EHR Coding Queue

Jacque Candelaria, CCS, CPC HIM Director, Santa Fe SU

Coding Queue

- Captures ALL electronically created visits into a holding queue
- Prevents visits not reviewed by data entry from passing directly to the billing package
- Visits captured include:
 - Paperless Refills
 - ALL EHR created visits

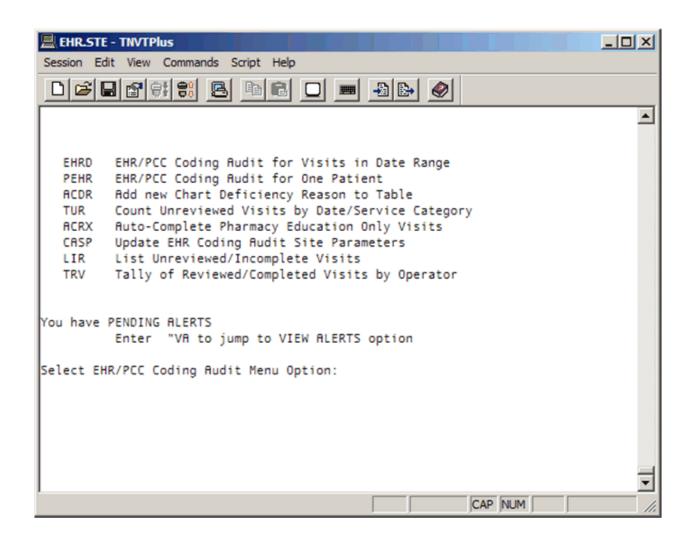
Turning on the Coding Queue

- When does my site need to turn coding queue on?
 - As soon as you turn on paperless refill you need to turn on the coding queue
- What date should my site use when turning on the coding queue?
 - Use the same date that you use when you turn on paperless refill.
- Where does my site turn on the coding queue?
 - Can be turned on in 2 places
 - PCC Manager Menu
 - EHR Chart Audit Start Date?
 - Fileman
 - EHR/Chart Audit Start Date:
 - Need to confirm all packages pass data to PCC
 - The date for the coding queue needs to be the same date that you implement paperless refill
- Who is responsible for turning on the coding queue?
 - Site manager, CAC, Data Entry Supervisor
 - Must communicate with Pharmacy or CAC in order to determine when they will implement paperless refill or documenting in EHR

How do I get to the Coding Menu?

- 1. PCC
- 2. PCC Management Reports (PCC)
- 3. Enter/Modify/Append PCC Data (ENT)
- 4. EHR/PCC Coding Audit Menu (EHRC)

Let's explore these menus



(EHRD) Visit by Date Range

- Used to audit visits that are created by EHR users
- Visit display in list are those with an INCOMPLETE or blank chart audit status
- List can be sorted by date, primary provider, clinic code, hospital location (scheduling clinic), & facility

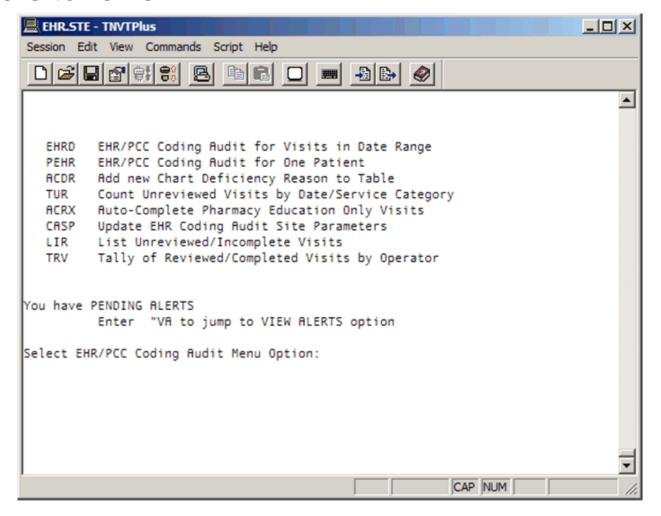
Visit by Date Range, cont'd

- Once the visit is reviewed, the reviewed status can be set to:
 - Reviewed/Complete
 - Incomplete
- All visits set as Reviewed/Complete will be passed to the IHS/RPMS TP Billing package
 - A visit will NOT pass to billing until it is marked Reviewed/Completed

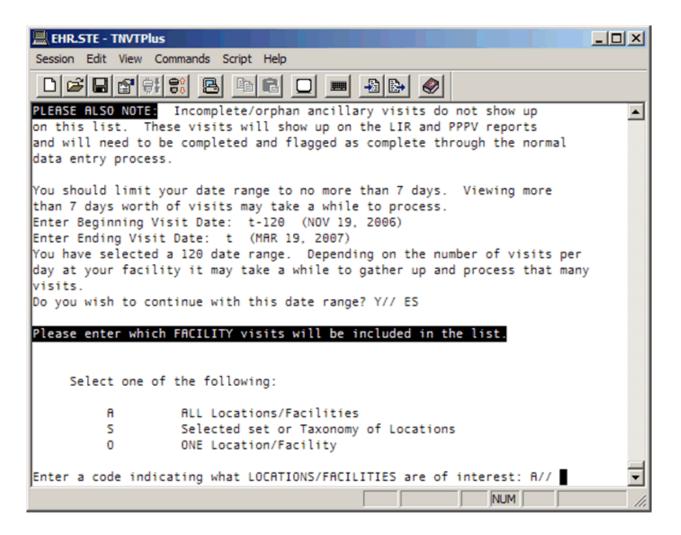
Visit by Date Range, cont'd

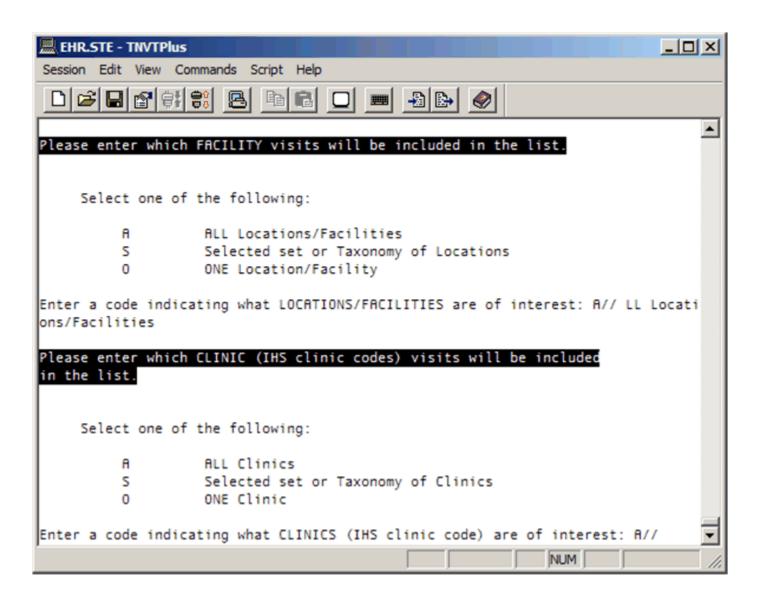
- Incomplete/Orphan ancillary visits:
 - Will **NOT** appear on the EHRD report list
 - These visits will show up on the LIR and the PPPV reports
 - This type of visits will need to be completed and flagged as complete through the normal data entry process

