Nuance CDE Clinical Documentation Excellence

User Guide

Release 2.1.1

Nuance® CDE

Client Support

Phone:	800.892.5049
Fax:	877.238.2776
Web Portal:	http://www.nuance.com/support/index.htm

Proprietary Statement

Copyright Statement

Contents

List of Figures

List of Tables

What's New

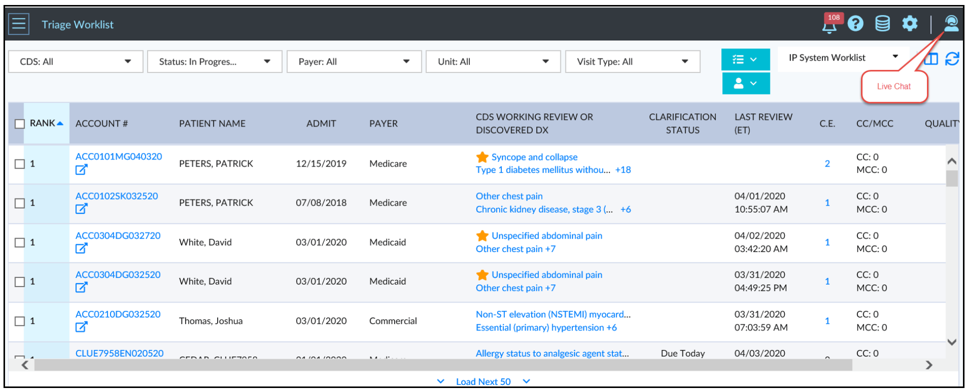
Table 1: General Enhancements

Enhancement	Reference
The Product Training section now includes training for **Getting Started with CDE For the Coder** .	CDE Training on page xix
CDE Login page copyright year has been updated.	First Time Sign In on page 39 Standard Sign In on page 40
Tooltip has been added to the values of **Admit DX** column of *Triage Worklist* screen. The **Facility** drop-down now shows a list of facility ids with their respective description. Current user and date/time information can be added to the worksheet section using a short-cut key.	Triage Worklist Columns and Descriptions on page 51 Triage Worklist Screen Features and Descriptions on page 48 About Worksheet on page 89
Refresh button has been provided on the *Laboratory* tab of the *CDS Assistant* screen. Documents in the *Document Viewer* tab of the *CDS Assistant* screen, can now be sorted as newest to oldest or oldest to newest.	Overview of CDS Assistant on page 74 Document Viewer on page 85
Users can navigate to individual notifications or clarifications through the notification panel. While editing existing notes or clarifications, users can navigate to other notifications through the notification panel. The existing edited notes or clarifications stay in draft mode. Notifications for individual encounters can be followed or unfollowed.	Working with Notifications on page 140 Follow or Unfollow Notifications on page 142
Triage Prioritization Logic has been updated.	Overview of Prioritization on page 193
New reference categories *Patient Safety Indicators (AHRQ) Adult* and *Patient Safety Indicators (AHRQ) Pediatric* have been added to *Knowledge Base*. The Patient Safety Indicators (PSI) help in measuring the safety of hospital care through analysis of inpatient discharge data.	About Knowledge Base on page 175 Patient Safety Indicators (AHRQ) Adult on page 188 Patient Safety Indicators (AHRQ) Pediatric on page 189

Live Chat

Overview

CDE is offering Live Chat for some customers. This feature allows the CDS to connect with a Training or Support agent and chat with the agent live. This feature may also be used to facilitate virtual remote training sessions either at go live or after. Virtual training and support allows your agent to send the CDS a URL in the Live Chat dialog box. The user will click the URL to initiate the virtual training or support session. Users can chat by typing and also share their screen with support team and get resolution to the issues faced by them.



Live chat provides two options:

- Support – for ‘how to’ types of CDE application questions
- Training – for CDI process training

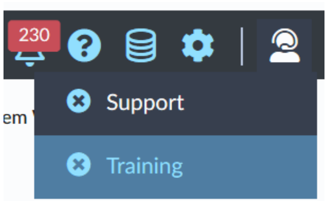


Figure 1: Live Chat - Options

For any kind of support, a window pops up and gives the status of support agent availability. In case the agent is available, you can chat in the window.

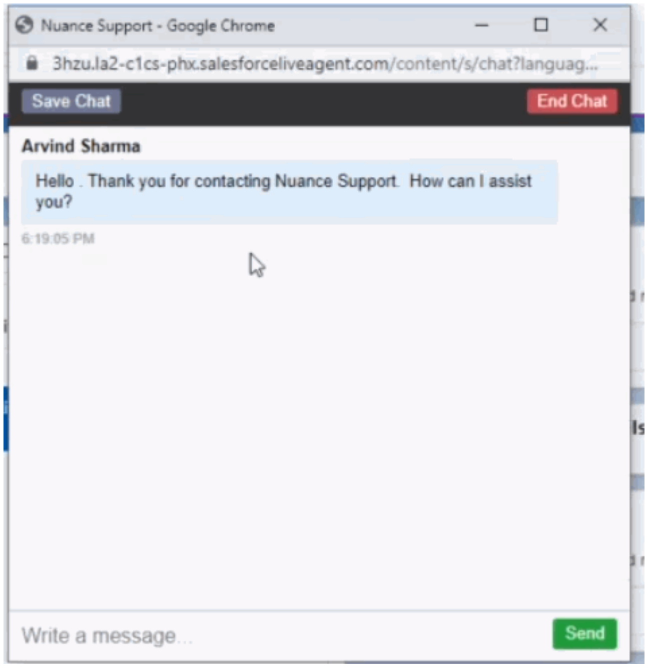


Figure 2: Live chat Window - Agent Available

In case the agent is unavailable, you will have to wait and try again.

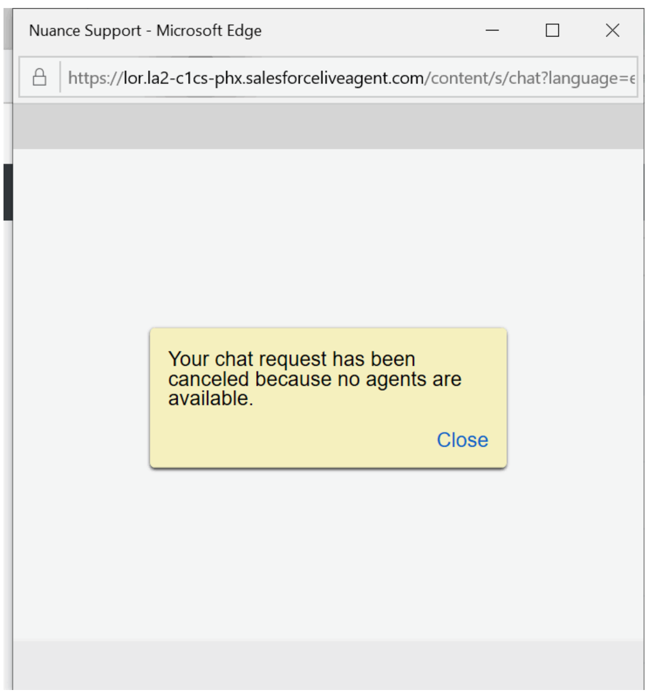


Figure 3: Live chat Window - Agent Unavailable

Features

- When Support or Training option is selected, following information is passed to SalesForce Live Chat: - Training or support, First Name, Last Name, Email Address, the user's Healthcare Organization. User does not need to share this information manually with the Agent
- User is made aware of with whom he/she are live chatting with.

- Audio or video is made available from the Live Chat dialog for either Training or Support. The Agent embeds a link that launches the audio and video screen sharing application.

The live chat facility is currently only available to select early adopters. Please reach out to support if you would like to be considered as part of the early adopter program.

Client Support:

Phone: 800.892.5049

Fax: 877.238.2776

Web Portal: http://www.nuance.com/support/index.htm

CDE Training

This content will help you find links to training and resources that will help you get up to speed on the CDE One workflow, plus in-depth training on all the features and functionality of CDE One.

We have designed the training modules so that you can learn the entire workflow or return for a quick refresher on a specific topic if you need some help from a tutorial or the FAQs. The content is divided into three sections:

What's New

This section highlights from each major product release with training on the new features and functions.

- What's New for CDE 2.0
- What’s New for CDE 2.0.3
- What's New for CDE 2.1
- What’s New for CDE 2.1.1

Product Training

This is a series of training modules, giving you in-depth training for each phase of the CDE workflow. Each module includes interactive lessons, best practices, frequently asked questions and practice scenarios. These modules are equally useful for new CDSs or for current CDSs that need a refresher on the workflow or product functionality.

- Getting Started With CDE
- The CDE Workflow
- Navigating CDE
- Managing Your Worklist
- The CDE Worksheet
- CDS Assistant
- Review
- Clarifications
- Reconciliation
- Getting started with CDE For the Coder

Resources

These are links to our CDE application training resources, like training end user guides and quick reference guides.

- CDE CDS Training End User Guide
- CDE Quick Reference Guide

Chapter 1

About This Guide

Topics:

Overview

This user guide provides in-depth information about Nuance CDE.

Audience and Assumptions

The information in this guide is prepared on the assumption that you have:

- Experience working in the Microsoft Windows environment.
- A computer that has access to Nuance CDE and is connected to a network.
- Appropriate access to patient records.
- Appropriate permission within the application to perform the tasks outlined in this guide. If you find you cannot perform a certain task, check with your System Administrator to see if you have been assigned the appropriate permission.

Chapter 2

About Nuance CDE

Topics:

What is Nuance CDE

Nuance CDE is a comprehensive portfolio of documentation guidance technologies and services that enable CDI teams to focus on quality, and improve clinical and revenue integrity.

Benefits of Nuance CDE

CDE One includes functionality and features to improve workflow, effectiveness, and outcomes. Some benefits of CDE One include:

- **Security and stability**: Industry-best disaster recovery and business continuity.
- **Faster deployment**: Nuance can take input from clients and quickly deploy to all customers. Customers' IT teams no longer will have to manage releases as with existing on-premise solutions.
- **Cost savings**: Cloud-based architecture will decrease IT and support costs.
- **One user experience**: CDI teams benefit from a new design, seamlessly transition between encounter prioritization and workflow management while increasing efficiency, productivity, and satisfaction.
- **Advanced analytics**: Cloud-based architecture allows clients to generate program status dashboards, drill-down reports and peer-group comparisons, as often as they'd like. No more manual data submission.

Advantages of Nuance CDE

This section describes the advantages of using Nuance CDE.

- Priority ranking of encounters which can be configured
- CLU (Clinical Language Understanding) based columns to reflect the following:
    - CLU suggested or user added codes
    - CC/MCC counts
    - Quality indicators
- All the diagnoses and procedure codes suggested by CLU are displayed under CDS Assistant
- Snippets of documents containing CLU suggested code evidence are displayed in the CDS Assistant snippet view, and the complete document is displayed in the Document Viewer within CDS Assistant

Chapter 3

Getting Started

Topics:

About Getting Started

This chapter covers the following initial procedure that you need to perform before using Nuance CDE.

- Overview of Browser on page 30
- First Time Sign In on page 39
- Standard Sign In on page 40
- Rules for Creating Passwords on page 42
- Updating Password on page 41
- Logging Out on page 44

Before you start using the application, your system administrator must set up an account for you and the screen resolution must be 1280 x 768 (or higher) pixels.

Browser Configuration

Overview of Browser

Nuance CDE uses Microsoft Internet Explorer as its web browser. For the application to function properly, you need to configure your browser to display the correct font size, use the proper settings, and get updated pages every time it connects to the server.

Configuring Standard Browser Settings

Note: Please make sure that you are not signed in to Nuance CDE application when configuring the browser.

1. Start Internet Explorer.
2. Configure the Internet options as follows:
   a. Select **Tools** > **Internet Options**.
   b. On the **General** tab, in the **Temporary Internet Files** or **Browsing History** section, click **Settings**.

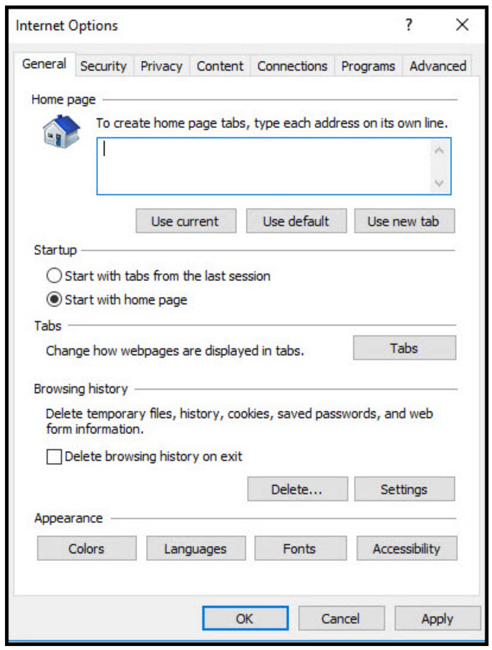


Figure 4: General Tab

   c. On the **Temporary Internet Files** tab, from the **Check for newer versions of stored pages** section, select one of the following radio buttons as necessary:
      - **Every time I visit the page**
      - **Every time I start Internet Explorer**
      - **Automatically**

Note: Do not select the **Never** radio button.

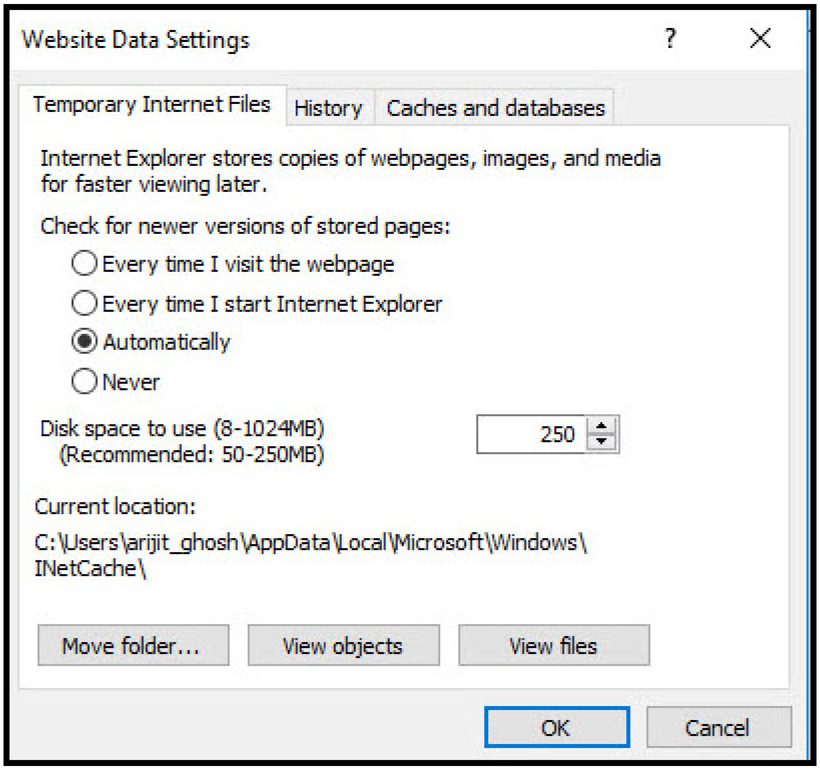


Figure 5: Temporary Internet Files Tab

- **d.** Click **OK** to close the **Settings** window and apply the change.
- **e.** Click **OK** to close the Internet Options window.

3. Configure the text size by selecting **View** > > **Text Size** > **Medium**.
4. Configure the encoding by selecting **View** > **Encoding** > **Auto-Select**.
5. Restart your browser to apply all settings.

Note: The use of supplemental browser toolbars such as Yahoo! Companion or Google is not recommended with Nuance CDE. You should remove or disable these toolbars when using Nuance CDE.

Disabling the Clipboard Pop Up

This section describes how to disable the clipboard pop-up.

1. In the Internet Explorer browser window, select **Tools** > **Internet Options**.
2. In the Internet Options window, Click the **Security** tab.

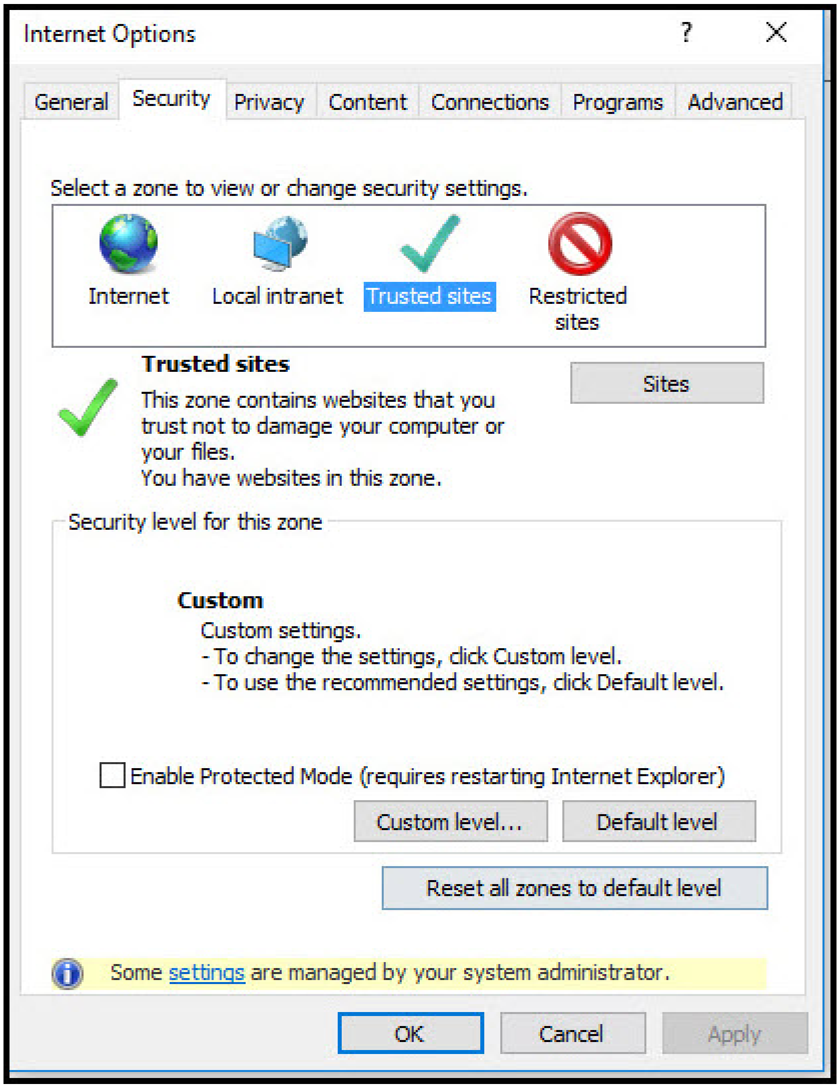


Figure 6: Security Tab- Trusted Sites Settings

3. Click the **Trusted Sites** symbol.
4. From the **Security** tab, click the **Custom Level** button.
   The Security Settings - Trusted Sites Zone window is displayed.

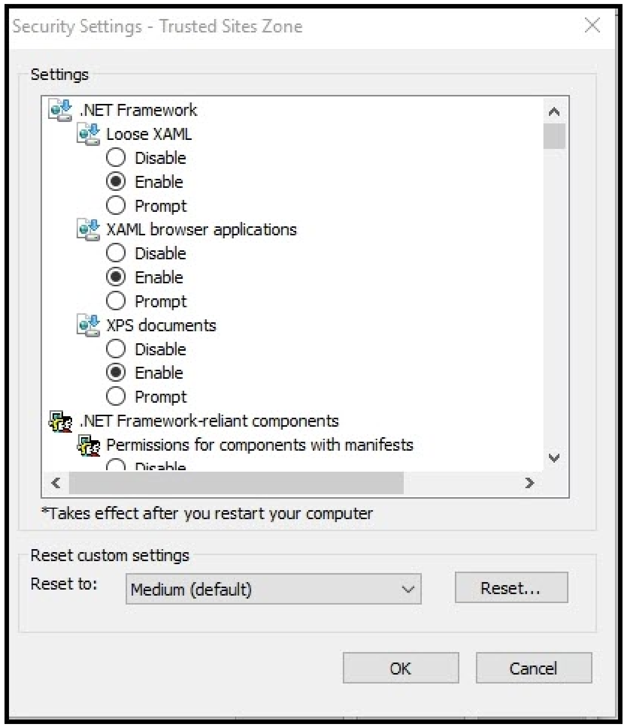


Figure 7: Security Settings - Trusted Sites Zone

5. From the **Scripting** section, select **Enable** for **Allow Programmatic Clipboard Access**.

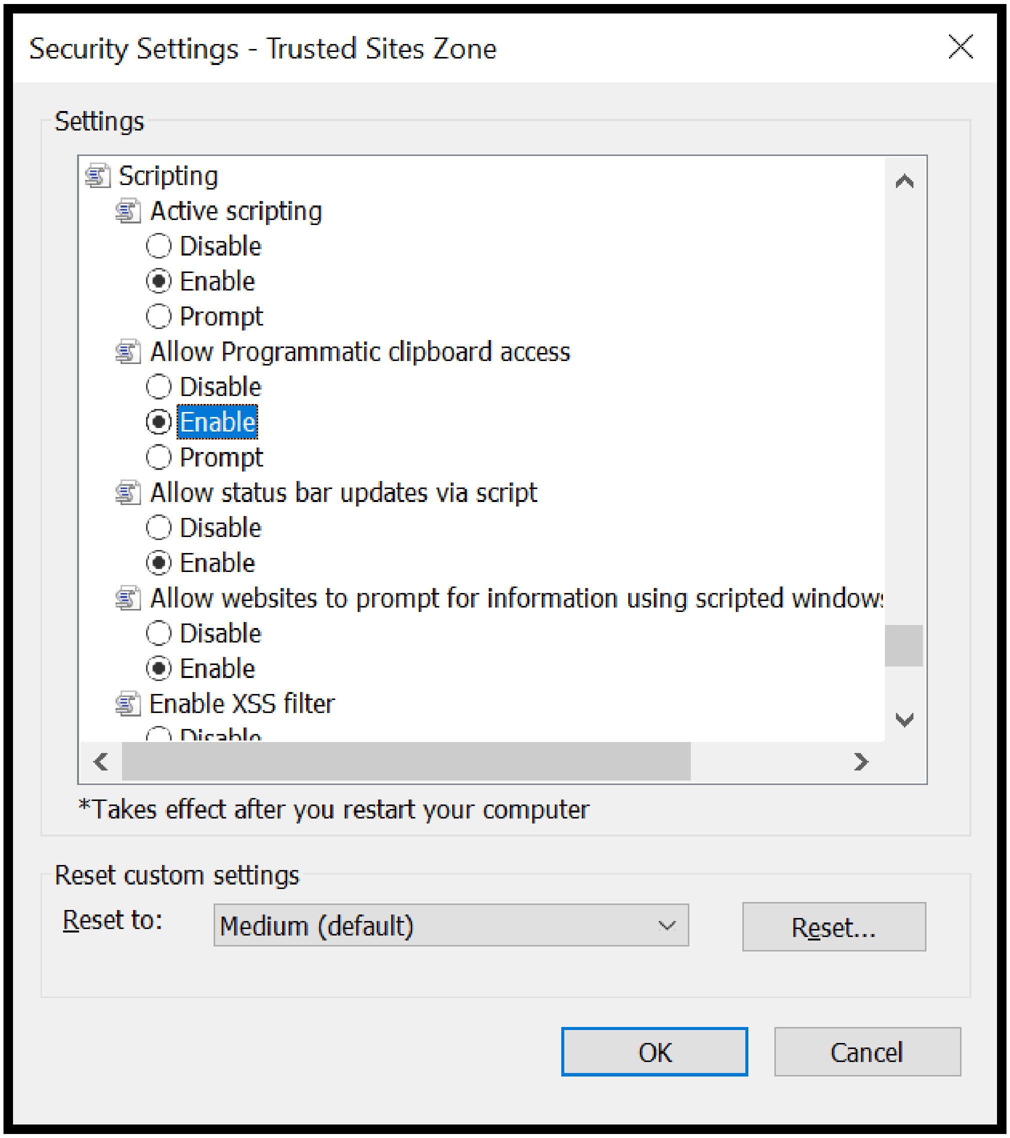


Figure 8: Security Settings Scripting

6. Click **OK** to return to the Internet Options window.

Security Settings

Requisites for Configuring Security Settings

Prior to running the application or integration, the following Internet Explorer settings must be set. These settings apply to any workstation that uses the application or integration. The Nuance CDE server is added as a trusted site, so that these settings apply only to the Nuance CDE application, but do not affect other Internet or Intranet applications.

You can use the Internet Explorer Administration Kit (IEAK) provided by Microsoft to create and manage custom browser software packages with the application settings. When these packages are installed on clients' desktops, they receive customized versions of Internet Explorer with the settings and options selected. After you deploy Internet Explorer, you can use the IEAK Profile Manager to change browser settings and restrictions automatically.

Configuring Security Settings

These settings apply only to Nuance CDE, and do not affect other Internet or Intranet applications you use from your browser.

1. Take note of the location of the Nuance CDE production server (and test server, if applicable). You can find the name of the location by opening the application and viewing the URL. The name appears after https:// and is followed by a colon.
2. In the Internet Explorer browser window, select **Tools\Internet Options**.
3. In the Internet Options window, Click the **Security** tab.

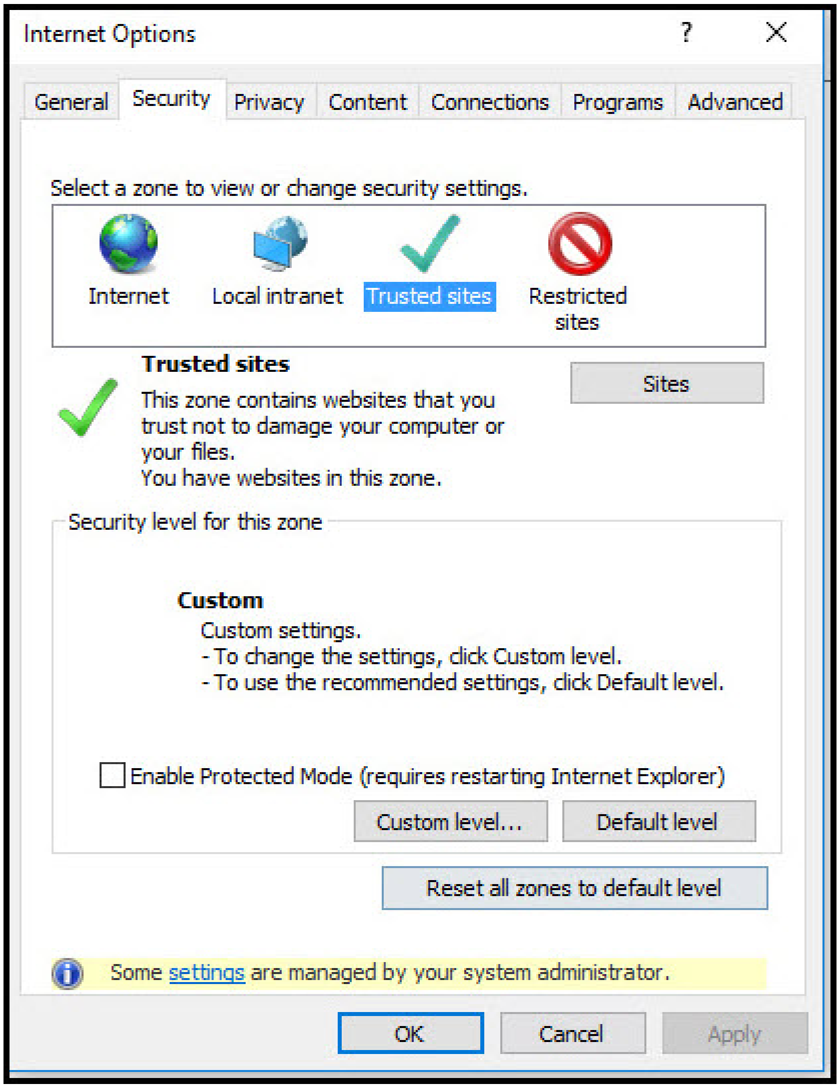


Figure 9: Security Tab- Trusted Sites Settings

4. Click the **Trusted Sites** symbol and then click the **Sites** button
5. In the **Trusted Sites** window, do the following:
   a) In the edit box located at top of the window, type `https://<application URL>` and then click the **Add** button. The name appears in the Websites list.

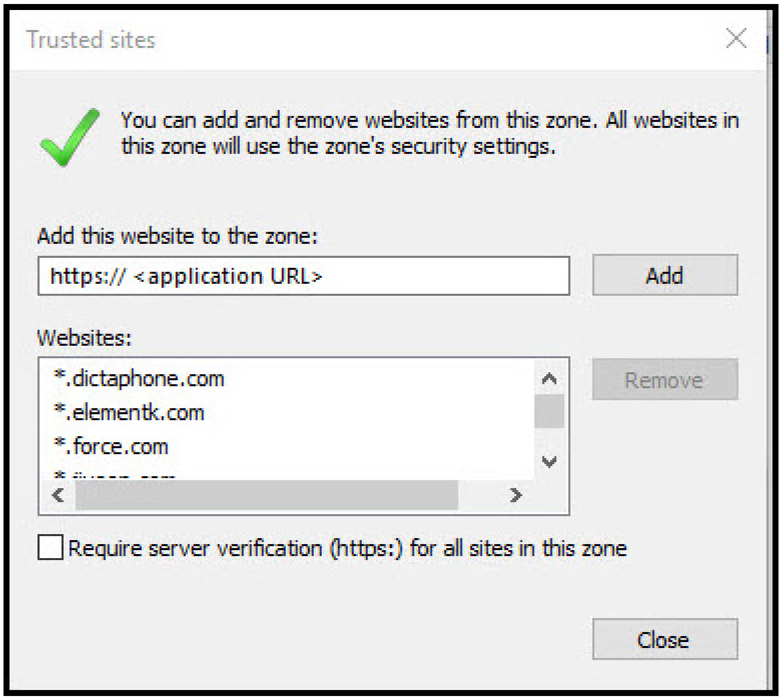


Figure 10: Trusted Sites Window

b) Uncheck the **Require server verification (https:) for all sites in this zone** check box.

Note: Add the following URLs to the trusted site list:

- https://app.powerbi.com/: used for accessing the CDE Analytics
- https://dc.services.visualstudio.com/: used for accessing the application insight
- https://az416426.vo.msecnd.net: used for accessing the CDE Analytics
- https://*.analysis.windows.net/: used for accessing the CDE Analytics
- https://nuancehdp.auth0.com: used for the central authentication

6. Click **OK** or Cancel.

7. From the **Security** tab with the **Trusted Sites** symbol selected, click the **Custom Level** button. The Security Settings - Trusted Sites Zone window is displayed.

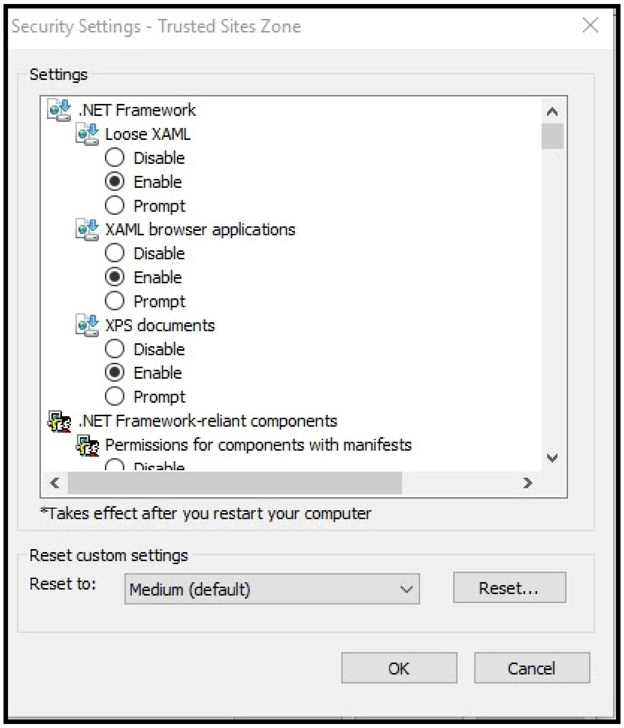


Figure 11: Security Settings - Trusted Sites Zone

8. From the **Settings** section, select **Enable** for **Font download**.

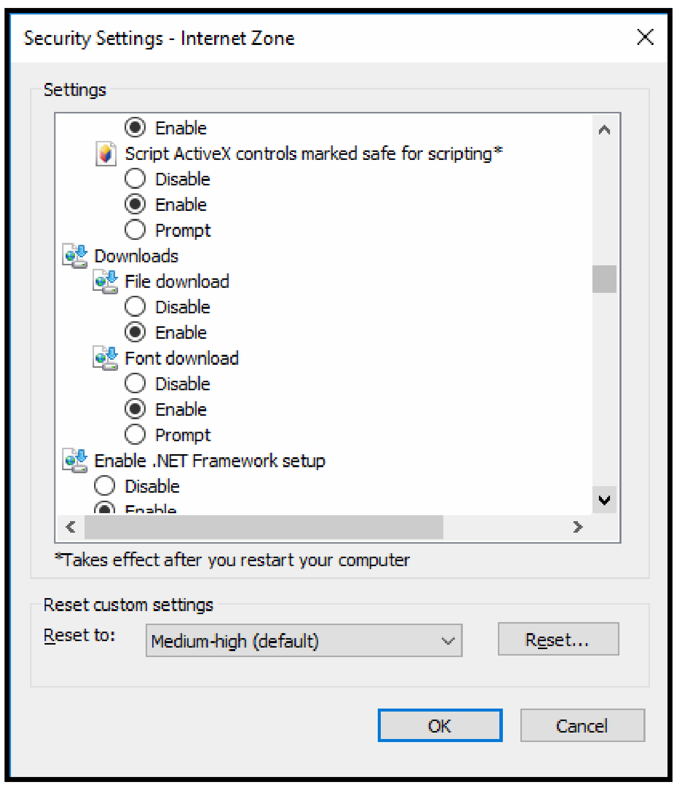


Figure 12: Security Settings Font Download

9. Click **OK** to return to the Internet Options window.

Recommended Options

Blocking Debugger

Block debugger error messages by adjusting two settings:

1. In your browser, select **Tools** > **Internet Options**.
2. Click the **Advanced** tab.
3. Check **Disable script debugging** for **Internet Explorer** and **Other**
4. Uncheck **Display a notification about every script error**.

Allowing Pop-ups

1. In your browser, select **Tools** > **Internet Options**.
2. Click the **Privacy** tab.
3. Click on the **Settings** button to view and modify the behavior of the pop-up blocker.
   The **Pop-up Blocker Settings** window is displayed.
4. Add the address of the website from which you wish to allow pop-up windows.

   Note: Type the address as follows, `https://<application URL>`
5. Click the **Add** button.
   The address gets displayed in the **Allowed Sites:** list.
6. Select **Medium** from the **Blocking Level** drop-down list to block all pop-up windows except those located in your Local Intranet or Trusted Sites content zones.
7. Click **Close**.

Setting Multiple Windows Option

1. If you want to open a new web site in a separate window while keeping the application open in its own window, uncheck **Reuse windows for launching shortcuts**
2. Click **OK** to save the settings and close the Internet Options window.

Using Disable Toolbars Option

1. Select **View\Toolbars**.
2. On the list of toolbars, uncheck the relevant toolbar.

Setting Print Page Options

When you print from Nuance CDE applications, you can change the appearance of the page.

1. From your browser, select **File\Page Setup**.
2. Select your preferred settings and click **OK**.

Sign In

Local Authentication

First Time Sign In

This section describes how you can sign-in to Nuance CDE for the first time.

Before you start, your system administrator must set up an account for you.

For first time sign in follow the below steps:

1. Start your web browser.
   Nuance recommends using Microsoft Internet Explorer 11 (IE 11) as the default web browser.
2. Type the URL in the **Address** field and press **Enter** or click Search icon.

   The Nuance CDE login screen is displayed.

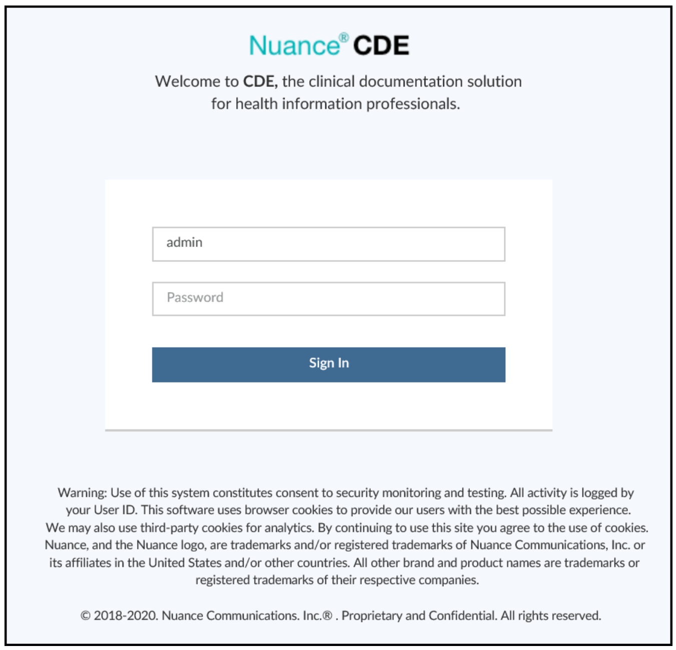


Figure 13: Login Screen

3. Type your ID in the **User ID** field.

   Note: If you do not know your User ID, ask your system administrator.

4. Type the password provided by your system administrator in the **Password** field.
5. Press **Enter** or click **Sign In**.
   The update password screen is displayed.

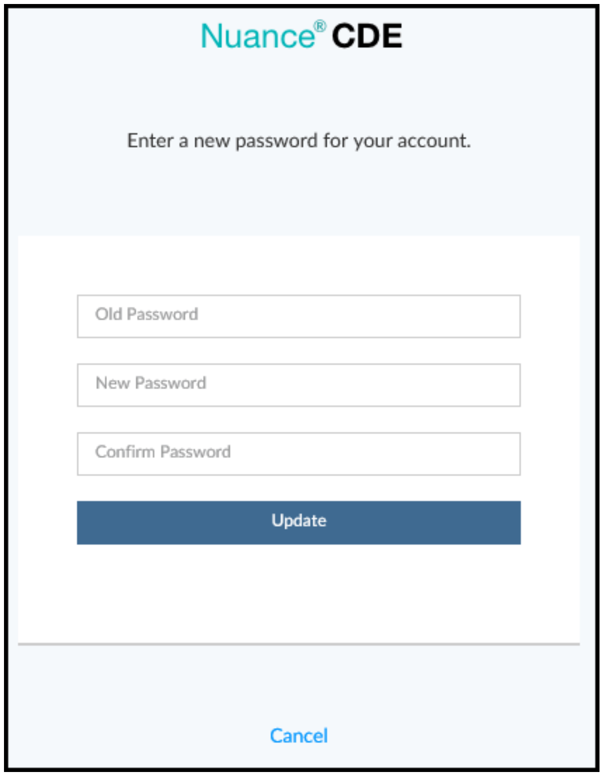


Figure 14: Update Password Screen

6. Type the password provided by the system administrator in the **Old Password** field.
7. Type a new password in the **New Password** field.
8. Again, type the new password in the **Confirm Password** field.
9. Click **Update** to change the password or click **Cancel** to abort.

   The Triage Worklist screen is displayed.

Related concepts

Rules for Creating Passwords on page 42

Password Settings on page 42

Standard Sign In

This section describes how you can sign-in to Nuance CDE.

1. Start your web browser.

   It is recommended to use Microsoft Internet Explorer 11 (IE 11) as the default web browser.
2. Type the URL in the **Address** field and press **Enter** or click Search icon.

   The Nuance CDE login screen is displayed.

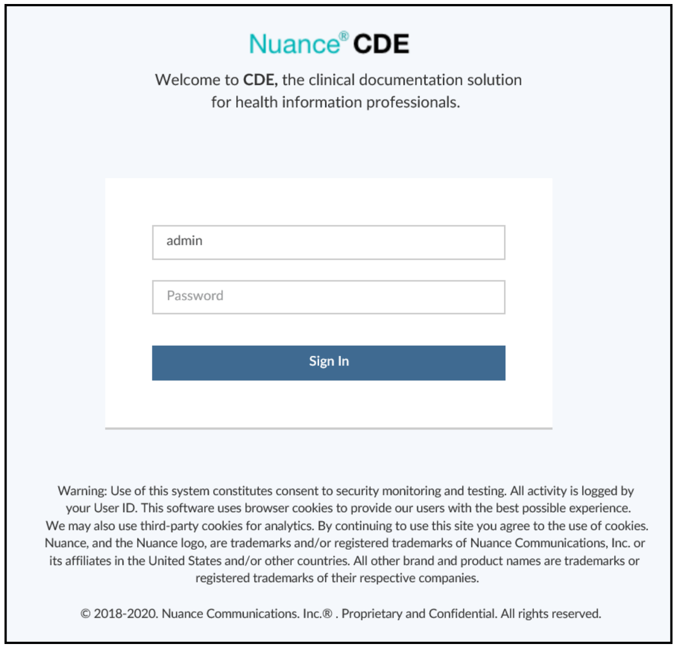


Figure 15: Login Screen

3. Type your ID in the **User ID** field.

   Note: If you do not know you User ID, ask your system administrator.

4. Type the password in the **Password** field.
5. Press **Enter** or click **Sign In**.

   The Triage Worklist screen is displayed.

Updating Password

Nuance CDE allows you to change your password from the Triage Worklist screen.

1. Sign in to the application.
2. From the top right, navigate to the icon with your name, and then click the **Update Password** link.

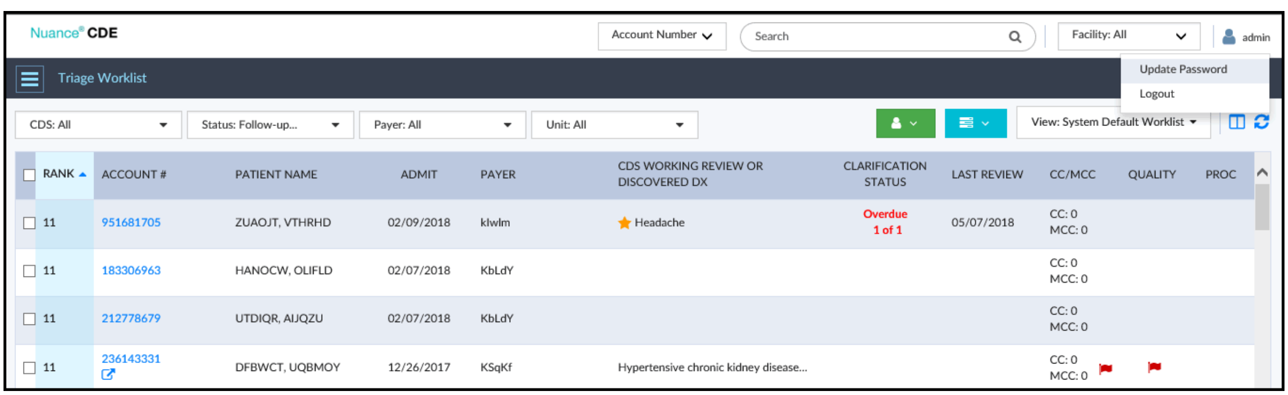


Figure 16: Update Password Link

3. Type the old password in the **Old Password** field.

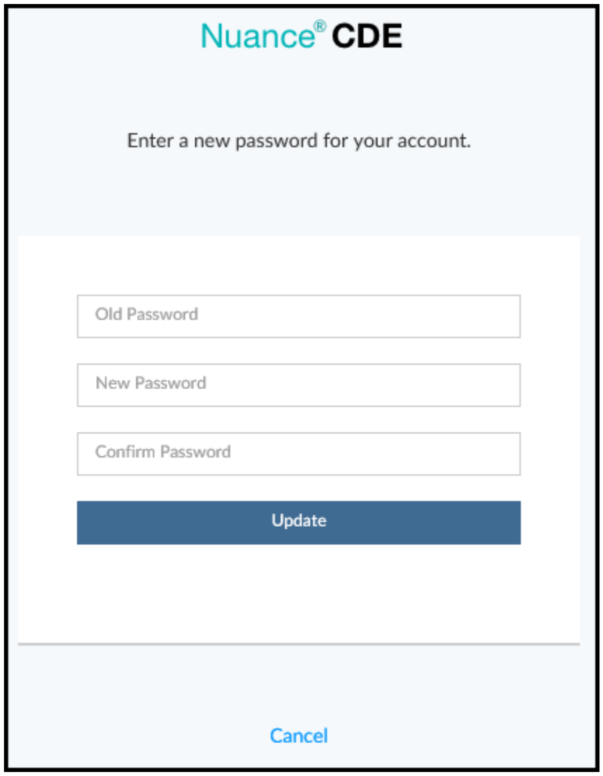


Figure 17: Update Password Screen

4. Type a new password in the **New Password** field.
5. Again, type the new password in the **Confirm Password** field.
6. Click **Update** to change the password or click **Cancel** to abort.
   The *Triage Worklist* screen is displayed.

Related concepts

Rules for Creating Passwords on page 42

Password Settings on page 42

Rules for Creating Passwords

Follow these rules when creating a password:

- Choose a password that is easy for you to remember, but difficult for others to guess. Avoid using your name or the names of family members, familiar dates, such as birthdays, or common words, such as password. Pass-phrases can also be used.
- The password must comply with the following rules that define a strong password. It must be between 8 and 128 characters in length and must include at least three out of the following four criteria:
  - Upper case letter
  - Lower case letter
  - Number
  - Special character
- Apart from the above rules, the password cannot be same as previous 10 passwords that you had set.
- Passwords are case sensitive. For instance, Pb2Ag and pb2ag are different passwords. To make your password more secure, use a mixture of uppercase and lowercase letters.

Password Settings

- The maximum password age is 90 days.

- Password once changed can only be updated after a minimum of one day.
- While logging into the application, if you enter a wrong password five times, your account gets locked out, as you cross the maximum failed attempts allowed.

Note: After the last failed login attempt, your account stays locked out for 15 minutes.

Single Sign On

About Single Sign-On

Single Sign-On (SSO) helps you to use your own identity provider (IdP) to access supported Nuance applications. Single sign-on eliminates the need of maintaining multiple credentials and also improves overall system security.

When you login to the application using the single sign-on, the system directly displays the *Triage Worklist* screen, no login credentials are required. If you have any issue with the login, please contact your system administrator.

Logging Out

This section describes about how to log out from the Nuance CDE.

From the top right, navigate to the icon with your name, and then click the **Logout** link.

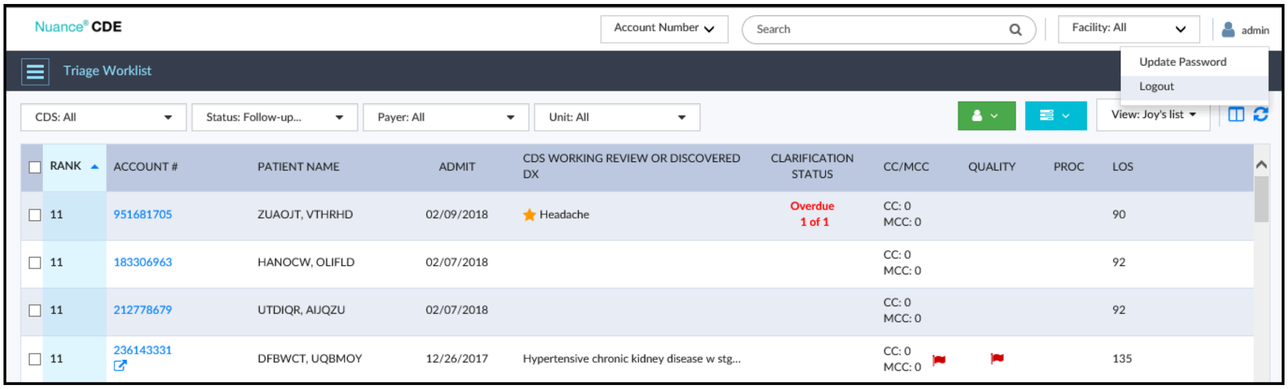


Figure 18: Logout Link

`You have successfully logged out` message is displayed and you are logged out from the application.

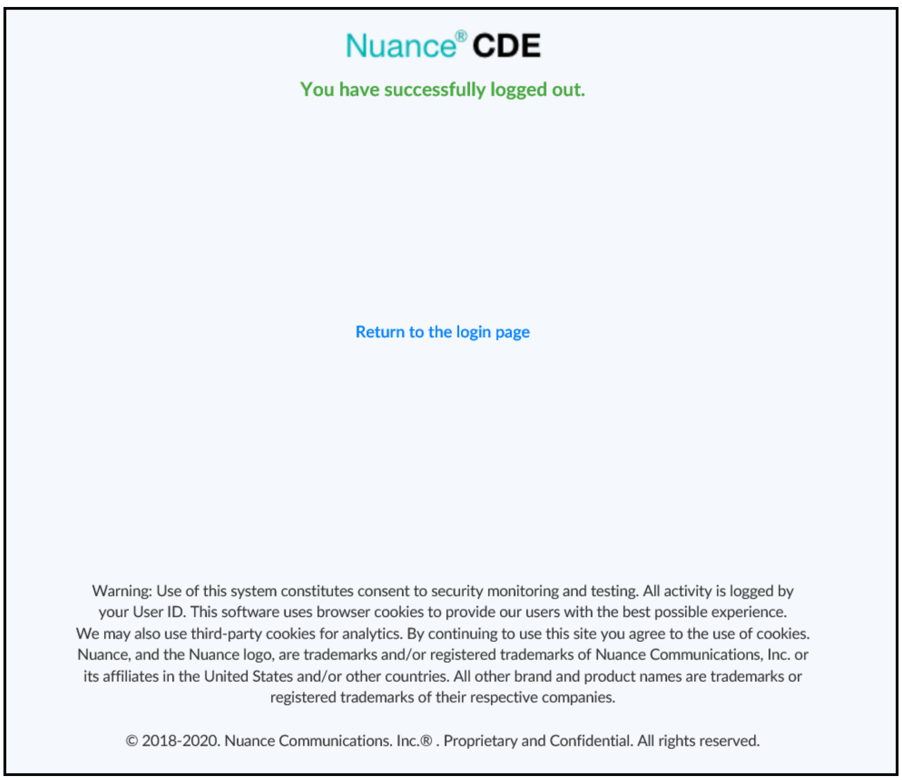


Figure 19: Logout Screen

Note: To return to the login screen, click the **Return to the login page** link. If your facility is using single sign-on then after clicking the **Return to the login page** link, the *Triage Worklist* screen is displayed.

