# SmartCare™ November 2025 MSP Release Notes (Changes)

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### Audience

These release notes are for general SmartCare™ users trained in the basic workflow and use of SmartCare™.

### Applicable Releases

The functionality documented these release notes supports SC.CORE.6.0_1.40.000.2511.011 and later.

### Permissions

You can only access screens/items granted per your user login referred to as Permissions. Depending on your current level of permissions, you may need to contact your system administrator to have your permissions changed.

### Global Codes, Recodes, and Configuration Keys

Refer to the Global Codes, Recodes, and Configuration Keys sections of these release notes for a list and definition of each code or key.

# TASKS LIST - 'ACTIVE CHANGE' (9)

**Note:** An ***active change*** is a product update that is automatically applied with the build and does not require any setup or action from the customer to take effect.

| Sl. No | Task No | Summary | Module Name |
|---|---|---|---|
| 6 | EII # 132831 | Dispense Qty Calculation doesn't calculate correctly when Unit = Each (also including Unit = mg for Potency Units = Lozenge, Patch, Film, or Implant) | Client Orders |
| 7 | EII # 132619 | Layman's Terms - Implementation of Dose initialization and unit Initialization based on the StrengthUnit = Unit | Client Orders |
| 11 | EII # 132329 | Modified the functionality of the 'Physical Exam' tab in 'History and Physical' document. | Documents |
| 17 | EII # 125821 | Updates for IPFQR Reporting List Page for data collection in 2025 and reporting in 2026. | IPFQR List Page |
| 18 | EII # 129426 | Changes are implemented in Clinical and Facility XML File Creation for IPFQR 2025 data reporting due August 2026. | IPFQR List Page |
| 34 | EII # 132797 | Implementation to auto initialize Unit and Potency Unit based on Medication Strength in Rx. | RX Application |
| 35 | EII # 132826 | To automatically calculate Dispense Quantity (Dispense Qty) for specific medication. | RX Application |

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|---|---|---|---|
| 36 | EII # 132618 | Layman's Terms: Implementation of Dose initialization and unit Initialization based on the StrengthUnit = Unit. | RX Application |
| 37 | EII # 132174 | Scanning: Changes are implemented in the Scanning Detail and Upload Detail screens. | Scanning |

# TASKS LIST – 'PASSIVE CHANGE' (32)

**Note:** A ***passive change*** is a product update that is applied with the build but requires the customer to complete configuration or other setup steps before the new functionality can be used.

| Sl. No | Task No | Summary | Module Name |
|---|---|---|---|
| 1 | EII # 130560 | Tech Debt Create Permanent tables to define the structure of temp tables. | Charges/Claims |
| 2 | EII # 130524 | Changes are implemented to fetch Original and accurate PCN Number on 837 Institutional and UB04 claims. | Charges/Claims |
| 3 | EII # 132546 | CN1 segment added under Loop 2300 on both 837 Claims. | Charges/Claims |
| 4 | EII # 132283 | Validate Time Entry on Claim Lines: to ensure accurate unit calculation for time-based billing codes by enforcing proper entry and validation of From (Start) and To (End) times during claim line creation. | Claim Line |
| 5 | EII # 132810 | To Move the Family Statement to the new Guarantor Statement model so that this feature is to encapsulate the addition of a custom logic hook in the Core Guarantor statement process, to facilitate customizations in the future | Client Account |
| 8 | EII # 132570 | Introduced a new icon on the DFA Editor screen, when selected, launches the CK Editor interface. | DFA (Dynamic Forms) |
| 9 | EII # 132513 & EII # 132510 | Incorporating Disposition Common Control into DFA Architecture- Non DFA Documents, DFA documents and Service Notes. | DFA (Dynamic Forms) |
| 10 | EII # 132536 | Change to Core ISP/Care Plan initialization stored procedure to add scsp call to support DFA tabs. | DFA (Dynamic Forms) |
| ~~12~~ | ~~EII # 131624~~ | ~~Update the Client Placement History when a child is deselected from the Referral screen and update the Open Beds field whenever there is a change in placement.~~ | ~~Foster Care~~ |

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|---|---|---|---|
| ~~13~~ | ~~EII # 132512~~ | ~~Added Assessment Group value to the "Pull Needs From" popup within the Individual Service Plan/Care Plan.~~ | ~~Individual Service Plan~~ |
| 14 | EII # 131851 | Reconciliation Action Log (UI + Logic) for Clinical Data Incorporation. | Inpatient Reconciliation |
| 15 | EII # 132290 | Implementation of Clinical Reconciliation Audit Log Report. | Inpatient Reconciliation |
| 16 | EII # 132464 | Inquiry: Crisis tab: Procedure Code options to adhere to the selected program based on the Configuration Key | Inquiry Details |
| 19 | EII # 132698 | Changes are implemented to include TEDS Episodes in the 'Merge Clients'. | Merge Clients |
| ~~20~~ | ~~EII # 132755~~ | ~~MAT -Changes are Updated to the MAT Emergency Dispensing Report layout to display all columns on a single page.~~ | ~~Methadone~~ |
| ~~21~~ | ~~EII # 133029~~ | ~~The 'SciLog -Dispenser' model/manufacturer has been added to the MAT Dispenser screen.~~ | ~~Methadone~~ |
| 22 | EII # 131618 | Implementation of a new 'IPFQR Screening SDOH' report. | My Reports |
| ~~23~~ | ~~EII # 132758~~ | ~~Implementation to display form information that includes multi-select checkboxes submitted in the Patient Portal within the SmartCare application via API calls.~~ | ~~Patient Portal~~ |
| 24 | EII # 132720 | Procedure Code Details: Added Service Diagnosis section. | Procedure rates |
| 25 | EII # 130798 | Implemented changes to list the Billing Diagnosis Category configuration at the procedure level mapping. | Procedure rates |
| 26 | EII # 132718 | To introduce a new configuration key 'EnableSMARTreplicaDatabaseReporting' to utilize the SMARTreplica Database for reporting purposes. | Reports |
| 27 | EII # 132108 | SMARTreplica Database: SC Operational Reports to be redirected to query a mirror or read-only replica database as this offloads reporting workloads from the primary system, helping maintain application responsiveness and stability. | Reports |
| 28 | EII # 132470 | SmartReplica Database for SmartCare Operational Reports. | Reports |
| 29 | EII # 132562 | Implementation of 'Staff Caseload with address and phone' and 'Staff Roles and Permissions. | Reports |

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|---|---|---|---|
| 30 | EII # 132069 | Implementation of Therapy Progress Report. | Reports |
| 31 | EII # 132799 | 835 ER File Reports and the 835 Rollback Process - Front End: To ensure accurate tracking of user actions by capturing the actual staff member who performs an ERFile rollback. | ROLLBACK ELECTRONIC REMITTANCE |
| 32 | EII # 130891 | Implementation of "835 Rollback Report". | Rollback Electronic Remittance |
| 33 | EII # 132750 | RWQM Work Queue: a blank white line and a small box in the in the filter section. | RWMQ |
| 38 | EII # 130808 | Column parenthesis labels are removed from the 'List Page Configurations' popup of any list page. | SmartCare Improvements |
| 39 | EII # 132344 | Implementation of new field in "Screen Details" page. | SmartCare Improvements |
| 40 | EII # 127489 | List Page Optimization Through Screen-Level Pagination Settings. | SmartCare Improvements |
| 41 | EII # 132467 | Added configurable searchable textboxes for Providers, Sites, Staff, and Billing Codes on the specified MCO screens. | SmartCare Improvements |

## Functionality Task Details

### Charges/Claims

| Reference No | Task No | Description |
|---|---|---|
| 1 | EII # 130560 | Tech Debt Create Permanent tables to define the structure of temp tables. |
| 2 | EII # 130524 | Changes are implemented to fetch Original and accurate PCN Number on 837 Institutional and UB04 claims. |
| 3 | EII # 132546 | CN1 segment added under Loop 2300 on both 837 Claims. |

### 1. EII # 130560 (Feature # 522436): Tech Debt Create Permanent tables to define the structure of temp tables.

**Note:** This is a passive change.
**What's Changed:**
There are **no functional changes**; the only workaround for this task was the creation of **permanent tables** to define the structure of the **temporary tables** used by the following **stored procedures (SPs)**. As part of the task, regression testing was performed to validate the related functionality of the following SPs.

- ssp_PMClaimsGetPlaceOfServiceForGetBillingCodes.sql
- ssp_PMCreateInitialCharge.sql
- ssp_PMUpdateChargesAndClaimsStatus.sql

- ssp_UpdateBillingCodesForSecondaryCharge.sql
- ssp_UpdateChargeAllowedAmounts.sql

**How it Helps:**
Creating permanent tables to define the structure of temporary tables is mainly used to ensure consistency, reusability, and easier maintenance of complex stored procedures. It provides a fixed schema reference so that temp tables can be created reliably without repeatedly redefining column names and data types.

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## 2. EII # 130524 (Feature # 520607): Changes are implemented to fetch Original and accurate PCN Number on 837 Institutional and UB04 claims.

**Note:** This is a passive change.
**What's Changed:**

With this release, an issue - the Original Payer Claim Number (PCN) was missing on Void and Replacement claims for 837I and UB04 format- is resolved.

Now, when a charge is billed with multiple PCCN numbers on a claim line item, the PCCN number will be correctly pulled onto 837 Institutional claims and UB-04 claims based on the radio button selection in the 'Coverage Plan Details' screen.

**For Void/ Replacement Claims:**

- If the plan uses the "Most Recent PCN" radio button, then the latest PCN will be sent on claims.
- If the plan uses the "First Billed PCN" radio button, then the original PCN from the initial claim will be sent.

837 Claims includes the PCCN number on REF*F8 segment, and UB04 claims displayed the PCCN number on Box 64.
**Prerequisites:**

- Required radio button option is selected in 'Plan Details' screen through the below **path**

  **Path:** 'Administration' -- 'Plan' -- click on 'New' button – or -- click on client coverage 'Plan Name' hyperlink -- 'Plan Details' screen -- 'Genera' tab -- 'Claim Information' section -- "PCN on subsequent submission" – select either "Most recent PCN" – or -- "First billed PCN" – radio buttons.

  - A charge is billed first to create an associated claim line-item ID.
  - Once the claim line item is created, it can be marked in the billing history as either "To Be Voided" or "To Be Replaced" using the following methods:
    - Browse to the Claim Line-Item record using the Claim Line Item Id link and click on the override button to mark it as 'To Be Voided' or 'To Be Replaced'.
    - Use the Action dropdown on the Charges/Claims screen to select "To Be Voided" or "To Be Replaced".
  - Required 'Payer Claim Number' is entered in the 'Claim Line Item Detail' screen.
  - Ensure that subsequent claim submissions (claim line item ID) include multiple PCNs.

**Where To Find It:**

**Path 1:** 'My Office' -- 'Charges/Claims' -- Select the chargeID – click on 'E-Claim' icon -- Bill the charge -- close the 'Claim Processing' popup screen -- Select the billed chargeID in 'Charges/Claims' list page – click on 'Select Action' drop down – click on 'Mark Claim Line 'To Be Voided' option or 'To Be Replaced' – Click on 'Ok' button in the pop-up -- Click on 'ClaimLine Iteam Id' hyperlink of charge -- 'Claim Line Item Detail" screen – Enter the "Payer Claim Number" in the 'Claim Details' tab – save the screen -- Navigate to 'Charges/Claims' -- Select the same Charge Id and click on 'E-Claim' icon -- Bill the charge.
**Path 2:** 'My Office' -- 'Charges/Claims' -- Select the charge ID -- Click on 'Paper Claim' icon -- Bill the charge -- close the 'Claim Processing' popup screen -- Select the billed charge ID in 'Charges/Claims' list page -- click on 'Select Action' drop down -- click on 'Mark Claim Line 'To Be Voided' option or 'To Be Replaced' -- Click on 'Ok' button in the pop-up -- Click on 'ClaimLine Iteam Id' hyperlink of charge -- 'Claim Line Item Detail" screen – Enter the "Payer Claim Number" in the 'Claim Details' tab - save the screen -- Navigate to 'Charges/Claims' -- Select the same Charge Id and click on 'Paper Claim' icon -- Bill the charge.

**How It Helps:**

- Generates claims for 837I and UB04 formats handle PCNs accurately and consistently.

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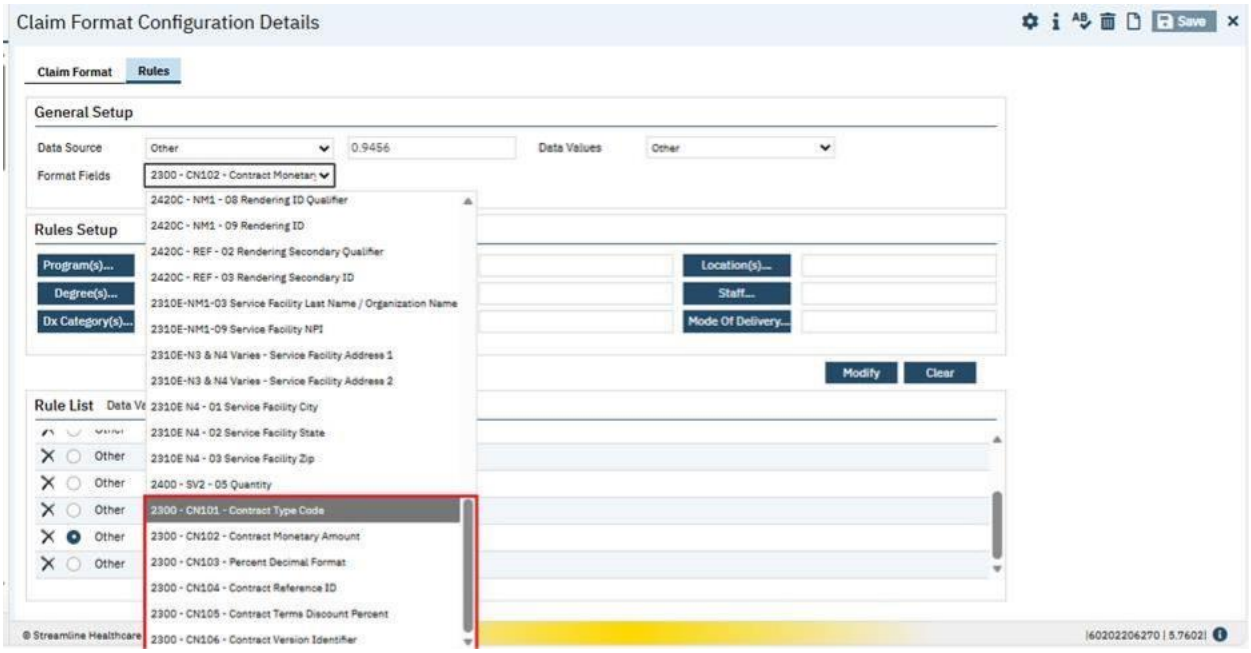
## 3. EII # 132546 (Feature # 607819): CN1 segment added under Loop 2300 on both 837 Claims.

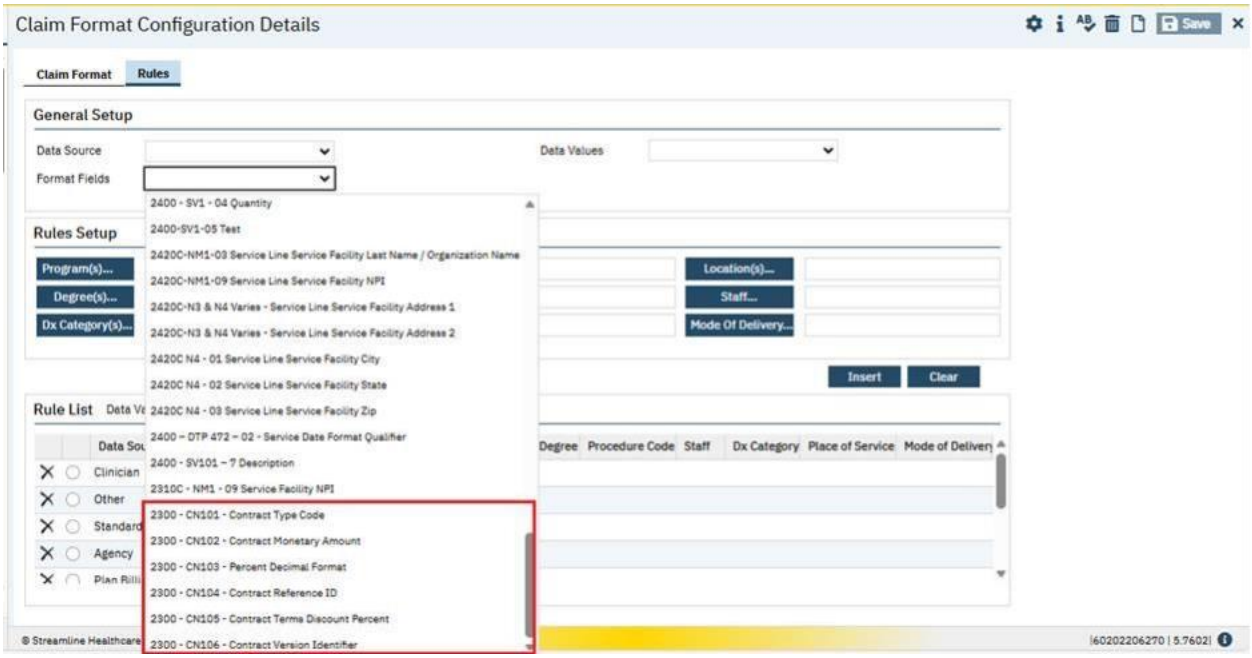
**Note:** This is passive change.
**What's Changed:**
With this release, new global subcodes are added to the "CLAIMFORMATTYPE" global code category. The following new subcodes will now appear in the "Format Fields" dropdown for both '837 Professional (2300)' and '837 Institutional (2300)' claim formats under 'Rules' tab in the 'Claim Formats Configuration Details' screen.

- 2300 - CN101 - Contract Type Code
- 2300 - CN102 - Contract Monetary Amount
- 2300 - CN103 - Percent, Decimal Format
- 2300 - CN104 - Contract Reference ID
- 2300 - CN105 - Contract Terms Discount Percent
- 2300 - CN106 - Contract Version Identifier

**837 Institutional claim formats:**



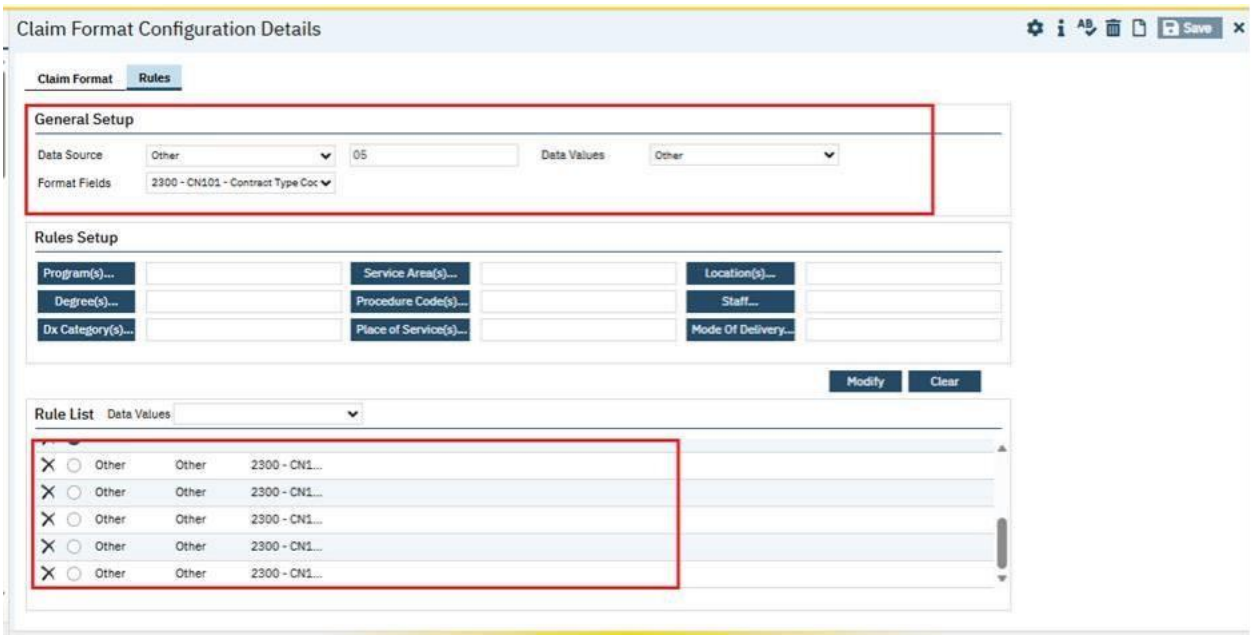

**837 Professional claim formats:**



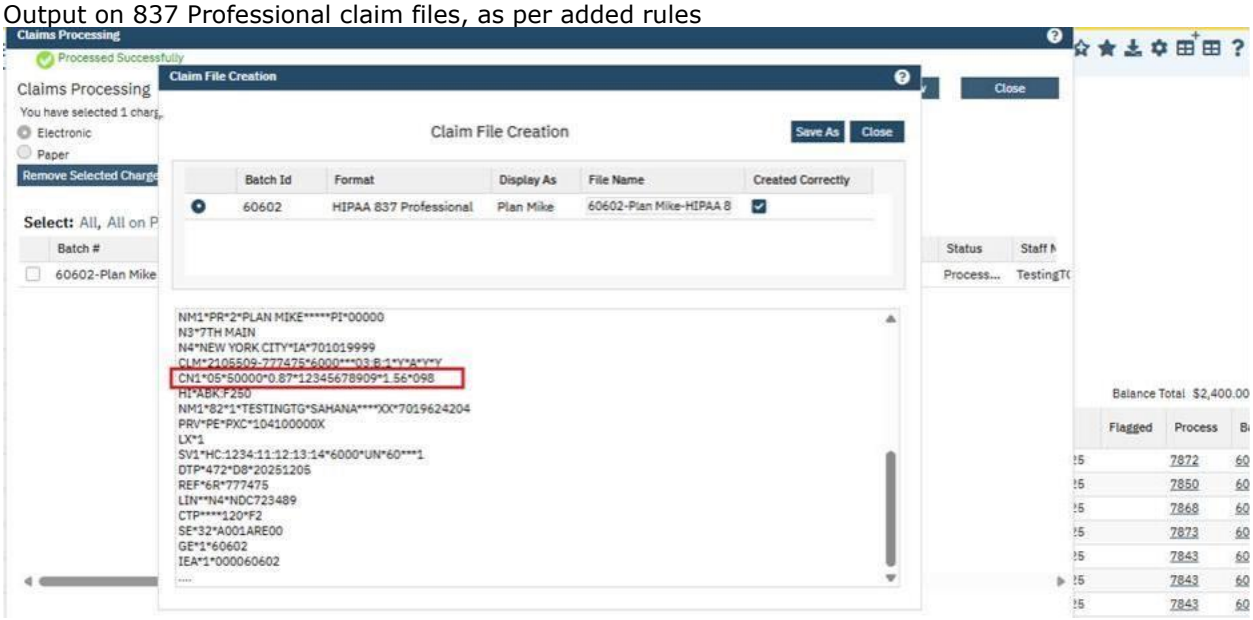

**"837 Professional" format:**

The users can now configure rules using the newly added 2300 CN01 to CN06 format fields, including "Data Source as Other" and "Data Value as Other." When these rules are applied, the system will display the CN1 loop on 837 Professional claims under the 2300 loop as per the configured claim format rule.

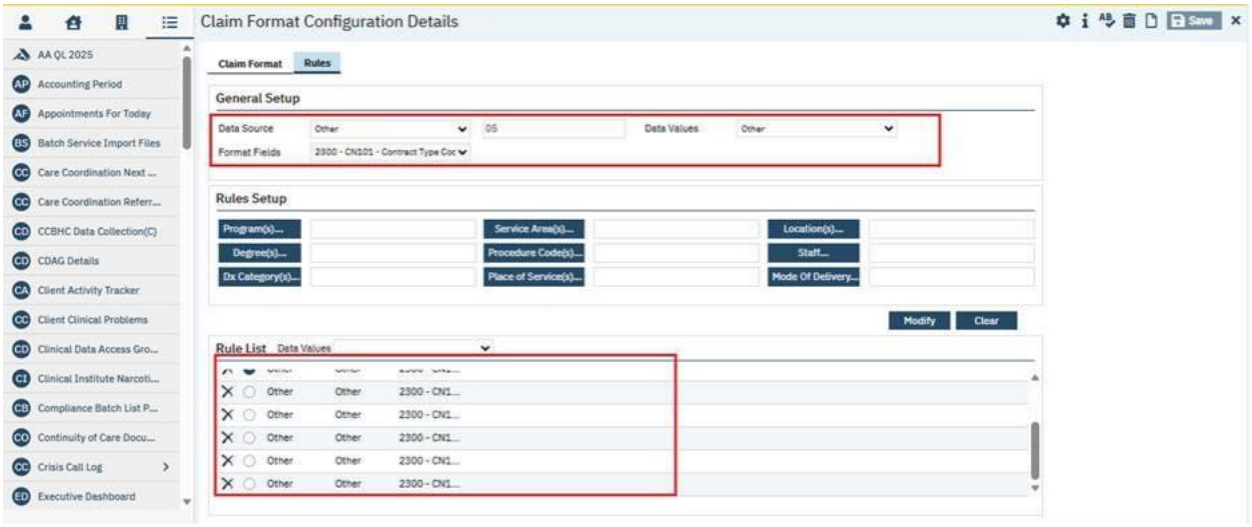
**Example:** Screenshot of the rules added in the claim format configuration screen with 'CN101 to CN106' on 837 P



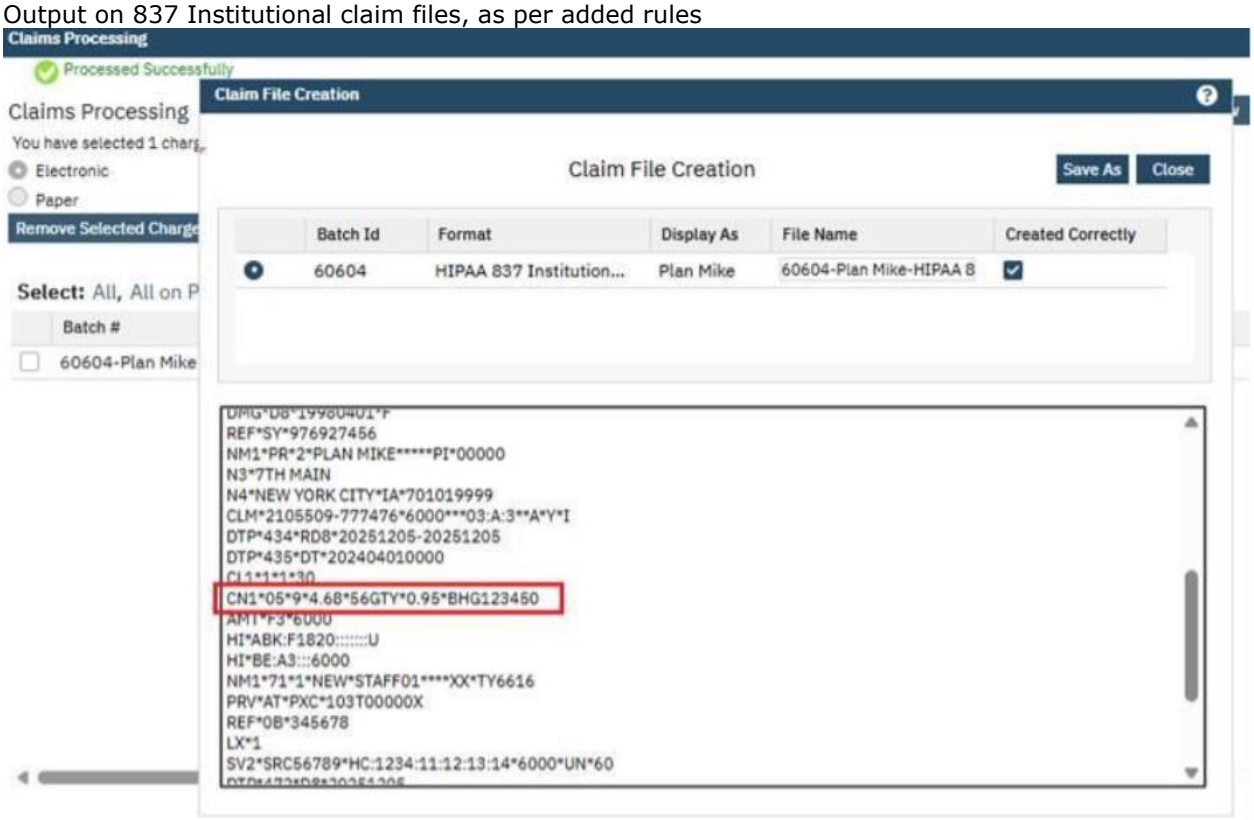

Output on 837 Professional claim files, as per added rules




**"837 Institutional" format:**
Users can now configure claim format rules using the newly added 2300 CN01 to CN06 format field options, along with "Data Source as Other," "Data Value as Other," and the required data in the text box field. When these rules are applied, the system will display the CN1 segment on 837 Institutional claims under the 2300 loop as per the configured claim format rule.
**Example**: Screenshot of the rules added in the claim format configuration screen with 'CN101 to CN106' on 837 Inst




Output on 837 Institutional claim files, as per added rules




**Note:**

- Users are instructed to add a claim format rule as explained above (In the General Setup section, select Data source as "Other" and Data Value as "Other", enter required value in the text box field.).
- If the Data Source of Other is selected and no values are entered in the field, the system will not include the loop or segment information on the claim file.
- If the user enters invalid data—for example, a non-numeric value—in any of the following fields: ContractMonetaryAmount, ContractPercent, or ContractTermsDiscountPercent, the system will display a red error message on the claims processing screen indicating a data-conversion (type) error. This will be covered in a separate tech debt.

**Prerequisites for "837 Professional" format:**

- In the 'Coverage Plan details' screen, select the "837 Professional" format from the 'Standard E-claim Format' drop-down through the below path:

**Path:** 'My Office' -- 'Plans' -- Click on the coverage Plan Name hyperlink -- 'Plan Details' screen -- select '837 Professional' claim format from the 'Standard E Claim Format' drop-down -- Click on 'Save'.

- Rule is added with new 'Format Fields' in the "Claim Format Configuration Details" screen through the below-mentioned path:

**Path:** Administration -- 'Claims Format Configurations' -- Click on the 837 Professional 'Claim FormatId' hyperlink -- 'Claims Format Configurations Details' screen -- 'Rules' tab – add the rule by selecting data source as "Other" and data value as "Other" -- Enter the required value in the text box that appears next to the data source drop-down -- Select newly added Format Fields (2300 loop CN101 to CN106) click on the 'Insert' button – Save.

**Prerequisites for "837 Institutional" format:**

- In the Coverage Plan Details screen, select the "837 Institutional" format from the 'Standard E-claim Format' drop-down through the below path:

**Path:** 'My Office' -- 'Plans' -- Click on the coverage Plan Name hyperlink -- 'Plan Details' screen -- select '837 Institutional claim format from the 'Standard E Claim Format' drop-down -- Save

- Add a Rule with new 'Format Fields' in the "Claim Format Configuration Details" screen through the below-mentioned path:

**Path:** Administration – 'Claims Format Configurations' -- Click on the 837 Institutional 'Claim FormatId' hyperlink – 'Claims Format Configurations Details' screen -- 'Rules' tab -- Add the rule by selecting data source as "Other" and data value as "Other" -- Enter the required value in the text box that appears next to the data source drop-down -- Select newly added Format Fields (2300 loop CN101 to CN106) click on the 'Insert' button – Click 'Save'.

**Where To Find It:**

**Path 1:** Administration -- 'Claims Format Configurations' -- Click on 'Claim Format Id' hyperlink – 'Claims Format Configurations' Details – 'Rules' tab -- 'Format Fields' dropdown.

**Path 2:** 'My Office' -- 'Charges/Claims' -- select the required ChargeId -- Click on 'E Claim' button -- click on 'Process Now' button in the 'Claim Processing' pop-up -- click on 'Create Claim File' button – click on 'Save As' button in the 'Claim File Creation' pop-up screen.

**How It Helps:**

- This will help users to include contract information on 837claims.
- Helps users to meet payer requirements when submitting claims.

## Claim Line

| Reference No | Task No | Description |
|---|---|---|
| 4 | EII # 132283 | Validate Time Entry on Claim Lines: to ensure accurate unit calculation for time-based billing codes by enforcing proper entry and validation of From (Start) and To (End) times during claim line creation. |

### 4. EII # 132283 (Feature # 586125): Validate Time Entry on Claim Lines: to ensure accurate unit calculation for time-based billing codes by enforcing proper entry and validation of From (Start) and To (End) times during claim line creation.

**Note:** This is a passive change.

**What's Changed:**

When the configuration key EnableClaimEntryStartStopTime is set to **Y**, the time fields in the claim entry screen becomes mandatory for all billing codes that use Hour/Minutes as units. In addition, validation messages are displayed for the time fields on the claim entry screen and the respective From or To fields will be highlighted.
**EnableClaimEntryStartStopTime:** This key used to control the visibility and validation behavior of the time fields within the "Service Lines" section of the "Claim Entry" screens. Based on the value of this configuration key, the system will either display or hide the time fields and restrict users entering invalid time values.
The conditions for displaying validation messages for **Claim Entry- Professional**, **Claim Entry - Provider** screens are as below:
**Validation message1: The 'From' and 'To' time fields must not be left blank.**' This Validation message is displayed when clicking on insert for the below mentioned scenarios.

- When From and To fields are enabled and not updated with any time inputs.
- When only one of the fields (**From** or **To**) is left blank.

**Validation message2: The 'To' time must be later than the 'From' time.**' Validation message is displayed when clicking on insert for the below mentioned scenarios.

- When the 'To' time is earlier than the 'From' time.
- When the 'To' time is equal to the 'From' time.

The conditions for displaying validation messages For Institutional and Provider Institutional screens are as below:
**Validation message1: The 'To' time must be later than the 'From' time.**' Validation messages are displayed when click on insert for the below mentioned scenarios.

- When the 'To' time is earlier than the 'From' time.
- When the 'To' time is equal to the 'From' time.

**Prerequisite Setup:**
1. 'Administration' -- 'Configuration Keys' -- Select 'EnableClaimEntryStartStopTime' -- Set as '**Y'**
**Where To Find It:**
**Path 1:** Go to My Office – Claims.
**Path 2:** Select Claim type -- 'I'/'P'/'PI'/'PP' -- Select Client from client search -- 'Claim entry screen -- 'Services lines' section -- Ener Date with from and To time, Contract rate **–** Insert.
**How It Helps:**

- It ensures accurate unit calculation for time-based billing codes.
- Prevents saving claim lines with missing or invalid time values.
- Improves billing accuracy and maintains data integrity.

## Client Account

| Reference No | Task No | Description |
|---|---|---|
| 5 | EII # 132810 | To Move the Family Statement to the new Guarantor Statement model so that this feature is to encapsulate the addition of a custom logic hook in the Core Guarantor statement process, to facilitate customizations in the future. |

### 5. EII # 132810 (Feature # 623308): To Move the Family Statement to the new Guarantor Statement model so that this feature is to encapsulate the addition of a custom logic hook in the Core Guarantor statement process, to facilitate customizations in the future.

