ENCLOSURE 1
ARMY
FY 2015 DATA QUALITY MANAGEMENT CONTROL REVIEW LIST

Table 1. Data Quality Management Control Review List

Instructions: The Military Treatment Facility (MTF) Data Quality (DQ) Manager and members of the DQ Assurance Team (or other designated structure) will forward the completed DQMC Review List to the MTF Executive Committee and Commander for review, coordination and action to meet timelines for completing the Commander's Data Quality (DQ) Statement, **to be signed by the Commander of the MTF**. Fill in the form with a Yes or No answer, count or percentage, date or other entry as indicated. The completed list provides information for the completion of the monthly Commander's Data Quality Statement. **Bolded items contain data required to complete the Commander's Data Quality Statement. Explain negative responses with proposed corrective actions in the comment sections.** The Review list is an internal tool to assist in identifying and correcting financial and clinical workload data problems. All items on this checklist will be completed on a monthly basis (data month – 2 months prior) unless otherwise specified or the question does not apply to the MTF in which case the answer is Not Applicable (na). For tracking purposes, the completed forms and accompanying working papers or audit support documents (summary level only and supports answers to the Review List) must be kept on file for five years or as otherwise noted in supporting guidance for the statements in Sections A-F below:	
A . Organizational Factors	
Leadership commitment and support are critical to assure the appropriate environment for data quality. Questions A.5 – A.7 are to be completed quarterly and all others in this section to be completed monthly.	
POC Name(s) and Phone Number(s)	
A.1. The MTF Commander signed last month's Commander's Data Quality Statement acknowledging responsibility for the quality of data reported from the MTF.	Date signed:
A.2. The MTF DQ Manager submitted last month's Commander's Data Quality Statement to the Service's respective DQ Manager(s).	Date submitted:
A.3. The Data Quality Assurance Team or other designated structure met during the month to complete the DQMC Review List. (Recommend attaching meeting minutes.) Data Month: _____	Date completed:
A.4. The DQ Manager briefed last month's DQMC Review List, and Financial and Workload Data Reconciliation and Validation results to the MTF Executive Committee. (Question 13 of DQ Statement.)	**Date briefed:**
A.5. Does your MTF have a Coding Compliance Plan. a) Reviewed and approved annually for update? Date: _____ b) Reviewed and approved quarterly for compliance? Date: _____	Yes or No a) b)
A.6. Does your MTF have a Uniform Business Office (UBO) Compliance Plan. a) Reviewed and approved annually for update? Date: _____ b) Reviewed and approved quarterly for compliance? Date: _____	Yes or No a) b)
A.7. Has your Data Quality Manager or Data Quality Assurance Team members attended: a) Data Quality Training Course (DQ Manager in the last three years) or DQMC Webinars (at least two in the FY)? Date(s) attended: _____ b) Data Quality Training Course (DQ Assurance Team) or DQMC Webinars (at least two in the FY)? Latest date(s) attended: _____ c) Have the members of the DQ Assurance Team been trained in their area of responsibility? Note: A.7.c is to be used locally to ensure that team members have training in their functions and responsibilities. (E.g., Analysis: WISDOM; Medical Expense and Performance Reporting System (MEPRS): MADI; Uniformed Business Office (UBO): webinars; Patient Administration (PAD): Service PAD Course.)	Yes or No a) b) c)
A.8. Was there evidence in meeting minutes or other sources of corrective plans, of appropriate resourcing and actions to follow-up on the previous month's negative findings?	Yes or No
A. Comments: (Include comments for any items reflected above as non-compliant, to include corrective actions being taken, incident tickets initiated (if applicable), impact of incident, and estimated correction date.)	

