

All the Different Places for Diagnosis Codes

There are many different places throughout the program in which diagnosis codes are stored. This document will outline some of the different places and suggestions on how to move forward.

This document will detail:

- Different places Diagnosis Codes are stored
- Suggestions on moving forward

This document will take you through some of the various places throughout eTHOMAS and even outside of eTHOMAS where Diagnosis Codes are stored. Why does it matter where these codes are stored? Right now, these codes that are attached to your patients, inside Case Management, attached to referrals, etc. are ICD-9 codes. You will eventually need to create the ICD-10 equivalents within these areas of eTHOMAS.

Patient Tab



From within the Patient, we have listed the different areas that store diagnosis codes.


Patient Information; Default Diagnosis Codes (2)

If you have default diagnosis codes stored in the patient information, after the October 1, 2014 ICD-10 deadline you will want to take some type of action.

The screenshot shows a form with the following fields: Doctor (01 - MEREDITH L GREY MD), Location (01 - GENIUS SOLUTIONS PC), Patient Type, Ref Type, Referral, and Pri Care Phy. Below these fields are two rows for diagnosis codes: DX 1: 1101 MYCOTIC NAIL and DX 2: 25000 DIABETES. Red arrows point to the DX 1 and DX 2 labels.

- You can go through all of your patients and remove the diagnosis codes (this will be very time consuming)
- You can go through all of your patients and replace the diagnosis codes with the ICD-10 equivalent (this would be after the ICD-10 deadline of October 1, 2014) and would also be very time consuming.
- Set up the system setting DEFAULTDX with a value of '1' so that when posting charges the system will use the diagnosis codes from the previous claim instead of from the default diagnosis codes inside the patient information.
- Run a patient export list to show the primary and secondary diagnosis. This way you can get an idea on how many patients have the default diagnosis filled out and you can come up with a plan as to when and how you might want to tackle the primary and secondary diagnosis codes inside the Patient.

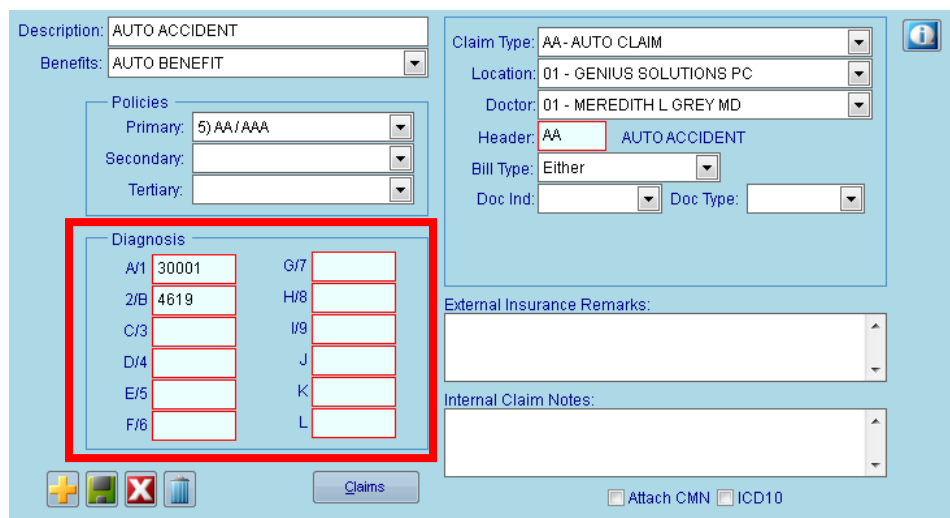
To run a Patient Export, click on the Patient Tab, click on the magnifying glass  if you are on a Patient in order to get to the Patient List screen. Once in the Patient List screen, click the Export button . You will be brought to an Export Fields screen. Select PATACTNO, LAST_NAME, FIRST_NAME, PRI_DIAG, and SEC_DIAG



