

**PRODUCTIVITY AND STAFFING IN OUTPATIENT CLINICAL ENCOUNTERS FOR
MENTAL HEALTH PROVIDERS**

1. REASON FOR ISSUE. This Veterans Health Administration (VHA) Directive provides policy on outpatient provider productivity based on outpatient clinical encounters for all psychiatrists and psychologists, as well as for those advanced practice nurses, social workers, and physician assistants who work in mental health settings.

AUTHORITY: Title 38 U.S.C. §§ 1706 and 8110.

2. SUMMARY OF MAJOR CHANGES. This is a new VHA Directive.

3. RELATED ISSUES. VHA Handbook 1160.01.

4. RESPONSIBLE OFFICE. FOLLOW-UP RESPONSIBILITY. The Office of the Deputy Under Secretary for Health for Operations and Management for Clinical Operations, Office of Mental Health Operations (10NC5) is responsible for the contents of this Directive. Questions may be directed to the Director of Mental Health Operations. Questions may be addressed at 202-461-6990.

5. RESCISSIONS. None.

6. RECERTIFICATION. This VHA Directive is scheduled for recertification on or before the last working day of June 2018.

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PRODUCTIVITY AND STAFFING IN OUTPATIENT CLINICAL ENCOUNTERS FOR MENTAL HEALTH PROVIDERS

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy on outpatient provider productivity based on outpatient clinical encounters for all psychiatrists and psychologists, as well as for those advanced practice nurses, social workers, and physician assistants who work in mental health settings. *NOTE: Psychiatrists, psychologists, social workers, counselors, and other staff of VA's Readjustment Counseling Service are excluded from this Directive.*

AUTHORITY: Title 38 U.S.C. §§ 1706 and 8110.

2. BACKGROUND

a. In January 2003, the Deputy Under Secretary for Health for Operations and Management charged a VHA Advisory Group on Physician Productivity with developing productivity models for physicians in VHA.

b. This Advisory Group developed a Relative Value Unit (RVU)-based model for measuring productivity of specialty providers and providing staffing guidance for specialty services. For purposes of physician productivity measurement, only the work component of the RVU value is utilized, and is referred to as Work Relative Value Units (wRVU). This is consistent with external benchmark data from the Medical Group Management Association (MGMA).

c. In 2007, the wRVU-based analysis of productivity was extended to mental health providers. A study was made of mental health productivity within VHA during fiscal years 2007 and 2008 using workload and provider data from national electronic sources, which has continued to be run in subsequent fiscal years. *NOTE: See <http://opes.vssc.med.va.gov/Pages/MentalHealthWorkforce.aspx> - This is an internal VA Web site and is not available to the public.* The Mental Health Study consisted of two phases: Phase I included an evaluation of Psychiatrists (physicians) and Phase II included Associated Mental Health Providers (all Psychologists regardless of work setting plus Social Workers, Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs) and Physician Assistants (PAs) working in Mental Health settings. When multiple providers were listed on any encounter, each provider received work load credit for the intervention. Trainee and non-Licensed Independent Provider (LIP) workload was credited to the supervising provider when recorded on the same encounter form. The study elements are described as follows:

(1) **Psychiatrist Workload.** In Phase I of the mental health analysis, all workload data (Unique Patients, Encounters and wRVUs) were collected from all providers having a person class of psychiatrist. Outpatient Current Procedural Terminology (CPT) codes were associated with Centers for Medicare and Medicaid Services (CMS) wRVUs contained within the Physician Productivity Cube.

(2) **Psychiatrist Workforce or Clinical Full-time Equivalent (FTE(c)).** Psychiatry Full-time Equivalent (FTE), adjusted for time spent in direct clinical care (Medical Doctor (MD) FTE(c)), was obtained from Decision Support System (DSS) labor mapping and is contained

within the physician productivity cube. MD Outpatient Clinic (OPC) FTE (c) adjusts for time spent in direct clinical outpatient care. *NOTE: The fraction of time the employee devoted to administration, teaching, and research, as specified in the current DSS Labor Mapping Directive, was excluded from the FTE(c) calculation.*

(3) **Fee Physicians.** In-house fee physician FTE equals total dollars expended from the Fee files divided by MGMA average private practice salary, geographically adjusted. All Fee basis employed physician FTE was assumed to represent 100 percent direct patient care time.

(4) **Contract Physicians.** Contract physician productivity equals total wRVUs generated by contract or without compensation (WOC) providers divided by the observed mean VHA Personnel and Accounting Integrated Data System (PAID) FTE. For all contracted physician services, FTE was assumed to represent 100 percent direct patient care time.

(5) **Associated Mental Health Provider Workload.** In Phase II, mental health workload was analyzed for psychologists and for the following providers, including only those who work in mental health programs: social workers, NPs, CNSs and PAs. For psychologists, workload is defined by all stop codes, both in the 500 series and outside the 500 series. For all other associated mental health providers, workload is defined by the stop code – 500 series and applicable 700 series stop codes. Home-based health care (HBHC) (stop codes 156/157) is also included if the secondary stop codes are in the 500 series. wRVUs data were collected on all providers having a person class of Psychologist, and all of the following providers if working in a mental health setting: NP, CNS, PA, and Social Worker. CMS wRVUs were calculated with outpatient CPT codes contained within the National Patient Care Database (NPCD) during the time period. The Department of Veterans Affairs (VA) now has added Licensed Professional Counselors and Licensed Marriage and Family Therapists as additional mental health providers eligible for hire in VA. *NOTE: Data have not been available to determine relevant work load productivity standards for these new groups. Likewise, VA recognizes that mental health trained clinical pharmacy specialists are often used as mid-level providers in VHA for medication therapy management and monitoring. Data have not been available to determine relevant work load productivity standards for Clinical Pharmacy Specialists. Also, Licensed Marriage and Family Therapists, Licensed Professional Mental Health Counselors, and Peer Support Technicians and Counselors are not held to productivity standards in this Directive because sufficient data do not yet exist for these professions.*

(6) **Associated Mental Health Provider Workforce.** Psychologists, Social Workers, NPs, CNS, and PAs labor mapped Mental Health FTE were derived from the Monthly Program Cost Report 3 (MPCR3). For psychologists, FTE adjusted for time spent in direct clinical care was obtained from MPCR3 for all clinic stops. For all other associated mental health providers, FTE adjusted for time spent in direct FTE(c) was obtained from the MPCR3 in the Mental Health clinic stops. OPC FTE(c) adjusts for time spent in direct clinical outpatient care.