Table 1. Data Quality Management Control Review List, Continued

B . Data Input		
Controls in this category are designed to ensure data are entered into the application in an accurate, complete, and timely manner. The following procedures must exist: *1) There will be a point of contact (POC) appointed in writing for each system that the MTF uses.* *2) There will be procedures and documentation in place to ensure that all assigned personnel responsible for data entry receive training and education on all data entry system that the MTF uses (such as CHCS, MEPRS (EAS), and ADM etc.).* *3) There will be written Standard Operating Procedures (SOPs) in place to assure routine system software and hardware maintenance for all systems that the MTF has control over.*		
POC Name(s) and Phone Number(s)		
B.1. List the current version of software being used? Version released will be centrally populated.	Most recent DHA version released	MTF software version used
a) AHLTA b) CCE (centrally managed) c) CHCS d) DMHRSi (centrally managed) e) Essentris f) MEPRS (EAS) (centrally managed)	a) b) na c) d) na e) f) na	a) b) na c) d) na e) f) na
B.2. Are data month central system upgrades (and associated loading activities) being received and loaded. Annual ICD Codes should be available by Oct 1: Date received a) AHLTA _____ b) CCE _____ c) CHCS _____ Annual CPT and HCPCS Codes should be available by Jan 1: Date received d) AHLTA _____ e) CCE _____ f) CHCS _____		Date loaded a) b) c) Date loaded d) e) f)
B.3. There will be written procedures readily available and used by staff for entering, identifying, correcting, and reprocessing data into the systems applicable to the MTF. Were all rejected data corrected and retransmitted? (As applicable.)	Count	Percentage
a) AHLTA Formula: Number of AHLTA ADM write-back errors corrected / number of AHLTA ADM write-back errors. b) CHCS Formula: Number of Patient Information Transfer (PIT) errors corrected / number of PIT errors	a) ___/____ b) ___/____	a)_____% b)_____%

Table 1. Data Quality Management Control Review List, Continued

B . Data Input (Continued)		
B.4. In the data month (include only B* and FBN* accounts):**	**Count**	**Percentage**
a) What percentage of appointments was closed in meeting your "End of Day" processing requirement, "Every appointment – Every day?" (Question 1a of DQ Statement.) Formula: Number of closed CHCS appointments / total CHCS appointments for the month.	**a)** ___/____	**a)**_____%
		Yes or No
b) Has the CHCS Monthly Statistical Report been successfully run?		b)
c) Were all workload discrepancies on the CHCS Monthly Statistical Report corrected prior to processing the WAM files?	Number of Admin Closed Encounters	c)
d) Do you have a process or policy in place to ensure the appropriate use of using "admin" when closing encounters in CHCS? NOTE: Administratively closing an appointment is as if the appointment never existed. "Admin" should be used for one of the reasons below: 1. Training and Testing purposes 2. Duplicate encounters 3. Appointment created in error	d) _____	d)
B.5. In accordance with legal and medical coding practices have all of the following occurred (See Applicable DoDD or DoDI on Medical Records Retention and Coding) : (Question 2 (a, b, c) of DQ Statement)	**Count**	**Percentage**
a) What percentage of Outpatient Encounters, other than Ambulatory Procedure Visits (APVs), has been coded within 3 business days of the encounter? (E.g., if day of encounter is Monday, then coding must be completed by the third business day, Thursday, close of business.)	**a)** ___/____	**a)**_____%
b) What percentage of APVs has been coded within 15 calendar days of the encounter?	**b)** ___/____	**b)**_____%
c) What percentage of inpatient records has been coded within 30 calendar days after discharge (for MTFs with Inpatient capability)?	**c)** ___/____	**c)**_____%

Table 1. Data Quality Management Control Review List, Continued

B. Data Input (Concluded)		
B.6. From the monthly CCE Encounter Status Summary report:	Count	Percentage
a) From the monthly CCE Encounter Status Summary report (complete list) for outpatient and APV, what percentage of billable encounters has an encounter coding status of "Completed"? Formula: Number of billable encounters with coding status of "Completed" / number of total billable encounters.	a) ___/____	a)_____%
b) What percentage of billable encounters has an encounter coding status of "Auto Released in CCE"? Formula: Number of billable encounters with coding status of "Auto Released in CCE" / number of total billable encounters.	b) ___/____	b)_____%
c) What percentage of billable encounters has an encounter coding status of "On Review Hold"? Formula: Number of billable encounters with coding status of "On Review Hold" / number of total billable encounters.	c) ___/____	c)_____%
d) What percentage of billable encounters does not have an encounter coding status? Formula: Number of billable encounters with coding status of "?" /number of total billable encounters. Note: These questions are to determine CCE Utility.	d) ___/____	d)_____%
B. Comments: (Include comments for any items reflected above as non-compliant, to include corrective actions being taken, incident tickets initiated (if applicable), impact of incident, and estimated correction date.)		

