

**New MEPRS Codes established
by the Workload Standardization Work Group**

References: Workload Standardization Concept of Operations (CONOPS), Workload Standardization and the MHS Provider Booklet of 24 Aug 99.

INTRODUCTION

MEPRS reporting captures workload, labor hrs (FTEs) and expenses at the workcenter/MEPRS cost center level. This is the lowest level of detail by which data is reported from service and DoD automated systems and interfaced for MEPRS reporting purposes into MEPRS/EAS. Today, clinical workload such as OBDs, admissions, dispositions, visits, etc., are reported and aggregated in CHCS at the MEPRS code level. Commodities such as supplies, equipment and purchased contract services are reported and aggregated from Service-unique financial accounting systems by MEPRS code level. Labor hours (FTEs) and expenses are reported and aggregated from Service-specific manpower and personnel systems at the MEPRS code level. These combined data sources enable MEPRS/EAS to allocate costs and report average unit costs by the MEPRS Code work center and/or cost center, as appropriate.

To obtain other information regarding the performance of the MTF other than what is available in MEPRS/EAS, systems such as CEIS will utilize MEPRS data and more detailed clinical data to perform calculations for PLCA statistically derived costing management reports. The Workload Standardization initiative will provide TMA, Service Headquarters and MTF management with provider statistically derived provider and institutional costing.

Under this approach, the data reported in the ADS will include all provider workload when a provider-patient encounter occurs whether a patient is a hospital patient, non-traditional hospitalized inpatient or an outpatient. Facility workload, consisting of all support labor personnel, overhead, material and other supporting costs associated with delivery of patient care will be reported in CHCS. This in turn, will be reported in MEPRS/EAS systems to separately and discretely calculate and report costs for non-traditional hospitalized stays and provider ADS encounter data.

The impact of this initiative will bring about change in business practices and processes in patient administration and

inpatient/outpatient provider reporting practices. The development and implementation of workload standardization will be accomplished in phases. The initial phase will not require any system software or policy change to be made in MEPRS/EAS.

Given the system constraints in implementing an integrated operational structure, the below requirements maybe difficult if personnel do not understand t the overall MEPRS/EAS reporting requirements.

GUIDANCE - Part One

The following is the guidance for the MTFs implementing the new workcenters for FY00:

I. Definitions.

Hospice Care Services Provided in MTF

AZA

FUNCTION: Hospice Care provides for the palliation or management of a terminal illness and related conditions. The following are included as hospice services: nursing care; medical social services; physician's services; counseling services; medical appliances and supplies, including drugs and biologicals; and physical and occupational therapy. A physician must have certified that the individuals are terminally ill. An individual is considered to be terminally ill if he/she has a medical prognosis that his/her life expectancy is 6 months or less. A plan of care must be established before services are provided and all services must comply with the plan of care. In general, the services must be related to the palliation or management of the patient's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

PERFORMANCE FACTOR: Occupied Bed Day.

ASSIGNMENT PROCEDURE: This final operating expense account shall not be reassigned during the expense allocation process described in Chapter 3.

Skilled Nursing Facility Services Provided in MTF

AZB

FUNCTION: Skilled Nursing Facility (SNF) Care Services care is provided during the active or convalescent stage of injury or illness. SNF care is comprehensive inpatient care designed for someone who has an illness, injury, or exacerbation of a disease process. It is goal oriented treatment rendered immediately after, or instead of, acute hospitalization to treat one or more specific active complex medical conditions or to administer one

or more technically complex treatments, in the context of a person's underlying long term care condition and overall situations. Patients in the AZB workcenter do not meet InterQual standards for admissions as acute care hospitalized inpatients.

PERFORMANCE FACTOR: Occupied bed day.

ASSIGNMENT PROCEDURE: This final operating expense account shall not be reassigned during the expense allocation process described in Chapter 3.

Minimal Care Services Provided in the MTF

AZC

FUNCTION: A physician provided minimal care services to patients who require some level of nursing care and periodic evaluation. The workcenter provides care and treatment to eligible patients who do not meet the InterQual criteria for admission to SNF.

PERFORMANCE FACTOR: Occupied bed day.

ASSIGNMENT PROCEDURE: This final operating expense account shall not be reassigned during the expense allocation process described in Chapter 3.

II. Criteria to Define Non-Traditional Hospitalized Stays.

These codes are to be used when the patient care being delivered does not satisfy InterQual standards for admission or continued stay to the MTF (hospital). The level of care (MEPRS code used for admission) is determined by the physician.

III. Systems/Program Requirements.

A. Tri-Service Financial Accounting Systems: MEPRS reporting activities are to establish accounting structures that support and apply the program element code (PEC 87700), Non-Traditional Hospitalized Services (AZ**) accounts, to ensure all commodities used in support of these services are captured and reported (e.g., supplies, equipment, available/productive labor). Service specific financial guidance will address the reporting structures necessary for implementation in FY 00 and the MTF Resource Management Offices will establish MTF-applicable codes in their official accounting systems.

B. Labor Utilization

The Service-specific manpower structure will not be affected. MTF personnel assigned who support or perform in the

MTF Non-Traditional Hospitalized areas will report their labor hours in the same manner as currently reported for inpatient care. Personnel who are considered in support of these services include front desk clerks, clinic managers, technicians, nurses, providers, and physicians. It is recognized that provider time will be minimal when patients are admitted to any of the above codes. Loaned labor will be reported to the facility where the health care services were rendered.

The following Service-unique specific systems must capture and report personnel (FTE) information:

Navy - Standard Personnel Management System (SPMS)
Army - Uniform Chart of Accounts Personnel (UCAPERS)
Air Force - EAS III Personnel Subsystem

The above systems provide the necessary labor utilization data elements necessary for interfacing FTEs and labor expenses into MEPRS/EAS. MTFs utilizing man-hour templates must change their monthly time percentage for accurate cost reporting. These reporting systems must link Service-specific accounting data elements accurately or the costs will not reconcile in MEPPRS/EAS.

C. CHCS and WAM Reporting

The performance factor for Non-Traditional Hospitalized Stays (AZ**) accounts is OBDs (recording stays). These accounts should be set up in the Site Definable MEPRS table and PAD module within CHCS to capture events which generate inpatient workload (admit a patient, transfer a patient, enter a clinical service change and a disposition of a patient). MTFs need to ensure providers supporting AZ** areas are defined in CHCS.

The following are guidelines for recording stays of AZ** hospitalized services:

- (1) Hospital inpatient admissions are not altered by this policy.
- (2) All non-traditional hospital stays are to be recorded during FY00 using the "admission" processing of CHCS. Minimal care delivered in existing ward locations will be treated in the same manner as a regular admission
- (3) AZ** inpatient admissions are admitted by the service describing the care (for example, AZA for hospice) to the ward where they are housed. If an "AZ**" patient is placed

in mixed ward location, the admitting "AZ**", will be identified as the MEPRS code.

- (4) A patient who is transferred among work centers within an institution setting (within hospitalized stay wards or within Non-Traditional Hospitalized AZ** stay areas) can be recorded in CHCS as a transfer identically to the way hospital inpatients have been transferred between wards in the past.
- (5) Transfers across institutional setting boundaries, whether a hospitalized inpatient switching to Non-Traditional Hospitalized AZ** or vice versa, require a discharge from the old setting and an admission to the new one in CHCS. Consequently, every SIDR will consist solely of hospitalized or AZ** stays, never both types.
- (6) As the current local systems will count hospital admissions and hospital bed days and will assign DRGs to these non-hospitalized stays, these should be removed from totals when calculating accurate inpatientl workload. While AZ codes represent legitimate workload, in the future, these types of stays will be coded and counted differently in order to optimize the value of these non-traditional hospitalized services.

More details on how to tabulate AZ** workload with the respective relative resource intensity factors are provided in the CONOPS and booklet.

D. ADS

Every Non-Traditional Hospitalized AZ** service must be recorded in ADS. Generally, a SADR should be created if a provider performs a patient service of sufficient substance that it should be documented in the patient record. Two exceptions are noteworthy: (1) Non-clinician and ancillary personnel working routinely in the patient setting and attending to patients staying in the work center of the personnel should not record routine services; and, (2) Provider groups (such as Grand Rounds for educational purposes) should not create any SADRs unless one member of the group takes an action sufficient to document the patient record (in which case only that provider would record the encounter). In addition, where provider contact is especially frequent or continuous (such as with some ICU patients), a single ADS form (bubble sheet) can be used during a period of time (not to exceed a day) to record each procedure (CPT code) performed by that provider.

In addition to the normal process of completing the forms will require special instructions. Encounters for Inpatients (whether hospitalized or Non-Traditional Hospitalized AZ** stays) are to be recorded as follow:

- The encounter should be coded as "inpatient" by filling in the inpatient bubble.
- The work center (clinic) should be the service to which the provider is assigned and not the patient stay location.
- The preferred method to generate an ADS form for such Non-Traditional Hospitalized (AZ**) patients is to use the "walk-in" functionality of ADS, which is the least burdensome administratively. Other alternatives include:
 - (1) Making daily appointments for each inpatient prior to the morning and leaving an encounter form in the inpatient record for use by the provider;
 - (2) Using any approved ADS automated front-end system (e.g., KG-ADS) to record the encounter on a terminal as it occurs;
 - (3) Scheduling a "walk-in" appointment in CHCS at the time of the encounter, then retrieving and using the encounter form generated; and,
 - (4) Using a blank ADS Encounter Form to record the patient, diagnosis, and procedure(s) for later transfer and recording by administrative personnel.

Specific Guidelines for recording discrete services in ADS including the special services by using pseudo-provider identifiers for Home Health, Telemedicine Consultant/Initiator, External Facility/Provider are illustrated in the CONOPS and the booklet . In recording these discrete services, all appropriate CPT and HCPCS codes will be used as they are defined for their intended purpose. For example, no restriction is placed on the E&M code 99211 limiting its use to non-physicians. Due to the limitations of ADS, however, one and only one E&M code may be recorded.

E. MEPRS/EAS Allocation

These new codes need to be set up in the EAS Account Definition (ASD) table. In order to appropriately allocate overhead (support service) costs in MEPRS/EAS, square footage needs to be assigned to the "AZ*" areas. MTFs that provide clinical and administrative support to these areas must

determine the amount of square footage used. This data is necessary for the MEPRS/EAS expense allocation process, which allocates overhead support expenses such as plant management expense based on square footage, as appropriate. (need "cost pool" language)

MEPRS/EAS step down guidance provides those accounts for which AZ** square footage is reported. Refer to service specific financial guidance for details on square footage allocations. MEPRS personnel will add the AZ** square footage to the appropriate MEPRS/EAS Step-down Assignment Statistics (SASs). If the square footage spaces are jointly used and the square footage cannot be easily designated for the individual "AZ**" areas, then the square footage estimated, as appropriate.

Additionally, the following MEPRS/EAS Standard SASs will report AZ** workload beginning FY 00:

- SAS - 001 - Occupied Bed Days
 - SAS - 007 - Dispositions
 - SAS - 008 - Admissions
 - SAS - 012 - Meal days
 - SAS - 014 - Weighted Nutrition Procedures
- Appropriate SASs in the 800 Series - MTF Available FTEs.

Equipment purchased for these areas at 100k or above should be directly depreciated to the appropriate "AZ** account and the depreciation SAS.

GUIDANCE - Part Two

I. Definitions

Case-Management Services

FAR

FUNCTION: Case-Management Services provides all case-management and related support services by nursing and other personnel in support of a patient's primary care manager during hospitalized Non-Traditional Hospitalized stays or outpatient visits.

COSTS: The Case-Management Services work center shall be a subaccount that includes all expenses incurred in operating and maintaining the function, such as case-management activities, disease management, and other population health management activities.

SERVICE UNIT: **PENDING?** NA?

ASSIGNMENT PROCEDURE:. This final operating expense account shall not be reassigned during the expense allocation process described in Chapter 3.

Self-Care Service

FAS

FUNCTION: Self-Care Service work center does not provide any services beyond an overnight bed.

COSTS: The Self-Care Service work center captures costs associated with housing of self-care patients or family members. A physician, physician assistant, nurse practitioner, or other staff member as designated by the local MTF commander, will make the determination to allow self-care patients or family members performing non-medical attendant functions to reside in the MTF overnight.

SERVICE UNIT: **PENDING? NA?**

ASSIGNMENT PROCEDURE: This final operating expense account shall not be reassigned during the expense allocation process described in Chapter 3.

NOTES: Examples of self-care include patients who do not have immediate access to medical care during their last phase of pregnancy (stork nesting); mothers breast feeding or bonding with hospitalized newborns; patients requiring diagnostic tests of an extensive nature of short-term rehabilitation services; family advocacy patients and/or family members who are the victims of abuse, neglect, or abandonment requiring placement pending disposition to home or as inpatients; and soldiers returning from convalescent leave that are awaiting disposition.

