



**QUALITY: AUDIOLOGY AND SPEECH
ANALYSIS AND REPORTING
(QUASAR)
USER MANUAL**

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I. Introduction

Quality: Audiology and Speech Analysis and Reporting (QUASAR) is a VISTA software package written for the Audiology and Speech Pathology Service. QUASAR is used to enter, edit, and retrieve data for each episode of care. It provides transmission of visit data to the Patient Care Encounter (PCE) program in order to incorporate QUASAR Visit Data in ACRP Workload Reporting as well as to the Decision Support System (DSS). It produces a variety of reports useful to local managers, medical center management, and central planners. QUASAR also contains a VA FileMan function that permits users to generate customized reports using data from QUASAR's A&SP Clinic Visit file (#509850.6) or A&SP Patient file (#509850.2). QUASAR produces an automated Cost Distribution RCS 10-0141 Report (CDR) and has an option for generating and processing audiology compensation and pension examinations through an agreement with the Automated Medical Information Exchange (AMIE) package.

Acronyms Used in this Manual

A&SP	Audiology and Speech Pathology.
CDR	Cost Distribution Report.
C&P	Compensation and Pension.
CPT	Current Procedural Terminology.
DSS	Decision Support System.
HCFA	Health Care Financing Administration.
HCPCS	HCFA Common Procedure Coding System.
ICD-9-CM	<i>International Classification of Diseases, Ninth Edition, with Clinical Modifications.</i>
PCE	Patient Care Encounter.
QUASAR	Quality: Audiology and Speech Analysis and Reporting.
VACO	Veterans Affairs Central Office.
VARO	Veterans Affairs Regional Office.
VHA	Veterans Health Administration.
VISTA	Veterans Health Information System and Technology Architecture.

II. Implementing & Maintaining the QUASAR Package

Implementation Checklist (Virgin Installations Only)

Each of the following steps is described in greater detail within this chapter.

- Assign menu options to users.
- Assign the ACKQ ADHOC key to those users who will be designing reports using the Tailor-Made A&SP Reports option.
- Add appropriate A&SP staff to the USR Class Membership file # 8930.3 and assign a User Class to each. After staff are added to the USR Class Membership file, add the same A&SP staff to the A&SP Staff file #509850.3. Also ensure that each A&SP staff member has an appropriate Person Class entry within the New Person file #200.
- Define site parameters using the A&SP Site Parameters option.
- (Optional) Use the Update Files per CO Directive to add diagnoses to the A&SP Diagnostic Condition file and procedures to the A&SP Procedure Code file.
- (Optional) Apply local cost amounts to each procedure using the Enter Cost Information Procedure option. You may use locally developed cost data, DSS product costs, community fees, insurance reasonable rates, or Medicare reasonable rates.

Implementation Checklist (Installations over V. 2.0)

- Define site parameters using the A&SP Site Parameters option.
- Make sure each entry in the A&SP Staff file #509850.3 also has an appropriate Person Class entry within the New Person file #200.
- (Optional) Use the Update Files per CO Directive to make any required changes to the A&SP Diagnostic Condition file and the A&SP Procedure Code file.
- (Optional) Apply local cost amounts to each procedure using the Enter Cost Information Procedure option.

Menu Option Assignment

A&SP Supervisor Menu

The A&SP Supervisor Menu [ACKQAS SUPER] option is assigned to supervisory personnel. It is the main menu and contains options for setting up and maintaining the QUASAR package, entering clinic visit data, generating management reports, and adequating Compensation and Pension (C&P) exams.

Set Up/Maintenance

- Staff (Enter/Edit)
- A&SP Site Parameters
- Update Files per CO Directive
- Print A&SP File Entries
- Enter Cost Information for Procedures
- Update CPT Modifiers per CO Directive

Audiology & Speech Visit Tracking System

- New Clinic Visits
- Edit an Existing Visit
- Inquire - A&SP Patient
- A&SP Reports
 - Visits by Diagnosis
 - Patients by City
 - Statistics by Procedure
 - Cost Comparison Report
 - Tailor-Made A&SP Reports **Locked: ACKQ ADHOC**
 - PCE Exception Report
 - Workload Report

Management Reports A&SP

- Generate A&SP Service CDR
- Print A&SP Service CDR
- Compile A&SP Capitation Data
- Print A&SP Capitation Report

C&P Exam Adequation

- Delete an A&SP Clinic Visit

Audiology & Speech Visit Tracking System

The Audiology & Speech Visit Tracking System [ACKQAS MASTER] menu option is assigned to personnel who will be entering clinic visit data and generating reports.

New Clinic Visits

- Edit an Existing Visit
- Inquire - A&SP Patient
- A&SP Reports
 - Visits by Diagnosis
 - Patients by City
 - Statistics by Procedure
 - Cost Comparison Report

Tailor-Made A&SP Reports ****Locked: ACKQ ADHOC****
PCE Exception Report
Workload Report

A&SP Reports

The A&SP Reports [ACKQAS REPORTS] menu contains only report options. This menu can be assigned to users who may not enter or modify any of the data, but need to be able to see the data generated by these reports.

Visits by Diagnosis
Patients by City
Statistics by Procedure
Cost Comparison Report
Tailor-Made A&SP Reports ****Locked: ACKQ ADHOC****
PCE Exception Report
Workload Report

Key Assignment

Give the **ACKQ ADHOC** key to all users who will be creating/designing reports using the option Tailor-Made A&SP Reports. This option uses VA FileMan to sort and print data from the A&SP Clinic Visit (#509850.6) and A&SP Patient (#509850.2) files.

Options for Implementing and Maintaining the Package Set Up/Maintenance Menu ...

The Set Up/Maintenance menu [ACKQAS SET UP MENU] can be accessed by anyone assigned the A&SP Supervisor menu. It contains the options needed to implement the package and maintain or update the data used by the package.

Staff (Enter/Edit) [ACKQAS CLINICIAN ENTRY]

A&SP Site Parameters [ACKQAS SITE PARAMS]

Update Files per CO Directive [ACKQAS VACO DIRECTIVE] (Only A&SP staff designated as supervisors can access this option.)

Print A&SP File Entries [ACKQAS FILE PRINT]

Enter Cost Information for Procedures [ACKQAS COST ENTRY] (Only A&SP staff designated as supervisors can access this option.)

Update CPT Modifiers per CO Directive [ACKQAS UPDATE CPT MODIFIERS]

Set Up/Maintenance Menu ...
Staff (Enter/Edit)
[ACKQAS CLINICIAN ENTRY]

The Staff (Enter/Edit) option allows you to enter data for clinicians, fee-basis personnel, other providers (e.g., health technicians), and students into the A&SP STAFF file (#509850.3). The information includes the staff person's name, activation and inactivation dates, status, an ID number for sites that choose to use code numbers, and whether or not the person is designated as a supervisor.

Note: Any entries in this file must also be members in the USR CLASS MEMBERSHIP file #8930.3.

Note: Staff members should never be deleted because entries in the A&SP Clinic Visit file (#509850.6) reference them. This option is used to activate and inactivate staff members as appropriate.

A&SP Staff Name: Names added to the A&SP STAFF file (#509850.3) must be in the New Person file (#200) and in the USR Class Membership file #8930.3. The A&SP Service Chief should contact IRM if an entry needs to be made to the New Person file.

Status: Assign one of the following statuses to each staff member entry:

S	STUDENT
C	CLINICIAN
F	FEE BASIS CLINICIAN
O	OTHER PROVIDER

Activation Date: An activation date is required to associate the staff member with a clinic visit. The activation date is the date the staff member became an active member. For the staff member to receive credit for a patient visit, he or she must have been active on or before the visit date.

Inactivation Date: Enter a date when the staff member is no longer active.

ID Number: The ID Number field is used at stations that use code numbers in lieu of provider names. QUASAR provides a sequential default number starting with 0001, but any unique four digit number is accepted.

Supervisor: Selected clinicians can be designated as supervisors. Supervisors have access to certain functionality that is not available to other staff members (e.g., adequating any C&P exam).

Set Up/Maintenance ...
A&SP Site Parameters
[ACKQAS SITE PARAMS]

The A&SP Site Parameters option allows you to enter data into the A&SP Site Parameters file (#509850.8). The parameters define how you want the program to run at your site and at each division within your site.

Site Name: Enter your station name or number. Only one entry is allowed in the A&SP Site Parameters file.

Interface with PCE: If you want QUASAR to send visit data to PCE, answer YES. If you check out patients via PCE and wish to continue to do so, answer NO. This parameter determines whether or not to activate the interface with PCE. If this parameter is set to NO, data **will not** be sent to PCE. If set to YES, visit data **will be** transmitted to PCE for each division that has its Send To PCE parameter also set to YES.

Division: Even if you are a single division site, enter that division here. This allows for workload crediting by division. At this point, you need to define all the following parameters for **each** Division using this program.

Division Status: Enter ACTIVE. If the division should become inactive, change the status at that time to INACTIVE. No new visits can be added to an Inactive division.

Send to PCE: If you want data for this division sent to PCE, the INTERFACE TO PCE parameter for the Site (see above) must be set to YES and you must also set this parameter (SEND TO PCE) for the division to YES. When a new visit is entered, or an existing visit is edited or deleted, the system looks at the SEND TO PCE parameter for the division to determine whether the visit data should be transmitted to PCE. A multi-divisional site has the choice of sending visit data to PCE for some divisions and not for others.

Note: Data is transmitted to PCE as soon as you exit the record.

PCE Interface Start Date: Enter the first Visit Date to be sent to PCE. QUASAR will only send Visits for this Division if the Visit Date falls on or after the PCE INTERFACE START DATE.

If you enter the 1st of the next calendar month for instance, you may continue to enter, edit or delete visits for the current calendar month and QUASAR will not transmit them to PCE. Once new Visits are entered for the new month they will automatically be transmitted to PCE.

If you enter a date in the past, QUASAR will not automatically transmit visits that are already on file, even if their Visit Date is after the PCE INTERFACE START DATE. These visits will be reported on the PCE Exception Report and must be edited in QUASAR to initiate transfer to PCE.

¹Update PCE Problem List: No//: This is a new field within the A&SP Site Parameters file (509850.8). This field can be edited.

The default setting is No. If you answer with a No, there are no changes to the prompts that you will view. You will continue with the “**Use ASP Clinic File Number**” prompt. The PCE Problem list is not updated.

If you answer with a Yes, a Diagnosis Code will be sent to PCE. This prompt occurs in the **New Visit** and **Edit Visit** options for each Diagnostic code that is entered, but only if the PCE Interface is active for the Division.

If you select to update the PCE Problem List, you will be asked who was the **Diagnosis Provider**. Currently, when data is transferred to PCE, a PCE Encounter is created using the QUASAR visit data. However, if you answer Yes to the “**Update the PCE Problem List**” prompt, the system will also attempt to update the PCE Problem List with all selected Diagnosis Codes and their associated Providers.

Use ASP Clinic File Number: For those sites that have existing LOCAL (not medical center) file numbers associated with their Audiology and Speech Pathology patients and wish to continue using these numbers, answer YES. By doing this, you can cross-reference QUASAR visit entries to your current file numbering system.

Use C&P: Answer YES if you wish to use QUASAR’s AMIE/C&P interface. If you use a different reporting procedure and do not wish to use the AMIE/C&P interface, answer NO.

If you answer YES to use the AMIE/C&P interface, staff involved must have an electronic signature. An electronic signature can be established using the Edit Electronic Signature Code option in the User’s Toolbox menu.

The AMIE linkage feature allows:

- Entry of text and audiometric data in the AMIE format,
- Adequation of the results, and
- Hand-off of the report to the AMIE Compensation and Pension package.

If this functionality is enabled, QUASAR checks to see if an audiology C&P exam is scheduled. When an entry is made for the patient, the user is asked “Is this a C&P exam?” If the user responds yes, in addition to the usual QUASAR information, narrative data is requested for generating the AMIE report.

¹ This is a new field contained in Patch ACKQ*3.0*1.

