Milan Medical

A Quality Electronic Medical Records And Billing Service

User Manual
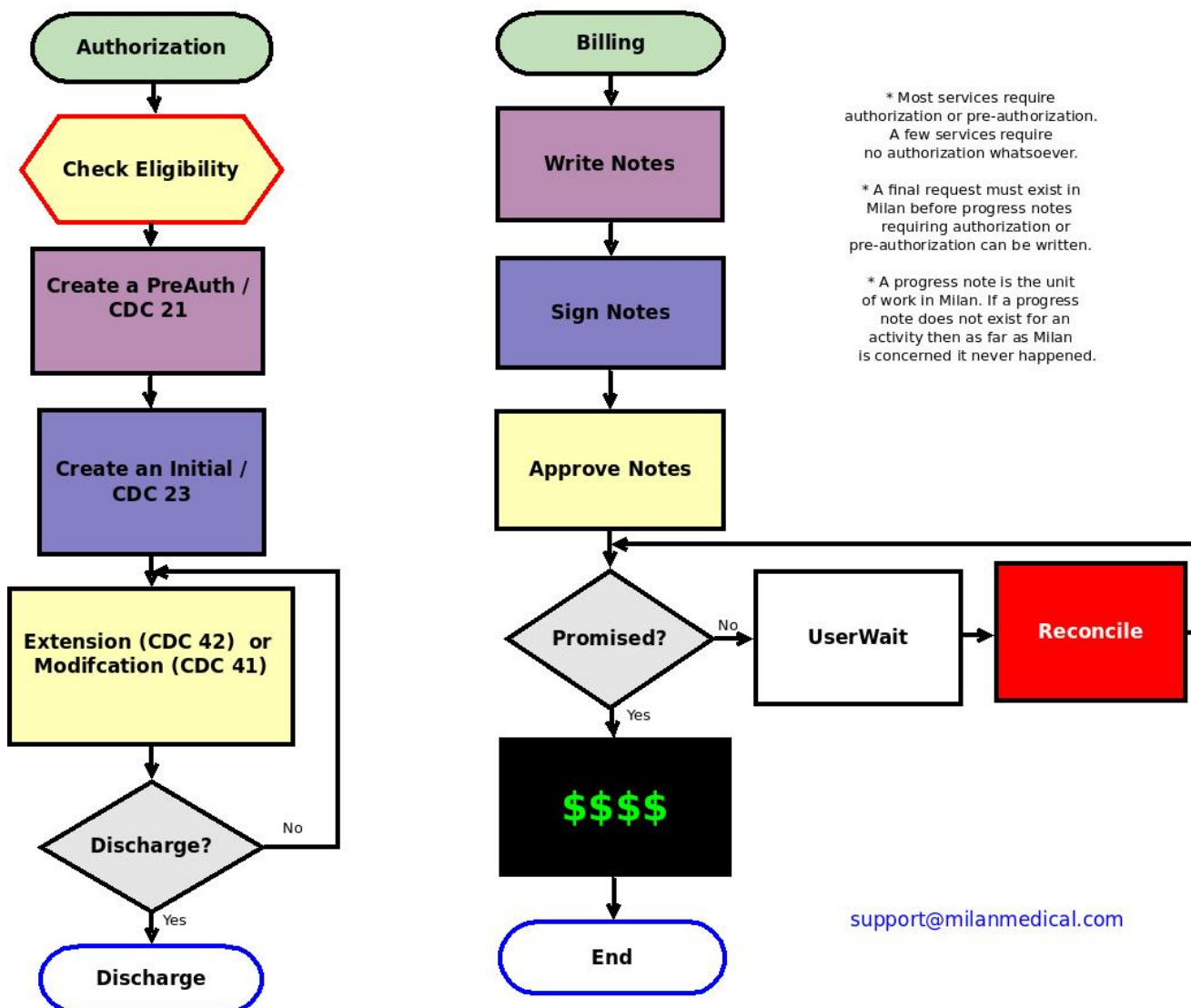
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Introduction to Milan

Milan Medical is a program designed to help your organization operate efficiently. Milan can manage information critical to your business, help you enter progress notes, bill claims and reconcile them from various payors (Medicaid, Medicare, insurance companies, etc.). It can also facilitate activities such as patient eligibility verification, authorization submission and utilization, reporting, document imaging, and even payroll.

One of the most important services we provide is customer support. This help file is constantly updated in order to incorporate your feedback, so if you ever have any questions or comments about this documentation or the Milan program, please give us a call. In addition to this help file we also provide support via a help desk and our web site. Please consult our Support page.

![Milan Medical logo]

Authorization

Check Eligibility

Create a PreAuth / CDC 21

Create an Initial / CDC 23

Extension (CDC 42) or Modifcation (CDC 41)

Discharge? — No / Yes

Discharge

Billing

Write Notes

Sign Notes

Approve Notes

Promised? — No → **UserWait** → **Reconcile** / Yes

$$$$

End

* Most services require authorization or pre-authorization. A few services require no authorization whatsoever.

* A final request must exist in Milan before progress notes requiring authorization or pre-authorization can be written.

* A progress note is the unit of work in Milan. If a progress note does not exist for an activity then as far as Milan is concerned it never happened.

support@milanmedical.com

Milan Medical Terminology

Batch Processing - Batch processing is where many claims are submitted at once instead of using the payor web site or paper to submit them individually.

Claim - A claim is the billing-specific information from all progress notes that is submitted for a patient on the same day. The payor does not care about some information such as the progress note text or time of day except during an audit.

ClaimItem - Several claim items are bundled up to make a claim. Usually a claim item is unique for each patient, date, and specific service performed.

CDC (Customer Data Core) - in Milan, this is a general type of electronic transaction we send to payors as a basis for future payments. There are several primary subtypes: a 21 to ask for PreAuth services, a 23 which is sent with the initial treatment plan/request, and a 42 which is for Extension.

da Vinci or da Vinci Network Services - the name of our company. Milan Medical is the name of the medical billing service and software that we provide.

Facility - A facility can be a site, a provider number, or anything else that a provider defines to make reporting easier. Usually a facility refers to a category of services provided at a specific physical location.

Patient - The terms client and patient are interchangeable in the software.

PAUW (Prior Authorization UserWait) - a treatment plan's status when denied or partially approved.

Payor - A payor is an organization that provides reimbursement for submitted claims for services performed.

Progress Note - What a therapist creates and prints out to document his or her work and doesn't necessarily indicate patient progress or that a service was performed. The unit of work in Milan, which means no note = no billing or payroll.

Provider - A provider is an organization that has facilities and therapists.

RA - Stands for Remittance Advice, and details what claims have been paid or denied.

Region - A group of facilities. Therapists can also be assigned to a region.

Treatment Plan (TxPlan) - A snapshot of the patient's chart, as well as the type and amount of services to be performed.

Getting More Help

The first time you log into Milan, you need to go to ***http://www.milanmedical.com***. In addition to logging into Milan, you can also download this help file there, initiate a remote assistance session with the help desk, and more.

Our help desk is available 24 hours a day, but most major issues are handled during business hours. The phone number for the help desk is ***(866) 773-3867*** and the fax number is (405) 773-8675. You can also email us any time at support@milanmedical.com. Sometimes when an error occurs you are given the opportunity to report the bug, and if you do report it the information is emailed to us.

When you contact the help desk please give us your name, the organization you work for, and how we can contact you. ***Never, ever give us your password***. We can do anything we need to do without it.

Sometimes we may need to see more information than can be easily communicated verbally. In these instances, we will ask you to initiate a remote assistance session so we can evaluate your system and see exactly what is occurring.
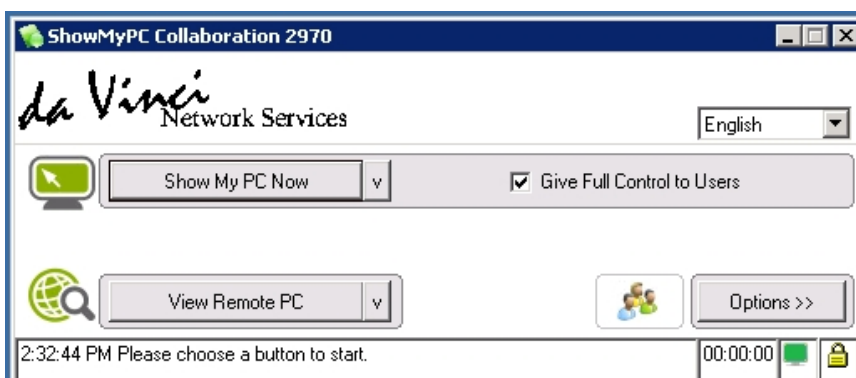
Logging In

To log in to Milan the first time, you will need to go to our web site, www.milanmedical.com to download the client software.

Milan has two databases, a Training database and a Normal database, which is what you access every day. Click on the Training Login if you are a new user and want to learn the system without making any permanent changes. The Training database is overwritten with a fresh copy of Normal every Wednesday morning.

Click on the Normal link, then Log In, and the Milan software will be downloaded to your computer and a shortcut will be placed on your desktop so that you can access the system without going to our web site each time.

Once the shortcut is downloaded to your desktop and you double-click on it, this login window will pop up:
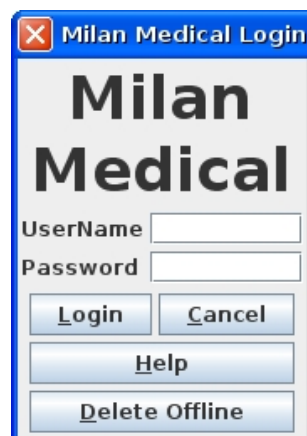
Your username and temporary password will be given to you by your local administrators.

If you are using a Mac, make sure you have operating system version 10.5 (Leopard) or later, otherwise the necessary version of Java will not run properly.

If you are having trouble logging in, click here.

Once you log in you will start out viewing the Cockpit.

Using Milan Offline

Milan Offline allows you to, while you are connected to the internet, download your charts to your computer (usually a laptop), disconnect from the internet, take your laptop home and write notes, then come back to work, connect to the internet and upload them.