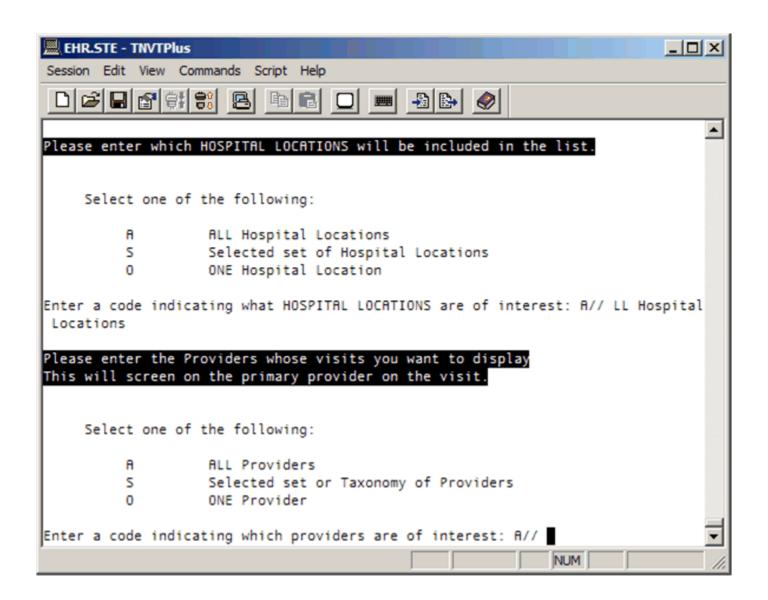
The EHRD option is where most of your work resides. At this point the coding queue will bring all visit into the queue for coders to review

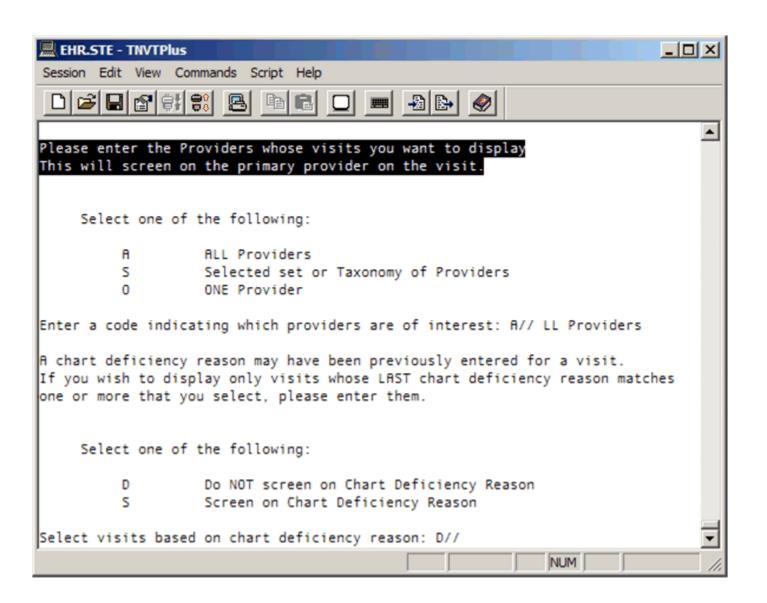


After selecting my search dates, I would follow the prompts and edit these prompts, as appropriate