II. Criteria to Define Non-Traditional Hospitalized Case Management (FAR) and Self Care (FAS)

These codes are to be used to capture the cost of providing Case Management in the MTF, and to identify an area to capture the activity described below as "self care".

III. Systems/Program Requirements. The following guidance is provided for the MTFs implementing these new workcenter codes for FY00:

A. **Tri-Service Accounting Systems:** MEPRS reporting activities are to establish accounting structures that support and apply the program element code (PEC 87700), FAR and FAS accounts, to ensure all commodities used in support of the these services are captured and reported (e.g., supplies, equipment, available/productive labor). Service specific financial guidance will address the reporting structures

necessary for implementation in FY 00 and the MTF Resource Management Offices will establish MTF-applicable codes in their official accounting systems the codes, which are applicable to the MTF.

B. Labor Utilization

The Service-specific manpower structure will not be affected. MTF personnel assigned who support or perform in these FA**areas will report their hours accordingly. Personnel who are considered in support of these services include front desk clerks, clinic managers, technicians, nurses, providers, and physicians. Loaned labor will be reported to the facility where the health care services were rendered.

The following Service-specific systems must capture and report manpower and personnel information:

- Navy - Standard Personnel Management System (SPMS)
- Army - Uniform Chart of Accounts Personnel (UCAPERS)
- Air Force - EAS III Personnel Subsystem

The above systems provide the necessary person specific data elements necessary for interfacing FTEs and labor expenses into MEPRS/EAS. MTFs utilizing man-hour templates must change their monthly time percentage for accurate cost reporting. These reporting systems must link Service-specific accounting data elements accurately or the costs will not reconcile in MEPRS/EAS.

C. CHCS and WAM Reporting

Performance factor? These accounts should be set up in the Site Definable MEPRS table module within CHCS. MTFs need to ensure that the providers supporting FA** areas are defined in CHCS.

D. ADS

E. MEPRS/EAS Allocation

These new codes need to be set up in the EAS Account Definition (ASD) table. In order to appropriately allocate overhead (support service) costs in MEPRS/EAS, square footage needs to be assigned to the FA** areas. MTFs that provide clinical and administrative support to these areas must determine the amount of square footage used. This data is

necessary for the MEPRS/EAS step down process, which allocates overhead support expenses such as plant management based on square footage, as appropriate.

MEPRS/EAS step down guidance provides those accounts for which FC** square footage is reported. Refer to service specific financial guidance for details on square footage allocations. MEPRS personnel will add the FC** square footage to the appropriate MEPRS/EAS Step-down Assignment Statistics (SASs). If square footage (spaces) is jointly used and the square footage cannot be easily designated for the individual "FA**" areas, then the square footage estimated, as appropriate.

Additionally, the following MEPRS/EAS Standard SASs will report FA** workload beginning FY 00:

Appropriate SASs in the 800 Series - MTF Available FTEs.

Equipment purchased for these areas at 100k or above should be directly depreciated to the appropriate "FA** account and the depreciation SAS.

Memorandum for Record

Subject: Workload Standardization

1. Overview of Operations for FY 00 Workload. The MEPRS Management Improvement Group (MMIG) met via teleconference 15 July 1999 to develop a formal MMIG response to the "Workload Standardization Overview of Operations for FY00 Workload". This memorandum summarizes the discussion of the group and provides a MMIG response to this proposal.

2. General Statement.

a. Before embarking on this initiative, it should be made clear that the following have been addressed by TMA policy prior to implementation by the MTFs:

b. The initiative does not conflict with federal policy regarding the performance of commercial activities as outlined in OMB Circular A-76.

c. The concept can be executed within current licensure and certification requirements such as for Skilled Nursing Facilities and/or Hospice Care.

d. The concept does not exceed the scope of DHP appropriations and does not provide a level of care to beneficiaries that crosses into other federally appropriated programs (e.g., VA)?

3. The operational concept for standardizing workload represents an attempt to use existing data elements and in some cases new data to increase the level of detail and specificity for reporting workload. The MMIG recognizes the need to separate and account for provider resources and facility resources and to the extent possible, costing provider inputs and facility inputs in the same place. However, the concept fails to explain in detail, the purpose of the initiative, the expected outcomes of how the data will be used within TMA policy for budgeting and resourcing, nor link the proposed costing methodology to MEPRS cost reporting requirements. The concept represents a unique approach to aligning costing and pricing of the commodities with those of the civilian sector. However, it may not fully consider the uniqueness of the "federal instrumentality" for budgeting and for resourcing. The fundamental goals (intent) of the document need to be more concisely described and some operational concepts need to be

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further clarified (e.g., Home Health Care, TMA policy regarding Telemedicine, External Facility, External Provider).

4. The date (FY00) for implementation is very aggressive. It is recommended that this initiative be implemented first at the Medicare Subvention Sites. These sites are currently poised for changes in the established business practices and the associated traditional cost accounting concepts. They have most likely invested more resources into data quality activities and could possible leverage the current "Hawthone Effect" associated with Subvention with the changes proposed by the concept.

5. The document presents a "cold start" to the basic reader, needing an introduction and background section to show the value added by the 'To-Be' over the 'As-Is' model.

6. It is not clear that this concept is in concert with MEPRS. The MMIG is therefore forwarding a series of comments and questions to extend the understanding of the concept and to provide appropriate support to the initiative.

a. Under Concepts:

(1) The concept should state what short-term standardization is automated and not automated and what is expected to be collected and reported beginning FY00.

(2) The terms "visits" and "extended visits" as described within the Discrete Events needs to be clarified.

(3) Under this concept, a visit and ADS bubble sheet is prepared for patients who are admitted to the hospital. Today, the physician's time/hours are recorded to the inpatient specialty in MEPRS.

(4) The MMIG workload and FTE reconciliation for outpatient and inpatient physician labor distribution must be changed to reflect this new concept. Business rules must be established to outline when providers report their time/hours to the inpatient specialty code.

(5) The term "top provider" is not clearly understood. Please explain.

(6) The "Class of Provider" table on page 8 also needs clarification and possible expansion to cover the full range of potential providers.

(6) The concept suggests differences in the relative resource intensity of the providers. MMIG suggest using the term "Relative Resource Intensity" vice "Costliness Equivalent".

(7) The terms Discrete Services / Discrete Events are used interchangeable and should be distinguished and or used consistently.

(8) APGs are not currently available in all facilities for short-term tabulation of RVUs.

(a) If the MTF does not see the outcome or is not provided feedback on a timely basis, compliance will be difficult at best.

(b) Why are the APGs not deployed at the MTF level?

(9) Extended Visits (i.e., Observation) are measured in minutes of service. Therefore, it is not clear how the tabulations will be done.

(10) What is meant by "observed provider workload" when describing provider labor?

b. Under Business Practices for Discrete Events.

(1) Preparing Data Systems for FY00.

(2) Provider Table Refinement.

(3) Current system constraints for Pseudo-Providers: Per Dr. Coventry, the concept applies only to ambulatory care and is not applicable to hospitalized or non-hospitalized stays. The MMIG would suggest the UBU define these care settings within the list of standardized appointment types used to deliver ambulatory health care. In such cases, provider workload as well as facility resources could be identified within the current MEPRS business rules if the appointment types were standardized.

(4) Telemedicine Consult - What is meant by "documented consultation"?

(5) The phrase suggests the use of some Standard Form such as SF 512 or SF 513.

(6) The documents should clarify that ancillary workload will be addressed under Priority 4 of the standardization targets.

c. Under External Provider:

(1) The current business rules for MEPRS labor/hour when DOD providers are providing care outside their assigned MTF is to charge the labor costs to a MEPRS "F" code; Support to Another Facility.

(2) Today, we have physicians who perform health care services for patients at locations other than their assigned facility.

(3) These physicians DO NOT credit their labor hours to their assigned outpatient clinic nor do they submit an ADS bubble sheet at their assigned facility. They are considered on loan at the facility where they are rendering services.

(4) Under this concept the current MEPRS labor / hour reporting was ignored. The concept requires MEPRS to credit the physician appropriate outpatient clinic with their labor hours. It does not address that MEPRS no longer would report physician time / hours to a MEPRS "F" account. Their labor hours would be attributed to their assigned outpatient work center.

(5) This concept does not address whether a visit count would be credited to the assigned facility.

(6) Additionally, an appointment type would need to be established in CHCS as either an appointment type mapped as count or non-count workload.

(7) MEPRS would be required to implement external facility and the external provider concepts denoted in this document.

(8) Figure 1, Guidelines for Reporting Discrete Events in ADS; Scenarios #5 and #6 should be revised in view of the comment noted above.

(9) Omission of Unusable providers. MMIG requests further detailed clarification of this paragraph.

d. Under Attaching Providers to Clinics - The document does not clearly address the issue of Managed Care Primary Care Teams.

e. Under Updating MEPRS Codes.

(1) Appendix A of the UBU document defines the healthcare services for the new clinical cost centers needed to support this initiative. The MMIG feels these definitions need to be rewritten, specifying not only the functions of each work center, including a description of the cost procedures, performance factors, and where applicable, the assignment procedures.

(2) The concept document does not provide sufficient information regarding the processes for assuring that current business practices related to CHCS ADT are maintained. Specific MMIG questions deal with how PAD is notified of admissions and transfers as well as the clinical structures by way of specific examples of how non-hospitalized stay patients will be located in the facility.

(3) The MMIG will need more information regarding AZC, AZX, D** and F** in order to provide cogent comments. (please note the apparent typographical error in Appendix A wherein AZC is labeled AZD)

f. Under Identifying Recordable Discrete Events. Please clarify. Clarify per examples, how non-clinicians and ancillary personnel record routine services.

g. Under Generating Encounter Templates (Appointing).

(1) ADS does not allow walk-ins.

(2) The ADS system requires the appointment be scheduled in CHCS.

h. Under Recording Discrete Events:

(1) One must assume that "Acute" and "Non-acute" refers to Hospitalized and Non-Hospitalized Stays. Is that correct?

(2) Application of "same specialty": business rules need to be supported by examples in the document. The point is illustrated if one considers what happens if a provider visits a

"Hospice" patient, in which the care could be classified as either an inpatient or outpatient discrete event.

(3) Use of CPT and HCPCS. Need to clarify what is meant by Dental Procedures: What are the Business Rules?

i. Under Central Processing of Discrete Events.

(1) What is meant by provider costliness?

(2) What MEPRS FTE cost?

(3) Labor expenses reported in MEPRS/EAS III include productive, non-productive, loaned and borrowed expenses.

(4) The concept of "Costliness Equivalent" is not well understood. Please explain further.

(5) MMIG proposes using the term "Relative Resource Intensity" to describe the variance in cost of providers.

(6) The same comment is made regarding Facility costing.

j. Under Recording Stays. Although the current local system will count hospital admissions and hospital bed days, and assign DRGs to non-hospitalized stays, these should be removed from total when accurate detail workload is required. Observation, Skilled Nursing, Hospice and Minimal are considered non-hospitalized stays but inpatient MEPRS codes will be used. Recommend that "H" versus "A" codes be used. CHCS MEPRS tables must be updated to incorporate both codes. May be a restriction on "H" codes being reported in the SIDR.

k. Under Self Care Services Provided in MTF. Unclear, needs more information and clarification.

l. Under Minimal Care -- Is not well defined. Please explain further.

7. Use of MEPRS data in this concept must be clearly defined and understood. Calculations derived from workload standardization calculation should be in concert with MEPRS and provide an enhanced level of patient detail for analyses at all levels of the organization.

Workload Standardization Concept of Operations Overview of Policy and Guidance for Operations during FY00

Purpose: This Workload Standardization document describes the process for transforming the measurement of Military Health System (MHS) medical treatment facility (MTF) workload from the existing systems to a re-engineered system for FY00. This process is an interim concept of operations to better represent the resources that are required to generate workload. In addition, through this process MHS workload measurement becomes quite similar to current best practices in industry. Since automation changes to fielded standardized systems are not feasible for implementation on 1 October 1999, this guidance requires no change in software in any of the related MHS systems: CHCS, ADS, CEIS, or MEPRS (EAS III). It does require minor changes or new entries in certain tables used by these systems that are normally and routinely updated prior to the start of each new fiscal year.

Scope: This document addresses only the highest priority shortcomings in the previous workload system, and defers both less urgent problems and more elegant solutions that would require software modifications. The deferred improvements occur in later phases that are to be implemented in subsequent fiscal years. For FY00, this guidance addresses only minor modifications to the way ADS and CHCS are used to capture MTF non-ancillary patient services. It does not require any modifications in the procedures used by other health care entities (e.g., Dental Clinics and Area Reference Laboratories) or in the recording of expenses into MEPRS.

