FEI Systems

WITS

MS-WITS

End-User

Clinical Guide

Applies to:

WITS Version 23.1.0+

See Also:

WITS Basics User Guide

Mississippi Department of Mental Health

Last Updated June 2023

Mississippi Department of Mental Health

MS-WITS

Preface

The WITS System is a web-based application system specifically designed for organizations to manage their TEDS and Block grant data collections effectively. Capable of creating and managing contracts and funds. WITS also includes core clinical features essential to managing substance abuse services and treatment case management.

Intended Audience

This user guide has been prepared for clinical users. Topics covered include client setup, admission process, and other clinical functionality.

System Requirements

WITS is a web-based application accessed through an Internet (web) browser using Internet connection.

Internet Browsers

WITS is compatible with up-to-date versions of most modern Internet browsers such as:

Google Chrome™

Microsoft Edge™

Mozilla® Firefox®

Apple® Safari®

Note: Do not allow your Internet browser to save your password, as this information will be routinely updated.

Pop-up Blocker

Certain features in WITS, such as Snapshot and Scheduler, will open in a separate browser window when selected. Make sure your browser allows pop-ups from WITS.

Customer URL Links

Training Site:	https://ms-training.witsweb.org
Production Site:	https://ms.witsweb.org

The **Training Site** allows staff members to practice using the system before entering actual data in the Production Site. ***Do not enter real client information in the training site.***

Table of Contents

Part 1: Customer Specific Information

This section is designed to include customer specific information for this particular user guide.

Examples of customer specific information includes:

- Business rules
- Specific terminology
- Workflow diagrams and explanation

Part 2: Client Setup

Search for a Client

Where: ***First Section*** *>* ***Second Section*** *>* ***Destination Screen***

Before creating a new client record, search for your client to make sure the client is not already in WITS.

1. To view clients within your agency, click on the **Client List** menu item. A blank Client List screen will appear.
2. Use the fields in the **Client Search** section to narrow your results. You may also select **Advanced Search** to view additional fields.

> **NOTE •** When searching for a client, try to use unique information, such as birthdates or social security numbers, if possible. You can also enter a partial name (or another field) followed by a "*". This is called a **wildcard search**. For instance, if you search for Last Name of "Smit*", the search results will display people with the last name of "Smith", "Smitty", "Smithson", etc.

3. After selecting from the search fields, click **Search** to view the results.

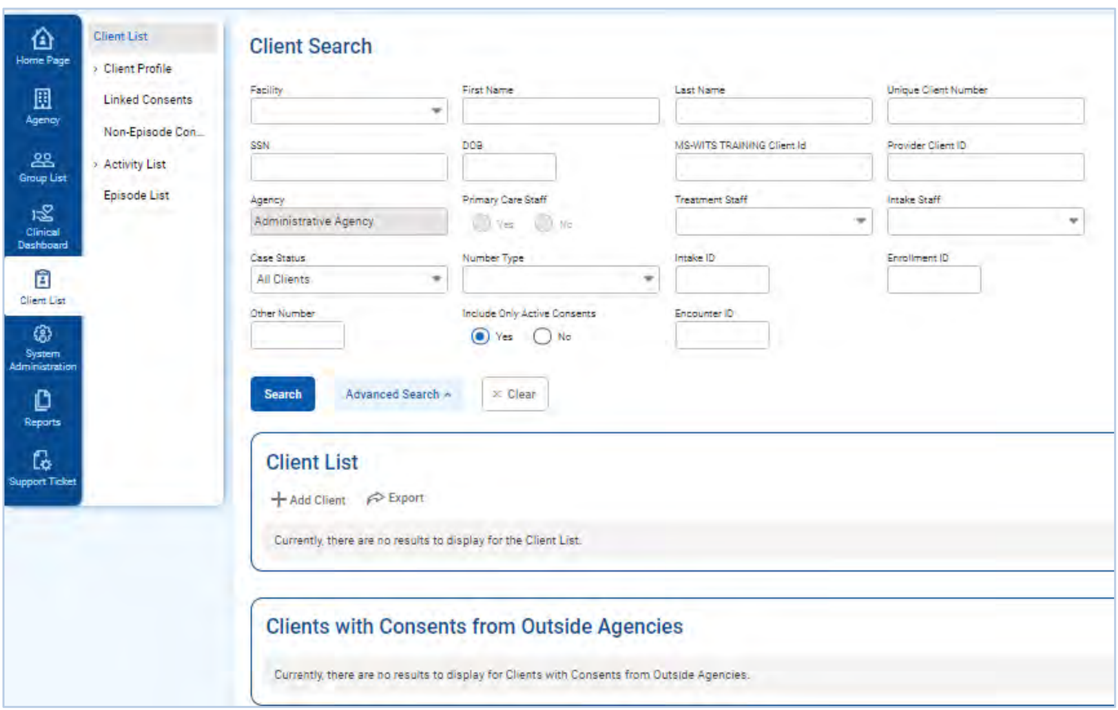


Figure 2-1: Client List screen, Action links

4. Look for your client in the **Client List**. If you find the right person, view their profile by clicking on the **Ellipsis** icon located on the far-right side of the client's record listed. If you do not find your client, you can create a new client record.

Client Search Tips

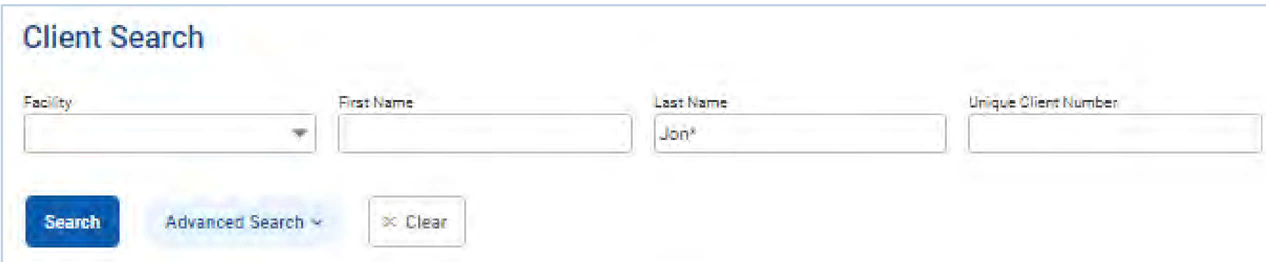
Client Name or Number

Use a client's nickname or alternate names in the **First Name** or **Last Name** fields.

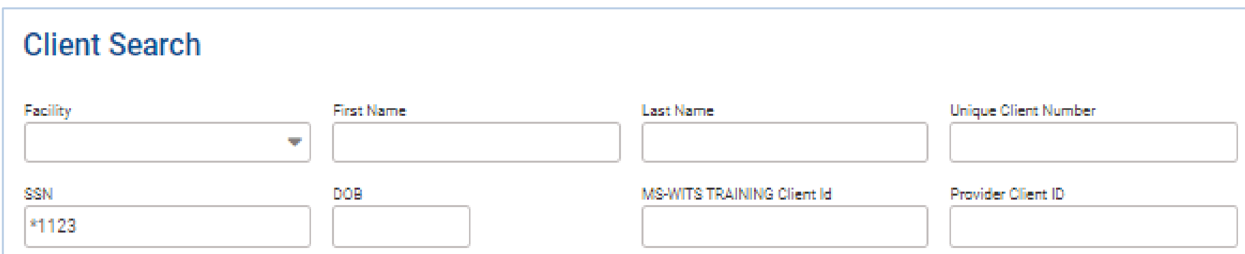
Use an **asterisk** (*) to perform a wildcard search.

Examples:

- Find clients whose last name starts with "Jon": Jon*



- Search by the last 4 digits of a client's SSN: *1123

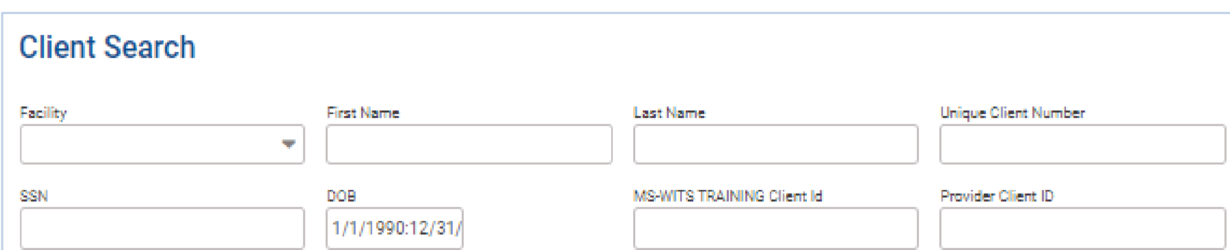


Client Birthday or Age

Search within a timeframe by separating the two dates with a **colon** (**:**). Search for clients born after a certain date with a **greater than sign** (**>**). Search for clients born before a certain date with a **less than sign** (**<**).

Examples:

- Find clients born in the year 1990: 1/1/1990:12/31/1990



- Find clients born after a certain date: >12/30/1959

Create Client Profile

Where:* *Client List* > *Client Profile

Note: Please search for each client before creating a new record.

To add a new client to the system, follow the steps below.

1. On the left menu, click **Client List**.
2. On the Client List screen, click **Add Client**.

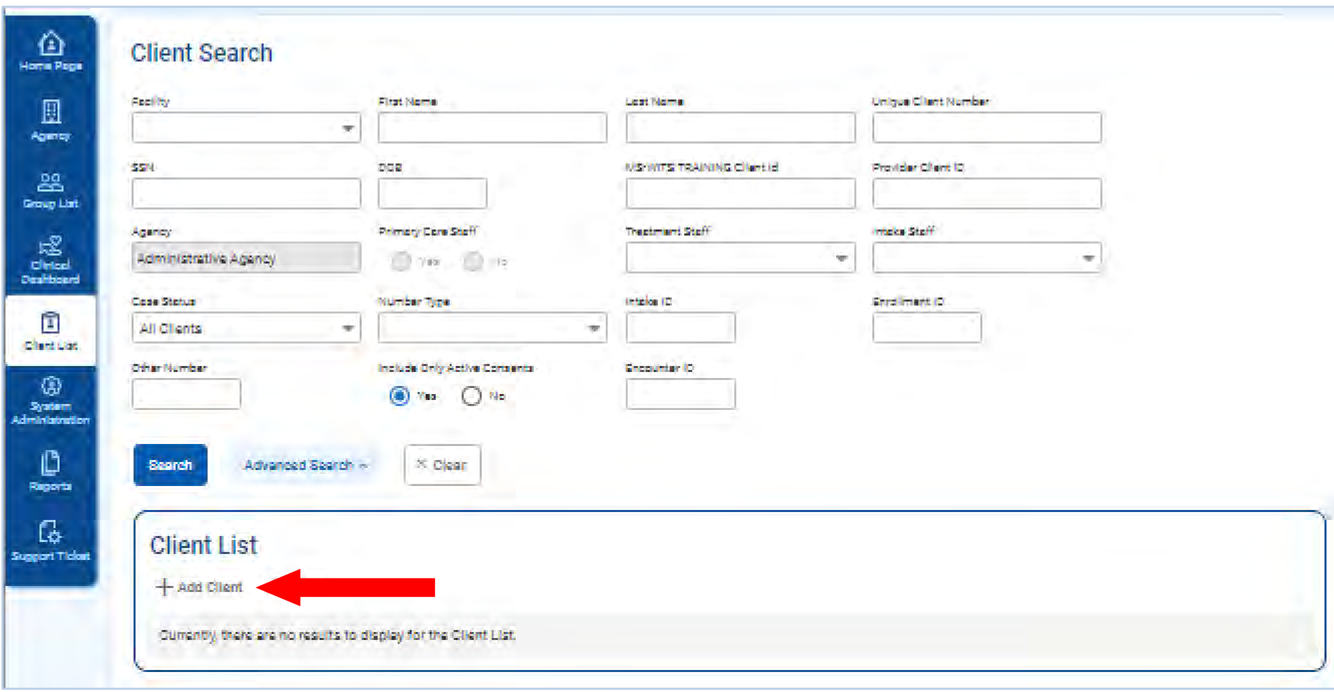


Figure 2-2: Client Search/List screen; Add Client link

3. On the **Client Profile** screen, enter the required client information. See the table below for information on each field.

When adding new clients to the system, review the **Client Profile** fields for accuracy before saving the screen. Once the Client Profile screen is saved, a **Unique Client Number (UCN)** is created based on the data provided. It is important to enter client information correctly to avoid duplicate client entry in the future.

Table 2-1: Client Profile fields

Field	Description
First Name	Type the client's current first name.
Middle Name	(Optional)
Last Name	Type the client's current last name.
Mother's Maiden Name	(Optional)
Suffix	(Optional)

Field	Description
Sex	Select the client's sex from the drop-down list.
Gender	(Optional)
DOB	Enter the client's date of birth.
SSN	Type the client's Social Security Number.
Driver's License and State	(Optional) Type the number and then select the State from the drop-down list.
Has paper file	(Optional) Select Yes or No. Field defaults to Yes.
Provider Client ID	Type the client's chart number or agency unique identifier for the client.

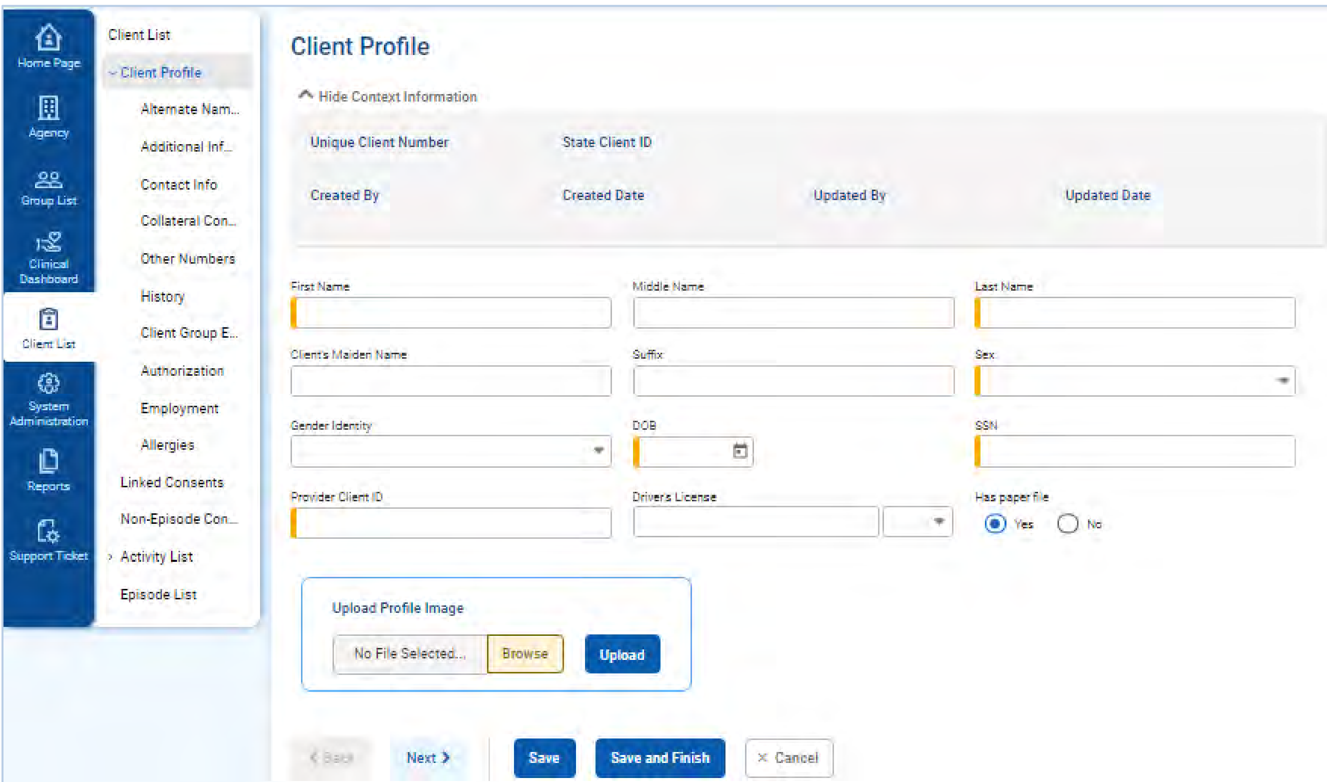


Figure 2-3: Client Profile screen

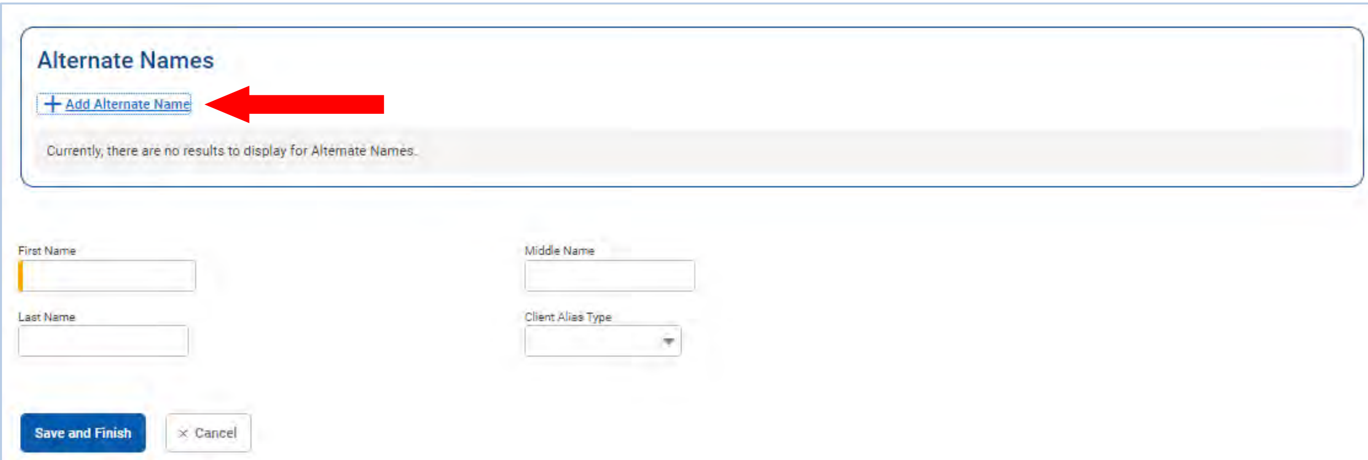
4. Review the profile fields for accuracy and then click **Save**.
5. Click the **right-arrow** to move to the **Alternate Names** screen.

Alternate Names

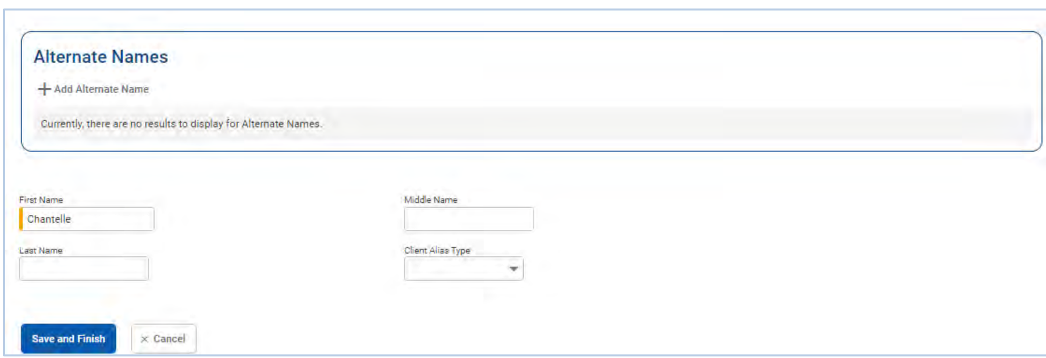
The client's nickname may be entered on this screen.

Tip: Alternative names can also be used to search for the client's profile in the future. On the Client Search screen, type the client's alternative name in the First Name and/or Last Name fields.

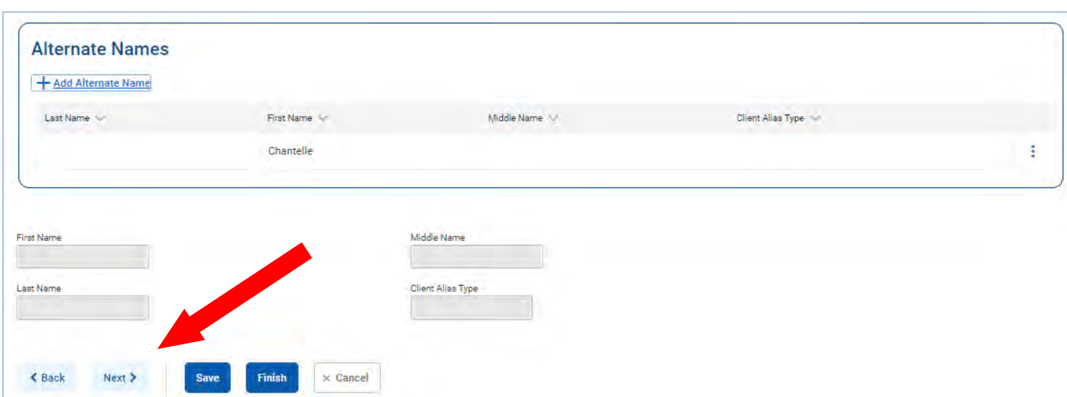
1. On the Alternate Names screen, click **Add Alternate Name**, and the bottom half of the screen becomes editable.



2. Complete at least the **First Name** field.



3. Select **Save and Finish**. The name will now appear in the list at the top of the screen.
4. From the Alternate Names screen, click the **Next** button to open the **Additional Information** screen.



Additional Information (Required)

Note: The light-yellow fields are required for TEDS.

1. On the **Additional Information** screen, complete at least the light-yellow fields, as these are required for TEDS reporting and must be completed before creating an Intake.

Table 2-2: Additional Information screen – Required Fields for TEDS Reporting

Field	Description
Ethnicity	Select from the drop-down list.
Selected Races	Select one or more races.
Veteran Status	Select from the drop-down list.
Citizenship	Select from the drop-down list.

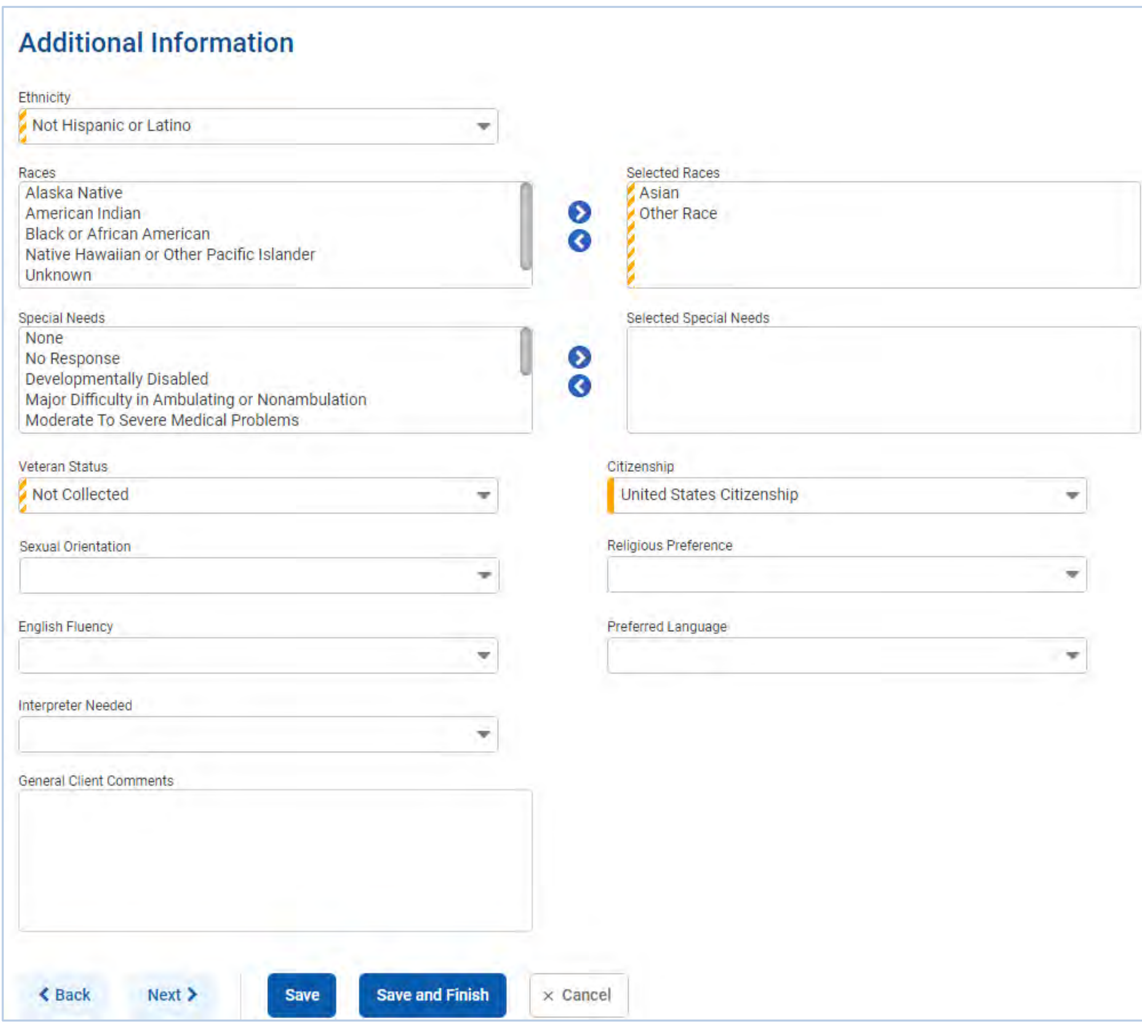


Figure 2-4: Client Profile, Additional Information screen

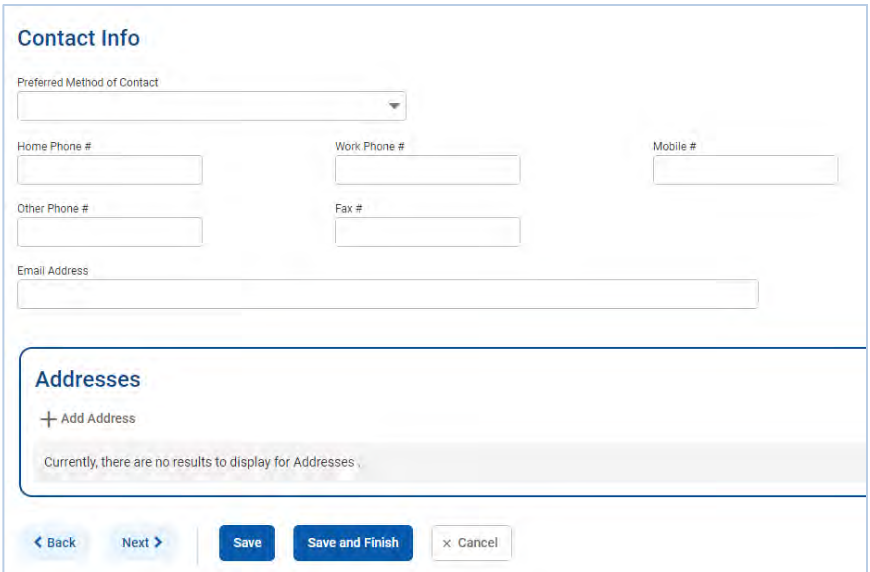
2. When complete, click **Save**, then click the **Next** button to open the **Contact Info** screen.

Contact Info (Required)

Mississippi Requirement: Add Client's Home Address

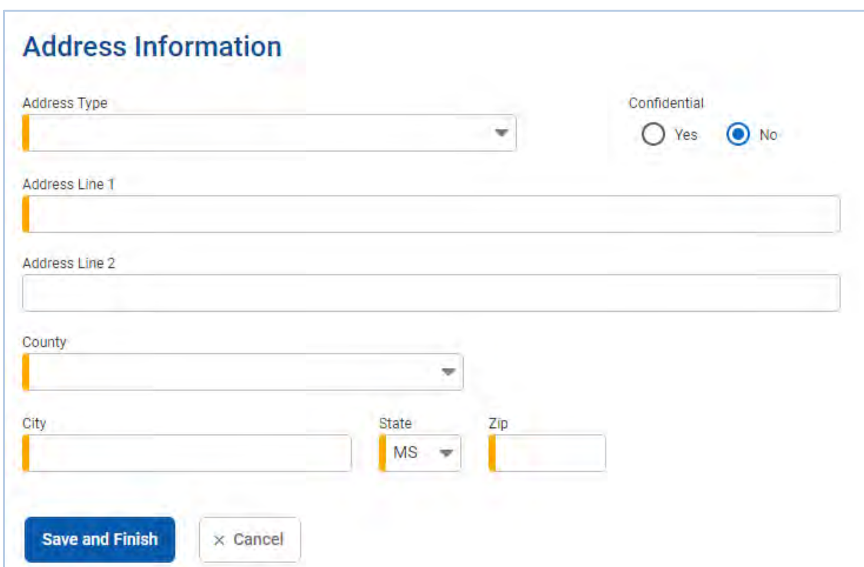
1. On the **Contact Info** screen, a phone number can be entered for the client.

2. To enter an address, click **Add Address**. This will open the Address Information screen.



Contact Info screen

3. Enter the client's Address Type, Address line 1, County, City, State, and Zip Code.



Address Information screen

4. When complete, click **Save and Finish**, and the client's address information will show up on the Contact Info screen. You may enter several addresses for a client. If a client has a new address, update the Address Type of the current address record to "Previous", then create a new address.

5. From the **Contact Info** screen, click the **right-arrow** button to open the **Collateral Contacts** screen.

Collateral Contacts

1. On the **Collateral Contacts** screen, note the fields below are grey, and click the **Add Contact** link.

Table 2-3: Caption for Sample Table

Field	Description
First Name	Type the contact's first name.
Last Name	Type the contact's last name.
Relation	Select the collateral contact's relation to the client from the drop-down menu.
Address, **City**, **State**	Type the contact's address information
Can Contact	Select Yes or No.
Consent On File	Select Yes or No.

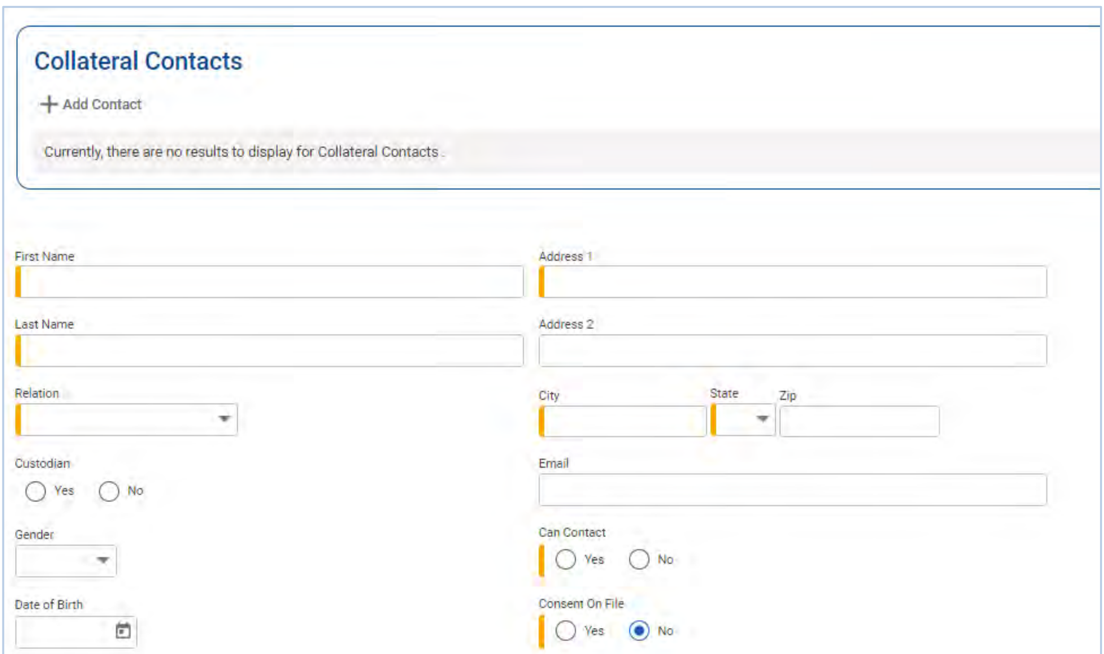


Figure 2-5: Add Collateral Contacts screen

2. When complete, click **Save and Finish**. The names now show up in the table on top of the screen.

3. From the **Collateral Contacts** screen, click the **right-arrow** button to open the **Other Numbers** screen.

Other Numbers

In this section, users can add additional identifying numbers for a client, such as a court case number. This section is OPTIONAL and does not need to be completed for the profile to be considered complete.

