit inhouse resident	A01
Transfer	A02
Discharge	A03
Register an outpatient	A04
Pre-admission	A05
Update Resident	A08
Cancel admit	A11
Cancel transfer	A12
Cancel discharge	A13
Pending discharge	A16
Swap	A17
Bed status update	A20
Resident goes on Leave	A21
Resident returns from leave	A22
Delete a patient record	A23
Cancel pending discharge	A25
Add patient info	A28
Delete patient info	A29
Merge patient info	A30
Update person (inbound messages only)	A31
Merge patient info – ID only	A34
Observation Result	ORU^R01
Change visit admit date	Z34
RUGS III Assessment (inbound only VK, inbound and outbound NS)	ZR3
RUGS IV Assessment (inbound only VK, inbound and outbound NS)	ZR4
MDS 3.0 / PDPM (inbound and outbound NS)	ZR5
Acknowledge receipt of ADT message	ACK

<b>MFN Event</b>	<b>Event Code</b>
Add record to master file	MAD
Update record in master file	MUP
Delete record from master file	MDL
Discontinue record in master file	MDC
Reactivate deactivated record in master file	MAC
Acknowledge receipt of MFN message	ACK

# Messages

## Introduction

For each HL7 message, this section lists the message structure Cantata Health supports. Note that Cantata Health includes all required segments and omits only those optional segments that are not used. Cantata Health Development has created a user-defined segment ZR1 to allow interfacing of fields NetSolutions captures that are not part of the HL7 standard.

HL7 messages are composed of groups and segments that use this hierarchy:

- A **message** contains groups and segments.
- A **segment** contains fields.
- A **field** contains components.
- A **component** contains subcomponents.

When looking at the structure of an HL7 message in this document:

- No brackets and no braces surrounding a segment indicate that the message must contain exactly one value for the segment and only one value.
- [...] (brackets) around a segment indicate that the message can contain either one or no value.
- {...} (braces) around a segment indicate that the message requires one or more values.
- [...] (brackets surrounding braces) around a segment indicate that the message can contain any number of values or no value at all.

## Admit a patient (A01)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
[ ZP1 ]	Additional Patient Information	
[ { NK1 } ]	Next of Kin	3
PV1	Patient Visit	3
PV2	Patient Visit 2	3
[ { AL1 } ]	Allergy Information	3
[ { DG1 } ]	Diagnosis Information	6
[ { GT1 } ]	Guarantor Information	6
[ { IN1 } ]	Insurance Information	6
[ZC1]	HIE Consent Information	
[ ZR1 ]	Resident Information	
[ ZR2 ]	Additional Resident Information	
[ ZPV ]	Additional Visit Information	
[ { ZAP } ]	Account-Plan Information	
[ { ZAG } ]	Account-Plan-Seg Information	
[ { ZAL } ]	Account-Plan Split Information	
[ { ZAX } ]	Account-Plan Private Portion Trx Information	
[ { ZRD } ]	Account-Plan Rolling Date Information	



[ ZNK ]	Additional Contact Information
[ ZGT ]	Additional Guarantor Information
[ ZHS ]	Hospital Stay Information

**Notes:**

- Re-reads the visit record into the buffer before processing the IN1 segment so that the proper Admission Date is used to determine the Plan Start Date.
- Automatically keeps any active apt/AL visit when an AL or SNF admission is received.

### Transfer a patient (A02)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
[ ZP1 ]	Additional Patient Information	
PV1	Patient Visit	3
[ZC1]	HIE Consent Information	
[ ZR1 ]	Resident Information	
[ ZPV ]	Additional Visit Information	

**Notes:**

For the outbound interface to Omnicare (Interface Name = OMNICARE):

- The ZRC segment is not sent as part of the A02 message.
- NetSolutions sends an A08 message following each A02 message triggered.

### Discharge a patient (A03)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	
EVN	Event Type	3
PID	Patient Identification	3
PV1	Patient Visit	3
[ ZPV ]	Additional Visit Information	

**Notes:**

- If a resident is on bed hold when discharged, the A03 message cancels the bed hold before discharging the resident.
- If a resident is discharged from an SNF visit and the resident has a kept apartment, NetSolutions discharges the SNF visit and no longer keeps the apartment.

## Register a patient (A04)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
[ ZP1 ]	Additional Patient Information	
[ { NK1 } ]	Next of Kin	3
PV1	Patient Visit	3
PV2	Patient Visit 2	3
[ { AL1 } ]	Allergy Information	3
[ { DG1 } ]	Diagnosis Information	6
[ { GT1 } ]	Guarantor Information	6
[ { IN1 } ]	Insurance Information	6
[ ZR1 ]	Resident Information	
[ ZR2 ]	Additional Resident Information	
[ ZPV ]	Additional Visit Information	
[ { ZAP } ]	Account-Plan Information	
[ { ZAG } ]	Account-Plan-Seg Information	
[ { ZAL } ]	Account-Plan Split Information	
[ { ZAX } ]	Account-Plan Private Portion Trx Information	
[ { ZRD } ]	Account-Plan Rolling Date Information	
[ ZNK ]	Additional Contact Information	
[ ZGT ]	Additional Guarantor Information	
[ ZHS ]	Hospital Stay Information	

## Pre-admission (A05)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
[ ZP1 ]	Additional Patient Information	
[ { NK1 } ]	Next of Kin	3
PV1	Patient Visit	3
PV2	Patient Visit 2	3
[ { AL1 } ]	Allergy Information	3
[ { DG1 } ]	Diagnosis Information	6
[ { GT1 } ]	Guarantor Information	6
[ { IN1 } ]	Insurance Information	6

[ZC1]	HIE Consent Information
[ ZR1 ]	Resident Information
[ ZR2 ]	Additional Resident Information
[ ZPV ]	Additional Visit Information
[ { ZAP } ]	Account-Plan Information
[ { ZAG } ]	Account-Plan-Seg Information
[ { ZAL } ]	Account-Plan Split Information
[ { ZAX } ]	Account-Plan Private Portion Trx Information
[ { ZRD } ]	Account-Plan Rolling Date Information
[ ZNK ]	Additional Contact Information
[ ZGT ]	Additional Guarantor Information
[ ZHS ]	Hospital Stay Information

**Note:**

When you disable a05 messages for prospects, NetSolutions also disables A03 and A08 messages for prospects as well.

### Update patient information (A08)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
[ ZP1 ]	Additional Patient Information	
[ { NK1 } ]	Next of Kin	3
PV1	Patient Visit	3
[ { AL1 } ]	Allergy Information	3
[ { DG1 } ]	Diagnosis Information	6
[ { GT1 } ]	Guarantor Information	6
[ { IN1 } ]	Insurance Information	6
[ZC1]	HIE Consent Information	
[ ZR1 ]	Resident Information	
[ ZR2 ]	Additional Resident Information	
[ ZPV ]	Additional Visit Information	
[ { ZAP } ]	Account-Plan Information	
[ { ZAG } ]	Account-Plan-Seg Information	
[ { ZAL } ]	Account-Plan Split Information	
[ { ZAX } ]	Account-Plan Private Portion Trx Information	
[ { ZRD } ]	Account-Plan Rolling Date Information	
[ ZNK ]	Additional Contact Information	
[ ZGT ]	Additional Guarantor Information	
[ ZHS ]	Hospital Stay Information	

**Note:**

NetSolutions holds all A08 transactions created when a resident is registered or when a resident's registration is updated for 10 minutes before sending. Whenever a user clicks the Next button during registration (or while updating registration) the record is saved and an A08 message generated. Holding the

messages prevents NetSolutions from creating new messages during the registration process and flooding the receiving application; instead, after 10 minutes a single A08 message containing all the new or updated information is sent.

## Cancel admit (A11)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
PV1	Patient Visit	3
[ ZPV ]	Additional Visit Information	

## Cancel transfer (A12)

A12 messages (Cancel Transfer) are received or routed only. NetSolutions does not trigger this message.

When NetSolutions receives an A12 message, the program reassigned the resident to the bed in the PV1 assigned patient location field.

If routing the A12, NetSolutions uses the prior bed information to populate the PV1-6 section (Prior Location) of the A12 message that is exported.

## Cancel discharge (A13)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
PV1	Patient Visit	3
[ ZPV ]	Additional Visit Information	

## Pending discharge (A16)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
PV1	Patient Visit	3

## Swap patients (A17)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient (1) Identification	3
PV1	Patient (1) Visit	3
ZPV	Additional (1) Visit Information	
PID	Patient (2) Identification	3
PV1	Patient (2) Visit	3
ZPV	Additional (2) Visit Information	

## Bed status update (A20)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
NPU	Non-patient Update	3

## Patient goes on a "leave of absence" (A21)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
[ ZP1 ]	Additional Patient Information	
PV1	Patient Visit	3
[ ZPV ]	Additional Visit Information	
[ ZHS ]	Hospital Stay Information	

## Patient returns from a "leave of absence" (A22)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
[ ZP1 ]	Additional Patient Information	
PV1	Patient Visit	3
[ ZR1 ]	Resident Information	
[ ZPV ]	Additional Visit Information	
[ ZHS ]	Hospital Stay Information	

## Delete a patient record (A23)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
PV1	Patient Visit	3

## Cancel pending discharge (A25)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
PV1	Patient Visit	3

## Add patient info (A28)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
[ ZP1 ]	Additional Patient Information	
[ { AL1 } ]	Allergy Information	3
[ { NK1 } ]	Next of Kin	3
PV1	Patient Visit	3
[ { DG1 } ]	Diagnosis Information	6
[ { GT1 } ]	Guarantor Information	6
[ { IN1 } ]	Insurance Information	6
[ ZR1 ]	Resident Information	
[ { ZAP } ]	Account-Plan Information	
[ { ZAG } ]	Account-Plan-Seg Information	
[ { ZAL } ]	Account-Plan Split Information	
[ { ZAX } ]	Account-Plan Private Portion Trx Information	
[ { ZRD } ]	Account-Plan Rolling Date Information	
[ ZNK ]	Additional Contact Information	
[ ZGT ]	Additional Guarantor Information	

## Delete patient info (A29)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2

EVN	Event Type	3
PID	Patient Identification	3
[ZC1]	HIE Consent Information	

### Merge patient info (A30)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
MRG	Merge Information	3

### Update person (A31)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
PV1	Patient Visit	3
[ZC1]	HIE Consent Information	
[{OBX}]	Observation/Result	
[{AL1}]	Patient Allergy Information	

**Note:**

The update person message (A31) is recognized by the interface for inbound messages and processed in the same manner as a update patient information (A08) message. The update person (A31) event is not supported for outbound ADT messages.

### Observation Result (ORU^R01)

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
PID	Patient Identification	3
PV1	Patient Visit	3
PV2	Patient Visit 2	3
[OBR]	Observation Request	

**Note:s**

- If the OBX has an OBX-3 value &GDT, the OBX-5 is processed as an IPN note. The note date is either OBX-14 or OBR-8 or OBR-7, whichever

has the first non-blank value. The physician name in OBX-16 is used in the note text to indicate who wrote the note. The IPN category for the note is Phys Notes.

- The R01 event has been added to the following interfaces: CCT, OptimaRehab, Casamba, and Standard HL7.

## **Merge patient information - patient ID only (A34)**

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
MRG	Merge Information	3

### **Note:**

The inbound A34 handler checks for the MRG-4 value on A34 messages. If this value is available and numeric, NetSolutions modifies the resident.epi\_number rather than the health\_rec\_nbr using the first component of the PID-2 value. If the MRG-4 value is present in the message but is not numeric, NetSolutions rejects the message. For A34 messages with no MRG-4 value, NetSolutions uses the MRG-1 value to identify the resident to be changed and the PID-3 value as the new health record number.

## **Update visit information (Z01)**

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
PV1	Patient Visit	3
Z01	RAM/Clinical Visit Information	
{ ZHS }	Hospital Stay Information	

## **Change admit date (Z34)**

<u>ADT</u>	<u>ADT Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
PV1	Patient Visit	3
ZR1	Resident Information	
ZOV	Original Visit Information	



**Note:**

The EVN event planned date and time are the new admit date and time.

**IRF-PAI (ZIR)**

<u>ZIR</u>	<u>ZIR Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
PV1	Patient Visit	3
{ ZIR }	Assessment scores	

**Resident Assessment (ZR3)**

<u>ZR3</u>	<u>ZR3 Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
PV1	Patient Visit	3
{ ZR3 }	Resident Assessment RUGS III	

**Resident Assessment (ZR4)**

<u>ZR4</u>	<u>ZR4 Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
PV1	Patient Visit	3
{ ZR4 }	Resident Assessment	

**MDS 3.0 / PDPM (ZR5)**

<u>ZR5</u>	<u>ZR4 Message</u>	<u>Chapter</u>
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
PV1	Patient Visit	3
{ ZR5 }	Resident Assessment	

## General acknowledgement

<u>ACK</u>	<u>ACK Message</u>	<u>Chapter</u>
MSH	Message Header	2
MSA	Message Acknowledgement	2
[ ERR ]	Error	2

## Master file update

<u>MFN</u>	<u>Master File Notification</u>	<u>Chapter</u>
MSH	Message Header	2
MFI	Master File Identification	8
MFE	Master File Entry	8
STF	Staff Identification	8
PRA	Practitioner	8

## Master file acknowledgement

<u>MFK</u>	<u>Master File Acknowledgement</u>	<u>Chapter</u>
MSH	Message Header	2
MSA	Acknowledgement	2
MFI	Master File Identification	8
MFA	Master file ACK segment	8

## Query for immediate response

<u>QRY</u>	<u>Query</u>	<u>Chapter</u>
MSH	Message Header	2
QRD	Query Definition	2

## Detailed financial transaction (DFT)

<u>DSR</u>	<u>Response</u>	<u>Chapter</u>
MSH	Message Header	2
PID	Patient Identification	3
PV1	Patient Visit	3
FT1	Financial Transaction	6



# Segments

For each Segment, this lists each data element. In the Required/Optional column, if HL7 has a field marked as Required, we include the field. For optional fields, we check mark the fields we send and take in. Fields marked either Required, Conditional, or with a check mark will be ignored by the Resident Accounting interface.

## AL1 - Allergy information

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI	R			00203	Set Id
2	2	ID			0127	00204	Allergy Type
3	60	CE	R			002-5	Allergy Code/Mnemonic/Description
4	2	ID			0128	00206	Allergy Severity
5	15	ST				00207	Allergy Reaction
6	8	DT				00208	Identification Date

### Field Notes:

- Set ID  
Start with 1 increment by 1 for each additional segment
- Allergy Type  
From table 127 - DA - Drug, FA - Food, MA – Miscellaneous  
For the interface ID BDMHL7 **only** NetSolutions includes the allergy type in segment AL1-2 as "DA". For example, AL1 | 1 | DA | ^NKA^ | | 20170505 |
- Allergy Code/Mnemonic/Description  
res-allergy.description  
Only use 2nd component. For example - ^allergy description^^^^  
Also, indicates if the resident has No Known Allergies. When a resident has No Known Allergies, the AL1 segment is sent like this: AL1 | 1 | ^NKA^ | | 20170505 |
- Allergy Severity  
res-allergy.severity or Y/N for ongoing for VCLIN interfaces
- Allergy Reaction  
res-allergy.reaction
- Identification Date  
res-allergy.id-date

## DG1 - Diagnosis

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI	R			00375	Set ID - diagnosis
2	2	ID	R		0053	00376	Diagnosis coding method
3	8	ID	—		0051	00377	Diagnosis code
4	40	ST	—			00378	Diagnosis description
5	26	TS	—			00379	Diagnosis date/time
6	2	ID	R		0052	00380	Diagnosis/DRG type
7	60	CE			0118	00381	Major diagnostic category
8	4	ID			0055	00382	Diagnostic related group
9	2	ID	—			00383	DRG approval indicator
10	2	ID			0056	00384	DRG grouper review code
11	60	CE			0083	00385	Outlier type
12	3	NM				00386	Outlier days
13	12	NM	—			00387	Outlier cost
14	4	ST				00388	Grouper version and type
15	2	NM				00389	Diagnosis/DRG priority
16	60	CN			0228	00390	Diagnosing clinician
17	3	IS	—		0136	00766	Diagnosis Classification
18	1	ID				00767	Confidential Indicator
19	26	TS				00768	Attestation Date/Time

### General Notes:

Standard ICD9 codes and descriptions are used.

NetSolutions accepts a delete marker DG1 segment to clear out all diagnoses.

- To clear out all ICD9 diagnoses send a single DG1|1|I9|"".
- To clear out all ICD10 diagnoses send a single DG1|1|I10|"".
- To clear out both send two DG1 segments DG1|1|I9|"" and DG1|2|I10|"".

### Field Notes:

- 1 Set ID - diagnosis  
start with 1 increment by 1 for each additional segment
- 2 Diagnosis coding Method:  
literal value 'I9' or 'I10'
- 3 Diagnosis code: (required by RAM)  
diagnoses.icd9-code when field 6 is admit  
dsch-diagnoses.icd9-code when field 6 is final  
for ICD-10 ICD10 code^ dx description^I10
- 4 Diagnosis Description:  
if diagnoses.user-desc is non-blank then use it else use icd9.icd9-description of diagnoses  
for ICD-10 this is blank
- 5 Diagnosis Date/Time:  
diagnoses.start-date for Admit diagnoses; visit.discharge-date for final diagnoses if available,  
otherwise, blank.
- 6 Diagnosis DRG type:  
literal values 'C' or 'F', for current or final  
The following types are accepted when not VistaKeane Clinicals:

Blank, A (admt), I (intermediate), AD, C, CU (current diagnosis) H (history), D (discharge), F (discharge diagnosis)

**NOTE:** When the DG1-6 segment contains an invalid value, NetSolutions gives a warning and the diagnosis is set as a current diagnosis.

For VistaKeane Clinicals - string containing one or more of the following literals: 'C' for current, 'F' for final/discharge, 'B' for part-b, 'L' for leave.

10 DRG Grouper Review Code:

if current diagnosis then 'Y' if part-b diagnosis, 'N' if not.

15 Diagnosis/DRG Priority:

if diagnosis is primary (sequence = 01) then '1' else '2';

when receiving, if '1' then sequence assigned to 01,

diagnoses sequenced in order they are received; for VistaKeane Clinicals sequence left alone, new ones added to end.

19 Attestation Date/Time:

diagnosis.stop-date, blank for discharge diagnoses

## DSP - Response to query

SEQ	LEN	DT	OPT	RP/#	TBL #	ITEM #	ELEMENT NAME
1	4	SI	O			00061	Set ID - DSP
2	4	SI	O			00062	Display Level
3	300	TX	R			00063	Data Line

### General Notes:

The DSP segment is used to contain data that has been preformatted by the sender for display. The semantic content of the data is lost; the data is simply treated as lines of text.

### Field Notes:

- 1 Set ID  
This will be empty
- 2 Display Level  
This will be empty
- 3 Data Line  
In response to query type 'ZAN' this will contain the Resident Account Number that corresponds to the Medical Record Number received.  
In response to query type 'ZBU', this will contain the description of the Business Unit associated with the bed the resident occupies.

## ERR - Error

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	80	CM	R	Y	0060	00024	Error Code and Location

### General Notes:

The error code is defined by the sender and reported by the receiver on the error log report. We will send and report up to sixty characters.

### Field Notes:

- 1 Error Code and Location  
Format "segment ID^sequence ID^field position^error code". This data will be ignored by this version of the interface. It is sent because it is required by HL7.

## EVN - Event type

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	3	ID	R		0003	00099	Event Type Code
2	26	TS	R			00100	Date/Time of Event
3	26	TS	—			00101	Date/Time Planned Event
4	3	ID			0062	00102	Event Reason Code
5	5	ID			0188	00103	Operator ID

### Field Notes:

- 1 Event code  
A three character code indicating the event that generated the message. The supported event codes are listed in the Trigger Events section of this document.
- 2 Date/Time of Event  
date and time the event occurs
- 3 Date/Time Planned Event  
date and time the event is to happen - admit date for A01, transfer date for A02, discharge date for A03, ...  
When the EVN-3 segment of an inbound HL7 message is left blank, NetSolutions puts the EVN-2 value in the EVN-3 position. EVN-3 is an optional field by the HL7 standard, though NetSolutions requires EVN-3 to have a value or else the message is rejected.
- 4 Event Reason Code  
In **A02**: used to identify whether a transfer is normal (to the same bed type):  
Empty - normal  
200 - normal  
210 - marks the apartment/alf as kept, then a new A01 can be sent to admit the resident into the snf bed  
212 - returns the kept apt/alf to active after a discharging an open snf visit with an A03  
NetSolutions reports an error if the EVN-4 value is invalid and rolls back any changes if an error occurs.



in **A21**: used to distinguish between a new leave and updating an already existing leave (could not use A22 because it has an order end date and it does not have the hold reason nor the hold provider):

- 800 - start a new leave

- 808 - update an already existing leave

in **A22**: used to distinguish between ending and canceling a leave:

- 800 - end a leave

- 802 - cancel a leave

## FT1 - Financial transaction

SEQ	LEN	DT	OPT	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI	O			00355	Set ID - FT1
2	12	ST	O			00356	Transaction ID
3	10	ST	O			00357	Transaction Batch ID
4	26	TS	R			00358	Transaction Date
5	26	TS	O			00359	Transaction Posting Date
6	8	IS	R		0017	00360	Transaction Type
7	80	CE	R		0132	00361	Transaction Code
8	40	ST	B			00362	Transaction Description
9	40	ST	B			00363	Transaction Description - Alt
10	6	NM	O			00364	Transaction Quantity
11	12	CP	O			00365	Transaction Amount - Extended
12	12	CP	O			00366	Transaction Amount - Unit
13	60	CE	O		0049	00367	Department Code
14	60	CE	O		0072	00368	Insurance Plan ID
15	12	CP	O			00369	Insurance Amount
16	80	PL	O			00133	Assigned Patient Location
17	1	IS	O		0024	00370	Fee Schedule
18	2	IS	O		0018	00148	Patient Type
19	60	CE	O	Y	0051	00371	Diagnosis Code - FT1
20	120	XCN	O	Y	0084	00372	Performed By Code
21	120	XCN	O	Y		00373	Ordered By Code
22	12	CP	O			00374	Unit Cost
23	22	EI	O			00217	Filler Order Number
24	120	XCN	O	Y		00765	Entered By Code
25	80	CE	O		0088	00393	Procedure Code
26	80	CE	O	Y	0340	01316	Procedure Code Modifier

### Field Notes:

- 4 Transaction Date  
date of service for transaction
- 6 Transaction Type  
when 'Credit' then t-ft1.t-seg-f-{@w-ft1-trx-type} = 'R'. /\* KIC \*/  
when 'Charge' then t-ft1.t-seg-f-{@w-ft1-trx-type} = 'C'. /\* KIC \*/  
when 'V' then t-ft1.t-seg-f-{@w-ft1-trx-type} = 'C'. /\* Pyxis Vend \*/  
when 'W' then t-ft1.t-seg-f-{@w-ft1-trx-type} = 'C'. /\* Pyxis Waste \*/
- 7 Transaction Code  
must match item.item-code from the RAM Item Profile
- 10 Quantity  
If an amount is present in field 11 and the sending interface ID is KEANECLIN, set the quantity to 1 and use the amount as the extended override price. Provide a warning if the quantity is changed to 1. IF the interface is not KEANECLIN and the quantity is not 1, treat the amount as the unit price.
- If there is no value in field 11, but a value in field 12 set the quantity to 1. Provide a warning if the quantity is changed to 1. Use the field 12 amount as the extended amount.
- 11 Transaction Amount Extended  
If null, omitted or 0 and field 12 is null, omitted or 0, then use the price from the Item Profile

### 12 Transaction Amount Unit

If null, omitted or 0 and field 12 is null, omitted or 0, then use the price from the Item Profile

Note that the handling of the amount fields is reversed as according to the 2.3 standard. This is a current program bug that will be addressed as needed.

## GT1 - Guarantor

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM #	ELEMENT NAME
1	4	SI	R			00405	Set ID - guarantor
2	20	CK	—			00406	Guarantor number
3	48	PN	R			00407	Guarantor name
4	48	PN				00408	Guarantor spouse name
5	106	AD	—			00409	Guarantor address
6	40	TN	—			00410	Guarantor ph num- home
7	40	TN	—	Y/3		00411	Guarantor ph num-business
8	8	DT		Y/3		00412	Guarantor date of birth
9	1	ID			0001	00413	Guarantor sex
10	2	ID			0068	00414	Guarantor type
11	2	ID	—		0063	00415	Guarantor relationship
12	11	ST				00416	Guarantor SSN
13	8	DT				00417	Guarantor date - begin
14	8	DT				00418	Guarantor date - end
15	2	NM				00419	Guarantor priority
16	45	ST				00420	Guarantor employer name
17	106	AD				00421	Guarantor employer address
18	40	TN				00422	Guarantor employ phone number
19	20	ST		Y/3		00423	Guarantor employee ID num
20	2	ID			0066	00424	Guarantor employment status
21	60	ST				00425	Guarantor organization
...							...
45	48	XPN				00748	Contact Person's Name

## Field Notes:

- 1 Set ID - guarantor  
always '1'
- 2 Guarantor number  
payor.short-name of guarantor
- 3 Guarantor name  
payor.payor-name of guarantor: last-name^first-name^middle-initial
- 5 Guarantor address  
payor.address-1^payor.address-2^payor.city^payor.state^payor.zip-code of guarantor
- 6 Guarantor ph num-home  
payor.phone of guarantor
- 7 Guarantor ph num-business  
guarantor.bus-phone
- 11 Guarantor relationship  
relation of guarantor; sent as relationID^relationDescription
- 21 Guarantor organization  
Organization name^notify in case of death ^notify in case of emergency^print guarantor statement
- 45 Guarantor contact

# IN1 - Insurance

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME	
1	4	SI	R	Y/3	0072	00426	Set ID - insurance	
2	8	ID	R			00427	Insurance plan ID	
3	6	ST	R			00428	Insurance company ID	
4	45	ST	—			00429	Insurance company name	
5	106	AD				00430	Insurance company address	
6	48	PN				00431	Insurance co. Contact pers	
7	40	TN				00432	Insurance co phone number	
8	12	ST				00433	Group number	
9	35	ST				00434	Group name	
10	12	ST				00435	Insured's group emp ID	
11	45	ST				00436	Insured's group emp Name	
12	8	DT				00437	Plan effective date	
13	8	DT				00438	Plan expiration date	
14	55	CM				00439	Authorization information	
15	2	ID	—			0086	00440	Plan type
16	48	PN				0063	00441	Name of insured
17	2	ID					00442	Insured's relationship to patient
18	8	DT					00443	Insured's date of birth
19	106	AD				0135	00444	Insured's address
20	2	ID		00445	Assignment of benefits			
21	2	ID		0173	00446		Coordination of benefits	
22	2	ST		0084	00447	Coord of ben. Priority		
23	2	ID			00448	Notice of admission code		
24	8	DT			00449	Notice of admission date		
25	2	ID		0094	00450	Rpt of eligibility code		
26	8	DT			00451	Rpt of eligibility date		
27	2	ID			0093	00452	Release information code	
28	15	ST			00453	Pre-admit cert (PAC)		
29	26	TS			00454	Verification date/time		
30	60	CN			00455	Verification by		
31	2	ID		0098	00456	Type of agreement code		
32	2	ID			0022	00457	Billing status	
33	4	NM			00458	lifetime reserve days		
34	4	NM		0042	00459	Delay before L. R. day		
35	8	ID			00460	Company plan code		
36	15	ST	—		00461	Policy number		
37	12	NM			00462	Policy deductible		
38	12	NM			00463	Policy limit - amount		
39	4	NM			00464	Policy limit - days		
40	12	NM			00465	Room rate - semi-private		
41	12	NM			00466	Room rate - private		
42	60	CE			0066	00467	Insured's employment status	
43	1	ID		0001	00468	Insured's sex		
44	106	AD			00469	Insured's employer address		
45	2	ST			00470	Verification status		
46	8	ID		0072	00471	Prior insurance plan ID		
49	250	CX	Y		01230	Insured's ID number		

**General Notes:**

The insurance segment is used to interface Medicare and Medicaid numbers and commercial insurer name and policy number. The policy number field is used for the Medicare, Medicaid and commercial policy number.

If you select the Include Only Active Insurance Plans checkbox on the Interface Definitions page, the IN1 segment skips IN1, ZAPs and ZAGs for inactive, voided, or ended plans.

**Field Notes:**

- 1 Set ID - insurance  
start with 1 increment by 1 for each additional segment
- 2 Insurance plan ID  
plan.hl7-plan-id
- 3 Insurance company ID  
first 6 positions of payor.payor-shortname
- 4 Insurance company name  
payor.payor-name
- 15 Plan Type  
MR (Medicare), MD (Medicaid), PV (private), CO (commercial)
- 17 Insured's relationship to patient  
the ANSI Individual Relationship Code from the Reimb Table/Policy Info when the payor type for a resident is Commercial.  
if the ANSI Individual Relationship Code is blank, the value in the 1500 Box No/Other Code is sent instead.  
if both these fields are blank and the receiving app is QS1 then the value 00 is sent in IN1-17  
if the receiving app is not QS1 then the IN1-17 is left blank
- 22 Coordination of benefits Priority – Priority sequence of insurance; for RAM this is the value of Set ID
- 35 Company plan code  
when the payor is Medicare then this field is 'A' when the payor is Medicare A and 'B' when it is Medicare B; the payor.payortype-type field is used
- 36 Policy number  
resident.medicaid-num or resident.medicare-num or  
acc-plan.group-number depending on field 15  
updates the Policy Holder ID field on the Plan Summary page when an inbound message containing this segment adds or updates a commercial insurance plan.

## MDM-T02 - Original document notification and content

The HL7 MDM message helps manage medical records by transmitting new or updated documents, or by transmitting important status information and/or updates for the record. The MDM-T02 contains the original document notification and the document contents.

NetSolutions uses the MDM-T02 segment to import IPN Progressed Notes using the OptimaRehab or HL7 Generic interface types.

### General Notes:

The OBX segment is an important part of MDM-T02 messages, which include document contents. It is used to separate the body contents from places where headings or other separations might occur. Message types that include document contents are significantly longer, and may have repeating OBX segments depending on how much data needs to be conveyed.

## MFA - Master file acknowledgement segment

SEQ	LEN	DT	C	RP/#	TBL#	ITEM#	ELEMENT NAME
1	3	ID	R		0180	00664	Record-level event code
2	20	ST	C			00665	MFN control ID
3	26	TS	C			00668	Event completion date/time
4	60	CE	R		0181	00669	Error return code and/or text
5	60	CE	R	Y		00670	Primary key value

### Field Notes:

- 1 Record-level event code  
Return record-level event code from MFE segment of initial message
- 2 MFN control-ID  
omit
- 3 Event completion date/time  
omit
- 4 Error return code and/or text  
sender defined error code or text - receiver will display on error log
- 5 Primary key value  
Primary key value from MFE segment of initial message

## MFE - Master file entry

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	3	ID	R		0180	00664	Record-level event code
2	20	ST	C			00665	MFN control ID
3	26	TS				00666	Effective date/time

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
4	60	CE	R	Y		00667	Primary key value

**Field Notes:**

- 1 Record-level event code  
'MAD' 'MUP' 'MDL' 'MDC' 'MAC'
- 4 Primary key value  
For PRA (practitioner master file) - physician.upin

**MFI - Master file identification**

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	60	CE	R	N	0175	00658	Master file identifier
2	6	ID			0176	00659	Master file application identifier
3	3	ID	R		0178	00660	File-level event code
4	26	TS				00661	Entered date/time
5	26	TS				00662	Effective date/time
6	2	ID	R		0179	00663	Response level code

**General Notes:**

Keane will support record level event processing only. MFN messages will always be acknowledged whether errors exist or not.

**Field Notes:**

- 1 Master file identifier  
Identifies a standard HL7 master file or site-specific (Z) file. Use one of the following:

PRA - Practitioner Master

Only the first component, the identifier, will be used here.

- 3 File-level event code  
value 'UPD'
- 6 Response level code  
value 'AL'

**MRG - Merge information**

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	20	C	R			00211	Prior Patient ID - Internal
2	16	M				00212	Prior Alternate Patient ID
3	20	ST				00213	Prior Patient Account Number
4	16	CK				00214	Prior Patient ID - External



### General Notes:

This segment is used in the A30 event (Merge patient info) to identify patient, whose info needs to be changed and in the A34 event (Merge patient info - ID only) to identify that the patient's primary ID number has changed.

### Field Notes:

- 1 Prior Patient ID - Internal  
resident.mrnum in A30 and visit.mrnum/resident/health\_rec\_nbr in A34 (depending on the facility medical record number resident or visit setting)  
Also propagates updates to resident.medical\_rec\_nbr, and the fields in the residentNumbers table.

- 4 Prior Patient ID – External  
Used to update the resident epi\_number to a new value  
For A34 messages, if MRG-4 value is present, the resident.epi\_number is updated with the PID-2 value and the medical record numbers are not.

Any other field values in the PID segment are also applied to the resident (ie name, address,...)

## MSA - Message acknowledgement

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	2	ID	R		0008	00018	Acknowledgement Code
2	20	ST	R			00019	Message Control ID
3	80	ST	—			00020	Text Message
4	15	N				00021	Expected Sequence Number
5	1	M			0102	00022	Delayed Acknowledgement Type
6	100	ID CE				00023	Error Condition

### Field Notes:

- 1 Acknowledgement code  
values 'AA' 'AR' or 'AE' from table 18
- 2 Message Control ID  
message number of message which this acknowledges
- 3 Text Message  
if the acknowledgement code is AR or AE then this text will give a summary description of why the message was rejected. This information will also be written to the Interface Error Log.

## MSH - Message header

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	1	ST	R			00001	Field separator
2	4	ST	R			00002	Encoding characters
3	15	ST	—			00003	Sending application
4	20	ST	—			00004	Sending facility
5	30	ST	—			00005	Receiving application
6	30	ST	—			00006	Receiving facility
7	26	TS	—			00007	Date/time of message
8	40	ST				00008	Security
9	7	C	R		0076	00009	Message type
10	20	M	R			00010	Message control ID
11	1	ST	R		0103	00011	Processing ID
12	8	ID	R		0104	00012	Version ID
13	15	ID				00013	Sequence number
14	180	N				00014	Continuation pointer
15	2	M			0155	00015	Accept acknowledgement type
16	2	ST			0155	00016	Application acknowledgement type
17	2	ID				00017	Country code
		ID					
		ID					

### Field Notes:

- Field Separator:  
let's use HL7 recommended "|"
- Encoding Characters:  
four separators: component, repetition, escape, sub-component. Let's use HL7 recommended ^~\&
- Sending Application:  
User-defined three character code (we suggest RAM for outbound messages)
- Sending Facility:  
facility.facility-code for outbound messages
- Receiving Application:  
User-defined three character code (we suggest RAM for inbound messages)
- Receiving Facility:  
001, 002, 003, ...  
If omitted on inbound we will assume 001.
- Date/Time of Message:  
YYYYMMDDHHmm
- Message Type:  
ADT, ACK, MFN, MFK  
Can also be the Message Type followed by '^' and then the event type. For example, 'ADT^A03'
- Message Control ID:  
format 9999999 increasing from one by one - rolls over to 1 at value 9999999.
- Processing ID:  
[D]ebugging, [P]roduction, [T]raining. When 'D' messages may be viewed and modified before being processed.
- Version ID:  
value '2.2' or '220' or '2.3'

## NK1 - Next-of-kin

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI	R			00190	Set ID - Next of Kin
2	48	PN	—			00191	Name
3	60	CE	—		0063	00192	Relationship
4	106	AD	—			00193	Address
5	40	TN	—	Y/3		00194	Phone Number
6	40	TN	—			00195	Business Phone Number
7	60	CE	—		0131	00196	Contact Role
8	8	DT				00197	Start Date
9	8	DT				00198	End Date
10	60	ST				00199	Next of Kin Job Title
11	20	C				00200	Next of Kin Job Code/Class
12	20	M	—			00201	Next of Kin Employee Number
13	60	ST				00202	Organization Name
...		ST	—				...
33	30	CX				00751	Next of Kin/Associated Party's Identifiers

### Field Notes:

- Set ID - Next of Kin  
increment by 1 for each next of kin/contact.
- Name  
last-name^first-name^middle-initial^modifier^title
- Relationship  
relation of contact.relation-code  
This is sent as relationID^relationDescription
- Address  
address1, address2, city, state, zip-code
- Phone Number  
PhoneNumber ^TelecommunicationUseCode^.TelecommunicationEquipmentType^  
EmailAddress  
Repeating element  
Home phone number:  
TelecommunicationUseCode = "PRN" .TelecommunicationEquipmentType = "PH"  
Other personal phone number:  
TelecommunicationUseCode = "ORN" .TelecommunicationEquipmentType = "PH"
- Business Phone Number  
PhoneNumber ^TelecommunicationUseCode^.TelecommunicationEquipmentType  
Repeating element  
Office number  
TelecommunicationUseCode = "WPN" .TelecommunicationEquipmentType = "PH"  
Pager number  
TelecommunicationUseCode = "WPN" .TelecommunicationEquipmentType = "BP"  
Fax number  
TelecommunicationUseCode = "WPN" .TelecommunicationEquipmentType = "FX"  
Cell number  
TelecommunicationUseCode = "WPN" .TelecommunicationEquipmentType = "CP"  
Modem number  
TelecommunicationUseCode = "WPN" .TelecommunicationEquipmentType = "MD"

Email address

TelecommunicationUseCode = "NET" .TelecommunicationEquipmentType = "x.400"

7 Contact Role

roleID^roleDescription

The role associated with the contact. If more than one role is associated with the contact, a separate NK1 segment will be sent for each one.

13 Organization Name

This field is made of the following four parts:

agency name^notify in case of death indicator^notify in case of emergency indicator^print statement indicator

33 Next of Kin/Associated Party's Identifiers

Value^^^IdentifierTypeCode

Repeating element

Notes

.IdentifierTypeCode = "TypeCode " Value = role.hl7-id

.IdentifierTypeCode = "Comments" Value = contact.comments

.IdentifierTypeCode = "Rank" Value = rank of contact within role

## NPU - Non-patient update

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	12	C	R		0079	00209	Bed Location
2	1	M			0116	00170	Bed Status
		ID					

### Field Notes:

1 Bed Location

bed.bed-name^bed-status where bed-status = C for closed or U for unoccupied.

example - 2E^201^A^C - bed is closed

## OBX - Result

SEQ	LEN	DT	OPT	RP/#	TBL#	ITEM #	ELEMENT NAME
1	10	SI	O			00569	Set ID - OBX
2	3	ID	C		0125	00570	Value Type
3	590	CE	R			00571	Observation Identifier
4	20	ST	C			00572	Observation Sub-ID
5	65536	*	C	Y <sup>1</sup>		00573	Observation Value
6	60	CE	O			00574	Units
7	60	ST	O			00575	References Range
8	5	ID	O	Y/5	0078	00576	Abnormal Flags
9	5	NM	O			00577	Probability
10	2	ID	O	Y	0080	00578	Nature of Abnormal Test
11	1	ID	R		0085	00579	Observation Result Status

### Field Notes:

OBX-1: Always 1

OBX-2: ED

OBX-3: CCD^

OBX-5: 5<sup>th</sup> component - Base 64 encoded CCD xml for the given patient identified in the PID segment

For **ORU^R01** messages, if the OBX has an OBX-3 value &GDT, the OBX-5 is processed as an IPN note. The note date is either OBX-14 or OBR-8 or OBR-7, whichever has the first non-blank value. The physician name in OBX-16 is used in the note text to indicate who wrote the note. The IPN category for the note is Phys Notes; this category is added if it does not already exist.

OBX-11: F

## PID - Resident identification

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI				00104	Set ID - Patient ID
2	16	CK				00105	Patient ID (External ID)
3	20	CM	R	Y		00106	Patient ID (Internal ID)
4	12	ST				00107	Alternate Patient ID
5	48	PN	R			00108	Patient Name
6	30	ST	—			00109	Mother's Maiden Name
7	8	DT	—			00110	Date of Birth
8	1	ID	—		0001	00111	Sex
9	48	PN	—	Y		00112	Patient Alias
10	1	ID	—		0005	00113	Race
11	106	AD	—	Y/3		00114	Patient Address
12	4	ID	—			00115	County Code
13	40	TN	—	Y/3		00116	Phone Number - Home
14	40	TN	—	Y/3		00117	Phone Number - Business
15	25	ST				00118	Language - Patient
16	1	ID	—		0002	00119	Marital Status
17	3	ID	—		0006	00120	Religion
18	20	CK	—			00121	Patient Account Number
19	16	ST	—			00122	SSN Number - Patient
20	25	CM				00123	Driver's Lic Num - Patient
21	20	CK				00124	Mother's Identifier
22	1	ID			0189	00125	Ethnic Group
23	25	ST	—			00126	Birth Place
24	2	ID				00127	Multiple Birth Indicator
25	2	NM				00128	Birth Order
26	3	ID	—	Y		00129	Citizenship
27	60	CE				00130	Veterans Military Status
28	80	CE				00131	Nationality
29	26	TS	—			00132	Patient Death Date and Time
30	1	ID	—			00133	Patient Death Indicator

### Field Notes:

- 3 Patient ID (Internal ID)  
visit.mrnum  
When the interface ID is RehabOptima, NetSolutions appends ^^^HR^ to the end of the health record number in PID-3 for outbound messages, as required by the 2.3 HL7 standard.
- 5 Patient Name  
resident.last-name, etc
- 6 Mother's Maiden Name  
resident.mother-name (may or may not be maiden name depending on what user enters)
- 7 Date of Birth  
resident.date-of-birth
- 8 Sex  
resident.sex - translate O to U on inbound
- 10 Race  
race.hl7-id of resident
- 11 Patient Address  
resident.adress-1, etc

- 12 County Code  
county.hl7-id of resident^county.description
- 13 Phone Number - Home  
resident.phone
- 15 Language – Patient  
Code-list.map-id of Resident.prim-lang^ Code-list.code-text of Resident.prim-lang
- 16 Marital Status  
resident.marital - translate A to X  
A - Separated  
C - Couple  
D - Divorced  
M - Married  
S - Single  
U - Unknown  
W - Widowed
- 17 Religion  
religion.hl7-id of resident
- 18 Patient Account Number  
account.account-code
- 19 SSN Number - Patient  
resident.ssn  
When NetSolutions processes incoming messages it indicates a missing social security number by placing a null in this field.
- 23 Birthplace  
resident.birthplace
- 26 Citizenship  
citizenship.hl7-id
- 29 Patient Death Date and Time  
Visit discharge date and time if federal discharge code indicates resident is expired.
- 30 Patient Death Indicator  
Y if federal discharge code indicates resident is expired otherwise N.

## PRA - Practitioner

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	20	ST	R			00685	PRA - primary key value
2	60	CE		Y		00686	Practitioner group
3	3	ID		Y		00687	Practitioner Category
4	1	ID			0186	00688	Provider Billing
5	100	CM		Y	0187	00689	Specialty
6	100	CM	—	Y		00690	Practitioner ID Numbers
7	200	CM		Y		00691	Privileges

### Field Notes:

- 1 PRA - primary key value  
physician.upin
- 6 Practitioner ID Numbers  
format is number^type^state  
ignore last component (state)  
repeating field separated by ~

use UPIN, MCR, MCD, LIC, and NPI for UPIN, Medicare, Medicaid, license, and National Provider ID

example:

physician.license-num^LIC~physician.upin^UPIN~physician.medicaid-num^MCD~physician.medicare-num^MCR~NPI^physician.npi

## PV1 - Visit

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI				00131	Set ID - Patient Visit
2	1	ID	R		0004	00132	Patient Class
3	12	CM	—			00133	Assigned Patient Location
4	2	ID	—		0007	00134	Admission Type
5	20	ST				00135	Preadmit Number
6	12	CM				00136	Prior Patient Location
7	60	CN	—		0010	00137	Attending Doctor
8	60	CN	—		0010	00138	Referring Doctor
9	60	CN	—	Y	0010	00139	Consulting Doctor
10	3	ID	—		0069	00140	Hospital Service
11	12	CM			0079	00141	Temporary Location
12	2	ID			0087	00142	Preadmit Test Indicator
13	2	ID	—		0092	00143	Readmission Indicator
14	3	ID	—		0023	00144	Admit Source
15	2	ID		Y	0009	00145	Ambulatory Status
16	2	ID			0099	00146	VIP Indicator
17	60	CN	—		0010	00147	Admitting Doctor
18	2	ID			0018	00148	Patient Type
19	15	NM				00149	Visit Number
20	50	CM	—	Y/4	0064	00150	Financial Class
21	2	ID			0032	00151	Charge Price Indicator
22	2	ID			0045	00152	Courtesy Code
23	2	ID			0046	00153	Credit Rating
24	2	ID		Y	0044	00154	Contract Code
25	8	DT		Y		00155	Contract Effective Date
26	12	NM		Y		00156	Contract Amount
27	3	NM		Y		00157	Contract Period
28	2	ID			0073	00158	Interest Code
29	1	ID			0110	00159	Transfer to Bad Debt Code
30	8	DT				00160	Transfer to Bad Debt Date
31	10	ID			0021	00161	Bad Debt Agency Code
32	12	NM				00162	Bad Debt Transfer Amount
33	12	NM				00163	Bad Debt Recovery Amount
34	1	ID			0111	00164	Delete Account Indicator
35	8	DT				00165	Delete Account Date
36	3	ID	—		0112	00166	Discharge Disposition
37	25	CM	—		0113	00167	Discharged to Location
38	2	ID			0114	00168	Diet Type
39	2	ID			0115	00169	Servicing Facility
40	1	ID			0116	00170	Bed Status
41	2	ID			0117	00171	Account Status
42	12	CM	—			00172	Pending Location
43	12	CM				00173	Prior Temporary Location



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SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
44	26	TS	—			00174	Admit Date/Time
45	26	TS	—			00175	Discharge Date/Time
46	12	NM				00176	Current Patient Balance
47	12	NM				00177	Total Charges
48	12	NM				00178	Total Adjustments
49	12	NM				00179	Total Payments
50	20	CM			xxxx	00180	Alternate Visit ID

### General Notes:

HL7 does not define the size of the unit, room and bed fields of the various resident location fields. The field sizes of these components are user-defined in Resident Accounting and should easily be mapped to any foreign system's requirements.

If the incoming HL7 message has a Physician ID with more than 7 components and the 8th component is blank, NetSolutions defaults the ID type to UPIN and processes the physician based on UPIN.

Send "" for any blank components.

### Field Notes:

- 2 Resident Class:  
I=in O=out P=preadmit
- 3 Assigned Resident Location:  
bed.bed-name of visit - format " Building + Station^Room^Bed" where Building + Station is a concatenation of the two text values.  
The lengths of the component fields are controlled by the Area Unit Room Bed position and lengths in the Facility General Parameters page. For incoming messages the system separates the Building+Station into its fields based on the Area and Unit position and lengths.
- 4 Admission Type:  
admtype.hl7-id of visit.admission-type
- 7 Attending Doctor:  
physician.upin,name of vis-phy - format "id^last^first^middle^suffix^title^degree^id type"  
**Notes:**
  - NetSolutions does not use the *degree* portion.
  - *id type* can be either an NPI or UPIN. If this portion is left blank, NetSolutions assumes UPIN.
- 8 Referring Doctor:  
physician.upin,name of vis-phy - format "id^last^first^middle^suffix^title^degree^id type"  
**Notes:**
  - NetSolutions does not use the *degree* portion.
  - *id type* can be either an NPI or UPIN. If this portion is left blank, NetSolutions assumes UPIN.
- 9 Consulting Doctor:  
physician.upin of vis-phy format "id^last^first^middle^suffix^title^degree^id type"  
**Notes:**
  - NetSolutions does not use the *degree* portion.
  - *id type* can be either an NPI or UPIN. If this portion is left blank, NetSolutions assumes UPIN.
- 10 Medical Service:  
business-unit.hl7-id of visit.bu-pl

13 Re-Admission indicator:

value 'R' if this is a readmission

14 Admit source:

admsource.hl7-id of visit.admission-source

17 Admitting Doctor:

physician.upin,name of vis-phy - format "id^last^first^middle^suffix^title^degree^id type"

**Notes:**

- NetSolutions does not use the *degree* portion.
- *id type* can be either an NPI or UPIN. If this portion is left blank, NetSolutions assumes UPIN.

19 Visit Number:

- In a one-way interface originating from NetSolutions, the value of PV1-19 will be the NetSolutions visit code from visit.visit\_code in the form 10818^^E (E indicates the value is external to the receiving system).
- In two-way interfaces where the registration was created by an incoming A01/A04/A05 with a PV1-19 value present, NetSolutions returns the external system's original value as 1939^^I (I indicates the value is internal to the receiving system).  
NetSolutions maintains a cross-walk of received numbers to its internally generated visit\_code values, and returns the cross-walked value when available. If no cross-walk value is present for the visit\_code, then the NetSolutions value is returned in the form 10818^^E.

20 Financial class:

values: Medicare, Medicaid, Commercial, Private, Guarantor

format "class^effective date". Class in user defined table 64. Up to 4 occurrences.

36 Discharge disposition:

dschrcode.mds\_value of visit.federal\_discharge\_code

User defined table 112.

37 Discharge to location:

visit.discharge-destination

User defined table 113.

42 Pending Location:

bed.bed-name of future dated visitseg of visit

44 Admit Date/Time:

visit.admit-date, visit.admit-time

45 Discharge Date/Time:

visit.discharge-date, visit.discharge-time

## PV2 - Visit 2

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	12	CM				00181	Prior Pending Location
2	60	CE			0129	00182	Accommodation Code
3	60	CE				00183	Admit Reason
4	60	CE				00184	Transfer Reason
5	25	ST		Y		00185	Patient Valuables
6	25	ST				00186	Patient Valuables Location
7	2	ID			0130	00187	Visit User Code
8	8	DT				00188	Expected Admit Date
9	8	DT				00189	Expected Discharge Date

### General Notes:

This segment is sent on A01 and A04 events only for integration with Keane clinical systems which require an admit reason. The first diagnosis description is used since RAM does not carry a separate field for this. If no diagnoses are entered, then blank is sent. The segment is not processed on inbound ADT events.

### Field Notes:

- 3 Admit Reason:  
lcd9.description of first diagnoses record for visit

## QRD - Query

SEQ	LEN	DT	OPT	RP/#	TBL#	ITEM #	ELEMENT NAME
1	26	TS	R			00025	Query Date/Time
2	1	ID	R		0106	00026	Query Format Code
3	1	ID	R		0091	00027	Query Priority
4	10	ST	R			00028	Query ID
5	1	ID	O		0107	00029	Deferred Response Type
6	26	TS	O			00030	Deferred Response Date/Time
7	10	CQ	R		0126	00031	Quantity Limited Request
8	60	XCN	R	Y		00032	Who Subject Filter
9	60	CE	R	Y	0048	00033	What Subject Filter
10	60	CE	R	Y		00034	What Department Data Code
11	20	CM	O	Y		00035	What Data Code Value Qual.
12	1	ID	O		0108	00036	Query Results Level

### General Notes:

The QRD segment is used to define a query.

### Field Notes:

- 1 Query date/time  
date the query was generated by the application program
- 2 Query format code  
D = Response is in display format
- 3 Query priority  
The time frame in which the response is expected. Values come from *HL7 table 0091*.  
I = Immediate
- 4 Query ID  
A unique identifier for the query. Assigned by the querying application. Returned intact by the responding application.
- 5 Deferred response type  
This optional field will be ignored. Values come from *HL7 table 0107*.
- 6 Deferred response date/time  
This optional field will be ignored. The date/time before or after which to send a deferred response.
- 7 Quantity limited request  
Unit values come from *HL7 table 0126*. 1^LI means one line.
- 8 Who subject filter  
identifies the subject, or who the inquiry is about.  
<Medical Record Number> ^ <Last name> ^ <first name> ^ <middle initial>
- 9 What subject filter  
Describes the kind of information that is required to satisfy the request. Values come from *HL7 table 0048*.  
'ZAN' will be used to request the account number associated with the resident.  
'ZBU' will be used to request the Business Unit associated with the bed the resident is in.
- 10 What department data code  
This field will be empty.
- 11 What data code value qualifier  
Optional date value (in hl7 format). Used to find the account code or business unit for a specific date. If a date is not specified, the account code or business unit as of the current date (or last discharge if resident is discharged) is returned.

### 12 Query results level

This optional field will be ignored. It is used to control level of detail in results. Refer to *HL7 table 0108 - Query results level* for valid values.

## STF - Staff identification

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	60	CE	R			00671	STF - primary key value
2	60	CE		Y		00672	Staff ID Code
3	48	PN	—			00673	Staff Name
4	2	ID	—	Y	0182	00674	Staff Type
5	1	ID			0001	00111	Sex
6	8	DT				00110	Date of Birth
7	1	ID			0183	00675	Active/inactive
8	200	CE		Y	0184	00676	Department
9	200	CE		Y		00677	Service
10	40	TN	—	Y		00678	Phone
11	106	AD	—	Y/2		00679	Office/Home Address
12	26	CM		Y		00680	Activation Date
13	26	CM		Y		00681	Inactivation Date
14	60	CE		Y		00682	Backup Person ID
15	40	ST		Y		00683	E-mail Address
16	1	ID		Y	0185	00684	Preferred PhoneMethod of Contact

### Field Notes:

- 1 STF - Primary Key Value  
physician.upin
- 3 Staff Name  
physician.last-name, physician.first-name physician.middle,...
- 4 Staff Type  
physician.hl7-type one of  
"PHY", "THE", "DEN", "POD"
- 10 Phone  
physician.phone
- 11 Office/home address  
physician.address-1,...

