[CompanyLogo]

[product-name]™ User's Guide

This is a step-by-step guide on using *[company]'s [product-name]* tool.

Contents

1. Introduction

What Is *[product-name]*?

[product-name] is offers *[redacted]* through the final coding of a patient stay at a hospital. The end goal is to provide the most accurate claim-level coding possible.

Our integrated application helps streamline your workflow and builds synergy. Our content works together to provide:

- One integrated system to unite coders, *[role]* specialists, Charge Integrity, and management
- Increased productivity of clinical documentation and coding staff
- Specific communication with providers
- Cross-collaboration and seamless workflows for your teams
- Effective and immediate communication between coders and *[role]* specialists
- Concurrent working DRG at the beginning of a patient visit
- Trends related to *[role]* , coding, charging, and billing practices
- An improved overall case mix index
- Accurate Risk of Mortality and Severity of Illness Scores
- Reporting, dashboards, and quality indicators for a true and real-time reflection of care

Add-on Modules/Products:

- APR-DRG Grouper
- EAPG Grouper

Start *[product-name]* and Log In

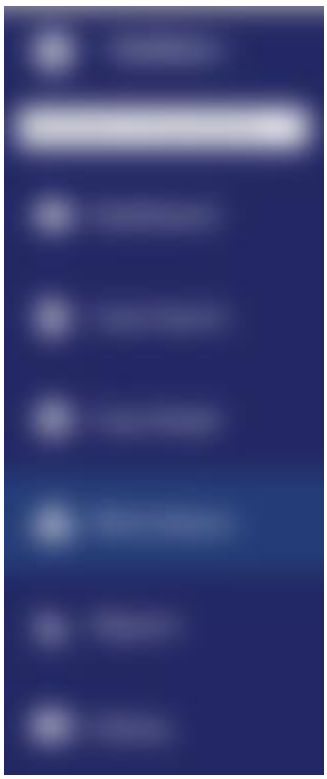
1. Use your web browser to navigate to the product portal: https://secure.*[company]*.com.
2. On the login page, type your username and password in the fields provided. Your username looks like this: *domain**userID*, where “domain” is your institution or organization.
3. Click **Sign in**.

   If you are having problems logging in, or the system isn’t behaving as expected, see Chapter 8, **Troubleshooting**, on page 70.

If you are at the product portal, click Products>***[product-name]***>.
[product-name] opens in a new browser page. By default, the **Dashboard** page appears.

Main Menu

[product-name]'s main menu is visible on the left side of the page. It provides navigation to all key areas of *[product-name]*. In this user guide, each menu item is described in a separate chapter.



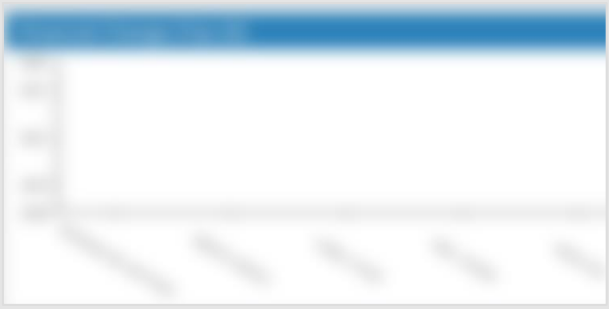
Entity Menu	Select your business entity. This is available if your organization has multiple business locations that use *[product-name]*.
Dashboard	View a set of graphs specific to your entity.
Case Search	Select from your HL7 cases.
Case Detail	When you select case from the Case Search screen you are brought to the Case Detail screen of that specific account.
Work Queue	This is a list of cases assigned to you for various work activity. It is where most users focus their attention.
Reports	Several reports are available for you to pull specific data related to your facility.
Library	Use the Library feature to review coding guidelines and information in the application without having to switch to another tool or browser page. Use this to keep your team up-to-date on advanced coding, regulatory and reimbursements.

2. Dashboard

The dashboard provides a set of graphs showing month-to-month changes that affect charge settlements. You can modify the graphs by clicking the legend entries on or off. This reformats the graph to properly display the remaining entries.

The following graphs are available:

Financial Change (Top 20)

This graph displays the changes in reimbursements that occurred after clarifications and optimal coding were performed. This typically results in a net positive change. This demonstrates the value in managing clarifications and medical coding.	

Clarification Responses

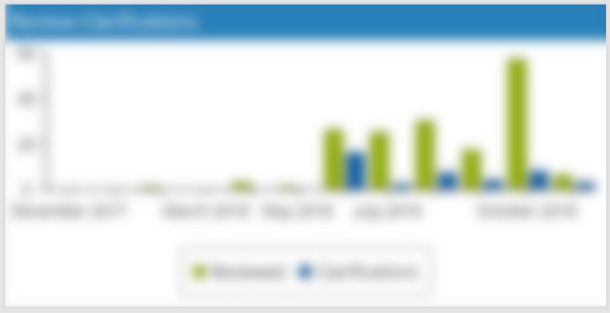
This graph displays a month-by-month count of clarifications and responses by type. This graph illustrates how the clarification process is being utilized.	
Clarifications	The total number of clarifications made.
Agreed responses	The number of agreements on the clarifications.
Disagreed responses	The number of disagreements on the clarifications.
No response	The number of undecided clarifications.
Other	Miscellaneous clarifications.

Agreed Rate

This graph displays the number of cases that were settled as agreed, and the agree rate. This graph illustrates the trend of how much communication was required to get an expected settlement. More communication indicates more time required per case and could indicate inefficient coding practices. Best efficiency is when the more recent green and blue bars are nearly equal.	

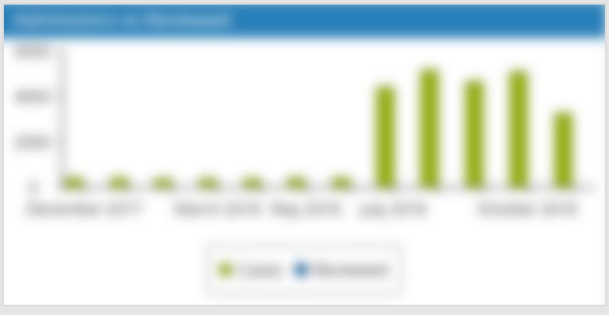
Cases	The total number of cases for the month .
Agreed	The number that are settled as agreed.
Agree Rate	The percentage of settled as agreed.

Review Clarifications

This graph displays the amount of communication required per case. Short (or nonexistent) blue bars indicate best efficiency.	

Reviewed	The percentage of cases that have been reviewed.
Clarifications	The percentage of cases that require clarification.

Admissions vs Reviewed

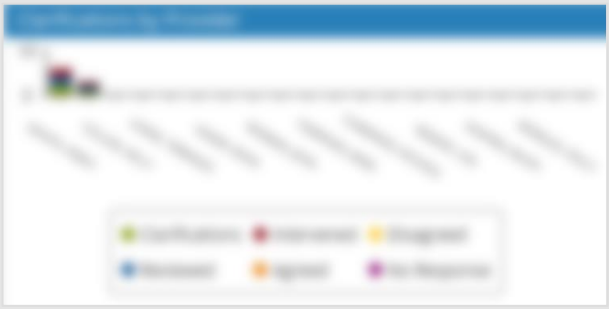
This graph displays the trend in admissions compared to those under review (not settled). Short (or nonexistent) blue bars indicate better efficiency.	

Cases	The total number of cases for the month.
Reviewed	The number of cases under review.

Clarifications by Provider

This graph shows the top ten providers that responded with changes.

This is a type of Pareto chart, which provides insight into issues that may need attention. For example, if a provider is showing many disagrees or no-responses, it could indicate a communication or training issue.



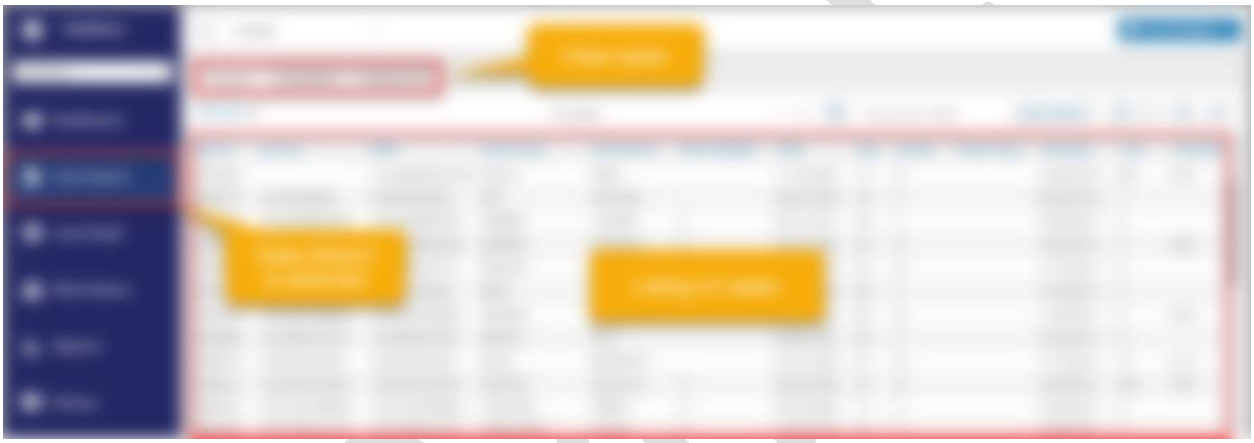
Clarifications	The provider generated a clarification.
Reviewed	The provider reviewed a clarification.
Intervened	The case is no longer applicable, sometimes due to a case having been transferred out of the system.
Agreed	The provider agreed with a clarification.
Disagreed	The provider disagreed with a clarification.
No Response	The provider did not respond to a clarification.

3. Case Search

Case Search is used to find an individual case or set of cases that matches the parameters you provide.

- The default view lists all patients in your facility.
- Depending on your facility and how your account is configured, you may be able to select among Inpatient, Outpatient and Professional. These places of service are selectable in the tabs near the top of the listing. Most *[product-name]* users are concerned with just one of these places.

Note: In *[product-name]*, a *case* is a medical record that corresponds to a patient. A *patient* contains attributes on which a search can be performed.



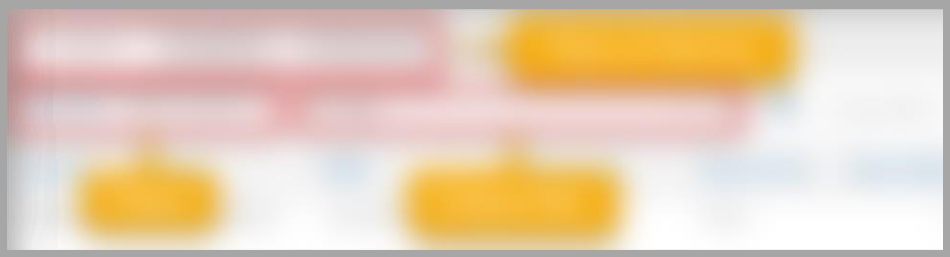
The listing can be sorted on any table column by clicking on a column header.

The table columns can be resized, rearranged, added or removed to suit your preference.

Where are the cases?

If you case list is short, non-existent or unfamiliar, check the following:

- Is the correct Place of Service (case types) selected?
- Are filters applied? If you save a filter it persists even if you log off.
- Is the correct Default Filter selected?



How to Customize the View

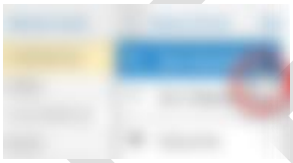
The Case List is customizable. Customization options are available for the Case List tab as well as individual reports. Within the display area, hover over any of the column headings to reveal a down arrow.

To access the view customization options in a drop-down list, click on the down arrow in the heading.

How to Sort the List

The entire table can be sorted either ascending or descending on any column.

1. Hover over a column header name.
2. Click the drop-down control.
3. Click on **Sort Ascending** or **Sort Descending**.



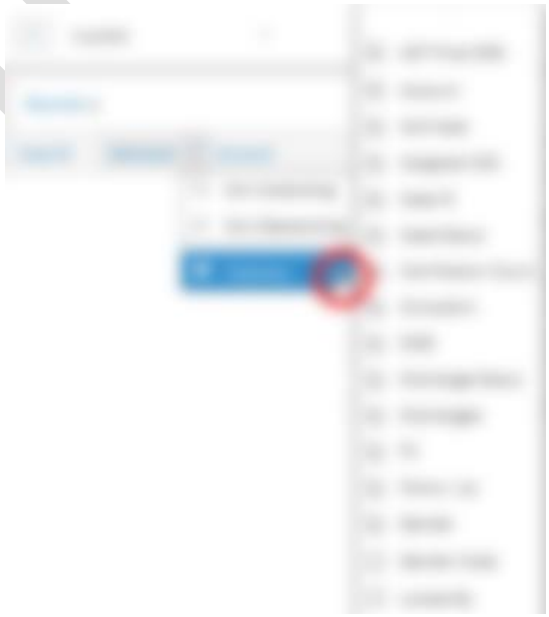
How to Rearrange the Columns

Click a column header, then drag it left or right to a new position.