The 'Export Fields' dialog box displays a grid of fields for selection. The fields are organized into four columns. The first column contains fields like PATACTNO, PATIENT_ID, LAST_NAME, FIRST_NAME, MID_NAME, ADDRESS, CITY, STATE, ZIP_CODE, PHONE, WORK_PHONE, WORK_EXT, FAX, OTHERPHONE, OTHERNOTE, EMGINFO, EMAIL, BIRTH_DATE, CASH_BAL, DOCTOR, INS_BAL, FIRST_DATE, REF_TYPE, LAST_DATE, REFERRAL, SEX, SOCIAL, STATUS, TITLE, and STMENT. The second column contains fields like APP_DATE, APP_TIME, APP_DR, APP_TYPE, SCHOOL, SC_CITY, ALERT, NOTES, VISIT, BUSNO, PRI_DIAG, SEC_DIAG, MAILLIST, LAST_STMT, LAST_AGED, CBAL30, CBAL60, CBAL90, CBAL120, IBAL30, IBAL60, IBAL90, IBAL120, LASTXRAY, INTRST, COLLECTION, INVOICENUM, REFNO, CASE_NUM, and MISC_DATE. The third column contains fields like PATFLAG, AUTOAPP, EXPIRED, NUMPTRANS, NUMCLAIMS, MISCDATE1, MISCDATE2, MISCDATE3, MISCDATE4, MISCDATE5, LASTUPDATE, GNAME, GFNAME, GLNAME, GADDR, GCITY, GSTATE, GZIP, GPHONE, GNOTE, GSOCIAL, GDOB, GEMPLOYER, GRELATION, RECALLINT, RECALLREM, PATTYPE, DOSPATID, USER, and COUNTY. The fourth column contains fields like EXPIREDATE, SIGSTART, SIGEND, CALLTYPE, EMPLOYER, CREATED, LASTUPTIME, VFC, SUFFIX, PCP, GREENFLAGP, GREENFLAGI, GFROM, GTO, GYEARLY, LASTPAY, LASTPAYAMT, CELLPHONE, ADAMSHIP, ADAMSWP, ADAMSCP, ADAMSOP, ADAMSFIX, ADAMSEMAIL, ADAMSSMS, PMC, LINKID, PTSTML1, and PTSTML2. The 'FIRST_NAME' field is highlighted with a yellow border. The 'Export' button is at the top left, and the 'Exit' button is at the top right.

Case Management

Diagnosis information entered within the case will default on the claim when posting charges if a case is chosen. A new case should be added to report ICD10 codes.



The 'Case Management' form is divided into several sections. The 'Description' section at the top left contains a text box for 'Description' (AUTO ACCIDENT) and a dropdown for 'Benefits' (AUTO BENEFIT). Below this is the 'Policies' section with dropdowns for 'Primary' (5) AA/AAA), 'Secondary', and 'Tertiary'. The 'Diagnosis' section is highlighted with a red border and contains a table with columns for diagnosis codes and descriptions. The table has two columns: one for codes (A/1, 2/B, C/3, D/4, E/5, F/6) and one for descriptions (G/7, H/8, I/9, J, K, L). The 'Claim Type' section on the right contains dropdowns for 'Claim Type' (AA - AUTO CLAIM), 'Location' (01 - GENIUS SOLUTIONS PC), 'Doctor' (01 - MEREDITH L GREY MD), 'Header' (AA), 'Bill Type' (Either), 'Doc Ind', and 'Doc Type'. Below the 'Claim Type' section are text boxes for 'External Insurance Remarks' and 'Internal Claim Notes'. At the bottom right, there are checkboxes for 'Attach CMN' and 'ICD10'.

Patient Referrals

There is diagnosis code information stored in the patient referral section, which can be used to create referral sheets to be sent to primary care physician for treatment. A new Patient Referral should be added once you are required to use ICD10 codes.

