Department of Veterans Affairs **VHA DIRECTIVE 1082**
Veterans Health Administration **Transmittal Sheet**
Washington, DC 20420 **March 24, 2015**

PATIENT CARE DATA CAPTURE

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) Directive establishes policy requiring the capture of all outpatient encounters, inpatient appointments in outpatient clinics, inpatient mental health services, rehabilitation treatment program services, inpatient clinical pharmacy services, and billable encounters not captured elsewhere.

2. SUMMARY OF MAJOR CHANGES:

a. Clarifies definition of secured messaging within My HealtheVet to communicate non-urgent health queries to Veterans.

b. Clarifies instances in which VHA staff should list a Physician Assistant or Nurse Practitioner as a primary provider of record.

c. Adds a reference to VHA Directive 1063.

3. RELATED ISSUES: VHA Directive 1731.

4. RESPONSIBLE OFFICE: Director, Health Information Management (10P2C) is responsible for the content of this Directive. Questions may be referred to 760-777-1170.

5. RESCISSIONS: VHA Directive 2009-002, dated January 23, 2009, is rescinded.

6. RECERTIFICATION: This VHA Directive is scheduled for recertification on or before the last working day of March 2020.

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DISTRIBUTION: Emailed to the VHA Publications Distribution List on 03/24 /2015.

PATIENT CARE DATA CAPTURE

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes policy requiring the capture of all outpatient encounters, inpatient appointments in outpatient clinics, inpatient mental health services, rehabilitation treatment program services, inpatient clinical pharmacy services, and billable encounters not captured elsewhere. **AUTHORITY:** 38 U.S.C. 7311(a).

2. BACKGROUND:

a. Since October 1, 1996, Department of Veterans Affairs (VA) medical facilities have been required to electronically report data concerning the provision of care, inpatient facility services, and outpatient professional services provided in VHA, to the National Patient Care Database (NPCD) in Austin, Texas. Effective October 1, 2006, the capture of billable inpatient appointments in outpatient clinics and billable inpatient services was added to the requirement of encounter data to be captured. This Directive extends the requirement to capture inpatient and outpatient clinical pharmacy services that include a clinical encounter such as disease management, comprehensive medication management, medication therapy management, and medication consultation. This Directive also provides additional information on the capture of inpatient professional services for all mental health care, including the Mental Health Rehabilitation Treatment Program, delivered by psychiatrists, psychologists, physician assistants, nurse practitioners, clinical nurse specialists, and social workers. VHA is required to utilize data definitions for clinical and administrative data promulgated by internationally and nationally recognized standard setting organizations (e.g., American Society for Testing and Materials (ASTM), American National Standards Institute (ANSI), Centers for Medicare and Medicaid Services (CMS), Health Insurance Portability and Accountability Act of 1996 (HIPAA), etc.).

b. VHA information systems were modified in January 2005 to enable the transmission of all encounters (both inpatient and outpatient) from Patient Care Encounter (PCE) to the NPCD. The provider of the services is required to complete the encounter data in Computerized Patient Record System (CPRS).

c. All coded data for professional service encounters may not be billable. Third-party payers have business rules that require health care data to be submitted in a specific format before the claim for payment can be adjudicated. As such, there will be specific circumstances where the code sequence or codes in PCE do not match one-to-one with the bill created in the Integrated Billing Package.

d. VA medical facilities utilize a variety of software packages to capture inpatient and outpatient delivery of care. Regardless of the software package utilized, all data must pass, or be transferred, into PCE (if not directly entered into PCE) and ultimately to the NPCD.