Table 1. Data Quality Management Control Review List, Continued

C. Data Output		
Data Output controls are used to ensure the accurate and timely distribution of outputs. At a minimum, Questions C.5 – 7 are answered quarterly for the last data month of the quarter (I.e., Dec, Mar, Jun, and Sep data). Services may report these questions monthly.		
POC Name(s) and Phone Number(s)		
C.1. *Medical Expense and Performance Reporting System for Fixed Military Medical and Dental Treatment Facilities Manual* (MEPRS Manual), DoD 6010.13-M, dated April 7, 2008, paragraph C3.3.4, requires report reconciliation. (Question 3 (a, b, c, d) of DQ Statement.) **Data Month: _____** **a) Was the monthly MEPRS (EAS) financial reconciliation completed, validated, and approved by the MTF Resource Manager (i.e., Navy or Army Comptroller or Air Force Budget Officer or Analyst) prior to MEPRS monthly transmission?** b) Were monthly Inpatient and Outpatient MEPRS (EAS) reconciliation processes completed (excluding coding audits performed in C.5, C.6 and C.7)? **c) Were the data load status, outlier and allocation tabs in the MEWACS document reviewed and explanations provided in the comments section for flagged data anomalies?** 1. EAS IV Repository MEPRS data load status and compliance with the 45-day reporting suspense or Service Guidance whichever is earlier. If the facility has a pattern (2 or more) of flagged cells on this tab, has it corrected it or developed a plan to correct it. Provide an explanation in the Comments Section. 2. MTF-specific summary data outliers. If the facility has any Prior Fiscal Year or Current Fiscal Year flagged cells on this tab, provide an explanation in the Comments Section. 3. Ancillary and Support expense allocation tests. If the facility is flagged in the Prior Fiscal Year or Current Fiscal Year due to incomplete allocation of ancillary or support expenses, provide an explanation in the Comments Section, including projected date for submitting corrected data. Note: For MEPRS related guidance consult the following Web site: http://www.meprs.info d) For DMHRSi, have the "DoD Batch and Timecard Status Report" and "HR Data Issues affecting EAS" or similar reports been run and the results presented to the Commanding Officer for review?		**Yes or No** **a)** b) **c)** d)
	Count	Percentage
e) For DMHRSi, what is the percentage of submitted timecards by the suspense date? (Timecards submitted by Service determined date.) Formula: Number of timecards submitted on-time / total number of timecards for an MTF.	**e) ___/___**	**e)_____%**
f) For DMHRSi, what is the percentage of timecards approved by the suspense date? (Timecards submitted by Service determined date.) Formula: Number of timecards approved on-time / total number of timecards for an MTF.	**f) ___/___**	**f)_____%**

Table 1. Data Quality Management Control Review List, Continued

C. Data Output (Continued)		
C.2. Use CHCS during the data month to identify potential duplicate patient registration and duplicate National Provider Identifier (NPIs). Potential Duplicate Patient Registration **a) For CHCS or AHLTA hosts only, what was the number of potential duplicate patient registration in the data month for all MTFs under the host? (Question 10a of DQ Statement.)** (1) Beginning balance (2) Number of duplicates identified this month (3) Number of duplicates resolved this month **(4) Ending balance (next month's beginning balance) (Question 10.a of DQ Statement)** Run the CHCS standard report – "Potential Duplicate Patient Search". List the DMIS IDs of the MTFs included in the comments section. Note: Resolution of duplicates includes identifying false positives such as twins. For current advice about how to identify duplicate records, see DQMC Web page: http://www.tricare.mil/ocfo/mcfs/dqmcp/refs_regs.cfm. Potential duplicate patient registration can be minimized by performing DEERS validation checks.		Number a.1) a.2) a.3) **a.4)**
b) Do you have a process to reduce the number of duplicate patient registration? Recommend running the CHCS standard report – "User Registration". c) Has your MTF determined how to correct the duplicate appointments or encounters and avoid the errors in the future? d) Have incident tickets been filed with MHS Service Desk for duplicate records in CHCS or AHLTA that cannot be resolved at the MTF level? Note: All AHLTA issues must be fixed with an MHS Service Desk incident ticket.		Yes or No b) c) d)
e) Number of AHLTA patient merge incident tickets submitted to the MHS Service desk. Duplicate NPIs f) How many providers were found with duplicate NPIs? g) How many were resolved?		Number e) _____ f) _____ g) _____
C.3. Were system outputs transmitted to central repositories by date specified in DHA and Service-Level guidelines? (Question 4 (a, b, c, d) of DQ Statement.)	Date or Initials	**Yes or No**
a) MEPRS (EAS) (45 calendar days or Service guidance whichever is earlier) **b) SIDR (CHCS) (5th and 20th calendar day of the following month)**	a) b)	**a)** **b)**
	Count	**Percentage**
c) CAPER (ADM): Number of days with successful transmissions / number of days in the month. **d) Daily Outpatient Workload Detailed Report (DOWDR), also known as the Daily Patient Appointments File: Number of successful daily transmissions / number of days in the month.**	**c) ___/___** **d) ___/___**	**c) _____%** **d)_____%**
C.4. Were the following activities performed:		Yes or No
a) Check the "ADM SADR/CAPER Error Report"? b) Correct the errors listed on the report?		a) b)