How to Add or Remove Columns

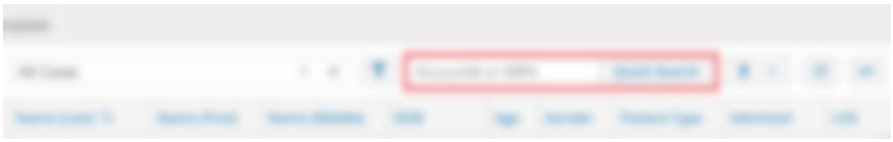
Columns can be selected for display or hidden from the grid.

1. Hover over a column header name.
2. Click the drop-down control.
3. Select the expand control on the right of **Columns**.
4. Select or de-select a checkbox to display or hide a column.



How to Find a Case

Use Quick Search to Find a Specific Case

Quick Search is located on top of the Case Search page.	

To use Quick Search, type either an account number or an MRN in the field, then click the **Quick Search** button. It automatically opens the corresponding account. If an MRN is entered, it will display a list of accounts corresponding to that MRN.

- A **Medical Record Number** (MRN) is most often used to look up a patient's health records. An MRN is unique to a patient and provider, but not necessarily unique among different providers.
- If a patient is admitted and has an MRN, an **Account Number** is assigned. Account numbers are unique to each patient admission. A patient's account number and MRN are often identical; however, they will differ when a patient is admitted more than once or has been seen at multiple locations.

Quick Search is not case-sensitive but must include any special characters such as a hyphen (-).

If an *exact match* is found, the **Case Detail** page will open.

Case ID is *[company]*'s internal numbering system for tracking cases. It is unique for each patient and admission.

Use Filters to Find Multiple Similar Cases

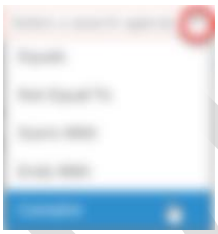
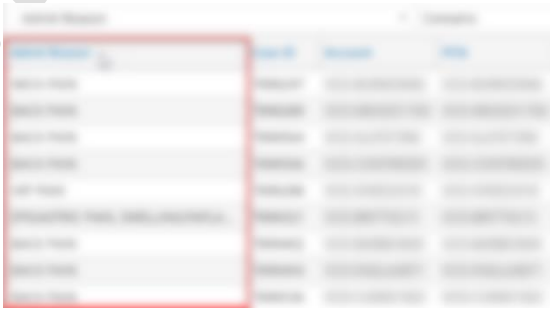
The default view of Case Search can contain hundreds or thousands of records. Use one or more filters to reduce the results based on criteria you provide.

Filters are available on *[product-name]* pages that display information in tabular form, such as on **Case Detail**, **Work Queue**, **Reports** and **Library**.

Searching on a Text Phrase

This example shows how to find one or more admissions where the reason includes the word "pain".

1. Click the Filter icon.	
Notice a new field appears. This is where you specify how to filter.	

2. Click the drop-down list. 3. Select a field to filter. In this example, select **Admit Reason**.	
4. In the field to the right, click the drop-down control and select a *search operator*. This is the method by which Search finds a match. In this example, choose **Contains**.	
5. In the next field to the right, click inside the field and type your filter text. In this example, type **pain**. (Text search is not case-sensitive.) The search text can be anything you want. Shorter text searches will more often return better results. 6. Click Search.	
Note that the list of cases is much shorter, where the **Admit Reason** column contains the word "**pain**" by itself or with other words.	

From here, you can sort the list by clicking a column header or narrow the results further by adding another filter.

As you become familiar with how search works, you'll become a power-user.

Each column has a different set of search operators. The remainder of this section provides more examples of how to use search.

Searching on a Numeric Range

To search a range of values, such as an account number, select the “Between” operator. Type a numeric range in the two fields.

Search on a Patient Sex

Searching on a patient’s sex can be:

- Male, Female.
- Unspecified. Use this for patients whose sex hasn’t been determined.

Search on a Date or Date Range

When you are searching by Admittance Date, you usually know the exact or an approximate date. The operators available are:

- Equals
- Not Equal To
- Greater Than
- Less Than
- Greater Than or Equal To
- Less Than or Equal To

To search a date range, such as Admit, Discharge or Follow-Up date, select the “Between” operator. This opens two date fields. You can either type the date in the boxes (format is: mm/dd/yyyy) or click the Calendar icon and select a date.	

Searching on a Case Status

You can search on a patient’s Case Status.

Available operators:

- Equals
- Not Equal To

The status you select can be one of the following:

- Assigned
- Closed
- Completed
- In Progress
- Unassigned

Clearing Search Filters

To clear (remove) all filters, click the Clear button.

To clear a single filter (if there are multiple), click the delete icon next to the filter you want to delete.

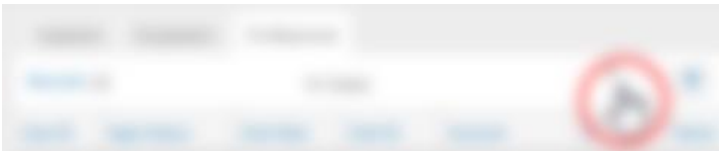
Place of Service Tabs

Case Search has several tabs at the top of the page where you can select the place of service. This is where you can specify the general category of cases to display.

Tab Name	Description
Inpatient	This is the default category. This displays all inpatient cases.
Outpatient	This displays only the outpatient cases.
Professional	This displays cases from professional services such as doctor's offices and clinics.

Inpatient Case Types

If you are viewing the Inpatients, you can select from several built-in case types. By default, "All Cases" is selected. You can change this by clicking the drop-down control next to "All Cases" and then select the case type.



Case Type	Description
All Cases	(default) This displays all cases in this category.
Census List	This displays all currently-admitted cases.

Case Type	Description
Discharge List	This displays the admitted cases that have been recently discharged.
Follow-up List	This displays cases that have been flagged for follow-up.
Retrospective	This displays cases that have been discharged but have been recently reexamined.
Reviewed Clarifications	This displays cases that have been previously reviewed.
Rounding List	This displays all currently admitted cases.
Sent Electronically	This displays cases that have been previously reviewed and send electronically.

Case Search Columns

Column	Description
Account	This is the facility-based unique account number assigned to the patient.
Admin Reason	This is the reason the patient was admitted. Often, this is the medical symptom or issue given by the patient as the reason for the visit, and not necessarily the diagnosis entered by an admitting provider.
Admit Reason Code	This is the code that identifies the reason the patient was admitted.
Admitted	This is the date the patient was admitted.
Admitting Provider	This is the provider who admitted the patient.
Age	This is the age of the patient.
Assigned CDS	This is the name of the CDS assigned to the case.
Assigned Coder	This is the name of the Coder assigned to the case.
Attending Provider	This is the provider who is attending to the patient.
***[role]* Review Status**	This is the status of the *[role]* review.
Case ID	This is the facility-based unique case ID provided to the patient.
Case Status	This is the status of the case.
Clarification Count	This is the number of clarifications completed for that patient.
Coding Priority	This is the assigned coding priority for the case.
Coding Status	This is the status of the coding for the case.
DOB	This is the patient's date of birth.
Discharge Disp	This is the patient's discharge disposition, where they went upon discharge.

Column	Description
Discharged	This is the date the patient was discharged.
FC	This is the financial class of the patient.
Floor	This is the This is the facility floor where the patient is being treated.
Follow-Up	If flagged, the case should be followed-up by the CDS or Coder.
Gender	The patient's gender.
Gender Code	The patient's gender code.
Insurance	The patient's current insurance coverage.
Locked By	Indicated if the case if locked by a CDS or Coder.
MRN	The patient's unique Medical Record Number.
Name (First)	The patient's first name.
Name (Last)	The patient's last name.
Name (Middle)	The patient's middle name.
PCN	The facility-based Patient Case Number.
Patient Type	The patient's facility type, for example, Inpatient, Outpatient.
Review Type	The CDS review type – concurrent, retrospective, etc.
Room	The facility room number where the patient is located.
Service	The service the patient is receiving.
Total Charges	The patient's total dollar amount, as received from the Healthcare Information System.
Type of Bill	The facility-specific bill type.
UPID	The physician's Unique Provider ID number.
Unit	The unique facility unit where the patient is being treated.

4. Case Detail

When you select a case using Case Search or your Work Queue, that case detail is populated here.

Each time you select a case, a new case tab opens in Case Detail. There is no limit to the number of cases that can be opened, however excessive case tabs can slow your computer.

Action Tabs

Each of these tabs are discussed in detail later in this guide.

Case Detail tab	This tab contains the top-level case information.
Clarifications tab	This tab lets you create and track clarifications to and from a medical provider. The number in parenthesis indicates how many clarifications have been created.
***[role]* tab**	This tab lets *[role]* specialists assign billing codes during the concurrent *[role]* review process. This content drives the working DRG.
Coding tab	This tab lets coders review the *original codes* produced by the admission team, and *working codes* produced by the *[role]* team, accept as-is or make changes, then approve and finalize for billing.

Case Detail Tab

This is the default view when you open a case. From here, you can review the patient's demographic information, and a summary of that patient's work state for *[role]* and or Coding along with comments from team members that have touched the case. All action tabs are accessible through this page.

1	**Patient Demographic**	This is automatically populated from the ADT feed and cannot be manually modified within *[product-name]*. This includes information about the patient, admission and discharge dates, unit, attending physician and financial class. If no data is available from the ADT feed, this area will be blank.
2	**Workflow**	These tabs let you change the *[role]* and/or Coding workflow (depending on your system configuration). For example, review case status and assignments for the *[role]* process and separately the Coding process.
3	**Real time Reimbursement Tracking**	For Inpatient cases, MS-DRG grouping and APR-DRG grouping information is displayed in real-time based on original, working and final DRG assignment. For Outpatient cases, APC grouping and EAPG grouping information is displayed in real-time based on original, working and final reimbursement.
4	**Comments**	Use this to add general comments about the case. Comments indicate who created them and when, and are visible to everyone.

Workflow Tabs

Note: Depending on your system configuration, you may have *[role]* , Coding or both tabs present in this panel.

The following information is displayed in the Workflow tabs:

Case Status	The Case Status drop-down menu is used primarily for internal tracking of workflow by the *[role]* member. **00** Unassigned – Not assigned for review **05** Assigned – Assigned for review **10** In Progress – Currently being reviewed **20** Completed – Review completed **21** Closed – Review closed with or without review
Review Status	The 'Review Status' drop-down menu is used to indicate the state of the review activity on the case. The default setting for this list is **00 – No review performed**. Any change from this default setting indicates that a review was performed and will impact the number of 'Reviewed' cases in reporting. **00** No review performed **01** Chart not available **02** Not enough information Available **03** Post-discharge review initiated **05** No clarification needed **10** Intervened – Open for further review **25** Patient discharged - retro follow-up needed **26** Patient status changed (IP to Observation, or Insurance change)
Assigned CDS	The 'Assigned CDS' field will either display blank or will display the CDS member who has been automatically assigned if your facility is using the auto-assign function. Members of your facility are added to the 'Assigned CDS' drop-down list upon their initial login to *[product-name]*.
Case View Count	The 'Case View Count' is an automated calculation that indicates the number of times the selected case has been opened and a change has been saved on either the 'Account Detail' tab or the' Clarifications' tab.

Follow-Up Date	The 'Follow-Up Date' is blank by default but can be updated by selecting the calendar icon.
Review Type	The 'Review Type' indicates whether the review is concurrent or retrospective. **Concurrent:** The patient is admitted. **Retrospective:** The patient has been discharged.

Real-Time Reimbursement Tracking

This information is automatically assigned when coding is captured in the Original, Working and Final Coding tabs. This is designed to track the patient's journey through the case coding process.

Inpatient Cases

These fields are initially blank and require manual completion.

Series	This displays the set of DRG codes for admission (Original), in-progress (Working), and at patient discharge (Final). **Original** This is assigned to the case upon patient admission. This automatically populates from your Hospital System. **Working** This is assigned during the patient's stay. This automatically updates when a DRG code change is made in the *[role]* tab. **Final** This is assigned at or following the patient's discharge. This is automatically filled from your HL7 ADT feed, when it becomes available.
Code	The specific DRG code.
Description	This description is automatically pulled when the DRG code is assigned.
Estimated Reimbursement	The estimate reimbursement based on the assigned DRG
SOI	APR-DRG Severity of Illness (SOI). This is an APR-DRG numeric assignment, usually 1–4, of the illness severity.