**Note:** This is a Passive change. A custom hook has been implemented to take care of the customized version for the guarantor model. So, any customers who would be using the customized version of the guarantor model can use this implementation.

**What's Changed:**

A configurable mechanism has been added to handle Client-specific rules and support future state or client-specific enhancements, ensuring consistency with the Core Guarantor Statement model. This allows future updates without impacting existing processes and keeps current statement generation workflows running smoothly.

**Where To Find It:** NA

**How it Helps:**

To encapsulate the addition of a custom logic hook in the Core Guarantor statement process, to facilitate customizations for the future.

## Client Orders

| Reference No | Task No | Description |
|---|---|---|
| 6 | EII # 132831 | Dispense Qty Calculation doesn't calculate correctly when Unit = Each (also including Unit = mg for Potency Units = Lozenge, Patch, Film, or Implant) |
| 7 | EII # 132619 | Layman's Terms - Implementation of Dose initialization and unit Initialization based on the StrengthUnit = Unit |

### 6. EII # 132831 (Feature # 623825): Dispense Qty Calculation doesn't calculate correctly when Unit = Each (also including Unit = mg for Potency Units = Lozenge, Patch, Film, or Implant)

🟧 **ACTIVE CHANGE**

**What's Changed:**

With this release, the **Dispense Quantity** now correctly calculates for medications with the below units and potency units in the Client Orders screen: 'Order tab', 'Order Set' tab and 'Preferences' tab using the formula. Currently, the system does not perform this calculation for Dispense Quantity and causes users to manually calculate this.

- When **Unit = 'Each'** and the **Potency Units** is one of the following: Tablet, Capsule, Each, Blister, Film, Gram, Gum, Implant, Insert, Kit, Lancet, Lozenge, Milliliter, Packet, Pad, Patch, Pen Needle, Ring, Sponge, Stick, Strip, Suppository, Swab, Troche, Unspecified, or Wafer.
- When **Unit = 'mg'** and the **Potency Units** is one of the following: Implant, Lozenge, Patch, or Film.
- **Formula: When Unit = 'Each'**

**Dispense Quantity = (Dose+Unit) * (Frequency) * (# of Days)**

- **When Unit = 'Each' and Potency Units is one of the following: Gram, Kit,** Millilitre, or Unspecified, **Dispense Quantity** will be **initialized as '1'.**
- **Formula: When Unit = 'mg'**

**Dispense Quantity = (Dose+Unit) / (Strength) * (Frequency) * (# of Days)**

**Example**: **When Unit = 'Each'**

**Strength**: buprenorphine 12 mg-naloxone 3 mg sublingual film
**Dose+Unit**: 20 each
**Frequency**: 3 Times Per Day
**Days**: 3
**Potency Units**: Film
**Dispense Qty**: 180
(20 each) x (3) x (3) = **180 Film**

**Example**: **When Unit = 'Each' and Potency Units = 'Kit'**

**Strength**: Nicotine 21mg/24hr-14mg/24hr-7mg/24hr daily transderm patches,sequentl
**Dose+Unit**: 25 each
**Frequency**: Daily
**Days**: 6
**Potency Units**: Kit
**Dispense Qty**: 1

**Example**: **When Unit = 'Mg' and Potency Units = 'Implant'**

**Strength**: Nexplanon
**Dose+Unit**: 68 mg
**Frequency**: 4 Times per day
**Days**: 5
**Potency Units**: Implant
**Dispense Qty**: 20

(68 mg) / (68 mg) x (4) x (5) = **20 Implant**

**Where To Find It:**

**Path 1:** 'Client' – 'Client Orders' – 'New' icon – 'Order' tab --- Search for Medication Order which has 'Unit' = 'Each' and any one of the potency units (Patch, Implant, Film and Lozenge etc) – Select 'Frequency' – Select 'Day Supply' – Enter Required field - 'Dispense Quantity' field - Click on 'Insert' button --- Click on 'Save/Sign' button.

**Path 2:** 'Client' – 'Client Orders' – 'New' icon – 'Order Set' tab --- Search for an 'Order Set' which has medications where 'Unit' = 'Each' any one of the potency units (Patch, Implant, Film and Lozenge etc) – Select 'Frequency' – Select 'Day Supply' – Enter Required field - 'Dispense Quantity' field - Click on 'Insert' button --- Click on 'Save/Sign' button.

**Path 3:** 'Client' – 'Client Orders' – 'New' icon – 'Preferences' tab --- Select the checkbox for 'Medication Order' which has medications where 'Unit' = 'Each' any one of the potency units (Patch, Implant, Film and Lozenge etc) – Select 'Frequency' – Select 'Day Supply' – Enter Required field - 'Dispense Quantity' field - Click on 'Insert' button --- Click on 'Save/Sign' button.

**How It Helps:**

Calculates the Dispense Quantity (Dispense Qty) automatically for specific medication types where Unit = Each and having potency units as patches, implants, films, and lozenges etc.

## 7. EII # 132619 (Feature # 612415): Layman's Terms - Implementation of Dose initialization and unit Initialization based on the StrengthUnit = Unit

**ACTIVE CHANGE**

**What's Changed:**

With this release, the Dose and Unit fields now correctly initialize for medications when StrengthUnit = Unit, in the Client Orders screen: Order tab', 'Order Set' tab and 'Preferences' tab based on the below mapping.

| StrengthUnit | Volume Unit | Potency Unit | Order - Unit Drop Down Value | Dose Field Initialization |
|---|---|---|---|---|
| Unit | NULL | Each | Each | 1 |
| Unit | Gram | Each | Unit | NULL |
| Unit | mg | Each | Unit | NULL |
| Unit | ml | Each | Unit | NULL |
| Unit | NULL | Capsule | Unit | StrengthValue Column |
| Unit | NULL | Gram | Each | NULL |
| Unit | Gram | Gram | Unit | NULL |
| Unit | NULL | Kit | Each | 1 |
| Unit | mL | Milliliter | Unit | NULL |
| Unit | mL | Spray | Unit | StrengthValue Column |
| Unit | Gram | Packet | Unit | StrengthValue Column |
| Unit | NULL | Tablet | Unit | StrengthValue Column |
| Unit | NULL | Unspecifed | Unit | NULL |
| Unit | Gram | Unspecifed | Unit | NULL |
| Unit | mL | Unspecifed | Unit | NULL |
| Unit | mg | Unspecifed | Unit | NULL |
| Unit | Spray | Milliliter | Unit | StrengthValue Column |

- When **StrengthUnit = Unit** and the medication does not meet the conditions defined in the mapping, the **Dose** will be initialized to **NULL**.
- When **StrengthUnit = Unit** and the medication does not meet the conditions defined in the mapping, the **Unit** will be initialized to **StrengthUnit**.

**Example 1**: When StrengthUnit = Unit, Volume Unit = Null and Potency Units = Each, then Dose will be initialized as '1' and Unit be initialized as 'Each'.

**Example 2**: When StrengthUnit = Unit, Volume Unit = Null and Potency Units = Gram, then Dose will be initialized as 'Null' and Unit be initialized as 'Each'.

**Example 3**: When StrengthUnit = Unit, Volume Unit = Null and Potency Units = Capsule, then Dose will be initialized as 'StrengthValue' and Unit be initialized as 'Unit'.

**Where To Find It:**

**Path 1:** 'Client' – 'Client Orders' – 'New' icon – 'Order' tab --- Search for Medication Order where 'StrengthUnit' = 'Unit - Observe 'Dose' field and 'Unit' field - Enter Required field - Click on 'Insert' button --- Click on 'Save/Sign' button.

**Path 2:** 'Client' – 'Client Orders' – 'New' icon – 'Order Set' tab --- Search for an 'Order Set' where 'StrengthUnit' = 'Unit - Observe 'Dose' field and 'Unit' field - Enter Required field - Click on 'Insert' button --- Click on 'Save/Sign' button.

**Path 3:** 'Client' – 'Client Orders' – 'New' icon – 'Preferences' tab --- Select the checkbox for 'Medication Order' where 'StrengthUnit' = 'Unit – Observe 'Dose' field and 'Unit' field - Enter Required field - Click on 'Insert' button --- Click on 'Save/Sign' button.

**How It Helps:**

Ensures that the Dose and Unit field are initialized correctly when **StrengthUnit =Unit**.

Eliminated users to manually enter values and leading to additional unnecessary clicks.

---

## DFA (Dynamic Forms)

| Reference No | Task No | Description |
|---|---|---|
| 8 | EII # 132570 | Introduced a new icon on the DFA Editor screen, when selected, launches the CK Editor interface. |
| 9 | EII # 132513 & EII # 132510 | Incorporating Disposition Common Control into DFA Architecture- Non DFA Documents, DFA documents and Service Notes. |
| 10 | EII # 132536 | Change to Core ISP/Care Plan initialization stored procedure to add scsp call to support DFA tabs. |

### 8. EII # 132570 (Feature # 609374): Introduced a new icon on the DFA Editor screen, when selected, launches the CK Editor interface.

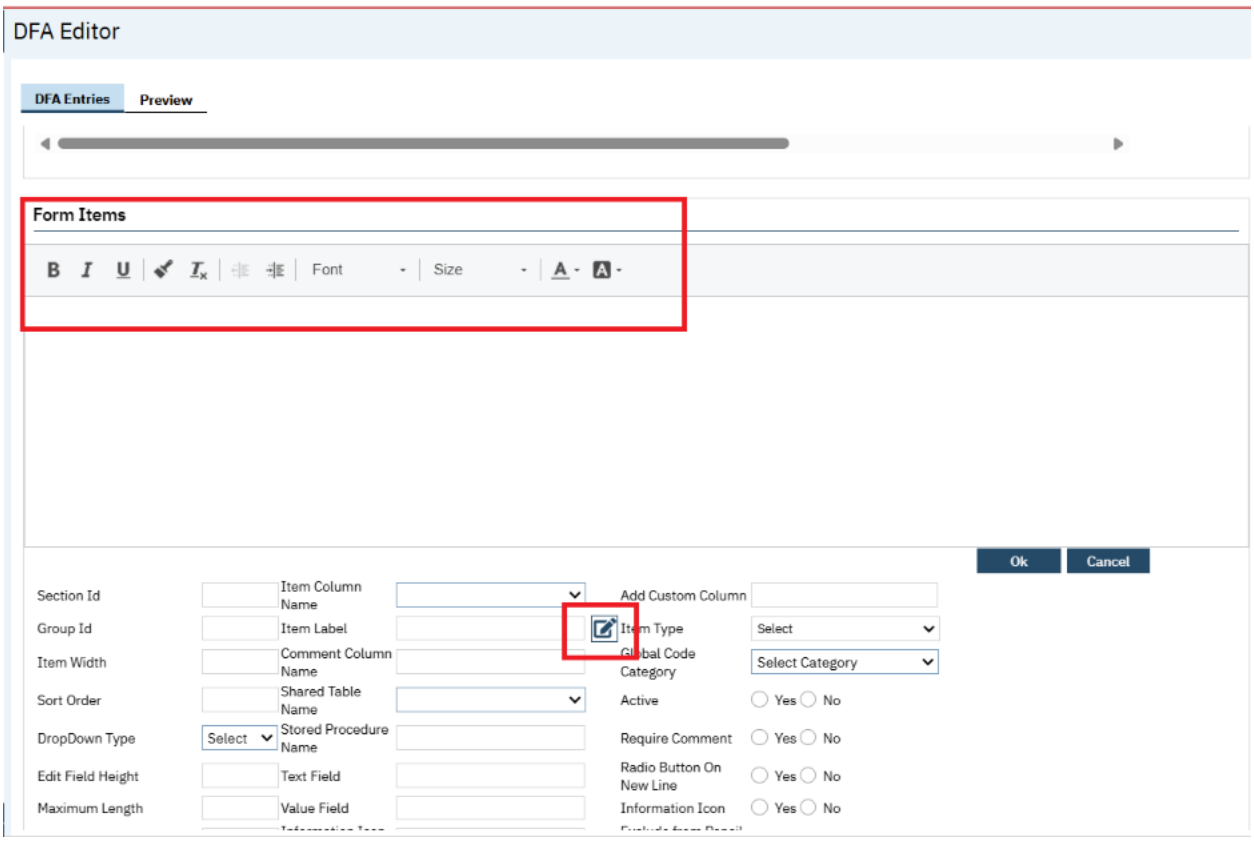
**Note:** This is a passive change**.** A new icon will now be visible in the 'Form Item' section of the 'DFA Editor' Screen.

**What's Changed:**

The CK Editor no longer opens automatically when the user enters text in the 'Item Label' field and tabs out. Instead, a new icon has been added next to the 'Item Label' field in the 'Form Item' section of the DFA Editor screen, allowing users to manually open the CK Editor only when needed.

The CK Editor will now open only when this new icon is clicked.

Additionally, the current 1000-character limit on the Item Label field has been increased to the maximum supported limit. This change ensures that the field can accommodate rich-text content formatted or styled through the CK Editor.




**Where to Find It:**

**Path:** Login to 'SmartCare' application - **'**Administration' - 'DFA Editor' Screen – 'Form Items' Field – 'Item Label' text field – Click on 'CK Editor' icon.

**How It Helps:**

- The new icon added next to the 'Item Label' field in the 'Form Item' section of the DFA Editor screen, will ensure the users to manually open the CK Editor only when needed.

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## 9. EII # 132513 & EII #132510 (Feature # 606765 & Feature # 606580): Incorporating Disposition Common Control into DFA Architecture- Non DFA Documents, DFA documents and Service Notes.

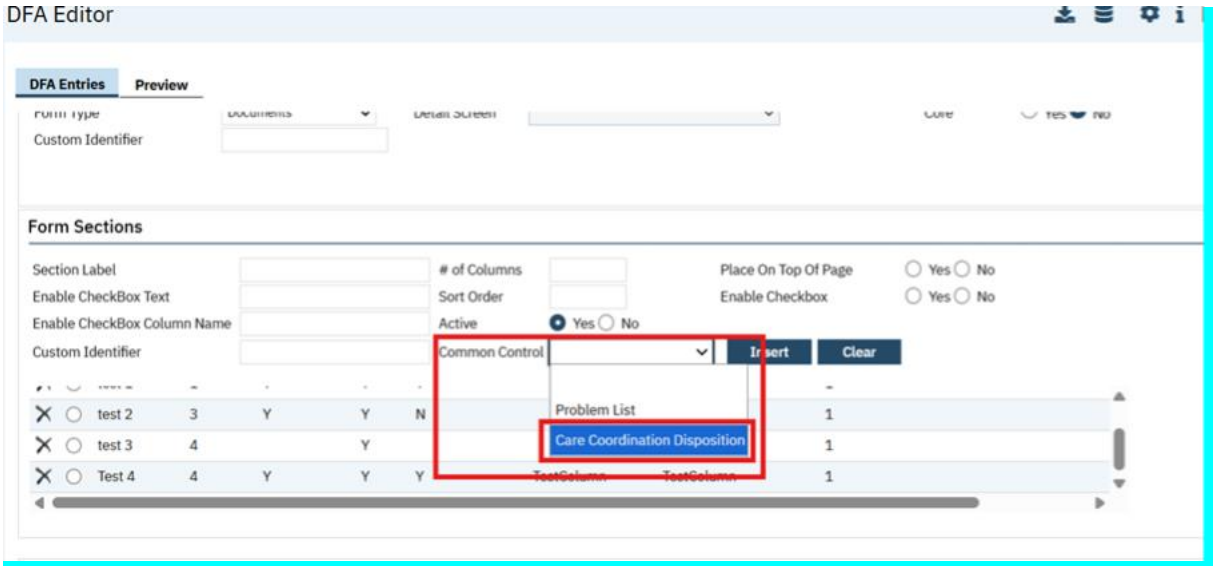
**Note:** This is a Passive change.

**What's Changed:**

SmartCare enhances the existing DFA system to support additional "Controls" as part of DFA definitions. This passive change enhancement introduces the ability to select a control (such as Problem List, Care Coordination Disposition, or others) directly from the DFA editor.

**'DFA Editor' Enhancement:**

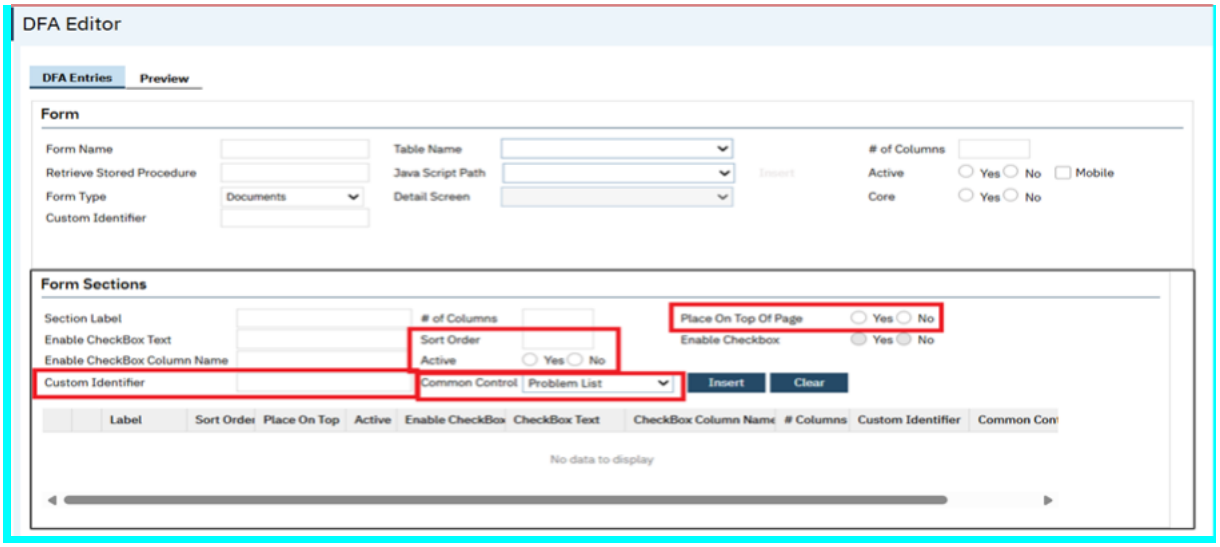
- In 'DFA Editor' screen, a new 'Care Coordination Disposition' control option has been added to the "Common Control" dropdown under 'Form' Sections to allow users to select from available Common Controls.




When the 'Care Coordination Disposition' Common Control is selected in the dropdown, only the following fields under 'Form Sections' are enabled:

- Sort Order
- Place on Top
- Active
- Custom Identifier

All other fields remain disabled.




When a Common Control is added in the 'Form Sections', the corresponding Form Section Groups and Form Items become disabled.

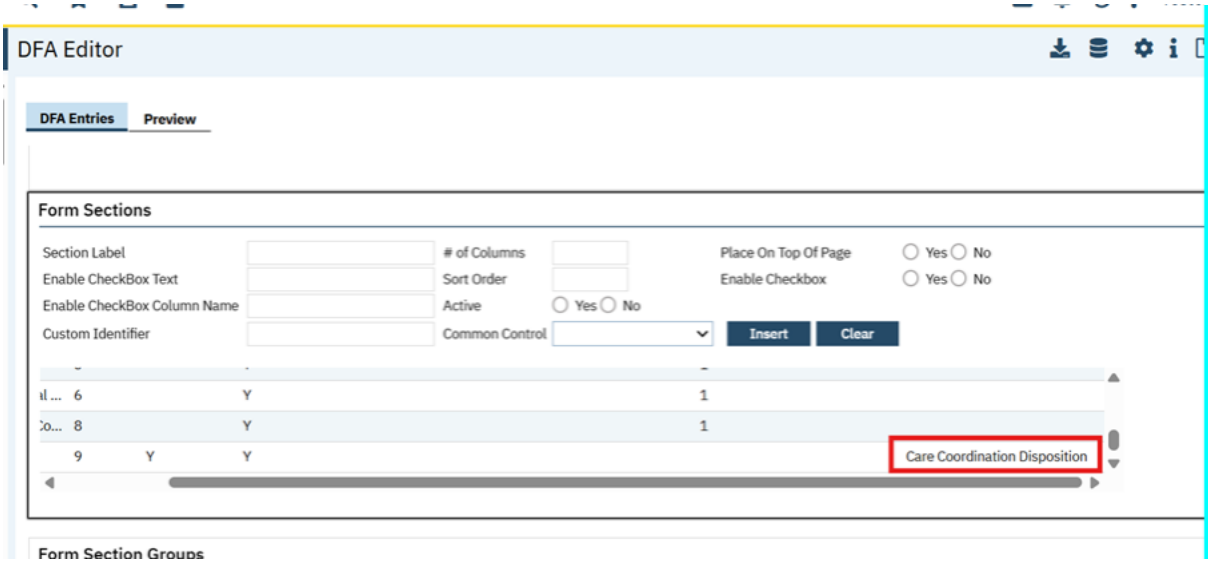
Users can insert the Common Control (Care Coordination Disposition) between sections in the 'Preview' of the DFA document.

If the same Common Control is added more than once within the same form, the system displays the following warning message:

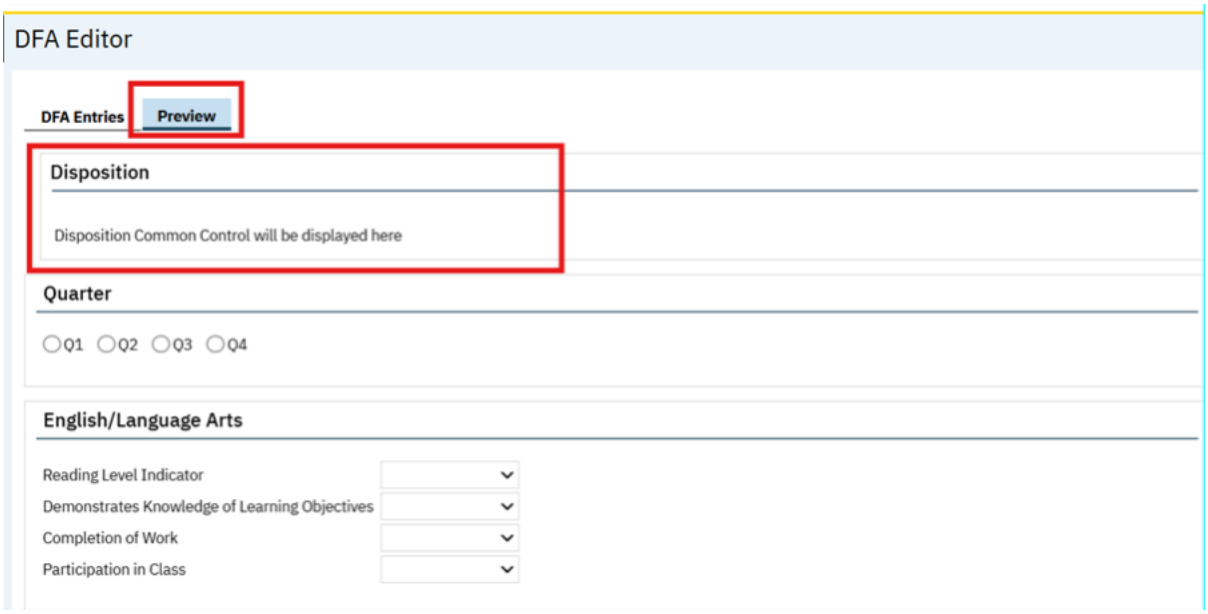
**Warning Message:** *"This Common Control already exists in the Form Section."*

**'From Sections' Grid:**

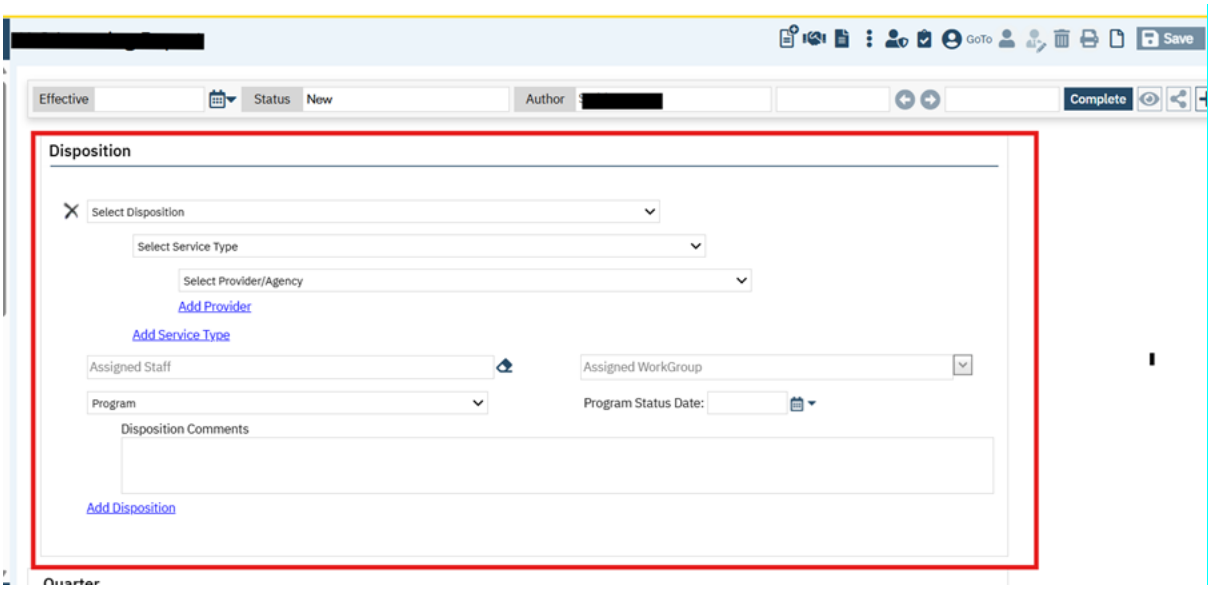
- When the user clicks 'Insert', the 'Common Control' column in the Grid displays the selected control (Care Coordination Disposition).



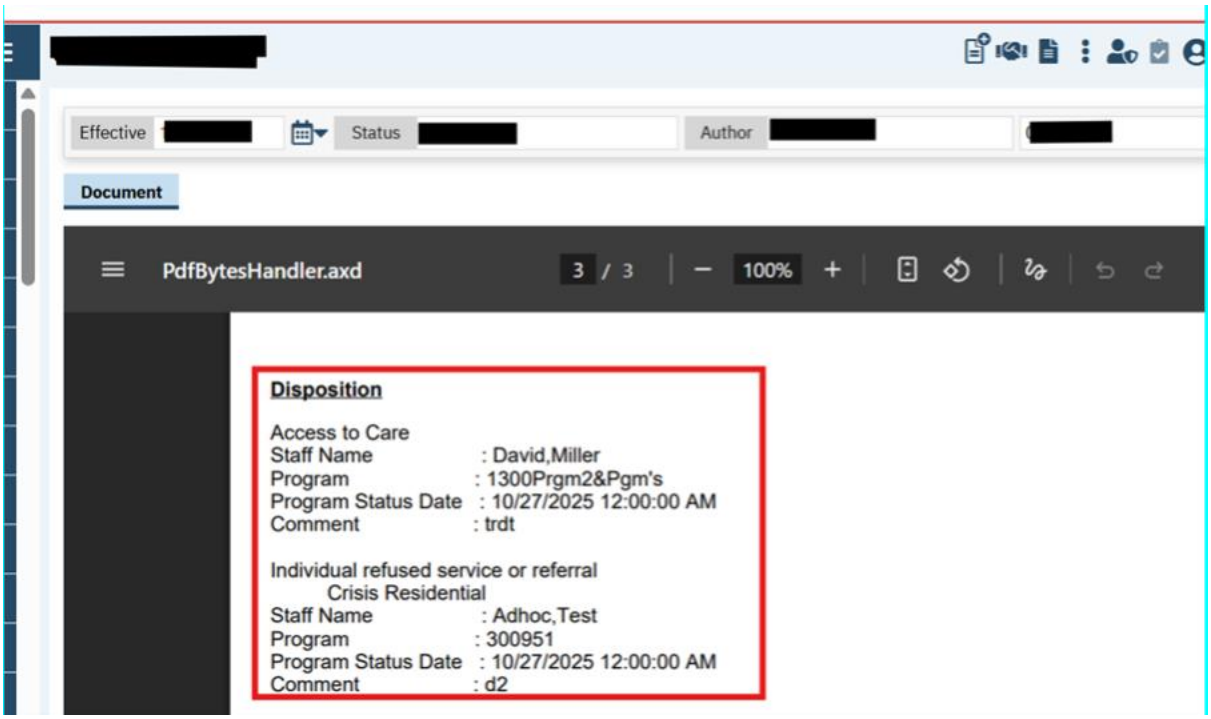

**'Preview' tab:** The specified common control in the 'Forms Sections' is displayed in the 'Preview' tab.



Added Common Control displaying in the Non-DFA + DFA Documents and Service Notes:




Added Common Control displaying in the Non-DFA + DFA Documents and Service Notes PDF:




**Where To Find It:**

**Path:** 'Administration' -- 'Forms' -- 'Forms' list page -- Select any form -- 'DFA Editor' screen – 'Form Sections' section**.**

**How It Helps:**

- Provides ability to select 'Care Coordination Disposition' control from the DFA editor.

## 10. EII # 132536 (Feature # 607439): Change to Core ISP/Care Plan initialization stored procedure to add scsp call to support DFA tabs.

**Note 1:** This is Passive Change.
**Note 2:** This change is specific to the customer who is having custom implementation.

**What's Changed:**

A custom hook has been added in the stored procedure scsp_InitDFACarePlanInitial to display custom logic changes in the ''Individualized Service Plan, SUD Treatment Plan, Assessment,Agency/Program Discharge Documents.

**Where to Find It:** NA

**How it Helps:**

This is to display custom logic changes in ''Individualized Service Plan, SUD Treatment Plan, Assessment Agency/Program Discharge Documents.

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## Documents

| Reference No | Task No | Description |
|---|---|---|
| 11 | EII # 132329 | Modified the functionality of the 'Physical Exam' tab in 'History and Physical' document. |

## 11. EII # 132329 (Feature # 588025): Modified the functionality of the 'Physical Exam' tab in 'History and Physical' document.

🟧 **ACTIVE CHANGE**

***DISCLAIMER:*** ***The document is only available to those customers who have purchased an annual subscription. It is a premium add-on to SmartCare and not included in SmartCare Base Subscription. If you are interested in learning more about this document, please contact your account manager.***

**What's Changed:**
To keep track of 'Not Assessed' areas of the 'History and Physical' document below mentioned changes are done.
--The "History of Present Illness" tab is renamed to "Physical Exam" in the document and PDF.
--The default initialization to 'Normal' radio button in "Physical Exam" tab is removed.
--Moved 'Not Assessed' Radio button in all the sections above 'Normal' Radio button.
-- For Skin section, the checkboxes are right aligned for the 'Abnormal' radio button to differentiate between the radio button and check boxes.
--For Chest, Abdomen, Extremities and Back sections, renaming "Positive Finding(s)" label to 'Comments' and keeping them enabled and visible all the time.
--New Section 'General' is added in the "Physical Exam" tab with new radio buttons named "Not Assessed", Normal and "Abnormal".
1) When "Not Assessed" radio button is selected then 'Not Assessed' is auto selected in all the sections within this document.
2) When "Abnormal" radio button is selected then 'Abnormal' is auto selected in all the sections within this document
3) When "Normal" radio button is selected then 'Normal' is auto selected in all the sections within this document

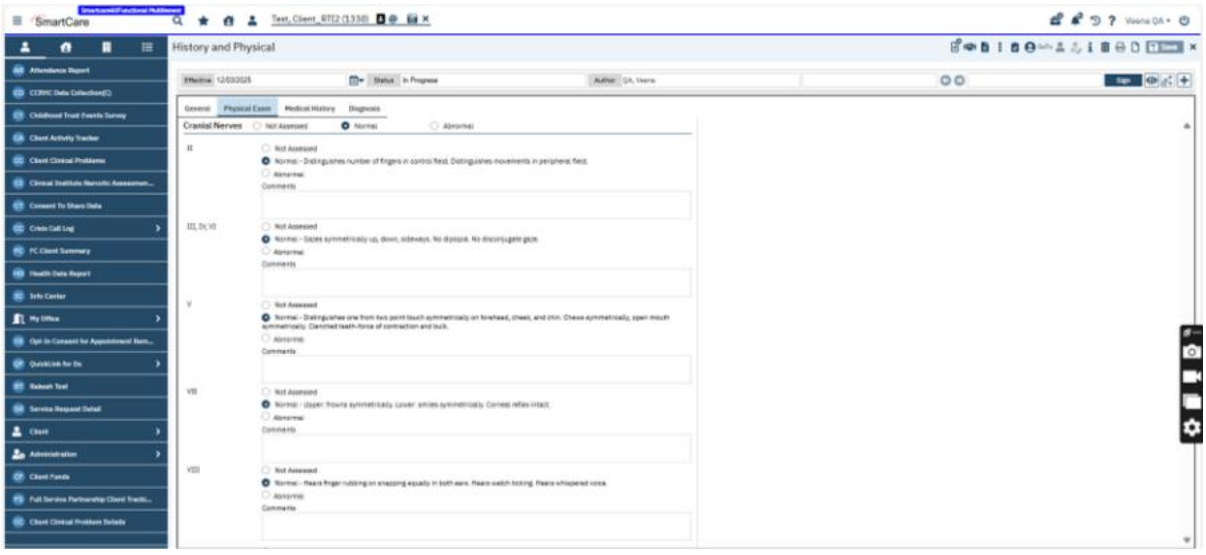

--For 'HEENT', 'Chest', 'Neurological Exam' and 'Cranial Nerves' section header is having the radio buttons "Not Assessed", Normal and "Abnormal".

1) When "Not Assessed" radio button is selected then 'Not Assessed' is auto selected for each sub items within that section.

2) When "Abnormal" radio button is selected then 'Abnormal' is auto-selected for each sub items within that section.

3) When "Normal" radio button is selected then 'Normal' is auto selected for each sub items within that section.

-- For 'Cranial Nerves' section the checkboxes are modified to radio buttons for the sub items




-- For Reflexes, Neurological Exam and Cranial Nerves section the text box is renamed as 'Comments' and is enabled and visible all time.

-- For 'Generative Organs' and 'Rectal sections' section the 'Findings' radio button is renamed to 'Not Assessed' and text box is named as comments and is enabled and visible all time.

**Note:** For all **existing** In-Progress documents **Data Migration script** is considered as mentioned below.

- Data migration for the **Chest** and **HEENT** checkbox selections to the new radio button columns.
  - Example: If **Chest** and **HEENT** checkboxes were selected previously, the corresponding new radio button values are updated as **Normal**.
- For **Cranial Nerves Section** the checkboxes are converted to radio buttons and data migration is handled as mentioned below.

1. Data will migrate to the new radio button only if **one** checkbox (out of the three existing checkboxes) was selected.
2. If multiple checkboxes were selected (e.g., both *Not Assessed* and *Normal*), no migration will occur.