Before using Milan offline, for the machine you want to try it on that you can go online and log on. This ensures that you have a good username, password and connection.

To use the software while offline you first need to login while still connected to the internet. After logging in you can go offline by accessing the Actions drop-down menu and clicking Go Offline. This will be used to download all your charts offline. Once all your charts have been downloaded the left side of the Cockpit will disappear and be replaced with a message that you are, indeed, offline.

All the downloaded charts will be listed as usual on the right side, and if they aren't then you know there is a problem. At this point you can disconnect from the internet and add progress notes. If you exit Milan and then log in again (while still disconnected from the internet) then the software will still be offline. However, the next time you log in (while connected to the internet) you will be asked if you want to go online. If you say yes then all the notes that you added while offline will be sent to the server. If you say no then you will stay in offline mode.

One mistake to avoid is going offline, going online, pulling the plug on your internet connection, and then expecting your charts to be there later. Going back online right after "Going Offline" wipes the charts you just downloaded. The only way offline works is if you "Go Offline," and then do not log in again (and say yes to go online) until your done working with your notes and you are connected to the internet.

Cockpit

Each time you log in to Milan, the first thing that opens will be your Cockpit window.

The Cockpit is used to see useful information regarding your prior authorizations/[treatment plans](#), [progress notes](#), and miscellaneous items such as credentials that are about to expire or claim items that denied or underpaid.

On the right side of the Cockpit you can see all the patients whose charts you are able to view and edit according to your permissions in Milan. You can sort your view of the list by selecting the Facility, Therapist and/or entering the name of the patient in the fields above the list window.

If you don't see a patient you think is supposed to be there, click the View All button to show your current and discharged patients. It is also a good idea to use the View All button if you are re-admitting a patient to see if they are already in the database, and have simply been discharged.

The colors indicate different problems. You can find out why a client is highlighted by simply moving your mouse pointer over the name, but here's a cheat sheet:

- Red = ineligible for main payor
- Orange = missing or expiring partial/treatment plan
- Yellow = hasn't had a note written for them in 30/60/90 days

On the left side of the Cockpit is what we call the 'Cockpit proper.' It is a convenient visual overview of the most important things you need to know about in Milan. We urge you to get rid of the Red data. Yellow data should be looked at, Orange data is more urgent, and Red data simply must be addressed.

Only administrators or clerks with appropriate privileges will see the Admin drop-down menu option at the top and the Edit Patient and New Patient buttons at bottom-right.

The Cockpit proper is split into three panels:

- Treatment Plans
- Progress Notes
- Miscellaneous

Each line of each panel is divided into three columns to give an indication of how urgent each item is. The left column is ok, and the further right you go the worse it gets. The Cockpit is very configurable, and may look different for each provider. Double-clicking on a line displays a report to show more detailed information.

The Treatment Plans panel is a listing of patients that do not or will not have a valid prior authorization in place, and what stage in the authorization process they are in. Nothing shows up in the panel for discharged patients, patients with a valid prior authorization in

place, or patients with their FullChart option set to None. The possible Cockpit lines are:

- Missing - clients without partial/treatment plans, or those that are ineligible for their main payor.
- TPR - stands for Treatment Plan Review, shows you how many days you have until certain patients' authorizations for their current plans expire. Therapists will receive an email notification approximately two weeks before a treatment plan expires
- Staffing - Therapist(s) are reviewing the patient's chart and treatment plan. May not exist for all organizations.
- QA - The patient's chart and treatment plan is undergoing quality assurance. May not exist for all organizations.
- Proposed - A prior authorization is being worked on by the therapist.
- Completed - A prior authorization is complete, awaiting the patient's signature from the therapist.
- Submitted - A prior authorization has been submitted to the payor.
- CDCUW (Customer Data Core UserWait) - Something was incorrect in the CDC we sent for these clients. You may have to change something, look into it, then if you can't resolve it, call us.
- PAUW (Prior Authorization UserWait) - Something was incorrect in the request. You may have to change something, look into it, then if you can't resolve it, call us.
- Preapproved - The authorization has been approved. This status is usually used to make sure the paper chart is in order and may not exist for all organizations.

The Progress Notes panel keeps track of all progress notes entered by therapists that have not been paid, written off, or deleted. This ensures that notes are never lost.

The Miscellaneous panel currently keeps track of therapist credential expiration and some billing reports for administrators. If you are an administrator, look at our Claims Billing page for more detail on the claim statuses.

Notices

This tab is used to display important messages from Milan and from your Administrators. You should keep this tab cleared of unread messages whenever possible.

Groups

You can set up groups to help you write a series of notes for your group therapy sessions. It keeps the common information from one note to the next. This functionality is only available on a service by service basis, so if you have a group with more than one service (i.e. some patients of the group are PreAuth, and others have an approved treatment plan), you will probably need to set up two (or more) groups, as the information may not be carried over from one service to another.

Charts

When in the <u>Cockpit</u>, you can double-click on a patient's name in a list to the right to open up their chart.

First, let's look at those buttons at the bottom of the window. The SAVE button to the left is the most important button. It needs to be clicked often when working in Milan. The Edit Patient button opens up the window for editing if needed. Any time something on a patient's chart is edited, Milan flags a Medicaid eligibility check for that night. The Refresh Chart button is to see changes you have recently made reflected on-screen. You can click the Open Chart button to pull up a quick list of all your patients to navigate to their chart more easily. You can click the Discard Changes button instead of the SAVE button if you change your mind about edits you've made.

When you initially double-click on a patient's name in the Cockpit to open their chart, or you click Open Chart at the bottom of the screen and access it that way, the chart will open to the Notes tab, and if you go to the Patient tab as I have above, you will see the basic information for the patient. If there's something wrong on this tab, only an administrator or clerk can fix it.

There are two big factors that determine how much of the chart is required for a patient when completing the treatment plan. The first is the 'Full Chart' option (None, Optional, Warning or Required) on the patient's basic information window, and the second is the main payor selected on the treatment plan. When the Full Chart option is set to optional, warning, or none, then only the primary diagnosis, an address, CAR scores, goals and objectives are required before a treatment plan can be completed. If the Full Chart option is set to Required and the treatment plan payor is Medicaid, most of the tabs are required before a treatment plan can be completed.

The Patient Programs pane is one of the most important areas on the patient's chart. The program chosen for them severely affects choices down the road when setting up treatment plans and writing notes. The variety of programs depends on your organization, but the most common programs are Mental Health (MH), Substance Abuse (A/D) and Integrated.

On the Patient Therapists pane the main therapist to be contacted in relation to this patient should a situation arise needs to be given the role of QA or Both, with any other therapists assigned to the patient given None.

The Patient Payors pane is the first place you should look if something seems to be going wrong when writing notes or trying to complete treatment plans. Most likely you will see that their Medicaid (or some other payor) eligibility has expired. If you know it hasn't, this means the correct information is not in Milan and needs to be double-checked. The Priority column allows you to set up multiple payors for the patient and specify, using a larger number, which payor will be consulted first. For example, if Medicaid and NOPAY are on there, and you want to bill Medicaid first and then send the rest to NOPAY, set Medicaid's number to 100 and NOPAY's to 50 (or any other combination of that), as long as Medicaid's priority number is bigger than NOPAY's.

If billing claims for a patient consistently receive the $3 co-pay, and end up in UserWait because of it, make sure to go to this window under Edit Patient and set the Co-pay amount at the top to 3, which will automatically adjust the amount received. Alternatively, you can click Adjust on the appropriate UserWaits and instead of using the Write Off option, you can uncheck that and check the box for Patient Co-Pay and put in 3, Treatment Plans .

Scans Tab

The Scans tab in the patient's chart is where you can upload any scanned piece of paper applicable to the patient's chart history.
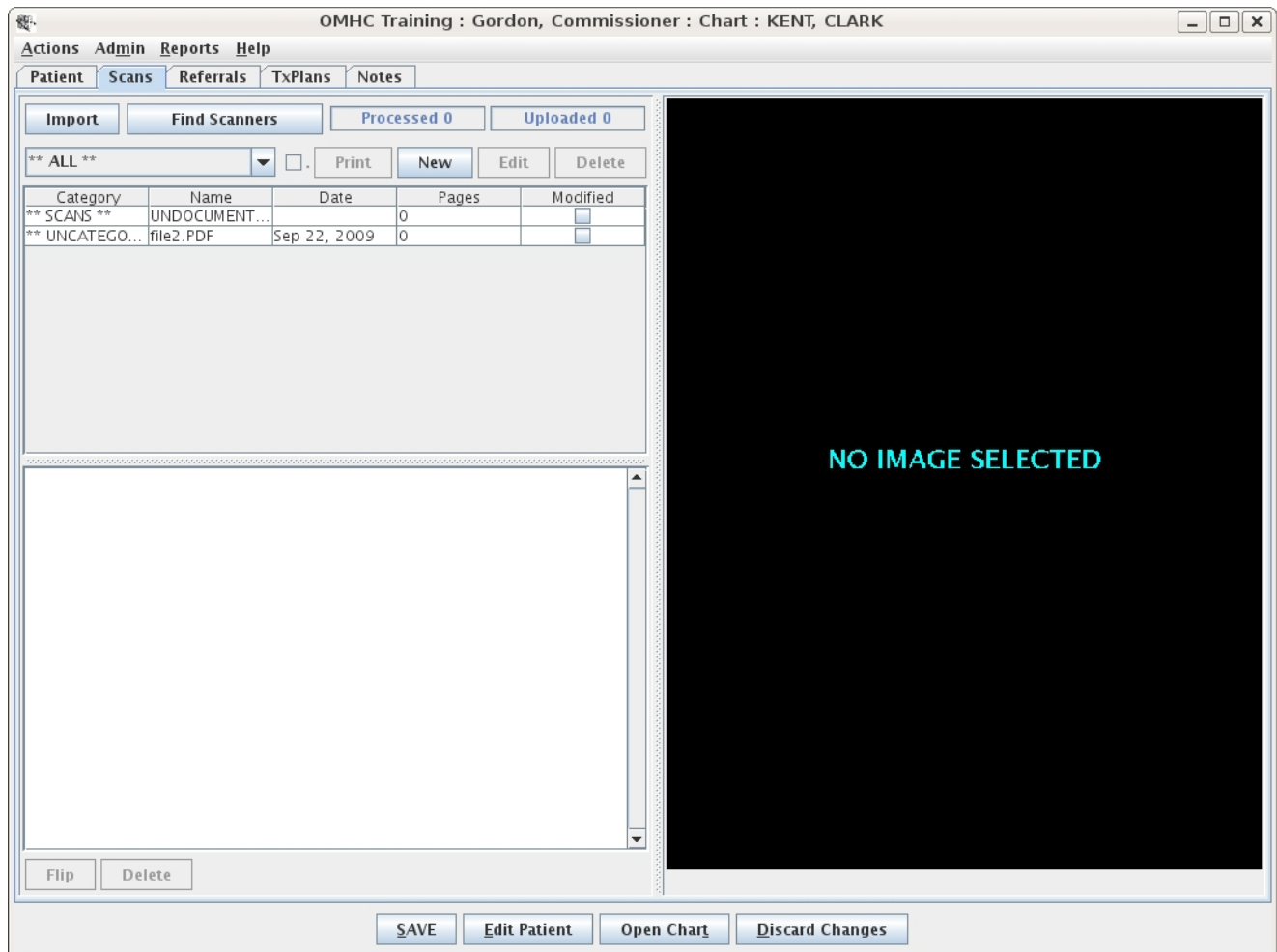
You can either import a PDF file or scan directly from an attached TWAIN scanner. Most scanners come with TWAIN drivers.

