Table Maintenance - HIM

Table Maintenance - HIM

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Chapter 1   Introduction

1.1   Attestation Disclaimer

Promoting Interoperability Program attestation confirms the use of a certified Electronic Health Record (EHR) to regulatory standards over a specified period of time. TruBridge Promoting Interoperability Program certified products, recommended processes and supporting documentation are based on TruBridge's interpretation of the Promoting Interoperability Program regulations, technical specifications and vendor specifications provided by CMS, ONC and NIST. Each client is solely responsible for its attestation being a complete and accurate reflection of its EHR use during the attestation period and that any records needed to defend the attestation in an audit are maintained. With the exception of vendor documentation that may be required in support of a client's attestation, TruBridge bears no responsibility for attestation information submitted by the client.

1.2   What's New

This section introduces the new features and improvements for **Table Maintenance - HIM** for release Version 22.01. A brief summary of each enhancement is given referencing its particular location if applicable. As new branches of Version 22.01 are made available, the original enhancements will be moved to the Previous Work Requests section. The enhancements related to the most current branch available will be listed under the main What's New section.

Each enhancement includes the Work Request (WR) Number and the description. If further information is needed, please contact **Client Services** Support.

NOTE: Version 22.01 does not include any new enhancements.

Chapter 2   Overview

This user guide describes the Health Information Management Tables that are maintained via Table Maintenance.
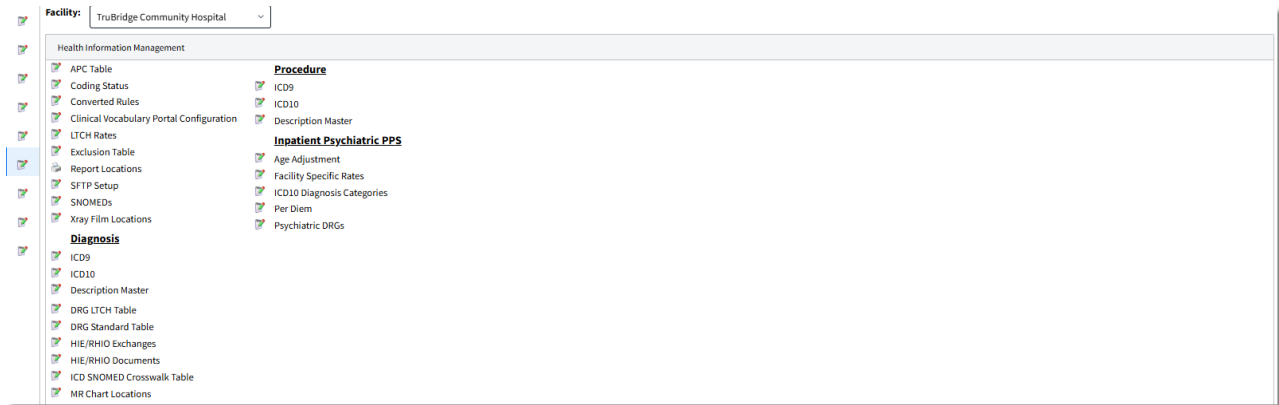
Select **Web Client** > **Tables** > **HIM**
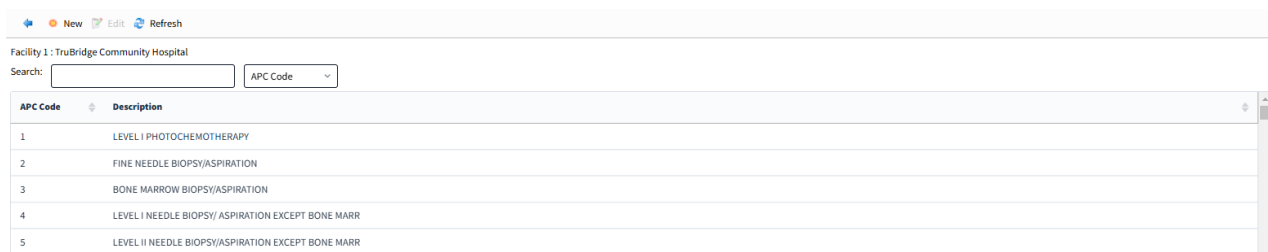
Table Maintenance - HIM

NOTE: *Facilities outside of the United States may choose a date format of MMDDYY, DDMMYY or YYMMDD to be used on all date fields in the HIM tables. Where four-digit dates display, a date format of MMDD, DDMM or MMDD, respectively, will be used. Whichever date format is selected will be reflected in all date fields and column displays throughout the tables. A TruBridge Support Representative should be contacted in order for the date format to be changed.*

Chapter 3   HIM

3.1   APC Table

Select **Web Client > Tables > HIM > <u>APC Table</u>**

APC Table List

The search option allows APC codes to be looked up by the APC Code or description.

Select   **New** to enter a new APC code or select an existing code from the list and select

Edit.

Below is a description of each field.

- **APC Code**: Enter the desired APC code, which can be up to four-digits in length.

- **Description**: Enter the name of the Ambulatory Payment Classification group.

- **As Of Dates**: Enter the effective date of the corresponding Status Indicator.

- **Status Indicator**: The Status Indicator provides information on the type of service represented by the APC and indicates how or if the selected APC will be reimbursed. Select the correct Status Indicator.

NOTE: If an account has multiple APC codes with a Status Indicator of T, the highest reimbursement is paid at 100%. For each additional T APC after that, the Payment Rate and Co-Pay rate are reduced by 50%.

- **Relative Weight**: This field contains the Relative Weight for the selected APC. This figure is used to compute the unadjusted payment rate.

- **Payment Rate**: This field contains the unadjusted payment rate for the selected APC. This is the total payment amount including copays, deductible, and payment from the insurance that can be received for the selected APC code.

- **Nat. Unadj. Copay**: This field contains the national unadjusted coinsurance rate for the selected APC. The Copay can never exceed the I/P Deductible, which is currently $776.00 but changes yearly.

- **Min. Unadj. Copay**: This field contains the minimum unadjusted coinsurance amount for the selected APC. This represents 20-25 percent of the APC payment amount in field 4.

- **Adj Reduced Copay**: Enter the facility-discounted coinsurance amount for the selected APC. Coinsurances may be discounted by individual facilities on a yearly basis by APC group.

The following options are available on the action bar:

- **Show Shared**: If the site is sharing tables, when this option is selected the fields that are shared between facilities will be highlighted in yellow.

- **Print**: This option will display the table settings in Adobe.

- **Delete**: This option will delete the table settings.

- **Save**: This option will save changes made to the table settings.

- **Refresh**: This option allows changes to show immediately in the APC Table list.

Select the **Back Arrow** to return to the previous screen.

3.2   Coding Status

Select **Web Client > Tables > HIM > Coding Status**

Coding Status Table

- **Active Only:** Selecting this option will only display Coding Statuses marked as active.

- **Inactive Only:** Selecting this option will only display Coding Statuses marked as inactive.

- **Both:** Selecting this option will display both active and inactive Coding Statuses.

- **Search:** The Search options allows Coding Statuses to be looked up by description.

For existing Coding Statuses, the following information will display:

- **Description:** this column will display the HIM Coding Status Description.

- **Active:** This column will display a **Y** to indicate the Coding Status is marked as active or an **N** to indicate it is marked as inactive.