1. On the **Other Numbers** screen, click the **Add Other Number** link. The bottom half of the screen now becomes editable.

2. Fill in information such as, Number Type, Number, Start Date, Status, and Contact.

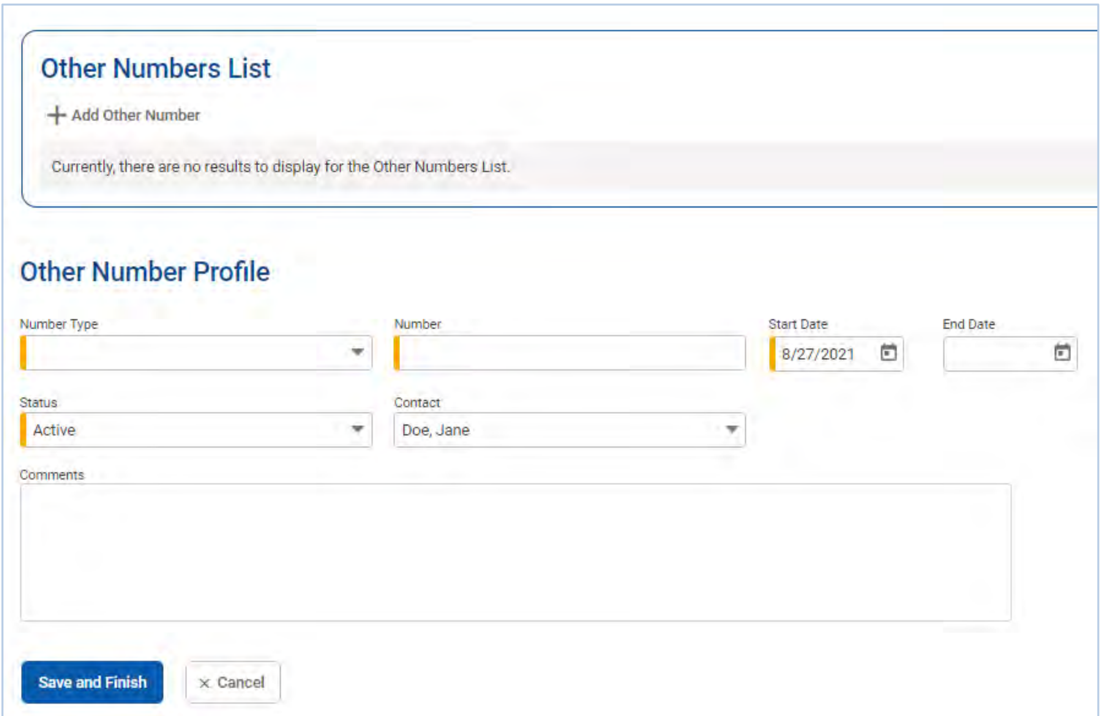


Figure 2-6: Other Numbers screen, saved collateral contact

3. The **Contact** dropdown box will display the names of any saved Collateral Contacts from the previous screen. If the name of the Collateral Contact is not present, click on the **Collateral Contacts** screen to add a new record.

4. When complete, click **Save and Finish**. The names now show up in the table on top of the screen.

5. Click **Finish** again, and you are redirected to the **Client Search** screen.

History

The **History** sub-menu displays a list of all changes that have been made to the client information as well as any access to this client's record. It lists the date, the staff person, and a description of the access or change.

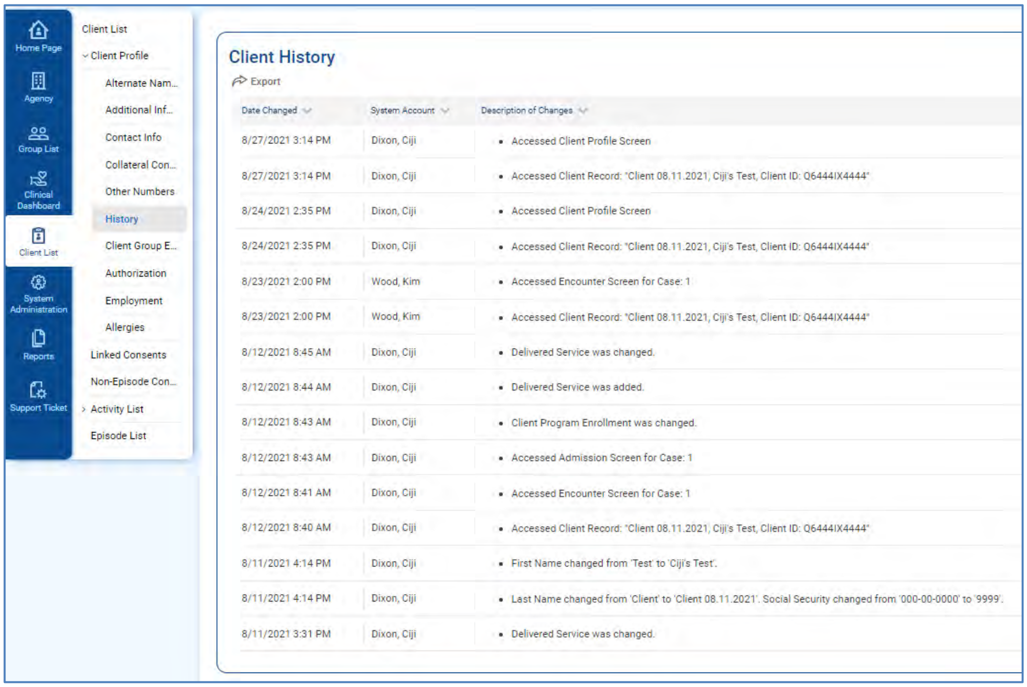
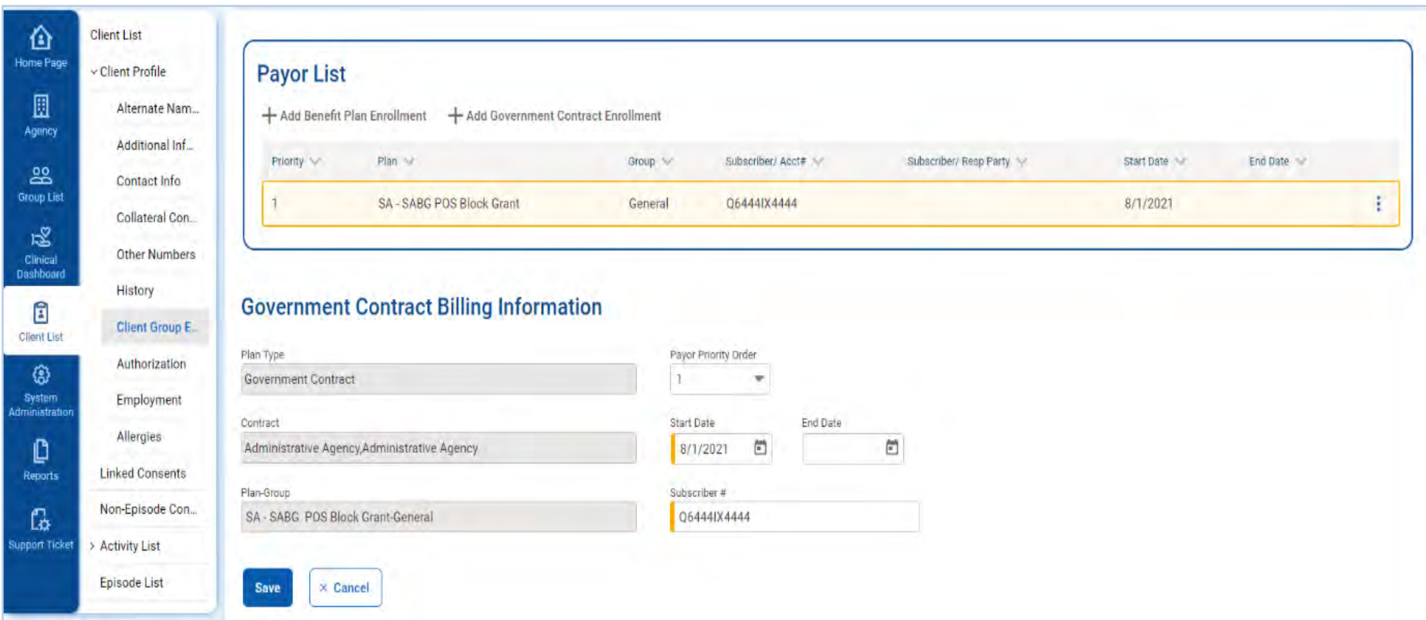


Figure 2-7: Client History screen

Client Group Enrollment

Note: This section must be completed prior to selecting **Release to Billing** on billable Encounters.

The **Client Group Enrollment** sub-menu displays a list of all Payor Plan/Groups to be selected as funding sources for billable encounters. This section lists the Plan, Group, Subscriber/Account#, Start Date of plan, End Date of plan, and Plan Type (Benefit Plan Enrollment or Government Contract Enrollment). If no plans are listed, you may select the **Add Government Contract Enrollment** link at the top-right of the Payor List section. This option will allow you to select from available contracts and plans/groups assigned to your agency. You will add the **Government Contract Billing Information** at the bottom of the screen. Select the **Save** button once completed.

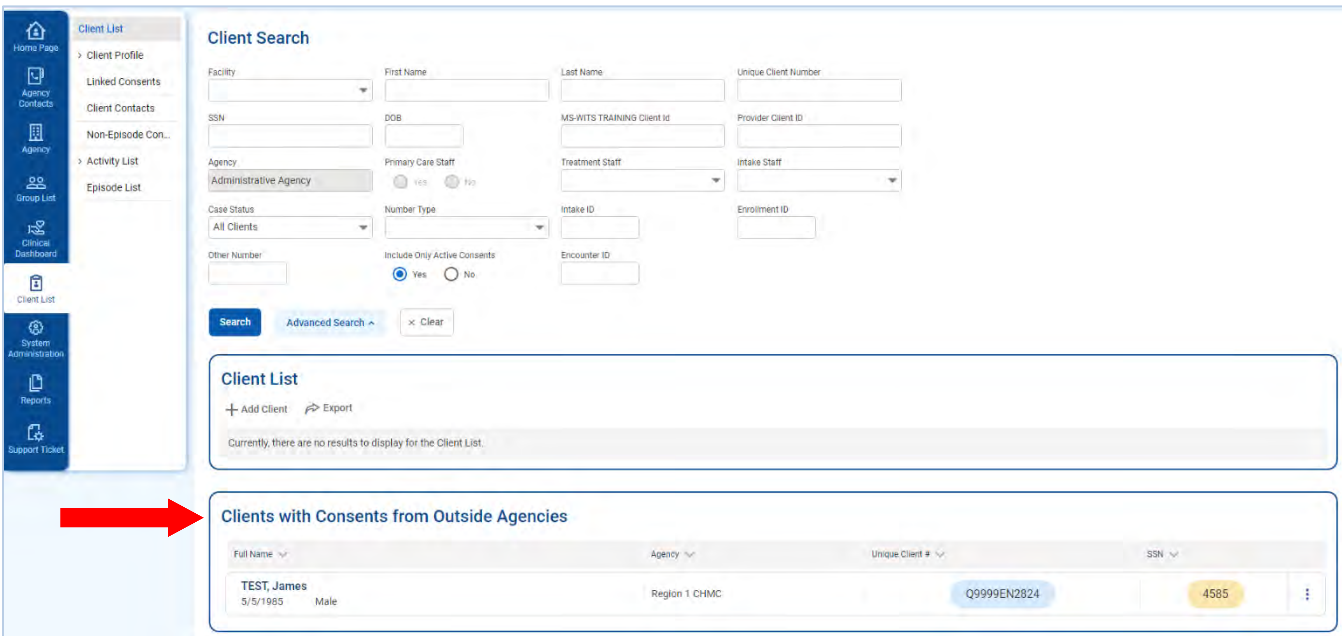


Linked Consents

Where: ***Client List*** ***> Clients with Consents from Outside Agencies***

Each time another agency consents client information to your agency, a row will be displayed on the "**Clients with Consents from Outside Agencies**" section of the **Client List** screen. Always look at the linked consents first to make sure you do not already have that client entered.

If the consent is sent along with a referral and the referral is accepted at the referred to agency, users with a Clinical Supervisor role may manually link and unlink consents. This action is available when it is clear that a client with consented information is in fact the same person as a client that exists in the agency. They may not have been automatically linked because the names or other identifying information may have been different in the sending agency than they are in the receiving agency.



For example:

A client named "James" is referred into your agency from an outside agency. Your agency already has a record for a client named "Jimmy". The Linked Consents screen allows you to compare the New/Referred Client Information (James) with the Existing Client Information (Jimmy). Using this screen, you can tell that James and Jimmy are the same person. Therefore, these two profiles can be linked together so the same client will not have two different client profiles within the same agency.

Link to Consented Client

1. On the left menu, click **Client List** and then click **Search**.

2. In the **Clients with Consents from Outside Agencies** section, hover over the Ellipsis icon in the far-right column of the client's record and click **Link**.

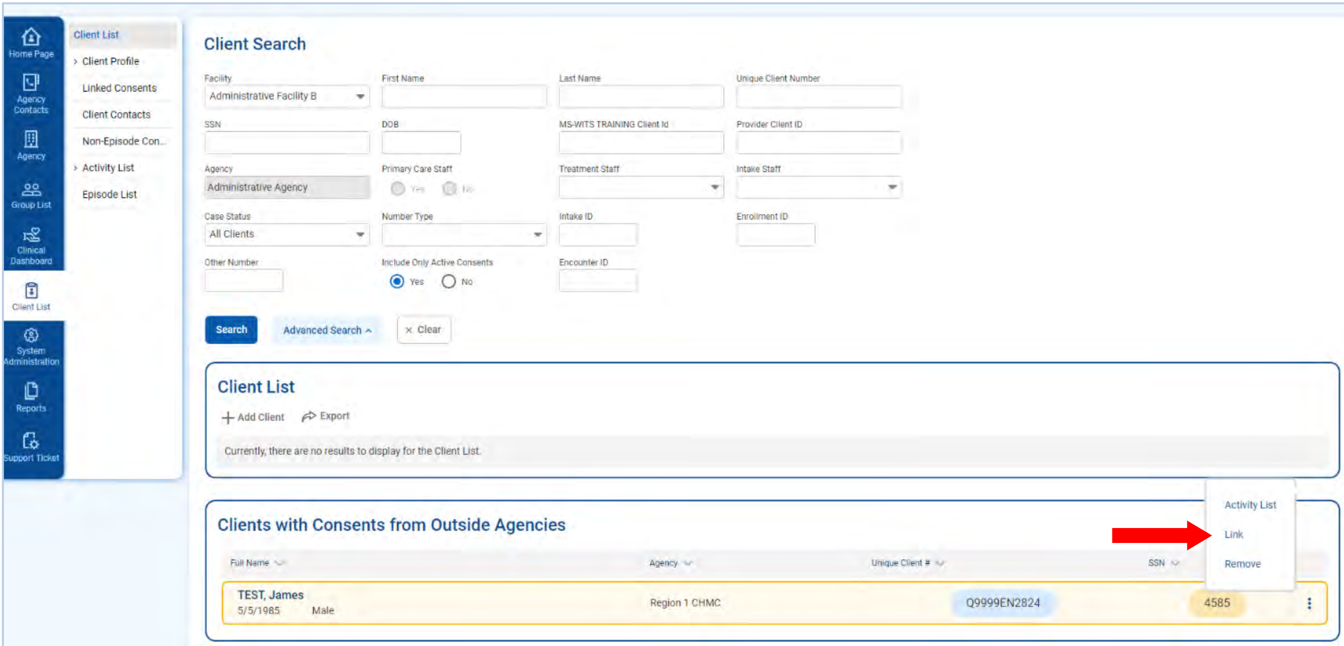


Figure 2-8: Client List screen, Clients with Consents from Outside Agencies section, Link action item

3. The **Link Client Search** screen will appear and the Consented Client information is displayed as read-only fields.

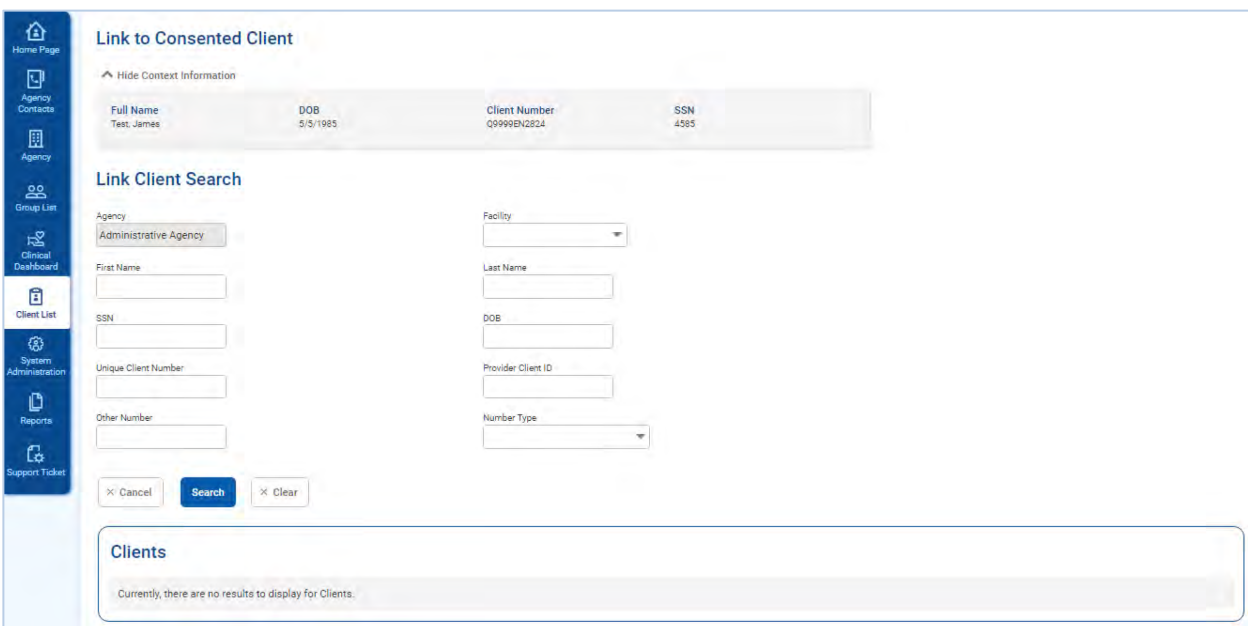


Figure 2-9: Link Client Search screen

4. Use the search fields to find a client with similar information. It is helpful to copy and paste some of the consented client's information into the search fields. The example in Figure 2-10 uses the Consented Client's Unique Client Number in the search field.

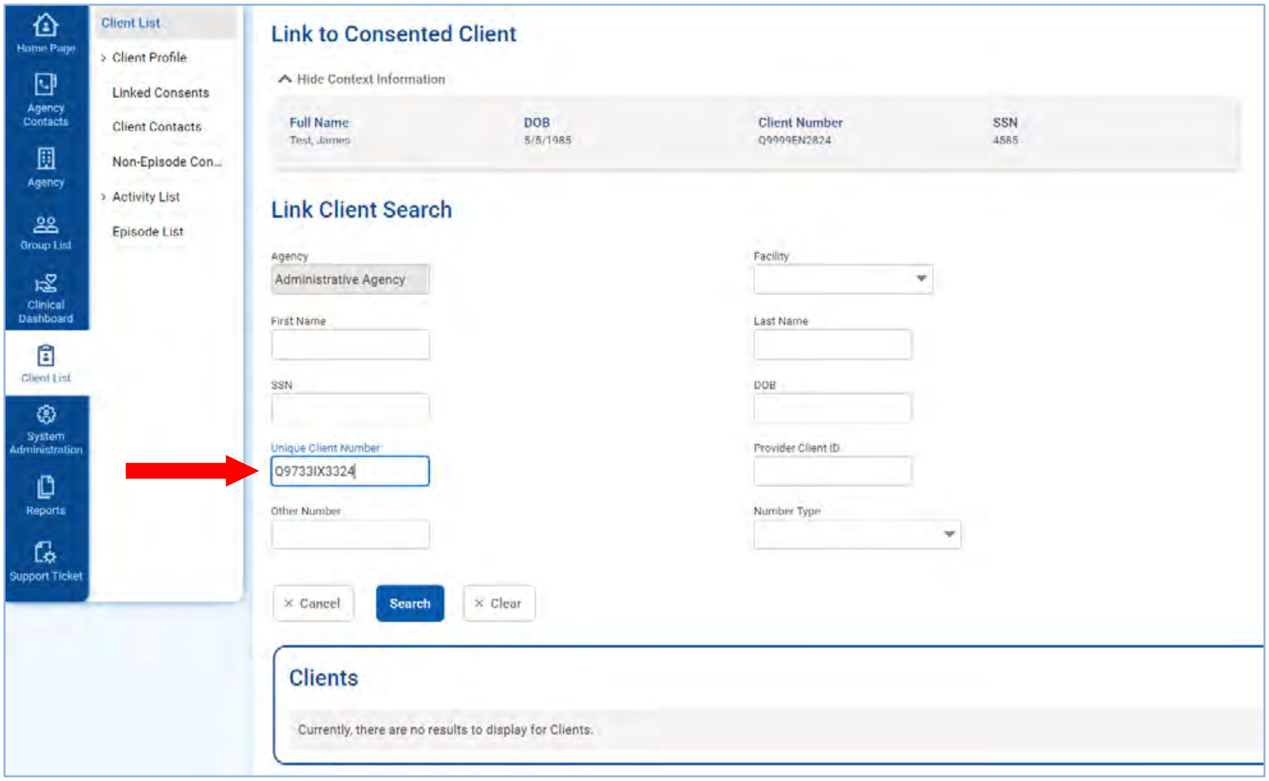


Figure 2-10: Link Client Search screen, search by Unique Client Number

5. After filling out one or more search fields, click **Search** and then review the search results.

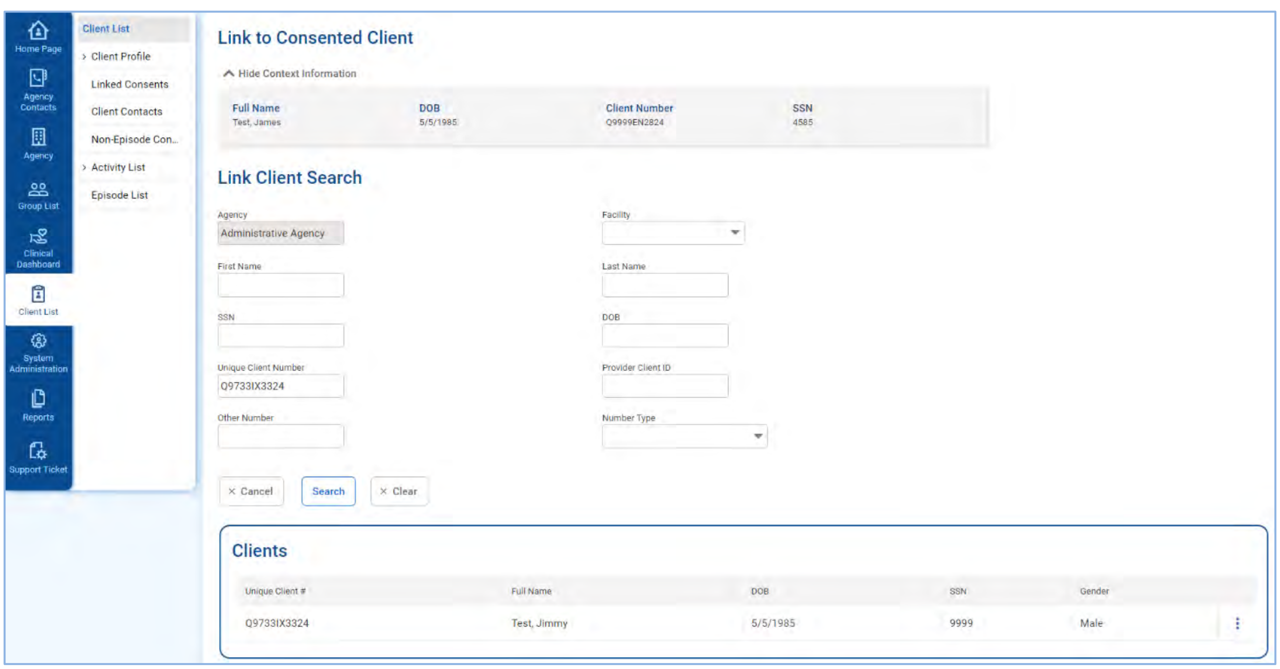


Figure 2-11: Link Client Search screen with search results

6. If the information in the search results matches the Consented Client information, hover over the ellipsis icon and then select **Link**.

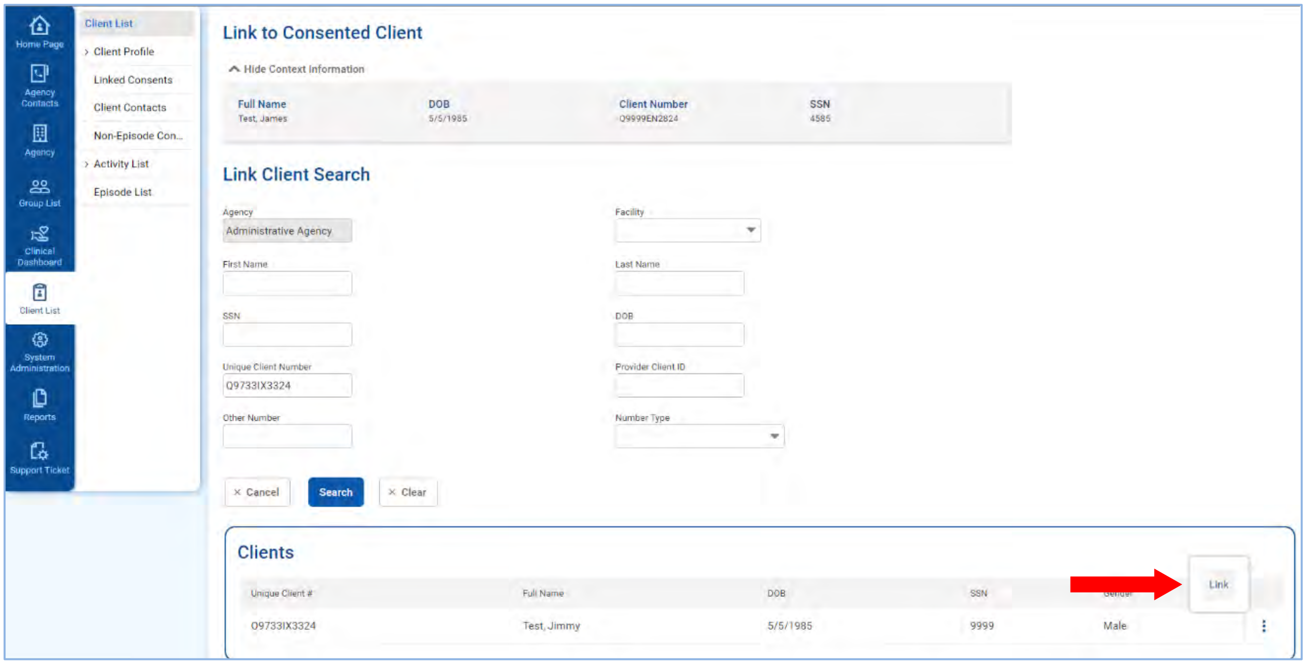


Figure 2-12: Link Client Search screen, Link Consent record

7. Click **Yes**.

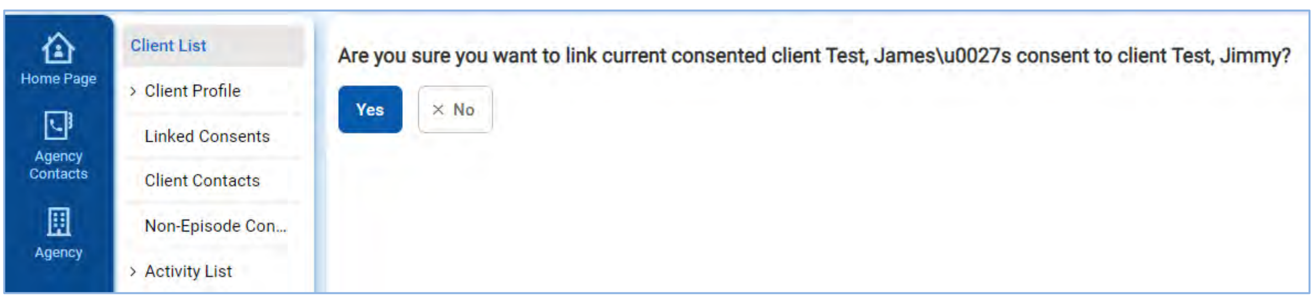


Figure 2-13: Are you sure you want to link current consented client to the consent client

8. The client's Linked Consent screen will now display the consent record from the other agency.

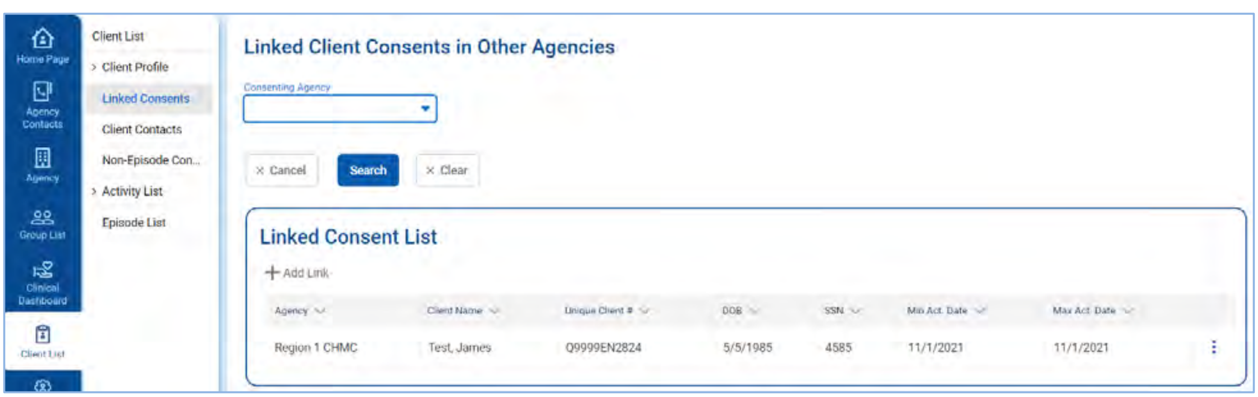


Figure 2-14: Linked Consents screen

Part 3: Client Intake and Program Enrollment

Client Activity List

It is important to understand that data collection in WITS happens within a Client's Activity List. The Case, or Episode of Care, is the container that holds all client activities. The beginning and end of a client's Episode of Care are recorded on the Intake transaction, where the Intake Date starts the Episode and the Intake Date Closed marks the end of the Episode.

The concept diagram below illustrates how this data collection is structured within the client Activity List. This Activity List is comprised of three (3) primary nested containers: Episode (e.g., Case, or Intake), Admission, and Program. The double lines connecting the Program container represent multiple program enrollments, which are allowed within a single Admission. In the diagram, arrows denote the sequence of progressing through each container.

When an Episode of Care ends for a client, this signifies that the client is no longer receiving services. It is possible for that client to return at a future date.