Referrals Tab

This is for your source referral and release information. At the bottom is a HIPAA release log, so if you do release information to anyone you can make a record of who it was and when you did it. The release information from this tab doesn't tie to anything else in Milan, so nothing here is mandatory.

TxPlans Tab

The 'TxPlans' tab will show you treatment plans and transactions (commonly called CDCs) for the patient and allow you to add new treatment plan information and requests.

If you have Admin privileges you can take advantage of most of the buttons appearing beneath the list window. Depending on how old the plan is, or what your privileges are, your options may be more limited.

You create a treatment plan either by clicking the Initial button or by selecting an existing treatment plan on that same tab and clicking the Extension button to create an Extension treatment plan. Depending on what status the treatment plan is in, the Finalize button may show up to the right of the Print button to move the treatment plan on to the next step. Once a valid Final treatment

plan is in place, progress notes for services requiring authorization can be entered.

Treatment plans are listed by date and you can view historical treatment plans. Below the treatment plan list and buttons are the historical record of generated and uploaded CDC transactions. The status of each CDC directly affects the status of its respective request above. Each CDC can also be viewed or affected by the buttons directly below the list.

For specific information about treatment plans including how to write one, see Treatment Plans and Making a Treatment Plan.

Treatment Plans

Treatment plans in Milan represent two things: the actual service plan of care for the patient and the authorization request. The requests are used to manage utilization, and may need to be submitted to a third party for approval. You can see these two identities separately by clicking on the 'View TxPlan' button on the TxPlans tab to see the multi-faceted plan which holds the clinical information, or by clicking on 'View Request' to see what the request is going to look like.

The goal is to have an unbroken chain of plans in the list window. The important things to notice here are the effective dates and the duration of each plan backing up to the next one.

Here is the life cycle of a treatment plan:

- PreAuth - in Oklahoma, some services can be provided while awaiting the initial authorization (see [Customer Data Core](#) for more information)
- Review - for a small number of organizations, this treatment plan is still in the multiple stages of review before completion is possible
- Proposed - clinician has started working on it, still incomplete
- Completed - awaiting the patient's signature from the therapist.
- Submitted - waiting on approval from a third party (such as ODMHSAS for CDCs)
- PAUW (maybe) - we'll go over this later, but this is if it was sent to a third party and had issues
- Preapproved - the same as Final as far as therapists are concerned, but administrators can leave it in preapproved until the treatment plan is printed/filed
- Final - after this you can only change units, expiration date of the request and start/end dates of authorizations

If the payor for the plan is fully supported, the plan will go directly from Completed to Preapproved or Final status. Which status the plan goes to is set on an organizational level, and can be changed to fit your needs.

There are two processes for creating a treatment plan in Milan: Short and Extended.

On our [Making A Treatment Plan](#) page we deal with the most common, the Short method, where therapists write a treatment plan that starts in Proposed status. But this isn't always the case. Another method, Extended, assigns therapists to Review plans for consistency and someone else to provide Quality Assurance support, where the administrators oversee the writing of the plan more than the therapists do.

Here is how the Extended process works. You will need to do this so we can get a plan to Proposed status before going to the Making A Treatment Plan page.

- The admin or clerk first creates the patient, and hits the Initial button on the TxPlans tab to create a Review PriorAuth request, placing a line on the TxPlans tab representing the initial request, ready to receive a treatment plan on top of it
- At this point the therapist can click the Edit TxPlan button to fill in the needed data - if there is just an OK button at the bottom of the window when filling out the treatment plan, that means that this therapist is not assigned as the official reviewer of the plan
- Once the plan is done, the user assigned to Review (on the Patient tab) looks through the treatment plan and when everything is filled out correctly, clicks the Review button at the bottom of the window
- If there is a separate person/entity assigned for Quality Assurance, it is now their job to do the same thing, hitting the QA button, finally putting the plan in Proposed status
- If the therapist writing the treatment plan (or another) is assigned to both Review and QA, he/she simply hits the Review button on the first go-around and the plan is considered reviewed and quality assured all at once and is placed in Proposed status, with the admin now having the responsibility to Complete the plan

When printing a treatment plan, the signature page will say DRAFT until the plan reaches Completed status, at which point the patient signs it. After this point, nothing on the treatment plan can be changed that affects the signature page without the patient's consent and additional signatures.

Customer Data Core

The Customer Data Core, commonly called a CDC is made up of several sets of information relating to your patient that OHCA needs to verify in order for you to get authorized services approved.

The most frequently sent CDC-based transactions that we send are 21 (PreAuth), 23 (Initial), and 42 (Extension).

A CDC 21 (PreAuth) tells the state that you have just admitted a new client and you want an approval to bill pre-admission services. A 23 (Initial) is sent attached to a treatment plan/request and requests approval for six months of services for a particular patient. Milan automatically sends a 23 with every Initial request/treatment plan you upload. The 42 is sent automatically with an Extension request/treatment plan.

Sending a PreAuth (CDC 21)

For Milan to send a 21, we need some very basic information as soon as you admit the client. On top of adding them to Milan using the New Patient button, you must fill out a "partial treatment plan." When your client first shows up in your [cockpit](#), the first time you try to open their [chart](#) Milan will ask you if you want to fill out a partial treatment plan, and you should click Yes.
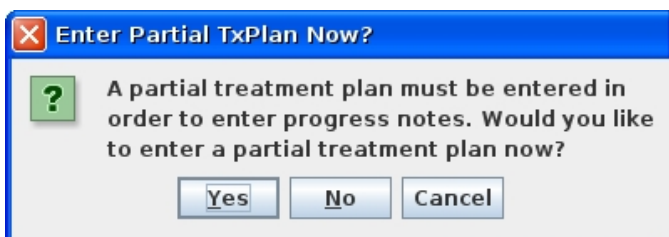
Three of the treatment plan tabs pop up.

On each of the three tabs, something needs to be filled out so you can receive pre-admission authorization and put those notes in Milan.

On the Basic tab (as seen above):

Service Focus, Race, Screening drop-down boxes (if you don't do screenings, put all three as Not Administered) and CDC Referrals (usually Primary is Self and Secondary is None, but don't leave either one blank).

On the Residence tab, the same information required for the full plan is required here: the three living situation drop-downs and a phone number and address.

On the Diagnosis tab, in order to be able to write these PreAuth notes in Milan you need to put something as the Primary 1a Diagnosis, even if it's V71.09: the no-diagnosis diagnosis. This is

required not for the 21 itself, but to start writing notes for that patient.

At this point, you can click OK, then click Save in the chart, and that night we will upload a 21 for you. It will have a default effective date of 10 calendar days prior to the date of saving the partial chart, or the Patient Admission date, whichever is more recent. Until the 21 is uploaded, the effective date can be adjusted in the TxPlan Tab by Uncompleting the Preauth request when in Completed or Submitted status.

The day after uploading the 21, you can look it up on the PICIS website, where it should have both the 21 and a PG038 request. If the PG038 is approved they will authorize you for 60 days of pre-admission services. For children (under 19 for Group, under 21 for Family and Individual services) this translates to a dollar limit is $493, where for an adult the limit is $483. This amount is exactly enough for 4 hours of Family, Group, Individual, etc. services, plus one Assessment and one Treatment Plan note.

Sending a CDC 23/42 request for services (6-month treatment plan request)

Once a partial treatment plan has been done you will be able to view the status of your 21 CDC on the TxPlans tab. It starts in Draft status, indicating we will send it that night, and ends up in Final once it is approved by a third party. In between Draft and Final, it is shown in Submitted status. In the example above, this client has already had a PreAuth and request approved, and has uploaded a request for 6 months of services, to which we attach a CDC 23/42, depending on whether the request is an Initial or Extension. If we haven't heard back whether the request has been Approved or not, both the CDC and request are still in Submitted until we can change both to Final.

CDCUW (Customer Data Core Userwait)

In the Treatment Plans section of the Cockpit there is a report line for your CDCUWs, the CDCs that have been rejected by the OHCA. If a CDC comes back from upload into CDCUW status either necessary information is missing or the information that is there is wrong, or something is missing on the OHCA's end of the line. There are many reasons why they might reject a CDC, and some of them you will be able to fix by yourself, and some of them you will need our help to fix.

The list below is constantly evolving, but these are all of the reasons that may appear in the Comments section of the CDC as to why the OHCA rejected them, and included are our best guesses as to why they rejected and what you/we can do about them.