## TXA - Transcription documentation

### TXA Segment Transcription Documentation

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI	R			00914	Set ID- TXA
2	30	IS	R		0270	00915	Document Type
3	2	ID	C		0191	00916	Document Content Presentation
4	26	TS	O			00917	Activity Date/Time
5	60	XCN	C	Y		00918	Primary Activity Provider Code/Name
6	26	TS	O			00919	Origination Date/Time
7	26	TS	C			00920	Transcription Date/Time
8	26	TS	O	Y		00921	Edit Date/Time
9	60	XCN	O	Y		00922	Originator Code/Name
10	60	XC	O	Y		00923	Assigned Document Authenticator
11	48	XCN	C	Y		00924	Transcriptionist Code/Name
12	30	EI	R			00925	Unique Document Number
13	30	EI	C			00926	Parent Document Number
14	22	EI	O	Y		00216	Placer Order Number
15	22	EI	O			00217	Filler Order Number
16	30	ST	O			00927	Unique Document File Name
17	2	ID	R		0271	00928	Document Completion Status

#### Field Notes:

NetSolutions uses an abbreviated TXA segment.

TXA-1: Always 1

TXA-2: CCD

TXA-12: ccd\_history.ccd\_snbr^CN

TXA-17: AU

## Z01 - RAM/Clinical visit information

SEQ	LEN	DT	R/O	RP/#	TBL #	ITEM#	ELEMENT NAME
1	1	ST					Pay Day of Discharge

### Field Notes:

#### 1 Pay Day of Discharge indicator

If day of discharge is paid for then 'Y' else 'N'.

**Note:** When using the Z01 message to communicate more than the pay day of discharge indicator (like hospital stay information), the pay day of discharge indicator will be null.

## ZAP - Account-Plan information

The ZAP and associated segments (ZAG, ZAL, ZAX, and ZRD) are used to transmit reimbursement table information. They are included in any HL7 message that includes an IN1 segment. (Note: The ZAP and associated segments are not included in VistaKEANE RAM/Clinical interface messages. It may make the HL7 message too long for the Clinical import to handle and the Clinical application does not process them anyway.)

SEQ	LEN	DT	R/O	RP/#	TBL #	ITEM#	ELEMENT NAME
1		N					Account Code
2		M					Internal ID (accp-code)
3		N					Assign Benefits Indicator
4		M					Billed Thru Date
5		ST					Days Left
6		DT					Days Left date
7		N					Days-used-at-admit
8		M					Deductible date
9		DT					Deductible paid
10		N					Dollars left
11		M					Dollars-used-at-admit
12		DT					Employer address
13		N					Employer city
14		M					Employer name
15		N					Employer state
16		M					Employer Zip
17		N					Employment Status
18		M					Plan End Date
19		ST					Group name
20		ST					Group number
21		ST					Policy Holder Address-1
22		ST					Policy Holder Address-2
23		ST					Policy Holder City



## NetSolutions Trigger Events and Message Definitions

[illegible]

SEQ	LEN	DT	R/O	RP/#	TBL #	ITEM#	ELEMENT NAME
		ST					

**General Notes:**

One ZAP per acc-plan record in the reimbursement table. ZAP-39 (sequence) determines the order. The ZAG, ZAL, ZAX, and ZRD segments associated with the acc-plan follow the ZAP (in that order).

**Field Notes:**

- 1 Resident Account  
acc-plan.account-code
- 2 Internal ID of Account Plan.  
acc-plan.accp-code
- 3 Assign Benefits Indicator  
"Y" or "N"
- 4 Billed Thru Date  
acc-plan.billed-thru
- 5 Days Left  
acc-plan.days-left
- 6 Days Left Date  
acc-plan.days-left-date
- 7 Days used at admit  
acc-plan.days-used-at-admit
- 8 Deductible Date  
acc-plan.deductible-date
- 9 Deductible Paid  
acc-plan.deductible-paid
- 10 Dollars Left  
acc-plan.dollars-left
- 11 Dollars used at admit  
acc-plan.dollars-used-at-admit
- 18 Plan End Date  
acc-plan.end-date
- Plan Inactivated Date  
acc-plan.inactivated-date
- 37 Relation to Policy Holder  
acc-plan.relation-to-holder
- 38 Release Info Indicator  
acc-plan.release-info-ind
- 39 Sequence  
acc-plan.sequence
- 40 Plan Start Date  
acc-plan.start-date
- 41 Kept Apt days used at admit  
acc-plan.kapt-days-used-at-admit
- 42 Anniversary Date  
acc-plan.anniversary-date
- 43 Void Indicator  
if acc-plan.void then 'Y' else 'N'
- 44 Spell End Date  
acc-plan.spell-end-date = " then "" else v-accp-spell-end-dtm)

- 48 New Spell Indicator  
If hospital stay is a new spell then "Y" else "N"
- 50 Visit Admit Date  
Admit date of visit the hospital stay is associated with.
- 51 Original Sequence  
If sequence of plan has been changed, this is what it was.
- 52 Bills Thru Date  
acc-plan.bills-thru
- 53 Employment Information Data  
acc-plan.employment-info
- 54 Policy Holder Email Address  
acc-plan.holder-email
- 55 Policy Holder phone1  
acc-plan.holder-phone1
- 56 Policy Holder phone1 type  
"home", "work/office", "fax", "cell", "pager", "modem", "other" (acc-plan.holder-phone1-type)
- 57 Policy Holder phone2  
acc-plan.holder-phone2
- 58 Policy Holder phone2 type  
"home", "work/office", "fax", "cell", "pager", "modem", "other" (acc-plan.holder-phone2-type)
- 59 Policy Holder phone3  
acc-plan.holder-phone3
- 60 Policy Holder phone3 type  
"home", "work/office", "fax", "cell", "pager", "modem", "other" (acc-plan.holder-phone3-type)
- 61 Policy Holder phone4  
acc-plan.holder-phone4
- 62 Policy Holder phone4 type  
"home", "work/office", "fax", "cell", "pager", "modem", "other" (acc-plan.holder-phone4-type)
- 63 Policy Holder phone5  
acc-plan.holder-phone5
- 64 Policy Holder phone5 type  
"home", "work/office", "fax", "cell", "pager", "modem", "other" (acc-plan.holder-phone5-type)
- 65 ANSI Individual Relationship Code  
acc-plan.individual-relationship-code
- 66 Policy Signature Source Code  
acc-plan.patient-signature-source-code
- 67 future-use  
acc-plan.future-use

## ZAG - Account-Plan-Seg information

Error! Bookmark not defined. SEQ	LEN	DT	R/O	RP/#	TBL #	ITEM#	ELEMENT NAME

Error! Book mark not defined. SEQ	LEN	DT	R/O	RP/#	TBL #	ITEM#	ELEMENT NAME
1		ST					Set ID
2		N					Account Code
3		M					Co-Insurer
4		ST					Copayor Revenue Indicator
5		ST					End Date
6		DT					Plan Description
7		ST					Private Portion
8		N					Reimbursement Rate
9		M					Reimbursement Unit
10		N					Start Date
11		M					Treatment Authorization Code
12		ST					Deductible Plan
13		DT					Over Max Limit Plan
14		ST					Under Min Limit Plan
15		ST					Level
16		ST					Coinsurance Rate
17		ST					Coinsurance Unit
18		ST					Authorized By
19							Deductible Payor
20		ST					Resource Amount
21							Future Use
22							Admit Date Override
		ST					
		DT					

**General Notes:**

One ZAG per acc-plan-seg record associated with the acc-plan.

**Field Notes:**

- 1 Set Id  
start with 1 increment by 1 for each additional segment
- 2 Resident Account  
acc-plan.account-code
- 3 Co-Insurer  
Plan Description of co-insurer. Blank if no co-insurer.
- 4 Co-payor Revenue Indicator  
If acc-plan-seg.copayor-revenue = yes then 'Y' else 'N'.
- 5 End Date  
End date of segment
- 6 Plan Description  
Plan description of associated plan.
- 10 Start Date  
Start date of segment.

**12 Deductible Plan**

Plan description of deductible plan. Blank if not deductible plan.

**13 Over Max Limit Plan**

Plan description of over maximum limit plan.

**14 Under Min Limit Plan**

Plan description of under minimum limit plan.

**15 Level**

If plan is equiv exempt, then plan level assigned to the plan.

**22 Admit Date Override**

If plan set to override admit date this is a new admit date

**ZAL - Account-Plan-Split information**

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1		ST					Set ID
2		N					Internal ID (accp-code)
3		M					Portion Amount
4		N					Portion Type
5		M					Plan Description
6		ST					Sequence
7		ST					future-use
		N					
		M					
		ST					

**General Notes:**

One ZAL per acc-plan-split record associated with the acc-plan.

**Field Notes:**

- 1 Set Id  
start with 1 increment by 1 for each additional segment
- 2 Internal ID of associated Account Plan.  
accp-code of associated acc-plan
- 3 Portion Amount  
acc-plan-split.portion amount
- 4 Portion Type  
"F" if fund portion, "P" if private portion
- 5 Plan Description  
If private portion split, plan description of plan.
- 6 Sequence  
acc-plan-split.sequence
- 7 future-use  
acc-plan-split.future-use

**ZAX - Account-Plan private portion trx information**

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1		ST					Set ID
2		N					Account Code
3		M					Plan Description
4		ST					Private Portion
5		N					Start Date
6		M					Transaction Date
		DT					
		DT					

**General Notes:**

One ZAX per priv-port-trx associated with the account and plan.

**Field Notes:**

- 1 Set Id  
start with 1 increment by 1 for each additional segment
- 2 Resident Account  
acc-plan.account-code
- 3 Plan Description  
Plan description of associated plan.
- 4 Private Portion  
Private portion amount.
- 5 Start Date  
priv-port-trx.start-date.
- 6 Transaction Date  
priv-port-trx.trx-date

**ZC1 - HIE consent information**

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	2	ST	R				HIE Consent
2	8	Dt	O				Consent Date

**General Notes:**

The ZC1 segment is part of an A01, A04 and A05 message. It also triggers the creation of an A08 message with the ZC1 segment also included in that message.

**Field Notes:**

- 1 HIE Consent  
Y (Accepted), N (Declined) or NA (Not Asked)
- 2 Consent Date  
The date the consent form was signed by the resident.

## ZGT - Additional guarantor information

The ZGT segment includes additional guarantor information not included in the GT1 segment.

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI	R				Set ID - set id of associated GT1 segment
2	1	ST					Notify In Case Of Emergency
3	1	ST					Notify In Case Of Death
4	1	ST					Print Statement

### Field Notes:

- Set ID  
must match the set id of the associated GT1 segment.
- Notify In Case Of Emergency  
guarantor.notify-emergency; "Y" for yes "N" for no.
- Notify In Case Of Death  
guarantor.notify-death; "Y" for yes, "N" for no.
- Print Statement  
guarantor.statement-ind; "Y" for yes "N" for no.

## ZHS - Hospital stay information

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI					Set ID - Hospital Stay
2	7	N					RAM ID
3		M					Hospital Admit Date
4		DT					Hospital Discharge Date
5	50	DT					Hospital Name
6	1	ST					New spell of illness indicator
7	16	ST					Hospital Provider Number

### Field Notes:

- Set ID - Hospital Stay  
increment by 1 for each hospital stay.
- RAM ID for Hospital Stay  
The unique internal code given to the hospital stay record when created in RAM.
- Hospital Admit Date  
hosp-stay.hospital-admit-date
- Hospital Discharge Date  
hosp-stay.hospital-discharge-date
- Hospital Name  
hosp-stay.hospital-name

- 6 New spell of illness  
if hosp-stay.new-spell = yes then "Y" else "N"
- 7 Hospital Provider Number  
hosp-stay.provider-num

The system sends ZHS|""<CR> if there are no hospital stay records. The system deletes all hospital stays if that segment is the only one received.

## ZNK - Additional contact information

The ZNK segment includes additional contact information not included in the NK1 segment.

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI	R				Set ID - set id of associated NK1 segment
2	1	ST					Notify In Case Of Emergency
3	1	ST					Notify In Case Of Death
4	1	ST					Print Statement

### Field Notes:

- 1 Set ID  
must match the set id of the associated NK1 segment.
- 2 Notify In Case Of Emergency  
contact.notify-emergency; "Y" for yes "N" for no.
- 3 Notify In Case Of Death  
contact.notify-death; "Y" for yes, "N" for no.
- 4 Print Statement  
contact.statement-ind; "Y" for yes "N" for no.

## ZOV - Original visit information

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	14	TS					The visit's original admit date and time
2	14	TS					The visit's new admit date and time
3		ST					The visit's new override bed rate

### Field Notes:

- 1 Original admit date and time
- 2 New admit date and time
- 3 New Override Rate  
Override Amount ^Override Unit for the bed order associated with this Event.



## ZP1 - Additional patient information

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1		ST					Primary payer
2		ID					Education
3		ST					Occupation
4		ST					English Speaking Ability
20		ST					Part D Plan Info
21		ST					Resident Control Number

### Field Notes:

- 1 Primary payer: HL7 id of the visit's primary plan for the given message date  
For vclin interfaces this is hl7 id^end date~hl7 id^end date~...~hl7 id
- 2 Education: HL7 id of resident.education
- 3 Occupation: resident.occupation
- 4 English Speaking Ability: resident.lang-ability ("none","poor","fair","good","excellent")
- 20 Part D Plan Info: state code^plan description^effective date^resident plan ID. State code is ZZ for federal plans
- 21 Resident Control Number: resident.rcn – internal resident number

## ZPV - Additional visit information

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1		ST					OBSOLETE: Hospital Provider Num
2		DT					OBSOLETE: Hospital Admit Date
3		DT					OBSOLETE: Hospital Discharge Date
4		ST					OBSOLETE: Hospital Name
5	10	ST					Visit User Field 1
6	10	ST					Visit User Field 2
7	20	ST					Visit User Field 3
8	20	ST					Visit User Field 4
9	30	ST					Visit User Field 5
10	30	ST					Visit Source Description
11	8	DT					Account Start Date
12							Order Override Amount
13	30	ST					Discharge Destination Description
14	3	ID					State Discharge HL7 id
15	16	ST					Discharge Provider Number
16	8	ST					Hold Reason
17		ST					OBSOLETE: Hold Provider Number
18	60	CN					Operating Physician
19	60	CN					Physical Therapist
20	10	ST					Arrived By
21	3	ST					State Admit Source
22	1	ST					Hold Type
23	60	CN					Ophthalmologist Physician
24	60	CN					Occupational Therapist

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
25	60	CN					Speech Therapist
26	30	ST					Visit User Field 6

**Field Notes:**

- 1 – 4 Formerly hospital information fields. These are no longer used. They are superseded by ZHS information.
- 5 – 9 User fields from the visit record  
visit.user1, visit.user2, visit.user3, visit.user4, visit.user5
- 10 Visit Source Description  
visit-source.description for the visit.source-code
- 11 Account Start Date  
account.start-date format yyyymmdd
- 12 Order Override Amount  
Override Rate, if any, for the bed order associated with this Event.
- 13 Discharge Destination Description  
Visit-dest.description for visit-dest.dest-code that matches visit.dest-code
- 14 State Discharge HL7 ID  
dschcode.hl7-id for the dschcode.discharge-code that matches visit.state-discharge-code
- 15 Discharge Provider Number  
visit.discharge-provider-num
- 16 Hold Reason  
visitseg.hold-reason
- 17 No Longer Used
- 18 Operating Physician  
physician.upin,name of vis-phy - format "physician upin id^ last^first^mi"
- 19 Physical Therapist  
physician.upin,name of vis-phy - format "physician upin id^ last^first^mi" (repeating)
- 20 Arrived By  
Visit.arrived-by
- 21 State Admit Source  
admsource.hl7-id of visit.state-admission-source
- 22 Hold Type  
RAM sends "H" or "P" depending on the hold. RAM translates the VistaKEANE Clinical (VC) hold types as follows:  
VC value of F → RAM's H  
VC value of L or H → RAM's P
- 23 Ophthalmologist Physician  
physician.upin,name of vis-phy - format "physician upin id^ last^first^mi"
- 24 Occupational Therapist  
physician.upin,name of vis-phy - format "physician upin id^ last^first^mi" (repeating)
- 25 Speech Therapist  
physician.upin,name of vis-phy - format "physician upin id^ last^first^mi" (repeating)

## ZR1 - Resident information

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	15	ST					Occupation
2	156	ST					Church
3	156	ST					Pharmacy
4	156	ST					Mortuary
5	60	CN					Alternate Physician
6	60	CN					Dentist
7	60	CN					Podiatrist
8	10	CN					Clinical LOC
9	44	ST					Financial LOC

### Field Notes:

- 1 Occupation  
resident.occupation
- 2 Church  
resident.church – org-name^addr1^city^state^zip^phone^contact name
- 3 Pharmacy  
resident.pharmacy - org-name^addr1^city^state^zip^phone^contact name
- 4 Mortuary  
resident.funeral-home - org-name^addr1^city^state^zip^phone^contact name
- 5 Alternate Phy  
physician.upin,name of vis-phy - format "physician id^ last^first^mi"
- 6 Dentist  
physician.upin,name of vis-phy - format "physician id^ last^first^mi"
- 7 Podiatrist  
physician.upin,name of vis-phy - format "physician id^ last^first^mi"
- 8 Clinical LOC  
input data element - store in new field visit.clin-loc
- 9 Fin LOC  
payor-level.level-name of visit for primary plan ^ visitseg.equiv

## ZR2 - More resident information

(fields not captured elsewhere)

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	10	ST	O				Code Status
2	40	ST	O				Father's name
3	30	ST	O				Medicaid number
4	14	ST	O				Medicare number
5	40	ST	O				Mother's name
6	30	ST	O				Other ID number
7	50	ST	O				Resident user field 1
8	50	ST	O				Resident user field 2

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
9	50	ST	O				Resident user field 3
10	50	ST	O				Resident user field 4
11	50	ST	O				Resident user field 5
12	1	ST	O				Veteran Status
13	30	ST	O				Welfare number
14	156	ST	O				Ambulance Service
15	40	ST	O				Spouse's name
16	1	ST	O				Resident statement indicator

**Field Notes:**

12 Veteran Status

"Y" or blank

14 Ambulance Service

resident.ambulance - org-name^addr1^city^state^zip^phone^contact name

**ZR3 - RUGS III Assessment**

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	8	DT	R				Reference Date
2	3	ST	O				RUGIII Score
3	1	ST	O				Type
4	1	ST	O				Frequency
5	2	ST	O				Modifier
6	2	CD	O				Assessment Status
7	8	DT	O				Census From Date
8	8	DT	O				Census To Date
9	5	ST	O				Tracking Number ATN
10	2	ST	O				Sequence Number ASN
11	2	ST	O				Action

**Field Notes:**

1 Reference Date

The reference date for the assessment

2 RUGIII Score

One of the HCFA defined RUG III codes

3 Type

A single number indicating the type of assessment (full,comprehensive,...) from question AA8A of the MDS 2.0 assessment.

4 Frequency

A single number indicating which period the assessment is for (5 day, 14 day...) from question AA8B of the MDS 2.0 assessment.

5 Modifier

The HIPPS modifier. When this field is present, the Type and Frequency will be ignored and not required. Blank for Inactivation record.

6 Assessment Status

This value identifies the status of the assessment using a code: 5 = Final assessment; all other values = Interim.

7 Census From Date

- 8 Census To Date
- 9 Tracking Number ATN  
Assessment Tracking Number assigned by Clinical product. Modifications and Inactivations have the same ATN.
- 10 Sequence Number  
HCFA defined number assigned to Modifications and Inactivations. Blank for original assessments; 1-99 for Inactivations and Modifications.
- 11 Action  
Code indicating deleted and/or inactivated assessments.  
"D" = deleted, "I" = inactivated, "DI" = delete Inactivated record, blank for all other cases.

## **ZR4 - RUGS IV Assessment**

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	8	DT	R				Entry/Reentry date
2	8	DT	R				Reference Date
3	7	ST	R				RUG IV Score Rehab
4	7	ST	R				RUG IV Score non-Rehab
5	2	ST	O				Assessment Status
6	8	DT	O				Therapy Start Date
7	8	DT	O				Therapy End Date
8	2	ST	O				Federal OBRA Reason for Assessment
9	2	ST	O				PPS Assessment
10	1	ST	O				PPS Other Medicare Required
							Assessment –OMRA
11	11	ST	R				Unique MDS identifier
12	14	ST	O				Correction number^Unique MDS identifier
13	2	ST	O				Action
14	1	ST	O				Version
15	20	ST	O				Billing Periods for Keane PatCom interface only
16	8	DT	O				Medicare stay start date
17	8	DT	O				Medicare stay end date
18	8	DT	O				Resumption of Therapy

### **Field Notes:**

- 1 Entry/reentry date—YYYYMMDD  
The entry/reentry date from the assessment (A1600)
- 2 Reference Date—YYYYMMDD  
The reference date for the assessment (A2300)
- 3 RUGIV Score Rehab  
One of the HCFA defined RUG IV codes (Z0100A), which includes the modifier.
- 4 RUGIV Score non-Rehab  
One of the HCFA defined RUG IV codes (Z0150A), which includes the modifier.
- 5 Assessment Status  
Active –Assessment \_status <> 14 AND Assessment \_status < 90  
Inactivation –Assessment \_status = 14
- 6 Therapy Start Date – YYYYMMDD  
Send the earliest date from O0400A5, O0400B5, or O0400C5

- 7 Therapy End Date – YYYYMMDD  
Send the latest date from O0400A6, O0400B6, or O0400C6. Or if one of the mentioned fields has 8 dashes then no date should be sent. The 8 dashes indicate that therapy is continuing in that discipline.
- 8 Federal OBRA Reason for Assessment (A0310A)
- 9 PPS Assessment (A0310B)
- 10 PPS Other Medicare Required Assessment –OMRA (A0310C)
- 11 Unique MDS identifier  
MDS\_snbr
- 12 Correction number ^Unique MDS identifier  
Correction number = X0800  
Unique MDS identifier = MDS\_snbr of the corrected assessment  
(Attested\_MDS\_snbr)
- 13 Action Code indicating inactivation assessment.  
I = Inactivation, blank for all other cases.
- 14 Version 3 = MDS 3.0
- 15 Billing Periods For outbound PatCom interface only  
MMDDYYYY^MMDDYYYY^##
- 16 Medicare stay start date – YYYYMMDD  
Start date of most recent Medicare stay (A2400B)
- 17 Medicare stay end date  
End date of most recent Medicare stay (A2400C)
- 18 Resumption of Therapy  
Date that Therapy restarted (O0450B)

For the PatCom interface Billing Periods

For standard PPS assessments, A310A would equal 1 or 99 and A310B would be 1-6. The AI portion of the HIPPS code would be: first digit 1-5 and the second digit would be 0 (zero)

## ZR5 - PDPM Assessment

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	8	DT	R				Entry/Reentry date
2	8	DT	R				Reference Date
3	7	ST	R				PDPM HIPPS code
4	2	ST	O				Assessment Status
5	2	ST	O				Federal OBRA Reason for Assessment
6	2	ST	O				PPS Assessment
7	11	ST	R				Unique MDS identifier
8	14	ST	O				Correction number^Unique MDS identifier
9	2	ST	O				Action
10	1	ST	O				Version
11	8	ID	O				Primary ICD Code

### Field Notes:

- 1 Entry/reentry date—YYYYMMDD  
The entry/reentry date from the assessment (A1600)
- 2 Reference Date—YYYYMMDD  
The reference date for the assessment (A2300)

- 4 PDPM HIPPS Code  
One of the HCFA defined PDPM HIPPS codes (Z0100A), which includes the modifier.
- 5 Federal OBRA Reason for Assessment (A0310A)
- 6 PPS Assessment (A0310B)
- 7 Unique MDS identifier  
MDS snbr
- 8 Correction number ^Unique MDS identifier  
Correction number = X0800; Unique MDS identifier = MDS\_snbr of the corrected assessment; (Attested\_MDS\_snbr)
- 9 Action Code indicating inactivation assessment.  
I = Inactivation, blank for all other cases.
- 10 Version 3 = MDS 3.0
- 11 Primary diagnosis code (I0020B)

## ZRC - Insurance

This segment is used to identify primary payers by effective date. It is used in older Omnicare interfaces; later Omnicare interfaces use the IN1 segments instead.

SEQ	ELEMENT NAME	
1	Set ID - ZRC	Not used
2	Start Date	Start date plan is effective
3	End Date	Last date plan is effective
4	Patient Identifier List	HRNum^^^PN~account_code ^^FI
5	Assigned Patient Location	Not used
6	Admit Date	Not used
7	Plan(Type)	HL7 Plan ID
8	Policy(Number)	Not used
9	Guarantor(Name)	Not used
10	Guarantor(Address)	Not used
11	Guarantor Phone Number - Home	Not used
12	Guarantor(Relationship)	Not used
13	Insurance Company Name	Not used
14	Name of Insured	Not used
15	Level of Care	Y/N - Rx Paid by Facility

### Field Notes:

- 3 End Date  
This value is no longer sent to OmniCare.

## ZRD - Account-Plan rolling date information

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1		ST					Set ID
2		N					Resident Account
3		M					Internal ID (accp-code)
4		N					Sequence
5		M					Type of Limit
6		N					Anniversary Date
7		M					BillThru Date
8		ST					Plan Description
9		DT					Payor Shortname
10		DT					Quantity
11		ST					Level of Care
12		ST					Item Description
		N					
		M					
		ST					
		ST					

### General Notes:

One ZRD per rolling-date record associated with the acc-plan.

### Field Notes:

- 1 Set Id  
start with 1 increment by 1 for each additional segment
- 2 Resident Account  
acc-plan.account-code
- 3 Internal ID of associated Account Plan.  
accp-code of associated acc-plan
- 4 Sequence  
Rolling-date.sequence
- 5 Type of Limit  
rolling-date.type
- 6 Anniversary Date  
rolling-date.start-date
- 7 BillThru Date  
rolling-date.billthru-date
- 8 Plan Description  
Plan description of associated acc-plan.
- 9 Payor Shortname  
Payor shortname of associated acc-plan.
- 10 Quantity  
rolling-date.qty
- 11 Level of Care  
rolling-date.level
- 12 Item Description  
item.billing-description of associated item.



## Example Admit Transaction

```
MSH|^~\|LS+RAM|MCM|MCHART|MCM|199308181126||ADT^A01|MSG00001|P|2.3|<cr>
EVN|A01|199308181123||<cr>
PID|||PATID1234^5^M11||JONES^WILLIAM^A^JR||19310615|M||C|1200 N ELM
STREET^GREENSBORO^NC^27401-1020|GL|(919)379-1212|
(919)271-3434||M||PATID12345001^2^M10|123456789|987654^NC|<cr>
NK1|1|JONES^BARBARA^K|WIFE|<cr>
PV1|||C^201^01|||004777^LEBAUER^SIDNEY^J.||SUR|||ADM|AO|<cr>
DG1|1|I9|41300||19941212181126|ADMIT|<cr>
DG1|2|I9|41302||19941212181126|ADMIT|<cr>
DG1|1|I10|50.22^Chronic systolic (congestive) heart
failure^I10||20150707000000|C|||N|||002|||""|<cr>
DG1|2|I10|J15.29^Pneumonia due to other
staphylococcus^I10||20150707000000|C|||N|||001|||""|<cr>
GT1|...|<cr>
ZR1|Plumber|St. Matthews|Rite-
Aid||12345^Watson^Tim|12929^James^Martha|02933^Roberts^Harold<cr>
```

The message header indicates:

- the HL7 recommended separators are being used
- this transaction is sent by the Leadership Plus Resident Accounting Application at the facility known within it's larger organization as MCM to the MasterChart application at the same facility
- the message was created August 8, 1993 at 11:26 am.
- this is an ADT message that has been assigned control number MSG00001 by the sending system
- this is an actual production [P] message based on HL7 version 2.3

The event segment indicates:

- this is an admit that occurred August 8, 1993 at 11:23 am.

The PID (resident identifier) segment indicates:

- internal resident ID is PATID1234 which has a check-digit= 9 using the Mod11 scheme
- the Resident is William A. Jones Jr., born June 15, 1931, male caucasian
- his address in Greensboro, North Carolina with county code= GL
- his home and business phone numbers
- he is married
- he is assigned billing account number PATID12345001, check digit 2, Mod10 scheme
- his SSN is 123-45-6789 and his North Carolina drivers license # is 987654

The next-of-kin segment indicates:

- his wife Barbara K. Jones

The visit segment indicates:

- there is a visit set ID of 1 and this is an inpatient visit
- the resident is in unit C room 201 bed 1.
- attending doctor is Sidney J. Lebauer (ID= 004777)
- resident is admitted to Geriatric service with ambulatory status= AO

The two diagnosis segments indicate the ICD9 diagnoses

The guarantor segment indicates guarantor information

The Resident Information segment indicates other resident information not carried by the HL7 standard

## Example Financial Transaction

MSH|^~\&|PYXIS|RAM|RAM|BILLFAC|20010207121746||DFT^P03|EVM^020701121746|P|2.3||  
PID|||1386|1386|JONES^MARTHA|||||||||||  
PV1|||2E^124^^2E|||||||||||  
**FT1**|||20010207|20010207|V|270^GLOVE VINYL POWDER FREE  
MED|||1|10|||||||BAAR^MARNE, CHRISTINA|^|

## Resident Accounting Field Sizes and Datatypes

This table shows all Resident Accounting data fields that are involved in the interface, which segments they are used in and their field sizes. This table will be important during implementation since some of our fields sizes are larger than the HL7 standard - profiles must be setup to accommodate the interface field sizes. This table will also be useful for producers of interfacing systems in matching our fields to theirs.

Field Name	Segments	Data-type/Size
diagnoses.icd9-code	DG1	x(6)
icd9.icd9-description	DG1	x(40)
diagnoses.begin-date	DG1	standard HL7
payor.shortname	GT1,IN1	x(10)
payor.payor-name	GT1,IN1	x(40)
payor.address-1	GT1	x(30)
payor.address-2	GT1	x(30)
payor.city	GT1	x(25)
payor.state	GT1	x(2)
payor.zip-code	GT1	x(10)
payor.phone	GT1	9(10)
relation.relation	GT1	x(2)
resident.last-name	PID	x(20)
resident.first-name	PID	x(20)
resident.middle-initial	PID	x(1)
resident.name-modifier	PID	x(3)
resident.address-1, address-2, city, state, zip-code	PID	same as payor. fields
resident.phone	PID	9(10)
resident.date-of-birth	PID	standard HL7
resident.sex	PID	x(1)
resident.ssn	PID	9(9)
plan.hl7-id	IN1	x(8)
payor.payor-shortname	IN1,GT1	x(10) - HL7 limits to x(6) for IN1
resident.medicaid-num	IN1	x(30) - HL7 limits to 15

<b>Field Name</b>	<b>Segments</b>	<b>Data-type/Size</b>
resident.medicare-num	IN1	x(14)
acc-plan.group-number	IN1	x(17) - HL7 limits to 15
physician.upin	MFE,STA,PRA, PV1,ZR1	x(20)
kin.last-name,first-name,middle- initial, modifier, title	NK1	same as resident. fields
relation.relation	NK1	x(2)
kin.address-1, address2, city, state, zip-code	NK1	same as resident. fields
kin.phone-number	NK1	9(10)
visit.mrnum	PID	x(15)
race.hl7-id	PID	x(1)
county.hl7-id	PID	x(4)
resident.marital	PID	x(1)
religion.religion	PID	x(3)
account.account-code	PID	9(9)
resident.ssn	PID	9(9)
physician.license-num	PRA	x(20)
physician.medicaid-num	PRA	x(20)
physician.medicare-num	PRA	x(20)
bed.bed-name	PV1	x(10) - unit, room, bed field sizes user-defined within the 10
admttype.hl7-id	PV1	x(1)
business-unit.hl7-id	PV1	x(3)
admsrc.hl7-id	PV1	x(3)
dschrcode.hl7-id	PV1	x(3)
visit.discharge-destination	PV1	x(15) - free text
visit.admit-date	PV1	standard HL7
visit.discharge-date, visit.discharge-time	PV1	standard HL7
physician.physician-last	STF	x(20)
physician.physician-first	STF	x(15)
physician.physician-middle	STF	x(1)
physician.phone	STF	9(10)

Field Name	Segments	Data-type/Size
physician.address-1, address-2, city, state, zip-code	STF	same as resident fields
resident.occupation	ZR1	x(15)
resident.church	ZR1	x(25)
resident.funeral-home	ZR1	x(30)
resident.pharmacy	ZR1	x(25)

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# NetSolutions

**ADT**

**7.1**

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**Training Guide**

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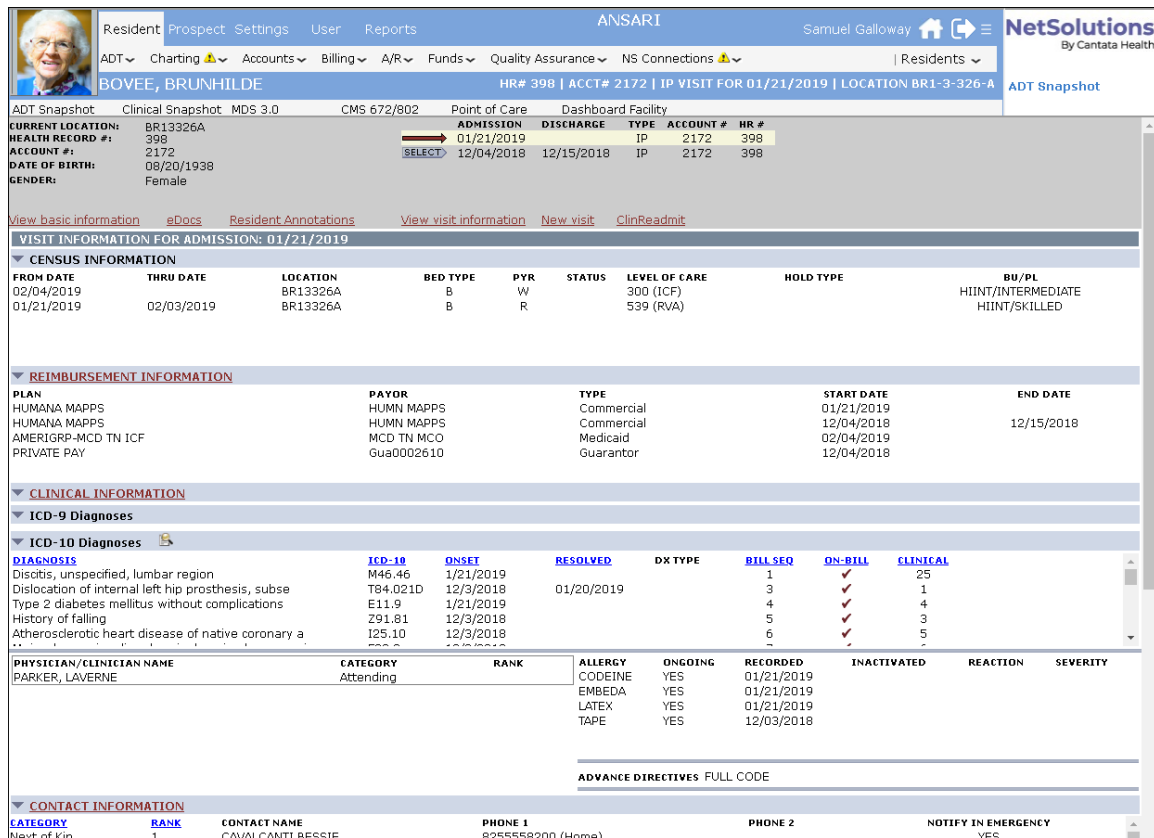
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# Introduction to ADT

Welcome to NetSolutions ADT. The ADT program enables you to collect and manage resident visit information and maintain your facility's census data. You can admit, discharge, transfer residents, and maintain such resident information as demographic data, contacts, physicians, guarantors, and insurance. You can view bed availability and select beds for residents, make bed holds, transfers and swaps, and maintain information about guests and other visitors.



Resident Prospect Settings User Reports

ANSARI Samuel Galloway

NetSolutions By Cantata Health

ADT Charting Accounts Billing A/R Funds Quality Assurance NS Connections Residents

BOVEE, BRUNHILDE HR# 398 | ACCT# 2172 | IP VISIT FOR 01/21/2019 | LOCATION BR1-3-326-A

ADT Snapshot Clinical Snapshot MDS 3.0 CMS 672/802 Point of Care Dashboard Facility

CURRENT LOCATION: BR13326A

HEALTH RECORD #: 398

ACCOUNT #: 2172

DATE OF BIRTH: 08/20/1938

GENDER: Female

ADMISSION: 01/21/2019

DISCHARGE: 12/15/2018

TYPE: IP

ACCOUNT #: 2172

HR #: 398

[View basic information](#)
[eDocs](#)
[Resident Annotations](#)
[View visit information](#)
[New visit](#)
[ClinReadmit](#)

VISIT INFORMATION FOR ADMISSION: 01/21/2019

CENSUS INFORMATION

FROM DATE	THRU DATE	LOCATION	BED TYPE	PYR	STATUS	LEVEL OF CARE	HOLD TYPE	BU/PL
02/04/2019		BR13326A	B	W		300 (ICF)		HIINT/INTERMEDIATE
01/21/2019	02/03/2019	BR13326A	B	R		539 (RVA)		HIINT/SKILLED

REIMBURSEMENT INFORMATION

PLAN	PAYOR	TYPE	START DATE	END DATE
HUMANA MAPPS	HUMN MAPPS	Commercial	01/21/2019	
HUMANA MAPPS	HUMN MAPPS	Commercial	12/04/2018	12/15/2018
AMERIGRP-MCD TN ICF	MCD TN MCO	Medicaid	02/04/2019	
PRIVATE PAY	Gua0002610	Guarantor	12/04/2018	

CLINICAL INFORMATION

ICD-9 Diagnoses

ICD-10 Diagnoses

DIAGNOSIS	ICD-10	ONSET	RESOLVED	DX TYPE	BILL SEQ	ON-BILL	CLINICAL
Disoids, unspecified, lumbar region	M46.46	1/21/2019			1	✓	25
Dislocation of internal left hip prosthesis, subse	T84.021D	12/3/2018	01/20/2019		3	✓	1
Type 2 diabetes mellitus without complications	E11.9	1/21/2019			4	✓	4
History of falling	Z91.81	12/3/2018			5	✓	3
Atherosclerotic heart disease of native coronary a	I25.10	12/3/2018			6	✓	5

PHYSICIAN/CLINICIAN NAME	CATEGORY	RANK	ALLERGY	ONGOING	RECORDED	INACTIVATED	REACTION	SEVERITY
PARKER, LAVERNE	Attending		CODEINE	YES	01/21/2019			
			EMBEDA	YES	01/21/2019			
			LATEX	YES	01/21/2019			
			TAPE	YES	12/03/2018			

ADVANCE DIRECTIVES FULL CODE

CONTACT INFORMATION

CATEGORY	RANK	CONTACT NAME	PHONE 1	PHONE 2	NOTIFY IN EMERGENCY
Next of Kin	1	CAVALCANTI BESSIE	8255558200 (Home)		YES

Use NetSolutions ADT to register clients as inpatients or outpatients, to preregister prospective clients, and to admit pre-registered prospects to the facility. Enter information about hospital stays and other status changes.

ADT provides a wide array of reports for viewing resident information and census data. You can print a full resident roster, or print resident information relating to charge cards, contacts, physicians, birthdays, and pending discharges. Census reports provide information on daily activity, statistics, history, and bed and status changes. ADT reports provide flexible reporting criteria to enable you to view the data you need in the format you want to see it.

Need help? Send an email to Cantata Health Product Support.





# Settings

## Overview

When you install ADT, it automatically includes setup information and master data that enable you to get to work right away. However, there are a variety of options you can choose or adjust to customize the way ADT operates. You can also set up your master files to contain the information that will speed data entry for system users.

The NetSolutions system is designed so that the amount of preparatory work is minimal, but some libraries and masters have to be set up before you can begin using the system effectively. NetSolutions ADT uses a wide variety of program options and master data. Some of these items are specific to ADT while others are shared between ADT and other programs. All options and master file settings are located under the ADT menu on the Settings tab.

Use the Settings tab to set up or modify facility and system information for NetSolutions ADT. Use the items under the ADT menu to specify ADT master data that is specific to the current facility.

The following items are available on the ADT menu:

- **Admission Source**
- **Admission Types**
- **Advance Directives**
- **Allergy Master**
- **Allergy Reactions**
- **Care Level**
- **Citizenship**
- **Clinician Types Master**
- **Clinicians**
- **County**
- **Default Reimbursement Table**
- **Discharge Code**
- **Disclosure Purpose**
- **Hold Reason**
- **ICD-9 Master**
- **ICD-10 Master**
- **Language Master**
- **Organizations**

- **PayType**
- **Race**
- **Relation**
- **Religion**
- **Role**
- **Transfer Condition**
- **Transfer Contributing Reason**
- **Transfer Diagnoses**
- **Transfer Reason Master**
- **VA Disability Master**
- **Veteran Master**
- **Visit Destination**
- **Visit Source**

## Admission Source

Create and maintain the entries that are available in the Federal Admission Source and State Admission Source dropdowns using the Admission Source master page. Admission sources are similar to visit sources; they indicate the location from which the resident is being admitted or the reason for the admission. Admission source codes are defined by the federal government and some state agencies.

ADMISSION SOURCE SUMMARY					
EDIT	DEL	ADMISSION SOURCE	DESCRIPTION	TYPE	ACH OR CAH
		1	Physician	F	No
		2	Clinic	F	No
		3	HMO	F	No
		4	Trans Hosp	F	Yes
		5	Trans SNF	F	No
		6	Trans HC	F	No
		7	ER	F	Yes
		8	Court/Law	F	No
		9	Info NA	F	No

ADMISSION SOURCE DETAILS	
Admission Source: *	<input type="text" value="4"/>
Description:	<input type="text" value="Trans Hosp"/>
Type:	<input type="text" value="Federal"/>
HL7 ID: *	<input type="text" value="4"/>
Location:	<input checked="" type="checkbox"/> Acute Care Hospital or Critical Access Hospital

SAVE CANCEL


You enter a resident's federal and state admission source codes on the Visit page in Registration.


### Adding an admission source to the master:

1. On the Settings tab, select the ADT menu, then click Admission Source.
2. On the Detail panel, enter the appropriate information in each field.
  - **Admission Source (required).** Enter a unique 1-character code for the admission source.
  - **Description.** Enter a description of the admission source using up to 10 characters.
  - **Type.** Select the type of admission source: Federal, State, or Both. This selection determines the dropdown(s) in which the code appears on the Visit page.
  - **HL7 ID (required).** Enter a 3-character unique identifier to be used in HL7 Interface messages. If you are using the HL7 interface to send Census information to another system, this value needs to have a match in the other system.

- **Location.** Select this checkbox to indicate that the admission source is either an Acute Care Hospital (ACH) or Critical Access Hospital (CAH). If you select this checkbox, NetSolutions displays a Yes in the ACH or CAH column in the Summary panel.










3. Click Save.

**Edit** an admission source by clicking its  button and editing the fields. Then click Save.

**Delete** an admission source by clicking its  button and confirming the deletion.


## Admission Type Profile

Create and maintain the admission types that are available in the Admit Type dropdown using the Admission Type Profile page.

ADMISSION TYPE PROFILE SUMMARY					1 - 4 of 4
EDIT	DEL	TYPE	DESCRIPTION	HL7 ID	
		1	Emergency	1	
		2	Urgent	2	
		3	Elective	3	
		9	Info N/A	9	
ADD		<input type="text"/>	<input type="text"/>	<input type="text"/>	

You enter a resident's admission type on the Visit page in Registration.

### Adding an admission type to the master:

1. On the Settings tab, select the ADT menu, then click Admission Type.
2. On the Add row, enter the appropriate information in each field.
  - **Admission Type (required).** Enter a unique 1-character identifier for the admission type.
  - **Description.** Enter the full name or description of the admission type using up to 10 characters.
  - **HL7 ID (required).** Enter a 1-character unique identifier to be used in HL7 Interface messages. If you are using the HL7 interface to communicate Census information to another system, this value needs to have a match in the other system.
3. Click the Save  button.

**Edit** an admission type by clicking its  button and editing the text. Then click .

**Delete** an admission type by clicking its  button and confirming the deletion.

## Advance Directives Master

Create and maintain the entries that are available in the Search For Advance Directives dialog using the Advance Directives master page. An advance directive provides instructions to be followed in the event the resident expires or is unable to make decisions for him or herself.

ADVANCE DIRECTIVES						1 - 9 of 9
EDIT	DEL	MOVE	SEQUENCE	DESCRIPTION	CCD CODE	
			10	Living Will	71388002	
			20	Do Not Resuscitate	304253006	
			30	Power of Attorney for Health Care	71388002	
			31	Full Code	71388002	
			32	Power of Attorney for Health Care	71388002	
			33	Health Care Surrogate	71388002	
			34	Health Care Guardian	71388002	
			35	Hospital Personal Repres. Designation	71388002	
			36	Power of Attorney for Finance	71388002	
ADD						

You enter a resident's advance directives on the Clinical page in Registration. The Search dialog enables you to select one or more advance directives for the resident.

### Adding an advance directive to the master:

- On the Settings tab, select the ADT menu, then click Advance Directives.
- On the Add row, enter the appropriate information in each field.
  - Sequence (required).** Enter a sequence value for the advance directive. This value determines the order in which the items are displayed in the grid and the search dialog and the sequence in which they print on facesheets. Click one of the Move buttons in the grid to move a role up or down in the list, increasing or decreasing its sequence value. Other sequence numbers in the list are renumbered as necessary.
  - Description (required).** Enter a unique description for the advance directive using up to 40-characters.
  - CCD Code (required).** Enter the CCD code. If the directive does not match one of the SNOMED values, use the Unknown SNOMED value 99999999.
- Click the Save button.

**Edit** an advance directive by clicking its button and editing the text. Then click .

**Delete** an advance directive by clicking its button and confirming the deletion.

## Allergy Master

Create and maintain the allergies, including brand name drugs, that appear in the Search for Allergies dialog using the Allergy Master. For brand name medications, the GFC code is used as the allergy ID.

Search by: Description ☐ Begins with  ☐ Contains SEARCH

ALLERGY SUMMARY Total: 1000

EDIT	DEL	DESCRIPTION	TYPE	ALLERGY ID	CUSTOM ALLERGY
		4-AMINOQUINOLINE	Miscellaneous	7702390	NO
		8-AMINOQUINOLINE	Miscellaneous	7702391	NO
		ACCUPRIL	Drug	103367	NO
		ACE INHIBITOR	Miscellaneous	7702392	NO
		ACE INHIBITORS	Drug	129206	NO
		ACETAMINOPHEN	Drug	7700223	NO
		ACETAZOLAMIDE	Drug	7700096	NO
		ACETOHEXAMIDE	Drug	7700115	NO
		ACETOPHENAZINE	Drug	7700825	NO
		ACETYLCYSTEINE	Drug	7700125	NO
		ACIPHEX	Drug	114038	NO
		ACRIDINE DERIVED PRODUCT	Miscellaneous	7704192	NO

ALLERGY DETAIL

Description:

Type:  Allergy ID:

SAVE CANCEL

You enter a resident's allergies on the Clinical page. View them along with other clinical info on the Snapshot page. If the Drug Interaction module is installed, when you add a brand name drug (such as Lipitor) in Physician Orders to a resident with an allergy to that drug, it will trigger the allergy/drug contraindication.

### Adding an allergy to the master:


- On the Settings tab, select the ADT menu, then click Allergy Master.
- On the Allergy Detail panel, enter the appropriate information in each field.
  - Description (required).** Enter the name of the allergen.
  - Type (required).** Select the allergy type such as food, drug, miscellaneous.
  - Allergy ID.** Enter the allergy ID in this field or click to select it from the Search for Allergy ID dialog. This ID is used by NetSolutions to keep track of drug interactions. By default, NetSolutions sets the value of this field to 0. This field is only available when the Drug Interactions module is activated.

**Note:** When you enter a custom allergy in the Allergy Master, NetSolutions does not use that allergy when checking for drug interactions. In order to have NetSolutions include an allergy when it checks for drug interactions, you must enter a valid allergy ID in this field.

For example, when entering a name-brand drug in the Allergy Master, you should first look up the generic version of the drug in Physician Orders and write down the allergy ID. Then, when you enter the name-brand drug in the Allergy Master, use the generic version's allergy ID to ensure that the name brand drug is included when checking for drug interactions.

**Note:** When adding an entry such as NKA or NKDA, leave the Allergy ID value for the entry at 0. This ensures that the entry is not picked up as part of the drug interactions check.




























3. Click Save.

**Edit** an allergy by clicking its Edit  button and editing the information. Then click Save.

**Delete** an allergy by clicking its Delete  button and confirming the deletion.

## Allergy Reactions

Create and maintain the allergy reactions that appear in the Reaction drop-down on the Allergies section of the Clinical Information page. This information is also included in the Continuity of Care Document (CCD).

ALLERGY REACTIONS				
EDIT	DEL	REACTION	CCD CODE	ACTIVE
		"anaphalaxis"	99999999	Yes
		"feels sick"	99999999	Yes
		"feels strange"	99999999	Yes
		"shakes"	99999999	Yes
		"sick"	99999999	Yes
		"Upset my ulcer	99999999	Yes
		02 sat decrease	99999999	Yes
		02 sats dropss	99999999	Yes
		1	99999999	Yes
		2	99999999	Yes
		3	99999999	Yes
		Abd. pain	99999999	Yes
		abdominal pain	99999999	Yes
<b>ADD</b>		<input type="text"/>	<input type="text"/>	<input type="checkbox"/> 


**Note:** The initial values in this master are derived from existing free-text reactions entered in the Allergies section of the Clinical Information page.

### Adding an allergy reaction:

1. On the Settings tab, select the ADT menu, then click Allergy Reactions.
2. On the Add line of the Allergy Reactions panel, enter the appropriate information in each field.
  - **Reaction (required).** Enter the allergy reaction using up to 50 characters.
  - **CCD Code.** Enter the CCD code. If the reaction does not match one of the SNOMED values, use the Unknown SNOMED value 99999999.

- **Active.** Select this checkbox to indicate that the allergy reaction is active. Only active allergy reactions display in the Reaction drop-down.












3. Click .

**Edit** an allergy reaction by clicking its Edit  button and editing the information. Then click .

**Delete** an allergy reaction by clicking its Delete  button and confirming the deletion.


## Care Level Profile

Create and maintain the care level values that are available in the Care Level search window using the Care Level Selection page. A level of care defines a resident's overall health status and the amount of medical care he or she requires. A resident's care level affects the reimbursement that can be received for the resident's care.

CARE LEVEL SUMMARY					<Previous 61 - 65 of 65	
EDIT	DEL	LEVEL	DESCRIPTION	BILLING CODE		
		852	RVX			
		853	RUL			
		854	RUX			
		855	RUZ			
		99999	Skilled-Extra			
ADD		<input type="text"/>	<input type="text"/>	<input type="text"/>		

You enter a resident's care level initially on the Visit page in Registration and can change it on the Change Care Level page in ADT.

### Adding a care level to the master:

1. On the Settings tab, select the ADT menu, then click Care Level.
2. On the Add row, enter the appropriate information in each field.
  - **Level (required).** Enter a 3-character care level value.
  - **Description (required).** Enter a description of the care level using up to 15 characters.
  - **Billing Code.** Enter a code for this care level that is available for printing on bills.
3. Click the Save  button.

**Edit** a care level by clicking its  button and editing the text. Then click .

**Delete** a care level by clicking its  button and confirming the deletion.




## Citizenship Master

Create and maintain the citizenship values that are available in the Citizenship dropdown using the Citizenship Selection page. Citizenship is a facility-defined code representing a resident's nationality.

CITIZENSHIP SELECTION				
EDIT	DEL	CITIZENSHIP	CITIZENSHIP DESC	HL7 ID
		CAN	CANADA	CAN
		MEX	MEXICO	MEX
		USA	UNITED STATES	USA
ADD		<input type="text"/>	<input type="text"/>	<input type="text"/> 

You enter a resident's country of citizenship on the Basic Information page in Registration.

### Adding a citizenship value to the master:

1. On the Settings tab, select the ADT menu, then click Citizenship.
2. On the Add row, enter the appropriate information in each field.
  - **Citizenship (required).** Enter a 3-character abbreviation of the country of citizenship.
  - **Citizenship Desc.** Enter the full name or description of the country of citizenship using up to 30 characters.
  - **HL7 ID (required).** Enter a 3-character unique identifier to be used in HL7 Interface messages. If you are using the HL7 interface to send Census information to another system, this value needs to have a match in the other system.
3. Click .

**Edit** a citizenship value by clicking its  button and editing the text. Then click .

**Delete** a citizenship value by clicking its  button and confirming the deletion.

## Clinician Types Master

Use this master to create and maintain types of clinicians for your facility.