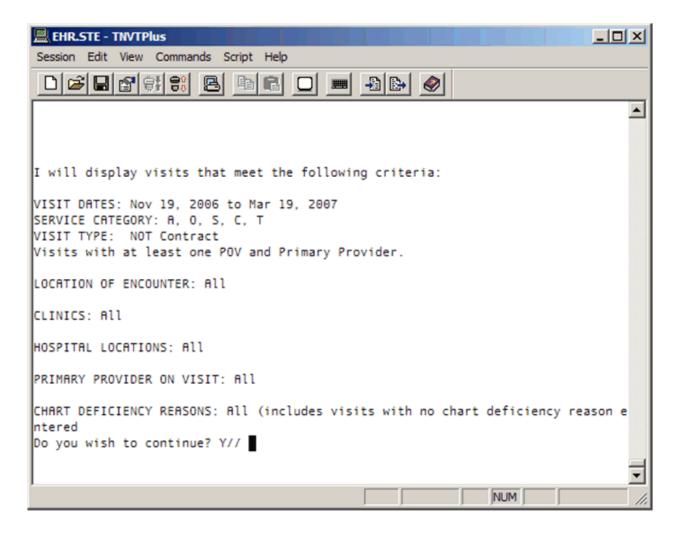


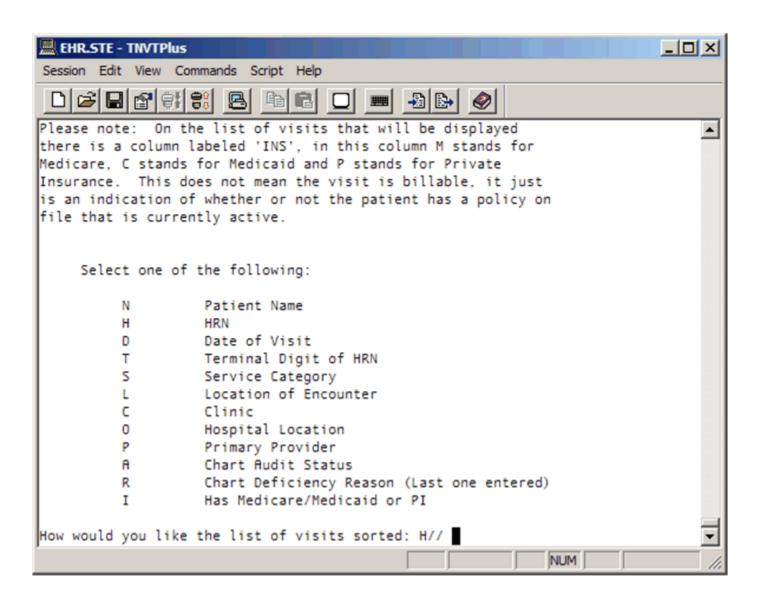


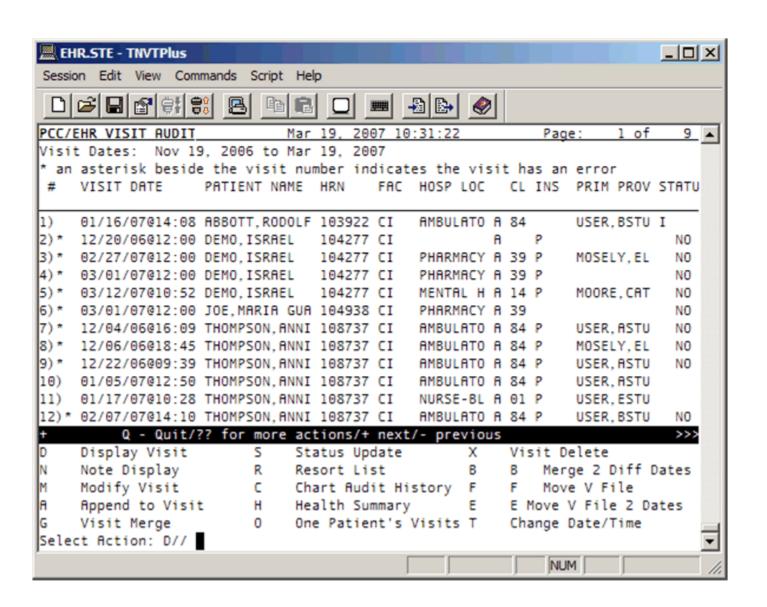




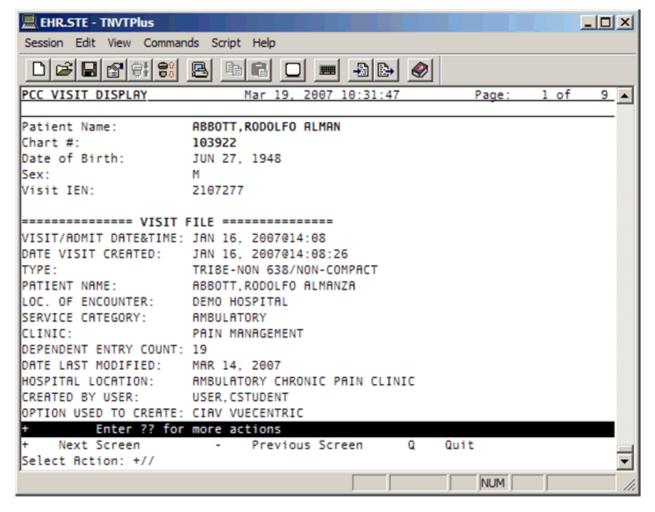
The system displays a summary of your choices. You may chose to continue or you may edit your sort fields



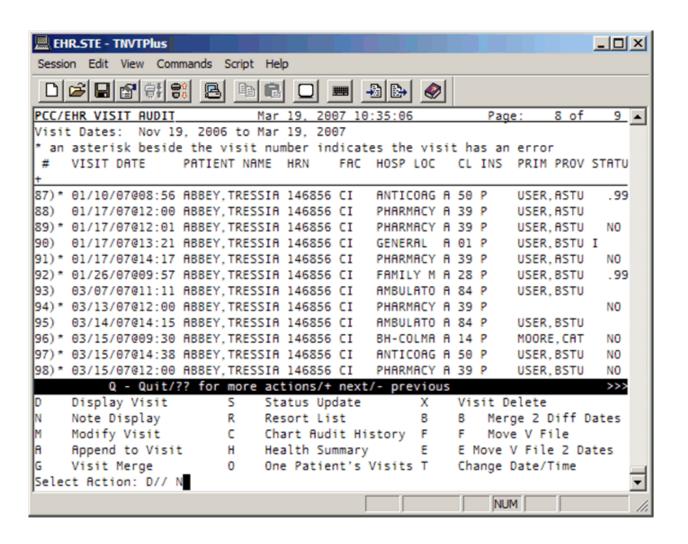




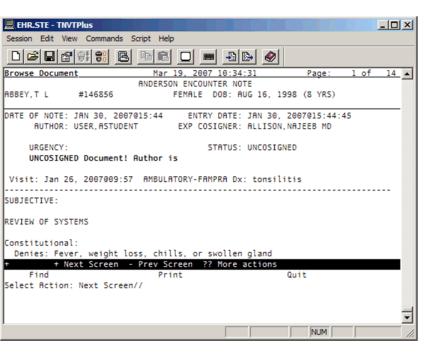
When you select Display, the system displays your visit similar to the way the DVB menu displays it in PCC

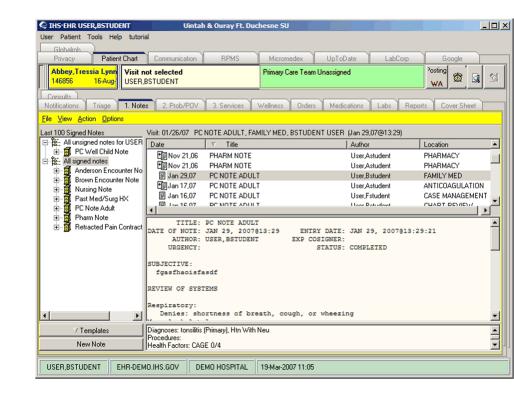


Displaying notes in the coding queue

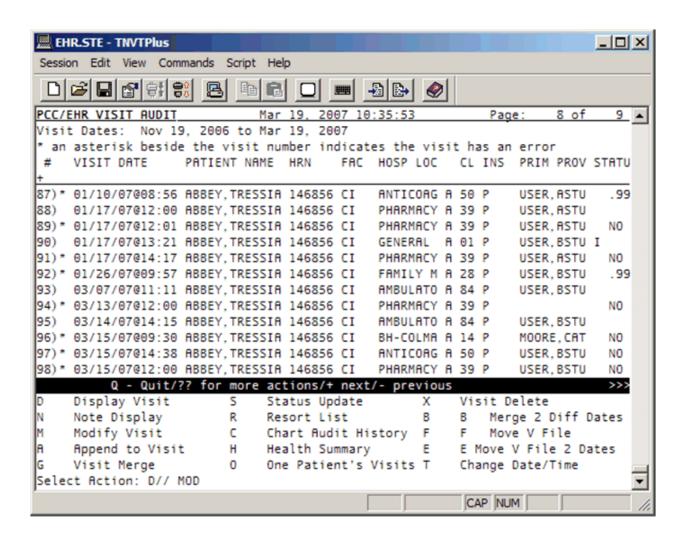


The system will display the note. Coders can view notes in the coding queue or in EHR.





