PASBA
Patient Administration Systems and Biostatistics Activity
THE AMEDD LINK TO QUALITY
INFORMATION FOR EFFECTIVE MANAGEMENT

FISCAL YEAR 2016
DATA QUALITY MANAGEMENT CONTROL PROGRAM (DQMCP)

DATA QUALITY STATEMENT USER'S GUIDE

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Prepared by:

Data Quality Section
Patient Administration Systems and Biostatistics Activity
ATTN: MCHS-IQ
2404 Stanley Rd
Fort Sam Houston, TX 78234-5053

Contents

Introduction

This document contains Data Quality Management Control (DQMC) Program information and provides assistance to prepare the monthly Data Quality Commanders Statement. The latest versions of the DQ Review List and the Data Quality Commander's Statement are posted under *Other Resources* (right side of the page) of the **Data Quality** section of the PASBA website at https://pasba.army.mil/. For DQMCP application: Select *My Apps* on the maroon menu bar, and then select *DQMCP Program (.NET).* Scroll down to the *Form Selection* section and select a year, a region, and a MTF*;* next, select the current data month to enter your MTF's data. Data are entered into the Review List and this data populates the Commander's Statement.

Note: This document will be updated as changes occur and the latest version will be posted on the Data Quality section of the PASBA website. To ensure you have the latest version, check the effective date on the front page of this document. Users are encouraged to provide comments and suggestions that would make this document easier to use and more effective. Please send your comments or suggestions to:
usarmy.jbsa.medcom-pasba.list.pasba-data-quality@mail.mil

The Assistant Secretary of Defense for Health Affairs (ASD-HA) directed the implementation of the DQMC Program in 2001 because of findings by the Department of Defense Inspector General and the Government Accountability Office (GAO); they found material weaknesses within the DoD Military Health System in reporting financial and clinical workload related data. The ASD-HA appointed the TRICARE Management Activity ((DHA) now the Defense Health Agency (DHA)) as its Executive Agent. The program is overseen by the Military Health System's (MHS) DQMC Committee, a Tri-Service group that meets on a monthly basis to monitor information contained within the DQMC Program. Representatives from the Army, Navy, and Air Force are responsible for reviewing, coordinating, and developing requirements, policies, and guidance for the DQMC Program. The DQMC Program provides command oversight and recommended structure to improve the submission of complete, accurate, and timely data and to ensure uniformity and standardization of information across the MHS. The DQMC Program's *Data Quality Statement* is an extract of selected questions from the *DQMC Program's Review List*. The DQMC Program Review List is intended to address some of the basic business operations within military treatment facilities. While the list is not intended to be all-encompassing, it does represent a substantial start to basic data quality review of MTF operations.

An integral part of performance measurement for the MHS is data quality. Providing the right information to the right people at the right time requires accurate, timely, and complete data. The MHS cost and workload-reporting systems provide data that are used for:

- making healthcare policy decisions
- preparing cost allocations
- negotiating with managed care support contractors
- establishing billing rates
- justifying expenditures and budgets

- supports Medicare Eligible Retiree Health Care Fund (MERHCF)
- supporting third party collections and Medicare subvention initiatives

The Chief of the Data Quality Section at the Patient Administration Systems and Biostatistics Activity (PASBA) is the Army Surgeon General's representative to DHA's DQMC Program working group, and acts as the Army's Data Quality Manager. The Data Quality Section is responsible for receiving, reviewing and submitting a consolidated DQMC Program report to Army leadership and DHA. The section is also responsible for preparing and briefing Army leadership on the status of the DQMC Program across the AMEDD. One of the section's goals is to encourage the sharing of information to assist MTFs in their efforts to provide the best healthcare possible.

DQMC Program Metrics

The DQMC Program Metrics are posted under Data Quality (Maroon menu bar of page) of the **Data Quality** section of the PASBA website at https://pasba.army.mil/. For DQMC Program Metrics: Select *Data Quality* on the maroon menu bar, and then select *DQMC Program Metrics.* Scroll down to the *Report Selection* and select the month and Year; next, select view.

- DQMCP Monthly report
  The DQMCP Monthly Report includes the Army, region, and MTF values for Questions 1 through 16 of the DQMCP Commander's Statement. This report is updated monthly.
- DQMCP Year-to-Date Report
  The DQMCP Year-to-Date Report shows the Army, region, and MTF values for Questions 1 through 16 of the DQMCP Commander's Statement for the first month of the fiscal year to the most currently available data month (two months before current month). The report is updated monthly.
- DQ Statement Completion Report
  The DQMCP Completion Report shows which MTFs signed the DQ Statement on time for the last 15 months. This report is updated monthly. The suspense date for submitting an MTF Commander approved DQ Statement is the 5th calendar day of the month after the reporting month (i.e. the reporting month is January the suspense date is 5 February).
- Admin.-Closed Encounters (Review List B.5d (B.4d1 as of Oct 14))
  The Admin-Closed Encounter Report quantifies the number of appointments using "Admin" when closing encounters in CHCS. There is a tabular display of the data and an additional worksheet explaining the MTF's utilization of 'admin'. The report is updated monthly.
- CCE Utility Report (Review List B.6a as of Oct 14)
  The Coding Compliance Editor (CCE) Utility report divides the number of encounters with the status of 'completed' in CCE by the total number of encounters for the data month and provides the quotient as a percentage. There is a tabular display of the data and an additional worksheet explaining the MTF's status. The report is updated monthly.
- DQ Commanders Certifications
  The DQ Commanders' Certification for the MEDCOM regional medical commands (RMC) is available for each quarter of the fiscal year. These DQ Commanders' Certifications are updated quarterly. Reported by the end of the month for the

previous quarter (e.g. FY 1st Quarter no later than 31 January).

DHA Data Quality Management Control Program Metrics and Reports by Service

The DHA DQMCP Metrics and Reports are posted under *Data Quality Management Control* (Blue tab menu bar of page) of the **Data Quality Management Control** section of the Tricare website at http://www.tricare.mil/ocfo/mcfs/dqmcp/metrics_reports.cfm.
For DQMCP Metrics and Reports by service, select *Data Quality Management Control* on the blue tab menu bar, then scroll down to the *Metric and Reports section* and double click on the report.

Compliance Percentages for FY-16

A facility's responses to all questions should meet or exceed a 97% compliance rate.

- FY16 Compliance thresholds:
  97% - 100% is green
  90 - 96% is Amber
  0% - 89% or no response is red
- Question 2a includes (non-APV) B and FBN MEPRS Kept, Walk-In, Sick-Call, count T-Cons and excludes non-count T-Cons.
- Questions 3c and 3d Army standard in FY-16 is 100%. Questions 9a-d goal for FY-16 is 97%. **If over 103%, a comment is required.**
- Army-specific questions have no compliance percentage standards.
- Comments: Provide problem statement, corrective actions (being taken), expected compliance (MM/DD/YYYY), trouble tickets (initiated if applicable), and a summary statement. Note: Summary statement must include a brief statement stating the problem, corrective actions being taken, and any incident tickets initiated (if applicable) in 110 characters or less.
- The RAD* and RAD** appointment types are excluded whenever Daily Outpatient Workload Daily Report DOWDRs are used. This will affect DQ Statement questions 1, 2a, 2b, 9a, and 9c.
- Any question over 103% requires a comment.

FY 2016 Data Quality Statement

Questions

PASBA-populated questions in the FY 2016 DQ Statement (underlined below) are:

1a, 2a, 2b, 4a, 4b, 4c, 4d, 9a, 9b, 9c, 9d, 12a (1-12), 12b, 13a (1-12), and 13b.

Question 1. In the data month (include only B*** and FBN* accounts): (Review List Question (R. L. Q B. 4. a)

Question 1. a) What percentage of appointments was closed in meeting your "End of Day" processing requirement, "Every appointment – Every day?" (R. L. Q B. 4. a; PASBA-populated question)

Question 2. In accordance with legal and medical coding practices, have all of the following occurred: (R. L. Q B. 5. a, b, c, d):

Question 2. a) What percentage of Outpatient Encounters, other than Ambulatory Procedure Visits (APVs), has been coded within 3 business days of the encounter? (R. L. Q B. 5. a; **PASBA-populated question**)

Question 2. b) What percentage of APVs has been coded within 15 calendar days of the encounter? (R. L. Q B. 5. b; **PASBA-populated question**)

Question 2. c) What percentage of inpatient records has been coded within 30 calendar days after discharge? (R. L. Q B. 5. C; MTF Reported)

Question 3. 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 C 3.3.4, requires report reconciliation. (R. L. Q C. 1. a, c, e, and f):

Question 3. a) Was the monthly MEPRS (EAS) financial reconciliation completed, validated, and approved by the MTF Resource Manager (i.e., a Navy/Army comptroller, or an Air Force Budget Officer or Analyst) prior to MEPRS monthly transmission? (R. L. Q C. 1. a; MTF Reported)

Question 3. b) 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? (R. L. Q C. 1. c; MTF Reported)

Question 3. c) For DMHRSi, what is the percentage of submitted timecards by the suspense date? (R. L. Q C. 1. e; MTF Reported)

Question 3. d) For DMHRSi, what is the percentage of approved timecards by the suspense date? (R. L. Q C. 1. f; MTF Reported)

Question 4. Were system outputs transmitted to central repositories by date specified in DHA and Service-Level guidelines? (R. L. Q C. 3. a, b, c, d):

Question 4. a) MEPRS (EAS) – 45 calendar days. (R. L. Q C. 3. a; **PASBA-populated question)**

Question 4. b) SIDR (CHCS) – 5th and 20th calendar day of the following month. (R. L. Q C. 3. b; PASBA-populated question)

Question 4. c) CAPER (ADM) – Daily transmissions. (R. L. Q C. 3. c; PASBA-populated question)

Question 4. d.) DOWDR or Daily Patient Appointment File – daily transmissions. (R. L. Q C. 3. d; PASBA-populated question)

Question 5. Outcome of monthly Inpatient Coding audit: (R. L. Q C. 5. c, e, f, g):

Question 5. a) Percentage of Inpatient medical records whose assigned DRG Codes were correct? (R. L. Q C. 5. c; MTF Reported)

Question 5. b) Percentage of Inpatient Professional Services Rounds encounters E&M Codes audited and deemed correct? (R. L. Q C. 5. e; MTF Reported)

Question 5. c) Percentage of Inpatient Professional Services Rounds encounters ICD-10 Codes audited and deemed correct? (R. L. Q C. 5. f; MTF Reported)

Question 5. d) Percentage of Inpatient Professional Services Rounds encounters CPT® Codes audited and deemed correct? (R. L. Q C. 5. g; MTF Reported)

Question 6. Outcome of monthly Outpatient Records audit. (R. L. Q C. 6. a, b, c, d):

Question 6. 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. (Note: Denominator equals sample size.) (R. L. Q C. 6. a; MTF Reported)

Question 6. b) What is the percentage of E&M Codes deemed correct? (E&M Code must comply with current DoD guidance.) (R. L. Q C. 6. b; MTF Reported)

Question 6. c) What is the percentage of ICD-10 Codes deemed correct? (R. L. Q C. 6. c; MTF Reported)

Question 6. d) What is the percentage of CPT Codes deemed correct? (CPT Code must comply with current DoD guidance.) (R. L. Q C. 6. d; MTF Reported)

Question 7. Outcome of monthly Ambulatory Procedure Visits (APV) audit. (R. L. Q C. 7. a, b, c):

Question 7. 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. (Note: Denominator equals sample size.) (R. L. Q C. 7. a; MTF Reported)

Question 7. b) What is the percentage of ICD-10 Codes deemed correct? (R. L. Q C. 7. b; MTF Reported)

Question 7. c) What is the percentage of CPT Codes deemed correct? (CPT Code must comply with current DoD guidance.) (R. L. Q C. 7. c; MTF Reported)

Question 8. DD-2569 forms. (R. L. Q C. 8. a, b, c, d, e, f):

Inpatient dispositions

Question 8. a) What percentage of completed and current OHI information documents (DD Form 2569s signed within the past 12 months or evidence of OHI discovery dated within the past 12 months) is available for review? (R. L. Q C. 8. a; MTF Reported, using audit pull list provided by PASBA)

Question 8. b) What percentage of available, current, and complete OHI information documents (DD Form 2569s or evidence of OHI discovery) is verified to be correct in the Patient Insurance Information (PII) module in CHCS? (R. L. Q C. 8. b; MTF Reported)

Outpatient encounters

Question 8. c) What percentage of completed and current OHI information documents (DD Form 2569s signed within the past 12 months or evidence of OHI discovery dated within the past 12 months) is available for review? (R. L. Q C. 8. c; MTF Reported, using audit pull list provided by PASBA)

Question 8. d) What percentage of available, current, and complete OHI information documents (DD Form 2569s or evidence of OHI discovery) is verified to be correct in the Patient Insurance Information (PII) module in CHCS? (R. L. Q C. 8. d; MTF Reported)

APVs

Question 8. e) What percentage of completed and current OHI information documents (DD Form 2569s signed within the past 12 months or evidence of OHI discovery dated within the past 12 months) is available for review? (R. L. Q C. 8. e; MTF Reported, using audit pull list provided by PASBA)

Question 8. f) What percentage of available, current, and complete OHI information

documents (DD Form 2569s (or evidence of OHI discovery) is verified to be correct in the Patient Insurance Information (PII) module in CHCS? (R. L. Q C. 8. f; MTF Reported)

Question 9. Comparison of reported workload data. (R. L. Q C. 9a, b, c, d):

Question 9. a) Number of CAPER encounters / number of Kept-Appointments. (R. L. Q C. 9. a; **PASBA-populated question)**

Question 9. b) Number of MEPRS dispositions from EAS / number of SIDR D and E status dispositions. (R. L. Q C. 9. b; **PASBA-populated question)**

Question 9. c) Number of MEPRS visits / number of Kept-Appointments (count only). (R. L. Q C. 9. c; **PASBA-populated question)**

Question 9. d) Number of Inpatient Professional Services Rounds CAPER encounters **(A*** ** CAPERS) / number of Total Bed Days + Dispositions from EAS. (R. L. Q C. 9. d; **PASBA-populated question)**

Note: Questions a-d above are allowed to be greater than 100%, with comment required for amounts over 103%.

Question 10. Use CHCS during the data month to identify potential duplicate patient registration. (R. L. Q C. 2. a. 4):

Question 10. a) For CHCS or AHLTA hosts only, what was the number of potential duplicate patient registrations in the data month for all MTFs under the host? List the DMIS IDs of the MTFs included in the Comments section. Ending balance (R. L. Q C. 2. a. 4; MTF Reported)

Question 11. Results of the Data Quality Coding Error Reports. (R. L. Q C. 10. a. 2, a. 3. b):

Question 11. a) Total CAPER Errors corrected with Gender Conflicts / Total Outpatient Encounters with Gender Conflicts. (R. L. Q C. 10. a. 2; MTF Reported)

Question 11. b) Total CAPER Errors Corrected with Age Conflicts / Total Outpatient Encounters with Age Conflicts. (R. L. Q C. 10. a. 2; MTF Reported)

Question 11. c) Total detected Inpatient Errors corrected / Total Invalid Inpatient Records detected. (R. L. Q C. 10. b; MTF Reported)

Question 12. Incomplete CAPER Report (or Service equivalent, includes APVs) (Goal is 100%). Metric should be refreshed and reported for each period through current data month. (R. L. Q C. 11. a. (1-12), C. 11. b)

Question 12. a) Number of CAPER encounters / number of Kept Appointments. (R. L. Q C. 11. a)

Question 12. a. 1) October current fiscal year **(**R. L. Q C. 11. a. 1; **PASBA-populated question; Army-specific question)**

Question 12. a. 2) November current fiscal year **(**R. L. Q C. 11. a. 2; **PASBA-populated question; Army-specific question)**

Question 12. a. 3) December current fiscal year **(**R. L. Q C. 11. a. 3; **PASBA-populated question; Army-specific question)**

Question 12. a. 4) January current fiscal year **(**R. L. Q C. 11. a. 4; **PASBA-populated question; Army-specific question)**

Question 12. a. 5) February current fiscal year **(**R. L. Q C. 11. a. 5; **PASBA-populated question; Army-specific question)**

Question 12. a. 6) March current fiscal year **(**R. L. Q C. 11 .a. 6; **PASBA-populated question; Army-specific question)**

Question 12. a. 7) April current fiscal year **(**R. L. Q C. 11 .a. 7; **PASBA-populated question; Army-specific question)**

Question 12. a. 8) May current fiscal year (R. L. Q C. 11. a. 8; **PASBA-populated question; Army-specific question)**

Question 12. a. 9) June current fiscal year **(**R. L. Q C. 11. a. 9; **PASBA-populated question; Army-specific question)**

Question 12. a. 10) July current fiscal year **(**R. L. Q C. 11. a. 10; **PASBA-populated question; Army-specific question)**

Question 12. a. 11) August current fiscal year **(**R. L. Q C. 11. a. 11; **PASBA-populated question; Army-specific question)**

Question 12. a. 12) September current fiscal year (R. L. Q C. 11. a. 12; **PASBA-populated question; Army-specific question)**

Question 12. b) Prior FY Number of CAPER encounters / number of Kept Appointments (Oct – Sep prior FY) **(**R. L. Q C. 11. b; **PASBA-populated question; Army-specific question)**

Question 13. Incomplete SIDR Report (or Service equivalent) (Goal is 100%). Metric should be refreshed and reported for each period through current data month. (R. L. Q C. 12. a (1-12), C. 12. b)

Question 13. a) Number of SIDR dispositions / number of SIDR D and E status dispositions. (R. L. Q C. 12. a)

Question 13. a. 1) October current fiscal year (R. L. Q C. 12. a. 1; **PASBA-populated question; Army-specific question)**

Question 13. a. 2) November current fiscal year (R. L. Q C. 12. a. 2; **PASBA-populated question; Army-specific question)**

Question 13. a. 3) December current fiscal year (R. L. Q C. 12. a. 3; **PASBA-populated question; Army-specific question)**

Question 13. a. 4) January current fiscal year (R. L. Q C. 12. a. 4; **PASBA-populated question; Army-specific question)**

Question 13. a. 5) February current fiscal year (R. L. Q C. 12. a. 5; **PASBA-populated question; Army-specific question)**

Question 13. a. 6) March current fiscal year (R. L. Q C. 12. a. 6; **PASBA-populated question; Army-specific question)**

Question 13. a. 7) April current fiscal year (R. L. Q C. 12. a. 7; **PASBA-populated question; Army-specific question)**

Question 13. a. 8) May current fiscal year (R. L. Q C. 12. a. 8; **PASBA-populated question; Army-specific question)**

Question 13. a. 9) June current fiscal year (R. L. Q C. 12. a. 9; **PASBA-populated question; Army-specific question)**

Question 13. a. 10) July current fiscal year (R. L. Q C. 12. a. 10; **PASBA-populated question; Army-specific question)**

Question 13. a. 11) August current fiscal year (R. L. Q C. 12. a. 11; **PASBA-populated question; Army-specific question)**

Question 13. a. 12) September current fiscal year (R. L. Q C. 12. a. 12**; PASBA-populated question; Army-specific question)**

Question 13. b) Prior FY Number of SIDR dispositions / number of SIDR D and E status dispositions (Oct – Sep Prior FY) (R. L. C. 12. b; **PASBA-populated question; Army-specific** question)

Question 14. ICD-10 Training.