CLINICIAN TYPES MASTER					
TYPE	ROLE	Description	Max per Visit	Require NPI	
PHY	ADM	Admitting	1	yes	
PHY	ALT	Alternate	1	yes	
PHY	ATT	Attending	1	yes	
PHY	CON	Consulting		yes	
DEN	DEN	Dentist		no	
NEU	NEU	Neurologist		yes	
PHY	OPR	Operating		yes	
OPT	OPT	Ophthalmologist		no	
OTH	OTH	Occupational Therapist		no	
PHY	PHY	Physician		yes	
POD	POD	Podiatrist		yes	
PSI	PSI	Physiatrist		yes	
PSY	PSY	Psychiatrist		yes	
PTH	PTH	Physical Therapist		no	
PUL	PUL	Pulmonologist		yes	
PHY	REF	Referring		yes	
STH	STH	Speech Therapist		no	

ADDITIONAL CLINICIAN TYPES					
			1 - 2 of 2		
EDIT	DEL	TYPE	DESCRIPTION	Max per Visit	Require NPI
		TES	TEST	0	no
		YYW	VetRGJMEY	99	yes
ADD		<input type="text"/>	<input type="text"/>	<input type="text" value="1"/>	<input type="text" value="yes"/>

When you save a new clinician type, it appears at the bottom page as a user-defined clinician type. This new clinician type is then available in the dropdown list on the Clinical Information page for the role of the resident's clinician, and also on the Clinician Master as a physician type.

### Adding clinician type to the master:

- On the Settings tab, select the ADT menu, then click Clinician Types Master.
- On the Additional Clinician Types panel, enter the appropriate information in each field.
  - Type (required).** Enter the clinician type using three letters. This entry is assigned as both the type and role of the clinician. Once the clinician type has been assigned to a resident record, you cannot change the entry in this field.
  - Description (required).** Enter the name of the clinician type.
  - Max Per Visit (required).** Enter the maximum per visit. By default, NetSolutions sets this number at 1.
  - Require NPI (required).** Indicate whether an entry in the NPI field is required. By default, NetSolutions enters Yes in this field.
- Click .

**Edit** a clinician type by clicking and editing the information. Then click .

**Delete** a clinician type by clicking its Delete button and confirming the deletion. If the clinician type has already been assigned to a resident record, you cannot delete the clinician type; you can, however, change the Description, Max per Visit and the Require NPI fields.

## Clinician Master

Create and maintain the clinicians that appear in the Search for Clinician dialog using the Clinician Master.

SEARCH BY

Category: All

☐ Include inactive

SEARCH

CLINICIAN SUMMARY

1 - 168 of 168

EDIT DEL CATEGORY

		PHY	Alers, Manuel Genevieve	<a href="#">NAME</a>	<a href="#">INACTIVE</a>
		PHY	Anarella, Marietheresa Madelyn		
		PHY	Argento, Rosemamie Jacob		
		PHY	Austin, Velia Emmett		
		PHY	Baldo, Wesley Velda		
		PHY	Barbato, Kathy Warren		
		PHY	Bartocci, Hester Tyrone		
		PHY	Batog, Cletus Willis		

CLINICIAN DETAIL

Short name:

HALLMANC

Type:

Physician

Code:

44

Last name:

Barbato

First Name:

Kathy

Middle Name:

Warren

Suffix:

Address 1:

95215 Woodruff Str

Address 2:

Ferris Building

City:

Beagle

State:

WA

Zip:

50054

Phone #

1. (857)555-3392

2.

3.

4.

5.

Type

work/office

Inactive

☐

Email:

Mohr@abc.com

UPIN:

Medicaid #:

225365926118

Taxonomy code:

0932853538

DEA number:

Direct Addr:

NPI:

3875024112

Federal EIN:

015905511407

License #:

380694492896

ePrescribing ID:

Send PDF

☐

Send CCDA

☐

SAVE

CANCEL

Physicians are added to resident records in several places in NetSolutions including on the Clinical Information page in Registration and in the Physician Orders and Therapy programs. They also appear on various reports such as the Plan of Care.

In a multi-facility system, you set up a separate Physician master for each facility in the system.

### Adding a clinician to the master:

- On the Settings tab, select the ADT menu, then click Clinicians.
- On the Clinician Detail panel, enter the appropriate information in each field.
  - Short name (required).** Enter a short name for the clinician using up to 10 characters. This identifier must be unique in the system.
  - Type (required).** Select a clinician type such as physician, dentist, ophthalmologist.

- **Last name (required).** Enter the clinician's last name using up to 20 characters.
- **First name (required).** Enter the clinician's first name using up to 15 characters. Note that you can change a clinician name without affecting the residents that are assigned to that clinician.
- **Middle name.** Enter the clinician's middle initial.
- **Suffix.** Enter the clinician name suffix, title, or certification using up to 10 characters.
- **Address 1.** Enter the clinician's office address.
- **Address 2.** Enter additional address info if needed.
- **City.** Enter the city where the clinician is located.
- **State.** Enter the state where the clinician is located.
- **Zip.** Enter the zip code of the clinician's office.
- **Email.** Enter the clinician's email address.
- **UPIN.** Enter the clinician's Unique Physician Identification Number, if applicable, using up to 22 characters.
- **NPI (required).** Enter the clinician's National Provider Identifier using up to 10 characters. This field defaults to the entry in the UPIN field (formerly the UPIN/NPI) field if that entry matches the NPI format. This number is required for ePrescribing; an electronic prescription will be rejected if this field is empty for the prescribing clinician.

**Note:** CMS and Medicare transitioned physician ID numbers from the UPIN to the NPI. The transition started January 3, 2006 and finished May 23, 2007. See the CMS website (<http://www.cms.hhs.gov/>) for details.

- **Medicaid #.** Enter the clinician's Medicaid provider number using up to 20 characters.
- **Federal EIN.** Enter the clinician's Employer Identification Number using up to 20 characters, if applicable.
- **Taxonomy code.** Enter a provider taxonomy code for the clinician using up to 12 characters.
- **License #.** Enter the clinician's medical license number using up to 20 characters.
- **DEA number.** Enter the clinician's Drug Enforcement Administration number using up to 35 characters. This number is required for ePrescribing; an electronic prescription will be rejected if this field is empty for the prescribing clinician.
- **Direct Addr.** Enter the address registered through a Direct Exchange administrator.
- **Send PDF.** Select this checkbox to include a PDF file of the disclosure record.

- **Send C-CDA.** Select this checkbox to include a C-CDA file of the disclosure record.
- **Inactive.** Select this checkbox if the clinician is no longer actively working with the facility. If you select this checkbox for a clinician who is assigned to active residents, NetSolutions asks you to confirm that you want to inactivate the clinician.
- **Phone #.** Enter up to five phone numbers for the clinician.
- **Type.** Select the type of clinician phone number such as home, work/office, fax, cell.
















3. Click Save.

**Edit** a clinician entry by clicking its Edit  button and editing the information. Then click Save.

**Delete** a clinician entry by clicking its Delete  button and confirming the deletion. If a clinician is in use in the Physician Orders or eCharting programs, it cannot be deleted.

## County Profile

Create and maintain the counties that are available in the County dropdown using the County Profile page. The County master defines the counties in which residents lived before entering the facility.

COUNTY PROFILE				
EDIT	DEL	COUNTY CODE	DESCRIPTION	HL7 ID
		Mont	Montgomery	Mont
		MOR	Morgan	10
		Muskingham	Muskingham	MUSK
		Preble	Preble	PREB
		Shelby	Shelby	SHEL
		TX-ST	TEXAS	TX
		Warren	Warren5	WARR
ADD		<input type="text"/>	<input type="text"/>	<input type="text"/> 

You enter a resident's county on the Basic Information page in Registration.

### Adding a county to the master:

1. On the Settings tab, select the ADT menu, then click County.
2. On the Add row, enter the appropriate information in each field.
  - **County Code (required).** Enter the county identifier using up to 15 characters.
  - **Description.** Enter the full name or description of the county using up to 15 characters.

- **HL7 ID (required).** Enter a 4-character unique identifier to be used in HL7 Interface messages. If you are using the HL7 interface to send Census information to another system, this value needs to have a match in the other system.

3. Click the Save  button.

**Edit** a county by clicking its  button and editing the text. Then click .











**Delete** a county by clicking its  button and confirming the deletion.


## Default Reimbursement Table

Use the Default Reimbursement Table page to set up the reimbursement tables that are available when admitting a resident.





**SEARCH BY**  
 Table:

**DEFAULT REIMBURSEMENT TABLE**

EDIT	DEL	TABLE NAME
		BC/BS / Guarantor
		Guarantor
		Guarantor Co-Insurance / Guarantor
		Hospice - Medicaid
		Hospice - Private


**ADD/MODIFY TABLE: \***  

**ADD/MODIFY PLANS**

EDIT	DEL	SEQ	PLAN	PAYOR	TYPE	COIN	DED PYR	OLMT PYR	ULMT PYR
		10	Medicare A	Medicare A	Medicare	30	0	0	0
		11	MCR A NO PAY 10/01/06 Medicare B-	Medicare A	Medicare	0	0	0	0

**PLAN DETAIL**



Sequence: \*

Plan Description: \*  

Co-insurer:  Deductible Payor:




Over Limit Payor:  Under Limit Payor:

Payor Shortname:  Payor Type:

This page enables you to view and update the default reimbursement tables that can be used when creating the reimbursement table for a resident's account.


The page has four panels:

- **Search.** Use this panel to find a default reimbursement table. Enter one or more characters in the Table field and click Search. Reimbursement tables beginning with the entered characters display in the Default Reimbursement Table grid. To display all tables, leave the Table field blank and click Search.
- **Default Reimbursement Table.** This panel displays the default reimbursement tables currently in the system. Modify a reimbursement table by clicking its  button in the grid. The plans in the table then display in the Add/Modify Plans panel below. Delete a table by clicking .
- **Add/Modify Plans.** This panel displays the payors / insurance plans included in the reimbursement table selected above. Click  to modify a plan on the Plan Detail panel below.
- **Plan Detail.** This panel displays detailed information for the plan selected above. Use the fields on this panel to add or edit a plan.

To add a default reimbursement table, you first name the table, then add one or more payors/plans to the table, put the plans in the correct sequence, and edit the details for each plan as needed.

### To add a default reimbursement table:

1. On the Settings tab, select the ADT menu, then click Default Reimbursement Table.
2. On the Default Reimbursement Table panel, in the Add/Modify Table field, enter the reimbursement table name.
3. On the Plan Detail panel, add a payor/plan to the reimbursement table.
  - **Sequence (required).** Enter a sequence number for the payor/plan using up to 4 characters. The sequence number determines the plan's position in the table and its priority in reimbursing claims.
  - **Plan Description (required).** Enter the payor/plan name or select it from the Search for Plan dialog. The plans available in the dialog are maintained in the Payor/Plan master. Only payors with active plans are displayed in the dialog.
  - **Enter or edit** information in the other Plan Detail fields as needed.

PLAN DETAIL			
Sequence: *	<input type="text" value="10"/>		
Plan Description: *	<input type="text" value="Medicare A"/>		
Co-insurer:	<input type="text" value="30"/>	Deductible Payor:	<input type="text" value="0"/>
Over Limit Payor:	<input type="text" value="0"/>	Under Limit Payor:	<input type="text" value="0"/>
Payor Shortname:	<input type="text" value="Medicare A"/>	Payor Type:	<input type="text" value="Medicare"/>

- **Co-insurer.** Enter the sequence number for the plan that is this plan's co-insurer, using up to 4 characters.
- **Deductible Payor.** Enter the sequence number for the plan that is this plan's deductible payor, using up to 4 characters.

- **Over Limit Payor.** Enter the sequence number for the plan that is this plan's over-limit payor, using up to 4 characters.
  - **Under Limit Payor.** Enter the sequence number for the plan that is this plan's under-limit payor, using up to 4 characters.
  - **Payor Shortname.** This field displays the payor/plan shortname as entered in the Payor/Plan master.
  - **Payor Type.** This field displays the payor type as set up in the Payor/Plan master.
- **Save.** Click Save to add the plan to the reimbursement table.
4. Repeat step 3 for each plan you want to add to the reimbursement table.
  5. When the default reimbursement table is complete, click Save.

If you have been viewing or editing a table, return to Add mode (with no tables or plans selected) by clicking Cancel or Search.

## Discharge Code Profile

Create and maintain the discharge codes that are available in the Federal and State dropdowns on the Discharge page using the Discharge Code Profile page.

DISCHARGE CODE PROFILE SUMMARY							
EDIT	DEL	CODE	DESCRIPTION	TYPE	EXPIRED	ACH OR CAH	HL7 IDENTIFIER
		01	Discharged to home	B	No	No	01
		03	Discharged to SNF	B	No	No	03
		07	Left Against Medical Advice	B	No	No	07
		04	Discharged to ICF	B	No	No	04
		20	Expired	B	Yes	No	20
		02	Disc/Transfer to Hospital	B	No	Yes	02
		05	D/C Transfer to Another Type Institute	B	No	No	05
		06	D/C Transfer to Home w/Home Health	B	No	No	06
		08	D/C Transfer To Home w/IV Provider	B	No	No	08
		99	OTHER	B	No	No	99
		09	DC'ED TO HOSPITAL & NOT RETURN	B	No	No	
		66	Disch/Trans to Critical Access Hospital	F	No	Yes	66

DISCHARGE CODE PROFILE DETAIL	
Code: *	<input type="text" value="02"/>
Description:	<input type="text" value="Disc/Transfer to Hospital"/>
Type: *	<input type="text" value="Both"/> ▼
MDS Value:	<input type="text" value=""/> ▼
HL7 Identifier:	<input type="text" value="02"/>
Expiration:	<input type="checkbox"/> Expired?
Location:	<input checked="" type="checkbox"/> Acute Care Hospital or Critical Access Hospital
<input type="button" value="SAVE"/> <input type="button" value="CANCEL"/>	

When you discharge a resident, selection of a federal discharge code is required. Depending on the state, you may also need to select a state discharge code. You can set up your state's list, and maintain the federal list, using this page.



### Adding a discharge code to the master:

1. On the Settings tab, select the ADT menu, then click Discharge Code in the task menu under ADT.
2. On the Detail panel, enter the appropriate information in each field.
  - **Code (required).** Enter a unique 2-digit identifier for the discharge code.
  - **Description.** Enter a description of the discharge code using up to 40 characters.
  - **Type (required).** Select the type of discharge code: Federal, State, or Both if the code applies to both and can be used as either State or Federal.
  - **MDS Value.** Enter a unique 3-character identifier for use in interface messages. If you are sending Census information to another system, this value must have a match in the other system.

**Note:** NetSolutions adds the default Federal Discharge Codes during setup.






- **HL7 Identifier.** Enter the HL7 Identifier using up to 3 characters. NetSolutions uses this code when an inbound HL7 message does not have an MDS value attached. This code must be unique.
  - **Expiration.** Select the Expired? checkbox if the code is used when the resident has expired.
  - **Location.** Select this checkbox to indicate that the admission source is either an Acute Care Hospital (ACH) or Critical Access Hospital (CAH). If you select this checkbox, NetSolutions displays a Yes in the ACH or CAH column in the Summary panel.
3. Click Save.

**Edit** a discharge code by clicking its  button and editing the fields. Then click Save.


**Delete** a discharge code by clicking its  button and confirming the deletion.

## Disclosure Purpose


Create and maintain the disclosure purpose values that are available in the Purpose dropdown on the Record Disclosure page. This is a facility-defined code representing the reason for disclosing a resident's record.

DISCLOSURE PURPOSE		1 - 2 of 2
EDIT DEL	<a href="#">DISCLOSURE PURPOSE</a>	
 	Testing	
 	Evaluating	
ADD	<input type="text"/>	

**Adding a disclosure purpose value to the master:**








1. On the Settings tab, select the ADT menu, then click Disclosure Purpose.
2. On the Add row, enter the description of the disclosure purpose using up to 30 characters.
3. Click .

**Edit** a disclosure purpose value by clicking its  button and editing the text. Then click .

**Delete** a disclosure purpose value by clicking its  button and confirming the deletion.


**Hold Reasons**

Create and maintain the entries that are available in the Reason dropdown using the Hold Reasons master page. A hold reason can indicate a general reason for a hold or may specify where the resident is going while the bed is being held. Hold reasons are used for Medicare and Medicaid reporting and can be used for gathering statistical information.

HOLD REASONS SUMMARY						1 - 3 of 3
EDIT	DEL	REASON	TYPE	CODE	ACH OR CAH	
		Personal	P		No	
		Hospital	H		Yes	
		<24 hrs	H		Yes	
ADD		<input type="text"/>	H	<input type="text"/>	Acute Care or Critical Access Hospital <input type="checkbox"/>	

You enter a resident's hold reason on the Hold page in ADT/Census.

**Adding a hold reason to the master:**

1. On the Settings tab, select the ADT menu, then click Hold Reason.
2. On the Add line, enter the appropriate information in each field.
  - **Hold Reason (required).** Enter a description of the hold reason using up to 30 characters.
  - **Hold Type (required).** Select a 1-character identifier for the hold reason type: H or P.
  - **Status code.** Enter an optional state/intermediary status code for the hold type using up to 5 characters.
  - **Acute Care or Critical Access Hospital.** Select this checkbox to indicate that the defined hold reason is either an Acute Care Hospital (ACH) or Critical Access Hospital (CAH). If you select this checkbox, NetSolutions displays a Yes in the ACH or CAH column.
3. Click .

**Edit** a hold reason by clicking its  button and editing the fields. Then click Save.

**Delete** a hold reason by clicking its  button and confirming the deletion.

## ICD-10 Master

Create and maintain the ICD-10 codes that appear in the Search for Diagnosis dialog using the ICD-10 Master.

ICD-10 codes are 3 to 7 characters long (excluding the period) and use the format xxx.yyyy. For example: S72.142R. The first character of the code (Xxx.yyyy) is always alphabetical; all letters except U are eligible to be used in this position. The second character (xXx.yyyy) is always numeric. The remaining characters can be either alphabetical or numeric and are not case-sensitive.

Search by: ICD-10 Code ☒ Begins with   
☐ Commonly Used only ☐ Contains  
☐ Excluded from EDS only SEARCH [Add ICD-10 Code](#)

1 - 10 of 56 [Next>](#)

ICD-10 SUMMARY								
EDIT	DEL	ICD-10 CODE	DESCRIPTION	ABBREVIATION	ACTIVE AS OF	INACTIVE DATE	COMMONLY USED	EXCLUDE FROM EDS
		N10.	Acute tubulo-interstitial nephritis	Acute tubulo-interstitial n...			No	No
		N11.	Chronic tubulo-interstitial nephritis	Chronic tubulo-interstitial...			No	No
		N11.0	Nonobstructive reflux-associated chronic py...	Nonobstructive reflux-assoc...			No	No
		N11.1	Chronic obstructive pyelonephritis	Chronic obstructive pyelone...			No	No
		N11.8	Other chronic tubulo-interstitial nephritis	Other chronic tubulo-inters...			No	No
		N11.9	Chronic tubulo-interstitial nephritis, unsp...	Chronic tubulo-interstitial...			No	No
		N12.	Tubulo-interstitial nephritis, not specifi...	Tubulo-interstitial nephrit...			No	No
		N13.	Obstructive and reflux uropathy	Obstructive and reflux urop...			No	No
		N13.1	Hydronephrosis with ureteral stricture, not...	Hydronephrosis w ureteral s...			No	No
		N13.2	Hydronephrosis with renal and ureteral calc...	Hydronephrosis with renal a...			No	No

ICD-10 DETAIL

ICD-10 code:

Description:

Abbreviation:

Active as of:  ☐ Commonly used

Inactive date:  ☐ Exclude from MDS 3.0 EDS [MDS 3.0 Correlation](#)

SAVE  CANCEL

NetSolutions uses International Classification of Diseases, 10th revision (ICD-10) codes to identify diseases and diagnoses. The ICD-10 Master enables you to maintain a list of ICD-10 codes used by your system. The codes entered on this page appear in the Search for Diagnosis dialog available from any ICD-10 Code field. A pre-loaded list of ICD-10 codes is included with the NetSolutions system.



### Adding an ICD-10 code to the master:

1. On the Settings tab, select the ADT menu, then click ICD-10 Master.
2. On the ICD-10 Master page, click the Add ICD-10 Code Link.

3. On the ICD-10 Detail panel, enter the appropriate information in each field.

- **ICD-10 code (required).** Enter the International Classification of Diseases, 10th revision (ICD-10) code using up to 8 characters, including a period, in the format xxx.yyyy.


**Note:** If you enter the ICD-10 code, you do not have to type the decimal. You can enter the code and when you save, NetSolutions adds the decimal after the third character.

- **Description (required).** Enter the description of the ICD-10 code using up to 130 characters.
- **Abbreviation.** Enter or edit an abbreviation for the ICD-10 code using up to 60 characters.
- **Active as of.** Enter the date on which the ICD-10 code is active in the system using the format mm/dd/yyyy, or click  to select a date from the Calendar.
- **Inactive date.** Enter the date on which the ICD-10 code is inactive in the system using the format mm/dd/yyyy, or click  to select a date from the Calendar.
- **Commonly used.** Select this checkbox to indicate that this code is commonly used in your facility. In some locations in NetSolutions, when you search for an ICD-10 code you can choose to view all ICD-10 codes or only those marked as commonly used. If you select this checkbox, the ICD-10 code appears in the Commonly Used list.

**Note:** Once you assign an ICD-10 code to a resident, NetSolutions automatically marks the Commonly Used checkbox if it hasn't already been selected.

- **Exclude from MDS 3.0 EDS.** Select this checkbox to exclude diagnoses with this ICD-10 code from being send with Electronic Data Submissions. By default, this item is not checked.
- **MDS 3.0 Correlation.** Click this link to access the MDS 3.0 Correlation dialog where you can correlate ICD-10 codes to items on the Minimum Data Set 3.0. This link is enabled only if your facility is using the NetSolutions Resident Assessment program.
- **Clinical Category.** This field displays the category to which the ICD-10 code is assigned.
- **Prior Surgery Related to Active SNF Care?** This field displays the applicable major procedure to which the code is related.

4. Click Save.

**Edit** an ICD-10 code by clicking its Edit  button and modifying the information. For ICD-10 codes from the library, the Code and Description fields cannot be edited and remain grayed out. For manually entered ICD-10 codes, authorized users can modify the Code and Description fields; however, once the ICD-10 code has been used you can no longer modify the Code value. When you have finished modifying the information for the ICD-10 code, click Save.

**Note:** When ICD-10 codes are modified, the changes are reflected in the ICD-10 Diagnoses section of the Clinical Information page, on the ADT and Clinical snapshots, and on reports that print diagnoses such as the Plan of Care and Charting Record.

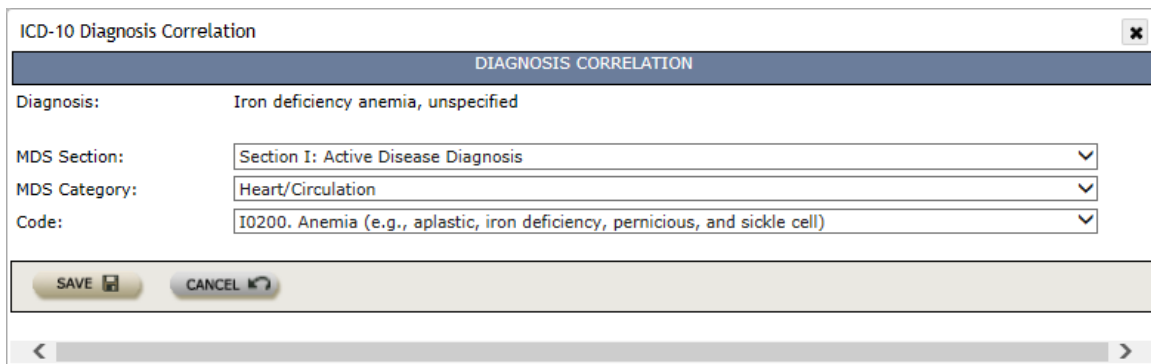
**Search.** You can search for an ICD-10 code by ICD-10 code, description or abbreviation. You can limit the search to specific sets of codes using the other options in the Search panel at the top of the page.

- **Commonly Used Only.** Select this checkbox to limit the search to those codes marked as commonly used
- **Excluded from EDS Only.** Select this checkbox to limit the search to those codes that are excluded from electronic data submission.
- **In Clinical Category.** Select a category from this drop-down list to limit the search to the ICD-10 codes that belong to selected category. By default, all categories are selected.
- **Exclude Return to Provider.** Select this checkbox to exclude all ICD-10 codes that are marked as Return to Provider from the search. If you select a specific clinical category, this checkbox is not available.

**Delete** an ICD-10 code by clicking its Delete  button and confirming the deletion.

## Correlating ICD-10 codes to MDS items

Establish correlations between ICD-10 codes and MDS diagnoses in the MDS Correlation dialog.




Correlations establish a two-way flow of information between MDS Section I and the resident's diagnoses in Registration. When you add a correlated ICD-10 to the resident's diagnoses list on the Clinical Information page, that diagnosis is selected automatically in Section I on the resident's next MDS. Similarly, if you select a correlated diagnosis in Section I, you are prompted to add the diagnosis to the resident's Dx list on the Clinical Info page.

It is not possible to create correlations for all ICD-10 items; for example, several diagnoses have more than one possible ICD-10 correlation. For codes that have not been correlated, you will need to verify the diagnoses selected and update the MDS manually or create a correlation.

**Note:** Correlated diagnosis information only flows between RA and Registration if the Perform Diagnosis Correlations checkbox on the MDS 3.0 Facility Product Options page is selected.

**To correlate an ICD-10 code to an MDS item:**

1. On the ICD-10 Master page, use the Search panel to find the diagnosis you want to correlate.
2. Click the Edit  button beside the ICD-10 code.
3. On the ICD-10 Detail panel, click the MDS 3.0 Correlation link.
4. In the MDS Correlation dialog, select the Section I items to which you want to correlate the ICD-10 code.
  - **Diagnosis.** This field displays the diagnosis selected on the ICD-10 Master page.
  - **MDS Section.** Select the MDS 3.0 section to which the specified ICD-10 code correlates. When you select a section, the ICD-10 is correlated to all items appearing under that section on the MDS.
  - **MDS Category.** Select the MDS 3.0 category to which the specified ICD-10 correlates. Only categories within the selected section are available in the list. When you select a category, the ICD-9 is correlated to all items appearing under the specified section and category on the MDS.
  - **Code.** Select the MDS 3.0 code to which the specified ICD-10 correlates. Only codes within the selected category are available in the list. When you select a code, the ICD-10 is correlated to that MDS 3.0 code for a specific item under the section and category on the MDS.
5. Click Save.

## ICD-9 Master

Create and maintain the ICD-9 codes that appear in the Search for Diagnosis dialog using the ICD-9 Master.

Search by:  ☒ Begins with  ☐ Contains

☐ Commonly used only ☐ Exclude from EDS only

[Add ICD-9 Code](#)

1 - 10 of 635 [Next>](#) ICD-9 SUMMARY

ICD-9 EDIT DEL CODE	DESCRIPTION	ABBREVIATION	ACTIVE AS OF	INACTIVE DATE	COMMONLY USED	EXCLUDE FROM EDS
X 100.	Leptospirosis	Leptospirosis				
X 100.0	Leptospirosis icterohemorrhagica	Leptospirosis icterohemorrha...				
X 100.8	Leptospirosis, other specified leptospiral i...	Oth spec leptospiral inf				
X 100.81	Leptospirosis, leptospiral meningitis (asept...	Leptospirosis, leptospiral m...				
X 100.89	Leptospirosis, other	Leptospirosis NEC				
X 100.9	Leptospirosis, unspecified	Leptospirosis NOS				
X 101.	Vincent` s angina	Vincent` s angina				
X 102.	Yaws	Yaws				
X 102.0	Yaws, initial lesions	Yaws, initial lesions				
X 102.1	Yaws, multiple papillomata and wet crab yaws...	Multi papillomata				

ICD-9 DETAIL

ICD-9 code:

Description:

Abbreviation:



Active as of:  ☐ Commonly used [MDS 2.0 Correlation](#)

Inactive date:  ☐ Exclude from MDS 3.0 EDS [MDS 3.0 Correlation](#)

NetSolutions uses International Classification of Diseases, 9th revision (ICD-9) codes to identify diseases and diagnoses. The ICD-9 Master enables you to maintain a list of ICD-9 codes used by your system. The codes entered on this page appear in the Search for Diagnosis dialog available from any ICD-9 Code field. A pre-loaded list of ICD-9 codes is included with the NetSolutions system.

### Adding an ICD-9 code to the master:

- On the Settings tab, select the ADT menu, then click ICD-9 Master.
- On the ICD-9 Detail panel, enter the appropriate information in each field.
  - ICD-9 code (required).** Enter or edit the International Classification of Diseases, 9th revision (ICD-9) code using one of the following formats:
    - Disease Codes: 999.99
    - External Codes: E999.99
    - Supplemental Codes: V99.99
  - Description (required).** Enter or edit the description of the ICD-9 code using up to 130 characters.
  - Abbreviation.** Enter or edit an abbreviation for the ICD-9 code using up to 35 characters.

- **Active as of.** Enter the date on which the ICD-9 code is active in the system, or click  to select a date from the Calendar.
- **Inactive date.** Enter the date on which the ICD-9 code is inactive in the system, or click  to select a date from the Calendar.
- **Commonly used.** Select this checkbox to indicate that this code is commonly used in your facility. In some locations in NetSolutions, when you search for an ICD-9 code you can choose to view all ICD-9 codes or only those marked as commonly used. If you select this checkbox, the ICD-9 code appears in the Commonly Used list.
- **Exclude from MDS 3.0 EDS.** Select this checkbox to exclude diagnoses with this ICD-9 code from being send with Electronic Data Submissions. By default, this item is not checked.
- **MDS 2.0 Correlation.** Click this link to access the MDS Correlation dialog where you can correlate ICD-9 codes to items on the Minimum Data Set 2.0. This link is enabled only if your facility is using the NetSolutions Resident Assessment program.
- **MDS 3.0 Correlation.** Click this link to access the MDS 3.0 Correlation dialog where you can correlate ICD-9 codes to items on the Minimum Data Set 3.0. This link is enabled only if your facility is using the NetSolutions Resident Assessment program.

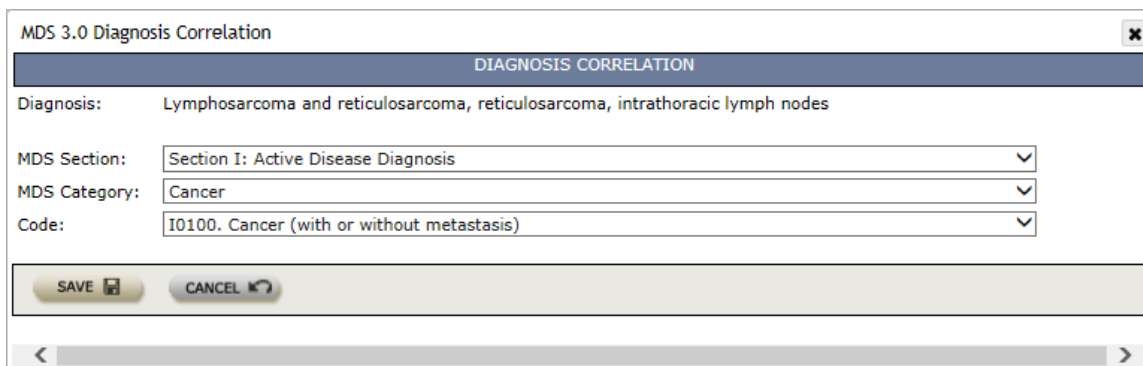
3. Click Save.

**Edit** an ICD-9 code by clicking its Edit  button and editing the information. Then click Save.

**Delete** an ICD-9 code by clicking its Delete  button and confirming the deletion.

## Correlating ICD-9 codes to MDS items

Establish correlations between ICD-9 codes and MDS diagnoses in the MDS Correlation dialog.




Correlations establish a two-way flow of information between MDS Section I and the resident's diagnoses in Registration. When you add a correlated ICD-9 to the resident's diagnoses list on the Clinical Information page, that diagnosis is selected automatically in Section I on the resident's next MDS. Similarly, if you select a correlated diagnosis in Section I, you are prompted to add the diagnosis to the resident's Dx list on the Clinical Info page.












**Note:** Correlated diagnosis information only flows between RA and Registration if the Perform Diagnosis Correlations? checkbox on the Resident Assessment Facility Product Options page is selected.

#### To correlate an ICD-9 code to an MDS item:

1. On the ICD-9 Master page, use the Search panel to find the diagnosis you want to correlate.
2. Click the Edit  button beside the ICD-9 code.
3. On the ICD-9 Detail panel, click either the MDS 2.0 Correlation link or the MDS 3.0 Correlation.
4. In the MDS Correlation dialog, select the Section I items to which you want to correlate the ICD-9 code.
  - **Diagnosis.** This field displays the diagnosis selected on the ICD-9 Master page.
  - **MDS Section.** Select the MDS 3.0 section to which the specified ICD-9 code correlates. When you select a section, the ICD-9 is correlated to all items appearing under that section on the MDS.
  - **MDS Category.** Select the MDS 3.0 category to which the specified ICD-9 correlates. Only categories within the selected section are available in the list. When you select a category, the ICD-9 is correlated to all items appearing under the specified section and category on the MDS.
  - **Code.** Select the MDS 3.0 code to which the specified ICD-9 correlates. Only codes within the selected category are available in the list. When you select a code, the ICD-9 is correlated to that MDS 3.0 code for a specific item under the section and category on the MDS.
5. Click Save.


## Language Master

Create and maintain the languages that appear in the Primary Language dropdown using the Language Master. The language master defines the languages spoken by the residents in the facility.

LANGUAGE					1 - 4 of 4
EDIT	DELETE	DESCRIPTION*	ASSESSMENT VALUE*	CCD Code	
		English	0	eng-en	
		French	2	fre-fr	
		Other	3		
		Spanish	1	spa-es	
ADD		<input type="text"/>	<input type="text" value="3"/>	<input type="text"/>	

You enter a primary language for a resident on the Basic Information page in Registration. The resident's language and corresponding assessment value pull automatically into NetSolutions assessments such as the MDS and IRF-PAI.

**Adding a language to the master:**

1. On the Settings tab, select the ADT menu, then click Language Master.
2. On the Add row, enter the appropriate information in each field.
  - **Description (required).** Enter the name of the language using up to 15 characters.
  - **Assessment value (required).** Enter the assessment value for the language. If your facility uses NetSolutions assessments such as the MDS or IRF-PAI, this value should be a 3 for languages other than English, Spanish, and French.
  - **CCD Code.** Enter the Continuity of Care Document (CCD) code corresponding to the language description, using up to six characters including a hyphen. When NetSolutions is installed initially, four CCD codes are added to the Language Master: English (eng-en), French (fre-fr), Spanish (spa-es) and Other. Additional language codes are listed in the table at the bottom of this help topic.
3. Click the Save  button.

**Edit** a language by clicking its  button and editing the text. Then click .













**Delete** a language by clicking its  button and confirming the deletion.

CCD Code	Language
Ara-ar	Arabic
Arm-hy	Armenian
Cze-cs	Czech
Chi-zh	Chinese
Dan-da	Danish
Ger-de	German
Dut-nl	Dutch; Flemish
Gre-el	Greek
Eng-en	English
Fao-fo	Faroese
Fin-fi	Finnish
Fre-fr	French

<b>CCD Code</b>	<b>Language</b>
Hat-ht	Haitian; Haitian Creole
Heb-he	Hebrew
Hun-hu	Hungarian
Ice-is	Icelandic
Ind-id	Indonesian
Ita-it	Italian
Jpn-ja	Japanese
Kor-ko	Korean
Lat-la	Latin
Mis	Uncoded languages
Nor-no	Norwegian
Pol-pl	Polish
Por-pt	Portuguese
Rus-ru	Russian
Sgn	Sign Languages
Spa-es	Spanish; Castilian
Swe-sv	Swedish
Tah-ty	Tahitian
Tgl-tl	Tagalog
Ukr-uk	Ukrainian
Vie-vi	Vietnamese
Zxx	No linguistic content; Not applicable


## PayType Code



Create and maintain the pay type codes used for setting the PayType code on the Payor/Plan page and for determining the census count on the CMS 672 report.


PAYTYPE CODE SUMMARY				1 - 6 of 6
EDIT	DEL	DESCRIPTION	TYPE	CMS 672 Value
		commercial	H	OTHER [F77]
		medicare	M	MEDICARE [F75]
		private	P	OTHER [F77]
		medicaid	W	MEDICAID [F76]
		commercial	X	OTHER [F77]
ADD		<input type="text"/>	<input type="text"/>	<input type="text" value="Medicare [F75]"/>  

You enter a resident's admission type on the Visit page in Registration.

### Adding a pay type code to the master:

- On the Settings tab, select the ADT menu, then click PayType.
- On the Add row, enter the appropriate information in each field.
  - Description (required).** Enter the full name or description of the admission type using up to 20 characters.
  - Type (required).** Enter a unique 1-character identifier for the paytype.
  - CMS 672 Value (required).** Select a CMS 672 value for the paytype. Available options are:
    - Medicare [F75]
    - Medicaid [F76]
    - Other [F77]
- Click .

**Edit** a paytype by clicking its  button and editing the text. Then click . You cannot modify the descriptions for Commercial, Private, or Medicare codes.

**Delete** a paytype by clicking its  button and confirming the deletion. You cannot delete a paytype once it has been assigned.

## Organization Master

Create and maintain the organizations that are available in various Registration drop-downs using the Organization Master. An organization can be a group, institution, or other organization to which the resident belongs. It can also be a service or company the resident utilizes.

SEARCH BY  
Type: All SEARCH

ORGANIZATION SUMMARY						1 - 68 of 68
EDIT	DEL	TYPE	NAME	CONTACT	DEFAULT	
		Ambulance	ABC AMBULANCE COMPANY			
		Church	BAUERLEIN Church	INEZ TANTILLO		
		Church	KUPKA Church	SISTER MARY DENTLEY		
		Funeral Home	ASHMAN Funeral Home	GEARLDINE TKAC		
		Funeral Home	BAASE Funeral Home	VERNABELLE BURROWS		
		Funeral Home	BAITY Funeral Home	LORRAINE INSALACO		
		Funeral Home	BALDO Funeral Home	HELENE JORDAN		
		Funeral Home	BALDWIN Org	HERBERT LACHNIGHT		
		Funeral Home	BALLOU Funeral Home	ELFRIEDA BENGSCHE		
		Funeral Home	BLACKWOOD Funeral Home	MARILYNN CHATTERTON		

ORGANIZATION DETAIL

Type: Pharmacy  
☒ Set as default pharmacy

Name: CAPUANO Pharmacy  
Address: 3663 AnyStreet  
City: AnyTown  
State: CA Zip: 70104  
Contact:  
Email:  
NPI:  
NCPDPID:

Long Distance  
Phone#  
Type  
Comments:

☐ (301)555-5358 work/office  
☐ (425)307-2220 fax  
☐ (444)565-8877 other  
☐  
☐

☒ Send CancelRx for ePrescribing orders with future DC date immediately  
☐ Require physician DEA number for ePrescribing / Auto-Fax  
☒ Use previous Rx number on reorders  
☐ Receive new orders via RxFill  
☐ Send administration times to pharmacy

☐ Rx number required on reorders  
☐ Suppress CancelRx on resident discharge  
☐ Suppress CancelRx if missing required pharmacy data  
☐ Suppress Start Date, only send Order Date  
☐ Send controlled substance orders to pharmacy

☐ New ☒ Reorder ☒ Cancel

SAVE CANCEL

The organizations in the master appear in the dropdown lists for such fields as Ambulance, Church, Funeral Home, Pharmacy, and Hospital. These fields appear on the Basic Information page in Registration.

**Pharmacies for ePrescribing.** If your facility uses the NetSolutions ePrescribing program, any pharmacies with which you will exchange electronic information must have a valid entry in the NCPDPID field. This number is used in the Interface Manager to link the pharmacy to a pair of interfaces through which electronic messages are sent and received. ePrescribing pharmacies also have extra options to define their interface with NetSolutions.

In a multi-facility system, you set up a separate Organization master for each facility in the system.

### Adding an organization to the master:

1. On the Settings tab, select the ADT menu, then click Organizations.

2. On the Organization Detail panel, enter the appropriate information in each field.
- **Type (required).** Select the organization type such as Ambulance, Church, Funeral Home, Hospital, Lab, Pharmacy, or X-ray. The type determines the Registration dropdown in which the organization appears. It also determines whether certain organization type-specific fields display below.
  - **Set As Default Pharmacy.** Select this checkbox to specify the current pharmacy as the default for new residents. You can change a resident's pharmacy from the default pharmacy to another pharmacy as necessary. Only one pharmacy can be specified as the default. If you select this checkbox and another pharmacy is already defined as the default, NetSolutions displays a message enabling you to change the default pharmacy to the new pharmacy. By default, this checkbox is not selected.
  - **Name (required).** Enter the name of the organization.
  - **Address.** Enter the organization's address.
  - **City.** Enter the city where the organization is located.
  - **State.** Enter the state where the organization is located.
  - **Zip.** Enter the zip code for the organization's address.
  - **Contact.** Enter the name of a contact person for the organization.
  - **Email.** Enter an email address for the organization's contact person.
  - **Provider #.** Enter the provider number for the organization. This field is only available when Hospital is chosen in the Type field above.
  - **Long Distance.** Select this checkbox if the organization is outside your local calling area. When this checkbox is selected, NetSolutions automatically dials a 1 before dialing the number.
  - **Phone.** Enter up to five phone numbers for the organization.
  - **Type.** Select the type of phone number entered in the associated Phone field, such as Home, Work/office, fax, cell. A fax number is required for organizations (pharmacies, labs, and x-ray companies) that will receive automatic faxes through the ePrescribing module.
  - **Comments.** Enter comments pertaining to the organization using up to 1000 characters.
  - **NPI (Pharmacies and Lab/X-ray companies).** Enter the 10-digit National Provider ID number for the pharmacy or company. This field appears only for organizations of type Pharmacy, Lab, or X-ray. After May 23, 2007, pharmacies are required to have an NPI number as specified in the HIPAA act. For lab and x-ray companies, the NPI number is optional.
  - **NCPDPID.** Enter the 7-digit NCPDP (National Council for Prescription Drug Programs) ID number for the pharmacy. This field appears only for organizations of type Pharmacy. (The pharmacy NCPDP number was formerly known as the NABP number.) An entry in this field is required for ePrescribing with the pharmacy.

- **Send CancelRx for ePrescribing orders with future D/C date immediately** (Pharmacies only). Select this checkbox to indicate that the pharmacy wants to receive notification immediately when a future D/C date is added to a physician order. If the checkbox is selected, the D/C date is sent to the pharmacy when it is saved on an ePrescribing order. If the checkbox is not selected, the future D/C date is sent when that date arrives. By default, this checkbox is not selected.
- **Require physician DEA number for ePrescribing / Auto-Fax** (Pharmacies only). Select this checkbox to indicate that the pharmacy requires a physician DEA number on electronic orders and automatic order faxes. If the checkbox is selected, warning and alert messages are generated when an order is saved if the DEA number is missing. If this checkbox is not selected, the DEA number is not required by the pharmacy and no warnings or alerts are generated. By default, this checkbox is not selected.
- **Use previous Rx number on reorders** (Pharmacies only). Select this checkbox to indicate that the pharmacy uses the same Rx number on refills as on the original prescription. When this checkbox is selected, the Rx Number field in the Mark for Reorder dialog and the Process Reorders page is filled by default with the previous Rx number, which you can edit if necessary.
- **Receive new orders via RxFill** (Pharmacies only). Select this checkbox to receive new orders from the pharmacy into NetSolutions. Orders created in NetSolutions contain a system-generated value in the Prescriber Order Number (PON) field. When this checkbox is selected, incoming RxFill messages with either a blank PON field or a PON that does not match one already in the system are treated as new orders on the Receive Orders page. By default, this option is not selected. NOTE: Facilities that send their physician orders from NetSolutions to the pharmacy should NOT select this option.
- **Send administration times to pharmacy** (Pharmacies only). Select this checkbox to include the order frequency and time values in the Directions field in NewRx messages sent to the pharmacy. For example, the Directions element might include "Frequency: Daily|Time: 02:00, 08:00". If there is not enough room in the Directions field, this data continues in the Notes field with a label of Directions Continued. If eSignatures is in use, the Directions field is locked, so the frequency and time values are placed in the Notes field.
- **Rx number required on reorders** (Pharmacies only). Select this checkbox to require entry of an Rx prescription number when processing a medication reorder on the Rx Medication Reorder page. When this checkbox is selected, the Rx Number field on that page is required and displays in yellow. Some pharmacies require an Rx number while others do not; check with the pharmacy to determine what they require. The Rx number is included in ePrescribing messages sent to pharmacies and prints on the Auto-Fax Pharmacy Request report.
- **Suppress CancelRx on resident discharge** (Pharmacies only). Select this checkbox to suppress the CancelRx transaction on the auto D/C due to a resident discharge. Auto D/C of an order modified by the user will still send CancelRx.

- **Suppress CancelRx if missing required pharmacy data** (Pharmacies only). Select this checkbox to suppress CancelRx messages if the required pharmacy data is missing. If ePrescribing is in use, when a physician order is discontinued or deleted a CancelRx message is sent to the pharmacy. If this checkbox is selected and any data required on pharmacy orders is missing, the CancelRx message is not sent and no alert is generated. The order is updated in the Medication Order Status dialog as "Suppressed." This option is intended primarily for facilities that are cleaning up their orders to begin using ePrescribing. By default, this checkbox is not selected.
- **Suppress Start Date, only send Order Date.** Select this checkbox to suppress sending the Start Date as the Effective Date when creating NewRx and ReSupply transactions. When this checkbox is selected, the Effective Date will be blank or not included.
- **Send controlled substance orders to pharmacy: New, Reorder, Cancel** (Pharmacies only). Use the three checkboxes on this panel to indicate whether controlled substance orders, reorders, and cancellations should be sent to the pharmacy electronically. By default, the Reorder and Cancel checkboxes are selected, the New checkbox is not. Controlled substances are determined by the schedule level associated with the NDC code. When these checkboxes are selected, controlled substance orders, reorders, and cancellations are sent to the pharmacy electronically like other orders. If a checkbox is not selected, when a controlled substance order is created, re-ordered, or cancelled, a message displays stating that the pharmacy cannot receive this information electronically. These options enable you to comply with evolving state and federal regulations and organization policies by allowing you to choose electronic submission of controlled-substance orders on a pharmacy by pharmacy basis.
- **Direct Addr** (Hospitals only). Enter the hospital's direct address as registered through a Direct Exchange administrator.
- **Send PDF** (Hospitals only). Select this checkbox to include a PDF file of the disclosure record.
- **Send C-CDA** (Hospitals only). Select this checkbox to include a C-CDA file of the disclosure record.
- **Primary Lab** (Labs only). Select this checkbox to indicate that the lab is the primary laboratory services provider for the facility. Only one lab can be designated the primary lab for the facility. When the Lab field appears on a physician order, the primary lab is entered in the field by default. If ePrescribing is installed, new and re-ordered lab orders are auto-faxed to the lab company.
- **Primary X-ray** (X-ray companies only). Select this checkbox to indicate that the x-ray company is the primary x-ray services provider for the facility. Only one organization can be designated the primary x-ray provider for the facility. When the X-ray field appears on a physician order, the primary x-ray company is entered in the field by default. If ePrescribing is installed, new and re-ordered x-ray orders are auto-faxed to the x-ray company.

3. Click Save.

















**Edit** an organization by clicking its Edit  button and editing the information. Then click Save.

**Delete** an organization by clicking its Delete  button and confirming the deletion.



## Race

Create and maintain the entries that are available in the Race dropdown using the Race master page.

RACE SELECTION					1 - 8 of 8	
EDIT	DEL	RACE	HL7 ID	MDS 2.0	MDS 3.0	CCD Code
		African American	00	3	C	2054-5
		American Indian	01	1	A	1002-5
		Aleutian	02	1	A	1002-5
		Asian/Pacific Islander	03	2	B	2028-9
		Caucasian	04	5	F	2106-3
		Hispanic	05	4	D	2131-1
		Native Hawaiian or other Pacific Islander	2E	2	E	2076-8
		Indian	13	0	A	
ADD						

You enter a resident's race on the Basic Information page in Registration.

### Adding a race to the master:

- On the Settings tab, select the ADT menu, then click Race.
- On the Add row, enter the appropriate information in each field.
  - Race (required).** Enter a name or description of the race using up to 75 characters.
  - HL7 ID (required).** Enter a 2-character unique identifier to be used in HL7 Interface messages. If you are using the HL7 interface to send Census information to another system, this value needs to have a match in the other system.
  - MDS 2.0.** Enter the 2-character code for the equivalent race on the MDS 2.0 assessment.
  - MDS 3.0.** Enter the 1-character code for the equivalent race on the MDS 3.0 assessment.
  - CCD Code.** Enter the Continuity of Care Document (CCD) code corresponding to the race, using up to six characters including a hyphen. When NetSolutions is installed initially, seven CCD codes are added to the Race Master: African American, American Indian, Aleutian, Asian/Pacific Islander, Caucasian, Native Hawaiian or other Pacific Islander, and Spanish-American.
- Click .

**Edit** a race by clicking its button and editing the fields. Then click .

**Delete** a race by clicking its button and confirming the deletion.

## Relation

Create and maintain the entries that are available in the Relationship dropdown using the Relation master page.

RELATION SUMMARY			
EDIT	DEL	RELATION	DESCRIPTION
		01	Spouse
		03	Child/Fin Resp
		04	Grandparent
		05	Grandchild
		07	Nephew/Niece
		10	Foster Child
		15	Ward
		17	Stepchild
		18	Self
		19	Child

RELATION DETAILS	
Relation: *	<input type="text"/>
Description: *	<input type="text"/>
Invalid Marital Status:	<input type="checkbox"/> S - Single <input type="checkbox"/> M - Married <input type="checkbox"/> W - Widowed <input type="checkbox"/> X - Separated <input type="checkbox"/> C - Couple <input type="checkbox"/> U - Unknown
<div> <div>SAVE </div> <div>CANCEL </div> </div>	

You enter a contact's relationship to the resident on the Contacts and Guarantor pages in Registration.

### Adding a relation to the master:










































- On the Settings tab, select the ADT menu, then click Relation.
- On the Add row, enter the appropriate information in each field.
  - Relation (required).** Enter a two-character code for the relationship.
  - Description (required).** Enter a description of the relationship using up to 20 characters. This is the name of the relationship that will appear in the Relationship dropdown in Registration.
  - Invalid Marital Status.** Select one or more resident marital statuses that you want to designate as invalid for a relationship. For example, if the relationship is "spouse," you might mark as invalid the marital statuses Single, Widowed, and Divorced. Then if a resident's marital status on the Basic Information page is Single, Widowed, or Divorced and you attempt to add a "spouse" contact, an error message displays.
- Click Save.

**Edit** a relation by clicking its  button and editing the text. Then click .

**Delete** a relation by clicking its  button and confirming the deletion.

## Religion

Create and maintain the entries that are available in the Religion dropdown using the Religion master page.

RELIGION SELECTION					1 - 20 of 22 Next>
EDIT	DEL	RELIGION	HL7 ID	CCD Code	
		Agnostic	06	1004	
		Atheist	133		
		Baptist	01	1009	
		Buddhist	19	1059	
		Catholic	02	1041	
		Christian	16	1013	
		Christian Scientist	15	1063	
		Church of God	31		
		Epsicopal	32		
		EVANGELICAL	09	1070	
		Jehovah Witness	14	1025	
		Jewish	07	1036	
		Lutheran	03	1028	
		Methodist	04	1073	
		Mormon	17	1027	
		Moslim	18		
		None Stated	13		
		Other	10		
		PENTECOSTAL	22		
		Presbyterian	05	1076	
ADD		<input type="text"/>	<input type="text"/>	<input type="text"/>	

You enter a resident's religion on the Basic Information page in Registration.

### Adding a religion to the master:

- On the Settings tab, select the ADT menu, then click Religion.
- On the Add row, enter the appropriate information in each field.
  - Religion (required).** Enter a description of the religion using up to 10 characters.

- **HL7 ID (required).** Enter a 3-character unique identifier to be used in HL7 Interface messages. If you are using the HL7 interface to send Census information to another system, this value needs to have a match in the other system.
- **CCD Code.** Enter the Continuity of Care Document (CCD) code corresponding to the religion, using up to five characters. When NetSolutions is installed initially, nineteen CCD codes are added to the Language Master: Agnostic, Baptist, Buddhist, Catholic, Christian, Christian Scientist, Church of Christ, Episcopal, Jehovah's Witnesses, Jewish, Lutheran, Methodist, Mormon, Moslem, Presbyterian, Protestant, Seventh Day Adventist, None Stated, and Other. Additional religion codes are listed in the table at the bottom of this help topic.