e. Each clinic must be set up with appropriate Decision Support System (DSS) Identifiers. Utilized both locally and nationally, these identifiers describe DSS clinical work units. The DSS Program Office is responsible for maintaining and nationally distributing the list of DSS identifiers which are updated annually (see VHA Directive 1731, Decision Support System Outpatient Identifiers and the VHA Decision Support Office (DSO) Website at

http://vaww.dss.med.va.gov/programdocs/pd_oident.asp). ***NOTE:*** *This is an internal VA Web site and is not available to the public.*

f. Use of electronic encounter forms and documentation templates were mandated in May 2003. The nationally developed templates and encounter forms support quality documentation and coding; they are user friendly, efficient, meet compliance criteria, and incorporate instructional text to avoid omission of appropriate information. These nationally developed templates and encounter forms may be edited at the facility level. VA medical facilities need to continue to refine local templates and encounter forms to ensure quality documentation and data capture. VHA Program Offices develop and provide guidance on program specific templates. All nationally developed templates and encounter forms can be found on the VHA Health Information Management (HIM) Web site at http://vaww.vhaco.va.gov/him/natldoctemplates.html. ***NOTE:*** *This is an internal VA link not available to the public.*

g. For VHA purposes, a VA medical facility including all identified divisions and community based outpatient clinics (CBOC), is considered to be the business entity furnishing health care at the organizational level. Sub-organizational level entities by which data needs to be retrievable include: parent and community site, specific clinic (regardless of whether the site has more than one type of station suffix, e.g., a CBOC), treatment team, and individual provider. A Person Class taxonomy code for each billable provider with the VA medical facility and VA medical facility division code is reported to the NPCD (see VHA Directive 2012-003, Person Class File Taxonomy).

3. POLICY: It is VHA policy to capture and report inpatient appointments in outpatient clinics, inpatient billable professional services, inpatient clinical pharmacy services, inpatient professional mental health services, and outpatient care data to support the continuity of patient care, resource allocation, performance measurement, quality management, provider productivity, research, and third-party payer collections.

4. RESPONSIBILITIES:

a. **Veteran Integrated Service Network Director.** The Veterans Integrated Service Network (VISN) Director is responsible for ensuring:

(1) The Patient Information Management System (PIMS) and PCE software packages are maintained on all medical facility Veterans Health Information Systems and Technology Architecture (VistA) systems in accordance with nationally distributed software and software patches.

(2) Electronic encounter forms are created, implemented, and utilized to optimize health record documentation and the revenue cycle.

(3) All encounters are entered into a software application such as CPRS or Appointment Management that results in the encounter data being reported to the PCE application in order to transmit to the NPCD. ***NOTE:*** *If a package does not pass workload to PCE automatically, that workload must be entered manually (e.g., the Medicine Package).*

b. **VA Medical Facility Director and Facility Chief of Staff.** The VA medical facility Director and facility Chief of Staff are responsible for ensuring that:

(1) Clinical staff document clinical information in conformance with VA medical facility policies and bylaws in a format that conforms to the software requirements for defining the practitioner; the patient's active problems, diagnosis(es), or reason for visit; and the services provided to the patient.

(2) Psychiatrists, Psychologists, Social Workers, Pharmacists, and Advanced and Practice Providers (Advanced Practice Registered Nurse, CNS, PA) document and enter encounter data on all mental health professional services provided in an inpatient or residential rehab setting. ***NOTE:*** *The entry of the data requires the same data elements as the outpatient encounters.*

(3) Staff accurately document patient demographics, the date and time of service, and the place of service in conformance with the requirements of the software.

(4) VA Medical facility staff continue to maintain, on each clinic set up in the Scheduling Package, a primary DSS identifier and credit pair (if appropriate) as the work group associated with that clinic set up. A primary DSS identifier must be assigned to encounters in outpatient, residential rehab and inpatient settings. The primary DSS identifier needs to depict the primary clinical workgroup responsible for the type of services provided during the encounter. The secondary DSS identifier serves as a modifier to further define the primary workgroup or type of services provided. The costs and workload are to be mapped appropriately for inpatient care reporting using the encounter identifier number. The DSS identifier(s) for a patient setting must meet the definitions outlined in the DSS directive (see VHA Directive 1731, DSS Outpatient Identifiers).

(5) The encounter forms, like those from the Automated Information Collection System (AICS), are used as a tool to manage the collection of coded information manually or on data collection screens. Data validation is required to ensure that only valid codes are used on all encounter forms. Regular maintenance of these forms is required at least twice each year. According to the releases of CPT, HCPCS, and ICD--CM coding changes, the nationally approved code sets are changed twice annually; generally on October 1 and January 1. Trained and competent coding staff must perform data validation of the coded information in accordance with the data validation requirements of the facility. The data on the encounter forms must conform to the definitions and conventions included in the appropriate coding methodologies noted previously.