**Where to Find It:**

Client Search – Select the client – Client – Documents – open History and Physical document – 'Physical Exam' tab – verified all the necessary changes – fill the data – 'Sign' – PDF is displayed with the changes.

**How It Helps:**
Provides a way to document the areas which are not assessed in the 'History and Physical' document.

**Data Model Changes:**

Added the below new columns to DocumentHistoryAndPhysicalGenerals table.
PhysicalExamGeneral
Heent
Chest
NeurologicalExam
CranialNerves
CranialNervesII
CranialNervesIII
CranialNervesV
CranialNervesVII
CranialNervesVIII
CranialNervesIX
CranialNervesX
CranialNervesXI
CranialNervesXII

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## ~~Foster Care~~

| ~~Reference No~~ | ~~Task No~~ | ~~Description~~ |
|---|---|---|
| ~~12~~ | ~~EII # 131624~~ | ~~Update the Client Placement History when a child is deselected from the Referral screen and update the Open Beds field whenever there is a change in placement.~~ |

### ~~12. EII # 131624 (Feature # 548619): Update the Client Placement History when a child is deselected from the Referral screen and update the Open Beds field whenever there is a change in placement.~~

~~**Note:** This is a Passive Change. When the Placement is started or ended, the 'Open Beds' and '# of Current Placements' will be updated accordingly.~~

~~**What's Changed:**~~

~~With this release, the below changes have been implemented:~~
~~When a child is de-selected from the Placements tab of the **Referrals** screen by clicking the Child(ren) hyperlink in the **Referral Children** Pop up, the system will update the Placement Status to **Closed** and set the Placement End Date to the date the child was de-selected, upon saving in the **Placement History Details** screen.~~

- ~~If a placement has ended (it can be either from the Referral or Placement History Details), the system will **add 1** to *Open Beds* and **subtract 1** from *# of Current Placements* for the associated Placement Family.~~

- If a placement has started, (it can be either from the Referral or Placement History Details), the system will **subtract 1** from *Open Beds* and **add 1** to *# of Current Placements* for the associated Placement Family.
- When user updates the **Max # Placements** field in the Placement Families Details screen, the system will update the **Open Beds** and **Current placements** field accordingly.

***Note:*** *Open Beds = 'Max # Placements – # of Current Placements'.*

**Where to Find It:**

**Path 1:** Login to SmartCare → My Office → Referrals → Click on New/Open existing Referral → Placements tab → Click on All Children (Hyperlink) Referral Children Pop up.

**Path 2:** Login to SmartCare → My Office → Placement History.
**Path 3:** Login to SmartCare → My Office → Placement Families.

**How It Helps:** Automatically updating **Open Beds** and **# of Current Placements** when a placement starts or ends, ensures that the placement capacity is always accurate and up to date.

**Data Model Changes:**
The new columns ActivePlacements and OpenBeds are added to PlacementFamilies table.

---

## Individual Service Plan

| Reference No | Task No | Description |
|---|---|---|
| 13 | EII # 132512 | Added **Assessment Group** value to the **"Pull Needs From"** popup within the Individual Service Plan/Care Plan. |

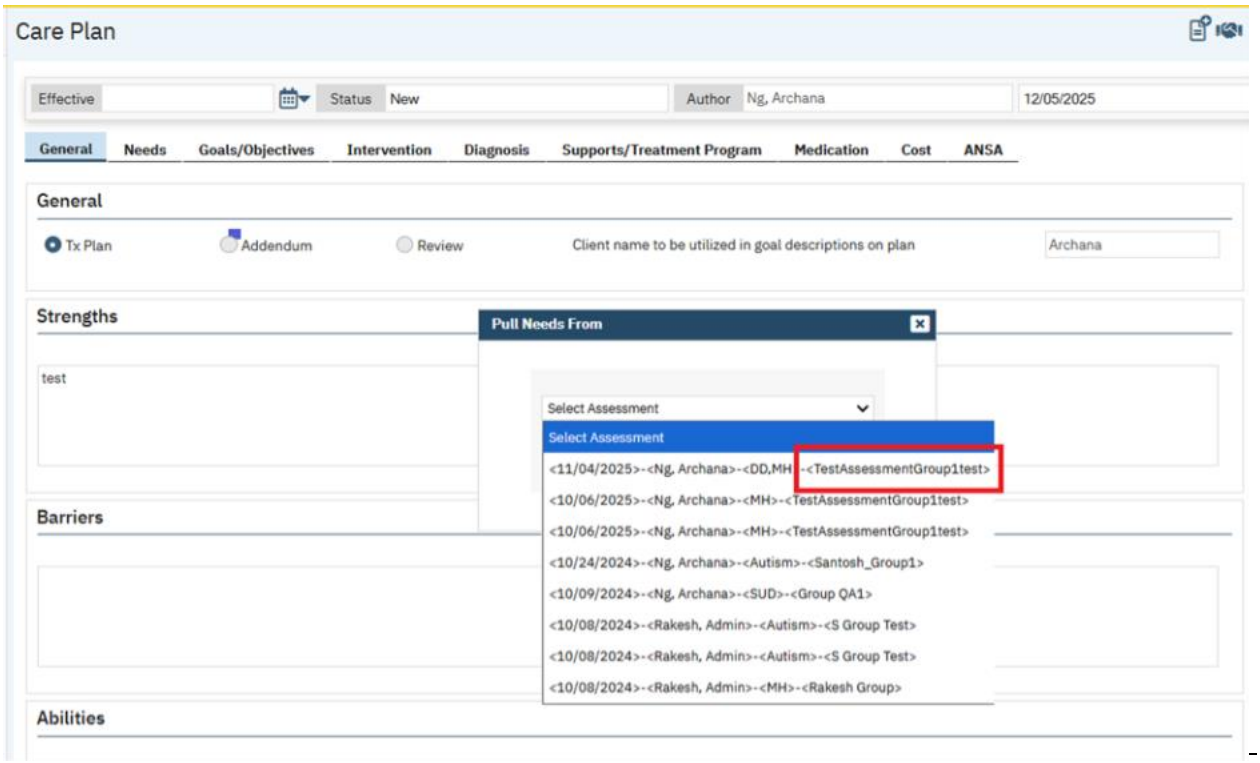
## 13. EII # 132512 (Feature # 606667): Added Assessment Group value to the "Pull Needs From" popup within the Individual Service Plan/Care Plan.

**Note:** This is a passive change.
**What's Changed:**

The Assessment Group value is added to the "Pull Needs From" popup in the Individualized Service Plan/Care Plan with the following changes:

1. The associated Assessment Group value is now displayed for each listed Assessment in the "Pull Needs From" popup within the Individualized Service Plan/Care Plan document.
2. The Assessment Group value is initialized from the setup configuration: Assessment (C) → General tab → Assessment Group.
3. The Assessment Group value is shown along with the existing details: Date, Author, Population, and Assessment Group Name. and 'Assessment Group' value is displayed after the 'Population' values

'Assessment Group' Name is displayed after the population values in the 'Pull Needs From' pop up.




**Prerequisite:** Document codes (Administration) → Select 'Individualized Service Plan (ISP)/Care Plan' document → select 'Allow To Select Assessment For Initialization' check box → save.

**Where to Find It:**

**Path 1:** Client → Select 'Assessment (C)' document → select 'Add to Needs List' → add required data → Save → Sign.

**Path 2:** Client → Select 'Individual Service Plan' document → Select the required 'Assessment' from the 'Pull Needs From' → Add required data → Save → Sign.

**Path 3:** Client → Select 'Individual Service Plan – MCO' → add data required 'Save' → Sign.

**How It Helps:**

- Users can easily identify the Assessment Group when selecting an Assessment in the ISP popup.

## Inpatient Reconciliation

| Reference No | Task No | Description |
|---|---|---|
| 14 | EII # 131851 | Reconciliation Action Log (UI + Logic) for Clinical Data Incorporation. |
| 15 | EII # 132290 | Implementation of Clinical Reconciliation Audit Log Report. |

### 14. EII # 131851 (Feature # 558725): Reconciliation Action Log (UI + Logic) for Clinical Data Incorporation.

**Note:** This is a Passive Change.

**What's Changed:**

1. For Diagnosis and Client Allergies, the unselected CCD records will be saved in the respective tables — DocumentDiagnosisCodes and ClientAllergies — with the flag RecordDeleted set to "Y" and DeletedBy set to *"CCDIntakeProcess"*.
2. For Diagnosis and Client Allergies, CreatedBy and ModifiedBy Field of records added from Reconciliation Popup will have data like Usercode-ClientCCDDId.
3. For the Inpatient Reconciliation and Medication Reconciliation screens, all CCD records will be inserted into the tables DocumentInpatientReconciliationCCDMedications and MedicationReconciliationCCDMedications, respectively.
4. In DocumentInpatientReconciliationCCDMedications, medications discontinued from the screen will have the column DiscontinuedMedication set to *"Y"*.

   In MedicationReconciliationCCDMedications, CCD medication records selected on the screen will have DiscontinuedMedication set to *"Y"*, while the unselected ones will be marked as *"N"*.
5. For all selected and unselected records from CCD file, the records will be tagged with the same Added/Modified and Date and Time.

**Where to Find It:**

**Path 1: '**Client' – 'Diagnosis Document' – Reconciliation icon.

**Path 2: '**Client' – 'Client Allergies' – Reconciliation icon.

**Path 3: '**Client' – 'Medication Reconciliation' – CCD radio button – CCD section.

**Path 4: '**Client' – 'Inpatient Reconciliation' – CCD section.

**How It Helps:**

These changes are made to build the designed report.

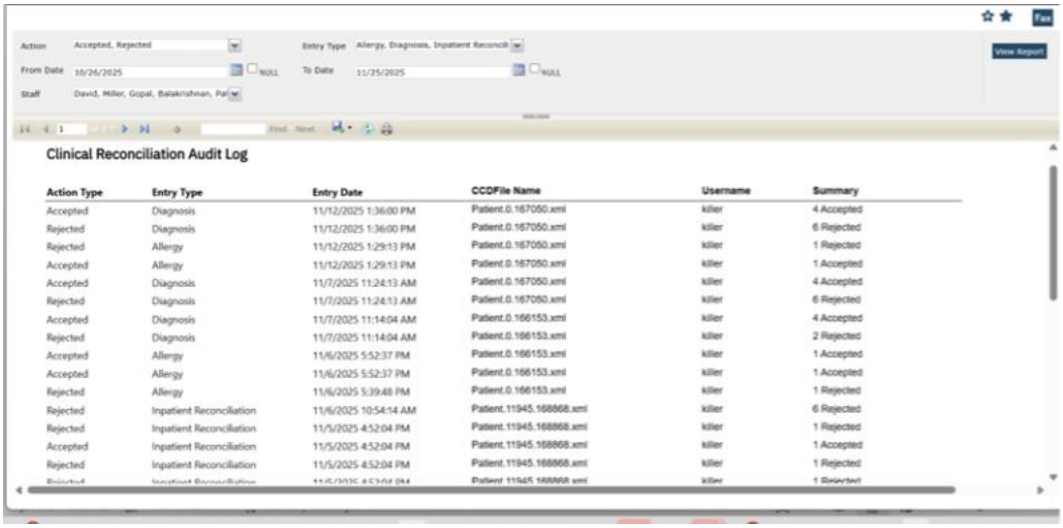
---

### 15. EII # 132290 (Feature # 586502): Implementation of Clinical Reconciliation Audit Log Report.

**Note:** This is a Passive Change.

**What's Changed:**

With this release, the Clinical Reconciliation Audit Log Report has been implemented.




**Filter Section:** The filter section displayed with the following fields:

**1. Action:** This is a multi-select drop down, the drop down is displayed with the below options,

- Accepted
- Rejected

**2. Entry Type:** This is a multi-select drop down, the drop down is displayed with the below options,

- Allergy
- Diagnosis
- Inpatient Reconciliation
- Medication Reconciliation

**3. From Date:** This is a Date control field and Defaults to the past 30 days.
**4. To Date:** This is a Date control field, by default, today's date will be displayed.

**7. Null:** The checkbox is displayed next to the **From Date** and **To Date** fields. When this checkbox is checked the From an To date fields will be disabled.

**5. Staff:** This is a multi-select drop down; it will display the usernames who performed reconciliation.

**6. View Report:** On clicking the 'View Report' button, the report will be generated based on the filter selected.

**Grid Section:** The section is displayed with the following columns:

**Action Type:** Displays the 'Accepted' and 'Rejected' values. Based on user selection from CCD grid in Client Allergies, Diagnosis Document or Medication Reconciliation Document.

**Entry Type:** Displays the values from the CCD grid section.
**Entry Date:** Displays the system generated Date/Time.
**CCD File Name:** It will be pulled from the CCD Import.
**Username:** Displays the username from the auto populated session.
**Summary:** Displays the 'Accepted' and 'Rejected' values. Based on user selection from CCD grid.

**Prerequisites:**

**Setup for Client Allergies:**

1.Login to SmartCare application -> Select a client > Create Client Allergies ->Navigate to the Client Allergies-Enter all the required fields ->Click on insert -> Save.

2. Go to USCDI Summary of Care ->Fill in the required fields and sign the document ->Click on the 'Print Summary of Care' icon in the toolbar -> Pop Up will be displayed. -Select Direct message radio button clicks on OK button -> redirected to Direct messaging screen with the CCD PDF attached- Enter the details for

to = streamline2@direct.smartcare.com and cc = streamline1@direct.smartcare.com, add subject and message> click on Save and Close icon.

3. Navigate to Direct Message list screen > user will have the received message that just sent > Open that message > There is a client field on the right side > Add any of the client, select details and click on Link button.

**Diagnosis Document**

1. Login to SmartCare application -> Select a client ->Navigate to the Diagnosis Document-> Click on the Reconciliation icon in the toolbar -> Pop Up will be displayed->Add the File name and Reconciliation Type -> add the diagnosis list ->click on add button -> Click on save button.

2. Go to USCDI Summary of Care ->Enter all the required fields and sign the document->Click on the 'Print Summary of Care' icon in the toolbar -> Pop Up will be displayed-Select Direct message radio button click on OK button -> redirected to Direct messaging screen with the CCD PDF attached-Enter the details for

to = streamline2@direct.smartcare.com and cc = streamline1@direct.smartcare.com, add subject and message-> click on Save and Close icon.

3. Navigate to Direct Message list screen -> User will have received message that just sent -> Open that message -> There is a client field on the right side > Add any of the client, select details and click on the Link button.

**Inpatient Reconciliation:**

1. Login to SmartCare application -> Select a client ->Navigate to the Inpatient Reconciliation Document-> add the allergies click on save.

2. Go to USCDI Summary of care ->Fill the required fields sign the document->Click on the 'Print Summary of Care' icon in the toolbar -> Pop Up will be displayed->Select Direct message radio button click on OK button -> redirected to Direct messaging screen with the CCD PDF attached-Enter the details for

to = streamline2@direct.smartcare.com and cc = streamline1@direct.smartcare.com, add subject and message> click on Save and Close icon

3.Navigate to Direct Message list screen > User will have received the message that just sent > Open that message > There is a client field on the right side > Add any of the client, select details and click on the Link button.

**Medication Reconciliation:**

1. Login to SmartCare application -> Select a client ->Navigate to the Medication Management -> add the medications.

2. Go to USCDI Summary of care ->Fill the required fields and sign the document-click on'Print Summary of Care' icon in the toolbar -> Pop Up will be displayed- >Select Direct message radio button clicks on OK button -> redirected to Direct messaging screen with the CCD PDF attached-Enter the details for

to = streamline2@direct.smartcare.com and cc = streamline1@direct.smartcare.com, add subject and message> click on Save and Close icon.

3. Navigate Direct Message list screen -> user will have received the message that just sent > Open that message > There is a client field on the right side > Add any of the client, select details and click on the Link button.

**Where To Find It:**

**Path:** Login to the SmartCare application-> Navigate to the Clinical Reconciliation Audit Log -> Clinical Reconciliation Audit Log Report will display -> Select the required filters - Click on 'View Report'.

**How this helps:**

This feature adds structured logging of **Accepted, Rejected** actions taken by users during reconciliation of CCD or FHIR data. While SmartCare currently tracks if reconciliation occurred at a document level, this feature ensures that each individual item is logged for certification auditability.

This change is applicable in the **Diagnosis** Document, **Medication** Reconciliation Document**,** **Inpatient** Reconciliation Document, and **Client Allergies** where the user can complete reconciliation of CCD data.

This report allows users to view the reconciliation of actions**.**

---

## Inquiry Details

| Reference No | Task No | Description |
|---|---|---|
| 16 | EII # 132464 | Inquiry: Crisis tab: Procedure Code options to adhere to the selected program based on the Configuration Key. |

## 16. EII # 132464 (Feature # 601647): Inquiry: Crisis tab: Procedure Code options to adhere to the selected program based on the Configuration Key

**Note:** This is a Passive Change.

**What's Changed:**

Now, in the Inquiry: Crisis tab, the Procedure Code dropdown values pull the Crisis Procedures based on the system configuration key-

'EnforceServiceDropDownConfigurations'and ServiceDropDownConfigurations table setup.

**System Configuration Key Details:**

**System Configuration Key:** EnforceServiceDropDownConfigurations

**Read Key as:** Enforce Service Dropdown Configurations.

**Allowed Values:** Yes, No

**Default Value:** No

**Modules:** SCM Client Intake/Inquiry

**Description:** This is a change to an existing feature of our core product by introducing a system configuration key. When a service is created from the Inquiry - Crisis tab, the Procedure dropdown does not adhere to the logic in the ServiceDropDownConfigurations table. Existing Logic for Procedure Code Drop Down: Displays all Active Crisis Procedure Codes. The value of this key is used to control the logic of the Procedure dropdown.

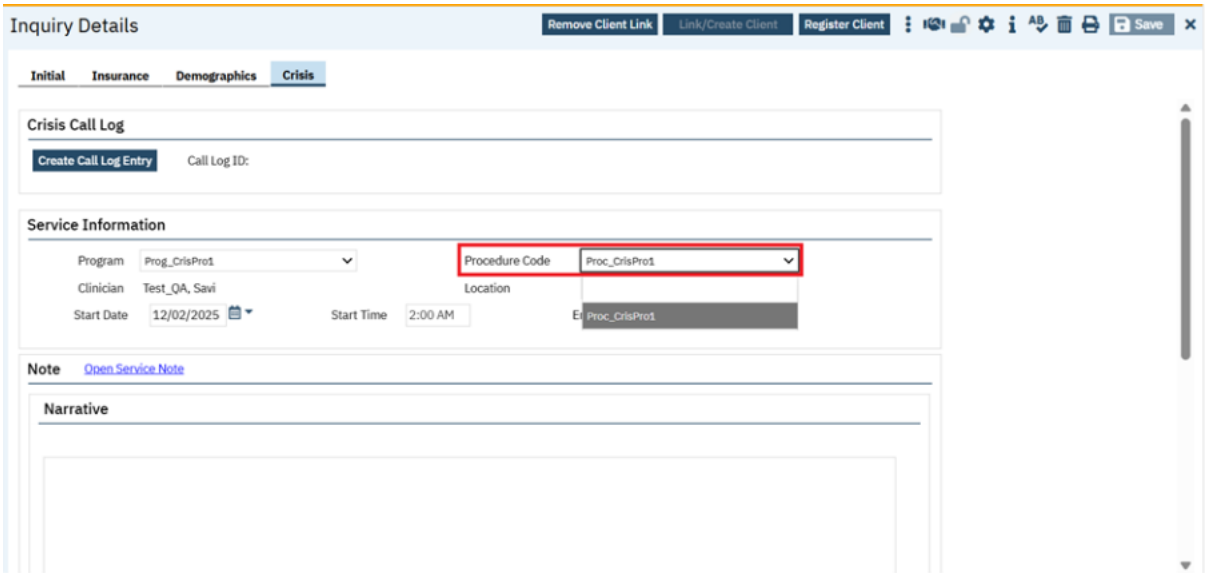
- If the value is set to "Yes", the Procedure dropdown will adhere to the ServiceDropDownConfigurations table logic along with Existing Logic.
- If the value is set to "No", the Procedure dropdown will display all active Crisis Procedure Codes. **This will be the default value of the key as it drives the existing behavior**.

**Note:** If the value of the key is unavailable or updated with any value apart from the allowed values, the system will consider **the default behavior**, i.e., the same as the key value being "No". Existing Logic: Displays all Active Crisis Procedure Codes

**Inquiry Details screen:**

The **Procedure Code** dropdown values pull the Crisis Procedure which is based on the selected Clinician, Program and Location value and this refresh will happen on 2 conditions

- When the **System Configuration Key** 'EnforceServiceDropDownConfigurations' is set to **Yes**
- When **ServiceDropDownConfigurations** table **ProcedureCodeIdFilterBy** column has a setup
- If the setup is **ProgramId,** then Procedure Code filter is based on the Program selection.




- If the setup is **LocationId,** then Procedure Code filter is based on the Location selection.
- If the setup is **ClinicianId,** then Procedure Code filter is based on the Clinician selection.

- If the setup is **Multiple Id's,** then Procedure Code filter is based on the all the Id's selection.

**Where To Find It:**

**Path 1:** Login to 'SmartCare' application -- Configuration Keys' -- 'Configuration Keys' list page -- Search with Key -- EnforceServiceDropDownConfigurations' -- Apply Filter -- Configuration Key Details' screen -- - 'Yes' or 'No' -- 'Save'.

**Path 2:** 'Client search popup' -- Inquiry (New Client)' button -- 'Inquiry Details' screen -- 'Initial' tab -- 'Inquirer Information' section -- Click on 'Crisis' checkbox -- 'Crisis' tab -- Procedure Code dropdown field.

**How it Helps:**

This implementation validates that the Procedure Code dropdown in the Inquiry → Crisis tab adheres to the logic defined in the ServiceDropDownConfigurations table, based on the System Configuration Key EnforceServiceDropDownConfigurations. This change ensures consistent filtering behavior across all modules (Inquiry, Service, etc.) and enforces the same business rules when selecting Procedure Codes.

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## IPFQR List Page

| Reference No | Task No | Description |
|---|---|---|
| 17 | EII # 125821 | Updates for IPFQR Reporting List Page for data collection in 2025 and reporting in 2026. |
| 18 | EII # 129426 | Changes are implemented in Clinical and Facility XML File Creation for IPFQR 2025 data reporting due August 2026. |

### 17. EII # 125821 (Feature # 298291): Updates for IPFQR Reporting List Page for data collection in 2025 and reporting in 2026.

🟧 **ACTIVE CHANGE**

**What's Changed:**

The update introduces a new Discharge Year filter with improved date validations and removes outdated filters and actions. Key actions such as Accept, Cancel Submission, Create Batch, and Refresh now follow stricter status-based rules with clear validation messages. The grid has been simplified by removing Version ID and Submission Status, retaining only the updated Record Status values.

**Validation & UI Enhancements**

**Filter Updates**

1. A new Discharge Year filter has been added with selectable values 2025 and 2024, displayed in descending order.
   • 2025 uses v1.3 specifications
   • 2024 uses v1.2a specifications

2. The From Date filter now validates that the selected date must fall within the chosen Discharge Year.

**Validation Message**: "Start date must be within the Discharge year selected."

3. The From Date filter also validates that discharge dates must be greater than or equal to the selected Start Date.

4. The To Date filter validates that the selected date must fall within the chosen Discharge Year.

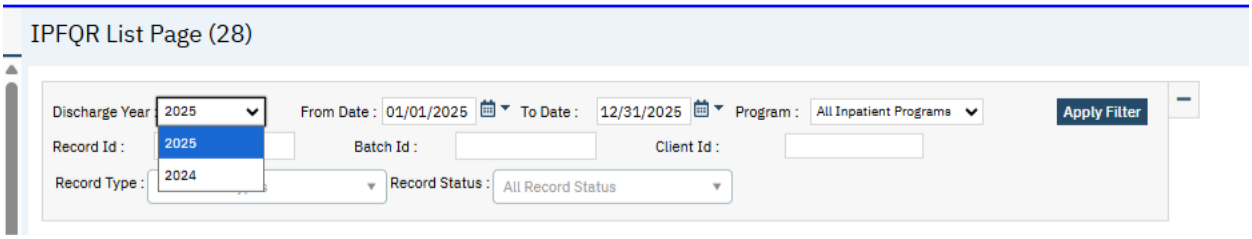
**Validation Message:** "End date must be within the Discharge year selected."

5. The To Date filter also enforces that discharge dates must be less than or equal to the selected End Date.

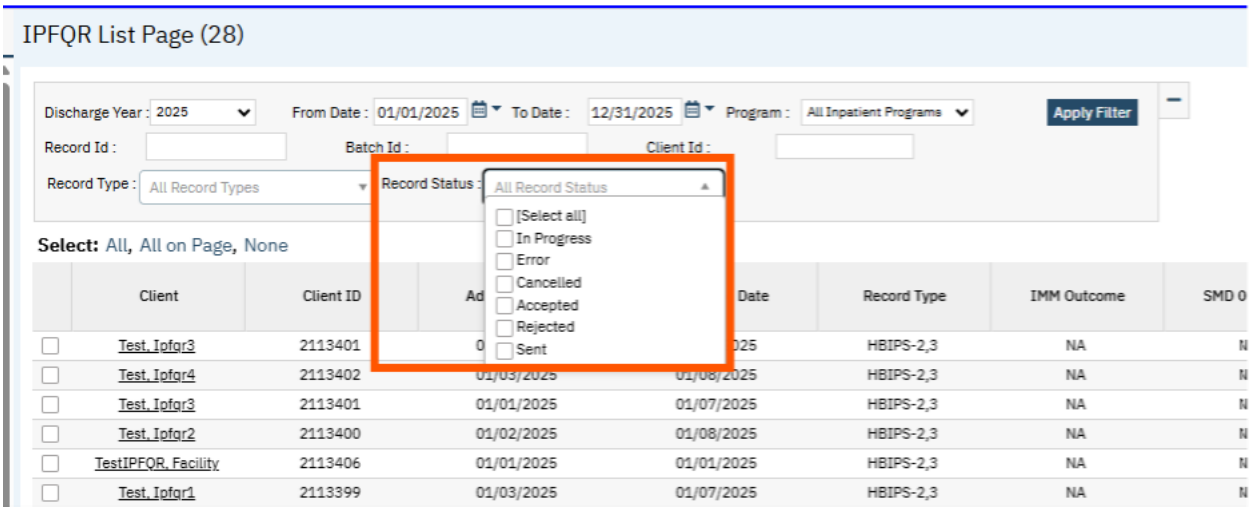
6. The Record status filter values have been added with values 'Accepted', and 'Rejected'. Updated the 'Created' value with the 'Sent'. Also, 'Delete' & 'Update' values have been removed.

7. The Submission Status filter has been removed from the UI.

**Filter section:**




**Record Status Checklist:**




**Action Updates**

**Accept Records**

1. The action name has been updated to remove the words "Selected" and "Records" from the previous value and display just as 'Accepted'.

2. A record can be accepted only if all selected records already in any batch

**Validation Message:** "Please create a batch for all selected records"

3. Records are eligible for acceptance only when their status is Sent.

**Cancel**

1. Action name updated to 'Cancel' from 'Cancel Selected Records'.
2. Cancellation is allowed only when the record status is 'Sent'.
3. If the user attempts to cancel an Accepted record:

**Validation Message**: "Accepted records cannot be cancelled."

4. If the user attempts to cancel a record that is not Accepted but also not in a valid cancellable state:

**Validation Message**: "Do a refresh action on the selected record and change the status"

**Create Batch Submission**

1. The action name has been updated from 'Create New Batch Submission' to 'Create Batch Submission'.
2. A batch can be created only when all selected records are in 'In Progress' status.
3. When a batch is successfully created, the status of all included records automatically changes to 'Sent'.
4. If any selected record is already part of a batch:
   **Validation Message**: "PLEASE SELECT NON-BATCH RECORDS FOR CREATING BATCH"

**Create Batch Submission with Error**

1. The action name has been updated from 'Create New Batch Submission with Error' to 'Create Batch Submission with Error'.
2. A batch can be created only when all selected records are in 'In Progress' and 'Error' status.
3. When a batch is successfully created, the status of all included records automatically changes to 'Sent'.
4. If any selected record is already part of a batch:
   **Validation Message**: "PLEASE SELECT NON-BATCH RECORDS FOR CREATING BATCH WITH ERRORS"

**Reject Records**

1. Records can be Rejected only when all selected records are in 'In Progress' and 'Error' status.
2. When a record is successfully rejected, the status of all included records automatically changes to 'Rejected'.
3. If any selected record is already part of a batch:

**Validation Message**: "PLEASE SELECT NON-BATCH RECORDS FOR CREATING BATCH WITH ERRORS"

4. If any selected record is not in 'Sent' status, and reject action is performed in the system:

**Validation Message**: "Please create a Batch for all the selected records"

**Removed Actions**

The following actions have been removed from the dropdown:

- Update Accepted Records
- Create Update Record Batch
- Delete Accepted Records
- Create Delete Record Batch
- Set Status to Cancelled

**Refresh Data**

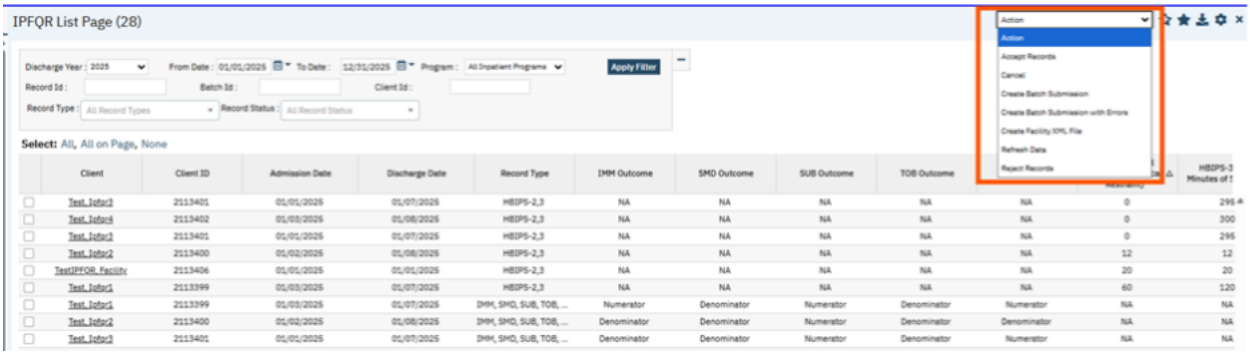
1. Refresh is allowed only for records whose submission status is not Accepted.

2. For records in In Progress, Error, or Cancelled status, Refresh updates the existing record with the latest IPFQR client data and retains the record in In Progress or Error based on validation.

3. For records in Created or Update status:
   • If the source data changed, the system creates a new record version with updated audit details and increments the version number.
   • If the source data did not change, no new record version is created.

4. If Refresh is used on a 'Delete' status record:
   **Validation Message:** "Delete records cannot be updated, they must match the accepted record being deleted."

**Actions screenshot:**



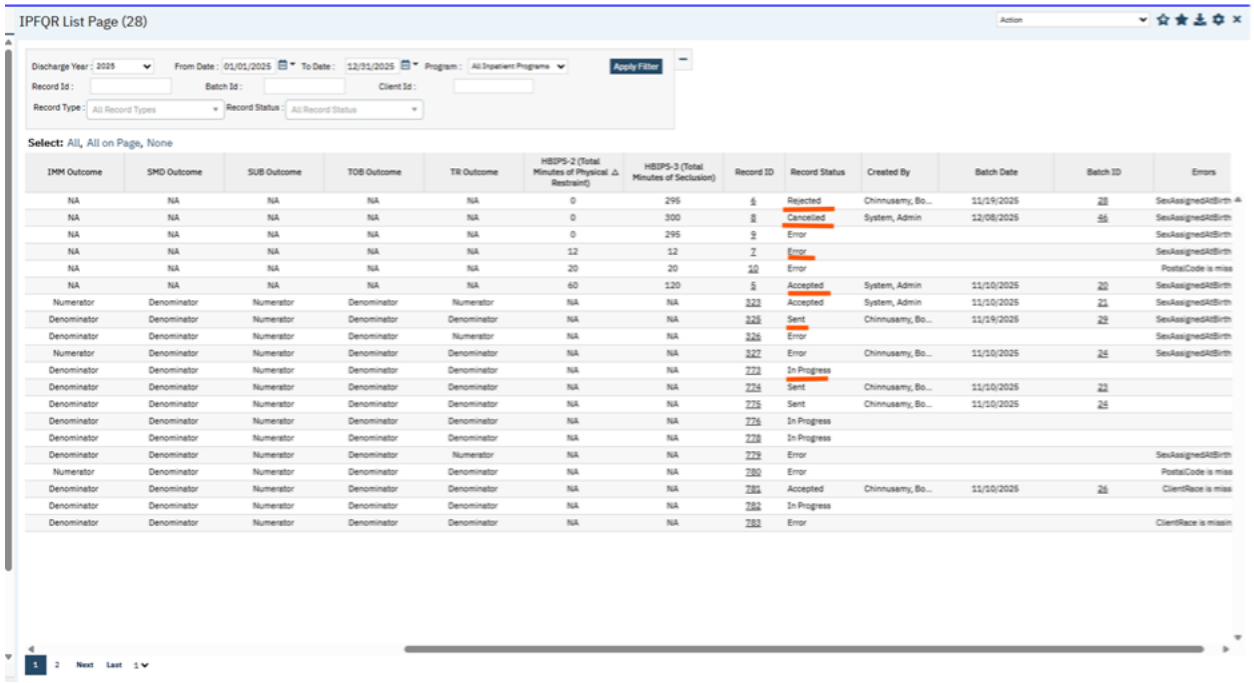

**Grid Updates:**

1. The 'Version ID' column has been removed from the List page grid, and the detail page.

2. The 'Submission Status' column has been removed from the 'Record' filter, list page grid and the detail page.

3. The 'Record Status' column remains and now displays the updated statuses:
   'In Progress', 'Error', 'Cancelled', 'Accepted', 'Rejected', 'Created', 'Sent'.

