

## Add ICD Codes for a Patient (nonHH)

1. Pull up the patient from the **Select Patient** screen (Main Menu).
2. From Barnestorm Office click the **Patient Histories** button from the Main Menu. A menu will pop up right underneath that, and from there you will select **ICD History**. From Point of Care select the **ICD History** button or use the **Current ICD > Edit ICDs** screen within a visit assessment.

You can key up to 50 ICD codes into the history. Note that only the first 15 will pull into the 485.

### **Step 1: Adding a New Effective Date**

3. Under the **ICD Effective Dates** label, click on the drop down arrow to select the from date for the new ICD codes. Or type in the date that you desire. This will be the date of the visit to your patient, when you determined that the condition of the patient has changed. This occurs most frequently on a resumption of care after an inpatient stay.

Note: If you are entering ICD codes for the first time, be sure the From date is at least on or before the patient's admit date. This could cause billing issues.

4. Click the **New Date** button. This will populate the date selected into the list of **ICD From Date** in the panel below. If a previous date already exist then the most recent ICD codes will copy into the new **ICD From Date**.

### **Step 2: Add/Change/Remove Diagnosis Code for Selected Effective Date:**

5. To add diagnosis: Look up diagnosis code, by Code/Number or by Description. A list of all codes that contain those numbers or description will appear. Select the appropriate code.
6. Select the onset date, O/E, and severity level. (The Onset Date cannot be dated after the ICD From Date.) Click Save button after each entry. Proceed with next code entry.

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7. When finished entering all codes click on the red **Save All Changes** button and then **Exit**.

100230 - TYME, JUST N Admitted 09/09/2005 View Codes Only Save All Changes Help Exit

Step 1: Select the effective date. If the patient's condition changed, add a new date. Step 2: Add / change diagnoses as needed.

**1: ICD Effective Date**  
Dates diagnosis codes changed for this patient:  
11/08/05  
09/09/05

To add a new date, select it and click New Date.  
11/ 8/2005

Remove date and codes.

**2: Add / Change / Remove Diagnosis Code for Selected Effective Date**  
To add a new code, click the Add a New Diagnosis Code button, look up code, and Save.  
To edit a code, select it from the list below, make changes, and Save Changes.

**Look up Diagnosis Code**

Code Number	Code Description
ICD Code: <input type="text"/>	<input type="text"/>

**Severity (OASIS)**  
 0  1  2  3  4

**Onset or Exacerbation Tracking (485)**  
O=Onset, E=Exacerbation:  O  E  blank

Date of O/E: 9/ 9/2005

Click the Save All Changes button at the top right of the screen to save all changes.

**Change Order of Diagnosis Codes**  
Use these buttons to re-order the ICD codes. Only the top 6 ICDs will appear on the OASIS.

##	Onset Date	Code	Description	O/E	Sev
01	08/01/05	788.30	URINARY INCONTINENCE, UNSPECIFIED	O	
02	09/09/05	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		0

Knowledgebase

<http://kb.barnestorm.biz/KnowledgebaseArticle50218.aspx>