3. Click .

**Edit** a religion by clicking its  button and editing the text. Then click .

**Delete** a religion by clicking its  button and confirming the deletion.

CCD Code	Religion
1001	Adventist
1002	African Religions
1003	Afro-Caribbean Religions
1004	Agnosticism
1005	Anglican
1006	Animism
1007	Atheism
1008	Babi & Baha'I faiths
1009	Baptist
1010	Bon
1011	Cao Dai
1012	Celticism
1013	Christian (non-Catholic, non-specific)
1014	Confucianism

<b>CCD Code</b>	<b>Religion</b>
1015	Cyberculture Religions
1016	Divination
1017	Fourth Way
1018	Free Daism
1019	Gnosis
1020	Hinduism
1021	Humanism
1022	Independent
1023	Islam
1024	Jainism
1025	Jehovah's Witnesses
1026	Judaism
1027	Latter Day Saints
1028	Lutheran
1029	Mahayana
1030	Meditation
1031	Messianic Judaism
1032	Mitraism
1033	New Age
1034	non-Roman Catholic
1035	Occult
1036	Orthodox
1037	Paganism
1038	Pentecostal

CCD Code	Religion
1039	Process, The
1040	Reformed/Presbyterian
1041	Roman Catholic Church
1042	Satanism
1043	Scientology
1044	Shamanism
1045	Shiite (Islam)
1046	Shinto
1047	Sikism
1048	Spiritualism
1049	Sunni (Islam)
1050	Taoism
1051	Theravada
1052	Unitarian-Universalism
1053	Universal Life Church
1054	Vajrayana (Tibetan)
1055	Veda
1056	Voodoo
1057	Wicca
1058	Yaohushua
1059	Zen Buddhism
1060	Zoroastrianism
1061	Assembly of God
1062	Brethren

<b>CCD Code</b>	<b>Religion</b>
1063	Christian Scientist
1064	Church of Christ
1065	Church of God
1066	Congregational
1067	Disciples of Christ
1068	Eastern Orthodox
1069	Episcopalian
1070	Evangelical Covenant
1071	Friends
1072	Full Gospel
1073	Methodist
1074	Native American
1075	Nazarene
1076	Presbyterian
1077	Protestant
1078	Protestant, No Denomination
1079	Reformed
1080	Salvation Army
1081	Unitarian Universalist
1082	United Church of Christ

## Role

Create and maintain the contact roles (also called categories) that are available in the Category dropdown using the Role master page. A role defines a contact's relationship to the resident, whether personal or professional. Examples of roles are Financial Power of Attorney, Health Power of Attorney, Executor, Emergency Contact. A contact may be assigned more than one role for the resident.

ROLE SELECTION							1 - 8 of 8
EDIT	DEL	MOVE	ROLE SEQ	ROLE DESC	HL7 ID	PRIMARY CONTACT	
			1	Next of Kin	NK	<input checked="" type="checkbox"/>	
			2	Guest	GU	<input type="checkbox"/>	
			3	Employer	EM	<input type="checkbox"/>	
			4	Friend	FR1	<input type="checkbox"/>	
			5	Other Visitor	OV	<input type="checkbox"/>	
ADD			<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	

You enter a resident contact's category/role on the Contact page in Registration.

### Adding a category/role to the master:

- On the Settings tab, select the ADT menu, then click Role.
- On the Add row, enter the appropriate information in each field.
  - Role Seq (required).** Enter a sequence value for the role. This value determines the order contacts are displayed on the resident Contacts page. For example, if "Emergency Contact" is assigned a sequence number of 1, contacts assigned that role will appear first in the list of contacts for the resident. Click one of the Move buttons in the grid to move a role up or down in the list, increasing or decreasing its sequence value. Other sequence numbers in the list are renumbered as necessary.
  - Description (required).** Enter a unique description for the category/role using up to 40-characters.
  - HL7 ID (required).** Enter a unique 2-character identifier to be used in HL7 Interface messages. If you are using the HL7 interface to send Census information to other systems, this value identifies the same role in the other systems.
  - Primary Contact.** Select this checkbox to indicate that contacts with this role should be considered primary contacts for the resident. Primary contacts appear on such things as facesheets and statements.

- Click .

**Edit** a role by clicking its button and editing the fields. Then click .

**Delete** a role by clicking its button and confirming the deletion.



## Transfer Condition

Create and maintain the transfer conditions that are available in the Trx Condition field on the Discharge page using the Transfer Condition Master.

TRANSFER CONDITION				
EDIT	DEL	DESCRIPTION	SEQUENCE	STATUS
		Abdominal pain	1	Active
		Abnormal lab or test	2	Active
		Abnormal vital signs	3	Active
		Altered mental status	4	Active
		Behavioral symptom's (agitation, psychosis, etc.)	5	Active
		Bleeding other than GI	7	Active
		Blood sugar (high/low)	8	Active
		Chest pain	9	Active
		Constipation	10	Active
		Diarrhea	11	Active
		Edema (new or worsening)	12	Active
		EKG abnormality	13	Active
		Fall(s)	14	Active
		Fever	15	Active
		Functional decline	16	Active
		GI bleeding	17	Active
		Loss of consciousness	18	Active
		Nausea/Vomiting	19	Active
		Nutrition (inadequate intake food/fluid)	20	Active
		Pain (uncontrolled)	21	Active
		Shortness of breath	22	Active
		Skin wound or ulcer	23	Active
		Trauma (fall related or other)	24	Active
		Unresponsive	25	Active
		Urinary Incontinence	26	Active
		Weight loss	27	Active
		Other Sign/Symptom	28	Active
ADD			29	<input type="checkbox"/> Active

### Adding a condition to the master:


- On the Settings tab, select the ADT menu, then click Transfer Condition.
- On the Transfer Condition panel, enter the appropriate information in each field.
  - Description (required).** Enter the description of the transfer condition using up to 50 characters.
  - Sequence (required).** Enter a sequence number for the condition using up to 3 numeric characters. This value determines the order in which the items are displayed. NetSolutions automatically enters the next number in the sequence in this field. If you enter a sequence number that is already in use, NetSolutions rennumbers the entries with duplicate or lower sequence numbers.
  - Active.** Select this checkbox to indicate that the condition is active. Only active conditions are displayed in the Trx Condition dropdown field.
- Click .

The following transfer conditions are pre-defined and activated by Cantata Health:

- Abdominal pain

- Abnormal lab or test
- Abnormal vital signs
- Altered mental status
- Behavioral symptoms (agitation, psychosis, etc.)
- Bleeding, other than GI
- Blood sugar (high/low)
- Chest pain
- Constipation
- Diarrhea
- Edema (new or worsening)
- EKG abnormality
- Fall(s)
- Fever
- Functional decline
- GI bleeding
- Loss of consciousness
- Nausea/Vomiting
- Nutrition (inadequate intake food/fluid)
- Pain (uncontrolled)
- Shortness of breath
- Skin wound or ulcer
- Trauma (fall related or other)
- Unresponsive
- Urinary Incontinence
- Weight loss
- Other Sign/Symptom

**Edit** a transfer condition by clicking its Edit  button and editing the information. Then click .

**Delete** a transfer condition by clicking its Delete  button and confirming the deletion. You cannot delete a transfer condition that has been assigned to a resident.

## Transfer Contributing Reason

Create and maintain the transfer contributing reasons that are available in the Trx Contributing Reason field on the Discharge page using the Transfer Contributing Reason Master.

TRANSFER CONTRIBUTING REASON				
EDIT	DEL	DESCRIPTION	SEQUENCE	STATUS
		Advance care plan not in place	1	Active
		Practitioner unable to provide face-to-face assess	2	Active
		Supplies/Resources	5	Active
		Medication management's	6	Active
		Equipment not available	8	Active
		Problems w/nursing staff resources	9	Active
		Lack of diagnostic services	10	Active
		Resident preference	11	Active
		Family preference	12	Active
		Clinician insisted	13	Active
		Health plan request	14	Active
		Other	15	Active
ADD		<input type="text"/>	<input type="text" value="16"/>	<input type="checkbox"/> Active



### Adding a contributing reason to the master:


- On the Settings tab, select the ADT menu, then click Transfer Contributing Reason.
- On the Transfer Contributing Reason panel, enter the appropriate information in each field.
  - Description (required).** Enter the description of the transfer contributing reason using up to 50 characters.
  - Sequence (required).** Enter a sequence number for the contributing reason using up to 3 numeric characters. This value determines the order in which the items are displayed. NetSolutions automatically enters the next number in the sequence in this field. If you enter a sequence number that is already in use, NetSolutions rennumbers the entries with duplicate or lower sequence numbers.
  - Active.** Select this checkbox to indicate that the contributing reason is active. Only active contributing reasons are displayed in the Trx Contributing Reason dropdown field.
- Click .

The following transfer contributing reasons are pre-defined and activated by Cantata Health:

- Advance care plan not in place
- Practitioner unable to provide face-to-face assessment
- Supplies/Resources
- Medication management
- Equipment not available
- Problems w/nursing staff resources
- Lack of diagnostic services
- Resident preference
- Family preference






- Clinician insisted
- Health plan request
- Other

**Edit** a transfer contributing reason by clicking its Edit  button and editing the information. Then click .

**Delete** a transfer contributing reason by clicking its Delete  button and confirming the deletion. You cannot delete a transfer contributing reason that has been assigned to a resident.

## Transfer Diagnoses

Create and maintain the transfer diagnoses that are available in the Trx Diagnoses field on the Discharge page using the Transfer Diagnoses Master.

TRANSFER DIAGNOSES				
EDIT	DEL	DESCRIPTION	SEQUENCE	STATUS
		Acute renal failure	1	Active
		Anemia	2	Active
		C. difficile (diarrhea)	3	Active
		Cardiac arrest	4	Active
		Cellulitis'	5	Active
		CHF	7	Active
		COPD, asthma, bronchitis	8	Active
		Dehydration	9	Active
		DVT (deep vein thrombosis)	10	Active
		Failure to Thrive	11	Active
		Fracture	12	Active
		Gastroenteritis	13	Active
		Gastrostomy tube blocked/displaced	14	Active
		Hypertension	15	Active
		Hypotension	16	Active
		Pneumonia/Bronchitis	17	Active
		Respiratory arrest	18	Active
		Respiratory infection	19	Active
		Seizure	20	Active
		Sepsis	21	Active
		Stroke/CVA/TIA/new neurological sign	22	Active
		UTI	23	Active
		Other Dx/Presumed Dx	24	Active
ADD			25	<input type="checkbox"/> Active 

### Adding a diagnosis to the master:



1. On the Settings tab, select the ADT menu, then click Transfer Diagnose.
2. On the Transfer Diagnoses panel, enter the appropriate information in each field.
  - **Description (required).** Enter the description of the transfer diagnosis using up to 50 characters.
  - **Sequence (required).** Enter a sequence number for the diagnosis using up to 3 numeric characters. This value determines the order in which the items are displayed. NetSolutions automatically enters the next number in the sequence in this field. If you enter a sequence number that is already in use, NetSolutions rennumbers the entries with duplicate or lower sequence numbers.


- **Active.** Select this checkbox to indicate that the diagnosis is active. Only active diagnoses are displayed in the Trx Diagnoses dropdown field.

3. Click .

The following transfer conditions are pre-defined and activated by Cantata Health:








- Acute renal failure
- Anemia
- *C. difficile* (diarrhea)
- Cardiac arrest
- Cellulitis
- CHF
- COPD, asthma, bronchitis
- Dehydration
- DVT (deep vein thrombosis)
- Failure to Thrive
- Fracture
- Gastroenteritis
- Gastrostomy tube blocked/displaced
- Hypertension
- Hypotension
- Pneumonia/Bronchitis
- Respiratory arrest
- Respiratory infection
- Seizure
- Sepsis
- Stroke/CVA/TIA/new neurological sign
- UTI
- Other Dx/Presumed Dx

**Edit** a transfer diagnosis by clicking its Edit  button and editing the information. Then click .


**Delete** a transfer diagnosis by clicking its Delete  button and confirming the deletion. You cannot delete a transfer diagnosis that has been assigned to a resident.

## Transfer Reason Master

Use this page to create and maintain the entries that are available in the Transfer Reason dropdown on the Transfer and Swap pages, and the LOC Reason dropdown on the Care Level page.

TRANSFER REASON			1 - 3 of 3
EDIT	DEL	DESCRIPTION	
		Changed level of care	
		Issues with roommate	
		Requested different room	
ADD		<input type="text"/>	

### Entering transfer reasons:

1. On the Settings tab, select the ADT menu, then click Transfer Reason.
2. In the Description field on the Add line, enter the reason for transfer using up to 25 characters.
3. Click .

**Note:** Once a transfer reason has been used on a resident record, you cannot delete it from this page.

## VA Disability Master

Create and maintain entries that are available in the VA Service Connected Disability panel on the Clinical Information page. You enter a resident's VA Disability codes in the VA Service Connected Disability panel in Registration. This panel is only available if the Use VA Service Connected Disability checkbox is selected on the Physician Orders Product Options page.

Search by: VA Dx Code
☒ Begins with 
☐ Contains

SEARCH

[Add VA Diagnostic Code](#)

1 - 10 of 747 [Next >](#)

VA DISABILITY SUMMARY					
EDIT	DEL	VA Dx Code	DESCRIPTION	ACTIVE AS OF	INACTIVE DATE
		5000	Osteomyelitis, acute, subacute, or chronic.		
		5001	Bones and Joints, tuberculosis.		
		5002	Arthritis, rheumatoid (atrophic).		
		5003	Arthritis, degenerative (hypertrophic or osteoarthritis).		
		5004	Arthritis, gonorrheal.		
		5005	Arthritis, pneumococcic.		
		5006	Arthritis, typhoid.		
		5007	Arthritis, syphilitic.		
		5008	Arthritis, streptococcic.		
		5009	Arthritis, other types (specify).		

VA DISABILITY DETAIL

VA diagnostic code:

Description:

Active as of:

Inactive date:

SAVE

CANCEL

### Adding a VA disability code to the master:

- On the Settings tab, select the ADT menu, then click VA Disability Master.
- On the Detail panel, enter the appropriate information in each field.
  - VA Diagnostic Code (required).** Enter a unique code for the VA disability.
  - Description (required).** Enter a description of the VA disability.
  - Active As Of.** Enter the date for which the code becomes active using the format mm/dd/yyyy, or click to select a date from the Calendar. An entry in this field is not required for the disability to be active.
  - Inactive Date.** Enter the date for which the code becomes inactive using the format mm/dd/yyyy, or click to select a date from the Calendar.
- Click Save.

**Edit** a VA Disability code by clicking its button and editing the fields. Then click Save.

**Delete** a VA Disability code by clicking its button and confirming the deletion. A code can only be deleted if it is not attached to any resident record.

## Veteran Master

Create and maintain the veteran status descriptions that are available in the Veteran dropdown using the Basic Information page. By default, Veteran and Wartime Veteran are automatically added to the Veteran Master upon installation.

**Note:** Because some VA benefits depend on whether a veteran served in wartime, you should not delete these two entries.

VETERAN MASTER			1 - 2 of 2
EDIT DEL	CODE	DESCRIPTION	
 	1	Veteran	
 	2	Wartime Veteran	
ADD		<input type="text"/>	

You enter a resident's veteran status on the Basic Information page in Registration.

### Adding a veteran status to the master:

1. On the Settings tab, select the ADT menu, then click Veteran Master.
2. On the Add row, enter an HL7 code using up to four characters.
3. Enter unique description for the veteran status using up to 25 characters.

**Note:** You cannot edit or delete a description once the code has been assigned to a resident.








4. Click .

**Edit** a veteran status by clicking its  button and editing the text. Then click .

**Delete** a veteran status by clicking its  button and confirming the deletion.

## Visit Destination

Create and maintain the visit destinations that are available in the Destination dropdown using the Visit Destination page. A visit destination indicates where the resident is going when being discharged from the facility.


VISIT DESTINATION			1 - 3 of 3
EDIT DEL	DESCRIPTION		
 	Entered Facility		
 	Transfer to Hospital		
 	Went Home		
ADD		<input type="text"/>	

You enter a resident's visit destination when discharging the resident on the Discharge page.

### Adding a visit destination to the master:

1. On the Settings tab, select the ADT menu, then click Visit Destination.






















- On the Add row, enter a unique description for the visit destination using up to 40 characters. Typical visit destinations include 'Transfer to Hospital' and 'Home'.
- Click .

**Edit** a visit destination by clicking its  button and editing the text. Then click .

**Delete** a visit destination by clicking its  button and confirming the deletion.


## Visit Source Selection

Create and maintain the entries that are available in the Visit Source dropdown using the Visit Source master page. A visit source indicates the type of residence or living situation from which a resident has come when they are admitted to the facility.

VISIT SOURCE SELECTION				1 - 9 of 9
EDIT	DEL	DESCRIPTION	HL7 ID	
		Acute Care Hospital	1	
		Assisted Living	5	
		Home with NO home health	6	
		Intermediate Care	4	
		Nursing Home	3	
		Other	9	
		Private Home/Apt with Home Care	6	
		Psychiatric Hospital	4	
		Rehabilitation Hospital	4	
ADD				

You enter a resident's visit source on the Visit page in Registration.

### Adding a visit source to the master:

- On the Settings tab, select the ADT menu, then click Visit Source.
- On the Add row, enter the appropriate information in each field.
  - Description (required).** Enter a description of the visit source using up to 40 characters.
  - HL7 ID (required).** Enter a 3-character unique identifier to be used in HL7 Interface messages. If you are using the HL7 interface to send Census information to another system, this value needs to have a match in the other system.
- Click .

**Edit** a visit source by clicking its  button and editing the fields. Then click .

**Delete** a visit source by clicking its  button and confirming the deletion.



# Using ADT

## Introduction

NetSolutions ADT enables you to enter and maintain registration and census data for your residents. ADT enables you to register the following types of residents:

- Prospects
- Inpatients
- Outpatients

Once residents are entered into the system, you will maintain their information by performing the following primary tasks:

- Selecting a resident
- Viewing the ADT Snapshot
- Viewing the Charting Snapshot
- Maintaining Census information
- Viewing reports

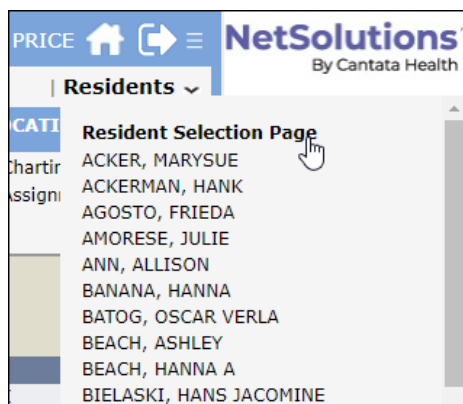
## Selecting a resident

Select a resident in NetSolutions using the Residents dropdown or the Select a Resident page.


### Residents dropdown



On the Resident tab, use the Residents dropdown at top right to choose from an alphabetical listing of all active residents, including inpatients and outpatients. This dropdown enables you to switch residents while remaining on the page where you are currently working.

**Home Page residents list.** On your Home Page, you can set up your own custom list of residents you work with regularly. This shorter list will then display in the Residents dropdown instead of all active residents. To access residents who are not in your list, choose the first option in the dropdown, Resident Selection Page, to open the Select a Resident page as shown below.



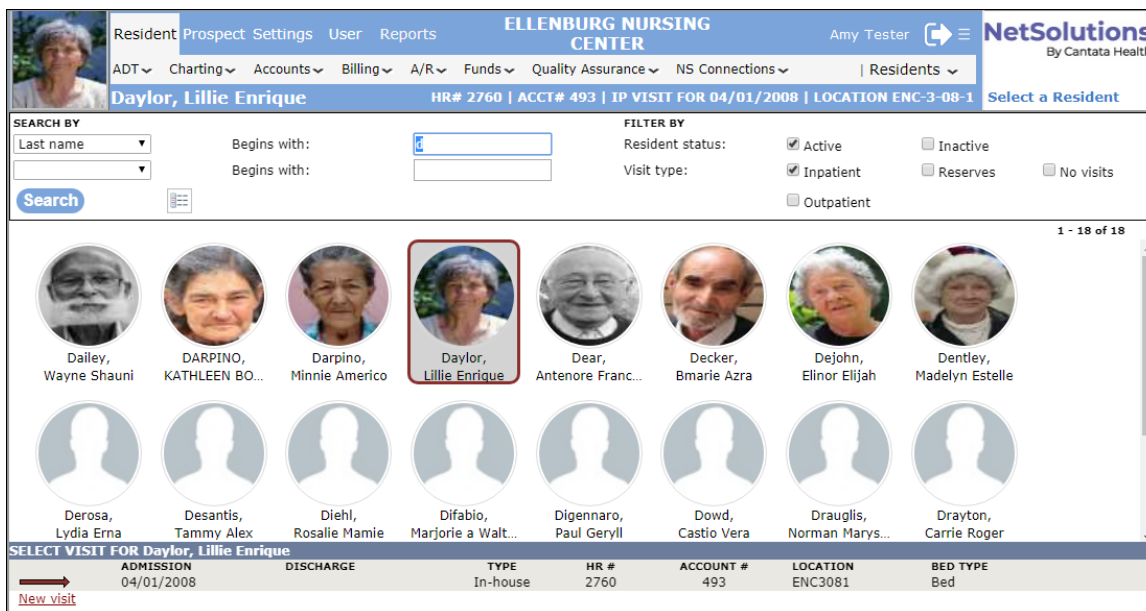
## Select a Resident page


When you first log into NetSolutions, the Select a Resident page displays. To return to this page at any time, choose Resident Selection Page from the Residents dropdown as shown above or point to the Common Tasks  icon and choose Select Resident.

Choose residents by photograph or from a list with resident details. Toggle the view by clicking the Photo  or Details  icon beside the Search button. You can select your default view on the Settings tab of the Home Page.

### Selecting by photo


Click or press on a photo to select a resident. The resident's info then displays above and all visits display at the bottom.



**Resident** Prospect Settings User Reports **ELLENBURG NURSING CENTER** Amy Tester  **NetSolutions**  
By Cantata Health









ADT Charting Accounts Billing A/R Funds Quality Assurance NS Connections Residents

**Daylor, Lillie Enrique** HR# 2760 | ACCT# 493 | IP VISIT FOR 04/01/2008 | LOCATION ENC-3-08-1 [Select a Resident](#)


**SEARCH BY**  
Last name  Begins with:    
[Search](#)

**FILTER BY**  
Resident status: ☒ Active ☐ Inactive  
Visit type: ☒ Inpatient ☐ Reserves ☐ No visits  
☐ Outpatient

1 - 18 of 18

							
Darosa, Lydia Erna	Desantis, Tammy Alex	Diehl, Rosalie Mamie	Difabio, Marjorie a Walt...	Digennaro, Paul Geryll	Dowd, Castio Vera	Drauglis, Norman Marys...	Drayton, Carrie Roger

**SELECT VISIT FOR Daylor, Lillie Enrique**

	ADMISSION	DISCHARGE	TYPE	HR #	ACCOUNT #	LOCATION	BED TYPE
	04/01/2008		In-house	2760	493	ENC3081	Bed

### Selecting by list

Click or press on a Select button to select a resident. Then select a visit at the bottom.

The list view displays the resident name, status, birthdate, location (room), payor type, health record number, admit date, discharge date, admitted from location and discharged to location. Click a blue column heading to sort the grid by that data item; click again to reverse the sort.

### Using the Search panel


Use the Search panel to find a resident or filter the list.

1. On the Search panel, enter search criteria for the resident you want to find.
  - **Search By.** Use these two lists to select the resident identifier you want to search by. Select Last Name, First Name, Health Record #, Location, Social Security #, Medicare #, or Birthdate. The first Search By list defaults to Last Name.
    - When you select the **Social Security #** option, the Begins With field changes to the SS# field. This option finds a single resident only. Enter the resident's full 9-digit Social Security number in the SS# field without dashes (the page will remove the dashes if you enter them). The resident's SS number does not display in the grid below; it can be verified on the Basic Information screen.
  - **Begins with.** For each Search By list, enter the value you want to find. For example, you might select Last Name in the Search By list and then enter a single letter in the Begins With field. Narrow your search further by using both sets of Search By and Begins With fields.
  - **Filter By: Resident status.** Select the type of residents you want to show up in your search: Active or Inactive. Select both check boxes to include all residents.
  - **Filter By: Visit type.** Select the resident visit types you want to show up in your search: Inpatient, Outpatient, Reserves, or No Visits.
    - Your Filter By checkbox selections (both Resident status and Visit type) are saved when you leave this page and are selected again the next time you open it.
2. Click the Search button. The residents matching your search criteria display below, either by photo or detail list.

When you click a task in the task menu, the selected resident's information appears on the page.

### Selecting a resident with Imprivata

If your facility uses the Imprivata palm scan system, you can use it to find the resident you want to work with. In order to search for a resident using Imprivata, the resident must be enrolled in the system. See "Entering Basic Information" in the ADT help/training guide for more information about enrolling a resident in Imprivata.

1. Point to the Common Tasks icon  at top right and choose Select Resident or point to the Residents dropdown and choose the first item, Resident Selection Page.
2. On the Select a Resident page on the upper Search panel, select the Authenticate Resident link.
3. Proceed with the palm scan. Once the system verifies the palm scan, the resident's information displays.
4. Select the resident visit with which you want to work.

When you click a task in the task menu, the selected resident's information appears on the page.

**Note:** The Authenticate Resident link can also be accessed on the Initiate EPI Search page. When the palm scan is initiated from this page, the resident's name and date of birth will populate the search criteria fields and you can press the Search button to return results. For information on setting up the Enterprise Person Index (EPI) see the Interface Manager help/training guide.

## ADT Snapshot

The ADT Snapshot provides a one-page summary of a resident's registration and census data in view-only mode. The ADT Snapshot is divided into sections that display summaries of the information from each Registration page. You can also view a summary of the resident's clinical information on the Charting Snapshot page.

The ADT Snapshot page contains the following sections:

- **Basic Information**

This section provides the following links:

- **View basic information.** Click to open the Basic Information page in Registration.
- **View visit information.** Click to open the Visit page in Registration.
- **New visit.** Click to create a new visit for the resident. The Visit page opens in Add mode and prompts you for the type of visit you want to create.
- **ClinReadmit.** Click to open the ResStatus dialog where you can indicate a clinical re-admission by changing the From Type on a resident status period within the current visit.

- **Census Information**

- **Reimbursement Information**

- **Clinical Information**

- **Contact Information**

- **Additional Information**

From each section of the snapshot, you can jump to the corresponding Registration page to edit the data. Once on a Registration page, you can navigate between Registration pages to edit the resident's information.

Resident Prospect Settings User Reports

Loewenguth Facility

CCS

NetSolutions  
By Cantata Health

ADT Charting Accounts Billing A/R NS Connections Residents

ABRAHAMSON, CLIF

HR# 8519.006 | ACCT# 1399 | OP VISIT FOR 07/08/2013

ADT Snapshot

CURRENT LOCATION:

HEALTH RECORD #: 8519.006

ACCOUNT #: 1399

DATE OF BIRTH: 10/30/1958

GENDER: Male

ADMISSION DISCHARGE TYPE ACCOUNT # HR #

07/08/2013 OP 1399 8519.006

View basic information eDocs Resident Annotations View visit information New visit

VIST INFORMATION FOR ADMISSION: 07/08/2013

CENSUS INFORMATION

FROM DATE	THRU DATE	LOCATION	BED TYPE	PYR	STATUS	LEVEL OF CARE	HOLD TYPE	BU/PL
11/01/2013				M		31 (NP-Hagerstown)		HC/1
07/08/2013	10/31/2013					31 (NP-Hagerstown)		HC/1

REIMBURSEMENT INFORMATION

PLAN	PAYOR	TYPE	START DATE	END DATE
MCR B-NP-HAG	MCR B-PHYS	Medicare	07/08/2013	
PRIVATE COINSURANCE	KENSICBYIN	Guarantor	07/08/2013	

CLINICAL INFORMATION

ICD-9 Diagnoses

ICD-10 Diagnoses

DIAGNOSIS	ICD-10	ONSET	RESOLVED	DX TYPE	BILL_SEQ	ON-BILL	CLINICAL
Diabetes mellitus due to underlying condition with	E08.65	7/8/2013			1	✓	1

PHYSICIAN/CLINICIAN NAME	CATEGORY	RANK	ALLERGY	ONGOING	RECORDED	INACTIVATED	REACTION	SEVERITY
Dematteo, Rina	Alternate							
Flagg, Carmen	Attending							
Wainwright, Garnett	Referring	1						

ADVANCE DIRECTIVES

CONTACT INFORMATION

CATEGORY	RANK	CONTACT NAME	PHONE 1	PHONE 2	NOTIFY IN EMERGENCY
Next of Kin	1	Abrahamson, Ellroy	5558256914 (Cell)		YES

GUARANTOR Ibrahim, Nora 2345556247 (home)

View guarantor information

ADDITIONAL INFORMATION

**Note:** In the Clinical Information section, when you hold the mouse pointer over an ICD-9 or ICD-10 diagnosis, NetSolutions displays a popup of the entire diagnosis description. This is especially useful for ICD-10, where descriptions can be very long.

## Viewing the ADT Snapshot:

1. On the Resident tab, select a resident visit.
2. In the ADT menu, select Snapshot.

3. On the ADT Snapshot page, you can do the following:
  - View another visit by clicking **SELECT** beside a visit in the information panel at the top of the page.
  - Scroll down the page to view all sections of the snapshot. You can also scroll side-to-side and within sections to view more information.
  - Click a link on the Snapshot page to edit that section's data.
4. You can also print the following reports from the ADT Snapshot page:
  - Click the Print Record of Admission link at the bottom to print the facesheet for the resident's current (most recent) visit. To print the ICD-10 Record of Admission click the Print ICD-10 Record of Admission link.
  - Click the View Event History link to print the Event Tracking report for the resident's current visit.
  - Click the View Resident Demographic History link to print a listing of modifications to the resident's demographic information as entered on the Basic Information page.
5. To view more detailed information about the resident's account, click the Account Utility link to open the Account utility.
  - Click the resident's name and the links on the right-hand side of the Resident Accounts page to view more details about the resident's account.

RESIDENT ACCOUNTS				1 - 1 of 1
SELECT	LAST NAME	FIRST NAME	HR#	ACCOUNT CODE
	Abrahamson	Clifford	8519.006	1399

ACCOUNT RECORD	
Account Code:	1399
Res Snbr:	1201
Start Date:	7/8/2013
End Date:	
Assets:	0.00
Entrance Fee:	0.00
Last Charge Date:	5/9/2014
Ar Close Date:	4/30/2014
Billed Thru:	5/31/2014
Valid Table:	True
Advanced Thru:	6/30/2014
Billed Strt:	5/31/2014
Bills Strt:	5/31/2014
Bills Thru:	5/31/2014
Start Interest Chrg:	4/30/2014
Last Charges:	
Chrg Interest:	True
VKTimestamp:	2014062014310402

<a href="#">Visits</a>	<a href="#">Receipts</a>
<a href="#">Charges</a>	<a href="#">Reimb Table</a>
<a href="#">Bills</a>	<a href="#">Balances</a>
<a href="#">Statements</a>	<a href="#">Days/Dollars</a>
<a href="#">Adjustments</a>	

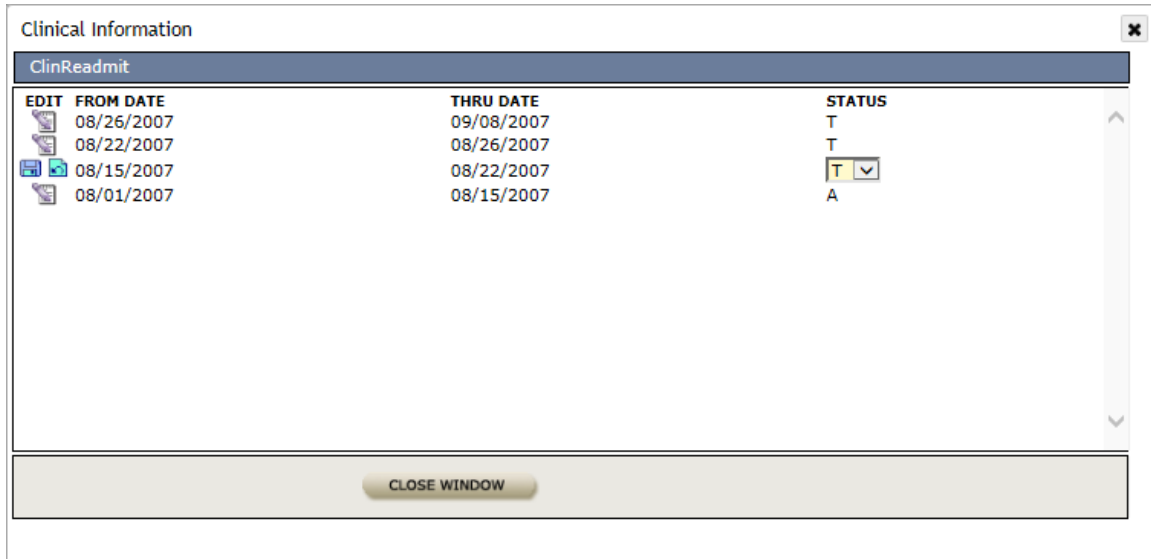
For detailed information about the fields in the Snapshot, see the Help topics for Registration.

**Note:** Census, diagnosis, and physician information is stored by visit; all other registration data is stored by resident.



## Entering a clinical readmit

Enter a clinical readmission for the resident in the Clinical Information dialog, accessed from the ADT Snapshot page.



The Clinical Information dialog box displays a table of status periods. The table has four columns: EDIT, FROM DATE, THRU DATE, and STATUS. The STATUS column has a dropdown menu showing 'T' and 'A'.

EDIT	FROM DATE	THRU DATE	STATUS
	08/26/2007	09/08/2007	T
	08/22/2007	08/26/2007	T
	08/15/2007	08/22/2007	T
	08/01/2007	08/15/2007	A


At the bottom of the dialog is a button labeled "CLOSE WINDOW".

This dialog enables you to change the clinical From Type on the status periods within the current visit. The dialog displays the From and Thru date for each status period along with the From Type status code, and enables you to edit only the code. You should make note of the status period you want to modify before opening the dialog, for example by viewing the resident's care level changes in the Census Information section of the Snapshot.

To indicate a clinical readmission, you set the From Type status code to R. This restarts the clinical PPS (Medicare) cycle for the resident, indicating a new 5-day MDS assessment will be due. The assessment then appears on the Due Dates report and in Case Mix history.

The Hold page also enables you to indicate a clinical readmit when you enter an end date on a hold. Selecting the Clinical Readmit checkbox on that page sets the From Type to R. (Status periods set to R on the Hold page cannot be edited in the Clinical Information dialog; edit them on the Hold page.) The Clinical Information dialog provides a way to enter a clinical readmit at any time, such as when a resident has a care level or payor type change that starts a new PPS cycle, without a leave or bed hold.

### To enter a clinical readmit:

1. Select a resident visit, and then in the ADT menu click Snapshot.
2. In the top section of the ADT Snapshot, click the ClinReadmit link.
3. In the Clinical Information dialog, click  for the status period you want to modify.
4. In the Status column, edit the From Type code to one of the following:
  - **R** - clinical readmit
  - **T** - transfer or other census change
  - **A** - admission (display only; cannot change code to A)

5. Click  to save your changes.

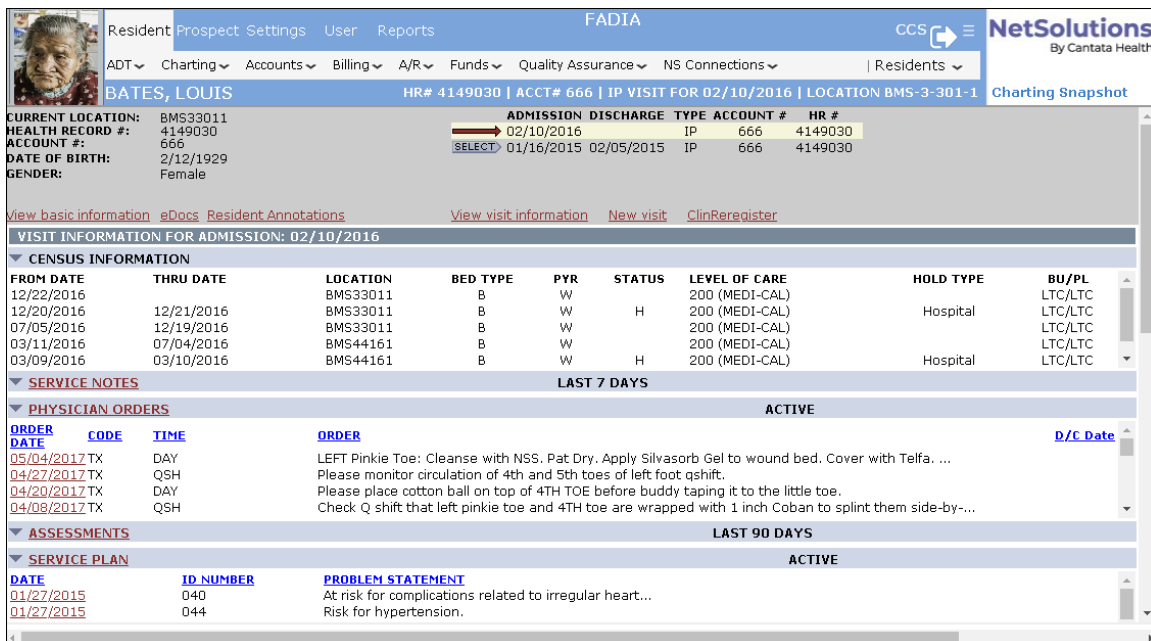
## Charting Snapshot

The Charting Snapshot provides a one-page summary of a resident's clinical data in view-only mode. The Charting Snapshot is divided into sections that display summaries of the information from each clinical application. You can also view a summary of the resident's registration and census information on the ADT Snapshot page.

The Charting Snapshot page contains the following sections:

- Census Information
- Interdisciplinary Progress Notes
- Physician Orders
- Assessments
- Care Plan
- Vitals
- Clinical Information
- Additional Information

Click a section heading in the snapshot to jump to that application's start page where you can work with the resident's data in that program.



Resident: **BATES, LOUIS** | HR# 4149030 | ACCT# 666 | IP VISIT FOR 02/10/2016 | LOCATION BMS-3-301-1

**CURRENT LOCATION:** BMS33011  
**HEALTH RECORD #:** 4149030  
**ACCOUNT #:** 666  
**DATE OF BIRTH:** 2/12/1929  
**GENDER:** Female

**ADMISSION DISCHARGE TYPE ACCOUNT # HR #**  
 02/10/2016 IP 666 4149030  
 SELECT 01/16/2015 02/05/2015 IP 666 4149030

[view basic information](#) [eDocs](#) [Resident Annotations](#) [View visit information](#) [New visit](#) [ClinReregister](#)

**VISIT INFORMATION FOR ADMISSION: 02/10/2016**

FROM DATE	THRU DATE	LOCATION	BED TYPE	PYR	STATUS	LEVEL OF CARE	HOLD TYPE	BU/PL
12/22/2016		BMS33011	B	W		200 (MEDI-CAL)		LTC/LTC
12/20/2016	12/21/2016	BMS33011	B	W	H	200 (MEDI-CAL)	Hospital	LTC/LTC
07/05/2016	12/19/2016	BMS33011	B	W		200 (MEDI-CAL)		LTC/LTC
03/11/2016	07/04/2016	BMS44161	B	W		200 (MEDI-CAL)		LTC/LTC
03/09/2016	03/10/2016	BMS44161	B	W	H	200 (MEDI-CAL)	Hospital	LTC/LTC

**SERVICE NOTES** **LAST 7 DAYS**

**PHYSICIAN ORDERS** **ACTIVE**

ORDER DATE	CODE	TIME	ORDER	D/C Date
05/04/2017	TX	DAY	LEFT Pinkie Toe: Cleanse with NSS. Pat Dry. Apply Silvasorb Gel to wound bed. Cover with Telfa. ...	
04/27/2017	TX	QSH	Please monitor circulation of 4th and 5th toes of left foot qshift.	
04/20/2017	TX	DAY	Please place cotton ball on top of 4TH TOE before buddy taping it to the little toe.	
04/08/2017	TX	QSH	Check Q shift that left pinkie toe and 4TH toe are wrapped with 1 inch Coban to splint them side-by-...	

**ASSESSMENTS** **LAST 90 DAYS**

**SERVICE PLAN** **ACTIVE**

DATE	ID NUMBER	PROBLEM STATEMENT
01/27/2015	040	At risk for complications related to irregular heart...
01/27/2015	044	Risk for hypertension.

**Note:** In the Clinical Information section, when you hold the mouse pointer over an ICD-9 or ICD-10 diagnosis, NetSolutions displays a popup of the entire diagnosis description. This is especially useful for ICD-10, where descriptions can be very long.

### Viewing the Charting Snapshot:

1. On the Resident tab, select a resident visit.
2. In the Charting menu, select Snapshot.
3. On the Charting Snapshot page, you can do the following:
  - View another visit by clicking the Select button beside a visit in the Basic Info section.
  - Scroll down the page to view all sections of the snapshot. You can also scroll side-to-side and vertically within sections to view more information.
  - Click a link on the Snapshot page to edit that section's data.
4. You can also print the following reports from the Charting Snapshot page:
  - Click the [Print Record of Admission](#) link at the bottom to print the facesheet for the resident's current (most recent) visit.
  - Click the [Print Transfer Reports](#) link to open the Transfer Reports dialog where you can quickly print several reports typically needed when a resident transfers.
  - Click the [Print Resident Photo](#) link to print a small report containing the resident's photograph along with the name, location, health record number, account number, date of birth and gender.
  - Click the [Print Client Diagnosis Report](#) link to print a diagnosis report for the resident's most current visit.

For detailed information about the fields in the Charting Snapshot, see the Help topics for the corresponding clinical program.

## Transfer Reports

On the Charting Snapshot page, click the **Print Transfer Reports** link at the bottom to open the Transfer Reports dialog where you can quickly print several reports typically needed when a resident transfers.

NetSolutions Report

TRANSFER REPORTS

Resident name:

**SELECT REPORT**

<input type="checkbox"/>	Record of Admission	<a href="#">Print</a>
<input checked="" type="checkbox"/>	ICD-10 Record of Admission	<a href="#">Print</a>
<input checked="" type="checkbox"/>	Physician Order	<a href="#">Print</a>
<input checked="" type="checkbox"/>	eMAR	<a href="#">Print</a>
<input type="checkbox"/>	eTAR	<a href="#">Print</a>
<input checked="" type="checkbox"/>	IPN Report	<a href="#">Print</a>
<input type="checkbox"/>	Immunization Record	<a href="#">Print</a>
<input type="checkbox"/>	MDS 3.0 Comprehensive Assessment	<a href="#">Print</a>
<input type="checkbox"/>	MDS 3.0 Quarterly Assessment	<a href="#">Print</a>
<input type="checkbox"/>	Client Diagnosis Report	<a href="#">Print</a>
<input type="checkbox"/>	Vital Parameters Report	<a href="#">Print</a>

**PRINT**

This dialog contains two panels:

- **Select Resident.** On the top panel, the Resident Name field defaults to the resident selected on the Charting Snapshot page. You can use the Search dialog to select another resident.
- **Select Reports.** On the lower panel, four reports - the Record of Admission, Physician Orders, eMAR, and IPN reports - are selected by default. Also available for printing are the eTAR, MDS 3.0 Comprehensive Assessment, MDS 3.0 Quarterly Assessment, Client Diagnosis and Vital Parameters reports.

### To print transfer reports:

**PRINT** When you click this button in the Transfer Reports dialog, all selected reports are sent in succession to the Report Viewer using default criteria, and print the following:

- **Record of Admission, ICD-10 Record of Admission:** Face sheet information for the current visit. By default, ICD-10 Record of Admission is selected.
- **Physician Orders, eMAR, eTAR:** Orders and charting info for the last 30 days.
- **IPN:** Progress notes entered in the last three days.
- **Immunization Record.** Immunization records that meet the specified report criteria.
- **MDS reports:** The most recent comprehensive or quarterly assessment.
- **Diagnosis:** Diagnoses by resident.

- **Vital Parameters:** All vital parameter records entered within the current day plus the three previous days.

**Print.** Click this link for a specific report to access its report criteria and print the report separately using any criteria you choose.

**Note.** Since these reports are concatenated into a single continuous document when printed as a group, to export the reports to another format, you must print them individually.

## Resident Photo report

On the Charting Snapshot page, click the [Print Resident Photo](#) link at the bottom to open the Crystal Reports dialog where you can quickly print a small report containing the resident's photograph along with the name, location, health record number, account number, date of birth and gender of the resident.

<a href="#">Print Record of Admission</a>	<a href="#">Print ICD-10 Record of Admission</a>	<a href="#">Print Transfer Reports</a>	<a href="#">Print Resident Photo</a>	<a href="#">Print Client Diagnosis Report</a>
---	--	--	--------------------------------------	---

### To print the Resident Photo report:

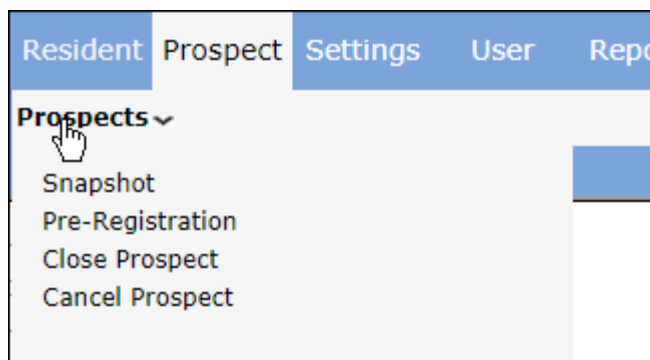
1. On the Resident tab, select a resident visit.
2. In the Charting menu, select Snapshot.
3. At the bottom of the Charting Snapshot page, click the [Print Resident Photo](#) link.
4. Save the report file.

## Pre-Registration

### Overview

Pre-register a prospective resident to your facility using the Prospects tab. When you pre-register a prospect, you use the same registration pages and enter most of the same data as for admitted residents. A prospect receives a visit type of Prospect (PR).

Once a prospect is pre-registered, you can view their Prospect Snapshot, add physician orders for the prospect, and conduct user-defined assessments. For more information, see the Snapshot, Physician Orders, and UDA Help or training guides.



**Pre-register a prospect.** To pre-register a prospect, click the Prospects tab. Then click the Prospects menu and choose Pre-Registration. Proceed through the Pre-Registration pages. These pages are the same as those for regular registration except for a few minor differences, including the following:

- The Admit Date/Time fields are changed to Estimated Admit Date/Time.
- Data entry in some fields is optional in pre-registration where it is required in registration. For example, a care level and a location are not required for a prospect.
- Some page and field names are changed to reflect that you are working with a prospect in pre-registration.
- The Waitlist is available so you can track a pre-registration prospects.
- When you add a prospect, you can enter diagnoses for the prospect using future onset dates.

**Step-by-step instructions.** For more information about the registration process, see Registering a resident and the Help topics for each of the registration pages.

**Closing a prospect visit.** When you admit a pre-registered prospect to your facility, their prospect visit is closed automatically. You can also close a prospect visit manually.

**Canceling a prospect visit.** If a prospect will not be entering your facility, you can cancel the prospect visit. Canceling a visit removes it from the system (closing a visit keeps it in the system and gives it an end date).

**Checking eligibility.** You can check 270/271 eligibility for a pre-prospect before he or she has been registered as a prospect or admitted to the facility. Use the Check Eligibility item on the Prospects menu to enter the information needed for an eligibility request and then submit the request. Once a pre-prospect has been admitted to the facility, these eligibility checks are attached to the resident record and are available to view. Use the Eligibility History report to view a list Eligibility reports by resident, payor and/or date.

**Note:** You must set up the eligibility profile on the Eligibility Profile page and enter an eligibility payor ID in the Bill Codes panel of the Payor/Plan page before you can use this feature.

**Security.** NetSolutions includes security items for individual sections of the clinical information pages. Security can be applied to Allergies, Diagnoses, Physicians, and Advance Directives. Choose to let staff view, add to, or edit information on some or all of these pages. Those pages to which a staff member does not have access are not displayed when he or she logs in

## Prospect Snapshot

Once a prospect is pre-registered, you can view their Prospect Snapshot. The Prospect Snapshot provides a one-page summary of a prospect's registration and census data in view-only mode. When you pre-register a prospect, you use the same registration pages and enter most of the same data as for admitted residents.

For specific information about the fields in the Prospect Snapshot, see the ADT Snapshot topic in the ADT help or training guide.

[Resident](#)
[Prospect](#)
[Settings](#)
[User](#)
[Reports](#)

**Platek Admit Facility**

[CCS](#)

**NetSolutions**  
By Cantata Health

[Prospects](#)
[Charting](#)
[NS Connections](#)

[Prospects](#)

**BAKER, TOM**

**HR# 630 | ACCT# 312 | PR VISIT FOR 09/03/2016**

**ADT Snapshot**

**CURRENT LOCATION:**

**HEALTH RECORD #:** 630
 **ADMISSION** 09/03/2016
 **DISCHARGE**
**TYPE** PR
 **ACCOUNT #** 312
 **HR #** 630

**ACCOUNT #:** 312

**DATE OF BIRTH:** 09/01/1905

**GENDER:** Male

[View basic information](#)
[eDocs](#)
[Resident Annotations](#)
[View visit information](#)
[New visit](#)

**VISIT INFORMATION FOR ADMISSION: 09/03/2016**

**▼ CENSUS INFORMATION**

FROM DATE	THRU DATE	LOCATION	BED TYPE	PYR	STATUS	LEVEL OF CARE	HOLD TYPE	BU/PL
09/03/2016						1 (RESERVED)		

**▼ REIMBURSEMENT INFORMATION**

PLAN	PAYOR	TYPE	START DATE	END DATE
COMMERCIAL INSURANCE	COMM	Commercial	09/01/2016	

**▼ CLINICAL INFORMATION**

**▼ ICD-9 Diagnoses**

**▼ ICD-10 Diagnoses**

DIAGNOSIS	ICD-10	ONSET	RESOLVED	DX TYPE	ON-BILL	CLINICAL
Benign prostatic hyperplasia without lower urinary	N40.0	9/3/2016			✓	1

PHYSICIAN/CLINICIAN NAME	CATEGORY	RANK	ALLERGY	ONGOING	RECORDED	INACTIVATED	REACTION	SEVERITY
Corbett, Wendy	Admitting							
Cox, Neal	Attending							

**ADVANCE DIRECTIVES** DNR

**▼ CONTACT INFORMATION**

**▼ ADDITIONAL INFORMATION**

Comments:

[Print Record of Admission](#)
[Print ICD-10 Record of Admission](#)
[View Event History](#)
[View Resident Demographic History](#)
[Account Utility](#)

## Closing a prospect visit

You can close a prospect visit either automatically or manually. When you convert a prospect to a resident, the system closes the prospect visit automatically. If a pre-registered prospect will not be entering your facility and you want to close the prospect visit, use the Close Prospect page on the Prospects tab.

Baker, Tom		HR# 630   ACCT# 312   PR VISIT FOR 09/03/2016	Close Prospect:
Resident:	Baker, Tom		
Health record #:	630		
Expected admit date:	09/03/2016		
Closed date:			
<div> <div>CLOSE</div> <div>DONE </div> </div>			

1. Click the Prospects tab. The Select Prospect page appears.
2. Select the prospect and the visit you want to close the same way you select a resident visit.
3. In the Prospects menu, click Close Prospect.
4. On the Close Prospect page, verify the prospect's information, then click the Close button.
  - o The Close button changes to the Reopen button, which you can click to reverse the closure.
5. Click Done to return to the Select Prospect page.

**Reopen** a previously closed prospect visit by selecting a closed prospect visit on the Select Prospect page, then clicking the Close Prospect link in the task menu. On the Close Prospect page, click the Reopen button.

## Canceling a prospect visit

If a prospect will not be entering your facility, you can cancel the prospect visit. Canceling a visit removes it from the system (closing a visit keeps it in the system and gives it an end date).

Baker, Tom		HR# 630   ACCT# 312   PR VISIT FOR 09/03/2016	Cancel Prospect
To cancel the prospect visit for this resident, select options, then press "Save".			
Resident:	Baker, Tom		
Health record #:	630		
Admit date:	9/3/2016 9:00:00 AM		
<input checked="" type="checkbox"/> Delete account and reimbursement table.			
<input checked="" type="checkbox"/> Delete beginning balances			
<div> <div>SAVE </div> <div>CANCEL </div> </div>			

1. Click the Prospects tab. The Select Prospect page appears.
2. Select the prospect and the visit you want to cancel the same way you select a resident visit.



3. In the Prospects menu, click Cancel Prospect.
4. On the Cancel Prospect page, verify the prospect's information.
5. Select the appropriate options:
  - **Delete account and reimbursement table.** Select this checkbox to delete the prospect's account and reimbursement info, if necessary.
  - **Delete beginning balances.** Select this checkbox to delete any beginning balances established for the account.
6. Click Save. A confirmation message appears.
7. Click OK.





### Checking 271 eligibility for a prospect

Use the Check Eligibility page on the Prospects tab to check the prospect's 271 eligibility for a payor electronically. You can check eligibility for as far back as 27 months in the past and up to four months in the future. Actual dates in this time span are determined by the date the transaction was received.

**Note:** You must set up the eligibility profile on the Eligibility Profile page and enter an eligibility payor ID in the Bill Codes panel of the Payor/Plan page before you can use this feature.

1. Click the Prospects tab. The Select Prospect page appears.
2. Select the prospect and the visit you want to check the same way you select a resident visit.
3. In the Prospects menu, click Check Eligibility.
4. In the Benefit Inquiry panel, enter the appropriate information.