Modifying visit



```
Select Action: D// MOD Modify Visit
Modify which Visit: (1-98): 92
Looking for ancillary data to merge into this visit...

MNEMONIC: PV Purpose of Visit ALLOWED VISIT RELATED ONLY
1 .9999 ABBEY, TRESSIA LYNN JAN 26, 2007@09:57
2 401.9 ABBEY, TRESSIA LYNN JAN 26, 2007@09:57

Choose: 1

POV: .9999// HTN
401.9 (HYPERTENSION NOS)
UNSPECIFIED ESSENTIAL HYPERTENSION
```

If I am not ready to release this visit, then I would mark it Incomplete

```
MNEMONIC:
Looking for ancillary data to merge into this visit ...
Do you want to update the Chart Audit Status for this visit? Y// ES
CHART AUDIT STATUS: ?
     Choose from:
                REVIEWED/COMPLETE
                INCOMPLETE
CHART AUDIT STATUS: I INCOMPLETE
CHART DEFICIENCY REASON: ??
Choose from:
   ABNORMAL LABORATORY
   BLOOD TRANSFUSION
   CAUSE OF INJURY
   CHIEF COMPLAINT
   CONSENT FORM
   CONSULTATION REPORT
   CPT CODES
```

When you mark visit incomplete, you must enter the reason why the visit was not complete.

- CHART DEFICIENCY REASON: OTHER
- Do you want to update the Chart Audit Notes for this visit? N// YES

Adding chart audit notes is a way to communicate important info to other coders

- CHART AUDIT NOTES:
- No existing text
- Edit? NO// Y

You will enter a short note here and exit by entering F1 E

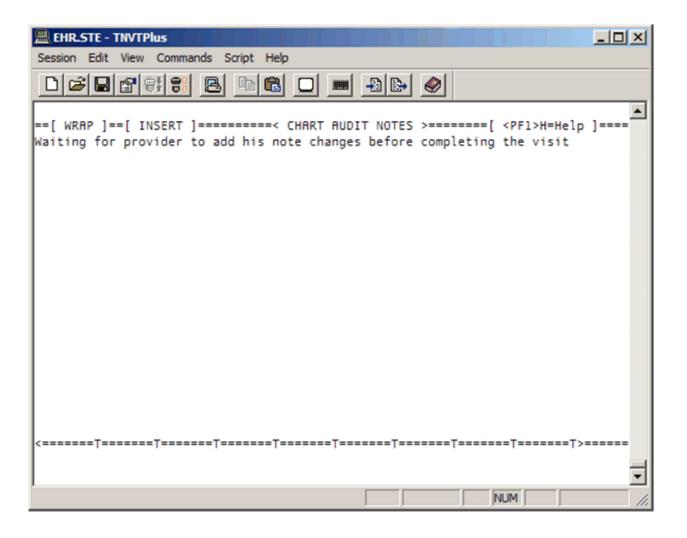
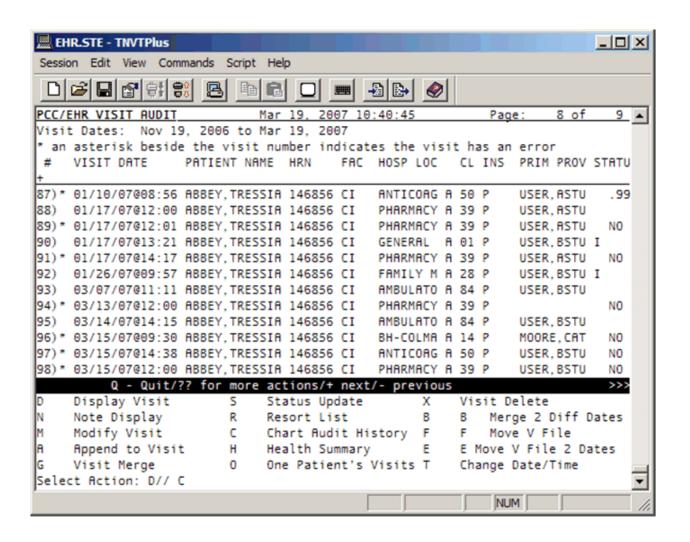
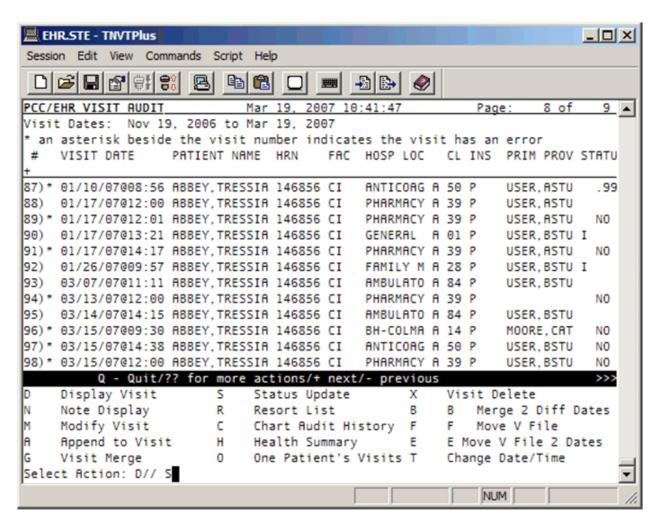