Concept: Patient services, other than ancillary diagnostic work, are recorded concurrently with work performance. Discrete services, such as visits and extended visits (e.g., ambulatory procedure visits, observation cases), are recorded using the Ambulatory Data System (ADS). Continuous services (stays) are recorded using the Composite Health Care System (CHCS). Direct provider services are always viewed as discrete services, regardless of whether they are delivered as stand-alone visits or as a component of a stay. Workload for these services is separated into provider workload, consisting solely of the physician or most skilled provider's labor, and facility workload, consisting of all other materiel, labor, overhead, and supporting costs that are associated with the patient service. Provider workload is recorded by care setting which, for the short run, is identified and input using pseudo-provider codes in a secondary provider field of the ADS encounter form.

Provider workload is tabulated in relative value units (RVU) based on the health care services as reported using Current Procedural Terminology (CPT) codes and HCFA Common Procedure Coding System (HCPCS II) and captured in ADS. Facility workload is tabulated according to setting. Hospitalized stays are tabulated in relative weighted products (RWPs) based on the diagnosis related group (DRG). Non-hospitalized stays are tabulated in RWPs based on the stay category and length of stay. These non-hospitalized stays do not meet InterQual standards for acute admissions, but include types of care similar to that found in skilled nursing facilities (SNF), hospice, or minimal care settings. Discrete services (including observation cases in the short-term) are tabulated in relative value units (RVUs) based on ambulatory patient groups (APG). In the short-term (FY00), workloads will be tabulated by the Health Program Analysis and Evaluation (HPA&E) office from the centrally collected encounter records generated by CHCS (Standard Inpatient Data Records, or SIDRs) and ADS (Standard Ambulatory Data Records, or SADRs). In the long term, ADS/CHCS will pass these tabulations to EAS and generate WWR reports. For both long and short-term, provider labor should be allocated based on observed provider workload, and other facility costs allocated using facility workload, to obtain the best estimates of the costliness of the various healthcare encounters and services. In the short-term, this will be done centrally with no change in current automated systems. In the long-term, automated systems should be modified to accomplish this allocation.

The description that follows is organized into two broad categories: discrete services (visits) and stays. Within each category are sections describing the local actions needed to prepare the automation systems, identification and recording of the services, and the methods by which central (corporate) processing will tabulate workload. After the body of the document are two appendices and an attachment. Appendix A provides definitions of categories of care for non-hospitalized stays, case management, and self-care. Appendix B provides descriptions for the work centers that provide that care. The attachment provides excerpts of the newest UBU guidance as it relates to using ADS to capture workload.

Business Practices for Discrete Services

a. Preparing the Data Systems for FY00

(1) Updating the CHCS Provider Table

- Pseudo-Providers.

The SADR from ADS will be “flagged” as special services by using artificial provider identifiers. To do this, pseudo-providers must be included in the CHCS provider table before an MTF can record a specialized discrete service, such as Home Health and Telemedicine. The new provider table entries should be:

Provider ID	Provider Name	Provider Specialty Type
000-00-0011	Home Health	600
000-00-0022	Telemedicine Consultant	600
000-00-0033	Telemedicine Initiator	600
000-00-0044	External Facility	600
000-00-0055	External Provider	600

These pseudo-providers are used to identify visits that satisfy the following definitions:

Home Health: A care provider visits a home to assess suitability of the environment for the provision of health care services or to provide care.

Telemedicine Consultant: A provider at one facility responds to a provider at a distant facility who requests documented consultation (non-ancillary diagnosis, prognosis, and/or treatment regimen guidance).

Telemedicine Initiator: A provider, co-located with the patient, requests and receives documented consultation (non-ancillary diagnosis, prognosis, and/or treatment regimen guidance) from a consultant at a distant facility.

External Facility: A DoD provider submits a SADR to his/her own ADS system reporting the rendering of health care services to a patient at a facility other than the one to which the provider is assigned. The provider was not on loan to that facility.

External Provider: A DoD provider completes two ADS Encounter Forms to report that he/she rendered health care services at a facility other than the one to which he/she is assigned. One ADS form is scanned at his/her assigned facility to capture the provider costs, and the second ADS form is scanned at the facility where services were performed to document institutional costs. The provider was not on loan to this facility.

- Omission of Unusable, Generic Providers - Currently, CHCS provider tables include a variety of "place holder" specialty types (e.g., "orthopedics") which do not identify a skill level. If these generic provider identifiers are present in the SADR output by ADS, the relative costliness of the actual provider cannot be known. Consequently, while generic provider descriptions can remain in the provider tables for use as "place holders," the ADS encounter forms (bubble sheets) must be updated to reflect the actual provider who performed the service. ADS will then automatically include on the SADR this provider's identifier together with the specialty type of the provider that includes skill level (e.g., orthopedic surgeon). If the primary provider on the bubble sheet is not updated, the workload cannot be credited.

(2) Attaching Providers to Clinics

Automated systems will not accept an appointment being made for a recorded provider who is not associated with a clinic/service. Before specialized discrete services can be appointed, (1) a conscious decision must be made by MTF management that a clinic/service will be authorized to perform specialized services (e.g., home health visits), and if so, (2) the clinic or service must be linked to the appropriate pseudo-provider in the provider table. However, this step is not required if the appointments will be scheduled for genuine providers rather than to the pseudo-provider type.

(3) Updating MEPRS Codes

New clinical/cost centers are required for FY00. Definitions for the following services and workcenters are provided in the Appendices.

MEPRS Code	Service Name
AZA	Hospice Care
AZB	Skilled Nursing Facility (SNF) Care
AZC	Minimal Care
AZD	Observation (will not be used in FY00)
AZX	Mixed Non-Hospital Stay Ward
FAR	Case Management
FAS	Self-Care

The Account Subset Definition (ASD) must be updated to include cost recognition and Stepdown Assignment Statistics (SAS) for these if they are to be used to capture costs as cost centers.

b. Identifying Recordable Discrete Services

Discrete services are recorded in ADS for most occasions when a provider-patient encounter occurs. This will normally include all services historically called “countable visits” and some that have not been considered “countable”. Whether the patient is a hospital inpatient, non-hospitalized inpatient (hospice, SNF, or minimal care), or an outpatient does not affect whether the service should be recorded. Generally, a SADR should be created if a provider performs a patient service of sufficient substance that it should be documented in the patient record. Two exceptions are noteworthy: (1) Non-clinician and ancillary personnel working routinely in the patient setting and attending to patients staying in the work center of the personnel should not record routine services; and, (2) Provider groups (such as Grand Rounds for educational purposes) should not create any SADRs unless one member of the group takes an action sufficient to document the patient record (in which case only that provider would record the encounter). In addition, where provider contact is especially frequent or continuous (such as with some ICU patients), a single ADS form (bubble sheet) can be used during a period of time (not to exceed a day) to record each procedure (CPT code) performed by that provider. Guidelines for recording discrete services are illustrated in Figure 1 on the following page.

In recording these discrete services, all appropriate CPT and HCPCS codes will be used as they are defined for their intended purpose. For example, no restriction is placed on the E&M code 99211 limiting its use to non-physicians. Due to the limitations of ADS, however, one and only one E&M code may be recorded. The Unified Biostatistical Utility (UBU) group has recommended changes to ADS coding guidelines which address SADR generation and CPT code restrictions. Excerpts from these recommendations affecting workload standardization are attached to this document.

Figure 1. Guidelines for Reporting Discrete Services in ADS

Scenario	Description	# of ADS Forms Required	Complete ADS Form for Provider Workload at Provider Facility (Y/N)	Complete ADS Form for Institutional Workload at the Provider Facility (Y/N)	Complete ADS Form for Institutional Workload at the External Facility (Y/N)	Explanation ¹	Pseudo-Provider Flag
1	A provider performs outpatient services at his/her assigned (or on loan to) DoD facility (including resource sharing and resource support)	1	YES	YES	N/A	The provider and institutional workload is collected by one ADS form scanned at the assigned facility.	None
2	A provider performs inpatient services at his/her assigned (or on loan to) DoD facility (including resource sharing and resource support)	1	YES	NO	N/A	The provider workload is collected by one ADS form scanned at the assigned facility. The institutional workload is captured by the DRG from the SIDR.	None
3	A provider performs outpatient services at another DoD facility. The provider is not loaned labor to the external facility	2	YES	NO	YES	The provider workload is collected by one ADS form, using <i>External Facility</i> , scanned at the assigned facility. The institutional workload is collected by another ADS form, using <i>External Provider</i> , scanned at the external facility.	External Provider at place of care; External Facility at provider's MTF
4	A provider performs inpatient services at another DoD facility. The provider is not loaned labor to the external facility.	1	YES	NO	NO	The provider workload is collected by one ADS form, using <i>External Facility</i> , scanned at the assigned facility. The institutional workload for the external facility is collected on the SIDR.	External Facility at provider's MTF

¹ The fundamental principle is that provider workload will be attributed to the same “location” as the provider costs. If the provider is actually on loan, his/her salary expenses will show up at the receiving (DoD) facility, and that is where the SADR should be recorded/credited using the normal process for recording encounters. If part of the provider’s normal responsibilities is providing care to his/her patients in a civilian setting, the salary expense and recorded workload might be attributed to his/her assigned work-center. Since current policy guidance is to report salary expense in this case to an F-account, the SADRs should also show the same F-account. (If policy changed such that salary expense and workload should be reported to the B-code of the provider’s normal assignment, the guidance would still be to record the SADR to the same cost center as the provider’s cost, which would then be a B-code rather than an F-code.)

Scenario	Description	# of ADS Forms Required	Complete ADS Form for Provider Workload at Provider Facility (Y/N)	Complete ADS Form for Institutional Workload at the Provider Facility (Y/N)	Complete ADS Form for Institutional Workload at the External Facility (Y/N)	Explanation ¹	Pseudo-Provider Flag
5	A provider performs patient services (any kind) at a non-DoD facility. The provider is not loaned labor to the external facility.	1	YES	NO	NO	The provider workload is collected by one ADS form, using <i>External Facility</i> , scanned at the assigned facility.	External Facility at provider's MTF
6	A provider initiates a request for Telemedicine consultation from a provider at another DoD facility	1	YES	YES	N/A	The initiating provider's (face-to-face with patient) workload is collected by one ADS form, using <i>Telemedicine Initiator</i> , scanned at the assigned facility.	Telemedicine Initiator at provider's MTF
7	A provider provides a consultation via Telemedicine	1	YES	NO	N/A	The consulting provider's workload is collected by one ADS form, using <i>Telemedicine Consultant</i> , scanned at the consultant's assigned facility.	Telemedicine Consultant at consultant's MTF
8	A provider performs a Home Health visit	1	YES	YES	N/A	The provider and institutional workload is collected by one ADS form, using <i>Home Health</i> , scanned at the assigned facility.	Home Health at provider's MTF

¹ The fundamental principle is that provider workload will be attributed to the same "location" as the provider costs. If the provider is actually on loan, his/her salary expenses will show up at the receiving (DoD) facility, and that is where the SADR should be recorded/credited using the normal process for recording encounters. If part of the provider's normal responsibilities is providing care to his/her patients in a civilian setting, the salary expense and recorded workload might be attributed to his/her assigned work-center. Since current policy guidance is to report salary expense in this case to an F-account, the SADRs should also show the same F-account. (If policy changed such that salary expense and workload should be reported to the B-code of the provider's normal assignment, the guidance would still be to record the SADR to the same cost center as the provider's cost, which would then be a B-code rather than an F-code.)

c. Generating Encounter Templates (Appointing)

The ADS captures encounters primarily through the scanning of “bubble sheets”. Administrative burden for providers is minimized when the forms are pre-printed and available at the time of the visit. For outpatients, this is routinely handled through the appointing process. For hospitalized and non-hospitalized inpatients, this may be facilitated in multiple ways. The preferred method for such inpatients is to use the “walk-in” functionality of ADS, which is the least burdensome administratively. Other alternatives include:

- ~~(1)~~(5) Making daily appointments for each inpatient prior to the morning and leaving an encounter form in the inpatient record for use by the provider;
- ~~(2)~~(6) Using any approved ADS automated front-end system (e.g., KG-ADS) to record the encounter on a terminal as it occurs;
- ~~(3)~~(7) Scheduling a “walk-in” appointment in CHCS at the time of the encounter, then retrieving and using the encounter form generated; and,
- ~~(4)~~(8) Using a blank ADS Encounter Form to record the patient, diagnosis, and procedure(s) for later transfer and recording by administrative personnel.

d. Recording Discrete Services

Every recordable discrete service must be recorded in ADS. In addition to the normal process of completing the forms, the following special instructions apply:

(1) Encounters for Inpatients (whether hospitalized or non-hospitalized stays)

- The encounter should be coded as “inpatient” by filling in the inpatient bubble.
- The work center (clinic) should be the service to which the provider is assigned and not the patient stay location.

