VA Butler Healthcare
Butler, PA

Medical Center Memorandum IM-06
February 1, 2013

PATIENT CARE DATA CAPTURE

I. PURPOSE: To provide guidelines for VA Butler Healthcare staff to follow to assure accurate and timely completion of patient care encounter data.

II. POLICY: The facility, in accordance with VHA policy, will capture and report inpatient appointments in outpatient clinics, inpatient billable professional services, and outpatient care data to support the continuity of patient care, resource allocation, performance measurement, quality management, provider productivity, research, and third-party payer collections.

III. PROCEDURES:

A. Workload data must be captured through electronic means, including electronic encounter forms, event capture, and the laboratory, radiology and surgery packages. Clinical documentation must be captured using national or locally developed electronic documentation templates.

B. Locally developed documentation templates must meet national and local documentation standards, and must be reviewed and updated by the facility annually.

C. Locally developed documentation templates will include, at a minimum, the following required elements:

1. Chief complaint which is the presenting problem(s) or reason for visit
2. History and objective data relative to the chief complaint
3. Assessment of the problem(s)
4. Treatment plan
5. Diagnoses treated, or that require further treatment and/or evaluation
6. Reason for ordering tests, consults, or changes in medication
7. Follow-up treatment and patient instructions

D. Locally developed electronic encounter forms are formally reviewed and updated by local clinical and qualified staff twice a year, once in October for the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) update and once in January for the Current Procedural Terminology (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) updates. Other updates to electronic encounter forms will be made as needed.

E. Radiology and laboratory packages are reviewed annually to verify code associations.

F. Sites using dictation will configure Text Integration Utility (TIU) and the Computerized Patient Record System (CPRS) to ensure that electronic encounter forms are available without the requirement to start or sign a progress note.

G. Entry of the required data must be based on documentation by the provider in the progress note for the encounter.

H. Electronic encounter form data entry must be performed by providers except in those situations where the responsibility has been given to qualified coding professionals for coding encounters.

I. Electronic encounter form data entry is to be entered on the same date as the encounter.

J. Facility staff will set up and maintain clinics assuring the accurate Decision Support System (DSS) identifiers are assigned. The set up of providers and clinic profiles and DSS identifier(s) will be confirmed with facility DSS staff and will accurately reflect the health care members for that clinic. Workload and data accuracy requirements necessitate accurate reporting of encounters.

K. Inpatient and outpatient encounter data will be transmitted to the National Patient Care Database (NPCD) at the Austin Automation Center (ACC), Austin, TX, and accepted to meet the close out date.

IV. PROCEDURES:

A. New clinic set ups and changes to established clinics will be done in accordance with PIMS V. 5.3 Scheduling Module User Manual, May 2005.

B. The provider will:

1. Provide documentation in the medical record in accordance with facility policy and the by-laws, ensuring the documentation is linked to the appropriate visit.

2. Complete the electronic encounter with diagnoses, visit type and/or procedures, designation of primary provider, and completion of classification questions on the date of service.

C. Clinic support staff will monitor scheduled appointments for no-shows and cancellations and make necessary entries into the Appointment Scheduling software.

D. Designated “Point of Contacts” will:

1. Generate the Encounter 'Action Required' Report (SCRPW ACTION REQUIRED REPORT) and notify providers daily of their open encounters.

2. Ensure provider completes encounter prior to close out date.

3. Generate the Incomplete Encounter Error Report (SCENI IEMM ERROR REPORT) of encounters rejected due to administrative errors and take necessary action to correct encounters.

4. Assure all encounters are transmitted daily and accepted no later than seven (7) days after visit. Providers will not receive workload for encounters that have not met the seven (7) day requirement.

5. Provide education, as needed, to providers responsible for completing encounters.

E. Chief, Health Information Management (HIM) or designee will review and update encounter forms in October and January as well as when needs arise.

F. Medical Records Committee (MRC) will approve the creation of newly created, locally developed documentation templates in accordance with their established procedures.

V. RESPONSIBILITIES:

A. Director is responsible for ensuring points of contacts are assigned for all clinical areas.

B. Associate Director is responsible for ensuring:

1. That all clinics are using the appropriate DSS identifiers.

2. That an annual review and update of locally developed documentation templates are performed.

3. That National and any locally developed electronic encounter forms are reviewed and updated twice a year when code changes occur.

4. That the data is transmitted and accepted by the close-out date.

C. Chief of Staff is responsible for ensuring:

1. That all medical and consultant staff document clinical information in conformance with facility documentation policies and by-laws.

2. That all encounter check out information is entered on date of service to guarantee transmission and acceptance of data by close-out date.

D. Associate Director/Patient Care Services is responsible for ensuring:

1. That nursing and clinical support staff document in accordance with facility documentation policies and that encounter data is entered in a timely manner to assure data transmission and acceptance by the close out date.

2. Ensuring that clinic support staff monitor and cancel appointments and indicate “No Shows” appropriately and timely to prevent these types of appointments from appearing on the Encounter 'Action Required' Report.

E. Program Managers and supervisors are responsible for ensuring that staff are aware and comply with the intent of this policy, including the management of appointments specific to their service.

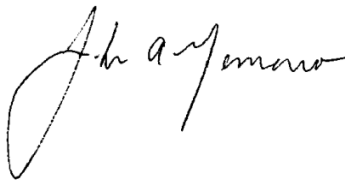
F. Physicians, physician extenders, and other healthcare staff are responsible for:

1. Providing care within their approved scope of clinical privileges and/or practice.

2. Proper documentation and completion of the electronic encounter on the date of service.

VI. REFERENCES: VHA Directive 2011-025, Closeout of Veterans Health Administration Corporate Patient Data Files Including Quarterly Inpatient Census and VHA Directive 2009-002, Patient Data Care Capture.