Question 14. a) Is ICD-10 Awareness Training being provided to the entire MTF staff? Provide comment – state method being used to educate staff (i.e., 3M Online Modules, in-service, newsletter, etc.) R. L. Q F. 3. a.; MTF Reported; Army-specific question)

Question 14. b) Are your ICD-10 approved trainers currently conducting ICD-10 training with MTF staff? Provide comment on what type of training is being conducted, frequency and to whom (i.e. physicians, nurses, coders, etc.) R. L. Q F. 3. b.; MTF Reported; Army-specific question)

Question 15. The DQ Manager briefed last month's DQMC Review List, and Financial and Workload Data Reconciliation and Validation results to the MTF Executive Committee. (R. L. Q A. 4, MTF Reported, Army-specific question)
Question 16. Nursing Hourly Rounds.

Question 16. a) Has the hourly rounding component of the Patient Caring Touch System (PCTS) been fully implemented for the inpatient units at your facility? (R. L. Q F. 4. a.; MTF Reported; Army-specific question)

Question 17. I am aware of the data quality issues identified by the completed Commander's Data Quality Statement and the Data Quality Management Control Review List and, when needed, have incorporated monitoring mechanisms and have taken corrective actions to improve the data from my facility. (R. L. Q F. 4; MTF Commander Reported)

FY 2016 Data Quality Commander's Statement

Questions with explanations

Question 1. In the data month (include only B*** and FBN* accounts):

Question 1. a) What percentage of appointments was closed in meeting your "End of Day" processing requirements "Every appointment – Every day"? (R. L. Q B. 4 a; PASBA-populated question).

Requirement

Every appointment entered into the Composite Health Care System must be closed out by midnight of the day of the appointment (no appointments left in a "PENDING' status). Twenty-four-hour clinics (e.g., emergency departments) are the only exception – they must close all appointments of the preceding day no later than 0700 hours on the following day. This requirement excludes "A" MEPRS for Inpatient Professional Services Rounds (IPSR).

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of closed CHCS appointments}}{\text{total CHCS appointments for the month}}$$

Formula note

- For compliance computation, an unclosed appointment (pending appointment status) counts only once – on the day of the appointment, not again for each subsequent daily failure to close the appointment. An appointment not closed out Monday, but closed on Wednesday, counts as one failure (for Monday), not as three failures (i.e., that is, for Monday, Tuesday, and Wednesday).
- Appointments in pending status are not considered closed in the number of closed CHCS appointments.
- RAD* and RAD** appointment types are excluded.

Criteria

Use DOWDR (Daily Patient Appointment File). The first time an appointment shows up on the DOWDR file is the appointment still in a 'Pending' status, if so then this appointment is a fail for this measure.

Background

The percentage of appointments properly closed provides a view of an MTF's compliance with EOD processing. Compared to the percentage of clinics in compliance, the percentage of appointments properly closed is less subject to variance because of the larger denominator. The Daily Outpatient Workload Detailed Report (DOWDR or Daily Patient Appointment file) is a tri-service report. The DOWDR data extract software will scan the CHCS Patient Appointment file, extracting appointment information that occurred in the previous 45 days. The Appointment Date/Time field within the CHCS Patient Appointment file is used as the date or record for determining inclusion in the data extract file. The resulting file will be automatically transmitted on a daily basis.

Facts

1. End of Day processing is a matter of system discipline. By completing EOD processing every day, the clinics avoid workload data gaps and large difficult backlogs in data processing that take more time, resources, and research to resolve.
2. Failure to perform EOD processing causes loss of workload accountability, overstatement of expenses from understated workload, and negatively affects other system processes.
    - If pending appointments and/or missing providers exist at the end of the month, CHCS will not report that clinic's workload statistics in the Patient Appointment and Scheduling (PAS) *Monthly Statistical Reports* (Managed Care Function), and CHCS will instead generate the *Delinquent End-of-Month* report for resolution.
    - The CHCS Workload Assignment Module (WAM) will populate the Expense Assignment System (EAS), but only with visits that have "Kept" as an appointment status.
    - EAS cannot calculate the Monthly Statistical Reports (MSR) until EOD processing is completed.
    - If EOD processing is not completed, a Military Treatment Facility (MTF) will fail to comply with coding all outpatient visits (except APV) within three business days. The appointment record will be available to a coder only after the EOD processing is completed.
    - There is an expectation that all appointments in a kept status (e.g. kept, walk-in, sick call, and T-Con) will have a corresponding completed CAPER encounter.

Process

For assistance in running the EOD process, see the *End of Day Processing Guide* located on the PASBA website at https://pasba.army.mil/. Select *Data Quality* on the menu bar, and then select *DQ Guidelines.* Next, click *End of Day Processing Guide, May 2002 (.pdf)* in the last line of the paragraph. The clinic-level compliance and appointment-level compliance can both be obtained from the facility-level *Delinquent EOD Report* or—if there are no delinquencies—the *End-of-Day Processing Report*.

Recommendations

1. All appointments in CHCS and AHLTA must be closed out as soon as possible to facilitate the correct capture of a facility's workload. The process of closing out appointments should be added to the clinics checklist of items to do at the end of the day.
2. Provide in-service education for all clinic staff personnel on the correct process for creating appointments and the procedure for placing appointments in a 'kept' status.
3. Clinic staff personnel should be cross-trained to perform EOD procedures. Lack of trained personnel to perform EOD processing is not an acceptable reason for non-compliance.
4. Recommend that the requirement for end of day processing be included in a clinic clerk's (front desk, checking in patients) job description.

Question 2. 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)? (R. L. Q B. 5. a, b, c):

Question 2. 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 the day of the encounter is Monday, then coding must be completed by the third business day, Thursday, close of business.) (R. L. Q B. 5. a; PASBA-populated question)

Requirement

DOD Instruction 6040.42, 10 June 2004, *Medical Encounter Coding at Military Treatment Facilities* (under HIMS and Coding on the menu bar; Select *References*) requires that 100% of outpatient encounters other than Ambulatory Procedure Visits (APVs) be coded within three business days of the encounter. (Select Data Quality on the menu bar, then DQ Guidelines. Next, click *ADM Compliance Report Instructions, December 2003* (.pdf) in the fourth line of the *ADM Compliance Report paragraph.*

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of Non-APV coded with 3 business days}}{\text{total Non-APV Encounters}}$$

Formula Note

1. "3 business days" is defined as three business days excluding the day of the encounter, federal holidays, and weekends. Training holidays are considered a business day. Note: This metric has a 3-business day requirement, which is not the same as 72 hours).
2. RAD* and RAD** appointment types are excluded.

Criteria

1. All appointments from the *Daily Outpatient Workload Detail Report* (DOWDR) that have an appointment status of kept, walk-in, sick call and T-Cons in a 'count' status. We expect to see a completed CAPER for any appointment in these statuses.
2. Any appointments left in a pending status (based on the last time any particular appointment shows up on the DOWDR) will be considered as a kept appointment for the calculation of this measure.
3. Records in all "B" and "FBN" clinics received. Any CAPERS received will have the 3-business day requirement applied, whether a particular CAPER was listed on the DOWDR or not.
4. Apply the 3-business day standard to all completed CAPERs in the status mentioned above.

Background

It is DoD policy that all medical encounters within the Military Health System (MHS) must be accurately and promptly documented and coded, adhering to legal and medical coding classification standards as permitted by MHS data collection systems.

Facts

Successful documentation and coding efforts assist with the following MTF operations:

- **Continuity of Care:** Facilitates quality of care and communication among providers.
- **Education and Training:** Supports education and training for an MTF's staff, students, and patients.
- **Financial Management:** Facilitates an MTF's revenue by supporting its Uniformed Business Office (UBO) with evidence of treatment and justification for reimbursement claims to third-party payers.
- **Medical Readiness:** Assures accurate medical information is documented in records of deployed forces and facilitates pre- and post-deployment health assessments.
- **Population Health Management:** Facilitates the assessment and management of healthcare requirements for the beneficiary population.
- **Quality Management/Improvement:** Facilitates healthcare quality and improvement initiatives by providing evidenced-based practice through evaluation of clinical outcome data; provides healthcare professionals with documentation for quality assurance, evaluation, and improvement of treatment methods.
- **Productivity:** Increases/improves provider productivity. Timely coding captures productivity information (relative value units and encounter counts), assures the likelihood of available documentation, and allows information to continuously flow for coding edits, correction, and validation.
- **Resource Allocation:** Aligns medical resources with operations; aids in support of resource sharing agreements.

Process

Run the *ADM Compliance Report* at the end of the day. Also see the walk-though screens available in the PASBA website. Select *Data Quality* on the menu bar, and then select *DQ Guidelines*. Next, select *ADM Compliance Report Instructions, December 2003 (.pdf).*

Recommendations

- Monitor clinics for incomplete records by running the *ADM Compliance Report* and the *ADM Records by Clinic Report* at the end of each day or at least twice weekly. Provide feedback to providers, coders, and their supervisors.
- Evaluate your MTF's business process for improvement opportunities.

Question 2. b) What percentage of APVs has been coded within 15 calendar days of the encounter? (R. L. Q B. 5. b; PASBA-populated question)

Requirement

DOD Instruction 6040.42, *Medical Encounter and Coding at Military Treatment Facilities*, 10 June 2004, requires that 100% of APVs be coded within 15 calendar days of an encounter. On the PASBA website, select *Data Quality* on the menu bar, and then select *DQ Guidelines.* Next, select *Tracking Ambulatory Patient Visits in CHCS, MAR 2004 (.doc).*

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of APV coded within 15 calendar days}}{\text{total APV encounters}}$$

Formula Note

The items used to calculate the days remaining to completion are:

- the appointment date
- the original CAPER extraction date from PASBA's CAPER database, and
- the number of completed APV-scheduled appointments received in the *Daily Outpatient Workload Detailed Report* (DOWDR).

Criteria

1. All APV appointments in a kept status on the DOWDR. We will expect to see a completed CAPER.
2. Any APV appointments left in a pending status will be considered as a kept appointment for the calculation of this measure (based on the last appointment status on the DOWDR for any particular appointment).
3. All records in "B**5" clinics. Any APV CAPERs received will have the 15 calendar day requirement applied, whether a particular CAPER was listed on the DOWDR or not.
4. The 15 calendar days requirement does not include the day of the appointment, but does include weekend and federal holidays.

The historical compliance report can be found on PASBA's website. Select *Data Quality* on the menu bar, and then select *Data Quality Program Metrics*. Next, select a month and a year for the report. Click ***View*** and select *Open* or *Save.*

Note: The formula differs from the *Outpatient Encounters Coding Report* in that it does not exclude Federal holidays and weekends. Coding must be completed within 15 calendar days. PASBA calculates this metric using the number of records transmitted and received at PASBA.

Some facilities have noticed discrepancies between the PASBA count and records on hand. What we have found is that the APVs may have been coded on time at the facility but there have not been any entries made in ADM. It is important to ensure that the coding is entered in ADM to get proper credit for coding timeliness.

Background

Refer to Question 2. a.

Facts

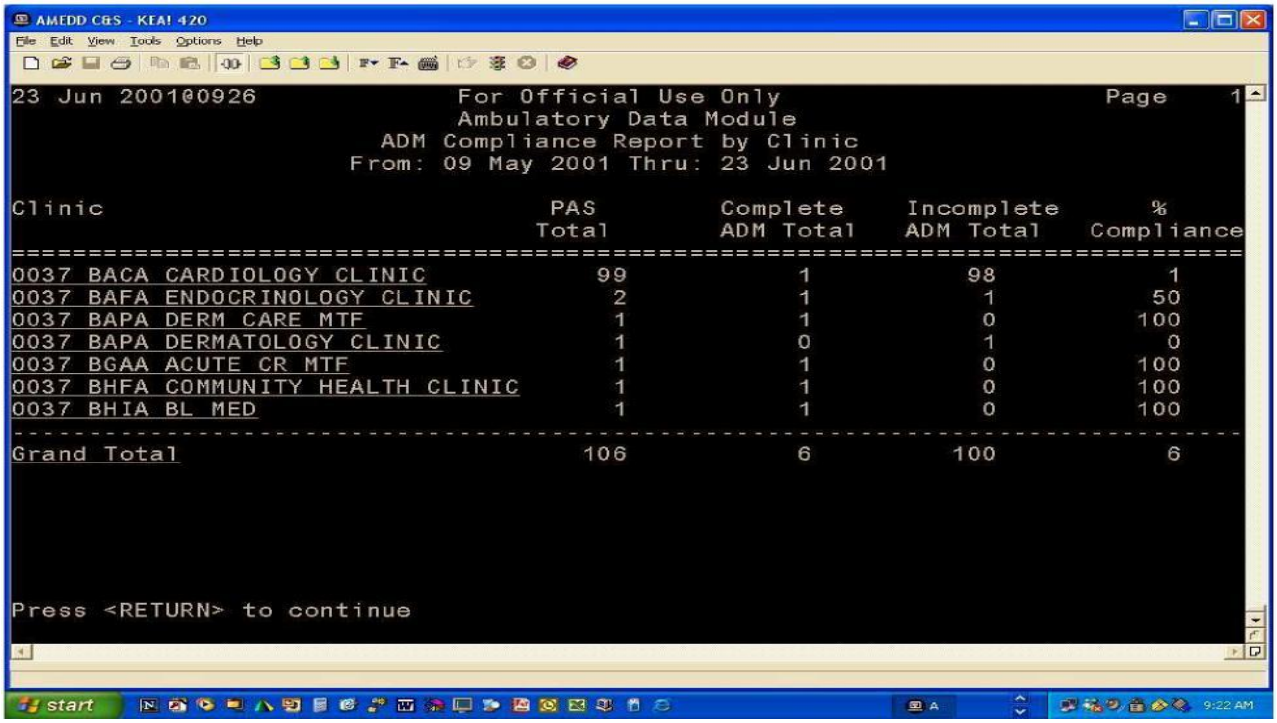
Refer to Question 2. a.

Process

Check how many APV records are incomplete by running the *ADM Compliance Report*. Select only 'B***5' clinics. Do this by selecting (M) for Multiple when prompted "Select (O)ne, (M)ultiple, (A)ll ADM clinics or (Q)uit: A//" on the second screen. Then select all providers and ask for a detailed report. The report will show the provider, the patient, and the day of the visit.

Walk-though screens are available from the PASBA website. Select *Data Quality* on the menu bar, and then select *DQ Guidelines*. Next, select *Tracking Ambulatory Patient Visits in CHCS, MAR 2004 (.doc)*.

The following screenshot is an example, of an *ADM Compliance Report by Clinic*, which displays a breakout by compliance status.



AMEDD C&S - KEA! 420

File Edit View Tools Options Help

23 Jun 2001@0926 For Official Use Only Page 1
Ambulatory Data Module
ADM Compliance Report by Clinic
From: 09 May 2001 Thru: 23 Jun 2001

Clinic	PAS Total	Complete ADM Total	Incomplete ADM Total	% Compliance
0037 BACA CARDIOLOGY CLINIC	99	1	98	1
0037 BAFA ENDOCRINOLOGY CLINIC	2	1	1	50
0037 BAPA DERM CARE MTF	1	1	0	100
0037 BAPA DERMATOLOGY CLINIC	1	0	1	0
0037 BGAA ACUTE CR MTF	1	1	0	100
0037 BHFA COMMUNITY HEALTH CLINIC	1	1	0	100
0037 BHIA BL MED	1	1	0	100
Grand Total	106	6	100	6

Press <RETURN> to continue

start 9:22 AM

Figure 1 Data run sample in an Ambulatory Data Module's report

Recommendations

1. Monitor compliance by running the *ADM Compliance Report*, by physician, to determine how many records are incomplete and need to be closed to avoid falling into the non-compliance category. Provide feedback to providers, coders, and the providers' or coders' supervisors.
2. Evaluate your MTF's business processes for improvement opportunities.

Use the Outpatient Record Transmission Tracking Tool (ORT3) on the PASBA website: Select *My Apps* on the menu bar and select *Outpatient Record Transmission Tracking Tool (ORT3).*

Question 2. c) What percentage of inpatient records has been coded within 30 calendar days after discharge (for MTFs with inpatient capability) (R. L. Q B. 5. c; MTF Reported)

Requirement

DoD Instruction 6040.42, *Medical Encounter and Coding at Military Treatment Facilities,* requires that 100% of all inpatient records should be coded within 30 calendar days after discharge.