ROM	APR-DRG Risk of Mortality (ROM). This is an APR-DRG numeric assignment, usually 1–4, of the risk of dying from the illness.
Weight	The estimated significance of severity based on the assigned DRG.

If you manually enter data into these fields, it's not necessary to scroll through the entire list of options. As you type the first few characters of the DRG code, the drop-down list includes only the matching codes.

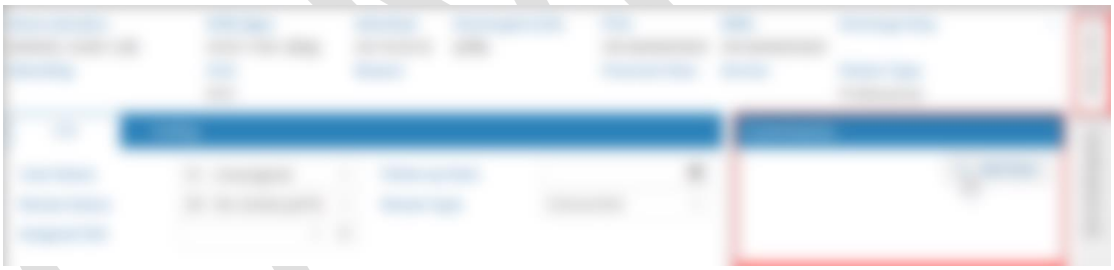
For Original, Proposed and Final APR-DRGs, the results in the drop-down list behaves the same way. Each drop-down list includes the relevant APR-SOI and APR-ROM selections.

***Note**: The APR-DRG function does not currently have financial data tied to it; thus, it will not affect financial reports.*

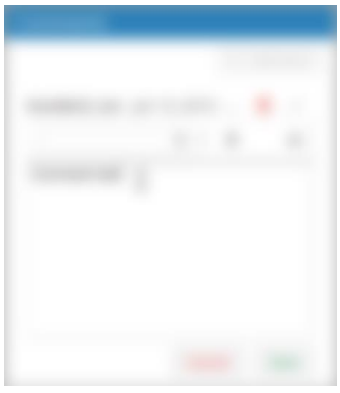
How to Add a Case Comment

To add a case comment:

1. Select the **Case Detail** tab.



2. In the Comments panel, click **+ Add New**.
3. Place the cursor in the text field and type your comments.
4. When finished, click **Save**.



To add a comment to a *Clarification*, see **Comments Tab**, on page 27.

Clarifications Tab

The Clarification tab lets you create clarifications along with tracking clarifications submitted to a provider for the patient. The number in parenthesis indicates how many clarifications have been created. The number in parenthesis on this tab indicates the number of clarifications that have been created for the selected case.

1	**Patient Demographic**	This includes information about the patient, admission and discharge dates, unit, attending physician and financial class.
2	**Clarifications list**	This is a list of clarifications that have been created for this case.
3	***[Redacted]***	This is *[company]*'s ICD *[Redacted]*™ intelligence to help users identify what terminology is required for code assignment based on the condition being reviewed. By choosing what has been documented the ICD *[Redacted]* engine will display what terminology is missing there by providing the basis for a coding clarification.
4	**Preview**	This is an electronic view of the clarification form that is being created or has been sent.
5	**Clarification Detail**	Use this panel to complete the key information for the Clarification Form.

Patient Demographic

This section is automatically populated from the ADT feed and cannot be manually modified within *[product-name]*. This includes information about the patient, admission and discharge dates, unit, attending physician and financial class. If no data is available from the ADT feed, this area will be blank.

Clarifications List

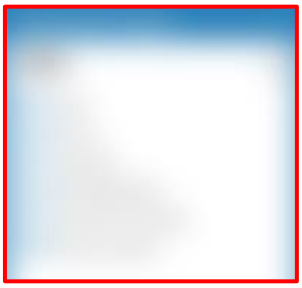
This section displays the clarifications that have been previously created. To open one of these clarifications for further review or documentation, double click on the line of the clarification you wish to open. It will display in the lower section.

Column	Description
	Delete icon. This is available only for clarifications you create.
	Document icon. View and print the clarification as a PDF document. This appears in a separate browser tab.
	Attachment icon. If a paperclip appears in this column, the respective clarification has an attachment.
Author	The name of the CDS or Coder who created the Clarification.
Case ID	Facility based unique case ID provided to the patient.
Clar ID	The unique clarification number.
Clar Provider	The provider to whom the clarification was sent.
Clar Provider Role	The provider's role – Admitting, Attending, etc.
Created	The date the clarification was created.
Delivery	The method used to deliver the clarification to the physician.
Reason	The reason the clarification was created.
Response	The response received from the physician.
Status	The name of the CDS or Coder who created the Clarification.
Status Code	Facility-based unique case ID provided to the patient.

The lower section of the display allows you to either view/edit previously created clarifications or create new clarifications.

Using *[Redacted]* for Clarifications

This is *[company]*'s *[Redacted]*™ intelligence to help users identify what terminology is required for code assignment based on the condition being reviewed. By choosing what has been documented the *[Redacted]* engine will display what terminology is missing there by providing the basis for a coding clarification.



Any applicable concepts in the patient record can be selected in *[Redacted]* to narrow down the possible remaining terms to identify what is missing in the documentation to get the most specificity of a code assignment.

In this example, the documentation lists the Type, Acuity and Severity/Grade. When options are selected in *[Redacted]*, they are added to the clarification form, as shown in the Preview.

When only one concept needs to be addressed, you can choose whether to include the other concepts in the clarification by selecting the respective check boxes.

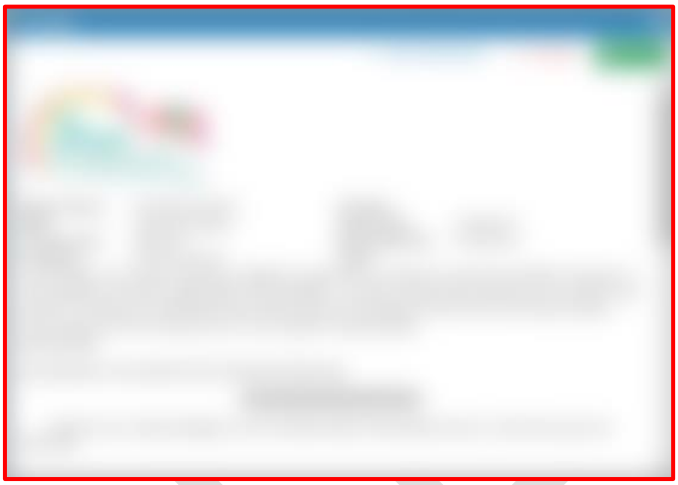
Also see "*Launch PDF Clarification*" section later in this document.

Preview Panel

This is an electronic view of the selected clarification form.

The top of the preview has these icons:

+ New Clarification	Create a new clarification.
× Cancel	Your changes are discarded.
Save	Your changes are saved. **Note**: If you selected "Electronic Delivery", **Save** will ask if you want to send to the recipient immediately.



Clarification Detail Panel

Use this panel to complete the top portion of the Clarification message.

This panel has the following tabs:

	Form Edit. Use this tab to fill out the clarification message.
	Comments. Use this tab to add your own comments. These Comments are tied to the clarification but are *not* included in the actual clarification itself.
	Attachments. When an attachment is added to a clarification, a paperclip icon appears in the respective column.

Form Edit Tab

Heading	Description
Form	Select a form from the drop-down list. The list of available forms is specific to your institution. Some forms activate the *[Redacted]* panel. Use *[Redacted]* to specify details.
Author	Your name is inserted here automatically and cannot be changed.

Heading	Description
Reason	Type a short reason description for this clarification message. **Note**: some form types will prefill this field. For example, the Heart Failure form will prefill this field with "CHF". You can still edit this text.
Delivery	Select the method for sending the clarification message. • Select **PDF** if you intend to print and deliver a hard copy. • Select **Electronic Delivery** to have the document automatically sent to the physician's Health Information System (HIS) in-box.
Provider	Select the recipient from the drop-down list. When creating a new clarification, this field defaults to the person listed as Attending in the Account Detail tab. The drop-down list contains all providers included on any cases that have been previously received via your ADT Feed.
Provider Role	This field is blank by default when a new clarification is created. Select the recipient's title from the drop-down list.
Status	This field is blank by default when a new clarification is created. This field is used primarily for CDS workflow tracking and is not included in any reports. Select a clarification status from the drop-down list: **10** Clarification form left on chart **15** First clarification follow-up **16** Second clarification follow-up **35** Clarification verbal – no form left on chart **38** Initial clarification sent to provider electronically **40** Clarification forwarded to Documentation Services **45** Clarification reviewed **46** Clarification sent to the physician's electronic in-box. This status is automatically sent when the Clarification has been sent to the recipient. **47** Clarification sent to the physician's secure HIS in-box. **48** Clarification will be presented in-person

Heading	Description
Response	Select a clarification response from the drop-down list: **01** Provider agreed with clarification, note on chart **02** Provider agreed with clarification, no note on chart **04** Hospitalist group member agreed with clarification, note on chart **05** Provider did not respond to clarification **08** Provider unable to determine clinically **09** Clarification is no longer necessary **10** Provider disagreed with clarification, note on chart **11** Provider disagreed with clarification, no note on chart **13** Hospitalist group disagreed with clarification, note on chart **22** Clarification closed within "x" business day hold limit **23** Provider agreed with Documentation Services clarification response **24** Provider disagreed with Documentation Services clarification response
Instructions	This field is blank by default and is a free text field. Use this to add your own words to the query/clarification. The information captured in this field will be transferred to the PDF Clarification Form.

Comments Tab

Use this tab to add comments to the Clarifications message.

Clarification Notes are for CDS use and will not transfer to the Clarification Form. This area is designed for CDS users to document any pertinent information they may want to reference later, as it relates to the case. This section can be expanded to accommodate more notes.

If you add a comment, be sure to click **Save**.

Attachments Tab

Use the paperclip tab to attach documents, pictures or other related files. You can add multiple documents to a clarification.	

The lower section of the display allows you to either view/edit previously created clarifications or create new clarifications. The lower section of the screen can be expanded upwards by hovering over the page split until the arrows appear and then dragging the split upwards to your desired location.

How to Find a Clarification

When a *[role]* Specialist wants to ask a question or get further detail on a case, this is when a *Clarification* is created. A clarification is a formal request for additional information, to double-check on existing information. A clarification (and any responses) become part of the case history.

1. Select a case, either from your **Work Queue** or by using **Case Search**. The case information opens the case in the **Case Detail** page.
2. In the *Validation tabs*, click on the **Clarifications** tab.
3. Check the existing clarifications to see if your question has already been addressed. Do this by clicking on the clarification

How to Create a New Clarification

1. To create a new clarification, click **+ New Clarification** in the *Preview* panel.

Your new (blank) clarification in the Clarifications list.

The delete icon indicates that you created this clarification, which means you can also edit or delete it.

2. The *Preview* panel shows what the clarification will look like. The *Edit* panel lets you customize the clarification to your needs.
3. The **Form Edit** tab in the *Edit* panel should already be selected. Use this tab to fill out the clarification message.
4. Start with the **Form type** selection and work your way down the list of fillable fields.
    - **Note**: Some forms activate the ***[Redacted]*** panel.
5. Refer to Form Edit Tab for an explanation of each field.
6. Look over the Preview to verify the content.
7. Click **Save**.

If "Electronic Feed" was selected as the delivery method, you have the option to send it immediately to the recipient.

The recipient receives the document in their in-box. Also, the Status field is automatically updated to reflect this.