(7) **Productivity Modifiers.** In order to identify what factors (modifiers) may influence productivity, the following were considered as possible factors: the number and various types of non-physician providers, clinical support staff, and residents and other trainees, capital (defined as psychiatric and residential treatment program beds), percent of inpatients versus outpatients, patient priority status, and other patient characteristics. In addition, the Veterans Equitable

Resource Allocation (VERA) measures of patient complexity such as Chronic Mentally Ill (CMI) registries, the size of the facility, facility complexity, and the degree of academic mission were considered. Each of the potential modifiers was tested to see if it had a significant association with outpatient productivity.

d. **Results.** The results of the productivity study are posted on the Office of Productivity, Efficiency and Staffing (OPES) Web site. **NOTE:** See <http://opes.vssc.med.va.gov/Pages/MentalHealthWorkforce.aspx> - This is an internal VA Web site and is not available to the public.

(1) The following are the mean and median wRVUs found per discipline for Outpatient Care in Fiscal Year (FY) 2011:

Observed Mean and Median wRVU by Discipline for Outpatient Care - FY 2011						
Measure	Psychiatrist	Psychologist	Social Work	NP	CNS	PA
OPC Productivity Mean (wRVU/FTE(c))	2671	2017	1299	2070	2224	2374
OPC Productivity Median (wRVU/FTE(c))	2574	1926	1194	1811	1977	2227

NOTE: For more detailed information, please see the full results of the productivity study (<http://opes.vssc.med.va.gov/Pages/MentalHealthWorkforce.aspx>). This is an internal VA Web site and is not available to the public.

(2) The only factor identified to be significantly associated with productivity was hospital complexity, although the effect varied across disciplines.

e. **Definitions**

(1) **Current Procedural Terminology (CPT).** The American Medical Association has defined a numerical code for each service or procedure. Level 1 Healthcare Common Procedure Coding System (HCPCS), also known as CPT codes are five digit numeric codes updated annually by the American Medical Association (AMA). Another category of codes, Level II HCPCS, may also be used in mental health settings for services not covered in the CPT codes (see App. B for further details). In VHA, these codes are assigned to an encounter based on the clinical service or procedure performed at the time of the encounter.

(2) **Relative Value Unit (RVU).** The Centers for Medicare and Medicaid Service (CMS) RVU is a measure of the complexity and time required to perform a professional service. In the private sector, the CMS RVU is used to compute reimbursement for services. The number of RVUs associated with each CPT code is determined by CMS as published in the CMS Medicare Fee Schedule. CMS RVUs are also employed to measure workload as well. It is important to note that the RVU used in this Directive and by CMS differ from time-based RVUs, defined locally by DSS which are used to compute VA cost for a rendered service. The total RVU consists of three components: work performed, practice expense, and malpractice expense. For purposes of productivity measurement, only the work component of the RVU value is utilized, and is referred to as wRVU. This is consistent with external benchmark data. **NOTE:** RVU

tables are available on the Veterans Integrated Service Network (VISN) Support Services Center (VSSC) Web site: <http://vssc.med.va.gov/tabreports/workload/cptrvu.aspx>. This is an internal VA Web site and is not available to the public.

(3) **Direct Patient Care Time.** Direct patient care time is defined as the time to prepare, provide for, and follow-up on the clinical care needs of patients. Direct patient care time, or “clinical” time, is time not occupied by administrative duties, teaching, or research. **NOTE:** For physicians and dentists, detailed definition of these duties, and how to account for them in DSS, is provided in current Directive regarding Physician and Dentist Labor Mapping. For all other mental health providers, see Appendix A.

(4) **FTE(c).** FTE(c) is the portion of a full time equivalent employee which is devoted to clinical, direct patient care as assigned in DSS labor mapping.

(5) **Associated Mental Health Providers.** For the purpose of this directive includes: all psychologists plus advanced practice providers (APP), such as: NPs, CNSs, PAs, and social workers assigned to mental health programs, not including VA’s Readjustment Counseling Service or Vet Centers.

(6) **Clinical Support Staff.** For the purpose of this directive, clinical support staff includes registered nurses, Licensed Practical Nurses (LPNs), health care technicians and aides, and other therapists assigned to the service.

(7) **Practice.** For purposes of this directive, a practice is defined as the providers in a medical center and its clinics who are providing mental health services. **NOTE:** In some medical centers, mental health providers may be assigned to multiple organizational departments or services, but are considered for the purpose of this Directive to be in the same practice if they are providing mental health services.

(8) **External Benchmarks.** External benchmarks were gathered from the Medical Group Management Association (MGMA). This is an association of medical group practices, both academic and non-academic, that surveys membership on an annual basis. External benchmarks are a primary source of information on productivity, support staff, and availability of capital assets at private sector and academic medical practices.

(9) **Veterans Equitable Resource Allocation (VERA) Patient Complexity.** The percentage of patients enrolled at each facility who meets the VERA methodology definition for complex care. **NOTE:** For an explanation of VERA methodology, see: http://vaww.bdc.med.va.gov/education/tutorials/VERA_prices_FY04/html/conprp.html. This is an internal VA Web site and is not available to the public.

(10) **Imputed Work Relative Value Unit (wRVU).** The number of RVUs associated with each CPT code is determined by the Centers for Medicare and Medicaid Services (CMS) as published in the CMS Medicare Fee Schedule. A zero (0) RVU assigned by CMS indicates there is no third-party reimbursement for this CPT procedure. Several CPT codes used in mental health are assigned a zero wRVU by CMS, but reflect services that are valued within VHA mental health settings, including many HCPCS Level II codes. However the Allocation

Resource Center (ARC) has imputed wRVUs for selected Level I and Level II HCPCS codes for VERA patient classification. **NOTE:** See Appendix E at http://vaww.arc.med.va.gov/references/Handbook/append_e_2015_imputed_weights.htm. These are known as “imputed work relative value units.” In addition, this Directive assigns imputed wRVU values to several additional Level I and Level II codes (see App. B).

3. POLICY: It is VHA policy that each facility Director must assess outpatient provider productivity based on outpatient clinical encounters for all psychiatrists and psychologists, as well as for those advanced practice nurses, social workers, and PAs who work in mental health on an annual basis using standardized methods .