The Army Standard will be at 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of inpatient records coded within 30 calendar days}}{\text{total number of inpatients discharged}}$$

Note: The PASBA *R299* report, located on the PASBA website (Select *My Apps* and *SIDR, R299/SIDR Report,* Select a month and year and then click ***View*** to open an R299 report). This is a good tool to check coding compliance for inpatient records. Look at the number of incomplete records and compare this number to what is being reported. If there are incomplete records then an MTF cannot be at 100%. The MTFs should independently track inpatient records completion and not rely solely on PASBA's R299 report. **Note: The R299 report is not based on SIDRs being completed within 30 days of discharge.**

Completed SIDRs have all documentation, correct dates, and are coded. Completed charts are considered "D" status (Disposition SIDR Status).

Background

Refer to question 2. a.

Facts

Refer to Question 2. a.

Process

Open the PAD Delinquency/Deficiency menu in CHCS.

The path is
PAD > IRM > DDM > DOUT > Option 2 (Consolidated Clinical Reports Menu)

Recommendations

1. Run the Consolidated Clinical report at least in 15-day intervals (or as directed by the command group) to monitor records that may fall into the non-compliance category.
2. Ensure the record disposition date is correct in the A&D module.
3. Evaluate the process periodically to detect any bottlenecks such as incomplete records, delinquent entry of disposition information, and delinquent transcription of required documents that delay analysis, abstraction, and/or coding.
4. Ensure inpatient records where patient admission is cancelled are correctly annotated and the cancelled status is transmitted to corporate databases.
5. Run the 462 Report at least in 15-day intervals to assist in monitoring non-compliance records.
6. Page 1 gives the number of dispositions and day's data by department for the period selected and will have a note with counts of records that have not been grouped.
7. Page two will provide a list of the register numbers of ungrouped records.
8. Instructions to run the 462 Report are below.

462 Report

ROM Registration Options Menu

ADT	ADT Processing Menu
PAM	Patient Affairs/Administrative Menu
BSM	Bed Status Menu
IRM	Inpatient Record Menu
OUT	Outpatient Record Menu
MRM	Medical Records Menu
SDM	System Definitions Menu
ORM	**Output Reports Menu**

Select PAD System Menu Option: ORM Output Reports Menu

ROUT	Registration Output Menu
AOUT	ADT Processing Output Menu
MOUT	MEPRS Reports Menu
POUT	Patient Affairs/Administrative Output Menu
BOUT	Bed Status Output Menu
DOUT	Deficiency/Delinquency Output Menu
FOUT	File Maintenance/Ad Hoc Reports Output Menu
EOUT	**Encoder Grouper Output Menu**
IOUT	Inpatient Record Output Menu

Select Output Reports Menu Option: EOUT Encoder Grouper Output Menu

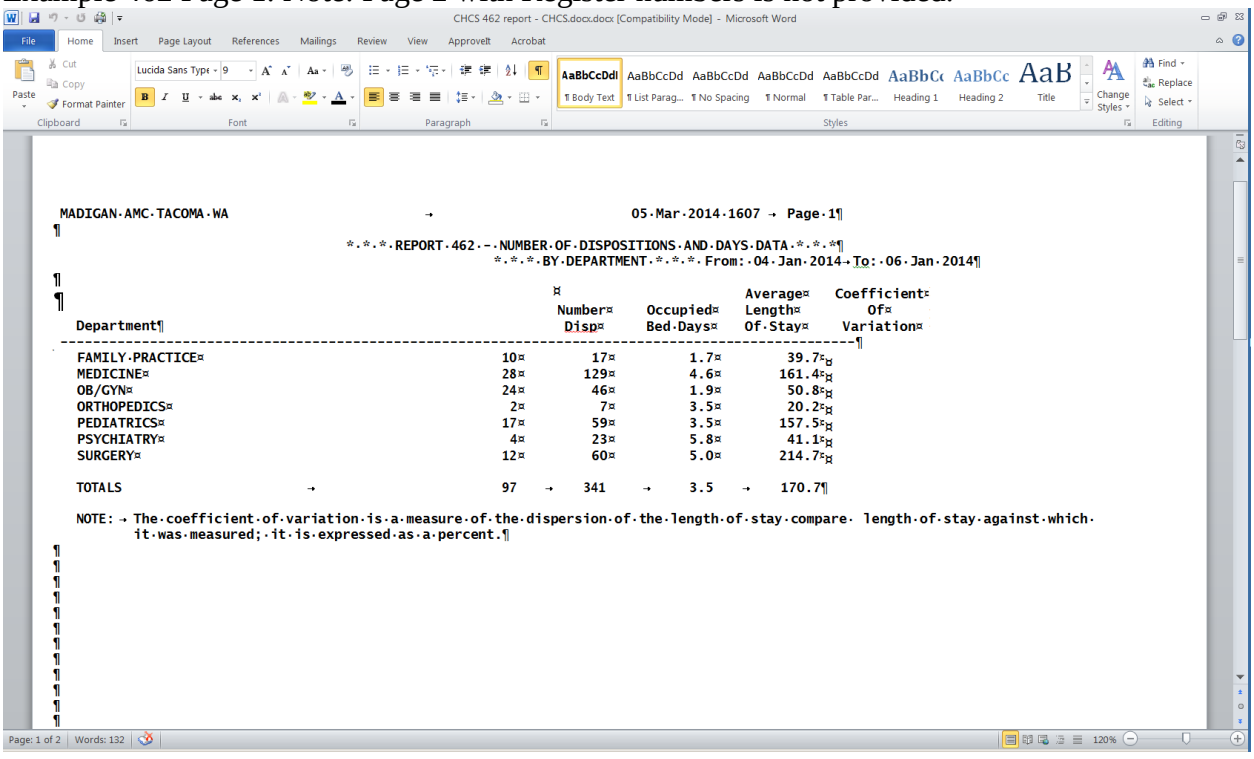
1 (460) No of Dispositions and Days Data by DRG
2 (461) Inpts Who Exceed DRG LOS
3 (462) No of Dispositions and Days Data by Category
4 (463) Records with DRGs 468, 469 or 470
5 (464) Case Mix Deviation from Expected Wt
6 (469) Patient Summary
7 (204) Clinical Records with Forced (Override) Flag
8 Batched Records Without DRGs
9 Final Diagnoses, Procedures, & DRG Report

Select Encoder Grouper Output Menu Option:

MADIGAN AMC TACOMA WA 19 Dec 2013@1343
REPORT 462 - NUMBER OF DISPOSITIONS AND DAYS DATA
*** Current report selections ***
Disposition date range:
Sort Criteria: Department
*** This is a 132 column report ***

[Report 462 Selection] **D**ates **S**ort **G**enerate **H**elp **Q**uit
Enter date range. A date range must be entered in order to generate Report 462.

Example 462 Page 1. Note: Page 2 with Register numbers is not provided.



MADIGAN·AMC·TACOMA·WA → 05·Mar·2014·1607 → Page·1¶

..*.REPORT·462·-·NUMBER·OF·DISPOSITIONS·AND·DAYS·DATA.*.*.*¶
..*.BY·DEPARTMENT.*.*.*.From:·04·Jan·2014→To:·06·Jan·2014¶

Department	Number Disp	Occupied Bed·Days	Average Length Of·Stay	Coefficient Of Variation
FAMILY·PRACTICE	10	17	1.7	39.7
MEDICINE	28	129	4.6	161.4
OB/GYN	24	46	1.9	50.8
ORTHOPEDICS	2	7	3.5	20.2
PEDIATRICS	17	59	3.5	157.5
PSYCHIATRY	4	23	5.8	41.1
SURGERY	12	60	5.0	214.7
TOTALS →	97 →	341 →	3.5 →	170.7

NOTE: → The·coefficient·of·variation·is·a·measure·of·the·dispersion·of·the·length·of·stay·compare· length·of·stay·against·which·it·was·measured;·it·is·expressed·as·a·percent.¶

Question 3. 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 C 3.3.4, requires report reconciliation. (R. L. Q C. 1. a, c, e, f):

Question 3. a) Was the monthly MEPRS(EAS) financial reconciliation completed, validated, and approved by the MTF Resource Manager (i.e. Navy/Army comptroller or Air Force budget officer/analyst) prior to the monthly MEPRS transmission? (YES/NO response required.). (R. L. Q C. 1. a; MTF Reported)

Requirement

The Medical Expense Performance and Reporting System (MEPRS) / Expense Assignment System (EAS) financial reconciliation must be completed prior to the monthly transmittal of data to the EAS repository. The financial reconciliation must be completed and submitted within 45 days of the end of the data month to meet MEPRS submission requirements.

***Yes* is 100% (green) and *No* is 0% (red).**

Background

Financial reconciliation verifies, explains, and validates data between MEPRS and the General Fund Enterprise Business System (GFEBS).

Facts

Failure to perform the MEPRS/EAS financial reconciliation places the integrity of the MEPRS data at risk for invalid costing models for external organizations (TRICARE, MEDCOM, and OTSG) and for any decision making process throughout the Military Health System (MHS).

Recommendations

1. Use the "Financial Recon User Guide" for the Army MEPRS Program Office (AMPO) Helpful Hints for MEPRS EASi Financial Reconciliation guide at http://www.ampo.amedd.army.mil/FUG/FUG.html. Other useful information is available at this website.
2. Please visit the TRICARE MEPRS home page at http://www.meprs.info to view the presentations from past MEPRS conferences.

Question 3. b) 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? (YES/NO response required) (R. L. Q C. 1. c; MTF Reported)

Requirement

The Data Quality Manager and/or MEPRS staff must review the current month's MEPRS Early Warning and Control System (MEWACS) spreadsheet, noting metrics and variance analysis. Any anomalies are to be noted on the appropriate comment section of the DQMC Review List.

***Yes* is 100% (green) and *No* is 0% (red).**

Background

MEWACS is an interactive data quality feedback tool developed by the Tri-Service MEPRS Management Improvement Group to proactively identify, investigate, resolve, or correct potential MEPRS data anomalies in a timely, consistent manner using systematic, repeatable processes. MEWACS was developed to help MEPRS users monitor data quality at their respective installations, and can be accessed via the MEPRS Information Portal at http://www.meprs.info. MEWACS is available in web-based and Excel® formats.

Fact

Early identification and resolution of data quality issues is the key to numerous MHS initiatives that depend on data for decision support. The Surgeon General and his staff need data that is accurate, reliable, and timely to make informed decisions that directly affect the delivery of healthcare across AMEDD.

Process

Download the MEWACS Excel® file from the MEWACS website at http://www.meprs.info/mewacsxls.cfm. Select the proper month of the MEWACS report and review it following the MEWACS User's Guide.
Note: This content is only available to registered My MEPRS members.

Recommendation

The *Executive Summary* (available on the MEWACS website at http://www.meprs.info/mol/execsum.cfm) provides a list of MTFs flagged in MEWACS based on Data Load Compliance, Outliers, Variance, and Allocation indicators. This document is useful for quickly determining which data anomalies were identified in MEWACS for each MTF. If an MTF does not appear in the summary, then no data irregularities were identified for that facility. The MEPRS coordinator or manager for a facility should be primarily responsible for explaining identified anomalies and annotating such in MEWACS.
Note: This content is only available to registered MyMEPRS members.

Question 3. c) For DMHRSi, what is the percentage of submitted timecards by the suspense date? (Timecards submitted by Service-determined date.) (R. L. Q C. 1. e; MTF Reported)

Requirement

Timecards submitted by Service-determined date.

To determine this, the formula is the number of timecards submitted on time divided by the total number of timecards for an MTF.

For the DQ Statement, the MTF's have been given a suspense date of the last calendar day of the month following the data month being reported.

DHA Standard in FY-16 for this question is 97%. Army requirement is 100%- if the percentage is less than 100% the MTF will need to provide a comment on the DQMCP.

Formula

$$\frac{\text{number of timecards submitted on time}}{\text{total number of timecards for an MTF}}$$

Background

DMHRSi is a web-based Human Resources commercial-off-the-shelf (COTS) product designed to simplify and standardize human resource management.

Facts

DMHRSi enables standardization and optimization of the management of human capital by improving decision making through the collection and analysis of critical human resources information.

Process

The requirement for this question is to determine that all timecards affecting the reporting month were in the right status. Before the MTF can process the month, they must have all pay periods that affect that month included. The report must always be run from the first day of the month to the last day of the month. The MTF will run the DoD Batch and Timecard Status Report at the end of the preceding month (i.e. for the January report, the MTF will need to pull the data for these questions on 28 February). To respond to question 3c, the MTF will need to give the percentage of timecards that show as being submitted when the report was run at the end of the month. This would include all timecards in any status except "working" or "not submitted".

Recommendations

For more information, use the **DMHRSi training materials** available at http://ampo.amedd.army.mil/DMHRSi%20Training/DMHRSiTNGPage.html.

Question 3. d) For DMHRSi, what is the percentage of timecards approved by the suspense date? (Timecards submitted by Service-determined date.) (R. L. Q C. 1. f; MTF Reported)

Requirement

Timecards approved by Service-determined date.

DHA Standard in FY-16 for this question is 97%. Army requirement is 100%. If the percentage is less than 100% the MTF will need to provide a comment on the DQMCP.

Formula

$$\frac{\text{number of timecards approved on time}}{\text{total number of timecards for an MTF}}$$

For the DQ Statement, the MTF's have been given a suspense date of the last calendar day of the month following the data month being reported.

Background

DMHRSi is a web-based Human Resources COTS product designed to simplify and standardize human resource management.

Facts

DMHRSi enables standardization and optimization of the management of human capital by improving decision making through the collection and analysis of critical human resources information.

Process

The requirement for this question is to determine the number of timecards in an approved status for the reporting month. Before the MTF can process the month, they must have all pay periods that affect that month included. The report must always be run from the first day of the month to the last day of the month. The MTF will run the *DoD Batch and Timecard Status Report* at the end of the preceding month (i.e., for the February report, the MTF will need to pull the data for these questions on 31 March). To respond to question 3d, the MTF will need to give the percentage of timecards that show as being approved when the report was run at the end of the month (everything except working, submitted, rejected, not submitted, etc.).

Question 4. Compliance with DHA or Service-Level guidance for timely submission of data. (R. L. Q C. 3. a, b, c, d):

Question 4. a) MEPRS (EAS) – 45 calendar days or Service guidance whichever is earlier (R. L. Q C. 3. a; PASBA-populated question)

Requirement

Submission of the EAS/MEPRS data to the EAS repository is due monthly on the date established by the Army MEPRS Program Office (AMPO). This date is 45 consecutive days after the end of the data month reported.

***Yes* is 100% (green) and *No* is 0% (red).**

Criteria

1. Query is run on the EAS IV Repository, looking for the initial submission of MEPRS data.
2. The suspense date for submission is determined by the MEDCOM AMPO.

Background

MEPRS is the MHS cost accounting system. It provides a Tri-Service uniform reporting methodology for consistent financial and operating performance data to assist in financial and manpower decision-making.

Facts

1. Failure to provide timely data impacts on management, planning, programming, and budgeting decisions at the Service, Office of the Assistant Secretary of Defense (Health Affairs) [OASD (HA)], and higher levels. The accuracy and timeliness of this information helps MTFs, MEDCOM and the OASD (HA) defend its resources and to rapidly and confidently respond to data queries by Congress and others.
2. Failure to provide timely data also influences the ability to reflect the clinical intensity and utilization of services and on any decision-making process throughout the MHS.

Process

After the monthly financial and workload reconciliations have been completed, the MEPRS staff must transmit the monthly MEPR to the EAS IV repository. The suspense for transmittal is established by AMPO. Compliance may be monitored for EAS Site Transmission Status on the MEPRS website at http://www.meprs.info/. Log in and select *MEWACS*; select *MEWACS Online*, then select *Data Load Status* under **Metrics**. In the **Parameters** section select *FY*, *Services*, *Most recent transmission dates*, then select *MTF* under the **Show** drop down and

submit.

Recommendations

1. Cross-train MEPRS staff members in all aspects of the MEPRS instead of allowing specialization in one aspect (e.g., the Uniform Chart of Account Personnel Utilization System or EAS). Provide training and education for MEPRS staff members (contact AMPO for availability).
2. Ensure field transmissions are followed up promptly. Early transmission is recommended to avoid failed timely submissions in the event of system firewall issues.
3. Ensure staff are aware of the transmission "handshakes" that confirm that the data was transmitted and received.

Question 4. b) SIDR (CHCS) – (Due on the fifth calendar day of the following month and twentieth of the current month). (R. L. Q C. 3. b; PASBA-populated question)

Requirement

Submission of the Standard Inpatient Data Record (SIDR) update is due to PASBA twice a month. The mid-month transmittal is **due on the fifteenth, but no later than, the twentieth** calendar day of the current month and the end-of-month transmittal is **due on the first, but not later than the fifth, calendar day of the following month.** Transmitting on due dates, or as close as possible, will provide you with a "buffer" in case the transmission fails.

***Yes* is 100% (green) and *No* is 0% (red).**

1. Background: The SIDR is a patient-specific set of data captured in CHCS and reported to M2 and PASBA for analysis. SIDR processing in CHCS permits the update of patient information, the recalculation of workload and Medical Service Account/Third Party Collections billing data, and the retransmission of the SIDR whenever corrections are entered into CHCS. Each SIDR update contains an incremental counter to provide a full audit trail of changes of previously transmitted records. The updates of individual records provide for continuous update of SIDR data in Service and Central DoD databases. SIDR updates can be processed within CHCS for any inpatient record with a disposition in the current and prior year. The MHS three data repositories where the SIDR records reside. The first one is The MHS Corporate Data Warehouse, the MHS Data Repository (MDR). The second system is the MHS Management Analysis and Reporting Tool (M2). The third system is the Army data repository, PASBA.