Chart Audit History

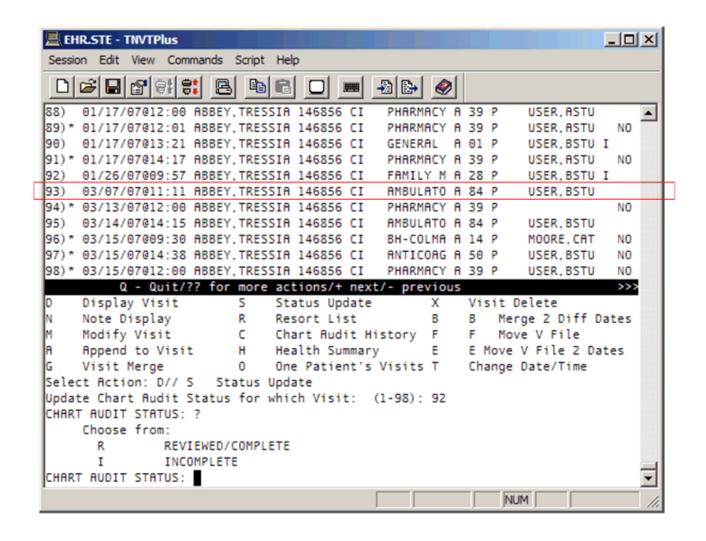


```
Select Action: D// C
     1 Chart Audit History
     2 Change Date/Time
CHOOSE 1-2: 1 Chart Audit History
Display Chart Audit History for which Visit: (1-98): 92
Chart Audit History for VISIT:
Visit Date: JAN 26, 2007@09:57 Patient Name: ABBEY, TRESSIA LYNN
Hospital Location: FAMILY MED Primary Provider: USER, BSTUDENT
DATE OF AUDIT
                   STATUS
                               USER WHO AUDITED
                                                  CHART DEFICIENCY
MAR 19, 2007@10:37 INCOMPLETE USER, BSTUDENT
                                                   OTHER
NOTES:
Waiting for provider to add his note changes before completing the
visit
Press Enter to Continue:
```

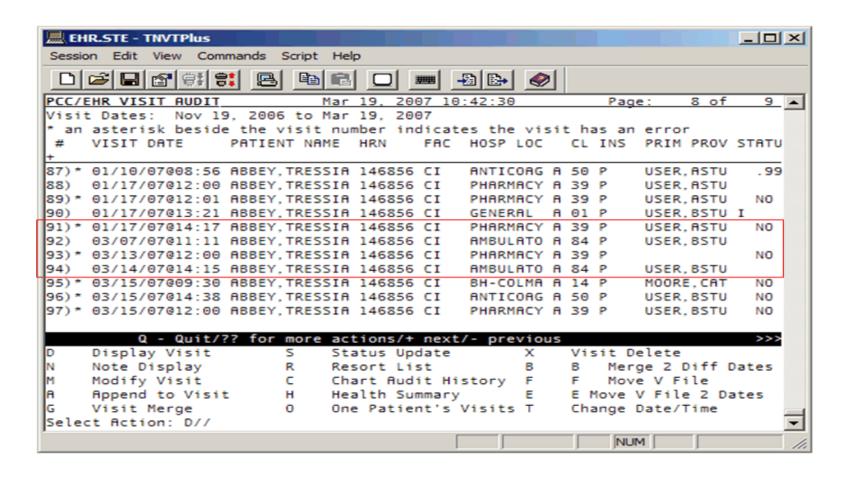
Changing the status from Incomplete to Complete/Reviewed