If the C&P exam prompt does not appear:

- (1) The patient entered is not a C&P patient,
- (2) Veterans Affairs Regional Office (VARO) did not request an AUDIO exam (see Form 2507), or
- (3) The patient's C&P claim has been closed by the C&P Unit. Users should contact their C&P Unit.

See [Forcing the C&P Prompt](#) for procedure to force the C&P prompt.

Bypass Audiometrics: Certain diagnosis codes (i.e., hearing loss codes) are flagged to require audiometric data to be entered when those codes are used for a visit. By answering YES for the Bypass Audiometrics field, you allow users to bypass the entry of that data. If you answer NO, users are not allowed to bypass the entry of audiometric data.

¹Event Capture Codes: Supervisors can set up a Division to use Event Capture Codes instead of the Procedure Codes (CPT) as a prompt to be displayed for the coming DSS extract period. In the Event Capture mode, answer “Yes” if you want the Division to use Event Capture Codes or “No” if you want this Division to use CPT codes.

The Division can be set up with this option to change the mode in Site Parameters within a two-week window from September 17-30 each year. The last day to change the mode is September 30 at midnight. Supervisors can re-edit this field within this time period, but all values after the September 30 will be final for the approaching Fiscal Year.

When a mode has been changed to use the Event Capture Code field, an automatic mailman message is sent to all active Supervisors within the Division.

Clinic Location: The only clinics that may be entered for a division are clinics for Audiology (Stop Code 203), Speech Pathology (Stop Code 204), and Telephone/Rehab and Support (Stop Code 216) that reside in the Hospital Location file (#44) at your site. There must be at least one clinic entered for this field.

Audiology DSS Unit Link and Speech Pathology DSS Unit Link: The last two fields are pointers to the DSS Unit file (#724) from Event Capture. These fields create linkage between QUASAR and a specific DSS unit in order to define data needed by the QUASAR/DSS extract. Enter the DSS units for these links. **Note: These are not division specific.**

¹ This is a new field contained in Patch ACKQ*3.0*1.

Set Up/Maintenance ...
Enter Cost Information for Procedures
[ACKQAS COST ENTRY]

The Enter Cost Information for Procedures option allows you to enter cost data for each procedure code in the A&SP Procedure Code file (#509850.4). You can select a single CPT-4 code, or you can edit all procedure codes. If you choose to edit all procedures, each procedure is displayed consecutively, and the current approximate private sector cost can be entered. You can obtain fee schedules from public or private sector clinics and hospitals, calculate their real costs, or use insurance reimbursement rates (e.g., Medicare/Medicaid or insurance UCRs).

Procedure cost information is used in generating the Cost Comparison Report on the A&SP Reports menu.

Set Up/Maintenance ...
Update Files per CO Directive
[ACKQAS VACO DIRECTIVE]

Note: In order to use this option, you must be designated as an active supervisor in the A&SP Staff file (#509850.3). Use the Staff (Enter/Edit) option to make this designation.

The Update Files per CO Directive option is to be used with extreme caution. Data in the CDR Account file (#509850), the A&SP Diagnostic Condition file (#509850.1), and the A&SP Procedure Code file (#509850.4) are standardized for roll-up to central data bases (e.g., DSS). File entries should be added or modified ONLY by directive from the Director, Audiology and Speech Pathology Service (VAHQ).

After selecting the file you wish to edit, you can choose to inactivate selected entries or add data for a new entry. When a new entry is added, all fields for that entry must be answered in order to maintain database integrity. If data is incomplete, the entry is automatically deleted.

Set Up/Maintenance ...
Print A&SP File Entries
[ACKQAS FILE PRINT]

The Print A&SP File Entries option lists the file entries from the CDR Account file, the A&SP Procedure Code file, or the A&SP Diagnostic Condition file. Select the file you want to print and enter a printer name.

Example:

A&SP PROCEDURE CODE LIST		OCT 14, 1999	09:53	PAGE 1
CODE	PROCEDURE	COST	ACTIVE	
	MODIFIER			
	DESCRIPTION	COST		

NNNNN	PROCEDURE	\$\$.00	ACTIVE	
NNNNN	PROCEDURE	\$\$.00	INACTIVE	
...				

Set Up/Maintenance ...
Update CPT Modifiers per CO Directive
[ACKQAS UPDATE CPT MODIFIERS]

This option allows you to select any modifier already defined in the A&SP Procedure Modifier file (#509850.5) and either activate or inactivate it. The option also allows you to add active CPT or HCPCS modifiers from the CPT Modifier file (#81.3) to the A&SP Procedure Modifier file. Modifiers cannot be deleted from the A&SP Modifier file; a modifier is removed from user selection lists by setting the Status of the modifier to Inactive.

The following modifiers were exported with this release:

22	UNUSUAL PROCEDURAL SERVICES
26	PROFESSIONAL COMPONENT
50	BILATERAL PROCEDURE
51	MULTIPLE PROCEDURES
52	REDUCED SERVICES
53	DISCONTINUED PROCEDURE
59	DISTINCT PROCEDURAL SERVICE
76	REPEAT PROCEDURE BY SAME PHYSICIAN
77	REPEAT PROCEDURE BY ANOTHER PHYSICIAN
99	MULTIPLE MODIFIERS
TC	TECHNICAL COMPONENT

III. Entering and Viewing Clinic Visit Data

The main function of the package is to add visit information to the program. This is done using options from the Audiology & Speech Visit Tracking System menu. Visit data can be viewed using the A&SP Reports menu.

Audiology & Speech Visit Tracking System [ACKQAS MASTER]

- New Clinic Visits [ACKQAS VISIT ENTRY]
- Edit an Existing Visit [ACKQAS VISIT EDIT]
- Inquire - A&SP Patient [ACKQAS PAT INQ]
- A&SP Reports [ACKQAS REPORTS]
 - Visits by Diagnosis [ACKQAS VISITS BY DIAG]
 - Patients by City [ACKQAS PAT BY CITY]
 - Statistics by Procedure [ACKQAS PROC STATS]
 - Cost Comparison Report [ACKQAS PRINT COST COMPARE]
 - Tailor-Made A&SP Reports [ACKQAS ADHOC]
 - PCE Exception Report [ACKQAS PCE EXCEPTION REPORT]
 - Workload Report [SDCLINIC WORKLOAD]

Appointment Management and PCE Interfaces

How Does It Work?

After entering the Clinic, Date and Patient name in the **New Clinic Visits** option, the program searches Appointment Management, QUASAR, and PCE to see if there is already a visit/appointment on file. The following discusses how the program works under different circumstances (no existing QUASAR visits as opposed to existing visits). This discussion assumes PCE is active.

No Existing QUASAR Visits

The following assumes there are no existing visits in QUASAR for the clinic, date and patient entered.

1. First, QUASAR checks for matching appointments in Appointment Management. If there are none, the program drops immediately to the Patient Inquiry screen and you may add new visit data.

Sites are strongly warned not to enter encounter data for appointments that do not exist in Appointment Management. If a patient presents to the clinic without a scheduled appointment (walk-ins), the patient MUST be entered into Appointment Management in accordance with the facility's policy prior to entering encounter data for the patient into QUASAR.

If Appointment Management is not used and a visit is added in QUASAR, it will not appear in Appointment Management, although it will exist in PCE. The data will transmit to the NPCDB. However, if there is a problem with the data, the clinic will not know that the encounter is in ACTION REQUIRED status. An incomplete encounter warning will come back to MAS, but they will not be able to find the offending encounter since it does not appear in Appointment Management. This is not strictly a QUASAR problem. Any appointment generated outside Appointment Management (e.g., CPRS, ECS) will not appear in Appointment Management.

2. If there are existing appointments in Appointment Management, then they are displayed.

```

- APPOINTMENT LIST -
Name : LIME, HARRY          SSN      : 389-38-9467
Date : 11/03/99           Clinic   : AUDIOLOGY

Appt Date/Time      Status          Appointment Type
1. NOV 3, 1999 08:00  NO ACTION TAKEN  REGULAR
Select Appointment (1-1) or (N)ew Visit : 1//
```

- a. If you select an existing appointment, then you are returned to QUASAR and shown the Patient Inquiry screen. You may begin entering visit data. The

Appointment Time will be the same as that in Appointment Management and it is un-editable in QUASAR.

- b. If you select New Visit, a warning message is displayed:

```
WARNING -  
  
You are Creating a Visit that does not exist within Appointment  
Management.  
This Visit will not be displayed within Appointment Management.  
  
Do you want to Continue ? NO//
```

Data should NOT be entered into QUASAR without having an appointment in the Appointment Management package. If, however, you should still elect to continue, you must enter a time **different** from that in Appointment Management.

Existing QUASAR Visits

Regardless of whether or not the appointment is already in Appointment Management, if there is an existing QUASAR visit for the clinic, date and patient entered, the program displays that QUASAR visit for selection first.

```
One visit has already been entered for this date and patient.

1. NOV 19, 1999    9:35 AM    AUDIOLOGY

Is the appointment shown here the one you wish to edit? No//
```

1. If the existing QUASAR visit is selected, then you are dropped immediately to the Patient Inquiry screen and may edit the existing visit data.
2. If the existing QUASAR visit is not selected, then you are shown any existing encounters in PCE which **should include** the visit already displayed from the QUASAR package and any others that may have been added to PCE through the Scheduling package:

```
Ok, adding another visit for this patient/date.

No. DATE          TIME          HOSPITAL LOCATION    CATEGORY    UNIQUE I D

                                END OF LIST

PAT/SEX/AGE/SSN: LIME,HARRY    MALE    86 Years                389-38-9467
ENCOUNTERS: ...Select an ENCOUNTER .....
```

No.	DATE	TIME	HOSPITAL LOCATION	CATEGORY	UNIQUE I D
- - 1 E N C O U N T E R S - -					
1	NOV 19, 1999	09:35	AUDIOLOGY	PRIMARY	14GG-TEST
2	NOV 19, 1999	07:00	AUDIOLOGY	PRIMARY	14CW-TEST
END OF LIST					

```
'RETURN' to continue or '-' for previous screen
Select ITEM No. or 'A' to ADD an Encounter:
```

You may select one of these encounters, add a new encounter, or press the <ret> key.

- a. If an encounter is selected from this screen that is not already in QUASAR, then QUASAR will copy the Visit Time Eligibility data and all Diagnosis, Procedure and Provider information from PCE and you will be presented with the Patient Inquiry screen. If you select the same visit that is already in QUASAR, then you will receive an Error message

```
ERROR - A visit already exists in QUASAR with the following details..

Visit Date: NOV 19, 1999    Appointment Time: 9:35 AM
Clinic: AUDIOLOGY
Patient: BORIS,SAM

If you choose to continue you must enter a different Appointment Time.
```

Note: QUASAR will not allow two visits for the same Patient and Clinic to have the exact same date and time. Also, since duplicate entry of workload data will affect the Capitation Statistics, DSS Extract, and ACRP Workload Reports, it is important that the same visit is not entered twice.

- b. If you elect to ADD an Encounter and there are no existing appointments, you get the following warning:

```
WARNING -  
You are Creating a Visit that does not exist within Appointment  
Management.  
This Visit will not be displayed within Appointment Management.  
Do you want to Continue ? NO//
```

- c. If you press the <ret> key and there are appointments in Appointment Management, then you get one **last chance** to select an appointment in Appointment Management.

```
                - APPOINTMENT LIST -  
Name : LIME,HARRY          SSN      : 389-38-9467  
Date : 11/19/99           Clinic  : AUDIOLOGY  
  
Appt Date/Time      Status          Appointment Type  
1. NOV 19,1999 07:00 NO ACTION TAKEN      REGULAR  
2. NOV 19,1999 09:35 NO ACTION TAKEN      REGULAR  
  
Select Appointment (1-2) or (N)ew Visit : 1//
```

3. If you do not select an existing QUASAR visit, PCE encounter, or Appointment or add a new encounter, then you are returned to the beginning of the option.

