THE INDIAN HEALTH SERVICE

PCC Data Entry
Coding Queue

RPMS EHR

Electronic Health Record

Superior Health Information Management
Now and for the Future

Patient Care Component (PCC) Coding Queue

- Captures ALL electronically created visits into a holding queue (like standing in line at the bank)
  - Paperless Refills
  - ALL EHR created visits
- Prevents visits not reviewed by the coder/data entry from passing directly to the TP Billing package

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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?**
  - *Use PCC Master Control File. See Coding Queue setup power point.*
- **Who is responsible for turning on the coding queue?**
  - HIM Director, PCC Supervisor, CAC, Site manager.
  - Must communicate with Pharmacy or CAC in order to determine when they will implement paperless refill or documenting in EHR.

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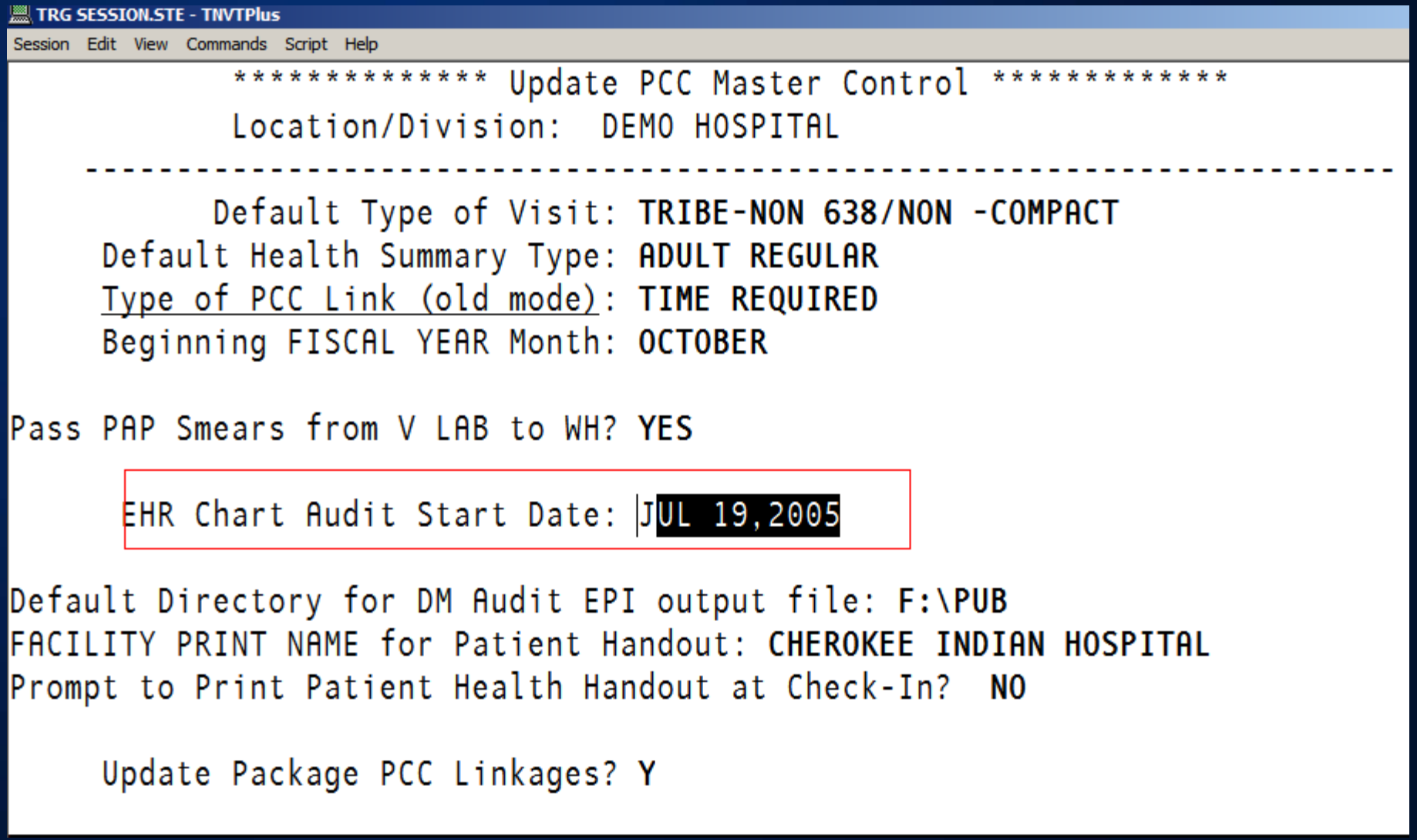
Turning on the Coding Queue



PCC Data Entry Module

How do I get to the Coding Queue Menu?