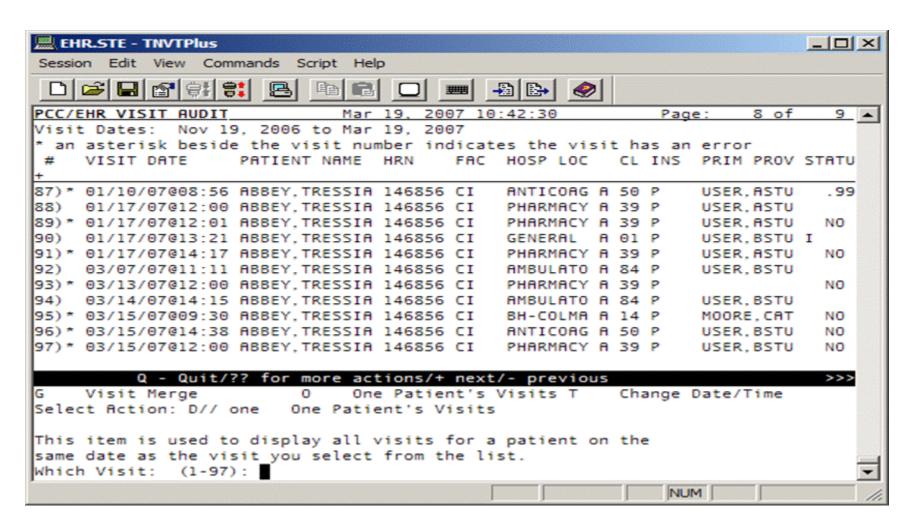
I will select R for reviewed/complete

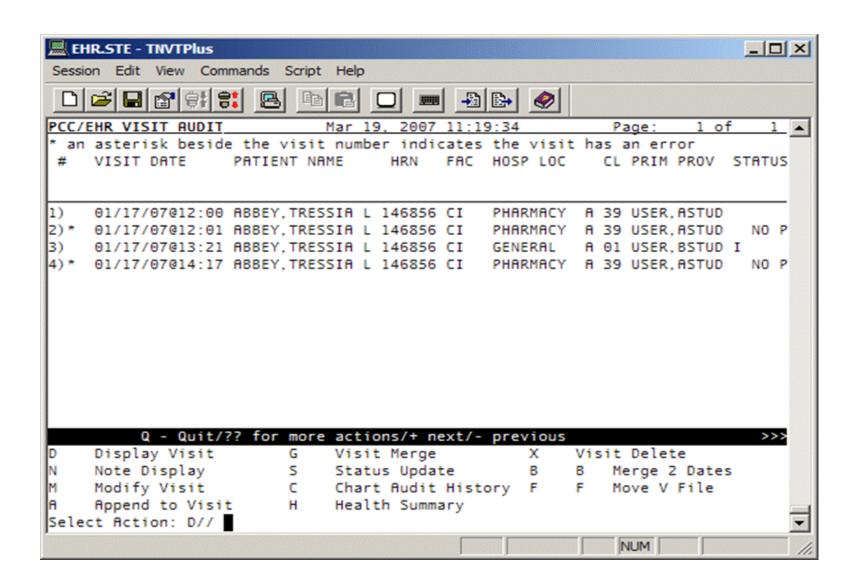


The visit is no longer in my queue

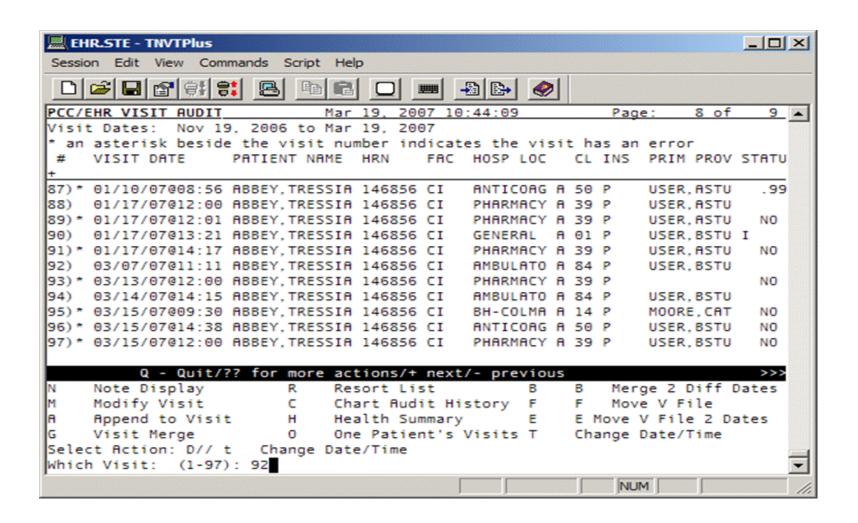


Displaying multiple visits for a patient on the same day

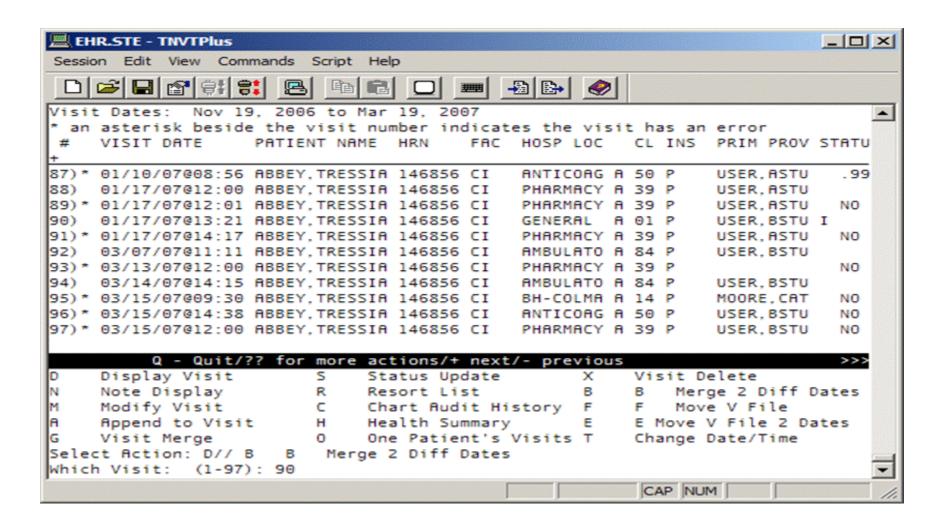


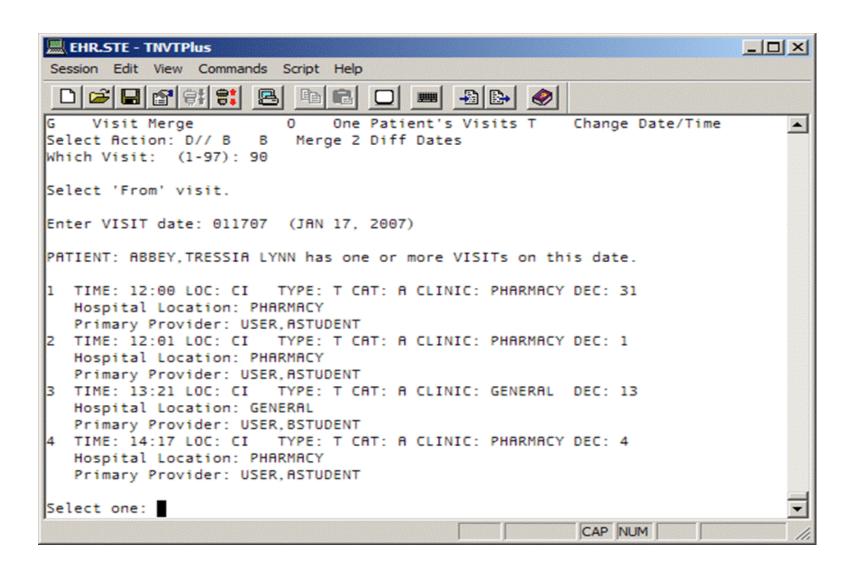


Changing date and time for a visit



Merging two visits with different dates





Adding chart deficiency reasons

ACDR Add new Chart Deficiency Reason to Table [APCDCAF ADD CHART DEF REASONS]

**> Locked with APCDZ ADD CDR

Enter "VA to jump to VIEW ALERTS option Select EHR/PCC Coding Audit Menu Option: ACDR Add new Chart Deficiency Reason to Table Select OUTPATIENT CHART DEFICIENCY REASONS: ? Answer with OUTPATIENT CHART DEFICIENCY REASONS Do you want the entire 48-Entry OUTPATIENT CHART DEFICIENCY REASONS List? Y (Yes) Choose from: ABNORMAL LABORATORY BLOOD TRANSFUSION CAUSE OF INJURY - History & Physical CHIEF COMPLAINT CONSENT FORM

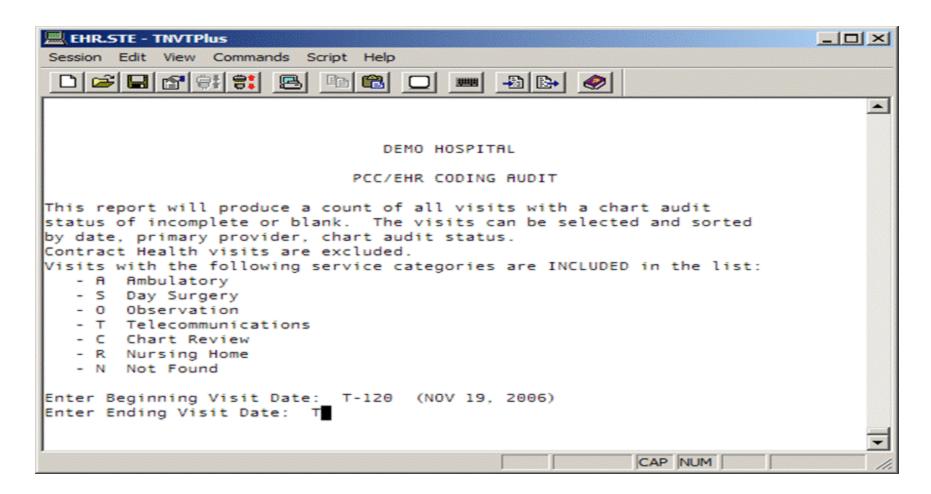
CONSULTATION REPORT

- Initials for Immunizations GIV
- Initials for Pelvic Exam
- IV Flow Sheets
- Lab POV
- Nursing Assessment
- Other
- Pathology Report
- Pediatric Record
- Problem List Updates
- Progress Notes
- Purpose of Visit
- Sign OP Report
- Sign PCC Form Nursing
- Sign PCC Form Pharmacy
- Sign PCC Form Primary Provider
- Time of Visit
- Transaction Code
- Unacceptable Abbreviations
- Vital Signs