(2) Use of CPT & HCPCS

- All applicable CPT codes should be recorded representing what occurred, regardless of whether the provider was a physician, and the codes should be used with their normal meaning as found in the CPT codebook references.
- Certain services should be recorded with the appropriate HCPCS Level II codes, especially if high cost or high volume. The table below identifies which HCPCS Level II codes are required and which are optional. The policy for recording is shown below. In the table, “Optional, High Cost” encourages recording if the cost of the item is over \$200.

HCPCS Category		Coding Guidance
A	Transportation, etc.: 1. Ambulance 2. Medical/Surgical Supplies 3. Chiropractic	1. Must record 2. Optional, high cost 3. Taken care of in CPTs
B	Enteral and Parenteral Supplies	Optional, high cost
D	Dental Procedures	Must record (inpatient cases only)
E	Durable Medical Equipment (DME, returnable)	Optional, high cost
G	Temporary Procedures for Professional Services	Omit
H	Rehabilitation Services	Omit
J	Drugs (Injections, Orals, and Chemotherapy)	Record all clinic-provided drugs. Pharmacy-provided drugs are recorded in CHCS and should not be recorded in a SADR.
K	DME	Optional, high cost
L	Orthotic Procedures	Optional, high cost
M	Medical Services	Omit
P	Pathology/Laboratory	Out of scope. Use CPT codes.
Q	Miscellaneous Services	Optional, high cost
R	Radiology Services	Out of scope. Use CPT codes.
T	Surgical Services	Omit
V	Vision, Hearing, and Speech	Need to map to a CPT code for just the services.

(3) Specialized Visit Services

Specialized visit services (such as home health, telemedicine, and visits where the provider is not charged to the facility where the service is rendered) are flagged by recording the pseudo-provider identifier matching the visit circumstances. This pseudo-provider identity code is placed in the first secondary provider field. For consistency, “paraprofessional” should be selected as the role of this pseudo-provider. The identity of the actual provider is entered in the provider ID field. If more than one actual provider is involved, the additional provider’s identity is entered in the second secondary provider field. If more than two providers are involved in a specialized visit service (an unlikely event), the primary provider is entered normally in the provider identity field, and the highest skilled of the additional providers is entered in the second secondary provider field.

e. Central Processing of Discrete Services

(1) Tabulations of Provider Workload

- The raw (provider) workload is measured for each SADR by converting each CPT code into its RVU equivalent and taking the sum of the largest RVU code plus 50% of all other RVU values in the SADR.
- Provider "costliness" is measured for each SADR by converting each provider type into its relative resource intensity using a scale similar to that shown below as an example, and summing the values. The actual scale is under development (in consultation with the MEPRS Management Improvement Group, MMIG) using salary expenses as reported in MEPRS. Generic provider specialty types that do not match a class (e.g., "orthopedics") are not included in the calculation.

Class of Provider	Relative Resource Intensity (Costliness)
Physician	1.0
Physician Extender	0.8
Nurse or Licensed Aide	0.6
Unlicensed Aide	0.4
Physician Resident	0.5

- The provider workload of the SADR is the product of the raw workload multiplied by the provider relative resource intensity. SADRs with provider workloads less than or equal to the workload equivalency of a physician assistant performing an intramuscular injection are not used in tabulating workload.
- Tabulations of provider workload for the organization are the sum of the SADR workloads for the time period desired.

(2) Tabulations of Facility Workload for Discrete Services:

- Each non-ancillary SADR (i.e., excluding MEPRS D codes) is grouped into its appropriate ambulatory patient group (APG).
- Each APG is converted into its relative weight.

- The medical APG and the E&M APG weights are combined.
- If the combined medical and E&M APG weight is less than any one of the procedural APG weights, it is dropped.
- The remaining APG weights are summed using 100% of the largest and 50% of any remaining APG weights. This sum is the facility workload for that SADR.
- Tabulations of facility workload for the work center or organization are the sum of the SADR workloads matching that center or organization for the time period desired.

Business Practices for Stays

a. Preparing the Data Systems for FY00

(Same preparation as for discrete services; need not be repeated)

b. Identifying Recordable Stays, and Types

(1) A stay should be recorded whenever a patient is assigned to a bed associated with any medical services and is not in observation status. Typically this will include the furnishing of a bed, linen, and a (shared) room at the expense of the facility (as defined in MEPRS), and may also include furnishing meals. This does not include housing people in "barracks" or non-facility housing.

(2) A patient who requires inpatient hospitalization should be admitted to the hospital. InterQual admission criteria must be used to determine appropriateness of hospital admissions.

(3) A patient who does not require acute hospitalization under InterQual criteria, but who stays at the facility as described above as recordable, must fall into one of the following categories. Detailed definitions of the categories are provided in Appendix A.

- Observation
- Skilled Nursing
- Hospice
- Minimal

c. Recording Stays

(7) All stays, other than observation, are to be recorded during FY00 using the "admission" processing of CHCS.

(8) Hospital inpatient admissions are not altered by this policy.

(9) Non-hospitalized inpatient admissions are admitted by the service describing the care (for example, AZA for hospice) to the ward where they are housed (for example, AZX for a mixed non-hospitalized ward, AAX for an internal medicine mixed ward).

(10) A patient who is transferred among work centers within an institution setting (within hospitalized stay wards or within non-hospitalized stay areas) can be recorded in

CHCS as a transfer identically to the way hospital inpatients have been transferred between wards in the past.

- (11) Transfers across institutional setting boundaries, whether a hospitalized inpatient switching to non-hospitalized or vice versa, require a discharge from the old setting and an admission to the new one in CHCS. Consequently, every SIDR will consist solely of hospitalized or non-hospitalized stays, never both types.
- (12) Although the current local systems will count *hospital admissions* and *hospital bed days* and will assign DRGs to non-hospitalized stays, these should be removed from totals when accurate reflection of hospital workload is required.

d. Central Processing of Stays

- (1) Hospital inpatient workload is tabulated based on DRG and using RWPs identically to past methods, except that any non-hospitalized stay inclusions should be excluded for most purposes.
- (2) Non-hospitalized inpatient workload will be tabulated as *weighted days* of work, using a scale in which a typical skilled nursing day of care is 1.00, as shown in the example below (actual weights are still under development):

Non-Hospitalized Stay Category	Relative Resource Intensity
Skilled Nursing	1.00
Hospice	0.75
Minimal	0.50

- (3) Work center or facility total workload is the sum of inpatient RWPs for hospital workload, and the sum of skilled nursing day equivalents for non-hospitalized stay workload based on the SIDRs of the period desired. For most purposes, SIDRs are assigned to the period of end-date-of-service, but for some purposes actual daily totals (partial SIDRs that span reporting periods) are more accurate.

Modifications to Third Party Collections

Manual interventions will be required in the short-term for non-hospitalized stays to avoid inappropriate billings.

Appendix A

Healthcare Service Definitions for Non-Hospitalized Stays

Hospice Services Provided within the MTF

The purpose of hospice care is to provide for the palliation or management of terminal illnesses and related conditions. The hospice service is available to individuals who have been certified by a physician to be terminally ill. An individual is considered to be terminally ill if he/she has a medical prognosis that his or her life expectancy is 6 months or less.

A plan of care must be established before services are provided and all services must comply with the plan of care. The following are included as hospice services: nursing care; medical social services; physician services; counseling services; medical appliances and supplies, including drugs and biologicals; and physical and occupational therapy. In general, the services must be related to the palliation or management of the patient's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

Skilled Nursing Facility Care Services Provided within the MTF

Skilled Nursing Facility (SNF) care is comprehensive institutional care designed for someone who has an illness, injury, or exacerbation of a disease process. It is goal oriented treatment rendered immediately after, or instead of, acute hospitalization to treat one or more specific active complex medical conditions or to administer one or more technically complex treatments, in the context of a person's underlying long term care condition and overall situations.

SNF care is for patients who (1) meet the InterQual criteria for admission to SNF, (2) require daily skilled nursing care or skilled rehabilitation services, plus other medical services, and (3) do not require frequent physician oversight. SNF care services include regular nursing care; meals, including special diets; physical, occupational, and speech therapy; drugs furnished by the facility; necessary medical supplies; and appliances.

Observation Services Provided within the MTF

Outpatient Observation Services are defined as those services furnished by a facility on the facility premises, including the use of a bed and periodic monitoring by a facility's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or to determine the need for a possible admission to a hospitalized stay as an inpatient or non-hospitalized stay such as SNF. Most observation services do not exceed 23 hours. However, in some instances, depending on medical necessity, up to 48 hours of observation services may be justified.

Minimal-Care Services Provided within the MTF

A physician will make a written determination to admit the minimal-care patient for services at the MTF. Self-care patients should not be admitted as minimal care (see definition of self-care).

Criteria are as follows:

1. Patients will not meet the InterQual criteria for admission to SNF;
2. Patients require some level of nursing care;
3. Patients require periodic physician evaluation; and
4. Patients require accommodation in an operating bed.

Examples:

1. Following receipt of acute care services, an Active Duty member with a severe burn to the hand requires daily nursing care and physical therapy for assessment of progress and resumption of full function.
2. A patient with an orthopedic injury requires monitoring and pain management for the first 72 hours following the injury.

Individuals who do not require any level of nursing care or physician evaluation, but who sleep in a bed located in the facility, would fall under Self-Care Services.

Self-Care Services Provided within the MTF

A physician, physician assistant, nurse practitioner, or other staff member as designated by the local MTF commander will make the determination to allow self-care patients or family members performing non-medical attendant functions to reside in the MTF overnight. Most MTFs currently have in place a holding unit for patients awaiting aeromedical evacuation and incorporation of those patients in the same self-care housing unit as the above beneficiaries is optional.

Criterion is as follows:

1. Nursing care or food delivery is not required.

Examples of self-care include:

1. Mothers breast feeding or bonding with hospitalized newborns.
2. Patients who do not have immediate access to medical care during their last phase of pregnancy (stork nesting).
3. Patients requiring diagnostic tests of an extensive nature or short-term rehabilitation services.
4. Family advocacy patients and/or family members who are the victims of abuse, neglect, or abandonment requiring placement pending disposition to home or as inpatients.
5. Soldiers returning from convalescent leave that are awaiting disposition.

Appendix B

Workcenter Definitions for Non-hospitalized Stay Locations

The following workcenter descriptions are provided for those MTFs that create a separate physical location for the specific non-hospitalized stay function, rather than simply using the corresponding MEPRS code to identify the non-hospitalized stay product. When the workcenter represents a physical location, hospitalized inpatients should not be commingled with the non-hospitalized stay cases.

Hospice Care Non-Hospitalized Stay

AZA

This workcenter provides hospice care for the palliation or management of a terminal illness and related conditions. The following are included as hospice services: nursing care; medical social services; physician services; counseling services; medical appliances and supplies, including drugs and biologicals; and physical and occupational therapy. A physician must have certified that the individuals are terminally ill. An individual is considered to be terminally ill if he/she has a medical prognosis that his or her life expectancy is 6 months or less. A plan of care must be established before services are provided and all services must comply with the plan of care. In general, the services must be related to the palliation or management of the patient's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

Skilled Nursing Facility Care Non-Hospitalized Stay

AZB

This workcenter provides skilled nursing facility (SNF) care during the active or convalescent stage of injury or illness. SNF care is comprehensive inpatient care designed for someone who has an illness, injury, or exacerbation of a disease process. It is goal oriented treatment rendered immediately after, or instead of, acute hospitalization to treat one or more specific active complex medical conditions or to administer one or more technically complex treatments, in the context of a person's underlying long term care condition and overall situations. Patients in the AZB workcenter do not meet InterQual standards for admission as acute care hospitalized inpatients.

Minimal Care Non-Hospitalized Stay

AZC

This workcenter provides minimal services to patients who require some level of nursing care and periodic evaluation by a physician. The workcenter provides care and treatment to eligible patients who do not meet the InterQual criteria for admission to SNF.

Mixed Non-Hospitalized Stay

AZX

This workcenter can provide any combination of the non-hospital stay services including hospice (AZA), SNF (AZB), or minimal (AZD) care services. This workcenter must meet all the standards prescribed for each of the non-hospital stay service types provided. Use this workcenter code when the volume of use is not sufficient to establish individual workcenters.

Case-Management Services

FAR

This workcenter provides all case-management and related support services by nursing and other personnel in support of a patient's primary care manager not related to direct patient care for the patient during hospitalized or non-hospitalized stays or outpatient visits. Costs for case-management activities, disease management, and other population health management activities will be reported in this cost center. All costs will be stepped-down to appropriate final accounts on the basis of the number of cases managed.

Self-Care Service

FAS

This workcenter does not provide any services beyond an overnight bed and is established to capture costs associated with housing of self-care patients or family members. A physician, physician assistant, nurse practitioner, or other staff member as designated by the local MTF commander, will make the determination to allow self-care patients or family members performing non-medical attendant functions to reside in the MTF overnight.