Chapter 4

CDE Triage

Topics:

- About Triage Worklist
- Triage Worklist Screen Features and Descriptions
- Triage Worklist Columns and Descriptions
- About Pediatric Worklist
- Pediatric Worklist Features
- Creating a Custom Worklist
- Editing a Custom Worklist
- Managing a Custom Worklist
- Visual Indicators
- Quality Indicators
- Resolving a quality alert
- Encounter Status and Description
- Using Quick Search from the Triage Worklist
- Setting-up the Triage Worklist Columns
- Assign and Unassign Encounter
- Assigning Encounters to Review Not Needed Status
- CDS Assistant
- Document Viewer

About Triage Worklist

System default worklist screen is displayed when you log into the application for the first time. You can create your customized worklist and set it as a default. After you setting the custom worklist as default, everytime you log into the application, the custom worklist is displayed.

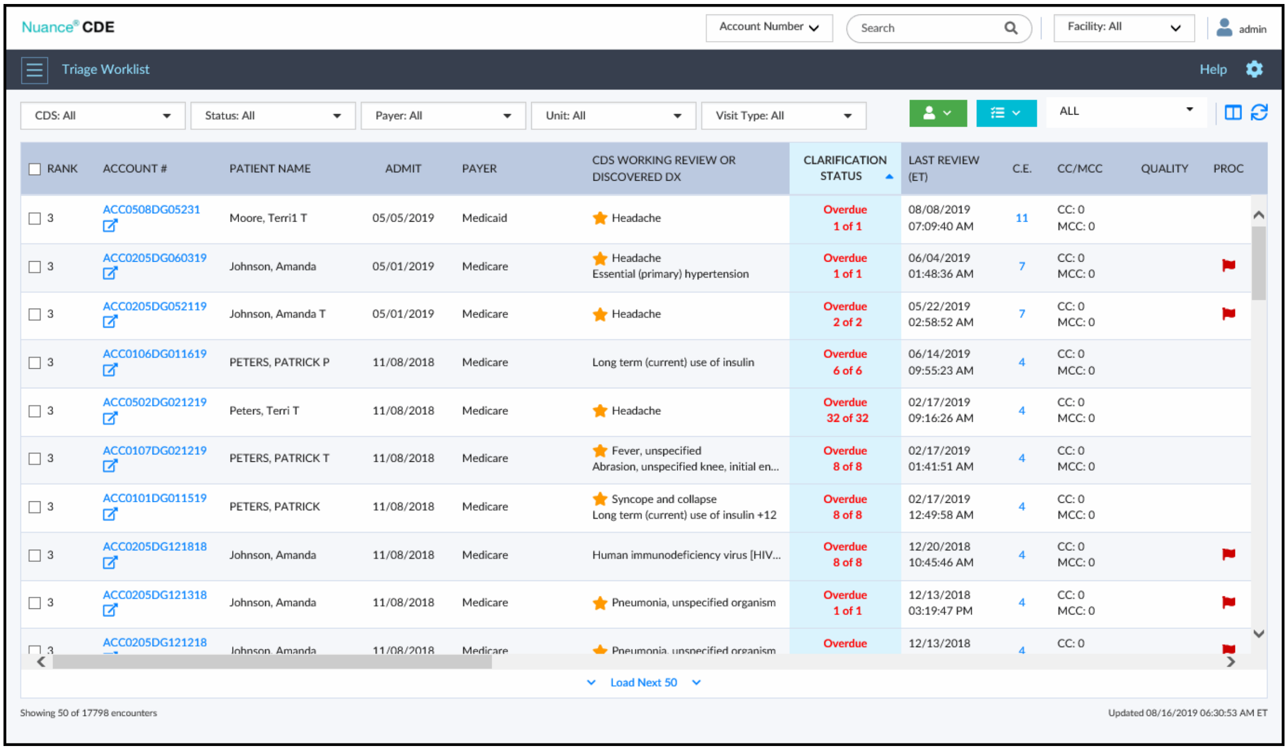


Figure 20: Triage Worklist Screen

Related tasks

Creating a Custom Worklist on page 58

Related reference

Triage Worklist Screen Features and Descriptions on page 48
Information in this section cover all the features available on the *Triage Worklist* screen.

Triage Worklist Columns and Descriptions on page 51
Information in this section covers all the Triage Worklist columns. You can configure these columns.

Triage Worklist Screen Features and Descriptions

Information in this section cover all the features available on the *Triage Worklist* screen.

Table 2: Triage Worklist Screen Features and Descriptions

Features	Description
	Main navigation. Navigates to *Triage Worklist*, *Analytics*, and *Audit Trail* screen.
	Quick search a specific account number, MRN, or patient name. For more information, refer to Using Quick Search from the Triage Worklist on page 66
	Displays a list of facilities (facility id with description). Select single, multiple or all facilities from the drop-down list. By default, all facilities are selected. The **Clear Selected Items** link appears only when one or more facility is selected. This link can be used to clear the selection.
	Retrieve a list of encounters which are unassigned or assigned to a CDS. One or more CDSs can be selected from drop-down list and it displays the list of the CDSs available for the selected facility. By default, your user name is selected. The **Clear Selected Items** link appears only when one or more CDS is selected. This link is used to clear the selection.

Features	Description
Status: All	Retrieve a list of encounters by selecting one or more statuses. By default, all the following status are selected: • Auto Reconciled • Discharged • In Progress • Reconcile - Impact • Reconcile - No Impact • Reconciliation Hold • Review Complete • Review Not Needed • Untouched The **Clear Selected Items** link appears only when one or more status is selected. This link is used to clear the selection. Refer to Encounter Status and Description on page 65.
Payer: All	Retrieve a list of encounters by selecting one or more payers. By default, all the payers are displayed in alphanumeric order. The **Clear Selected Items** link appears only when one or more payer is selected. This link is used to clear the selection.
Unit: All	Retrieve a list of encounters by selecting one or more units from the drop-down list and it displays the list of units available for the selected facility. By default, all the unit IDs are displayed in alphanumeric order. The **Clear Selected Items** link appears only when one or more unit is selected. This link is used to clear the selection.
Visit Type: All	Retrieve a list of encounters based on the visit type of the patient. By default, all the visit types are displayed.
Assign	Assign selected encounters to a CDS if you are an administrator, or to yourself, and also you can un-assign an encounter.
View: System Default Worklist	Create and manage worklists.
Status	Assign the **Review Not Needed status** to selected encounters.

Features	Description
	Navigate to *CDS Assistant* screen.
	Add or remove Triage Worklist columns.
	Refresh Triage Worklist columns.
	Navigate to the *Configuration* screen, if you have administration permissions.

Related tasks

Using Assign Encounters to CDS on page 69

Assigning Encounters to Review Not Needed Status on page 73

Related reference

Encounter Status and Description on page 65
This section describes the encounter status displayed on the Triage Worklist screen.

Triage Worklist Columns and Descriptions

Information in this section covers all the Triage Worklist columns. You can configure these columns.

Table 3: Triage Worklist Columns and Descriptions

Worklist Columns	Descriptions
ACCOUNT#	Patient's account number **Note:** This is a mandatory column and is displayed by default.
ADMIT DX (Admitting Diagnosis)	Diagnosis at the time of the patient's admission. **Note:** Tooltip has been added to the values to show the code as well as description.
ADMIT SERVICE (Admitting Service)	Provider group/service where the patient is admitted to, such as Cardiology or Orthopedics.
ADMIT (Admit Date)	Patient's date of admission
AGE	Patient's age at the time of admission
PROVIDER (Attending Provider)	Name of the attending physician
CC/MCC	Number of CC/MCC codes added in the Working Review section in the *Review* screen. **Note:** CC/MCC count on worklist should reflect all CC/MCCs in the Review Screen (not just the impacting ones). When a red flag displays, you can click the flag to open CDS Assistant with CLU suggested CC/MCC codes displayed.
CDS	Name of the Clinical Documentation Specialist assigned to the encounter.

Worklist Columns	Descriptions
CDS WORKING REVIEW OR DISCOVERED DX	Displays suggested code with a blue hyperlink, and manually added codes with black font. Target diagnosis codes are displayed with a star(*). Partial codes are displayed in upper-case, and fully qualified codes are displayed in mixed-case (upper and lower). Click the link to display CLU suggested CC, HAC, MCC, and Target diagnosis codes in the CDS Assistant. When you add a primary diagnosis code in the Working Review and save, this column then displays that diagnosis description and is no longer a link. If there are more than two codes in the column, then the count of extra codes is displayed in the second row. **Note:** This is a mandatory column and is displayed by default. It cannot be removed.
Clinical Evidence (C.E.)	Number of clinical evidences available for the encounter.
Clarification Status	Status of open clarifications • **Due Today** - Follow up date is today. • **Due in (X) days** - Follow up date is tomorrow or later. • **Overdue** - Follow up date was yesterday or prior.
DOB (Date of Birth)	Patient's date of birth
DISCHARGE (Discharge Date)	Patient's date of discharge
FACILITY	Facility ID associated with the encounter.
Final Coded DRG	Final coded DRG either imported from the coding system or manually added in the *Reconciliation* screen. **Note:** If the final imported codes have an incomplete coding status, then the system will not display the final coded DRG.
FOLLOW-UP (Encounter Follow-up Date)	Date entered in the encounter **Follow-up Date** field.
LAST REVIEW (Last Review Date and Time)	Date and time the encounter was last saved.
LOS (Length of Stay)	Patient's duration of stay in a facility. Duration is displayed in number of days.
MRN (Medical Record Number)	Patient's Medical Record Number
PATIENT NAME	Patient's name

Worklist Columns	Descriptions
PAYER	Primary payer (insurance) associated with the encounter.
PROC (Procedures)	Indicates CLU suggested procedure codes. When a red flag displays, you can click the flag to open CDS Assistant with CLU suggested procedure codes displayed.
QUALITY	Indicates CLU suggested codes related to potential HAC, PSI, or Core Measure opportunity. When a red flag displays, you can click the flag to open CDS Assistant with CLU suggested HAC or PSI codes displayed.
RANK	Priority of encounter. This could be any number from 1 to 11. Refer Unranked and Exclusion Criteria on page 193, to know more about the types of encounters excluded from the prioritization ranking. **Note:** • This is a mandatory column and is displayed by default. It cannot be removed. • Prioritization ranking is displayed based on pre-configured rules.
ROOM	Patient's room number in a facility.
SOI	Severity of illness. For APR DRG grouper the system displays the value associated with the grouper, and for CMS grouper system displays the value associated with CMS grouper. The Possible SOI value is displayed, and if the PossibleSOI is not present, the system displays the WorkingSOI value. Suggested SOI value is displayed when working or possible SOI values are unavailable. Suggested SOI values appear as hyperlink. If you click these values, system navigates you to the CDS Assistant screen.

Worklist Columns	**Descriptions**
ROM	Risk of mortality. For APR grouper the system displays the value associated with the grouper, and for CMS grouper system displays the value associated with CMS grouper. The Possible ROM value is displayed, and if the Possible ROM is not present, the system displays the Working ROM value. Suggested ROM value is displayed when working or possible ROM values are unavailable. Suggested ROM values appear as hyperlink. If you click these values, system navigates you to the CDS Assistant screen.
STATUS	Status of the encounter. Refer to Encounter Status and Description on page 65.
UNIT	Unit assigned to the encounter.
VISIT TYPE	Patient's visit type. Following are typical visit types: • **I** - Inpatient • **O** - Outpatient
DRG	Calculated DRG value. Following are the types of DRG values displayed. • Working DRG • Possible DRG • Suggested DRG Suggested DRG is displayed only when Working or Possible DRG values are unavailable.

Related concepts

Visual Indicators on page 62
This section describes the visual indicators (Flags and Icons) available on the Triage Worklist screen.

Overview of Prioritization on page 193

Unranked and Exclusion Criteria on page 193

Related tasks

Setting-up the Triage Worklist Columns on page 67
This section describes how to customize the Triage Worklist columns.

Assigning Encounters to Review Not Needed Status on page 73

Related reference

Encounter Status and Description on page 65
This section describes the encounter status displayed on the Triage Worklist screen.

About Pediatric Worklist

Pediatric Worklist can be viewed by selecting the desired option from the drop-down list on the top right side pane. You can also create your customized worklist.

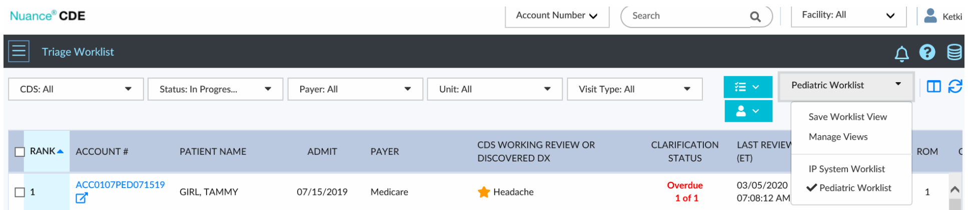


Figure 21: Drop down list

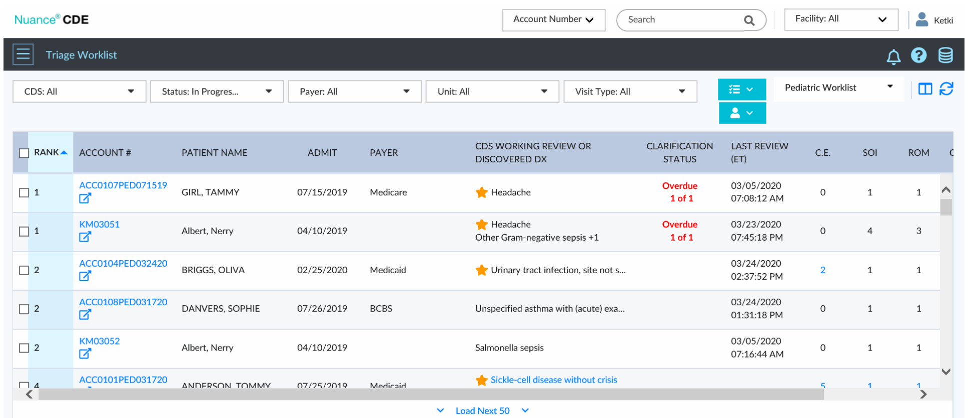


Figure 22: Pediatric Worklist Screen

The Pediatric worklist screen features are similar to Triage worklist. For details, refer Triage Worklist Screen Features and Descriptions on page 48.

Data in the Pediatric worklist is represented in the same way as Triage worklist. For column descriptions of Pediatric worklist, refer Triage Worklist Columns and Descriptions on page 51.

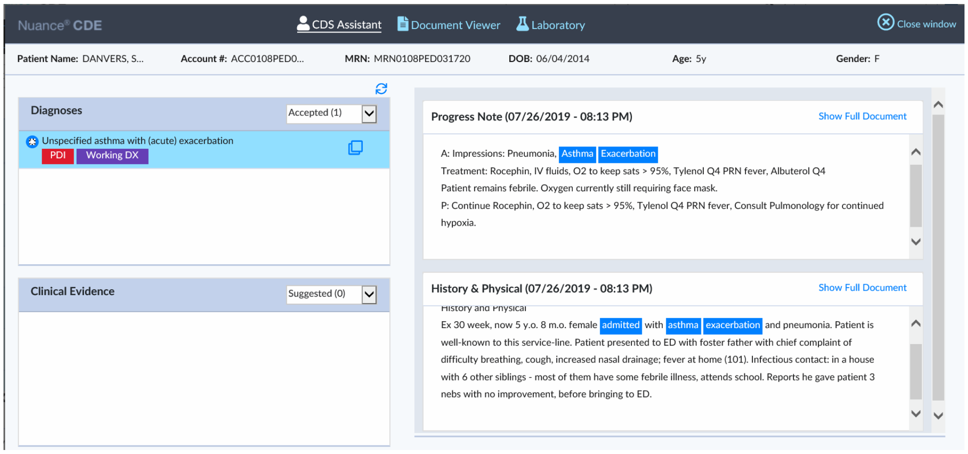
Note: The CC/MCC column will not be displayed by default in the Pediatric worklist. It can be added to the worklist if required.

Note: AGE column (age at admission) is also available and can be added to the worklist.

Pediatric Worklist Features

CDS Assistant

For CLU suggested PSI codes in the CDS Assistant screen, the PSI tag displays as PDI or NQI.



For a pediatric encounter, system will not display the symbols below for codes in the CDS Assistant.

Table 4: Codes not displayed

Category	codes
Diagnosis	C
	HC
	HR
	M
	P
	PC
	PCC
	C*
	PC*
	P**
	M*
	P*
	1-8
Procedure	POR*
	POR
	OR*
	PC*

Working or Possible Review

For a pediatric encounter, system will not display the defined symbols for codes in the Working or Possible Review. Includes codes:

- Added directly by CDS
- Copied from CDS Assistant
- Copied from IMO search result

Reconciliation Screen

For a pediatric encounter, system will not display the defined symbols for codes in the Reconciliation Screen: Final Coded Summary:

- P05 import
- Added directly by CDS

IMO (Clinical Language) or Code Index search

Refer Table 4: Codes not displayed on page 56 for Symbols which will not display in IMO (Clinical Language) or Code Index search results.

Creating a Custom Worklist

This section describes how to create a custom worklist.

1. To create a custom worklist, perform any of the following on the worklist columns:
   - Reorder
   - Add
   - Remove
   - Sort the worklist by applying quick filters for CDS, Status, Payer, and Unit
2. Click **Custom Worklists** and then click **Save Worklist View**.

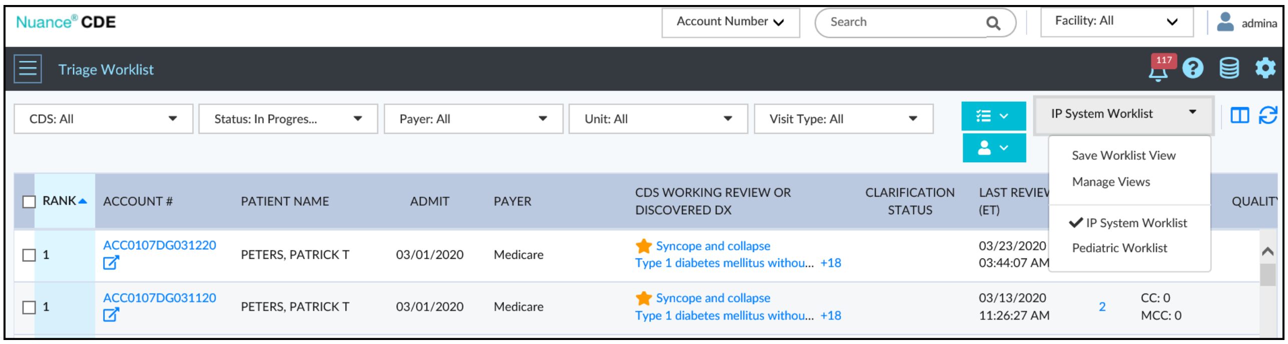


Figure 23: Custom Worklist - Save Worklist

The Save Worklist View dialog box is displayed.

Figure 24: Save Worklist View

3. In the **Enter View Name** field, type the name of the worklist that you want to create.

   Note: The custom worklist name must be unique, and must contain less than 50 characters.

4. If you want to make this worklist as a default, select the **My default** check box.
5. Click **Save**.
   Upon save, the worklist gets added to the **Custom Worklists** drop-down and retains the changes that you have done on the *Triage Worklist* screen.

Editing a Custom Worklist

This section describes how to edit a custom worklist view.

1. To create a custom worklist, perform any of the following on the worklist columns:
   - Reorder
   - Add
   - Remove
   - Sort the worklist by applying quick filters for CDS, Status, Payer, and Unit
2. Click **Custom Worklists** and then click **Save Worklist View**.

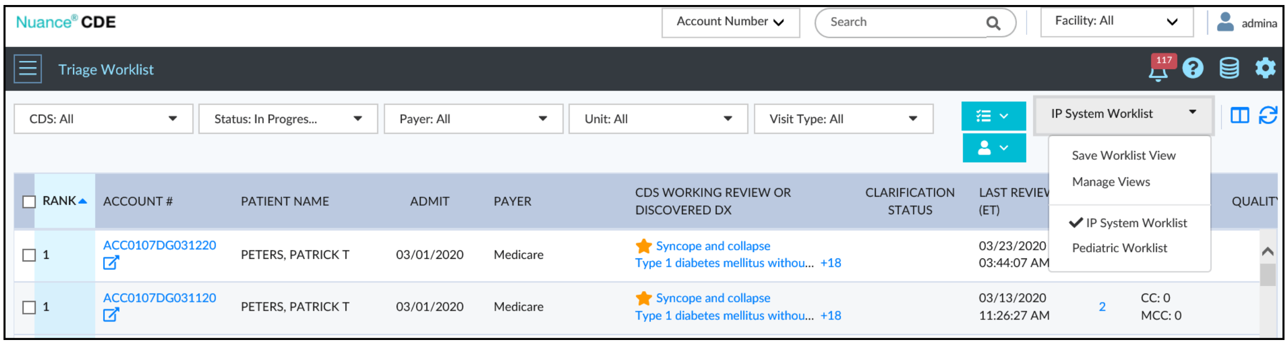


Figure 25: Custom Worklist - Save Worklist

The Save Worklist View dialog box is displayed.

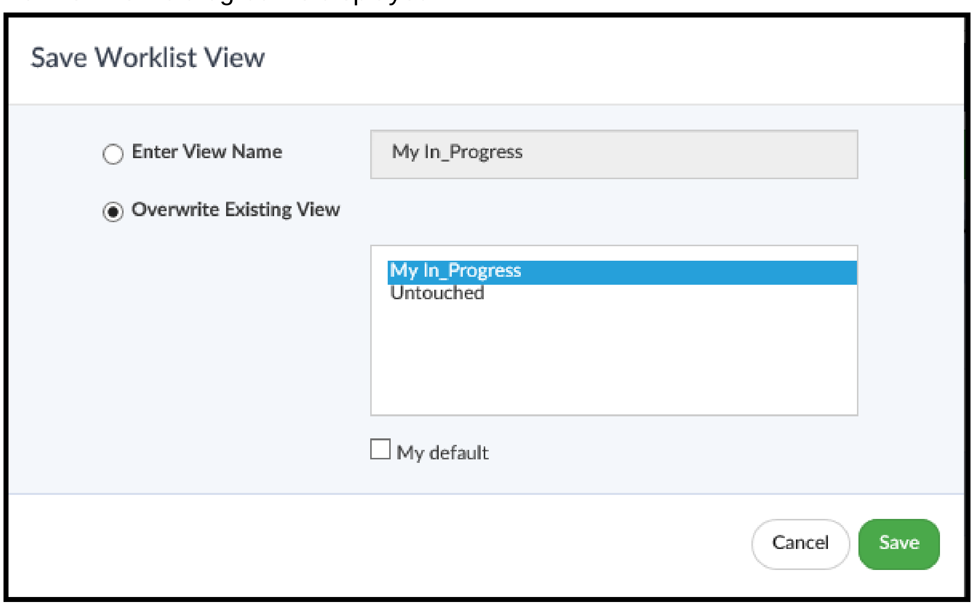


Figure 26: Save Worklist View - Overwrite

3. Select **Overwrite Existing View** and then select an existing custom worklist that you want to overwrite.

   Note: If you want to make this template as a default template, select the **My default** check box.

4. Click **Save**.

Managing a Custom Worklist

This section describes how to manage an existing custom worklist. From the Manage Worklist View, you can do the following:

- Defaulting an existing custom worklist
- Delete a custom worklist

Defaulting an Existing Custom Worklist

1. Click **Custom Worklists** and then click **Manage Views**.

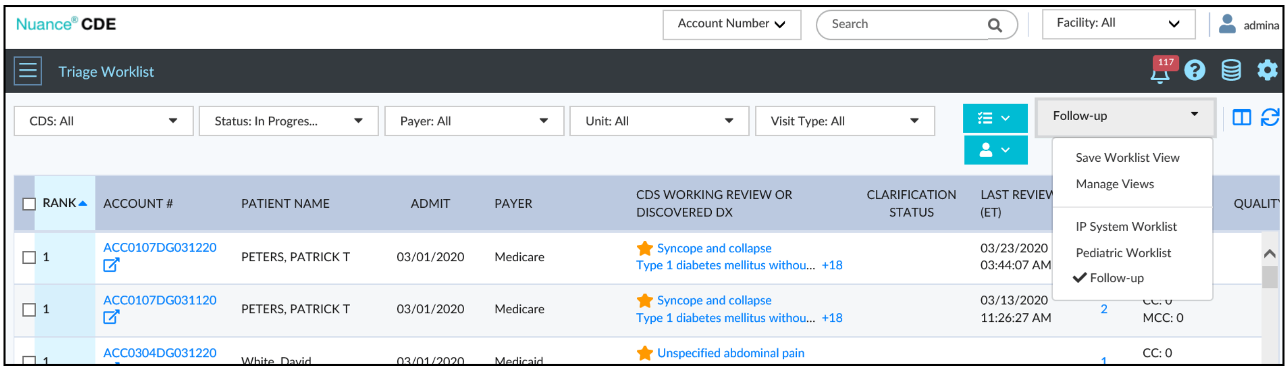


Figure 27: Custom Worklist- Manage Views

The Manage Worklist Views dialog box is displayed.

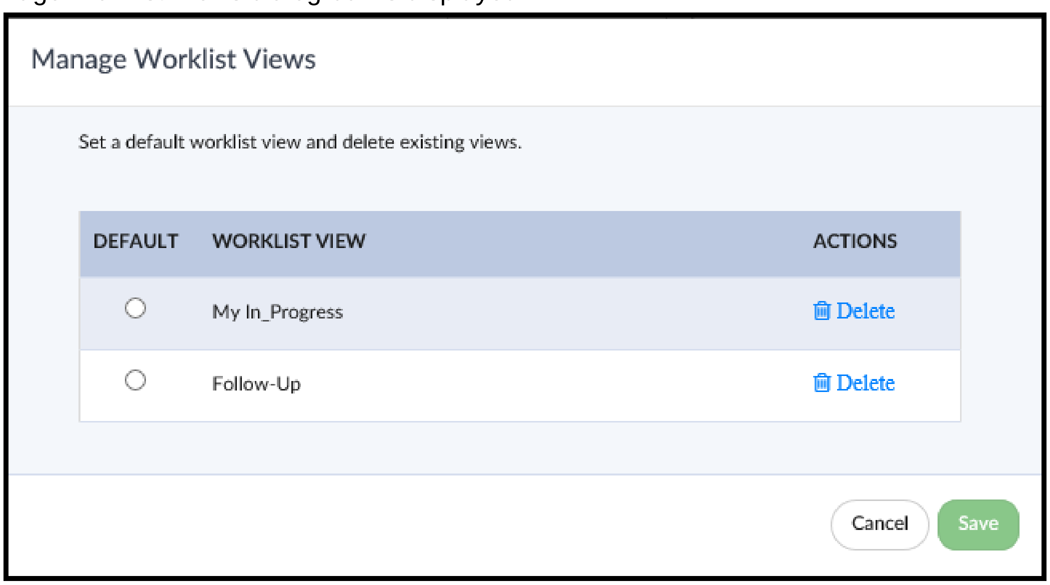


Figure 28: Manage Worklist Views

2. Select the **Default** radio button for the respective worklist that you want to set as default.
3. Click **Save**.

Deleting a Custom Worklist

1. Click **Custom Worklists** and then click **Manage Views**.

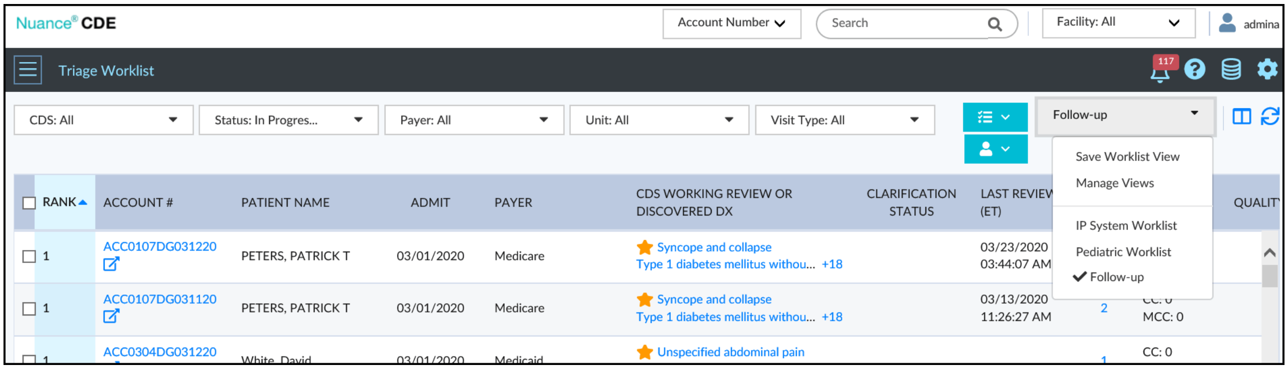


Figure 29: Custom Worklist- Manage Views

The Manage Worklist Views dialog box is displayed.

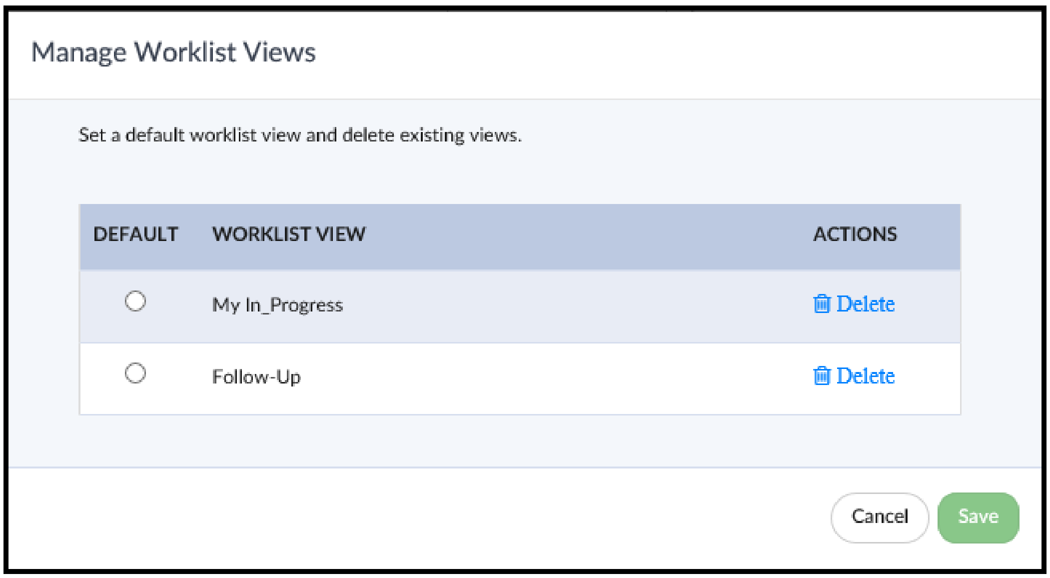


Figure 30: Manage Worklist Views

2. Click **Delete** corresponding to that worklist which you want to delete.

   Note: You can restore a deleted custom worklist by clicking **Restore**.

3. Click **Save**.
   The custom worklist gets deleted and the worklist does not appear in the **Custom Worklists** drop-down.

Visual Indicators

This section describes the visual indicators (Flags and Icons) available on the Triage Worklist screen.

Table 5: Visual Indicators and Descriptions

Visual Indicator	Description
Readmission Flag (**R**)	If the patient is readmitted within the 30 days of the discharge date, a readmission flag **R** displays next to the admit date. **Note:** When admission date is not available the calculation is done based on the facility's local time-zone.
Red Flag	A red flag ( ) is displayed when there is a CLU suggested code related to the following: • CC, MCC codes in the CC/MCC column. Tooltip on the flag displays count of suggested codes only. • Procedure codes in the PROC column. Tooltip on the flag displays count of PROC codes. • HAC, PSI, or Quality Measure codes in the Quality column. Tooltip on the flag displays count of suggested codes and also the count of unresolved quality related codes added in the Working Review section in the *Review* screen.
Green Check-mark	When you accept or reject all the CLU suggested HAC, PSI or Quality Measure codes, a green check-mark is displayed on the Quality and PROC columns.
Star Icon	A star icon is displayed next to a primary diagnosis code on the CDS Working Review or Discovered DX column indicating that the primary diagnosis code is a target diagnosis ICD-10 code. This code can either be manually added or CLU suggested.

Related reference

Triage Worklist Columns and Descriptions on page 51
Information in this section covers all the Triage Worklist columns. You can configure these columns.

Quality Indicators

The Patient Safety Indicators are filtered by the topics selected in **Configuration** > **CDE Preferences** > **Quality - NQI, PDI, PSI**. A red flag in the Quality column of the Triage Worklist page indicates CLU suggested codes related to potential HAC, PSI, or Core Measure opportunity. On hover, the tooltip displays the number of suggested quality alerts raised.

When there are open quality alert raised for CLU suggested codes, the reg flag in the Quality column is click-able. On click, the application navigates to **CDS Assistant** > **Quality category**, with CLU suggested HAC or PSI codes displayed. When these codes are copied to review, the red flag remains in the Quality column. The CDS can view the red or amber quality alert on the Review page.

When you manually enter a code on the Review page, which triggers a PSI alert, the encounter is in progress, and you navigate to Triage Worklist page. The red flag is displayed in the Quality column. In this case, when the red flag is clicked, the application navigates to the Review page, and not the CDS Assistant.

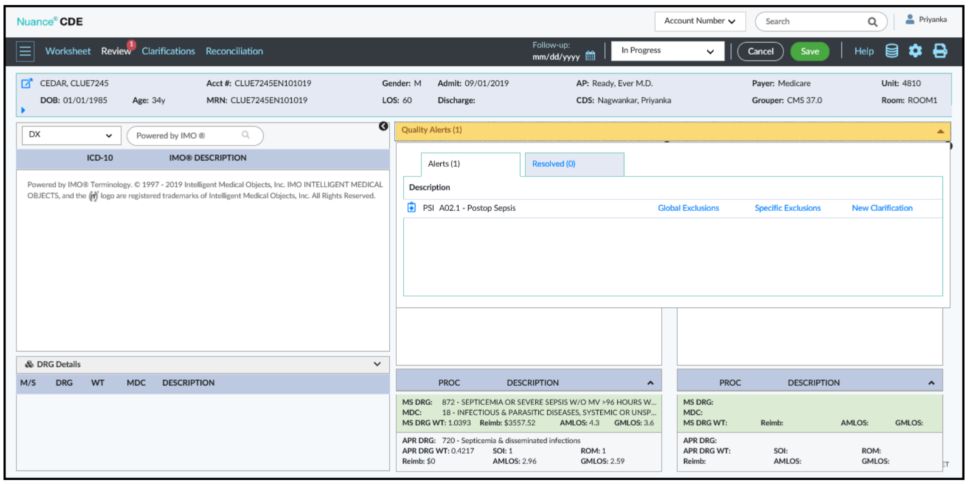


Figure 31: Quality Alert panel

You can resolve the alerts by selecting appropriate options displayed in the Quality Alert drop-down. When all the quality alerts are resolved , a green check is displayed.

Resolving a quality alert

This section describes how to resolve a quality alert.

1. Click the drop-down on the Quality Alert panel.

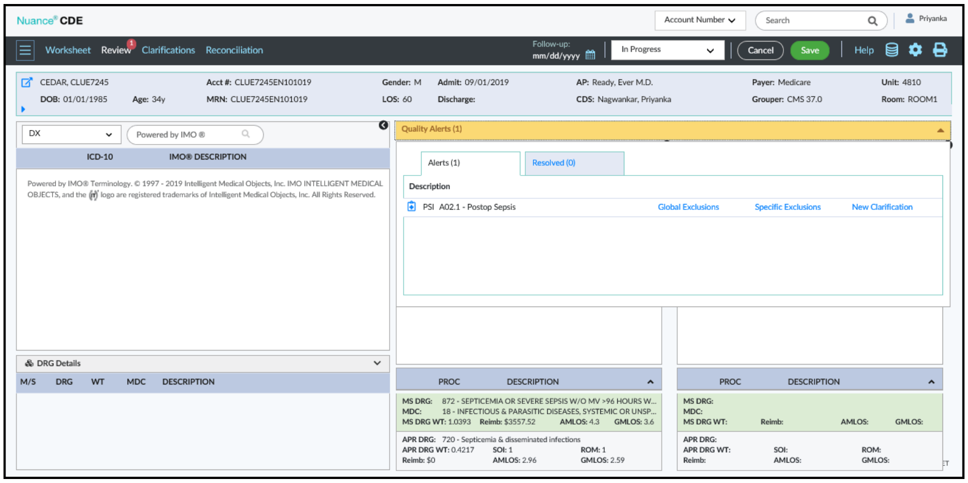


Figure 32: Quality Alert panel

2. Select an appropriate exclusion.
   A list of exclusion options are displayed in a pop-up.
3. Select an appropriate option and Click **Done**.

Encounter Status and Description

This section describes the encounter status displayed on the Triage Worklist screen.

Table 6: Encounter Status and Description

Encounter Status	Description
Auto Reconciled	For the MS DRG grouper, the Coding DRG, Coding DRG weight match with the Working DRG, Working DRG weight and the possible review is blank. For the APR DRG grouper, the Coding DRG, DRG WT, SOI, and ROM match with the Working DRG, Working DRG weight, SOI, and ROM and the possible review is blank.
Discharged	The patient has been discharged from the facility.
In Progress	The encounter is being reviewed by the CDS.
Reconciled Impact	Clarifications generated by the CDS have an impact on the final Coding DRG.
Reconciled No Impact	Clarifications generated by the CDS have no impact on the final Coding DRG.
Reconciliation Hold	The encounter is not auto reconciled, and is on hold till the coder and CDS discuss and wait for the new Final Coded Summary import.
Review Complete	Review is complete by CDS and the encounter is ready for reconciliation.
Review Not Needed	The encounter does not need review.
Untouched	The encounter has not been opened and is ready for initial review.
Ready to Reconcile	For the MS DRG grouper, the Coding DRG, Coding DRG weight does not match with the Working DRG, Working DRG weight and the possible review is blank. For the APR DRG grouper, the Coding DRG, DRG WT, SOI, and ROM does not match with the Working DRG, Working DRG weight, SOI, and ROM and the possible review is blank.

Related tasks

Assigning Encounters to Review Not Needed Status on page 73

Using Quick Search from the Triage Worklist

Using quick search from the *Triage Worklist* screen, you can search for a specific account number, MRN, and the patient name (**last name, first name** or **first name last name**).

Important: You must leave a space between the first name and last name.

1. From the **Criterion** drop-down list, select an appropriate option.
2. Type text in the search field.
3. Click **Search** ( ) icon.

   Important: The **Clear** link appears when a specific account number, MRN, or a patient name is searched. This link can be used to clear the selected criterion.

Setting-up the Triage Worklist Columns

This section describes how to customize the Triage Worklist columns.

You can add or remove the columns from the Triage Worklist screen. The sequence of the worklist columns can be modified.

1. From top-right corner of the Triage Worklist screen, click the **Add or Remove Worklist Columns** icon. The Worklist Column Settings dialog box is displayed.

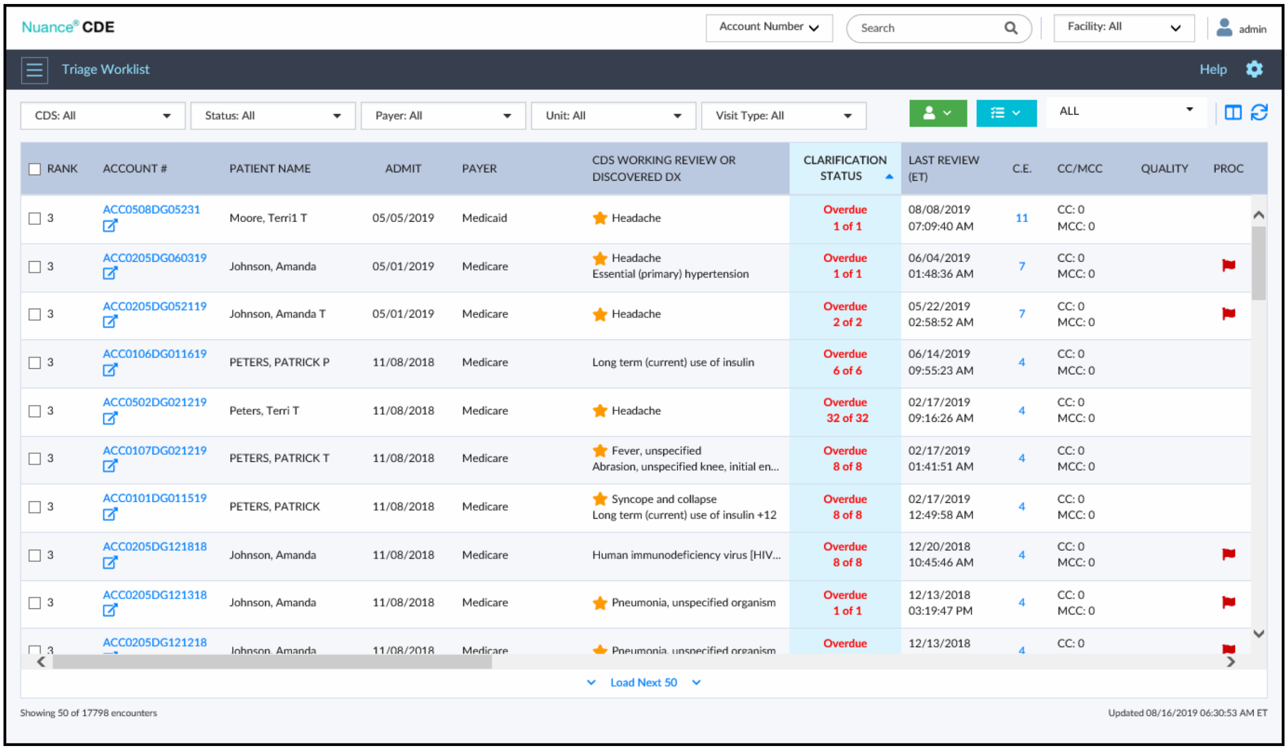


Figure 33: Triage Worklist Screen

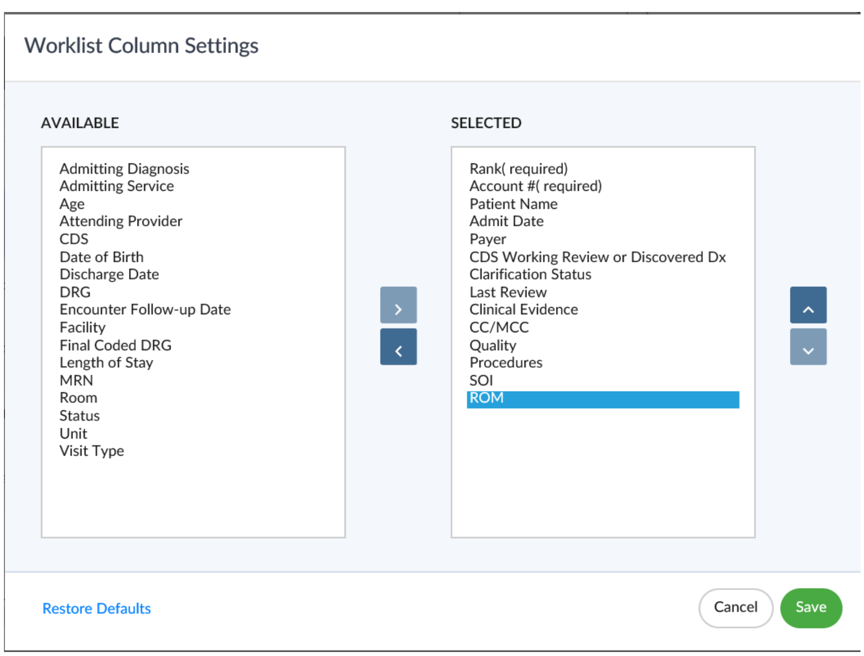


Figure 34: Worklist Column Settings Dialog Box

2. Select the column/columns that you want to display on the Triage Worklist screen from the **Available** box.

   Use the **Move Right** button and the **Move Left** button to add or remove the selected options from the **Available** and **Selected** box.

   To change the sequence of the selected columns, use the **Move Up** or **Move Down** button.
3. Click **Save** to save the changes or **Cancel** to discard.

   The Triage Worklist screen is displayed with the selected worklist columns.

   Note: To display the default worklist columns, click the **Restore Defaults** link.

Related reference

Triage Worklist Columns and Descriptions on page 51
Information in this section covers all the Triage Worklist columns. You can configure these columns.

Assign and Unassign Encounter

About Assign and Unassign Encounter

Encounters can be assigned using the following options from the **Assign** drop-down list:

- **Assign to CDS**: Assign encounters to another CDS.
- **Assign to me**: Assign encounters to yourself.
- **Un-Assign**: Unassign a CDS from an encounter. The encounter is moved to the unassigned status.

Using Assign Encounters to CDS

1. On the Triage Worklist screen, select the check boxes adjacent to the encounters you want to assign. Select the check box at the top of the Worklist column to select all encounters.

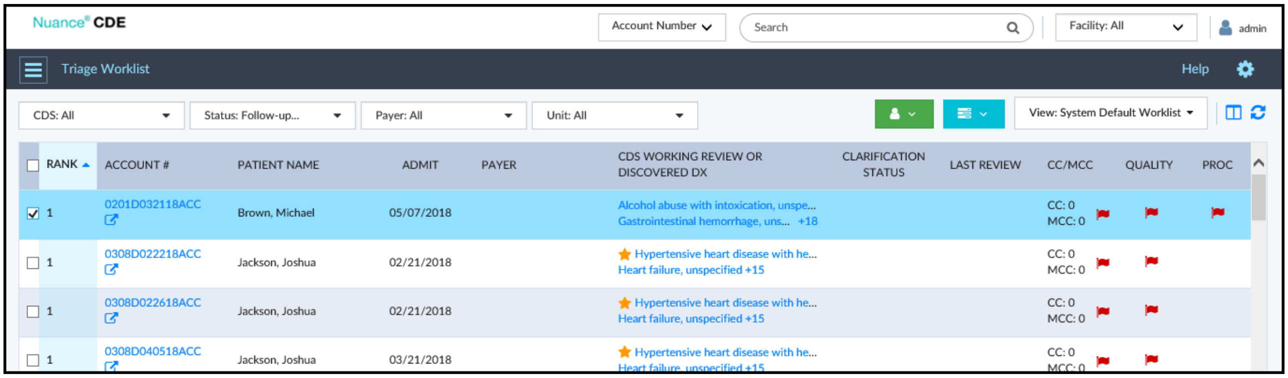


Figure 35: Triage Worklist Screen

2. From the **Assign** drop-down list, select **Assign to CDS** to assign the selected encounters to any CDS. The Assign Encounter dialog box is displayed with a list of CDS's assigned to that facility.

   Note: The **USER ID** and **NAME** columns can be sorted alphabetically.

   Note: You can navigate to the next set of 20 CDS names by using the **Load Next 20** button.

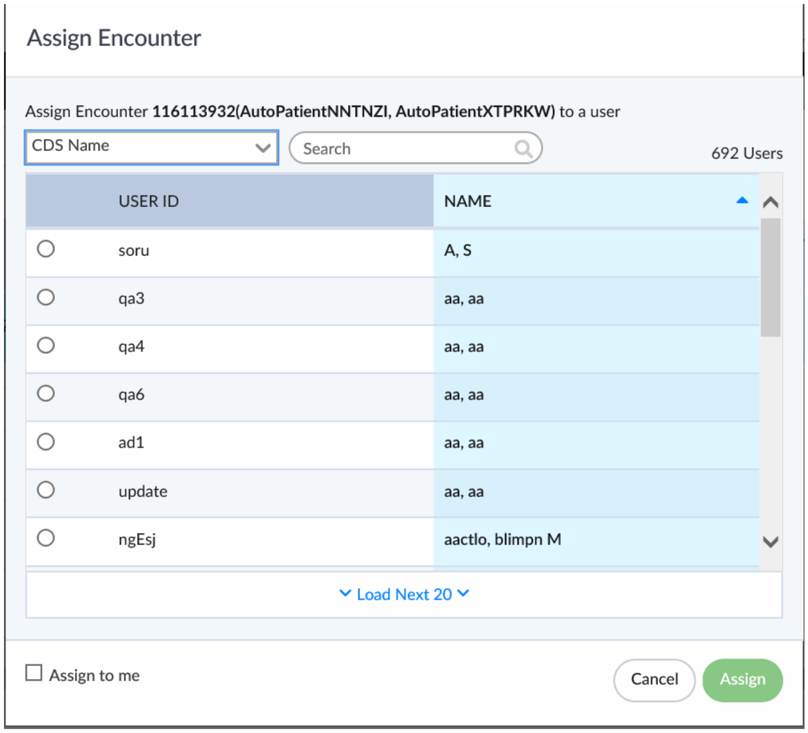


Figure 36: Assign Encounter Screen

3. Select **USER ID** or **NAME** from the drop-down list. Type the required **USER ID** or **NAME** to be searched and press **Enter**.
4. Select the CDS and the click **Assign** to assign the encounters.