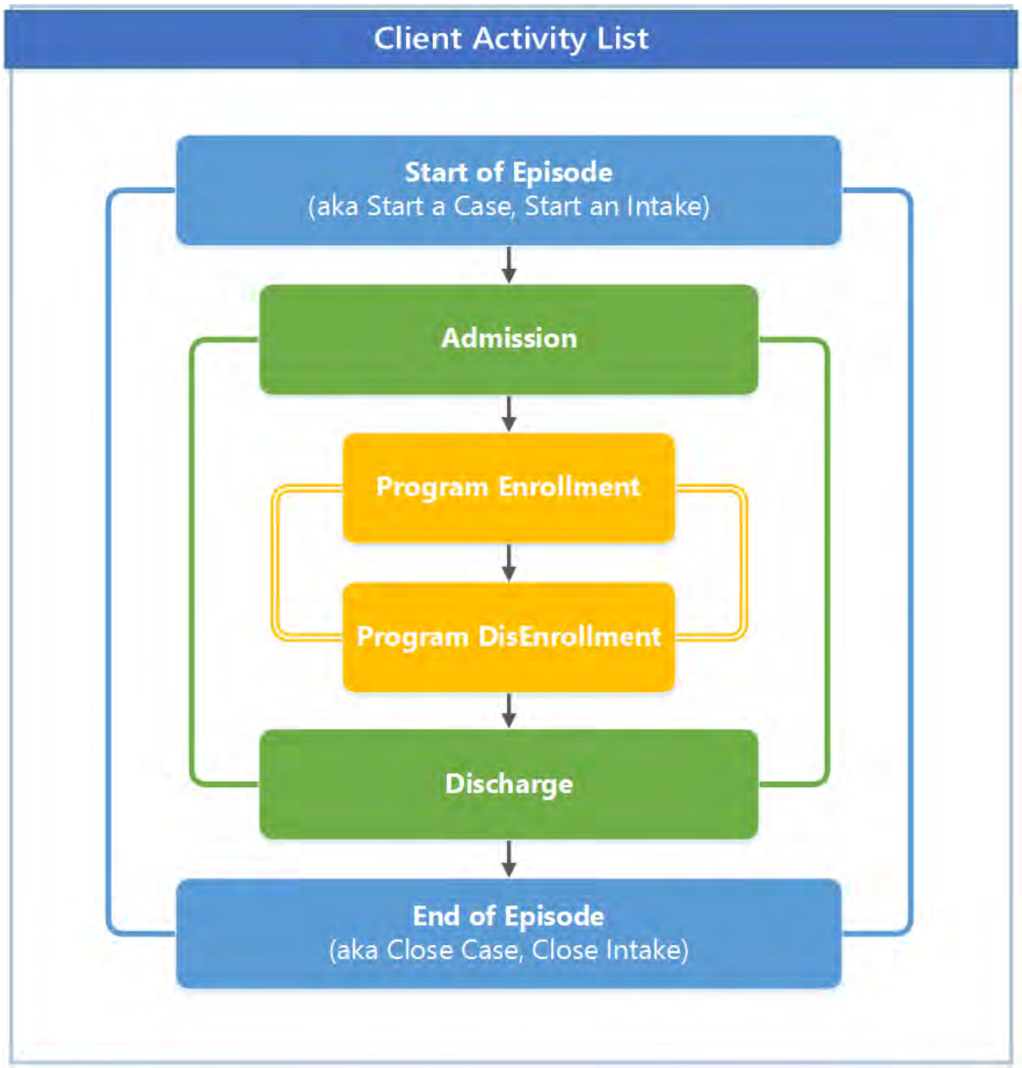


Figure 3-1: Concept Diagram of Data Collection Structure within Client Activity List

The **Client Activity List** can serve as a "dashboard' view for information that has been collected for a given client within an Episode. Each Activity on the Activity List has a status to help the end user determine if that activity is "Complete" or "In Progress". When an activity is "In Progress", a **Details** link is available which displays the information needed to complete the activity.

Certain client activities must be complete before you can proceed to a following activity. Validation rules will guide you throughout the workflow as you enter new data.

To access items within the Activity List, a client must be selected first.

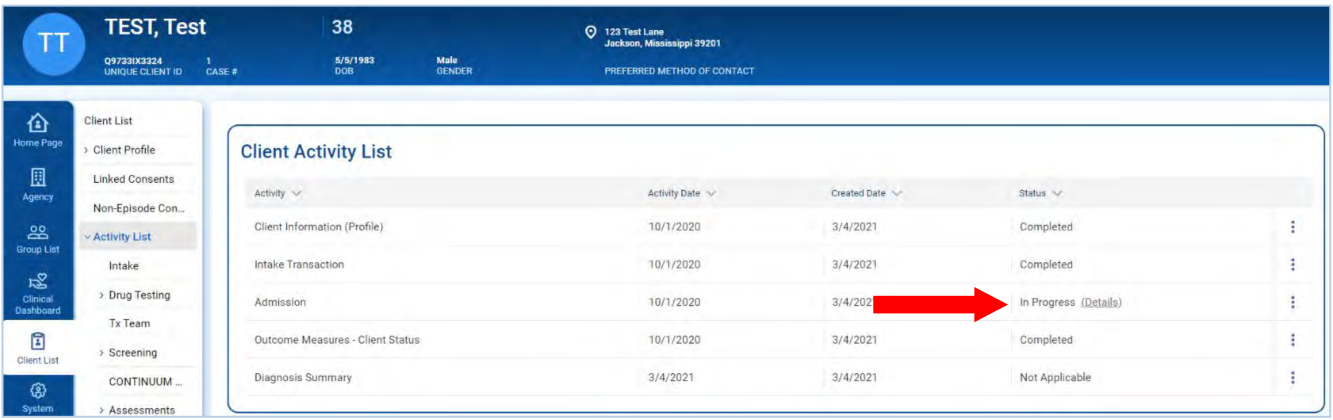


Figure 3-2: Client Activity List, Details link

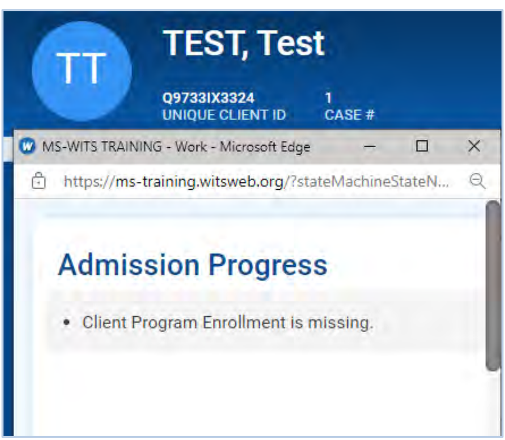


Figure 3-3: Details link, list of missing information

Some Client Activities do not have a concept of being complete. For those activities, the Status will be listed as Not Applicable.

Start New Episode (New Clients)

***Where:* Client List > Activity List > Episode List**

In WITS, all items located in a client's Activity List are based upon an active Episode of Care. In the screen capture below, note the Activity List in the left menu only displays one item, "Episode List". An episode must be created before accessing other items in the client's Activity List.

To start a new episode of care for a client, follow the steps below.

1. On the left menu, click **Episode List**.
2. Click the **Start New Episode** link.

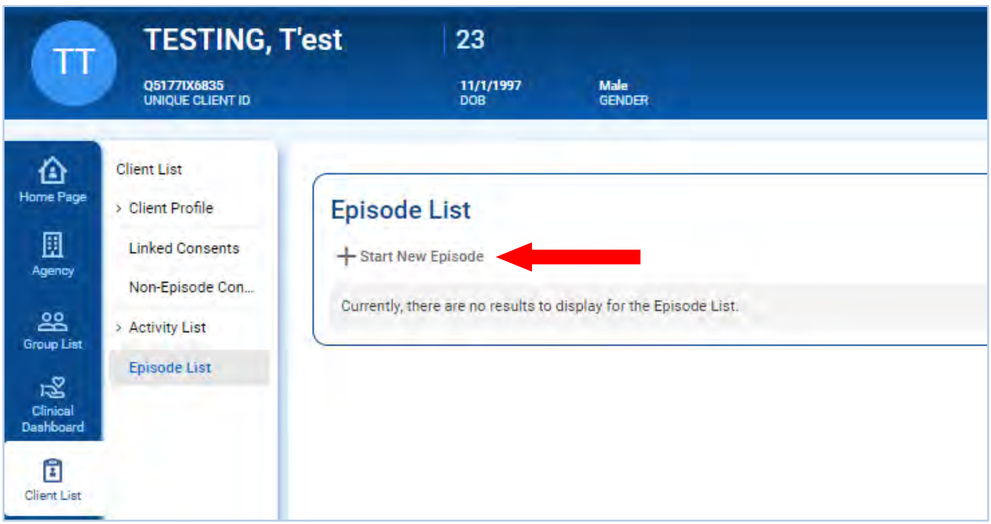


Figure 3-4: Episode List screen, Start New Episode link

If the client profile is missing certain information, such as an Address or fields on the Additional Information screen, a New Episode cannot be created and an error message will appear, as shown in Figure 3-5.

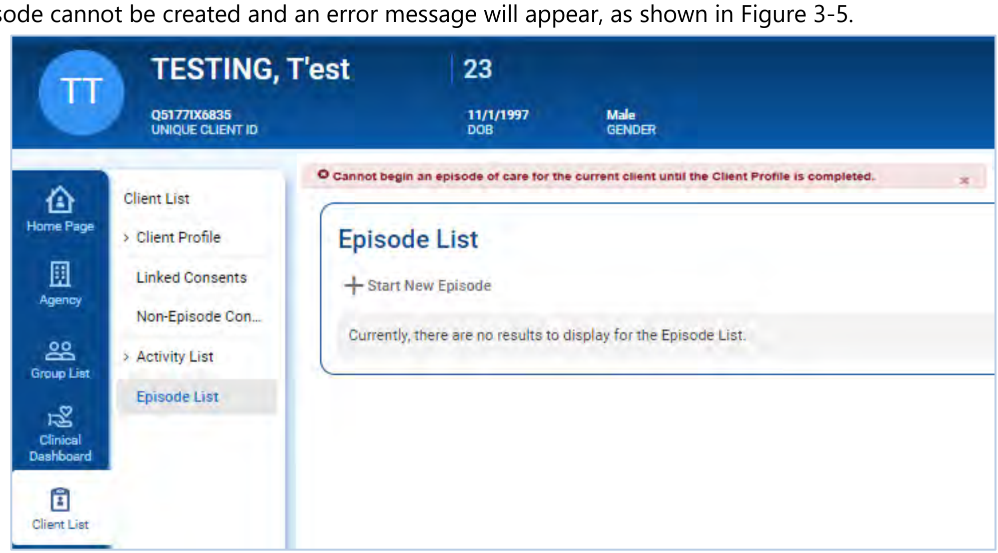


Figure 3-5: Episode List screen, Error Message

If the client profile is complete, clicking **Start New Episode** will open the **Intake Case Information** screen, as shown in Figure 3-6: Intake Case Information screen. *(Continue to next section)*

Intake

***Where:* Client List >Activity List > Intake**

Once an episode of care has been created (see above section), complete the client's intake.

1. On the Intake Case Information screen, complete the fields as shown in the table below.

Table 3-1: Intake Case Information Fields

Field	Description
Intake Facility	Pre-populates with the current facility location.
Intake Staff	Pre-populates with the current staff member name.
Initial Contact	Select from the drop-down list.
Case Status	Defaults to "Open Active".
Initial Contact Date	The date when the Client first reached out for treatment.
Intake Date	Enter the client's intake date, (which also marks the beginning of the client's Episode).
Pregnant	Is the client pregnant at the time of admission?Complete if applicable.
Due Date	If Pregnant 'Yes', the Due Date field will be required.
Prenatal Treatment	(Optional) Is the client also receiving prenataltreatment? Select Yes/No if applicable.
Residence	Enter the client's county of residence at intake.
Source of Referral	Select from the drop-down list.
Referral Contact	(Optional) Select from a list of the client's collateral contacts.
HIV Positive	Select from the drop-down list.
Injection Drug User	Select Yes or No.
DUI Offender	Select from the drop-down list.
Occupation	(Optional)
Problem Area	(Optional)
Presenting Problem (In Client's Own Words)	(Optional)
Special Initiatives/Populations Selected	Select one or more options.
Inter-Agency Service Selected	(Optional)
Selected Domains	This field will be pre-populated and read-only if there is only one domain associated with the agency. If the agency has multiple domains, select the appropriate domain(s) for the client.
Date Closed 	The Date Closed field is used to mark the end of the client's Episode.

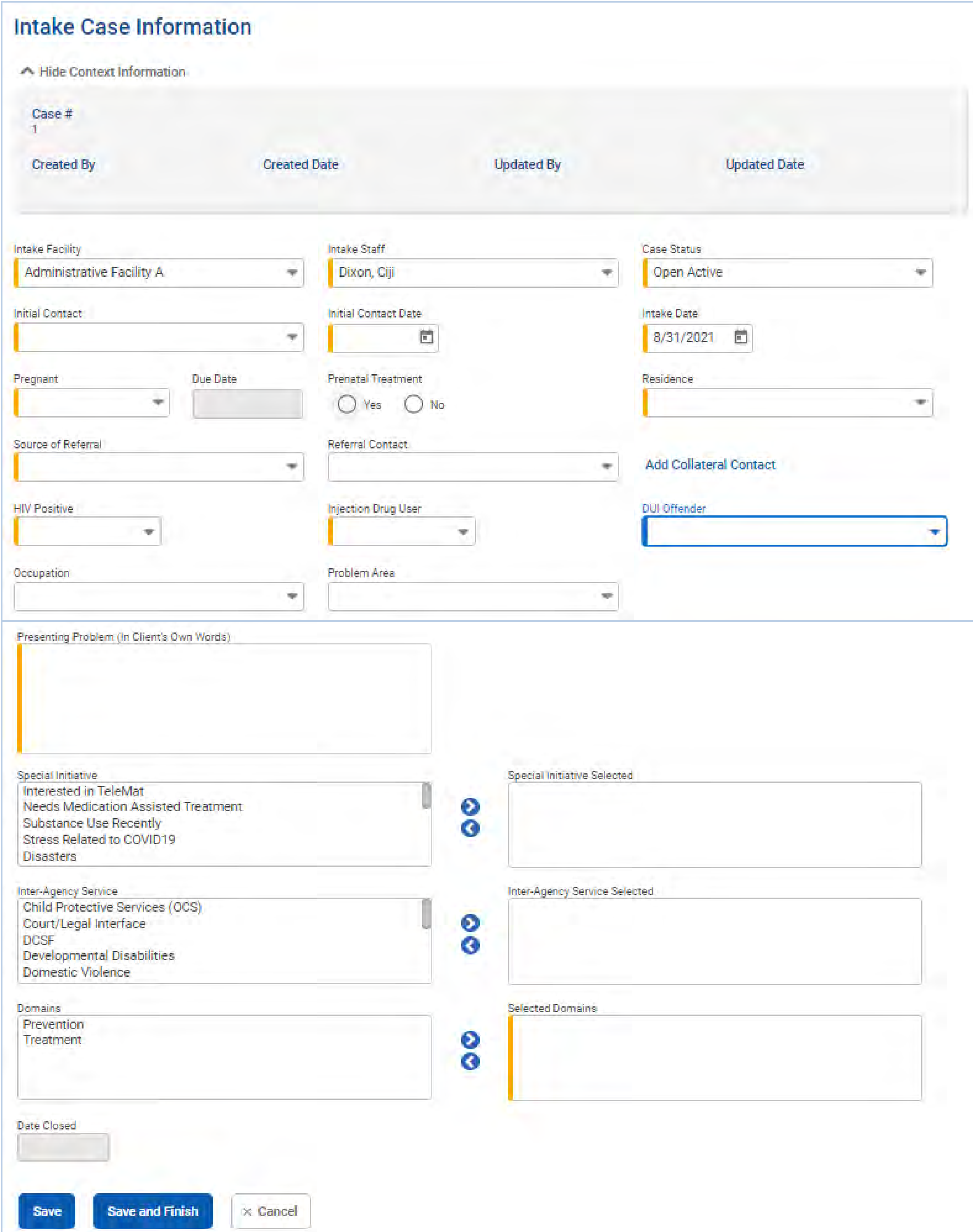


Figure 3-6: Intake Case Information screen

3. Click **Save and Finish**.

Admission

Where: Client List > Activity List > Admission

The Admission Screen in WITS denotes the date when a client has been admitted into Treatment, but does not always represent the date when a level of care has been assigned. The admission process may not be completed in one visit.

1. On the left menu, click **Client List** and search for a client.
2. Hover over the ellipsis on the right side of the client's record, and select **Activity List**.
3. On the left menu, click **Admission**.
4. Complete the fields on the Admission Profile.

Table 3-4: Admission Profile Fields

Field	Description
Admission Type	Defaults to Initial Admission.
Admission Staff	Defaults to the staff member currently signed in.
Admission Date	Defaults to the current date.
Selected Administrative Checklist Items	(Optional)

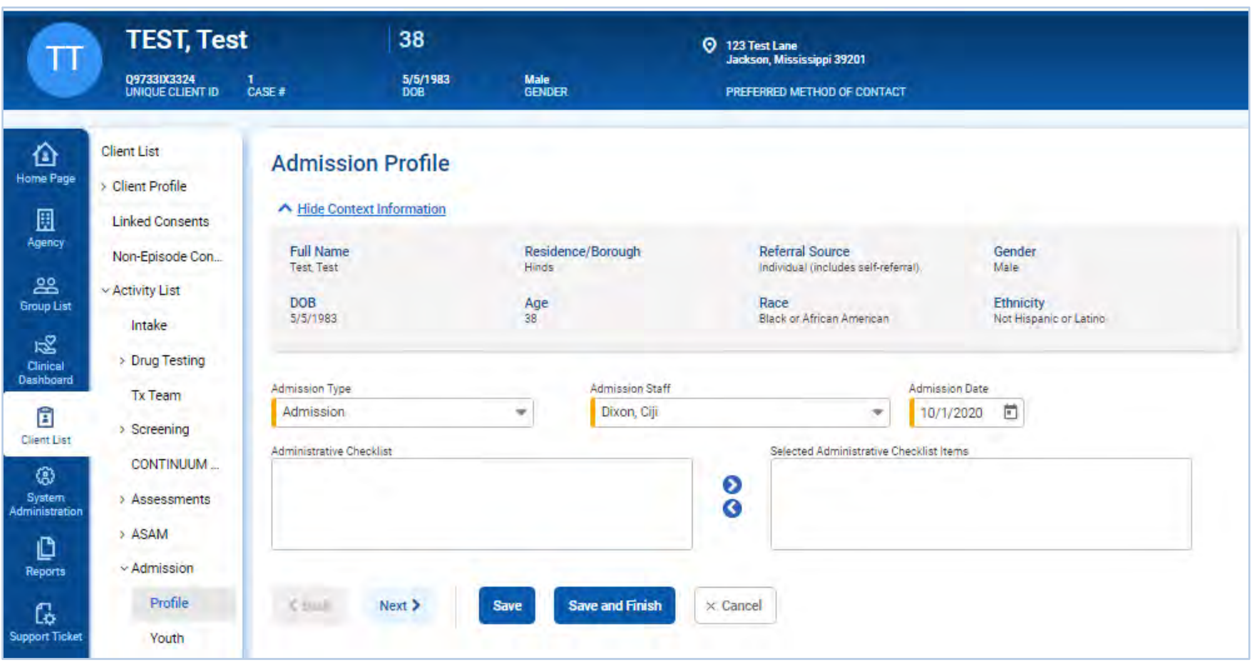


Figure 3-16: Admission Profile screen

5. Click **Save and Finish**.

NOTE • Optional information can be entered by clicking the **Next** button. Please see the following page.

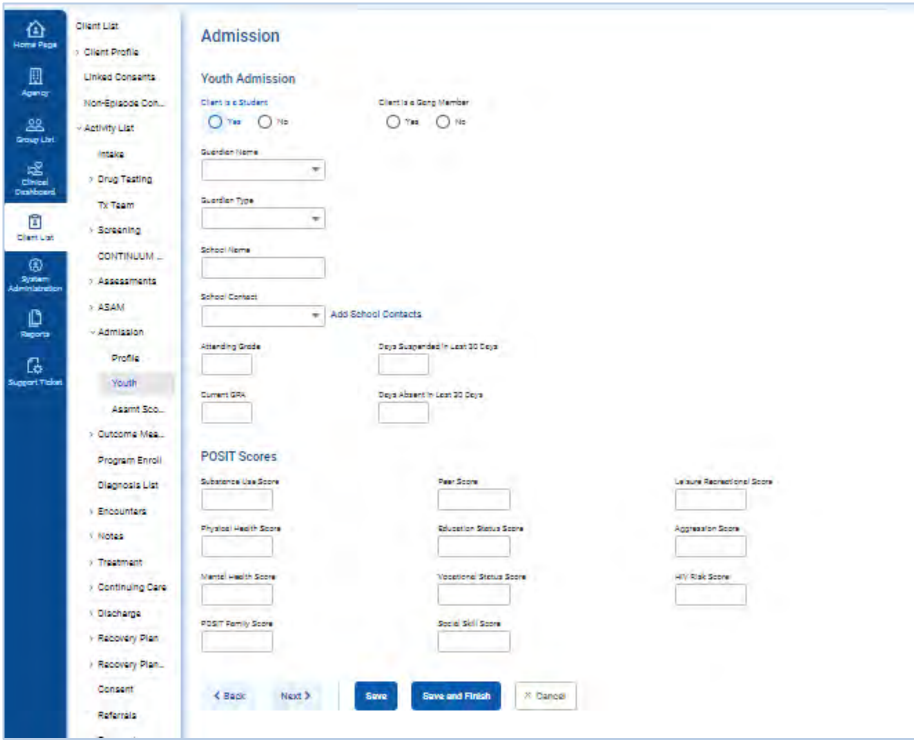


Figure 3-17: Admission, Youth Admission screen

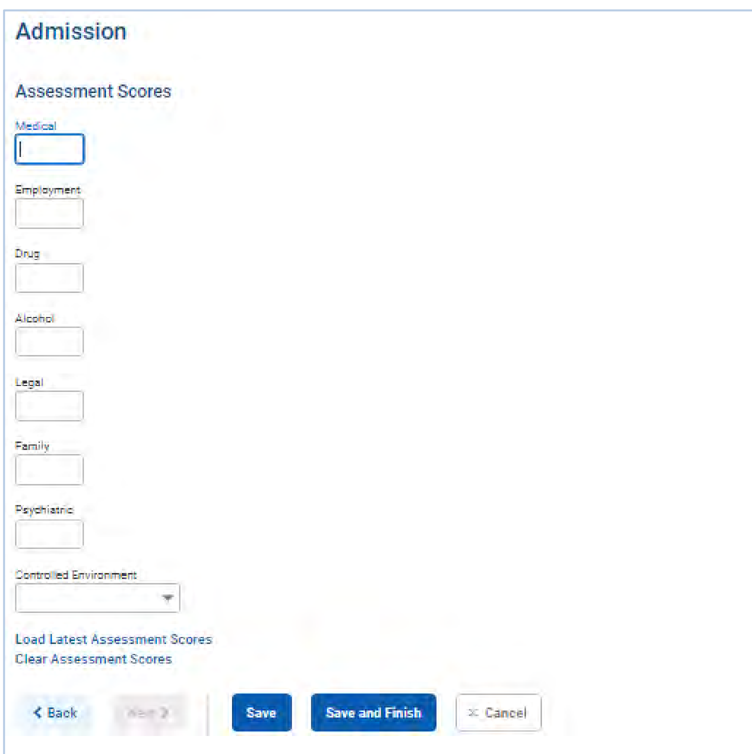


Figure 3-18: Admission, Assessment Scores screen

Part 4: Outcome Measures

***Where:* Client List > Activity List > Outcome Measures**

The Outcome Measures module in WITS is used to collect data needed for the NOMS extract, which is reported to SAMHSA. Be sure to complete all steps on the Outcome Measure screens to ensure accurate and complete TEDS information collection.

An **Initial Outcome Measure** must be completed and finalized within **thirty (30) days** of enrolling a client into a TEDS treatment program. This requirement is only applicable to programs that report TEDS data. Enrollment in Case Management programs do not have this requirement.

Initial Outcome Measures

1. On the left menu, click **Client List** and search for a client.
2. Hover over the ellipsis icon and click **Activity List**.
3. On the left menu, click **Outcome Measures**.
4. On the Outcome Measures List screen, click **Add New**. This will open the Outcome Measures - Client Status screen.

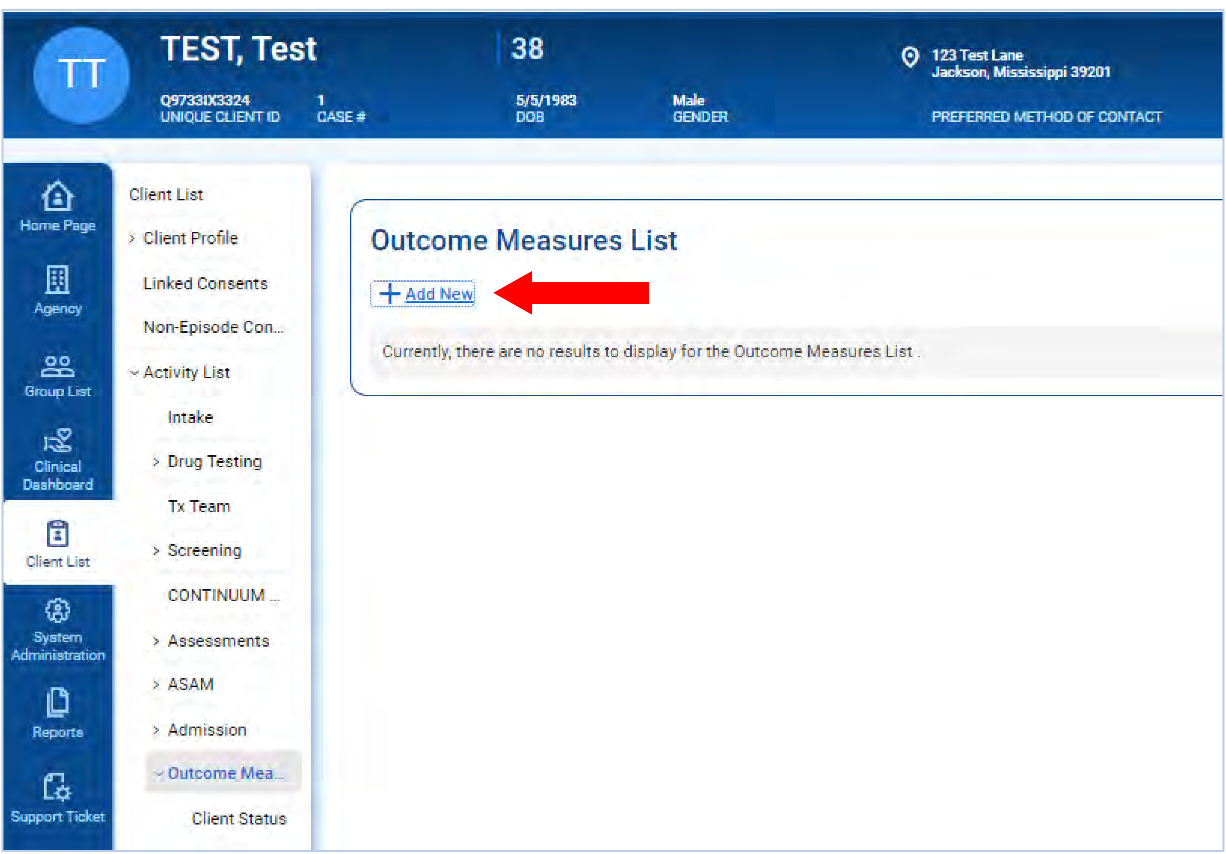


Figure 4-1: Outcome Measure screen, Add New link

Continue to next page

Client Status

Where:* Client List > Activity List > Outcome Measures > *Client Status

The **Outcome Measures – Client Status** screen displays a series of questions grouped into separate sections on screen.

Note: This portion of the documentation follows a slightly different format than the rest of the user guide.

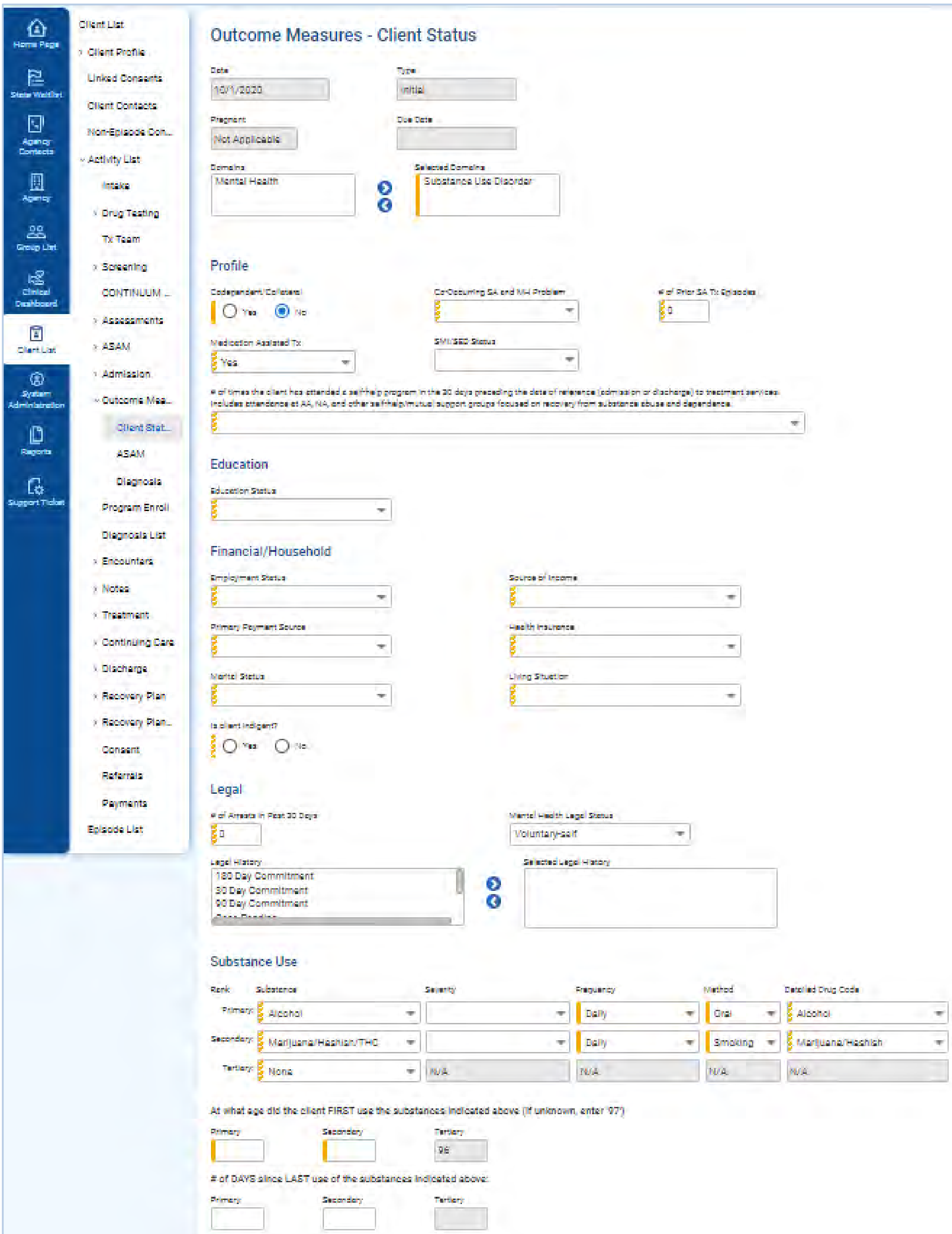


Figure 4-2: Initial Outcome Measures – Client Status screen

5. Complete the fields on the **Outcome Measures – Client Status** screen as shown in the sections provided below.

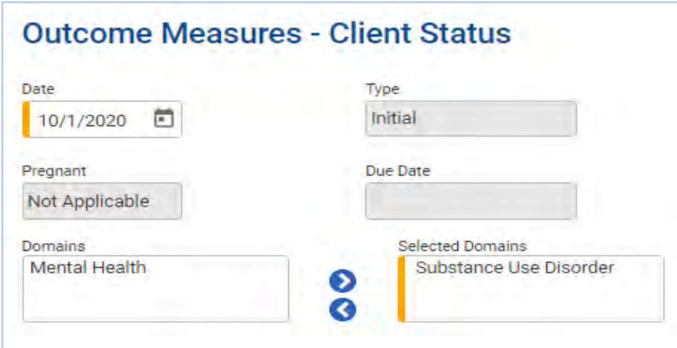


Table 4-1: Outcome Measures – Client Status (Initial) fields

Field	Description
Date	Pre-populates with the Admission Date.
Type	Defaults to **"Initial"** when adding the first Outcome Measure.
Pregnant	Pre-populates with the selection entered on the Intake screen. Select Yes or No, if applicable.
Due Date	Pre-populates with the selection entered on the Intake screen. Enter client's Due Date, if applicable.
Selected Domains	In the Domains box, select the appropriate option(s). Click the top arrow (>) button to move the chosen domain(s) to the Selected Domains box. **Note**: This field will be read-only until another domain is available in the system.