Table 1. Data Quality Management Control Review List, Continued

C. Data Output (Continued)		
C.5. In a random review of CHCS Inpatient dispositions from the data month, the Service Headquarters will determine the specific random sample to be audited. The minimum of 30 records or encounters should be pulled randomly from the entire population of MTF inpatient medical records for the audit data month (e.g., 1-30 June). (Question 5 (a, b, c, d) of the DQ Statement). **(See applicable DoDD or DoDI on Medical Records Retention and Coding and Service specific guidance.** Note: A random sample of 30 records per MTF will provide a statistical confidence level of 90%, with a confidence interval or sampling error range of plus or minus 15%. The Services may request that each MTF conduct additional focused internal audits, in addition to the random audits being conducted for the DQMC Program (i.e., pull an additional number of records to be used in a focused audit, on specific clinics or departments). The focused audits may assist each MTF in targeting its coding improvement efforts, while the random-sample audit results can be extrapolated to assess the overall coding accuracy for that MTF.		Date completed: _____
	Count	Percentage
a) Percentage of inpatient medical records located? Formula: Number of records available or documented as checked out / number of records requested for audit.	a) ___/___	a)_____%
b) Percentage of documentation that was complete. Formula: Number of medical records with complete documentation / total number of medical records.	b) ___/___	b)_____%
c) Percentage of inpatient medical records whose assigned DRG Codes were correct? **Note: This is a comparison of the paper record to computerized coded information.** Formula: Number of correct MS-DRGs / total number of MS-DRGs.	**c)** ___/___	**c)_____%**
d) Percentage of SIDRs completed (in a "D" status). Formula: Number of coded and approved SIDRs in a D status / total number of D and E SIDRs. Note: Auditing Sampling Methodology (for questions C.5.e,f,g) – One calendar day of the attending professional services during each audited hospitalization will be audited from the randomly selected sample. For hospitalizations which begin and terminate the same calendar day, that calendar day will be audited. For all other hospitalizations, the registration number will determine if services for the first or second calendar day will be audited. Odd registration numbers will be audited for the first day and even registration numbers will be audited for the second day.	d) ___/___	d)_____%
e) Percentage of Inpatient Professional Services Rounds encounters E & M Codes audited and deemed correct? Formula: Number of correct E&M Codes / total number of E&M Codes.*	**e)** ___/___	**e)_____%**
f) Percentage of Inpatient Professional Services Rounds encounters ICD-9 Codes audited and deemed correct? Formula: Number of correct ICD-9 Codes / total number of ICD-9 Codes.*	**f)** ___/___	**f)_____%**
g) Percentage of Inpatient Professional Services Rounds encounters CPT Codes audited and deemed correct? Formula: Number of correct CPT Codes / total number of CPT Codes.* *Note: The denominator for all categories should include codes identified by the auditor. See specific Service guidance for calculation details. (See applicable MHS Professional Services and Specialty Coding Guidelines for "Coding Audits" at: http://tricare.mil/ocfo/bea/ubu/coding_guidelines.cfm).	**g)** ___/___	**g)_____%**