(TUR) Count Unreviewed Visits

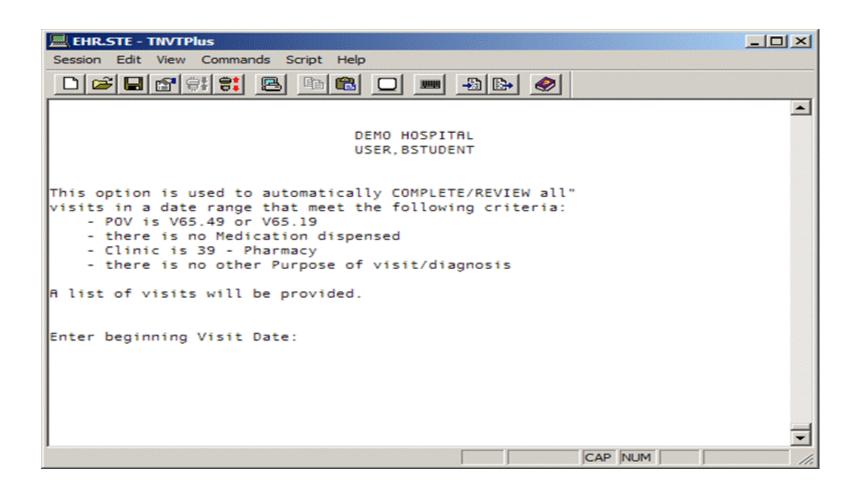
- Reports a count of all visits with a chart audit status of incomplete or blank
- Visits can be selected and sorted by:
 - Date
 - Primary provider
 - Chart audit status.
- Contract Health Visits are EXCLUDED

TUR Count Unreviewed Visits by Date/Service Category



```
Mar 19, 2007
Page: 1
                              PCC Data Entry Module
          COUNT OF VISITS WITH CHART AUDIT STATUS OF INCOMPLETE/BLANK
      **********************
              VISIT Date Range: NOV 19, 2006 through MAR 19, 2007
                   SERV CAT # UNREVIEWED VISITS
VISIT DATE
                                                             # W/NO PROV
                                                             (ANCILLARY)
Nov 21, 2006 AMBULATORY
Nov 27, 2006 AMBULATORY
Nov 28, 2006 AMBULATORY
Nov 29, 2006 AMBULATORY
              AMBULATORY
Dec 04, 2006
Dec 06, 2006 AMBULATORY
Dec 07, 2006 AMBULATORY
Dec 12, 2006 AMBULATORY
                   TELECOMMUNIC
Dec 19, 2006
              AMBULATORY
                                    1
                                                             1
```

ACRX Auto-Complete Pharmacy Education Only Visits



CASP Update EHR Coding Audit Site Parameters

```
EHR Coding Queue Parameter Update
Select PCC DATA ENTRY SITE PARAMETERS SITE NAME: DEMO HOSPITAL//
NASHVILL
E NON-IHS
          CHEROKEE
                                    NM HOSPITAL 1601
                              01
Service Category exclusions: If you would like to exclude
visits with a particular service category from the list of
visits displayed in the coding queue you must enter those
service categories to the list below. For example, if you
do not wish to have I - In Hospital visits in the list then
you should add 'I' to the list.
Please note: If you leave the list blank (empty) then all
direct (non-CHS) visits will display in the coding queue.
Event visits never display in the coding queue.
Your site is currently set up to exclude visits with the
following service categories from the coding queue:
          I - IN HOSPITAL
          H - HOSPITALIZATION
          D - DAILY HOSPITALIZATION DATA
          O - OBSERVATION
          R - NURSING HOME
     Select one of the following:
                   Add another service category to the list
                   Remove a service category from the list
                  Quit - list looks good
Do you wish to: Q//
```

Update EHR Coding Audit Site Parameters, cont'd

Do you wish to: Q// uit - list looks good

You have the option of seeing all visits in the coding queue regardless of how they were created. You can see all visits or limit the list of visits in the coding queue to only those on which a provider has been entered. If you choose to only see visits on which a provider was entered then you will not see visits that were created by an ancillary package. Most, if not all visits created by EHR users will have provider.

Include all visits in the coding queue list?: YES, INCLUDE VISITS WITH NO PROVIDER//

You can change the default to NO.

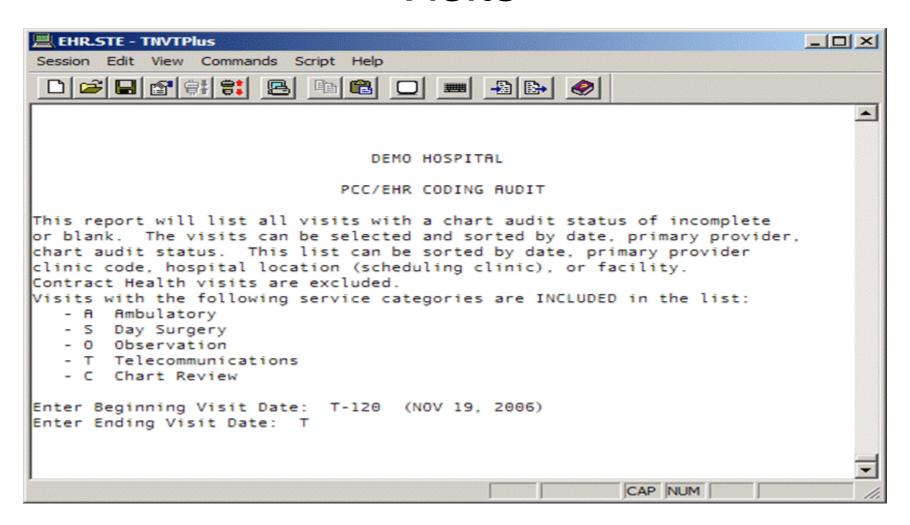
Default Response for 'Is Coding Complete?' in Data Entry: ?