2. Both MDR and the M2 are updated on a monthly basis around the twentieth of the month; PASBA processes SIDRs more frequently, normally one day after receipt (Bi-monthly, weekly, etc.). The SIDR records that fail to meet the monthly transmission for processing may not be available in the M2 dataset for an additional 30–40 days. This delay results in incomplete data being available for analysis and reporting.

Criteria

Query is run looking for a mid-month SIDR file transmission (no later than the 20th calendar day of the current month) and an end-of-month SIDR file transmission (no later than the 5th calendar day of the following month).

Facts

1. Failure to provide timely data impacts on management, planning, programming, and budgeting decisions at the Service, OASD (HA), and higher levels. The accuracy and timeliness of this information helps MTF's, MEDCOM and OASD (HA) defend their resources and to rapidly and confidently respond to data queries by Congress and others.
2. Failure to provide timely data also influences the ability to reflect the clinical

intensity.

Process

Once the Inpatient Coding Section, or other designee, prepares the SIDR updates, they are forwarded to the CHCS administrator for transmittal via the CHCS System Electronic Transfer Utility (SY-ETU). The system administrator should receive confirmation that the file was complete, or notice that the transfer was not successful from the recipient system.

Note: Check with your system administrator as to when the SIDR task is run and when the System Electronic Transfer Utility (SY- ETU) is set to run. If you wait to run the SIDR report on the last day of the suspense (either the fifth or the twentieth day of the month), and the transfer utility is set to run at 0200 hours, your transmission will be late.

Question 4. c) CAPER (ADM) – Daily transmissions. (R. L. Q C. 3. c; PASBA-populated question)

Requirement

Comprehensive Ambulatory/Professional Encounter Records (CAPER) must be transmitted daily to PASBA and the MHS Data Repository. CAPER encounters are automatically transmitted via the CHCS SY-ETU.

Formula

$$\frac{\text{number of successful CAPER transmissions}}{\text{number of days in the month}}$$

Criteria

Query is run looking for a transmitted daily CAPER file for the parent DMIS ID and all associated child DMIS IDs. (The number of records within each daily CAPER file is not a determining factor in this metric).

Background

The CAPER is a patient-specific set of data captured in CHCS and reported to the MHS Data Repositories and PASBA for analysis. The timely submission of the CAPER data is essential for the availability of up-to-date ambulatory data in the corporate databases for expedient decision support. Only completed (coded) CAPERs are transmitted.

The CAPER Daily Summary report is currently available daily via the PASBA website. Log on to the website https://pasba.army.mil/. Select *My Apps* on the menu bar, and select *CAPER Reports*. Next, select from one of the available processing reports. See Fig. 2 for an example.

If you have any functional questions regarding the operation of the reports, contact numbers are available on the CAPER Data Processing Report home page, located above the Reports table.

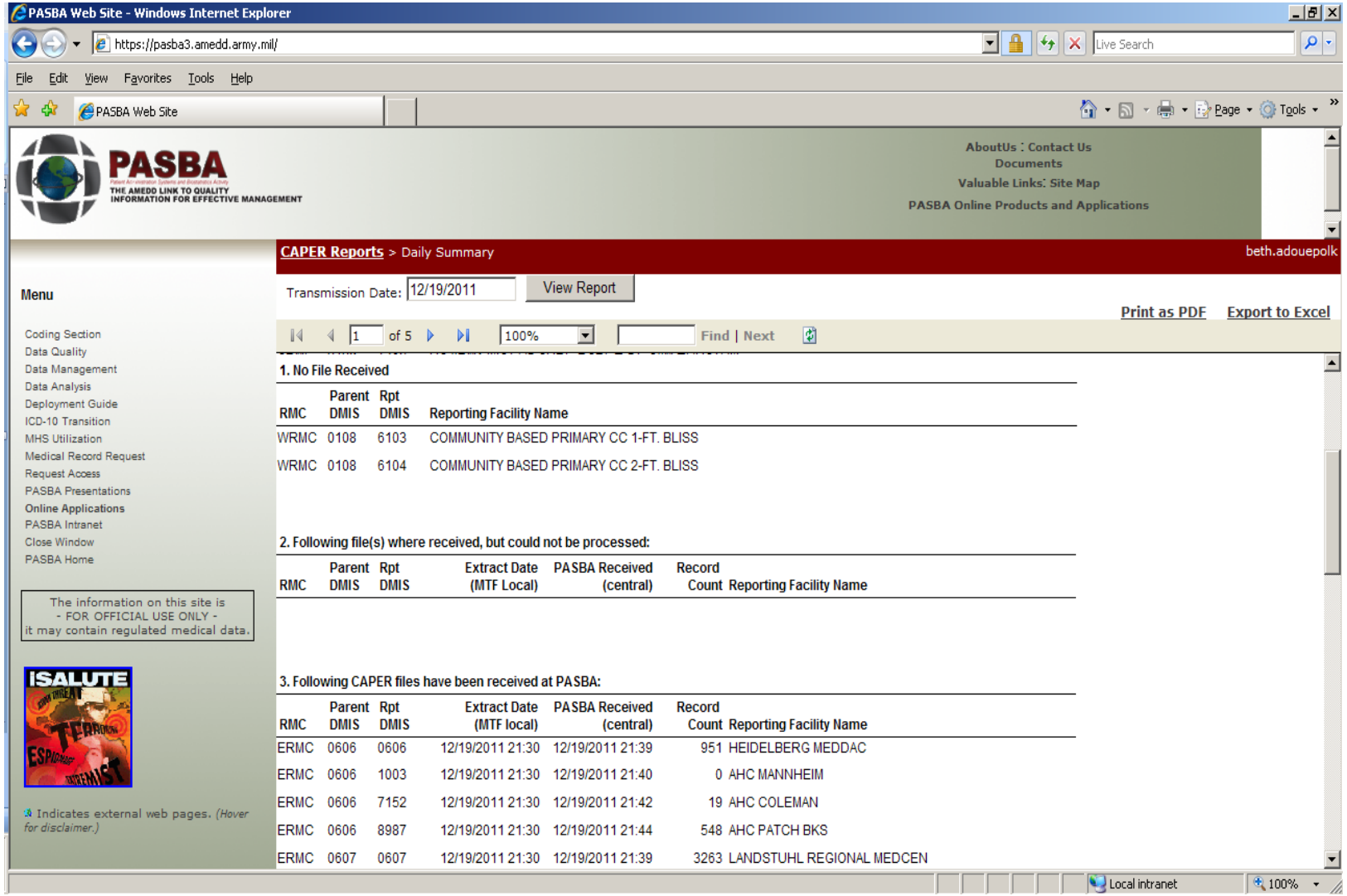


Figure 2 CAPER Daily Summary

Facts

1. CHCS Ambulatory Data Module (ADM) coding is the process where medical information is entered and joins administrative appointment information. Once coded, these records are incorporated into a CAPER file, transmitted to the Third Party Outpatient Collection System (TPOCS), or transmitted to the Medical Service Account billing processes in CHCS for itemized billing.
2. Appointments are not available for coding without a provider being identified in the record or if the appointment status is pending. Timely ADM processing is dependent upon appointment closures in CHCS and consistent EOD processing.
3. At the MHS Data Repository, CAPER files are processed in a batch mode on a weekly basis into the Ambulatory Procedure Grouper (APG), which appends up to four APGs and assigns the Relative Value Unit (RVU) for each Common Procedure Terminology (CPT®) code listed.
4. The MHS has three data repositories where the CAPERs reside. The first one is The MHS Corporate Data Warehouse, the MHS Data Repository (MDR). The second system is the MHS Management Analysis and Reporting Tool (M2). The third is the Army data repository, PASBA. Both the MDR and M2 are updated on a weekly basis, and the Army's data repository is updated daily.

Recommendations

1. ADM coding should be performed daily and before the medical record leaves the clinic to ensure that data recorded in ADM reflects the actual medical record.
2. The ADM manager should use the reports available in the CHCS ADM module to monitor daily completion statistics.
3. Timely appointment closures in CHCS and consistent EOD processing must be emphasized.

The CHCS or ADM administrator is typically the person in charge of the transmission of the CAPER files and verifying that the transmission was successful. When the transmission fails, the administrator must follow up for resolution of the problem. When a host site exists, the administrator must follow up with the host site to determine the nature of the problem, and obtain a trouble ticket number (if applicable) if the problem cannot be resolved at the MTF or installation level.

Question 4. d) Daily Outpatient Workload Detail Report (DOWDR) or Daily Patient Appointments File – daily transmissions. (R. L. Q C. 3. d; PASBA-populated question)

The DOWDR must be transmitted daily to PASBA and the MHS Data Repository.

Formula

$$\frac{\text{number of successful DOWDR transmissions}}{\text{number of days in the month}}$$

Criteria

Query is run looking for a transmitted daily DOWDR file for the parent DMIS ID and all associated child DMIS IDs. (The number of records within each daily DOWDR file is not a determining factor in this metric).

Question 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 - 31 July). (R. L. Q C. 5. c, e, f, g):

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 monthly 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 the MTF.

Question 5. a) Percentage of Inpatient records whose assigned DRG codes were correct? (R. L. Q C. 5. c; MTF Reported)

Note: This is a comparison of the paper record to computerized coded information.

Requirement

DOD Instruction 6040.42, 10 June 2004, *Medical Encounter and Coding at Military Treatment Facilities* requires that all medical encounters within the MHS be accurately documented and coded, adhering to legal and medical coding classification standards as permitted by the MHS data collection systems.

The Army Standard will be at 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of correct MS-DRGs}}{\text{total number of MS-DRGs}}$$

Background

Coding audits are currently required as a part of Department of Defense Instruction (DoDI) 6040.40, *Military Health System Data Quality Management Control Procedures*.

Facts

1. Coding audits insure that medical encounters are accurately documented, coded according to authorized guidelines, and that paper and electronic documentation accurately reflects the patient encounter.
2. Coded data must be accurate because it will be used for clinical and business decisions, and may be used for reimbursement.
3. To attain the goal of quality data, review (or audit) processes need to be in place.
4. Coding audits are currently required. Coding errors potentially understate the intensity of inpatient services for Third Party Collection (TPC) and Utilization Management decisions. If overstated, errors may generate fraudulent TPC claims. The Relative Weighted Product is based on the DRG Code.
5. Audits can be very informative and provide an objective and sometimes more knowledgeable review for facilities. After completion of these audits, appropriate actions should be taken based on issues identified to improve the coding quality.
6. Common actions include updating of data collection tools, feedback to providers and coders, provider education on documentation and coding, coder training, access to current coding books, revision of system templates, and developing system change requests to correct problems inherent in the system.
7. Coding errors may allow for malpractice judgments against the MHS.

Process

Inpatient Professional Services Rounds Encounters Audit

1. "Rounds" in this document refers to the attending inpatient professional services. This includes, but is not limited to the patient's room, the operating rooms, cardiac catheterization suites, and birthing units. It does not include services done in that portion of the facility where the predominant use of the room is outpatient, such as services provided in a physical therapy department, occupational therapy department, radiology department or laboratory.

1.1 Rounds encounters will be audited based on the attending documentation in accordance with the current Military Health System Professional Services and Medical Coding Guidelines, at http://health.mil/Military-Health-Topics/Technology/Support-Areas/MHS-Specific-Coding-Guidelines.

2. The audit will consist of a minimum of 30 records to mirror the minimum of 30 records required to audit inpatient Diagnosis Related Group (DRG). It is acceptable to use the same randomly selected records used for the DRG audit or another randomly selected group. Using the same set of records will decrease the amount of time generating the set, pulling the records and re-filing the records. Guidance for method of generating identified patient admissions to be audited will be Service specific.

3. One calendar day of the attending professional services during each audited hospitalization will be audited from the randomly selected sample.

3.1. For hospitalizations that 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.

3.2. All attending professional services documented on the selected day will be audited for correct coding.

3.2.1. There are occasions when an attending service may change. When this happens more than one round encounter may be auto generated for that specific date. Both encounters will be audited.

4. Reporting Audit Results.

Recommendations

1. Ensure the sample is a true randomly selected number of records.
2. Visit the PASBA *HIMS and Coding* webpage for coding information and resources. For additional guidance, see DoD Coding Guidelines at http://health.mil/Military-Health-Topics/Technology/Support-Areas/MHS-Specific-Coding-Guidelines.
3.
4. Use the edits built into the CCE.
5. Limit use of the CCE override key to the medical records supervisor.

Question 5. b) Percentage of Inpatient Professional Services Rounds encounters E&M Codes audited and deemed correct? (R. L. Q C. 5. e; MTF Reported)

Requirement

Refer to Question 5. a.

Formula

$$\frac{\text{number of correct E\&M codes}}{\text{total number of E\&M codes}}$$

Facts

Refer to Question 5. a.

Question 5. c) Percentage of Inpatient Professional Services Rounds encounters ICD-10 Codes audited and deemed correct? (R. L. Q C. 5. f; MTF Reported)

Requirement

Refer to Question 5. a.

Formula

$$\frac{\text{number of correct ICD-10 codes}}{\text{total number of ICD-10 codes}}$$

Facts

Refer to Question 5. a.

Question 5. d) Percentage of Inpatient Professional Services Rounds encounters CPT Codes audited and deemed correct? (R. L. Q C. 5. g; MTF Reported)

Requirement

Refer to Question 5. a.

Formula

$$\frac{\text{number of correct CPT codes}}{\text{total number of CPT codes}}$$

Facts

Refer to Question 5. a.

Process

1. Audits should be conducted in accordance with your MTF's Coding Compliance Plan, and the Military Health System coding guidance: professional services and specialty coding guidelines at http://health.mil/Military-Health-Topics/Technology/Support-Areas/MHS-Specific-Coding-Guidelines., under coding guidelines.
2. A minimum of 30 records are required to be audited for Inpatient Professional Services Encounter Rounds. (This is not 30 rounds for the same patient. However, if the total number of patients admitted for the month is less than 30 individuals, then this will be your sample size).

3. Select 30 records from a list of patients that were in an inpatient status. If the patients were not admitted as inpatients (observation only) then you would not expect to see notes. Selecting 1 patient record for a patient that was an inpatient for 30 days or more and auditing for round notes on this patient 30 times would not achieve the intent of this measurement. If you pulled 30 records for inpatients and there was not a single round note for any patient, then your compliance is 0%, not 100%, because no round notes were written when the expectation is to see at least one round note for every day the patient is in the hospital.
4. The rounds note should substantiate whatever code was given.

Recommendations

Refer to Question 5. a.
You need to ensure that the admission and disposition encounters are completed and coded; they carry the highest RVU weight.

Note: Auditing Sampling Methodology (for questions 5 a - d) – One calendar day of the attending professional services during each audited hospitalization will be audited from the randomly selected sample. For hospitalizations that 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.

The denominator for all categories should include codes identified by the auditor. See specific Service guidance for calculation details. See applicable current MHS professional services and coding guidelines for coding audits at http://health.mil/Military-Health-Topics/Technology/Support-Areas/MHS-Specific-Coding-Guidelines.

Question 6. Outcome of monthly Outpatient Records audit: 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 - 31 July). The Army uses results from the Code Auditing and Reporting Application for questions 6a, 6b, 6c and 6d. (R. L. Q C. 6. a, b, c, d)

(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 monthly 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). Focused audits may assist each MTF in targeting its coding improvement efforts, while random-sample audit results can be extrapolated to assess the overall coding accuracy for that MTF.

Question 6. 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. Availability of documentation should be reported using CARA results. (Denominator equals sample size). (R. L. Q C. 6. a; MTF Reported)

Requirement

DoD Instruction 6040.43, *Custody and Control of Outpatient Medical Records*, June 2004 at http://www.dtic.mil/whs/directives/corres/ins1.html.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of adequately documented encounters available}}{\text{number of requested encounters}}$$

Note: This question is asking, "Is adequate documentation of the encounter available to be audited?" If the documentation is available, but the patient's outpatient health record is not available, the "record of the encounter" is available for audit**. If mediation has not occurred, please place in your comment "Pre-CARA Mediation" or "pre-audit results", depending on your particular circumstance.**

Background

In 1999, the DoD Inspector General cited the MHS regarding the difficulty of locating outpatient records and for their inability to validate workload due to the lack of supporting documentation. Additionally, in 2003, the *Iowa Foundation Report* cited the inability to locate some outpatient medical records required for a coding audit at fifty MTFs. The consequences associated with the lack of documentation regarding medical care raises accreditation questions and weakens confidence in the direct care system.

Facts

1. It is a DoD policy that all beneficiary medical records are the property of the Department of Defense, and their maintenance and availability at MTFs is the key to appropriate medical care and legal and administrative proceedings. The medical record must be available for the following reasons. It provides:

    - A communications link to healthcare providers for the continuity of patient care.
    - Information to health care providers for quality assurance, evaluation, and improvement of treatment methods.
    - Evidence of treatment and justification for reimbursement claims to third party payers.
    - Information for disability evaluation and processing.
    - Accurate documentation of health care provided to patients.
    - Supporting documentation for education and training for MTF staff, students and patients.
    - Increased provider productivity.
    - Assurance that accurate medical information is documented in records of deployed forces and facilitates pre and post deployment health assessments.

2. Poor accountability represents a serious risk management issue if clinicians do not have the necessary clinical history to consider when making clinical treatment plans.
3. Poor accountability and protections creates the risk of invasion of patient privacy and noncompliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.
4. The absence of records precludes documentation and coding audits from occurring and removes supporting documentation for workload claimed for billing, budget defense, etc.
5. The use of AHLTA has significantly improved the availability of medical documentation on patients and has greatly enhanced the above-mentioned facts.