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

EHR/PCC Coding Audit Menu

What is the difference between the coding queue reports?

- EHRD
  - EHR/PCC Coding Audit for Visits in Date Range
- PEHR EHR/PCC
  - Coding Audit for One Patient
- TUR
  - Count Unreviewed Visits by Date/Service Category
- LIR
  - List Unreviewed/Incomplete Visits

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EHRD

Visit by Date Range

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

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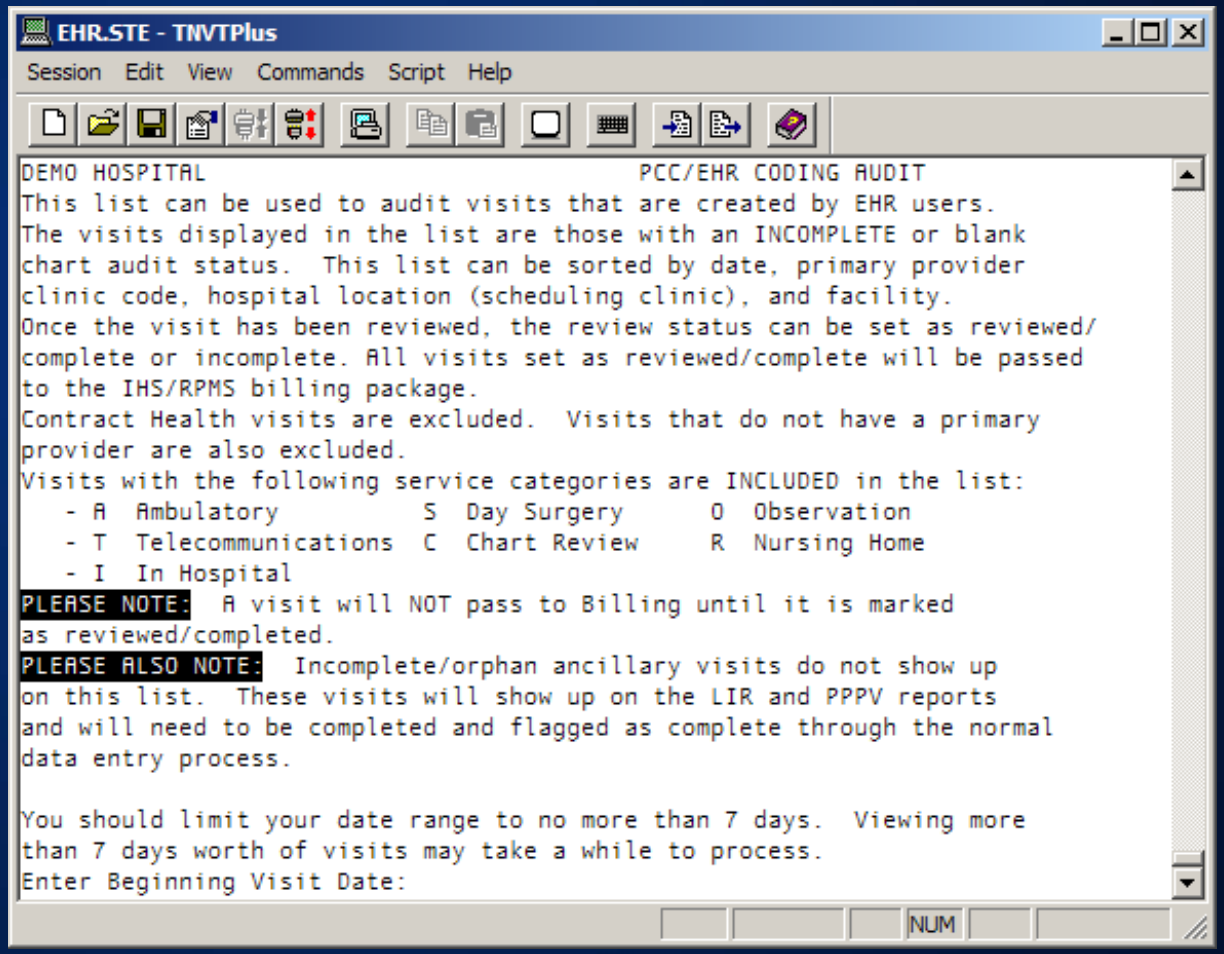
EHRD Menu


