

HENS Release Notes – August 1, 2022

The following changes (enhancements, updates, fixes) have been implemented in this release after the previous release for HENS 3.0.

1. Landing Page/Submit Date:

'Submit Date' is added to the filter option to allow searching for a document using the date range of 'Submitted on or before' and 'Submitted on or after'.

CONSUMER / DOCUMENT SEARCH

Filter(2) SUBMITTED ON/AFTER: 04/27/2022 SUBMITTED ON/BEFORE: 05/12/2022

First Name Max 60 characters 0 / 60	Last Name Max 60 characters 0 / 60	Submitter Last Name Max 60 characters 0 / 60	SSN All 9 digits 0 / 11	Date of Birth Format mm/dd/yyyy	Document ID All 9 digits 0 / 9
Create Date 04/27/2022 – 05/12/2022	Medicaid Number All 12 digits 0 / 12	PIMS Client Number All 9 digits 0 / 9	Type	Status	

DODD Status NF Status Level II Categorical Search Clear

2. Landing Page/Search Results:

'Create Date' column is added to the search results to display the date of document creation.

DOCUMENT ID	CREATE DATE	TYPE	STATUS	NAME	SSN	DATE OF BIRTH	MEDICAID NUMBER	PIMS CLIENT NUMBER	SUBMITTER FACILITY	SUBMITTER NAME	SUBMIT DATE	CATEGORICAL	LEVEL II	PSYCH DISCHARGE	ODMHAS STATUS	DODD STATUS
506043254	02/25/2022	RR	INPROCESS		XXX-XX-2558				ALTERCARE CAMBRIDGE	KUNWAR, PRAGYA		NONE				
506519210	05/03/2022	RR	INPROCESS		XXX-XX-4754				ALTERCARE CAMBRIDGE	KUNWAR, PRAGYA		NONE				
506519583	05/03/2022	RR	INPROCESS	TEST, SECTION	XXX-XX-6744	12/10/1975			ALTERCARE CAMBRIDGE	KUNWAR, PRAGYA		NONE				
506668948	09/21/2021	PAS	INPROCESS		XXX-XX-8968				ALTERCARE CAMBRIDGE	KUNWAR, PRAGYA						
506052666	03/07/2022	PAS	INPROCESS	FGRFG, TRTYRTEE	XXX-XX-8985	12/12/1960			ALTERCARE CAMBRIDGE	KUNWAR, PRAGYA						

Export to Excel

Items per page: 10 1 - 5 of 5

3. Review/Summary Page:

For DODD and ODMHAS Review section, the display for 'Further Review Results' drop down under *Determination* is expanded to make the list fully visible.

The screenshot shows the 'DODD Review' interface. On the left, there is a sidebar with options: 'Document Started' (checked), 'Refer to ODMHAS' (checkbox), 'Comments' (text area), 'Referrer' (text field), 'Referred Date' (text field), 'Review Complete' (checkbox), 'State Referral Reason' (text field), 'Further Review Results' (highlighted dropdown menu), and 'Determination Date' (text field). The dropdown menu is expanded, showing the following options: 'NO NF NEED, NO SS NEED', 'RULE OUT', 'NO NF NEED, SS NEED', 'LEVEL II - APPROVED SS - FACILITY SPECIFIC - RECON', 'LEVEL II - APPROVED NO SS - RECON - ST', 'LEVEL II - APPROVED SS - ST', and 'LEVEL II - APPROVED NO SS'.

4. Form ODM7000/PDF Version:

The ODM 7000 form which was posted online and the PDF generated in HENS had an error with regards to the numbering of the questions in Section B. There were two #3 questions on the form. The ODM 7000 version that appeared online had been updated. The PDF form generated in HENS has now also been updated.

SECTION B: DIAGNOSIS OF MENTAL ILLNESS, DEVELOPMENTAL DISABILITIES OR RELATED CONDITION

1) Was there an adverse PASRR determination within the past 60 days? Yes No
 If so, indicate date of most recent adverse PASRR determination* Date (mm/dd/yyyy) _____

The date of most recent adverse PASRR is only applicable for individuals with diagnoses of SMI and/or DD as indicated in this section. Call the State authorities if unable to verify via local records (Ohio MHAS: 614-466-1063 and/or DODD: 1-800-617-6733)

2) Does the individual have a diagnosis of any of the mental disorders listed below? Yes No

