

# Diagnoses

| ADT/ Face<br>Sheet | Demographic           | Face Sheet                  | Diagnoses                    | Census                  | Documents                            | Other                  |
|--------------------|-----------------------|-----------------------------|------------------------------|-------------------------|--------------------------------------|------------------------|
| Marketing Menu     | Add/ Update<br>Client | Admission                   | Add Diagnoses                | Daily Census            | Admission<br>Agreement<br>(e-Sig)    | Write Internal<br>Memo |
| Department Menu    |                       | Re-Admission                | View/ Edit<br>Diagnoses      | Statistics<br>Calendar  | Scan<br>Documents                    | Schedule               |
|                    |                       | Discharge/<br>Transfer/ LOA | Diagnosis List<br>(history)  | Room / Bed<br>List      | View Scanned/<br>Signed<br>Documents |                        |
|                    |                       | Room Change                 | Diagnosis List<br>(archived) | Admission/<br>Discharge |                                      |                        |
|                    |                       | View/ Edit Face<br>Sheet    | View Inactive<br>Diagnoses   |                         |                                      |                        |
|                    |                       | Face Sheet<br>Report        | Diagnoses<br>Report          |                         |                                      |                        |

# Enter Diagnoses

- 1. From the ADT/Face Sheet Access menu, click onto **Add Diagnoses**, select a name, and click **OK**.
- 2. A Write screen will load. Document the desired diagnosis by first selecting one of the Diagnosis Type words (ADMISSION, PRIMARY, SECONDARY, OTHER, or HISTORICAL).
  - a. Only <u>one admission</u> and <u>one primary</u> diagnosis can be entered with the same effective date. The system will not allow more than one and will present the user with an error if they attempt to add an additional one with the same effective date.
  - b. The admission and the primary diagnosis can be the same code.
  - c. If the facility does not differentiate between the admission and primary diagnosis code, one can be moved and only one needs to be utilized.
  - d. The UB04 can only electronically transmit up to <u>12 secondary diagnosis</u>, so it is recommended to not enter more than 12 secondary codes. This ensures that all codes entered are transmitted.
  - e. Use Other or Historical for remaining diagnosis codes.
- 3. Once you have selected a heading, a Diagnosis menu will appear. Begin typing the diagnosis name or ICD-10 code in the **Search** field (do not click Enter, the system searches automatically, but it may take a moment to begin the search). A list of matches will appear.



- 4. Select a diagnosis from the list and click **OK**. Do not select a red code (these are invalid codes).
- 5. Select the onset date of the condition (or the admission date if the onset date is unknown) and click **OK**.
- 6. The charting screen will display the diagnosis and date that was selected. The ICD-10 code will appear to be blank and will not appear until after save (do not type this in manually).
- 7. Repeat above steps for each diagnosis code.
- 8. Click **Sign** to save your entry(s) and return to the ADT/Face Sheet Access menu.

## View/Edit Diagnoses

- 1. From the ADT/Face Sheet Access menu, click onto View/Edit Diagnoses.
- 2. The diagnosis name, ICD-10 code, and effective date will appear.
- 3. Click **Exit** to close the screen and return to the ADT/Face Sheet Access menu.

#### Edit Diagnoses

Example 1: A part of a diagnosis entry/entries is charted incorrectly (e.g., wrong effective date, wrong code, wrong heading, charted codes on incorrect name)

- 1. Follow instructions for *View/Edit Diagnoses*.
- 2. Click the incorrect entry to turn it red. This is called 'tagging' the entry. You may tag multiple entries if all are incorrect.
- 3. Click the **Edit** button.
- 4. Select **Archive**. A box will pop up and ask: "Are you sure you want to archive all selected entries?" Click **Yes**.
- 5. The entry or entries will turn gray to show the edit is complete.
- 6. Click **Go** to refresh the screen and see your changes.

# Example 2: A diagnosis or multiple diagnoses are resolved (e.g., urinary tract infection or skin ulcer is healed)

- 1. Follow instructions for *View/Edit Diagnoses*.
- 2. Click the incorrect entry to turn it red. This is called 'tagging' the entry. You may tag multiple entries if all have resolved.
- 3. Click the **Edit** button.
- Select Discontinue and Append to resolve a single diagnosis or Discontinue All and Append All to resolve multiple diagnoses at the same time. A box will pop up and ask: "Are you sure you want to DC selected entry?" Click Yes.
- A Write screen will appear, with "(discontinued)" in the text box. Click onto DISCONTINUE DATE and select the date the diagnosis is considered to no longer be current. Specify whether the code is Inactive or Resolved.
- 6. Click **Next** to save the DC date and return to the View screen.
- 7. The entry or entries will appear gray to show the edit is complete.



8. Click Go to refresh the screen and see your changes.

Example 3: Update a diagnosis heading (e.g., a current primary diagnosis becomes a secondary or historical diagnosis)

- 1. Follow instructions for *View/Edit Diagnoses*.
- 2. Click the incorrect entry to turn it red. This is called 'tagging' the entry.
- 3. Click the **Edit** button.
- 4. Select **Discontinue and Append.** A box will pop up and ask: "Are you sure you want to DC selected entry?" Click **Yes**.
- 5. A Write screen will appear, with "(discontinued)" in the text box. Click onto **DISCONTINUE DATE** and select the date the diagnosis is considered to no longer be current. Specify whether the code is Inactive or Resolved.
- 6. Click **Save** to save the DC date.
- 7. In the Write screen, click onto the new appropriate heading. Follow instructions for *Enter Diagnoses*.
- 8. Click **Next** to save the new entry and return to the View screen.
- 9. Click **Go** to refresh the screen and see your changes.

## Diagnoses Reports/View Tasks

Additional buttons are available for viewing different forms of Diagnoses. To run a specific task, click onto the button, select name(s), and click **OK**. Below is a detailed description of each button.

- Diagnosis List (history) This button loads a View screen that displays all current diagnoses as well as any discontinued diagnoses. Click **Control** if wanting to narrow down entries that were only made during a specific date range. Then click **Go** to refresh the screen.
- Diagnosis List (archived) This button loads a View screen which displays only archived diagnoses. Keep in mind that an archived diagnosis indicates that it was made in complete error. However, this task may be useful if attempting to find a diagnosis that you are unsure as to where it went. Click **Control** if wanting to narrow down entries that were only made during a specific date range. Then click **Go** to refresh the screen.
- View Inactive Diagnoses This button loads a View screen which displays diagnosis codes that were once active (when they were originally entered in) but have since been made inactive. This will help to eliminate pulling inactive codes to the MDS or the UB04, which make cause a rejection. We recommend running this task at least 1-2 times a month.
- **Diagnoses Report** This button loads a report which displays all diagnoses codes broken out by each category.