Note: If an on-hand record [jacket] is missing documentation of the visit to be audited, find the documentation and complete the record for auditing if possible. If the documentation cannot be found, this record is included in your denominator.

Recommendations

1. Accountability must be maintained throughout the MTF through consistent,

disciplined use of the CHCS Record Tracking Module.
2. Clinic clerks must be trained to account for records.
3. Patients must be educated on the importance of returning records to the MTF.

Question 6. b) What is the percentage of E&M codes deemed correct? (E&M code must comply with current DoD Guidance.) (R. L. Q C. 6. b; MTF Reported; using CARA results)

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**. If mediation has not occurred, please place in your comment "Pre-CARA Mediation" or "pre-audit results", depending on your particular circumstance.**

A minimum of thirty (30) records must be selected for auditing question 6 b-3.

Requirement

DOD Instruction 6040.42. *Medical Encounter and Coding at Military Treatment Facilities*, 10 June 2004, available at http://www.dtic.mil/whs/directives/corres/ins1.html, requires that all medical encounters within the MHS be accurately coded, adhering to legal and medical coding classification standards as permitted by the MHS data collection systems.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of correct E\&M codes}}{\text{total number of E\&M codes}}$$

Background

Coding audits insure that medical encounters are accurately documented and coded, insuring that paper documentation and electronic documentation captured in the CHCS/AHLTA accurately reflects the patient encounter.

Facts

1. Refer to Question 2. a.
2. Errors understate or overstate the intensity of service for outpatient services for Itemized Outpatient Billing and Utilization Management decisions.
3. Coding errors may allow for malpractice judgments against the MHS.
4. Understated workload may lead to detrimental staffing or monetary cuts.

Process

Effective in FY 2010, the Code Auditing Reporting Application (CARA) results will be used for all outpatient audits. Once the facility's audit is completed, the facility reviews the results. If

they disagree with the results, they have an option to "mediate" with PASBA. The results for each month are posted on the PASBA website at https://pasba.army.mil/; Select *My Apps* on the menu bar and select *CARA*.

Recommendations

1. Visit the PASBA *HIMS and Coding* webpage for coding information and resources.
2. Goals:
   - Reinforce documentation requirements
   - Establishment of MTF coding coaches to assist providers in the selection of the appropriate codes to substantiate the documentation.
   - Coding coaches review results of CARA audits with providers and make recommendations.
   - Establish a Coding and Billing Compliance Program per OTSG/MEDCOM Policy Memo 09-088, *Coding and Billing Compliance Policy*, dated 17 Nov 2009.
   - Use of Coding Compliance Editor application can greatly assist in identifying potential coding errors.

Question 6. c) What is the percentage of ICD-10 codes deemed correct? (R. L. Q C. 6. c; MTF Reported; using CARA results)

Requirement

DODI 6040.42, *Medical Encounter and Coding at Military Treatment Facilities*, available at http://www.dtic.mil/whs/directives/corres/ins1.html requires that all medical encounters within the MHS be accurately coded, adhering to legal and medical coding classification standards as permitted by the MHS data collection systems.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of correct ICD-10 codes}}{\text{total number of ICD-10 codes}}$$

Background

Refer to Question 6. b.

Facts

Refer to Question 6. b.

Process

Refer to Question 6. b.

Recommendations

1. Refer to question 6. b.
2. Reference summary data by error type as defined in the coding guidelines.
3. Track and report per Coding Compliance Plan to Internal Coding Compliance Team.
4. Develop a strategy to observe data for sustained improvement. Contact PASBA Data Quality Section for assistance with M2 use and analysis.
5. Visit the Military Health System and the Defense Health Agency TRICARE Chief Financial Officer's webpage at http://www.tricare.mil/ocfo/ and click *Data Quality Management Control (DQMC) Training.* Select Training and then under Training, select the documents links to review the presentations offered during the DHA Data Quality Training Sessions. These are very interesting educational presentations covering information that can be beneficial to your organization. Some contain speaker's notes that may help you to get a better feel for the presentation.

If mediation has not occurred, please place in your comment "Pre-CARA Mediation" or "pre-audit results", depending on your particular circumstance.

Question 6. d) What is the percentage of CPT codes deemed correct? (CPT code must comply with current DoD guidance.) (R. L. Q C. 6. d; MTF Reported; using CARA results)

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.

The denominator for all categories should include codes identified by the auditor. See specific Service guidance for calculation details.

Select the current year's file for applicable MHS Professional Services and Specialty Coding Guidelines (Appendix F) for "Coding Audits" at http://tricare.mil/tma/dhcape/data/ubu.aspx.

If mediation has not occurred, please place in your comment "Pre-CARA Mediation" or "pre-audit results", depending on your particular circumstance.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of correct CPT codes}}{\text{total number of CPT codes}}$$

Background

Refer to Question 6. b.

Facts

Refer to Question 6. b.

Process

- Refer to Question 6. b.
- For further guidance: see the Coding Reviews/Audits of Professional Services and the military health system coding guidance: professional services and specialty coding guidelines at the Unified Biostatistical Utility website. Select the current year's file for *coding guidelines* at http://tricare.mil/tma/dhcape/data/ubu.aspx.

Note: *The denominator for all* categories should include codes identified by the auditor. See specific Service guidance for calculation details. (Select current year file for applicable MHS Professional Services and Specialty Coding Guidelines (Appendix F) for "Coding Audits" at http://tricare.mil/tma/dhcape/data/ubu.aspx)

If mediation has not occurred, please place in your comment "Pre-CARA Mediation" or "pre-audit results", depending on your particular circumstance.

Question 7. Outcome of monthly Ambulatory Procedure Visits (APV) audit. 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., 1 - 31 July) (R. L. Q C. 7. a, b, c)

(See applicable DoDD or DoDI guidance 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 monthly 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). Focused audits may assist each MTF in targeting its coding improvement efforts, while random-sample audit results can be extrapolated to assess the overall coding accuracy for that MTF.

Question 7. 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). (R. L. Q C. 7. a; MTF Reported)

Requirement

DODI 6040.43, *Custody and Control of Outpatient Medical Records*, establishes an availability standard of 100% for FY-08. "Availability" is defined as located within the MTF having functional responsibility for maintaining the record.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of adequately documented encounters available}}{\text{number of requested encounters}}$$

Background

In 1999, the DoD Inspector General cited the MHS regarding the difficulty of locating Outpatient Records, and the inability to validate workload due to the lack of supporting documentation. Additionally, in 2003, the Iowa Foundation Report cited the inability to locate some outpatient medical records required for a coding audit at 50 MTFs. The consequences associated with the paucity of documentation regarding medical care raises accreditation questions and weakens confidence in the direct care system.

Facts

1. Proper and complete documentation is paramount in healthcare delivery operations. It provides:
   - A communications link to health care providers for the continuity of patient care.
   - Information to health care providers for quality assurance, evaluation, and improvement of treatment methods.
   - Evidence of treatment and justification for reimbursement claims to third party payers.
   - Information for disability evaluation and processing.
   - Accurate documentation of health care provided to patients.
   - Supporting documentation for education and training for MTF staff, students and patients.
   - Increased provider productivity.
   - Assures accurate medical information is documented in records of deployed forces and facilitates pre- and post-deployment health assessments.
2. Poor documentation represents a serious risk management issue if clinicians do not have the necessary clinical history to consider when making clinical treatment plans.
3. The absence of records precludes documentation and coding audits from occurring, and removes supporting documentation for workload claimed for billing, budget defense, etc.

Process

If an on-hand record [jacket] is missing documentation of the visit to be audited, find the documentation and complete the record for auditing if possible. If the documentation cannot be found, this record is included in your denominator.

Recommendations

1. Accountability must be maintained throughout the MTF through consistent, disciplined use of the CHCS Record Tracking Module.
2. Clinic clerks must be trained to account for records.

Question 7. b) What is the percentage of ICD-10 codes deemed correct? (R. L. Q C. 7. b; MTF Reported)

Requirement

DODI 6040.42, Medical Encounter and Coding at Military Treatment Facilities, available at http://www.dtic.mil/whs/directives/corres/ins1.html requires that all medical encounters within the MHS be accurately coded, adhering to legal and medical coding classification standards as permitted by the MHS data collection systems.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of correct ICD-10 codes}}{\text{total number of ICD-10 codes}}$$

Background

Refer to Question 6. b.

Facts

Refer to Question 6. b.

Process

1. Refer to Question 6. c.
2. For further health system coding guidance, professional services and specialty coding guidelines see the Unified Biostatistical Utility website at http://tricare.mil/tma/dhcape/data/ubu.aspx. Select the current year's file under *Coding Guidelines.*

Recommendations

1. Refer to question 6. b.
2. Reference summary data by error type as defined in the coding guidelines.
3. Track and report per Coding Compliance Plan.
4. Develop a strategy to observe data for sustained improvement. Contact PASBA's Data Quality Section for assistance with M2 use and analysis.

Question 7. 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. (R. L. Q C. 7. c; MTF Reported)

Requirement

DOD Instruction 6040.42, *Medical Encounter and Coding at Military Treatment Facilities* June 10, 2004 requires that all medical encounters within the MHS be accurately coded, adhering to legal and medical coding classification standards as permitted by the MHS data collection systems.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of correct CPT codes}}{\text{total number of CPT codes}}$$

Note: The denominator for all categories should include codes identified by the auditor. See specific Service guidance for calculation details. Select current year file for applicable MHS Professional Services and Specialty Coding Guidelines (Appendix F) for coding audits at http://tricare.mil/tma/dhcape/data/ubu.aspx.

Background

Refer to Question 6. d.

Facts

Refer to Question 6. d.

Process

1. Refer to Question 6. d.
2. For further health system coding guidance, professional services and specialty coding guidelines see the Unified Biostatistical Utility website at http://tricare.mil/tma/dhcape/data/ubu.aspx. Select the current year's file under *Coding Guidelines.*

Recommendations

Refer to Question 6. d.

Note: The denominator for all categories should include codes identified by the auditor. See

specific Service guidance for calculation details. Select the current year's file for applicable MHS Professional Services and Specialty Coding Guidelines (Appendix F) for "Coding Audits" at http://tricare.mil/tma/dhcape/data/ubu.aspx.

Question 8) DD-2569 forms In a random review of Non-Active Duty medical records or encounters from the data month, looking for the Other Health Insurance (OHI) information documents (DD Form 2569s (Third Party Collection Insurance Information, electronic or hardcopy) or evidence of OHI discovery activity), 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 an MTF for the review data month (e.g., 1 - 31 July). (R. L. Q C. 8. a, b, c, d, e, f):

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 PASBA DQ Section produces a DD Form 2569 audit pull list (questions 8. a., 8. b., and 8. c.) and sends it directly to the MTF DQ managers. Each facility selected a range of encounters for APV, Outpatient and Inpatient encounters, with a minimum of 30 records per category. This audit pull list will be used by MTFs to determine which inpatient dispositions, outpatient encounters, and APVs will be audited for a completed DD Form 2569.

Based upon the Uniformed Business Office (UBO) guidelines, the DQMC program will accept Other Health Insurance (OHI) information documents (DD Form 2569s (Third Party Collection Insurance Information, (electronic or hardcopy) or evidence of OHI discovery activity). The form, in either electronic or hard copy, does not have to be maintained in a patient's record. The original document is maintained at the treating facility and a copy (either a hard copy or an electronic copy) must be sent to the MTF where the patient's medical records are maintained.

Recommendations

1. During initial registration, clerks must ask each non-active duty patient if they have any type of medical coverage other than TRICARE, and initiate a DD Form 2569.
2. Upon subsequent visits, clerks must check that a current DD Form 2569 is on file. A current DD Form 2569 is one completed within the last 12 months.
3. The most current version of the DD Form 2569 may be found at http://www.tricare.mil/ocfo/mcfs/ubo/sit_ohi.cfm . To open a PDF version, scroll down to the *DD 2569 2013* link under ***What is OHI?***

Background

The Third Party Collection Program (TPCP) was established under Title 10 U. S. Code, Section 1095 per reference at http://www.gpo.gov/fdsys/pkg/USCODE-2011-title10/html/USCODE-2011-title10-subtitleA-partII-chap55-sec1095.htm. The TPCP authorizes DOD to bill and collect from third party payers for the reasonable cost of health care provided to insured member's beneficiaries in military treatment facilities.

PASBA will provide random DD 2569 audit pull lists to each facility for Inpatients, Outpatients, and APVs. PASBA will provide this list around the 8th of the month for the previous month. You may request an audit of more than the 30 minimum records required and PASBA will add the

additional records to your pull lists. These audit pull lists contain patient identifiable information and must be encrypted before being sent to another individual.

For questions 8. a., 8. c. and 8. e. - the numerator should be the number of completed and current DD 2569s available. The denominator is the number of Non-Active Duty records audited (your sample size). (Formula: the number of complete and current DD 2569s divided by the number of Non-Active Duty records audited).

For questions 8. b., 8. d. and 8. f., the denominator should match the numerator (number of completed and current DD 2569s available) from the previous questions (8. a., 8. c., and 8. e.). The numerator will be the number of correct entries in the PII module. (formula: the number of correct entries in the PII module divided by the number of available, current and complete DD Form 2569s). Only those 2569s that indicated "Yes"—there is other health insurance—should be entered into the CHCS PII module. Any 2569s with a response of "No," stating there is no other health insurance, should be checked to ensure there is not something in the patient's data in the CHCS PII module indicating otherwise (i.e., in questions 8. a., 8. c. and 8. e. you audited 30 encounters for DD 2569s and you found 30 DD 2569s, some *Yes* for Other Health Insurance (OHI) and some *No* for OHI.) Your compliance for questions 8. a., 8. c. and 8. e. is 100%; you audited 30 encounters and you found 30 DD 2569s (30/30 equals 100%). In questions 8. b., 8. d. and 8. f. your denominator is 30; this is the number of DD 2569s you found for questions 8. a., 8. c. and 8. e. Out of the 30 DD 2569s that you found for each question, 15 were *Yes* for OHI and 15 were *No* for OHI. The 15 'Yes for OHI' DD 2569s' should be found in the PII module; if any of these responses for the OHI forms is not in the PII module then this would be considered a fail. You should not find any of the 15 *No* responses for the OHI DD 2569s in the PII module as having OHI; if you do, then that would be considered as a fail..

From the 30 randomly pulled inpatient dispositions:

Question 8. a) What percentage of completed and current OHI information documents (DD Form 2569s signed within the past 12 months or evidence of OHI discovery dated within the past 12 months) is available for review (non-active duty encounters only)? (See DoD 6010.15-M, MTF UBO Manual) (R. L. Q C. 8. a; MTF Reported; using audit pull list provided by PASBA)

Formula

$$\frac{\text{number of complete and current OHI information documents}}{\text{number of Non-Active Duty records audited}}$$

Availability may be an electronic or hard copy signed form maintained in other locations.

Question 8. b) What percentage of available, current and complete OHI information documents (DD Form 2569s or evidence of OHI discovery) is verified to be correct in the Patient Insurance Information (PII) module in CHCS? (R. L. Q C. 8. b; MTF Reported)

Formula

$$\frac{\text{number of correct entries in the PII module}}{\text{number of available, current and complete OHI discovery documents}}$$

From the 30 randomly pulled outpatient encounters:

Question 8. c) What percentage of completed and current OHI information documents (DD Form 2569s signed within the past 12 months or evidence of OHI discovery dated with the past 12 months) is available for review (non-active duty encounters only)? (See DoD 6010.15-M, MTF UBO Manual) (R. L. Q C. 8. c) (MTF reported, using audit pull list provided by PASBA)

Formula

$$\frac{\text{number of complete and current OHI information documents}}{\text{number of Non-Active Duty records audited}}$$

Availability may be electronic or hard copy signed form maintained in other locations.

Question 8. d) What percentage of available, current and complete OHI information documents (DD Form 2569s or evidence of OHI discovery) is verified to be correct in the Patient Insurance Information (PII) module in CHCS? (R. L. Q C. 8. d; MTF Reported)

Formula

$$\frac{\text{number of correct entries in the PII module}}{\text{number of available, current and complete OHI discovery documents}}$$

From the 30 randomly pulled APVs:

Question 8. e) What percentage of completed and current OHI information documents (DD Form 2569s signed within the past 12 months or evidence of OHI discovery dated within the past 12 months) is available for review (non-active duty encounters only)? (See DoD 6010.15-M, MTF UBO Manual) (R. L. Q C. 8. E; MTF Reported; using audit pull list provided by PASBA)

Formula

$$\frac{\text{number of complete and current OHI information documents}}{\text{number of Non-Active Duty records audited}}$$

Availability may be electronic or hard copy signed form maintained in other locations.

Question 8. 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? (R. L. Q C. 8. f; MTF Reported)

Formula

$$\frac{\text{number of correct entries in the PII module}}{\text{number of available, current and complete OHI discovery documents}}$$

Question 9. Comparison of reported workload data (R. L. Q C. 9. a, b, c, d):

Question 9. a) Number CAPER encounters / number of Kept-Appointments. (R. L. Q C. 9. a; PASBA-populated question)

Please read the notes at the end of each question.

The Army standard for questions 9. a. through 9. d. is 97-100%, green; 90-96%, amber; and less than 90% is red).

Requirement

If your facility meets or exceeds the 97%, you are not required to provide a comment. However, if your facility does not meet the goal, a comment is required, which indicates the problem identified, the corrective actions taken, and the data month and year your MTF expects compliance to meet the 97% goal. In addition if you facility is over 103% for this question, a comment is required which indicates the reason why.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of CAPER Encounters}}{\text{number of Kept-Appointments}}$$

Criteria

1. Number of completed CAPER encounters that are listed as appointments on DOWDR files.
2. Number of kept appointments are from the DOWDR. Appointments in a kept, walk-in, sick-call status, to include only T-cons in a count status. Any DOWDR appointments left in a pending status will be consider a kept appointment (based on last DOWDR received for any particular appointment).
3. Records from all "B" clinics and "FBN".