Patient Referral

SJ - 51 SMITH, JOHN
Cash: 0.00 Ins: 110.00

Description: CARDIOLOGIST Date: 10/03/2013
Insurance: BC - BLUE CROSS BLUE SHIELD
Referred By: 02-CHRISTINA YANG DO
Referred To: PALMER EDWARD PALMER MD
Diagnosis: 78650 PAIN CHEST
Date From: 10/01/2013 To: 11/01/2013
Location: Provider Office
Facility:
Visits: 0 Related To:
PCP Auth Dt: / / Ins Auth Dt: / /
Denial Dt: / / Ins Auth No:
☐ Revised ☐ Incoming
Comments:
Services:
☐ Consult or Office Visit
☐ Diagnostic Laboratory/Pathology
☐ Radiology/Imaging
☐ Diagnostic/Therapeutic Studies
☐ Injections & IV Therapy
☐ Allergy
☐ Audiology/Evaluation
☐ Cast/Fracture
☐ Oncology Services
☐ Dialysis
☐ OB/Perinatology
☐ Ophthalmological Services
☐ Surgery
☐ Pain Management
Other: Other:
Physical: 0 Occupational: 0
Speech: 0 Cardiac: 0
Templates:
Rename Template Make Template
Delete Template
Load Template

Reports Tab

Custom Reports

Any Custom Reports that have been previously set up to pull diagnosis information should be verified. Your office can either create new Custom Reports or modify the existing reports.

Custom Report - DIABETES

Name: DIABETES ☐ Names in Proper Case
Document:
Patient Type: All
Description: DIABETIC PATIENTS
Add Field

Combine	Not	Field	From	To	Equal	
AND	<input type="checkbox"/>	Transact Diagnosis			4619	

Service Analysis Report

The Service Analysis Report can contain diagnosis information. Please verify the information.

Service Analysis Report

Service Analysis Report - DIABETES

Name:
DIABETES

Description:
DIABETIC PATIENTS

Date From:
01/01/2013
To:
12/31/2013

Age From:
0
To:
0

Doctor:
System Summary

Location:
System Summary

Facility:

Sort Order:
Normal

☐ System Date
☐ Procedures with Insurance Balances Only

And

Procedure:

☐ Not

Date From:
To:

Procedures:

From:
To:

Financial:

From:
To:

Insurance:

From:
To:

Diagnosis:
25001

From:
To:

We have concentrated on giving you information from within eTHOMAS on where you should update diagnosis codes. We should now focus on one of the critical areas outside of the program, which is the Route Slip or encounter form.

Outside of eTHOMAS

Areas outside of eTHOMAS are just as important as those inside of the program. Whether you use pre-printed route slips (purchased from Genius Solutions) or one created in Microsoft® Word, you should begin thinking about what your plan is for your route slips or encounter forms after October 1, 2014 (provided you have diagnosis codes listed on your route slips). A suggestion is to create a cross-walk for your office. Take the diagnosis codes listed on your current route slip (these are probably your most commonly used diagnosis codes) and find the ICD-10 equivalent for these codes. There are many Internet sites you can use to begin your research. It is not recommended to change your existing route slip until you are more comfortable with ICD-10 coding. There has been some suggestion to leave the diagnosis code area blank on your route slip and allow the provider to write in the diagnosis.

If you have a pre-printed route slip, you will want to think about when and how much you should reorder of the route slips that have the ICD-9 codes listed. A suggestion would be to make photo copies of this route slip until you are ready to purchase new route slips with either ICD-10 codes or blank areas to write in the diagnosis codes. Don't be in a rush to order new forms right away. Get comfortable with the ICD-10 changes that are coming your way first. You will need to determine what codes your office will need on the route slip first anyway.

If you have a route slip created in Microsoft® Word, it is not advisable to change the existing route slip. Make a copy of that route slip and then you can begin making changes on the copy. Again, a suggestion would be not to rush into it but to think about what diagnosis codes, if any, you want on your route slip.

First, create yourself a cross-walk in order to aid you and your office. This cross-walk can also serve many functions. You will have created a guide for your office in which the commonly used ICD-9 codes will now have ICD-10 matches.