(6) Inpatient, Residential Rehabilitation and Outpatient Encounter data is transmitted to the NPCD at the Austin Information Technology Center (AITC) and accepted (making any necessary corrections that result in a rejection from the NPCD).

(7) General monitoring of the transmission and acceptance of encounter data at the NPCD is at regular intervals through the use of the Ambulatory Care Report Program (ACRP) Transmission report, Outpatient Activity Report (OPA) reports (the OPA includes all inpatient encounters when validating the transmission of workload data), messaging mail groups for transmission status, checking the logical link for the HL7 messages, and checking the

transmission queue. ***NOTE:*** *See Appendix A, which details the monitoring and validating transmission of workload data to NPCD.*

(8) Acceptable mechanisms to capture workload are implemented. These include:

(a) Direct Encounter Form Completion;

(b) Certain VistA Software Packages (e.g., Radiology, Surgical, and Laboratory Packages); and

(c) Event Capture System (ECS).

(9) All workload is transmitted using PCE to the NPCD, regardless of the mechanism utilized, and contains all required data elements. If PCE is not directly used for reporting encounters, the data is entered into an application that transmits data to the NPCD. ***NOTE:*** *PCE is the transmission mechanism of all encounter data for transmission of the data to NPCD.*

(10) The provider of the services is the individual who completes the encounter data in CPRS and ensures that the workload is submitted by the monthly closeout date. ***NOTE*****:** *Additional information regarding monthly close out can be found in VHA Directive 2011-025, Closeout of Veterans Health Administration Corporate Patient Data Files Including Quarterly Inpatient Census, or subsequent policy issue, and in the FAQs located on the Allocation Resource Center (ARC) Web site: http://vaww.arc.med.va.gov/references/faqs/faq_v2.html. This is an internal VA Web site and is not available to the public.*

c. **Vet Centers.** Vet Centers currently have patient contact information captured by the VHA Support Service Center (VSSC) using a data extract. This data reflects patient contacts including the number of contacts for outreach, Post Traumatic Stress Disorder, etc. Vet Centers will be asked to provide more detailed workload information above and beyond their current reporting once the centers have access to an electronic health record.

5. REFERENCES:

a. VHA Directive 1063, Utilization of Physician Assistants.

b. American Medical Association. Common Procedural Terminology (CPT).

c. American Society for Testing and Materials. (2007). E1384-07: Standard Guide for Content and Structure of the Electronic Health Record (EHR). West Conshohocken, PA.

d. Centers for Medicare and Medicaid Services, Healthcare Current Procedural Coding System, Level II and Level III Codes.

e. National Committee for Vital and Health Statistics (NCVHS) Uniform Ambulatory Medical Care Minimum Data Set.

f. World Health Organization International Classification of Diseases Clinical Modification (ICD-CM).

g. Youman, K.G. (2000). Basic Healthcare Statistics for Healthcare Information Management Professionals. Glossary. Chicago, IL: American Health Information Management Association (AHIMA).

h. DSS Identifier Web site: http://vaww.dss.med.va.gov/programdocs/pd_oident.asp. ***NOTE:*** *This is an internal VA website and is not available to the public.*

6. DEFINITIONS:

a. **Encounter.** An encounter is a professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in outpatient and inpatient settings (including Residential Rehab Treatment centers).

(1) Contact can include face-to-face interactions or those accomplished via telecommunications technology.

(2) Contact can be through Secure Messaging which is available through the My HealtheVet (MHV) personal health record (PHR). These non-urgent communications must meet the definition of an encounter. A review of the health record is done by the physician or qualified non-physician and clinical decision making is performed at some level. The care plan is communicated with the patient electronically. (The Secure Message that is related to a visit within the last 7 days cannot be captured as workload as it is considered part of the actual face-to-face visit). ***NOTE:*** *Veteran requirements – must be an established patient with the provider, be registered on My HealtheVet as a user, and have upgraded access by completing the requirements for In- Person Authentication. My HealtheVet (MHV) is planning to implement the capability for Providers and Healthcare Team members to claim Workload Credit through Secure Messaging. This will be achieved through saving Secure Messages that met the online evaluation criteria, as Progress Notes attached to Workload Credit Clinics in VistA. Clinic set-up at the medical centers is underway and national Secure Message note titles are being developed. This enhanced functionality is scheduled for release in March 2013.*

(3) Encounters are neither occasions of service nor activities incidental to an encounter for a provider visit. For example, the following activities are considered part of the encounter itself and do not constitute encounters on their own: taking vital signs, documenting chief complaint, giving injections, pulse oximetry, administering medications, etc.

