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PATIENT CARE DATA CAPTURE

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes the policy requiring the capture of all outpatient encounters, inpatient appointments in outpatient clinics, and inpatient billable professional services.

2. BACKGROUND

a. Since October 1, 1996, VHA facilities have been required to report all electronic data concerning the provision of services in VHA facilities, which included outpatient data, to the National Patient Care Database (NPCD) in Austin, TX. This Directive expands that requirement to include the capture of inpatient encounters for patients seen in outpatient clinics and inpatient billable professional services. When available, VHA is to utilize data definitions for clinical and administrative data promulgated by internationally and nationally-recognized standard setting organizations (e.g., American Society for Testing and Materials, American National Standards Institute (ANSI), American Health Information Management Association (AHIMA), etc.).

b. VHA information systems have been modified to enable the transmission of all encounters (both inpatient and outpatient) from Patient Care Encounter (PCE) to the NPCD. VHA facilities must ensure that all encounters in the outpatient setting as well as inpatient appointments in outpatient clinics and inpatient billable services are identified, coded, completed, and reside in the PCE package for transmission to NPCD.

c. All coded data for an encounter may not be billable. Third-party payers have business rules that require health care data to be submitted in a specific format before the claim for payment can be adjudicated. As such, there will be specific circumstances where the code sequence or codes in PCE, do not match 1:1 with the bill created in the Integrated Billing package.

d. VHA facilities utilize a variety of software packages to capture inpatient and outpatient workload. Regardless of software package utilized, all data must also pass, or be transferred, into PCE (if not directly entered into PCE).

e. Each clinic must be set up with the appropriate Decision Support System (DSS) Identifier. Utilized both locally and nationally, they describe DSS work units or DSS products. The DSS Program Office is responsible for maintaining and nationally distributing the list of DSS identifiers (see the current VHA policy). DSS identifiers are updated annually to appropriately identify encounters.

f. For VHA purposes, a Department of Veterans Affairs (VA) medical center, to include its identified divisions and Community-based Outpatient Clinics (CBOCs), is considered to be the business entity furnishing health care at the organizational level. Sub-organizational-level entities by which data needs to be retrievable include: parent and community site, specific clinic (regardless of whether the site has more than one type of station suffix, for example a CBOC),

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treatment team, and individual practitioner. A Person Class taxonomy code for each provider with the VA medical center and VA medical center division code is reported to the NPCD.

g. **Definitions.** The following definitions apply to PCE data:

(1) **Licensed Practitioner.** A licensed practitioner is an individual at any level of professional specialization who requires a public license and/or certification to practice the delivery of care to patients. A practitioner can also be a provider.

(2) **Non-Licensed Practitioner.** A non-licensed practitioner is an individual without a public license or certification who is supervised by a licensed and/or certified individual in delivering care to patients.

(3) **Provider.** A provider is a business entity that furnishes health care to a consumer; it includes a professionally-licensed practitioner who is authorized to operate in a health care delivery facility.

(4) **Encounter.** An encounter is a professional contact between a patient and a practitioner vested with primary responsibility for diagnosing, evaluating, and/or treating the patient's condition. Encounters occur in both the outpatient and inpatient setting. **NOTE:** *Previously, workload capture of encounters was only required in the outpatient setting.*

(a) Contact can include face-to-face interactions or those accomplished via telemedicine technology.

(b) Use of e-mail is to be limited and does not constitute an encounter at this time. As e-mail communications are not secure, e-mail must not contain patient specific information. **NOTE:** *In the future, when secure methods of e-mail communication for health care are widely used to ensure privacy and security of patient information, inclusion of e-mail interactions between patients and providers should be re-evaluated. E-mail is not be used to communicate urgent matters.*

(c) Encounters are neither occasions of service nor activities incidental to an encounter for a provider visit. For example, the following activities are considered part of the encounter itself and do not constitute encounters on their own: taking vital signs, documenting chief complaint, giving injections, pulse oximetry, etc. Activities that are an integral part of an encounter are not to be reported in a separate encounter. A patient may have multiple encounters per inpatient admission or outpatient visit.