Background

Workload reconciliation between the different Information Technology (IT) systems is important to ensure the MTF is capturing 100 percent of its workload.

Facts

Discrepancies give the perception that we cannot accurately account for workload even between internal systems, and place the Army Medical Department and the MTF at risk for invalid costing models for external organizations (General Accounting Office (GAO), Office of

Management and Budget (OMB), and others).

Process

Number CAPER Encounters:

Note: Questions a-d above are allowed to be greater than 100%, with a comment required for percentages over 103%.

Recommendations

1. Ensure all workload is captured.
2. Ensure timely completion of all CAPERs.

Question 9. b). Number of MEPRS dispositions from EAS / number of SIDR D and E status dispositions. (R. L. Q C. 9. b; PASBA-populated question)

Requirement

The number of MEPRS Dispositions from EAS should equal the number of D and E status Dispositions. The MEPRS Dispositions from EAS and the number of D and E status Dispositions do not include Absent Sick and CROs.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of MEPRS Dispositions from EAS}}{\text{number of SIDR D and E status Dispositions.}}$$

Criteria

1. MEPRS dispositions are extracted from the EAS IV Repository.
2. SIDR records in a D status (completed) and SIDR records in a E status (discharged), extracted from SIDR file transmissions.
3. Absent Sick and CRO (carded for record only) are not included, primarily due to MEPRS not reporting on these two statuses.
4. Number of SIDR D and E status Dispositions should match the R299 Total month column excluding CRO and Absent Sick cases.

Note: Questions a-d above, are allowed to be greater than 100%, with a comment required for percentages over 103%.

Background

Workload reconciliation between the different Information Technology (IT) systems is important to ensure the MTF is capturing 100 percent of its workload.

Facts

1. Discrepancies give the perception that we cannot accurately account for workload even between internal systems, and place the Army Medical Department and the MTF at risk for invalid costing models for external organizations (GAO, OMB, and others).
2. Unfortunately, unlike SIDR processing, the MEPRS/EAS, the CHCS Workload Assignment Module (WAM), do not automatically recalculate workload data for a prior submission. A manual recalculation is required in each case to account for corrections.
3. All completed SIDR dispositions with a "D" and "E" record status and MEPRS Dispositions from EAS are normally correlated. When there is a marked difference

between SIDR and MEPRS dispositions from EAS numbers (with SIDR being lower), there are three possibilities:

a. EAS transmission problems
b. SIDR records remain un-coded/incomplete at site
c. SIDR files were not received by PASBA and subsequently not included in the PASBA SIDR database. (Note: files not received by PASBA were also probably not received by DHA, and subsequently not included in the MHS Management Analysis and Reporting Tool (M2) database).

Process

Divide the number of MEPRS dispositions from EAS by the number of SIDR D and E status dispositions. When counting dispositions in SIDR, make sure you only include the number of "D" and "E" SIDRs (i.e., completed records and incomplete records) for the reporting month; excluding CRO and Absent Sick Records.

Question 9. c) Number of MEPRS visits / number Kept-Appointments (count only)
(R. L. Q C. 9. c; PASBA-populated question)

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of MEPRS visits}}{\text{Kept-Appointments (count only)}}$$

Criteria

1. Number of MEPRS visits (outpatient encounters) are extracted from the EAS IV Repository, MEPRS only reports count workload.
2. Number of kept appointments (kept, walk-in, sick call, T-con) from the DOWDR, count only workload.
3. Any appointments on the DOWDR in a pending status are considered KEPT appointments.

Note: Questions a-e above are allowed to be greater than 100%, with a comment required for percentages over 103%.

Background

Workload reconciliation between the different Information Technology (IT) systems is important to ensure the MTF is capturing 100 percent of its workload.

Facts

1. Discrepancies give the perception that we cannot accurately account for workload even between internal systems, and place the Army Medical Department and the MTF at risk for invalid cost models for external organizations (GAO, OMB, and others).
2. Unfortunately, unlike SIDR processing, the MEPRS/EAS, the CHCS Workload Assignment Module (WAM), do not automatically recalculate workload data for a prior submission. A manual recalculation is required in each case to account for corrections.

Recommendations

- Use the MEPRS/EAS "Outpatient Template and Workbook", which provides instructions for performing and reconciling outpatient data.
- Ensure corrections made in one data system are also made in the others.

Note: The EAS IV dispositions and visits are the numbers submitted by the MTF as of the suspense date and are downloaded from the EAS repository. Please check with your RM or MEPRS staff to validate the information. If your MTF

has submitted a corrected EAS transmission or has made a late transmission, let us know so we may refresh the data and update our files.

Question 9. d) Number of Inpatient Professional Services Rounds CAPERs encounters (A***CAPERs) / number of Total Bed days + Dispositions from EAS. (R. L. Q C. 9. d; (PASBA-populated question)

Note: Questions a - d above, are allowed to be greater than 100%, with a comment required for percentages over 103%.

Requirement

If your facility meets or exceeds the 97%, you are not required to provide a comment. However, if your facility does not meet the goal, a comment is required, which indicates the problem identified, the corrective actions taken, and the data month and year your MTF expects compliance to meet the 97% goal. In addition if you facility is over 103% for this question, a comment is required which indicates the reason why.

The Army Standard will remain at 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of Inpatient Professional Services Rounds CAPERs encounters (A***CAPERs)}}{\text{number of Bed days + Dispositions from EAS}}$$

Criteria

1. On 'A' CAPERs exclude any rounds that are from external resource sharing agreements/DMIS IDs.
2. Only accept 'A' CAPERs with an appointment type of 'Round'.
3. Exclude any rounds with only an E&M code of *99499* with no other E&M code or CPT code.
4. Exclude any rounds with only code of *V68.89* (administrative code).
5. The occupied bed days + dispositions come from the Expense Assignment System of MEPRS.

Note: Number of Inpatient Professional Services Rounds CAPERs Encounters should be completed rounds, not the total number of rounds created by CHCS.

Background

The Military Health System (MHS) is moving toward collecting professional services in a manner similar to the civilian healthcare industry. The civilian healthcare industry tracks workload using institutional (hospital) and professional services (performed by the

physician/provider) records. Historically, the MHS used a different system, which relied on inpatient and outpatient records. Coded data was collected regarding inpatient encounters in the Standard Inpatient Data Record (SIDR). Outpatient (e.g., office visits, observation and same day-surgeries) coded data were collected in the Standard Ambulatory Data Record (SADR) now referred to as Comprehensive Ambulatory Professional Encounter Record (CAPER). Due to marked differences in the two systems (institutional and professional versus inpatient and outpatient), it has not been possible to capture important clinical information for inpatient care, in order to reconcile direct care (MTF) care with purchased care ("downtown care"), and to use some civilian benchmarks. Current efforts are being emphasized to require one round note per day per patient.

Inpatient Professional Services Rounds (IPSR) Encounters Audit Methodology:

1. "Rounds" in this document refers to the attending inpatient professional services. This includes, but is not limited to the patient's room, the operating rooms, cardiac catheterization suites, and birthing units. It does not include services done in that portion of the facility where the predominant use of the room is for outpatients, such as services provided in a physical therapy department, occupational therapy department, radiology department or laboratory.
2. The audit will consist of a minimum of 30 records to mirror the minimum of 30 records required to audit inpatient Diagnosis Related Group (DRG). It is acceptable to use the same randomly selected records used for the DRG audit or another randomly selected group. Using the same set of records will decrease the amount of time generating the set, pulling the records and re-filing the records. Guidance for the method of generating identified patient admissions to be audited will be Service specific.
3. One calendar day of the attending professional services during each audited hospitalization will be audited from the randomly selected sample.
4. For hospitalizations that 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.
5. All attending professional services documented on the selected day will be audited for correct coding.
6. There are occasions when an attending service may change. When this happens more than one round encounter may be auto generated for that specific date. Both encounters will be audited.

Reporting Audit Results

1. Rounds encounters will be audited for correct E/M, CPT, and ICD-10 diagnosis.
2. Documentation. If there is no professional services documentation for the day, and no professional service is coded, it is considered correct. Refer to paragraph 1.1. above. If there is insufficient documentation to assign an E/M, and no E/M is assigned, it is considered correct.

3. Procedure but no separately identifiable evaluation and management. If there is documentation of a procedure (e.g., an operative report) but no separately identifiable evaluation and management encounter, the encounter will only be considered in determining diagnosis and procedure correctness.
4. This methodology excludes professional services consults from any specialty care or primary care service. These professional services are currently captured and audited in the outpatient B MEPRS audits.

Facts

1. Given the importance of accurate clinical coding, the ASD/HA and the Service Surgeons General agreed to improve our inpatient coding practices.
2. IPSR aligns the MHS with the civilian sector and paves the way for inpatient-itemized billing.
3. The goal is to align military workload capture with industry-standard civilian practices. Coding inpatient professional services is a step towards that goal.
4. IPSR currently relates only to the capture of inpatient encounters.
5. Provides full visibility of inpatient workload to support future clinical and business decisions. With the implementation of the Prospective Payment System (PPS), staffing and budget will be based on the productivity of the providers using the Provider Aggregate Relative Value Unit (RVU) generated.
6. Provides accurate measure of provider productivity to match MEPRS data.
7. Potential for increased third-party reimbursements.

Rationale: DHA has implemented the reporting of IPSR Rounds. DHA will use the goal of 97% for compliance.

Process

1. Each day a patient is hospitalized within an MTF, a new appointment (RNDS) will automatically be created in CHCS.
2. During hospitalization or at the end of a hospitalization, inpatient institutional coders will review the record, code professional services, and associate them with the RNDS appointments.
3. RNDS captures professional services provided directly to a patient by an individually privileged provider. At facilities that have Graduate Medical Education (GME) staff, the attending provider will need to document the care in order to receive workload credit based on CMS documentation rules.
4. RNDS does not capture institutional services of non-privileged providers/staff: interns, residents, fellows or resources associated with equipment, facilities, utilities and supplies that are utilized or consumed during an inpatient episode.
5. Rounds (IPSR) data will be transmitted with CAPER data records; institutional (hospital) services will continue to be coded "as is" and will be transmitted with the SIDR records.
6. Professional staff will familiarize themselves with the process in the Ambulatory

Data Module (ADM) in CHCS. The menu path is: ADS > Select Option 1 – ADM Data Entry Menu > Type RND or select Option 6.

Note: Some MTFS are reporting the number of IPSR rounds created in CHCS instead of the number of completed IPSR records. Use the M2 Professional Encounters Object (MEPRS4 Matches Pattern A %) to obtain the number of completed IPSR Rounds.

Recommendations

1. Continue to train physicians and coders. IPSR Rounds will be automatically deleted from the system 30 days after discharge. Start a tracking system so valuable RVU productivity will not be lost.
2. Create awareness of the possible negative financial implications of not counting the IPSR Rounds. Admission and disposition notes will generate the most RVUs; pay special attention to those.
3. Monitor activity (compliance) using the Professional Encounters Object in the MHS Management Analysis and Reporting Tool (M2).

Note: This computation uses the number of Total bed days and dispositions from EAS and the total number of CAPERS ("A***" MEPRS Code) that are in the PASBA CAPER database.

Validate Service report to the criteria below:

1. For ADM Encounters, omit Appointment Status of "No-Show", "Canceled", "Disposition Code" and "Left without being seen" but include Appointment Status "TelCon" and "Occ-Svc".
2. Exclude RAD* appointment types from denominator."
3. For MEPRS visits use outpatient visits that include APVs.
4. Only CAPER records in B**** and FBN* clinics that are marked complete "C" will be included.
5. SIDRs with a Disposition Status of "D" and "E" will be included.
6. SIDRS will exclude Carded for Record Only (CRO) and absent sick records (primarily Army issue).

ADM and MEPRS should include FBN and B MEPRS codes for encounters or visits.

For Inpatient Professional Services "RNDS" CAPER completions, include (A*** CAPERS) that were completed by the attending provider or service.

Question 10. Use CHCS during the data month to identify potential duplicate patient registration. (R. L. Q C. 2. a. 4):

Question 10. 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? List the DMIS IDs of the MTFs included in the comments section. Ending balance (R. L. Q C. 2. a. 4; MTF Reported)

Requirement

Host Server Sites will use the duplicate patient report in CHCS. The CHCS software version will be listed along with the count of duplicate patients and DMIS IDs that are used during the reporting month to identify duplicate patient registration records. (C. 2a). Potential duplicate patient records can be minimized by performing DEERS validation checks. CA>PAS>MAN>RMCP>RREG>DRDM. Use the demographics option to synchronize record after verification of DEERS data.

Background

Duplicate patients in the MHS databases have been an ongoing problem. It leads to incorrect counts and erroneous data. Each MTF is responsible for getting correct information into the databases. Errors cause decisions on funding, resources, and patient safety to be made on faulty data.

Fact

Duplicate data skews the analysis done on the data, and decisions are based on this erroneous information. Proactive action is necessary to correct this type of error.

Process

Run the CHCS standard report – "Potential Duplicate Patient Search". List the DMIS IDs of the MTFs included in the Problem Statement section and state the corrective action and summary comment for all duplicate patients. Example 5 potential duplicates found, 3 were excluded and 2 were merged.

Note: For current advice about how to identify duplicate records, please see TRICARE Data Quality Web page http://www.tricare.mil/ocfo/mcfs/dqmcp/refs_regs.cfm. Potential duplicate patient registration can be minimized by performing DEERS validation checks using the path CA>PAS>MAN>RMCP>RREG>DRDM. Use the demographics option to synchronize record after verification of DEERS data.

The MTFs do not need to identify which DMIS IDs the duplicate patient(s) are associated with in the Summary section, unless the DMIS ID is from a different service (i.e. Army MTF is CHCS Host Site and there are Air Force or Navy DMISIDs being hosted by the Army CHCS Host Site). Example Summary statement: Of potentials

identified; 3 CHCS merged, 0 excluded, 1 AHLTA found and corrected, 6 sets of twins and one potential duplicate sent to PAD for review and correction, 4 potential duplicates were for Air Force or Navy.

MTFs will use the same reporting month/data month format that the other DQMCP questions use. You are reporting activity from two months past.

Instructions for Potential Duplicate Patient Report are below.

CHCS menu path to run the **Potential Duplicate Patient Report**:

PAD System Menu (DG USER)

Registration Options Menu (DG REGISTRATIONS MENU)

Patient Management Menu (DG DUPLICATE PAT MGMT)

PDS Potential Duplicate Patient Search

1. Select Registration
2. Type "Y" to proceed with this report.

- *Start date* should be the first day of the data month that is being reported.
- *Stop date* should be the last day of the data month that is being reported.
- Matching Criteria Level will be *Standard*.

3. Select *Order.*

- Restart Time and Interruption Time use the default prompts.

4. Type "Spool".

- For Spool document name use *initials_PDS_data month and year* (example jeg_PDS_Nov2009)
- Expiration Date: T+7

5. Return after task number has been queued.
6. When the report is done running, open the spooled document and find the Potential Duplicate Patients results.

Question 11. Results of the Data Quality Coding Error reports (R. L. Q C. 10. a. 2, a. 3, b)

A series of Data Quality reports were developed to detect and report errors in coding that require correction. These reports must be run in M2 each data month for each parent DMIS ID to respond to the following questions:

Army service requirement question and will not be reported to DHA.

The following process applies to the FY-16 DQ Statement questions - 12. a. and 12. b.

1. All MTFs are required to enter the information requested for Data Quality Coding Error Reports.
Note: You will need access to the M2 to run these reports. Run these reports on the 1st week of the Reporting Month. This will give you the denominator. Keep track on number of errors corrected and prior to the Commander signature, input this number as your numerator.

2. The Data Quality coding error reports are run on the M2. To run the M2 Data Quality coding error reports logon to the MHS website
https://sso.csd.disa.mil/amserver/UI/Login?authlevel=3&org=cac_pki&goto=https%3A%2F%2Ftma-bi.csd.disa.mil%3A443%2FInfoViewApp%2Fbanner.jsp.

1. Sign in and go to public folders, and select the M2 folder;
2. Select the DHA/HA folder;
3. Select the Data Quality *WebI* folder and double click on the first report;
4. Select refresh data (upper right);
5. Enter FY start and end dates;
6. Enter a value for the *TMT Parent DMIS ID*;
7. Select *Run Query*;
8. Select the **DQMC Metric** tab, then view the rest of the tabs and run the rest of the reports.

3. Go to the DQ Review List Section *C. 10.* and enter the values for the Data Quality Coding Error Reports results. Do not forget to save before exiting the Review List.

These two questions from the Review List will populate the Data Quality Statement's questions 12. a. and 12. b, which is the designated area where we will extract the responses.

Question 11. a) CAPER Errors corrected with Gender Conflicts / Total Outpatient Encounters with Gender Conflicts (R. L. Q C. 10. a. 2; MTF Reported from Corporate M2 Query)

Requirement

DOD Instruction 6040.42, 10 June 2004, *Medical Encounter and Coding at Military Treatment Facilities* requires that all medical encounters within the MHS be accurately documented and

coded, adhering to legal and medical coding classification standards as permitted by the MHS data collection systems. The Data Quality Manager and/or coding staff must review the current month's records in error. Any anomalies are to be noted on the appropriate comment section of the DQMC Review List.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{total CAPER errors corrected with gender conflicts}}{\text{total outpatient encounters with gender conflicts}}$$

Background

It is DoD policy that all medical encounters within the Military Health System (MHS) must be accurately and promptly documented and coded, adhering to legal and medical coding classification standards as permitted by MHS data collection systems.

Fact

Early identification and resolution of records/encounters of Data Quality issues is the key to numerous MHS initiatives that depend on data. The Office of the Surgeon General, DHA, HA and other staff need data that is accurate, reliable, and timely to make informed decisions that directly impact the delivery of healthcare across AMEDD.