How to Update a Clarification

If an existing clarification needs more information, follow these steps:

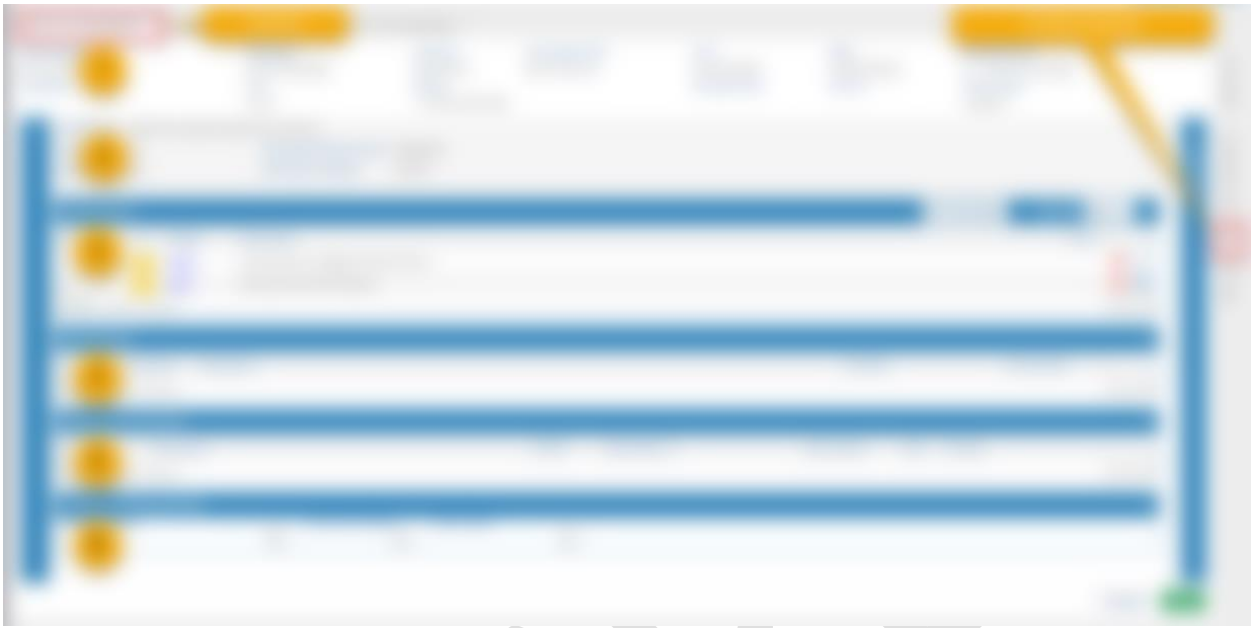
1. Find the relevant case. Use the **Case Search** menu (blue menu on the left) or select the case from your **Work Queue** (also from the blue menu).
2. Click on the **Clarifications** tab on the right side of the page.
3. In the **Clarifications List**, click the clarification you are interested in.
4. In the clarification, perform your update. The most updates in a clarification are:
    - Changing the Clarification Status and/or Response
    - Providing additional information, such as a *[Redacted]* codes
    - Providing additional instructions to the physician
5. When you are finished, click **Save**.

How to Print a Clarification

To view a clarification in a separate browser page, or to print a clarification follow these steps:

1. Find the relevant case.
    - Use the **Case Search** menu (blue menu on the left) or select the case from your **Work Queue** (also from the blue menu).
2. Click on the **Clarifications** tab on the right side of the page.
3. In the **Clarifications List**, click the corresponding document icon.
    - The clarification appears in a PDF viewer, in a new browser tab.
4. From the PDF viewer, click the print icon to send the document to your printer.

[role] Tab



1	**Patient Demographic**	This is automatically populated from the ADT feed and cannot be manually modified within *[product-name]*. This includes information about the patient, admission and discharge dates, unit, attending physician and financial class. If no data is available from the ADT feed, this area will be blank.
2	**DRG Summary**	If there are codes assigned and the case has been grouped, the DRG If there are codes assigned and the case has been grouped, information such as the LOS and the estimated reimbursement are displayed.
3	**Working DX panel**	During the review process and completion of the clarifications, this is where relevant diagnosis codes are captured. These codes are *reference-only*. They do not go back to the financial system but drive the Working DRG.
4	**Working PX panel**	During the review process and completion of the clarifications this is where relevant inpatient procedural codes are captured. These codes are reference only (do not go back to the financial system) but drive the Working DRG.
5	**Working CPT / HCPCS panel**	During the review process and completion of the clarifications, this is where relevant procedures/supply codes are captured. These codes are reference only (do not go back to the financial system) but drive the Working APC.
6	**Uniform Billing (UB-04) panel**	This is the additional information needed on the UB-04 **Condition Codes** — Identifies provisions and certain circumstances, such as billing for denial or medical appropriateness, with a bill.

		Occurrence Codes	Indicates events that occurred over time and affect payment, such as a qualifying three-day stay.
		Value Codes	Used for SNF stays, indicates number or covered days.

PX, DX, CPT/HCPCS, Uniform Billing Panels

These panels provide the following information:

P	Position. The number in this column designates the sequential order of the code.
S	Matching sequence.
F	Return Flags, populated from the grouper.
H	Flags for HAC and HCC
Diag(s)	This shows the ICD-10 diagnosis codes assigned to the case. The blue underlined text indicates a hyperlink. When clicked, this provides helpful coding information in the Validation panel.
Description	This shows the ICD-10 description for the diagnostic code.
RC	Revenue Code
HCPCS	Healthcare Common Procedure Coding System HCPCS code.
Mod Codes 1-4	Modifier codes.
Service Date	Date the service was provided.
UOS	Unit Of Service.
Provider	Name of provider who performed the service.
→ Pull Codes	In the *[role]* tab, this copies (or pulls) any codes from the original to the working series. In the Coding tab, this copies any codes from working to final. The benefit is combining several steps (involving expanding the left panel) into this one step. If this button is disabled, it indicates that there are no codes to pull.
Admit DX:	Admitting diagnosis.
Batch POA ▾	This lets you select a “Present On Admission” (POA) code to multiple lines at one time.

Icons

Ⓟ	Primary which has a CC or MCC listed and could potentially be the Primary
P	Primary Diagnosis
HCC	The code is a Hierarchical Condition Category (HCC).

HAC	The code is a Hospital Acquired Condition (HAC).
MC	Major Complication or Comorbidity, which *does* affect the DRG
MC	Major Complication or Comorbidity, which *does not* affect the DRG
CC	Complication or Comorbidity, which *does not* affect the DRG
CC	Complication or Comorbidity, which *does* affect the DRG
	You can delete the code if needed.
	There are no comments, but you can add your own.
	There are unsaved comments. Click **Save** to preserve them.
	A comment is available for viewing, and you can add your own.

How to Add Codes

There are multiple ways to add a code to a case.

Pull Codes

Click Pull Codes **Pull Codes**.

- On the ***[role]*** tab, this adds the *original* codes into the *working* codes panel.
- On the **Coding** tab, this adds the *working* codes into the *final* codes panel.

[Redacted] Quick Search

1. Place the cursor inside one of the "Search *[Redacted]*…" fields.

2. Type a at least three characters of the code you want to add.
3. If *[Redacted]* finds one or more matches, they are displayed below the search field.

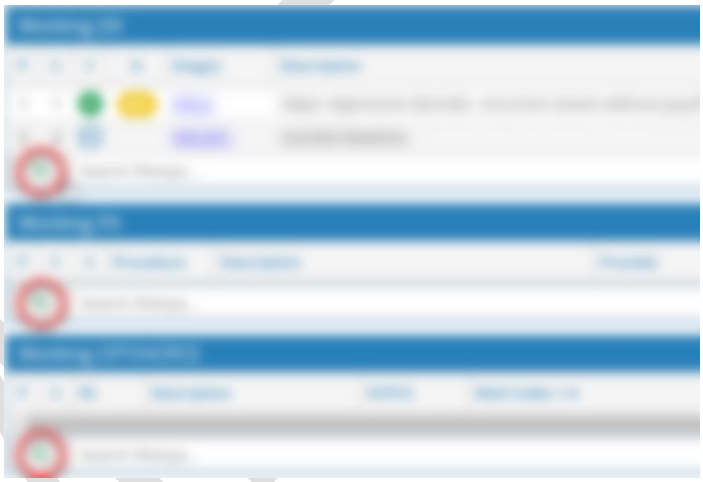
4. Click the code you want to add.

This code now appears in the working codes list.

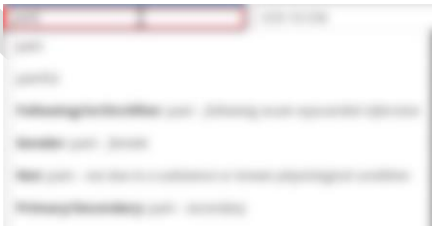
Note: In order to validate, you must specify the provider's name to the code. Type at least two characters in the highlighted field, then select from the drop-down list.

Code Lookup

1. Using *[Redacted]*, click one of the spyglass icons. This opens the **Code Lookup** window.



The *Code Lookup* window includes a left panel search and a main grid/main display area on the right. Access to additional information can be found in the lower panel.

2. Place the cursor in the Search field. 3. Type a at least three characters of the code you want to add.	
4. If *[Redacted]* finds one or more matches, they are displayed below the search field.	
5. Select a data set from the drop-down list. **ICD-10 CM** is the default.	
6. Click **Search**.	

The Code Lookup panel populates with a variety of views into the data set.

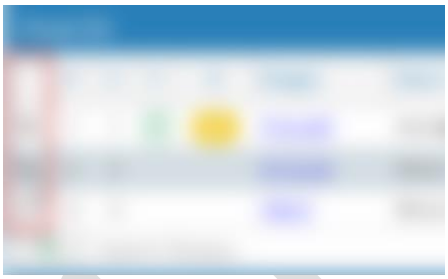
7. The panel on the left is *[Redacted]*'s concept categories. Use this to narrow the code results, shown in the Codes panel (lower-right). Each time you click on an item, it reduces the results based on the selections.
8. Click on a code (blue underlined link).
9. The view switches to Code Detail panel.
10. If this is the code you want, click **Select Code**. You can add as many codes as needed.
11. When finished, click **Add Selected Codes**. This closes the Code Lookup window and adds the code to the series.

Note: In order to validate, you must specify the provider's name to the code. Type at least two characters of the provider's last name in the highlighted field, then select from the drop-down list.

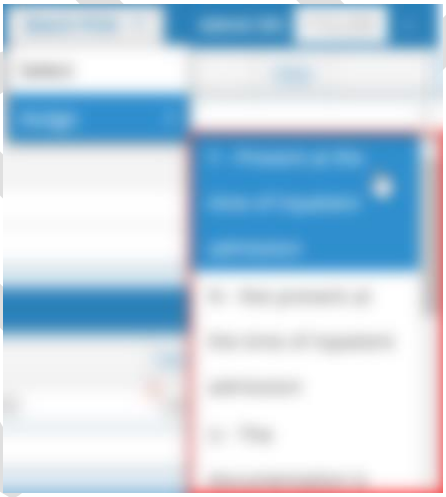
How to Assign POA to Multiple Codes

1. In the Final DX panel, click Batch POA.
2. In the drop-down, click **Select**.

3. A new column appears on the left side of the panel.
4. Select (click) each code that was Present On Admission (POA).



5. Click Batch POA again.
6. In the drop-down, click **Assign**.
7. Select the POA reason from the 2nd drop-down list.



The selections are:

Y Present at the time of impatient Admission. This is the most common selection.

N Not present at the time of inpatient admission. Use this to *remove* the POA assignment on the selected codes.

U The documentation is insufficient to determine if the condition was present at the time of admission.

W The provider is unable to clinically determine if the condition was present at the time of inpatient admission.

1 Unreported/Not used. Exempt from Present On Admission reporting.

How to Change the Code Priority

Whenever a panel contains two or more codes, you can change which one is tagged as the primary. This can potentially alter the payout.

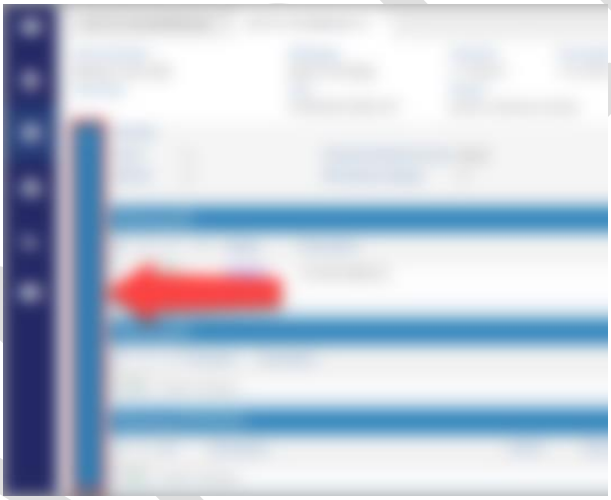
To change which one is primary, click anywhere on a code and drag above or below the others. Whichever code now appears at the top of the list becomes the new primary code.