EHR.STE - TNVTPlus
Session Edit View Commands Script Help
DEMO HOSPITAL PCC/EHR CODING AUDIT
This list can be used to audit visits that are created by EHR users.
The visits displayed in the list are those with an INCOMPLETE or blank
chart audit status. This list can be sorted by date, primary provider
clinic code, hospital location (scheduling clinic), and facility.
Once the visit has been reviewed, the review status can be set as reviewed/
complete or incomplete. All visits set as reviewed/complete will be passed
to the IHS/RPMS billing package.
Contract Health visits are excluded. Visits that do not have a primary
provider are also excluded.
Visits with the following service categories are INCLUDED in the list:
- A Ambulatory S Day Surgery O Observation
- T Telecommunications C Chart Review R Nursing Home
- I In Hospital
PLEASE NOTE: A visit will NOT pass to Billing until it is marked
as reviewed/completed.
PLEASE ALSO NOTE: Incomplete/orphan ancillary visits do not show up
on this list. These visits will show up on the LIR and PPPV reports
and will need to be completed and flagged as complete through the normal
data entry process.
You should limit your date range to no more than 7 days. Viewing more
than 7 days worth of visits may take a while to process.
Enter Beginning Visit Date:
NUM

EHRD
Visit by Date Range

- Once the visit is reviewed, the reviewed status can be set to:
  - Reviewed/Complete (visit data and coding are complete and accurate)
  - Incomplete (no documentation for a diagnosis, missing POV, waiting lab result). *This choice requires a reason*.

EHRD
Visit by Date Range

- 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

Do you want to update the Chart Audit Status for this visit? Y//

CHART AUDIT STATUS: REVIEWED/COMPLETE

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EHRD
Visit by Date Range

- 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

EHRD
Visit by Date Range

- Visits with the following service categories are included in the visits
  - (A) Ambulatory
  - (T) Telecommunications
  - (I) In Hospital
  - (S) Day Surgery
  - (C) Chart Review
  - (O) Observation
  - (R) Nursing Home

EHRD
Visit By Date Range

How do I run the EHRD report?

- Limit your date range to 7 days or less
  - Beginning and ending dates
- Select the Facility
- Select a Clinic
- Select Hospital Locations
- Select Providers

EHRD
Visit By Date Range

- Select Visit Based on Chart Deficiency Reason
  - (D) Do NOT screen on Chart Deficiency Reason
  - (S) Screen on Chart Deficiency Reason
- Sort Visit

EHRD
Visit By Date Range

- An asterisk * beside the number indicates that data is missing from the visit
- By using the right arrow key you can scroll to the right side of the screen to see what data is required before the visit can be completed
- Possible reasons for an asterisk* includes:
  - NO POV
  - 9999 Code
  - Missing Provider

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EHRD
Visit By Date Range

- More Actions
  - **Display Visit** – display the data captured from the electronic order entry
  - **Note Display** – view the EHR note
  - **Modify Visit** – allows Coders to EDIT data already in the electronic visit
  - **Append to Visit** – allows Coders to add NEW data to the electronic visit

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EHRD
Visit By Date Range

- More Actions cont…
  - **Visit Merge** – Allows Coders to merge orphan visits w/ primary visit
  - **Status Update** – Update visit from unreviewed/incomplete to reviewed/complete
  - **Re-sort List** – Allows Coder to select other sort options
  - **Chart Audit History –** Displays reason's why visit has not be been reviewed/completed
  - **Health Summary** – Displays patients health summary
  - **One Patient's Visits** – Displays individual patient visits
  - **Visit Delete** – Allows the Coder with the appropriate key to delete the visit

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PEHR

Coding Audit for one patient

PEHR
Audit for One Patient

- Used to review visits created by EHR users for ONE patient
- Visits displayed in list are those with an INCOMPLETE or BLANK audit status
- List can be sorted by date, primary provider, clinic code, hospital location (scheduling clinic), and facility
- Visit must be reviewed before they will pass to the IHS/RPMS billing package