Avoiding Mismatches Between QUASAR and PCE

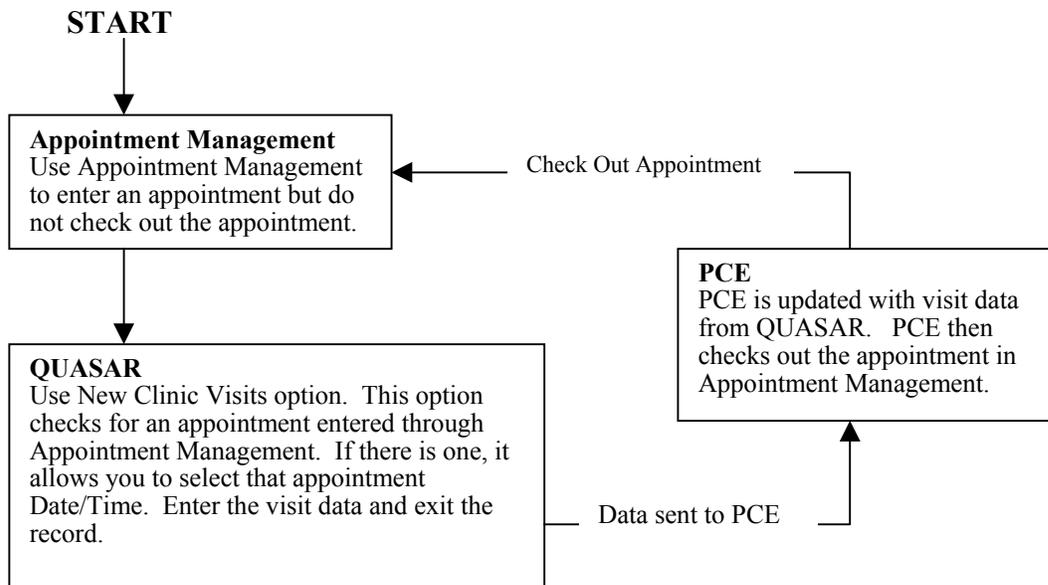
When is PCE Interface Active?

The PCE Interface is considered Active for the current Visit if **all** the following are true:

- The PCE Interface parameter for the Site is set to YES.
- The Send to PCE parameter for the Division is set to YES.
- The Visit Date falls on or after the PCE Interface Start Date for the Division. (**Note: If data is entered or edited in QUASAR for a date which is PRIOR to the PCE INTERFACE START DATE initially set in the site parameters, data mismatches will be reported in the PCE exception report.**)

Preferred Workflow

The general workflow should be from Appointment Management to QUASAR to PCE and back to Appointment Management to check out the appointment. If this workflow pattern is followed, you will have few or no instances of mismatched data between PCE and QUASAR.



Data Mismatch Between PCE and QUASAR

Remember, any data entered into QUASAR is automatically transmitted to PCE when the interface is Active; data entered first into QUASAR assumes the same data in PCE.

If there is mismatched data:

- The data in PCE was entered before that in QUASAR through Scheduling or Progress Notes.
- The data was altered in PCE following transmission of the data from QUASAR.
- The PCE interface was not active when the visit was entered into QUASAR and different values were entered into QUASAR and PCE.

If there is a mismatch, the fields with mismatches are displayed whenever you select a record to edit. The mismatch check is done on the Clinic Location, Visit Date, Appointment Time and Patient Name fields. If there is a mismatch, only the mismatched fields will be displayed.

The following fields within the PCE Visit entry linked to this Quasar visit no longer match.

CLINIC LOCATION
PATIENT
VISIT DATE

Due to this mismatch the link between this Quasar visit and the PCE visit will be broken.

It is suggested that you routinely run the PCE Exception Report and correct any problems found.

Audiology & Speech Visit Tracking System ...
New Clinic Visits
[ACKQAS VISIT ENTRY]

The New Clinic Visits option allows you to enter A&SP clinic visits into the computer.

Required Data

When entering a new visit, if all required information is not typed in, the entire visit is deleted. This is done to eliminate errors caused by incomplete data. Each of the following six fields must contain data for the visit to be filed in QUASAR:

- | | |
|---------------|---------------------|
| 1. DIVISION | 4. PATIENT |
| 2. CLINIC | 5. APPOINTMENT TIME |
| 3. VISIT DATE | 6. CDR ACCOUNT |

If all the above are present, the program checks for data in the following additional fields that are considered required but do not prevent the visit from being filed in QUASAR.

If the PCE interface is not active for the visit:

- | | | |
|----------------------|--------------|---------------------|
| 7. PRIMARY DIAGNOSIS | 8. PROCEDURE | 9. PRIMARY PROVIDER |
|----------------------|--------------|---------------------|

If the PCE interface is active for the visit:

- | | | |
|-----------------------|--------------------------|-----------------------|
| 7. VISIT ELIGIBILITY | 10. RADIATION EXPOSURE** | 12. PRIMARY DIAGNOSIS |
| 8. SERVICE CONNECTED* | 11. ENVIRONMENTAL | 13. PRIMARY PROVIDER |
| 9. AGENT ORANGE** | CONTAMINANTS** | 14. PROCEDURE |

* field required only if it applies to the Patient

** field required only if it applies to the Patient and the Visit is NOT Service Connected

The following prompts may or may not appear depending on the patient and the way the site parameters are defined:

Division: If this is a multi-divisional site and there is more than one Active Division defined in the A&SP Site Parameters, select the Division associated with the visit. If there is only one active Division, you will not see this prompt.

Clinic: If there is more than one Clinic location for the Division, identify the Clinic location for this visit.

Visit Date: Enter the visit date. QUASAR defaults to today's date and will accept any date format except a future date.

Patient Name: Enter the patient's name. If a new name is entered (i.e., a name not previously in the A&SP Patient file (#509850.2)), QUASAR asks if you want to add the new patient to the file.

Once you select a clinic, date and patient, the program searches QUASAR, Appointment Management, and PCE for existing visits/appointments.

See [Appointment Management and PCE Interfaces](#) for more complete information.

(Display of patient details)

Next, the system displays a Patient Inquiry summary/screen of the Patient you selected. The display includes the Division and Clinic selected for this visit, the Patient Name, Date of Birth, Social Security Number, Eligibility, and Initial Visit Date. If the patient is currently an Inpatient, the patient's ward, room and treating specialty are also displayed.

```
QUASAR V.3.  NEW VISIT ENTRY
CLINIC: AUD CLINIC 1          DIVISION: HINES ISC
PATIENT: PATIENT,MIKE        DOB: NOV 11,1959  SSN: 123-99-2043
ELIGIBILITY: NSC             INITIAL VISIT DATE: 08/19/99
Patient is not currently an inpatient.

Patient Diagnostic History
Mr. PATIENT has been seen for the following:

DIAGNOSIS                      DATE ENTERED
-----
141.9          MALIG NEO TONGUE NOS          09/12/99
V41.6          PROBLEM W SWALLOWING         08/19/99
```

If there have been previous visits, the patient's A&SP problem list will also be displayed.

Appointment Time: You are asked for an Appointment Time if an appointment or PCE visit was not selected or if there is a mismatch in Appointment Times between PCE and QUASAR. If this is the first recorded visit for the patient, you are also asked to enter the Initial Visit Date.

If the Use ASP Clinic File Number site parameter is set to YES, you will get the following prompt next:

ASP File Number: Enter the patient's ASP File Number or press the <ret> key to accept the default.

If you are using QUASAR's AMIE/C&P interface and an Audiology C&P exam is scheduled through AMIE for the patient, the following appears:

Is this a C&P Visit?: Answer YES to this prompt to link the QUASAR clinic visit to the appropriate AMIE entry.

If the C&P exam prompt does not appear:

- The patient entered is not a C&P patient,
- Veterans Affairs Regional Office (VARO) did not request an AUDIO exam (see Form 2507), or
- The patient's C&P claim has been closed by the C&P Unit. Contact your C&P Unit if necessary.

It is permissible to force the "Is this a C&P exam?" prompt and there are occasions when this is acceptable. To force the C&P prompt, enter "^C AND P" after the patient identifying information (e.g., at the "Select DIAGNOSTIC CODE:" prompt). A facility not using the AMIE/C&P interface might force the prompt to keep an accurate count of C&P exams. A facility using the AMIE/C&P interface might force the prompt in order to produce the C&P report for an allied war veteran with a C&P appointment. The allied war veteran's report would be signed manually, because only C&P exams requested through VARO can be adequated through QUASAR.

Diagnostic Code: Enter a diagnostic code (ICD-9-CM code).

Evaluations: The disease codes are those conditions found to exist after evaluation or are determined to exist based on observation or case history.

Previously noted conditions are not listed unless they are relevant to the management of the patient.

Treatment and therapy visits: The disease codes are those conditions which are treated. Conditions previously noted to exist but are not relevant to the management of the patient or are not treated during the visit are not entered. Disease codes are added to the A&SP problem list for the patient.

Note: If you wish to see a list of previously entered diagnostic codes, enter a ? at the "Select DIAGNOSTIC CODE:" prompt.

Is this the Primary Diagnosis ?: YES: This prompt appears until one of the Diagnostic Codes entered is designated as the Primary Diagnosis. If you don't define a Primary Diagnosis, the program will remind you and send you back to designate one as the primary.

¹**Update PCE Problem List with Diag. Code?:** This is a new conditional field within the **New Visit** option. This prompt displays only when you answer Yes to the "Update PCE Problem List?" prompt. This prompt exists for the **Diagnosis Provider** prompt, which displays after this prompt.

²**Diagnosis Provider:**

If you select to update the PCE Problem List, you will be asked who was the **Diagnosis Provider**. For each diagnosis added, you will need to add a Provider. The valid providers are also the same providers as on the "Secondary Provider" prompt.

Currently, when data is transferred to PCE, a PCE Encounter is created using the QUASAR visit data. However, if you answer Yes to the "Update the PCE Problem List" prompt, the system will also attempt to update the PCE Problem List with all selected Diagnosis Codes and their associated Providers.

¹ This is a new field contained in Patch ACKQ*3.0*1.

² This is a new field contained in Patch ACKQ*3.0*1.

Eligibility for this Appointment: This prompt only appears if the patient is Service Connected. The classification is displayed and you are asked to select the eligibility for the appointment. NSC is always a possible selection because the eligibility for the appointment might not be covered by the patient's service classification.

Example:

```
Service Classifications
SERVICE-CONNECTED

This Patient has other Entitled Eligibilities
NSC NON-SERVICE CONNECTED
PRISONER OF WAR PRISONER OF WAR

Enter the Eligibility for this Appointment: SERVICE CONNECTED 50% to 100%
// ??
Only Eligibilities associated with the visit are valid for entry.

Choose from:
NSC
PRISONER OF WAR
SERVICE CONNECTED 50% to 100%

Enter the Eligibility for this Appointment: SERVICE CONNECTED 50% to 100%
//
```

If the patient is Service Connected and has been exposed to Agent Orange, Environmental Contaminants, and/or Radiation, then the service connection and all exposures are listed and you are asked to enter the eligibility for the appointment.

Example:

```
Service Classifications
SERVICE-CONNECTED AGENT-ORANGE

This Patient has other Entitled Eligibilities
NSC NON-SERVICE CONNECTED
PRISONER OF WAR PRISONER OF WAR

Enter the Eligibility for this Appointment: SERVICE CONNECTED 50% to 100%
//
```

Was the Care for a SC Condition?: If the patient is Service Connected, this prompt also appears. Indicate here whether or not the visit is Service Connected.

The next prompt, "Was care related to ... Exposure", only appears:

- *If you answer NO at the "Was the Care for a SC Condition?" prompt, and the patient has been exposed to Agent Orange, Radiation or Environmental Contaminants, or*
- *If the patient is not service connected but has been exposed to Agent Orange, Radiation or Environmental Contaminants.*

Was care related to ... Exposure: If the patient is not Service Connected but has been exposed to Agent Orange, Environmental Contaminants, and/or Radiation, then

the classification is not displayed but you are asked to designate whether or not the care given during the visit was related to the exposure(s). This prompt does not appear if:

- The patient is Service Connected
- The patient is not service connected and has not been exposed to Agent Orange, Environmental Contaminants, or Radiation.

