McKESSON
Empowering Healthcare

STAR 2000™

STAR ICD-10 and ICD-10 DRG's Implementation Guide for STAR Release 15.0 or Later

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Reader comments

Any comments or suggestions regarding this publication are welcomed and should be forwarded to the attention of

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Trademarks

Documentation Conventions

Documentation for McKesson's STAR 2000™ line of products follows these conventions:

Revisions
Text revisions are indicated by a change bar in the left margin. Paragraphs that contain grammatical changes that do not affect content are not marked.

Canadian Documentation
This volume may include documentation for Canadian users of this product. Complete sections of Canadian text are identified by "CN" and "CN Only."

Key Names
Named keys, such as ENTER, SHIFT, CTRL, and ALT, appear in this document in uppercase (capital) letters. Symbol keys display according to the key name, followed by the symbol on the key in parentheses, such as hyphen (-) and asterisk (*).

Key Chords
Key chords are key entries that require you to hold down one or more keys (typically, CTRL, ALT, or SHIFT) before pressing another key. In this document, key chords display as the names of each key in the chord with a hyphen (-) between each (for example, CTRL-ALT-DEL). You should press the keys in the order indicated.

ENTER
ENTER is a key on a computer keyboard used to complete an entry on the STAR system. (This key may also be referred to as NEW LINE or NL in the STAR system.)

Data Entries
Letters or words you enter in response to the system display in **boldface** letters in this document. For example: Enter **Y** for Yes or **N** for No.

Selecting an Entry
This document often instructs you to "select an entry." The method you use to select an entry depends on whether you are using STAR from a terminal or IBM-compatible personal computer. Entry methods include:

- Entering the option number
- Using your arrow keys to highlight the option and pressing ENTER
- Clicking on the option using a mouse or other pointing device (PC only)

For more information about these options, see the *General Information Volume*.

Prompts
System prompts display at the bottom of many STAR screens when the system requests an entry or displays a message. Prompts display in this document italicized and indented from the rest of the text. For example:

Enter patient name--

Field Characteristics
STAR product documentation provides field explanation codes, in addition to a narrative description for each field on a screen. These codes display the maximum length of your entry in the field, the type of entry you make in the field, and whether the field is required. This information displays in the following format:

- DISPLAY ONLY for a field you cannot edit.
- For X-YY-Z field types, where:
  - X is the maximum number of characters permitted in the field:
    - P for a field length determined by a Parameter
    - T for a field length determined by a Table
    - U for a field having an Undefined length
  - YY is the type of entry technique permitted in the field:
    - A for Letters only
    - N for Numerals only
    - C for Characters (including punctuation)
    - AC for Letters and Punctuation only (no numbers)
    - NC for Numerals and Punctuation only (no letters)
    - AN for Letters and Numerals only (no punctuation)
  - Z is the requirement indicator of the field:
    - R if an entry is required to complete the function

      NOTE: Facilities can designate that certain fields be required. STAR product documentation does not display R for fields designated as required by a facility.
    - O if an entry is optional to complete the function
    - C if an entry is conditionally required or optional
  - For YY-Z field types, where YY is:
    - TABLE LOOKUP for a field that enables you to select from a displayed table. See the *General Information Volume* for more information regarding this entry technique.
    - SPECIAL FORMAT for a field having data entry requirements not conforming to standard format. The field definition contains the specific data entry requirements for the field.
    - DATE for a field subject to the date entry conventions described in the *General Information Volume*.
    - TIME for a field subject to the time entry conventions described in the *General Information Volume*.

    NOTE: For use of the Z position in this format, refer to the explanations for Z under X-YY-Z.

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Chapter 2 - IMPLEMENTING STAR RELEASE 15.0 OR LATER WITH ICD-10 and ICD-10 DRG'S

Introduction

This book contains the following chapters:

"Chapter 1 - IMPLEMENTING STAR ICD-10 and ICD-10 DRG'S" presents information about the changes that are visible in the various products / applications after the ICD-10 Enhancement STIs are moved in to the system but prior to implementing ICD-10 coding.

"Chapter 2 - IMPLEMENTING STAR RELEASE 15.0 OR LATER WITH ICD-10 and ICD-10 DRG'S" presents the steps to implement the ICD-10 Enhancement in STAR as well as the changes in the application.

Chapter 1 - IMPLEMENTING STAR ICD-10 and ICD-10 DRG'S

INTRODUCTION

The Department of Health and Human Services (HHS) issued a final rule for implementation of the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) for diagnosis coding and the International Classification of Diseases, 10th revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding. The new codes replace the current ICD-9-CM Volumes 1, 2 and 3. The compliance date issued with the final rule is October 1, 2013

To review the details of the final rule, refer to the following documentation:

Federal Register / Vol. 74, No. 11 / Friday, January 16, 2009 / Rules and Regulations page 3328

http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf

McKesson Corporation's STAR 2000™ Release 15.0 provides the required functionality for the STAR 2000 users to implement the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) for diagnosis coding and the International Classification of Diseases Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding. By making the changes available, Release 15.0 is the ICD-10-compliant release for STAR 2000.

STAR Release15.0 makes available parameters that allow for the continued use of the ICD-9 Coding System until the facility determines the dates for the implementation in both the test and live environments. After setting the flags in the test environment, the facility should perform thorough testing, develop the necessary policies and procedures, and prepare for training the staff. The addition of the parameters provides for an orderly transition to ICD-10.

With STAR Release 16.0 and higher, additional functionality is added for facilities using STAR GUI Abstracting with 3M Coding and Reimbursement System. STI M24872 adds the ability to code using both ICD-10 and ICD-9 codes and Group ICD-10 Medicare DRGs within 3M's Coding and Reimbursement System and return all coding/ grouping information to STAR.

This document contains information about the features available in Release 15.0 and Release 15.0 and 16.0. It is meant to be used in conjunction with the STAR Release 15.0 Enhancement Summaries, specified list of STIs and the documentation in the STAR 2000 Library and GUI help files.

This is a multi-product enhancement and the following is a list of the STAR Release15.0 STIs:

- M23013, M232127 for STAR Patient Processing
- M23800, and M24872 for STAR Medical Records

- M23867 for STAR Utilization Management
- M23015 for STAR Order Management
- L8022 for STAR Laboratory
- X5556 for STAR Radiology
- P8129 for STAR Pharmacy
- F9734, F10864, F10941 for STAR Patient Accounting
- M23113 for STAR Integration

A number of changes for this enhancement are available when the STIs are moved into the system. Several of these changes provide the functionality to perform necessary Table Maintenance for transition to ICD-10 coding.

Presented in this chapter are the explanations of the visible changes along with the instructions to explain maintenance that should be performed prior to implementing the ICD-10 and ICD-10 Coding and DRG enhancements to assist in the transition from ICD-9 to ICD-10. All ICD-9 coding/grouping functionality remains the same until the steps in Chapter 1 and 2 are performed to implement the ICD-10 Enhancements.

STAR PATIENT PROCESSING

Until the ICD-10 functionality is implemented, ICD-9 Diagnosis and Procedure processing in STAR Patient Processing remains the same except for some limited exceptions. When the specified list of STAR STIs are moved into the appropriate environments in the facility's system, some of the necessary changes to assist in the orderly transition to ICD-10 Diagnoses and Procedures are visible and functional prior to reaching the implementation date.

The users will see changes to several of the Patient Processing tables, screens and forms as well as some additional parameters. Many of the changes don't require any implementation until the users are ready to move forward with ICD-10 implementation. Changes to the screens and forms are visible as soon as M23013 is loaded. Procedurally, the facility should be ready to use the ICD-10-CM and ICD-10-PCS codes before defining the effective dates for the implementation of this enhancement. By making these changes in the tables available prior to the implementation date, STAR 2000 provides the facility the tools to prepare for using the ICD-10 coding.

The following is a list of changes that are visible in STAR Patient Processing when the ICD-10 Enhancement is moved to the appropriate environment:

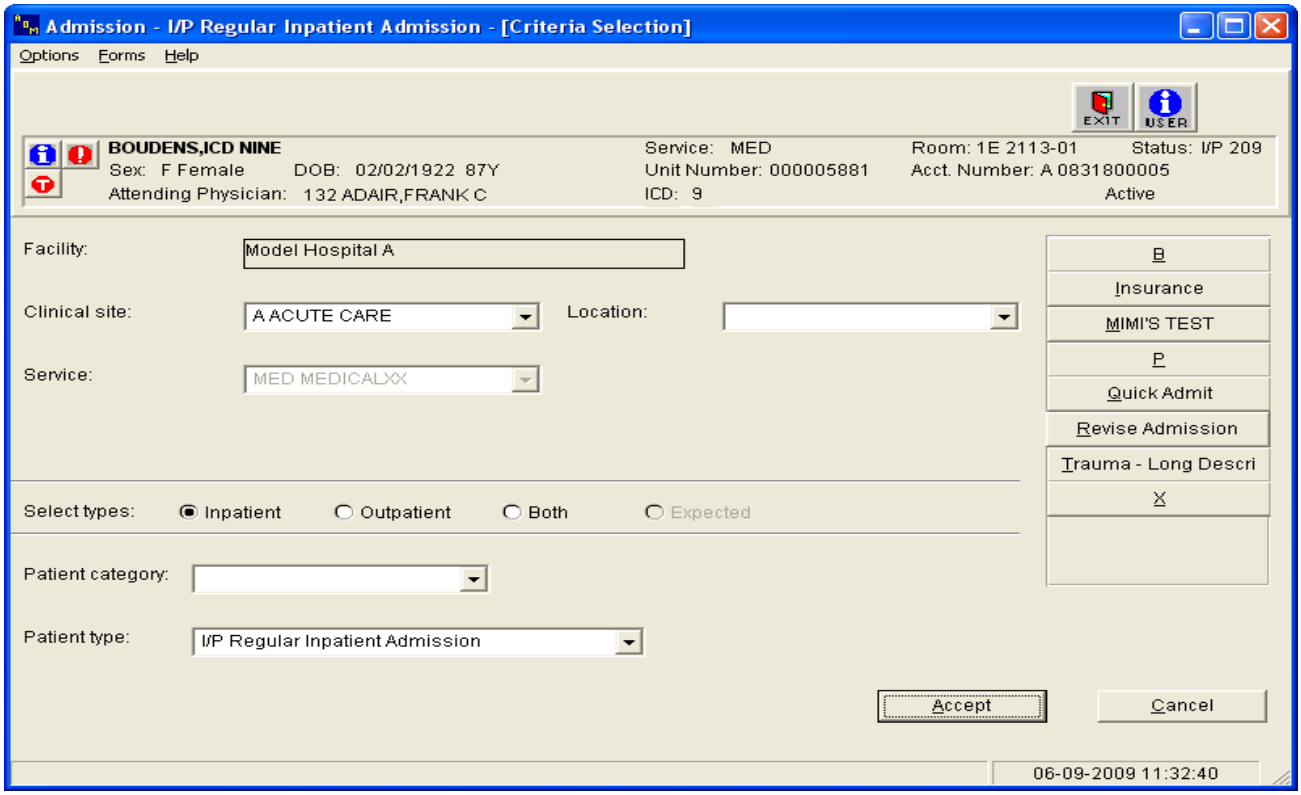
- Patient Demographic Header Screen Display - Within the patient header information of the Patient Processing functions, a new header element, *ICD*, is displayed. This new header was added to display the applicable ICD diagnosis and procedure indicator when a patient is selected in any Patient Processing function. This patient's indicator is determined by the STAR Patient Processing parameters. Prior to the implementation of the ICD-10 coding, the only ICD Indicator available for display with the ICD header is 9.

The following copy of the Patient Demographic Headers is an example of the Patient Demographic Header Screen Display prior to the implementation of the ICD-10 coding.

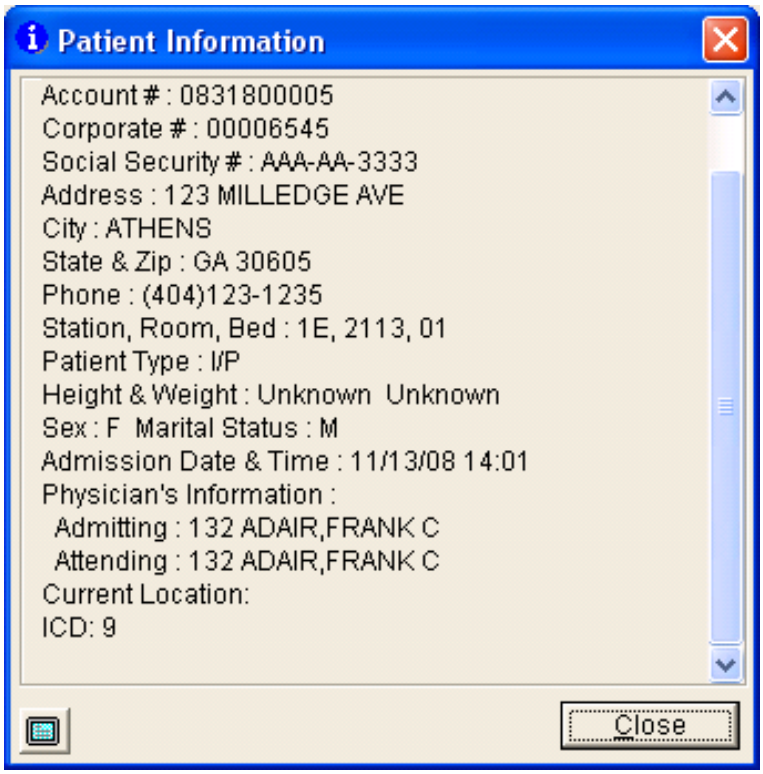
Example of Character Based Function Header:

```
              General Hospital Discharge Patient Processor
                                                 Tue Jun 09, 2009 11:26 am
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
0913400003    OPPY,PCA TEST     M  03/03/33 R07-01  HANCE,JENNIFECAR 9  OPB 27
```

Example of GUI Function Header:



- GUI Patient Information Button – The patient's ICD indicator is added to the information displayed:



- The following character-based screens have been rearranged to make room for the increased length of both the code (8) and description (60) of the ICD-10-CM Diagnosis Codes:

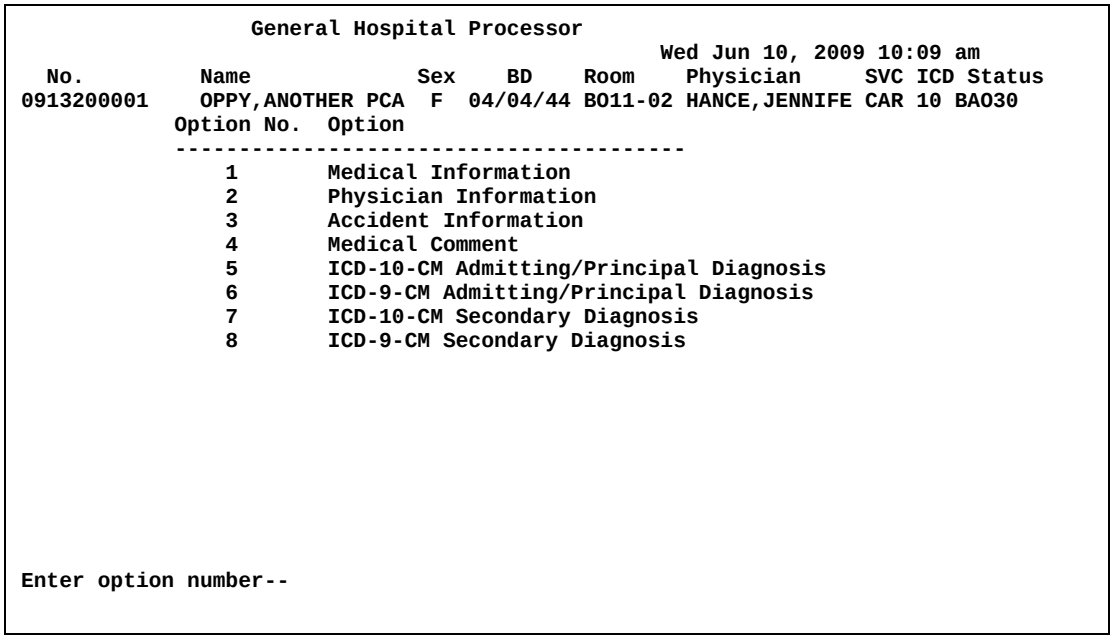
- Admission – Medical Page

```
                  General Hospital Medical Page Processor
                                                Tue Jun 16, 2009 12:22 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
0835100001    ICDNINE,OPPY      F  05/05/55 2107-01 HANCE,JENNIFEMED 9  I/P 183
 1 Locations   2 Admission Type       3 Admission Source    4 Arrival Mode
->               1 EMERGENCY            1 PHYS REF/NORMAL
 5 Arrival Date  6 Time     7 Allergies                                8 Smoker

 9 Service
   MED MEDICALXX
10 Admitting Diagnosis
   558.9-NONINF GASTROENTERIT NEC
11 Additional Diagnoses       12 Acc?                 13 Tumor Reg #
   Entries Defined               No
14 Surgery Scheduled                                  15 Date
   03.91-ANESTH INJECT-SPIN CANAL                        12/17/08
16 Opt Out  17 Opt Out Date   18 Publicity           19 Case Category
   No          12/16/08
20 ELOS-Dis Date  21 Plan Dis Time  22 Organ  23 ADs 24 ADs Ver Dt  25 Comment
   99-03/25/09


Enter department location code or first letter(s)`-` of description--          |
```

- Admission – Additional Diagnosis Page

```
                  General Hospital Medical Page Processor
                                                Tue Jun 16, 2009 12:22 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
0835100001    ICDNINE,OPPY      F  05/05/55 2107-01 HANCE,JENNIFEMED 9  I/P 183


 1 ICD
   ICD-9-CM
 2 Admitting Diagnosis
   558.9-NONINF GASTROENTERIT NEC
 3 Working Diagnosis
   558.9-NONINF GASTROENTERIT NEC
 4 Principal Diagnosis
   441.4-ABDOM AORTIC ANEURYSM

 5 Secondary Diagnoses
   008.42 PSEUDOMONAS ENTERITIS
   008.5  BACTERIAL ENTERITIS NOS




Enter field number or '/' starting field number--
```

- MPI Inquiry – Additional Screens are added for ICD-10



- Patient Location Tracking – Patient Information screen
- Delete Preadmission
- Dispositioning

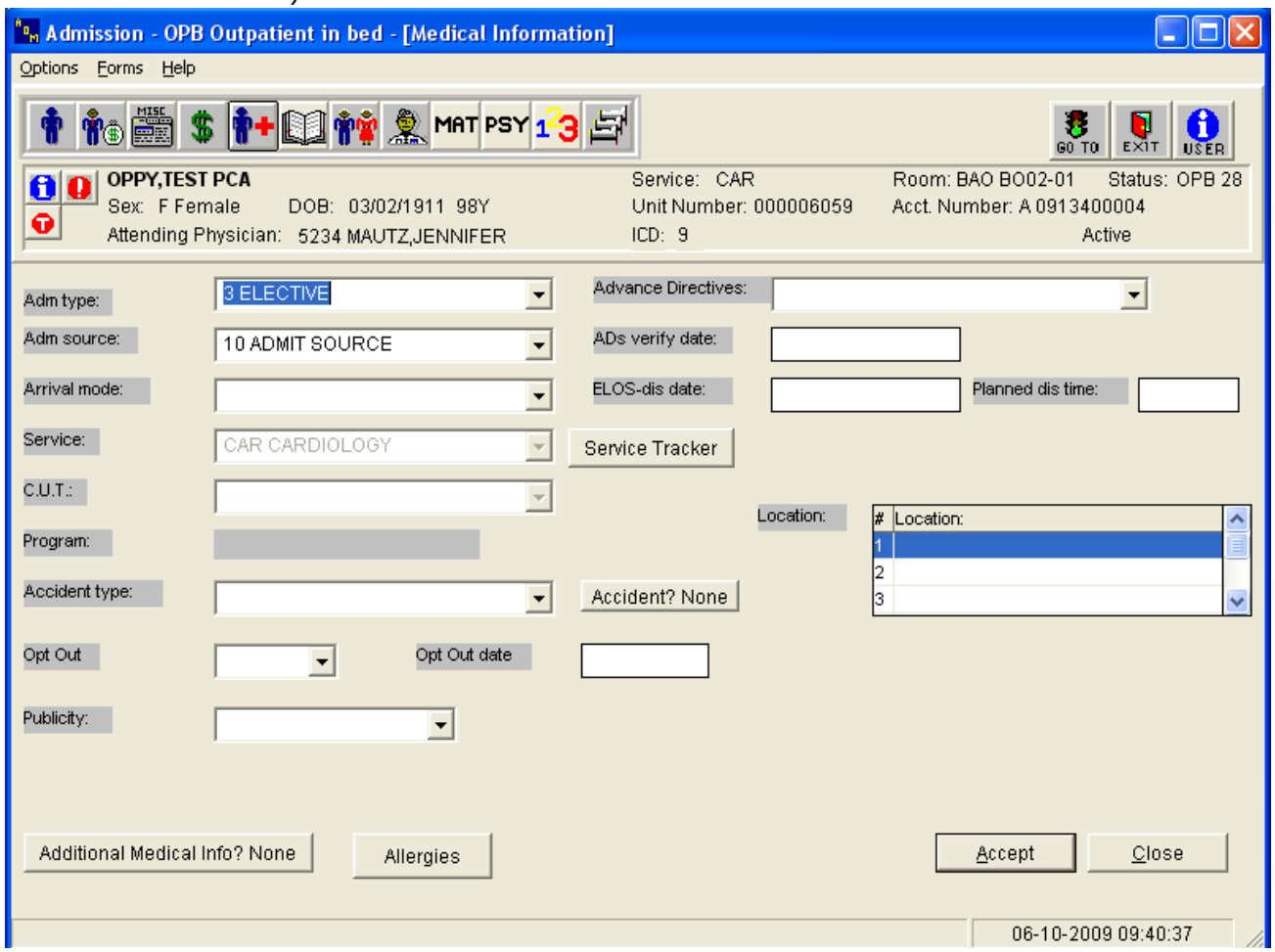
```
                General Hospital Discharge Patient Processor
                                                  Wed Jun 10, 2009 10:11 am
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
0913200001    OPPY,ANOTHER PCA  F  04/04/44 BO11-02 HANCE,JENNIFECAR 10 OPB 30
 1 Admitting Diagnosis
   B59-Pneumocystosis
 2 Comment                              3 Departments
->
 4 Principal Diagnosis

 5 DSM Code                           6 Secondary Diagnoses 7 Reason for Visit
                                        Entries Defined
 8 Procedure 1                         9 Procedure 2


10 Procedure 3                        11 HCPCS Procedure Code 1

12 HCPCS Procedure Code 2             13 HCPCS Procedure Code 3




Enter comment for disposition--                                    |
```

```
                General Hospital Discharge Patient Processor
                                                  Tue Jun 16, 2009 12:27 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
0901500002    CLINICALS,NINEOPO F  11/29/24 2110-01 ADAMS,JAY K  CAR 9  OPO 153
 1 ICD
   ICD-9-CM
 2 Admitting Diagnosis
   786.50-CHEST PAIN NOS
 3 Principal Diagnosis
   239.6-BRAIN NEOPLASM NOS



 4 Secondary Diagnoses
   441.4  ABDOM AORTIC ANEURYSM







    F1Prev Page F2Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

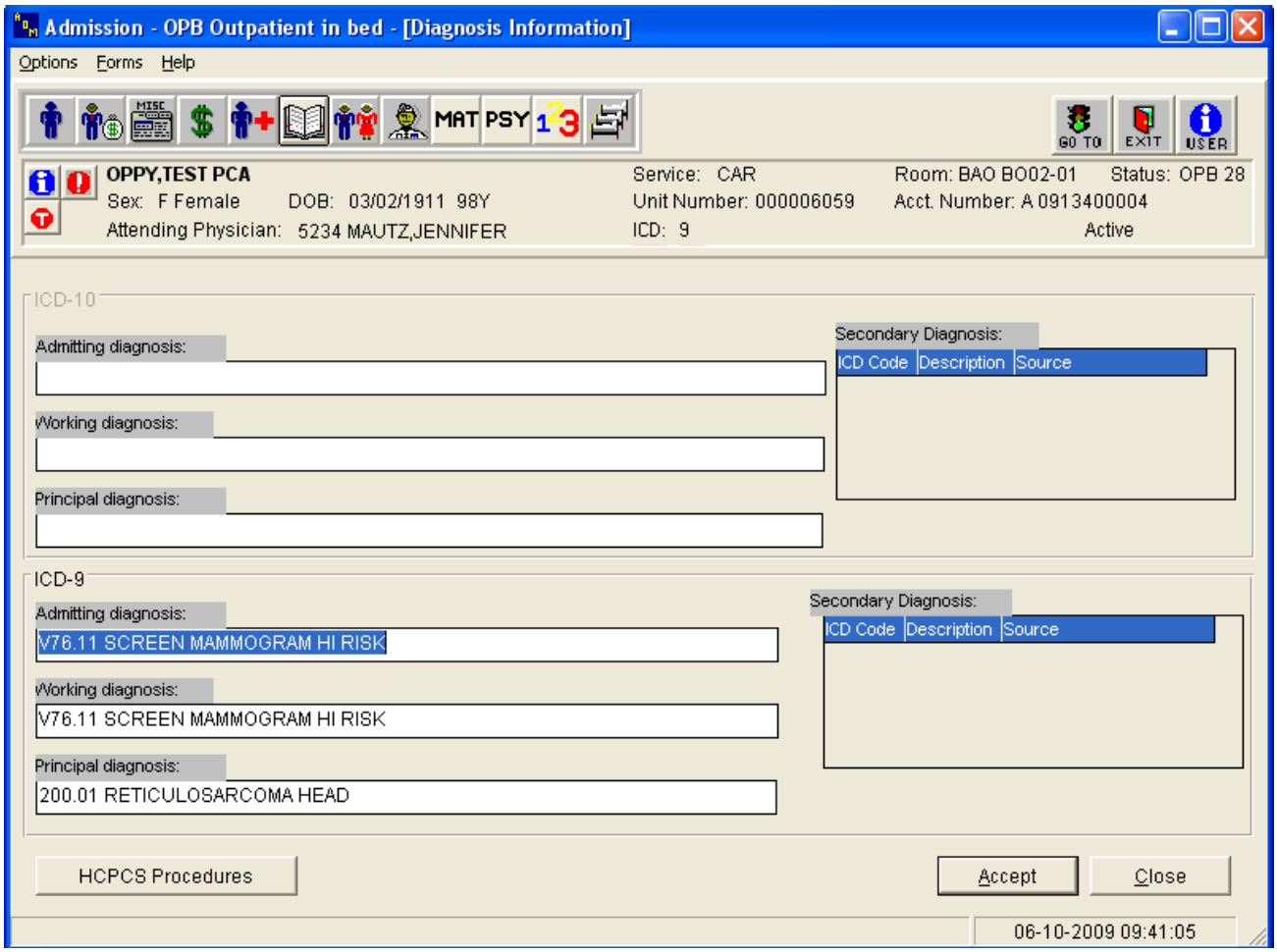
- Admitting – Revise Patient
- Nursing – Revise Patient

- The following GUI forms have been rearranged to make room for the increased length of both the code (8) and description (60) of the ICD-10-CM Diagnosis Codes:

  - Admission–Medical Form–Diagnosis Information Removed (only if using base forms)

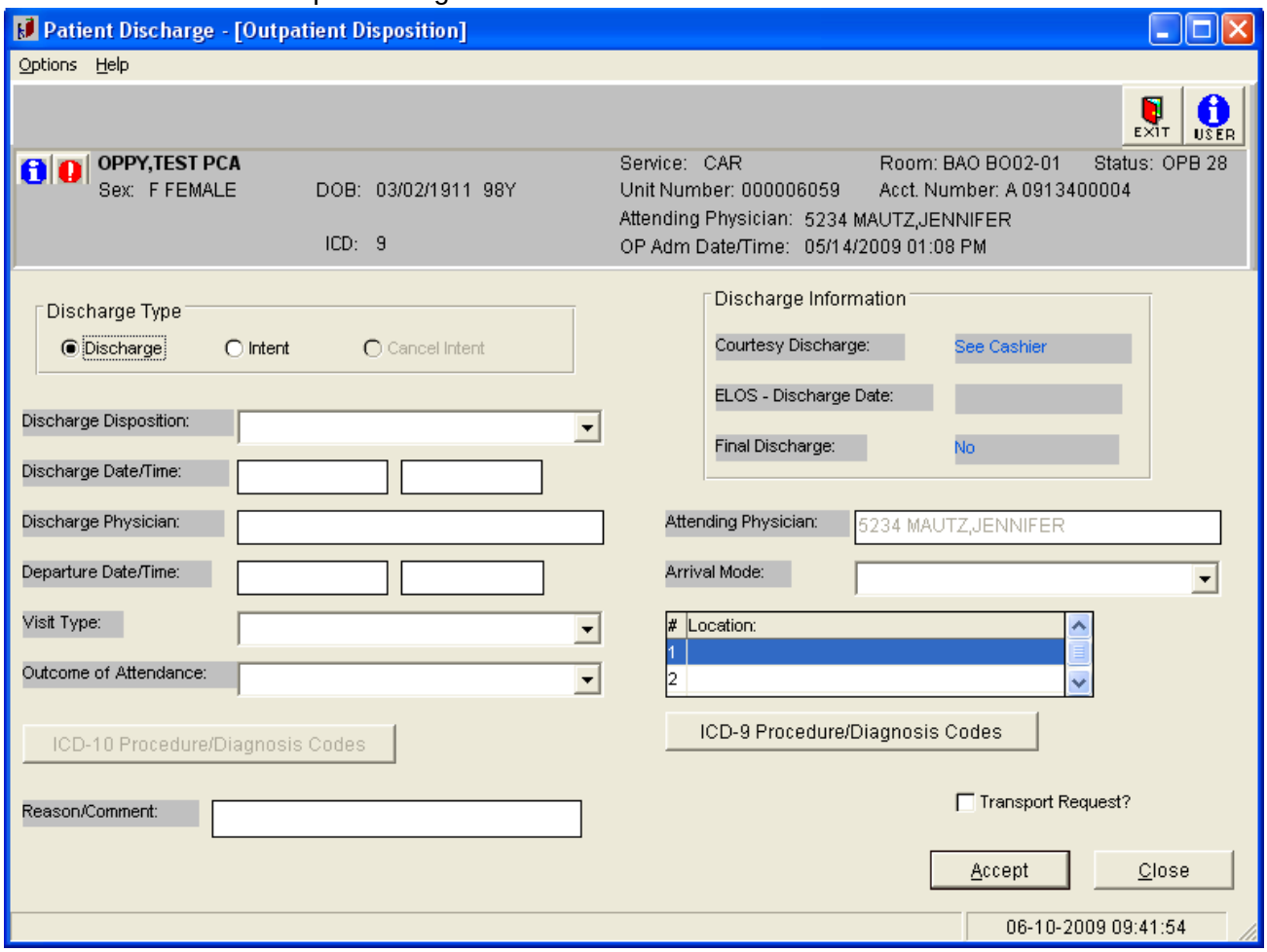


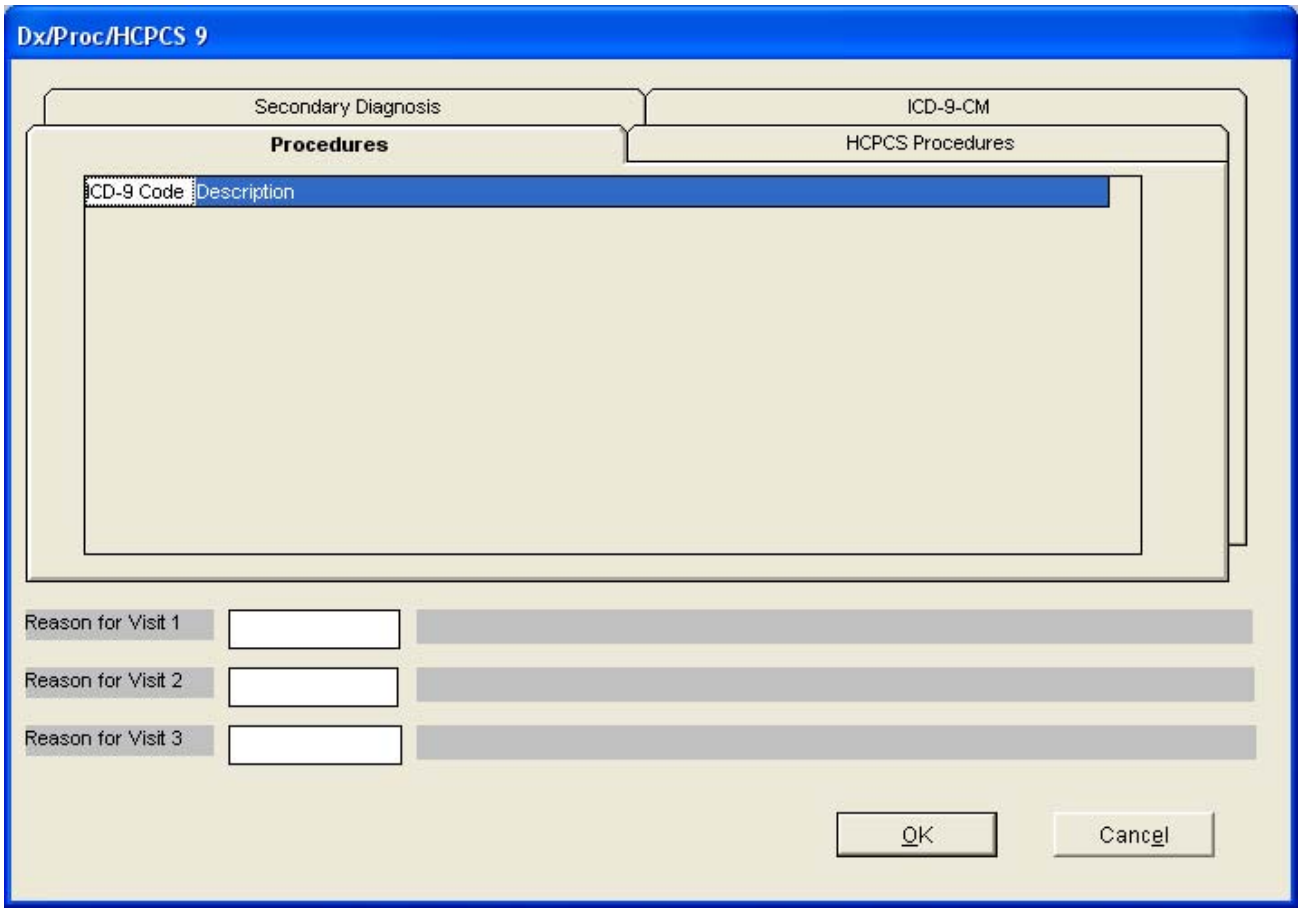
- Admission – New Diagnosis Form added (only if using base forms)



- MPI Review–Additional Form added for Diagnosis Information (only if using base forms)

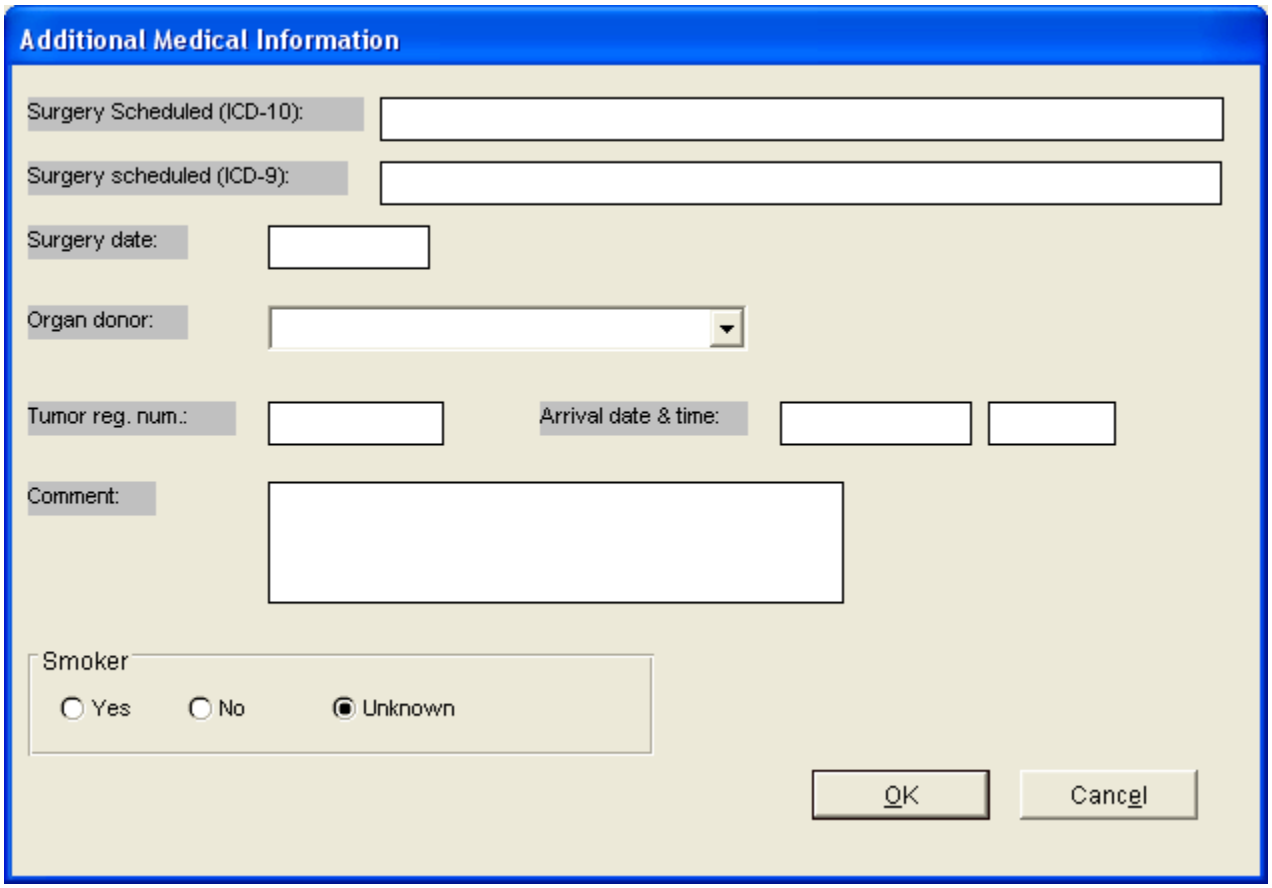
- GUI Dispositioning





- Bed Tracking/Patient Tracking – Patient Information

- The following character-based screens have been rearranged to make room for the increased length of the code (7) of the ICD-10-PCS Procedure Codes:
  - Dispositioning (see above)
  - Admission – Surgery Scheduled field (see above)
- The following GUI forms have been rearranged to make room for the increased length of the code (7) of the ICD-10-PCS Procedure Codes:
  - GUI Dispositioning (see above)
  - GUI Admission – Additional Medical Information button



- Midnight Processing reports that contain the diagnosis or procedure codes and descriptions have been adjusted to allow room for printing the length of the codes and up to 60 characters of the description on the reports:
  - 72 Hour Readmit Report (CA72x)
  - Daily Admission No Show Report (CFNSHOx)
  - Daily Expected O/P PAT Report (FPTROx), Daily Expected PAT Report (FPTRx), Daily PAT Report (FPRx) and Daily O/P PAT Report (FPRRx)
  - ER Log Report (CERLx) and Medical Day Care Report (CERMx)
  - Disposition Report (DISPx)
  - Multiple Procedure Review Report (CFCMNPRx)

- Online and Demand reports that contain the diagnosis or procedure codes and descriptions have been adjusted to allow room for printing the length of the codes and up to 60 characters of the description on the reports:

  - Admission/ER Registration Forms (caffrm, caffrma, caffrmb, caffrmc, cafrm1a, cafrm2a, cafrm3a, caffrm)

  - Form elements affected include (CCIDATA111F, CAMP101F, CAMP102F, CAMQ101F, CAHK33, CAHK36, CAHKA11, CAHKA12, CAHKA13, CAMK51F, CAMK53H)

  - Daily E/R Visit Report (CADERVRx)

  - O/P Demand Bill (CRFBIL)

  - MPI Face Sheet

  - Preadmission Form (cafpfrm)

  - Reservation Form (cafresv)

  - Detailed Vacant Bed Report

- Library elements have been created to print the values of the ICD-9 fields for an account regardless of the ICD status type. These elements are:

  - CAMP103F - Working Diagnosis (ICD-9)

  - CAMQ103F - Admitting Diagnosis (ICD-9)

  - CAMQ26F - Principal Diagnosis (ICD-9)

  Library elements have been created to print the values of the ICD-10 fields:

  - CAMP64F - Working Diagnosis (ICD-10)

  - CAMQ28F - Admitting Diagnosis (ICD-10)

  - CAMQ29F - Principal Diagnosis (ICD-10)

Implementation Steps

If you are using the base GUI Admissions and MPI Review forms, you must add the new diagnosis form to your form flows. The new form is titled "Diagnosis Information", and should be added directly following your Medical Information form. The new form has an associated icon that looks like an open book. There are No Implementation Steps for Patient Processing until the users are ready to begin implementing ICD-10 unless you are using the base admission forms for GUI Admissions.

Tables and Parameters

The users will see the following parameter and table additions and changes with the implementation of M23013 for Release 15.0 and M24872 for Release 16.0:

- Hospital Facility Options, Admissions and General Parameters:

  Release 15.0: A new field titled USA ICD-10 Eff Date has been added as field #12. The current ICD-10 Effective Date parameter has been changed to read "Canada ICD10 Eff Date" and has been moved to field #20.

  Release 16.0: See also Chapter 2 Discharge ICD-10 Effective Date parameter for M/R Abstracting and GUI Abstracting.

- Insurance Plans:

  Release 15.0: A new field titled ICD-10 Eff Date was added to the first page of the Insurance Plan table.

  Release 16.0: Payor Codes by Facility page revised from vertical to horizontal screen. A new field titled ICD 9 was added to this screen to let 3M know that the payor listed requires I-9 codes in addition to I-10 codes.

  Values for ICD-9 Field

  Yes-ICD-9 codes are required by Payor

  No- ICD-9 codes are not required by this payor. Note: If No is placed in this field then the program does check the Insurance Carrier or Financial Class screens.

  Blank- ICD-9 codes are not required by this payor.

- Insurance Carriers:

  Release 15.0: A new field titled ICD-10 Eff Date was added to the first page of the Insurance Plan table.

  Release 16.0 Payor Codes by Facility page revised from vertical to horizontal screen. A new field titled ICD 9 was added to this screen to let 3M know that the payor listed requires I-9 codes in addition to I-10 codes.

  Values for ICD-9 Field

  Yes-ICD-9 codes are required by Payor

No- ICD-9 codes are not required by this payor. Note: If No is placed in this field then the program does not check the Financial Class screen.

Blank- ICD-9 codes are not required by this payor.

- Financial Class:

  Release 15.0:A new field titled "ICD-10 Eff Date" was added to the first page of the Financial Class table. Additionally, the "DRG and APC/ASC Payor Codes" table has been added as the last page of the Financial Class table.

  Release 16.0: A field titled ICD9 was added to the last page of the Financial Class table to let 3M know that the payor listed requires I-9 codes in addition to I-10 codes.

  Yes-ICD-9 codes are required by Payor

  No- ICD-9 codes are not required by this payor.

  Blank- ICD-9 codes are not required by this payor.

- State ICD-10 Patient Type Exceptions:

  A new table has been added to the "Facility Options & Parameters menu" titled "State ICD-10 Patient Type Exceptions". The table is used to build state specific exceptions for the collection of diagnoses and procedures by patient type.

- ICD Diagnosis Pointer Table:

  The name of the Diagnosis Pointer Table is now just "ICD" without a version indication. Within the table, a new field titled "ICD-10-CM Code" has been added as field #4.

- ICD Procedure Pointer Table:

  The name of the Procedure Pointer Table is now just "ICD" without a version indication. Within the table, a new field titled "ICD-10-PCS Code" has been added as field #4.

- DSM Pointer Table:

  Within the DSM Pointer table, a new field titled "ICD-10-CM Code" has been added as field #5.

Testing Guidelines

Release 15.0 (M23013)

ICD-10

Once M23013 has been loaded into your test environment, perform the following steps to be sure that you are familiar with the changes that will be implemented regardless of whether you are implementing ICD-10 at this time:

1. Check the following tables to be sure the new ICD-10 fields are present:
   - Admissions and General Parameters
   - Insurance Carrier and Plan Tables
   - Financial Class Table
   - State ICD-10 Patient Type Exceptions
   - ICD Diagnosis Pointer Table
   - ICD Procedure Pointer Table
   - DSM Pointer Table
2. Check the Patient header in both the character-based system and GUI to see if the "ICD" indicator is displayed. Check the GUI Patient Information button to be sure the "ICD" field is present.
3. Check all of the character-based screens mentioned above to be sure that the screens have been adjusted to accommodate the ICD-10-CM and ICD-10-PCS codes and descriptions.
4. Check all of the GUI forms mentioned above to be sure that the forms have been adjusted to accommodate the ICD-10-CM and ICD-10-PCS codes and descriptions. (If you aren't using base forms you won't see any changes, and none are necessary until you implement ICD-10)
5. Check all of the Midnight Processing and Online/Demand forms mentioned above to be sure that the changes necessary to accommodate the ICD-10-CM and ICD-10-PCS codes and descriptions have been made.
6. Functional Testing:
   - Access the Admissions and General Parameters, and try to access the new US ICD-10 Eff Date field. You should get the message "Field Not Available". You cannot access the new US ICD-10 Eff Date field until a McKesson

representative sets the I10OK tilde as part of your readiness review. If you are in Canada, you cannot access the US field, but should be able to access the Canada field. If you are in the US, then you should not be able to access the Canada field.

- Access the ICD User Pointer table to validate access to the ICD-9-CM codes and the ICD-10-CM codes. Define additional user codes or update some of the previous codes to ensure the functionality.
- Perform the same steps in the ICD User Procedure Pointer table and the DSM Pointer table.
- Print the ICD User Pointer tables to review and validate the changes to the report.
- Admit some patients using various patient types, insurance carriers, insurance plans, and financial classes. Also enter some varied admitting diagnosis including Admitting, Working, Principal, and Secondary.
- Work with the Order Management/Patient Accounting group at your facility to combine this effort.
- Check the patient header in both the character-based system and GUI to be sure that ICD:9 is displayed.

  NOTE: In Canada, only ICD is displayed in the header. There are no indicators for **9**, **10**, or **B**.

- Check your admission and other pertinent forms to ensure they are still printing all data correctly.
- For one admission, select the working diagnosis from the DSM Pointer Table. In the Working Diagnosis, verify the actual ICD-9 code is displayed instead of the user-defined code.
- On one admission, enter a free text entry as one of the admitting diagnosis to verify that functionality is in place.
- If your facility uses the STAR Patient Processing/PCA pre-service integration, admit a patient as an outpatient in a bed with CMS compliant insurance. Test that the integration is working as expected.

Following the first Midnight Processing run, check the reports listed above to be sure the data is printed correctly.

Release 16.0

Once M24872 has been loaded into your test environment, perform the following steps to be sure that you are familiar with the table changes that will be implemented regardless of whether you are implementing ICD-10 with (3M) DRG's at this time:

1. Check the following tables to be sure the new fields are present:

    - ICD-10 Discharge Eff Date in Abstracting Facility Options Parameter
    - ICD-9 Flag on last page of Financial Class table
    - ICD-9 Flag on last page of Insurance Plan table
    - ICD-9 Flag on last page of Insurance Carrier table

STAR PHYSICIAN PRODUCTS

Until the ICD-10 functionality is implemented, ICD-9 Diagnosis processing in STAR Clinical Browser and STAR modules for Horizon$^{WP®}$ Physician Portal essentially remains the same with some limited exceptions.

When the specified list of STAR STIs are moved into the appropriate environments in the facility's system, some of the necessary changes to assist in the orderly transition to ICD-10 Diagnosis and Procedures are visible and functional prior to reaching the implementation date defined in the Patient Processing parameter, USA ICD10 Eff Date. (Please refer to the STAR Patient Processing sections of this *STAR ICD-10 Implementation Guide* for a detailed explanation of this parameter as well as the parameters added to the Insurance Plan table, the Insurance Carrier table, and the Financial Class table.)

Procedurally, the facility should be ready to use the ICD-10-CM and ICD-10-PCS codes before defining the effective dates for the implementation of this enhancement. By making these changes in the tables available prior to the implementation date, STAR provides the facility the tools to prepare for using the ICD-10 coding.

The following is a list of the ICD-10 Enhancement changes that are visible in STAR Physician Products prior to the ICD-10 effective date:

- Diagnosis displays

  All diagnosis fields were updated to display ICD-10 codes. Current functionality (display ICD-9) applies if the effective date is not activated. If only an ICD-9 diagnosis is collected for the patient, it displays in the current diagnosis fields.

  To accommodate the longer ICD-10 diagnosis descriptions, the current Diagnosis fields were modified to truncate at 35 characters or the maximum available space and append with a plus sign (+) to indicate the Dx description has been truncated. Since most ICD-9 descriptions do not reach 35 characters, the ICD-9 descriptions more than likely would not appear any different prior to the effective date.

- Reports

  In Release 15.0, the current diagnoses form elements were updated to print ICD-10 diagnosis when collected. If there is no ICD-10 diagnosis collected, the ICD-9 diagnosis is printed. The truncation for these form elements is set to 33 characters. The width of the column that displays the diagnoses accommodates up to 27 characters only, so some diagnoses overlay data in the next column. This may not be as apparent with ICD-9 codes as with the longer ICD-10 descriptions.

  Therefore, two new Physician Facesheet diagnosis elements were added to the cpffrm form in STAR base software. These elements truncate the diagnosis

description at 26 characters appended with a plus sign (+) as a convention to indicate the description has been truncated.

The current base elements continue to print the non-truncated ICD-9 diagnoses even if the form element implementation is not completed at this time. However, in order to print the truncated diagnoses, the forms implementation must be completed for the new changes to take effect.

Current custom diagnosis elements should continue to print ICD-9 diagnoses. These do not print the truncated ICD-9 or ICD-10 diagnoses unless they are retrofitted with the new changes.

- Horizon*WP* Physician Portal's STAR Radiologist Workflow (RWF) module

  ICD-9 admitting, working, and ordering diagnoses continue to display on several forms in the HPP Radiologist Workflow module.

  The Ordering diagnosis can be revised in several places once in the Review Detail form. Revising ICD-9 ordering diagnoses will still be allowed if the ICD-10 Effective Date Parameter is not activated but only in HPP releases prior to v13.2.

  One option for displaying the table of ICD-9 diagnosis codes for revision is the User Dx Pointer table. After the facility begins to build /add ICD-10 codes to the User Dx Pointer table (in Order Management tables), these ICD-10 User descriptions are not available for ICD-9 dx selection in the RWF Review form.

  In Horizon*WP* Physician Portal releases 13.2 or greater, the Order diagnosis revision hyperlink no longer is displayed on the Workflow screens. Order Diagnosis revision in Horizon*WP* Physician Portal's STAR Radiologist Workflow module is inactivated for both ICD-9 and ICD-10 diagnoses in this Horizon*WP* Physician Portal release.

Other than the limited changes listed above, the process of viewing ICD-9 diagnoses and procedures remains the same until the ICD-10 implementation date.

NOTE: Please refer to Chapter 2, STAR Physician Products section in this Implementation Guide for detailed information on the diagnosis and procedure field changes.

Implementation Steps

There are no specific implementation steps for the STAR Physician Products prior to the implementation of the ICD-10 coding. When the USA ICD Effective Date set on STAR Patient Processing is past, ICD-10 diagnoses and procedures may be collected/ viewed for the patient.

- STAR Forms

  All Diagnoses form elements were updated to print ICD-10 diagnosis when collected. If there is no ICD-10 diagnosis collected, the ICD-9 diagnosis are printed.

  New Physician Face Sheet diagnosis elements were added to the cpffrm form in STAR base software. These elements truncate the diagnosis description at 26 characters. The current longer ICD-9 diagnoses continue to print on the forms if the new form element changes are not implemented at this time.

Any custom Diagnosis elements on form cpffrm, or custom forms based on cpffrm, should be evaluated for deletion/addition of elements or retrofit of these changes.

Please refer to the Forms section of STI M24658 or Chapter 2, STAR Physician Products, Implementation section in this Implementation Guide for details of the form changes and implementation.

Tables and Parameters

There are no changes to any tables or parameters.

Testing Guidelines

McKesson recommends performing regression testing prior to implementing the ICD-10 enhancement to verify correct display of ICD-9 diagnosis codes/descriptions.

Test patients should be admitted with a variety of admitting diagnoses including principle, working, and secondary diagnoses. If the DSM pointer table is used in your facility, enter a working diagnosis using the DSM pointer table for at least one patient admission. Various orders should be placed so the ordering diagnosis fields can be verified. Work with the ADT / Patient Processing group at your facility to combine this effort.

- Validate /verify the correct ICD-9 Admitting, Working, Ordering diagnoses, and Medical Record Abstracting diagnoses and procedures are displayed and print on the Clinical Browser, Horizon*WP* Physician Portal STAR portlets and Radiologist Workflow module screens and reports.

- Verify correct code and description lengths are displayed and print as expected on screens and reports.

- Verify these match the diagnoses and procedures as entered on STAR.

Ordering Diagnosis revision in Radiologist Workflow module:

- Verify the Ordering Diagnosis can be edited for ICD-9 diagnosis codes prior to the ICD-10 Effective Date in Horizon*WP* Physician Portal releases prior to release 13.2.

- Verify the hyperlink is disabled after the Horizon*WP* Physician Portal 13.2 release is implemented.

NOTE: Please refer to Chapter 2, STAR Physician Products section in this Implementation Guide for detailed testing guidelines.

STAR ORDER MANAGEMENT

Until the ICD-10 functionality is implemented, ICD-9 Order Diagnosis processing remains the same except for some limited exceptions.

When the specified list of STAR STIs is moved into the appropriate environments in the facility's system, some of the necessary changes to assist in the orderly transition to ICD-10 Diagnosis and Procedures are visible and functional prior to reaching the implementation date defined in the Patient Processing parameter**,** USA ICD10 Eff Date. (Refer to "STAR PATIENT PROCESSING" on page 1-4 for a detailed explanation of this parameter as well as the parameters added to the Insurance Plan table, the Insurance Carrier table, and the Financial Class table.)

The changes visible prior to the implementation date for ICD-10 coding are current STAR tools that have been enhanced to provide the ability to perform maintenance in preparation for the implementation.

Procedurally, the facility should be ready to use the ICD-10-CM and ICD-10-PCS codes before defining the effective dates for the implementation of this enhancement. By making these changes in the tables available prior to the implementation date, STAR 2000 provides you with the tools to prepare for using the ICD-10 coding.

The following is a list of changes that are visible in STAR Order Management when the ICD-10 Enhancement is moved to the appropriate environment:

- Patient Demographic Header Screen Display - Within the patient header information of the Patient Care / Order Management functions, a new header element, ICD, is displayed. This new header was added to display the applicable ICD diagnosis and procedure indicator when a patient is selected in any Patient Care / Order Management function. This patient's indicator is determined by the STAR Patient Processing parameters. Prior to the implementation of the ICD-coding, the only ICD Indicator available for display with the ICD header is 9.

(Please refer to the STAR Patient Processing sections of this *STAR ICD-10 Implementation Guide* for a detailed explanation of this parameter as well as the parameters added to the Insurance Plan table, the Insurance Carrier table, and the Financial Class table.)

The following copy of the Patient Demographic Header is an example of the Patient Demographic Header Screen Display prior to the implementation of the ICD-10 coding.

```
                    General Hospital Charge Processor
                                                Tue Jun 09, 2009 11:26 am
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
0907600003    RDTWO,NINCEIPCOM  M  03/03/33 B006-01 HANCE,JENNIFECAR 9  I/P 76
```

- The titles of the ICD-9 User Diagnosis Pointer Table and the ICD-9 User Procedure Pointer Table have been changed by removing the 9 from the table description. The new titles are ICD Diagnosis Pointer Table and ICD Procedure Pointer Table.

- When the DX option in the Order or Charge prompt is used to access the list of "Admitting" ICD Diagnosis and the Working Diagnosis in the list was selected from the DSM Pointer table, the actual ICD code is displayed in the orders and charges. Previously, in this scenario, the code defined by the user was used in the display for the order or charge.

- In the ICD User Diagnosis Pointer table, the ICD User Procedure Pointer table, and the DSM table, the field to accommodate defining the ICD-10 code was added. The added field provides access to the ICD-10-CM codes or ICD-10-PCS codes as appropriate.

- Changes were made to the reports and a sort was added for the ICD User Diagnosis Pointer table, the ICD User Pointer Procedure Table and the DSM Pointer table. When spooled or printed, the tables are sorted to assist the user with maintaining the tables.

- An additional field was added to display the ICD-10-CM in Order Review when the G option is selected. This field remains null until the implementation of ICD-10 coding.

- Additional fields were added to the HCPCS Processor Table to accommodate defining the ICD-10 Valid Diagnosis Codes and ICD-10 Comment. The ICD-10 codes defined in the ICD-10 Valid Diagnosis field are used for the ABN / Medical Necessity processing after implementing the ICD-10 Enhancement.

Other than the limited changes listed above, the process of selecting ICD-9 diagnosis in the order and charge processors and the current ABN / Medical Necessity Processing with ICD-9 codes remains the same until the ICD-10 implementation date. The ABN/Medical Necessity Processing in STAR Order Management functions the same using the valid ICD-9 codes defined in the HCPCS Processor. The ABN Processing continues to use the ICD-9 codes until the implementation of the ICD-10 coding.

Implementation Steps

A number of changes for this enhancement are available by design as soon as the STIs are moved into the system. These changes provide the ability to perform necessary table maintenance for the transition to ICD-10 coding prior to the implementation date. The table maintenance is detailed in the following tables and parameters section.

There are no implementation steps for STAR Order Management.

Tables and Parameters

The appropriate tables and the maintenance that is necessary before the ICD-10 implementation in STAR Order Management are detailed in the following documentation:

- ICD Diagnosis Pointer Table Screen

```
                General Hospital Table Maintenance Processor
                                                    Tue Jul 14, 2009 11:26 am
ICD Diagnosis Pointer Table
( 1)Code          : 705
( 2)Description   : ALZHEIMER'S
( 3)ICD-9-CM Code : 331.0-ALZHEIMER'S DISEASE
( 4)ICD-10-CM Code: G30.9-Alzheimer's disease, unspecified
( 5)Average LOS   :

( 6)Edit by       : Stephens,John
( 7)Edit date     : 02/17/09 12:52

Page:01                     ICD-10-CM diagnosis codes
( 1) A00.0    Cholera due to Vibrio cholerae 01, biovar cholerae
( 2) A00.1    Cholera due to Vibrio cholerae 01, biovar eltor
( 3) A00.9    Cholera, unspecified
( 4) A01.00   Typhoid fever, unspecified
( 5) A01.01   Typhoid meningitis
( 6) A01.02   Typhoid fever with heart involvement
( 7) A01.03   Typhoid pneumonia
( 8) A01.04   Typhoid arthritis

Enter choice--
                        next pg(/ or PG DN)  Search(TAB)
```

The ICD-10-CM Code field is added to provide access to the ICD-10-CM table to select an ICD-10 diagnosis code. An ICD- 9-CM code and an ICD-10-CM code selected for the same user-defined ICD Diagnosis Pointer entry is considered mapped. Each user-defined entry requires either an ICD-9 code or an ICD-10 and permits one of each as appropriate.

The functionality of the other fields in the table remain the same as before the ICD-10 Enhancement.

Prior to the implementation of the ICD-10 Coding, the new field in the table should be used to define additional user diagnosis in the table or map ICD-9 and ICD-10 codes for use in Order Entry and Charge Entry. Until the implementation of the ICD-10 Enhancement, only ICD-9 codes are filed for use in processing the orders and charges.

- ICD Procedure Pointer Table

```
               General Hospital Table Maintenance Processor
                                                    Tue Jul 14, 2009 11:28 am
ICD Procedure Pointer Table
( 1)Code           : 38
( 2)Description    : CARPAL TUNNEL RELEASE
( 3)ICD-9-CM Code  :
( 4)ICD-10-PCS Code:

( 5)Edit by        : Stephens,John
( 6)Edit date      : 06/01/09 02:07









Enter field number or '/' starting field number--
```

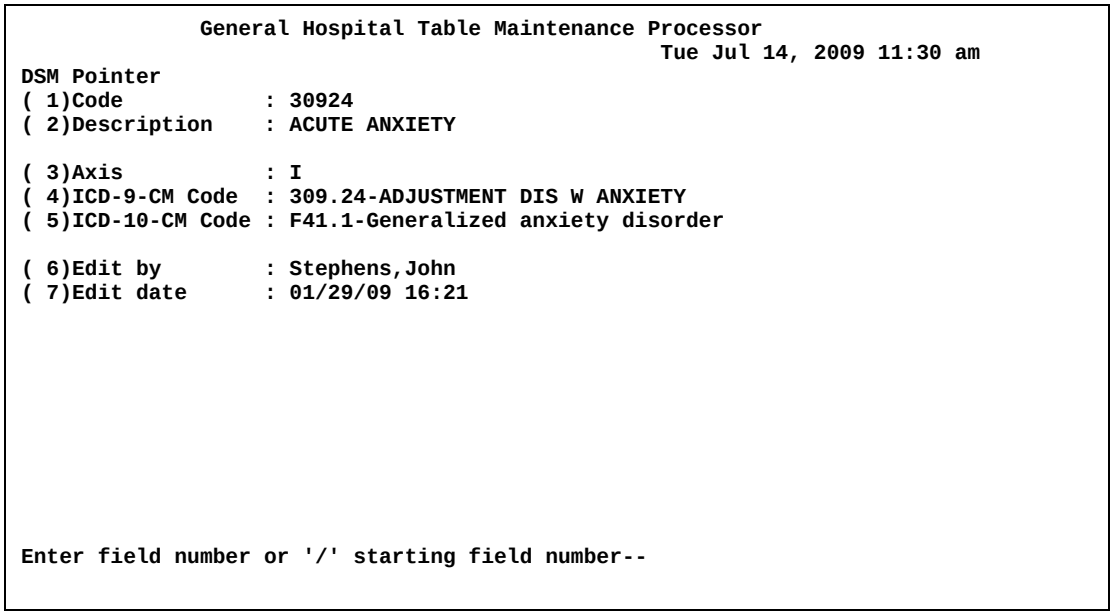
The ICD-10-PCS Code field is also a new field to provide access to add the ICD-10-PCS Code.

This table requires the entry of either an ICD-9 or an ICD-10 Procedure code and permits one of each as appropriate.

The functionality of the other fields in the table remain the same as before the ICD-10 Enhancement.

Prior to the implementation of the ICD-10 Coding, the new field in the table should be used to define additional user diagnosis in the table or map ICD-9 and ICD-10 codes for use in Order Entry and Charge Entry. Until the implementation of the ICD-10 Enhancement, only ICD-9 codes are filed for use in processing the orders and charges.

- DSM Pointer Table



The ICD-10-CM Code field is also a new field to provide access to add the ICD-10-CM code.

This table requires at least one ICD-9 code or ICD-10 code or one of each and permits one of each as appropriate.

The functionality of the other fields in the table remain the same as before the ICD-10 Enhancement.

Prior to the implementation of the ICD-10 Coding, the new field in the table should be used to define additional user diagnosis in the table or map ICD-9 and ICD-10 codes for use in Order Entry and Charge Entry. Until the implementation of the ICD-10 Enhancement, only ICD-9 codes are filed for use in processing the orders and charges.

- Order Review

```
                  General Hospital Order Review Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
0217200011    JOHNSON,HAL        M  04/23/32 2130-01 JAMES,STEVEN MED 9  OPO 56
 1 Order No.    2 Department          3 Item
   80             (A) Radiology         7120 XR CHEST PA & LAT  71020
 4 ABN     5 ABN Reason                          6 Frequency Limit
   App                                           Once every 180 days
 7 Med Nec Dup HCPCS          8 Med Nec Dup/Conflict HCPCS Override

 9 HCPCS/Modifiers           10 Conflicting HCPCS Code   11 Conflict Category
   71020
12 CCE Modifier Allowed      13 Order Dx ICD-9-CM
                                351.0-BELL'S PALSY
14 Order Dx ICD-10-CM




View order info(I), cancel(X), complete(C)--   |
                    next order(/) or previous order(/P) [/]
```

In Order Review, an additional field to display the ICD-10-CM has been added to the G option in the prompt. When the G option is selected, the new field displays along with the prior compliance fields on this screen. The Order Dx ICD-10-CM element (field 14) on the following screen displays the ICD-10 entry after the ICD-10 coding enhancement is implemented. Until the ICD-10 coding is implemented and some ICD-10-CM codes are selected during Order Entry, this field is null.

- ICD User Pointer Table Reports

In the following example, the abbreviated report represents the changes to the ICD User Diagnosis Pointer report, the ICD User Procedure Pointer Table report and the DSM Table report. The reports are printed in four sections. The first section lists the user-defined codes that have an ICD-9 and an ICD-10 code, the second section lists the user-defined codes with ICD-9 codes only, the third section lists the user-defined codes with ICD-10 codes only and the last section lists any user-defined codes with no ICD codes defined. This report assists the users when performing the maintenance, as needed, for these tables.

```
06/01/09 02:25           STAR Development System                    Page   1
                         ICD Diagnosis Pointer Table

 Code        Description                        Average LOS
                ICD-9-CM Code and Description
                ICD-10-CM Code and Description
-------------------------------------------------------------------------
  715        A-BOTH ICD CODES-9 & 10            3
                351.0    BELL'S PALSY
                G51.0    Bell's palsy
  111        A/A CHEST PAIN
                786.50   CHEST PAIN NOS
                B26.84   Mumps polyneuropathy
  412        ACUTE DUODENAL ULCER NO HEM/ULCER
                532.30   ACUTE DUODENAL ULCER NOS
                K26.3    Acute duodenal ulcer without hemorrhage,
```

```
06/01/09 02:25             STAR Development System                  Page   1
                         ICD Diagnosis Pointer Table

 Code        Description                        Average LOS
                ICD-9-CM Code and Description
-------------------------------------------------------------------------
  712        A-NINE ICD CODE ONLY               5
                791.1    CHYLURIA
  337        A/A BACK PAIN
                015.00   TB OF VERTEBRA-UNSPEC
  335        A/A CHEST INJURY
                959.1    TRUNK INJURY NOS
```

```
06/01/09 02:25             STAR Development System                  Page   1
                         ICD Diagnosis Pointer Table

 Code        Description                        Average LOS
                ICD-10-CM Code and Description
-------------------------------------------------------------------------
  713        A-ANOTHER 10 ONLY CODE                    6
                A17.89   Other tuberculosis of nervous system
  711        A-TEN ICD CODE ONLY                       5
                E21.0    Primary hyperparathyroidism

-------------------------------------------------------------------------
 Code        Description                        Average LOS
                          No ICD Code Defined
-------------------------------------------------------------------------
  329        CONCUSSION
  161        ENLARGED UTERUS


                              End of Report
```

- HCPCS PROCESSOR

```
              General Hospital HCPCS Table Maintenance Processor
                                                    Mon Jun 1, 2009 03:42 pm

( 1)HCPCS Code                : 80076
( 2)Description               : HEPATIC FUNCTION PANEL
( 3)Revenue Code              : 300
( 4)Out-of-Scope Ind          :
( 5)Sex Specific Code         :
( 6)Age "From" Restriction    :
( 7)Age "To" Restriction      :
( 8)Inactive Indicator        :
( 9)Inactive Date             :
(10)8xx Ambulatory Procedure  : Yes
(11)Valid ICD-9-CM CMS Codes  : 791.1-791.2
(12)ICD-9-CM Comment          :
(13)Valid ICD-10-CM CMS Codes : K50.013 A18.89 C83.72
(12)ICD-10-CM Comment         : Contact the FI to obtain the valid DX
(14)DPW Diagnostic Procedure  : No
(15)XREF HCPCS / CPT Codes    : 82040 82247 82248 82251 84075 84155 84450 more
(16)Frequency Limitation      :
(17)Effective Date            :
(18)
    Edit by, Date and Time    : Stephens,John, 03/17/09 1443

Enter field number or '/' starting field number--
```

The Valid ICD-10-CM CMS Codes field is available to define the list of valid ICD-10 codes for the specific HCPCS by using the same data entry functionality used to define the Valid ICD-9-CM CMS Codes.

The Valid ICD-10-CM CMS Codes should be defined in the HCPCS Processor table prior to the implementation of the ICD-10 enhancement.

Testing Guidelines

1. Access the ICD User Pointer table to validate access to the ICD-9-CM codes and the ICD-10-CM codes. Define additional user codes or update some of the previous codes to ensure the functionality.

2. Perform the same steps in the ICD User Procedure Pointer table and the DSM Pointer table.

3. Print the ICD User Pointer tables to review and validate the changes to the report.

4. Access the HCPCS Processor table to verify the access to the ICD-9 and ICD-10 codes in the appropriate Valid ICD Codes fields. Add some ICD-10 codes to several HCPCS entries. Select some HCPCS with previous valid ICD-9 codes and add valid ICD-10 codes. Select some entries with no valid ICD-9 codes and add valid ICD-10 codes only. Verify the HCPCS being used are defined in the FIM as expected.

5. Admit some patients using various patient types, insurance carriers, insurance plans, and financial classes. Also enter some varied admitting diagnosis including Admitting, Working, Principal, and Secondary.

6. Work with the ADT / Patient Processing group at your facility to combine this effort.

7. For one admission, select the working diagnosis from the DSM Pointer Table. In the Working Diagnosis, verify the actual ICD-9 code is displayed instead of the user-defined code.

8. On one admission, enter a free text entry as one of the admitting diagnosis to verify the display in the list and in STAR Order Management.

9. If your facility uses the STAR Order Management Medical Necessity Checking, admit a patient as an outpatient in a bed with CMS compliant insurance.

10. For the CMS compliant patient, enter order and charges to trigger the ABN checking, Duplicate HCPCS, and cross reference checking to validate the functionality.

11. Using the Order Entry Access points, enter Orders for STAR Laboratory, STAR Radiology, a Clinical Management department such as Respiratory Therapy, and some of the other ancillary departments. Use different options in the Ordering Diagnosis / Reason for Exam prompt including a free text entry.

12. After entering orders, check Order Review for all of the orders that have diagnosis entered. Use the G option in the prompt to review the new fields on this screen for the ICD-9 and ICD-10 codes. (ICD-10 field remains null until the ICD-10 Enhancement is implemented.) Validate the display of the free form entry in STAR Patient Accounting in the Account Inquiry function.

13. Review the requisitions for the orders.

14. If the facility uses Navigator in Order Management to review Order Review or Results Inquiry, login in to a Navigator session to validate the GUI functions,

15. Enter multiple manual charges for the patients using the options available in the Order Diagnosis prompt. In Charge Inquiry, review the charges and the ICD-9 codes. Review these charges in STAR Patient Accounting in the Account Inquiry option.

16. Cancel some of the charges as permitted in Charge Inquiry and review the credits in Charge Inquiry and account inquiry...

17. Enter multiple manual Credits. Review the credits in Charge Inquiry and Account Inquiry.

18. For the CMS compliant patient, review the ABN / Duplicate HCPCS Processor data and make some edits to the ICD-9 diagnosis.

19. Make some edits to the ICD codes using the Edit PA Charge function. Review these in Account Inquiry.

20. Enter some Late Charges and Late Credits and review the results.

21. Access the PA Charge Reversal function in STAR PA. Select some patients and charges to reverse. Review these results in Account Inquiry and Charge Inquiry.

22. Review the patient and station demand reports as applicable in your facility.

23. After the Orders are entered review the HL7 audit to verify the ICD-9 in the outbound messages and as applicable the inbound audit.

24. McKesson recommends performing regression testing prior to implementing the ICD-10 enhancement.

STAR LABORATORY

Until the ICD-10 functionality is implemented, ICD-9 Order Diagnosis processing essentially remains the same with some limited exceptions.

When the specified list of STAR STIs is moved into the appropriate environments in the facility's system, some of the necessary changes to assist in the orderly transition to ICD-10 Diagnosis and Procedures are visible and functional prior to reaching the implementation date defined in the Patient Processing parameter, USA ICD10 Eff Date. Please refer to the STAR Patient Processing sections of this *STAR ICD-10 Implementation Guide* for a detailed explanation of this parameter as well as the parameters added to the Insurance Plan table, the Insurance Carrier table, and the Financial Class table.

The changes visible in STAR Laboratory prior to the ICD-10 effective date are there to assist the user in identifying the correct diagnosis options at order and charge entry (when ICD-10 is implemented) and to accommodate the future display/print of ICD-10 diagnoses in Order, Charge, Inquiry processors and reports. Order and charge processing on STAR Laboratory is closely intertwined with the same processes on STAR Order Management. Tables related to diagnosis entry shared by the STAR clinical products (Order Management, Laboratory, Radiology), have been enhanced to provide the ability to perform maintenance in preparation for ICD-10 implementation. The shared tables affecting the Laboratory department include the ICD Diagnosis Pointer Table, the HCPCS table and the DSM Pointer table. The updates to these tables are documented in the Order Management Tables and Parameters section of this document. Please see this section for more detailed information. The clinical departments should work together to update the tables prior to the ICD-10 effective date.

Procedurally, the facility should be ready to use the ICD-10-CM and ICD-10-PCS codes before defining the effective date for the implementation of this enhancement. By making the changes in the tables available prior to the implementation date, STAR 2000 provides the facility the tools to prepare for using the ICD-10 coding.

There are no changes to any tables or parameters on STAR Laboratory and no specific STAR Laboratory implementation steps. You will see the following screen/report changes prior to the ICD-10 effective date.

- Patient Demographic Header

```
               General Hospital Patient Inquiry Processor
                                                  Wed Jun 10, 2009 02:15 pm
Unit #     Name            Sex Birthdate  Room    Physician     Srv ICD Status
A000006016 RDTWO,NINEOPMED  F  01/05/1931 211-1   ADAMS,JAY K   MED  9  OPB 86
```

The patient demographic header has been updated to display the ICD diagnosis and procedure indicator wherever a patient is selected in any STAR Laboratory

processor. The ICD indicator is designed to assist the user in diagnosis entry in order and charge processors. Prior to the ICD-10 effective date, all patients display a 9 indicator. After ICD-10 is implemented, patients may display either a 9, 10, or B (both) indicator, depending on if the patient was admitted prior to the ICD-10 effective date and whether the patient has insurance plan, insurance class, financial class, and/or patient type exceptions. After the ICD-10 effective date, most patients have an ICD indicator of 10 or B.

- Patient Inquiry

  The Order Diagnosis field in General information (G) has been expanded from 20 to 24 characters to accommodate the longer ICD-10 diagnosis descriptions. Other fields on the same line have been moved to the right to accommodate the increased field length.

  The Order Diagnosis field in Outpatient Charge Documentation (O) has been expanded from 30 to 46 characters to accommodate the longer ICD-10 diagnosis descriptions.

- History Cardfile Printed Report

  The Order Diagnosis (form element LHCFODX) on the History Cardfile printed report has been expanded from 15 to 21 characters to accommodate the longer ICD-10 diagnosis descriptions.

- Miscellaneous Charge/Credit Report

  If a free form order diagnosis is used to process a miscellaneous charge or credit on a CMS-compliant patient, it now prints on the Miscellaneous Charge/Credit.

Implementation Steps

There are no specific implementation steps for STAR Laboratory. The USA ICD Effective Date is set from STAR Patient Processing. When the effective date is past, ICD-10 diagnoses and procedures may be collected for the patient.

The ICD Diagnosis Pointer Table and HCPCS Table must be updated prior to the ICD-10 effective date. The ICD Diagnosis Pointer Table (U-) is the only method available for collecting both the ICD-9 and ICD-10 diagnosis codes in order and charge entry after the ICD-10 effective date, for those patients with a B indicator. Therefore, it is essential that this table be reviewed and updated and procedures put in place for those users responsible for order and charge entry. The effort to update these tables should be coordinated with the other STAR Clinical coordinators.

Tables and Parameters

Please see the STAR Order Management section of this document for common clinical tables that should be updated prior to the ICD-10 effective date.

Testing Guidelines

Test patients should be admitted using various patient types, insurance carriers, insurance plans and financial class. If your facility uses Outpatient Charge Documentation/ABN/Medical Necessity processing, admit patients that are CMS compliant. Use a variety of admitting diagnoses including principle and secondary diagnoses. If the DSM pointer table is used in your facility, enter a working diagnosis using the DSM pointer table for at least one patient admission.

1. Verify the following processes, functions and output:

    - Diagnosis entry in order and charge processors. Edit the order diagnosis in the following processors: Order Entry, Accessioning, Revise Order, Case Login, Previous Case Accession and Result Reporting (/A, /O, /AA, /OO). Test all methods of diagnosis entry: ICD diagnosis pointer table (U-), Approved Dx list (A-), Admit Dx list (Dx), ICD code entry and ICD table selection and free form where permitted.

    - Use a variety of different tests including General lab, Advanced Micro, Anatomic Pathology, tests with Professional fee items, Sendout tests, Interdepartment tests (if applicable) order panels and charge panels.

    - Use various order priorities including one with a STAT charge.

    - Order multiple tests/per accession and use different diagnoses per test

    - Verify correct diagnosis entry and prompts based on patient ICD indicator 9

    - Specimen Reject several accessions and verify correct diagnosis for Specimen Rejection Re-order.

    - Verify diagnosis prints on applicable barcode labels.

    - Verify diagnosis prints on applicable dot matrix labels.

2. Verify the following processes in Outpatient Charge Documentation (OPCD) for CMS Compliant Patients.

    - Diagnosis entry in the following order and charge processors: Order Entry, Revise Order, Miscellaneous Charge/Credit, Case Login, Professional Billing (attached to a SIM item and charged at resulting), Histotech Processing (add/ delete block), Adv Micro Result Reporting (menu options with billing and Misc Charges). Test all methods of diagnosis entry: ICD diagnosis pointer table (U-), Approved Dx list (A-), Admit Dx list (Dx), ICD code entry and ICD table selection and free form where permitted.

- Use a variety of different tests including General lab, Advanced Micro, Anatomic Pathology, tests with Professional fee items, Sendout tests, Interdepartment tests (if applicable) order panels and charge panels.
- Use various order priorities including one with a STAT charge.
- Order multiple tests/per accession and use different diagnoses per test
- Verify correct diagnosis entry and prompts based on patient ICD indicator 9
- Verify appropriate ABN processing occurs.
- Verify all ABN information is documented.
- Verify output on ABN.

3. Inquiry Processors. Verify the correct diagnosis displays on the following screens for all orders and charges.
   - Patient Inquiry - (G) General Information, Order Diagnosis field.
   - Patient Inquiry - (D) Admitting Diagnosis List, Code and Description.
   - Patient Inquiry - (O) Outpatient Charge Documentation, Order Diagnosis field.
   - Patient Inquiry - (H) History Cardfile, Order Diagnosis (description only).
4. Verify the correct diagnosis prints on History Cardfile, printed report.
5. Verify diagnosis displays/prints correctly on the following reports.
   - Miscellaneous Charge/Credit - display.
   - Miscellaneous Charge Report
   - Professional Billing Report
6. Verify correct ordering diagnosis description prints on long report for each demographic header type.
   - Print Hsp Info / Print Pat Demo Lits – LPFS1
   - Print Hsp Info / Suppress Pat Demo Lit – LPFS2
   - Suppress Hsp Info / Print Pat Demo Lit – LPFS3
   - Suppress Hsp Info / Suppress Pat Demo Lit – LPFS

- Long Report Hdr (Alt) – LPFS5

7. Verify correct working and ordering diagnosis description prints on Archive Summary report.

8. Verify diagnosis in interface transactions for all applicable interfaces. Some interfaces that may pass diagnosis information include:

   - Blood Bank interface
   - Reference Lab interface
   - Instrument interfaces

9. Use the Edit HCPCS/Modifiers on PA Charges function and edit diagnosis, HCPCS and modifier information for some lab charges. Verify changes are updated on STAR Patient Accounting.

10. Verify diagnosis for all orders/charges in STAR Patient Care Charge Inquiry and STAR Patient Accounting Account Inquiry.

STAR RADIOLOGY

Until the ICD-10 functionality is implemented, ICD-9 Order Diagnosis processing essentially remains the same with some limited exceptions.

When the specified list of STAR STIs are moved into the appropriate environments in the facility's system, some of the necessary changes to assist in the orderly transition to ICD-10 Diagnosis and Procedures are visible and functional prior to reaching the implementation date defined in the Patient Processing parameter, USA ICD10 Eff Date. (Please refer to the STAR Patient Processing sections of this *STAR ICD-10 Implementation Guide* for a detailed explanation of this parameter as well as the parameters added to the Insurance Plan table, the Insurance Carrier table, and the Financial Class table.)

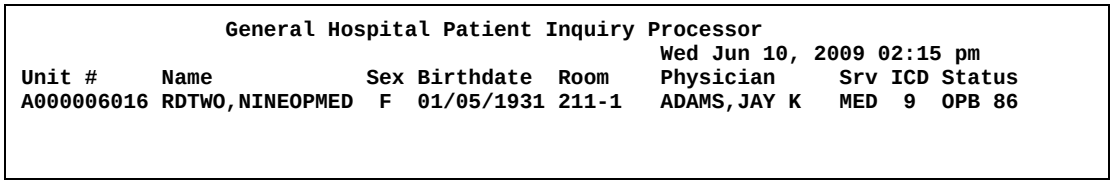
The changes visible in STAR Radiology prior to the ICD-10 effective date are there to assist the user in identifying the correct diagnosis options at order and charge entry (when ICD-10 is implemented) and to accommodate the future display/print of ICD-10 diagnoses in Order, Charge, Inquiry processors and reports. Order and charge processing on STAR Radiology is closely intertwined with the same processes on STAR Order Management.

Tables related to diagnosis entry shared by the STAR clinical products (Order Management, Laboratory, Radiology), have been enhanced to provide the ability to perform maintenance in preparation for ICD-10 implementation. The shared tables affecting the Radiology department include the ICD Diagnosis Pointer Table, the HCPCS table and the DSM Pointer table. The updates to these tables are documented in the Order Management Tables and Parameters section of this document. Please see this section for more detailed information. The clinical departments should work together to update the tables prior to the ICD-10 effective date.

Procedurally, the facility should be ready to use the ICD-10-CM and ICD-10-PCS codes before defining the effective dates for the implementation of this enhancement. By making these changes in the tables available prior to the implementation date, STAR 2000 provides the facility the tools to prepare for using the ICD-10 coding.

The following is a list of the ICD-10 Enhancement changes that are visible in STAR Radiology prior to the ICD-10 effective date:

- Patient Demographic Header



```
                General Hospital Patient Inquiry Processor
                                                    Wed Jun 10, 2009 02:15 pm
Unit #     Name            Sex Birthdate  Room    Physician     Srv ICD Status
A000006016 RDTWO,NINEOPMED  F  01/05/1931 211-1   ADAMS,JAY K   MED  9  OPB 86
```

The patient demographic header has been updated to display the new ICD diagnosis and procedure indicator wherever a patient is selected in any STAR

Radiology processor. The ICD indicator is designed to assist the user in diagnosis entry in order and charge processors. Prior to the ICD-10 effective date, all patients display a 9 indicator. After ICD-10 is implemented, patients may display either 9, 10, or B (both) indicator, depending on if the patient was admitted prior to the ICD-10 effective date and whether the patient has insurance plan, insurance class, financial class, and/or patient type exceptions. After the ICD-10 effective date, most patients have an ICD indicator of 10 or B.

- Patient Inquiry

  All diagnosis fields were updated to display ICD-10 codes. Current functionality (display ICD-9) applies if the effective date is not activated. If only an ICD-9 diagnosis is collected for the patient, it displays in the current diagnosis fields.

  To accommodate the longer ICD-10 diagnosis descriptions, the current Diagnosis fields were modified to truncate at maximum available space and append with a "+" to indicate the Dx description has been truncated.

- Billing Report

  The Billing Report was updated to display/ print the longer ICD-10-CM diagnosis codes. To accommodate this change the Ord DX column was lengthened to allow 10 characters. The ABN field was moved 3 characters to the right and the Freq Limit field was moved 2 characters to the right. The Freq Limit field was already truncated at 18 and now truncates at 15 to fit the line.

  When OPCD information (ordering diagnosis, ABN reason, etc.) is entered to process a nonprocedural charge on a CMS compliant patient, it now prints on the Billing Report.

- Patient Reports

  All "Diagnoses" form elements were updated to print ICD-10 diagnosis when collected. If there is no ICD-10 diagnosis collected, then the ICD-9 diagnosis is printed. These elements are used on the Flashcard or Exam Request/Transport Slip, Order Revision Notice, Outside Transcription Report and Final Report forms. The updated elements are in use once these forms are generated as part of the Upgrade or ESD move.

  The current elements continue to print ICD-9 diagnoses even if the form element implementation is not completed at this time. However, in order to print ICD-10 diagnoses, the forms must be generated for the new changes to take effect.

  Current custom diagnosis elements should continue to print ICD-9 diagnoses. These do not print ICD-10 diagnoses unless they are retrofitted with the new changes.

- Interfaces

Currently there are three base 2.2 interfaces used in Radiology. These are Mammography, Dictation/Transcription and Speech Recognition interfaces. They use versions of 2.2 data element 626 to send Ordering Diagnosis outbound. A new version of the 626 element was created to determine whether to send ICD-9 or ICD-10 and build the piece accordingly.

There is an implementation step in which the customer determines whether to use the new element or the current element. This step is only necessary when the customer implements ICD-10 Diagnosis Codes. Both the old and the new O/B 2.2 data element process ICD-9 dx codes.

- HPP Radiology Workflow

  ICD-9 admitting and ordering diagnoses continue to display on several forms in the HPP Radiologist Workflow (RWF) module. The Ordering Dx can be revised in several places once in the Review Detail form. One option for displaying the table of ICD-9 diagnosis codes for revision is the User Dx Pointer table. Once the facility begins to build /add ICD-10 codes to the Dx Pointer table (in Order Management tables), these User descriptions are not available for ICD-9 dx selection in the RWF Review form.

- HCPCS Table - Standalone systems

  If STAR Patient Care is not installed, the HCPCS Table can be accessed in the Location Maintenance processor. Additional fields were added to the HCPCS Processor Table to accommodate defining the ICD-10 Valid Diagnosis Codes and ICD-10 Comment. The ICD-10 codes defined in the ICD-10 Valid Diagnosis field are used for the ABN / Medical Necessity processing after implementing the ICD-10 Enhancement.

  Other than the limited changes listed above, the process of selecting ICD-9 diagnosis in the order and charge processors and the current ABN / Medical Necessity Processing with ICD-9 codes remains the same until the ICD-10 implementation date. The ABN/Medical Necessity Processing in STAR Radiology functions the same using the valid ICD-9 codes defined in the HCPCS Processor. The ABN Processing continues to use the ICD-9 codes until the implementation of the ICD-10

Implementation Steps

There are no specific implementation steps for STAR Radiology prior to the implementation of the ICD-10 coding.

When the USA ICD Effective Date set on STAR Patient Processing is past, ICD-10 diagnoses and procedures may be collected for the patient.

- Forms

All "Diagnoses" form elements were updated to print ICD-10 diagnosis when collected. If there is no ICD-10 diagnosis collected, then the ICD-9 diagnosis are printed. These elements are used on the Flashcard or Exam Request/Transport Slip, Order Revision Notice, Outside Transcription Report and Final Report forms.

If you are using these elements on any STAR Radiology forms, the form must be generated for the changes to take effect. Forms are auto generated as part of an Upgrade or ESD move process. If implementing this enhancement outside of an Upgrade or ESD move, the forms need to be generated manually.

Any custom Diagnosis elements should be evaluated for removal or retrofit.

ICD-9 diagnoses continue to print on the forms if the new form element changes are implemented or not at this time.

** Please refer to the Forms section of STI X5556 and also to the Radiology ICD-10 Implementation section of this guide for the list of elements and details of the changes.

- Interfaces

Customers using 2.2 outbound interfaces for Mammography, Transcription or Speech Recognition interfaces need to determine if they want to use the new Ordering Diagnosis data element. This pending change is for the addition of a new data element 626-04.

Both the old and the new O/B 2.2 data elements process ICD-9 prior to the ICD-10 implementation date. If customers want to use the new O/B 2.2 data element, they must implement and test the new data element.

This step is only necessary when the customer implements ICD-10 Diagnosis Codes.

** If the changes are to be implemented at this time please refer to the details of the element changes listed in the Miscellaneous section of STI X5556 and also in the Radiology ICD-10 Implementation section of this guide.

Tables and Parameters

There are no changes to any tables or parameters for STAR Radiology.

The ICD Diagnosis Pointer Table and HCPCS Table on Order Management must be updated prior to the ICD-10 effective date. The ICD Diagnosis Pointer Table (U-) is the only method available for collecting both the ICD-9 and ICD-10 diagnosis codes in order and charge entry after the ICD-10 effective date, for those patients with a B indicator. Therefore, it is essential that this table be reviewed and updated and procedures put in place for those users responsible for order and charge entry. The

effort to update these tables should be coordinated with the other STAR Clinical coordinators.

HCPCS Table – Standalone systems: If STAR Patient Care is not installed, the HCPCS Table can be accessed in the Location Maintenance processor.

Please see the STAR Order Management section of this document for common clinical tables that should be updated prior to the ICD-10 effective date.

Testing Guidelines

McKesson recommends performing regression testing prior to implementing the ICD-10 enhancement.

Test patients should be admitted using various patient types, insurance carriers, insurance plans and financial class. If your facility uses Outpatient Charge Documentation/ABN/Medical Necessity processing, admit patients that are CMS compliant.

Use a variety of admitting diagnoses including principle and secondary diagnoses. If the DSM pointer table is used in your facility, enter a working diagnosis using the DSM pointer table for at least one patient admission. Work with the ADT / Patient Processing group at your facility to combine this effort.

1. Verify the correct ICD Indicator (9 only until the ICD-10 Effective Date) displays in the demographic header. Verify that all other data in the header is properly displayed.

2. Verify correct transaction prompts in the following processes. Verify correct Ordering and/or Working Diagnosis is stored and sent to PA. Verify correct displays and printed output. (CheckIn Docs, Revision Notices, etc)

    - Verify correct Order Diagnosis and Working Diagnosis entry and display in Order and Charge processors:

        - Exam Request Entry

        - Patient CheckIn

            - CheckIn orders from STAR Pt. Care Order Management and STAR Radiology.

            - Include Orders that Auto CheckIn such as ER Patient types.

            - Order/CheckIn some exams using the Add-on and Order Revision functions.

        - Inactive Account Check In

- Order Revision - access via Patient CheckIn, Exam Data Entry, Report Review) - only Ordering diagnosis field.

- Verify correct diagnosis entry and transaction prompts based on patient's ICD indicator = 9.

- Verify all methods of dx entry from prompt: ICD diagnosis pointer table (U-), Approved Dx list (A-), Admit Dx list (Dx), ICD code entry and ICD table selection and free form where permitted.

- Use a variety of different exams including exams with Professional fee items, order panels and charge panels. Use various order priorities including one with a STAT charge.

- Order multiple exams/per CheckIn and use different diagnoses per exam. (if dept. uses multiple exams/Checkin)

3. Verify the following processes in Outpatient Charge Documentation (OPCD) for CMS Compliant Patients.

   - OPCD diagnosis entry and processing in Patient CheckIn (New Order, Add On Order, Exam Requests), Order Revision, Pro Fee Billing and Non-Procedural Charge Entry.

     - Verify correct diagnosis entry and transaction prompts based on patient's ICD indicator = 9.

     - Test all methods of diagnosis entry: ICD diagnosis pointer table (U-), Approved Dx list (A-), Admit Dx list (Dx), ICD code entry and ICD table selection and free form where permitted.

     - Use a variety of OPCD processing: Valid dx, ABN proc for invalid dx, Frequency Limit, Med Nec/Dup/Conflict HCPCS/Reasons, HCPCS modifiers.

     - Use a variety of different exams including exams with Professional fee items, order panels and charge panels. Use various order priorities including one with a STAT charge.

     - Order multiple exams/per CheckIn and use different diagnoses per exam. (if dept. uses multiple exams/Checkin)

   - Verify the correct ordering diagnosis files for the transaction on STAR OM and STAR Rad.

   - Verify the correct diagnosis/OPCD displays on Inquiry screens.

   - Verify appropriate ABN processing occurs

- Verify all ABN information is documented.

- Verify output on ABN

4. Verify correct display of Ordering, Admitting, and Working Diagnoses as applicable in the following screens:

   - Patient Inquiry - Demographic Screen, Exam Information Screen, Financial Screen

   - Patient Inquiry - Admitting Diagnosis List

   - Patient Inquiry - Screen Header - Activity tracking Incomplete Results screen, Results display screen.

   - Exam Data Entry screens – Demographic Header

   - Exam List screen - ordering diagnosis displays on line 2 of each CheckIn/exam display.

   - TELIC File - - Ordering diagnosis is displayed on the Create/Edit File Entry screen and also on the TELIC File Search screen/report.

   - HPP Radiologist Workflow - Admitting and Ordering Dx is displayed on several forms.

5. Verify proper output (displays/print) on the following reports:

   - Billing Report

   - Order Revision Report

   - 1500 Billing Exception Report

   Verify the positions of all headers on the reports.

   Verify all data in the body of the report prints in the proper positions.

   Verify that the reports reflect the correct diagnosis as entered or captured

6. Verify correct diagnosis prints on forms that use the diagnosis form library elements affected by this enhancement. These may include the following Patient Reports:

   - Cancel Notice, Archive Summary, Revision Notice, Request/transport Slips, Flashcard/CheckIn Documents, and Final Reports.

7. Verify ICD-9 diagnoses are correctly passed via network transactions of Orders, Charges, Revised Orders, Profee charges, Non-Procedural Charges, Cancel Exam Request (when a credit is issued on a CMS patient), Cancel/Credit CheckIn (when a credit is issued on a CMS patient).

   Verify diagnosis for all orders/charges in STAR Patient Care Charge Inquiry and STAR Patient Accounting Account Inquiry.

8. Stand Alone Radiology systems - Verify that the HCPCS table can be edited for ICD-10 codes. Users need to be able to define the new "Valid ICD-10 Dx'" fields.

9. Use the Edit HCPCS/Modifiers on PA Charges function and edit diagnosis, HCPCS and modifier information for some Rad charges. Verify changes are updated on STAR Patient Accounting.

10. After the Orders are entered, review the HL7 audit to verify the ICD-9 dx in the outbound messages.

    - Currently STAR Radiology has one base 2.2b interface. It is the HMI results interface. Verify that OBR.31 sends outbound the correct ICD diagnosis code. Inbound, STAR Rad does not process the OBR.31.

    - Currently there are three 2.2 interfaces. They are Mammography, Transcription and Speech Recognition. They use versions of 2.2 data element 626 to send Ordering Diagnosis outbound. An implementation step is required to use the new element if desired. Verify that if this element is used, the proper ICD code is passed. Verify that the downstream system received the correct diagnosis format. Inbound, STAR Radiology does not process the ordering diagnosis.

    - Verify diagnosis in interface transactions for all applicable site specific interfaces.

STAR PHARMACY

STAR Pharmacy was revised to display and print the diagnosis description for both ICD-9 and ICD-10 patients. Users see no changes in screens or reports with the exception of the pharmacy nursing screens (for example, Profile Inquiry, Floorstock Charge) which use the Patient Care patient header and now has the ICD indicator.

```
                    General Hospital Charge Processor
Laboratory Charge                                  Tue Jun 09, 2009 11:26 am
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
0907600003    RDTWO,NINEIPCOM   F  03/03/33 B006-01 HANCE,JENNIFEMED 9  I/P 76
```

The Ambulatory Care module was revised to add an ICD indicator in the outbound electronic claims (ECS) interface when a diagnosis is entered on the DUR screen for the prescription. The O/P Third Party Claim Info table was revised to add an ICD9/ ICD10 switch for each third party.

The PharmLINK interface was modified to populate the diagnosis description for both ICD-9 and ICD-10.

Implementation Steps

There are no implementation steps unless the Ambulatory Care electronic claims processing is implemented.

Tables and Parameters

If Ambulatory Care electronic claims have been implemented utilizing DUR, update the O/P Third Party Claim Info table to add an ICD9/ICD10 switch for each third party. The third parties should be set to ICD-9 until the third party sends notification that they can accept ICD-10 coding.