**Grid section screenshot:**




**Global Code Update**

The values for the below Global code 'IPFQRTobaccoStatus' has been updated to the following reportable values:

-Current everyday tobacco user

-Current some day tobacco user

-Former tobacco user

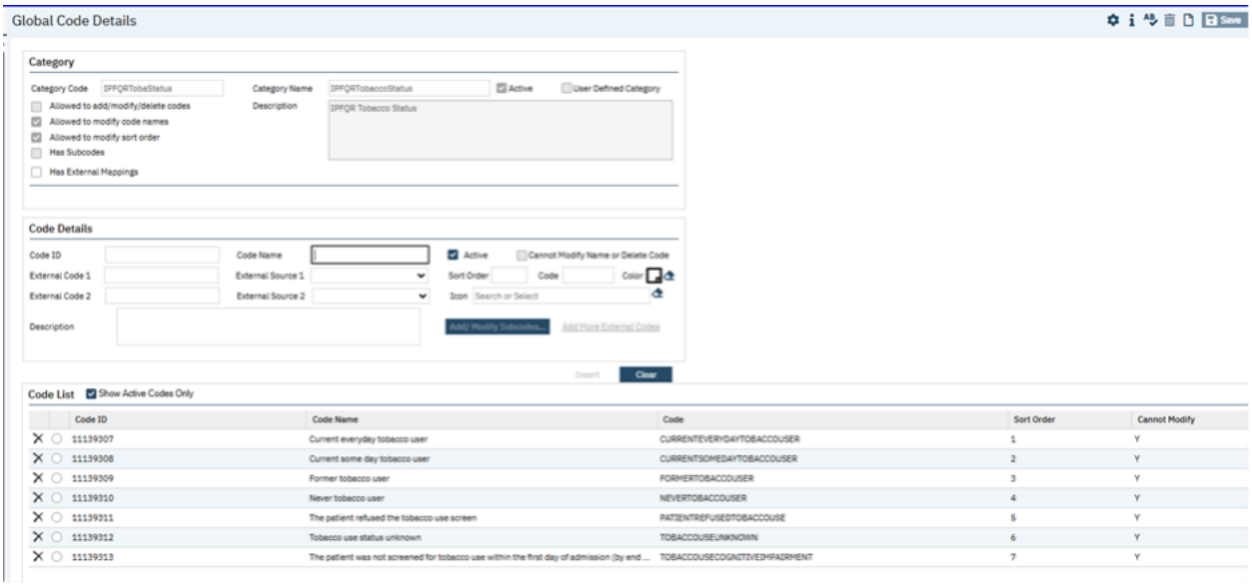
-Never tobacco user

-The patient refused the tobacco use screen

-Tobacco use status unknown

-The patient was not screened for tobacco use within the first day of admission (by end of Day 1) because of cognitive impairment

**Global Codes:**




**Pre-requisites:**

**1.** The list page must show records based on the logged-in user's Client Access Permissions, including assigned programs and provider permissions. Users with 'All Providers' access can view records across all providers.

2. Client must have the Inpatient Admission and Discharge within the reporting period.

**Where to Find It:**

**Path:** 'My Work' – 'My Reports' – 'IPFQR List Page'

**How It Helps:**

- The Inpatient Psychiatric Federal Quality Reporting (IPFQR) program is a program by CMS for reporting quality of care standard measures for inpatient psychiatric care.
- The data is required to be reported to maintain reimbursement levels from Medicare claims. If the organization does not report IPFQR data or meet the requirements of the data reported, they can lose up to 2% on their reimbursement rate from Medicare. So, it is used for data collection in 2025 and reporting in 2026.

---

## 18. EII # 129426 (Feature # 469094): Changes are implemented in Clinical and Facility XML File Creation for IPFQR 2025 data reporting due August 2026.

🟧 **ACTIVE CHANGE**

**What's Changed:**

With this release, the version of the IPFQR Clinical and Facility XML File is updated to 1.0 and some fields have been removed from the IPFQR Facility XML File and Clinical XML file for the IPFQR 2025 data reporting due August 2026.

**Facility XML File:**

The following fields are removed from the Facility XML file:

- Header – xml Version will be displayed.
- <file-audit-data>
- <create-date>
- <create-time>
- <create-by>
- <version>
- <create-by-tool>
- </file-audit-data>

```
▼<submission>
  <submission type="IPF" data="Non-measure" version="1.0" action-code="ADD"/>
 ▼<provider>
    <provider-id>212233</provider-id>
   ▼<time-period year="2025">
    ▼<hbips-evnt-data>
       <psych-inpt-days-med>0</psych-inpt-days-med>
       <psych-inpt-days-nonmed>2</psych-inpt-days-nonmed>
       <total-leave-days-med>0</total-leave-days-med>
       <total-leave-days-nonmed>0</total-leave-days-nonmed>
     </hbips-evnt-data>
    ▼<non-measure-data>
       <total-discharges>1</total-discharges>
      ▼<payer>
         <medicare>0</medicare>
         <non-medicare>1</non-medicare>
       </payer>
      ▼<age-strata>
         <children>0</children>
         <adolescent>0</adolescent>
         <adult>1</adult>
         <older-adult>0</older-adult>
       </age-strata>
      ▼<primdxcategory>
         <anxiety-651>0</anxiety-651>
         <delirium-653>0</delirium-653>
         <mood-657>0</mood-657>
         <schizophrenia-659>0</schizophrenia-659>
         <alcohol-660>0</alcohol-660>
         <substance-661>0</substance-661>
         <otherdx-category>0</otherdx-category>
       </primdxcategory>
     </non-measure-data>
   </time-period>
  </provider>
</submission>
```

**Clinical XML File:**

The following fields are removed from the Clinical XML File:

- Header

- <file-audit-data>
- <create-date>
- <create-time>
- <create-by>
- <version>
- <create-by-tool>
- </file-audit-data>
- <abstraction-audit-data>
- <abstraction-date>
- <abstractor-id>
- <total-abstraction-time>
- <comment>
- </abstraction-audit-data>
- <npi>
- <sex>
- <sexual-orientation>
- <gender-identity>

```
<submission type="IPF" data="CLINICAL" version="1.0" action-code="ADD">
  <provider>
    <provider-id>212233</provider-id>
    <patient>
      <first-name>298291_IPFQRCheck1</first-name>
      <last-name>CkClient</last-name>
      <birthdate>11-25-2000</birthdate>
      <sex-birth/>
      <race/>
      <ethnic>N</ethnic>
      <postal-code>HOMELESS</postal-code>
      <episode-of-care measure-set="TR">
        <admit-date>11-01-2025</admit-date>
        <discharge-date>11-01-2025</discharge-date>
        <patient-id>2113485</patient-id>
        <detail answer-code="2" row-number="0" question-cd="PMTSRCE"/>
        <detail answer-code="N" row-number="0" question-cd="SAMPLE"/>
        <detail answer-code="Y" row-number="0" question-cd="PSYCHSETNG"/>
        <detail answer-code="N" row-number="0" question-cd="247CONTACT"/>
        <detail answer-code="N" row-number="0" question-cd="ADPADSDM"/>
        <detail answer-code="N" row-number="0" question-cd="CNTCTPDGSTDS"/>
        <detail answer-code="N" row-number="0" question-cd="IPFMEDLIST"/>
        <detail answer-code="4" row-number="0" question-cd="IPFDISCHDISP"/>
        <detail answer-code="N" row-number="0" question-cd="MJRPXTESTS"/>
        <detail answer-code="N" row-number="0" question-cd="PRINDXIPFDISCH"/>
        <detail answer-code="N" row-number="0" question-cd="PTINSTRUCT"/>
        <detail answer-code="N" row-number="0" question-cd="PLNFLLWCARE"/>
        <detail answer-code="N" row-number="0" question-cd="PRIMEHCPFC"/>
        <detail answer-code="Y" row-number="0" question-cd="RSNIPFADMIT"/>
        <detail answer-code="N" row-number="0" question-cd="STUDIESPDG"/>
        <detail answer-code="2" row-number="0" question-cd="TRDISCPROV"/>
      </episode-of-care>
    </patient>
  </provider>
</submission>
```

**Where To Find It:**

**Path 1:** My Office – 'IPFQR List Page' -- Action Dropdown -- Create Batch Submission -- Clinical Xml file will be saved in Configured SFTP path

**Path 2:** My Office - 'IPFQR List Page' -- Action Dropdown -- 'Create Facility XML File' – Facility Xml file will be saved Configured SFTP path.

**How It Helps:**

- Reports the data to maintain reimbursement levels from Medicare claims.

## Merge Clients

| Reference No | Task No | Description |
|---|---|---|
| 19 | EII # 132698 | Changes are implemented to include TEDS Episodes in the 'Merge Clients'. |

## 19. EII # 132698 (Feature # 617224): Changes are implemented to include TEDS Episodes in the 'Merge Clients'.

**Note 1:** This is a Passive Change.

**Note 2:**

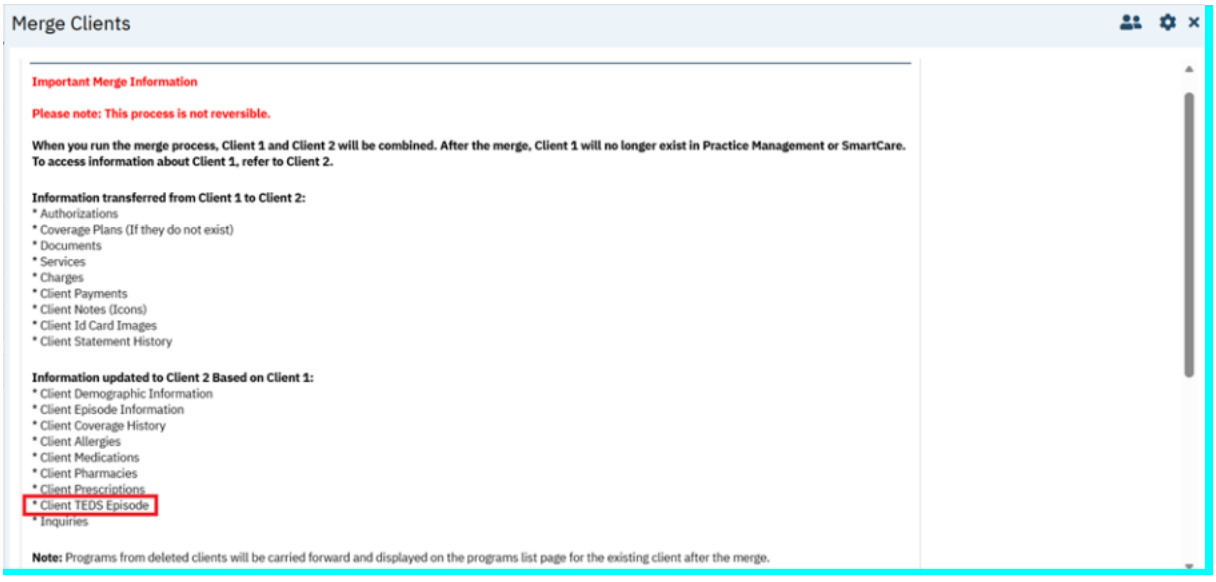
- This change is for specific customers who have custom implementation in their environment.
- If the specific customer stored procedure is not available, the Client Teds checkbox will remain hidden.

**What's Changed:**

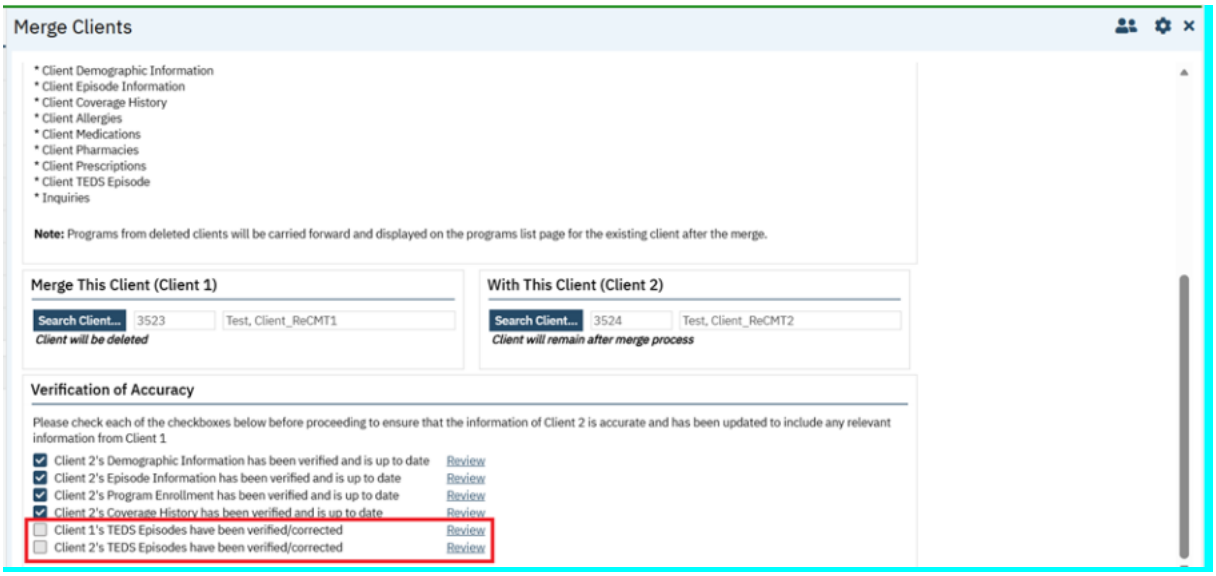
With this release, the following changes have been implemented to include TEDS Episodes in the 'Merge Clients'.

**'Merge Clients' screen:**

- A new label 'Client TEDS Episode' is added under the 'Information updated to Client 2 based on Client 1' section in the 'Merge Clients' screen.




- The following two Client's TEDS Episodes checkboxes are added under the 'Verification of Accuracy' section and each associated with the "Review" hyperlink:
- Client 1's TEDS Episodes have been verified/corrected.
- Client 2's TEDS Episodes have been verified/corrected.
- A Review hyperlink will allow users to navigate to the 'Teds Tracking List' screen, where users can review the episodes of Client 1 or Client 2 either prior to or following the client merge.



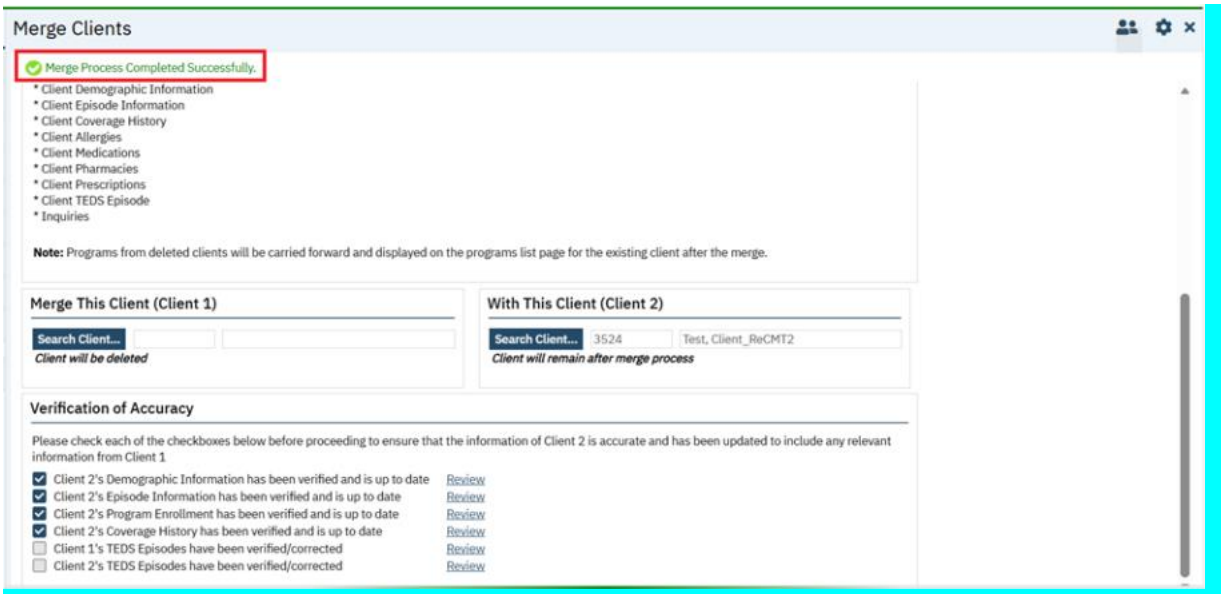

The client data will be merged on following conditions, depending on whether the TEDS Episodes checkboxes are enabled or disabled.

TEDS Episodes Checkboxes Behavior:

1) The Client's TEDS Episodes checkboxes will be displayed and disabled by default. These checkboxes will remain disabled whenever both Client's (Client 1 and Client 2) do not have a TEDS Episode.

Merge process: After merging data of Client 1 and Client 2:

- Client 1 will be deleted, and Client 1 data will be transferred to Client 2.
- The user can review the transferred data from Client 1 in Client 2 by clicking on 'Review' hyperlink of Client 2's TEDS Episodes checkbox.



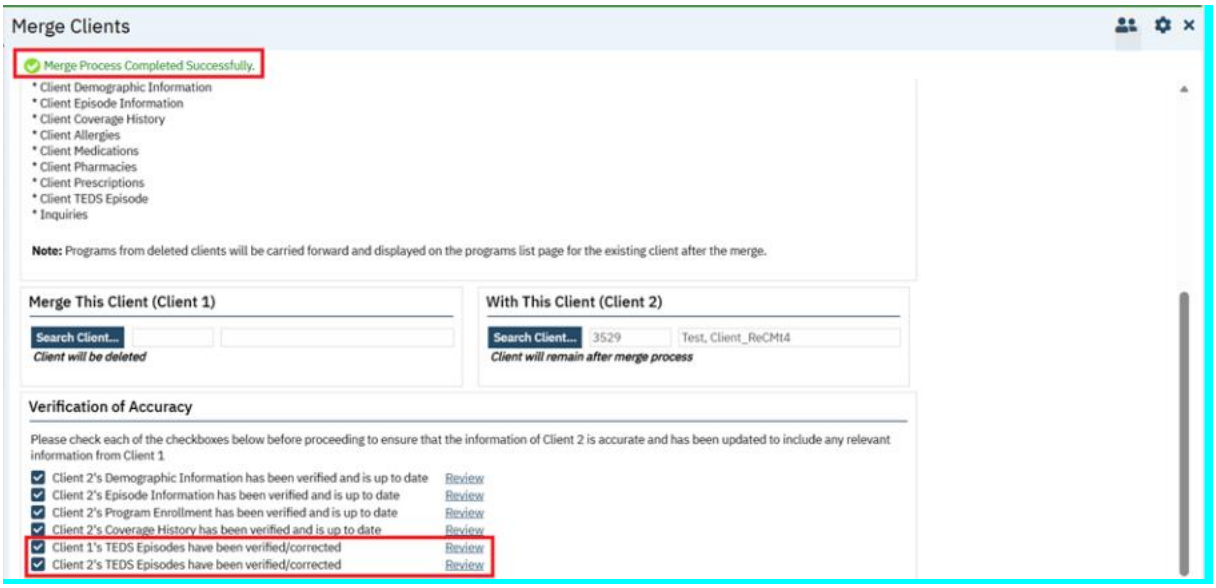

2) The Client's TEDS Episodes checkboxes will be displayed and enabled, if at least one client (Client 1 or Client 2), or both, have a TEDS Episode. If these enabled checkboxes remain unchecked, the system displays a TEDS Episode validation message.

Validation messages:

- Please check TEDS Episodes for Client 1.
- Please check TEDS Episodes for Client 2.

Merge process: After merging the data of Client 1 and Client 2:

- Client 1 will be deleted, and Client 1 data will be transferred to Client 2.
- The user can review the transferred data from Client 1 in Client 2 by clicking on 'Review' hyperlink of Client 2's TEDS Episodes checkbox which allows user to navigate to 'TEDS Tracking List' screen.




**Prerequisite:** The TEDS Episodes are available on the 'TEDS Tracking List' screen for the clients.

**Where to Find It:**

Administration -- 'Merge Clients' -- 'Merge Clients' screen.

**How It Helps:**

- Users can merge TEDS Episodes while merging clients.

---

## ~~Methadone~~

| ~~Reference No~~ | ~~Task No~~ | ~~Description~~ |
|---|---|---|
| ~~20~~ | ~~EII # 132755~~ | ~~MAT -Changes are Updated to the MAT Emergency Dispensing Report layout to display all columns on a single page.~~ |
| ~~21~~ | ~~EII # 133029~~ | ~~MAT: -The **'SciLog – Dispenser'** model/manufacturer has been added to the **MAT Dispenser** screen.~~ |

### ~~20. EII # 132755 (Feature # 619191): MAT -Changes are Updated to the MAT Emergency Dispensing Report layout to display all columns on a single page.~~

~~**Note:** This is Passive Change.~~

~~**What's Changed:**~~

~~With this release, the below mentioned changes have been implemented to the MAT Emergency Dispensing Report.~~

~~1.The page orientation has been changed from Portrait to Landscape mode to accommodate wider content.~~

~~2.The header and sub-header will be displayed only on the first page of the report and has been removed from all subsequent pages (Page 2 onwards).~~

~~3.The date will be displayed in the MM/DD/YYYY HH:MM AM/PM format for Report Run On header.~~

~~4.The label 'Dosage (MG)' has been renamed to 'Dose (MG)'.~~

~~5. The Form column has been removed from the grid, as the data related to this column is already present in the medication column (concentrate, tablet, film).~~

1301 W 22nd St, Oak Brook, OH 60525

**MAT Emergency Dispensing Report**

Report Run On: 12/11/2025 12:12 PM

**Start Date:** 12/12/2025
**End Date:** 12/12/2025
**Location:** All Locations
**Program:** All Programs
**Report Run By:** Test, Smruthi

| Location | Client | Program | DOB | SSN | Medication | Dose (MG) | TH | Dispense Date | Dispensed For | Staff | Bottle Id | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bangalore | Test, Taper3 (11774) | MAT Madhu | 10/1/2000 | 2734 | methadone 10 mg tablet | 11.00 | 0 | 12/12/2025 | 12/12/2025 | _____ | _____ | _____ |
| Label Location | Mat, Lighthouse1 (5119) | Service "M" AT | 5/17/1995 | 5444 | Methadone 10 mg/mL Oral Concentrate | 10.00 | 0 | 12/12/2025 | 12/12/2025 | _____ | _____ | _____ |
| Bangalore | Mat, Madhu (4677) | MAT Program | 1/1/2000 | 2111 | Methadone 10 mg/mL Oral Concentrate | 5.00 | 0 | 12/12/2025 | 12/12/2025 | _____ | _____ | _____ |
| Bangalore | Mat, Madhu (4677) | MAT Program | 1/1/2000 | 2111 | Methadone 10 mg/mL Oral Concentrate | 10.00 | 1 | 12/12/2025 | 12/12/2025 | _____ | _____ | _____ |
| Label Location | Test, Anuka (8644) | MAT Madhu | 12/31/2000 | 5666 | Methadone 10 mg/mL Oral Concentrate | 20.00 | 1 | | 12/12/2025 | _____ | _____ | _____ |
| Bangalore | Test, ScheduleV (11780) | MAT Madhu | 10/3/2000 | 8273 | methadone 10 mg tablet | 17.00 | 0 | 12/12/2025 | 12/12/2025 | _____ | _____ | _____ |
| Label Location | Test, ScheduleV1 (11781) | MAT Madhu | 10/2/2000 | 2734 | methadone 10 mg tablet | 15.00 | 0 | 12/12/2025 | 12/12/2025 | _____ | _____ | _____ |
| | Test, Schedulev2 (11791) | MAT Madhu | 10/8/2000 | 2938 | methadone 10 mg tablet | 5.00 | 0 | 12/12/2025 | 12/12/2025 | _____ | _____ | _____ |
| Bangalore | Test, Taper4 | MAT Madhu | 10/1/2000 | 2387 | methadone 10 mg | 10.00 | 1 | | 12/12/2025 | _____ | _____ | _____ |

~~**Prerequisites:**~~

~~**Navigation Path 1:** Go search → Orders - New - Order Details screen - Select Medication Order Type - Enter the required fields → Select (Medication Assisted Treatment (MAT), Machine Connection Required, Take Home Allowed) under Medication Assisted Treatment section - Save.~~

~~**Navigation Path 2:** My Office → 'Medication/Lot/Bottle' list page → New → 'Medication/Lot/Bottle Details' screen → Enter the required fields → Insert → Save.~~

~~**Navigation Path 3:** Go search → Client Orders - New - Select the Order created in Navigation Path 1 - Enter the required fields → Insert - Save and sign.~~

~~**Navigation Path 4:** Go search → MAT Management List page - Click on Dispense icon for Medication to be dispensed for Client → MAT Management Details screen.~~

~~**Where to Find It:**~~

~~**Path:** My Office → 'MAT Emergency Dispensing Report' → Select the required filters → Click on 'View Report'.~~

~~**How It Helps:**~~

~~This enhancement aims to optimize the report layout by reducing the width of specific columns to improve readability, alignment, and overall presentation of the report without losing data visibility.~~

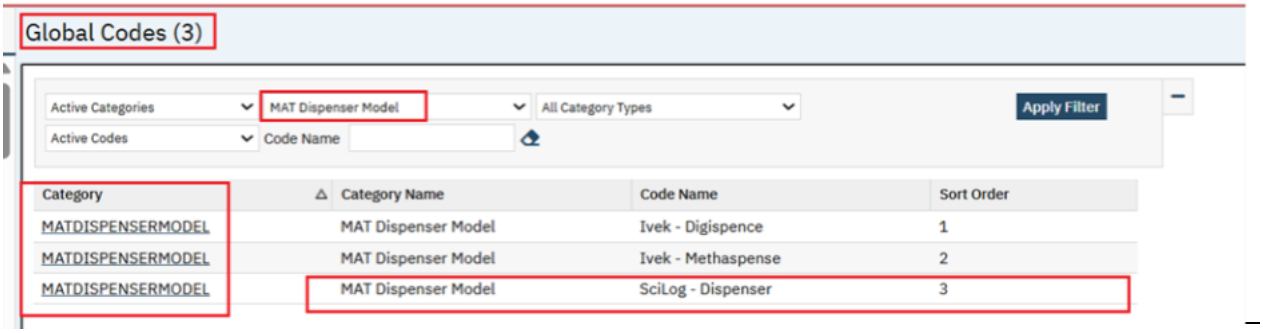
---

## ~~21. EII # 133029 (Feature# 619188): The 'SciLog – Dispenser' model/manufacturer has been added to the MAT Dispenser screen.~~

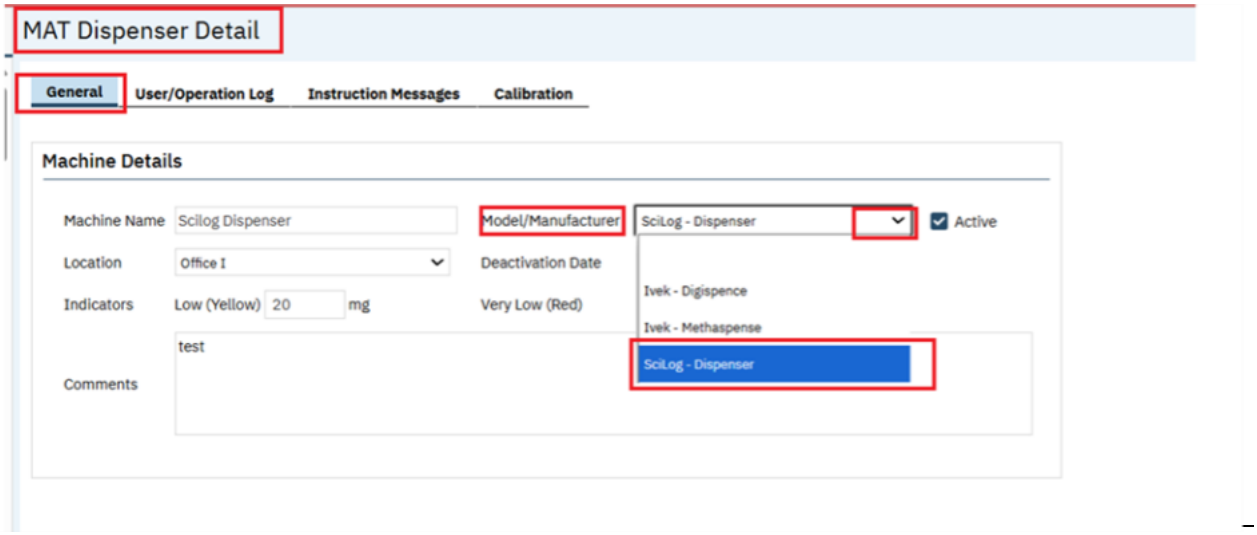
**Note:** This is Passive Change. This is for a specific customer who has the custom implementation in their environment.

**What's Changed:**

With this release, the below implementation has been done.
The **'SciLog – Dispenser'** model/manufacturer has been added to the **MAT Dispenser** screen.
In the global codes for the existing 'MAT Dispenser Model' category, the code **'SciLog – Dispenser'** has been added.




This added code **'SciLog – Dispenser'** will be displayed in the 'MAT Dispenser' screen under the model/manufacturer dropdown.

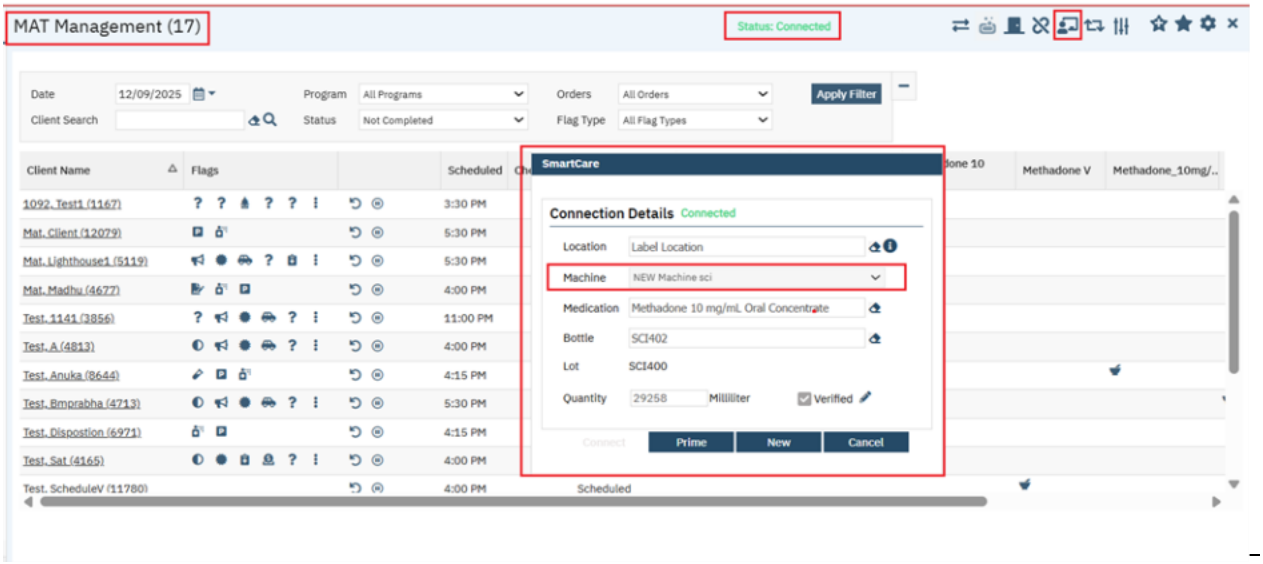



- After performing below operations using this **'SciLog – Dispenser'** in the MAT Management list page and MAT Management Details page, this will send the command to emulator/Dispenser.

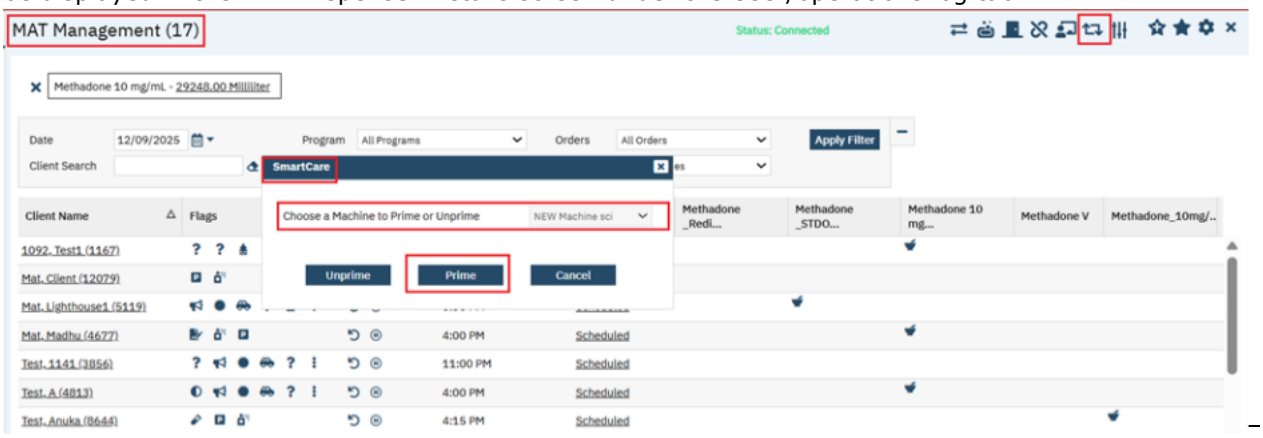
The following operations can be performed in the MAT Management List page.

1. Prime
2. Unprime
3. Calibration
4. Dispensed/ Re- dispensed/ Pre-Pour

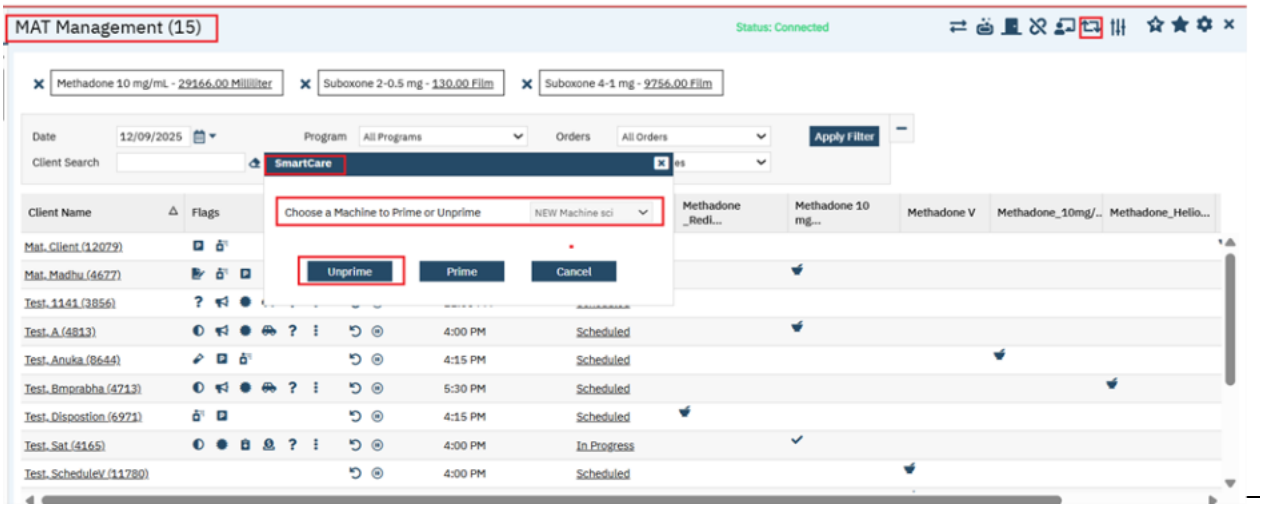
'New Machine sci' (or Any other configured machine from customer end) Machine has been connected in the MAT Management List page.



