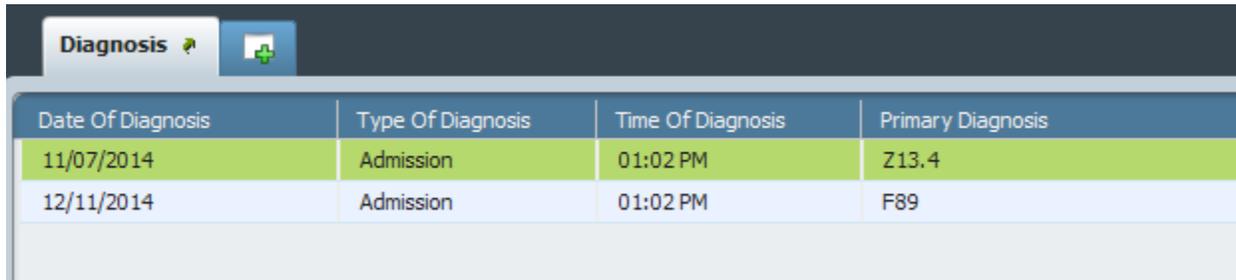


Training – Use of Diagnosis Module for ICD-10 Codes in HIS

This document will help to explain the changes in how diagnoses are assigned in HIS after the ICD-10 update which occurred during the weekend of September 5-8, 2015.

Diagnosis (formerly known as Medical Diagnosis)

The new Diagnosis form/module has changed in several ways when compared to the Medical Diagnosis form/module it is replacing. The changes to the form are outlined below.

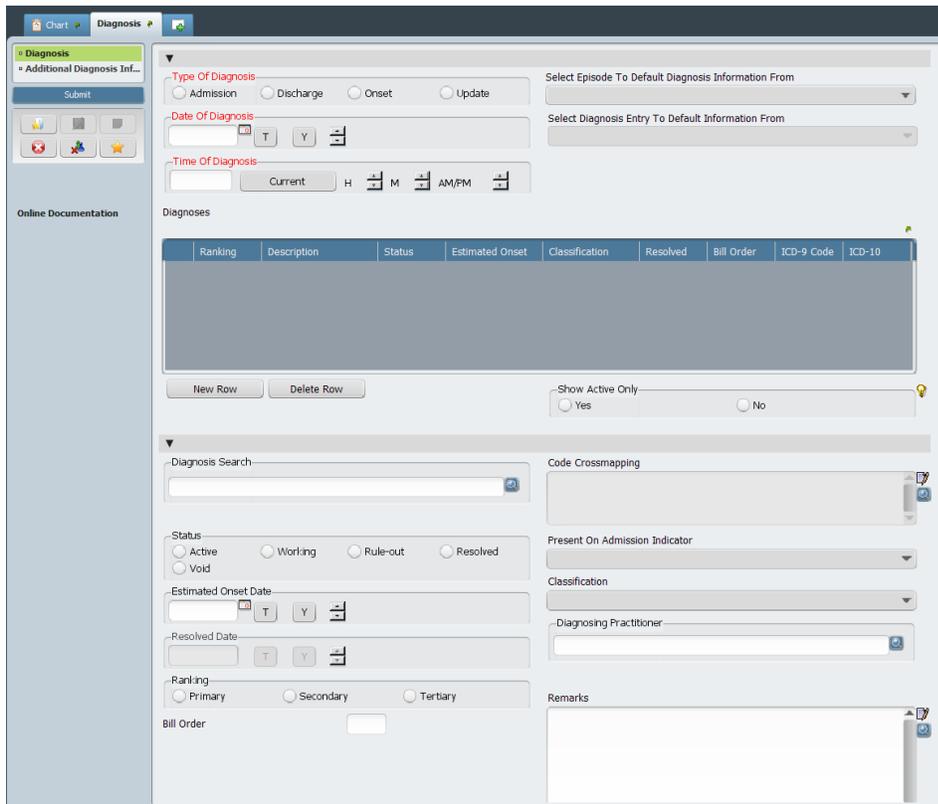


The screenshot shows the top of the Diagnosis module interface. It features a header bar with a 'Diagnosis' label and a green plus icon. Below the header is a table with four columns: 'Date Of Diagnosis', 'Type Of Diagnosis', 'Time Of Diagnosis', and 'Primary Diagnosis'. The table contains two rows of data.