```
             General Hospital RX Table Maintenance Processor
                                                  Tue Jul 14, 2009 12:18 pm
O/P Third Party Claim Info
 1 Code          2 Description
   GA              GEORGIA MEDICAID                       6 Record Length
 3 Block Size    4 Character Set    5 Tape Mode


 7 Direct Bill Nbr  8 Service Provider ID                 9 Processor Ctrl Nbr
                       770657                               9999999999
10 BIN           11 Claim Format    12 Prescriber Number   13 Software Cert ID
   610415           51-Variable        Prescriber# - 01

14 Tape Claim Retn      15 Paper Claim Retn    16 Electronic Claim Retn
   30 days                 30 days                4 days
17 ICD9/ICD10 Switch
   ICD10

18 Edit By                    19 Edit Date
   Stowe,Kristen                 03/03/09 15:52


Enter field number or '/' starting field number--
```

Testing Guidelines

1. Review all printed output that contains patient diagnosis to verify that the diagnosis appears. Reports to review are:

   - Medication Transfer Reorder Report
   - Discharge Planning Report
   - Ambulatory Care Patient Profile
   - Patient Profile (inpatient)
   - MAR
   - SAR
   - Discharge Summary
   - ADR Override Report
   - Drug-Drug Interaction Override Report
   - Allergy Deferment Report
   - DUE Worksheet

- Any custom reports/labels that contain diagnosis

2. Validate that the Pharmacy Demographics page accessed via Profile Maintenance screen displays the ICD-9 or the ICD-10 code descriptions correctly in the Diagnosis/complaint field.

3. ECS interface transactions cannot be seen by non-McKesson employees. If this interface is implemented, McKesson can provide screen prints of the interface transactions to confirm their content.

   Example transactions follow:

```
^PJ("PCS","B53")    ="A0100003150000000051B19999999999107TESTETST       20
                     080825           030 028AM01 028CX01 028CY555664534
                                028C419700101 028C51 028CAADAM         028
                     CBTEST             028CM4
                       028CNDEFAULT CITY          028CONJ 028CP30005
                          028CQ5555555555 028C700 0281C  030 028AM04 028C
                     2123                    028C90 028C103030205        028
                     C31   028C61 028FO123      029 030 028AM07 028EM1 028
                     D20000315 028E103 028D700045050104          028E70000
                     010000 028D300 028D5010 028D61 028D81 028DE20080825 028
                     DF02 028ET0000010000 028C800 028DT2 02828EA 030 028A
                     M02 028EY02 028E9                 030 028AM03 028EZ01
                      028DB1122334455      0281E10  028DRADAIR           030
                      028AM11 028D90000300{ 028DC0000050{ 028DX0000100{ 028
                     HA0000010{ 028DQ0000360{ 028DU0000360{ 028DN01 030 028
                     AM13 028VE1 028WE02 028DOA389"
^PJ("PCS","B54")    ="A0100003150190001351B1          1076506572        20
                     0808255101206570 030 028AM01 028CX01 028CY555664534
                                028C419700101 028C51 028CAADAM         028
                     CBTEST             028CM4
                       028CNDEFAULT CITY          028CONJ 028CP30005
                          028CQ5555555555 028C700 0281C  030 028AM04 028C
                     21                      028C90 028C103030205        028
                     C3    028C61 028FO123      029 030 028AM07 028EM1 028
                     D20000315 028E103 028D700045050104          028E70000
                     010000 028D301 028D5010 028D61 028D81 028DE20080825 028
                     DF02 028ET0000010000 028C800 028DT2 02828EA 030 028A
                     M03 028EZ01 028DB1122334455      0281E10  028DRADAIR
                                030 028AM11 028D90000300{ 028DC0000050{ 028
                     DX0000100{ 028HA0000010{ 028DQ0000360{ 028DU0000360{
                      028DN01 030 028AM13 028VE1 028WE01 028DO00320"
```

AM13 indicates the beginning of the clinical segment. "WE" is the diagnosis code qualifier. "01" after the WE means that it an ICD-9 code is being sent and "02" means that an ICD-10 code is being sent. The diagnosis code is in the field that starts with "DO" so in the first transaction, the code is "A389" and the next one is "00320.

4. If the PharmLINK interface is implemented, review outbound transactions to insure that the diagnosis description is included in the transaction.

STAR MEDICAL RECORDS

Until the ICD-10 functionality is implemented, ICD-9 Diagnosis and Procedure processing in STAR Medical Records essentially remains the same with some limited exception.

When the specified list of STAR STIs is moved into the appropriate environments in the facility's system, some of the necessary changes to assist in the orderly transition to ICD-10 Diagnoses and Procedures are visible and functional prior to reaching the implementation date.

Changes to several of the Medical Records tables, screens and forms as well as some additional parameters are visible. Many of the changes do not require implementation until you are ready to move forward with ICD-10 implementation. Changes to some of the screens and forms are visible as soon as STIs M23127 (Release 15.0) and M23800 and M24872 (Release 16.0) are loaded. Procedurally, the facility should be ready to use the ICD-10-CM and ICD-10-PCS codes before defining the effective dates for the implementation of these enhancements. HIM (Health Information Managers) Department should work with Patient Processing Department, to make sure Tables and Parameters in Patient Processing that impact M/R Abstracting and GUI Abstracting are set up correctly. These include the Financial Class, Insurance Carrier, Insurance Plan, and Patient Type State Exceptions.

- By making table changes available prior to the implementation date, STAR 2000 provides the facility the tools to prepare for using ICD-10 coding in STAR and 3M ICD-10 Coding and Medicare DRG grouping via the 3M Coding and Reimbursement Interface.

The following changes are visible in STAR Medical Records when the ICD-10 Enhancement STIs are moved to the appropriate environment.

- ICD-9 Abstracting changes for Character-Based Abstracting:

  For Release 15.0 STI M23127:

  Within the patient header information of the Abstracting functions, a new header element, *ICD*, is displayed. This new header was added to display the applicable ICD diagnosis and procedure indicator when a patient is selected in any Patient Processing function. This indicator is based on the Facility USA` ICD-10 Effective date and the account admission date. Prior to setting the ICD-10 effective date, the only ICD Indicator available for display with the ICD header is 9.

  For Release 16.0 STI M24872:

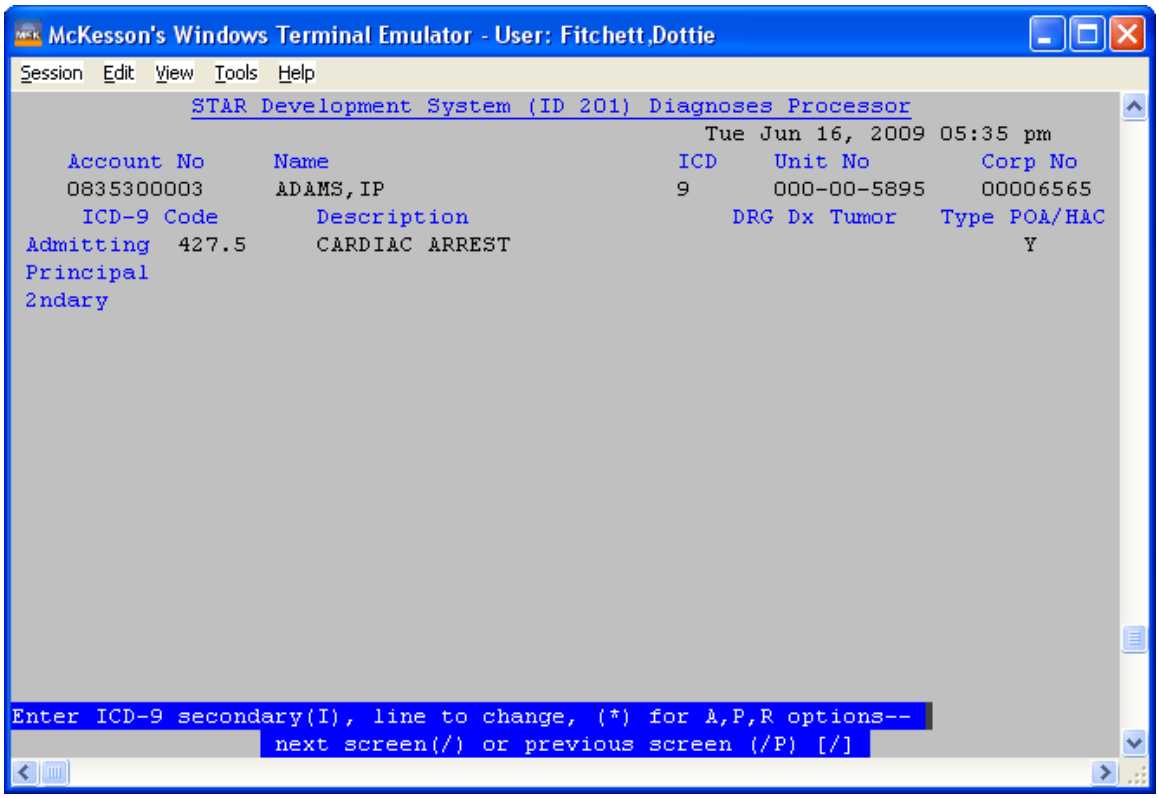
The header element, ICD, was changed to be based on the Discharge Effective Date parameter added to Abstracting Facility Parameter and the account discharge date. The date in the Discharge ICD-10 Effective Date must be ON or AFTER the current Facility USA ICD Effective Date.

- The Current Facility USA ICD Effective date (based on Admission Date) will continue to be used by Patient Processing and Clinicals.
- ICD-9 Diagnosis screen changes for Character-Based Abstracting Release

Release 15.0 STI M23127

- Column header is revised from *Code* to *ICD-9-CM Code*
- An updated screen prompt allows entry of (I)CD 9 codes and deletes the (E) for Encoder. Due to the number of options needed for this screen, some options were grouped and may be viewed using a secondary lookup screen by entering an asterisk (*).

- The (E)ncoder interface for the character-based system has not been functional since April 1, 2008.



ICD-9 form changes for GUI Abstracting

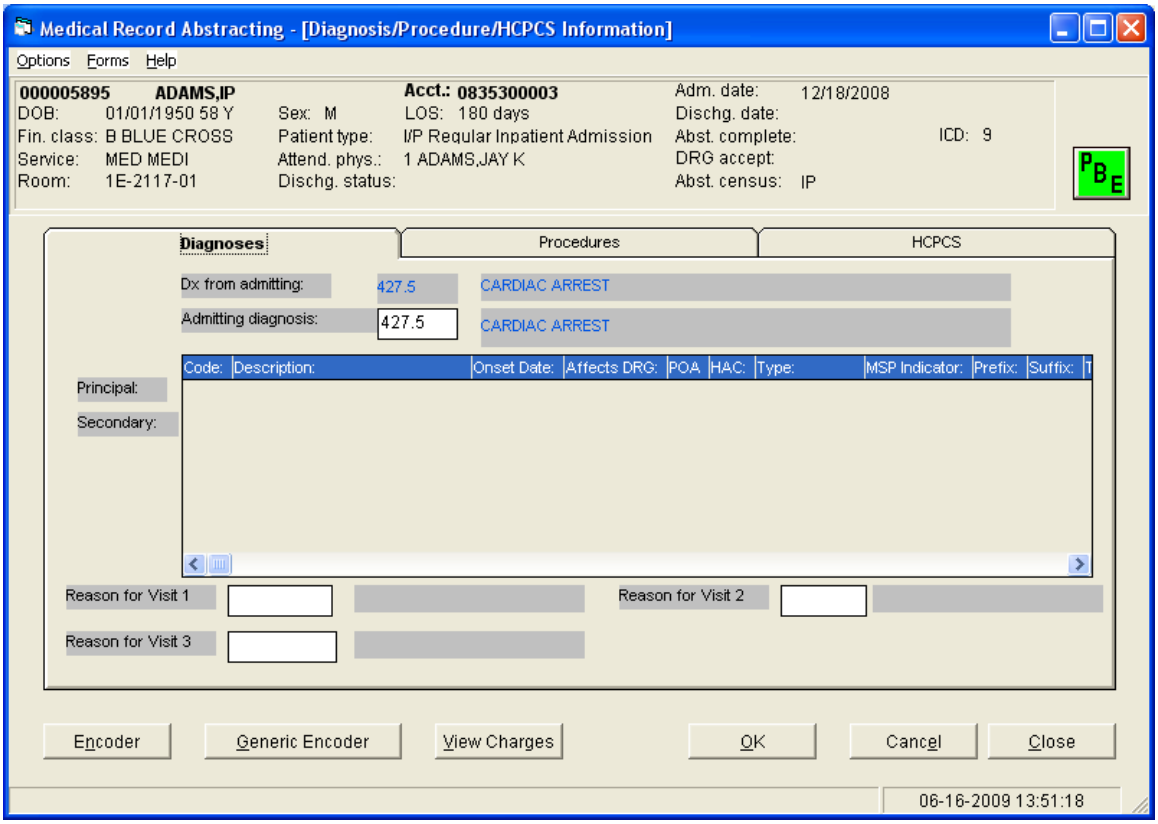
For Release 15.0 STI M23127:

- Within the patient header information of the Abstracting functions, a new header element, *ICD*, is displayed. This new header was added to display the applicable ICD diagnosis and procedure indicator when a patient is selected in any Patient Processing function. This indicator is based on the Facility USA` ICD-10 Effective date and the account admission date. Prior to setting the ICD-10 effective date, the only ICD Indicator available for display with the ICD header is 9.

For Release 16.0 STI M24872:

- The header element, ICD, was changed to be based on the Discharge Effective Date parameter added to Abstracting Facility Parameter and the account discharge date. The date in the Discharge ICD-10 Effective Date must be ON or AFTER the current Facility USA ICD Effective Date.

  The Indicator is also based on the ICD-9 Flag in the Financial Class, Insurance Carrier, and Insurance Plan Tables. This flag identifies payors that still require ICD-9 codes once the ICD-10 Discharge Effective Date has been met. Also new with the 17.0 Release, a "No" (instead of a blank) may be placed in this field as a "hard stop" (i.e. if the Insurance **Plan** ICD-9 Flag=No then the payor does not require ICD-9 codes and system does not check Insurance **Carrier** or **FC** tables.) See Patient Processing Implementation Steps.

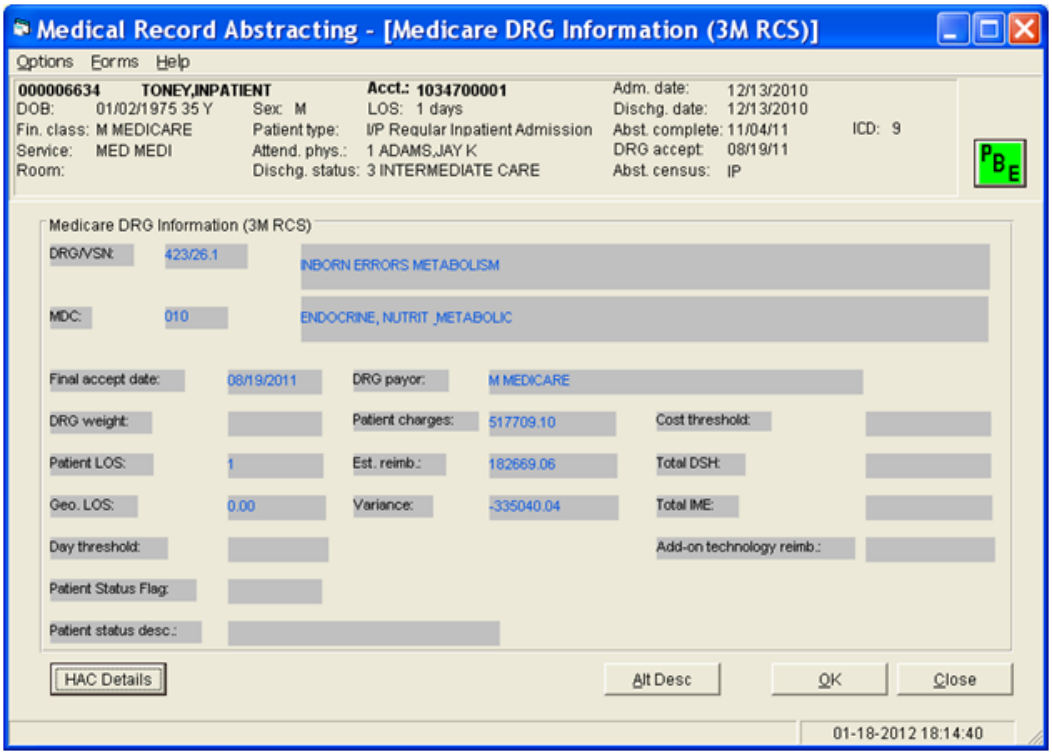


Release 15.0 STI M23127

- When USA ICD-10 effective date is set, the new Diag/Proc/HCPCS ICD-10 form needs to be added to the GUI form flow. The new form allows customers to toggle back and forth between ICD-10 and ICD-9 and should be used with all accounts that require ICD-10 codes. The old Diagnosis/Procedure/HCPCS form may be kept in the form flow to handle any accounts that just require I-9 codes.

  Also ICD Indicator on the header is changed to be discharge based rather than admission based.

Following is an example of the GUI Abstracting Header:



The following is an example of the character based Abstracting header:

```
                    General Hospital Diagnoses Processor
                                  Tue Jun 05, 2012 02:49 pm
Account No      Name                        ICD    Unit No        Corp No
1208900001      Adams, Ben                10/9   000-00-6216    00006924
ICD-10 Code       Description   DRG Dx Tumor  Type POA/HAC
Admitting  K80.13     CALCULUS OF GB W ACUTE AND CHR
Principal  K35.2      ACUTE APPENDICITIS WITH GENERA
```

Release 16.0 STI M24872

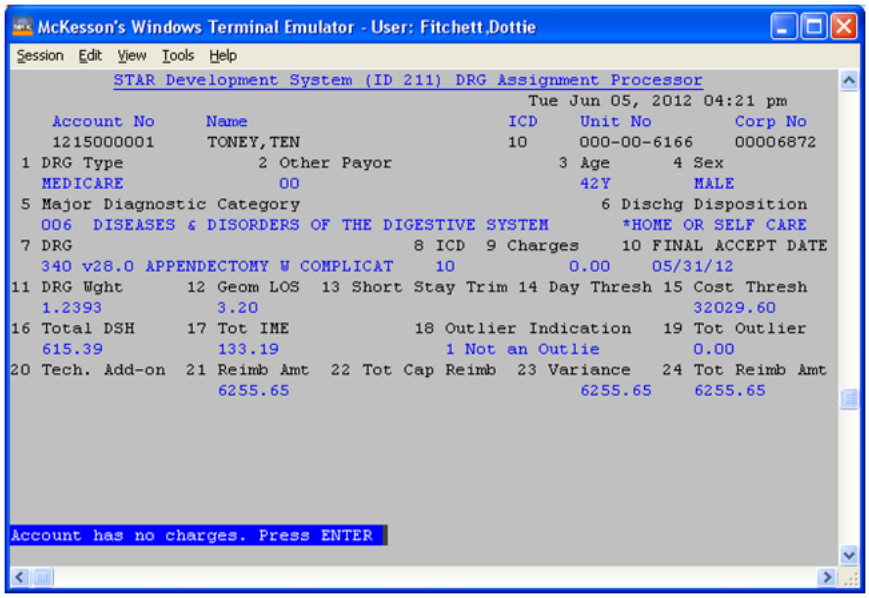
- The M24872 enhancement adds the ability to view both ICD-10 and ICD-9 Medicare DRG Information in GUI Abstracting & character based Abstracting.

- Character Based Abstracting

- With this enhancement the user will see the following new screen in Character Based Abstracting if they select DRG Assignment from the menu. They can then select the DRG they wish to view.

- This functionality will also be used to view DRG Information in Patient Accounting.

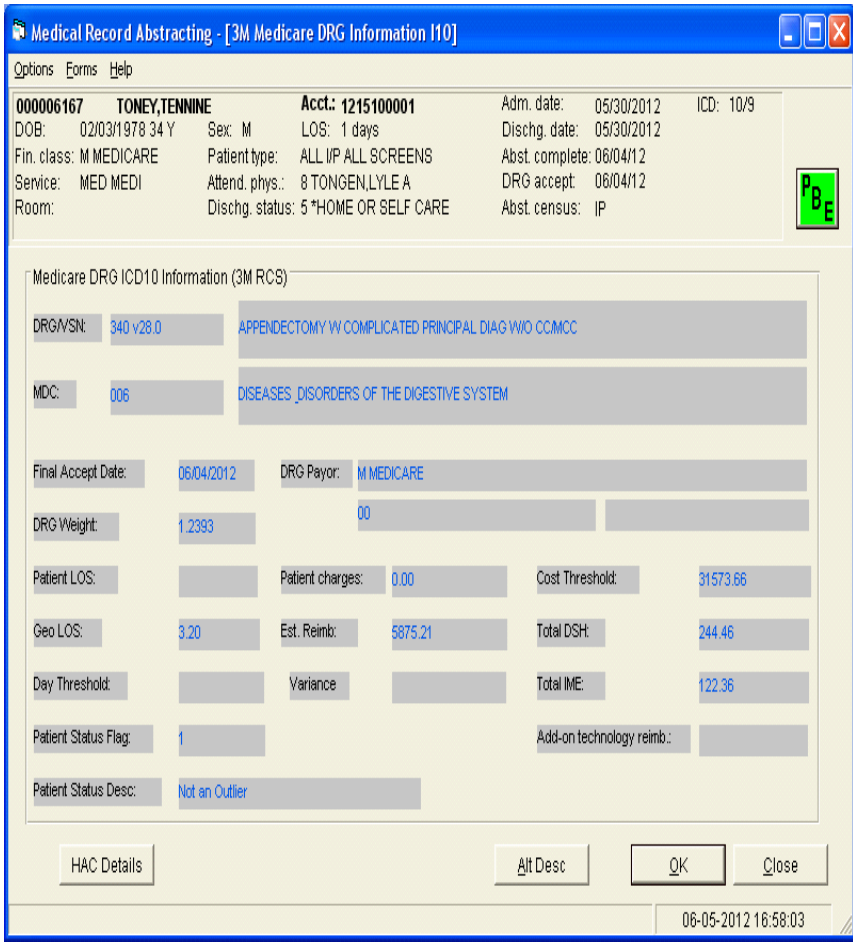
Example of Character Based ICD-10 DRG Assignment Screen



GUI Abstracting

The form below will need to be added to the GUI Abstracting Flow once the Discharge ICD-10 effective date is set.

Example of 3M Medicare DRG Information ICD-10 Form



- A check box titled Both was added next to Encoder buttons on Diag/Proc/HCPCS ICD-10 Form. This enhancement provides an override to the ICD Indicator and adds the ability to collect BOTH ICD-10 and ICD-9 code sets.

Other than the changes listed above, the process of STAR abstracting & coding using ICD-9 codes remains the same until the ICD-10 implementation date.

Implementation Steps

A number of changes for this enhancement are available as soon as the STIs are moved into the system. These changes provide the ability to perform necessary table maintenance for the transition to ICD-10 coding prior to the implementation date. The table maintenance is detailed in the following tables and parameters section.

Although there are no implementation steps for STAR Medical Record Abstracting changes prior to implementation of ICD-10 Effective Date, it is advised that HIM Departments begin working with other departments in the facility to assure the appropriate setup and procedures are in place prior to ICD-10 implementation.

Preliminary Considerations

1 Insurance and State Exceptions need to be identified.

- When the Discharge ICD-10 Effective date is set to a date at the Abstracting Facility level, the system looks to the discharge date for the inpatient, outpatient, emergency, or series patient type when displaying the appropriate Coding Indicator (9,10,10/9,or 9/10) in CB M/R Abstracting and GUI Abstracting. Coders use this indicator to determine which code set is needed for each account.

- Handling Exceptions: If particular Insurance Plans, Insurance Carriers, Financial Classes, or state reporting requires ICD-9 diagnosis and procedure codes AFTER the Discharge ICD-10 Effective Date, then those Exceptions should be listed in the Insurance Plan table, the Insurance Carrier table, the Financial Class table, and the Facility State ICD10 Options tables as outlined in the Patient Processing Implementation Steps. See Patient Processing Implementation.

- A Daily ICD-Indicator Update Report runs every day once the ICD-10 Effective Date has been set This report is for Patient Processing and Clinicals. See Patient Processing Functional Design for details. This report provides a list to the Department of changes to Insurance Plan, etc. which has resulted in a change to the Admitting. ICD Indicator for the account. It is the facility's responsibility to assure that all needed codes are entered for abstracting and insurance purposes.

- An Accounts to be Regrouped Report (MRRGRPx) is available for Medical Records. This report is updated each night at midnight processing. This report lists all accounts that require regrouping:

  - due to FC, Insurance Carrier, and Insurance plan change and ICD-9 flag(s) changed, where ICD-9 codes/grouping wasn't required and is now required, or

  - due to discharge date changing with resulting ICD Discharge Indicator change.

    Note: If ICD Discharge Indicator changes from 10/9 or 9/10 to 10, the account is not added to the report.

2 Software rollout in STAR must be coordinated with that of any third-party encoders/ groupers that Interface to STAR Abstracting and STAR GUI Abstracting.

3 STI M23800 must be loaded prior to the ICD-10 Effective Date. This STI provides uploads for the ICD-10-CM Diagnosis file and the ICD-10-PCS Procedure file.

Tables and Parameters

The following Medical Records parameter and table additions and changes are present with the implementation of M23127.

1 DRG Payor Table fields moved to Financial Classes Table

Payor code fields currently accessed via the DRG Payor Table have been moved to the Financial Classes Table. When STI M23127 is loaded, a conversion runs that moves existing payor codes from the DRG Payor Table to the Financial Classes table. All new payor codes that need to be set at the financial class level are now set within the Financial Classes table.

Example of old DRG Payor Table:

```
     General Hospital Medical Records & UM Table Maintenance Processor
                                                  Tue Apr 14, 2009 10:34 pm
DRG Payors
( 1)DRG Payor Code     : M
( 2)Payor Description  : MEDICARE
( 3)Financial Classes  : B,M,PK,DJ
( 4)Medicare Payor?    : Yes
( 5)Champus Payor?     : No
( 6)Diagnosis Type?    : Yes
( 7)Attestation Parms  : Select to Edit
( 8)MS-DRG Other Payor?:
( 9)HAC Other Payor?   :
(10)APC/ASC Payor Code : 23
(11)Attestation Parms  :

(12)Budgets            : 26 01/01/95  33 01/05/95  24 02/01/95  28 05/05/95
                         20 05/06/95  02 11/06/95  01 06/01/01

(13)Edited By          : Bradley,Margie M
(14)Edit date          : 02/11/08 12:37




Enter field number or '/' starting field number--
```

Example of new DRG Payor Table:

```
     General Hospital Medical Records & UM Table Maintenance Processor
                                                 Tue Apr 14, 2009 10:34 pm
DRG Payors
( 1)DRG Payor Code     : M
( 2)Payor Description  : MEDICARE
( 3)Financial Classes  : B,M,PK,DJ
( 4)Medicare Payor?    : Yes
( 5)Champus Payor?     : No
( 6)Diagnosis Type?    : Yes
( 7)Attestation Parms  : Select to Edit

( 8)Budgets            : 26 01/01/95  33 01/05/95  24 02/01/95  28 05/05/95
                         20 05/06/95  02 11/06/95  01 06/01/01

( 9)Edited By          : Bradley,Margie M
(10)Edit date          : 02/11/08 12:37







Enter field number or '/' starting field number--
```

Release 15.0 (STI M23127)

New Financial Classes Table screens (first screen)

```
                 General Hospital Table Maintenance Processor
                                                 Fri Mar 23, 2012 11:46 am
Financial Classes
 1 Code      2 Description
   M           MEDICARE FINANCIAL CLASS......
 3 Restricted to                          4 Allow Insurance Time Out?
                                            Yes
 5 Payment Transaction                    6 Edit Date
   P0001-PERSONAL PAYMENT-CHECK             08/19/11 03:31pm
 7 Refund Transaction                     8 Edit By
   R0001-GUARANTOR REFUND                   Ducote,Rodney J
 9 PA Collector Group                    10 PA Collector Group Exceptions
   2-JULIE CURNICK ONLY                     No
11 AR Collector Group                    12 AR Collector Group Exceptions
   2-JULIE CURNICK ONLY                     No
13 Collection Agency Group               14 Biller Group
   99-PMK INTERNAL BD GROUP                 BILLING GROUP
15 HCPCS Payor
   M-MEDICARE
16 Statistical Group              17 Sales Commission     18 ICD-10 Eff Date
   MEDICARE                          No                      01/01/2010

Enter field number or '/' starting field number--
```

Release 16.0 (STI M24872)

Examples of Financial Class, Insurance Carrier, and Insurance Plan Tables (Last Page) with new ICD-9 flag.

```
                    General Hospital Table Maintenance Processor
                                                 Fri Mar 23, 2012 11:58 am
Financial Classes
 1 Code      2 Description
   M           MEDICARE FINANCIAL CLASS......

DRG and APC/ASC Payor Codes  Edited By: Moon, Bob 02/06/12 02:38pm
DRG PAYOR             PAYOR    ICD-9  MSDRG HAC APC/ASC  DTE FROM    DTE TO
------------------------------------------------------------------------------
M-MEDICARE            00        Yes    Yes  Yes   23    01/01/2012  01/02/2012
M-MEDICARE            00               Yes  Yes   23    01/03/2012









                Enter DRG Payor Code or "-" for table lookup
   F1Prev Page F2Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

New Insurance Carrier Screen (Last page)

```
                General Hospital Table Maintenance Processor
                                                 Wed Jun 06, 2012 03:57 pm
Insurance Carriers
Payor Codes by Facility
( 1)Facility     : Model Hospital A
( 2)Payor        : *

( 3)Disch Eff Dt : 10/01/2009
( 4)Payor        : 00
( 5)ICD-9        : Yes
( 6)MSDRG        : Yes
( 7)HAC          : Yes

( 8)Disch Eff Dt : 10/01/2011
( 9)Payor        : 00
(10)ICD-9        : No
(11)MSDRG        : Yes
(12)HAC          : Yes

(13)Edit By      : Moon, Bob
(14)Edit Date    : 02/20/12 15:54
```

New Insurance Plans Screen (Last page)

```
             General Hospital Table Maintenance Processor
                                                  Wed Jun 06, 2012 04:01 pm
Insurance Plans                                              Carrier: MEDICARE
Payor Codes by Facility
( 1)Facility     : Model Hospital A
( 2)Payor        :

( 3)Disch Eff Dt :
( 4)Payor        :
( 5)ICD-9        :
( 6)MSDRG        :No
( 7)HAC          :

( 8)Disch Eff Dt : 10/01/2008
( 9)Payor        :
(10)ICD-9        :
(11)MSDRG        :  No
(12)HAC          :

(13)Edit By      :Moon, Bob
(14)Edit Date    :

Enter the other Payor Code (if any) for discharges prior to 10/01/2007--       |
                     next screen(/) or previous screen(/P)
```

2 ICD Table Update

The Apply USA ICD-10 Update File menu item has been added to the ICD Updates Processor:

```
                 General Hospital ICD Updates Processor
                                                  Wed Jun 06, 2012 04:08 pm
ICD Updates Input Options

            Option No.  Option
            ---------------------------------------
                1       Apply ICD-9-CM or ICD9 update file
                2       Regenerate ICD-9-CM/ICD9 Update Report
                3       Apply Canada ICD-10 Update Files
                4       Apply USA ICD-10 Update File
                5       Regenerate USA ICD-10 Update Report
```

3 ICD-10 Maintenance

Two new menu items, ICD-10-CM Maintenance and ICD-10-PCS Maintenance, have been added to the ICD-HCPCS Maintenance Processor:

```
          General Hospital ICD & HCPCS Maintenance Processor
                                                 Thu Jul 30, 2009 01:14 pm
ICD & HCPCS Maintenance Input Options

            Option No.  Option
            ---------------------------------------
                1       ICD-9-CM Maintenance
                2       ICD-10-CA Maintenance
                3       ICD-10-CCI Maintenance
                4       ICD-10-CM Maintenance
                5       ICD-10-PCS Maintenance

                6       HCPCS Table Maintenance
                7       HCPCS Revenue Code Assign
                8       HCPCS DPW Diagnostic Code Assignment







Enter option number--
```

4 HCPCS Processor

```
               General Hospital HCPCS Table Maintenance Processor
                                                    Mon Jun 1, 2009 03:42 pm

( 1)HCPCS Code                : 80076
( 2)Description               : HEPATIC FUNCTION PANEL
( 3)Revenue Code              : 300
( 4)Out-of-Scope Ind          :
( 5)Sex Specific Code         :
( 6)Age "From" Restriction    :
( 7)Age "To" Restriction      :
( 8)Inactive Indicator        :
( 9)Inactive Date             :
(10)8xx Ambulatory Procedure  : Yes
(11)Valid ICD-9-CM CMS Codes  : 791.1-791.2
(12)ICD-9-CM Comment          :
(13)Valid ICD-10-CM CMS Codes : K50.013 A18.89 C83.72
(12)ICD-10-CM Comment         : Contact the FI to obtain the valid DX
(14)DPW Diagnostic Procedure  : No
(15)XREF HCPCS / CPT Codes    : 82040 82247 82248 82251 84075 84155 84450 more
(16)Frequency Limitation      :
(17)Effective Date            :
(18)
    Edit by, Date and Time    : Stephens,John, 03/17/09 1443

Enter field number or '/' starting field number--
```

The Valid ICD-10-CM CMS Codes field is available to define the list of valid ICD-10 codes for the specific HCPCS by using the same data entry functionality used to define the Valid ICD-9-CM CMS Codes.

Testing Guidelines

Test the following processes, screens and reports where Diagnosis and Procedures can be entered, edited, viewed, printed:

- All abstracting processors
  - GUI and Character-Based Diagnosis entry
  - GUI and Character-Based Procedure entry
  - Character-Based Nosocomial code entry
- GUI Pre-Bill Edit entry if module is being used
- Inquiry Processors
  - M/R Abstract Inquiry
    - Diagnosis
    - Procedures
- Reports
  - Discharges by Diagnosis Core Report
  - Discharges by Procedure Core Report
  - Combined HCPCS Report Core Report
  - Abstract Summary and Attestation Reports

Test the following processes, screens and reports where ICD-10 DRG information may be displayed:

- DRG processors
  - GUI 3M Medicare ICD-10 Information Display Form
  - Character Based Medicare ICD-10 DRG Assignment screen
- Reports
  - Discharges by DRG Core Report
  - Abstract Summary and Attestation Reports

STAR PATIENT ACCOUNTING

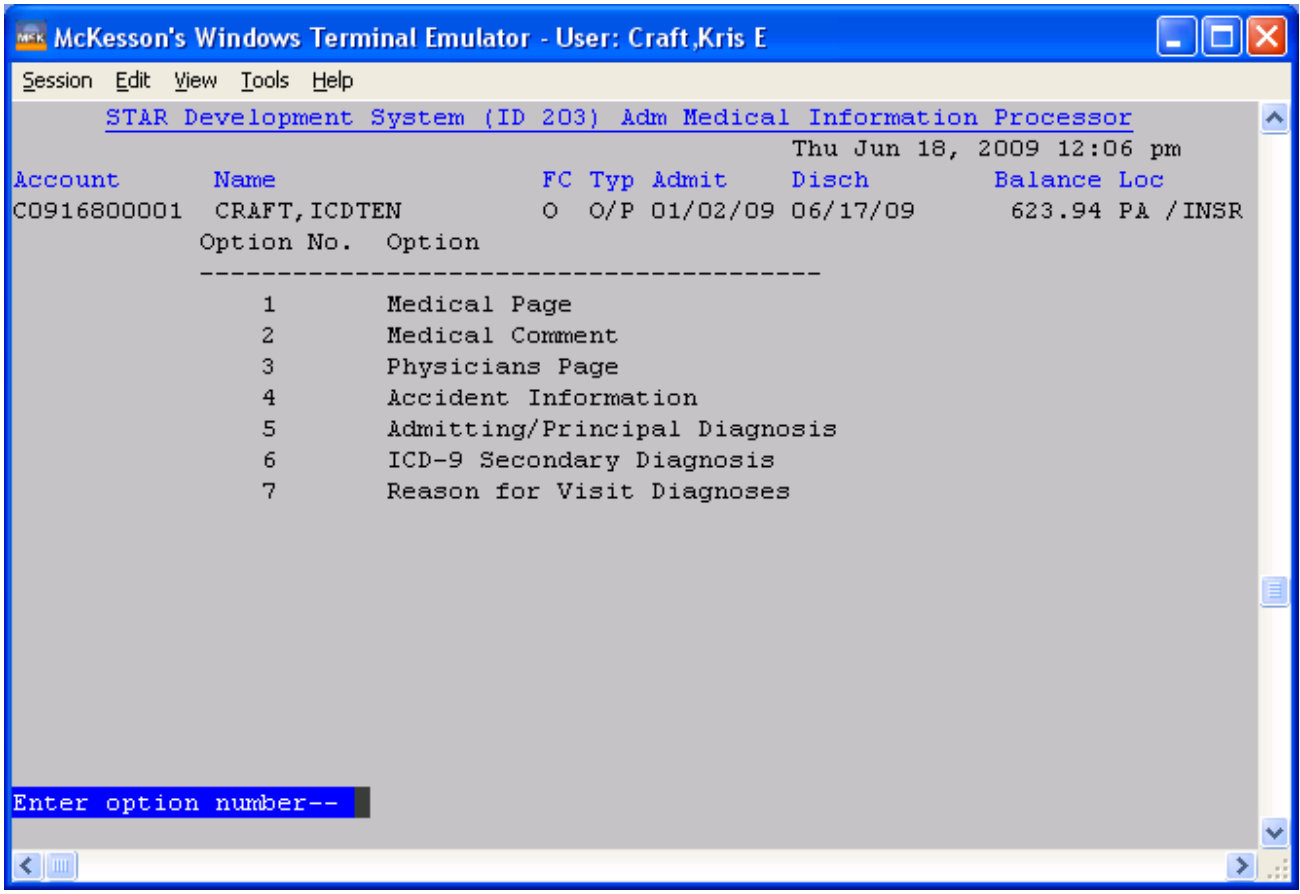
This section of the implementation guide includes the new labels and fields you will see in the enhancement for ICD-10 as well as for the ICD DRG enhancement. Also included in this section are Tables and Parameters, Implementation Steps and Testing Guidelines for each of the enhancements..

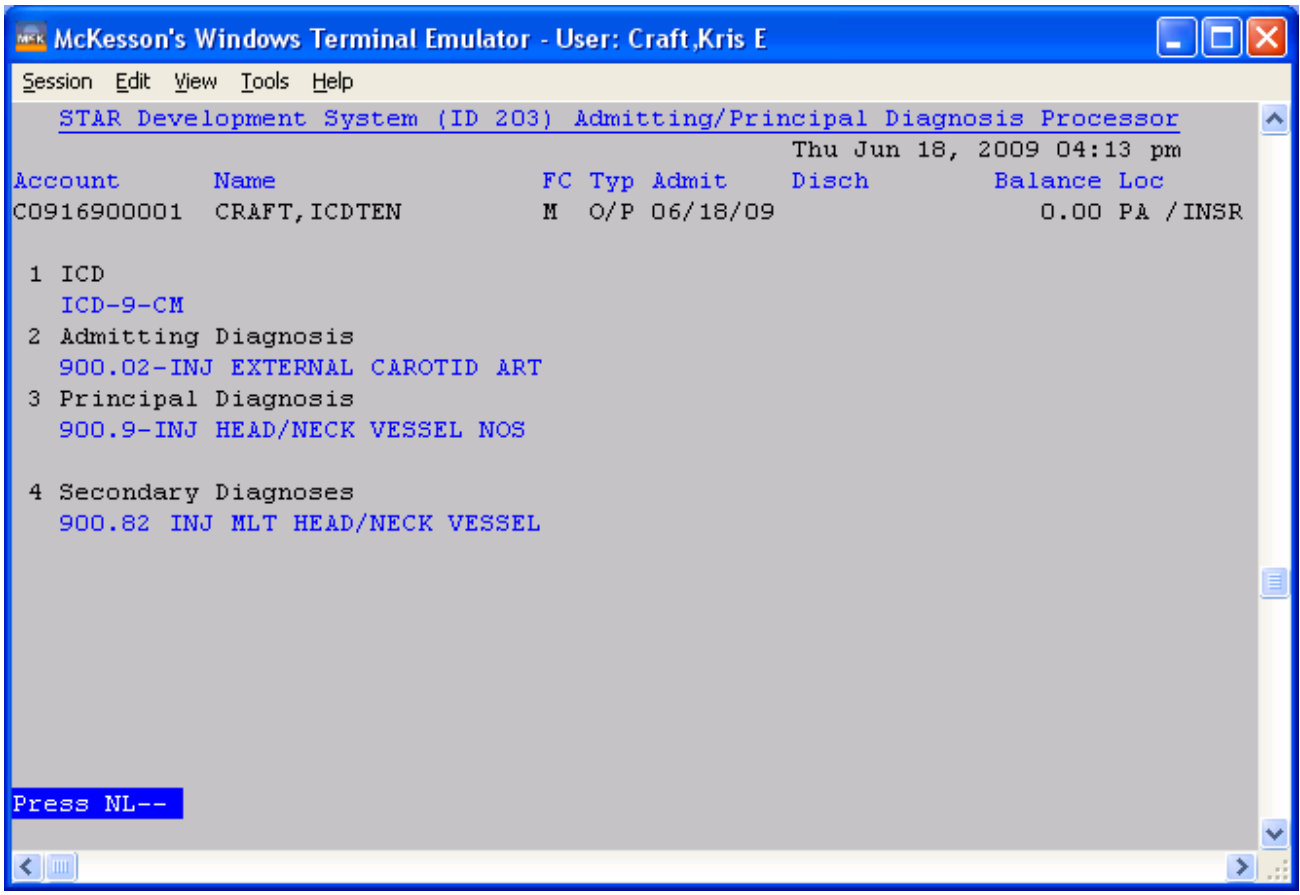
ICD 10 Enhancement

In anticipation of the need to distinguish ICD-9 and ICD-10 information, you will see new labels and fields in a number of existing functions. Following is a brief list of changes.

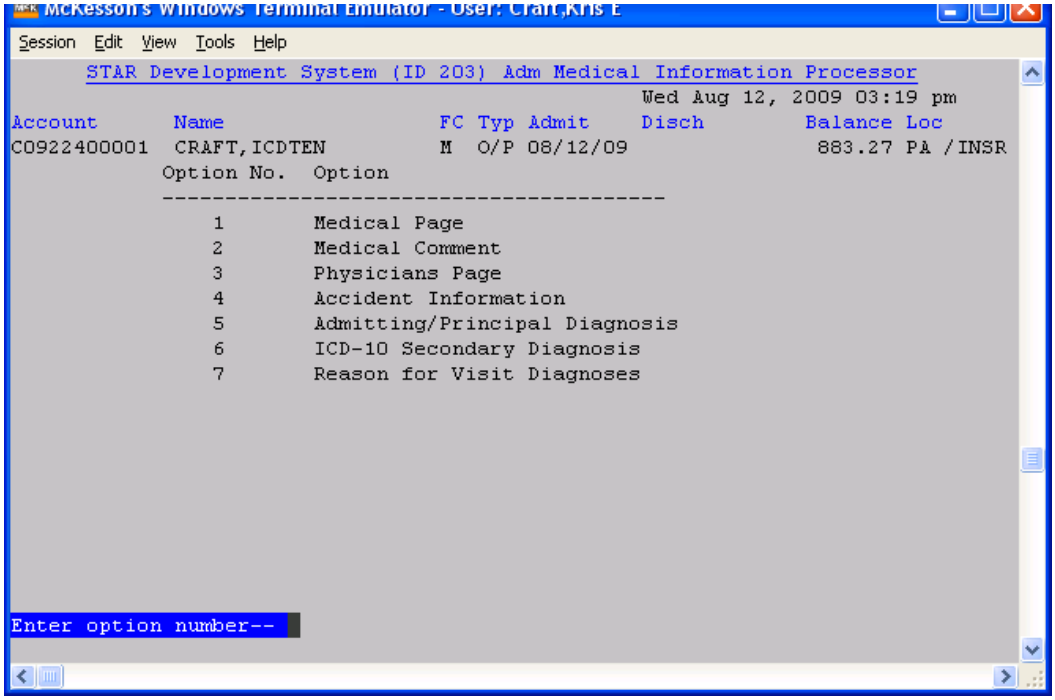
Displays of diagnosis and procedure information in Account Inquiry and Account Revision include information for ICD-9, ICD-10, or both. The menus that display depend on the existence of data for the account, and not on the Account ICD flag. This allows all data to be viewed in Patient Accounting.

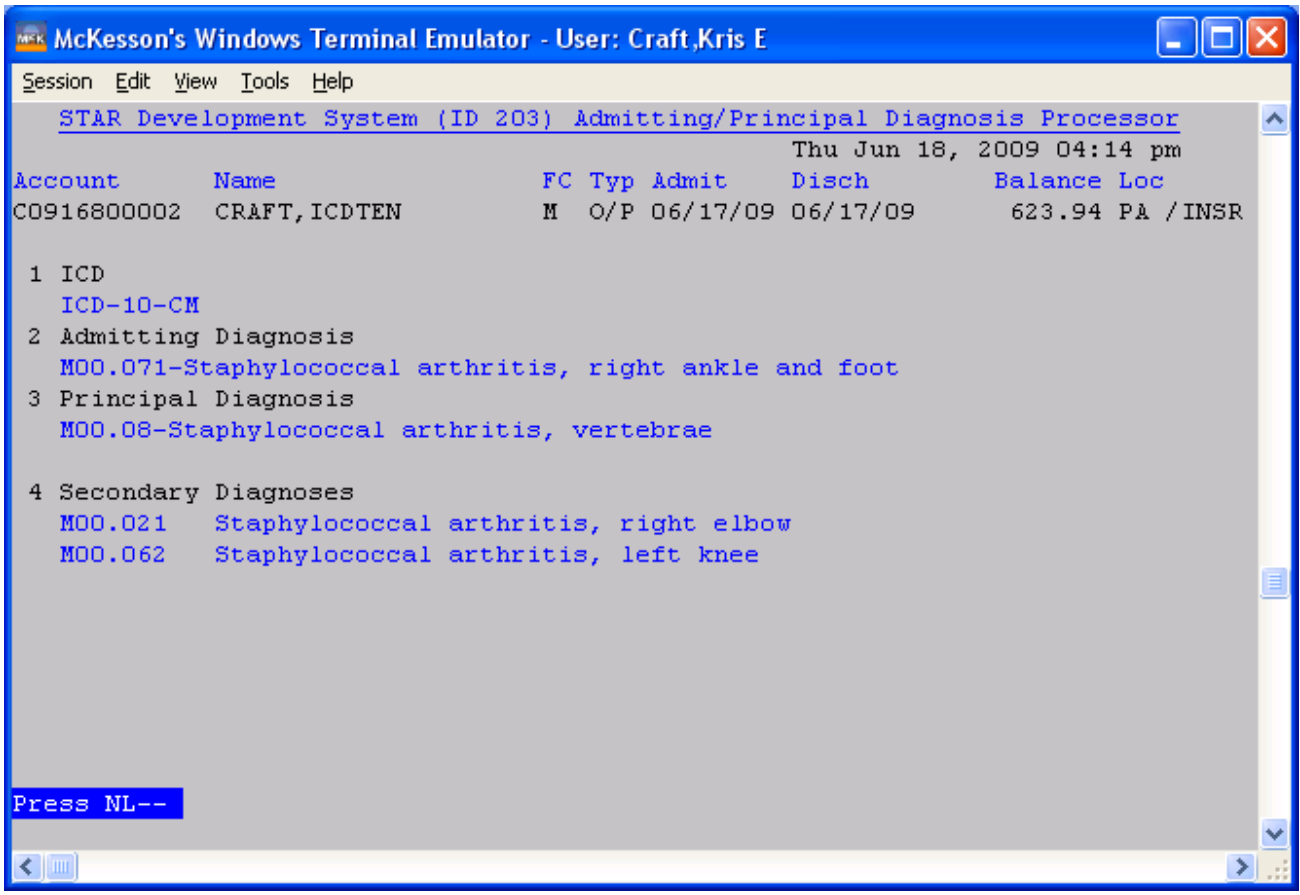
- Inquiry of Admission Medical Information for ICD-9 only account:




McKesson's Windows Terminal Emulator - User: Craft,Kris E
Session Edit View Tools Help
STAR Development System (ID 203) Admitting/Principal Diagnosis Processor
Thu Jun 18, 2009 04:13 pm
Account Name FC Typ Admit Disch Balance Loc
C0916900001 CRAFT,ICDTEN M O/P 06/18/09 0.00 PA /INSR
1 ICD
ICD-9-CM
2 Admitting Diagnosis
900.02-INJ EXTERNAL CAROTID ART
3 Principal Diagnosis
900.9-INJ HEAD/NECK VESSEL NOS
4 Secondary Diagnoses
900.82 INJ MLT HEAD/NECK VESSEL
Press NL--

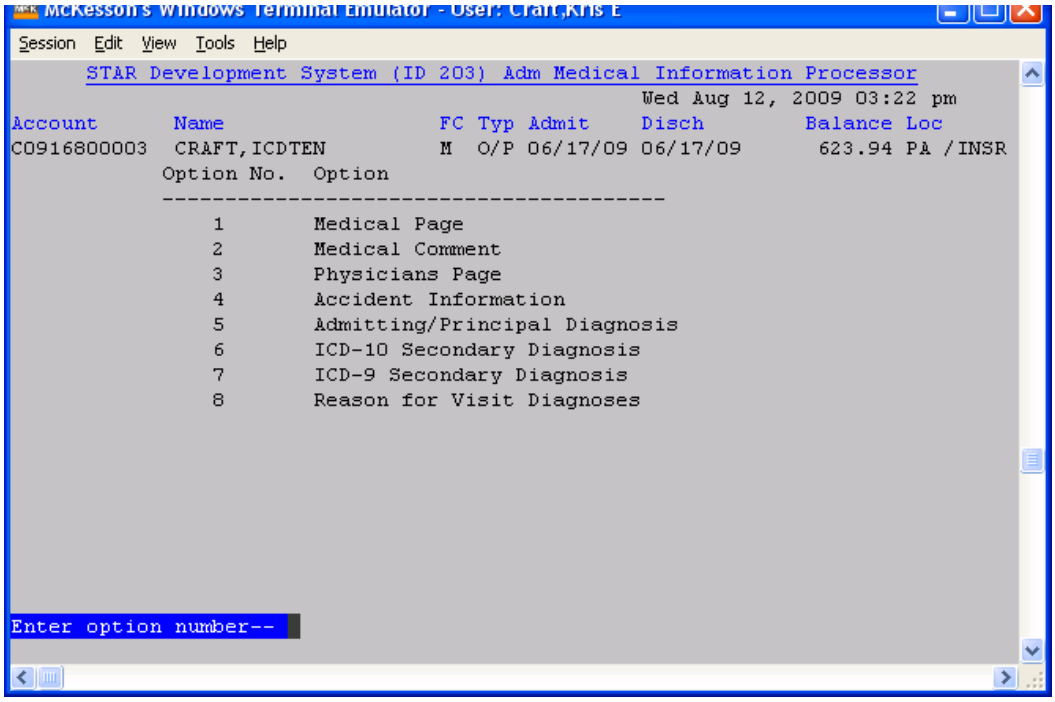
- Inquiry of Admission Medical Information for ICD-10 only account:

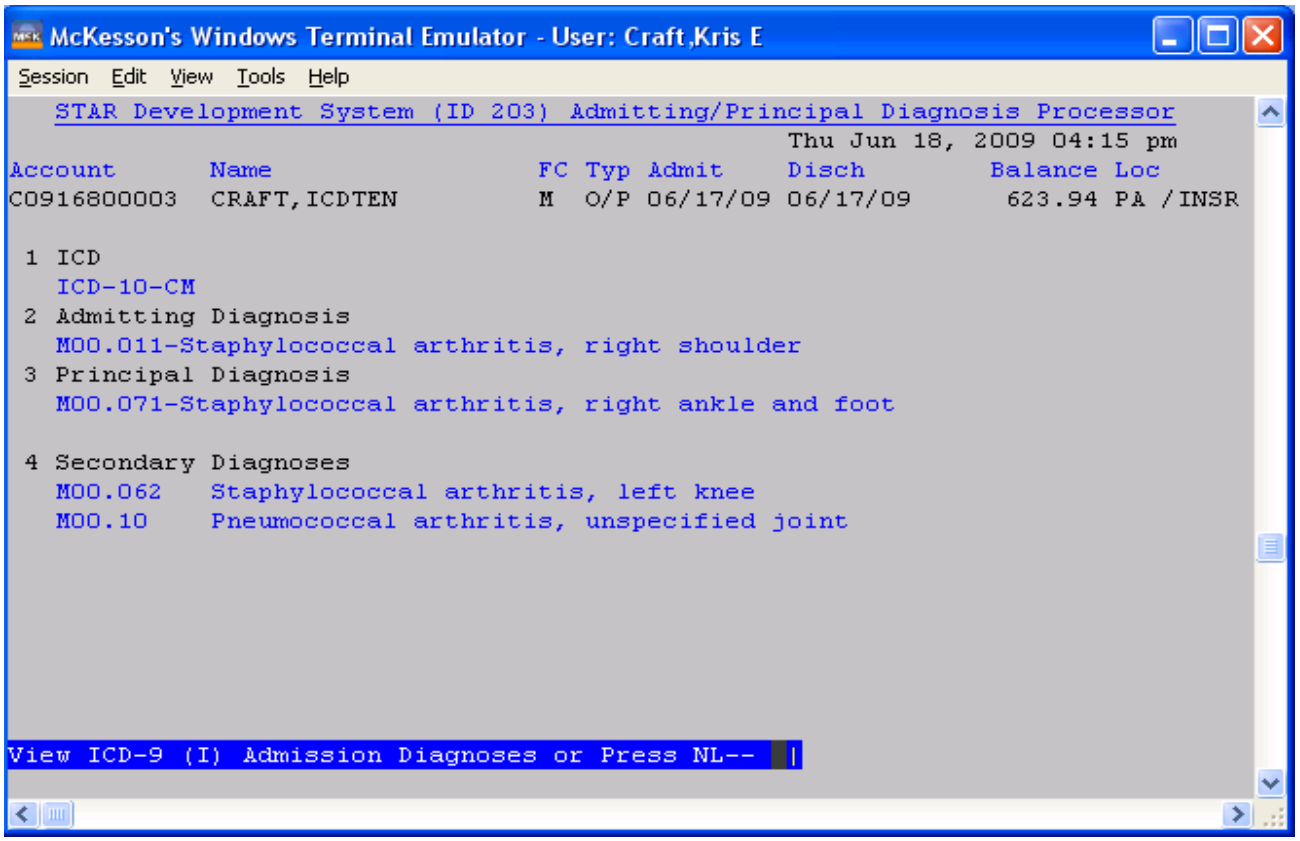


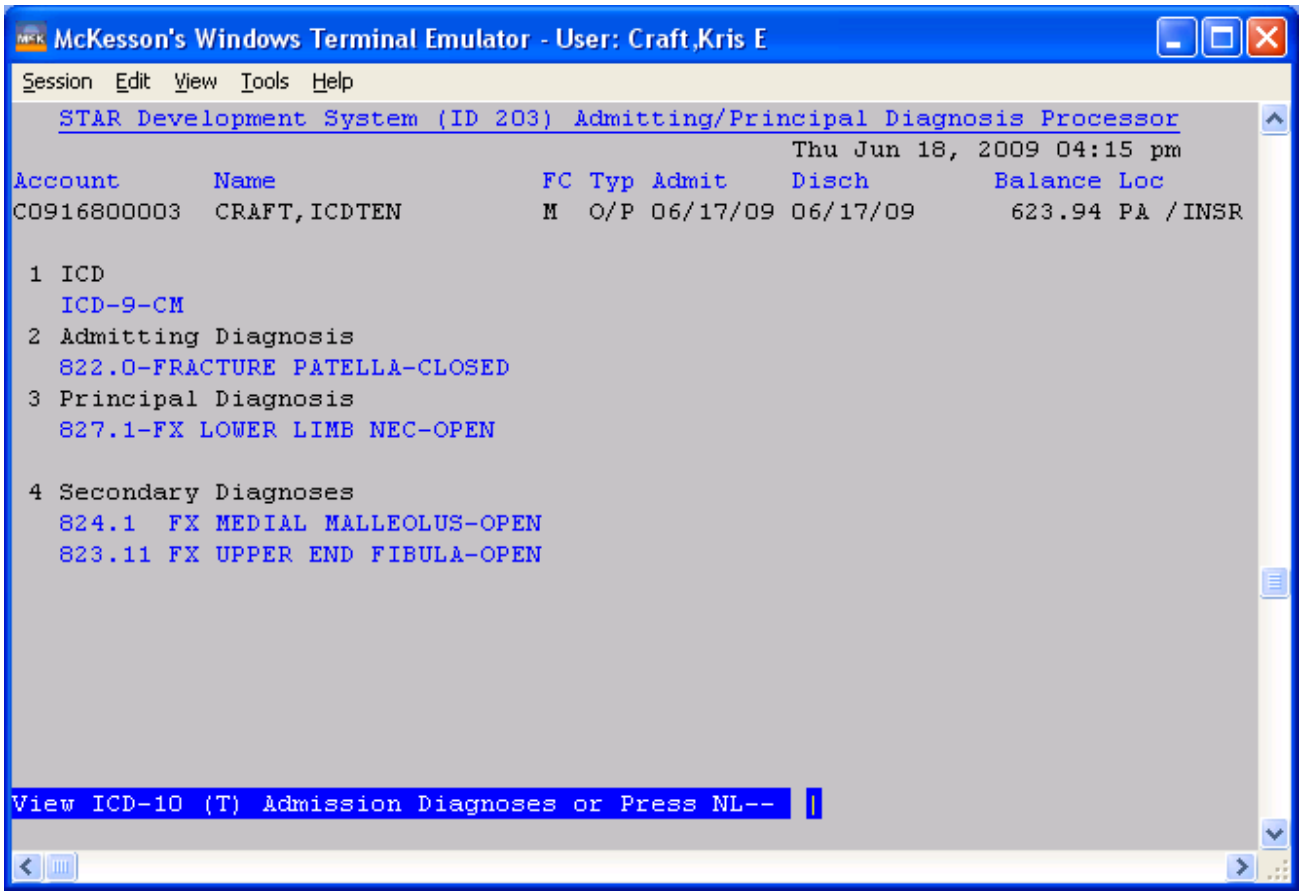

McKesson's Windows Terminal Emulator - User: Craft,Kris E
Session Edit View Tools Help
STAR Development System (ID 203) Admitting/Principal Diagnosis Processor
Thu Jun 18, 2009 04:14 pm
Account Name FC Typ Admit Disch Balance Loc
C0916800002 CRAFT,ICDTEN M O/P 06/17/09 06/17/09 623.94 PA /INSR
1 ICD
ICD-10-CM
2 Admitting Diagnosis
M00.071-Staphylococcal arthritis, right ankle and foot
3 Principal Diagnosis
M00.08-Staphylococcal arthritis, vertebrae
4 Secondary Diagnoses
M00.021 Staphylococcal arthritis, right elbow
M00.062 Staphylococcal arthritis, left knee
Press NL--

- Inquiry of Admission Medical Information for ICD-10 and ICD-9 account.

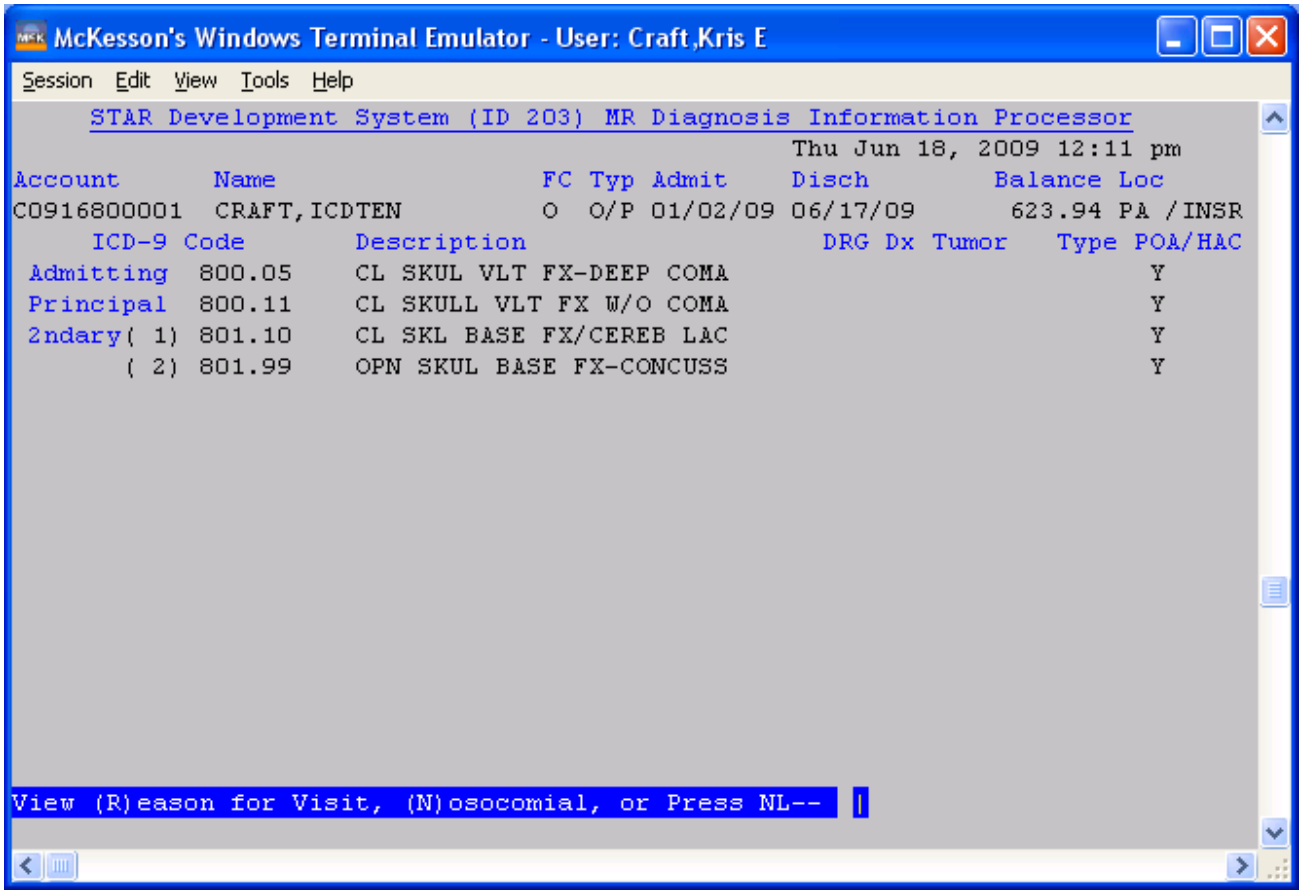
NOTE: Note that on the Admitting/Principal Diagnosis screen that users can toggle between ICD-10 (T) and ICD-9 (I):



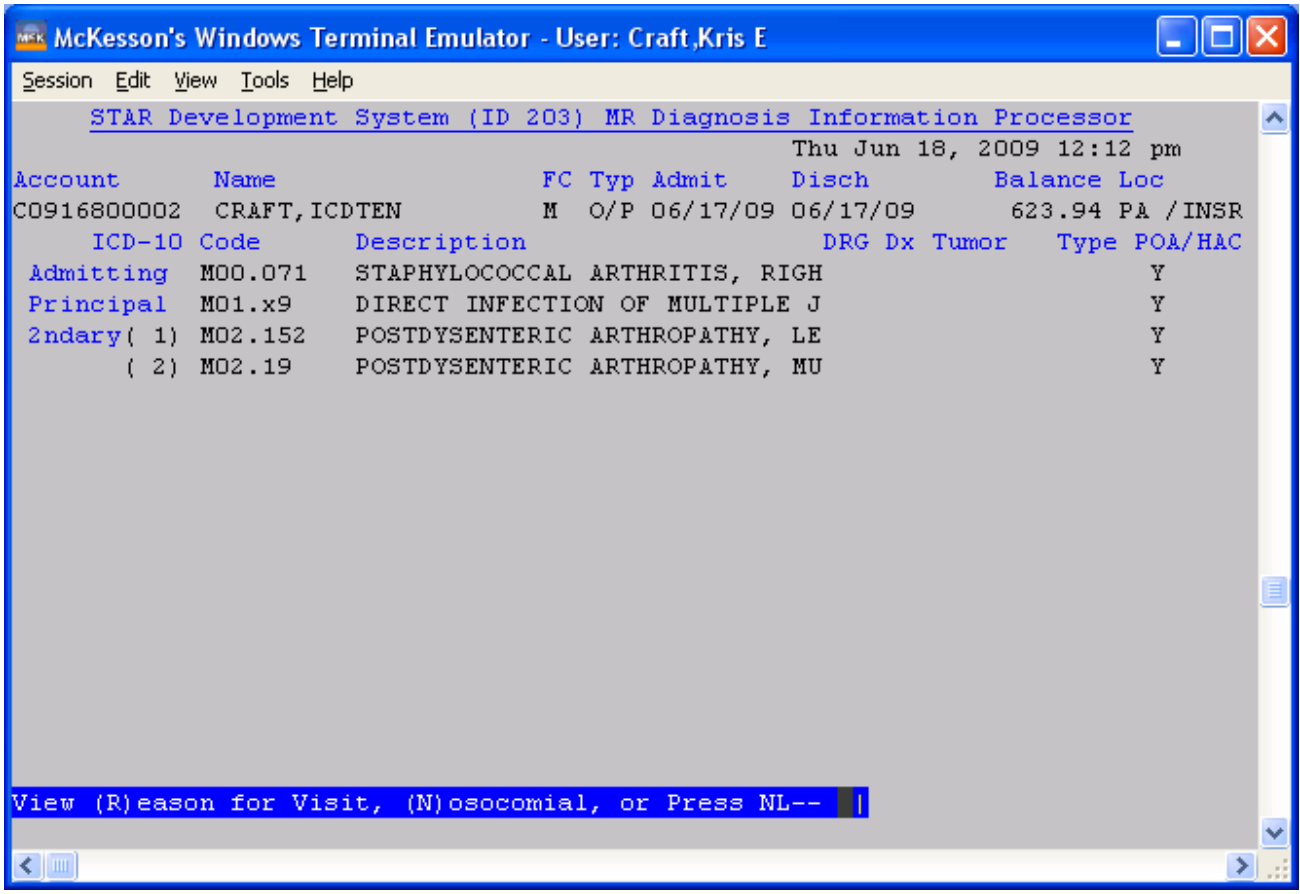

McKesson's Windows Terminal Emulator - User: Craft,Kris E
Session Edit View Tools Help
STAR Development System (ID 203) Admitting/Principal Diagnosis Processor
Thu Jun 18, 2009 04:15 pm
Account Name FC Typ Admit Disch Balance Loc
C0916800003 CRAFT,ICDTEN M O/P 06/17/09 06/17/09 623.94 PA /INSR
1 ICD
ICD-10-CM
2 Admitting Diagnosis
M00.011-Staphylococcal arthritis, right shoulder
3 Principal Diagnosis
M00.071-Staphylococcal arthritis, right ankle and foot
4 Secondary Diagnoses
M00.062 Staphylococcal arthritis, left knee
M00.10 Pneumococcal arthritis, unspecified joint
View ICD-9 (I) Admission Diagnoses or Press NL--


McKesson's Windows Terminal Emulator - User: Craft,Kris E
Session Edit View Tools Help
STAR Development System (ID 203) Admitting/Principal Diagnosis Processor
Thu Jun 18, 2009 04:15 pm
Account Name FC Typ Admit Disch Balance Loc
C0916800003 CRAFT,ICDTEN M O/P 06/17/09 06/17/09 623.94 PA /INSR
1 ICD
ICD-9-CM
2 Admitting Diagnosis
822.0-FRACTURE PATELLA-CLOSED
3 Principal Diagnosis
827.1-FX LOWER LIMB NEC-OPEN
4 Secondary Diagnoses
824.1 FX MEDIAL MALLEOLUS-OPEN
823.11 FX UPPER END FIBULA-OPEN
View ICD-10 (T) Admission Diagnoses or Press NL--

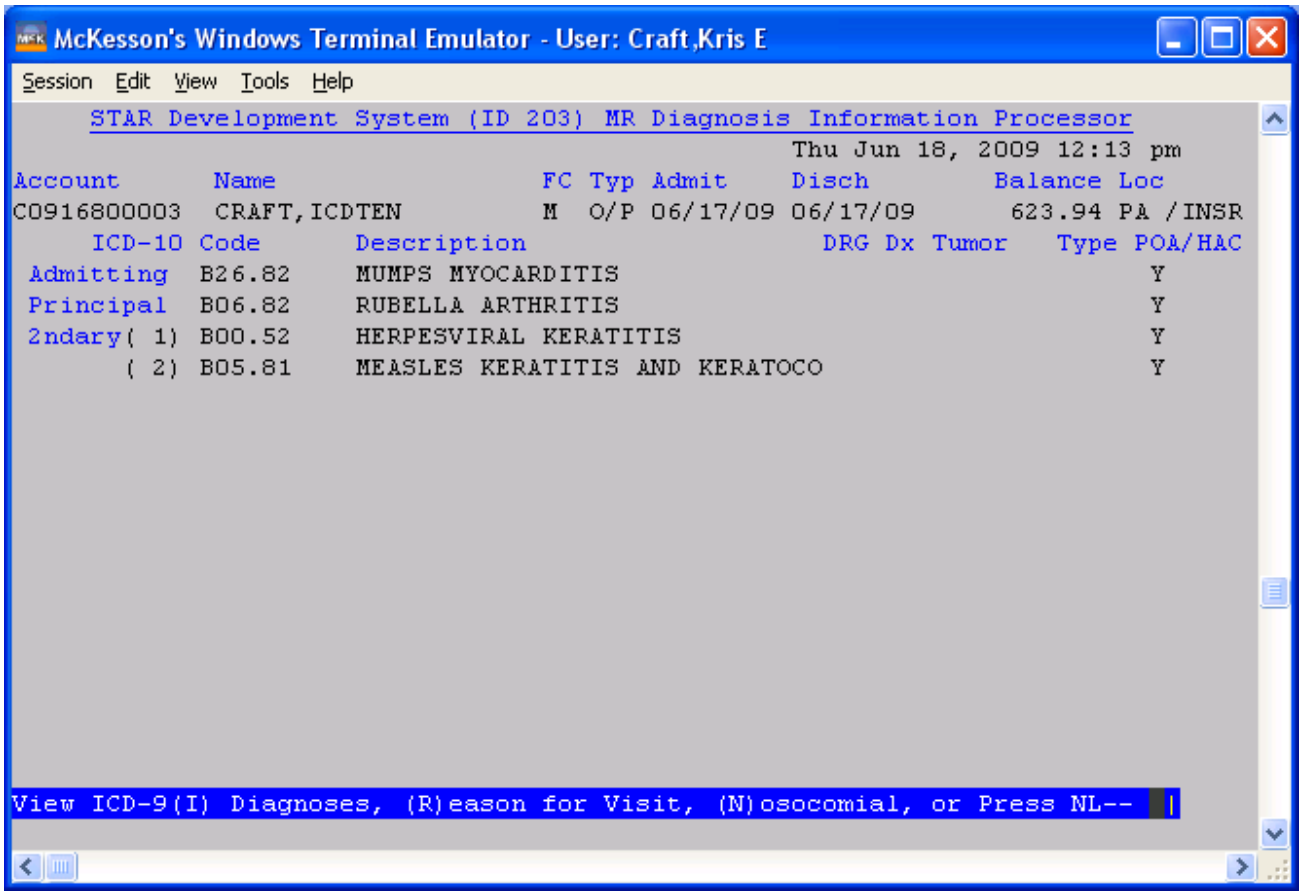
- Inquiry of Medical Records Diagnosis Information ICD-9 only account:

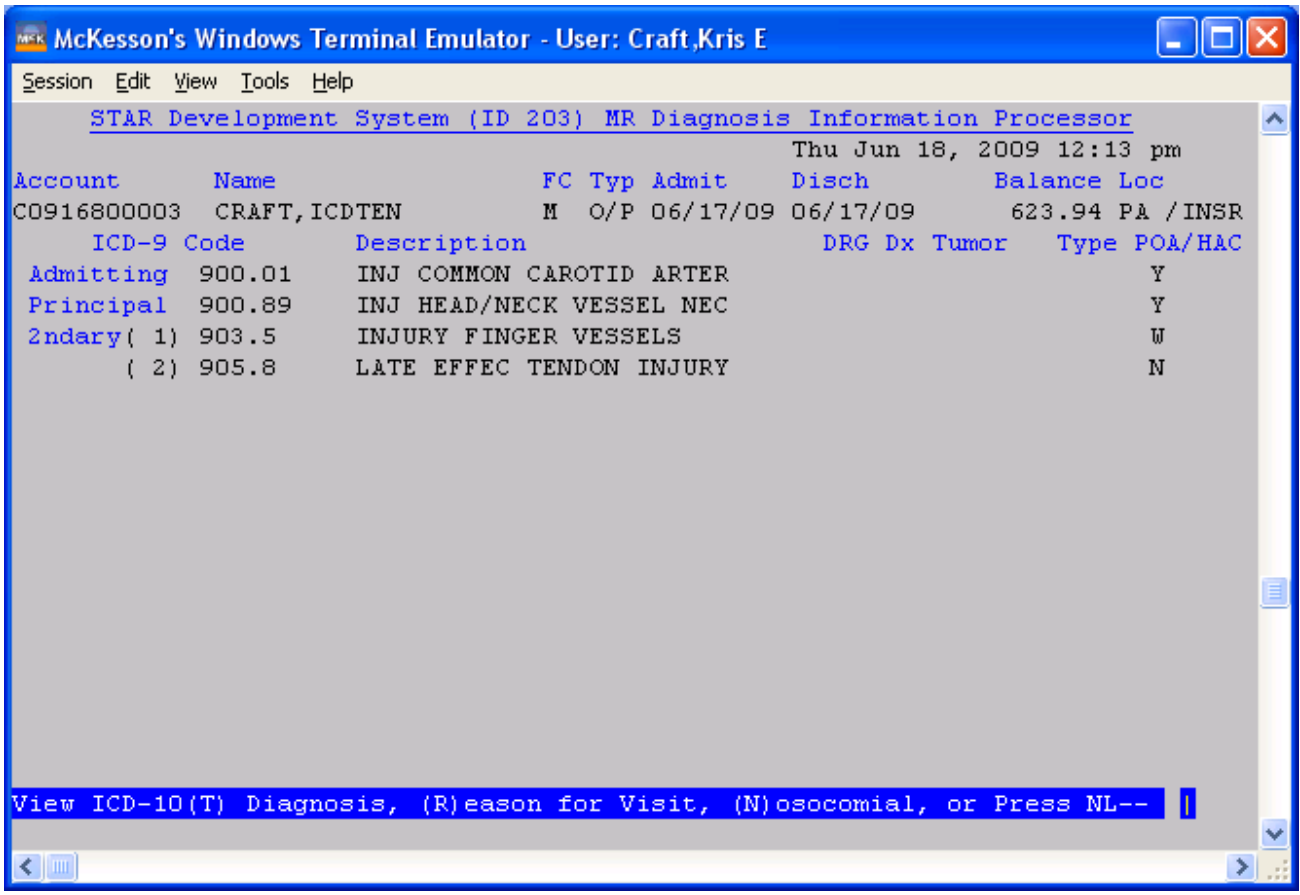


- Inquiry of Medical Records Diagnosis Information ICD-10 only account:

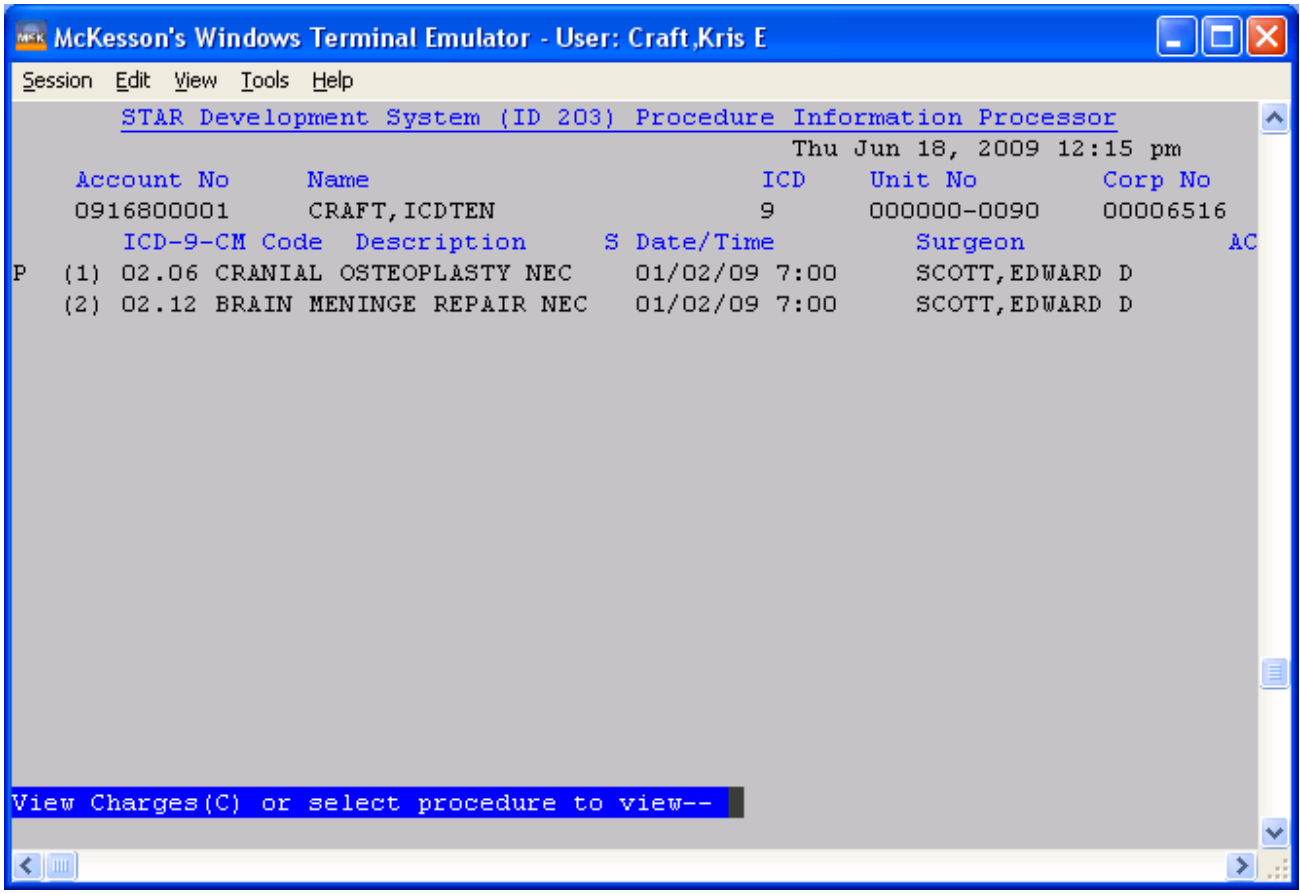


- Inquiry of Medical Records Diagnosis Information ICD-10 and ICD-9 account. Note that the user can toggle between ICD-9 (I) and ICD-10 (T):

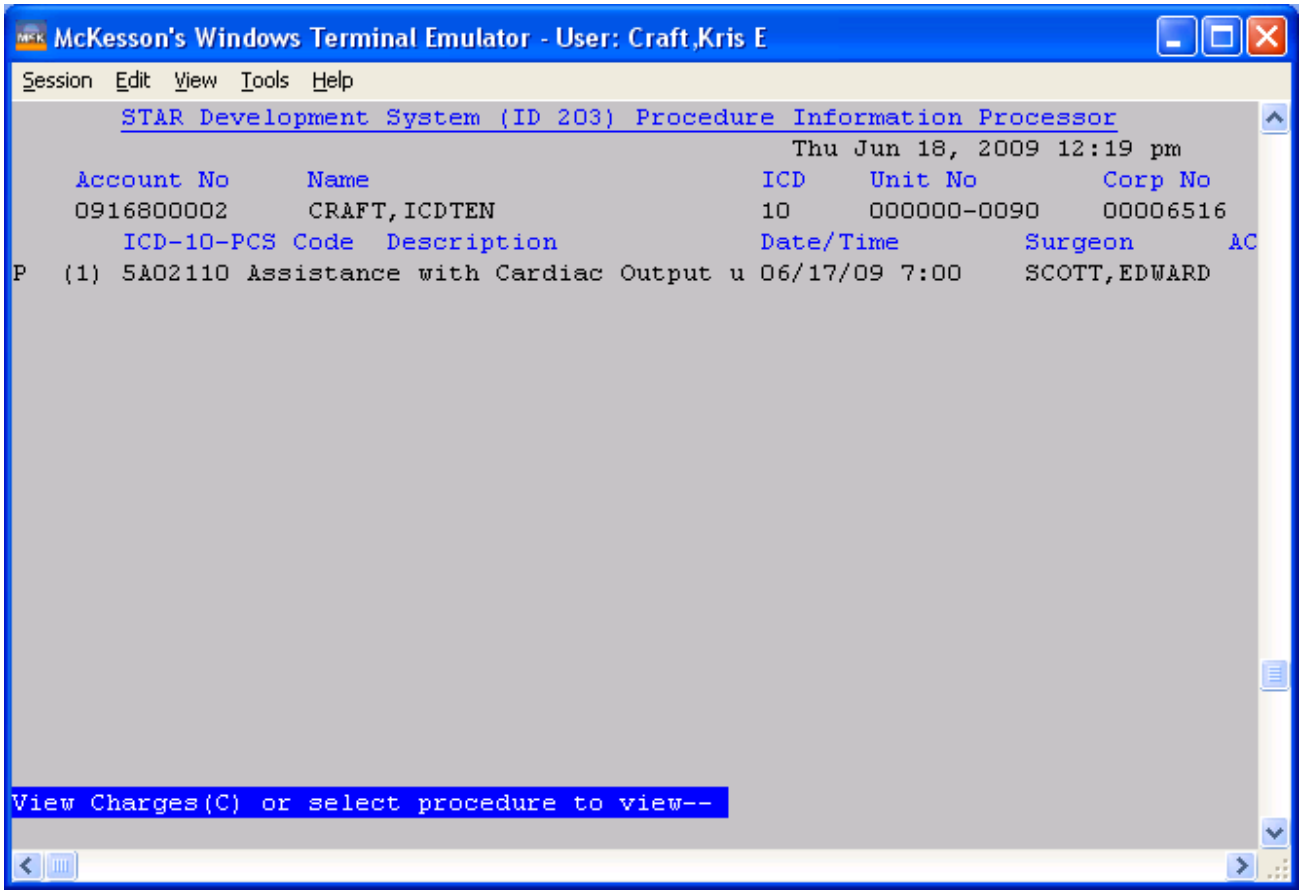



McKesson's Windows Terminal Emulator - User: Craft,Kris E
Session Edit View Tools Help
STAR Development System (ID 203) MR Diagnosis Information Processor
Thu Jun 18, 2009 12:13 pm
Account Name FC Typ Admit Disch Balance Loc
C0916800003 CRAFT,ICDTEN M O/P 06/17/09 06/17/09 623.94 PA /INSR
ICD-9 Code Description DRG Dx Tumor Type POA/HAC
Admitting 900.01 INJ COMMON CAROTID ARTER Y
Principal 900.89 INJ HEAD/NECK VESSEL NEC Y
2ndary(1) 903.5 INJURY FINGER VESSELS W
(2) 905.8 LATE EFFEC TENDON INJURY N
View ICD-10(T) Diagnosis, (R)eason for Visit, (N)osocomial, or Press NL--

- Inquiry of Medical Records Procedures ICD-9 only account:

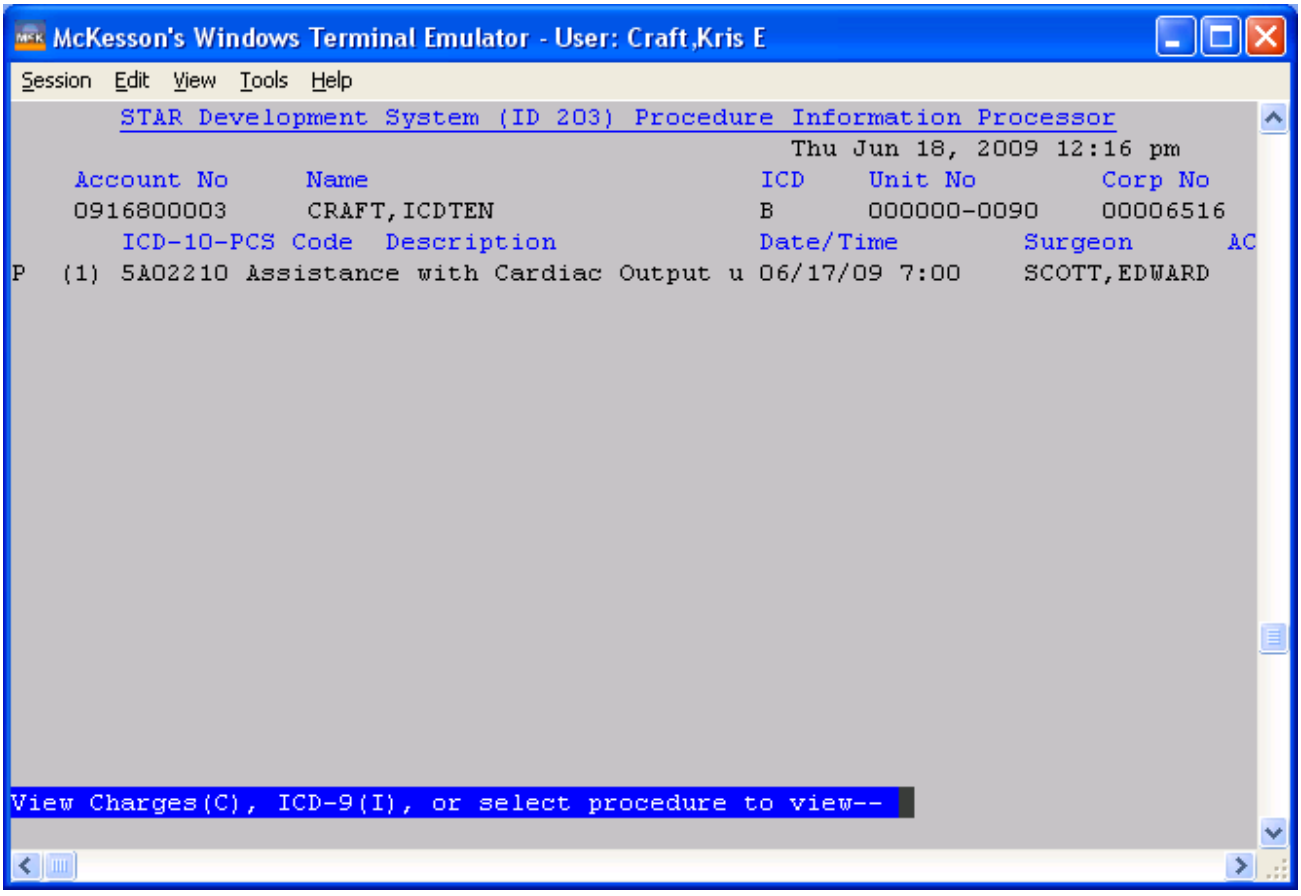


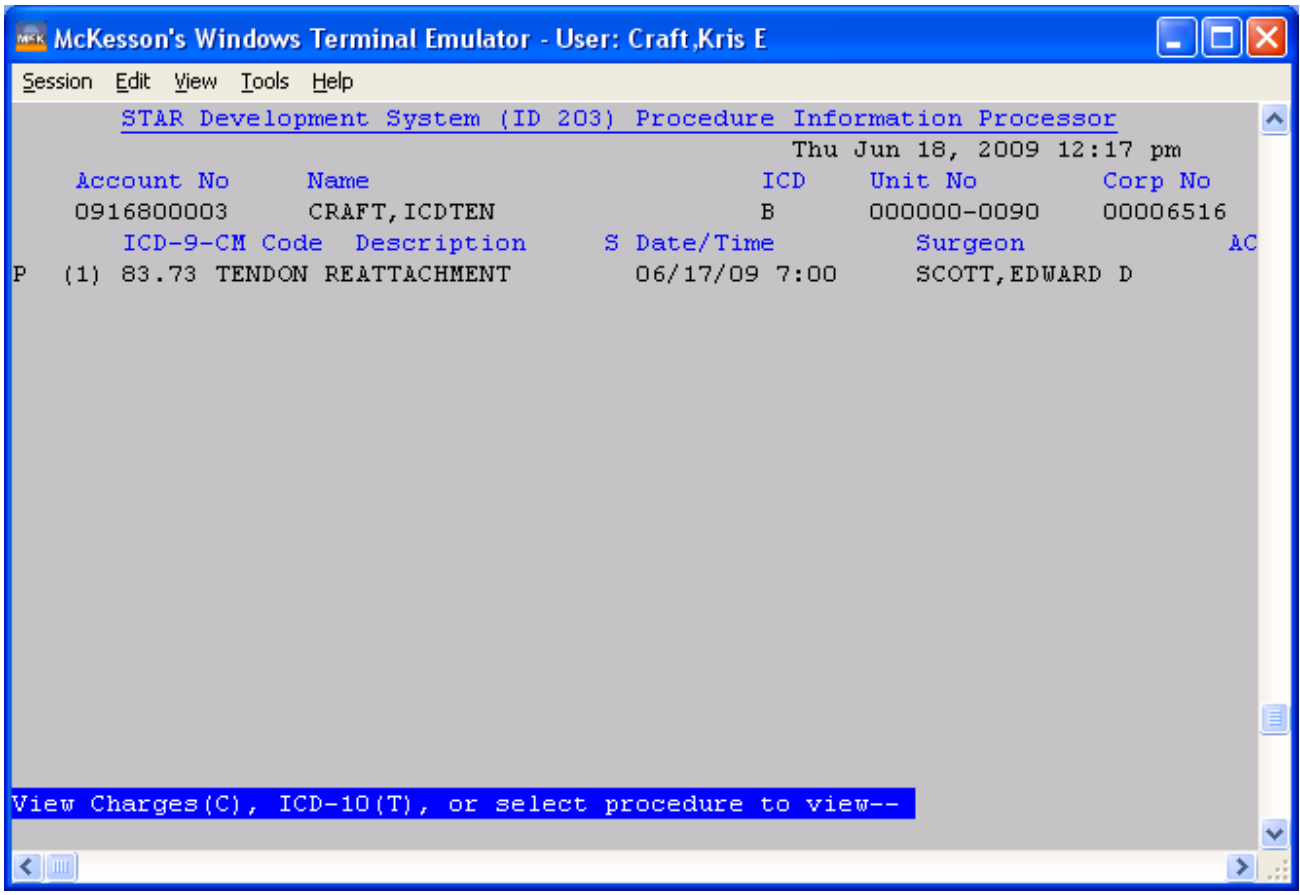
- Inquiry of Medical Records Procedures ICD-10 only account:



- Inquiry of Medical Records Procedure Information ICD-10 and ICD-9 account.

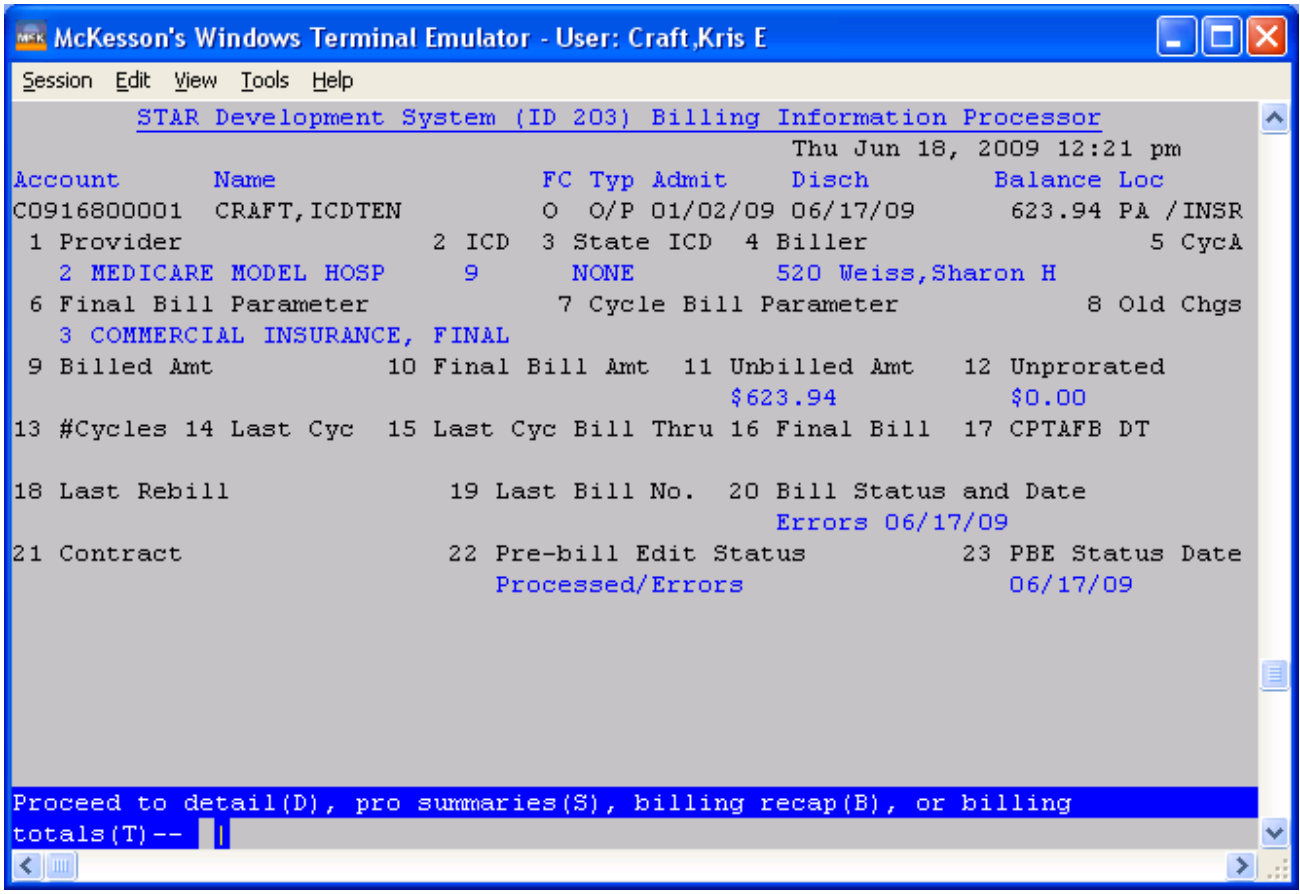
Note that the user can toggle between ICD-9 (I) and ICD-10 (T):



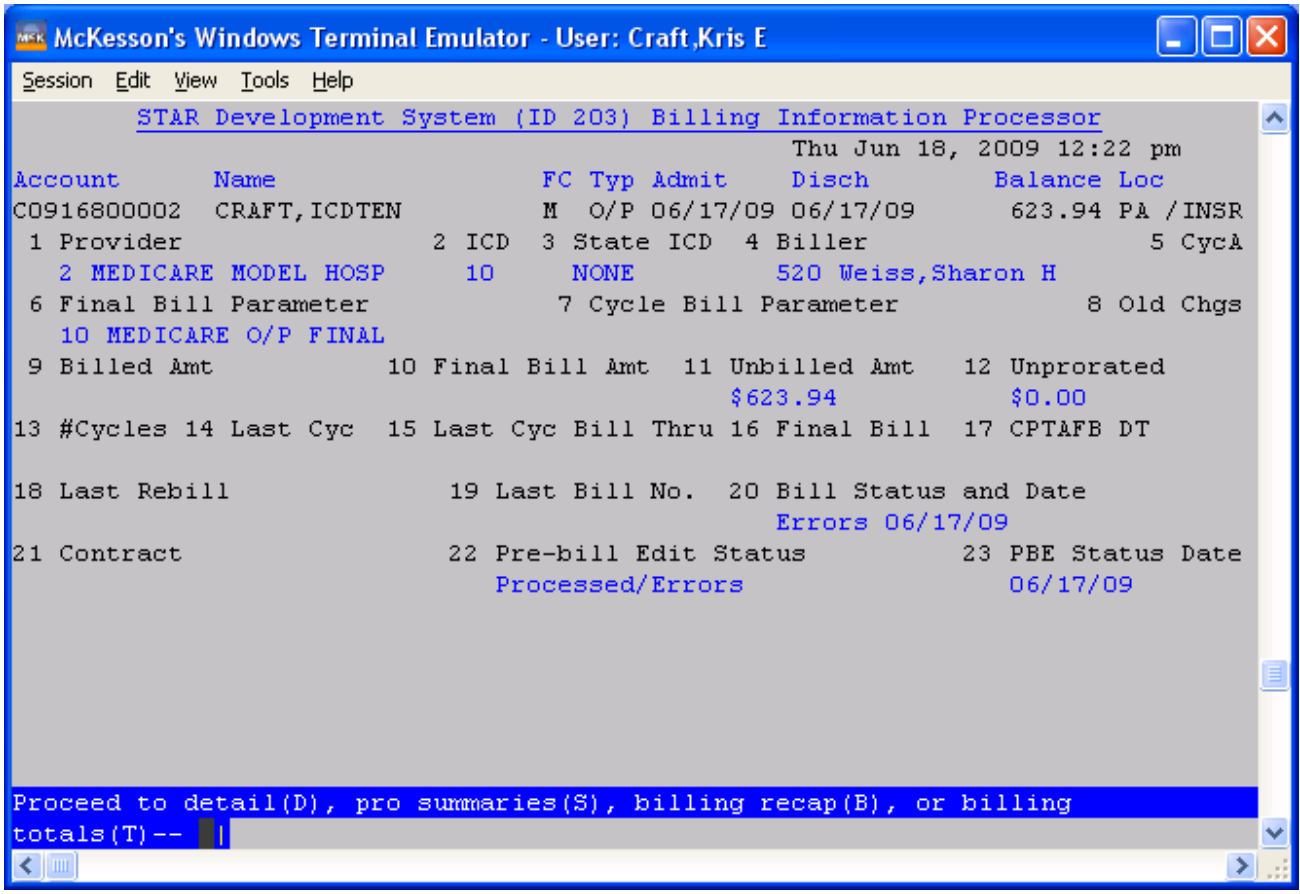

McKesson's Windows Terminal Emulator - User: Craft,Kris E
Session Edit View Tools Help
STAR Development System (ID 203) Procedure Information Processor
Thu Jun 18, 2009 12:17 pm
Account No Name ICD Unit No Corp No
0916800003 CRAFT,ICDTEN B 000000-0090 00006516
ICD-9-CM Code Description S Date/Time Surgeon AC
P (1) 83.73 TENDON REATTACHMENT 06/17/09 7:00 SCOTT,EDWARD D
View Charges(C), ICD-10(T), or select procedure to view--

- ICD flags for the account appear in Account Inquiry, Financial Information, Billing Information, field 2 for ICD.

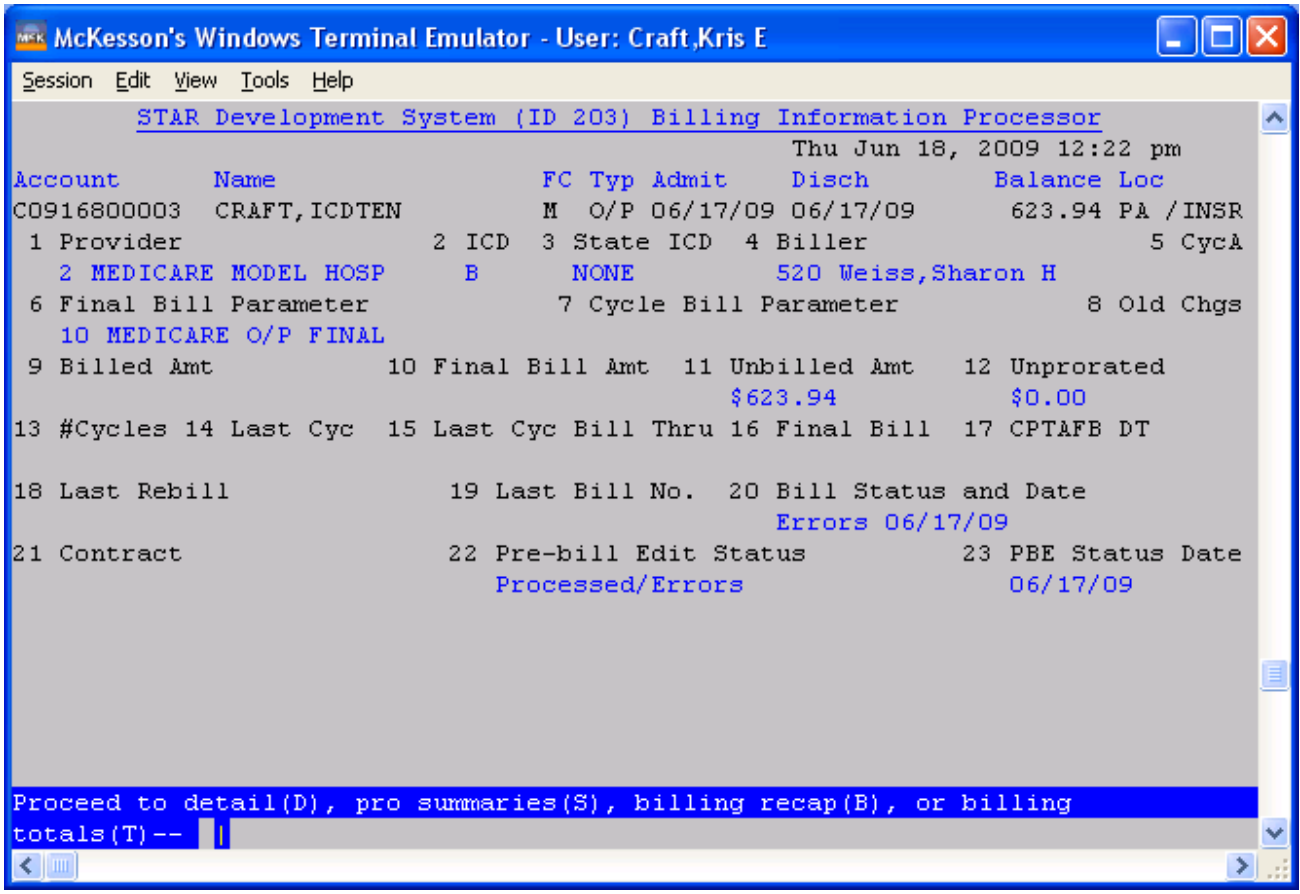
  - ICD-9 Account:



- ICD-10 Account:



- Account requiring Both ICD-10 and ICD-9 Codes:



- Account Inquiry and the DRG display screen, the system will now display a list of the DRGs that exist for the account and allows the user to select the DRG to view. The possible DRGs are: the Primary ICD-10 DRG (based on COB 1), the Primary ICD-9 DRG (based on COB 1), the Secondary ICD-10 DRG (not yet available), the Secondary ICD-9 DRG, and the Non Reimbursed APR ICD-9 DRG. The Non Reimbursed APR ICD-10 DRG is not yet available.

```
                  General Hospital DRG Information Processor
                                                  Thu Mar 15, 2012 09:37 pm
Account      Name                FC Typ Admit    Disch        Balance Loc
A12058-00002 CRANE, BOB          M  I/P 02/27/12              5743.75 PA /INSR

ICD Indicator for most recent bill (final): 10




Page:01                    Existing DRG's for Account
( 1) Primary ICD10 DRG
( 2) Primary ICD9 DRG
( 3) Secondary ICD9 DRG
( 4) Non Reimbursed APR ICD9 DRG









Enter choice--
```

- The ICD indicator for the DRG has been added to each DRG Inquiry screen. Placement may differ based on the screen that displays.

Primary ICD10 DRG

```
               DRG Information Processor General Hospital
                                          Thu Mar 15, 2012 04:23 pm
Account      Name                FC Typ Admit    Disch        Balance Loc
A1205200001  CRANE, BOB           M  I/P 02/21/12 02/26/12     2881.64 AR /ACCF
 1 DRG Payor            2 Other Payor  3 Age   4 Sex     5 Dischg Disposition
   M MEDICARE             00             72Y     FEMALE    *HOME OR SELF CARE
 6 Major Diagnostic Category                              7 Final Accept Date
   005  DISEASES & DISORDERS OF THE CIRCULATORY SYSTEM      02/26/12
 8 DRG                                 9 Version 10 ICD  11 LOS   12 Charges
   307  HYPERTENSION W/O MCC             28.0       10      5          4171.44
13 DRG Wght    14 Geom LOS  15 Short Stay Trim   16 Day Thresh  17 Cost Thresh
   0.6789         2.20                                          28335.39
18 Tot Cap Reimb  19 Reimb Amt  20 Total DSH     21 Total IME   22 Tot Outlier
                     3449.71       295.90          64.04          0.00
23 Tot Reimb Amt                24 Variance              25 Outlier Indication
   5678.90                           1507.46                 1 Not an Outlie
26 Initial Reimb  27 HAC Proc Required         28 HAC Status

29 Initial DRG    30 DRG Return Code



Press NL--
```

Primary ICD9 DRG:

```
              General Hospital DRG Information Processor
                                                 Thu Mar 15, 2012 04:23 pm
Account      Name                 FC Typ Admit    Disch        Balance Loc
A1205200001  CRANE, BOB            M  I/P 02/21/12 02/26/12     2881.64 AR /ACCF
 1 DRG Payor            2 Other Payor  3 Age   4 Sex     5 Dischg Disposition
   M MEDICARE             42             72Y     FEMALE    *HOME OR SELF CARE
 6 Major Diagnostic Category                                7 Final Accept Date
   005  DISEASES & DISORDERS OF THE CIRCULATORY SYSTEM      02/26/12
 8 DRG                                9 Version 10 ICD  11 LOS   12 Charges
   306  HYPERTENSION W/O MCC             27.0       9       5           4171.44
13 DRG Wght    14 Geom LOS  15 Short Stay Trim   16 Day Thresh  17 Cost Thresh
   0.5959         2.20                                          28335.39
18 Tot Cap Reimb  19 Reimb Amt  20 Total DSH     21 Total IME   22 Tot Outlier
                     3449.71       295.90           64.04          0.00
23 Tot Reimb Amt                24 Variance             25 Outlier Indication
   3449.71                           -721.73              1 Not an Outlie
26 Initial Reimb  27 HAC Proc Required         28 HAC Status

29 Initial DRG    30 DRG Return Code



Press NL--
```

Secondary ICD9 DRG:

```
                   General Hospital DRG Information Processor
                                                 Thu Mar 15, 2012 04:23 pm
Account      Name                 FC Typ Admit    Disch        Balance Loc
A1205200001  CRANE, BOB            M  I/P 02/21/12 02/26/12     2881.64 AR /ACCF
 1 DRG Type             2 Other Payor/Type           3 Age     4 Sex
   CHAMPUS                                             72Y       FEMALE
 5 Major Diagnostic Category                            6 Dischg Disposition
   005  DISEASES & DISORDERS OF THE CIRCULATORY SYSTEM     *HOME OR SELF CARE
 7 DRG                                8 ICD  9 Charges    10 FINAL ACCEPT DATE
   305 v27.0 HYPERTENSION W/O MCC       9         4171.44    02/26/12
11 DRG Wght      12 Geom LOS   13 Tech. Add-on   14 Day Thresh  15 Cost Thresh
   0.7033           1.90                                          76365.13
16 DRG Base Amt  17 Reimb Amt  18 Total DSH      19 Tot IME     20 Tot Outlier
                    6607.86                        611.62          0.00
21 Tot Reimb Amt               22 Variance             23 Outlier Indication
   6607.86                           2436.42              1 Standard paym







Press NL--
```

Non-Reimbursed APR ICD9 DRG:

```
                      General Hospital DRG Information Processor
                                                Thu Mar 15, 2012 04:23 pm
Account      Name                FC Typ Admit    Disch        Balance Loc
A1205200001  CRANE, BOB           M  I/P 02/21/12 02/26/12     2881.64 AR /ACCF
 1 Other Payor                      2 Age       3 Sex
   12                                 72Y         FEMALE
 4 Major Diagnostic Category                            5 Dischg Disposition
   005 CIRCULATORY SYSTEM                                 *HOME OR SELF CARE
 6 APRDRG                                               7 FINAL ACCEPT DATE
   199 HYPERTENSION                                       02/26/12
 8 Outlier Status                    9 LOS       10 Charges      11 Weight
   1 LOS INLIER                        5              4171.44      0.4800
12 Short Trim Point                    13 High Trim Point
   1                                      8
14 Severity of Illness                 15 Risk of Mortality
   1 Minor                                2 Moderate




Press NL--
```

- When a DRG based reimbursement method is used on STAR, the logic was updated to use the ICD-9 or the ICD-10 DRG information for the Primary DRG based on the ICD indicator for the Final/Adjustment Bill.

  The following STAR reimbursement methods are affected:

  A - ASC Reimbursement using the 3M Estimated Reimbursement

  C - Major Diagnostic Category

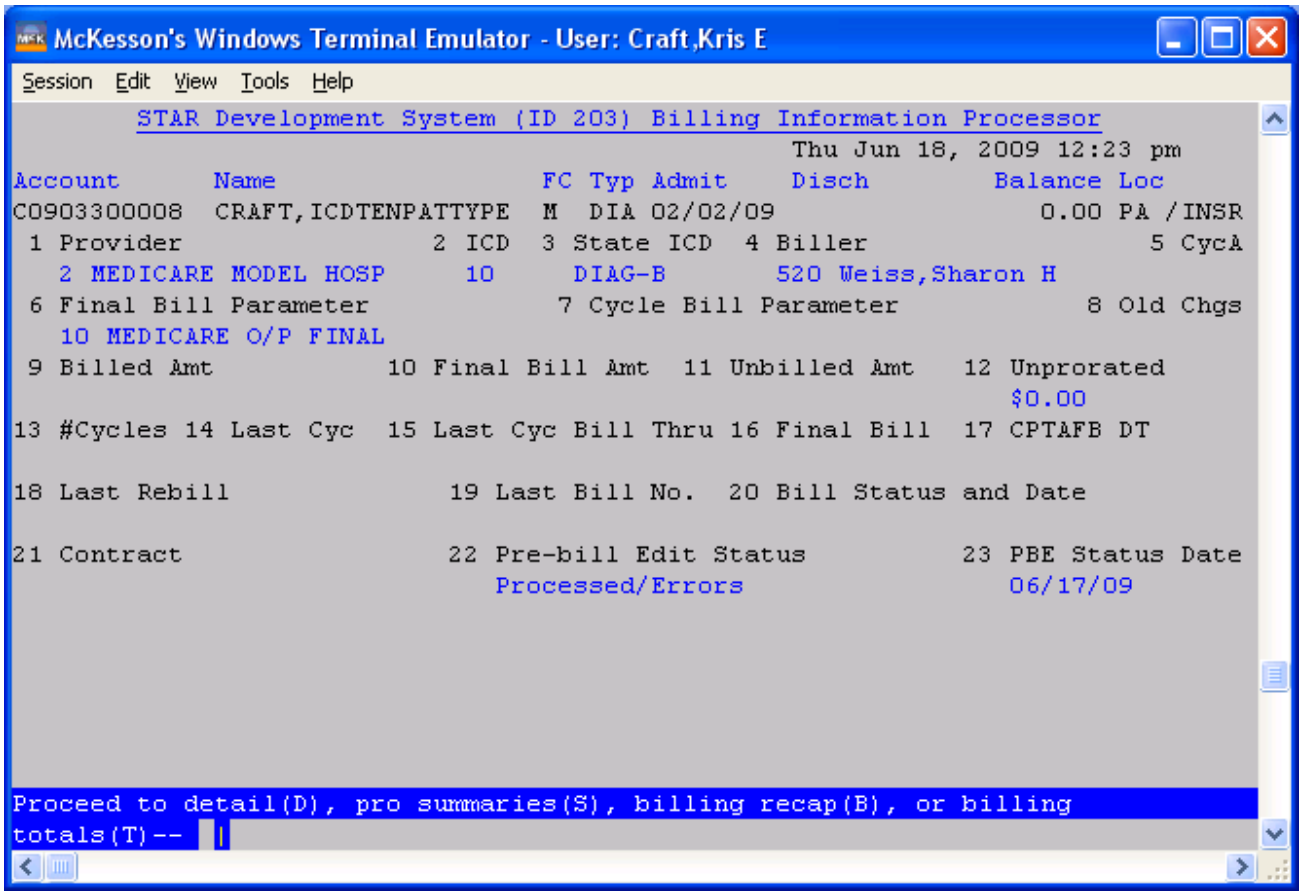
  G - DRG

  L - DRG+Alt Level of Care

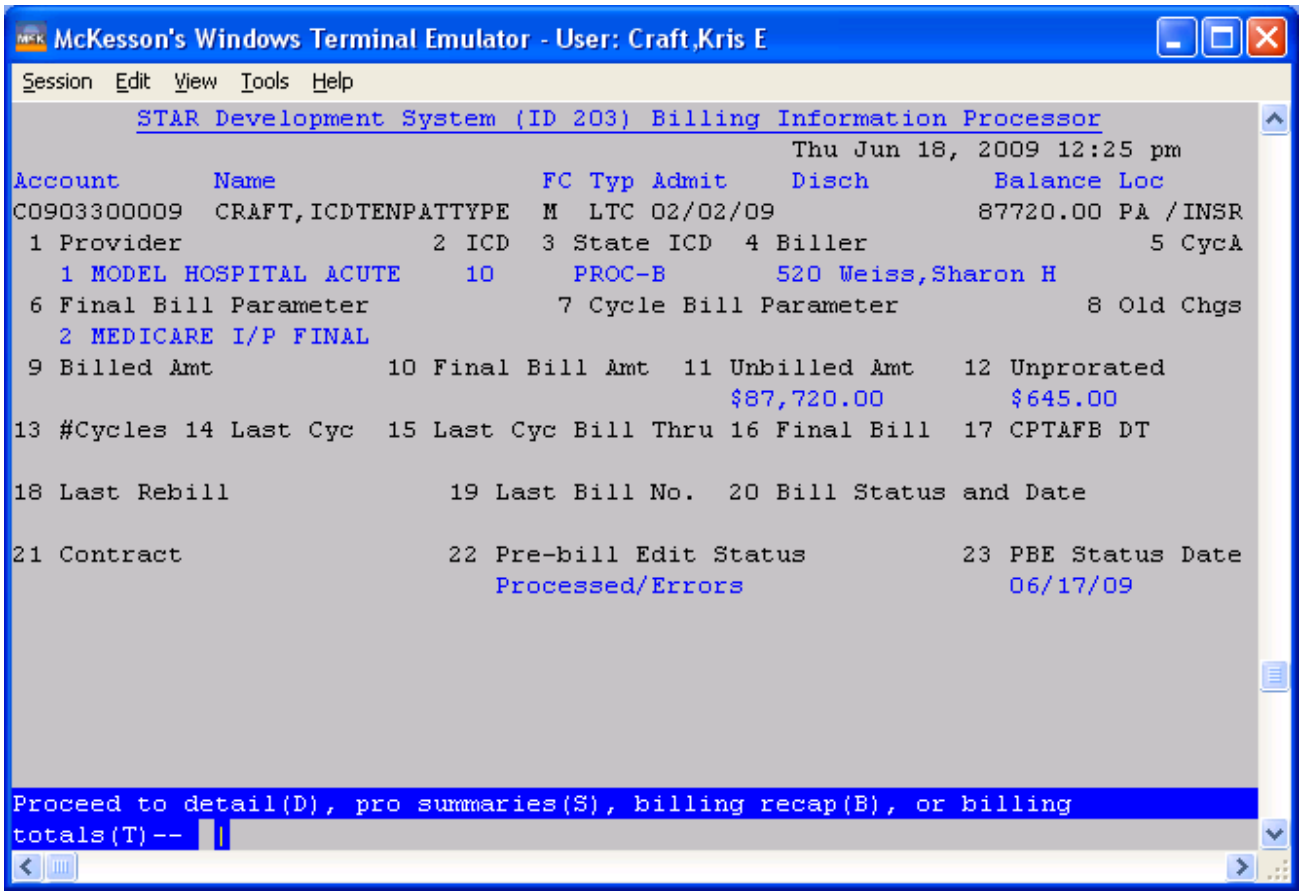
  S - Specified DRG Codes

  If the reimbursement method is J-PCON by Claim and the STAR calculated reimbursement method is DRG or New York, the logic was updated to use the DRG to use the DRG information for the ICD-9 or the ICD-10 DRG based on the ICD indicator for the Final/Adjustment Bill.