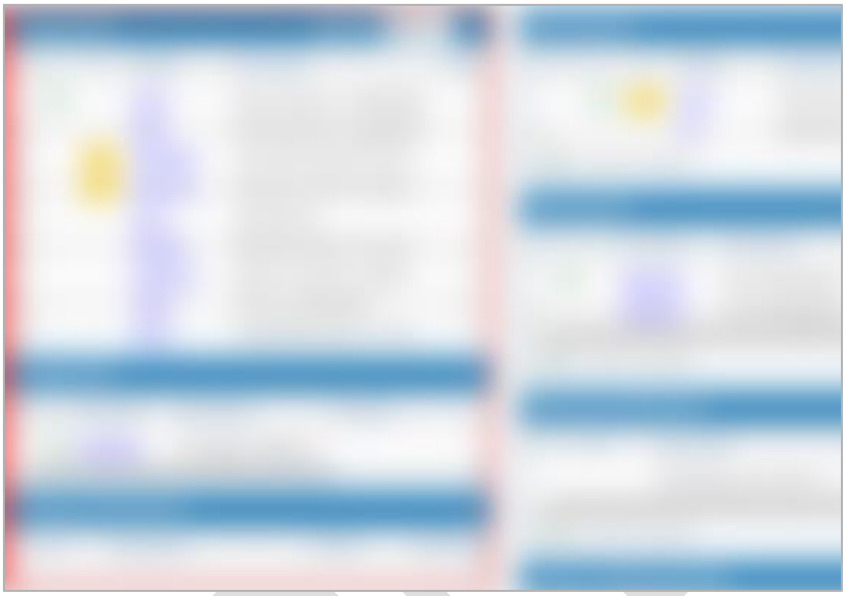
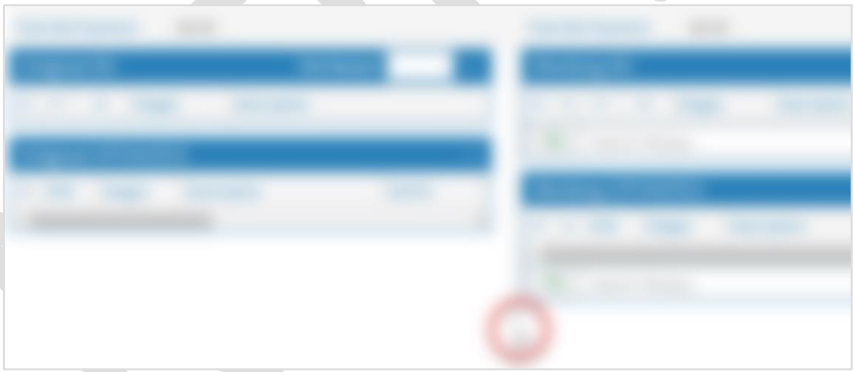
Original DX/PX, CPT/HCPCS Codes Panels

When using the ***[role]*** tab, normally you are concerned with the just the Working codes.

The Original codes panels are normally hidden in a collapsed panel on the left part of the page.

To view the Original and Working codes side-by-side for comparison, click on the blue bar on the left side of the page.



When the Original codes panels are open, they appear to the left of the Working panels. This lets you examine what codes have changed since the patient was admitted.	
To close the Original codes panels, find and click the "<" collapse icon in the margin between the two panels.	

[role] Validation Panel

This is the coding validation panel. The panel is normally collapsed to a vertical blue bar, as shown.	

When you are ready to perform a validation on your codes, click on the blue Validation bar to open it.	

If you see "'Validate' to see results", this means there are charges for codes that have not been computed.

1. Select what type of validation you want to perform from the drop-down list.
    a. For Outpatient (OP) cases, *[product-name]* will let you select APC or EAPG from this list.
    b. For Inpatient (IP) cases, you will be able to select MS-DRG/APR-DRG.
    c. For Professional cases, there are no validation options.
2. Click the **Validate** button at the bottom of the panel.

If these buttons are disabled, this indicates that the charges have been sent to billing and the case is complete.

DRG tab	DRG information.
PDX tab	Provides additional DRG information if a different PDX is selected.
DRG+ tab	Provides potential DRG information if additional diagnosis codes are added to the claim.
Edits tab	Provides potential edits for the claim based on the codes.
XRef tab	References available for codes submitted.

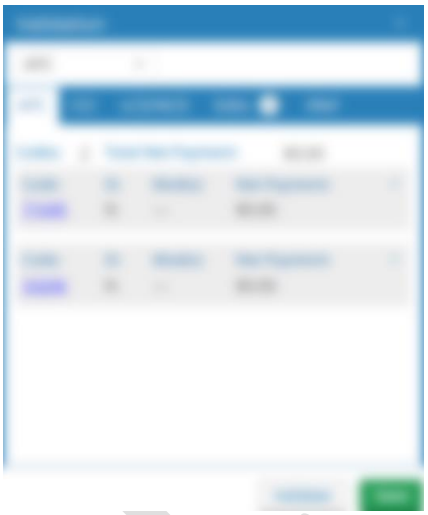
When you are ready to release the validated coding to billing, click **Complete**. Once you do this, no further changes can be made.

Click **Validate** to compute the code charges.

Click **Save** to save any changes you make, such as comments and coding changes.

Select the type of validation you want to perform:

APC	This is the outpatient (OP) Ambulatory Payment Classification (APC) codes.
MS-DRG, APR-DRG	These are the two Diagnostic-Related Groups for inpatient (IP).
EAPG	This is for outpatient Enhanced Ambulatory Payment Grouping (EAPG).
CCI	OP/Prof
LCD/NCD	OP/Prof
Edits	
XRef	This tab provides helpful cross-reference information on billing codes.



Some panels have a hyperlink on the billing codes. This link takes you to information in the XRef tab.

When you are finished with Validation, click on the blue Validation bar. The panel collapses to its original position.

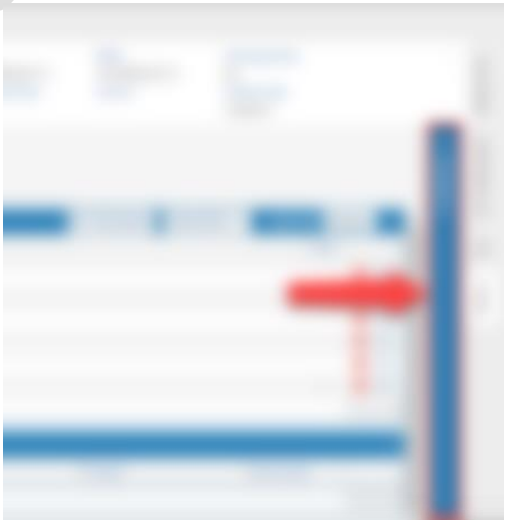
Coding Tab

1	**Patient Demographic**	This is automatically populated from the ADT feed and cannot be manually modified within *[product-name]*. This includes information about the patient, admission and discharge dates, unit, attending physician and financial class. If no data is available from the ADT feed, this area will be blank.
2	**DRG Summary**	Includes the DRG information such as the LOS and the estimated reimbursement
3	**Final DX panel**	Final diagnosis codes
4	**Final PX panel**	Final procedure codes
5	**Final CPT / HCPCS panel**	This is a list of all final CPT/HCPCS codes for the case.
6	**Uniform Billing (UB-04) panel**	This is the additional information needed on the UB-04 **Condition Codes** — Identifies provisions and certain circumstances, such as billing for denial or medical appropriateness, with a bill. **Occurrence Codes** — Indicates events that occurred over time and affect payment, such as a qualifying three-day stay. **Value Codes** — Used for SNF stays, indicates number or covered days.

Coding Validation Panel

The Validation panel is normally collapsed to a vertical blue bar, as shown.

When you are ready to perform a validation on your codes, click on the blue Validation bar.

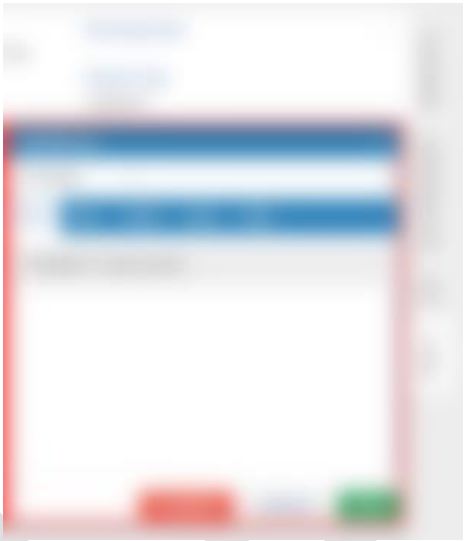


The Validation panel opens.

If you see "'Validate' to see results", this means there are charges for codes that have not been computed.

1. Select what type of validation you want to perform from the drop-down list.
    a. For outpatient (OP) cases, *[product]* will let you select APC or EAPG from this list.
    b. For inpatient (IP) cases, you will be able to select MS-DRG/APR-DRG.
    c. For Professional cases, there are no validation options.
2. Click the **Validate** button at the bottom of the page.

DRG tab	DRG information
PDX tab	Offers additional DRG information if a different PDX is selected
DRG+ tab	Offers potential DRG information if additional diagnosis codes are added to the claim
Edits tab	Offers potential edits for the claim based on the codes
XRef tab	References available for codes submitted
Complete	When you are ready to release the validated coding to billing, click **Complete**. Once you do this, no further changes can be made.
Validate	Click **Validate** to compute the code charges.
Save	Click **Save** to save any changes you make, such as comments and coding changes.



If these buttons are disabled, this indicates that the charges have been sent to billing and the case is complete.

DRG tab

This tab shows the results for the Diagnostic Related Group coded. Use this tab to evaluate and determine the optimal reimbursement. Also review ALOS and GMLOS to determine if this patient's stay length of stay is above the set limits.	

PDX tab

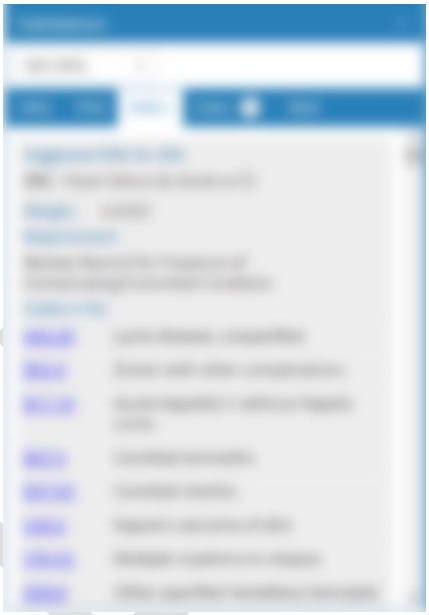
This shows you the criteria for the Primary Diagnosis (PDX). In some cases, you may have two or more possible Primary Diagnoses. Review and compare each PDX description and Estimated Reimbursement to determine the best reimbursement. To help you make informed decisions, you can view extensive details on each diagnostic code. Click on the PDX code link (blue underlined text). This information opens in the XRef tab.	

DRG+ tab

This tab may contain potential diagnosis codes that could be added to the series. Use your discretion to determine if any of these are valid for the case.

To add a DRG+ code to the series, click on the corresponding DRG code. When you do this, two icons appear just above the code.

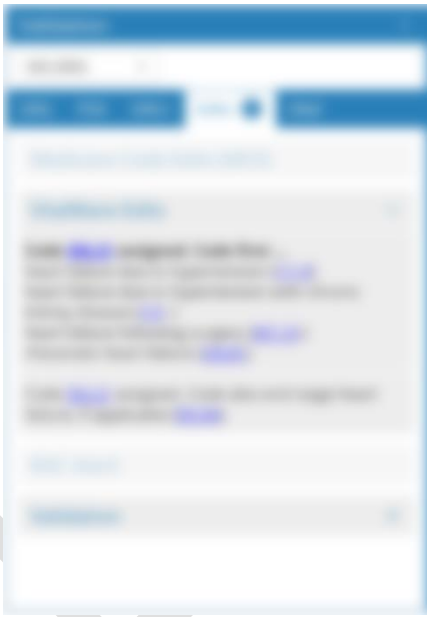
+	Adds the code to the series. You can confirm this in the **Working DX** panel.
ⓘ	Presents information about the code in the **XRef** tab.



Edits tab

This tab will provide you with the edits that have been associated with the codes you have assigned. This includes Medicare Code Edits (MCE), *{product}* custom edits, RAC Alerts and Validation edits.

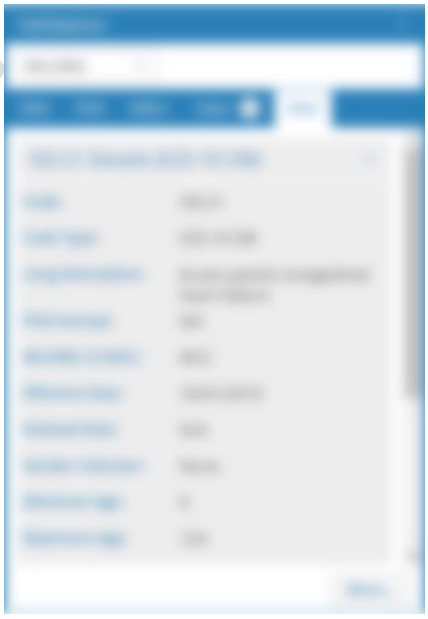
Note: If "RAC Alert!" is highlighted, the coding on this case could potentially trigger a RAC audit.