Date Of Diagnosis	Type Of Diagnosis	Time Of Diagnosis	Primary Diagnosis
11/07/2014	Admission	01:02 PM	Z13.4
12/11/2014	Admission	01:02 PM	F89

Pre-Display

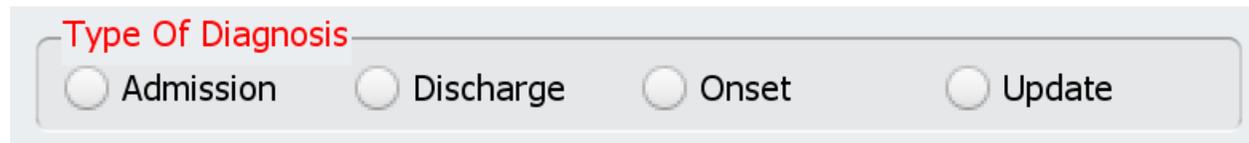
Prior to the current update, when a staff member opened the “Medical Diagnosis” form, the form opened and displayed any codes that had already been entered for the child, or displayed a blank grey screen that showed that no diagnosis had been entered. In the new “Diagnosis” form, there is now a pre-display which provides the user with a list of dates for which diagnoses were entered for the child. If this is the first time that a diagnosis will be entered for a child, the form will open up to the main data entry screen.



The screenshot displays the full Diagnosis form interface. On the left is a sidebar with a 'Diagnosis' tab and a 'Submit' button. The main area contains several sections: 'Type Of Diagnosis' with radio buttons for Admission, Discharge, Onset, and Update; 'Date Of Diagnosis' and 'Time Of Diagnosis' input fields; a 'Diagnoses' table with columns for Ranking, Description, Status, Estimated Onset, Classification, Resolved, Bill Order, ICD-9 Code, and ICD-10; a 'Diagnosis Search' field; 'Status' radio buttons (Active, Working, Rule-out, Resolved, Void); 'Estimated Onset Date' and 'Resolved Date' input fields; 'Ranking' radio buttons (Primary, Secondary, Tertiary); 'Bill Order' input field; 'Code Crossmapping' and 'Present On Admission Indicator' dropdowns; 'Classification' dropdown; 'Diagnosing Practitioner' input field; and a 'Remarks' text area.

Data Entry

The following step-by-step instructions will walk users through adding in diagnoses to a child's record in HIS using the Diagnosis module. Screen-shots are included wherever possible.



Type Of Diagnosis

Admission Discharge Onset Update

Type of Diagnosis: There are four choices for this required field.

Admission – To be used for all diagnoses (ICD codes) identified at the time the child is referred or enrolled in the program. The Date of Diagnosis will default to the child's Admission Date when selected.

Discharge – DO NOT USE.

Onset – DO NOT USE.

Update – To be used for all diagnoses (ICD codes) identified AFTER the child has been evaluated and enrolled in services.



Date Of Diagnosis

 T Y 

Date of Diagnosis: The date of diagnosis should be the date the evaluation/assessment occurred when the diagnosis was identified.



Time Of Diagnosis

Current H  M  AM/PM 

Time of Diagnosis: The time the diagnosis was made. This field is not important for data collection purposes, but must be completed.

Diagnoses

Ranking	Description	Status	Estimated Onset	Classification	Resolved	Bill Order	ICD-9 Code	ICD-10

New Row Delete Row Show Active Only

Diagnoses Table: This table lists the diagnoses as they are entered into the Diagnosis screen. The columns list the information in an easy-to-read display. No information should be entered directly into this table. To add a diagnosis to this table, click the “New Row” button on the bottom left. Once a New Row has been selected, the table will appear as below:

Diagnoses

Ranking	Description	Status	Estimated Onset	Classification	Resolved	Bill Order	ICD-9 Code	ICD-10
Primary (1)		Active (1)				1		

New Row Delete Row Show Active Only

Once this row is displayed, the information below the table must be completed in order to enter diagnosis information. Note that the first diagnosis will be defaulted as “Primary” in the Ranking column, and as “1” in the Bill Order column. These defaults can be modified below.

Diagnosis Search

Diagnosis Search: This search box allows the user to look up a diagnosis code. The search box allows for searching by ICD-9 or ICD-10 code or description. Below is an example of how the search results are displayed.