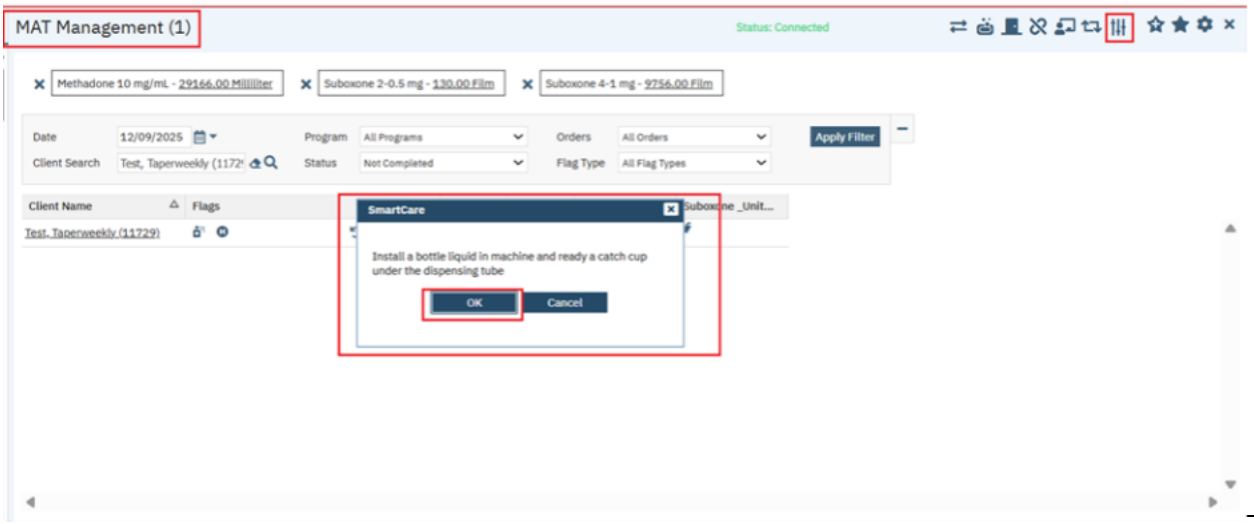

**1: Prime:** On performing Prime operation from MAT Management List/Details screen, Prime Operation log will be displayed in the MAT Dispenser Details screen under the User/operations log tab.



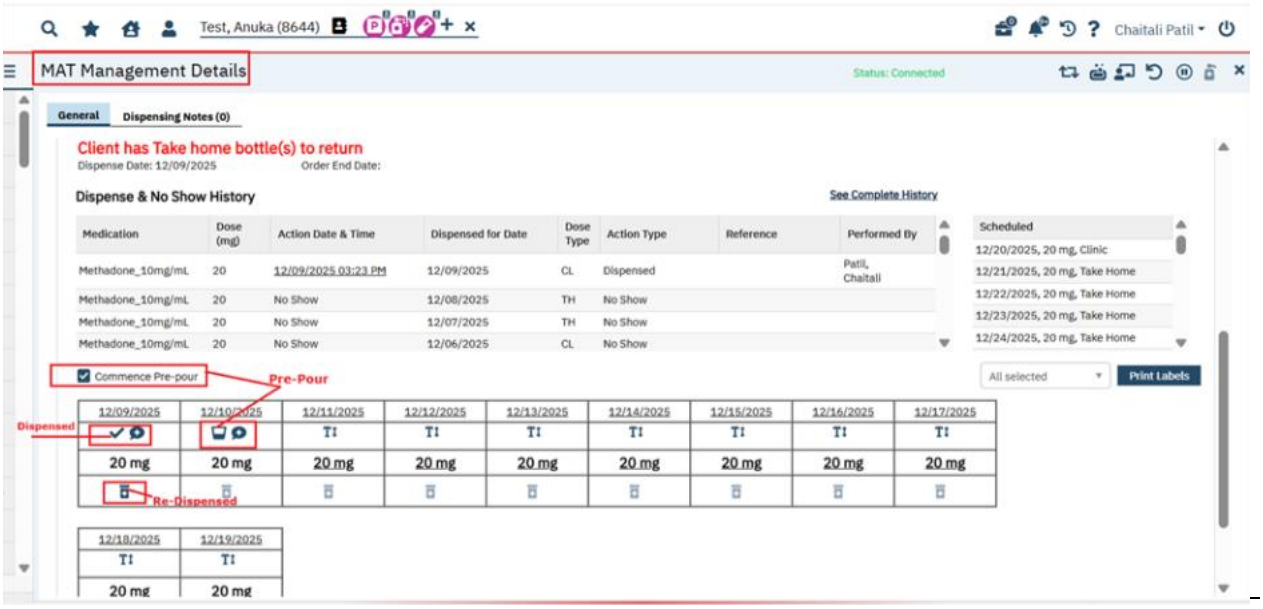

**2: Unprime:** On performing Unprime operation from MAT Management List/Details screen, Unprime Operation log will be displayed in the MAT Dispenser Details screen under the User/operations log tab.



**3: Calibrate:** On performing Calibrate operation from MAT Management List screen, and MAT Dispenser Screen Calibrate Operation log will be displayed in the MAT Dispenser Details screen under the User/operations log tab.




**4: Dispensed/ Re- dispensed/ Pre-Pour:** On Performing Dispense/ Re- dispense/ Pre-Pour Operation from the Mat Management details screen, respective quantity will be deducted from the connected Inventory through Machine.




**Where to Find It:**

**Path 1:** My office – MAT Dispenser – Click on new – MAT Dispenser Detail – add the Machine Name – select the 'Model/Manufacturer' as 'SciLog – Dispenser' – select the Location – fill required fields – Save.

**Path 2:** 'Administration' – 'Orders' – 'Orders' list page – New – 'Order Details' screen – Select 'Medication' Order Type – Enter the required fields – Select (Medication Assisted Treatment (MAT), Take Home Allowed), and Machine Connection = Yes, under 'Medication Assisted Treatment' section and display program? Must be 'Yes' for MAT Orders –fill other required fields – Click on 'Save'.

—

**Path 3:** My Office → 'Medication/Lot/Bottle' list page → New 'Medication/Lot/Bottle Details' screen → Select the Location → Enter other required fields →Insert → Save.

—

**Path 4:** 'Client' - 'Client Orders' - 'Client Orders' list page - New - 'Client Order details' screen - Select the Order created in (Navigation Path 2) → Enter the required fields → Insert order details into grid → Save and sign.

-

**Path 5:** 'My Office' - 'MAT Management 'list page – click on 'Connect User' icon – Connection Details pop up will be displayed → select the Machine which created in (Navigation path 1) and other required fields → Click on 'Verified' check box → and click on connect → Machine get connected.

—

**Path 6:** 'My Office' - 'MAT Management 'list page – Select the Order (Navigation path 3) and click on 'Dispense icon' → MAT Management Details → Dispense the scheduled dose OR Pre pour the Dose → Or Re-dispensed the dose – and after action performed Command will be sent to Emulator.

—

**Path 7:** 'My Office' - MAT Management 'list page – click on Prime/Unprime icon in the toollbar- Smart Care pop up will open → Choose a Machine to Prime or Unprime field → click **on Prime** Button → machine gets Prime and Command will be sent to Emulator.

—

**Path 8:** 'My Office' - MAT Management 'list page → click on Prime/Unprime icon in the tollbar- Smart Care pop up will open → Choose a Machine to Prime or Unprime field → click **on Unprime** Button → machine gets Unprime and Command will be sent to Emulator.

—

**Path 9:** 'My Office' - MAT Management 'list page → click on Calibrate icon in the tollbar- Smart Care pop up will open - Choose a Machine to **Calibrate** field – click on Ok Button – machine gets calibrate and Command will be sent to Emulator.

-

**Path 10:** Go Search Global Codes (Administration) MAT Dispenser Model Category → Verify the code name **'SciLog – Dispenser.**

-

**How It Helps:**

-

The **'SciLog – Dispenser'** model/manufacturer has been added to the **MAT Dispenser** screen to support the following functionalities:

1. **Transmit dispensing parameters** from the system to the SciLog Dispensing Pump.
2. **Establish a communication interface** that enables reliable data exchange between the system and the pump.
3. **Receive pump feedback**, including status updates and dispensing completion notifications.
4. **Present real-time dispensing information** to the user for monitoring and operational visibility.

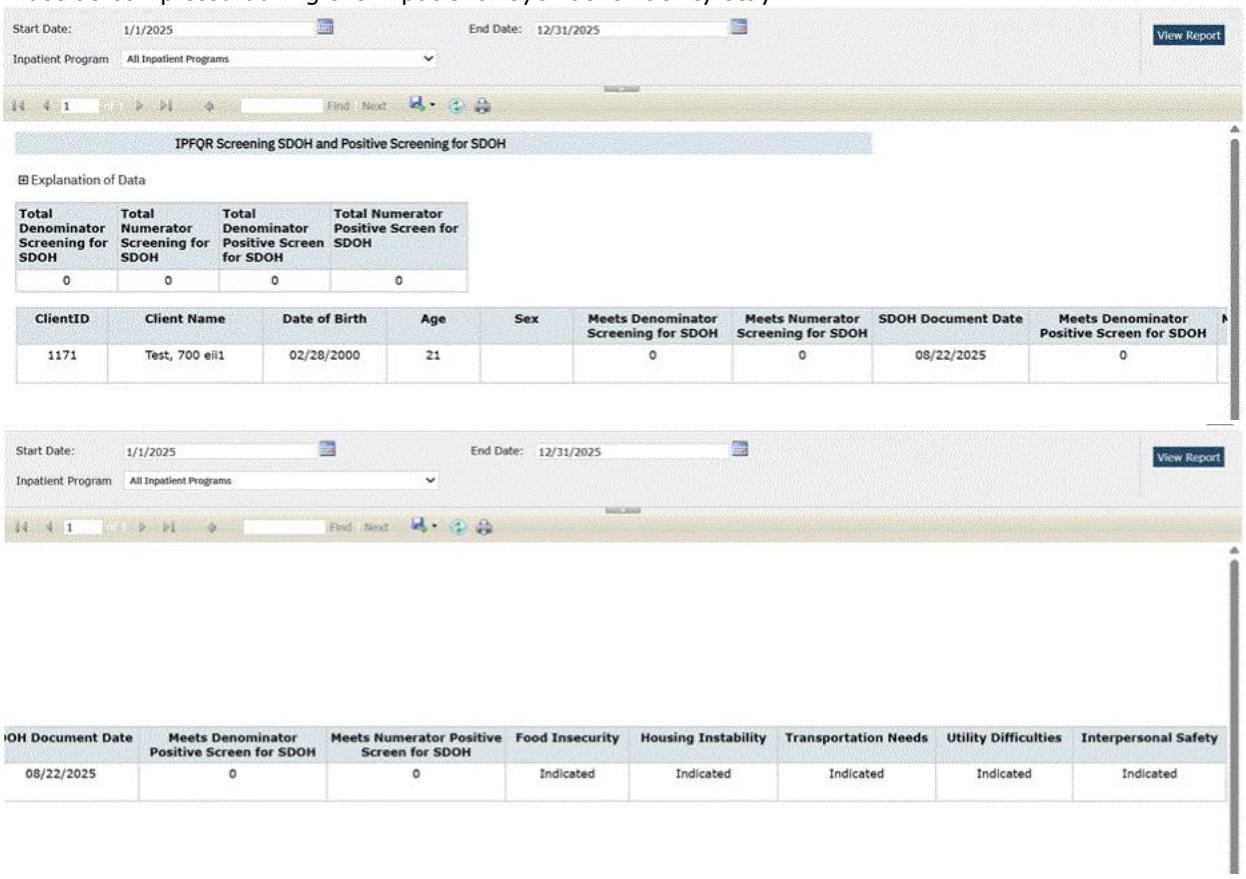
---

## My Reports

| Reference No | Task No | Description |
|---|---|---|
| 22 | EII # 131618 | Implementation of a new 'IPFQR Screening SDOH' report. |

## 22. EII # 131618 (Feature # 548596): Implementation of a new 'IPFQR Screening SDOH' report.

**Note:** This is Passive change.
**What's Changed:**
With this release, the 'IPFQR Screening SDOH' Report has been implemented for IPFQR facilities to capture Social Determinants of Health on all clients aged 18yrs and older, at the time of admission. The SDOH screening must be completed during the Inpatient Psychiatric Facility stay.




**Filter Section:**

- **Start date:** This is a Date Control field that allows users to select the date. It is a required Field to select a date while clicking on view report. It will Display clients in the report where inpatient visit admission date and discharge dates if present (discharge date is null) and the Effective date of the Signed Health-Related Social Needs Screening Tool document is within the specified From and To Dates.
- **End date:** This is a Date Control field that allows users to select the date. It is a required Field to select a date while clicking on view report. it will Display clients in the report where inpatient visit admission date and discharge dates if present (discharge date is null) and the Effective date of the Signed Health-Related Social Needs Screening Tool document is within the specified From and To Dates.
- **Inpatient Program:** This is a single select dropdown filter selection with default value as 'All Inpatient Programs' and it will display all the Inpatient Programs (Program Admin > Categories > Inpatient Program checkbox is selected).

**'IPFQR Screening SDOH and Positive Screening for SDOH':** This is a label
**Explanation Section:**

- **Explanation of Data:** It will show (+) and (-) symbols for expansion and collapse. By default, it will be in Collapse mode. And by clicking (+) it will display the explanations below.

IPFQR Screening SDOH and Positive Screening for SDOH

⊟ Explanation of Data

| Explanation of Data | |
|---|---|
| **Denominator** | 1. Screening for SDOH: The denominator population includes clients who are admitted to an IPF stay and who are 18 years or older on the date of admission.<br><br>2. Positive Screen for SDOH: The denominator population includes clients who are admitted for an IPF stay who are 18 years or older on the date of admission and are screened for all of the following five HSRN (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their IPF stay. |
| **Numerator** | 1. Screening for SDOH: The numerator population includes clients admitted to an IPF stay who are 18 years or older on the date of admission and are screened for all of the following five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during their IPF stay.<br><br>2. Positive Screen for SDOH: The numerator population includes clients admitted for an IPF stay who are 18 years or older on the date of admission, who were screened for all five HSRN, and who screen positive for having a need in one or more of the following five HRSNs (calculated separately): Food insecurity, housing instability, transportation needs, utility difficulties or interpersonal safety. |

**Summary Section:**

- **Total Denominator Screening for SDOH:** It displays the Sum of total number of clients where Meets Denominator Screening for SDOH = 1 in detail Grid.
- **Total Numerator Screening for SDOH:** It displays the Sum of total number of clients where Meets Numerator Screening for SDOH = 1 in detail Grid.
- **Total Denominator Positive Screen for SDOH:** It displays the Sum of total number of clients where Meets Denominator Positive Screen for SDOH = 1 in detail Grid.
- **Total Numerator Positive Screen for SDOH:** It displays the Sum of total number of clients where Meets Numerator Positive Screen for SDOH = 1 in detail Grid.

| Total Denominator Screening for SDOH | Total Numerator Screening for SDOH | Total Denominator Positive Screen for SDOH | Total Numerator Positive Screen for SDOH |
|---|---|---|---|
| 19 | 19 | 19 | 15 |

**Trigger Logic to display the Client into this Report:** Client Details will display in report if client has signed Core Health-Related Social Needs Screening Tool Document (SDOH document) that is during an Inpatient visit under an Inpatient Program (Program Admin > Categories > Inpatient Program checkbox is selected), and the client age is greater than or equal to 18 years old at the start of the Inpatient Admission. If multiple signed SDOH documents exist during the admission date and Discharge date of the client Inpatient visit or there are multiple client inpatient visits with an SDOH document signed during the reporting year, it will consider the most recent inpatient visit/document that falls within the start and end date filters of the report.

**Grid Section:**

- **ClientID:** This Field displays the Client ID from Client Information.
- **Client Name:** This Field displays the Client First name and Last name from Client Information in format (Last Name, First Name).
- **Date of Birth:** This Field displays the Date of Birth from Client Information.
- **Age:** This Field displays the Age from Client Information.
- **Sex:** This Field displays the Sex from Client Information – 'Sex assigned at birth'.
- **Meets Denominator Screening for SDOH:** It displays value as 1, if client Age is greater than or equal to 18 years on the date of the inpatient admission date and Client is admitted to an Inpatient Program (Program Admin > Categories > Inpatient Program checkbox is selected) during the reporting year. If it does not match this condition, it displays value as 0.

- **Meets Numerator Screening for SDOH:** It displays value as 1, if Meets Denominator Screening for SDOH is 1 and Client has a signed Core Health-Related Social Needs Screening Tool document during the Inpatient program admission. If it does not match this condition, it displays value as 0.
- **SDOH Document Date:** It displays the effective date of the most recent Health-Related Social Needs Screening Tool Document signed during the Inpatient program of admission.
- **Meets Denominator Positive Screen for SDOH:** It displays value as 1, if client Age is greater than or equal to 18 years on the date of the inpatient admission date and Client is admitted to an Inpatient Program (Program Admin > Categories > Inpatient Program checkbox is selected) during the reporting year and Client has a signed Core Health-Related Social Needs Screening Tool document during the Inpatient program admission. If it does not match this condition, it displays value as 0.
- **Meets Numerator Positive Screen for SDOH:** It displays value as 1, if Meets Denominator Positive Screen for SDOH is 1 and signed Core Health-Related Social Needs Screening Tool document > Score section > if one or more of the following Scores display "Indicated" (Living Situation HRSN, Food HRSN, Transportation HRSN, Utilities HRSN, Safety HRSN). If it does not match this condition, it displays value as 0.
- **Food Insecurity:**
    - It displays 'Indicated', if signed Core Health-Related Social Needs Screening Tool document during the Inpatient program admission start date and Inpatient Program discharge date where Food HRSN Score displays 'Indicated'.
    - It displays as 'Not Indicated', if signed Core Health-Related Social Needs Screening Tool document during the Inpatient program admission start date and Inpatient Program discharge date where Food HRSN Score displays 'Not Indicated'.
- **Housing Instability:**
    - It displays 'Indicated', if signed Core Health-Related Social Needs Screening Tool document during the Inpatient program admission start date and Inpatient Program discharge date where Living Situation HRSN Score displays 'Indicated'.
    - It displays as 'Not Indicated' if signed Core Health-Related Social Needs Screening Tool document during the Inpatient program admission start date and Inpatient Program discharge date where Living Situation HRSN Score displays 'Not Indicated'.
- **Transportation Needs:**
    - It displays 'Indicated', if signed Core Health-Related Social Needs Screening Tool document during the Inpatient program admission start date and Inpatient Program discharge date where Transportation HRSN Score displays 'Indicated'.
    - It displays as 'Not Indicated', if signed Core Health-Related Social Needs Screening Tool document during the Inpatient program admission start date and Inpatient Program discharge date where Transportation HRSN Score displays 'Not Indicated'.
- **Utility Difficulties:**
    - It displays 'Indicated', if signed Core Health-Related Social Needs Screening Tool document during the Inpatient program admission start date and Inpatient Program discharge date where Utilities HRSN Score displays 'Indicated'.
    - It displays as 'Not Indicated' if signed Core Health-Related Social Needs Screening Tool document during the Inpatient program admission start date and Inpatient Program discharge date where Utilities HRSN Score displays 'Not Indicated'.
- **Interpersonal Safety:**
    - It displays 'Indicated', if signed Core Health-Related Social Needs Screening Tool document during the Inpatient program admission start date and Inpatient Program discharge date where Safety HRSN Score displays 'Indicated'.

- It displays as 'Not Indicated' if signed Core Health-Related Social Needs Screening Tool document during the Inpatient program admission start date and Inpatient Program discharge date where Safety HRSN Score displays 'Not Indicated'.

**Where To Find It:**
**Path:** My Office -- 'IPFQR Screening SDOH' -- 'IPFQR Screening SDOH' report.

**How it Helps:**
Captures IPFQR facilities in Social Determinants of Health on all clients aged 18 years and older at the time of admission. Note that the staff must complete the SDOH screening during the Inpatient Psychiatric Facility stay. This report will also capture if a client tested positive for one or more of the following 5 Health-Related Social Needs: Food Insecurity, Housing Instability, Transportation Needs, Utility Difficulties, Interpersonal Safety.

## ~~Patient Portal~~

| ~~Reference No~~ | ~~Task No~~ | ~~Description~~ |
|---|---|---|
| ~~23~~ | ~~EII # 132758~~ | ~~Implementation to display form information that includes multi-select checkboxes submitted in the Patient Portal within the SmartCare application via API calls.~~ |

### ~~23. EII # 132758 (Feature # 620150): Implementation to display form information that includes multi-select checkboxes submitted in the Patient Portal within the SmartCare application via API calls.~~

~~**Note:** This is a passive change.~~
~~**What's Changed:**~~
~~The system now successfully retrieves and displays form data containing multi-select checkboxes in the SmartCare application, based on form submissions made in the Patient Portal using API calls.~~
~~**Where to Find It:**~~
~~**Path 1:** Login to the Intelichart using valid credentials.~~
~~**Path 2:** Client → Documents.~~
~~**How It Helps:**~~

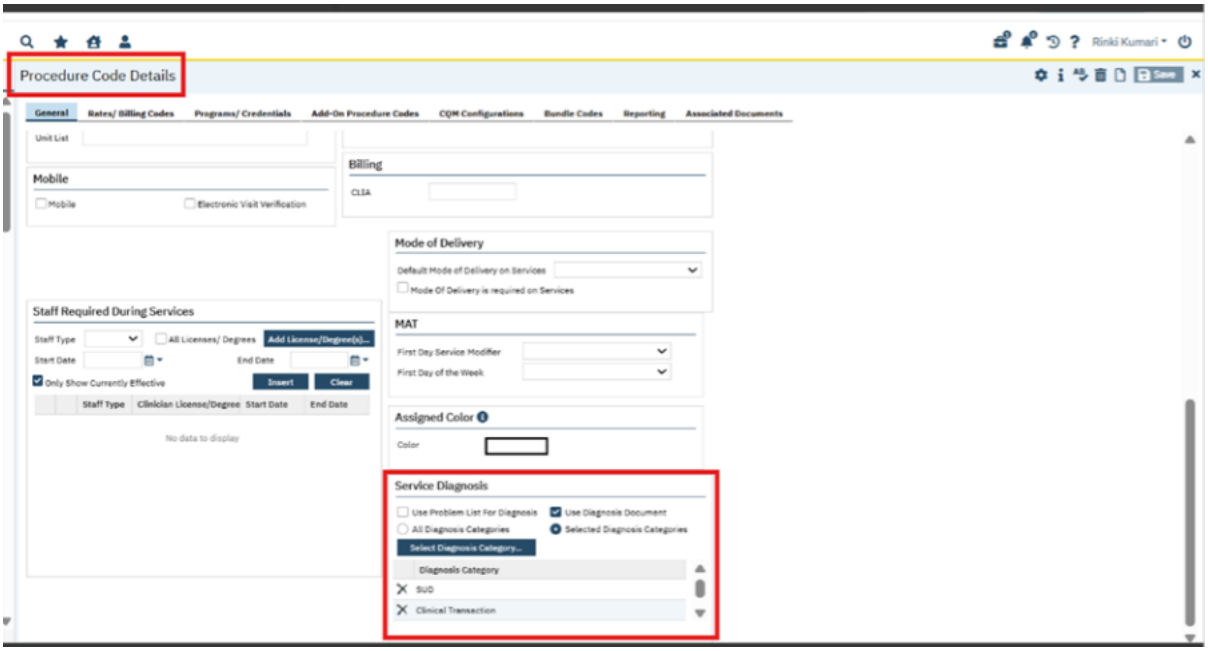
- ~~Users can now view complete form submissions, including multi-select checkbox responses, directly within the SmartCare application without manual intervention.~~
- ~~Eliminates the need to cross-check data between Patient Portal and SmartCare, reducing time and errors.~~

## Procedure/Rates

| Reference No | Task No | Description |
|---|---|---|
| 24 | EII # 132720 | Procedure Code Details: Added Service Diagnosis section. |
| 25 | EII # 130798 | Implemented changes to list the Billing Diagnosis Category configuration at the procedure level mapping. |

### 24. EII # 132720 (Feature # 618142): Procedure Code Details: Added Service Diagnosis section.

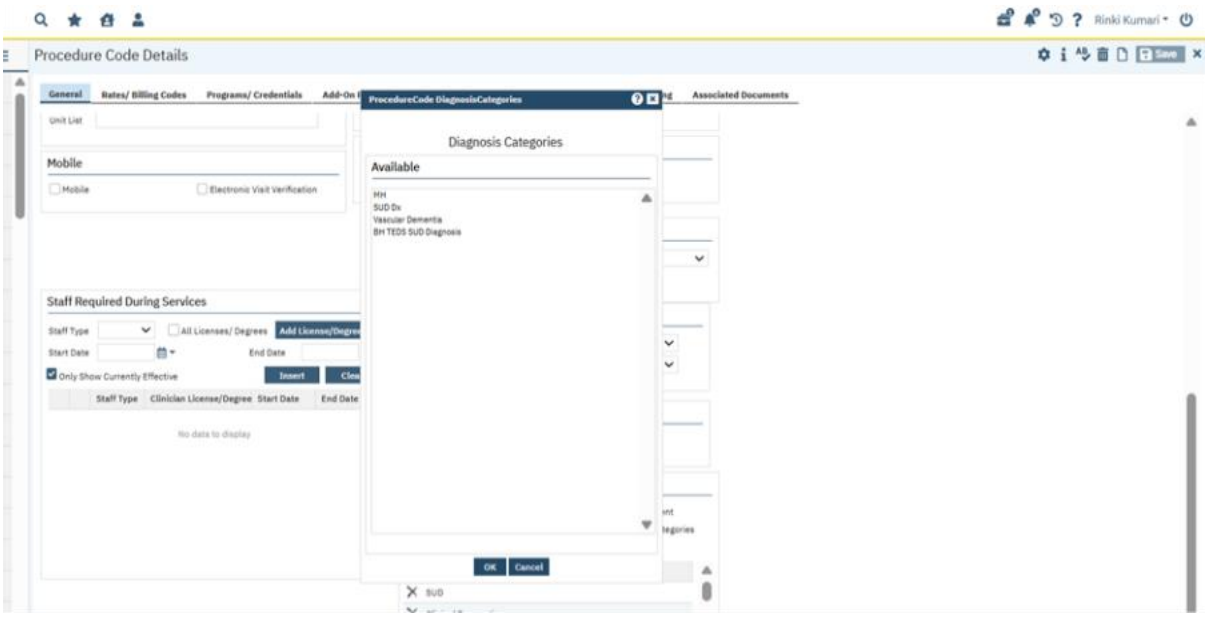
**Note:** This is passive change.
**What's Changed:**
With this release, new Service Diagnosis section has been added in the General tab of the Procedure Code Details screen. This enhancement aligns the screen functionality with the existing Service Diagnosis logic used in the Program → Service Diagnosis configuration.
**1. "Service Diagnosis" Section**




- A dedicated **Service Diagnosis** panel is now available under the **General** tab of **Procedure Code Details** screen.
- Use Problem List For Diagnosis and Use Diagnosis Document (checkboxes)
- Users can select:
  - **All Diagnosis Categories**, or
  - **Selected Diagnosis Categories**
- A **Select Diagnosis Category...** button is available to choose specific categories.
- A data grid displays selected diagnosis categories, with:
  - **Delete** option
  - **Reorder (Up/Down)** controls

**2. ProcedureCode Diagnosis Categories... pop up**

When the user clicks Select Diagnosis Category… ProcedureCode Diagnosis Categories… popup window opens:




- Lists **all available Diagnosis Categories**
- Allows **multiple category selections**
- Includes **Ok** and **Cancel** actions

**3. Popup Action Handling Enhanced**

- **Cancel Button**
  - Closes the popup without saving changes.
- **Ok Button**
  - Saves the selected diagnosis categories.
  - Closes the popup.
  - Displays selected categories in the Service Diagnosis grid.
  - Each selected category is shown as a separate row with delete.

**Prerequisites:**

The user has access to the system Configuration Key screen with edit permissions for INITIALIZEDIAGNOSISORDER and can set the key value to "Y", "N", or "B" to control the initialization and display order of diagnosis codes based on program or procedure code setup.
The configuration key is set to one of the supported values:

- "Y" – Initialize diagnosis order from the most recently signed Diagnosis Document *(default behavior)*
- "N" – Initialize diagnosis order based on Program setup or Procedure Code configuration (if defined)
- "B" – Do not initialize any diagnosis order

If the configuration key contains an invalid or unsupported value, the system will default to the "Y" behavior.

**Where to Find It:**

Login to SmartCare → Administration → Procedure/rates→ Click on Procedure/Rates name hyper link - Procedure/Rates Details screen- Service Diagnosis section.

**How It Helps:**

- Allows users to define diagnosis category rules at the procedure level.
- The user can select specific diagnosis categories that is associated with a procedure.
- Ensures accurate clinical documentation and billing validation.
- Maintains consistent diagnosis requirements across services and procedures.
- Improves control over which diagnoses are allowed or required during service entry.
- Ensures better alignment between procedure codes, clinical documentation, and claim generation by enabling granular, procedure-level diagnosis configuration.

**Data Model Changes:**

Added new columns **UseProblemListForDiagnosis**, **UseDiagnosisDocument**, and **DiagnosisDocumentCategoryAll** in the **ProcedureCodes** table.
Added **ProcedureCodeDiagnosisCategories** table.

---

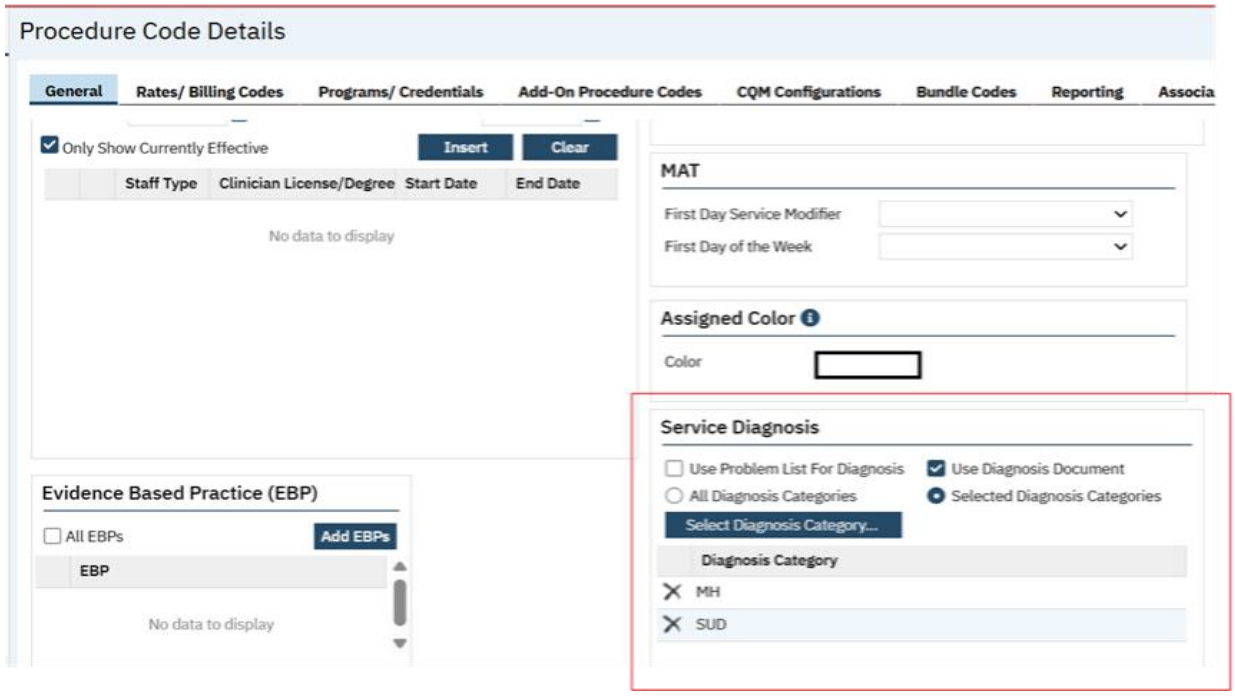
## 25. EII # 130798 (Feature 534673): Implemented changes to list the Billing Diagnosis Category configuration at the procedure level mapping.

**Note:** This is a Passive Change.

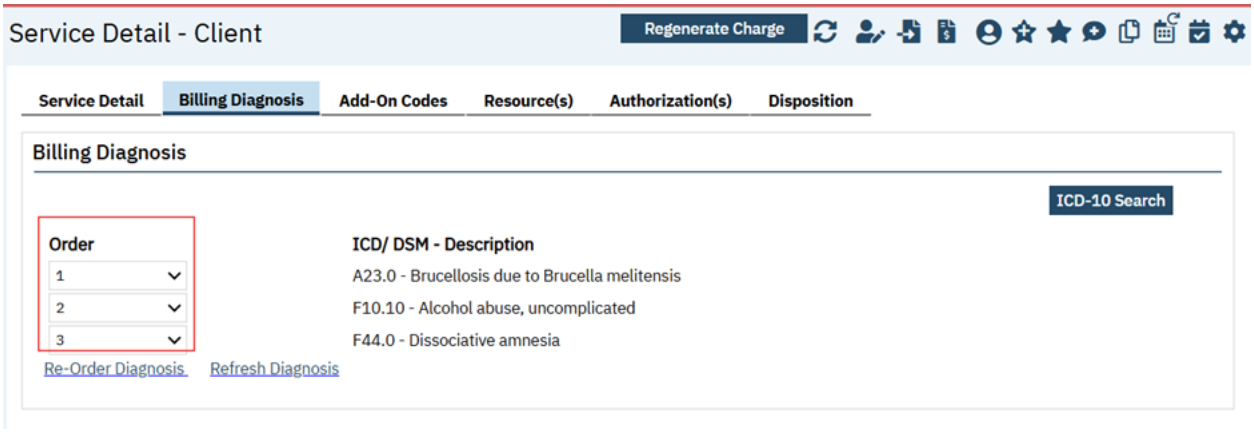
**What's Changed:**

In the Service Detail, Service Notes and Group Service Detail screens for the selected procedure, when the Diagnosis Category is mapped and the Client's Diagnosis document is signed with the Order list, the Billing Diagnosis tab will initialize with the corresponding Order and Diagnosis codes.

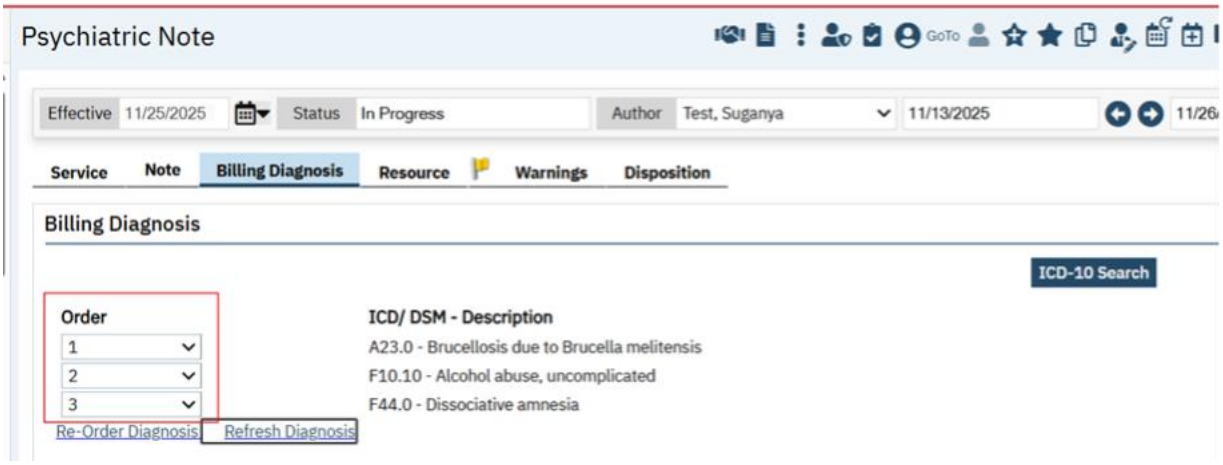
1. In the Service Diagnosis section of Procedure Code Details screen, the following diagnosis setup is done.