Note: If the contested CDCUW is a Discharge CDC, and when you look on the TxPlans tab of the chart it is the latest CDC we have uploaded, you can choose to fix what's wrong with it now and Resubmit it in case the client plans on returning for additional services, or you can Finalize the CDCUW in Milan and only worry about fixing what's wrong if the client ever returns.

"CDC Rejected by OKHCA: Customer not found in eligibility file,"or**"CDC Rejected: Recipient does not have eligibility for this trans date,"**or**"Upload aborted, unable to load PPS for APSCDC _____"**

This client is ineligible for their main payor (Medicaid/DMH) either according to the DMH or Milan. If you can look on the OHCA website and confirm they are eligible for either Title 19 (Medicaid) or Mental Health and Substance Abuse (DMH contract), make sure it is reflected in Milan, and if the information is correct in Milan, call the Department of Mental Health helpline at (405) 521-6444, or email them at gethelp@odmhsas.org to ask them why they are rejecting the CDCs.

"CDC Rejected: Only one 21 Contact per customer, per agency, per year is allowed"

The OHCA/DMH believes there has been a 21 submitted from your agency before this one. If you know there hasn't been, please contact them. If there has been one in the last year, you will not get a CDC 21 accepted until a full year has passed since the effective date of the last 21.

"CDC Rejected: Invalid transaction type: Contact CDCs must be submitted outside of CDC episodes"

The powers that be believe that this 21 has been submitted within a CDC episode, meaning a current 23 or 42 CDC is still in play, and if there was supposed to be a Discharge sometime in the past, they have not received a CDC as proof. If you have never seen this client at your agency before, you will need to contact them.

"CDC Rejected: Invalid transaction type: Customer already has an open CDC episode with this agency"

The powers believe that this 23 has been submitted directly after a previous 23 at your agency, without a Discharge CDC in between the two, or in place of what should actually be a 42 if you're extending services after the client's initial 6 months. This CDC should most likely NOT be a 23.

"CDC Rejected: Transaction date must be greater than previous transaction date"

This CDC's effective date/time most likely matches up with another CDC's date/time, or you have submitted a 21 CDC after the effective date/time of a 23. If you need the date/time of the 21 changed to be before the latest 23, send us an email at support@milanmedical.com and tell us what date you need the 21 to be for and we can re-upload it to the DMH with a new effective date. If this is a 23, it most likely has been coupled with a 21 for the same date/time, and an Administrator has the power to change the

effective date of the corresponding Initial request by highlighting it in Submitted status and pressing the Uncomplete button, then going in to the request and changing the effective date to be at least one day after the effective date of the 21/Preauth request. Once Completed and the Upload button has been pressed, we will upload that CDC with the new date overnight.

"Upload aborted, invalid BasicCDC employment type"or**"CDC Rejected: Employment type must be A-F if Employment equal 4"**or something similar...

The Employment Type and Employment fields on the BasicCDC tab of the treatment plan are mismatched. If the txplan/request is in Preapproved/Final status, you will need to email us to change it for you. If it is in any other status your Administrator will be able to set the txplan request back to Proposed so the BasicCDC tab can be updated.

"Upload aborted, invalid BasicCDC # of dependents"

On the BasicCDC tab of the treatment plan, in the Financial section the number of Dependents must be at least 1, even if the client is a Child.If the client is Discharged you can use the Draft TxPlan button to update that number and press Resubmit on the CDC if you are an administrator. Again, if the txplan request is in Preapproved/Final you will need to email us so you can change the number, otherwise an Administrator has the access to change it.

"CDC Rejected: Zip code must be 5 or 9 characters"

The ZIP code has been mistyped on the Residence tab of the treatment plan. Depending on the status of the txplan request you or an Administrator can update that tab. If it is currently a 5 or 9 digit ZIP in Milan, please send us an email and we will find out why the DMH rejected the CDC.

"Upload aborted, invalid BasicCDC Level of Care"

The Level of Care on the BasicCDC tab of the treatment plan is either missing or it has something other than Outpatient selected (our agencies that use Inpatient/Residential in that field are in the vast minority). Depending on the status of the txplan request, either we or you/your Administrators are able to fix it.

"CDC Rejected: Level of Care must match last Level of Care given on this transaction type"

You will need to contact the Department of Mental Health.

Making A Treatment Plan

To create a patient's first [treatment plan](#) in Milan, either click the Initial button on the TxPlans tab in the patient's chart or click the Draft TxPlan button. You will notice they both pop up the same thing: the tabs of the treatment plan, plus a TFC tab if needed. But the difference is in what's next. By using the Draft TxPlan button you can add information a little at a time and save it without having to complete the whole plan in one sitting. The Initial button is for when you have 30-45 minutes to knock out the whole plan at once because in this mode you cannot exit the plan and save your data unless you have finished everything that is required. Also, if you have worked on and completed your plan using Draft TxPlan, and now you are ready to do the request, the Initial button brings up the plan for you to look over, then pops up the request window where you formulate your authorization request.. We recommend working on and completing your plan in Draft TxPlan mode, then clicking Initial, reviewing what you've done, and formulating your request.

When the treatment plan appears, the tabs you see make up the content of the plans on paper you may be used to doing.

- The Basic tab stores information about a patient such as emergency contacts, guardianship and demographic information, including CDC 21 fields such as Race, Referrals and the Service Focus.
- The Residence tab stores information about the patient's current living situation
- The Diagnosis tab stores information about the patient's current diagnosis, GAF scores, and historical information. If you have entered a diagnosis (usually "Unspecified") and it asks you for a modifier, the text box to the right of the diagnosis needs to be utilized for more information.
- Our biggest tab on the treatment plan is the CAR scores tab seen below. As you're filling this tab out, we recommend doing the numeric Score values first, and the descriptor text boxes second. This way when you save (which you should be doing often), Milan is less likely to complain about the tab being incomplete.

The BasicCDC tab stores required information for treatment CDCs, such as the 23 Admission or the 42 Extension CDC. Minimum fields required:

- Level of Care
- Primary Presenting Problem
- Employment
- Employment Type
- Income
- Dependents/Contributors must read at least 1, even for a child, where you would list the parents' income and the number of people dependent on that income (siblings)
- Protective Order

The ASI tab stores ASI and TASI scores for the patient.

On the Testing tab is where you enter psychological testing information. You will notice that the Treatment History is required but the other fields are not if there are 0 hours planned.

The Addendum tab stores miscellaneous information about the client including treatment preferences, strengths/abilities and discharge criteria

Our next tab is the Goals tab seen below

The Internal Comments text box is for you to write notes to yourself about the patient and their treatment. These notes are just for viewing, they won't print out anywhere, but in the case of an audit are still visible. The Problems dialog box is what we'll be focusing on. If this is a New Patient, nothing will appear here.

You can use the Import button which will pull in Problems and Goals from other patients of yours that share a Primary Diagnosis code with this patient. Click Import, then select the Diagnosis you would like to search for matches, and if any of your previous clients with treatment plans have that code as well, then once you click OK we will display a list of their Problems and Goals from which you can select the ones you would like to Import.

But, let's say you need to write new material from scratch. When you click on the New button the Problem Dialog box will pop up. For example, Mr. Banner, has previous treatment plan information that has conveniently carried over. So for a New Patient you would select New and the Problem Dialog box will pop up.

Clicking the New button will bring up the Objective Dialog box or you can click the Import button to bring in the Objectives from

your imported Problems/Goals.

You can only have one Therapeutic Method per Objective.

There are different types of services under the Treatment Service drop-down menu, and picking one will affect your options in other areas of the treatment plan and it's corresponding future notes. Here we have selected a Psychological - Mental Health - Group program for Mr. Kent. The only reason we were able to select this is the Mental Health Program was selected on the Patient tab of Mr. Kent's chart. If you don't see a type of service you think you're supposed to in the Treatment Service drop-down, check the Patient tab and make sure the correct programs are selected.

 Once you click OK, and then click OK, and then click OK...and once all the treatment plan tabs have been filled out, the request window will appear.

This window is to set up the treatment plan **request**, which is separate from preparing the treatment plan. You must fill out any of the drop-down menus accessible in the top portion of the window. The most important field is the Effective Date, which according to latest regulation needs to be today's date (for good measure yesterday's) or a date in the past. Once the top portion is filled out authorizations should automatically appear. You should delete any authorizations that don't make sense and add any that are missing. To do that, click New near the bottom of the window, and a little window pops up called the Authorization Editor.

Once you put in the service you want to authorize, the therapist who will be administering all or most of the time, the payor (usually Medicaid) and the proposed number of units (needs to be at least 1), click OK and either add additional authorizations or click OK again. When selecting the service, if you have the option of selecting either an Adult, Bachelors or Masters level service, find out what level of service your credentials support and bill the highest service level you can.

If another therapist will be primarily administering a different service, you need to credit them using the Authorization Editor, as their credentials might be different than yours, and they may need a different level of service than you are authorized for.

Also, make sure the UserWait box is always checked, otherwise Milan will ask you about it. In the extremely rare circumstance when you know the first priority payor in Milan will always deny, defaulting to the second payor, you will leave the box unchecked, and ignore the warning from Milan.

Your newly drafted treatment plan should show up now as a line on the TxPlans tab in Proposed status.

Once you are satisfied, click the Complete button there on the TxPlans tab, click Save, and now your plan is ready to be printed with a clean signature page for your patient to sign.

Extensions and Modifications

PG033 extensions

Sometimes a treatment plan expires before you are able to perform a treatment plan review, not allowing you to use your 1 unit of Treatment Plan - Low Complexity review service. When that happens, you can upload a request to ask for an extension for just that one service, and it can even overlap the dates of your next 6-month extension treatment plan. First, you MUST put this request into Milan so that it goes on the TxPlans tab BEFORE the 6-month extension you're about to start, so when you look at it going from the bottom => up you see your last 6 months' treatment plan, your request for the extension of this service, and then your next 6 months' treatment plan at the top of the list.