¹**Was care related to MST?** This prompt indicates whether the patient's visit was related to Military Sexual Trauma. This prompt displays because the patient is registered on the MST file and the QUASAR Visit Date falls after the MST Active date.

If the Division is set up in **Site Parameters** to transmit data to PCE, and the above conditions exist and the answer of Yes or No to this prompt is included in the data that gets sent to PCE.

If the Division is not set up in **Site Parameters** to transmit data to PCE, then this prompt will not display.

CDR Account: QUASAR determines the CDR cost account. The program checks for inpatient/outpatient status and treating specialty to determine the CDR cost account. All outpatient workload is distributed to CDR account 2611.00 (Rehabilitative and Supportive Services). If the CDR account presented is correct, accept the default answer by pressing the return key (<RET>).

Audiometric Scores and the associated word processing fields (Review of Medical Records, Medical History, Physical Examination, Diagnostic and Clinical Tests, and Diagnosis) only appear when entering C&P Exam data. At least one of the diagnostic codes entered for the visit must be related to hearing loss.

Note: If the patient is found to have normal hearing, use ICD9-CM code V65.5 in addition to the code for the patient's chief complaint.

Audiometric Scores:

The program displays the patient's previous audiometric scores if either of the following conditions are true:

- The visit is a C&P Exam and the patient has previous audiometric scores.
- At least one of the diagnostic codes entered for the visit is defined as being Hearing Loss, the Bypass Audiometric site parameter is set to NO for the division, and the patient has previous audiometric scores.

¹ This is a new field contained in Patch ACKQ*3.0*1.

If one of the above conditions is met, the program displays the patient's previous scores and asks if you want to use those scores. If not, prompts appear for audiometric thresholds and word recognition scores. Enter a whole number between -10 and 105. No response at the limits of the audiometer is coded as 105.

Note: The A&SP Program Office prohibits presentation of audiometric stimuli exceeding 105 dB HL.

Audiometric scores are required if one of the following conditions is met:

- The visit is a C&P exam and the patient does not have previous scores.
- The visit is a C&P exam and the patient has previous scores but you have chosen not to use them.
- One or more of the diagnosis codes for the visit is defined as constituting hearing loss, the Bypass Audiometric site parameter for the division is set to NO, and the patient does not have previous scores.
- One or more of the diagnosis codes for the visits is defined as constituting hearing Loss, the Bypass Audiometric site parameter for the division is set to NO, the patient has previous scores, but you have chosen not to use them.

Review of Medical Records: Indicate whether the C-file was reviewed. You should state that the C-file was not reviewed or was not available for review.

Medical History: Comment on:

1. Chief Complaint.
2. Situation of greatest difficulty.
3. Pertinent service history.
4. History of military, occupational, and recreational noise exposure.
5. Tinnitus - If present, state:
 - a. Date and circumstances of onset
 - b. Whether it is unilateral or bilateral
 - c. Whether it is recurrent (indicate frequency and duration)
 - d. The most likely etiology of the tinnitus, and specifically, if hearing loss is present, whether the tinnitus is due to the same etiology (or causative factor) as the hearing loss.

Physical Examination: Enter the Objective Findings.

1. Measure pure tone thresholds in decibels at the indicated frequencies (air conduction):

```

=====RIGHT EAR=====LEFT EAR=====
A*  B  C  D  E  **  A*  B  C  D  E  **
500 1000 2000 3000 4000 average 500 1000 2000 3000 4000 average
  
```

*The pure tone threshold at 500 Hz is not used in determining the evaluation but is used in determining whether or not a ratable hearing loss exists.
 **The average of B, C, D, and E.

2. Speech Recognition Score:
 Maryland CNC word list _____% right ear _____% left ear

3. When only pure tone results should be used to evaluate hearing loss, the examiner, who must be a state-licensed audiologist, should certify that language difficulties or other problems (specify what the problems are) make the combined use of pure tone average and speech discrimination inappropriate.

Diagnostic and Clinical Tests:

1. Report middle-ear status, confirm type of loss, and indicate need for medical follow-up. In cases where there is poor inter-test reliability and/or positive Stenger test results, obtain and report estimates of hearing thresholds using a combination of behavioral testing, Stenger interference levels, and electrophysiological tests.
2. Include results of all diagnostic and clinical tests conducted in the examination report.

Diagnosis:

1. Summary of audiologic test results. Indicate type and degree of hearing loss for the frequency range from 500 to 4000 Hz. For type of loss, indicate whether it is normal, conductive, sensorineural, central, or mixed. For degree, indicate whether it is mild (26-40 dB HL), moderate (41-54 dB HL), moderately-severe (55-69 dB HL), severe (70-89 dB HL), or profound (90+ dB HL). For VA purposes, impaired hearing is considered to be a disability when the auditory threshold in any of the frequencies 500, 1000, 2000, 3000, and 4000 Hz is 40 dB HL or greater; or when the auditory thresholds for at least three of these frequencies are 26 dB HL or greater; or when speech recognition scores are less than 94%.
2. Note whether, based on audiologic results, medical follow-up is needed for an ear or hearing problem, and whether there is a problem that, if treated, might cause a change in hearing threshold levels.

Primary Provider, Secondary Provider, Student: Next, you are prompted for Primary Provider, Secondary Provider, and Student.

1. The Primary Provider field is required and contains the name of the primary A&SP clinician who participated in the exam.
2. You may enter more than one Secondary Provider. **This is the same as a Diagnosis Provider prompt. If more than one provider was involved in the exam, the name(s) of the Secondary Provider should be entered here. In order to enter a provider in this field, the provider must already exist in the A&SP Staff file (#509850.3) and the Activation Date and the Inactivation Date must indicate that the selected provider is active on the date of the exam. This field can also be left blank.**
3. You can only select providers and students who are active on the exam visit date.

¹**Event Capture Codes:** This is a conditional prompt that displays only if Event Capture Codes was set up in Site Parameters for a Division. You can enter Event Capture Codes instead of the Procedure Codes (CPT) for the Division at this prompt. A list will display for you to select an Event Capture Code. Multiple entries can be made.

²**Volume:** This is also a conditional prompt that displays only if Event Capture Codes was set up in the Site Parameters for the Division. This prompt denotes the number of times that the procedure was performed with the visit.

³**EC Procedure Provider:** This is also a conditional prompt that displays only if Event Capture Codes was set up in the Site Parameters for the Division. You can select a provider/clinician that performed the procedure at this prompt. The selection defaults to the same person as the “Primary Provider” if they were selected for the Encounter. It is also the same person as the CPT Procedure Provider and Diagnosis Provider.

Procedure Code: Enter all applicable procedure codes (CPT-4 codes).

Note: There are times when the same procedure is done more than once during a visit. In that case, enter the procedure once and at the next Procedure Code prompt, enter the same procedure in quotes as shown here:

```
Select PROCEDURE CODE: 92565 <RET>          STENGER TEST, PURE TONE
Select CPT MODIFIER: <RET>
VOLUME: 1// <RET>
PROCEDURE PROVIDER: SMITH, JOHN// <RET>      JS
Select PROCEDURE CODE: "92565" <RET>         STENGER TEST, PURE
TONE
```

⁴If a Supervisor answers “No” to the Event Capture Code prompt for a Division, then the Procedure Codes (CPT) prompt will be displayed instead of the Event Capture Codes. This prompt contains CPT procedure codes for this exam. QUASAR accepts multiple CPT-4 codes to be entered more than once if the second and subsequent codes are enclosed in quotation marks (e.g., “92507”). If this is not done, QUASAR assumes that the entry is a mistake and displays the entered code followed by double slant bars (e.g., 92507//). This is a signal that this code has already been entered for this visit.

CPT Modifier: You are prompted for modifiers when a modifiable CPT code is entered. Enter as many as apply. See [Using CPT Modifiers](#).

Volume: The default volume is one because most Audiology and Speech Pathology procedures are complexity-based, not time-based.

¹ This is a new field contained in Patch ACKQ*3.0*1.

² This is a new field contained in Patch ACKQ*3.0*1.

³ This is a new field contained in Patch ACKQ*3.0*1.

⁴ This is an updated field contained in Patch ACKQ*3.0*1.

Complexity-Based Procedures: The volumes for codes that are *complexity-based* are always "one". For example, if you provide treatment (92507), one code is entered regardless of how much time is spent with the patient. If the time spent exceeds the typical time for that procedure, you should enter CPT Modifier 22 to show that the complexity of procedure was unusual (see Using CPT Modifiers).

Time-Based Procedures: Some procedure (CPT) codes are time-based (e.g., 97703, 96105). One code is entered for each specified time period. For example, code 97703 has a period of 15 minutes. If the procedure was performed for 30 minutes, then a volume of "two" would be entered.

Repeated Procedures: If a procedure is repeated, the volume is **not** entered as "two". When the procedure is repeated by the **same** provider, modifier 76 is entered. If the procedure is repeated by **another** provider, modifier 77 is used (see Using CPT Modifiers).

The typical times associated with various procedures can be found in the *A&SP Product Code Manual*, on the A&SP Website at [VA National Audiology & Speech Pathology Service](http://152.128.6.2/audio-speech/index.htm) (<http://152.128.6.2/audio-speech/index.htm>) or from your local DSS Office.

Procedure Provider: The default is the Primary Provider. You may accept the default entry or enter a new provider.

Time Spent (minutes): Enter the total time spent during the clinic visit. Time is recorded in minutes and is to include direct (e.g., face-to-face) and indirect time (e.g., report writing, progress note writing, decision making, record review, and/or coordination of care). The chief use of procedure time data is the CDR. You can sort, tabulate, and print procedure time by clinic or provider using the Tailor-Made A&SP Reports option.

If all the required data has been entered and you are using the Amie/C&P interface, the program allows you to sign off on the exam.

Are you ready to sign off this exam? No// **y** (Yes)
SIGNATURE CODE: (Enter your signature code)
Ok...

Entering Visit Data for a New QUASAR Patient

In this example:

- The Send to PCE site parameter is set to YES.
- The patient is Service Connected.
- The patient has been exposed to Agent Orange and Radiation.
- The Use ASP Clinic File Number site parameter is set to YES.

New Clinic Visits

This option is used to enter new A&SP clinic visits. Existing clinic visits should be updated with the Edit an Existing Visit option.

Select DIVISION: **CIOFO HINES DEV** Station Number : 14100
Select CLINIC: **AUDIOLOGY**

Clinic: AUDIOLOGY Stop Code: 203
Enter Visit Date: TODAY// **<RET>** (OCT 26, 1999)
Select A&SP PATIENT NAME: **TINY, TOTT** 01-10-44 321456733 YES
SC VETERAN

- APPOINTMENT LIST -

Name : TINY, TOTT SSN : 389-38-9467
Date : 10/26/99 Clinic : AUDIOLOGY

Appt Date/Time	Status	Appointment Type
1. OCT 26, 1999 09:35	NO ACTION TAKEN	REGULAR

Select Appointment (1-1) or (N)ew Visit : 1// **<RET>**

QUASAR V.3. NEW VISIT ENTRY

Patient Inquiry

CLINIC: AUDIOLOGY DIVISION: CIOFO HINES DEV
PATIENT: TINY, TOTT DOB: JAN 10, 1944 SSN: 321-45-6733
ELIGIBILITY: SC LESS THAN 50% INITIAL VISIT DATE:
Patient is currently an inpatient.
WARD: 4AS ROOM/BED: TREATING SPEC: NEUROLOGY

This visit's Treatment:

Related to AGENT ORANGE ? : UNKNOWN Service Connected ? : UNKNOWN
Related to RADIATION EXPOSURE ? : UNKNOWN

Patient Diagnostic History
Ms. TINY has been seen for the following:

DIAGNOSIS DATE ENTERED

No A&SP Diagnostic Data for this Patient

APPOINTMENT TIME: 9:35 AM (Uneditable)

INITIAL VISIT DATE: OCT 26, 1999// <RET> (OCT 26, 1999)

ASP FILE NUMBER: **TINY123**

Select DIAGNOSTIC CODE: **784.3** APHASIA
 ...OK? Yes// <RET> (Yes)

784.3 APHASIA
We have no previous record of diagnostic condition 784.3 for Ms. TINY.
Ok, I've added this code to her permanent record !