RPMS EHR

PEHR
Audit for One Patient

- Visits with the following service categories are included in the visits
  - (A) Ambulatory
  - (T) Telecommunications
  - (I) In Hospital
  - (S) Day Surgery
  - (C) Chart Review
  - (O) Observation
  - (R) Nursing Home

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PEHR
Audit for One Patient

- Select Patient Name
- Sort visit by:
  - Date of Visit
  - Service Category
  - Location of Encounter
  - Clinic
  - Hospital Location
  - Primary Provider
  - Chart Audit Status
  - Chart Deficiency Reason (Last one entered)

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Audit for One Patient

PCC/EHR VISIT AUDIT Sep 16, 2009 11:52:57 Page: 1 of 3

Visit Dates: Jul 19, 2005 to Sep 16, 2009

* An asterisk beside the visit number indicates the visit has an error

#	VISIT DATE	PATIENT NAME	HRN	FAC	HOSP LOC	CL	INS	PRIM PROV	STATU
1)	05/15/06@13:55	DEMO,ISRAEL	104277	CI	AMBULATO A 84	P		USER,CSTU	
2)	05/16/06@14:00	DEMO,ISRAEL	104277	CI	AMBULATO A 84	P		USER,CSTU	
3)	05/16/06@16:10	DEMO,ISRAEL	104277	CI	AMBULATO A 84	P		USER,CSTU	
4)*	05/17/06@13:10	DEMO,ISRAEL	104277	CI	AMBULATO A 84	P		USER,CSTU	NO
5)*	10/31/06@13:00	DEMO,ISRAEL	104277	CI	FAMILY M A 28	P		USER,ESTU	NO
6)*	12/20/06@12:00	DEMO,ISRAEL	104277	CI	A	P		NO	