BENEFIT INQUIRY			
Eligibility Check Date:	04/13/2016	Thru Date:	
Payor:	Vendor	NPI:	1265442222
Last name:	Smith	Gender:	Female
First name:	Latitia	Date of birth:	08/09/1934  (Age: 81)
Middle name:			
Suffix:			
Policy holder is?	<input checked="" type="radio"/> Prospect <input type="radio"/> Other		
Medicare/Subscriber #:	055-26-8246A		
Policy holder ID:			
<a href="#">Eligibility Options</a>			
SUBMIT		CLOSE WINDOW	

- **Eligibility Check Date (required).** Enter the date for which you want to check eligibility using the format mm/dd/yyyy, or click  to open the Calendar and select a date.
- **Payor (required).** Click  to open the Search for Vender Payor dialog where you can select the payor for which you want to check eligibility.
- **Last Name (required).** Enter the prospect's last name.
- **First Name (required).** Enter the prospect's first name
- **Middle Name.** Enter the prospect's middle name, if necessary.
- **Suffix.** Enter the prospect's suffix, if applicable.
- **Policy Holder Is.** Indicate whether the prospect is the policy holder. If not, select Other.
- **Medicare/Subscriber # (required).** Enter the prospect's Medicare or subscriber number.
- **Policy Holder ID.** Enter the policy ID number.
- **Thru Date.** Enter the date thru which you want to check eligibility using the format mm/dd/yyyy, or click  to open the Calendar and select a date.
- **NPI (required).** Enter the NPI number.
- **Gender (required).** Select the prospect's gender.
- **Date of Birth (required).** Enter the prospect's birth date using the format mm/dd/yyyy, or click  to open the Calendar and select a date.
- **Eligibility Options.** Click this link to open the Benefit Inquiry dialog where you can specify the items for which you are checking eligibility. The default items displayed in this dialog are defined on the Eligibility Profile page. When you clear or select checkboxes in the Benefit Inquiry dialog those new selections are not saved and the next time you use this link the specified defaults display again.

5. Click the Submit button.

- NetSolutions displays a progress bar to indicate how the Eligibility Check process is progressing.

### Eligibility report

After an eligibility check has been made, NetSolutions automatically runs the Eligibility report. The report displays the eligibility information for the resident for which the check was submitted. You can also view this report by clicking the Review History link in the Benefit Inquiry dialog and selecting the date for which you want to review information.

The Eligibility report consists of the following sections:

- **Medicare.** This section contains information about the resident's Medicare Part A and Part B eligibility, including deductibles and therapy caps, secondary payor information, inpatient spell history, and as of April 2018 whether the resident is a railroad retirement beneficiary.

- **Medicare Advantage Information (Part C).** This section displays the option code, effective and termination dates and the plan name and number for Part C.
- **Medicaid.** This section contains information about the resident's Medicaid eligibility.
- **Commercial Ins.** This section contains information about the resident's commercial insurance.
- **Home Health Information.** This section contains home health care information for the resident.
- **Hospice Information.** This section contains information about the resident's hospice care.
- **Incarcerated/Alien.** This section contains information about the resident's history of incarceration and/or alien status.
- **Supplemental Insurance.** This section contains information about the resident's supplemental insurance.
- **Other Insurance.** This section contains information about the resident's other insurance.

## Registration

### Overview

Enter and maintain core information about your residents using Registration. You register, or "admit," a resident by completing the following web pages:

- Basic Information
- Guarantor
- Contacts
- Visits
- Clinical
- Reimbursement
- Additional Info

**Procedure.** Register a new resident by selecting an option under Registration in the ADT menu. You can register a resident as an inpatient or an outpatient. Move through the pages sequentially by clicking Next when a page is completed. Click a link at the top to jump to any Registration page. Once a resident is registered, edit the information by accessing the Registration pages either directly or through the resident Snapshot.

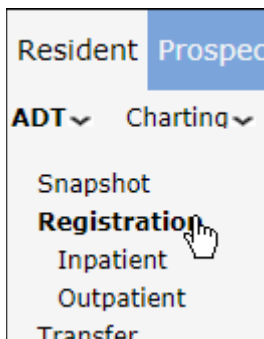
**Integration.** The data you enter in Registration is used throughout the NetSolutions system. When you enter account or billing transactions, or complete an assessment or care plan for a resident, that resident's Registration info is pulled into the application in which you are working. This both speeds data entry and avoids duplication errors.

**Reports.** NetSolutions Registration provides a wide array of reports for viewing and managing your residents' information. You can print detailed information for individual residents, summary info for many residents, and facility census data organized in many different ways. On the Reports tab, click the Clinical Reports link in the task menu and then expand the Census item in the main panel to access the full array of Registration and Census reports.

**Security.** NetSolutions includes security items for individual sections of the clinical information pages. Security can be applied to Allergies, Diagnoses, Physicians, and Advance Directives. Choose to let staff view, add to, or edit information on some or all of these pages. Those pages to which a staff member does not have access are not displayed when he or she logs in

## Registering a resident

Register a resident to admit them to the facility and gather core demographic, medical, and financial information for use throughout the NetSolutions system.



This topic provides a brief overview of the registration process. For detailed instructions on completing each Registration page, see the following topics:

- Entering basic information
- Entering a guarantor
- Entering contacts
- Entering a visit
- Entering clinical information
- Entering a reimbursement schedule
- Entering additional info

### Registering a new resident:

1. Click the Resident tab.
2. In the Registration section of the ADT menu, select either Inpatient or Outpatient.
  - The Basic Information page displays in Add mode.
3. Enter the appropriate information in each field.
4. When finished, click the Next button.

5. Continue through the remaining Registration pages.
6. When finished, click the Done button to view the ADT Snapshot.

**Note:** If you attempt to add a resident with a last name and social security number that matches a resident already in the system, NetSolutions displays a dialog box where you can choose to create a new visit for the existing resident, or create a new resident record.

## Basic Information

### Overview

Enter a resident's core demographic information on the Basic Information page.

BASIC		GUARANTOR	CONTACTS	VISIT	CLINICAL	REIMBURSEMENT	ADDITIONAL	Resident Annotations
Last name: *	Berends	Address:		2552 AnyStreet				
First name: *	Deforest	City:		AnyTown				
Middle name:	Arturo	State/Province:		WA	Zip:	38446		
Suffix:		County:		ANDERSON				
Maiden name:		Phone 1:						
Nickname:		Phone 2:						
Code status:		Phone 3:						
<a href="#">ATTACH PHOTO</a> <a href="#">eDocs</a>		Change effective date/time:		01/23/2018	13:10			
<b>NAME AND ADDRESS HISTORY</b>								
EDIT	DEL	EFFECTIVE DATE	RESIDENT NAME	NICKNAME	ADDRESS	COUNTY	PHONE 1	PHONE 2
Gender: *	Female	Veteran:						
Marital status: *	Widowed	Education:		8th grade/less				
Race/Ethnicity:	Caucasian	Preferred language:		English				
Date of birth: *	12/28/1924 (Age: 93)	English speaking ability:		Good				
Birthplace:	PICKENS	Religion:		Baptist				
Citizenship:	UNITED STATES	Church:		BAUERLEIN Church				
Occupation:	TEXTILES	Funeral home:		EARL Funeral Home				
Father's name:		Pharmacy:		WAINWRIGHT Pharmacy				
Mother's name:		Ambulance:						
Spouse's name:		Hospital:						
Social security #:	854-55-8292	Medicaid #:		032546414475				
Medicare MBI #:	137590994825	Approval Date:						
Org. Medicare #:	137590994825	Welfare #:						
<input type="checkbox"/> Railroad Retirement Beneficiary		Other ID#:						
Effective Dates:		Health record #:		2742				
Part A:	11/1/1989							
Part B:	11/1/1989							
<a href="#">Medicare Part D Plans</a>								
User field 1:								
User field 2:								
User field 3:								
User field 4:								
User field 5:								
Comments:	Had pneumonia vaccine past age 65							
HIE consent?	<input type="radio"/> Accepted <input type="radio"/> Declined <input checked="" type="radio"/> Not asked							
Print statement:	<input type="checkbox"/> Print a statement for this resident							
<a href="#">NEXT</a> <a href="#">SAVE</a> <a href="#">DONE</a> <a href="#">CANCEL</a>								
<a href="#">Add Organization</a>								

This page is divided into four sections where you do the following:

- Enter the resident's name, address, and phone number; attach a photo
- Enter personal info, and family and social relationships and affiliations
- Enter federal, state, medical, and other ID numbers
- Enter comments and facility-defined data

**Reports.** Basic information such as the resident's name and medical record number appears on many reports in the NetSolutions system. You can view a complete record demographic changes in the system using the Demographic Change Log. The Resident Inquiry and Facesheet reports provide detailed information on each resident.

### Entering basic information

You first enter a resident's basic information when registering the resident. You can edit the information at any time by accessing the Basic Information page through the ADT Snapshot.

1. Access the Basic Information page either by registering a new resident or by clicking the [View Basic Information](#) link on the resident Snapshot.
2. In the first section, enter the resident's name and address info.

The screenshot shows the 'BASIC' tab of the NetSolutions ADT system. The form is divided into two main columns. The left column contains fields for the resident's name: Last name (Aldridge), First name (Chake), Middle name (Joanne), Suffix, Maiden name, Nickname, and Code status. The right column contains fields for the resident's address and contact information: Address (5806 AnyStreet), City (AnyTown), State/Province (WA), Zip (47575), County (DODGE), Phone 1 (Home, (216)555-0311), Phone 2, Phone 3, and Change effective date/time (10/14/2016, 16:59). At the bottom left, there is an 'ATTACH PHOTO' button and links for 'eDocs' and 'Enroll in Imprivata'.

- **Last name (required).** Enter the resident's last name.
- **First name (required).** Enter the resident's first name.
- **Middle name.** Enter the resident's middle name.
- **Suffix.** Select the resident's suffix, if applicable.
- **Title.** Select the resident's title, if applicable.
- **Maiden name.** Enter the resident's maiden name, if applicable.
- **Nickname.** Enter the resident's nickname.
- **Address.** Enter the resident's primary address before entering the facility.
- **City, State/Province, and Zip.** Enter the city, state or province, and Zip code where the above address is located.

- **County.** Enter the county for the above address. Some payors require a county for reimbursement. The county values available in the dropdown are set up in the facility profile.
- **Phone 1 - 3.** Enter up to three phone numbers for the resident, one in each field. After you have entered a phone number, select the type of phone number (e.g. Home, Cell, Work/Office, etc.) from the corresponding drop-down list.
- **Code Status.** Specify a code status for the resident.
- **Change Effective Date/Time.** This field displays the date and time demographic information was last changed. Information in this field is automatically entered by NetSolutions each time a change is made, excepting only a change in the Maiden Name field. You cannot edit the information in this field.
- **Attach Photo.** Click this button to browse for an image file on your computer or network. Use this button to add a photo of the resident to his or her record.
- **eDocs.** Click this link to attach imported images and electronic documents from the resident's document list to a specific data record. Attach image files of lab results, x-rays, driver's licenses, receipts, or any other document you would like to save as part of the resident record.
- **Enroll in Imprivata.** Click this link to capture the palm scan of an existing resident who is not enrolled to the Imprivata system. The link only displays for existing residents; to enroll a new, unsaved resident, simply save the resident's basic information and NetSolutions automatically launches the enrollment process.

NAME AND ADDRESS HISTORY					
EDIT	DEL	EFFECTIVE DATE	RESIDENT NAME	NICKNAME	ADDRESS
		04/09/2012 16:23	Delost, Marylouise, Alvin		2886 AnyStreet, AnyTown, WA, 25983

**Name and Address History.** This section contains historic information for a resident's demographic data in both Registration and Pre-Registration. The columns in this section contain data from all the fields in the section above, except for Maiden Name. The entries in this section display in reverse chronological order, in other words, with the newest entry at the top.

This section contains the following fields:

- Effective Date
- Resident Name
- Nickname
- Address
- County
- Phone 1
- Phone 2
- Phone 3
- Code Status

For more information about these fields, refer to the items listed above.



**Note:** If you edit an entry in this section, the new data appears in the entry and the original data is not saved. To maintain the historic information, make changes in the section above.

3. In the second section, enter the resident's family, social, and other info.

Gender: *	Female	Veteran:	
Marital status: *	Widowed	Education:	
Race/Ethnicity:	Asian	Preferred language:	
Date of birth: *	8/18/1922 (Age: 90)	English speaking ability:	
Birthplace:	SALEM	Religion:	Baptist
Citizenship:	UNITED STATES1	Church:	
Occupation:	HOUSEWIFE	Funeral home:	FUKUI MORTUARY
Father's name:	Carrie	Pharmacy:	PHARMERICA
Mother's name:	Vida	Ambulance:	
Spouse's name:	Clarita	Hospital:	LITTLE COMPANY OF MARY HC

- **Gender (required).** Select the resident's gender.
- **Marital status (required).** Select the resident's marital status.
- **Race/Ethnicity.** In the dropdown, select the checkbox or checkboxes that correspond to the resident's ethnic group or groups. When you've selected the checkboxes you want, click outside the dropdown to have NetSolutions display these selections in the Race/Ethnicity field separated by commas. NetSolutions also displays the selected ethnicities in a tooltip when you hover over the field.
- **Date of birth (required).** Enter or select the resident's date of birth in mm/dd/yyyy format. The resident's age is displayed beside the Date of Birth field. This number is auto-calculated by the system based on the birth date entered and the current system date.
- **Birthplace.** Enter the resident's birthplace.
- **Citizenship.** Enter or select the country of which the resident is a citizen.
- **Occupation.** Enter the resident's occupation.
- **Father's name.** Enter the name of the resident's father.
- **Mother's name.** Enter the name of the resident's mother.
- **Spouse's name.** Enter the name of the resident's spouse.
- **Veteran.** Select the resident's status as a military veteran. Entries for this field are defined on the Veteran Master page. By default, NetSolutions includes Non-war-time veteran and War-time veteran in the Veteran Master. Some VA benefits depend on whether a veteran served in war-time.
- **Education.** Select the highest level of education attained by the resident. Available options are:
  - No Schooling
  - 8th Grade/Less
  - 9-11 Grades
  - High School
  - Some college

Technical/Trade School  
 Bachelor's Degree  
 Graduate Degree  
 Masters  
 Doctorate

- **Preferred language.** Enter or select the resident's preferred language.
- **English speaking ability.** Select the resident's level of fluency in English.
- **Religion.** Enter or select the resident's religious affiliation.
- **Church.** Select the resident's church. Available values are set up in the facility profile.
- **Funeral home.** Select the resident's funeral home. Available values are set up in the facility profile.
- **Pharmacy.** Select the resident's pharmacy. Available values are set up in the facility profile.
- **Ambulance.** Select the resident's ambulance provider. Available values are set up in the facility profile.
- **Print statement.** Select this check box to have the system generate a copy of the resident's bill for the resident.
- **Expired.** Enter the resident's date of passing in mm/dd/yyyy format. (This field is only visible if Erickson is the current GL Product.)

4. In the third section, enter the resident's Social Security and other ID numbers.

Social security #:	854-55-8292	Medicaid #:	032546414475
Medicare MBI #:	137590994825	Approval Date:	<input type="text"/>
Org. Medicare #:	137590994825	Welfare #:	<input type="text"/>
<input type="checkbox"/> Railroad Retirement Beneficiary		Other ID#:	<input type="text"/>
Effective Dates:		Health record #:	2742
Part A:	11/1/1989		
Part B:	11/1/1989		

[Medicare Part D Plans](#)

- **Social Security #.** Enter the resident's Social Security number in 999-99-9999 format. If the **Require SS# on Residents** option is selected on the Facility General Parameters page, then NetSolutions shades this field yellow and an entry in the field is required. If the option is not selected, an entry in this field is optional. If the **Hide SSN and Medicare Numbers** checkbox is selected on the Facility General Parameters page, NetSolutions masks the social security and Medicare numbers for users who do not have the necessary security rights to view them. The hidden numbers are displayed as asterisks; for example, a social security number displays as "\*\*\*\*-\*\*-3701".
- **Medicare MBI #.** Enter the resident's federal Medicare number. When you enter a Medicare number, the number is saved without formatting unless you enter dashes as part of the number, in which case NetSolutions saves the dashes as part of the number.

**Note:** The only special character allowed in Medicare numbers are dashes. All other special characters will create an error when saving.

If the **Hide SSN and Medicare Numbers** checkbox is selected on the Facility General Parameters page, NetSolutions masks all but the last four characters of the Medicare MBI number for users who do not have the necessary security rights to view them. All hidden characters are replaced with an asterisk (\*).

- **Orig. Medicare #.** Enter the resident's federal Medicare number. When you enter a Medicare number, the number is saved without formatting unless you enter dashes as part of the number, in which case NetSolutions saves the dashes as part of the number.

**Note:** The only special character allowed in Medicare numbers are dashes. All other special characters will create an error when saving.

If the **Hide SSN and Medicare Numbers** checkbox is selected on the Facility General Parameters page, NetSolutions masks all but the last four characters of the Medicare number for users who do not have the necessary security rights to view them. All hidden characters are replaced with an asterisk (\*). If you have entered dashes with the Medicare number, NetSolutions does not mask the dashes.

- **Railroad Retirement Beneficiary.** Select this checkbox if the resident is a beneficiary of Railroad Retirement.
- **Effective Dates.** Enter the date that the Medicare Part A and/or Part B plans became effective in the two fields, or select the dates using the Calendar.
- **Medicaid #.** Enter the resident's state Medicaid number.
- **Approval Date.** Enter the date that the Medicaid coverage was approved and went into effect. You can select a date from the Calendar.
- **Welfare #.** Enter the resident's Welfare number. Some states may use the Welfare number instead of a Medicaid number for billing purposes.
- **Other ID.** Enter any other ID number you want to record. Some states may use IDs other than Medicaid or Welfare numbers.
- **Health record # (required).** Enter the resident's system Health Record number. Once this number is entered and the visit is saved, this field is view-only.
- **Medicare Part D Plans.** Click this link to open the Medicare Part D Information dialog where you can add and edit the resident's Part D insurance plans.

5. In the fourth section, enter comments and user-defined data.

User field 1:	<input type="text"/>
User field 2:	<input type="text"/>
User field 3:	<input type="text"/>
User field 4:	<input type="text"/>
User field 5:	<input type="text"/>
Comments:	<input type="text"/>
HIE consent?	<input type="radio"/> Accepted <input type="radio"/> Declined <input checked="" type="radio"/> Not asked <input type="text"/>
Print statement:	<input type="checkbox"/> Print a statement for this resident

- **User fields 1-5.** These fields can be used for any information related to the resident. Each user field is 125 characters in length. The field names can be changed in the **User Labels** option in the Facility Profile.
- **Resident Optional Info.** You can add additional data entry fields to this section using the Resident Optional Info function in the Facility Profile.
- **Comments.** Enter any comments about the resident per facility guidelines.
- **HIE Consent.** Select an option to indicate whether the Health Information Exchange (HIE) or Regional Health Information Organization (RHIO) to which the facility belongs can share the resident's Personal Health Information (PHI) with other health organizations belonging to the same HIE. By default, Not Asked is selected. If you select either Accepted or Declined, NetSolutions automatically puts the current system date in the date field. You can modify this date if necessary.

**Note:** NetSolutions uses Convergence to exchange messages with the different HIEs and RHIOs. The messages are sent to Convergence and then forwarded to the different HIEs and RHIOs making any necessary changes.

- **Print a statement for this resident.** Select this checkbox to print a copy of the resident's statement for the resident himself/herself.

6. Click the Next button to save and move to the next Registration page.

Click the [Add Organization](#) link to access the Organization Master page, where you can add organizations that can be selected in such Basic Information fields as Ambulance, Church, Funeral Home, Hospital, and Pharmacy. For more information, see the Facility Setup Help.

### Attaching a photo

Attach a photograph of the resident on the Basic Information page. A photo provides a visual means of identifying the resident and ensures data entry is performed on the correct resident. The photo is displayed in the first section of the resident ADT Snapshot, Charting Snapshot, and eCharting Snapshot (if eCharting is installed).

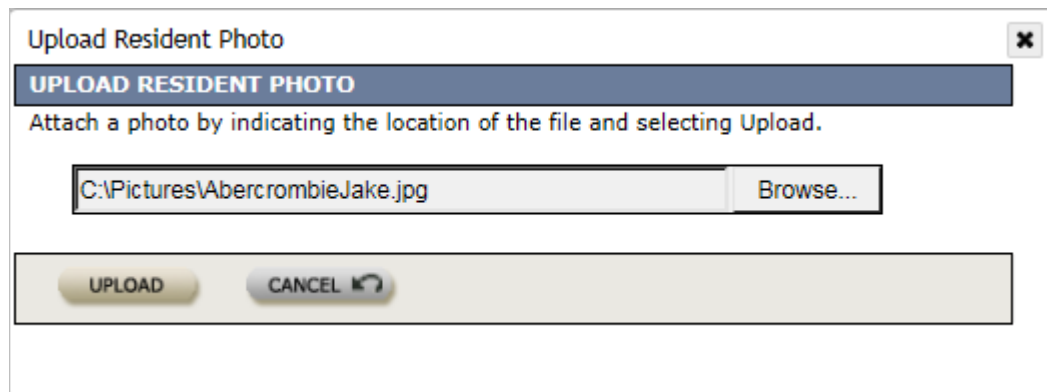
**Image files.** Photograph files must be in .jpeg, .jpg or .gif format. Photographs should be approximately 80 pixels wide by 110 high. Use image editing software such as the Microsoft Office Picture Manager to edit the image size before uploading it into NetSolutions. Otherwise, it may distort when displayed on the Snapshot page.

Images should be no larger than 200 KB. If you upload an image larger than this, NetSolutions automatically resizes the image. The program also creates a thumbnail of the picture that is used on the Snapshot pages. Images files are stored in the NetSolutions database.



1. Access the Basic Information page, and in the first section, click the Attach Photo button.

2. In the Upload Resident Photo dialog, enter the photo filename and path in the field. Select the file by clicking the Browse button.



3. Click the Upload button. The file is saved in the resident record and appears in the Snapshots.

To **replace** a photograph, repeat the above procedure, selecting a different file.

### Detaching a photo:

1. Access the Basic Information page, and in the first section, click the Attach Photo button.
2. In the Attach a Photo dialog, click the Detach button. A confirmation message appears.
3. Click OK.

## Entering a Medicare Part D plan

Enter a Medicare Part D coverage plan for a resident in the Medicare Part D Information dialog, accessed from the Basic Information page. Any existing plans for the resident appear in the Summary grid.

MEDICARE PART D PLANS FOR: Aldridge, Chake Joanne				Total: 1
EDIT DEL STATE	PLAN NAME	EFF DATE	PLAN NUMBER	
	MEMBERHEALTH	10/1/2016	877562	
<b>Add</b>	Unicare	10/01/2016	98765	

[View/Edit all plans](#)

Medicare Part D is the federally subsidized drug-coverage program for seniors. Part D plan information is used by pharmacies for reimbursement for a resident's medication costs. It is not part of a resident's standard reimbursement table of plans that cover room, board, and medical expenses.


*Entering a Medicare Part D plan:*

1. Access the Basic Information page for a resident and in the fourth section, click the [Medicare Part D Plans](#) link.
2. On the Add row in the Medicare Part D Information dialog, enter the appropriate information in each field.
  - **State (required).** Enter or select the two-character postal abbreviation identifying the state in which the client is eligible for Medicare Part D benefits. The entries in the State list are provided with your software.
  - **Plan name (required).** Enter the plan for the resident by clicking the Search button and selecting the plan from the state-specific list of Medicare Part D plans. The Search dialog displays only plans available for the selected state, along with the ten national plans and the three options used when the resident does not have Part D coverage.

- **Eff Date.** Enter or select the date the resident's Medicare Part D coverage became effective. You can type the date directly in the field using the format mm/dd/yyyy, or select a date from the Calendar. You can enter a date in this field only after specifying a Medicare Part D plan in the Plan Name field. After selecting a plan, this field is required; however, if you select one of the three options used when Part D coverage is not available, this field is not required.
- **Plan Number.** Enter the Medicare Part D plan number using up to 15 characters. You can enter a value in this field only after specifying a Medicare Part D plan in the Plan Name field. After selecting a plan, this field is required; however, if you select one of the three options used when Part D coverage is not available, this field is not required.

3. Click .

Click the [View/Edit all plans](#) link to edit the list of plans available in the Search dialog.

**Edit** a plan by clicking its Edit  button in the summary grid and editing the information.

**Delete** a plan by clicking its Delete  button and confirming the deletion.

## Guarantor

### Overview

Enter the resident's guarantor information on the Guarantor page.

BASIC		GUARANTOR		CONTACTS		VISIT		CLINICAL		REIMBURSEMENT		ADDITIONAL	
Shortname:	<input type="text" value="Mariolle G"/>	Contact:	<input type="text" value="Earline Sekovski"/>										
Last name: *	<input type="text" value="SEKOVSKI"/>	Address:	<input type="text" value="Kahler Street"/>										
First name:	<input type="text" value="EARLINE"/>	City:	<input type="text" value="LIESE TOWN"/>										
Middle Initial:	<input type="text"/>	State:	<input type="text" value="CA"/>	Zip:	<input type="text" value="86531"/>								
Title:	<input type="text"/>												
Relationship:	<input type="text" value="Self"/>												
<div> <div> <b>PRIMARY</b> </div> <div> <b>PRIMARY</b> </div> </div>													
Phone 1:	<input type="radio"/>	<input type="text"/>	<input type="text"/>	Phone 4:	<input type="radio"/>	<input type="text"/>	<input type="text"/>						
Phone 2:	<input type="radio"/>	<input type="text"/>	<input type="text"/>	Phone 5:	<input type="radio"/>	<input type="text"/>	<input type="text"/>						
Phone 3:	<input type="radio"/>	<input type="text"/>	<input type="text"/>	E-mail:	<input type="text"/>								
Options: <input type="checkbox"/> Notify in case of emergency <input type="checkbox"/> Notify in case of death <input checked="" type="checkbox"/> Print a statement for this contact <input checked="" type="checkbox"/> Care Conference Attendee													
<div> <div>NEXT</div> <div>SAVE</div> <div>DONE</div> <div>CANCEL</div> </div>													
Copy contact information from <input type="text"/> <input type="button" value="COPY"/>													

The guarantor is the person or entity that guarantees payment of the resident's bill. This page is divided into three sections where you do the following:

- Enter the guarantor's name, address, and relationship to the resident

- Enter phone numbers for the guarantor
- Select guarantor notification options

The guarantor is stored as a payor on the Reimbursement page. The guarantor shortname defaults to "Gua" plus the 7-digit system ID of the payor.

**Reports.** Since the guarantor is both a payor and, often, a contact, you can print information for the guarantor using the reports for those pages. For example, see the Resident Inquiry report and the Contacts report.

## Entering a guarantor

You first enter guarantor information when registering the resident. This is the second page in the registration process. Edit guarantor information at any time by accessing the Guarantor page through the Resident Snapshot.

1. Access the Guarantor page either by registering a new resident or by clicking the [View Guarantor Information](#) link in the Contacts section of the resident Snapshot.
2. In the first section, enter the guarantor's name and address information.

Shortname:	Gua0001750	Contact:	
Last name: *	Cancelmi	Address:	1566 Falkenberg Street x
First name:	Daisy		
Middle Initial:		City:	Lammes Town
Title:		State:	IL Zip: 58039
Relationship:	DAUGHTER		

- **Shortname.** The guarantor is stored as a payor on the Payor page. The guarantor shortname is generated by the system as "Gua" plus the 7-digit ID of the payor.
- **Last name (required).** Enter the guarantor's last name. The guarantor might also be a company or other entity whose name can be entered in this field and the First Name field.
- **First name (required).** Enter the guarantor's first name.
- **Middle initial.** Enter the guarantor's middle initial.
- **Title.** Enter the guarantor's title.
- **Relationship.** Select the guarantor's relationship to the resident. The relationship items available in the list can be set up in the facility profile.
- **Contact.** If the Guarantor is a company or other entity, enter the name of a contact person for that entity.
- **Address.** Enter the street address of the guarantor using up to two lines.
- **City.** Enter the city where the guarantor is located.
- **State.** Enter the state or province where the guarantor is located.



- **Zip.** Enter the Zip code where the guarantor is located.

3. In the second section, enter phone numbers and email for the guarantor.

PRIMARY		PRIMARY	
Phone 1:	<input checked="" type="radio"/> Cell <input type="text" value="(440)555-4375"/>	Phone 4:	<input type="radio"/> <input type="text"/>
Phone 2:	<input type="radio"/> Work/Office <input type="text" value="(026)555-6532"/>	Phone 5:	<input type="radio"/> <input type="text"/>
Phone 3:	<input type="radio"/> <input type="text"/>	E-mail:	<input type="text"/>

- **Phone 1-5.** Enter up to five phone numbers for the guarantor. For each phone number, select the type or location of the phone number from the drop-down list, then enter the number in the text field.
- **E-mail.** Enter an email address for the guarantor using up to 100 characters. Typical format is: emailaddress@host.com.
- **Primary.** Specify which of the listed phone numbers is the primary contact number.

4. In the third section, select guarantor notification options.

Options:	<input type="checkbox"/> Notify in case of emergency	<input checked="" type="checkbox"/> Care Conference Attendee
	<input type="checkbox"/> Notify in case of death	
	<input checked="" type="checkbox"/> Print a statement for this contact	

- **Notify in case of emergency.** Select this checkbox to indicate that the guarantor should be notified in case of an emergency with the resident. This information prints on some facesheets.
- **Notify in case of death.** Select this checkbox to indicate that the guarantor should be notified in case of the resident's death. This information prints on some facesheets.
- **Print a statement for this contact.** Select this checkbox to have the system generate a copy of the resident's billing statement for the guarantor.

**Note:** If neither the resident nor any other contact is selected to receive the resident's bill, the bill prints for the guarantor regardless of the selection in this field.

- **Care Conference Attendee.** Select this checkbox to indicate that this contact is an attendee at care plan conferences for the resident. When this checkbox is selected, the contact may receive letters from the facility about past and upcoming conferences. For information on care conference letters, see the Care Plan Help or Training Guide.

5. Click the Next button to save and move to the next Registration page.

**Copy an existing contact.** At the bottom of the Guarantor page, select an existing contact in the Copy Contact Information From list and then click the Copy button. Edit the copied data as needed.

## Contacts

### Overview

Use the Contacts page to view, add, modify, and delete resident contacts.

BASIC   GUARANTOR   <b>CONTACTS</b>   VISIT   CLINICAL   REIMBURSEMENT   ADDITIONAL							
<b>CONTACTS</b> <span style="float: right;">1 - 1 of 1</span>							
		<b>CATEGORY</b>	<b>CONTACT NAME</b>	<b>RELATIONSHIP</b>	<b>PHONE 1</b>	<b>PHONE 2</b>	<b>SEQ</b>
		Next of Kin	Sterlace, Nilde Anna	Spouse	(040)555-7127(H)		1
<b>EDIT CONTACT INFORMATION FOR STERLACE, NILDE ANNA</b>							
Last name: <input type="text" value="Sterlace"/>				Agency: <input type="text"/>			
First name: <input type="text" value="Nilde"/>				Address: <input type="text" value="15674 Wolf Str"/>			
Middle name: <input type="text" value="Anna"/>				<input type="text" value="Reaves Building"/>			
Suffix: <input type="text"/> Title: <input type="text"/>				City: <input type="text" value="Rufin"/>			
Other name: <input type="text" value="Aria"/>				State: <input type="text" value="WA"/>			
Relationship: <input type="text" value="Spouse"/>				Zip: <input type="text" value="23000"/>			
Phone 1: <input type="text" value="Home"/> <input type="text" value="(040)555-7127"/>				Phone 4: <input type="text"/>			
Phone 2: <input type="text"/>				Phone 5: <input type="text"/>			
Phone 3: <input type="text"/>				E-mail: <input type="text" value="Hermann@abc.com"/>			
Comments: <div><div></div></div>				Options: <input type="checkbox"/> Notify in case of emergency? <input type="checkbox"/> Notify in case of death? <input type="checkbox"/> Print a statement for this contact? <input checked="" type="checkbox"/> Care Conference Attendee			
<b>CATEGORIES</b> <span style="float: right;">1 - 1 of 1</span>							
		<b>CATEGORY</b>					<b>RANK</b>
		Next of Kin					1
<b>Add</b>		<input type="text"/>					
<div>  NEXT            SAVE            DONE            CANCEL         </div>							
Copy contact information from <input type="text"/>							
<a href="#">Print Contact Report</a>							

A contact is anyone who visits or communicates with the resident, or who has a legal relationship with the resident, including friends, guests, next of kin, power of attorney, and other visitors. Physicians are not considered contacts; they are maintained on the Clinical Information page.

**Categories.** Each contact must be associated with a category. Contacts can be associated with more than one category. Each unique contact/category combination is a separate record in the Contacts summary grid. (However, if you delete a contact/category record from the summary grid, all records for that contact are deleted.)

**Category rank.** Each category must be ranked (have a sequence number). The category rank enables you to put contacts in a hierarchy or order within each category. For example, for notification purposes you may need to know who is the first next of kin, then the second, third, and so on.

**Sorting.** Click the Category or Contact Name column header to sort the records in the grid. The default sort is by category. When the primary sort is by category, the secondary sort is by category rank (sequence number). When the primary sort is by contact name, the secondary sort is by category.

**Guests and other visitors.** Guests and other visitors are stored as contacts. Apply the Guest or Other Visitor category to the contact.

**Reports.** The Contacts report prints full contact information for a resident. This report is available from both the Contacts page and the Reports tab (under Clinical Reports/ Census).

### Entering contacts

You first enter contacts information when registering the resident. This is the third page in the registration process. Edit contacts information at any time by accessing the Contacts page through the Resident Snapshot.

1. Access the Contacts page either by registering a new resident or by clicking the [Contact Information](#) link in the resident Snapshot.
2. In the first section, enter the contact's name and address info.

Last name:	<input type="text" value="Harris"/>	Agency:	<input type="text"/>
First name:	<input type="text" value="Fredric"/>	Address:	<input type="text" value="123 Contact Street"/>
Middle name:	<input type="text" value="R"/>		<input type="text"/>
Suffix:	<input type="text"/>	Title:	<input type="text" value="Mr."/>
Other name:	<input type="text" value="Fred"/>	City:	<input type="text" value="So. Contact"/>
Relationship:	<input type="text" value="SON"/>	State:	<input type="text" value="PA"/>
		Zip:	<input type="text" value="03846"/>

- **Last name (required).** Enter the contact's last name using up to 30 characters. An entry is required in either the Last Name field or the Agency field.
- **First name (required).** Enter the contact's first name using up to 25 characters.
- **Middle initial.** Enter the contact's middle initial.
- **Suffix.** Select the contact's suffix, if applicable.
- **Title.** Select the contact's title, if applicable.
- **Other name.** Enter any other name for the contact, if applicable.
- **Relationship.** Select the contact's relationship to the resident. The relationship items available in the list can be set up in the facility profile.
- **Agency.** Enter the name of the agency, business, or other entity in contact with the resident, using up to 25 characters.
- **Address.** Enter the contact's street address using up to two lines of 50 characters each.
- **City.** Enter the city where the contact resides using up to 25 characters.
- **State.** Enter the state or province where the contact resides.
- **Zip.** Enter the Zip code of the address entered above.

3. In the second section, enter the contact's phone numbers and email.

Phone 1:	Home	(987)555-6181	Phone 4:		
Phone 2:	Home	(392)555-8020	Phone 5:		
Phone 3:	Cell	(987)324-2298	E-mail:	harris_fr@causeway.com	

- **Phone 1-5.** Enter up to five phone numbers for the contact. For each phone number, select the type or location of the phone number from the dropdown list, then enter the number in (999)999-9999 format.
- **E-mail.** Enter an email address for the contact using up to 100 characters. Typical format is: emailaddress@host.com.

4. In the third section, select contact notification options.

Comments:	Options:																				
	<input type="checkbox"/> Notify in case of emergency? <input type="checkbox"/> Notify in case of death? <input type="checkbox"/> Print a statement for this contact? <input checked="" type="checkbox"/> Care Conference Attendee																				
	<table border="1"> <thead> <tr> <th colspan="4">CATEGORIES</th> <th>1 - 1 of 1</th> </tr> <tr> <th>EDIT</th> <th>DEL</th> <th>CATEGORY</th> <th>RANK</th> <th></th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td>Next of Kin</td> <td>1</td> <td></td> </tr> <tr> <td colspan="2">Add</td> <td><input type="text"/></td> <td><input type="text"/></td> <td></td> </tr> </tbody> </table>	CATEGORIES				1 - 1 of 1	EDIT	DEL	CATEGORY	RANK				Next of Kin	1		Add		<input type="text"/>	<input type="text"/>	
CATEGORIES				1 - 1 of 1																	
EDIT	DEL	CATEGORY	RANK																		
		Next of Kin	1																		
Add		<input type="text"/>	<input type="text"/>																		

- **Notify in case of emergency.** Select this check box to indicate that the contact should be notified in case of an emergency with the resident. This information prints on some facesheets.
  - **Notify in case of death.** Select this check box to indicate that the contact should be notified in case of the resident's death. This information prints on some facesheets.
  - **Print a statement for this contact.** Select this check box to have the system generate a copy of the resident's bill for the contact.
  - **Care Conference Attendee.** Select this checkbox to indicate that this contact is an attendee at care plan conferences for the resident. When this checkbox is selected, the contact may receive letters from the facility about past and upcoming conferences. For information on care conference letters, see the Care Plan Help or Training Guide.
  - **Comments.** Enter free-hand comments pertaining to the contact.
5. In the Categories frame, add, edit, and delete categories for the contact. Each contact must belong to at least one category. Enter a category and rank.

CATEGORIES				1 - 1 of 1
EDIT	DEL	CATEGORY	RANK	
		Next of Kin	2	
Add		Power of Attorney	1	




- **Category (required).** Select a category from the dropdown list.


- **Rank (required).** Enter a sequence number (rank) for the contact in each category. When the category you add to the contact has been added before (for example, adding a second Next of Kin), the rank defaults to the next available number for that category. When you add a category that does not already exist for the resident, the rank defaults to 1. You may have to change the rank of other contacts in a category to get all contacts in the order you want.

**Note:** To remove a contact from a category, delete that category for the contact in the small Category frame. If you delete a contact/category record from the Contacts summary grid, all information for that contact is deleted.

6. Click the Next button to save and move to the next Registration page.

**Copy an existing contact.** At the bottom of the Contacts page, select an existing contact in the Copy Contact Information From list and then click the Copy button. Edit the copied data as needed.

**Editing a contact's rank.** To modify a contact's rank, click  to select the contact you want to work with in the Contacts panel, then select  again in the Categories panel. In the Rank field, enter the new rank you want to assign to the contact and click . Then click the Save button at the bottom of the Contacts page.

**Note:** Clicking  saves the new rank entry for the contact. Clicking the Save button at the bottom of the page saves the new rank information to the NetSolutions server.

## Visits

### Overview

Enter a resident's visit and hospital stay information on the Visit page. This page enables you to enter a new visit during registration and to edit an existing visit. You select the visit with which you want to work when you select a resident. You can also select a visit from the Resident Snapshot.

**Visit types.** Each visit belongs to one of the following types: inpatient, outpatient, pre-registered, or reserve. You create each type of visit during a corresponding process: registration, outpatient registration, pre-registration, or reservation. When you enter a reservation for a resident or prospect, a reserve visit is required only if you are charging for the reserved location.

**Clinical and Census data.** Some information in the system is stored once per resident; other information is stored separately for each resident visit. Clinical and census information is stored by visit. Each visit is linked to its own set of transfers, holds, and other Census records, along with its own set of allergies, diagnoses, and physicians.

**Hospital stays.** The Visit page lists the resident's hospital stays and enables you to enter and edit hospital stay information.

**User fields.** The Visit page also provides a set of User fields for entering visit-related information. The field names can be changed in the User Labels option in the Facility Profile.

**Reports.** The Admission Notice report provides a list of residents who have been admitted to the facility within a specified date range. Visit information is included on many Census reports such as the Census Activity and Status Change reports.


## Entering a visit

You first enter visit information when registering the resident. This is the fourth page in the registration process. Edit visit information at any time by accessing the Visit page through the Resident Snapshot or the Registration links.

BASIC		GUARANTOR		CONTACTS		VISIT		CLINICAL		REIMBURSEMENT		ADDITIONAL	
Admit date/time: *	05/17/2018	23:38	Business unit/Product line: *		ICF/MCD-WING 1								
Health Record #:	2004	Arrived by:											
Account #:	2025	Admit type:											
Care level: *	<a href="#">Payor level</a>	275	ICF-HOSPICE	Federal Adm source:									
Location: *		AF 11162		State Adm source:									
Bed rate:		\$195.00/day		Visit source:									
Override:				<input type="checkbox"/> Rehab?									
user-defined 1:				<a href="#">Leave information</a>								<a href="#">eDocs</a>	
user-defined 2:													
user-defined 3:													
user-defined 4:													
user-defined 5:													
user-defined 6:													
<div> <div>NEXT</div> <div>SAVE</div> <div>DONE</div> <div>CANCEL</div> </div>													
PRIOR HOSPITAL STAY SUMMARY													
EDIT DEL. HOSPITAL NAME		ADMIT DATE		DISCHARGE DATE		PROVIDER #		NEW SPELL OF ILLNESS?					
ADD								Yes					
<a href="#">Add Organization</a>													

1. Access the Visit page either by registering a new resident or by selecting a visit in the top right section of the resident Snapshot and then clicking the [View Visit Information](#) link.
2. In the first section, enter visit information.
  - **Admit date/time (required).** Enter the admit date and time for the visit. When registering a resident, these fields default to the current system time. The system validates that the admission time is no more than 5 minutes greater than the current time. When editing a visit, if more than one visit segment exists or if charges exist for the resident, then the Admit Date/Time fields display as labels.
  - **Health record # (required).** Enter or view the resident's health record number (also known as the medical record #, the term used in VistaKEANE RAM). This field can be a data entry field or a label depending on the selection for the MR# Method option on the General Parameters page of the facility profile. The option defines whether users enter the MR number on the Visit page or the Basic Info page. There is also an option enabling system-generated HR numbers.
  - **Account #.** View the account number for this visit. The account number is system-generated.

- **Care level (required).** Enter or select the care level for the resident on this visit. There are two ways to look up care levels for residents. The Search button provides a list of care levels set up in the facility profile. The Payor Level link enables you to select a care level from the levels associated with the payors in the resident's reimbursement table. For more information, see [Selecting a care level](#). When editing a visit, if more than one visit segment exists or if charges exist for the resident, then the Care Level field displays as a label.
- **Location (required).** Enter or select the resident's location for this visit. The available locations are set up in the location master. When editing a visit, if more than one visit segment exists or if charges exist for the resident, then the Location field displays as a label. For more information, see [Selecting a location or bed](#).
- **Bed rate.** This label displays the bed rate for the selected location.
- **Override.** Enter an override price for the bed, and select the pricing unit. This field is available only if bed rate can be overridden and the user has the proper security rights.
- **Business unit/Product line (required).** Select the business unit and product line for this visit. Appropriate business unit/product line pairs are set up in the facility profile.
- **Arrived by.** Enter the means of transportation by which the resident arrived at the facility for this visit.
- **Admit type.** Select the admission type for this visit, such as Emergency, Urgent, Elective, Info N/A. Additional selections can be set up in the census Admission Type profile. This information prints as a 1-character field on the UB92 bill and is included in the HIPAA electronic billing file.
- **Federal admit source.** Enter or select the federal admission source such as Clinic or HMO. Seven selections are provided; more can be user-defined. This field indicates where the resident was located prior to admission. Values in this field correspond to federal tables for admission source and are used for printing on the bill.
- **State admit source.** Enter or select the state admission source. Available items are user-defined in the facility profile. This field indicates where the resident was located prior to admission. Values in this field correspond to State tables for Admission Source and are used for printing on the bill. This field is used when there is no direct mapping between the state codes and the federal codes.
- **Visit source.** Select a visit source such as Acute Hospital, Assisted Living, Board & Care. Twelve selections are provided; more can be user-defined. This field indicates where the resident was located prior to admission. It can also be used to record a referral source ("ABC Referrals") rather than an actual location.
- **Rehab.** Select this checkbox to indicate that a resident is receiving rehabilitation therapy. If this checkbox is selected, rehab factors will be used in calculating some Diagnosis-Related Groups (DRG).
- **Leave information.** Click this link to view resident leave information for the current visit.

- **Estimated Admit Date/Time.** If this visit is for a prospect, this field displays the estimated date and time upon which the resident will be admitted to the facility.
  - **Waitlist.** If this visit is for a prospect, select this checkbox to add the resident to the facility's waitlist. When this checkbox is selected, the resident appears on the Waitlist report.
  - **Waitlist Date.** If this visit is for a prospect, enter the date the resident was added to the waitlist using the format mm/dd/yyyy, or click  to select a date from the Calendar.
3. In the second section, enter user-defined data for the visit.
    - **User fields 1-6.** Use these fields to enter information related to the visit. The field names can be defined in the **User Labels** option in the Facility Profile.
  4. At the bottom, enter a prior hospital stay for the resident, if applicable.
  5. Click the Next button to save and move to the next Registration page.

**Add Organization.** Click this link to open the Organization Master where you can add a new hospital that will be available in the Hospital Name dropdown.

## Hospital Stays

A hospital stay falls into one of two main categories: stays that precede admission to your facility, and stays resulting from a new spell of illness while in your facility, leading to a hospital leave and bed hold. A resident can have only one hospital stay record per episode: one prior to admission and one for each bed hold. Each hospital stay is associated with a visit or visit segment and an account plan.

**Pre-admission hospital stays.** Often a new resident comes to a long-term care facility as the result of a hospital stay. This type of stay is entered in Registration on the Visit page. Payment for care resulting from the hospital stay is determined by the reimbursement table set up during registration.

**Hospital leaves.** When a resident leaves your facility for the hospital, you enter a bed hold. The hold's start and end dates typically coincide with the hospital stay's admit and discharge dates. The hospital admit date *must* be on or before the hold start date; the discharge date must be on or one day after the hold end date.

**New spells of illness.** Both kinds of hospital stay can result from a "new spell of illness." A new spell of illness can trigger a new level of reimbursement for the resident. For example, a resident might receive a new 100 days of Medicare A. To qualify as a new spell of illness, a hospital stay must either occur before the visit admit date or be associated with a bed hold for a hospital leave. When you indicate that a hospital stay is for a new spell of illness, the system prompts you to select an account plan from the resident's reimbursement table.



**Account plans.** When you enter a prior hospital stay in Registration (on the Visit page), the active account plan is chosen when you enter the reimbursement table. The account plan for a new spell of illness starts when the resident returns and the bed hold ends. The bed hold end date is required before you can enter the account plan. When adding an account plan via the Hold page, you are prompted to select from account plans that (1) require a recent hospital visit and (2) have a maximum number of bed days. If none of the plans in the resident's reimbursement table meet these criteria, you are not prompted. You can add a plan on the Reimbursement page and associate it with the hospital stay in the Qualified Hospital Stay field.

### Entering a hospital stay in Registration:

A hospital stay entered in Registration is one that occurred prior to the resident's admission to the facility.

1. Access the Visit page either by registering a new resident or by selecting a visit in the top right section of the resident Snapshot and then clicking the [View Visit Information](#) link.
2. In the Hospital Stay section, enter the appropriate information in each field.
  - **Hospital name.** Select the hospital to which the resident was admitted. Items in this list are entered on the Organization Master page.
  - **Admit date.** Enter the resident's admit date to the hospital.
  - **Discharge date.** Enter the resident's discharge date from the hospital.
  - **Provider #.** Enter the provider number of the hospital.
  - **New spell of illness?** Select Yes or No to indicate whether this is a new spell of illness for the resident.
3. Click the Save button.

### Entering a hospital stay from the Hold page:

A hospital stay entered on the Hold page is tied directly to a single hold. The hospital leave is the reason for the bed hold.

1. Select a resident and then in the ADT menu select Hold.
2. In the Hold Effective Dates section, add a new hold by entering the hold start date and start time.
3. In the Reason list, select Hospital (or another H-type reason as set up in the facility profile).
4. Click the [Hospital Stay Information](#) link.

5. In the Hospital Stay Maintenance dialog, enter the appropriate information.

- **Hospital name.** Enter the name of the hospital to which the resident was admitted.
- **Admit date.** Enter the resident's admit date at the hospital. This field defaults to the start date of the hold. Edit if necessary.
- **Discharge date.** Enter the resident's planned discharge date from the hospital. If an end date has been entered for the hold, this field defaults to that date.
- **Provider #.** Enter the provider number of the hospital.
- **New spell of illness?** Select Yes or No to indicate whether this stay qualifies as a new spell of illness for the resident. A new spell of illness can result in a new 100 days of Medicare A for the resident.

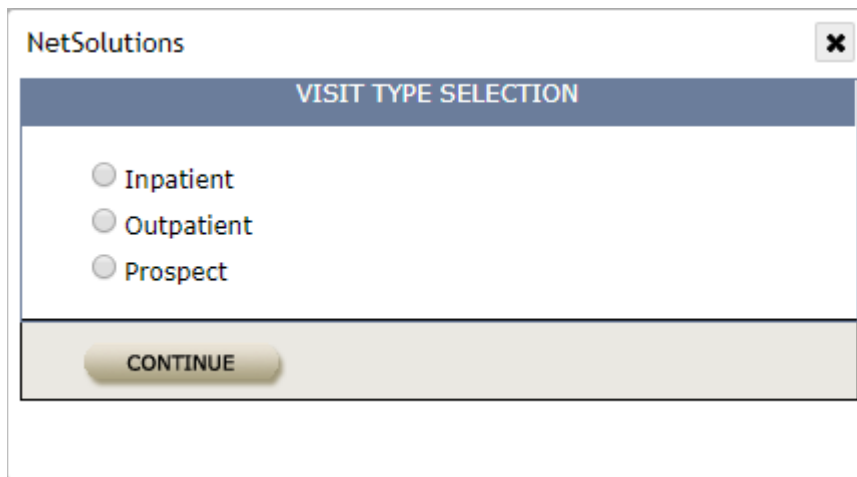
6. Click the Continue button.

### Converting residents from one visit type to another

You can create a new visit based on an existing one of a different type. Use this feature to convert an outpatient to an inpatient, a reservation to a pre-admission, or another combination. You can create an inpatient, outpatient, or pre-admission visit from one of those types or from a reservation visit.

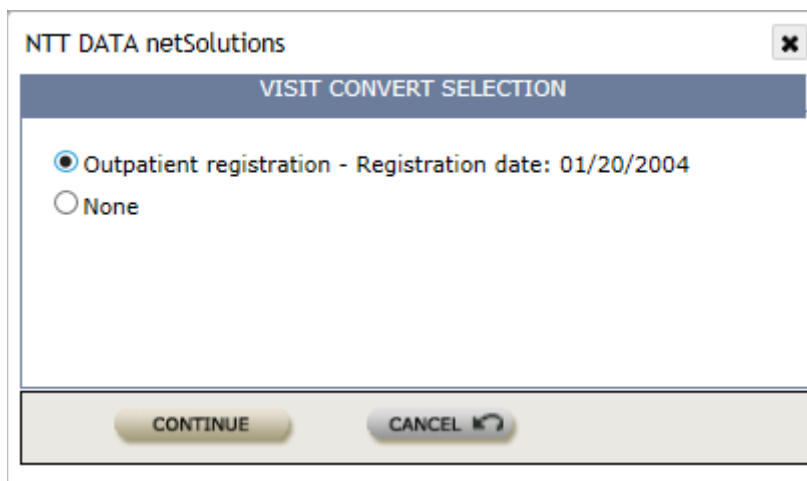
1. From either the Select Resident page or the resident Snapshot, click the [New Visit](#) link.

2. In the Visit Type Selection dialog, select the type of new visit you want to create: Inpatient, Outpatient, or Prospect.



The image shows a dialog box titled "NetSolutions" with a close button (X) in the top right corner. The main heading is "VISIT TYPE SELECTION". Below the heading, there are three radio button options: "Inpatient", "Outpatient", and "Prospect". At the bottom of the dialog, there is a single button labeled "CONTINUE".

3. If the resident has an open visit that can be converted, the Visit Convert Selection dialog appears. Select the visit you want to convert and click Continue.



The image shows a dialog box titled "NTT DATA netSolutions" with a close button (X) in the top right corner. The main heading is "VISIT CONVERT SELECTION". Below the heading, there are two radio button options: "Outpatient registration - Registration date: 01/20/2004" (which is selected) and "None". At the bottom of the dialog, there are two buttons: "CONTINUE" and "CANCEL" with a circular arrow icon next to it.

4. The Admission Default Selection dialog enables you to select the existing visit information you want copied into the new visit.

The screenshot shows a dialog box titled "NTT DATA netSolutions" with a close button (X) in the top right corner. The main title of the dialog is "ADMISSION DEFAULT SELECTION". Inside the dialog, there are five rows of options, each with a checkbox and a corresponding link:

Option	Link
<input checked="" type="checkbox"/> Default visit information	<a href="#">View Visit Info</a>
<input checked="" type="checkbox"/> Copy all active orders	<a href="#">View Orders</a>
<input checked="" type="checkbox"/> Default physician information	<a href="#">View Physician Info</a>
<input checked="" type="checkbox"/> Default diagnosis information	<a href="#">View Diagnosis Info</a>
<input type="checkbox"/> Move eDocuments to new visit	<a href="#">View eDocuments</a>

Below these options is a checkbox for "Use new visit date as onset date for all diagnoses", which is currently unchecked. At the bottom of the dialog are two buttons: "CONTINUE" and "CANCEL" with a return icon.