   When you try to assign an encounter which already has a CDS assigned, the **Duplicate Encounter Assignments** warning pop-up is displayed.

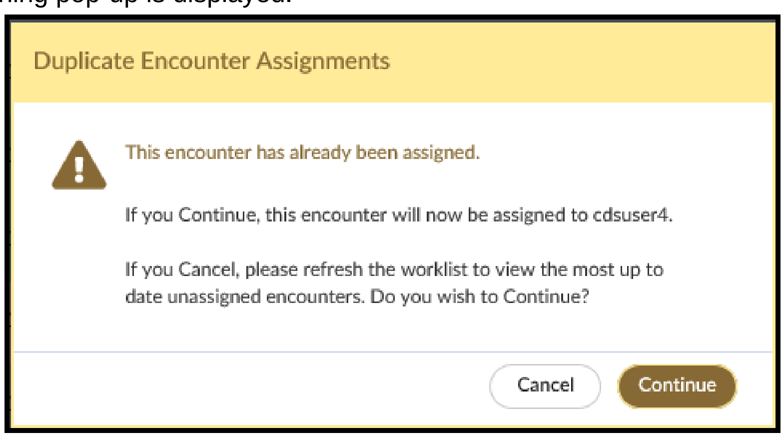


Figure 37: Duplicate Encounter Assignments

The Triage Worklist screen is displayed and the selected encounters are assigned to the selected CDS.

Note: If your worklist is not set to show the selected CDS, then those encounters are removed from the worklist.

Using Assign Encounter to Self

1. On the *Triage Worklist* screen, select the check boxes adjacent to the encounters you want to assign.

   Select the check box at the top of the Worklist column to select all encounters.

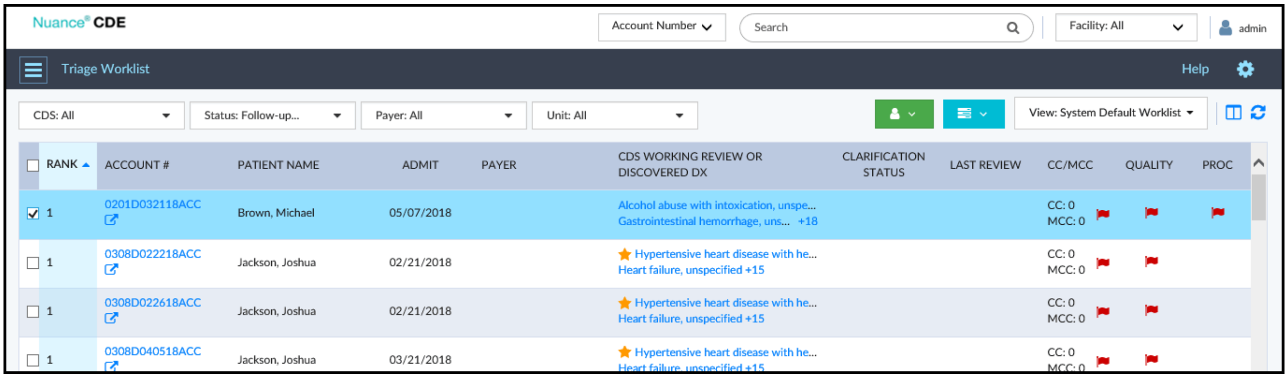


Figure 38: Triage Worklist Screen

2. From the **Assign** drop-down list, select **Assign to me** to assign the selected encounters to self.

   When you try to assign an encounter which already has a CDS assigned, the **Duplicate Encounter Assignments** warning pop-up is displayed.

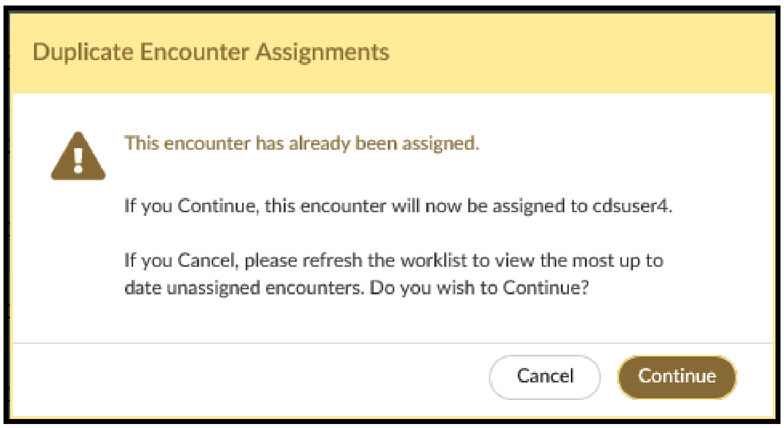


Figure 39: Duplicate Encounter Assignments

The Triage Worklist screen is displayed and the selected encounters are assigned to the selected CDS.

Note: If you have added to the CDS role, then only **Assign to me** option is displayed.

Using Un-Assign

1. On the Triage Worklist screen, select the check boxes adjacent to the encounters you want to unassign.

   Note: Encounter must have a CDS assigned.

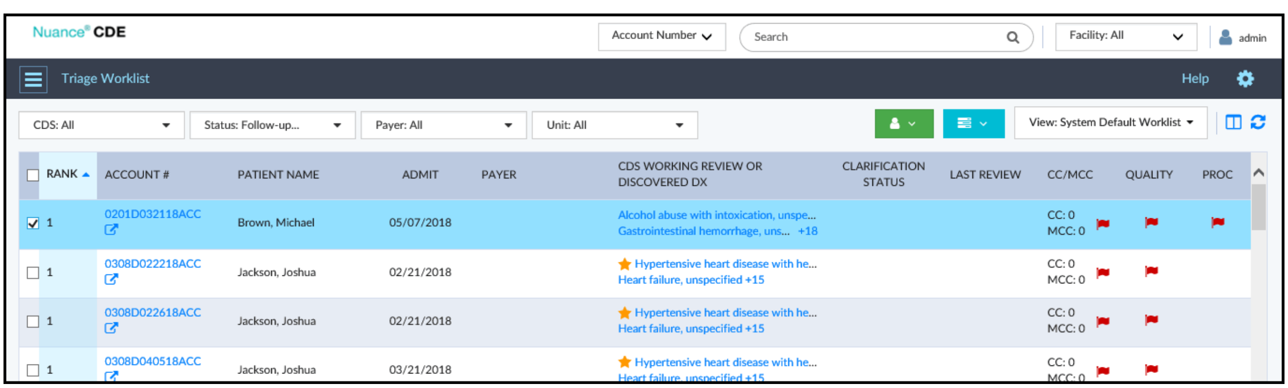


Figure 40: Triage Worklist Screen

2. From the **Assign** drop-down list, select **Un-Assign** to unassign the selected encounters.
   The Triage Worklist screen is displayed and the selected encounters are moved to the **Unassigned** status.

Assigning Encounters to Review Not Needed Status

This section describes how selected encounters can be assigned to **Review Not Needed** status. Encounters which does not require any review are assigned to this status.

1. On the Triage Worklist screen, select the check box adjacent to the encounters that you want to assign to **Review Not Needed**.

   Select the check box at the top of the Worklist column to select all encounters.

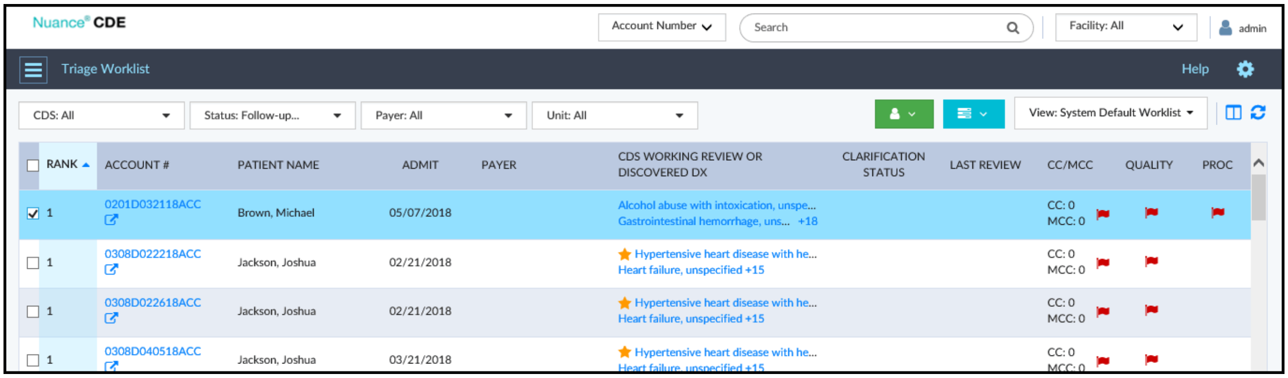


Figure 41: Triage Worklist Screen

2. From the **Status** drop-down list, select **Review Not Needed**.

   Encounter Status Change dialog box displays the selected account numbers.

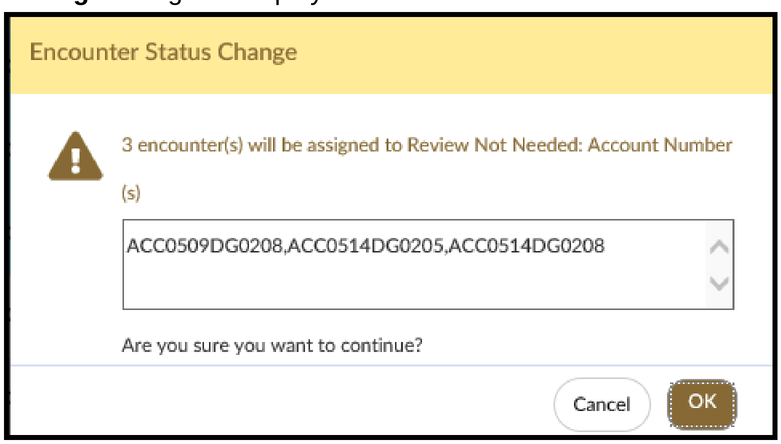


Figure 42: Encounter Status Change

3. Click **OK**.

   A success message *Encounter(s) assigned to status 'Review Not Needed' successfully* is displayed, and status of the selected encounters is changed to **Review Not Needed**.

   Note: If your worklist is not set to show the **Review Not Needed** status, encounters with **Review Not Needed** status are removed from the worklist.

Related reference

Encounter Status and Description on page 65

This section describes the encounter status displayed on the Triage Worklist screen.

CDS Assistant

Overview of CDS Assistant

CDS Assistant helps you to identify the correct diagnosis and procedure codes for the encounter, also it helps to identify the clinical evidences in the form of signs/symptoms, medications, lab results or procedures found within a provider document. Only CLU suggested codes are displayed on the **CDS Assistant** screen. You can refresh the CDS Assistant by clicking the Refresh ( ) icon. After you refresh the *CDS Assistant* screen, the last refreshed date and time is displayed.

CDS Assistant screen consists of the following:

- Diagnoses
- Clinical Evidence
- Procedures
- Snippet Viewer
- Full Document View

Other tabs on the CDS Assistant screen include:

- Document Viewer
- Laboratory

The CDS Assistant screen can be accessed from the Triage Worklist screen, by clicking the following:

- **Open CDS Assistant** icon on the Account # column
- CLU suggested code on the **CDS Working Review or Discovered DX** column
- Red flag on **CC/MCC**, **PROC**, and **QUALITY** columns
- Count (#) on the **C.E.** column

You can also open the CDS Assistant from the *Worksheet* screen, by clicking the **CDS Assistant** link.

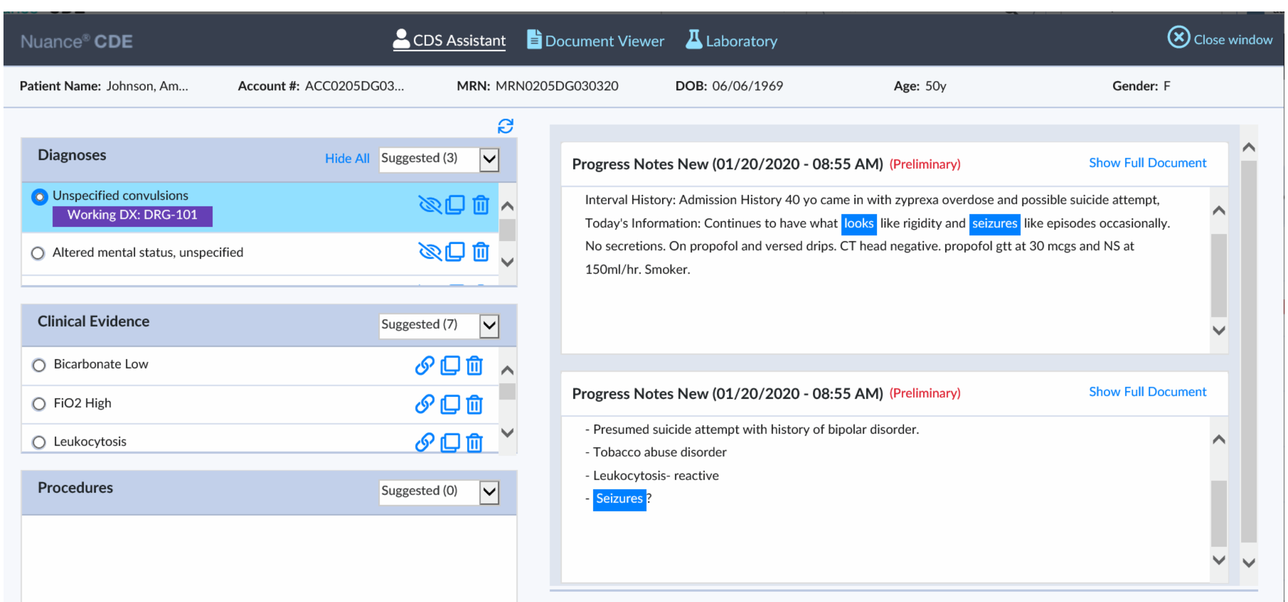
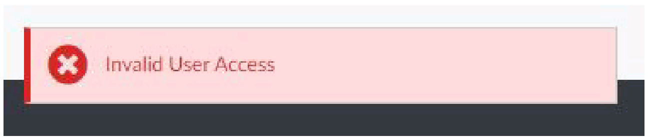


Figure 43: CDS Assistant Screen

Note: When trying to open CDS Assistant from Triage Worklist screen, any exception or unauthorized access causes error as shown below.

When trying to open CDS Assistant from Worksheet screen, any exception or unauthorized access causes error as shown below.



The system can process the non-image based RTF and the base64 encoded RTF documents. The Text, RTF, and XHTML are the document formats that can be accepted by the system.

The CLU documents automatically get purged 90 days after the patient discharge, or if there is no activity in the encounter for last 90 days. If you try to open a purged document then the system displays the following message: **Documents have been removed from CDE due to no encounter activity for 90 days. Please refer to your EMR for historical documents.**

Laboratory

The Laboratory tab displays data for the selected date range. In case no date range is selected, the data for the latest date/time will be displayed.

In case Laboratory data is not available for an encounter, this page will be blank.

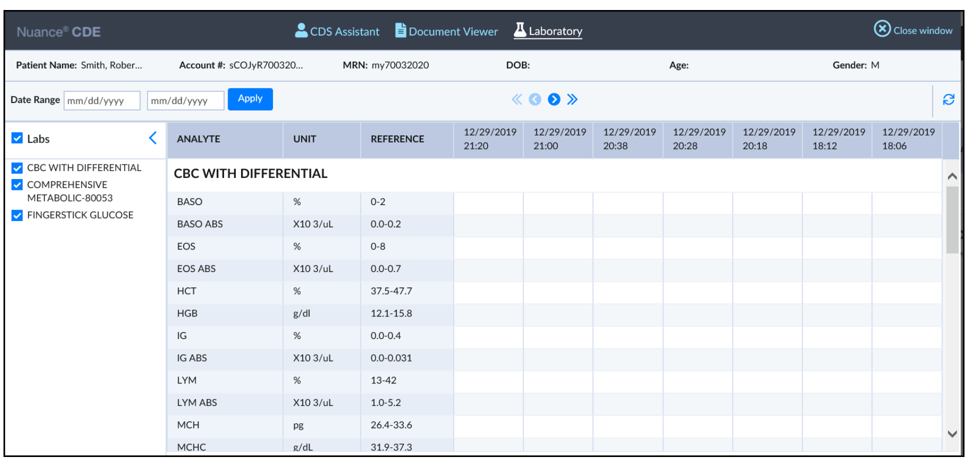


Figure 44: Laboratory data screen

The top pane displays Patient Name, Account Number, MRN, Age of the patient, Date of birth and Gender. Tooltips are available for these fields.

> **Note:** Use Refresh button to manually refresh and get any new available lab values.

1. For start date, type a date in the mm/dd/yyyy format or select a date from calendar control.

   > **Note:** If this field is blank and an end date has been entered, an error for selection of start date is displayed.

2. For end date, type a date in the mm/dd/yyyy format or select a date from calendar control.

Note: End date can be blank. If an end date is before start date, an error for selection of end date which is later than start date is displayed.

3. Click **Apply**.

   Note: Click **Clear** to clear out the date criteria.

4. Select the required **Labs** check box on the left side panel. The right side panel will display data only for the **Labs** selected.

   Note: If no Lab is selected, all available Lab panels will be shown in right panel by default.

   Note: If the **Labs** check box on the top is selected, then all Labs below get selected. This is a "select all" functionality.

   Note: The icon besides Lab is used to expand/collapse the left panel.

5. Use the navigation arrows on the top panel to navigate through the flow sheet Date/time data columns(right panel).

   Note: The left three columns in flowsheet (Analyte, Unit and Reference) are static. Flow sheet data is alphabetically sorted. Data in red colored font shows abnormal values.

   Note: The Date/Time columns are navigable. Default Chronological order for the Date/Time column is newest to oldest. Tooltips are available for the Date/Time data.

Document Type

Document type describes a document related to an encounter type that is created in a healthcare facility. The document type indicates that supporting documents are present in the medical record to support codes in an encounter.

Table 7: Documentation Sources for Nuance CDE

Admit Note	Infusion Report
Addendum Note	Labor and Delivery Note
Ancillary Therapy Report	Medical Student Report
Anesthesia Report	Nursing Note
Anticoagulation Therapy Report	Occupational Health Report
Article	Office Note
Autopsy Report	Operative Report
Brief OP Note	Pathology Report
Cardiac Note	Patient Care Conference Report
Care Summary	Patient Summary
Certificate form	Pharmacy Report
Clinical Documentation Query	Physician Orders
Coding Form	Psychiatric Evaluation Report
Consultation	Procedure Report
Continuity of Care Document	Progress Note
Correspondence	Radiology Report
Cover Letter	Respiratory Therapy Note

Diagnostic Procedure Report	Respiratory Therapy Report
Disclosure Log	Short Stay Note
DNR Documentation	Social Workers Note
Discharge Instructions	Speech Therapy Note
Discharge Summary	Surgical Pathology
Emergency Room Report	Telephone Note
Face Sheet	Transfer Summary
Flow Sheet	Wound Care Report
History and Physical	

Diagnosis, Clinical Evidence, and Procedure Sections

The section gives brief information about the Diagnoses, Clinical Evidence, and Procedure sections.

The *Diagnoses* section displays all the CLU suggested primary and secondary, manually added, rejected, and hidden diagnosis codes. The *Procedures* section displays all the CLU suggested, manually added, rejected, and hidden procedure codes. The *Clinical Evidence* section displays the signs, symptoms, medications, lab results or procedures found within a provider document.

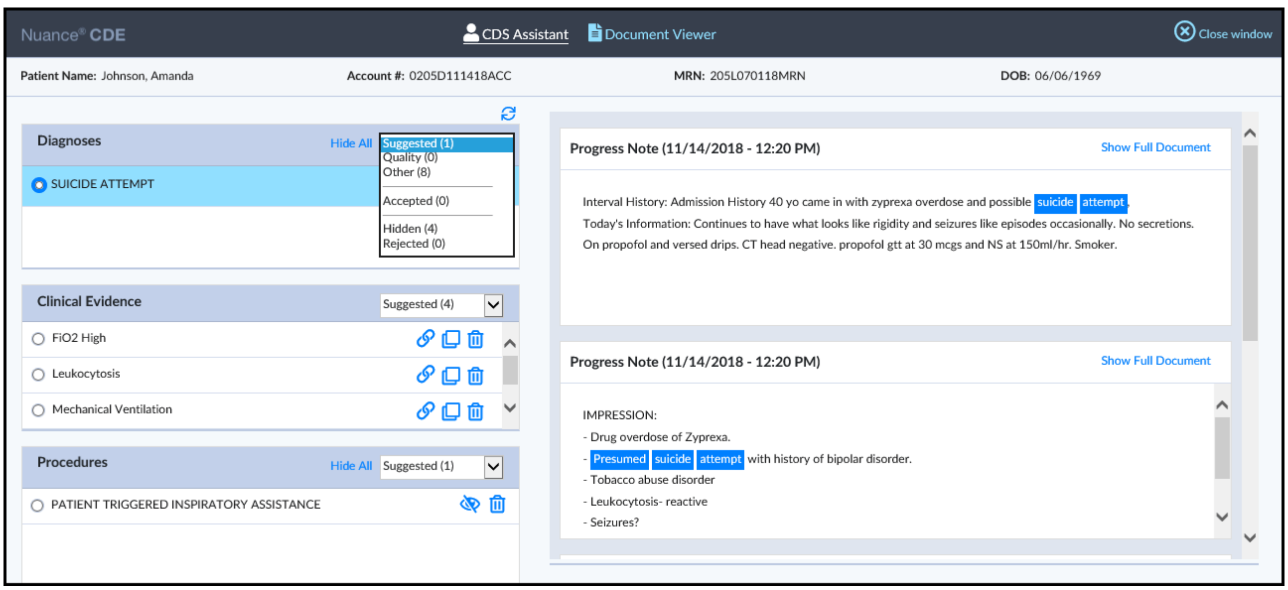


Figure 45: Diagnosis and Procedure Section Category Drop-down

Table 8: Diagnosis and Procedure Section Drop-down Category and Description

Category	Description
Suggested	Displays CC, MCC, target diagnosis, quality diagnosis code or symptom present on admission in the *Physician of Record Document*, and the patient condition is considered as Active, Chronic, Intermittent, Recurrent, Resolved, or Inherently Chronic and code must not be accepted, hidden, or rejected. Suggested codes are current, and not history (except for the inherently chronic conditions, these can be stated in history). Also suggested codes can be uncertain but not denied. It is possible that the same code is displayed in both the *Suggested* and *Quality* categories. Suggested PDX is flagged with **PDX** followed by the **Suggested DRG** value.
Quality	Displays suggested code that has HAC and PSI indicators and code must not be accepted, hidden, or rejected. It is possible that the same code is displayed in *Suggested* category.
Other	Displays non CC, MCC, target diagnosis, quality diagnosis code or symptom present on admission in the *Physician of Record Document*, and the patient condition is considered as Active, Chronic, Intermittent, Recurrent, Resolved, or Inherently Chronic and code must not be accepted, hidden, or rejected. *Other* category codes are current, and not history (except for the inherently chronic conditions, these can be stated in history). Also they can be uncertain but not denied.
Accepted	Displays diagnosis and procedure codes added in the **Working Review** or the **Possible Review** section on the *Review* screen. Resolved quality codes (HAC, PSI) display with a green check mark and unresolved quality codes display with red highlight.
Hidden	Displays diagnosis and procedure codes which are hidden by CDS.
Rejected	Displays manually rejected codes.

Note: If a diagnosis is active, it is displayed in the **Suggested** list, however if the diagnosis is historical, it displays in the **Others** list. For example, chronic in past medical history if the patient is diabetic.

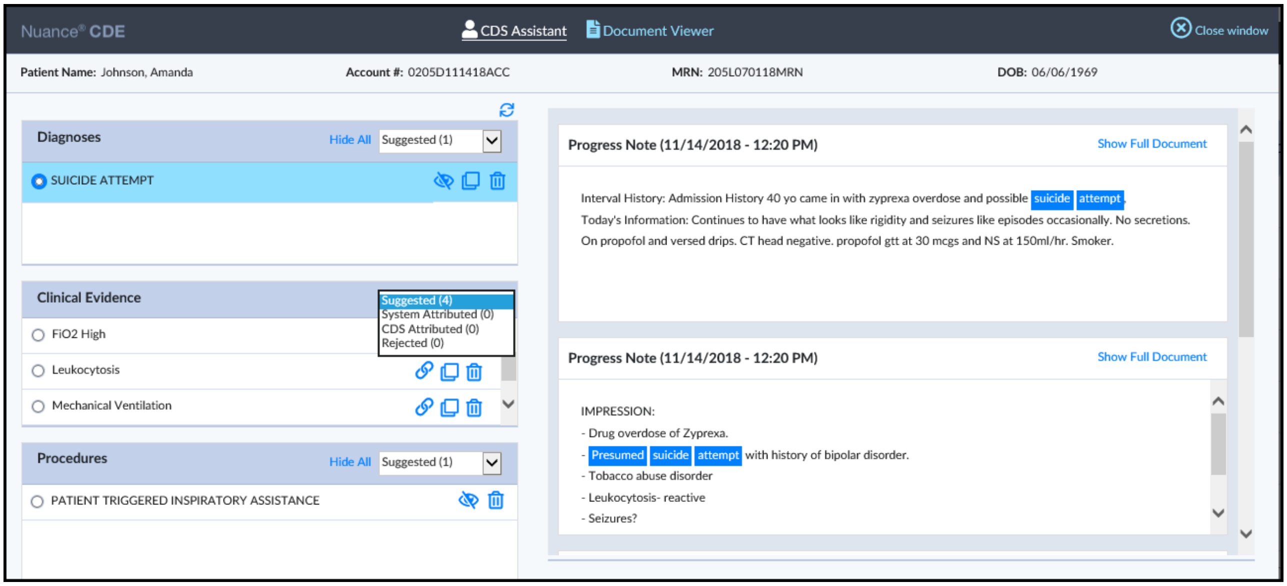


Figure 46: Clinical Evidence Category Drop-down

Table 9: Clinical Evidence Category Drop-down and Description

Category	Description
Suggested	Displays the evidence that has no suggested diagnosis code associated with it.
System Attributed	Displays the evidence that has suggested diagnosis code associated with it. Multiple diagnosis can be associated an evidence.
CDS Attributed	Displays the evidence that has been attributed to a suggested/working diagnosis by a CDS.
Rejected	Displays manually rejected evidences.

Suggested PDx/DRG

When the Working DRG and Possible DRG values are unavailable, the Suggested DRG value is displayed in the DRG column on the Triage Worklist screen. This value is click-able. When clicked, the application navigates you to the CDS Assistant page.

In the Diagnosis section of the CDS Assistant, the suggest primary diagnosis code is displayed at the top in the list in the Diagnoses section. The suggested PDx is flagged with **PDX: DRG -** followed by the suggested DRG value.

If you add the suggested primary diagnosis to Working review, the Suggested PDx is added to the accepted codes, under the Accepted drop-down, with the PDX flag. The DRG value is not displayed here. The working review tab is populated with the Suggested PDx and the DRG value.

The Suggested DRG is also sent outbound. The outbound message includes the following fields:

- DRG
- PDX
- AMLOS
- GMLOS
- SOI
- ROM
- Weight
- MDC

- Reimbursement
- Grouper/version
- Impact flags

Possible DRG is sent only when there is an agreed to clarification on any code.

Copy Diagnosis Code and Clinical Evidence

Copying Code from Diagnoses Section

This section describes how to copy a suggested code to the Working and Possible Review section in the *Review* screen.

1. Select a code description from the Diagnoses section.
2. Click the **Copy Codes** () icon.
3. Select an appropriate option from the **Copy Codes** context menu. Refer Copy Codes Context Menu Options on page 121.
   The selected code gets copied to working or possible review panel.
4. After all the desired codes are entered, click **Save** on the *Review* screen.
   After refresh, selected codes are moved to the **Accepted** category on the *CDS Assistant* screen.
5. Click **Close window**.

The selected code on the **CDS Working Review or Discovered DX** column no longer appears as a hyperlink.

Note: After the suggested codes are accepted, you must close the CDS Assistant and refresh the *Triage Worklist* screen, to see the updated worklist.

Copying Evidence from Clinical Evidence Section

This section describes how to copy a clinical evidence.

1. Select an evidence from the Clinical Evidence section.
2. Click the **Copy Evidence** () icon.
   The evidence gets copied to the clipboard and the evidence remains in the same category.

Hiding Diagnosis and Procedure Codes

This section describes how to hide a suggested code.

1. Select a code description from the Diagnoses or Procedures section.
2. Click **Hide Suggestion** ( ).
   The selected code is moved to the **Hidden** category.
3. Click **Close window**.

   The hidden code no longer appears in the applicable column of the *Triage Worklist* screen. Select the **Hide All** link to hide all codes from the **Suggested**, **Quality**, and **Other** category.
4. Click **Undo hiding** ( ) in the **Hidden** list to send the code back to the category list from where it is originated.

   Note: You can unhide only one code at a time.

Linking Evidence to a Diagnosis Code

This section describes how to link an evidence with a diagnosis code.

1. Select an evidence from the *Clinical Evidence* section.
2. Click the **Link Evidence** icon.

The **Link Evidence** dialog box is displayed.

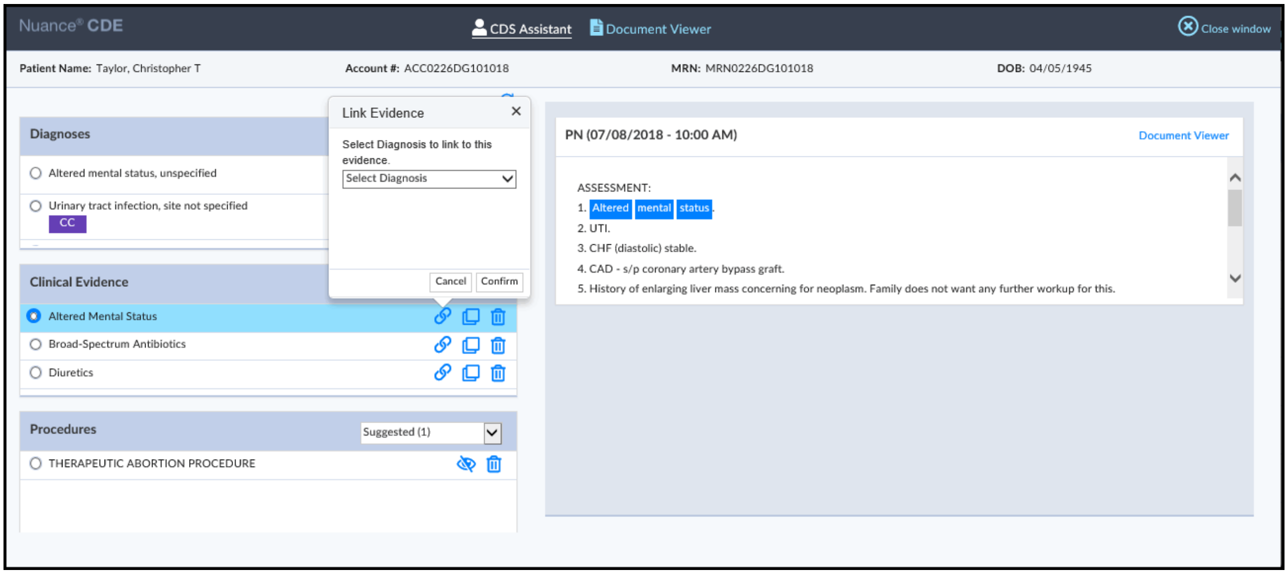


Figure 47: Link Clinical Evidence

3. From the **Select Diagnosis** drop-down list, select a diagnosis code that you want to link with the selected evidence.

   Note: The CLU suggested diagnosis codes, the quality diagnosis codes, and the diagnosis codes added in the **Working Review** section are displayed in the **Select Diagnosis** drop-down list. The rejected, hidden, and the other category codes are excluded from the list.

4. Click **Confirm**.
   The selected evidence is now linked with a diagnosis code and moved to the **CDS Attributed** category.

Removing Link Between Clinical Evidence and Diagnosis Code

This section describes how to remove link between Clinical Evidence and Diagnosis Code

1. In the *Clinical Evidence* section, select **CDS Attributed** from the the **Category** drop-down list.
2. Select the evidence.
3. Click the **Link Evidence** icon.

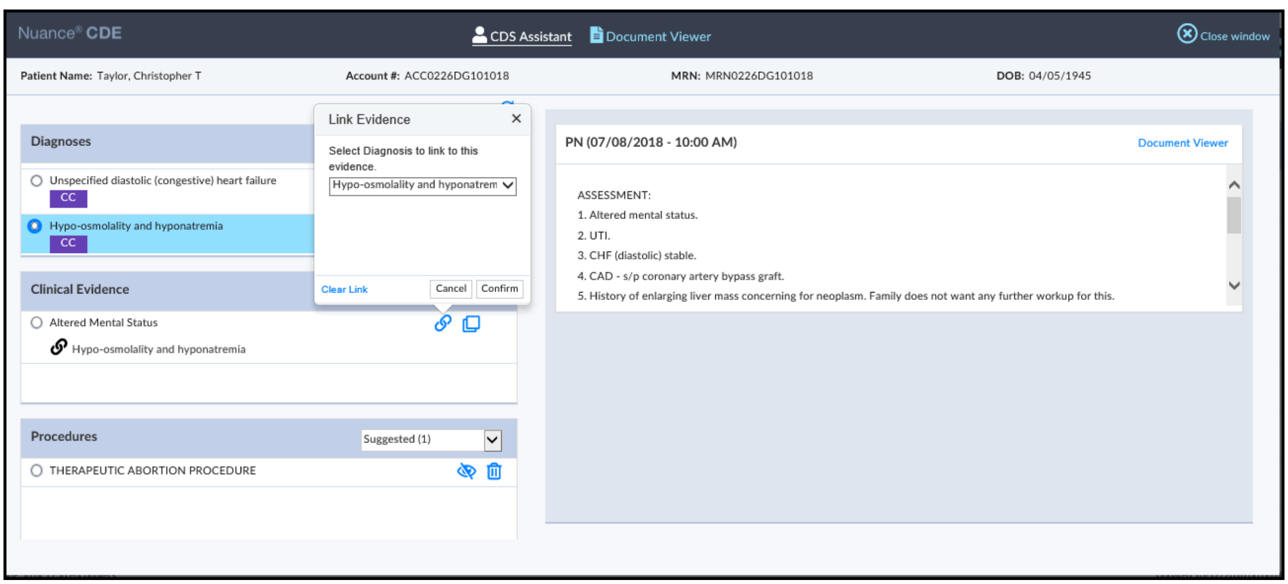


Figure 48: Remove Link- Clinical Evidence

4. Select **Clear Link** to remove the link with a diagnosis code.
   The selected evidence is no longer linked with a diagnosis code and moved to the **Suggested** category.

Replacing the Linked Diagnosis code with a New Diagnosis Code

1. In the *Clinical Evidence* section, select **CDS Attributed** from the the **Category** drop-down list.
2. Select the evidence.
3. Click the **Link Evidence** icon.

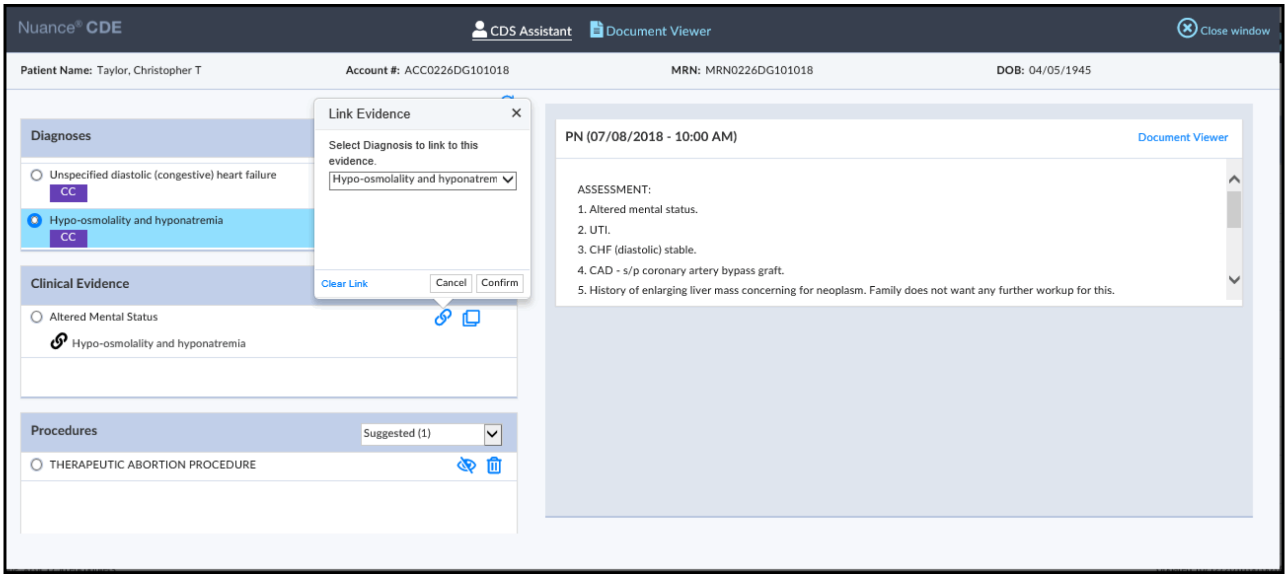


Figure 49: Replace Link- Clinical Evidence

4. Select the diagnosis code that you want to replace with the existing linked diagnosis code from the diagnosis code selection drop-down list.
5. Click **Confirm**.
   The selected evidence is now linked with the new diagnosis code.

Rejecting Code from Diagnoses, Procedures, and Clinical Evidence Sections

This section describes how to reject a suggested code.

1. Select a code description from the Diagnoses or Procedures section, or select the evidence from the Clinical Evidence section.
2. Click the **Reject suggestion** ( ) icon.
   The selected code is moved to the **Rejected** category.

   Note: If you try to reject a suggested diagnosis code that is linked with a clinical evidence, a warning dialog-box is displayed.

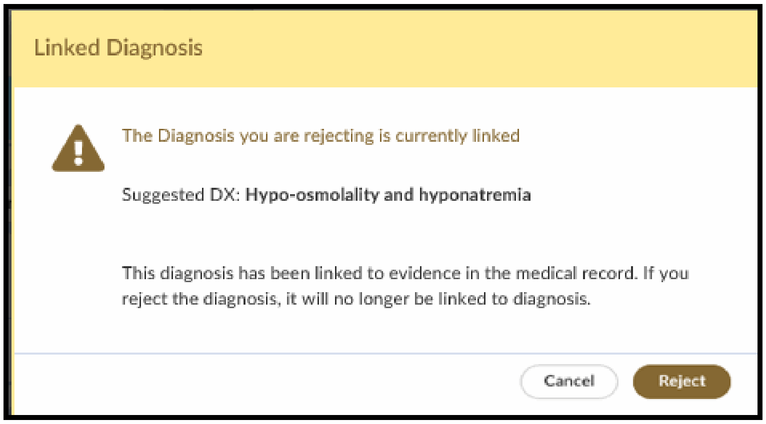


Figure 50: Linked Diagnosis Warning Dialog Box

3. Click **Close window**.
   The rejected code no longer appears in the applicable column of the Triage Worklist screen.
4. Click the **Undo rejection** ( ) icon in **Rejected** list to undo the rejection, and send the code back to the category list from where it originated.

Note:

- A code may reappear in the Suggested category if it is rejected, added to the review, and then deleted from the review.
- If you reject a code, you must refresh the worklist after closing CDS Assistant. This may affect the ranking of the encounter.
- You cannot reject evidence which is linked to a suggested code.

Snippet and Full Document View

In the snippet view, snippets of the documents associated to selected code from the Diagnoses or Procedures section are displayed and text associated with the selected code gets highlighted. Tool-tip displays the document type, document ID, provider name, provider ID, and provider specialty for each document.

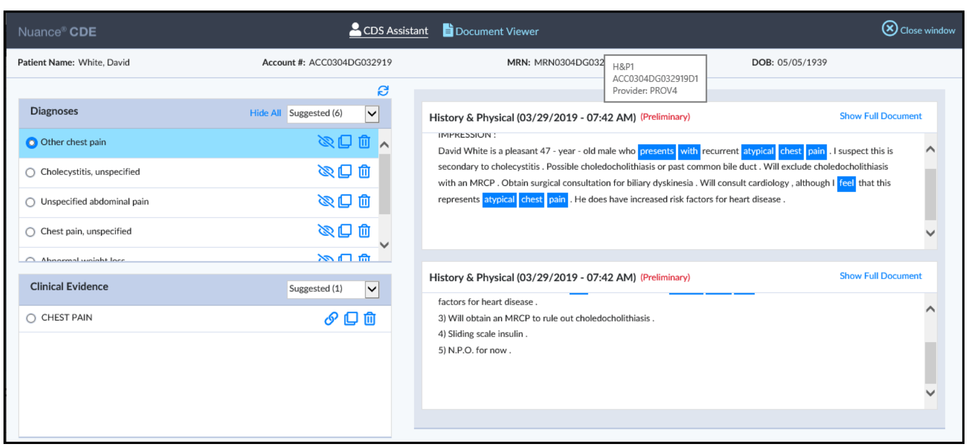


Figure 51: Snippet View

In the full document view, the complete document associated to the selected diagnoses or procedure code snippet is displayed in the *CDS Assistant* screen. Evidences related to the selected diagnoses or procedure code are highlighted with underlined blue background and rest of the evidences found in the document are displayed with blue highlight. The full snippet of the selected diagnoses or procedure code in the document is highlighted with light blue background. Tool-tip displays the document type, document ID, provider name, provider ID, and provider specialty for each document.

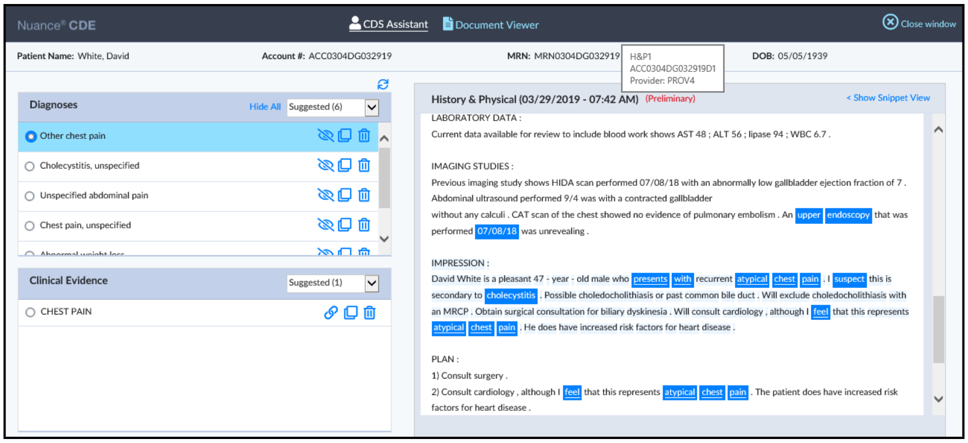


Figure 52: Full Document View

Note: Document status **(Preliminary)** is displayed in the header of the snippet viewer when the status of the document is a draft.

Accessing Full Document/ Snippet view

1. Click on the **Show full document** link on the snippet view to display complete document in the *CDS Assistant* screen.

   Note: When a complete document is displayed in the full document view, then the status of the document is changed to **Read** on the *Document Viewer* screen.

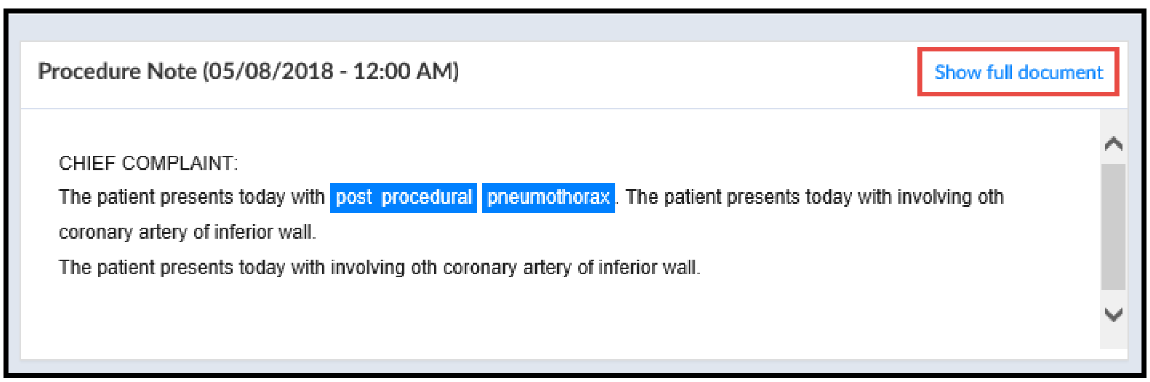


Figure 53: Document Viewer Link

2. Click on the **Show snippet view** link to go back to the snippet view from the complete document.

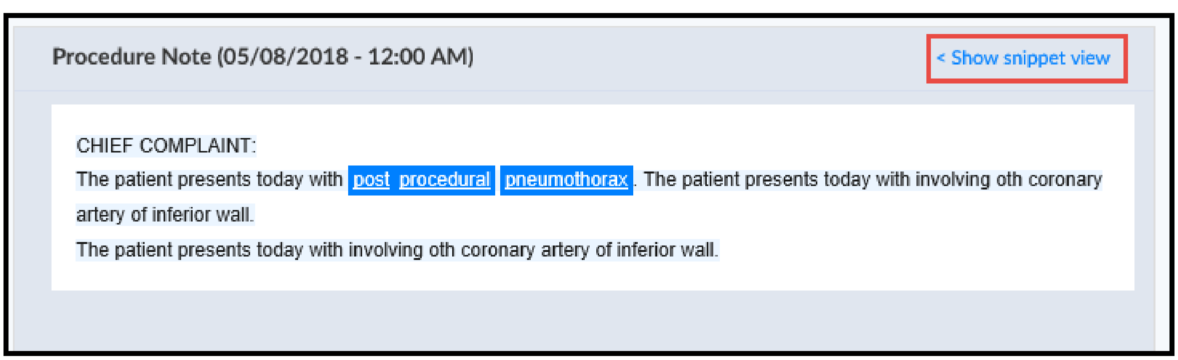


Figure 54: Return to Snippet Link

Document Viewer

The document viewer displays documents which are sent to Nuance CDE from the EHR, and may or may not contain CLU extracted diagnosis/procedure codes.

Document viewer consists of patient banner, document list panel, and the view document section.

The patient banner displays the basic patient demographic information such as patient name, account number, MRN, and date of birth.

The document list panel displays all the available documents for a specific encounter. Documents displayed in the document list panel are grouped by the document type and sorted by the document date in descending order. The document list displays the document date/time, external document type, external document ID, provider name, provider ID, and provider specialty for each document.

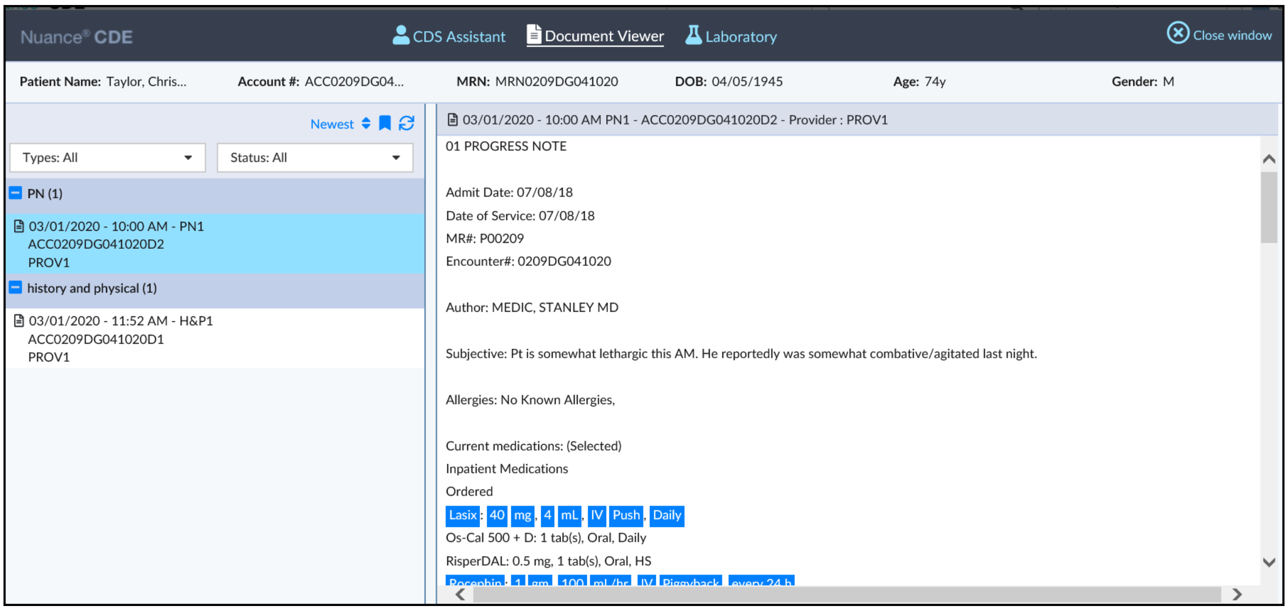


Figure 55: Document Viewer

The following quick filters are available on the document viewer:

- **Types**: You can filter the document list by the document type. By default all the document types are selected.
- **Status**: You can filter the document list by the status of the document such as **Read**, **Unread**, **Updated**, or **Bookmarked**. By default all the statuses are selected.

Documents can be sorted by clicking the Sort icon ( ). By default, the documents are sorted as newest to oldest.