Table 1. Data Quality Management Control Review List, Continued

C. Data Output (Continued)		
C.6. In a random review of CHCS outpatient encounters from the data month, the Service Headquarters will determine the specific random sample to be audited. The minimum of 30 records or encounters should be pulled randomly from the entire population of MTF outpatient encounters for the audit data month (e.g., 1-30 June). (Question 6 (a,b,c,d) of DQ Statement.) (See applicable DoDD or DoDI on Medical Records Retention and Coding and Service specific guidance*).*		Date completed: _____
	Count	**Percentage**
Note: A random sample of 30 records per MTF will provide a statistical confidence level of 90%, with a confidence interval or sampling error range of plus or minus 15%. The Services may request that each MTF conduct additional focused internal audits, in addition to the random audits being conducted for the DQMC Program (i.e., pull an additional number of records to be used in a focused audit, on specific clinics or departments). The focused audits may assist each MTF in targeting its coding improvement efforts, while the random-sample audit results can be extrapolated to assess the overall coding accuracy for that MTF.		
a) For the encounter selected to be audited, is complete documentation available for coding audit? Documentation includes documentation in the medical record, loose (hard copy) documentation or an electronic record of the encounter. **(Denominator equals sample size.)** Formula: Number of adequately documented encounters available / number of requested encounters. Note: This question is asking "Is adequate documentation of the encounter available to be audited?" If the documentation is available however the patient's outpatient health record is not available, the "record of the encounter" is available for audit**.**	**a) ___/___**	**a)_____%**
b) What is the percentage of E & M Codes deemed correct? (E & M Code must comply with current DoD guidance.) Note: If the paper record does not indicate an E&M Code was required and the computerized record does not have an E&M, the record is deemed correct**.** Formula: Number of correct E&M Codes / total number of E&M Codes.*	**b) ___/___**	**b)_____%**
c) What is the percentage of ICD-9 Codes deemed correct? Formula: Number of correct ICD-9 Codes / total number of ICD-9 Codes.*	**c) ___/___**	**c)_____%**
d) What is the percentage of CPT Codes deemed correct? (CPT Code must comply with current DoD guidance.) Note: If the paper record does not indicate a CPT was required and the computerized record does not have a CPT, the record is deemed correct. Formula: Number of correct CPT Codes / total number of CPT Codes.*	**d) ___/___**	**d)_____%**
Note: The denominator for all categories should include codes identified by the auditor. See specific Service Guidance for calculation details. (See applicable MHS Professional Services and Specialty Coding Guidelines for "Coding Audits" at: http://tricare.mil/ocfo/bea/ubu/coding_guidelines.cfm)		

Table 1. Data Quality Management Control Review List, Continued

C. Data Output (Continued)		
C.7. In a random review of CHCS Ambulatory Procedure Visits (APV) appointments from the data month, the Service Headquarters will determine the specific random sample to be audited. The minimum of 30 records or encounters should be pulled randomly from the entire population of MTF APV encounters for the audit data month (e.g., in 1-30 June). (Question 7 (a, b, c) of DQ Statement.) **(See applicable DoDD or DoDI on Medical Records Retention and Coding and Service specific guidance).** Note: A random sample of 30 records per MTF will provide a statistical confidence level of 90%, with a confidence interval or sampling error range of plus or minus 15%. The Services may request that each MTF conduct additional focused internal audits, in addition to the random audits being conducted for the DQMC Program (i.e., pull an additional number of records to be used in a focused audit, on specific clinics or departments). The focused audits may assist each MTF in targeting its coding improvement efforts, while the random-sample audit results can be extrapolated to assess the overall coding accuracy for that MTF.	**Count**	Date completed: _____ **Percentage**
a) For the encounter selected to be audited, is complete documentation available for coding audit? Documentation includes documentation in the medical record, loose (hard copy) documentation or an electronic record of the encounter. **(Denominator equals sample size.)** Formula: Number of adequately documented encounters available / number of requested encounters.	**a) ___/___**	**a)_____%**
b) What is the percentage of ICD-9 Codes deemed correct? Formula: Number of correct ICD-9 Codes / total number of ICD-9 Codes.*	**b) ___/___**	**b)_____%**
c) What is the percentage of CPT Codes deemed correct? (CPT Code must comply with current DoD guidance.) Note: If the paper record does not indicate a CPT was required and the computerized record does not have a CPT, the record is deemed correct. Formula: Number of correct CPT Codes / total number of CPT Codes.* Note: The denominator for all categories should include codes identified by the auditor. See specific Service guidance for calculation details. (See applicable MHS Professional Services and Specialty Coding Guidelines for "Coding Audits" at: http://tricare.mil/ocfo/bea/ubu/coding_guidelines.cfm)	**c) ___/___**	**c)_____%**