Select **New** from the action bar to create a new Coding Status or select an existing Coding Status from the listing and then select **Edit** to make any needed changes.

Select **Web Client > Tables > HIM > Coding Status > <u>New</u>**

Coding Status Edit Screen

- **Description:** Enter the Coding Status description as it should display in the Coding Status column within the HIM Coding Worklist.

- **Active:** Select this option if the Coding Status is current and should display as an option within the HIM Coding Worklist.

- **Last updated by:** This field will automatically update with the login of the user to last update the selected Coding Status.

- **Last updated Date/Time:** This field will automatically update with the date and time of when the last updates were made to the selected Coding Status.

Below is a list of each option on the action bar:

- **New:** Select this option to create a new Coding Status.

- **Edit:** Select an existing Coding Status from the listing and then select **Edit** to make changes to the existing Code Status.

- **Refresh:** Select this option after creating a new Coding Status so it will appear in the Coding Status listing.

3.3 Converted Rules

The Patient Portal Exclusions table is now named the Converted Rules table. This table is display only and will list any Exclusions that were previously created prior to the creation of the Exclusion Table.

NOTE: *This table is for reference only. All Exclusions will now look to the Exclusion Table.*
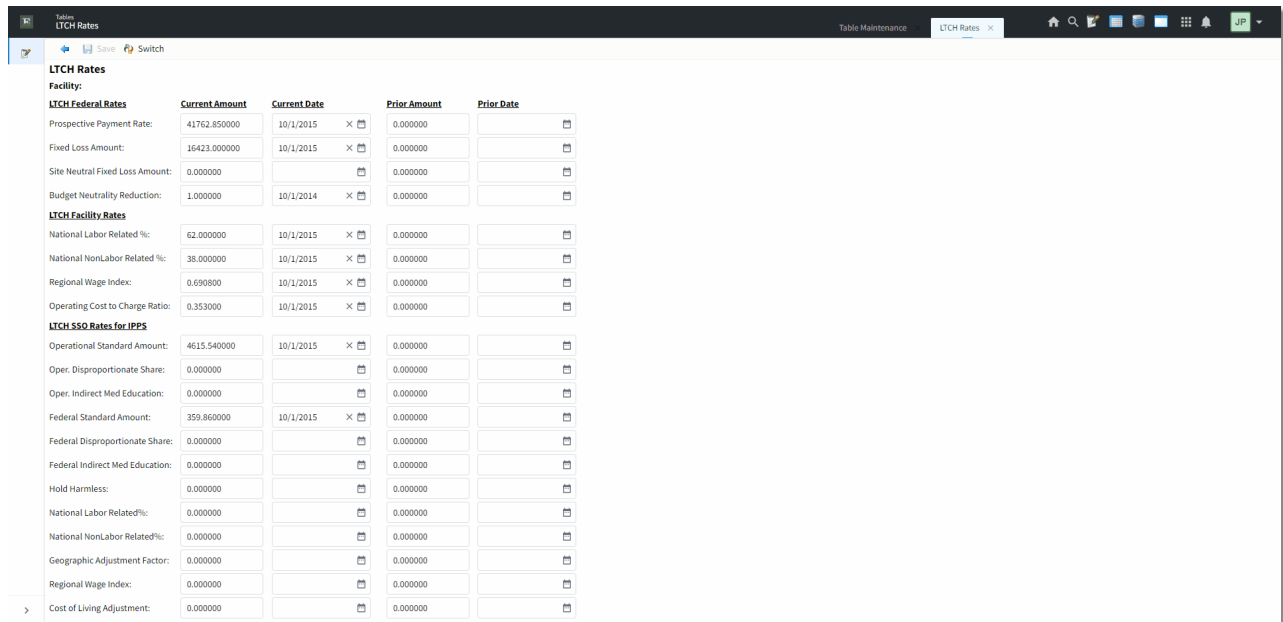
3.4 Clinical Vocabulary Portal Configuration

This table is for future use.

3.5 LTCH Rates

The LTCH Rates Table contains the necessary Medicare reimbursement figures to be used in the LTCH reimbursement calculations. For more information, please see the LTCH user guide.

Select **Web Client > Tables > HIM > LTCH Rates**

LTCH Rates

3.6   Exclusion Table

Effective April 5, 2021, the Information Blocking rule prohibits any action or practice that interferes with the access, exchange, or use of an individual's electronic health information (EHI). There are eight exceptions when interference with the access, exchange or use of an individual's EHI would not be considered Information Blocking. To avoid non-compliance, and potential non-compliance penalties, healthcare providers should ensure that suppression of any patient EHI meets one of the documented exceptions. Questions concerning the Information Blocking rule, and the eight exceptions, may be answered on the ONC's FAQ web page.

Exclusions may be set up to automatically exclude visits, images, transcriptions, problems, care team members, procedures and lab results from the patient, and/or CCDA. Each exclusion type may be broad or specific (i.e. only excluding patients within a particular age range). Exclusions may be applied to the patient (via Patient Portal) and/or the CCDA. Options to release the exclusions via Medical Records, or to make the unavailable for release, are also available from the patient's chart.

When accessing the Exclusion Table, a listing of existing exclusions will display. Each exclusion will display its name, type of exclusion and duration. An 'X' in the CCDA and/or Patient (Portal/API) column will designate where the information is being excluded from.

Below is a listing of each option on the action bar:

- **New:** Select this option to create a new Exclusion. See 'Creating an Exclusion' below for more information on this option.

- **Remove:** Select this option to remove an Exclusion from the table.

- **View Detail:** Select this option to view the Exclusion Detail screen. This screen will show all components of the Exclusion.

Creating an Exclusion

To begin creating an Exclusion, select **New** on the action bar.

Select **Web Client > Tables > HIM > Exclusion Table > New**

Exclusion Detail

Select one of the following options to exclude information from:
- **CCDA:** Select this option to set the Exclusion to be excluded from the CCDA.
- **Patient (Portal/API):** Select this option to set the Exclusion to be excluded from the Portal/any API.

Then select what the Exclusion is for: Visit, Image, Result, Procedure, Care Team, Problem, Transcription: Ancillary or Transcription: Medical Record. The selected Exclusion will be defined on the next screen. Select **Next** to continue.

A list of available filters will display on the screen. Double-click the filter to add it to the Exclusion. Once selected, the filter may be defined. The available filters are:
- **Admission Date:** Select this option to filter by Admission Date. The date will look to the Admission Date on the Census screen.
- **Admit Code:** Select this option to filter by an Admit Code. An Admit Code look-up is available and will display all codes created in the Admit Code table.
- **Age:** Select this option to filter by age. An age may then be populated.
- **Discharge Date:** Select this option to filter by Discharge Date. The date will look to the Discharge Date on the Census screen.
- **Provider:** Select this option to filter by a physician. A physician look-up is available and will display all physicians created in the Physician table.
- **Service Code**: Select this option to filter by a Service Code. A Service Code look-up is available and will display all codes created in the Service Code table.
- **Stay Type:** Select this option to filter by a Stay Type. The Service Code codes setup in AHIS will display on the screen.
- **Sub Type:** Select this option to filter by a Sub Type. A Sub Type look-up is available and will display all codes created in the Patient Sub Type Menu.