4. RESPONSIBILITIES

a. **Mental Health Services (MHS).** MHS is responsible for proposing productivity standards for mental health providers based on: productivity data, available quality and access indicators, and requesting the concurrence of the office of social work, nursing, and physician assistants and the approval of Patient Care Services and the Under Secretary for Health (see App. A).

b. **The Office of Productivity, Efficiency, and Staffing (OPES).** OPES is responsible for conducting an annual study of mental health productivity.

c. **Veterans Integrated Service Network (VISN) Director.** The VISN Director is responsible for reviewing the annual mental health productivity report in seeking to optimize mental health productivity and staffing at their facilities.

d. **Facility Director.** The facility Director is responsible for:

(1) Ensuring that each Chief of Staff (COS) and all mental health service chiefs engage in assessment activities including the quarterly review of mental health productivity;

(2) Certifying provider labor mapping assignments according to current VHA policy;

(3) Reviewing the mental health productivity reports;

(4) Verifying the Person Class Code in the Veterans Health Information and Technology Architecture (VistA) Person File for all Mental Health providers; and

(5) Reviewing and implementing plans to improve provider productivity as appropriate.

e. **Facility COS.** The facility COS is responsible for coordinating the activities of Mental Health Service Chiefs and discipline specific leaders in assessing and measuring productivity on a quarterly basis, including performing needs assessments for the hiring of additional providers (permanent staff, contract, or fee in mental health services(see VA Directive 1663).

f. **Facility Mental Health Service Chief.** The facility Mental Health Service Chief or discipline specific chiefs, as applicable, is responsible for:

(1) Performing the quarterly monitoring activities for measuring provider activities, workload, and contracting;

(2) Coordinating with the COS in reporting to the facility director annually that the monitoring activities have been accomplished;

(3) Developing plans for adjusting provider productivity and staffing, timeliness of care, and patient access, as needed; and

(4) Collaborating with discipline specific leaders (Social Work Chief or Executive; Nurse Executive; Psychology Chief) to ensure professional collaboration that supports appropriate professional practice standards.

5. REFERENCES

a. VA Directive 1663 (Healthcare Resources Contracting – Buying).

b. 38 U.S.C. 8110.

c. Medical Group Management Association (MGMA) Physician Compensation and Production Survey: 2011 Report Based on 2010 Data, Englewood, CO.

d. Medical Group Management Association (MGMA) Academic Practice Compensation and Production Survey: 2011 Report Based on 2010 Data, Englewood, CO.

RECOMMENDATIONS FOR MENTAL HEALTH PROVIDER PRODUCTIVITY STANDARDS AND MONITORING

1. RECOMMENDED STAFFING AND PRODUCTIVITY STANDARDS

a. General Considerations

(1) There are no national minimum productivity standards for any mental health profession; however, Veterans Health Administration (VHA) service chiefs need to track the productivity of each employee to ensure it meets local expectations. Variation in workload associated with program assignment and required non-relative value unit (RVU)-generating activities, quality of care, and customer satisfaction is expected and must be considered in evaluating individual employee productivity.

(2) Some outpatient mental health sites deliver services that are associated with current procedural terminology (CPT) codes with zero work relative value unit (wRVU) values, yet the services are integral, desirable components of Department of Veterans Affairs (VA) mental health care. The expected wRVU productivity of any VA mental health provider must be considered in relation to the inherent value of the work done as well as the average wRVUs/ Outpatient Clinical Full-time Equivalent (FTE(c)) of the total practice.

(3) VA relies primarily on the wRVUs assigned by Centers for Medicare and Medicaid Services (CMS) to Level I CPT codes (see for most recent listing of wRVUs - <https://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp>). The Veterans Equitable Resource Allocation (VERA) System Allocation Resource Center (ARC) Technical Manual already assigns imputed values to selected CPT and Healthcare Common Procedure Coding System (HCPCS) Level II codes for VERA patient classification, including imputed values related to Ingenix gap codes (see Appendix E, of http://vaww.arc.med.va.gov/references/Handbook/append_e_2015_imputed_weights.htm for examples of some imputed values) *NOTE: This is an internal VA Web site and is not available to the public.* To make some further correction for the concerns expressed in item 1.(a).(2), this Appendix describes an expanded set of imputed wRVU values for selected HCPCS Level I and II codes with zero wRVUs assigned by CMS. These must always be used in calculating the productivity of any provider in any of the professional categories (see App. B for listing of these imputed wRVUs). Productivity expectations are derived from the use of CMS RVUs supplemented with Ingenix Gap Codes and an imputed value for Compensation and Pension exams. When additional mental health imputed values are utilized, these expectations should be adjusted to address this differential.

b. Psychiatrist Productivity

(1) Mental health practices should strive for a yearly physician productivity target within a range around the median observed wRVU per Outpatient Clinical Full-time Equivalent FTE(c) averaged over all psychiatrists in Mental Health services, calculated using the methodology defined in this appendix. For purposes of physician productivity measurement, only the

physician work component of the RVU value is utilized, and referred to as wRVU. This is consistent with external benchmark data.

(2) Psychiatrists should strive for a yearly productivity target above 2574 per Outpatient FTE (c), though productivity between 2317-2831 (+/-10 percent of the median) is considered as meeting the standard, taking care not to compromise quality and patient access standards.

(3) There are no national minimum productivity standards; however, service chiefs need to track the productivity of each physician to ensure it meets local expectations. Variation in workload associated with program assignment, quality of care, and customer satisfaction are to be expected and considered in evaluating individual physician productivity.

c. **Associated Mental Health Provider Productivity**

(1) Mental health practices strive for a yearly Associated Mental Health Provider productivity target within a range around the median observed wRVU per Outpatient FTE(c) averaged over all of each type of Associated Mental Health Providers in Mental Health services, calculated using the methodology defined in this appendix. For purposes of Associated Mental Health Provider productivity measurement, only the provider work component of the RVU value is utilized, and referred to as wRVU. This is consistent with external benchmark data.

(2) Psychologists should strive for a yearly productivity target above 1926 per Outpatient FTE(c) though productivity within 1733-2119 (+/- 10 percent of the median) is considered as meeting the standard, taking care not to compromise quality and patient access standards.

(3) Social Workers should strive for a yearly productivity target above 1194 per Outpatient FTE(c) though productivity within 1075-1313(+/- 10 percent of the median) is considered as meeting the standard, taking care not to compromise quality and patient access standards.

(4) Clinical Nurse Specialists (CNS) should strive for a yearly productivity target above 1977 per Outpatient FTE(c) though productivity within 1779-2175 (+/-10 percent of the median) is considered as meeting the standard, taking care not to compromise quality and patient access standards. *NOTE: Because of small numbers of these staff and the range of potential assignments, the national benchmarks are unreliable for individual advanced practice providers.*

(5) Nurse Practitioners (NP) should strive for a yearly productivity target above 1811 per Outpatient FTE(c) though productivity within 1630-1992(+/- 10 percent of the median) is considered as meeting the standard, taking care not to compromise quality and patient access standards. *NOTE: Because of small numbers of these staff and the range of potential assignments, the national benchmarks are unreliable for individual advanced practice providers.*

(6) Physician's Assistants (PA) should strive for a yearly productivity target above 2227 per Outpatient FTE(c) though productivity within 2004-2450(+/- 10 percent of the median) is considered as meeting the standard, taking care not to compromise quality and patient access standards. *NOTE: Because of small numbers of these staff and the range of potential assignments, the national benchmarks are unreliable for individual advanced practice providers.*

(7) There are no national minimum productivity standards; however, service chiefs need to track the productivity of each associated mental health provider to ensure it meets local expectations and the guidelines in this directive. Variation in valued workload associated with important program assignment and type of work, such as case management with the patient not present that has little or no wRVUs associated with it, should be considered in evaluating individual associated mental health provider productivity. It must be recognized that a high level of productivity variability from the median should be expected and may be quite appropriate depending on the program assignment of the particular provider (e.g., driving time for Mental Health Intensive Case Management providers, Home-Based Primary Care providers, and Homeless Case Managers providing clinical care would need to have target expectations adjusted).