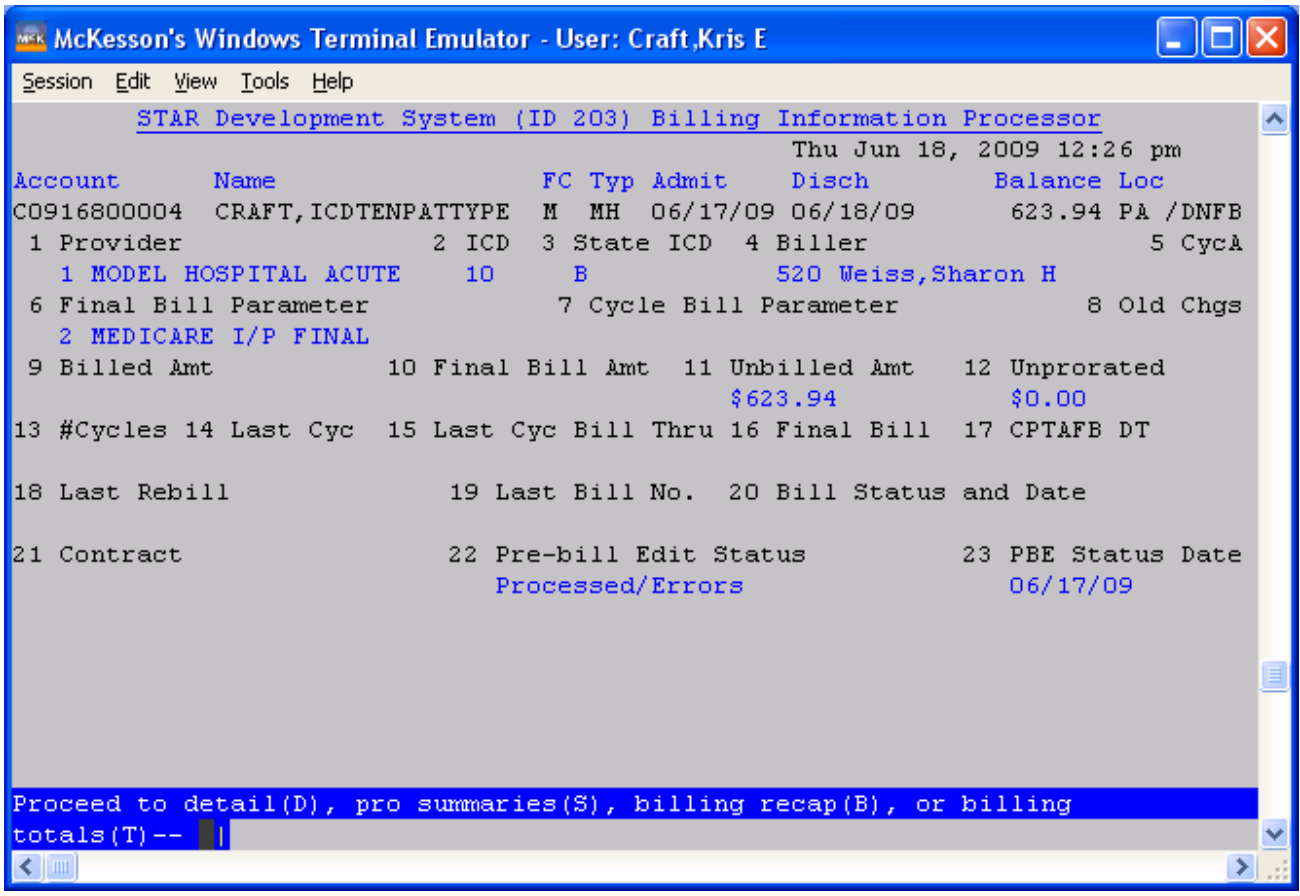
- State Exception field 3 for Diagnoses (collect both ICD-10 and ICD-9 for Diagnoses):



- State Exception field 3 for Procedures (collect both ICD-10 and ICD-9 for Procedures):

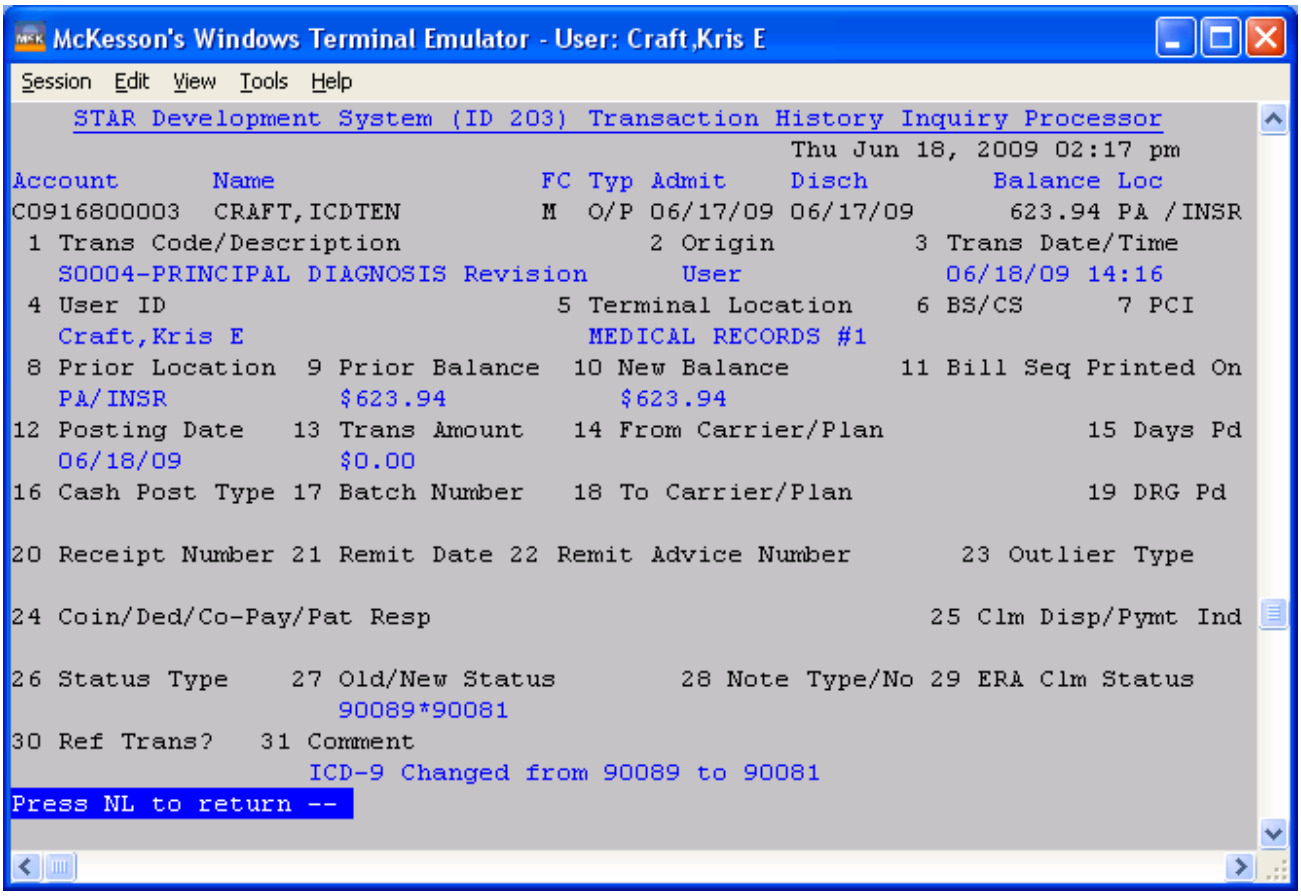


- State Exception field 3 for Both Diagnoses and Procedures (collect both ICD-10 and ICD-9):

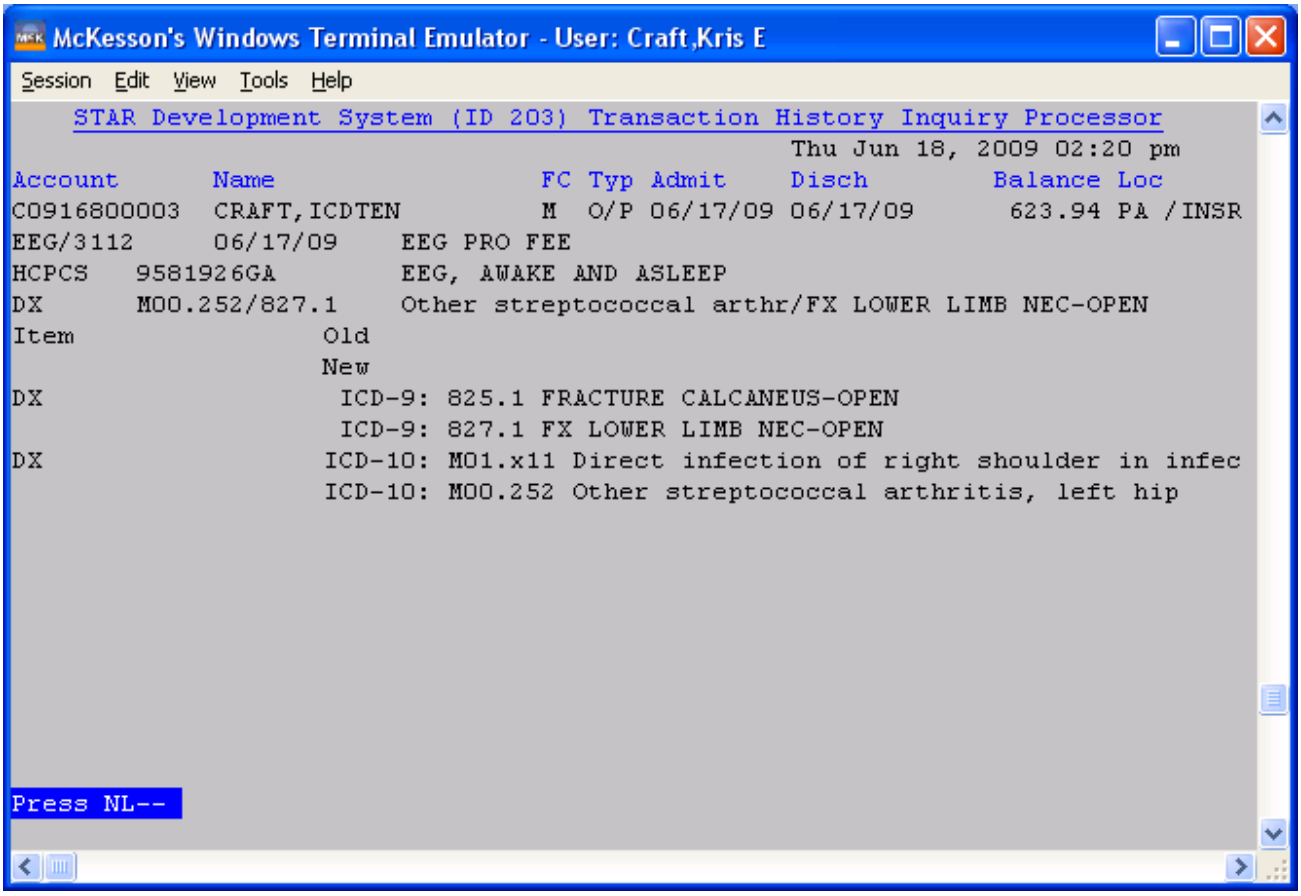


- Added the DRG ICD indicator to the transaction history message for changed DRG. Therefore, the format would be DRG Code/ICD/DRG Indicator/Version.

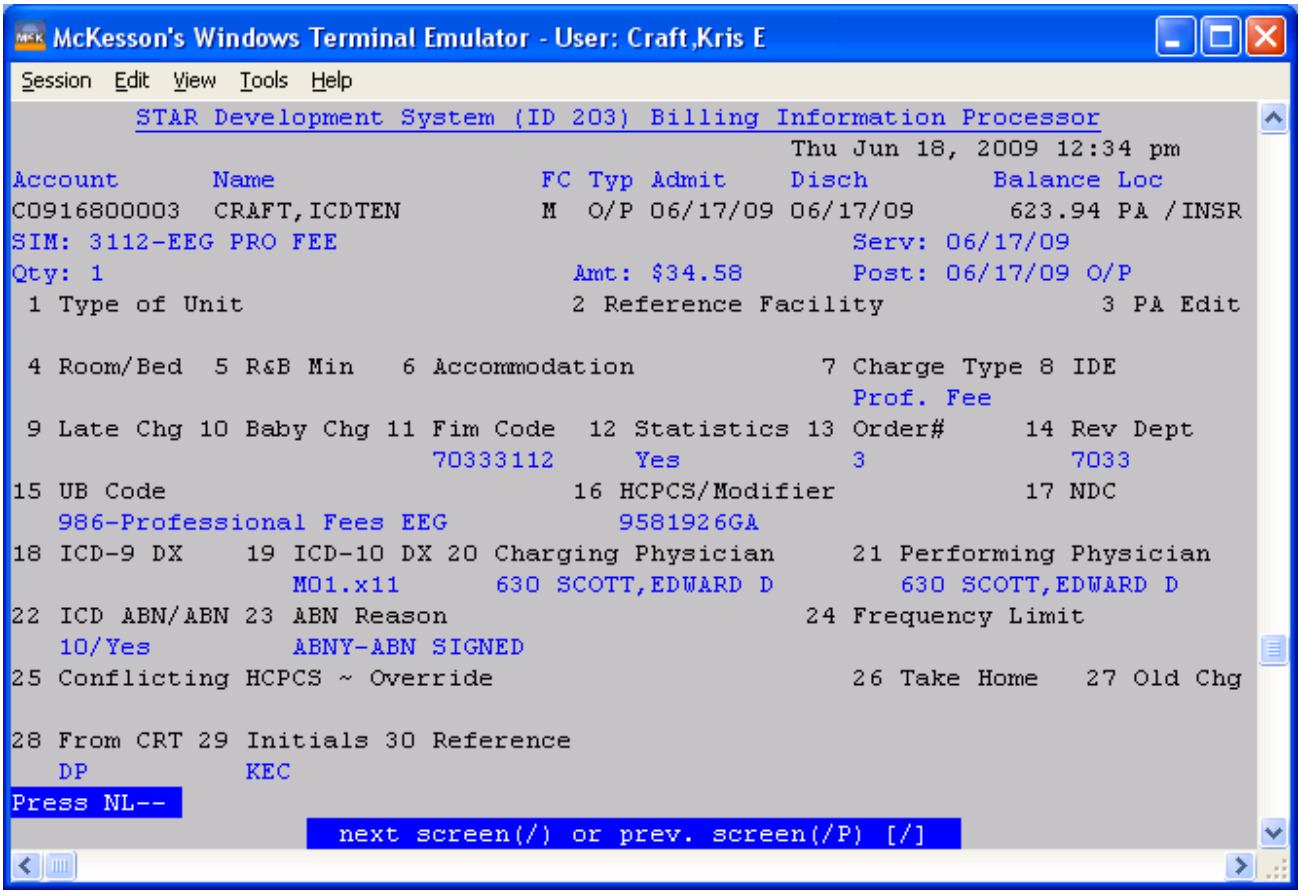
- Updates to information recorded in Transaction History are distinguished by ICD-9 or ICD-10 in the Comment field.



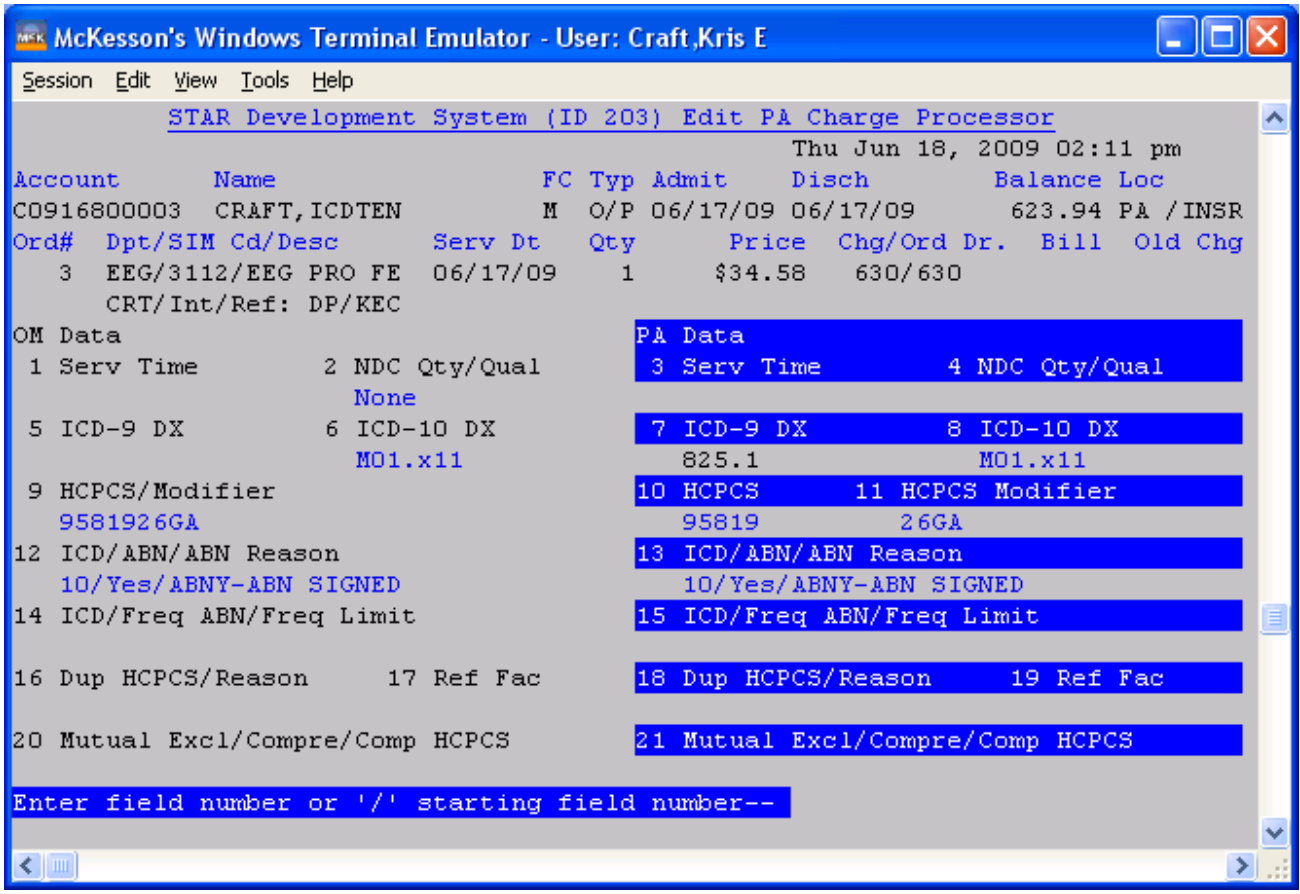
- Transaction History when List changes for Edit PA Charges:



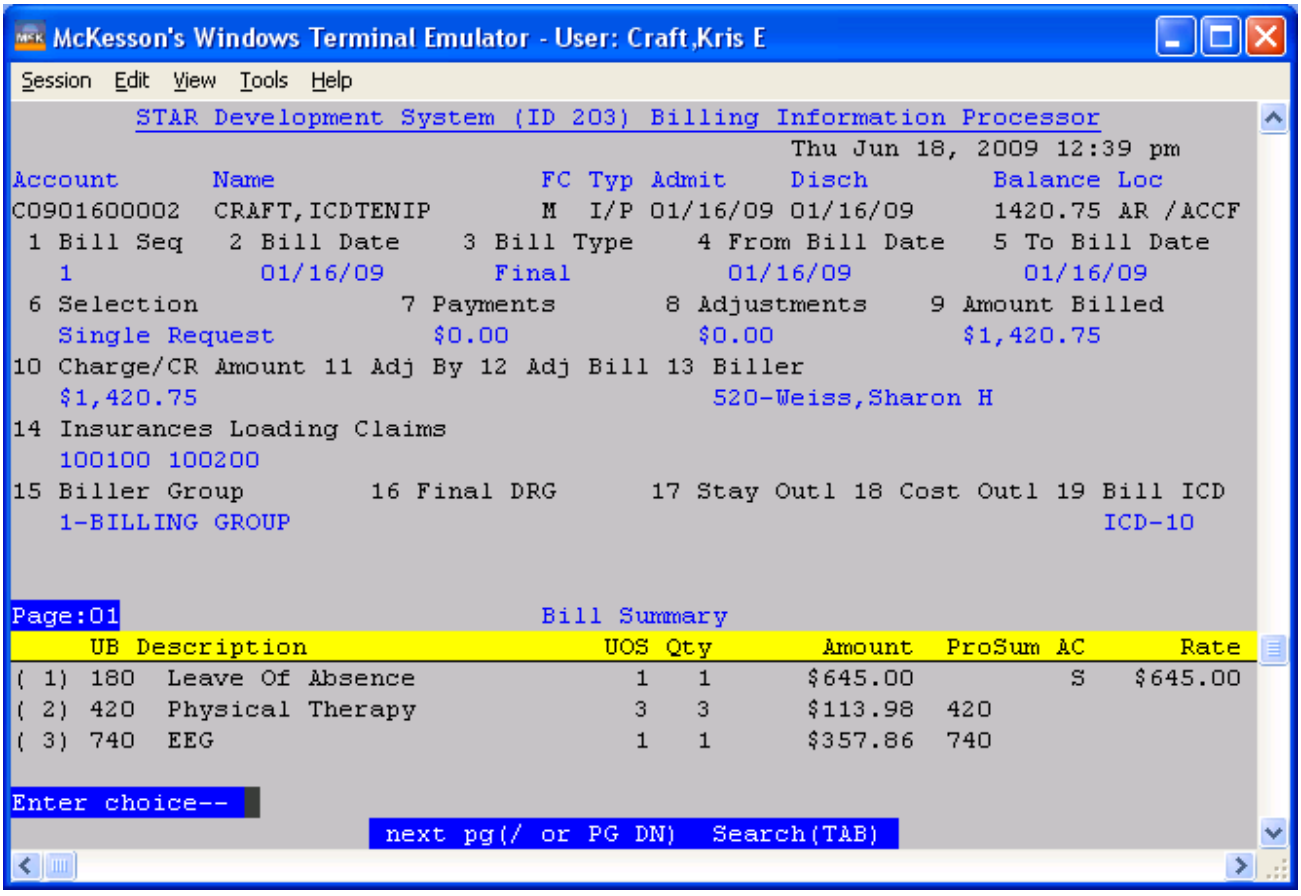
- An ICD-9 diagnosis (field 18) and/or ICD-10 diagnosis (field 19) appears for charges in PA Charge Inquiry and in Edit PA Charge. The ICD indicator for ABN information (field 22) is retained also.



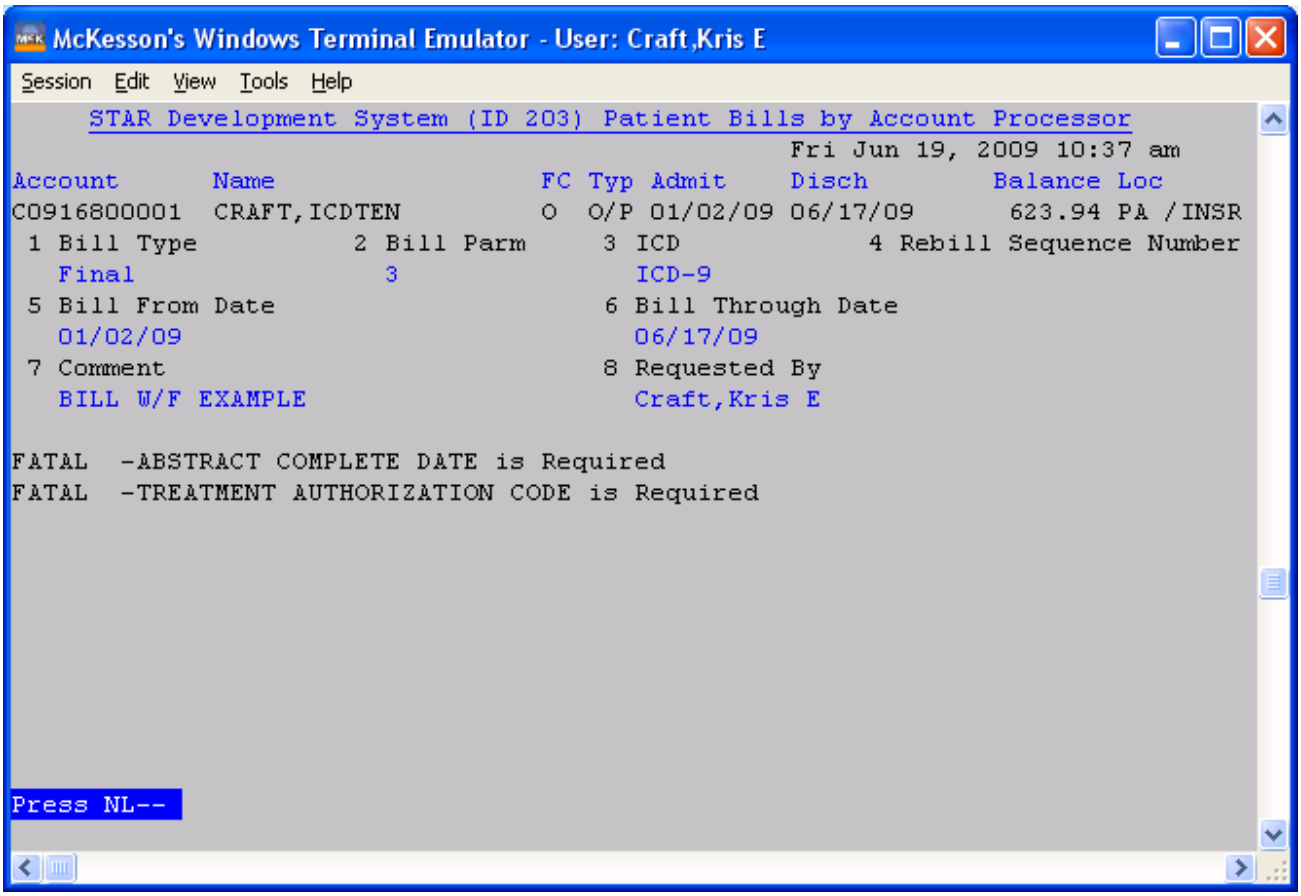
- Edit PA Charges for OM and PA (the PA side is now in blue), has fields for ICD-9 DX, and ICD-10 DX, and the ABN and Frequency ABN fields for OM and PA display the ICD indicator for the ABN. Logic has been updated for the system to assign the ABN ICD indicator.



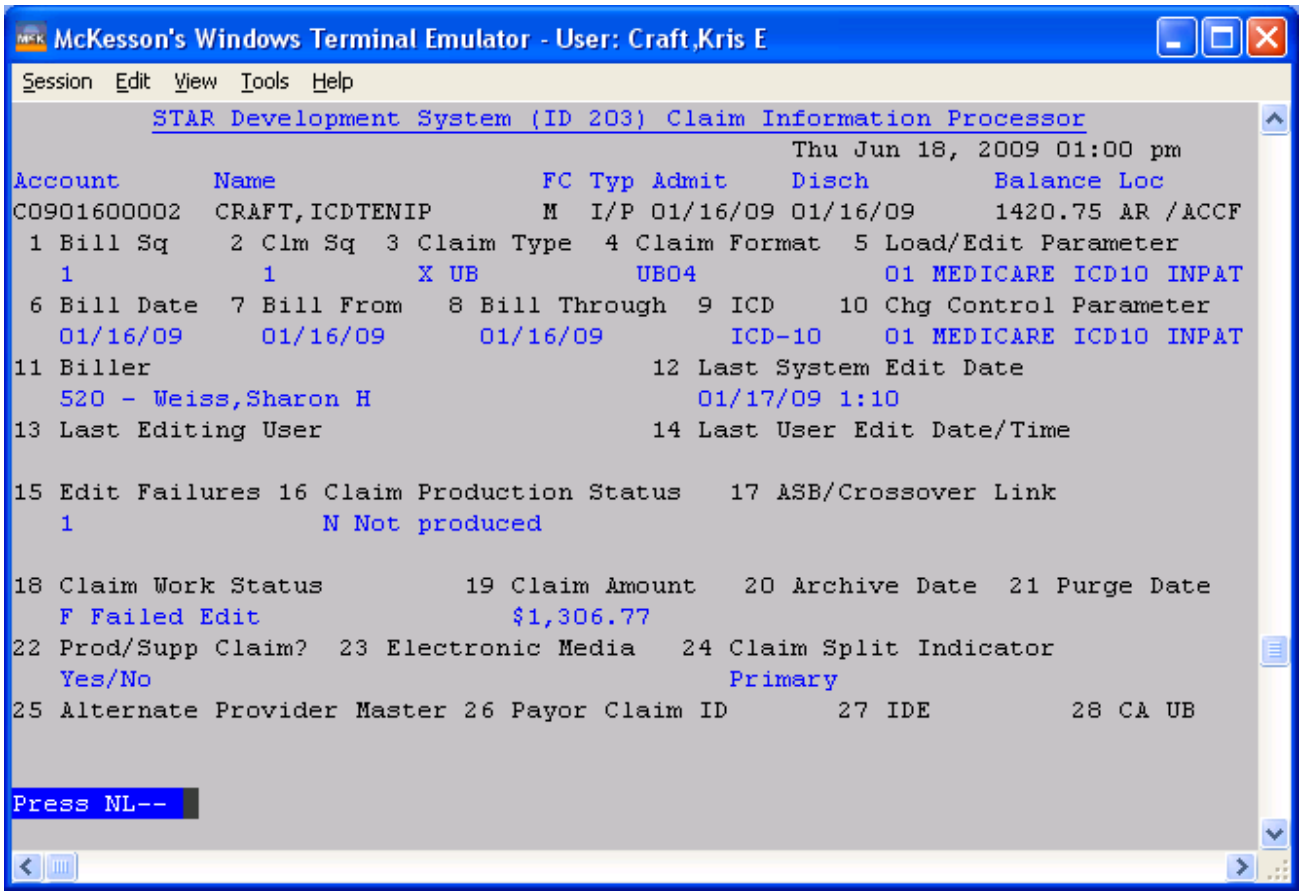
- The ICD flag for a bill can be seen under proration summaries in Account Inquiry, Financial Information, Billing Information, enter S for Pro Summaries, select the bill sequence, field 19 for Bill ICD.



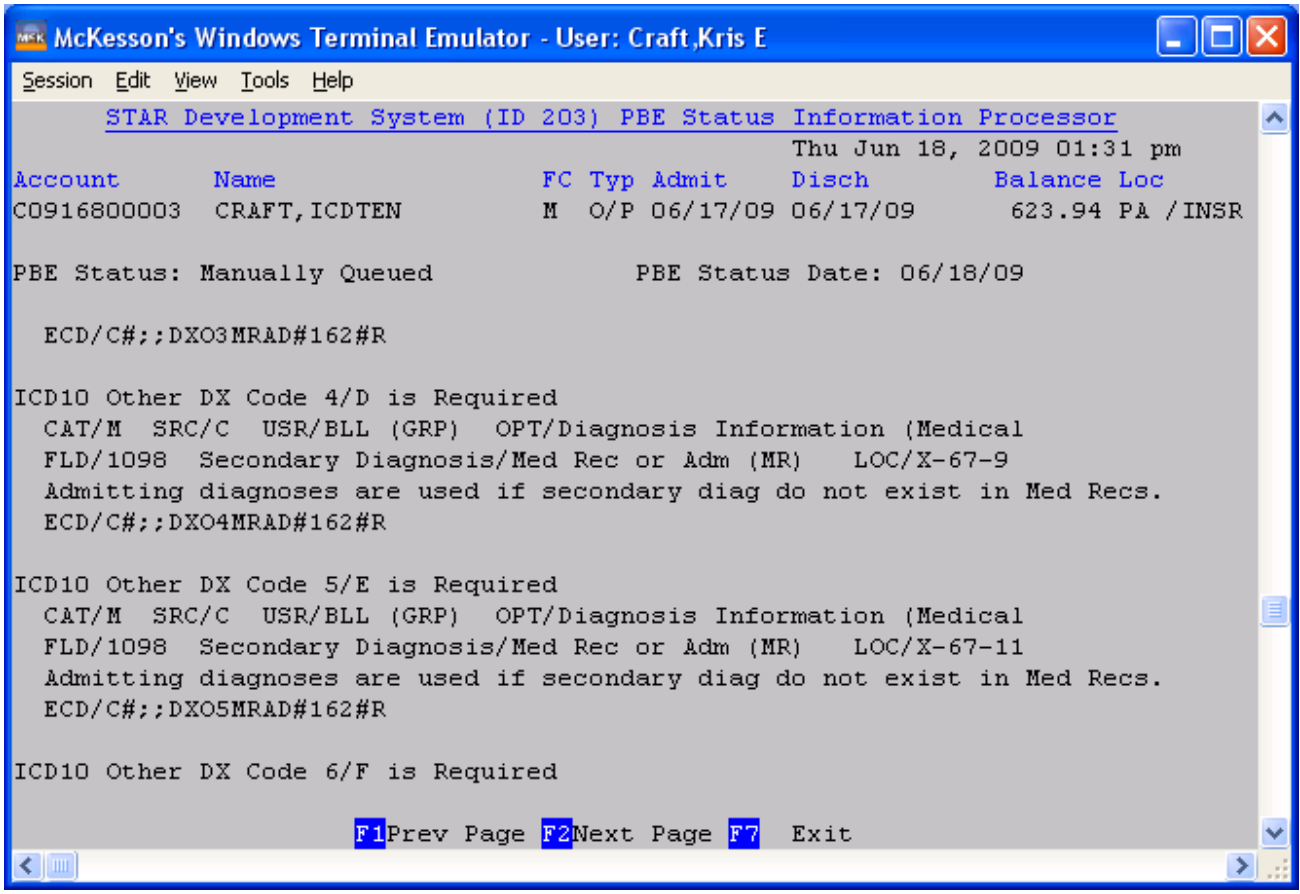
- The ICD for the bill (field 3) and the Billing Parameter (field 2) have been added to the Biller Workfile for bills failing edits. Therefore, if the bill fails for diagnosis and/ or procedure information, the user knows whether ICD-9 or ICD-10 codes are required.

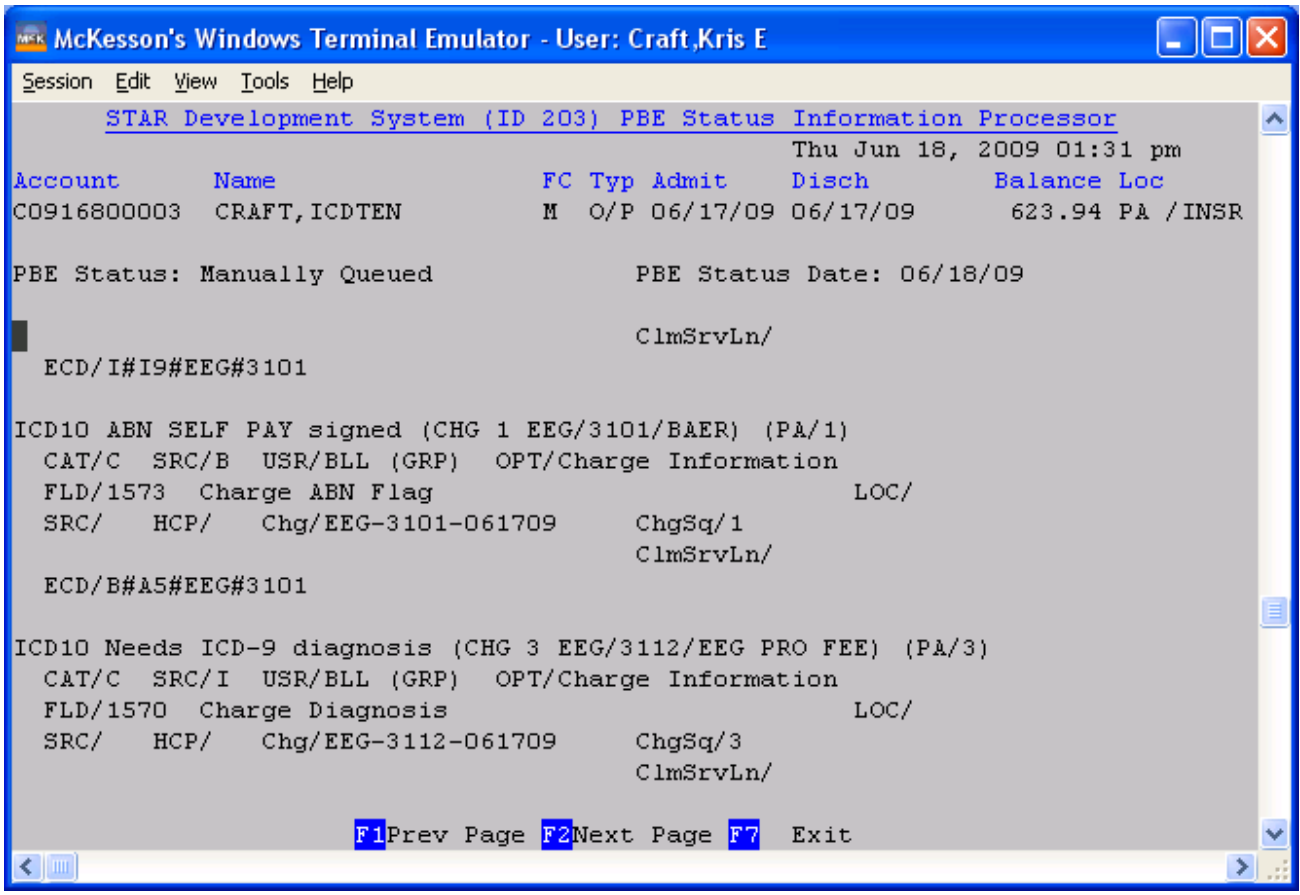


- Claim Status Information includes the new field ICD (field 9) identifying whether ICD-9 or ICD-10 codes loaded to the claim. This field appears on FCR250 also.

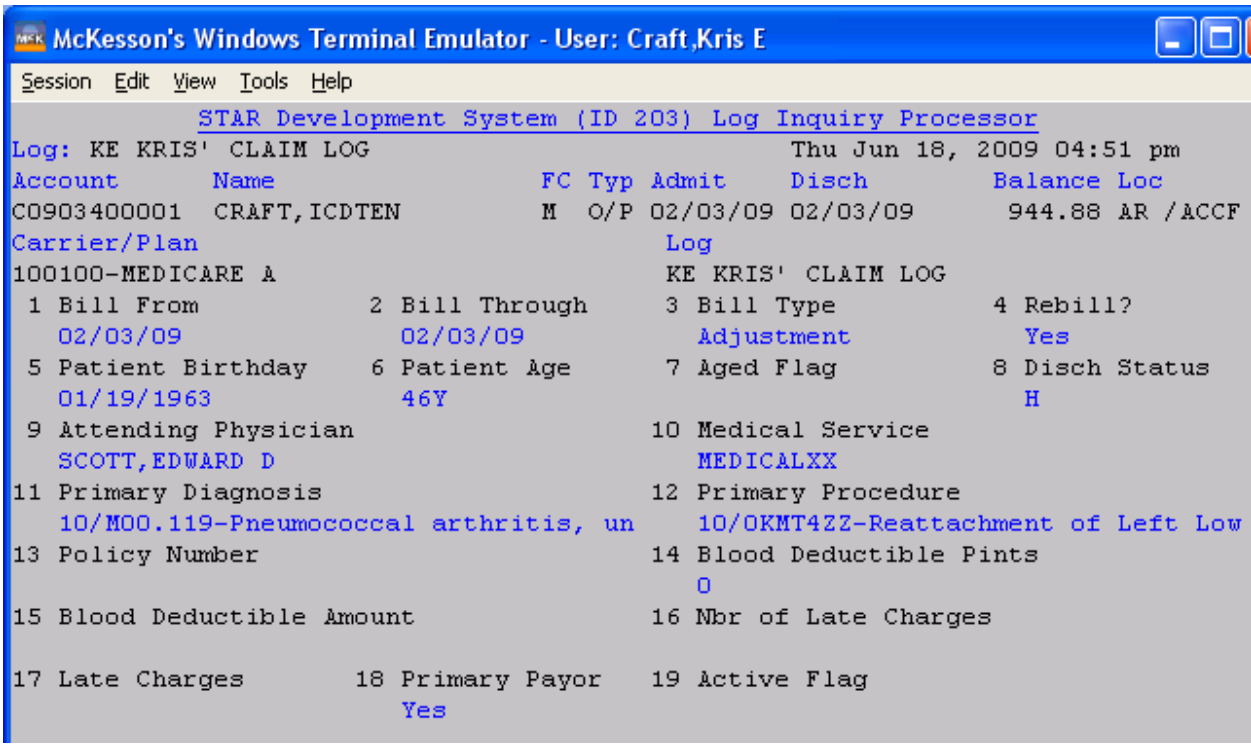


The Pre-Bill Edit descriptions for diagnosis and procedure edits have been updated to begin with ICD9 or ICD10, based on whether the Bill/Claim edit requires ICD-9 or ICD-10 coding. A new edit source of I for ICD was added for charge Ordering Diagnosis edits. When ICD-10 processing starts, this edit source can be used to identify accounts where the type of charge diagnosis appears to be incorrect for the account.



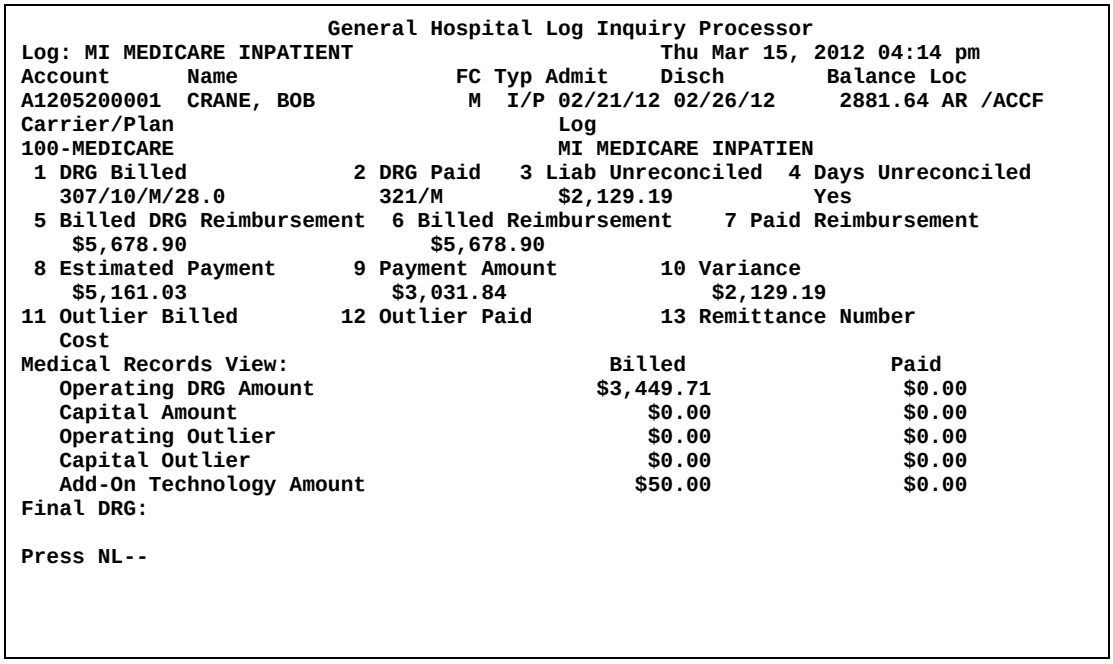

McKesson's Windows Terminal Emulator - User: Craft,Kris E
Session Edit View Tools Help
STAR Development System (ID 203) PBE Status Information Processor
Thu Jun 18, 2009 01:31 pm
Account Name FC Typ Admit Disch Balance Loc
C0916800003 CRAFT,ICDTEN M O/P 06/17/09 06/17/09 623.94 PA /INSR
PBE Status: Manually Queued PBE Status Date: 06/18/09
ClmSrvLn/
ECD/I#I9#EEG#3101
ICD10 ABN SELF PAY signed (CHG 1 EEG/3101/BAER) (PA/1)
CAT/C SRC/B USR/BLL (GRP) OPT/Charge Information
FLD/1573 Charge ABN Flag LOC/
SRC/ HCP/ Chg/EEG-3101-061709 ChgSq/1
ClmSrvLn/
ECD/B#A5#EEG#3101
ICD10 Needs ICD-9 diagnosis (CHG 3 EEG/3112/EEG PRO FEE) (PA/3)
CAT/C SRC/I USR/BLL (GRP) OPT/Charge Information
FLD/1570 Charge Diagnosis LOC/
SRC/ HCP/ Chg/EEG-3112-061709 ChgSq/3
ClmSrvLn/
F1Prev Page F2Next Page F7 Exit

- Third Party Logs, Log Demographics screen displays the ICD indicator of 9 or 10 before the fields Primary Diagnosis and Primary Procedure:



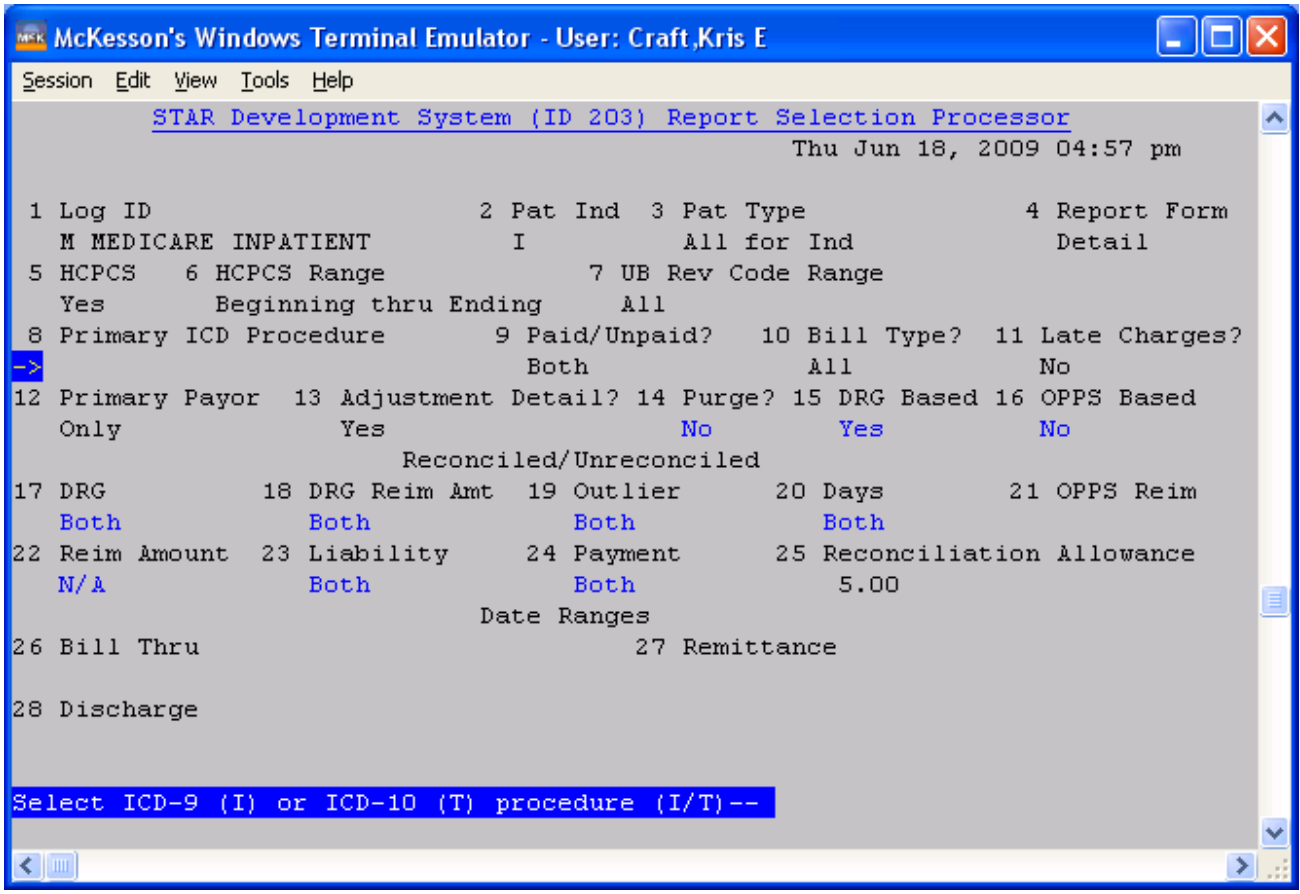
- Logs will display the ICD indicator for the reimbursed DRG in the Log Reimbursement and Reconcilliation screen, and on the Selected Log Account Report. The field DRG Billed will now display the ICD indicator for the DRG.

•



```
                      General Hospital Log Inquiry Processor
Log: MI MEDICARE INPATIENT                        Thu Mar 15, 2012 04:14 pm
Account      Name                FC Typ Admit    Disch        Balance Loc
A1205200001  CRANE, BOB           M  I/P 02/21/12 02/26/12     2881.64 AR /ACCF
Carrier/Plan                              Log
100-MEDICARE                              MI MEDICARE INPATIEN
 1 DRG Billed            2 DRG Paid   3 Liab Unreconciled  4 Days Unreconciled
   307/10/M/28.0           321/M         $2,129.19           Yes
 5 Billed DRG Reimbursement  6 Billed Reimbursement    7 Paid Reimbursement
    $5,678.90                  $5,678.90
 8 Estimated Payment      9 Payment Amount        10 Variance
    $5,161.03               $3,031.84               $2,129.19
11 Outlier Billed        12 Outlier Paid          13 Remittance Number
   Cost
Medical Records View:                          Billed               Paid
   Operating DRG Amount                      $3,449.71             $0.00
   Capital Amount                                $0.00             $0.00
   Operating Outlier                             $0.00             $0.00
   Capital Outlier                               $0.00             $0.00
   Add-On Technology Amount                     $50.00             $0.00
Final DRG:

Press NL--
```

- Third Party Logs, Log Report Selection, once the USA ICD-10 Effective Date is today or a date in the past, the field Primary ICD Procedure first prompts for ICD-9 or ICD-10:



Miscellaneous

- A new base GUI form flow was added called PB-DX because a new base GUI form is used to maintain diagnosis information in Patient Processing and in MPI Review. The mappings of the appropriate PBE fields have been updated. Mappings may need to be updated for hospital GUI forms.

- The layouts for the Collection Agency Tape have been updated to include the ICD-10 admitting diagnosis.

- The layout for the miscellaneous record in the External Agency (Pre-Collect) interface has been updated to include ICD-10 diagnoses.

- Reports have been updated to include ICD-10 or ICD-9 and ICD-10 DRG's as appropriate:
  - Failed Billing Requirements Report (FBR210)
  - Failed Billing Requirements Controlled by Report (FBR220)
  - DRG/Diagnosis/Procedure Modification Report (FBR400)
  - Failed Claims Requirement Report (FCR250)
  - Bad Debt Pre List Report (FFR300)
  - Change Patient Type After Final Bill Report (FACPTAFB)
  - Non-Covered Services With Signed Advanced Beneficiary Notification Report (FAHCFAY)
  - Non-Covered Services Without Signed Advanced Beneficiary Notification Report (FAHCFAN)
  - Covered Services Subject to Frequency Limit With Signed ABN Form Report (FAHCFLY)
  - Covered Services Subject to Frequency Limit Without Signed ABN Form Report (FAHCFLN)
  - Self Pay Services with Signed Advanced Beneficiary Notification (FAHCFSY)
  - Self Pay Services without Signed Advanced Beneficiary Notification (FAHCFSN)
  - Self Pay Services Subject to Frequency Limit with Signed ABN Form (FAHCFSFY)
  - Self Pay Services Subject to Frequency Limit without Signed ABN Form (FAHCFSFN)
  - Conflicting HCPCS Without Modifier Documentation (FAHCFAD)
  - Final Billing Parameters Report (FTFABP)
  - Claim Load Edit Parameters Report (FCRCP)
  - PA Charges Edited on MM/DD/YY by Account (FARCHGAx)
  - PA Charges Edited on MM/DD/YY by Department (FARCHGDx)

- DRG Payment Window Report (FBR072x)
- Reimbursement Table Report (FTR140)
- Charges Missing Diagnosis Report (new FARDXMx)

Implementation Steps

Until the ICD-10 Implementation Steps are completed on the STAR Patient Processing, STAR Medical Records, STAR Order Management, and STAR Laboratory and STAR Radiology systems, there are no required implementation steps on STAR Patient Accounting for staying on ICD-9 coding.

Automatic Updates with F9734:

Many of the internal elements used for billing and claims have been re-worked to look for ICD-9 or ICD-10 information depending upon the requirements for the account. For that reason, all billing requirements and claim load and edit parameters are regenerated when this STI moves to an environment. New internal elements have been authored for TRENDSTAR and Horizon Performance Management to provide ICD-9 information and to provide ICD-10 information, and these begin with *H/T*. Any existing parameters for TRENDSTAR or Horizon Performance Management have been updated to use the new elements, and post-processing re-generates those programs.

NOTE: Since ICD-10 Diagnosis and Procedure codes are required with discharges of 10/01/2013, ICD-10 codes should begin to be collected with admissions well before this date so that the required information is present on the accounts.

Automatic Updates with F10864:

- Existing internal elements will look to the ICD indicator for the claim, and pull either the ICD-9 DRG information, or the ICD-10 DRG information based on this.
- Internal Elements used for Billing Requirements, in Claims, and in Horizon Performance Management/TRENDSTAR were updated to use the ICD-9 or ICD-10 information based on the ICD indicator of the bill or claim. They were also updated so they cannot be used for Horizon Performance Management/ TRENDSTAR.
- New internal elements were developed for Horizon Performance Management/ TRENDSTAR.
- Post-processing with the STI will convert any UDF or UDA set-ups using Final DRG to use Horizon Performance Management/TRENDSTAR ICD9 Final DRG and using DRG REIMBURSEMENT AMOUNT to use Horizon Performance Management/TRENDSTAR ICD9 DRG REIMBURSEMENT AMOUNT.

- Internal Elements are marked to be used for TRENDSTAR/Horizon Performance Management and use ICD9 information. They will be re-labeled to identify them as ICD9 and a corresponding ICD10 Internal Element will be created.

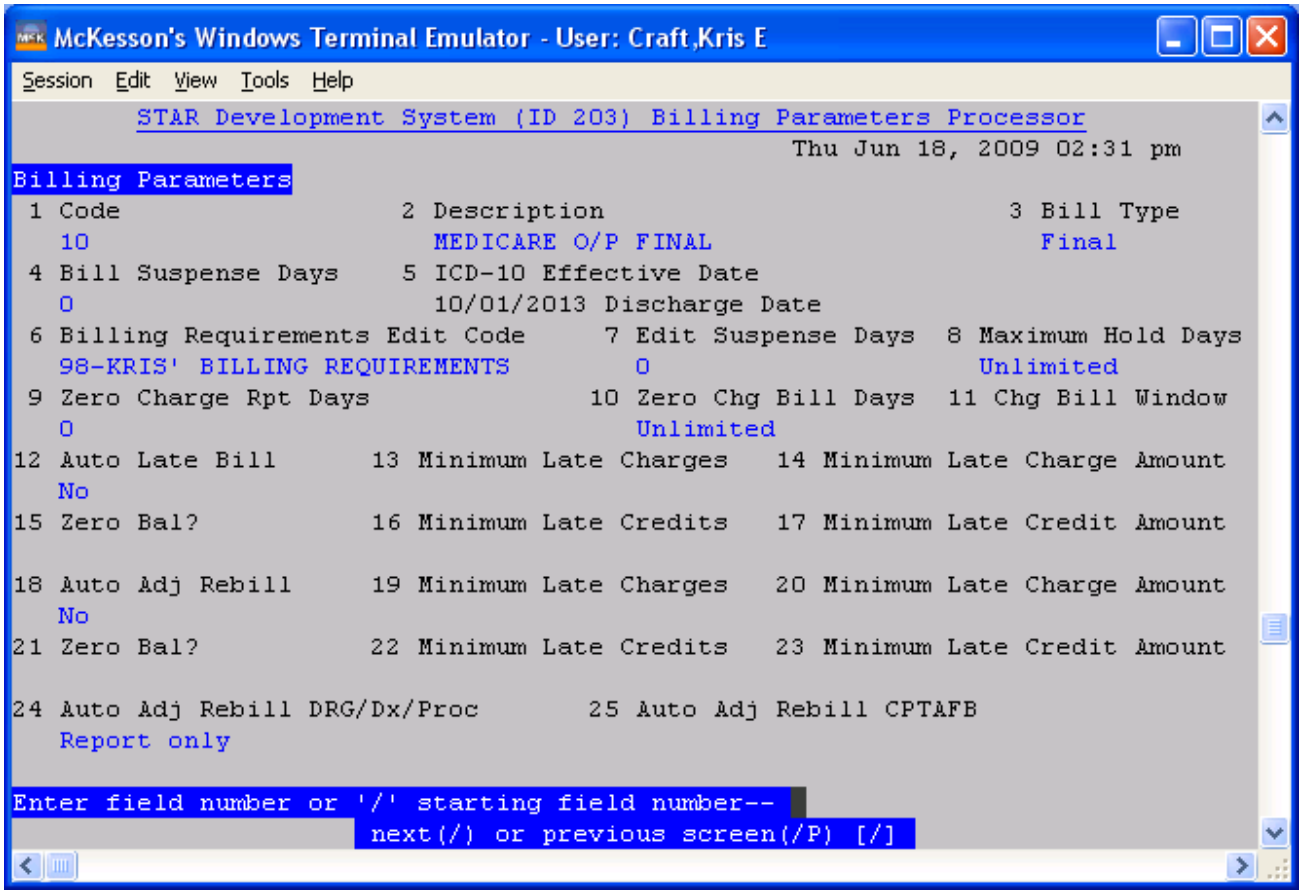
Tables and Parameters

The following Tables and Parameters have had new fields or revised fields for ICD-10 processing.

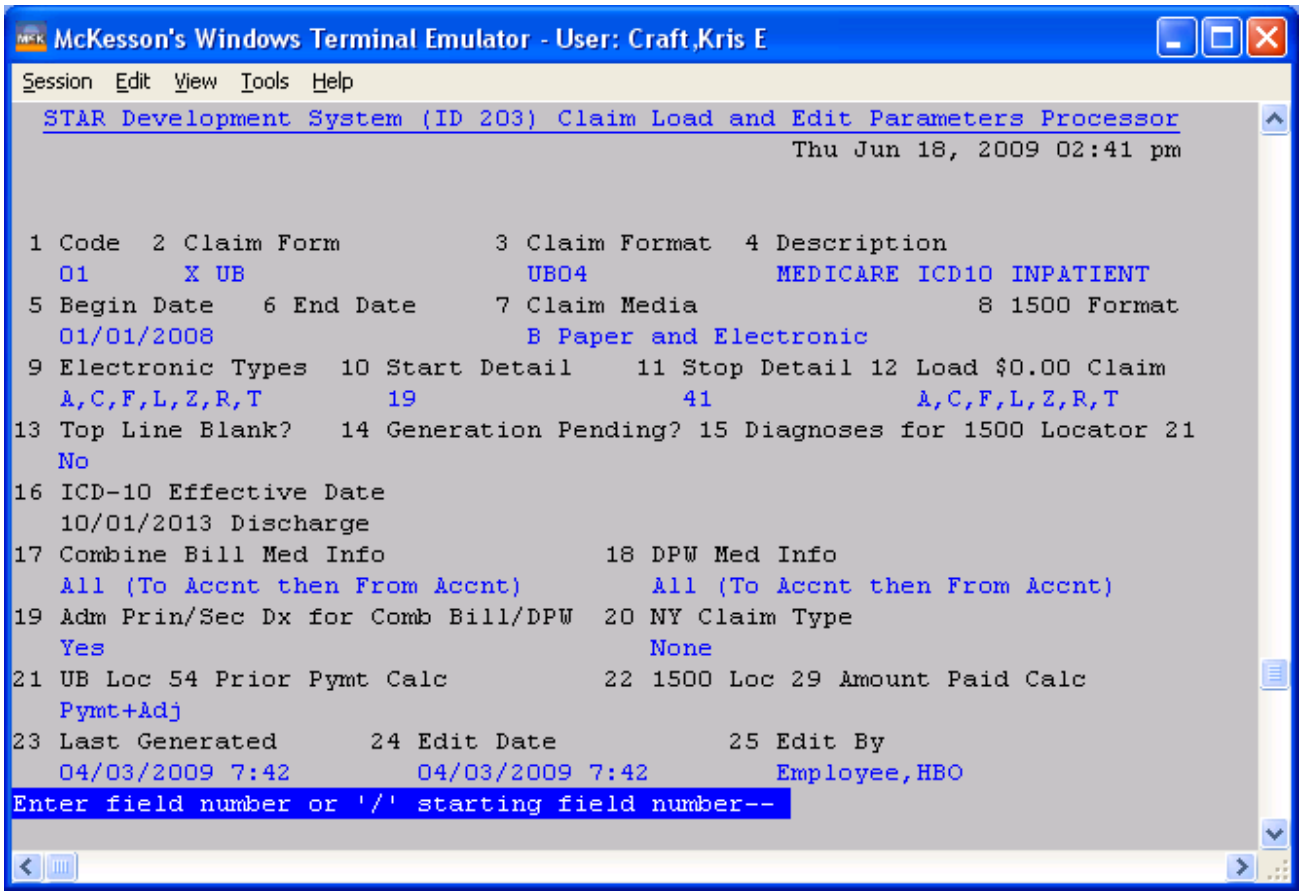
- Final Billing Parameter - Auto Adj Rebill DRG/Dx/Proc field. If this field is set to A for Automatic Adjustment Bill, R for Report Only, or B for Both, then if the DRG is updated, this will only produce an adjustment bill and be reflected on the report if the ICD indicator for the changed DRG matches the Bill ICD indicator for the account.

- When the Billing Requirements attached to the Final Bill Parameter for an account requires the Final DRG or the Secondary DRG, the system should require the DRG with the ICD indicator that matches the Bill ICD Indicator.

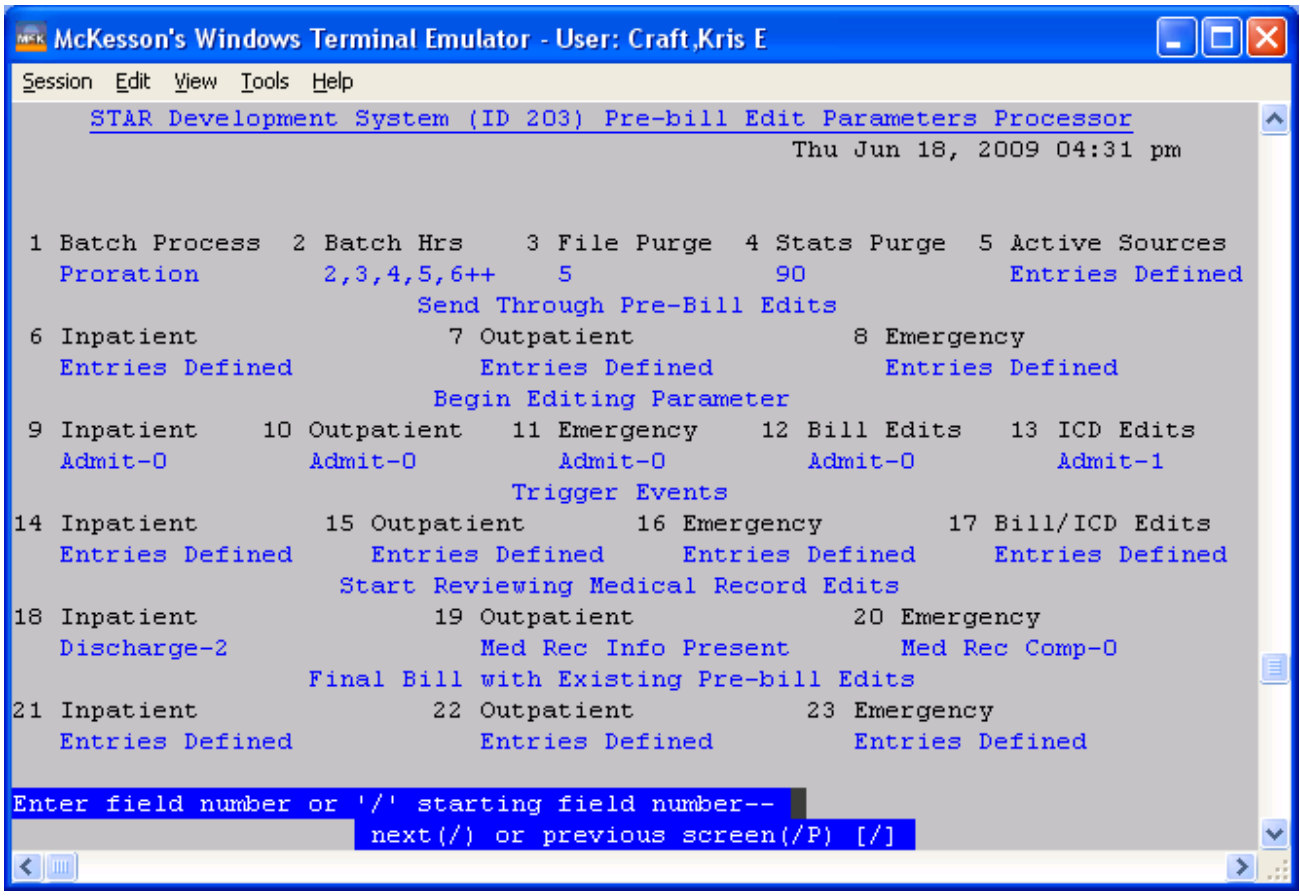
- Final Billing Parameter, ICD-10 Effective Date field:



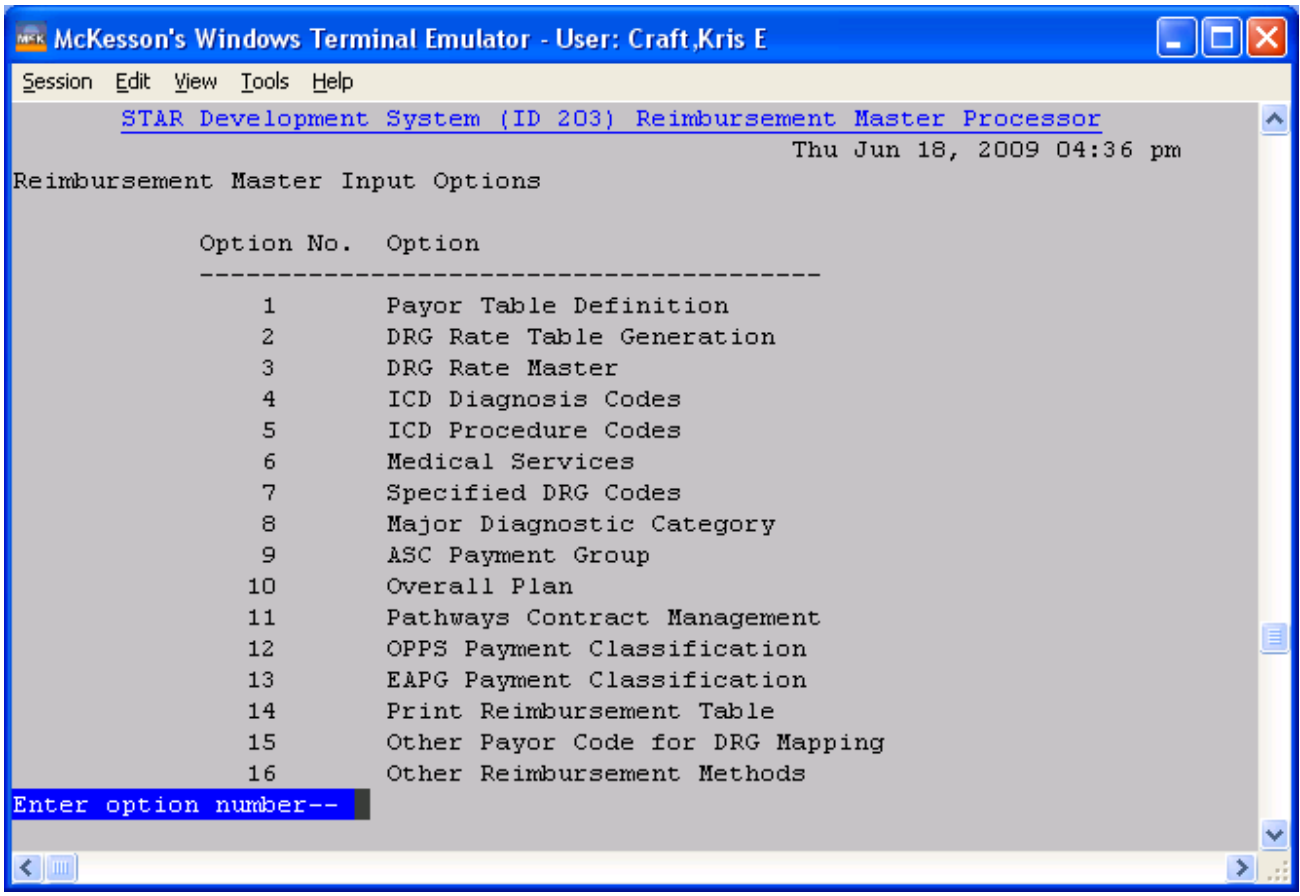
- Claim Load Edit Parameters, for ICD-10 Effective Date field, currently only for claim types X (UB), R (Medi-Cal UB), B (1500), and Z (Non Pro Fee 1500).



- Pre Bill Edit Parameters, Active Sources field (field 5) has a new source of I-ICD Charge Edits The ICD Edits field (field 13) is new.



- Reimbursement Master has options renamed as ICD Diagnosis Codes and ICD Procedure Codes. Within these tables both ICD-9 and ICD-10 codes can be defined for reimbursement:



Testing Guidelines

Previous to implementing ICD-10 in your Test environment, testing should be done for current ICD-9 processing. All functions should work properly as before moving the ICD-10 enhancements into your Test and Live environments.

Note that you see some screens with the ICD indicators, which are blank before you implement ICD-10. You also see some new fields on screens, tables, and parameters.

The following should be tested with typical patient samples:

- Entering diagnoses in the Admission flow, including Secondary Diagnoses
- Dispositioning a patient and entering in ICD-9 diagnoses and Procedures
- Entering ICD-9 diagnoses and procedures in Medical Records

- Entering External Cause of Injury diagnoses in Medical Records
- Advance Beneficiary Notification (ABN) charges for CMS compliant patients
- Load ABN Non Covered Charges on the UB04
- Viewing Admissions diagnoses in Account Inquiry
- Viewing Medical Records diagnoses and procedures in Account Inquiry
- Editing the ICD-9 Ordering Diagnosis on a charge in Edit PA Charge
- Editing the Final Bill for Primary Diagnosis and Primary Procedure
- Loading diagnoses and procedures to your federal claims (UB04, 1500, Non Pro Fee 1500)
- Using Pre Bill Edit for claims with diagnosis and procedure errors
- With Combine Bills, using the FROM account's diagnoses and procedures on the TO account's claim
- With DRG Payment Window, testing evaluating the Non Diagnostic Charges first based on the Outpatient diagnoses in the Abstract and the Primary and Secondary diagnoses for the Inpatient, and then based on the ICD-9 Ordering Diagnosis on the FROM account's charges compared to the Primary and Secondary diagnoses for the Inpatient
- If using the STAR Reimbursement types of ICD Diagnoses or ICD Procedures, these should be tested with ICD-9 codes.Review the Claim Log for a UB, 1500, and Non Pro Fee 1500 loading ICD-9 codes
- If you use PBE GUI, review the GUI form used to correct Patient Processing diagnosis information.
- If you are a TRENDSTAR user, review any diagnosis and procedure information provided by User Defined Fields.
- If you are a Horizon Performance Management user, review any diagnosis and procedure information provided by User Defined Attributes.
- Review changes to the layout for the Collection Agency Tape.
- Review changes to the layout for the External Agency (Pre-Collect) interface.
- All interfaces and customizations need to be considered and evaluated to determine the effect of implementing ICD-10.

Integration Considerations

Prior to the implementation of the ICD-10 Enhancement, there are not any changes needed for the inbound or outbound interface lines. During the time prior to the implementation of the ICD-10 Enhancement, all interface lines should be reviewed with the products receiving the outbound STAR messages to determine the status for receiving and sending ICD codes.

Other related STIs include the following:

- M23113 ICD-10 2.2b Integration Updates. Completed in Release 15.0 05/01/2009.
- F9931 Patient Accounting Updates to EC 2000 CA Interface for ICD-10. Open STI.
- F10255 Patient Accounting Updates for 5010 Version of Electronic Claims. Electronic Claims. Completed in Release 13.0 and higher 08/03/2009.
- F9940 Patient Accounting Updates to PCON Interface for ICD-10. Open STI.
- F10254 Horizon Performance Management and TRENDSTAR Updates for ICD-10. Completed in Release 15.0 08/05/2009.
- F10046 Change All State Reg Programs to Read Either ICD-9 or ICD 10 Codes - Not Both. Completed in Release 15.0 09/25/2008.
- F10246 Canada Changes to Accompany US ICD-10 Processing. Completed in Release 15.0 04/28/2009.
- MISC STIs For State Regulation changes to be identified as their data requirements migrate to requiring ICD-10 information.

Chapter 2 - IMPLEMENTING STAR RELEASE 15.0 OR LATER WITH ICD-10 and ICD-10 DRG'S

INTRODUCTION

This chapter contains application information and step-by-step instructions for implementing ICD-10 and ICD-10 Medicare DRG. The implementation process impact varies by product, thus separate sets of product-specific implementation steps and documentation are provided for each of the seven primary STAR products.

PATIENT PROCESSING

Overview

ICD-10

In preparation for replacing ICD-9 diagnosis and procedure codes with the proposed new ICD-10 standards, McKesson is building ICD-10 capabilities into STAR Patient Processing.

With Release 15.0, a new STAR Patient Processing facility-level parameter, **USA ICD10 Eff Date**, controls the date on which ICD-10 functionality becomes effective in the facility. This parameter, which is based on admission date, is located in STAR Patient Processing, Tables, Facility Options and Parameters, Hospital Facility Options, Admission and General Parameters. The parameter settings determine when an account begins to be prompted for ICD-10 diagnosis and procedure codes. ICD-10 updates take effect only after this parameter has been set and the effective date has been reached.

See also, Medical Records Implementation. With Release 16.0, a new STAR Medical Records Abstracting facility-level parameter Discharge ICD10 Effective Date parameter was added that is used just by M/R Abstracting and GUI Abstracting.

CN: For Canada, the existing ICD-10 parameter has been moved to field #20 and renamed **Canada ICD10 Eff Date**.

The facility must be ready to use ICD-10 diagnosis coding before this parameter is set. If the date of admission is prior to the ICD-10 effective date, the processing uses ICD-9 diagnosis coding. After the effective date is reached, there is limited access to ICD-9 diagnoses in the User pointer table.

Users can continue to use ICD-9 codes until their facility switches to ICD-10. For certain exceptions, both ICD-9 and ICD-10 codes can be used.

In addition to the new facility-level parameter to activate ICD-10, there are parameters that indicate exceptions for Insurance Plans, Insurance Carriers, and/or Financial Classes. For these exceptions, each patient can have only ICD-9 diagnosis and procedure codes, only ICD-10 diagnosis and procedure codes, or both ICD-9 and ICD-10 diagnosis and procedure codes. Both code sets are supported simultaneously.

Once the parameter is set, the system checks the admission date for the inpatient, outpatient, emergency, or series patient type whenever a diagnosis or procedure code is entered in Admissions, Dispositioning, and whenever a charge or credit is entered in Order Management. The system also checks the USA ICD-10 Effective Date on the number assignment page of the admission/registration when the permanent account number is assigned, and when the admission date is revised. The USA ICD-10 Effective Date is also used for ABN processing.

If the date is set, but the patient's admission date is before the ICD-10 Effective Date, the system continues to prompt and process ICD-9 codes only for the patient. This means that series patient types that were registered before this ICD-10 Effective Date continue to only collect ICD-9 diagnosis and procedure codes. These series patient types may need to be discharged and re-admitted once ICD-10 codes are required. If the patient doesn't have an admission date yet, then the system looks to see if an expected admission date is set; if not, then the current date is used for comparison to the date in the hospital facility options.

If the date is set, and the patient's admission date is on or after the ICD-10 Effective Date, then the system automatically prompts for ICD-10 Diagnosis and Procedure codes when entering diagnosis and/or procedure codes in Admissions, Dispositioning, and charging/crediting in Order Management. The system also looks to this USA ICD-10 Effective Date for ABN processing. If particular Insurance Plans, Insurance Carriers, or Financial Classes still require ICD-9 diagnosis and procedure codes after this USA ICD-10 Effective Date, then those Exceptions should be listed in the Insurance Plan table, the Insurance Carrier table, and/or the Financial Class table (see below documentation).

NOTE: If an account qualifies for ICD-10 processing because of the USA ICD-10 Effective Date field on the Hospital Facility Options, but the admission date for the patient is then backdated to a date prior to the USA ICD-10 Effective Date, the system flags the account as needing ICD-9 codes in addition to the ICD-10 codes. However, it is up to the hospital to enter the missing ICD-9 codes that are only currently coded in ICD-10 for the account. If the patient has insurance, the Pre Bill Edit claims, or the actual claims loaded via billing, may fail for missing Admitting Diagnosis Code or Principal Diagnosis Code if the insurance is set to require ICD-9 and only ICD-10 diagnoses are coded. The claims system cannot guarantee that all secondary diagnoses are coded in either version (ICD-9 versus ICD-10) since there is not a one to one correspondence. For example, six ICD-10 diagnosis codes may be equivalent to fourteen ICD-9 diagnosis codes, so there is no way for the system to guarantee that all equivalents were coded. The same holds true for Procedure codes – there is not a one to one correspondence between ICD-9 and ICD-10. NOTE: See ICD-10 with DRGs below.

Prior to setting your USA ICD-10 Eff Date, a McKesson Representative must set the tilde I10OK("facility")=1. For example, to set Facility B, the following would be set: I10OK("B")=1. A McKesson Representative is assigned to perform an ICD-10 readiness review, and once completed will set the tilde in the ID to indicate that the facility may set the USA ICD-10 Eff Date. This tilde must be set in all testing environments as well as the Live ID for each facility before the system administrators are able to access the USA ICD-10 Eff Date field on the Admissions and General Parameters screen. If you are ready to set your USA ICD-10 Eff Date field, please contact your McKesson upgrade or support representative. In most cases, this tilde is set in your test ID after your upgrade to the STAR 15.0 release, and during phase 2 of the upgrade implementation where you are testing STAR 15.0 with ICD-10. Setting this date in the live ID should only be done once the facility is sure of the date on which they

are ready to begin collecting ICD-10 diagnosis and procedure information on their live patients.

The STAR Patient Processing functionality for ICD-10 has been designed to allow the users to implement ICD-10 coding while at the same time still collecting ICD-9 codes whenever necessary. Once the USA ICD-10 Eff Date has passed, the user is considered live on ICD-10; however by setting available override dates in the Insurance Plan, Insurance Carrier and Financial Class tables, the users are able to collect both ICD-10 and ICD-9 codes when it is deemed necessary based on the patients' insurance data.

ICD-10 with DRG's

Effective with Release 16.0, STAR updated the Coding and Reimbursement Interface with 3M ICD-10 coding updates effective October 1, 2011. This allows customers the ability to code using both ICD-9 and ICD-10 Codes in 3M and to return both code sets information to STAR. It also allows Medicare ICD-10 DRGs to be calculated by 3M and returned to STAR.

A new parameter titled Discharge ICD-10 Effective Date was added to Abstracting Facility Parameters. The date in this parameter must be ON or AFTER current Facility USA ICD Effective Date. The Facility USA ICD Effective date parameter is edited so changes to this date may not be AFTER the Discharge ICD-10 Effective Date. This parameter is used in conjunction with the new ICD-9 Indicator added to the payor screen in Financial Classes, Insurance Carrier, and Insurance Plan tables to determine the 3M input flag for 3M Coding and Reimbursement Interface.

In addition to the new parameter to activate ICD-10 with DRG's, there is an ICD9 exception indicator on the Insurance Plans, Insurance Carriers, and/or Financial Classes. For each Payor Code/Eff Date listed that requires ICD-9 codes once the Discharge ICD-10 Effective date has been met, an I-9 DRG=Y (exception) indicator needs to be entered in the table. Values are Yes, No, and Blank.

- 9 Ind is used prior to the ICD-10 Discharge Effective Date. The current date is used if the account is not discharged.
- 10 Ind is used on or after ICD-10 Discharge Effective date if no ICD-9 Exception Flag=Y is present.
- 9/10 Ind is used if any ICD-9 Exception Flag=Y is present in FC, Ins Carrier, or Ins Plan tables or I-9 codes are required by State Discharge parameters AND Primary Insurance requires I-9.
- 10/9 Ind is used if any ICD-9 Exception Flag=Y is present in FC, Ins Carrier, or Ins Plan tables, or I-9 codes are required by State Discharge parameters AND Primary Insurance requires I-10.

NOTE: STAR table Indicators must be set prior to obtaining both I-10 and I-9 codes back from 3M. If they are not set and discharge date is after Discharge ICD10 Effective date, an indicator of I-10 will be sent to 3M and no I-9 codes will be returned in the interface.

State Patient Type exceptions must be set on the State Exception Types table for states requiring I-9 once the ICD-Eff Date is met. With this enhancement fields 5 and 6 were added to work with the new ICD-10 Discharge Effective Date to determine state requirements for Medical Records. These fields must be completed for State Exceptions to display in STAR Abstracting/GUI Abstracting.

For implementation steps, see "Implementation Steps – Build Process for ICD-10 with DRG's" beginning on page 2-54.

Implementation Steps – Build Process for ICD-10

1. FACILITY ICD-10 EFFECTIVE DATE

   Determine the date on which your facility wishes to implement ICD-10 in your test ID. Set the date on the Admissions and General parameters screen. The date should be entered in MM/DD/YYYY format. There is no default to this field, and there are no edits on the date entered except to ensure it is a valid date. If left blank, the STAR Patient Processing, STAR Medical Records, and STAR Order Management systems continue to prompt and process ICD-9 codes only. If this is a Canadian system, this field is bypassed.

   Once the date has been set, the following message prints on the console log every day **AT 12 NOON** within 30 days of the implementation date:

   Facility A:

   "*****WARNING – The ICD-10 Implementation Date is set to MM/DD/YYYY. Be sure this is still the anticipated implementation date. Please adjust the date immediately if this is not the desired implementation date.*****

2. ICD-10 EXCEPTIONS

   Enter any necessary exceptions into the Insurance Plan, Insurance Carrier or Financial Class tables. As outlined in Chapter 1, new ICD-10 Effective Date fields have been added to these three tables.

ICD-10 Effective Date Exceptions

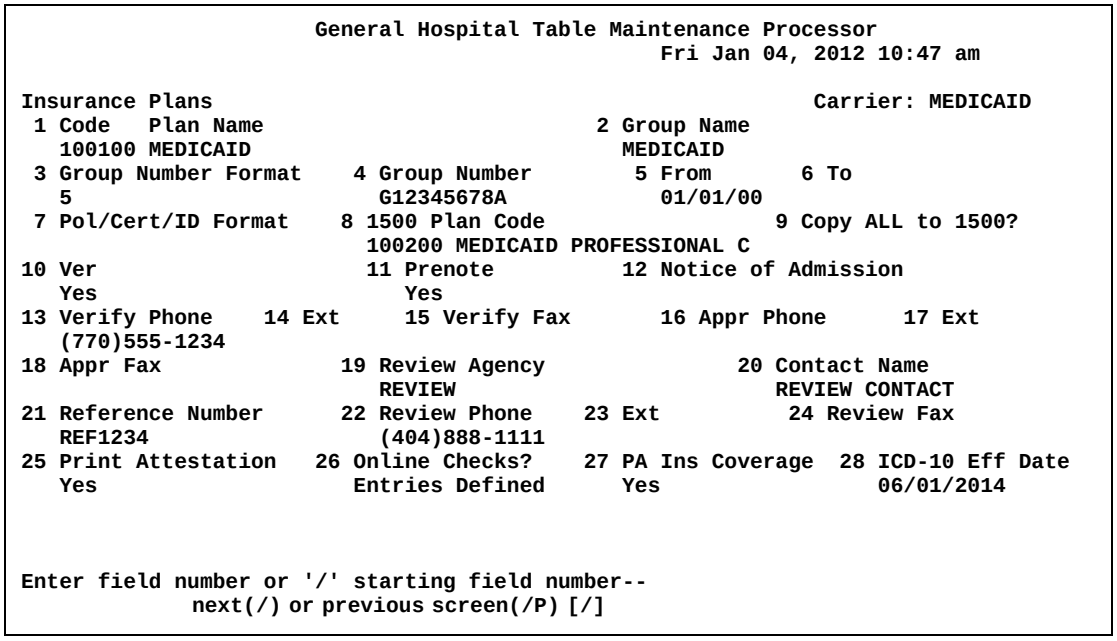
Any Insurance Plan, Insurance Carrier or Financial Class EXCEPTIONS to the USA ICD-10 Eff Date field found on the Hospital Facility Options table in STAR Patient Processing should be listed here.

The system prompts only for ICD-10 Diagnosis and Procedure codes for any account with an admission date on or after the date listed in the USA ICD-10 Eff Date field found on the Hospital Facility Options, *unless* exceptions are listed in the Insurance Plans table, the Insurance Carriers table, and/or the Financial Class table. If there is an Exception for the patient, users have the option to ALSO code ICD-9 Diagnosis and Procedure codes on the account (in addition to the ICD-10 Diagnosis and Procedure codes).

INSURANCE PLAN EXCEPTIONS

The second screen of the Insurance Plans table has been updated. This date is used by Patient Processing and Clinical modules and must be coordinated with the date associated with the payor code on the last page of the Insurance Plan table. ICD-10 Insurance Plan exceptions for M/R Abstracting and GUI Abstracting are set on those pages. Both screens can be found below:

Second Page of Insurance Plan:



```
                    General Hospital Table Maintenance Processor
                                              Fri Jan 04, 2012 10:47 am

Insurance Plans                                                Carrier: MEDICAID
 1 Code   Plan Name                          2 Group Name
   100100 MEDICAID                            MEDICAID
 3 Group Number Format    4 Group Number        5 From       6 To
   5                        G12345678A          01/01/00
 7 Pol/Cert/ID Format    8 1500 Plan Code                  9 Copy ALL to 1500?
                           100200 MEDICAID PROFESSIONAL C
10 Ver                     11 Prenote          12 Notice of Admission
   Yes                        Yes
13 Verify Phone    14 Ext     15 Verify Fax       16 Appr Phone      17 Ext
   (770)555-1234
18 Appr Fax              19 Review Agency               20 Contact Name
                            REVIEW                         REVIEW CONTACT
21 Reference Number      22 Review Phone    23 Ext          24 Review Fax
   REF1234                  (404)888-1111
25 Print Attestation   26 Online Checks?    27 PA Ins Coverage  28 ICD-10 Eff Date
   Yes                    Entries Defined     Yes                 06/01/2014



Enter field number or '/' starting field number--
             next(/) or previous screen(/P) [/]
```

Last Page of Insurance Plan

```
           General Hospital Table Maintenance Processor
                                                 Tue Feb 28, 2012 08:28 pm
Insurance Plans                                              Carrier: MEDICARE
Payor Codes by Facility
( 1)Facility     : Model Hospital A
( 2)Payor        : *

( 3)Disch Eff Dt : 01/01/2008
( 4)Payor        : 00
( 5)ICD-9        : No
( 6)MSDRG        : No
( 7)HAC          :

( 8)Disch Eff Dt : 10/01/2010
( 9)Payor        : 00
(10)ICD-9        : Yes
(11)MSDRG        : Yes
(12)HAC          :

(13)Edit By      : Moon, Bob
(14)Edit Date    : 02/06/12 03:39pm

Enter field number or '/' starting field number--
                   next screen(/) or previous screen(/P) [/]
```

INSURANCE CARRIER EXCEPTIONS

The second screen of the Insurance Carrier table has been updated. A new field of ICD Eff Date has been added as displayed below. This date is used by Patient Processing and Clinical modules and must be coordinated with the date associated with the payor code on the last page of the Insurance Carrier table.

```
                    General Hospital Table Maintenance Processor
                                                 Fri Jan 04, 2008 01:49 pm
Insurance Carriers
 1 Code  2 Insurance                          3 Primary?      4 MSP Screen?
   100     MEDICAID                             Yes             No
 5 Insurance Type                      6 Edit By               7 Edit Date
   D MEDICAID                            Bronson,Malcolm         12/06/07 06:58a
 8 Financial Classes            9 Default Financial Class   10 Print Attestation


11 Mail to Person                        12 Mail to Company
   CONTACT PERSON FOR MEDICAID
13 Address Line 1                        14 Address Line 2
   ADDRESS FOR MEDICAID                     ADDRESS LINE 2 MEDICAID
15 City                  16 State        17 ZIP Code    18 Country
   CITY FOR MEDICAID        TN             99383
19 Phone          20 Ext.   21 Group Number Format    22 Pol/Cert/ID Format


23 Online Checks?           24 Admission Office Text  25 ICD-10 Eff Date
   None                        Yes                       01/01/2015



Enter field number or '/' starting field number--
                       next(/) or previous screen(/P) [/]
```

Last Page of Insurance Plans

```
            General Hospital Table Maintenance Processor
                                                 Tue Feb 28, 2012 08:28 pm
Insurance Plans                                              Carrier: MEDICARE
Payor Codes by Facility
( 1)Facility     : Model Hospital A
( 2)Payor        : *

( 3)Disch Eff Dt : 01/01/2009
( 4)Payor        : 00
( 5)ICD-9        : Yes
( 6)MSDRG        : Yes
( 7)HAC          : Yes

( 8)Disch Eff Dt : 10/01/2011
( 9)Payor        : 00
(10)ICD-9        : No
(11)MSDRG        : Yes
(12)HAC          : Yes

(13)Edit By      : Moon, Bob
(14)Edit Date    : 02/06/12 03:39pm

Enter field number or '/' starting field number--
                   next screen(/) or previous screen(/P) [/]
```

FINANCIAL CLASS EXCEPTIONS

A new field of ICD Eff Date has been added as displayed below. This date is used by Patient Processing and Clinical modules and must be coordinated with the date associated with the payor code on the last page of the Financial Class table.

ICD-10 Financial Class exceptions for M/R Abstracting and GUI Abstracting are set on that last page. Both screens can be found below.

First Screen of Financial Class Table:

```
              STAR Development System (ID 191) Table Maintenance Processor
                                                    Sat Mar 24, 2012 09:20 pm
Financial Classes
 1 Code      2 Description
   K           MEDICAID
 3 Restricted to                          4 Allow Insurance Time Out?
                                            Yes
 5 Payment Transaction                    6 Edit Date
   P0001-PERSONAL PAYMENT-CHECK             04/23/09 14:34
 7 Refund Transaction                     8 Edit By
   R0001-GUARANTOR REFUND                   Weiss,Sharon
 9 PA Collector Group                    10 PA Collector Group Exceptions
   1-COLLECTION GROUP                       Yes
11 AR Collector Group                    12 AR Collector Group Exceptions
   98-Mike's group/3                        No
13 Collection Agency Group               14 Biller Group
   20-COLLECTION AGENCY GROUP               BILLING GROUP
15 HCPCS Payor

16 Statistical Group              17 Sales Commission     18 ICD-10 Eff Date
   MEDICAID                          Yes

Enter field number or '/' starting field number--
```

Last Page of Financial Classes Table Screen:

```
          General Hospital Table Maintenance Processor
                                                  Fri Mar 23, 2012 11:58 am
Financial Classes
 1 Code      2 Description
   M           MEDICARE FINANCIAL CLASS......

DRG and APC/ASC Payor Codes  Edited By: Moon, Bob 02/06/12 02:38pm
DRG PAYOR             PAYOR    ICD-9  MSDRG HAC APC/ASC  DTE FROM    DTE TO
-------------------------------------------------------------------------------
M-MEDICARE            00        Yes    Yes  Yes   23    01/01/2012  01/02/2012
M-MEDICARE            00               Yes  Yes   23    01/03/2012









                Enter DRG Payor Code or "-" for table lookup
   F1Prev Page F2Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

ICD-10 EXCEPTION PROCESSING

The system has a hierarchy for ICD-10 Exceptions. The system **first** looks to the ICD-10 Eff Date (ICD-10 Effective Date) field at the Insurance Plan Table when adding, deleting, or resequencing insurance, when the permanent account number is assigned in the admission/registration flow, and with admission date changes.

When the ICD-10 Eff Date is set to a date for an insurance on the account, if the patient's admission date is on or after the USA ICD-10 Eff Date found on the Hospital Facility Options, but is before the ICD-10 Eff Date for the insurance on the account, the system prompts the user to enter ICD-9 diagnosis and procedure codes IN ADDITION to the ICD-10 diagnosis and procedure codes. When any of the insurance plans for the patient have an ICD-10 Eff Date that is after the patient's admission date, a flag is set at the account level. This flag is accessed by STAR Patient Processing, STAR Order Management, and STAR Medical Records, to also prompt for ICD-9 diagnosis and procedure codes. The system prompts for ICD-9 diagnosis and procedure codes as long as at least 1 insurance plan for the account is flagged for ICD-9 processing.

When the ICD-10 Eff Date is set to a date for an insurance on the account, if the patient's admission date is on or after the USA ICD-10 Eff Date found on the Hospital Facility Options, and is also on or after any Insurance Plan ICD-10 Eff Dates for the insurances on the account, the system prompts only for ICD-10 diagnosis and procedure codes (unless there are exceptions that qualify in the Insurance Carrier table or the Financial Class table). If the patient doesn't have an admission date yet, then the system looks to see if an expected admission date is set; if not, then the current date is used for comparison to the date in the insurance plan table.

If the patient's admission date is before the USA ICD-10 Eff Date field found on the Hospital Facility Options, regardless of any exceptions, the system continues to prompt only for ICD-9 diagnosis and procedure codes. If the patient doesn't have an admission date yet, then the system looks to see if an expected admission date is set; if not, then the current date is used for comparison to the date in the hospital facility options.

The system **next** looks to the ICD-10 Eff Date in the Insurance Carriers Table when adding, deleting, or resequencing insurance, when the permanent account number is assigned in the admission/registration flow, and with admission date changes.

When the ICD-10 Eff Date is set to a date for an insurance carrier on the account, if the patient's admission date is on or after the USA ICD-10 Eff Date found on the Hospital Facility Options, but is before the ICD-10 Eff Date for the insurance on the account, the system prompts the user to enter ICD-9 diagnosis and procedure codes IN ADDITION to the ICD-10 diagnosis and procedure codes. When any of the insurance carriers for the patient have an ICD-10 Eff Date that is after the patient's admission date, a flag is set at the account level. This flag is accessed by STAR Patient Processing, STAR Order Management to also prompt for ICD-9 diagnosis and procedure codes. The system prompts for ICD-9 diagnosis and procedure codes as long as at least one insurance carrier for the account is flagged for ICD-9 processing.

When the ICD-10 Eff Date is set to a date for an insurance carrier on the account, if the patient's admission date is on or after the USA ICD-10 Eff Date found on the Hospital Facility Options, and is also on or after any Insurance Carrier ICD-10 Eff Dates for the insurance carriers on the account, the system prompts only for ICD-10 diagnosis and procedure codes (unless there are exceptions that qualify in the Insurance Plan table or the Financial Class table).

If the patient's admission date is before the USA ICD-10 Eff Date field found on the Hospital Facility Options, regardless of any exceptions, the system continues to prompt only for ICD-9 diagnosis and procedure codes.

The system **lastly** looks to the ICD-10 Eff Date in the Financial Class table when admitting a patient, and when adding, deleting, or resequencing insurance, when the permanent account number is assigned in the admission/registration flow, and with admission date changes.

When the ICD-10 Eff Date is set to a date for the Financial Class on the account, if the patient's admission date is on or after the USA ICD-10 Eff Date found on the Hospital Facility Options, but is before the ICD-10 Eff Date for the Financial Class on the account, the system prompts the user to enter ICD-9 diagnosis and procedure codes IN ADDITION to the ICD-10 diagnosis and procedure codes. When the patient's financial class has an ICD-10 Eff Date that is after the patient's admission date, a flag is set at the account level. This flag is accessed by STAR Patient Processing, STAR and STAR Order Management to also prompt for ICD-9 diagnosis and procedure codes.

NOTE: See also, STAR Medical Record Implementation Steps.

When the ICD-10 Eff Date is set to a date for the Financial Class on the account, if the patient's admission date is on or after the USA ICD-10 Eff Date found on the Hospital Facility Options, and is also on or after the ICD-10 Eff Date for the financial class on the account, the system prompts only for ICD-10 diagnosis and procedure codes (unless there are exceptions that qualify in the Insurance Plan table or the Insurance Carriers table).

If the patient's admission date is before the USA ICD-10 Eff Date field found on the Hospital Facility Options, regardless of any exceptions, the system continues to prompt only for ICD-9 diagnosis and procedure codes.

NOTE: If an account qualifies for ICD-10 processing ONLY because of the USA ICD-10 Eff Date field on the Hospital Facility Options, and there are no exceptions for the account, if the insurances are then revised (additions, deletions), and a new or changed insurance plan, insurance carrier, or financial class requires ICD-9 processing, the system flags the account as needing ICD-9 codes in addition to the ICD-10 codes. However, it is up to the hospital to enter the missing ICD-9 codes that are only currently coded in ICD-10 for the account. If the patient has insurance, the Pre Bill Edit claims, or the actual claims loaded via billing, may fail for missing Admitting Diagnosis Code or Principal Diagnosis Code if the insurance is set to require ICD-9 and only ICD-10 diagnoses are coded. However, the claims system can not guarantee that all secondary diagnoses are coded in either version (ICD-9 versus ICD-10) since there is not a one to one correspondence. For example, six ICD-10 diagnosis codes may be equivalent to fourteen ICD-9 diagnosis codes, so there is no way for the system to guarantee that all equivalents were coded. The same holds true for Procedure codes – there is not a one to one correspondence between ICD-9 and ICD-10.

NOTE: The ICD10 Eff Date exceptions set at the insurance plan, insurance carrier, and/or financial class tables should not be set to a date prior to the USA ICD-10 Eff Date set at the hospital facility options. If the exception is set to an earlier date, it is ignored and the date as set in the USA ICD-10 Eff Date field in the Hospital Facility Options is the effective date. This field is not used in Canada, and if completed is ignored.

The table printout for the Insurance Plan table, the Insurance Carrier table, and the Financial Class table is updated to include the new ICD-10 Effective Date.

3. Build the new State ICD-10 Patient Type Exceptions table as required

A new menu item of State ICD-10 Patient Type Exceptions has been added to the Facility Options & Parameters menu. Access Tables, Facility Options & Parameters, State ICD-10 Patient Type Exceptions.

The Patient Type Exceptions have been added for State reporting. In some cases, outpatient accounts may only report on HCPCS codes, which aren't affected by ICD-10, but the state may still require ICD-9 diagnosis codes. In this case, a patient type exception can be entered for Diagnoses only.

NOTE: Patient Type exceptions are ONLY referenced by STAR Medical Records, and in the STAR Patient Processing Dispositioning function, and not by STAR Patient Processing Admissions processing, STAR Order Management, STAR Laboratory, STAR Radiology, or STAR Pharmacy. Therefore, if exceptions to diagnoses and/or procedures need to be entered in STAR Patient Processing, Order Management, LAB/RAD/Pharmacy, then exceptions should be entered at the Insurance Plan, Insurance Carrier, or Financial Class level.