Is this the Primary Diagnosis ? : **Y** YES
Select DIAGNOSTIC CODE: <RET>

Service Classifications
SERVICE-CONNECTED AGENT-ORANGE RADIATION

This Patient has other Entitled Eligibilities
NSC NON-SERVICE CONNECTED
PRISONER OF WAR PRISONER OF WAR

Enter the Eligibility for this Appointment: SC LESS THAN 50%
 // **NSC**

Was care for SC Condition ? : **N** NO
Was care related to AO Exposure ? : **N** NO
Was care related to IR Exposure ? : **Y** YES

Suggested CDR Account :1111.00 NEUROLOGY

CDR ACCOUNT: 1111.00// <RET> NEUROLOGY
PRIMARY PROVIDER: **GILLETT, ANDREW** AG AUDIOLOGY AND SPEECH PATH

SECONDARY PROVIDER: <RET>
STUDENT: <RET>

Select PROCEDURE CODE: **92506** SPEECH & HEARING EVALUATION
Select CPT MODIFIER: ?

You may enter a new CPT MODIFIER, if you wish
Enter a Modifier code(s) for the selected Procedure.
Only valid Modifiers for the selected Procedure that are marked as
active on the A&SP CPT Modifiers File are available for selection.

Answer with A&SP PROCEDURE MODIFIER
Do you want the entire A&SP PROCEDURE MODIFIER List? **Y** (Yes)
Choose from:

22	UNUSUAL PROCEDURAL SERVICES	CPT
26	PROFESSIONAL COMPONENT	CPT
51	MULTIPLE PROCEDURES	CPT
52	REDUCED SERVICES	CPT
53	DISCONTINUED PROCEDURE	CPT
59	DISTINCT PROCEDURAL SERVICE	CPT
76	REPEAT PROCEDURE BY SAME PHYSICIAN	CPT
77	REPEAT PROCEDURE BY ANOTHER PHYSICIAN	CPT
99	MULTIPLE MODIFIERS	CPT
TC	TECHNICAL COMPONENT	HCPCS

Select CPT MODIFIER: <RET>
VOLUME: 1// <RET>
PROCEDURE PROVIDER: **GILLETT, ANDREW**// <RET>
Select PROCEDURE CODE: <RET>
TIME SPENT (minutes): **30**

Entering Audiometry Scores

If the USE C&P site parameter is answered YES, you are utilizing the AMIE/C&P interface. Staff involved in the C&P process must have an electronic signature. An electronic signature can be established using the Edit Electronic Signature Code option in the User's Toolbox menu.

The AMIE linkage feature allows entry of text and audiometric data in the AMIE format, adequation of the results, and hand-off of the report to the AMIE Compensation and Pension package. When an entry is made for the patient, you are asked "Is this a C&P exam?" If you respond YES, in addition to the usual QUASAR information, narrative data is requested for generating the AMIE report. When the exam is signed and adequated, the rating narrative and audiometric data are transmitted to the AMIE system.

The C&P exam prompt may not appear for the following reasons:

- (1) The patient is not a C&P patient. The chief reasons for this event is that VARO did not request an AUDIO exam (see Form 2507) or the examining physician requests an audiological assessment not requested by VARO. You should contact the C&P Unit to have AUDIO added to the selected exam list.
- (2) The patient's C&P claim has been closed by the C&P Unit. This event occurs when users do not use QUASAR to process rating summaries (i.e., the AMIE link is disabled) and QUASAR visit data are entered significantly after the visit date. You should contact your C&P Unit to see if the exam has been closed out.

If you are using the AMIE/C&P interface, QUASAR prompts for the AMIE rating summary fields. These fields may be filled by entering text through the line or text editor or by pasting text into the summary field from commercial word-processing software. If the AMIE/C&P interface is not enabled, the text fields do not appear.

Note: Procedures differ from clinic to clinic. The example below is for demonstration purposes only and is not intended to represent the official format for rating summaries.

.....

```
Is this a C&P Visit ?: YES// <RET> YES
Select DIAGNOSTIC CODE: 388.2 SUDDEN HEARING LOSS NOS
```

```
388.2 SUDDEN HEARING LOSS NOS
We have no previous record of diagnostic condition 388.2 for Mr. DOMINICK.
Ok, I've added this code to his permanent record !
```

```
Is this the Primary Diagnosis ?: Y YES
Select DIAGNOSTIC CODE: <RET>
```

```
Service Classifications
SERVICE-CONNECTED
```

```
This Patient has other Entitled Eligibilities
NSC NON-SERVICE CONNECTED
```

```
Enter the Eligibility for this Appointment: SERVICE CONNECTED 50% to 100%
// NSC
Was care for SC Condition ?: N NO
```

Suggested CDR Account :2611.00 REHABILITATIVE & SUPPORTIVE SERVICES

CDR ACCOUNT: 2611.00// <RET> REHABILITATIVE & SUPPORTIVE SERVICES

Enter Audiometrics :

TONE R500: 30
TONE R1000: 35
TONE R2000: 75
TONE R3000: 75
TONE R4000: 75
TONE L500: 30
TONE L1000: 30
TONE L2000: 75
TONE L3000: 75
TONE L4000: 75
CNC R: 85
CNC L: 80
W22 R: 1
W22 L: 1

Compensation and Pension Examination
For AUDIO
#1305 Worksheet

An examination of hearing impairment must be conducted by a state-licensed audiologist and must include a controlled speech discrimination test (specifically, the Maryland CNC recording) and a pure tone audiometry test in a sound isolated booth that meets American National Standards Institute standards (ANSI S3.1.1991) for ambient noise.

Measurements will be reported at the frequencies of 500, 1000, 2000, 3000, and 4000 Hz. The examination will include the following tests: pure tone audiometry by air conduction at 250, 500, 1000, 2000, 3000, 4000 Hz, and 8000 Hz; and by bone conduction at 250, 500, 1000, 2000, 3000, and 4000 Hz; spondee thresholds; speech recognition using the recorded Maryland CNC Test; tympanometry; and acoustic reflex tests, and, when necessary, Stenger tests. Bone conduction thresholds are measured when the air conduction thresholds are poorer than 15 dB HL. A modified Hughson-Westlake procedure will be used with appropriate masking. A Stenger test must be administered whenever pure tone air conduction thresholds at 500, 1000, 2000, 3000, and 4000 Hz differ by 20 dB or more between the two ears.

Press RETURN to continue:

Compensation and Pension Examination
For AUDIO
#1305 Worksheet (Continued)

Maximum speech recognition will be reported with the 50-word VA-approved recording of the Maryland CNC test. When speech recognition is 92% or less, a performance intensity function will be obtained with a starting presentation level of 40dB re SRT. If necessary, the starting level will be adjusted upward to obtain a level at least 5 dB above the threshold at 2000 Hz. The examination will be conducted without the use of hearing aids. Both ears must be examined for hearing impairment even if hearing loss in only one ear is at issue.

REVIEW OF MEDICAL RECORDS: Indicate whether the C-file was reviewed. If the C-file was not reviewed or was not available for review, the examiner should so state.

REVIEW OF MEDICAL RECORDS:

1>ENTER THE TEXT.

2> <RET>

EDIT Option: <RET>

MEDICAL HISTORY (SUBJECTIVE COMPLAINTS):

Comment on:

1. Chief Complaint.
2. Situation of greatest difficulty.
3. Pertinent service history.
4. History of military, occupational, and recreational noise exposure.
5. Tinnitus - If present, state:
 - a. date and circumstances of onset
 - b. whether it is unilateral or bilateral
 - c. whether it is recurrent (indicate frequency and duration)
 - d. State the most likely etiology of the tinnitus, and specifically, if hearing loss is present, whether the tinnitus is due to the same etiology (or causative factor) as the hearing loss.

MEDICAL HISTORY:

- 1>ENTER THE TEXT
- 2> <RET>

EDIT Option: <RET>

PHYSICAL EXAMINATION (OBJECTIVE FINDINGS):

1. Measure pure tone thresholds in decibels at the indicated frequencies (air conduction):

=====RIGHT EAR=====						=====LEFT EAR=====					
A*	B	C	D	E	**	A*	B	C	D	E	**
500	1000	2000	3000	4000	average	500	1000	2000	3000	4000	average

*The pure tone threshold at 500 Hz is not used in determining the evaluation but is used in determining whether or not a ratable hearing loss exists.

**The average of B, C, D, and E.

2. Speech Recognition Score:
Maryland CNC word list _____% right ear _____% left ear
3. When only pure tone results should be used to evaluate hearing loss, the examiner, who must be a state-licensed audiologist, should certify that language difficulties or other problems (specify what the problems are) make the combined use of pure tone average and speech discrimination inappropriate.

PHYSICAL EXAMINATION:

- 1>ENTER THE TEXT.
- 2> <RET>

EDIT Option: <RET>

DIAGNOSTIC AND CLINICAL TESTS:

1. Report middle-ear status, confirm type of loss, and indicate need for medical follow-up. In cases where there is poor inter-test reliability and/or positive Stenger test results, obtain and report estimates of hearing thresholds using a combination of behavioral testing, Stenger interference levels, and electrophysiological tests.
2. Include results of all diagnostic and clinical tests conducted in the examination report.

DIAGNOSTIC AND CLINICAL TESTS:

- 1>ENTER THE TEXT
- 2> <RET>

EDIT Option: <RET>

DIAGNOSIS:

1. Summary of audiologic test results. Indicate type and degree of hearing loss for the frequency range from 500 to 4000 Hz. For type of loss, indicate whether it is normal, conductive, sensorineural, central, or mixed. For degree, indicate whether it is mild (26-40 dB HL), moderate (41-54 dB HL), moderately-severe (55-69 dB HL), severe (70-89 dB HL), or profound (90+ dB HL). For VA purposes, impaired

hearing is considered to be a disability when the auditory threshold in any of the frequencies 500, 1000, 2000, 3000, and 4000 Hz is 40 dB HL or greater; or when the auditory thresholds for at least three of these frequencies are 26 dB HL or greater; or when speech recognition scores are less than 94%.

2. Note whether, based on audiologic results, medical follow-up is needed for an ear or hearing problem, and whether there is a problem that, if treated, might cause a change in hearing threshold levels.

DIAGNOSIS:

1>**ENTER THE TEXT**

2> **<RET>**

EDIT Option: **<RET>**

Forcing the C&P Prompt

(Not Using the AMIE/C&P Interface or Audiometric Data for Hearing Loss Codes).

It is permissible to force the "Is this a C&P exam?" prompt and there are occasions when this is acceptable. To force the C&P prompt, enter "^C AND P" after the patient identifying information (e.g., at the "Select DIAGNOSTIC CODE:" prompt). A facility not using the AMIE/C&P interface might force the prompt to keep an accurate count of C&P exams. A facility using the AMIE/C&P interface might force the prompt in order to produce the C&P report for an allied war veteran with a C&P appointment. The allied war veteran's report would be signed manually, because only C&P exams requested through VARO can be adequated through QUASAR.

If your facility uses the AMIE/C&P interface, you must keep in mind that forcing the "Is this a C&P exam?" prompt DOES NOT create the required linkage information between QUASAR and AMIE. If the C&P question does not appear during data input, you should confer with your C&P Unit to determine the cause.

Note: Exams with forced C&P prompts cannot be adequated and may not be available to the AMIE package.

The example below presumes the AMIE/C&P interface is inactivated and the facility has the BYPASS AUDIOMETRICS site parameter set to YES. The facility uses QUASAR to track the number of C&P exams.

[Patient Inquiry screen]

```
Select DIAGNOSTIC CODE: ^C
  1   C AND P
  2   CDR ACCOUNT
  3   CLINICIAN
  4   CNC L
  5   CNC R
CHOOSE 1-5: 1
Is this a C&P visit? : YES// <ret> YES
```

Deleting a Non-Hearing Loss Code to Obtain Audiometric Display

Certain diagnosis codes (i.e., hearing loss codes) are flagged to require audiometric data to be entered when those codes are used for a visit. If the Bypass Audiometrics site parameter is answered NO, you are asked to enter audiometric data.