The following filters will display based on the Exclusion selected:
- **Image Title:** Select this option to filter by an Image Title. An Image Title look-up is available and will display all titles created in the Image Title table.
- **Test Name:** Select this option to filter by a test. An Ancillary Order look-up is available and will display all tests created in the Item Master.
- **Procedure:** Select this option to filter by a Procedure Code. Procedure Code may then be added by selecting **Add** on the action bar. A search option is available to search for the correct code.
- **Problem Description:** Select this option to filter by a Problem/Diagnosis. Diagnosis codes may then be added by selecting **Add** on the action bar. A search option is available to search for the correct code.
- **Transcription Title (Ancillary):** Select this option to filter by an Ancillary Transcription. A look-up is available and will display all test names setup to be transcribed in the Item Master.
- **Transcription Title (Medical Record):** Select this option to filter by a Medical Record Transcription. A look-up is available and will display all transcription titles setup in the Physician Headers table.

NOTE: If Care Team is selected to be excluded, the entire care team will be excluded. The only filtering options for Care Team will be Admission Date, Admit Code, Age, Discharge Date, Service Code, Stay Type and Sub Type.

As filters are defined, they will appear in the Selected Filters column. Once the Exclusion has all the filters selected and defined, select **Next** to continue.

The Exclusion may then be named. Then select the time frame for which the Exclusion will hold:
- **Until Released:** Select this option to exclude this rule indefinitely until the rule is manually released.
- **Unavailable For Release:** This option is only available for the Image exclusion type. When selected, this will prevent the Exclusion from ever being released.

Select **Save** to continue.
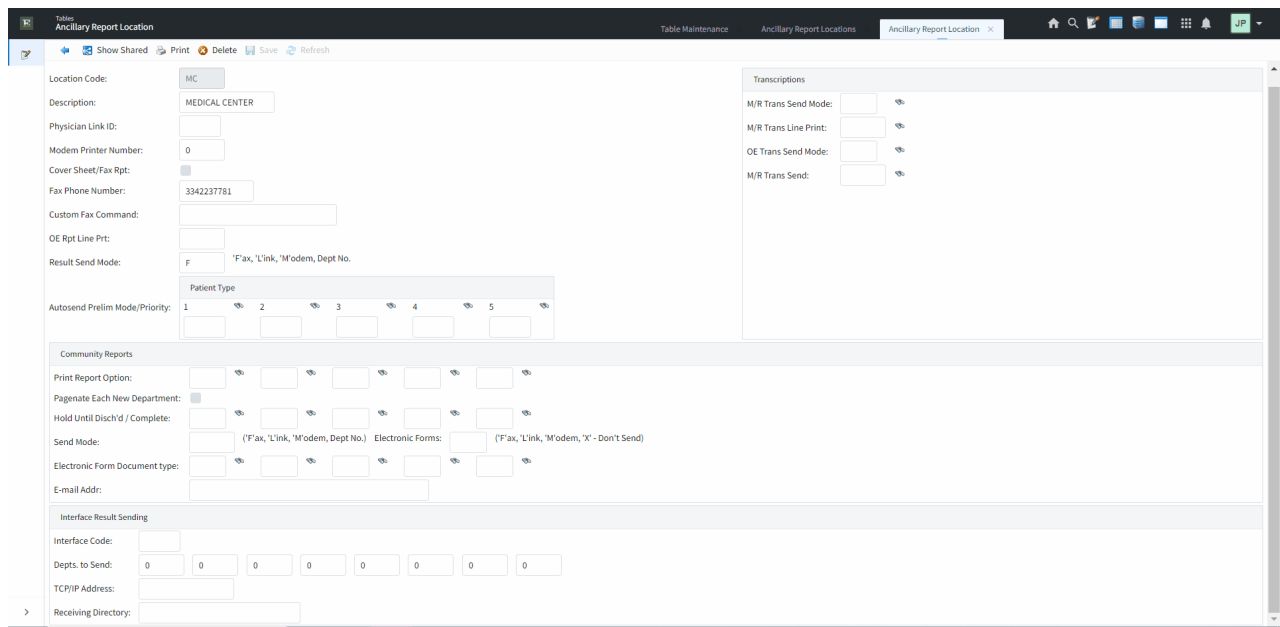
The Exclusion Confirmation Screen will then display a summary of what exclusion settings were created. To exit this screen, the table will need to be closed from the navigation panel.

3.7   Report Locations

Select **New** to enter a new Report Location Code or select an existing code from the list and select **Edit**.

Select **Web Client > Tables > HIM > Report Locations > Select a Location**

Report Locations Maintenance

- **Location Code**: This field displays the three-character Location Code.

- **Description:** Enter a specific Department Location Description up to 13 characters in length.

- **Physician Link ID:** Enter the two-character Physician Link ID in this field. This is required when the Result Send Mode is **L**.

- **Modem Printer No:** Enter the Modem Printer number.

- **Cover Sheet/Fax Rpt:** Select this field if a cover sheet is desired.

- **Fax Phone No:** Enter the Fax Phone Number for this Report Location.

- **Custom Fax Command:** This is a 30-character field that can accommodate any special fax number needed. It may include the 1 for long distance, area code, extension, etc. When there is no entry in field 4, the system will dial the number found in this custom command field.

- **OE Rpt Line Prt:** Enter the Line printer number for Order Entry Reports.

- **Result Send Mode:** This field controls how results and/or transcriptions are sent to the Location. The options are: **F**-Fax, **L**-Physician Link, **M**-Modem Printer, or **P**-Print to designated printer.

- **Autosend Prelim Mode/Priority:** When an order is resulted and completed, the system will refer to this field to determine if and how (mode) the Location receives the Preliminary report. Each of the two-character fields responds to each of the five patient types. The first character of each field determines the mode by which preliminary reports are sent. The options are: **L**-Physicians Link, **M**-Modem Printer, **P**-Lab Printer, and **F**-Fax. The second character determines the priority and may be: **S**-Stat Orders only or **A**-All orders.

- **Print Report Option:** The entry in each of the five fields determines the type of report produced for the corresponding patient type at runtime. The options are: **S**-Single account cumulative vertical, **M**-Multi-account cumulative vertical, **V**-Single account cumulative by Sub-Department, **C**-Multi-account cumulative by Sub-Department, **@**-Lab Results by Physician with Pending, **N**-Non-cumulative vertical, **R**-Lab Results by Physician, **X**-Do not send a report, and blank defaults to option **S** - Single account cumulative.

- **Paginate each new department:** Determines if laboratory sub-departments will print on separate pages for report options **N**, **C**, **V**, **S**, and **M**.

- **Hold Until Disch'd & Complete:** If a **Y** is entered in any of the five fields, then no Community reports will be sent to the location for that Patient Type until the patient has been discharged and all orders have been completed, canceled or discontinued.

- **Send Mode:** Enter **F** - by fax or **M** - by modem, to designate how Community Reports are to be sent.

- **Electronic Form Document Type:** Enter **N** - Narrative (ACD forms), **T** - Template (Clinical forms) or **B** - Both.

- **E-mail Addr:** Enter the e-mail address of the recipient. This is an informational field only.