Process

Check the Total Outpatient Encounters Detected in the DQ Coding Error Reports by running the required Data Quality Reports developed on the M2 to detect and report errors in coding that require correction.

Recommendations

Run the DQ Coding Error Reports the 1st week of the Reporting Month to get the denominator. Keep track of the number of errors corrected and input the number of errors corrected as your numerator prior to the Commander's signature.

A process must be developed to address the Encounters/Records Detected in the DQ Coding Error Reports.

Develop a strategy to observe data for sustained improvement. Contact PASBA Data Quality Section for assistance with M2 use and analysis.

Evaluate the process periodically to detect any bottlenecks that may cause records not being corrected in a timely manner.

Provide feedback to providers, coders, and coders' supervisors.

Evaluate your MTFs business processes for improvement opportunities, training and education.

Methodology

Reports must be run on the first duty day of the reporting month in M2 for each data month and for each parent DMIS ID to respond to the question.

The *Total Outpatient Encounters Detected with Gender Conflicts* (Review List C. 10. a. 2) (total of C. 10. a. 2. A., C. 10. a. 2. b. and C. 10. a. 2. c.) is the sum of the total from the *Encounters with Female Only Diagnosis in Male Patients Report* (Review List C. 10. a. 2. a.), the total from the *Encounters with Male Only Diagnosis in Female Patients Report* (Review List C. 10. a. 2. b.), and the total from the *Encounters with Maternity Diagnosis in Non-Maternity Patients Report* (Review List C. 10. a. 2. c.).

Question 11. b) Total CAPER Errors corrected with Age Conflicts / Total Outpatient Encounters with Age Conflicts. (R. L. Q C. 10. a. 3; MTF Reported from Corporate M2 Query)

Requirement

DOD Instruction 6040.42, 10 June 2004, *Medical Encounter and Coding at Military Treatment Facilities*, requires that all medical encounters within the MHS be accurately documented and coded, adhering to legal and medical coding classification standards as permitted by the MHS data collection systems. The Data Quality Manager and/or coding staff must review the current month's records in error. Any anomalies are to be noted on the appropriate comment section of the DQMC Review List.

The Army Standard will remain at 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{total CAPER errors corrected with age conflicts}}{\text{total outpatient encounters with age conflicts}}$$

Background

It is DoD policy that all medical encounters within the Military Health System (MHS) must be accurately and promptly documented and coded, adhering to legal and medical coding classification standards as permitted by MHS data collection systems.

Fact

Early identification and resolution of records/encounters of Data Quality issues is the key to numerous MHS initiatives that depend on data. The Office of the Surgeon General, DHA, HA and other staff need data that is accurate, reliable, and timely to make informed decisions that directly impact the delivery of healthcare across AMEDD.

Process

Check the Total Outpatient Encounters Detected in the DQ Coding Error Reports by running the required Data Quality Reports developed on the M2 to detect and report errors in coding that require correction.

Recommendations

Run the DQ Coding Error Reports to get the denominator. Keep track of the number of errors corrected and prior to the Commander signature, input the number of errors corrected as your numerator.

A process must be developed to address the Total Outpatient Encounters Corrected and the Total Invalid Inpatient Records Detected in the DQ Coding Error Reports.

Develop a strategy to observe data for sustained improvement. Contact PASBA Data Quality Section for assistance with M2 use and analysis.

Evaluate the process periodically to detect any bottlenecks that may cause records not being corrected in a timely manner.

Provide feedback to providers, coders, and coders' supervisors.

Evaluate your MTFs business processes for improvement opportunities, training and education.

Methodology

The Total Encounters Detected with Age Conflicts (Review List C. 10. a. 3.) (total of C. 10. 1.3. a., C. 10.1. 3. b. and C. 10. a. 3. c.) is the sum of the Total from Encounters with Adult Diagnosis in Pediatric Patients Report (Review List C. 10. a. 3. a.), the Total from Newborn Diagnosis in Older Patients Report (Review List C. 10. a. 3. b.), and the Total from Pediatric Diagnosis in Adult Patients Report (Review List C. 10. a. 3. c.).

Question 11. c) Total Detected Inpatient Records Corrected /Total Invalid Inpatient Records Detected in the DQ Coding Error Reports. (total results of C. 10. b. 1. and C. 10. b. 2.) (R. L. Q C. 10. b; MTF Reported from Corporate M2 Query)

Requirement

DOD Instruction 6040.42, 10 June 2004, *Medical Encounter and Coding at Military Treatment Facilities*, requires that all medical encounters within the MHS be accurately documented and coded, adhering to legal and medical coding classification standards as permitted by the MHS data collection systems. The Data Quality Manager and/or coding staff must review the current month's records in error. Any anomalies are to be noted on the appropriate comment section of the DQMC Review List.

The Army Standard will remain at 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{total detected inpatient records corrected}}{\text{total invalid inpatient records detected}}$$

Background

It is DoD policy that all medical encounters within the Military Health System (MHS) must be accurately and promptly documented and coded, adhering to legal and medical coding classification standards as permitted by MHS data collection systems.

Fact

Early identification and resolution of records/encounters of Data Quality issues is the key to numerous MHS initiatives that depend on data. The Office of the Surgeon General, DHA, HA and other staff need data that is accurate, reliable, and timely to make informed decisions that directly impact the delivery of healthcare across AMEDD.

Process

Check the Total Outpatient Encounters Detected in the DQ Coding Error Reports by running the required Data Quality Reports developed on the M2 to detect and report errors in coding that require correction.

Recommendations

Run the DQ Coding Error Reports to get the denominator. Keep track of the number of errors corrected and prior to the Commander signature, input the number of errors corrected as your numerator.

A process must be developed to address the Total Outpatient Encounters Corrected and the Total Invalid Inpatient Records Detected in the DQ Coding Error Reports.

Develop a strategy to observe data for sustained improvement. Contact PASBA Data Quality Section for assistance with M2 use and analysis.

Evaluate the process periodically to detect any bottlenecks that may cause records not being corrected in a timely manner.

Provide feedback to providers, coders, and coders' supervisors.

Evaluate your MTFs business processes for improvement opportunities, training and education.

Methodology

Reports must be run on the first duty day of the reporting month in M2 for each data month and for each parent DMIS ID to respond to the question.

Total Detected Inpatient Records Corrected is the sum of records corrected for all error categories in the *Total Invalid Inpatient Records Detected in the DQ Coding Error Reports*.

The *Total Invalid Inpatient Records Detected in the DQ Coding Error Reports* consists of the sum of total inpatient records from the *Questionable Admission Based on Diagnosis Report* (C. 10. b. 1.) and total inpatient records from the *Un-groupable MS-DRG Report* (C. 10. b. 2.).

Question 12. Incomplete CAPER Report (or Service equivalent, includes APVs) (Goal is 100%). Metric should be refreshed and reported for each period through current data month. (R. L. Q C. 11. a. (1-12), C. 11. b)

Question 12. a) Number of CAPER encounters / number of Kept Appointments. (Oct – current FM current FY) (R. L. Q C. 11. a)

Requirement

If your facility meets or exceeds 97%, you are not required to provide a comment. However, if your facility does not meet the goal, a comment is required, which indicates the problem identified, the corrective actions taken, and the data month and year your MTF expects compliance to meet the 97% goal. In addition if you facility is over 103% for this question, a comment is required which indicates the reason why.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of CAPER encounters (Oct – current FM current FY)}}{\text{number of Kept Appointments (Oct – current FM current FY)}}$$

Formula Note

1. The CAPER encounter includes APVs and Non-APVs.
2. RAD* and RAD** and non-count T-Cons appointment types are excluded.
3. The number of Kept APV and Non-APVs scheduled appointments received in the *Daily Outpatient Workload Detailed Report* (DOWDR)
4. PASBA calculates this metric using the number of records transmitted and received at PASBA. Some facilities have noticed discrepancies between the PASBA count and records on hand. What we have found is that the APVs may have been coded on time at the facility but there have not been any entries in ADM. It is important to ensure that the coding is entered in ADM to get proper credit for coding timeliness.

Criteria

1. Includes APVs and non-APVs.
2. Numbers of kept appointments are from the DOWDR. Appointments in a kept walk-in, sick-call status, to include T-cons in a count status. Any DOWDR appointments left in a pending status will be consider a kept appointment (based on last DOWDR received for any particular appointment).
3. The 3 business day (non-APVs) and 15 calendar day (APV) timelines do not apply to this metric. This metric only addresses completeness, not timeliness.

The historical compliance report can be found on PASBA's website. Select *Data Quality* on the menu bar, and then select *Data Quality Program Metrics*. Next, select a month and a year for the report. Click ***View*** and select Open or Save.

Background

It is DoD policy that all medical encounters within the Military Health System (MHS) must be accurately and promptly documented and coded, adhering to legal and medical coding classification standards as permitted by MHS data collection systems.

Facts

Successful documentation and coding efforts assist with the following MTF operations:

- **Continuity of Care:** Facilitates quality of care and communication among providers.
- **Education and Training:** Supports education and training for an MTF's staff, students, and patients.
- **Financial Management:** Facilitates an MTF's revenue by supporting its Uniformed Business Office (UBO) with evidence of treatment and justification for reimbursement claims to third-party payers.
- **Medical Readiness:** Assures accurate medical information is documented in records of deployed forces and facilitates pre- and post-deployment health assessments.
- **Population Health Management:** Facilitates the assessment and management of healthcare requirements for the beneficiary population.
- **Quality Management/Improvement:** Facilitates healthcare quality and improvement initiatives by providing evidenced-based practice through evaluation of clinical outcome data; provides healthcare professionals with documentation for quality assurance, evaluation, and improvement of treatment methods.
- **Productivity:** Increases/improves provider productivity. Timely coding captures productivity information (relative value units and encounter counts), assures the likelihood of available documentation, and allows information to continuously flow for coding edits, correction, and validation.
- **Resource Allocation:** Aligns medical resources with operations; aids in support of resource sharing agreements.

Process

Refer to Q 9. a. for the numerator and denominator for the current reporting Data Month number of CAPER encounters and the Number of Kept Appointments.

Outpatient encounters other than Ambulatory Procedure Visits (APV)

Run the *ADM Compliance Report* at the end of the day. Also see the walk-though screens available in the PASBA website. Select *Data Quality* on the menu bar, and then select *DQ Guidelines*. Next, select *ADM Compliance Report Instructions, December 2003 (.pdf).*

Ambulatory Procedure Visits (APV)

Check how many APV records are incomplete by running the *ADM Compliance Report*. Select only 'B***5' clinics. Do this by selecting (M) for Multiple when prompted "Select (O)ne, (M)ultiple, (A)ll ADM clinics or (Q)uit: A//" on the second screen. Then select all providers and ask for a detailed report. The report will show the provider, the patient, and the day of the visit.

Walk-though screens are available from the PASBA website. Select *Data Quality* on the menu bar, and then select *DQ Guidelines.* Next, select *Tracking Ambulatory Patient Visits in CHCS, MAR 2004 (.doc).*

The following screenshot is an example, of an *ADM Compliance Report by Clinic*, which displays a breakout by compliance status.

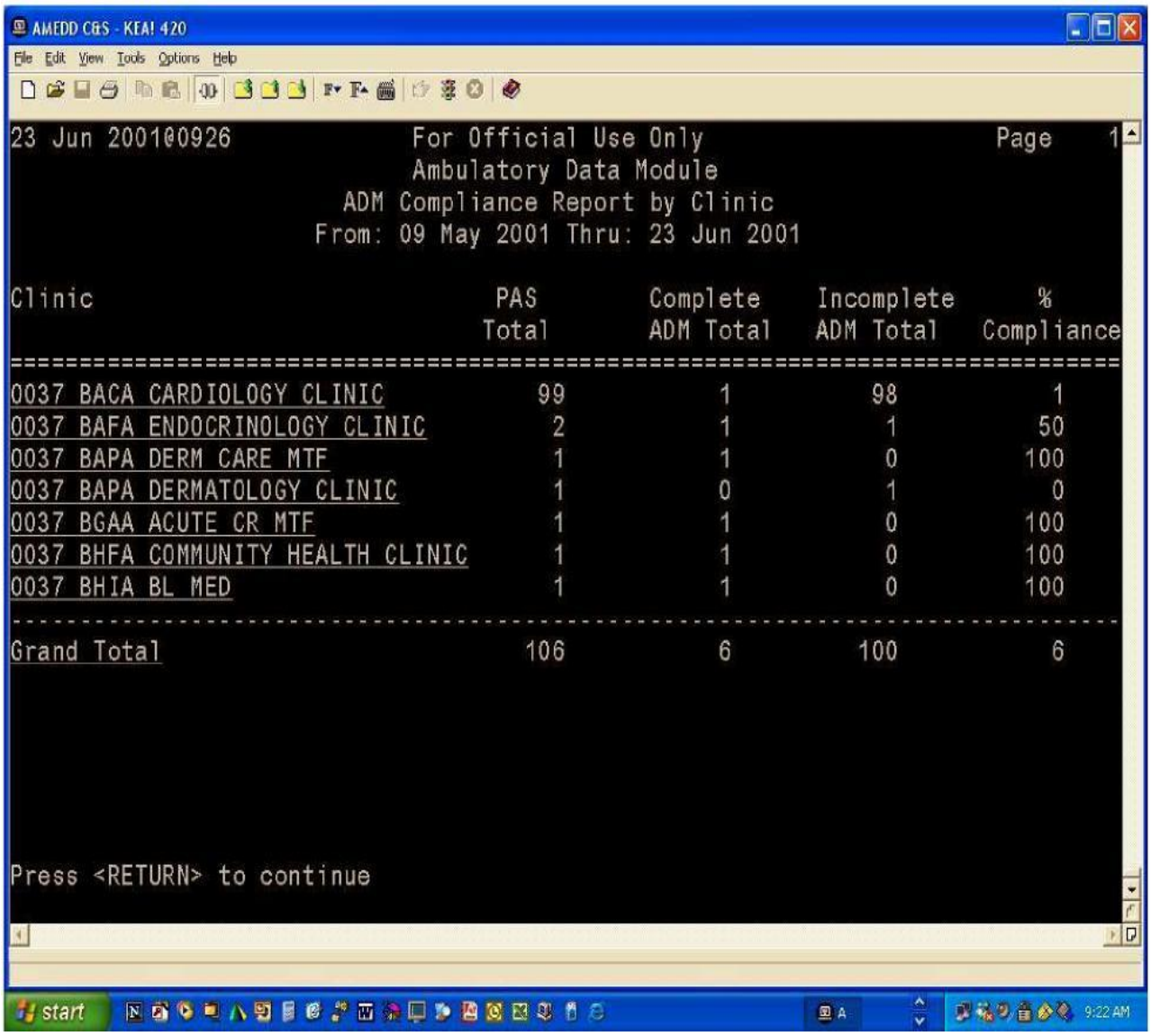


Figure 3 Data run sample in an Ambulatory Data Module's report

Recommendations

1. **Outpatient encounters other than Ambulatory Procedure Visits (APV)**
    - Monitor clinics for incomplete records by running the *ADM Compliance Report* and the *ADM Records by Clinic Report* at the end of each day. Provide feedback to providers, coders, and their supervisors.
    - Evaluate your MTF's business process for improvement opportunities.
2. **Ambulatory Procedure Visits (APV)**
    - Monitor compliance by running the *ADM Compliance Report*, by physician, to determine how many records are incomplete and need to be closed to avoid falling into the non-compliance category. Provide feedback to providers, coders, and the providers or coders' supervisors.
    - Evaluate your MTF's business processes for improvement opportunities.

    - Use the Outpatient Record Transmission Tracking Tool (ORT3) on the PASBA website: Select *My Apps* on the menu bar and select *Outpatient Record Transmission Tracking Tool*

Question 12. a. 1) October current fiscal year **(**R. L. Q C. 11. a. 1; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 12. a.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of October (current year) CAPER encounters}}{\text{number of October (current year) Kept Appointments}}$$

Criteria

Refer to Question 12. a.

Background

Refer to Question 12. a.

Facts

Refer to Question 12. a.

Process

Refer to Question 12. a.

Question 12. a. 2) November current fiscal year (R. L. Q C. 11. a. 2; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 12. a.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.
Formula

$$\frac{\text{number of November (current year) CAPER encounters}}{\text{number of November (current year) Kept Appointments}}$$

Criteria

Refer to Question 12. a.

Background

Refer to Question 12. a.

Facts

Refer to Question 12. a.

Process

Refer to Question 12. a.

Recommendations

Refer to Question 12. a.

Question 12 a. 3) December current fiscal year (R. L. Q C. 11. a. 3; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 12. a.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of December (current year) CAPER encounters}}{\text{number of December (current year) Kept Appointments}}$$

Criteria

Refer to Question 12. a.

Background

Refer to Question 12. a.

Facts

Refer to Question 12. a.

Process

Refer to Question 12. a.

Recommendations

Refer to Question 12. a.

Question 12. a. 4) January current fiscal year (R. L. Q C. 11. a. 4; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 12. a.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of January (current year) CAPER encounters}}{\text{number of January (current year) Kept Appointments}}$$

Criteria

Refer to Question 12. a.

Background

Refer to Question 12. a.

Facts

Refer to Question 12. a.

Process
Refer to Question 12. a.

Recommendations

Refer to Question 12. a.

Question 12. a. 5) February current fiscal year (R. L. Q C. 11. a. 5; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 12. a.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of February (current year) CAPER encounters}}{\text{number of February (current year) Kept Appointments}}$$

Criteria

Refer to Question 12. a.

Background

Refer to Question 12. a.

Facts

Refer to Question 12. a.

Process

Refer to Question 12. a.

Recommendations

Refer to Question 12. a.