Profile

Complete the fields in the **Profile** section.

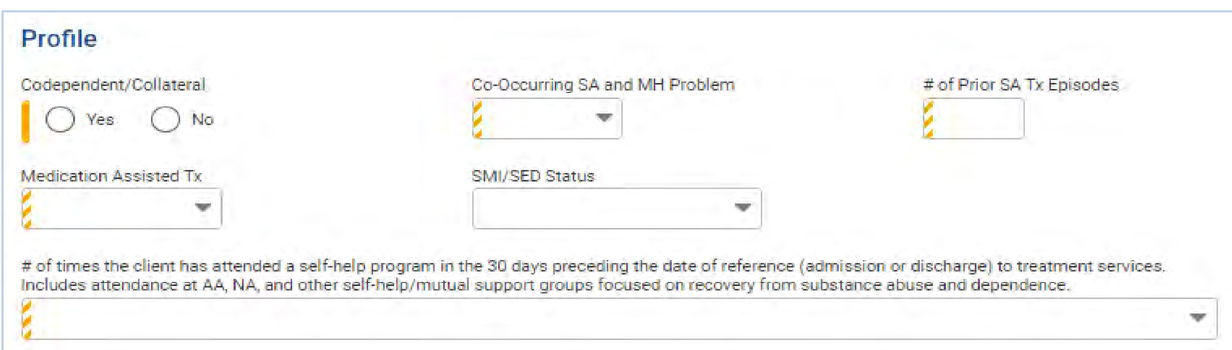


Table 4-2: Outcome Measures – Client Status screen; Profile section fields

Field	Description
Codependent/Collateral	Select Yes/No.
Co-Occurring SA and MH Problem	Select an option from the drop-down list.
Medication Assisted Tx	Select an option from the drop-down list.
SMI/SED Status	(Optional) Select an option from the drop-down list.
# of Prior SA Tx Episodes	Type an integer.

Field	Description
# of times the client has attended a self-help program in the 30 days preceding the date of reference (admission or discharge) to treatment services. Includes attendance at AA, NA, and other self-help/mutual support groups focused on recovery from substance abuse and dependence.	Select an option from the drop-down list.

Education

Complete the field in the **Education** section.

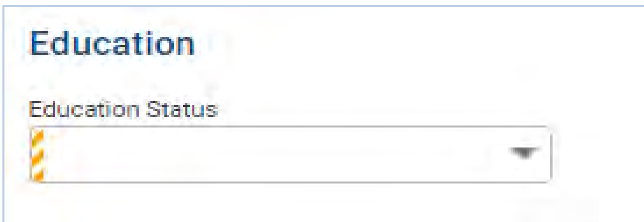


Table 4-3: Outcome Measures – Client Status screen; Education section

Field	Description
Education Status	Select an option from the drop-down list.

Financial/Household

Complete the fields in the **Financial/Household** section.

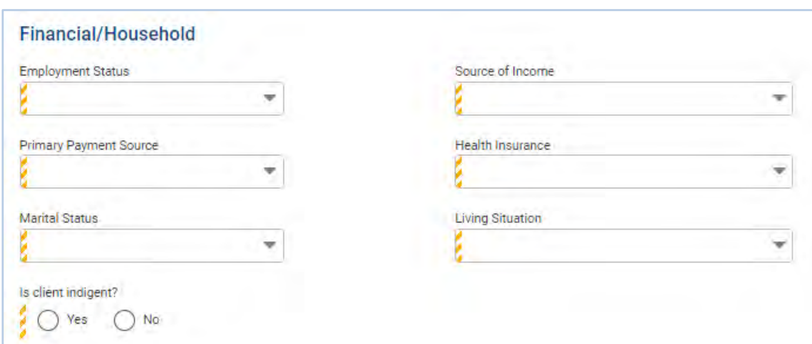


Table 4-4: Outcome Measures – Client Status screen; Financial/Household section

Field	Description
Employment Status	Select an option from the drop-down list.
Source of Income	Select an option from the drop-down list.
Primary Payment Source	Select an option from the drop-down list.
Health Insurance	Select an option from the drop-down list.
Marital Status	Select an option from the drop-down list.
Living Situation	Select an option from the drop-down list.
Is client Indigent?	Select Yes/No.

Legal

Complete the fields in the **Legal** section.

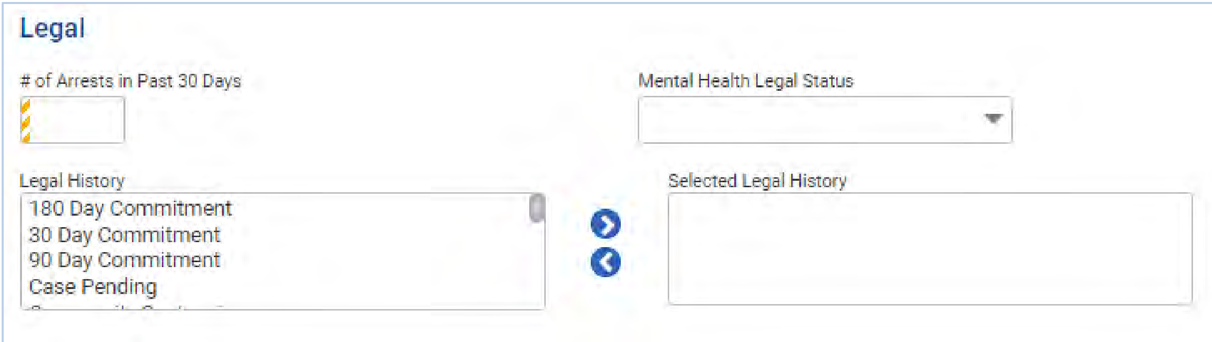


Table 4-5: Outcome Measures – Client Status screen; Legal section

Field	Description
# of Arrests in Past 30 Days	Type an integer.
Mental Health Legal Status	Select an option from the drop-down list. **Note**: System Administrators control the values displayed in this drop-down list through a code table. If values are missing, contact your System Administrator for assistance.
Selected Legal History	In the Legal History box, select the appropriate option(s). Click the top arrow (>) button to move the selected options to the Selected Legal History box.

Substance Use

For each field in the Substance Use section, select options for the client's Primary, Secondary, and Tertiary substances as applicable.

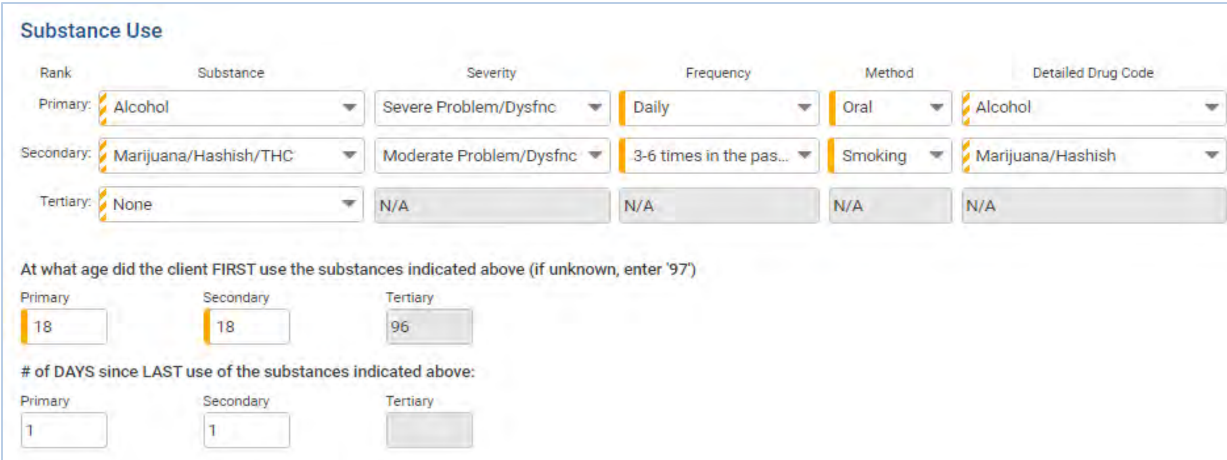


Table 4-6: Outcome Measures – Client Status screen; Substance Abuse section

Field	Description
Substance	Select an option from the drop-down list.
Severity	(Optional) Select an option from the drop-down list.
Frequency	Select the frequency of use from the drop-down list.
Method	This field may pre-populate based on the option selected in Substance field. Select an option from the drop-down list as applicable.
Detailed Drug Code	This field may pre-populate based on the option selected in Substance field. Select an option from the drop-down list as applicable.
At what age did the client FIRST use the substances indicated above (if unknown, enter '97')	Type an integer.
# Of DAYS since LAST use of the substancesindicated above:	(Optional) Type an integer.

Tobacco/Nicotine

In the Tobacco/Nicotine section, complete the field, **"Have you ever used Tobacco/Nicotine products?"** by selecting **Yes**, **No**, or **Unknown**. This answer will update the other fields in the Tobacco/Nicotine section.

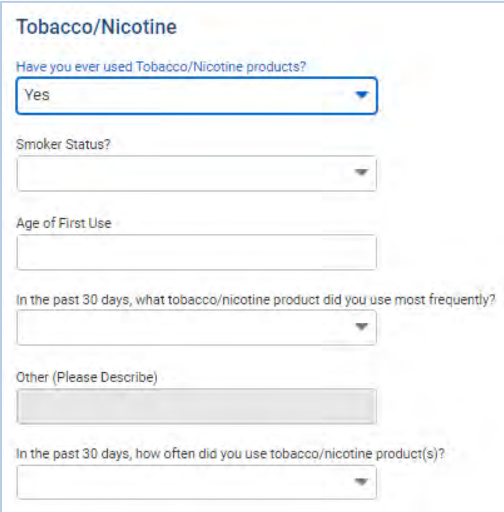
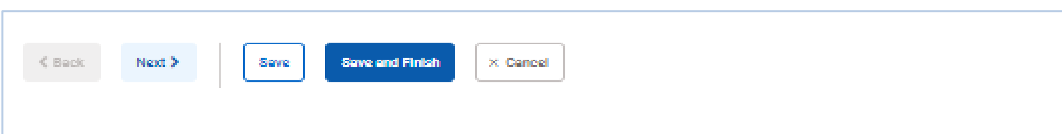


Table 4-7: Outcome Measures – Client Status screen; Tobacco/Nicotine section

Field	Description
Have you ever used Tobacco/Nicotine products?	Select Yes, No, or Unknown. If Yes is selected, the following fields will become editable.
Smoker Status?	Read-only field unless client answered "Yes" to ever using Tobacco/Nicotine products.
Age of First Use	Read-only field unless client answered "Yes" to ever using Tobacco/Nicotine products.
In the past 30 days, what tobacco/nicotine product did you use most frequently?	Read-only field unless client answered "Yes" to ever using Tobacco/Nicotine products.
Other (Please Describe)	Read-only field unless client answered "Yes" to ever using Tobacco/Nicotine products and if "Other" was selected as the type of product used most frequently in the last 30 days.
In the past 30 days, how often did you use tobacco/nicotine product(s)?	Read-only field unless client answered "Yes" to ever using Tobacco/Nicotine products.



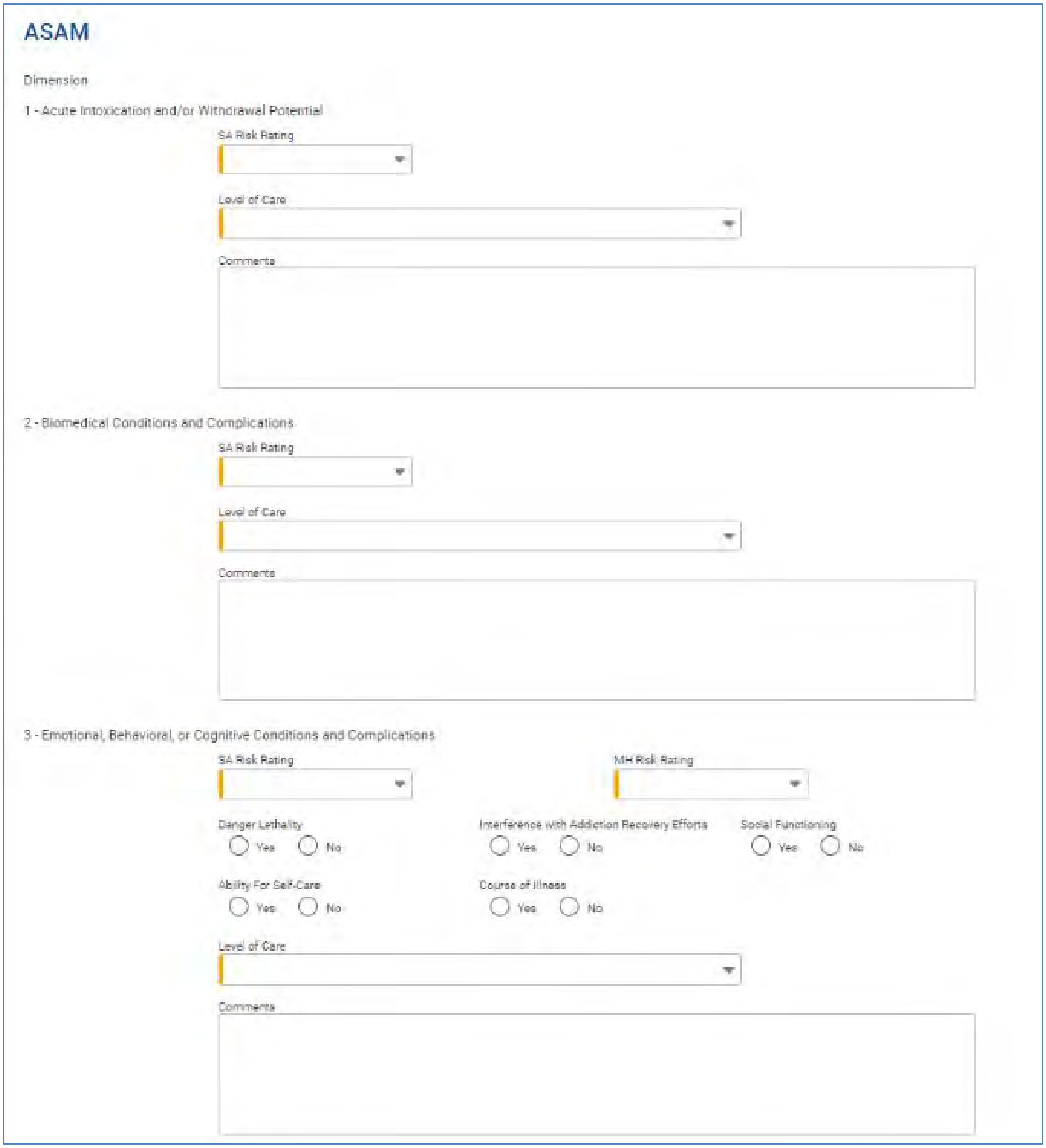
6. Once all required fields have been completed, Click **Save**.
7. Click the **Next** button until you reach the **Client Diagnosis** screen.

ASAM

***Where:* Client List > Activity List > Outcome Measures > ASAM**

1. Complete the fields on the ASAM screen.

Note: The ASAM screen is required for the **Substance Use** treatment domain **ONLY**.



4 - Readiness to Change

SA Risk Rating

MH Risk Rating

SA Risk Sub-Rating

MH Risk Sub-Rating

Level of Care

Comments

5 - Relapse, Continued Use, or Continued Problem Potential

SA Risk Rating

MH Risk Rating

SA Risk Sub-Rating

MH Risk Sub-Rating

Level of Care

Comments

6 - Recovery / Living Environment

SA Risk Rating

MH Risk Rating

SA Risk Sub-Rating

MH Risk Sub-Rating

Level of Care

Comments

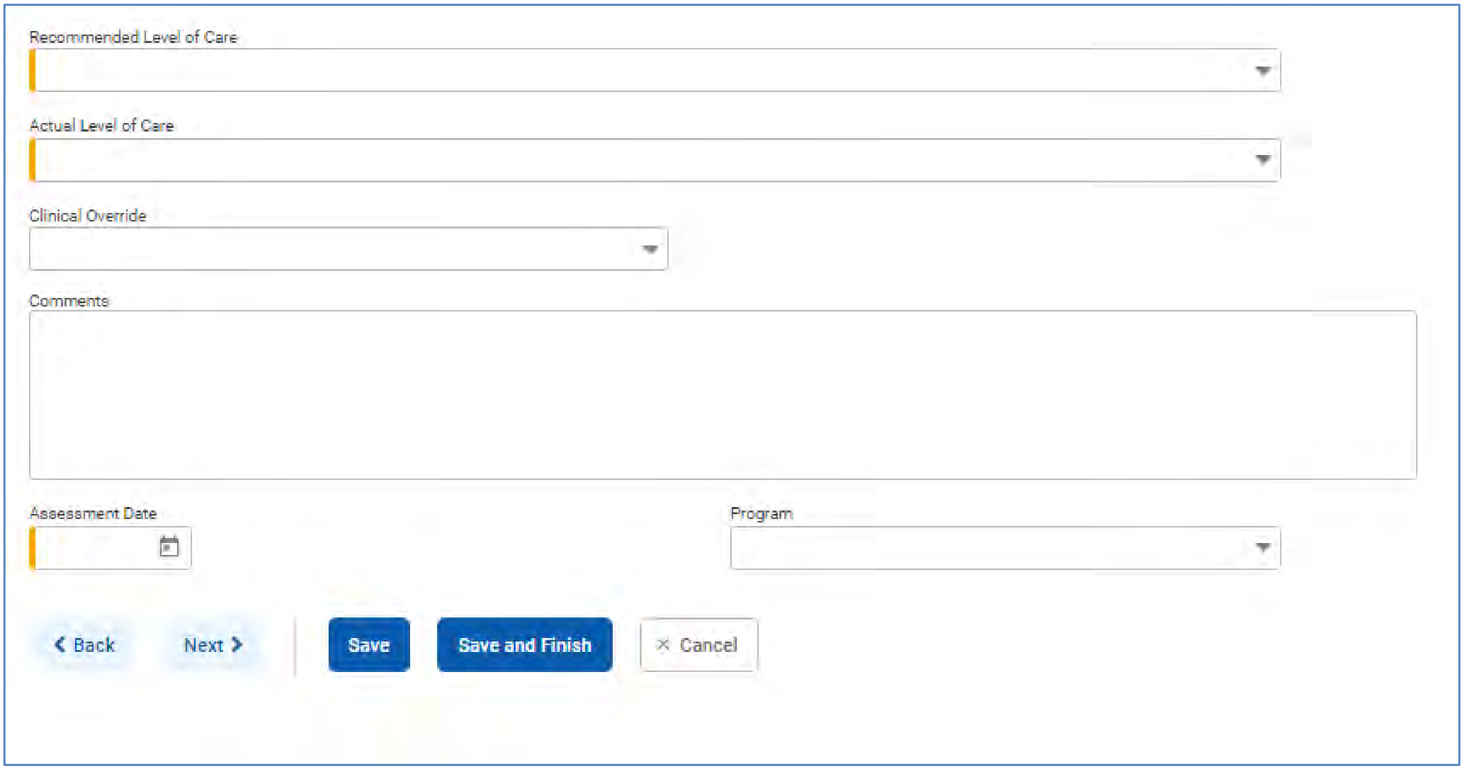


Figure 4-3: Outcome Measures - ASAM screen

2. Click **Save**. Click the **Next** button. This will open the Client Diagnosis screen.

Client Diagnosis

Where:* Client List > Activity List > Outcome Measures > *Client Diagnosis

3. Complete the required fields on the **Client Diagnosis** screen as listed in the table below.

Note: These fields may be prepopulated by the system. If so, please review and edit the fields as needed.

Table 4-8: Client Diagnosis fields

Field	Description
Effective Date	Pre-populates to the Outcome Measure date.
Time	Pre-populates to current time.
Diagnosing Clinician	In the drop-down list, select the staff member who diagnosed the client. **Note**: this field will only display staff members with the Client Diagnosis role.
GAF Score	(Optional)

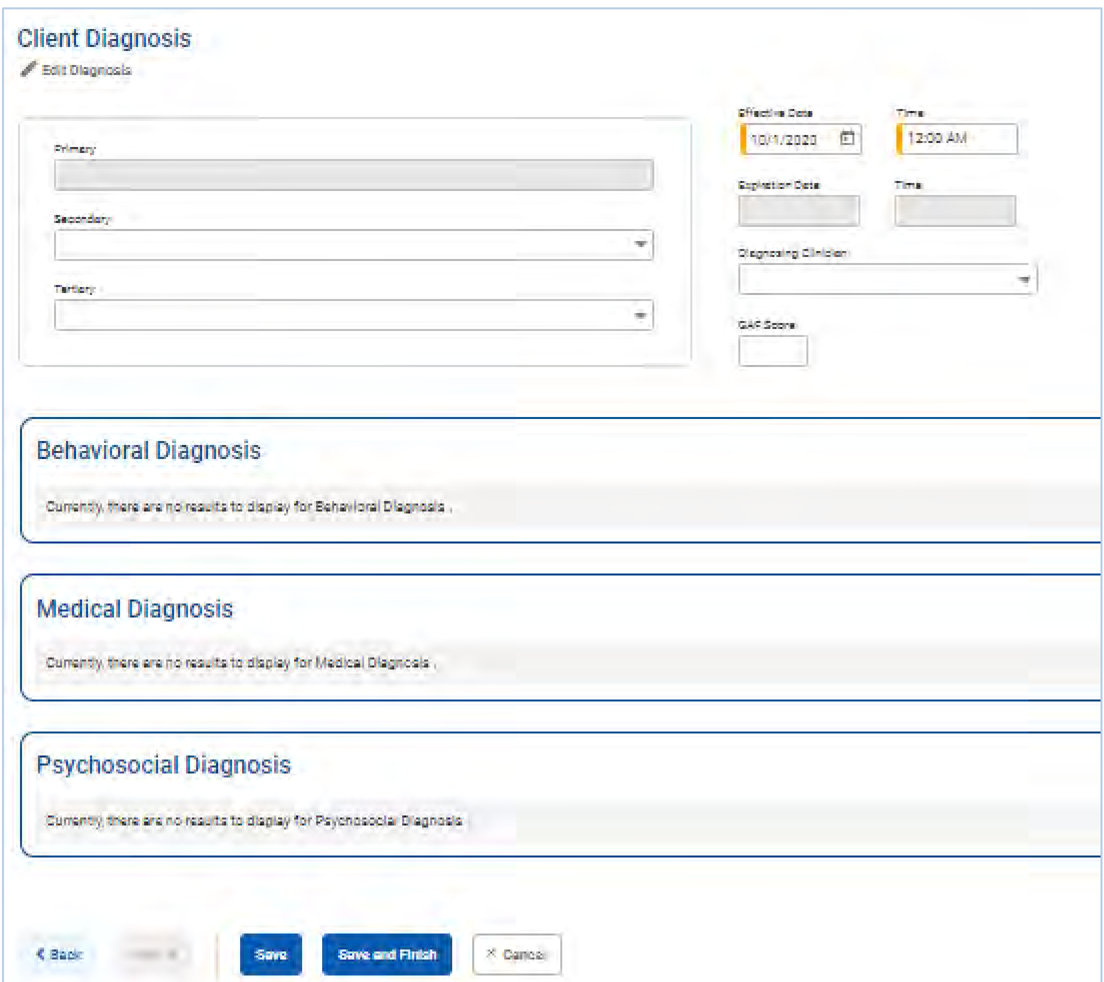


Figure 4-4: Outcome Measures - Diagnosis screen

4. Click **Edit Diagnosis** to add one or more diagnoses for the client. This will open the Edit Diagnosis screen. *(Continue to next page)*

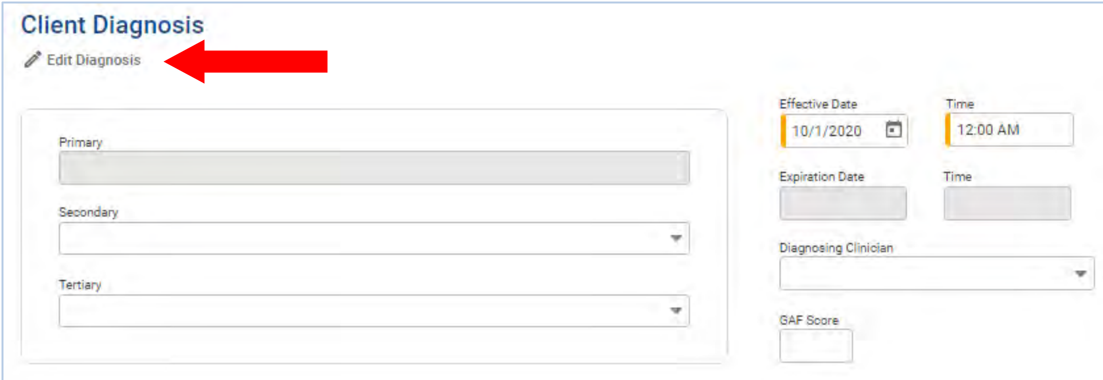


Figure 4-5: Outcome Measures - Client Diagnosis screen, Edit Diagnosis link

Note: This link can also be used to edit a previously recorded diagnosis.

Edit Diagnosis

5. On the **Edit Diagnosis** screen, add one or more diagnoses by completing the fields described in the table below.

Table 4-9: Client Diagnosis, Edit Diagnoses fields

Field	Description
Type	Select "Behavioral", "Medical", or "Psychosocial" from the drop-down list.
Diagnosis	Type at least two (2) characters for options to appear in the drop-down list. Select an option.
Principal Diagnosis	Select Yes or No. **Note**: At least one diagnosis must be marked "Yes" as the Principal Diagnosis.
Comments	Type any comments if applicable.

6. Click **Save**. The diagnosis will be saved in its corresponding Type list on screen.

7. Stay on this screen to enter additional diagnoses as applicable, otherwise click **Finish**. This will return to the Client Diagnosis screen. If adding additional diagnoses, please see section, *"(Optional) Add Secondary & Tertiary Diagnosis."*

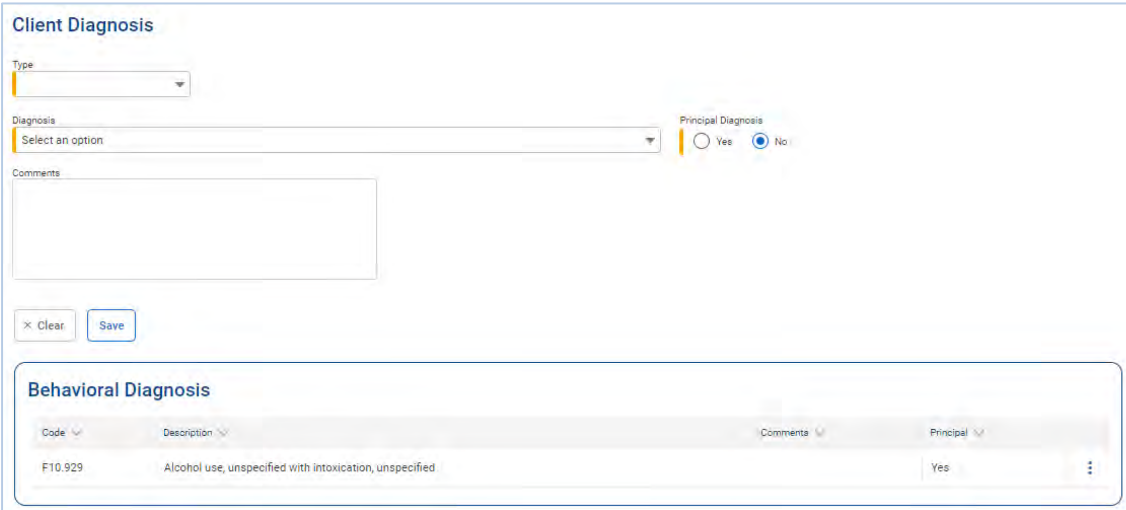


Figure 4-6: Outcome Measures - Client Diagnosis, Edit Diagnosis screen, click Finish

8. On the Client Diagnosis screen, notice the read-only field labeled "Primary" has been filled in with the client's primary diagnosis.

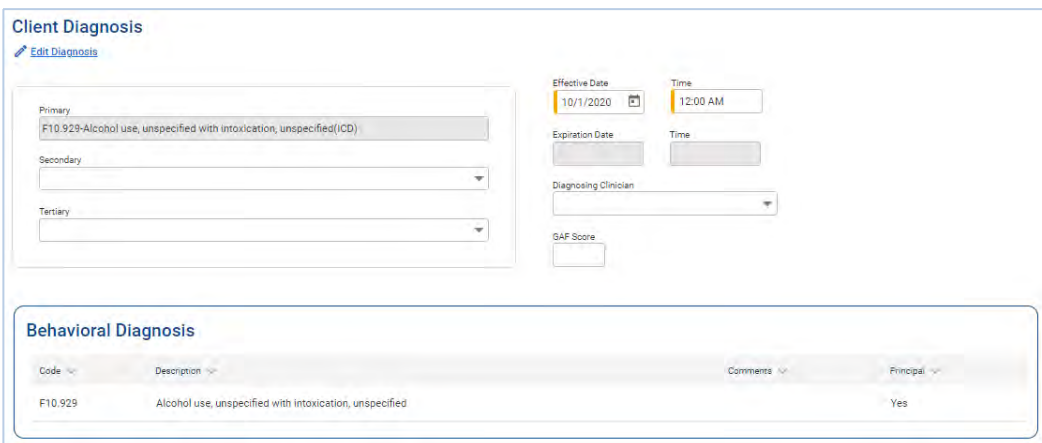


Figure 4-7: Outcome Measures - Client Diagnosis screen, Primary diagnosis field highlighted

9. On the Client Diagnosis screen, click **Save and Finish**. This will return to the Outcome Measures List screen.

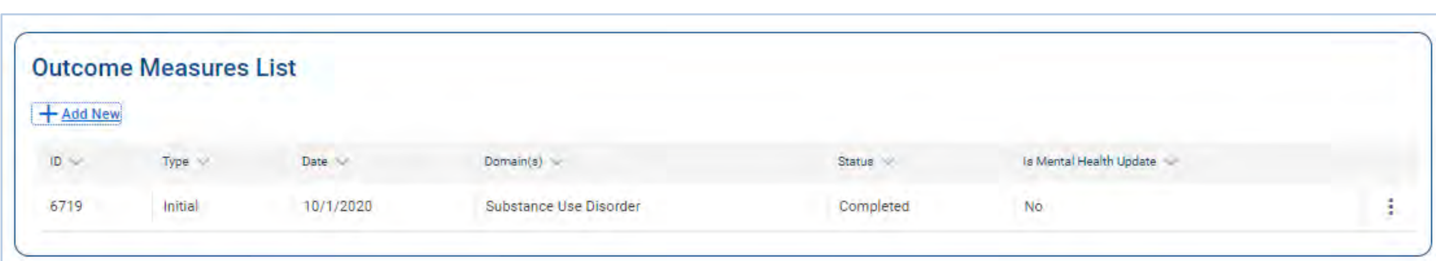


Figure 4-8: Outcome Measures List

(Optional) Add Secondary & Tertiary Diagnosis

Note: TEDS does not collect Secondary and Tertiary diagnoses.

Continuing from section, *"Edit Diagnosis."* The following screen capture displays the Edit Diagnosis screen where multiple diagnoses have been added for a client.