Unread documents are displayed in bold font. You can bookmark a document for review by clicking the **Bookmark** icon ( ) at the top of the panel, and the bookmarked document is displayed with a red flag ( ) in the document list. You can refresh the document viewer by clicking the Refresh ( ) icon. When an existing document is updated, the updated flag (Updated) is displayed. On the *CDS Assistant* screen, when you view a document in full document view, then the status of that document is considered as read.

The complete document is displayed in the view document section and evidence related to the diagnoses or procedure code is highlighted with a blue background.

The CLU documents automatically get purged 90 days after the patient discharge, or if there is no activity in the encounter for last 90 days. If you try to open a purged document then the system displays the following message: **Documents have been removed from CDE due to no encounter activity for 90 days. Please refer to your EMR for historical documents.**

Chapter 5

Worksheet

Topics:

About Worksheet

The worksheet provides a way to record and collect clinical data for patients that are being reviewed. Also you can add clinical information throughout the patient's stay in the hospital.

The *Worksheet* screen is accessible from the *Triage Worklist* screen, by clicking on the patient account number.

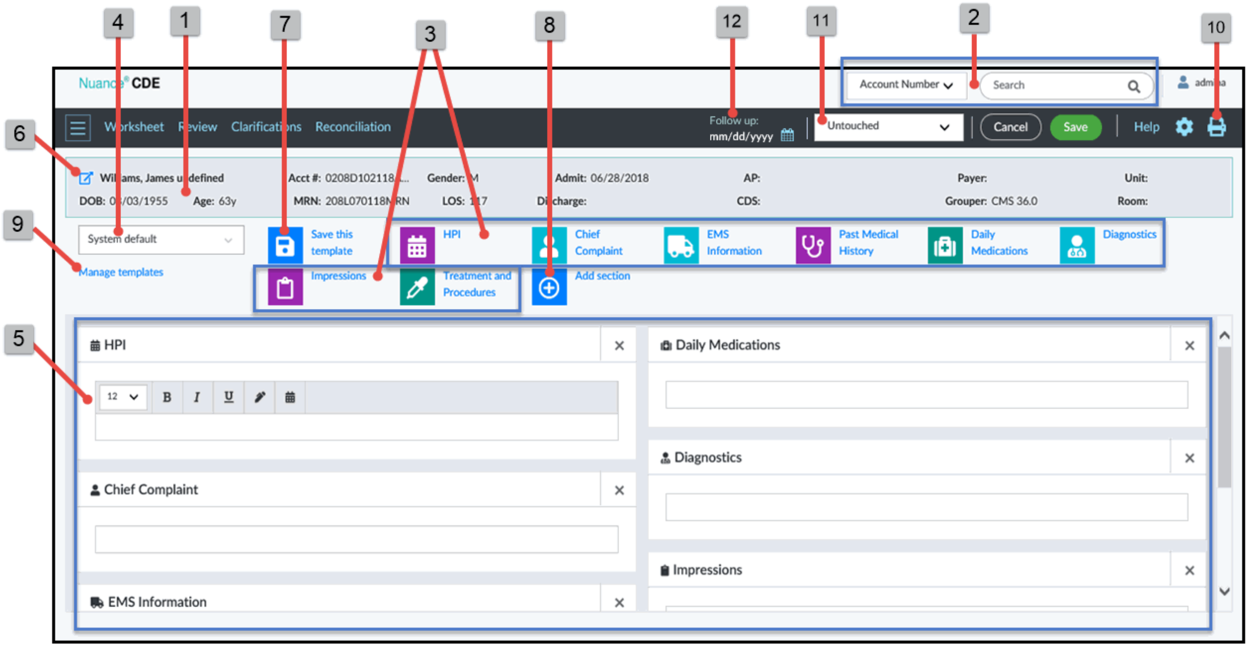


Figure 56: Worksheet Screen

Table 10: Worksheet Screen Identification and Purpose

Item	Description	Purpose
1	Patient banner	Displays the patient demographic information, discharge status, visit type, payer, and grouper information.
2	Quick search	Search for a specific account number, MRN, or patient name.
3	Worksheet icon panel	Navigate between worksheet sections.
4	Select template drop-down	Select custom or system default template.
5	Worksheet section	Enter documented evidences for the patient. Press `Alt+p` to auto populate the current user and date/time information.
6	View CDS Assistant and Document Viewer	Displays CDS Assistant and Document Viewer screen.
7	Save this template	Create or modify custom a worksheet template.
8	Add section	Create, remove, reorder, and delete a custom section.
9	Manage templates	Rename, or delete an existing custom worksheet template. You can also set a worksheet template as default.

Item	Description	Purpose
10	Print	Print the encounter worksheet.
11	Encounter Status drop-down	Displays the status of the encounter.
12	Encounter Follow-up	Displays the encounter follow-up date.

Note: If you are viewing a worksheet that is assigned to another CDS, then in the template drop-down list the **Select Template** option is displayed.

Worksheet Section

The following system default sections are displayed on the Worksheet screen, where you can add/view patient related information:

- HPI
- Chief Complaint
- EMS Information
- Past Medical History
- Daily Medications
- Diagnostics
- Impressions
- Treatment and Procedures

Apart from system default sections, you can create custom sections as required in the Worksheet screen. Refer Creating Custom Section on page 92.

Creating Custom Section

This section describes how to create a custom section in the Worksheet.

1. On the *Worksheet* screen, click **Add section**.
   The Add Worksheet Section dialog box is displayed.

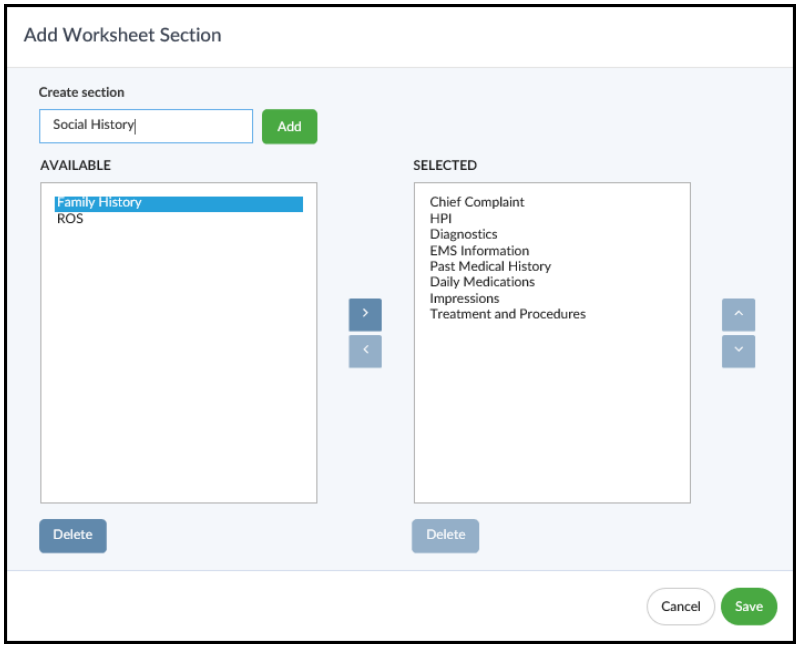


Figure 57: Add Worksheet Section - Create

2. In the **Create section** field, type the name of the custom section that you want to create.

   Important: The section name must be unique, and can contain alphanumeric characters, dash, space, and underscore. Maximum 30 characters are allowed.

3. Click **Add**.
   The worksheet sections are displayed in alphabetical order in the **Available** list.
4. Click **Save**.

Adding Section to the Worksheet

This section describes how to add the sections on the Worksheet screen.

1. On the Worksheet screen, click **Add section**.
   The Add Worksheet Section dialog box is displayed.

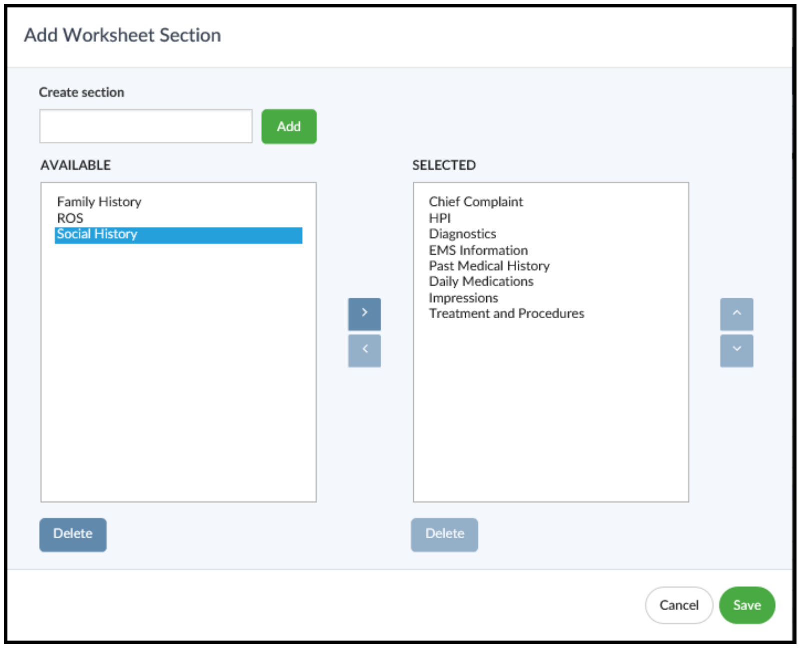


Figure 58: Add Worksheet Section - Add

2. Select one or more sections that you want to add on the Worksheet screen from the **Available** box.
   Use the **Move Right** button to move the selected sections from the **Available** to the **Selected** box.
   To change the sequence of the selected sections, use the **Move Up** or **Move Down** button.
3. Click **Save** to save the change, or click **Cancel** to discard.
   Upon save, the selected section gets added to the worksheet.

Note: After you added a section to the worksheet, if you do not edit or create a template then this change is applicable only for that encounter. For more information about creating or editing a template, please refer Creating Custom Worksheet Template on page 98, Editing Custom Worksheet Template on page 99.

Removing a Section from the Worksheet

This section describes how to remove section from the Worksheet screen. When you remove a section from the worksheet, information available in that section is also gets deleted.

There are two ways to remove section from the Worksheet screen:

- Using **Close**
- From **Add Section**

Using Close

1. On the Worksheet screen, select the section you want to delete.
2. Click **Close**(✕).

Note: If the section contains evidence, the following warning message is displayed: *Are you sure you want to remove the section?If you remove the section, the information you have entered will be permanently deleted. Press 'OK' to remove the section or 'Cancel' to stay on the current page without removing the section.*

Using the Add Worksheet Section Dialog Box

1. On the Worksheet screen, click **Add section**.
The Add Worksheet Section dialog box is displayed.

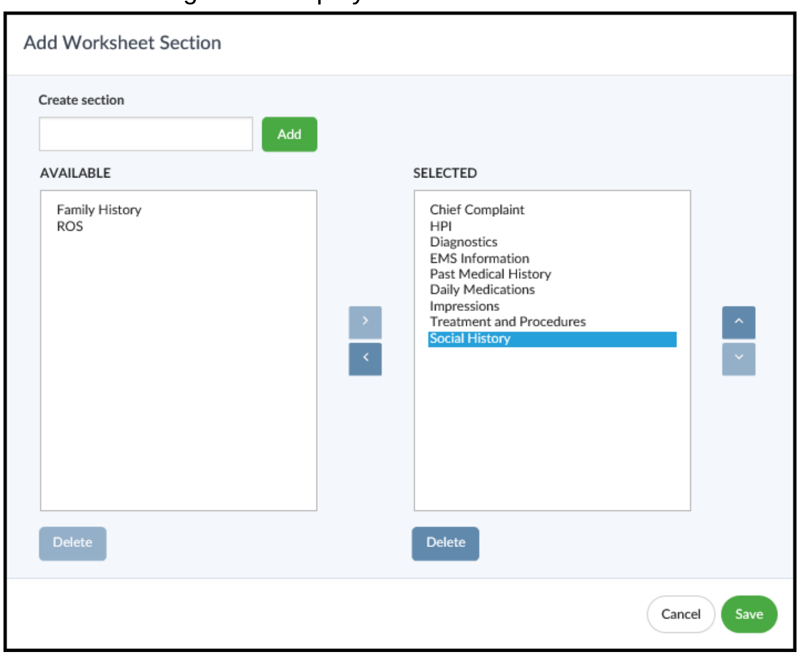


Figure 59: Add Worksheet Section - Remove

2. From the **Selected** box, select one or more sections that you want to remove from the Worksheet screen.

   Use the **Move Left** button to move the selected sections from the **Selected** to the **Available** box.

Note: If you have any documented evidence in that section, the following warning message is displayed: *Moving the section from SELECTED to AVAILABLE will delete the information you may have entered in the section.*

3. Click **Save** to save the change, or click **Cancel** to discard.
Upon save, the selected section gets removed from the worksheet.

Note: If the removed section was created by a different CDS, then the section does not appear on the Worksheet or on the Add Worksheet Section dialog box again.

Note: After you remove a section from the worksheet, if you do not edit or create a template then this change is applicable only for that encounter. For more information about creating or editing a template, please refer Creating Custom Worksheet Template on page 98, Editing Custom Worksheet Template on page 99.

Deleting Custom Section

This section describes how to delete a custom section from the worksheet. When you delete a section from the worksheet, the section gets permanently deleted and you cannot use the section in future.

Note: You can not delete following sections:

- System default
- Sections which have documented evidences
- Sections which are created by another CDS

1. From the Worksheet screen, click **Add section**.
   The Add Worksheet Section dialog box is displayed.

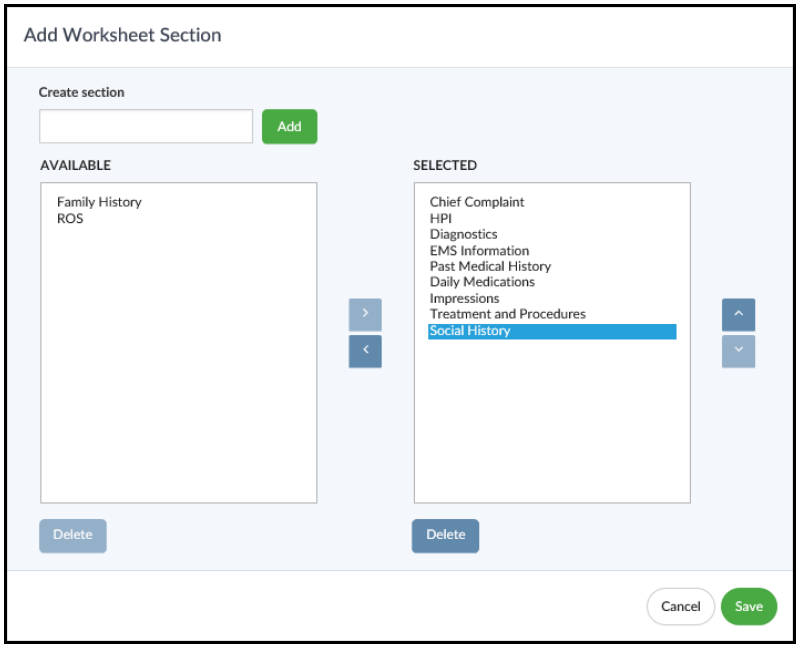


Figure 60: Add Worksheet Section - Delete

2. Select one or more sections from the **Available** or **Selected** box that you want to delete.
3. Click **Delete**.
4. Click **Save**.
   The selected sections get permanently deleted from the worksheet.

Formatting Text within the Sections

The worksheet includes several formatting tools that allow you to customize your text. Depending on the purpose of your document, altering certain formatting elements like changing font size, underline, bold, italics, or highlighting may be crucial. You can also enter dates in the section. The following section outlines what worksheet allows you to format and how to best utilize it.

Note: Maximum 20,000 characters are supported in each worksheet section.

Table 11: Section Formatting

Format Type	Description	Purpose
	Font-size Selector	This can be used to change the size of the selected font between 10 and 36. By default 12 font size is selected.
	Bold Icon	This can be used to bold/unbold the selected text.
	Italics Icon	This can be used to italicize the selected text.
	Underline Icon	This can be used to underline the selected text.
	Highlight Icon	This can be used to highlight the selected text.
	Date-picker Icon	This can be used to enter a date in the section.

You must save the worksheet after you add or modify any information. Without saving the worksheet if you try to move away, the following error message is displayed: *Unsaved changes will be lost. Press OK to continue without saving, or Cancel to stay on the current page*.

Creating Custom Worksheet Template

This section describes how to create a custom worksheet template.

1. To create a custom worksheet template, perform any of the following on the Worksheet:
   - Reorder the sections
   - Add a section
   - Remove a section
2. Click **Save this template**.
   The Save Worksheet Template dialog box is displayed.

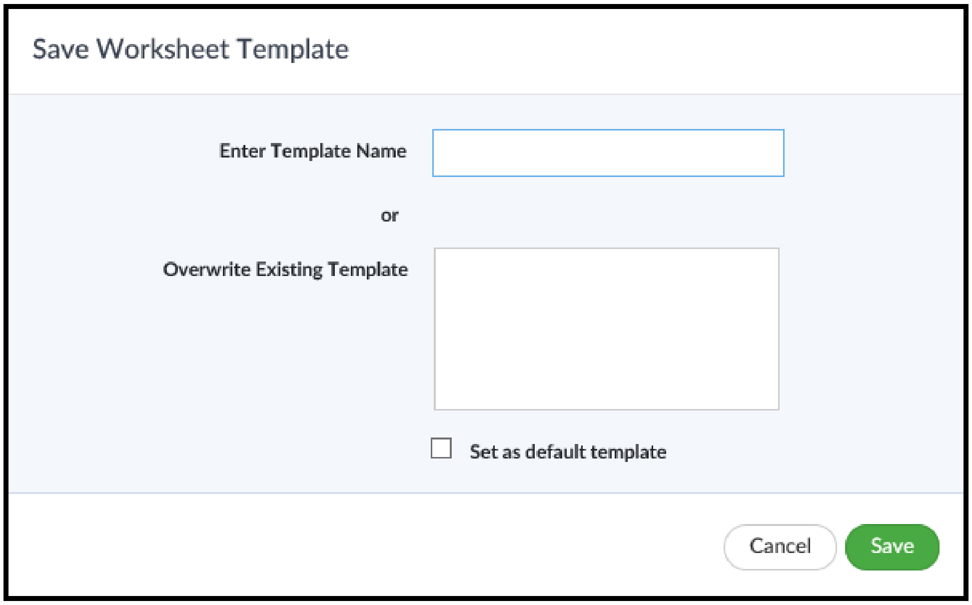


Figure 61: Save Worksheet Template - Create

3. In the **Enter Template Name** field, type the name of the template that you want to create.

   Important: The template name must be unique, and can contain alphanumeric characters, dash, space, and underscore. Maximum 50 characters are allowed.
4. If you want to make this template as a default template, select the **Make default template** check box.
5. Click **Save**.
6. Select the template from the **Select Template** drop-down to apply the template.

Editing Custom Worksheet Template

This section describes how to edit a custom worksheet template.

1. Reorder, add, or remove any sections from the worksheet as necessary.
2. Click **Save this template**.
   The Save Worksheet Template dialog box is displayed.

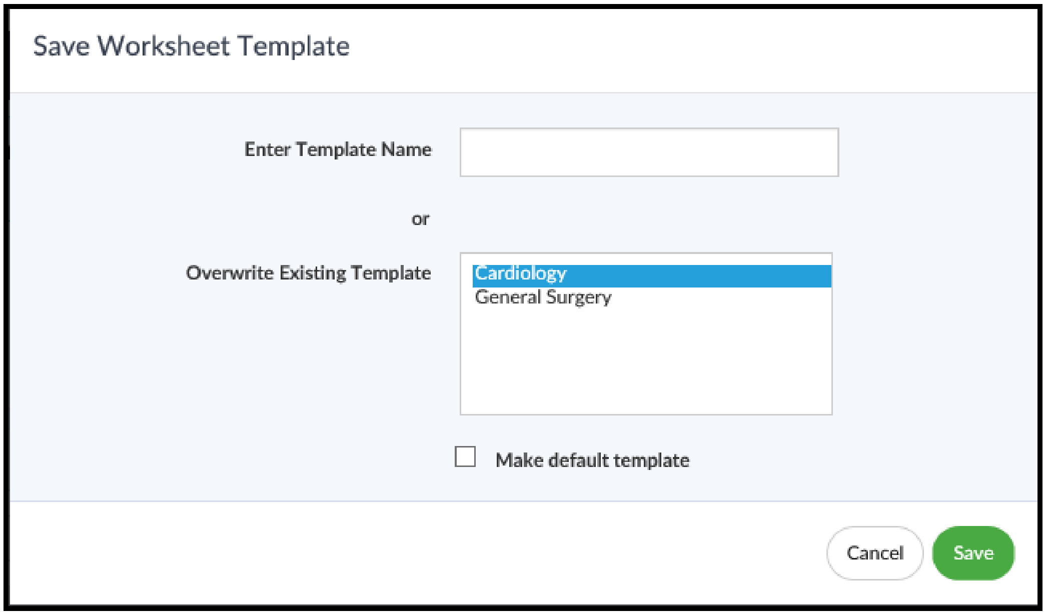


Figure 62: Save Worksheet Template - Edit

3. From the **Overwrite Existing Template** section, select an existing template that you want to overwrite.

   Note: If you want to make this template as a default template, select the **Make default template** check box.

4. Click **Save**.

Managing Custom Worksheet Templates

This section describes how to manage an existing custom worksheet. From the Manage Worksheet Templates, you can do the following:

- Select the existing worksheet template as default
- Rename a worksheet template
- Delete a worksheet template

Defaulting an Existing Worksheet Template

1. On the Worksheet screen, click **Manage templates**.
   The Manage Worksheet Templates dialog box is displayed.
2. Select the radio button next to the worksheet template that you want to set as default.

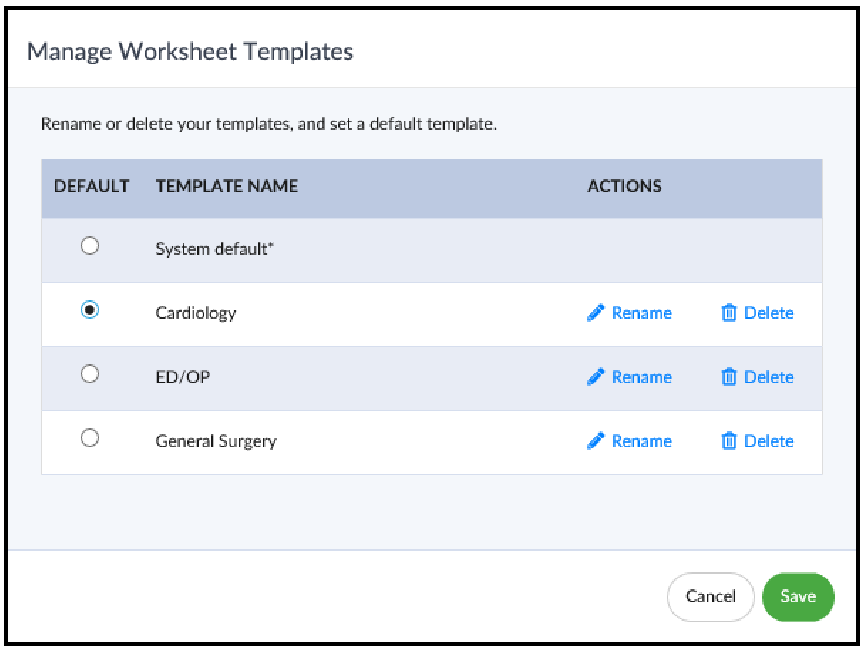


Figure 63: Manage Worksheet Templates - Default

3. Click **Save**.

Renaming a Worksheet Template

1. On the Worksheet screen, click **Manage templates**.
   The Manage Worksheet Templates dialog box is displayed.
2. Click **Rename** to rename a worksheet.

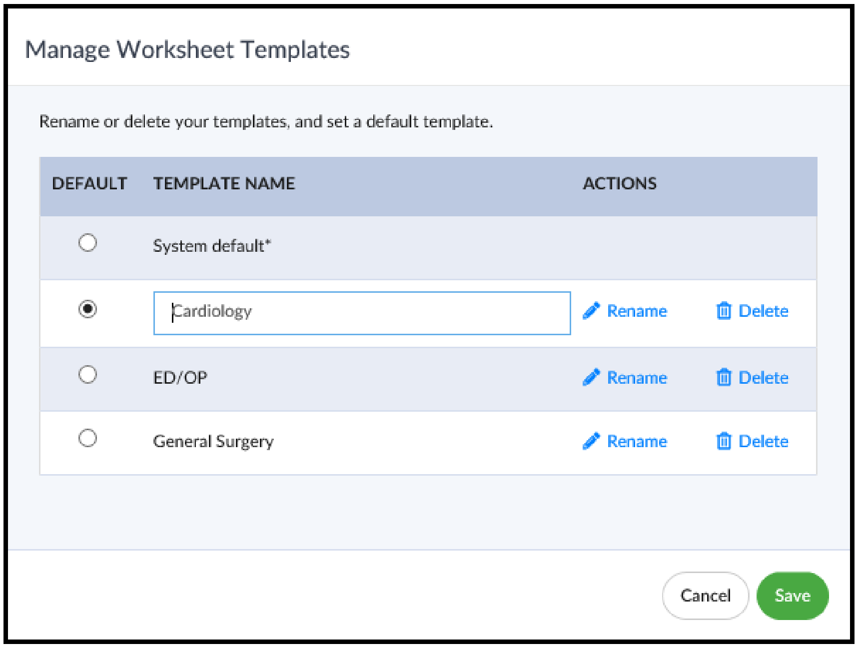


Figure 64: Manage Worksheet Templates - Rename

3. Type the name of the template in the **TEMPLATE NAME** column.

   Note: The name must be unique for the same CDS, and maximum 50 characters are allowed.

4. Click **Save**.

Deleting a Worksheet Template

1. On the Worksheet screen, click **Manage templates**.
   The Manage Worksheet Templates dialog box is displayed.
2. Click **Delete** to delete a worksheet.

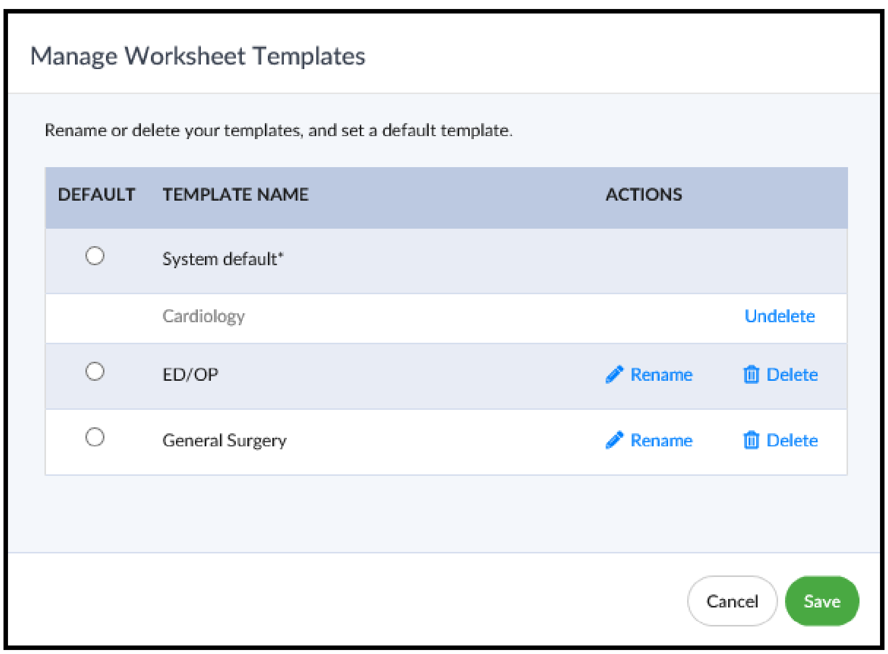


Figure 65: Manage Worksheet Templates - Delete

Note: You can restore a deleted worksheet template by clicking **Undelete**.

3. Click **Save**.
   The worksheet template gets deleted and does not appear in the **Select template** drop-down.

   Note: If you delete your default template, then the system default template becomes the default.

Using Quick Search From the Worksheet

Using quick search from the Worksheet screen, you can search for a specific account number, MRN, or patient name and directly open the worksheet for the selected encounter.

1. From the Criterion drop-down list, select **Account Number**, **MRN**, or **Patient Name**.

Figure 66: Quick Search

2. Type text/number in the search field based on the above selection.
3. Click **Search**( ).
   The system navigates back to the Triage Worklist screen and displays all the possible matches.

Printing a Worksheet

This section describes how to print the worksheet.

1. Click **Print**.
   The **Print Encounter** dialog-box is displayed.

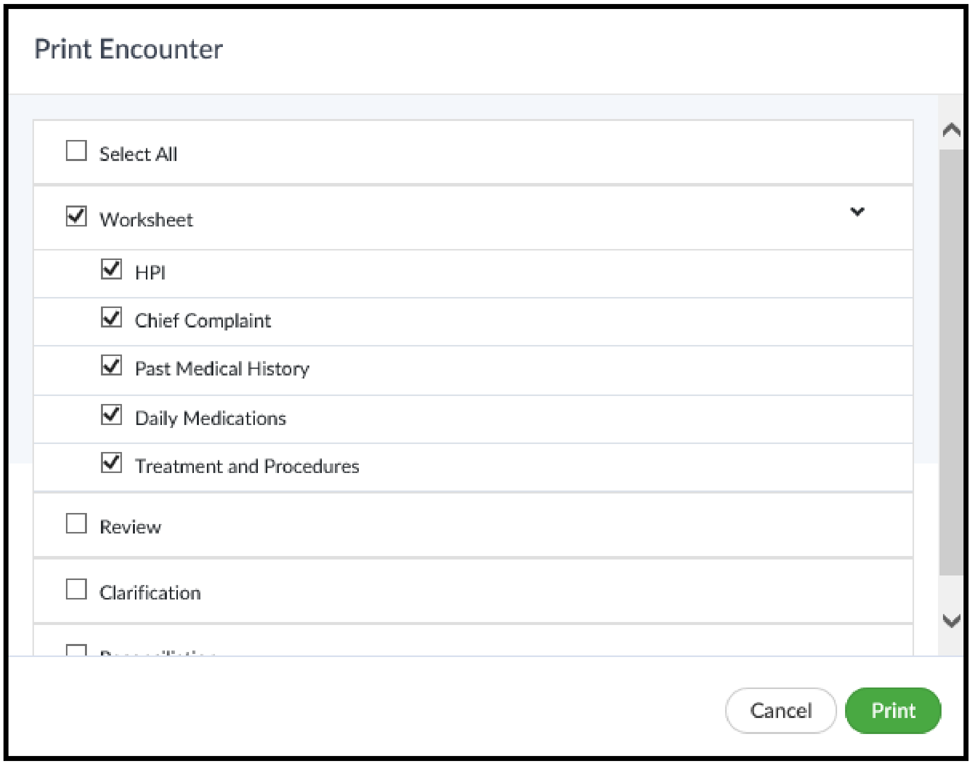


Figure 67: Print Encounter Dialog-box - Worksheet

Important: Only the worksheet sections which have data gets displayed.

2. Select the worksheet sections that you want to print or select the **Select All** checkbox to print the complete encounter documentation (Worksheet, Review, Clarification, and Reconciliation).
3. Click **Print**.
   The print preview window is displayed.

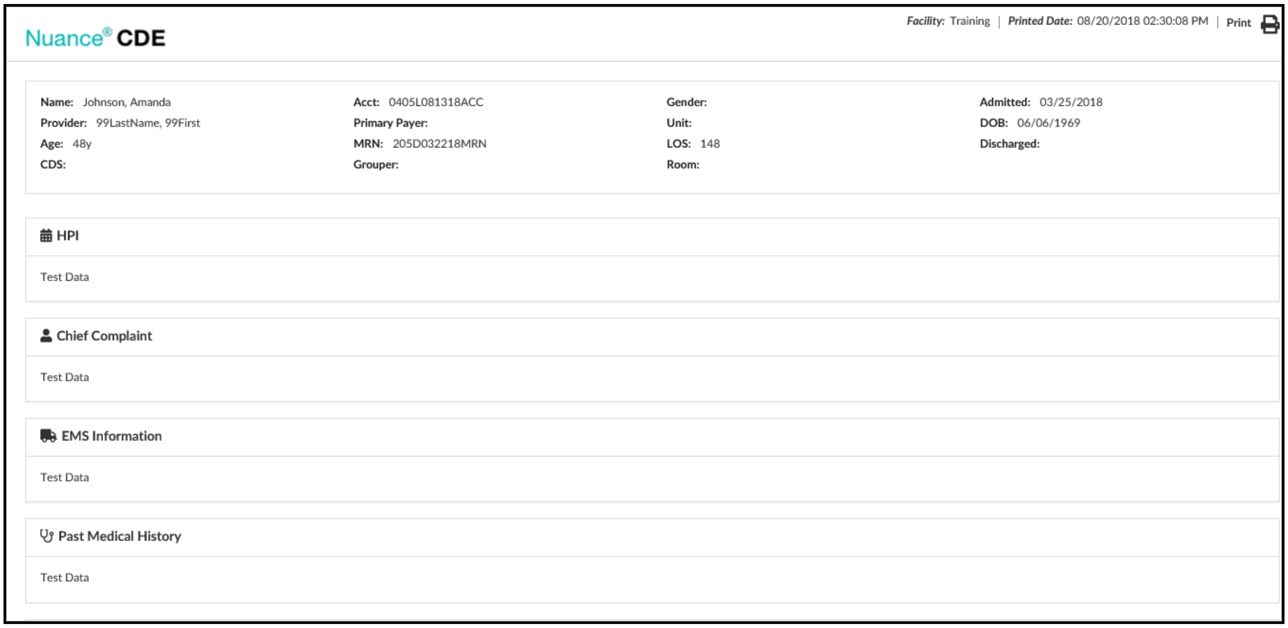


Figure 68: Print Preview Screen - Worksheet

4. Click **Print**.
   The **Print** dialog-box is displayed.

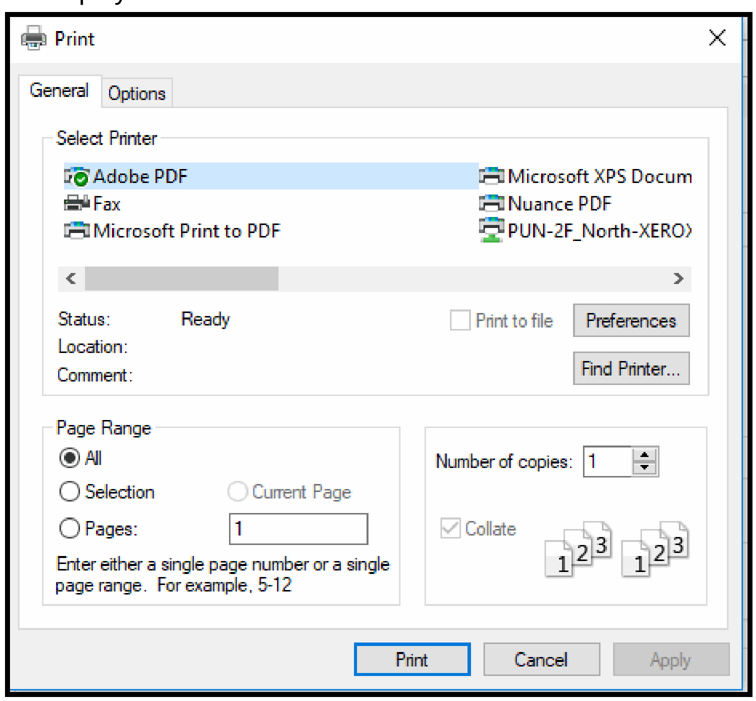


Figure 69: Print Dialog-box

5. Set the print settings for your desired print options.

   You can select the quantity of copies desired, page selection locations, page orientation (portrait to landscape and vice versa), and printer.
6. Click **Apply**, if you've made changes in the print setting.
7. Click **Print**.

Encounter Follow-up Date

When you save an encounter with **Untouched** or **Reconciliation Hold** status, then the encounter status automatically changes to **In Progress** and you are prompted to enter the follow-up date. To change the follow-up date of an **In Progress** encounter, you must manually select the **Follow up date picker** icon ( ) icon and set the encounter follow-up date before you save the encounter.

1. Open an encounter with status **Untouched** or **Reconciliation Hold**.
2. Make necessary changes in the encounter.
3. Click **Save**.
   The **Set Follow-up Date** dialog box is displayed.

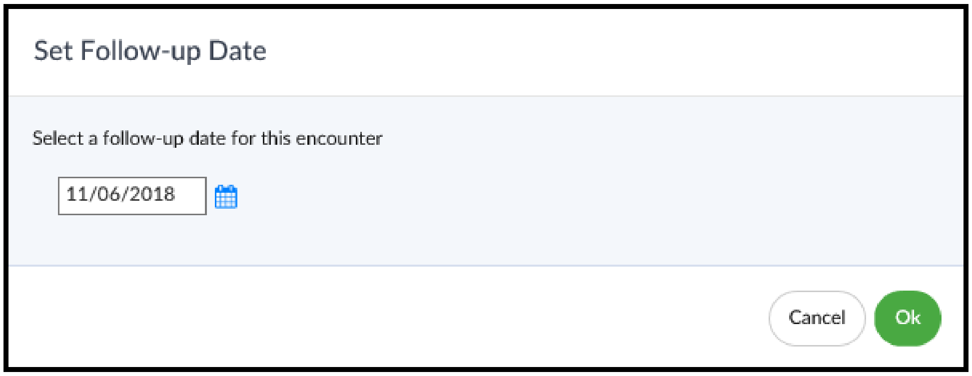


Figure 70: Set Follow-up Date

   For an *In Progress* encounter if the previously saved follow-up date has expired, then system displays the **Set Follow-up Date** dialog box.
4. Select the follow-up date from the date look-up or manually enter the date in **mm/dd/yyyy** format.
5. Click **Ok**.
   The encounter gets saved and the follow-up date is displayed on the *Triage Worklist* screen.

   Note: For an **In Progress** encounter if your previously saved follow-up date hasn't expired, still you can edit the existing date by clicking on the **Follow up date picker** icon ( ) before you save the encounter.

Working with Dragon Medical One

About Dragon Medical One

The Dragon Medical One (DM One) is a speech recognition solution that provides a consistent and personalized clinical documentation experience. The DM One allows the CDS to dictate text directly into the encounter worksheet quickly and accurately using their voice.

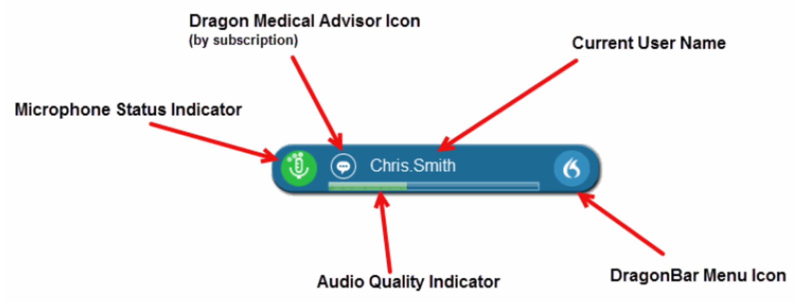


Figure 71: Dragon Bar

Microphone Status Indicator

Use the microphone button to turn the microphone on and off. Green appears for the active status and the microphone is listening. Red appears for the inactive status. The Microphone Status Indicator shows a spinning motion to let you know that DM One is listening and processing your speech or commands.

Audio Quality Indicator

The Voice Activity Detection (VAD) indicates audio is recording and displays the volume level. For optimal performance, it is recommended to position your microphone approximately 1 inch below your mouth and 1-3 inches away.

Current User Name

This indicates the user name of the person currently logged into the DM One. Users must be logged into the Dragon to access their individual commands and settings.

DragonBar Menu

The DragonBar Menu includes user and microphone settings and options that allow you to access information about the DM One application and the configuration.

Figure 72: DragonBar Menu

- **Log Off**: Allows you to change Users, Microphones, and Specialties without having to re-launch DM One from the desktop icon. Depending on your sign-in environment, you may be required to Exit DM One and relaunch to change your settings.
- **Options**: Allows you to set your own preferences. Such as: PowerMic button customization.
- **Manage Auto-Text**: Manage and create Auto-text commands
- **Manage Step-by-step Commands**: Manage and create Step-by-step command
- **Manage Vocabulary**: Add and edit custom words or phrases for better accuracy.
- **Show/Hide Dictation Box**: A free-text box that allows you to collect dictated text independent of your worksheet sections and then copy the text into the worksheet.
- **Help**: Walks you through the detailed steps on how to use the dictation.

Voice Commands

Table 12: Command Name and Function

Topic	Command Name	Function
User Settings	Open Settings	Modify the DMO user settings.
Dragon	Hide Dragon	Control the DMO application.
Anchoring	Show anchored application	Control the application that has the speech focus anchored to it.
Recording	Microphone off	Control the microphone using your voice.
Personalization and Help	Open Help	Switch between your dictation and the online help.

Command Name	Function
Scratch that	Erase the last word or phrase spoken
Deselect that or Unselect that	Deselect the highlighted text

Command Name	Function
Undo That	The same as pressing CTRL+Z to undo the last action
Redo That	The same as pressing CTRL+Y to redo the last action
Go back	Return the cursor to the position prior to the selection command
Bold that	Bold the selected text
Select again or Select previous	Scroll backwards through the text to select a different occurrence of the selected text

Chapter 6

Review

Topics:

About the Review Screen

The main purpose of the *Review* screen is to add the codes in the encounter based on the current documentation, and also based on the documentation that may be pending from the provider clarifications.

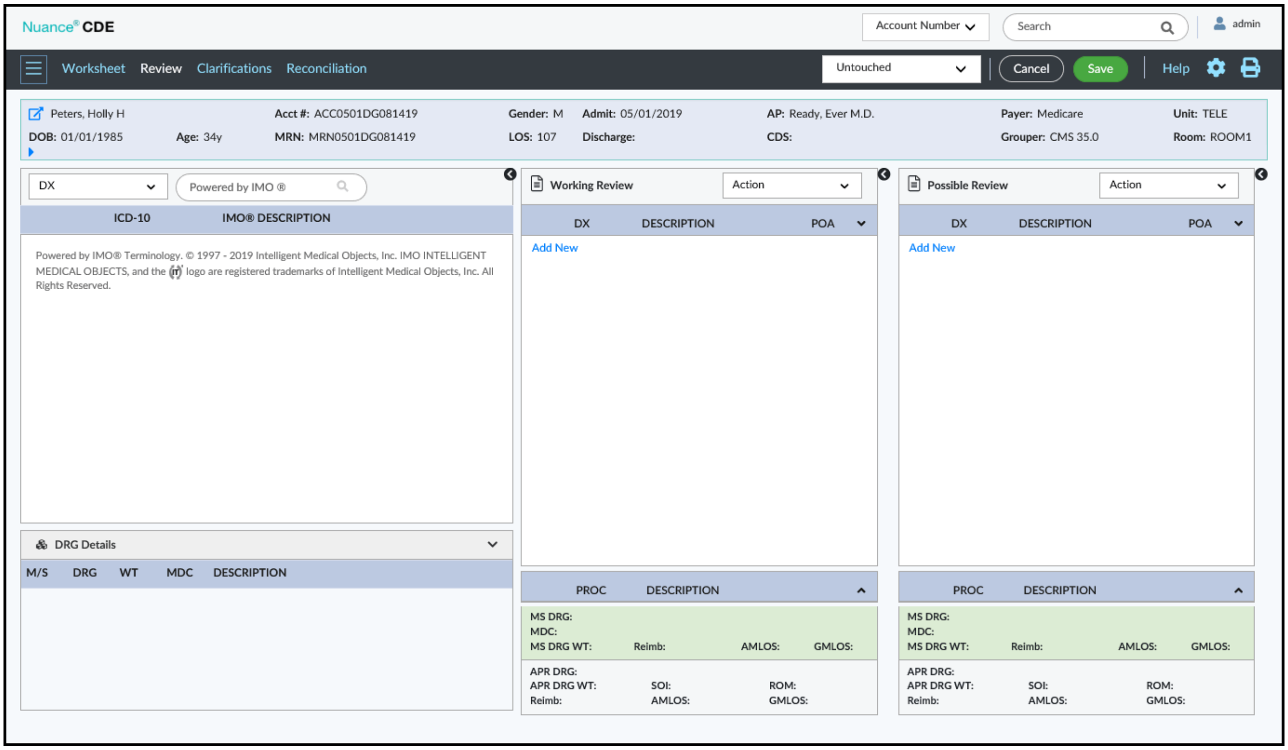


Figure 73: Review Screen

The *Review* screen is consist of the following sections:

- **Patient Banner**: It displays the patient demographic information, Payer, and Grouper information for the selected encounter.
- **Code Search**: This panel is used to search ICD-10 diagnosis and procedure codes.
- **Working Review**: This panel is used to add codes based on the current documentation in the record.
- **Possible Review**: This panel is used to add codes based on the where evidence exists for a possible diagnosis or procedure but not fully documented by the provider. A clarification may be pending to fulfill the diagnosis or procedure.

Note: Grouping and content is based on discharge date. If the encounter does not have a discharge date, then the current system date is used as discharge date.

Related concepts

About Clinical Language Code Search on page 114

Code Search

About Index Search

In the index search panel you can search ICD-10 diagnosis and procedure codes. You can quickly find the most specific diagnoses and procedure codes by simply searching for the medical terms that you are naturally familiar with and add them to your working and possible review, or both.

Note: The Index Search tab is selected by default on the Review Screen for your first search after login. Once you navigate to other screen and revisit the Review screen, your last performed type of search (Index or Clinical language) will be selected.

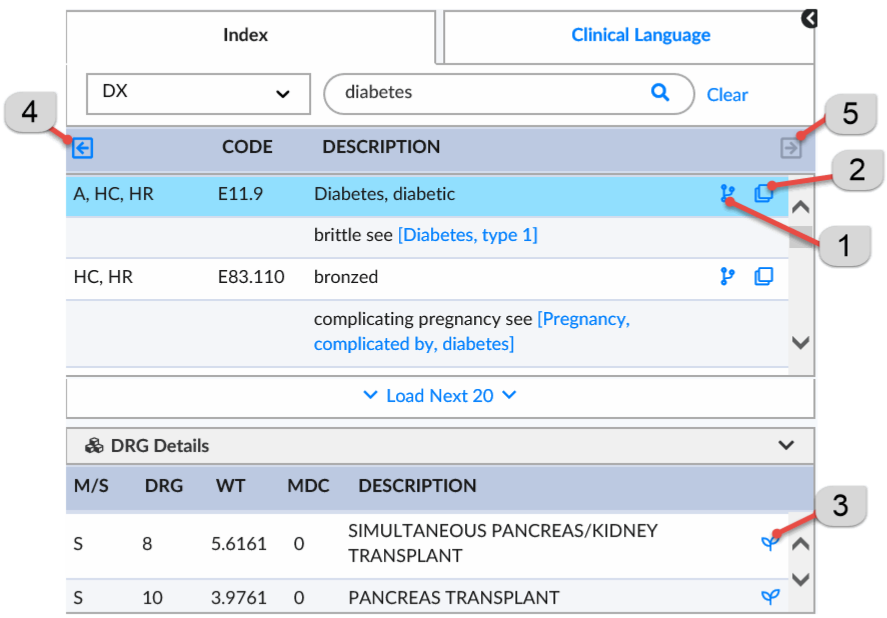


Figure 74: Index Search Panel Identification

Table 13: Index Search Panel Identification and Purpose

Item	Description	Purpose
1	Code Level Note	Displays inclusions and exclusions note specific to the code.
2	Copy Codes	Copy codes to the working review, possible review panel, or both.
3	Decision Tree	Displays the Nuance CDMP decision trees specific to a DRG associated with the selected diagnosis or the procedure code.
4	Back Button	You can navigate to the previous search results using the Back button. **Note:** The Back button gets activated only if you click the search result code or description hyperlink (in blue color).

Item	Description	Purpose
5	Forward button	You can navigate to the initially clicked code with this button. **Note:** This button gets enabled only when the Back button is used.

Secondary Search

Codes can be searched upto secondary level, using shortcuts in Index Search.

For example, select **DX** as code search criteria and type keyword `Rec--Recurrent` in the search field. You can also search by using **PROC** as search criteria and keyword `Rec--Rectoplasty` in the search field. The search results show the required code and its description.

Working in Index Search Panel

In the Index Search panel you can perform the following task:

- Searching a Code in Index Search
- Accessing Code Level Notes

Searching a Code in Index Search

This section describes how to search a code from Index Search on the *Review* screen.

1. Select a search criteria from the **Criteria** drop-down list. Refer Table 15: Code Search Criteria and Description on page 121.