 You submit this request by highlighting the line on the TxPlans tab that represents your last 6 months of treatment, then clicking the Extension button. Click OK when the treatment plan pops up, and when the request page appears, put in TxPlan Review as the Level, 1 month as the Duration, and then delete any authorizations that pop up below except for the Treatment Plan MH or A/D - Low Complexity service. The bundle to the left should read PG033. Complete it, making sure you add the therapist's name and unit amount (should always be 1), and Upload it like you do other requests. IMPORTANT: The plan review extension request must be in Final status with your approved PA# and dates before you can put in a request for your next 6 months of treatment. Once it is that far in Milan, you may then put in your next 6 months' Extension request to upload by selecting the line representing your new Final 1 month request and clicking the Extension button.

Note: You need to have an effective date of the day you submit it, or later, or else it will automatically get rejected.

Extension Treatment Plans

Doing an extension treatment plan in Milan follows the same process as making an Initial one, but takes about a quarter of the

time. Once your Initial or last Extension is about to expire, highlight that line on the TxPlans tab and click the Extension button.

The treatment plan with all of its tabs will automatically pop up so you can edit anything that needs to be changed for the next 3-6 months of service, usually involving GAF/CAR scores and probably some of the Goals/Objectives. Once you click OK, just like when you used the Initial button, the request Prior Auth window automatically pops up so you can select your services and propose units for your new Extension request.

There are two types of Modifications in Milan: those we submit and those we don't.

If you are needing to add goals or objectives to a treatment plan, and then add any corresponding services to the request complete with proposed and granted units - if that service is available in Milan for that bundle (this only matters to Medicaid folks anyway) then you don't need to notify OHCA about it. You can click the

Modification button when highlighting the current request on the TxPlans tab, change what you need to change, and after you have Completed it, the administrator (or whoever has permission) presses the Submit button instead of the Upload button. After clicking Yes, telling Milan it's going to be faxed, don't fax it. It's Preapproved and Finalized by using the same PA# and dates from the original request.

If you are changing either the Level of treatment needed or the Facility for the patient, then OHCA needs to know about it. Complete the treatment plan, and then after pressing the same Submit button, use the Print Request button and fax it to . After an unspecified amount of time, the request should show up on Care Connection or the OHCA website with a PA# and dates needed for Preapproval and Finalization.

Notes Tab

The Notes tab is where you document the work you have done on behalf of the patient. This includes but is not limited to assessments, developing treatment plans, therapy, testing and missed sessions.

As with the treatment plans, depending on your authorizations you can have access to different buttons beneath the list window.

Progress Notes

The progress note is the unit of work in Milan. It is what gets you paid. In Milan, if there's not a progress note about an event, it didn't happen. This system was designed to make entering progress notes as easy as possible. Choices are limited as much as possible based on the program, treatment plan, payor, credentials, etc.

First, there are three types of notes:

- No authorization - Crisis Intervention, Cancelled Sessions, and For Information Only notes for example
- Pre-authorization (PreAuth) - As long as the PreAuth request is in Final status on the TxPlans tab of the chart, you are allowed to write, on average, four notes, plus an Assessment and TxPlan note, while working on an Initial treatment plan
- Prior Authorization - your most common note, such as Individual Psych MH treatment, shown below, which requires a final treatment plan on the TxPlans tab of the chart

Writing A Progress Note

After loading a patient's chart the Notes tab is selected by default. Before you can enter a progress note for a patient for the first time at least a primary diagnosis and an address needs to be entered first. If a service requires authorization then a valid treatment plan must be in place first. On the Notes tab, seen above, click the New button near the bottom of the screen.

In general, fill out the Main tab of the progress note from top to bottom, left to right. It is very important to get the start date correct, or else some required selections may be empty. The lists of facilities, therapists and codes are limited to fairly appropriate selections. Most fields are only available when a certain service code is selected. For example, goals and objectives are only available when a therapy code requiring authorization is selected. If a code requires authorization, the number of units authorized and the number of units left will be displayed. Once the Main tab is filled out, select the Note tab and enter any text fields. The number and names of text fields are different for each provider and also depends on the service code selected. When you are finished, click the Save button at the bottom of the note window and then the Save button at the bottom of the main window.

Signing A Note/Groups of Notes

If you have a single note to sign, you can navigate to the Notes tab of the patient, single-click on the line of the Draft note and click the Sign button at the bottom of the window. After entering the same password you use to log in to Milan, click the save button, and your note will be signed. If you have multiple notes to sign, it's much easier to double-click on your Draft line on your Cockpit which will

automatically bring up all of your notes in Draft status. From there you can select all the notes at once and click the Sign button, having only to enter your password once to sign multiple notes. It will take a little time to sign multiple notes, so if it appears Milan has frozen, it should be just signing the notes. If it takes a truly radical amount of time (longer than 30 minutes), call us.

Progression of a Note

- Draft - the therapist is still working on it
- Signed - therapist approved, now waiting on administrator
- Approved - sits here until Tuesday around 10PM when it's billed. If it stays past that, go to the Note and check the Event Details tab.
- Rejected - going into the note and reading the Event Details should tell you why
- Billed - waiting for results from payor
- Final - paid or written off
- Defunct - shows up on old notes that have newer revisions (obsolete)

Dealing with rejected notes is something you will be doing consistently for your therapists. On an ever-growing Rejected Notes page, we give you some tips on how most efficiently to diagnose and act on the flagged problem.

Writing Group Notes

To access your patient group, or to make a new one, click on the Groups tab in from the Cockpit. If you are making a new group, hit the New Group button and use the +/- controls on the right for adding or removing patients. There must be at least two patients in a group. If multiple therapists are going to be involved in writing notes for the group, select Yes for the Public option. Once you've made your group, a line will appear in the Patient Groups window representing your new group, and you can highlight it and click New Notes. When you do this, a window will pop up for EACH PATIENT so that you can write individual "group" notes. Once you hit OK after writing a group note for one patient, the next will

automatically pop up. Information from certain fields will conveniently carry over from note to note. Hit the Cancel button to skip writing a note for a patient in the group.

Rejected Notes

There are many reasons why Milan might reject a [note](#). The note data has to pass through Milan's rigorous scan before being submitted to the payor.

Diagnosing and correcting these flawed notes is a big part of why Milan exists, so the list of possible rejection reasons is extensive. For our purposes here, we have included the most common rejections that need some guidance to correct. There are more that occur frequently that are very self-explanatory in their message, and we decided to let you figure those out for yourself. There are also very rare errors that should never happen, and we haven't included those either. If you see a message on a rejected note that you don't understand, and it's not here in the manual, call us.

Check out the Event Details tab of the note and look up the rejection reason here before calling.

Remember, after fixing any one of these possibilities, you then go to the Notes tab on the chart and highlight the rejected note by single-clicking it, and press the Unreject button at the bottom to send it back to Draft status.

First, let's find the rejected note. You can either double-click on the Rejected line in the Progress Notes pane in the [Cockpit](#), double-clicking on the note you're interested in when the report pops up, or you can go to the patient's chart by way of the list in the Cockpit or by clicking on Open Chart at the bottom of the screen and navigating to their Notes tab where you can double-click on the appropriate note(s).
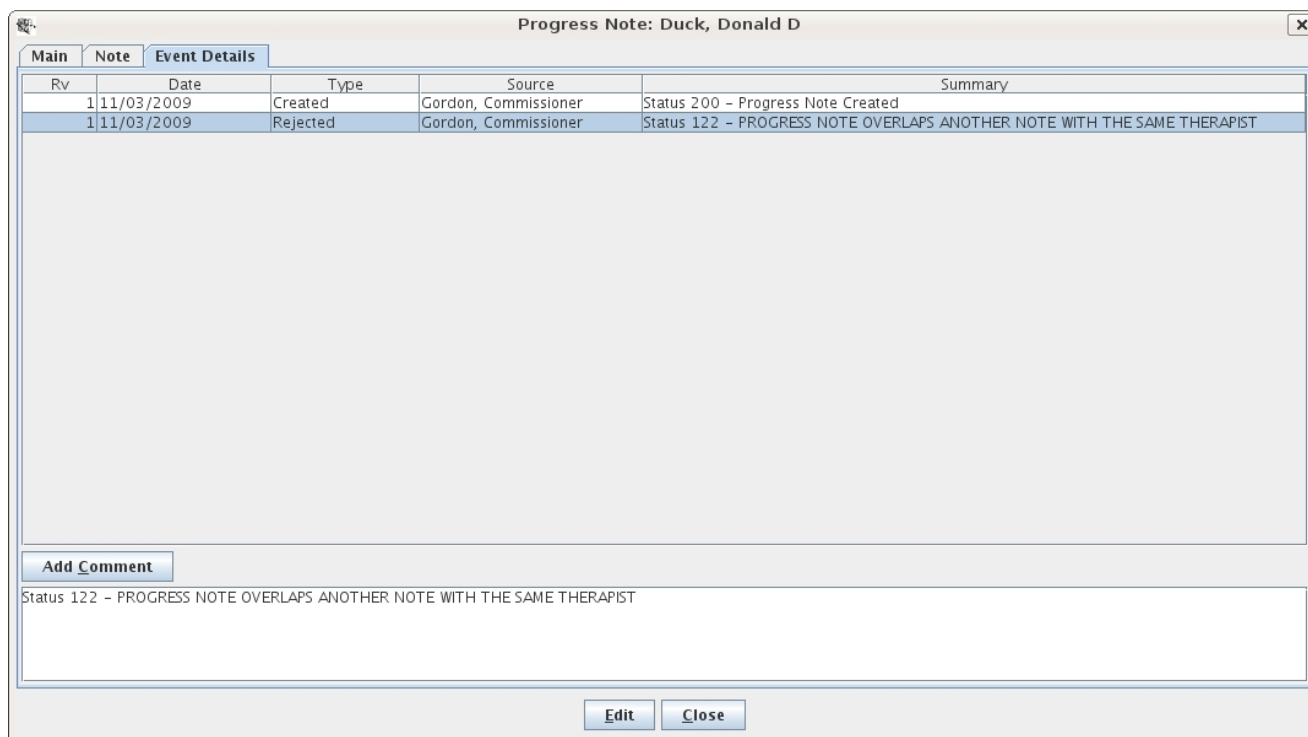
Progress note overlaps another note with the same therapist/patient

Doing either one will take you to the Main tab of your note, and when you go to the Event Details tab, as shown above, the status on the Rejected line should give you a simple explanation. Here, the date, time and minute length of this note's session for Mr. Duck overlaps (possibly by just one minute) a note for a session for one of Commissioner Gordon's other patients. We call this double billing. The thing to do now is find the other patient's note so you can compare the two and adjust one or the other accordingly.