```
             General Hospital State ICD-10 Patient Type Exceptions Processor
                                                  Thu Jun 11, 2009 11:45 am
Model Hospital A
Page:01              State ICD-10 Patient Type Exceptions
( 1) DIA-Dialysis Series Outpatient                  02/01/09   Diagnoses
( 2) LTC-Long Term Care                              02/01/09   Both
( 3) MHO-MENTAL HEALTH OUTPATIENT                    02/01/09   Diagnoses




Enter choice--
```

Once a patient type is selected from the display, the following screen is displayed for updating:

```
             General Hospital State ICD-10 Patient Type Exceptions Processor
                                                  Wed Aug 06, 2008 12:04 pm
Model Hospital A
( 1)Patient Type          : I/P
( 2)Description           : Regular Inpatient Admission


( 3)ICD-10 Effective Date : 09/01/14
( 4)Diag/Proc/Both        : Both


( 5)Edit By               : Doright,Dudley
( 6)Edit Date             : 08/05/08 1925







Enter field number or '/' starting field number--
                  next screen(/) or previous screen(/P) [/]
```

This Effective Date should be after the Discharge ICD-10 Effective Date field in Abstracting Facility Options. If the date in the State ICD-10 Patient Type Exceptions table is before theDischarge ICD-10 Effective Date in the Abstracting Facility Options, the patient type date is ignored and the system continues to collect ICD-9 diagnosis and procedure codes for the patient types up to discharges on or after the Discharge ICD-10 Effective Date.

Once the State Patient Type ICD-10 Effective Date is entered, the system takes the user to the DIAG/PROC/Both field for Diagnosis/Procedure. The following prompt is displayed:

Is the Patient Type Exception for ICD Diagnoses, ICD Procedures, or Both? (D/P/B)—

Once the DIAG/PROC/Both field is entered, the system displays the following prompt:

Copy exception values to other Patient Types? (Y/N)--

A table lookup is allowed on the Patient Type Table. Highlight all patient types for the exception.

These State ICD-10 Patient Type Exceptions can be used when ICD-10 diagnosis and procedure codes are being collected for the accounts for use in Medical Records and Claims, but the State Discharge Data still requires ICD-9 information. These State ICD-10 Patient Type Exceptions are looked at *after* the Hospital Facility Options, Insurance Plan Exceptions, Insurance Carrier Exceptions, and Financial Class Exceptions.

If the Discharge Date for the account is on or after the Discharge ICD-10 Effective Date on the Abstracting Facility Options parameter, then ICD-10 Diagnosis and Procedure Codes are collected for the account. If the account has any Exceptions per last page of Insurance Plan, Insurance Carrier, or the Financial Class tables, ICD-9 Diagnosis and Procedure Codes are also collected in addition to the ICD-10 Diagnosis and Procedure Codes. In this situation, where there are exceptions and both code sets are collected, the State ICD-10 Patient Type Exceptions are ignored.

If the Discharge Date for the account is on or after the Discharge ICD-10 Effective Date on the Abstracting Facility Options parameter, then ICD-10 Diagnosis and Procedure Codes are collected for the account. If the account has NO Exceptions per last page of Insurance Plan, Insurance Carrier, or the Financial Class tables, the system then looks to the State ICD-10 Patient Type Exceptions. The account can have a S Discharge Date of the account is ON or after the Discharge ICD-10 Effective Date in the Abstracting Facility Optionsparameter, but is before the ICD-10 Effective Date for the patient type.

When the ICD-10 Effective Date is set to a date for the Patient Type on the account, if the patient's discharge date is on or after the Discharge ICD-10 Eff Date found on the Abstracting Facility Options parameter, but is before the ICD-10 Effective Date for the Patient Type on the account, the STAR Medical Records system prompts the user to enter ICD-9 diagnosis and procedure codes IN ADDITION to the ICD-10 diagnosis and

procedure codes. When the patient's patient type has a ICD-10 Effective Date that is after the patient's discharge date, a State ICD flag is set at the account level. This flag is accessed by STAR Patient Processing and STAR Medical Records to also prompt for ICD-9 diagnosis and procedure codes during the disposition and abstract process.

When the ICD-10 Effective Date is set to a date for the Patient Type on the account, if the patient's discharge date is on or after the Discharge ICD-10 Eff Date found on the Abstacting Facility Options parameter, and is also on or after the ICD-10 Effective Date for the patient type on the account, the system prompts only for ICD-10 diagnosis and procedure codes (unless there are exceptions that qualify on the last page of the Insurance Plan table, the Insurance Carriers table, or the Financial Class Table).

When the Account ICD flag is set to 10 for ICD-10, if there is an exception for Diagnoses only for the patient type, then the STAR system prompts for BOTH ICD-10 and ICD-9 Diagnosis Codes. The system prompts only for ICD-10 Procedure Codes. If there is an exception for Procedures only for the patient type, then the STAR system prompts for both ICD-10 and ICD-9 Procedure Codes. The system prompts only for ICD-10 Diagnosis Codes. If there is an exception for Both Diagnoses and Procedures for the patient type, then the STAR system prompts for both ICD-10 and ICD-9 Diagnosis and Procedure Codes.

The system has a hierarchy for ICD-10 Exceptions.

For Patient Processing and Clinicals The system first looks to the ICD-10 Eff Date (ICD-10 Effective Date) field at the Insurance Plan Table when adding, deleting, or resequencing insurance, when the permanent account number is assigned in the admission/registration flow, and with admission date changes. The system then looks to the ICD-10 Eff Date in the Insurance Carriers Table when adding, deleting, or resequencing insurance, when the permanent account number is assigned in the admission/registration flow, and with admission date changes. The system then looks to the ICD-10 Eff Date in the Financial Class table when admitting a patient, and when adding, deleting, or resequencing insurance, when the permanent account number is assigned in the admission/registration flow, and with admission date changes. The system then sets the Account Level ICD flag based on the USA ICD-10 Effective Date field and the above exceptions.

See Medical Record Implementation Steps: For M/R Abstracting and GUI Abstracting. The system follows the same logic as above, but uses the Discharges ICD-10 Effective Date in Abstracting Facility Options and the accounts discharge date.

Finally, the system looks to the State ICD-10 Patient Type Exceptions. at discharge, with discharge date changes, and with changes to patient type. The system then sets the State Level ICD flag based on the Discharge ICD-10 Effective Date field and the State ICD-10 Patient Type Exceptions.

NOTE: If an account qualifies for ICD-10 processing ONLY because of the USA ICD-10 Eff Date field on the Hospital Facility Options, and there are no exceptions for the Insurance Plans, Insurance Carriers, Financial Class or Patient Type, if the patient type

is then revised, and this updates the State ICD flag for the account so that it now requires ICD-9 processing, the system flags the account as needing ICD-9 codes in addition to the ICD-10 codes. However, it is up to the hospital to enter the missing ICD-9 codes that are only currently coded in ICD-10 for the account.

Exceptions to ICD-10 processing can be entered for particular states by Patient Types. When the patient has one of the specified Patient Type exceptions, the STAR Patient Processing system looks at this during the disposition process and prompts the user to enter additional ICD-9 diagnosis and procedure codes if needed. Medical Records displays to the users an additional indicator for any state-level exceptions when entering diagnosis and procedure codes.

For Patient Processing and Clinical Modules: The following table outlines what version of the diagnoses and procedures the system prompts for, ICD-9, ICD-10, or both, based on the patient's admission date, and the settings in the Hospital Facility Options, Insurance Plans table, Insurance Carriers table, and the Financial Class table.

Table	**Insurance Plan Table**	**Insurance Plan Table**	**Insurance Carrier Table**	**Insurance Carrier Table**	**Financial Class Table**	**Financial Class Table**
Patient Admission Date	**On or After Effective Date**	**Before Effective Date**	**On or After Effective Date**	**Before Effective Date**	**On or After Effective Date**	**Before Effective Date**
Hosp Facility Options: Patient Admission Date On or After Effective Date	ICD-10 Only	ICD-10 and ICD-9	ICD-10 Only	ICD-10 and ICD-9	ICD-10 Only	ICD-10 and ICD-9
Hospital Facility Options: Patient Admission Date Before Effective Date	ICD-9 Only (the Hospital Facility Options setting overrides the exceptions)	ICD-9 Only	ICD-9 Only	ICD-9 Only	ICD-9 Only	ICD-9 Only

For Medical Records M/R Abstracting and GUI Abstracting Modules: The following table outlines what version of the diagnoses and procedures the system prompts for, ICD-9, ICD-10, or both, based on the patient's discharge date, and the settings in the Abstracting Facility Options parameter, Insurance Plans table, Insurance Carriers table, and the Financial Class table.

ACCOUNT LEVEL Discharge ICD	**STATE EXCEPTION ICD**	**STAR ABSTRACT PROCESSING**
Ind = 9 Discharged before ICD-10 Effective Date on Abstracting Facility Options.		STAR Abstracting collects only ICD-9 Diagnosis and Procedure codes for the account.
Ind = 10 Discharged on or after ICD-10 Discharge Effective Date with NO Insurance Plan, Insurance Carrier, or Financial Class Exceptions.		STAR Abstracting collects only ICD-10 Diagnosis and Procedure codes for the account.
Ind = 10 Discharged on or after ICD-10 Discharge Effective Date and NO Insurance Plan, Insurance Carrier, or Financial Class Exception.	Patient Type has an Exception for Diagnoses Only. Account State ICD field displays "**DIAG-B**".	STAR Abstracting collects only ICD-10 Procedure codes for the account, and both ICD-9 and ICD-10 Diagnosis codes for the account.
Ind = 10 Discharged on or after ICD-10 Discharge Effective Date and NO Insurance Plan, Insurance Carrier, or Financial Class Exception).	Patient Type has an Exception for Procedures Only. Account State ICD field displays "PROC-B".	STAR Abstracting collects only ICD-10 Diagnosis codes for the account, and both ICD-9 and ICD-10 Procedure codes for the account.
Ind = 10 Discharged on or after ICD-10 Discharge Effective Date and NO Insurance Plan, Insurance Carrier, or Financial Class Exception.	Patient Type has Exceptions for Both Diagnoses and Procedures. Account State ICD field displays "B".	STAR Abstracting collects Both ICD-10 and ICD-9 Diagnosis Codes and Procedure Codes for the account.

ACCOUNT LEVEL Discharge ICD	STATE EXCEPTION ICD	STAR ABSTRACT PROCESSING
Ind = 10/9 Discharged on or after ICD-10 Discharge Effective Date and the Insurance Plan, Insurance Carrier, or Financial Class for a Secondary Insurance HAS an Exception. This indicates that the primary is 10 and the paired is "9".	Anytime the Account ICD flag is set to 10/9 or 9/10, the State parameters are ignored since both code sets are collected for the account.	STAR Abstracting collects Both ICD-10 and ICD-9 Diagnosis Codes and Procedure Codes for the account.
Ind = 9/10 Discharged on or after ICD-10 Discharge Effective Date and the Insurance Plan, Insurance Carrier, or Financial Class for Primary Insurance HAS an Exception. This indicates that the primary is 9 and the paired is "10".		

A printout of the new State ICD-10 Patient Type Exceptions table has been created.

4. DIAGNOSIS AND PROCEDURE POINTER TABLES

Both the diagnosis and procedure pointer tables contain the ICD-9 and ICD-10 codes as described in Chapter 1 of this manual. This has already been completed for Canada, and will be adapted to the US environment. Also, the names of these two tables are being changed from ICD-9-CM to just ICD.

When the user accesses the pointer tables, they now appear as follows:

- ICD Diagnosis Pointer Table
- ICD Procedure Pointer Table

When the user accesses either of these tables, a new field is added to allow entry of the appropriate ICD-10 code. A careful review of these tables to determine if ICD-10 codes will be added to the current entries or if new entries need to be made to the tables should be a key piece of the implementation process. The ICD Pointer tables are a key tool in the conversion from ICD-9 to ICD-10, and it is critical that the users review these tables carefully in order to make this transition as easy on their users as

possible. Both of these tables now require the entry of either an ICD-9 or an ICD-10 code. New print outs of the tables are available, are divided by entries with ICD-9 only codes, entries with ICD-10 only codes, entries with both codes and entries with no codes.

Once a code has been entered, whenever the user utilizes the pointer table when entering a diagnosis or procedure code on a patient, the appropriate code from the table is placed into the diagnosis or procedure field. If the patient's account only requires an ICD-9-CM code, then only this code is pulled into the patient's record. If the patient's account only requires an ICD-10-CM code, then only this code is pulled into the patient's record. If both codes are required, then both codes from the pointer table are pulled into the patient's record. The Canadian environment continues to keep its own version of the tables.

5. DSM POINTER TABLE

There is the ability to indicate an ICD-9-CM and ICD-10-CM diagnosis code in the DSM Pointer table, as described in chapter 1 of this manual. This change has already been done for Canada, but needs to be incorporated into the US system. A new field has been added to the DSM Pointer table to allow for the entry of the associated ICD-10-CM code. The DSM Pointer table allows the users to build a crosswalk between the DSM codes and the ICD-9-CM and now the ICD-10-CM codes for diagnosis coding on Psychiatric or Mental Health patients.

When the user accesses the table, a new field is added to allow entry of the appropriate ICD-10 code. A careful review of the table to determine if ICD-10 codes will be added to the current entries or if new entries need to be made to the table should be a key piece of the implementation process. The table print out has been enhanced to also print the ICD-10 code if it exists.

6. CHARACTER-BASED SCREEN FLOW

The screens in the character-based base admission flow and the base admission revision flow have been changed so that the insurance screen precedes the medical screen. This change is being done, and is suggested to our users because it is necessary to know the patients insurance in order to determine which coding method(s) is necessary on the patient's account.

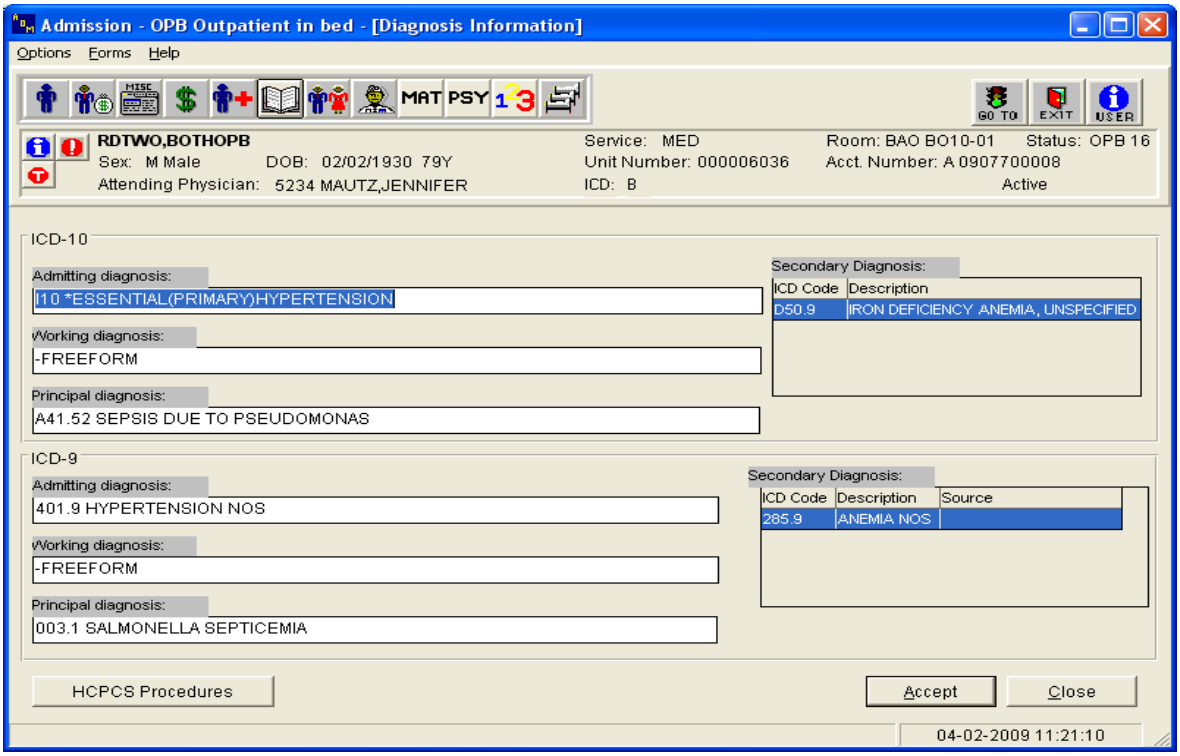
7. GUI FORMS

The forms in the GUI base admission flow and the GUI base admission revision flow have been changed so that they are in the following order:

- Medical form
- Insurance form
- Diagnosis form

The new diagnosis information form follows the insurance form. This change is being done and is suggested to our users because it is necessary to know the patient's insurance in order to determine which coding method(s) is necessary on the patient's account. After the ICD-10 software has been loaded, the new diagnosis form is used instead of having the diagnosis data on the medical form. GUI users need to review their current forms and determine how these changes affect their form flows.

New Icon: The Open Book icon displayed below is associated with the new Diagnosis Information form displayed below:



Implementation Steps – ICD-10 Functions

1. Character-Based Admissions

Diagnosis coding:

Each account has a flag to indicate if the user is to collect ICD-10-CM, ICD-9-CM or both types of diagnosis codes. This flag is displayed in all locations where the diagnosis is collected to assist the user in collecting the correct type of data. Additionally, prompts and reminder prompts are used to assist the user in the data entry process. **In some cases, the insurance information is not known at the time of entering the diagnosis information, and therefore the system is not able to determine if the account requires the ICD-10 or ICD-9 coding method. In this case, if the ICD-10 implementation date in the Hospital Facility Options is the current day or a date in the past, then the ICD-10 coding method is used.** The display of the diagnosis and procedure tables for ICD-10 is changed to only show 1 code

per line so that up to 60 characters of the description is displayed. There is no change to the display for ICD-9 codes.

In all locations where diagnosis information is collected in character-based patient processing, the ability to enter or view the ICD-10-CM codes as well as the ICD-9-CM is available. In addition, if freeform or pointer table entries are used these are also displayed. The medical page of the admission process (cahmed) is changed as follows with all other screens using a similar format:

```
                General Hospital Processor
              Medical               Page 10 of 16Thu Apr 02, 2009 08:24 am
  No.         Name             Sex    BD    Room    Physician     SVC ICD Status
0907800006    RDTWO,BOTHBACKDAT M  02/03/30 BO12-01 COLEMAN,MICHA MED B  BAO15
 1 Locations   2 Admission Type       3 Admission Source    4 Arrival Mode
                 1 EMERGENCY           1 PHYS REF/NORMAL
 5 Arrival Date  6 Time     7 Allergies                                8 Smoker

 9 Service
   MED MEDICALXX
10 Admitting Diagnosis
-> G51.0-BELL'S PALSY
11 Additional Diagnoses       12 Acc?                 13 Tumor Reg #
   Entries Defined
14 Surgery Scheduled                                  15 Date

16 Opt Out  17 Opt Out Date   18 Publicity           19 Case Category

20 ELOS-Dis Date  21 Plan Dis Time  22 Organ  23 ADs 24 ADs Ver Dt  25 Comment
   3-03/22/09


Enter ICD-10-CM diagnosis code--                                   |
         `U-`ser Dx, `-` for list, -free form `I` ICD-9 Entry [adm Dx]
```

Field 10 – Admitting Diagnosis

This field has been adjusted to also allow entry of an ICD-10-CM code (up to 8 characters) and description up to 60 characters. The prompt now changes based on the patient's ICD flag.

- If the patient's account is flagged to collect **only ICD-10-CM codes**, then the prompt is:

  Enter ICD-10-CM diagnosis code-- |
  `U-`ser Dx, `-` for list, -free form

  The entered code is displayed in the admitting diagnosis field. If a Diagnosis Pointer Table entry is used, then the associated ICD-10-CM code is displayed. When displaying the Diagnosis Pointer Table, only entries which contain an ICD-10 code are displayed for selection.

- If the patient's account is flagged to collect **only ICD-9-CM codes**, then the prompt remains unchanged.

The entered code is displayed in the admitting diagnosis field. If a Diagnosis Pointer Table entry is used, then the associated ICD-9-CM code is displayed. When displaying the Diagnosis Pointer Table, only entries which contain an ICD-9 code are displayed for selection.

- If the patient's account is flagged to collect **both ICD-10-CM and ICD-9-CM codes**, then the prompt is as follows:

  Enter ICD-10-CM diagnosis code-- |
  `U-`ser Dx, `-` for list, -free form, or (I) for ICD-9-CM entry ---

  If the user enters a hyphen (-) at this point, then the ICD-10-CM table is displayed. If the user chooses from the Diagnosis Pointer Table, then the ICD-10-CM code is displayed, but the associated ICD-9-CM code is pulled to display on the ICD-9-CM screen described below. If the user makes a freeform entry, then that freeform wording is copied to both the ICD-10-CM admitting diagnosis and the ICD-9-CM admitting diagnosis fields. If the user enters an "I" to indicate that they wish to enter an ICD-9-CM code, then the system branches to a sub-screen to allow entry of that code:

```
                    General Hospital Medical Page Processor
                                                 Tue Jan 29, 2008 12:08 pm
  No          Name             Sex    BD    Room    Physician     SVC   Status
0730200002    OPPY,EMERGENCY    F  02/02/22 BO18-01 HANCE,JENNIFE MED   OPB 93
 1 Admitting Diagnosis
   786.50-CHEST PAIN NOS



Enter ICD-9-CM diagnosis code--                                      |
                     `U-`ser Dx,`-` for list, -freeform, press "Enter" to exit---
```

The user should enter the appropriate ICD-9-CM code. If on the previous screen the user made a selection from the Diagnosis Pointer Table or made a freeform entry, then this field may already be completed. If the user wishes to return to the previous screen, then they should press the ENTER. When both coding methods are required, the ICD-10-CM coding always shows on the primary medical screen.

Field 11 – Additional Diagnoses

When this field is accessed, the system displays the following prompts:

- If the patient's account is flagged to collect **only ICD-10-CM codes**, then the prompt is displayed:

  Enter Additional ICD-10-CM Diagnosis? (Y/N) [N]-- |

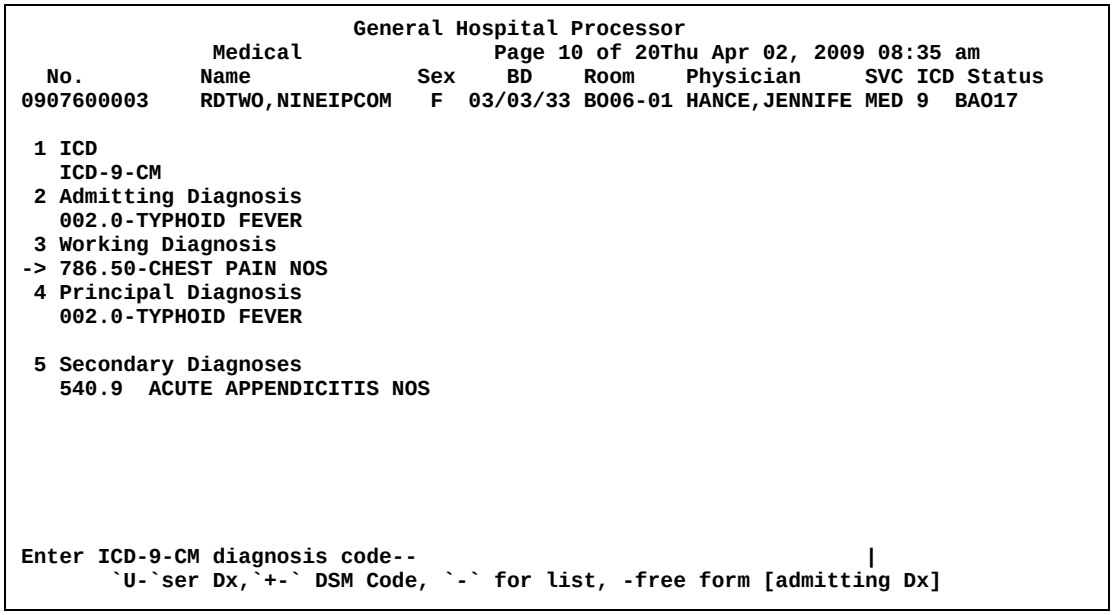
The ICD-10-CM Additional Diagnosis screen looks as follows:

```
                        General Hospital Processor
              Medical                Page 10 of 16Thu Apr 02, 2009 08:31 am
  No.         Name              Sex    BD    Room    Physician     SVC ICD Status
0907700007    RDTWO,NOEXOPCOM    M  06/06/66 BO01-02 ADAMS,JAY K   MED 10 BAO16

 1 ICD
   ICD-10-CM
 2 Admitting Diagnosis
   E21.0-PRIMARY HYPERPARATHYROIDISM
 3 Working Diagnosis
-> FREEFORM
 4 Principal Diagnosis
   G51.0-BELL'S PALSY

 5 Secondary Diagnoses









Enter ICD-10-CM diagnosis code--                                        |
       `U-`ser Dx,`+-` DSM Code, `-` for list, -free form [admitting Dx]
```

The ICD-10-CM Admitting Diagnosis from the previous screen is displayed, and the user may then enter the ICD-10-CM Working Diagnosis, Principal Diagnosis and Secondary Diagnoses. Up to 60 characters of the description are displayed for all of the diagnosis entries. Access to the DSM Pointer table has been changed from a “D” to a “+."

- If the patient’s account is flagged to collect **only ICD-9-CM codes**, then the prompt remains unchanged except for using a “+” to access the DSM Pointer table.

  Enter Additional ICD-9-CM Diagnosis? (Y/N) [N]-- |



The ICD-9-CM Admitting Diagnosis from the previous screen is displayed, and the user may then enter the ICD-9-CM Working Diagnosis, Principal Diagnosis and Secondary Diagnoses.

- If the patient's account is flagged to collect **both ICD-10-CM and ICD-9-CM codes**, then the prompt reads as follows:

  Enter Additional Diagnosis Codes ? (Y/N) [N]

  If the user enters **Y**, the diagnosis sub-screen is displayed with the following prompt:

```
                        General Hospital Processor
              Medical                Page 10 of 16Thu Apr 02, 2009 08:42 am
  No.         Name              Sex    BD    Room    Physician     SVC ICD Status
0907700008    RDTWO,BOTHOPB      M  02/02/30 BO10-01 HANCE,JENNIFE MED B  BAO16

 1 ICD
   ICD-10-CM
 2 Admitting Diagnosis
   I10-*ESSENTIAL(PRIMARY)HYPERTENSION
 3 Working Diagnosis
-> FREEFORM
 4 Principal Diagnosis
   A41.52-SEPSIS DUE TO PSEUDOMONAS

 5 ICD-10 Secondary Diagnoses <<<       6 ICD-9 Secondary Diagnoses
   D50.9     IRON DEFICIENCY ANEMIA, UNSPECIFIED




Enter ICD-10-CM diagnosis code--                                        |
   `U-`ser Dx,`+-` DSM Cd, `-` for list, -free form `I` ICD-9 Entry [adm Dx]
```

If the Diagnosis Pointer Table is used in any of these fields, then the associated ICD-9-CM code is pulled to the ICD-9-CM Additional Diagnosis screen. If any diagnoses are free formed, these are also copied to the ICD-9-CM Additional Diagnosis screen. If the user pulls from the DSM code table, then the associated ICD-10-CM code is pulled to this screen, and the associated ICD-9-CM is pulled to the ICD-9-CM sub-screen.

If the user enters field #5, the ICD-10 Secondary Diagnosis list is displayed, and the user can add ICD-10 Secondary Diagnosis. The secondary diagnosis display and entry area is shared by ICD-10 and ICD-9 data, therefore the system highlights, and places arrows next to either field #5 or field #6 to indicate which data is currently being displayed or updated. When the ICD-10 Secondary Diagnoses are being displayed or updated, the screen looks as follows:

```
                    General Hospital Processor
               Medical              Page 10 of 16Thu Apr 02, 2009 08:42 am
  No.          Name             Sex    BD    Room    Physician     SVC ICD Status
0907700008     RDTWO,BOTHOPB     M  02/02/30 BO10-01 HANCE,JENNIFE MED B  BAO16

 1 ICD
   ICD-10-CM
 2 Admitting Diagnosis
   I10-*ESSENTIAL(PRIMARY)HYPERTENSION
 3 Working Diagnosis
   FREEFORM
 4 Principal Diagnosis
   A41.52-SEPSIS DUE TO PSEUDOMONAS

 5 ICD-10 Secondary Diagnoses <<<       6 ICD-9 Secondary Diagnoses
   D50.9     IRON DEFICIENCY ANEMIA, UNSPECIFIED









    F1Prev Page F2Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

When field #6 is accessed and the ICD-9 Secondary Diagnoses are being displayed or updated, the screen looks as follows:

```
                       General Hospital Processor
               Medical              Page 10 of 16Thu Apr 02, 2009 08:42 am
  No.          Name             Sex    BD    Room    Physician     SVC ICD Status
0907700008     RDTWO,BOTHOPB     M  02/02/30 BO10-01 HANCE,JENNIFE MED B  BAO16

 1 ICD
   ICD-10-CM
 2 Admitting Diagnosis
   I10-*ESSENTIAL(PRIMARY)HYPERTENSION
 3 Working Diagnosis
   FREEFORM
 4 Principal Diagnosis
   A41.52-SEPSIS DUE TO PSEUDOMONAS

 5 ICD-10 Secondary Diagnoses           6 ICD-9 Secondary Diagnoses <<<
   285.9  ANEMIA NOS









    F1Prev Page F2Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

If the Diagnosis Pointer Table is used in any of these fields, then the associated ICD-10-CM code is pulled to the ICD-10-CM Additional Diagnosis screen. If any diagnoses are free formed, these are also copied to the ICD-10-CM Additional Diagnosis screen. If the user pulls from the DSM code table, then the associated ICD-9-CM code is pulled to this screen, and the associated ICD-10-CM is pulled to the ICD-10-CM sub-screen.

Users need to be educated to look at the "<<<" to determine if the system is displaying the ICD-9 or ICD-10 diagnosis codes.

The prompts on the screens are used to assist the users in entering the appropriate diagnosis codes. When accepting the medical screen (cahmed) during admission, if the patient's account requires only ICD-10-CM or ICD-9-CM coding, then only the current warnings about the required fields are displayed. If the patient's account requires both ICD-10-CM and ICD-9-CM coding, then the following additional warnings are displayed:

- If the user has only entered data in the ICD-10-CM Admitting Diagnosis field:

  ICD-9-CM diagnosis codes were not entered, do you wish to accept? (Y/N) [Y]---

- If the user has only entered data in the ICD-9-CM fields:

  ICD-10-CM diagnosis codes were not entered.

  In this case the user must enter something in the Admitting Diagnosis field.

  An entry in the admitting diagnosis field is still required, but STAR requires only that the ICD-10-CM field be completed, not both.

Field 14 - Surgery Scheduled

This field now allows for the entry of the ICD-10-PCS code and an ICD-9-CM code, an entry from the user pointer table or a freeform entry. Once the ICD-10 implementation date has been set in the Hospital Facility Options, this field is changed to collect the ICD-10-PCS procedure code instead of the ICD-9 code. The field is adjusted to display the 7 character code and up to 50 characters of the description. The prompt now changes based on the patient's ICD flag.

- If the patient's account is flagged to collect **only ICD-10-PCS codes**, then the prompt is as follows:

  Enter ICD-10 procedure code,`U-`user procedure code,`-`for list,`-`freeform—

  The entered code is displayed in the surgery scheduled field. If a Procedure Pointer Table entry is used, then the associated ICD-10-PCS code is displayed. When displaying the Procedure Pointer Table, only entries which contain an ICD-10 code are displayed for selection.

- If the patient's account is flagged to collect **only ICD-9-CM codes**, then the prompt remains unchanged.

  The entered code is displayed in the surgery scheduled field. If a Procedure Pointer Table entry is used, then the associated ICD-9-CM code is displayed.

When displaying the Procedure Pointer Table, only entries which contain an ICD-9 code are displayed for selection.

- * If the patient's account is flagged to collect **both ICD-10-PCS and ICD-9-CM codes**, then the following prompt is displayed:

Enter ICD-10 procedure code,`U-`user procedure code,`-`for list,`-`freeform (I) for ICD-9-CM Entry-- |

If the user enters a hyphen (-) at this point, the ICD-10-PCS table is displayed. If the user chooses from the Procedure Pointer Table, then the ICD-10-PCS code is displayed, but the associated ICD-9-CM code is pulled to display on the ICD-9-CM screen described below. If the user makes a freeform entry, then that freeform wording is copied to both the ICD-10-PCS surgery scheduled and the ICD-9-CM surgery scheduled fields. If the user enters an "I" to indicate that they want to enter an ICD-9-CM code, then STAR branches to a sub-screen to allow entry of that code:

```
                General Hospital Medical Page Processor
                                                Mon Apr 06, 2009 10:56 am
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
0907600011    RDTWO,BOTHPAT      F  02/02/22 BO08-01 GALLA,BERNIE CAR B  I/P 20
 1 Surgery Scheduled
-> 88.38-OTHER C.A.T. SCAN


Enter ICD-9 procedure code,`U-`user procedure code,`-`for list,`-`freeform--
```

The user should enter the appropriate ICD-9-CM code. If on the previous screen the user made a selection from the Procedure Pointer Table or made a freeform entry, then this field may already be completed. If the user wishes to return to the previous screen, then they should press ENTER. When both coding methods are required, the ICD-10-PCS coding always shows on the primary medical screen.

OTHER CHARACTER-BASED FUNCTIONS

- cahsdx, cahsdx2, cahsdx3, cahsdxi – Diagnosis sub-screens

  All of these are diagnosis sub-screens called from a main screen. All of these screens contain various combinations of the diagnosis fields. All four of these sub-screens require an ICD-10-CM version and an ICD-9-CM version. Just as has already been outlined, if the patient's account only requires ICD-10-CM coding, then only the ICD-10-CM version of the sub-screen is used. If the patient's account only requires ICD-9-CM coding, then only the ICD-9-CM version of the sub-screen is used. If the patient's account requires both coding methods, then the prompt on each main screen allows the user to indicate which method they wish to enter:

Enter ICD-10-CM diagnosis code-- |
`U-`ser Dx,`+-` DSM Cd, `-` for list `I` ICD-9 Entry or `=` for Prnc Adm DX

(The exact wording on the prompt may vary slightly depending on the function and which diagnosis fields are present, but each screen works similarly to the diagnosis sub-screen already described for admissions.)

If the user enters I, the ICD-9-CM sub-screen is displayed. The sub-screens are the same as the additional diagnosis sub-screens outlined for cahmed except that each one contains different combinations of the diagnosis fields. One of these sub-screens is an inquiry-only screen, but the main screen still allows the user to indicate on the prompt if the user wishes to view the ICD-10-CM or the ICD-9-CM sub-screen. The functions that call one of these sub-screens are:

Admitting, Revise Admission, Revise MPI, MPI Inquiry, Dispositioning and Bed Reservations

- **The MPI Inquiry menu** – **chmmr11** now appears as follows:

```
                          General Hospital Processor
                                                Thu Apr 02, 2009 09:47 am
  No.         Name              Sex    BD    Room    Physician     SVC ICD Status
0907800006    RDTWO,BOTHBACKDAT M  02/03/30 BO12-01 COLEMAN,MICHA MED B  BAO15
            Option No.  Option
            ---------------------------------------
                1       Medical Information
                2       Physician Information
                3       Accident Information
                4       Medical Comment
                5       ICD-10-CM Admitting/Principal Diagnosis
                6       ICD-9-CM Admitting/Principal Diagnosis
                7       ICD-10-CM Secondary Diagnosis
                8       ICD-9-CM Secondary Diagnosis



Enter option number--
```

The indicator is ignored in this case, as the patient may have data due to the indicator having changed during the visit, and it may be valuable to the users to see all of the entered data even if it no longer applies to the patient's account.

- **chhepi** – **visit level MPI medical information**

There is no room on this screen to display the expanded diagnosis codes and descriptions; therefore the Medical Detail menu for both MPI Inquiry and Revise MPI are expanded to add new menu choices for ICD-9-CM and ICD-10-CM diagnosis displays:

```
                          General Hospital Processor
                                                  Thu Apr 02, 2009 09:47 am
  No.         Name              Sex    BD    Room    Physician     SVC ICD Status
0907800006    RDTWO,BOTHBACKDAT M  02/03/30 BO12-01 COLEMAN,MICHA MED B  BAO15
            Option No.  Option
            ---------------------------------------
                1       Medical Information
                2       Physician Information
                3       Accident Information
                4       Medical Comment
                5       ICD-10-CM Admitting/Principal Diagnosis
                6       ICD-9-CM Admitting/Principal Diagnosis
                7       ICD-10-CM Secondary Diagnosis
                8       ICD-9-CM Secondary Diagnosis



Enter option number--
```

The Admitting Diagnosis and Additional Diagnosis fields are removed from the chhepi screen.

The indicator should be ignored in this case, as the patient may have data due to the indicator having changed during the visit, and it may be valuable to the users to see all of the entered data even if it no longer applies to the patient's account.

- **crhopd1** – **dispositioning**

  The disposition screen is similar to the admission medical screen (cahmed) and functions similarly, but with a few exceptions:

```
              General Hospital Discharge Patient Processor
                                                  Wed Jan 30, 2008 11:30 am
  No          Name              Sex    BD    Room    Physician     SVC   Status
0730200002    OPPY,EMERGENCY    F  02/02/22 BO18-01 HANCE,JENNIFE MED   OPB 94
 1 Admitting Diagnosis
-> SICK
 2 Comment                                    3 Departments

 4 Principal Diagnosis
   786.50-CHEST PAIN NOS
 5 DSM Code                                6 Secondary Diagnoses      7 Reason for Visit
                                              Entries Defined
 8 Procedure 1                              9 Procedure 2

10 Procedure 3                             11 HCPCS Procedure Code 1

12 HCPCS Procedure Code 2                  13 HCPCS Procedure Code 3




Enter ICD-9-CM diagnosis code--                                      |
                     `U-`ser Dx, `-` for list, -free form
```

The admitting diagnosis field works exactly like this same field in admission. The comment field is moved to the next line next to the Departments field, and the admitting diagnosis field is expanded to show the first 60 characters of the description. **If the patient's account requires ICD-10-CM diagnosis codes only, then an additional check of the state patient type exceptions is made to determine if the ICD-9-CM codes must also be collected. If state exceptions do exist for diagnoses for the patient's assigned patient type, then the prompt for both coding methods should be displayed.**

The principal diagnosis field works just like the admitting diagnosis field. If the account requires both ICD-10-CM and ICD-9-CM coding, the ICD-10-CM code is shown on this screen with the user having the option on the prompt to branch to the ICD-9-CM sub-screen for review or entry. This field is adjusted to show the 8 character code and up to 60 characters of the description. If the patient's account requires ICD-10-CM diagnosis codes only, then an additional check of the state patient type exceptions is made to determine if the ICD-9-CM codes must also be collected. If state exceptions do exist for diagnoses for the patient's assigned patient type, then the prompt for both coding methods should be displayed.

Enter ICD-10-CM diagnosis code-- |
`U-`ser Dx,`+-` DSM Cd, `-` for list `I` ICD-9 Entry or `=` for Prnc Adm DX

The DSM Code field pulls in either the ICD-10-CM or the ICD-9-CM code as appropriate. If both codes are required, then both codes are copied from the DSM pointer table. This field is being moved down 1 line to allow enough space to display the description in the Principal Diagnosis field.

The Secondary Diagnosis field has the same prompt and functionality as in admission (cahmed). The prompt gives the user the option to branch to either the ICD-10-CM or the ICD-9-CM sub-screen**.** If the patient's account requires ICD-10-CM diagnosis codes only, then an additional check of the state patient type exceptions is made to determine if the ICD-9-CM codes must also be collected. If state exceptions do exist for diagnoses for the patients assigned patient type, then the prompt for both coding methods should be displayed.

Enter Additional Diagnosis ? (Y/N) [N] –

If the user answers "Y" on the above prompt, then the Additional Diagnosis sub-screen identical to the one in admissions is displayed.

The Reason for Visit field has the following prompt:

Enter Reason for Visit diagnoses? (Y/N) [N]—

The system branches to the appropriate sub-screen for entry of the Reason for Visit diagnosis codes. If an "N" for no is entered, this field is bypassed. Each of

the Reason for Visit fields is expanded to show the 8 character code and up to 60 characters of the description.

The Procedure 1,2 and 3 fields work just as the diagnosis fields are working. If the patient's account requires ICD-10-PCS procedure codes only, then an additional check of the state patient type exceptions is made to determine if the ICD-9-CM codes must also be collected. If state exceptions do exist for procedures for the patient's assigned patient type, then the prompt for both coding methods should be displayed.

- If the account requires only ICD-10-PCS coding, then the following prompt is displayed:

  Enter ICD-10-PCS procedure code,`U-`user procedure code,`-`for list—

- If the account requires only ICD-9-CM coding, then the following prompt is displayed (no change):

  Enter ICD-9 procedure code,`U-`user procedure code,`-`for list—

- If both coding methods are required on the account, then the fields work just like the admitting diagnosis field branching to sub-screens for the entry of the ICD-9-CM codes:

  Enter ICD-10 procedure code,`U-`user procedure code,`-`for list (I) for ICD-9-CM Entry-- |

```
                General Hospital Medical Page Processor
                                                  Tue Jan 29, 2008 12:08 pm
  No          Name              Sex    BD    Room    Physician     SVC   Status
0730200002    OPPY,EMERGENCY     F  02/02/22 BO18-01 HANCE,JENNIFE MED   OPB 93
 1 Procedure 1
   89.65-ARTERIAL BLD GAS MEASURE


 Enter ICD-9 procedure code,`U-`user procedure code,`-`for list--
```

These fields are adjusted to show the 7 character code and are expanded by 6 characters to show up to 31 characters of the description.

There is no change in the HCPCS Procedure fields as the HCPCS coding isn't changing with the implementation of ICD-10.

The prompts on the screen are used to assist the users in entering the appropriate diagnosis and procedure codes. When accepting the dispositioning screen (crhopd1), if the patient's account requires only ICD-10 or ICD-9 coding, then only the current warnings about the required fields are displayed. If the patient's account requires both ICD-10 and ICD-9 coding, then the following additional warnings are displayed:

- If the user has only entered data in the ICD-10 fields:

  ICD-9 diagnosis or procedure codes were not entered, do you wish to accept? (Y/N) [Y]---

- If the user has only entered data in the ICD-9 fields:

  ICD-10 diagnosis or procedure codes were not entered.

  An entry in the admitting diagnosis field is still required, but the system requires only that the ICD-10-CM field be completed, not both.

- cnhrev1 – nursing revise patient

```
                  General Hospital Medical Page Processor
                                                  Thu Jun 25, 2009 11:39 am
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
0907900002    SAKOWSKI,BROCCOLI F  03/05/93 2109-02 ADAMS,JAY K  MED 10 LTC 98
 1 Working Diagnosis
   D50.9-Iron deficiency anemia, unspecified
 2 Allergies

 3 Precaution 1                          4 Precaution 2

 5 Precaution 3                    6 Condition            7 Level of Care
                                                            1 LEVEL 1
 8 Height               9 Weight              10 IBW      11 BSA

12 Isolation           13 Oxygen Therapy      14 IV Therapy          15 Organ

16 Surgery Scheduled                                                17 Date
   HZ2ZZZZ-Detoxification Services for Substance Abu                   06/27/09
18 ADs   19 ADs Ver Dt   20 ELOS-Dis Date 21 Plan Dis Time  22 Case Team(s)
->                          5-03/25/09



Enter Advanced directives code or `-` to list--         |
```

Field 1 – Working Diagnosis

- If the patient's account only requires ICD-10-CM coding, then the following prompt is displayed in the field:

  Enter ICD-10-CM diagnosis code-- |
  `U-`ser Dx,`+-` DSM Code, `-` for list, -free form [admitting Dx]

- If the patient's account only requires ICD-9-CM coding, then the following prompt is displayed in the field:

  Enter ICD-9-CM diagnosis code-- |
  `U-`ser Dx,`+-` DSM Code, `-` for list, -free form [admitting Dx]

- If the patient's account requires both coding methods, then the following prompt is displayed in the field:

  Enter ICD-10-CM diagnosis code-- |
  `U-`ser Dx,`+-` DSM Cd, `-` for list, -free form `I` ICD-9 Entry [adm Dx]

Entry of any alternative coding methods on this screen uses the ICD-10-CM method (DSM, Adm Dx, Sec Dx, Pri Dx). Once the user enters an "I" for ICD-9-CM coding, the system branches to a sub-screen for entry with the following prompt:

Enter ICD-9-CM diagnosis code-- |
`U-`ser Dx,`+-` DSM Code, `-` for list, -free form [admitting Dx]

Entry of any alternative coding methods on this screen uses the ICD-9-CM method (DSM, Adm Dx, Sec Dx, Pri Dx).

The working diagnosis field on this screen won't be changed in length, but displays up to 8 characters of the code with up to 24 characters of the diagnosis description.

Field 16 – Surgery Scheduled
This field now allows for the entry of the ICD-10-PCS code and an ICD-9-CM code, an entry from the user pointer table or a freeform entry. Once the ICD-10 implementation date has been set in the Hospital Facility Options, this field is changed to collect the ICD-10-PCS procedure code instead of the ICD-9 code. The field is adjusted to display the 7 character code and up to 50 characters of the description. The Date and Organ fields are moved to make enough room for the expanded code and description field on the revise patient nursing page. The prompt now changes based on the patient's ICD flag.

- If the patient's account is flagged to collect **only ICD-10-PCS codes**, then the following prompt is displayed:

  Enter ICD-10 procedure code,`U-`user procedure code,`-`for list,`-`freeform—

  The entered code is displayed in the surgery scheduled field. If a Procedure Pointer Table entry is used, then the associated ICD-10-PCS code is displayed. When displaying the Procedure Pointer Table, only entries which contain an ICD-10 code should be displayed for selection.

- If the patient's account is flagged to collect **only ICD-9-CM codes**, then the prompt remains unchanged.

  The entered code is displayed in the surgery scheduled field. If a Procedure Pointer Table entry is used, then the associated ICD-9-CM code is displayed. When displaying the Procedure Pointer Table, only entries which contain an ICD-9 code should be displayed for selection.

- If the patient's account is flagged to collect **both ICD-10-PCS and ICD-9-CM codes**, then the following prompt is displayed:

  Enter ICD-10 procedure code,`U-`user procedure code,`-`for list,`-`freeform (I) for ICD-9-CM Entry-- |

  If the user enters a hyphen (-) at this point, then the ICD-10-PCS table is displayed. If the user chooses from the Procedure Pointer Table, then the ICD-10-PCS code is displayed, but the associated ICD-9-CM code is pulled to display on the ICD-9-CM screen described below. If the user makes a freeform entry, then that freeform wording is copied to both the ICD-10-PCS surgery scheduled and the ICD-9-CM surgery scheduled fields. If the user enters an "I" to indicate that they wish to enter an ICD-9-CM code, then the system branches to a sub-screen to allow entry of that code:

```
                General Hospital Medical Page Processor
                                                  Mon Apr 06, 2009 10:56 am
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
0907600011    RDTWO,BOTHPAT     F  02/02/22 BO08-01 GALLA,BERNIE CAR B  I/P 20
 1 Surgery Scheduled
-> 88.38-OTHER C.A.T. SCAN

Enter ICD-9 procedure code,`U-`user procedure code,`-`for list,`-`freeform--
                               |
```

  The user should enter the appropriate ICD-9-CM code. If on the previous screen the user made a selection from the Procedure Pointer Table or made a freeform entry, then this field may already be completed. If the user wishes to return to the previous screen, then they should press ENTER. When both coding methods are required, the ICD-10-PCS coding is always shown on the primary medical screen.

- cahsvbd – display vacant bed

  This screen displays the admitting diagnosis and has no significant changes with the implementation of ICD-10. If the patient's account requires ICD-10-CM coding, then the ICD-10-CM Admitting Diagnosis data is displayed. The current display length is not adjusted. If the patient's account requires ICD-9-CM coding, then the ICD-9-CM Admitting Diagnosis data is displayed. If the patient's account requires both ICD-10-CM and ICD-9-CM coding, then the ICD-10-CM Admitting Diagnosis data is displayed.

- cbhmed – bed reservation medical information

  The admitting diagnosis and additional diagnosis fields exist on this screen, and are adjusted just as they are in cahmed. The only exception is that the display lengths are not changed. In most cases, the insurance information is not known at the time of making a bed reservation, and therefore the system is not able to determine if the account requires the ICD-10 or ICD-9 coding method. In this case, if the ICD-10 implementation date in the Hospital Facility Options is today or a date in the past, then the ICD-10 coding method is used.

GUI Admissions

Because the current medical form in GUI Admissions is so crowded, STAR Admissions decided to add a new form to the admission process for the diagnosis and HCPCS procedure data. The new form contains both ICD-10-CM and ICD-9-CM diagnosis data as well as the HCPCS procedure button.

- Screen Navigation

  The forms in the base admission flow and the base admission revision flow are changed so that the insurance form precedes the new diagnosis form. The new diagnosis information form follows the medical form. This change is being done and is suggested to our users because it is necessary to know the patient's insurance in order to determine which coding method(s) are necessary on the patient's account. After the ICD-10 software has been loaded, the new diagnosis form is used instead of having the diagnosis data on the medical form. GUI users must review their current forms and determine how these changes affect their form flows.

- **New Icon**: The Open Book icon is associated with the new Diagnosis Information Form.

  If the patient's account requires only ICD-10 entry, then the ICD-9 area is grayed out. If the patient's account requires only ICD-9 entry, then the ICD-10 area is grayed out. If the patient's account requires both ICD-9 and ICD-10 entry, then both areas are accessible. When accessing any of the diagnosis fields in the ICD-10 area, the user is allowed to access the ICD-10-CM diagnosis code table, the user diagnosis pointer table or make a freeform entry. When accessing any of the diagnosis fields in the ICD-9 area, the user is allowed to access the ICD-9-CM diagnosis code table, the diagnosis pointer table or make a freeform entry. If the user makes a choice from the pointer table, then both the ICD-9 and the ICD-10 code associated with the table entry are pulled into the patients record if both codes are required. If the user makes a freeform entry, the entry is copied into both the ICD-9 and the ICD-10 corresponding fields if both codes are required.

  The message lines on the screens are used to assist the users in entering the appropriate diagnosis codes. If the patient's account requires both ICD-10-CM and ICD-9-CM coding, then the following additional warnings are displayed:

  - If the user has only entered data in the ICD-10-CM fields:

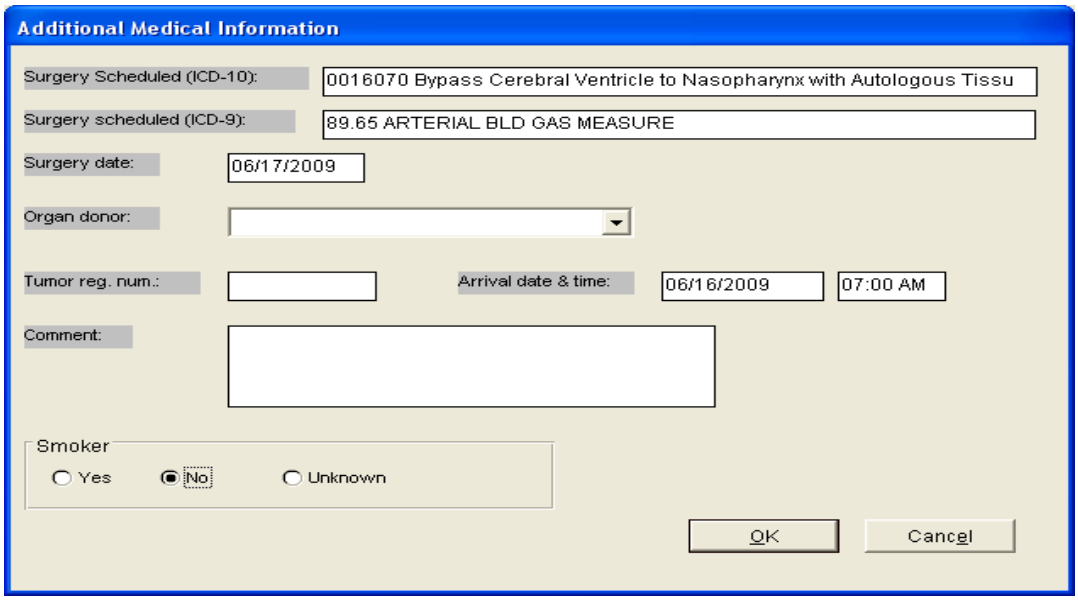
  ICD-9-CM diagnosis codes were not entered, do you wish to accept? (Y/N) [Y]---

  - If the user has only entered data in the ICD-9-CM fields:

  ICD-10-CM diagnosis codes were not entered.

- Additional Medical Info button

The additional medical information form is used to collect important medical information pertaining to the visit at the time of admission.



- Surgery Scheduled

  This field now allows for the entry of the ICD-10-PCS code and the ICD-9-CM code, an entry from the user pointer table or a freeform entry. Once the ICD-10 implementation date has been set in the Hospital Facility Options, this field is changed to collect the ICD-10-PCS procedure code in addition to the ICD-9 code. As was stated above, if the user chooses an entry from the procedure pointer table, and both an ICD-10-PCS and an ICD-9-CM code are in the table, then both codes are pulled into the patients record. If a freeform entry is made in either of the fields, the same data is pulled into both the ICD-10-PCS and ICD-9-CM fields if both coding formats are required. The new field displays the 7 character code and up to 60 characters of the description. The Surgery Date field has been moved down to make enough room for the new field on the admission additional medical information form. If the user only requires an ICD-10 code, then the ICD-9 field is grayed out and the user can't access the field for entry. If the user only requires an ICD-9 code, then the ICD-10 field is grayed out and the user can't access the field for entry.

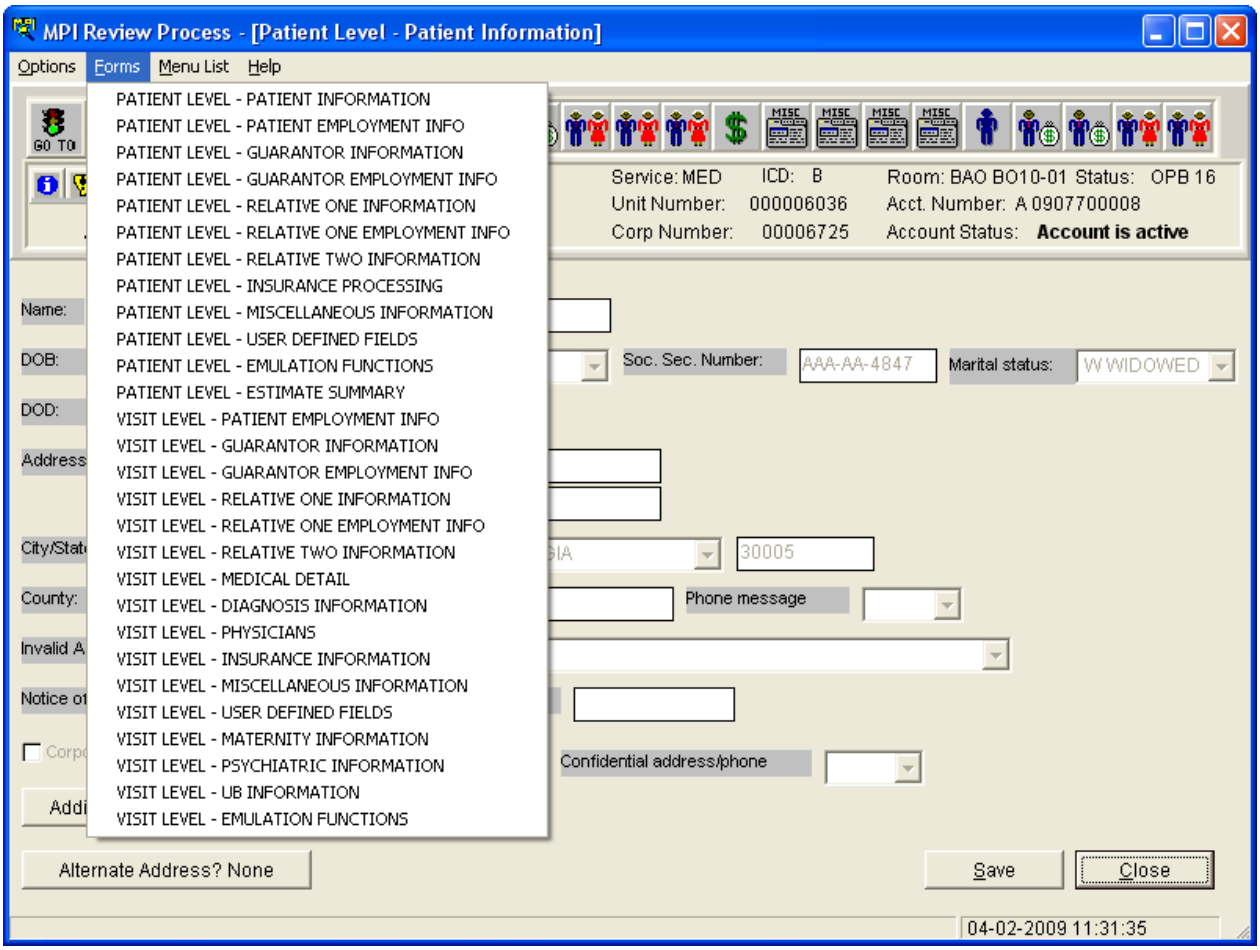
OTHER GUI FUNCTIONS

- MPI Review

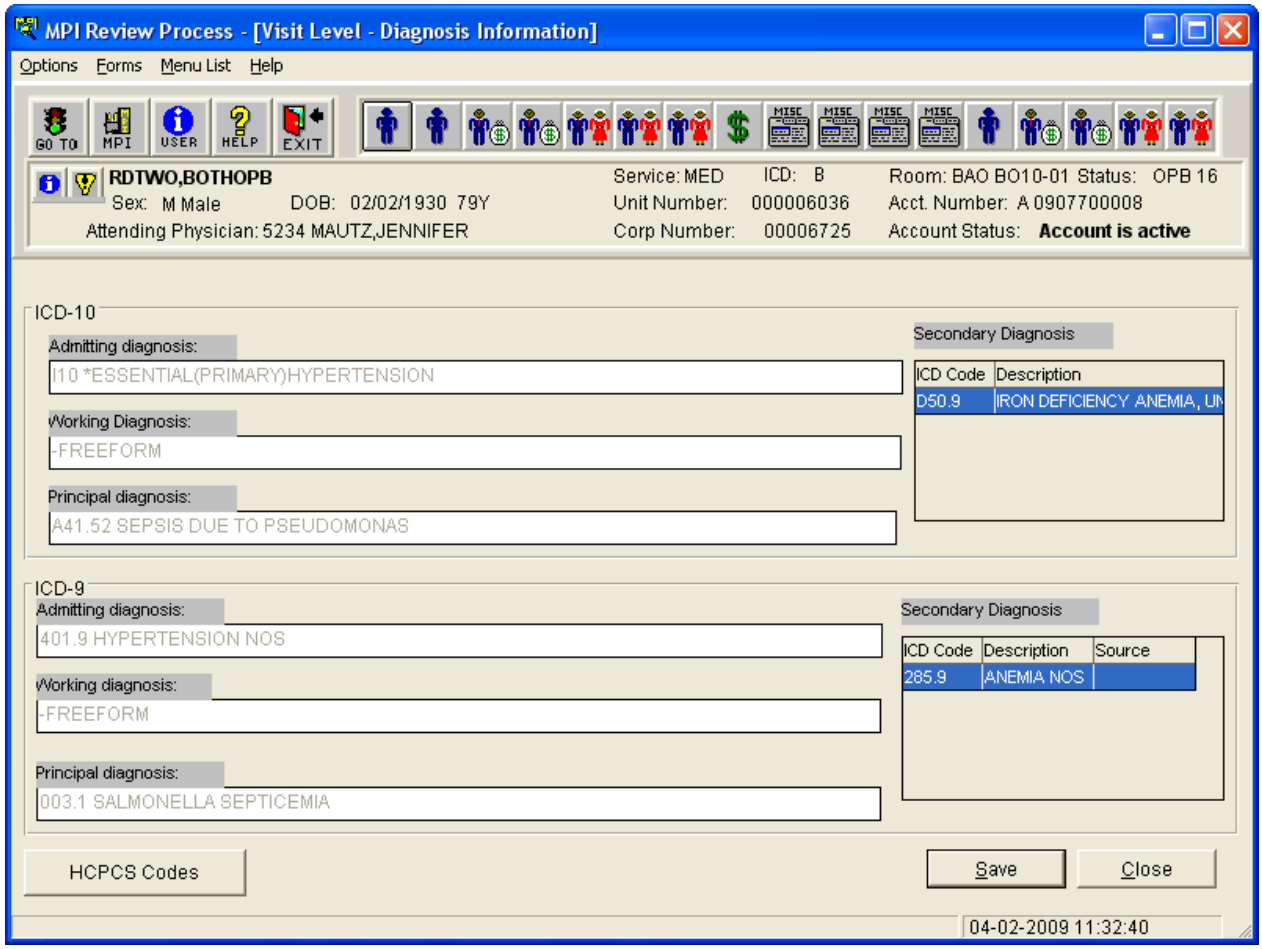
MPI Review allows the users to review in GUI the patients MPI record at both the patient and visit level. The new Diagnosis Information form is added to the visit level data available for viewing in MPI Review.

- Screen Navigation

  The new Diagnosis Information form follows the Medical Detail form.



When the Diagnosis Information form is selected, the following form is displayed:



If the patient's account is still active (as in the display above), this data becomes display only and no entry allowed except through the admission or admission revision function. If the patient's account is inactive and requires only ICD-10 entry, the ICD-9 area is grayed out. If the patient's account requires only ICD-9 entry, the ICD-10 area is grayed out. If the patient's account requires both ICD-9 and ICD-10 entry, then both areas are accessible. When accessing any of the diagnosis fields in the ICD-10 area, the user is allowed to access the ICD-10-CM diagnosis code table, the user diagnosis pointer table or make a freeform entry. When accessing any of the diagnosis fields in the ICD-9 area, the user is allowed to access the ICD-9-CM diagnosis code table, the diagnosis pointer table or make a freeform entry. If the user makes a choice from the pointer table, both the ICD-9 and the ICD-10 code associated with the table entry are pulled into the patient's record if both codes are required. If the user makes a freeform entry, the entry is copied into both the ICD-9 and the ICD-10 corresponding fields if both codes are required.

The message lines on the screens are used to assist users in entering the appropriate diagnosis codes. If the patient's account requires both ICD-10-CM and

ICD-9-CM coding, the following additional warnings are displayed **if the user is using the base form**:

- If the user has only entered data in the ICD-10-CM fields:

  ICD-9-CM diagnosis codes were not entered, do you wish to accept? (Y/N) [Y]---

- If the user has only entered data in the ICD-9-CM fields:

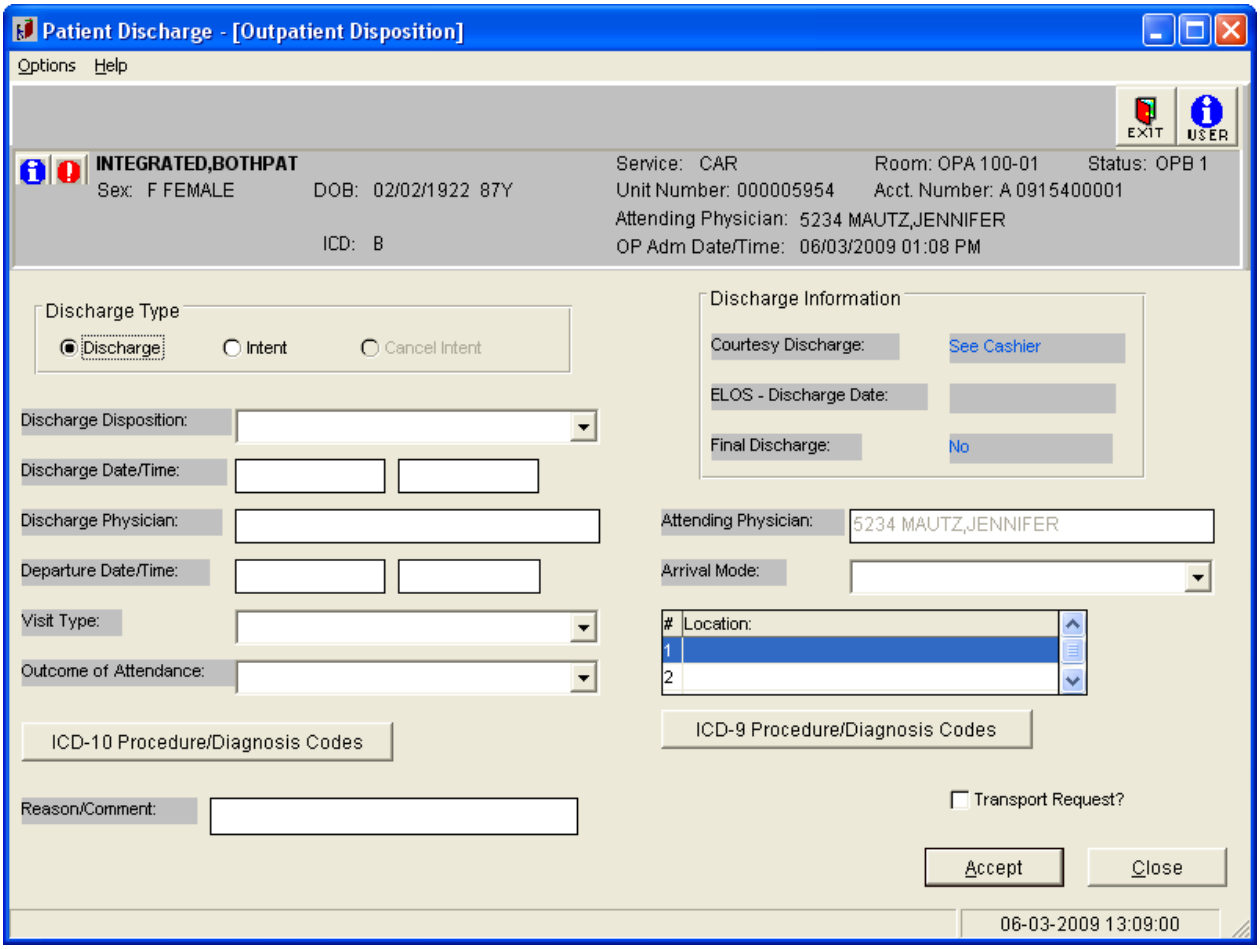
  ICD-10-CM diagnosis codes were not entered.

If the user chooses not to use the base form, then these messages are displayed to the user at the time they try to exit the admitting process.

- **GUI Dispositioning**

  The GUI Outpatient Dispositioning function is used to discharge outpatients and capture the diagnosis and procedure data necessary for the claim as many of these patients will not be abstracted.

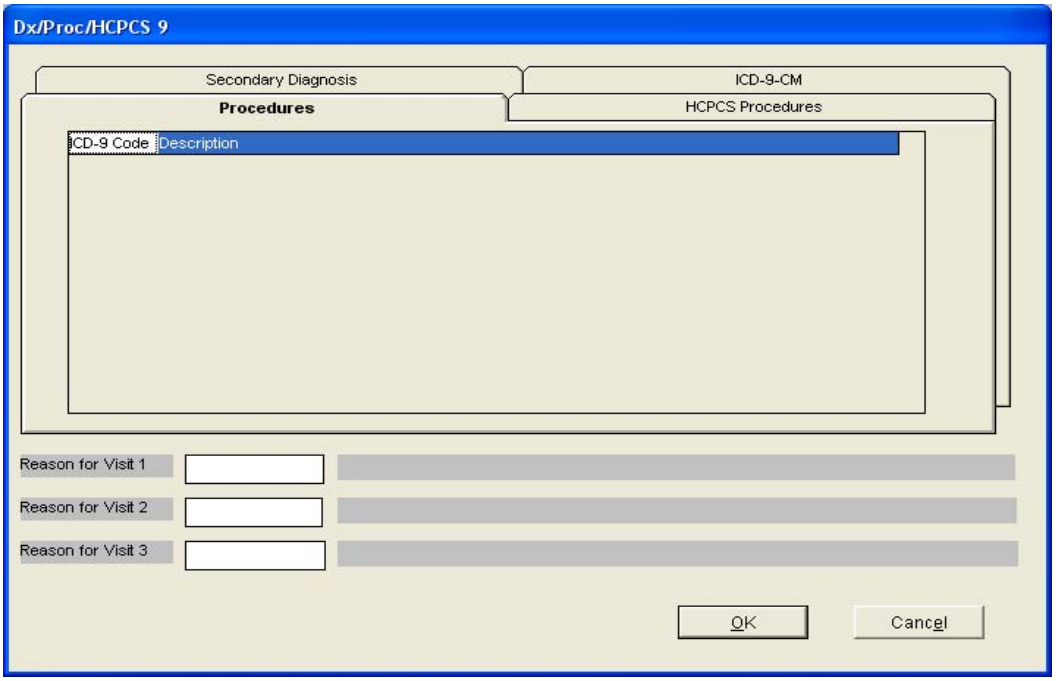
Screen Navigation



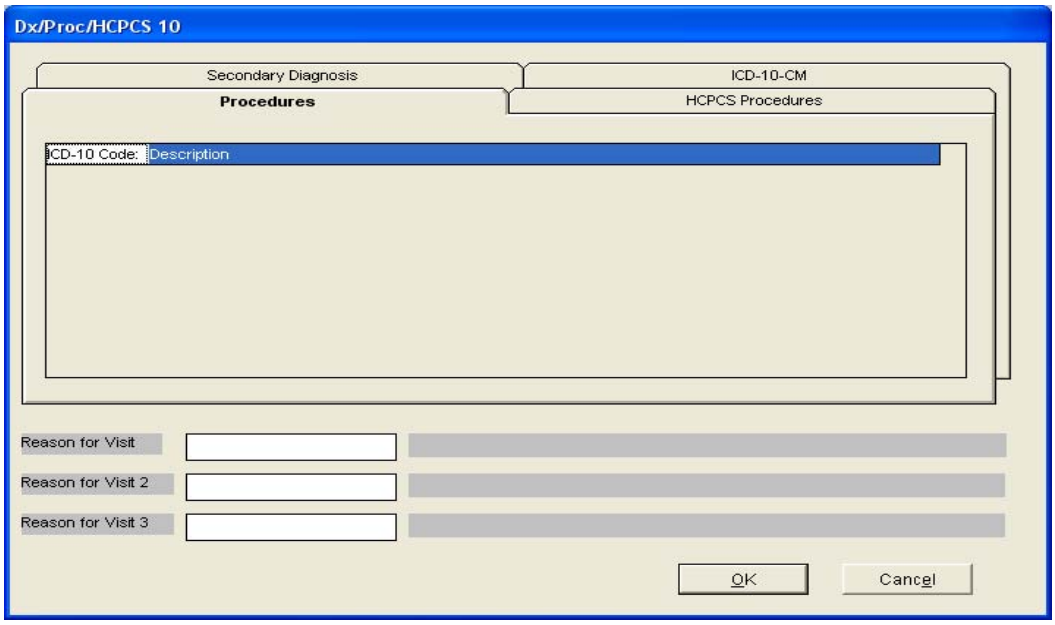
The ICD type indicator is added to the patient header information on this form directly below the birth date field, and will appear as *ICD: 9/10/B*. The Admitting Dx and the Principal Dx fields are being removed from the disposition form, and there will now be separate buttons for the ICD-10 and ICD-9 diagnosis and procedure information. If the patient's account only requires ICD-10 codes, then the ICD-9 button is grayed out and not accessible. If the patient's account requires only ICD-9 codes, then the ICD-10 button is grayed out and not accessible. If the patient's account requires both types of codes, then both buttons can be accessed. As was stated above, if the user chooses an entry from the diagnosis pointer table, and both an ICD-10-CM and an ICD-9-CM code are in the table, then both codes are pulled into the patients record. If a freeform entry is made in any of the fields, the same data is pulled into both the ICD-10-CM and ICD-9-CM fields if both coding formats are required. If the patient's account requires ICD-10 codes only, then an additional check of the state patient type exceptions is made to determine if the ICD-9-CM codes must also be collected. If state exceptions do exist for diagnosis

or procedures for the patients assigned patient type, then the ICD-9 button will not be grayed out.

Once the user clicks on the ICD-9 button, the following form is displayed:



The header on the form is changed to read *Dx/Proc/HCPCS 9*. Another folder is added titled *Dx/Proc/HCPCS 10* when the user clicks on the ICD-10 button.



The new folders contain the admitting and principal diagnosis. If the user clicks on the ICD-9 button, then the new folder is titled *ICD-9-CM* and contains the admitting and principal diagnosis. In all folders containing the ICD-10-CM diagnosis codes, the code field is 8 characters in length and the description is 60 characters in length. The appropriate Reason for Visit fields are added at the bottom of the form for both ICD-9 and ICD-10 coding.

Upon exiting the disposition function, if the patient's account requires both ICD-10 and ICD-9 coding, then the following additional warnings are displayed:

- If the user has only entered data in the ICD-10 fields:

ICD-9 diagnosis or procedure codes were not entered, do you wish to accept? (Y/N) [Y]---

- If the user has only entered data in the ICD-9 fields:

ICD-10 diagnosis or procedure codes were not entered.

An entry in the admitting diagnosis field is still required, but the system requires that only the ICD-10-CM field be completed, not both.

MIDNIGHT PROCESSING REPORTS/ONLINE & DEMAND REPORTS/FORMS

- Daily ICD Flag Change Report (CFICDCHx)

A new daily report is being added to indicate when a change has been made to the patients ICD indicator. The new report is titled Daily ICD Flag Change Report and is created during Midnight Processing. The report lists all patients whose ICD flag has been changed during the day as a result of an admission date change or an insurance data update.

The purpose of this new report is to list any patients whose ICD flag at the account or state level has changed during the day. The report does not list patients whose flag was not set, then is set on the day that the software is implemented. If a patient's ICD flag at either level changes as a result of an admission date revision, an update to their insurance data, or a patient type change then they are printed on this report.

The report assists both records management and patient accounting in the abstracting and billing process to insure that accurate diagnosis and procedure data is being collected for the patient.

It lists all patients regardless of the patient type.

Header Page - The report uses the common header used for all Midnight Processing Patient Processing reports.

Body Detail – The report contains the admission date, account #, unit #, name, old account level ICD flag, new account level ICD flag, old state level ICD flag, new state level ICD flag, discharge date (if applicable), insurances, financial class, patient type and charge indicator.

Sort Order – The report is sorted first by admission date and then by account number.

Footer page – No tallies are required for the report, therefore no footer page is required.

The following is a sample report:

```
Tue 06/13/11 02:03am                Model Hospital A
Page 1
Report CFCHGICDA                 Change ICD Flag Report
For 06/13/11


ADM DATE    DIS DATE  UNIT NO.    ACCOUNT NO. ACCOUNT NAME         PT  FC  INS PLANS
NEW ACCT. ICD    OLD ACCT. ICD  NEW STATE ICD OLD STATE ICD    CHARGES?

01/01/2011  01/05/2011   101606     05181-00001  TAYLOR,MATT          OP  M   100100
ICD:B            ICD:10      PROC-B             B        YES     200100

300200

01/01/2011  01/06/2011   203456     05181-00010  JONES,JOHN           IP  C   300500
ICD:10           ICD:B     DIAG-B             9   NO   400200

01/01/2011               222333     05181-02030  DAVIS,JANE           OPS C   400500
                                    B               PROC-B           YES     300600

                                        End of Report
```

The base forms are adjusted to reflect the ICD-10-CM admitting code and description; however, since most users have custom forms, these need to be evaluated and adjusted at each site. These forms are not adjusted to allow all 60 characters of the description to print since they are always customized at the customer site.

The following data elements are affected by the change to ICD-10:

CCIDATA111F, CAMP101F, CAMP102F, CAMQ101F, CAHK33, CAHK36, CAHKA11, CAHKA12, CAHKA13, CAMK51F, CAMK53H

- Midnight Processing reports that contain the diagnosis or procedure codes and descriptions have been adjusted to allow room for printing the length of the codes and up to 60 characters of the description on the reports:
  - 72 Hour Readmit Report (CA72x)
  - Daily Admission No Show Report (CFNSHOx)
  - Daily Expected O/P PAT Report (FPTROx), Daily Expected PAT Report (FPTRx), Daily PAT Report (FPRx) and Daily O/P PAT Report (FPRRx)
  - ER Log Report (CERLx) and Medical Day Care Report (CERMx)
  - Disposition Report (DISPx)
  - Multiple Procedure Review Report (CFCMNPRx)

- Online and Demand reports that contain the diagnosis or procedure codes and descriptions have been adjusted to allow room for printing the length of the codes and up to 60 characters of the description on the reports:

- Admission/ER Registration Forms (caffrm, caffrma, caffrmb, caffrmc, cafrm1a, cafrm2a, cafrm3a, caffrm)

- Form elements affected include (CCIDATA111F, CAMP101F, CAMP102F, CAMQ101F, CAHK33, CAHK36, CAHKA11, CAHKA12, CAHKA13, CAMK51F, CAMK53H)

- Daily E/R Visit Report (CADERVRx)

- O/P Demand Bill (CRFBIL)

- MPI Face Sheet

- Preadmission Form (cafpfrm)

- Reservation Form (cafresv)

- Detailed Vacant Bed Report

HL7 INTEGRATION

In all HL7 messages where any of the diagnosis codes or procedure codes are sent, there is now the ability to send both the ICD-10 and the ICD-9 codes. The changes are made in 2.2b version of the messages only.

An indicator is added to every diagnosis code or procedure code sent in an HL7 message to flag the code as ICD-10 or ICD-9. For ICD-10 codes, a *0* indicator is used, and for ICD-9 codes a *9* indicator is used. All of the changes outlined in this requirement apply to Canada as well. Once the ICD-10 implementation date has been reached, then all HL7 transactions both incoming and outgoing require that the coding system be included with all diagnosis and procedure codes. STAR is adding the ICD indicator from the patient's account record to the HL7 records for use by any downstream systems.

Once the ICD-10 implementation date parameter has been set in the Hospital Facility Options, all outgoing HL7 transactions contain all diagnoses and procedures on the patient's account, both ICD-10 and ICD-9.

If STAR supports the processing of a diagnosis or procedures segment that is passed in an HL7 inbound transaction, STAR stores them in the patient's account record regardless of the ICD indicator for the account.

STAR processes any inbound insurance segment in the currently defined inbound transactions only if the patient's account does not already have insurance assigned in

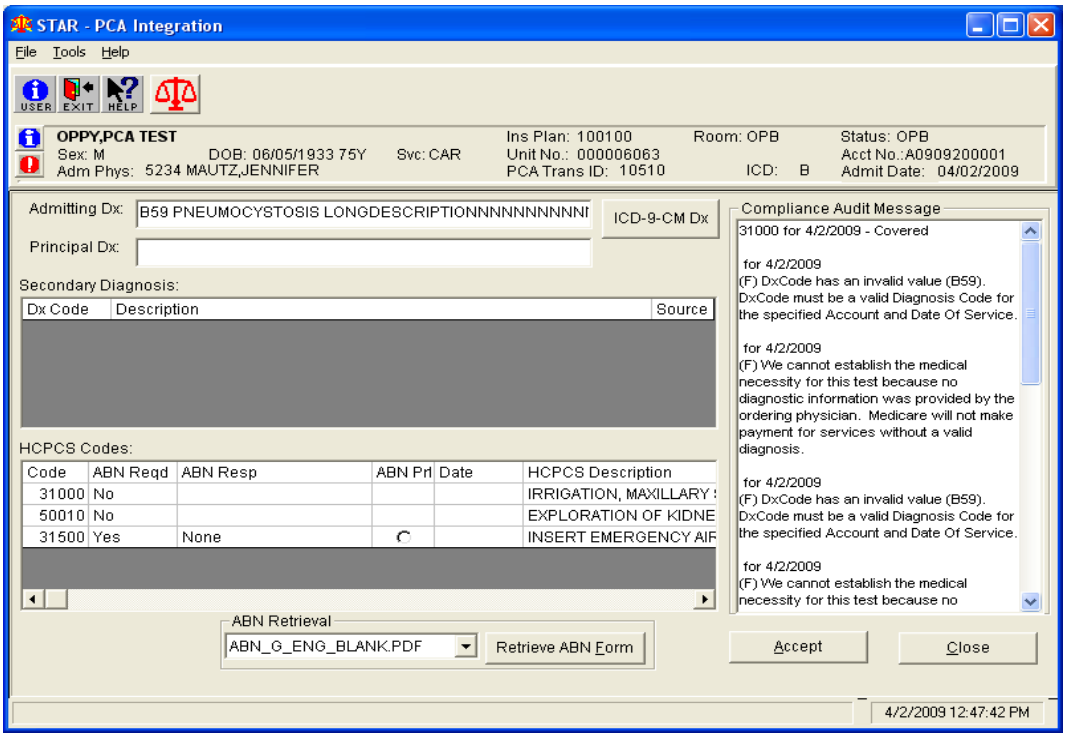
the STAR database. If insurance is already assigned to the patient account in STAR, the inbound insurance segment is ignored and a warning message is logged to audit inquiry. If the insurance is valid to be processed on the account, the ICD flag for the patient is updated based on the data received.

PCA/STAR PATIENT PROCESSING PRE-SERVICE INTEGRATION

For the STAR/PCA integration which occurs during the admission process in GUI or from the standalone navigator functions for the character-based system, an indicator is added to the diagnosis codes to flag the code as ICD-10 or ICD-9. The HCPCS codes are not changing at this time, so no change is required in the sending of these codes.

All diagnoses collected during the admission process are sent to PCA when requesting an audit, and are returned to STAR on a recall. Each of these diagnosis codes is now flagged with a 0 for an ICD-10 code and a 9 for an ICD-9 code. When both codes are present in the patient's account, all codes are sent to both PCA and STAR. All other functionality of the interface remains unchanged. STAR logs the diagnoses in the appropriate location in the patient's record based on whether it is an ICD-10 or an ICD-9 code. The STAR/PCA Integration Form is being enhanced to show both the ICD-10 codes and the ICD-9 codes. Currently, Pathways Compliance Advisor is not available in Canada, so these changes are not applicable.

STAR/PCA INTEGRATION FORM



The STAR/PCA Integration form displays the ICD-10-CM diagnosis codes in the Admitting Dx, Principal Dx, and Secondary Diagnosis fields. A toggle button is added to the right of the Admitting Dx field. Upon entering the integration form the ICD-10-CM codes are displayed and the toggle button displays *ICD-9-CM Dx*. If the user clicks the button, the ICD-9-CM diagnosis codes and descriptions are displayed in the fields, and the button displays *ICD-10-CM Dx*. If the toggle button is clicked again, the ICD-10-CM diagnosis codes and descriptions are once again displayed. This is similar to the way the toggle buttons work in several of the census functions. In addition, the ICD type indicator is added to the header between the PCA Trans ID and the Admit Date fields. Once the ICD-10 implementation date has been reached, all transactions between STAR and PCA require that the coding system indication be present on all diagnosis codes.

The diagnosis data entered during the admission is displayed on the integration form; however, the user is allowed to add, delete and update any of the diagnosis data as needed.

Testing Guidelines

- Each of the tables needs to be tested to be sure the parameter can be set, updated and deleted. Any date should be allowed in the fields.

- The indicator should be set all three ways and checked in both the character-based system and GUI to be sure that the indicator is displayed in all the correct places. Also, the indicator for a specific patient should be updated and reviewed to be sure the update is seen in all locations.

- Both the diagnosis and procedure pointer tables should be reviewed to be sure that the new ICD-10 code field is present. An ICD-10 code should be added, updated and deleted from each table. Review the table printout to be sure that the ICD-10 code is added to the printout. Check to be sure that the name of the tables has been changed in the Table Maintenance function to be *ICD*.

- The DSM pointer table should be reviewed to be sure that the new ICD-10 code field is present. An ICD-10 code should be added, updated and deleted from the table. Review the table printout to be sure that the ICD-10 code is added to the printout.

- Each character-based screen discussed needs to be tested to be sure that both the ICD-10 and ICD-9 diagnosis codes can be seen and entered as appropriate based on the patient indicator. The functions should all be tested with a patient requiring ICD-10 only codes, a patient requiring ICD-9 only codes and a patient who requires both coding methods. In addition, all of the alternative coding methods need to be tested, use of the pointer tables, freeform and pulling from the DSM table. Testing needs to be done to be sure that if a patient requires both coding methods that the appropriate codes are pulled and displayed from the pointer table and that if freeform entries are used they are displayed in both the ICD-10 and the ICD-9 fields. Review of the displays should be done to ensure that all characters of the

code and the appropriate number of characters of the description are seen on all screens.

- Each GUI form discussed needs to be tested to be sure that both the ICD-10 and ICD-9 diagnosis codes can be seen and entered as appropriate based on the patient indicator. The functions should all be tested with a patient requiring ICD-10 only codes, a patient requiring ICD-9 only codes and a patient who requires both coding methods. In addition, all of the alternative coding methods need to be tested, use of the pointer tables, freeform and pulling from the DSM table. Testing needs to be done to be sure that if a patient requires both coding methods that the appropriate codes are pulled and displayed from the pointer table and that if freeform entries are used they are displayed in both the ICD-10 and the ICD-9 fields. Review of the displays should be done to ensure that all characters of the code and the appropriate number of characters of the description are seen on all screens.

- Review of the displays should be done to ensure that all characters of the code and the appropriate number of characters of the description are seen on all screens in the character-based system and on all form in GUI.

- Each of the Midnight Processing Reports discussed needs to be tested. They should be tested with a mix of patients requiring ICD-10 only, ICD-9 only and both coding methods. If an ICD-10 code exists it should be printed even if an ICD-9 code also exists. Additionally, the length and format of the codes and descriptions should be reviewed to be sure that the changes have been made and that the reports are still formatted so that they are useful to the users.

- Each of the Demand and Online Reports discussed needs to be tested. They should be tested with a mix of patients requiring ICD-10 only, ICD-9 only and both coding methods. If an ICD-10 code exists it should be printed even if an ICD-9 code also exists. Additionally, the length and format of the codes and descriptions should be reviewed to be sure that the changes have been made and that the reports are still formatted so that they are useful to the users.

- The users need to test the HL7 transactions to all systems with which they use HL7 integration. The users must communicate with the other vendors to ensure that their systems are ready to receive the HL7 records containing both ICD-10 and ICD-9 diagnoses.

- The STAR/PCA integration needs to be tested with the implementation date parameter set and not set. In addition, testing should be done with patients who require only ICD-9-CM codes, patients who require only ICD-10-CM codes and patients who require both coding methods.

Procedural Considerations

There are many procedural considerations for the ICD-10 implementation. It is necessary that all users be made aware that both ICD-10 and ICD-9 processing are

running simultaneously for a period of time. This requires that the users pay close attention to the account indicators and be familiar with both coding systems. Procedurally, the users need to review their current coding process to be sure that the change to ICD-10 coding doesn't require any changes. Because not all providers are switching to ICD-10 at the same time, there is bound to be some confusion about the dual coding system, and which codes each account requires. The users need to put procedures in place to review each of the accounts for accuracy not only in the codes themselves, but in the coding system that was used. If the patient's insurance information changes during the visit, or the patients admission date is adjusted there may be a change in the coding requirements. The system is unable to force any recoding in the event a patient's coding method is changed, therefore procedures must be in place to review the claims before billing.

Training Requirements

As with any new enhancement, it is necessary to train the staff on the changes. For the ICD-10 implementation, admission personnel, nursing personnel and anyone else who is using the STAR Patient Processing software need to be educated on the changes. Anyone who is responsible for entering any diagnosis or procedure codes needs to be educated on the ICD-10 coding method as well as how to support dual coding methods on a single account.

Implementation Considerations

The implementation date for the ICD-10 enhancements should be carefully considered by the users. Once the ICD-10 implementation date is set in the Hospital Facility Options, then all of the changes outlined in this design go into effect. The users need to be sure that they have reviewed all of their procedures and put the necessary changes in place. All personnel must be trained on the changes to be seen with the ICD-10 coding method. Any necessary form or menu changes must be made prior to setting the ICD-10 implementation date. It is very important that the users check with their other vendors to be sure that they have addressed the impact that implementing ICD-10 has on any of the other systems. Although the flag to set the ICD-10 implementation date is contained in the Hospital Facility Options controlled by STAR Patient Processing, all STAR products are affected by the setting of this date, and the enhancements across all STAR products are implemented.

Documentation

- STI M23013

Enhancement Topic	Document	Chapter or Topic
ICD-10 Enhancements	*Tables Volume*	Chapters 2, 3 and 4
	Patient Processing Volume	Chapters 1, 2, 3, 4, 5, 6 and 7
	General Information Volume	Chapters 4, 5, 6 and 8
	Report Names Volume	Chapters 1, 2 and 3
	GUI Admissions Help	New topics and forms under new Diagnosis Information chapter
	GUI Discharge Help	OP Dispositioning, Procedures/Diagnosis Codes
	GUI MPI Review Help	New topics and forms under new Visit Level-Diagnosis Information chapter
	GUI STAR PCA Integration Help	Looking Up A Diagnosis Code

Implementation Steps – Build Process for ICD-10 with DRG's

1. ICD-10 Discharge Eff Date

   Determine the date on which your facility wishes to implement ICD-10 with DRG's in your test ID, for Medical Record Abstracting/GUI Abstracting only. Set the date on the Abstract Facility Options screen. The date should be entered in MM/DD/YYYY format.

   This date replaces, in Medical Record Abstracting/GUI Abstracting only, the current USA ICD-10 Effective Date that is based on Admission date. That date will continue to be used by Patient Processing and Clinicals.

2. EXCEPTIONS

   For each Payor Code/Eff Date listed in the Financial Class, Insurance Plans, and Insurance Carrier tables, an ICD-9 =Y exception indicator must be entered for all payors that require ICD-9 codes once the ICD-10 Discharge Effective date has been met. The new ICD-9 field is found on the last page of these tables.

   STAR table Indicators must be set prior to obtaining both I-10 and I-9 codes back from 3M. If they are not set and the discharge date is on or after the Discharge ICD-10 Effective date, an indicator of I-10 will be sent to 3M and no I-9 codes will be returned in the interface.

3. State ICD Indicator

   State Exceptions are used to set patient type exceptions for states requiring I-9 once ICD-Eff Date is met. See the Implementation Steps in Patient Processing

4. Encoder buttons on ICD-10 Diagnosis, Procedure, HCPCS form

   A checkbox titled Both was added next to Encoder buttons on ICD-10 Diagnosis, Procedure, HCPCS form. If this box is checked then a Tag will be sent in the interface requesting BOTH ICD-10 and ICD-9 code sets/groupers. This overrides the normal Dsch ICD Indicator.

Payor Exceptions

STAR Financial Class, Insurance Carrier, and Insurance Plan tables were updated with the new ICD-9 Flag.

- For each Payor Code/Eff Date listed in those tables, an ICD-9 =Y exception indicator must be entered for ALL payors that require ICD-9 codes once the Discharge ICD-10 Effect date has been met.

- STAR table Indicators must be set prior to obtaining both I-10 and I-9 codes back from 3M. If they are not set and discharge date is on or after Discharge ICD-10 Eff date, an indicator of I-10 will be sent to 3M and no I-9 codes/DRG grouper will be returned in the interface.

Financial Class Exceptions

This screen is used to set payor code values at the Financial Class Level. Payor Code information is sent to 3M via 3M Coding and Reimbursement System Interface. This screen is also used to send payor code information to other 3rd party encoders/grouper via the STAR Generic Encoder Interface. The new flag lets 3M know that the payor listed requires I-9 codes in addition to I-10 codes.

The fourth screen of the Financial Class Table/DRG and APC/ASC Payor Codes table has been updated. A new field of ICD-9 has been added as displayed below.

```
               General Hospital Table Maintenance Processor
                                                  Tue Feb 28, 2012 08:26 pm
Financial Classes
 1 Code      2 Description
   M           MEDICARE FINANCIAL CLASS......

DRG and APC/ASC Payor Codes  Edited By: Moon, Bob 02/06/12 02:38pm
DRG PAYOR             PAYOR    ICD-9  MSDRG HAC APC/ASC  DTE FROM    DTE TO
-------------------------------------------------------------------------------
C-CHAMPUS DRG PAYOR.X 00        Yes    Yes  Yes   23    01/01/2012  01/02/2012
M-MEDICARE            00               Yes  Yes   23    01/03/2012









               Are ICD-9 codes required for this payor? (Y/N)--
    F1Prev Page F2Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

There are three values for the ICD-9 Flag field: Y,N, Blank. When determining if an account requires ICD-9 codes:

- If the Plan level ICD9 indicator is set to Yes, the Insurance Requires 9s. If the indicator is set to No, the insurance does not require 9s.
- If there is a BLANK at the Insurance Plan Level, the system looks at the Insurance Carrier. If the ICD9 indicator is set to Yes, the Insurance requires 9s. If the ICD9 indicator is set to No, the insurance does not require 9s.
- If there is a blank at the Insurance Carrier level, the system looks at the Financial Class table. If the ICD9 indicator is set to If Yes, the Insurance requires 9s. If No, then the insurance does not require 9s.
- If there is a blank at ALL levels, the insurance does not require 9s.

Insurance Carrier/Payor Codes by Facility

This screen is used to set payor code values at the Insurance Carrier Level. Payor Code information is sent to 3M via 3M Coding and Reimbursement System Interface. This screen is also used to send payor code information to other 3rd party encoders/ grouper via the STAR Generic Encoder Interface. The new ICD-9 flag lets 3M know that the payor listed requires I-9 codes in addition to I-10 codes.

The ICD9 indicator was added to the following screen:

```
          General Hospital Table Maintenance Processor
                                                  Tue Feb 28, 2012 08:27 pm
Insurance Carriers
Payor Codes by Facility
( 1)Facility     : Model Hospital A
( 2)Payor        : *

( 3)Disch Eff Dt : 10/02/2008
( 4)Payor        : 00
( 5)ICD-9        : No
( 6)MSDRG        : No
( 7)HAC          : Yes

( 8)Disch Eff Dt : 10/02/2011
( 9)Payor        : 03
(10)ICD-9        :
(11)MSDRG        :
(12)HAC          : Yes

(13)Edit By      : Moon, Bob
(14)Edit Date    : 02/06/12 02:37pm

Enter field number or '/' starting field number--
                  next screen(/) or previous screen(/P) [/]
```

There are three values for the ICD-9 Flag field: Y,N, Blank.

When determining if an account requires ICD-9 codes:

- If the Plan level ICD9 indicator is set to Yes, the Insurance requires 9s. If the indicator is set to No, the insurance does not require 9s.
- If there is a BLANK at the Insurance Plan Level, the system looks at the Insurance Carrier. If the ICD9 indicator is set to Yes, the Insurance requires 9s. If the ICD9 indicator is set to No, the insurance does not require 9s.
- If there is a blank at the Insurance Carrier level, the system looks at the Financial Class table. If the ICD9 indicator is set to If Yes, the Insurance requires 9s. If No, then the insurance does not require 9s.
- If there is a blank at ALL levels, the insurance does not require 9s.

Insurance Plans/Payor Codes by Facility

This screen is used to set payor code values at the Insurance Plan Level. Payor Code information is sent to 3M via the 3M Coding and Reimbursement System Interface. The new flag lets 3M know that the payor listed requires I-9 codes in addition to I-10 codes.

The ICD9 indicator was added to the following screen:

```
 General Hospital Table Maintenance Processor
                                                    Tue Feb 28, 2012 08:28 pm
Insurance Plans                                              Carrier: MEDICARE
Payor Codes by Facility
( 1)Facility     : Model Hospital A
( 2)Payor        : *

( 3)Disch Eff Dt : 01/01/2008
( 4)Payor        : 00
( 5)ICD-9        : No
( 6)MSDRG        : No
( 7)HAC          :

( 8)Disch Eff Dt : 10/01/2010
( 9)Payor        : 00
(10)ICD-9        : Yes
(11)MSDRG        : Yes
(12)HAC          :

(13)Edit By      : Moon, Bob
(14)Edit Date    : 02/06/12 03:39pm

Enter field number or '/' starting field number--
                   next screen(/) or previous screen(/P) [/]
```

There are three values for the ICD-9 Flag field: Y,N, Blank.

When determining if an account requires ICD-9 codes:

- If the Plan level ICD9 indicator is set to Yes, the Insurance requires 9s. If the indicator is set to No, the insurance does not require 9s.
- If there is a BLANK at the Insurance Plan Level, the system looks at the Insurance Carrier. If the ICD9 indicator is set to Yes, the Insurance requires 9s. If the ICD9 indicator is set to No, the insurance does not require 9s.
- If there is a blank at the Insurance Carrier level, the system looks at the Financial Class table. If the ICD9 indicator is set to If Yes, the Insurance requires 9s. If No, then the insurance does not require 9s.
- If there is a blank at ALL levels, the insurance does not require 9s.

State ICD-10 Patient Type Exceptions Parameter

This screen is used to set state patient type exceptions for states requiring I-9 once ICD-Eff Date is met. With this enhancement fields 5 and 6 were added to work with the new ICD-10 Discharge Effective Date to determine state requirements for Medical Records. These fields must be completed for State Exceptions to display in STAR Abstracting/GUI Abstracting.

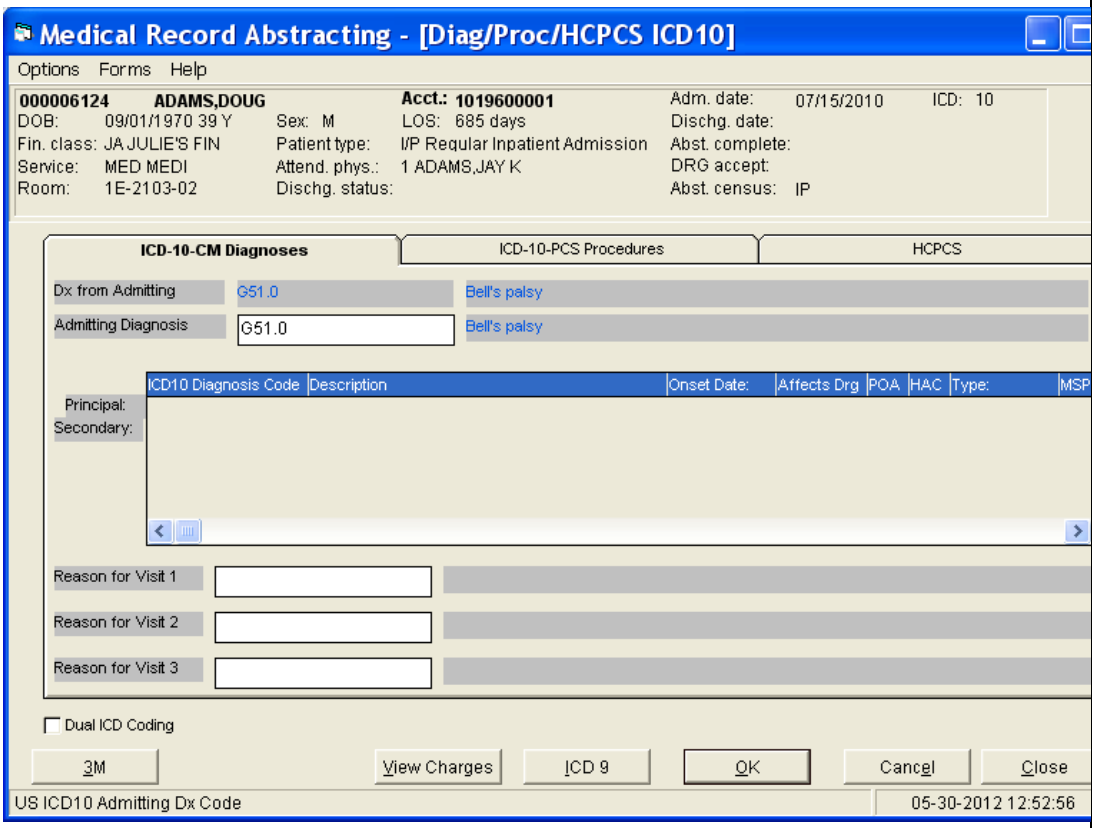
The following is a sample of the State ICD-10 Patient Type Exceptions:

```
                General Hospital State ICD-10 Patient Type Exceptions Processor
                                                    Sun Mar 25, 2012 07:35 pm
Model Hospital A
( 1)Patient Type          : LTC
( 2)Description           : Long Term Care

Admitting
( 3)ICD-10 Disch Eff Date : 01/01/2010
( 4)Diag/Proc/Both        : Both


( 7)Edit By               : Moon, Bob
( 8)Edit Date             : 01/19/12 1240




Enter field number or '/' starting field number--
                  next screen(/) or previous screen(/P) [/]
```

Encoder Buttons - GUI ICD-10 on Diagnosis Procedure, HCPCS form

Check the Dual Coding check boxBoth box so a Tag will be sent in the interface requesting BOTH ICD-10 and ICD-9 code sets/groupers. This overrides normal Dsch ICD.

Following is a sample of the screen:



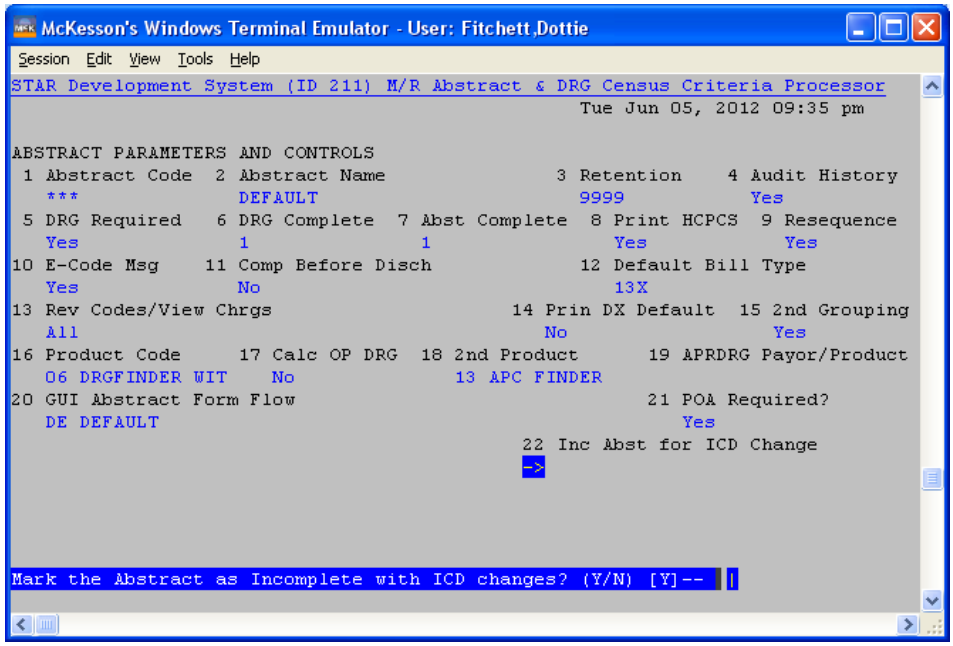
New Parameter on M/R Abstract & DRG Census Criteria

Enter Yes in Incomplete Abstract (Y/N) parameter to incomplete abstract

- if change to FC, Insurance Carrier, and Insurance Plan, or STATE Reporting Discharge parameters results in change to Discharge ICD-10 Ind from 9 or 10 to 10/9 or 9/10, or

- if change in discharge date causes an account to change from a discharge ICD indicator of 10 or 9 to 10/9 or 9/10.

- If Y is selected & change listed above occurs, then system will incomplete the abstract and add account to existing Incomplete Abstract Report.



Testing Guidelines

- Each of the tables needs to be tested to be sure the parameters can be set, updated and deleted.

- The ICD indicator should created for 9,10, 10/9, and 9/10 and checked in both the character-based system and GUI to be sure that the indicator is displayed in all the correct places. Also, the indicator for a specific patient should be updated (for instance by changing insurance plan) and reviewed to be sure the update is seen in all locations.

- The GUI Diag/Proc/HCPCS ICD-10 form needs to be tested to be sure that the Dual Coding checkbox is available to request BOTH ICD-10 and ICD-9 code sets/ groupers.

- Each of the Midnight Processing Reports discussed needs to be tested. They should be tested with a mix of patients requiring ICD-10 only, ICD-9 only and both coding methods. If an ICD-10 code exists it should be printed even if an ICD-9 code also exists. Additionally, the length and format of the codes and descriptions should be reviewed to be sure that the changes have been made and that the reports are still formatted so that they are useful to the users.

- Each of the Demand and Online Reports discussed needs to be tested. They should be tested with a mix of patients requiring ICD-10 only, ICD-9 only and both

coding methods. If an ICD-10 code exists it should be printed even if an ICD-9 code also exists. Additionally, the length and format of the codes and descriptions should be reviewed to be sure that the changes have been made and that the reports are still formatted so that they are useful to the users.

- The users need to test the HL7 transactions to all systems with which they use HL7 integration. The users must communicate with the other vendors to ensure that their systems are ready to receive the HL7 records containing both ICD-10 and ICD-9 diagnoses. (Note: HL7 changes for ICD-10 DRGs will be released with STI M25377).

Procedural Considerations

All users must be made aware that both ICD-10 and ICD-9 processing will be required to run simultaneously for a period of time. This requires that the users pay close attention to the account indicators and be familiar with both coding systems. Procedurally, the users need to review their current coding process to be sure that the change to ICD-10 coding doesn't require any changes. Because not all providers are switching to ICD-10 at the same time, there is bound to be some confusion about the dual coding system, and which codes each account requires. The users need to put procedures in place to review each of the accounts for accuracy not only in the codes themselves, but in the coding system that was used. If the patient's insurance information changes during the visit, or the patient's discharge date is adjusted, there may be a change in the coding requirements. The system is unable to force any recoding in the event a patient's coding method is changed, therefore procedures must be in place to review the claims before billing.

Training Requirements

As with any new enhancement, it is necessary to train the staff on the changes. For the ICD-10 implementation, Health Information Management personnel, admission personnel, nursing personnel and anyone else who is using the STAR Patient Processing software need to be educated on the changes.

Implementation Considerations

The implementation date for the ICD-10 with DRGs enhancements should be carefully considered by the users. Once the Discharge ICD Effective Date implementation date is set in the Abstracting Facility Parameters, all of the changes outlined in this design go into effect. The users need to be sure that they have reviewed all of their procedures and put the necessary changes in place.

Documentation

- STI M24872

Enhancement Topic	Document	Chapter or Topic
ICD-10 with DRG's Enhancements	*Tables Volume* *Patient Processing Volume* *Reports Name Volume*	Chapter 2 Chapter 2 Chapter 1

PHYSICIAN PRODUCTS

Overview

In conjunction with all of the STAR 2000 Modules/ Applications, STAR Physician Products (Clinical Browser and the Horizon*WP*® Physician Portal STAR modules) were enhanced to replace ICD-9 diagnosis and procedure codes with the proposed new ICD-10-CM standards. After a date is defined in the STAR Patient Processing parameter and the date is reached, the additional enhancements will be functional for ICD-10.

ICD-10 diagnosis processing will only take affect if the facility level parameter, USA ICD10 Effective Date, is set and the effective date has passed. This parameter is accessed from STAR Patient Processing, therefore Patient Processing will determine when/if the account is prompted for ICD-10 diagnosis and procedure codes. In the Insurance Plans, Insurance Carriers, and the Financial Class tables, additional effective dates may also be defined. These dates represent exceptions to the effective date defined in the Hospital Facility parameter.

By using these parameters, the STAR Patient Processing application determines when/if the account requires ICD-9-CM codes, ICD-10-CM / ICD-10-PCS codes, or both ICD-9-CM or ICD-10-CM / ICD-10-PCS codes. From this determination, STAR Patient Processing will set the ICD indicator for the patient's account. The ICD indicators are 9 for ICD-9-CM entry, 10 for ICD-10-CM, or B for both the ICD-9-CM and ICD-10-CM.

NOTE: Please refer to Chapter 2, STAR Patient Processing section, Overview and Implementation, in this Implementation Guide for a detailed explanation of implementing ICD-10 processing including detailed information pertaining to the STAR Patient Processing parameters, the effective dates, admit dates, the hierarchy of the parameters, adding, deleting, re-sequencing insurance plans or carriers, and the change in admission dates.

Application Changes

Modifications have been made in the STAR Clinical Browser system and the Horizon*WP* Physician Portal STAR modules to allow and accommodate diagnosis code processing for both ICD-9 and ICD-10 diagnosis and procedure codes.

STAR Clinical Browser

The following screens and reports display/print diagnosis (Dx) information in STAR Clinical Browser and have been updated to accommodate ICD-10 diagnosis processing:

- Patient Information - Admitting Dx, Working Dx - truncated to 35 characters, and a "+"

- Patient List Report - Working Dx - truncated to 48 characters and append a "+"
- Physician Face Sheet - Admitting Dx, Working Dx - 26 characters with a "+"
- Diagnoses & Procedures - Admitting Dx, Working Dx, MR Abstracting Dx's and Procedures - No truncation.

If the STAR Patient Processing facility level parameter, USA ICD-10 Effective Date Parameter is activated and there is an ICD-10 diagnosis code logged on the patient, the ICD-10 code/description is displayed in the current diagnosis fields on Clinical Browser screens.

For accounts with a "B" patient ICD Indicator on STAR, the system files both the ICD-10 and the ICD-9 diagnosis selected for use by STAR Patient Accounting. If both are collected, they are displayed in some STAR Inquiry screens. STAR Clinical Browser screens display only the ICD-10-CM diagnosis in these instances.

If only ICD-9 diagnosis is collected for the patient, it is displayed in the current diagnosis fields on Clinical Browser screens.

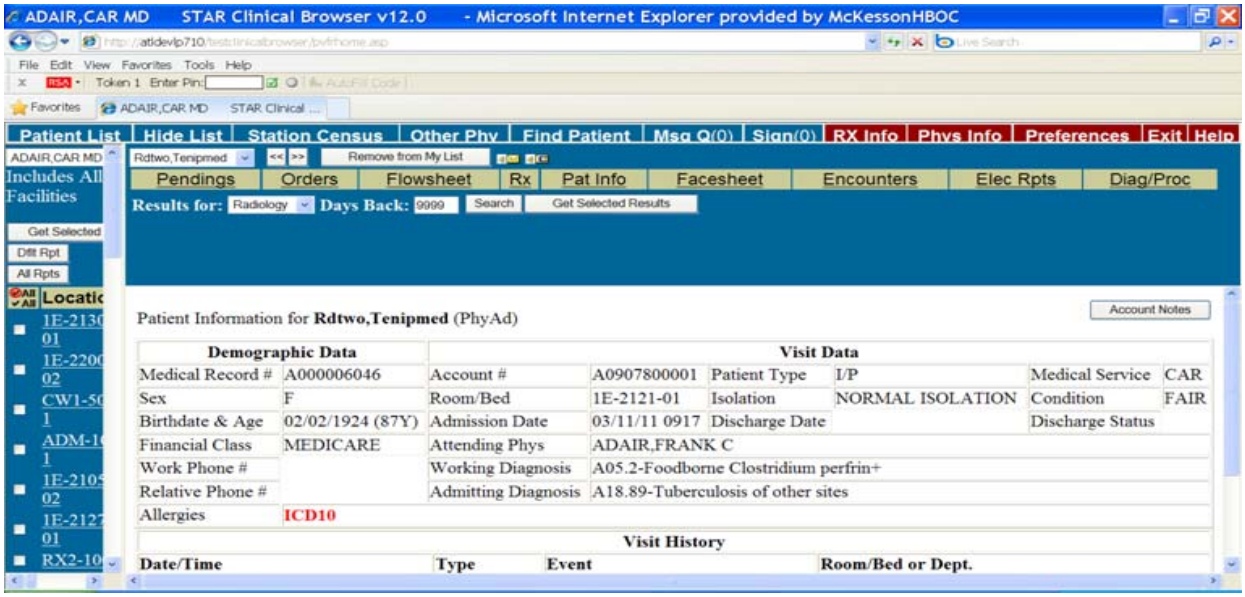
Current functionality (display ICD-9) applies if the Effective Date parameter is not activated.

The ICD-10-CM Diagnosis codes are up to eight characters in length. The ICD-10-PCS Procedure codes are up to seven characters in length. In all places where the ICD-10-CM diagnosis or procedure codes are displayed, the screens were adjusted to accommodate the longer ICD-10 codes and descriptions. On most CB screens there just is not enough room to display the longer ICD-10 descriptions and a shortened version of the description is displayed with a "+" appended as a convention to indicate the description has been truncated.

The following screens detail the ICD-10 Admitting Diagnosis, Working Diagnosis, and MR Diag & Procedure fields.

Patient Information

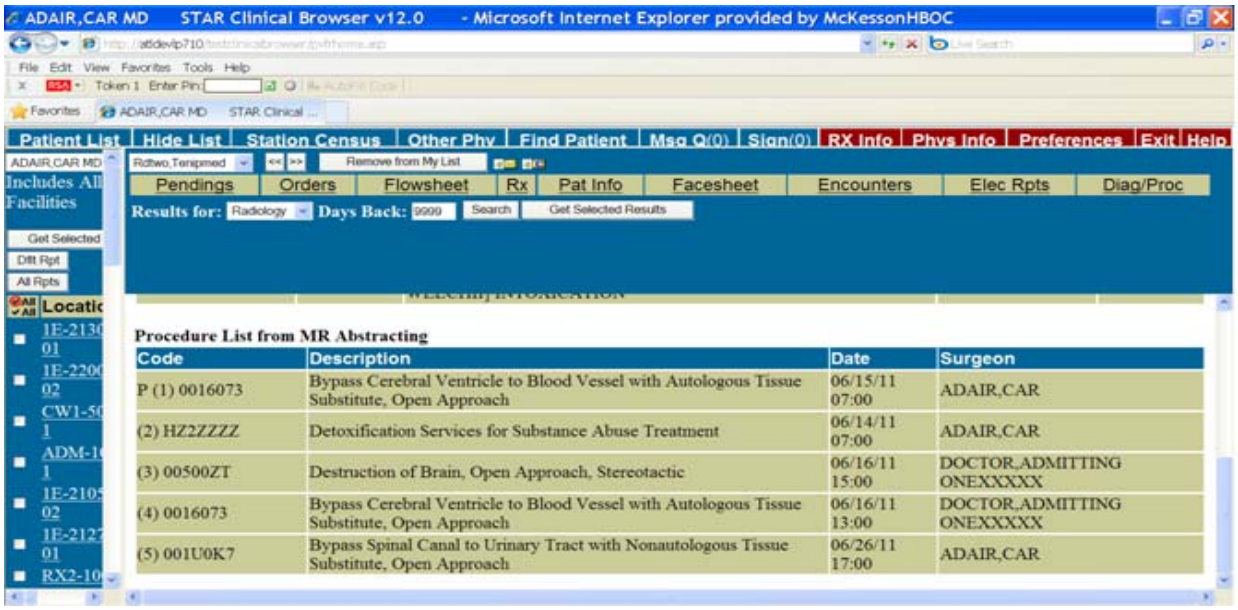
This screen displays Working and Admitting Diagnoses under Visit Data. If the length of the combined diagnosis and description is greater than 35 characters, they are truncated to 35 characters, and a "+" is appended as a convention to indicate the description has been truncated.



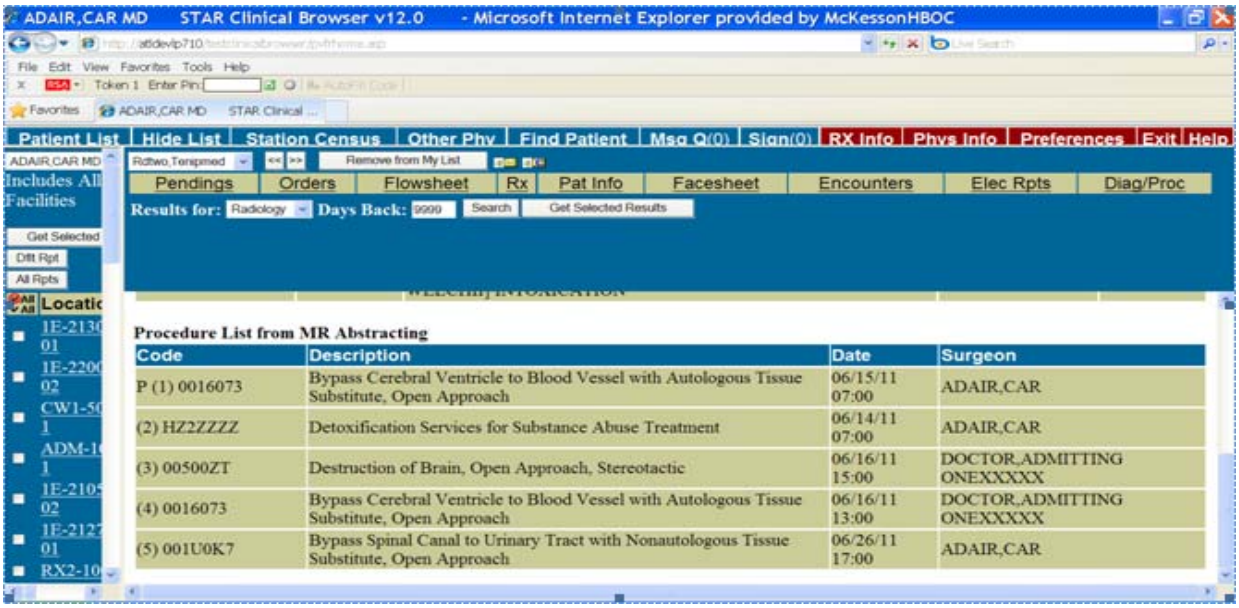
Diagnoses & Procedures

This screen displays Visit-level Working diagnoses and Admitting diagnoses in header. Admitting, Principal, and Secondary Diagnoses, and Primary and Secondary Procedures entered through Medical Records Abstracting are displayed in the bottom half of the screen. No truncation.

The following screen is an example of MR Abstracting Diagnoses.



The following screen is an example of MR Abstracting Procedures.



ADMITTING DIAGNOSIS
This field displays the admitting diagnosis entered during Admission.

WORKING DIAGNOSIS
This field displays the working diagnosis entered during Admission.

MR ABSTRACTING DX'S AND PROCEDURES
These fields display the diagnoses and procedures entered during STAR Medical Records Abstracting.

Reports

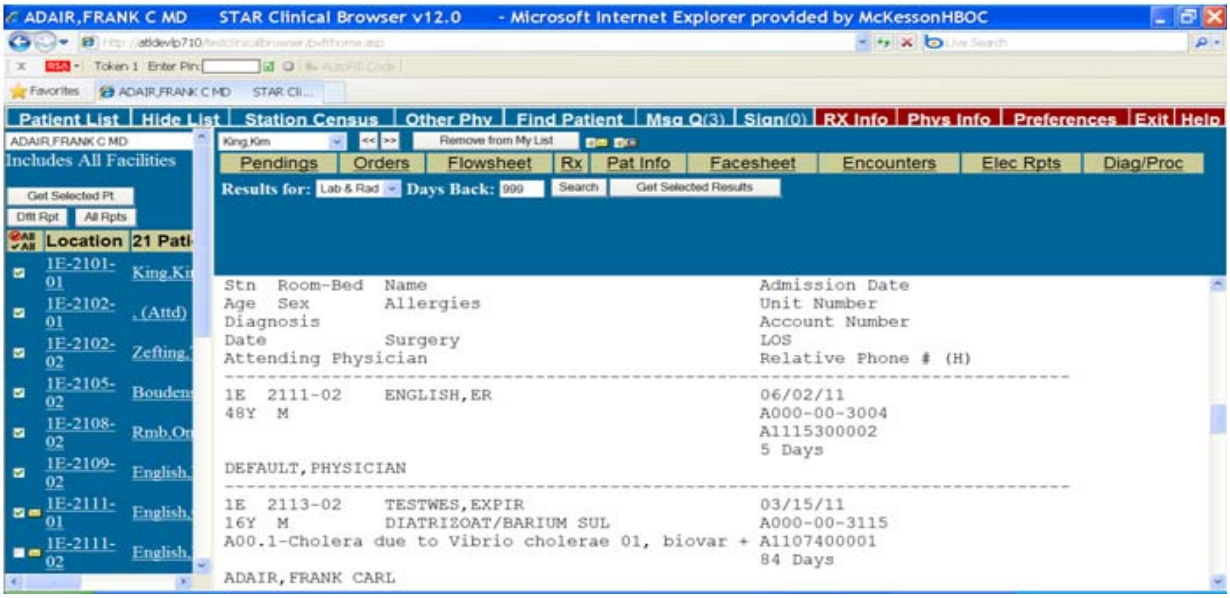
After the effective date, if an ICD-10-CM diagnosis code exists for the patient it is printed on reports that include the diagnosis codes. If both ICD-10 and ICD-9 diagnoses are collected, only the ICD-10 diagnosis prints on reports. If only an ICD-9 diagnosis is collected for the patient, it is displayed/printed in the current diagnosis fields. On some of the reports, the description is truncated due to space restriction.

The following reports have been updated to accommodate ICD-10 diagnosis display.

- **Patient List Report**

  Displays/prints the Working Diagnosis information and accommodates ICD-10-CM diagnosis processing on the Detailed Census report. The Working Dx field is printed as entered for the account on STAR. Since the ICD-10 diagnosis descriptions may be significantly longer than ICD-9, there is the potential for the display of that field to overlap the account number field, so the diagnosis code and description display are truncated to 48 characters and append a "+" to indicate that the description has been truncated.

The following screen is an example of the Patient List Detail Report.



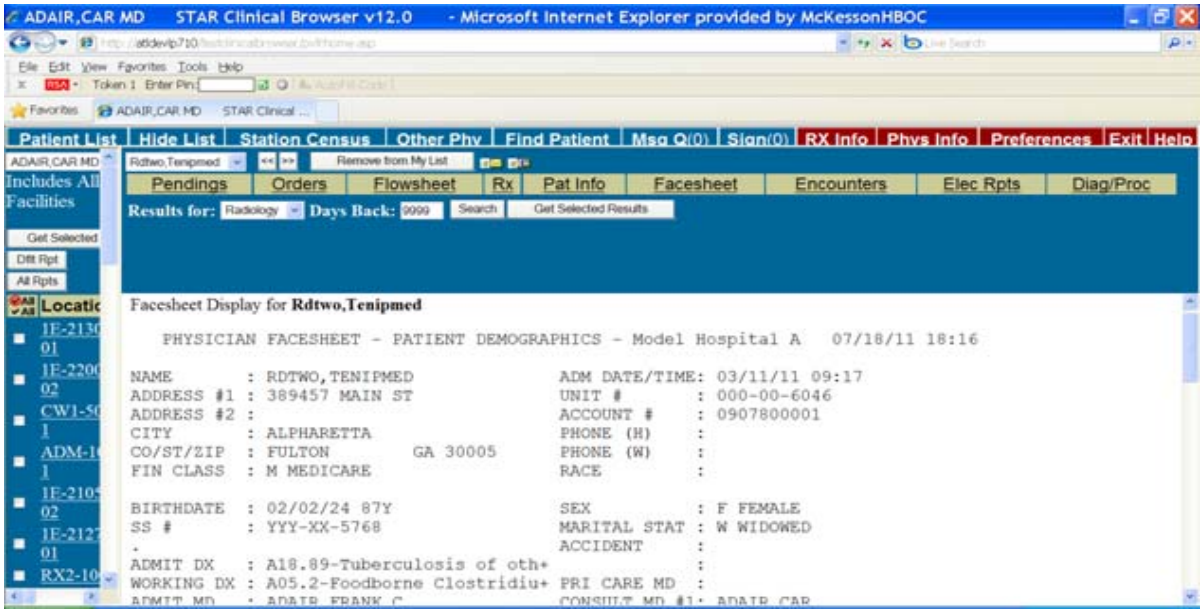
- **Physician Face Sheet**

  The admitting and working diagnoses are displayed/printed on the Physician Face Sheet report. As described in the previous section, the admitting and working diagnoses are displayed/printed for the patient as entered for the account on STAR.