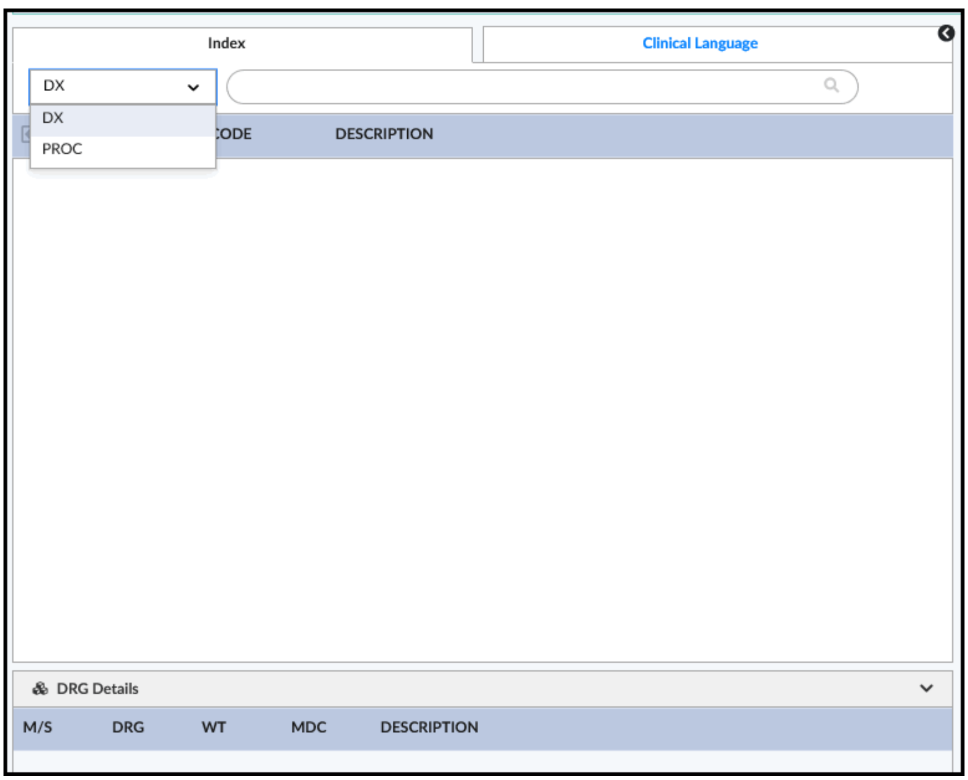


Figure 75: Code Search in Index Search

Note: When searching for diagnosis code, you can enter either a diagnosis code or a description in the search field.

2. Type the code or the description as necessary in the search text field.

Note:

- You can use normal clinical language and does not require specific syntax of ICD-10 code descriptions.
- You can search the code using the standard acronyms such as *AMI*, *CHF*, *CABG* etc.

3. Click ( ) or press **Enter**.
The result is displayed in the code search panel as shown below:

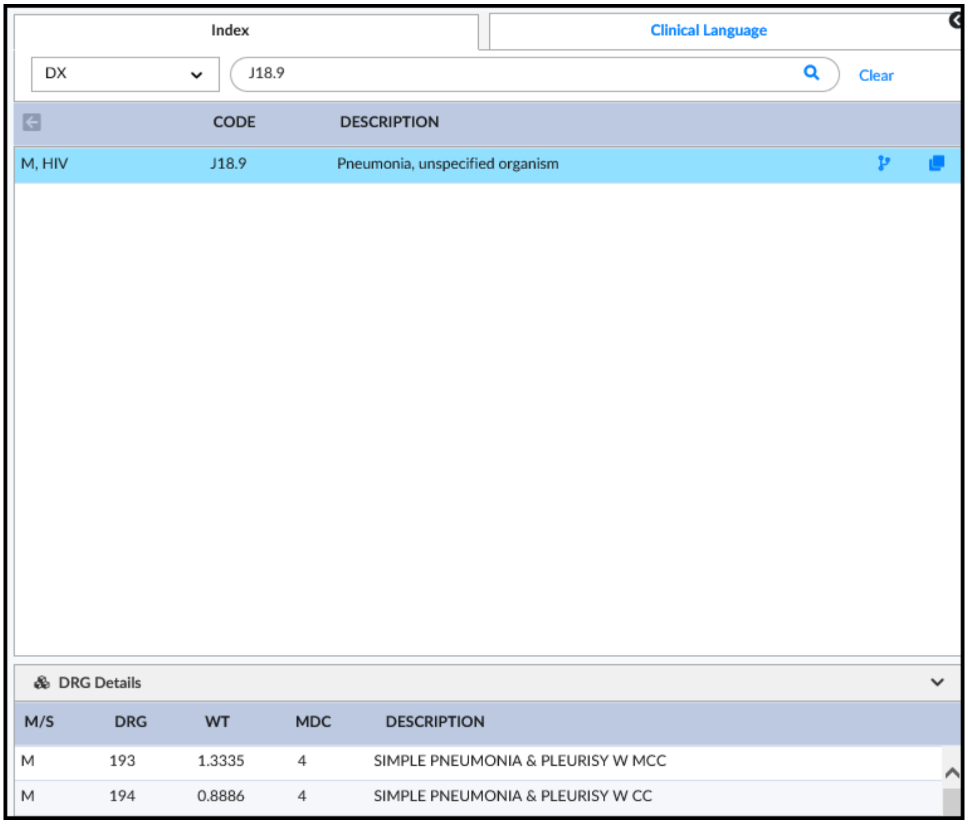


Figure 76: Code Search Result in Index search

Note: If no results are found against a searched term, then the system displays the **No results found** message.

Accessing Code Level Notes
This section describes how to search a code from the *Review* screen. Refer Accessing Code Level Notes on page 119.

About Clinical Language Code Search

In the code search panel you can search ICD-10 diagnosis and procedure codes. You can quickly find the most specific diagnoses and procedure codes by simply searching for the medical terms that you are naturally familiar with and add them to your working and/or possible review.

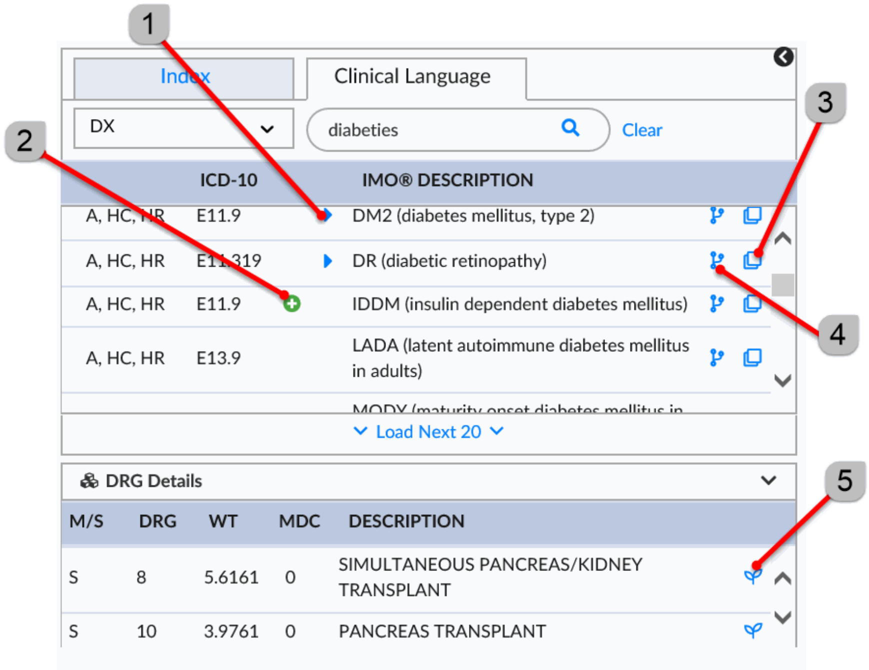


Figure 77: Clinical Language Code Search Panel Identification

Table 14: Clinical Language Code Search Panel Identification and Purpose

Item	Description	Purpose
1	Show IMO Specificity/ Show One of These	The **Show IMO Specificity** icon displays additional specificity selections to get to the most appropriate and specific diagnosis code. The **Show One of These** icon displays all the specified codes listed under the unspecified procedure description. This helps to get to the most appropriate and specific procedure code.
2	Show Combo Code	Displays multiple codes that must be added together along with the main code.
3	Copy Codes	Copy codes to the working review, possible review panel, or both
4	Code Level Note	Displays inclusions and exclusions note specific to the code..
5	Decision Tree	Displays the Nuance CDMP decision trees specific to a DRG associated with the selected diagnosis or the procedure code.

Working in Clinical Language Code Search Panel

In the Clinical Language Code Search panel you can perform the following task:

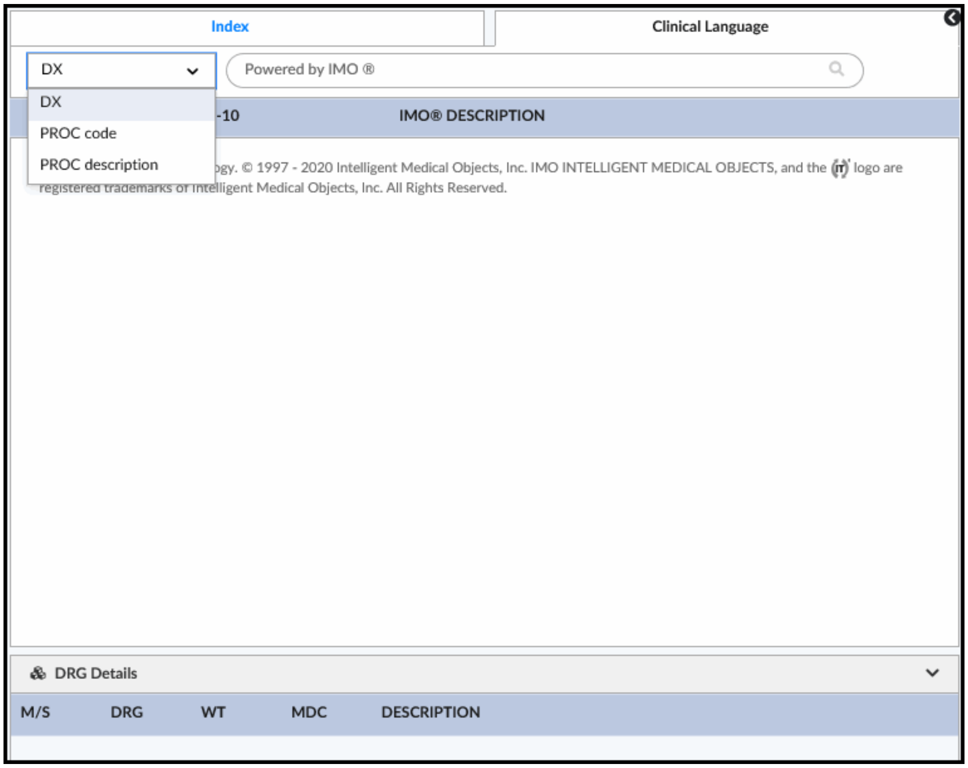
- Search for a Code
- Using Code Specificity
- Search for a Combo Code
- Search for a Code Level Note
- Access the CDMP Guide
- Copy Code from the Code Search Panel

Searching a Code in Clinical Language Code Search

This section describes how to search a code from Clinical Language Search in the *Review* screen.

1. Select a search criteria from the **Criteria** drop-down list. Refer Table 15: Code Search Criteria and Description on page 121.

   Figure 78: Code Search in Clinical Language Search



   Note: When searching for diagnosis code, you can enter either a diagnosis code or a description in the search field.

2. Type the code or the description as necessary in the search text field.

   Note:

   - You can use normal clinical language and does not require specific syntax of ICD-10 code descriptions.
   - You can search the code using the standard acronyms such as *AMI*, *CHF*, *CABG* etc.

3. Click () or press **Enter**.
   The result is displayed in the code search panel as shown below:

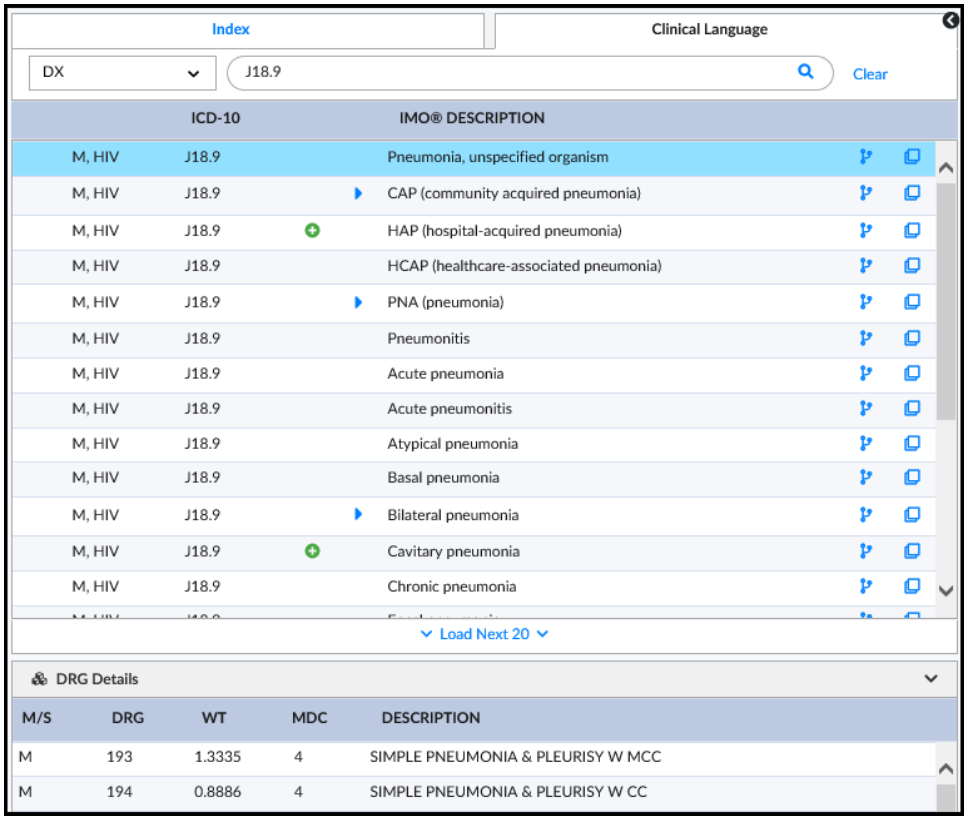


Figure 79: Code Search Result

Note: If no results are found against a searched term, then the system displays the **No results found** message.

Using Code Specificity

This section describes how to refine a specific diagnosis code to the most appropriate level of specificity in the *Code Search* panel. The diagnosis code specificity is displayed only for the applicable codes.

For example: If you search for *J18.9* diagnosis code, in the search result **Show IMO Specificity** ( ) icon is displayed.

1. Search a diagnosis code.
2. In the code search results section, click the **Show IMO Specificity** ( ) icon on the code to display the IMO specificity.
   The available filter types are displayed with their possible values.

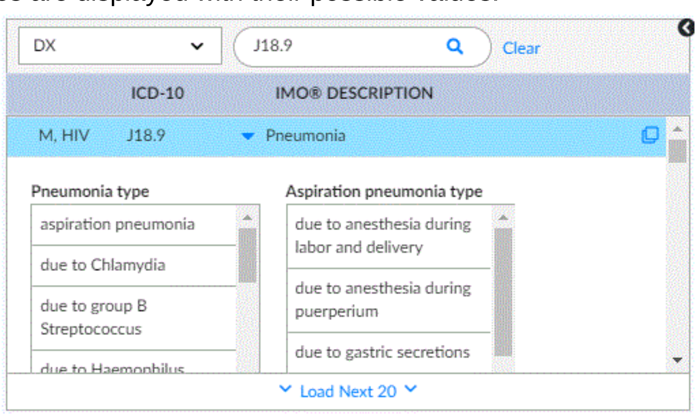


Figure 80: IMO Specificity

3. For each filter type, click one of the values.
   A list of specific diagnoses is displayed below the filters according to the selections you have made.

Searching Possible Procedure Code
This section describes how to refine an unspecified procedure description to the most appropriate procedure code in the *Code Search* panel.

For example: If you search for the *hip replacement* procedure then in the search result **Show Procedure Codes** (▸) icon is displayed.

1. Search the unspecified procedure description.
2. Click the **Show Procedure Code** (▸) icon to display the procedure codes associated with the searched description.

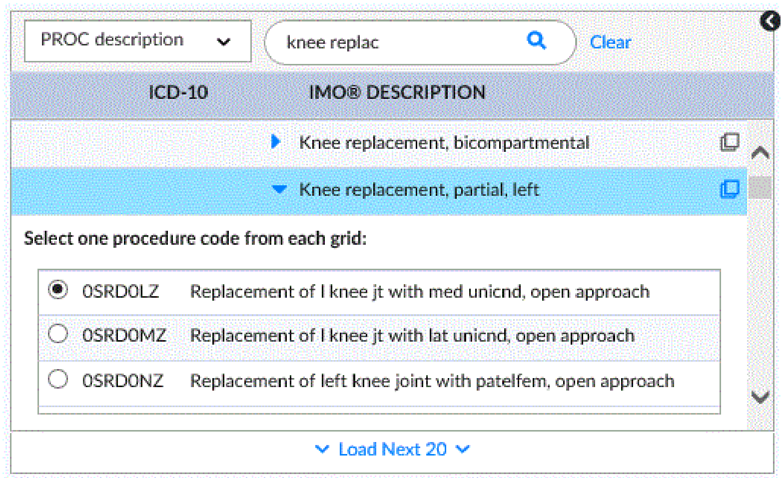


Figure 81: Possible Procedure Codes

3. Select the desired procedure codes from the each **Select one procedure code from each grid** sections.

   Note: If you don't select codes from any of the sections, the system displays the following warning message: *You should select a code from this grid for a complete code set.*

4. Click the **Copy Codes** (⧉) icon to copy the selected procedure code to the working review, possible review, or both.

Using Combo Codes
This section describes how to use the search results to identify multiple codes that should be added and correspond with a diagnosis or procedure.

For example: If you search for *O26.899*diagnosis code, in the search result **Combo Codes**(⊕) icon is displayed.

1. Search the diagnosis or procedure code.
2. Click the **Show Combo Codes**(⊕) icon to display all the other codes and their description associated with the diagnosis or procedure.
   The system displays the multiple ICD-10 codes associated to the selected diagnosis or procedure.

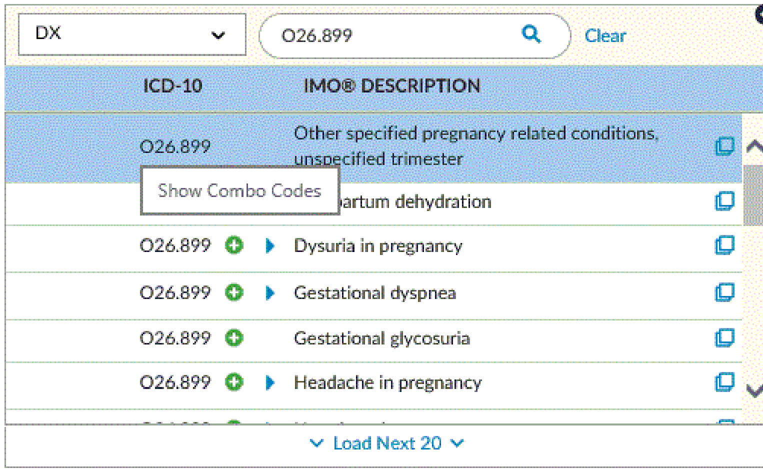


Figure 82: Combo Code

3. Click away to close the combo codes.

Accessing Code Level Notes

The section describes how to access the note for a specific code. The Code Level Notes provide guidance on the inclusions and exclusions when using the selected code.

1. Search a diagnosis code. Refer Searching a Code in Clinical Language Code Search on page 116.
2. Click the **Show Code Level Notes**( ) icon to display the note specific to that code.

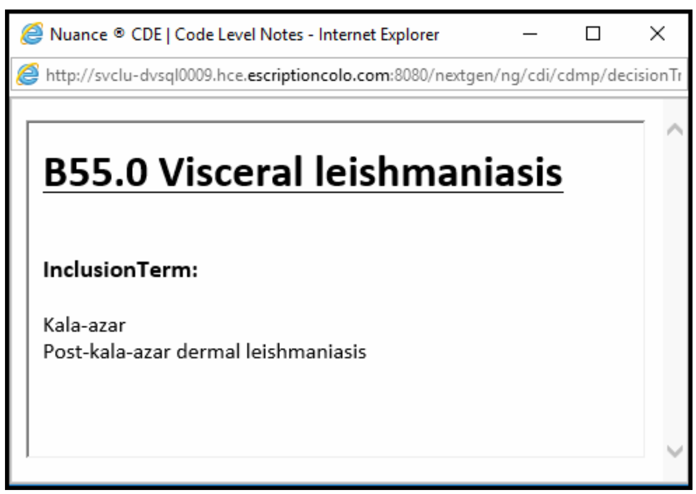


Figure 83: Code Level Note

Accessing Nuance CDMP Decision Trees

This section describes how to access the Nuance CDMP decision tree.

1. Search and select the diagnosis or the procedure code. Refer Searching a Code in Clinical Language Code Search on page 116.

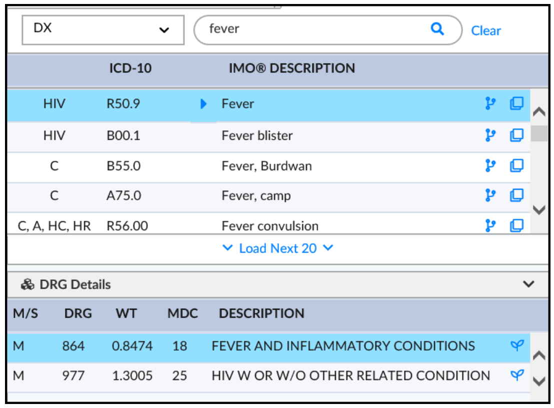


Figure 84: Decision Tree

2. In the *DRG Details* section, click the **Decision Tree**( ) icon to display the clinical strategy related to that DRG.

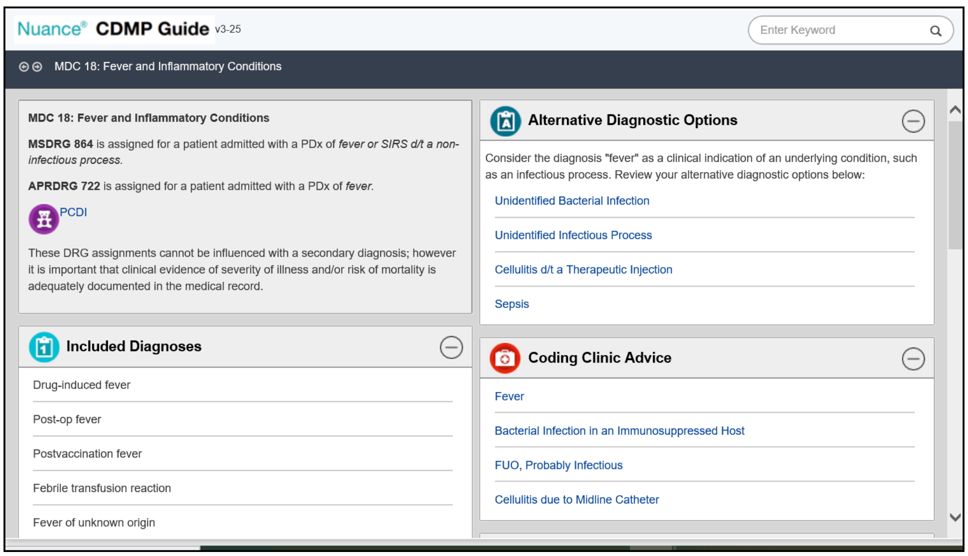


Figure 85: Nuance CDMP Screen

Note: Pediatric content PCDI (hyperlink) appears with a teddy bear icon next to it.

Note: You can not print the Nuance CDMP decision trees.

Copying Code from the Code Search Panel

1. In the *Code Search* panel, search a code that you want to add in the working, possible review, or both.
2. Click the **Copy Codes** ( ) icon.

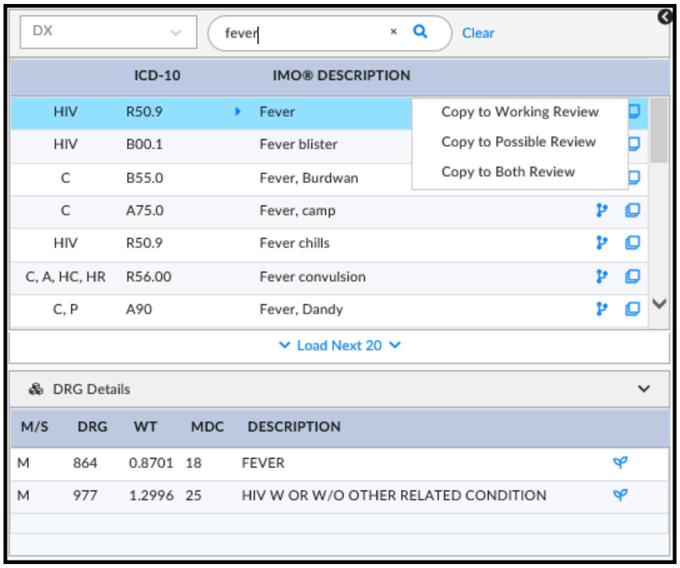


Figure 86: Copy Codes - Code Search Panel

3. Select an appropriate option from the **Copy Codes** context menu. Refer Copy Codes Context Menu Options on page 121.
   Selected code moves to the next available row in the working, possible, or both review panels.

   Important: When you copy a combo code in the working or possible review, codes get added in the same sequence as it is displayed in the search panel.
4. Click **Save**.

Code Search Criteria and Description

Table 15: Code Search Criteria and Description

Criteria	Description
DX	Search based on the ICD-10 diagnosis code and description
Proc code	Search based on the ICD-10 procedure code
Proc description	Search based on the ICD-10 procedure code description

Copy Codes Context Menu Options

Table 16: Copy Codes Context Menu Options and Description

Option	Description
Copy to Working Review	Code gets added only to the **Working Review** section
Copy to Possible Review	Code gets added only to the **Possible Review** section
Copy to Both Review	Code gets added to both the **Working Review**and **Possible Review** sections

DRG Details – Code Search Panel

Table 17: DRG Details Columns and Descriptions – Code Search Panel

Column	Description
M/S	M is displayed for Medical DRG and S is displayed for Surgical DRG
DRG	Diagnosis Related Group **Note:** For APR DRG groupers, this column should be ignored.
WT	The relative weight value for the DRG **Note:** For APR DRG groupers,this column should be ignored.
MDC	The Major Diagnostic Category to which the DRG is associated
Description	The description for the DRG

Nuance CDMP

About Nuance CDMP Decision Tree

Nuance CDMP Decision Tree helps to analyze and understand the content, combined with clinical documentation improvement guidelines in the following ways:

- Improves documentation
- Improves CMI
- Ensures compliance
- Ensures appropriate reimbursement

Nuance CDMP Decision Tree also helps you to refer all the important information on the same page.

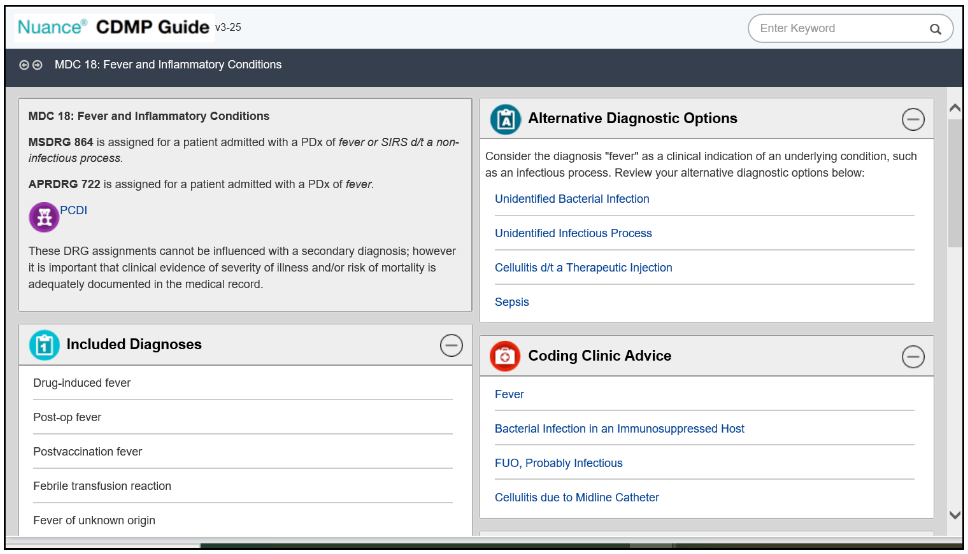


Figure 87: Nuance CDMP Decision Tree Screen

Nuance CDMP Decision Tree Panels

Table 18: Nuance CDMP Decision Tree Panel and Description

Panel Name	Description
DRG Description	This panel contains a brief description of the MS DRG and APR DRG assignment associated with the launch page topic. The panel may also include additional information or instruction, especially with regard to follow-up reviews.
Included Diagnosis	This panel gives the user a short, non-inclusive list of principal diagnoses associated with the launch page MS DRG and APR DRG assignments. All medical launch pages include this panel – surgical launch pages include this panel if the surgical DRG assignment requires a specific PDX.
Common Secondary Diagnosis	This panel includes a list of common secondary diagnoses associated with the PDx or the surgical procedure associated with the launch page topic.
Alternative Diagnostic Options	This panel includes the alternative diagnostic options that might apply to the launch page topic. Not every launch page will include a panel for alternative diagnostic options.

Panel Name	Description
Coding Clinic Advice	Coding Clinics are found in the medical and surgical launch pages.
Official CM Guidelines	There are CM guidelines embedded within the appropriate launch pages. You can also find some CM guidelines within the surgical launch pages; especially those that require a specific PDX for assignment.
Additional Clinical References	Nearly every launch page will include an additional clinical references panel. This panel includes information about a PDx, secondary diagnoses, important references like the coma scale or SIRS criteria, links to the docu-prompters, your PCS assist links and clinical examples.
Quality Considerations	You will find a quality consideration panel for those teams responsible for monitoring HCC diagnoses, hospital acquired conditions, and patient safety indicators. The HCC reminder is just that, a reminder of diagnoses associated with the launch page that qualify as HCCs. The core measure, HAC and PSI links include the applicable reference pages for the topic.
Pediatric Content	The content is pediatric related but the content in the other panels, such as coding clinics and official guidelines, should also be reviewed.

<table>
<tr><th>Panel Name</th><th>Description</th></tr>
<tr><td>Clinical Denials Response Form</td><td>The clinical denial template allows you to collect clinical evidence necessary to support a payer denied diagnosis. While these documents are not intended to replace an appeal letter, they do assist in the collection of clinical evidence necessary to support an appeal but not limited to the following:
• Clinical Indicators
• Diagnostics
• Risk Factors
• Treatment
• Physician Impressions
• Topic-specific supporting references such as the Official Guidelines for Coding and Reporting and/or the Coding Clinics
• Appeals Recommendations
• Physician Advisor findings/recommendations

The denial template should be copied and pasted into a word document, enter the required details, and then submit to the health system's denials manager for further evaluation. There are 32 diagnosis-specific clinical denial templates available in the application.

The denial templates are available for the following topics:
• Acute Blood Loss Anemia
• Acute Cor Pulmonale
• Acute Exacerbation of COPD
• Acute Exacerbation of Heart Failure
• Acute Myocardial Infarction
• Acute Renal Failure/Kidney Injury
• Acute Respiratory Failure
• Acute Tubular Necrosis
• AIDS/HIV
• Alcohol Abuse/Dependence
• Chronic Respiratory Failure
• Encephalopathy
• Functional Quadriplegia
• Malnutrition
• Opioid Abuse/Dependence
• Pathological Fracture
• Sepsis
• Severe Sepsis
• Septic Shock
• SIRS d/t a Non-Infectious Organism
• Hypo/Hypernatremia</td></tr>
</table>

Working and Possible Review

About Working and Possible Review

Working Review: This section is used to add codes based on the current documentation in the record. If the *Encounter Status* is **In Progress**, **Untouched** this section is actively used.

Possible Review: This section is used to add codes based on the documentation that may be pending from the provider clarifications.

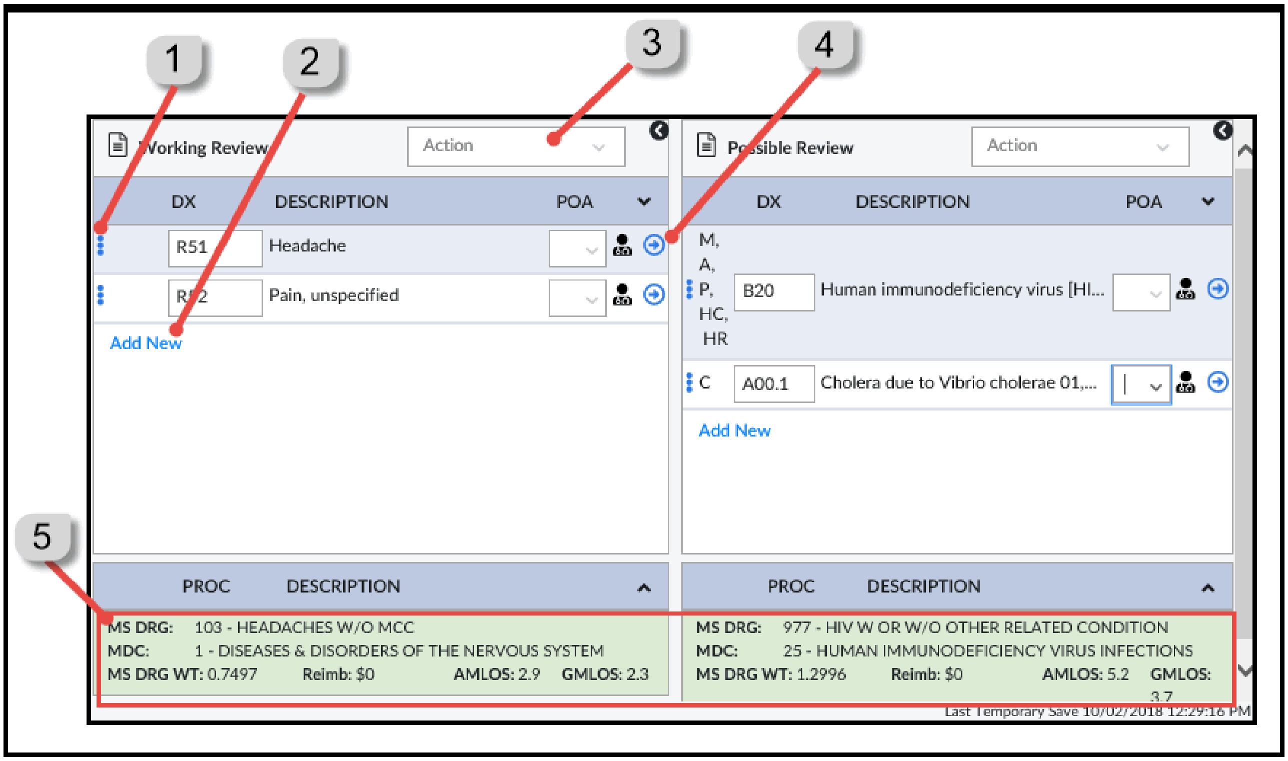


Figure 88: Working and Possible Review Screen Identification

Table 19: Working and Possible Review Screen Identification and Purpose

Item	Description	Purpose
1	Three Dots Icon	Manually move code from one row to another row (up and down)
2	Add New	Add a new row
3	Action Drop-down	Move all codes to working or possible review, delete all codes from working or possible review
4	Blue Arrow Icon	Displays context menu with options to move code to principal position, copy code to working or possible review, add code to *Provider Clarification* screen, highlight/unhighlight a code and delete a row.
5	DRG Details section	Displays all DRG related information.

Present On Admission (POA)

The following are the NUBC approved default values for POA:

- Y- Yes
- N- No
- U- No information in record
- W- Clinically undetermined

One of the following values are displayed to designate the exempted code based on your configuration in the POA configuration screen:

- 1
- E

POA value gets populated automatically for the exempted codes.

The POA value for the primary diagnosis code can not be marked as **N** and neither you can keep it blank. Similarly, the POA value for any Hospital Acquired Condition codes must not be left blank.

Advance APR Support

If your facility has a license for APR, then the SOI, ROM, APR DRG, and APR DRG WT fields are displayed in the working and possible review for non APR DRG payers. This helps you to understand the severity and risk of mortality of the case based on the diagnoses documented.

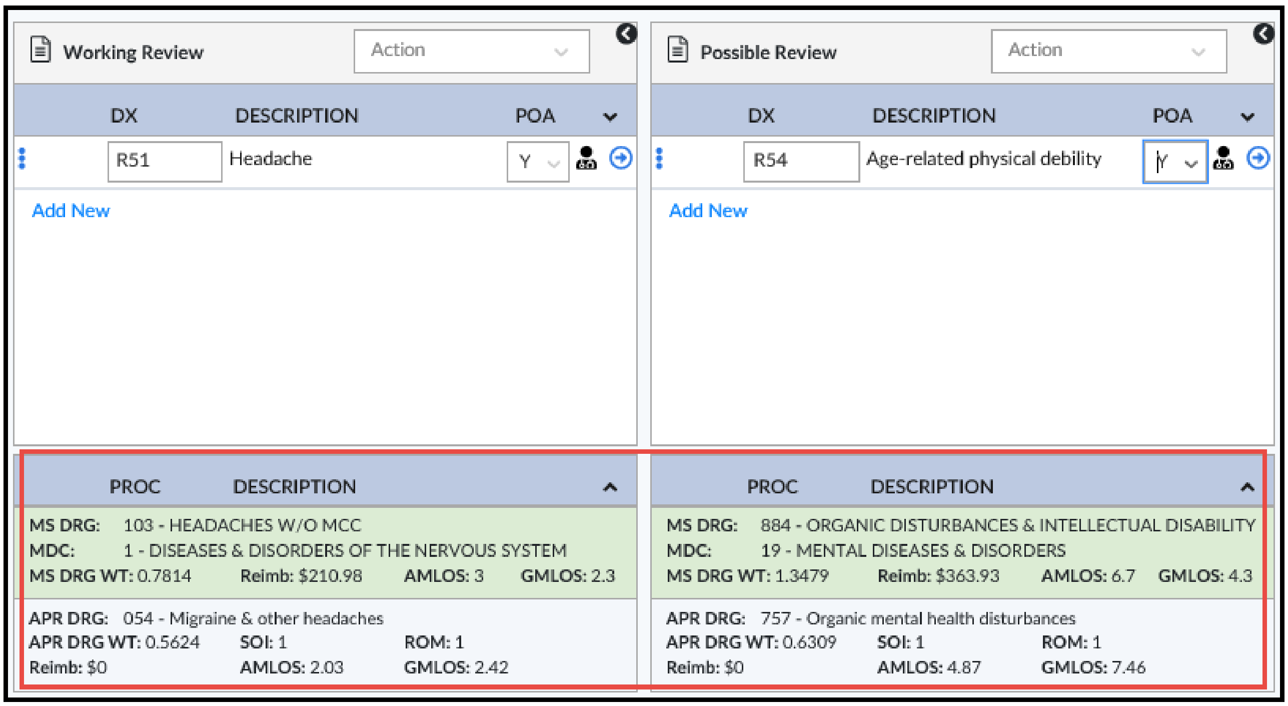


Figure 89: MS DRG and APR DRG Details

For the APR DRG grouper, the *Cost Weights and Trim Points Only* pricer is used. There is no reimbursement calculation for this pricer and it does not return a reimbursement dollar amount. But it does return some other reimbursement fields (WT, AMLOS, GMLOS, etc.).

Auto-shuffle

The secondary diagnosis codes get auto shuffled based on the MCC and CC code types. The principal diagnosis code never gets auto shuffled. As per the auto-shuffle logic, all the MCC codes get placed in the code grid after the principal diagnosis code, and then followed by the CC codes. The code that does not have code symbol displays after the last CC code in the code grid.

The procedure codes auto shuffled based on the NOR and OR code symbols. As per the auto-shuffle logic, first all the OR codes get placed in the code grid and then the NOR codes. The code that does not have code symbol displays after the last NOR code in the code grid.

The auto-shuffle happens when the focus moves from the code row, and it is applicable for the CMS, LTCH, IPF groupers.

Related reference

Encounter Status and Description on page 65

This section describes the encounter status displayed on the Triage Worklist screen.

DRG Details - Working and Possible Review Panel

Table 20: DRG Details Columns and Descriptions – Working and Possible Review Panel

Column	Description
MS DRG	Diagnosis Related Group based on CMS MSDRG grouper
APR DRG	Diagnosis Related Group based on APR DRG grouper
MDC	The Major Diagnostic Category associated with CMS MSDRG grouper
MS DRG WT	The relative weight value for the CMS MSDRG grouper
APR DRG WT	The relative weight value for the APR DRG grouper
Reimb	Total estimated reimbursement based on DRG
AMLOS	Arithmetic Mean Length of Stay based on DRG
GMLOS	Geometric Mean Length of Stay based on DRG
SOI	Severity of Illness **Note:** For the CMS grouper, this column displays the calculated SOI value.
ROM	Risk of Mortality **Note:** For the CMS grouper, this column displays the calculated ROM value.

Adding Codes to Working and Possible Review

You can add codes in the working and possible review panels in three ways:

- Copy code from the *CDS Assistant* screen
- Copy code from the *Code Search* panel.
- Direct code entry in the working and possible review panel

Copying Code from the CDS Assistant Screen

1. Select a code description from the **Diagnoses** section.
2. Click the **Copy Codes** ( ) icon.
3. Select an appropriate option from the **Copy Codes** context menu. Refer Copy Codes Context Menu Options on page 121.
   In the *Review* screen selected code moved to working or possible review panel depending on the selection and in the *CDS Assistant* screen selected codes are moved to **Accepted** category.

Direct Entry in the Working and Possible Review

1. Open the *Review* screen.

2. Click **Add New**.
3. Add the applicable codes to the encounter.
   The DRG data displays at the bottom of the panel based on the codes that are present.
4. Click **Save**.

Depending upon the impact on the DRG, the impact symbol for the added or modified code gets updated in the *Working Review* or the *Possible Review* section. For more information, refer Code Symbols on page 205.

Moving Code to Principal Diagnosis and Procedure

The section describes how to move the code to the first row in the Working and Possible Review panels.

1. Select the Blue Arrow ( ) icon on the row for the code that you want to move to the principal position.

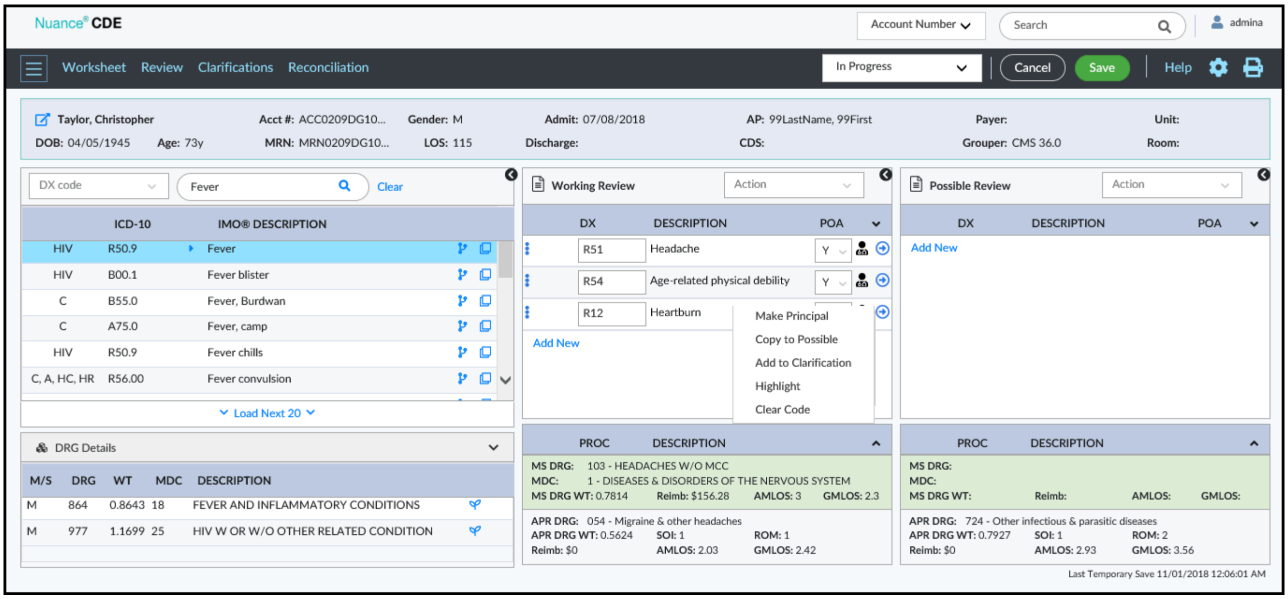


Figure 90: Move to Principal Position

2. Select **Make Principal** from the context menu.
   The code is moved to the first row and DRG values are updated accordingly.
3. Click **Save**.

Depending upon the impact on the DRG, the impact symbol for the added or modified code gets updated in the *Working Review* or the *Possible Review* section. For more information, refer Code Symbols on page 205.

Working and Possible Review Context Menu Options

Table 21: Working and Possible Review Context Menu Options and Description

Option	Description
Make Principal	Move codes to principal diagnosis or procedures position.
Copy to Possible	Copy code from Working Review to Possible Review.
Copy to Working	Copy code from Possible Review to Working Review.
Add to Clarification	Add code to *Provider Clarification* screen from the Working and Possible Review and Initiate a clarification using the code associated with the context menu.

Option	Description
Highlight/ Remove Highlight	Highlight or remove highlight from the selected code.
Clear Code	Delete codes from the Working or Possible Review.

Table 22: Action Drop-down Menu Option and Description

Option	Description
Move all to Possible	Move all codes from the Working to Possible Review panel
Move all to Working	Move all codes from the Possible to Working Review panel
Clear All	Remove all codes from the Working or Possible Review panel

Printing Review

This section describes how to print the encounter review screen.

1. Click **Print**.
   The **Print Encounter** dialog-box is displayed.

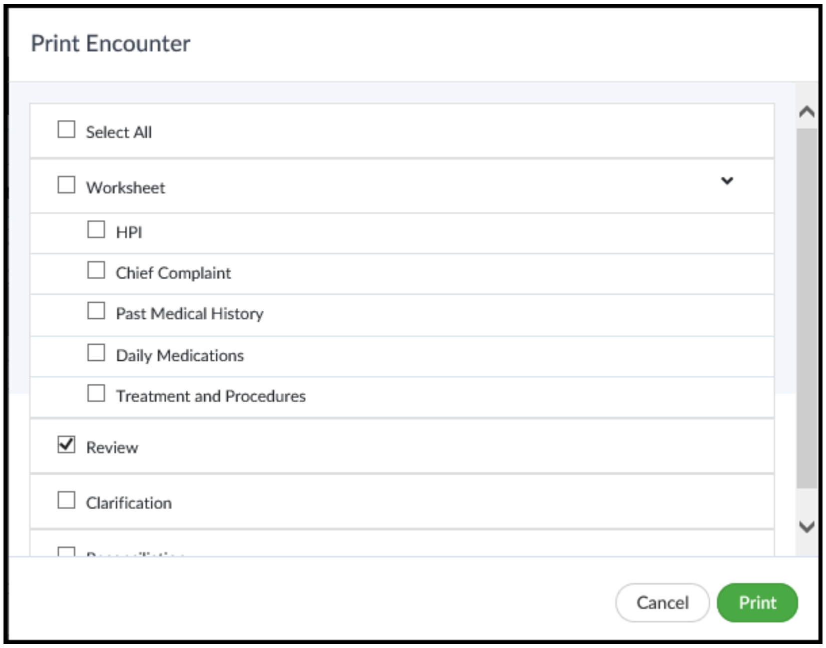


Figure 91: Print Encounter Dialog-box - Review

> **Note:** By default the **Review** is selected to print the review screen, and also you can select the **Select All** checkbox to print the complete encounter documentation (Worksheet, Review, Clarification, and Reconciliation).

2. Click **Print**.
   The print preview window is displayed.

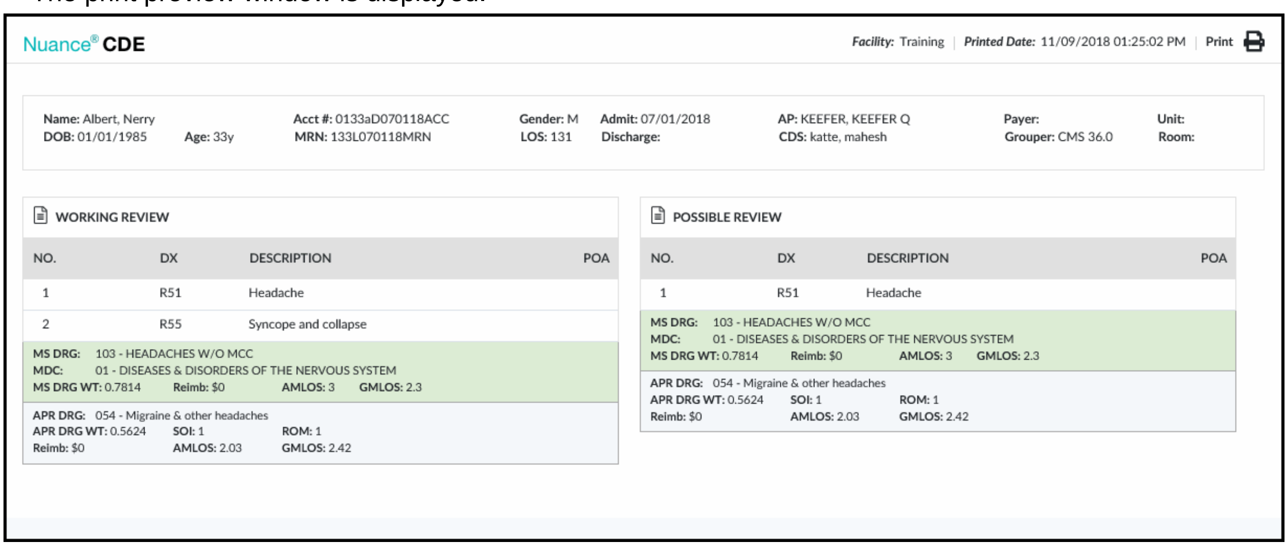


Figure 92: Print Preview Screen - Review

3. Click **Print**.
   The **Print** dialog-box is displayed.

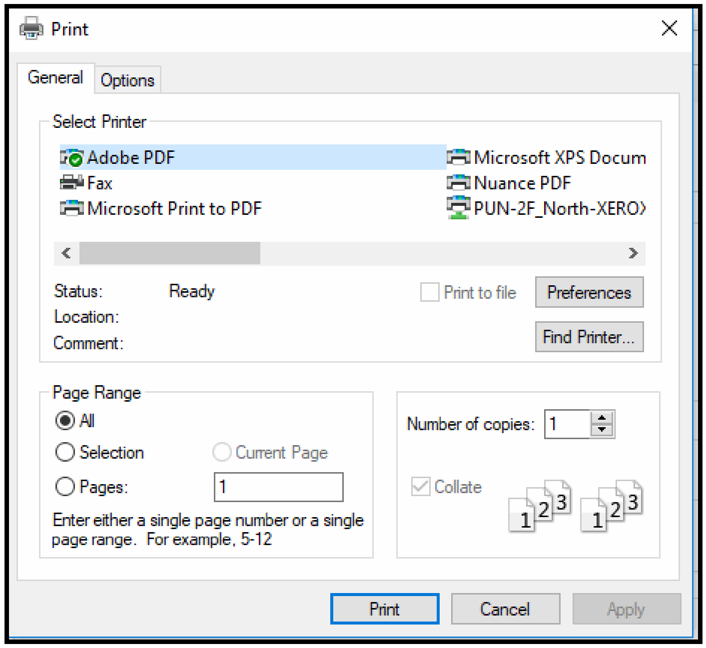


Figure 93: Print Dialog-box

4. Set the print settings for your desired print options.

   You can select the quantity of copies desired, page selection locations, page orientation (portrait to landscape and vice versa), and printer.