1. Click **Finish**. This will return to the Client Diagnosis screen.

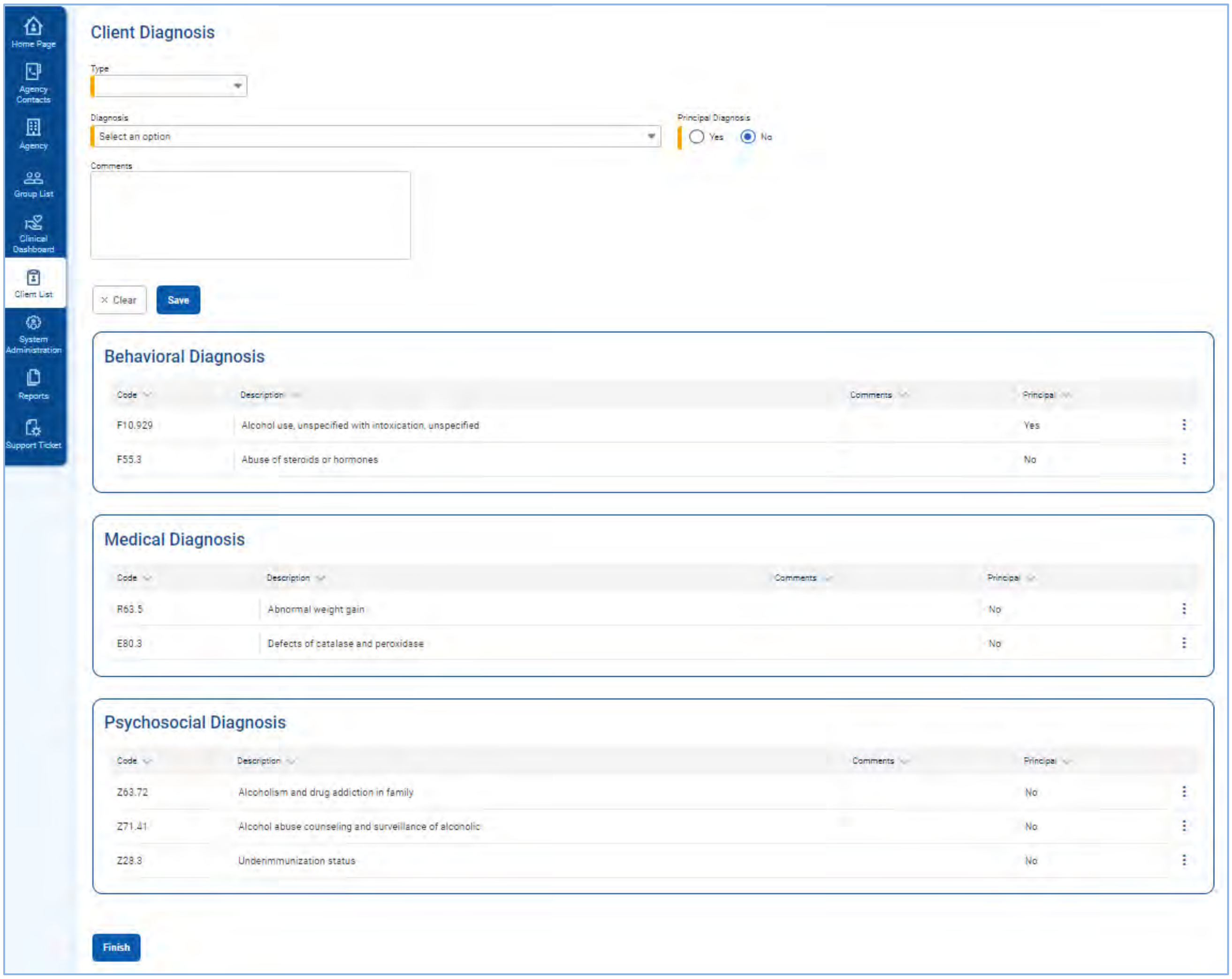


Figure 4-9: Client Diagnosis, Edit Diagnosis screen with multiple diagnoses

2. On the Client Diagnosis screen, notice the read-only field labeled "Primary" has been filled in with the client's primary diagnosis.

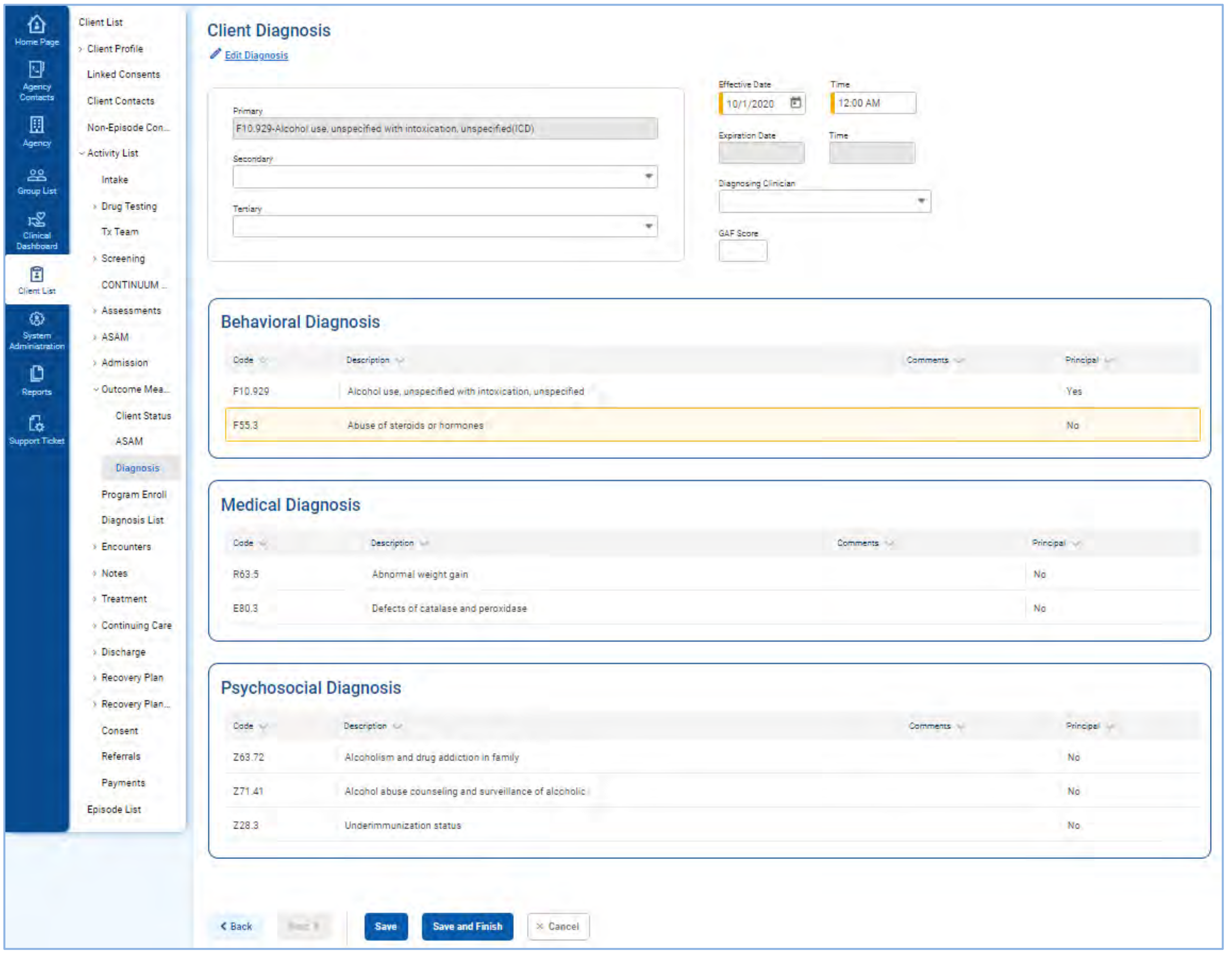


Figure 4-10: Outcome Measures - Client Diagnosis screen with list of client's diagnoses

3. In the **Secondary** field, click the drop-down field and select the client's Secondary diagnosis, as applicable.

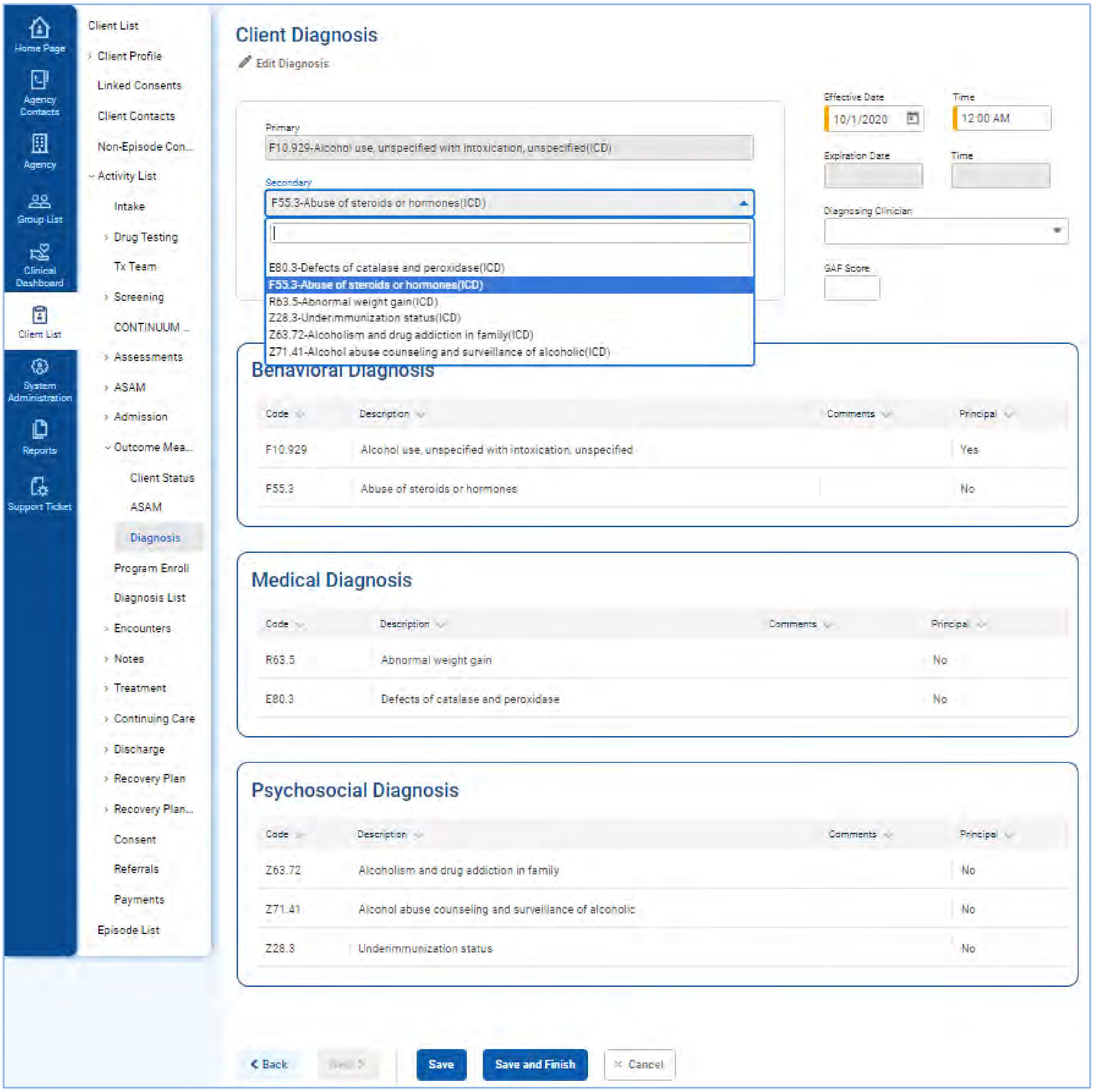


Figure 4-11: Client Diagnosis screen, select Secondary diagnosis

4. In the **Tertiary** field, click the drop-down field and select the client's Tertiary diagnosis, as applicable.

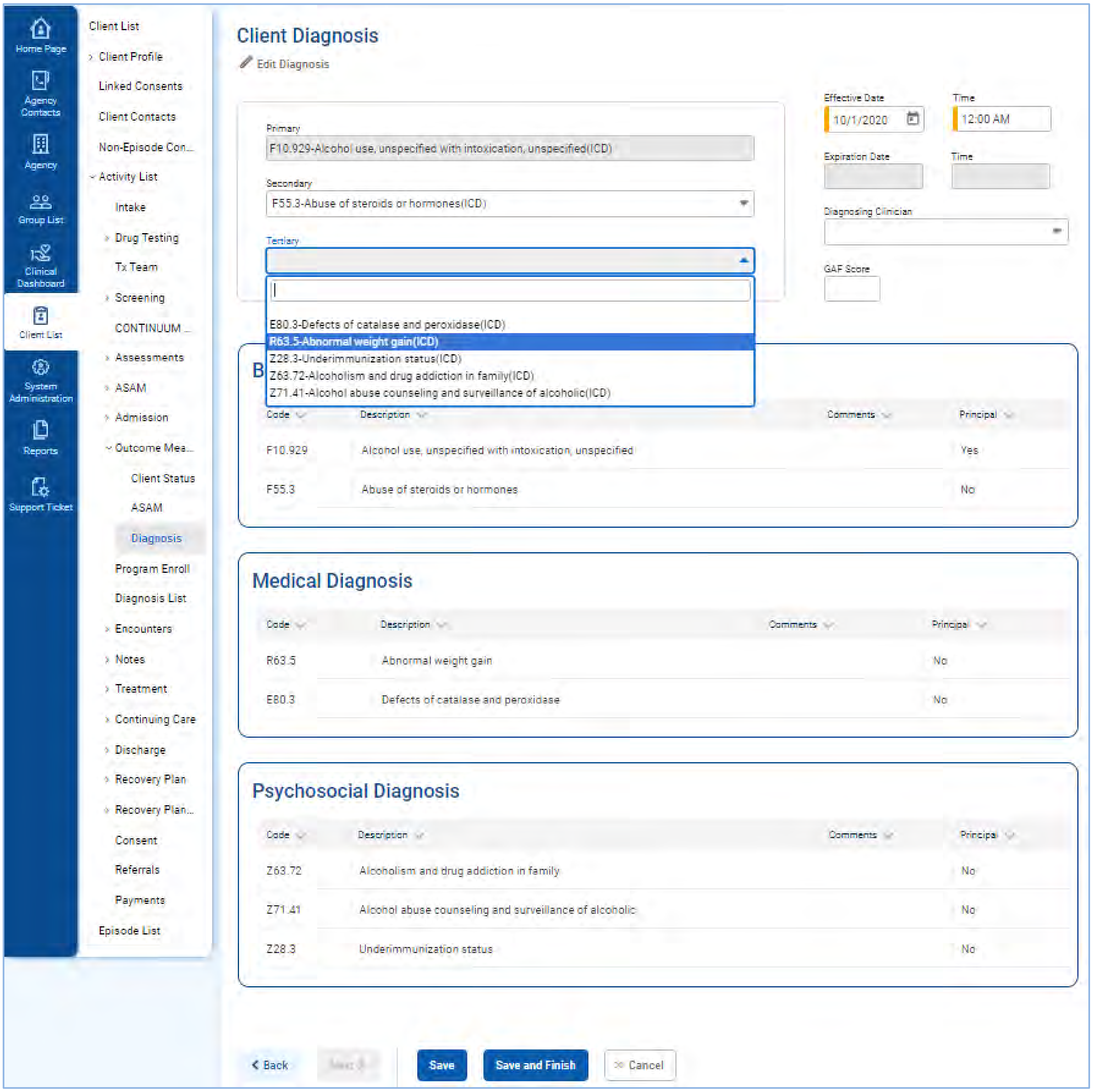


Figure 4-12: Client Diagnosis screen, select Tertiary diagnosis

5. Click **Save and Finish** to return to the Outcome Measures List.

Diagnosis List

Where:* *Client List* > *Activity List* > *Diagnosis List

Note: If Outcome Measures have already been created for the client, the Diagnosis List screen will display the diagnoses previously entered for the client in the Outcome Measures section.

Review Diagnosis (Read-only View)

1. On the left menu, click **Client List** and search for a client.
2. Hover over the ellipsis icon and click **Activity List**.
3. On the left menu, click **Diagnosis List**.
4. On the Diagnosis List screen, locate a previously entered diagnosis from the list, hover over the ellipsis icon and click **Review**. This will display a read-only view of the Client Diagnosis screen.

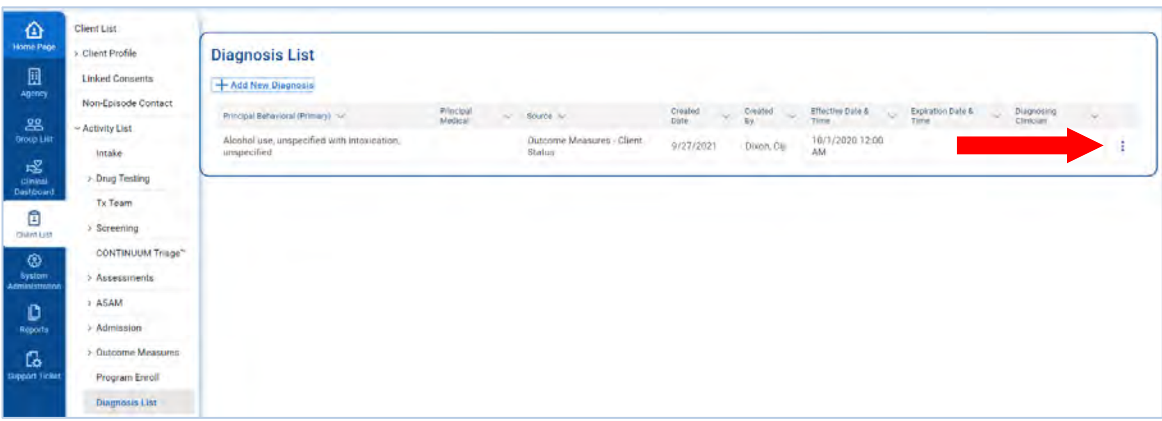


Figure 5-15: Diagnosis List, Review previously entered Diagnosis

5. Review the Client Diagnosis screen, and then click **Finish**. The system will redirect to the Diagnosis List screen.

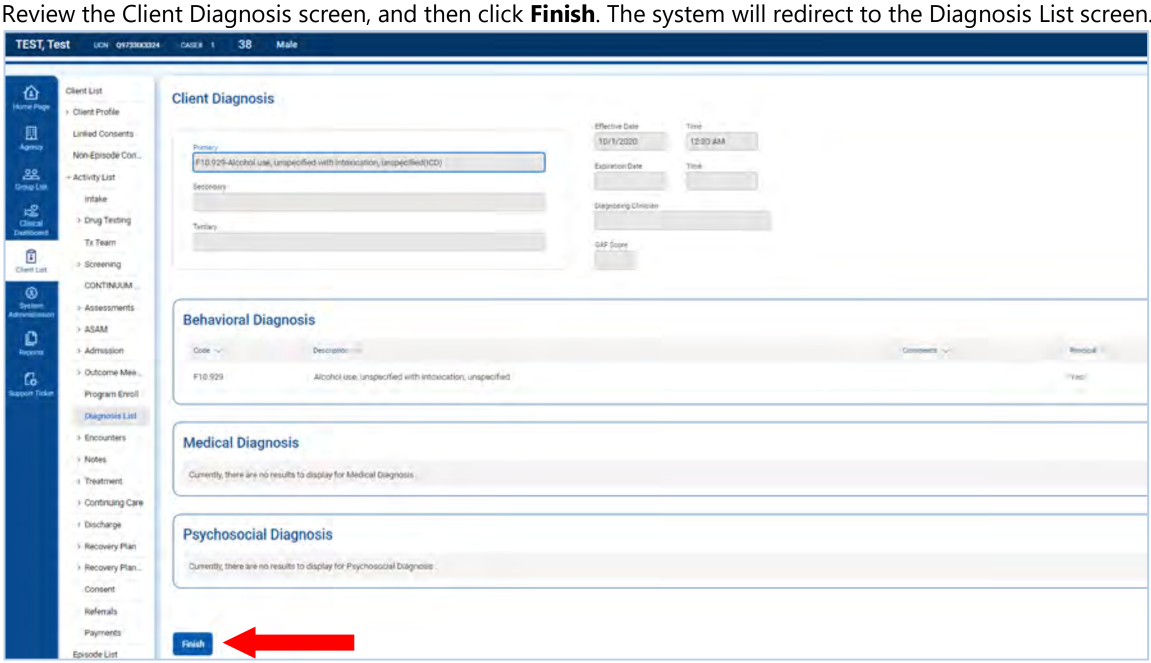


Figure 5-16: Review Diagnosis

Update/Final Outcome Measures

Where: Client List > Activity List > Outcome Measures

When the client is ready to be disenrolled from a treatment program, or if the client needs to be moved to a different level of care, an **Update** or **Final Outcome Measure** will be required. The client's Outcome Measure data must be collected and finalized within **thirty (30)** days of disenrolling the client from a TEDS program.

> **!** An **Updated Outcome Measure** must be completed and finalized prior to disenrolling a client from a TEDS treatment program. This requirement is only applicable to programs that report TEDS data.
> Enrollment in Case Management programs do not have this requirement.

1. On the left menu, click **Client List** and search for a client.
2. Hover over the ellipsis icon and click **Activity List**.
3. On the left menu, click **Outcome Measures**.
4. On the Outcome Measures List screen, click **Add New**. This will open the Outcome Measures - Client Status screen.

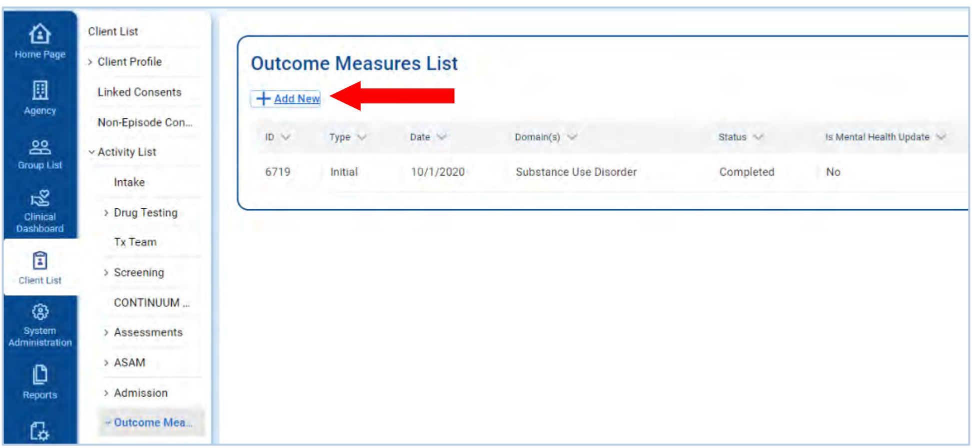


Figure 4-16: Add New Outcome Measure

5. On the Outcome Measures – Client Status screen, the **Type** field will change to "Update".

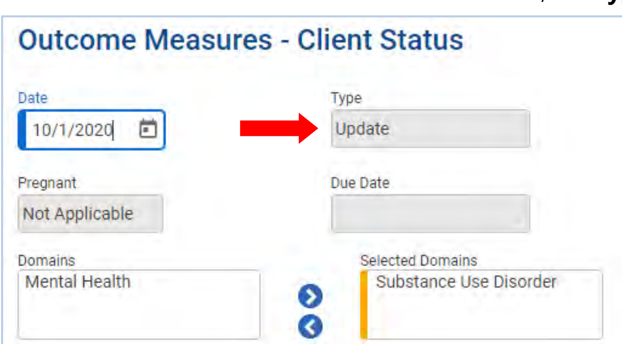


Figure 4-17: Updated Type Field

6. In the **Date of Last Contact** field**,** enter the date.
7. Responses from the client's previous Outcome Measures are pre-populated in the remaining fields on screen. Make additional updates as needed. See section, *"Initial Outcome* Measures*"* for more information.

Part 5: Program Enrollment (TEDS)

Where:* *Client List* > *Activity List* > *Outcome Measures* > *Program Enroll

An **Initial Outcome Measure** must be completed and finalized within **thirty (30) days** of enrolling a client into a TEDS treatment program. This requirement is only applicable to programs that report TEDS data. Enrollment in Case Management programs do not have this requirement.

1. On the Program Enrollment screen, click **Add Enrollment**. This will open the Program Enrollment Profile screen.

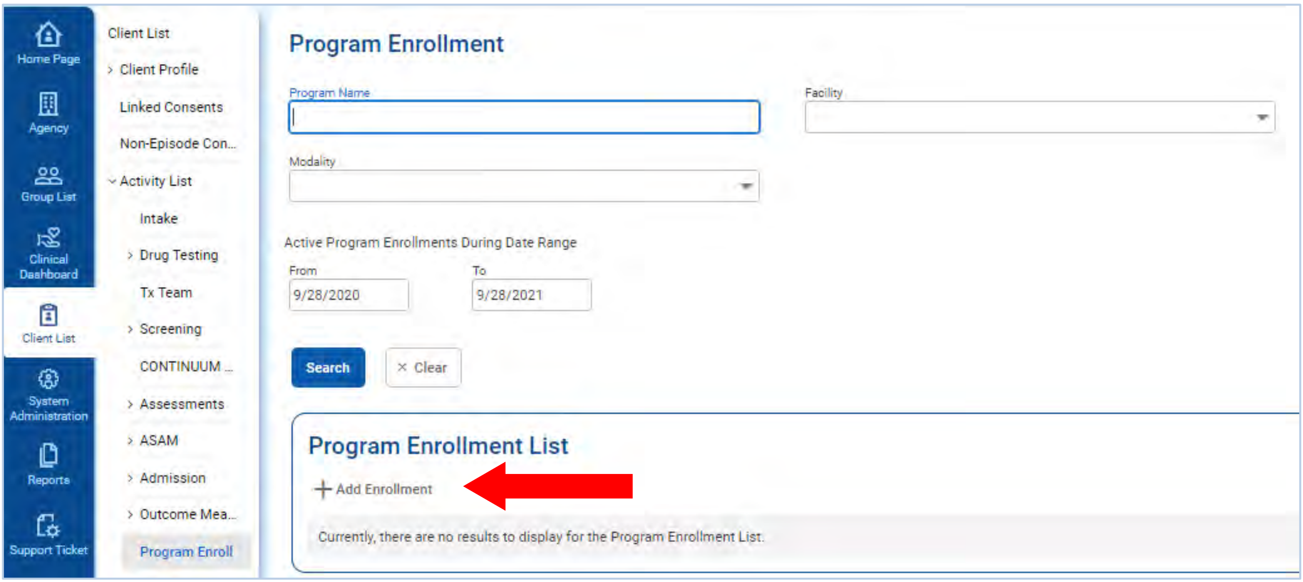


Figure 5-1: Outcome Measures – Program Enrollment screen

2. Complete fields on the Program Enrollment Profile as described in the table below.

Table 5-1: Program Enrollment Profile fields

Field	Description
Facility	Defaults to the currently Facility name.
Program Name	Select from the programs available.
Program Staff	Pre-populates with the current staff member name.
Start Date	Pre-populates with the Outcome Measure date.
Domain	Read-only field. Displays the domain associated with the selected Program Name.
Days on Wait List	Type the number of days the client was waiting, if applicable.
Notes	Type any notes as needed.

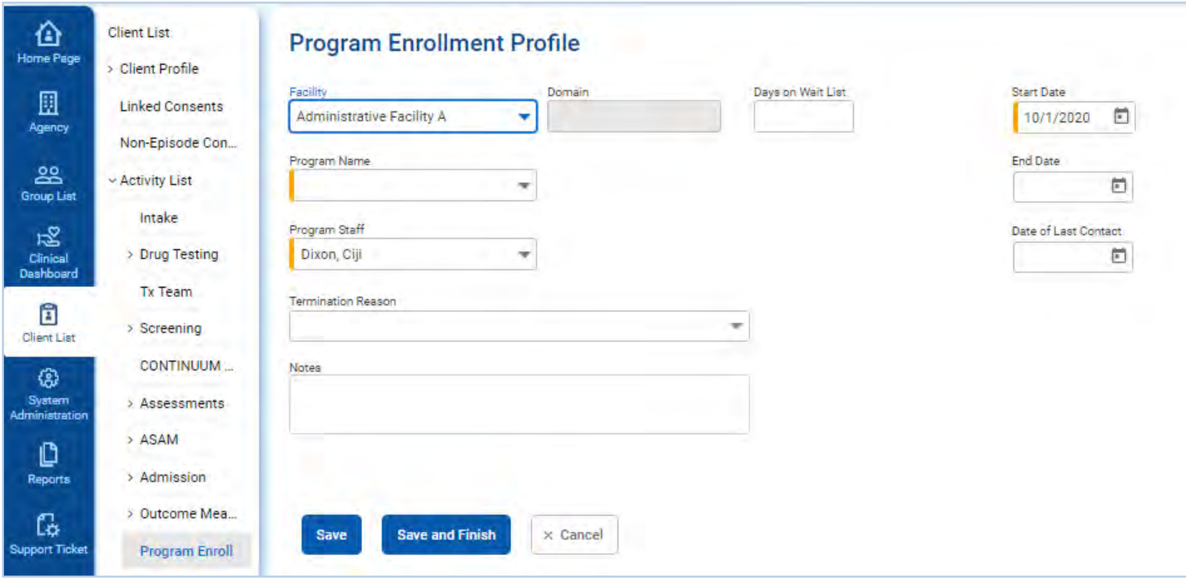


Figure 5-2: Program Enrollment Profile screen

3. On the Program Enrollment Profile screen, click **Save and Finish**. A soft warning will appear to inform the user to complete a Functional Assessment *(see next section for instructions on how to add a Functional Assessment)*.
4. On the Program Enrollment screen, click **Finish** to return to the **Client Activity List**.

Functional Assessments

***Where:* Client List > Activity List > Assessments > Functional Assessment**

After saving the Program Enrollment, a soft warning will appear at the top of the Program Enrollment screen indicating that a functional assessment must be completed.

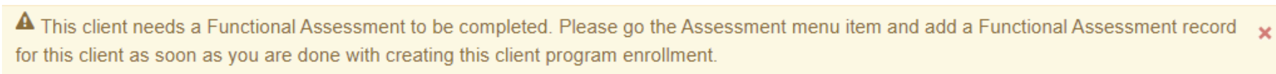


Figure 5-3: Functional Assessment Warning

5. On the left menu, click **Client List** and search for a client.

6. Hover over the ellipsis icon and click **Activity List**.

7. On the left menu, click **Assessments**. Then click **Functional Assessments**.

8. On the Functional Assessment screen, click **Create New Functional Assessment**. This will open the **Add Functional Assessment** window.

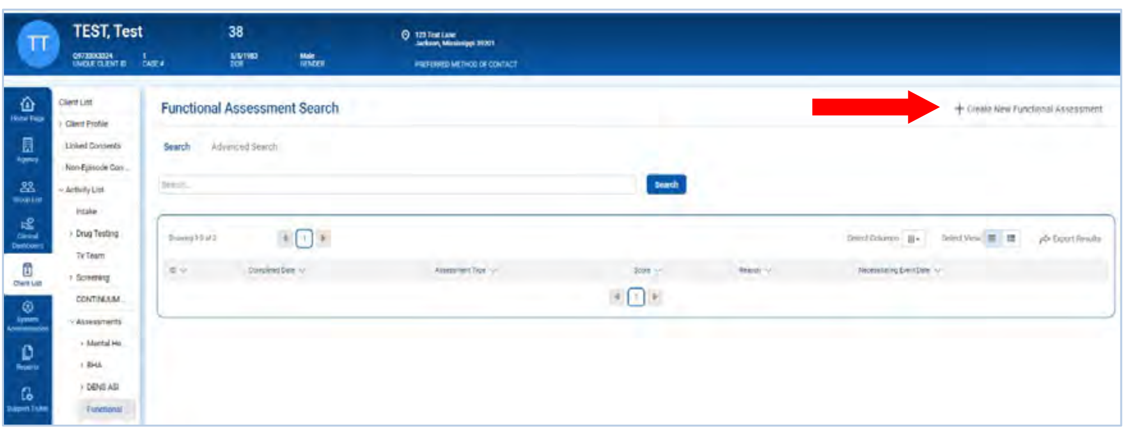


Figure 5-4: Create New Functional Assessment

5. Select an Assessment Type and add a completed date. The client's program enrollment will automatically populate. Next, complete the Functional Assessment entry by adding the Necessitating Event Date, Reason, and the functional assessment score. Select **Save**.