Attachment - UBU

UBU Recommendations for Changes to the ADS Coding Guidelines Which Address SADR Generation

The following are a subset of the UBU recommendations for changes to *ADS Coding Guidelines for Diagnosis and Procedure Coding* (May 30, 1997) which address specific services associated with SADR generation.

- Section 3.2 (Paragraph 1) *As a general rule, therapeutic services (including therapeutic ancillary services, such as radiation oncology) should report encounters using ADS encounter forms, while diagnostic services (e.g., lab, x-ray) that are already reported through CHCS are not.*

The UBU recommends the following for this paragraph:

Therapeutic services (including therapeutic ancillary services, such as hemodialysis, peritoneal dialysis, etc.) should report encounters using ADS encounter forms, while diagnostic services (e.g., lab, x-ray) that are already reported through CHCS, should not. In the case where ancillary services are performed and interpreted within a clinic, coding of an ADS Encounter Form is appropriate.

- Section 3.2 (Paragraph 2) *Encounters with inpatient and partial hospitalization patients occurring in clinics other than the admitting specialty will be reported using ADS. Inpatient encounters to ambulatory clinics of the admitting specialty are considered part of the inpatient stay and are not to be reported using ADS.*

The UBU recommends deletion of this section from the coding guidelines.

- Section 3.2.1 *Full fracture care (i.e., evaluation, reduction, initial casting, and removal from the initial cast) will be coded using the appropriate orthopedic codes, 23500 - 28000. Casts that replace a previously applied cast, regardless of whether the cost was part of a global fracture care or simply a means of stabilization prior to fracture care, are coded using the application of casts and strapping codes, 29000 through 29750.*

The UBU recommends the following wording for this paragraph:

Full fracture care (i.e., evaluation, reduction, initial casting, and removal from the initial cast) will be coded using the appropriate orthopedic codes, 23500 - 28000. Casts that replace a previously applied cast, regardless of whether the cast was part of a global fracture care or simply a means of stabilization prior to fracture care, are coded using the application of casts and strapping codes, 29000 through 29750. A separate ADS Encounter Form is required for each encounter within these global services.

- Section 3.3 ADS Encounter Summary Forms will be prepared for each day of partial hospitalization, as is done for outpatient surgery patients.

The UBU recommends the following modification:

ADS Encounter Summary Forms will be prepared for each day of partial hospitalization.

- Section 4.1 If the MTF pays the provider for the services from its operations and maintenance (O&M) account, then ADS documents the encounter and MEPRS determines the workload. If the provider is paid from Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)/ Managed Care Support Contract (MCSC) funds, the event is documented in CHAMPUS reports and an ADS encounter form is not appropriate.

The UBU recommends that this section be modified as follows.

If a TRICARE/CHAMPUS provider performs services within the MTF, ADS should be used to capture the institutional workload using the External Provider pseudo-SSN designator. If the care is provided in an external facility, ADS should not be used to document any of the services.

- Section 4.2 For military providers who are assigned to one facility but provide care at other locations, ADS will always be used to document the encounter in the clinic in which the care is provided. (The loaning facility records the provider's nonavailable time in MEPRS code FCD).

The UBU recommends modification to this section as follows.

When a DoD provider is assigned to one facility and provides care in another DoD facility, two ADS Encounter Forms need to be completed. One ADS Encounter Form is coded using the External Provider Pseudo-SSN designator and is scanned in the ADS system at the facility where services were performed. The

second ADS Encounter Form is coded using the External Facility Pseudo-SSN designator and is scanned into the ADS system at the provider's assigned facility.

When a DoD provider is assigned to one facility and provides care in a non- DoD facility, one ADS Encounter Form needs to be completed. This ADS Encounter Form is coded using the External Facility Pseudo-SSN designator and is scanned into the ADS system at the provider's assigned facility.

- Section 4.4 *At this time, ADS only captures ambulatory data for fixed MTFs. It does not capture encounter information for providers in non-DHP (direct health program) owned and operated facilities (i.e., any service that is resourced by the Line).*

The UBU recommends modification to this section as follows.

ADS Encounter Summary Forms should be used to capture encounter information for medically-funded or privileged DoD providers in non-medically owned and operated DoD facilities (any service that is resourced by the Line).

UBU recommends the following additions to ADS coding guidelines which address SADR generation:

For recording provider workload for inpatient services, a general rule of one ADS Encounter Form per patient per day is appropriate. The provider will use the E&M codes to document the variability in acuity across patients and time. The following four methods are proposed to document rounds:

1. ADS Encounter Forms with *walk-in* for the *Appointment Type*;
2. Physicians input data into automated ADS applications;
3. Each day, using CHCS Patient Appointment Scheduling Module, preprint ADS Encounter Forms for appointed rounds and only amend records if rounds are not performed; or
4. Physician annotates record and clinic staffs generate appointment and complete ADS Encounter Form.

A second ADS Encounter Form may be used to document Grand Rounds, if a physician other than the attending physician conducted the rounds and documented care in the medical record.

Ancillary departments (i.e., laboratory, radiology, etc) should not generate SADRs; their services will be represented through

the institutional workload and should not complete SADR's for inpatient care.

Those providers who are restricted to using E&M Code 99211 as the one and only applicable E&M code, will not complete ADS Encounter Forms for their inpatient services.

**UBU Recommendations for Changes to the ADS Coding Guidelines
Which Address CPT Coding Restrictions**

The following are UBU recommendations for changes to *ADS Coding Guidelines for Diagnosis and Procedure Coding* (May 30, 1997) that address restrictions placed on the use of CPT codes by clinic personnel:

- Section 3.1 *Privileged Providers may use all E&M codes except 99211.*

The UBU recommends that the restrictions placed on the use of 99211 by privileged providers be removed. All non-privileged providers are restricted to the use of 99211 or one of the three telephone consultation E&M Codes used by the advice nurses. There are a number of routine procedures (bandage replacement, blood pressure check, PAP smears, etc.,) that do not have any corresponding CPT codes and will only be collected as part of a more complex procedure performed by a provider.

- Section 3.1.4.3 *Privileged providers may choose from three E&M codes for telephone consults (i.e., 99371, 99372, and 99373). Non-privileged providers may also use all three telephone consults as long as the SSN of a privileged provider is entered as a supervising provider in the additional provider block on the back of the ADS Encounter Form.*

UBU recommends the following wording for this section:

Privileged providers may choose from three E&M codes for telephone consults (i.e., 99371, 99372, and 99373). Non-privileged providers may also use all three telephone consults as long as the SSN of a privileged provider is entered as a supervising provider in the additional provider block on the back of the ADS Encounter Form. Advice Nurses functioning under written and approved clinic protocol may complete an ADS Encounter Form for telephone consults.

- *Section 3.1.4.6 E&M code 99499 will be used for APVs along with the APV bubble on the ADS Encounter Form on the date of procedure only. APVs are to be reported using an ADS Encounter Form for B**5 and C885 Ambulatory Procedure Units (APUs). Pre- and post-operative appointments will be documented as an encounter using an ADS form, but will not be denoted with the APV bubble. This is a departure from civilian practices that might include these visits under the concept of global care.*

UBU recommends the following wording for this section:

*E&M code 99499 will be used for APVs along with the APV bubble on the ADS Encounter Form on the date of procedure only. APVs are to be reported using an ADS Encounter Form for B**5 or C**5. Pre- and post-operative appointments will be documented as an encounter using an ADS form, but will not be denoted with the APV bubble. This is a departure from civilian practices that might include these visits under the concept of global care.*

- *Section 3.2.3 Although CPT provides separate E&M codes (92002, 92004, 92012, and 92014) for new and established ophthalmology patients, they are not to be used for ADS purposes. The codes to be used are 99204, 99205, for new patients and 99214, 99215 for established patients.*

The UBU recommends that this restriction be removed and the codes 92002, 92004, 92012, and 92014 be applied for new and established ophthalmology patients.

UBU-1

Encl 2a(3)

MEMORANDUM FOR RECORD

Workload Standardization Overview of Operations for FY 00
Workload

1. The MEPRS Management Improvement Group (MMIG) met via teleconference 15 July 1999 to develop a formal MMIG response to the "Workload Standardization Overview of Operations for FY00 Workload". This memorandum summarizes the discussion of the group and provides a MMIG response to this proposal.

2. General Statement.

a. Before embarking on this initiative, it should be made clear that the following have been addressed by TMA policy prior to implementation by the MTFs:

b. The initiative does not conflict with federal policy regarding the performance of commercial activities as outlined in OMB Circular A-76.

c. The concept can be executed within current licensure and certification requirements such as for Skilled Nursing Facilities and/or Hospice Care.

c. The concept does not exceed the scope of DHP appropriations and does not provide a level of care to beneficiaries that crosses into other federally appropriated programs (e.g., VA)?

3. The operational concept for standardizing workload represents an attempt to use existing data elements and in some cases new data to increase the level of detail and specificity for reporting workload. The MMIG recognizes the need to separate and account for provider resources and facility resources and to the extent possible, costing provider inputs and facility inputs in the same place. However, the concept fails to explain in detail, the purpose of the initiative, the expected outcomes of how the data will be used within TMA policy for budgeting and resourcing, nor link the proposed costing methodology to MEPRS cost reporting requirements. The concept represents a unique approach to aligning costing and pricing of the commodities with those of the civilian sector. However, it may not fully consider the uniqueness of the "federal instrumentality" for budgeting and for resourcing. The fundamental goals (intent) of the document need to be more

concisely described and some operational concepts need to be further clarified (e.g., Home Health Care, TMA policy regarding Telemedicine, External Facility, External Provider).

4. The date (FY00) for implementation is very aggressive. It is recommended that this initiative be implemented first at the Medicare Subvention Sites. These sites are currently poised for changes in the established business practices and the associated traditional cost accounting concepts. They have most likely invested more resources into data quality activities and could possible leverage the current "Hawthone Effect" associated with Subvention with the changes proposed by the concept.

5. The document presents a "cold start" to the basic reader, needing an introduction and background section to show the value added by the 'To-Be' over the 'As-Is' model.

6. It is not clear that this concept is in concert with MEPRS. The MMIG is therefore forwarding a series of comments and questions to extend the understanding of the concept and to provide appropriate support to the initiative.

a. Under Concepts:

(1) The concept should state what short-term standardization is automated and not automated and what is expected to be collected and reported beginning FY00.

(2) The terms "visits" and "extended visits" as described within the Discrete Events needs to be clarified.

(3) Under this concept, a visit and ADS bubble sheet is prepared for patients who are admitted to the hospital. Today, the physician's time/hours are recorded to the inpatient specialty in MEPRS.

(4) The MMIG workload and FTE reconciliation for outpatient and inpatient physician labor distribution must be changed to reflect this new concept. Business rules must be established to outline when providers report their time/hours to the inpatient specialty code.

(5) The term "top provider" is not clearly understood. Please explain.

(6) The "Class of Provider" table on page 8 also needs clarification and possible expansion to cover the full range of potential providers.

(7) The concept suggests differences in the relative resource intensity of the providers. MMIG suggest using the term "Relative Resource Intensity" vice "Costliness Equivalent".

(8) The terms Discrete Services / Discrete Events are used interchangeable and should be distinguished and or used consistently.

(9) APGs are not currently available in all facilities for short-term tabulation of RVUs.

(10) If the MTF does not see the outcome or is not provided feedback on a timely basis, compliance will be difficult at best.

(11) Why are the APGs not deployed at the MTF level?

(12) Extended Visits (i.e., Observation) are measured in minutes of service. Therefore, it is not clear how the tabulations will be done.

(13) What is meant by "observed provider workload" when describing provider labor?

b. Under Business Practices for Discrete Events
Preparing Data Systems for FY00.

(1) Provider Table Refinement

(2) Current system constraints for Pseudo-Providers: Per Dr. Coventry, the concept applies only to ambulatory care and is not applicable to hospitalized or non-hospitalized stays. The MMIG would suggest the UBU define these care settings within the list of standardized appointment types used to deliver ambulatory health care. In such cases, provider workload as well as facility resources could be identified within the current MEPRS business rules if the appointment types were standardized.

(3) Telemedicine Consult - What is meant by "documented consultation"?

(4) The phrase suggests the use of some Standard Form such as SF 512 or SF 513.

(5) The documents should clarify that ancillary workload will be addressed under Priority 4 of the standardization targets.

c. Under External Provider:

(1) The current business rules for MEPRS labor /hour when DoD providers are providing care outside their assigned MTF is to charge the labor costs to a MEPRS "F" code; Support to Another Facility.

(2) Today, we have physicians who perform health care services for patients at locations other than their assigned facility.

(3) These physicians DO NOT credit their labor hours to their assigned outpatient clinic nor do they submit an ADS bubble sheet at their assigned facility. They are considered on loan at the facility where they are rendering services.