- **M/R Trans Send Mode:** Select one of the options in the highlighted box to indicate mode for sending transcription documents to this location. **F**ax will utilize the number loaded in field 5-Fax Phone No., **L**ink will send through the Physician Link, **M**odem will send to the number loaded in field 3-Modem Printer No., **P**rint will send to the line printer loaded in the M/R Trans Line Print field, or **X**-Don't Send.

- **M/R Trans Line Print:** Select a line printer for Medical Record Transcription Documents to print to for this Department.

- **OE Trans Send Mode:** The Order Entry department distributes transcriptions to the Locations via options in this field.

- **MR Trans Send:** The Medical Records Department distributes transcriptions to the locations via options in this field. Enter a **P** to send when transcribed, **F** when signed, or **B** for both.

- **Interface Code**: Used for transmitting preliminary laboratory reports to Non-TruBridge physician practice systems.

- **Depts. To Send**: This field should contain all hospital departments that are sending results via the interface defined in field 14.

- **TCP/IP Address**: The TCP/IP Address of the interface PC should be entered in this field.

- **Receiving Directory**: The TruBridge EHR directory that the data should be sent to via the interface.

The following options are available on the action bar:

- **Show Shared**: If the site is sharing tables, when this option is selected the fields that are shared between facilities will be highlighted in yellow.

- **Print**: This option will display the table settings in Adobe.

- **Delete**: This option will delete the table settings.

- **Save**: This option will save the changes made to the table settings.

- **Refresh**: This option will allow changes to show immediately in the Report Location list.

Select **Back Arrow** to return to the previous screen.

3.8   SFTP Setup

The Secure File Transfer Protocol (SFTP) Setup table will be used with the Data Export and Report Scheduler applications located within the Report Dashboard. These options allow CCDA documents to be sent to a configured location. The end location must be configured in the SFTP Setup Table in order to send CCDA documents.

NOTE: In order to access this table, the user must have the Table Maintenance Behavior Control for SFTP Setup set to Allow. Users in the System Administrator Role will have this Behavior Control by default. For more information please see the Identity Management user guide.

The SFTP Setup screen will display a list of locations that have been setup for the facility. The following options are available to filter the locations that are displayed on the screen.

- **Active**: This option allows only those locations currently being used to display.

- **All**: This option allows both the Active and Inactive locations to display.

Select **New** to create an new SFTP location or select an existing location from the list and select **Edit**.

Select **Web Client > Tables > HIM > SFTP Setup > <u>Select a Location</u>**

SFTP Edit

- **SFTP Name**: The name given to the SFTP server.

- **Server Name**: This is the IP address or the URL that will host the SFTP server.

- **Username**: The login that will access the SFTP server.

- **Password**: The password to the SFTP server.

NOTE: The password field is hidden while typing and encrypted in the database to keep the SFTP server access secure.

- **Location**: The file location on the SFTP server where the CCDA documents will be stored.

- **Inactive**: If selected, the SFTP server will not be available from Data Export or the Report Scheduler.

Select **Save** to keep the changes made to the table.

Select **Back Arrow** to return to the previous screen.

View History

The View History option will provide an audit log for the changes made to the locations in SFTP Setup table. To access the audit log, select a location and then select **View History**.

The SFTP History screen will display the following.

- **Date/Time**: The date and time that the change was made to the SFTP Setup table for the selected location.

- **User**: The UBL of the user who made the change.

- **Field**: The field in the SFTP Setup table that was changed.

- **Old Value**: The old value of the field.

- **New Value**: The new value of the field.

Select [Back Arrow icon] **Back Arrow** to return to the previous screen.

3.9   SNOMEDs

This table is not used at this time.

3.10   Xray Film Locations

The Xray Film Locations Table contains the user-defined locations of Xray Film.

Select **Web Client > Tables > HIM > Xray Film Locations**

Xray Film Locations Table

Up to 20 Xray Film Locations may be entered in this table.

The following options are available on the action bar:

- **Show Shared**: If the site is sharing tables, when this option is selected the fields that are shared between facilities will be highlighted in yellow.

- **Print**: This option will display the table settings in Adobe.

- **Delete**: This option will delete the table settings.

- **Save**: This option will save the changes made to the table settings.

- **Refresh**: This option will allow changes to show immediately in the Xray Film Locations table.

Select **Back Arrow** to return to the previous screen.
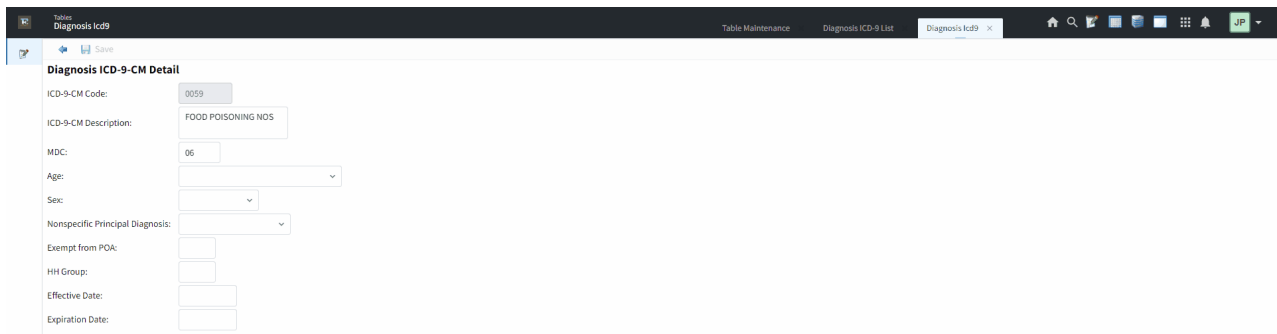
Chapter 4   Diagnosis

4.1   ICD9

The ICD-9 Diagnosis Code table maintains the diagnostic ICD-9 codes used in the TruBridge EHR system.

The search option allows ICD-9 Diagnosis Codes to be looked up by code or description.

Select [New] **New** to enter a new ICD-9 Diagnosis Code or select an existing code from the list and select [Edit] **Edit**.

Select **Web Client > Tables > HIM > ICD9 > <u>Select Code</u>**

ICD-9 Diagnosis Detail

- **ICD-9-CM Code**: Enter the five-character ICD-9 code.

- **ICD-9-CM Description**: Enter the description of the ICD-9 code. This may up to 250 characters.

- **MDC**:This field contains the Major Diagnostic Category for this diagnosis.

- **Age**: If this diagnosis has an age specification, then it should be entered in this field. This character will pull in the first space of the MCE (Medicare Code Edit) field in the DRG Grouper screen when the diagnosis is entered.

- **Sex**: If this diagnosis has a sex specification, then it should be entered in this field. This character will pull in the second space of the MCE (Medicare Code Edit) field in the DRG Grouper screen when the diagnosis is entered.

- **Nonspecific Principal Diagnosis**: If this diagnosis has a Nonspecific Principal Diagnosis qualification, then it should be entered in this field. This character will pull to the third space of the MCE (Medicare Code Edit) field in the DRG Grouper screen when this diagnosis is entered as the principal diagnosis.

- **Exempt from POA**: Answering this field **Y** will populate an E in the @ADM field on the DRG Grouper screen after entering in the diagnosis and leave the POA locator on the UB blank. Answering this **N** will populate a Y in the @ADM field on the DRG Grouper screen after entering in the diagnosis. This field defaults to **Y**.