To start, exit out of the note window we're in, go to the Reports drop-down menu and select the NoteDoubleBill report. Click Search.

The note that it overlaps might be just one minute one way or the other. Whether it be one note or the other that needs to be edited, you can access either by simply double-clicking on the corresponding line to fly right to it.

PreAuth Units Exceeded

This rejection message tells you that you have exceeded what you can do outside of a finalized treatment plan. Most of the time, you are limited to an assessment and treatment plan note, plus four other sessions before Finalizing a 6-month authorization.

Authorized Units Exceeded

If this is the error message you read on the Event Details tab of the note, you have exceeded the number of units you have been granted for that service you are trying to perform (Psychotherapy MH - Individual for example). To view/edit the number of units that service has been granted on the PA (Prior Authorization), go to the patient's chart using your route of choice, access the TxPlans tab and double-click on the one you are writing that particular note against.

Status	Final		Facility	Gotham OMHC		CM Facility	Gotham OMHC	
Level	Level III		MainPayor	NOPAY		Duration	6 Months	
Writer	Clinton, William		Contact	Gordon, Commissioner		Request	Extension	
TxPlan Type	Outpatient Mental Health		Reviewer			Completed	09/18/2007	
Submitted	09/18/2007 11:02 AM		Effective	02/12/2007		Expires	08/11/2007	

Public Comments: OFMQ information

Internal Comments: sadf

System Comments:

Authorizations

Id	Payor	Bundle	Service	Therapist	Pro...	Gra...	PA#	From	Through	Status	UW
72925	NOPAY	NONE	Rehab MH – Individual (Adult) H2017	Gordon, Com...	96	96	---n/a---	02/12/2007	08/11/2007	Approved	✔
72926	NOPAY	NONE	Psychotherapy MH – Individual (Adu...	Gordon, Com...	24	25	---n/a---	02/12/2007	08/11/2007	Approved	✔
72927	NOPAY	NONE	Treatment Plan MH – Low Complexi...	Gordon, Com...	1	1	---n/a---	02/12/2007	08/11/2007	Approved	✔

Edit   New   ☐ Show empty usages

Usage

Id	Auth	Extent	EP	Payor	Code	From	Thru	Granted	Total	Paid	Unpaid
62971	72926	56433	1	NOPAY	Psychotherapy MH – Individ...	02/12/2007	08/11/2007	25	0	0	0

OK   Cancel

It will bring up the PriorAuth window, and when you select the service for which your note is written in the Authorizations pane, a line will pop up in the Usage pane on which you then need to double-click. It will open a window with the service, the number of granted units so far, and +/- buttons on either side of it. By clicking the +/- buttons, you essentially change the number of granted units for that service. If the patient is covered by Medicaid, those units will be part of a bundle and you will have a MAX amount shown in that window that you must stay under before you get too trigger happy with the + button. Once you increase the units, Unreject the note, setting it back to Draft status and when the next billing train comes along it should go through.

You can also do that same thing if, when you go to the note, you have a button with a + on top of a - next to the Units Usage field. If you click that button you get to the same authorizations window with the +/- buttons.

No eligible payors found for patient

This patient appears to be ineligible for whatever payor they are set up with. If you go to the [Patient tab](#) of their chart you can see their eligibility dates at the bottom. If the date shows their eligibility has expired, and you have already checked the OHCA website to confirm they really are still eligible (usually looking for Title 19 eligibility for Medicaid), Milan has failed to connect the patient to the site for various reasons. Before you call us, check their Medicaid number first, then their DOB and SSN. If they are all accurate, call us.

No prior authorization found/Patient ineligible for authorized payor

Most of the time this happens when there is a note written for a certain service authorization and then someone goes and messes with the dates of the authorization in the PriorAuth window, or the patient isn't eligible for whatever payor is showing on their Patient tab. First, check that there is a PA# for their treatment plan PriorAuth request, and if there is check with the payor to confirm they really are eligible, then call us.

Invalid code for patient age

The code for the service you are trying to bill for is meant for someone older or younger than your patient (Adult vs. Child services).

Invalid patient address/dob/diagnosis

Check the patient's address, date of birth, and/or Diagnosis tab of their treatment plan and look for numbers where there should be letters, vice versa, or any odd ($#%^&*) characters.

Unable to sign progress note

Make sure you are typing in the same password you use to log in to Milan. (Check the CAPS lock)

Progress note is not the latest revision

Someone has updated this note and made a newer version of it, making this note obsolete and unbillable. The Rejection is solved overnight, after which the note can be Unrejected.

Invalid service for therapist credentials

The therapist's current credentials in Milan do not allow them to write notes for that particular service.

Invalid facility for prior authorization

The facility listed in the treatment plan needs to match the facility listed for the therapist and/or the patient.

Invalid therapist for patient or facility

The patient does not have that therapist added to their chart or that therapist does not have that facility added to their profile.

MustRead notes must be reviewed

Some services written by doctors must be reviewed. These notes are flagged with the letter M, and until someone reads the note **all other notes will reject automatically**.

No matching codes found for eligible payors

You might have selected a service with a code that is eligible for Medicaid, but your patient might only be eligible for ICIS, or any modification of that example. The eligibility of the service code and eligibility of the patient do not match.

Unable to bill progress note: claim being billed

This happens when a note is stuck in Approved status and appears like a rejection notification in the same place to tell you that other notes for that patient and day are already in the process of being billed, and once they are through this one will be up for billing.

Reports

When viewing the Cockpit or a chart, you can pull down the Actions menu and click on Open Reports to access the reports mode.

The reports mode displays a list of reports in the main window. Some reports are displayed and ready for use by default, while other ones appear after selecting them from the Reports menu. The reports are very powerful and may take some time to master. Since only the briefest overview is given here, please contact technical support if you have any questions.

All the reports have some things in common. All reports have Search, Defaults, and Clear buttons that are hopefully self-explanatory. The general procedure is you select or enter search criteria on the top of the screen, click Search, and the results appear on the bottom of the screen.

All reports have the Print/Export button to print the report or export the results to a file that can be imported into your favorite spreadsheet. The buttons on the top-left (Search, Defaults, Clear) do not require a selection, in which case the action affects all the items on the report.

On most reports you can then select one or more items and perform actions on them by clicking buttons either to the right of the Clear button or at the bottom of the screen.

Most reports have a default action that occurs when you double-click on an item.

Take a look at the [Report List](#) to see information about each type of report.

Therapists - you will get a weekly e-mail report from us telling you how soon gaps in your treatment plans are approaching

Administrators - you will be getting a monthly or bi-monthly report detailing utilization records for your therapists and displaying issues like neglected patients and/or treatment plans needing review

Report List

Patient - Here you can list all your patients using different criteria

PatientAging - Used to determine, by therapist, the last time notes were written for patients

Eligibility - Lists patients and their eligibility status. Viewing an item allows you to edit the basic information for a patient. This can also be used to manually flag a patient for a Medicaid eligibility check tonight.

CDC - Lists the status of client's CDC submissions and gives options to edit them in Milan

PriorAuth - Lists prior authorization requests that can be viewed and easily edited

AuthDetail - Lists authorizations you are currently utilizing and approved for

AuthSummary - Lists summary information for groups of authorizations

NoteDoubleBill - Very similar to the NoteDetail report except returns only instances where the times for two different individual progress notes overlap. The Force button allows the administrator to override the system and submit progress notes with overlapping times.

NoteBarCode - Normally used with a barcode scanner to quickly and easily approve, reject, delete, view, or reprint a stack of printed progress notes. It is still somewhat useful without a barcode scanner.

NoteDetail - Lists individual progress notes that can be viewed and usually edited. This is a common report to use to move progress notes along their natural processes. Edited progress notes are automatically rebilled for you if needed. Status and Performed Start and Stop are extremely useful criteria for searching.

NoteSummary - Lists summary information for groups of progress notes. Summary and Performed Start and Stop are extremely useful

criteria for searching. The Summary field is also extremely useful. The Detailed button runs a Detailed report with the current search criteria.

ClaimDetail - Useful for printing and/or billing claims for unsupported payors not set to automatically be billed

ClaimSummary - Useful for an overview of claims to be billed or being billed

ClaimItemAging - A financial report used for showing 30-60-90 outstanding revenue, geared towards accounting personnel

ClaimItemDetail - Useful for dealing with claim items for unsupported payors

ClaimItemResult - can be used to find out more details about payment of claims, as in whether they were paid, adjusted, or written off

ClaimItemSummary - Useful for an overview of claim items being billed or already billed

Billing - Lists billing batches, useful for manually billing for unsupported payors

RA - Lists electronic remittance advices received from supported payors or generated by the system for unsupported payors. The Invoice field is very useful. The View button shows the raw data received from the payor. The Detailed and Summary buttons run a claim item report with the current search criteria.

Payroll - Lists generated timesheets in case they need to be printed again

PayrollDetail - shows you what timesheets, if any, a service showed up on for a given date range

Opening Milan

If you are having trouble opening Milan, and getting an error reading "Unable to launch application," follow these steps to correct it:

- Go to your Start menu (bottom left hand corner) and go to Settings>Control Panel, or straight to Control Panel
- If you see a lot of smaller icons, double-click on the one that says Java. If you see maybe 10 larger icons, you are in Category View and you must switch to Classic View. You can find the link to switch on the upper left hand side of the toolbar in Windows XP, and on the upper right hand side inside the empty space where the icons are in Windows Vista/7.
- Once double-clicking on the Java icon, a window will pop up, and you need to click the Settings button near the bottom
- Once that window pops up, click the Delete Files button
- Make sure that both of the smaller checkboxes in the pop-up window are checked, then click OK
- Once that window goes away, get out of everything and restart your computer
- Your shortcut for Milan will be missing from your desktop, so you will need to log in through our website to refresh Java and restore the icon for Milan

 If you try and open Milan and it says "You appear to already be running Milan," restart your computer and try again.