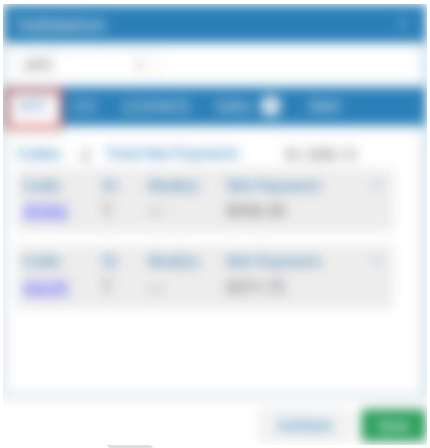
XRef tab

This tab will show you the references that are applicable to the codes you have assigned to the account. All the references that are available in the **Library** tab are available here.

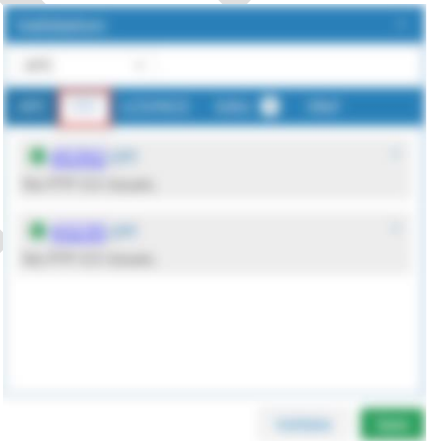
If you are not seeing the reference you need, click the More... button.



APC tab (OP accounts only)

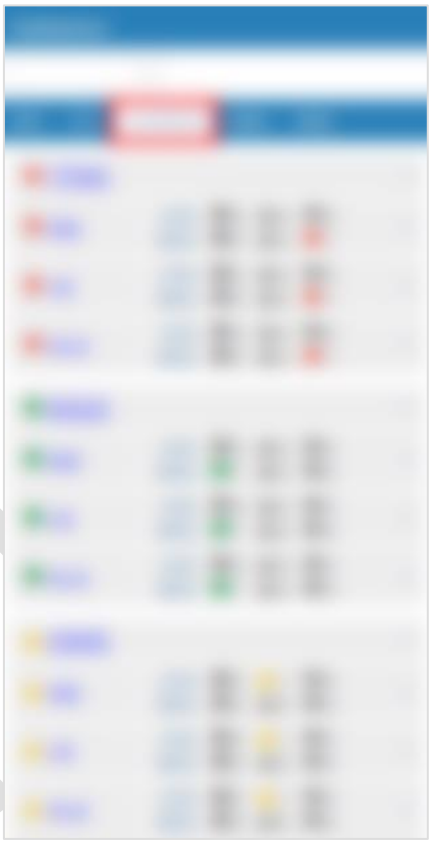
This tab shows the results for the Ambulatory Patient Classification (APC) coded, including the net payment expected.	

CCI tab (Outpatient cases only)

This tab shows the results for the Correct Coding Initiatives (CCI) edits for the codes assigned.	

LCD/NCD tab (Outpatient accounts only)

When validating a claim for an outpatient case, you can find LCD/NCD edits specific to your hospital's Medicare Administrative Contractor (MAC). The validation process looks for policies that pertain to your *procedure code* and *diagnostic code* combinations.

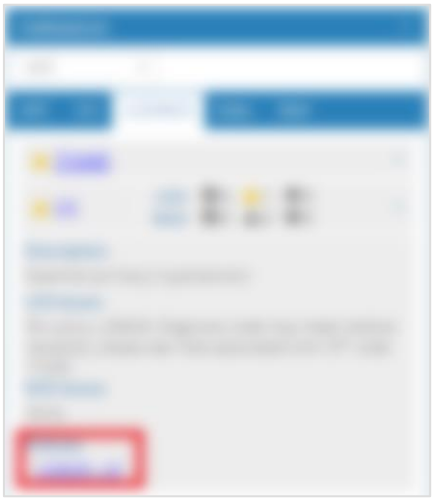


You may see the following symbols:

	A **green** check-mark indicates that a policy was found for the code combination, and it meets medical necessity.
	A **yellow** triangle indicates a conflict in the code combination that may have a policy issue or is not considered best practice.
	A **red** stop sign indicates that a policy was found for the code combination, and it does not meet medical necessity.

If the symbols are gray, no issues have been detected.

You can look-up a short description of policy issues by clicking the code link (blue underlined text). This appears at the bottom of the Validation panel.

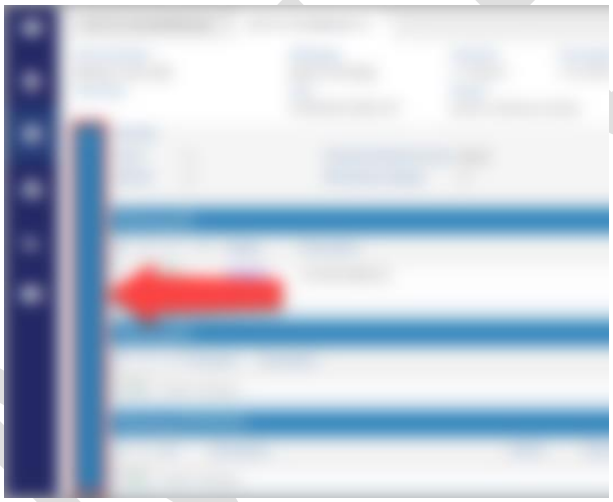


Description	This is a short text description of the LCD/NCD code.
LCD Issues, NCD Issues	If any issues are detected, they are described here.
Policies	The **Policies** link opens a panel that fully describes the relevant policies (see below).

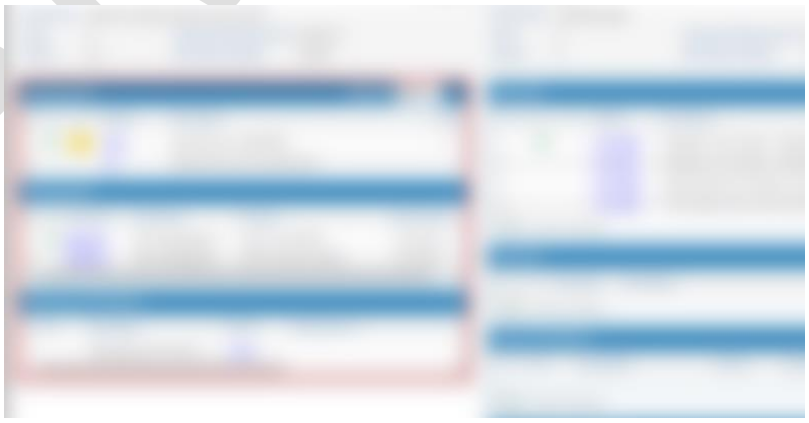
Working Final DX/PX, CPT/HCPCS Codes Panel

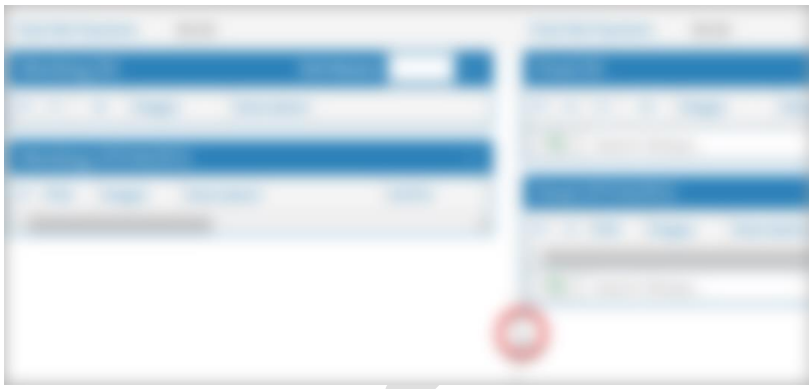
When using the **Codes** tab, normally you are concerned with the just the Final codes. The Working codes are normally hidden in a collapsed panel. You can view the working codes alongside the final codes for comparison.

To open this panel, click on the blue bar on the left side of the page.



When the Working Codes panels are open, they appear to the left of the Final panels. This lets you examine what codes have changed.



To close the Working Codes panel, find and click the “<” collapse icon in the margin between the two panels.	

5. Work Queue

The Work Queue contains a list of patients assigned to you for various work activity. This is where most users focus their attention.

Table Columns

Column	Description
Account	This number is unique to each patient admission. A patient can have multiple account numbers. This indicates the patient has been admitted multiple times or has been seen at multiple locations.
Admitted	This is the date the patient was admitted.
ADT Final DRG	This is the final DRG received through ADT messaging
Assigned CDS	This is the CDS person assigned to the case.
Case ID	This is a number which is only used within your facility. It is unique to each case.
Case Status	The status of the case
Clarification Count	The number of clarifications completed for that patient
Complaint	This is the original medical reason for the patient's arrival, as cited by the patient.
Discharge Status	The patient's discharge disposition, where did they go upon discharge
Discharged	The date the patient was discharged
DOB	Date Of Birth
FC	Financial Class. Also known as the primary payer.
Follow-Up	Indicated if the case is flagged for follow-up by the CDS or Coder
Gender	Patient sex (male or female)

Gender Code	The patient's gender code
Locked By	Indicated if the case if locked by a CDS or Coder
MRN	The patient's unique Medical Record Number
Patient First Name	Legal name
Patient Last Name	Legal name
PCN	Facility based Patient Case Number
Provider	Name of physician providing services to the patient
Review Status	Status of the *[role]* review
Review Type	Type of *[role]* review
Room	This is the physical room where the admitted patient can be found.
Service	The service type the patient is receiving
Service	The facility specific bill type
Type of Bill	This is the final DRG received through ADT messaging
Unit	This is the hospital department where the admitted patient can be found.

What to Look For

The **Working Queue** has several columns from which to view. Several fields automatically update as needed, so you may want to move these columns for optimal viewing:

- Case Status
- Review Status
- Assigned CDS
- Review Type

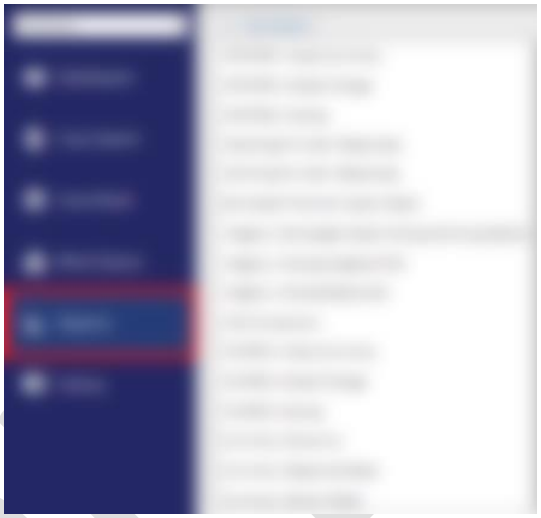
Selecting Case Status

By default, the work queue displays cases which requires follow-up work. Use the drop-down menu to select the type of cases to display.

Case Status	Description
Follow-Ups	This displays all cases with a follow-up date set in the Account Tab (Follow-Up Date is populated).
New Admits	This displays all cases that were newly admitted to the facility since the last request
Clarification Indicated	This displays all cases in date order of when the clarification was initiated
Returned Clarifications	This displays all cases that have been indicated as returned.

6. Reports

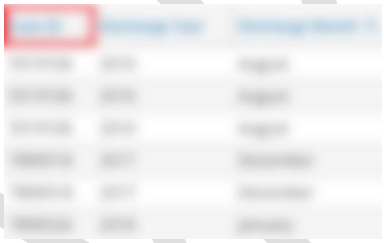
Use the Reports feature to do analysis on various statistics that are automatically generated by the application.



To display a report:

1. Click **Reports** in the Main Menu.
2. Click the **+ New Report** button at the top of the page. The drop-down menu displays the reports from which you can choose.
3. Select a report type. The report opens in a new tab. You can repeat these steps to display as many reports as you need.

For reports that have a Case ID column, you can view case detail by clicking inside any row.