RPMS EHR

TUR

Count Unreviewed Visits

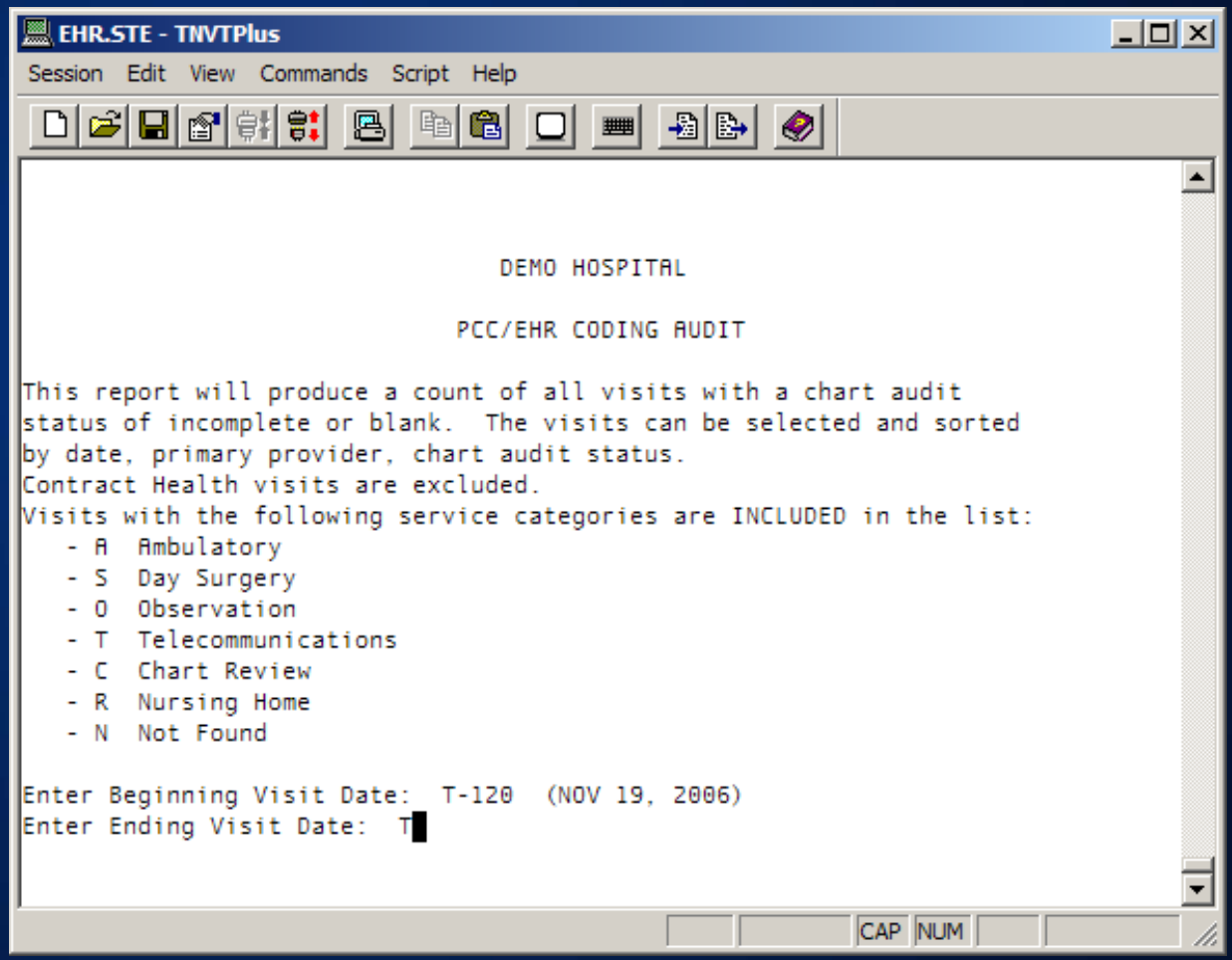
TUR
Count Unreviewed Visits

- 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

Count Unreviewed Visits by Date/Service Category

- Select TUR option
- Visits included in TUR:
  - Ambulatory
  - Day Surgery
  - Observations
  - Telecommunications
  - Chart Review
  - Nursing Home
  - Not Found
- Use same process as in EHRD (slide 12)

Count Unreviewed Visits



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ACRX

Auto-Complete Pharmacy Education

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ACRX

- It automatically completes/reviews all visits in a date range that meet all of the following criteria:
  - POV is V65.49 (other specified counseling) or V65.19 (other person consulting on behalf of another person)
  - There is no meds dispensed
  - Clinic code is 39 (Pharmacy)
  - There is no other POV or visit/diagnosis

ACRX

```
                                        DEMO HOSPITAL
                                        MOSELY,ELVIRA


This option is used to automatically COMPLETE/REVIEW all"
visits in a date range that meet the following criteria:
     - POV is V65.49 or V65.19
     - there is no Medication dispensed
     - Clinic is 39 - Pharmacy
     - there is no other Purpose of visit/diagnosis

A list of visits will be provided.


Enter beginning Visit Date:
```

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CASP

Coding Audit Site Parameters

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CASP

This option is used to customize a facility's list of service categories in the Coding Queue

- Add or exclude visits with a particular service category (never exclude ambulatory visits)
- For example if you want observation in the list, then you add O – Observation

Coding Audit Site Parameters

```
Your site is currently set up to exclude visits with the
following service categories from the coding queue:
          I - IN HOSPITAL
          H - HOSPITALIZATION
          O - OBSERVATION
          D - DAILY HOSP DATA

     Select one of the following:

          A         Add another service category to the list
          R         Remove a service category from the list
          Q         Quit - list looks good

Do you wish to: Q//
```

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LIR

List Unreviewed/Incomplete Visits

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LIR
List Unreviewed/Incomplete Visits

- Reports all visits with a chart audit of incomplete or blank
- Visits can be sorted by:
  - Date
  - Primary provider
  - Clinic code
  - Hospital location (scheduling clinic)
  - Facility

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LIR
List Unreviewed/Incomplete Visits

- Visits with following service categories are included:
  - Ambulatory
  - Day Surgery
  - Observation
  - Telecommunications
  - Chart Review
- Select Facility Visits
- Select Clinic (IHS Clinic Codes) visits
- Select F

List Unreviewed/Incomplete Visits

```
                                DEMO HOSPITAL

                            PCC/EHR CODING AUDIT

This report will list all visits with a chart audit status of incomplete
or blank.  The visits can be selected and sorted by date, primary provider,
chart audit status.  This list can be sorted by date, primary provider
clinic code, hospital location (scheduling clinic), or facility.
Contract Health visits are excluded.
Visits with the following service categories are INCLUDED in the list:
   - A  Ambulatory
   - S  Day Surgery
   - T  Telecommunications
   - C  Chart Review
   - R  Nursing Home
   - N  Not Found

Enter Beginning Visit Date:
```