- **HH Group**: Enter the Home Health Diagnostic Group Code.

NOTE: The HH Group field will only be displayed if the facility is using the TruBridge Home Health software.

- **Effective Date**: The date that this Diagnosis Code became valid.

- **Expiration Date**: The date that this Diagnosis Code is no longer valid.

Select ![Save button] **Save** to keep the changes made to the table.

Select ![Back Arrow button] **Back Arrow** to return to the previous screen.

4.2   ICD10

The ICD-10 Diagnosis Code table maintains the diagnostic ICD-10 codes used in the TruBridge EHR system.

The search option allows ICD-10 Diagnosis Codes to be looked up by code or description.
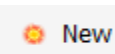
Select ![New button] **New** to enter a new ICD-10 Diagnosis Code or select an existing code from the list and select ![Edit button] **Edit**.
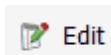
ICD-10 Diagnosis Detail

- **ICD-10-CM Code**: Enter the seven-character ICD-10 code.

- **ICD-10-CM Short Description**: Enter a short description of the ICD-10 code. This may up to 60 characters. The short description will be used in the Diagnosis Description Master.

- **ICD-10-CM Long Description:** Enter the description of the ICD-10 code. This may up to 250 characters.

- **MDC**:This field contains the Major Diagnostic Category for this diagnosis.

- **Age**: If this diagnosis has an age specification, then it should be entered in this field. This character will pull to the MCE (Medicare Code Edit) field in the Grouper screen when the diagnosis is entered.

- **Sex**: If this diagnosis has a sex specification, then it should be entered in this field. This character will pull to the MCE (Medicare Code Edit) field in the Grouper screen when the diagnosis is entered.

- **Nonspecific Principal Diagnosis**: If this diagnosis has a Nonspecific Principal Diagnosis qualification, then it should be entered in this field. This character will pull to the MCE (Medicare Code Edit) field in the Grouper screen when this diagnosis is entered as the Principal Diagnosis.

- **Exempt from POA**: Answering this field **Y** will populate an E in the POA field on the Grouper screen after entering in the diagnosis and leave the POA locator on the UB blank. Answering this **N** will populate a Y in the POA field on the Grouper screen after entering in the diagnosis. This field defaults to **Y**.

- **HH Group**: Enter the Home Health Diagnostic Group Code.

NOTE: The HH Group field will only be displayed if the facility is using the TruBridge Home Health software.

- **Creation Date**: This is the date the ICD-10 was released from CMS.

- **Effective Date**: The date that this Diagnosis Code became valid.

- **Expiration Date**: The date that this Diagnosis Code is no longer valid.
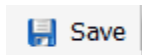
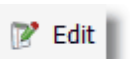Select **Save** to keep the changes made to the table.

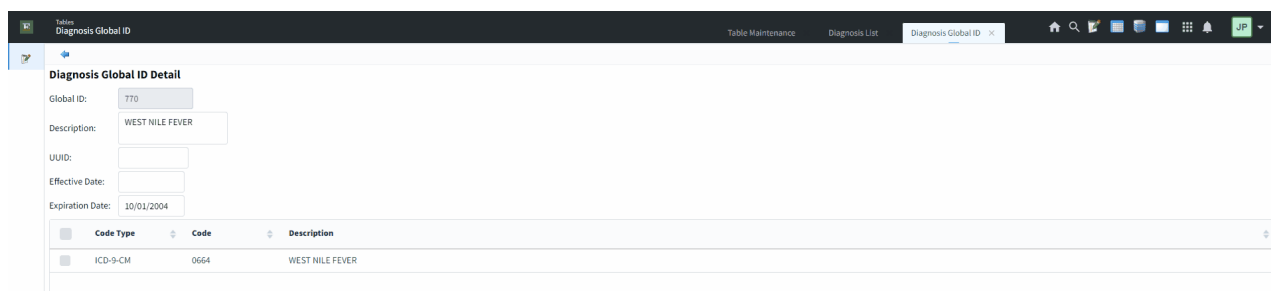Select **Back Arrow** to return to the previous screen.

4.3   Description Master

The Diagnosis Description Master allows global codes and their associated ICD-9, ICD-10, SNOMED to be viewed. Each code is assigned a unique TruBridge number called the Global Code. This Global codes may have ICD-9's, ICD-10's or SNOMED codes attached to them. TruBridge will be responsible for maintaining the Global Codes. For assistance with attaching ICD-9, ICD-10 or SNOMED codes to a Global Code, please contact a TruBridge Support Representative.

The search option allows ICD-9, ICD-10, SNOMED, and Global Codes to be looked up by code or description.

Select **New** to create a new Global Code. To edit an existing code, select a code then select **Edit.**

NOTE: Global codes may be created and edited in the system; however, only a TruBridge Representative may add or edit the corresponding ICD-9, ICD-10, and SNOMED codes.

Diagnosis Description Master Detail

- **Global ID**: The unique TruBridge code assigned to every diagnosis code entered into the table. This number will automatically populate when entering a new diagnosis code and may not be changed.

- **Description**: The description of the Diagnosis Code. The description may not be changed once it is saved.

- **UUID**: The nine-digit code from Clinical Vocab.

- **Effective Date**: The date that this Diagnosis Code became valid.

- **Expiration Date**: The date that this Diagnosis Code is no longer valid.

- **Codes Type**: Identifies they type of code that is tied to the Global ID. This will be an ICD-9, ICD-10, or SNOMED code.

- **Code**: The ICD-9, ICD-10, or SNOMED code that is tied to the Global ID. This field may be up to 20 characters in length.

- **Description**: The description of the ICD-9, ICD-10 or SNOMED code that is tied to the Global ID.
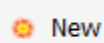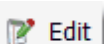
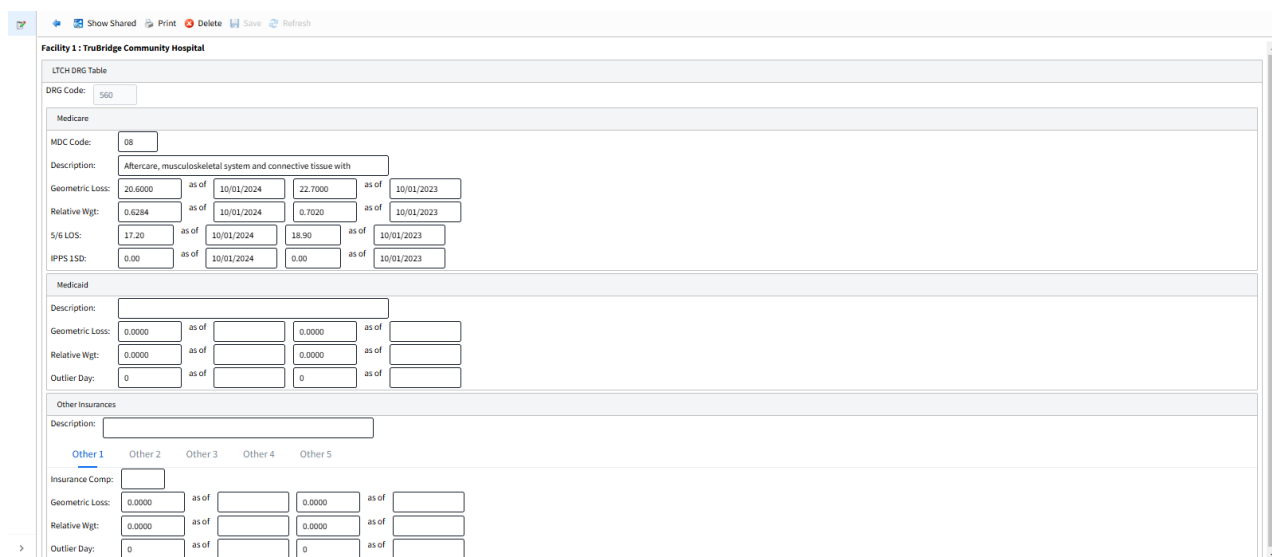Select **Back Arrow** to return to the previous screen.