5. Click **Apply**, if you've made changes in the print setting.
6. Click **Print**.

Chapter 7

Notes

Topics:

About Notes

Notes have two way interactions between systems (CDE One and a 3rd party Coding application) and are associated to an encounter. Users assigned to or accessing the encounter get notified of a new or updated note.

Features of Notes

- It has the ability to have a conversation (sequence of notes) associated with an encounter.
- The notification framework is used for the notification to the CDS or Coder, if a note associated with an encounter has been received.
- In CDE, a Coder role gives access to Notes to read and respond to Notes for an encounter. A note added by a coder in an encounter is not considered as review.
- The notes functionality accommodates:
    - Sending new note associated with an encounter including Subject, type and message.
    - Receiving a note including date/time stamp received, ID from where the note has been sent, subject, and body of note .
    - Displaying conversation of notes on the encounter.
- The receiving system initiates new note, receives note, and allows a respondent to respond to the note, ideally with the same capabilities as above.
- A User who has created the note (owner) will not receive the notification for that particular note.

Received notes

CDE has the ability to receive notes from third party applications. The received notes have following content:

- Subject - As provided in note subject. If not provided in note, first 50 characters of the message are considered as subject.
- Owner - Owner name displayed, Format - Last Name, First Name's initial.
- Type - As note comes from coding application then note type should be 'CDE-Coding'.
- Date and time - Date and time when CDE receives the note. Format - MM/DD/YYYY, HH:MM:MsMs Time zone (Facility time zone).
- Message - Message text.

Note: In case the original note gets updated, the note received in CDE will also get updated. The note will show an **Updated** badge on the top of the message.

Creating a Note

A note can be created by CDS or a coder. In an encounter, a note can be created and saved as a draft. The saved draft can be further edited and sent. Once a note is sent, it cannot be edited.

Steps below show how to create a new note.

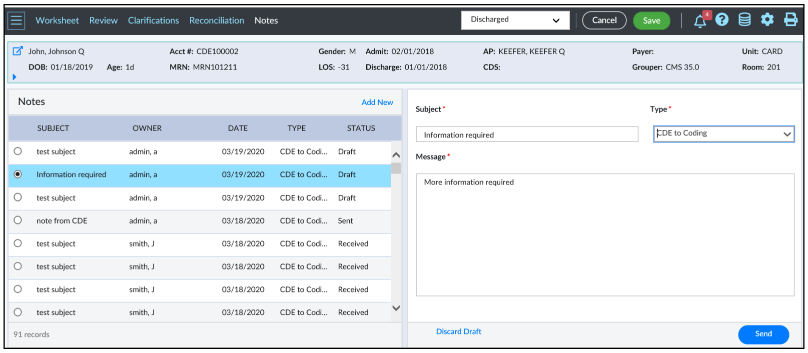


Figure 94: Notes Screen – Creating a Note

1. In an encounter, click **Notes** on the top panel.
2. In the left pane, click **Add New**.
   A blank form appears on the right-side pane.
3. Type text in the **Subject** text box.

Note: This is a mandatory field. It can accommodate upto 50 characters.

4. Select **Type** from the drop-down list.

Note:

This is a mandatory field.

- CDS can send notes to Coding system by selecting the type - CDE to Coding and CDE - CDE.
- Coder can send notes from CDE system selecting type - Coding to CDE

5. Type text in the **Message** text area.

Note: This is a mandatory field. It must have more than 2 characters and less than 2000 characters.

6. Click **Save**.
   System displays new row for added note on the left side pane .

   Note: CDE - CDE type notes draft will be visible to all users who can view the encounter.

7. Click **Send**.
8. **Discard Draft** will cancel any changes made to the fields.

Replying a Note

Notes have the feature to display conversation and send a reply to a received note. All notes are displayed on the left side panel. The note selected on the left side panel will be displayed in detail on the right side panel. Reply option is available for all notes except for notes in draft mode and new notes.

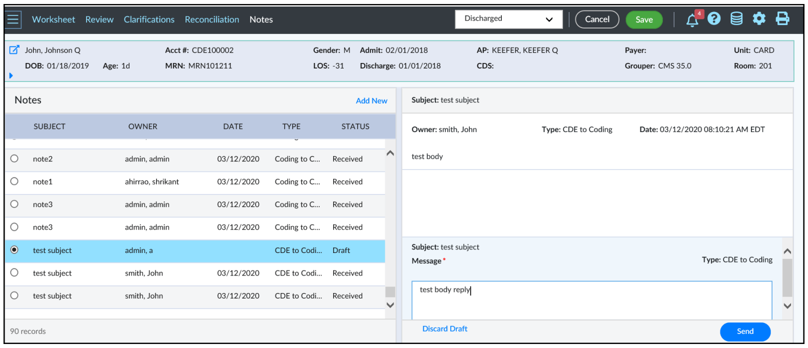


Figure 95: Notes screen - Reply a Note

To reply a note, follow these steps:

1. Type **Message** in the text box.

Note: The reply note Type is provided by the system and cannot be edited.

- If the original/received note type is 'CDE-Coding' or 'Coding-CDE', reply note type is 'CDE-Coding' for CDS user.
- If the original/received note type is 'CDE-Coding' or 'Coding-CDE', reply note type is 'Coding-CDE' for Coder user.
- If the original/received note type is 'CDE-CDE', reply note type is 'CDE- CDE' for CDS user.

2. Click **Save** to save the message.
3. Click **Send** to send the reply.
4. **Discard Draft** will cancel any changes made to the message field.

Chapter 8

Notifications

Topics:

About Notifications

Notifications is a reusable notification panel framework which houses various types of content. It is a mechanism to see notifications from a variety of sources. These sources could be new coder notes, a received clarification response, and so on.

Key Features

- Available from the worklist. The list contains notifications corresponding to all encounters for which the user is watcher of notifications.
- Available from the encounter. The list contains notifications corresponding to that encounter.
- A user who has created a note does not receive the notification for that particular note.
- A framework that can be collapsed and expanded.
- When collapsed:
    - Gives a visual sign when new notifications have been received.
    - Gives a count of unread notifications.
    - Is easily expandable when the CDS is outside or inside an encounter (from Worklist or CDE One).
- When expanded:
    - Shows contents in reverse chronological order (with newest notificationat the top).
    - Shows the type of notification (Notes or clarification).
    - Shows date and time when the notification is received.
    - Shows who the notification is from (coder name, System and so on).
    - Provides visual differentiation between read and unread notifications. Unread notifications appear in bold font. Read notifications appear in regular font.
    - Provides a way to navigate directly to the content screen.
- The framework has options to filter the notifications based on the category that is Notes/clarification/ read/unread.
- Allows the user to scroll through list of notifications.
- The list of notifications gets refreshed every 30 seconds.
- A list can include upto 50 notifications. Beyond that, another list displays the next set of notifications.
- System expires a notification if it has Read status and is 30 days old.
- Deleted notes receive notifications.

Working with Notifications

Notifications can be viewed from the worklist as well as from the encounter. The encounter screen notifications include notifications related only to the specific encounter.

Watcher/Follower

A watcher/follower list is created by the system. System adds users to watcher/follower list for below scenarios:

- An Encounter gets assigned to user
- User sends the note from the encounter
- User sends the clarification from the encounter
    - If user is initiating CDS for sent encounter
    - If user is follow-up CDS for sent encounter

Note: Watcher/follower is applicable for worklist notification panel only.

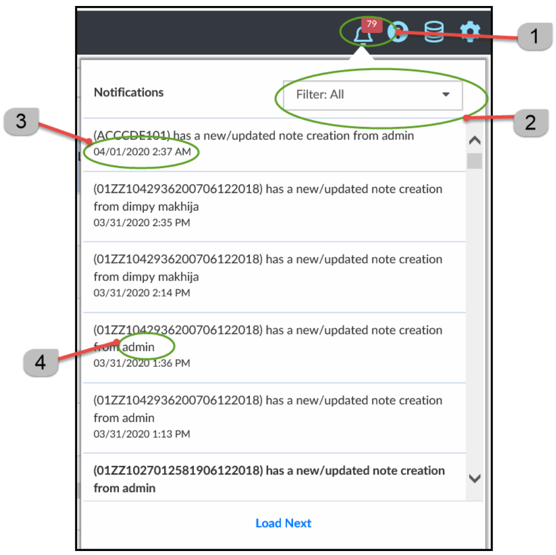


Figure 96: Notification Panel

Table 23: Notification Panel details

Call out	Description
1	Number of notifications
2	Filter for classifying notifications based on the criteria
3	Date and Time of the received notification
4	Notification whereabouts (coder name or provider name)

1. In the Triage Worklist view, click the Bell Notification icon on the top right side panel.
   A list of notifications is opened. The last received notification appears on the top.
2. Select any filter to sort the notifications.

Note: By default, all notification types will be displayed in list. The list can be filtered on the basis of Notes, Clarification, Read and Unread filters. You can apply the notification type (Notes or Clarification) and status (Read or Unread) filters together.

3. Click individual notifications to navigate to the particular Notes or Clarifications instance.

The Notification or clarification clicked by you appears highlighted on the left side panel and displays in detail on the right side panel.

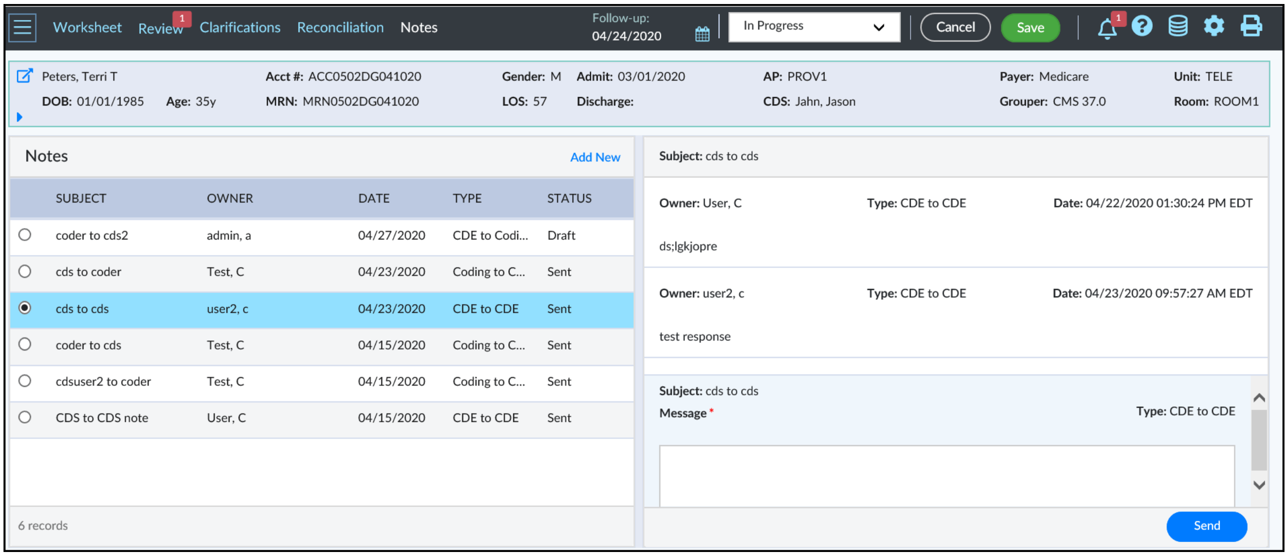


Figure 97: Notifications - Navigation to Individual Notes

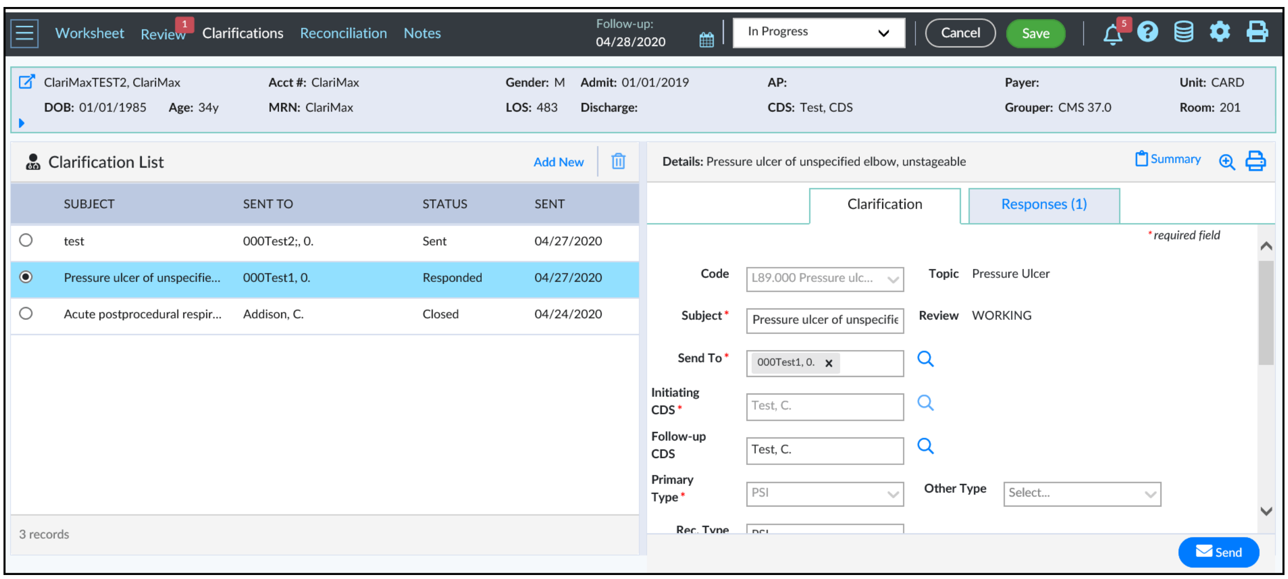


Figure 98: Notifications - Navigation to Individual clarifications

4. Edit an existing note and without saving click on the Notifications panel. Click an individual notification. System navigates you to this notification and the previously edited note stays in draft state. Similarly, if you navigate to some other clarification while editing an existing one, the existing edited clarification stays in draft state.

Follow or Unfollow Notifications

You can now follow/unfollow notifications related to specific encounters. This can be done from the Triage Worklist screen.

Users who can avail this function are:

- Nuance Admin
- CDS
- Coder
- CDS Manager

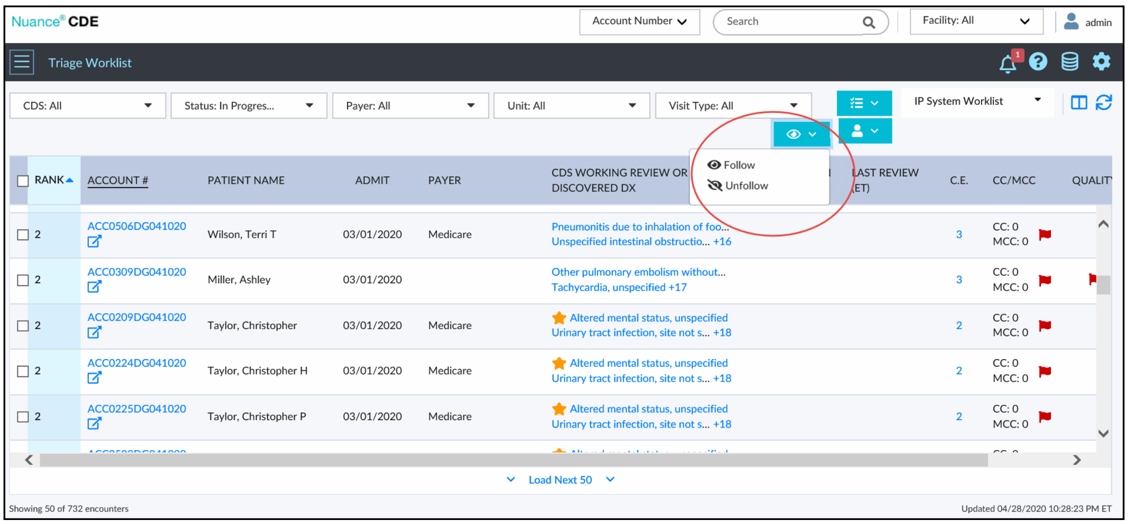


Figure 99: Triage Worklist - Follow/Unfollow

1. On the *Triage Worklist* screen, select the encounters you want to follow.
2. Click **Follow**.
   A pop-up message saying you have successfully followed the selected accounts will appear.

Note: In order to unfollow , select the encounters and click **Unfollow**. Pop-up message for successfully unfollowing the accounts will appear.

Chapter 9

Provider Clarification

Topics:

Working with Clarification Tab

This section describes how to create and send a clarification.

Creating a Clarification

1. Click the **Clarification** link.
   The *Clarification* screen is displayed.
2. Click **Add New** link to create a clarification, or you can create a clarification based on a code in the *Review* screen.

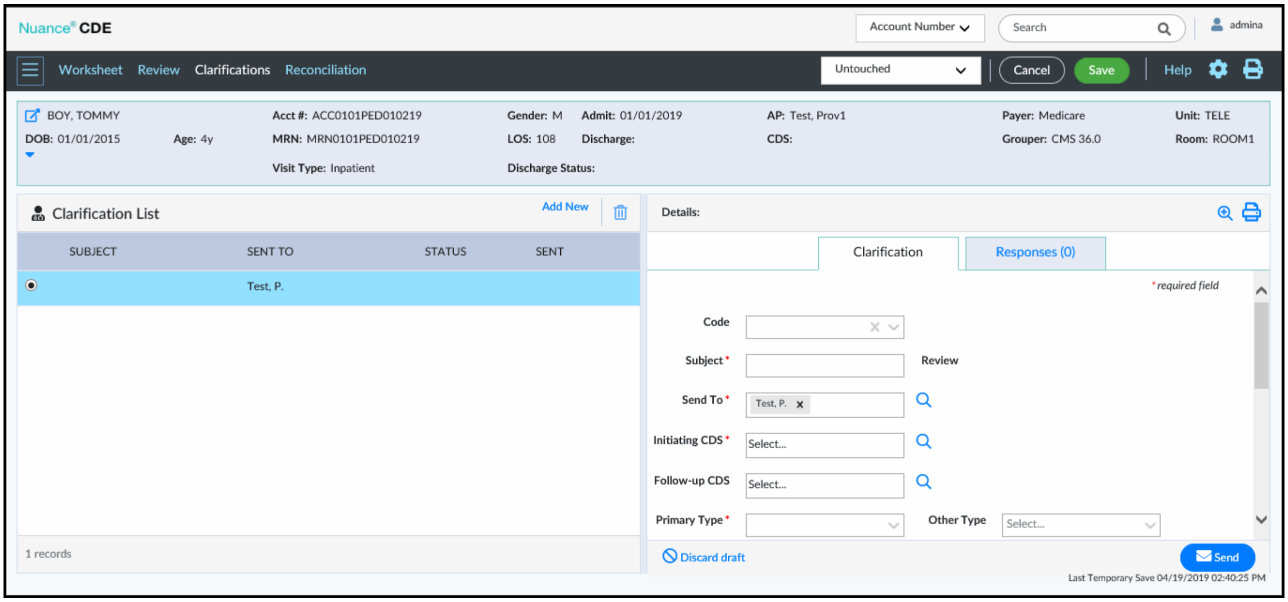


Figure 100: Provide Clarification - Add New

3. Type the subject of the clarification in the **Subject** field for a generic clarification.

   Important: If you create the clarification from the review screen, the **Subject** field gets auto populated with that selected code and description.

4. Select the code for that you want a clarification from the **Code** drop-down list.

   Note: The **Review** field either displays as **Working** or **Possible** based on your code selection. If the code is from the *Working Review* panel then **Working** is displayed or If the code is from the *Possible Review* panel then **Possible** is displayed. The subject of the clarification is also gets updated based on the selected code.

   Important: If you are creating a generic clarification then you must keep the **Code** field empty and the **Review** field displays as **Generic**.

5. Type the provider name in the **Send To** field to whom you want to send the clarification, or to search for a provide select the **Provider Lookup** icon.

   a) In the *Provider lookup* dialog box, select a search criterion from the drop-down list and type a search value in the text field.

   You can search for a provider based on the following search criteria:

   - **Provider Name**: Search based on the provider *LastName, FirstName* or *FirstName LastName*.

     Note: You must type the combination of both *FirstName* and *LastName* to search for a provider.

   - **Provider ID**: Search based on the provider ID.
   - **Specialty**: Search based on the provider specialty.

- **Department**: Search based on the provider department.

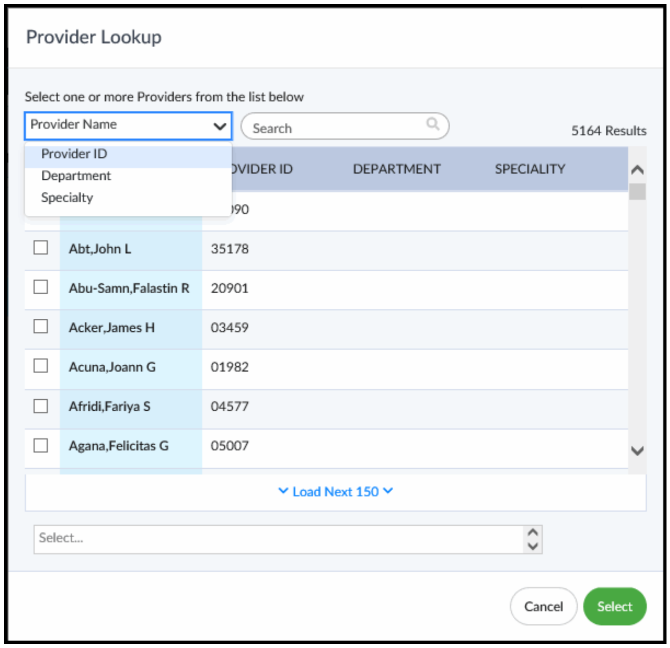


Figure 101: Provider Lookup

b) Click on the **Search** icon.
   The system displays the provider based on your search entry.

c) Select the checkbox(es).

> **Note:** You can select multiple providers.

d) Click **Select**.

6. Type the name in the **Initiating CDS** field who created the clarification, or to search for a CDS select the **CDS Lookup** icon.

> **Note:** By default it displays the name of the CDS who is currently logged in.

a) In the *CDS Lookup* dialog box, select a search criterion from the drop-down list and type a search value in the text field.

   You can search for a CDS based on the following search criteria:

   - **CDS Name**: Search based on the CDS name.
   - **CDS ID**: Search based on the CDS ID.

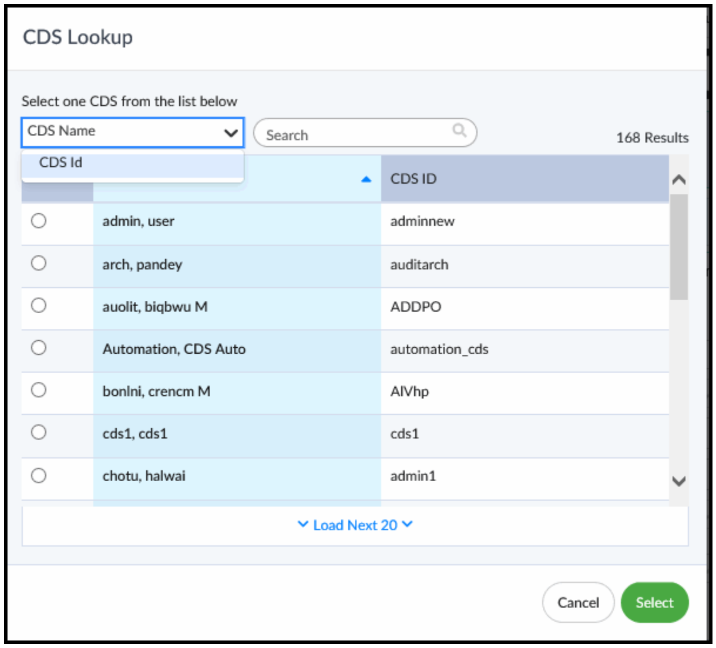


Figure 102: CDS Lookup

b) Click on the **Search** icon.
The system displays the CDS based on your search entry.

c) Select the checkbox.

d) Click **Select**.

Note: Once you send the clarification, you can not edit the **Initiating CDS** field.

7. Type the name in the **Follow-up CDS** field who will follow-up on the clarification, or to search for a CDS select the **CDS Lookup** icon.

Note: By default it displays the name of the CDS who is currently logged in.

a) In the *CDS Lookup* dialog box, select a search criterion from the drop-down list and type a search value in the text field.

You can search for a CDS based on the following search criteria:

- **CDS Name**: Search based on the CDS name.
- **CDS ID**: Search based on the CDS ID.

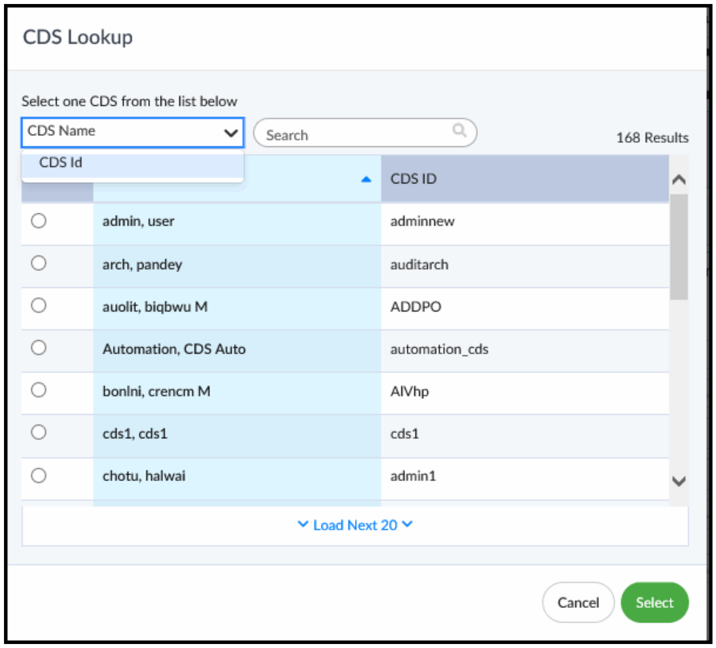


Figure 103: CDS Lookup

b) Click on the **Search** icon.
The system displays the CDS based on your search entry.

c) Select the checkbox.

d) Click **Select**.

8. Select a primary clarification type from the **Primary Type** drop-down list. Refer Clarification Types and Templates on page 150.
9. Select a secondary clarification type from the **Other Type** drop-down list.
10. At the time of reconciliation, select a clarification type from the **Rec. Type** drop-down list if you want to change the primary clarification type.

    Important: When you change the primary clarification from the **Rec. Type** drop-down list, then the **Clarification Type** automatically gets updated in the *Reconciliation* screen.

11. Select the date when the clarification is created from the date look-up or manually enter the date in **mm/dd/yyyy** format in the **Created** field.

    Note: By default it displays the today's date.

12. Select the date when the clarification is sent from the date look-up or manually enter the date in **mm/dd/yyyy** format in the **Sent** field.
13. Select the date when the clarification is closed from the date look-up or manually enter the date in **mm/dd/yyyy** format in the **Closed** field.
14. Select a standard or a custom clarification template that you want to use to type the message from the **Template** drop-down list. Refer Clarification Types and Templates on page 150.

    Note: System automatically selects template based on the selected primary clarification type.

15. Type the clarification message in the **Message** field.
16. Click **Save**.

    Note: **Status** is a system generated clarification status field and you can not edit it. Refer Clarification Status on page 152.

Sending a Clarification

1. Create a clarification. Refer Creating a Clarification on page 145.

2. Click **Send**.

   Based on the configured send method selected by your facility, you can send the clarification manually with or without printing.

   If your facility has chosen the **Manual Send without Printing** option then when you click **OK** the clarification sent date is automatically displayed in the **Sent** field, although you can manually edit it and the status is updated to **Sent**. The system displays the sent date in the configured timezone.

   If your facility has chosen the **Print and Manually Deliver** option then when you click **OK**, the system displays the print preview of the clarification so that you can print the clarification and manually deliver it to the provider. The clarification sent date is automatically gets displayed in the **Sent** field, although you can manually edit it and the status is updated to **Sent**. The system displays the sent date in the configured timezone.

   If your facility has chosen all the options, then when you click **OK**, the system displays the **Sent Clarification** pop-up.

Figure 104: Send Clarification Pop-up

   From the **Send Clarification** pop-up you can select any of the send method that you want to use and then select **OK**. The **Set as Default** option can be used to make the selection default for the CDS.

   Note: When the clarification is sent the **Pending** clarification response status automatically gets displayed on the **Responses** tab.

   If the encounter status is Review Complete, Reconciled - Impact, Reconciled - No Impact, Auto Reconciled, and you click OK on the Send Clarification pop-up the following message is displayed:

   Clarification cannot be sent. Please change Encounter Status to In Progress.

Retracting a Clarification

This section describes how to edit an existing clarification which is already sent to a provider.

Note: You can only retract the clarification if the status is **Sent**, or **Overdue** and all of the clarification responses are pending.

1. Select a clarification from the *Clarification List* panel.
2. Click **Retract**.

   Note: When you retract the clarification, the clarification status is automatically gets updated to **Retracted**.

3. Make the necessary changes in the clarification. Refer Creating a Clarification on page 145.

   Note: you cannot edit the **Code**, **Primary Type** and the **Other Type** fields after you retracted the clarification.

4. Click **Save** to save the changes or click **Send** to send the modified clarification.

Clarification Types and Templates

Table 24: Clarification Type Details and Associated Template

Clarification Type	Description	Financial Impact	Quality Impact	Associated Template
PDX	Principal diagnosis	Yes	No	Dx Clarification Template.doc
CC	Complication/Co-morbidity	Yes	No	Dx Clarification Template.doc
MCC	Major Complication/ Co-morbidity	Yes	No	Dx Clarification Template.doc
PROC	Procedure	Yes	No	Proc Clarification Template.doc
MST	Multiple Significant Trauma	Yes	No	Dx Clarification Template.doc
HIV	Human immunodeficiency virus related condition	Yes	No	Dx Clarification Template.doc
PC	Psychiatric Condition -Medical Condition that impacts reimbursement for inpatient psychiatric admissions	Yes	No	Dx Clarification Template.doc
SEV	Severity of illness	Yes	No	Dx Clarification Template.doc
HCC	Hierarchical condition category diagnosis	No	Yes	Dx Clarification Template.doc
CLIN VAL	Clinical validation	No	Yes	Clinical Validation Clarification Template.doc
POA	Present on admission	Yes	Yes	POA Clarification Template.doc
PSI	Patient safety indicator	No	Yes	POA Clarification Template.doc
Generic	Sign note, incomplete note	N/A	N/A	N/A

Clarification Summary pop-up

When the template that you select from the template drop-down is configured to display the summary, in the template builder on the Configuration Directory page, the **Summary** link is displayed on the Clarification and Responses tab. If selected template does not have the Summary field configured, the Summary link is not displayed.

You may use the **Summary** link to view the summary of the associated clarification. The **Summary** pop-up displays data as per the selections made in the Template Setup on the **Configuration Directory** > **Clarifications** page. You can copy and paste this information to any third-party application.

When a clarification is sent using a custom template and then the custom clarification template is deleted, the summary configurations are deleted and the **Summary** link is not displayed on the Clarification page.

Figure 105: Summary pop-up

Clarification Status

Table 25: Clarification Statuses and Descriptions

Clarification Status	Description	Consideration for Reconciliation
New	Clarification is created.	neither open nor closed
Sent	You have sent the clarification to a provider.	Open
Responded	You have manually updated the response date.	Open
Closed	You have manually entered the closed date or marked a response as the final response. When you marked a response as final, closed date is automatically set to current date/time.	Closed
Reopened	Reopened a closed clarification.	Open
Deleted	Clarification is deleted.	neither open nor closed
Retracted	You have retracted a clarification by selecting retract option or select **Retracted** from the **Response** drop-down list for a manual clarification.	neither open nor closed
Overdue	You had sent the clarification more than 24 hours ago and response date is empty.	Open

Working with Responses Tab

This section how to update the response status, response date of the sent clarification and also how to close an open clarification.

Updating Response Status and Date

1. On the **Responses** tab, select an instance of the provider clarification.
   Response related to the clarification is displayed in the **Message** field.

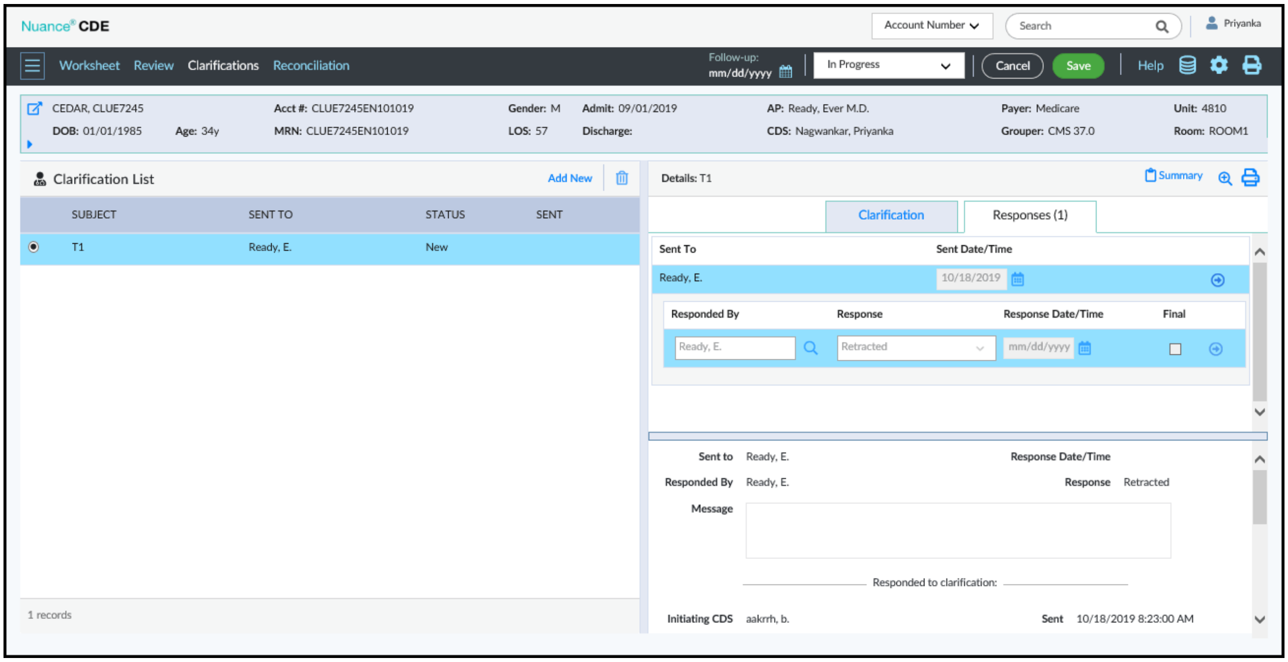


Figure 106: Responses Tab

2. Select the status of the response from the **Response** drop-down list. Refer Clarification Response Status on page 155.
   When you update the response status, the response date automatically gets displayed in the **Response Date/Time** field, although you can manually edit that. The response date/time is displayed in the UTC timezone.
3. Click **Save**.

Retracting a Clarification Instance

1. On the **Responses** tab, select an instance of the provider clarification that you want to retract.
   Response related to the clarification is displayed in the **Message** field.
2. Select **Retracted** from the **Response** drop-down list, or click the **Retract Clarification Instance**( ) icon.
3. Click **Save**.

Closing a Clarification

1. On the **Responses** tab, select an instance of the provider clarification.
   Response related to the clarification is displayed in the **Message** field.
2. Update the status of the response from the **Response** drop-down list. Refer Clarification Response Status on page 155.

   Note: You cannot close the clarification if the response status is **Pending**.

3. Select the **Final** checkbox for that respective clarification instance.
4. Click **Save**.
   The clarification status is changed to **Closed** and in the **Clarification** tab the clarification close date is automatically gets displayed in the **Closed** field. Also, you can manually update the clarification close date after the clarification is closed.

If the clarification is sent to a provider, and the provider has responded with any of the following options, then the system automatically marks the response as **Final** and closes the clarification:

- Agree
- Not Agree
- Unable to determine
- Alternative diagnosis
- Other explanation

If necessary, you can uncheck the **Final** checkbox manually.

Clarification Response Status

Table 26: Clarification Response Status Types and Descriptions

Response	Description	Applicable to Manual Clarification	Applicable to Electronic Clarification
Agreed	Provider agreed with the proposed clarification content and documented the requested information in the medical record.	Yes	Yes
Alternative Diagnosis	Provider documented a new diagnosis in the medical record which is currently not present.	Yes	Yes
Discuss	Discussion happened between provider and CDS.	No	Yes
Not Agreed	Provider disagreed with the proposed clarification and did not document the requested information in the medical record.	Yes	Yes
No Response	No response received from the provider.	Yes	Yes
Other explanation	Provider responded but offered another explanation for the clinical presentation or intent of the procedure.	Yes	Yes
Pending	Clarification has been sent to the provider, and you are awaiting a response. The system automatically selects this option when the clarification is sent. **Note:** Once you update the clarification response status as **Pending**, the clarification status changes back to **Sent**.	Yes	Yes
Retracted	CDS has withdrawn the provider clarification.	Yes	Yes
Send to another Provider	Provider responded but requested the clarification to be sent to another provider.	Yes	Yes
Unable to Determine	Provider indicated that after careful study, they were unable to determine an explanation for the clinical presentation or intent of the procedure.	Yes	No

Re-opening a Clarification

This section describes how to re-open a closed clarification.

1. Select a closed clarification that you want to re-open from the **Clarification List** panel.

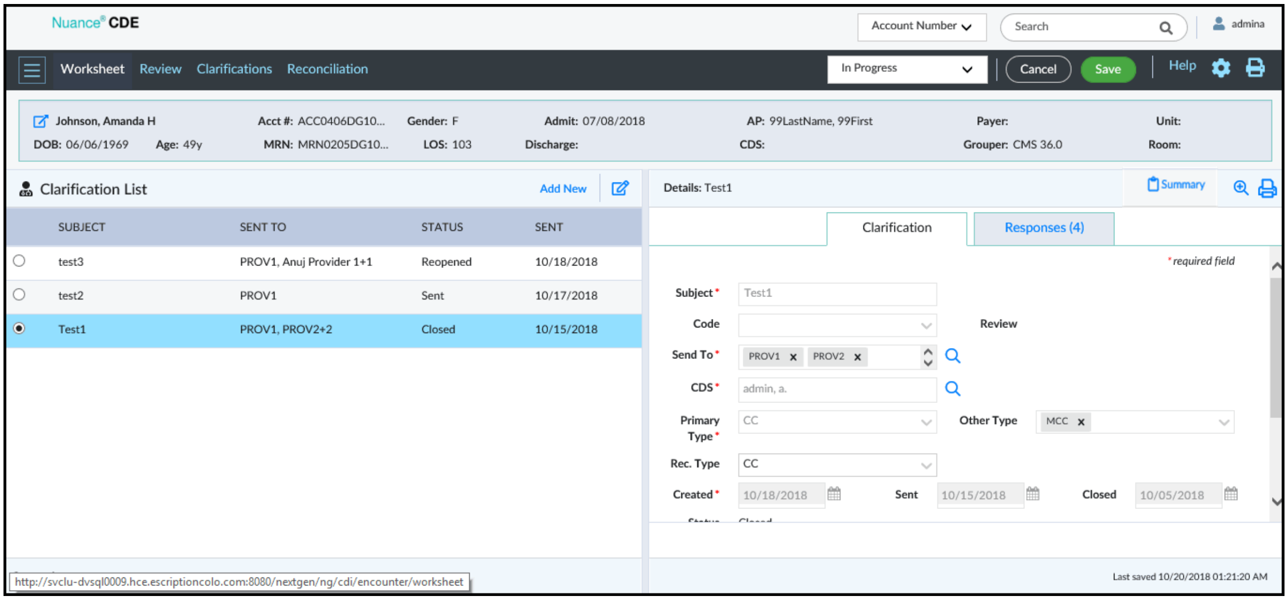


Figure 107: Reopen Clarification

2. Click **Reopen Clarification** ( ) icon.
   The clarification status is changed to **Reopened**.

Deleting a Clarification

This section describes how to delete a clarification.

1. Select a clarification that you want to delete from the **Clarification List** panel.

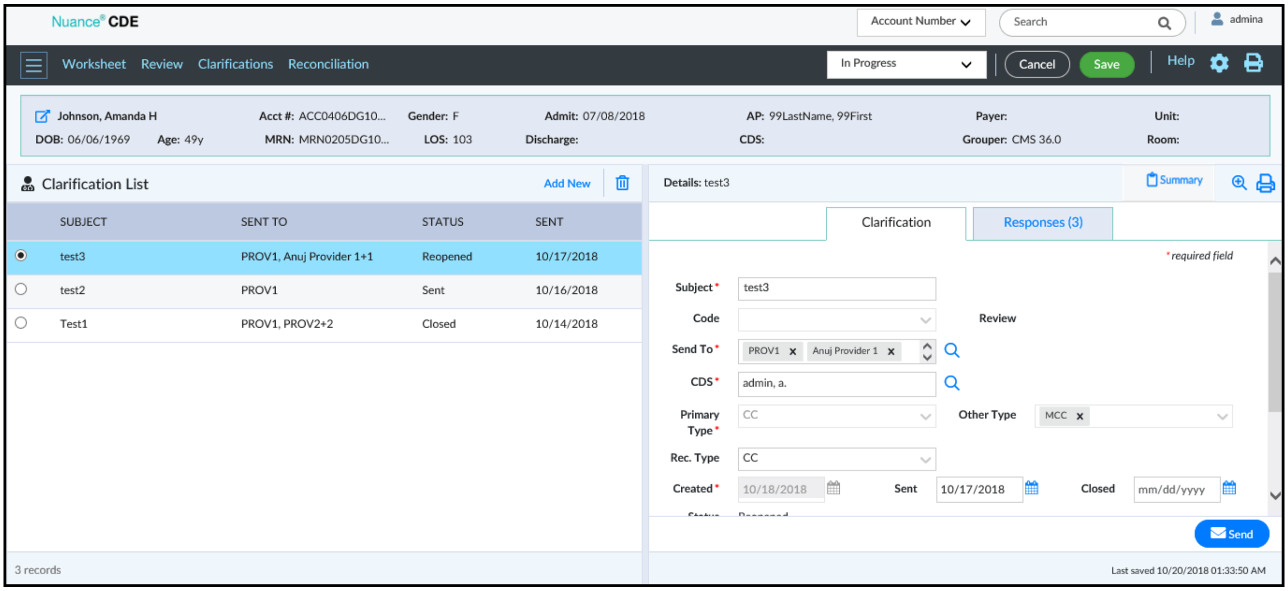


Figure 108: Delete Clarification

> **Note:** You cannot delete a closed clarification.

2. Select the **Delete Clarification** () icon.
   The clarification status is changed to **Deleted** and you can not delete a clarification which is closed.

After you deleted a clarification, you can undo the deletion by clicking the **Undo Delete Clarification** () icon. When Undo Delete Clarification icon is used, the clarification status is updated to New. The clarification now appears as a draft to the CDS, which can either be resent or discarded.

Print Clarification

Print Clarification Using Print Encounter Summary Icon

This section describes how to print the encounter clarification screen.

1. Click **Print**.
   The **Print Encounter** dialog-box is displayed.

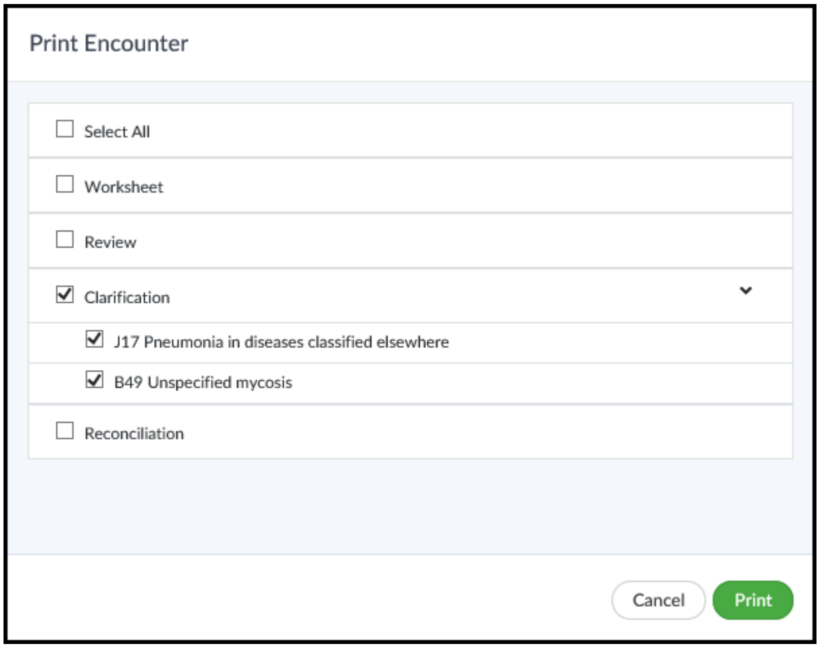


Figure 109: Print Encounter Dialog-box - Clarification

> **Note:** By default all the available clarifications are selected for print, and also you can select the **Select All** checkbox to print the complete encounter documentation (Worksheet, Review, Clarification, and Reconciliation).

2. Click **Print**.
   The print preview of the clarification is displayed..

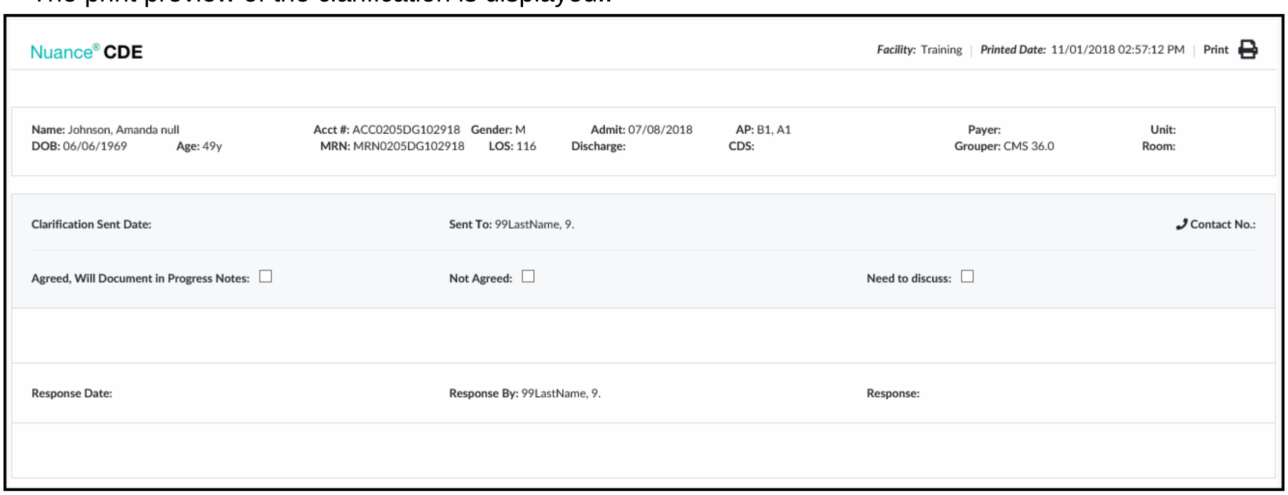


Figure 110: Print Preview Screen - Clarification

3. Click **Print**.
   The **Print** dialog-box is displayed.

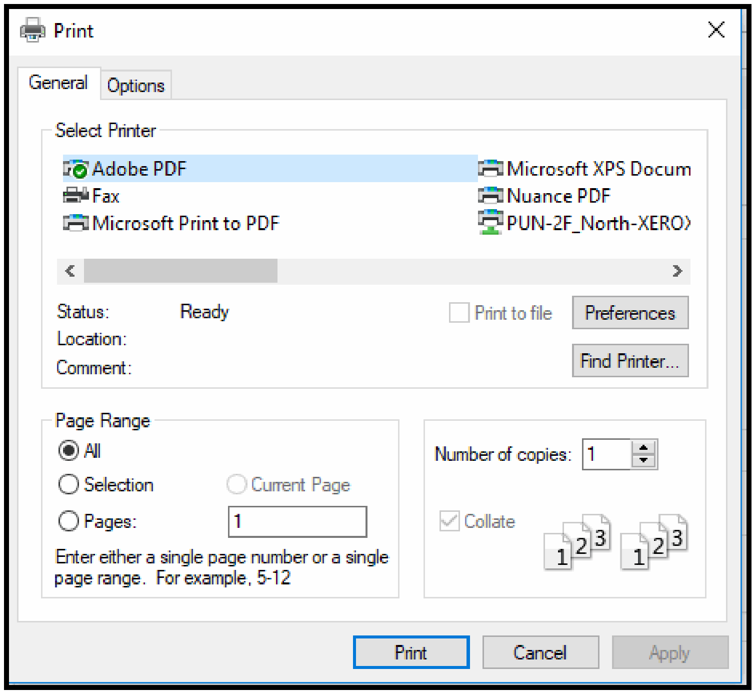


Figure 111: Print Dialog-box

4. Set the print settings for your desired print options.

   You can select the quantity of copies desired, page selection locations, page orientation (portrait to landscape and vice versa), and printer.