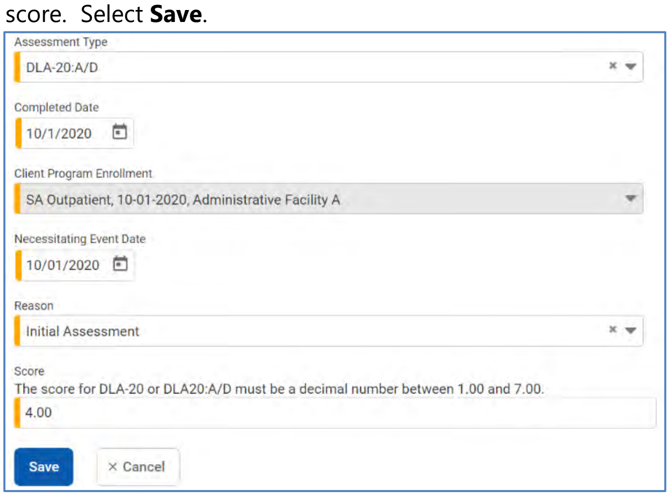


Figure 5-5: Complete Functional Assessment

6. To delete a Functional Assessment record, hover over the three-dot vertical ellipsis icon and select **Delete**. When the prompt appears asking, "Are you sure you want to delete the selected assessment?", you may select the **Delete** option, or select **Cancel** if you do not want to delete the record.
7. To edit a Functional Assessment record, hover over the three-dot vertical ellipsis icon and select **Review**. Hover over the pencil icon in the far-right corner of the record, and select **Edit**. Once edits have been completed, click **Save** to complete the record. Once returned to the Functional Assessment screen, you may then select the **Done Editing** button.

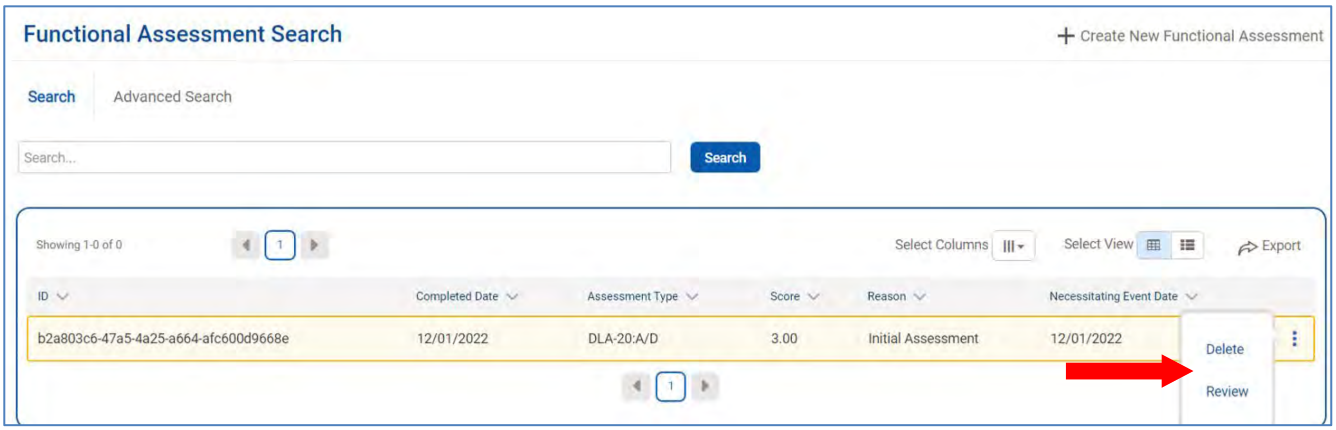


Figure 5-6: Review or Delete a Functional Assessment

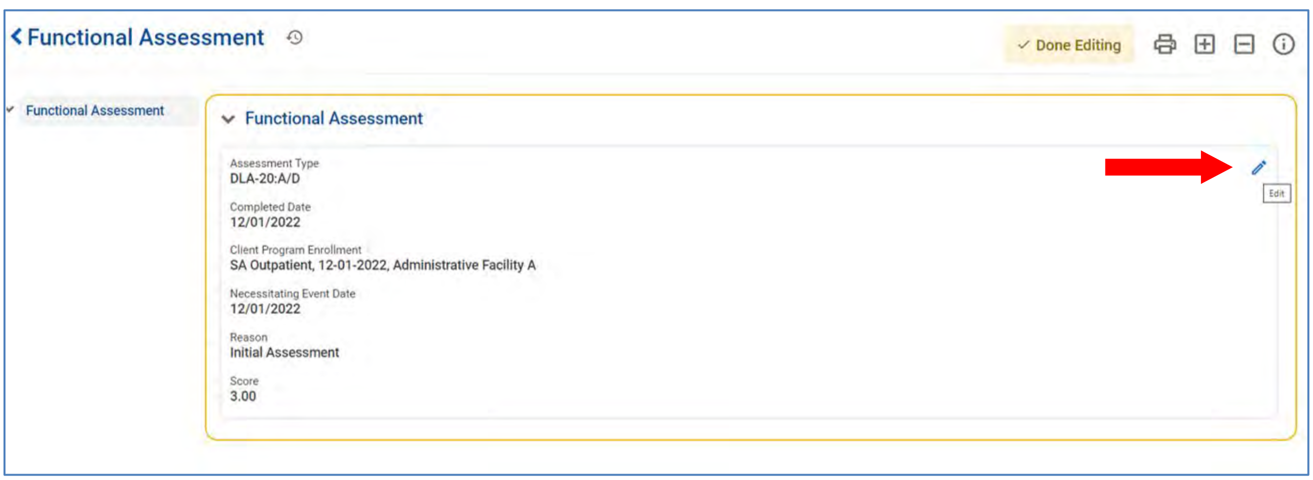


Figure 5-7: Edit Functional Assessment

Part 6: Encounters / Rendered Services

Encounters

***Where:* Client List > Activity List > Encounters**

The Encounters screen allows staff members to add services rendered to a client along with the service date, # of service units/sessions, rendering staff member(s), location of service, etc. Staff may also view and search through an individual client's encounter records for services received at a specific location. Follow the steps below to add new Encounters and to view the Encounters screen.

1. On the left menu, click **Client List** and search for a client.
2. Hover over the ellipsis icon and click **Activity List**.
3. On the left menu, click **Encounters**. This will display the Encounter Search/List screen.
4. To view previous encounters, complete the search fields and click **Go**.

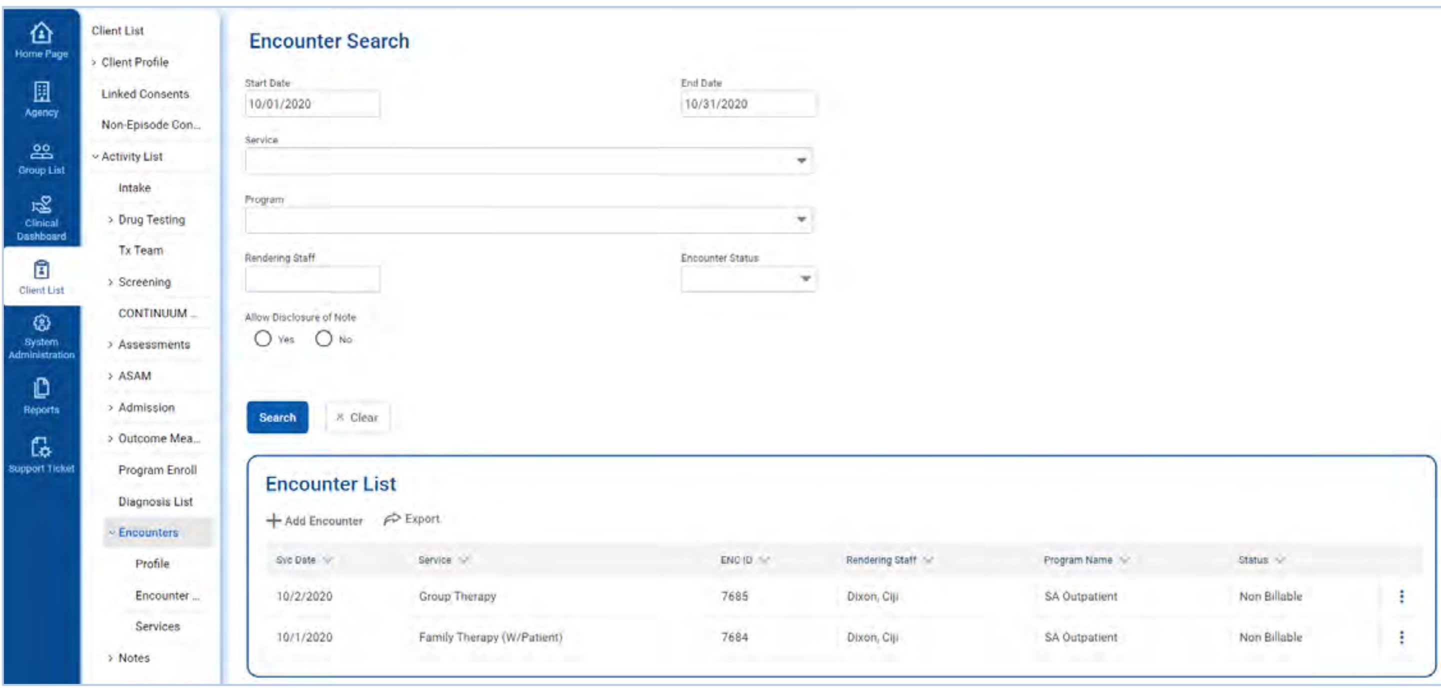


Figure 6-1: Encounter List screen

Create Encounter Notes

***Where:* Client List > Activity List > Encounters**

Follow the steps below to add an Encounter for a client.

1. On the left menu, click **Client List** and search for a client.
2. Hover over the ellipsis icon and click **Activity List**.
3. On the left menu, click **Encounters**. This will display the Encounter Search/List screen.
4. Click **Add Encounter**. This will open the Encounter Profile screen.

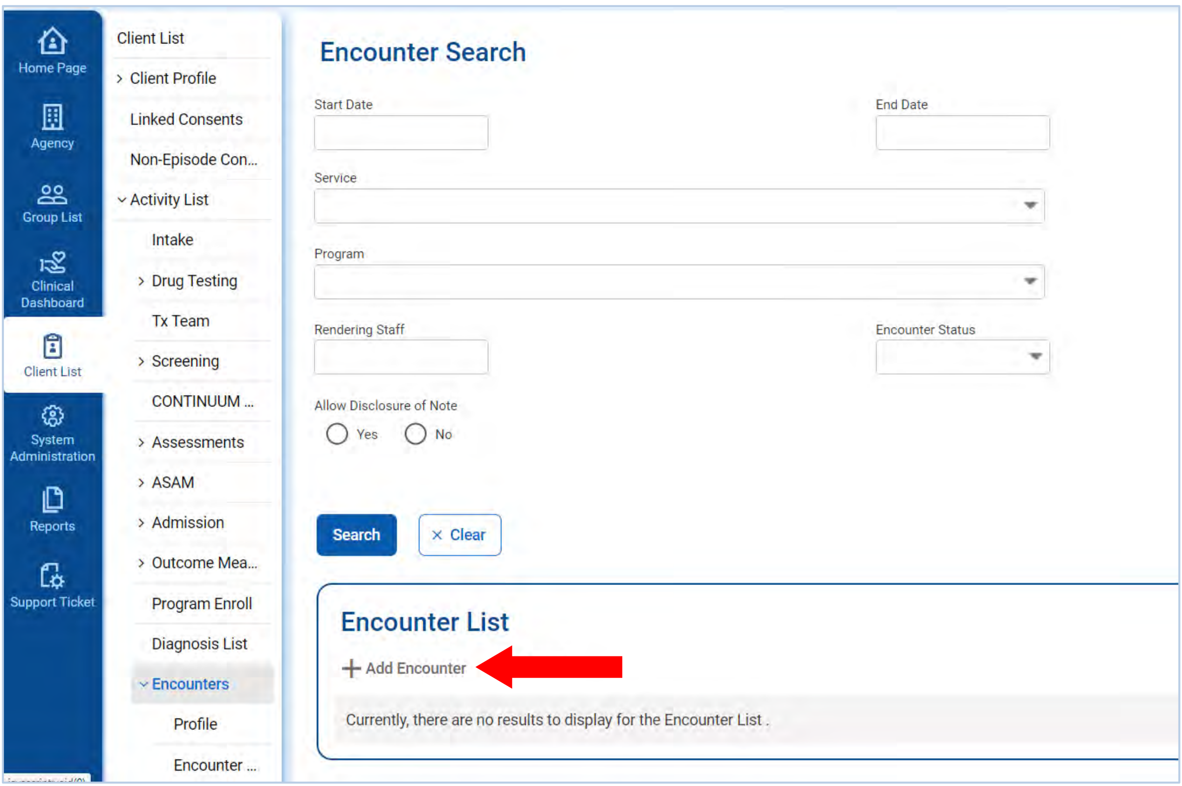


Figure 6-2: Encounter screen, Add Encounter

Note: The client must be enrolled in a program before an encounter note can be added. If the client has not been enrolled in a program, the following message will appear on screen:

Encounter Profile

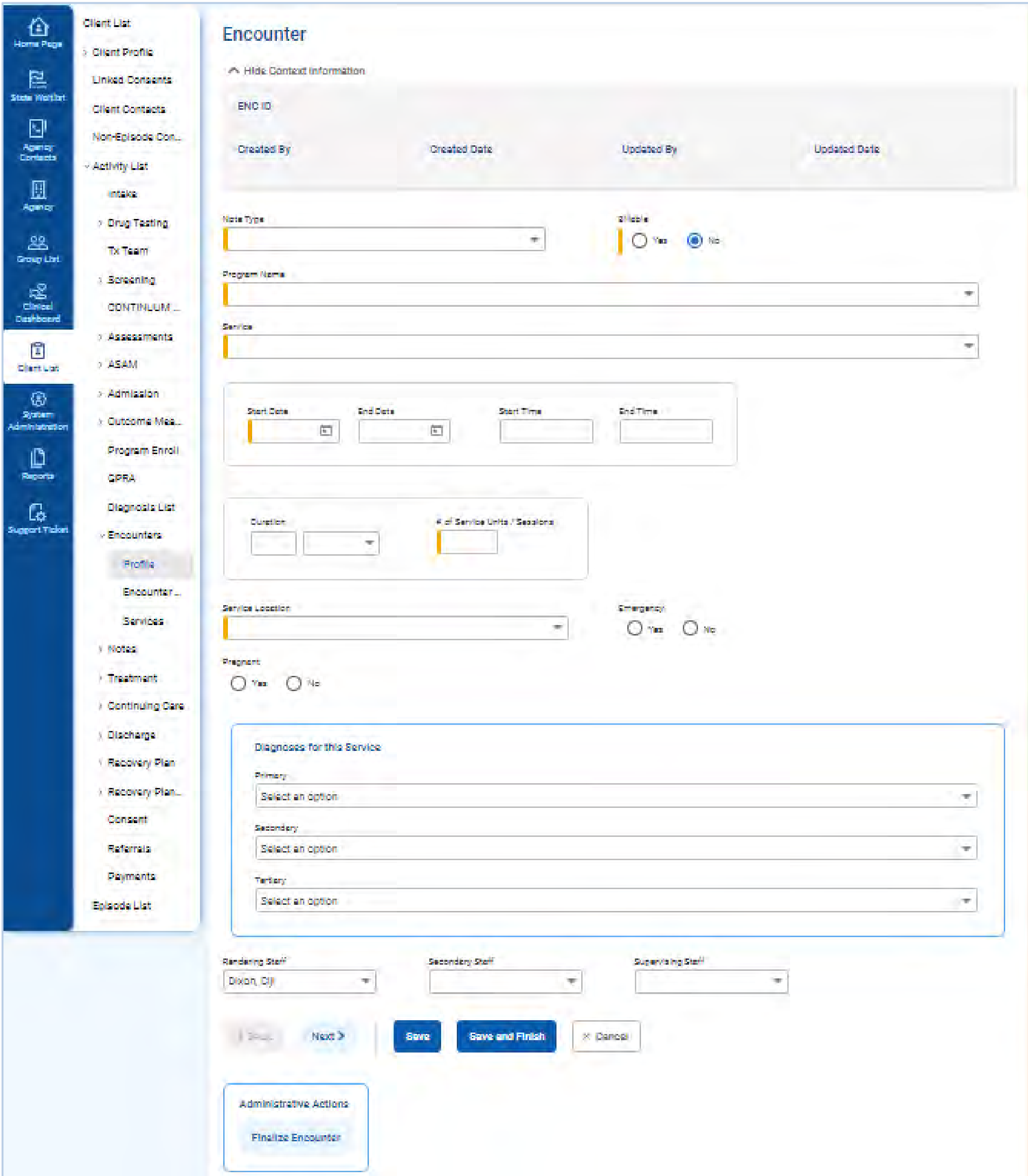


Figure 6-3: Encounter Profile screen

5. Complete the fields on the Encounter Profile screen. See table below for information on each field.

Table 6-1: Encounter Profile fields

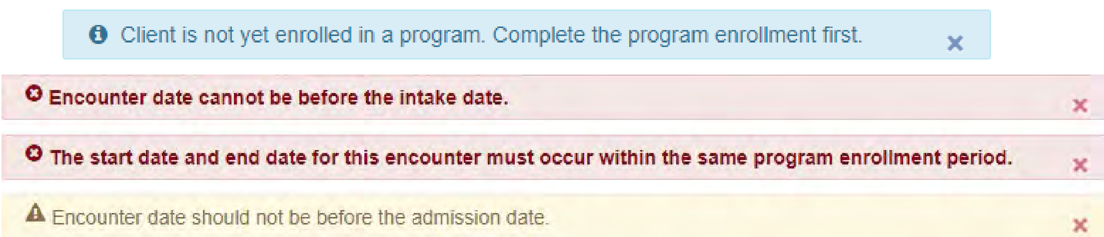
Field	Description
Note Type	Select from the drop-down field.
ENC ID	Read-only field. When the encounter is saved, this field will display its unique ID number.
Created Date	Read-only field. This field will display the date and time when the encounter is saved.
Program Name	This field will pre-populate with the client's current program enrollment name and program enrollment start date. 
Service	Select a service from the drop-down list.
Billable	This field may be pre-populated.
Service Location	Select an option from the drop-down list. This field may be pre-populated if this information was added to the facility profile.
Start Date	Enter the date when this service was rendered. **Note**: The start date for this encounter must occur within the same program enrollment period. Encounter date cannot be before the intake date.
Start Time	Enter the time when this service was rendered. This field is optional.
End Date	Enter the date when this service ended. This field may be optional or required depending on the selected service. Some services may be set up to require this information. **Note**: The end date for this encounter must occur within the same program enrollment period.
End Time	Enter the time when this encounter ended. This field may be optional or required depending on the selected service. Some services may be set up to require this information.
Duration	In the Duration field, type an integer to record time spent for this encounter. In the Duration drop-down field, select the unit of time. **Note**: The duration field will only accept whole numbers. Decimals (e.g., 0.5) are not accepted. These fields may be optional or required depending on the selected service. Some services may be set up to require this information.
# of Service Units/Sessions	Type an integer representing the number of units or sessions spent for this service. Your administrator may have established policy guidelines regarding how services are recorded.
Emergency	(Optional) Select from the drop-down list.
Pregnant	(Optional) Select from the drop-down list.
Diagnoses for this Service	
Primary	(Optional) This field will pre-populate with the client's primary diagnosis based on the encounter start date.

Secondary	(Optional) This field will pre-populate with the client's secondary diagnosis based on the encounter start date.
Tertiary	(Optional) This field will pre-populate with the client's tertiary diagnosis based on the encounter start date.
Rendering Staff	This field will pre-populate to the user logged in. To change the rendering staff, select the correct staff member from the drop-down list.
Supervising Staff	(Optional) In the drop-down list, select the Supervisor for the Rendering Staff member, if applicable. **Note**: Declaring staff members as "supervisors" is a feature controlled through the staff member's profile by adding relationships.

6. Click **Save**, then click the **right-arrow** button.

Encounter Error/Warning Message Examples

- Client is not yet enrolled in a program. Complete the program enrollment first.
- Encounter date cannot be before the intake date.
- The start date and end date for this encounter must occur within the same program enrollment period.
- Encounter date should not be before the admission date.



Encounter Notes

The **Encounter Notes** section of the Encounter allows staff to enter notes related to the time spent with the client. If the client has an Active Treatment Plan, the staff can add Goals, Objectives, and Interventions to the encounter.

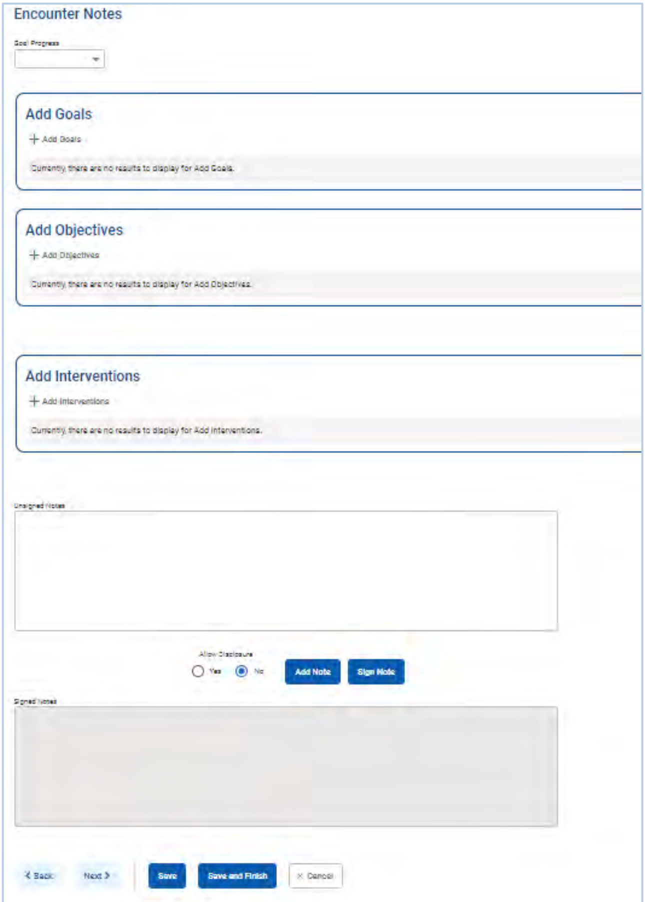


Figure 6-4: Encounter Note, Add Goals, Objectives, and Interventions

7. On the **Encounter Notes** screen, in the **Unsigned Notes** text box, type notes regarding the service provided.

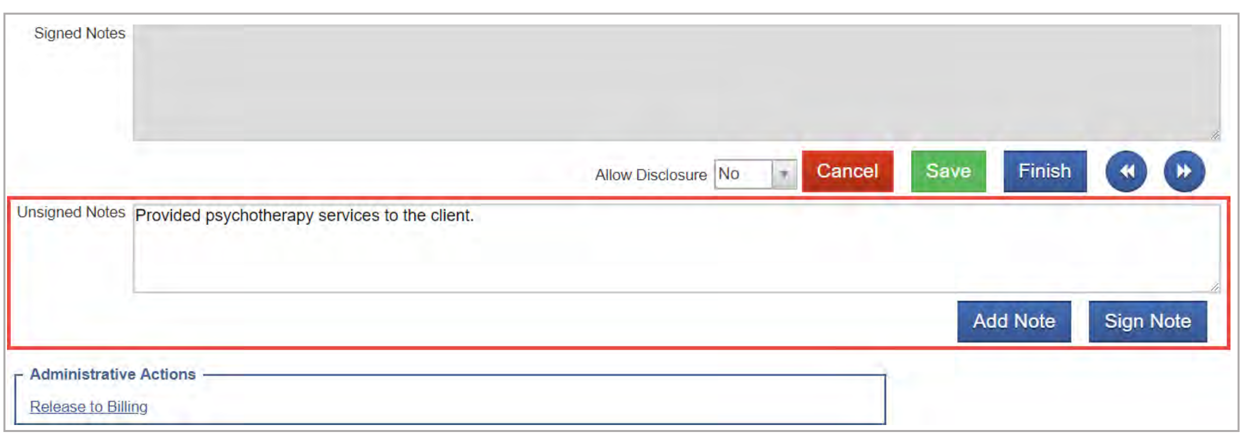


Figure 6-5: Unsigned Notes text box

8. To sign the notes, click **Sign Note**.

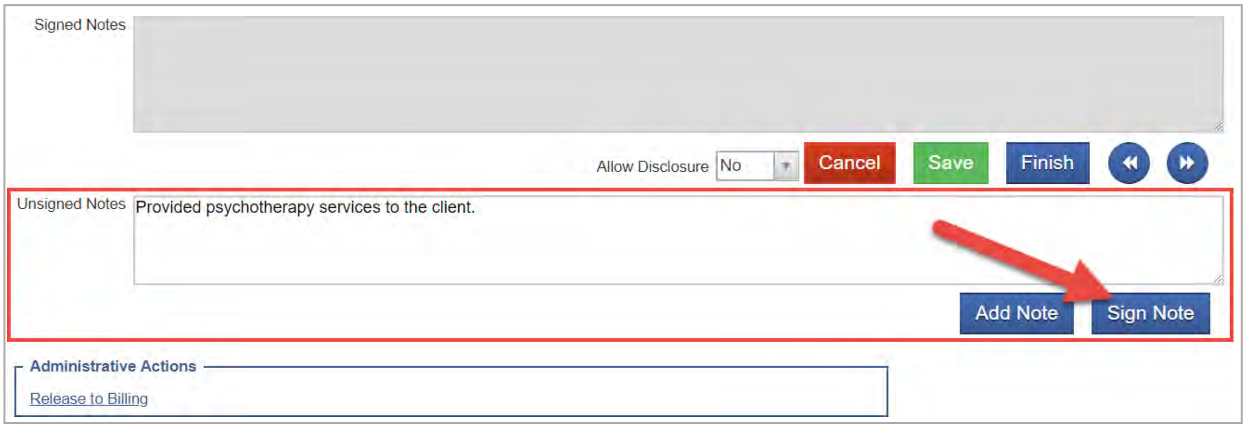


Figure 6-6: Add and Sign Note

The notes will then be displayed in the read-only field, **Signed Notes**.

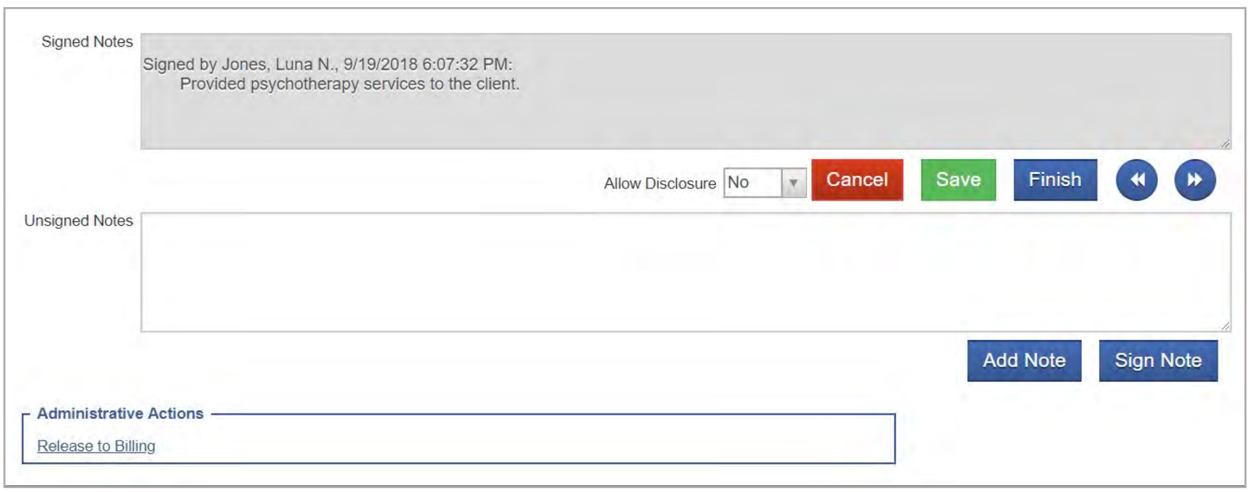


Figure 6-7: Signed Note

9. Click **Save** to stay on screen. Click **Finish** to return to the Encounter List screen.

Release to Billing

Required Role(s):

- Release To Billing

Note: The [Client Group Enrollment]() must be completed prior to releasing grant-billable encounters to billing in WITS.

When an encounter record is complete, it should be released to billing. To release an encounter, staff members must have the role "Release to Billing" assigned. Staff members with this role will have a link available in the **Administrative Actions** box on encounter screens.

Figure 6-8: Administrative Actions box, Release to Billing link

Administrative Actions are available on both the Encounter Profile screen and the Encounter Notes screen. Click the **Release to Billing** link on either of these screens.

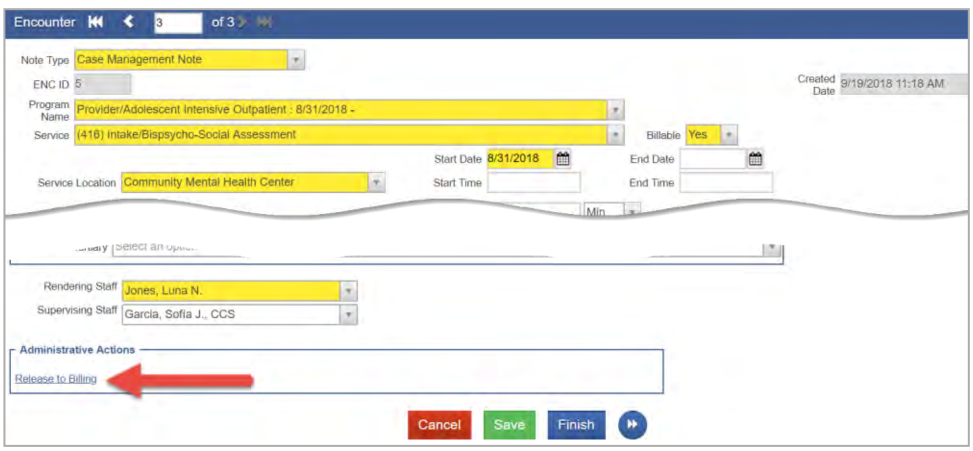


Figure 6-9: Encounter Profile screen, Release to Billing link

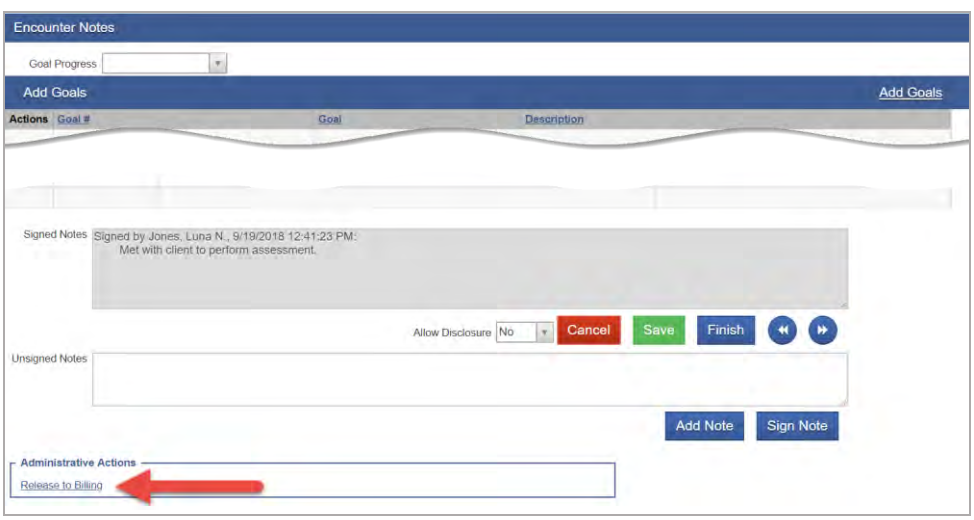


Figure 6-10: Encounter Notes screen, Release to Billing link

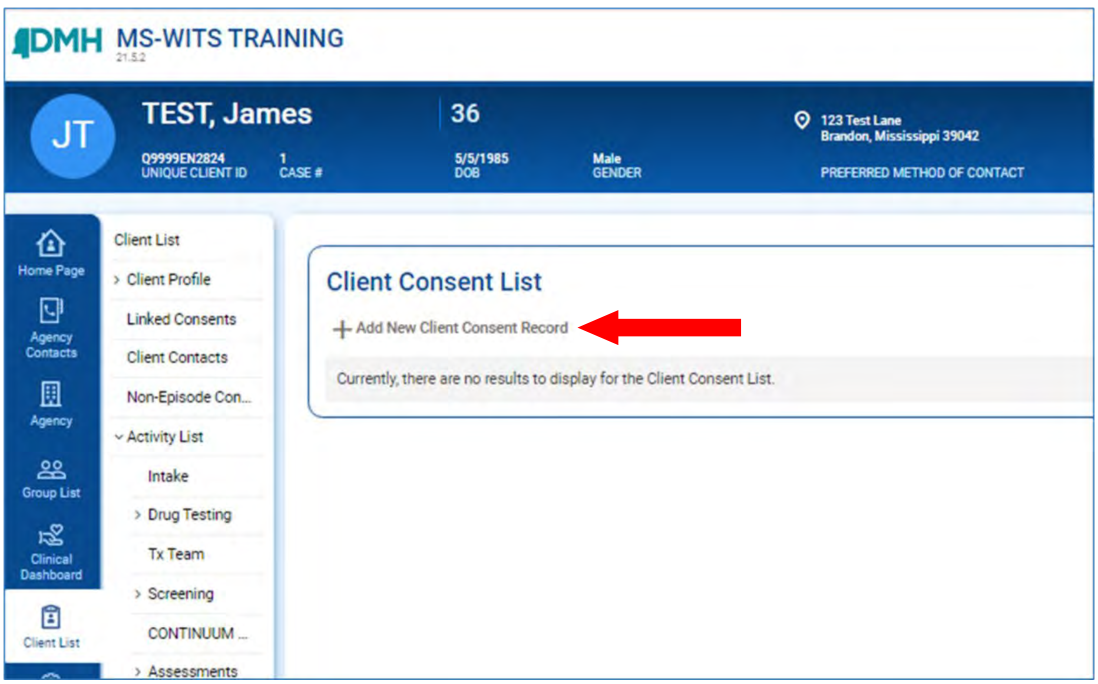
Consent

Create Client Consent Record

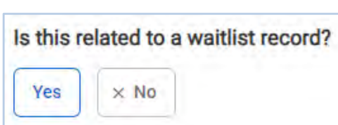
***Where:* Client List > Activity List > Consent**

The consent is a formal process adhering to 42 CFR Part 2, which governs the sharing of client information between agencies and facilities using WITS. A consent may also be used to record the sharing of information (on paper) with agencies who do not use WITS, making the consent part of the electronic health record.