(d) A telephone contact between a practitioner and a patient is only considered an encounter if 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 meet the definition of an encounter or an occasion of service.*

(5) **Telemedicine and or Tele-health 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 among providers. For VHA purposes, a telemedicine contact between a practitioner and a patient is considered to be an encounter if the specific conditions are met as outlined in DSS instructions for Telemedicine. *NOTE: Refer to VHA policy and instructions on Telemedicine and Telehealth Services.*

(6) **Collateral Services.** Collateral services are services provided to persons other than the patient as a 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.

(7) **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(s). *NOTE: Occasions of service replace the previously used term "ancillary services."*

(a) Occasions of service are the result of an encounter (e.g., tests or procedures ordered as part of an encounter). Clinical laboratory tests, radiological studies, physical medicine interventions, medication administration, and vital sign monitoring are all examples of occasions of service.

(b) A patient may have multiple occasions of service per encounter.

(c) Some occasions of service, such as clinical laboratory and radiology studies and/or tests, are automatically loaded to the PCE database from other Veterans Health Information Systems and Technology Architecture (VistA) packages.

(d) To appropriately identify occasions of service, DSS identifiers are updated annually.

(8) **Statistic Only (formerly known as workload only).** Situations may exist which are "workload only." That is, they meet neither the definition of an encounter nor an "occasion of service." "Statistics 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.

(9) **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 within 1 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 CBOCs it must include the suffix (STA6A)).

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e. In addition to the current administrative data elements, such as: eligibility, period of service and service-related condition information, patient address, next-of-kin, etc; the minimum clinical data elements required to constitute an encounter or occasion of service are as follows:

(1) **Patient.** The person receiving health care services.

(a) Veterans Health Information Systems and Technology Architecture (VistA). The full legal name, date of birth, Social Security Number (SSN) or pseudo-SSN, eligibility, etc.

(b) NPCD. The full legal name, date of birth, SSN, or pseudo-SSN, eligibility, etc.

(2) **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 that 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, but for scheduled appointments that date will be the date services are actually provided, (e.g., when the appointment is checked out, when the laboratory test is performed, etc.).

(3) **Practitioner.** See the definition in preceding paragraphs. VistA stores specific practitioner information from the New Person and Person Class files for an individual provider. In order for encounters to be transmitted, each practitioner must be designated within the NEW PERSON FILE with a correct defined specific practitioner type from the PERSON CLASS FILE; this applies to all: physicians, nurse practitioners, physician assistants, and other licensed health care providers as well as those non-licensed providers that provide patient care. **NOTE:** *Refer to the current VHA policy.*

(4) **Place of Service.** Information about the location where the service was provided. In both VistA and NPCD, this includes the three-digit medical center and/or station identifier, with any applicable suffixes (STA6A), as well as the DSS Identifier(s). In the future, place of service must include the five-character medical center national VHA division value. The division value must reflect the location where care was provided.

(5) **Active Problems.** Problem and/or diagnosis(es) treated that relate to the encounter are required to be reported as International Classification of Diseases, 9th Revision, Clinical Modification (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 affected the treatment of the patient during the encounter need to be included as additional secondary codes.

(6) **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, or Military Sexual Trauma, Combat Veterans, 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. VistA maintains and stores text descriptions along with coded values. Only the coded values are transmitted to NPCD.

NOTE: *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.*

(7) **The Service Provided.** Services provided to the patient by the practitioner or provider must be fully supported by medical documentation. Only nationally-accepted coding schemes, such as full Current Procedural Terminology (CPT)-4 codes and Healthcare Common Procedural Coding System (HCPCS) Level II codes are to be used to reflect all services provided by applicable practitioners, including modifiers when appropriate. VistA maintains and stores text descriptions along with the coded values. Only the coded values are transmitted to NPCD.

(a) Guidelines published by the American Medical Association (AMA) must be followed for CPT-4 code assignment.

(b) 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. **NOTE:** *Use of evaluation and 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 or licensure may limit the use of many E & M codes.*

(c) Guidelines published by the Centers for Medicare and Medicaid Services (CMS) in general are followed for HCPCS Level II code assignment and for assignment of any approved Level III codes. Code assignment must depict services rendered and documented. **NOTE:** *Only providers or a qualified coder should complete or edit encounters.*

3. POLICY: It is VHA policy to 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. **NOTE:** *See Attachment A, which provides answers to frequently asked questions (FAQs) about Inpatient Appointments in Outpatient Clinics.*

4. ACTION

a. **Network Directors.** Network Directors must ensure that:

(1) The Patient Information Management System (PIMS) and PCE software packages are maintained on all medical centers' VistA systems in accordance with nationally-distributed software and software patches.