Summary of Reports

Report Name	Description
APR-DRG: Impact Summary	This report summarizes the differences between the Original, Proposed and Final APR-DRG in the Account Tab, and helps to measure the effectiveness of the *[role]* Clarifications in impacting Final APR-DRG assignment. This report only includes Accounts where all three APR-DRG fields are assigned (not blank).
APR-DRG: Missed Change	This report displays discharged cases (Discharge date is populated) that have the same Original and Final APR-DRG but have a different Proposed APR-DRG. It is used to identify records where the *[role]* Specialist expected to see a DRG change as the result of a clarification, but the Final coded APR-DRG did not reflect the expected change.
APR-DRG: Missing	This report displays discharged cases (Discharge date is populated) that are missing either the Original, Proposed, or Final APR-DRG in the 'Account Detail' tab. It is used to determine records that require APR-DRG data to be added for the case to be included in financial impact reports. Within the report, you can click on the link in the Account column to open the Account Detail Tab for any specified record.
Attending Provider: Responses	This report displays a summary of the number of cases per provider per month and the provider's response to any clarifications. This report is helpful in assessing provider adoption of the *[role]* program, identifying provider training opportunities, and identifying providers that are already documenting well and do not require *[role]* intervention. All cases are included in this report.
Clarifying Provider: Responses	This report shows the number of clarifications delivered to providers, their response counts differentiated by Month.
Estimated Financial Impact: Detail	This report displays the calculated estimated financial impact by estimating the difference in reimbursement between the Original, Proposed, and Final MS-DRG assigned in the Account Tab. Additional fields such as 'Proposed DRG = Final DRG' or 'Clarification Agreed' aid in isolating the financial impact of specific scenarios. Accounts included in this report must have an Original and Final MS-DRG assigned in the 'Account Tab' and have had at least one Clarification documented. Account detail can be viewed by clicking on an Account number within this report.

Report Name	Description
Integrity: Discharged Cases Missing Clarifying Details	This report displays incomplete clarifications for discharged cases (Discharge date is populated). Missing elements will display blank, indicating no values have been entered for that field. This report can be used to ensure that all fields required for reporting have been populated within clarifications. Account detail can be viewed by clicking on an Account number within this report.
Integrity: Missing Assigned CDS	This report displays a list of discharged cases (Discharge date is populated) that do not have an Assigned CDS but do contain data indicating that work has been done within the case (e.g. DRG has been entered; Review Status has been altered from default). Account detail can be viewed by clicking on an Account number within this report.
Integrity: Missing Responses	This report displays a list of Clarifications for discharged cases (Discharge date is populated) that have an open Clarification without a Clarification Response specified. Account detail can be viewed by clicking on an Account number within this report.
LOS Comparison	This report shows the trending difference of the cumulative Length of Stay, Average Length of Stay and Geometric Mean Length of Stay.
MS-DRG: Impact Summary	This report provides a summary of the differences between the Original, Proposed, and Final MS-DRG and helps to measure the effectiveness of the *[role]* Clarifications in impacting Final MS-DRG assignment. This report only includes Accounts where all three MS-DRG fields are assigned (not blank).
MS-DRG: Missed Change	This report displays discharged cases (Discharge date is populated) that have the same Original and Final MS-DRG but have a different Proposed MS-DRG. It is used to identify records where the *[role]* Specialist expected to see a DRG change as the result of a Clarification, but the Final DRG coded did not reflect the expected change. Account detail can be viewed by clicking on an Account number within this report.
MS-DRG: Missing	This report displays discharged cases (Discharge date is populated) that are missing either the Original, Proposed, or Final MS-DRG in the Account Detail Tab. It is used to determine records that have missing DRG data needed in for the case to be included in financial impact reports. Account detail can be viewed by clicking on an Account number within this report.
Summary: Executive	
Summary: Response Rates	This report contains a summary view of the types of responses received on a monthly basis. All cases that have clarifications are included in this report. Below is a description of the columns contained in this report.

Report Name	Description
Summary: Review Rates	This report provides a summary view of the *[role]* activity on a per month basis. All cases are included in this report.

Description of Table Columns

Column	Description
Account	Facility-based unique account number assigned to the case
A-Difference	
Agree	The count of clarifications where the provider agreed with the CDS or Coder
Agree %	The percentage of clarifications where the provider agreed with the CDS or Coder
Agreed	Count of clarifications where the word 'agreed' in the description
Agreed Rate	This is a percentage calculation: Agreed divided by Clarifications.
ALOS	Average Length of Stay.
APR-DRG Impact	The differences between the Original, Proposed and Final APR-DRGs listed in the Account tab - separated into the following groupings: All Different: Original, Proposed, and Final APR-DRGs are all different. All Same: Original, Proposed and Final APR-DRGs are all the same. Different Final: The Final APR-DRG is different from the Original and Proposed APR-DRGs. Missed DRG Change: The Original and Final APR-DRG is the same, the Proposed is different.
Assigned	This is the number of cases assigned to a CDS (the Assigned CDS field in the Account Tab is not blank)
Assigned %	This is the percent of cases assigned to a CDS (the Assigned CDS field in the Account Tab is not blank)
Assigned Rate	This is a calculation expressed as a percentage: Assigned count ÷ Cases total
Avg Case Views / Assigned	Calculation: Average number of Case Views performed ÷ Assigned Case
Avg Case Views / Intervened	Calculation: Average number of Case Views performed ÷ Intervened Case

Column	Description
Avg Case Views / Reviewed	Calculation: Average number of Case Views performed ÷ Reviewed Case
Avg Clarifications / Assigned	Calculation: Average number of Clarifications performed ÷ Assigned Case
Avg Clarifications / Intervened	Calculation: Average number of Clarifications performed ÷ Intervened Case
Avg Clarifications / Reviewed	Calculation: Average number of Clarifications performed ÷ Reviewed Case
Case Count	This is the total number of cases
Case ID	This is a number which is only used within *[company]*. It is unique to each case.
Case View Count	Count of the number of times a case has been opened and a change has been made and saved.
Cases	Count of cases that fall into the specified impact grouping, such as during a specified month or DRG. All following columns will be subset of these cases.
***[role]* ID**	*[company]*'s Unique Facility ID.
CDS	Clinical Documentation Specialist
CDS Key	Key Identifier for a CDS
CDS Name	Name of the CDS
Clarification Agreed	If a response supporting the question of the Clarification is agreed on.
Clarification Count	Number of Clarifications for a specific Case.
Clarification or Comment Exists	If the Clarification or Comment Exists on a Case.
Clarification Reason	The Main Diagnosis associated with a Clarification.
Clarification Reviewed %	The Percentage of Clarifications that were viewed by providers.
Clarifications	The total count of Clarifications
Date (MM/YY)	Date expressed as month and year. Click on this column to sort the results chronologically.
Disagree %	The percentage of clarifications that were not agreed with.

Column	Description
Disagreed	Count of clarifications where the Clarification Response includes the word 'disagreed' in the description
Disagreed Rate	This is a calculation expressed as a percentage: Disagreed count ÷ Clarifications count
Discharge Month	Month cases were discharged (displayed as a Month + Year string) All other columns and calculations in this row are a subset of this month/year.
Discharge Month Digit	The numeric value of the month (1-12). This column is useful if you want to sort the results chronological month.
Discharge Year	The year in which the case was discharged.
Discharged	Cases that have been discharged.
Final APR-DRG	The Final APR-DRG used for billing.
Final MS-DRG	The final MS-DRG used for billing.
Final MS-DRG – Original MS-DRG	The DRG change from original to final
Final MS-DRG – Working MS-DRG	The DRG change between the working and the final.
Final MS-DRG Description	The name of the Final DRG.
GM-Difference	The difference between the LOS and the GMLOS
GMLOS	Generic Mean Length of Stay
Intervened	Count of Cases that have at least one Clarification
Intervened Rate / Assigned	This is a calculation expressed as a percentage: Reviewed count ÷ Assigned count
Intervened Rate / Cases	This is a calculation expressed as a percentage: Intervened count ÷ Cases total
Intervened Rate / Reviewed	This is a calculation expressed as a percentage: Reviewed count ÷ Reviewed count
Locked By	The person who has locked a case.
LOS	Length of Stay
MS-DRG Changes $ Impact (Original != Final)	The Dollar Impact of the original DRG compared to the Final DRG.
MS-DRG Changes $ Impact (Working = Final)	No dollar change between working and final DRG.

Column	Description
MS-DRG Changes (Original != Final)	The Change of the original as it compares to the final DRG.
MS-DRG Changes (Working = Final)	No change between the working and the final DRG.
MS-DRG Delta (Final Minus Original)	The Change between the final and the original DRG.
MS-DRG Delta (Final Minus Working)	The change between the final and working DRG.
MS-DRG Delta (Working Minus Original)	The change between the working and the original DRG.
MS-DRG Final Minus Original $	The dollar change between the final and the original DRG.
MS-DRG Impact	The differences between the Original, Proposed and Final MS-DRGs listed in the Account tab - separated into the groupings listed below: • All Different: Original, Proposed, and Final MS-DRGs are all different • All Same: Original, Proposed and Final MS-DRGs are all the same • Different Final: The Final MS-DRG is different from the Original and Proposed MS-DRGs • Missed DRG Change: The Original and Final MS-DRG is the same, the Proposed is different
MS-DRG Missed Opportunities $ Impact (Original = Final)	Potential dollars not captured due to clarifications not being responded to.
MS-DRG Missed Opportunities (Original = Final)	Potential change in DRG due to clarification not being responded to.
MS-DRG Working Minus Original $	The change in dollars between the working and the original.
No Response	Count of clarifications where the Clarification includes 'did not respond' in the description
No Response %	The percentage of clarifications not responded to.
No Response Rate	This is a calculation expressed as a percentage: No Response count ÷ Clarifications count
Original APR-DRG	The original APR-DRG calculation.

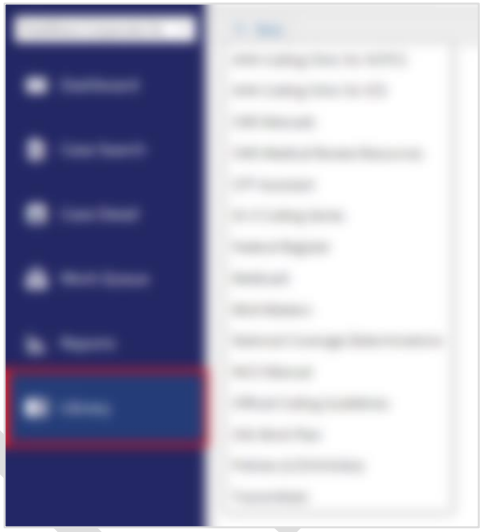
Column	Description
Original MS-DRG	The original MS-DRG calculation.
Original MS-DRG Description	The name of the original MS-DRG.
Other	Count of clarifications that have a Clarification Response other than Agreed, Disagreed, or No Response
Other Rate	This is a calculation expressed as a percentage: Other count ÷ Clarifications count
Other Response %	The percentage of clarifications that were not agreed to, disagreed with, or not responded to.
Provider	A clinician that cares for the case. Typically, this is a physician or ARNP.
Provider Name	Provider listed in the Clarifying Provider field on the Clarifications tab. All other columns are a subset of the clarifications for this provider
Provider Type	The type of provider.
Review %	The percentage of cases reviewed.
Review % Absolute	The percentage of cases reviewed.
Review Count	The number of cases reviewed.
Review Notes	Notes about a specific review.
Review Status	The status of the review.
Reviewed	Count of cases that were reviewed by a CDS. Derived from subset of values in the Review Status field in the Account tab.
Reviewed Rate / Assigned	This is a calculation expressed as a percentage: Reviewed ÷ Assigned
Reviewed Rate / Cases	This is a calculation expressed as a percentage: Reviewed ÷ Cases
Unit	The unit the patient is on.
Working APR-DRG	The current APR-DRG typically provided by the CDS.
Working MS-DRG	The current MS-DRG typically provided by the CDS.
Working MS-DRG Description	The name of the working DRG.

Customizing Report Views

You can rearrange or sort columns and choose which columns to display via a checkbox in the drop-down of the column headers.

Once a report has been opened, it can be exported to Excel using the ‘Export’ button in the upper left-hand corner.

7. Library



Use the Library feature to review coding guidelines and information in the application without having to switch to another tool or browser page. Use this to keep your team up-to-date on advanced coding, regulatory and reimbursements.

The Library is also available in *[company]*'s *[product]* application.

To display a library:

1. Click **Library** in the Main Menu.
2. Click the **+ New** button at the top of the page. The drop-down menu displays the libraries from which you can choose.
3. Select a library name. The library opens in a new tab. You can repeat these steps to display as many library categories as you need.

Many libraries use a search feature to narrow the field of items to display. For example:

- Narrow the search based on a publication date range.
- Some libraries let you select from a data set, such as CPT/HCPCS, ICD9-CM Diagnosis, or Revenue Codes.