(a) Clinical Support Staffing. Sufficient support staff should be assigned so that:

1. Veterans receive timely service, and
2. Providers are not drawn away from their professional services in order to carry out duties that should be performed by clinical support staff.

(b) Provider Staffing. The ideal mental health service staffing model considers the practice productivity, access and quality standards, types of services provided, and the needs of the population served. Mental health provider staffing is defined as adequate when the mental health providers' mean productivity falls within an acceptable range, performance standards are being met, high-quality services are provided, patient satisfaction is high, staff turnover is low, and the needs of the population are served.

2. LABOR MAPPING FOR ASSOCIATED MENTAL HEALTH PROVIDERS: The appropriate service chief, in consultation with the Chief of Staff, assigns the fraction of time devoted to clinical care, administration, teaching, and research for each employee in the practice, and is responsible for updating these values in the Decision Support System (DSS) in a timely manner as duties change. Labor assignments as entered in DSS are the basis for computing FTE(c). The following recommendations are intended to be consistent with guidelines established for physicians in the DSS labor mapping Directive 2011-009.

a. Clinical Time. Clinical time is the time left when approved administrative, teaching, and research hours have been subtracted. Direct Patient Care time is defined as the time to prepare, to provide for, and follow-up on the clinical care needs of patients and includes:

- (1) Providing direct clinical care.
- (2) Time spent in reviewing patient data.
- (3) Consulting about patient care with colleagues.
- (4) Reviewing medical literature.

(5) Contacting the patient or caregivers to discuss their needs.

(6) The labor hours provided by a mental health licensed independent provider who is supervising trainees and/or other non-LIPs providing care in a clinical setting. **NOTE:** *See the following documents for further guidance related to adding the supervisor as the primary provider in these encounters: VHA Handbook 1400.01 Resident Supervision, VHA Handbook 1400.04 Supervision of Associated Health Trainees, and the current directive on revised billing guidance for services provided by supervising practitioners and residents.*

It includes time for required employee training, continuing education, breaks, staff meetings, team meetings, driving time for clinical care, committee work and other management support activities typical of a front line clinician without major leadership or administrative responsibilities.

b. **Education Time.** Education is defined as time spent providing formal training (didactic education). This includes preparation, as well as actual classroom or lecture time for educators or presenters. Time spent receiving training is considered a cost of direct patient care. Resident, trainee, and non-LIP clinical supervision is considered direct clinical care time.

c. **Research Time.** Research time is defined as time spent performing formal, approved health care research, or in activities in direct support of approved research. Formal, approved research is research that is approved through the medical facility's research review process. Support activities include time spent by the investigator in direct support of research activities.

d. **Administrative Time.** Administrative time includes time spent on managerial or administrative duties, generally at the level of the department, service, medical center, Veterans Integrated Service Network (VISN) or nationally, both within and outside VA that go beyond the requirements of a typical front line clinician. This time should be mapped for individuals with major and formal administrative and leadership responsibilities that go beyond those of a typical front line clinician. Service line and discipline specific service chiefs, clinical program directors and coordinators are examples of positions that would be mapping administrative time. Additionally, time should be mapped administratively for any committee work requiring an hour or more of time for a provider weekly. For example, this would include time to chair an administrative committee like the Disruptive Behavior Committee or a Professional Standards Board that meets regularly and has the equivalent of at least an hour of work per week. It may also involve service in a particular role, such as being the Training Director, Military Sexual Trauma Coordinator, Post-Traumatic Stress Disorder (PTSD) Clinical Team Leader, Local Recovery Coordinator, Suicide Prevention Coordinator, VISN PTSD Mentor, or Facility Evidence Based Psychotherapy Coordinators.

e. **Labor Mapping Scenarios.** The following examples illustrate how to map the time of mental health providers with a range of different responsibilities:

(1) **PTSD Program Manager or Director of Psychology Training.** A female psychologist assigned to program manager of a PTSD Clinical Team (PCT) has a functional statement which allows for 25 percent of their time to be administrative to oversee the functions of the PCT,

including supervision of the employees within that clinic. Additionally, she is the Training Director for psychology, overseeing 15 trainees, for which she has been given 25 percent administrative time. This psychologist would be mapped to administration for 50 percent and to clinical for 50 percent.

(2) **Outpatient Mental Health Chief.** A male social worker is assigned to oversee all outpatient mental health services and his functional statement allows for 75 percent administrative time and 25 percent clinical time. He would be mapped to 75 percent for administration and 25 percent for clinical.

(3) **Advance Practice Nurse (APN) Researcher or Clinician.** A female APN is employed in the research unit of the hospital, working approximately 75 percent of her time in manuscript preparation, data collection, data analysis, literature review, and grant writing. Her remaining 25 percent time is dedicated to the supervision of nursing students in the mental health setting, but she does not lead formal didactics nor does she hold responsibility for the overall nursing training program. She is mapped to research for 75 percent of her time and to clinical for 25 percent.

(4) **Health Care for Homeless Veterans (HCHV) Program Coordinator.** A female social worker is assigned to oversee the HCHV program, as well as conduct community outreach. She spends 80 percent of her time in HCHV program coordination and staff supervision/management activities. She spends 20 percent of her time in community outreach services with Veterans, which includes traveling to and from community agencies. This social worker would be mapped 80 percent time administrative and 20 percent time clinical.

3. APPROPRIATE CPT CODING: Mental health providers are to sufficiently document in the Medical Record the services delivered. Providers are not to expand the scope of a patients' care, thereby increasing wRVUs, without clinical justification specific to that patient. All providers must follow the precepts of the Centers for Medicare and Medicaid Services (CMS) Correct Coding Initiative. **NOTE:** See VHA Handbook 1907.03, *Health Information Management Clinical Coding Program Procedures* at: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2794.