(4) A telephone contact between a provider and a patient is only considered an encounter if the telephone contact is documented and that documentation include the appropriate elements of a face-to-face encounter, namely history and clinical decision-making. Telephone encounters must be associated with a clinic assigned to one of the DSS Identifier telephone codes and are to be designated as count clinics. ***NOTE:*** *Count refers to workload that meets the definition of an encounter or an occasion of service. The American Medical Association (AMA) changed the definition of the 2008 CPT Telephone Call codes. Many of VHA's performance monitors require follow-up care delivered by telephone, therefore, the 2008 CPT telephone codes are to be used as previously defined.*

c. **Licensed Provider.** A licensed practitioner is an individual at any level of professional specialization who requires the official or legal permission to practice in an occupation as evidenced by documentation issued by a State in the form of a license and/or registration. A practitioner can also be a provider.

d. **Non-Licensed Independent Provider.** A non-licensed practitioner is an individual without the official or legal permission to practice in an occupation and supervised by a licensed or certified individual in deliver care to patients.

e. **Mental Health Inpatient and Residential Rehab Professional Services.** Mental Health Inpatient and Residential Rehab Professional Services are inclusive of daily evaluation and management, therapy sessions, consultations, etc. For purposes of patient care data capture, mental health services include inpatient and residential Rehab professional services performed by a psychiatrist with the credentials of Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO), psychologist with the credentials of Doctor of Philosophy (PhD) or Doctor of Psychology (PsyD), masters level social workers, or physician extender with the credentials of Nurse Practitioner NP), Clinical Nurse Specialist (CNS) or Physician Assistant (PA).

f. **Minimum Clinical Data Elements.** In addition to the current administrative data elements, such as: eligibility, period of service and service-related condition information, patient address, next-of-kin, etc., the minimum clinical data elements required to constitute an encounter or occasion of service are as follows:

(1) **Patient.** The person receiving health care services.

(a) NPCD. The full legal name, date of birth, SSN, or pseudo-SSN (or other personal identifier), eligibility, etc.

(b) VistA. The full legal name, date of birth, Social Security Number (SSN) or pseudo-SSN (or other personal identifier), eligibility, etc.

(2) **Active Problems.** Problems and/or diagnosis(es) treated are required to be reported as International Classification of Diseases (ICD), current edition, (e.g., ICD-9-CM Vol. 1 – 3, ICD-10-CM and ICD-10-PCS) codes with a minimum of one required. When more than one active problem or diagnosis is designated for an encounter, the provider must determine which one is the primary reason the patient sought treatment. All additional diagnoses or conditions that affected the treatment of the patient during the encounter need to be included as additional secondary codes. ***NOTE:*** *CM = Clinical Modification and PCS = Procedure Coding System.*

(3) **Classification Questions.** The determination of whether or not a treatment was related to an adjudicated service-connected condition or treatment of conditions related to exposure (Agent Orange, Ionizing Radiation, Military Sexual Trauma, combat veterans, or environmental Contaminants) must be based on all conditions treated during the encounter and the entire encounter must be designated service-connected, or designated as being related to the special categories. VistA maintains and stores text descriptions along with coded values. Only the coded values are transmitted to NPCD.

(4) **Date and Time of Service.** Time is a single entry indicating the time that the encounter was scheduled to occur and the data element is taken from the Appointment Scheduling software. For all scheduled appointments the date is the date services are actually provided and when unscheduled appointments are entered, the date and time the encounter is entered into VistA is what is used as the encounter date and transmitted.