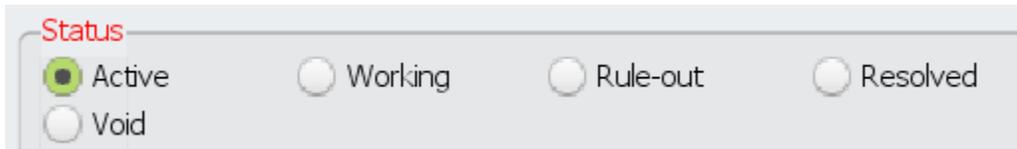
Example: Diagnosis Search box for ICD-10 code F88

Diagnosis	ICD-9	ICD-10
Other disorders of psychological development	315.8	F88
Borderline delay of cognitive development	315.8	F88
Delayed emotional development	315.8	F88
Delayed social and emotional development	315.8	F88
Delayed social development	315.8	F88
Development disorder, mixed	315.5	F88
Developmental agnosia	784.69	F88
Developmental mental disorder	315.8	F88
Global developmental delay	315.8	F88
Mixed development disease	315.5	F88
Mixed development disorder	315.5	F88

<= Previous 25 Next 25 =>

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Please note that the system displays the description in the first column (Diagnosis), the ICD-9 code in the second column (ICD-9), and the ICD-10 code in the third column (ICD-10). The descriptions in the first column (Diagnosis) are the ICD-10 descriptions, rather than the ICD-9 descriptions as previously appeared before the recent update. There are often several descriptions for each ICD-10 code in the system – please refer to the ICD-10 Cheat Sheet distributed by the EI Branch for examples of which descriptions to use for each code.



The screenshot shows a 'Status' field with five radio button options: Active (selected), Working, Rule-out, Resolved, and Void.

Status: There are five choices in this required field.

Active – The diagnosis is active and can be used as a billing diagnosis by staff.

Working – DO NOT USE.

Rule-Out – DO NOT USE.

Resolved – If a diagnosis is no longer applicable or should not be used by staff for billing, then a diagnosis should be considered “Resolved.” This field will require data entry into the “Resolved Date” field. Once a “Resolved Date” has been entered, the diagnosis code will no longer be available to be selected for billing using the Ambulatory Progress Notes (Diagnosis Entry) form.

Void – DO NOT USE. If an incorrect diagnosis is entered into the Diagnosis Table, then the entire row should be deleted using the “Delete Row” button, rather than voiding the diagnosis.



The screenshot shows an 'Estimated Onset Date' field with a date input box, a 'T' button, a 'Y' button, and a dropdown menu.

Estimated Onset Date: This field can be used with any diagnosis, however this field is not required. If used, please follow the following rules:

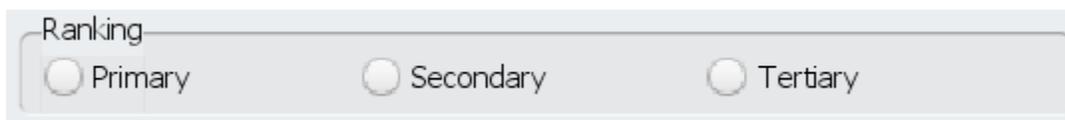
- Use *date of birth* for congenital conditions such as prematurity, low birth weight, Down syndrome, hearing loss and other congenital anomalies.
- Use *date of evaluation* for everything else.
- Rarely, another onset date may be documented in medical records, such as the date of a first seizure. It’s ok to use that date but not mandatory to search for details like that.



The screenshot shows a 'Resolved Date' field with a date input box, a 'T' button, a 'Y' button, and a dropdown menu.

Resolved Date: This will be greyed out and not able to be selected unless “Resolved” has been chosen as the Status of the diagnosis. If “Resolved” has been selected as the status, the date field will turn red

(required). The date entered into this field should correspond to the last date that the diagnosis should be usable for billing.



A horizontal form titled "Ranking" containing three radio button options: "Primary", "Secondary", and "Tertiary".

Ranking: This field allows the user to designate the importance of the diagnosis being entered.

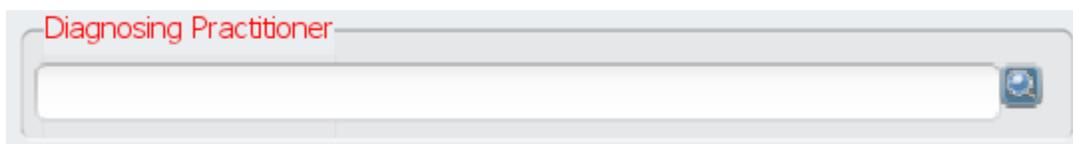
Primary – The most severe (major) diagnosis should be classified as the Primary ranking for each child. The system will allow only one diagnosis code as the Primary ranking.

Secondary or Tertiary – All diagnosis codes that are not the Primary code can be considered a Secondary or Tertiary ranking. The system will allow for multiple codes to be ranked as Secondary or Tertiary.