Table 1. Data Quality Management Control Review List, Continued

C. Data Output (Continued)		
C.8. In a random review of Non-Active Duty medical records or encounters from the data month, looking for the DD Form 2569s (electronic or hardcopy), the Uniformed Business Office staff in coordination with the Service Headquarters will determine the specific random sample to be audited for each type of record Inpatient, Outpatient, and Ambulatory Procedure Visits (APVs): The minimum of 30 records or encounters should be pulled randomly from the entire population of MTF for the audit data month (e.g., 1 - 31 July). (Question 8 (a, b, c, d, e, f) of DQ Statement.) Note: A random sample of 30 records per MTF will provide a statistical confidence level of 90%, with a confidence interval or sampling error range of plus or minus 15%.		Date completed: _____
	Count	**Percentage**
From the 30 randomly pulled Inpatient dispositions: **a) What percentage of completed and current (signed within the past 12 months) DD Form 2569s (Third Party Collection Insurance Info) is available for audit (non-active duty encounters only)? (See DoD 6010.15-M, MTF UBO Manual)** Formula: Number of complete and current DD 2569s / number of Non-Active Duty records audited. Availability may be electronic, loose, or signed form maintained in other locations.	**a) ___/___**	**a)_____%**
b) What percentage of available, current and complete DD Form 2569s is verified to be correct in the Patient Insurance Information (PII) module in CHCS? Formula: Number of correct entries in the PII module / number of available, current and complete DD Form 2569s.	**b) ___/___**	**b)_____%**
From the 30 randomly pulled Outpatient encounters: **c) What percentage of completed and current (signed within the past 12 months) DD Form 2569s (TPC Insurance Info) is available for audit (non-active duty encounters only)? (See DoD 6010.15-M, MTF UBO Manual)** Formula: Number of complete and current DD2569s / number of Non-Active Duty records audited. Availability may be electronic, loose, or signed form maintained in other locations.	**c) ___/___**	**c)_____%**
d) What percentage of available, current and complete DD Form 2569s is verified to be correct in the Patient Insurance Information (PII) module in CHCS? Formula: Number of correct entries in the PII module / number of available, current and complete DD Form 2569s.	**d) ___/___**	**d)_____%**
From the 30 randomly pulled APVs: **e) What percentage of completed and current (signed within the past 12 months) DD Form 2569s (TPC Insurance Info) is available for audit (non-active duty encounters only)? (See DoD 6010.15-M, MTF UBO Manual)** Formula: Number of complete and current DD2569s / number of Non-Active Duty records audited. Availability may be electronic, loose, or signed form maintained in other locations.	**e) ___/___**	**e)_____%**
f) What percentage of available, current and complete DD Form 2569s is verified to be correct in the Patient Insurance Information (PII) module in CHCS? Formula: Number of correct entries in the PII module / number of available, current and complete DD Form 2569s.	**f) ___/___**	**f)_____%**

Table 1. Data Quality Management Control Review List, Continued

C. Data Output (Continued)		
C.9. Comparison of reported workload data. (Question 9 (a, b, c, d) of DQ Statement)	**Count**	**Percentage**
a) Number of CAPER encounters * / number of Kept-Appointments.	**a) ___/____**	**a)_____%**
b) Number of MEPRS dispositions from EAS (or WAM, if EAS is unavailable) / number of SIDR D and E status dispositions.	**b) ___/____**	**b)_____%**
c) Number of MEPRS visits / number of Kept-Appointments (count only).	**c) ___/____**	**c)_____%**
Note: Questions a - c above, are allowed to be greater than 100%, with comment over 105%.		
d) Number of Inpatient Professional Service Rounds CAPER encounters (A* CAPERs) that were completed by the attending provider or service / number of Total Bed days + Dispositions from EAS (or WAM, if EAS is unavailable).** Note: Question d) answers that are above 110% need an explanation.	**d) ___/____**	**d)_____%**
Validate Service report to the criteria below: * For ADM Encounters, omit Appointment Status of "No-Show," "Canceled," and Disposition Code "Left without being seen," but include Appointment Status "TelCon," and "Occ-Svc." * Exclude RAD* appointment types from denominator. * Only CAPER records in B**** and FBN* clinics that are marked complete "C" will be included. * SIDRs with a Disposition Status of "D" will be included. * SIDRS to exclude Carded for Record Only (CRO) and absent sick records (primarily Army issue).		
C.10. Data Quality Coding Error Reports	**Count**	**Percentage**
A series of Data Quality reports were developed to detect and report errors in coding that require correction. These reports must be run each data month for each parent DMIS ID to respond to the following questions: (Question 11 (a, b, c) of DQ Statement)		
a) CAPER Errors		
(1) Total Invalid Outpatient Encounters **(**for RNs or techs) Corrected / Total Invalid Outpatient Encounters (for RNs or techs) Detected *(total a-d below)*	a(1) ___/___	a(1)_____%
(a) Total from Encounters with Invalid E&M Codes Report for RNs/techs (exclude TCONs)	(a) ____	
(b) Total from Encounters with Incorrectly coded Immunizations Report	(b) ____	
(c) Total from Encounters with Injury Related Codes with No Injury Related Flag Report	(c) ____	
(d) Total from Encounters with Incorrectly Coded TCONs by RNs/techs	(d) ____	
(2) Total Outpatient Encounters Corrected with Gender Conflicts / Total Outpatient Encounters Detected with Gender Conflicts	**a(2) ___/___**	**a(2)_____%**
(a) Total from Encounters with Female Only Diagnosis in Male Patients Report	(a) ____	
(b) Total from Encounters with Male Only Diagnosis in Female Patients Report	(b) ____	
(c) Total from Encounters with Maternity Diagnosis in Non-Maternity Patients Report	(c) ____	
(3) Total Outpatient Encounters Corrected with Age Conflicts / Total Outpatient Encounters Detected with Age Conflicts	**a(3) ___/___**	**a(3)_____%**
(a) Total from Encounters with Adult Diagnosis in Pediatric Patients Report	(a) ____	
(b) Total from Newborn Diagnosis in Older Patients Report	(b) ____	
(c) Total from Pediatric Diagnosis in non-pediatric Patients Report	(c) ____	