  The base form "cpffrm" has been adjusted to reflect the ICD-10-CM diagnosis codes and description. Two new form elements were created for the truncated admitting and working diagnosis display on the base Physician Face Sheet form "cpffrm". The truncation length for both the admitting and working diagnosis has been set to 26 characters with a "+" sign, so that the description does not overlay data in the next column.

  Facilities using custom versions of the forms and elements need to evaluate and adjust them as necessary for these changes to take affect.

  The following screen is an example of the Physician Face Sheet.



Horizon^{WP} Physician Portal STAR Portlets and Radiologist Workflow (RWF) Module

STAR portlets and modules has been updated with the required changes to display ICD-9-CM and ICD-10-CM diagnoses in Admitting, Working, Principal, Secondary, and Ordering Diagnosis fields and display ICD-10-PCS procedures in the Primary and Secondary procedures fields in the Horizon^{WP} Physician Portal.

If the STAR Patient Processing facility level parameter, USA ICD-10 Effective Date Parameter is activated and there is an ICD-10 diagnosis code logged on the patient, the ICD-10 codes will display in the current diagnosis fields.

NOTE: For patient accounts with a "B" ICD Indicator, the system may file both the ICD-10 and the ICD-9 diagnosis for use by STAR Patient Accounting. The Horizon^{WP} Physician Portal/RWF screens display only the ICD-10-CM diagnosis.

Current functionality (display ICD-9) applies if the effective date is not activated. If only ICD-9 diagnosis is collected for the patient, it is displayed in the current diagnosis fields.

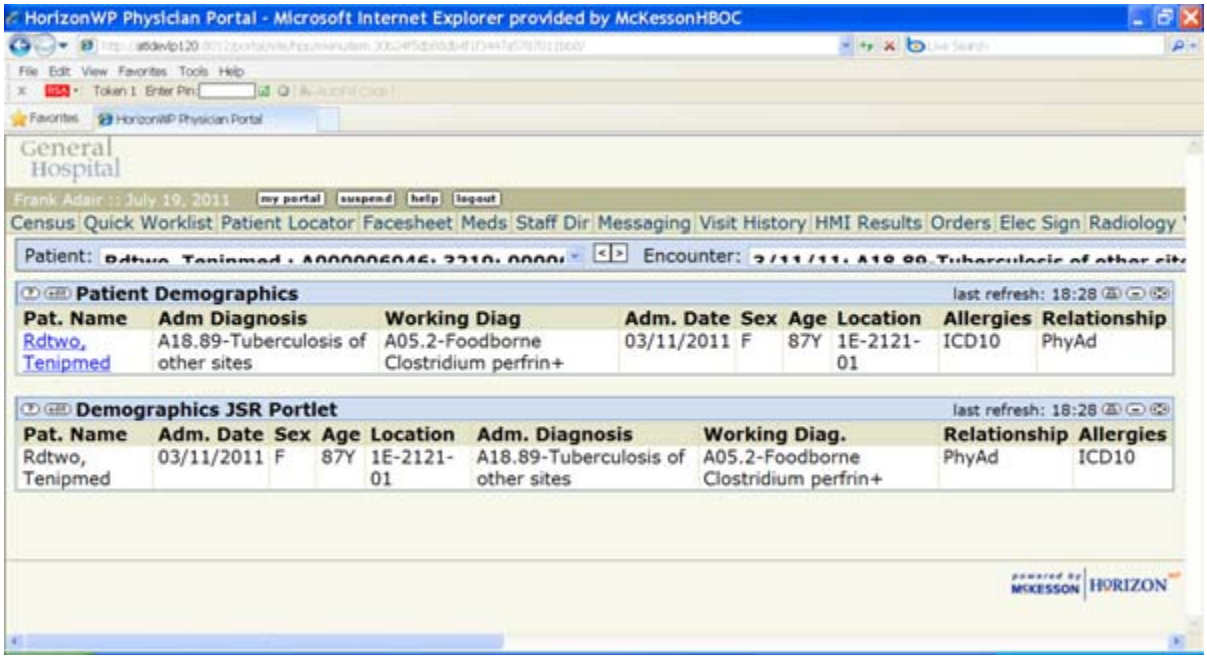
The ICD-10-CM Diagnosis codes are up to eight characters in length. The ICD-10-PCS Procedure codes are up to seven characters in length. In all places where the ICD-10-CM diagnosis or procedure codes/descriptions are displayed, the screens were adjusted to accommodate the longer ICD-10 codes and descriptions.

If the length of the combined diagnosis code and description is greater than 35 characters, they are truncated to 35 characters, and a "+" is appended as a convention to indicate the description has been truncated.

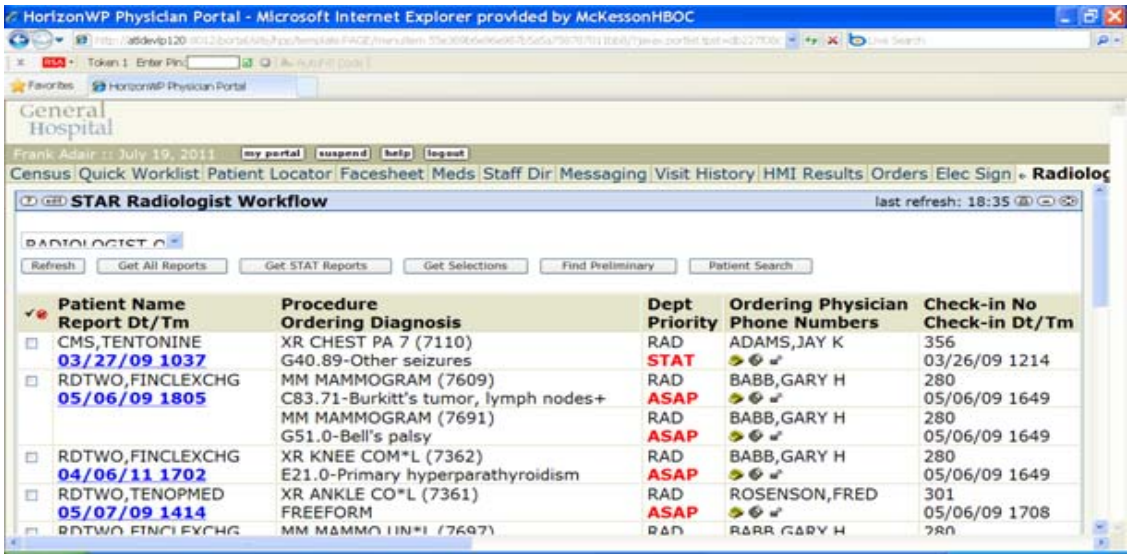
The following screens contain changes related to the display of ICD-10 diagnoses data unless otherwise noted.

- Patient Demographics - Admitting and Working diagnoses
- Patient Nav Banner - Admitting diagnosis
- Working Patient List (WPL) - Admitting and Working diagnoses
- Station Census - Admitting and Working diagnoses
- Clinical Notes - Ordering diagnoses
- Radiology Results Viewer - Ordering diagnosis
- Radiologist Workflow module (RWF) - Admitting, Working, and ordering diagnoses
- RWF Report Queue List - Ordering diagnosis
    - Get All Reports & Get Prelim Rpts - Ordering diagnosis
    - Patient Visit Info - Admitting and Working diagnoses
- RWF Review Detail form
    - RWF Find Preliminary - Ordering diagnosis
    - RWF Get Previous Exams - Ordering diagnosis
    - RWF View Linked Exams - Ordering diagnosis
    - RWF View Priors - Ordering diagnosis
    - RWF Latest Addendum - Ordering diagnosis

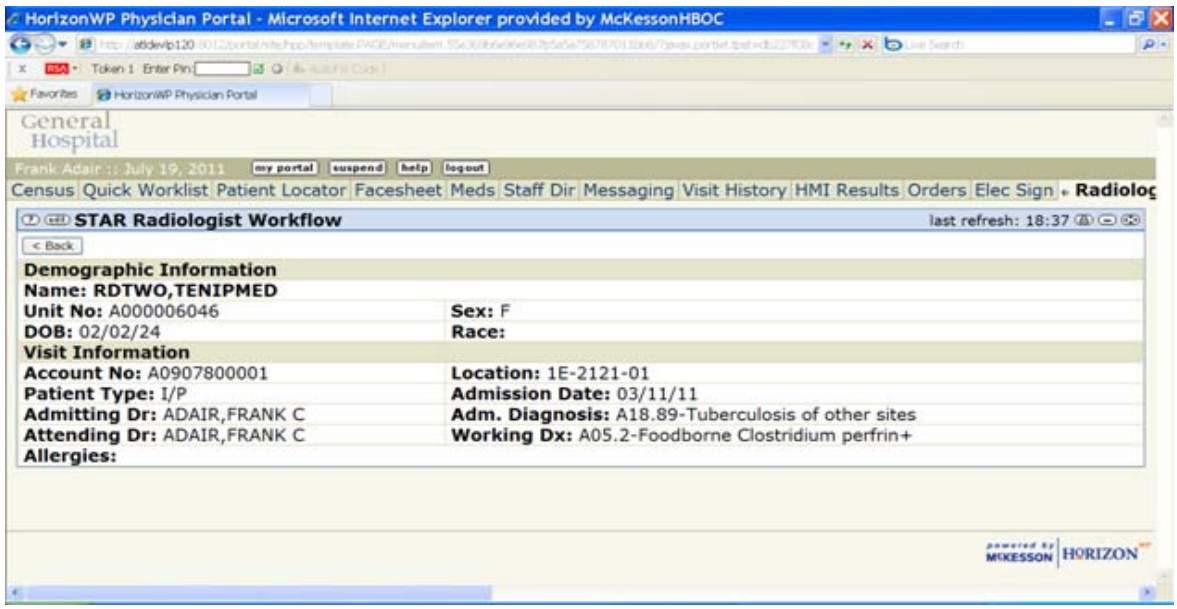
The following screen is an example of the Patient Demographics & Navigation Banner.



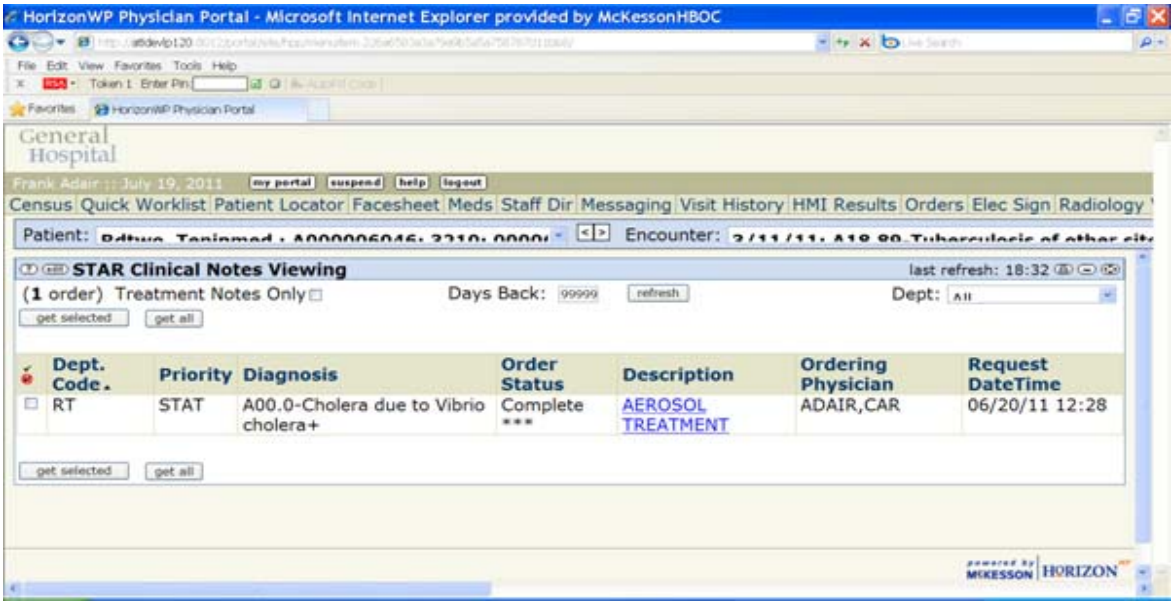
The following Radiologist Workflow module (RWF) screens are examples of an Horizon*WP* Physician Portal portlet displaying ICD-10-CM Admitting, Working, & Ordering Diagnoses.



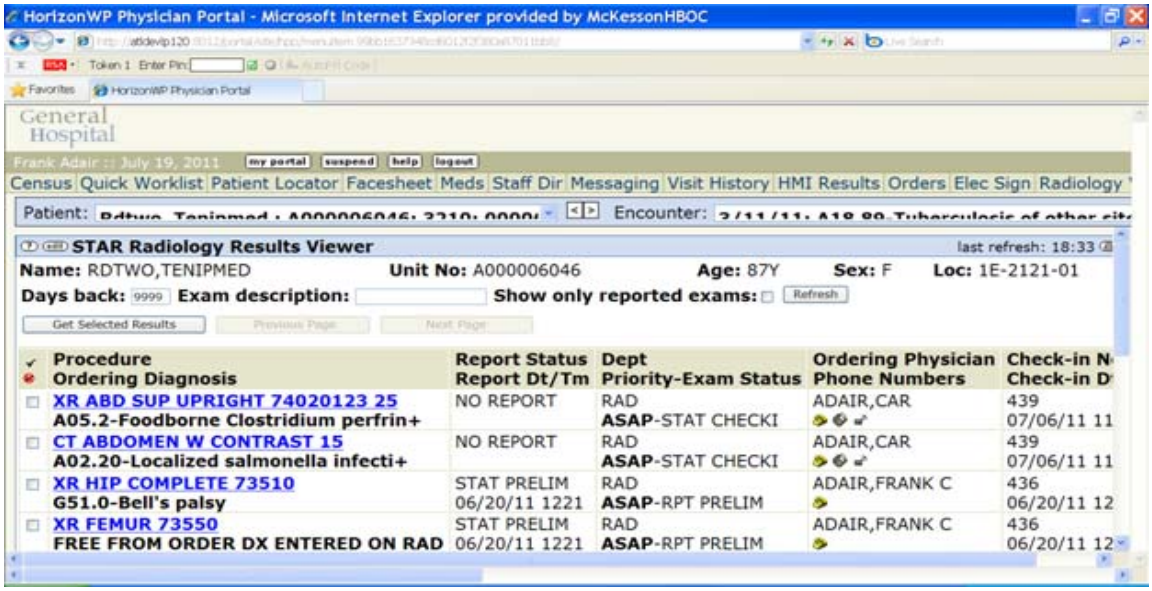
RWF Click Patient's Name:



The following screen is an example of the Clinical Notes Viewer:



The following screen is an example of the Radiology Results Viewer:



ADMITTING DIAGNOSIS
This field displays the admitting diagnosis entered during Admission.

WORKING DIAGNOSIS
This field displays the working diagnosis entered during Admission.

ORDERING DIAGNOSIS
This field displays the ordering diagnosis entered during the department order.

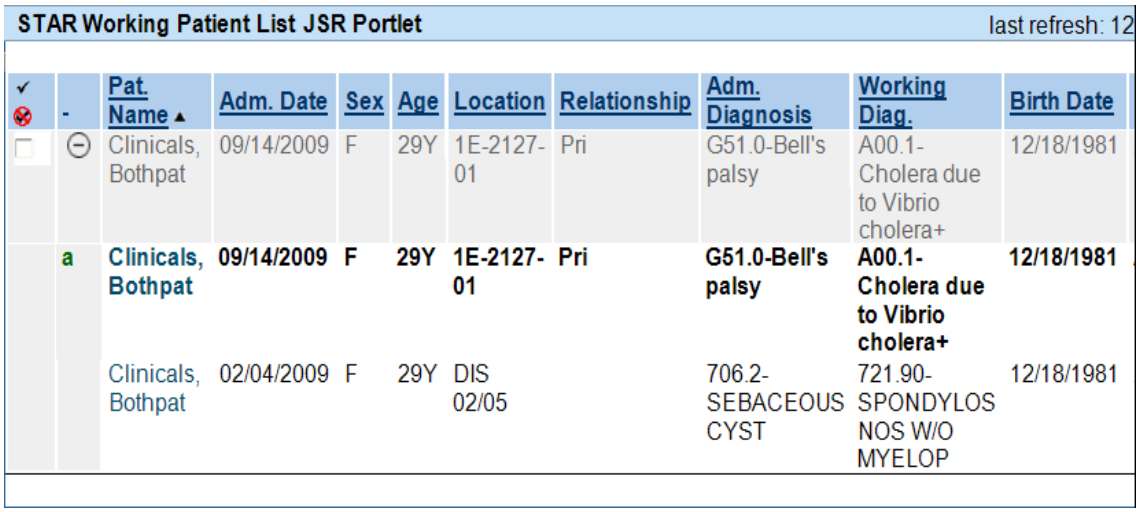
Reports

The following reports have been updated to accommodate ICD-10 diagnosis display.

- **Patient Walk Order Report**

  The Working Dx field is printed as entered for the account on STAR on the existing report. Since the ICD-10 diagnosis descriptions may be significantly longer than ICD-9, there is the potential for the display of that field to overlap the account number field, so the diagnosis code and description display are truncated to 48 characters and appended with a "+" to indicate the description has been truncated.

  This example of the STAR Working Patient List shows Previous encounters. ICD-9 and ICD-10 diagnosis display based on visit:



STAR Working Patient List JSR Portlet last refresh: 12

✓	-	Pat. Name ▲	Adm. Date	Sex	Age	Location	Relationship	Adm. Diagnosis	Working Diag.	Birth Date
☐	⊖	Clinicals, Bothpat	09/14/2009	F	29Y	1E-2127-01	Pri	G51.0-Bell's palsy	A00.1-Cholera due to Vibrio cholera+	12/18/1981
	a	**Clinicals, Bothpat**	**09/14/2009**	**F**	**29Y**	**1E-2127-01**	**Pri**	**G51.0-Bell's palsy**	**A00.1-Cholera due to Vibrio cholera+**	**12/18/1981**
		Clinicals, Bothpat	02/04/2009	F	29Y	DIS 02/05		706.2-SEBACEOUS CYST	721.90-SPONDYLOS NOS W/O MYELOP	12/18/1981

Walk Order Printed Report Example:

Fri 06/24/11 12:25 STAR Development System Page 1
Report BIT 32-ADAIR,CAR -- Detailed Census
(All Facilities)

Stn Room-Bed Name Admission Date
Age Sex Allergies Unit Number
Diagnosis Account Number
Date Surgery LOS
Attending Physician Relative Phone # (H)

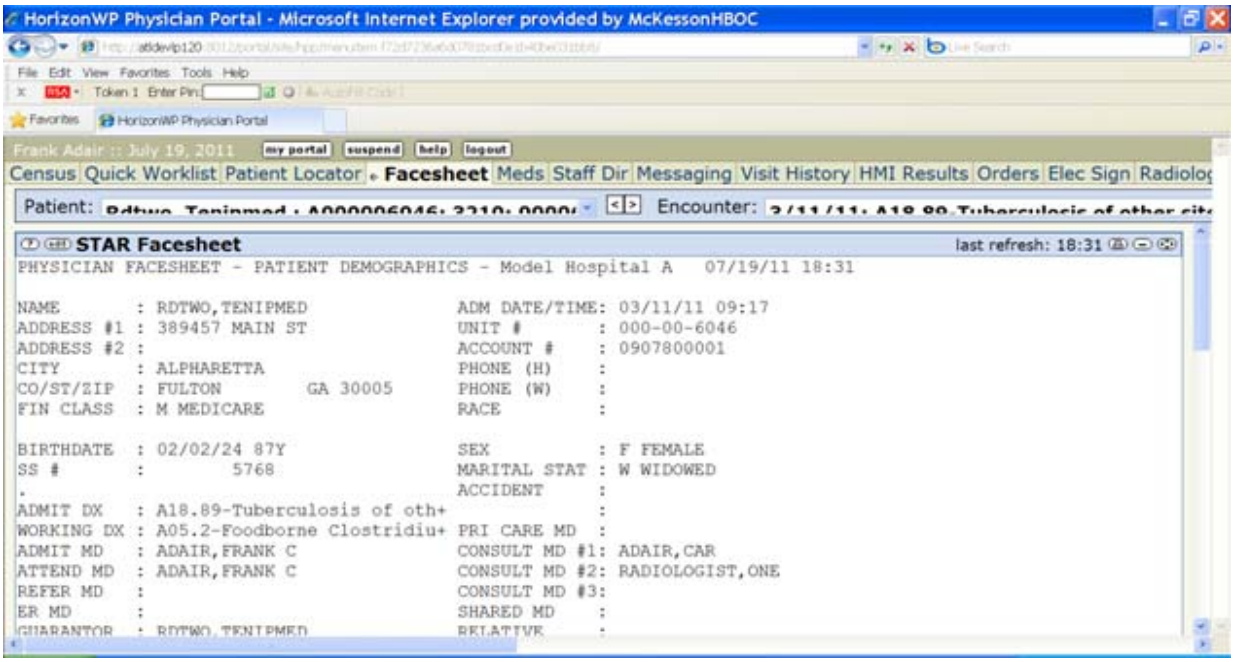
1E 2121-01 RDTWO,TENIPMED 03/11/11
87Y F ICD10 A000-00-6046
A05.2-Foodborne Clostridium perfringens [Clostri+ A0907800001
106 Days
ADAIR,FRANK C

BAO BO07-02 RDTWO,TENOPMED 03/19/11
81Y F A000-00-6047
FREE FORM WORKING DX ENTERED ON P A0907800002
98 Days
ROSENSON,FRED

- **Physician Face Sheet**

  The admitting and working diagnoses are displayed/printed on the Physician Face Sheet as entered for the account on STAR on the existing report. The base form is "cpffrm". Two new form elements were created for the truncated admitting and working diagnosis display. The truncation length for both the admitting and working diagnosis has been set to 26 characters with a "+" sign, so that the description will not overlay data in the next column.

  This screen is an example of the Horizon*WP* Physician Portal Physician Face Sheet:



Horizon*WP* Physician Portal - STAR Medical Records Abstracting

If the ICD-10 Effective Date Parameter is activated, it is possible that both the ICD-10 and the ICD-9 diagnoses and procedures are entered in STAR Medical Records Abstracting.

If both are collected, they are both displayed in some STAR Medical Records Inquiry screens. However, the Horizon*WP* Physician Portal STAR Medical Records Abstracting displays are based on the patient's current account level ICD indicator on STAR.

For accounts with a "10" or a " B" ICD Indicator, the Horizon*WP* Physician Portal screens display only the ICD-10-CM diagnoses and procedures. For accounts with a "9" ICD Indicator, the Horizon*WP* Physician Portal screens display only the ICD-9 diagnoses and procedures.

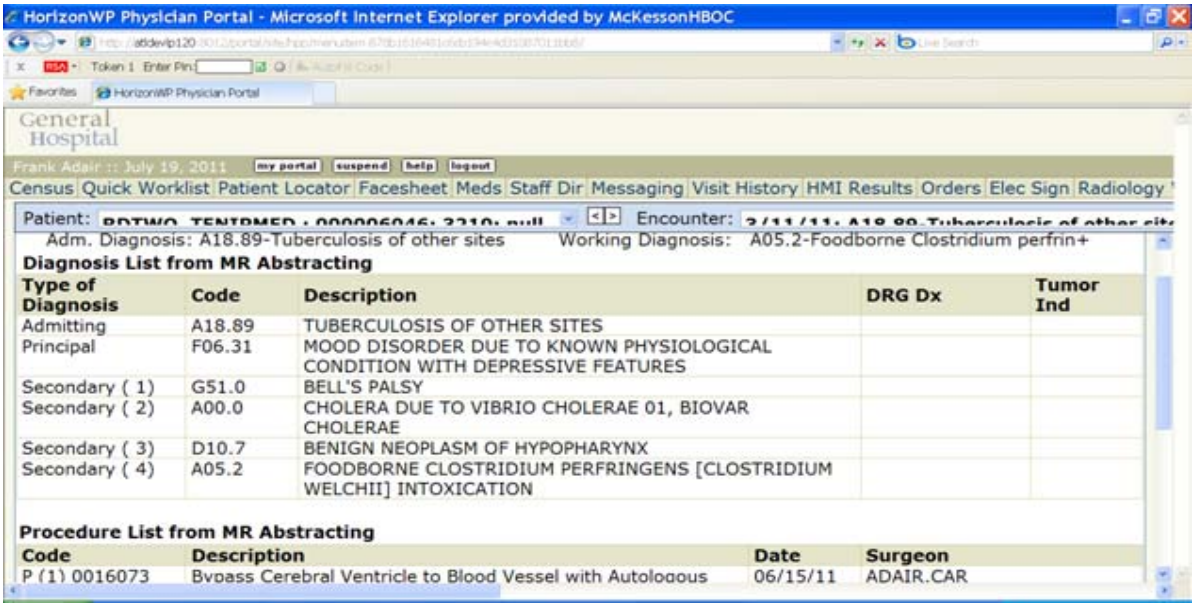
The following screens contain the changes related to the display of diagnoses and procedures data.

- Diagnosis and Procedures - Displays Visit-level Working & Admitting diagnoses in header.

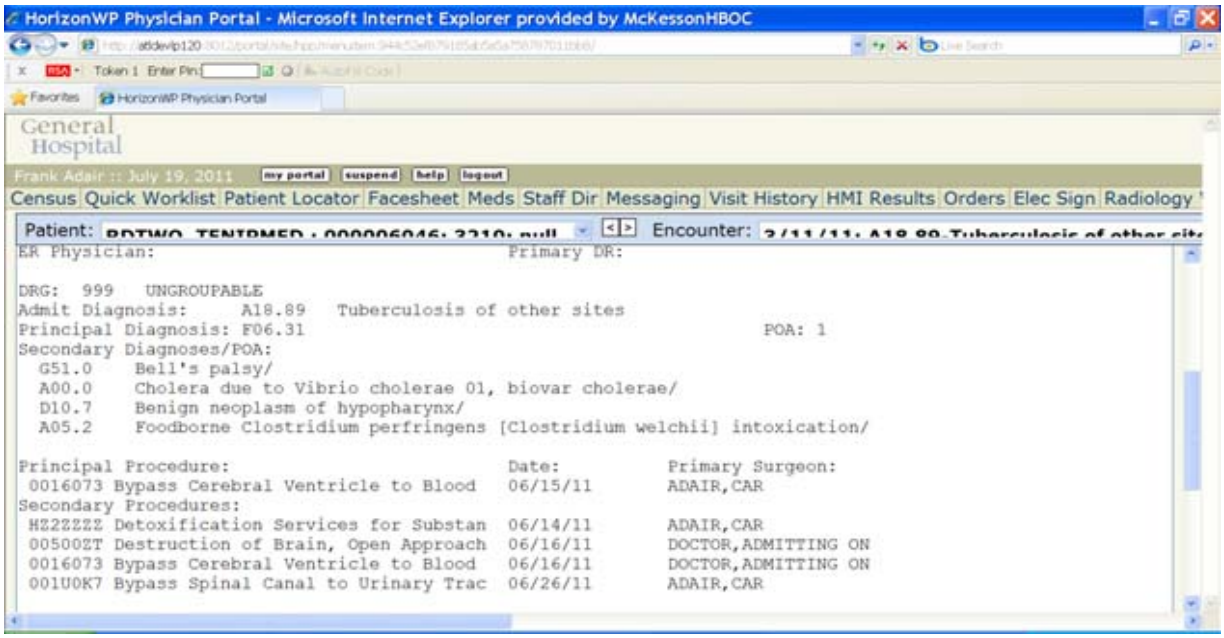
- Diagnosis and Procedures -Displays Admitting, Principal, and Secondary Diagnoses, Primary and Secondary Procedures entered through Medical Records Abstracting in the bottom half of screen. NO TRUNCATION

- Medical Record Coding Summary - Displays Admitting, Principal, and Secondary Diagnoses, Primary and Secondary Procedures from the main STAR Abstract Summary. Truncation based on character based form.

The following screen is an example of Diagnosis and Procedures - Visit Admit & Working in Patient Header, Diagnosis and Procedures entered in STAR Medical Records Abstracting:



The following screen is an example of the Medical Record Coding Summary:



MR ABSTRACTING DX'S and PROCEDURES
These fields display the diagnoses and procedures entered during STAR Medical Records Abstracting.

Horizon*WP* Physician Portal Radiologist Workflow - Order Diagnosis Revision

STAR has been updated to accommodate Order Revision changes in the Horizon*WP* Physician Portal STAR Radiologist Workflow module. After the STAR Patient Processing ICD-10 Effective Date Parameter is activated, revising the ordering diagnosis is not allowed if the patient's visit ICD-10 indicator is set to "10" for ICD-10 or "B" for both ICD-9 and ICD-10, or if there is already an existing ICD-10 ordering diagnosis.

Additionally, Order Diagnosis Revision in Horizon*WP* Physician Portal/RWF will be totally inactivated for both ICD-9 and ICD-10 diagnoses in Horizon*WP* Physician Portal Release 13.2. In Horizon*WP* Physician Portal Release 13.2 and later, the Order diagnosis revision hyperlinks will no longer display on the screen.

In the Radiologist's queue within the Radiologist Workflow module, the ordering diagnosis revision functionality will be disabled on the following screens:

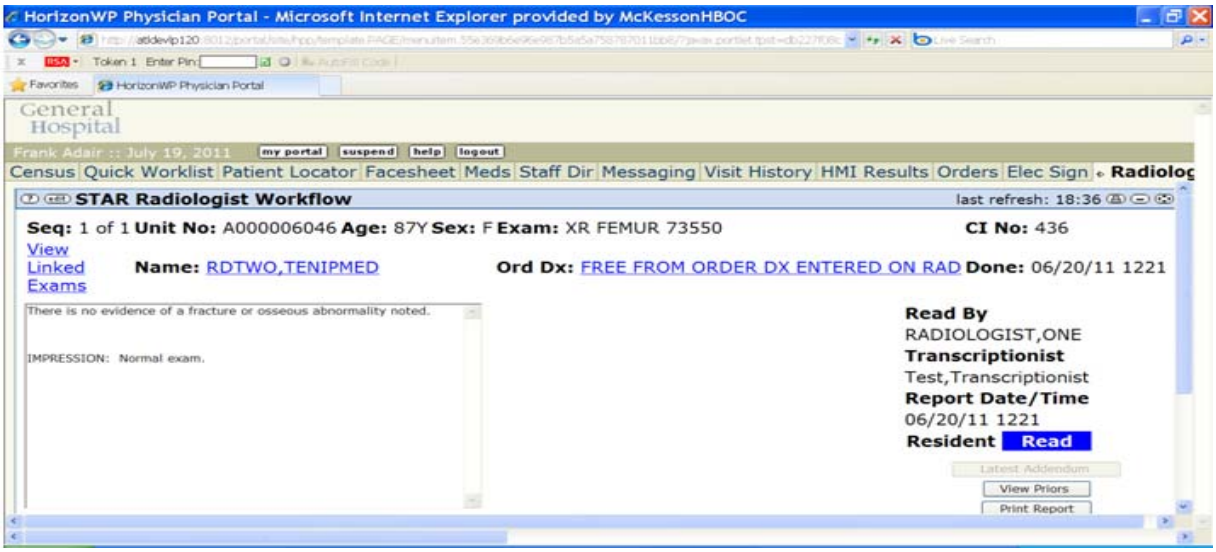
- Report display
- View Linked Exams function

Prior to Horizon^{WP} Physician Portal Release 13.2, a message is displayed on the screen that updates are not allowed for ICD-10 patients and diagnoses:

ICD9 Code update failed !!!
Reason: Visit uses ICD-10 coding - exam update not allowed !!

Revising ICD-9 ordering diagnosis is allowed, but only in Horizon^{WP} Physician Portal releases prior to 13.2.

The following screen is an example of RWF Review Queue. After Horizon^{WP} Physician Portal Release 13.2, the Revise Ordering Diagnosis hyperlink will not appear.



Implementation Steps - Build Process

Tables and Parameters

There are no specific table or parameter implementation steps in STAR Clinical Browser and the Horizon^{WP} Physician Portal STAR portlets/modules prior to the implementation of the ICD-10 coding.

There are no conversions or McKesson Implementation steps needed with this project.

When the USA ICD Effective Date set on STAR Patient Processing is past, the ICD-10 diagnoses and procedures changes described here will take place for STAR Clinical Browser and the Horizon^{WP} Physician Portal STAR portlets/modules.

After Horizon^{WP} Physician Portal Release 13.2 is implemented, the Radiologist Workflow Order Dx Revision hyperlink option will be disabled and unavailable for all patient's accounts (ICD indicator = 9,10, or B). This is not dependent on the USA ICD

Effective Date being set and past. You should be prepared for this change prior to implementing the new Horizon^{WP} Physician Portal release.

Forms

- STAR Forms

  The current base Physician Face Sheet form, cpffrm, uses form elements CAMQ101F for admitting and CAMP102F for working diagnosis display. These elements were modified in STAR Release 15.0 to display/print ICD-10 diagnoses when collected on the patient. If there is no ICD-10 diagnosis collected, then the ICD-9 diagnosis is printed.

  The truncation for these form elements is set to 33 characters, but the width of the column that displays the diagnoses accommodates only up to 27 characters, so some diagnoses overlay data in the next column. Therefore, two New Physician Face Sheet diagnosis elements were added to the "cpffrm" form in STAR base software. These elements truncate the diagnosis description at 26 characters appended with a "+" sign as a convention to indicate the description has been truncated. The current non-truncated ICD diagnoses continue to print on the forms if the new form element changes are not implemented.

  Review site-specific Physician Face Sheet reports to determine any changes that are required for custom form elements. Any custom Diagnosis elements on form cpffrm, or custom forms based on cpffrm, should be evaluated for deletion/addition of elements or retrofit of these changes. Changes to site-specific form library elements are required to accommodate printing the ICD-10-CM codes.

Form Elements Updated in Base

The elements listed below were added to print ICD-10 diagnoses on the Physician Face Sheet (base form = cpffrm) with a length of 26 characters. Review site-specific Face Sheet reports to determine where to implement the two new base form elements. If you are adding these elements on any STAR forms, the form needs to be generated for the changes to take effect.

Form elements within the Physician Face Sheet were modified as follows:

ELEMENTS DELETED:

Line, Column	Library (name)	Library (functional description)
13,14	CAMQ101F	ADMITTING DIAGNOSIS/ COMPLAINT
14,14	CAMP102F	Working Diagnosis

ELEMENTS INSERTED:

Line, Column	Library (name)	Library (functional description)
13,14	CAMQ283F	ADMITTING DIAGNOSIS, ICD10 OR ICD9
14,14	CAMP641F	WORKING DIAGNOSIS, ICD10 OR ICD9

NOTE: This step should be executed on the STAR Patient Care CPU. This information is included in the Implementation section of STI M24658.

Testing Guidelines

After activating the STAR ICD-10 Effective Date parameter in the testing environment, follow these steps.

1 Test patients should be admitted using various patient types, insurance carriers, insurance plans and financial class classes with varied effective dates for implementation.

- Post ICD-10 effective date, your test patients should have ICD indicators with 9, 10 and B. Patients with an admission date prior to the ICD-10 effective date will still have an ICD-9 indicator. Patients with insurance carrier, plan or financial class exceptions will have a B indicator. Patient admitted after the ICD-10 effective date (and no exceptions) would have a 10 indicator. Test scenarios should include patients with all three indicators.

- Use a variety of admitting diagnoses including principle, working, and secondary diagnoses. If using the DSM pointer table at your facility, enter a working diagnosis using the DSM pointer table for at least one patient admission.

- Enter various department orders so the ordering diagnosis fields can be verified.
- Enter various diagnoses and procedures in Medical Record Abstracting.
- In addition, all of the alternative coding methods need to be tested, use of the pointer tables, freeform and pulling from the DSM table. Testing needs to be done to be sure that if a patient requires both coding methods that the appropriate codes are pulled and displayed from the pointer table and that if freeform entries are used they are displayed in the diagnosis fields.
- Verify all methods of diagnosis entry on admissions and orders: ICD diagnosis pointer table (U-) Approved Dx list (Ad), Admit Dx list (Dx), ICD code entry and ICD table selection and free form where permitted.
- Work with the ADT / Patient Processing group at your facility to combine this effort.

2 Verify the correct Ordering, Admitting, and Working diagnoses, and procedures display/print on the Clinical Browser, Horizon^{WP} Physician Portal STAR portlets and Radiologist Workflow module screens and reports.

- Verify correct code, description, and lengths display/print as expected on screens and reports. All characters of the code and the appropriate number of characters of the description are seen on all screens.
- Verify these match the Diagnoses and Procedures as entered on STAR.
- Verify correct patient and diagnosis displays when the STAR Physician Table is facility split and/or the patient has multiple facility accounts.

Clinical Browser

1 Verify the Admitting Diagnosis and Working Diagnosis displays/prints on the following Clinical Browser screens:

- Patient Information - Admitting Dx, Working Dx - truncated to 35 characters, and a "+"
- Patient List Report - Working Dx - truncated to 48 characters and append a "+"
- Physician Face Sheet - Admitting Dx, Working Dx - 26 characters with a "+"
- Diagnoses & Procedures - Admitting Dx, Working Dx, MR Abstracting Dx's and Procedures; no truncation.

2 Diagnosis and Procedures - displays Visit-level Working & Admitting diagnoses in header; no truncation.

3 Verify correct diagnosis based on patient's ICD indicator 9, 10, B.

4 Diagnosis and Procedures - displays Admitting, Principal, and Secondary Diagnoses, Primary and Secondary Procedures entered through STAR Medical Records Abstracting in the bottom half of screen; no truncation.

Horizon*WP* Physician Portal STAR Portlets and Radiologist Workflow Module

1 Validate /verify that the correct Ordering, Admitting, and Working Diagnoses as applicable display/print on the following Horizon*WP* Physician Portal STAR portlets and Radiologist Workflow module screens and reports and they match the Diagnosis field displayed on STAR. Descriptions truncate at 35 characters with a "+" unless otherwise noted.

- Patient Demographics - Admitting and Working diagnoses
- Patient Nav Banner - Admitting diagnosis
- Working Patient List (WPL) - Admitting and Working diagnoses
- Station Census - Admitting and Working diagnoses
- Clinical Notes - Ordering diagnoses
- Radiology Results Viewer - Ordering diagnosis
- Horizon*WP* Physician Portal Radiologist Workflow module (RWF) - Admitting, Working, and ordering diagnoses
  - RWF Report Queue List - Ordering diagnosis
    - Get All Reports & Get Prelim Rpts - Ordering diagnosis
    - Patient Visit Info - Admitting and Working diagnoses
  - RWF Review Detail form
    - RWF Find Preliminary - Ordering diagnosis
    - RWF Get Previous Exams - Ordering diagnosis
    - RWF View Linked Exams - Ordering diagnosis
    - RWF View Priors - Ordering diagnosis
    - RWF Latest Addendum - Ordering diagnosis

- Patient Walk Order Rpt - Working diagnosis - truncated to 48 characters with a "+"
- Face Sheet - Admitting and Working diagnoses - 26 characters with a "+"
- Diagnosis and Procedures - displays Visit-level Working & Admitting diagnoses in header; no truncation

Horizon^{WP} Physician Portal - STAR Medical Records Abstracting

1 Verify the Horizon^{WP} Physician Portal STAR Medical Records Abstracting diagnoses and procedures display based on the patient's current account level ICD indicator on STAR.

- Once the ICD-10 Effective Date Parameter is activated, enter both the ICD-10 and the ICD-9 diagnoses and procedures in STAR Medical Records Abstracting on patients with ICD indicator of 9, 10, and B.
- For accounts with a "10" or a " B" ICD Indicator, verify the Horizon^{WP} Physician Portal screens display the ICD-10-CM diagnoses and procedures. If the ICD-10 diagnoses and procedures were not entered in STAR Medical Records Abstracting on the patients, the fields display blank.
- For accounts with a "9" ICD Indicator, verify the Horizon^{WP} Physician Portal screens display the ICD-9 diagnoses and procedures.

The following screens contain the changes related to the display of diagnoses and procedures:

- Diagnosis and Procedures - displays Admitting, Principal, and Secondary Diagnoses, Primary and Secondary Procedures entered through Medical Records Abstracting in the bottom half of screen; no truncation.
- Medical Record Coding Summary - displays/prints Admitting, Principal, and Secondary Diagnoses, Primary and Secondary Procedures from the main STAR Abstract Summary. Truncation is based on the character based form.

Reports/Printed Output

Each of the reports discussed needs to be tested. They should be tested with a mix of patients requiring ICD-10 only, ICD-9 only and both coding methods. If an ICD-10 code exists, it should be printed even if an ICD-9 code also exists. Additionally, the length and format of the codes and descriptions should be reviewed to be sure that the changes have been made and that the reports are still formatted so that they are useful to the users.

1 Verify the correct Diagnoses and Procedures as entered on STAR print on the following reports.

- Clinical Browser Patient List Report - prints the Working Diagnosis information on the Detailed Census report.

- Horizon^{WP} Physician Portal Patient Walk Order Report - Working diagnosis field print as entered for the account on STAR on the existing report.

Since the ICD-10 diagnosis descriptions may be significantly longer than ICD-9, there is the potential for the display of that field to overlap the account number field, so the diagnosis code and description display are truncated to 48 characters and a "+" is appended to indicate the description has been truncated.

2 Verify correct diagnosis prints on forms that use the "diagnosis" form library elements affected by this enhancement. These include the following Reports:

- Clinical Browser - Physician Face Sheet

- Horizon^{WP} Physician Portal Physician - Physician Face Sheet

The admitting and working diagnoses are printed on the Physician Face Sheet report as entered for the account on STAR. The base Physician Face Sheet form - "cpffrm" was adjusted to reflect the ICD-10-CM diagnosis codes and description. Verify the two new form elements truncate the admitting and working diagnosis display on the base Physician Face Sheet form "cpffrm". The truncation length for both the admitting and working diagnosis has been set to 26 characters with a "+" sign, so that the description will not overlay data in the next column.

Facilities using custom versions of the forms and elements need to evaluate and adjust them as necessary for these changes.

NOTE: For Patient List testing, the same program routine is shared by the Horizon^{WP} Physician Portal Walk Order Report and the Print Physician Patient List function within the Print Census menu in character-based processing, so there will be testing considerations.

3 Verify correct Diagnosis and Procedures prints on the Medical Record Coding Summary forms. See testing details in previous *Horizon^{WP} Physician Portal - STAR Medical Records Abstracting* section.

- Medical Record Coding Summary - prints Admitting, Principal, and Secondary Diagnoses, Primary and Secondary Procedures from the main STAR MR Abstract Summary. Truncation is based on the character based form.

Ordering Diagnosis Revision in Radiologist Workflow Module

1 Verify Order revision changes in the Radiologist's queue within the Radiologist Workflow module on the following screens as follows:

- Report display
- View Linked Exams function

2 Verify the Ordering Diagnoses can be revised for ICD-9 diagnosis codes.

3 Verify revising the ordering diagnosis will not be allowed if either the patient's visit ICD-10 indicator is set to "10" for ICD-10 or "B" for both ICD-9 and ICD-10, **or** if there is already an existing ICD-10 ordering diagnosis.

- Prior to Horizon^{WP} Physician Portal Release 13.2, verify that the following error message is displayed indicating that updates are not allowed for ICD-10 patients and diagnoses:

  ICD9 Code update failed !!!
  Reason: Visit uses ICD-10 coding - exam update not allowed !!

- Verify the "Ordering Dx" revision hyperlink is disabled (not displayed on screen) after Horizon^{WP} Physician Portal Release 13.2 is implemented.

Procedural Considerations

There are many procedural considerations for the ICD-10 implementation.

- Carefully consider the implementation date for the ICD-10 enhancements. Once the USA ICD10 Eff Date parameter has been set and the effective date has passed, all of the changes outlined in this section will go into effect for STAR Clinical Browser and the Horizon^{WP} Physician Portal STAR portlets/modules. All users must be made aware that both ICD-10 and ICD-9 processing will be running simultaneously for a period of time.

- Ensure that all users have a thorough understanding of the ICD Indicators and the reasons for the ICD Indicators, including backdating and the exceptions in the additional STAR Patient Processing parameters.

- Procedurally, the facility should be ready to use the ICD-10-CM and ICD-10-PCS codes before defining the effective dates for the implementation of this enhancement.

- Perform a thorough review of the documentation for this enhancement.

- After the documentation review, develop a plan for training the appropriate personnel and review the facility's current policies and procedures.

- Update the policies and procedures as needed. New policies and procedures may be required to address concerns that occur with this enhancement, such as backdating the admission date for a patient's account after the implementation date. Procedures to address edits when a patient's 10 indicator is changed to a 9 indicator due to backdating and affects the ICD codes entered prior to the change in the patient indicator.

- Ensure that users

  - are aware of the changes that are functional prior to the implementation of the STAR Patient Processing Parameter(s) and the designed usefulness of these changes while still using the ICD-9 coding

  - understand the additional changes that are functional after the implementation of the STAR Patient Processing Parameters

  - have reviewed all of their procedures and put the necessary changes in place.

Training Requirements

As with any new enhancement, it is necessary to train the staff on the changes.

- Training should be conducted to alert the Clinical Browser/ Horizon*WP* Physician Portal users to the differences in the processors as well in the screen displays and reports to accommodate the new ICD-10-CM diagnosis and procedure codes.

- Training should include alerting the Horizon*WP* Physician Portal Radiologist Workflow users that ICD-10 Ordering Diagnoses will not be revisable. The new alert message will display. ICD-9 diagnoses will still be revisable on Horizon*WP* Physician Portal releases prior to v13.2.

- Training should include alerting the Horizon*WP* Physician Portal Radiologist Workflow users that the Order Diagnosis Revision hyperlink option will be disabled and unavailable for all patient's accounts (ICD indicator = 9,10, or B) after Horizon*WP* Physician Portal Release 13.2 is implemented. This is **not** dependent on the USA ICD Effective Date being set and past. Users should be prepared for this change.

- Training requirements should involve a discussion with the end user about the new ICD-10-CM diagnosis and procedure codes, the changes and additions to policies and procedures, and their impact for the facility.

- Training time is minimal.

Implementation Considerations

- This is a multi-product enhancement, and the following is a list of the STAR ICD-10 STIs:
  - M23013 for STAR Patient Processing
  - M23127 and M23800 for STAR Medical Records
  - M23867 for STAR Utilization Management
  - M23015 for STAR Order Management
  - L8022 for STAR Laboratory
  - X5556 for STAR Radiology
  - X5562 for Horizon^{WP} Physician Portal/STAR Radiologist Workflow (combined w/ M24658)
  - P8129 for STAR Pharmacy
  - F9734 for STAR Patient Accounting
  - M23113 for STAR Integration
  - M24658 for STAR Physician Products
- Carefully consider the implementation date for the ICD-10 enhancements. Once the ICD-10 implementation date is set in the Hospital Facility Options, all of the changes outlined in this design will go into effect.
- Ensure that users have reviewed all applicable procedures and put the necessary changes in place.
- Train all personnel on the changes with the ICD-10 coding method. Any necessary form or menu changes must be made prior to setting the ICD-10 implementation date.
- Check with your vendors to be sure that they have addressed the impact that implementing ICD-10 will have on their systems.
- Although the flag to set the ICD-10 implementation date is contained in the Hospital Facility Options controlled by STAR Patient Processing, all STAR products will be affected by the setting of this date, and the enhancements across all STAR products will be implemented.

For specific STAR Patient Processing ICD-10 implementation steps and guidelines, refer to the STAR Patient Processing Overview and Implementation sections in this chapter.

Implementation Guidelines

- Perform a thorough review of the documentation when the enhancement STIs are received and prior to implementation.
- Perform applicable maintenance prior to the user-defined implementation date being entered in the STAR Patient Processing parameter(s).
- Review policies and procedures that are applicable and update and/or add new policies and procedures as required.
- Develop a training plan to cover changes when the STIs are moved to the system and when the user-defined implementation date is reached.
- Develop a test plan based on the facility requirements.
- Perform Regression testing after the STIs are received as well as additional testing after the implementation of the enhancement.
- Review the forms to determine any changes that are required for custom forms.
- Address the implementation of the ICD-10 coding and the temporary dual coding of ICD-9 and ICD-10 with all vendors to plan for any impact that may develop when the enhancement is implemented.

Documentation

In addition to the Enhancement Summary for Release 17.0 STAR Patient Processing, the *STAR ICD-10 Implementation Guide*, and the STI documentation, the following documentation has been updated as a result of this enhancement.

- Clinical Browser Release Notes
- Horizon*WP* Physician Portal Release Notes

ORDER MANAGEMENT

Overview

In conjunction with all of the STAR 2000 Modules/ Applications, STAR Order Management is providing changes to prepare collecting ICD-10 Diagnosis and Procedure codes to meet the Department of Health and Human Services (HHS) final rule. After a date is defined in the STAR Patient Processing parameter and the date is reached, the additional enhancements are functional for ICD-10.

NOTE: Refer to the STAR Patient Processing section (Overview and Implementation in this *STAR ICD-10 Implementation Guide* for a detailed explanation of implementing ICD-10 processing.

The STAR Patient Processing parameter, USA ICD10 Eff Date, on the Hospital Facility Options screen and the additional Patient processing ICD parameters, determines the ICD status indicator for the patient after the effective date defined in the parameter is reached:

ICD-9 Indicator - When the ICD enhancement is moved into the system, all patients have an ICD indicator of 9 until the effective date for the ICD-10 implementation. Patients admitted prior to the implementation date retain the 9 indicator through discharge.

ICD-10 Indicator - After the effective date is entered in the ICD-10 parameter and the date is reached, new admissions receive an ICD indicator of 10 while patients admitted prior to the effective date retain their 9 indicator for their current visit.

ICD B Indicator - In addition to the facility-level parameter to activate ICD-10, there are parameters that indicate exceptions for Insurance Plans, Insurance Carriers, and/or Financial Classes. For a patient that has one insurance accepting ICD-10 codes and another insurance continuing to use ICD-9 codes, the ICD indicator is a B. The B ICD indicator provides limited access in STAR Order Management to collect both ICD-9 and ICD-10 codes.

The system also looks to the USA ICD-10 Effective Date on the number assignment page of the admission/registration when the permanent account number is assigned, and when the admission date is revised. (If the admission date of a patient that was on or after the date defined in the **USA ICD-10 Eff Date field** is backdated to a date prior to the effective date in the parameter, the ICD indicator is updated to a 9 and the subsequent ICD codes collected are ICD-9-CM codes. However, it is up to the hospital to enter the missing ICD-9 codes that are only currently coded in ICD-10 for the account.)

Based on the dates defined in the parameters and the hierarchy of the defined parameters, STAR Order Management provides the appropriate options in the prompts to capture the ICD codes.

Common Clinical Impact by ICD-10 Implementation

The following table illustrates the collection of ICD codes scenarios:

Patient Account Status	STAR Action	ICD Indicator	ICD collected
Patients with active accounts admitted prior to reaching the implementation date for ICD-10 and accounts backdated to a date prior to the ICD 10 implementation date.	STAR continues to collect ICD-9 codes until these accounts are discharged.	9 (ABN Processing with ICD-9 only.)	STAR collects ICD-9 codes only
Patients with admission dates on or after the effective date defined in the ICD parameter.	STAR provides functionality to collect ICD-10 codes as appropriate.	10 (ABN Processing with ICD-10 only)	STAR collects ICD-10 codes only.
Patients with admission dates on or after the effective date defined in the facility ICD parameter but also have an insurance plan, insurance carrier, or financial class that indicates an exception to facility parameter.	STAR checks for exceptions to the effective date in the ICD-10 parameter. The additional parameters are checked in this order: Insurance Plan Insurance Carrier Financial Class Effective date on the number assignment page	B (ABN Processing with ICD-10 only)	STAR Order Management provides the limited ability to collect both ICD-9 and ICD-10 codes by using the enhanced ICD User Diagnosis Pointer Table.

ICD Diagnosis Pointer Table (U- option in the Order/Charge Entry Diagnosis/Reason for Exam prompt)

The changes provided by STAR Patient Processing provides the functionality to add the ICD-10-CM codes to the existing user-defined diagnosis with ICD-9-CM codes already defined in the table. Also additional user friendly defined diagnosis may be added with an ICD-9 and an ICD-10 code defined for each entry. As documented in Chapter 1, Order Management, Tables and Parameters, this table should be evaluated for additional entries using ICD-10 codes and also to add ICD-10 codes to the current ICD-9 entries.

The ICD Procedure Pointer Table and the DSM Pointer Table have the new field added to allow for the addition of the ICD-10 code to these tables to like the ICD Diagnosis Pointer Table

The functionality in the ICD Diagnosis Pointer Table to define an ICD-9 and an ICD-10 for each user-defined diagnosis provides the option in the order and charge entry processors to collect an ICD-9 code and an ICD-10 code for the patient account with

a defined exception in the additional parameters. The B ICD Indicator alerts the user to select an entry from the ICD Diagnosis Pointer table with an ICD-9 and an ICD-10 code if available. If the pointer table does not have the appropriate diagnosis defined, the other options in the Order Diagnosis/ Reason for Exam prompt provide the ability to select an ICD-10 code.

The ICD Indicator is referenced during order entry or charge entry to determine the codes that are displayed for selection when the ICD Diagnosis Pointer Table is accessed as well as which codes are filed for the order or charge.

The list provided when the ICD User Diagnosis Pointer table is accessed is directly determined by the ICD indicator. This is the only option available in STAR Order Management that provides the option to collect both a 9 and a 10 for the patients with a B indicator.

ICD Diagnosis Pointer Table Display Logic and System Messages in Order or Charge Entry

If the ICD Indicator is a 9, when the ICD User Pointer Table entries are displayed all of the entries in the ICD Pointer table with an ICD-9-CM code defined are displayed. If an entry has both an ICD-9 and an ICD-10, the entry displays for the user to select the option number. Even with both a 9 and a 10 in the entry selected, only the ICD-9-CM codes are collected and filed for the item being charged or ordered. Entries with only an ICD-10 code defined do not display in the list for selection if the ICD Indicator is a 9.

If the ICD Indicator is a 10, when the ICD User Pointer Table is displayed, all of the entries with a ICD-10 code defined in the table are displayed. If an entry has both an ICD-9 and an ICD-10, the entry displays for the user to select the option number. Even with both a 9 and a 10 in the entry selected, only the ICD-10-CM codes are collected and filed for the item being charged or ordered. Entries with only a ICD-9 code defined do not display in the list for selection if the ICD Indicator is a 10.

If the ICD Indicator is a B, when the ICD Pointer List is displayed all entries with a ICD-10 code and all entries with both a ICD-10 and a ICD-9 code defined in the table are displayed. The ICD-10 code and the ICD-9 code are collected and filed for the item being charged or ordered. Entries with only a ICD-9 code defined do not display in the list for selection if the ICD Indicator is a B.

If the ICD Indicator is a 9, and the ICD Pointer table is accessed and does not have any entries with a ICD-9 code defined, the following message is displayed to alert the user to the reason no entries are displayed for selection:

No ICD-9 Codes in the Pointer Table / Press Enter to return to prompt

The user must press enter to return to the prompt to select the ICD-9-CM codes using one of the other options available in the prompt or enter a free form diagnosis at the prompt on the order entry screen.

If the ICD Indicator is a 10 and the ICD Pointer table is accessed and does not have any entries with a ICD-10 code defined, the following message is displayed to alert the user to the reason no entries are displayed for selection:

No ICD-10 Codes in the Pointer Table / Press Enter to return to the prompt

The user must press enter to return to the prompt to select the ICD-10-CM codes using one of the other options available in the prompt or enter a free form diagnosis at the prompt on the order entry screen.

If the ICD Indicator is a B which indicates the need to collect both ICD codes and the table does not have any entries with both a ICD-9 and a ICD-10 code defined, but there are entries for ICD-10-CM codes, the following ***Warning*** message is displayed:

Collecting ICD-10 and 9! No entries defined with both! / Press Enter to select entries with ICD-10-CM codes

If the ICD Indicator is a B which indicates the need to collect both ICD codes and the table does not have any entries with both a ICD-9 and a ICD-10 code defined, and there are no entries for ICD-10-CM codes, the following message is displayed:

Collecting ICD-10 and 9! No entries defined with both! / No ICD10-CM codes defined / Press enter to return to prompt"

The user must press enter to return to the prompt to select the ICD-10-CM codes using one of the other options available in the prompt or enter a free form diagnosis at the prompt on the order entry screen.

NOTE: See the ICD Diagnosis Pointer Report explanation and example in Chapter 1, Order Management, Tables and Parameters in this STAR ICD-10 Implementation guide. The ICD Procedure Pointer Report and the DSM Pointer Report has the same format as the example ICD Diagnosis Pointer Report.) The ICD-10 codes defined in the ICD-10 Valid Diagnosis field are used for the ABN / Medical Necessity processing after implementing the ICD-10 Enhancement.

HCPCS PROCESSOR TABLE (VALID ICD CODES LISTED WHEN A- ENTERED IN THE ORDER DIAGNOSIS/REASON FOR EXAM PROMPT)

Changes were made to the HCPCS Processor Table to support adding the valid ICD-10 diagnosis codes using the same data entry functionality and a comment as appropriate. (Chapter 1, Order Management, Tables and Parameters for screen example and additional documentation). The ICD-10 codes defined in the ICD-10 Valid Diagnosis field are used for the ABN / Medical Necessity processing after implementing the ICD-10 Enhancement for patient with an ICD Indicator of 10 or B.

The A- option accesses the list of approved diagnosis in the HCPCS processor table based on the patient's ICD indicator. If the HCPCS has both ICD-9 valid codes and ICD-10 valid codes defined, the indicator determines which list displays for selection.

For additional details pertaining to the HCPCS Processor, reference the STAR Medical Records Sections of this *STAR ICD-10 Implementation Guide*.

OUTPATIENT CHARGE DOCUMENTATION (OPCD) – ABN PROCESSING

ABN Processing is performed based on the ICD indicator that determined the ICD code table/list for selection.

With the implementation of the ICD-10 enhancement, the accounts with a 9 ICD Indicator referencing the Valid ICD-9 linked in the HCPCS Processor continue with current ABN Processing. The ABN processing is based on the Valid ICD-9 codes defined in the HCPCS Processor. The two ABN Forms remain unchanged at this time for the patient accounts with a 9 indicator.

If the patient has an indicator of 10 or B, the ABN processing is performed referencing the ICD-10 valid diagnosis linked in the HCPCS processor table.

The ABN Forms are updated to print the ICD-10-CM diagnosis code on the form as appropriate.

Valid ICD-10-CM codes must be defined in the new ICD-10 field in the HCPCS Processor. When the Valid ICD-10-CM codes are added to the new field in the HCPCS Processor, these valid codes are displayed in the Approved Diagnosis list for patient accounts with a 10 indicator when accessed from the Order Diagnosis prompt using the A-.

After defining the valid ICD-10 codes, the A- option for a patient with a 9 indicator continues to access the valid ICD-9-CM list.

After defining the valid ICD-10 codes in the HCPCS Processor, the A- option for a patient with a 10 or a B indicator accesses the valid ICD-10-CM list only.

The CMS ABN (CCFABN) form updates the Reason for Denial library element (CCABNRD) in order to use the ICD-10 codes on the CCFABN if the patient account has the 10 or B ICD Indicator.

The Non-CMS form also has the Ordering Diagnosis field updated to support the ICD-10 codes for patients with a 10 or a B ICD indicator. Also on the Non-CMS form, the patients with a 9 ICD Indicator continues to use the ICD-9-CM code on the form.

All of the other functionality for ABN Processing or Medical Necessity remains unchanged including the ABN indicator.

NOTE: When an ABN is triggered by a ICD-10-CM diagnosis code, an internal indicator is passed to STAR Patient Accounting. The internal indicator piece (ICDIND) supplies STAR Patient Accounting the information that ABN checking was performed on an ICD-10 Diagnosis.

Piece Name	Piece / Multi-Piece #	Description	Format	Length	Multi-piece Delimiter
ICDIND	14	Indicates ABN Checking Performed on ICD-10 Diagnosis Null,0,1 (1=Yes)	N	1	N/A

ORDER AND CHARGE ENTRY

When performing order entry or charge entry on or after the effective date defined in the Hospital Facility parameter, **USA ICD-10 Eff Date,** the system references the ICD indicator. Depending on the ICD indicator detected for the patient's account, the appropriate prompt linked to the appropriate list displays for the Order Diagnosis/ Reason for Exam field with the options that are applicable.

NOTE: The availability of three of the options in the Order Diagnosis field prompt depends on the definition of the applicable parameters in the SIM department table. These parameters are Approved Diagnosis List, Admit Diagnosis List, and Free Form Diagnosis. The Free Form Diagnosis parameter is applicable to order entry only.)

If the ICD indicator detected is a 9, the prompt displayed for the Ordering Diagnosis field is the same prompt displayed prior to the implementation of ICD-10 codes.

If the ICD Indicator detected is a 10, the prompt displayed provides options to collect only ICD-10-CM codes.

If the ICD indicator detected is a B, the options available in the prompt provide the ability to collect ICD-10 code and limited access to collect ICD-9 code. The B ICD Indicator alerts the user to an exception in the other parameters. The ICD Diagnosis Pointer Table is the option in the prompt that may be used to collect the ICD-9 code along with the selection of the ICD-10 code. (Details of the functionality for the ICD Diagnosis Pointer Table are described previously in Chapter 2, in the Order Management section of this *STAR ICD-10 Implementation Guide*.)

In the following order entry screen, the ICD indicator is a B. In all of the options in the Reason for Exam / Order Diagnosis prompt, the ICD code list are ICD-10 codes except

the ICD Diagnosis Pointer Table which provides the option to select an entry that contains a 9 and a 10.

```
                General Hospital Department Orders Processor
(A) Radiology Order                                 Tue Aug 04, 2009 03:19 pm
No         Name             Sex    BD    Room    Physician     SVC ICD Status
0907800006 RDTWO,BOTHBACKDAT M  02/03/30 2123-01 COLEMAN,MICHA MED B  OPB 139
                                                                          1
 1 Item                                    2 L/R  3 Initials   4 Print Loc
   7110 XR CHEST PA 71010 6-2                 J S          Department
 5 Priority     6 Frequency     7 Schedule Days
   STAT           1               ONCE
 8 Times

 9 Start Date 10 Start Time    11 Duration     12 Stop Date  13 Stop Time
   08/04/09      15:19            1 Occur         08/04/09      15:19
14 Ordering Physician                          15 Performing Physician
   10 COLEMAN,MICHAEL K
16 Transportation                        17 Prompt Response / Message
   WHEELCHAIR
18 Reason for Exam                       19 Modifier
->
20 Comment


Enter ICD-10-CM diagnosis code--                                        |
             `U-`ser Dx, `A-`pproved Dx, `Dx` Admit, `-` for list
```

The following list provides a brief explanation of the Reason for Exam or Order Diagnosis order entry options in the prompt:

- *Enter ICD-10-CM diagnosis* - Enter a dash to display the entire list of ICD-10-CM codes to make a selection

```
                General Hospital Department Orders Processor
(A) Radiology Order                                 Tue Aug 04, 2009 03:19 pm
  No       Name             Sex    BD    Room    Physician     SVC ICD Status
0907800006 RDTWO,BOTHBACKDAT M  02/03/30 2123-01 COLEMAN,MICHA MED B  OPB 139
                                                                          1
 1 Item                                    2 L/R  3 Initials   4 Print Loc
   7110 XR CHEST PA 71010 6-2                 J S          Department
Page:01                          ICD-10-CM
( 1) A00.0    Cholera due to Vibrio cholerae 01, biovar cholerae
( 2) A00.1    Cholera due to Vibrio cholerae 01, biovar eltor
( 3) A00.9    Cholera, unspecified
( 4) A01.00   Typhoid fever, unspecified
( 5) A01.01   Typhoid meningitis
( 6) A01.02   Typhoid fever with heart involvement
( 7) A01.03   Typhoid pneumonia
( 8) A01.04   Typhoid arthritis
( 9) A01.05   Typhoid osteomyelitis
(10) A01.09   Typhoid fever with other complications
(11) A01.1    Paratyphoid fever A
(12) A01.2    Paratyphoid fever B
(13) A01.3    Paratyphoid fever C

Enter choice--
                       next pg(/ or PG DN)  Search(TAB)
```

To accommodate the increased number of characters in the ICD-10 codes and descriptions, the display of the ICD-10 diagnosis code table in STAR Order Management's Order and Charge entry has been changed to a single column display when the dash is entered. (The display of ICD-9-CM diagnosis codes table remains unchanged as a two column display.)

- *U- ser Dx* – Enter U- to gain access to the appropriate entries in the ICD Diagnosis Pointer table.

  The list provided when the ICD User Diagnosis Pointer table is accessed is directly determined by the ICD indicator. This is the only option available in STAR Order Management that provides the option to collect both a 9 and a 10 for the patients with a B indicator.

- *A- pproved Dx* – Enter A- to access the list of valid ICD-10-CM codes defined in the HCPCS Processor table.The Approved List of ICD-10-CM codes defined by the facility in the HCPCS Processor table are accessed by entering A-. If the ICD Indicator is a 10 or a B, only the Valid ICD-10-CM codes are displayed for selecting the ICD code in order or charge entry. If there are ICD-9-CM codes defined in the HCPCS Processor table, these ICD-9 codes are not displayed for a patient with a 10 or a B.

- *Dx Admit* – Enter Dx to display the Admitting Diagnosis List. The functionality and display of the Admitting Diagnosis List is dependent on the ICD Indicator of the patients.

  If the ICD indicator is either a 9 or a 10, there will only be ICD-9 or ICD-10 (respectively) available during the admission process. Therefore, in STAR Order Management, the Dx Admit list contains only ICD-9 codes for a patient with a 9 ICD Indicator and only ICD-10 codes for a patient with a 10 ICD Indicator.

  If a patient's ICD indicator is a B, and an ICD-9 diagnosis is on the Dx Admit list, in STAR Order Management, the ICD-9-CM code is displayed in dim video, with no option number so the ICD-9-CM code may not be selected. The following screen is the example of ICD-10 and ICD-9 codes on the Admitting Diagnosis list for a patient with a B indicator.

ADMITTING DIAGNOSIS SCREEN

```
                General Hospital Department Orders Processor
(A) Radiology Order                                  Tue Aug 04, 2009 03:19 pm
  No       Name             Sex    BD    Room    Physician    SVC ICD Status
0907800006 RDTWO,BOTHBACKDAT M  02/03/30 2123-01 COLEMAN,MICHA MED B  OPB 139
                                                                            1
 1 Item                                    2 L/R  3 Initials   4 Print Loc
   7110 XR CHEST PA 71010 6-2                     J S          Department
                          Admitting Diagnosis List
( 1) ADMITTING    G51.0    Bell's palsy
                  351.0    BELL'S PALSY
( 2) WORKING      D50.9    Iron deficiency anemia, unspecified
                  285.9    ANEMIA NOS
     PRINCIPAL    331.0    ALZHEIMER'S DISEASE
( 3) SECONDARY    B59      Pneumocystosis
                  486      PNEUMONIA, ORGANISM NOS









Enter Choice--
```

5. FREE FORM

Key in a dash and without hitting ENTER, type the free form / free test entry followed by enter. Free Form entry is permitted in Order Entry if the parameter for the SIM Department is set to permit Free Form. Free Form is not permitted in Charge Entry.

CHARGE ENTRY SCREEN

```
                   General Hospital Charge Processor
Laboratory Charge                                    Tue Aug 04, 2009 03:43 pm
  No        Name             Sex    BD    Room    Physician    SVC ICD Status
0907800006  RDTWO,BOTHBACKDAT M  02/03/30 2123-01 COLEMAN,MICHAMED B  OPB 139

 1 Item    2 Description                                        3 Initials
   1615      POTASSIUM,SERUM 022405                               J S
 4 Date of Service   5 Time                     6 Charging Physician
   08/04/09            1543                      10 COLEMAN,MICHAEL K
 7 Quantity/Minutes                            8 Price
   1                                             $14.89
 9 Charge Location                            10 Serial Number
   ER EMERGENCY ROOM
PROFESSIONAL FEE    11 Performing Physician        12 HCPCS Code

13 Order Diagnosis                                14 Modifier
->




Enter ICD-10-CM diagnosis code--                                      |
             `U-`ser Dx, `A-`pproved Dx, `Dx` Admit, `-` for list
```

The options in the prompt for the Order Diagnosis field on the Charge Screen above have the same functionality as described in the previous screens with one exception.

This is current functionality that Free Form entry is not supported in the Charge Entry Screen.

Order Review

The following screen is an example of the changes to Order Review to provide access to view the ICD-9 and ICD-10 code, if applicable. The change to the Outpatient Charge Documentation Screen in Order Review is also applicable to the OPCD screen in the Inactive Visit Order Review functionality.

The following screen shows Order Review utilizing the G option:

```
                    General Hospital Order Review Processor
                                                  Tue Aug 04, 2009 03:12 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
0907800006    RDTWO,BOTHBACKDAT M  02/03/30 2123-01 COLEMAN,MICHAMED B  OPB 139
 1 Order No.    2 Department          3 Item
   111            RESPIRATORY THERAP    2941 AEROSOL TREATMENT
 4 ABN     5 ABN Reason                          6 Frequency Limit
   SPS       SELF PAY/PATIENT SIGNED
 7 Med Nec Dup HCPCS          8 Med Nec Dup/Conflict HCPCS Override

 9 HCPCS/Modifiers           10 Conflicting HCPCS Code   11 Conflict Category
   55555
12 CCE Modifier Allowed      13 Order Dx ICD-9-CM
                                351.0-BELL'S PALSY
14 Order Dx ICD-10-CM
   G51.0-Bell's palsy




View order info(I), cancel(X), complete(C)--   |
                    next order(/) or previous order(/P) [/]
```

When the ICD Diagnosis Pointer table is used for the accounts with a B indicator, the ability to collect both a ICD-9 and a ICD-10-CM code exist. If the user selects a user-defined entry from the ICD Diagnosis Pointer table, the option may have both an ICD-10 and an ICD-9 code defined for the entry. For the accounts with a B ICD Indicator, if the entry selected has an ICD-10 and an ICD-9 present, the system files both versions of the ICD diagnosis codes from the user pointer table. The ICD-9-CM and the ICD-10-CM codes are both filed for use by STAR Patient Accounting. As a result of collecting and filing an ICD-9 and an ICD-10 for one item on the accounts with a B indicator, the review and inquiry screens have been updated to display both of the ICD codes.

Charge Inquiry

The charge screen below is an example of a B Indicator with an entry selected from the ICD-10 Diagnosis pointer. The ICD Diagnosis Pointer selected has an ICD-10 and an ICD-9 defined so both codes are filed.

```
                General Hospital Charge Inquiry Processor
                                                 Tue Jul 14, 2009 05:40 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
0907800006    RDTWO,BOTHBACKDAT M  02/03/30 2123-01 COLEMAN,MICHAMED B  OPB 118
 1 Charge Number  2 From CRT            3 Department            4 Type
   176              DP Data Processing    Laboratory              Charge
 5 Charge Location          6 Date Charged            7 Charged By
   ER EMERGENCY ROOM          07/02/09 00:41            Stephens,John
 8 Code   Bill Code          9 Description
   1615   7011-1615            POTASSIUM,SERUM 022405
10 QTY    11 Price        12 D/T of Service  13 Order Diagnosis
   1         $14.89          07/02/09 0010      ICD-9/ICD-10 Entries
14 Charging Physician  15 Performing Physician       16 Revenue Code
   10 COLEMAN,MICHAEL                                 LAB/CHEMISTRY
17 Accommodation Code      18 HCPCS Code       19 HCPCS Modifiers
                             84132
20 AdV Panel    21 Reference Facility  22 ABN  23 ABN Reason
                                       SPNS    PT SELF PAY & NO ABN SIGNED
24 Med Nec Dup HCPCS   25 Med Nec Dup/Conflict HCPCS Override 26 Take Home Drug

27 Conflict Code/Category     28 CCE Mod Allowed   29 Frequency Limit

(E)dit charge?--
                  next charge(/) or previous charge(/P) [/]
```

If the patient has a B indicator and an ICD-10 code and an ICD-9 code are captured for the charge, the Order Diagnosis field indicates the drop down screen exist by displaying ICD-10/ICD-9 Entries in the description field. The drop down screen is available only for accounts with a B ICD indicator and an ICD-9 and an ICD-10 code captured for the charge. In the Charge Inquiry Processor, you must enter E to Edit to access the options on the screen. If the patient has a B as the ICD Indicator in the header and ICD-10/ICD-9 Entries in the Order Diagnosis field, enter the option number to access the Order Diagnosis field which provides access to the drop down screen. The drop down screen displays the ICD-9 and the ICD-10 codes. The screen below is an example of the drop down screen. This is a view only display of the ICD Diagnosis codes.

Display of the ICD-9 and the ICD-10 codes in Charge Inquiry

```
             General Hospital Charge Inquiry Processor
                                                Tue Jul 14, 2009 05:40 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
0907800006    RDTWO,BOTHBACKDAT M  02/03/30 2123-01 COLEMAN,MICHAMED B  OPB 118
 1 Charge Number  2 From CRT            3 Department            4 Type
   176              DP Data Processing    Laboratory              Charge
 5 Charge Location          6 Date Charged            7 Charged By
   ER EMERGENCY ROOM          07/02/09 00:41            Stephens,John
 8 Code   Bill Code          9 Description
   1615   7011-1615            POTASSIUM,SERUM 022405
10 QTY    11 Price        12 D/T of Service  13 Order Diagnosis
   1         $14.89          07/02/09 0010   -> ICD-9/ICD-10 Entries

( 1)ICD-9 Diagnosis : 331.0-ALZHEIMER'S DISEASE
( 2)ICD-10 Diagnosis: G30.9-Alzheimer's disease, unspecified









Press NL--
```

The following Late Charge Inquiry detail screen is an example of a diagnosis selected from the User Diagnosis Pointer Table. The user-defined entry selected in this example had an ICD-9 and an ICD-10 and the patient's account had a B indicator when the patient's account was active, so both diagnosis are captured and displayed. The ICD-9 is displayed in the Order Diagnosis field and the ICD-10 diagnosis is displayed in the new ICD-10 Order Diagnosis field.

Late Charge Inquiry

```
            General Hospital Late Charge Inquiry Processor
                                                Tue Jul 14, 2009 05:46 pm
Late Charges for  Eligible DepartmenDuring the 24 Hours Ending  07/05/09

  No.          Name              Sex    BD
000006036     RDTWO,BOTHOPB      M  02/02/30
 1 Charge Number            2 From CRT               3 Department
                              DP Data Processing       Laboratory
 4 Charge Location          5 Date Charged           6 Charged By
   ER EMERGENCY ROOM          07/05/09 21:46           Stephens,John
 7 Code   Bill Code         8 Description
   1615   7011-1615          POTASSIUM,SERUM 022405
 9 QTY    10 Price        11 D/T of Service  12 Order Diagnosis
   1        $14.89           04/17/09 0001      351.0-BELL'S PALSY
13 Charging Physician       14 Performing Physician
   5234 HANCE,JENNIFE
15 Revenue Code             16 Accommodation Code              17 HCPCS Code
   LAB/CHEMISTRY                                                  84132
18 HCPCS Modifiers          19 ABN          20 ABN Reason
                               No              Late Charge - Patient not ava
21 Frequency Limit          22 Type         23 ICD-10 Order Diagnosis
                               Charge          G51.0-Bell's palsy
Press NL--
                                  next (/) [/]
```

ABN Duplicate HCPCS Processing Processor

This processor is used to make edits to OPCD information for CMS compliant patient only

```
        General Hospital ABN Duplicate HCPCS Processing Processor
                                                Tue Jul 14, 2009 05:48 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
0907800006    RDTWO,BOTHBACKDAT M  02/03/30 2123-01 COLEMAN,MICHAMED B  OPB 118
 1 Charge Number  2 From CRT            3 Department            4 Type
   176              DP Data Processing    Laboratory              Charge
 5 Charge Location          6 Date Charged             7 Charged By
   ER EMERGENCY ROOM          07/02/09 00:41             Stephens,John
 8 Code   Bill Code         9 Description
   1615   7011-1615          POTASSIUM,SERUM 022405
10 QTY    11 Price        12 D/T of Service  13 Order Diagnosis
   1        $14.89           07/02/09 0010      ICD-9/ICD-10 Entries
14 Charging Physician  15 Performing Physician       16 Revenue Code
   10 COLEMAN,MICHAEL                                  LAB/CHEMISTRY
17 Accommodation Code     18 HCPCS Code        19 HCPCS Modifiers
                             84132
20 AdV Panel    21 Reference Facility  22 ABN  23 ABN Reason
                                       SPNS    PT SELF PAY & NO ABN SIGNED
24 Med Nec Dup HCPCS   25 Med Nec Dup/Conflict HCPCS Override 26 Take Home Drug

27 Conflict Code/Category     28 CCE Mod Allowed   29 Frequency Limit

Enter field number or '/' starting field number--
```

In the ABN Duplicate HCPCS Processing when the ICD codes are accessed in the Order Diagnosis field and the drop screen displays the ICD-9 and the ICD-10 codes,

these ICD codes may be edited. In the example below, the diagnosis may be changed using the options in the prompt.

```
        General Hospital ABN Duplicate HCPCS Processing Processor
                                                  Tue Jul 14, 2009 05:48 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
0907800006    RDTWO,BOTHBACKDAT M  02/03/30 2123-01 COLEMAN,MICHAMED B  OPB 118
 1 Charge Number  2 From CRT            3 Department            4 Type
   176              DP Data Processing    Laboratory              Charge
 5 Charge Location          6 Date Charged            7 Charged By
   ER EMERGENCY ROOM          07/02/09 00:41            Stephens,John
 8 Code   Bill Code         9 Description
   1615   7011-1615           POTASSIUM,SERUM 022405
10 QTY    11 Price        12 D/T of Service  13 Order Diagnosis
   1         $14.89          07/02/09 0010   -> ICD-9/ICD-10 Entries

( 1)ICD-9 Diagnosis : 331.0-ALZHEIMER'S DISEASE
( 2)ICD-10 Diagnosis: G30.9-Alzheimer's disease, unspecified









Enter ICD-9-CM diagnosis code--                                          |
             `U-`ser Dx, `A-`pproved Dx, `Dx` Admit, `-` for list
```

The following logic is associated with the prompts in the ABN Duplicate HCPCS Processor when both codes were collected:

- When only a new ICD-10 is selected using the hyphen or direct code entry option, the ICD-9 Code is blanked because this is no longer a part of the User Pointer codes defined together in the ICD Pointer Diagnosis table.

- When only a new ICD-9 code is selected using the hyphen or direct code entry option, the new 9 code is filed without blanking the ICD-10 because the ABN/ Medical Necessity processing is based on the ICD-10 code.

- When the **U-** option is selected, if the option selected has both a 10 and a 9 defined, the newly selected codes replace the current codes as appropriate. If a selection is selected with only a 10 defined, the 9 is blanked. A selection with only a 9 is not provided for selection for a B indicator patient.

- When the **A-** option is selected, only ICD-10 codes are displayed from the HCPCS Processor table as Valid ICD Codes. If a 10 is selected, the 9 is blanked.

- When the **Dx** option is selected, the diagnosis entered during the admission process and the working diagnosis are displayed. The ICD-10 codes are displayed for selection with the ICD-9 codes displayed in dim with no selection option numbers.

NOTE: If the Order Diagnosis field is updated for any order or charge, it may alter the display of the applicable ABN/Medical Necessity fields; however, all of the

applicable changes do not necessarily display until the screen is accepted, exited and reentered. Changes to this information update the Charge Detail Screen in STAR Patient Accounting. This information does not go directly on the UB claim form.

STAR Order Management Reports

The STAR Order Management Reports and the elements used to print and display the Order Diagnosis code have been updated to print and display the ICD-10 codes as the default for all of the patients with the 10 and the B indicator. The patients with the 9 indicator continue to print and display the ICD-9 codes until they are discharged.

If an ICD-10 code exists it is printed on the STAR Order Management Reports, Requisitions, and Online Reports that include a diagnosis code. If no ICD-10 code exists for the patient to print or display, then the ICD-9 code is printed if one is present. The ICD-10-CM diagnosis codes are the default to print or display.

The ICD-10-CM diagnosis codes utilize 8 spaces for the code and greater than 60 spaces for the description. On some of the forms the description is truncated to the current 33 characters due to space restriction on the forms.

The base forms have been adjusted to reflect the ICD-10-CM diagnosis code and description. Facilities may have created custom versions of the forms and elements listed below. The forms and elements must be evaluated to determine the updates needed for the custom versions.

REQUISITIONS - BUT NOT LIMITED TO THE FOLLOWING LIST OF FORMS AND ELEMENTS.

FORM code	Description	Working Diagnosis	Order Reason (Diagnosis)	Treatment/Diagnosis on Order
CDFEC	Cardiology Requisition	CAMP101F	CATC41F	
CDFEE	EEG Requisition	CAMP101F	CATC41F	
CDFLB	LAB Requisition	CAMP101F	CATC41F	
CDFXR	RAD Requisition	CAMP101F	CATC41F	
CDFGN	RT Requisition	CAMP101F		CATC42F
CDFRT	RT Requisition	CAMP101F		CATC42F

CDFPT	PT Requisition	CAMP101F		CATC42F
CDFCNS	Department Consult Requisition	CAMP101F		
CDFDT	Dietary Requisition	CAMP101F		
CDFNH	Nourishment Requisition	CAMP101F		

ADMITTING DIAGNOSIS IN THE PATIENT BLOCK ON CERTAIN REPORTS

Admitting Diagnosis element was updated in STAR Patient Processing. STAR Order Management uses the updated element

- Patient Care Profile
- Nursing Plan of Care
- Care Reference Sheet
- Discharge Plan

CLINICAL MANAGEMENT REPORTS AND ONLINE REPORT DISPLAY

Medicare Therapy Information Form (CCMCX) includes the Admitting Diagnosis (CAMQ102F) and the Working diagnosis (CAMP101F).

Patient Follow Up Report (CCMFX) ALSO INCLUDES THE ADMITTING AND WORKING DIAGNOSIS.

ONLINE REPORTS IN CLINICAL MANAGEMENT:

- Work list:
- Patient Information Header includes the Working Diagnosis
- Ordering Information includes the treatment diagnosis.
- Nursing Reports - Verify length constraints of I-10 descriptions for space limitations.
  - **DWSCWP2,**PR (Modify) – Custom Worksheet prints working diagnosis
    DWSCWP,PR (Modify) – Custom Worksheet also prints surgery procedure
    CWSGEN,PR (Modify) – General Worksheet, prints diagnosis from the station

- **DWSAO1**,PR (Modify) – Active Order Worksheet, prints diagnosis from station, modify same as above. Also same changes for surgical procedure.

- **DWSADL**,PR (Modify) – ADL/Misc. Worksheet prints diagnosis from station global, modify same as above.

- **CWSDT**,PR (Modify) – Diet Worksheet – prints working diagnosis from station global, same changes needed as above.

- **DFBP**,PR (Modify) – Fluid Balance Report, prints working diagnosis from **DFBPM**,PR (Modify) – Fluid Balance Report also same changes as above

- **DVSP1**,PR (Modify) – Vital Signs Reports, same as above.

- **DVSPM1**,PR (Modify) – Another version of same routine above which requires the same changes.

- **CCED7**,PR (Modify) – subroutine PB formats the patient block for specific nursing reports which prints the patient data including the working diagnosis. This is used in the following nursing reports:

    - Patient Assessment Report
    - Patient Inactive Assessment Report
    - Patient Problem List
    - Patient Assessment Worksheet
    - Patient Discharge Plan
    - Patient Critical Pathways
    - Patient Care Profiles – Base and User-Defined PCPs, print & display
    - Patient Care Reference Sheet
    - Nursing Plan of Care
    - Clinicare Patient Results Print
    - Patient IO Summary report
    - PCR Audit

Integration Requirements

In the HL7 IB and OB Order (ORM) Message, there is now the ability to send both the ICD-10 and the ICD-9 codes.

Only 2.2b Interface processes have been updated Facility must be using a 2.2b interface for the ICD-10 functionality for order and charge messages. The messages and fields impacted by this change are:

- OBR.31 – ORM order message
- FT1.19 – P03 charge message

Update to Inbound and Outbound Charge & Order message (ORM & P03) to accept both the ICD-9 & ICD-10 Diagnosis Codes and store these codes appropriately.

- Updates to the outbound OBR to support the sending of ICD-10-CM diagnosis codes and ICD-9-CM Diagnosis.
- Updates to the inbound OBR to support receiving the ICD-10-CM diagnosis codes and the ICD-9-CM Diagnosis codes.
- Updates to support receiving the ICD-10-CM codes and the ICD-9-CM codes inbound in the FT1.

STAR Order Management stores only one I-9 and one I-10 code per order or charge, if multiple I-9 and/or multiple I-10 codes are passed in the FT1.19, the first entry of each is used as STAR Order Management uses only one I-9 & I-10 code per order/charge.

An indicator is added to every diagnosis code or procedure code sent in an HL7 message to flag the code as ICD-10 or ICD-9. For ICD-10 codes, a 0 indicator is used, and for ICD-9 codes a 9 indicator is used.

Implementation Steps – Build Process

There are no implementation steps for STAR Order Management. (Please reference the STAR Patient Processing Implementation Steps in Chapter 2 of this implementation guide.

Below are tables that should be evaluated to validate correct table loads for use in the system:

- ICD-10-CM Maintenance
- ICD-10-PCS Maintenance

Tables to evaluate for adequate maintenance before the implementation date for the ICD-functionality:

- ICD Diagnosis Pointer Table
- HCPCS Processor Table

Review the ICD Diagnosis Pointer Table Report to validate the table maintenance

Evaluate the forms and menus for custom forms and menus to update as needed.

Testing Guidelines

1. Access the ICD User Pointer table to validate the maintenance has prepared the ICD-10-CM entries in the table for use with the implementation of ICD-10 codes. Define additional user codes or update some of the previous codes to as appropriate for the ICD-10 implementation.

2. Perform the same steps in the ICD User Procedure Pointer and the DSM Pointer tables in order to validate these tables are ready for use with the ICD-10 codes as appropriate.

3. Print the ICD User Pointer table reports to use in reviewing and validating the entries as appropriate,

4. Access the HCPCS Processor table to validate the access to the ICD-9 and ICD-10 codes in the appropriate Valid ICD Codes fields.

5. Validate the entries with valid ICD-10 codes have been defined as needed for the implementation of the ICD-10 coding. (Verify the HCPCS being used are defined in the FIM as expected.)

6. Work with the ADT / Patient Processing group at your facility to combine the effort required for the following admission steps.

7. Admit patients using various patient types, insurance carriers, insurance plans, and financial classes with varied effective dates for implementation to create patients with a B and a 10 ICD Indicator. (Admit patients on a date prior to the implementation date to have patients with a 9 ICD Indicator.)

8. During admissions, enter varied admitting diagnosis including Admitting, Working, Principal, and Secondary.

9. For one admission, select the working diagnosis from the DSM Pointer Table. In the Working Diagnosis, verify the actual ICD-10 code is displayed instead of the user-defined code.

10. On one admission, enter a free text entry as one of the admitting diagnosis to verify the display in the list and in STAR Order Management.

11. If your facility uses the STAR Order Management Medical Necessity Checking, admit several patients as outpatients in a bed with CMS compliant insurance. Use one of the insurance carrier or plan with delayed effective dates to include a B indicator patient.

12. For the CMS compliant patient, enter orders and charges to trigger the ABN checking, Duplicate HCPCS, and cross reference checking to validate the functionality.

13. Using the Order Entry Access points, enter Orders for STAR Laboratory, STAR Radiology, a Clinical Management department such as Respiratory Therapy, and some of the other ancillary departments. Use different options in the Ordering Diagnosis / Reason for Exam prompt including a free text entry.

14. After entering orders, check Order Review for all of the orders that have diagnosis entered. Use the G option in the prompt to review the new fields on this screen for the display of ICD-9 and ICD-10 codes. Validate the display of the free form entry in STAR Patient Accounting in the Account Inquiry function.

15. Review the requisitions for the orders.

16. If the facility uses STAR Navigator in Order Management to review Order Review or Results Inquiry, log on to a Navigator session to validate the GUI functions,

17. Enter multiple manual charges for the patients using the options available in the Order Diagnosis prompt. In Charge Inquiry, review the charges and the ICD-9 codes. Review these charges in STAR Patient Accounting in the Account Inquiry option.

18. Cancel some of the charges as permitted in Charge Inquiry and review the credits in Charge Inquiry and account inquiry.

19. Enter multiple manual Credits. Review the credits in Charge Inquiry and Account Inquiry.

20. For the CMS compliant patient, review the ABN / Duplicate HCPCS Processor data and make some edits to the ICD-10 and ICD-9 diagnosis.

21. Make some edits to the ICD codes using the Edit PA Charge function. Review these in Account Inquiry.

22. Enter some late charges and late credits and review the results.

23. Access the PA Charge Reversal function in STAR Patient Accounting. Select some patients and charges to reverse. Review these results in Account Inquiry and Charge Inquiry.

24. Review the patient and station demand reports as applicable in your facility.

25. After the Orders are entered, review the HL7 audit or queue to verify the ICD-9 and ICD-10 in the outbound messages and, if appropriate, and, as applicable, the inbound audit.

26. Verify orders and charges received inbound correctly store both I-9 and I-10 codes if passed inbound**.**

27. Verify order and charges are sent outbound with both the I-9 and I-10 codes in the repeating fields (OBR.31 & FT1.19) with the correct coding systems.

28. McKesson recommends performing a full regression testing prior to implementing the ICD-10 enhancement.

Procedural Considerations

Perform a thorough review of the documentation for this enhancement.

After the documentation review, develop a plan for training the appropriate personnel and review the facility's current policies and procedures

Update the policies and procedures as needed. New policies and procedures may be required to address concerns that occur with this enhancement, such as backdating the admission date for a patient's account after the implementation date. Procedures to address edits when a patient's 10 indicator is changed to a 9 indicator due to backdating and affects the ICD codes entered prior to the change in the patient indicator.

Policies and procedures must be developed to consistently enter the coding as appropriate based on the ICD Indicators and changes to the indicators as insurance or financial class changes.

Users should be aware of the changes that are functional prior to the implementation of the STAR Patient Processing Parameter(s) and the designed usefulness of these changes while still using the ICD-9 coding.

Users should understand the additional changes that are functional after the implementation of the STAR Patient Processing Parameters.

Users must have a thorough understanding of the ICD Indicators, and the reasons for the ICD Indicators including backdating and the exceptions in the additional STAR Patient Processing parameters.

Procedurally, the facility should be ready to use the ICD-10-CM and ICD-10-PCS codes before defining the effective dates for the implementation of this enhancement.

All system interfaces must be evaluated to determine if the ICD-10 codes will be sent outbound and /or received inbound.

Customized code including interfaces must be evaluated for possible impact by this enhancement.

Training Requirements

The changes necessary to add the ICD-10 processing throughout STAR Order Management impacts most users of the system. The changes impact both the character-based and GUI functions and requires that all users are educated on the changes made to the system.

Training requirements include some form of training for all users. For many users, this training involves a discussion with the end user about the new ICD-10-CM diagnosis and procedure codes, the changes and additions to policies and procedures, and the impact to the facility.

Anyone who is responsible for entering any diagnosis or procedure codes must be educated on the ICD-10 coding method as well as how to support dual coding methods on a single account.

New procedures must be reviewed during training to assure a consistent outcome when making edits to the diagnosis or the patient indicators.

Users must have a thorough understanding of the ICD Indicator in relation to the ICD code selections. Also, users must be trained on the impact when a patient‘s admission date is backdated to a date prior to the implementation date. These users should understand the procedures to edit the ICD codes as needed.

Implementation Considerations

HARDWARE

Hardware performance for this enhancement is not affected.

SOFTWARE

This is a multi-product enhancement and the following is a list of the STAR Release 15.0 STIs:

- M23013 for STAR Patient Processing
- M23127 and M23800 for STAR Medical Records
- M23867 for STAR Utilization Management
- M23015 for STAR Order Management

- L8022 for STAR Laboratory
- X5556 for STAR Radiology
- P8129 for STAR Pharmacy
- F9734 for STAR Patient Accounting
- M23113 for STAR Integration

INTERFACE/INTEGRATION

The changes for the ICD-10-CM diagnosis codes are available only in the STAR 2.2b interface. Changes are applicable to outbound orders and inbound orders and charges.

SYSTEM ADMINISTRATION

No additional security or user privileges are required for this enhancement. No additional database management or system administration is required to implement or maintain the new functionality.

IMPLEMENTATION GUIDELINES

- Perform a thorough review of the documentation when the enhancement STIs are received and prior to implementation.
- Perform applicable maintenance prior to the user-defined implementation date being entered in the STAR Patient Processing parameter(s).
- Review policies and procedures that are applicable and update and/or add new policies and procedures as required.
- Develop a training plan to cover changes when the STIs are moved to the system and when the user-defined implementation date is reached.
- Develop a test plan based on the facility requirements.
- Perform Regression testing after the STIs are received as well as additional testing after the implementation of the enhancement.
- Review the Forms and Menus to determine any changes that are required for custom forms and menus.
- Address the implementation of the ICD-10 coding and the temporary dual coding of ICD-9 and ICD-10 with all vendors to plan for any impact that may develop when the enhancement is implemented.

Documentation

In addition to the Enhancement Summary for Release 15.0, the *STAR ICD-10 Implementation Guide*, and the STI documentation, the following is a list of updates to the reference guides:

Enhancement Topic	Document	Chapter
Order Entry	*Order Management/ Charge Processing Volume I*	Chapter 1: Order Management
Charge Entry	*Order Management/ Charge Processing Volume II*	Chapter 7: Charge Processing
Demographic Header	*throughout*	
ICD Diagnosis Pointer Table ICD Procedure Pointer Table	*Tables Volume*	Chapter 3: General Tables
Reports	*Order Management/ Charge Processing Volume II*	Chapter 9: Online Reports/ Forms
Patient Care Profile Report Nursing Plan of Care Report Care Reference Sheet	*Care Planning and Documentation Module*	Chapter 6: Reports
Patient Care Profile	*Care Planning and Documentation Module*	Chapter 9: Build and Format PCPs and Worksheets
Medicare Therapy Medical Information Form Patient Follow Up Report	*Clinical Management Module*	Chapter 9: Midnight Processing
Work list	*Clinical Management Module*	Chapter 8: Online Reports

LABORATORY

Overview

The updates to STAR Laboratory to accommodate ICD-10 diagnosis processing are pervasive throughout the system and affect every order and charge related processor. ICD-10 diagnosis processing only takes affect if the facility level parameter, *USA ICD10 Effective Date*, is set and the effective date has passed. This parameter is accessed from STAR Patient Processing; therefore Patient Processing determines when/if the account is prompted for ICD-10 diagnosis and procedure codes. Before the effective date is set, the facility needs to consider the impact to all hospital departments. The facility should be ready to fully embrace ICD-10 diagnosis coding before this parameter is set.

If the *USA ICD10 Effective Date* is set, but the patient's admission date is before the effective date, the system continues to prompt and process ICD-9 diagnosis codes for the patient. For these patients, ABN processing continues to occur on the ICD-9 diagnosis. You are able to identify these patients by the ICD 9 indicator in the Patient Demographic header throughout the STAR applications.

If the *USA ICD10 Effective Date* is set, and the patient's admission date is on or after the effective date, the system automatically prompts only for ICD-10 Diagnosis codes when entering or editing diagnosis codes in order and charge processors. For CMS compliant patients, the system performs ABN processing only on ICD-10 diagnosis. You are able to identity these patients by the ICD 10 indicator in the Patient Demographic header throughout the STAR applications.

If particular Insurance Plans, Insurance Carriers, or Financial Classes still require ICD-9 diagnosis and procedure codes after the *USA ICD-10 Effective Date* is past, then those exceptions should be listed in the Insurance Plan table, the Insurance Carrier table, and/or the Financial Class table. (Please see the Patient Processing and Patient Accounting sections of this Guide for more details). For patients admitted with these exceptions, both ICD-9 and ICD-10 diagnoses may be collected in order and charge processors. You are able to identity these patients by the ICD B indicator in the Patient Demographic header throughout the STAR applications.

Application Changes

PATIENT DEMOGRAPHIC HEADER

```
                    General Hospital Patient Inquiry Processor
                                                  Wed Jun 10, 2009 02:15 pm
Unit #     Name            Sex Birthdate  Room    Physician     Srv ICD Status
A000006016 RDTWO,NINEOPMED  F  01/05/1931 211-1   ADAMS,JAY K   MED  9  OPB 86
```

The patient demographic header has been updated to display the ICD diagnosis and procedure indicator wherever a patient is selected in any STAR Laboratory processor. The ICD indicator is designed to assist the user in diagnosis entry in order and charge processors. After the ICD-10 effective date, patients may display either a 9, 10, or B (both) indicator.

- ICD: 9 – indicates the patient requires ICD-9 coding only. This would apply to patients whose admission date is prior to the USA ICD-10 Effective date. Current ICD-9 diagnosis processing applies for these patients. Prompts and diagnosis lists are unchanged. ABN processing occurs on ICD-9 diagnoses.

- ICD:10 – indicates the patient requires ICD-10 coding. Prompts and diagnosis lists are changed for ICD-10. ABN processing occurs only on ICD-10 diagnosis.

- ICD: B – indicates the patient requires both coding methods due to insurance plan, insurance carrier or financial class exceptions. Prompts and diagnosis lists are changed for ICD-10. ABN processing occurs on ICD-10 diagnosis only.

ORDER, ACCESSION AND CHARGE PROCESSORS

The following processors have been updated to accommodate ICD-10 diagnosis processing.

- Order Entry

- Accessioning

- Revise Order

- Case Login

- Previous Case Accession

- Result Reporting (/O, /A, /OO, /AA). This includes AP Result Reporting and Adv Micro Result Reporting.

- Label output from the above processes (Barcode and Dot matrix)

The following screen is from STAR Laboratory Order Entry. The prompts and screens are essentially the same in the other processor listed.

```
        General Hospital Central Processing Specimen Order Processor
                                                    Thu Jan 03, 2008 01:57 pm
Unit #     Name            Sex Birthdate   Room    Physician     Srv ICD Status
A100005173 TEST,PATIENT A   M  04/04/1964  2009-1  JEKYL SECOND, MED  B  I/P 337
 1 Priority     2 Collection Time    3 Copy To            4 Default Printer
   STAT           01/03/08 1401        None                 Printer Matrix

   Code  Description                          Section        Specimen Type
   Specimen Modifier          Ordering Physician
 5 Ordering Comment                         Ordering Diagnosis
   1390  ELECTROLYTE PANEL, SERUM             CHM-Chemistry  Blood
                            JEKYL SECOND,JONAS
                                             Y









Enter ICD-10-CM diagnosis code--                                        |
       `U-`ser Dx, `A-`pproved Dx, `Dx` Admit, `-` for list [working Dx]
```

The following prompt displays when the patient ICD indicator is a 10 or B.

Enter ICD-10-CM diagnosis code-- |
`U-`ser Dx, `A-`pproved Dx, `Dx` Admit, `-` for list [working Dx]

ICD TABLE DISPLAY

Only ICD-10 diagnoses are available if you enter the code directly or enter a hyphen (-) for list. The table display has been changed from a 2-column display to a 1-column display so more of the ICD-10 description may display to aid in selection.

```
      General Hospital Central Processing Specimen Order Processor
                                                  Thu Jan 03, 2008 01:57 pm
Unit #     Name            Sex Birthdate   Room    Physician     Srv ICD Status
A100005173 TEST,PATIENT A   M  04/04/1964  2009-1  JEKYL SECOND, MED  B  I/P 337
 1 Priority     2 Collection Time    3 Copy To            4 Default Printer
   STAT           01/03/08 1401        None                 Printer Matrix

   Code  Description                          Section        Specimen Type
   Specimen Modifier          Ordering Physician
 5 Ordering Comment                        Ordering Diagnosis
   1390  ELECTROLYTE PANEL, SERUM             CHM-Chemistry  Blood
 Page:01                    ICD-10-CM diagnosis codes
( 1) A00.0    CHOLERA DUE TO VIBRIO CHOLERAE 01, BIOVAR CHOLERAE
( 2) A00.1    CHOLERA DUE TO VIBRIO CHOLERAE 01, BIOVAR ELTOR
( 3) A00.9    CHOLERA UNSPECIFIED
( 4) A01.0    TYPHOID FEVER
( 5) A01.00   TYPHOID FEVER, UNSPECIFIED
( 6) A01.01   TYPHOID MENINGITIS
( 7) A01.02   TYPHOID FEVER WITH HEART INVOLVEMENT
( 8) A01.03   TYPHOID PNEUMONIA
( 9) A01.04   TYPHOID ARTHRITIS

Enter choice--
                      next pg(/ or PG DN)  Search(TAB)
```

USER DIAGNOSIS TABLE

The User diagnosis table (U-) may contain both ICD-9 and ICD-10 diagnosis pointers, based on the definition of ICD-9 and ICD-10 codes in the *ICD Diagnosis Pointer* table and the patient ICD indicator. A particular diagnosis may actually point to both ICD-9 and ICD-10 diagnosis codes. If the insurance plan, carrier, or financial class exceptions for ICD-9 are indicated for the patient, the user table would be the only choice for diagnosis entry in order to obtain both ICD-9 and ICD-10 diagnosis codes. The User pointer table limits display based on the ICD patient indicator as follows:

- ICD = 9 – Displays entries with 9 or both; Only ICD-9 diagnosis is filed.
- ICD = 10 – Display entries with 10 or both; Only ICD-10 diagnosis is filed.
- ICD = B – Display entries with 10 or both; Both ICD-9 and ICD-10 diagnosis are filed.

If the ICD Indicator is a 9, and the ICD Pointer table does not have any entries with a ICD-9 code defined, the following message is displayed to alert the user to the reason no entries are displayed for selection:

No ICD-9 Codes in the Pointer Table

If the ICD Indicator is a 10 and the table does not have any entries with a ICD-10 code defined, the following message is displayed to alert the user to the reason no entries are displayed for selection:

No ICD-10 Codes in the Pointer Table

If the ICD Indicator is a B which indicates the need to collect both ICD codes and the table does not have any entries with both a ICD-9 and a ICD-10 code defined, the following ***Warning*** message is displayed:

Collecting ICD-10 and 9! No entries defined with both!

See the Order Management section of this Guide for more information on the messages.

APPROVED DX LIST

The approved (A-) diagnosis list displays only the valid ICD-10 diagnosis defined for the HCPCS code specified for the ordered SIM/FIM item for patients with an ICD indicator of 10 or B.

DX ADMIT LIST

The Dx Admit list (Dx) lists all diagnoses entered at admission. If a patient's ICD indicator = B, and an ICD-9 diagnosis is on the Dx Admit list, it displays in dim video, with no option number so it may not be selected. If the ICD indicator is either 9 or 10, there would only be ICD-9 or ICD-10 (respectively) available at admission. Therefore, the Dx Admit list would only contain ICD-9 for a 9 patient and ICD-10 for a 10 patient.

```
    General Hospital Central Processing Specimen Order Processor
                                                    Thu Jan 03, 2008 01:57 pm
Unit #     Name            Sex Birthdate   Room    Physician     Srv ICD Status
A100005173 TEST,PATIENT A   M  04/04/1964  2009-1  JEKYL SECOND, MED  B  I/P 337
1 Priority     2 Collection Time    3 Copy To            4 Default Printer
   ASAP           02/15/08 1218        None                Printer Matrix

   Code  Description                          Section        Specimen Type
   Specimen Modifier          Ordering Physician
 5 Ordering Comment                         Ordering Diagnosis
   1390  ELECTROLYTE PANEL, SERUM             CHM-Chemistry  Blood
                            JEKYL SECOND,JONAS
Page:01                    Admitting Diagnosis List
( 1) ADMITTING    D61.1  DRUG INDUCED APLASTIC ANEMIA
( 2) WORKING      G93.6  CEREBRAL EDEMA
( 3) PRINCIPAL    I25.5  ISCHEMIC CARDIOMYOPATHY
     SECONDARY    757.9  INTEGUMENT ANOMALY NOS




Enter choice--
```

The above screen is an example of Dx admit list with ICD-10 and ICD-9 diagnosis in dim.

The working diagnosis continues to be the default response.

No matter how the diagnosis is selected, the ordering diagnosis display on the order entry screen remains the same at 31 characters code and description.

BARCODE LABELS

Barcode labels may be generated as output from ordering, accessioning, case login and resulting processes. The following base barcode labels either use or are eligible to use the diagnosis barcode element, DG.

Use Barcode Element DG	2,MCD; 3,CTD; 8,MLM; 8,MLW (Type#, Format ID)
Eligible to Use Barcode Element DG	4,BYD; 4,SID; 5,MAD; 6,MPD (Type#, Format ID)

The labels print the diagnosis description only. If the patient has a 9 indicator, the ICD-9 diagnosis prints; otherwise the ICD-10 diagnosis always prints. There are no outward application changes to barcode elements/labels.

DOT MATRIX LABELS

Dot matrix labels may be generated as output from ordering, accessioning, case login and resulting processes. The following base dot matrix labels either use or are eligible

to use the diagnosis element: Master Collection Labels, Container Labels, Master Accession Labels, Bay Labels, Micro Media Labels.

The labels print the diagnosis description only. If the patient has a 9 indicator, the ICD-9 diagnosis prints; otherwise the ICD-10 diagnosis always prints. There are no outward application changes to dot matrix elements/labels.

OUTPATIENT CHARGE DOCUMENTATION (OPCD) PROCESSING

Outpatient Charge documentation and associated ABN processing is updated to accommodate ICD-10 diagnosis entry.

The following processors are affected:

- Order Entry
- Miscellaneous Charge/Credit
- Professional Billing
- Histotech Processing
- Adv Micro Result Reporting (menu options with billing and Misc Charges)

When an order is entered on a CMS compliant patient, the following Outpatient Medicare Diagnosis/Modifier Entry screen displays.

```
      General Hospital Central Processing Specimen Order Processor
                                                 Wed Jan 23, 2008 02:54 pm
Unit #     Name            Sex Birthdate   Room    Physician     Srv  ICD Status
A100007256 CMS,PATIENT      F  01/07/1940          TESTDOC,WESFO MS    10 OPO
Outpatient Medicare Diagnosis/Modifier Entry
Seq Item                          Diagnosis                    Modifier
1   ELECTROLYTE PANEL, SERUM









Enter ICD-10-CM diagnosis code--                                        |
             `U-`ser Dx, `A-`pproved Dx, `Dx` Admit, `-` for list
```

The following prompt displays when the patient ICD indicator is 10 or B.

Enter ICD-10-CM diagnosis code-- |
`U-`ser Dx, `A-`pproved Dx, `Dx` Admit, `-` for list

Only ICD-10 diagnoses are available if you enter the code directly or enter a hyphen (-) for list. The table display has been changed from a 2 column display to a 1 column display so more of the ICD-10 description may display to aid in selection. The table display has to allow for an 8 character code plus description.

```
       General Hospital Central Processing Specimen Order Processor
                                                  Thu Jan 03, 2008 01:57 pm
Unit #     Name            Sex Birthdate   Room    Physician     Srv ICD Status
A100005173 TEST,PATIENT A   M  04/04/1964  2009-1  JEKYL SECOND, MED  B  I/P 337
 1 Priority     2 Collection Time    3 Copy To            4 Default Printer
   STAT           01/03/08 1401        None                 Printer Matrix

   Code  Description                          Section        Specimen Type
   Specimen Modifier          Ordering Physician
 5 Ordering Comment                          Ordering Diagnosis
   1390  ELECTROLYTE PANEL, SERUM             CHM-Chemistry  Blood
 Page:01                    ICD-10-CM diagnosis codes
( 1) A00.0    CHOLERA DUE TO VIBRIO CHOLERAE 01, BIOVAR CHOLERAE
( 2) A00.1    CHOLERA DUE TO VIBRIO CHOLERAE 01, BIOVAR ELTOR
( 3) A00.9    CHOLERA UNSPECIFIED
( 4) A01.0    TYPHOID FEVER
( 5) A01.00   TYPHOID FEVER, UNSPECIFIED
( 6) A01.01   TYPHOID MENINGITIS
( 7) A01.02   TYPHOID FEVER WITH HEART INVOLVEMENT
( 8) A01.03   TYPHOID PNEUMONIA
( 9) A01.04   TYPHOID ARTHRITIS

Enter choice--
                       next pg(/ or PG DN)  Search(TAB)
```

USER DIAGNOSIS TABLE

The User diagnosis table (U-) may contain both ICD-9 and ICD-10 diagnosis pointers, based on the definition of ICD-9 and ICD-10 codes in the *ICD Diagnosis Pointer* table. A particular diagnosis may actually point to both ICD-9 and ICD-10 diagnosis codes. If the insurance plan, carrier, or financial class exceptions for ICD-9 are indicated for the patient, the user table would be the only choice for diagnosis entry in order to obtain both ICD-9 and ICD-10 diagnosis codes. The User pointer table limits display based on the ICD patient indicator as follows:

- ICD = 9 – Displays entries with 9 or both; Only ICD-9 diagnosis is filed.
- ICD = 10 – Display entries with 10 or both; Only ICD-10 diagnosis is filed.
- ICD = B – Display entries with 10 or both; Both ICD-9 and ICD-10 diagnosis are filed.