(5) **Place of Service.** Information about the location where the service was provided, in both VistA and NPCD, this includes the three-digit medical center and/or station identifier, with any applicable suffixes (STA6A), as well as the DSS Identifier(s). The place of service must include the five-character medical center national VHA division value. The division value must reflect the location where care was provided.

(6) **Provider.** VistA stores specific provider information from the New Person and Person Class files for an individual provider to allow for encounters to be transmitted. Each provider must be designated within the NEW PERSON FILE with a correct defined specific provider type from the PERSON CLASS FILE; this applies to all: physicians, nurse practitioners, physician assistants, other licensed health care providers, and those non-licensed independent providers that provide patient care. ***NOTE:*** *Refer to VHA Directive 2012-003, Person Class File Taxonomy.*

(7) **Primary Provider.** A Licensed Independent Provider, who is the attending and/or supervising provider, is always to be listed as the primary provider for all encounters provided by a Medical Resident, Psychology Intern, and when the patient is seen in conjunction with another qualified health care provider such as a nurse during the same appointment visit. For instance, if the Veteran is being seen by a Physician Assistant and a Physician within the same Clinic visit, the Physician would be the primary provider with the Physician Assistant listed as a secondary provider. However, if the Veteran is being seen by a Physician Assistant and is treated only by the Physician Assistant, the Physician Assistant is the primary provider of record.

(8) **The relevant other Licensed Independent Providers.** The relevant other Licensed Independent Providers. e.g., Psychologist, Pharmacist, Licensed Clinical Social Worker, is to be listed as the primary provider for any trainees they supervise (e.g., Psychology Intern, Pharmacy Resident) or any other non-licensed independent provider (NLIP) under their supervision. ***NOTE:*** *Use of evaluation and management (E & M) codes require that certain criteria be met within the coding guidelines, such as scope of practice, and may limit the use of many E & M codes. Physician Assistants, by scope of practice, have an assigned collaborating physician. The collaborating physician is not required to co-sign the progress note documenting the care delivered solely by the Physician Assistant. The level of Physician Assistant practice autonomy is defined in a scope of practice established by the facility. Supervision policies for associated health trainees, such as social workers, technicians, etc., can be found in VHA Handbook 1400.04, Supervision of Associated Health Trainees.*

(9) **The Service Provided.** The reason for the services provided (diagnosis) and the actual services provided to the patient by the provider must be fully and clearly documented and coded using nationally-accepted coding schemes, such as International Classification of Disease, Clinical Modification (ICD-CM) codes, current edition, Current Procedural Terminology (CPT) codes and Healthcare Common Procedural Coding System (HCPCS). VistA maintains and stores text descriptions along with the coded values. Only the coded values are transmitted to NPCD.

NOTE: *Guidelines published by the American Medical Association (AMA) must be followed for CPT code assignment and guidelines published by the Centers for Medicare and Medicaid Services (CMS) must be followed for HCPCS code assignment and guidelines approved by the four organizations that make up the Cooperating Parties for the ICD-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.*

g. **Occasion of Service (formerly known as ancillary service).** An occasion of service is a specified identifiable instance of an act of technical and administrative service involved in the care of a patient or consumer which is not an encounter and does not require independent clinical judgment in the overall diagnosing, evaluating, and treating the patient's condition(s).

(1) Occasions of service are the result of an encounter. Examples are: clinical laboratory tests, radiological studies, physical medicine interventions, medication administration, and vital sign monitoring are all examples of occasions of service.

(2) Occasions of service, such as clinical laboratory, radiology studies, and tests are automatically loaded to the PCE database from other VistA packages.

h. **Statistics Only (formerly known as workload only).** Situations may exist which do not meet the definition of an encounter nor an "occasion of service." "Statistics Only" clinics within the Scheduling application need to be set to non-count and non-billable and are tracked for workload only (internal use), and are not transmitted to the NPCD.

i. **Telehealth.** Telehealth in VHA is the use of health informatics, disease management and Telehealth technologies to enhance and extend care and case management to facilitate access to care and improve the health of designated individuals and populations with the specific intent of providing the right care in the right place at the right time. Telehealth Services may be described as:

(1) **Clinical Video Telehealth.** General Telehealth is the use of real-time interactive video conferencing technology, sometimes with supportive peripheral devices, to provide care and consultation between providers and patients at VA medical facilities and clinics and other remote sites such as Vet Centers.