Table 1. Data Quality Management Control Review List, Continued

C. Data Output (Continued)		
C.10. Data Quality Coding Error Reports	Count	Percentage
(4) Total A*** CAPER Encounters with Invalid E&M Codes Corrected / Total CAPER Encounters Detected in the Incorrectly Coded A*** CAPER DQ Coding Error Reports* Note: Valid E&M Codes either are within range 99217 – 99239, 99460 – 99480, or have an E&M Code 99499 with a procedure code. All other "A*** CAPER" encounters are considered invalid.	a(4) ___/___	a(4)_____%
b) Total Detected Inpatient Records Corrected / Total Invalid Inpatient Records Detected *(total (1) and (2))*	**b) ___/___**	**b)_____%**
(1) Total Inpatient Records from Questionable Admissions Based on Diagnosis Report	(1) _____	
(2) Total Inpatient Records from the Un-groupable MS-DRG Report	(2) _____	
Note: For current advice about how to run the Data Quality Coding Error Reports, see Data Quality Web page: http://www.tricare.mil/ocfo/mcfs/dqmcp/refs_regs.cfm.		
C.11. Incomplete CAPER Report (or Service equivalent, includes APVs) (Goal is 100%). Metric should be refreshed and reported for each period through current data month. (Question 14 (a, b) of DQ Statement)	**Count**	**Percentage**
a) Number of CAPER encounters / number of Kept Appointments.		
(1) October current fiscal year	**a(1) ___/___**	**a(1)_____%**
(2) November current fiscal year	**a(2) ___/___**	**a(2)_____%**
(3) December current fiscal year	**a(3) ___/___**	**a(3)_____%**
(4)January current fiscal year	**a(4) ___/___**	**a(4)_____%**
(5) February current fiscal year	**a(5) ___/___**	**a(5)_____%**
(6) March current fiscal year	**a(6) ___/___**	**a(6)_____%**
(7) April current fiscal year	**a(7) ___/___**	**a(7)_____%**
(8) May current fiscal year	**a(8) ___/___**	**a(8)_____%**
(9) June current fiscal year	**a(9) ___/___**	**a(9)_____%**
(10) July current fiscal year	**a(10) ___/___**	**a(10)_____%**
(11) August current fiscal year	**a(11) ___/___**	**a(11)_____%**
(12) September current fiscal year	**a(12) ___/___**	**a(12)_____%**
b) Prior FY Number of CAPER encounters / number of Kept Appointments (Oct – Sep prior FY)	**(b) ___/____**	**(b)_____%**