If the ICD Indicator is a 9, and the ICD Pointer table does not have any entries with a ICD-9 code defined, the following message is displayed to alert the user to the reason no entries are displayed for selection:

No ICD-9 Codes in the Pointer Table

If the ICD Indicator is a 10 and the table does not have any entries with a ICD-10 code defined, the following message is displayed to alert the user to the reason no entries are displayed for selection:

No ICD-10 Codes in the Pointer Table

If the ICD Indicator is a B which indicates the need to collect both ICD codes and the table does not have any entries with both a ICD-9 and a ICD-10 code defined, the following ***Warning*** message is displayed:

Collecting ICD-10 and 9! No entries defined with both!

See the Order Management section of this Guide more information on messages.

APPROVED DIAGNOSIS LIST

The approved (A-) diagnosis list displays only the valid ICD-10 diagnosis defined for the HCPCS code specified for the ordered SIM/FIM item for patients with ICD indicator of 10 or B.

DX ADMIT LIST

The Dx Admit list (Dx) lists all diagnoses entered at admission. If a patient's ICD indicator = B, and an ICD-9 diagnosis is on the Dx Admit list, it displays in dim video, with no option number so it may not be selected. If the ICD indicator is either 9 or 10, there would only be ICD-9 or ICD-10 (respectively) available at admission. Therefore, the Dx Admit list would only contain ICD-9 for a 9 patient and ICD-10 for a 10 patient.

INQUIRY PROCESSORS

The following Inquiry screens display diagnosis information in STAR Laboratory and have been updated to accommodate ICD-10 diagnosis processing.

- Patient Inquiry – (G) General Information

  The Order Diagnosis field has been expanded from 20 to 24 characters to accommodate the longer ICD-10 diagnosis descriptions. Other fields on the same line have been moved to the right to accommodate the increased field length.

- Patient Inquiry – (D) Admitting Diagnosis List

```
              General Hospital Patient Inquiry Processor
                                                  Tue Jan 29, 2008 03:04 pm
Unit #     Name            Sex Birthdate   Room    Physician     Srv ICD Status
A100007256 CMS,PATIENT      F  01/07/1940          TESTDOC,WESFO MS   B  OPO HME
                            Acct #: A0802300003

                  Code           Description
ADMITTING         D61.1      DRUG INDUCED APLASTIC ANEMIA
WORKING           G93.6      CEREBRAL EDEMA
PRINCIPAL         I25.5      ISCHEMIC CARDIOMYOPATHY
SECONDARY         757.9      INTEGUMENT ANOMALY NOS









Press NL--
```

The Dx Admit List display has been changed to display ICD-9 diagnoses in dim video to be consistent with the display in order entry and other processors using the Dx Admit list to select a diagnosis.

PATIENT INQUIRY – (O) OUTPATIENT CHARGE DOCUMENTATION

The Order Diagnosis field has been expanded from 30 to 46 characters to accommodate the longer ICD-10 diagnosis descriptions.

PATIENT INQUIRY – (H) HISTORY CARDFILE, HISTORY CARDFILE NETWORK, CARDFILE INQUIRY

The History cardfile display report available in these processors has been updated to accommodate the ICD-10 diagnosis description. The Order Diagnosis (form element LHCFODX) on the History Cardfile printed report has been expanded from 15 to 21 characters to accommodate the longer ICD-10 diagnosis descriptions.

ADMINISTRATIVE REPORTS

The Miscellaneous Charge/Credit Report (display and print) and the Professional Billing report are updated to accommodate the ICD-10 diagnosis. In addition, if a free form order diagnosis is used to process a miscellaneous charge or credit on a CMS compliant patient (by taking the default order diagnosis), it now displays/prints on the Miscellaneous Charge/Credit report.

PATIENT REPORTS

The following patient reports have been updated for ICD-10 diagnosis processing. If both ICD-10 and ICD-9 diagnoses are collected, only the ICD-10 diagnosis description prints on applicable patient reports.

- Long Reports

  The order diagnosis prints in the Long report demographic header. The following elements are affected. The demographic header for the long report is defined in Long Report Parameters, located in Maintenance-Report/Printer/Fax. The correct diagnosis is retrieved from the patient's record.

  - Print Hsp Info / Print Pat Demo Lits – LPFS1
  - Print Hsp Info / Suppress Pat Demo Lit – LPFS2
  - Suppress Hsp Info / Print Pat Demo Lit – LPFS3
  - Suppress Hsp Info / Suppress Pat Demo Lit – LPFS4
  - Long Report Hdr (Alt) – LPFS5

- Archive Lab Summary

  There are parameters to print the working diagnosis in the demographic header and the ordering diagnosis for the test on the Archive Summary report. This does not use a form, but retrieves the correct diagnosis from the patient's record.

INTERFACES

Interfaces that have the ability to pass diagnosis information are updated to accommodate ICD-10 diagnosis processing. The following interfaces are affected:

- HL7 Blood Bank Interface
- Non-HL7 Blood Bank Interfaces, such as Hemocare and Western Star
- Reference Lab Interface
- Lab Instrument Interfaces

Implementation

There are no specific implementation steps for STAR Laboratory. The USA ICD Effective Date is set from STAR Patient Processing. When the effective date is past, ICD-10 diagnoses and procedures may be collected for the patient.

The ICD Diagnosis Pointer Table and HCPCS Table must be updated prior to the ICD-10 effective date. The ICD Diagnosis Pointer table (User Dx table) is updated from STAR Patient Care. This table has to be updated with ICD-10 diagnoses. This table is accessed by STAR Laboratory during diagnosis entry by entering **U-**. The ICD Diagnosis Pointer Table (U-) is the only method available for collecting both the ICD-9 and ICD-10 diagnosis codes in order and charge entry after the ICD-10 effective date

for those patients with a B indicator. Therefore, it is essential that this table be reviewed and updated and procedures put in place for those users responsible for order and charge entry. In addition, the HCPCS table must be updated with the valid ICD-10 diagnosis codes. This table is updated from STAR Medical Records. The effort to update both these tables should be coordinated with the other STAR Clinical coordinators.

Testing Guidelines

Test patients should be admitted using various patient types, insurance carriers, insurance plans and financial class. Post ICD-10 effective date, your test patients should have ICD indicators with 9, 10 and B. Patients with an admission date prior to the ICD-10 effective date still have an ICD-9 indicator. Patients with insurance carrier, plan or financial class exceptions have a B indicator. Patient admitted after the ICD-10 effective date (and no exceptions) have a 10 indicator. Test scenarios should include patients with all 3 indicators. If your facility uses Outpatient Charge Documentation/ Medical Necessity processing, admit patients that are CMS compliant. Use a variety of admitting diagnoses including principle and secondary diagnoses. If the DSM pointer table is used in your facility, enter a working diagnosis using the DSM pointer table for at least one patient admission.

1. Verify the following processes, functions and output:

    - Diagnosis entry in order and charge processors. Edit the order diagnosis in the following processors: Order Entry, Accessioning, Revise Order, Case Login, Previous Case Accession and Result Reporting (/A, /O, /AA, /OO). Test all methods of diagnosis entry: ICD diagnosis pointer table (U-), Approved Dx list (A-), Admit Dx list (Dx), ICD code entry and ICD table selection and free form where permitted.

    - Verify correct diagnosis entry and prompts based on patient ICD indicator 9, 10, B

    - Verify ICD-9 and ICD-10 diagnosis files in Charge Inquiry for B patients when selecting a diagnosis with both ICD-9 and ICD-10 definition from the User Diagnosis pointer table

    - Specimen Reject several accessions and verify correct diagnosis for Specimen Rejection Re-order.

    - Verify diagnosis on applicable barcode labels.

    - Verify diagnosis on applicable dot matrix labels.

2. Verify the following processes in Outpatient Charge Documentation (OPCD) for CMS Compliant Patients.

- Diagnosis entry in the following order and charge processors: Order Entry, Miscellaneous Charge/Credit, Case Login, Professional Billing (attached to a SIM item and charged at resulting), Histotech Processing (add/delete block), Adv Micro Result Reporting (menu options with billing and Misc Charges). Test all methods of diagnosis entry: ICD diagnosis pointer table (U-), Approved Dx list (A-), Admit Dx list (Dx), ICD code entry and ICD table selection and free form where permitted.

- Verify correct diagnosis entry and prompts based on patient ICD indicator 9, 10, B

- Verify ICD-9 and ICD-10 diagnosis files in Charge Inquiry for B patients when selecting a diagnosis with both ICD-9 and ICD-10 definition from the User Diagnosis pointer table

- Verify appropriate ABN processing occurs.

- Verify output on ABN.

3. Inquiry Processors. Verify the correct diagnosis displays on the following screens.

   - Patient Inquiry - (G) General Information, Order Diagnosis field.

   - Patient Inquiry - (D) Admitting Diagnosis List, Code and Description.

   - Patient Inquiry - (O) Outpatient Charge Documentation, Order Diagnosis field.

   - Patient Inquiry - (H) History Cardfile, Order Diagnosis (description only).

4. Verify the correct diagnosis prints on History Cardfile, printed report.

5. Verify diagnosis displays/prints correctly on the following reports.

   - Miscellaneous Charge/Credit - display.

   - Miscellaneous Charge Report

   - Professional Billing Report

6. Verify correct ordering diagnosis description prints on long report for each demographic header type.

   - Print Hsp Info / Print Pat Demo Lits – LPFS1

   - Print Hsp Info / Suppress Pat Demo Lit – LPFS2

- Suppress Hsp Info / Print Pat Demo Lit – LPFS3
- Suppress Hsp Info / Suppress Pat Demo Lit – LPFS
- Long Report Hdr (Alt) – LPFS5

7. Verify correct working and ordering diagnosis description prints on Archive Summary report.
8. Verify diagnosis in interface transactions for all applicable interfaces. Some interfaces that may pass diagnosis information include:
   - Blood Bank interface
   - Reference Lab interface
   - Instrument interfaces
9. Verify diagnosis for all orders/charges in STAR Patient Care Charge Inquiry and STAR Patient Accounting Account Inquiry.

Procedural Considerations

The facility must review the documentation and consider the impact to all departments before implementing the enhancement. Procedurally, the facility should be ready to fully embrace the use of ICD-10-CM and ICD-10-PCS codes before defining the effective dates for the implementation of this enhancement.

Procedural and education considerations consist of informing appropriate personnel of these changes. The following should be considered. It is necessary that all users be made aware that both ICD-10 and ICD-9 processing are running simultaneously for a period of time. This requires that the users pay close attention to the account indicators and be familiar with both coding systems. Procedurally, the users need to review their current diagnosis entry process to be sure that the change to ICD-10 coding doesn't require any changes. Because not all providers are switching to ICD-10 at the same time, there is bound to be some confusion about the dual coding system, and which codes each account requires. If the patient's insurance information changes during the visit, or the patients admission date is adjusted there may be a change in the coding requirements. The system is unable to force any recoding in the event a patient's coding method is changed, therefore procedures must be in place to review the claims before billing.

Any third-party system interface or ADT interface must be evaluated to determine if the ICD-10 codes can and should be entered.

Hospitals that have customized code should be evaluated to determine if this enhancement has any impacts on the customization.

Training Requirements

Training requirements may involve a discussion with the end user about the new ICD-10-CM diagnosis and procedure codes and their impact for the facility.

Also training should be conducted to alert the Laboratory users to the differences in the Order and Charge processors, as well as in the Patient Inquiry displays, printed output and management reports. Any user responsible for order and charge entry should be included in training.

Documentation

The following documentation is updated as a result of this enhancement.

Enhancement Topic	Document	Chapter
Long Report	*General Applications Volume I*	Chapter 8: Patient Reports
Archive Lab Summary Report	*General Applications Volume II*	Chapter 16: Archive Patients/Archive Lab Summaries
Demographic header changes	throughout the STAR Laboratory documents	
Order Entry	*General Applications Volume I*	Chapter 2: Order Management Chapter 4: Accessioning
Bar code	*Maintenance Functions Volume II*	Chapter 10: Bar Code
	General Applications Volume I	Chapter 1: Inquiry Processors
History Cardfile	*General Applications Volume II*	Chapter 15: History Cardfile
Miscellaneous Charge/Credit Professional Billing Report	*General Applications Volume II*	Chapter 12: Billing and Charging

RADIOLOGY

Overview

NOTE: For ***Canadian*** systems these changes are not applicable. However, Radiology Diagnosis display fields have been changed with this enhancement and these changes are apparent in a Canadian System. Please review these changes in the "Inquiry Processor" section below.

In conjunction with all of the STAR 2000 Modules/ Applications, STAR Radiology is providing changes to prepare collecting ICD-10 Diagnosis codes to meet the Department of Health and Human Services (HHS) final rule. After a date is defined in the STAR Patient Processing parameter and the date is reached, the additional enhancements are functional for ICD-10.

The updates to STAR Radiology to accommodate ICD-10-CM diagnosis processing are pervasive throughout the system and affect every order and charge related processor. ICD-10 diagnosis processing takes affect only if the facility level parameter, *USA ICD10 Effective Date*, is set and the effective date has passed. This parameter is accessed from STAR Patient Processing; therefore Patient Processing determines when/if the account is prompted for ICD-10 diagnosis and procedure codes. In the Insurance Plans, Insurance Carriers, and the Financial Class tables, additional effective dates may also be defined. These dates represent exceptions to the effective date defined in the Hospital Facility parameter.

By utilizing these parameters, the STAR Patient Processing application determines when/if the account requires ICD-9-CM codes, ICD-10-CM / ICD-10-PCS codes, or both ICD-9-CM or ICD-10-CM / ICD-10-PCS codes. From this determination, STAR Patient Processing sets the ICD indicator for the patient's account. The ICD indicators are 9 for ICD-9-CM entry, 10 for ICD-10-CM, or B for both the ICD-9-CM and ICD-10-CM. This ICD indicator is referenced by the STAR Radiology application when the Diagnosis field is accessed to determine the appropriate prompt to display in the order entry and charge entry prompt.

NOTE: Please refer to Chapter 2, STAR Patient Processing section, Overview and Implementation in this Implementation Guide for a detailed explanation of implementing ICD-10 processing including detailed information pertaining to the STAR Patient Processing parameters, the effective dates, admit dates, the hierarchy of the parameters, adding, deleting, re-sequencing insurance plans or carriers, and the change in admission dates.

Integration Requirements

PATIENT DEMOGRAPHIC HEADER

The new ICD indicator also displays in the patient demographic header wherever a patient is selected in any STAR Radiology processor

Once the account level is entered/accessed, the following revised header displays with the new ICD indicator. This is just an example screen, as this same header is used throughout the character-based screens.

```
         General Hospital Patient Inquiry Processor
                                                  Wed Jun 10, 2009 02:15 pm
Unit #     Name            Sex Birthdate  Room    Physician     Srv ICD Status
A000006016 RDTWO,TENOPMED  F  01/05/1931 211-1   ADAMS,JAY K   MED  10 OPB 86
```

The ICD indicator is designed to assist the user in diagnosis entry in order and charge processors After ICD-10 is implemented, patients may display either 9, 10, or B (both) indicator.

- ICD: 9 – indicates the patient requires ICD-9 coding only. This would apply to patients whose admission date is prior to the USA ICD-10 Effective date. Current ICD-9 diagnosis processing applies for these patients. Prompts and diagnosis lists are unchanged. ABN processing occurs on ICD-9 diagnoses.

- ICD:10 – indicates the patient requires ICD-10 coding. Prompts and diagnosis lists are changed for ICD-10. ABN processing occurs only on ICD-10 diagnosis.

- ICD: B – indicates the patient requires both coding methods due to insurance plan, insurance carrier or financial class exceptions. Prompts and diagnosis lists are changed for ICD-10 ABN processing occurs on ICD-10 diagnosis only. The B ICD indicator provides limited access in STAR Radiology to collect both ICD-9 and ICD-10 codes.

RADIOLOGY ORDER AND CHARGE PROCESSORS

STAR Radiology Order and Charge processors allowing diagnosis entry have been updated to accommodate ICD-10-CM as well as ICD-9 diagnosis entry and display:

- Exam Request

- Inactive Account Check-in

- Order Revision (access via Patient CheckIn, Exam Data Entry, Report Review

- Patient CheckIn

The following screen details the new ICD-10 Order Diagnosis and Working Diagnosis entry in Patient Check In. However, the prompts and screens are essentially the same in the processors listed above.

```
     STAR Development System Patient Check-In Processor
Req:  New Order
Unit #     Name               Sx Birthdate  Room    Physician     Srv  ICD Status
A000005399 NETWORK,CMS THREE  F 12/14/1954  202-1   DOCTOR,ADMITT CAR   B  OPO 198
Rad#: A987                                      Allergies Exhibited
 1 Opt Code Description            Ordering Diagnosis          Modifiers
 -> (1) 7450 CT ABDOMEN WO CONTRA
 2 Priority          3 Requested-For Date/Time  4 Check-in Date/Time
   ASAP                02/08/08 0845              02/08/08 1242
 5 Ordering Physician                          6 Transportation Method
   200 DOCTOR,ADMITTING TWOX                     WHEELCHAIR
 7 Working Diagnosis                       8 Special Handling
   SICK FREE FORM
 9 Comment

10 Allergies
   No allergies defined

Enter ICD-10-CM diagnosis code--
`U-`ser Dx, `A-`pproved Dx, `Dx` Admit, `-` for list, -free form
```

EXAM CODE/ORDERING DIAGNOSIS

This field defines the ordering diagnosis of the requested exam.

NOTE: Prompt line options depend on parameter settings defined for the department in the SIM Dept table. The free form option continues to display per current functionality for each product (OM, LAB, RAD). No matter how the diagnosis is selected, the diagnosis display length on the screen remains the same.

Upon accessing this field, the following prompt is displayed:

Enter ICD-10-CM diagnosis code--
`U-`ser Dx, `A-`pproved Dx, `Dx` Admit, `-` for list, -free form

Enter the diagnosis code using one of the following methods:

- *Enter ICD-10-CM diagnosis code--*

  Enter the exact ICD-10-CM diagnosis code.

- *`-` for list --*

  Enter a hyphen (**-**) for the system to display the ICD-10-CM Diagnosis table.

The table display has been changed from a 2-column display to a 1-column display so more of the ICD-10 description may display to aid in selection.

```
        STAR Development System Patient Check-In Processor
Req:  New Order
Unit #     Name               Sx Birthdate  Room   Physician    Srv ICD Status
A000006047 RDTWO,TENOPMED     F 02/03/1930  BO07-02ROSENSON,FRE MED 10  OPB 104

 1 Opt Code Description            Ordering Diagnosis          Modifiers
   (1) 7422 XR ABD SERIES W/PA C




Page:          ICD-10-CM

( 1) S30.98xS Unspecified superficial injury of anus, sequela
( 2) S31.000A Unspecified open wound of lower back and pelvis without penet
( 3) S31.000D Unspecified open wound of lower back and pelvis without penet
( 4) S31.000S Unspecified open wound of lower back and pelvis without penet
( 5) S31.001A Unspecified open wound of lower back and pelvis with penetrat
( 6) S31.001D Unspecified open wound of lower back and pelvis with penetrat
( 7) S31.001S Unspecified open wound of lower back and pelvis with penetrat
( 8) S31.010A Laceration without foreign body of lower back and pelvis with


Enter choice--
                        next pg(/ or PG DN)  Search(TAB)
```

- *`U-`ser Dx --*

  The User diagnosis table (U-) may contain both ICD-9 and ICD-10 diagnosis pointers, based on the definition of ICD-9 and ICD-10 codes in the *ICD Diagnosis Pointer* table and the patient ICD indicator. A particular diagnosis may actually point to both ICD-9 and ICD-10 diagnosis codes. If the insurance plan, carrier, or financial class exceptions for ICD-9 are indicated for the patient, the user table would be the only choice for diagnosis entry in order to obtain both ICD-9 and ICD-10 diagnosis codes.

  The User pointer table limits display based on the ICD patient indicator as follows:

  - ICD = 9 – Displays entries with 9 or both; Only ICD-9 diagnosis is filed.
  - ICD = 10 – Display entries with 10 or both; Only ICD-10 diagnosis is filed.
  - ICD = B – Display entries with 10 or both; Both ICD-9 and ICD-10 diagnosis are filed.

  If the ICD Indicator is a 9, and the ICD Pointer table does not have any entries with a ICD-9 code defined, the following message is displayed to alert the user to the reason no entries are displayed for selection:

  No ICD-9 Codes in the Pointer Table

If the ICD Indicator is a 10 and the table does not have any entries with a ICD-10 code defined, the following message is displayed to alert the user to the reason no entries are displayed for selection:

No ICD-10 Codes in the Pointer Table

If the ICD Indicator is a B which indicates the need to collect both ICD codes and the table does not have any entries with both a ICD-9 and a ICD-10 code defined, the following ***Warning*** message is displayed:

Collecting ICD-10 and 9! No entries defined with both!

See the Order Management section of this Guide for more information on the messages.

- *`A-`pproved Dx, --*

  The Approved Diagnosis List (**A**) option displays only the valid ICD-10 diagnosis defined for the HCPCS code specified for the ordered SIM/FIM item for patients with an ICD indicator of 10 or B.

  NOTE: The Approved Diagnosis List option is available only if the following condition is satisfied:

  Integrated systems: If STAR Patient Care is installed, the Approved Diagnosis List field must be set to **Yes** in the SIM Department Table.

  Standalone systems: If STAR Patient Care is not installed, the HCPCS Table in the Location Maintenance processor must be built for the HCPCS code assigned to the exam.

- *`Dx` Admit --*

  The Dx Admit list (Dx) lists all diagnoses entered at admission. If a patient's ICD indicator = B, and an ICD-9 diagnosis is on the Dx Admit list, it displays in dim video, with no option number so it may not be selected. If the ICD indicator is either 9 or 10, there would only be ICD-9 or ICD-10 (respectively) available at admission. Therefore, the Dx Admit list would only contain ICD-9 for a 9 patient and ICD-10 for a 10 patient.

  If freeform diagnosis entry is permitted in STAR Order Management, and a free-form diagnosis was entered at Admission, the free-form diagnosis is displayed in the Admitting Diagnosis List and is eligible for selection. If free-form diagnosis entry is *not* permitted in STAR Order Management and a free-form diagnosis was entered at Admission, the free-form diagnosis is not displayed in the Admitting Diagnosis List.

This screen is an example of Dx admit list with ICD-10 and ICD-9 diagnosis in dim.

```
          STAR Development System Patient Check-In Processor
Req:  New Order
Unit #     Name               Sx Birthdate  Room   Physician    Srv ICD Status
A000006049 RDTWO,BOTHNOCHANGE M 02/02/1930  BO04-02HOLT,VALERIE MED  B  OPB 104
Rad#: A352
 1 Opt Code Description            Ordering Diagnosis          Modifiers
   (1) 7422 XR ABD SERIES W/PA C




Page:01                     Admitting Diagnosis List
( 1) ADMITTING    D61.1  DRUG INDUCED APLASTIC ANEMIA
( 2) WORKING      G93.6  CEREBRAL EDEMA
( 3) PRINCIPAL    G30.9    Alzheimer's disease, unspecified
                  331.0    ALZHEIMER'S DISEASE
     SECONDARY    757.9  INTEGUMENT ANOMALY NOS

Enter choice--
```

- *-free form –*

  Enter a hyphen (**-**) and a free-form diagnosis description to enter free form dx.

WORKING DIAGNOSIS
This field displays the working diagnosis entered during Admission. When you want to edit the working diagnosis for a patient, you can edit it through the Patient Check-in processor.

Upon accessing this field, the following prompt is displayed:

Enter ICD-10-CM diagnosis code--
`U-`ser Dx, `A-`pproved Dx, `Dx` Admit, `-` for list, -free form [working Dx]

Entry options are as explained above. The default option is the working diagnosis collected at admission.

OUTPATIENT CHARGE DOCUMENTATION (OPCD)

STAR Radiology Outpatient Charge Documentation (OPCD) has been updated to accommodate ICD-10 diagnosis entry with associated ABN processing. The following processors are affected:

- Order Entry in Patient CheckIn
- Order Revision
- Professional Billing (captured at CheckIn when Profee is attached to Ordered exam)

- Non-Procedural Charge Entry

OUTPATIENT MEDICARE DIAGNOSIS/MODIFIER ENTRY

After initial Order Entry/CheckIn, diagnosis entry for orders or charges entered on a CMS compliant patient, is performed in the Outpatient Medicare Diagnosis/Modifier Entry screen.

This example screen shows a Profee charge at CheckIn:

```
STAR Development System Patient Check-In Processor
Req:  New Order
Unit #     Name               Sx Birthdate  Room    Physician     Srv  ICD Status
A100007256 CMS,PATIENT        F 04/04/1940  2194-01 JEKYL,JONAS J SUR   10  OPS 6
Outpatient Medicare Diagnosis/Modifier Entry
Seq Item                          Diagnosis                    Modifier
1   RAD PRO FEE - SIMPLE PRICE 4









Enter ICD-10-CM diagnosis code--                                        |
       `U-`ser Dx, `A-`pproved Dx, `Dx` Admit, `-` for list [ordering Dx]
```

ADVANCED BENEFICIARY NOTICE (ABN) PROCESSING

Changes were made to the HCPCS processor table to accommodate the addition of the Valid ICD-10-CM Codes. The details of the changes to the HCPCS processor table are described in the STAR Order Management section of this guide and the Medical Record STI M23127.

With the implementation of the ICD-10 enhancement, the accounts with a 9 ICD Indicator continue with current ABN Processing. The ABN processing is based on the Valid ICD-9 codes defined in the HCPCS Processor. The two ABN Forms remain unchanged at this time.

With the implementation of the ICD-10 enhancement, the accounts with a 10 and a B as the ICD Indicator, base the ABN processing on the Valid ICD-10 codes defined in the HCPCS processor. The ABN Forms are updated to print the ICD-10-CM code on the form.

For CMS patients with a B as the ICD Indicator, if a diagnosis is selected from the User Pointer Table containing an ICD-9 and ICD-10 diagnosis code, only the ICD-10 diagnosis code is used for ABN processing.

COMMON CLINICAL IMPACT BY ICD-10 IMPLEMENTATION

Please refer to Chapter 2, STAR Order Management section in this Implementation Guide for more detailed explanations of the following:

- HCPC Processing Table / Valid ICD-10 dx processing
- USER Dx Pointer table.
- Order/Charge Processing - Dx entry transaction prompt options
- ABN Processing /Medical Necessity/ Out Patient Charge Documentation (OPCD)
- Charge Inquiry

RADIOLOGY INQUIRY PROCESSORS

The following Inquiry screens display diagnosis information in STAR Radiology and have been updated to accommodate ICD-10 diagnosis processing.

If the ICD-10 Effective Date Parameter is activated and there is an ICD-10 diagnosis code logged on the patient, the ICD-10 codes are displayed in the current diagnosis fields. If only ICD-9 diagnosis is collected for the patient, it is displayed in the current diagnosis fields. Current functionality (display ICD-9) applies if the effective date is not activated.

For accounts with a B ICD Indicator, the system files both the ICD-10 and the ICD-9 diagnosis selected from the user pointer table during order entry for use by STAR Patient Accounting. If both are collected, they are displayed in Order Management Charge Inquiry. Radiology Review and inquiry screens displays **only** the ICD-10-CM diagnosis.

To accommodate the longer ICD-10 diagnosis descriptions, the current Diagnosis fields were modified to truncate at maximum available space and append with a "+" to indicate the Dx description has been truncated**.**

CN: Although the ICD Indicator is not applicable, Canadian customers do see the longer truncated descriptions display on inquiry screens when the STI is loaded on site.

- Patient Inquiry - Demographic Screen, Exam Information Screen, Financial Screen,
- Patient Inquiry - Admitting Diagnosis List.

  For patients that have both ICD-10 and the ICD-9 diagnosis entered for their admitting diagnoses, the Dx Admit List display has been changed to display ICD-9

diagnoses in dim video to be consistent with the display in order entry and other processors using the Dx Admit list to select a diagnosis.

- Patient Inquiry - Screen Header - Activity tracking Incomplete Results screen, Results display screen.

- Exam Data Entry screens – Demographic Header – The ordering diagnosis displays on the Result display, Table and/or menu display, Report display, Missing results display, and Linked exams display screens.

- Exam List screen – ordering diagnosis displays on line 2 of each CheckIn/exam display. This listing display is used through out the system as most patient identification prompt responses.

- Including but not limited to: Pt. CheckIn – Add-on order, Exam Data Entry, Patient Inquiry, Order Revision, Cancel/credit request, Cancel/credit CheckIn, Report Review, Non-Procedural Charge, CheckIn Document Reprint, Check-in Label Reprint

- TELIC File - Ordering diagnosis is displayed on the Create/Edit File Entry screen and also on the TELIC File Search screen/report.

RADIOLOGY ADMINISTRATIVE REPORTS

The STAR Radiology Billing Report, Order Revision Report, and Form 1500 Exception Reports are updated to display/ print the ICD-10-CM diagnosis codes when available for the patient. If only an ICD-9 diagnosis is collected for the patient, it displays/prints in the current diagnosis fields.

Additionally, the Billing Report was updated to display/ print the longer ICD-10-CM diagnosis codes. To accommodate this change, the Ord DX column was lengthened to allow 10 characters. The ABN field was moved 3 characters to the right and the Freq Limit field was moved 2 characters to the right. The Freq Limit field was already truncated at 18 and now truncates at 15 to fit the line.

RADIOLOGY PATIENT REPORTS

The following patient reports have been updated for ICD-10-CM diagnosis processing. After the effective date, if only ICD-10 diagnosis is collected for the patient, it prints. If both ICD-10 and ICD-9 diagnoses are collected, only the ICD-10 diagnosis prints on patient reports. If only ICD-9 diagnosis is collected for the patient, it prints. The updated diagnosis elements are in use once these forms are generated as part of the Upgrade or ESD move.

- Flashcard or Exam Request/Transport Slip

- Order Revision Notice

- Outside Transcription Report
- Final Report
- Cancel Notice
- Archive Summary

RADIOLOGY INTERFACES

Currently there are three base 2.2 interfaces used in Radiology. These are Mammography, Dictation/Transcription and Speech Recognition interfaces. They use versions of 2.2 data element 626 to send Ordering Diagnosis outbound. A new version of the 626 element was created to determine whether to send ICD-9 or ICD-10 and build the piece accordingly.

There is an implementation step in which the customer determines whether to use the new element or the current element. This step is necessary when implementing ICD-10 Diagnosis Codes. Both the old and the new O/B 2.2 data element process ICD-9 dx codes.

Currently STAR Radiology has one outbound 2.2b interface. It is the HMI results interface. The correct ICD diagnosis code (ICD-9 or ICD-10) is sent outbound in OBR31. Inbound, STAR Rad does not process the OBR.31.

HORIZON*WP* PHYSICIAN PORTAL RADIOLOGIST WORKFLOW

Both Admitting and Ordering diagnosis fields are displayed on several forms in Radiologist Workflow (RWF) module and in Portal Results Inquiry screens. All diagnosis fields were updated to display the ICD-10-CM diagnosis codes when available for the patient. Current functionality (display ICD-9) applies if the effective date is not activated. After the effective date, if only an ICD-9 diagnosis is collected for the patient, it is displayed in the current diagnosis fields.

Implementation Steps – Build Process

NOTE: This information can also be found in the Implementation section of STI X5556.

There are no specific table or parameter implementation steps in STAR Radiology prior to the implementation of the ICD-10 coding.

When the USA ICD Effective Date set on STAR Patient Processing is past, ICD-10 diagnoses and procedures may be collected for the patient.

COMMON CLINICAL TABLES AND PARAMETERS

Please reference the STAR Patient Processing and Order Management Implementation Steps in Chapter 2 of this implementation guide for more information on these common clinical tables that should be updated prior to the ICD-10 effective date:

ICD-10-CM Maintenance and ICD-10-PCS Maintenance tables on STAR Medical Records should be evaluated to validate correct table loads for use in the system.

The ICD Diagnosis Pointer Table and HCPCS Table on STAR Patient Care must be updated with ICD-10 diagnoses prior to the ICD-10 effective date.

The ICD Diagnosis Pointer table (User Dx table) is used by STAR Radiology during diagnosis entry by entering **U-**. It is the only method available for collecting both the ICD-9 and ICD-10 diagnosis codes in order and charge entry after the ICD-10 effective date, for those patients with a B indicator. Therefore, it is essential that this table be reviewed and updated and procedures put in place for those users responsible for order and charge entry. The effort to update these tables should be coordinated with the other STAR Clinical coordinators.

The HCPCS table is updated from STAR Medical Records. This table has to be updated to include the valid ICD-10 diagnoses for each HCPCS code. This is required for diagnosis entry for CMS-compliant patients. Updating both the ICD Diagnosis Pointer table and the HCPCS table should be coordinated with the appropriate STAR product personnel within the facility.

HCPCS TABLE - STANDALONE SYSTEMS

If STAR Patient Care is not installed, the HCPCS Table can be accessed in the Location Maintenance processor. Additional fields were added to the HCPCS Processor Table to accommodate defining the ICD-10 Valid Diagnosis Codes and ICD-10 Comment. The ICD-10 codes defined in the ICD-10 Valid Diagnosis field are used for the ABN / Medical Necessity processing after implementing the ICD-10 Enhancement.

FORMS

Current base Diagnosis form library elements were updated to print ICD-10 diagnosis when collected. If there is no ICD-10 diagnosis collected, then the ICD-9 diagnosis is printed.

The elements listed below are used on the following Patient Reports: Flashcard or Exam Request/Transport Slip, Order Revision Notice, Outside Transcription Report and Final Report forms in STAR Radiology.

If you are using these elements on any STAR Radiology forms, the form needs to be generated in order to print ICD-10 diagnoses. Forms are auto generated as part of an

Upgrade or ESD move process. If implementing this enhancement outside of an Upgrade or ESD move then the forms need to be generated manually.

Any custom Diagnosis elements should be evaluated for removal or retrofit. Changes to site specific form library elements are required to accommodate printing the ICD-10-CM codes.

FORM ELEMENTS UPDATED IN BASE

The following form elements are used to print Ordering and Working Diagnosis on the Patient Reports.

```
Library name  Description
------------|-----------------------------------------------------
FORM  Exam Request Slip/Flashcard
-----------------------------------

XFLSHDX      WORKING DIAGNOSIS                          49-0 No Truncation
XFLSHDX1     WORKING DIAGNOSIS                          30-0 No Truncation
XFLSHDX2     WORKING DIAGNOSIS                          30-0 No Truncation
XFLSHDX200   WORKING DIAGNOSIS                          40-0 No Truncation
XFLSHDX201   XFLSH - ADM DIAG, 20 CHAR                  20-1 Truncate
XFLSHOD1     Ordering Diagnosis Exam #1                 40-0 No Truncation
XFLSHOD2     Ordering Diagnosis Exam #2                 40-0 No Truncation
XFLSHOD3     Ordering Diagnosis Exam #3                 40-0 No Truncation
XFLSHOD4     Ordering Diagnosis Exam #4                 40-0 No Truncation


FORM - STAR Radiology Final Report
-----------------------------------
FORM ELEMENT AVAILABLE IN HEADER OR FOOTER:

XFRHODD      XFRH  WORKING DIAGNOSIS                  30-0 No Truncation
XFRHODD1     XFRH - WORKING DIAG. W/ HEADER           70-0 No Truncation
XFRHPTD      XFRH - WORKING DIAGNOSIS W/ HEADER       30-1 Truncate
XFRHPTD200   XFRH - WORKING DIAGNOSIS                 30-1 Truncate

XFRHODR      XFRH - EXAM ORD. DIAG. W/ HEADER         44-0 No Truncation
XFRHODR1     XFRH - EXAM ORD. DIAG. W/OUT HEADER      44-0 No Truncation
XFRHODR200   XFRH- EXAM ORD DIAG W/O HDR, 20 CHAR     20-1 Truncate

FORM ELEMENT AVAILABLE IN EXAM INFORMATION HEADER:

XFRHODRLK*    XFRH - LINKED EXAM ORDER. DIAGNOSIS     40-1 Truncate

* This form element can ONLY be used in the Exam Information Header
   of the Final Report.
```

```
FORM  Order Revision Notice
----------------------------

XORND        New Ordering Diagnosis 1                30-1 Truncate
XORND1       New Ordering Diagnosis 2                30-1 Truncate
XORND2       New Ordering Diagnosis 3                30-1 Truncate
XORND3       New Ordering Diagnosis 4                30-1 Truncate
XOROD        Old Ordering Diagnosis 1                30-1 Truncate
XOROD1       Old Ordering Diagnosis 2                30-1 Truncate
XOROD2       Old Ordering Diagnosis 3                30-1 Truncate
XOROD3       Old Ordering Diagnosis 4                30-1 Truncate

FORM - Outside Transcription Report

-----------------------------------

XOTDIAG      OT - DIAGNOSIS/REASON                   30-0 No Truncation
XOTDIAG2     OT - DIAGNOSIS/REASON W/TITLE           35-0 No Truncation

FORM  ERS*/Transport Slip
--------------------------

XREQUIDG     WORKING DIAGNOSIS "DIAG-"               40-0 No Truncation
XREQUIDG3    WORKING DIAGNOSIS MP NODE               40-0 No Truncation
XTRNSPDG     XTRNSP - WORKING DIAGNOSIS              30-0 No Truncation
XTRNSPDG1    XTRNSP - WORK DIAG TRUNCATE 30          30-1 Truncate
XTRNSPRE     ORDERING DIAGNOSIS EXAM #1              35-0 No Truncation
XTRNSPRE1    ORDERING DIAGNOSIS W/ HDR EXAM 1        35-0 No Truncation
XTRNSPRE2    ORDERING DIAGNOSIS EXAM #2              30-0 No Truncation
XTRNSPRE21   ORD DIAG EXAM #2 W/ HDR                 30-0 No Truncation
XTRNSPRE22   ORDERING DIAGNOSIS EXAM #1              35-0 No Truncation
XTRNSPRE3    ORDERING DIAGNOSIS EXAM #3              30-0 No Truncation
XTRNSPRE31   ORD DIAGNOSIS EXAM #3 W/ HDR            30-0 No Truncation
XTRNSPRE4    ORDERING DIAGNOSIS EXAM #4              30-0 No Truncation
XTRNSPRE41   ORD DIAGNOSIS EXAM #4 W/ HDR            30-0 No Truncation
```

Interfaces

Base STAR Radiology 2.2 (non-2.2b) Interfaces: Mammography, Transcription, & Speech Recognition

Currently there are three 2.2 (non-2.2b) Radiology interfaces; Mammography, Transcription and Speech Recognition which were all updated for the ICD-10 -CM diagnosis codes changes. They use versions of data element 626 to send Ordering Diagnosis in 2.2 outbound Unsolicited messages. Inbound, Radiology does not process the ordering diagnosis. A new version of the 626 element was created to send ICD-9 or ICD-10 (based on the ICD Indicator) and build the piece accordingly. It passes ICD-10 codes if they exist. Otherwise it passes ICD-9 codes. Non 2.2b interfaces require new elements be implemented. This pending change is for the addition of a new data element 626-04.

Customers using 2.2 outbound interfaces for Mammography, Transcription or Speech Recognition interfaces need to determine if they wish to use the new Ordering Diagnosis data element to populate OBR.31. If so, they need to implement and test the new data element to ensure the correct ICD dx codes is passed. This requirement may also depend on the ability of the vendor to receive/transmit ICD-10 diagnoses.

All other site specific interfaces need to be evaluated for changes required to accommodate the ICD-10-CM codes. Customers using other 2.2 outbound interfaces need to determine if they wish to use the new Ordering Diagnosis data element. If so, they need to implement and test the new data element to ensure the correct ICD dx codes is passed. This requirement may also depend on the ability of the vendor to receive/transmit ICD-10 diagnoses.

Please refer to the STI X5556 for details on how to Apply Pending Changes. This step cannot be automated because manual intervention is necessary to implement Pending HL7 Changes. This pending change is for the addition of a new data element 626-04. This is only necessary if the customer is going to be using ICD-10 Diagnosis Codes.

Base STAR Radiology 2.2B Interface: Horizon Medical Imaging (HMI)

Currently STAR Radiology has one 2.2b interface. It is the HMI results interface. Ensure that OBR31 sends outbound the correct ICD diagnosis code. Inbound, STAR Rad does not process the OBR.31. Downstream systems must be aware of the possibility of ICD-10 codes being passed in OBR.31.

Testing Guidelines

Test patients should be admitted using various patient types, insurance carriers, insurance plans and financial class. Post ICD-10 effective date, your test patients should have ICD indicators with 9, 10 and B. Patients with an admission date prior to the ICD-10 effective date still have an ICD-9 indicator. Patients with insurance carrier, plan or financial class exceptions have a B indicator. Patient admitted after the ICD-10 effective date (and no exceptions) have a 10 indicator. Test scenarios should include patients with all 3 indicators. If your facility uses Outpatient Charge Documentation/ Medical Necessity processing, verify the HCPCS table has been updated with Valid ICD-10 dx's. Admit patients that are CMS compliant. Use a variety of admitting diagnoses including principle and secondary diagnoses. If the DSM pointer table is used in your facility, enter a working diagnosis using the DSM pointer table for at least one patient admission. Work with the ADT / Patient Processing group at your facility to combine this effort.

1. Verify the correct ICD Indicator (9,10,B) displays in the demographic header. Verify that all other data in the header is properly displayed. (Indicator is determined by applicable parameters: ICD-10 active, not active, insurance plans, carriers, financial class exceptions).

2. Verify correct Diagnosis entry transaction prompts in the following processes. Verify correct Ordering and/or Working Diagnosis is stored and sent to PA. Verify correct displays and printed output. (CheckIn Docs, Revision Notices, etc)

    - Verify correct Order Diagnosis and Working Diagnosis entry and display in Order and Charge processors:

        - Exam Request Entry

        - Patient CheckIn

            - CheckIn orders from STAR Pt. Care Order Management and STAR Radiology.

            - Include Orders that Auto CheckIn such as ER Patient types.

            - Order/CheckIn some exams using the Add-on and Order Revision functions.

        - Inactive Account Check In

        - Order Revision - access via Patient CheckIn, Exam Data Entry, Report Review - only Ordering diagnosis field.

    - Verify correct diagnosis entry and transaction prompts based on patient's ICD indicator 9, 10, B.

    - Verify ICD-9 and ICD-10 diagnosis files in Charge Inquiry for B patients when selecting a diagnosis with both ICD-9 and ICD-10 definition from the User Diagnosis pointer table

    - Verify all methods of dx entry from prompt: ICD diagnosis pointer table (U-), Approved Dx list (A-), Admit Dx list (Dx), ICD code entry and ICD table selection and free form where permitted.

    - Verify ICD-9 and ICD-10 diagnosis files in Charge Inquiry for B patients when selecting a diagnosis with both ICD-9 and ICD-10 definition from the User Diagnosis pointer table

    - Use a variety of different exams including exams with Professional fee items, order panels and charge panels. Use various order priorities including one with a STAT charge.

    - Order multiple exams/per CheckIn and use different diagnoses per exam. (if dept. uses multiple exams/Checkin)

3. Verify the following processes in Outpatient Charge Documentation (OPCD) for CMS Compliant Patients.

- Diagnosis entry and processing in Patient CheckIn (New Order, Add On Order, Exam Requests), Order Revision, Professional Billing (attached to a SIM item) and Non-Procedural Charge Entry.

NOTE: ABN/Medical Necessity processing occurs only on ICD-10 diagnoses when the patient indicator is a 10 or a B. If a user diagnosis is selected from the user pointer table containing an ICD-9 and ICD-10 diagnosis code, only the ICD-10 diagnosis code is processed for CMS patients.

ABN processing does not occur on ICD-9 diagnoses unless the patient ICD indicator is a 9.

  - Verify correct diagnosis entry and transaction prompts based on patient's ICD indicator - 9, 10, or B.

  - Test all methods of diagnosis entry: ICD diagnosis pointer table (U-), Approved Dx list (A-), Admit Dx list (Dx), ICD code entry and ICD table selection and free form where permitted.

  - Use a variety of OPCD processing: Valid dx, ABN proc for invalid dx, Frequency Limit, Med Nec/Dup/Conflict HCPCS/Reasons, HCPCS modifiers.

  - Use a variety of different exams including exams with Professional fee items, order panels and charge panels. Use various order priorities including one with a STAT charge.

  - Order multiple exams/per CheckIn and use different diagnoses per exam. (if dept. uses multiple exams/Checkin)

- Verify the correct ordering diagnosis files for the transaction on STAR OM and STAR Rad.

- Verify the correct diagnosis/OPCD displays on Inquiry screens.

- Verify appropriate ABN processing occurs based on patient indicator.

  - Verify all ABN information is documented.

  - Verify output on ABN

4. Verify correct display of Ordering, Admitting, and Working Diagnoses as applicable in the following screens:

   - Patient Inquiry - Demographic Screen, Exam Information Screen, Financial Screen

   - Patient Inquiry - Admitting Diagnosis List

- Patient Inquiry - Screen Header - Activity tracking Incomplete Results screen, Results display screen.
- Exam Data Entry screens – Demographic Header
- Exam List screen - ordering diagnosis displays on line 2 of each CheckIn/exam display.
- TELIC File - - Ordering diagnosis is displayed on the Create/Edit File Entry screen and also on the TELIC File Search screen/report.
- Horizon^{WP} Physician Portal Radiologist Workflow - Admitting and Ordering Dx is displayed on several forms.

5. Verify proper output (displays/print) on the following reports:.

   - Billing Report
   - Order Revision Report
   - 1500 Billing Exception Report

   Verify that the reports reflect the correct diagnosis as entered or captured

6. Verify correct diagnosis prints on forms that use the diagnosis form library elements affected by this enhancement. These may include the following Patient Reports:

   Cancel Notice, Archive Summary, Revision Notice, Request/transport Slips, Flashcard/CheckIn Documents, and Final Reports.

7. Verify ICD-9 diagnoses are correctly passed via network transactions of Orders, Charges, Revised Orders, Profee charges, Non-Procedural Charges, Cancel Exam Request (when a credit is issued on a CMS patient), Cancel/Credit CheckIn (when a credit is issued on a CMS patient).

   Verify diagnosis for all orders/charges in STAR Patient Care Charge Inquiry and STAR Patient Accounting Account Inquiry.

8. Stand Alone Radiology systems - Verify that the HCPCS table can be edited for ICD-10 codes. Users need to be able to define the new Valid ICD-10 Dx fields.

9. Use the Edit HCPCS/Modifiers on PA Charges function and edit diagnosis, HCPCS and modifier information for some Rad charges. Verify changes are updated on STAR Patient Accounting.

10. After the Orders are entered, review the HL7 audit to verify the correct dx in the outbound messages. Verify diagnosis in interface transactions for all applicable site specific interfaces. Some interfaces that may pass diagnosis information include:

    - HMI results interface. - Currently the only base STAR Rad 2.2b interface.
        - Verify that OBR.31 sends outbound the correct ICD diagnosis code.
        - Inbound, STAR Rad does not process the OBR.31.
    - Base 2.2 interfaces - Mammography, Transcription and Speech Recognition use versions of 2.2 data element 626 to send Ordering Diagnosis outbound. Inbound, STAR Radiology does not process the ordering diagnosis. Note: Complete the required implementation step to use the new element.
        - Verify that if this element is used, the proper ICD code is passed.
        - Verify that the downstream system received the correct diagnosis format.

Procedural Considerations

Perform a thorough review of the documentation for this enhancement.

After the documentation review, develop a plan for training the appropriate personnel and review the facility's current policies and procedures

Update the policies and procedures as needed. New policies and procedures may be required to address concerns that occur with this enhancement, such as backdating the admission date for a patient's account after the implementation date. Procedures to address edits when a patient's 10 indicator is changed to a 9 indicator due to backdating and affects the ICD codes entered prior to the change in the patient indicator.

Policies and procedures must be developed to consistently enter the coding as appropriate based on the ICD Indicators and changes to the indicators as insurance or financial class changes.

Users should be aware of the changes that are functional prior to the implementation of the STAR Patient Processing Parameter(s) and the designed usefulness of these changes while still using the ICD-9 coding.

Users should understand the additional changes that are functional after the implementation of the STAR Patient Processing Parameters.

Users must have a thorough understanding of the ICD Indicators, and the reasons for the ICD Indicators including backdating and the exceptions in the additional STAR Patient Processing parameters.

Procedurally, the facility should be ready to use the ICD-10-CM and ICD-10-PCS codes before defining the effective dates for the implementation of this enhancement.

All system interfaces must be evaluated to determine if the ICD-10 codes will be sent outbound and /or received inbound.

Customized code including interfaces must be evaluated for possible impact by this enhancement.

Training Requirements

Training requirements include some form of training for all users. For many users, this training involves a discussion with the end user about the new ICD-10-CM diagnosis and procedure codes, the changes and additions to policies and procedures, and the impact to the facility.

Also extensive training should be conducted to alert the Radiology users to the differences in the Order and Charge processors as well as in the Patient Inquiry displays, Printed Output and Management reports.

New procedures must be reviewed during training to assure a consistent outcome when making edits to the diagnosis or the patient indicators.

Anyone who is responsible for entering any diagnosis or procedure codes must be educated on the ICD-10 coding method as well as how to support dual coding methods on a single account.

Any user responsible for order and charge entry should be included in training.

Implementation Considerations

This is a multi-product enhancement and the following is a list of the STAR ER15.0 STIs:

- M23013 for STAR Patient Processing
- M23127 and M23800 for STAR Medical Records
- M23867 for STAR Utilization Management
- M23015 for STAR Order Management
- L8022 for STAR Laboratory
- X5556 for STAR Radiology
- X5562 for Horizon^{WP} Physician Portal/STAR Radiologist Workflow (not released yet)

- P8129 for STAR Pharmacy
- F9734 for STAR Patient Accounting
- M23113 for STAR Integration

The implementation date for the ICD-10 enhancements should be carefully considered by the users. Once the ICD-10 implementation date is set in the Hospital Facility Options, then all of the changes outlined in this design go into effect. The users need to be sure that they have reviewed all of their procedures and put the necessary changes in place. All personnel must be trained on the changes with the ICD-10 coding method. Any necessary form or menu changes must be made prior to setting the ICD-10 implementation date. It is very important that the users check with their other vendors to be sure that they have addressed the impact that implementing ICD-10 has on any of the other systems. Although the flag to set the ICD-10 implementation date is contained in the Hospital Facility Options controlled by STAR Patient Processing, all STAR products are affected by the setting of this date, and the enhancements across all STAR products are implemented.

IMPLEMENTATION GUIDELINES

- Perform a thorough review of the documentation when the enhancement STIs are received and prior to implementation.
- Perform applicable maintenance prior to the user-defined implementation date being entered in the STAR Patient Processing parameter(s).
- Review policies and procedures that are applicable and update and/or add new policies and procedures as required.
- Develop a training plan to cover changes when the STIs are moved to the system and when the user-defined implementation date is reached.
- Develop a test plan based on the facility requirements.
- Perform Regression testing after the STIs are received as well as additional testing after the implementation of the enhancement.
- Review the Forms and Menus to determine any changes that are required for custom forms and menus.
- Address the implementation of the ICD-10 coding and the temporary dual coding of ICD-9 and ICD-10 with all vendors to plan for any impact that may develop when the enhancement is implemented

Documentation

In addition to the ER 15 Enhancement Summary, this ER ICD-10 Implementation Guide and the STI documentation, the following documentation is updated as a result of this enhancement.

Enhancement Topic	Document	Chapters
ICD-10 Enhancements	*STAR Radiology Reference Guide: Applications Volume*	1 - Order Processing 2 - Exam Data Entry 3 - Report Review 4 - Film Room Management 5 - Outside Film Management 6 - Administration 7 - Activity Tracking 8 - Historical Patient Management 9 - Patient Inquiry 10 - Physician Activity Report 11 - Monitors
	STAR Radiology Reference Guide: General Information Volume	3 - Menus 4 - Information Entry Techniques 15 - Star Common Clinicals Allergy Processing Tool
	STAR Radiology Reference Guide: Maintenance Volume	12 - Location
	STAR Radiology Reference Guide: Worksheets Volume	3 - Order Processing

MEDICAL RECORD/UTILIZATION MANAGEMENT

Overview

This section takes you through the steps required to implement ICD-10 processing and ICD with DRG's processing. For STAR Records Management/Utilization Management there are very few implementation steps. This section also describes the screen, form, and report changes you will see after implementing ICD-10 and ICD-10 with DRG's processing.

- ICD-10 implementation is described in "ICD-10" beginning on page 2-149
- ICD-10 with DRGs implementation is described in "ICD-10 with DRGs" beginning on page 2-170

ICD-10

When ready to begin using ICD-10 codes, the facility sets the new USA ICD10 Effective Date parameter. The parameter, located in STAR Patient Processing, determines when the account is prompted for ICD-10 diagnosis and procedure codes. The ICD-10 updates to STAR Medical Records take effect only after the facility-level parameter, USA ICD10 Effective Date, is set and the effective date has been reached. This parameter is located in STAR Patient Processing: Tables, Facility Options and Parameters, Hospital Facility Options, Admission and General Parameters.

NOTE: The facility must be ready to use ICD-10 diagnosis coding before this parameter is set. After the effective date is reached, there is limited access to ICD-9 diagnoses in the User pointer table in order and charge entry.

In addition to the facility-level parameter to activate ICD-10, there are **parameters that indicate exceptions** for Insurance Plans, Insurance Carriers, and/or Financial Classes. For these exceptions, each patient may have only ICD-9 diagnosis and procedure codes, only ICD-10 diagnosis and procedure codes, or both ICD-9 and ICD-10 diagnosis and procedure codes. Both code sets are supported simultaneously.

State-level exceptions to ICD-10 processing are entered for particular states by Patient Type using the State ICD-10 Patient Type Exceptions table in STAR Patient Processing. STAR Medical Records displays an additional indicator for any state level exceptions when entering diagnosis and procedure codes. The ICD indicator field on STAR Medical Records screens, which usually displays a 9, 10, or B (Both), also includes a two-digit code indicating any state reporting requirements defined in STAR Patient Processing.

The effective dates defined in the parameters described above have a direct impact on the ICD code indicator that appears on each page of the abstract. This indicator lets

the coder know which codes (ICD-10, ICD-9, or both) are need to meet insurance and/or state reporting requirements.

If the date of admission is prior to the effective date, current processing using ICD-9 diagnosis entry applies.

After STI M23127 Is Loaded (Before USA ICD-10 Effective Date Is Set)

A number of changes for this enhancement are available by design when the STI(s) is moved into the system. Several of these changes provide the functionality to perform necessary Table Maintenance for transition to ICD-10 coding.

MEDICAL RECORD

- All screens/forms and programs necessary to implement ICD-10 are available.
- A conversion runs that moves existing payor codes from the DRG Payors Table to the Financial Classes table.
- Character-based Abstracting Screens include these changes:
  - Display new ICD Header and ICD Indicator of 9
  - Option E eliminated from new prompt on Diagnoses Processor screen (3M character-based interface is no longer available)
- GUI Diagnosis/Procedure/HCPCS form displays ICD Indicator of 9
- Mental Health form displays ICD-10 fields
- Pre- Bill Edit form displays ICD-10 fields
- Core Report Criteria screens displays ICD-10 fields

UTILIZATION MANAGEMENT

- UM Miscellaneous Review Information screen/form displays ICD-10 fields in both character-based and GUI systems when STI M23867 is loaded.
  - ICD 10 UM Working Diagnosis
  - US ICD 10 Surgery Scheduled

After USA ICD-10 Effective Date Is Set

Once the USA ICD-10 Effective Date is set, the following Implementation steps must be made prior to the effective date:

1. ICD-10 Tables must be loaded into STAR. See STI M23800. This STI contains upload files/instructions for ICD-10 2008/2009 files. These files need to be loaded well in advance of the USA ICD-10 Effective date, as these tables will be used by Order Management and Clinicals to set up necessary Pointer Tables.

2. New GUI ICD-10 forms must be loaded into GUI Abstract form flow by the US ICD-10 Effective Date.

    - Diag/Proc/ HCPCS ICD10 - New form allows for entry of both ICD-10 and ICD-9 codes.

    - Mental Health Detail ICD-10 - New form allows for entry of both ICD-10 and ICD-9 codes on DSM tab.

After the USA ICD-10 Effective Date is set and that date passes, the following changes are present in the system:

MEDICAL RECORD

- Character-based ICD-10 screens replace ICD-9 screens or accounts requiring ICD-10 codes.

    - Screens allow entry of ICD-10 codes, ICD-9 codes, or both with ability to toggle back and forth between the two code sets.

- ICD Indicator in the Abstract Header is displayed as 10, 9 or (B)oth depending on Insurance (payor) Requirements.

    See Admission and General Parameters of the Patient Processing ICD-10 Functional Design, *F PP M23013 ICD Enhancements.*

- State Exceptions

    - In the character-based Medical Record Abstracting system, a prompt is displayed if ICD 9 Diag or Proc is required for State Exceptions.

    - In GUI Abstracting, State Exceptions are displayed with the ICD Indicator following a (/) slash. Values: D/P/B (Diag/Proc/Both)

        NOTE: Are displayed only if (insurance) ICD Indicator = 10

        Example:
        If ICD Indicator is 10 and State exception is P, ICD Indicator is 10/P.

- Character-Based M/R Abstract Inquiry screens display ICD-10, ICD-9, or Both depending on codes available for account

- Discharge Summary and Attestation Reports contain ICD-10 and/or ICD 9 data.

- ICD-10 data available via Core Reports.
  - Discharges by Diagnosis
  - Discharges by Procedure
  - Combined HCPCS Report
- ICD-10 diagnosis field on Prebill Edit form is now accessible.

UTILIZATION MANAGEMENT

ICD-10 fields available for entry on the UM Miscellaneous Review Information screen/ form in both character-based and GUI Systems include:

- ICD 10 UM Working Diagnosis
- US ICD 10 Surgery Scheduled

Implementation Steps – Build Process

The steps required to implement ICD-10 processing for STAR Medical Record/ Utilization Management are outlined below.

1. Setting the USA ICD-10 Effective date

   Although this parameter is discussed in detail in the Patient Processing Implementation section of this document, there are important implications for STAR Medical Record/Utilization Management.

   In STAR, the USA Effective date is based on the patient's Admission Date. Since CMS ICD-10-CM effective date is based on the patient's discharge date, the STAR USA ICD-10 Effective date should be set well in advance of the CMS Effective date, so that accounts requiring ICD-10 codes can be coded with new ICD-10 codes, beginning with the Admissions Department. It is important that Admitting and Charge Diagnoses for accounts discharged beginning Oct 1, 2010 are available for those accounts discharged after the CMS Effective date.

   In Medical Record Abstracting, when the Effective date is set at the Hospital Facility Level, the character-based ICD-10 screens replace the ICD-9 screens for all accounts requiring ICD-10 codes. GUI ICD-10 forms must be added to the Abstract Form Flow when the hospital is ready to start coding with ICD-10, but at least by the USA ICD-10 Effective Date. See Admission and General Parameters of the Patient Processing ICD-10 Functional Design, *F PP M23013 ICD Enhancements.* See also the section of this guide on DRGs and ICD-10.

   New Coding Indicator: When the ICD-10 Effective date is set to a date at the Hospital Facility level, the system checks the admission date for the inpatient,

outpatient, emergency, or series patient type when displaying the appropriate Coding Indicator (ICD-9, ICD-10, or both) in character-based Medical Record Abstracting and GUI Abstracting. Coders use this indicator to determine which code set is needed for each account.

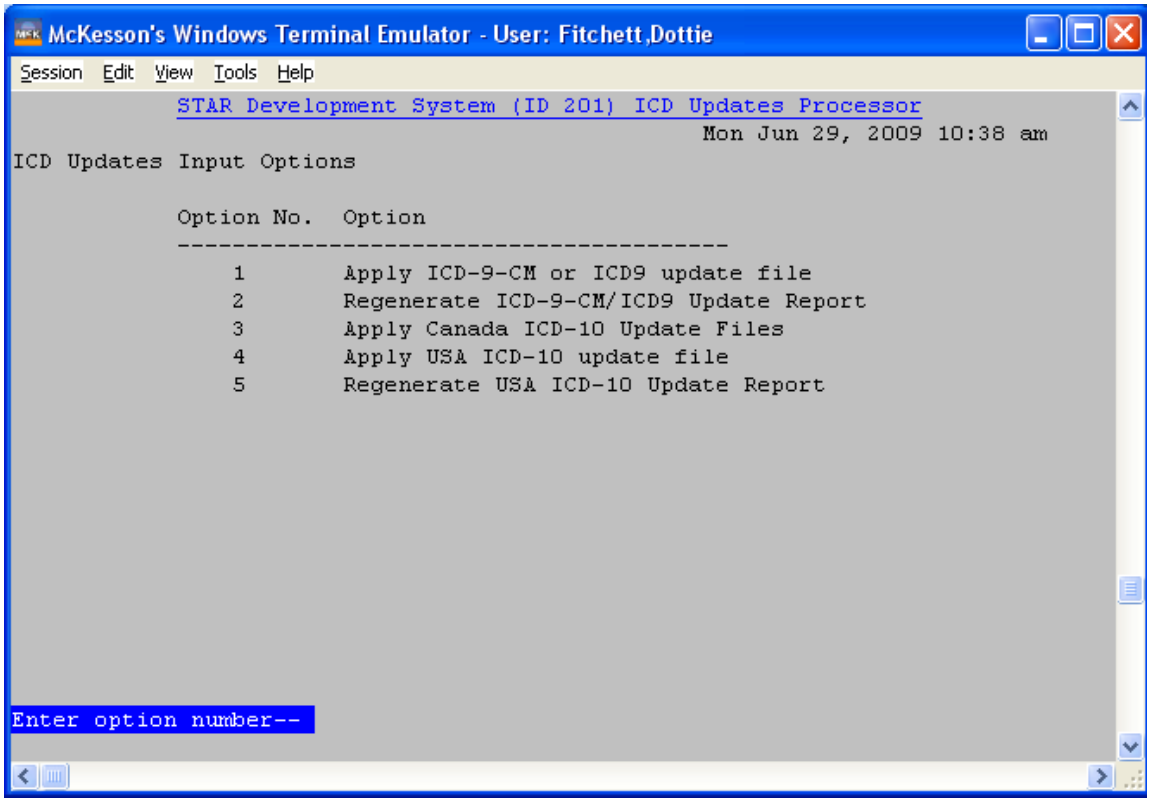
Exceptions: If particular Insurance Plans, Insurance Carriers, Financial Classes, or state reporting requires ICD-9 diagnosis and procedure codes **after** this USA ICD-10 Effective Date, those exceptions should be listed in the Insurance Plan table, the Insurance Carrier table, the Financial Classes table, and the Facility State ICD10 Options table as outlined in the Patient Processing functional design, *F PP M23013 ICD-10 Enhancements.*

A Daily ICD-Indicator Update Report runs every day once the ICD-10 Effective Date has been set. See Patient Processing Functional Design for details. This report provides a list to the Records Management Department of changes to Insurance Plan, etc., which has resulted in a change to the ICD Indicator for the account. It is the facility's responsibility to assure that all needed codes are entered for abstracting and insurance purposes.

2. Table and Parameter Build

   - ICD-10-CM Diagnosis and ICD-9-PCS Table Build

     Upload ICD-10 Tables following the implementation steps in STI M23800, using the ICD Updates Processor. There are two new menu items available: 1) Apply USA ICD10 update file, and 2) Regenerate USA ICD-10 update files. The functionality is the same for ICD-10 as it was for ICD-9. However, it takes longer to run the ICD-10 update.

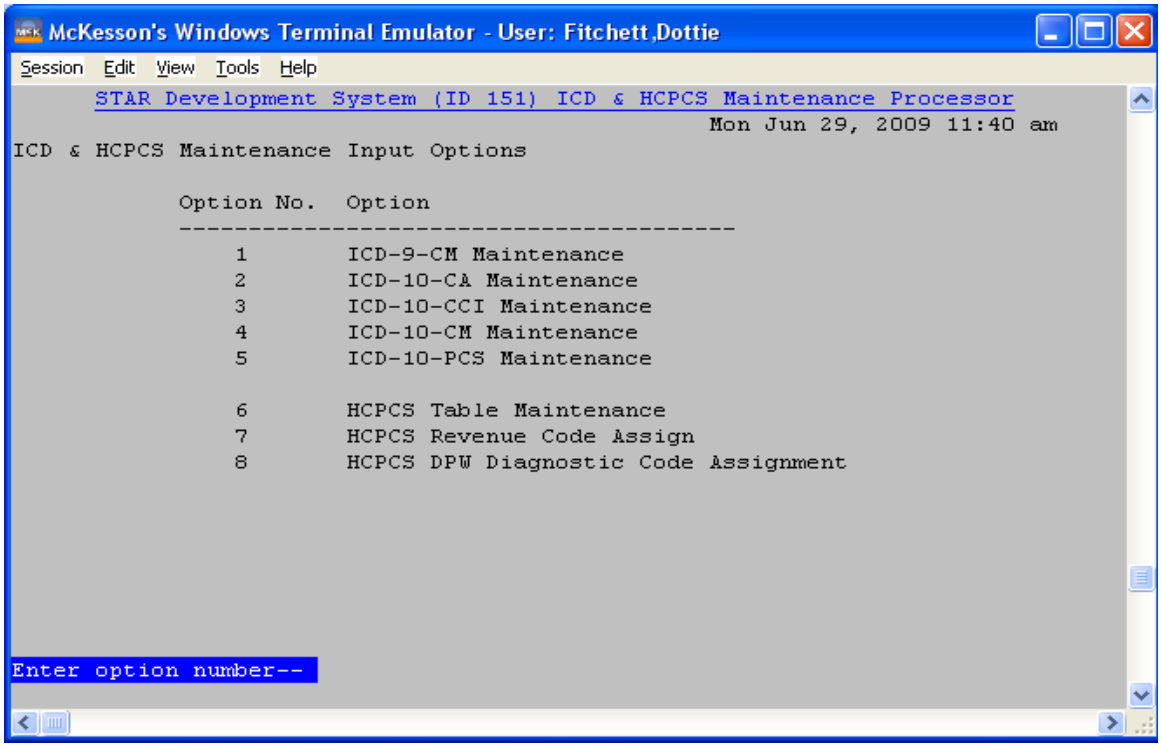


- ICD-10-CM AND ICD-10-PCS Table Maintenance

  Two new menu items have been added to the ICD & HCPCS Maintenance Processor:

  - ICD-10 CM Maintenance
  - ICD-10-PCS Maintenance

The functionality is the same for ICD-10 as it was for ICD-9.



- DRGs and ICD-10

  NOTE: ICD-10 codes **do not** map to a DRG with the I5.0 Release. A future STI will add this functionality when ICD-10 DRG Rate Tables are available from CMS**.** No implementation steps are required at this time.

  How to use DRG Version to determine if Grouper is based on ICD-9 or ICD-10 codes:

  For the STAR Medicare grouper, the versioning is as follows:

  - When Medicare adopts ICD-10, it is done at the time of their regular October DRG Update in October, 2013.

  - The Medicare DRG for all versions from the date Medicare adopts ICD-10 codes is ICD-10 based. All earlier versions are ICD-9.

  For Third Party groupers, the versioning is based on the ICD-10 Effective Date for the associated FC, Insurance Carrier, Insurance Plan. Entry in these fields need to be coordinated with entry of payor codes. Payor codes are currently assigned at the FC (Financial Classes) level, the Insurance Carrier and Insurance Plan levels in those respective tables.

NOTE: DRG Payor codes currently set by Financial Class in the DRG Payor Table move with the M23127 STI load to the Financial Classes Table. When STI M23127 is loaded, a conversion program downloads all current payor codes in the DRG payor table, to the Financial Classes Table.

- GUI Form Flow

  The following forms must be added to the GUI Abstracting Form Flow by ICD-10 Effective Date:

  - Diag/Proc/HCPCS ICD-10 form
  - Mental Health Detail Form

  Details for these forms are provided in the table in the following section.

Screen/Form Enhancements

The screen and form functionality changes added for ICD-10 are explained below.

CHARACTER-BASED MR ABSTRACTING SCREEN ENHANCEMENTS

The following table outlines the enhancements for character-based Medical Record Abstracting Screens. Some sample screens are provided in the section after the table. Refer to the reference guide documentation for additional screen examples.

Screen Name & Navigation	Purpose	Description
ICD-10 Diagnoses Processor Path: Abstracting & DRG Assignment Functions > M/R Abstracting Select M/R Abstracting > Diagnoses See sample screen.	Allows entry of ICD-10-CM Diagnosis codes and provides access to ICD-9-CM entry.	This new screen is a duplicate of the ICD-9-CM Diagnosis Processor screen, except: • It contains the ICD Indicator in header • Column header revised from "Code" to "ICD-10-CM Code" • Allows entry of ICD-10 codes (8 digits) • Accesses ICD-10 table for table lookups for Admitting, Principal, and Secondary Diagnoses • Updates screen prompt with option to enter (I)CD 9 codes and deletes option (E) for Encoder (Encoder interface for character-based system no longer functional as of April 1, 2008) • Adds warning message when leaving screen, if ICD-9 codes are also needed. **Impact:** ICD-10-CM codes can be entered from this screen and ICD-9-CM code entry can be accessed from this screen. This screen is not available when STI M23127 is loaded. It is available when the facility USA ICD-10 Effective date is set for accounts whose admission date is equal to or after the ICD-10 Effective Date. This screen allows you to toggle back and forth between ICD-10 and ICD-9 when both codes are required per the ICD Indicator. See Admission and General Parameters of the STAR Patient Processing ICD-10 functional design, *F PP M23013 ICD-10 Enhancements*.
ICD-10 Diagnoses Sub-screen - **(A)dmit Secondary Diagnosis** Path: Option "A" for Admit 2ndry Dx codes at prompt on Diagnosis Processor No sample screen.	Allows access to Secondary ICD-10 Diagnosis codes from Admission	This sub-screen is a duplicate of the ICD-9-CM Secondary Dx screen. The only difference is in the screen logic: it pulls just ICD-10 admitting diagnoses for selection. **Impact:** Codes selected from this screen for the abstract are stored in the new location for ICD 10 codes. This sub-screen is available with the ICD-10 Diagnosis Processor screen once the ICD-10 Effective date is set.

Screen Name & Navigation	Purpose	Description
ICD-10 Diagnoses Sub-screen - **(R)eason for Visit** Path: Option “R” for Reason for Visit at prompt on Diagnoses Processor No sample screen.	Allows entry of ICD-10 Reason (Diagnosis) Codes	This sub-screen is a duplicate of the ICD-9-CM Secondary Dx screen. The only difference is that it uses the ICD-10 look up table. **Impact:** Codes entered on this screen are stored in the new ICD-10 location in the database. This sub-screen is available with the ICD-10 Diagnosis Processor screen once the ICD-10 effective date is set.
ICD-10 Diagnoses Sub-screen - **(N)osocomial** Path: Option “N” for Nosocomial at prompt on Diagnoses Processor No sample screen.	Allows entry of Nosocomial data for each account, including ICD-10 Nosocomial procedure codes	This new subscreen is a duplicate of the ICD-9-CM Nosocomial screen, except the procedure field uses the ICD-10 table. **Impact:** Codes entered on this screen are stored in the new ICD 10 location in the database. This sub-screen is available with the ICD-10 Diagnosis Processor screen.
ICD-9 Diagnoses Processor Screen Path: This screen can only be accessed through the new ICD-10 Diagnosis screen Option (I) for ICD-9. See sample screen.	Allows entry of ICD-9-CM codes for insurance companies, etc., that require ICD-9 codes once the facility has switched to ICD-10.	When STI M23127 is loaded, this new ICD-9 screen is used to enter needed ICD-9 codes. The screen display is the same as for the ICD-10 Diagnosis Screen, except: • Column Heading is changed from Code to ICD-9 Code • Prompt adds a prompt for ICD-10 (T) and deletes the prompt for ICD-9 (I) All other functionality for this ICD-9 screen remains as it was prior to the ICD-10 Enhancement. **Impact:** Codes entered on this screen are stored in the ICD 9 location in the database. This screen is available when the USA ICD-10 effective date is set. It is the primary screen when the ICD Indicator is 9. It is the secondary screen if the ICD-Indicator is 10 or B. See Admission and General Parameters of the STAR Patient Processing ICD-10 functional Design, *F PP M23013 ICD-10 Enhancements*.

Screen Name & Navigation	Purpose	Description
Mental Health Processor This screen is only accessed if patient is a mental health patient type. Path: Abstracting & DRG Assignment Functions > M/R Abstracting Select M/R Abstracting > Mental Health No sample screen.	Allows entry of DSM codes and pulls in associated ICD codes from DSM Pointer Table. See Patient Processing functional design*, F PP M23013 ICD 10 Enhancements*, for details. New with ICD-10, pulls in both the ICD-10 and ICD-9 pointer codes.	Revised Mental Health Processor screen replaces the current Mental Health Processor screen when M23127 is loaded. Adds field for ICD-10 codes. ICD-10 codes from the DSM pointer table pull in for the primary DSM code. This screen is available when STI M23127 is loaded.
Mental Health Processor Subscreen - **Additional DSM Codes** This screen is only accessed if patient is a mental health patient type. Path: Select field for Additional DSM codes from Mental Health screen. No sample screen.	Allows entry of additional DSM codes and pulls in associated ICD codes from DSM Pointer Table. See Patient Processing functional design*, F PP M23013 ICD-10 Enhancements*, for details. New with ICD-10, pulls in both the ICD-10 and ICD-9 pointer codes. ICD-9 codes once the facility has switched to ICD-10.	Revised mental health processor sub-screen replaces the current Mental Health Processor sub-screen when STI M23127 is loaded. Adds fields for ICD-10 codes. ICD-10 codes from the DSM pointer table pull in for the primary DSM code. This screen is available when STI M23127 is loaded.

Screen Name & Navigation	Purpose	Description
ICD-10 Procedure Processor Path: Abstracting & DRG Assignment Functions > M/R Abstracting Select M/R Abstracting > Procedures See sample screen.	Allows entry of ICD-10-PCS Procedure Codes and provides access to ICD-9-CM entry.	This new screen is a duplicate of the ICD-9-CM Diagnosis Processor screen, except: • It contains an ICD Indicator in the header • Column is revised from “Code” to “ICD-10-PCS Code" • Allows entry of ICD-10-PCS codes (7-characters) • Provides table lookups from ICD-10 table • Updates screen prompt with option for (I)CD 9 codes and deletes option (E) for Encoder (Encoder interface for character-based system no longer functional as of April 1, 2008) • Adds warning message when leaving screen, if ICD-9 codes are also needed. **Impact:** Codes entered on this screen are stored in the new ICD 10 location in the database. This screen is available when the ICD-10 Effective Date is set. It becomes the primary screen, when the facility USA ICD-10 Effective date is set, for any accounts whose admission date is equal to or after the ICD-10 Effective Date **and** the Version Indicator is **not** 9. See Admission and General Parameters of the STAR Patient Processing ICD-10 functional design, *F PP M23013 ICD-10 Enhancements.*
Procedure Detail Screen Path: Option “A” for ‘A-’dd Procedure at prompt on Procedure Processor screen No sample screen.	Allows entry of ICD-10-PCS Procedure Code Detail	This new screen is a duplicate of ICD-9-CM Procedure Detail screen, except it: • Contains ICD Indicator in header • Allows entry of ICD-10-PCS codes • Provides table lookups from ICD-10 table **Impact:** Codes entered on this screen are stored in the new ICD 10 location in the database. This sub-screen is available with the ICD-10 Procedure Processor screen when the ICD-10 effective date is set.

Screen Name & Navigation	Purpose	Description
ICD-9 Diagnosis Processor Screen Path: Abstracting & DRG Assignment Functions > M/R Abstracting Select M/R Abstracting > Procedures No sample screen.	Allows entry of ICD-9-CM codes for insurance companies, etc., that require ICD-9 codes once the facility has switched to ICD-10.	When the ICD Effective date is set, this updated ICD-9 screen is used to enter ICD-9 codes. This screen is a duplicate of the current ICD-9-CM Procedure screen, except: • Column name is revised from "Code" to "ICD-9-CM Code" • Updated prompt allows entry of ICD-10 (T) codes and deletes option (E) for Encoder (Encoder interface for character-based system no longer functional as of April 1, 2008) All other functionality for this ICD-9 screen remains as it was prior to the ICD-10 Enhancement. It pulls in and stores ICD-9 codes only. **Impact:** Codes entered on this screen are stored in the ICD 9 location in the database. This screen is available when the ICD-10 Effective Date is set. It becomes the secondary screen, when the facility USA ICD-10 Effective date is set, for any accounts whose admission date is equal to or after the ICD-10 Effective Date **and** the ICD Indicator is **not** 9. If the ICD Indicator **is** 9, it is the primary screen. See Admission and General Parameters of the STAR Patient Processing ICD-10 functional design, *F PP M23013 ICD-10 Enhancements.*
Abstract Inquiry/ Diagnoses and Procedures See sample screen.	These screens display diagnoses and procedures for the account.	Adds ability to view ICD-10 codes, ICD-9 codes or Both using displays from new ICD-10 and ICD-9 screens above, and adds option to view (N) osocomial Information.

Screen Name & Navigation	Purpose	Description
DRG Payors Table No sample screen.	The DRG Payors table enables you to define parameters based on patient's financial class.	A conversion runs when STI M23127 is loaded that moves the following fields from the DRG Payors table to the Financial Classes table. • DRG Payor Code/Description, except prompt in FC table allows table look-up only • Other Payor Code • MS-DRG • APC/ASC Payor Code **Notes:** • Effective date fields (To/From) are added to indicate effective dates for the Other Payor Codes for the DRG and APC/ASC payors in the Financial Classes Table. See STAR Patient Processing functional design, *F PP M23013 ICD-10 Enhancements*. • The DRG Payor Code/ Description appears in both Tables. However, in the Financial Classes Table, only table look ups are permitted. All new Payor Codes must be entered via the DRG Payors table. • Financial Classes field in the DRG Payors table is now display-only. As new financial classes are assigned to a DRG Payor, these updates are reflected in this field in the DRG Payors Table.

SAMPLE SCREENS

- Character-based Diagnosis Processor for entry of ICD-10 codes:

```
                  General Hospital Diagnoses Processor
                                              Fri Mar 20, 2009 06:36 pm
    Account No     Name                        ICD    Unit No        Corp No
    0825500001     DONER,ABIGAIL               10     000-00-5811    00006478
     ICD-10 Code      Description                 DRG Dx Tumor   Type POA/HAC
 Admitting  F43.0     ACUTE STRESS REACTION                          Y
 Principal  G30.9     ALZHEIMER'S DISEASE, UNSPECIFI
 2ndary( 1) F41.1     GENERALIZED ANXIETY DISORDER                   W
       ( 2) D50.9     IRON DEFICIENCY ANEMIA, UNSPEC









Enter ICD-10 secondary(T), line to change, ICD-9(I), (*) for A,P,R,N options--
                  next screen(/) or previous screen (/P) [/]
```

If you select (I) from prompt at bottom of screen, you can toggle to the new ICD-9 screen.

```
                  General Hospital Diagnoses Processor
                                              Fri Mar 20, 2009 07:06 pm
    Account No     Name                        ICD    Unit No        Corp No
    0825500001     DONER,ABIGAIL               10     000-00-5811    00006478
     ICD-9 Code       Description                 DRG Dx Tumor   Type POA/HAC
 Admitting  789.01    ABDMNAL PAIN RT UPR QUAD                       Y
 Principal  003.0     SALMONELLA ENTERITIS
 2ndary( 1) 002.0     TYPHOID FEVER                                  N









Enter ICD-9 secondary(I), line to change, ICD-10(T), (*) for A,P,R,N options--
                  next screen(/) or previous screen (/P) [/]
```

If you select (T) on this screen you can toggle back to the ICD-10 Diagnosis Processor screen.

The Procedure screens works the same way, with the ability to toggle and forth between the ICD-10 Procedure Processor screen and the ICD-9 Procedure Processor screen.

- ICD-10 Procedure Processor Screen

```
                  General Hospital Procedures Processor
                                                Tue Mar 24, 2009 01:48 pm
    Account No     Name                         ICD    Unit No        Corp No
    0904200002     TONEY,TIM                    10     000-00-5885    00006552
ICD-10-PCS Code  Description                    Date/Time        Surgeon      AC
P  (1) HZ80ZZZ MEDICATION MANAGEMENT OF NICOTIN 02/11/09 07:00   ADAIR,CAR
   (2) 00160K0 0 Medical and Surgical|0 Central 02/11/09 07:00   TONGEN,LYLE









Select procedure to revise, View Charges(C), ICD-9(I), or add(A)--
                     next screen (/) or previous (/P) [/]
```

Clicking (I) on this screen takes you to the ICD-9 Procedure Processor screen.

Abstract Inquiry screens display all codes (ICD-10, ICD-9, or Both) available for an account. ICD-10 codes display first, with the ability to toggle to ICD-9 (I).

```
                  General Hospital Diagnoses Processor
                                                Fri Mar 20, 2009 06:36 pm
    Account No     Name                         ICD    Unit No        Corp No
    0825500001     DONER,ABIGAIL                10     000-00-5811    00006478
     ICD-10 Code      Description                   DRG Dx Tumor   Type POA/HAC
 Admitting  F43.0     ACUTE STRESS REACTION                            Y
 Principal  G30.9     ALZHEIMER'S DISEASE, UNSPECIFI
 2ndary( 1) F41.1     GENERALIZED ANXIETY DISORDER                     W
       ( 2) D50.9     IRON DEFICIENCY ANEMIA, UNSPEC









View ICD-9(I) Diagnoses, (R)eason for Visit, or Press NL--
```

GUI ABSTRACTING FORM ENHANCEMENTS

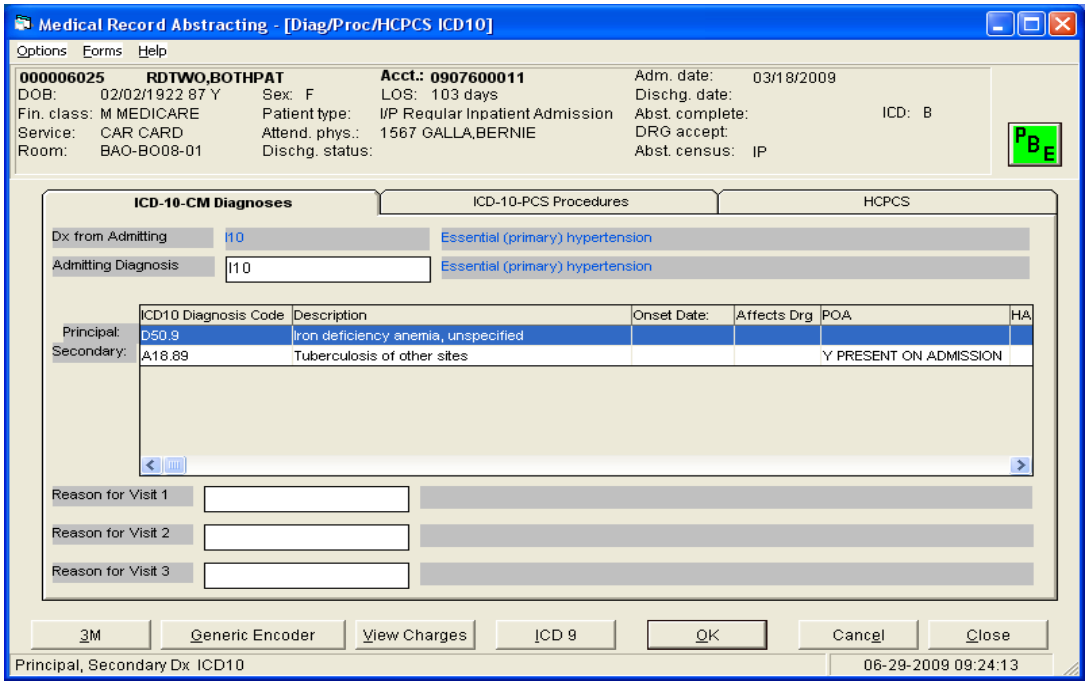
The following table outlines the enhancements for GUI Abstracting forms. Some sample forms are provided in the section following the table.

Form Name & Navigation	Purpose	Description
Diag /Proc/HCPCS ICD-10 form Path: Main MR Menu > Abstracting Tab > Abstracting (GUI) > Select patient > Click Forms menu at top left of form and Go to Diag/Proc/ HPCPCS ICD-10 form See sample form.	Allows entry of ICD-10-CM Diagnosis codes, ICD-10-PCS Procedure Codes, and HCPCS codes for an account	This new form is a duplicate of ICD-9-CM Diagnosis/Procedure/HCPCS form, except: • Contains ICD Indicator in header • Allows entry of 8-character ICD-10-CM codes and 7-character ICD-10-PCS codes • Table lookups use ICD-10 table • Adds new button to allow entry of (I)CD 9 codes **Impact:** Codes entered on this form are stored in the new ICD 10 location in the database. This form is available when STI M23127 is loaded. This form needs to **replace** the existing Diagnosis/ Procedure/HCPCS form on the date the facility begins to code with ICD-10 (USA ICD-10 Effective Date). **Note:** All new sub-screens are added with this form.
Diagnosis Sub-screen - **(A)dmit Secondary Diagnosis** Path: Enter "A-" in Admission Diagnosis field on Diagnosis/ Procedure/HCPCS Form. No sample form.	Allows access to Secondary ICD-10 Diagnosis codes from Admission	This new form is a duplicate of the ICD-9-CM Secondary Dx form, except the system pulls just ICD-10 admitting diagnoses for selection. **Impact:** Codes selected from this form for the abstract are stored in the new ICD 10 location in the database.
Diagnosis Sub-screen - **(R)eason for Visit** No sample form.	Allows for entry of ICD-10 Reason (Diagnosis) Codes	This new form is a duplicate of the ICD-9-CM Reason for Visit form, except the ICD look up table is for ICD-10 diagnoses. **Impact:** Codes entered on this form are stored in the new ICD-10 location in the database.

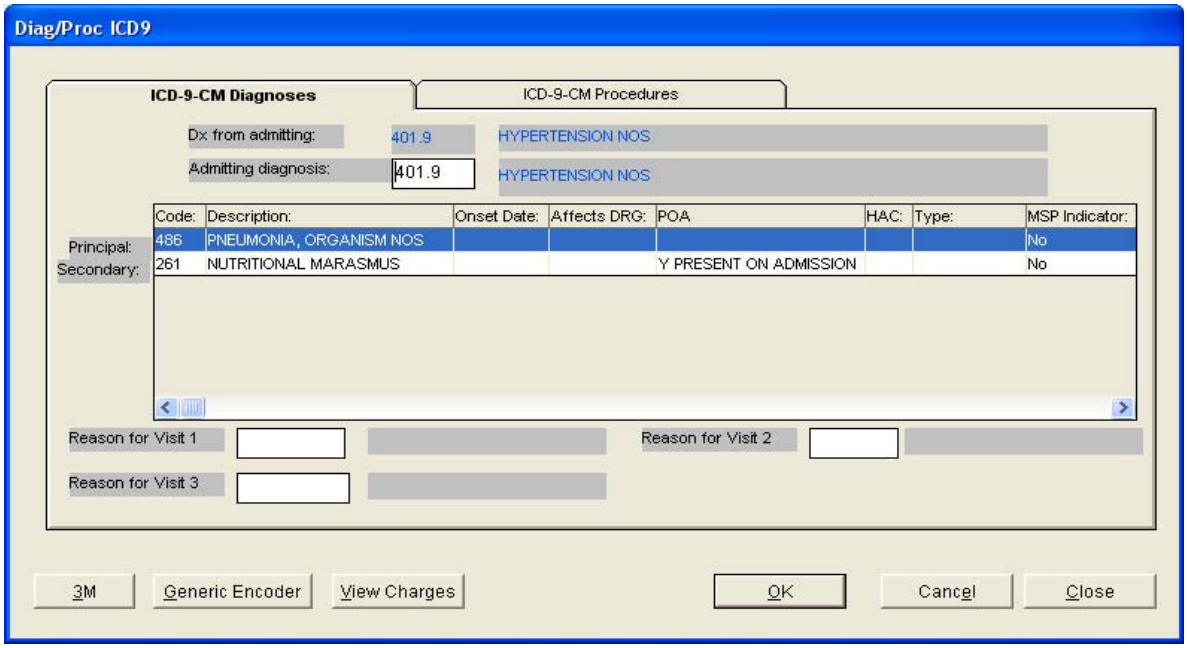
Form Name & Navigation	Purpose	Description
Procedure Detail / Procedures No sample form.	Allows entry of ICD-10-PCS Procedure Codes	This new form is a duplicate of the ICD-9-CM Procedure screen, except: • Allows entry of ICD-10-PCS codes • Provides table look-ups from ICD-10 table **Impact:** Codes entered on this form are stored in the new ICD-10 location in the database. Activation of new form occurs for any accounts whose admission date is equal to or after the USA ICD-10 Effective date. See Admission and General Parameters of the STAR Patient Processing ICD-10 functional design for more detail.
ICD-9 Diagnosis/ Procedure form See sample form.	Allows entry of ICD-9-CM Procedure Codes once ICD Effective date has been set	This is the new ICD-9 form that is accessed from the button on the new ICD-10 form. • Tab headings revised to: ICD-9-CM Diagnoses / ICD-9-CM Procedures • Contains ICD Indicator in header • Table lookups use ICD-9 table **Impact:** Codes entered on this form are stored in the current ICD-9 location in the database.
Mental Health Detail Form **DSM Tab** This screen is only accessed if in the Form flow for the account (i.e. mental health account) patient type. See sample form.	Allows entry of additional DSM codes and pulls in associated ICD codes from DSM Pointer Table. See STAR Patient Processing functional design*, F PP M23013 ICD-10 Enhancements*, for details. New with ICD-10, pulls in both the ICD-10 and ICD-9 pointer codes. ICD-9 codes once the facility has switched to ICD-10.	This new form is a duplicate of ICD-9-CM Mental Health Detail form, except it pulls in associated ICD-10 codes, ICD-9 or both, depending on values in the DSM Pointer Table. This form is available when STI M23127 is loaded. This form needs to **replace** the existing Mental Health Detail form on the date the facility begins to code with ICD-10 (USA ICD-10 Effective Date).

SAMPLE GUI FORMS

- New GUI Diag/Proc/HCPCS ICD-10 form allows the entry of both ICD-10 and ICD-9 codes. A button is used to toggle to the ICD-9 form.

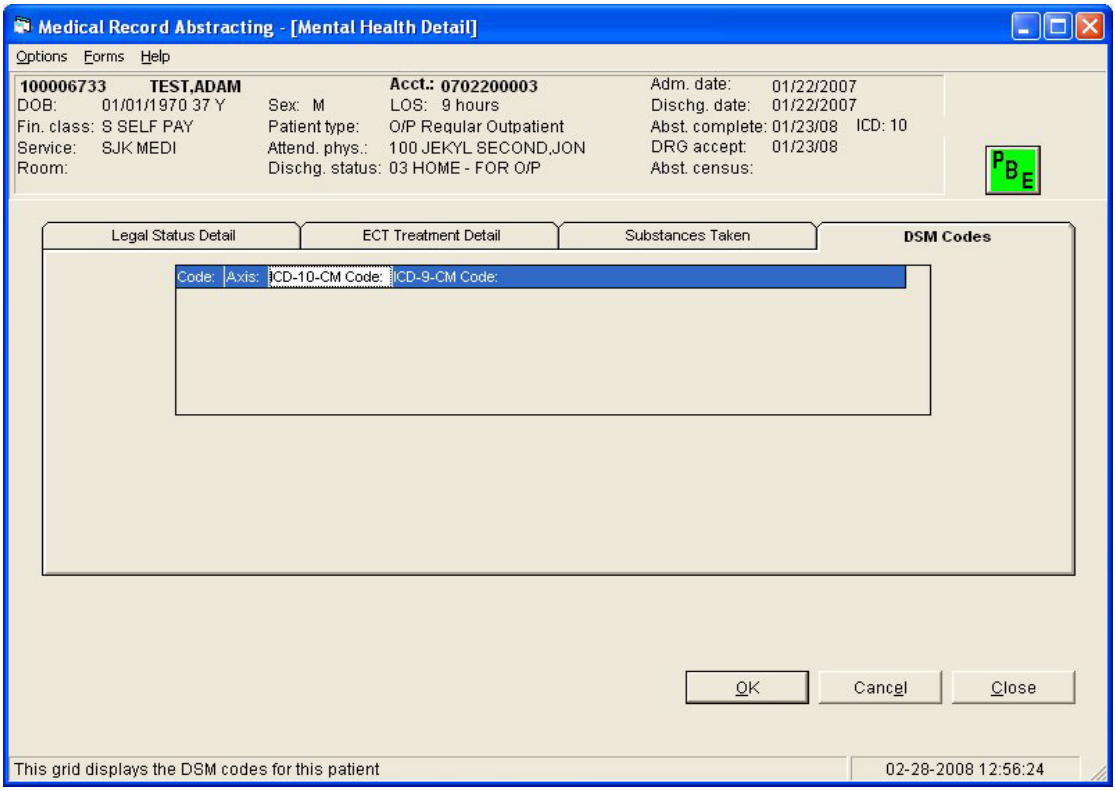


- The new ICD-9 form displays just two tabs for ICD-9-CM Diagnoses and ICD-9-CM Procedures. The HCPCS tab just displays once with the main Diag/Proc/HCPCS form.



Clicking on the Cancel or Close button returns you to the ICD-10 form.

- The new Mental Health Detail Form / DSM Codes Tab displays ICD-10 codes from the DSM Pointer table.



Testing Guidelines

- Validate ability to abstract using ICD-10 codes, ICD-9 codes, or Both.
- Access ICD Update function and validate new menu for ICD-10 Update.
- Access Maintenance functions and validate ICD-10-CM and ICD-10-PCS menu items added to Maintenance menus.
- Abstract some patients using various patient types, insurance carriers, insurance plans, and financial classes.
- Work with the Patient Processing or Admitting group at your facility to validate that ICD-10 admission codes are displaying correctly when pulled up in Abstracting.
- Check the Patient header in both the character-based system and GUI Abstracting to see if the correct ICD indicator is displayed for accounts needing ICD-10 codes, ICD-9 codes, or both.

- Check all of the character-based screens mentioned above to be sure that the screens have been adjusted to accommodate the ICD-10-CM and ICD-10-PCS codes and descriptions.

- Check all of the GUI forms mentioned above to be sure that the forms have been adjusted to accommodate the ICD-10-CM and ICD-10-PCS codes and descriptions.

- Validate appropriate ICD-10, ICD-9, or both codes appear on the Abstract Summary Report and Attestation as outlined in the ICD-10 Records Management Functional Design.

Training Requirements

The changes necessary to add ICD-10 processing throughout STAR Records Management impacts most users of the system. The changes impact both character-based and GUI systems and require that all users are educated on the changes made to the system.

Training requirements include some form of training for all users, but more extensive training is required for abstracting and coding staff.

Implementation Considerations

ICD-10 Diagnoses and Procedures are now sent in the outbound HL7 Interface.

Documentation

In addition to the *Enhancement Summary* for Release 15.0, the *STAR 2000 ICD-10 Implementation Guide*, and the STI documentation, the following is a list of updates to the reference guides for STAR Medical Record and Utilization Management:

Enhancement Topic	Document	Chapter
Entry of ICD-10-CM Diagnosis codes, ICD-10-PCS Procedure Codes, and HCPCS codes for an account	*Medical Record Abstracting Online Help*	Topic: ICD-10 Diagnosis/ Procedure/HCPCS form
Entry of ICD-9-CM Diagnosis codes, ICD-9-PCS Procedure Codes, and HCPCS codes for an account	*Medical Record Abstracting Online Help*	Topic: ICD-9 Diagnosis/ Procedure/HCPCS form
Mental Health data and ICD-10 codes pulled from DSM Pointer table	*Medical Record Abstracting Online Help*	Topic: Mental Health Detail form

Enhancement Topic	Document	Chapter
ICD-9 and ICD-10 Diagnosis and Procedure Processor screens and reports	*STAR Patient Care Reference Guide - Medical Record Abstracting Volume*	All chapters
DRG Payors Table	*STAR Patient Care Reference Guide - Tables Volume*	4: Medical Record Tables
DRG Payors	*STAR Patient Care Reference Guide - Medical Record Worksheets Volume*	2: M/R Table Worksheets: Part 1
Financial Classes table	*STAR Patient Care Reference Guide - Tables Volume*	3: General Tables
	STAR Patient Care STAR/3M Coding and Reimbursement Interface Guide	9: Using RCS
	STAR Patient Care Reference Guide - Medical Record Generic Encoder Interface Guide	2: System Implementation
HCPCS Table Maintenance	*STAR Patient Care Reference Guide - Tables Volume*	2: High Level Tables
ICD-9 and ICD-10 Diagnosis and Procedure Processor screens	*STAR Patient Care Reference Guide - DRG Assignment Module*	1: Simulation 2: Assignment
ICD-10 references	*STAR Patient Care Reference Guide - Utilization Management Module*	All chapters
Additional UB Condition Codes and Occurrence Span Codes	*STAR Patient Care Reference Guide - Utilization Management Module*	2: UM Options
Apply USA ICD-10 Update File menu item added to the ICD Updates Processor	*STAR Patient Care Reference Guide - General Information Volume*	8: System Management
ICD-10-CM Maintenance and ICD-10-PCS Maintenance menu options	*STAR Patient Care Reference Guide - Tables Volume*	2: High Level Tables

ICD-10 with DRGs

When customers using STAR GUI abstracting and 3M Coding and Reimbursement Interface are ready to begin using ICD-10 codes, the facility sets the new Discharge ICD-10 Effective Date parameter**.** The parameter, located in STAR Abstracting Facility Parameters, determines the date when all discharged accounts will begin to be coded using ICD-10 codes and when the parameter will be used to set the 3M input tag to determine code sets that 3M needs to process (I-10 or BOTH I-10 and I-9).

NOTE: The Current Facility USA ICD Effective date (based on Admission Date) will continue to be used by Patient Processing and Clinicals.

The Discharge ICD-10 Effective Date must be on or after the current Facility USA ICD Effective Date. The Facility USA ICD Effective date parameter is edited so changes to this date may not be after the new Discharge ICD-10 Effective Date.

The Discharge ICD-10 Effective Date will be used in conjunction with new ICD-9 Indicator added to payor screen in FC, Insurance Carrier, and Insurance Plan table to determine 3M input flag for 3M Coding and Reimbursement Interface.

NOTE: The parameter will be used to create the new Discharge ICD Indicator to be used in M/R Abstracting , GUI Abstracting, and DRG Assignment.

After STI M24872 Is Loaded (Before Discharge ICD-10 Effective Date Is Set)

A number of changes for this enhancement are available by design when the STI(s) is moved into the system.

- All screens/forms and programs necessary to implement ICD-10 **w DRG's** are available.
- Character-based Abstracting Screens include these changes:
  - Display new ICD Discharge Indicator.
  - Discharge ICD Indicator is displayed on the header of DRG screens/forms. Values are: 9,10,9/10,10/9.
  - New parameter added to M/R Abstract & DRG Census Criteria
- Reports
  - New report titled Accounts to be Regrouped.
- GUI Abstracting
  - ICD-10 Diagnosis, Procedure, HCPCS form displays BOTH checkbox next to to Encoder buttons.

Implementation Steps – Build Process

The steps required to implement ICD-10 DRG processing for STAR Medical Record/ Utilization Management are outlined below.

1. Setting the Discharge ICD-10 Effective Date in Abstracting Facility Parameters. This new parameter will be looked at for determining the date when all discharged accounts will begin to be coded using ICD-10 codes.

Although this parameter is discussed in detail in the Patient Processing Implementation section of this document, there are important implications for STAR Medical Record/Utilization Management.

- Date must be on or after the current Facility USA ICD Effective Date.
- Changes to the Facility USA ICD Effective date parameter may not be AFTER the new Discharge ICD-10 Effective Date.

EXCEPTIONS:

If a payor code/effective date requires ICD-9 codes once the Discharge ICD-10 Effect date has been met, an I-9 DRG=Y (exception) indicator needs to be entered in the Financial Class, Insurance Plans, or Insurance Carriers table. Values are: Y,N, Blank. See Chapter 1 for information on these tables.

Testing Guidelines

Training Requirements

The changes necessary to add ICD-10 DRG processing throughout STAR Records Management impacts most users of the system. The changes impact both character-based and GUI systems and require that all users are educated on the changes made to the system.

Training requirements include some form of training for all users, but more extensive training is required for abstracting and coding staff.

Implementation Considerations

The new DRG ICD Indicator on DRG Assignment screens/forms will be used to send HL7 message: ICD Indicator for DRG calculated.

Documentation

In addition to the *Enhancement Summary* for Release 15.0, the *STAR 2000 ICD-10 Implementation Guide*, and the STI documentation, the following is a list of updates to the reference guides for STAR Medical Record and Utilization Management:

Enhancement Topic	Document	Chapter
Discharge Effective Date added to Hospital Facility Parameters	*Medical Record Abstracting*	4: M/R Maintenance

Enhancement Topic	Document	Chapter
ICD9 Exception Indicator Insurance Plans Insurance Carriers Financial Class s	*Tables Volume*	2: High Level Tables 2: High Level Tables 3: General Tables
ICD9 Indicator on GUI Abstract Header	*GUI Abstracting Help*	
DRG Indicator for DRG Processed on DRG Assignment Screen	*DRG Assignment Module*	2: DRG Assignment
ICD9 Indicator State ICD-10 Patient Type Exceptions	*Tables Volume*	2: High Level Tables
ICD9 Indicator added to Reports Abstract Summary Report Attestation Report Discharges by DRG Core Report	*Report Names Volume*	3: System Report Names by Module
New Report - Accounts to be Regrouped	*Report Names Volume*	3: System Report Names by Module
New Parameter - M/R Abstract & DRG Census Criteria: Incomplete Abstract (Y/N)	*Medical Record Abstracting Module Volume*	4: M/R Maintenance

PATIENT ACCOUNTING

Overview

Chapter 2 of the ICD-10 User Implementation Guide takes you through the steps required to implement ICD-10 processing and ICD-10 DRG's processing. Complete documentation for all screens, reports, tables, and parameters exists in the 18.0 STAR Online Documentation. Please refer to the online documentation for further explanation or examples.

This section of the implementation guide includes the new labels and fields you will see in the enhancement for ICD-10 as well as for the ICD DRG's.

- ISTAR Patient Accounting supports both ICD-9 and ICD-10 processing concurrently. Based on payer requirements, the same patient may have both ICD-10 and ICD-9 diagnosis and procedure codes, and can send an ICD-10 claim to one payer while sending an ICD-9 claim to another.

- The USA ICD-10 Effective Date field on STAR Patient Processing is based on the patient's Admission Date so that the appropriate diagnosis and procedure codes can be entered in Admissions, Medical Records, Lab, Rad, Pharmacy, and Order Management for the patient.

- STAR Patient Accounting allows the Billing and Claim Parameters to be based on either the Admission Date or the Discharge Date. This allows the bills and claims to hold for the required ICD-10 information with Discharges as of 10/01/2013.

- STAR Patient Accounting supports ICD-10 DRGs, while concurrently supporting ICD-9 DRGs when grouping on a third party system such as 3M.

Implementation Steps - Build Process

NOTE: The implementation steps that follow are for the ICD-10 enhancement. There are no implementation steps for ICD-10 with DRG's on the STAR Patient Accounting application. Please see STAR Medical Records for implementation steps for ICD-10 with DRG's. When STI F10864 is loaded, the changes in the application are visible. For visible changes, refer to Chapter 1, Patient Accounting.

SCREENS

Displays of diagnosis and procedure information in Account Inquiry include information for ICD-9, ICD-10, or both. The menus and screens that are displayed depend on the existence of data for the account, and not on the Account ICD flag. This allows all data to be viewed in Patient Accounting.

Each of the Account Inquiry screens uses the following logic to display information:

- If ICD-10 and ICD-9 data exist, the system starts with ICD-10 data with the ability to flip to ICD-9.
- If only ICD-9 data exists, the system displays ICD-9 only.
- If only ICD-10 data exists, then the system displays ICD-10 only.
- If no information exists, the system displays the ICD-10 screen only if indicated by the admission date of the patient and the Effective Date for ICD-10 on the Hospital Facility Options screen in Patient Processing.

Otherwise, the system displays the ICD-9 screen only.

Please see Chapter 1 of the User Implementation Guide, Patient Accounting, for examples of screens updated, and the 18.0 STAR Patient Accounting Online Documentation, Account Inquiry and Revision volume.

Tables and Parameters

BILLING PARAMETERS

The Final Bill Billing Parameters table, screen 2, has been updated with the ICD-10 Effective Date field to specify the beginning admission date or discharge date of patients that require ICD-10 diagnosis and procedure codes. Note that the Billing Parameter is assigned based on the COB 1 insurance plan, and if there are no insurances on the account, on the Financial Class of the account.

If the ICD-10 Effective Date on the Final bill Billing Parameters is blank, the system then accesses the USA ICD-10 Effective Date field in the Hospital Facility Options, and the Insurance Plan table for the COB 1 insurance, then the Insurance Carrier table for the COB 1 insurance, and finally the Financial Class table to determine if the final bill should edit for ICD-9 or ICD-10 diagnosis and procedure codes.

All Billing Data Base Elements that look to diagnoses or procedures have been updated to access the Bill ICD flag to determine if ICD-10 or ICD-9 codes are required.

```
                General Hospital Billing Parameters Processor
                                                Wed Jun 10, 2009 02:15 pm
Billing Parameters
1 Code                  2 Description                          3 Bill Type
   99                      TEST FINAL BILL PARAMETER             Final
 4 Bill Suspense Days   5 ICD-10 Effective Date
   3                       10/01/2013 Discharge Date
 6 Billing Requirements Edit Code     7 Edit Suspense Days  8 Maximum Hold Days
   99-TESTING REQUIREMENTS              0                     Unlimited
 9 Zero Charge Rpt Days              10 Zero Chg Bill Days  11 Chg Bill Window
   1                                    Unlimited
12 Auto Late Bill      13 Minimum Late Charges   14 Minimum Late Charge Amount
   No
15 Zero Bal?           16 Minimum Late Credits   17 Minimum Late Credit Amount


18 Auto Adj Rebill     19 Minimum Late Charges   20 Minimum Late Charge Amount
   No
21 Zero Bal?           22 Minimum Late Credits   23 Minimum Late Credit Amount


24 Auto Adj Rebill DRG/Dx/Proc       25 Auto Adj Rebill CPTAFB
   Report only                          No


Enter field number or '/' starting field number--
                      next(/) or previous screen(/P) [/]
```

ICD-10 EFFECTIVE DATE

First line of logic – Final Bill Parameter ICD-10 Effective Date

While the STAR Patient Processing application determines when the ICD-10 codes are collected and reported, the **ICD-10 Effective Date field on the Final Bill Parameter** determines which patients are identified by the billing function to edit these ICD-10 diagnoses and procedures. The Patient Processing and the Patient Accounting tables and parameters should complement each other. It's up to the hospital to verify that the tables are in sync for the payers.

When accessing the ICD-10 Effective Date field, the system first prompts:

Enter the Effective Date for ICD-10 Diagnosis and Procedure processing (MM/DD/YYYY) –

The system then prompts:

Is the ICD-10 Effective Date based on Admission Date (A) or Discharge Date (D) [A]--

The system displays the date and either Admission Date or Discharge Date. For example: 01/01/2013 Admission Date or 10/01/2013 Discharge Date.

NOTE: For the below, in order to collect ICD-10 diagnoses and procedures on the account, the USA ICD-10 Eff Date field on the Admission and General Parameters screen of the Hospital Facility Options on STAR Patient Processing must be a date that is either on or before the account's admission date.

If the date is set, for the *Admission Date*, but the patient's admission date is before the ICD-10 Effective Date, the Bill ICD flag is set to 9, and the system continues to load and edit the ICD-9 codes only for the patient's bill. This means that series patient types that were registered before this ICD-10 Effective Date continue to edit only ICD-9 diagnosis and procedure codes on the bill. These series patient types may need to be discharged and re-admitted once ICD-10 codes are required. If the date is set, for the Admission Date, and the patient's admission date is on or after the ICD-10 Effective Date, the Bill ICD flag is set to 10, and the system edits the ICD-10 codes only for the patient's bill.

If the date is set, for the *Discharge Date*, but the patient's discharge date is before the ICD-10 Effective Date, the Bill ICD flag is set to 9, and the system continues to edit the ICD-9 codes only for the patient's bill. This means that series patient types that were discharged before this ICD-10 Effective Date continue to edit only ICD-9 diagnosis and procedure codes to the bill. These series patient types may need to be discharged and re-admitted once ICD-10 codes are required. If the date is set, for the Discharge Date, and the patient's discharge date is on or after the ICD-10 Effective Date, the Bill ICD flag is set to 10 and the system edits the ICD-10 codes only for the patient's bill.