 If you are able to open Milan, but unable to log in, and it is not a username/password issue, follow the steps below. If you use our offline feature, make sure you don't have notes ready to upload, otherwise the last step of this process will delete those.

- Get out of everything Milan related and re-open the log in window
- Type in your username and password
- Click the Delete Offline button

If Milan doesn't like your computer time, try changing your time and time zone, save, and then change it back. If that doesn't work, lie to your computer and match your time with Milan's. The most likely problem is that your computer isn't updated with all the latest Windows Updates, which included a daylight savings update.

Progress Note Troubleshooting

When you are unable to find the service you are wanting in the drop-down menu and/or perhaps you only find the For Information Only option, these are signs of the most common problems encountered when trying to write a progress note, which are that the patient is not authorized and/or eligible anymore. You can see if they're authorized for services by going to the latest treatment plan on the TxPlans tab and double-clicking on it to view the date ranges for individual services. You can check their eligibility at the bottom of the Patient tab on their chart. If Milan says they're ineligible for Medicaid, but you have checked online and they are listed as eligible, make sure their Medicaid number, DOB and SSN are all correct in Milan. If they are, call us.

The second most common problem when writing a progress note is that you've run out of units. Most of the time, you might have more units available than you originally budgeted for, and you or your admin can go in and simply hit a + button (x) amount of times to add units. You can do this by double-clicking on the note's line and hitting the +/- button next to "Units Usage," or you can double click on the treatment plan line on the TxPlans tab, highlight a treatment authorization request and go to the window below that and double-click on the month you want to edit and play with the units there.

If you are writing a note and the appropriate (Child) service does not appear, and you have checked the Patient tab to a) make sure the patient is eligible for their payor, and b) checked to make sure you as a therapist are listed on that patient's chart, then check the patient's birth date. If they have just turned 19 or 21, an internal Modification (typically does not need to go to the payor) needs to be done in Milan to switch from (Child) to regular (Adult) services.

If notes give a Moderate complexity option and not a Low, the therapist has probably missed the window of authorized time to write a note using that complexity. The range of time can be viewed

in the PriorAuth window when you double-click on a treatment plan
line.

Admin Intro

This section is for administrators wanting to learn about finalizing treatment plans, claim billing, UserWaits and how to interpret the monthly report emails, as well as adding new employees with all of the correct roles and permissions.

Finalizing Treatment Plans

Once you have finished the treatment plan, completed the authorization request and obtained the patient's signature, it needs to be finalized. Most of what happens now is up to an Administrator or Clerk to do.

- Once you've completed the Draft TxPlan and the Initial request, gone through the Review and QA process if applicable, and now at this point the plan should be Proposed and ready to add authorization information.
- Once it's proposed, select the plan, click the Complete button. Click save and then...yes, the big Save button.
- At this point, if you print the TxPlan all pages except the signature page have a big "DRAFT" on them, and the intention is to print it out and have the patient review and sign off on it. Nothing which affects the signature page can be changed once the request is completed.

Here's where the therapist's role ends and the Administrator or Clerk takes over. If the patient is covered by something other than Medicaid, these next few steps happen automatically.

- They will select the plan and click the Upload button. For Medicaid/DMH requests, this queues a CDC to upload.
- Once we get the CDC back as approved, we move the request to Preapproved or Final status, depending on agency defaults.

What if it ends up in PAUW status?

- After submitting a request to a third party for approval, the request status is set to PAUW if they have an issue with it. Reasons can range from complete denial to something minor.

Claims Billing

Automatic

The first step in the billing process is approving the note. Approved notes automatically get billed Wednesday morning.

There are several settings in Milan that determine how claims are handled. Billing for fully electronic payors just sort of happens without anybody doing anything unless they land in UserWait. Normally all other payors are also set up to just happen on their own, except they get automatically marked as paid in full. When initially setting up your organization, the process through Posted, Billed and Marked as Paid statuses happens automatically for your payors. If you are on the fully automatic process, you are used to seeing Billed, UserWait and Final.

We can set up payors for you to be almost fully manual. Notes will work the same way they always do, namely that they need to be approved and magic happens on Wednesday. But the billing and marking as paid can be a manual process (ex: insurance claims).

There is a new option in Milan under the Admin drop-down labeled Edit Payor Rates. For those of you who bill payors outside of Medicaid, this can be really useful. Call us to set up a custom rate set, and with this you can actively edit amounts receivable for individual services, specifying what amount makes your services think they are paid or not.

Manual

Payor sources in Milan can be divided into two groups: Fully supported or partially supported. For fully supported payor sources we automatically generate and upload batch eligibility, authorization, billing, and billing inquiry files, as well as automatically download and process the associated response files. By default, for partially supported payor sources, the system does not update eligibility for patients and just automatically marks claims as paid. When requested, we can configure the system to allow you to manually process billing for partially supported payor sources.

The first step to set up a partially supported payor source to be handled manually is to create a custom rateset. A rateset is a list of services, with the minutes per unit and the rate per unit listed for each service. Normally a single rateset is created for most partially supported payor sources an organization has, which matches the "Retail" rates that the organization feels that a service is worth, regardless what the payor source is. However, an organization can have a different rateset for each payor source. A good place to start compiling a rateset is to go to Admin -> Edit Payor Rates, searching for the services for a desired payor source, and then export that list to a spreadsheet. Once you have a spreadsheet, simply delete any undesirable services and update the rates to what you feel is appropriate. It is very helpful to keep the other information in the spreadsheet intact. For self pay, the system will let you designate a single percentage per patient that will be applied against the custom rateset when calculating the amount due for a particular service.

Once the rateset is set up for a payor source, the next step is to decide how manual you want the manual process to be. The Milan billing life cycle is this:
1) Progress note is approved.
2) Claim for progress note is created (Initial status: Approved).
3) Claim items for claim created, claim is marked as Posted.
4) HFCA-1500 for claim can be printed or billed electronically.
5) Claim and claim items marked as Billed.
6) Result for each claim item is entered manually or electronically.
7) Claim item marked as UserWait if not paid in full.
8) Claim marked as Final when all claim items fully paid or adjusted.

For both fully and partially supported payor sources, steps 1,2,7, and 8 work the same way. For fully supported payor sources, all steps are performed automatically with steps 4 and 6 performed electronically. For partially supported payors, most of the steps are optional by default but can be set to be performed manually. Basically, for partially supported payors the default is to automatically mark services as paid, but you can also set them up to manually bill services and/or manually reconcile the results. To set up a partially supported payor source for manual billing, email the rateset to the help desk and specify if you want manual billing and/or reconcile.

To manually bill a partially supported payor source, use the ClaimDetail report and search for Posted claims for the desired payor source. You can select one or more claims and then click the Print button to print a HFCA-1500 for each claim selected. Then click the Billed button to set each claim selected to Billed status. There is a cockpit line available to facilitate this process.

To manually reconcile a partially supported payor source, use the ClaimItemDetailed report to search for Billed claim items for the desired payor source. You can select one or more claim items and then click the Paid, Denied, or Partial button to mark each claim item appropriately. Paid claims will have their status changed to Final, while denied and partially paid claims will have their status changed to UserWait. UserWait claim items are handled the same way that UserWait claim items for fully supported payor sources are handled. There is a cockpit line available to facilitate this process.

A fictitious RA will be created every week for partially supported payor sources.

UserWaits

UserWaits are items that have for some reason or another been denied payment or have only been partially paid, and are holding up the rest of the overall claim from moving to Final status. These warrant special attention from administrators and/or accounting staff. The frustrating thing about UserWaits is that the reasons why they were partially paid or denied altogether are often too vague to warrant confident action on your part. The process for navigating UserWaits is laid out below.

- The bottom data line on your Cockpit Proper should be the UserWait data. Double-click on that line to bring up a report list of all the claim items stalled in UserWait

- For each line/claim item you can double-click on it, and near the bottom of the pop-up window there is a Reports pane with what should be a single line containing the word Denied or Approved, where Approved really means partially accepted since it being in UserWait in the first place means it wasn't paid in full.

- If you double-click on the Denied/Approved line we give you all of the reasons OHCA tells us it was denied/partially paid. These reasons are usually vague. To get a better understanding, there is a helpdesk of sorts you can call to get more specific answers. The number is **1-800-522-0114**. When you call, you will need a number called the ICN#. You find this number by double-clicking on the UserWait data line in your cockpit, then double-clicking on one of the claim item lines, then looking in the Reports pane at that line that says Denied or Approved. To the far right is a column labeled PayorID, and the number in that column is the ICN#. This will help them find and diagnose the problem with the request.

- Once you have figured out why it stalled, there are two paths to follow. If it was denied and something was wrong with it that is fixable, go in, fix the problem, and when you highlight or single-click the claim item line in the UserWait report there will be a Rebill button at the bottom of the window you can click to have that item bill again the following Wednesday with the rest of your organization's claims/notes. You do not want to

automatically write off claim items that were completely denied, as they can usually be fixed and rebilled.

- If your claim was partially paid for, most of the time that means that the therapist asked for more units than the daily limit allows, so they paid for all the units that are allowed, and none of the extra. Sometimes it is due to a specific error that the claim was partially paid, but most of the time you will end up writing off the unpaid amount, as painful as it may be. To do this, you highlight/single-click on one of the claim item lines in the UserWait report and click the Adjust button that appears at the bottom. It automatically fills in the Write-Off check box, and the Unpaid amount, so that you should just be able to hit OK, and the amount is written off, moving the claim to Final and out of UserWait.

New Employees

Hopefully your organization is consistently growing. Each person that writes progress notes needs their own log in, as it is against the law to access confidential information under another user's identity.

Setting up new users in Milan is very easy. If the new users are going to be writing [progress notes](), they need to be added as both a Therapist and a User. Otherwise, they only need to be added as a User. When adding a Therapist and a User (the same person), add them as a Therapist first. To do this, click on the Admin drop-down menu at the top of the Milan window and click on New Therapist.

