# Manually Coding an Admission (for 3rd party tool)

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This describes the process to manually code an admission. Coding of an Admission can be completed in two ways:

- Via the Patient record
- Via the Clinic location

To complete the coding, the coder (or staff member) manually updates the DRG code details against the patient admission. This requires the use of a 3rd party product (external to CareRight) to determine the correct DRG code. An Admission is considered "Coded" once it has been discharged and has been grouped (the DRG (diagnosis\_related\_group) updated. This process assumes the patient has been discharged.

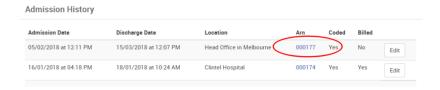
## System Administration Setup

To ensure that the user/coder has access to the Admission Details summary page via Locations, the "Can edit ATS details" permission/privilege setting needs to be enabled via Users and Groups.

#### Via Patient Record

- 1. From the CareRight Dashboard.
- 2. Select Patients from the menu.
- 3. Enter the patient name/mrn etc. (e.g., John Smith).
- 4. Select **Search** button, matching account will display.
- 5. Select Show button to access the Patient summary and menu.
- 6. Select **Admissions** menu item, the Active admissions & Admission history will display.
- 7. Select the ARN (Admission Record Number) link to open the admission details.
- 8. To complete the admission for coding it requires the following to be updated:
  - a. Diagnoses
  - b. Procedure

- 9. Select the Edit Admission button
- 10. Scroll down through the admission to add Diagnosis & Procedures.
  - a. Note: These values can be added dynamically, start typing each code into the relevant field. You can add multiple codes.
- 11. 'Update' the Admission
  - a. The admission is ready to be grouped.



# Grouping the Admission (Manually)

If you are coding manually, you will need to utilise your 3rd party software to obtain the DRG code.

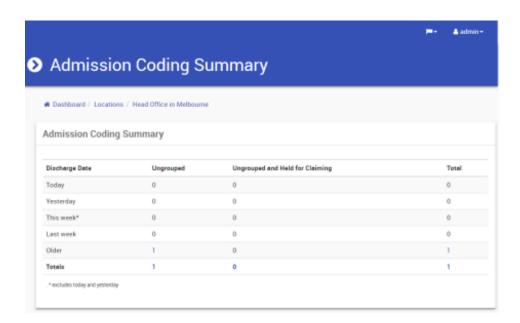
- 1. To manually add the DRG code in CareRight, you need to edit the Admission.
- 2. Select the **Edit Admission** button, scroll down to the Diagnoses section.
  - a. The Grouper Version will default to the value set in System Administration.
- 3. Enter the DRG code into the Diagnosis Related Group (DRG) field.
- 4. Scroll to the bottom of the page and click Update.
  - a. The admission is now considered to be grouped.



#### Via Location

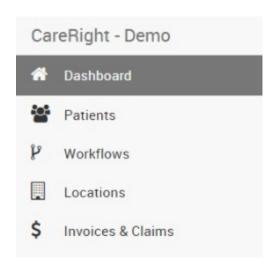
This approach allows for the coder to access all patient admissions to be coded from a central area.

- 1. From the CareRight Dashboard.
- 2. Select Locations from the menu.
- 3. Select relevant clinic location from the list.
- 4. Select Admission Coding from the menu.
  - a. The Admission Coding Summary will display.
- 5. Select the count hyperlink, the Admissions screen will display. This screen will show all uncoded Admissions with relevant details including Patient name.
- 6. Click Select the **ARN** (Admission Record Number) link against each patient to open the admissions details.
- 7. Scroll down through the admission to update the Diagnosis and Procedure sections.
- 8. The admission can be manually coded as per the process above (via Patient).





Uncoded / Ungrouped Admissions can also be accessed via the Invoices and Claims screen from the main CareRight dashboard. A message under the IHC claims table states: "Uninvoiced counts exclude Admissions that have not been coded/grouped yet" with a link to Admissions Coding Summary screen.



### Tips & Tricks

If you are accessing multiple admissions from the Admission Coding Detail summary, rather than click the ARN hyperlink (which takes you directly to the patient record). Follow these steps:

- 1. Hover the mouse cursor over the link and right-click.
- Select Open Link in a New Tab this will open a new web browser tab within the Patient Admission screen.
- 3. When done coding the admission, return to the original tab and repeat the process.
- 4. Between steps, click F5 to refresh the Admission Coding Detail summary.