(2) Software applications that do not pass encounter data to PCE are not used (for example the Medicine Package does not pass workload data to PCE).

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(3) All encounters are entered into a software application such as Computerized Patient Record System (CPRS) or PCE that results in the encounter data being reported to the PCE application in order to transmit to the NPCD.

b. **Facility Directors and Facility Chiefs of Staff.** Facility Directors and facility Chiefs of Staff must ensure:

(1) That clinical staff document clinical information in conformance with medical center documentation policies and by-laws, and in a format that conforms to the software requirements for defining the practitioner; the patient's active problems, diagnosis(es) or reason for visit; and the service provided to the patient.

(2) That staff accurately document patient demographics, the date and time of service, and the place of service in conformance with the requirements of the software.

(3) That facility staff continue to maintain, on each clinic set up in the Scheduling Package, a Primary DSS Identifier and/or credit pair (if appropriate) as the work group associated with that clinic set up.

(a) A primary DSS identifier must be assigned to encounters in outpatient settings. Those DSS Identifiers must be assigned for inpatient encounters; however, costs and workload are to be mapped appropriately to inpatient care via the encounter identifier number. Secondary DSS identifiers can be used in certain instances. The DSS identifier(s) for a patient setting must meet the definitions outlined in the DSS Directive. **NOTE:** *See the current VHA policy.*

(b) The primary DSS identifier needs to depict the primary clinical workgroup responsible for the type of services provided during the encounter. The secondary DSS identifier serves as a modifier to further define the primary work group or type of services provided. Each site is to ensure that the set up of the provider and clinic profile and DSS identifier(s) is confirmed with the local DSS staff, and accurately reflects the health care members for that clinic (i.e., the physician, the nurse, the dietitian, the social worker, etc.). Workload and data accuracy requirements necessitate accurate reporting of encounters. **NOTE:** *When additional encounters are created to capture work that is already included within a patient encounter, unnecessary duplication of work is created, and dilution of workload as well as costs occur, which affects the data accuracy for DSS, the Revenue Office, Performance Measurement, etc.*

(4) Where encounter forms, like those from the Automated Information Collection System (AICS), are used as a tool to manage the collection of coded information manually or on data collection screens, that data validation is performed to ensure that only valid codes are used on all encounter forms. Regular maintenance of these forms is required at least twice each year. The nationally-approved code sets are changed twice annually each year generally on October 1 and January 1, according to the releases of CPT-4, HCPCS, and ICD-9-CM coding changes. Trained and competent coding staff must perform data validation of the coded information in

accordance with the data validation requirements of the facility. The data on the encounter forms must conform to the definitions and conventions included in the appropriate coding methodologies noted previously.

(5) Inpatient and Outpatient Encounter data is transmitted to the NPCD at the Austin Automation Center (AAC), Austin, TX, and accepted (making any necessary corrections that result in a rejection from the NPCD).

(6) General monitoring of the transmission of encounter data is at regular intervals through the use of the Ambulatory Care Report Program (ACRP) Transmission report, Outpatient Activity Report (OPA) reports, messaging mail groups for transmission status, checking the logical link for the HL7 messages, and checking the transmission queue. **NOTE:** See *Attachment B, which details the monitoring and validating transmission of workload data to NPCD.*

(7) All inpatient billable professional services, inpatient appointments in outpatient clinics and outpatient encounter data is entered into an application that transmits the encounter data to PCE if PCE is not directly used for entering the data. PCE is the transmission mechanism of all encounter data for transmission of the data to NPCD. The workload is to be submitted by monthly closeout date.

5. REFERENCES

- a. American Medical Association. Common Procedural Terminology (CPT-4).
- b. American Society for Testing and Materials. (1999). E1384-99: Standard Guide for Content and Structure of the Electronic Health Record (EHR). West Conshohocken, PA:
- c. Centers for Medicare and Medicaid Services . Healthcare Current Procedural Coding System, Level II and Level III Codes.
- d. National Committee for Vital and Health Statistics, NCVHS, Uniform Ambulatory Medical Care Minimum Data Set.
- e. World Health Organization International Classification of Diseases-9th Edition –Clinical Modification (ICD-9-CM).
- f. Youman, K.G. (2000). Basic Healthcare Statistics for Healthcare Information Management Professionals. Glossary. Chicago, IL: American Health Information Management Association (AHIMA).