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INCV

List Visits Marked as Incomplete

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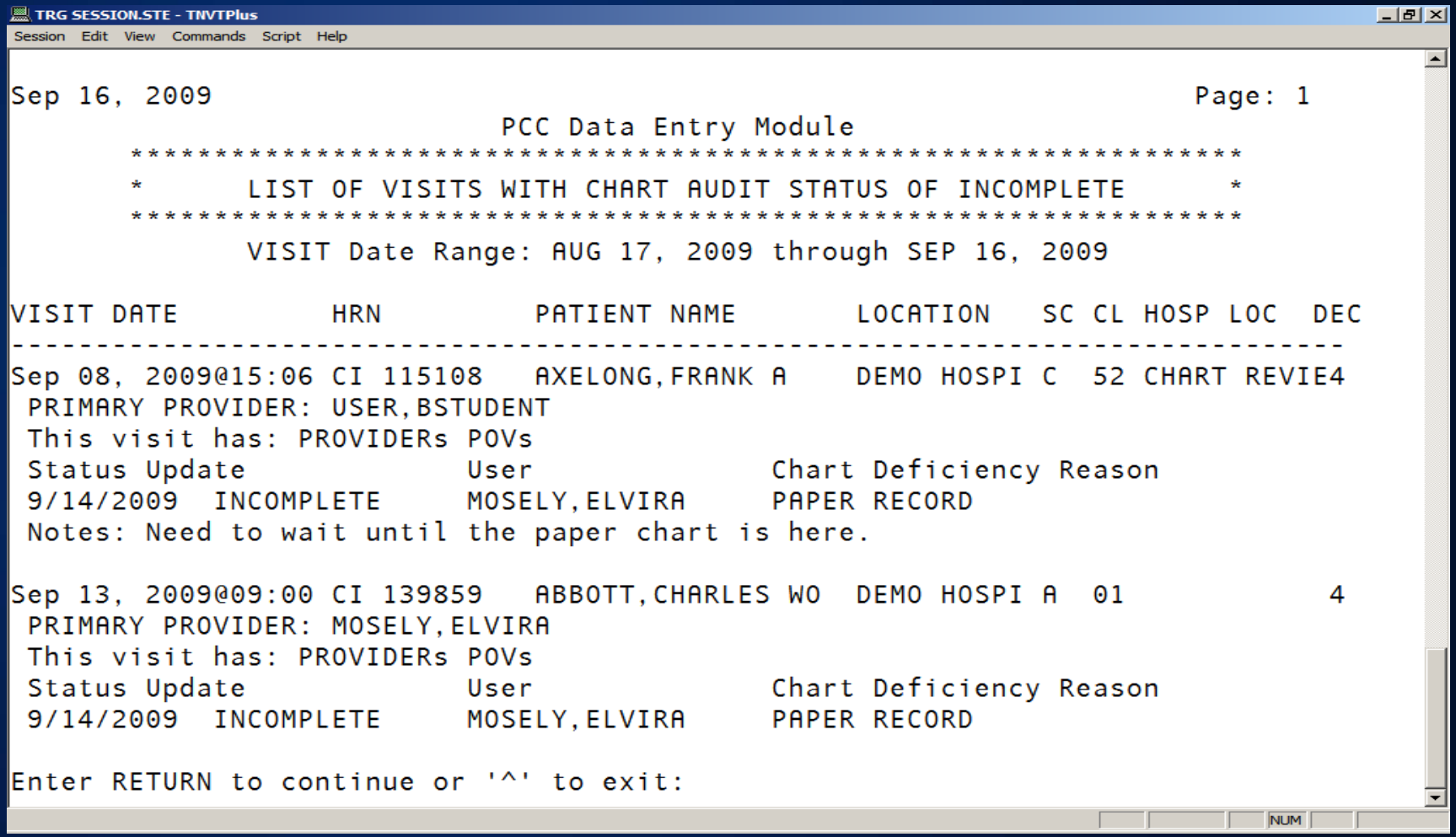
TRG SESSION.STE - TNVTPlus
Session Edit View Commands Script Help
Sep 16, 2009 Page: 1
PCC Data Entry Module
LIST OF VISITS WITH CHART AUDIT STATUS OF INCOMPLETE
VISIT Date Range: AUG 17, 2009 through SEP 16, 2009
VISIT DATE HRN PATIENT NAME LOCATION SC CL HOSP LOC DEC
Sep 08, 2009@15:06 CI 115108 AXELONG,FRANK A DEMO HOSPI C 52 CHART REVIE4
PRIMARY PROVIDER: USER,BSTUDENT
This visit has: PROVIDERs POVs
Status Update User Chart Deficiency Reason
9/14/2009 INCOMPLETE MOSELY,ELVIRA PAPER RECORD
Notes: Need to wait until the paper chart is here.
Sep 13, 2009@09:00 CI 139859 ABBOTT,CHARLES WO DEMO HOSPI A 01 4
PRIMARY PROVIDER: MOSELY,ELVIRA
This visit has: PROVIDERs POVs
Status Update User Chart Deficiency Reason
9/14/2009 INCOMPLETE MOSELY,ELVIRA PAPER RECORD
Enter RETURN to continue or '^' to exit:
NUM