5. Click **Apply**, if you've made changes in the print setting.
6. Click **Print**.

Print Clarification Using Print Clarification Icon

1. On the **Clarification List** panel, select the clarification that you want to print.
2. Click **Print Clarification** ( ) icon from the clarification details section.

   The print preview of the clarification is displayed.

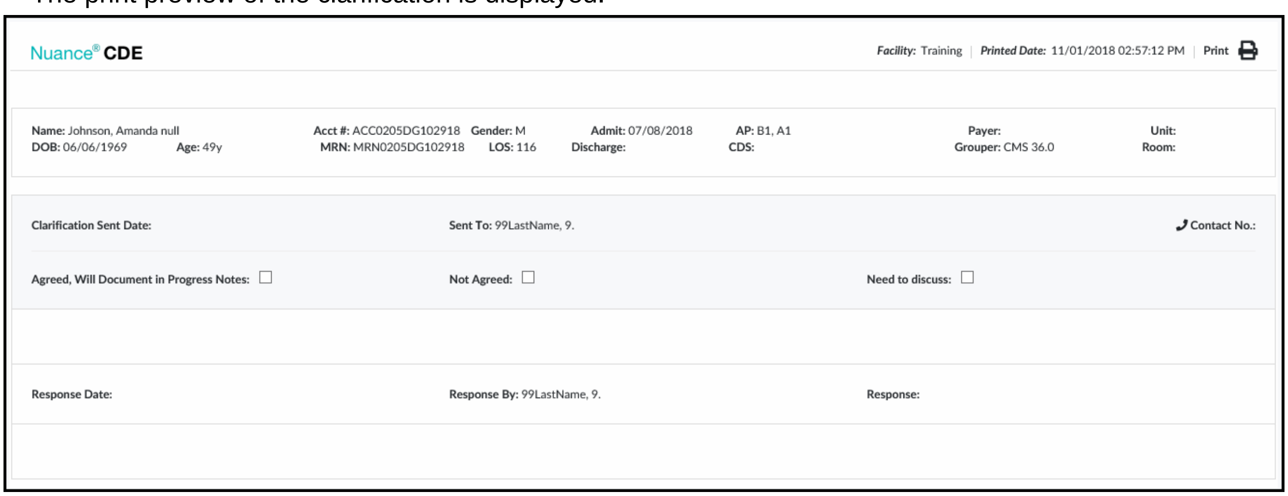


Figure 112: Print Preview Screen - Clarification

3. Set the print settings for your desired print options.

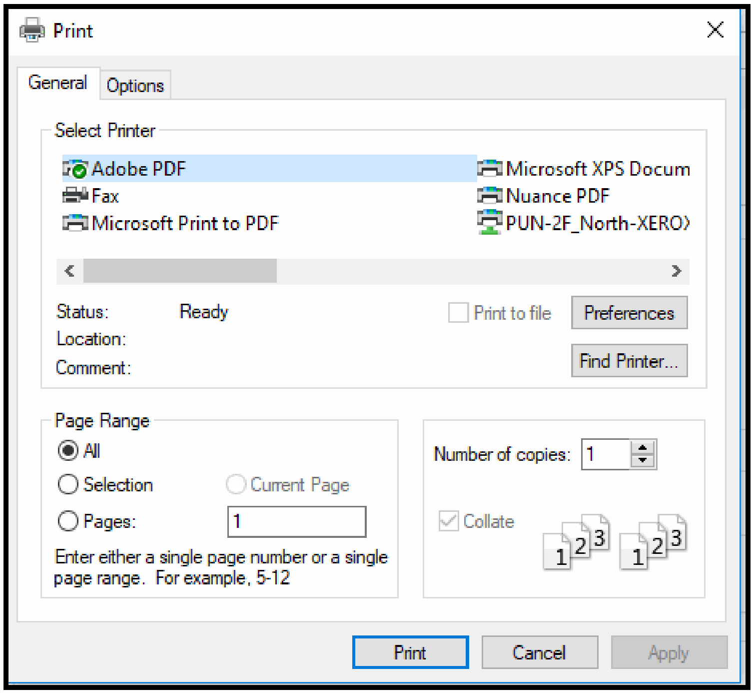


Figure 113: Print Dialog-box

You can select the quantity of copies desired, page selection locations, page orientation (portrait to landscape and vice versa), and printer.

4. Click **Apply**, if you've made changes in the print setting.
5. Click **Print**.

Printing Clarification Response

1. On the **Clarification List** panel, select the clarification.
2. Click **Responses** tab.
3. Select a provider response that you want print.
4. Click **Print Clarification** ( ) icon.
   The print preview of the clarification is displayed.

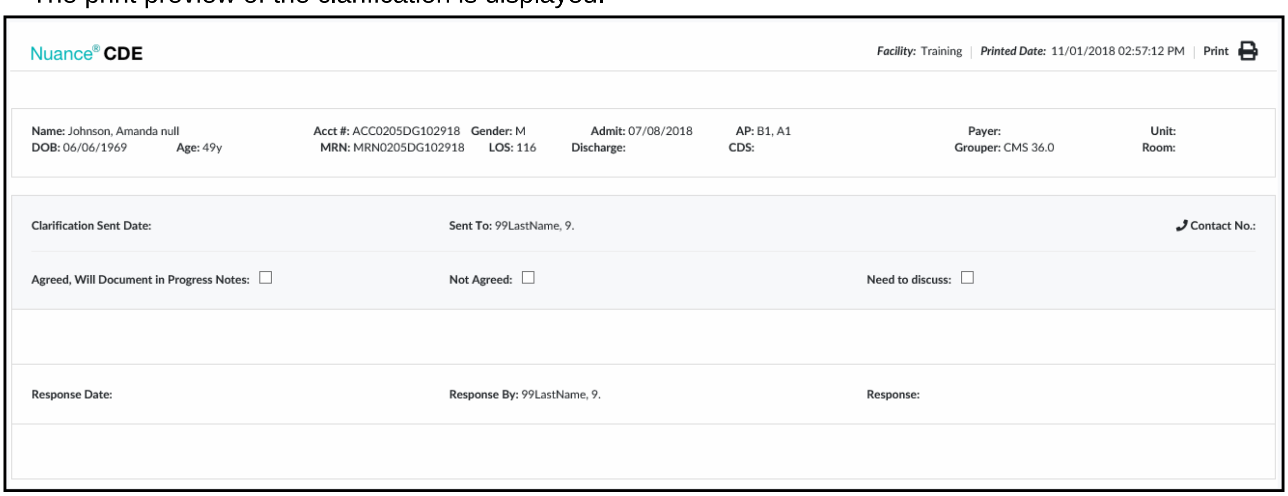


Figure 114: Print Preview Screen - Clarification

5. Set the print settings for your desired print options.

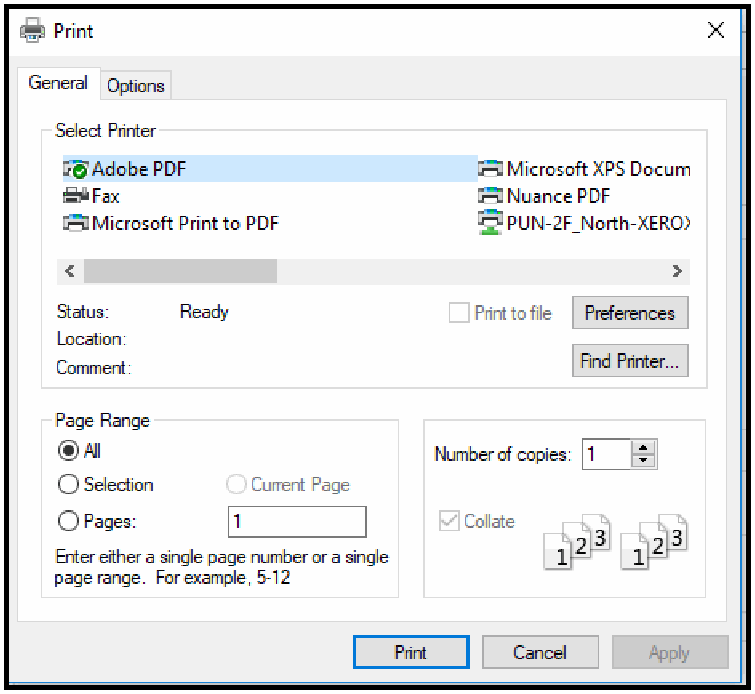


Figure 115: Print Dialog-box

You can select the quantity of copies desired, page selection locations, page orientation (portrait to landscape and vice versa), and printer.

6. Click **Apply**, if you have made changes in the print setting.
7. Click **Print**.

Chapter 10

Reconciliation

Topics:

About Reconciliation

Reconciliation is the process where the Working DRG, Working DRG weight, Possible DRG, and Possible DRG weight available in the application are compared to the final coded or billed DRG and DRG weight to determine the impact that the CDS had on the encounter. This may be completed manually or through auto-reconciliation.

When the Working DRG, Working DRG weight, Possible DRG, and Possible DRG weight matches with the final coded or billed DRG and DRG weight then system may automatically reconcile the encounter. If the DRGs and weights do not match with the final coded or billed DRG and DRG weight, then you need to manually reconcile the encounter.

Note: For the APR DRG encounters the Working APR DRG, Working APR weight, and Working, Working ROM are compared to the final coded or billed DRG, DRG weight, SOI, and ROM.

Manual Reconciliation

When the final billing codes, DRGs and DRG weights are available from your coding department, you can use the *Reconciliation* screen to manually reconcile an encounter. The encounter status must be **Review Complete**. If the system cannot auto-reconcile the encounter, the encounter status remains **Review Complete**. The encounter needs to be reconciled manually by choosing an impact status from the **Impact Status** drop-down in the *Reconciliation* screen. The encounter status automatically changes to *Reconciled – Impact* or *Reconciled – No Impact* depending on the impact status chosen during the reconciliation.

Final DRG Import

When your facility has the Final DRG Import setup, then the billing codes are imported from the coding system to the **Final Coded Summary** section in the *Reconciliation* screen. If the system cannot auto-reconcile the encounter, the encounter status changes to **Ready to Reconcile**. The encounter will need to be reconciled manually by choosing an impact status from the **Impact Status** drop-down in the *Reconciliation* screen. The encounter status automatically changes to *Reconciled – Impact* or *Reconciled – No Impact* depending on the impact status chosen during the reconciliation.

Note: When the system imports incomplete billing codes, the system will not run the auto-reconciliation logic. For the incomplete billing codes, the **Coding Status** is displayed as **Incomplete** in the *Reconciliation* screen.

Auto Reconciliation

If the facility chooses to use the auto-reconciliation, when the encounter review is completed and final billing codes are available in the system for the reconciliation process, the system automatically reconciles the encounter based on the reconciliation logic. Only those encounters where the CDS has no impact get auto-reconciled. The auto-reconciliation saves the reconciliation time and increases the productivity of the CDS.

Note: Auto-reconciliation can be turned off completely or can be turned off for the encounter that has clarifications or any open clarification.

Auto-reconciliation logic for the MS-DRG grouper:

- If the working DRG and DRG weight matches the final coded DRG and DRG weight, and there is no possible review, then the encounter gets auto-reconciled. The encounter status changes to **Auto Reconciled**.
- If the Working DRG and DRG weight, the Possible DRG and DRG weight, and the final coded DRG and DRG weight matches, then the encounter gets auto-reconcile. The encounter status changes to **Auto Reconciled**.

Auto-reconciliation logic for APR-DRG grouper:

- If the working DRG, working DRG weight, working SOI, and working ROM matches the final coded DRG, DRG weight, SOI, and ROM, and there is no possible review or clarifications issued, the encounter gets auto-reconciled. The encounter status changes to **Auto Reconciled**.

Note: For the APR-DRG groupers the encounter with the possible review, or the encounter with any clarification must be reconciled manually.

If there is a difference and the system cannot auto-reconcile the encounter, then you will need to manually update the reconciliation impact by choosing an impact status from the *Reconciliation* screen. The encounter status is automatically changed to either *Reconciled – Impact* or *Reconciled - No Impact* depending on the impact status chosen during reconciliation.

Present On Admission (POA)

The following are the NUBC approved default values for POA:

- Y- Yes
- N- No
- U- No information in record
- W- Clinically undetermined

One of the following values are displayed to designate the exempted code based on your configuration in the POA configuration screen:

- 1
- E

POA value gets populated automatically for the exempted codes.

The POA value for the primary diagnosis code can not be marked as **N** and neither you can keep it blank. Similarly, the POA value for any Hospital Acquired Condition codes must not be left blank.

Frequently Asked Questions

When a chart that is recoded and I use the final DRG import and there was no change in the DRG, DRG WT, SOI or ROM, what happens? Will the encounter status change to ready to reconcile?

No change to encounter status since nothing has changed, assuming the DRG weight hasn't changed either. But if the weight has changed then the encounter cannot be auto-reconcile, and the status changes to **Ready to Reconcile**.

When a chart that is recoded and I use the final DRG import and the DRG remains the same but the SOI or ROM changes, what happens? Will the encounter status change to ready to reconcile?

For the MS-DRG grouper, only the DRG value and weight matter. If they haven't changed, the status remains the same.

For the APR-DRG grouper, if the DRG, weight, SOI and ROM haven't changed, the status remains the same. If any of the values change and encounter cannot auto-reconcile, the status changes to **Ready to Reconcile**.

When a chart that is recoded and I use the final DRG import and the DRG changes, what happens? Will the encounter status change to ready to reconcile?

If the DRG changes the encounter can not be auto-reconcile, and the encounter status changes to **Ready to Reconcile**.

Working with Reconciliation

The section describes how to manually reconcile an encounter. Using this Reconciliation Assessment, you can easily see the impact on the case. To start the reconciliation, final coded summary of the encounter should be available. Encounter review must be completed, and should be in the **Review Complete** status.

Adding Codes in the Final Coded Summary Section

1. Click the **Reconciliation** tab.
   The *Reconciliation* screen is displayed.

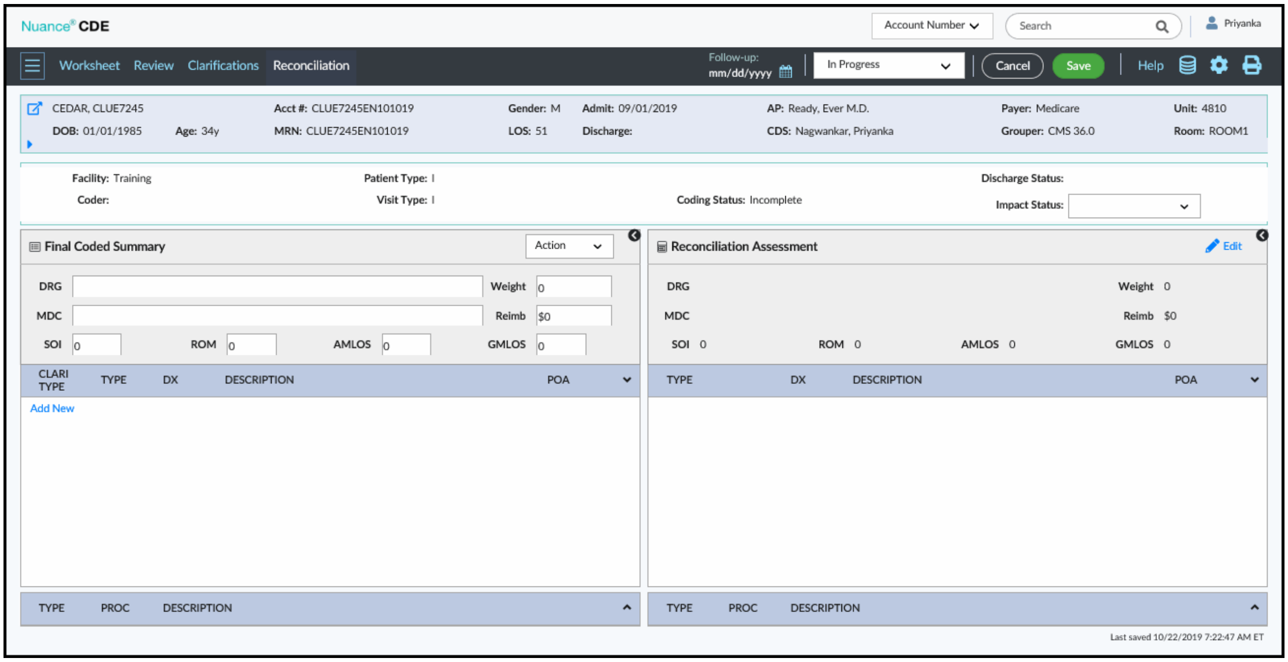


Figure 116: Reconciliation Screen

2. Final billing codes get imported in the **Final Coded Summary** section from the coding system, or you can manually add them.

   Note: After you have manually added the code in the **Final Coded Summary** section you cannot enter the DRG and DRG weight without removing the code.

   - If the added code has an agreed clarification and the clarification is final, then the code will be highlighted and it will not appear on the **Reconciliation Assessment** section and will not be included in the assessment.
   - The principal code that begins the reconciliation assessment is always the principal code from the ' Working Review section.
   - Both the **Final Coded Summary** and the **Reconciliation Assessment** sections will group to the grouper associated with the payer.

3. Compare the DRG, Weight, SOI, ROM, Reimbursement and LOS of the **Final Code Summary** against the **Reconciliation Assessment** and then update the impact of the reconciliation from the **Impact Status** drop-down list, as necessary. Refer to Impact Status on page 170.

   The **Reconciliation Assessment** section displays codes that do not have any impact with an agreed clarification and available in the **Final Coded Summary** section.

   The encounter status is automatically changed to either **Reconciled - Impact** or **Reconciled - No Impact** depending on the impact of the encounter reconciliation. Refer to Encounter Status and Description on page 65.

Note: SOI and ROM values are estimated and displayed only for a encounter that is grouped with an MS-DRG.

4. Click **Save**.

Adding DRG in the Final Coded Summary Section

This section describes how to enter the final coded DRG and Weight in the Final Coded Summary without entering the codes.

1. Click the **Reconciliation** tab.
   The *Reconciliation* screen is displayed.

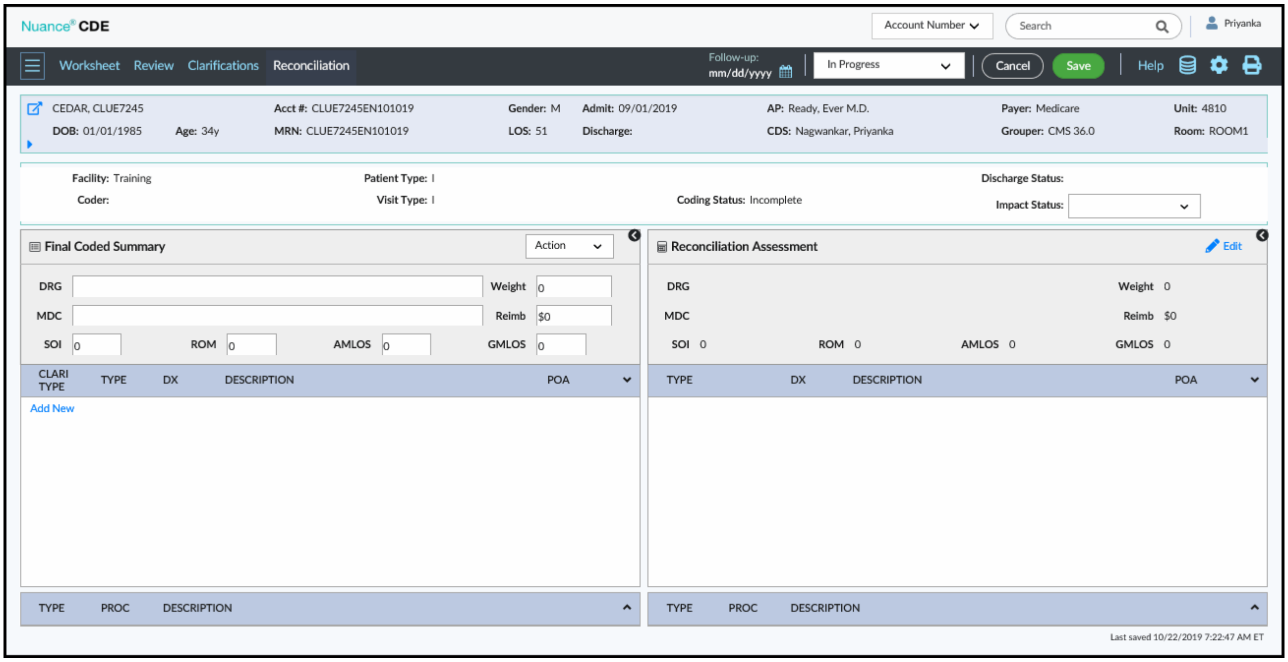


Figure 117: Reconciliation Screen

2. The final coded *DRG* gets imported in the **Final Coded Summary** section from the coding system, or you can manually add the DRG.
   For the MS DRG grouper, system automatically displays Weight, SOI, ROM, LOS, and reimbursement values after you have tabbed out from the **DRG** field. For the APR DRG grouper, you need to add all the details (APR DRG, APR DRG WT, APR GMLOS, SOI, ROM, APR reimbursement) manually that you wish to save for the encounter.
3. Select the impact of the reconciliation from the **Impact Status** drop-down list depending on the impact of the encounter reconciliation.

   The encounter status is automatically changed to either **Reconciled - Impact** or **Reconciled - No Impact** depending on the impact of the encounter reconciliation. Refer Encounter Status and Description on page 65.
4. Click **Save**.

   Note: The reconciliation assessment will not be generated.

Adding DRG in the Reconciliation Assessment Section

You can make the Reconciliation Assessment section editable by clicking the Edit icon. When in editable mode, you can add or delete codes and POA value in the reconciliation table. You can also reorder the codes using the Three Dots icon. When you edit the reconciliation, any more imports to Final Coded side do not impact the assessment. When codes are added, removed, or resequenced in the assessment side, the subsequent imports are not impacted.

1. Click the **Reconciliation** tab.

The *Reconciliation* screen is displayed.

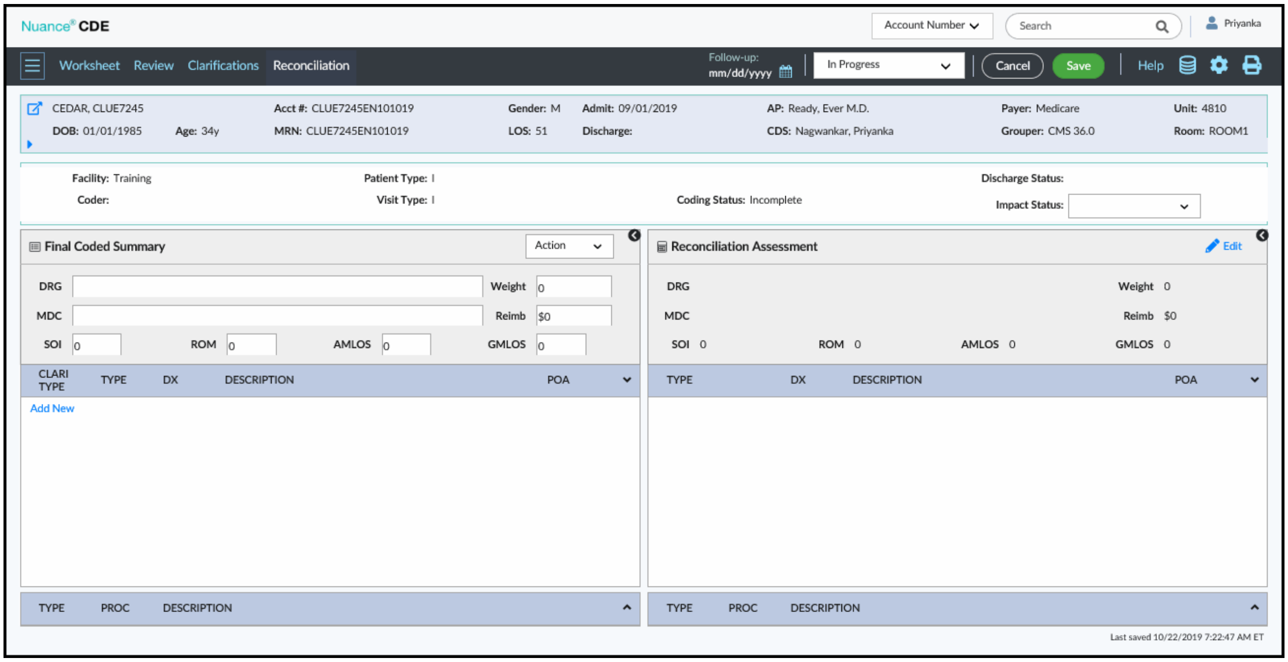
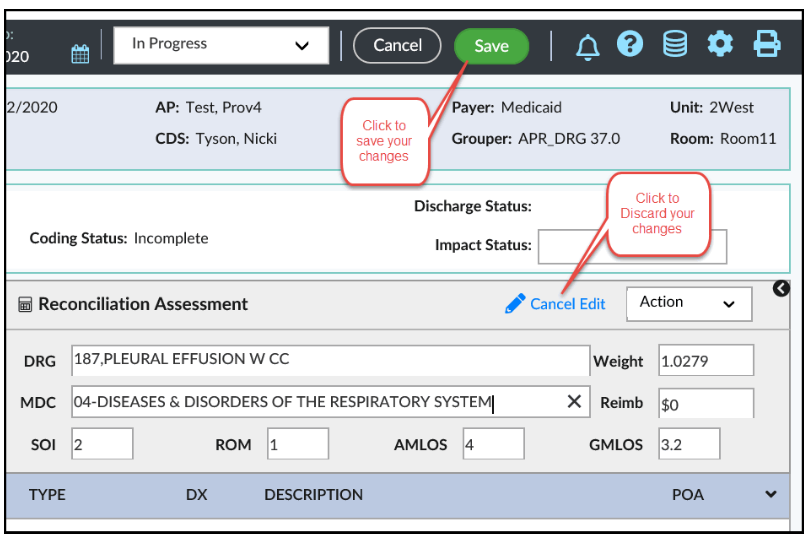


Figure 118: Reconciliation Screen

2. Click **Edit** in the Reconciliation Assessment section to make it editable.
3. Make the necessary edits. Click **Save**.Changes you made to the Reconciliation Assessment will be saved.

Figure 119: Save and Cancel Options



Note:

If you click **Cancel Edit**, the application displays the following warning pop-up.

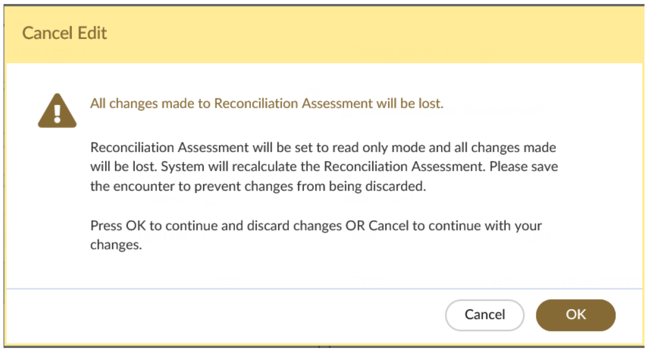


Figure 120: Cancel Edit Mode warning pop-up

If you click **Cancel**, then click Save.

- Any changes you made to the the Reconciliation Assessment in this session will be retained.
- You will be prompted to set a follow-up date.
- CDE One updates the DRG to reflect your changes.

If you click **OK**,

- Any changes you made to the Reconciliation Assessment in this session will be lost.
- Reconciliation Assessment is set to read only.
- CDE One resets the DRG to what it was before you made changes to the Reconciliation Assessment.

Note: The **Clear All** option in the Action drop-down can be used to clear all the fields.

Impact Status

Table 27: Reconciliation Impact Status and Description

Impact Type	Description
Financial Impact	Change in reimbursement driven by one or more agreed to clarifications sent by you.
SOI/ROM Impact	Change in severity of illness/risk of mortality driven by one or more agreed to clarifications sent by you.
Both Impact	Change in both reimbursement and severity of illness/risk of mortality driven by one or more agreed to clarifications sent by you.
No Impact	Clarifications were not sent, or clarifications sent by you had no impact on the encounter.

Printing Reconciliation

This section describes how to print the encounter reconciliation screen.

1. Click **Print**.
   The **Print Encounter** dialog-box is displayed.

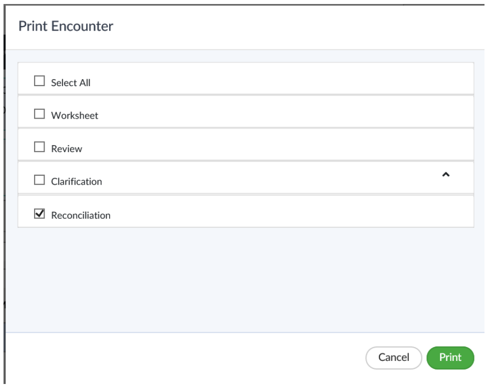


Figure 121: Print Encounter Dialog-box - Reconciliation

> **Note:** By default the **Reconciliation** is selected to print the reconciliation screen, and also you can select the **Select All** check box to print the complete encounter documentation (Worksheet, Review, Clarification, and Reconciliation).

2. Click **Print**.
   The print preview window is displayed.
3. Click **Print**.
   The **Print** dialog-box is displayed.

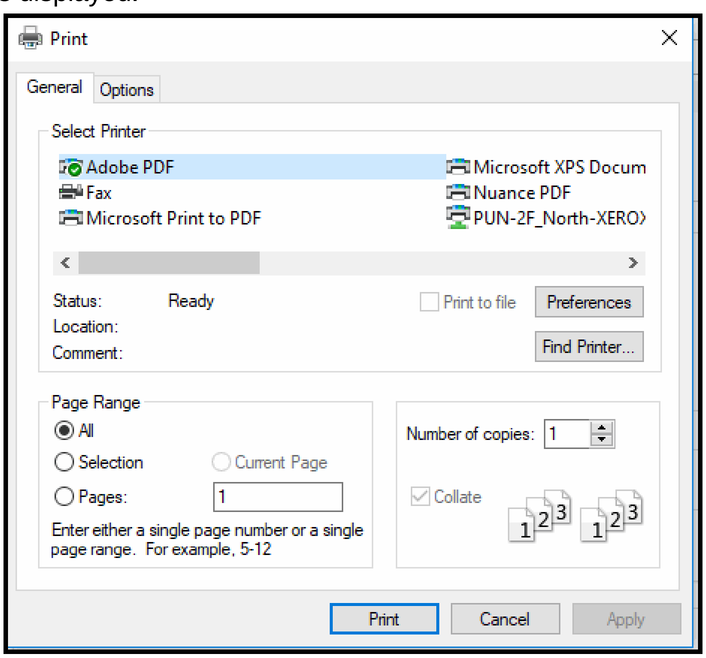


Figure 122: Print Dialog-box

4. Set the print settings for your desired print options.

   You can select the quantity of copies desired, page selection locations, page orientation (portrait to landscape and vice versa), and printer.
5. Click **Apply**, if you've made changes in the print setting.

6. Click **Print**.

Chapter 11

Knowledge Base

Topics:

About Knowledge Base

The Knowledge Base feature provides access to various knowledge bases (reference materials) during the course of CDS work both while working on an encounter, or independent of an encounter. You can use this feature as reference while working on an encounter, or while working independently.

Knowledge Base has been integrated with the application. The Knowledge Base window can be accessed from the Triage Worklist, and Audit Trail pages, and the tabs within them, including the encounters.

The Knowledge Base window closes automatically when the application session times out or when the CDS closes the application window.

You can navigate through the references by clicking on the plus sign, next to it. When the you click on an article within the reference, the content is displayed in the Document section.

You can also search by typing in a keyword in the Keywords box. The search results display the occurrance of the typed keyword in the Search tab. By clicking on the links in the Search tab, you can view the articles with the searched keyword in the Document section.

Knowledge Base contains the following Reference Types:

- **Decision Tree**
- **ICD-10 CM Guidelines**
- **ICD-9 Coding Clinic Reference**
- **ICD-10 Coding Clinic Reference**
- **ICD-10 Coding Clinical Indicator**
- **ICD-10 PCS Guideline**
- **ICD-10 PCS Reference Manual**
- **Patient Safety Indicators (AHRQ) Adult**
- **Patient Safety Indicators (AHRQ) Pediatric**

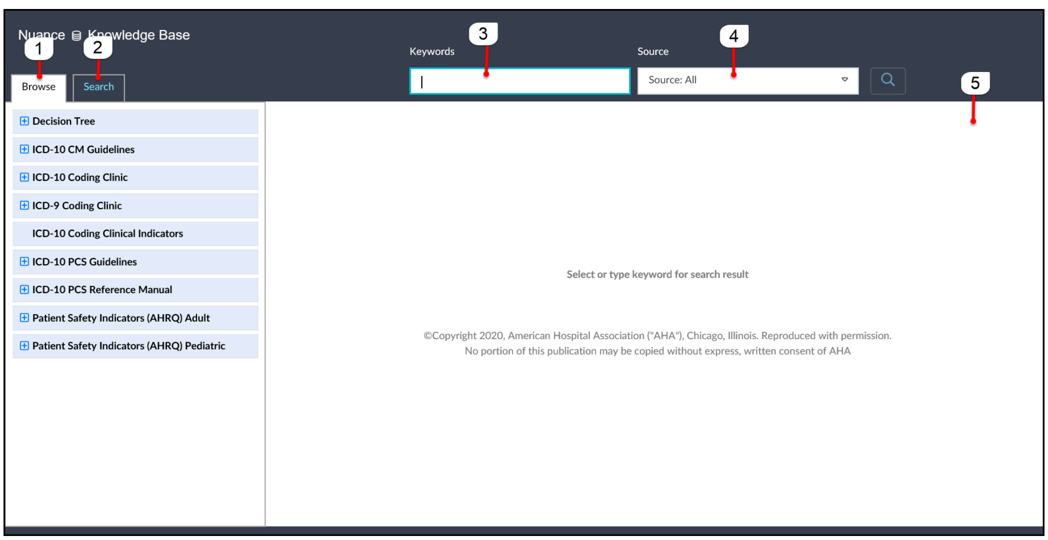


Figure 123: Knowledge Base Screen

Table 28: Knowledge Base Screen Identification and Purpose

Item	Description	Purpose
1	Browse	Displays the list of available references. The plus button next to the reference is used to expand the references to drill-down further.

Item	Description	Purpose
2	Search	Displays a list of articles that have instances of the searched keyword. The top five articles are displayed. If the searched keyword occurs in more than five articles, Load Next link is displayed. The Load Next link shows the remaining list.
3	Keywords	Enter keyword to be searched in the reference type.
4	Source	Select the source from the drop-down, to specify within which reference type should the keyword be searched in.
5	Document section	Displays the selected article from the reference type.

Searching in Knowledge Base

You can search by typing keywords in the Search box.

1. On the Knowledge Base screen, type the keyword in the Search box.
   a) To search for individual or multiple terms, type the term in the Search box and click the search icon.
   b) To search for a phrase, type the phrase within double quotes and click the search icon.
   c) To search for individual or multiple terms, or a phrase within a particular reference type, type in the term or phrase and select the reference type from the Source drop-down. Click the search icon.

   The search result for the searched term or phrase is displayed in the Search tab on the left pane.

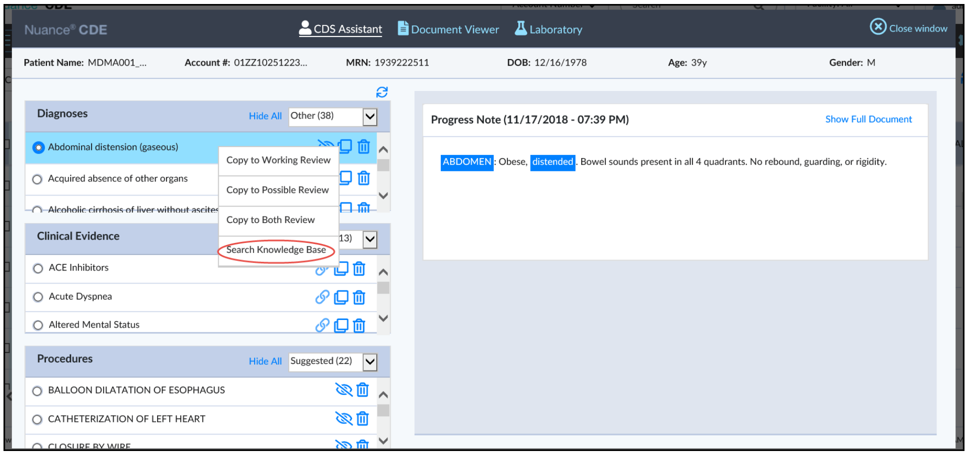
   The Search tab displays the first five results that best match the searched keywords. The first result contains the maximum instances of the searched keywords. If there are more than five search results, **Load Next** link is displayed at the bottom of the results. You can click the **Load Next** link to display the next five. When the search result contains more than one result statement, the count of result statements with a + sign is displayed at the end of the result. When you hover over the result, you can view the remaining result statements, as a tool tip.
2. Click on the search result to view the complete content in the Document section.
   After the list of search results is displayed in the Search tab, if you navigate to the Browse tab, the Browse tab displays the exact location of the selected article within the reference type.

Accessing Knowledge Base

The **Search Knowledge Base** function can be accessed from CDS Assistant, Review and Reconciliation screens.

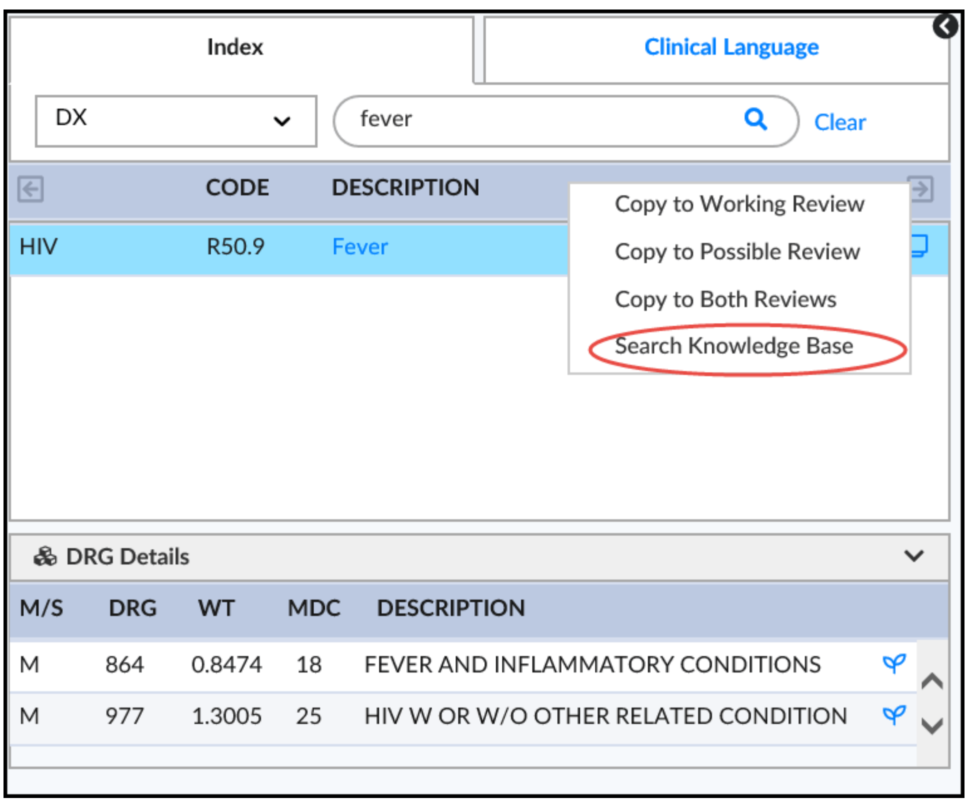
Search Knowledge Base through CDS Assistant Screen

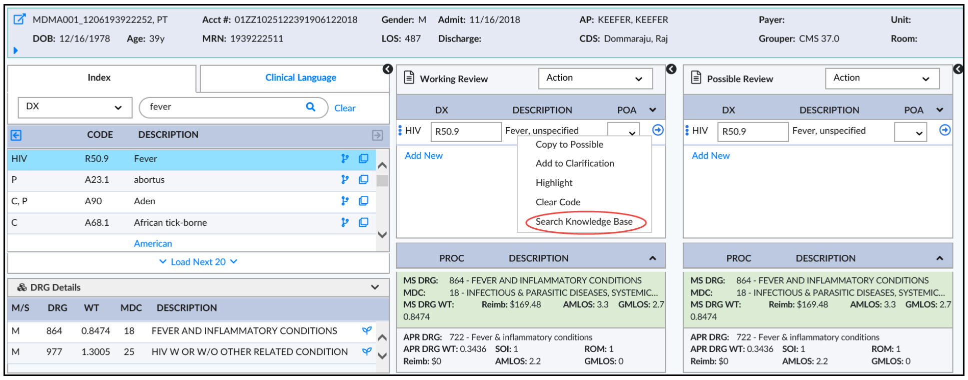
The *CDS Assistant* screen can be accessed directly from the worklist or through encounter. Select CM context menu, system displays context menu options. **Search Knowledge Base** displays last in the list.

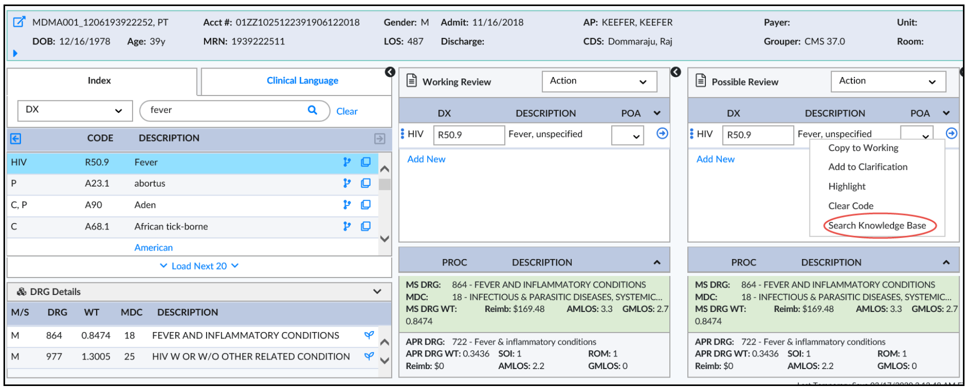


Search Knowledge Base through Review Screen

Knowledge base can be accessed through Index and Clinical Language Code search. Search for the desired code or description and add it to Working and Possible Review sections. **Search Knowledge Base** displays last in all the lists. The **Search Knowledge Base** option is available for the Reviews DX and Proc.

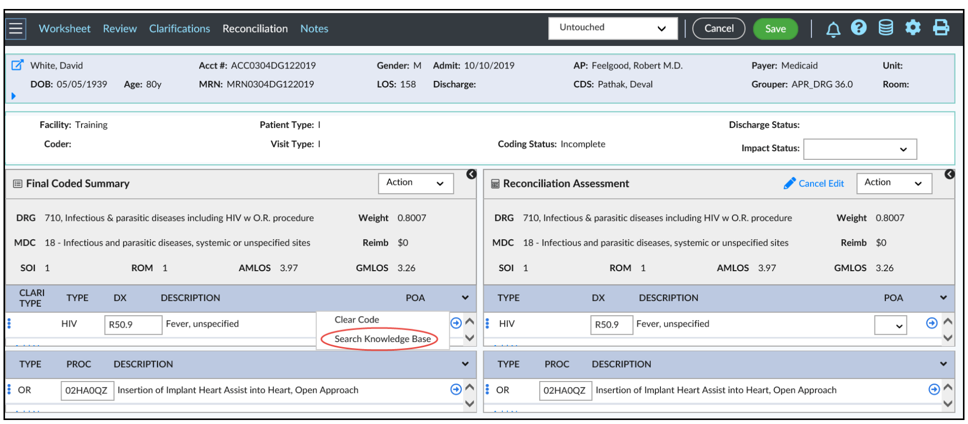


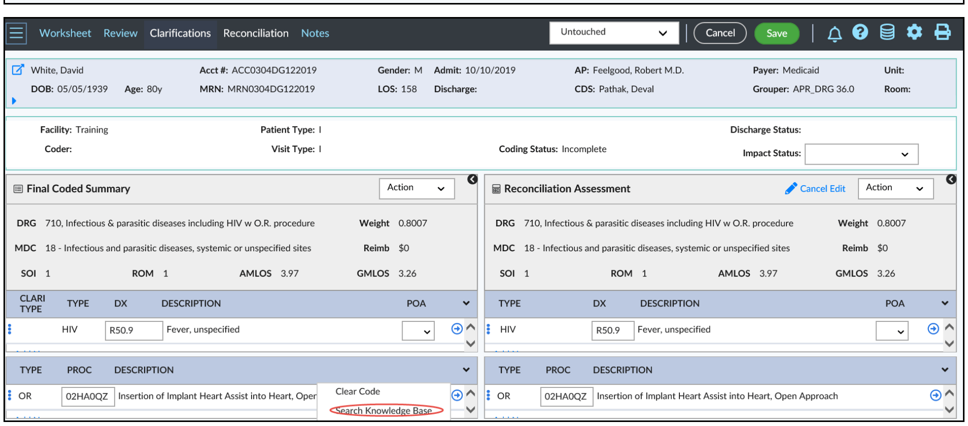


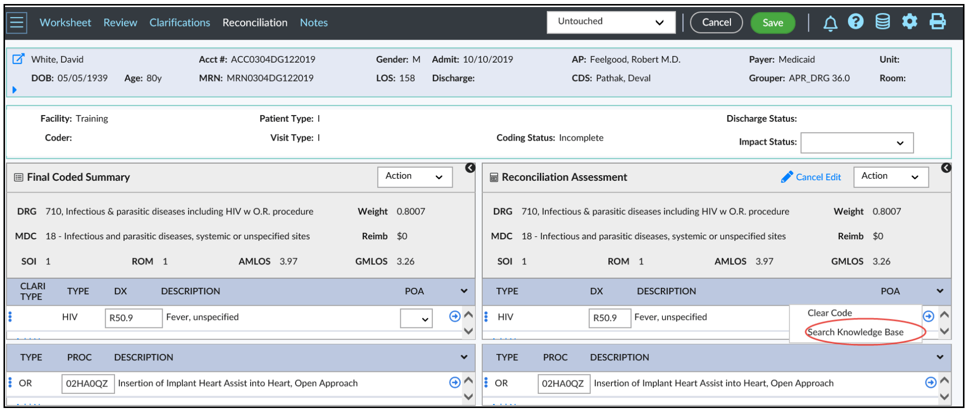


Search Knowledge Base through Reconciliation Screen

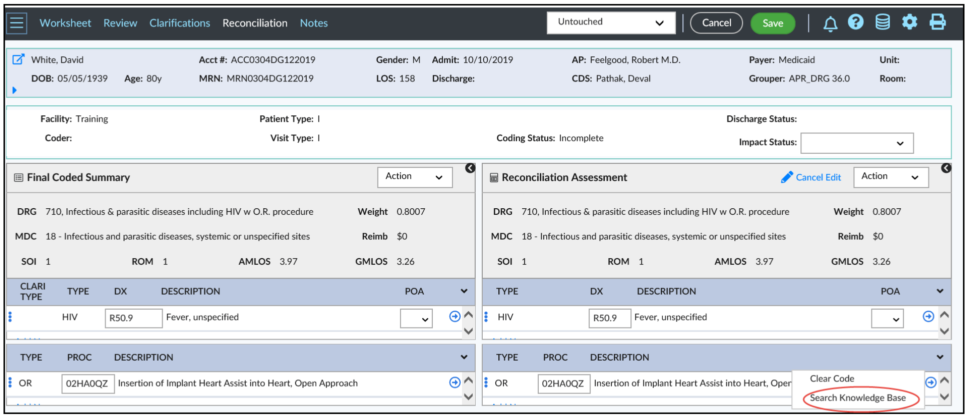
The **Search Knowledge Base** option is available for the *Reconciliation* Screen for DX and Proc.