6. FOLLOW-UP RESPONSIBILITY: Director, Health Data and Informatics (19F), is responsible for the content of this Directive. Questions may be addressed to 414-389-4191.

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7. RESCISSIONS: VHA Directive 96-057 and VHA Directive 2002-020 are rescinded. This VHA Directive expires May 31, 2011.

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ATTACHMENT A

INPATIENT DATA TRANSMISSION FREQUENTLY ASKED QUESTIONS

Question 1: Is there a mandate to enter all inpatient professional information (both billable and non-billable) into Patient Care Encounter (PCE)?

Answer: At this time, there is not a mandate to enter all professional services (both billable and non-billable). Sites are required to record the inpatient professional services for billable admissions.

Question 2: Why was there a decision to transmit inpatient professional services encounters to Austin?

Answer: For several years, researchers, budget forecasters, and now the Veterans Health Administration (VHA) Physician Productivity and Advisory Group have requested data related to inpatient professional encounters. In response to those continuous requests, a new service request was submitted and the work to remove the inpatient flag (barrier) to transmitting inpatient PCE data to Austin was begun. The patches to allow the transmission of any inpatient encounters located in the PCE were finished in early December 2004. Patches SD*5.3*387 and DG*5.3*617 were released 12/14/04 (installation compliance date was January 4, 2005).

Question 3: In order to transmit inpatient encounters to PCE, what attributes must be included?

Answer: Patches SD*5.3*398 and DG*5.3*617 require that inpatient encounters processed in PCE and appointment management must be checked out with diagnosis, procedure, provider and other checkout items like classifications or they will accumulate as local Veterans Health Information Systems and Technology Architecture (VistA) errors in the Incomplete Encounter Module. *NOTE: If you have questions or concerns, log a Remedy ticket to Scheduling.*

Question 4: We already have count clinics set up to capture this information. Can we change them to non-count clinics?

Answer: Sites should not change count clinics to non-count purely to avoid entering checkout information. In clinics where there are provider-patient interactions, the clinics should be marked count, even if the patients being seen are inpatients. Valid reasons for marking a clinic non-count are instances where the credit is being passed by another application (Radiology, Surgery) and the clinic is only used to assign appointment times for the patient.

Question 5: I have one inpatient clinic set up that is used to collect all inpatient encounters; what stop code should I use?

Answer: Coders can enter data into inpatient professional clinics or inpatient encounter forms can be used, if developed locally by the site. It is recommended that an inpatient clinic be

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created for each specialty using the Decision Support System (DSS) Identifier that most accurately depicts the service being performed.

Question 6: What if we are using the 801 Screen to enter professional encounters?

Answer: Data entered into the 801 Screen in VistA creates a PCE entry and will transmit to the Austin database and the data remains available to the billing functionality within Integrated Billing. The QuadraMed EPS nCoder+ gives you the ability to enter data into an 801 screen in Patient Treatment File (PTF). Currently that does not transmit to Austin. **NOTE:** *A patch will be sent to the field early in Calendar Year (CY) 20 06 that will provide the same functionality found within VistA. Those sites using the QuadraMed product do not need to begin using VistA. They can and should wait for the patch to be sent.*

Question 7: Is there a mandate to use either PCE or the 801 Screen to capture inpatient professional services?

Answer: **At this time, either PCE or the 801 can be used for data entry.** It must be remembered, however, that data entered into the 801 will not pass to PCE or the Austin National Patient Care Database (NPCD) at this time. Workload for the same encounter should not be entered into both systems to prevent duplicate entries..

Question 8: Do we have to do anything new or different with Fee PTF as a result of this change?

Answer: No, there are no changes to the way in which Fee cases are coded and entered into VistA.

Question 9: How does this affect Domiciliary workload?

Answer: Domiciliary workload was not part of the block previously and will continue to require associated data and will continue to be transmitted to Austin. With the associated encounters, standard edit checks will be applied and corrections must be made for any rejected encounters (inpatient or outpatient).

Question 10: How do we know if any of the encounters for inpatients seen in outpatient clinics were rejected?