If the date is set for the Discharge Date and if the Admission Date precedes the USA ICD-10 Effective Date on Patient Processing (so the Account ICD indicator is set to 9), but the account's discharge date, or Bill Through Date if no discharge date, is on or after the USA ICD-10 Effective Date on Patient Processing, the system does the following:

a) Look to the Billing Parameter. If the billing parameter ICD-10 Effective Date is based on Discharge Date, then use the account's discharge date, or the Bill Through Date if no discharge date, to determine the bill ICD indicator. If the billing parameter ICD-10 Effective Date is based on Admission Date, then do no further analysis. The bill will edit for ICD-9.

b) Look to the Claim Parameter. If the claim parameter ICD-10 Effective Date is based on Discharge Date, then use the account's discharge date, or the Bill Through Date of the bill that loaded the claim if no discharge date, to determine the claim ICD indicator. If the claim parameter ICD-10 Effective Date is based on Admission Date, then do no further analysis. The claim will load and edit for ICD-9.

NOTE: This logic means that you can fail an account's bill and claims for missing ICD-10 information, when ICD-10 information was not entered on the account, and the account has an Account ICD indicator of 9.

In order to correct this situation, the ICD-10 information would need to be entered via Medical Records. As long as the USA ICD-10 Effective Date on Patient Processing is Today or a date in the past, Medical Records allows ICD-10 information to be entered on an account regardless of the Account ICD indicator.

EXAMPLES

**** USA ICD-10 Effective Date is 09/14/2011

Account 1:

- Admitted 09/01/11

- Account ICD indicator is 9

- Final Bill Parm is set to DISCHARGE DATE 10/01/2011

- Cycle 1, produced with BILL THROUGH DATE of 9/30, cycle does not edit but is loaded with Bill ICD of 9.

- Claim Load Edit is set to DISCHARGE DATE 10/01/2011

- Cycle Claim, produced with BILL THROUGH DATE of 9/30 (bill that loads claim) loads/edits for ICD-9

- Account discharged 10/5/2011.

- Final Bill produced with BILL THROUGH DATE of 10/5 edits for ICD-10

- Final Claim produced with BILL THROUGH DATE of 10/5 loads/edits for ICD-10

Account 2:

- Admitted 09/01/11

- Account ICD indicator is 9

- Account is Discharged on 9/26/2011

- Final Bill Parm is set to DISCHARGE DATE 10/01/2011

- Claim Load Edit is set to DISCHARGE DATE 10/01/2011

- Final Bill produced with BILL THROUGH DATE of 9/26 edits for ICD-9

- Final Claim produced with BILL THROUGH DATE of 9/26 loads/edits for ICD-9

Account 3:

- Admitted 09/01/11

- Account ICD indicator is 9

- Final Bill Parm is set to ADMISSION DATE 10/01/2011

- Cycle 1, produced with BILL THROUGH DATE of 9/30, cycle does not edit but is loaded with Bill ICD of 9.

- Claim Load Edit is set to ADMISSION DATE 10/01/2011

- Cycle Claim, produced with BILL THROUGH DATE of 9/30 (bill that loads claim) loads/edits for ICD-9

- Account discharged 10/5/2011.

- Final Bill produced with BILL THROUGH DATE of 10/5 edits for ICD-9

- Final Claim produced with BILL THROUGH DATE of 10/5 loads/edits for ICD-9

NOTE ON BILLS:

Regular bills produced via Midnight Processing or Instant Adjustment Bill look for the existence of a Discharge Date when evaluating the Billing ICD-10 Effective Date when based on Discharge Date.

For cycle bills, the Bill Thru Date is used when evaluating if the bill or claim should be ICD-9 or ICD-10 based on an ICD Effective Date that uses Discharge Date. Since the Cycle Billing Parameters do not have an ICD-10 Effective Date field (and do not edit), the system looks to the Final Billing Parameters ICD-10 Effective Date. For the cycle bill, it will then compare the Bill Thru Date for the cycle to this ICD-10 Effective Date, to determine if the cycle should load for ICD-9 or ICD-10 data.

Once the account is actually discharged, the true discharge date is used to determine if the bill and claims should load/edit ICD-9 or ICD-10.

Pre-bill Edit bills will use Today's Date as the Discharge Date when evaluating the Billing ICD-10 Effective Date when based on Discharge

Date. This is because the Pre-bills are anticipating what will be required when a bill is produced. Each time the account is re-evaluated for Pre-bill Edits, the system will use Today's Date if there is no Discharge Date.

NOTE ON CLAIMS:

Regular claims produced via Midnight Processing, Instant Adjustment Bill, or Add Claim to Insurance look for the existence of a Discharge Date when evaluating the Claim ICD-10 Effective Date when based on Discharge Date. If there is no discharge date at the time the claim is created, the Bill Thru Date for the bill that loaded the claim is used when evaluating if the bill or claim should be ICD-9 or ICD-10 based on an ICD Effective Date that uses Discharge Date.

Pre-bill Edit claims will use Today's Date as the Discharge Date when evaluating the Claim ICD-10 Effective Date when based on Discharge Date. This is because the Pre-bill Edit claims are anticipating what will be required when a claim is produced. Each time the account is re-evaluated for Pre-bill Edits, the system will use Today's Date if there is no Discharge Date.

Benefits of Final Billing Parameter ICD-10 Effective Date Processing

The ICD-10 Effective Date field on the Final Billing Parameter can be based on either Admission Date or Discharge Date (whereas the Patient Processing USA ICD-10 Effective Date, the Insurance Plan ICD-10 Effective Date, the Insurance Carrier ICD-10 Effective Date, and the Financial Class ICD-10 Effective Date are all based on Admission Date only). The STAR Patient Processing, Medical Records, Order Management and Clinical applications need their ICD-10 Effective Date based on the admission date since coding and charging (which can have an Ordering Diagnosis) can occur before the account is discharged.

Since CMS mandated ICD-10 diagnosis and procedure codes based on the discharge date of the account, the billing process can catch those accounts that were admitted before the USA ICD-10 Effective Date on Patient Processing, but were discharged on or after the CMS ICD-10 discharge date. For example, if the USA ICD-10 Effective Date field is set to 10/01/2011, an account admitted on 09/28/2011 and discharged on 10/03/2011 would only collect ICD-9 diagnosis and procedure codes. If CMS mandated ICD-10 for discharges of 10/01/2011, the Final Bill Parameter ICD-10 Effective Date field could be set to 10/01/2011 for Discharge Date. For this account, the Bill ICD flag is set to 10. If any of the diagnosis or procedure fields are required, the bill fails. At this point, the diagnosis and procedure codes could be coded in Medical Records and Bill Edit would update the bill for the missing information.

This is really an issue for your Inpatient and Series accounts. These accounts should be discharged and re-admitted as of the CMS ICD-10 effective date. If the account has previously billed, the payer would need to determine if only one code set should be

reported for the life of the account (either ICD-9 or ICD-10 for the cycle and final bills and claims, and not some bills and claims in ICD-9 and others in ICD-10).

For your one day stays, if the collection of ICD-10 codes is based on Admission Date, but the CMS- mandated date is based on Discharge Date, the Final Billing Parameter ICD-10 Effective Date field can be set to Discharge Date to catch these accounts in the transition period.

Second line of logic – Exceptions for Insurance Plan, Insurance Carrier, or Financial Class

- If the Final Bill Parameter ICD-10 Effective Date field is left blank, the system then checks the USA ICD-10 Effective Date on the Hospital Facility Options on STAR Patient Processing.

- If the admission date of the account is before the USA ICD-10 Effective Date, the Bill ICD flag is set to 9, and the bill requires ICD-9 diagnosis and procedure codes.

- If the admission date of the account is on or after the USA ICD-10 Effective Date, the system then looks for Exceptions to the ICD-10 coding as follows:

  a) The system first accesses the **Insurance Plan Table** for the COB 1 insurance loading the bill to determine if there is an ICD-10 Effective Date for the insurance plan. The ICD-10 Effective Date in the insurance plan is only based on Admission Date. If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, but is before the Insurance Plan ICD-10 Effective Date, the Bill ICD flag is set to 9, and the bill requires ICD-9 diagnosis and procedure codes. If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, and is on or after the Insurance Plan ICD-10 Effective Date, or the Insurance Plan ICD-10 Effective Date field is blank, the system looks to the Insurance Carrier Table for the COB 1 insurance loading the bill.

  b) If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, but is before the **Insurance Carrier Table** ICD-10 Effective Date, the Bill ICD flag is set to 9, and the bill requires ICD-9 diagnosis and procedure codes. If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, and is on or after the Insurance Carrier ICD-10 Effective Date, or the Insurance Carrier ICD-10 Effective Date field is blank, the system looks to the Financial Class for the account.

  c) If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, but is before the **Financial Class Table** ICD-10 Effective Date, the Bill ICD flag is set to 9, and the bill requires ICD-9 diagnosis and procedure codes. If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, and is on or after the Financial Class ICD-10 Effective Date, or the Financial Class ICD-

10 Effective Date field is blank, the system determines there are no exceptions for the account, and set the Bill ICD flag to 10. The bill requires ICD-10 diagnosis and procedure codes.

Benefits of ICD-10 Exception Processing

By looking to the ICD-10 Effective Date fields on the Insurance Plan Table, the Insurance Carrier Table, and the Financial Class Table, instead of looking to the actual account ICD flag, the billing process can catch those situations where:

- The account was registered on or after the USA ICD-10 Effective Date field on the Hospital Facility Parameters, there were no exceptions in the Insurance Plan Table, the Insurance Carrier Table, or Financial Class Table, only ICD-10 Diagnoses and Procedure codes were collected on the account, and then the Insurance Plan Table, the Insurance Carrier Table, or the Financial Class Table is set with an ICD-10 Effective Date that would have set the account ICD to require BOTH ICD-10 codes and ICD-9 codes. The Bill ICD is set to 9 for ICD-9. If any of the diagnosis or procedure codes are required, the bill fails. At this point, the ICD-9 codes can be added to Medical Records, and the bill re-edited.

- The account was registered on or after the USA ICD-10 Effective Date field on the Hospital Facility Parameters, there were no exceptions in the Insurance Plan Table, the Insurance Carrier Table, or Financial Class Table, only ICD-10 Diagnoses and Procedure codes were collected on the account, and then the USA ICD-10 Effective Date field on the Hospital Facility Parameters was changed to be a date in the future (past the admission date of the account). The Bill ICD is set to 9 for ICD-9. If any of the diagnosis or procedure codes are required, the bill fails. At this point, the ICD-9 codes can be added to Medical Records, and the bill re-edited.

- The account was registered before the USA ICD-10 Effective Date field on the Hospital Facility Parameters, and only ICD-9 Diagnoses and Procedure codes were collected on the account. The USA ICD-10 Effective Date field on the Hospital Facility Parameters is then changed to be a past date (that is on or before the admission date of the account). The Bill ICD is set to 10 for ICD-10 (if there are no exceptions for the account at the Insurance Plan, Insurance Carrier, or Financial Class level). If any of the diagnosis or procedure code are required, the bill fails. At this point, the ICD-10 codes can be added to Medical Records, and the bill re-edited.

The billing function looks to this Bill ICD flag when using any of the Data Base Elements that reference ICD diagnosis and/or procedure information in the Billing Requirements Table linked to the Final Billing Parameter.

By adding the ICD-10 Effective Date field to the Billing Parameters screen, and not to the Billing Requirements screen, this allows users to have the same Data Base Elements that are required, such as Principal and Admitting Diagnosis, that can be shared across Billing Parameter Tables. But, one Billing Parameter table (say for

Medicare) may require ICD-10 codes for the patient, while another Billing Parameter table (say for Medicaid) may require ICD-9 codes.

The logic for the Auto Adj Rebill DRG/Dx/Proc field on the second screen of the Billing Parameters screen has also been updated to look to the new Final Billing Parameters ICD-10 Effective Date field and the bill ICD flag that is in turn set. If the field is set to A for generating an adjustment bill and report, or R for generating the report only, the system only generates the adjustment bill and/or the report if the specified diagnosis or procedure was updated. For example, if the bill ICD flag for the patient is set to ICD-10 (0), and the Auto Adj Rebill DRG/Dx/Proc is set to A for Adjustment Bill and Report, if the Principal ICD-9 Diagnosis Code is updated, this would not generate the adjustment bill and report. Only if an ICD-10 diagnosis code or procedure code (or DRG) is updated would the system produce the adjustment bill and report. The following is the current documentation for this field, which is updated for the new Final Billing Parameters ICD-10 Effective Date field and bill ICD flag.

This field indicates whether the system should generate an automatic adjustment bill and/or generate the DRG/Procedure/Diagnosis Modification Report if the DRG, any diagnosis code, or any procedure code is changed on a patient. Entry options are **A** for generating an adjustment bill and report, **R** for generating the report only, or **N** if neither is desired. When the field is accessed, the following prompt is displayed:

Produce (A)utomatic adj bill, (R)eport only, or (N)either if DRG, Dx codes or Proc codes change (A/R/N) [N]—

If you select A, an automatic adjustment bill and the DRG/Procedure/Diagnosis Modification Report is generated if the diagnosis codes, procedure codes, or the DRG on the account are changed, and Auto Adj Bill is displayed in the field. If an R is selected, only the DRG/Procedure/Diagnosis Modification Report (FBR400) is generated and Report Only is displayed in the field. If N is selected, no report or bills are generated, and Neither is displayed in the field.

NOTE: The Billing Parameter is based on the patient primary (COB 1) insurance. If the patient does not have insurance, the billing parameters on the patient financial class are used for the assignment.

BILL EDIT

Based on the Bill ICD flag at the time of Bill Select and Edit, the bill edits either ICD-9 diagnosis and procedure codes, or ICD-10 diagnosis and procedure codes (depending on the Data Base Elements set as Required in the Billing Requirements Table linked to the Final Bill Parameter).

- BILLING REQUIREMENTS

  1) The following billing Data Base Elements have been updated to look to the Bill ICD flag (based on the Final Billing Parameters ICD-10 Effective Date and the admission date or discharge date of the account, or on any Insurance Plan,

Insurance Carrier, or Financial Class exception for the COB 1 plan and on the admission date of the account).

The system looks to the Bill ICD flag for any billing Data Base Element in the Billing Requirements table that looks to either diagnosis or procedure codes. If the Bill ICD flag is set to 9 for ICD-9, then only the ICD-9 diagnoses and procedures are accessed for the appropriate data base elements. If the Bill ICD flag is set to 10 for ICD-10, then only the ICD-10 diagnoses and procedures are accessed for the appropriate data base elements. The Billing Requirements Edit Code (table), which in turn lists all required data elements, is linked to the final bill Billing Requirements table on the second screen.

By adding the ICD-10 Effective Date field to the Billing Parameters screen, and not to the Billing Requirements screen, users have the same Data Base Elements that are required, such as Principal and Admitting Diagnosis, that can be shared across Billing Parameter Tables. But, one Billing Parameter table (say for Medicare) may require ICD-10 codes for the patient, while another Billing Parameter table (say for Medicaid) may require ICD-9 codes.

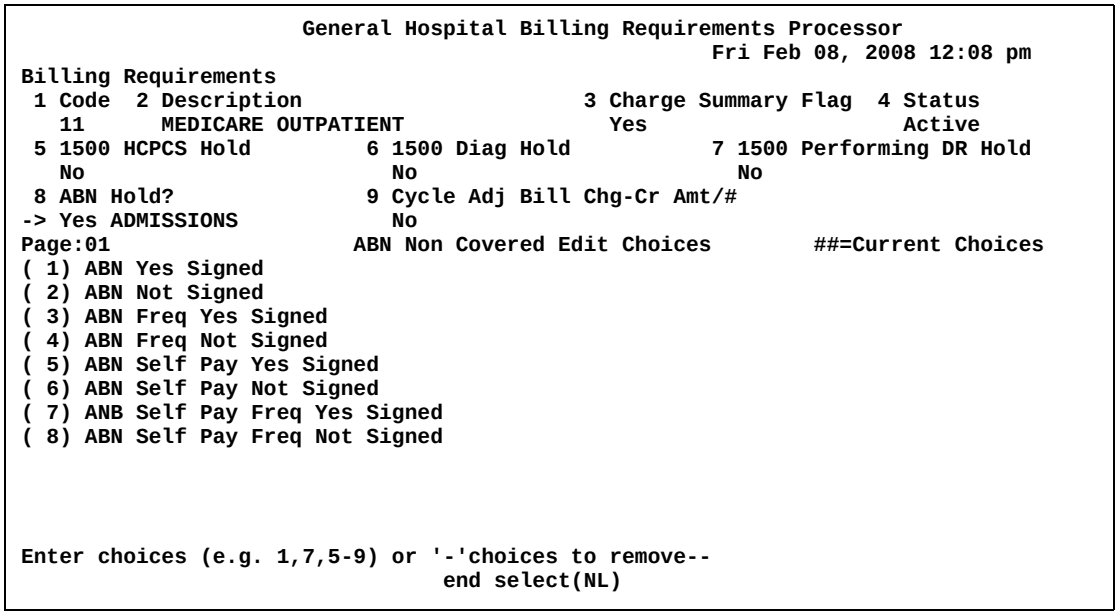
The following existing Billing Data Base Elements, assigned in the Billing Requirements Parameters, have been updated to look to the Bill ICD flag for the account:

- ADMITTING DIAGNOSIS CODE (MR/ADM)
- ADMITTING DIAGNOSIS DESCRIPTION
- PRIN (MR/ADM) OR WORKING DIAG CODE
- PRINC DX POA FOR BILL
- PRINCIPAL DIAG CODE (MR/ADM)
- PRINCIPAL DIAGNOSIS CODE
- PRINCIPAL OR WORKING DIAG CODE
- PRINCIPAL PROCEDURE CODE
- PRINCIPAL PROCEDURE DATE

2) The ABN Hold field has been updated. Previous to this enhancement, the field allowed you to hold the bill if any of the charges had an ABN flag of No, or an ABN flag of No (ABN Not Signed) or Yes (ABN Signed). The prompt was:

Hold bills with charges that have an ABN value of "No" (N), charges with an ABN value of "No" or "Yes" (Y), or do not edit for ABN values (D)? [D]--

The field has been updated to allow the user to select which ABN flags should hold the bill. When accessing the field, users must highlight the ABN indicators that should hold the bill. A conversion runs with the STAR Patient Accounting STI F9734: If the field was set to No before, then the ABN Not Signed is highlighted. If the field was set to Yes before, then both the ABN Yes Signed and the ABN Not Signed are highlighted.



When accessing the field, the system first prompts:

Do you want to edit charges for ABN values? (Y/N) [N]--

When entering Y for Yes, the system displays the ABN options that can be selected to hold the bill. The system looks to the BILL ICD flag of 9 for ICD-9 or 10 for ICD-10, and looks only for charges with an ABN ICD flag that matches the Bill ICD flag. In other words, if the Bill ICD flag is a 9, and the bill is editing for ICD-9 data, even if all ABN flags are highlighted as a Billing Requirement, if the ABN ICD flags on the charges are a 10 for ICD-10, these charge ABNs would not hold the bill. The bill would only hold for highlighted ABN types that also had an ABN ICD indicator of 9.

NOTE: The system can only edit the final bill for charge errors while the account is active on Patient Care. Once inactive on Patient Care, the bill does not hold for charge errors.

```
Page:01                  ABN Non Covered Edit Choices        ##=Current Choices
( 1) ABN Yes Signed
( 2) ABN Not Signed
( 3) ABN Freq Yes Signed
( 4) ABN Freq Not Signed
( 5) ABN Self Pay Yes Signed
( 6) ABN Self Pay Not Signed
( 7) ANB Self Pay Freq Yes Signed
( 8) ABN Self Pay Freq Not Signed


Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
                                 end select(NL)
```

The ABN Bill Edits display in the following format for the Biller Workfile, the FBR210 Failed Billing Requirement Report, and the FBR220 Failed Billing Requirement Controlled By Report: The first line of the error has *FATAL* followed by the SIM (Service Item Master) number, the charge number, the charge Department, and the charge description. The second line of the error lists the ABN flag. The valid values are:

- No – ABN Not Signed
- Yes – ABN Signed
- FQ/Y – Frequency ABN Signed
- FQ/N – Frequency ABN Not Signed
- SP/Y – Self Pay ABN Signed
- SP/N – Self Pay ABN Not Signed
- SP/FQ/Y – Self Pay Frequency ABN Signed
- SP/FQ/N – Self Pay Frequency ABN Not Signed

For example:

FATAL -SIM: 3112 CHG #: 4 DEPT/DESC: EEG EEG PRO FEE
ABN INDICATOR=SP/N

FATAL -SIM: 3112 CHG #: 3 DEPT/DESC: EEG EEG PRO FEE
ABN INDICATOR=SP/Y

FATAL -SIM: 3130 CHG #: 2 DEPT/DESC: EEG EEG / BRAINMAPPING
ABN INDICATOR=FQ/N

BILLER WORKFILE

The screen displaying the Bill Errors, both Patient Bills by Account, and Patient Bills by Biller displays the ICD diagnosis and procedure codes that were required for a bill, as follows:

ICD (Display Only)
This field displays either a ICD-9 if ICD-9 diagnosis and procedure codes were required for the bill, or a ICD-10 if ICD-10 diagnosis and procedure codes were required for the bill. A blank bill ICD flag defaults to ICD-9. Which code sets are edited is determined by the ICD-10 Effective Date field on the Final Billing Parameter, and the Admission Date or Discharge Date of the patient, or on any Insurance Plan, Insurance Carrier, or Financial Class exception for the COB 1 plan and the admission date of the patient, at the time of Bill Select/Bill Edit. By displaying this field, for those data base elements that deal with either diagnosis or procedure codes, the user knows which codes were missing and failed, either ICD-9 or ICD-10.

```
              General Hospital Patient Bills by Biller Processor
                                                    Fri Feb 08, 2008 03:28 pm
Account      Name                 FC Typ Admit    Disch        Balance Loc
A03127-00016 TEST,VIGGO           M  OPC 05/07/08 05/07/08     1000.00 PA
 1 Bill Type           2 Bill Parm    3 ICD     4 Rebill Sequence Number
   Final                 99             ICD-10
 5 Bill From Date                     6 Bill Through Date
   05/07/08                           05/07/08
 7 Comment                            8 Requested By
   SYSTEM FINAL

FATAL  -PRINCIPAL DIAGNOSIS CODE is Required
FATAL  -BILL. INS. CERT/SSN/HIC ID NUMBER is Required
FATAL  -ADMITTING DIAGNOSIS CODE is Required









Press NL--
```

CLAIM LOAD EDIT PARAMETERS

The ICD-10 Effective Date field on the Claim Load Edit Parameters specifies the beginning admission date or discharge date of patients that require ICD-10 diagnosis and procedure codes to load to the claim.

The ICD-10 Effective Date field can be accessed only for Claim Types (Forms) X-UB, R-Medi-Cal UB, B-1500, and Z-Non Professional Fee 1500. Within the X-UB and R-Medi-Cal UB claim types, the field can be accessed only if the Claim Format is UB04. If the Claim Format is UB92, users cannot access this field. Within the B-1500 and the

Z-Non Professional Fee 1500 claim types, the field can be accessed only if the Claim Format is 08/05. If the Claim Format is 1992, users cannot access this field.

State claim forms (other than the Medi-Cal UB) are allowed access to this field on a state-by-state basis, under separate STI numbers.

```
            General Hospital Claim Load and Edit Parameters Processor
                                                    Wed Feb 13, 2008 08:41 am


 1 Code  2 Claim Form          3 Claim Format  4 Description
   99      X UB                  UB04            MEDICARE INPATIENT
 5 Begin Date   6 End Date     7 Claim Media                  8 1500 Format
   05/23/2007                    B Paper and Electronic
 9 Electronic Types  10 Start Detail    11 Stop Detail 12 Load $0.00 Claim
   A,C,F,L,Z             19                 41             A,C,F,L,Z
13 Top Line Blank?   14 Generation Pending? 15 Diagnoses for 1500 Locator 21
   No
16 ICD-10 Effective Date
   10/01/2013 Disch
17 Combine Bill Med Info                 18 DPW Med Info
   Prc, DX (To Accnt then From Accnt)       Prc, DX (To Accnt then From Accnt)
19 Adm Prin/Sec Dx for Comb Bill/DPW  20 NY Claim Type
   Yes                                   None
21 UB Loc 54 Prior Pymt Calc          22 1500 Loc 29 Amount Paid Calc
   Pymt+Adj
23 Last Generated      24 Edit Date           25 Edit By
   02/11/2008 09:59am     02/11/2008 09:59am     Clark,Kent

Enter field number or '/' starting field number--
```

The ICD-10 Effective Date field on the Hospital Facility Options screen in STAR Patient Processing determines when ICD-10 diagnosis and procedure codes are collected and reported. Exceptions can also be listed in the Insurance Plan Table, the Insurance Coverage Table, and the Financial Class Table to collect also ICD-9 diagnosis and procedure codes after this ICD-10 Effective Date.

First line of logic – Claim Load Edit ICD-10 Effective Date

While the Patient Processing application determines when the ICD-10 codes are collected and reported, the **ICD-10 Effective Date field on the Claim Load Edit Parameter** determines which patients are identified by the claims function to Load and Edit these ICD-10 diagnoses and procedures. The Patient Processing and the Patient Accounting tables and parameters should complement each other. It's up to the hospital to verify that the tables are in sync for the payers.

When accessing the ICD-10 Effective Date field, the system first prompts:

Enter the Effective Date for ICD-10 Diagnosis and Procedure processing (MM/DD/YYYY) –

The system then prompts:

Is the ICD-10 Effective Date based on Admission Date (A) or Discharge Date (D) [A]--

The system displays the date and *Admission* or *Discharge*. For example: 01/01/2013 Admission or 10/01/2013 Discharge.

If the date is set, for the *Admission Date*, but the patient's admission date is before the ICD-10 Effective Date, the Claim ICD flag is set to 9 and the system continues to load and edit the ICD-9 codes only for the patient's claim. This means that series patient types that were registered before this ICD-10 Effective Date continue to only load and edit ICD-9 diagnosis and procedure codes to the claim. These series patient types may need to be discharged and re-admitted once ICD-10 codes are required. If the date is set, for the Admission Date, and the patient's admission date is on or after the ICD-10 Effective Date, the Claim ICD flag is set to 10 and the system loads and edits the ICD-10 codes only for the patient's claim.

If the date is set, for the *Discharge Date*, but the patient's discharge date is before the ICD-10 Effective Date, the Claim ICD flag is set to 9 and the system continues to load and edit the ICD-9 codes only for the patient's claim. This means that series patient types that were discharged before this ICD-10 Effective Date continue to only load and edit ICD-9 diagnosis and procedure codes to the claim. These series patient types may need to be discharged and re-admitted once ICD-10 codes are required. If the date is set, for the Discharge Date, and the patient's discharge date is on or after the ICD-10 Effective Date, the Claim ICD flag is set to 10 and the system loads and edits the ICD-10 codes only for the patient's claim.

If the date is set for the Discharge Date and if the Admission Date precedes the USA ICD-10 Effective Date on Patient Processing (so the Account ICD indicator is set to 9), but the account's discharge date, or Bill Through Date if no discharge date, is on or after the USA ICD-10 Effective Date on Patient Processing, the system does the following:

a) Look to the Billing Parameter. If the billing parameter ICD-10 Effective Date is based on Discharge Date, then use the account's discharge date, or the Bill Through Date if no discharge date, to determine the bill ICD indicator. If the billing parameter ICD-10 Effective Date is based on Admission Date, then do no further analysis. The bill will edit for ICD-9.

b) Look to the Claim Parameter. If the claim parameter ICD-10 Effective Date is based on Discharge Date, then use the account's discharge date, or the Bill Through Date of the bill that loaded the claim if no discharge date, to determine the claim ICD indicator. If the claim parameter ICD-10 Effective Date is based on Admission Date, then do no further analysis. The claim will load and edit for ICD-9.

NOTE: This logic means that you can fail an account's bill and claims for missing ICD-10 information, when ICD-10 information was not entered on the account, and the account has an Account ICD indicator of 9.

In order to correct this situation, the ICD-10 information would need to be entered via Medical Records. As long as the USA ICD-10 Effective Date on Patient Processing is Today or a date in the past, Medical Records

allows ICD-10 information to be entered on an account regardless of the Account ICD indicator.

EXAMPLES

**** USA ICD-10 Effective Date is 09/14/2011

Account 1:

- Admitted 09/01/11

- Account ICD indicator is 9

- Final Bill Parm is set to DISCHARGE DATE 10/01/2011

- Cycle 1, produced with BILL THROUGH DATE of 9/30, cycle does not edit but is loaded with Bill ICD of 9.

- Claim Load Edit is set to DISCHARGE DATE 10/01/2011

- Cycle Claim, produced with BILL THROUGH DATE of 9/30 (bill that loads claim) loads/edits for ICD-9

- Account discharged 10/5/2011.

- Final Bill produced with BILL THROUGH DATE of 10/5 edits for ICD-10

- Final Claim produced with BILL THROUGH DATE of 10/5 loads/edits for ICD-10

Account 2:

- Admitted 09/01/11

- Account ICD indicator is 9

- Account is Discharged on 9/26/2011

- Final Bill Parm is set to DISCHARGE DATE 10/01/2011

- Claim Load Edit is set to DISCHARGE DATE 10/01/2011

- Final Bill produced with BILL THROUGH DATE of 9/26 edits for ICD-9

- Final Claim produced with BILL THROUGH DATE of 9/26 loads/edits for ICD-9

Account 3:

- Admitted 09/01/11

- Account ICD indicator is 9

- Final Bill Parm is set to ADMISSION DATE 10/01/2011

- Cycle 1, produced with BILL THROUGH DATE of 9/30, cycle does not edit but is loaded with Bill ICD of 9.

- Claim Load Edit is set to ADMISSION DATE 10/01/2011

- Cycle Claim, produced with BILL THROUGH DATE of 9/30 (bill that loads claim) loads/edits for ICD-9

- Account discharged 10/5/2011.

- Final Bill produced with BILL THROUGH DATE of 10/5 edits for ICD-9

- Final Claim produced with BILL THROUGH DATE of 10/5 loads/edits for ICD-9

NOTE ON BILLS:

Regular bills produced via Midnight Processing or Instant Adjustment Bill look for the existence of a Discharge Date when evaluating the Billing ICD-10 Effective Date when based on Discharge Date.

For cycle bills, the Bill Thru Date is used when evaluating if the bill or claim should be ICD-9 or ICD-10 based on an ICD Effective Date that uses Discharge Date. Since the Cycle Billing Parameters do not have an ICD-10 Effective Date field (and do not edit), the system looks to the Final Billing Parameters ICD-10 Effective Date. For the cycle bill, it will then compare the Bill Thru Date for the cycle to this ICD-10 Effective Date, to determine if the cycle should load for ICD-9 or ICD-10 data.

Once the account is actually discharged, the true discharge date is used to determine if the bill and claims should load/edit ICD-9 or ICD-10.

Pre-bill Edit bills will use Today's Date as the Discharge Date when evaluating the Billing ICD-10 Effective Date when based on Discharge Date. This is because the Pre-bills are anticipating what will be required

when a bill is produced. Each time the account is re-evaluated for Pre-bill Edits, the system will use Today's Date if there is no Discharge Date.

NOTE ON CLAIMS:

Regular claims produced via Midnight Processing, Instant Adjustment Bill, or Add Claim to Insurance look for the existence of a Discharge Date when evaluating the Claim ICD-10 Effective Date when based on Discharge Date. If there is no discharge date at the time the claim is created, the Bill Thru Date of the bill that loaded the claim is used when evaluating if the claim should be ICD-9 or ICD-10 based on an ICD Effective Date that uses Discharge Date.

Pre-bill Edit claims will use Today's Date as the Discharge Date when evaluating the Claim ICD-10 Effective Date when based on Discharge Date. This is because the Pre-bill Edit claims are anticipating what will be required when a claim is produced. Each time the account is re-evaluated for Pre-bill Edits, the system will use Today's Date if there is no Discharge Date.

NOTE: Using Discharge Date, your series accounts may load and edit ICD-9 diagnosis and procedure codes for the Cycle Claims loaded prior to discharge date, but then may load (if present) and edit ICD-10 diagnosis and procedure codes for the Final Claim once the account is discharged. The payer needs to determine if Series accounts should only reflect one type of coding method for the life of the account for reporting, editing, and reimbursement reasons.

Benefits Of Claim Load Edit ICD-10 Effective Date Processing

The ICD-10 Effective Date field on the Claim Load Edit Parameter can be based on either Admission Date or Discharge Date (whereas the Patient Processing USA ICD-10 Effective Date, the Insurance Plan ICD-10 Effective Date, the Insurance Carrier ICD-10 Effective Date, and the Financial Class ICD-10 Effective Date are all based on Admission Date only). The STAR Patient Processing, Medical Records, Order Management and Clinical applications need their ICD-10 Effective Date based on the admission date since coding and charging (which can have an Ordering Diagnosis) can occur before the account is discharged.

Since CMS-mandated ICD-10 diagnosis and procedure codes based on a discharge date of the account, the claims process can catch those accounts that were admitted before the USA ICD-10 Effective Date on Patient Processing, but were discharged on or after the CMS ICD-10 discharge date. For example, if the USA ICD-10 Effective Date field is set to 10/01/2013, an account admitted on 09/28/2013 and discharged on 10/03/2013 would only collect ICD-9 diagnosis and procedure codes. If CMS mandates ICD-10 for discharges of 10/01/2013, the Claim Load Edit ICD-10 Effective Date field could be set to 10/01/2013 for Discharge Date. For this account, the Claim ICD flag is set to 10. If any of the diagnosis or procedure fields are required, the claim fails. At this point, the claim can be edited to have these ICD-10 codes, or the diagnosis

and procedure codes could be coded in Medical Records and Claim Reload would update the claim for the failed locators.

This is really an issue for your Inpatient and Series accounts. These accounts should be discharged and re-admitted as of the CMS ICD-10 effective date. If the account has previously billed, the payer would need to determine if only one code set should be reported for the life of the account (either ICD-9 or ICD-10 for the cycle and final claims, and not some claims in ICD-9 and others in ICD-10).

For your one day stays, if the collection of ICD-10 codes is based on Admission Date, but the CMS mandated date is based on Discharge Date, the Claim Load Edit ICD-10 Effective Date field can be set to Discharge Date to catch these accounts in the transition period.

Second line of logic – Exceptions for Insurance Plan, Insurance Carrier, or Financial Class

If the Claim Load Edit Parameter ICD-10 Effective Date field is left blank, the system then checks the USA ICD-10 Effective Date on the Hospital Facility Options on STAR Patient Processing.

If the admission date of the account is before the USA ICD-10 Effective Date, the Claim ICD flag is set to 9, and the claim prompts and requires ICD-9 diagnosis and procedure codes.

If the admission date of the account is on or after the USA ICD-10 Effective Date, the system then looks for Exceptions to the ICD-10 coding as follows:

- The system first accesses the **Insurance Plan Table** for the insurance loading the claim to determine if there is an ICD-10 Effective Date for the insurance plan. The ICD-10 Effective Date in the insurance plan is ONLY based on Admission Date. If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, but is before the Insurance Plan ICD-10 Effective Date, then the Claim ICD flag is set to 9, and the claim prompts and requires ICD-9 diagnosis and procedure codes. If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, and is on or after the Insurance Plan ICD-10 Effective Date, or the Insurance Plan ICD-10 Effective Date field is blank, then the system looks to the Insurance Carrier Table for the insurance loading the claim.

- If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, but is before the **Insurance Carrier Table** ICD-10 Effective Date, then the Claim ICD flag is set to 9, and the claim prompts and requires ICD-9 diagnosis and procedure codes. If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, and is on or after the Insurance Carrier ICD-10 Effective Date, or the Insurance Carrier ICD-10 Effective Date field is blank, then the system looks to the Financial Class for the account.

- If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, but is before the **Financial Class Table** ICD-10 Effective Date, then the Claim ICD flag is set to 9, and the claim prompts and requires ICD-9 diagnosis and procedure codes. If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, and is on or after the Financial Class ICD-10 Effective Date, or the Financial Class ICD-10 Effective Date field is blank, then the system determines there are no exceptions for the account, and sets the Claim ICD flag to 10. The claim prompts and requires ICD-10 diagnosis and procedure codes.

NOTE ON FINANCIAL CLASS EXCEPTIONS

STAR Patient Processing is setting the Account ICD flag based on the Financial Class at the account level. Therefore, if the COB 1 insurance has an exception for the Financial Class, or the Self Pay Financial Class has an exception, the Account ICD flag is set to B for Both in order to collect both ICD-10 codes and ICD-9 codes.

The claims process is looking to the Default Financial Class for EACH insurance loading a claim. At the time the insurance is assigned to the account, this is stored at the account level for the insurance. This is taken from the Default Financial Class field when accessing Tables, PA/AR Master File Maintenance, Insurance Plan Coverage, enter the carrier and plan, Facility Options, Billing/Claim Parameters, screen 1, field Default Financial Class. This allows some claims for the account to load ICD-9 diagnosis and procedure codes based on the financial class exception, while other claims load ICD-10 diagnosis and procedure codes.

For example, if Financial Class H was set as a Financial Class Exception, then for an account with the below insurances, COB 1 and COB 2 would load ICD-9 codes, and COB 3 and COB 4 would load ICD-10 codes:

COB 1	900100	UB	Default Financial Class H
COB 2	900200	1500	Default Financial Class H
COB 3	444111	UB	Default Financial Class O
COB 4	444222	1500	Default Financial Class O

BENEFITS OF ICD-10 EXCEPTION PROCESSING

By looking to the ICD-10 Effective Date fields on the Insurance Plan Table, the Insurance Carrier Table, and the Financial Class Table, instead of looking to the actual account ICD flag, the claims process can catch those situations where:

- The account was registered on or after the USA ICD-10 Effective Date field on the Hospital Facility Parameters, there were no exceptions in the Insurance Plan Table, the Insurance Carrier Table, or Financial Class Table, only ICD-10 Diagnoses and Procedure codes were collected on the account, and then the Insurance Plan Table, the Insurance Carrier Table, or the Financial Class Table is set with an ICD-10 Effective Date that WOULD HAVE set the account ICD to

require BOTH ICD-10 codes and ICD-9 codes. The Claim ICD is set to 9 for ICD-9. If any of the diagnosis or procedure fields are required, the claim fails. At this point, either the ICD-9 codes can be added to Medical Records, and the claim reloaded, or the claim can be edited to have these ICD-9 codes.

- The account was registered on or after the USA ICD-10 Effective Date field on the Hospital Facility Parameters, there were no exceptions in the Insurance Plan Table, the Insurance Carrier Table, or Financial Class Table, only ICD-10 Diagnoses and Procedure codes were collected on the account, and then the USA ICD-10 Effective Date field on the Hospital Facility Parameters was changed to be a date in the future (past the admission date of the account). The Claim ICD is set to 9 for ICD-9. If any of the diagnosis or procedure fields are required, the claim fails. At this point, either the ICD-9 codes can be added to Medical Records, and the claim reloaded, or the claim can be edited to have these ICD-9 codes.

- The account was registered before the USA ICD-10 Effective Date field on the Hospital Facility Parameters, and only ICD-9 Diagnoses and Procedure codes were collected on the account. The USA ICD-10 Effective Date field on the Hospital Facility Parameters is then changed to be a past date (that is on or before the admission date of the account). The Claim ICD is set to 10 for ICD-10 (if there are no exceptions for the account at the Insurance Plan, Insurance Carrier, or Financial Class level). If any of the diagnosis or procedure fields are required, the claim fails. At this point, either the ICD-10 codes can be added to Medical Records, and the claim reloaded, or the claim can be edited to have these ICD-10 codes.

The claims processing system looks to the **Claim ICD** field when using any of the Internal Elements, Setup Routines, Access Routines, Print Routines, Display Routines, or Pre Entry Routines that access diagnosis and/or procedure information.

CLAIM RELOAD

Based on the Claim ICD flag, the claim loads and edits either ICD-9 diagnosis and procedure codes, or ICD-10 diagnosis and procedure codes.

The system sets an ICD flag at time of Claim Select. This flag is set to either 9 for ICD-9 or 10 for ICD-10. The claim maintains this flag for the life of the claim. Therefore, if the claim is Failing for any internal element that is requiring a diagnosis or procedure code, the Claim Reload function only looks for and loads the information from either the ICD-9 data or the ICD-10 data, depending on the ICD flag on the claim.

MANUAL CLAIM EDITS

When the user accesses the claim, and any of the locators that are set to load diagnosis or procedure information, the system looks to the ICD flag and prompts for either ICD-9 or ICD-10 information. For example, the system could give one of the following prompts for diagnosis information:

- *Enter ICD-9-CM diagnosis code, `U`ser diagnosis code, `-` for list—*

- *Enter ICD-10 diagnosis code, `U`ser diagnosis code, `-` for list--*

The system could give one of the following prompts for procedure information:

- *Enter ICD-9-CM procedure code, `U`ser procedure code, `-` for list—*
- *Enter ICD-10 procedure code, `U`ser procedure code, `-` for list—*

UB04 LOCATOR 72 EXTERNAL CAUSE OF INJURY

The UB04 Claim Master and hospital defined UB04 Claim Load Edit Parameters have the following fields renamed. For ICD-9 diagnosis codes, external cause of injury codes start with the letter *E.* However, for ICD-10 diagnosis codes, external cause of injury codes are in the range of V01-Y98. Therefore, the following fields were renamed. These field names display when in Claims Management for a UB04 claim.

FROM:

(1) 1-E-Code 1

(2) 2-E DX Code 1 POA

(3) 3-E-Code 2

(4) 4-E DX Code 2 POA

(5) 5-E-Code 3

(6) 6-E DX Code 3 POA

TO:

(1) 1-Ext Cause Inj Dx Code 1

(2) 2-Ext Cause Inj Dx Code 1 POA

(3) 3-Ext Cause Inj Dx Code 2

(4) 4-Ext Cause Inj Dx Code 2 POA

(5) 5-Ext Cause Inj Dx Code 3

(6) 6-Ext Cause Inj Dx Code 3 POA

NEW INTERNAL ELEMENT FOR UB04

A new internal element of *PROCEDURE CODING METHOD FOR CLAIM* has been added to the list of Internal Elements. This Internal Element looks to the CLAIM ICD

indicator to determine if ICD-9 or ICD-10 codes are loaded to the claim. When the CLAIM ICD indicator is 9, the internal element loads a value of 9. When the CLAIM ICD indicator is 10, the internal element loads 0 (per NUBC specifications for UB04 Locator 66). The conversion that runs with F9734 updates the UB04 Claim Master (claim type X), the Medi-Cal UB04 Claim Master (claim type R), and any individual federal UB04 or Medi-Cal UB04 claim load edit parameters that were using Procedure Coding Method to use the new Procedure Coding Method For Claim internal element.

CLAIM STATUS INFORMATION SCREEN

A display only field of ICD has been added to the screen. This field displays the ICD indicator (9 or 10) for diagnosis and procedure codes that were loaded to the claim:

```
                General Hospital Maintain Claims by Account Processor
                                                        Thu Feb 14, 2008 10:14 am
Account      Name                 FC Typ Admit    Disch        Balance Loc
C08018-00002 TEST,ICD             C  O/P 01/18/08 01/18/08      523.82 AR /ACCF
 1 Bill Sq    2 Clm Sq  3 Claim Type  4 Claim Format  5 Load/Edit Parameter
   1            1         X UB          UB04            99 MEDICARE O/P
 6 Bill Date  7 Bill From  8 Bill Through  9 ICD     10 Chg Control Parameter
   01/30/08     01/18/08     01/18/08        ICD-10     99 MEDICARE O/P CHG
11 Biller                                 12 Last System Edit Date
   3 - BILLERTHREE,BILLER                    02/14/08 01:30am
13 Last Editing User                      14 Last User Edit Date/Time
                                             02/14/08 01:30am
15 Edit Failures 16 Claim Production Status   17 ASB/Crossover Link
   15               N Not produced

18 Claim Work Status         19 Claim Amount   20 Archive Date  21 Purge Date
   F Failed Edit                $290.12
22 Prod/Supp Claim?  23 Electronic Media   24 Claim Split Indicator
   Yes/No                                    Primary
25 Alternate Provider Master          26 Payor Claim ID       27 IDE



Enter field number or '/' starting field number--
```

ICD (Display Only)
This field displays either a ICD-9 if ICD-9 diagnosis and procedure codes were loaded to the claim, or a ICD-10 if ICD-10 diagnosis and procedure codes were loaded to the claim. Which code sets load is determined by the ICD-10 Effective Date field on the Claim Load Edit Parameter, and the Admission Date or Discharge Date of the patient, or on any Insurance Plan, Insurance Carrier, or Financial Class exception and the Admission Date of the patient. The ICD flag is set for the claim at time of Claim Load, and does not change for the life of the claim. Therefore, if the ICD-10 Effective Date is updated on the Claim Load Edit Parameter, this does not update the ICD flag of previously loaded claims.

UB04 CHARGE CONTROL PARAMETER

The Print Non Covered Charges logic has been updated:

The fields and screen remain the same. Only the logic has been updated for the Print Non-Covered Charges field. When any of the ABN charges are highlighted to print as Non Covered (in the Print Non Covered? field), the charges only print as non covered if the ICD flag for the ABN matches the ICD flag for the claim. Therefore, if the Claim ICD is 10, but the particular charge ABN ICD flag is 9, this charge does not print in the Non Covered column. It continues to print in the Total Charges column. If the Claim ICD is 9, but the particular charge ABN ICD flag is 10, this charge does not print in the Non Covered column. It continues to print in the Total Charges column.

```
              General Hospital UB Charge Control Processor
                                                    Tue Jul 01, 2008 03:54 pm


 1 Code  2 Description                          3 Summarize By        4 EC2000
   99      COMMERICAL O/P UB92                    Srv Date/No Supp      Account
 5 Edit Room Chgs?          6 HCPCS Cross Reference     7 Prin Proc Rev Code
   No
 8 M/R HCPCS UB Rev Code    9 Print Non-Covered Chgs?  10 Non Cvd Separate Line
   99 - KRIS' MR HCPCS U      See Entries Defined         No
11 Comb Pro Fees? 12 001/0001 Total Rev Code & Desc 13 Total First? 14 NY Claim
   No               001-TOTAL CHARGES                 No
15 Use RX Qty?    16 I/P Rehab 17 Edit Chg Srv Dates?  18 Zero Fill UB Rev Cd?
   Yes              No           No                     Yes
19 Reference Facility  20 RF Rev Codes                 21 Exclude ABN Self Pay?
   Yes                    All                           See Entries Defined
22 IDE Code 23 IDE Rev Codes   24 Edit Unused MR HCPCS 25 Edit MR HCPCS Rev Cd
   Yes         All                Yes                    All
26 Unused Med Rec HCPCS Prim or Prim/Split   27 Earliest Serv Date UB Rev Codes
   Primary and Split
28 Req Rev Codes               29 Edit by              30 Edit date
                                  Seashore,Amanda         07/01/08 03:47pm


Enter field number or '/' starting field number--
```

1500 DIAGNOSIS PROCESSING

Logic for diagnosis processing for Locator 21 and 24E is as follows:

1 For the 1500 (claim type B), format 08/05, the ICD-10 Effective Date field on the Claim Load Edit Parameter is also used by the Diagnosis for 1500 Locator 21 field on the Claim Load Edit Parameter table. Based on the ICD-10 Effective Date field and the admission date or discharge date of the patient loading the 1500 claim, or on any Insurance Plan, Insurance Carrier, or Financial Class exception and the admission date of the patient, the ICD flag for the claim is set to either a 9 for ICD-9, or a 10 for ICD-10. When loading diagnosis codes to Locator 21, the system loads either ICD-9 or ICD-10 diagnosis codes based on the ICD flag. If the ICD flag is blank, the system assumes ICD-9. The logic for loading diagnosis codes to Locator 21 has not changed. The user continues to enter the choices and order for loading diagnoses to Locator 21 (which can be loaded from Medical Records, Admissions, and the charge level).

   The Diagnosis Codes that load to Locator 21 are dependent on the Diagnosis for 1500

Locator 21 field on the header screen of the 1500 Claim Load Edit Parameter when using internal elements 1500 Diagnosis Box 21 - Field 1, 1500 Diagnosis Box 21 – Field 2, 1500 Diagnosis Box 21 - Field 3, and 1500 Diagnosis Box 21 - Field 4. If using another internal element in the diagnosis code fields in Locator 21, the system does not access the Diagnosis for 1500 Locator 21 field on the Claim Load and Edit Parameter. It pulls the diagnosis code, depending on the internal element only.

** Please see online documentation on the Diagnosis for 1500 Locator 21 field in the Claim Load Edit Parameters (in the Tables, Masters, and Parameters volume).

2 For the 1500 (claim type B), format 08/05, the ICD-10 Effective Date field on the Claim Load Edit Parameter not only affects any demographic locator that is set to load diagnosis or procedure information, it also affects which charge Ordering Diagnosis is used for the claim form. The system loads either the ICD-9 or the ICD-10 Ordering Diagnosis for each charge and uses the current logic to match the Ordering Diagnosis on the charge (locator 24E) to the diagnosis codes in Locator 21-1, 21-2, 21-3, and 21-4.

NOTE: Users can continue to edit for the existence of the diagnosis/reference number at the claim charge level by setting the 1500 Charge Control Parameter field Edit Pro Fee Charges to have Diagnosis Code/Reference Number highlighted. The system again looks to either the ICD-9 or the ICD-10 diagnosis information based on the claim ICD flag. Note also that the 08/05 format of the 1500 claim form does not allow an actual diagnosis code in Locator 24E of the claim charge line. Only a reference number is allowed. Therefore, when editing or inserting a 1500 claim charge line, the system does not prompt for either an ICD-9 or ICD-10 diagnosis code. The system prompts for one or more reference numbers to link the charge to the diagnoses in Locator 21.

1500 Print

When the Claim Load Edit Parameter, Locator 21-1, 21-2, 21-3, and 21-4 are set to use the Print Routine of **1500 DIAGNOSIS PRINT**, when printing ICD-9 diagnosis codes in Locator 21 of the claim, the system formats as follows: if the diagnosis code begins with *E*, such as E821.1 then the system prints *E8211*. The decimal is removed because the logic assumes 4 characters before the decimal. If the diagnosis code does not begin with E such as 800.12, then the system inserts a space and prints 800 12. When printing ICD-10 diagnosis codes in Locator 21 of the claim, the system prints a space where the decimal would be. For example, code M84.872 prints as *M84 872*.

When the Claim Load Edit Parameter, Locator 21-1, 21-2, 21-3, and 21-4 are set to use the Print Routine of **ICD DIAGNOSIS CODE**, when printing either ICD-9 or ICD-10 diagnosis codes, the system retains the decimal. Therefore, ICD-9 codes E821.1 and 825.1 print as E821.1 and 825.1. ICD-10 codes M84.872 and Y08.02xA print as M84.872 and Y08.02xA.

NON PRO FEE 1500 CHARGE CONTROL PARAMETER

For the Non Professional Fee 1500 (claim type Z), format 08/05, the ICD-10 Effective Date field on the Claim Load Edit Parameter is also used by the Non Pro Fee 1500 Charge Control Parameters Diag To Be Printed field. Based on the ICD-10 Effective Date field and the admission date or discharge date of the patient, or on any Insurance Plan, Insurance Carrier, or Financial Class exception and the admission date of the patient loading the Non Professional fee 1500 claim, the ICD flag for the claim is set to either a 9 for ICD-9, or a 10 for ICD-10. When loading diagnosis codes/reference numbers to the claim charge lines in Locator 24E, the system loads either ICD-9 or ICD-10 diagnosis codes based on the ICD flag. If the ICD flag is blank, the system assumes ICD-9. The logic for loading diagnosis codes to Locator 24E has not changed.

```
            General Hospital Non Pro Fee 1500 Charge Control Processor
                                                    Fri Feb 15, 2008 11:14 am


 1 Code  2 Description                    3 Separate Claim by Dept?  4 EC2000
   99      MEDICAID                         Yes                        Claim
 5 Detail/Summarize?         6 Print UOS?  7 Place of Service  8 24A Date Print
   Summarize                   Yes           Inpatient Hospit    MM  DD  YY
 9 Departments to Include   10 Print TOS? 11 TOS Cross Ref    12 Print EMG?
   Entries Defined             Yes                              Yes
13 Diag to be Printed       14 HCPCS Cross Reference          15 EPSDT Value
   Principal/Working                                            N
1992 (24K)   16 Phys/Dept ID Upper                 17 Phys/Dept ID Lower
                Doctor Name                          NPI, Upin
08/05 (24J)  18 Phys/Dept ID Upper                 19 Phys/Dept ID Lower
                Upin-1G, Medicaid-1D                 NPI
20 Default Physician        21 Use Med Rec HCPCS   22 M/R HCPCS UB Rev Code
                               Yes
23 Print Anesth Time        24 Edit Charges?       25 PCON Phy/Dept ID
   Yes                         Yes H,D,U,L           Lower/Lower
                            26 Edit Date           27 Edit By
                               02/15/08 11:14am      Hansen,Olaf


Enter field number or '/' starting field number--
```

DIAG TO BE PRINTED (1-A-R)
This field determines whether the admitting, or if blank, the working diagnosis, should print for each charge line in locator 24E, or if the principal, or if blank, the working diagnosis should print for each line in locator 24E. Entry options are A for Admitting/ Working, P for Principal/Working or R for Reference Number 1.

NOTE: The 1992 1500 Format of the Non Pro Fee 1500 claim can accommodate either the actual diagnosis code or a reference number. The 08/05 1500 Format cannot accommodate an actual diagnosis code. The 08/05 1500 Format can only take 1 to 4 reference numbers, without punctuation/commas. Therefore, if the claim loads in the 08/05 1500 Format, and this field is set to A for Admitting/Working Diagnosis or P for Principal/Working Diagnosis, the system determines if this diagnosis is in Locator 21-1, 21-2, 21-3, or 21-4. If

the diagnosis exists in one of these locators, say locator 21-2, each charge line would reflect this reference number, here, reference number 2. For the 08/05 1500 Format of the Non Pro Fee 1500 claim, if this field is set to A for Admitting/Working or P for Principal/Working, and if the diagnosis that is set to load is not one that exists in Locator 21-1, 21-2, 21-3, or 21-4 (based on the internal elements used for Locator 21 in the Claim Load Edit Parameter), the claim can have a DX error if the field Edit Charges includes D for Diagnosis/ Reference Number.

The system prints only four unique diagnoses in form locator 21. If more than four diagnoses exist, the system does not print the reference in form locator 24E for charges relating to a diagnosis that does not display on the form in locator 21.

Non Pro Fee 1500 Print

When the Claim Load Edit Parameter, Locator 21-1, 21-2, 21-3, and 21-4 are set to use the Print Routine of **1500 DIAGNOSIS PRINT**, when printing ICD-9 diagnosis codes in Locator 21 of the claim, the system formats as follows: if the diagnosis code begins with “E," such as E821.1 then the system prints E8211. The decimal is removed because the logic assumes 4 characters before the decimal. If the diagnosis code does not begin with E such as 800.12, then the system inserts a space and prints 800 12. When printing ICD-10 diagnosis codes in Locator 21 of the claim, the system prints a space where the decimal would be. For example, code M84.872 prints as M84 872.

When the Claim Load Edit Parameter, Locator 21-1, 21-2, 21-3, and 21-4 are set to use the Print Routine of **ICD DIAGNOSIS CODE**, when printing either ICD-9 or ICD-10 diagnosis codes, the system retains the decimal. Therefore, ICD-9 codes E821.1 and 825.1 print as E821.1 and 825.1. ICD-10 codes M84.872 and Y08.02xA print as M84.872 and Y08.02xA.

PRE BILL EDIT

1) Pre Bill Edit Parameters. Access Tables, PA/AR Parameter Maintenance, Billing Parameters, Pre Bill Edit Parameters.

On the first screen, the Active Sources has been updated. A new option of I–ICD charge edits has been added. When highlighted, this edit looks to the ICD flag at the ACCOUNT level to determine if this account requires ICD-10 diagnosis and procedure codes, both ICD-10 and ICD-9 diagnosis and procedure codes, or only ICD-9 diagnosis and procedure codes. This flag at the account level is based on the ICD-10 Effective Date in the Hospital Facility Options of the STAR Patient Processing application, and based on any exceptions in the Insurance Plan Table, Insurance Carrier Table, and the Financial Class Table. A blank ICD flag means that only ICD-9 codes are collected on the account.

- If the ICD flag at the account level is set to **B for Both ICD-10 and ICD-9** codes, the PBE edit scans the charges. For any charge with an Ordering Diagnosis, if there is an ICD-9 Ordering Diagnosis but no ICD-10 Ordering Diagnosis, or there

is an ICD-10 Ordering Diagnosis but no ICD-9 Ordering Diagnosis, the charge has a Pre Bill Edit charge error if the parameter is set to edit for the Ordering Diagnoses.

- If the ICD flag at the account level is set to **10 for ICD-10** codes, the PBE edit scans the charges. For any charge with an ICD-9 Ordering Diagnosis but no ICD-10 Ordering Diagnosis, the charge has a Pre Bill Edit charge error if the parameter is set to edit the Ordering Diagnoses.

- If the ICD flag at the account level is set to **9 for ICD-9** codes, the PBE edit scans the charges. For any charge with an ICD-10 Ordering Diagnosis but no ICD-9 Ordering Diagnosis, the charge has a Pre Bill Edit charge error if the parameter is set to edit the Ordering Diagnoses.

One of four edit messages can be produced for a charge using the existing PBE field 1570 (Charge Diagnosis) with the Active Sources option of I-ICD charge edit:

- Needs ICD-9 diagnosis

- Needs ICD-10 diagnosis

- Needs ICD-9 diagnosis not ICD-10 diagnosis

- Needs ICD-10 diagnosis not ICD-9 diagnosis

Each of the preceding edits is tallied separately in the PBE reports counting the occurrence of edits.

Charges with NO Ordering Diagnosis do not error in PBE for this edit.

On the first screen, the **Trigger Event** named Update ICD-9-CM Diagnosis Information has been renamed to **Update ICD Diagnosis Information**. If either the ICD-9 or the ICD-10 diagnosis information is updated, the account triggers to PBE. The Trigger Event named Update ICD-9-CM Procedure Information has been renamed to **Update**

ICD Procedure Information. If either the ICD-9 or the ICD-10 procedure information is updated, the account triggers to PBE.

```
                General Hospital Pre-bill Edit Parameters Processor
                                                    Sat Feb 16, 2008 09:47 am

 1 Batch Process  2 Batch Hrs    3 File Purge  4 Stats Purge  5 Active Sources
   Proration        16             5             1              Entries Defined
                          Send Through Pre-Bill Edits
 6 Inpatient                7 Outpatient              8 Emergency
   Entries Defined            Entries Defined           Entries Defined
                           Begin Editing Parameter
 9 Inpatient    10 Outpatient   11 Emergency    12 Bill Edits   13 ICD Edits
   Admit-0         Admit-0         Admit-0         Admit-0         Admit-1
                                 Trigger Events
14 Inpatient        15 Outpatient       16 Emergency        17 Bill Edits
   Entries Defined     Entries Defined     Entries Defined     Entries Defined
                    Start Reviewing Medical Record Edits
18 Inpatient               19 Outpatient              20 Emergency
   Med Rec Info Present       Admit-0                    Admit-0
                  Final Bill with Existing Pre-bill Edits
21 Inpatient               22 Outpatient           23 Emergency
   Entries Defined            Entries Defined         Entries Defined


Enter field number or '/' starting field number--
                      next(/) or previous screen(/P) [/]
```

Field 5 for Active Sources is displayed:

```
Page:01                        Pre-bill Edit Sources          ##=Current Choices
( 1) B-Star billing edits
( 2) C-Star claim edits
( 3) E-CA claim edits
( 4) I-ICD charge edits
( 5) O-OPPS claim edits
```

The ICD Edits field is new and works with field 5 Active Sources when option I-ICD charge edits is highlighted. When accessing the field, the system prompts:

Start the editing process based on (A)dmit, (D)ischg, (M)ed Rcd Complete/Days (i.e. A/2)—

Users enter the start of editing criteria (A, D, or M) and the number of days past this criteria to start. For example, A/1 to start editing the data one day after admission.

When accessing any of the Trigger Event fields, the options for Diagnosis and Procedure have been renamed as follows:

```
              General Hospital Pre-bill Edit Parameters Processor
                                                  Fri Feb 15, 2008 05:38 pm
Page:01                  Pre-bill Edit Trigger Events        ##=Current Choices
( 1) Abstract Flagged as Complete        (17) Update ICD Diagnosis Information
( 2) Charge Revision                     (18) Update ICD Procedure Information
( 3) Combine Bill                        (19) Update Insurance Information
( 4) Cycle Adjustment Bill               (20) Update Medical Information
( 5) Cycle Bill                          (21) Update Medical Records HCPCS
( 6) DPW Addition/Change/Deletion        (22) Update Misc Visit Information
( 7) Patient Discharge/Disposition       (23) Update Patient Employer
( 8) Patient Historization               (24) Update Special Studies Informatio
( 9) Proration                           (25) Update UB Data
(10) Update Abstract General Informati   (26) Update User Defined MPI Fields
(11) Update Abstract Newborn/Death Cla   (27) Update User Defined Visit Fields
(12) Update Addl Demographic Informati   (28) Update Utilization Review Informa
(13) Update Addl Episode Information
(14) Update DRG Information
(15) Update Demographic Information
(16) Update Guarantor Information



Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
                                end select(NL)
```

PRE BILL EDIT STATUS INFORMATION

Access Billing and Claims, Pre-bill Edit, PBE Status Information, enter the facility and account, **I for Charge Edit (I)nformation**.

The following displays for the new ICD-10 charge edit (when the Pre Bill Edit Parameters Active Sources field includes I-ICD charge edits).

```
                  General Hospital PBE Status Information Processor
                                                  Sat Feb 16, 2008 01:20 pm
Account      Name                FC Typ Admit    Disch        Balance Loc
C08042-00001 TEST,ICD            C  O/P 02/11/08 02/11/08      350.75 PA /INSR

PBE Status: Manually Queued             PBE Status Date: 02/16/08
  Message followed by claim line and accounts charges comprising the claim line
ICD10 Needs ICD-9 diagnosis (CHG 3 EEG/3112/EEG PRO FEE) (PA/3)
  SRC/I
    A3 EEG/3112  EEG PRO FEE               9581926   02/11/08 1            34.58
ICD10 Needs ICD-10 diagnosis (CHG 2 EEG/3130/EEG / BRAINMAPPING) (PA/2)
  SRC/I
    A2 EEG/3130  EEG / BRAINMAPPING        95826GZ   02/11/08 1           357.86









                       F1Prev Page F2Next Page F7  Exit
```

The error message is prefaced by *ICD10*, followed by what is needed, either the ICD-9 diagnosis or the ICD-10 diagnosis, and in parenthesis, the charge number, the charge department, SIM item number, and the description. The detail on the charge again lists the internal charge number, the charge department, the SIM item, description, any HCPCS/modifiers, the service date, units, and charge amount.

Access Billing and Claims, Pre-bill Edit, PBE Status Information, enter the facility and account, enter **D for (D)etailed Edits**, the following displays for the new edit:

```
          STAR Development System PBE Status Information Processor
                                                Sat Feb 16, 2008 01:20 pm
Account      Name                 FC Typ Admit    Disch        Balance Loc
C08042-00001 TEST,ICD             C  O/P 02/11/08 02/11/08      350.75 PA /INSR


PBE Status: Manually Queued             PBE Status Date: 02/16/08


ICD10 Needs ICD-9 diagnosis (CHG 3 EEG/3112/EEG PRO FEE) (PA/3)
  CAT/C  SRC/I  USR/BLL (GRP)  OPT/Charge Information
  FLD/1570  Charge Diagnosis                          LOC/
  SRC/   HCP/   Chg/EEG-3112-041409     ChgSq/3
                                        ClmSrvLn/
  ECD/I#I9#EEG#3112

ICD10 Needs ICD-10 diagnosis (CHG 2 EEG/3130/EEG / BRAINMAPPING) (PA/2)
  CAT/C  SRC/I  USR/BLL (GRP)  OPT/Charge Information
  FLD/1570  Charge Diagnosis                          LOC/
  SRC/   HCP/   Chg/EEG-3130-041409     ChgSq/2
                                        ClmSrvLn/
  ECD/I#I0#EEG#3130




                     F1Prev Page F2Next Page F7  Exit
```

When on the PBE Status Information screen, and selecting either (E)dits, or (D)etailed Edits, if the edit is regarding a diagnosis or procedure, and the ICD-10 Effective Date is today or a date in the past on the Hospital Facility Options on STAR Patient Processing, the error has a leading ICD9 or ICD10 to indicate which coding method is missing.

```
                General Hospital PBE Status Information Processor
                                                      Sat May 23, 2009 01:43 pm
Account      Name                FC Typ Admit    Disch        Balance Loc
C08042-00001 TEST,ICD            C  O/P 02/11/09 02/11/09      350.75 PA /INSR

PBE Status: Processed/Errors            PBE Status Date: 05/02/09

ICD10 PRINCIPAL DIAG CODE (MR/ADM) is Required
  CAT/D  SRC/B  USR/RGG (GRP)  OPT/Medical Information Page
  FLD/2638  Principal Diagnosis (MR/ADM) (ADM)        LOC/
  Principal diagnosis from Medical Records or Admitting.
  ECD/B#;;DXPRMRAD#R

ICD9 Diagnosis Code - 1 FL 21 is Required
  CAT/D  SRC/C  USR/RGG (GRP)  OPT/Medical Information Page
  FLD/2638  Principal Diagnosis (MR/ADM) (ADM)        LOC/B-21-1
  Principal diagnosis from Medical Records or Admitting.
 ECD/C#;;DXPRMRAD##R









                    F1Prev Page F2Next Page F7  Exit
```

EDIT PA CHARGES

The charge selection screen has been updated as follows:

- The field PA Dx now displays the ICD-10 Ordering Diagnosis if present, followed by a slash (/) and the ICD-9 Ordering Diagnosis if present. If there is only an ICD-10 Ordering Diagnosis, the screen displays this code and the slash, such as A12.34xD/ if the charge has not been edited, or A12.34xD/None if the charge had been edited in Edit PA Charge. If there is only an ICD-9 Ordering Diagnosis, the screen displays the slash and then the code, such as /825.1 if the charge has not been edited, or None/825.1 if the charge had been edited in Edit PA Charge. If there is an ICD-10 Ordering Diagnosis and an ICD-9 Ordering Diagnosis, both are displayed as follows: A12.34xD/825.1.

- The field OM Dx now displays the ICD-10 Ordering Diagnosis if present, followed by a slash (/) and the ICD-9 Ordering Diagnosis if present. If there is only an ICD-10 Ordering Diagnosis, the screen displays this code and the slash, such as A12.34xD/ if the charge has not been edited, or A12.34xD/None if the charge had been edited in Edit PA Charge. If there is only an ICD-9 Ordering Diagnosis, the screen displays the slash and then the code, such as /825.1 if the charge has not been edited, or None/825.1 if the charge had been edited in Edit PA Charge. If there is an ICD-10 Ordering Diagnosis and an ICD-9 Ordering Diagnosis, both are displayed as follows: A12.34xD/825.1.

```
                  General Hospital Edit PA Charge Processor
                                                      Mon Feb 04, 2008 03:17 pm
Account      Name                 FC Typ Admit    Disch        Balance Loc
C08018-00002 TEST,ICD             C  O/P 01/18/08 01/18/08      390.18 AR /ACCF
                                 Charge Summary
     Dpt SIM   Description                    Srv Date Time    PA HCPCS/Mod
     Billed    Price     Qty  PA Dx           OM Dx            OM HCPCS/Mod
( 1) CAR 1104  ECG PROFESSIONAL FEE           01/18/08         93010
     FIN      $16.09      1   M48.50xD/123.4  M12.34xA/567.8   9301099887766
( 2) CAR 1100  DUPLICATE ECG 12 LEAD          01/18/08         93015
     FIN     $109.50      1
( 3) CAR 1103  RHYTHM STRIP                   01/18/08         93015
     FIN      $50.25      1
( 4) CAR 1125  THALLIUM TREADMILL             01/18/08         93015
     FIN      $98.18      1
( 5) CAR 1105  RHYTHM STRIP PROFESSIONAL FEE  01/18/08         93042
     FIN       $8.05      1




Select charges to be edited--
```

The Edit PA Charges function allows the user to edit both the ICD-9 Ordering Diagnosis and the ICD-10 Ordering Diagnosis, regardless of the account or state ICD flag for the account. In other words, if the ICD flag is a 10 for the account, the system still allows the user to enter an ICD-9 Ordering Diagnosis on the charge. If the ICD flag is a 9 for the account, IF the USA ICD-10 Effective Date is today or a date in the past, the system allows the user to enter an ICD-10 Ordering Diagnosis on the charge.

The screen has been updated to have an OM Data header on the left, and a PA Data header on the right. The leading *OM* and *PA* have been removed from the individual fields.

The PA fields on the right side of the screen are now highlighted in blue (with white letters), while the OM fields on the left side of the screen remain as before this enhancement with black lettering, no highlights.

The previous fields of 22 From CRT, 23 Initials, and 24 Reference have been moved from the bottom of the screen, to the top of the screen under the Dpt/SIM Cd/Desc values with the combined name of CRT/Int/Ref. The data now displays in a string as follows:

CRT/Int/Ref: DP/K E/Comb From : A 0813500002 SNOW,WHITE

The OM Dx field has been updated to (OM) ICD-9 Dx and continues to display the ICD-9 Ordering Diagnosis if present on the charge.

A new field of (OM) ICD-10 Dx has been added and displays the ICD-10 Ordering Diagnosis if present on the charge. This renumbers all remaining fields.

The PA Dx field has been updated to (PA) ICD-9 Dx and continues to display the ICD-9 Ordering Diagnosis if present on the charge. The field allows updates, and users can display a lookup on the ICD-9 Diagnosis Table.

A new field of (PA) ICD-10 Dx has been added and displays the ICD-10 Ordering Diagnosis if present on the charge. The field allows updates, and users can display a lookup on the ICD-10 Diagnosis Table.

The field OM ABN/ABN Reason has been renamed (OM) ICD/ABN/ABN Reason and now displays the ICD flag of 10 or 9 to indicate if the ABN processing was performed using the ICD-10 Ordering Diagnosis or the ICD-9 Ordering Diagnosis. If both the ICD-10 and the ICD-9 Ordering Diagnosis exist on a charge, STAR Order Management, STAR Laboratory, and STAR Radiology use the ICD-10 Ordering Diagnosis only for ABN processing.

The field PA ABN/ABN Reason has been renamed (PA) ICD/ABN/ABN Reason. The system automatically sets the PA ICD flag to a 9 or 10 if edits are made to the ABN code based on the ordering diagnoses present on the charge. See below documentation.

The field OM FREQ ABN/FREQ LIMIT has been renamed (OM) ICD/FREQ ABN/ FREQ LIMIT and now displays the ICD flag of 10 or 9 to indicate if the ABN frequency processing was performed using the ICD-10 Ordering Diagnosis or the ICD-9 Ordering Diagnosis. NOTE, if both the ICD-10 and the ICD-9 Ordering Diagnosis exist on a charge, STAR Order Management, STAR Laboratory, and STAR Radiology use the ICD-10 Ordering Diagnosis only for ABN processing.

The field PA FREQ ABN/FREQ LIMIT has been renamed (PA) ICD/FREQ ABN/FREQ LIMIT. The system automatically sets the PA ICD flag to a 9 or 10 if edits are made to the ABN frequency code based on the ordering diagnoses present on the charge. See below documentation.

The (OM) Ref Fac display has been moved to field 17 and shortened to display up to 12 characters only (from 23 characters). The code displays, a dash, and as much of the description as can fit. For example, SK-Smith Kli.

The (PA) Ref Fac display has been moved to field 19 and shortened to display up to 12 characters only (from 23 characters). The code displays, a dash, and as much of the description as can fit. For example, SK-Smith Kli.

The (OM) and (PA) Dup HCPCS/Reason display has been shortened from 36 characters to 20.

Once selecting a charge to update, the following screen displays:

```
                  General Hospital Edit PA Charge Processor
                                                        Mon Feb 04, 2008 03:17 pm
Account      Name                  FC Typ Admit    Disch        Balance Loc
A08135-00002 TEST,ICD              A  OPC 05/14/08 05/14/08      446.78 AR /ACCF
Ord#  Dpt/SIM Cd/Desc      Serv Dt   Qty      Price  Chg/Ord Dr.  Bill  Old Chg
   1  CAR/1104/ECG PROFES  05/14/08    1     $16.09   32/32       ADJ
      CRT/Int/Ref: DP/T C/Comb From :  A0813200004 SNOW,FLAKE
OM Data                                PA Data
 1 Serv Time        2 NDC Qty/Qual       3 Serv Time        4 NDC Qty/Qual
   13:38              None
 5 ICD-9 DX         6 ICD-10 DX          7 ICD-9 DX         8 ICD-10 DX
 826.1    A12.34xD    825.1    A45.67xD

 9 HCPCS/Modifier                       10 HCPCS      11 HCPCS Modifier
   93010
12 ICD/ABN/ABN Reason                   13 ICD/ABN/ABN Reason
 10/Yes/ABNY-Patientsignedandwitne 10/No/ABNN-Patientunconscious

14 ICD/Freq ABN/Freq Limit              15 ICD/Freq ABN/Freq Limit

16 Dup HCPCS/Reason     17 Ref Fac      18 Dup HCPCS/Reason     19 Ref Fac
         SK-Smith KLi          AB-Abbott La

20 Mutual Excl/Compre/Comp HCPCS        21 Mutual Excl/Compre/Comp HCPCS

Enter field number or '/' starting field number--
```

(OM) ICD-9 DX (DISPLAY ONLY)
This field contains the ICD-9 ordering diagnosis for the charge which is received when the charge is posted in STAR Patient Accounting or when a charge is revised in STAR Order Management.

(OM) ICD-10 DX (DISPLAY ONLY)
This field contains the ICD-10 ordering diagnosis for the charge which is received when the charge is posted in STAR Patient Accounting or when a charge is revised in STAR Order Management.

(PA) ICD-9 DX (7-AN-O)
When this field is accessed, the system prompts as follows:

Enter ICD-9-CM diagnosis code-- |
`U-`ser Dx, `-` for list

If you enter a diagnosis code, it is validated against the table of ICD-9 diagnosis codes. You can enter an ICD-9 Diagnosis code or select one from a table by entering U (User DX Code), followed by the beginning of the diagnosis description, and ending with a hyphen (-). To select a diagnosis from the Diagnosis Table, key the beginning of the diagnosis code followed by hyphen (-).

If the charge service date for the selected or keyed diagnosis code precedes the effective date for the diagnosis code indicated in the Diagnosis Table, the following prompt must be answered with Y for Yes to use the diagnosis code:

This code valid for service dates after MM/DD/YY! Accept? (Y/N) [N]--

If a diagnosis code is indicated for PA ICD-9 Diagnosis or it is changed to be blank (None), and STAR Patient Accounting charge data was not edited previously, Order

Management data is populated for OM HCPCS/Modifier, OM Freq ABN/Freq Limit, OM Dup HCPCS/Reason, and OM mutual Excl/Compre/Comp HCPCS by copying from the PA fields.

If the PA ICD-9 Diagnosis field is used, no PA charge data was changed, and the (OM) **ICD/ABN/ABN Reason** field is used, the information is not copied to (PA) **ICD/ABN/ ABN Reason**, and the following prompt is displayed:

***PA ICD/ABN/ABN Reason** is not being updated from **OM ICD/ABN/ABN Reason**. Press ENTER.*

If the PA ICD-9 Diagnosis field is changed, PA charge data was changed, and the (PA) **ICD/ABN/ABN Reason** field is used, information in the (PA) **ICD/ABN/ABN Reason** field and the ABN flag for ICD-10 or ICD-9 is **removed** and the following prompt is displayed:

***PA ICD/ABN/ABN Reason** information is being removed due to change in PA Diagnosis. Press ENTER.*

If an ABN code/ABN Reason is then entered in the PA ICD/ABN/ABN Reason field, the system sets the ICD flag for the ABN based on which ordering diagnoses exist on the account. See below field for PA ICD/ABN/ABN Reason.

(PA) ICD-10 DX (8-AN-O)
Access is only allowed to this field if the USA ICD-10 Effective Date on the Hospital Facility Options of STAR Patient Processing is today or a date in the past. When this field is accessed, the system now prompts as follows:

Enter ICD-10-CA diagnosis code-- |
`U-`ser Dx, `-` for list

Note that when doing a table lookup on the ICD-10-CM diagnosis codes, the system displays only a single column of data, and you have to page forward. This is because the diagnosis descriptions for ICD-10 diagnoses are longer than the ICD-9 diagnosis descriptions. When doing a table lookup on the ICD-9-CM diagnosis codes, the system continues to display two columns of data to select from.

If you enter a diagnosis code, it is validated against the table of ICD-10 diagnosis codes. You can enter an ICD-10 Diagnosis code or select one from a table by entering U (User DX Code), followed by the beginning of the diagnosis description, and ending with a hyphen (-). To select a diagnosis from the Diagnosis Table, key the beginning of the diagnosis code followed by hyphen (-).

If the charge service date for the selected or keyed diagnosis code precedes the effective date for the diagnosis code indicated in the Diagnosis Table, the following prompt must be answered with Y for Yes to use the diagnosis code:

This code valid for service dates after MM/DD/YY! Accept? (Y/N) [N]--

If a diagnosis code is indicated for PA ICD-10 Diagnosis or it is changed to be blank (None), and STAR Patient Accounting charge data was not edited previously, Order

Management data is populated for OM HCPCS/Modifier, OM Freq ABN/Freq Limit, OM Dup HCPCS/Reason, and OM mutual Excl/Compre/Comp HCPCS by copying from the PA fields.

If the PA ICD-10 Diagnosis field is used, no PA charge data was changed, and the (OM) **ICD/ABN/ABN Reason** field is used, the information is not copied to (PA) **ICD/ ABN/ABN Reason**, and the following prompt is displayed:

***PA ICD/ABN/ABN Reason** is not being updated from **OM ICD/ABN/ABN Reason**. Press ENTER.*

If the PA ICD-10 Diagnosis field is changed, PA charge data was changed, and the (PA) **ICD/ABN/ABN Reason** field is used, information in the (PA) **ICD/ABN/ABN Reason** field and the ABN flag for ICD-10 or ICD-9 is **removed** and the following prompt is displayed:

***PA ICD/ABN/ABN Reason** information is being removed due to change in PA Diagnosis. Press ENTER.*

If an ABN code/ABN Reason is then entered in the PA ICD/ABN/ABN Reason field, the system sets the ICD flag for the ABN based on which ordering diagnoses exist on the account. See below field for PA ICD/ABN/ABN Reason.

(OM) ICD/ABN/ABN REASON (DISPLAY ONLY)
This field contains the ICD flag for the ABN, the ABN code and ABN reason from STAR Order Management. The ICD flag of 10 or 9 indicates if the ABN processing was performed using the ICD-10 Ordering Diagnosis or the ICD-9 Ordering Diagnosis. NOTE, if both the ICD-10 and the ICD-9 Ordering Diagnosis exist on a charge, STAR Order Management, STAR Laboratory, and STAR Radiology use the ICD-10 Ordering Diagnosis only for ABN processing.

(PA) ICD/ABN/ABN REASON (1-A-O)
This field indicates whether the ABN flag is set to ABN Not signed, ABN Signed, Self Pay ABN Signed, Self Pay ABN Not Signed, or ABN Approved and also displays the ABN Reason from the ABN Modifier and Reason Table in STAR Order Management. The ABN Reason is displayed when the PA ABN is Signed (Yes), Not Signed (No), Self Pay ABN Signed (SP/Y), and Self Pay ABN Not Signed (SP/N). This field cannot be edited unless STAR Patient Accounting HCPCS and **an Ordering Diagnosis** exist and the STAR Patient Accounting charge data has been edited. The field cannot be edited

if the STAR Patient Accounting Freq ABN/Freq Limit field contains information. When this field is accessed, the following prompt is displayed:

Enter (A) for approved diagnosis, (Y) for ABN signed, (N) for ABN not signed, (S) for self pay signed, and (X) for self pay not signed--

You can enter **A** (Approved Diagnosis) if an ABN is not required. You can enter Y

(Yes), ABN signed or N (No), ABN not signed. If you enter **Y** (ABN signed), the system displays the list of reasons defined for the GA modifier in the ABN Modifier and Reason Table from STAR Order Management. You can select the ABN Reason from the screen. If there are no entries in the ABN Modifier and Reason Table for the GA Modifier, and the PA ABN is set to Yes, the system automatically assigns Modifier GA.

If you enter **N** (no signed ABN), the system displays the list of reasons defined for the GZ modifier in the ABN Modifier and Reason Table from STAR Order Management. You can select the ABN Reason from the screen. If there are no entries in the ABN Modifier and Reason Table for the GZ Modifier, and the PA ABN is set to No, the system automatically assigns Modifier GZ.

If you enter **Y** (ABN Signed) or **N** (ABN Not Signed), any information in the PA Dup HCPCS/Reason field and in the PA Mutual Excl/Compre/Comp HCPCS field is removed. If either ABN Signed or ABN Not Signed is entered, and the ABN flag is selected for the field Print Non-Covered Chgs? for the UB Charge Control Parameter, the charge amount is displayed in the non-covered column for the UB claim. If ABN Signed is indicated, the charge is marked to appear on the nightly report, Non-covered Services with Signed Advanced Beneficiary Notification (FAHCFAYx). If ABN Not Signed is indicated, the charge is marked to appear on the nightly report, Non-covered Services without Signed Advanced Beneficiary Notification (FAHCFANx).

When entering **S** for self pay signed, the system displays the ABN Reasons in the ABN Modifier and Reason Table that have the field for Self Pay Indicator set to PS (Self Pay/ Patient/Witness Signed). When in the ABN Modifier and Reason Table, and selecting PS, the Self Pay Indicator displays SPS. If the ABN flag is selected for the field Print Non-Covered Chgs? for the UB Charge Control Parameter, the charge amount is displayed in the non-covered column for the UB claim. If Self Pay ABN Signed is indicated, the charge is marked to appear on the nightly report, Self Pay Services with Signed Advanced Beneficiary Notification (FAHCFSYx).

When entering **X** for self pay not signed, the system displays the ABN Reasons in the ABN Modifier and Reason Table that have the field for Self Pay Indicator set to NS (Self Pay/No Signature). When in the ABN Modifier and Reason Table, and selecting NS, the Self Pay Indicator displays SPNS. If the ABN flag is selected for the field Print Non-Covered Chgs? for the UB Charge Control Parameter, the charge amount is displayed in the non-covered column for the UB claim. If Self Pay ABN Not Signed is indicated, the charge is marked to appear on the nightly report, Self Pay Services without Signed Advanced Beneficiary Notification (FAHCFSNx).

If the ABN code/reason is updated in the (PA) ICD/ABN/ABN Reason field, the system automatically sets the ICD flag for the ABN as follows. The ABN flag tells the user if the ICD-10 or the ICD-9 Ordering Diagnosis on the charge was used for ABN processing. The field displays 10 for ICD-10 and a 9 for ICD-9 before the ABN code itself in the following format:

10/Yes/ABNY-Patient signed and witnessed

9/Yes/ABNY-Patient signed and witnessed

10/No/ABNN-Patient unconscious or refused

9/No/ABNN-Patient unconscious or refused.

(OM) ICD/FREQ ABN/FREQ LIMIT (DISPLAY ONLY)
This field contains the ICD flag for the ABN, the ABN code and ABN reason from STAR Order Management. The ICD flag of 10 or 9 indicates if the ABN processing was performed using the ICD-10 Ordering Diagnosis or the ICD-9 Ordering Diagnosis. NOTE, if both the ICD-10 and the ICD-9 Ordering Diagnosis exist on a charge, STAR Order Management, STAR Laboratory, and STAR Radiology use the ICD-10 Ordering Diagnosis only for ABN processing.

The OM Freq ABN/Freq Limit field displays the ABN codes and then displays the Frequency Limit. Self Pay ABN codes are represented by SP and then Y for Yes or N for No. For example:

SP/Y/365 DAYS/SPFY-SELF PAY FREQ SIGNED

(PA) ICD/FREQ ABN/FREQ LIMIT
This field contains the frequency ABN and limit from STAR Patient Accounting. The Freq ABN flag must be set to ABN Freq Not Signed, ABN Freq Signed, Self Pay ABN Freq Not Signed, or Self Pay ABN Freq Signed. If the Freq ABN flag is set, the frequency limit from the Medical Records HCPCS table is the second part of this field. This field cannot be edited unless PA HCPCS exists and the PA charge data has been edited. The field cannot be edited if PA ABN/ABN Reason has information. The field cannot be edited unless Frequency Limitation has been defined for the PA HCPCS code in the Medical Records HCPCS code table. If the field is accessed and no Frequency Limitation has been defined for the PA HCPCS code in the Medical Records HCPCS code table, the following message is displayed:

Frequency Limitation is not defined in Medical Records HCPCS code table!

If the field is accessed, and a Frequency Limitation was defined for the PA HCPCS code in the Medical Records HCPCS code table, the following prompt is displayed:

To document a frequency limit for a procedure, enter (Y) for ABN signed, (N) for ABN not signed, (S) for self pay signed, and (X) for self pay not signed--

If you enter **Y** for ABN signed or **N** for ABN not signed, any information in PA Dup HCPCS/Reason and in PA Mutual Excl/Compre/Comp HCPCS is removed. Also, the frequency limit is provided from the HCPCS table.

You can enter Y (Yes), ABN signed or N (No), ABN not signed. If you enter **Y** (ABN signed) or the PA ABN is FQ/Y Frequency with Signed ABN, the system displays the list of reasons defined for the GA modifier in the ABN Modifier and Reason Table from STAR Order Management. You can select the ABN Reason from the screen. If there are no entries in the ABN Modifier and Reason Table for the GA Modifier, and the PA ABN is set to either Yes or FQ/Y for Frequency with Signed ABN, the system automatically assigns Modifier GA.

If you enter **N** (no signed ABN) or the PA ABN is set to FQ/No for Frequency Limit with no signed ABN, the system displays the list of reasons defined for the GZ modifier in the ABN Modifier and Reason Table from STAR Order Management. You can select the ABN Reason from the screen. If there are no entries in the ABN Modifier and Reason Table for the GZ Modifier, and the PA ABN is set to either No or FQ/N for Frequency and No Signed ABN, the system automatically assigns Modifier GZ.

If either ABN Signed or ABN Not Signed is entered, and the ABN flag is selected for the field Print Non-Covered Chgs? for the UB Charge Control Parameter, the charge amount is displayed in the non-covered column for the UB claim. If Frequency ABN Signed is indicated, the charge is marked to appear on the nightly report, Non-covered Services Subject to Frequency Limit with Signed Advanced Beneficiary Notification (FAHCFAYx). If Frequency ABN Not Signed is indicated, the charge is marked to appear on the nightly report, Non-covered Services Subject to Frequency Limit without Signed Advanced Beneficiary Notification (FAHCFANx).

When entering **S** for self pay signed, the system displays the ABN Reasons in the ABN Modifier and Reason Table that have the field for Self Pay Indicator set to PS (Self Pay/ Patient/Witness Signed). When in the ABN Modifier and Reason Table, and selecting PS, the Self Pay Indicator displays SPS. If the ABN flag is selected for the field Print Non-Covered Chgs? for the UB Charge Control Parameter, the charge amount is displayed in the non-covered column for the UB claim. If Self Pay Frequency ABN Signed is indicated, the charge is marked to appear on the nightly report, Self Pay Services Subject to Frequency Limit with Signed Advanced Beneficiary Notification (FAHCFSFYx).

When entering **X** for self pay not signed, the system displays the ABN Reasons in the ABN Modifier and Reason Table that have the new field for Self Pay Indicator set to NS (Self Pay/No Signature). When in the ABN Modifier and Reason Table, and selecting NS, the Self Pay Indicator displays SPNS. If the ABN flag is selected for the field Print Non-Covered Chgs? for the UB Charge Control Parameter, the charge amount is displayed in the non-covered column for the UB claim. If Self Pay Frequency ABN Not Signed is indicated, the charge is marked to appear on the nightly report, Self Pay Services Subject to Frequency Limit without Signed Advanced Beneficiary Notification (FAHCFSFNx).

ABN ICD FLAG LOGIC

The following scenarios outline the ABN ICD flag. This logic is in effect for the field (PA) ICD/ABN/ABN REASON field. The (PA) ICD/FREQ ABN/FREQ LIMIT field does not follow this logic, and only verifies that the HCPCS entered has a Frequency Limit defined in the HCPCS Master.

- The charge has an ICD-10 Ordering Diagnosis only, and an ABN flag of 10 and ABN Reason. An ICD-9 Ordering Diagnosis is added. The system retains the ABN flag of 10 and ABN Code/Reason.

- The charge has an ICD-10 Ordering Diagnosis only, and an ABN flag of 10 and ABN Reason. The ICD-10 Diagnosis is deleted. The system clears the ABN flag and ABN Code/Reason.

    - If an ICD-9 Ordering Diagnosis is then entered, if an ABN Code/Reason is entered, the system automatically sets the flag to 9.

- The charge has an ICD-10 Ordering Diagnosis only, and an ABN flag of 10 and ABN Reason. The ICD-10 Ordering Diagnosis is updated. The system clears the ABN flag and ABN Reason.

- The charge has an ICD-10 Ordering Diagnosis only, and an ABN flag of 10 and ABN Reason. The ABN Reason is updated. The system retains the ABN flag of 10.

- The charge has an ICD-9 Ordering Diagnosis only, and an ABN flag of 9 and ABN Reason. An ICD-10 Ordering Diagnosis is added. The system clears the ABN flag of 9 and ABN Reason since ABN processing is for Medicare, and a more current, ICD-10 diagnosis was entered.

- The charge has an ICD-9 Ordering Diagnosis only, and an ABN flag of 9 and ABN Reason. The ICD-9 Diagnosis is deleted. The system clears the ABN flag and ABN Reason.

    - If an ICD-10 Ordering Diagnosis is then entered, if an ABN Reason is entered, the system automatically sets the flag to 10.

- The charge has an ICD-9 Ordering Diagnosis only, and an ABN flag of 9 and ABN Reason. The ICD-9 Ordering Diagnosis is updated. The system clears the ABN flag and ABN Reason.

- The charge has an ICD-9 Ordering Diagnosis only, and an ABN flag of 9 and ABN Reason. The ABN Reason is updated. The system retains the ABN flag of 9.

- The charge has BOTH an ICD-10 Ordering Diagnosis and ICD-9 Ordering Diagnosis, and an ABN flag of 10 and ABN Reason. The ICD-9 Ordering Diagnosis is deleted. The system retains the ABN flag of 10 and ABN Reason.

The system gives the message:

PA ICD/ABN/ABN Reason information is not being removed because ICD-10 diagnosis exists. Press ENTER

- The charge has BOTH an ICD-10 Ordering Diagnosis and ICD-9 Ordering Diagnosis, and an ABN flag of 10 and ABN Reason. The ICD-10 Ordering Diagnosis is deleted. The system clears the ABN flag and ABN Reason.

- The charge has BOTH an ICD-10 Ordering Diagnosis and ICD-9 Ordering Diagnosis, and an ABN flag of 10 and ABN Reason. The ABN Reason is updated. The system retains the ABN flag of 10.

- The charge has BOTH an ICD-10 Ordering Diagnosis and ICD-9 Ordering Diagnosis, and an ABN flag of 10 and ABN Reason. The ICD-9 Ordering Diagnosis is updated. The system retains the ABN flag of 10 and ABN Reason.

- The charge has BOTH an ICD-10 Ordering Diagnosis and ICD-9 Ordering Diagnosis, and an ABN flag of 10 and ABN Reason. The ICD-10 Ordering Diagnosis is updated. The system clears the ABN flag and ABN Reason.

Transaction History for Edit PA Charges

When pressing F5 on the Transaction History for Edit PA Chg for Inactive (Active) Account, the Comment field continues to display the SIM Department, a slash (/), the SIM Item, and then DX for changes to the Ordering Diagnosis for the charge. There have been no changes to this field. When entering L on this screen to List changes, the screen has been updated.

On the **List** changes screen, the **DX** field in the **upper left** displays the most recent ordering diagnoses and descriptions on the charge. The diagnosis codes display first. The ICD-10 Ordering Diagnosis displays if present, followed by a slash (/) and the ICD-9 Ordering Diagnosis if present. If there is only an ICD-10 Ordering Diagnosis, the screen displays this code and the slash, such as: A12.34xD/. If there is only an ICD-9 Ordering Diagnosis, the screen displays the slash and then the code, such as: /825.1. If there is an ICD-10 Ordering Diagnosis and an ICD-9 Ordering Diagnosis, both are displayed as follows: A12.34xD/825.1. The diagnosis descriptions then display. The ICD-10 Ordering Diagnosis description displays if present, followed by a slash (/) and the ICD-9 Ordering Diagnosis description if present. If there is only an ICD-10 Ordering Diagnosis, the screen displays this description and the slash, such as: Collapsed Vertebra NOS, Site Unspecified /. If there is only an ICD-9 Ordering Diagnosis, the screen displays the slash and then the code, such as /Vertebra Injury. If there is an ICD-10 Ordering Diagnosis and an ICD-9 Ordering Diagnosis, both are displayed as follows Collapsed Vertebra NOS, Site Unspecified/ Vertebra Injury.

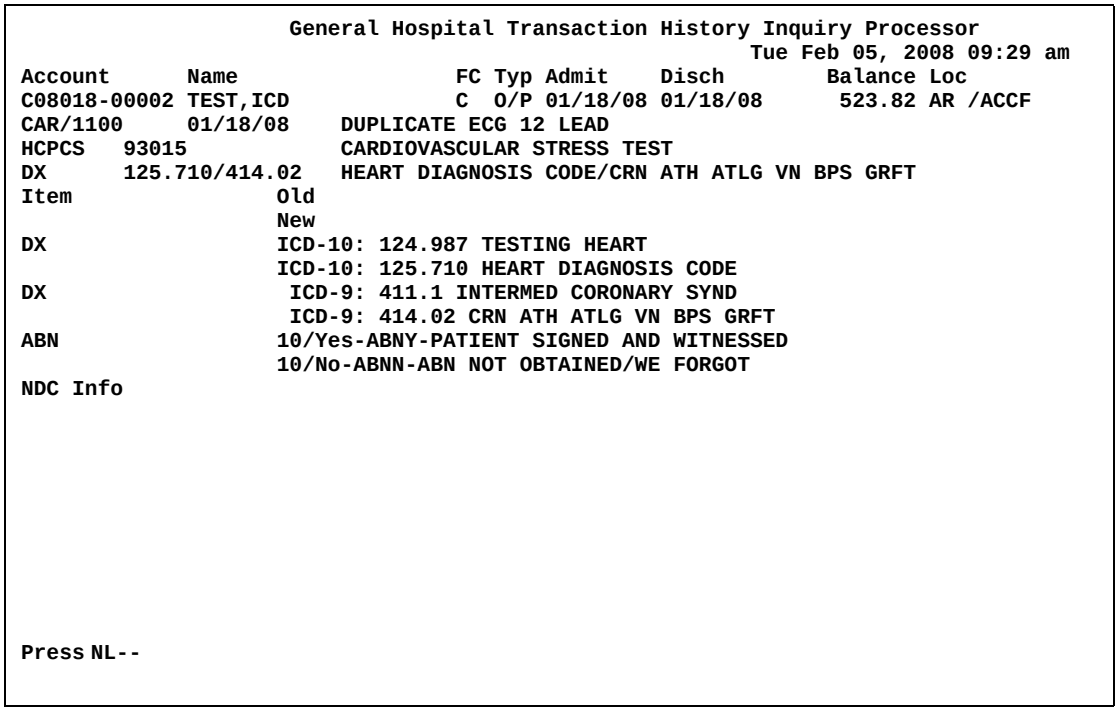
On the List changes screen, for the **Old** and **New DX** changes, the system first lists the Old and New (stacked) ICD-10 Ordering Diagnoses (if any), followed by the Old and

New (stacked) ICD-9 Ordering Diagnoses (if any). The diagnoses are now labeled with ICD-10 and ICD-9 as appropriate.

Also on the List changes screen, for the **Old** and **New ABN** changes, the system lists the ABN ICD flag of 9 or 10, a slash (/), the ABN, a dash, and the ABN Reason. A blank ICD flag displays a 9. For example:

10/Yes-ABNY-PATIENT SIGNED AND WITNESSED

9/No-ABNN-PATIENT UNWILLING TO SIGN



PROVIDER MASTER

The logic for the auto load of Occurrence Code 10 – Last Menstrual Period, has been updated for ICD-10 diagnoses.

If highlighted in the Provider Master, Occurrence Code 10 – Last Menstrual Period, can load to the UB claim. This occurrence code looks to the ICD diagnosis codes in Medical Records.

- The logic for Occurrence Code 10 – Last Menstrual Period, using **ICD-9 codes**, remains as follows:

  10 - Last Menstrual Period

  Occurrence Code 10 loads to the claim as follows:

- If there is an ICD-9-CM Principal Diagnosis Code in Medical Records in the 634 -639 range for Abortion, but no Last Menstrual Period date is entered on the account, Occurrence Code 10 loads to the claim with no date.

- If there is an ICD-9-CM Principal Diagnosis Code in Medical Records in the 634 - 639 range for Abortion, and a Last Menstrual Period date is entered on the account, Occurrence Code 10 loads to the claim with an Occurrence Code Date of the last menstrual period.

- If a Last Menstrual Period date is entered on the account, regardless of the Principal Diagnosis Code entered in Medical Records, Occurrence Code 10 loads to the claim with an Occurrence Code Date of the last menstrual period.

• The logic for Occurrence Code 10 – Last Menstrual Period, using **ICD-10 codes**, has been added as follows:

  10 - Last Menstrual Period

  Occurrence Code 10 loads to the claim as follows:

  - If there is an ICD-10-CM Principal Diagnosis Code in Medical Records with leading digits in the O00 - O08 range for Abortion, but no Last Menstrual Period date is entered on the account, Occurrence Code 10 loads to the claim with no date.

  - If there is an ICD-10-CM Principal Diagnosis Code in Medical Records with leading digits in the O00 – O08 range for Abortion, and a Last Menstrual Period date is entered on the account, Occurrence Code 10 loads to the claim with an Occurrence Code Date of the last menstrual period.

  - If a Last Menstrual Period date is entered on the account, regardless of the Principal Diagnosis Code entered in Medical Records, Occurrence Code 10 loads to the claim with an Occurrence Code Date of the last menstrual period.

COMBINE BILLING/DRG PAYMENT WINDOW

1) DRG Payment Window Parameters

The fields O/P Abstract and I/P Abstract have been updated to look to the TO (Inpatient) account's Final Bill Parameter. The system uses the same logic as that in Billing to determine if the TO account's bill requires ICD-10 or ICD-9 diagnosis and procedure codes.

If the TO account's bill edits for the existence of ICD-10 diagnosis and procedure codes, then the system looks to the ICD-10 diagnosis codes on both the FROM and the TO accounts when performing the O/P Abstract and the I/P Abstract logic (meaning, the ICD-10 charge diagnoses, or the Principal ICD-10 Diagnosis in Medical Records on the Outpatient Account(s) are compared to the Principal and Secondary ICD-10 Diagnoses codes in Medical Records on the Inpatient Account).

If the TO account's bill edits for the existence of ICD-9 diagnosis and procedure codes, then the system looks to the ICD-9 diagnosis codes on both the FROM and the TO accounts when performing the O/P Abstract and the I/P Abstract logic (meaning, the ICD-9 charge diagnoses, or the Principal ICD-9 Diagnosis in Medical Records on the Outpatient Account(s) are compared to the Principal and Secondary ICD-9 Diagnoses codes in Medical Records on the Inpatient Account).

If there is a mismatch between the coding methods on the TO (inpatient) account and any of the FROM accounts, this is a DPW error and is reflected on the DRG Payment Window Report (FBR072x). For example, if the TO account requires ICD-10 codes, and the FROM account(s) only have ICD-9 codes, this would be a mismatch and the accounts would be reflected on the report. This could occur when the Inpatient admission date is on or after the ICD-10 Effective Date on the Hospital Facility Options screen in STAR Patient Processing, but the Series account for the same patient is coded only in ICD-9 codes. The opposite would also be true: if the TO account requires ICD-9 codes, and the FROM account(s) only have ICD-10 codes, this would be a mismatch and the accounts would be reflected on the report.

When there is a mismatch on the TO and FROM account(s) for the coding methods, the accounts are listed on the DRG Payment Window Report with the error message *DPW Hold. ICD9/ICD10 Mismatch*. The accounts are put on DPW Bill Hold (existing bill DPW hold). The system keeps the accounts on DPW bill hold until the mismatch is corrected (meaning, the needed version of the diagnosis codes are coded on the FROM accounts), or charges can be manually selected and moved via the DRG Payment Window Processor from the FROM account(s) to the TO account, and the DPW Bill Hold manually removed on the Account Status screen within Account Revision.

The following logic still holds true. But, the logic is looking to EITHER the ICD-10 Diagnosis Codes, or the ICD-9 Diagnosis Codes, and not both. The system cannot compare one coding system to another coding system across accounts.

Informational Documentation:

The I/P Abstract parameter field gives you a choice of using either the inpatient's Primary Medical Records diagnosis codes or All Medical Records diagnosis codes.

The I/P Abstract parameter (field 9) determines whether Primary or All diagnoses for the inpatient should be used in comparison to the outpatient's **non-diagnostic** charges.

Diagnostic charges are those defined in the Diagnostic Revenue Code Table (the charges have the specified revenue code and the HCPCS on the charge is flagged as Yes for DPW Diagnostic Procedure in the HCPCS Master if the field Requires HCPCS for DPW Program is set to Yes for the revenue code in the Diagnostic Revenue Code Table) and they have service dates less than or equal to the Eval Diag Charges field (field 14).

Charges with a revenue department not in the Diagnostic Revenue Code Table are reviewed by diagnosis codes (these are **non-diagnostic charges**). This is when the O/P Abstract (field 8) and I/P Abstract (field 9) parameters are used. The O/P Abstract fields determine if the Medical Record or Charge diagnosis should be compared to the inpatient diagnosis codes (I/P Abstract parameter).

If the charge is not diagnostic, the charge is marked Pending until the inpatient account is marked Abstract Complete by Medical Records.

- If O/P Abstract = No, the system uses the charge information. Outpatient charges with no diagnosis codes automatically transfer to the inpatient account. If a diagnosis code is present, this information is compared to the I/P Abstract data. The ICD-10-CM or the ICD-9-CM Ordering Diagnosis code on each of the outpatient charges marked pending is evaluated to determine if there is a match with the inpatient Principal or Secondary ICD-10-CM or ICD-9-CM code.

- If O/P Abstract = Yes, the system uses Medical Records diagnosis information to compare with the I/P Abstract data. The charges are evaluated when both the inpatient and outpatient abstracts are complete. If the outpatient abstract is required, pending charges are evaluated to determine if the outpatient Principal ICD-10-CM or ICD-9-CM code matches the inpatient Principal or Secondary ICD-10-CM or ICD-9-CM code.

8. O/P ABSTRACT (1-A-O)
This field indicates whether the Principal Diagnosis in the outpatient abstract or the diagnosis in the charge is used to determine if a non-diagnostic charge is admission related. If this field contains Y for Yes, pending charges are evaluated when the outpatient account is abstracted to determine if the outpatient primary ICD-10-CM or ICD-9-CM code matches an inpatient principal or a secondary ICD-10-CM or ICD-9-CM code. The charges are evaluated when both the inpatient and outpatient abstracts are complete. If this field contains NO, the charge diagnosis is used in the evaluation. The ICD-10-CM or ICD-9-CM code on each of the outpatient charges marked pending is evaluated to determine if there is a match with the inpatient principal or secondary ICD-10-CM or ICD-9-CM code.

9. I/P ABSTRACT (1-A-O)
This field determines which diagnosis codes are used to compare with outpatient diagnosis codes. The parameter settings are **P** for primary diagnosis or **A** for all diagnosis codes from Medical Records on the inpatient visit.

```
                General Hospital DRG Payment Window Parameters Processor
                                                      Mon Feb 18, 2008 04:39 pm


 1 DPW Code           2 DPW Description                3 Edit Date
   MED                  MEDICARE                         03/26/07 05:29pm
 4 Financial Classes  5 Patient Types          6 Edit By
   B,M                  IP,OP,SER                  Viking,Han
 7 Insurance Carrier/Plan                      8 O/P Abstract  9 I/P Abstract
   100100, 400100                                No              All
10 Start Trans Code/Desc 11 Exclude FIM Dept             12 Exclude FIM Codes
   S0005-DPW Initiated                                      No
13 All Chgs    14 Eval Diag Chgs 15 Eval Non-Diag Chgs   16 Discharge Day Chgs
   Report/1       Report/3          Report/3                Report
17 Rpt Detail Charges            18 Rpt Cumulative       19 Rpt Facilities
   Yes                               Yes                     B
20 End Trans Code/Desc           21 Chg Trans Code/Desc  22 Effective Date
   S0007-DPW Deleted                 S0006-DPW Changed/Mo    03/02/99




Enter field number or '/' starting field number--
```

2) Preview Screen for DRG Payment Window and Combined Billing

Both the Combine Billing function and the DRG Payment Window function display the same screens.

- For Combine Billing, access Billing and Claims, Patient Billing, Combine Bills.

  After entering the From and To accounts, the system displays a screen with the following prompt:

  Request bill(B), add account(A), delete account(D), remove all links(R), preview comb med info(P), use adm dx's in preview(U), or [NL] to exit --

- For DRG Payment Window, access Billing and Claims, DRG Payment Window Functions, DRG Payment Window Processor, enter the facility and the account, select an account. The system displays a screen with the following prompt:

  (D)eactivate DPW, (C)hange DPW, (E)valuate Charges, (R)eview Charges, or (P)review Combined Medical Info, (U)se adm dx's in Preview Comb Med Info--

For Combine Billing and DRG Payment Window the (P) screen for Preview Combined Medical Information, and the (U) screen for Use Admission Diagnoses in Preview have been updated as outlined below.

- P: Preview Combined Medical Information

  Enter **P** to preview combined medical information for linked charges. The preview screen does not access the TO account's UB Claim Load Edit Parameter to determine if diagnoses and procedure information from a FROM account is used on the TO account's claim. The preview screen shows the Medical Record diagnoses and procedure information that COULD BE used on the TO account's claim if the UB Claim Load Edit Parameter has the following fields set to Diagnoses, Procedures, Both Diagnoses and Procedures, or All (which includes HCPCS):

  - Combine Bill Med Info
  - DPW Med Info

  Charge level diagnoses are not displayed.

- U: (U) screen for Use Admission Diagnoses in Preview

  Enter **U** to preview combined medical and admissions information for linked accounts. This screen differs from the Preview Combined Medical Info option in that the **P** option displays only the diagnoses information entered on the TO and FROM accounts in Medical Records. The Use Adm Diagnoses in Preview option (**U**) displays the diagnosis information entered on the To and FROM accounts in Medical Records if it exists. If there is no principal or secondary diagnosis information on the TO or FROM account, the diagnosis information entered on the account in Admissions is displayed.

  The preview screen does not access the TO account's UB Claim Load Edit Parameter to determine if diagnoses and procedure information from a FROM account is to be used on the TO account's claim. The preview shows the Medical Record diagnoses and procedure information that COULD BE used on the TO account's claim if the UB Claim Load Edit Parameter has the following fields set to Diagnoses, Procedures, or Both Diagnoses and Procedures, or All (which includes HCPCS):

  - Combine Bill Med Info
  - DPW Med Info

  This combined Medical Records and Admissions diagnosis information can be reflected on the TO account's claim (in a Combine Bill) or on the inpatient DPW claim (TO account in linked DPW) if the (MR/ADM) internal elements are used and if the Use Adm Prin/Sec Dx for Combine Bill/DPW Med Info field on the first screen of the TO account’s Claim Load and Edit Parameters is set to Yes.

  Charge level diagnoses are not displayed.

Screen Updates

Both the (P)review and the (U)se screen are in the same format, but can display different data. Therefore, the below screens apply to both.

Abbreviations

PDX Principal Diagnosis

ODX01-ODXxx Other Diagnoses (secondary). As many entered are displayed, such as ODX01, ODX02, ODX03.

ADX Admitting Diagnosis

ECDxx External Cause of Injury Diagnosis (01, 02, 03)

PRCP Principal Procedure

PRC01-PRCxx Other Procedures (secondary). As many entered are displayed, such as PRC01, PRC02, PRC03.

A field of ICD- was added for the diagnosis and procedure information. This field displays ICD-10 when displaying the ICD-10 diagnoses and procedures, and displays ICD-9 when displaying the ICD-9 diagnoses and procedures.

When there are *both* ICD-10 and ICD-9 diagnosis codes and/or procedure codes, on either or both the FROM account(s) and TO account, the system automatically displays the ICD-10 diagnosis and procedure codes first, and then displays any ICD-9 diagnosis and procedure codes. These are followed by any Medical Records HCPCS. Therefore, if there are two or more FROM accounts, and one FROM account has ICD-10 diagnoses and/or procedures, but another FROM account only has ICD-9 diagnoses and/or procedures, the FROM account with only ICD-9 codes are displayed after the ICD-10 information.