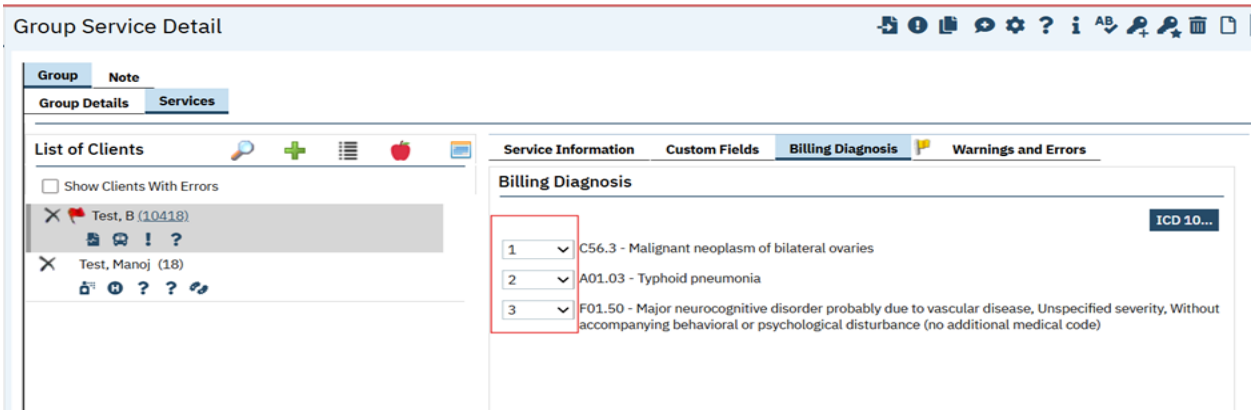

2. Based on the above Diagnosis Category, the active ICD-10 Code values is mapped to the Clients, and the Diagnosis document is signed with Billable as 'Yes' with the Order.
3. In the Service Details screen, under the Billing Diagnosis tab, both the ICD-10 code values and the Order list displays when the mapped procedure is selected.




4. In the Billing Diagnosis tab of Service/Notes Details screen, both the ICD-10 code values and the Order list displays when the mapped procedure is selected.




5. In the Billing Diagnosis tab of Group Service Details screen, both the ICD-10 code values and the Order list displays when the mapped procedure is selected.




**Prerequisites:**

1.The 'INITIALIZEDIAGNOSISORDER' system configuration key is set to N.

If the key-value is set to "N", then Diagnosis order is initialized based on the program setup. However, if the Procedure Code on the Service that has the diagnosis configured on the General tab of the Procedure Code Details screen, then that will take precedence over the Program level Setup.

**Where to Find It:**

**Path 1**: Administration --- Procedures/Rates --- Procedure/Rates List page --- Click on the hyperlink under the Procedure column --- Procedure Code Detail screen --- Under Service Diagnosis section --- Select Use Diagnosis Document checkbox --- Select Diagnosis Categories Radio button --- Select Diagnosis Category Button --- Procedure Code Diagnosis Categories popup displays --- Select Values in Available section --- Click on OK button.

**Path 2:** Perform Client Search --- Select Client --- Navigate to Services --- Client --- Click on New Icon --- Service Detail Page --- Select Prog/Proc/Loc values --- Enter all the required fields --- Navigate to Billing Diagnosis tab --- Ensure Values got initialized --- Click on Save icon.

**Path 3:** Navigate to Services/Notes --- Client --- Service/Note List Page --- Click on New Icon --- Service Note Detail page --- Select Prog/Proc/Loc values --- Navigate to Note tab --- Enter all the required fields --- Navigate

to Billing Diagnosis tab --- Ensure Values got Click on Save icon --- Click on Sign Button --- Signature popup displays --- PDF generated.

**Path 4:** My Office -- Groups -- Groups List page --- Click on New Icon --- Group Detail page --- Enter all the required fields in General tab --- Click on Save button --- Navigate to Schedule tab --- Click on New Group Service button --- Group Service Clients popup --- Select Date of Service and Clients --- Click on Select button.

**Path 5:** Navigate to Group Service Detail Screen --- In Group tab --- Navigate to Group Details tab --- Ensure all details in Group section are initialized correctly --- In Staff section --- Ensure Staff Name, Unit, Type, Start and End timings are initialized correctly ---- Navigate to Services tab --- In List of Client section --- Ensure all Clients added are present in the list --- Enter all the required fields in the Service Information Tab and Custom fields --- Navigate to Billing diagnosis tabs --- Ensure Values got initialized --- Click on Save Button.

**How It Helps:**

Allows system to select the Diagnosis Category based on the Procedure level configuration, where the Claims reflect the correct Billing Diagnosis.

To prevent claim denials and audit related payment issue, this new implementation will ensure correct NPI assignment and compliant claim submission for services involving multiple diagnosis categories.

This also allows for more granular control over diagnosis category ordering, ensuring that Procedure-specific configurations are prioritized when applicable.

---

## Reports

| Reference No | Task No | Description |
|---|---|---|
| 26 | EII # 132718 | To introduce a new configuration key 'EnableSMARTreplicaDatabaseReporting' to utilize the SMARTreplica Database for reporting purposes. |
| 27 | EII # 132108 | SMARTreplica Database: SC Operational Reports to be redirected to query a mirror or read-only replica database as this offloads reporting workloads from the primary system, helping maintain application responsiveness and stability. |
| 28 | EII # 132470 | SmartReplica Database for SmartCare Operational Reports. |
| 29 | EII #132562 | Implementation of 'Staff Caseload with address and phone' and 'Staff Roles and Permissions'. |
| 30 | EII # 132069 | Implementation of Therapy Progress Report. |

### 26. EII # 132718 (Feature # 602197): To introduce a new configuration key 'EnableSMARTreplicaDatabaseReporting' to utilize the SMARTreplica Database for reporting purposes.

**Note:** This is Passive Change.

**What's Changed:**

A new configuration key 'EnableSMARTreplicaDatabaseReporting' is introduced. This setting controls whether the system will utilize the SMARTreplica Database for reporting purposes.

**System Configuration Key Details:**

**Key Name:** EnableSMARTreplicaDatabaseReporting

**Read Key as:** Enable SMART replica Database Reporting.

**Default Value:** No

**Allowed Values:** Yes, No

**Description:**

This is a new feature being added to the core product by introducing a system configuration key. This setting controls whether the system can utilize the SMARTreplica Database for reporting purposes.

a) If the config key value is "No", then the checkbox "Use Replica Data Source" will be hidden in the Report Detail screen. **This will be the default value of the key as it drives the existing behavior**.

b) If the config key value is "Yes", then the checkbox "Use Replica Data Source" will be displayed in the Report Detail screen. The system can utilize the SMARTReplica Database for reporting purposes.

**Note:**

1. If by chance the value of the key is updated with any value apart from the allowed values, the system will **consider the default behavior, i.e. same as the value "No"**

2. This functionality will work only in the Production environment where the SMARTreplica Database is setup.

3. These changes applies only to customers who have purchased this functionality.

**Where To Find It:**

**Path:** Login to SmartCare → Configuration Keys (Administration)

**How It Helps:**

To reduce the performance impact on the primary production database, reports can be redirected to query a mirror or read-only replica database. This approach offloads reporting workloads from the primary system, helping maintain application responsiveness and stability.

**Date Model Changes:**
New column named 'DataSourceServerPath' and
'DataSourceReplicaServerPath' are added to the ReportServers table.

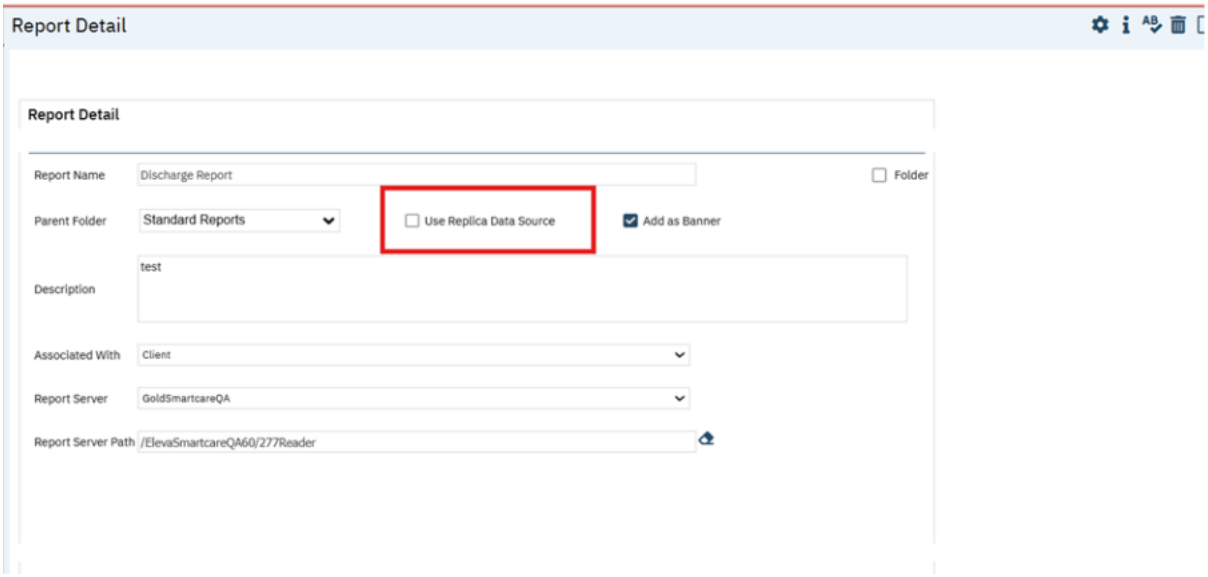
---

## 27. EII # 132108 (Feature # 572699): SMARTreplica Database: SC Operational Reports to be redirected to query a mirror or read-only replica database as this offloads reporting workloads from the primary system, helping maintain application responsiveness and stability.

**Note:** This is Passive Change.
**What's Changed:**

A new checkbox labelled "Use Replica Data Source" has been introduced in the 'Report Details' screen.
**'Use Replica Data Source' field details:**

- The **Use Replica Data Source** field is a checkbox.
- By default, the checkbox is **unchecked**.
- The checkbox will be displayed only if the configuration key **'EnableSMARTreplicaDatabaseReporting'** is set to "Yes".
- If the configuration key 'EnableSMARTreplicaDatabaseReporting' value is **"No"**, the checkbox will remain hidden.
- When the checkbox is checked and the SMARTreplica Database setup is missing (i.e., either 'DataSourceServerPath' or 'DataSourceReplicaServerPath' or both are NULL in the ReportServers table), then upon saving the Report Details, a **red validation message** will be displayed: **Validation Message:** *"SMARTreplica Database setup is missing."*




**Where To Find It:**
**Path**: Login to SmartCare → Reports (Administration) → Click on the report name hyperlink.

**How It Helps**:
To reduce the performance impact on the primary production database, reports can be redirected to query a read-only replica database. This approach offloads reporting workloads from the primary system, helping maintain application responsiveness and stability.

**Data Model Changes**: New columns named **'UseReplicaDataSource'** and **'IsUsingReplicaDataSource'** are added to the **Reports** table.

---

## 28. EII # 132470 (Feature # 602198): SmartReplica Database for SmartCare Operational Reports.

**Note:** This is Passive Change.

**What's Changed:**
The Reporting has been enhanced to dynamically redirect reports to the replica database based on the system setup and system configuration before the report is opened.
System Configuration key "EnableSMARTReplicaDatabaseReporting" will control whether the system can utilize the SMART replica database for reporting purposes.

The Stored procedure ssp_SetReportDataSource executes "IsUsingReplicaDataSource" column will update to 'Y' or 'N' in the Reports table according to the usage of the SmartReplica DataBase by the Reports.
Column IsUsingReplicaDataSource, indicates whether the report is currently using the replica data source.

**Where To Find It:**
Login to SmartCare → Reports (Administration) → do the system setup and system configuration set up - Run the Reports.

**How It Help's**: To reduce the performance impact on the primary production database, reports can be redirected to query a read-only replica database. This approach offloads reporting workloads from the primary system, helping maintain application responsiveness and stability.

**Data Model Changes**:

1. A new column named '**UseReplicaDataSource'** and **'IsUsingReplicaDataSource'** are added to the **Reports** table.

---

## 29. EII # 132562 (Feature # 608739): Implementation of 'Staff Caseload with address and phone' and 'Staff Roles and Permissions'.

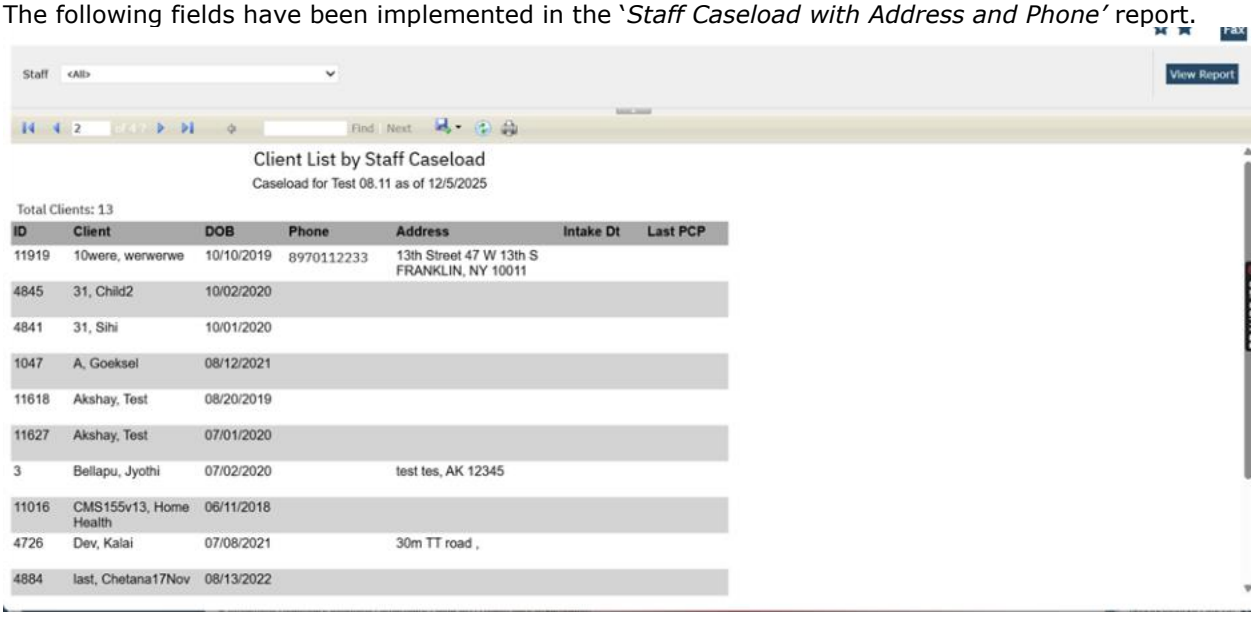
**Note:** This is Passive Change.

**What's Changed:**
The following two reports are implemented:

- Staff Caseload with Address and Phone
- Staff Roles and Permissions

A new recode category 'SetDocumentCodeIdForLastPCPField' has been implemented to map the document code id to initialize the effective date of the most recently signed document which is mapped in the recode. The effective date of the document will be initialized to Last PCP column in the **'Staff Caseload with address and phone'** report.
If for any Document, the Document Code Id is not specified in the Recode category, the "Last PCP" field will be blank for that 'Client' in the report.

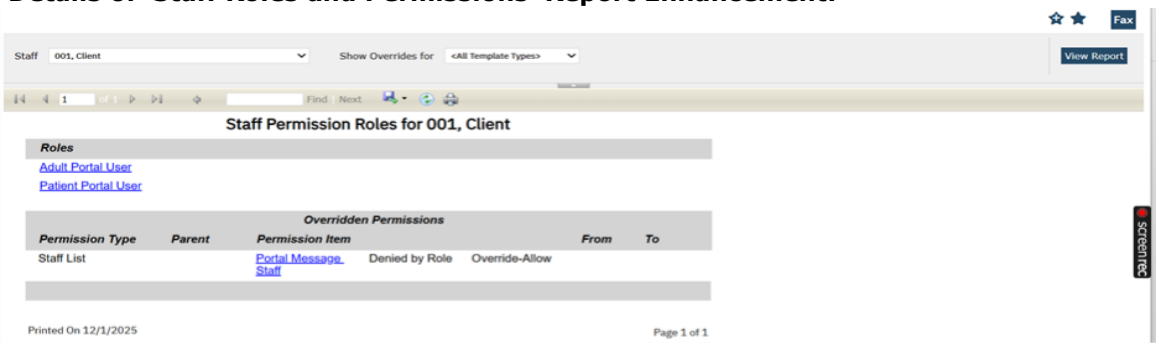
**Details of 'Staff Caseload with address and phone' Report Enhancement.**
The following fields have been implemented in the '*Staff Caseload with Address and Phone'* report.



This report will list the client details based on the selected 'Primary Clinician' filter.

- **Staff** - Drop down in Filter section, it lists all the Staff and All are displayed by default.
- **ID** – This column in the grid displays the Client IDs.
- **Client** – This column displays the Client name in the format of Last Name, First Name.
- **DOB** – This column displays the 'Date of Birth' of the Client.
- **Phone** – This column displays the 'Phone Number' of the Client.
- **Address** – This column displays the Client's address.
- **Intake Date** – This column displays the 'Assessment Date' from the 'Client Episode' tab in 'Client Information' screen.
- **Last PCP** – Displays the Effective Date of the most recently signed document which is mapped in the recode category SetDocumentCodeIdForLastPCPField.

**Details of 'Staff Roles and Permissions' Report Enhancement:**

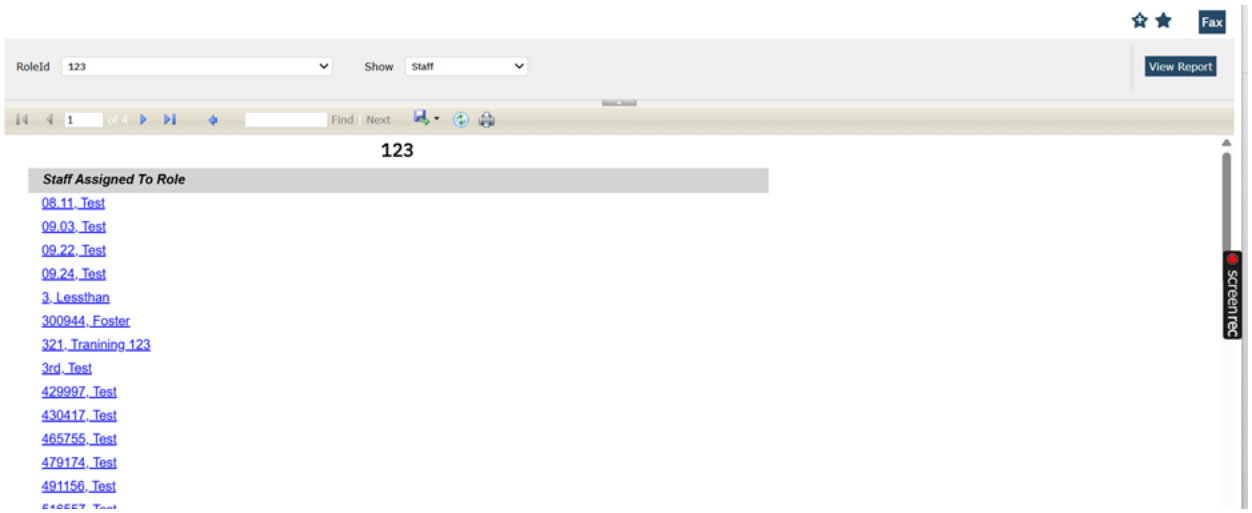



- **Staff** – 'Staff' dropdown in the filter section lists all the 'Active Staff'
- **Show Overrides for** – Displays all the 'Permission types' in 'Templates present' dropdown

The report displays two sections as follows:

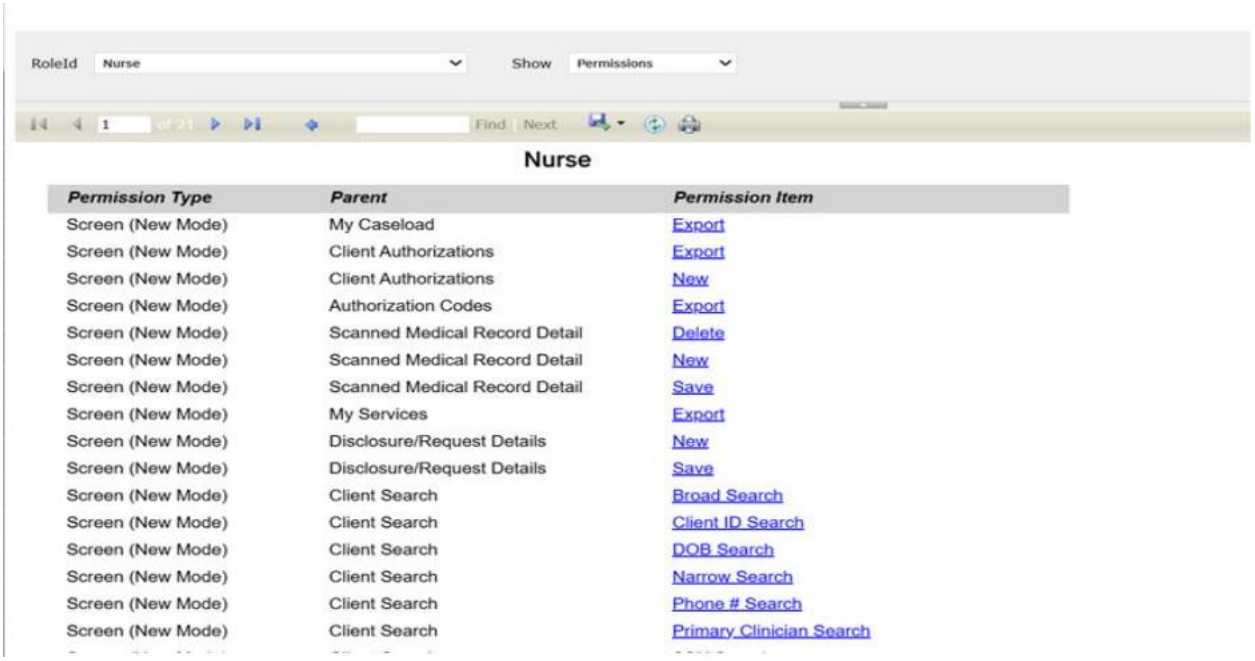
- Roles
- Overridden Permissions

**First Section of Main Report-- Roles** – The Roles section in the grid displays the assigned Roles for the selected Staff.
When the user clicks the 'Roles' hyperlink, it will navigate to a sub-report that includes the 'Role ID' and 'Show' dropdown fields in the filter section. The 'Show' dropdown is auto populated with "Staff," and the user must manually select a 'Role ID' to proceed.
The report displays the staff members assigned to the selected role.

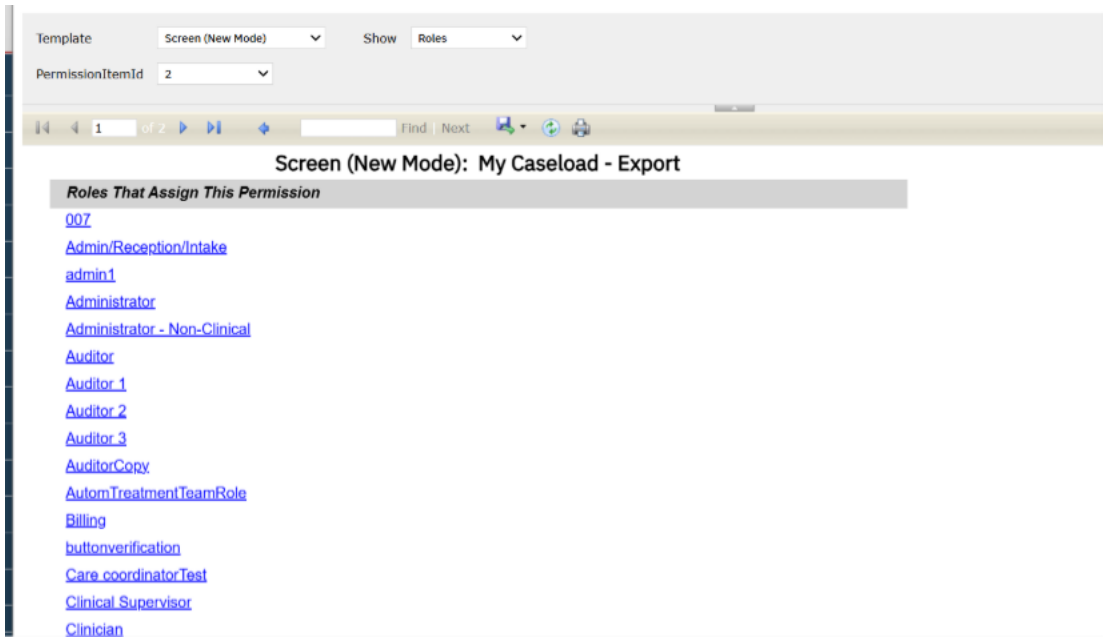



When "Permissions" is selected in the 'Show' dropdown in Filter section, the report displays the following fields:

- Permission Type
- Parent
- Permission Item (as a hyperlink)

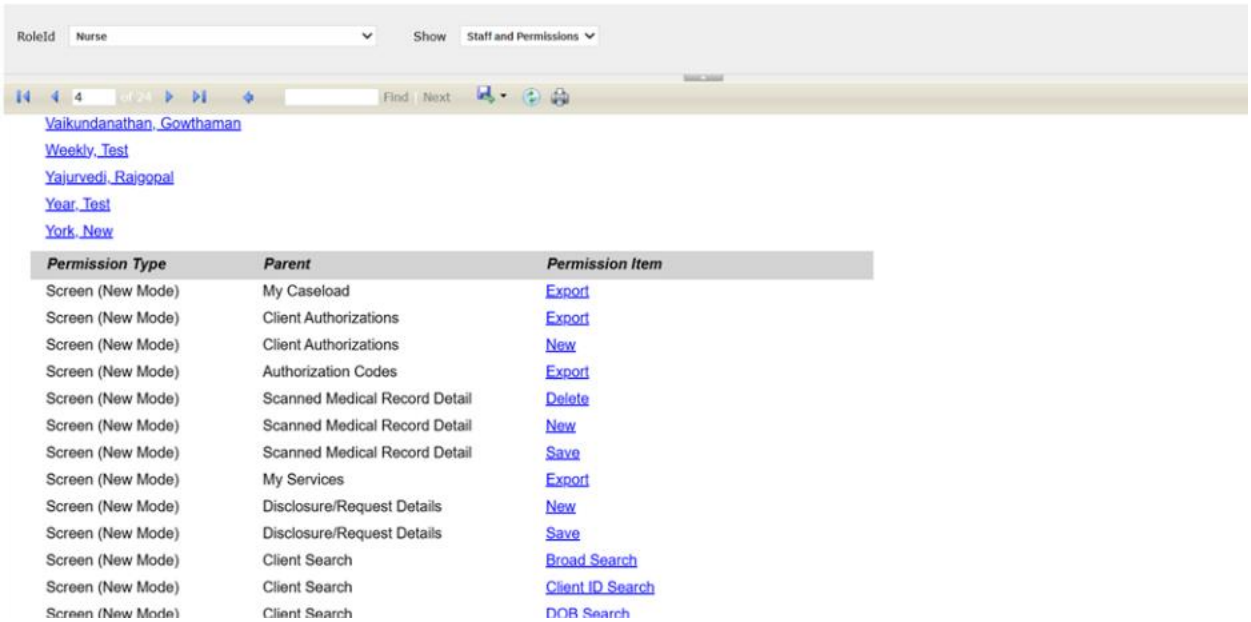



When the user clicks the 'Permission Item' hyperlink, the report displays all roles that are assigned the selected permission.




When both 'Permission' and 'Staff' are selected in the 'Show' dropdown under Filter section, the report displays two sets of information:

- Staff assigned to the selected Role, and
- Set of Permissions.

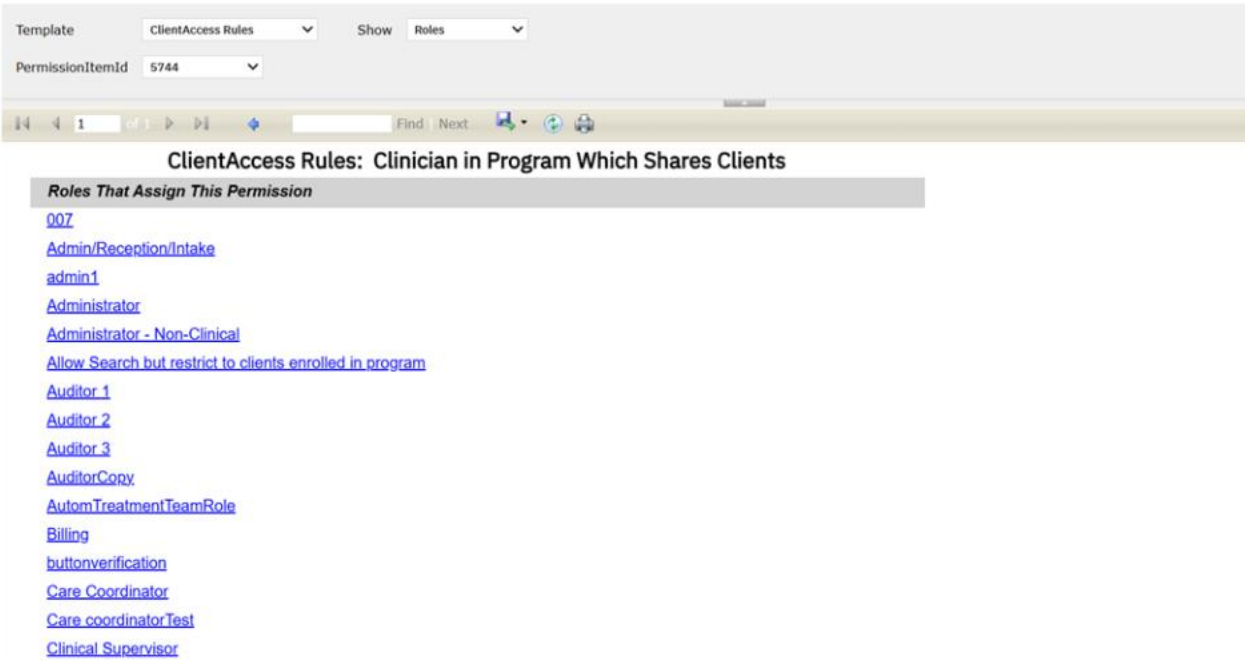



**Second Section of Main Report--Overridden Permissions –** The Overridden Permissions section displays the below fields:

- **Permission Type** – Displays the Permission Type in which the permission has been overridden in Staff Details screen.
- **Parent** – Displays the Parent of the particular Permission Type.
- **Permission Item** – Displays the Permission Item which is overridden. This is displays as a hyperlink.

- **From and To** – Displays the From date and To date of the overridden permission item.


When the user clicks the 'Permission Item' hyperlink, it will navigate to the sub-report that displays the **'Roles That Assigned This Permission'.**




**Filter values of Sub report:**

- **Template:** Displays all the Permission templates. When navigated from main report by clicking on Permission Item and that particular Template is auto selected.
- **Show:** Have three dropdown values Roles, Staff and Roles and Staff options. Roles is defaulted when navigated from main report by clicking on Permission Item.
- **Permission Item ID:** Displays the Permission Item ID.

The sub-report displays the Roles that are assigned to the selected Permission, and each Role is shown as a hyperlink. When the user clicks on a 'Role' hyperlink, the report displays the Staff members assigned to that Role.

**Where to Find It:**
**Path 1:** My Office – My Reports - Staff Caseload with address and phone.
**Path 2:** My Office – My Reports - Staff Roles and Permissions.

**How It Helps:**

- These reports, 'Staff Caseload with Address and Phone' and 'Staff Roles and Permissions' help customers retrieve list of case load information or client lists and details. And also helps to get the list of Roles and Overridden Permissions for the selected staff.

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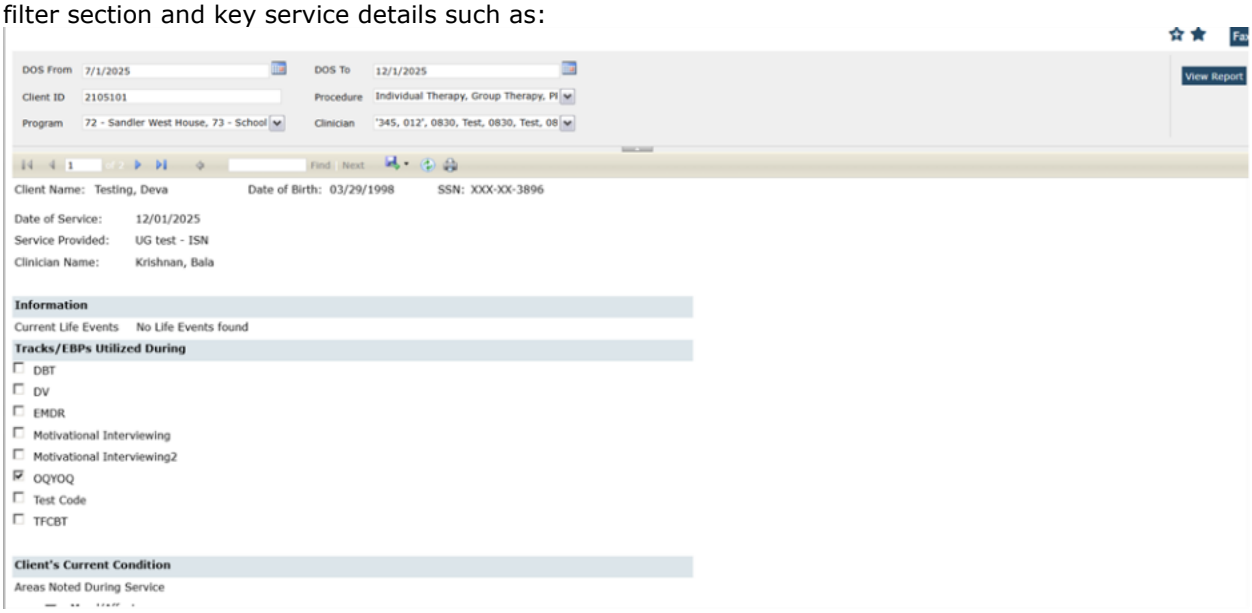
## 30. EII # 132069 (Feature # 570430): Implementation of Therapy Progress Report.