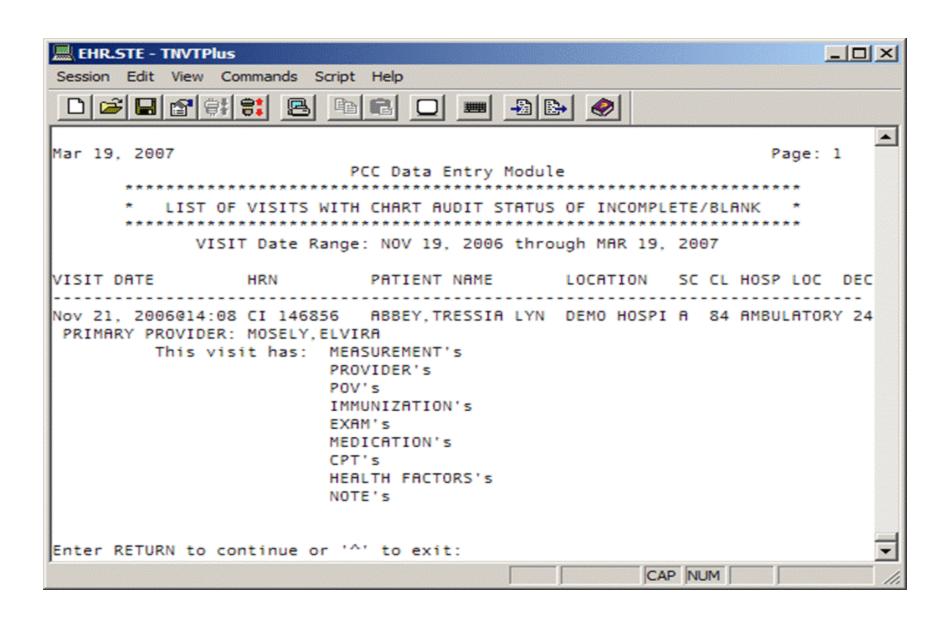
Choose from:

Y YES

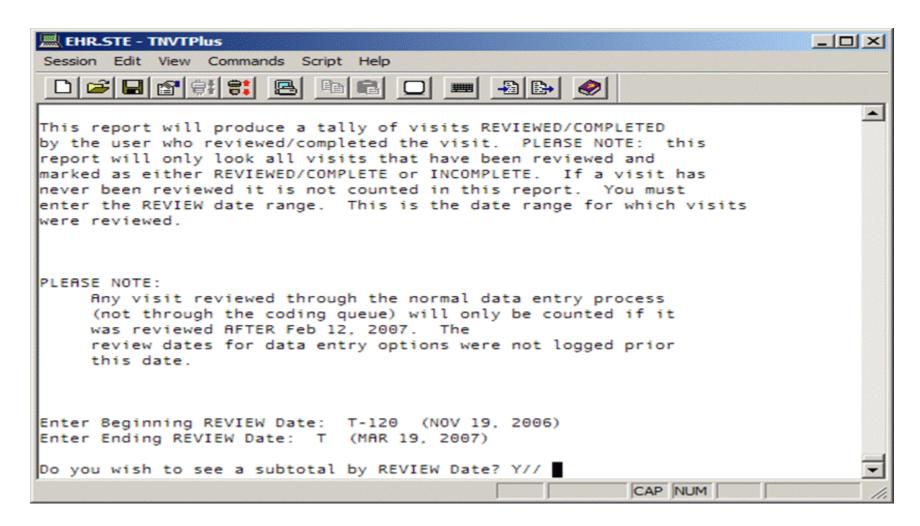
N NO

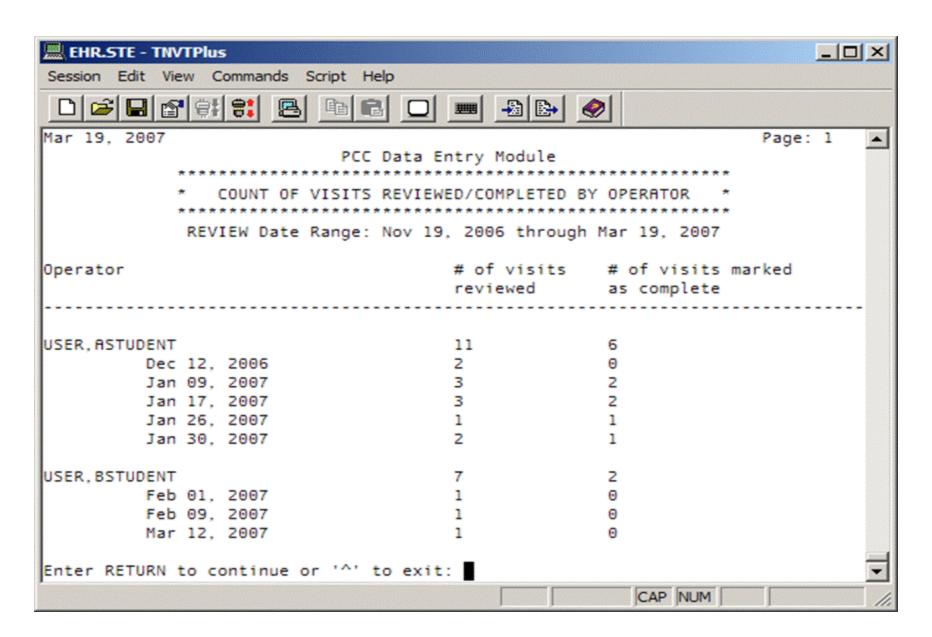
LIR List Unreviewed/Incomplete Visits





TRV Tally of Reviewed/Completed Visits by Operator





Recommendations

- All visits should be completed REGARDLESS if they are billable or not
- When documenting chart deficiency reasons try not to select OTHER
 - Not enough information for other coders or supervisors reviewing incomplete visits in the future.

Downside to NOT maintaining Coding Queue

- Increased 9999 codes
- Missing provider
- Missing POV
- Missing CPT

Communication

- Data Entry needs to communicate with Clinical Applications Coordinator if issues/errors become repetitive
- CAC needs to inform Data Entry when new providers or clinics go live with EHR so they can review their data daily
- Data Entry needs to work with users to teach them how to code correctly and efficiently

Questions?