Question 12. a. 6) March current fiscal year (R. L. Q C. 11. a. 6; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 12. a.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of March (current year) CAPER encounters}}{\text{number of March (current year) Kept Appointments}}$$

Criteria

Refer to Question 12. a.

Background

Refer to Question 12. a.

Facts

Refer to Question 12. a.

Process

Refer to Question 12. a.

Recommendations

Refer to Question 12. a.

Question 12. a. 7) April current fiscal year (R. L. Q C. 11. a. 7; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 12. a.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of April (current year) CAPER encounters}}{\text{number of April (current year) Kept Appointments}}$$

Criteria

Refer to Question 12. a.

Background

Refer to Question 12. a.

Facts

Refer to Question 12. a.

Process
Refer to Question 12. a.

Recommendations

Refer to Question 12. a.

Question 12. a. 8) May current fiscal year (R. L. Q C. 11. a. 8; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 12. a.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of May (current year) CAPER encounters}}{\text{number of May (current year) Kept Appointments}}$$

Criteria

Refer to Question 12. a.

Background

Refer to Question 12. a.

Facts

Refer to Question 12. a.

Process

Refer to Question 12. a.

Recommendations

Refer to Question 12. a.

Question 12. a. 9) June current fiscal year (R. L. Q C. 11. a. 9; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 12. a.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of June (current year) CAPER encounters}}{\text{number of June (current year) Kept Appointments}}$$

Criteria

Refer to Question 12. a.

Background

Refer to Question 12. a.

Facts

Refer to Question 12. a.

Process

Refer to Question 12. a.

Recommendations

Refer to Question 12. a.

Question 12. a. 10) July current fiscal year (R. L. Q C. 11. a. 10; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 12. a.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of July (current year) CAPER encounters}}{\text{number of July (current year) Kept Appointments}}$$

Criteria

Refer to Question 12. a.

Background

Refer to Question 12. a.

Facts

Refer to Question 12. a.

Process

Refer to Question 12. a.

Recommendations

Refer to Question 12. a.

Question 12. a. 11) August current fiscal year (R. L. Q C. 11. a. 11; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 12. a.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of August (current year) CAPER encounters}}{\text{number of August (current year) Kept Appointments}}$$

Criteria

Refer to Question 12. a.

Background

Refer to Question 12. a.

Facts

Refer to Question 12. a.

Process

Refer to Question 12. a.

Recommendations

Refer to Question 12. a.

Question 12. a. 12) September current fiscal year (R. L. Q C. 11. a. 12; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 12. a.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of September (current year) CAPER encounters}}{\text{number of September (current year) Kept Appointments}}$$

Criteria

Refer to Question 12. a.

Background

Refer to Question 12. a.

Facts

Refer to Question 12. a.

Process

Refer to Question 12. a.

Recommendations

Refer to Question 12. a.

Question 12. b) Prior FY number of CAPER encounters / number of Kept Appointments (Oct – Sep prior FY) (R. L. Q C. 11. b; PASBA-populated question; Army-specific question)

Requirement

Refer to Question 12. a.
(Oct – Sep prior FY).

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{prior FY number of CAPER encounters}}{\text{number of Kept Appointments (Oct – Sep prior FY)}}$$

Criteria

Refer to Question 12. a.

Background

Refer to Question 12. a.

Facts

Refer to Question 12. a.

Process

Refer to Question 12. a.

Recommendations

Refer to Question 12. a.

Question 13. Incomplete SIDR Report (or Service equivalent) (Goal is 100%). Metric should be refreshed and reported for each period through current data month. (R. L. Q C. 12. a (1-12), C. 12. b)

Question 13. a) Number of SIDR dispositions /number of SIDR D and E status dispositions (Oct – current FM current FY) (R. L. Q C. 12. a).

Requirement

The number of SIDR Dispositions should equal the number of D and E status Dispositions including CRO and Absent Sick Cases. The SIDR Dispositions and the Number of D and E status Dispositions includes CROs and Absent Sick Cases.
NOTE: The monthly R299, Total Month Column should match the number of SIDR D and E status dispositions, which includes CRO and Absent Sick Cases.

The Army Standard is 97% or above through FY-16. If over 103%, a comment is required.

Formula

$$\frac{\text{number of SIDR dispositions (Disposition Status D Records Only) (Oct – current FM current FY)}}{\text{number of SIDR D and E status dispositions (Oct – current FM current FY)}}$$

Note: Questions 15. a. 1. – a. 12. are allowed to be greater than 100%, with a comment required for percentages over 103%.

Criteria

1. Number of completed SIDRs (D status records)
2. SIDR records in a D status (completed) and SIDR records in a E status (discharged), extracted from SIDR file transmissions
3. Absent Sick and CRO (carded for record only) records are included.

Background

Workload reconciliation between the different Information Technology (IT) systems is important to ensure the MTF is capturing 100 percent of its workload.

Facts

1. Discrepancies give the perception that we cannot accurately account for workload even between internal systems, and place the Army Medical Department and the MTF at risk for invalid cost models for external organizations (GAO, OMB, and others).
2. All completed SIDR dispositions with "D" and "E" records can be checked against the

total dispositions on the R299 report or checked against M2. When there is marked difference between SIDR dispositions and SIDR "D" and "E" records there are three possibilities.

a. SIDR records remain un-coded/incomplete at site
b. SIDR files were not received by PASBA and subsequently not included in the PASBA SIDR database. (Note: files not received by PASBA were also probably not received by DHA, and subsequently not included in the MHS Management Analysis and Reporting Tool (M2) database).
c. Run the 462 Report

Process

The Number of SIDR dispositions and the number of SIDR D and E status dispositions include Absent Sick and CROs.

Divide the number of SIDR dispositions by the number of SIDR D and E status dispositions. When counting dispositions in SIDR, make sure you only include the number of "D" and "E" SIDRs (i.e., completed records and incomplete records) for the reporting month; including CRO and Absent Sick Records.

Recommendations

The R299 report, MEPRS dispositions from EAS and M2 SIDR counts can be used as a benchmark for the total SIDR dispositions.

Question 13. a. 1) October current fiscal year (R. L. Q C. 12. a. 1; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 13. a.

The Army Standard is 97% or above through FY-16. If over 103% a comment is required.

Formula

$$\frac{\text{number of October (current fiscal year) SIDR Dispositions}}{\text{number of October (current fiscal year) SIDR D and E status dispositions}}$$

Criteria

Refer to Question 13. a.

Background

Refer to Question 13. a.

Facts

Refer to Question 13. a.

Process

Refer to Question 13. a.

Recommendations

Refer to Question 13. a.

Question 13. a. 2) November current fiscal year (R. L. Q C. 12. a. 2; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 13. a.

The Army Standard is 97% or above through FY-16. If over 103% a comment is required.

Formula

$$\frac{\text{number of November (current fiscal year) SIDR Dispositions}}{\text{number of November (current fiscal year) SIDR D and E status dispositions}}$$

Criteria

Refer to Question 13. a.

Background

Refer to Question 13. a.

Facts

Refer to Question 13. a.

Process

Refer to Question 13. a.

Recommendations

Refer to Question 13. a.

Question 13. a. 3) December current fiscal year (R. L. Q C. 12. a. 3; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 13. a.

The Army Standard will remain at 97% or above through FY-16. If over 103% a comment is required.

Formula

$$\frac{\text{number of December (current fiscal year) SIDR Dispositions}}{\text{number of December (current fiscal year) SIDR D and E status dispositions}}$$

Criteria

Refer to Question 13. a.

Background

Refer to Question 13. a.

Facts

Refer to Question 13. a.

Process

Refer to Question 13. a.

Recommendations

Refer to Question 13. a.

Question 13. a. 4) January current fiscal year (R. L. Q C. 12. a. 4; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 13. a.

The Army Standard will remain at 97% or above through FY-16. If over 103% a comment is required.

Formula

$$\frac{\text{number of January (current fiscal year) SIDR Dispositions}}{\text{number of January (current fiscal year) SIDR D and E status dispositions}}$$

Criteria

Refer to Question 13. a.

Background

Refer to Question 13. a.

Facts

Refer to Question 13. a.

Process

Refer to Question 13. a.

Recommendations

Refer to Question 13. a.

Question 13. a. 5) February current fiscal year (R. L. Q C. 12. a. 5; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 13. a.

The Army Standard will remain at 97% or above through FY-16. If over 103% a comment is required.

Formula

$$\frac{\text{number of February (current fiscal year) SIDR Dispositions}}{\text{number of February (current fiscal year) SIDR D and E status dispositions}}$$

Criteria

Refer to Question 13. a.

Background

Refer to Question 13. a.

Facts

Refer to Question 13. a.

Process

Refer to Question 13. a.

Recommendations

Refer to Question 13. a.

Question 13. a. 6) March current fiscal year (R. L. Q C. 12. a. 6; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 13. a.

The Army Standard will remain at 97% or above through FY-16. If over 103% a comment is required.

Formula

$$\frac{\text{number of March (current fiscal year) SIDR Dispositions}}{\text{number of March (current fiscal year) SIDR D and E status dispositions}}$$

Criteria

Refer to Question 13. a.

Background

Refer to Question 13. a.

Facts

Refer to Question 13. a.

Process

Refer to Question 13. a.

Recommendations

Refer to Question 13. a.

Question 13. a. 7) April current fiscal year (R. L. Q C. 12. a. 7; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 13. a.

The Army Standard will remain at 97% or above through FY-16. If over 103 % a comment is required.

Formula

$$\frac{\text{number of April (current fiscal year) SIDR Dispositions}}{\text{number of April (current fiscal year) SIDR D and E status dispositions}}$$

Criteria

Refer to Question 13. a.

Background

Refer to Question 13. a.

Facts

Refer to Question 13. a.

Process

Refer to Question 13. a.

Recommendations

Refer to Question 13. a.

Question 13. a. 8) May current fiscal year (R. L. Q C. 12. a. 8; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 13. a.

The Army Standard will remain at 97% or above through FY-16. If over 103% a comment is required.

Formula

$$\frac{\text{number of May (current fiscal year) SIDR Dispositions}}{\text{number of May (current fiscal year) SIDR D and E status dispositions}}$$

Criteria

Refer to Question 13. a.

Background

Refer to Question 13. a.

Facts

Refer to Question 13. a.

Process

Refer to Question 13. a.

Recommendations

Refer to Question 13. a.

Question 13. a. 9) June current fiscal year (R. L. Q C. 12. a. 9; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 13. a.

The Army Standard will remain at 97% or above through FY-16. If over 103% a comment is required.

Formula

$$\frac{\text{number of June (current fiscal year) SIDR Dispositions}}{\text{number of June (current fiscal year) SIDR D and E status dispositions}}$$

Criteria

Refer to Question 13. a.

Background

Refer to Question 13. a.

Facts

Refer to Question 13. a.

Process

Refer to Question 13. a.

Recommendations

Refer to Question 13. a.

Question 13. a. 10) July current fiscal year (R. L. Q C. 12. a. 10; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 13. a.

The Army Standard will remain at 97% or above through FY-16. If over 103% a comment is required.

Formula

$$\frac{\text{number of July (current fiscal year) SIDR Dispositions}}{\text{number of July (current fiscal year) SIDR D and E status dispositions}}$$

Criteria

Refer to Question 13. a.

Background

Refer to Question 13. a.

Facts

Refer to Question 13. a.

Process

Refer to Question 13. a.

Recommendations

Refer to Question 13. a.

Question 13. a. 11) August current fiscal year (R. L. Q C. 12. a. 11; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 13. a.

The Army Standard will remain at 97% or above through FY-16. If over 103% a comment is required.

Formula

$$\frac{\text{number of August (current fiscal year) SIDR Dispositions}}{\text{number of August (current fiscal year) SIDR D and E status dispositions}}$$

Criteria

Refer to Question 13. a.

Background

Refer to Question 13. a.

Facts

Refer to Question 13. a.

Process

Refer to Question 13. a.

Recommendations

Refer to Question 13. a.

Question 13. a. 12) September current fiscal year (R. L. Q C. 12. a. 12; PASBA-populated question; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Refer to Question 13. a.

The Army Standard will remain at 97% or above through FY-16. If over 103% a comment is required.

Formula

$$\frac{\text{number of September (current fiscal year) SIDR Dispositions}}{\text{number of September (current fiscal year) SIDR D and E status dispositions}}$$

Criteria

Refer to Question 13. a.

Background

Refer to Question 13. a.

Facts

Refer to Question 13. a.

Process

Refer to Question 13. a.

Recommendations

Refer to Question 13. a.

Question 13. b) Prior FY Number of SIDR dispositions / number of SIDR D and E status dispositions (Oct – Sep Prior FY) (R. L. C. 12. b; PASBA-populated question; Army-specific question)

Requirement

Refer to Question 13. a.
(Oct – Sep prior FY).

The Army Standard will remain at 97% or above through FY-16. If over 103% a comment is required.

Formula

$$\frac{\text{prior FY number of SIDR Dispositions}}{\text{number of SIDR D and E status dispositions (OCT – SEP prior FY)}}$$

Criteria

Refer to question 13. a.

Background

Refer to Question 13. a.

Facts

Refer to Question 13. a.

Process

Refer to Question 13. a.

Recommendations

Refer to Question 13. a.

Question 14. ICD-10 Training

Army service requirement question and will not be reported to DHA.

The following process applies to the FY-16 DQ Statement questions – 14. a.

1. All MTFs are required to enter the information requested for ICD-10 Training.

2. Go to the DQ Review List Section F, *Army Specific Question*, and enter the values for ICD-10 training questions F. 3. a. Do not forget to save before exiting the Review List.

3. These two questions from the Review List will populate Data Quality Statement questions 14. a. and 14. b., which is the designated area where we will extract the responses. Provide comments for each question.

4. On the PASBA website at https://pasba.army.mil/. Select *ICD_10 Transition* on the menu bar to locate various documents addressing the transition to ICD-10.

Question 14. a) Is the ICD-10 Awareness Training being provided to the entire MTF staff? Provide comment – state method being used to educate staff (i.e. 3M Online Modules, in-service, newsletter, etc.) (R. L. Q F. 3. a; MTF Reported; Army-specific question)

Army service requirement question and will not be reported to DHA.

Refer to the PASBA website at https://pasba.army.mil/. Select *ICD-10 Transition* on the menu bar to locate various documents addressing the transition to ICD-10, including **requirements, background, facts, processes and recommendations.**

Question 14. b) Are your ICD-10 approved trainers currently conducting ICD-10 training with MTF Staff? (Provide comment on what type of training is being conducted, state frequency **(**i.e. monthly, quarterly, etc.) and to whom (i.e. physicians, nurses, coders, etc.).) (R. L. Q F. 3. a; MTF Reported; Army-specific question)

Army service requirement question and will not be reported to DHA.

Refer to the PASBA website at https://pasba.army.mil/. Select *ICD-10 Transition* on the menu bar to locate various documents addressing the transition to ICD-10, including **requirements, background, facts, processes and recommendations.**

Question 15. The DQ Manager briefed last month's DQMC Review List, and Financial and Workload Data Reconciliation and Validation results to the MTF Executive Committee. (R. L. Q A. 4; MTF Reported; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

Enter date DQM Manager briefed last month's DQMC Review List, Financial and Workload Data Reconciliation and Validation results to the MTF Executive Committee and attach meeting minutes. Date briefed: MM/DD/YYYY.

Recommendations

1. Monitor Financial and Workload Data Reconciliation and Validation results.
2. Brief the executive Committee Review List, Financial and Workload Data Reconciliation and Validation results.
3. Attach meeting minutes.

Question 16. Nursing Hourly Rounds

Question 16. a. Has the hourly rounding component of the Patient caring Touch System (PCTS) been fully implemented for the inpatient units at your facility? (R. L. Q F. 4; MTF Reported; Army-specific question)

Army service requirement question and will not be reported to DHA.

Requirement

The purpose of the question on the DQMCP is to acknowledge that inpatient facilities are conducting bedside patient-centered rounds. There is no differentiation between inpatient unit types or what occurs during the rounds.

Further clarification and specifics will come after the re-write of the CPG, which is currently underway.

Background

The Patient Caring Touch System is the framework for nursing. Additional information can be found at: http://armynursecorps.amedd.army.mil/care.html.

Question 17. I am aware of data quality issues identified by the completed Commander's Data Quality Statement and the Data Quality Management Control Program Review List and when needed, have incorporated monitoring mechanisms and have taken corrective actions to improve the data from my facility. (R. L. Q F. 4; (MTF Commander Reported)

Requirement

The MTF commander will review and sign the Commander's Monthly Data Quality Statement attesting to the status of the compliance measures listed in the monthly statement.

Background

The commander has the ultimate responsibility for data quality at the MTF. Command emphasis and leadership and management support at all levels is crucial to the success of the DQMC Program.

Fact

A Commander's direct involvement and support is paramount for the success or failure of the DQMC Program.

Process

The Data Quality Assurance Team (or other designated group) must meet monthly to complete the DQMC Review List. The DQ Manager then briefs the reporting month's DQMC Review List to the MTF Executive Committee. The DQ Manager then briefs the Commander and obtains the Commander's approval and signature on the Commander's Monthly Data Quality Statement.

Recommendations

1. Attach the Data Quality Assurance Team meeting minutes to the Review List.
2. Include evidence in the meeting minutes or other sources of corrective plans of appropriate resources and actions to follow-up on the previous month's negative findings. An issue-tracking log should be maintained.
3. The commander must comment on any outlier in the Comment section of the Commander's Monthly Data Quality Statement, or on a separate memorandum. The comment should succinctly identify: the problem; the corrective action (to include any associated information technology trouble ticket numbers); an expected resolution date; the data month the MTF expects to be in compliance, and the names and telephone numbers of the primary and alternate corrective action point-of-contact.
4. For tracking purposes, the completed forms and accompanying working papers or audit support documents must be kept on file for five years.