**Note:** This is Passive Change.

**What's Changed:**
With this release, implemented a new **Therapy Progress Report**. This report displays detailed information for all services that have a **signed Individual Service Note** within the selected date range. The report includes filter section and key service details such as:




**Filter Section includes the following fields:**

- **DOS From:** This is a Date Control Text Box, this is a required field and by default it displays blank.
- **DOS To:** This is a Date Control Text Box, this is a required field and bydefault it displays blank.
- **Client ID:** This is a Text Box, this is a required field and by default it displays blank.
- **Procedure:** This is a Multi select drop down and lists all procedure codes where the linked document = 'Individual Service Note'. By default, it displays 'All'
- **Program:** This is a Multi select drop down and lists all Programs which are mapped to the procedure codes where the linked document = 'Individual Service Note'. This is a required field and by default it displays 'All'.
- **Clinician:** This is a multiselect drop down and displays all active clinicians.

**Key service details:**

- **Client Name:** Displays Client's Name from Client Information.
- **Date of Birth:** Displays Client's Date of Birth from Client information screen.
- **SSN:** Displays last 4 digit of Client's SSN in XXX-XX-1234 format.
- **Date of Service (DOS):** Displays Date of Service associated with the service.

- **Clinician Name:** Displays Clinician Name from the service note.

**Grid section:** The below details are displayed from the signed **Individual Service Note** Content (summary, based on configuration).

**Billing Diagnosis:** Displays all billing diagnosis from the service notes.
**Current Life Events:** This is a label, Displays the value from Individual Service Note -> Note -> General -> Information.
**Tracks/EBPs Utilized During the Session**: Displays the value from Individual Service Note -> Note -> General -> Tracks/EBPs Utilized During the Session.
**Objectives Addressed by this Service:** Displays the value from Individual Service Note -> Note -> General -> Objectives Addressed by this Service.
**Client's Current Condition:** This is the label header.
**Areas Noted During Service**: Displays the value from Individual Service Note -> Note -> General -> Areas Noted During Service.
**Suicidality*:** Displays the value from Individual Service Note -> Note -> General -> Suicidality*.
**Harm to Others*:** Displays the value from Individual Service Note -> Note -> General -> Harm to Others*.
**Harm to Property*:** Displays the value from Individual Service Note -> Note -> General -> Harm to Property*.
**Safety Plan:** Displays the value from Individual Service Note -> Note -> General -> Safety Plan section.
**Intervention/Progress:** This is a header.
**What was the focus of the session (i.e. alleviation of emotional disturbances, reversal or change of maladaptive Patterns or behaviors, encouragement of personality growth or development)?** : This is a label : Displays the value from Individual Service Note -> Note -> General -> What was the focus of the session (i.e. alleviation of emotional disturbances, reversal or change of maladaptive Patterns or behaviors, encouragement of personality growth or development)?.
**Describe the interventions provided:** Displays the value from Individual Service Note -> Note -> General -> Describe the interventions provided.

**Describe the client's response to the intervention, progress made toward goals and clients strengths. If progress is not being made, describe reasons and barriers to progress:** This is a label, Displays the value from Individual Service Note -> Note -> General -> Describe the client's response to the intervention, progress made toward goals and clients strengths. If progress is not being made, describe reasons and barriers to progress.

**Document the plan. If there were barriers describe the plan to overcome the barriers**: This is a label, displays the value from Individual Service Note -> Note -> General -> Document the plan.
**Plan from Last Service:** This is a label. Display the value from Individual Service Note -> Note -> General -> Plan from Last Service.
**Prerequisite:** An Individual Service note is signed.

**Where to Find It:**
**Path:** 'My Office' – 'Therapy Progress Report' – Enter the filter values – Click on Apply filter.

**How It Helps:**
This enhancement ensures that users can easily review therapy progress by accessing all relevant signed notes in one consolidated report.

## Rollback Electronic Remittance

| Reference No | Task No | Description |
|---|---|---|
| 31 | EII # 132799 | 835 ER File Reports and the 835 Rollback Process - Front End: To ensure accurate tracking of user actions by capturing the actual staff member who performs an ERFile rollback. |
| 32 | EII # 130891 | Implementation of "835 Rollback Report". |

## 31. EII # 132799 (Feature # 622934): 835 ER File Reports and the 835 Rollback Process - Front End: To ensure accurate tracking of user actions by capturing the actual staff member who performs an ERFile rollback.

**Note:** This is Passive Change.
**What's Changed:**
When an ERFile was rolled back from the frontend, the system automatically updated the deletedBy field to "ERFileRollback", making it impossible to identify which staff member performed the rollback action. The front end now captures the logged-in user's code during the rollback. This user code is sent to the backend and saved into the DeletedBy field. Each rollback action can now be clearly linked to the staff member who performed it. This improves auditing, compliance, and traceability of ERFile rollback operations.

**Where To Find It:**
**Path 1:** Go to 'My Office' -- Select 'Payments/Adjustments ' -- Payments/Adjustments list page -- click the Rollback Electronic Remittance icon -- Rollback Electronic Remittance" pop-up window is displayed -- Select the radio button for the specific ER File Id -- Click on Rollback ER button -- Confirmation pop-up appears with the message: "Are you sure you want to Rollback this ER File?" -- Click on Yes.
**Path 2:** Navigate to 'Administration' -- Select 'Table Editor' -- Table Editor screen -- Select Table name from table dropdown -- Click on Execute button -- DeletedBy field is displayed.

**How it Helps:**
Previously, the deletedBy field shows a generic value ("ERFileRollback"), preventing proper auditability. This change allows the frontend to send the logged-in user's code during rollback so the system can correctly record who initiated the action, improving traceability, accountability, and audit compliance.

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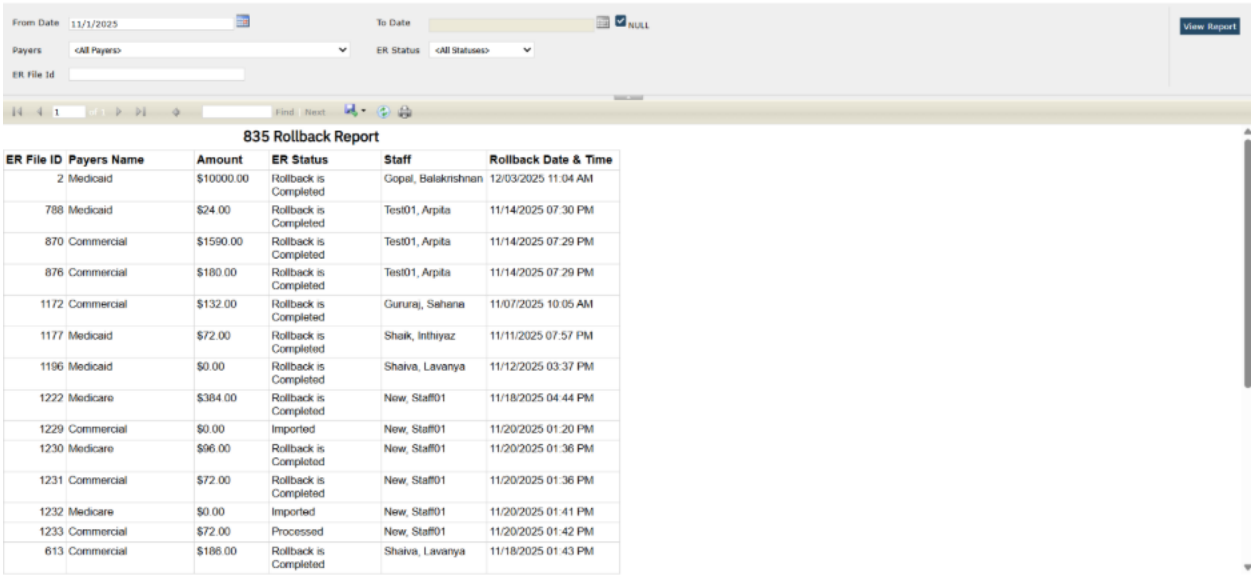
## 32. EII # 130891 (Feature # 538352): Implementation of "835 Rollback Report".

**Note:** This is Passive Change.
**What's Changed:**

With this release, implemented a new report, "835 Rollback Report," where it is able to run 835 Rollback Report, and which displays the details of the rolled back ER files such as the ER File ID, associated staff name, Rollback date and time and Current ER status, to ensure accurate tracking, traceability, and accountability of each rollback operation.

The "835 Rollback Report" has been implemented with the below-mentioned fields:




835 Rollback Report

| ER File ID | Payers Name | Amount | ER Status | Staff | Rollback Date & Time |
|---|---|---|---|---|---|
| 2 | Medicaid | $10000.00 | Rollback is Completed | Gopal, Balakrishnan | 12/03/2025 11:04 AM |
| 788 | Medicaid | $24.00 | Rollback is Completed | Test01, Arpita | 11/14/2025 07:30 PM |
| 870 | Commercial | $1590.00 | Rollback is Completed | Test01, Arpita | 11/14/2025 07:29 PM |
| 876 | Commercial | $180.00 | Rollback is Completed | Test01, Arpita | 11/14/2025 07:29 PM |
| 1172 | Commercial | $132.00 | Rollback is Completed | Gururaj, Sahana | 11/07/2025 10:05 AM |
| 1177 | Medicaid | $72.00 | Rollback is Completed | Shaik, Inthiyaz | 11/11/2025 07:57 PM |
| 1196 | Medicaid | $0.00 | Rollback is Completed | Shaiva, Lavanya | 11/12/2025 03:37 PM |
| 1222 | Medicare | $384.00 | Rollback is Completed | New, Staff01 | 11/18/2025 04:44 PM |
| 1229 | Commercial | $0.00 | Imported | New, Staff01 | 11/20/2025 01:20 PM |
| 1230 | Medicare | $96.00 | Rollback is Completed | New, Staff01 | 11/20/2025 01:36 PM |
| 1231 | Commercial | $72.00 | Rollback is Completed | New, Staff01 | 11/20/2025 01:36 PM |
| 1232 | Medicare | $0.00 | Imported | New, Staff01 | 11/20/2025 01:41 PM |
| 1233 | Commercial | $72.00 | Processed | New, Staff01 | 11/20/2025 01:42 PM |
| 613 | Commercial | $186.00 | Rollback is Completed | Shaiva, Lavanya | 11/18/2025 01:43 PM |

Filter Section: In the filter section the below fields will be displayed.
**From Date:** This is a Date Control text field. The date will be displayed in the format of "MM/DD/YYYY". This is a required field. The Default date for the From Date field will be the first day of the previous month.
**To Date:** This is a Date Control text field. The date will be displayed in the format of "MM/DD/YYYY". By default, it displays blank.
**Payers:** This is a drop-down field. The 'Payers' dropdown will have the option such as 'All Payers' and with all the active Payers created in the application. By default, it displays "All Payers "value.
**ER Status:** This is a drop-down field. The 'ER Status' dropdown will have the option such as 'All Statuses' and with all the active statutes in the application. By default, it displays "All Statuses" value.
**ER File ID:** This is a Text-box field, the records will be displayed based on the ER File Id entered. By default, it displays 'Blank'.
**"View Report"** Button**:** On clicking this button, the report displays in the grid section with the specified filter criteria.
**Grid Section:** The Grid section is displayed below columns:
**1. ER File ID:** This column will display the ER file Id.
**2. Payers Name:** This column displays the Payers name associated with the ER File.
**3. Amount:** This column displays the amount associated with the ER File.
**4. ER Status:** This column displays the status of the ER file.
**5. Staff:** This column displays the name of the staff member who performed the rollback in the Last Name, First Name format. Example: Deo, John
**6. Rollback Date & Time:** This column displays the associated rollback date and time in the MM/DD/YYYY HH:MM AM format.

**Where to Find It:**
**Path :** Go to the 'My Office' – 'My Reports' – In the search text box enter "835 Rollback Report" and click on 'Apply Filter' button – the report will be displayed in the 'Grid' section – Click on 'Report Name' hyperlink – report will be opened in a new window – enter the required data in the 'Filter' section and click on 'View' report button.

**How It Helps:**
This 835 Rollback Report has been created to track all ER file rollback operations, capturing the ER File ID, roll back ER files with details of staff, date and time, and current status to improve auditability, traceability, and accountability.

## RWQM

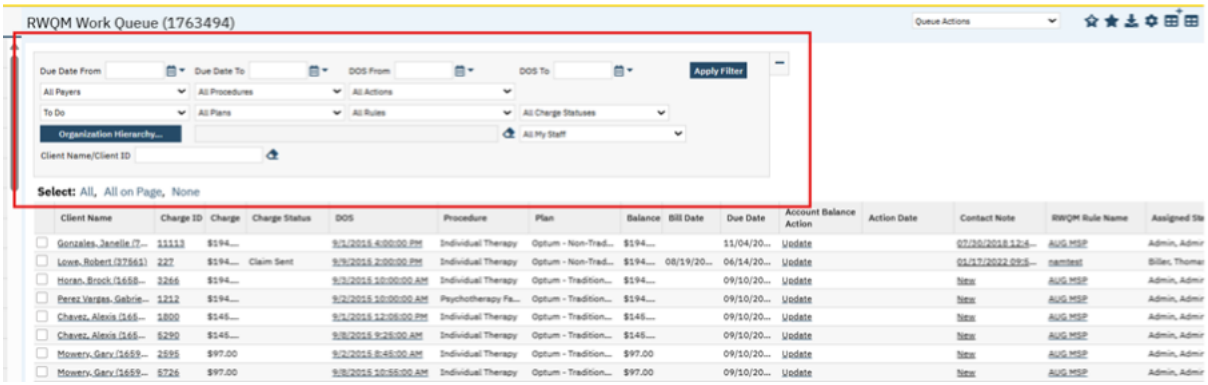
| Reference No | Task No | Description |
|---|---|---|
| 33 | EII # 132750 | RWQM Work Queue: a blank white line and a small box in the filter section. |

### 33. EII # 132750 (Feature # 618931): RWQM Work Queue: a blank white line and a small box in the filter section.

**Note:** This is Passive Change.

**What's Changed:**
With this release, a blank white line and a small box has been removed, that appeared in the filter box of 'RWQM Work Queue' list page.

**Screenshot of 'RWQM Work Queue' list page**




**Where To Find It:**
**Path:** 'My Office' – 'RWQM Work Queue'.
**How It Helps:**

- Ensures that the RWQM Work Queue screen displays correctly.
- Provides a clean, professional, and user-friendly interface by removing any unintended visual artifacts that appear during filtering operations

## Rx Application

| Reference No | Task No | Description |
|---|---|---|
| 34 | EII # 132797 | Implementation to auto initialize Unit and Potency Unit based on Medication Strength in Rx. |
| 35 | EII # 132826 | To automatically calculate Dispense Quantity (Dispense Qty) for specific medication. |
| 36 | EII # 132618 | Laman's Terms: Implementation of Dose initialization and unit Initialization based on the StrengthUnit = Unit. |

## 34. EII # 132797 (Feature # 622891): Implementation to auto initialize Unit and Potency Unit based on Medication Strength in Rx.

🟧 **ACTIVE CHANGE**

This change request updates the Rx module's initialization logic for **Dose**, **Unit**, and **Potency Unit** fields when pulling in **pre-layman's medication orders**.

**What's Changed:**

In the Rx Application -- on the Re-Order page, when user selects the radio button for the medication in the Medication List, the below changes are made:

- **Dose** will initialize as blank.
- **Unit** and **Potency Unit** will auto-initialize based on medication strength.
- **Dispense Qty** will be auto-calculated once Dose is entered based on below calculation.

**Dispense Qty Calculation Logic**:

- **Scenario A** (Unit = Each):

Dispense Qty = Dose x Frequency x Days

- **Scenario B** (Unit ≠ Each):
  Dispense Qty = (Dose+Unit) / Strength x Frequency x Days
- It will reduced manual steps and improved prescription readiness.

**Prerequisites**:

1.Prescribe the medication via below New Order path

Login to SmartCare Application – Client Search – My Office – Medications – Rx application – Start Page – Patient Summary – New Order button – New Medication Order Page - Select the Drug with starting three letters – Fill all required fields – click on 'Insert' button - Fee-Text Sig popup - Update the Instruction(Sig) - Click 'Update and Close' button - Select the EPCS Pharmacy – Click on 'Prescribe' button – Prescribe page – Click on 'Prescribe' button - 'Patient Summary' page

**2.**Queue the medication via below New Order path

**New order Path**: Login to SmartCare Application – Client Search – My Office – Medications – Rx application – Start Page – Patient Summary – New Order button – New Medication Order Page - Select the Drug with starting three letters – Fill all required fields – click on 'Insert' button - Fee-Text Sig popup - Update the Instruction(Sig) - Click 'Update and Close' button – Click on '**Queue Order**' button - 'Patient Summary' page

3. Create a client order of medication type in the SmartCare Application via below path

**Client Order Path** - Login to SmartCare Application – Client Search – Client Order – New – Client Order details page – Search and Select the medications – Fill the required fields – Click Sign button - Signature Page popup - Sign the Client Order

**Where to Find It:**

**Re-Order Path:** Login to SmartCare Application – Client Search – My Office – Medications – Rx application – Start Page – Patient Summary – Select the medication in medication list - Click Re-Order button – Re-Order Medication Page - Select the radio button - Fields in Medication grid populated – Click on 'Modify' button -Free-Text Sig popup - - Click 'Update and Close' button - Click on 'Prescribe' button – Prescribe page – Click on 'Prescribe' button - 'Patient Summary' page

**Change Order Path**: Login to SmartCare Application – Client Search – My Office – Medications – Rx application – Start Page – Patient Summary – Select the medication in medication list - Click Change Order button – Change Medication Page - Select the radio button - Fields in Medication grid populated – Click on

'Modify' button - Free-Text Sig popup - - Click 'Update and Close' button - Click on 'Prescribe' button – Prescribe page – Click on 'Prescribe' button - 'Patient Summary' page

**Adjust Dosage/Schedule path:** Login to SmartCare Application – My Office Tab – Medications – Rx application – Start Page - Queued Order page - Select the medication radio button - Click Adjust Dosage/Schedule button - Adjust Dosage/Schedule page - Select the radio button - Fields in Medication grid populated – Click on 'Modify' button – Free-Text Sig popup - Click 'Update and Close' button - Click 'Save Adjustments' - Prescribe Page - Click 'Update Order' - Queued Order page

**Pharmacy Refill Request Reorder path:** Login to SmartCare Application – My Office Tab – Medications – Rx application – Start Page -' Pharmacy Refill Request' tab - Click 'Approve with Changes' button - Re-Order Medication Page - Select the radio button - Fields in Medication grid populated – Click on 'Modify' button –Free-Text Sig popup - Click 'Update and Close' button - Click on 'Prescribe' button – Prescribe page – Click on 'Prescribe' button - Start Page

**Patient Refill Request Reorder path:** Login to SmartCare Application – My Office Tab – Medications – Rx application – Start Page -' Patient Refill Request' tab - Click 'Approve with Changes' button - Re-Order Medication Page - Select the radio button - Fields in Medication grid populated – Click on 'Modify' button – Free-Text Sig popup - Click 'Update and Close' button - Click on 'Prescribe' button – Prescribe page – Click on 'Prescribe' button - Start Page

**Complete Order Path:** Login to SmartCare Application – Client Search – My Office – Medications – Rx application – Start Page – Patient Summary – Select the SmartCare order in medication list - Click Complete Order button – Complete Medication Page - Select the radio button - Fields in Medication grid populated – Click on 'Clear' button - Click on 'Prescribe' button – Prescribe page – Click on 'Prescribe' button - 'Patient Summary' page

**How It Helps:**

- Reduces manual input.
- Improves workflow efficiency by auto-initializing fields and calculating **Dispense Quantity** based on entered values.

---

## 35. EII # 132826 (Feature # 623823): To automatically calculate Dispense Quantity (Dispense Qty) for specific medication.

🟧 **ACTIVE CHANGE**

**What's Changed:**

The Dispense Quantity now correctly calculates for medications with the below units and potency units in the Rx Application across the Order screens in the below scenarios. Previously, the system did not perform this calculation for Dispense Quantity and caused users to manually calculate this.

- When **Unit = 'Each'** and the **Potency Units** is one of the following: Tablet, Capsule, Each, Blister, Film, Gram, Gum, Implant, Insert, Kit, Lancet, Lozenge, Milliliter, Packet, Pad, Patch, Pen Needle, Ring, Sponge, Stick, Strip, Suppository, Swab, Troche, Unspecified, or Wafer.
- **Formula: When Unit = 'Each'**

  **Dispense Quantity = (Dose+Unit) * (Frequency) * (# of Days)**
- **When Unit = 'Each' and Potency Units is one of the following: Gram, Kit, Milliliter, or Unspecified, Dispense Quantity will be initialized as '1'.**

**Example: When Unit = 'Each'**

**Medication Strength:** buprenorphine 12 mg-naloxone 3 mg sublingual film
**Dose+Unit:** 2 each
**Frequency:** 3 Times Per Day
**Days:** 30
**Potency Units:** Film
**Dispense Quantity = (Dose+Unit) * (Frequency) * (# of Days)**
**Dispense Qty:** (20 each) x (3) x (3) **= 180 Films**

**Example: When Unit = 'Each' and Potency Units = 'Kit'**
**Medication Strength:** Blood Pressure Kit
**Dose+Unit:** 1 each
**Frequency:** Daily
**Days:** 10
**Potency Units:** Kit
**Dispense Qty:** 1

**Where To Find It:**
**Path 1:** Login to SmartCare Application – Search and Select a client – Search for Medication Management (Client) – Patient Summary screen (Rx Application)—Click on New Order button – In New Medication Order screen select a medication having unit as each —Enter all the required fields – Check the Dispense Quantity is calculated -- Click on Insert button – Click on prescribe button – IN Prescribe screen click on prescribe button.
**Path 2:** Login to SmartCare Application – Search and Select a client – Search for Medication Management (Client) – Patient Summary screen (Rx Application) – Select a medication and click on Re order Button – In Re-Order Medication order screen select a medication having unit as each —Enter all the required fields – Check the Dispense Quantity is calculated -- Click on Insert button – Click on prescribe button – IN Prescribe screen click on prescribe button.
**Path 3:** Login to SmartCare Application – Search and Select a client – Search for Medication Management (Client) – Patient Summary screen (Rx Application) – Select a non-controlled medication and click on Change order Button – In Change Medication order screen select a medication having unit as each --Enter all the required fields – Check the Dispense Quantity is calculated -- Click on Insert button – Click on prescribe button – IN Prescribe screen click on prescribe button.
**Path 4:** Login to SmartCare Application – search for medication management (My Office) – Start page (Rx Application) – Click on Queue order button – In order approval screen select a medication – Click on Adjust Dosage/Schedule button -In Adjust Dosage / Schedule screen select a medication having unit as each —Enter all the required fields – Check the Dispense Quantity is calculated -- Click on Save Adjustment button—in Prescribe screen click on update order button.
**How It Helps:**
Calculates the Dispense Quantity (Dispense Qty) automatically for specific medication types where Unit = Each

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## 36. EII # 132618 (Feature # 612414): Layman's Terms: Implementation of Dose initialization and unit Initialization based on the StrengthUnit = Unit.

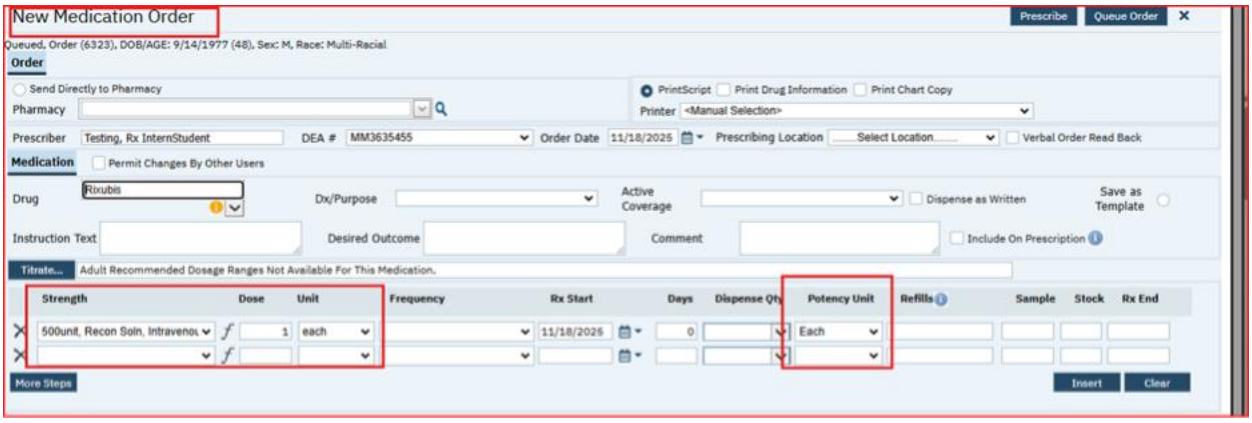
🟧 **ACTIVE CHANGE**

**What's Changed:**
With this release, the system now correctly initializes the 'Dose' and 'Unit' fields for medications when Strength Unit equals Unit in the 'Client Orders' screen—across the 'Order' tab, 'Order Set' tab, and 'Preferences' tab—based on the mapping below.

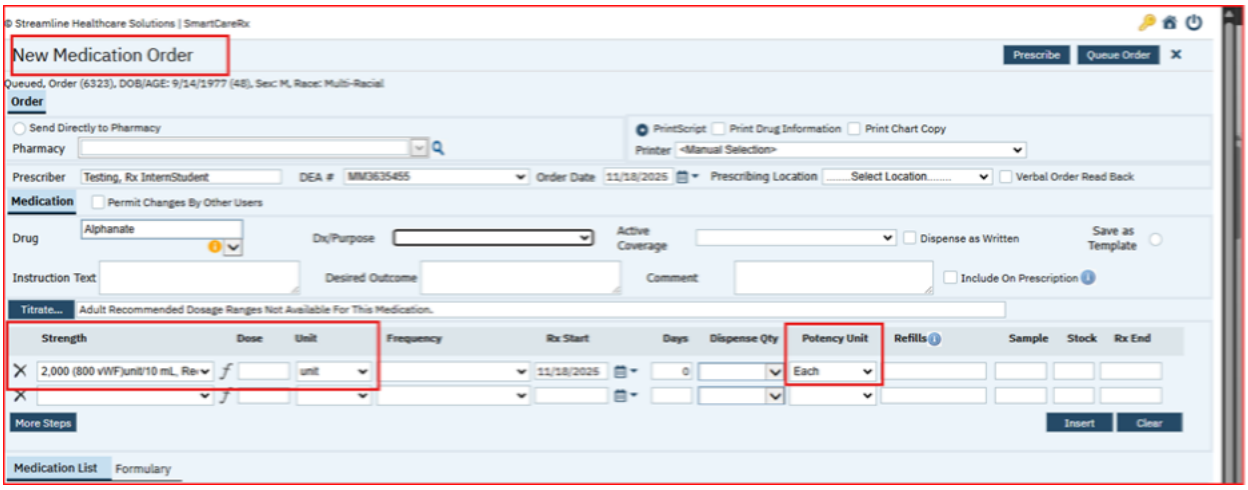
| StrengthUnit | Volume Unit | Potency Unit | Order & Rx - Unit Drop Down Value | Dose Field Initialization |
|---|---|---|---|---|
| Unit | NULL | Each | Each | 1 |
| Unit | Gram | Each | Unit | NULL |
| Unit | mg | Each | Unit | NULL |
| Unit | ml | Each | Unit | NULL |
| Unit | NULL | Capsule | Unit | StrengthValue Column |
| Unit | NULL | Gram | Each | NULL |
| Unit | Gram | Gram | Unit | NULL |
| Unit | NULL | Kit | Each | 1 |
| Unit | mL | Milliliter | Unit | NULL |
| Unit | mL | Spray | Unit | StrengthValue Column |
| Unit | Gram | Packet | Unit | StrengthValue Column |
| Unit | NULL | Tablet | Unit | StrengthValue Column |
| Unit | NULL | Unspecifed | Unit | NULL |
| Unit | Gram | Unspecifed | Unit | NULL |
| Unit | mL | Unspecifed | Unit | NULL |
| Unit | mg | Unspecifed | Unit | NULL |
| Unit | Spray | Milliliter | Unit | StrengthValue Column |

- When **StrengthUnit = Unit** and the medication do not meet the conditions defined in the mapping, the **Dose** will be initialized to **NULL**.
- When **StrengthUnit = Unit** and the medication do not meet the conditions defined in the mapping, the **Unit** will be initialized to **StrengthUnit**.

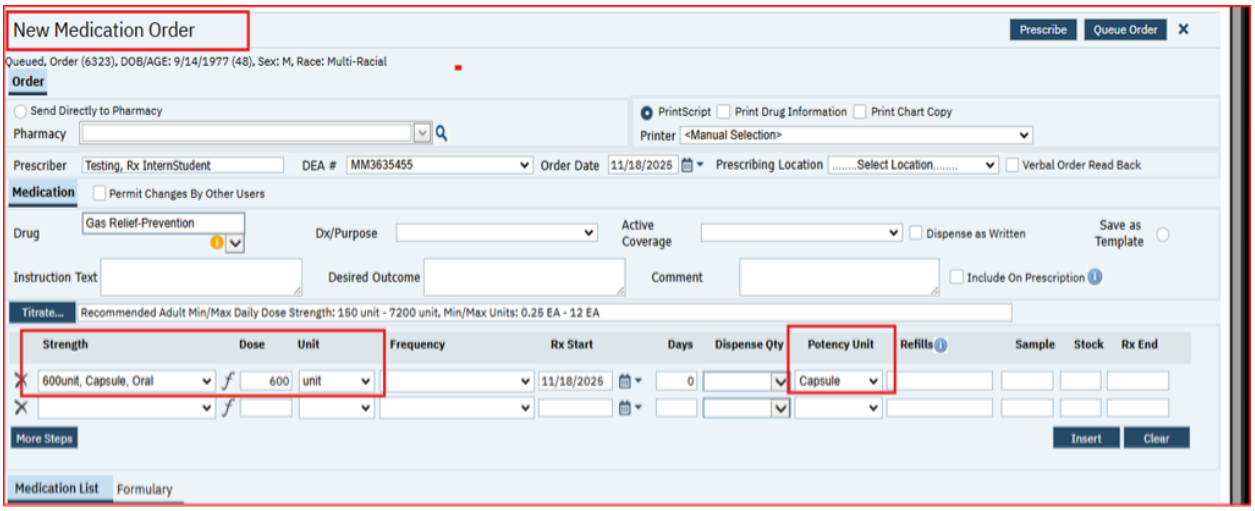
**Example: 1:** When StrengthUnit = Unit, Volume Unit = Null and Potency Units = Each, then Dose will be initialized as '1' and Unit be initialized as 'Each'.




**Example: 2:** When StrengthUnit = Unit, Volume Unit = Gram and Potency Units = Each, then Dose will be Blank and Unit be initialized as 'Unit'.




**Example: 3:** When Strength Unit = Unit, Volume Unit = Null and Potency Units = Capsule, then Dose will be Initialized as the strength of the medication and Unit be initialized as 'Unit'.




When a user attempts to Re-Order or Approve a Pre-Layman's order and clicks 'Prescribe' without making any changes, the system retains the original details (sigtext, dose, unit, and potency unit code) from before the Layman's update. Consequently, the Unit will not align with the new post-Layman's standards.

**Where To Find It:**

**Path 1:** Login to SmartCare Application -- Search and select a Client -- Search for 'Medication Management (Client)' -- 'Patient Summary' screen (Rx Application) -- Click on 'New Order' button -- 'New Medication Order' screen -- Select a medication whose strengthUnit is unit -- Check the 'Dose' and 'Unit' fields initializations -- Enter all the required fields -- Click on 'Insert' button -- In Free Sig text pop up click on Update and close button -- Click on prescribe button – 'Prescribe' screen -- Click on 'Prescribe' button.

**Path 2**: Login to SmartCare Application -- Search and Select a client -- Search for 'Medication Management (Client)' – 'Patient Summary' screen (Rx Application) -- Select a medication and click on 'Re Order' Button – 'Re-Order Medication Order' screen -- Select a medication whose strengthUnit is unit-- Check the Dose and Unit fields initializations -- Enter all the required fields -- Click on 'Insert' button – In Free Sigtext pop up click on Update and Close button -- Click on 'Prescribe' button – 'Prescribe' screen -- click on 'Prescribe' button.

**Path 3**: Login to SmartCare Application -- Search and Select a client -- Search for 'Medication Management (Client)' -- 'Patient Summary' screen (Rx Application) -- Select a non-controlled medication and click on 'Change Order' Button – 'Change Medication Order' screen --Select a medication whose strengthUnit is unit -- Check the Dose and Unit fields initializations -- Enter all the required fields -- Click on 'Insert' button – In Free Sigtext pop up click on Update and Close button -- Click on prescribe button – In Prescribe screen click on prescribe button.

**Path 4:** Login to SmartCare Application -- search for medication management (My Office) – Start page (Rx Application) – Click on Queue order button – In order approval screen select a medication – Click on 'Adjust Dosage/Schedule' button -- 'Adjust Dosage / Schedule' screen select a medication whose strengthUnit is unit-- Check the Dose and Unit fields initializations -- Enter all the required fields -- Click on Insert button – In Free Sigtext pop up click on Update and close button -- Click on 'Save Adjustment' button --in Prescribe screen click on update order button.

**Path 5:** Login to SmartCare Application -- Search and Select a client -- Search for Medication Management (Client) -- 'Patient Summary' screen (Rx Application) -- Click on 'Add Medication' Button -- Add Medication Screen -- Select a medication whose strengthUnit is unit-- Check the Dose and Unit fields initializations -- Enter all the required fields -- Click on 'Insert' button – Click on Save Button.

**Path 6:** Login to SmartCare Application -- search for 'Medication Management (My Office)' – 'Start page' (Rx Application) -- Click on 'Rx Change' Tab – Click on Approve with Changes button -- 'Approving with Changes Medication Order' screen -- Select a medication whose strength Unit is unit -- Check the Dose and Unit fields initializations -- Enter all the required fields -- Click on 'Insert' button -- In Free Sigtext pop up click on Update and close button -- Click on 'Prescribe' button -- 'Prescribe' screen -- Click on 'Prescribe' button.

**How It Helps:**

- Ensures that the Dose and Unit field are initialized correctly when **StrengthUnit = Unit**.
- Reduces manual data entry and eliminates unnecessary clicks.

## Scanning

| Reference No | Task No | Description |
|---|---|---|
| 37 | EII # 132174 | Scanning: Changes are implemented in the Scanning Detail and Upload Detail screens. |

## 37. EII # 132174 (Feature # 453934): Scanning: Changes are implemented in the Scanning Detail and Upload Detail screens.