4. MONITORS OF PRODUCTIVITY: Each year VHA conducts a study of mental health provider productivity. **NOTE:** The results of this study are posted on the Office of Productivity, Efficiency and Staffing (OPES) Portal under Clinical Care at: <http://vssc.med.va.gov/>. This is an internal VA Web site and is not available to the public.

a. If the productivity level of the practice is found to be below the median range (-10 percent) listed above, the service chief must devise an action plan to increase productivity to acceptable levels, which will be submitted to the facility director for review. This action plan must be developed in collaboration with the appropriate discipline leader(s). Service chiefs should also review for productivity above the median range (+10 percent and higher), in particular to assess for burnout of staff members. Workload productivity numbers significantly higher than the median range might suggest a need to reassign staff to assist in clinical areas with increasing service needs and a possible need to adjust future business planning to request

additional staffing. In addition, workload productivity numbers outside the median range might reflect improper coding, and service chiefs are encouraged to monitor for compliance with national coding guidelines. *NOTE: The homeless programs office will be providing additional guidance related to clinic set up, including Fixed Direct Labor and Variable Direct Labor instructions.*

b. The service chief or service line director, in collaboration with the discipline leaders, must use the productivity monitor to help ensure equitable assignments, as appropriate, to each individual provider. *NOTE: The productivity monitor does not account for the frequency or difficulty of on-call responsibilities, the specific program to which the provider is assigned, or the presence or lack of productivity modifiers such as number of clinical support staff (see subpar. 2c(5) of the Directive) or complexity level of the facility.* These and other additional factors may be used in an informal way when comparing productivities and setting duty assignments. In addition, these indicators of productivity may be useful when assigning duties, such as teaching and research, as relevant to the mission of the service. It must be recognized, however, that a high level of variability around the median found at the individual provider level may be extremely appropriate and expected depending on their program assignment (e.g., driving time for Mental Health Intensive Case Management providers, Home-Based Primary Care providers, Health Behavior Coordinators, and Homeless Case Managers would need to have target expectations adjusted).

c. Although the productivity performance standard applies to the practice as a whole, service chiefs need to track productivity for each mental health provider. The productivity record is to be produced and reviewed at least annually in collaboration with the discipline leaders.

d. Instructions for calculating Mental Health Provider FTE are as follows:

(1) **Outpatient Clinical FTE(c).**

(a) The **Outpatient Clinical FTE(c)** for individual employees for each year is calculated as:

1. Physician Employee **Outpatient Clinical FTE(c)** =
Outpatient clinical hours per pay period / 80 x (251 x Full-time Equivalent (FTE) employee – non-discretionary leave (NDL) days) / (251 x FTE).

2. Other MH Provider **Outpatient Clinical FTE(c)** =
Outpatient clinical hours per pay period / 80 x (2008 x FTE) – NDL hours) / (2008 x FTE).

(b) Where the symbol “x” denotes multiplication, clinical hours per pay period is the DSS outpatient clinical labor assignment per pay period, 80 is the number of hours per pay period for a full time employee, 251 is the number of week days per year minus Federal holidays, 2008 is the number of hours per year, Outpatient Clinical FTE(c) is the fraction of appointment (example: a half-time employee would be 0.5), and NDL days or hours are the total days of Family Care, Sick Leave, Military Leave, Adoption Leave, and Leave Without Pay. The number of leave days may be found in the Employee Leave History report of the Veterans Health

Information and Technology Architecture (VistA) Time and Attendance menu and are removed from the FTE.

(2) **Contractor and In-house Fee Providers Outpatient Clinical FTE(c).** The FTE of contractors may be corrected for percent time not assigned to clinical duties, if the contract states that the contractor is paid to provide teaching, research, or administrative services, using official DSS definitions defined in current VHA policy. The fraction of time devoted to teaching, research and clinical duties must be specified by the contract. *NOTE: VA Directive 1663 outlines the procedures for contracting with physicians either on the basis of time or per procedure (paid by the study).*

(a) Contractor FTE(c) = (fraction of time clinical) x (FTE). The FTE of contractors paid on the basis of time worked, such as per diem or locum tenens contractors, may be computed by dividing the number of hours on service for the year by 2080, as: Per diem contractor FTE(c) = (fraction of time clinical) x hours on service/2080.

(b) The number of hours on service are usually the number of days on service times eight. The fraction of time clinical is usually one.

(3) **Monitoring Contractor Groups.** If the medical center contracts with a group who staff a position from a pool of providers in rotation, then the productivity of the contract can be monitored as a group. In that case, the wRVU is the sum of the wRVU for the contract, and the FTE(c) is the clinical part of the FTE for the contract.

(4) **Exempt Provider.** The following providers do not need to be tracked in the quarterly report:

(a) Providers who have no clinical assignment.

(b) Providers who work without compensation.

(c) Contract providers who are paid per encounter/procedure, rather than by the hour or FTE.

(d) Contractors that cover on-call emergency duties only.

(e) A contract that is staffed for fewer than 5 days of service per quarter. When deciding whether contracted position(s) are staffed fewer than 5 days per quarter, one must add the days of attendance of all providers in the contract.

(f) Providers who are not working in outpatient settings.

IMPUTED WORK RELATIVE VALUE UNIT

1. WORK RELATIVE VALUE UNIT WEIGHTING: Work Relative Value Units (wRVU) are associated with current procedural terminology (CPT) codes by the Centers for Medicare and Medicaid Services (CMS) *NOTE:* See http://vaww.arc.med.va.gov/vapublic/cpt_input.html. *This is an internal Department of Veterans Affairs (VA) Web site and is not available to the public.* However, several CPT codes are assigned a zero wRVU, such as care management and home-based care visits, which are valued within the veterans Health Administration (VHA). An initial analysis comparing workload with zero assigned wRVUs across six disciplines found that the greatest impact on productivity was for the Social Work discipline though all were affected. In order to give credit to providers and programs providing these services, the following imputed wRVUs provided are to be utilized when assessing mental health productivity.

2. IMPUTED WORK RELATIVE VALUE UNITS

a. General Considerations

(1) Whenever possible licensed independent mental health providers are to utilize coding that has assigned wRVU credit (as outlined in the provided table in subpar. 2b(3)(b)).