(4) Under this concept the current MEPRS labor / hour reporting was ignored. The concept requires MEPRS to credit the physician appropriate outpatient clinic with their labor hours. It does not address that MEPRS no longer would report physician time / hours to a MEPRS "F" account. Their labor hours would be attributed to their assigned outpatient work center.

(5) This concept does not address whether a visit count would be credited to the assigned facility.

(6) Additionally, an appointment type would need to be established in CHCS as either an appointment type mapped as count or non-count workload.

(7) MEPRS would be required to implement external facility and the external provider concepts denoted in this document.

(8) Figure 1, Guidelines for Reporting Discrete Events in ADS; Scenarios #5 and #6 should be revised in view of the comment noted above

(9) Omission of Unusable providers. MMIG requests further detailed clarification of this paragraph.

(10) Under Attaching Providers to Clinics - The document does not clearly address the issue of Managed Care Primary Care Teams.

c. Under Updating MEPRS Codes

(1) Appendix A of the UBU document defines the healthcare services for the new clinical cost centers needed to support this initiative. The MMIG feels these definitions need to be rewritten, specifying not only the functions of each work center, including a description of the cost procedures, performance factors, and where applicable, the assignment procedures.

(2) The concept document does not provide sufficient information regarding the processes for assuring that current business practices related to CHCS ADT are maintained. Specific MMIG questions deal with how PAD is notified of admissions and transfers as well as the clinical structures by way of specific examples of how non-hospitalized stay patients will be located in the facility.

(3) The MMIG will need more information regarding AZC, AZX, D** and F** in order to provide cogent comments. (please note the apparent typographical error in Appendix A wherein AZC is labeled AZD)

d. Under Identifying Recordable Discrete Events - Please clarify. Clarify per examples, how non-clinicians and ancillary personnel record routine services.

e. Under Generating Encounter Templates (Appointing)

(1) ADS does not allow walk-ins.

(2) The ADS system requires the appointment be scheduled in CHCS.

f. Under Recording Discrete Events:

(1) One must assume that "Acute" and "Non-acute" refers to Hospitalized and Non-Hospitalized Stays. Is that correct?

(2) Application of "same specialty": business rules need to be supported by examples in the document. The point is illustrated if one considers what happens if a provider visits a

"Hospice" patient, in which the care could be classified as either an inpatient or outpatient discrete event.

(3) Use of CPT and HCPCS

(4) Need to clarify what is meant by Dental Procedures: What are the Business Rules?

g. Under Central Processing of Discrete Events

(1) What is meant by provider costliness?

(2) What MEPRS FTE cost?

(3) Labor expenses reported in MEPRS / EAS III include productive, non-productive, loaned and borrowed expenses.

(4) The concept of "Costliness Equivalent" is not well understood. Please explain further.

(5) MMIG proposes using the term "Relative Resource Intensity" to describe the variance in cost of providers.

(6) The same comment is made regarding Facility costing.

h. Under Recording Stays. Although the current local system will count hospital admissions and hospital bed days, and assign DRGs to non-hospitalized stays, these should be removed from total when accurate detail workload is required. Observation, Skilled Nursing, Hospice and Minimal are considered non-hospitalized stays but inpatient MEPRS codes will be used. Recommend that "H" versus "A" codes be used. CHCS MEPRS tables must be updated to incorporate both codes. May be a restriction on "H" codes being reported in the SIDR.

i. Under Self Care Services Provided in MTF. Unclear, needs more information and clarification.

j. Under Minimal Care -- Is not well defined. Please explain further.

7. Use of MEPRS data in this concept must be clearly defined and understood. Calculations derived from workload standardization calculation should be in concert with MEPRS and

provide an enhanced level of patient detail for analyses at all levels of the organization.

Workload Standardization Concept of Operations Overview of Policy and Guidance for Operations during FY00

Purpose: This Workload Standardization document describes the process for transforming the measurement of Military Health System (MHS) medical treatment facility (MTF) workload from the existing systems to a re-engineered system for FY00. This process is an interim concept of operations to better represent the resources that are required to generate workload. In addition, through this process MHS workload measurement becomes quite similar to current best practices in industry. Since automation changes to fielded standardized systems are not feasible for implementation on 1 October 1999, this guidance requires no change in software in any of the related MHS systems: CHCS, ADS, CEIS, or MEPRS (EAS III). It does require minor changes or new entries in certain tables used by these systems that are normally and routinely updated prior to the start of each new fiscal year.

Scope: This document addresses only the highest priority shortcomings in the previous workload system, and defers both less urgent problems and more elegant solutions that would require software modifications. The deferred improvements occur in later phases that are to be implemented in subsequent fiscal years. For FY00, this guidance addresses only minor modifications to the way ADS and CHCS are used to capture MTF non-ancillary patient services. It does not require any modifications in the procedures used by other health care entities (e.g., Dental Clinics and Area Reference Laboratories) or in the recording of expenses into MEPRS.

Concept: Patient services, other than ancillary diagnostic work, are recorded concurrently with work performance. Discrete services, such as visits and extended visits (e.g., ambulatory procedure visits, observation cases), are recorded using the Ambulatory Data System (ADS). Continuous services (stays) are recorded using the Composite Health Care System (CHCS). Direct provider services are always viewed as discrete services, regardless of whether they are delivered as stand-alone visits or as a component of a stay. Workload for these services is separated into provider workload, consisting solely of the physician or most skilled provider's labor, and facility workload, consisting of all other materiel, labor, overhead, and supporting costs that are associated with the patient service. Provider workload is recorded by care setting which, for the short run, is identified and input using pseudo-provider codes in a secondary provider field of the ADS encounter form.

Provider workload is tabulated in relative value units (RVU) based on the health care services as reported using Current Procedural Terminology (CPT) codes and HCFA Common Procedure Coding System (HCPCS II) and captured in ADS. Facility workload is tabulated according to setting. Hospitalized stays are tabulated in relative weighted products (Raps) based on the diagnosis related group (DRG). Non-hospitalized stays are tabulated in Raps based on the stay category and length of stay. These non-hospitalized stays do not meet InterQual standards for acute admissions, but include types of care similar to that found in skilled nursing facilities (SNF), hospice, or minimal care settings. Discrete services (including observation cases in the short-term) are tabulated in relative value units (RVUs) based on ambulatory patient groups (APG). In the short-term (FY00), workloads will be tabulated by the Health Program Analysis and Evaluation (HPA&E) office from the centrally collected encounter records generated by CHCS (Standard Inpatient Data Records, or SIDRs) and ADS (Standard Ambulatory Data Records, or SADRs). In the long term, ADS/CHCS will pass these tabulations to EAS and generate WWR reports. For both long and short-term, provider labor should be allocated based on observed provider workload, and other facility costs allocated using facility workload, to obtain the best estimates of the costliness of the various healthcare encounters and services. In the short-term, this will be done centrally with no change in current automated systems. In the long-term, automated systems should be modified to accomplish this allocation.

The description that follows is organized into two broad categories: discrete services (visits) and stays. Within each category are sections describing the local actions needed to prepare the automation systems, identification and recording of the services, and the methods by which central (corporate) processing will tabulate workload. After the body of the document are two appendices and an attachment. Appendix A provides definitions of categories of care for non-hospitalized stays, case management, and self-care. Appendix B provides descriptions for the work centers that provide that care. The attachment provides excerpts of the newest UBU guidance as it relates to using ADS to capture workload.

Business Practices for Discrete Services

a. Preparing the Data Systems for FY00

(1)-(4) Updating the CHCS Provider Table

- Pseudo-Providers.

The SADRs from ADS will be "flagged" as special services by using artificial provider identifiers. To do this, pseudo providers must be included in the CHCS provider table before an MTF can record a specialized discrete service, such as Home Health and Telemedicine. The new provider table entries should be:

Provider ID	Provider Name	Provider Specialty Type
000-00-0011	Home Health	600
000-00-0022	Telemedicine Consultant	600
000-00-0033	Telemedicine Initiator	600
000-00-0044	External Facility	600
000-00-0055	External Provider	600

These pseudo-providers are used to identify visits that satisfy the following definitions:

Home Health: A care provider visits a home to assess suitability of the environment for the provision of health care services or to provide care.

Telemedicine Consultant: A provider at one facility responds to a provider at a distant facility who requests documented consultation (non-ancillary diagnosis, prognosis, and/or treatment regimen guidance).

Telemedicine Initiator: A provider, co-located with the patient, requests and receives documented consultation (non-ancillary diagnosis, prognosis, and/or treatment regimen guidance) from a consultant at a distant facility.

External Facility: A DoD provider submits a SADR to his/her own ADS system reporting the rendering of health care services to a patient at a facility other than the one to which the provider is assigned. The provider was not on loan to that facility.

External Provider: A DoD provider completes two ADS Encounter Forms to report that he/she rendered health care services at a facility other than the one to which he/she is assigned. One ADS form is scanned at his/her assigned facility to capture the provider costs, and the second ADS form is scanned at the facility where services were performed to document institutional costs. The provider was not on loan to this facility.

- Omission of Unusable, Generic Providers - Currently, CHCS provider tables include a variety of "place holder" specialty types (e.g., "orthopedics") which do not identify a skill level. If these generic provider identifiers are present in the SADR output by ADS, the relative costliness of the actual provider cannot be known. Consequently, while generic provider descriptions can remain in the provider tables for use as "place holders," the ADS encounter forms (bubble sheets) must be updated to reflect the actual provider who performed the service. ADS will then automatically include on the SADR this provider's identifier together with the specialty type of the provider that includes skill level (e.g., orthopedic surgeon). If the primary provider on the bubble sheet is not updated, the workload cannot be credited.

(2) (5) Attaching Providers to Clinics

Automated systems will not accept an appointment being made for a recorded provider who is not associated with a clinic/service. Before specialized discrete services can be appointed, (1) a conscious decision must be made by MTF management that a clinic/service will be authorized to perform specialized services (e.g., home health visits), and if so, (2) the clinic or service must be linked to the appropriate pseudo-provider in the provider table. However, this step is not required if the appointments will be scheduled for genuine providers rather than to the pseudo-provider type.

(3) (6) Updating MEPRS Codes

New clinical/cost centers are required for FY00. Definitions for the following services and workcenters are provided in the Appendices.

MEPRS Code	Service Name
AZA	Hospice Care
AZB	Skilled Nursing Facility (SNF) Care
AZC	Minimal Care
AZD	Observation (will not be used in FY00)

AZX	Mixed Non-Hospital Stay Ward
FAR	Case Management
FAS	Self-Care

The Account Subset Definition (ASD) must be updated to include cost recognition and Stepdown Assignment Statistics (SAS) for these if they are to be used to capture costs as cost centers.

b. Identifying Recordable Discrete Services

Discrete services are recorded in ADS for most occasions when a provider-patient encounter occurs. This will normally include all services historically called "countable visits" and some that have not been considered "countable". Whether the patient is a hospital inpatient, non-hospitalized inpatient (hospice, SNF, or minimal care), or an outpatient does not affect whether the service should be recorded. Generally, a SADR should be created if a provider performs a patient service of sufficient substance that it should be documented in the patient record. Two exceptions are noteworthy: (1) Non-clinician and ancillary personnel working routinely in the patient setting and attending to patients staying in the work center of the personnel should not record routine services; and, (2) Provider groups (such as Grand Rounds for educational purposes) should not create any SADRs unless one member of the group takes an action sufficient to document the patient record (in which case only that provider would record the encounter). In addition, where provider contact is especially frequent or continuous (such as with some ICU patients), a single ADS form (bubble sheet) can be used during a period of time (not to exceed a day) to record each procedure (CPT code) performed by that provider. Guidelines for recording discrete services are illustrated in Figure 1 on the following page.

In recording these discrete services, all appropriate CPT and HCPCS codes will be used as they are defined for their intended purpose. For example, no restriction is placed on the E&M code 99211 limiting its use to non-physicians. Due to the limitations of ADS, however, one and only one E&M code may be recorded. The Unified Biostatistical Utility (UBU) group has recommended changes to ADS coding guidelines which address SADR generation and CPT code restrictions. Excerpts from these recommendations affecting workload standardization are attached to this document.