(2) **Home Telehealth.** Home Telehealth is the use of in-home Telehealth technologies, such as non-video messaging and monitoring devices or video technology for Veteran patients with chronic diseases such as diabetes, heart failure, and chronic pulmonary disease for home monitoring.

(3) **Store and Forward.** Store and Forward is the use of imaging technologies at the patient site to acquire and store clinical information (e.g., data, image, sound, video) that is then forwarded to (or retrieved by) another health care provider site for reading, review and clinical evaluation. For VHA purposes, a Telehealth contact between a provider and a patient is considered to be an encounter if the specific conditions are met as outlined in DSS instructions for Telehealth. The provider's encounter does not always occur simultaneously with the patient's encounter.

j. **Visit.** The term "visit" is used for the purpose of reporting services provided to a Veteran and patient in a 24-hour period; for example, the visit of an outpatient to one or more clinics or units within 1 calendar day at the facility level, including the station number and the suffix identifiers (i.e., for facilities, visits are to be reported at the three-digit station level, for visits reported; for instance, at CBOCs it must include the suffix (STA6A)).

APPENDIX A

INSTRUCTIONS FOR INFORMATION RESOURCES MANAGEMENT STAFF TRANSMITTING WORKLOAD TO THE NATIONAL PATIENT CARE DATABASE

1. Ambulatory Care Nightly Transmission to National Patient Care Database (NPCD) Option: Ensure that the option Ambulatory Care Nightly Transmission (including inpatient encounters) to NPCD [SCDX AMBCAR NIGHTLY XMIT] is scheduled to run on a daily basis, as this is the background job that generates the AmbCare HL7 messages. After each completion of this job, a summary bulletin stating the number of encounters included in the HL7 messages is sent to members of the mail group assigned to the SCDX AMBCARE TO NPCDB SUMMARY bulletin.

2. Systems Link Monitor Option: Using the option Systems Link Monitor [HL MESSAGE MONITOR] ensures the following:

a. At least one incoming filer is running.

b. At least one outgoing filer is running.

c. The AMB-CARE logical link is running (STATE column lists IDLE).

d. Values in the MESSAGES RECEIVED and MESSAGES PROCESSED columns for the AMB-CARE logical link increase on a daily basis.

e. Values in the MESSAGES TO SEND and MESSAGES SENT columns for the AMBCARE logical link increase on a daily basis.

3. Logical Link Possibilities:

a. The HL7 outgoing filer is probably not running if the MESSAGES TO SEND for the AMB-CARE logical link does not increase and the Ambulatory Care Nightly Transmission to NPCDB job has run. If this happens, use the option Monitor, Start, Stop Filers [HL FILER MONITOR] to start an outgoing filer.

b. The HL7 incoming filer is probably not running if the MESSAGES RECEIVED for the AMB-CARE logical link continues to increase while the MESSAGES PROCESSED does not. If this happens, use the option Monitor, Start, Stop Filers [HL FILER MONITOR] to start an incoming filer.

c. It is highly likely that the AMB-CARE logical link is not running if the MESSAGES TO SEND for the AMB-CARE logical link continues to increase while the MESSAGES SENT do not. If this happens, use the option Start and Stop Links [HL START] to stop and then start the AMB-CARE logical link.

4. Using the option Transmission History Report - Full [SCDX AMBCAR XMIT HIST FULL], generate the Ambulatory Care Reporting Program TRANSMISSION HISTORY report for previous days: This report lists all the encounters transmitted to the National Patient

Care Database (NPCD) in Austin during a given time frame and includes whether or not an acknowledgement was received. Acknowledgements are usually received within two days of transmission and if you are not seeing the acknowledgements, it is highly likely that something is not running and all AmbCare and HL7 background processes should be checked.

5. Monitor the Outpatient Activity Report (OPA reports) coming from NPCD in Austin to ensure that they reflect receipt of data: Not seeing receipt of data in Austin through these reports indicates something is not running and all AmbCare and HL7 background *processes* should be checked.