(2) Most Healthcare Common Procedure Coding System (HCPCS) Level II codes have zero wRVUs assigned by CMS; however, the Allocation Resource Center has imputed wRVUs for selected Level I and Level HCPCS codes for Veterans Equitable Resource Allocation (VERA) patient classification, for example for the code 90899, Unlisted Psychiatric Service or Procedure, which has an Allocation Resource Center (ARC) imputed value of .5 (see at Appendix E at http://vaww.arc.med.va.gov/references/Handbook/append_e_2015_imputed_weights.htm). *NOTE:* *This is an internal VA Web site and is not available to the public.*

(3) HCPCS codes with imputed wRVUs (as outlined in the table in subpar. 2b(3)(b)) are to be utilized to appropriately assign workload credit to the provider.

b. Home Visits, Group Psychotherapy, and Mental Health Services (MHS) Imputed wRVUs

(1) **Home Visits for Psychotherapy.** Psychotherapy codes (90846-90847) are authorized for use for psychotherapy services provided in the home for family therapy by licensed independent providers and do have wRVU credit assigned. The use of psychotherapy codes for home psychotherapy services may require modifications to the Department of Veterans Affairs (VA) encounter form and may require other billing office actions to ensure that the “home” is recognized as a place of service for psychotherapy interventions. An additional .7 wRVU is to be added to the wRVU for psychotherapy codes used in the home to account for travel time.

(2) **Group Psychotherapy and Interventions.** Consistent with CMS standards, the group psychotherapy CPT code, 90853 with a 2011 wRVU of .59 per participant, may be utilized for group psychotherapy with an upper limit of 12 participants. *NOTE:* See http://vaww.arc.med.va.gov/vapublic/cpt_input.html. *This is an internal VA Web site and is not*

available to the public. Group counseling for alcohol and drug use may be coded with the CPT code H0005, which has an existing ARC imputed wRVU of .4 per participant. Other group interventions that accommodate larger numbers of patients or do not meet the standards of group psychotherapy would have an imputed wRVU of .1 per participant regardless of the length of the encounter, consistent with the wRVU assigned to CPT code 96153 in 2011.

(3) Other Services

(a) Other services with CPT codes with zero wRVU are outlined in the following table, with imputed wRVUs as well as suggested alternatives for coding. **NOTE:** *Some services with zero wRVU, such as 99499, Unlisted Evaluation and Management Service, were not included here as an imputed value as no determination was able to be made as to the type of service provided.* Providers are encouraged to utilize codes that best match the actual service provided in accordance with coding guidelines (*Additional coding guidance for Mental Health can be found in VHA Procedure Guide 1601C.03, available in Section 03.6.D at the following Web site: (http://vaww.va.gov/CBO/apps/policyguides/contents.asp?address=VHA_PG_1601C). This is an internal VA Web site and is not available to the public. The preceding coding is for individual encounters, unless specifically identified as a group encounter code).*

(b) APP means Advanced practice providers: Nurse Practitioners, Clinical Nurse Specialists, Physician Assistants; Less than (<), More than (>)

CPT Code	Code Description	Imputed wRVU	Discipline Permitted to Use				Alternative Coding Options
			Psychiatry	APP *	Psychology	Social Work	
H0001	Alcohol and/or Drug Assessment	0.5	x	x	x	x	90801 for comprehensive assessment; 96150 for health and behavior assessment
H0014	Alcohol and Prescription (Rx) Service; Ambulatory De-toxification	0.95	x	x			

CPT Code	Code Description	Imputed wRVU	Discipline Permitted to Use				Alternative Coding Options
			Psychiatry	APP *	Psychology	Social Work	
H0024	Behavioral Health Prevention Information Dissemination Service	0.1	x	x	x	x	
H0025	Behavioral Health Prevention Education Service	0.5	x	x	x	x	
H2017	Psychosocial Rehab Service (15 min)	0.5			x	x	
H2023	Support Employment (15 min)	0.5			x	x	
H2025	Ongoing Supported Maintain Employment (15 min)	0.5			x	x	
H2027	Psycho-educational Service (15 min)	0.5			x	x	
S9445	Patient Education Not Otherwise Classified (NOC) NOC Non-MD Provider Individual Session	0.5			x	x	

CPT Code	Code Description	Imputed wRVU	Discipline Permitted to Use				Alternative Coding Options
			Psychiatry	APP *	Psychology	Social Work	
S9446	Patient Education NOC Non-MD Prov Group Session	0.1			x	x	
S9449	Weight Management Class Non-MD Per Session	0.1			x	x	96153, Health and behavior intervention, each 15 minutes, may be used
S9452	Nutrition Classes Non-MD Per Session	0.1			x	x	96153, Health and behavior intervention, each 15 minutes, may be used
S9453	Smoking Cessation Class Non-MD Per Session	0.1			x	x	96153, Health and behavior intervention, each 15 minutes, may be used
S9454	Stress Management Class Non-MD Per Session	0.1			x	x	96153, Health and behavior intervention, each 15 minutes, may be used

CPT Code	Code Description	Imputed wRVU	Discipline Permitted to Use				Alternative Coding Options
			Psychiatry	APP *	Psychology	Social Work	
G0175	Scheduled Inter-disciplinary Team Conference with Veteran Present	.5 (<30 min) or 1.16 (>30 min)	x	x	x	x	99366 may be used if >30 min; 90899 may be used for <30 minutes
G0177	Training and Education of Patients with Disability related to Mental Health Per Session	0.5	x	x	x	x	
T1001	Nursing Assessment and Evaluation	0.5		x			
T1016	Case Management (15 min)	0.5	x	x	x	x	
99078	Group Health Education	0.1	x	x			
99510	Home Visit, Individual, Marital, or Family Counseling	RVU for equivalent therapy code + .7	x	x	x	x	90846-90847 may be utilized +.7 for marital/family therapy*

NOTE: Additional coding guidance for Mental Health can be found in VHA Procedure Guide 1601C.03, available in Section 03.6.D at the following Web site: (http://vaww1.va.gov/CBO/apps/policyguides/contents.asp?address=VHA_PG_1601C). This is an internal VA Web site and is not available to the public. The preceding coding is for individual encounters, unless specifically identified as a group encounter code.

3. UPDATED wRVU GUIDANCE: Annual updates for CPT codes and wRVUs used by CMS are available at http://vaww.arc.med.va.gov/vapublic/cpt_input.html. **NOTE:** *The following are internal VA Web site's and are not available to the public. Updates on ARC imputed wRVUs are available in Appendix E at:*

http://vaww.arc.med.va.gov/references/Handbook/append_e_2015_imputed_weights.htm.

Additional updates for imputed wRVUs covered in this Directive may be completed annually and are available on the Mental Health Services Web site at: <http://vaww.mentalhealth.va.gov/>.