🟧**ACTIVE CHANGE**

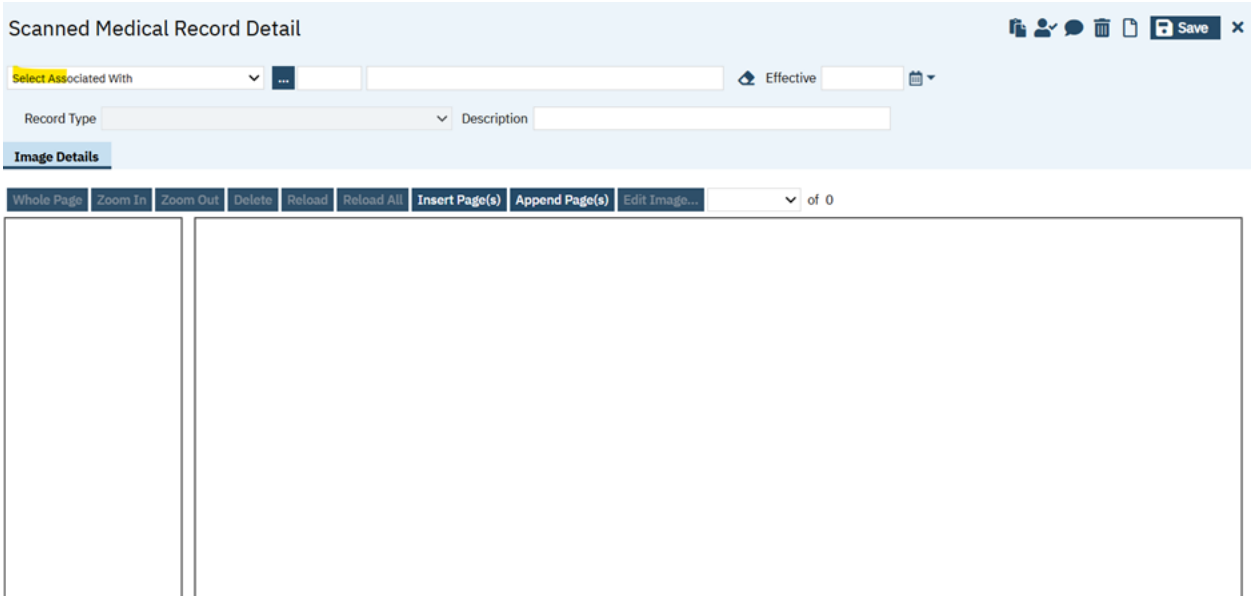
**Note:** The previous Scanning detail page had several usability challenges that impacted the user experience. To address these issues, we are enhancing functional behaviors and simplifying the interface. Users will continue to have the ability to scan or upload files as before, but with better user experience.

**What's Changed:**

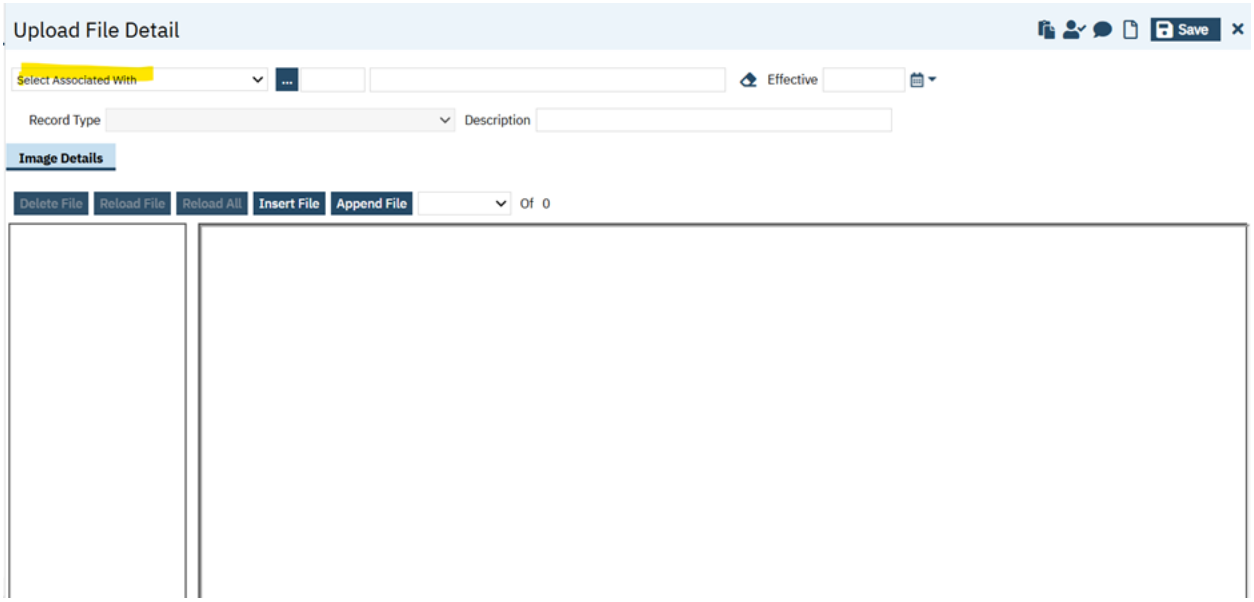
**Scanning Detail and Upload Detail screens Enhancement:**

The following changes have been implemented in the 'Scanned Medical Record Details and Upload File Detail' screen.

1. The 'Select Associated With' placeholder name has been implemented in the 'Association' dropdown under 'Scanned Medical Record Details' and 'Upload File Detail' screen.



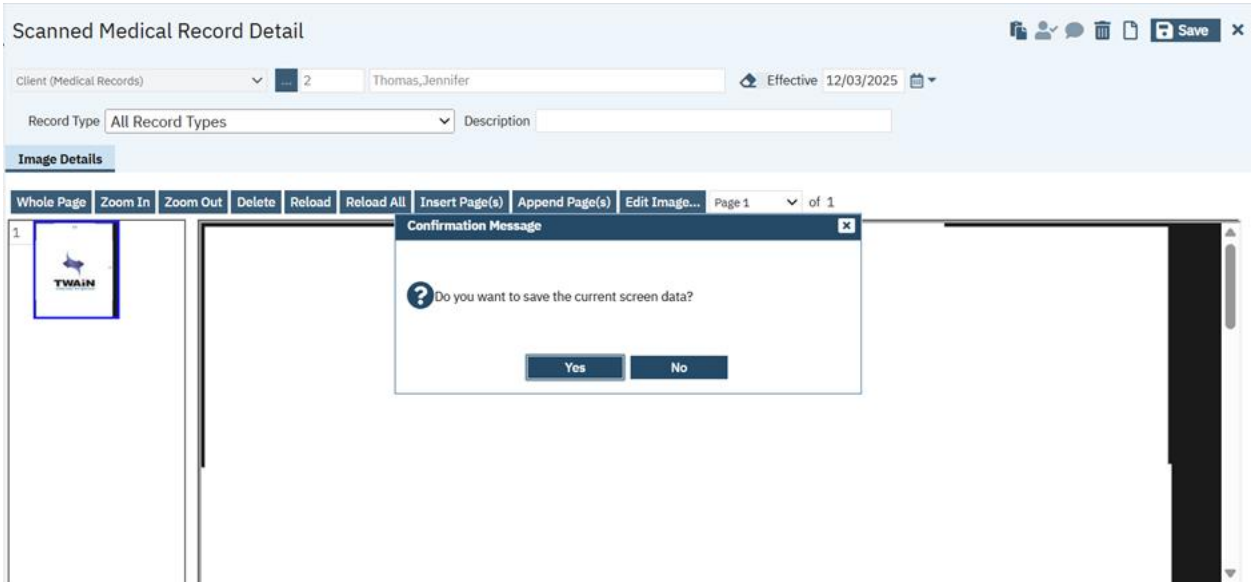

**Upload File Detail screen:**

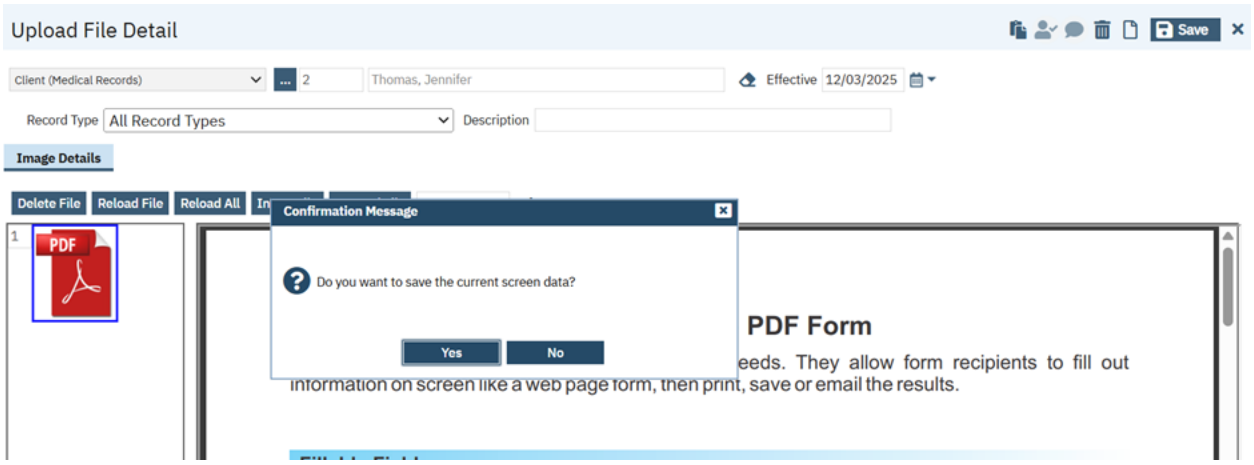



2. The confirmation popup text called **'Do you want to complete the document (s)?'** which is displaying while closing or creating new Scanned/Uploaded record from the existing screen without completing/saving, has been renamed to **"Do you want to save the current screen data?"** with 'Yes' and 'No' radio buttons and functioning as below:

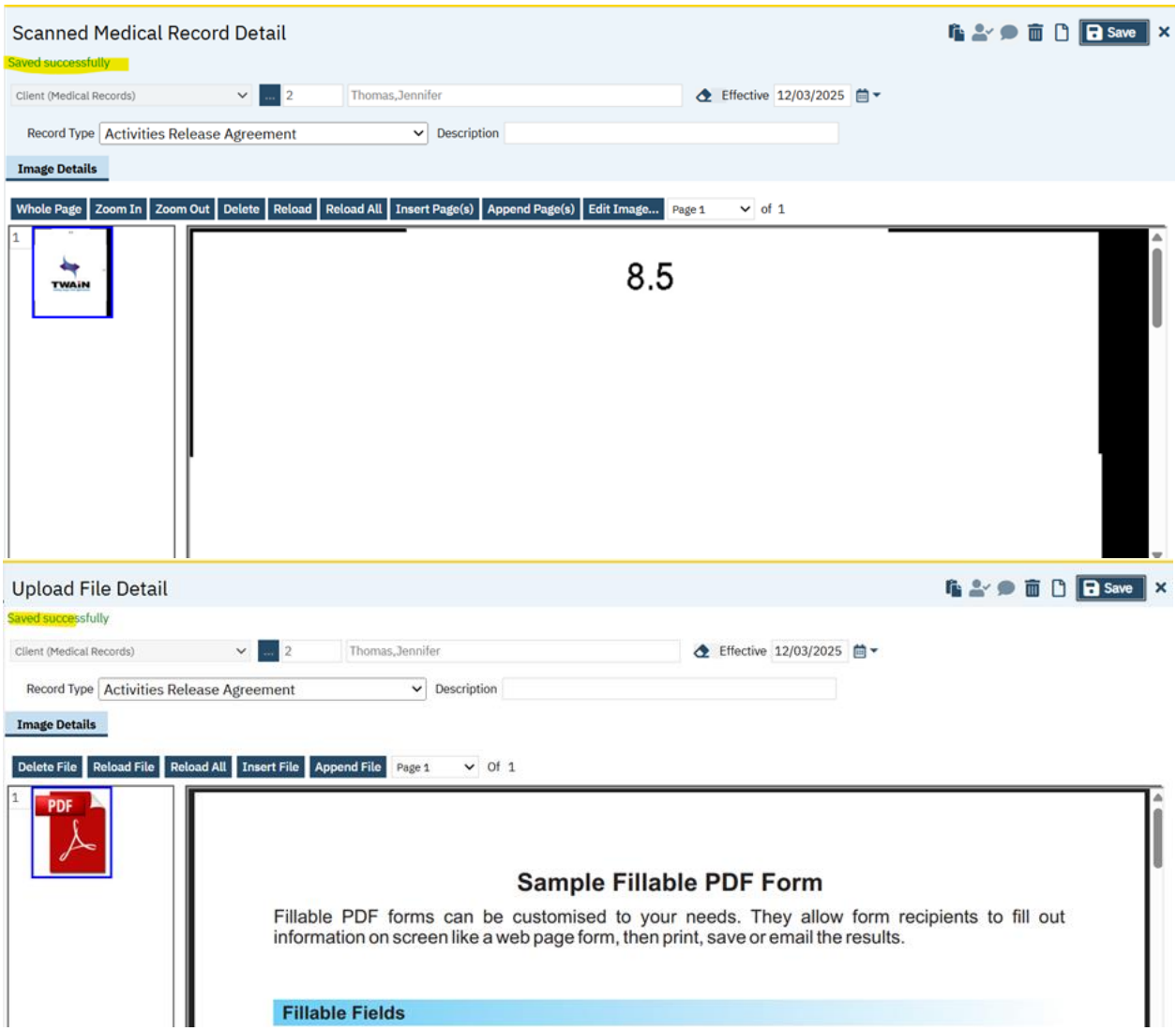
   a. In the "Do you want to save the current screen data?" confirmation popup:
      - On click off Yes from the **new** icon, saving the current screen data by triggering the validation if any or saving the record and the control is navigating to the new screen
      - On click off Yes from **close** icon, saving the current screen data by triggering the validation if any or saving the current screen data.
      - On click off No from **new** icon, the new screen is opening without saving the current screen data

- On click off No from **close** icon, the control is navigating back to previous screen without saving the current screen data
- The 'Cancel' button has been removed from the popup



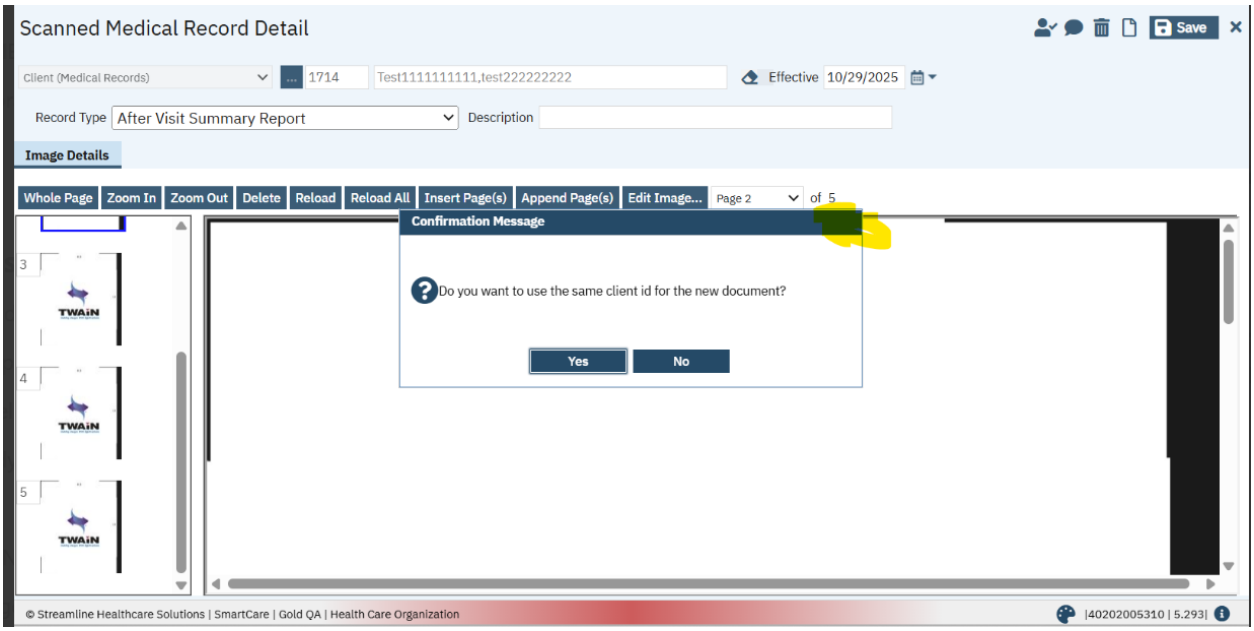




3. The 'Saved Successfully' message has been implemented on saving the 'Upload File Detail' and 'Scanned Medical Record Detail' screen with all the required values.




4. When creating a new record from an existing one **with a client selected and without saving the current screen data**, the confirmation popup that previously appeared has been **removed**. The system now directly proceeds with the new record creation without prompting the user.

5. When creating a new record from a completed scanned/uploaded record **with a client selected.** The following confirmation Pop-up will be displayed, and the **Close(X) icon** has been removed.




**Where To Find It:**
**Path 1:** Client/My office' -- 'Scanning' -- 'Scan New Images' - Scan the record and enter the required values -- Save the 'Scanned Medical Record Detail' screen.
**Path 2:** 'Client/My Office' -Scanning -'Upload New Images' - Upload the PDF record and enter the required values --- Save the 'Upload File Detail' screen.

**How It Helps:**
- To simplify the user experience, enhanced few functional behaviors in the current Scanning detail page.

---

## SmartCare Improvements

| Reference No | Task No | Description |
|---|---|---|
| 38 | EII # 130808 | Column parenthesis labels are removed from the 'List Page Configurations' popup of any list page. |
| 39 | EII # 132344 | Implementation of new field in "Screen Details" page. |
| 40 | EII # 127489 | List Page Optimization Through Screen-Level Pagination Settings. |
| 41 | EII # 132467 | Added configurable searchable textboxes for Providers, Sites, Staff, and Billing Codes on the specified MCO screens. |

### 38. EII # 130808 (Feature # 535235): Column parenthesis labels are removed from the 'List Page Configurations' popup of any list page.

**Note:** This is a Passive Change

**What's Changed:**
With this release, the label within parenthesis is removed from the following columns in the 'List Page Configurations' popup:
**'Show Column':** Removed the parenthesis labels 'Show' and 'Hide'.
**'Fixed' Column:** Removed the parenthesis label 'Not Fixed'.

**'Export' Column:** Removed the parenthesis label 'Export' and 'Not Export'.
**'Order' Column:** Removed the parenthesis label.

**Where to Find It:**
**Path:** Open any list page -- Click on 'New/Edit Column Configurations' icon -- 'List Page Configurations' popup.

**How It Helps:**
1. Improves clarity and reduces confusion for the users.
2. Enhances the user experience.

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## 39. EII # 132344 (Feature # 589008): Implementation of new field in "Screen Details" page.

**Note:** This is Passive Change.

**What's Fixed:**
With this enhancement, a new text box field named "List Page Rows Per Page" is implemented in "Screen Details" page. This field will not be initialized to any value by default, and it accepts only numeric values between 1 to 200. '1' is the minimum value allowed into this field and maximum value user can enter to this field is '200'.
System will clear the field when user enters any value that does not meet above mentioned criteria (minimum and maximum value)

**Where To Find It:**
**Path:** 'Administration– 'Screens'.

**How It Helps:**
Provides more granular control over the number of rows displayed per page on list pages.

**Data Model Change**:
Added 'ListPageRowsPerPage' column to the Screens table.

---

## 40. EII # 127489 (Feature # 364072): List Page Optimization Through Screen-Level Pagination Settings.

**Note:** This is Passive Change.

**What's Changed:**
The List Page framework is enhanced to determine the number of rows displayed per page based on the following logic:

- If Screens.ListPageRowsPerPage is defined as greater than zero, and less than or equal to 200, the system will use the Screens.ListPageRowsPerPage value.
- Otherwise, the value set in System Configurations key "ListPageRowsPerPage" will be used.

Introducing a screen-level ListPageRowsPerPage setting allows each list page to define its optimal number of rows, improving performance and reducing the risk of '*System Out of Memory'* errors.

**Where to Find It:**

**Path 1:** SmartCare - Administration - Configuration Keys - Set the value for the 'ListPageRowsPerPage' configuration key.

**Path 2:** SmartCare - Administration - Screens list page - Enter a value in the List Page Rows Per Page field.

**How It Helps:**
This will provide screen-level control over the number of rows displayed per page on list pages, a configurable field will be introduced at the screen level. This enhancement allows individual screens to define their own pagination limits instead of relying solely on the global configuration.

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## 41. EII # 132467 (Feature # 601841): Added configurable searchable textboxes for Providers, Sites, Staff, and Billing Codes on the specified MCO screens.

**Note:** This is Passive Change.

**What's Changed:**
A new configuration key EnableTypeableSearchTextboxOnMCOScreens has been added to convert dropdown fields into typeable search boxes in MCO screens. When the configuration key is set to **Yes**, dropdowns are replaced with typeable search boxes. When set to **No**, the screens retain their current behavior and continue to display dropdowns. By default, the configuration key is set to **No**, **which preserves the existing system behavior.**

**System configuration Key Details:**
**System Config Key**: EnableTypeableSearchTextboxOnMCOScreens
**Read Key as:** Enable Typeable Search Textboxes for Providers, Sites, Staff, and Billing Codes on the specified MCO screens.
**Allowed Values:** Yes, No
**Default Value:** No
**Module:** SCM MCO Core

**Description**: This is a change to our core product by introducing a system configuration key. Currently, these screens use dropdowns, which can be with large datasets. This key will control how selection fields for Staff, Providers, Sites, and Billing Codes are displayed, offering a more efficient experience especially in high-volume environments.
1. If the key value is set to "Yes", all dropdowns (Providers, Sites, Staff, and Billing Codes) on the screens listed below will be replaced with typeable search textboxes, allowing users to search and filter options more efficiently.
2. If the key is set to "No", the screens will retain the current behavior, displaying dropdowns. This is the default behavior as **drives existing system behavior**.

The following screens will reflect this behavior based on the configuration key value:
**My Office:** Claim Bundles List Page, Claim Bundle Details, Contract Details, Claim Denial Overrides, Batch Claim Uploads, CM Authorizations, Combined Authorizations, Refunds, Services From Claims, Denial Letters, Checks, Credentialing, Batch Contract Rate Uploads.

**Provider:** Contract Details, Provider Information, Site Review.

**Client:** Client Claims, CM Authorization Details, Combined Authorizations, CM Events.
**Note:** If by chance the value of the key is updated with any value apart from the allowed values, the system **will consider the default behavior, i.e. same as the key value being "No"**
The below mentioned screens and fields where the typeable search box has been implemented (based on system configuration key setting) :

1. Claim Bundles List Page: Provider and Site filters.
2. Claim Bundle Details: Provider and Site fields.
3. Contract Details (My Office): Billing Code filter in Contracted Rates tab.
4. Contract Details (Provider): Billing Code filter in Contracted Rates tab.
5. Provider Information: Associated Clinician field in General tab of Provider Information.
6. Claim Denial Overrides list page: Providers and Billing Codes filter.

7. Batch Claim Uploads (List page): Providers filter.
8. Client Claims List Page: Providers and Sites filters.
9. CM Authorizations List Page: Providers and Billing Codes filters.
10. CM Authorization Details: Provider/Site and Billing Code fields.
11. Combined Authorizations: Providers and Billing Codes filters.
12. Combined Authorizations (Client): Providers and Billing Codes filters.
13. CM Events: Providers filter
14. Refunds – Providers filter
15. Services From Claims: Providers, Sites and Billing Codes filters
16. Denial Letters: Providers filter
17. Checks: Providers filter
18. Site Review: Staff filter
19. Credentialing: Providers and Sites filters
20. Batch Contract Rate Uploads: Uploaded By filter

**Where To Find It:**
**Path:**

1. My Office -' Claim Bundles'
2. My Office-' Claim Bundles' - 'New' - 'Claim Bundle Details'
3. 'My Office' -'Contract' - Select Contract id -'Contract Details' screen - 'Contracted Rates' tab.
4. 'My Office' -'Provider Contract' -Select Provider name hyperlink -'Provider' -'Provider Contract' -'Contract Details' Screen -'Contracted Rates' tab.
5. 'My Office' -'Provider Contract' -Select Provider name hyperlink -'Provider Summary' - 'Provider Name' hyperlink - 'Provider Information' Screen - 'General' tab.
6. 'My Office' -'Claim Denial Overrides'
7. 'My Office' -'Batch Claim Uploads'
8. 'Client' -'Client Claims'
9. 'My Office' -'CM Authorization'
10. 'Client -'CM Client Authorization' - Click on New - 'CM Authorization Details' screen
11. 'My Office' -'Combined Authorizations'
12. 'Client' -'Combined Authorizations'
13. 'Client' - 'CM Events'
14. 'My Office' -'Refunds'
15. 'My Office' -'Services From Claims'
16. 'My Office' - 'Denial Letters'
17. 'My Office' -'Checks'
18. 'My Office' -'Provider Contract' -Select Provider name hyperlink -'Provider' -'Site Review'
19. 'My Office' - 'Credentialing'
20. 'My Office' -'Batch Contract Rate Uploads'

**How It Helps:**

The purpose of this change is to enhance the user experience by replacing dropdowns with typeable search textboxes. This change improves the usability, especially when dealing with dropdowns that contain a large number of options.

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## Global Codes

Global Codes are the individual entries or options assigned to a Global Code Category. Global Codes can be core or custom. For example, a Global Code Category and the associated Global Codes are the options you will select from a dropdown list.

Review and configure the following Global Code Categories and Global Codes that belong to each category before performing the workflows documented in these release notes.

| Ref No. | Category Name |
|---|---|
| 03 | CLAIMFORMATTYPE |
| 17 | IPFQRTobaccoStatus |
| 21 | MATDISPENSERMODEL |

## Recodes

A Recode is a subset of other system codes that populate a list for a specific reporting purpose. Recodes create an allowed list of entries from multiple larger lists.

Review and configure the following before performing the workflows documented in these release notes.

| Ref No. | Category Code |
|---|---|
| 29 | SetDocumentCodeIdForLastPCPField |

## System Configuration Keys

Configuration keys are settings that instruct the system (or a particular module or page) to behave in a desired way. Each Key has a set of values that correspond to particular behaviors. The organization should determine Configuration Key settings and adjust them as needed.

Review and configure the following before performing the workflows documented in these release notes.

| Ref No. | Key Name |
|---|---|
| 04 | EnableClaimEntryStartStopTime |
| 16 | EnforceServiceDropDownConfigurations |
| 24 | INITIALIZEDIAGNOSISORDER |
| 25 | INITIALIZEDIAGNOSISORDER |
| 26 | EnableSMARTreplicaDatabaseReporting |
| 27 | EnableSMARTreplicaDatabaseReporting |
| 28 | EnableSMARTReplicaDatabaseReporting |
| 40 | ListPageRowsPerPage |
| 41 | EnableTypeableSearchTextboxOnMCOScreens |

## Date Model Changes

| Ref No. | Data Model Change |
|---|---|
| 11 | Added the below new columns to DocumentHistoryAndPhysicalGenerals table. 'PhysicalExamGeneral', 'Heent', 'Chest', 'NeurologicalExam', 'CranialNerves', 'CranialNervesII', 'CranialNervesIII', 'CranialNervesV', 'CranialNervesVII', 'CranialNervesVIII', 'CranialNervesIX', 'CranialNervesX', 'CranialNervesXI', 'CranialNervesXII' |
| 12 | The new columns ActivePlacements and OpenBeds are added to PlacementFamilies table. |
| 24 | Added new columns UseProblemListForDiagnosis, UseDiagnosisDocument, DiagnosisDocumentCategoryAll in the ProcedureCodes table.<br>Added ProcedureCodeDiagnosisCategories table. |
| 26 | New column named 'DataSourceServerPath' and 'DataSourceReplicaServerPath' are added to the ReportServers table. |
| 27 | New columns named 'UseReplicaDataSource' and 'IsUsingReplicaDataSource' are added to the Reports table. |
| 28 | A new column named **'UseReplicaDataSource'** and **'IsUsingReplicaDataSource'** are added to the **Reports** table |
| 39 | Added 'ListPageRowsPerPage' column to the Screens table. |

## SmartCare Testing Strategy – November 2025 MSP – EII Focus

**Purpose:**
To confirm that key workflows in each module function correctly after the release, focusing specifically on **Engineering Improvement Initiatives (EIIs)**. Testing should validate both active changes (requiring customer setup/action) and passive changes (enabled by default but beneficial to verify).

### How to Use This Strategy

1. Start with modules you use most often in daily operations.
2. Within each module, test workflows tied to EII changes.
3. Follow the navigation paths in the release notes for each task.
4. Document:
    a. Pass / Fail outcome
    b. Unexpected behaviors
    c. Follow-up questions or concerns

**Note:** The 🟧 orange icon indicates an **active change**, meaning the update requires customer setup or direct action (such as enabling a new field, adjusting a configuration, or testing a newly introduced workflow) rather than being applied automatically in the system.

These testing workflows may vary depending on your organization's specific SmartCare configuration, so be sure to adjust steps as needed to align with your local settings and processes.

### Testing Workflow by Module – EIIs Only

**Below are the EIIs identified in the release-note excerpts provided.**

**Charges / Claims**

- **EII #130560 –** Tech Debt: Permanent tables for temp-table SP structures
  Test:
    - Execute standard billing workflows (create charge → process e-claim/paper claim → update statuses).
    - Confirm no regressions in SP behavior (place of service, allowed amounts, secondary charge updates).
- **EII #130524 –** Correct PCN selection for 837I and UB-04 (void/replacement)
  Test:
    - Configure Coverage Plan → set PCN radio button (Most recent / First billed).
    - Bill, mark claim line "To Be Voided" or "To Be Replaced," re-bill.
    - Validate PCN in REF*F8 (837) and Box 64 (UB-04).
- **EII #132546 –** CN1 segment added under Loop 2300 on 837P/837I
  Test:
    - Add claim format rules for CN101–CN106 in Claim Format Configurations.

- Generate claim file; confirm CN1 segment appears correctly.

- **EII #132283 –** Validate From/To time on claim lines for time-based units
  Test:
  - Enable config key EnableClaimEntryStartStopTime = Y.
  - Insert service lines with Hour/Minute units; verify mandatory fields and validation messages.

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**Client Orders**

- **EII #132831 –** Dispense Qty calculation for Unit = Each / mg
  Test:
  - Create medication order with Unit = Each or mg; verify Dispense Qty auto-calculates per formula.

- **EII #132619 –** Dose & Unit initialization when StrengthUnit = Unit
  Test:
  - Create medication order where StrengthUnit = Unit; confirm Dose and Unit fields initialize correctly.

---

**Dynamic Form Architecture (DFA)**

- **EII #132570 –** CK Editor icon added in DFA Editor
  Test:
  - Open DFA Editor → Form Items; verify CK Editor opens only via icon, supports long labels.

- **EII #132513 / #132510 –** Disposition Common Control in DFA & Service Notes
  Test:
  - Insert Care Coordination Disposition control in DFA Editor; verify preview, duplicate warning, PDF rendering.

- **EII #132536 –** ISP/Care Plan DFA tabs supported via stored-procedure hook
  Test:
  - For custom environments: initialize ISP/Care Plan with DFA tabs; confirm custom logic executes.

---

**Documents**

- **EII #132329 –** History & Physical: Physical Exam tab redesign
  Test:
    - Open History & Physical → Physical Exam tab; verify new General section, auto-propagation of radios, comments visibility, and PDF output.

~~**Foster Care**~~

- ~~**EII #131624** – Placement History & Open Beds auto-update~~
  ~~Test:~~
    - ~~De-select child in Referral → verify Placement closes and Open Beds/# Current Placements update.~~
    - ~~End/start placement → confirm Open Beds and Current Placements adjust correctly.~~

**Inquiry Details**

- **EII #132464 –** Crisis tab Procedure Code filtering based on config key
  Test:
    - Enable EnforceServiceDropDownConfigurations = Yes; configure ServiceDropDownConfigurations.
    - Verify Procedure Code dropdown filters by Program/Location/Clinician as per setup.

**IPFQR List Page**

- **EII #125821 –** New Discharge Year filter & validations
- **EII #129426 –** Clinical & Facility XML updates for 2025 reporting
  Test:
    - Validate filter logic, action eligibility, batch creation, and XML file generation on SFTP**.**

**Rx Application**

- **EII #132797 –** Auto-init Unit & Potency Unit based on medication strength
- **EII #132826 –** Auto-calculate Dispense Qty for Unit = Each scenarios
- **EII #132618 –** Dose & Unit initialization when StrengthUnit = Unit
  Test:
    - Re-Order/Change/Adjust flows; confirm initialization and Dispense Qty formulas apply correctly.

---

**Scanning**

- **EII #132174 –** Enhanced Scanning & Upload Detail screens
  Test:

- Verify new confirmation popup text, save behavior, success messages, and removal of old prompts.

**Reports**

- **EII #132718 / #132108 / #132470 –** SmartReplica DB reporting enhancements
- **EII #132562 –** Staff Caseload & Roles/Permissions reports
- **EII #132069 –** Therapy Progress Report

  Test:

  - Enable config key; validate replica DB toggle and dynamic redirection.
  - Run new reports; confirm filters, data accuracy, and expected columns.

~~**Methadone**~~

- ~~**EII #132755 –** MAT Emergency Dispensing Report layout changes~~
- ~~**EII #133029 –** SciLog Dispenser model added~~
  ~~Test:~~

  - ~~Validate report layout (landscape, header changes).~~
  - ~~Add SciLog dispenser; perform Prime/Unprime/Calibrate/Dispense; confirm commands sent to emulator.~~

**Merge Clients**

- **EII #132698 –** Include TEDS Episodes in Merge Clients
  Test:

  - Merge clients with TEDS Episodes; verify checkboxes, validation messages, and Review navigation.

**My Reports**

- **EII #131618 –** IPFQR Screening SDOH report
  Test:

  - Run report; validate filters, summary counts, and logic for Denominator/Numerator screening.

**Procedure/Rates**

- **EII #132720 –** Service Diagnosis section added to Procedure Code Details
  Test:
    - Configure diagnosis categories; verify initialization in Service Details, Service Notes, and Group Service screens**.**

**Rollback Electronic Remittance**

- **EII #132799 –** Capture staff user during ER rollback
- **EII #130891 –** 835 Rollback Report implemented
  Test:
    - Perform rollback; confirm DeletedBy field shows actual user.
    - Run report; validate filters and grid columns (ER File ID, Staff, Date/Time).

**RWQM**

- **EII #132750 –** Removed blank line/box in Work Queue filter section
  Test:
    - Open RWQM Work Queue; confirm UI cleanup**.**

**Services**

- **EII #130798 –** Billing Diagnosis Category mapping at procedure level
  Test:
    - Configure diagnosis categories; verify initialization in Service Details, Service Notes, and Group Service screens.

**SmartCare Improvements**

- **EII #130808 –** Remove parenthesis labels in List Page Configurations popup
- **EII #132344 –** New field "List Page Rows Per Page" in Screen Details
- **EII #127489 –** Screen-level pagination settings
- **EII #132467 –** Typeable search textboxes for MCO screens
  Test:
    - Validate UI changes in List Page Configurations.
    - Set pagination values; confirm rows per page behavior.
    - Enable config key for typeable search; verify dropdowns convert to search boxes.

**If a Test Fails:**
Create a Zendesk ticket with the module name, task number, detailed steps to reproduce, expected vs. actual results, and attach any relevant screenshots or error messages.

## Revision History

| Version | Description | MSP Version |
|---|---|---|
| 1.0 | Initial Release | November 2025 MSP |