There are two potential ways to correctly enter Current ICDs on SOC/ROC visit notes:

If you have coders:

1. Clinicians complete visit.
2. Coders enter codes using ICD History and communicate to nurse when coding is complete.
3. Nurse re-opens visit, goes to Currect ICD screen, and clicks Pull to pull the codes.
4. Nurse rebuilds 485 and OASIS afterward to be sure to pick up matching codes on all documentation.

If nurses do their own coding:

1. Clinician goes to Current ICD screen in the visit note, clicks Edit ICDs, and adds a new ICD set on the admission date.
2. Once ICD History is complete, nurse closes that pop-up, which leaves her back on the Current ICD screen, and clicks Pull to pull the codes.
3. Nurse rebuilds 485 and OASIS to be sure to pick up matching codes on all documentation.

The reason for these procedures is to ensure that the ICD set matches on 485, OASIS, and visit for audit purposes. Nurses will never enter individual codes on the Current ICD screen, as that will create a mismatch.

Knowledgebase
http://kb.barnestorm.biz/KnowledgebaseArticle51477.aspx