VII. RESCISSION: None



JOHN A. GENNARO
Director

(Automatic Review Date: February 1, 2016)

ATTACHMENT A

DEFINITIONS

Action Required: This is the terminology used to indicate an encounter that is incomplete. The provider will not receive workload credit; the facility will not receive reimbursement through Veteran Equitable Resource Allocation (VERA), the Veteran's third party reimbursable health insurance plan, and any first party copays the Veteran may be responsible for.

Active Problems: Problem and/or diagnosis(es) treated that relate to the encounter are required to be reported as ICD-9-CM codes for each encounter. A minimum of one is required. When more than one active problem or diagnosis is designated for an encounter, the practitioner must determine which one is the primary reason the patient sought treatment at that encounter. Additional diagnoses or conditions that were treated, evaluated, or affected the treatment of the patient during the encounter must be included as additional secondary codes. Only the codes are transmitted to NPCD. Guidelines published by the American Hospital Association, ICD-9-CM, and the National ICD-9-CM coding conventions and guidelines must be followed for ICD-9-CM code assignment.

Classification Questions: The determination of whether or not a treatment was related to an adjudicated service-connected condition or treatment of conditions related to exposure and/or experience for (Agent Orange, Ionizing Radiation, Military Sexual Trauma, Combat Veterans, or Environmental Contaminants) must be based on all conditions treated during the encounter and the entire encounter will be designated service-connected or designated as being related to the special categories, if any treatment related to these conditions was provided.

Collateral Services: Collateral services are services provided to persons other than the patient as part of the patient's care (such as family therapy). They are not to be reported separately. Collateral services provided directly to the collateral (for example, to the spouse) separate from the patient must be reported separately for the collateral, i.e., stress reduction skills.

Date and Time of Service: The actual date and time that the encounter or service was scheduled to occur. Time is a single entry indicating the time the encounter was scheduled to occur. This data element is taken from the Appointment Scheduling software. When unscheduled encounters are entered, the date and time that the encounter is entered into VistA is what is used as the encounter date and transmitted. The date and time data elements must be identical in VistA and NPCD.

Encounter: An encounter is a professional contact between a patient and a practitioner with the primary responsibility for diagnosing, evaluating, and/or treating the patient's condition. Encounters occur in both the outpatient and inpatient setting. Contact can include face-to-face interactions or those accomplished via telemedicine technology.

Occasion of Service: An "occasion of service" is a specified identifiable instance of an act of technical and/or administrative service involved in the care of a patient or consumer which is not an encounter; that is, does not include the exercise of independent medical judgment in the

overall diagnosing, evaluating, and/or treating the patient's condition. (Note: Occasions of service replace the previously used term "ancillary services"). Examples of "occasion of service" include Clinical laboratory tests, radiological studies, physical medicine interventions, medication administration, and vital sign monitoring.

Patient: The person receiving health care services.

Practitioner: Health care staff providing services to the patient. This includes medical staff providers, patient care services staff, and staff of all other clinical services.

Service Provided: Services provided to the patient by the practitioner must be fully supported by medical documentation. Only nationally accepted coding systems such as Current Procedural Terminology 4 (CPT-4) codes and Health Care Procedure Coding System (HCPCS) codes are to be used to reflect all services provided by applicable practitioners, including modifiers, when appropriate. Guidelines established by the American Medical Association must be followed for CPT-4 code assignment.

- The supervising or attending physician is to be listed as the primary provider for all encounters. Other providers or practitioners need to assign themselves as the secondary provider. Use of Evaluation & Management (E&M) codes require that certain criteria be met within the coding guidelines. Those practitioners licensed and privileged within the scope of their practice may limit the use of many E&M codes.

- Guidelines published by the Centers for Medicare & Medicaid Services (CMS) in general are followed for HCPCS code assignment.

- Code assignment must depict services rendered and documented. Only providers or qualified coders are to complete or edit encounters.

Telemedicine and/or Telehealth Services: Telemedicine is generally described as the use of communication equipment to link health care practitioners and patients in different locations. This technology is used by health care providers for many reasons, including cost efficiency, reduced transportation expenses, improved patient access to specialists and mental health providers, improved quality of care, and better communication between providers. For Veterans Health Administration purposes, a telemedicine contact between a practitioner and a patient is considered an encounter if the specific conditions are met as outlined in DSS instructions for Telemedicine.

Telephone contact: Contact between a practitioner and a patient is only considered an encounter when the telephone contact is documented and that documentation includes the appropriate elements of a face-to-face encounter, namely history and medical decision-making. Telephone encounters must be associated with a telephone clinic that is assigned one of the DSS telephone three-digit identifiers. Telephone encounters are to be designated as non-billable and are count clinics. (Note: "Count" refers to workload that meets the definition of an encounter or an occasion of service).

Visit: "Visit" is used for the purpose of reporting services provided to a Veteran and/or patient in a 24-hour period; for example, the visit of an outpatient to one or more clinics or units with one calendar day at the facility level, including the station number and the suffix identifiers (i.e., for facilities, visits are to be reported at the three digit station level, for visits reported; for instance, at Community Based Outpatient Clinic's it must include the suffix).

Workload Only: Situations may exist which are workload only. That is, they meet neither the definition of an encounter nor an "occasion of service". "Workload only" clinics within the scheduling application need to be set to non-count and non-billable. These are tracked for workload only (internal use), and are neither an encounter nor an occasion of service.