You can select visit, active orders, physician, diagnosis, and eDocuments. By default, all these check boxes are selected. You can also specify whether the new visit date is the onset date for all diagnoses. By default, this is not selected. Preview the data you are copying by clicking the accompanying links. When finished with your selections, click Continue.

5. A message appears prompting you to close the existing visit. Click Yes. The system closes the old visit and creates the new one.

**Note:** If you are converting from a pre-admission visit, NetSolutions changes the Estimated Admit Date/Time of the pre-admission visit to the Admit Date/Time of the new visit.

## Clinical Information

### Overview

Enter and maintain a resident's clinical information on the Clinical page.

BASIC   GUARANTOR   CONTACTS   VISIT   <b>CLINICAL</b>   REIMBURSEMENT   ADDITIONAL									
<b>ALLERGIES</b> <span style="float: right;">1 - 3 of 3</span>									
<input type="checkbox"/> No known allergies/adverse reactions           DATE/TIME RECORDED: <input type="text"/> USER: <input type="text"/>									
EDIT DEL	ALLERGY *	ONSET	ONGOING?	SEQ	REACTION	SEVERITY	DATE/TIME RECORDED *	USER	
	X DARVO CET		Yes	1					
	X LEXAPRO		Yes	2					
	X SULFA		Yes	3					
<input type="button" value="Add"/> <input type="text"/> <input type="button" value="Yes"/> <input type="button" value="No"/>									
<b>DIAGNOSES</b> <span style="float: right;">1 - 40 of 40</span>									
<b>ICD-9</b> <a href="#">Add Previous Diagnoses</a>									
<b>ICD-10</b> <a href="#">Add Previous Diagnoses</a> <span style="float: right;">1 - 31 of 31</span>									
ADD	DIAGNOSIS	ICD10 *	ONSET *	BILL SEQ	ON BILL	CLIN RANK	DX TYPE	RESOLVED DATE	DATE/TIME RESOLVED *
			05/28/2014	999	<input checked="" type="checkbox"/>	999	<input type="checkbox"/> Part B <input type="checkbox"/> Leave <input type="checkbox"/> Discharge		
EDIT DEL	DIAGNOSIS *	ICD10 *	ONSET *	BILL SEQ	ON BILL	CLIN RANK	DX TYPE	RESOLVED DATE	DATE/TIME RESOLVED *
	X Dementia in other diseases cla	F02.80	06/08/2015	1	<input checked="" type="checkbox"/>	001	P-B		
	X Low back pain	M54.5	12/17/2014	2	<input checked="" type="checkbox"/>	002	P-B		
	X Difficulty in walking, not els	R26.2	12/17/2014	3	<input checked="" type="checkbox"/>	003	P-B		
	X Parkinson's disease	G20.	02/24/2015	4	<input checked="" type="checkbox"/>	004			
	X Encounter for other specified	Z51.89	05/28/2014	5	<input checked="" type="checkbox"/>	005			
	X Pain in unspecified hip	M25.559	04/08/2015	6	<input checked="" type="checkbox"/>	006			
	X Nutritional anemia, unspecie	D53.9	05/28/2014	999	<input checked="" type="checkbox"/>	999			
	X Hypothyroidism, unspecified	E03.9	05/28/2014	999	<input checked="" type="checkbox"/>	999			
	X Type 2 diabetes mellitus with	E11.65	05/28/2014	999	<input checked="" type="checkbox"/>	999			
	X Generalized anxiety disorder	F41.1	05/28/2014	999	<input checked="" type="checkbox"/>	999			
	X Unspecified blepharitis unspec	H01.009	07/03/2014	999	<input checked="" type="checkbox"/>	999			
	X Dry eye syndrome of unspecie	H04.129	07/03/2014	999	<input checked="" type="checkbox"/>	999			
	X Unspecified age-related catara	H25.9	07/03/2014	999	<input checked="" type="checkbox"/>	999			
	X Unspecified atrial fibrillatio	I48.91	05/28/2014	999	<input checked="" type="checkbox"/>	999			
<b>PHYSICIANS/CLINICIANS</b> <span style="float: right;">1 - 4 of 4</span>									
EDIT DEL	CATEGORY *	NAME *	RANK						
	X Alternate	Woodhall, Aurelio							
	X Attending	Woods, Peter							
	X Dentist	Rodems, Cecilia	0						
	X Ophthalmologist	Ettaro, Ida	0						
<input type="button" value="Add"/> <input type="text"/> <input type="button" value="Yes"/> <input type="button" value="No"/>									
<b>ADVANCE DIRECTIVES</b>									
EDIT DEL	ADVANCE DIRECTIVES *	DATE *	TIME *	USER ID *	CANCELLED DATE	TIME	USER ID *		
	X NO CPR	06/13/2014	14:07	Wincentina Ayers					
<input type="button" value="Add"/> <input type="text"/> <input type="button" value="Yes"/> <input type="button" value="No"/>									
<input type="button" value="NEXT"/> <input type="button" value="SAVE"/> <input type="button" value="DONE"/> <input type="button" value="CANCEL"/>									
<a href="#">Allergy Master</a> <a href="#">Clinician Master</a> <a href="#">ICD-9 Master</a> <a href="#">ICD-10 Master</a> <a href="#">ICD-10 to ICD-9 Cross Reference</a> <a href="#">eDocs</a> <a href="#">Check drug interactions</a>									

This page is divided into five sections where you enter the following for the resident:

- Allergies
- Diagnoses
- VA Service Connected Disability\*
- Physicians/Clinicians
- Advanced Directives

\* The VA Service Connected Disability panel is only available when the Use VA Service Connected Disability checkbox is selected in Physician Orders Product Options.

Each section contains a summary grid and set of Add fields.

At the bottom of the page, you can click the [Allergy Master](#), [Clinician Master](#), and [ICD-10 Master](#), links to add items to these three facility masters; click the [eDoc](#) link to attach imported images and electronic documents to the resident's record; and check for drug interactions.



**Visit-specific data.** Clinical information is stored by visit. Each resident visit is associated with its own set of allergies, diagnoses, and physicians. When you admit a resident, the [Add Previous Diagnoses](#) link displays in the title bars for the ICD-9 and ICD-10 panels, enabling you to add diagnoses from the resident's most recent visit that had diagnoses attached, to the new visit. If a diagnosis from the previous visit is already displayed in the ICD-9 or ICD-10 panels, NetSolutions does not present that diagnosis in the Diagnoses from Previous Visit dialog.

**Reports.** The Physician Roster shows a current listing of attending physicians and the residents that are under their care. The VA Service Connected Disability report displays residents and their VA Service Connected Combined Disability Ratings, along with the VA Disability codes assigned to the resident. Clinical information is also printed on the Resident Inquiry and Facesheet reports.

## Entering clinical information

You first enter a resident's clinical information when registering the resident. Add one or more allergies, diagnoses, and physicians to the client record. Edit the information at any time by accessing the Clinical Information page through the Resident Snapshot.

1. Access the Clinical page either by registering a new resident or by clicking the Clinical Information link in the Resident Snapshot. Clinical information is visit-specific. To view clinical info for another visit, first select that visit at the top right of the Snapshot.
2. In the Allergies section, enter the appropriate information.

ALLERGIES		DATE/TIME RECORDED	USER
	<input checked="" type="checkbox"/> No known allergies/adverse reactions	03/26/2012  12:00	Callista Hoffer

- **No Known Allergies/Adverse Reactions.** Select this checkbox to indicate that the resident has no known allergies. When you select this checkbox, NetSolutions enters the current system date and time in the **Date/Time Recorded** fields and enters the name of the current user in the **User** field. You can modify the date and time if necessary; however, the User field cannot be edited. When you select this checkbox, NetSolutions displays "No known allergies/adverse reactions" on the ADT and Clinical snapshot pages.

If you add an allergy to a resident's record after selecting the No Known Allergies/Adverse Reactions checkbox, NetSolutions automatically clears the checkbox and displays "Previously recorded no known allergies" beside the User field. Information in the Date/Time Recorded and User fields remain.

EDIT DEL	ALLERGY *	ONSET	ONGOING?	SEQ	REACTION	SEVERITY	DATE/TIME RECORDED *	USER	DATE/TIME INACTIVATED	USER
	X VIOXX		Yes	2			06/11/2014 09:26	MARJANNA PROVO		
	X CARBAHAZEPINE		Yes	3			06/11/2014 09:26	MARJANNA PROVO		
	Add		Yes				01/19/2017 12:36	ARCHIE LAVELL		

- **Allergy (required).** Enter the name of the medication, food, or other allergen, or click and select it from the Search for Resident Allergy dialog. If the allergen required is not available in the Search dialog, click the Allergy Master link at the bottom of the page to add it.
- **Onset.** Enter the onset date of the allergy using the format mm/dd/yyyy, or click to select a date from the Calendar.
- **Ongoing?** Select Yes or No to indicate whether the allergy currently affects the resident. If the entry in this field is No but the allergy is once again affecting the resident, you can add another entry for the same allergy to this panel with the Ongoing field set to Yes.

**Note:** You can only add another entry for an allergy when the previous entry has No entered in the Ongoing? field.

- **Seq (required).** Enter a sequence number for the allergy. The sequence number determines the order in which the allergy displays in the Summary grid and on some reports. You can also sort entries in the Allergies panel by clicking this heading.
- **Reaction.** Select a reaction from the drop-down list. Values for the drop-down are maintained on the Allergy Reactions master page.
- **Severity.** Select the severity of the resident's reaction to the allergen. Available answers are Mild, Moderate, or Severe.
- **Date/Time Recorded (required).** When you enter an onset date, the date and time the entry was made displays in this field. You can change the time and date in this field if necessary.
- **User.** When you enter an onset date, NetSolutions automatically enters the currently logged-in user in this field. You cannot modify the entry in this field.
- **Date/Time Inactivated.** When you select No in the Ongoing? field, the date and time the entry was made displays in this field. You can change the time and date in this field if necessary. You can also sort entries in the Allergies panel by clicking this heading.


**Note:** When you edit an allergy and enter an inactivation date and time, the onset date/time/user information is not updated, but reverts back to the original values if *only* inactivation information is entered.

- **User.** When you select No in the Ongoing? field, NetSolutions automatically enters the currently logged-in user in this field. You cannot modify the entry in this field.
- **Save.** Click on the data entry line to save the allergy.

3. In the Diagnoses section, enter the appropriate information.

DIAGNOSES											
ICD-9 <a href="#">Add Previous Diagnoses</a> 1 - 40 of 40											
ICD-10 <a href="#">Add Previous Diagnoses</a> 1 - 31 of 31											
ADD	DIAGNOSIS	ICD10 *	ONSET *	BILL SEQ	ON BILL	CLIN RANK	DX TYPE	RESOLVED DATE	DATE/TIME RESOLVED *	USER	DATE/TIME RECORDED
			05/28/2014	999	✓	999	Part B Leave Discharge				08/26/2016 12:51
EDIT DEL	DIAGNOSIS *	ICD10 *	ONSET *	BILL SEQ	ON BILL	CLIN RANK	DX TYPE	RESOLVED DATE	DATE/TIME RESOLVED *	USER	DATE/TIME RECORDED
	X Dementia in other diseases cla	F02.80	06/08/2015	1	✓	001	P-B				12/01/2015 09:38 Ch
	X Low back pain	M54.5	12/17/2014	2	✓	002	P-B				12/01/2015 09:38 Ch
	X Difficulty in walking, not els	R26.2	12/17/2014	3	✓	003	P-B				12/01/2015 09:38 Ch
	X Parkinson's disease	G20.	02/24/2015	4	✓	004					12/01/2015 09:38 Ch
	X Encounter for other specified	Z51.89	05/28/2014	5	✓	005					12/01/2015 09:38 Ch
	X Pain in unspecified hip	M25.559	04/08/2015	6	✓	006					12/01/2015 09:38 Ch
	X Nutritional anemia, unspecie	D53.9	05/28/2014	999	✓	999					12/01/2015 09:38 Ch
	X Hypothyroidism, unspecified	E03.9	05/28/2014	999	✓	999					12/01/2015 09:38 Ch
	X Type 2 diabetes mellitus with	E11.65	05/28/2014	999	✓	999					12/01/2015 09:38 Ch
	X Generalized anxiety disorder	F41.1	05/28/2014	999	✓	999					12/01/2015 09:38 Ch
	X Unspecified blepharitis unspec	H01.009	07/03/2014	999	✓	999					12/01/2015 09:38 Ch
	X Dry eye syndrome of unspecie	H04.129	07/03/2014	999	✓	999					12/01/2015 09:38 Ch
	X Unspecified age-related catara	H25.9	07/03/2014	999	✓	999					12/01/2015 09:38 Ch
	X Unspecified atrial fibrillatio	I48.91	05/28/2014	999	✓	999					12/01/2015 09:38 Ch


## ICD-9/ICD-10

If you are viewing ICD-10 information using the ADT Snapshot page, click the  icon in the ICD-10 title bar to open the ICD-10 Diagnosis dialog where you can view more ICD-10 diagnoses at a single glance than is possible on the ICD-10 section of the Diagnoses panel on Snapshot.


- **Add Previous Diagnoses.** If you are re-admitting the resident, click the [Add Previous Diagnoses](#) link in the ICD-10 or ICD-9 title bar to select from the diagnoses on the resident's most recent visit. When you add a previous diagnosis, all information for that diagnosis including the onset date, is added to the new record. When you click this link, NetSolutions displays the Diagnoses from Previous Visit dialog, from which you can choose which ICD-9 and ICD-10 diagnoses to pull into the new visit. You can also click the List Missing ICD-10 Dx Codes link to run the Missing ICD-10 Codes report and see which ICD-10 codes are missing for the resident. This link is the only way you can access this report.

When you click the [Add Previous Diagnoses](#) link NetSolutions checks the last inhouse visit; if there are ICD-10 codes assigned to the visit, these codes are displayed in the Diagnoses from Previous Visit dialog. If no ICD-10 codes are attached to the most recent inhouse visit, NetSolutions looks at the previous inhouse visit and displays the ICD-10 codes attached there, if any. If NetSolutions searches through all inhouse visits without finding attached ICD-10 codes, it checks any existing prospect visits and displays the ICD-10 codes assigned there, if any.

**Note:** If there is a one-to-one correlation between an ICD-9 code and an ICD-10 code, or if there are both ICD-9 and ICD-10 codes available, those codes are displayed in the Diagnoses from Previous Visit dialog with the checkboxes selected. If a correlated ICD-10 code was not found, or if multiple codes were found, NetSolutions displays a Search link in place of the Select checkbox. Click this link to open the Search for Client Diagnosis dialog and select an appropriate ICD-10 code. If there are ICD-10 codes to bring into the new admission but no ICD-9 codes, the ICD-10 code is displayed with the checkbox selected and no ICD-9 code is displayed.

- **Save.** Click  on the data entry line to save the diagnosis.




- **Diagnosis (required).** Enter the diagnosis or click  to select it from the Search for Treatment Diagnosis dialog. Selecting a diagnosis description from the Search dialog populates both the Diagnosis and ICD-9 fields.
- **ICD-9 (required).** Enter or select the ICD-9 code. Selecting an ICD-9 code from the Search for Treatment Diagnosis dialog populates both the Diagnosis and ICD-9 fields.
- **ICD-10 (required).** Enter or select the ICD-10 code. Selecting an ICD-10 code from the Search for ICD-10 Keyword dialog populates both the Diagnosis and ICD-10 fields.

In the Search dialog, select a category from the In Clinical Category drop-down list to limit the search to the ICD-10 codes that belong to selected category. By default, all categories are selected. Select the Exclude Return to Provider checkbox to exclude all ICD-10 codes that are marked as Return to Provider from the search.

If you select the Commonly Used Only checkbox, NetSolutions remembers your selection and automatically marks this checkbox the next time you open this Search For dialog. This information is stored separately for each user, not for each time the dialog is opened.

If you enter the ICD-10 code, you do not have to type the decimal. You can enter the code and when you save, NetSolutions adds the decimal after the third character.

- **Onset (required).** Enter the onset date of the diagnosed condition using the format mm/dd/yyyy, or click  and select a date from the Calendar. You cannot enter a future date in this field.
- **Bill Seq (required).** Enter a billing sequence number for the diagnosis. On a UB 92 bill, up to eighteen diagnoses can print; in an 837 (5010) electronic bill, up to twelve diagnoses can be included. You cannot enter duplicate bill sequence numbers for a resident. This field appears only if the RAM financial applications are installed.


**Note:** When you add a diagnosis, the Bill Sequence and Clinical Rank must match. If you enter a different Bill Sequence and Clinical Rank, NetSolutions will reset the Clinical Rank to match the Bill Sequence. If you edit a diagnosis, you can change either the Bill Sequence or Clinical Rank so they do not match; the values must only match when the diagnosis is added.

- **On Bill.** Indicate whether the diagnosis should be included on the billing claim. If this checkbox is not selected for a diagnosis, that diagnosis is not included on the bill (UB-04, CMS1500, or electronic claim).
- **Clin Rank (required).** Enter a clinical sequence number for the diagnosis using up to three digits. If you enter a single or double digit in this field, NetSolutions automatically fills in the leading zeros. The number entered in this field determines the ranking of diagnoses in the Clinical applications. You can enter the same value in this field you entered in the Bill Seq field, or you can use a different ranking since clinicians may want to prioritize diagnoses in a sequence that differs from the billing sequence.

**Note - ICD-9:** If you enter a clinical sequence number already used by another diagnosis, the new diagnosis is given that rank and all other diagnoses are shifted one rank lower.

**Note - ICD-10:** You can enter duplicate clinical ranks for a resident.

**Note -- Adding a Dx:** When you add a diagnosis, the Bill Sequence and Clinical Rank must match. If you enter a different Bill Sequence and Clinical Rank, NetSolutions will reset the Clinical Rank to match the Bill Sequence. If you edit a diagnosis, you can change either the Bill Sequence or Clinical Rank so they do not match; the values must only match when the diagnosis is added.

- **Dx Type.** Specify the diagnosis type. Select the Part B checkbox if the diagnosis prints on the Medicare Part B bill. Select the Leave checkbox if the diagnosis requires a leave from the facility. Select the Discharge check box if the diagnosis is associated with a resident discharge on the Discharge page.
- **Primary.** Select this checkbox to indicate that the corresponding ICD-10 code is the primary diagnosis for the resident for this visit. Only one code can be listed as the primary diagnosis. To change the primary diagnosis you must first clear the Primary checkbox for the ICD-10 code that is the current primary, then select the checkbox for the new primary diagnosis.
- **Clinical Category.** This field displays the clinical category to which the ICD-10 code is assigned.
- **Resolved Date.** Enter the date when the diagnosis was resolved, if applicable, using the format mm/dd/yyyy, or click  and select a date from the Calendar. You cannot enter a future date in this field.
- **Date/Time Resolved.** When you enter a resolved date, the date and time the entry was made displays in this field. You can change the time and date in this field if necessary; however, you cannot enter a future date in this field.
- **User.** When you enter an onset date, NetSolutions automatically enters the currently logged-in user in this field. You cannot modify the entry in this field.
- **Date/Time Recorded (required).** When you enter an onset date, the date and time the entry was made displays in this field. You can change the time and date in this field if necessary. You cannot enter a future date in this field.
- **User.** When you enter a resolved date, NetSolutions automatically enters the currently logged-in user in this field. You cannot modify the entry in this field.

## Notes



- The number entered in the Bill Seq field for each diagnosis, in conjunction with the Onset and Resolved date range, determines the order in which it prints on the bill. If the Onset and Resolved date range falls anywhere within the bill's claim dates, then the bill sequence number determines the order of diagnoses on the bill. If the range does not fall within the claim dates, the diagnosis is not included on the bill.

- NetSolutions determines which diagnosis is the Admitting diagnosis using the first diagnosis in the bill sequence with a date range that falls within the bill's claim dates and that has an onset date equal to or less than the bill's admission date.
- When checking drug interactions, if the server has not responded to the request in 10 seconds, NetSolutions displays a message asking if you want to stop the drug interaction checking process. Clicking **OK** ends the check for the current session; you must either leave the page and return or sign out of NetSolutions and then sign back in to attempt to check drug interactions again. Clicking **Cancel** tells NetSolutions to continue attempting to connect to the server; if no connection is made in 10 sections, NetSolutions displays the message again.
- If NetSolutions is interfaced with Therapute, ADT sends up to 10 diagnoses from NetSolutions to the medical diagnosis field in Therapute. Only diagnoses from the most current visit are sent to Therapute and diagnoses are sent in the order they are ranked in the resident record.
- If you select an ICD-9 or ICD-10 code and there is another, more-specific code available, NetSolutions alerts you to this and enables you to select the more specific code.
- NetSolutions displays a tooltip containing the complete description of an ICD-10 code when you hover the mouse over an ICD-10 code on the Clinical Information page.

4. In the VA Service Connected Disability section, enter the appropriate information.











VA SERVICE CONNECTED DISABILITY							
		PERCENTAGE	DATE/TIME RECORDED *		USER		
VA combined SC disability rating:		35%	11/14/2016 17:42		Dave Brote		
EDIT	DEL	DISABILITY *	DIAGNOSTIC *	% *	ONSET *	DATE/TIME RECORDED *	USER
		Addison's disease	7911	20%	03/01/2010	10/13/2016 15:33	Suzy Gre
		Anemia	7700	25%	02/01/1980	10/13/2016 15:34	Suzy Gre
		Diabetes, Milletus	7913	30%	03/01/2010	10/13/2016 15:35	Suzy Gre
		Hepatitis C	7354	25%	01/01/1972	10/13/2016 15:35	Suzy Gre
		Impairment of Humerus	5202	30%	01/01/1972	10/13/2016 15:35	Suzy Gre
Add					03/01/2010	11/14/2016 17:35	Dave Bro


- Disability.** Enter the description of the disability, or click to open the Search for VA Disability dialog where you can select the VA Combined Disability code for the resident. If you enter the disability description manually, you must also enter the diagnostic code below.
- Diagnostic.** This field displays the VA Diagnostic code associated with the disability. This code is entered in the VA Disability Master and is displayed when you select the corresponding disability. If you entered the disability manually, you must also enter the code here.
- Location.** Select the location of the disability. This field is only required if you enter a subsequent VA Disability code with the same onset date for the resident.
- %.** Enter the percentage for the Combined Disability Rating, from 0% to 100%. When you enter a value in this field, NetSolutions automatically adds the current Date and Time and User. When you update this value, NetSolutions updates the Date/Time Recorded and User fields.

- **Onset.** Enter the onset date for the disability using the format mm/dd/yyyy, or click  to select a date from the Calendar. By default, the resident's admission date is entered here.
- **Date/Time Recorded.** Enter the date and time the Combined Disability Rating was entered or modified using the format mm/dd/yyyy, or click  to select a date from the Calendar. When you enter a value in the % field, NetSolutions automatically enters the current date and time in this field.
- **User.** This field displays the name of the user who added or modified the disability in the resident record. When you enter a value in the % field, NetSolutions automatically enters the current user in this field.

**Note:** The VA Service Connected Disability panel is only available when the Use VA Service Connected Disability checkbox is selected in Physician Orders Product Options.

5. In the Physicians/Clinicians section, enter the appropriate information.



PHYSICIANS		1 - 10 of 10
	 Referring	Johnson, Sarah 2
	 Referring	Nickerson, Gary 4
	 Speech Therapist	Lee, Lena 2
	 Speech Therapist	Fraser, Paula 3
<b>Add</b>	<div> <div>Consulting</div> <div>Warren, Jacob</div> <div></div> </div>	<div>1</div> <div></div>


- **Category (required).** Select the category of the physician/clinician you want to add. You must select a category before adding a physician or clinician.
- **Name (required).** Enter the name of the physician/clinician or click  to select one from the Search for Physician Name dialog. The Search dialog contains a list of physicians/clinicians associated with the selected category. If a physician/clinician is not available in the Search dialog and the category selected is correct, click the Clinician Master link at the bottom of the page to add the physician/clinician.
- **Rank (required).** Enter the rank of the physician/clinician within the category, using a value between 1 and 999. This rank determines the order of clinicians on various reports. You can edit the ranks of other physicians/clinicians to create the correct sequence.

If the physician/clinician category allows the entry of only one physician or clinician (i.e., Attending, Alternate and Admitting), this field is unavailable. If the maximum number of physician/clinicians per visit is greater than 1, an entry in this field is required.

- **Save.** Click  on the data entry line to save the physician/clinician.

6. In the Clinical Directives section, enter the appropriate information.

- **Advance Directives (required).** Click  to open the Search for Advance Directives dialog where you can select the Advance Directive you want to add to the resident's clinical directives.
- **Date (required).** Click  to select the date on which the advance directive takes effect.

- **Time (required).** Enter the time at which the advance directive takes effect using the format hh:mm.
- **User ID.** This field displays the ID of the user who assigned the advance directive.
- **Cancel Date.** Click  to select the date on which the advance directive was cancelled.
- **Time.** Enter the time at which the advance directive is cancelled using the format hh:mm.
- **User ID.** This field displays the ID of the user who cancelled the advance directive.

7. Click the Next button to save all records and move to the next Registration page.

Click the [Allergy Master](#) link to add an allergy to the facility master. The Allergy Master is where you maintain the list of allergies that appear in the Search for Allergies dialog. You can also access the Allergy Master on the System tab

Click the [Clinician Master](#) link to add a physician/clinician to the facility master. You can also access the Clinician master on the Facility tab.

Click the [ICD-10 Master](#) link to add an ICD-10 code to the facility master. You can also access the ICD-10 master on the Facility tab.

Click the [eDocs](#) link to attach imported images and electronic documents from the resident's document list to a specific data record.

Click the [Check Drug Interactions](#) link to check your residents' medications, allergies, and diagnoses for possible interactions and contraindications.

## Reimbursement













### Overview

Enter and maintain a resident's reimbursement table on the Reimbursement page.

The reimbursement table is a list of plans (contracts) associated with a resident's account that allows coordination of benefits to occur. When an account is billed for a bed or ancillary item, each active plan in the reimbursement table is processed, starting at the top, to determine if the plan will cover all or any portion of the charges for that item. Any amount not covered by the plan is passed on (if the plan allows) to the next plan in the table and so on until the rest of the charge is billed or written off.

**Default tables.** You can either build a resident's reimbursement table manually or insert a default reimbursement table by selecting from a set of tables provided by the system or set up by your facility.

**Reimbursement Summary.** The reimbursement table displays in the Reimbursement Summary grid. Click an option above the grid to display Active or All account plans. Click Edit for a plan to view its information below. Change the sequence of plans (the payment order) by editing the sequence number of one or more plans. Sort the plans by start date by clicking the Start Date column head. The Billed Thru date for the resident's account displays in the title bar.

BASIC		GUARANTOR	CONTACTS	VISIT	CLINICAL	REIMBURSEMENT	ADDITIONAL		
 Active		 All		REIMBURSEMENT SUMMARY		BILLED THRU: 09/30/2006		1 - 5 of 5	
EDIT	DEL	SEQ	PLAN NAME	PAYOR	TYPE	START DATE	END DATE	VOID	INTERNAL END
		11	BC/BS OF MN PT A 220 G	BC/BS	Commercial	11/18/2004		NO	
		21	MEDICARE B VACCINE	Medicare B	Medicare	11/24/2004		NO	
		22	BC/BS OF MN PT B 220 G	BC/BS	Commercial	11/24/2004		NO	
		50	PRIVATE ROOM PRIVATE PAY	2875	Guarantor	11/18/2004		NO	
		51	BC OF CA PT A COINS	BC/BS	Commercial	03/13/2007		NO	
<div><div></div></div>									
Summary	Detail	Splits	Rolling Date	Beginning Caps	Zero Payors	Add New Plan	Insert Default Table	Validate	

**Reimbursement pages.** Click Edit for a plan in the Reimbursement Summary grid and then use the links below the grid to do the following:

- Enter plan summary info
- Enter account plan details
- Enter account plan splits
- Specify rolling dates and limits
- Establish beginning caps
- Identify zero payors
- Add a new plan to the reimbursement table
- Insert one of your facility's pre-defined reimbursement tables as a default table.

**Validation.** When you have completed entering or editing all data, you can validate the reimbursement table by clicking the Validate button at the bottom right. If the Auto Validate Reimbursement Table checkbox is selected on the Facility - General Parameters page, NetSolutions automatically validates the reimbursement table each time you make a change and click Next, Save, or Done.

The reimbursement table will not pass the validation check if either the standard Guarantor or standard Resident are assigned as the payor of the plan.

If the reimbursement tables are not validated, either manually or automatically, NetSolutions validates them when charges are calculated and any errors are reported there.

**Retroactive changes.** When you make changes to the table that may affect accounts retroactively, retroactive processing is initiated. The system issues the appropriate warnings and enables you to cancel the process if necessary.

**Procedure.** You enter the resident's reimbursement table during registration. It can then be accessed either through the Resident Snapshot or by clicking the [Reimbursement Table](#) link in the Accounts section of the task menu.

**Reports.** Reimbursement information prints on many ADT/Census reports, including the Resident Inquiry report, the Medicare Roster report, and the Monthly Census report.

### Inserting a default reimbursement table

Click the [Insert Default Table](#) link, located at the bottom of the Reimbursement page, to insert one of your facility's pre-defined reimbursement tables into the resident's table. After clicking the link, you select the table you want and enter a start date and beginning sequence number for the new plans. All plans in the selected table are inserted into the resident's existing table.

**Note:** Only payors with active plans are displayed on this page

Each new plan receives the start date you entered and a sequence number beginning with the one you entered. If there are multiple new plans, the sequence numbers increase by one. You can then edit the reimbursement table to re-sequence the plans, inactivate plans, or edit data on individual plans.

**REIMBURSEMENT TABLE**

Please select one of the following tables.

<a href="#">SELECT</a>	MED B/ PRIVATE PAY
<a href="#">SELECT</a>	MED B/BCBS/PP
<a href="#">SELECT</a>	Med B/Medicaid/Private Pay
<a href="#">SELECT</a>	MEDB/PHYMUT/PP
<a href="#">SELECT</a>	Medicaid-Private Pay
<a href="#">SELECT</a>	Medicare A/Private Pay

Enter starting sequence for the new plans:

Enter start date for the new plans:

NEXT 
CANCEL

*Inserting a default reimbursement table:*

1. Access the Reimbursement page either by registering a new resident, by clicking the [Reimbursement Information](#) link in the Resident Snapshot, or by clicking the Reimbursement Table link in the Accounts section of the task menu.
2. On the Reimbursement page, click the [Insert Default Table](#) link at the bottom of the Reimbursement Summary panel.
3. On the Reimbursement Table selection page, click the Select button beside the reimbursement table you want to add to the resident's table.

**Note:** Only payors with active plans are displayed on this page.

4. Enter the appropriate information in the two fields:
  - **Enter starting sequence for the new plans (required).** Enter the sequence number you want the first new plan in the table to receive. If there are multiple plans being inserted into the table, each successive new plan receives the previous sequence number plus one.
  - **Enter start date for the new plans (required).** Enter or select the start date that appears on all plans inserted into the table. You can edit this date on each plan once in the resident's table, if necessary.
5. Click the Next button.

Edit the resident's reimbursement table as necessary.

## Plan Summary

View and enter core information about an account plan on the Reimbursement page. When you first access the Reimbursement page, the Reimbursement Summary panel displays for the first account plan in the reimbursement table. Click the Edit button beside another plan to view its summary info. Click the Summary link below the grid at any time to view the Plan Summary panel for the currently selected plan. The Plan Summary panel is divided into four sections:

- Plan Information - core information about the account plan
- Policy Details - information about the specific policy that appears on the bill
- Policy Holder - information about the policy holder
- Employment Information - the policy holder's employment info

### Entering plan summary information:

1. Access the Reimbursement page either by registering a new resident, by clicking the Reimbursement Information link in the resident Snapshot, or by clicking the Reimbursement Table link in the Accounts section of the task menu.
2. On the Reimbursement page, click the Edit button beside the account plan for which you want to enter plan summary info.

If you are registering a resident, the Plan Summary page appears automatically.

3. In the Plan Information section, enter the appropriate information.

PLAN SUMMARY FOR MCR A NO PAY 10/01/06 3			
<b>PLAN INFORMATION</b>			
Plan name: *	MCR A NO PAY 10/01/06 3	Sequence: *	5 <a href="#">eDocs</a>
Plan start date: *	12/24/2010	Qualified hospital stay:	
Plan end date:		Admit date:	
Prior days used:		Discharge date:	
Prior dollars used:		Void account plan?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Deductible paid:		<a href="#">Check Eligibility</a>	



- **Plan name (required).** Enter or select the plan name. Clicking the Search button opens the Select Plan window, where you can select from the active plans available in your facility.

Once you select the plan name, many fields are populated automatically with data for the plan as entered in the plan profile.

- **Plan start date (required).** This field defaults to the current system date, which you can modify if necessary.
- **Plan end date.** Enter the plan end date, if applicable. If the plan is days dependent, leave the end date blank and enter a value in the Prior Days Used field.
- **Prior days used.** Enter the number of days already charged to the plan when the resident is admitted under this account. This value is subtracted from the maximum days covered by the plan (as specified in the plan profile) to determine how many days are left before the plan is exhausted. If the plan is not days-dependent (the Max Days field in the plan profile is blank), this field is ignored.
- **Prior dollars used.** Enter the number of dollars already charged to the plan when the resident is admitted under this account. This value is subtracted from the plan limit (as specified in the plan profile) to determine how much the plan will pay before it is exhausted. If there is no plan limit (the Plan Limit field in the plan profile is blank), this field is ignored.
- **Deductible paid.** Enter the amount already applied to the plan deductible at the plan start date. This may be an amount the resident paid for services from another provider prior to admission. You can no longer access this field once the account has been charged. Up until the first A/R close you can reset the account and modify this amount. This field always displays the initial deductible amount you entered; it does not show the current deductible-paid amount as calculated by the system.
- **Sequence (required).** Enter the sequence number where the plan is to be inserted into the reimbursement table. If you enter an existing number, the other plans at and below the same level in the table renumber automatically.
- **Qualified hospital stay.** This field displays the hospital stay associated with the plan, if any. Select a resident hospital stay from the Search window to associate it with the plan. You cannot type in the field. The system validates whether a stay is allowed by the plan.
- **Clear.** Click this link to remove the entry in the Qualified Hospital Stay field.
- **Admit date.** This label displays the admit date of the qualified hospital stay entered above.
- **Discharge date.** This label displays the discharge date of the qualified hospital stay in the field above.
- **Void account plan?** Select the Yes option to void the plan and remove it from the active reimbursement table. This option is only available when editing a plan. When adding a new plan, No is selected and the option is grayed out.

- **Check Eligibility.** Click this link to open the Benefit Inquiring dialog where you can submit an inquiry and view a plan's eligibility history. If the inquiry is successful, you can view the results in the Eligibility report (see below), which NetSolutions runs automatically. If the inquiry is not successful, you can open the file in the RQ to troubleshoot the issue.

4. In the Policy Details section, enter the appropriate information.

POLICY DETAILS			
Group number:	<input type="text" value="A290"/>	Release information?	<input type="text" value="Y"/>
Group name:	<input type="text" value="GTE"/>	Assign benefits?	<input type="text" value="Y"/>
Policy holder ID:	<input type="text" value="57589"/> x	Signature source code:	<input type="text" value="B"/>

- **Group number.** Enter the group number associated with the policy.
- **Group name.** Enter the group name associated with the policy.
- **Policy holder ID.** Enter the unique identifier assigned to the policyholder by the payor.
- **Release information.** Indicate whether the provider is allowed to release information related to a claim. If you enter N (No), the provider is not allowed to release data; if you enter Y (Yes), the provider has a signed statement permitting release of medical billing data related to a claim.
- **Assign benefits?** Enter Y (Yes) or N (No) to indicate whether the provider has a signed form authorizing the third party to pay the provider.
- **Signature source code.** Enter a code indicating how the patient authorization signature was obtained and how the provider is retaining them. Commonly used values are:
  - B – Signed signature authorization form for both CMS-1500 claim form block 12 and block 13 are on file
  - C – Signed CMS-1500 claim form on file
  - M – Signed signature authorization form for CMS-1500 claim form block 13 on file
  - P – Signature generated by provider because patient was not physically present for services
  - S – Signed signature authorization form for CMS-1500 claim form block 12 on file.

5. In the Policy Holder section, enter the appropriate information.

POLICY HOLDER			
Policy holder is? <input type="radio"/> Resident <input checked="" type="radio"/> Other			
Last name:	<input type="text" value="Abercrombie"/>	Address:	<input type="text" value="1324 55th"/>
First name:	<input type="text" value="Jake"/>		<input type="text"/>
Middle initial:	<input type="text"/>	Title:	<input type="text" value="Jr."/>
Gender:	<input type="text" value="Male"/>	City:	<input type="text" value="Redding"/>
Date of birth:	<input type="text" value="02/06/1948"/> (Age: 58)	State:	<input type="text" value="CA"/> Zip: <input type="text" value="87234"/>
ANSI relationship code:	<input type="text" value="02"/>	Phone:	<input type="text" value="(343)876-4039"/>
1500 Box#/Other code:	<input type="text" value="02"/>		

- **Policy holder is?.** Indicate whether the resident is the policyholder. If so, the resident's information appears automatically in the fields in this section (it is pulled from the Basic Info page). If the resident is not the policyholder, enter the policyholder's name, address, and other information in the fields below.
- **Last name.** Enter the last name of the individual the insurance policy is carried under.
- **First name.** Enter the policy holder's first name.
- **Middle initial.** Enter the policy holder's middle initial.
- **Title.** Select the policy holder's title.
- **Gender.** Select the policy holder's gender.
- **Date of birth.** Enter or select the policy holder's birth date.
- **ANSI relationship code.** Enter the 2-character ANSI-defined code indicating the relationship of the policyholder to the resident. Valid values are:

01-Spouse  
 04-Grandparent  
 05-Grandchild  
 07-Niece/Nephew  
 10-Foster Child  
 15-Ward Of Court  
 17-Stepchild  
 18-Self  
 19-Child/Insured Financial Responsibility  
 20-Employee  
 21-Unknown  
 22-Handicapped Dependent  
 23-Sponsored Dependent  
 24-Dependent of a Minor Dependent  
 29-Significant Other  
 32-Mother  
 33-Father  
 36-Emancipated Minor  
 39-Organ Donor  
 40-Cadaver Donor  
 41-Injured Plaintiff

43-Child/Insured Does Not Have Financial Responsibility  
 53-Life Partner  
 G8-Other Relationship

- **1500 Box #/Other code.** Enter the 1500 billing box number or two-character other billing code indicating the relationship of the policyholder to the resident.
- **Address.** Enter the policy holder's address.
- **City, State, Zip.** Enter the city, state or province, and Zip code for the address entered above.
- **Phone.** Enter the policy holder's phone number.

6. In the Employment Information section, enter the appropriate information.

EMPLOYMENT INFORMATION			
Employment status:	<input type="text" value="R"/>	Address:	<input type="text" value="231 1st Ave"/>
Employer name:	<input type="text" value="GTE"/>	City:	<input type="text" value="Redding"/>
Employment info:	<input type="text"/>	State:	<input type="text" value="CA"/> Zip: <input type="text" value="87234"/>

- **Employment status.** Enter a code indicating the policy holder's employment status.
- **Employer name.** Enter the name of the policy holder's employer.
- **Employment info.** Enter any other employer information specific to this policy.
- **Employer address.** Enter the address of the policy holder's employer.
- **City, State, Zip.** Enter the city, state or province, and Zip code for the address above.

7. Click the Save button.

When you save any changes to the reimbursement table on the Plan Summary page, validation is triggered.

### Eligibility report

After an eligibility check has been made, NetSolutions automatically runs the Eligibility report. The report displays the eligibility information for the resident for which the check was submitted. You can also view this report by clicking the Review History link in the Benefit Inquiry dialog and selecting the date for which you want to review information.

The Eligibility report consists of the following sections:

- **Medicare.** This section contains information about the resident's Medicare Part A and Part B eligibility, including deductibles and therapy caps, secondary payor information and inpatient spell history.
- **Medicare Advantage Information (Part C).** This section displays the option code, effective and termination dates and the plan name and number for Part C.
- **Medicaid.** This section contains information about the resident's Medicaid eligibility.

- **Commercial Ins.** This section contains information about the resident's commercial insurance.
- **Home Health Information.** This section contains home health care information for the resident.
- **Hospice Information.** This section contains information about the resident's hospice care.
- **(no label).** This section contains information about the resident's history of incarceration and/or alien status.
- **Crossover Information.** This section contains crossover insurance information for the resident.
- **Preventative Services.** This section contains information about preventative services the resident has received.

### Eligibility History report

Use this report to get a list Eligibility reports by resident, payor and/or date. Use the report to view historical eligibility requests.

**Note:** You can also check eligibility and run the Eligibility History report for pre-admission prospects on the Prospects tab.

### Plan Details

Use the Plan Details panel to change the private portion for a plan, and to maintain other components of a plan that may change during its lifetime. A complete history of changes is kept to allow the system to provide accurate retroactive billing.

**Page layout.** This panel contains a summary of all plan detail records. Each record displays the date range to which the plan details apply. Click a record in the grid to view the details for that date range in the fields below.

**Add/Edit.** There is no Add function on this page. Enter a thru date on the current open record and the system generates a new detail record. When editing an existing record, if you enter a new set of start and end dates that do not overlap the existing dates, a new record is created. If your new dates do overlap an existing date range, the information is only changed for the new dates. When you create a new detail record, NetSolutions copies the existing Care and Maintenance Worksheet to the new record.

**Changing multiple records.** When making a change that effects more than one date range, the system will ask if you want only those values you actually changed to affect other overlapping date ranges, or if you want all of the current values to be updated throughout the current date range. If you choose 'All,' you may unintentionally overwrite some values in the other date ranges which your new dates overlap.

**Care and Maintenance Worksheet.** Use this worksheet to enter the amounts used for calculating the monthly private portion amount. The version of the worksheet that opens depends on the version selected in the Financial Worksheet field on the Facility General Parameters page. Once you have entered all the amounts, click the Calculate button to have NetSolutions determine the private portion.

The worksheet is only available when the Enable Care and Maintenance Worksheet checkbox is selected in the Billing Indicators panel of the Bill Setup section of the Payor/Plan page.

**Special conditions.** Certain plan profile settings and state-specific plans trigger the appearance of additional fields, or name changes to existing fields, on the Plan Detail page.

PLAN DETAILS FOR MEDICAID SOUTH CAROLINA					
EDIT	FROM DATE	THRU DATE	PRIVATE PORTION	TREATMENT AUTH	CO-INSURER
	01/01/2014		\$771.25		PRIVATE LIABILITY
	01/01/2013	12/31/2013	\$762.89		PRIVATE LIABILITY
	03/01/2012	12/31/2012	\$763.74		PRIVATE LIABILITY
	01/01/2012	02/29/2012	\$766.41		PRIVATE LIABILITY
	03/01/2011	12/31/2011	\$730.41		PRIVATE LIABILITY

From date: *	<input type="text" value="01/01/2014"/>	Treatment Auth:	<input type="text"/>
Thru date:	<input type="text"/>	Authorized by:	<input type="text"/>
Reimbursement rate:	<input type="text"/> <input type="text"/>	Co-insurer:	<input type="text" value="PRIVATE LIABILITY"/>
Transaction date:	<input type="text" value="01/29/2014"/> <input type="button" value="HISTORY"/>	Deductible plan:	<input type="text"/>
Co-insurance rate:	<input type="text"/>	Over max limit plan:	<input type="text"/>
Co-insurance %:	<input type="text"/>	Under min limit plan:	<input type="text"/>
Debit Co-insurer?	<input type="radio"/> Yes <input checked="" type="radio"/> No	MSP A Plan:	<input type="text"/>
Private portion:	<input type="text" value="\$771.25"/>	MSP B Plan:	<input type="text"/>

Care and Maintenance Worksheet

SAVE CANCEL

### Entering plan details:

- On the Reimbursement page, click Edit for a plan in the reimbursement table and then click the [Detail](#) link below the table.
- In the Plan Details panel, click to edit an existing record.
- In the lower panel, enter the appropriate information.
  - From date.** Enter the date on which the changes take effect.
  - Thru date.** Enter the last date on which your changes are in effect. If you leave this date blank, your changes will remain in effect until the plan ends, or until you make a new set of changes that override your current values.
  - Reimbursement rate/unit.** Enter the reimbursement rate as a dollar amount per diem. If you enter a rate, you must also select the unit from the accompanying drop-down, either Day, Month, Year or Each. When a rate is not required by the plan, leave the field blank.
 

**Note:** You should only select Each from the unit drop-down for physical items, such as vaccines or assistive devices.
  - Transaction date.** Enter the date the facility and/or the resident was notified about this private portion amount change for this effective date.
  - History button.** Click this button to view the history for this account plan's private portion amounts, effective dates, and transaction dates (when notification of the private portion amount was received).
  - Coinsurance rate/unit.** This is used by method P020. The method uses the amount from the reimbursement table if there is one, otherwise from the method detail. A unit must be specified when a rate is entered. When a rate is not required by the plan, leave the field blank.
 

**Note:** You should only select Each from the unit drop-down for physical items, such as vaccines or assistive devices.

- **Co-insurance %.** Enter a value here if you have assigned the P028 method to this reimbursement plan. The value in this field is the percentage of the reimbursement rate that is assigned to the co-insurer. If you leave this field blank but assign the P028 method, the percentage assigned to the co-insurer will be determined by the method.
- **Debit Co-insurer?** Indicate whether the general ledger revenue account debit should go against the co-insurer or against the plan. Select the Yes option to have the system debit the co-insurer's revenue account.
- **Private portion.** Enter the dollar amount per period this plan requires the resident to pay. (This is what the plan requires the resident to pay, not what the payor must pay. See also Account Plan Splits.) If you are using the Care and Maintenance Worksheet (see below), this figure is calculated and entered by NetSolutions.
- **Care and Maintenance Worksheet.** Click this link to open the Care and Maintenance Worksheet dialog where you can enter values in the following categories:

- Resident Income
- Resident Deduction
- Community Spouse Income
- Community Spouse Deductions
- Percent of Adjustment Income/Total Care and Maintenance

When you click the Calculate button, NetSolutions calculates totals for the resident and spouse, including Net Income, Allowable Deductions and Adjustment Net Income. To save the worksheet data and import the final figure into the Private Portion field (see above), click the Done button.







Click the [View Care and Maintenance Report](#) link at the bottom of the dialog to have NetSolutions produce a report of the Care and Maintenance values entered for the resident. The report can only be run from this link.

This link is only available if the Enable Care and Maintenance Worksheet checkbox is selected in the Billing Indicators panel of the Bill Setup section of the Payor/Plan page. NetSolutions displays either the New Jersey or Michigan worksheet depending on the selection in the Financial Worksheet field on the Facility General Parameters page.

- **Coord MSP.** Select this checkbox if the plan uses the K003 method and the amount not covered by the primary plan should fall to Medicare A or B. If this checkbox is not selected, the K003 method will write off the coordinated amount instead of passing it on.
- **Rx Paid by Facility.** Indicate whether the facility or the insurance provider should pay for the resident's prescriptions. Select Y (Yes) to bill the facility for the pharmacy charges (Rx included in plan per diem). Select N (No) to bill the insurance company (Rx not included in the plan per diem). This option is only available for facilities using OmniCare, and for plans that pay for beds (primary plans).

**Note:** When a primary plan is added to a resident's reimbursement table, this field will default to Y for Medicare A and all Commercial plans, and N for Guarantor, Resident and Medicaid plans. Changes to the field will not

cause retroactive processing but will trigger an A08 message with the appropriate effective date.

- **Treatment Auth.** Enter the authorization number or code issued by the payor to indicate that the payor has approved certain treatments, using up to 25 characters. An entry in this field may be required based on the plan setup in the facility profile.
- **Authorized by.** Enter the name of the person that obtained the treatment authorization.
- **Co-insurer?** Select the plan in the drop-down list to be used as this plan's co-insurer, or click  to open the Reimbursement Plans Selection dialog where you can choose from the active plans in the current reimbursement table or from all available active plans. The drop-down list contains all active plans in the current reimbursement table.
- **Deductible plan.** Select the plan in the drop-down list to which the deductible amount will be passed for payment, or click  to open the Reimbursement Plans Selection dialog where you can choose from the active plans in the current reimbursement table or from all available active plans. The drop-down list contains all active plans in the current reimbursement table.
- **Over max limit plan.** Select the plan in the drop-down list to which the amount over the maximum limit will be passed for payment, or click  to open the Reimbursement Plans Selection dialog where you can choose from the active plans in the current reimbursement table or from all available active plans. The drop-down list contains all active plans in the current reimbursement table.
- **Under min limit plan.** Select the plan in the drop-down list to which the amount under the minimum limit will be passed for payment, or click  to open the Reimbursement Plans Selection dialog where you can choose from the active plans in the current reimbursement table or from all available active plans. The drop-down list contains all active plans in the current reimbursement table.
- **MSP A Plan.** Enter the Medicare A Secondary Plan or click  to select a plan from the Reimbursement Plan Selection dialog. Plans that are primary to Medicare on the reimbursement tables should indicate the Medicare A Secondary Plan in this field.
- **MSP B Plan.** Enter the Medicare B Secondary Plan or click  to select a plan from the Reimbursement Plan Selection dialog. Plans that are primary to Medicare on the reimbursement tables should indicate the Medicare B Secondary Plan in this field. The methods used by the MSP B plan are C001 and P018.
- **Payor/Plan Level.** (This field appears only if the plan is set up as "equivalent exempt" in the plan profile.) Enter the care level for the equivalent exempt plan. Since the plan is equivalent exempt, this level can differ from the care level associated with the primary plan. For more information, see the Help for the Plan Maintenance profile screen.
- **Billing Admit Date Override.** (This field appears only when the plan profile has been set up to allow overrides of the admit date for billing purposes.) Enter a date, different from the resident's registration admit date, to use as the admit date for billing.



If the plan is Medicare No Pay, the following fields appear:

No pay bill method override:	Normal	No pay status:	Benefits Exhausted
------------------------------	--------	----------------	--------------------

- **No pay bill method override.** Select a no pay bill method from the dropdown. Your selection overrides the default method set up for the plan on the Plan Maintenance profile. Available options are:
  - Normal - no pay bills are processed monthly.
  - Summarized - the Process No Pay Summary Bills option is used.
  - Auto-Summarized - claims are processed as summarized under normal bill processing for the no pay plan once a resident is discharged, goes to the hospital, or moves to a non-certified bed.
- **No pay status.** Select the resident's no pay status for the plan:
  - Benefits Exhausted - indicates a benefits exhaust-type bill with all charges in the Total Charges column on the UB and bill type 21x.
  - No Pay - indicates the bill is a no pay bill with charges in both the Total Charges and Non-Covered Charges columns on the UB and bill type 210.
  - Non Certified No Pay - a no pay demand bill is generated when resident is transferred to a non-certified bed.
  - No Bill - indicates the resident was not Medicare A as of 10/01/06 or does not require a no pay bill after that date.
  - Blank - same as No Bill.

For more information on Medicare No Pay plans, see the Medicare Benefits Exhaust and No Pay Billing document available on the Insider under AR Billing.

4. Click the Save button.

### Plan Splits



Use the Splits panel to specify what portion of incoming cash (i.e. cash receipts) received from a payor is to be applied to a resident's fund or set aside for future private portion charges before the cash is used for anything else.

**Resident as payor.** Splits are usually only associated with plans where the resident is the payor. Whenever a cash receipt from the payor of the plan is applied, all or part of that receipt goes towards meeting the fund and private portion amounts for the current processing month before being applied against any outstanding bills. Amounts applied towards the fund and private portion are accumulated to show when the portion amounts have been met for that processing period. When the next processing period starts, the portion amounts must be met again by the payor.

**Procedures.** To apportion an amount of incoming cash for a period to the resident's fund, select **Fund** and enter the dollar amount. To set aside an amount of incoming cash to pay for future private portion charges, select **Private** and then select the plan from the resident's reimbursement table whose private portion charges you wish to set money aside for. A dollar amount is not necessary because the routine that applies cash receipts will determine the amount of private portion required by the plan for the period and set aside the appropriate amount.

SPLITS FOR GUARANTOR					
EDIT	DEL	SEQ	TYPE	PLAN NAME	AMOUNT
Add		1	<input checked="" type="radio"/> Fund <input type="radio"/> Private		\$500.00

#### Entering plan splits:

1. On the Reimbursement page, click Edit for a plan in the reimbursement table and then click the Splits link below the table.
2. Edit a split record by clicking  beside it in the Splits panel. Use the Add row to add a new record.
3. Enter the appropriate information.
  - **Seq.** Enter a sequence number. If both fund and private portion splits are associated with the account plan, the sequence will determine which portion must be met first.
  - **Type.** Select Fund or Private. If you select Private you will be given access to the Plan Pick option. If you select Fund, you will be given access to the amount field.
  - **Plan Name.** If the type is a Private, click  and select the plan name from the reimbursement table. If the type is Fund, the Plan Name will read 'Fund.'
  - **Amount.** The dollar amount that must be met each processing period.
4. Click the Save button.