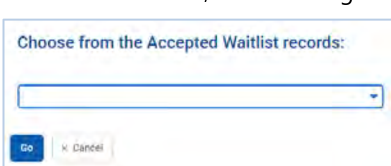
1. On the left menu, click **Client Lis**t and search for a client.
2. Locate the client, hover over the ellipsis icon, and then click **Activity List**.
3. On the left menu, click **Consent**.
4. Click the **Add New Client Consent Record** link.



5. Select **Yes** or **No**.



6. If **Yes** is selected, the following screen will appear. Select from the drop-down list, then click **Go**.



7. On the Client Disclosure Agreement screen, complete the following fields.

Table 6-3: Client Disclosure Agreement fields

Field	Description
Entities with Disclosure Agreements	Select from the drop-down list. This field will display a list of agencies that have previously created a Disclosure template. This will prepopulate fields in the "Client Information To Be Consented" section, which can then be modified if needed.
System Agency	Select "Yes" if the agency uses WITS.

Field	Description
Disclosed to Agency	Select the agency that will be receiving the client's information.
Facility	Select the facility within the selected Agency that will be receiving the client's information. Select All Facilities, or an individual facility.
Purpose for Disclosure	Type the reason for creating the Consent record.
Earliest date of services to be consented	Select the date.
Has the client signed the paper agreement form	Select "No" to save the screen and have the client sign the paper form (see below), after client has signed, select "Yes".
Date client signed consent	This field will become editable when "Yes" is selected in the previous field.

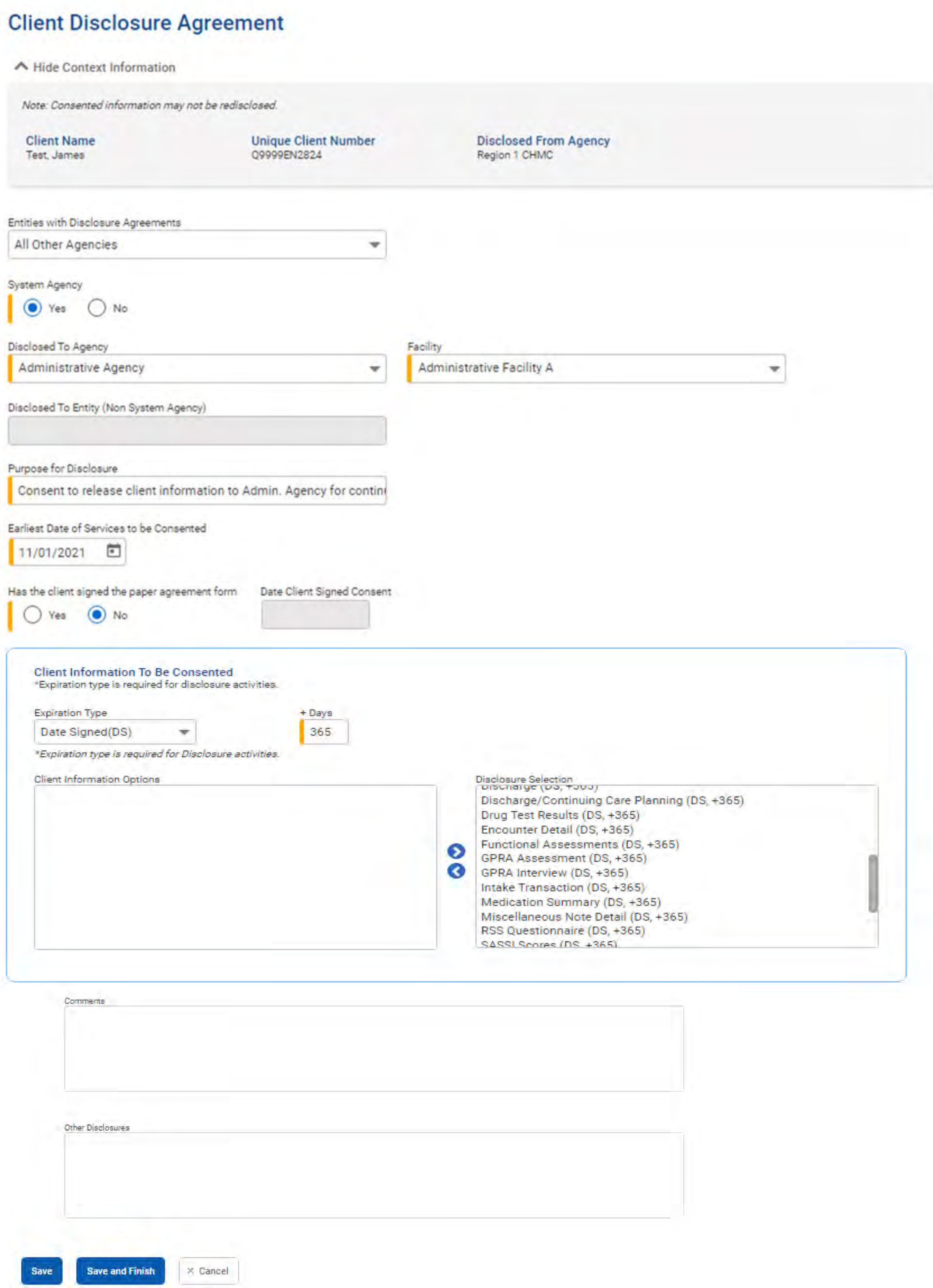


Figure 5-11: Client Disclosure Agreement screen

8. If additional consent information needs to be added or removed from the client's disclosure agreement, update the options from the "Client Information To Be Consented" section. Your agency administrator may have set up templates for the disclosure agreement.

Table 6-4: Client Information To Be Consented fields

Field	Description
Expiration Type and + Days	Select either "Discharge (UD)" or "Date Signed (DS)", then when the yellow field appears, enter the number of days the consent will expire.
Client Information Options/Disclosure Selection	Select options from the box and use the mover buttons to add or remove the desired consent options.

9. When all required fields are complete, click **Save**.

Print the Client Consent Form

10. After saving the Client Disclosure Agreement screen, click the **Generate Report** link to print the Client Consent Form to get the client's signature on the paper copy. The printed consent form includes items from the Client Information Options box along with the Consent Expires information.

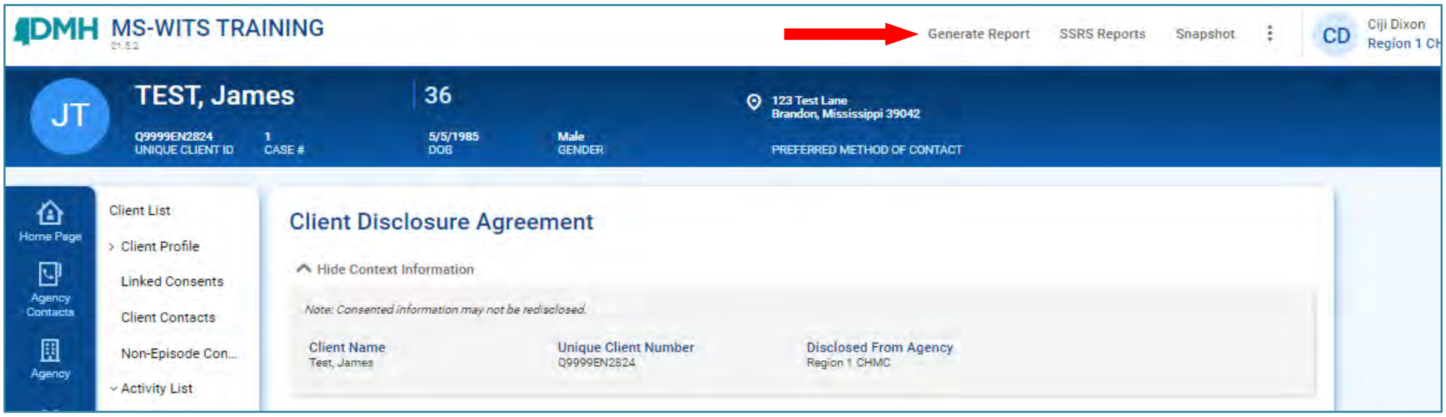
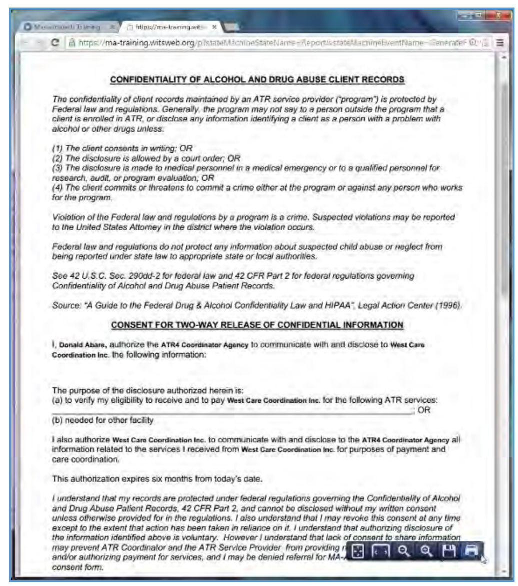


Figure 6-12: Client Disclosure Agreement screen, Generate Report

11. Once the client has signed the paper form, update these fields:
    - **Has client signed the paper agreement form**: select "Yes"
    - **Date client signed consent**: defaults to current date
12. Click **Save** and stay on this screen (notice the fields are now grayed out).
13. After saving the client consent, a link to add a Client Referral for this consent will be available. This will open the client referral screen, and will pre-populate the signed consent and Agency fields of the Referred to section.
14. Click the link, **Create Referral Using this Disclosure Agreement**, and continue to the next section.



Printable Consent Form

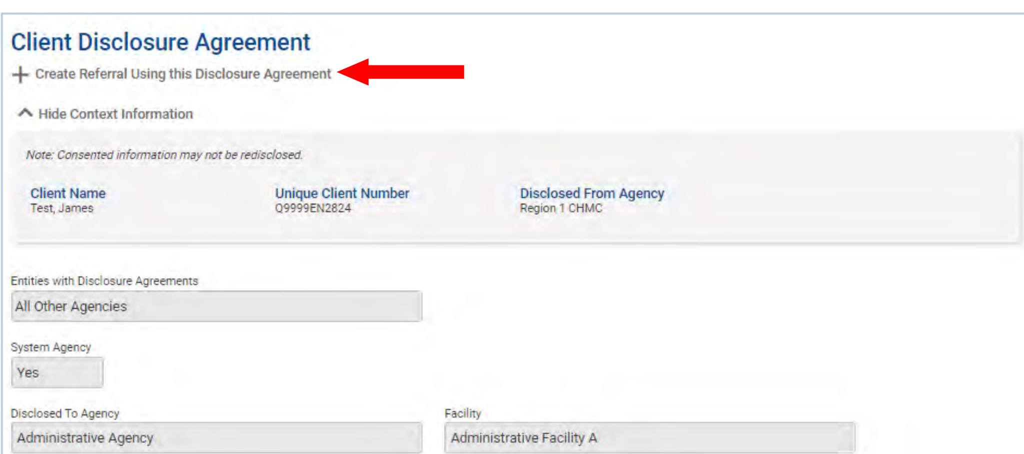


Figure 6-13: Create Referral Using this Disclosure Agreement link

Referrals

Create a Client Referral

***Where:* Client List > Activity List > Referrals**

Continuing from previous section…

Once the Client Consent is complete, create the Client Referral Record. A referral is used when the receiving agency (another WITS agency) will be providing services for the client. Referrals may also be done from one facility to another facility within the same agency.

1. After clicking the **Create Referral Using this Disclosure Agreement** link, the Referral screen will open.

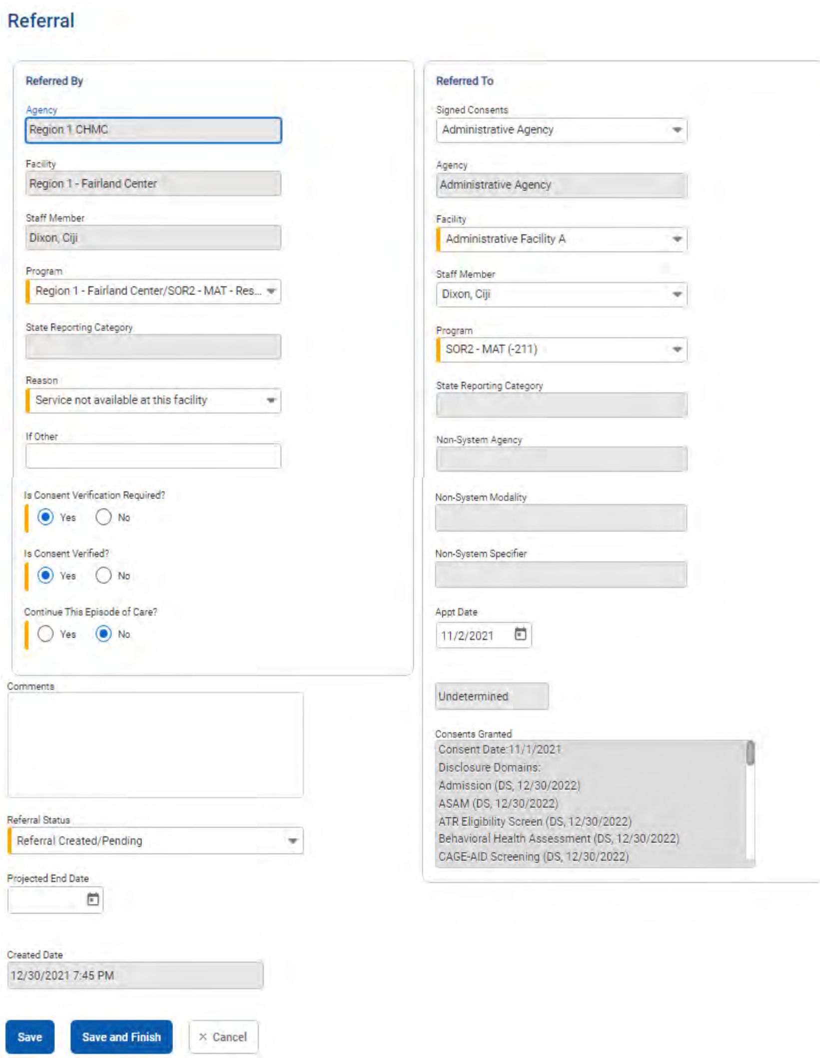


Figure 6-14: Referral screen

2. On the Client Referral screen, complete the required fields in the **Referred By** section, including:

Table 6-5: Referred By fields

Field	Description
Program	Select the Program, if available.
Reason	In the drop-down field, select the reason why this client is being referred.
Is Consent Verification Required?	Select Yes.
Is Consent Verified?	Select Yes.
Continue Episode of Care?	Select No.
Referral Status	State of the referral (this should be "Referral Created/Pending").
Created Date	Date client is referred.

3. Next, in the **Referred To** section, complete all the required fields, including:

Table 6-6: Referred To fields

Field	Description
Signed Consents	Select the consent from list of available consents.
Agency	This field will auto populate based on the "Consent" selected.
Facility	The facility the client is being referred to.
Program	The program the client is being referred to.

4. When complete, click **Save and Finish**.

Part 7: Client Discharge and Case Closure

Add Updated Outcome Measures

Where:* *Client* > *Activity List* > *Outcome Measures

An **Updated Outcome Measure** must be completed prior to disenrolling a client from a program. This requirement is only applicable to programs that report TEDS data.

1. Hover over the ellipsis icon and click **Activity List**.
2. On the left menu, click **Outcome Measures**.
3. On the Outcome Measures List screen, click **Add New** to add an updated current Outcome Measures record. This will open the Outcome Measures - Client Status screen. You will notice the previous record is listed for the Initial Outcome Measure entered for the client.

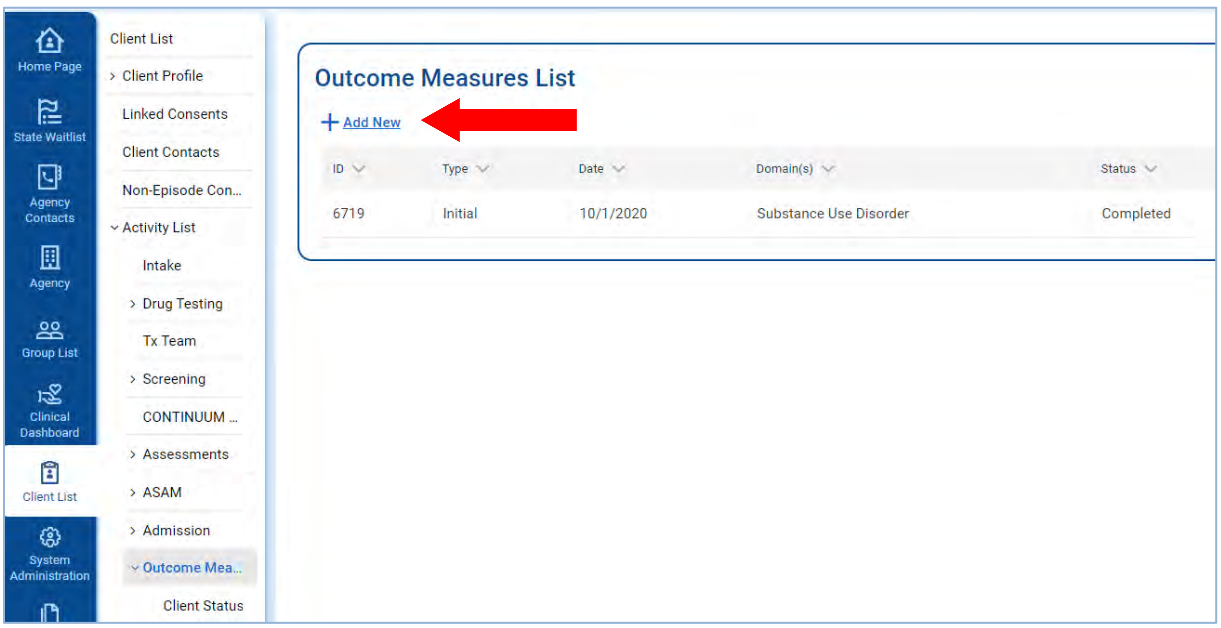


Figure 7-1: Outcome Measure screen, Add New link

4. You will then be taken to the Client Status page of the Updated Outcome Measures.

Client Status Updates

***Where:* Client List > Activity List > Outcome Measures > Client Status**

The Updated **Outcome Measures – Client Status** screen displays all pre-populated fields with the fields previously reported on the Initial Outcome Measures.

1. The Type field will indicate that you are editing an updated version of the Outcome Measures.
2. Add a current date, and make additional updates as needed related to any changes in the client's information.
3. Once the updated information has been added on all Outcome Measure screens as needed, select **Save and Finish**.

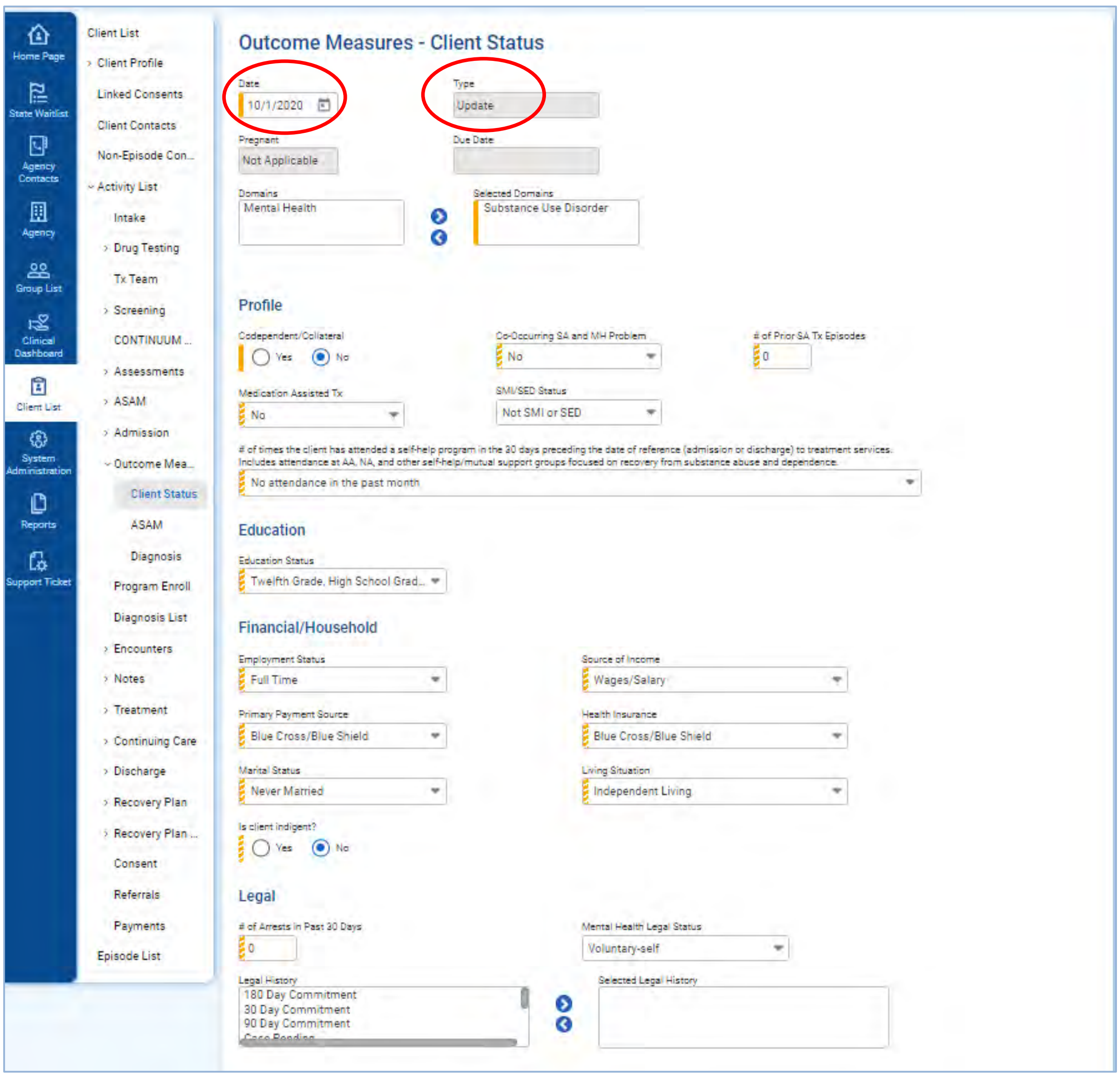


Figure 7-2: Updated Outcome Measures – Client Status screen

Disenroll the Client from the Program(s)

Where:* Client > Activity List > Client Activity List > *Client Program Enrollment

1. On the Client Activity List, hover your cursor over the vertical ellipsis icon next to the Client Program Enrollment and select **Review**.

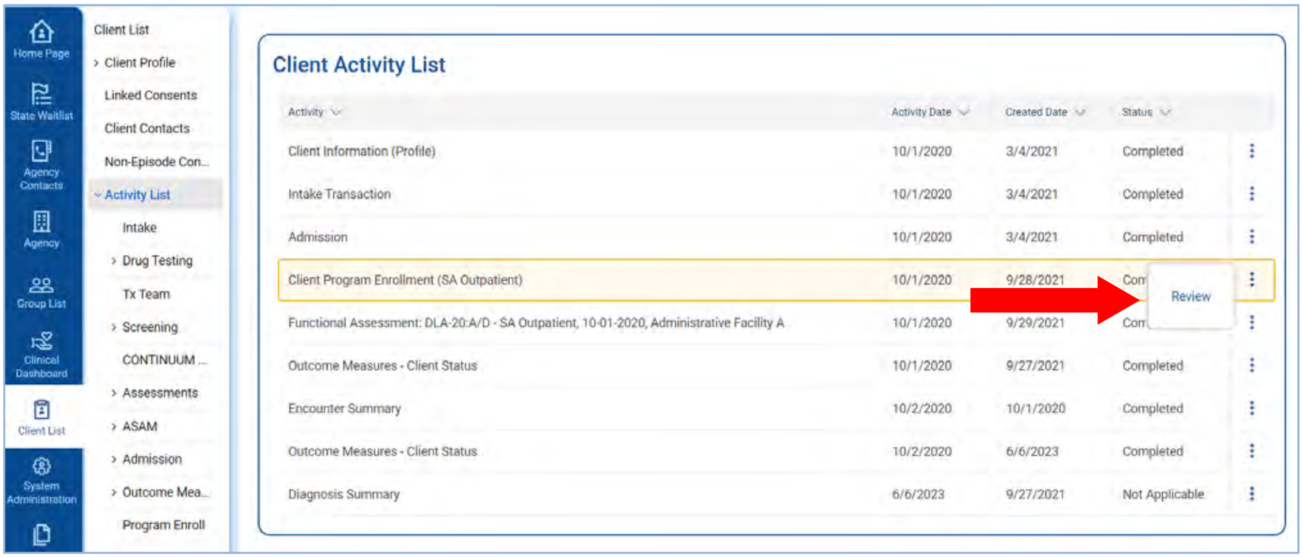


Figure 7-3: Client Program Enrollment Review

2. Complete the Days on Wait List, End Date, Date of Last Contact, and Termination Reason fields. Once completed, select **Save and Finish** to return to the Activity List.

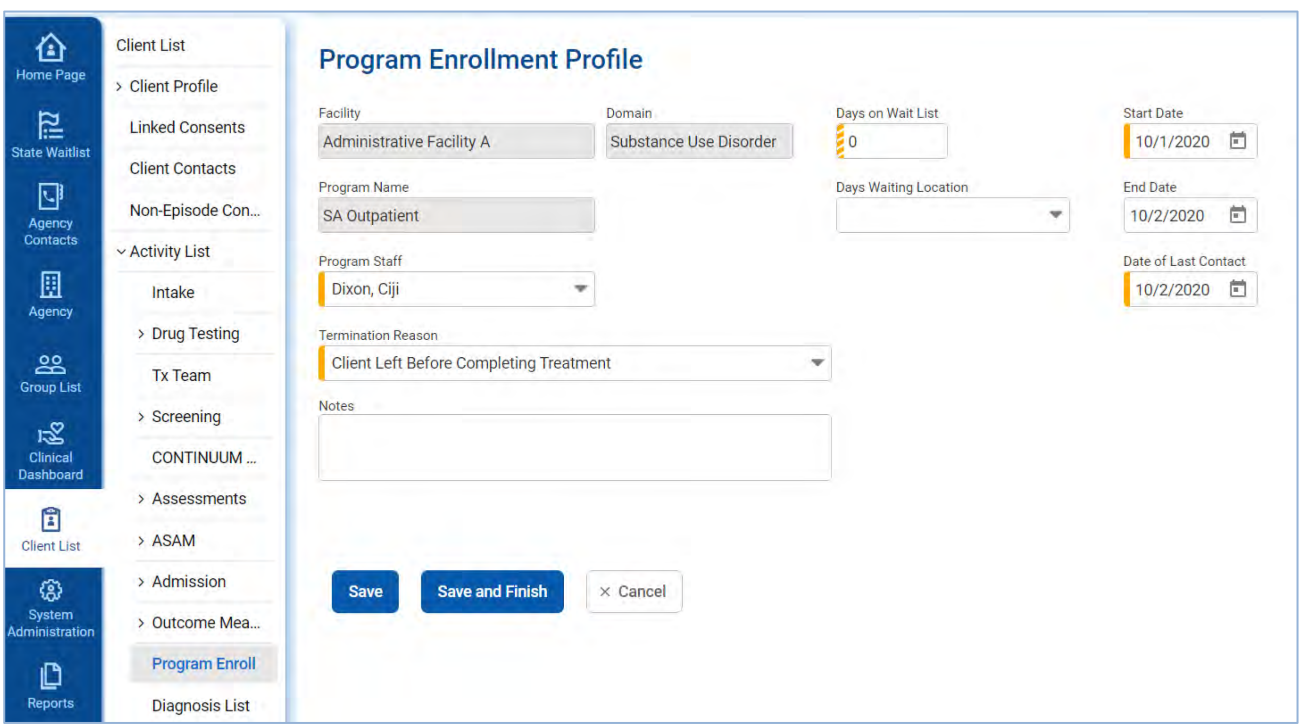


Figure 7-4: Disenroll Client from Program Enrollment Profile

Discharge the Client/Close the Case (Treatment Episode)

Where: Client > Activity List > Discharge

Before discharging a client and closing the case, assure that all services rendered to the client have been reported within the **Encounters** section of WITS.

1) From the client's Activity List, select **Discharge**. You will then be taken to the Discharge Profile screen.