After audiometric data is entered for a patient's visit, you may wish to edit the audiometric fields. When a non-hearing loss code is the last ICD9-CM code entered, the audiometric fields are not displayed for editing. In order to edit, follow these steps.

- (1) Delete the non-hearing loss code from the record.
- (2) Edit the audiometric data field(s).
- (3) Re-enter the deleted non-hearing loss code using the ^ (shift-6) key to skip to the diagnostic code field.

Delete the non-hearing loss code:

```
Select DIAGNOSTIC CODE: 388.9// @
      SURE YOU WANT TO DELETE THE ENTIRE DIAGNOSTIC CODE? Y (Yes)
Select DIAGNOSTIC CODE: 389.10// <ret>
      DIAGNOSTIC CODE: 389.10// <ret>
Select DIAGNOSTIC CODE: <ret>

Suggested CDR Account: 2611.00 REHABILITATIVE & SUPPORTIVE SERVICES

CDR ACCOUNT: 2611.00// <ret>
```

Audiometric testing for this patient last completed 09/17/94.

```
PURE TONE RESULTS:
R500: 30           L500: 30
R1000: 35          L1000: 30
R2000: 75          L2000: 75
R3000: 75          L3000: 75
R4000: 75          L4000: 75
R AVG: 65          L AVG: 63
CNC R: 85          CNC L: 80
W22 R: 10          W22 L: 10
```

Edit the audiometric data field(s):

Do you wish to use these scores? NO

Enter Audiometrics:

```
TONE R500: 30// ^TONE L1000
TONE L1000: 30// 35
TONE L2000: 75// ^DIAGNOSTIC CODE
```

Re-enter the deleted non-hearing loss code:

```
Select DIAGNOSTIC CODE: 389.10// 388.9          DISORDER OF EAR NOS
      ...OK? Yes// <ret> (Yes)
Are you adding '388.9' as a new DIAGNOSTIC CODE (the 2ND for this A&SP CLINIC
VISIT)? Y (Yes)
Select DIAGNOSTIC CODE: ^
```

Audiology & Speech Visit Tracking System ...
Edit an Existing Visit
[ACKQAS VISIT EDIT]

The **Edit an Existing Visit** option is used to modify an existing clinic visit when the data is incorrect, incomplete, or needs to be updated. This option is not to be used to enter a new visit. Fields in this option appear as shown in the **New Clinic Visits** option.

Note: If you want to delete a visit entered in error, use the option Delete an A&SP Clinic Visit.

Note: The “**Appointment Time**” prompt is NOT an editable field.

Audiology & Speech Visit Tracking System ...
Inquire - A&SP Patient
[ACKQAS PAT INQ]

The Inquire - A&SP Patient option displays demographic information for an A&SP patient which includes date of birth, social security number, eligibility, service connected status, and initial visit date. Additionally the option shows inpatient status and diagnostic history. Output can be sent to a printer.

After selecting the A&SP patient's name, you are given an opportunity to update the diagnostic history. The problem list is recompiled using this logic: All clinic visits for the patient are examined. Unique diagnostic codes and the earliest date for each code are determined. The A&SP Patient file is updated with these codes and dates. Also, the earliest diagnostic date found becomes the Initial Visit Date.

Audiology & Speech Visit Tracking System ...
A&SP Reports
[ACKQAS REPORTS]

The A&SP Reports menu contains options to print Audiology and Speech Pathology reports. This menu can be assigned to users who do not enter or modify A&SP data, but require read only access.

Visits by Diagnosis [ACKQAS VISITS BY DIAG]
Patients by City [ACKQAS PAT BY CITY]
Statistics by Procedure [ACKQAS PROC STATS]
Cost Comparison Report [ACKQAS PRINT COST COMPARE]
Tailor-Made A&SP Reports [ACKQAS ADHOC] **Locked with ACKQ ADHOC**
PCE Exception Report [ACKQAS PCE EXCEPTION REPORT]
Workload Report [SDCLINIC WORKLOAD]

Audiology & Speech Visit Tracking System ...
A&SP Reports ...
Visits by Diagnosis
[ACKQAS VISITS BY DIAG]

The Visits by Diagnosis report is printed by selected Division(s) and a date range. You can print the report for Audiology (includes Telephone Audiology) only, Speech Pathology (includes Telephone Speech) only, or both Audiology and Speech Pathology.

You can choose to print the report for one or all clinician(s), other provider(s), or student(s).

The report lists clinic visits for the date range and selected Division(s) sorted by ICD-9CM diagnostic codes. Since the diagnostic code field is a multiple field, the visit shows up once under each diagnostic code entered for that visit.

Audiology & Speech Pathology Diagnostic Code Statistics for Provider, Andy Covering Visits from 11/28/99 to 11/29/99 For Division: CIOFO HINES DEV			

STOP CODE: SPEECH TELEPHONE			
CLINIC: SPEECH TELEPHONE			
CLINICIAN: PROVIDER, ANDY			
141.9	MALIG NEO TONGUE NOS	COUNT:	1
...			

Audiology & Speech Visit Tracking System ...
A&SP Reports ...
Patients by City
[ACKQAS PAT BY CITY]

The Patients by City option generates a patient count report by selected Division(s) and date range. The report shows the number of patients seen, sorted by city of residence.

Audiology & Speech Pathology Unique Patients by City Visits from 11/01/99 to 11/30/99 For Division: CIOFO HINES DEV	

CLINIC: AUDIOLOGY	
STOP CODE: AUDIOLOGY	
CHICAGO, IL:	13 patients
MAYWOOD, IL:	4 patient
MELROSE PARK, IL:	2 patients
...	

**Audiology & Speech Visit Tracking System ...
A&SP Reports ...**

**¹Statistics by Event Capture Procedure
[ACKQAS EC PROC STATS]**

The Statistics by Event Capture Procedure report is printed by selected Division(s) and a date range. You can print the report for Audiology (includes Telephone Audiology) only, Speech Pathology (includes Telephone Speech Pathology) only, or both Audiology and Speech Pathology.

You can choose to print the report for one or all clinician(s), other provider(s), or student(s).

The report lists clinic visits for the date range and selected Division(s) sorted by Event Capture codes.

```
Audiology & Speech Pathology
EC Procedure Statistics
for
All Clinicians
Covering Visits from 10/02/00 to 11/21/00
For Division: CIOFO HINES DEV
-----
STOP CODE: AUDIOLOGY

CLINIC: AUDIOLOGY AND SPEECH PATHOLOGY

CLINICIAN: HICKS, BRENT
SP002    SPCH LOUDNESS TOLERANCE TEST          COUNT:    2
SP010    SPEECH/LANGUAGE SCREENING             COUNT:    2
SP025    HEARING TREATMENT NEC                 COUNT:    1
SP053    INSTRUM STUDY OF NASAL FUNCTION       COUNT:    1
SP104    HEARING AID EVALUATION BIN           COUNT:    1
SP106    HEARING AID CHECK/REPAIR/ADJUST, BIN  COUNT:    3
SP110    EAR CANAL PROBE MEASUREMENT, BIN     COUNT:    1
SP128    SPECIAL SUPPLIES                     COUNT:   44
...

```

¹ New Report included in Patch ACKQ*3.0*1.

Audiology & Speech Visit Tracking System ...
A&SP Reports ...
Statistics by Procedure
[ACKQAS PROC STATS]

The Statistics by Procedure report is printed by selected Division(s) and a date range. You can print the report for Audiology (includes Telephone Audiology) only, Speech Pathology (includes Telephone Speech Pathology) only, or both Audiology and Speech Pathology.

You can choose to print the report for one or all clinician(s), other provider(s), or student(s).

The report lists clinic visits for the date range and selected Division(s) sorted by CPT-4 procedure codes. Since the procedure code field is a multiple field, the visit shows up once under each procedure code entered for that visit.

Audiology & Speech Pathology Procedure Statistics for Provider, Andy Covering Visits from 11/27/99 to 11/29/99 For Division: CIOFO HINES DEV			

STOP CODE: SPEECH PATHOLOGY			
CLINIC: SPEECH			
CLINICIAN: PROVIDER, ANDY			
31505	DIAGNOSTIC LARYNGOSCOPY	COUNT:	1
...			

Audiology & Speech Visit Tracking System ...
A&SP Reports ...
Cost Comparison Report
 [ACKQAS PRINT COST COMPARE]

The Cost Comparison Report option produces a report of all CPT-4 procedure codes and their associated costs used within a selected date range. The cost linked to a CPT code is based upon approximate private sector cost. Cost is entered by local A&SP supervisors using the Enter Cost Information for Procedures option on the Set Up/Maintenance menu.

The following example is for demonstration purposes only and is not meant to reflect actual costs:

Procedure Cost Comparison				
for Date Range				
08/21/99 to 11/29/99				
For Division: CIOFO HINES DEV				
QUAN	CODE	DESCRIPTION	COST	TOTAL

STOP CODE: Speech Pathology				
1	31505	DIAGNOSTIC LARYNGOSCOPY	\$60.00	\$60.00
1	31575	DIAGNOSTIC LARYNGOSCOPY	\$60.00	\$60.00
2	92506	SPEECH & HEARING EVALUATION	\$60.00	\$120.00
7	92508	SPEECH/HEARING THERAPY	\$60.00	\$420.00
5	92511	NASOPHARYNGOSCOPY	\$100.00	\$500.00
3	92512	NASAL FUNCTION STUDIES	\$60.00	\$180.00
Speech Pathology Total:				\$1340.00
...				

Audiology & Speech Visit Tracking System ...

A&SP Reports ...

Tailor-Made A&SP Reports

[ACKQAS ADHOC] ****Locked: ACKQ ADHOC****

The Tailor-Made A&SP Reports option allows you to design reports using the VA FileMan sort and print functionality. Reports can be generated from the A&SP Clinic Visit file (#509850.6) or the A&SP Patient file (#509850.2). You must be familiar with VA FileMan's Print and Sort functions as well as the structure of the file from which the data is printed.

Access to this option is controlled by the ACKQ ADHOC security key. Allocation of this key is at the discretion of the IRM chief. The option may not be available at all sites. If available, this option can provide various statistical reports from the QUASAR package. However, its indiscriminate use could have a negative impact on system performance. Complicated sorts or reports that could be expected to impact system performance should be queued to run during off-hours.

Refer to the chapter [Creating Tailor-Made Reports](#) for additional information. This section contains tips and examples on how to generate your own tailor-made reports.

Note: Check all sort and print routines created in the previous version for field name changes.

Audiology & Speech Visit Tracking System ...
A&SP Reports ...
PCE Exception Report
[ACKQAS PCE EXCEPTION REPORT]

This report lists all A&SP Clinic Visits from the date range selected for the Division that have not been successfully updated in PCE. See Required Data, page III-2 for those fields that pass data to PCE.

Reasons for Exceptions

A Visit will be included on the report if it falls into one of the following categories:

1. The last time QUASAR attempted to send the Visit to PCE, the Visit was rejected. In this case, the report will include the error messages returned by the PCE Interface. See the following example:

```

Audiology & Speech Pathology
PCE Exception Report
For Division: CIOFO HINES DEV
-----
Clinic: SPEECH PATHOLOGY

Visit Date: MAY 01, 1999      Patient: NAME1,PATIENT
Appnt. Time: 5:00 AM         SSN: 111-11-1111
PRIMARY PROVIDER - HAMWAY,NORMAN
The Provider does not have an ACTIVE person class!

Visit Date: AUG 30, 1999      Patient: NAME2,PATIENT
Appnt. Time: 8:00 PM         SSN: 544-44-4444
PCE VISIT -
Unable to Delete PCE Visit

Visit Date: SEP 30, 1999      Patient: NAME3,PATIENT
Appnt. Time: 12:00 AM        SSN: 559-00-4321
ENC D/T - SEP 30, 1999
You are missing the TIME of the visit in FileManager internal format.
Unless this is an HISTORICAL encounter, you must have the time.