## Rolling Dates

Use the Rolling Date page to specify any beginning amounts for rolling limits. Limits for personal and hospital leaves, kept apartments and kept assisted living can be calculated on a rolling year.

**Panel.** The Rolling Date grid displays existing records. The fields below are in Add mode by default. Click Edit to change an existing record. Sequence numbers are generated automatically. Each record displays either sequence 0, for starting records, or sequence 1, for anniversary starts.

ROLLING DATE FOR MEDICARE A				
EDIT	SEQ	START DATE	TYPE	DAYS LEVEL
	0	11/29/2005	K	4

Anniversary date: \* 
Type of limit: \*

Days used at admit: \* 
Level of care:

Item number:

### Entering rolling dates:

- On the Reimbursement page, click Edit for a plan in the reimbursement table and then click the Rolling Date link below the table.
- In the Rolling Date panel, enter the appropriate information.
  - Anniversary date.** Enter the anniversary date (beginning date of 1st rolling limit type) closest to the current A/R period. Please note that if a resident's anniversary date was 6/95, then he has until 6/96, but if this feature isn't being implemented until 11/96 and they haven't had any occurrences of the type since 6/96, there is no need to even enter anything. You're already past the anniversary date.
  - Type of Limit.** Select either Kept Apartment, Kept Assisted Living, Personal Leave, or Hospital Leave.
  - Days Used at Admit.** Indicate the number of days already charged to the plan before the plan and before the resident was first admitted under this account. The days should be the number of days since the anniversary date. This value is used to start the rolling year days limit.
  - Level Of Care.** If this rolling limit is specific for a level of care, enter the payor level. Level is only applicable for Personal and Hospital types.
  - Item Number.** If this rolling limit is specific for an item, enter the item number. Item number is only applicable for Personal and Hospital types.
- Click the Save button.

## Beginning Caps

Use the Beginning Caps page to specify any beginning amounts for plan group limits. The amounts reflect charges that have been billed on a prior system for the earlier part of the year, and will be ignored once the facility reaches the year following the start year. Billing Caps function for any year, not just the year the system started, enabling you, for example, to use the therapy cap for a resident who has entered the facility after starting therapy as an outpatient at another facility.

**Setup.** Beginning cap records are set up in the facility profile after a mid-year installation. Each plan that has been billed during the fiscal year and before system installation receives a beginning caps record. You then edit the amounts used on this page.

**Note:** Tracking of beginning caps information is no longer required by CMS.

BEGINNING CAP VALUES FOR MEDICARE B THERAPY CAP							1
EDIT	GROUP	START DATE	END DATE	LEVEL	AMT USED YTD	AMT USED PTD	
	Therapies	01/01/1998			\$5.00	\$62.00	

### Entering beginning caps:

1. On the Reimbursement page, click Edit for a plan in the reimbursement table and then click the [Beginning Caps](#) link below the table.
2. On the Beginning Caps page, click the Edit button beside the beginning cap record you want to modify.
3. Enter the appropriate information in each field.
  - **Amt Used YTD.** Enter the amount billed on the plan for the fiscal year before installation of the NetSolutions system.
  - **Amt Used PTD.** Enter the amount billed on the plan for the fiscal period before installation of the NetSolutions system.
4. Click the Save button.

## Zero Payors

Use the Zero Payor page to identify any non-reimbursing payors that need to appear on bills for the current account plan. Non-reimbursing payors are payors that do not reimburse any portion of the charges being billed. Some states require that such payors appear on bills to indicate that these other sources of payment have been exhausted before the charges are passed on to them.

ZERO PAYORS FOR MD MEDICAID				
EDIT	DEL	SEQ	PAYOR NAME	DATE RANGE
		1	Achworth, jr, Paul	05/12/2005 - 08/12/2005
		2	Medicare B	07/15/2005 - 08/31/2005

ADD A ZERO PAYOR	
Seq:	* <input type="text" value="1"/>
Payor:	* <input type="text" value="Gua0001638"/> Achworth, jr, Paul
Claims range start:	* <input type="text" value="05/12/2005"/>
Claims range end:	<input type="text" value="08/12/2005"/>
UB data codes:	<input type="text"/>
Remarks:	<input type="text"/>

### Entering a zero payor:

- On the Reimbursement page, click Edit for a plan in the reimbursement table and then click the [Zero Payors](#) link below the table.
- In the Add a Zero Payor panel, enter the appropriate information.
  - Seq.** Enter the sequence number to use for the zero payor when sorting the order of the payors on the bill. For reimbursing payors on the bill, this comes from the sequence number in the reimbursement table. Note that if a non-reimbursing payor (zero payor) is assigned a sequence number greater than a reimbursing payor is assigned on the reimbursement table then the zero payor will not appear above it on the bill.
  - Payor.** Select the payor that will appear on bills for this account plan as a zero payor. The Search window enables you to choose from the payors currently in the resident's reimbursement table.

**Note:** Only payors with active plans are displayed in the dialog.

- Claims range start.** Enter the start date of the claim period during which this payor should appear on bills for the account plan as a zero payor.
- Claims range end.** Enter the end date of the claim period during which this payor should appear on bills for the account plan as a zero payor. This field can be left blank to indicate an open-ended date range.
- UB data codes.** Enter one or more UB data codes for the zero payor. Bills that require zero payors may also need special UB Data codes reported. For example, Condition Code Y1 may be required to indicate the benefit maximum has been reached. Enter multiple UB Data codes for a zero payor as a comma delimited string with a colon separating each parameter. For example, condition codes Y1 and Y9 would be entered as "CC:Y1,CC:Y9".

The value CC indicates a condition code (format "CC:XX"); OC indicates an occurrence code (format "OC:XX:99/99/99"); OS indicates an occurrence span code (format "OS:XX:99/99/99:99/99/99"); and VC indicates a value code (format "VC:XX:9.99"). An example that includes one of each type would be: "CC:Y1,OC:45:12/30/04,OS:74:12/01/04:12/15:04,VC:82:1.33"

- **Remarks.** Enter any required remarks for the zero payor. Bills that show zero payors may also need custom remarks reported. For example, "Not A Medicare Covered Service" may be required when Medicare is listed as a zero payor. Any remarks entered here are associated with FL84 on the UB92 and the associated ANSI fields.

3. Click the Save button.

### Adding a new account plan

The reimbursement table is most often created by inserting a default reimbursement table. You can also insert a single account plan into the table, or build the entire table by hand, using the following procedure.

1. Access the Reimbursement page either by registering a new resident, or by clicking the [Reimbursement Information](#) link in the resident Snapshot.
2. On the Reimbursement page, click the [Add New Plan](#) link beneath the reimbursement table. The Reimbursement Summary page displays in Add mode.
3. In the Plan Summary panel, enter the appropriate data. For information about each field, see the topic Plan Summary in the ADT training guide.
4. When finished entering Plan Summary information, click the Save button. The new account plan appears in the reimbursement table.

To enter more information about the account plan, click the Edit button beside the plan in the reimbursement table and then click one of the following links:

- Plan Detail
- Splits
- Rolling Date
- Beginning Caps
- Zero Payors

### Validate the Reimbursement Table

Click the Validate link, located at the bottom of the Reimbursement Summary panel on the Reimbursement page, to run a validity check on the Reimbursement Table. If the Auto Validate Reimbursement Table checkbox is selected on the Facility-General Parameters page, NetSolutions automatically validates the reimbursement table each time you make a change and click Next, Save, or Done.

The reimbursement table must meet certain conditions in order for the billing process to execute successfully. The validation check is used to confirm that these conditions are met. If the table does not successfully pass the check, the account cannot be billed.

When validation finishes, the results display onscreen. The first line indicates whether the table passed or failed the check. Next appears a list of all plans in the table indicating which plans passed or failed the check. All plans must pass the validation check for the reimbursement table to pass the check.

If the reimbursement table fails validation, one or more validation messages appear.

**Note:** If these tables are not validated by NetSolutions or the user, they will be validated when charges are calculated and any errors reported there.

To see a list of all possible validation messages, see the online Help.

### Retroactive Changes to the Reimbursement Table

The following changes to the reimbursement table or to an account plan in the reimbursement table result in retroactive processing of the account:

- A plan is inserted with a start date prior to the last bill date of the account.
- A plan with a start date prior to the last bill date of the account is moved within the table.
- The start date of a plan is changed and either the original start date or the new start date is prior to the last bill date of the account.
- The end date of a plan is changed and either the original end date or the new end date is prior to the last bill date of the account.
- The days or dollars at admit value is changed and the start date of the plan is prior to the last bill date of the account.
- A change to the Account Plan Detail fields (reimbursement rate, private portion, treatment authorization, co-insurer, debit co-insurer) is effective prior to the last bill date of the account.

Retroactive processing of the account involves reversing all charges for the account from the effective date of the change onward. Billing is then responsible for retroactive billing of the account based on the modified reimbursement table. (When the monthly billing cycle is run, the previous month's bill that was changed retroactively is re-generated.)

If you make a change that requires retroactive processing, the system warns you first and allows you to exit without saving your changes. If you go ahead with retro processing and the Resident Comments option on the Facility-General Parameters page has been selected, the system prompts you to enter a comment relative to the change being made.

**Security.** If you do not have security rights to perform retroactive processing, the system does not allow you to make the changes.

**Reports.** The Resident Comments Log shows comments entered by the user when retroactive changes are made in the system.

## Additional Info

### Overview


Use the Additional Info page to enter additional, user-defined data about the resident. The Additional Info page contains a Comments field and an unlimited number of user-defined fields whose names, field lengths, and formats are set up in the facility profile.

**Setup.** The fields available on the Additional Info page are defined on the Resident Optional Information page accessed from the General menu on the Settings page. Your facility can set up these fields to store resident information not captured by any built-in fields. These fields are similar to the user-defined fields available on the Basic Information page, which are set up on the User Labels page accessed from the General menu on the Settings page.

**Reports.** Additional information prints at the end of the Facesheet report under the heading "Other."

### Entering additional information

Enter and maintain additional, user-defined data about a resident on the Additional Information page.

BASIC	GUARANTOR	CONTACTS	VISIT	CLINICAL	REIMBURSEMENT	ADDITIONAL
Comments:		Needs social interaction.				
Registered to Vote:		Yes 				
Anniversary Date:		08/01 				

1. Access the Additional Info page either by registering a new resident or by clicking the [Additional Information](#) link on the resident Snapshot.
2. Enter the appropriate information in each field:
  - **Comments.** Enter any comments about the resident according to facility guidelines.
  - **User-defined fields.** Enter information into one or more fields defined by your facility. These fields may be set up as text-entry fields, Yes/No drop-down lists, or date fields allowing manual entry or selection from the Calendar.
3. Click the Next, Save, or Done button to save the data.
  - The Next button returns you to the Basic Information page.
  - The Save button keeps you on the Additional Information page.

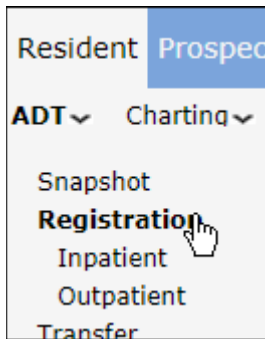


- The Done button takes you to the resident Snapshot.

## Outpatient Registration

### Overview

NetSolutions enables you to register outpatients the same way you register inpatient residents. You use the same registration pages and enter the same set of data, except that you register outpatients with a different visit type (O for outpatient) and with no location (since they do not occupy a room or bed in the facility).



**Registering an outpatient.** To register an outpatient, select Outpatient in the Registration section of the ADT menu. Then proceed through the Outpatient Registration pages. These pages are the same as those for inpatient registration, except that some location fields are not present.

**Step-by-step instructions.** For more information about the registration process, see Registering a resident and the Help topics for each of the registration pages.

### Canceling an outpatient registration

The Cancel Outpatient Registration page enables you to cancel an outpatient visit and delete its associated information. You can also delete the resident's account and reimbursement table. If there are charges or bills on the resident's account, you cannot cancel the registration.

To cancel the outpatient visit for this resident, press "Save".

Resident:           Hale, Joe

Health record #:

Admit date:

☒ Delete account and reimbursement table

1. Access the Cancel Outpatient Registration page by selecting a resident visit then choosing Outpatient in the Registration section of the ADT menu.
2. Verify the information for the outpatient whose registration you are canceling.

3. Select the Delete Account and Reimbursement Table checkbox to delete the resident's account and reimbursement table when you cancel the admission. If the resident has another visit or if there are bills or transactions on the account, this checkbox is unavailable.
4. Click Save. A confirmation message appears.
5. Click OK.

The following information is removed along with the outpatient visit: Physicians, Diagnoses, Orders, and UB data. The resident's basic demographic information remains.

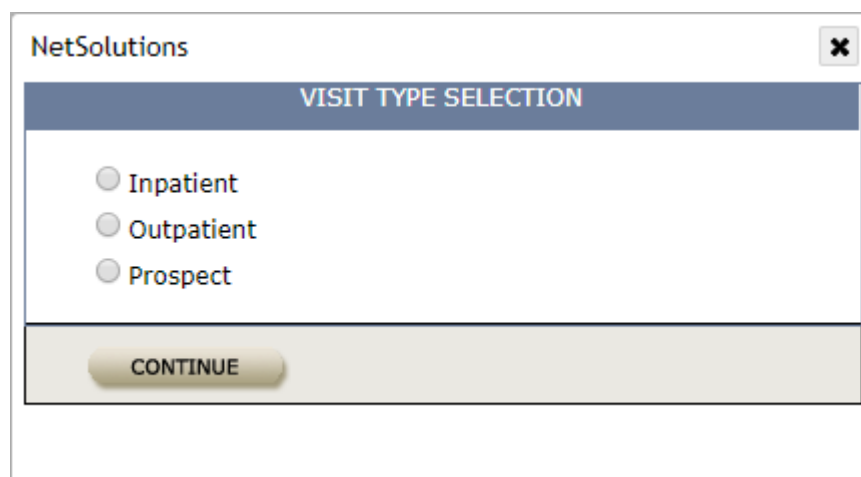
## Discharging an outpatient

Discharge your outpatient residents using the same Discharge page you use to discharge in-house residents. When you select a resident for discharge, NetSolutions recognizes the resident as an outpatient and adjusts the page accordingly. For instance, no location information displays for the resident on the Discharge page.

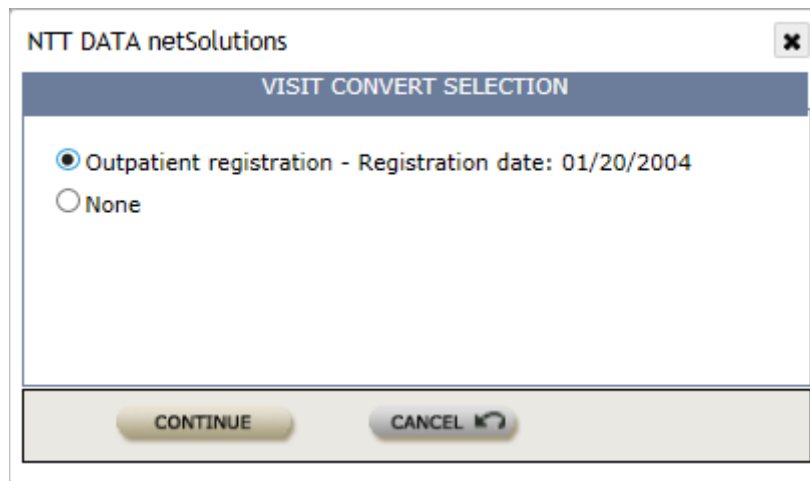
## Converting residents from one visit type to another

You can create a new visit based on an existing one of a different type. Use this feature to convert an outpatient to an inpatient, a reservation to a pre-admission, or another combination. You can create an inpatient, outpatient, or pre-admission visit from one of those types or from a reservation visit.

1. From either the Select Resident page or the resident Snapshot, click the [New Visit](#) link.
2. In the Visit Type Selection dialog, select the type of new visit you want to create: Inpatient, Outpatient, or Prospect.

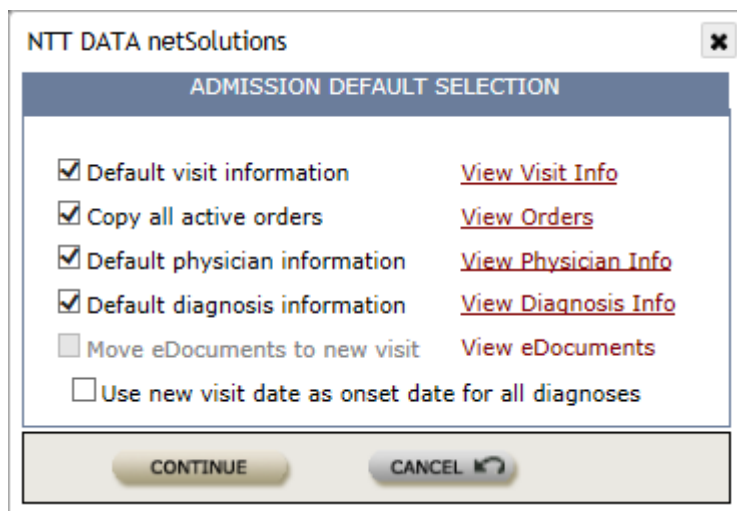


3. If the resident has an open visit that can be converted, the Visit Convert Selection dialog appears. Select the visit you want to convert and click Continue.



The screenshot shows a dialog box titled "NTT DATA netSolutions" with a close button (X) in the top right corner. The main heading is "VISIT CONVERT SELECTION". Below the heading, there are two radio button options: "Outpatient registration - Registration date: 01/20/2004" (which is selected) and "None". At the bottom of the dialog, there are two buttons: "CONTINUE" and "CANCEL" with a circular arrow icon.

4. The Admission Default Selection dialog enables you to select the existing visit information you want copied into the new visit.



The screenshot shows a dialog box titled "NTT DATA netSolutions" with a close button (X) in the top right corner. The main heading is "ADMISSION DEFAULT SELECTION". Below the heading, there are five rows of options, each with a checkbox and a corresponding link: "Default visit information" (checked) with link "View Visit Info", "Copy all active orders" (checked) with link "View Orders", "Default physician information" (checked) with link "View Physician Info", "Default diagnosis information" (checked) with link "View Diagnosis Info", and "Move eDocuments to new visit" (unchecked) with link "View eDocuments". At the bottom, there is an unchecked checkbox for "Use new visit date as onset date for all diagnoses". At the bottom of the dialog, there are two buttons: "CONTINUE" and "CANCEL" with a circular arrow icon.

You can select visit, active orders, physician, diagnosis, and eDocuments. By default, all these check boxes are selected. You can also specify whether the new visit date is the onset date for all diagnoses. By default, this is not selected. Preview the data you are copying by clicking the accompanying links. When finished with your selections, click Continue.

5. A message appears prompting you to close the existing visit. Click Yes. The system closes the old visit and creates the new one.

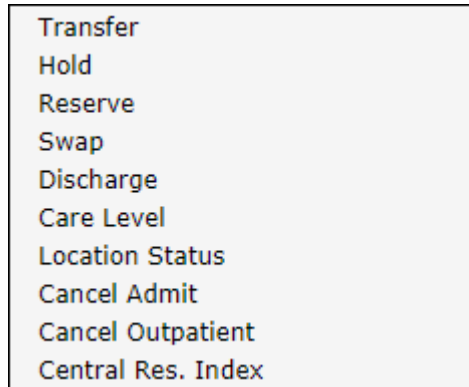
**Note:** If you are converting from a pre-admission visit, NetSolutions changes the Estimated Admit Date/Time of the pre-admission visit to the Admit Date/Time of the new visit.

## Census

### Overview

NetSolutions ADT can be divided conceptually into two main sections: Registration and Census.

Registration is where you enter and maintain core demographic and financial information about a resident. It includes the resident Snapshot and the Registration pages.



Census is where you enter and maintain information about the locations in your facility and your residents' movement among them. The Census pages enable you to do the following:

- Transfer a resident from one location to another.
- Hold a location for a resident while they are away on leave.
- Reserve a location for a current or prospective resident.
- Swap two residents between locations of the same type.
- Discharge inpatient and outpatient residents.
- Enter Care Level changes for a resident.
- Close and reopen locations in your facility.
- Cancel inpatient and outpatient admissions.
- List of all the residents currently in your facility's Central Resident Index.

**Reports.** ADT Census provides a wide variety of reports tracking census activity. You can print a list of all residents in the facility, residents away from the facility, and residents who have had a status change during the report period. You can print census activity organized by resident, by day, or by date range.

## Transfers

### Overview

Transfer residents from one location to another using the Transfer page. There are three main types of transfers:

- Bed to apartment
- Apartment to bed
- Same location type (Bed to bed or apartment to apartment)

**Reservations.** If the resident has a reservation for the location to which they are transferring, the transfer process enables you to accept the reserved location and discharge the reserve visit.

**Default data.** The transfer pages automatically provide most of the data needed to complete the transfer. You can edit the data as you go through the process. For example, when you select the new or reserved bed, the default rate for the item is provided, which you can edit if you have the necessary user rights.

**Orders.** When you transfer a resident, the order for the From bed is stopped on the day before the transfer, and a new order is created for the To bed starting on the transfer date.

**Visits.** Similarly, when you transfer a resident across location types, the From visit is discharged the day before the transfer, and a new visit begins on the transfer date (unless transferring back to a kept apartment). When you transfer within the same location type, the existing visit continues, but the latest visit segment is ended the date before the transfer and a new segment begins on the transfer date. The new location and rate are added to the visit record.

**Bed Types.** All transfers in NetSolutions where bed types change must use the current or a past date. Future transfers are not allowed when the bed type changes as a result of the transfer.

**Reports.** Transfers appear on the reports that track census activity, such as the Census Activity report, the Census Days report, and the Census History report.

### Retroactive Transfers

If you enter a transfer start date that is in the past and precedes the last billing of resident's account, retroactive processing is triggered. If you have retro privileges, a message appears asking if you want to proceed. If you continue the transfer, the retro process reverses all charges on the resident's account back to the transfer date. Billing is then responsible for correcting the bill. (When the next monthly billing cycle is run, the previous month's bill that was changed retroactively is re-generated.)

A retro transfer is the same as a regular transfer, with the following differences:

- If the Resident Comments option in the Facility General Parameters Profile has been selected, the system prompts you to enter a comment about the change being made.
- Unlike a regular transfer, the retro transfer process does not validate any information about the To location except that it exists in the facility. It assumes that you already know what bed the resident was transferred to and that it was valid for the resident at that time.

- If you are transferring across bed types (from a bed to an apartment or vice-versa) and the From visit has been discharged, you are not allowed to proceed. In this situation, you may wish to cancel the discharge of the From visit. Then you can perform the Transfer.
- If you want to process a transfer from an apartment to a bed for a discharged apartment visit and you do not want to keep the apartment, you first cancel the discharge, then perform the retro transfer to the bed and keep the apartment. Then, use the Retro Admit/Discharge Date page to change the discharge date for the apartment visit to be the date of the transfer.

### Transferring between locations of the same type

When a resident transfers between locations of the same type (bed to bed, apartment to apartment, etc.), they continue the same visit and begin a new visit segment. No discharge or admission processes are required.

To transfer Georgia Angie Arena to a new location, indicate the correct transfer information below.

EFFECTIVE DATE			
Transfer start: *	04/01/2016	Location name: *	ENC1082
Care level: *	300	Payor Level	CONTINUE

**TRANSFER RESIDENT FROM THIS LOCATION**

Location name: ENC2101

Location type: B (Bed)

Location rate: \$160.00 day

Override rate:

Care level: 300 ICF MEDICAID

Business unit/Product line: Nursing/Unit 4

➔

**TRANSFER RESIDENT TO THIS NEW LOCATION**

Location name: ENC1082

Location type: Bed

Location rate: \$160.00 day

Override rate:

Care level: 300 ICF MEDICAID

Business unit/Product line: \* Nursing/Unit 1

Transfer Reason: Issues with roommate

TRANSFER 
CANCEL

1. Access the Transfer page by selecting a resident visit then choosing Transfer in the ADT menu.
2. If the resident has a reservation for the new location, a message appears. Click Yes to make the reserved location appear as the To location on the Transfer page.
3. The Transfer page displays. In the Effective Date frame, enter the required information.
  - **Transfer start (required).** Enter the effective date of the transfer. This field defaults to the current system date, which you can edit if necessary. If you enter a past date, it cannot be earlier than the resident's admission date or the most recent charge date on the resident's account. Future transfer dates are not allowed. If you enter a transfer date on which the resident was in a different location (of the same type) than the current one, the Transfer From information updates to the earlier location.

**Note:** You cannot transfer a resident currently on bed hold. The hold must be ended at least one day before the transfer.

- **Location name (required).** Select the location to which the resident is transferring. The location should be appropriate for the resident's care level as of the transfer date. If transferring to a reserved location, that location appears in this field.
  - **Care level (required).** Enter the care level of the resident as of the transfer date. This field defaults to the resident's current care level, which you can edit.
  - **Payor Level.** As an alternative to selecting a care level from the Search For Care Level dialog, click the Payor Level link to select a care level from the Payor Level Select dialog. This dialog enables you to select a care level associated with a Payor in the resident's reimbursement table.
4. Click the Continue button. The Transfer Resident To... frame is updated with the info just entered in the Effective Date frame.
  5. In the Transfer Resident To... frame, enter the appropriate information.
    - **Location name, type, and rate.** These fields display default information for the location being transferred to.
    - **Override rate.** If the bed rate is overrideable in the facility profile and you have the necessary permissions, you can modify the rate and unit for the bed.
    - **Care level.** This label displays the care level entered in the Effective Date frame.
    - **Business unit/Product line (required).** Edit the business unit/product line for the new location, if necessary. Select a combination from the list.
    - **Transfer Reason.** Select the reason for the transfer. Entries in this list are maintained on the Transfer Reason master page.
  6. Click the Transfer button. A message appears confirming the transfer.
  7. Click OK. The transfer is complete.

## Transferring a resident from apartment to bed

When transferring from an apartment (or assisted living) to a bed, a resident can keep their apartment to return to it later.

To transfer Bobby Warren Billings to a new location, indicate the correct transfer information below.

EFFECTIVE DATE			
Transfer start: *	04/04/2016	Location name: *	FNTG14 1
Care level: *	301	Payor Level	CONTINUE

**TRANSFER RESIDENT FROM THIS LOCATION**

Location name: GNA44131

Location type: A (Apartment)

Location rate: \$0.00 day

Override rate:

Care level: 301 IND-AL

Business unit/Product line: IND-AL2/SCLA

➔

**TRANSFER RESIDENT TO THIS NEW LOCATION**

Location name: FNTG14 1

Location type: Bed

Location rate: \$0.00 day

Override rate:

Care level: 301 IND-AL

Business unit/Product line: \* SNF1/SCLA

Transfer Reason: Resident Requested

1. Access the Transfer page by selecting a resident visit then choosing Transfer in the ADT menu.
2. If the resident has a reservation for the new bed, a message appears. Click Yes to make the reserved bed appear as the To bed on the Transfer page.
3. The Transfer page displays. In the Effective Date frame, enter the required information.

- **Transfer start (required).** Enter the effective date of the transfer. This field defaults to the current system date, which you can edit if necessary. If you enter a past date, it cannot be earlier than the resident's admission date or the most recent charge date on the resident's account. Future transfer dates are not allowed. If you enter a transfer date on which the resident was in a different location (of the same type) than the current one, the Transfer From information updates to the earlier location.

**Note:** You cannot transfer a resident currently on bed hold. The hold must be ended at least one day before the transfer.

- **Location name (required).** Select the location to which the resident is transferring. The location should be appropriate for the resident's care level as of the transfer date. If transferring to a reserved bed, that bed appears in this field.
- **Care level (required).** Enter the care level of the resident as of the transfer date. This field defaults to the resident's current care level, which you can edit.
- **Payor Level.** As an alternative to selecting a care level from the Search For Care Level dialog, click the [Payor Level](#) link to select a care level from the Payor Level Select dialog. This dialog enables you to select a care level associated with a Payor in the resident's reimbursement table.



4. Click the Continue button. The Transfer Resident To... frame is updated with the info just entered in the Effective Date frame.
5. In the Transfer Resident To... frame, enter the appropriate information.
  - **Location name, type, and rate.** These fields display default information for the location being transferred to.
  - **Override rate.** If the bed rate is overrideable in the facility profile and you have the necessary permissions, you can modify the rate and unit for the bed.
  - **Care level.** This label displays the care level entered in the Effective Date frame.
  - **Business unit/Product line (required).** Edit the business unit/product line for the new location, if necessary. Select a combination from the list.
  - **Transfer Reason.** Select the reason for the transfer. Entries in this list are maintained on the Transfer Reason master page.
6. Click the Transfer button. A message appears asking if the resident wants to keep their apartment. Do one of the following:
  - Click Yes to **keep the apartment**. After an information message, the Rate Selection page appears. You may want to reduce the rate on the apartment while the resident is in the bed. Modify the rate, if needed, and click OK.
  - Click No to **discharge from the apartment**. After an information message, the In-house Discharge page appears. Edit the discharge information as necessary and click OK. A message appears confirming the discharge.
7. If the resident has more than one account, the Select Account dialog appears. Select an account for the resident, then click OK. The Modify Visit page appears.
8. Edit the new visit for the bed. If the bed rate is overrideable and you have the necessary permissions, you can modify the bed rate and unit. When finished, click OK.
9. A message appears confirming the admission. When you click OK, the Diagnoses page appears.
10. Enter one or more diagnoses for the new visit. At least one diagnosis is required. Save each diagnosis by clicking OK, then click Exit.
11. A message appears advising you to edit the resident's reimbursement table, if necessary. After finishing the transfer, you can access the reimbursement page through the Resident Snapshot. When you click OK in the message box, the Resident's Physicians page appears.
12. Edit the resident's physician list, if necessary. Then click Exit. A message appears.
13. Click OK. The transfer is complete.

## Transferring a resident from bed to apartment

When a resident transfers from a bed to an apartment, the system checks whether they have a visit for a kept apartment. If so, you can restore the resident to the kept apartment.

**Note:** When you transfer a resident from a bed to an apartment, NetSolutions automatically discharges the resident from the bed before completing the transfer to the apartment by creating a new visit. Enter the Inhouse Discharge Information when the dialog displays, then enter the information for the new visit in the Visit Information dialog.

To transfer jack tom to a new location, indicate the correct transfer information below.

EFFECTIVE DATE			
Transfer start: *	04/04/2016	Location name:*	GNA44011
Care level: *	1	Payor Level	CONTINUE

**TRANSFER RESIDENT FROM THIS LOCATION**

Location name: FNT22041

Location type: B (Bed)

Location rate: \$0.00 day

Override rate:

Care level: 1      RESERVED

Business unit/Product line: SNF1/SCLA

➡

**TRANSFER RESIDENT TO THIS NEW LOCATION**

Location name: GNA44011

Location type: Apartment

Location rate: \$0.00 day

Override rate:

Care level: 1      RESERVED

Business unit/Product line: \*

Transfer Reason:

There are two main ways to transfer a resident from a bed to an apartment:

*Restoring the resident to a kept apartment:*

1. Access the Transfer page by selecting a resident visit then choosing Transfer in the ADT menu.
2. A message appears informing you that the resident has a kept apartment. Choose Yes.
3. The Discharge page displays, where you discharge the visit for the From bed. Edit the Discharge screen and click OK. When the discharge is complete, the resident's visit for the kept apartment is the only active visit.
4. The Rate Selection page appears. Kept apartments are often held at a reduced rate; you may want to restore the full rate at this time. Accept or modify the bed rate and unit, then click OK. The transfer is complete.
  - If you want to transfer a resident to an apartment other than their kept apartment, you must first complete the transfer to the kept apartment, then do a second transfer to the new apartment.

*Transferring the resident to a new apartment:*

1. Access the Transfer page by selecting a resident visit then choosing Transfer in the ADT menu.

2. If the resident has a reservation for the new apartment, a message appears. Click Yes to make the reserved apartment appear as the To location on the Transfer page.
3. The Transfer page appears. In the Effective Date frame, enter the required information.
  - **Transfer start (required).** Enter the effective date of the transfer. This field defaults to the current system date, which you can edit if necessary. If you enter a past date, it cannot be earlier than the resident's admission date or the most recent charge date on the resident's account. Future transfer dates are not allowed. If you enter a transfer date on which the resident was in a different location (of the same type) than the current one, the Transfer From information updates to the earlier location.

**Note:** You cannot transfer a resident currently on bed hold. The hold must be ended at least one day before the transfer.
  - **Location name (required).** Select the location to which the resident is transferring. The location should be appropriate for the resident's care level as of the transfer date. If transferring to a reserved apartment, that apartment appears in this field.
  - **Care level (required).** Enter the care level of the resident as of the transfer date. This field defaults to the resident's current care level, which you can edit.
  - **Payor Level.** As an alternative to selecting a care level from the Search For Care Level dialog, click the [Payor Level](#) link to select a care level from the Payor Level Select dialog. This dialog enables you to select a care level associated with a Payor in the resident's reimbursement table.
4. Click the Continue button. The Transfer Resident To... frame is updated with the info just entered in the Effective Date frame.
5. In the Transfer Resident To... frame, enter the appropriate information.
  - **Location name, type, and rate.** These fields display default information for the location being transferred to.
  - **Override rate.** This field is unavailable when transferring from a bed to a new apartment.
  - **Care level.** This label displays the care level entered in the Effective Date frame.
  - **Business unit/Product line (required).** Edit the business unit/product line for the new location, if necessary. Select a combination from the list.
  - **Transfer Reason.** Select the reason for the transfer. Entries in this list are maintained on the Transfer Reason master page.
6. Click the Save button. A message appears.
7. Click OK. The In-house Discharge page appears.
8. Discharge the resident from the existing bed by editing the fields on the Discharge page, then click OK. The Select Account page appears.
9. If the resident has more than one account, the Select Account dialog appears. Select an account for the resident, then click OK. The Modify Visit page appears.

10. Edit the new visit for the apartment, then click OK. A message appears confirming the admission. When you click OK, the Diagnoses page appears.
11. Enter one or more diagnoses for the new visit. At least one diagnosis is required. Save each diagnosis by clicking OK, then click Exit.
12. A message appears advising you to edit the resident's reimbursement table, if necessary. After finishing the transfer, you can access the reimbursement page through the Resident Snapshot. When you click OK in the message box, the Resident's Physicians page appears.
13. Edit the resident's physician list, if necessary. Then click Exit. A message appears.
14. Click OK. The transfer is complete.

## Holds

### Overview

Hold a location in your facility for a resident while they are on leave using the Hold page.

HOLD SUMMARY								1 - 1 of 1
		START DATE	START TIME	END DATE	END TIME	TYPE	REASON	
		11/01/2013	09:53	11/01/2013	09:54	H	Hospital	

HOLD EFFECTIVE DATES	LOCATION INFORMATION
Hold start date: * <input type="text" value="11/01/2013"/> Start time: * <input type="text" value="09:53"/> Hold Care Level: <input type="text" value="400"/> > SKILLED	Location: ENC1042 Rate: \$1.00 / day Override rate: <input type="text"/> / <input type="text" value="Day"/>
Hold end date: <input type="text" value="11/01/2013"/> <input type="checkbox"/> Clinical readmit Return time: <input type="text" value="09:54"/> Return Care Level: <input type="text" value="400"/> > SKILLED  Reason: * <input type="text" value="Hospital"/> <a href="#">Leave information</a> Type: <input type="radio"/> Planned <input type="radio"/> Unplanned Hospital Trx Outcome: <input type="text"/> Purpose of current stay: <input type="radio"/> Post-Acute Care <input type="radio"/> Chronic LTC Trx condition: <input type="text"/> Trx diagnoses: <input type="text"/> Trx contributing reason: <input type="text"/> Destination: <input type="text"/> <a href="#">Hospital stay information</a> <a href="#">Leave diagnosis</a> <input type="checkbox"/> Medicaid/Insurance approves holding of bed <input type="checkbox"/> Resident approves holding of bed	TRANSFER TO <input type="checkbox"/> Another location <input type="checkbox"/> Another facility <div style="border: 1px solid #ccc; height: 100px; margin-top: 5px;"></div>
SEND DISCHARGE SUMMARY <input type="checkbox"/> Send discharge summary via disclosure	

[Perform another hold for this resident](#)    [View current occupancy rate](#)

To create a hold, you enter a hold start date and other information such as the reason for the hold, change in care level, the leave destination, and any associated hospital stay or diagnosis data. Entering a hold moves the resident from in-house to on-hold status. On-hold residents are not included in the daily census; however, your facility may continue charging for the bed while it is being held.

When the resident returns from the leave, you return to the Hold page and enter an end date for the hold.

**Location rates.** The bed profile enables your facility to set several rates for a location. When you place a hold, depending on the bed profile and leave type, the resident may be charged a different rate than when occupying the bed. If the bed profile allows it, you can override the default hold rate for the bed when entering the hold.

**Retroactive holds.** If you enter or modify a hold so that it spans back into a period for which charges have been calculated, retroactive processing is initiated. You must have the necessary security rights to enter a retroactive hold. All charges for the account from the start of the hold are reversed. You then must recalculate the charges on the account. If billed charges have been reversed, the bill will be regenerated in the next billing cycle.

**Transfers.** Transfer a resident to another location when they return from a hold by selecting the Another Location check box in the Transfer To frame. When you enter a hold end date and save the hold, the Transfer page appears, enabling you to complete the transfer for the resident.

**Facility transfers.** If your facility has purchased the Inter-Facility Transfer module, you can transfer a resident to another facility from the Hold page. Select the Another Facility check box in the Transfer To frame and then select the interface through which you want to send the HL7 message. The message is sent to the other facility when you enter an end date and save the hold.

**Occupancy rate.** Moving residents to on-hold status changes your occupancy rate. Calculate your occupancy rate from the Hold page by clicking the [View Current Occupancy Rate](#) link.

**Reports.** The Away (Bed Hold) report shows all residents, for a specified date, that are considered to have an "away" status: reserves and residents on bed hold. Holds also appear on the various reports that track census activity.

## Entering a hold


Hold a location in your facility for a resident while they are on leave using the Hold page.

1. Access the Hold page by selecting a resident visit then choosing Hold in the ADT menu.

2. In the Hold Effective Dates frame, enter the appropriate information.

HOLD EFFECTIVE DATES	
Hold start date: *	11/01/2013
Start time: *	09:53
Hold Care Level:	400  > SKILLED
<hr/>	
Hold end date:	11/01/2013 <input type="checkbox"/> Clinical readmit
Return time:	09:54
Return Care Level:	400  > SKILLED
Reason: *	Hospital
<a href="#">Leave information</a>	
Type:	<input type="radio"/> Planned <input type="radio"/> Unplanned
Hospital Trx Outcome:	
Purpose of current stay:	<input type="radio"/> Post-Acute Care <input type="radio"/> Chronic LTC
Trx condition:	
Trx diagnoses:	
Trx contributing reason:	
Destination:	
<a href="#">Hospital stay information</a> <a href="#">Leave diagnosis</a>	
<input type="checkbox"/> Medicaid/Insurance approves holding of bed <input type="checkbox"/> Resident approves holding of bed	

- **Hold Start date (required).** Enter the hold start date. This date cannot be after the current date, prior to the admission date, or before the last date the account was billed unless you have Retroactive Bed Hold rights.
- **Start time (required).** Enter the actual time the resident left the facility to go on leave.
- **Hold Care Level.** If the care level changes when the resident goes on hold, enter the new care level or click to select it from the Search for Care Level dialog. When you enter a hold start date and a hold care level, the new care level is effective as of the start date.

- **Equiv Exempt Level.** Click this link to change the equivalent exempt levels on some or all plans. This link is only available if the reimbursement table contains equivalent exempt plans that have not ended or been voided before the hold start date.
- **Hold End date.** When the resident has completed the hold, enter the hold end date. This date should be the day before the resident returns to the facility. It must be after the start date, on or before today's date, and after the last billing date unless you have Retroactive Bed Hold rights.
- **Clinical Readmit.** Select this checkbox to tell the NetSolutions Clinical products that the end of the hold is considered a clinical readmission. This checkbox becomes available when the hold end date is entered.
- **Return time.** Enter the actual time that the resident came back to the facility. When you enter an end date, an entry in this field is also required.
- **Return Care Level.** If the care level changes when the hold ends, enter the new care level or click  to select it from the Search for Care Level dialog. When you enter a hold end date and a return care level, the new care level is effective as of the day after the hold end date.
- **Equiv Exempt Level.** Click this link to change the equivalent exempt levels on some or all plans. This link is only available if the reimbursement table contains equivalent exempt plans that have not ended or been voided before the hold end date.
- **Reason (required).** Select the reason for the hold. Default reasons include Personal, Hospital, <24 Hours, and <72 Hours. Other reasons can be set up in the facility profile. When you select a type H (Hospital) reason, such as <24 Hours, the [Hospital stay information](#) link and the [Leave diagnosis](#) link are enabled.
- **Type.** Indicate whether the hold was planned or unplanned. This field is required only when the Hospital Readmission KPI is active. By default, neither option is selected.
- **Hospital Trx Outcome.** Select the reason for the hospital transfer. The value selected here is used when calculating the results for the Hospital Readmission KPI in the Dashboard. This field is required only when the Hospital Readmission KPI is active. The available responses are:
  - ED visit only
  - Admitted, inpatient
  - Admitted, observation
  - Admitted, status uncertain
  - Other

If the Federal field is set for an Acute Care Hospital (ACH) or Critical Access Hospital (CAH), this field is required; otherwise, the field is not available.



- **Purpose of Current Stay.** Indicate the purpose of the stay. If the stay is for an ongoing condition, choose Chronic LTC; if the stay is for a specific issue that is not ongoing, for example a broken bone as the result of a fall or surgery, choose Post-Acute Care. The value selected here is used when calculating the results for the Hospital Readmission KPI in the Dashboard. This field is required only when the Hospital Readmission KPI is active. If the Federal field is set for an Acute Care Hospital (ACH) or Critical Access Hospital (CAH), this field is required; otherwise, the field is not available.

**Note:** Select Post-Acute Care for a resident who has been admitted and is planning to be discharged within 100 days. Select Chronic LTC for a resident who has been or is expected to be admitted for more than 100 days.

- **Trx Condition.** Select the condition that caused the need for the transfer. Values for this dropdown list are defined on the Transfer Condition master page. The value specified is used for selection purposes on the Hospital Readmission graph.
- **Trx Diagnoses.** Select the diagnoses that caused the need for the transfer. Values for this dropdown list are defined on the Transfer Diagnoses master page. The value specified is used for selection purposes on the Hospital Readmission graph.
- **Trx contributing reason.** Select the contributing reason that caused the need for the transfer. Values for this dropdown list are defined on the Transfer Contributing Reason master page. The value specified is used for selection purposes on the Hospital Readmission graph.
- **Destination.** Select the destination where the resident is going. The available selections are set up in the census Visit Destination profile.

**Note:** If the facility's GL Product is LCCA and 01, 06, 50, or 51 is selected in the Federal field above, then you must specify a Destination in this field.

- **Medicaid/Insurance approves holding of bed.** Select this checkbox to indicate that Medicaid should be billed for the hold day. This field is enabled only when the hold reason is <24 Hours or <72 Hours.
- **Resident approves holding of bed.** Select this checkbox to indicate that the Resident should be billed for the hold day. This field is enabled only when the hold reason is <24 Hours or <72 Hours.
- **Pass non-covered bed hold to private.** Select this checkbox to pass the non-covered bed hold to private. This checkbox is only enabled if the resident has a TN or MN Medicaid plan on their reimbursement table.

- Click the [Leave information](#) link to open the Leave Information dialog. Enter the appropriate information.

**Hold Leave Info**

**LEAVE INFORMATION**

Leave start: 01/25/2015      Leave end: 01/27/2015

Destination: Northwest Rehab

Comments: Rehab stay after fall.

CONTINUE      CANCEL

- **Leave Start.** This field displays the date the leave began.
  - **Leave End.** This field displays the date the leave ended.
  - **Destination.** Enter the destination of the resident during the leave. This could be a medical facility, a residence, a vacation place, etc.
  - **Comments.** Enter any other information relevant to the leave.
  - **Continue / Cancel.** Click the Continue button to close the dialog and store your changes in memory (they are saved when you save the hold). Click the Cancel button to close and cancel any changes.
- Click the Hospital stay information link to open the Hospital Stay Maintenance dialog. This link is available when you select a type H (Hospital) item in the Reason list. Enter the appropriate information.

**NetSolutions**

**HOSPITAL STAY MAINTENANCE**

Hospital name: RODAK Hospital

Admit date: 01/25/2015      Discharge date: 01/28/2015

Provider #:

☒ New spell of illness?

CONTINUE      CANCEL

- **Hospital name.** Select the hospital to which the resident was admitted. Items in this list are entered on the Organization Master page.

- **Admit date.** Enter the resident's admit date at the hospital. This field defaults to the start date of the hold. Edit if necessary.
  - **Discharge date.** Enter the resident's planned discharge date from the hospital. If an end date has been entered for the hold, this field defaults to that date.
  - **Provider #.** Enter the provider number of the hospital.
  - **New spell of illness?** Select Yes or No to indicate whether this stay qualifies as a new spell of illness for the resident. If this checkbox is selected and the hold end date has been entered, the Select Plan(s) For New Spell of Illness dialog appears when you save the hold. This enables you to select a Medicare A plan for the new spell of illness.
  - **Continue / Cancel.** Click the Continue button to close the dialog and store your changes in memory (they are saved when you save the hold). Click the Cancel button to close and cancel any changes.
5. Click the Leave diagnoses link to enter the diagnoses associated with this hold. The link opens the Clinical Information page in a dialog, where you can enter ICD-9 and ICD-10 codes for the Leave diagnoses. You must select the Leave checkbox in the DX Type field to make the diagnoses you enter here Leave diagnoses. This link is available when you select a type H (Hospital) item in the Reason list.
  6. In the Location Information panel, enter the appropriate information.

LOCATION INFORMATION		
Location:	SNFB241	
Rate:	\$149.00	/ day
Override rate:	<input type="text"/>	/ Day ▼

- **Location.** This label displays the resident's location on the hold start date.
- **Rate.** This label displays the location hold rate for the type of leave selected.
- **Override rate/unit.** Override the default hold rate for the location by entering a value in this field. Select a unit to change the time period to which the rate applies. An entry of zero (0) in the Override Rate field results in no charge. To restore the default hold rate for the location, enter a ? in the field. Note: To override the rate, you must have the necessary security rights and the bed profile must allow an override.

7. If you are entering an end date for the hold, you have the option to transfer the resident to another location. In the Transfer To frame, enter the appropriate information.

- **Another location.** Select this check box to transfer the resident to another location starting the day after the hold's end. When you select this check box, enter a hold end date, and click Save, you are taken to the Transfer page, where you complete the resident transfer.
  - **Another facility.** Select this check box after entering a hold end date to transfer the resident to another facility using the HL7 interface. This may only be selected on a new hold.
  - **HL7 Interfaces list.** After selecting the Another Facility check box, select one or more interfaces in this list through which HL7 messages are sent to another facility.
8. In the Send Discharge Summary panel, select the Send Discharge Summary Via Disclosure checkbox to automatically send a discharge summary using the Record Disclosure feature each time a resident is put on bed hold, and each time a hold record is updated.
9. Click the Save button. The data is saved and, depending on the data entered and options selected, one or more of the following happens:
- **New spells:** If you have indicated that this is a new spell of illness in the Hospital Stay Maintenance dialog, the Select Plan(s) for New Spell of Illness dialog opens, enabling you to select a Medicare A plan to cover the new spell.
  - **Retro:** If the hold spans back into a period for which charges have already been calculated, retroactive processing is triggered.
  - **More info:** You may be prompted to enter leave, hospital, or diagnosis information. You may also be given the opportunity to override the bed rate.
  - **Ancillary orders:** If the resident has ancillary orders, you are prompted to either suppress or continue the ancillary orders during the hold.
  - **Transfers:** If you are transferring the resident, you are taken to the Transfer page or an HL7 message is sent.

Click the [Perform another hold for this resident](#) link to enter another hold.

Click the [View current occupancy rate](#) link to calculate an updated occupancy rate.

**Note:** If you have made a care level change for a future date and do not want to override or re-enter the change, **do not** enter a new care level in either the Hold Care Level field or the Return Care Level field.

## Reserves

### Overview

Reserve a location in your facility for a resident or prospect using the Reserves page. A reservation (or "reserve") places a location on reserved status, which means that the location belongs to the resident though they are not occupying it.

Last name: <input type="text" value="a"/>		Reserve from: <input type="text" value=""/>	
First name: <input type="text" value=""/>		Location: <input type="text" value=""/>	
<input type="button" value="SEARCH"/>			

RESERVE SUMMARY										1 - 5 of 31	<a href="#">Next &gt;</a>
END	CANCEL	LAST NAME	FIRST NAME	CARE LEVEL	FROM DATE	THRU DATE	LOCATION	TYPE	MIN CERT	MAX CERT	
		Aaron	Lisa	802	06/29/2005	06/29/2005	66 366A 4	B	700	800	
		Aaron	Lisa	802	07/27/2005	08/17/2005	66 388A 4	B	700	800	
		Aaron	Lisa	802	01/05/2006	01/05/2006	A3 120A 1	A	600	600	
		Aaron	Mack	600	04/05/1998	12/13/2005	78908	B	700	800	
		Aaron	Marges	800	06/13/2005	06/13/2005	66 361B 4	B	700	800	

RESERVE DETAIL	
Resident:*	<input type="text" value="Abercrombie, Jake"/>
Care level:*	<input type="text" value="700"/> INTERMEDIATE
Location:*	<input type="text" value="D2 159A 2"/>
Location type:	Apartment
Room type:	Private
Min certification:	600
Max certification:	600
Rate:	\$1,273.00 / mo
Override:	<input type="text" value=""/> / <input type="text" value=""/> <input checked="" type="checkbox"/> Charge for reserve
Reserve from:*	<input type="text" value="02/07/2006"/>
Reserve thru:	<input type="text" value=""/>
<input type="button" value="SAVE"/> <input type="button" value="CANCEL"/>	
<a href="#">Perform another reserve</a>	

**Resident status.** You can reserve a location for a resident before or after admitting them to the facility. If you are charging for the reserved bed, the resident must be admitted with a reserve visit and must have an account for billing purposes. If you do not charge, no visit or account is required. Any registered resident - inpatient, outpatient, on leave - can have a reservation for a future location. Again, if that reservation is charged for, it requires a separate reserve visit and a resident account.

**Rate overrides.** When you select a reserve location, that location's reserve rate, as defined in the facility profile, appears by default. If the bed profile allows a rate override and you have the necessary rights, you can override this rate.

**Retroactive reserves.** If you enter a Reserve From date that is earlier than the last date the resident's account was billed, retroactive processing is triggered. You must have the necessary security rights to enter a retroactive reserve.

**Admissions.** When you admit a resident or prospect who has a reservation, the system prompts you to accept the reserved location. Whether you use the reservation or pick a different location, the reserve and any associated order are ended on the admit date.

**Reports.** The Away (Bed Hold) report shows all residents, for a specified date, that are considered to have an "away" status: reserves and residents on bed hold. Reserves also appear on the various reports that track census activity.

### Entering a reserve

The Reserve page opens in Add mode. At top is a filter for displaying current reserves in the Reserve Summary grid. Click Edit on a reserve to view its details below. Return to Add mode by clicking the [Perform another reserve](#) link at bottom.

1. On the Resident tab, choose Reserve from the ADT menu.
2. In the Reserve Detail frame, enter the appropriate information.



Resident:*	<input type="text" value="Abbott, Ralph"/>		
Care level:*	<input type="text" value="300"/>		Private
Location:*	<input type="text" value="SNFA222"/>		
		Location type:	Bed
		Min certification:	400
		Max certification:	999
Rate:	\$102.00	/	Day
Override:	<input type="text"/>	/	<input type="text"/>
			<input checked="" type="checkbox"/> Charge for reserve
Reserve from:*	<input type="text" value="7/28/2006"/>		
Reserve thru:	<input type="text"/>		

- **Resident (required).** Select the resident for whom you want to enter a reservation. You cannot type in this field; use the Resident Selection dialog. Click the [New Resident](#) link in the dialog to add a new resident to the system.
- **Care level (required).** Enter or select the care level you expect the resident to have when they occupy the reserved location. This field is for informational purposes. Since the resident's care level may change before they occupy the bed, the system does not require that the resident's care level match the location's care level range.
- **Location (required).** Select the location you want to reserve for the resident or prospect. You cannot type in this field; use the Search dialog. When you select a location, the Location Type, Min Certification, Max Certification, and Room Type labels display the corresponding data.
- **Rate.** This label displays the default rate and unit for the bed as established in the facility profile.
- **Override.** Enter an override rate and unit for the location. These fields are available only if the location is defined as overrideable in the bed profile and if you have security rights to override rates. Entering a rate of zero results in no charge for the location. To restore the default reserve rate, enter a ? in the field.