The most important thing to see in the New Therapist window is the section at the bottom for the credentials. Make sure that all of the therapists' credentials are properly added, as missed ones can cause problems later on for certain services. The second most important thing is filling out the Therapist Payors field, since the NPI,

Taxonomy and Zip code, as on file with the payor of your new employee is now required for billing . Fill it out appropriately, click OK, then go back to the Admin drop-down and click on New User.

Fill it out left-to-right, top-to-bottom, paying close attention to the Main Role and Access fields. These two selections greatly affect what the user will be able to do or not do in Milan. For example, if you want them to be an Admin, but you or they don't want to see all of the organization's information in their cockpit, just their facility, you can assign them the Main Role of an Admin and then under Access select By Facility, as seen in the example above. Then, under User Facilities, Add the different facilities to which they require access. If you are adding a therapist it is much easier. Simply add their Main Role as Therapist and their Access as By Therapist, and then under User Therapists add their name. Once you've entered the information, click the New Password button. This creates a temporary password. Then call the new user, tell them their User Name and their temporary password, and when they

log in they'll be forced to change the password to something different (since not even you are supposed to know their password).

Monthly Reports

Every month you will receive a report by email from us containing lots of useful information. Please call us about it. The reason we send it is so we can help you run your organization as efficiently as possible, while receiving the most relevant data on your performance. The administrator receives this report from us as the default contact for your agency. You can call us to change this, or go to Admin -> Edit Facility to review the contact list.

The report is divided into two sections:

- The first section is the summary section, and will probably be extremely useful to you and is mostly self-explanatory, except for the utilization sub-section:

  o The utilization sub-section is pretty accurate but not perfect. It is intended as a summary, and if you have any questions please consult the AuthDetail report. To make utilization more accurate:

    - Update the "Current Therapist" on the authorizations. No matter who performs the services, the utilization credits whomever is designated as the current therapist on the authorizations. A problem with a therapist having low utilization could be that they are assigned to authorizations on a lot more clients than they are writing notes for, and those clients may not be very active.
    - Utilization increases if the number of granted units is decreased
    - Utilization decreases if the client is not eligible for the authorized payors, or if you have "backup" authorizations that you don't expect to use if the first payor runs out of units

- The second section is for issues that need to be addressed, and the most reasonable goal is to have nothing in that section. Again, it is (hopefully) mostly self-explanatory except:

  o Needy authorization requests are past or nearly past their requested effective dates

- o Needy progress notes are more than a month old and are neither final or deleted
- o Needy claim items are more than a month old and are not final
- o Unengaged patients are ones that have two or three progress notes on their chart, but for a certain amount of time after that, they have had no more notes entered
- o Neglected active clients have had no progress notes entered in the last 3 months
- o Very neglected active clients have had no progress note entered in the last year. These clients need to be looked at to see whether they should be in the system.

Main Roles and Other Roles

The following main roles are available:

- ADMIN - the most powerful users of the system with access to all charts, reports, information and functions
- CLERK - the second most powerful users with access to all charts, most reports, most information, and almost all functions
- DIRECTOR - this permission allows access read-only access to most agency information, with no editing. This role is very configurable.
- THERAPIST - usually has access only to patients assigned to them and has limited access to other information and reports. One therapist can be assigned access to other therapist's and intern's charts.
- INTERN - the most limited clinical user with access only to assigned charts and can only view charts and enter progress notes
- FRONTDESK - very limited, only able to add patients and edit basic information for all patients. It is intended in the future for this role to have access to cash payments and patient invoices.

The following other roles are available:

- VIEWONLY - makes a user unable to add or modify any information
- BILLING - allows the user access to financial reports and information
- NOTEAUTO - automatically approves progress notes entered by the user that do not get rejected by the system
- NOTECLONE - enables a clone button that allows the user to create a new progress note based on an existing progress note for the same patient
- NOTEEDIT - enables the user to create/edit/delete unsigned progress notes
- NOUSEREDIT - removes the ability for an administrator to add or modify other users
- PATIENTEDIT - grants Therapists and Clerks the ability to edit basic information on the Patient tab of their clients' charts.

- PAEDIT - allows the user to create prior authorizations and take them to Completed status
- PAQA - allows the user to submit and finalize prior authorizations
- SCANNING - allows a user to scan paper documents into a client's chart using the Scans tab

The system is very configurable, and looks and behaves differently to a great degree based on the providers' wishes. Each user of the system is assigned certain roles and permissions that further determine how the system looks and behaves for them. Every user should be assigned to only one main role. As many additional permissions can be assigned to each role as desired. Permissions are a la carte roles. For instance, you can have a user with the main role of CLERK, and if you want them to be able to finalize prior authorizations (not the best idea), you can assign them the PAQA permission.

Posting Payroll

Payroll and timesheets are highly customizable to fit your organization's needs. Call us at 1-866-773-3867.

When therapists enter notes, they fall into a virtual bucket until they are entered into payroll. Posting payroll, or timesheets, is the way they are tallied and pay is calculated. Later, you can view all postings if needed.

When you "Post Payroll," Milan gathers all the notes that haven't been on a timesheet and/or notes that have been on one before but have gone through a timesheet-affecting change. Some examples of this are billing with an incorrect number of units, revising it, and billing it again, or if a claim denies or just partially pays.

Here is how you post payroll:

- Go to the upper-left corner to the Actions drop-down menu
- Click on Post Payroll
- Put in an end date (customizable as far as what this means)
- Ignore work days
- Select one or more therapists
- Click the Timesheet/Payroll button

Now all your timesheets are displayed and ready to print out. You can come back later and look at them using the Payroll report.

Let's go over the Payroll report. It is there for you to view all timesheets/payrolls you have posted. You as administrators can edit certain things. You can add notes to a timesheet, you can adjust services that are there, or you can add extra entries (like paid time off) that don't tie to any notes. For things like that or just supervisory purposes there is a history button that shows you the edits that have been made.

There is also the PayrollDetail report for further examination.

Editing Payroll

Pull down the [Reports](#) menu and click on Payroll. Select the therapist and click Search. Single-click the timesheet you're looking for and you can view it and its history, or you can edit it, or repost it after editing it, all using the buttons at the bottom of the window. Let's focus on the Edit button.

When you click the Edit button, it will bring up a window showing all of the sessions and services performed for that selected payroll period. If you select one and click the Service Adjustment button on the bottom of the window, you can edit the totals of units, mileage, amounts (what this means is customizable for you) and hours. If you want to increase or decrease the totals of any of these you put in positive or negative (-) numbers respectively into the red text boxes and a new adjustment line is created with the numbers you put in, where positive numbers bring totals up and negative ones bring the totals down.

If you click the Add Extra Entry button instead of Service Adjustment it will let you do just that, if, for example, you wanted to put in a new note's services, or if you wanted to add something in there that doesn't tie to notes or anything, like paid time off, or paying a therapist back for letting you borrow $15 at lunch. You put in a Description, Quantity (how many...), of Units(...of what?) and the Amount of whatever that it comes to (usually dollars). I know it seems contradictory to put in Mary Kay Payment, 80, Dollars, and then 80 again, but the "Amount" field is what generates the pay for that person on the payroll.

Payroll Options

Payroll is extremely customizable. There are many things you can tweak, and you really only have to think about this when you first start using payroll or when you start using Milan. You can edit some parts of this by accessing the Admin drop-down menu and selecting Edit Payscale Rates. Using this you can customize a lot of payroll, but we strongly recommend that you call us first.

Here are the different customizations and a short description of each:

Q: When do you want to credit the therapist with doing the progress note?

A: No money comes in until the note is done through and through. So you can pick a "trigger" for crediting the note to the therapist. The possible status triggers are:

- Signed
- Approved
- Billed
- Promised (only makes sense for Medicaid)
- Paid

Q: Who can post payroll?

A: By default, clerk/admins have this permission

Q: What does the Post Payroll End Date mean?

A: This can be either when the service was performed, or when the trigger status occurred

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Q: Do you want a "Timesheet" button (timesheets order the details by service date), a "Payroll" button (payrolls order the details by payor and service), or both?

Q: What do you want to show up on the timesheet? (all optional)

    * Duration
    * Units
    * Mileage
    * Facility
    * Patient name
    * Signature line
    * $ Amount (you can change what this represents)

A: To setup and/or change any of this, call us at 1-866-773-3867.

Licensed Behavioral Health Providers

If you are coming from an accredited agency, starting the LBHP process on your own can be daunting. The bad news is LBHP billing is very different from billing within an agency; the good news is we are here to help.

Since our help manual has many other pages devoted to the basic layout of Milan, as well as accessing treatment plans and notes, that material will not be covered again here. We will go over some of the unique guidelines and practices used in LBHP billing.

- Under Medicaid, you can only take children as primary clients, and can only treat families as long as one of the children is your client. This is not necessarily true for other payors.

- Unlike agencies, PreAuth services, or Pre-admission services, do not exist for you. You get a Psychiatric Assessment before receiving authorization, which is meant to combine the traditional MH Assessment and Treatment Plan sessions. Crisis Intervention is also available at any time and does not require authorization.

- There are only two bundles you can be authorized for: PG030 and PG040. PG030 allows initial treatment while PG040 authorizes extensions. Even though the requirements are fewer for a PG030 than for a PG040, for auditing purposes you should fill out the treatment plan as fully as you can up front. As of March 2011, as far as documentation is concerned, APS is still figuring out exactly how to handle LBHP authorizations in general and the PG040 in particular. The best thing to do is fill out the full treatment plan like you're requesting a PG040 bundle. Even though there are no regulatory compliance/guidance issues for the PG030, we recommend that you follow proper clinical procedures/guidelines for treatment.

- When you fill out your treatment plan request, the Level should read Private Practice, and your unit totals should equal 48 (8 units/month for 6 months). For example, if you are wanting to provide Individual and Family services, one should ask for 18 units, the other 30. Multiples of 6 works best when proposing

units; that way Milan will break down the units evenly per month when you receive your approval.

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