CALCULATION AND TRACKING OF INDIVIDUAL PROVIDER PRODUCTIVITY

*NOTE: Physician productivity cubes are available at the following Web site:
<http://vssc.med.va.gov/products.asp?PgmArea=18>. This is an internal VA Web site and is not available to the public.*

1. AMBULATORY CARE REPORTING PROGRAM (ACRP) REPORT CREATION: In order to track individual productivity, a mental health supervisor may create an ACRP report within Veterans Health Information and Technology Architecture (VistA) for each individual provider under their supervision. The final printout includes a review of all patients seen in a given time period, diagnostic summary of patients seen, the number and type of CPT encounter codes utilized. The following is a list of instruction in how to run this report in VistA:

- a. Select Mental Health Clinician's Menu Option: **^ACRP**

ACRP Ad Hoc Report Menu [SCRPW AD HOC RPT MENU]

ACRP Reports Menu [SCRPW ACRP REPORTS MENU]

ACRP Ad Hoc Report [SCRPW AD HOC REPORT]

- b. Type '^' to stop, or choose a number from 1 to 3 :**1 ACRP Ad Hoc Report Menu**

- c. Select ACRP Ad Hoc Report Menu Option:

AAH ACRP Ad Hoc Report

DTP Display Ad Hoc Report Template Parameters

PAH Print from Ad Hoc Template

- d. Select ACRP Ad Hoc Report Menu Option: **AAH**

- e. Select one of the following:

D DETAILED

S SUMMARY

- f. Select report format: **SUMMARY// D**

- g. Select one of the following:

E ENCOUNTER/VISIT/UNIQUE LIST

D DIAGNOSIS/PROCEDURE RANKING

B BOTH ACTIVITY & DX/PROC. LISTS

- h. Select type of detail: **B**

- i. Select one of the following:

E ENCOUNTER

V VISIT

U UNIQUE

- j. List activity by: **E**
- k. Limit Dx/procedure list to most frequent: (1-999): 50// (Enter)
- l. Select one of the following:
 - F **FORMATTED TEXT**
 - D **DELIMITED VALUES FOR EXPORT TO SPREADSHEET**
- m. Produce output as: **FORMATTED TEXT**// (Enter)
- n. Select one of the following:
 - CL **CLINIC**
 - SC **STOP CODE**
 - PR **PROVIDER**
 - DX **DIAGNOSIS**
 - AP **AMBULATORY PROCEDURE**
 - VF **V FILE ELEMENT**
 - PD **PATIENT DEMOGRAPHICS**
 - PE **PATIENT ELIGIBILITY**
 - PC **PRIMARY CARE**
 - EH **ENROLLMENT (HISTORICAL)**
 - EC **ENROLLMENT (CURRENT)**
 - OE **OUTPATIENT ENCOUNTER**
 - PM **PERF MONITOR**
- o. Select report perspective: **PR**
- p. Select one of the following:
 - PP **PRIMARY PROVIDER**
 - SP **SECONDARY PROVIDER**
 - AP **ALL PROVIDERS**
 - PC **PRIMARY PROVIDER PERSON CLASS**
 - SC **SECONDARY PROVIDER PERSON CLASS**
 - AC **ALL PROVIDERS PERSON CLASS**
- q. Select PROVIDER category: **AP**
- r. Select one of the following:
 - L **LIST**
 - N **NULL (NO DATA VALUE)**
- s. Limit this factor by: **L**
- t. Select NEW PERSON NAME: (**Last Name, First Name**)
- u. Select NEW PERSON NAME: (**Enter when last name submitted**)

Beginning date: **1/1/11**

Ending date: **3/31/11**

v. Select additional output limiting factor: (optional) **(Enter)**

w. Select one of the following:

CL CLINIC
SC STOP CODE
PR PROVIDER
DX DIAGNOSIS
AP AMBULATORY PROCEDURE
VF V FILE ELEMENT
PD PATIENT DEMOGRAPHICS
PE PATIENT ELIGIBILITY
PC PRIMARY CARE
EH ENROLLMENT (HISTORICAL)
EC ENROLLMENT (CURRENT)
OE OUTPATIENT ENCOUNTER
PM PERF MONITOR

x. Select limiting factor: **(Enter)**

y. Select one of the following:

A ALPHABETIC
E ENCOUNTER TOTAL
V VISIT TOTAL
U UNIQUE TOTAL

z. Select report print order: ALPHABETIC// **(Enter)**

aa. Report descriptive title (optional): **(Enter)**

bb. Select additional print fields for patient detail: (optional) **(Enter)**

cc. Select one of the following: **(Enter)**

CL CLINIC
SC STOP CODE
PR PROVIDER
DX DIAGNOSIS
AP AMBULATORY PROCEDURE
VF V FILE ELEMENT
PD PATIENT DEMOGRAPHICS
PE PATIENT ELIGIBILITY
PC PRIMARY CARE
EH ENROLLMENT (HISTORICAL)

- | | |
|----|----------------------|
| EC | ENROLLMENT (CURRENT) |
| OE | OUTPATIENT ENCOUNTER |
| PM | PERF MONITOR |
- dd. Specify additional print field: **(Enter)**
- ee. Report output format: DETAILED
- ff. Type of detail: BOTH ACTIVITY & DX/PROC. LISTS
- gg. List activity detail by: ENCOUNTER
- hh. Limit Dx/Proc. list to most frequent: 50
- ii. Produce output as: FORMATTED TEXT
- jj. Perspective category: PROVIDER
- kk. Perspective sub-category: ALL PROVIDERS
- ll. Detail list:
- mm. Starting date: JAN 1,2011
- nn. Ending date: MAR 31,2011
- oo. Output order: ALPHABETIC
- pp. Select one of the following:
- | | |
|---|-----------------------|
| C | CONTINUE |
| E | EDIT PARAMETERS |
| R | RE-DISPLAY PARAMETERS |
| P | PRINT PARAMETERS |
| Q | QUIT |
- qq. Select report action: CONTINUE// **(Enter)**
- rr. DEVICE: HOME// ENTER PRINTER NAME
- ss. Requested Start Time: NOW// **(Enter)**

2. INDIVIDUAL PRODUCTIVITY TRACKING: In order to track individual productivity, the mental health supervisor must take the data from the ACRP report and place it in an Excel Spreadsheet to calculate wRVU based on CPT encounter code, typically on a quarterly basis.