Worksheet Review Clarifications Reconciliation Notes
Untouched
Cancel
Save
White, David
DOB: 05/05/1939 Age: 80y
Acct #: ACC0304DG122019
MRN: MRN0304DG122019
Gender: M Admit: 10/10/2019
LOS: 158 Discharge:
AP: Feelgood, Robert M.D.
CDS: Pathak, Deval
Payer: Medicaid
Grouper: APR_DRG 36.0
Unit:
Room:
Facility: Training
Coder:
Patient Type: I
Visit Type: I
Coding Status: Incomplete
Discharge Status:
Impact Status:
Final Coded Summary
Action
Reconciliation Assessment
Cancel Edit
DRG 710, Infectious & parasitic diseases including HIV w O.R. procedure
Weight 0.8007
MDC 18 - Infectious and parasitic diseases, systemic or unspecified sites
Reimb $0
SOI 1 ROM 1 AMLOS 3.97 GMLOS 3.26
CLARI TYPE TYPE DX DESCRIPTION POA
HIV R50.9 Fever, unspecified
Clear Code
Search Knowledge Base
TYPE PROC DESCRIPTION
OR 02HA0QZ Insertion of Implant Heart Assist into Heart, Open Approach



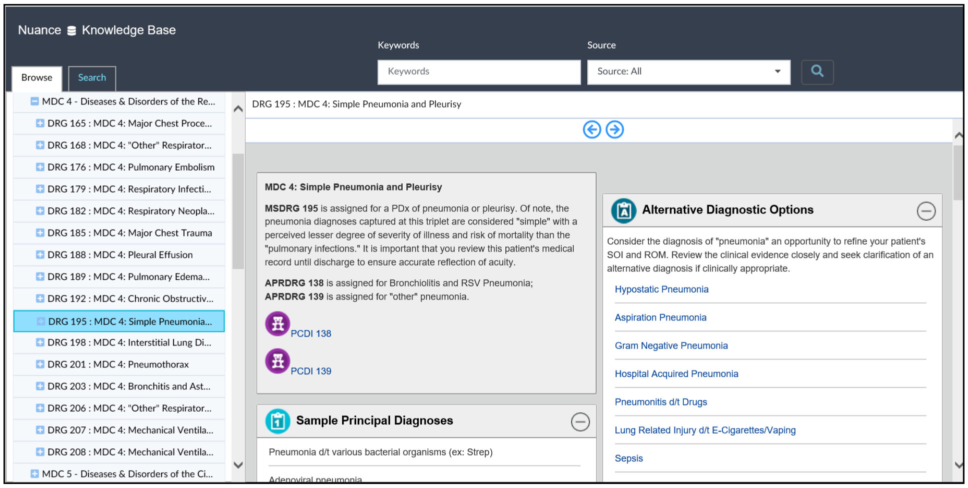
Worksheet Review Clarifications Reconciliation Notes
Untouched
Cancel
Save
White, David
DOB: 05/05/1939 Age: 80y
Acct #: ACC0304DG122019
MRN: MRN0304DG122019
Gender: M Admit: 10/10/2019
LOS: 158 Discharge:
AP: Feelgood, Robert M.D.
CDS: Pathak, Deval
Payer: Medicaid
Grouper: APR_DRG 36.0
Unit:
Room:
Facility: Training
Coder:
Patient Type: I
Visit Type: I
Coding Status: Incomplete
Discharge Status:
Impact Status:
Final Coded Summary
Action
Reconciliation Assessment
Cancel Edit
DRG 710, Infectious & parasitic diseases including HIV w O.R. procedure
Weight 0.8007
MDC 18 - Infectious and parasitic diseases, systemic or unspecified sites
Reimb $0
SOI 1 ROM 1 AMLOS 3.97 GMLOS 3.26
CLARI TYPE TYPE DX DESCRIPTION POA
HIV R50.9 Fever, unspecified
TYPE PROC DESCRIPTION
OR 02HA0QZ Insertion of Implant Heart Assist into Heart, Open Approach
Clear Code
Search Knowledge Base

Decision Tree

Decision Tree interface facilitates access to desired information in quick and easier way.

The Decision Tree has been enabled with a search feature. This feature allows keyword, Dx Code and DRG code search. The system searches the JATA content for that keyword or code and displays a list of topics that contain the word with hyperlinks. These hyperlinks allow to navigate to additional details.

Pediatric content PCDI (hyperlink) appears with a teddy bear icon next to it.



ICD-10 CM Guidelines

Use ICD-10 CM Guidelines to review information to guide coding provided by the Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS). These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

Content for Supplement Coding encounters related to COVID-19 has been added to ICD-10-CM Official Coding Guidelines.

ICD-9 Coding Clinic Reference

As a CDE user, you can search and browse ICD-9 coding clinics. This gives you access to the content that wasn't migrated by the vendor to ICD-10 CM/PCS coding clinics. Coding Clinic is the full text of AHA Coding Clinic for ICD-9, the quarterly publication by the American Hospital Association Central Office on ICD-9. This publication includes official guidelines for accurate and complete coding. When more than one Coding Clinic article is associated with a code, articles appear in reverse chronological order, with the most recent article appearing first. Each Coding Clinic article is marked with the volume number and date of its publication.

ICD-10 Coding Clinic Reference

ICD-10 Coding Clinic is the full text of AHA Coding Clinic for ICD-10, the quarterly publication by the American Hospital Association Central Office on ICD-10. This publication includes official guidelines for accurate and complete coding. When more than one Coding Clinic article is associated with a code, articles appear in reverse chronological order, with the most recent article appearing first. Each Coding Clinic article is marked with the volume number and date of its publication.

A quarterly publication of the Central Office on ICD-10-CM/PCS has been added to the ICD-10 Coding Clinic Reference.

ICD-10 Coding Clinical Indicators

Clinical Indicators provide comprehensive information ICD-10 diagnoses and procedures. They are compiled by HIM Professionals from a variety of medical resources and references.

Clinical Indicators are intended to enhance the coder’s knowledge of the cause, manifestations, and treatment of disease processes. They are not intended to be a guide to clinical management or a tool for case management review.

For each CM code listed, there is a description of disease processes and information about the symptoms, standard treatment practices, and documentation guidelines.

For each PCS code listed there is a description of the process, sample conditions on which the procedure is performed, and a description of the procedure.

ICD-10 PCS Guideline

Use ICD-10 PCS Guidelines to review information to guide coding that was developed with the support of the Centers for Medicare and Medicaid Services (CMS) under contract with 3M™ Health Information Systems. These guidelines are based on the coding and sequencing instructions in the Tables, Index and Definitions of ICD-10-PCS and provide additional instruction.

ICD-10 PCS Reference Manual

Use ICD-10 PCS Reference Manual to review information to guide coding that was developed with the support of the Centers for Medicare and Medicaid Services (CMS) under contract with 3M™ Health Information Systems.

The ICD-10-PCS Reference Manual provides reference material on PCS code structure, root operation definitions, code examples, and coding exercises. It contains listings of the root operations by section, approaches with definitions and device and substance classification references.

Patient Safety Indicators (AHRQ) Adult

The Patient Safety Indicators (PSIs) provide information on potentially avoidable safety events that represent opportunities for improvement in the delivery of care. More specifically, they focus on potential in-hospital complications and adverse events following surgeries, procedures, and childbirth.

The PSIs can be used to help hospitals assess the incidence of adverse events and in-hospital complications and identify issues that might need further study.

Patient Safety Indicators (AHRQ) Adult reference category gives access to a set of PSI documentation related to adult health issues.

Patient Safety Indicators (AHRQ) Pediatric

Patient Safety Indicators can be used to help hospitals and health care organizations assess, monitor, track, and improve the safety of inpatient care.

Patient Safety Indicators (AHRQ) Pediatric reference category gives access to a set of PSI documentation related to pediatric health issues.

You can search and browse through the PSI documents. In search mode, when you click on a search result, system navigates you to the first occurrence of the searched terms. In browse mode, system navigates you to the beginning of the page (instead of the exact location of the article on the page).

Appendix

Appendices

Topics:

Appendix A

Encounter Prioritization

Topics:

Overview of Prioritization

Based on the prioritization rules, the encounters are assigned with ranks between one and eleven, one being the highest priority, and eleven being the lowest. This rank is displayed in the **Rank** column of the Triage Worklist screen.

Encounters marked as rank 1, are displayed at the top of the worklist column followed by rank 2, rank 3, rank 4, and so on.

Table 29: Prioritization Rules

Rank	Description
1	New/untouched encounter with no initial review present, and without CLU suggested CC/MCC code
2	New/untouched encounter with no initial review present, having one or more CLU suggested CC codes or has 0 (zero) or one CLU suggested MCC code
3	Follow-up encounter with initial review present, and without CLU suggested or manually entered CC/MCC code
4	Follow-up encounter with initial review present, with CLU Suggested or manually entered CC code and NO CLU suggested or manually entered MCC code.
5	Follow-up encounter without manually entered MCC code and current LOS is greater than GMLOS (from CDS Working Dx)
6	New/untouched encounter with no initial review present, and having two or more CLU suggested MCC codes
7	Encounter with procedure note, and has manually entered Procedure code
8	CLU suggested one or more diagnosis (Dx) code with PSI or require POA/HAC
9	Follow-up encounter with initial review present, target Dx present, or CLU suggested or manually entered MCC code >0 (encounter has both target diagnosis and MCC code)
10	Encounter with initial review present, no manually entered target Dx code and has CLU suggested or manually added MCC code (encounter does not have target diagnosis and has a MCC code)
11	If neither any of the above rules are satisfied nor the exclusion criteria

Unranked and Exclusion Criteria

By default, the following types of encounters are excluded from the prioritization ranking and are displayed after the ranked encounters:

- Number of hours since admission is less than 24 hours
- No History & Physical and no Progress note document
- Encounters without admit date
- Encounters with the following status:
    - Discharged
    - Review not needed
    - Auto-reconciled
    - Reconciled with impact

- Reconciled with no impact
- Review Complete
- Ready to Reconcile

Exclusion from CDE Triage worklist

By default, the following types of encounters are not displayed on the *CDE Triage* worklist:

- Patient age is equal to or less than 18 years. It is driven from Org/Facility patient cutoff configuration.
- Outpatient encounters

Note: These are the default criteria. If your facility needs to modify any of the criteria, please contact *Nuance Support*.

Related reference

Triage Worklist Columns and Descriptions on page 51
Information in this section covers all the Triage Worklist columns. You can configure these columns.

Pediatric Prioritization

Based on the prioritization rules, the encounters are assigned with ranks between one and six, one being the highest priority, and six being the lowest. This rank is displayed in the **Rank** column of the Pediatric Worklist.

Table 30: Prioritization Rules

Rank	Description
1	Pediatric Encounters with Overdue Clarifications
2	Pediatric encounters with Pediatric Quality Alert and SOI(Severity Of Illness) equals to either 1 or 2
3	Untouched Pediatric encounters with Pediatric Quality Alert and SOI equals to either 3 or 4
4	Untouched Pediatric encounters with No Pediatric Quality Alert and SOI equals to 1
5	Follow up encounter with initial review present and SOI equals to either 1 or 2
6	Default rank rule

Appendix B

Auto Recovery

Topics:

About Auto Recovery

Auto recovery temporarily saves any changes that you have made in the encounter, but have not yet saved. It retains the unsaved changes and helps you retrieve them, in case of a computer crash, power failure, or technical error.

Note: Invalid codes in the working and possible review sections are also temporarily saved.

After every few seconds, the unsaved changes on the worksheet, review, clarification, and reconciliation screen gets temporarily saved, and at the bottom right corner of the screen, the **Last Temporary Save** date and time is displayed. Temporarily saved data which is older than 15 days get purged automatically.

Recover the Unsaved Changes

This section describes how to recover the unsaved changes for the selected encounter.

Recovering Your Unsaved Changes

1. Click on the account number to open the encounter.

   Important: If there are any unsaved saved changes in the encounter made by you, then the following message is displayed:

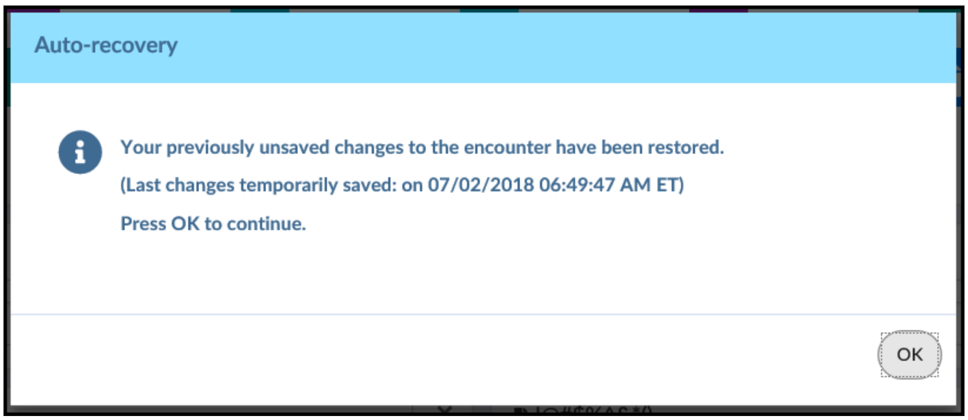


Figure 124: Auto-recovery Dialog Box

2. Click **OK**.
   The unsaved encounter changes in the *Worksheet*, *Review*, *Clarification* and *Reconciliation* screen are restored.

Recovering the Unsaved Changes from a Different CDS

1. Click on the account number to open the encounter.

   Important: If there are any unsaved saved changes in the encounter made by another CDS, then the following message is displayed:

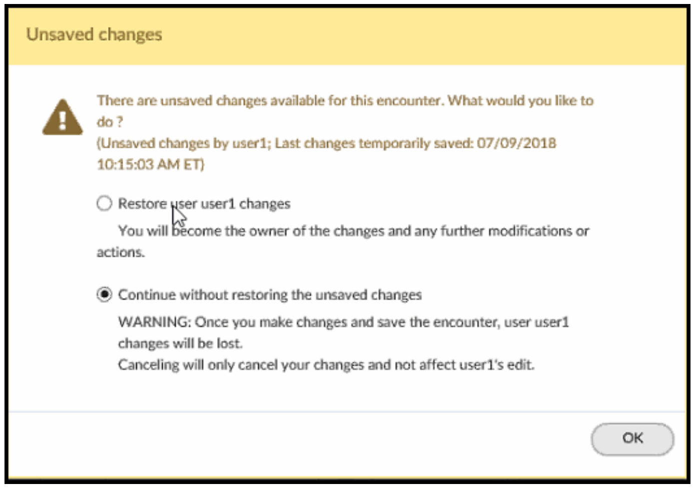


Figure 125: Unsaved Changes

2. Select either **Restore user xxx changes** to restore the draft, or select **Continue without restoring the unsaved changes** to open a blank encounter.
3. Click **OK**.

Warning: If you select the **Continue without restoring the unsaved changes** option, then any unsaved changes done by other CDS is not restored, and the unsaved change gets deleted when you save the encounter.

Appendix C

Recommended Search Tips

Topics:

Procedure Code Search Tips

Table 31: Procedure Code and Search Term

PCS Code	Definition	Code Search Term	IMO® Recommended Search Term
0SRC0J9	Replacement of Right Knee Joint with synthetic Substitute, Cemented, Open Approach	*TKR*	*knee repla*
5A1945Z	Respiratory Ventilation, 24-96 Consecutive Hours	*Mech Vent*	*respira vent*
0FT44ZZ	Resection of Gallbladder, Percutaneous Endoscopic Approach	*LAP Chole CDE*	*lapar cholec*
4A023N7	Measurement of Cardiac Sampling and Pressure, Left Heart, Percutaneous Approach	*Left Heart CathLeft LHC*	*cath left heart perct card sampl pres lef hea*
0SG00AJ	Fusion Lumbar joint with Interbody Fusion Dev, Post Approach Anterior Col, Open	*Lumbar Ant Fusion*	*post fus lumb ant inter*
027034Z	Dilation of Coronary Artery, One Artery with Drug-eluting Intraluminal Device, Percutaneous Approach	*PTCA DES*	*inser drug elut stent percut trans angiopla insert sten percut dilat corona arter drug elut*
0JH604Z	Insertion of Pacemaker, Single Chamber into Chest Subcutaneous Tissue and Fascia, Open Approach	*Pacemaker Sing Pacer Sing*	*open inse pace sing cham*
02H73JZ	Insertion of Pacemaker Lead into Left Atrium, Perc Approach	*Pacemaker lead + the site*	*percut insert pacem lead lef atr*
0JB90ZZ	Excision of Buttock Subcu/Fascia, Open Approach	*Excis Fasc Butt*	*excisi subcutaneous tissue and fas* **approach**: *open or perc*
0Y6J0Z3	Detachment at Left Lower Leg, Low, Open Approach	*Amp Low Leg* *Amp Low Leg Open*	*low leg ampu* **qualifier term**: *high, mid, low*
021209W	Bypass 3 Coronary Artery from Aorta with Autologous venous tissue, Open Approach	*Bypass 3 Cor Open Aorta*	*bypass coron art three open*

PCS Code	Definition	Code Search Term	IMO® Recommended Search Term
0B9J8ZX	Drainage of left lower lung lobe, via natural or artificial opening endoscopic, diagnostic	*Endo drainage lung*	*diag drain lung* **approach**: *open or endosc*
02RF08Z	Replacement of Aortic Valve with Zooplastic Tissue, Open Approach	*Zoo Val Repl*	*open replacement of aortic valve with zooplastic tissue*
0BTC0ZZ	Resection of Right Upper Lung Lobe, Open	*Lung Res R Up*	*open resect right up lung*
0SR9029	Replace of R Hip Jt with Synth Substitue, metal on polyethylene, Cement, Open Approach	*R Hip Repla Met*	*replace hip synth* **Approach, device type or qualifier term**: *open, metal, cement*
0W9G3ZZ	Drainage of Peritoneal Cavity, Percutaneous Approach	*Abd Para*	*abdomin paracents* *percut drain periton*
00B03ZX	Excision of brain, percutaneous, diagnostic	*BURR*	*burr hole biop brain* *need biop brain* *percut diag exci brai*
0DBN0ZZ	Resection of Sigmoid Colon, Open Approach	*Open Sig*	*open excis sigmo colo* *sigmoid colect*
0FBG0ZZ	Excision of Pancreas, Open Approach	*Excis Pan Op*	*excision pancreas*
0TY10Z0	Transplantation of Left Kidney, Allogeneic, Open Approach	*transplantation kid*	*open allog transpl lef kidn* *cad transpl lef kidn*
03CJ0ZZ 03CM0ZZ	Carotid Endarterectomy	N/A	*remove solid matter carotid artery*

PCS Code	Definition	Code Search Term	IMO® Recommended Search Term
0BBJ8ZZ	VATS wedge resection – left lower lobe lung	N/A	*endo exci lobe lung* **Approach or qualifier term**: *endo, diagn*
6A750Z7	ACOUSTIC PULSE THROMBOLYSIS WITH EKOS CATHETERS	N/A	*ultrasound therap*
02583ZZ	Diagnostic EPS and RF ablation of Atrial fibrillation	N/A	*card tot abl*
OJH 632Z	Loop recorder	N/A	*insert impl loop rec with card ele*
0B5N4ZZ	VATS Pleurodesis	N/A	*today until multiple map* **Functionality**: *lap pleurode of right ple spa percut endo destruct right pleura*
0B5P4ZZ	VATS Pleurodesis	N/A	*today until multiple map* **Functionality**: *lap pleur left sid percut endo destruct left pleura*
5A02210	Intra-Aortic Balloon Pump	N/A	*today until multiple map* **Functionality**: *cont assist card ball*
0DBP0ZZ	Proctectomy (partial)	N/A	*part protect ana* *open exc rect*
0DTP0ZZ	Proctectomy (complete)	N/A	*open proctect* *open resect rect* *compl proct abd appro*

Appendix D

Code Symbols

Topics:

Code Symbols

Table 32: Diagnosis Code Symbols and Descriptions

Code Symbol	Description
A	Agency for Healthcare Research and Quality (AHRQ) comorbidities.
C	Comorbidities or Complications that impact the DRG. **Note:** This is also known as **CC**.
C*	Comorbidities or Complications that do not impact the DRG. **Note:** This is also known as ******.
M	Major Complications that impact the DRG. **Note:** This is also known as **MCC**.
M*	Major Complications that do not impact the DRG. **Note:** This is also known as *****.
H	Hospital Acquired Condition (HAC) that impacts the DRG. (HAC with POA Indicator N or U).
HC	HCC or Hierarchical Condition Category
HR	RxHCC or Hierarchical Condition Category, medication related.
HIV	HIV related conditions.
X	Signifies that the code is excluded from ROM/SOI value (APR-DRG only).
P	IPF CC that impacts the DRG. Secondary condition that impacts the IPF DRG.
P*	MCC and IPF MCC that do not impact the DRG.
P**	Comorbidities or Complications and IPF CC that do not impact the DRG.
PC	Comorbidities or Complications that impact the IPF DRG.
PC*	Comorbidities or Complications that do not impact the IPF DRG.
PCC	Comorbidities or Complications and IPF CC that impact the DRG.

Code Symbol	Description
1-8	MST (Multiple Significant Trauma - Body Part). For example, when code S32.401A is entered, the number 6 will display between the M and HC symbols. Body Site Categories: • 1 - Head • 2 - Chest • 3 - Abdomen • 4 - Kidney • 5 - Urinary • 6 - Pelvis/Spine • 7 - Upper Limb • 8 - Lower Limb

Table 33: Procedure Code Symbols and Descriptions

Code Symbol	Description
NOR	Non-operative procedure the impact the DRG.
OR	Significant operative procedure that impact the DRG.
OR*	Significant operative procedure that does not impact the DRG.
POR	Significant operative procedure and IPF Complication or Comorbidity that impact the DRG.
POR*	Significant operative procedure and IPF Complication or Comorbidity that does not impact the DRG.

Appendix E

Coder View

Topics:

About Coder View

As a coder when you login to the application you have permission for the following:

- View the *Triage Worklist* screen in read-only mode
- Use the search Knowledge base functionality through *CDS Assistant* screen.
- View the *Worksheet* screen in read-only mode.
- Use *Index* search. *Clinical language* search is not available. You can
    - Select code for Code Level Notes.
    - Select code context menu for 'Search Knowledge Base' only.
    - Select code for DRG – Decision trees.
- View the *Clarifications* screen in read-only mode.
- View the *Reconciliation* screen in read-only mode.
- Use *Notes* screen and view notes of type
    - Coding to CDE
    - CDE to Coding

  Create a new note with type Coding to CDE.

  Use Reply Notes functionality.
- Print the encounter summary

Triage Worklist Screen - Coder View

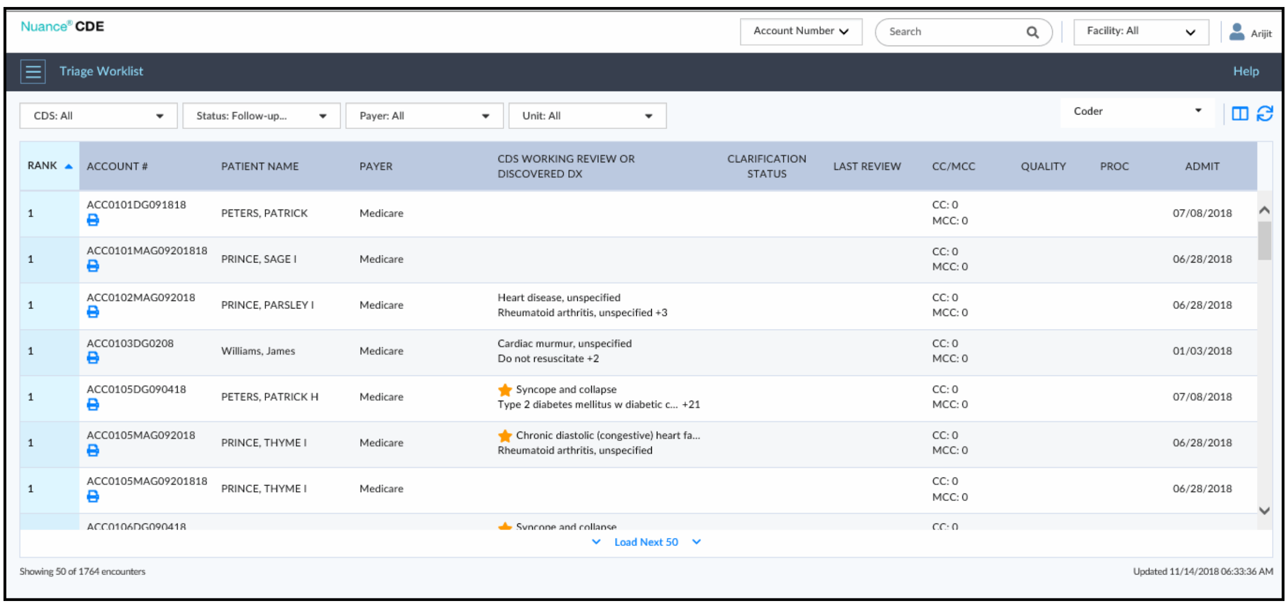


Figure 126: Triage Worklist Screen - Coder View

Table 34: Triage Worklist Columns and Descriptions

Worklist Columns	Descriptions
ACCOUNT#	Patient's account number **Note:** This is a mandatory column and is displayed by default.

Worklist Columns	Descriptions
ADMIT DX (Admitting Diagnosis)	Diagnosis at the time of the patient's admission. **Note:** Tooltip has been added to the values to show the code as well as description.
ADMIT SERVICE (Admitting Service)	Provider group/service where the patient is admitted to, such as Cardiology or Orthopedics.
ADMIT (Admit Date)	Patient's date of admission
AGE	Patient's age at the time of admission
PROVIDER (Attending Provider)	Name of the attending physician
CC/MCC	Number of CC/MCC codes added in the Working Review section in the *Review* screen. **Note:** CC/MCC count on worklist should reflect all CC/MCCs in the Review Screen (not just the impacting ones). When a red flag displays, you can click the flag to open CDS Assistant with CLU suggested CC/MCC codes displayed.
CDS	Name of the Clinical Documentation Specialist assigned to the encounter.
CDS WORKING REVIEW OR DISCOVERED DX	Displays suggested code with a blue hyperlink, and manually added codes with black font. Target diagnosis codes are displayed with a star(*). Partial codes are displayed in upper-case, and fully qualified codes are displayed in mixed-case (upper and lower). Click the link to display CLU suggested CC, HAC, MCC, and Target diagnosis codes in the CDS Assistant. When you add a primary diagnosis code in the Working Review and save, this column then displays that diagnosis description and is no longer a link. If there are more than two codes in the column, then the count of extra codes is displayed in the second row. **Note:** This is a mandatory column and is displayed by default. It cannot be removed.
Clinical Evidence (C.E.)	Number of clinical evidences available for the encounter.

Worklist Columns	Descriptions
Clarification Status	Status of open clarifications • **Due Today** - Follow up date is today. • **Due in (X) days** - Follow up date is tomorrow or later. • **Overdue** - Follow up date was yesterday or prior.
DOB (Date of Birth)	Patient's date of birth
DISCHARGE (Discharge Date)	Patient's date of discharge
FACILITY	Facility ID associated with the encounter.
Final Coded DRG	Final coded DRG either imported from the coding system or manually added in the *Reconciliation* screen. **Note:** If the final imported codes have an incomplete coding status, then the system will not display the final coded DRG.
FOLLOW-UP (Encounter Follow-up Date)	Date entered in the encounter **Follow-up Date** field.
LAST REVIEW (Last Review Date and Time)	Date and time the encounter was last saved.
LOS (Length of Stay)	Patient's duration of stay in a facility. Duration is displayed in number of days.
MRN (Medical Record Number)	Patient's Medical Record Number
PATIENT NAME	Patient's name
PAYER	Primary payer (insurance) associated with the encounter.
PROC (Procedures)	Indicates CLU suggested procedure codes. When a red flag displays, you can click the flag to open CDS Assistant with CLU suggested procedure codes displayed.
QUALITY	Indicates CLU suggested codes related to potential HAC, PSI, or Core Measure opportunity. When a red flag displays, you can click the flag to open CDS Assistant with CLU suggested HAC or PSI codes displayed.

Worklist Columns	Descriptions
RANK	Priority of encounter. This could be any number from 1 to 11. Refer Unranked and Exclusion Criteria on page 193, to know more about the types of encounters excluded from the prioritization ranking. **Note:** • This is a mandatory column and is displayed by default. It cannot be removed. • Prioritization ranking is displayed based on pre-configured rules.
ROOM	Patient's room number in a facility.
SOI	Severity of illness. For APR DRG grouper the system displays the value associated with the grouper, and for CMS grouper system displays the value associated with CMS grouper. The Possible SOI value is displayed, and if the PossibleSOI is not present, the system displays the WorkingSOI value. Suggested SOI value is displayed when working or possible SOI values are unavailable. Suggested SOI values appear as hyperlink. If you click these values, system navigates you to the CDS Assistant screen.
ROM	Risk of mortality. For APR grouper the system displays the value associated with the grouper, and for CMS grouper system displays the value associated with CMS grouper. The Possible ROM value is displayed, and if the Possible ROM is not present, the system displays the Working ROM value. Suggested ROM value is displayed when working or possible ROM values are unavailable. Suggested ROM values appear as hyperlink. If you click these values, system navigates you to the CDS Assistant screen.
STATUS	Status of the encounter. Refer to Encounter Status and Description on page 65.
UNIT	Unit assigned to the encounter.
VISIT TYPE	Patient's visit type. Following are typical visit types: • **I -** Inpatient • **O -** Outpatient

Worklist Columns	Descriptions
DRG	Calculated DRG value. Following are the types of DRG values displayed: • Working DRG • Possible DRG • Suggested DRG Suggested DRG is displayed only when Working or Possible DRG values are unavailable.

As a coder you can perform the following tasks:

- Customize the *Triage Worklist* screen, refer Setting-up the Triage Worklist Columns on page 67.
- Create a customized worklist, refer Creating a Custom Worklist on page 58.
- Print an encounter summary

Printing Encounter Summary

This section describes how to print the encounter summary from the *Triage Worklist* screen.

1. Click **Open/Print Encounter Summary**.
   The **Print Encounter** dialog-box is displayed.

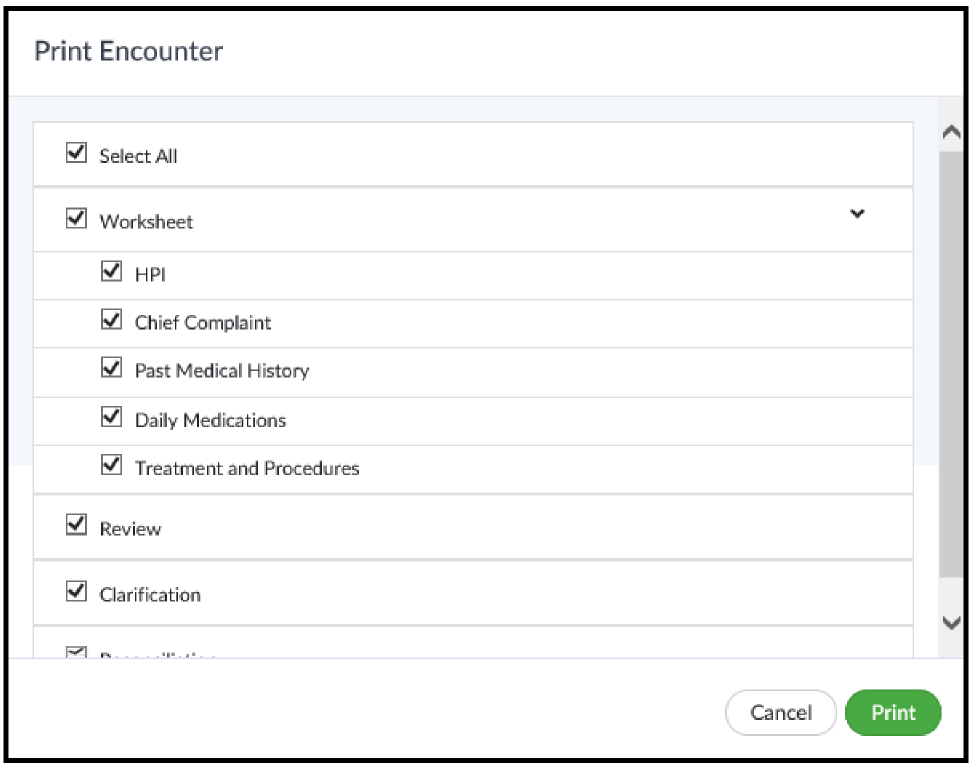


Figure 127: Print Encounter Summary Dialog-box

Note: By default all the checkboxes are selected. Although you can change the selection as per your need.

2. Click **Print**.
   The print preview window is displayed.

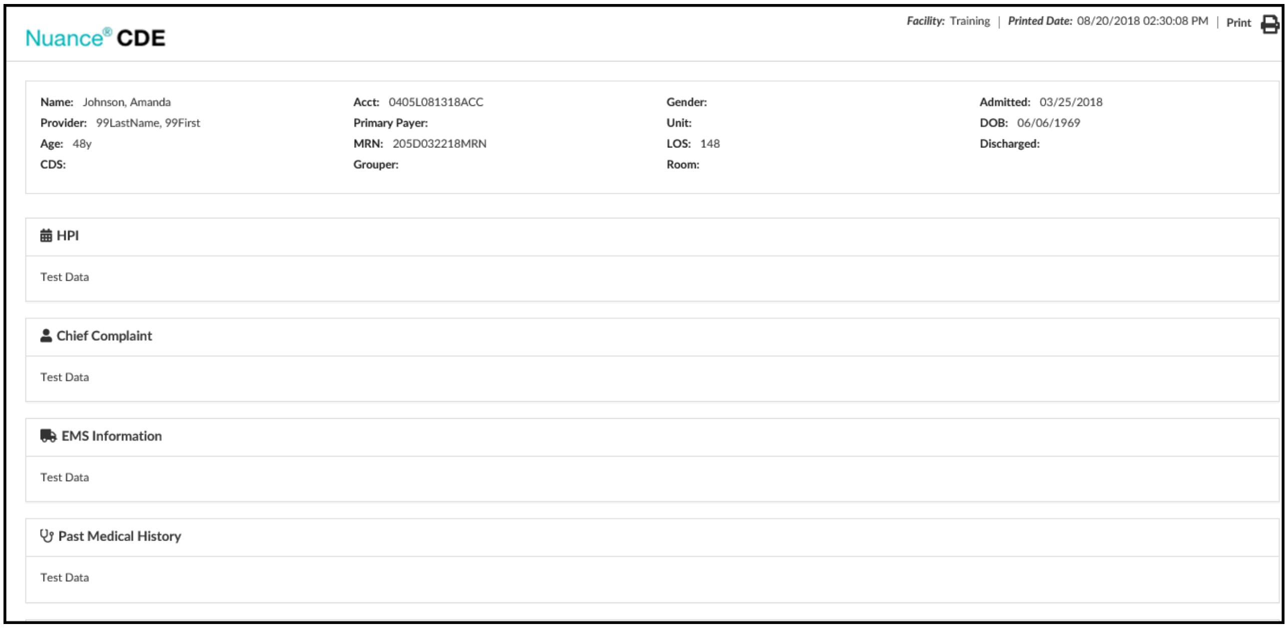


Figure 128: Print Preview Screen - Encounter

3. Click **Print**.
   The **Print** dialog-box is displayed.

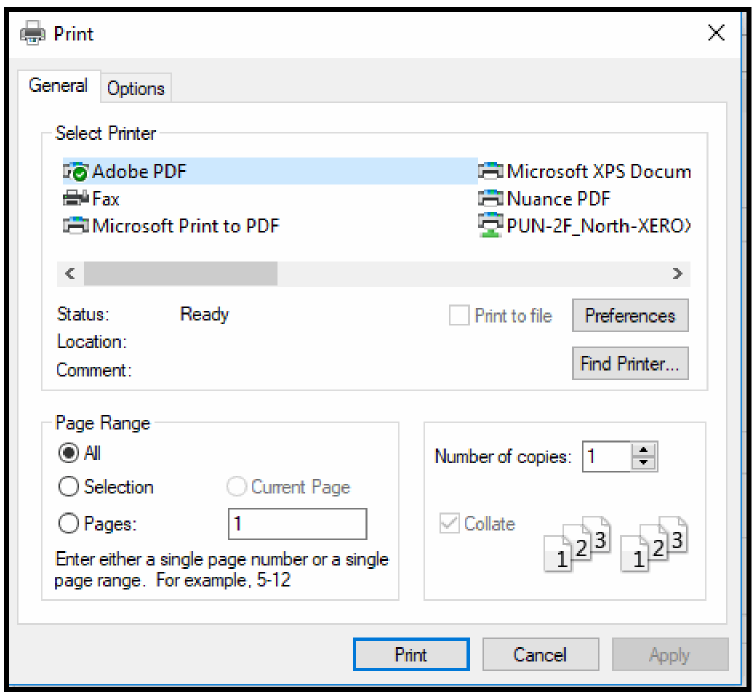


Figure 129: Print Dialog-box

4. Set the print settings for your desired print options.

   You can select the quantity of copies desired, page selection locations, page orientation (portrait to landscape and vice versa), and printer.
5. Click **Apply**, if you've made changes in the print setting.
6. Click **Print**.

Appendix F

Glossary Terms

Topics:

Glossary Terms for Nuance CDE

Table 35: Glossary Terms and Description

Term	Description
Admit Service	Provider group/service area where the patient was admitted to, such as Cardiology or Orthopedics.
Admit Source	Admit source associated to the encounter, such as Home or Rehab.
Base Rate	A dollar amount established for each hospital that is multiplied by the relative weight of a DRG to determine Medicare inpatient reimbursement. The base rate varies from hospital to hospital depending on the following factors: geographic location of the facility, hospital status, (e.g., teaching facility, urban or rural) and local costs of labor. This rate is adjusted annually.
Blended Rate	The base rate plus any add-on reimbursement factors (i.e., for indirect costs of medical education, capital acquisitions, and disproportionate share of Medicare patients).
CDI	Clinical Documentation Improvement: a process for improving the DRG coding information present in physician clinical documentation.
CDIS	Clinical Documentation Improvement Specialist.
CDS	Clinical Documentation Specialist: a person, typically a nurse, trained to read physician documentation and identify issues relevant to DRG coding as well as other issues such as Medical Necessity, Present on Admission, and Patient Safety Indicators. This person reviews clinical documentation, and provides feedback to, and queries physicians.
Clarifications	Another name for queries. These are questions generated by the CDS user and given to physicians.
CLU (Clinical Language Understanding)	An application of NLP (Natural Language Processing). It reads and understands clinical text and suggests code. This is reflected in snippets and documentation, as well as suggested codes and ranking in the Triage worklist.
CMS	Centers for Medicare and Medicaid Services.
Concurrent Review	CDS user adds a Working DRG to a new case prior to the Discharge Date of the encounter.
Core Measure	Set of care processes within a national, standardized performance measurement system, jointly implemented by TJC and CMS.
DRG (Diagnostic Related Group)	One of several categorizations of an inpatient that use sets of diagnosis and procedure codes to group these into a DRG category. The most common of these are MS-DRG and APR-DRG.
Evidence	Related to CLU. Actual words and associated values found in physician documentation. This is the highlighted text within a snippet or document.
Grouper	Software program used by both providers and payers to group each case into a DRG based on diagnosis, procedure codes and demographic information
HL7	Industry standard for communication between IT systems in health care. It refers to a method of sending documents and patient/visit metadata and updates between applications, such as CDI and the EHR.

Term	Description
Impact	Term used to describe the shifting of an encounter's DRG based on the intervention of a CDS.
Initial Review	CDS user adds a code to Working Review for the first time, which generates the Working DRG, and saves the record.
NLP (Natural Language Processing)	This is related to CLU. This is a field of computer science concerned with the interactions between computers and human languages; requires large amounts of domain knowledge, such as medicine and clinical practice.
PSI (Patient Safety Indicator)	Reportable quality indicators tied to value-based purchasing initiatives; these indicators are tied to harmful conditions and complications that should not occur after a patient is admitted.
Possible Review	Located in the *Review* screen, the list that contains codes with a DRG assignment reflecting potential code(s) and DRG assignment after CDS intervention. Note: if there is no impact, the DRG assignment will remain the same as shown in Working Review.
Queries	Another name for clarifications. These are questions generated by the CDS user and given to physicians.
Retrospective Review	CDS user adds a Working DRG to a new case on or after the Discharge Date of the encounter.
TJC (The Joint Commission)	An independent, not-for-profit organization. The Joint Commission accredits and certifies nearly 21,000 health care organizations and programs in the United States. Reflects an organization's commitment to meeting certain performance standards
Tokens	Related to CLU. Actual words and associated values found in physician documentation. This is the highlighted text within the document itself.
Value-based Purchasing	Initiative implemented by CMS that strives to align payment incentives with the quality of care and resources used to deliver care to encourage high-value health care.
Working Review	Located in the *Review* screen, the list that contains codes with a DRG assignment reflecting current documentation prior to CDS intervention.

Indexing Shortcuts

The Indexing Shortcuts can be used to search the index codes.

Table 36:

INDEXSHORTCUT DIAGNOSIS	CLINICAL TERM
AAA	ABDOMINAL AORTIC ANEURYSM
ABLA	ACUTE BLOOD LOSS ANEMIA
AF	ATRIAL FIBRILLATION
AKI	ACUTE KIDNEY INJURY
AMI	ACUTE MYOCARDIAL INFARCTION
AMS	ALTEREDMENTAL STATUS

INDEXSHORTCUT DIAGNOSIS	CLINICAL TERM
ARDS	ACUTE RESPIRATORY DISTRESS SYNDROME
ARF	ACUTE RENAL FAILURE
AS	AORTIC STENOSIS
ATN	ACUTETUBULAR NECROSIS
AVM	ARTERIOVENOUS MALFORMATION
CAD	CORONARY ARTERY DISEASE
CDIFF	CLOSTRIDIUM DIFFICILE (ENTEROCOLITIS)
CHF	CONGESTIVE HEART FAILURE
CKD	CHRONIC KIDNEY DISEASE
COPD	CHRONIC OBSTRUCTIVE PULMONARY DISEASE
CVA	CEREBROVASCULAR ACCIDENT
DIC	DISSEMINATED INTRAVASCULAR COAGULATION
DKA	DIABETESWITH KETOACIDOSIS (TYPE 1)
DM1	DIABETESMELLITUS TYPE 1
DM2	DIABETES MELLITUS TYPE 2
DVT	DEEP VEIN THROMBOSIS
ESRD	ENDSTAGE RENAL FAILURE
FTT	FAILURE TO THRIVE
HFpEF	DIASTOLIC HEART FAILURE
HFrEF	SYSTOLICHEART FAILURE
HHNK	HYPERGLYCEMIC-HYPEROSMOLAR HHNK NON-KETOTIC (DM2 WITH HYPEROSMOLARITY)
HTN	HYPERTENSION
IBS	IRRITABLE BOWEL SYNDROME
ILD	INTERSTITIAL LUNG DISEASE
ITP	IDIOPATHIC THROMBOCYTOPENIC PURPURA
MR	MITRAL REGURGITATION
MDS	MYELODYSPLASTIC SYNDROME

INDEXSHORTCUT DIAGNOSIS	CLINICAL TERM
MS	MULTIPLE SCLEROSIS
NSCLC	NON-SMALL CELL LUNG CARCINOMA
NSTEMI	NON-ST ELEVATION MYOCARDIAL INFARCTION
OA	OSTEOARTHRITIS
OHS	OBESITY HYPOVENTILATION SYNDROME
OSA	OBSTRUCTIVE SLEEP APNEA
PE	PULMONARY EMBOLISM

Table 37:

INDEXSHORTCUT DIAGNOSIS	CLINICAL TERM
PAD	PERIPHERAL ARTERIAL DISEASE
PVD	PERIPHERAL VASCULAR DISEASE
SAH	SUBARCHNOID HEMORRHAGE
SBO	SMALL BOWEL OBSTRUCTION
SDH	SUBDURAL HEMORRHAGE
SIADH	SYNDROME INAPPROPRIATE SIADH SECRETION ANTIDIURETIC HORMONE
SIRS	SYSTEMICINFLAMMATORY RESPONSE SYNDROME
SSS	SICKSINUS SYNDROME
STEMI	ST-ELEVATION MYOCARDIAL
SVT	SUPRAVENTRICULAR TACHYCARDIA
TIA	TRANSIENT ISCHEMIC ATTACK
TLS	TUMOR LYSIS SYNDROME
TR	TRICUSPID REGURGITATION
URI	UPPER RESPIRATORY INFECTION
UTI	URINARY TRACT INFECTION
VF	VENTRICULAR FIBRILLATION
VT	VENTRICULAR TACHYCARDIA
WPW	WOLFF-PARKINSON-WHITE SYNDROME

INDEXSHORTCUT DIAGNOSIS	CLINICAL TERM
AKA	ABOVE KNEE AMPUTATION (DETACHMENT)
BKA	BELOWKNEE AMPUTATION (DETACHMENT)
CABG	CORONARY ARTERY BYPASS
CEA	CAROTID ENDARTERECTOMY (EXTIRPATION)
ORIF	OPEN REDUCTION INTERNAL FIXATION (REPOSITION)
TAH	TOTAL ABDOMINAL HYSTERECTOMY (RESECTION)
TAVR	TRANSAPICAL AORTIC VALVE REPLACEMENT
THR	TOTAL HIP REPLACEMENT
TKR	TOTAL KNEE REPLACEMENT
WHIPPLE	PANCREAS EXCISION

Appendix G

Third Party License Agreements

CDE One is accompanied by, or makes use of, the following software:

Table 38: Product and Services

Service	Vendor	Purpose
Azure Platform Services	Microsoft	Azure PAAS and infrastructure services
Azure Service Bus	Microsoft	Messaging
Federated Single Sign-on	Auth0	Authentication & authorization platform for web, mobile and legacy applications
IMO Search	IMO	Code search
Power BI	Microsoft	Analytics and Reporting
Prometheus	Prometheus	Application Monitoring
Sumo Logic	Sumo Logic	Log file management
3M GPCS	3M	Grouping service

Table 39: Framework

Software	Version	Tier	Open Source	Vendor/ Author	License
Apache CXF - JAX-RS and JAX-WS API	3.1.9	Server	Yes	Apache	Apache License 2.0
Bootstrap	4.2.1	Client	Yes	Open Source	MIT License
Elastic Search	5.6.1	Server	Yes	Elastic Co	Apache License 2.0
Hibernate ORM	5.2	Server	Yes	JBoss	LGPL 2.1

Software	Version	Tier	Open Source	Vendor/ Author	License
Jersey JAX-RS API	2.25	Server	Yes	Oracle	CDDL Version 1.1
Log4j	2.11.1	Server	Yes	Apache Software	Apache License 2.0
MobX	4.9.2	Client	Yes	MobxJS	MIT License
MobX React	5.4.3	Client	Yes	MobxJS	MIT License
Microsoft Azure Service bus Queue	1.2.6	Server	Yes	Microsoft	MIT License
React	16.7.0	Client	Yes	Facebook	MIT License
Slf4j	1.7.21	Server	Yes	Quality Open Software	MIT License
Spring	4.3.4	Server	Yes	Pivotal	Apache License 2.0

Table 40: Library

Software	Version	Tier	Open Source	Vendor/ Author	License
Commons IO	2.5	Server	Yes	Apache Software	Apache License 2.0
Commons Lang3	3.5	Server	Yes	Apache	Apache License 2.0
Commons-csv	1.5	Server	Yes	Apache	Apache License 2.0
Commons-fileupload	1.3.3	Server	Yes	Apache	Apache License 2.0
EHCache	2.10.3	Server	Yes	Software AG	Apache License 2.0
ES6-Promise	4.0.5	Client	Yes	Stefan Penner	MIT License
Failsafe	2.0.1	Server	Yes	Jonathan Halterman	Apache License 2.0

Software	Version	Tier	Open Source	Vendor/ Author	License
Font Awesome	5.7.1	Client	Yes	Open Source	The Font Awesome Pro commercial license
GSON - json processing API	2.8.0	Server	Yes	Google	Apache License 2.0
Jackson - data binding and streaming API	2.8.0	Server	Yes	FasterXML	Apache License 2.0
JSON-java	20141113	Server	Yes	Sean Leary	JSON
Microsoft Azure Active Directory Authentication Library (ADAL) for Java	1.3.0	Server	Yes	Microsoft	MIT License
Moment	2.24.0	Client	Yes	Moment	MIT License
Nimbus Jose + JWT	5.7	Server	Yes	Connect2id	Apache License 2.0
OpenCSV	4.0	Server	Yes	Apache	Apache License 2.0
Pac4j-oidc	3.1.0	Server	Yes	Pac4j.org	Apache License 2.0
Power Bi-Client	2.6.5	Client	Yes	Microsoft	MIT License
Prometheus JVM Client	0.4.0	Server	Yes	Prometheus	Apache License 2.0
Prop-types	15.6.2	Client	Yes	Facebook	MIT License
React Router	4.2.3	Client	Yes	ReactTraining	MIT License

Software	Version	Tier	Open Source	Vendor/ Author	License
Redis (Or Redis Azure Service)	3.0	Server	Yes	MS OpenTech	MS Open Tech
Xpack	5.6.1	Server	No	Elastic/Xpack	X-Pack License
Jquery	3.3.1	Client	Yes	Jquery	MIT License
OWASP Java Encoder	1.2.2	Server	Yes	Owasp	BSD license
Clipboard	2.0.4	Client	Yes	Zeno Rocha	MIT License
react-dom	16.7.0	Client	Yes	Facebook	MIT License
popper.js	1.14.7	Client	Yes	FezVrasta	MIT License
Jquery-UI	1.12.1	Client	Yes	JQuery	JQuery Foundation

Table 41: Programming Language

Softwar	Version	Tier	Open Source	Vendor/ Author	License
Java 8	1.8.0.111	Server	Yes	Oracle	Oracle Binary Code License

Table 42: UI Shim

Software	Version	Tier	Open Source	Vendor/ Author	License
Babel-polyfill	6.26.0	Client	Yes	Babel	MIT License

Table 43: UI Component

Software	Version	Tier	Open Source	Vendor/ Author	License
Draft-js	0.10.5	Client	Yes	Facebook	BSD License
React-select	2.3.0	Client	yes	Jed Watson	MIT License
React-dates	18.4.0	Client	Yes	Airbnb	MIT License
React-helmet	5.2.0	Client	Yes	NFL	MIT License
React-tabs	2.3.0	Client	Yes	reactjs	MIT License

Software	Version	Tier	Open Source	Vendor/ Author	License
React-beautiful-dnd	10.04	Client	Yes	Atlassian	Apache License, Version 2.0

Table 44: Web Server

Software	Version	Tier	Open Source	Vendor/ Author	License
Apache Tomcat	8.5.20	Server	Yes	Apache Software	Apache License 2.0