A horizontal form titled "Bill Order" with a text input field containing the number "1".

Bill Order: This field instructs the system which order to bill when there are multiple diagnoses entered into HIS. The diagnosis designated as Primary will ALWAYS be "1" for the Bill Order. However, all subsequent diagnoses can have the Bill Order adjusted. For example, if there are several diagnoses ranked as Secondary, then the clinician can choose the order for which the Secondary diagnoses should be billed. Please note that the Bill Order will only affect the order of diagnoses billed on an Ambulatory Progress Note (Diagnosis Entry), with the Primary Diagnosis always billed first.



A horizontal form titled "Diagnosing Practitioner" with a large empty text input field and a search icon on the right.

Diagnosing Practitioner: This field should be used to identify the individual at the CDSA who made the decision about which diagnosis code to use for the child. Please see the EI Branch State Office ICD-10 Coding Guide for additional information.

Other Fields Not Required: The following data entry fields are available in the Diagnosis screen but are not required and therefore should not be used unless a need is determined.

Select Episode to Default Diagnosis Information From, Select Diagnosis Entry to Default Information From, Present on Admission Indicator, Classification, Remarks, and Add to Problem List.

Adding Additional Diagnoses : Once the information for the current row in the Diagnosis Table is complete, additional diagnoses can be added clicking the "New Row" button on the bottom left of the Diagnoses Table. This will add an additional row to the Diagnoses Table, which can then be completed in the same manner as described above.

Submit the Diagnosis Form: Once all diagnoses have been entered into the Diagnoses Table, the user will need to click the "Submit" button in the top left corner of the page for HIS to save all changes.

Diagnoses Table Explained

The screenshot shows a table with the following columns: Ranking, Description, Status, Estimated Onset, Classification, Resolved, Bill Order, ICD-9 Code, and ICD-10. Below the table are buttons for 'New Row', 'Delete Row', and 'Show Active Only'.

Ranking	Description	Status	Estimated Onset	Classification	Resolved	Bill Order	ICD-9 Code	ICD-10
Secondary...	Developmental ment...	Active (1)	12/11/2014			2	315.8	F88
Primary (1)	Child development d...	Active (1)	12/11/2014			1	315.9	F89
	Nonverbal learning di...	Resolved (4)	06/24/2015		07/23/2015		315.8	F81.89

Callouts in the image explain the following elements:

- Ranking of Diagnoses:** Points to the Ranking column.
- ICD-9 or ICD-10 Description:** Points to the Description column.
- Estimated Onset Date:** Points to the Estimated Onset column.
- Resolved Date: Date should only appear if diagnosis is resolved:** Points to the Resolved column.
- ICD-9 Code:** Points to the ICD-9 Code column.
- ICD-10 Code:** Points to the ICD-10 column.
- Number of Diagnoses (3 in this example):** Points to the row numbers 1, 2, and 3.
- Status of Diagnosis (Active or Resolved):** Points to the Status column.
- Classification – DO NOT USE:** Points to the Classification column.
- The Bill Order set for each diagnosis:** Points to the Bill Order column.

Ambulatory Progress Notes (Diagnosis Entry)

This HIS form did not change in appearance after the most recent update to the system. However, it is important to note that there are some changes to the results displayed when searching for a diagnosis using this form.

The screenshot shows a form with two main components:

- Active Diagnosis:** A dropdown menu for selecting a previously entered diagnosis.
- Diagnosis 1:** A search box for looking up a diagnosis code, featuring a magnifying glass icon.

Active Diagnosis: This field allows the user to select a diagnosis that has previously been entered into the Diagnosis form. This drop-down will display both ICD-9 codes/descriptions and ICD-10 descriptions. Due to a system issue that is currently under investigation, the order of diagnoses displayed DOES NOT correspond with the Ranking or Bill Order on the Diagnosis form. The diagnosis codes displayed in this drop-down Active Diagnosis screen are listed by Alpha-Numeric order. Therefore it is important that staff determine which code they are to use for billing prior to using the Active Diagnosis drop-down choices.

Diagnosis 1: This search box allows the user to look up a diagnosis code, and works exactly like the Diagnosis Search box in the Diagnosis form. Clinicians should avoid using this search box to look up and enter billing diagnoses directly into the Ambulatory Progress Notes (Diagnosis Entry) whenever possible, as preference is for consistent use of the Diagnosis form/module to enter ICD codes.

Additional Diagnoses – Additional diagnosis can be entered into the Ambulatory Progress Notes (Diagnosis Entry) form (up to four) using the fields for Active Diagnosis 2 through 4.