- a. An example of this individualized spreadsheet follows:

NAME:										
		WORK	Q1		Q2		Q3		Q4	
HCPCS	DESCRIPTION	RVU	#	RVUs	#	RVUs	#	RVUs	#	RVUs
90801	Psy Interview/Dx	2.80	82	229.6	59	165.2	50	140	9	25.2
90804	Psytx, office, 20-30 min	1.21	47	56.87	73	88.33	101	122.21	151	182.71
90805	Psytx, off, 20-30 min w/e&m	1.37		0		0		0		0
90806	Psytx, off, 45-50 min	1.86	186	345.96	140	260.4	92	171.12	55	102.3
90807	Psytx, off, 45-50 min w/e&m	2.02		0		0		0		0
90808	Psytx, office, 75-80 min	2.79		0		0		0		0
90809	Psytx, off, 75-80, w/e&m	2.95		0		0		0		0
90810	Intac psytx, off, 20-30 min	1.32		0		0		0		0
90811	Intac psytx, 20-30, w/e&m	1.48		0		0		0		0
90812	Intac psytx, off, 45-50 min	1.97		0		0		0		0
90813	Intac psytx, 45-50 min w/e&m	2.13		0		0		0		0
90814	Intac psytx, off, 75-80 min	2.90		0		0		0		0
90815	Intac psytx, 75-80 w/e&m	3.06		0		0		0		0
90816	Psytx, hosp, 20-30 min	1.25		0		0		0		0
90817	Psytx, hosp, 20-30 min w/e&m	1.41		0		0		0		0
90818	Psytx, hosp, 45-50 min	1.89		0		0		0		0
90819	Psytx, hosp, 45-50 min w/e&m	2.05		0		0		0		0
90821	Psytx, hosp, 75-80 min	2.83		0		0		0		0
90822	Psytx, hosp, 75-80 min w/e&m	2.99		0		0		0		0

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NAME:										
		WORK	Q2		Q3		Q4		Q2	
HCPCS	DESCRIPTION	RVU	#	RVUs	#	RVUs	#	RVUs	#	RVUs
90823	Intac psytx, hosp, 20-30 min	1.36		0		0		0		0
90824	Intac psytx, hsp 20-30 w/e&m	1.52		0		0		0		0
90826	Intac psytx, hosp, 45-50 min	2.01		0		0		0		0
90827	Intac psytx, hsp 45-50 w/e&m	2.16		0		0		0		0
90828	Intac psytx, hosp, 75-80 min	2.94		0		0		0		0
90829	Intac psytx, hsp 75-80 w/e&m	3.10		0		0		0		0
90845	Psychoanalysis	1.79		0		0		0		0
90846	Family psytx w/o patient	1.83		0		0		0		0
90847	Family psytx w/patient	2.21	6	13.26	1	2.21		0		0
90849	Multiple family group psytx	0.59		0		0		0		0
90853	Group psychotherapy	0.59	42	24.78	59	34.81	68	40.12	138	81.42
90857	Intac group psytx	0.63		0		0		0		0
90862	Pharmacological Management	.95		0		0		0		0
90880	Hypnotherapy	2.19		0		0		0		0
90885	Psy evaluation of records	0.97	4	3.88		0		0		0
90887	Consultation with family	1.48		0		0		0		0
96101	Psycho testing by psych/phys	1.86		0		0		0		0
96102	Psycho testing by technician	0.50		0		0		0		0
96103	Psycho testing admin by comp	0.51		0		0		0		0
96105	Assessment of aphasia	1.75		0		0		0		0
96110	Developmental test, lim	0.00		0		0		0		0
96111	Developmental test, extend	2.60		0		0		0		0

NAME:		WORK	Q2		Q3		Q4		Q2	
		RVU	#	RVUs	#	RVUs	#	RVUs	#	RVUs
96116	Neurobehavioral status exam	1.86		0		0		0		0
96118	Neuropsych test by psych/phys	1.86		0		0		0		0
96119	Neuropsych testing by tech	0.55		0		0		0		0
96120	Neuropsych tst admin w/comp	0.51		0		0		0		0
96150	Assess hlth/behave, init (per 15')	0.50		0		0		0	13	6.5
96151	Assess hlth/behave, subseq (15')	0.48		0		0		0		0
96152	Intervene hlth/behave, indiv (15')	0.46		0		0		0		0
96153	Intervene hlth/behave, group (15)	0.10		0		0		0		0
96154	Interv hlth/behav, fam w/pt (15')	0.45		0		0		0		0
96155	Interv hlth/behav fam no pt (15')	0.44		0		0		0		0
97150	Group therapeutic procedures	0.27		0		0		0		0
97530	Therapeutic activities	0.44		0		0		0		0
97532	Cognitive skills development	0.44		0		0		0		0
97535	Self care mgmt training	0.45		0		0		0		0
97537	Community/work reintegration	0.45		0		0		0		0
99366	Physician/team conference	0.82	1	0.82		0		0		0
99367	Physician/team conference w/o pt	0.72		0		0		0		0
99441	Physician phone consultation	0.25		0						

NAME:		WORK	Q2		Q3		Q4		Q2	
		RVU	#	RVUs	#	RVUs	#	RVUs	#	RVUs
99442	Physician phone consultation	0.50		0						
99443	Physician phone consultation	0.75		3						
HCPCS	DESCRIPTION	RVU	#	RVUs	#	RVUs	#	RVUs	#	RVUs
	TOTALS		368	675.17	332	550.95	311	473.45	366	398.13
	Target			481.5		481.5		481.5		481.5
	% of Target			140.2%		114.4%		98.3%		82.7%

b. In the preceding example, the supervisor has given the provider a target of 481.5 RVUs per quarter based on the individual's labor mapping.

c. Following is an example of how to merge the individual providers' data into a report for a service of ten providers, noting each individual provider's quarterly target, accounting for non-clinical time labor mapped to other areas:

					Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY Total
	NAME	FTE	Time	Target	%RVU	%RVU	%RVU	%RVU	Target
1		1.0	85%	409.3	117%	129%	149%	116%	128%
2		1.0	100%	481.5	95%	122%	122%	109%	112%
3		1.0	85%	409.3	143%	134%	127%	119%	131%
4		1.0	85%	409.3	143%	212%	148%	136%	160%
5		1.0	85%	409.3	68%	108%	92%	145%	103%
6		1.0	100%	481.5	94%	104%	86%	88%	93%
7		1.0	75%	361.13	86%	88%	157%	116%	112%
8		1.0	85%	409.3	86%	78%	63%	74%	75%
9		1.0	100%	481.5	143%	212%	212%	136%	176%
10		1.0	100%	481.5	58%	97%	214%	118%	122%
	TOTAL/AVE	10.0	89%	4333.63	108%	132%	128%	115%	121%
KEY									

d. An example spreadsheet tracking all individual providers and rolling up to an overview of a service is available on the Mental Health Services Administrator Web site at: <http://vaww.mentalhealth.va.gov/>. *NOTE: This is an internal VA Web site and is not available to the public.*

e. Currently productivity cubes are not available for associated mental health providers, except psychologists. Those obtaining data on workload productivity from ACRP reports must note that differences may exist between this data and the productivity cubes as different business rules are applied. Additionally, data from the physician productivity cube does not provide

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workload credit for imputed values in Appendix B and mental health leadership should make accommodations to credit this difference.