Chapter 5   DRG LTCH Table

In order to use the DRG LTCH table for DRG Reimbursements the "LTCH:" field must be set to **Y**es on AHIS, page 4.

The search option allows DRGs to be looked up by DRG code or description.

Select **New** to enter a new LTCH DRG code or select an existing code from the list and select **Edit**.

Select **Web Client > Tables > HIM > DRG LTCH Table > <u>Select a Code</u>**

DRG LTCH Maintenance

- **DRG Code**: The three-digit Diagnosis Related Group Code pulls to this field.

- **MDC Code**: The Major Diagnostic Category Code for this DRG is loaded in this field.

- **Description**: The DRG description may contain up to 60 characters. The system will allow a separate description for Medicare, Medicaid and other Insurances.

- **Medicare and Medicaid**: These fields contain the Geometric Length of Stay, Relative Weight, and Outlier Day for Medicare and Medicaid, respectively, that are used in the DRG Reimbursement calculation. The current and previous dates and the values associated with them affect the DRG Reimbursement calculation. For example, using the above table, if a patient is admitted 09/30/13 and discharged 09/30/13 prior values are used in the calculation. If a patient is admitted 09/30/13 and discharged 10/01/13 current values are used in the calculation.

- **Other Insurances**: The Geometric Length of Stay, Relative Weight, and Outlier Day can be loaded for up to five Insurance Company Codes other than Medicare or Medicaid. By selecting tabs **Other 1** through **Other 5**.
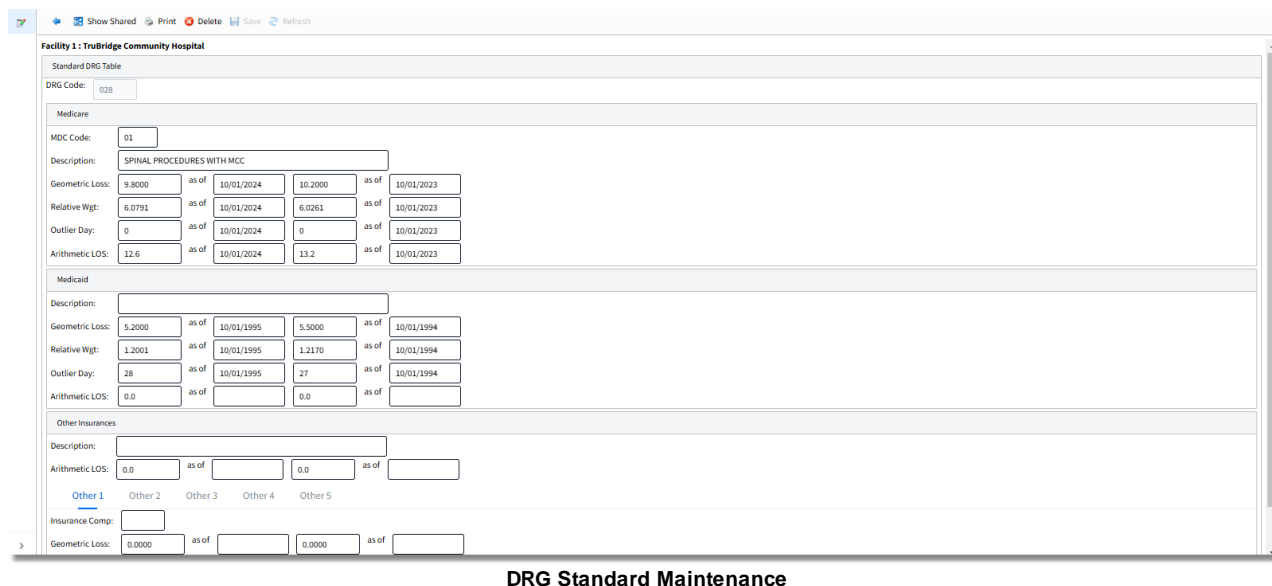
Chapter 6   DRG Standard Table

In order to use the DRG LTCH table for DRG Reimbursements the "LTCH:" field must be set to **Y**es on AHIS, page 4.

The search option allows DRGs to be looked up by DRG code or description.

Select **⚙ New**   **New** to enter a new DRG code or select an existing code from the list and select

📝 Edit   **Edit**.

Select **Web Client > Tables > HIM > DRG Standard Table > Select a Code**

DRG Standard Maintenance

- **DRG Code**: The three-digit Diagnosis Related Group Code pulls to this field.

- **MDC Code**: The Major Diagnostic Category Code for this DRG is loaded in this field.

- **Description**: The DRG description may contain up to 60 characters. The system will allow a separate description for Medicare, Medicaid and other Insurances.

- **Medicare and Medicaid**: These fields contain the Geometric Length of Stay, Relative Weight, and Outlier Day for Medicare and Medicaid, respectively, that are used in the DRG Reimbursement calculation. The current and previous dates and the values associated with them affect the DRG Reimbursement calculation. For example, using the above table, if a patient is admitted 09/30/13 and discharged 09/30/13 prior values are used in the calculation. If a patient is admitted 09/30/13 and discharged 10/01/13 current values are used in the calculation.

- **Other Insurances**: The Geometric Length of Stay, Relative Weight, and Outlier Day can be loaded for up to five Insurance Company Codes other than Medicare or Medicaid. By selecting tabs **Other 1** through **Other 5**.

Chapter 7   HIE/RHIO Exchanges

Please contact a TruBridge Support Representative to make changes to this table.
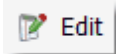
Chapter 8   HIE/RHIO Documents

Please contact a TruBridge Support Representative to make changes to this table.

Chapter 9   ICD SNOMED Crosswalk Table

This table is not used at this time.

Chapter 10 MR Chart Locations

The MR Chart Locations Table contains the user-defined locations of Medical Record charts. These are used with the Chart Tracking module in Medical Records.

Select **New** to enter a new Chart Location Code or select an existing code from the list and select **Edit.**

Select **Web Client > Tables > HIM > MR Chart Locations > <u>Select a Chart Location</u>**
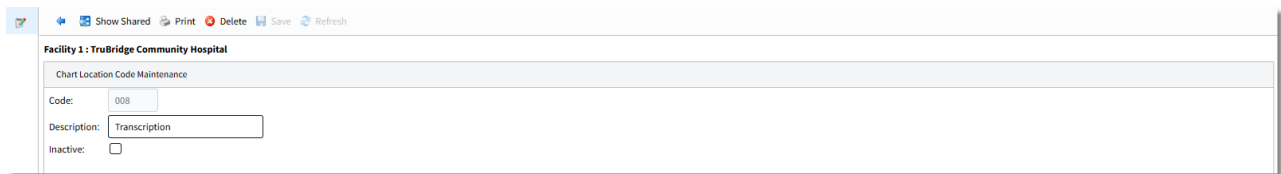

Chart Location Maintenance

- **Code**: Enter a three-character code for the location.