Table 1. Data Quality Management Control Review List, Continued

C. Data Output (Continued)		
C.12. Incomplete SIDR Report (or Service equivalent) (Goal is 100%). Metric should be refreshed and reported for each period through current data month. (Question 15 (a, b) of DQ Statement)	**Count**	**Percentage**
a) Number of SIDR dispositions / number of SIDR D and E status dispositions.	**a(1) ___/___**	**a(1)_____%**
(1) October current fiscal year	**a(2) ___/___**	**a(2)_____%**
(2) November current fiscal year	**a(3) ___/___**	**a(3)_____%**
(3) December current fiscal year	**a(4) ___/___**	**a(4)_____%**
(4)January current fiscal year	**a(5) ___/___**	**a(5)_____%**
(5) February current fiscal year	**a(6) ___/___**	**a(6)_____%**
(6) March current fiscal year	**a(7) ___/___**	**a(7)_____%**
(7) April current fiscal year	**a(8) ___/___**	**a(8)_____%**
(8) May current fiscal year	**a(9) ___/___**	**a(9)_____%**
(9) June current fiscal year	**a(10) __/___**	**a(10)_____%**
(10) July current fiscal year	**a(11) __/___**	**a(11)_____%**
(11) August current fiscal year	**a(12) __/___**	**a(12)_____%**
(12) September current fiscal year		
b) Prior FY Number of SIDR dispositions / number of SIDR D and E status dispositions (Oct – Sep Prior FY)	**(b) ___/____**	**(b)_____%**
C. Comments: (Include comments for any items reflected above as non-compliant, to include corrective actions being taken, incident tickets initiated (if applicable), impact of incident, and estimated correction date.)		

Table 1. Data Quality Management Control Review List, Continued

D . Security		
These controls should provide assurances that computers and the data they contain are properly protected against theft, loss, unauthorized access, and natural disaster.		
POC Name(s) and Phone Number(s)		
D.1. Security keys: a) Are there internal controls and procedures in place to approve and manage assignment of security key privileges?		Yes or No a)
b) Have all Security key holders for new patient registration been identified and their need for security key privileges validated? Formula: Number of Individuals With Required Access / Number of Individuals Who Need This Access	Count b) ___/____	Percentage b) ___ %
D. Comments: (Include comments for any items reflected above as non-compliant, to include corrective actions being taken, incident tickets initiated (if applicable), impact of incident, and estimated correction date.)		

Table 1. Data Quality Management Control Review List, Continued

E . System Design, Development, and Operations	
*Controls in this category are intended to ensure that systems meet user needs, are developed economically, and are thoroughly documented and tested.. Question E.1 is answered monthly***.**	
POC Name(s) and Phone Number(s)	
E.1. What is the number of unresolved incident tickets (to include incident tickets with no action taken)? a) AHLTA # of Tickets Data Month _____ Previous Data Months _____ b) CCE _____ _____ c) CHCS _____ _____ d) DMHRSi _____ _____ e) Essentris _____ _____ f) MEPRS (EAS)_____ _____ g) ABACUS _____ _____	
E. Comments: (Include comments for any items reflected above as non-compliant, to include corrective actions being taken, incident tickets initiated (if applicable), impact of incident, and estimated correction date.)	

F. ARMY Specific Questions (This is an Army service requirement only and will not be reported to TMA.)		
F. 1. Loose forms, documents and papers. a) Provide the number of loose forms/documents/papers that are currently waiting to be filed, either electronically or in the hard-copy medical record. b) Provide the number of loose forms/documents/papers that are currently waiting to be filed, either electronically or in the hard-copy medical record, 30 days after an active duty soldier has retired or separated from the service.	**Count** **a)**_____ **b)**_____	
F.2. Appointments in Writing. a) Is your DQ Manager appointed in writing? (If response is no, provide comment.) b) Are your Data Quality Assurance Team members appointed in writing? (If response is no, provide comment.)	**Yes or No** **a)**_____ **b)**_____	
F.3. ICD-10 Training. **a) Is the ICD-10 Committee meeting monthly or quarterly? (Provide comment – state frequency (i.e. monthly or quarterly.) (Question 12 (a) of DQ Statement)**	**Yes or No** **a)**_____	
F.4. I am aware of data quality issues identified by the completed Commander's DQ Statement and Review List and when needed, have incorporated monitoring mechanisms and have taken corrective actions to improve the data from my facility. **(Question 16 of DQ Statement.)**	Date _____	Yes or No _____
F. Comments: (Include comments for any items reflected above as non-compliant, to include corrective actions being taken, incident tickets initiated (if applicable), and estimated correction date.)		