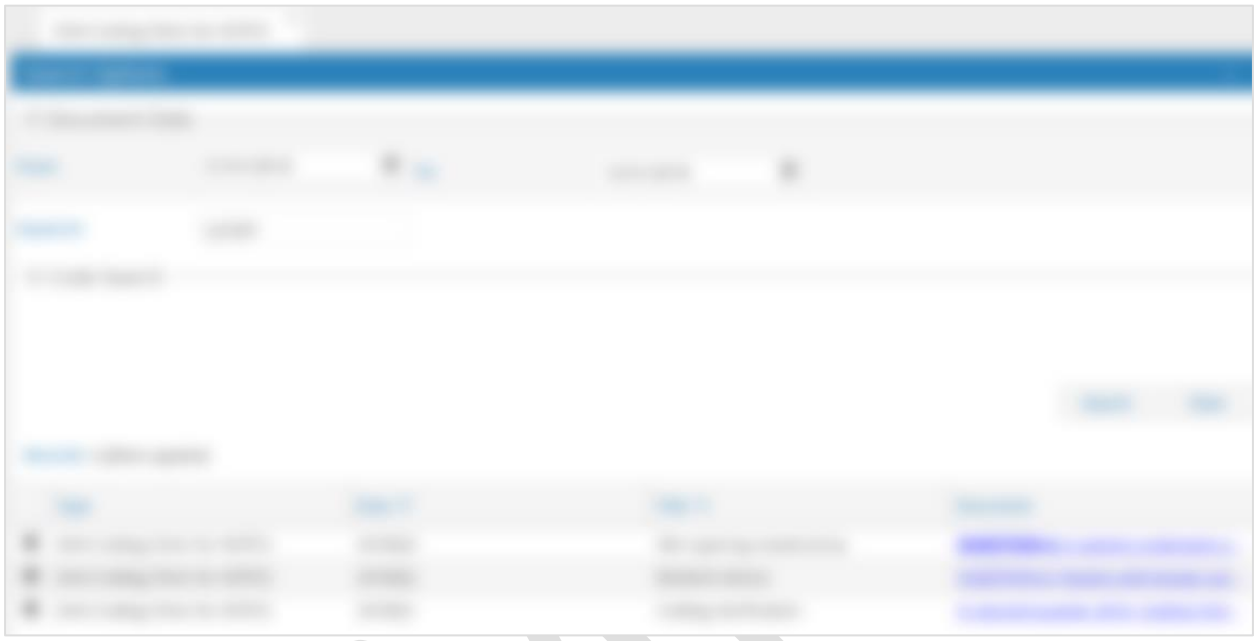
All document links open in a separate browser tab.

***Handy tip**: When displaying PDF files in your browser, use **Ctrl + ** to toggle between fit-page and fit-width.*

Library Modules

AHA Coding Clinic for HCPCS

This displays all AHA Coding Clinic for HCPCS articles.

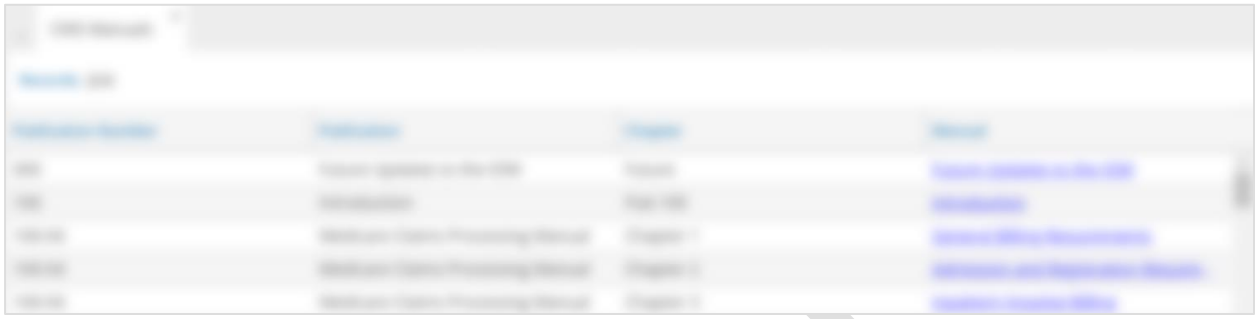


AHA Coding Clinic for ICD

This displays all AHA Coding Clinic for ICD articles.

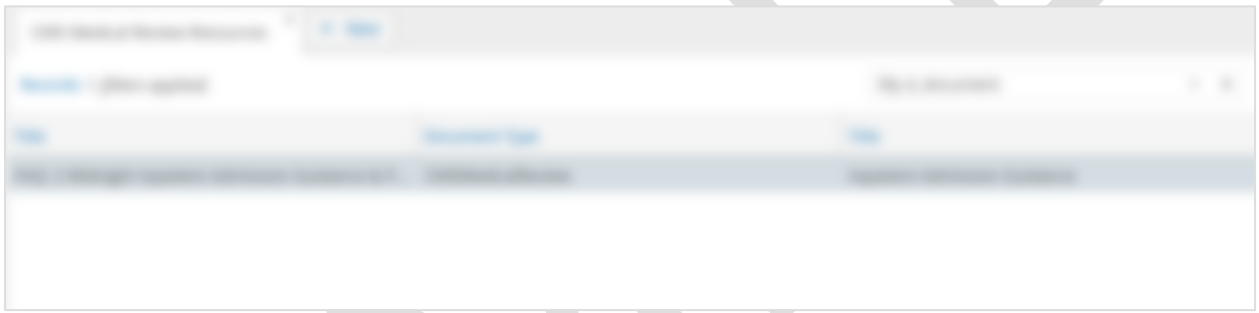
CMS Manuals

This displays all CMS Medicare Claims Processing Manuals.



CMS Medical Review Resources

This contains Frequently Asked Questions from CMS.

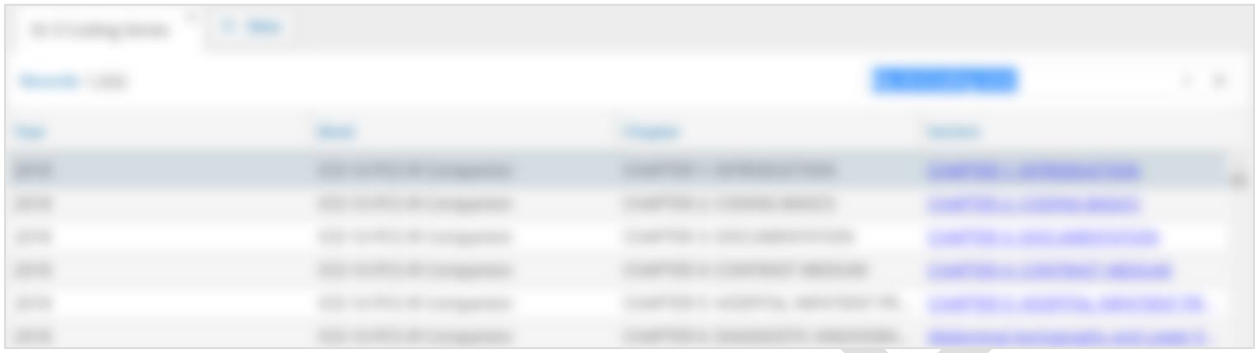


CPT Assistant

This displays all AMA CPT Assistant articles.

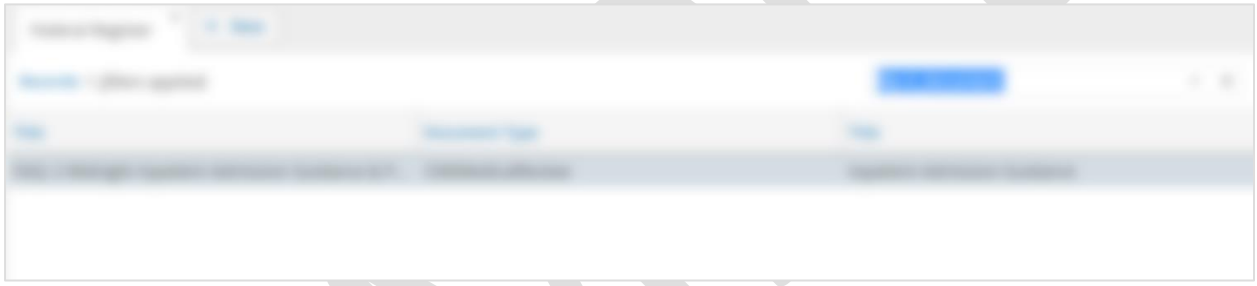
DR Z Coding Series

This displays 2017-2018 Dr. Z Coding Series Chapters.



Federal Register

This displays 2013-current CMS Federal Registers articles.



Medicaid

This displays the Medicaid Manuals and Bulletins per state.

MLN Matters

This displays all MedLearn Matters articles.

National Coverage Determinations

This displays all National Coverage Determination documents.

NCCI Manual

This displays all National Correct Coding Initiatives for Procedure to Procedure facility billing as it relates to CPT/HCPCS coding.

Official Coding Guidelines

This displays Official Coding Guidelines for ICD-9-CM, ICD-10-CM, ICD-10-PCS and CPT Guidelines.

OIG Work Plan

This displays all Office of Inspector General articles.

Policies (LCD/ Articles)

This displays all Local Coverage Determination documents and articles. This defaults to the state and contractor set up for your facility.

Transmittals

This displays all CMS Transmittals.

8. Troubleshooting

Overview

All *[company]* software operates online and interacts with you through your web browser. Therefore, the best software experience requires these two things:

- A modern, well-configured computer
- A fast, reliable network connection to *[company]* servers

[company]'s servers and network connections are designed with high-reliability and high-availability. But on the rare occasions when our end might be experiencing problems, you can check with us.

Before you contact us, there are a few things we'd like you to check and consider.

Are You Having Problems Logging In?

Check these things:

1. Is your keyboard Caps-Lock turned on? Make sure it is off, then check the spelling.
2. Has your password changed recently? Be sure you're using the correct password.
3. Is your computer online? Try opening a web page to another website, such as https://google.com. If you suspect this is the problem, check with your system administrator for additional steps.
4. Have your account privileges changed recently? Check with your supervisor.
5. Use **Login with External Login** only if your institution has instructed you to do so.
6. For security, *[company]* automatically logs you out after a period of inactivity.

Do You Need to Rest Your Password?

1. Go to the Login page and click **Reset Password**.
2. Type your username in the field provided. Your username looks like this: domain\userID, where "domain" is your institution or organization.

Is the Problem at a Single Computer?

If the computer you're currently using seems to be slower than normal, there are a few remedies that are generally considered safe:

- Clear your browser's cache.
- Restart your computer.
- Shut down (exit) applications that are not required.
- Check your computer for stuck print jobs.

Check with your supervisor or system administrator for instructions.

Are You Experiencing a Network Problem?

If multiple computers seem sluggish, this could be due to problems at:

- Your organization's network
- Your internet service provider, or the regional Internet

For these issues, check with your system administrator for suggested remedies or next steps.

Has Your Account Been Compromised?

If you believe that your account has been compromised, *Contact [company] immediately*. We will help to secure your account.

Are You Seeing Error Messages?

Intermittent Messages

Occasionally *[product-name]* will display an error message. This can occur during periods of high usage or network congestion. If this happens, close the message and proceed. If it happens frequently or is obstructing your work routine, you can report it to *[company]* as a software bug (see below).

How to Report a Software Bug

Our reputation depends on us getting you productive as soon as possible.

1. Contact your assigned *[company]* Account Manager, or
2. Contact *[company]* Customer Support if you are experiencing any problems:

   Phone: xxx-xxx-xxxx

   Email: cs@*[company]*.com

Have the following information ready:

- Your client (business/organization) name
- Your name, contact information (phone number and/or email address)
- Your *[company]* login ID (not your password)
- Describe the problem to us:
  - What web page or program operation caused the problem?
  - The area in *[product-name]* where the problem is occurring. For example, Login, Dashboard, Case Search, Case Detail. Being very specific helps us.
  - Is the problem repeatable?
  - Are other people experiencing the same or similar problems?
  - What type of computer you're using? For example: Windows, Mac.
  - What browser you're using. For example, Chrome, Firefox, Internet Explorer.
- Include a screen capture, if that helps to describe the problem.

9. Glossary

Acronym	Definition

10. About *[company]*

Our reputation depends on keeping you productive. If you have any questions or problems using our products, don't hesitate to contact us.

The preferred method is to contact your account manager at [company].

You can also contact Client Support if you have questions or issues with [company] products.

Phone: xxx-xxx-xxxx. Select option y.

Email: cs@company.com

Support hours: 24/7

Have the following information handy:

- Your client's *[company]* ID or organization name, such as "ABC"
- Your name, contact information (phone number and/or email address)
- Your *[company]* login ID (not your password)

Document Revision History

Version	Date	Revision Description
1.0	10/10/2018	Original Publication
1.1	01/18/2019	Technical review