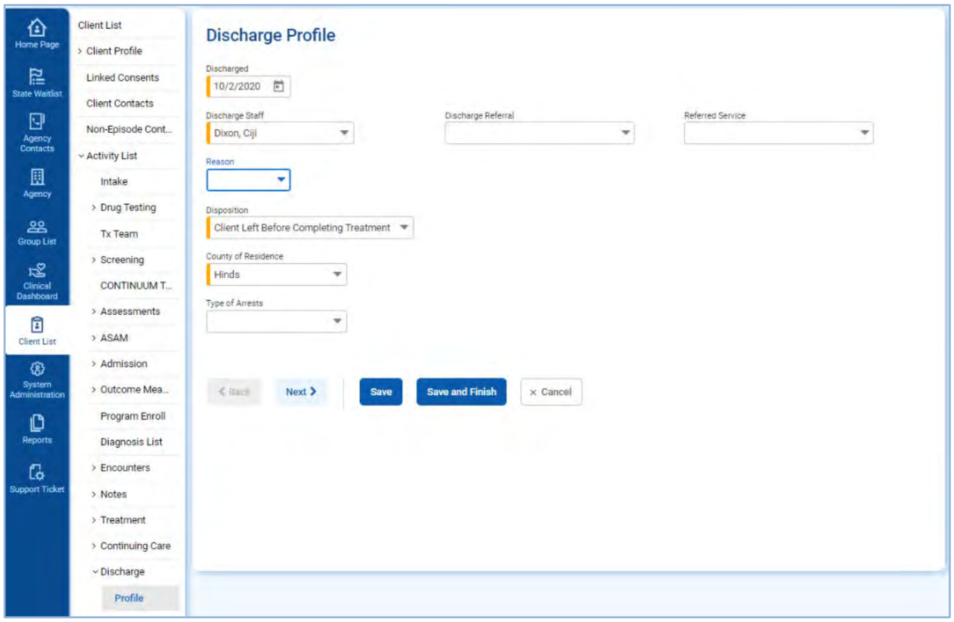


Figure 7-5: Discharge Profile

2) Complete all required fields on the first page. Once completed, select **Save and Finish**.

3) A prompt will appear on the screen stating, "Client is discharge. Do you want to close this case also?" If you are ready to close the case completed, select the **Yes** option.

4) If you are not yet ready to close the case, you may select the **No** option. This option may be necessary if you have additional records (i.e., service Encounters) to report. Once the case is closed, all editable fields will be greyed out to prevent updates.

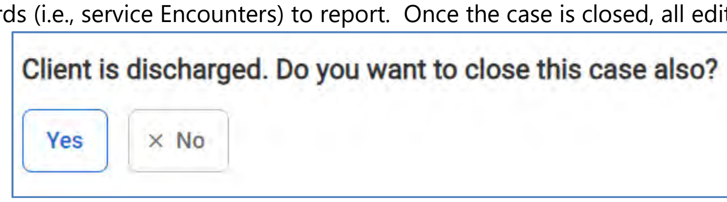


Figure 7-6: Case Closure from Discharge Screen

5) If **No** is selected to make additional updates, and you are now ready to close the case,
   a) you may return back to the completed Discharge Profile screen and select **Save and Finish**. Or,
   b) you may close the case from the Intake screen by adding a case closure date and selecting **Save & Close the Case**.

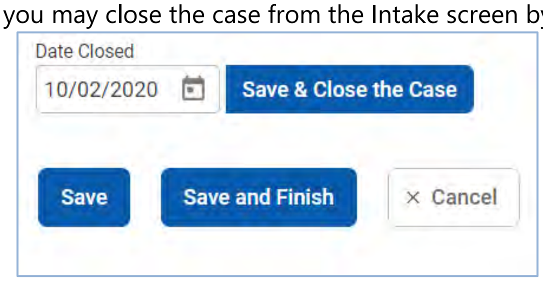


Figure 7-7: Case Closure from Intake Screen

Reopen a Case/Treatment Episode

Where: Client > Activity List > Intake Transaction

1. On the Activity List, you may select **Intake** from the navigation menu. Or, you may hover your cursor over the vertical ellipsis icon next to the Intake Transaction record under the Client Activity List section and select **Review**.

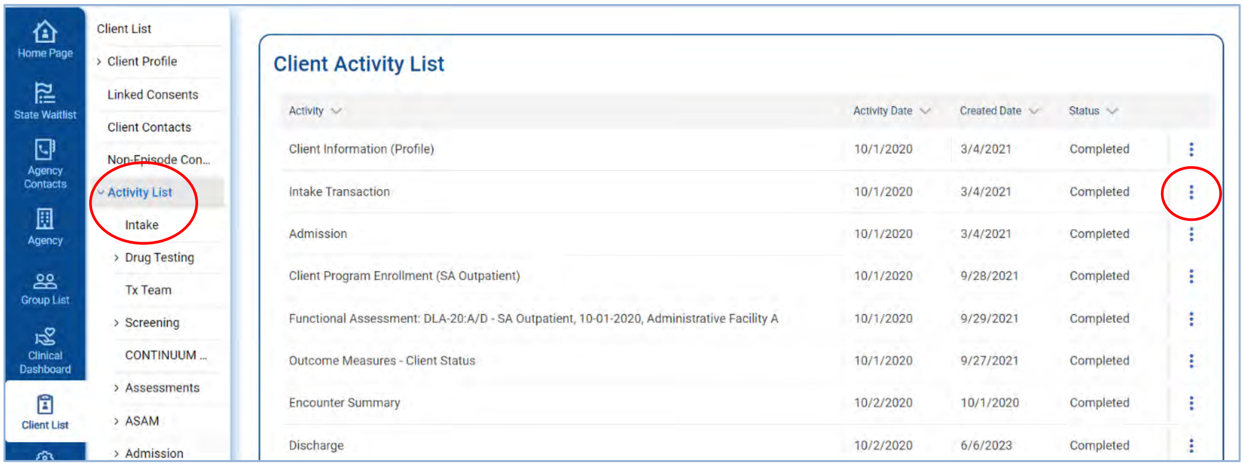


Figure 7-8: Activity List – Intake Transaction Review

2. At the bottom of the Intake Transaction screen, you will select the option to **Re-Open Case** which will now open all fields within the treatment episode for editing as necessary. Remember to always close the case out after all updates have been made.

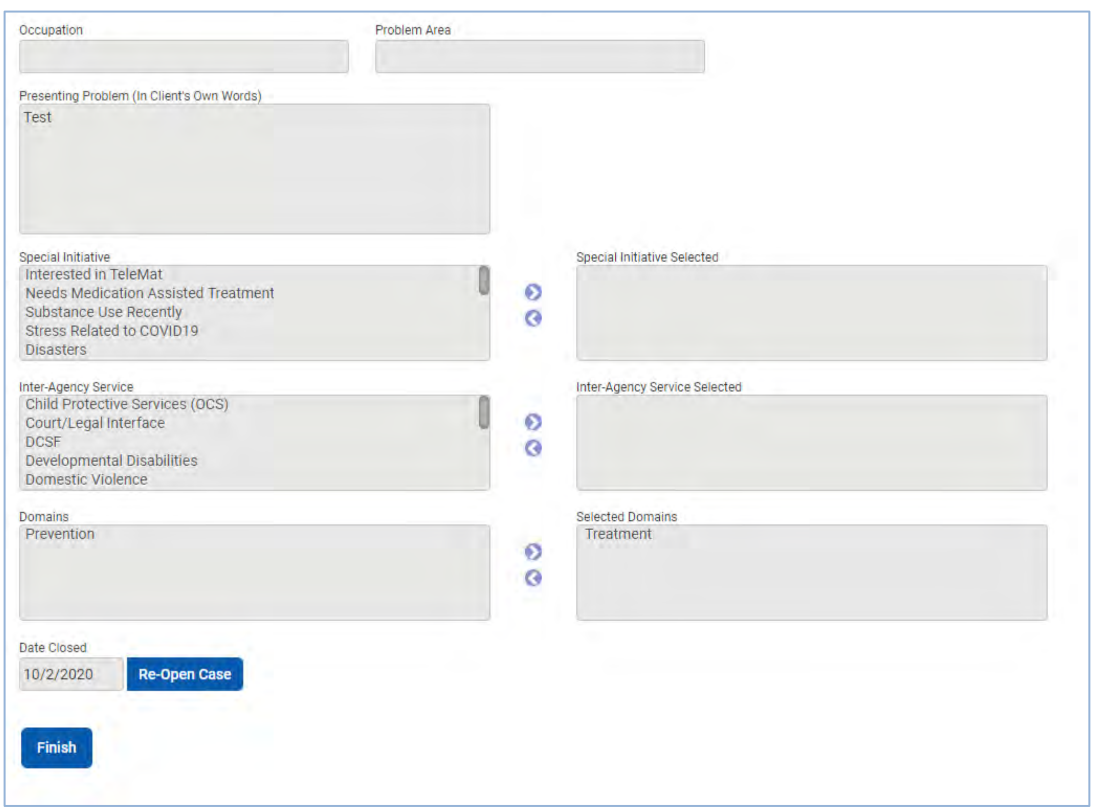


Figure 7-9: Reopen Case from Intake Transaction

Part 8: Agency Billing

Review and Adjust Claims

Where: Agency > Billing > Claim Item List

Once an Encounter is released to billing, it is now referred to as a "Claim Item".

Required Role(s):

- Create Agency Claim Batch
- Create Facility Claim Batches

1. To view claim items, click **Agency**, then **Billing**, and then click **Claim Item List**. Note the Claim Item List will display claim items with a status of "All Awaiting Review" by default.

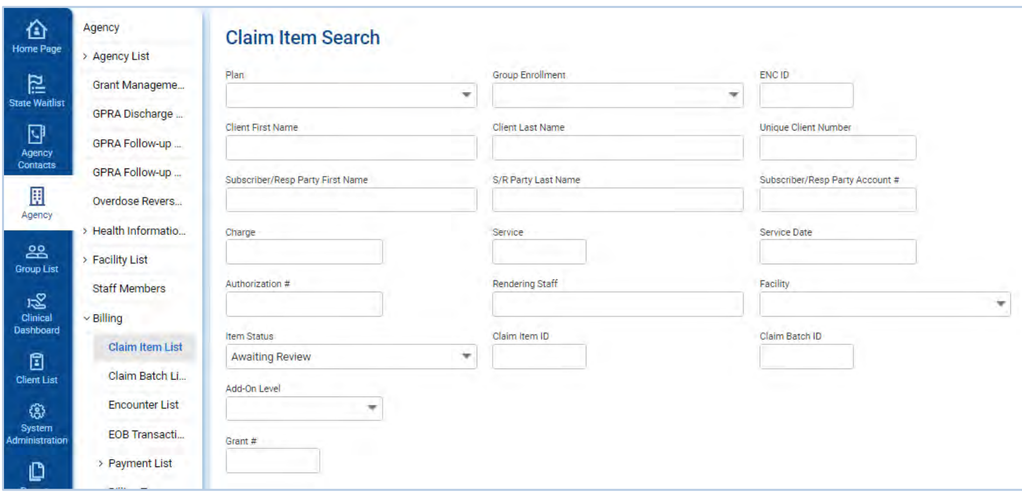


Figure 8-1: Claim Item List screen

2. Use the search fields to find a specific claim item or to filter your results, then click **Search**.

> To view all available claim items, click **Clear** and then click **Search**.

3. The claim item list will display the following information:

Table 8-1: Claim Item List information

Field	Description
Item #	Claim item number
Client Name	Name of client record
Grant #	Claim funding source / Grant
Service Date	Date of service
Service	Service code
Status	Status of claim item
Release Date	Date the claim item was released to billing
Charge	Total amount billed

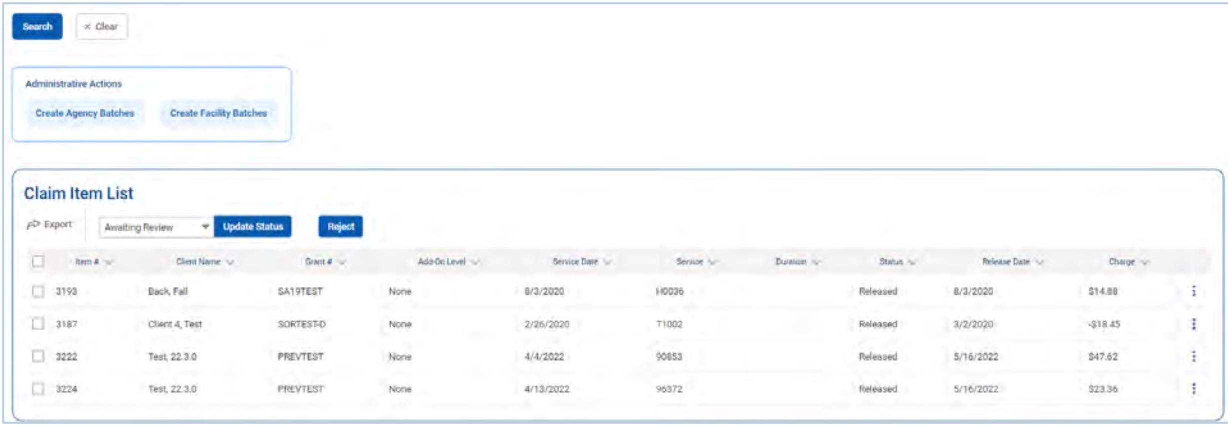


Figure 8-2: Claim Item List screen, Profile link

4. Next, hover over the three dots (ellipsis) icon on the right of the claim item record and click on the **Profile** link.

5. The **Profile for Claim #** screen displays all of the claim information and allows for claim item adjustments to be made if needed. Note you will only be able to edit a few active fields, as the remaining fields will be read-only.

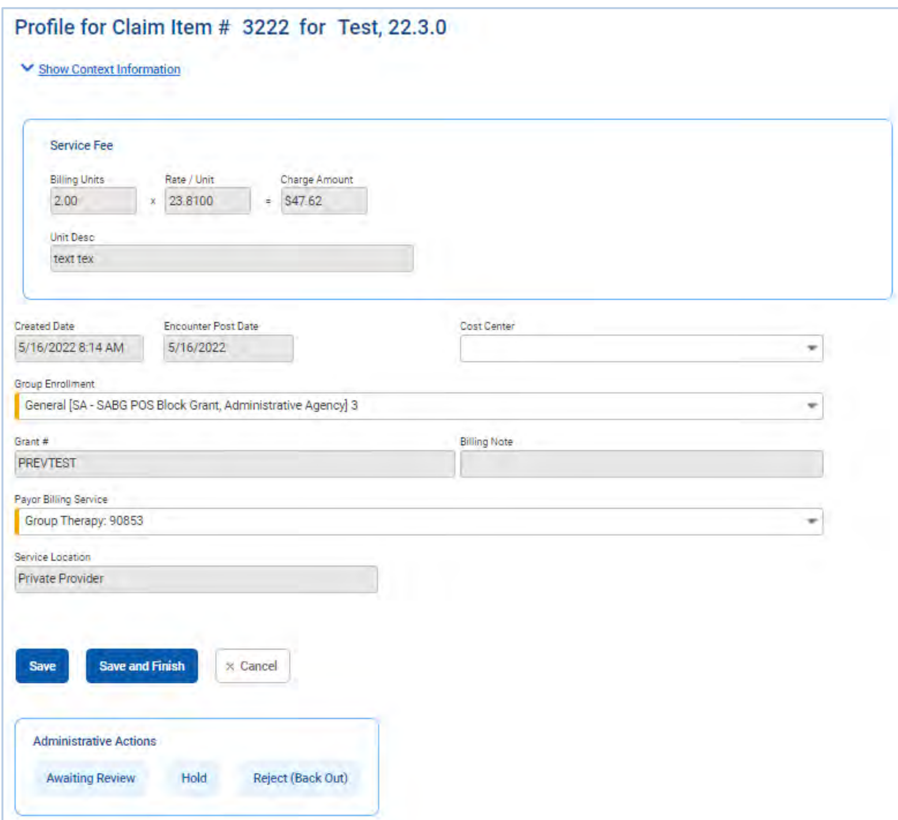


Figure 8-3: Profile for Claim # screen

6. Next, you have the option of changing the claim item status. The **Administrative Actions** will vary based on the claim item status. If the claim item is **Released**, choose from the following actions In the **Administrative Actions** box:

Table 8-2: Claim Item Administrative Actions

Action	Description
Awaiting Review	This action link will indicate that the claim is awaiting review and approval to release.
Hold	This action link will indicate that the item is pending and is not ready to be batched and billed.
Reject (Back Out)	This action link will indicate that the claim item may not be billed.

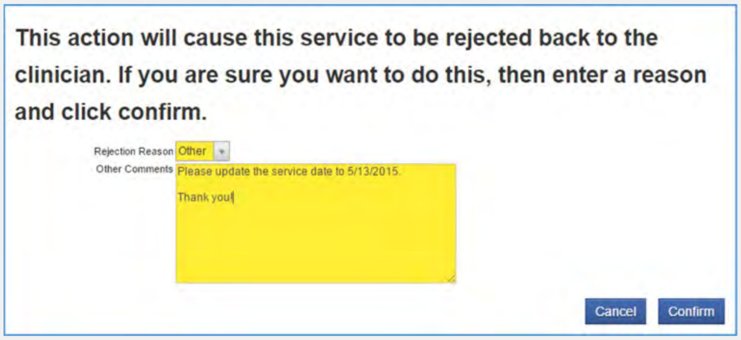
7. After selecting an Administrative Action, the browser window will reload, and the claim status is changed. Click **Save and Finish** to save and complete your action.

Note: Reversal and Adjustment

The reversal and adjustment claim items are automatically created with the released status. They will then be batched and billed when the next process runs.

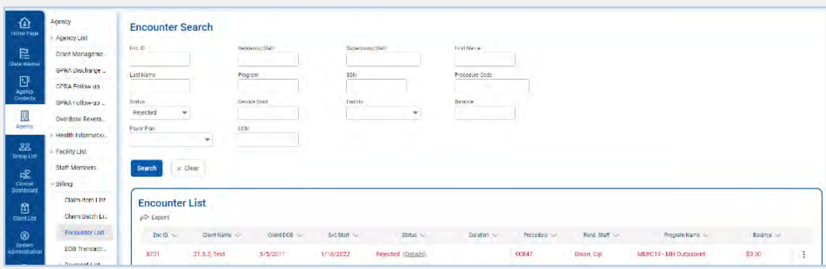
Note: Reject (Back Out) a Claim Item

1. If rejecting a claim, another screen will appear and you will need to provide a reason.



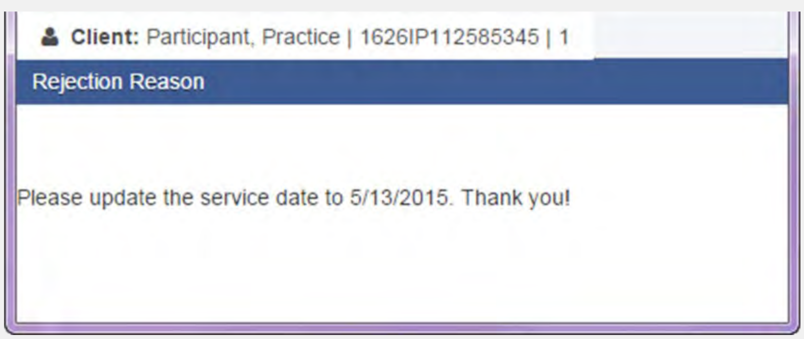
Reject (Back Out) Claim Item Reason

2. Once the claim is rejected, the encounter will appear in red on the encounter list.



Encounter List, Rejected Item in Red

3. The user will then be able to see the rejection reason by clicking the **"Details"** link. This link will open another window and will provide the user with information to make any changes.



Rejection Reason

Create Agency/Facility Claim Item Batches

***Where:* Agency > Billing > Claim Item List**

Next, after reviewing all of the claim items, they will need to be batched. Batches can be made either for an agency or for a facility. This ability is assigned through the roles, Create Agency Claim Batch, and Create Facility Claim Batches.

For staff members with either of these roles, the Claim Item List screen will display an Administrative Actions box, with one or both of those links.

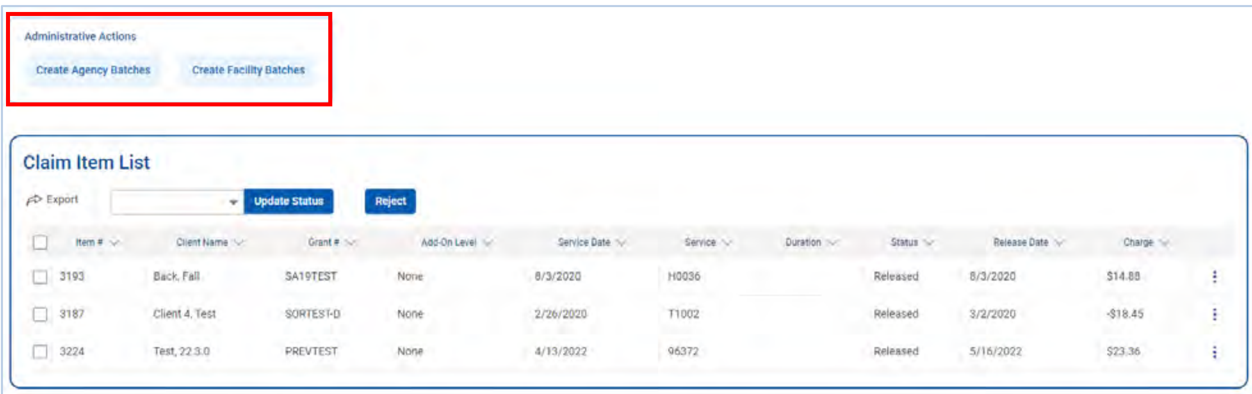
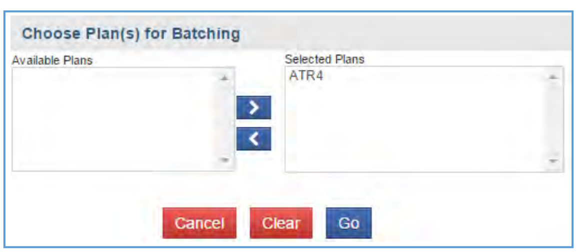


Figure 8-4: Claim Item List screen, Create Agency/Facility Batches

1. To create an Agency and/or Facility Batch, click one of those links in the Administrative Actions box.
2. On the **Choose Plan(s) for Batching** screen, select an available plan and move it to the "Selected Plans" box, and then click **Go**.



Choose Plan(s) for Batching screen

3. A message will appear on the screen indicating that the claim items are being batched.

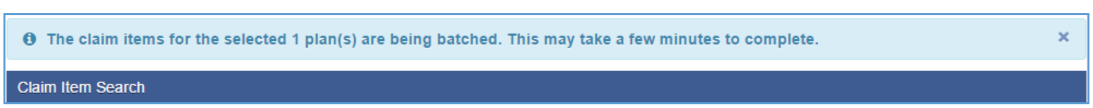


Figure 8-5: Batched Claim Items message

4. Check the Claim Batch by clicking the **Claim Batch List** link in the left menu. ***See next section…***

Claim Batch List

***Where:* Agency > Billing > Claim Batch List**

The Claim Batch List screen allows you to review the Claim Batch profile, including all of the claim items associated with that batch, and then submit the claim batch to the payor for payment processing.

1. From the left menu, click **Agency**, **Billing**, and then click **Claim Batch List**.

2. Click **Clear** to remove pre-filled items in the search fields, and then click **Search** to view all of the claim batches.

3. Hover over the ellipsis icon on the far right of the claim batch record and click the **Claim Items** link.

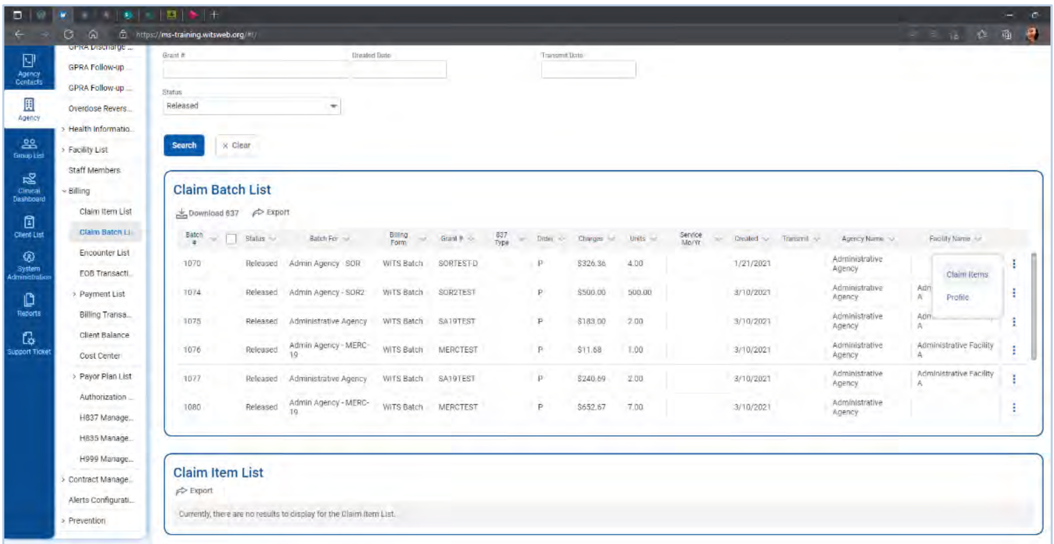


Figure 8-6: Claim Batch List, click Claim Items link

4. The **Claim Item List** will then display all of the claim items associated with that batch. These can be reviewed before submitting the batch.

5. On the **Claim Batch List**, review the batched claim item by hovering over the Actions column, and select the **Profile** link.

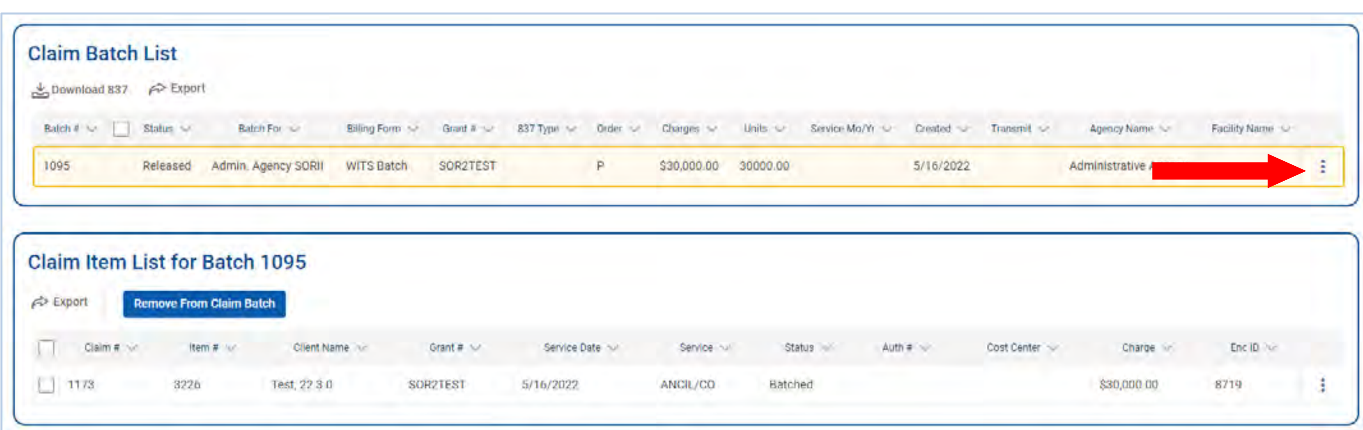


Figure 8-7: Claim Item List and Batch List

6. On the **Profile** screen of a Batched Claim Batch item, the Administration Actions box will display the following links:

Table 6-3: Provider Claim Batch Profile Administrative Actions

Administrative Action	Description
Awaiting Review	Indicates that the batch needs further review.
Hold	Indicates that the batch is pending and is not ready to be billed.
Void	This will void the batch.
Bill It	This will submit the batch for the Contractor agency (payor) for payment processing; the status of the claim batch will be updated once the payor accepts the batch and approves for payment.

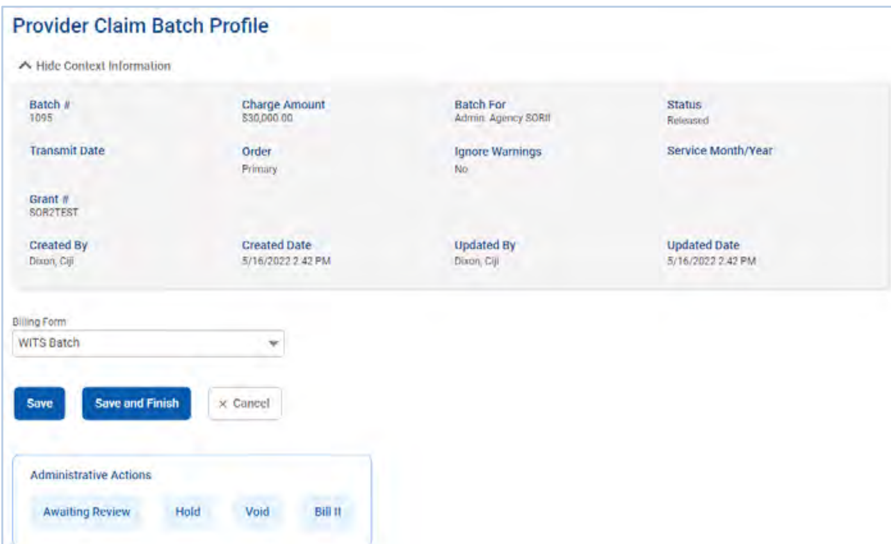


Figure 8-8: Provider Claim Batch Profile, Administrative Actions links

7. Click any of the links in the Administrative Actions box, and then click **Finish**. This will return to the Claim Batch List screen.

8. If viewing the Profile of Batched Claim Item that has been fully adjudicated by the payor, the following actions will be available in the Administrative Actions box:

Table 8-4: Reverse and Adjust Administrative Actions

Administrative Action	Description
Reverse	This selection will create a reverse transaction of the original claim item; The charge will appear as a negative amount on the Claim Item List screen.
Adjust	This selection will create a reverse transaction of the original claim item as well as a new claim corresponding to the adjustment you just entered; The Claim Item List screen will then show two claim items: negative charge and the adjusted amount.

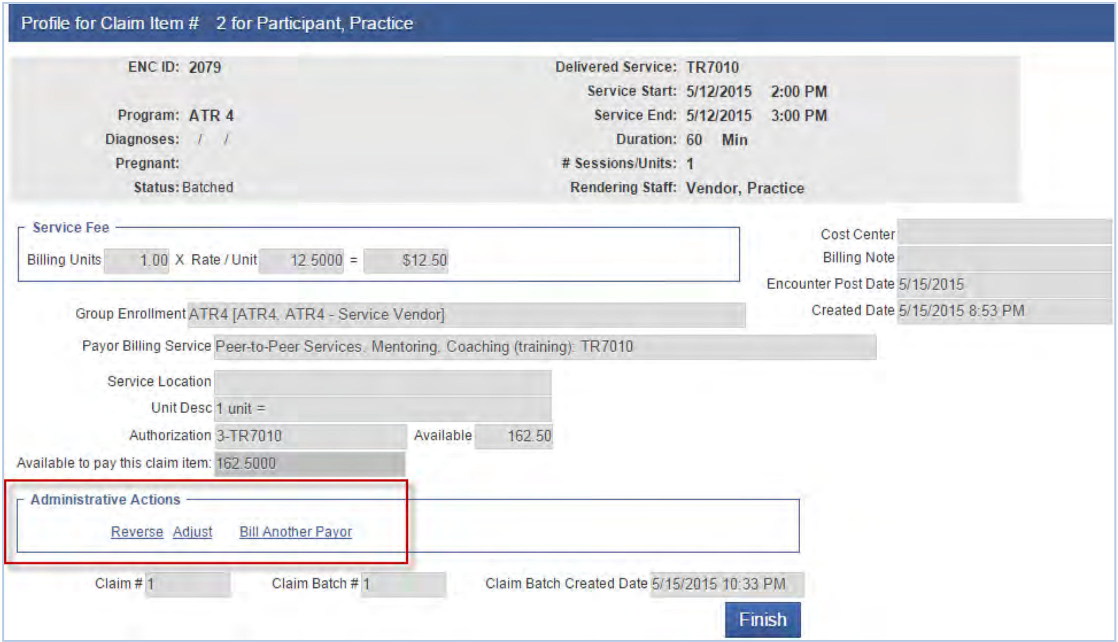


Figure 8-9: Accepted Claim Batch, Profile link of Claim Item

9. Clicking "Reverse", or "Adjust", will open a confirmation screen. Click **Yes** to continue.

10. Complete your selection by clicking **Finish** to go back to the **Claim Item List** screen.

Tip: When the intake is closed, all of the authorizations related to this intake are closed. You may re-open the intake if necessary. You need to be granted the "Case Reopen" role to do so.