<input checked="" type="checkbox"/> Schizophrenia	<input checked="" type="checkbox"/> Personality Disorder(s)
<input type="checkbox"/> Mood Disorder(s)	<input type="checkbox"/> Other Psychotic Disorder(s)
<input type="checkbox"/> Delusional Disorder(s)	<input type="checkbox"/> Another mental disorder that may lead to a chronic disability
<input type="checkbox"/> Panic or other Severe Anxiety Disorder(s)	If so, describe: _____
<input type="checkbox"/> Somatic Symptom Disorder(s)	

Individual Last Name LAST	Individual First Name FIRST
3) Does the individual have a physical or mental disability, or related condition, that is not solely caused by mental illness AND was manifested prior to the age of 22? <input checked="" type="checkbox"/> Yes (select all that apply below) <input type="checkbox"/> No	
<input checked="" type="checkbox"/> Autism	<input checked="" type="checkbox"/> Traumatic Brain Injury
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Blindness
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Deafness
	<input checked="" type="checkbox"/> Intellectual Disability
	<input type="checkbox"/> Other (specify condition) _____

SECTION B: DIAGNOSIS OF MENTAL ILLNESS, DEVELOPMENTAL DISABILITIES OR RELATED CONDITION

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2) Does the individual have a diagnosis of any of the mental disorders listed below?* Yes No

Check all that apply

Schizophrenia Personality Disorder(s)

Mood Disorder(s) Other Psychotic Disorder(s)

Delusional Disorder(s) Another mental disorder other than DD that may lead to chronic disability. If so, describe

Panic or other Severe Anxiety Disorder(s)

Somatic Symptom Disorder(s)

Describe

Max 4000 characters 0 / 4000

3) Does the individual have a physical or mental disability, or related condition, that is not solely caused by mental illness AND was manifested prior to the age of 22? * Yes No

Check all that apply

Autism Traumatic Brain Injury Intellectual Disability

Epilepsy Blindness Other (specify condition)

Cerebral Palsy Deafness

Describe

Max 4000 characters 0 / 4000

5. Help Page - FAQs:

A FAQs section and Help Desk FAQ document has been added to HENS 3.0. It can be found on the 'Help' page in HENS.

HELP


<p>User Guides</p> <p>General User</p> <p>Admin User</p> <p>MCO User</p>	<p>User Training Videos</p> <p>The Basics</p> <p>PASRR (ODM3622)</p> <p>Hospital Exemption (ODM7000)</p>	<p>FAQs</p> <p>Help Desk FAQ</p>	<p>Releases</p> <p>Release Notes - 08/01/2022</p>
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Help Contact Information

Issue	Contact	Examples
PASRR deletions/withdrawals	PASRR@medicaid.ohio.gov	<ul style="list-style-type: none"> Please send your delete requests to PASRR@medicaid.ohio.gov with the following information: HENS ID: Last Name: Last 4 digits of SSN: Reason(s) for requesting to delete/withdraw the above HENS document: HENS document submitter name: <p>After approval, ODM team will forward the request to the ODA team for deletion.</p>
PASRR Policy/Rule Questions	PASRR@medicaid.ohio.gov	<ul style="list-style-type: none"> How do I answer a question on the ODM3622/ODM7000 based on this individual's circumstances? Should I do a PAS or an RR for this individual? Which RR reason should I choose? I submitted the wrong document type, what do I do now?
HENS User Questions	PAS-RR@age.ohio.gov	<ul style="list-style-type: none"> How do I change my HENS password? How do I create a new ODM7000 document? I need to report a broken link in the User Guide.

6. Help Page - Releases:

A Releases section and release notes document has been added to HENS 3.0. It can be found on the 'Help' page in HENS.



Healthcare Electronic Notification System (HENS)

[Help](#) [Login](#)

HELP

User Guides

[General User](#)

[Admin User](#)

[MCO User](#)

User Training Videos

[The Basics](#)

[PASRR \(ODM3622\)](#)

[Hospital Exemption \(ODM7000\)](#)

FAQs

[Help Desk FAQ](#)

Releases

[Release Notes - 08/01/2022](#)

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HENS User Questions	PAS-RR@age.ohio.gov	<ul style="list-style-type: none"> How do I change my HENS password? How do I create a new ODM7000 document? I need to report a broken link in the User Guide.

7. Form ODM3622/Section E:

The issue which was causing the PDF to fill the total as 'Zero' if the count was less than 2 or if the answer was 'No' has been corrected.

SECTION E: INDICATIONS OF SERIOUS MENTAL ILLNESS - All questions in Section E must be completed

1) Does the individual have a diagnosis(es) of any of the mental disorders listed below? No Yes Unknown

Check all that apply.