Figure 1. Guidelines for Reporting Discrete Services in ADS

Scenario	Description	# of ADS Forms Required	Complete ADS Form for Provider Workload at Provider Facility (Y/N)	Complete ADS Form for Institutional Workload at the Provider Facility (Y/N)	Complete ADS Form for Institutional Workload at the External Facility (Y/N)	Explanation ²	Pseudo-Provider Flag
1	A provider performs outpatient services at his/her assigned (or on loan to) DoD facility (including resource sharing and resource support)	1	YES	YES	N/A	The provider and institutional workload is collected by one ADS form scanned at the assigned facility.	None
2	A provider performs inpatient services at his/her assigned (or on loan to) DoD facility (including resource sharing and resource support)	1	YES	NO	N/A	The provider workload is collected by one ADS form scanned at the assigned facility. The institutional workload is captured by the DRG from the SIDR.	None
3	A provider performs outpatient services at another DoD facility. The provider is not loaned labor to the external facility	2	YES	NO	YES	The provider workload is collected by one ADS form, using <i>External Facility</i> , scanned at the assigned facility. The institutional workload is collected by another ADS form, using <i>External Provider</i> , scanned at the external facility.	External Provider at place of care; External Facility at provider's MTF
4	A provider performs inpatient services at another DoD facility. The provider is not loaned labor to the external facility.	1	YES	NO	NO	The provider workload is collected by one ADS form, using <i>External Facility</i> , scanned at the assigned facility. The institutional workload for the external facility is collected on the SIDR.	External Facility at provider's MTF

² The fundamental principle is that provider workload will be attributed to the same “location” as the provider costs. If the provider is actually on loan, his/her salary expenses will show up at the receiving (DoD) facility, and that is where the SADR should be recorded/credited using the normal process for recording encounters. If part of the provider’s normal responsibilities is providing care to his/her patients in a civilian setting, the salary expense and recorded workload might be attributed to his/her assigned work-center. Since current policy guidance is to report salary expense in this case to an F-account, the SADRs should also show the same F-account. (If policy changed such that salary expense and workload should be reported to the B-code of the provider’s normal assignment, the guidance would still be to record the SADR to the same cost center as the provider’s cost, which would then be a B-code rather than an F-code.)

Scenario	Description	# of ADS Forms Required	Complete ADS Form for Provider Workload at Provider Facility (Y/N)	Complete ADS Form for Institutional Workload at the Provider Facility (Y/N)	Complete ADS Form for Institutional Workload at the External Facility (Y/N)	Explanation ²	Pseudo-Provider Flag
5	A provider performs patient services (any kind) at a non-DoD facility. The provider is not loaned labor to the external facility.	1	YES	NO	NO	The provider workload is collected by one ADS form, using <i>External Facility</i> , scanned at the assigned facility.	External Facility at provider's MTF
6	A provider initiates a request for Telemedicine consultation from a provider at another DoD facility	1	YES	YES	N/A	The initiating provider's (face-to-face with patient) workload is collected by one ADS form, using <i>Telemedicine Initiator</i> , scanned at the assigned facility.	Telemedicine Initiator at provider's MTF
7	A provider provides a consultation via Telemedicine	1	YES	NO	N/A	The consulting provider's workload is collected by one ADS form, using <i>Telemedicine Consultant</i> , scanned at the consultant's assigned facility.	Telemedicine Consultant at consultant's MTF
8	A provider performs a Home Health visit	1	YES	YES	N/A	The provider and institutional workload is collected by one ADS form, using <i>Home Health</i> , scanned at the assigned facility.	Home Health at provider's MTF

¹ The fundamental principle is that provider workload will be attributed to the same "location" as the provider costs. If the provider is actually on loan, his/her salary expenses will show up at the receiving (DoD) facility, and that is where the SADR should be recorded/credited using the normal process for recording encounters. If part of the provider's normal responsibilities is providing care to his/her patients in a civilian setting, the salary expense and recorded workload might be attributed to his/her assigned work-center. Since current policy guidance is to report salary expense in this case to an F-account, the SADRs should also show the same F-account. (If policy changed such that salary expense and workload should be reported to the B-code of the provider's normal assignment, the guidance would still be to record the SADR to the same cost center as the provider's cost, which would then be a B-code rather than an F-code.)

c. Generating Encounter Templates (Appointing)

The ADS captures encounters primarily through the scanning of "bubble sheets". Administrative burden for providers is minimized when the forms are pre-printed and available at the time of the visit. For outpatients, this is routinely handled through the appointing process. For hospitalized and non-hospitalized inpatients, this may be facilitated in multiple ways. The preferred method for such inpatients is to use the "walk-in" functionality of ADS, which is the least burdensome administratively. Other alternatives include:

~~(1)~~(9) Making daily appointments for each inpatient prior to the morning and leaving an encounter form in the inpatient record for use by the provider;

~~(2)~~(10) Using any approved ADS automated front-end system (e.g., KG-ADS) to record the encounter on a terminal as it occurs;

~~(3)~~(11) Scheduling a "walk-in" appointment in CHCS at the time of the encounter, then retrieving and using the encounter form generated; and,

~~(4)~~(12) Using a blank ADS Encounter Form to record the patient, diagnosis, and procedure(s) for later transfer and recording by administrative personnel.

d. Recording Discrete Services

Every recordable discrete service must be recorded in ADS. In addition to the normal process of completing the forms, the following special instructions apply:

~~(1)~~(4) Encounters for Inpatients (whether hospitalized or non-hospitalized stays)

- The encounter should be coded as "inpatient" by filling in the inpatient bubble.
- The work center (clinic) should be the service to which the provider is assigned and not the patient stay location.

~~(2)~~(5) Use of CPT & HCPCS

- All applicable CPT codes should be recorded representing what occurred, regardless of whether the provider was a physician, and the codes should be used with their normal meaning as found in the CPT codebook references.

▪ Certain services should be recorded with the appropriate HCPCS Level II codes, especially if high cost or high volume. The table below identifies which HCPCS Level II codes are required and which are optional. The policy for recording is shown below. In the table, "Optional, High Cost" encourages recording if the cost of the item is over \$200.

HCPCS Category		Coding Guidance
A	Transportation, etc.: 1. Ambulance 2. Medical/Surgical Supplies 3. Chiropractic	1. Must record 2. Optional, high cost 3. Taken care of in CPTs
B	Enteral and Parenteral Supplies	Optional, high cost
D	Dental Procedures	Must record (inpatient cases only)
E	Durable Medical Equipment (DME, returnable)	Optional, high cost
G	Temporary Procedures for Professional Services	Omit
H	Rehabilitation Services	Omit
J	Drugs (Injections, Orals, and Chemoteraphy)	Record all clinic-provided drugs. Pharmacy-provided drugs are recorded in CHCS and should not be recorded in a SADR.
K	DME	Optional, high cost
L	Orthotic Procedures	Optional, high cost
M	Medical Services	Omit
P	Pathology/Laboratory	Out of scope. Use CPT codes.
Q	Miscellaneous Services	Optional, high cost
R	Radiology Services	Out of scope. Use CPT codes.
T	Surgical Services	Omit
V	Vision, Hearing, and Speech	Need to map to a CPT code for just the services.

(6) Specialized Visit Services

Specialized visit services (such as home health, telemedicine, and visits where the provider is not charged to the facility where the service is rendered) are flagged by recording the pseudo-provider identifier matching the visit circumstances. This pseudo-provider identity code is placed in the first secondary provider field. For consistency, "paraprofessional" should be selected as the role of this pseudo-provider. The identity of the actual provider is entered in the provider ID field. If more than one actual provider is involved, the additional provider's identity is entered in the second secondary provider field. If more than two providers are involved in a specialized visit service (an unlikely event), the primary provider is entered normally in the provider identity

field, and the highest skilled of the additional providers is entered in the second secondary provider field.

e. Central Processing of Discrete Services

(1)(3) Tabulations of Provider Workload

▪ The raw (provider) workload is measured for each SADR by converting each CPT code into its RVU equivalent and taking the sum of the largest RVU code plus 50% of all other RVU values in the SADR.

▪ Provider "costliness" is measured for each SADR by converting each provider type into its relative resource intensity using a scale similar to that shown below as an example, and summing the values. The actual scale is under development (in consultation with the MEPRS Management Improvement Group, MMIG) using salary expenses as reported in MEPRS. Generic provider specialty types that do not match a class (e.g., "orthopedics") are not included in the calculation.

Class of Provider	Relative Resource Intensity (Costliness)
Physician	1.0
Physician Extender	0.8
Nurse or Licensed Aide	0.6
Unlicensed Aide	0.4
Physician Resident	0.5

▪ The provider workload of the SADR is the product of the raw workload multiplied by the provider relative resource intensity. SADRs with provider workloads less than or equal to the workload equivalency of a physician assistant performing an intramuscular injection are not used in tabulating workload.

▪ Tabulations of provider workload for the organization are the sum of the SADR workloads for the time period desired.

(2)(4) Tabulations of Facility Workload for Discrete Services:

▪ Each non-ancillary SADR (i.e., excluding MEPRS D codes) is grouped into its appropriate ambulatory patient group (APG).

▪ Each APG is converted into its relative weight.

▪ The medical APG and the E&M APG weights are combined.

- If the combined medical and E&M APG weight is less than any one of the procedural APG weights, it is dropped.
- The remaining APG weights are summed using 100% of the largest and 50% of any remaining APG weights. This sum is the facility workload for that SADR.
- Tabulations of facility workload for the work center or organization are the sum of the SADR workloads matching that center or organization for the time period desired.

Business Practices for Stays

a. Preparing the Data Systems for FY00

(Same preparation as for discrete services; need not be repeated)

b-e. Identifying Recordable Stays, and Types

(4) A stay should be recorded whenever a patient is assigned to a bed associated with any medical services and is not in observation status. Typically this will include the furnishing of a bed, linen, and a (shared) room at the expense of the facility (as defined in MEPRS), and may also include furnishing meals. This does not include housing people in "barracks" or non-facility housing.

(5) A patient who requires inpatient hospitalization should be admitted to the hospital. InterQual admission criteria must be used to determine appropriateness of hospital admissions.

(6) A patient who does not require acute hospitalization under InterQual criteria, but who stays at the facility as described above as recordable, must fall into one of the following categories. Detailed definitions of the categories are provided in Appendix A.

- Observation
- Skilled Nursing
- Hospice
- Minimal

f. Recording Stays

(13) All stays, other than observation, are to be recorded during FY00 using the "admission" processing of CHCS.

(14) Hospital inpatient admissions are not altered by this policy.

(15) Non-hospitalized inpatient admissions are admitted by the service describing the care (for example, AZA for hospice) to the ward where they are housed (for example, AZX for a mixed non-hospitalized ward, AAX for an internal medicine mixed ward).

(16) A patient who is transferred among work centers within an institution setting (within hospitalized stay wards or within non-hospitalized stay areas) can be recorded in CHCS as a transfer identically to the way hospital inpatients have been transferred between wards in the past.

(17) Transfers across institutional setting boundaries, whether a hospitalized inpatient switching to non-hospitalized or vice versa, require a discharge from the old setting and an admission to the new one in CHCS. Consequently, every SIDR will consist solely of hospitalized or non-hospitalized stays, never both types.

(18) Although the current local systems will count *hospital admissions* and *hospital bed days* and will assign DRGs to non-hospitalized stays, these should be removed from totals when accurate reflection of hospital workload is required.

d.g. Central Processing of Stays

(4) Hospital inpatient workload is tabulated based on DRG and using RWPs identically to past methods, except that any non-hospitalized stay inclusions should be excluded for most purposes.

(5) Non-hospitalized inpatient workload will be tabulated as *weighted days* of work, using a scale in which a typical skilled nursing day of care is 1.00, as shown in the example below (actual weights are still under development):

Non-Hospitalized Stay Category	Relative Resource Intensity
Skilled Nursing	1.00
Hospice	0.75
Minimal	0.50

(6) Work center or facility total workload is the sum of inpatient RWPs for hospital workload, and the sum of skilled nursing day equivalents for non-hospitalized stay workload based on the SIDRs of the period desired. For most purposes, SIDRs are assigned to the period of end-date-of-service, but for some purposes actual daily totals (partial SIDRs that span reporting periods) are more accurate.

Modifications to Third Party Collections

Manual interventions will be required in the short-term for non-hospitalized stays to avoid inappropriate billings.

Appendix A

Healthcare Service Definitions for Non-Hospitalized Stays

Hospice Services Provided within the MTF

The purpose of hospice care is to provide for the palliation or management of terminal illnesses and related conditions. The hospice service is available to individuals who have been certified by a physician to be terminally ill. An individual is considered to be terminally ill if he/she has a medical prognosis that his or her life expectancy is 6 months or less.

A plan of care must be established before services are provided and all services must comply with the plan of care. The following are included as hospice services: nursing care; medical social services; physician services; counseling services; medical appliances and supplies, including drugs and biologicals; and physical and occupational therapy. In general, the services must be related to the palliation or management of the patient's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

Skilled Nursing Facility Care Services Provided within the MTF

Skilled Nursing Facility (SNF) care is comprehensive institutional care designed for someone who has an illness, injury, or exacerbation of a disease process. It is goal oriented treatment rendered immediately after, or instead of, acute hospitalization to treat one or more specific active complex medical conditions or to administer one or more technically complex treatments, in the context of a person's underlying long term care condition and overall situations.

SNF care is for patients who (1) meet the InterQual criteria for admission to SNF, (2) require daily skilled nursing care or skilled rehabilitation services, plus other medical services, and (3) do not require frequent physician oversight. SNF care services include regular nursing care; meals, including special diets; physical, occupational, and speech therapy; drugs furnished by the facility; necessary medical supplies; and appliances.