Answer: Health Information Management (HIM) should be an integral part of reviewing both inpatient and outpatient encounter error rejections that pertain to HIM, i.e. diagnosis or procedure code rejections. Inpatient encounters rejected by either VistA or NPCD use the same error codes as outpatient encounters with the exception of the new error code 421 for an incomplete admission date and/or time. Errors are handled in the same way as outpatient encounters using the VistA package Incomplete Encounter Management Module (IEMM).

Question 11: How do Inpatient Data transmissions affect providers and were instructions provided to them on any such changes that do affect them?

Answer: This should have minimal impact for providers as patch DG*5.3*617 transmits inpatient appointments that are currently being entered in outpatient clinics. However, those inpatient appointments will require the classification questions be answered which apply to those encounters within PCE. Instructions were provided on several different forums via email, conference calls and as a part of the flip cards distributed in August 2005 to all facilities titled the Physician Documentation Workgroup. For more information please reference webpage <http://vaww.vhaco.va.gov/him/NationalDocTemplate.asp>

Question 12: Will there be any reports that I can run to evaluate encounter data for inpatients seen in outpatient clinics data?

Answer: Reports that mirror the outpatient (OP) reports are being created and are available on the NPCD Web page. The NPCD homepage is <http://vaww.aac.va.gov/npcd> and the reports page is located at <http://vaww.aac.va.gov/npcd/AmbulatoryReports.php>. Select the reports that begin with IP for information about your facilities inpatient encounters transmitted to NPCD.

ATTACHMENT B

**INSTRUCTIONS FOR
INFORMATION RESOURCES MANAGEMENT (IRM) STAFF TRANSMITTING
WORKLOAD TO THE NATIONAL PATIENT CARE DATABASE (NPCD)**

1. Ambulatory Care Nightly Transmission to National Patient Care Database (NPCD)

Option. Ensure that the option Ambulatory Care Nightly Transmission (including Inpatient encounters) to NPCD [SCDX AMBCAR NIGHTLY XMIT] is scheduled to run on a daily basis, as this is the background job that generates the AmbCare HL7 messages. After each completion of this job, a summary bulletin stating the number of encounters included in the HL7 messages is sent to members of the mail group assigned to the SCDX AMBCARE TO NPCDB SUMMARY bulletin.

2. Systems Link Monitor Option. Using the option Systems Link Monitor [HL MESSAGE MONITOR] ensure the following:

- a. At least one incoming filer is running.
- b. At least one outgoing filer is running.
- c. The AMB-CARE logical link is running (STATE column lists IDLE).
- d. Values in the MESSAGES RECEIVED and MESSAGES PROCESSED columns for the AMB-CARE logical link increase on a daily basis.
- e. Values in the MESSAGES TO SEND and MESSAGES SENT columns for the AMB-CARE logical link increase on a daily basis.

3. Logical Link Possibilities

a. The HL7 outgoing filer is probably not running if the MESSAGES TO SEND for the AMB-CARE logical link does not increase and the Ambulatory Care Nightly Transmission to NPCDB job has run. If this happens, use the option Monitor, Start, Stop Filers [HL FILER MONITOR] to start an outgoing filer.

b. The HL7 incoming filer is probably not running if the MESSAGES RECEIVED for the AMB-CARE logical link continues to increase while the MESSAGES PROCESSED does not. If this happens, use the option Monitor, Start, Stop Filers [HL FILER MONITOR] to start an incoming filer.

c. It is highly likely that the AMB-CARE logical link is not running if the MESSAGES TO SEND for the AMB-CARE logical link continues to increase while the MESSAGES SENT does not. If this happens, use the option Start and Stop Links [HL START] to stop and then start the AMB-CARE logical link.

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4. Using the option Transmission History Report - Full [SCDX AMBCAR XMIT HIST FULL], generate the ACRP TRANSMISSION HISTORY report for previous days. This report lists all the encounters transmitted to Austin during a given time frame and includes whether or not an acknowledgement was received. Acknowledgements are usually received within 2 days of transmission and if you are not seeing the acknowledgements, it is highly likely that something is not running and all AmbCare and HL7 background processes should be checked.

5. Monitor the OPA reports coming from Austin to ensure that they reflect receipt of data. Not seeing receipt of data in Austin via these reports indicates something is not running and all AmbCare and HL7 background processes should be checked.