<input type="checkbox"/> Schizophrenia <input type="checkbox"/> Mood Disorder(s) <input type="checkbox"/> Delusional Disorder(s) <input type="checkbox"/> Panic or other Severe Anxiety Disorder(s) <input type="checkbox"/> Somatic Symptom Disorder(s)	<input type="checkbox"/> Personality Disorder(s) <input type="checkbox"/> Other Psychotic Disorder(s) <input checked="" type="checkbox"/> Another mental disorder that may lead to a chronic disability If so, describe: _____
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2) Does the individual have a diagnosis(es) of a substance use related disorder? No Yes Unknown

If Yes, specify diagnosis(es): _____ Last reported usage: 02/01/2021

3) Within the last TWO (2) years, has the individual utilized psychiatric services listed below more than once **DUE TO THE MENTAL DISORDER?** No Yes Unknown

Complete information below before responding

Indicate the number of times the individual utilized each service over the past 2 years. If the total score below is greater than 1 answer yes in the question above.

0	Ongoing case management from a mental health agency
1	Emergency mental health services
0	Inpatient psychiatric hospitalization
0	Partial hospitalization treatment program for psychiatric reasons
0	Admission to residential facility for mental health services provided by mental health agency
1	TOTAL

8. Form ODM3622/Section F:

The issue which changed the answer for Question number 2 as the same answer as question number 1 upon saving has been corrected.

SECTION F: INDICATIONS OF INTELLECTUAL & DEVELOPMENTAL DISABILITY OR RELATED CONDITION

1) Does the individual have a physical or mental disability, or related condition, that is not solely caused by mental illness?*

Yes No Unknown

Check all that apply

<input type="checkbox"/> Autism	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Blindness	<input type="checkbox"/> Deafness
<input type="checkbox"/> Intellectual Disability	<input type="checkbox"/> Other	

Please specify other
.....
Max 4000 characters 0 / 4000

2) Did the condition manifest before the individual's 22nd birthday?*

Yes No Unknown

3) Is the condition likely to continue indefinitely?*

Yes No Unknown

4) Does the individual have indications of substantial functional impairments in any of the major life activity areas ?*
(self-care, language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency)

Yes No Unknown

5) Does the individual currently receive, or have they previously received, services from a County Board of DD?*

Yes No Unknown

The individual has indications of DD/ID or related condition if any of the following are true:
Answered YES OR Unknown to two or more questions F(1) through F(4) OR
Answered YES or Unknown to question F(5)

Does the individual have indications of DD?

Supporting documentation required. Use the File Upload function in the Submit section to attach 'DODD Diagnosis Documentation'.

Yes
Two or more questions F(1) through F(4) are answered 'Yes' or 'Unknown'.

9. Form ODM3622/Submit Section:

The Fax Number field is required. The Fax Number field for the Submitter's Information section has been updated with a message 'This is a required field, please update your fax number in your profile and try again.', so that the user can successfully submit the document.

1 Screening Type **2** Section A Individual's Basic Information **3** Section B Admitting Nursing Facility **4** Section D Medical Diagnosis **5** Section E Indications of SMI **6** Section F Indications of ID/DD OR Related Condition **7** Section G Legal Guardian/ POA Information **8** Section H Attending Physician Information **9** Submit Submitter Information/Certification

HENS ID: 506744955 Consumer Name: D6DBD ABCD

To process the screen, the submitter must provide his/her name and address and sign below. Complete the form fully and with accuracy. Incomplete forms may be returned with a request for further information. The nursing facility shall not admit or retain individuals with indications of Serious Mental Illness and/or Developmental Disabilities or a related condition without further review by Ohio Department of Mental Health and Addiction Services and/or Ohio Department of Developmental Disabilities in accordance with Ohio Administrative Code rules 5160-3-15.1 and 5160-3-15.2.

Last Name KUNWAR	First Name PRAGYA		
Facility/Organization Name ALTERCARE CAMBRIDGE	Email Address PKUNWAR@AGE.OHIO.GOV		
Street Address 66731 OLD TWENTY-ONE ROAD	Zip Code 43725	County GUERNSEY	City CAMBRIDGE
State OH			
Telephone Primary (614)-785-8569	Fax Number Please enter Fax Number	This is a required field, please update your fax number in your profile and try again.	

I understand this screening information may be relied upon in the payment of claims from Federal and State funds, and that any willful falsification or concealment of a material fact may be prosecuted under Federal and State laws. I certify to the best of my knowledge the foregoing information is true, accurate and complete.

This form must be signed and dated in order to be valid.

Signature*
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