- **Description**: Enter a Description for the location.

- **Inactivate:** Will prevent this Chart Location from displaying in the lookup options and will prevent this location from being entered in the TruBridge System. This location may be activated at anytime by de-selecting the Inactive field.

The following options are available on the action bar:

- **Show Shared**: If the site is sharing tables, when this option is selected the fields that are shared between facilities will be highlighted in yellow.

- **Print**: This option displays the table settings in Adobe.

- **Delete**: This option deletes the table settings.

- **Save**: This option saves changes made to the table settings.

- **Refresh**: This option allows changes to show immediately in the Chart Location list.

Select **Back Arrow** to return to the previous screen.
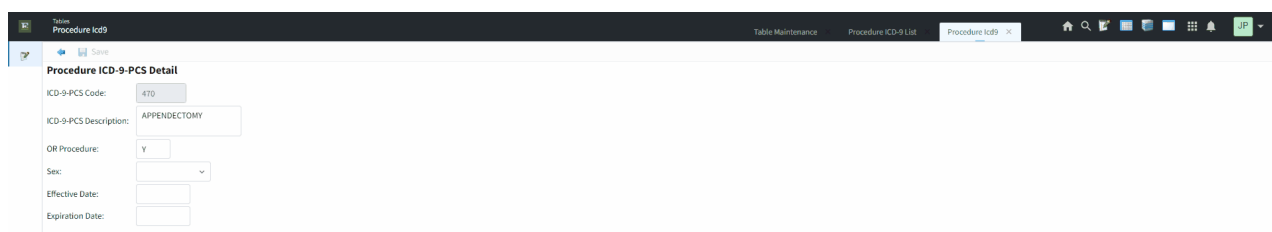
Chapter 11 Procedure

11.1 ICD9

The ICD-9 Procedure Code table maintains the procedural ICD-9 codes used in the TruBridge EHR system.

The search option allows ICD-9 Procedure Codes to be looked up by code or description.

Select **New** to enter a new ICD-9 Procedure Code or select an existing code from the list and select **Edit**.

Select **Web Client > Tables > HIM > ICD9 > Select Code**

ICD-9 Procedure Detail

- **ICD-9-PCS Code**:Enter the five-character ICD-9 code.

- **ICD-9-PCS Description**:Enter the description of the ICD-9 code. This may up to 250 characters.

- **OR Procedure**: Enter a Y to indicate that this is an Operating Room procedure. This will allow this procedure code to pull to the Operative Procedures report.

- **Sex**: If a procedure has a sex specification, then it should be entered in this field. This character will pull to the MCE (Medicare Code Edit) field in the DRG Grouper screen if the patient does not meet this specification.

- **Effective Date**: The date that this Procedure Code became valid.

- **Expiration Date**: The date that this Procedure Code is no longer valid.

Select **Save** to keep the changes made to the table.

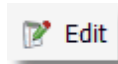Select **Back Arrow** to return to the previous screen.

11.2   ICD10

The ICD-10 Procedure Code table maintains the procedural ICD-10 codes used in the TruBridge EHR system.

The search option allows ICD-10 Procedure Codes to be looked up by code or description.

Select **New** to enter a new ICD-10 Procedure Code or select an existing code from the list and select **Edit**.

Select **Web Client > Tables > HIM > ICD10 > Select Code**

ICD-10 Procedure Detail

- **ICD-10-PCS Code**: Enter the seven-character ICD-10 code.

- **ICD-10-PCS Short Description**: Enter a short description of the ICD-10 code. This may up to 60 characters. The short description will be used in the Procedure Description Master.

- **ICD-10-PCS Long Description:** Enter the description of the ICD-10 code. This may up to 250 characters.

- **OR Procedure**: Enter a Y to indicate that this is an Operating Room procedure. This will allow this procedure code to pull to the Operative Procedures report.

- **Sex**: If a procedure has a sex specification, then it should be entered in this field. This character will pull to the MCE (Medicare Code Edit) field in the Grouper screen if the patient does not meet this specification.

- **Non-covered Procedure**: If this procedure has a non-covered procedure specification, then it should be entered in this field. This character will pull to the MCE (Medicare Code Edit) field in the Grouper screen when this procedure is entered.

- **Creation Date**: This is the date the ICD-10 was released from CMS.

- **Effective Date**: The date that this Procedure Code became valid.

- **Expiration Date**: The date that this Procedure Code is no longer valid.
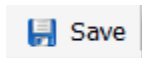
Select   **💾 Save**   **Save** to keep the changes made to the table.

Select   **⬅**   **Back Arrow** to return to the previous screen.

11.3   Description Master

The Procedure Description Master allows global codes and their associated ICD-9, ICD-10, SNOMED to be viewed. Each code is assigned a unique TruBridge number called the Global Code. This Global Codes may have ICD-9's, ICD-10's or SNOMED codes attached to them. TruBridge will be responsible for maintaining the Global Codes. For assistance with attaching ICD-9, ICD-10 or SNOMED codes to a Global code, please contact a TruBridge Representative.

The search option allows ICD-9, ICD-10, SNOMED, and Global Codes to be looked up by code or description.
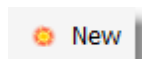
Select   **⚙ New**   **New** to create a new Global Code. To edit an existing code, select a code then select   **📝 Edit**   **Edit.**
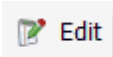
NOTE: Global Codes may be created and edited in the system; however, only a TruBridge representative may add or edit the corresponding ICD-9, ICD-10, and SNOMED codes.

Select **Web Client > Tables > HIM > Description Master > <u>Select Description</u>**

Procedure Description Master Detail

- **Global ID**: The unique TruBridge code assigned to every Procedure Code entered into the table. This number will automatically populate when entering a new procedure code and may not be changed.

- **Description**: The description of the Procedure Code. The description may not be changed once it is saved.

- **UUID**: The nine-digit code from Clinical Vocab.

- **Effective Date**: The date this Procedure Code became valid.

- **Expiration Date**: The date this Procedure Code is no longer valid.

- **Codes Type**: Identifies they type of code that is tied to the Global ID. This will be an ICD-9, ICD-10, or SNOMED code.

- **Code**: The ICD-9, ICD-10, or SNOMED code that is tied to the Global ID. This field may be up to 20 characters in length.

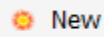- **Description**: The description of the ICD-9, ICD-10 or SNOMED code that is tied to the Global ID.

Select [Back Arrow icon] **Back Arrow** to return to the previous screen.

Chapter 12 Inpatient Psychiatric PPS

12.1   Age Adjustment

The Age Adjustment Table provides the adjustment amounts to be used in the calculation based on the age of the patient.

Once the table is selected, the system will display the Age From and To and the As of Date for the existing table entries.

Select **New** to create a new entry or select an existing entry from the list and select **Edit**.