When there are *only* ICD-10 diagnosis codes and/or procedure codes, on both the FROM account(s) and TO account, the system automatically displays the ICD-10 diagnoses and procedures.

When there are *only* ICD-9 diagnosis codes and/or procedure codes, on both the FROM account(s) and TO account, the system automatically displays the ICD-9 diagnoses and procedures.

The Preview Combined Medical Information screen and the Use Admission Diagnoses in Preview screen display all possible diagnosis, procedure, and HCPCS information that can be used on the TO account. What is actually used for the TO account's Bill and Claim, however, is based on the TO account's Bill ICD indicator, and on the TO account's Claim ICD indicator, Claim Load Edit Parameter settings, and internal elements used.

PREVIEW COMBINED MEDICAL INFORMATION/USE ADMISSION DIAGNOSES IN PREVIEW

The same screens are seen within Combine Bills and DRG Payment Window. The following examples are from Combine Bills. The screen header would display *DRG Payment Window Processor* for that function.

```
              General Hospital Combine Bills Processor
                                                 Fri Jan 18, 2008 03:56 pm
Account      Name                 FC Typ Admit    Disch        Balance Loc
C08018-00002 TEST,ICD             C  O/P 01/18/08 01/18/08      290.12 PA /INSR

The medical information displayed below may change prior to the load of
the UB claim.
                         Combined UB Information Review
Type  Code     Description         POA/Dt   Reference     Typ Admit    Disch
ICD-10
PDX   M79.661A TEST DIAGNOSIS      Y
ODX01 M48.50xA YET ANOTHER TEST    U
ODX02 A23.456D MORE TESTING        W
ODX03 B34.56xA TESTINGTESTING      Y        C0801800001   O/P 01/18/08 01/18/08
ODX04 C98.76xD LONGDIAGNOSIS       Y        C0801800001   O/P 01/18/08 01/18/08
ODX05 H34.567A NEWCODE             W        C0801800001   O/P 01/18/08 01/18/08
ADX   M87.65xD SICKDIAGNOSIS
PRCP  0JPT0PZ  SPINAL X-RAY NEC    01/18/08
PRC01 1AB23C4  LUMBOSAC SPINE X-RA 01/18/08
PRC02 2KE34D5  MUSCLE REATTACHMENT 01/18/08 C0801800001   O/P 01/18/08 01/18/08
ICD-9
PDX   850.9    CONCUSSION NOS      Y

                     F1Prev Page F2Next Page F7  Exit
```

```
                  General Hospital Combine Bills Processor
                                                 Fri Jan 18, 2008 03:56 pm
Account      Name                 FC Typ Admit    Disch        Balance Loc
C08018-00002 TEST,ICD             C  O/P 01/18/08 01/18/08      290.12 PA /INSR


The medical information displayed below may change prior to the load of
the UB claim.
                         Combined UB Information Review
Type  Code     Description         POA/Dt   Reference     Typ Admit    Disch
ODX01 851.01   CORTEX CONTUSION-NO U
ODX02 851.02   CORTEX CONTUS-BRIEF W
ODX03 900.9    INJ HEAD/NECK VESSE Y        C0801800001   O/P 01/18/08 01/18/08
ODX04 900.1    INJ INTERNL JUGULAR Y        C0801800001   O/P 01/18/08 01/18/08
ODX05 900.82   INJ MLT HEAD/NECK V W        C0801800001   O/P 01/18/08 01/18/08
ADX   850.0    CONCUSSION W/O COMA
PRCP  8729     SPINAL X-RAY NEC    01/18/08
PRC01 8724     LUMBOSAC SPINE X-RA 01/18/08
PRC02 8374     MUSCLE REATTACHMENT 01/18/08 C0801800001   O/P 01/18/08 01/18/08
PRC03 8373     TENDON REATTACHMENT 01/18/08 C0801800001   O/P 01/18/08 01/18/08
ATT   501 TEST,ABC
OTH   2042 SILVA,MD ONE


                     F1Prev Page F2Next Page F7  Exit
```

```
              General Hospital Combine Bills Processor
                                                  Fri Jan 18, 2008 03:56 pm
Account      Name                 FC Typ Admit    Disch        Balance Loc
C08018-00002 TEST,ICD             C  O/P 01/18/08 01/18/08      290.12 PA /INSR


The medical information displayed below may change prior to the load of
the UB claim.
                         Combined UB Information Review
Type  Code     Description          POA/Dt   Reference     Typ Admit    Disch

Type  Code     Modifier(s)    Rev  Date     Reference     Typ Admit    Disch
HCPCS 11111                   740  01/18/08 C0801800001   O/P 01/18/08 01/18/08
HCPCS 22222                   360  01/18/08 C0801800001   O/P 01/18/08 01/18/08
HCPCS 33333    4780217723     740  01/18/08 C0801800001   O/P 01/18/08 01/18/08









                      F1Prev Page F2Next Page F7  Exit
```

3) DRG Payment Window Processor

On the initial DRG Payment Window Processor screen, which lists the linked accounts, the fields "**To ICD**" and "**From ICD**" have been added. The "To ICD" displays the calculated To account's final bill ICD indicator at the time the DPW pair is established or updated. The "From ICD" displays the calculated From account's final bill ICD indicator at the time the DPW pair is established or updated.

NOTE: If the To account and the From account do not match on the ICD indicator, then the charges are not moved from the From account to the To account, and the accounts are listed on the FBR072x DRG Payment Window Report with an ICD9/ICD10 Mismatch error.

The "Dx" fields were removed from the Header portion of all DPW screens.

DRG Payment Window Processor Screen:

```
              General Hospital DRG Payment Window Processor Processor
                                                 Wed Jan 30, 2008 11:54 am
Account      Name                 FC Typ Admit    Disch        Balance Loc
C08029-00001 TEST,DRG             C  O/P 01/29/08 01/29/08      350.75 PA /INSR
                                                   Last Cycle Date:
------------------------------------------------------------------------------
   Account        To ICD           FC Type Admit    Disch        Balance Loc
   DPW/Status     From ICD                Suspense  # of Chgs    DPW Amount

1  C0802900002    ICD-10              C  I/P  01/29/08            $2255.93  PA
   KEC/Active     ICD-10                                  6       $126.98









Select an account, (A)dd a DPW, or previous screen(/P)--
```

Select an Account screen:

```
              General Hospital DRG Payment Window Processor Processor
                                                 Wed Jan 30, 2008 11:54 am
Account      Name                 FC Typ Admit    Disch        Balance Loc
C08029-00001 TEST,DRG             C  O/P 01/29/08 01/29/08      350.75 PA /INSR
                                                   Last Cycle Date:
------------------------------------------------------------------------------
   Account              To ICD      FC Type Admit    Disch        Balance Loc
   DPW/Status           From ICD            Suspense  # of Chgs    DPW Amount
    C0802900002         ICD-10           C  I/P  01/29/08            $2255.93  PA
   KEC/Active           ICD-10                                  6       $126.98
    Last Cycle Date  Billed Amount     Final Billed Amount      Unbilled Amount
                                                                    $2255.93









(D)eactivate DPW, (C)hange DPW, (E)valuate Charges, (R)eview Charges, or
(P)review Combined Medical Info, (U)se adm dx's in Preview Comb Med Info--
```

4) Claims Management, Combined Medical Information

a) The claims logic for both Combined Billing and the DRG Payment Window looks to the TO (inpatient) account's Claim Load Edit Parameter. Based on the Claim ICD flag, the TO account's claim pulls either ICD-10 Diagnosis and Procedure Codes, or ICD-9 Diagnosis and Procedure Codes.

If the TO account's claim qualifies for ICD-10 Diagnosis and Procedure Codes, but one or more FROM accounts only have ICD-9 Diagnosis and Procedure Codes, the ICD-9 Diagnosis and Procedure Codes for this FROM account are not used on the TO account's claim.

If the TO account's claim qualifies for ICD-9 Diagnosis and Procedure Codes, but one or more FROM accounts only have ICD-10 Diagnosis and Procedure Codes, the ICD-10 Diagnosis and Procedure Codes for this FROM account are not used on the TO account's claim.

NOTE: The fields **Combine Bill Med Info**, **DPW Med Info** and **Adm Prin/Sec Dx for Comb Bill/DPW** on the UB Claim Load Edit Parameter of the TO account's claim continues to determine if the FROM account's medical information is used on the TO account's claim. Please see current documentation.

The DRG Payment Window parameters can look to the ICD-10 Effective Date field on the TO account's Final Billing Parameter, and the Admission Date or Discharge Date of the TO account, to determine if the TO account's bill requires ICD-10 or ICD-9 diagnosis and procedure codes. If the TO account requires ICD-10 codes, and one or more FROM accounts only have ICD-9 codes, this puts the DPW accounts on a DPW Bill Hold, and the accounts are on the FBR072x report with the error "DPW Hold. ICD9/ ICD10 Mismatch.

There is no such logic for Combine Billing. This means that the TO account's claim may load CHARGES from the FROM account, while not using the Diagnosis or Procedure information from the FROM account on the TO account's claim if the coding methods do not match.

If using Pre Bill Edit, for charges that have already moved to the TO account, if there are charges with an ICD-10 Ordering Diagnosis, but no ICD-9 Ordering Diagnosis (or vice versa: charges with an ICD-9 Ordering Diagnosis, but no ICD-10 Ordering Diagnosis), if the TO account is requiring BOTH ICD-10 and ICD-9 Diagnosis and Procedure Codes based on the Patient Processing Hospital Facility Options ICD-10 Effective Date, and exceptions in the Insurance Plan, Insurance Carrier, and/or Financial Class Table, these charges can create a Pre Bill Edit charge error of "Charge Dx Mismatch ICD9/ICD10.

The Combined Medical Information screen within Claims Management allows the user to view the diagnoses, procedures, and HCPCS codes from both the FROM and the TO accounts on the TO account's claim for combined bill and DRG Payment Window accounts. The screen does not have a header field of "ICD-10" or "ICD-9" as seen in the Preview screen within Combine Bills and DRG Payment Window Parameters. The Combined Medical Information screen within Claims Management displays the codes actually loaded to the claim, based on the claim ICD that can be seen on the Claim Status Information screen.

Access Billing and Claims, Claims Management, Maintain Claims by Account or Maintain Claims by Biller, enter the TO/Inpatient account and claim, and access the Claim Demographic/Visit Data - Select Screens.

The system prompts:

View Combined Medical Information? (Y/N) [N]-- |

The Combined Medical Information displays the diagnosis codes, procedure codes, and HCPCS that were actually used on the TO account's claim.

Since the Combined Medical Information screen in Claims Management displays what was actually loaded to the TO account's claim, the system displays EITHER the ICD-10 information, or the ICD-9 information, based on the ICD flag on the TO account's claim.

Abbreviations:

PDX Principal Diagnosis

ODX01-ODXxx Other Diagnoses (secondary). As many entered are displayed, such as ODX01, ODX02, ODX03.

ECDxx External Cause of Injury Diagnosis (01, 02, 03)

ADX Admitting Diagnosis

PRCP Principal Procedure

PRC01-PRCxx Other Procedures (secondary). As many entered are displayed, such as PRC01, PRC02, PRC03.

```
              General Hospital Maintain Claims by Account Processor
                                                  Fri Jan 18, 2008 03:56 pm
Account      Name                 FC Typ Admit    Disch        Balance Loc
C08018-00002 TEST,ICD             C  O/P 01/18/08 01/18/08      290.12 PA /INSR

The medical information displayed below may change prior to the release of
the UB claim due to user edits.

                          Combined UB Information Review
Type  Code     Description          POA/Dt   Reference     Typ Admit    Disch
PDX   M79.661A TEST DIAGNOSIS       Y
ODX01 M48.50xA YET ANOTHER TEST     U
ODX02 A23.456D MORE TESTING         W
ODX03 B34.56xA TESTINGTESTING       Y        C0801800001   O/P 01/18/08 01/18/08
ODX04 C98.76xD LONGDIAGNOSIS        Y        C0801800001   O/P 01/18/08 01/18/08
ODX05 H34.567A NEWCODE              W        C0801800001   O/P 01/18/08 01/18/08
ADX   M87.65xD SICKDIAGNOSIS
PRCP  0JPT0PZ  SPINAL X-RAY NEC     01/18/08
PRC01 1AB23C4  LUMBOSAC SPINE X-RA  01/18/08
PRC02 2KE34D5  MUSCLE REATTACHMENT  01/18/08 C0801800001   O/P 01/18/08 01/18/08
PRC03 3DM45K6  TENDON REATTACHMENT  01/18/08 C0801800001   O/P 01/18/08 01/18/08
ATT   501 TEST,ABC
OTH   2042 SILVA,MD ONE


                       F1Prev Page F2Next Page F7  Exit
```

```
              General Hospital Maintain Claims by Account Processor
                                                  Fri Jan 18, 2008 03:56 pm
Account      Name                 FC Typ Admit    Disch        Balance Loc
C08018-00002 TEST,ICD             C  O/P 01/18/08 01/18/08      290.12 PA /INSR


The medical information displayed below may change prior to the release of
the UB claim due to user edits.
                          Combined UB Information Review
Type  Code     Description          POA/Dt   Reference     Typ Admit    Disch

Type  Code     Modifier(s)     Rev  Date     Reference     Typ Admit    Disch
HCPCS 11111                    740  01/18/08 C0801800001   O/P 01/18/08 01/18/08
HCPCS 22222                    360  01/18/08 C0801800001   O/P 01/18/08 01/18/08
HCPCS 33333    4780217723      740  01/18/08 C0801800001   O/P 01/18/08 01/18/08









                       F1Prev Page F2Next Page F7  Exit
```

STAR REIMBURSEMENT

1. The reimbursement method of ICD-9 Diagnosis Codes has been renamed to ICD Diagnosis Codes. The reimbursement method of ICD-9 Procedure Codes has been renamed to ICD Procedure Codes.

```
              General Hospital Reimbursement Master Processor
                                                    Tue Feb 19, 2008 10:17 pm
Reimbursement Master Input Options


            Option No.  Option
            ---------------------------------------
                1       Payor Table Definition
                2       DRG Rate Table Generation
                3       DRG Rate Master
                4       ICD Diagnosis Codes
                5       ICD Procedure Codes
                6       Medical Services
                7       Specified DRG Codes
                8       Major Diagnostic Category
                9       ASC Payment Group
               10       Overall Plan
               11       Pathways Contract Management
               12       OPPS Payment Classification
               13       Alternate Level of Care
               14       Claim Amount
               15       Print Reimbursement Table
               16       Other Payor Code for DRG Mapping
Enter option number--
```

   When an account is using the STAR Reimbursement Type of ICD Diagnosis Codes or ICD Procedure Codes, the system looks to the Bill ICD flag on the Final Bill (for COB 1).

   If the Bill ICD flag is set to 10, the system uses the ICD-10 Diagnoses for the reimbursement type of ICD Diagnosis Codes. If the Bill ICD flag is set to 9, or is blank, the system uses the ICD-9 Diagnoses for the reimbursement type of ICD Diagnosis Codes.

   If the Bill ICD flag is set to 10, the system uses the ICD-10 Procedures for the reimbursement type of ICD Procedure Codes. If the Bill ICD flag is set to 9, or is blank, the system uses the ICD-9 Procedures for the reimbursement type of ICD Procedure Codes.

2. The STAR Reimbursement type of “ICD-9 Diagnosis Codes” has been renamed to “ICD Diagnosis Codes.

   Access Tables, PA/AR Master File Maintenance, Reimbursement Master, ICD Diagnosis Codes, enter the Payor Code, access the table number.

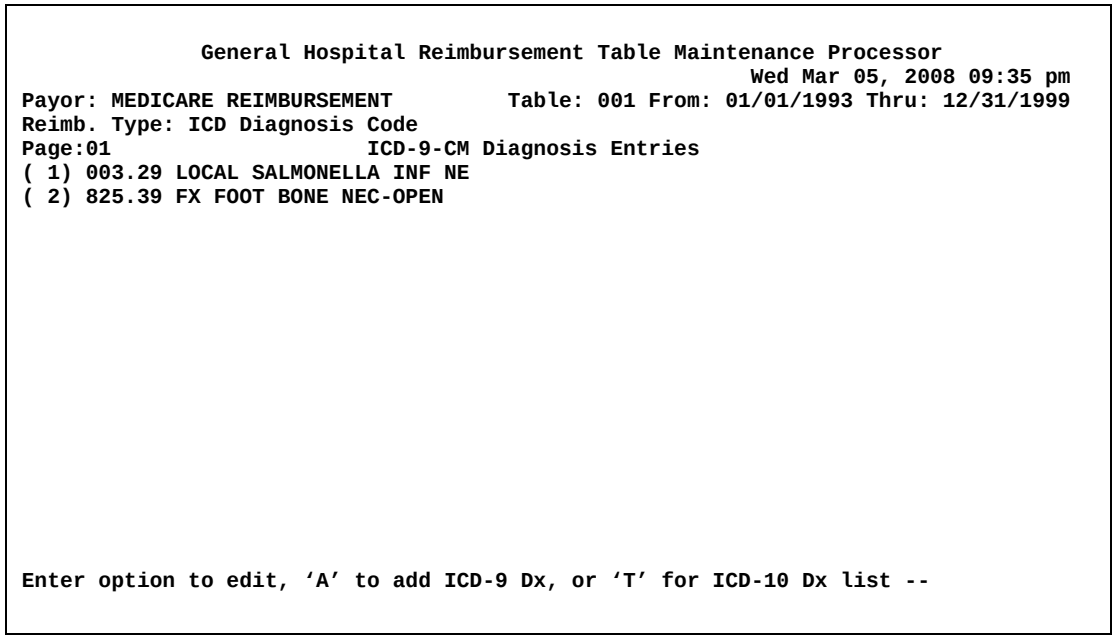
   The system processes as follows:

- If there are existing codes for ICD-10, then the table listing the ICD-10 codes is displayed, which allows you to edit the existing ICD-10 codes, add more ICD-10 codes, and to access the ICD-9 list.

- If there are NO existing codes for ICD-10, then the table listing the ICD-9 codes is displayed, which allows you to edit the existing ICD-9 codes, add more ICD-9 codes, and to access the ICD-10 list.

- If there are NO codes, for either ICD-10 or ICD-9, then if there is an ICD-10 Effective Date in the Hospital Facility Options on Patient Processing (even if this is a future date), then the table listing the ICD-10 codes is displayed, which allows you to edit the existing ICD-10 codes, add ICD-10 codes, and to access the ICD-9 list.

- If there are NO codes, for either ICD-10 or ICD-9, then if there is NO ICD-10 Effective Date in the Hospital Facility Options on Patient Processing, then the table listing the ICD-9 codes is displayed, which allows you to edit the existing ICD-9 codes, add ICD-9 codes, and to access the ICD-10 list.



```
              General Hospital Reimbursement Table Maintenance Processor
                                                              Wed Mar 05, 2008 09:35 pm
Payor: MEDICARE REIMBURSEMENT         Table: 001 From: 01/01/2011 Thru: 12/31/2011
Reimb. Type: ICD Diagnosis Code
Page:01                       ICD-10-CM Diagnosis Entries
( 1) A12.34xD TESTING NEW CODES
( 2) B45.67xA ANOTHER TEST CODE









Enter option to edit, 'A' to add ICD-10 Dx, or 'I' for ICD-9 Dx list --
```

Upon accessing the reimbursement table, the user enters the Payor Code, then selects the Table Number. Currently, the ICD-9-CM Diagnoses set for reimbursement list on the screen.

The prompt for the screen is:

Enter option to edit or 'A' to add --

This prompt has been updated to:

Enter option to edit, 'A' to add ICD-9 Dx, or 'T' for ICD-10 Dx list --

When Adding an ICD-9 diagnosis, the system continues to prompt:

Enter ICD-9-CM diagnosis code, `U`ser diagnosis code, `-` for list--

When entering a T for ICD-10 diagnosis list, the system displays any ICD-10-CM Diagnoses set for reimbursement. The prompt on this new screen is:

Enter option to edit, 'A' to add ICD-10 Dx, or 'I' for ICD-9 Dx list --

When Adding an ICD-10 diagnosis, the system prompts:

Enter ICD-10-CM diagnosis code, `U`ser diagnosis code, `-` for list—

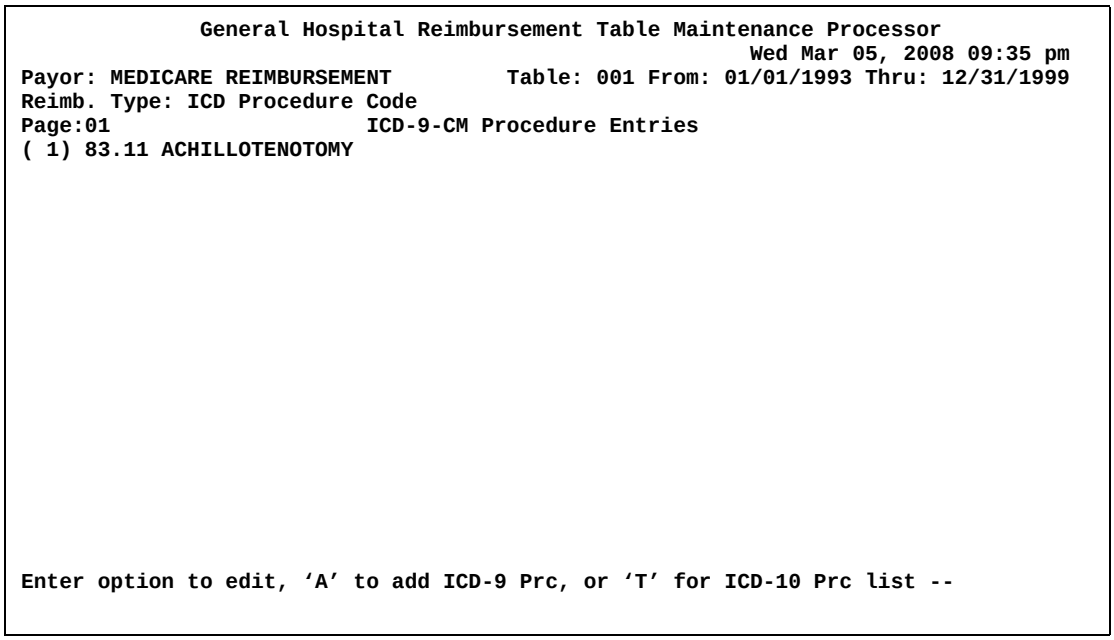
The display of ICD-10-CM diagnoses is only one column, to make room for the longer descriptions. The display of ICD-9-CM diagnoses continue to display two columns.

3) The STAR Reimbursement type of "ICD-9 Procedure Codes" has been renamed to "ICD Procedure Codes.

Access Tables, PA/AR Master File Maintenance, Reimbursement Master, ICD Procedure Codes, enter the Payor Code, access the table number.

The system processes as follows:

- If there are existing codes for ICD-10, then the table listing the ICD-10 codes is displayed, which allows you to edit the existing ICD-10 codes, add more ICD-10 codes, and to access the ICD-9 list.
- If there are NO existing codes for ICD-10, then the table listing the ICD-9 codes is displayed, which allows you to edit the existing ICD-9 codes, add more ICD-9 codes, and to access the ICD-10 list.
- If there are NO codes, for either ICD-10 or ICD-9, then if there is an ICD-10 Effective Date in the Hospital Facility Options on Patient Processing (even if this is a future date), then the table listing the ICD-10 codes is displayed, which allows you to edit the existing ICD-10 codes, add ICD-10 codes, and to access the ICD-9 list.
- If there are NO codes, for either ICD-10 or ICD-9, then if there is NO ICD-10 Effective Date in the Hospital Facility Options on Patient Processing, then the table listing the ICD-9 codes is displayed, which allows you to edit the existing ICD-9 codes, add ICD-9 codes, and to access the ICD-10 list.



```
               General Hospital Reimbursement Table Maintenance Processor
                                                          Wed Mar 05, 2008 09:35 pm
Payor: MEDICARE REIMBURSEMENT        Table: 001 From: 01/01/2011 Thru: 12/31/2011
Reimb. Type: ICD Procedure Code
Page:01                    ICD-10-PCS Procedure Entries
( 1) 0JPT0PZ TESTING NEW CODES
( 2) 0JH60P3 ANOTHER TEST CODE









Enter option to edit, 'A' to add ICD-10 Prc, or 'I' for ICD-9 Prc list --
```

Upon accessing the reimbursement table, the user enters the Payor Code, then selects the Table Number. Currently, the ICD-9-CM Procedures set for reimbursement list on the screen.

The prompt for the screen is:

Enter option to edit or 'A' to add --

This prompt has been updated to:

Enter option to edit, 'A' to add ICD-9 Prc, or 'T' for ICD-10 Prc list --

When Adding an ICD-9 procedure, the system continues to prompt:

Enter ICD-9-CM procedure code, `U`ser procedure code, `-` for list--

When entering a T for ICD-10 procedure list, the system displays any ICD-10-PCS Procedures set for reimbursement. The prompt on this new screen is:

Enter option to edit, 'A' to add ICD-10 Prc, or 'I' for ICD-9 Prc list --

When Adding an ICD-10 procedure, the system prompts:

Enter ICD-10-PCS procedure code, `U`ser procedure code, `-` for list—

The display of ICD-10-PCS procedures is only one column, to make room for the longer descriptions. The display of ICD-9-PCS procedures continue to display two columns.

THIRD PARTY LOGS

1. Log Demographics Screen

   Access: Billing and Claims, Third Party Logs, **Log Inquiry**, enter the Log ID, access the log by Account or Carrier, select the Claim Sequence, and Log Demographics.

   The same screen is displayed by accessing Billing and Claims, Third Party Logs, **Revise Log Account**, enter the Log ID, access the log by Account or Carrier, select the Claim Sequence, and Log Demographics.

   The field Primary Diagnosis now displays either a leading 10 for ICD-10, or a leading 9 for ICD-9, a slash (/) and then the Primary Diagnosis code and description. An example is "9/827.1-FX LOWER LIMB NEC-OPEN. **This field cannot be revised in Revise Log Account.**

   Currently, if the claim type is X for the Federal UB, B for the 1500, or Z for the Non Pro Fee 1500, and a primary diagnosis exists in the claim, it is used. The system looks to UB04 Locator 67-1 for the Principal Diagnosis, and to Locator 21-1 for the Principal Diagnosis on a 1500 or Non Pro Fee 1500 claim. The log field displays the claim ICD indicator of 9 or 10 before the claim Primary Diagnosis.

   Next the logic uses the Primary Diagnosis from Medical Records if it exists. The ICD-9 or ICD-10 primary diagnosis from Medical Records is used based on the ICD flag for the claim.

   Next the logic uses the admitting diagnosis from Medical Records if it exists. The ICD-9 or ICD-10 admitting diagnosis from Medical Records is used based on the ICD flag for the claim.

   Next the logic uses the admitting diagnosis from Patient Processing if it exists. The diagnosis is used only if the format is correct and if the diagnosis exists in the ICD-9 diagnosis tables. The existing logic is used if the ICD flag for the claim indicates ICD-9. Otherwise the ICD-10 admitting diagnosis from Patient Processing is used and is verified using the ICD-10 diagnosis tables.

   Next the logic uses the working diagnosis from Patient Processing if it exists. The diagnosis is used only if the format is correct and if the diagnosis exists in the ICD-9 diagnosis tables. The existing logic is used if the ICD flag for the claim indicates ICD-9. Otherwise the ICD-10 working diagnosis from Patient Processing is used and is verified using the ICD-10 diagnosis tables. If no diagnosis is found, then the field is set to "-".

   The field Primary Procedure now displays either a leading 10 for ICD-10, or a leading 9 for ICD-9, a slash (/) and then the Primary Procedure code and description. An example is "9/83.74 MUSCLE REATTACHMENT. **This field cannot be revised in Revise Log Account.**

Currently, if the claim type is X for the Federal UB and a primary procedure exists in the claim it is used. This is UB04 Locator 74-1 and UB92 Locator 80.

Next the logic uses the principal procedure from Medical Records if it exists. The ICD-9 or ICD-10 principal procedure from Medical Records is used based on the ICD flag for the claim. If no procedure is found, then the field is set to a hyphen (-).

```
                    General Hospital Log Inquiry Processor

Log: MI MEDICARE INPATIENT                              Thu Jul 03, 2008 03:24 pm
Account      Name                    FC Type Admit    Disch        Balance Loc
C0722900001  FROST,JACK              O   I/P 08/10/07 08/17/07    $4989.21 AR
Carrier/Plan                             Log
500999-MEDICARE                          MI MEDICARE INPATIENT
 1 Bill From           2 Bill Through     3 Bill Type          4 Rebill?
   08/10/07              08/17/07           Adjustment           Yes
 5 Patient Birthday    6 Patient Age      7 Aged Flag          8 Disch Status
   01/19/1963            44Y                                     HO
 9 Attending Physician                   10 Medical Service
   ADMIT,NOPATIENTS                         MEDICAL SERVICE
11 Primary Diagnosis                     12 Primary Procedure
   9/827.1-FX LOWER LIMB NEC-OPEN           9/83.74 MUSCLE REATTACHMENT
13 Policy Number                         14 Blood Deductible Pints
                                            0
15 Blood Deductible Amount               16 Nbr of Late Charges


17 Late Charges       18 Primary Payor   19 Active Flag
                         Yes




Press NL
```

2) Log Reports Request Screen

Access: Billing and Claims, Third Party Logs, Log Reports, Report Selection.

Field 8 has been renamed from “Primary ICD9 Procedure” to “Primary ICD Procedure” and processes as follows:

When accessing the field, if the ICD-10 Effective Date on the Hospital Facility Options, Admission and General Parameters screen of STAR Patient Processing is today or a date in the past, the system prompts for ICD-9 or ICD-10 procedures. Before this date, the system assumes ICD-9.

Select ICD-9 (I) or ICD-10 (T) procedure (I/T) –

The user must enter I to look up and enter one or more ICD-9-CM procedure codes, or enter T to look up and enter one or more ICD-10-PCS procedure codes.

When entering I for ICD-9, the system continues to prompt as follows:

Enter one or more ICD-9-CM procedure codes, `U`ser procedure code, `-` for list, or beginning-ending ICD-9-CM procedure code--

When entering T for ICD-10, the system prompts as follows:

Enter one or more ICD-10-PCS procedure codes, `U`ser procedure code, `-` for list, or beginning-ending ICD-10-PCS procedure code--

The user can enter in a dash for a complete list, or enter a partial code and a dash for the search to start with the beginning characters.

For UB claims (claim type X), the system first searches for the Principal Procedure in UB92 Locator 80, and in UB04 Locator 74. If the claim does not have a Principal Procedure Code, the system then looks for the Principal Procedure Code in Medical Records at the account level. All other claim types look for the Principal Procedure only in Medical Records at the account level.

In order for the claim to appear on the Selected Log Report, the claim/account must have one of the entered Principal Procedure Codes, as well as the other entered criteria. If an ICD-9 procedure code is entered, the system searches UB claims only if the claim ICD indicator is 9, and searches in Medical Records only on the entered ICD-9 procedure codes. If an ICD-10 procedure code is entered, the system searches UB claims only if the claim ICD indicator is 10, and searches in Medical Records only on the entered ICD-10 procedure codes.

On the Detail log report, the Primary ICD Procedure field now displays either a leading 10 for ICD-10, or a leading 9 for ICD-9, a slash (/) and then the Primary Procedure code and description.

```
                    General Hospital Report Selection Processor
                                                  Tue Jul 08, 2008 12:44 pm


 1 Log ID                    2 Pat Ind  3 Pat Type              4 Report Form
   MI MEDICARE INPATIENT       I          All for Ind             Detail
 5 HCPCS   6 HCPCS Range             7 UB Rev Code Range
   Yes       Beginning thru Ending     All
 8 Primary ICD Procedure     9 Paid/Unpaid?    10 Bill Type?    11 Late Charges?
   9/9005 TOXICOLOGY-NERVOUS   Both               All              No
12 Primary Payor  13 Adjustment Detail? 14 Purge? 15 DRG Based 16 OPPS Based
   Only             Yes                  No         Yes           No
                        Reconciled/Unreconciled
17 DRG          18 DRG Reim Amt  19 Outlier      20 Days        21 OPPS Reim
   Both            Both             Both           Both
22 Reim Amount  23 Liability     24 Payment      25 Reconciliation Allowance
   N/A             Both             Both            5.00
                           Date Ranges
26 Bill Thru                          27 Remittance
   Earliest thru Latest
28 Discharge
   Earliest thru Latest


Enter field number or '/' starting field number--
```

TRENDSTAR/HPM

The TRENDSTAR® and Horizon Performance Manager™ (HPM) interfaces have been updated for accounts with ICD-10 diagnosis and procedure codes.

STAR sends ICD-9 or ICD-10 codes to Horizon Performance Manager and TRENDSTAR, but not both.

The existing HPM/TRENDSTAR **Internal Elements** were updated to have a preceding H/T ICD9.

New internal elements were added for ICD-10 that have a preceding H/T ICD10.

The following lists the Horizon Performance Manager/TRENDSTAR Internal Elements:

- H/T ICD9 ADM DIAG CODE (MR/ADM)
- H/T ICD9 ADMITTING DIAG AND PREFIX
- H/T ICD9 ADMITTING DIAG DESCRIPTION
- H/T ICD9 ANESTHESIA CODE
- H/T ICD9 ANESTHESIA START TIME
- H/T ICD9 ANESTHESIA STOP TIME

- H/T ICD9 DX CODE 3 (MR/ADM-UB04)
- H/T ICD9 ECODE DIAG CODE 1 (UB04)
- H/T ICD9 ECODE DIAG CODE 3 (UB04)
- H/T ICD9 ECODE DX 1 (MR/ADM-UB04)
- H/T ICD9 ECODE DX 2 (MR/ADM-UB04)
- H/T ICD9 ECODE DX CODE 2 (UB04)
- H/T ICD9 OTHER DIAG DESCRIPTION 1
- H/T ICD9 OTHER DIAG DESCRIPTION 2
- H/T ICD9 OTHER DIAG DESCRIPTION 3
- H/T ICD9 OTHER DIAG DESCRIPTION 4
- H/T ICD9 OTHER DX DESC 1 (MR/ADM)
- H/T ICD9 OTHER DX DESC 2 (MR/ADM)
- H/T ICD9 OTHER DX DESC 3 (MR/ADM)
- H/T ICD9 OTHER DX DESC 4 (MR/ADM)
- H/T ICD9 OTHER PROCEDURE 1 DATE
- H/T ICD9 OTHER PROCEDURE 2 DATE
- H/T ICD9 PRIN (MR/ADM) OR WORK DX
- H/T ICD9 PRIN DIAG DESC (MR/ADM)
- H/T ICD9 PRIN OR WORKING DIAG DESC
- H/T ICD9 PRIN OR WORKING DX CODE
- H/T ICD9 PRIN PHYSICIAN PROC 3
- H/T ICD9 PRIN(MR/ADM) OR WRK DX DS
- H/T ICD9 PRINCIPAL DIAG DESCRIPTION
- H/T ICD9 PRINCIPAL PROCEDURE DATE

- H/T ICD9 PRINCIPAL PROCEDURE DESC
- H/T ICD9 SURGERY SCHEDULED CODE
- H/T ICD9 WORKING DIAGNOSIS CODE
- H/T ICD10 ADM DIAG CODE (MR/ADM)
- H/T ICD10 ADM DIAG DESCRIPTION
- H/T ICD10 ADMITTING DIAGNOSIS CODE
- H/T ICD10 ANESTHESIA CODE
- H/T ICD10 ANESTHESIA START TIME
- H/T ICD10 ANESTHESIA STOP TIME
- H/T ICD10 EXT CAUSE INJ 1 (MR/ADM)
- H/T ICD10 EXT CAUSE INJ 1
- H/T ICD10 EXT CAUSE INJ 2 (MR/ADM)
- H/T ICD10 EXT CAUSE INJ 2
- H/T ICD10 EXT CAUSE INJ 3 (MR/ADM)
- H/T ICD10 EXT CAUSE INJ 3
- H/T ICD10 OTHER DIAG DESCRIPTION 1
- H/T ICD10 OTHER DIAG DESCRIPTION 2
- H/T ICD10 OTHER DIAG DESCRIPTION 3
- H/T ICD10 OTHER DIAG DESCRIPTION 4
- H/T ICD10 OTHER DX DESC 1 (MR/ADM)
- H/T ICD10 OTHER DX DESC 2 (MR/ADM)
- H/T ICD10 OTHER DX DESC 3 (MR/ADM)
- H/T ICD10 OTHER DX DESC 4 (MR/ADM)
- H/T ICD10 OTHER PROCEDURE 1 DATE

- H/T ICD10 OTHER PROCEDURE 2 DATE
- H/T ICD10 PRIN (MR/ADM) OR WORK DX
- H/T ICD10 PRIN DIAG DESC (MR/ADM)
- H/T ICD10 PRIN OR WORK DIAG DESC
- H/T ICD10 PRIN OR WORKING DX CODE
- H/T ICD10 PRIN PHYSICIAN PROC 3
- H/T ICD10 PRIN PROC DESCRIPTION
- H/T ICD10 PRIN(MR/ADM) OR WRK DX DS
- H/T ICD10 PRINCIPAL DIAGNOSIS DESC
- H/T ICD10 PRINCIPAL PROCEDURE DATE
- H/T ICD10 SURGERY SCHEDULED CODE
- H/T ICD10 WORKING DIAGNOSIS CODE

The existing HPM/TRENDSTAR **Access Routines** were updated to have a preceding "H/T ICD9.

New Access Routines were added for ICD-10 that have a preceding "H/T ICD10.

The following lists the Horizon Performance Manager/TRENDSTAR Access Routines:

- H/T ICD10 ADM DIAGNOSIS CODE
- H/T ICD10 ADM DIAGNOSIS DESC
- H/T ICD10 ANES START TIME
- H/T ICD10 ANESTHESIA CODE
- H/T ICD10 ANESTHESIA STOP TIME
- H/T ICD10 EXT CAUSE 1 (MR/ADM)
- H/T ICD10 EXT CAUSE 2 (MR/ADM)
- H/T ICD10 EXT CAUSE 3 (MR/ADM)
- H/T ICD10 EXT CAUSE INJ 1

- H/T ICD10 EXT CAUSE INJ 2
- H/T ICD10 EXT CAUSE INJ 3
- H/T ICD10 OTH DX DSC1 (MR/ADM)
- H/T ICD10 OTH DX DSC2 (MR/ADM)
- H/T ICD10 OTH DX DSC3 (MR/ADM)
- H/T ICD10 OTH DX DSC4 (MR/ADM)
- H/T ICD10 OTHER DX DESC 1
- H/T ICD10 OTHER DX DESC 2
- H/T ICD10 OTHER DX DESC 3
- H/T ICD10 OTHER DX DESC 4
- H/T ICD10 OTHER PROC DATE 1
- H/T ICD10 OTHER PROC DATE 2
- H/T ICD10 PRIN DIAGNOSIS DESC
- H/T ICD10 PRIN DX DSC (MR/ADM)
- H/T ICD10 PRIN PROCEDURE DATE
- H/T ICD10 PRIN/WORKING DX CODE
- H/T ICD10 PRIN/WRK DIAG DESC
- H/T ICD10 PRINCIPAL PROC DESC
- H/T ICD10 PRN(MR/ADM)/WR DX CD
- H/T ICD10 PRN(MR/ADM)/WR DX DS
- H/T ICD10 SURGERY SCHED CODE
- H/T ICD10 SURGICAL PHYSICIAN 3
- H/T ICD10 WORKING DIAG CODE
- H/T ICD9 ADM DIAGNOSIS CODE

- H/T ICD9 ADM DIAGNOSIS DESC
- H/T ICD9 ANESTHESIA CODE
- H/T ICD9 ANESTHESIA START TIME
- H/T ICD9 ANESTHESIA STOP TIME
- H/T ICD9 DX CODE 1 (MR/ADM)
- H/T ICD9 ECODE DX 2 (MR/ADM)
- H/T ICD9 ECODE DX 3 (MR/ADM)
- H/T ICD9 ECODE DX CODE 1
- H/T ICD9 ECODE DX CODE 2
- H/T ICD9 ECODE DX CODE 3
- H/T ICD9 OTH DX DESC1 (MR/ADM)
- H/T ICD9 OTH DX DESC2 (MR/ADM)
- H/T ICD9 OTH DX DESC3 (MR/ADM)
- H/T ICD9 OTH DX DESC4 (MR/ADM)
- H/T ICD9 OTHER DX DESC 1
- H/T ICD9 OTHER DX DESC 2
- H/T ICD9 OTHER DX DESC 3
- H/T ICD9 OTHER DX DESC 4
- H/T ICD9 OTHER PROC DATE 1
- H/T ICD9 OTHER PROC DATE 2
- H/T ICD9 PRIN DX DESC (MR/ADM)
- H/T ICD9 PRIN PROCEDURE DATE
- H/T ICD9 PRIN PROCEDURE DESC
- H/T ICD9 PRIN(MR/ADM)/WRK DX

- H/T ICD9 PRIN/WORKING DX CODE
- H/T ICD9 PRIN/WRKING DIAG DESC
- H/T ICD9 PRINCIPAL DIAG DESC
- H/T ICD9 PRN(MR/ADM)/WRK DX DS
- H/T ICD9 SURG SCHEDULED CODE
- H/T ICD9 SURGICAL PHY 3
- H/T ICD9 WORKING DIAG CODE

COLLECTION AGENCY TAPE

Two layouts are provided for the Collection Agency Tape. One is provided for four insurances and the other is provided for nine insurances. In both layouts, the ICD-10 admitting diagnosis has been added to the end of the 02 record.

The updated layout for record 2 for the four insurance format is as follows:

Description	Location	Length
Record (02)		
Patient Number	1-10	10
Admitting Diagnosis	11-15	5
Patient Phone Number	16-28	13
Patient Soc Sec No	29-39	11
Patient Employer Name	40-69	30
Patient Employer Phone #	70-82	13
Discharge Date	83-88	6
Last Payment Date	89-94	6
Last Payment Amount	95-104	10
Transfer Balance	105-114	10
Financial Class	115-116	2
Transfer Date	117-122	6
Patient Address	123-147	25
Patient City	148-165	18
Patient State	166-167	2
Patient ZIP	168-176	9
Guarantor Phone	177-189	13

Description	Location	Length
Admit Date	190-195	6
Admit Time	196-197	2
Medical Record Number	198-207	10
Patient Age	208-210	3
Patient Race	211	1
Patient Sex	212	1
Attending Phy Name/No	213-237	25
Patient Marital Status	238	1
ICD-10 Adm Diag	239-245	7
Filler	246-248	3
Record Type	249-250	2

The updated layout for record 2 for the nine insurance format is as follows:

Description	Location	Length
Rec (02)		
Pat Number	1-10	10
ICD-9 Adm Diag	11-15	5
Pat Phone#	16-28	13
Pat Soc Sec#	29-39	11
Pat Emp Name	40-69	30
Pat Emp PhoneE	70-82	13
Discharge Date	83-88	6
Last Pay Date	89-94	6
Last Payment Amt	95-104	10
Transfer Balance	105-114	10
Financial Class	115-116	2
Transfer Date	117-122	6
Pat Address	123-147	25
Pat City	148-165	18
Pat States	166-167	2
Pat ZIP	168-176	9
Guar Phone	177-189	13

Description	Location	Length
Admit Date	190-195	6
Admit Time	196-197	2
Med Rec#	198-207	10
Pat Age	208-210	3
Pat Race	211	1
Pat Sex	212	1
Att Phy Name/Num	213-237	25
Pat Martial Stat	238	1
ICD-10 Adm Diag	239-245	7
Filler	246-248	3
Rec Type	249-250	2

Both of these layouts indicate admitting diagnosis but the working diagnosis is the element supplied.

Miscellaneous Information

The miscellaneous record in the External Agency (Pre-Collect) interface record was updated. Previous to F9734, the admission diagnosis, principal diagnosis, and principal diagnosis description are supplied with ICD-9 codes. The corresponding fields are supplied for ICD-10 codes as indicated in the following layout.

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
MISC		Record Type	4	1-4		Hard-coded to "MISC"
MISC		Facility Code	1	5-5	A;MP;13	First character
MISC		Account Number	10	6-15	A;MP;13	
MISC		Process Indicator	1	16-16		"D" = Deleted from agency "N" = New Account Added "U" = Information Updated
MISC	01	Admit Date	8	17-24	A;MP;8 (1)	
MISC	02	Admit Time	4	25-28	A;MP;8 (2)	
MISC	03	Discharge Date	8	29-36	A;MP;14	
MISC	04	Patient Location	1	37-37	FA;FAA;5	1 = PA 2 = AR 3 = BD
MISC	05	Patient Indicator	1	38-38	FA;FAA;20	
MISC	06	Patient Type	3	39-41	FA;FAA;18	
MISC	07	Financial Class	2	42-43	FA;FAA;21	
MISC	08	Attending Phy Name	37	44-80	D;PC;2	Based on doctor table and doctor code defined in next field
MISC	09	Attending Phys Number	12	81-92	A;MP;12	
MISC	10	ICD-9 Diagnosis – Admit	5	93-97	A;HK;1	
MISC	11	ICD-9 Diag Principal Code	5	98-102	A;HK;2	
MISC	12	ICD-9 Diag Principal Descr	30	103-132		Table lookup
MISC	13	NPI number	10	133-142		NPI value from Demographics / Default screen.
MISC	14	ICD-10 Diagnosis - Admit	7	143-149		
MISC	15	ICD-10 Diag Principal Code	7	150-156		Table lookup
MISC	16	ICD-10 Diag Principal Descr	30	157-186		
MISC	14	Filler	63	187-250		

CHARGES MISSING DIAGNOSIS REPORT

The Charges Missing Diagnoses Report (FARDXMx) prints the accounts that have an Account ICD flag of B for Both, that have charges with an ICD-10 Ordering Diagnosis, but no ICD-9 Ordering Diagnosis, and charges with an ICD-9 Ordering Diagnosis, but no ICD-10 Ordering Diagnosis.

This report also prints the accounts that have an Account ICD flag of 9 for ICD-9, that have charges with only an ICD-10 Ordering Diagnosis, and accounts that have an Account ICD flag of 10 for ICD-10, that have charges with only an ICD-9 Ordering Diagnosis.

Charges that have NO Ordering Diagnosis are not on the report.

The report sorts by Account Number.

The report prints nightly out of Midnight Processing, and charges appear on the Midnight Processing version of the report only once.

To produce a cumulative report, users can access Billing and Claims, Patient Billing, Rerun Charges Missing Diagnosis Report. Users select the facility, and then the system prompts:

Enter starting date for report-- |

The system can only produce a cumulative report for the last 35 days. If a starting date is entered that is previous to that, the system gives the following error message:

Error: Date cannot precede current date by more than 35 days!

Once the starting date is entered, the system prompts for the ending date:

Enter ending date for report-- |

On the cumulative report, the Account ICD flag is re-checked, as are the charges, to see if either the Account ICD flag was updated to negate the charges being on the report, or the charges updated to have the missing ordering diagnosis.

Header Page

The header for each account prints the Patient Account Number (Patient #), the Patient Name (Name), the COB 1 Carrier/Plan (Carr/Pln), the Financial Class (F/C), the Patient Type (Pat Type), the account Location (Loc, which is PA, AR, BD), the Account ICD flag (Acct ICD, which is 10 for ICD-10, 9 for ICD-9, or B for Both).

Body Detail

For each charge, the report prints the Charge Department (Dept), the SIM Code (Code), the charge Item Description (Item Description), the Initials of the person placing the charge (Int), the Charge Number (Chg#), the Quantity on the charge (Qty), the Charge Amount (Chg Amt), the Service Date (Srv Dte), the Posting Date (P Date), the Ordering Diagnosis that exists on the charge (DX), and the type of diagnosis (Type, which is either 10 for ICD-10 or 9 for ICD-9).

The Type field prints the ordering diagnosis that exists on the account, so that the equivalent diagnosis can be coded in the other ICD version.

Sort Order

Numeric by Patient Account Number.

```
Date: 07/02/08                                  Windward Medical University                  Page : 1
Time: 02:38pm                            Charges Missing Diagnoses for 07/01/08              Report: FAR


Patient #    Name                          Carr/Pln F/C  Pat Type Loc     Acct ICD
 Dept Code Item Description                Int  Chg#     Qty      Chg Amt Srv Dte  P Date   DX
-------------------------------------------------------------------------------------------------------
A0000500300  HANSEN,PEG                    500/700  S    OPE      AR  B
 CSR  6070 CONNECTOR, "Y----------------    P M  000001     1         5.00 07/01/08 07/01/08 M48.50xA-TESTING F
 EEG  3120 24 HOUR AMBULATORY EEG / SCAN    P M  000002     1        80.00 07/01/08 06/30/08 825.1-FRACTURE CAL
 CAR  1100 ECG 12 LEAD------------------    P M  000003     1       109.50 07/01/08 07/01/08 M79.661A-MORE 10 T
 CSR  6070 CONNECTOR, "Y"----------------   P M             1         5.00 07/01/08 07/01/08 823.11-FX FEMUR SH
                                 Patient Total              4       199.50 07/01/08 06/30/08 123.45xD-ANOTHER T
```

Reports

The following reports have been updated for ICD-10 processing. Please see the 15.0 STAR Patient Accounting Reports volume for more information:

- Failed Billing Requirements Report (FBR210)
- Failed Billing Requirements Controlled by Report (FBR220)
- DRG/Diagnosis/Procedure Modification Report (FBR400)
- Failed Claims Requirement Report (FCR250)
- Bad Debt Pre List Report (FFR300)
- Change Patient Type After Final Bill Report (FACPTAFB)
- Non-Covered Services With Signed Advanced Beneficiary Notification Report (FAHCFAY)
- Non-Covered Services Without Signed Advanced Beneficiary Notification Report (FAHCFAN)
- Covered Services Subject to Frequency Limit With Signed ABN Form Report (FAHCFLY)
- Covered Services Subject to Frequency Limit Without Signed ABN Form Report (FAHCFLN)
- Self Pay Services with Signed Advanced Beneficiary Notification (FAHCFSY)
- Self Pay Services without Signed Advanced Beneficiary Notification (FAHCFSN)
    - Self Pay Services Subject to Frequency Limit with Signed ABN Form (FAHCFSFY)
    - Self Pay Services Subject to Frequency Limit without Signed ABN Form (FAHCFSFN)
    - Conflicting HCPCS Without Modifier Documentation (FAHCFAD)
    - Final Billing Parameters Report (FTFABP)
    - Claim Load Edit Parameters Report (FCRCP)
    - PA Charges Edited on MM/DD/YY by Account (FARCHGAx)
    - PA Charges Edited on MM/DD/YY by Department (FARCHGDx)

- DRG Payment Window Report (FBR072x)
- Reimbursement Table Report (FTR140)
- Charges Missing Diagnosis Report (new FARDXMx)

Testing Guidelines

TEST MEDICARE ICD-10 ACCOUNT WITH NO EXCEPTIONS

1 Admit Date Prior

Description:

- Test with an Admission Date PRIOR to the ICD-10 Effective Date in the Hospital Facility Options.
- Test with Diagnosis Codes in Admissions, Medical Records, and on the charges, and with Procedure Codes in Medical Records.

Expected Result:

Only ICD-9 diagnosis and procedure codes are collected.

2 Admit Date On

Description:

- Test with an Admission Date ON the ICD-10 Effective Date in the Hospital Facility Options.
- Test with Diagnosis Codes in Admissions, Medical Records, and on the charges, and with Procedure Codes in Medical Records.

Expected Result:

Since there are no exceptions, only ICD-10 diagnosis and procedure codes should be collected.

3 Admit Date After

Description:

- Test with an Admission Date AFTER the ICD-10 Effective Date in the Hospital Facility Options.

- Test with Diagnosis Codes in Admissions, Medical Records, and on the charges, and with Procedure Codes in Medical Records.

Expected Result:

Since there are no exceptions, only ICD-10 diagnosis and procedure codes should be collected.

4 Admit Date Change

Description:

Test with an Admission Date on or after the ICD-10 Effective Date in the Hospital Facility Options, but after charges and coding has begun, backdate the Admission Date to be PRIOR to the ICD-10 Effective Date in the Hospital Facility Options. Test with Diagnosis Codes in Admissions, Medical Records, and on the charges, and with Procedure Codes in Medical Records.

Expected Result:

Once the admission date is backdated, the system prompts for ICD-9 diagnosis and procedure codes only. The ICD-10 codes previously coded remain on the account.

TEST PRE ACCOUNT WITH NO EXCEPTIONS

1 Permanent Account Number Prior

Description:

Test where the permanent account number is assigned Prior to the ICD-10 Effective Date in the Hospital Facility Options.

Expected Result:

Only ICD-9 diagnosis and procedure codes are collected.

2 Permanent Account Number On

Description:

Test where the permanent account number is assigned On the ICD-10 Effective Date in the Hospital Facility Options.

Expected Result:

ICD-10 diagnosis and procedure codes are collected on the account.

3 Permanent Account Number After

Description:

Test where the permanent account number is assigned After the ICD-10 Effective Date in the Hospital Facility Options.

Expected Result:

ICD-10 diagnosis and procedure codes are collected on the account.

TEST INSURANCE PLAN EXCEPTION

Description:

Test using Plan where the ICD-10 Effective Date on the insurance plan creates an exception.

The ICD-10 Effective Date in the Hospital Facility Options should be a date in the past so that ICD-10 codes are collected on the test account.

Test with Diagnosis Codes in Admissions, in Medical Records, and on the charges (Ordering Dx), and with Procedure Codes on the dispositioning screen and in Medical Records.

1 Insurance Assigned with Admission

Description:

Test where the insurance plan exception is assigned with the admission.

Expected Result:

Both ICD-10 and ICD-9 diagnosis and procedure codes are collected on the account.

2 Insurance Assigned After ICD-10 Coding

Description:

Test where the insurance plan exception is assigned after ICD-10 coding has already taken place. The account should already have in Admissions and in Medical Records the Admitting and Principal Diagnosis Code that is in the ICD-10 format, and should have charges with ICD-10 Ordering Diagnosis codes, and a Principal and other Procedures in Medical Records in the ICD-10 format.

Expected Result:

Once the insurance plan exception is assigned, the system prompts for both ICD-10 and ICD-9 diagnosis and procedure codes. If using Pre Bill Edit, the claims may error for missing ICD-9 Admitting and Principal Diagnosis Code, for missing ICD-9 Procedure Code, and for missing ICD-9 Ordering Diagnoses. See Pre Bill test items.

3 Insurance Deleted After Coding

Description:

Test where the insurance plan exception is deleted after both ICD-9 and ICD-10 coding has occurred.

Expected Result:

From the point of the deletion, the system prompts only for ICD-10 diagnosis and procedure codes. The ICD-9 diagnosis and procedure codes previously coded remain on the account.

4 Insurance Exception Does Not Apply

Description:

Test where the insurance plan has an ICD-10 Effective Date that is After the ICD-10 Effective Date on the Hospital Facility Options, but is Prior to the account's admission date, therefore the exception does not apply.

Expected Result:

Since the exception does not apply, only ICD-10 diagnosis and procedure codes are collected on the account.

TEST INSURANCE CARRIER EXCEPTION

Description:

- Test using insurance carrier where the plan does not have an exception, only the carrier has an exception.

The ICD-10 Effective Date in the Hospital Facility Options should be a date in the past so that ICD-10 codes are collected on the test account.

- Test with Diagnosis Codes in Admissions, Medical Records, and on the charges, and with Procedures from the Dispositioning screen and in Medical Records.

1 Insurance Carrier Assigned with Admission

Description:

Test where the insurance carrier exception is assigned with the admission.

Expected Result:

Both ICD-10 and ICD-9 diagnosis and procedure codes are collected on the account.

2 Insurance Carrier Assigned After ICD-10 Coding

Description:

Test where the insurance carrier exception is assigned after ICD-10 coding has already taken place. The account should already have in Admissions and in Medical Records the Admitting and Principal Diagnosis Code that is in the ICD-10 format, and should have charges with ICD-10 Ordering Diagnosis codes, and a Principal and other Procedures in Medical Records in the ICD-10 format.

Expected Result:

Once the insurance carrier exception is assigned, the system prompts for both ICD-10 and ICD-9 diagnosis and procedure codes. If using Pre Bill Edit, the claims may error for missing ICD-9 Admitting and Principal Diagnosis Code, for missing ICD-9 Procedure Code, and for missing ICD-9 Ordering Diagnoses. See Pre Bill test items.

3 Insurance Carrier Deleted After Coding

Description:

Test where the insurance carrier exception is deleted after both ICD-9 and ICD-10 coding has occurred.

Expected Result:

From the point of the deletion, the system prompts only for ICD-10 diagnosis and procedure codes. The ICD-9 diagnosis and procedure codes previously coded remain on the account.

4 Carrier Exception Does Not Apply

Description:

Test where the insurance carrier has an ICD-10 Effective Date that is After the ICD-10 Effective Date on the Hospital Facility Options, but is Prior to the account's admission date, therefore the exception does not apply.

Expected Result:

Since the exception does not apply, only ICD-10 diagnosis and procedure codes are collected on the account.

TEST FINANCIAL CLASS EXCEPTION

Description:

Test using a plan as COB 1, that does not have an Insurance Plan or Insurance Carrier exception, but that has a Default Financial Classthat is set as a Financial Class Exception.

The ICD-10 Effective Date on the Hospital Facility Options should be a date in the past so that ICD-10 codes are collected on the account.

Test with Diagnosis Codes in Admissions, Medical Records, and on the charges, and with Procedure Codes entered in the Dispositioning screen and Medical Records.

1 Financial Class Assigned with Admission

Description:

Test where the Financial Class exception is assigned with the admission.

Expected Result:

Both ICD-10 and ICD-9 diagnosis and procedure codes are collected on the account.

2 Financial Class Assigned After ICD-10 Coding

Description:

Test where the Financial Class exception is assigned after ICD-10 coding has already taken place. The account should already have in Admissions and in Medical Records the Admitting and Principal Diagnosis Code that is in the ICD-10 format, and should have charges with ICD-10 Ordering Diagnosis codes, and a Principal and other Procedures in Medical Records in the ICD-10 format.

Expected Result:

Once the Financial Class exception is assigned, the system prompts for both ICD-10 and ICD-9 diagnosis and procedure codes. If using Pre Bill Edit, the claims may error for missing ICD-9 Admitting and Principal Diagnosis Code, for missing ICD-9 Procedure Code, and for missing ICD-9 Ordering Diagnoses. See Pre Bill test items.

3 Financial Class Exception Removed After Coding

Description:

Test where the Financial Class exception is removed by deleting the COB 1 plan after both ICD-9 and ICD-10 coding has occurred.

Expected Result:

From the point of the insurance deletion (which should change the FC to one without an exception), the system prompts only for ICD-10 diagnosis and procedure codes. The ICD-9 diagnosis and procedure codes previously coded remain on the account.

4 Financial Class Exception Does Not Apply

Description:

Test where the Financial Class has an ICD-10 Effective Date that is After the ICD-10 Effective Date on the Hospital Facility Options, but is Prior to the account's admission date, therefore the exception does not apply.

Expected Result:

Since the exception does not apply, only ICD-10 diagnosis and procedure codes are collected on the account.

TEST PATIENT TYPE EXCEPTIONS

Description:

Test first with an Inpatient, then with an Outpatient.

1 PT Assigned to Acct at Admission

Description:

Test an account with only a Diagnosis Exception. Test an account with only a Procedure Exception. Test an account with BOTH a Diagnosis and Procedure Exception.

Expected Result:

The accounts should not have exceptions other than the Patient Type Exception. Verify that the Medical Record application only prompts for ICD-9 codes for the selected exception(s).

2 Changed PT to Exception After Coding

Description:

With the do not have a patient type exception. Code and enter charges with ICD-10 codes. After coding, change the Patient Type to the exception patient type. Test an account with only a Diagnosis Exception. Test an account with only a Procedure Exception. Test an account with Both a Diagnosis and Procedure Exception.

Expected Result:

Once the patient type is changed to the exception, verify that the Medical Record application only prompts for the selected exception(s). Verify that the existing ICD-10 codes remain on the account.

3 Change PT from Exception to Non Exception

Description:

With the admission, assign the exception patient type. Code in both ICD-10 and ICD-9, and enter charges with an ICD-10 Ordering Diagnosis. After coding/ charges, change the patient type to a non exception.

Test with an account that goes from a Diagnosis Exception to no exception.

Test with an account that goes from a Procedure Exception to no exception.

Test with an account that goes from Both a Diagnosis and Procedure Exception to no exception.

Expected Result:

With the exception, verify that the Medical Record system only prompts for ICD-9 for the selected exception(s). Once the patient type is changed to a non exception, verify that the ICD-9 and ICD-10 codes already coded remain on the account, and that the applications now only prompt for ICD-10.

TEST COMBINATION OF EXCEPTIONS

Description: This test is to verify the hierarchy for the exceptions.

The system should first look for an insurance plan exception, then an insurance carrier exception, then a financial class exception.

1 Insurance Plan

Description:

Test with an account with the following attributes. Assume for this example only that the Facility Level ICD-10 Effective Date is 01/01/08, and today is 09/01/08.

- Insurance Plan Exception of 10/01/08
- Insurance Carrier Exception of 07/01/08 (so exception no longer applies)
- Financial Class Exception of 08/01/08 (so exception no longer applies)

Expected Result:

The Insurance Plan Exception should apply, and the account should be prompted for both ICD-10 and ICD-9 codes.

2 Insurance Carrier

Description:

Test with an account with the below attributes. Assume for this example only that the Facility Level ICD-10 Effective Date is 01/01/08, and today is 09/01/08.

- Insurance Plan Exception of 07/01/08 (so exception no longer applies)
- Insurance Carrier Exception of 10/01/08
- Financial Class Exception of 08/01/08 (so exception no longer applies)

Expected Result:

The Insurance Carrier Exception should apply, and the account should be prompted for both ICD-10 and ICD-9 codes.

3 Financial Class

Description: Test with an account with the below attributes. Assume for this EXAMPLE ONLY that the Facility Level ICD-10 Effective Date is 01/01/08, and today is 09/01/08.

- Insurance Plan Exception of 07/01/08 (so exception no longer applies)
- Insurance Carrier Exception of 08/01/08 (so exception no longer applies)
- Financial Class Exception of 10/01/08

Expected Result:

The Financial should apply, and the account should be prompted for both ICD-10 and ICD-9 codes.

TEST FACILITY DIFFERENCES - FAC OPTIONS

Description:

Tests should be done in at least two facilities, where the ICD-10 Effective Dates differ.

1 Hospital Facility Options

Description:

- Admit the same patient in Facility A where the ICD-10 Effective Date is today or a date in the past, and then in Facility B where the ICD-10 Effective Date is a date in the future.
- Admit the same patient in Facility B where the ICD-10 Effective Date is today or a date in the past, and then in Facility A where the ICD-10 Effective Date is a date in the future.

Expected Result:

Verify that the system is looking to the correct ICD-10 Effective Date by facility. The system should only prompt for ICD-10 codes if the Effective Date is today or a date in the past (and the patient's admission date is on a date that qualifies).

TEST REASON FOR VISIT DIAGNOSIS CODES

Description:

Test the Reason for Visit diagnosis codes (1-3) on outpatient accounts.
The ICD-10 Effective Date in the Hospital Facility Options should be a date in the past so that ICD-10 codes are collected.

1 Reason for Visit

Description:

- Test with an outpatient account where the Reason for Visit codes are entered via the Dispositioning screen.
- Test with an outpatient account where the Reason for Visit codes are entered via Medical Records.

Expected Result:

Reason for Visit diagnosis codes in the ICD-10 format can be entered. On the UB04 claim, these Reason for Visit diagnosis codes need to be tested with the Reason for Visit... internal elements.

TEST EXTERNAL CAUSE OF INJURY DIAGNOSES

Description:

Test External Cause of Injury Codes in the ICD-10 format. The ICD-10 Effective Date field on the Hospital Facility Options should be a date in the past, so that ICD-10 codes are collected on the account.

1 External Cause of Injury

Description:

Enter ICD-10 external cause of injury diagnosis codes in the range of V01-Y98. Some should have a 7th digit of either **A** initial encounter, **D** subsequent encounter, or **S**. The format is xxx.xxxX, where the capital X is the A, D, or S.

Examples: V04.11, V04.11xA, W01.198, W01.198D, X08.01, X08.01xS, Y08.02, Y08.02xA.

Test entering diagnoses in Admissions and in Medical Records.

Expected Result:

External cause of injury codes can be entered for ICD-10 diagnoses

TEST ABN PROCESSING

Description:

For EACH Design Step, the following need to be tested:

- Not Signed (0)
- Signed (1)
- Approved (2)
- Frequency Signed (3)
- Frequency Not Signed (4)
- Self Pay Signed (5)
- Self Pay Not Signed (6)
- Self Pay with Frequency Signed (7)
- Self Pay with Frequency Not Signed (8)

1 ICD-10 Only

Description:

Test when the account is set to ONLY collect ICD-10.

Expected Result:

ICD-10 codes are used for ABN.

2 ICD-9 Only

Description: Test where the account is set to ONLY collect ICD-9.

Expected Result:

ICD-9 codes are used for ABN processing.

3 Both ICD-10 and ICD-9

Description: Test where both the ICD-10 and ICD-9 codes are collected.

Expected Result:

The ICD-10 codes are used for ABN processing.

4 Exception Deleted

Description:

Test when the account was set to collect Both ICD-10 and ICD-9 codes, but then the exception insurance plan is deleted, and the account goes to ICD-10 only.

Expected Result:

The ICD-10 codes are used for ABN processing.

5 Exception Added

Description:

Test when an account was set to Only collect ICD-10, and then an exception insurance plan is added so that the account goes to both ICD-10 and ICD-9.

Expected Result:

ICD-10 codes are used for ABN processing. For Patient Accounting, the charges with only the ICD-10 Ordering Diagnosis should error in Pre Bill Edit.

6 ICD-9 to Both

Description:

Test when an account collects only ICD-9 codes because of the ICD-10 Effective Date on the Hospital Facility Options. Enter charges with an ICD-9 Ordering Diagnosis, and enter diagnoses and procedures that go through ABN processing. Then either update the Admission Date on the account so that it qualifies for ICD-10 processing, or update the ICD-10 Effective Date on the Hospital Facility Options so that the account qualifies for ICD-10 processing.

Expected Result:

The system first processes the ABN logic using the ICD-9 codes. Once the account also qualifies for ICD-10 codes, only the ICD-10 codes are used for ABN processing.

For STAR Patient Accounting, those charges with an ICD-9 Ordering Diagnosis but no ICD-10 Ordering Diagnosis should fail in Pre Bill Edit.

TEST INQUIRY SCREENS

Description:

The Account Inquiry screens are accessed by signing onto Patient Accounting, Account Inquiry, enter the Facility and account.

For Admissions information, then access Admission Information, Adm Medical Information, and then select the following screens to review: Admitting/Principal Diagnosis, Secondary Diagnoses, and Reason for Visit Diagnoses.

For Medical Records information, then access Medical Information, then select the following screens to review: MR Diagnosis Information, Procedure Information. From the MR Diagnosis Information screen, enter **R** for Reason for Visit Diagnoses, and enter **N** for Nosocomial information.

For the Charge Information, then access Financial Information, Billing Information (view the ICD Flags on this screen), enter **D** for Detail Charges, and select the charges.

1 Inquiry Screens

Description: Each of the following screens should be tested with

- an account with only ICD-9 codes
- an account with only ICD-10 codes and

- an account with both ICD-9 and ICD-10 codes.

Display Medical Records Diagnoses in Account Inquiry

Display Medical Records Procedures in Account Inquiry

Display Admission Diagnoses in Account Inquiry

Display Reason for Visit Diagnoses via Medical Records in Account Inquiry

Display Reason for Visit Diagnoses via Admissions in Account Inquiry

Display the Nosocomial Information in Account Inquiry

Display the Charge Detail in Account Inquiry

Display the Account Level ICD flag and the State Level ICD flag in Account Inquiry, Billing Information

Expected Result:

Both the ICD-9 and the ICD-10 codes display correctly.

TEST EDIT PA CHARGES

Description:

Test the Ordering Diagnosis and ABN updates in Edit PA Charge.

To access Edit PA Charges, access Billing and Claims, Edit PA Charge. The last screen in PAAR Control has to have the fields set for Edit PA Charge

1 Edit PA Charges Screens

Description:

Test the screen displays and the new and revised fields: PA Dx, OM Dx, OM ICD-9 Dx, PA ICD-9 Dx, OM ICD-10 Dx, PA ICD-10 Dx, OM ICD/ABN/ABN Reason, and PA ICD/ABN/ABN Reason.

Test with only ICD-9 Codes, only ICD-10 Codes, and both ICD-9 and ICD-10 Codes.

Expected Result:

The diagnosis and ABN fields display correctly.

2 Edit PA Charges ABN Logic

Description:

Test the ABN logic. When there is only an ICD-9 Ordering Diagnosis, the ABN ICD is set to 9. When there is only an ICD-10 Ordering Diagnosis, the ABN ICD is set to 10. When there is both an ICD-9 and an ICD-10 Ordering Diagnosis, the ABN ICD is set to 10.

Expected Result:

The ABN logic processes correctly. When the charge has both an ICD-9 and an ICD-10 Ordering Diagnosis, the ICD-10 Ordering Diagnosis is used for ABN processing.

3 Edit PA Charges Trans History

Description:

Check Transaction History for all updates. Access Account Inquiry, Financial Information, Transaction History, press F5 for View Detail Transaction on the Edit PA Chg for Inactive (Active) Account. From here, enter **L** for List Changes, and verify that the OLD and NEW DX values are recorded correctly. Also verify that the OLD and NEW ABN changes list the ICD flag for the ABN.

Expected Result:

Transaction History displays correctly.

4 Edit PA Charges Reports

Description:

Review the following reports. The diagnosis fields should be preceded by ICD-9 or ICD-10, and the ABN fields should be preceded by the ABN ICD flag of 9 or 10: FARCHGAx PA Charges Edited on MM/DD/YY, FARCHGDx PA Charges Edited by Department.

Expected Result:

The report updates for diagnosis and ABN print correctly.

TEST BILLING UPDATES

Description:

Test the Billing logic for ICD-10. Access the Billing Parameters by accessing Tables, PA/AR Parameter Maintenance, Billing Parameters, Billing Parameters (again).

1 FB Parm Set Admit Date

Description:

For an account with Insurance, test that the Final Bill Parameter has the ICD-10 Effective Date field set with a date and Admission Date. The date should be after the ICD-10 Effective Date in the Hospital Facility Options on Patient Processing.

Test each of the billing Data Base Elements that look to Diagnosis or Procedure.

Test when each billing Data Base Element that looks to Diagnosis or Procedure for when the account has the data, and when the account does not have the data and it's required (therefore the bill fails).

Test that the Bill ICD-10 Effective Date is After the account's admission date; therefore the bill edits for ICD-9 codes.

Test that the Bill ICD-10 Effective Date is On the account's admission date; therefore the bill edits for ICD-10 codes.

Test that the Bill ICD-10 Effective Date is Before the account's admission date; therefore the bill edits for ICD-10 codes.

Expected Result:

Test results as noted above.

2 Self Pay

Description:

For an account with NO Insurance, the Final Bill Parameter that is assigned to the account (based on the Financial Class Table) should be accessed to determine if there is an ICD-10 Effective Date in the Final Bill Parameters.

If there is an ICD-10 Effective Date, this works the same as an account with insurance.

If there is NO ICD-10 Effective Date in the Final Bill Parameter assigned to the Self Pay account, test that the system defaults to looking to the Financial Class Table for the ICD-10 Effective Date. The ICD-10 Effective Date in the Financial Class Table uses Admission Date only. There is no option for Discharge Date. The Financial Class ICD-10 Effective Date should be after the ICD-10 Effective Date in the Hospital Facility Options on Patient Processing.

Test each of the billing Data Base Elements that look to Diagnosis or Procedure.

Test when each billing Data Base Element that looks to Diagnosis or Procedure for when the account has the data, and when the account does not have the data and it's required (therefore the bill fails).

- Test that the FC ICD-10 Effective Date is After the account's Admission date; therefore the bill edits for ICD-9 codes.
- Test that the FC ICD-10 Effective Date is On the account's Admission date; therefore the bill edits for ICD-10 codes.
- Test that the FC ICD-10 Effective Date is Before the account's Admission date; therefore the bill edits for ICD-10 codes.

3 FB Parm Set to Discharge Date

Description:

For an account with insurance, test that the Final Bill Parameter has the ICD-10 Effective Date field set to a date and Discharge Date. The Final Bill Parameter ICD-10 Effective Date should be after the ICD-10 Effective Date in the Hospital Facility Options on Patient Processing.

Test each of the billing Data Base Elements that look to Diagnosis or Procedure.

Test when each billing Data Base Element that looks to Diagnosis or Procedure for when the account has the data, and when the account does not have the data and it's required (therefore the bill fails).

- Test that the Bill ICD-10 Effective Date is After the account's Discharge date; therefore the bill edits for ICD-9 codes.
- Test that the Bill ICD-10 Effective Date is On the account's Discharge date; therefore the bill edits for ICD-10 codes.
- Test that the Bill ICD-10 Effective Date is Before the account's Discharge date; therefore the bill edits for ICD-10 codes.

4 FB Blank ICD-10 Eff Date

Description:

Test with an account with insurance, that has no ICD-10 Effective Date in the Final Bill Parameter. The system should then use the ICD-10 processing logic that is based on the Hospital Facility Options, and the exceptions in the Insurance Plan, Insurance Carrier, and the Financial Class. Since the Billing Parameters are based on the COB 1 insurance, the system looks only to the Insurance Plan and Insurance Carrier for the COB 1 insurance, and does not look for exceptions for the secondary insurances when setting the BILL ICD.

Test:

- The COB 1 Insurance Plan results in a Bill ICD flag of 9, whereas the next highest insurance plan would have resulted in an ICD flag of 10.
- The COB 1 Insurance Plan results in a Bill ICD flag of 10, whereas the next highest insurance plan would have resulted in an ICD flag of 9.
- The COB 1 Insurance Carrier results in a Bill ICD flag of 9, whereas the next highest insurance carrier would have resulted in an ICD flag of 10.
- The COB 1 Insurance Carrier results in a Bill ICD flag of 10, whereas the next highest insurance carrier would have resulted in an ICD flag of 9.

Expected Result:

The Bill ICD flag is based on the Hospital Facility Table, the Insurance Plan and Insurance Carrier exceptions for the COB 1 plan only, and on Financial Class.

5 Auto Adj Rebill DRG/DX/Proc

Description:

Test that the automatic adjustment bill and/or report is produced only if the appropriate diagnosis or procedure is update:

The DRG/Procedure/Modification Report Name is FBR400x.

- If the Bill ICD is set to 9, if the Principal ICD-9 Diagnosis or Procedure is updated, the bill/report is generated.
- If the Bill ICD is set to 9, if the Principal ICD-10 Diagnosis or Procedure is updated, the bill/report is not generated.
- If the Bill ICD is set to 10, if the Principal ICD-10 Diagnosis or Procedure is updated, the bill/report is generated.
- If the Bill ICD is set to 10, if the Principal ICD-9 Diagnosis or Procedure is updated, the bill/report is not generated.

Expected Result:

The system produces an automatic bill and/or report based on the Bill ICD flag and changes to the DRG, the Principal Diagnosis, and the Principal Procedure.

6 Biller Workfile

Description:

Access Billing and Claims, Patient Billing, Biller Workfiles, Patient Bills by Account, select the facility, account, and bill. Or, Billing and Claims, Patient Billing, Biller Workfiles, Patient Bills by Biller, enter the Biller, F for Failed Edits, select the bill.

Verify the new field Bill Parm displays the Final Bill Parameter at the time of billing.

Verify the new field ICD displays the Bill ICD indicator at the time of bill select/bill edit.

Expected Result:

Verify the fields display the final bill parameter and bill ICD setting.

7 Bill Reports

Description:

- Test the Final Bill Parameter Report FTFABP

  Verify the report prints the ICD-10 Effective Date and then either Admission Date or Discharge Date, or that the field is blank.

- Test the Failed Billing Requirements Report (FBR210x) and the Failed Billing Requirements Controlled By Report (FBR220x).

  Verify the reports print the Bill Parm - the final bill parameter at time of billing, and the ICD Req - the bill ICD indicator at time of bill select/edit. Also verify the FBR220x field Admitting/Working Diagnosis first prints the ICD-10 diagnosis information before defaulting to the ICD-9 information.

- Test the DRG/Procedure/Modification Report (FBR400x). Verify the report prefaces the diagnosis and procedure changes with either ICD-10 or ICD-9.

Expected Result:

The reports print as indicated above.

TEST CLAIM LOAD EDIT PARAMETERS

Description:

Test each step with the below:

- UB04 (claim type X)
  - diagnoses from Admissions only
  - diagnoses from Medical Records

- 1500 in 08/05 format (claim type B)
  - diagnoses from Admissions only (and on the charge records)
  - diagnoses from Medical Records
- Non Pro Fee 1500 in 08/05 format (claim type Z)
  - diagnoses from Admissions only (and on the charge records)
  - diagnoses from Medical Records

1 CLE Parm Set to Admit Date

Description:

For an account with Insurance, test that the Claim Load Edit Parameter has the ICD-10 Effective Date field set with a date and Admission Date. The date should be after the ICD-10 Effective Date in the Hospital Facility Options on Patient Processing.

Test with each Internal Element, Setup Routine, Access Routine, Print Routine, Display Routine, and Pre Entry Routine that looks to Diagnosis or Procedure for when the account has the data, and when the account does not have the data and it's required (therefore the claim fails).

Test with only Admission diagnoses, and then test with Medical Records diagnoses.

For each of the below, test where the data exists with the initial claim LOAD, and test where the data does not exist with the initial claim load, but then having the data entered, and loading with claim RELOAD.

- Test that the Claim ICD-10 Effective Date is After the account's admission date; therefore the claim loads and edits for ICD-9 codes.
- Test that the Claim ICD-10 Effective Date is On the account's admission date; therefore the claim loads and edits for ICD-10 codes.
- Test that the Claim ICD-10 Effective Date is Before the account's admission date; therefore the claim loads and edits for ICD-10 codes.

2 CLE Parm Set to Discharge Date

Description:

For an account with insurance, test that the Claim Load Edit Parameter has the ICD-10Effective Date field set to a date and Discharge Date. The Claim Load Edit

Parameter ICD-10 Effective Date should be after the ICD-10 Effective Date in the Hospital Facility Options on Patient Processing.

Test with each Internal Element, Setup Routine, Access Routine, Print Routine, Display Routine, and Pre Entry Routine that looks to Diagnosis or Procedure for when the account has the data, and when the account does not have the data and it's required (therefore the claim fails). Test with only Admissions diagnoses, and then test with Medical Records diagnoses.

For each of the below, test where the data exists with the initial claim LOAD, and test where the data does not exist with the initial claim load, but then having the data entered, and loading with claim RELOAD.

- Test that the Claim ICD-10 Effective Date is After the account's Discharge date; therefore the claim loads and edits for ICD-9 codes.
- Test that the Claim ICD-10 Effective Date is On the account's Discharge date; therefore the claim loads and edits for ICD-10 codes.
- Test that the Claim ICD-10 Effective Date is Before the account's Discharge date; therefore the claim loads and edits for ICD-10 codes.
- When there is NO Discharge Date, test that the system uses the Midnight Processing Date for the Claim Load Date, and uses the current date for claims loaded online in Add Claim to Insurance and Instant Adjustment Bill.
    - Test when the Processing Date is Before the Claim ICD-10 Effective Date; therefore the claim loads and edits for ICD-9 codes.
    - Test when the Processing Date is On the Claim ICD-10 Effective Date; therefore the claim loads and edits for ICD-10 codes.
    - Test when the Processing Date is After the Claim ICD-10 Effective Date; therefore the claim loads and edits for ICD-10 codes.

Expected Result:

Test results as noted above.

3 CLE Blank ICD-10 Eff Date

Description:

Test with an account with insurance, that has no ICD-10 Effective Date in the Claim Load Edit Parameter. The system should then use the ICD-10 processing logic that is based on the Hospital Facility Options, and the exceptions in the Insurance Plan, Insurance Carrier, and the Financial Class.

Test with each Internal Element, Setup Routine, Access Routine, Print Routine, Display Routine, and Pre Entry Routine that looks to Diagnosis or Procedure for when the account has the data, and when the account does not have the data and it's required (therefore the claim fails). Test with only Admission diagnoses, and then test with Medical Records diagnoses.

4 Claim Status Information Screen

Description:

Access Billing and Claims, Maintain Claims by Account or Maintain Claims by Biller, enter the facility, account, and claim sequence or the biller number, type of claim (Failed, Passed, etc.), the date search, and the claim sequence, and finally select the Claim Status Information screen.

Verify the new field ICD displays the Claim ICD indicator at the time of claim load, and that the claim maintains this setting for the life of the claim.

5 Claim Reports

Description:

Test the Claim Load Edit Parameters Rpt FCRCP.

Verify that the ICD-10 Effective Date field prints for claim types X, R, B, and Z with the date and then either Admission Date or Discharge Date depending on if/how the field is set.

Test the Failed Claims Requirement Report FCR250x. Verify the claim ICD indicator at time of claim load prints for claim types X, R, B, and Z.

Expected Result:

The reports print as indicated above.

TEST 1500 CLAIMS

1 Diagnoses Locator 21

Description:

Verify that the system loads diagnoses into Locator 21 based on the Claim ICD flag, and on the current logic that uses the field Diagnosis for 1500 Locator 21 on the header screen of the 1500 Claim Load Edit Parameter, and the internal elements 1500 Diagnosis Box 21 - Field 1, 1500 Diagnosis Box 21 - Field 2, 1500 Diagnosis Box 21 - Field 3, and 1500 Diagnosis Box 21 - Field 4.

Test the following scenarios for each of the Diagnosis for Locator 21 options:

(1) Principal/Admitting from Admission

(2) Principal/Working from Admission

(3) Admitting from Admission

(4) Admitting from Medical Records

(5) Working from Admission

(6) Secondary Diagnoses 1-4

(7) Charge Diagnoses

- The claim ICD is set to 9, and the ICD-9 diagnoses exist on the account
- The claim ICD is set to 9, but the ICD-9 diagnoses do NOT exist on the account, and therefore the claim fails. There should be ICD-10 diagnoses on the account, which should not load to the claim. Enter the ICD-9 codes and test Claim Reload.
- The claim ICD is set to 10, and the ICD-10 diagnoses exist on the account
- The claim ICD is set to 10, but the ICD-10 diagnoses do NOT exist on the account, and therefore the claim fails. There should be ICD-9 diagnoses on the account, which should not load to the claim. Enter the ICD-10 codes and test Claim Reload.

Expected Result:

As stated above.

2 Diagnoses in Locator 24E

Description:

Verify that the system loads diagnoses into Locator 24E based on the Claim ICD flag and the Ordering Diagnosis on the charge. Set the field Diagnosis for 1500 Locator 21 on the header screen of the 1500 Claim Load Edit Parameter to Charge Diagnoses for the First Choice for 1500 Diagnosis, and leave the other choices blank.

Test the following:

- The claim ICD is set to 9, and the ICD-9 diagnoses exist on the charges. Verify the diagnoses are added to Locator 21 and that the correct reference number is used in Locator 24E for the charge line.

- The claim ICD is set to 9, but the ICD-9 diagnoses do NOT exist on the charges, and therefore the claim fails. There should be ICD-10 diagnoses on the charges, which should not load to the claim. Enter the ICD-9 codes on the charges (in Edit PA Charges) and test Claim Reload. Verify the diagnoses are added to Locator 21 and that the correct reference number is used in Locator 24E for the charge line.

- The claim ICD is set to 10, and the ICD-10 diagnoses exist on the charges. Verify the diagnoses are added to Locator 21 and that the correct reference number is used in Locator 24E for the charge line.

- The claim ICD is set to 10, but the ICD-10 diagnoses do NOT exist on the charges, and therefore the claim fails. There should be ICD-9 diagnoses on the charges, which should not load to the claim. Enter the ICD-10 codes on the charges (in Edit PA Charges) and test Claim Reload. Verify the diagnoses are added to Locator 21 and that the correct reference number is used in Locator 24E for the charge line.

Expected Result:

As stated above.

3 Test 1500 Claim Print

Description:

Test the claim print. Verify each diagnosis code and procedure code field.

Expected Result:

The alignment is correct.

TEST NON PRO FEE 1500

1 Diagnosis Locator 24E

Description:

Verify that the system loads diagnoses into Locator 24E based on the Claim ICD flag, and on the current logic that uses the field Diag to be Printed on the Non Professional Fee Charge Control Parameter.

Test each of the following scenarios, for **a** through **e**:

a Diag to be Printed is set to Admitting/Working, and there is an Admitting diagnosis.

b Diag to be Printed is set to Admitting/Working, and there is no Admitting diagnosis, but there is a Working

c Diag to be Printed is set to Principal/Working, and there is a Principal diagnosis.

d Diag to be Printed is set to Principal/Working, and there is no Principal diagnosis, but there is a Working

e Diag to be Printed is set to Reference Number 1

- The claim ICD is set to 9, and the ICD-9 diagnoses exist on the account
- The claim ICD is set to 9, but the ICD-9 diagnoses do NOT exist on the account, and therefore the claim fails. There should be ICD-10 diagnoses on the account, which should not load to the claim. Enter the ICD-9 codes and test Claim Reload.
- The claim ICD is set to 10, and the ICD-10 diagnoses exist on the account
- The claim ICD is set to 10, but the ICD-10 diagnoses do NOT exist on the account, and therefore the claim fails. There should be ICD-9 diagnoses on the account, which should not load to the claim. Enter the ICD-10 codes and test Claim Reload.

Expected Result:

As stated above

2 Test Non Pro Fee 1500 Claim Print

Description:

Test the claim print. Test each diagnosis and procedure field.

Expected Result:

The alignment is correct.

TEST PRE BILL EDIT

1 PBE Trigger Events

Description:

- Test when the trigger event Update ICD Diagnosis Information is highlighted.
  - update an ICD-9 diagnosis and verify the account is re-queued to PBE

- update an ICD-10 diagnosis and verify the account is re-queued to PBE

• Test when the trigger event Update ICD Procedure Information is highlighted.

- update an ICD-9 procedure and verify the account is re-queued to PBE
- update an ICD-10 procedure and verify the account is re-queued to PBE

Expected Result:

As stated above.

2 PBE Ordering Diagnosis Edit

Description:

Set the Pre Bill Edit field Active Sources to include I-ICD charge edits. Set the field ICD Edits (field 13) to Admit-0. Test the following scenarios:

The account ICD flag is set to B for Both.

- Charges with an ICD-9 Ordering Dx but no ICD-10 Ordering Dx fail
- Charges with an ICD-10 Ordering Dx but no ICD-9 Ordering Dx fail
- Charges with NO Ordering Dx do not fail

The account ICD flag is set to 10

- Charges with an ICD-9 Ordering Dx but no ICD-10 Ordering Dx fail
- Charges with NO Ordering Dx do not fail

The Account ICD flag is set to 9

- Charges with an ICD-10 Ordering Dx but no ICD-9 Ordering Dx fail
- Charges with NO Ordering Dx do not fail

TEST PROVIDER MASTER

Description:

Access Tables, PA/AR Master File Maintenance, Provider Master

1 Test LMP with ICD-10

Description:

Highlight the Occurrence Code 10 for Last Menstrual Period.

Test with the ICD-10 Diagnosis Codes for Abortion (O00 - O08 range) to verify the occurrence code loads correctly. The ICD-9 Diagnosis Codes for Abortion are in the 634-639 range.

Expected Result:

The abortion ICD-10 diagnosis codes load Occurrence Code 10 as outlined for the ICD-9 diagnosis codes for abortion.

TEST COMBINE BILL AND DRG PAYMENT WINDOW

Description:

To access the functions/tables:

- Combine Billing: Billing and Claims, Patient Billing, Combine Bills
- DPW: Access Tables, PA/AR Master File Maintenance, CMS Compliance Master, DPW Payment Window Parameters.

1 DRG Payment Window Parameters

Description:

- Verify that the logic for DRG Payment Window Parameter fields O/P Abstract and I/P Abstract look to the TO account's COB 1 insurance (or the self pay Financial Class) ICD flag.
- Verify if the TO account's bill edit for the existence of ICD-10 diagnosis and procedure codes, then the system looks to the ICD-10 diagnosis codes on both the FROM and the TO accounts when performing the O/P Abstract and the I/P Abstract logic (meaning, the ICD-10 charge diagnoses, or the Principal ICD-10 Diagnosis in Medical Records on the Outpatient Account(s) are compared to the Principal and Secondary ICD-10 Diagnoses codes in Medical Records on the Inpatient Account).
- Verify If the TO account's bill edits for the existence of ICD-9 diagnosis and procedure codes, then the system looks to the ICD-9 diagnosis codes on both the FROM and the TO accounts when performing the O/P Abstract and the I/P Abstract logic (meaning, the ICD-9 charge diagnoses, or the Principal ICD-9 Diagnosis in Medical Records on the Outpatient Account(s) are compared to the Principal and Secondary ICD-9 Diagnoses codes in Medical Records on the Inpatient Account).
- Test a mismatch on coding methods with a Series account with an Admission Date before the ICD-10 Effective Date on the Hospital Facility Options, and with

an Inpatient with an Admission Date on or after the ICD-10 Effective Date on the Hospital Facility Options. Verify that the accounts are listed on the DRG Payment Window Parameter Report (FBR072) with the error DPW Hold. ICD9/ ICD10 Mismatch.

Expected Result:

Combine Billing and DRG Payment Window use the Bill ICD indicator to use ICD-10 or ICD-9 codes for processing.

2 Preview Screens

Description:

For Combine Billing, access Billing and Claims, Patient Billing, Combine Bills. After entering the From and To accounts, the system displays a screen with the following prompt:

Request bill(B), add account(A), delete account(D), remove all links(R), preview comb med info(P), use adm dx's in preview(U), or [NL] to exit --

For DRG Payment Window, access Billing and Claims, DRG Payment Window Functions, DRG Payment Window Processor, enter the facility and the account, select an account. The system displays a screen with the following prompt:

(D)eactivate DPW, (C)hange DPW, (E)valuate Charges, (R)eview Charges, or (P)review Combined Medical Info, (U)se adm dx's in Preview Comb MedInfo--

Both the P and the U screens (which are the same screen, but can display different information) have been updated.

- Verify that a new field of ICD was added to the top of the screen displaying the diagnosis and procedure codes. Verify this field displays either ICD-10 or ICD-9.

- Test where the TO and the FROM accounts have BOTH ICD-10 and ICD-9 codes. Verify that the ICD-10 diagnoses and procedures display first, and that you have to page forward to display the ICD-9 diagnoses and procedures.

- Test where the TO and the FROM accounts have only ICD-10 codes. Verify that these ICD-10 diagnoses and procedures display, and that you do not receive a blank screen for ICD-9.

- Test where the TO and the FROM accounts have only ICD-9 codes. Verify that these ICD-9 diagnoses and procedures display, and that you do not receive a blank screen for ICD-10.

Expected Result:

The Preview and Use screens display the ICD value correctly and the associated diagnoses and procedures for either ICD-10 or ICD-9.

3 DRG Payment Window Processor Screens

Description:

Access Billing and Claims, DRG Payment Window Functions, access DRG Payment Window Processor, enter the facility and account, or access DRG Payment Window Worklist, enter the facility and select an account.

Verify that the Dx field was removed from the following screens:

- DRG Payment Window Processor Screen
- Select an Account Screen
- Review Charges Screen
- Preview Combined Medical Information
- Use Adm Dx's in Preview Comb Med Info

Expected Result:

The Dx field was removed from the header fields of the above screens.

4 Claims Management

Description:

- Verify the UB04 claim for the TO account looks to the TO account's Claim ICD flag.
- Combine Billing: Test where the TO account's claim ICD flag is ICD-10, where one FROM account has BOTH ICD-10 and ICD-9 diagnosis and procedure codes, and one FROM account has only ICD-9 diagnosis and procedure codes. Verify that only the ICD-10 diagnosis and procedure codes are used on the TO account's claim. In this case, verify that the charges were moved from the FROM account to the TO account, but that only the appropriate diagnoses and procedures were used.
- Test where the TO account's claim ICD flag is ICD-9, where one FROM account has BOTH ICD-10 and ICD-9 diagnosis and procedure codes, and one FROM account has only ICD-10 diagnosis and procedure codes. Verify that only the ICD-9 diagnosis and procedure codes are used on the TO account's claim. In this case, verify that the charges were moved from the FROM account

to the TO account, but that only the appropriate diagnoses and procedures were used.

For the above situations, access Billing and Claims, Claims Management, Maintain Claims by Account or Maintain Claims by Biller, enter the TO/Inpatient account and claim, and access the Claim Demographic/Visit Data - Select Screens.

The system prompts:

View Combined Medical Information? (Y/N) [N]-- |

Verify that the screen displays EITHER ICD-10 diagnoses and procedures, or ICD-9 diagnoses and procedures, based on the TO account's Claim ICD flag.

Verify that the new ICD field on the top of the screen displays either ICD-10 or ICD-9.

Expected Result:

Either the ICD-10 or the ICD-9 diagnoses and procedures move from the FROM account to the TO account, based on the TO account's Claim ICD flag.

5 DRG Payment Window Report

Description:

Verify the edit message DPW Hold. ICD9/ICD10 Mismatch. This should have been completed in Step 1 above.

- Test the new ICD indicator before the Diagnosis field.
- Where the inpatient final bill parameters would set the bill ICD to 10
- Where the inpatient final bill parameters would set the bill ICD to 9
- Where the outpatient final bill parameters would set the bill ICD to 10
- Where the outpatient final bill parameters would set the bill ICD to 9

Expected Result:

The Diagnosis field is prefaced with 10 for ICD-10 or 9 for ICD-9 based on the Inpatient and Outpatient Final Bill Parameters and the ICD-10 parameters.

TEST STAR REIMBURSEMENT

Description:

Access Tables, PA/AR Master File Maintenance, Reimbursement Master

1 ICD Diagnosis Codes

Description:

- Verify that the old ICD-9 Diagnosis Codes was renamed to ICD Diagnosis Codes.
- Verify in the ICD Diagnosis Codes reimbursement table, that a T can be entered to access and update the ICD-10 diagnosis codes.
- Test where the Account is collecting BOTH ICD-10 and ICD-9 Diagnosis Codes, but the COB 1 plan has a Bill ICD flag of 10. Verify that the ICD Diagnosis Codes reimbursement method uses the ICD-10 diagnosis codes.
- Test where the Account is collecting BOTH ICD-10 and ICD-9 Diagnosis Codes, but the COB 1 plan has a Bill ICD flag of 9. Verify that the ICD Diagnosis Codes reimbursement method uses the ICD-9 diagnosis codes.

Expected Result:

As stated above. The Bill ICD flag is used to determine if ICD-10 or ICD-9 codes are used for reimbursement.

2 ICD Procedure Codes

Description:

- Verify that the old ICD-9 Procedure Codes was renamed to ICD Procedure Codes
- Verify in the ICD Procedure Codes reimbursement table, that a T can be entered to access and update the ICD-10 procedure codes.
- Test where the Account is collecting BOTH ICD-10 and ICD-9 Procedure Codes, but the COB 1plan has a Bill ICD flag of 10. Verify that the ICD Procedure Codes reimbursement method uses the ICD-10 procedure codes.
- Test where the Account is collecting BOTH ICD-10 and ICD-9 Procedure Codes, but the COB 1 plan has a Bill ICD flag of 9. Verify that the ICD Procedure Codes reimbursement method uses the ICD-9 procedure codes.

Expected Result:

As stated above. The Bill ICD flag is used to determine if ICD-10 or ICD-9 codes are used for reimbursement.

3 Reimbursement Table Report

Description:

- After setting up both ICD-10 and ICD-9 ICD Diagnosis Codes, print the Reimbursement Table Report, FTR140. Verify the ICD-10 codes print followed by the ICD-9 codes.
- After setting up both ICD-10 and ICD-9 ICD Procedure Codes, print the Reimbursement Table Report, FTR140. Verify the ICD-10 codes print followed by the ICD-9 codes.

Expected Result:

The ICD-10 codes print followed by the ICD-9 codes.

TEST ABN NON COVERED CHARGES

Description:

Access Tables, PA/AR Parameter Maintenance, Claim Parameters, UB Charge Control Parameters. Highlight all ABN options in the Print Non-Covered Chgs field.

Step 1

Description:

Test by highlighting each of the below in the Print Non Covered Chgs field and the following situations for each:

- the ABN ICD is 10, and the Claim ICD is 10 (prints in Non Covered)
- the ABN ICD is 9, and the Claim ICD is 9 (prints in Non Covered)
- the ABN ICD is 10, and the Claim ICD is 9 (does NOT print in Non Covered)
- the ABN ICD is 9, and the Claim ICD is 10 (does NOT print in Non Covered)

ABN Yes Signed

ABN Not Signed

ABN Freq Yes Signed

ABN Freq Not Signed

ABN Self Pay Yes Signed

ABN Self Pay Not Signed

ABN Self Pay Freq Yes Signed

ABN Self Pay Freq Not Signed

Expected Result:

The ABN charges print in Non Covered only if the ABN ICD flag matches the Claim ICD flag.

Step 2 Test UB Claim Print

Description:

Of the UB04. Test the Non Covered Charges Column. Test also each diagnosis and procedure field.

Expected Result:

The alignment is correct.

MISCELLANEOUS TESTS

- If you are a TRENDSTAR user, review any diagnosis and procedure information provided by User Defined Fields.
- If you are a Horizon Performance Management user, review any diagnosis and procedure information provided by User Defined Attributes.
- Review changes to the layout for the Collection Agency Tape.
- Review changes to the layout for the External Agency (Pre-Collect) interface.
- Test all Inbound Interfaces that Pass Diagnosis and/or Procedure Information
- Test all Custom Programs

Procedural Considerations

1 In order to collect the required ICD-10 data prior to the 10/01/2013 Discharge Date requirement from CMS, hospitals should begin to collect ICD-10 data well in advance of 10/01/2013.

2 An option would be to collect both ICD-9 and ICD-10 data on accounts well in advance of the mandated date. This could be achieved by setting the USA ICD-10 Effective Date to a date well in advance of the 10/01/2013 mandated date (for example 10/01/2012), and also entering Insurance Carrier and/or Financial Class Exceptions with an ICD-10 Effective Date in the far future (for example 10/01/2015). These exceptions would then require ICD-9 coding IN ADDITION to the ICD-10 coding. The exceptions could later be removed, or the dates updated to a date in the past.

3 Since the Patient Type Exceptions are used only in Medical Records (and not in Admissions, Lab, Rad, Pharmacy, or Order Management), exceptions should be entered at the Insurance Plan, Insurance Carrier, and/or Financial Class level to ensure that both ICD-10 and ICD-9 codes are collected for a time period before the CMS mandated date for ICD-10.

4 In the admission flow, hospitals want their Insurance Processing screens to come before the Medical Page, so that if there are any Exceptions for the Insurance Plan, Insurance Carrier, or Financial Class, this exception is noted on the account before any Admission diagnosis codes are entered on the Medical Page.

5 If there is no admission date for the account yet (since this admission date is not determined until the end of the admission flow), the system uses Today's Date for the admission date when determining whether ICD-10, ICD-9, or Both code sets are collected for the account.

6 If an account's admission date is on or after the USA ICD-10 Eff Date on the Hospital Facility Options, regardless if the account's ICD flag is set to 10 for ICD-10, or B for Both ICD-10 and ICD-9 if there are exceptions, ABN processing is done only on the ICD-10 diagnosis codes. This is because ABN processing is used to comply with CMS regulations, and the USA ICD-10 Effective Date field is set to the CMS mandated date.

7 If the USA ICD-10 Eff Date field on the Hospital Facility Options is prematurely set, or set to an incorrect date, if there are accounts admitted on or after that date, that are flagged to only collect ICD-10 codes, that really need ICD-9 codes, hospitals would have to do the following:

- Update the USA ICD-10 Eff Date field on the Hospital Facility Options to a future date.

- Access the accounts that need to collect ICD-9 diagnosis and procedure codes, and do a dummy update that resets the Account ICD flag. Users can re-sequence the insurances and re-sequence back, can change the financial class and change back, change the admission date and change back, or change the patient type and change back. You must do one of the listed revisions to re-set the Account ICD flag. Simply changing the USA ICD-10 Effective Date on the Hospital Facility Options, or changing the ICD-10

Effective Date in the Insurance Plan table, Insurance Carrier table, or Financial Class table does not scan all existing accounts in order to update them.

NOTE: This means you will have accounts that used to have an account ICD flag of 10, that now have an ICD flag of 9, that already have coded ICD-10 diagnosis and/or procedure codes. The equivalent codes need to be entered for ICD-9.

8. If the USA ICD-10 Eff Date field on the Hospital Facility Options is either not set, or set too far in the future, if there are accounts admitted before that date, that are flagged to only collect ICD-9 codes, that really need ICD-10 codes, hospitals would have to do the following:

    - Update the USA ICD-10 Eff Date field on the Hospital Facility Options to a past or today's date.

    - Access the accounts that need to collect ICD-10 diagnosis and procedure codes, and do a dummy update that resets the Account ICD flag. Users can re-sequence the insurances and re-sequence back, can change the financial class and change back, change the admission date and change back, or change the patient type and change back. You must do one of the listed revisions to re-set the Account ICD flag. Simply changing the USA ICD-10 Effective Date on the Hospital Facility Options, or changing the ICD-10 Effective Date in the Insurance Plan table, Insurance Carrier table, or Financial Class table does not scan all existing accounts in order to update them.

        NOTE: This means you will have accounts that used to have an account ICD flag of 9, that now have an ICD flag of 10 or B for Both, that already have coded ICD-9 diagnosis and/or procedure codes. The equivalent codes need to be entered for ICD-10.

9. If the USA ICD-10 Eff Date field on the Hospital Facility Options is set, if there are accounts admitted on or after that date, that are flagged to only collect ICD-10 codes, if the admission date is backdated to a date previous to the USA ICD-10 Effective Date, the system resets the account ICD flag to a 9. This means you will have accounts that used to have an account ICD flag of 10, that now have an ICD flag of 9, that already have coded ICD-10 diagnosis and/or procedure codes. The equivalent codes need to be entered for ICD-9.

Implementation Considerations

The following STIs have ICD-10 implications:

- F9931 Patient Accounting Updates to EC 2000 CA Interface for ICD-10.

- F10255 Patient Accounting Updates for 5010 Version of Electronic Claims.

- F10127 EC2000 CA 5010 Enhancements.

- F9940 Patient Accounting Updates to PCON Interface for ICD-10.
- F10254 HPM and TRENDSTAR Updates for ICD-10.

When 3M publishes their updates to the 3M Core Grouping Software with APC's, STAR Patient Accounting will open a corresponding STI.

State changes to support ICD-10 codes on claims and with the discharge data are handled with separate STIs for each state.

Documentation - ICD-10

The following is a list of updates to the STAR reference guides:

Enhancement Topic	Document	Chapter
Inquiry screens display both ICD-9 Diagnosis and/or ICD-10 Diagnosis and Procedure Codes	*Account Inquiry and Revision*	1: Account Inquiry
The ICD and State ICD for the account appear on the Billing Information screen. The Bill ICD can be seen on the header screen for the proration summary display.		
Specify the ICD-10 Effective Date for requiring ICD-10 diagnosis and procedure codes on the Final Billing Parameters table.	*Tables, Masters, and Parameters Volume*	3: PA/AR Parameter File

Enhancement Topic	Document	Chapter
Pre Bill Edit: Update the Pre-Bill Edit Parameters with the new Active Sources option of I-ICD charge edits, add field ICD Edits, and verbiage changes. Update the PBE Status Information displays. Mark edits for diagnosis and procedure codes to be ICD-9 or ICD-10.	(continued)	
Claim Load Edit Parameters have a field to specify the ICD-10 Effective date for diagnosis and procedure codes to load to the claim.		
Update the STAR Reimbursement Types of ICD-9 Diagnosis Codes and ICD-9 Procedure Codes to ICD Diagnosis Codes and ICD Procedure Codes. Both should allow ICD-9 and ICD-10 codes to be defined and used based on the Final Bill ICD indicator.		
Provider Master: Update auto load Occurrence Code 10 for Last Menstrual Period to look to the appropriate ICD-9 or ICD-10 diagnosis codes.		
The options for ABN Hold? in Billing Requirements are expanded to match the options for Print Non-Covered Chgs? for UB charges.		
Updated the UB04 Claim Master, and the hospital-defined UB04 Claim Load Edit Parameters for Locator 72 - External Cause of Injury Codes.		
Updated all Claim Internal Elements, Setup Routines, Access Routines, Print Routines, Display Routines, and Pre Entry Routines that look to diagnoses or procedures to access the Claim ICD field to determine if ICD-10 or ICD-9 codes are required.		

Enhancement Topic	Document	Chapter
The Biller Workfile displays the ICD indicator for the Final Bill.	*Billing and Claims Volume*	2: Billing
In Combine Billing, the Preview screen and the Use Admission Diagnoses in Preview screens display both ICD-9 and ICD-10 codes		
Edit PA Charge screen displays both the ICD-10 Ordering Diagnosis and the ICD-9 Ordering Diagnosis for the charge, and allows you to update one or both on a charge. Updated ABN logic based on ABN ICD indicator		3: Claims
The ICD version for the claim is available on the Claim Status screen.		
Log Inquiry displays the ICD indicator for the Primary Diagnosis and Primary Procedure. Log Report Selection Processor for the Primary ICD Procedure prompts for ICD-9 or ICD-10.		4: Third Party Logs
DRG Payment Window was updated to evaluate the DPW link and the charges to look to the final bill ICD indicator for the Inpatient (To) account compared to the final bill ICD indicator for the Outpatient/ Series (From) account.		6: DRG Payment Window Processor
Report FARDXM was created to identify charges for which diagnoses appear to be missing. This report begins to run when USA ICD-10 processing is activated.	*Reports Volume*	3: Claim Reports

Documentation - ICD-10 DRG

The following is a list of updates to the STAR reference guides:

Enhancement Topic	Document	Chapter
Account Inquiry DRG Display The screen displays a list of the DRGs that exist for the account, and allows the user to select the DRG to view. The possible DRGs are: the Primary ICD-10 DRG (based on COB 1), the Primary ICD-9 DRG (based on COB 1), the Secondary ICD-10 DRG (not yet available), the Secondary ICD-9 DRG, and the Non Reimbursed APR ICD-9 DRG. The Non Reimbursed APR ICD-10 DRG is not yet available.	*Account Inquiry and Revision*	1: Account Inquiry
Billing Requirement for DRG When the Billing Requirements attached to the Final Bill Parameter for an account Requires the Final DRG or the Secondary DRG, the system should require the DRG with the ICD indicator that matches the Bill ICD Indicator	*Tables, Masters, and Parameters*	2: PA/AR Parameters
Final Bill Type Auto Adj Rebill DRG/Dx/Proc. If this field is set to A for Automatic Adjustment Bill, R for Report Only, or B for Both, and if the DRG is updated, this will only produce an adjustment bil.	*Tables, Masters, and Parameters*	2: PA/AR Parameters
FBR400 DRG/PROC/DX MODIFICATION RPT Only the logic has been updated for reporting on and producing an auto adjustment bill based on a changed DRG.	*Reports*	

Enhancement Topic	Document	Chapter
Transaction History DRG ICD indicator is displayed with the transaction history message for changed DRG.	*Account Inquiry and Revision*	1: Account Inquiry
Log Inquiry Logs will display the ICD indicator for the reimbursed DRG in the Log Reimbursement and Reconciliation screen, and on the Selected Log Account Report.	*Billing and Claims*	4: Third Party Logs
TRENDSTAR Internal Elements updated to use the ICD-9 or ICD-10 information based on the ICD indicator of the bill or claim.	*TRENDSTAR Interface Guide*	Appendix A: TRENDSTAR Data Descriptions
HPM Internal Elements updated to use the ICD-9 or ICD-10 information based on the ICD indicator of the bill or claim.	*Horizon Performance Manager*	Appendix A: Horizon Performance Manager Data Descriptions
Updated to use information for the Primary ICD-9 DRG or the Primary ICD-10 DRG per the ICD indicator for the claim.	*Electronic Claim System Interface Guide*	1: Overview
Updated the interface so the DRGs included in the interface are limited to those with the same ICD indicator as the ICD indicator for the claim.	*Pathways Contract Manager*	1: Using the Standard Interface

■ Reader Comment Form ■

We value your suggestions for improving our documentation. Please use this form to evaluate the *STAR ICD-10 Implementation Guide* for STAR Release 18.0 or Later..

Topic	Poor	Fair	Good	Excellent
Organization of information	❑	❑	❑	❑
Accuracy of information	❑	❑	❑	❑
Completeness of information	❑	❑	❑	❑
Clarity of information	❑	❑	❑	❑
Amount of overview information	❑	❑	❑	❑
Explanation of processes	❑	❑	❑	❑

Are there parts of this manual that could be made more helpful to you? Please explain.

Other Comments:

Thanks for your help in improving the documentation.

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