```

2. The Visit was edited in QUASAR but the new Visit data was not sent to PCE because the PCE Interface was switched off. In this case the report will show the date/time of the last QUASAR update versus the date/time of the last time the Visit was sent to PCE. See the example below:

```

Audiology & Speech Pathology
PCE Exception Report
For Division: CIOFO HINES DEV
-----
Visit Date: SEP 22, 1999      Patient: NAME,PATIENT
Appnt. Time: 2:00 PM         SSN: 377-66-1111
Last Edit in QSR: SEP 22, 1999@16:35:22
Last Sent to PCE: SEP 22, 1999@14:00:20
PCE time is before QSR time

Visit Date: SEP 23, 1999      Patient:
Appnt. Time: 12:00 AM        SSN:
Last Edit in QSR: SEP 23, 1999@10:46:49
Last Sent to PCE:
No PCE time

```

To remove a Visit from the Exception report, the PCE Interface must be activated for the Site, and for the Division in which the Visit took place, then correct the error.

1. Errors may include data missing in non QUASAR files such as the New Person file #200 or the USR Class Membership file # 8930.3. In that situation, you may

- need to contact IRM for assistance. Once corrected, you must reedit the visit using the option Edit an Existing Visit to send the corrected data to PCE.
2. If the errors are in QUASAR:
 - In files other than the A&SP Clinic Visit file, make the corrections and then use the option Edit an Existing Visit to send the corrected data to PCE.
 - In the A&SP Clinic Visit file, use the option Edit an Existing Visit to edit the data and send the corrected information to PCE.
 3. If you delete a visit and it still exists in PCE ("Unable to Delete PCE Visit"), use PCE to delete the visit.

Once the Visit data is the same in both systems (QUASAR and PCE), the visit will be removed from the PCE Exception Report.

¹Warning Message:

You will be prompted to enter a Beginning Date and Ending Date for the PCE Exception Report date range. When entering a Beginning Date prior to March 17, 2000, which was the date that Version 3.0 of QUASAR was installed, a WARNING message will be displayed as shown below.

```
QUASAR - PCE Exception Report

This option produces a report listing all the A&SP Clinic Visits that have been
reported as an exception by PCE.

Select DIVISION: ALL

Beginning Date: T-2000 (MAY 27, 1995)
Ending Date: T

Warning - You are running a report using a start date that falls either on or
before the installation of Version 3.0 of Quasar.

Quasar Version 3.0 was installed on - MAR 17, 2000

Note that all PCE related functionality was developed within Quasar version 3.0.
It is recommended that this report be run using start dates that fall after the
installation date.

Do you want to Continue ? NO//
```

¹ New Warning Message included in Patch ACKQ*3.0*1.

Audiology & Speech Visit Tracking System ...
A&SP Reports ...
Workload Report
[SDCLINIC WORKLOAD]

The Workload Report is **not** a QUASAR option. It is on the A&SP Reports menu with permission from the Scheduling package. This option displays daily patient appointment transactions by division for a selected date range. It allows you to determine the relative activity within a clinic during specified periods and allows you to compare activity for selected clinics for the previous year. You may want to print the report only for Audiology (203), Speech Pathology (204), and/or Telephone/Rehab and Support (216) Stop Code.

Caution: The default Stop Code for this report is ALL. This means that all Stop Codes will be reported. Be careful to enter only Stop Code/DSS identifier 203, 204, or 216. See example below:

```
Select division: ALL// HINES ISC      578
Select another division:
```

```
**** Date Range Selection ****
```

```
Beginning DATE : 9/1/99 (SEP 01, 1999)
```

```
Ending DATE : 9/30/99 (SEP 30, 1999)
```

```
Will now check if outpatient encounter dates have been updated...
```

```
.....
```

```
Note: To obtain accurate statistics, this workload report should
      be run again after the outpatient encounter status update
      process has been completed for these dates.
```

```
Totals by (C)LINIC or (S)TOP CODE?: C//STOP CODE
```

```
Enter Stop Code: ALL//203
```

```
AUDIOLOGY      203
```

```
Enter Stop Code: 204
```

```
SPEECH PATHOLOGY 204
```

```
Enter Stop Code: 216
```

```
TELEPHONE/REHAB AND SUPPORT 216
```

```
Enter Stop Code: <RET>
```

```
Do you want to include add/edits? No// <RET> (No)
```

```
Brief or Expanded Report? E// <RET> EXPANDED
```

```
(D)ETAIL BY DAY or (S)UMMARY BY MONTH?: D// <RET> DETAIL BY DAY
```

```
Do you want to see patient names? No// <RET> (No)
```

```
Do you want to compare this data to the same period in the previous year? No//
```

IV. Generating Management Reports

Management Reports A&SP

[ACKQAS MANAGEMENT REPORTS]

The Management Reports A&SP menu allows you to generate the Audiology and Speech Pathology CDR, and to compile and print the A&SP Capitation report. This data is stored in the A&SP Workload file (#509850.7).

Generate A&SP Service CDR [ACKQAS CDR]

Print A&SP Service CDR [ACKQAS CDR PRINT]

Compile A&SP Capitation Data [ACKQAS WKLD GEN MAN]

Print A&SP Capitation Report [ACKQAS WKLD VERIFY]

Management Reports A&SP ...
Generate A&SP Service CDR
[ACKQAS CDR]

The Generate A&SP Service CDR option generates and prints the RCS 10-0141 report for Audiology and Speech Pathology by Division.

Once each month you should run and save a CDR report. It is saved in the A&SP Workload file (#509850.7). If you choose to save the CDR, it must be run for a single entire month. If you choose not to save the report, you can run the CDR for any date range.

You must enter the month for which the report is to be generated. The total number of clinic visit hours and instructional support (.12) hours for the month is displayed. You are prompted for the total number of paid hours.

You can enter a flat number of hours to be distributed among all administrative support (.13), continuing education (.14), and research (.21 and .22) accounts or you can enter hours for each account individually. You are then asked for pass through account hours. When entering hours for these accounts, keep in mind the number of clinic visit hours. Do not let the number of hours remaining go below the total number of clinic visit hours.

The A&SP CDR is an 80 column report which displays only the CDR accounts with activity during the date range.

Management Reports A&SP ...
Print A&SP Service CDR
[ACKQAS CDR PRINT]

The Print A&SP Service CDR option prints the RCS 10-014 report for Audiology and Speech Pathology. Use this option to reprint the CDR report that you created using the Generate A&SP Service CDR option. If your CDR is reported by Division, you must select the Division(s) to be printed. Then enter the month that you wish to print. The report will print the CDR for the month and Divisions that have been generated.

Management Reports A&SP ...
Compile A&SP Capitation Data
[ACKQAS WKLD GEN MAN]

The Compile A&SP Capitation Data option is used to generate capitation data by Division for a selected month. If data has previously been compiled for the month selected, you are asked if you wish to continue. If you do so, the previously compiled data is deleted and the information is recalculated. The compilation takes place in the background, and you are notified by an e-mail message when the task is finished. You can use the Print A&SP Capitation Report to review the data.

Management Reports A&SP ...
Print A&SP Capitation Report
[ACKQAS WKLD VERIFY]

When the Compile A&SP Capitation Data option has generated information for selected Division(s) and a selected month, you are notified by an e-mail message. You can then use the **Print A&SP Capitation Report** to review the data. This option produces a three-part report by Division that includes demographic, diagnostic, procedure data. This is followed by a summary (not separated by Division) that includes demographic, diagnostic and procedure data.

V. Adequating a C&P Exam

C&P Exam Adequation [ACKQAS CP ADEQ]

This option allows you to adequate a C&P exam. Only exams that are complete (i.e., having a status of AWAITING ADEQUATION) and signed off on can be adequated.

When an audiologist provides his or her electronic signature to a C&P exam, the chief adequator sees a list of exams waiting to be adequated. He or she can review, print, or edit the report using the Edit an Existing Visit option. Finally, he or she can provide an electronic signature using the C&P Exam Adequation option to release the report to the AMIE package. Entering the electronic signature to adequate an exam causes all exam results to be transferred to the AMIE C&P package and the exam is marked CLOSED. The results are made available to the regional office. Non-supervisory clinicians can adequate their own C&P exams. A clinician designated as a supervisor in the A&SP Staff file (#509850.3) can adequate other clinicians' C&P exams.

VI. Deleting a Clinic Visit

Delete an A&SP Clinic Visit [ACKQAS DELETE VISIT]

This option allows you to delete an A&SP Clinic Visit that has been entered in error. If the selected visit was sent to PCE, then this function will also attempt to delete the visit from PCE. If the PCE deletion fails, you will see a warning message displayed.

Warning - This QUASAR Visit is linked to a PCE Visit but the PCE Interface is not active. If you delete this visit, it will be deleted from QUASAR but the corresponding PCE VISIT will remain. To delete the visit from PCE you must use the PCE package options.

Or

ERROR: The PCE Visit linked to this QUASAR Visit could not be deleted.

If you choose to continue, the QUASAR visit will be deleted but the PCE Visit will remain. Corrective action to the PCE Visit will be required using the PCE system.

You may then choose to continue or abort the deletion. If you continue, the Quasar Visit will be deleted but you will have to use the PCE package to delete the same visit from PCE.

VII. Glossary

A&SP	Audiology and Speech Pathology.
CDR	Cost Distribution Report.
C&P	Compensation and Pension.
CPT Codes	Codes listed in the <i>Physicians Current Procedural Terminology Handbook</i> .
DSS	Decision Support System.
HCFA	Health Care Financing Administration.
HCPCS	HCFA Common Procedure Coding System.
ICD-9-CM	<i>International Classification of Diseases, Ninth Edition, with Clinical Modifications</i> .
PCE	Patient Care Encounter.
QUASAR	Quality: Audiology and Speech Analysis and Reporting.
VACO	Veterans Affairs Central Office.
VARO	Veterans Affairs Regional Office.
VHA	Veterans Health Administration.
VISTA	Veterans Health Information System and Technology Architecture.

VIII. Creating Tailor-Made Reports

Introduction

This appendix provides instruction on sorting data and printing reports using the option Tailor-Made A&SP Reports. Any of the QUASAR data fields and some of the data fields contained in the Patient file # 2 can be sorted and printed. The Tailor-Made A&SP Reports option is a restricted version of VA FileMan. It permits sorting, basic arithmetic operations, Boolean logic, saving of sort logic, and customized formatting of reports. Users are encouraged to contact their IRM Service to obtain training and training materials on VA FileMan report generation.

Access to the Tailor-Made A&SP Reports option is controlled by the ACKQ ADHOC security key. Allocation of this key is at the discretion of the IRM Chief. Therefore, Tailor-Made A&SP Reports may not be available at all sites.

*****IMPORTANT*****

Indiscriminate use of VA FileMan may have a negative impact on system performance. Complicated sorting routines or reports should be queued to run during off-hours.

VA FileMan functions like a index card filing system. Any data entered in QUASAR data fields can be accessed, sorted and printed as can data in any "pointed to" file (e.g., Patient file #2).

Data Dictionaries

A&SP Patient file #509850.2

The A&SP Patient file contains identifying, demographic, and other clinical information for all patients seen in the Audiology and Speech Pathology clinics.

Field #	Label	Description
.01	Name	The NAME field contains the name of the patient seen in the Audiology and Speech Pathology clinics.
.03	ASP File Number	The ASP FILE NUMBER field contains an existing LOCAL file number associated with this Audiology and Speech Pathology patient.
1	Initial Visit Date	The INITIAL VISIT DATE field contains the date (if known) of this patient's first visit to the Audiology and/or Speech Pathology clinic at this site. This field can be left blank.
2	Diagnostic Condition	The DIAGNOSTIC CONDITION field contains the ICD-9CM diagnostic condition code for the A&SP patient. Disease codes listed in this field appear in the A&SP Problem List.
.01	Diagnostic Condition	The DIAGNOSTIC CONDITION field contains the ICD-9CM diagnostic condition code for the A&SP patient. Disease codes listed in this field appear in the A&SP Problem List.

1	Date Condition Entered	The DATE CONDITION ENTERED field contains the date the DIAGNOSTIC CONDITION was entered for the A&SP patient. This field appears in the A&SP Problem List.
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A&SP Clinic Visit file #509850.6

The A&SP Clinic Visit file contains all data specific to each patient encounter. This includes the patient, the providers and students involved, the diagnostic and procedure codes, the date of the visit, procedure time, and the CDR cost account.