- **Charge for reserve.** Select this checkbox to charge for the reserved location. When you select this checkbox and save the reservation, you are prompted to enter a reserve visit for the resident. The resident also must have an account for billing.
  - **Reserve from (required).** Enter or select the starting date of the reservation. If this date is before the resident's last billing date, retroactive processing is triggered. The reserve start date must be in the current cycle; it cannot be in a previous month.
  - **Reserve thru.** Enter the date the resident or prospect will occupy the location. Entering the current date (or a past date) in the Reserve Thru field ends the reservation. You can leave this field blank and enter a date when the resident is admitted.
3. Click Save. If you are charging for the reservation, the system runs the following checks:
- **Account.** If the resident has no account or more than one account, a dialog appears enabling you to select or create an account. When you create a new account, you also select a reimbursement table for the resident.
  - **Visit.** The reservation requires a separate visit of type Reserve. The Reserve Visit dialog appears where you create the new visit.
  - **Retro.** If the From date precedes the resident's last billing date, retroactive processing is triggered. A warning appears and, if the Resident Comments option is selected in the facility profile, you are prompted to enter a comment.
  - **Registration.** If the resident is not registered, a message appears. When you click OK, you are redirected to the Basic Information page where you can work through the Registration pages.

### Ending a reserve

To end a reservation, you enter a Thru date, which closes the reservation period. If you charged for the reservation, you also must discharge the reserve visit.

1. On the Resident tab, choose Reserve from the ADT menu.
2. Use the fields at the top of the page to filter for the reservation you want to end.
  - The reserves that meet the filter criteria display in the Reserve Summary panel.
3. In the Reserve Summary panel, click  for the reserve record you want to end.
  - NetSolutions displays a confirmation message.
4. Click OK. The reserve record appears in the Reserve Detail frame, with the Reserve Thru field enabled.
5. Enter a date in the Reserve Thru field using the format mm/dd/yyyy, or click  and select a date from the Calendar.
6. Click Save.
  - If you were charging for the reservation, the Reserve Discharge dialog displays.

7. In the Reserve Discharge dialog, enter the appropriate information.

**Discharge Modal**

**RESERVE DISCHARGE INFORMATION**

Resident: Farmer, Gerald Loretta

Location: SNFB151

Admit date: 09/29/2016 Time: 10:16

Discharge date: 11/01/2016 Time: \* 16:36

Federal: \* 01-Discharged to home

State: 99-OTHER

Destination: 126 NORTH DRIVE

Info/Reason:

Provider #:

Provider type:

**DONE** **CANCEL** [Diagnoses](#)


- **Resident.** This label displays the resident for whom you are discharging the reserve visit.
- **Admit date/time.** This label displays the admit date and time on the reservation.
- **Discharge date.** This label displays the date just entered in the Reserve Thru field.
- **Discharge time (required).** Enter the actual time you are discharging the reserve visit.
- **Federal (required).** Select a federal code for the resident's destination on this discharge. An entry is required in either this or the State field.
- **State (required).** Select a state code for the resident's destination on this discharge. An entry is required in either this or the Federal field.
- **Destination.** Select the destination where the resident is going after being discharged. The available selections are set up in the census Visit Destination profile.
- **Info/Reason.** Enter the reason for, or other information related to, this discharge.
- **Provider #.** Enter the provider number for the discharge, if applicable, using up to 20 characters.
- **Provider Type.** Enter a provider type. This field is used on the bill for the NY referring/discharge provider type as long as the discharge destination and the provider number are also entered.



- **Diagnoses.** Click the [Diagnoses](#) link to access the Diagnoses dialog where you can enter a discharge diagnosis for the visit.
8. Click the Done button. If the thru date is before the resident's last billing date, retroactive processing is triggered.
    - On the Reserve page, the reserve now appears discharged (with a Thru date) in the Reserve Summary panel.

### Canceling a reserve

Canceling a reservation deletes the reserve record from the system.

1. On the Resident tab, choose Reserve from the ADT menu.
2. Use the fields at the top of the page to filter for the reservation you want to cancel.
3. In the Reserve Summary panel, click Cancel  for the reserve record you want to cancel.
  - NetSolutions displays a confirmation message.
4. Click OK.
  - If there are charges for the reservation, one or more messages may appear. If you continue with the cancellation, charges for the reservation are reversed. Any affected bills on the resident's account must be re-generated.

## Swaps

### Overview

Swap the locations of two residents using the Swap page.

To swap the location for two residents, select the appropriate resident names and ensure the correct information is available. Once you click Save, the current visit segment will be closed and a new segment will be opened with the new information.

EFFECTIVE DATE

Start date: \* 4/4/2016

SWAP LOCATION FOR RESIDENT "A"

Resident name: \* Andolina, Salome

Client identifier: HR #3195/Acct #961

Location name: ENC2222

Care level: \* 400 SKILLED MCAID  
Payor level

Business unit/Product line: \* Nursing/Unit 2

↔

SWAP LOCATION FOR RESIDENT "B"

Resident name: \* Darnieder, Susie

Client identifier: HR #3149/Acct #915

Location name: ENC4131

Care level: \* 400 SKILLED MCAID  
Payor level

Business unit/Product line: \* Nursing/Unit 4

Transfer Reason: Issues with roommate

SAVE

CANCEL

[Perform another swap](#)

**Limitations.** Swap is a convenience feature enabling you to trade the locations of two residents who have similar census characteristics. There are three main limitations:

- **Location type.** To perform a swap, the two residents must have the same current location type. You can swap residents between two apartments, two beds, or two assisted living beds.
- **Rates.** A swap does not allow you to override bed rates. When you perform the swap, each resident is transferred into their new location at the default rate for the bed. If you want to override bed rates, you must transfer each resident separately using the Transfer page.
- **Billing.** You cannot perform a swap when one of the resident accounts has been billed through the swap date. The swap would require retroactive processing which NetSolutions does not do for swaps.


**Orders.** When two residents are swapped, their existing bed orders stop on the day before the swap, and two new bed orders begin on the swap date. Each new order uses the price specified in the bed profile for the item.

**BU/PL.** When resident beds are swapped, the cost center assigned originally to each bed does not change. The BU/PL for the new bed is now assigned to the new resident.

**Reports.** Swaps appear on the reports that track census activity, such as the Census Activity report, the Census Days report, and the Census History report.


## Performing a swap

Use the Swap page to swap the locations of two residents. You can select one of the residents to be swapped before clicking the Swap link, or select both residents on the Swap page.

1. On the Resident tab, choose Swap in the ADT menu.
  - The Swap page displays.
2. In the two Swap Location frames (for Resident "A" and Resident "B"), enter the appropriate information:
  - **Effective Date (required).** Enter the date the swap is effective using the format mm/dd/yyyy, or click  to select a date from the Calendar. By default to the current date is entered in this field.


**Note:** You cannot enter a future date in this field. Past dates are accepted back to the most recent admit date or charge date for either resident's account. A swap cannot trigger retroactive processing.


SWAP LOCATION FOR RESIDENT "B"


Resident name: \*  

Client identifier: HR #3149/Acct #915

Location name: ENC4131

Care level: \*   SKILLED MCAID  
Payor level

Business unit/  
Product line: \*  

Transfer Reason:  

- **Resident name (required).** Select the residents whose locations you want to swap. You cannot type in this field; use the Resident Selection dialog.
- **Client identifier.** This label displays the client identifier for the selected resident.
- **Location name.** This label displays the current location of the selected resident.
- **Care level (required).** This field defaults to the current care level of the selected resident, which you can edit if necessary. If the care level does not match the care level range of the resident's new bed, a warning is issued.
- **Business unit/Product line (required).** This field defaults to the current BU/PL for the selected resident, which you can change if necessary. The BU/PL you choose is assigned to the resident visit in the new location.
- **Transfer Reason.** Select the reason for the transfer. Entries in this list are maintained on the Transfer Reason master page.

3. Click Save. The system validates the swap. Warning messages may appear for any of the following:
  - The beds must be same type. Neither bed can be closed or reserved.
  - The gender of the residents is checked against the gender of their new roommates.
  - The care level of the residents is checked against the certification level of the new beds.
  - If the account has been billed through the swap date, the swap is not allowed.

Click the [Perform another swap](#) link to clear all fields and start another swap.

**Note:** When you swap residents, each resident is assigned the business unit - product line combination (BU/PL) appropriate for the new bed. The BU/PL for the original bed remains with that bed. A BU/PL combination is used to identify a cost center for billing purposes.

## Discharges

### Overview of Discharges

The Discharge page enables you to discharge inpatient and outpatient residents, and to edit or cancel previous discharges. When you discharge a resident, their status changes to Inactive and the room's status changes to Available.

DISCHARGE SUMMARY								1 - 1 of 1
Edit	D/C	Cancel	Admit Date	Admit Time	Discharge Date	Discharge Time	Location	Bed Type
			05/10/2013	12:45	06/03/2013	12:33	ENC4161	B

#### DISCHARGE INFORMATION

Discharge date: \*

Discharge time: \*

Federal: \*

State:

Type: \* ☒ Planned ☐ Unplanned

Hospital Trx Outcome:

Purpose of stay: ☐ Post-Acute Care ☐ Chronic LTC

Trx condition:

Trx diagnoses:

Trx contributing reason:

Destination:

Info/Reason:

Provider #:

Provider type:

[Diagnosis](#)

#### TRANSFER RESIDENT

☐ Transfer resident into another facility

SAVE

DONE

CANCEL

The Discharge Summary panel displays the resident's visits. Click the D/C button beside an active visit to discharge the visit. The resident's most recent active visit is selected by default. Click Edit on an inactive (discharged) visit to modify the discharge information in the frames below. Click Cancel on an inactive visit to reverse the discharge.

**Orders.** The resident's orders are ended the day preceding the discharge. However, if any plan in the resident's reimbursement table pays for day-of-discharge, the bed order ends on the discharge date. If the resident has ancillary orders, the system prompts you to end those orders during the discharge process.

**Guests.** When you discharge a resident from an apartment, all guests associated with the resident are deleted from the system. If you later cancel the discharge, the guests must be re-admitted manually.


**Canceling a discharge.** When you cancel (or 'reverse') a discharge, the resident is returned to Active status and, if it is still available, to the same location. You cannot cancel a discharge if the resident has another active visit in the system.









**Retro.** A discharge triggers retroactive processing if its date precedes any posted charges on the resident's account. Similarly, a discharge reversal triggers retro if the account has been billed since the discharge took place.


**Reports.** Discharges appear on the reports that track census activity such as the Census Activity report. The Pending Discharges report shows a current listing of all active in-house and outpatient residents that have a pending discharge date. Information about discharges that have triggered retroactive processing may appear on the Resident Comments Log.

### Discharging a resident

Use the Discharge page to discharge an inpatient or outpatient resident. You also use this to indicate when a resident has expired.

1. Access the Discharge page by selecting a resident visit then choosing Discharge in the ADT menu.
2. In the Discharge Summary panel, the resident's current active visit is selected by default. Click  beside another active visit to discharge that visit.
3. In the Discharge Information panel, enter the appropriate information.

DISCHARGE INFORMATION	
Discharge date: *	06/03/2013 
Discharge time: *	12:33
Federal: *	05 - D/C Transfer to Another Type I 
State:	05 - D/C Transfer to Another Type I 
Type: *	<input checked="" type="radio"/> Planned <input type="radio"/> Unplanned
Hospital Trx Outcome:	
Purpose of stay:	<input type="radio"/> Post-Acute Care <input type="radio"/> Chronic LTC
Trx condition:	
Trx diagnoses:	
Trx contributing reason:	
Destination:	DISCHARGED TO ANOTHER FACILIT 
Info/Reason:	Surgery
Provider #:	<input type="text"/>
Provider type:	<input type="text"/>
<u>Diagnosis</u>	

- **Discharge date (required).** Enter the discharge date using the format mm/dd/yyyy or click  and select a date from the Calendar. By default, the current date is entered in this field. In this case, no other fields are required. Return later and process the full discharge. If the resident has expired, enter the date of death here.

**Note:** A discharge date that precedes any posted charges on the resident's account triggers retroactive processing. Enter a future date to indicate a pending discharge.

- **Discharge time (required).** Enter the actual time you are discharging the visit. By default, the current time is entered in this field.
- **Federal (required).** Select a federal code for the resident's destination on this discharge. An entry is required in either this or the State field.

**Note:** When you select a Federal discharge code that is also a state discharge code, NetSolutions enters this same code in the state discharge code field. If the state code field already has a code selected, NetSolutions does not change the existing code.

- **State (required).** Select a state code for the resident's destination on this discharge. An entry is required in either this or the Federal field.
- **Type.** Indicate whether the discharge was planned or unplanned. This field is required only when the Hospital Readmission KPI is active. By default, neither option is selected.
- **Hospital Trx Outcome.** Select the reason for the hospital transfer. The value selected here is used when calculating the results for the Hospital Readmission KPI in the Dashboard. This field is required only when the Hospital Readmission KPI is active. The available responses are:

ED visit only

Admitted, inpatient

Admitted, observation

Admitted, status uncertain

Other

If the Federal field is set for an Acute Care Hospital (ACH) or Critical Access Hospital (CAH), this field is required; otherwise, the field is not available.

- **Purpose of Stay.** Indicate the purpose of the stay. If the stay is for an ongoing condition, choose Chronic LTC; if the stay is for a specific issue that is not ongoing, for example a broken bone as the result of a fall or surgery, choose Post-Acute Care. The value selected here is used when calculating the results for the Hospital Readmission KPI in the Dashboard. This field is required only when the Hospital Readmission KPI is active. If the Federal field is set for an Acute Care Hospital (ACH) or Critical Access Hospital (CAH), this field is required; otherwise, the field is not available.

**Note:** Select Post-Acute Care for a resident who has been admitted and is planning to be discharged within 100 days. Select Chronic LTC for a

resident who has been or is expected to be admitted for more than 100 days.

- **Trx Condition.** Select the condition that caused the need for the transfer. Values for this dropdown list are defined on the Transfer Condition master page. The value specified is used for selection purposes on the Hospital Readmission graph.
- **Trx Diagnoses.** Select the diagnoses that caused the need for the transfer. Values for this dropdown list are defined on the Transfer Diagnoses master page. The value specified is used for selection purposes on the Hospital Readmission graph.
- **Trx contributing reason.** Select the contributing reason that caused the need for the transfer. Values for this dropdown list are defined on the Transfer Contributing Reason master page. The value specified is used for selection purposes on the Hospital Readmission graph.
- **Destination.** Select the destination where the resident is going after being discharged. The available selections are set up in the census Visit Destination profile.


**Note:** If the facility's GL Product is LCCA and 01, 06, 50, or 51 is selected in the Federal field above, then you must specify a Destination in this field.

- **Info/Reason.** Enter the reason for, or other information related to, this discharge.
  - **Provider #.** Enter the provider number for the discharge, if applicable, using up to 20 characters.
  - **Provider Type.** Enter a provider type. This field is used on the bill for the NY referring/discharge provider type if a discharge destination and provider number are also entered.
  - **Diagnosis.** Click the [Diagnosis](#) link to enter discharge diagnoses. The link opens the Clinical Information page in a dialog, where you can enter ICD-9 and ICD-10 codes for the discharge diagnoses. You must select the Discharge checkbox in the DX Type field to make the diagnoses you enter here Discharge diagnoses.
4. If you want to transfer the resident to another facility as part of the discharge, select the Transfer Resident into Another Facility checkbox then, in the list below it, select the HL7 interface for the facility to which the resident is transferring.
  5. In the Send Discharge Summary panel, select the Send Discharge Summary Via Disclosure checkbox to automatically send a discharge summary using the Record Disclosure feature each time a resident is discharged and each time a discharge record is updated.
  6. Click Save.



### Canceling a discharge

Canceling a discharge restores the resident to their former location. You cannot cancel a discharge if the resident already has an active visit in the system.

1. Access the Discharge page by selecting a resident visit then choosing Discharge in the ADT menu.
2. In the Discharge Summary panel, click  beside the inactive visit you want to re-activate. A confirmation message displays.
3. Click OK.

If the resident's account has been billed since the visit was discharged, retroactive processing is triggered.

**Kept apartments and assisted living.** You can cancel a discharge on an apartment or assisted living visit when one later visit has already been added. When canceling the discharge, NetSolutions changes the apartment or assisted living visit to become a Kept visit for the duration of the later visit. NetSolutions performs Retro from the period of the discharge date onward. This applies to in-patient visits only.

If a visit has more than one subsequent visits added, you cannot cancel the discharge.

**Note:** Any ancillary orders that were voided by the original discharge are restored when the discharge is cancelled. The end dates for any recurring ancillary orders that were stopped by the original discharge are removed.

## Care Levels

### Overview

Use the Care Level page to modify a resident's level of care for the current processing month.

CARE LEVEL INFORMATION					
Effective date: *	03/01/2016	CONTINUE	Thru date:		
Current care level:	300	ICF MEDICAID	New level:	150	Payor level
			Transfer Reason:	Changed level of care	
EQUIVALENT EXEMPT PLANS					
EDIT	PLAN DESCRIPTION	PLAN LEVEL	LEVEL DESCRIPTION		
UTILIZATION REVIEW					
Is this change the result of a utilization review? <input type="radio"/> Yes <input checked="" type="radio"/> No					
Outcome:			Next review:		
START DATE	LEVEL OF CARE	UTIL RVW	OUTCOME	POST DATE	POST TIME
01/20/2015	400	No		01/20/2015	16:46
01/20/2015	300	No		02/06/2015	15:41
01/19/2015	513	No		02/09/2015	00:00
01/19/2015	500	No		01/19/2015	16:02
01/17/2015	400	No		01/19/2015	14:43
12/19/2014	534	No		01/13/2015	00:00
-----	---	..		-----	----
<div> <div>SAVE</div> <div>CANCEL</div> </div>					

This page is normally used for non-Medicare A residents. For more information regarding changing the level of care for Medicare A residents, see *Entering a Resident Assessment* in the *AccountsTraining Guide*.

NetSolutions stores a history of the resident's level of care and displays each care level change in the panel at the bottom of this page.

**Retro.** If the effective date of a care level change is earlier than the last bill date for the account, retroactive processing is initiated. Retro changes can only be performed by users with the necessary security rights. If the Resident Comments option has been selected for the facility, the system prompts you to enter a comment about the retroactive change.


### Changing a resident's care level

Change a resident's level of care using the Care Level page:

1. Access the Care Level page by selecting a resident then choosing Care Level in the ADT menu.

- On the Care Level Information panel, enter an effective date then click Continue. The resident's current care level and exempt plan records display.

CARE LEVEL INFORMATION			
Effective date: *	<input type="text" value="03/01/2016"/>	<input type="button" value="CONTINUE"/>	Thru date: <input type="text"/>
Current care level:	300	ICF MEDICAID	New level: <input type="text" value="150"/> <a href="#">Payor level</a>
Transfer Reason:			<input type="text" value="Changed level of care"/>

- In the New Level field, enter or select the resident's new care level.
- In the Transfer Reason field, select the reason for the change in the resident's level of care. Entries for this dropdown are maintained on the Transfer Reason master page.
- If you know the end date of the new care level period, enter it in the Thru Date field; otherwise, leave the field blank. When an effective date is entered for a new level of care, the system enters that date as the Thru date on the previous care level.
- If the resident has any equivalent exempt plans, you can update the care level on those plans. On the Equivalent Exempt Plans panel, click the Edit  button beside a plan, edit the value in the Plan Level column, then click Save.

EQUIVALENT EXEMPT PLANS			
EDIT	PLAN DESCRIPTION	PLAN LEVEL	LEVEL DESCRIPTION

- On the Utilization Review panel, enter the appropriate information in each field.

UTILIZATION REVIEW	
Is this change the result of a utilization review?	<input checked="" type="radio"/> Yes <input type="radio"/> No
Outcome: <input type="text" value="Under-utilized level"/>	Next review: <input type="text" value="01/31/2007"/>

- Is This Change the Result of a Utilization Review.** Select the yes or no option. A utilization review is a review conducted or required by an outside agency such as the state or federal government.
  - Outcome.** If you answered yes, enter the outcome of the utilization review.
  - Next review.** Enter the date of the next scheduled utilization review.
- Click Save. The change record displays in the grid at the bottom of the page.

## Location Status

### Overview

Use the Location Status page to move beds between Open and Closed status. If a bed is unavailable due to construction or other issues, you can temporarily close the bed so that it does not reduce your occupancy rate.

1 - 25 of 130 <a href="#">Next&gt;</a>				Last charge date: 04/29/2009			
	LOCATION	TYPE	MAX. OCC	LOCATION DETAIL FOR BPH1 140 2 <span>1 - 3 of 3</span>			
<a href="#">SELECT</a>	BPH1 127 1	B	10	OPEN/CLOSE	DEL FROM	THRU	STATUS
<a href="#">SELECT</a>	BPH1 127 2	B	10	<a href="#">OPEN</a>	11/4/2009		CLOSED
<a href="#">SELECT</a>	BPH1 128 1	B	10	<a href="#">CLOSE</a>	10/31/2009	11/3/2009	OPEN
<a href="#">SELECT</a>	BPH1 128 2	B	10	<a href="#">OPEN</a>	4/30/2009	10/30/2009	CLOSED
<a href="#">SELECT</a>	BPH1 134 1	B	10				
<a href="#">SELECT</a>	BPH1 134 2	B	10				
<a href="#">SELECT</a>	BPH1 138 1	B	10				
<a href="#">SELECT</a>	BPH1 138 2	B	10				
<a href="#">SELECT</a>	BPH1 138 3	B	10				
<a href="#">SELECT</a>	BPH1 139 1	B	10				
<a href="#">SELECT</a>	BPH1 139 2	B	10				
<a href="#">SELECT</a>	BPH1 139 3	B	10				
<a href="#">SELECT</a>	BPH1 140 1	B	10				
<a href="#">SELECT</a>	BPH1 140 2	B	10				
<a href="#">SELECT</a>	BPH1 141 1	B	10				

The Location Status page provides a Search field for finding the location whose status you want to change. When you select a location, that location's status history displays in the Location Detail frame. You can open and close status periods in this frame. When you open or close a status period the previous one is ended on the day before the new period's From date.

You cannot close a bed that is currently occupied, unless the resident has a pending discharge that will occur before the bed is closed. A closed bed cannot be reserved, nor can it be chosen when admitting or transferring a resident.






**Reports.** The Rent Roll by Business Unit report shows first-day-of-the-month occupancy and monthly room and board amounts for each bed in the system. The Daily Bed Census report can be printed for all units in the system.


### Closing or opening a location

Use the Location Status page to close or open a bed in your facility.

1. Access the Location Status page by choosing Location Status from the ADT menu.
2. In the Search field, enter one or more letter or number, then click the Search button.
  - o The locations that match the search criteria appear in the list below.
3. Click [SELECT](#) beside the location you want to work with. The selected location's status history appears in the Location Detail frame to the right.
4. If the location is available for editing, click the [OPEN](#) or [CLOSE](#) button beside the location status period you want to change (usually the current period). The fields in the panel become available for editing.

- In the Location Detail panel, edit the appropriate information.

LOCATION DETAIL FOR BPH1 140 2					1 - 3 of 3
OPEN/CLOSE	DEL	FROM	THRU	STATUS	REASON
		11/4/2009		OPEN	
		10/31/2009	11/3/2009	OPEN	
		4/30/2009	10/30/2009	CLOSED	x

- From (required).** Enter the date when you want the change in status to begin.
  - Thru.** Enter the day when the new status period will end, if known. You can leave this field blank.
  - Status.** This field displays the status of the location. When you click the Open or Close button the status changes accordingly. When a location is occupied by a resident, this field displays OCCUPIED. You cannot change information for an occupied location.
  - Reason (required).** Enter the reason for the status change (cleaning, remodel, etc.). This field is only available when the new status is Closed.
- Click  in the Location Detail panel. The previous period receives a Thru date of the day before the date entered in the From field above and a new status period is opened.

**Delete** a status period by clicking  beside a record in the grid.

## Canceling an admission

The Cancel Admit page enables you to cancel an admission and delete all information associated with the visit. You can also delete the resident's account and related data. If there are charges or bills on the resident's account, you cannot cancel the admission.

- Access the Cancel Admit page by selecting a resident visit then choosing the Cancel Admit item in the ADT section of the task menu.
- In the Resident Information panel, verify the resident whose admission you are canceling.
- In the Select Activities panel, choose the appropriate options.

SELECT ACTIVITIES
<input type="checkbox"/> Delete account
<input type="checkbox"/> Delete beginning balances

- **Delete account.** Select this checkbox to delete the resident's account when you cancel the admission. If there are charges or bills on the account, this checkbox is unavailable. You have the option to cancel the admission but leave the resident's account in the system.
- **Delete beginning balances.** Select this checkbox to delete any beginning balances on the resident's account. If you do not delete the resident's account, you can clear any beginning balances on the account using this option.

4. Click Save.

- NetSolutions displays a confirmation message.

5. Click OK.

The following information is removed along with the visit: Physicians, Diagnoses, Location info, Orders, Guests, and UB data. The resident's basic demographic information remains.

## Central Resident Index

Use the Central Resident Index to view a roster of all residents in the system, to verify a resident name, or to quickly view basic info for one or more residents. The top of the page provides search criteria fields for filtering the resident list.

The Central Resident Index page displays each resident's last name, first name, and middle initial; health record number; and admit and discharge dates. Sort the list by any of these fields by clicking a column header.

SEARCH BY		Last name		Begins with:	SEARCH
LAST NAME	FIRST NAME	MI	HEALTH RECORD #	ADMIT DATE	DISCHARGE DATE
Bartlett	Wesley	Shirely	10862	02/27/2012	11/02/2012
Bartnick	Charlene	Julian	11186	06/04/2013	07/06/2013
Bartocci	Russel	Maryjoyce	11325	03/13/2014	04/20/2014
Basil	Veneranda	Robin	10742	10/28/2009	10/30/2009
Battisti	Bonnylu	Lilian	10583	08/27/2015	01/01/2016
Batz	Leo	Atio	10588	04/04/2012	04/08/2012
Batz	Leo	Atio	10588	11/15/2007	04/30/2012
Bauman	Evelyn	Doris	10769	03/25/2010	06/23/2010
Baumgarner	Ernest	Kattie	10243	03/17/2006	05/18/2006
Baumgarner	Ernest	Kattie	10243	05/18/2006	07/28/2006
Baumgarner	Ernest	Kattie	10243	10/13/2005	03/01/2006
Baumgartner	Ruthie	Lynn	00767	03/23/2000	06/03/2003
Beaney	Sally	Clyde	00834	08/27/2001	04/17/2002
Beaney	Serafina	Grazia	10743	02/27/2013	04/13/2013
Beaney	Serafina	Grazia	10743	04/13/2013	
Beaney	Serafina	Grazia	10743	09/10/2009	11/01/2009
Beaney	Serafina	Grazia	10743	10/01/2011	02/26/2013
Beare	Edith	Jill	11288	01/02/2014	02/21/2014
Bedner	Warwara	Gregoria	10001	08/14/2006	06/18/2009
Bedner	Warwara	Gregoria	10001	08/28/2004	09/25/2006
Beghini	Cecil	Bridget	10975	01/27/2012	02/13/2012
Beghini	Cecil	Bridget	10975	02/17/2012	03/17/2012
Beideck	Gordon	Elene	10542	01/15/2008	02/04/2008
Beideck	Gordon	Elene	10542	03/07/2005	03/08/2005
Beideck	Gordon	Elene	10542	03/08/2005	04/07/2005
Beideck	Gordon	Elene	10542	05/08/2007	02/22/2008

## Displaying the entire Central Resident Index

1. In the Resident tab, open the ADT menu and select Central Res. Index.

2. Leave the Begins With field empty and click the Search button. All residents display in the list.

### Filtering the resident list

1. In the Resident tab, open the ADT menu and select Central Res. Index.
2. In the Search By dropdown, select the criterion by which you want to find residents. You can search by resident last name or health record number.
3. In the Begins With field, enter one or more letter or number. To find a particular resident, enter a full last name.
4. Click the Search button. The residents that match the criteria display below.

**Note:** The Central Resident Index page does not link to detailed resident information. To view more information about a resident in the list, use Select Resident and the resident Snapshot. The Census Report prints list of all residents currently in the system.

## Disclosure

### Overview

HIPAA's Privacy Rule includes a right to an "accounting of disclosures" — that is, a listing of all disclosures of an individual's Protected Health Information (PHI) made by the facility or its business associates for up to six previous years. In accordance with HIPAA's Privacy Rule, NetSolutions includes the ability to report on specific information disclosed to a resident's associated providers. The disclosure process includes managing the disclosure of resident information, creating the disclosure using the Continuity of Care Document (CCD) format, and identifying all providers associated with the resident care.

Disclosure records must include:

- The date of the disclosure
- The name of the entity or person who received the PHI and, if known, the address of such entity or person
- A brief description of the PHI disclosed
- A brief statement of the purpose of the disclosure

The record may exclude disclosures made to carry out treatment, payment, and health care operations.

Only advance directives that are active at any point during the specified date range are included in the disclosure. Any cancelled directives for that period are not shown.

Disclosure records can be sent to providers and used as an electronic health record.

**Direct Exchange.** Direct Exchange is a system for sending and receiving secure messages between healthcare providers. Direct Exchange uses secure SMTP to safely transfer encrypted email messages between systems. Each participating healthcare provider has a Direct Exchange address registered through a Direct Exchange administrator. NetSolutions uses the Exchange address to send the existing Disclosure documents (PDF report and C-CDA) to the appropriate

healthcare provider. NetSolutions can also receive incoming Direct Exchange messages, which are stored as eDocuments. NetSolutions uses eAssignments to notify staff of new incoming documents.

## Consolidated Clinical Document Architecture (C-CDA)

The Consolidated Clinical Document Architecture (**C-CDA**) includes nine document types, one of which is an updated version of the Continuity of Care Document (**CCD**). CCD is an XML-based markup standard intended to specify a framework for encoding, structure, and semantics in patient summary clinical documents. The C-CDA adds specific architecture to the CCD that enables more accurate transmission of data.

NetSolutions sends C-CDA messages to other facilities or information systems through HL7 messaging in an MDM-CCD (Medical Document Management) message—a standard message format for CCDs—or using Direct Exchange. In the NetSolutions Interface Manager on the Interface Definitions page, set up a Sending interface. If such an interface is active, NetSolutions will generate an MDM-CCD message when specific events occur in the system. Messages are triggered by the following:

- Resident Basic Info update
- Admit
- Discharge
- Diagnosis add, update, or delete
- Allergies add, update, or delete
- Physician order add, modify, discontinue, or auto-DC
- Vital parameters add
- Advanced Directive add, update, or delete
- Payer change (insert new plan)
- Physician change (add, modify, or delete attending physician)

When the CCD is triggered, an MDM-CCD message is generated in the Outgoing Queue in the Interface Manager. It is then sent automatically by the KNS Sender. When a completed MDS exists for the resident, it includes that in a MDM segment of the message.

**Note:** When sending the Disclosure Record as a C-CDA document, NetSolutions does not include the Medicare/Medicare MBI number. When the report is sent using the Health Record report, NetSolutions does include the Medicare/Medicare MBI number.

**Direct Exchange.** Direct Exchange is a system for sending and receiving secure messages between healthcare providers. Direct Exchange uses secure SMTP to safely transfer encrypted email messages between systems. Each participating healthcare provider has a Direct Exchange address registered through a Direct Exchange administrator. NetSolutions uses the Exchange address to send the existing Disclosure documents (PDF report and C-CDA) to the appropriate healthcare provider when indicated.

Use the Clinician Master and Organization Master tables to enter Direct Exchange addresses for individuals or organizations.

**Note:** You can only enter Direct Exchange addresses for Hospital-type organizations.



**Disclosure Record.** When you select the Send Via Direct checkbox on the Record Disclosure page, NetSolutions uses the Exchange address entered for the recipient to send the disclosure record rather than an interface such as Convergence that has been set up in Interface Manager.

- **Discharge and Bed Hold.** Use the Send Discharge Summary panels on the Discharge and Bed Hold pages to automatically send a discharge summary via the Record Disclosure feature each time a resident is discharged or put on bed hold and each time a hold or discharge record is updated.

**Sending Interface.** The sending interface builds an MDM message with the PDF or C-CDA. If the Direct address in the interface trigger record is not empty, a ZEM segment is added to the MDM message containing the To and From Direct address values. The ZEM data can be used to forward a PDF to the specified provider as a Direct e-mail message.

## Recording a disclosure

Use the Disclosure Record page to add a new disclosure record, or modify or delete an existing record. Disclosure records can be sent to providers and used as an electronic health record.


NetSolutions includes information from all locked assessments that fall within the designated time frame in the disclosure record.

RECORD DISCLOSURE SUMMARY						
EDIT	DEL	DATE/TIME	USER	DISCLOSED TO	PURPOSE	DATE RANGE
		04/23/2013 13:55	NTT Data Customer Support	Marc Chizuk	sadvXX	04/01/2013 - 04/23/2013
						<a href="#">Download</a>


RECORD DISCLOSURE DETAIL	
Date/Time of disclosure:	04/23/2013 13:55
Resident authorization on file:	Disclosing user: NTT Data Customer Support
<input type="radio"/> Yes <input checked="" type="radio"/> No <input checked="" type="checkbox"/> Send via Direct	
Disclosure to recipient:	Marc Chizuk
Address1:	91118 Norton Str
Address2:	Jenkins Building
City:	Root
State:	WA Zip: 26595
Email:	Quetchenbach@abc.com
Date range:	04/01/2013 to 04/23/2013
Purpose:	sadvXX
Information disclosed:	Personal Information, Contacts, Health Provider, Insurance Provider, Advanced Directives, Allergies, Diagnoses, Physician Orders, Immunizations, Vital Signs, Diagnostic Results, Procedures, Interdisciplinary Progress Notes, Functional Status, Plan of Care, MDS 3.0, User Defined Assessment, eDocuments
Other Information to disclose:	
<input type="button" value="SAVE"/> <input type="button" value="CANCEL"/>	


**To add a disclosure record:**


1. Select the resident you want to work with.
2. In the ADT menu, select Record Disclosure.
  - The Record Disclosure page opens in Add mode.
3. In the Record Disclosure Detail panel, enter the appropriate information.
  - **Date/Time of Disclosure (required).** Enter the date and time of the creation of the disclosure. By default, NetSolutions enters the current date and time in this field.
  - **Disclosing User (required).** NetSolutions enters the currently-logged-in user in this field.
  - **Resident Authorization on File (required).** Indicate whether the resident's authorization is on file with the facility.
  - **Disclosed to Recipient (required).** Click  to select the intended recipient of the disclosure. If the contact information for the recipient has been entered into NetSolutions, that information is displayed when the recipient is selected.
  - **Address.** Enter the recipient's primary address.
  - **City, State/Province, and Zip.** Enter the city, state or province, and Zip code where the above address is located.
  - **Phone # 1 - 5.** Enter up to five phone numbers for the recipient, one in each field. After you have entered a phone number, select the **Type** of phone number (e.g. Home, Cell, Work/Office, etc.) from the corresponding drop-down list.
  - **Email.** Enter the recipient's email address.
  - **Date Range.** Enter the from and to dates for which you want to included data in the disclosure. Only data of the specified type that falls within the defined date range is included in the disclosure.

**Note:** If you change the date range values after defining the disclosure criteria (clicking the Disclosure Criteria link) you must re-open the Disclosure Criteria dialog to update the fields there to the new date range.
  - **Purpose.** Select the purpose of the disclosure. The entries for this list are defined in the Disclosure Purpose master.
4. Click the Disclosure Criteria link.
  - NetSolutions opens the Disclosure Health Record dialog.
5. Specify the information you want to include in the disclosure and click Continue.
  - In the Information Disclosed field, NetSolutions displays the information specified. To change the data in this field, click the Disclosure Criteria link and make any changes in the Disclosure Health Record dialog.
6. In the Other Information to disclose field, enter any addition information you want to add to the record.

7. Click Save.
  - NetSolutions add the new record to the Record Disclosure Summary panel.
8. Once the record has been saved, you can click the View Disclosure Record link to open a PDF of the report.


**Edit.** Click  in the Record Disclosure Summary panel to edit the details of the corresponding disclosure.

**Delete.** Click  in the Record Disclosure Summary panel to delete the corresponding disclosure record.

**Download.** Click the Download link in the Image field to save a PDF version of the disclosure. Click  to open the PDF file of the disclosure.


**Note:** The Quality Assurance modules Incident Tracking and Infection Control are excluded from the disclosure.

### Sending a disclosure record

1. Select a resident.
2. In the ADT menu, select Record Disclosure.
3. In the Record Disclosure Detail panel, click  beside the disclosure record you want to send.
4. Click the Process Now button.
  - If you selected the Send Via Direct checkbox, specify the disclosure recipient or recipients to whom you want to send the record.

**Note:** Clicking Process Now generates a PDF file of the disclosure report and/or a C-CDA output document, according to the Disclosure Criteria. If multiple recipients are chosen, a message is triggered for each recipient. If both PDF and C-CDA are selected in the recipient's record, a separate message is triggered for each type.

### Viewing associated providers

1. Select the resident you want to work with.
2. In the ADT menu, select Associated Providers.
3. In the Date Range fields, enter a beginning and an ending date using the format mm/dd/yyyy, or click  and select each date from the Calendar.

4. Click the Search button.
  - NetSolutions search for all providers associated with the resident within the specified date range and displays the associate providers with their titles.

**Note:** The Quality Assurance modules Incident Tracking and Infection Control, and IPNs with an author of Therapute User are excluded from the search.

5. In the Provider panel, click the provider you want to work with.

PROVIDER	TITLE
<a href="#">DEBBIE BUCKLIN</a>	RN
<a href="#">PEERASAB</a>	SE

6. In the Provider detail panel, click an associated link to view the corresponding report, or click ► to expand a section and view all associated records for that type.

Some resident/provider associations are maintained in Event History, in which case you can run an Event History report displaying those associations. Other associations are not maintained in Event History but instead by the modules. Expand the module selection to view the corresponding associations.

PROVIDER: DEBBIE BUCKLIN			
ADT	<a href="#">EVENT HISTORY</a>		
▶ MDS 3.0			
▼ UDA			
ASSESSMENT DESCRIPTION	ASSESSMENT DATE	COMPLETION DATE	TYPE
643sp6.904	6/27/2013		harsh_assessment
* 1	7/19/2013		Entry
UDA_Template	7/25/2013		Peer
Peer_Template	7/25/2013		Peer
peer_test2	7/25/2013		Peer
CARE PLAN	<a href="#">EVENT HISTORY</a>		
PHYSICIAN ORDERS	<a href="#">EVENT HISTORY</a>		
eCHARTING	<a href="#">TRANSACTION REPORT</a>		
IPN	<a href="#">EVENT HISTORY</a>		
VITAL SIGNS	<a href="#">EVENT HISTORY</a>		
<a href="#">Print Associated Providers</a>			

- **ADT.** Click the Event History link to display the Event History report criteria with the following fields pre-populated:
  - Resident Name
  - Application
  - Event From and To Dates
  - User Name

- Field Changes box selected
- **MDS 3.0.** When expanded, this section displays ARD, OBRA Reason, PPS Reason and Sections Completed for assessments where the Assessment Reference Date falls within the specified date range. The MDS assessments display for each MDS for which there is an association.
- **UDA.** When expanded, this section displays Assessment Description, Assessment Date, Completion Date and Type of Assessment for assessments that fall within the specified date range. Associated UDA assessments display for each applicable assessment.
- **Care Plan.** Click the Event History link to display the Event History report criteria with the following fields already populated:
  - Resident Name
  - Application
  - Event From and To Dates
  - User Name
  - Field Changes box selected
- **Physician Orders.** Click the Event History link to display the Event History report criteria with the following fields already populated:
  - Resident Name
  - Application
  - Event From and To Dates
  - User Name
  - Field Changes box selected
- **eCharting.** Click the Transaction Report link to display the Transaction Report criteria with the following fields already populated:
  - Transactions From and Through Dates
  - Resident Name
  - User
- **IPN.** Click the Event History link to display the Event History report criteria with the following fields already populated:
  - Resident Name
  - Application
  - Event From and To Dates
  - User Name
  - Field Changes box selected

- **Vital Signs.** Click the Event History link to display the Event History report criteria with the following fields already populated:
  - Resident Name
  - Application
  - Event From and To Dates
  - User Name
  - Field Changes box selected

7. To print a list of associated providers, click the Print Associated Providers link.

- NetSolutions displays the Associated Providers Report criteria dialog, where you can specify the providers to include in the report.

## Associated Providers Report

The **Associated Providers** report is available on the Associated Providers page on the Resident tab, accessed by clicking the [Print Associated Providers](#) link.

The Associated Providers report lists all providers associated with a resident during the specified date range.

The resident name and date range are already selected and cannot be changed. The list of associated providers displays in the Include Details field with a check box next to each name. To include the detail for each provider, select the checkbox.

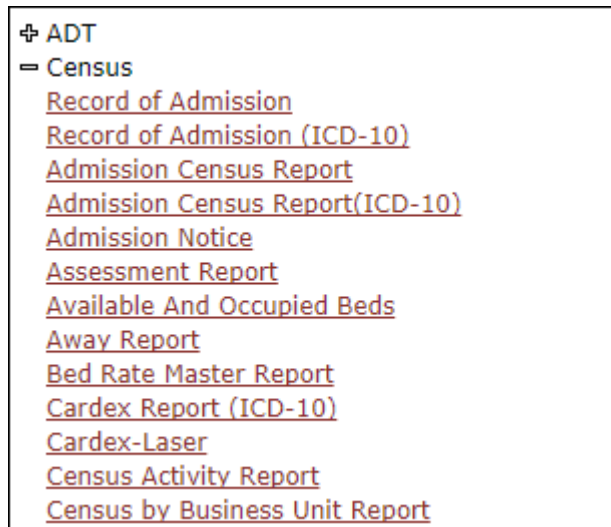
**Note:** This report can only be run for a given date range at the time the range is defined. The data gathered by NetSolutions for that range is not saved once the Associated Providers page is closed. To run the report again, you must re-define the date range and re-select the provider.

- To run the report, click the Print Associated Providers link on the Associated Providers page, then enter report criteria and click the Print button.
- For detailed information on running reports and using the Report Viewer, see the Printing Reports section in Getting Started.

# Reports

## Overview of ADT Reports

NetSolutions ADT provides a wide array of reports to help you view and analyze your facility data. Print resident information organized by resident name, by business unit, by location, and by account information.



**ADT reports.** Print resident demographic and clinical information using ADT reports. You can print your list of residents organized by age, allergies, contacts, and several other parameters; print those same items (allergies, contacts, diagnoses) organized by resident; and print facility-wide information such as resident birthdays, levels of care, and next physician visits.

**Census reports.** Print facility census activity by resident or by location, for a single day or a range of days, in a variety of formats. You can print a standard facility census, a list of residents who are away from the facility, a community census for any date, and history reports of resident status and census changes.

**Pre-reg reports.** For prospective residents, you can print the Pre-Admission Record and the facility Waitlist report.

**Profile reports.** Currently, these reports are only available to run "as is." In future releases report criteria will be made available to tailor the information presented by the reports

NetSolutions also offers several custom-report options such as user-defined reports, report templates, and custom facesheets.

For more information about running NetSolutions reports and using the Report Viewer, see the NetSolutions Reports topics in Getting Started.

## ADT Reports: Brief Descriptions

<b>ADT Reports</b>	
All Contacts by Resident	Lists the name, address, rank and role of all contacts for a given resident or residents.
Client Advance Directives	Lists the advance directives for each resident.
Client Allergy	Lists the allergies entered for each client.
Client Birthdays	Lists the name, ID number, location, birth date, and age of each client.
Client Diagnosis	Lists client diagnoses by visit.
Clients by Age	Lists clients by age.
Clients by Allergy	Lists all clients who have a specific allergy.
Clients by Diagnosis	Lists all clients who have a specific diagnosis.
Clients by Diagnosis (ICD-10)	Lists all clients who have a specific ICD-10 diagnosis.
Clients by Location	Lists the location (facility, building, station, room, and bed) and name of each client.
Clients by Religion	Lists clients by religion.
Clients with Inactive Diagnoses	Lists the resident and location of clients with inactive diagnoses.
Code Resident	Lists residents who have decided that certain heroic efforts should not be made to keep them alive in the event of a debilitating or life-threatening change in their medical condition.
Contacts Report	Gives the addresses, telephone numbers, and miscellaneous information for each contact for a single resident.
Event Tracking	Prints the history of all data changes and viewing done in the ADT program.
Guarantor Labels	Prints mailing labels for the guarantors entered in your system
Level of Care	Lists the status period dates for each client by level of care.
Medicare Numbers	Prints the health record number, Medicare MBI number, Original Medicare number, and whether the resident is a railroad beneficiary.
Next Physician Visit	Provides a list of physicians who visit your facility and the next dates they are due to visit each client.
Optional Information Search	Displays the client's optional information responses in a specific NetSolutions application.
Optional Information	Prints optional titles and responses listed by client and sorted by prompt sequence number.



Physicians by Resident	Prints information about the physicians associated with each resident visit.
Resident Annotations	Prints resident annotation records based on a wide variety of criteria.
Resident Directory	Lists all in-house residents in the facility in alphabetical order for a specified date.
Residents by Organization	Lists the residents associated with each organization.
Residents by Physician	Lists the residents associated with each physician.
VA Service Connected Disability	Displays residents and their VA Service Connected Combined Disability Ratings, along with the VA Disability codes assigned to the resident.
Veteran Status	Lists the name, ID number, location, and veteran status of each resident.
<b>Census Reports</b>	
Record of Admission (Facesheet)	Provides a face sheet of detailed resident information.
Admission Census	Lists the name, location, admission date, and physician's name for each client.
Admission Notice	Lists residents admitted to the facility within the specified date range.
Assessments	Prints assessment scores and statuses within a chosen date range.
Available and Occupied Beds	Shows the rooms and beds for a location, and includes the client name, number, gender, pay type, and level of care.
Away (Bed Hold)	Lists all "away" status residents: reserves and bed holds.
Bed Rate Master	Shows daily bed rate information for a one-month period for all in-house residents.
Beneficiary Notice	Lists residents who were discharged from a Medicare covered Part A stay in the past 6 months and who have benefit days remaining.
Cardex Report	Prints a cardex of basic client information for each client's medical record.
Census	Provides a current listing of all in-house residents.
Census Activity	Shows all census activity for a resident and the date each activity occurred.
Census by Business Unit	Lists all beds occupied during a selected AR period, showing number of patient days for each bed.
Census Days	Shows census activity for each resident over a specified date range.
Census Daily Activity	Lists daily census transactions for individual business units.

Census Daily Statistics	Shows census and statistical information for individual units within a business unit.
Census History	Details census changes for all or selected residents for a specified date range.
Census Unit Statistics	Shows census counts and occupancy info for individual units within a business unit.
Charge Card	Reprints charge cards generated from the <i>Automatic Printing of Selected Reports</i> .
Community Census	Lists all residents in the facility on a specific date.
Daily Activity	Details all census activity that occurred on the day requested.
Daily Bed Census	Shows the activity for a bed within a selected date range.
Demographic Change Log	Shows all demographic data changes.
Discharge Census	Lists the resident name, location, discharge date, reason for discharge, and the means by which the resident left the facility
Length of Stay	Lists clients along with the client census period records, a length of stay, and average length of stay calculations.
Master Client Index	Prints the name, census period dates, and level of care for each client.
Medicare Denial Letter Reprint	Reprints denial letters generated from the <i>Automatic Printing of Selected Reports</i> .
Medicare Part D	Prints all Medicare Part D information per client.
Medicare Roster	Shows information for residents receiving Medicare Part A or Part B benefits.
Month to Date Occupancy	Prints occupancy information for all building and station combinations within a facility.
Monthly Census	Shows the resident's payor and level for each day of a selected month.
Mortician Receipt/Record of Death	Provides an individualized mortician receipt for clients.
Pending Discharge	Lists all active in-house and outpatient residents with a pending discharge date.
Physician Roster	Lists attending physicians and residents under their care.
Record of Discharge	Prints a face sheet of basic client information for each client's medical record and discharge information.
Rent Roll by Business Unit	Shows occupancy and monthly room and board amounts for each bed in the system.
Resident Bed Analysis	Provides a listing of room reimbursement rates.
Resident Birthday	Lists birthdays for all residents in the facility.
Resident Census Periods	Lists census period information for each resident.

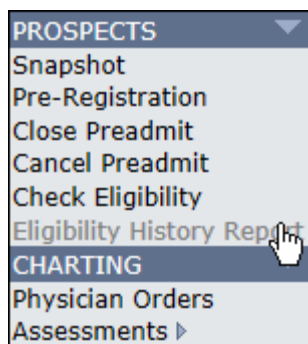
Resident Comments Log	Shows comments entered by users when making retroactive changes in the system.
Resident Inquiry	Shows detailed information about a resident.
Resident Roster	Prints selected census and billing info for current residents and residents discharged within the last 6 months.
Status Change/Audit List	Details census activity for all residents in the facility for a specified date range.
Transfer Census	Lists the name, reason for transfer, transfer date, and previous and current location for each client who was transferred during the reporting period.
<b>Prospect Reports</b>	
Eligibility History	Use this report to view historical eligibility requests.
Prospect Facesheet	Prints a facesheet of basic client information for each prospective client's medical record.
Waitlist Report	Lists prospects and their statuses on the waiting list for the facility in which they want to be admitted.
<b>Profile Reports</b>	
Bed File	Lists bed information from the Location Master.
Local Organizations	Lists local organizations alphabetically by organization category.
Physician List	Lists physicians defined in the facility's master.

## Prospect Reports

### Eligibility History

The **Eligibility History** report is available in three different locations:

- On the Reports tab under Financial Reports / Eligibility
- On the Reports tab under Prospect Reports / Prospect
- On the Prospect tab under Prospects



This report lists Eligibility reports by resident, payor and/or date. Use the report to view historical eligibility requests.

This report is only available if the facility has purchased the 270/271 program.

- To run the report, enter report criteria and then click the Generate Report button.
- For detailed information on running reports and using the Report Viewer, see the Printing Reports section of Getting Started.

## **Health Record**



### **Running the Disclosure Report**


NetSolutions can generate and print all or part of a resident's health record based on user-specified parameters for reporting purposes. The electronic Health Record includes the following sections:


- Personal Information
- Resident Contacts
- Healthcare Provider
- Insurance Providers
- Allergies
- Diagnoses
- Physician Orders
- Advanced Directives
- Immunizations
- Vital Signs
- Diagnostic Results
- Progress Notes
- Procedures
- Functional Status
- Plan of Care
- Resident Annotations
- MDS 3.0
- Point of Care History
- User Defined Assessments

- eDocuments

### To run the Health Record Disclosure report:

1. On the Reports tab, select Clinical Reports from the Reports menu.
2. On the Clinical Reporting page, expand the Health Record item and click Disclosure Report.
3. In the Resident Name Panel, click  to open the Search for Resident dialog where you can select the resident whose health record you want to view.
  - NetSolutions automatically fills in the Date/Time of Disclosure, Disclosing User, Resident Authorization on File, and Disclosed Resident fields when you select a resident, though you can modify these entries later if you want.
4. In the Record Disclosure Detail panel, click  beside the Disclosure to Recipient field to open the Search for Recipient dialog where you can select the recipient of the Disclosure report. An entry in this field is required.
  - NetSolutions automatically fills in the contact information for the recipient you select, though you can modify these entries later.
5. Specify the date range for the information you want to include in the report. An entry in these fields is required.
6. Select the purpose of the disclosure. An entry in this field is required.
7. Click the Disclosure Criteria link to open the Disclosure Health Record Criteria dialog where you can specify the information to include in the Disclosure report.
  - When you click Continue in the Disclosure Health Record Criteria dialog, NetSolutions displays the information you have selected to disclose in the Information Disclosed field.
8. In the Other Information to Disclose, specify any additional information you want to include in the report.
9. Click the Process Now button.
  - NetSolutions creates a PDF containing the Disclosure Report and places a reference to it in the Record Disclosure Summary panel.



**Edit.** To edit an existing Health Record report, click  in the Record Disclosure Summary panel then modify the information.

**Delete.** To delete an existing Health Record report, click  in the Record Disclosure Summary panel.


## Viewing a Disclosure Report

### To view a Disclosure report:

1. On the Reports tab, select Clinical Reports from the Reports menu.

2. On the Clinical Reporting page, expand the Health Record item and click Disclosure Report.
3. In the Resident Name Panel, click  to open the Search for Resident dialog where you can select the resident whose health record you want to view.
4. In the Record Summary Disclosure panel, click  beside the report you want to view.
5. In the Record Disclosure Detail panel, click the View Disclosure Record link.

**To download a Disclosure report:**

1. On the Reports tab, select Clinical Reports from the Reports menu.
2. On the Clinical Reporting page, expand the Health Record item and click Disclosure Report.
3. In the Resident Name Panel, click  to open the Search for Resident dialog where you can select the resident whose health record you want to view.
4. In the Record Summary Disclosure panel, click the Download link for the report you want to download.
5. Specify where to save the PDF file.

## **Associated Providers Report**

The **Associated Providers** report is available on the Associated Providers page on the Resident tab, accessed by clicking the [Print Associated Providers](#) link.

The Associated Providers report lists all providers associated with a resident during the specified date range.

The resident name and date range are already selected and cannot be changed. The list of associated providers displays in the Include Details field with a check box next to each name. To include the detail for each provider, select the checkbox.

**Note:** This report can only be run for a given date range at the time the range is defined. The data gathered by NetSolutions for that range is not saved once the Associated Providers page is closed. To run the report again, you must re-define the date range and re-select the provider.

- To run the report, click the Print Associated Providers link on the Associated Providers page, then enter report criteria and click the Print button.
- For detailed information on running reports and using the Report Viewer, see the Printing Reports section in Getting Started.

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