Select **Web Client > Tables > HIM > Age Adjustment > <u>Select Entry</u>**

Age Adjustments Maintenance

The From and To Age range and Amounts will be the same for every facility. This data can be found in the Federal Register.

The following options are available on the action bar:

- **Show Shared**: If the site is sharing tables, when this option is selected, the fields that are shared between facilities will be highlighted in yellow.

- **Print**: This option displays the table settings in Adobe.

- **Delete**: This option deletes the table settings.

- **Save**: This option saves changes made to the table settings.

- **Refresh**: This option allows changes to show immediately in the Age Adjustments list.

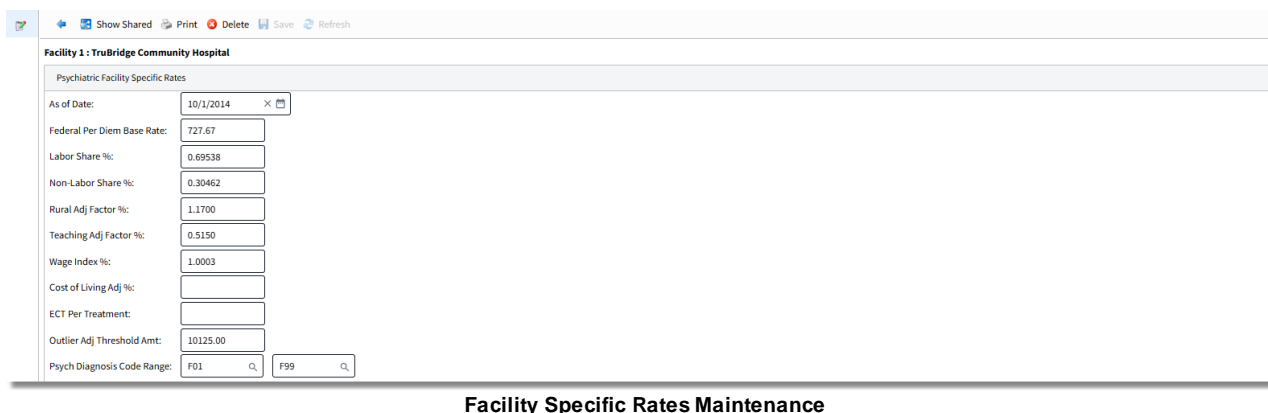Select **Back Arrow** to return to the previous screen.

12.2 Facility Specific Rates

The Facility Specific Rates table contains reimbursement information for Psychiatric facilities. The data loaded in this table can be found in the Federal Register.

Once the table is selected, the system will display the Starting and Ending ICD-10 range and the As of Date for the existing table entries.

Select **New** to create a new entry or select an existing entry from the list and select **Edit**.

Select **Web Client > Tables > HIM > Facility Specific Rates > <u>Select Entry</u>**

Facility Specific Rates Maintenance

The Federal Per Diem Base Rate, Labor Share %, Non-Labor Share %, ECT Per Treatment, Outlier Adj Threshold Amt will be the same for every facility. The facility will need to manipulate the tables as this information is updated or changed by Medicare. The Rural Adj Factor, Teaching Adj Factor %, Wage Index % and the Cost of Living Adj % will be site-specific and may or may not be applicable. The Cost of Living Adj % only applies to facilities in Hawaii and Alaska and can be found in the Final Rule of the Federal Register.

- **Psych Diagnosis Code Range**: If the Primary Diagnosis Code for a patient account is within the range of diagnosis codes entered in this field the psych reimbursement method will be used. A search feature may be accessed by selecting the lookup.

The following options are available on the action bar:

- **Show Shared**: If the site is sharing tables, when this option is selected the fields that are shared between facilities will be highlighted in yellow.

- **Print**: This option displays the table settings in Adobe.

- **Delete**: This option deletes the table settings.

- **Save**: This option saves changes made to the table settings.

- **Refresh**: This option allows changes to show immediately in the Facility Specific Rates list.

Select **Back Arrow** to return to the previous screen.

12.3   ICD 10 Diagnosis Categories

The ICD-10 adjustment amounts only apply to secondary diagnoses. The system utilizes the ICD-10 Adjustment Table to get the appropriate adjustment amounts for each secondary diagnosis loaded on the patient account. These adjustment amounts are multiplied together when used in the Psych PPS calculation.

Once the table is selected, the system will display the Category Code, Category Description, ICD-10 Diagnosis Code range, and the As of Date for the existing table entries.
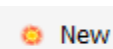
Select **New** to create a new entry or select an existing entry from the list and select **Edit**.
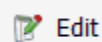
Select **Web Client > Tables > HIM > ICD10 Diagnosis Categories > Select Entry**

ICD-10 Adjustments Maintenance

The ICD-10 Codes and Amounts will be the same for every facility. This data can be found in the Federal Register.

The following options are available on the action bar:

- **Show Shared**: If the site is sharing tables, when this option is selected the fields that are shared between facilities will be highlighted in yellow.

- **Print**: This option displays the table settings in Adobe.

- **Delete**: This option deletes the table settings.

- **Save**: This option saves changes made to the table settings.

- **Refresh**: This option allows changes to show immediately in the ICD-10 Diagnosis Categories list.

Select **Back Arrow** to return to the previous screen.

12.4 Per Diem

The Per Diem adjustment table provides the daily adjustment amounts to be used for the individual days of a patient's stay.

Once the table is selected, the system will display the Per Diem Days From and To and the As of Date for the existing table entries.
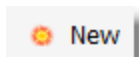
Select **New** to create a new entry or select an existing entry from the list and select **Edit**.
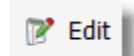
Select **Web Client > Tables > HIM > Per Diem > Select Entry**

Per Diem Adjustments Maintenance

The Per Diem From and To days and Amounts will be the same for every facility. This data can be found in the Federal Register.

The following options are available on the action bar:

- **Show Shared**: If the site is sharing tables, when this option is selected the fields that are shared between facilities will be highlighted in yellow.

- **Print**: This option displays the table settings in Adobe.

- **Delete**: This option deletes the table settings.

- **Save**: This option saves changes made to the table settings.

- **Refresh**: This option allows changes to show immediately in the Per Diem Adjustments list.

Select **Back Arrow** to return to the previous screen.

12.5   Psychiatric DRGs

The DRG adjustment amounts only apply when a DRG found in the table is the calculated DRG on the patient's account in the Medical Record Grouper screen. An account does not have to have one of the DRG's loaded in this table for the Psych PPS calculation to apply.

Once the table is selected, the system will display the DRG code, DRG Description and the As of Date for the existing table entries.
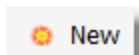
Select **New** to create a new entry or select an existing entry from the list and select **Edit**.
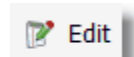
Select **Web Client > Tables > HIM > Psychiatric DRGs > Select Entry**

DRG Adjustments Maintenance

The DRG Codes and Amounts will be the same for every facility. This data can be found in the Federal Register.

The following options are available on the action bar:

- **Show Shared**: If the site is sharing tables, when this option is selected the fields that are shared between facilities will be highlighted in yellow.

- **Print**: This option displays the table settings in Adobe.

- **Delete**: This option deletes the table settings.

- **Save**: This option saves changes made to the table settings.

- **Refresh**: This option allows changes to show immediately in the Psychiatric DRGs list.

Select **Back Arrow** to return to the previous screen.