Observation Services Provided within the MTF

Outpatient Observation Services are defined as those services furnished by a facility on the facility premises, including the use of a bed and periodic monitoring by a facility's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or to determine the need for a possible admission to a hospitalized stay as an inpatient or non-hospitalized stay such as SNF. Most observation services do not exceed 23 hours. However, in some instances, depending on medical necessity, up to 48 hours of observation services may be justified.

Minimal-Care Services Provided within the MTF

A physician will make a written determination to admit the minimal-care patient for services at the MTF. Self-care patients should not be admitted as minimal care (see definition of self-care).

Criteria are as follows:

- 1-5. Patients will not meet the InterQual criteria for admission to SNF;
- 2-6. Patients require some level of nursing care;
- 3-7. Patients require periodic physician evaluation; and
- 4-8. Patients require accommodation in an operating bed.

Examples:

- 1-3. Following receipt of acute care services, an Active Duty member with a severe burn to the hand requires daily nursing care and physical therapy for assessment of progress and resumption of full function.
- 2-4. A patient with an orthopedic injury requires monitoring and pain management for the first 72 hours following the injury.

Individuals who do not require any level of nursing care or physician evaluation, but who sleep in a bed located in the facility, would fall under Self-Care Services.

Self-Care Services Provided within the MTF

A physician, physician assistant, nurse practitioner, or other staff member as designated by the local MTF commander will make the determination to allow self-care patients or family members performing non-medical attendant functions to reside in the MTF overnight. Most MTFs currently have in place a holding unit for patients awaiting aeromedical evacuation and incorporation of

those patients in the same self-care housing unit as the above beneficiaries is optional.

Criterion is as follows:

1.2. Nursing care or food delivery is not required. |

Examples of self-care include:

1.6. Mothers breast feeding or bonding with hospitalized newborns. |

2.7. Patients who do not have immediate access to medical care during their last phase of pregnancy (stork nesting). |

3.8. Patients requiring diagnostic tests of an extensive nature or short-term rehabilitation services. |

4.9. Family advocacy patients and/or family members who are the victims of abuse, neglect, or abandonment requiring placement pending disposition to home or as inpatients. |

5.10. Soldiers returning from convalescent leave that are awaiting disposition. |

Appendix B

Workcenter Definitions for Non-hospitalized Stay Locations

The following workcenter descriptions are provided for those MTFs that create a separate physical location for the specific non-hospitalized stay function, rather than simply using the corresponding MEPRS code to identify the non-hospitalized stay product. When the workcenter represents a physical location, hospitalized inpatients should not be commingled with the non-hospitalized stay cases.

Hospice Care Non-Hospitalized Stay AZA

This workcenter provides hospice care for the palliation or management of a terminal illness and related conditions. The following are included as hospice services: nursing care; medical social services; physician services; counseling services; medical appliances and supplies, including drugs and biologicals; and physical and occupational therapy. A physician must have certified that the individuals are terminally ill. An individual is considered to be terminally ill if he/she has a medical prognosis that his or her life expectancy is 6 months or less. A plan of care must be established before services are provided and all services must comply with the plan of care. In general, the services must be related to the palliation or management of the patient's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

Skilled Nursing Facility Care Non-Hospitalized Stay AZB

This workcenter provides skilled nursing facility (SNF) care during the active or convalescent stage of injury or illness. SNF care is comprehensive inpatient care designed for someone who has an illness, injury, or exacerbation of a disease process. It is goal oriented treatment rendered immediately after, or instead of, acute hospitalization to treat one or more specific active complex medical conditions or to administer one or more technically complex treatments, in the context of a person's underlying long term care condition and overall situations. Patients in the AZB workcenter do not meet InterQual standards for admission as acute care hospitalized inpatients.

Minimal Care Non-Hospitalized Stay AZC

This workcenter provides minimal services to patients who require some level of nursing care and periodic evaluation by a physician. The workcenter provides care and treatment to eligible patients who do not meet the InterQual criteria for admission to SNF.

Mixed Non-Hospitalized Stay

AZX

This workcenter can provide any combination of the non-hospital stay services including hospice (AZA), SNF (AZB), or minimal (AZD) care services. This workcenter must meet all the standards prescribed for each of the non-hospital stay service types provided. Use this workcenter code when the volume of use is not sufficient to establish individual workcenters.

Case-Management Services

FAR

This workcenter provides all case-management and related support services by nursing and other personnel in support of a patient's primary care manager not related to direct patient care for the patient during hospitalized or non-hospitalized stays or outpatient visits. Costs for case-management activities, disease management, and other population health management activities will be reported in this cost center. All costs will be stepped-down to appropriate final accounts on the basis of the number of cases managed.

Self-Care Service

FAS

This workcenter does not provide any services beyond an overnight bed and is established to capture costs associated with housing of self-care patients or family members. A physician, physician assistant, nurse practitioner, or other staff member as designated by the local MTF commander, will make the determination to allow self-care patients or family members performing non-medical attendant functions to reside in the MTF overnight.

Attachment - UBU

UBU Recommendations for Changes to the ADS Coding Guidelines Which Address SADR Generation

The following are a subset of the UBU recommendations for changes to *ADS Coding Guidelines for Diagnosis and Procedure Coding* (May 30, 1997) which address specific services associated with SADR generation.

- Section 3.2 (Paragraph 1) *As a general rule, therapeutic services (including therapeutic ancillary services, such as radiation oncology) should report encounters using ADS encounter forms, while diagnostic services (e.g., lab, x-ray) that are already reported through CHCS are not.*

The UBU recommends the following for this paragraph:

Therapeutic services (including therapeutic ancillary services, such as hemodialysis, peritoneal dialysis, etc.) should report encounters using ADS encounter forms, while diagnostic services (e.g., lab, x-ray) that are already reported through CHCS, should not. In the case where ancillary services are performed and interpreted within a clinic, coding of an ADS Encounter Form is appropriate.

- Section 3.2 (Paragraph 2) *Encounters with inpatient and partial hospitalization patients occurring in clinics other than the admitting specialty will be reported using ADS. Inpatient encounters to ambulatory clinics of the admitting specialty are considered part of the inpatient stay and are not to be reported using ADS.*

The UBU recommends deletion of this section from the coding guidelines.

- Section 3.2.1 *Full fracture care (i.e., evaluation, reduction, initial casting, and removal from the initial cast) will be coded using the appropriate orthopedic codes, 23500 - 28000. Casts that replace a previously applied cast, regardless of whether the cost was part of a global fracture care or simply a means of stabilization prior to fracture care, are coded using the application of casts and strapping codes, 29000 through 29750.*

The UBU recommends the following wording for this paragraph:

Full fracture care (i.e., evaluation, reduction, initial casting, and removal from the initial cast) will be coded using the appropriate orthopedic codes, 23500 - 28000. Casts that replace a previously applied cast, regardless of whether the cast was part of a global fracture care or simply a means of stabilization prior to fracture care, are coded using the application of casts and strapping codes, 29000 through 29750. A separate ADS Encounter Form is required for each encounter within these global services.

- Section 3.3 ADS Encounter Summary Forms will be prepared for each day of partial hospitalization, as is done for outpatient surgery patients.

The UBU recommends the following modification:

ADS Encounter Summary Forms will be prepared for each day of partial hospitalization.

- Section 4.1 If the MTF pays the provider for the services from its operations and maintenance (O&M) account, then ADS documents the encounter and MEPRS determines the workload. If the provider is paid from Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)/ Managed Care Support Contract (MCSC) funds, the event is documented in CHAMPUS reports and an ADS encounter form is not appropriate.

The UBU recommends that this section be modified as follows.

If a TRICARE/CHAMPUS provider performs services within the MTF, ADS should be used to capture the institutional workload using the External Provider pseudo-SSN designator. If the care is provided in an external facility, ADS should not be used to document any of the services.

- Section 4.2 For military providers who are assigned to one facility but provide care at other locations, ADS will always be used to document the encounter in the clinic in which the care is provided. (The loaning facility records the provider's nonavailable time in MEPRS code FCD).

The UBU recommends modification to this section as follows.

When a DoD provider is assigned to one facility and provides care in another DoD facility, two ADS Encounter Forms need to be completed. One ADS Encounter Form is coded using the External Provider Pseudo-SSN designator and is scanned in the ADS system at the facility where services were performed. The

second ADS Encounter Form is coded using the External Facility Pseudo-SSN designator and is scanned into the ADS system at the provider's assigned facility.

When a DoD provider is assigned to one facility and provides care in a non- DoD facility, one ADS Encounter Form needs to be completed. This ADS Encounter Form is coded using the External Facility Pseudo-SSN designator and is scanned into the ADS system at the provider's assigned facility.

- *Section 4.4 At this time, ADS only captures ambulatory data for fixed MTFs. It does not capture encounter information for providers in non-DHP (direct health program) owned and operated facilities (i.e., any service that is resourced by the Line).*

The UBU recommends modification to this section as follows.

ADS Encounter Summary Forms should be used to capture encounter information for medically-funded or privileged DoD providers in non-medically owned and operated DoD facilities (any service that is resourced by the Line).

UBU recommends the following additions to ADS coding guidelines which address SADR generation:

For recording provider workload for inpatient services, a general rule of one ADS Encounter Form per patient per day is appropriate. The provider will use the E&M codes to document the variability in acuity across patients and time. The following four methods are proposed to document rounds:

- 1-5. ADS Encounter Forms with *walk-in* for the Appointment Type;
- 2-6. Physicians input data into automated ADS applications;
- 3-7. Each day, using CHCS Patient Appointment Scheduling Module, preprint ADS Encounter Forms for appointed rounds and only amend records if rounds are not performed; or
- 4-8. Physician annotates record and clinic staffs generate appointment and complete ADS Encounter Form.

A second ADS Encounter Form may be used to document Grand Rounds, if a physician other than the attending physician conducted the rounds and documented care in the medical record.

Ancillary departments (i.e., laboratory, radiology, etc) should not generate SADRs; their services will be represented through

the institutional workload and should not complete SADR's for inpatient care.

Those providers who are restricted to using E&M Code 99211 as the one and only applicable E&M code, will not complete ADS Encounter Forms for their inpatient services.

UBU Recommendations for Changes to the ADS Coding Guidelines Which Address CPT Coding Restrictions

The following are UBU recommendations for changes to *ADS Coding Guidelines for Diagnosis and Procedure Coding* (May 30, 1997) that address restrictions placed on the use of CPT codes by clinic personnel:

- Section 3.1 *Privileged Providers may use all E&M codes except 99211.*

The UBU recommends that the restrictions placed on the use of 99211 by privileged providers be removed. All non-privileged providers are restricted to the use of 99211 or one of the three telephone consultation E&M Codes used by the advice nurses. There are a number of routine procedures (bandage replacement, blood pressure check, PAP smears, etc.,) that do not have any corresponding CPT codes and will only be collected as part of a more complex procedure performed by a provider.

- Section 3.1.4.3 *Privileged providers may choose from three E&M codes for telephone consults (i.e., 99371, 99372, and 99373). Non-privileged providers may also use all three telephone consults as long as the SSN of a privileged provider is entered as a supervising provider in the additional provider block on the back of the ADS Encounter Form.*

UBU recommends the following wording for this section:

Privileged providers may choose from three E&M codes for telephone consults (i.e., 99371, 99372, and 99373). Non-privileged providers may also use all three telephone consults as long as the SSN of a privileged provider is entered as a supervising provider in the additional provider block on the back of the ADS Encounter Form. Advice Nurses functioning under written and approved clinic protocol may complete an ADS Encounter Form for telephone consults.

- *Section 3.1.4.6 E&M code 99499 will be used for APVs along with the APV bubble on the ADS Encounter Form on the date of procedure only. APVs are to be reported using an ADS Encounter Form for B**5 and C885 Ambulatory Procedure Units (APUs). Pre- and post-operative appointments will be documented as an encounter using an ADS form, but will not be denoted with the APV bubble. This is a departure from civilian practices that might include these visits under the concept of global care.*

UBU recommends the following wording for this section:

*E&M code 99499 will be used for APVs along with the APV bubble on the ADS Encounter Form on the date of procedure only. APVs are to be reported using an ADS Encounter Form for B**5 or C**5. Pre- and post-operative appointments will be documented as an encounter using an ADS form, but will not be denoted with the APV bubble. This is a departure from civilian practices that might include these visits under the concept of global care.*

- *Section 3.2.3 Although CPT provides separate E&M codes (92002, 92004, 92012, and 92014) for new and established ophthalmology patients, they are not to be used for ADS purposes. The codes to be used are 99204, 99205, for new patients and 99214, 99215 for established patients.*

The UBU recommends that this restriction be removed and the codes 92002, 92004, 92012, and 92014 be applied for new and established ophthalmology patients.