TRV

Tally of Reviewed/Completed Visits by Operator

TRV

- This report looks at all visits reviewed, and all visits marked as complete by the user/operator.
- Use this report for managing workload and user/operator productivity.

TRV

PCC Data Entry Module

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* **COUNT OF VISITS REVIEWED/COMPLETED BY OPERATOR** *

****

REVIEW Date Range: Jun 18, 2009 through Sep 16, 2009

Operator	# of visits reviewed	# of visits marked as complete
USER,OSTUDENT	4	2
MOSELY,ELVIRA	4	1
Total Number of Visits:	8	3

End of report. PRESS ENTER:

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Coding Queue
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:

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Entering Chart Deficiencies

- Incomplete visit data will be marked as Incomplete and a reason will be entered.
- Notification should be sent to the provider for clarifications, advising of code changes, omissions, etc.
- Coders should follow-up on notifications.
- Marking the chart incomplete will prevent the visit from going to third party billing.

Chart Deficiency Reasons

Chart Deficiency Reasons cont…

- Abnormal Laboratory
- Blood Transfusion
- Cause of Injury
- Chief Complaint
- Consent Form
- Consultation Report
- CPT Codes
- Date of Visit
- DICT OP Report
- Documentation for Procedures
- E&M Code by Provider
- EKG Code by Provider
- EKG Report
- ER Condition of Discharge
- ER Discharge Time
- ER Disposition
- ER Means of Arrival
- ETOH/Employment Related
- HCPCS Codes

Add reasons using the ACDR option

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ACDR

Adding Chart Deficiency Reason

RPMS EHR

ACDR Keys

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

**> Locked with APCDZ ADD CDR

Adding a new Chart Deficiency Reason

Select EHR/PCC Coding Audit Menu Option: ACDR Add new Chart Deficiency Reason To Table

Select OUTPATIENT CHART DEFICIENCY REASONS: ??

Choose from:

- ABNORMAL LABORATORY
- BLOOD TRANSFUSION
- CAUSE OF INJURY
- CHIEF COMPLAINT

Select OUTPATIENT CHART DEFICIENCY REASONS: PAT'S REASON

Are you adding 'PAT'S REASON' as a new OUTPATIENT CHART DEFICIENCY REASONS (the 51ST)? No// Y (Yes)

REASON: PAT'S REASON//

Complete Electronic Chart Review

- Review PCC Data Entry Reports including coding queue reports
- Review all electronic health record data
- IF still using paper – review for consistencies in the EHR

Daily Reports

Recommend that HIM run these reports daily

- EHRD report
- LIR report
- Uncoded Diagnosis report

Coding Queue Recommendations

- All visits should be completed REGARDLESS if they are billable or not
- When documenting chart deficiency reasons, if OTHER is selected, enter in appropriate information.

Data Entry and Coding Outsource

- It is emphasized to use reason codes for all deficiencies.
- It is optimal to ensure that comments are used with the OTHER reason option.
- Ensure that clear lines of responsibilities are delineated between the vendor and facility.

Downside to NOT maintaining Coding Queue

- Increased 9999 codes
- Missing provider
- Missing POV
- Missing CPT
- Decreased cash flow

Communication

- Data Entry/Coder needs to communicate with HIM Director and the provider if issues/errors become repetitive
- The HIM Director should communicate with the HIM Committee when issues are not resolved
- CAC needs to inform HIM Director and Data Entry/Coder when new providers or clinics go live with EHR so they can review their data daily
- The appropriate HIM staff person needs to work with providers and CACs regarding documentation

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Questions?

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