Field #	Label	Description
.01	Name	The DATE field contains the encounter date or date and time.
.07	Time Spent (minutes)	The TIME SPENT field is used to record the TOTAL number of minutes that were used during this clinic visit.
.08	Linked C&P Exam	For C&P exams, the LINKED C&P EXAM field is automatically filled in by the QUASAR package. It provides a means of linking this QUASAR visit with a specific AMIE C&P request. If the visit is not a C&P exam this field is left blank.
.09	C and P Status	The C AND P STATUS field indicates the status of the C&P exam (if any). 0 stands for NOT A C&P EXAM, 1 stands for NOT SIGNED OFF, 2 stands for AWAITING ADEQUATION, and 3 stands for COMPLETE.
.25	Secondary Provider	This is a multiple. If more than one provider was involved in this exam, the name(s) of the SECONDARY PROVIDER should be entered here. The SECONDARY PROVIDER field can be left blank.
.27	*Lead Role	This field is starred for deletion.
1	Patient Name	The PATIENT NAME field contains the name of the patient seen during this clinic visit. This is a pointer to the Patient file #2.
1.5	Age on Appointment	This is the patient's age.
2	Patient Eligibility Code	This is the Primary Eligibility of the patient.
2.5	C and P	The C AND P field contains 0 or NO if this is not a C&P exam. The field contains 1 or YES if this is a C&P exam.
2.6	Clinic Location	The CLINIC LOCATION field is a pointer to the HOSPITAL LOCATION file (#44).
2.7	Secondary Provider	This is the provider(s) not considered the primary provider.
3	Diagnostic Code	The DIAGNOSTIC CODE field is a pointer to the A&SP DIAGNOSTIC CONDITION file (#509850.1).
	.01 Diagnostic Code	
	.12 Primary	YES or NO

	Diagnosis .15 *Modifier	This field starred for deletion.
4	Clinic Stop Code	The CLINIC STOP CODE field contains A for Audiology, S for Speech Pathology, AT for an Audiology Telephone visit and ST for Speech Telephone visit.
4.01	Tone R500	The TONE R500 field indicates the patient's pure tone threshold at 500Hz.
4.02	Tone R1000	The TONE R1000 field indicates the pure tone threshold (Right) at 1000Hz for this patient.
4.03	Tone R2000	The TONE R2000 field indicates the pure tone threshold (Right) at 2000Hz for this patient.
4.04	Tone R3000	The TONE R3000 field indicates the pure tone threshold (Right) at 3000Hz for this patient.
4.05	Tone R4000	The TONE R4000 field indicates the pure tone threshold (Right) at 4000Hz for this patient.
4.06	Tone R Average	The TONE R AVERAGE field is the average pure tone threshold for this patient's right ear.
4.07	Tone L500	The TONE L500 field indicates the patient's pure tone threshold at 500Hz.
4.08	Tone L1000	The TONE L1000 field indicates the pure tone threshold (Left) at 1000Hz for this patient.
4.09	Tone L2000	The TONE L2000 field indicates the pure tone threshold (Left) at 2000Hz for this patient.
4.1	Tone L3000	The TONE L3000 field indicates the pure tone threshold (Left) at 3000Hz for this patient.
4.11	Tone L4000	The TONE L4000 field indicates the pure tone threshold (Left) at 4000Hz for this patient.
4.12	Tone L Average	The TONE L AVERAGE field is the average pure tone threshold for this patient's left ear.
4.13	CNC R	The CNC R field contains the patient's (Right) word recognition score for Maryland CNC material. This score is a percentage between 0 and 100.
4.14	CNC L	The CNC L field contains the patient's (Left) word recognition score for Maryland CNC material. This score is a percentage between 0 and 100.
4.15	W22 R	The W22 R field contains the patient's (Right) word recognition score for CID W-22 material. This score is a percentage between 0 and 100.
4.16	W22 L	The W22 L field contains the patient's (Left) word recognition score for CID W-22 material. This score is a percentage between 0 and 100.
4.17	Signature	For C&P exams, the SIGNATURE field contains the electronic signature of the audiologist who completed the exam. When the exam is signed, it is released for adequation by the supervisor.
4.18	Date Signed	For C&P exams, the DATE SIGNED field contains the date that the electronic signature was entered, thereby releasing the C&P exam for adequation.
4.19	Adequated By	The ADEQUATED BY field contains the electronic

		signature of the audiologist who adequated the clinic visit.
4.2	Date Adequated	The DATE ADEQUATED field contains the date that the electronic signature was entered for the adequation of this C&P exam.
4.23	Date of Audiometric Testing	When audiometric data are pulled from a past visit (i.e., testing is not done on the current date), the DATE OF AUDIOMETRIC TESTING field is filled with the date when actual testing was done.
4.24	Completer Title	For C&P exams, the COMPLETER TITLE field contains the title of the audiologist who completed the exam.
4.25	Adequator Title	For C&P exams, the ADEQUATOR TITLE field contains the title of the audiologist who adequated the clinic visit.
5	CDR Account	The CDR ACCOUNT field contains the CDR account number to be credited with this clinic visit.
6	Primary Provider	The PRIMARY PROVIDER field contains the name of the primary A&SP Provider who participated in this exam.
6.5	PCE Error	This multiple contains any error messages returned by PCE when this visit was transmitted via the Interface to PCE.
	.01 PCE Error	
	.02 PCE Field Name	
	.03 PCE Field Internal Value	
	.04 PCE Field External Value	
	1 PCE Error Message	
7	Student	If a student or trainee participated in this exam, the name of the STUDENT should be entered here.
8	*Other Provider	This field is starred for deletion.
8	*Disposition	This field is starred for deletion.
10	Procedure Code	The PROCEDURE CODE field contains CPT-4 procedure codes and modifiers, if any, for this exam.
	.01 Procedure	
	.02 *Modifier	Starred for deletion.
	.03 Volume	
	.04 CPT Modifier	
	.05 Procedure Provider	
20	Service Connected	This prompt allows the user to indicate if the visit is Service Connected or not.
25	Agent Orange	Y or N indicates whether the visit is related to Agent Orange Exposure.
30	Radiation	Y or N indicates whether the visit is related to Radiation Exposure.
35	Environmental	Y or N indicates whether the visit is related to

	Contaminants	Environmental Contaminants Exposure.
55	Appointment Time	The time the visit took place.
60	Division	This is the division at which the visit took place.
80	Visit Eligibility	Only Eligibilities associated with the visit are valid for entry.
100	Review of Medical Records	Word Processing field.
101	Medical History	Word Processing field.
102	Physical Examination	Word Processing field.
103	Diagnostic and Clinical Tests	Word Processing field.
104	Diagnosis	Word Processing field.
125	PCE Visit IEN	This is the IEN of the PCE visit passed back by the send to PCE processing.
135	Last Sent to PCE	The Date/Time that the system last attempted to send this data to PCE.
140	Last Edited in QUASAR	This date is the date when the visit record was last edited in Quasar.
900	Exception Date	Set to NOW whenever the system determines that the Visit has become a PCE Exception.

VA FileMan Sort and Print Options

PRINT OPTIONS			
FORMATTING CODES:	EXAMPLES:	EXPLANATIONS:	
C	Column Assignment	FIRST PRINT FIELD: NAME;C10	Print NAME starting in Column 10
S	Skip Lines	FIRST PRINT FIELD: NAME;S1	Skip 1 line before printing the next NAME
L	Left Justify	FIRST PRINT FIELD: PROVIDER;L8	Print only the first 8 characters of the PROVIDER name.
R	Right Justify	FIRST PRINT FIELD: DATE;R30	Right justify the DATE 30 columns from the end of the last value plus 2 column spacers
W	Word Wrap	FIRST PRINT FIELD: MEDICAL HISTORY;W20	Wrap after 20 columns of text but will not split words
D	Decimal Points	FIRST PRINT FIELD: COST;D2	Use two decimal places
N	No Repeat	FIRST PRINT FIELD: NAME;N	Will not repeat consecutive occurrence of the same name
Y	Start at Row	FIRST PRINT FIELD: NAME;Y10 FIRST PRINT FIELD: NAME;Y-10	Start printing 10 rows from top of page Start printing 10 rows from bottom of page
@	Suppress Heading	HEADING: A&SP... Replace @	Suppresses the entire Heading (from the dash line up)
X	Suppress Spacing	FIRST PRINT FIELD: .01 NAME THEN PRINT FIELD: SSN;X	Suppress spacing between the name and the SSN
T	Print Title	FIRST PRINT FIELD: TIME SPENT;T	Print title (Time Spent in Minutes) as column header instead of label
" "	Print Different Header	FIRST PRINT FIELD: TIME SPENT;"Time"	Print Time as a column header rather than TIME SPENT
_	Concatenate (Join)	FIRST PRINT FIELD: ADEQUATED BY_" " ADEQUATOR TITLE	Joins field values with literals or other fields, i.e.... JOHN DOE, CHIEF
:	Forward Pointing	FIRST PRINT FIELD: NAME: THEN PRINT PATIENT FIELD: SSN	Follows the NAME pointer field from the A&SP Patient File to the Patient File to get the SSN
ARITHMETIC OPERATORS:	EXAMPLES:	EXPLANATIONS:	
!	Counts Any Field	FIRST PRINT FIELD: !NAME	Counts the entries that have values in the NAME field
&	Totals Numerics	FIRST PRINT FIELD: &TIME SPENT/60;D1	Totals numeric fields; totals TIME SPENT and divides by 60 with 1 decimal place
+	Totals, Count & Mean	FIRST PRINT FIELD: +TIME SPENT	Totals and Counts fields and provides a mean value
#	Totals, Count, Mean, Minimum, Maximum, & Standard Division	FIRST PRINT FIELD: #TIME SPENT	Totals and Counts fields and provides a minimum value and a maximum value found with the average value and standard deviation
BINARY OPERATORS:	EXAMPLES:	EXPLANATIONS:	
+	Addition	FIRST PRINT FIELD: &TIME SPENT+600	Add 10 hours to the total TIME SPENT
-	Subtract	FIRST PRINT FIELD: &TIME SPENT-600	Subtract 10 hours from total TIME SPENT
*	Multiply	FIRST PRINT FIELD: &TIME SPENT*.25	Multiply total TIME SPENT by .25
/	Divide	FIRST PRINT FIELD: &TIME SPENT/60;D1	Divide total TIME SPENT by 60 to get total hours to 1 decimal place
\	Integer Division	FIRST PRINT FIELD: &TIME SPENT\60	Divide the TIME SPENT by 60 leaving off all remainders

SORT OPTIONS

SORT OPTIONS			
FORMATTING CODES:	EXAMPLES:	EXPLANATIONS:	
C	Column Assignment	SORT BY: DATE;C30	Print DATE sub-header in column 30
S	Skip Lines	SORT BY: DATE;S2	Skip 2 lines before printing the next DATE sub-header
L	Left Justify	SORT BY: PRIMARY PROVIDER;L10	Print only the first 10 characters of the PRIMARY PROVIDER as the sub-header
" "	Print Your Header	SORT BY: PRIMARY PROVIDER;"Provider: "	Prints Provider: as a sub-header rather than PRIMARY PROVIDER
@	Suppress Sub-Header	SORT BY: @DATE	Sorts by the selected Field (DATE) but suppresses the sub-header
SORT FUNCTIONS:	EXAMPLES:	EXPLANATIONS:	
!	Ranking Numbers	SORT BY: !DATE	Items printed under DATE sub-header will have ranking numbers
+	Sub Totals	SORT BY: +NAME	All print fields with !,&,+,# will be sub-totalled at each new NAME
#	Form Feed	SORT BY: #PRIMARY PROVIDER	A form feed will be generated for each new PRIMARY PROVIDER
-	Reverse Order	SORT BY: -DATE	Will reverse order of print from lowest-highest to highest-lowest order
'	Select Entries	SORT BY: 'DATE	Select items only, rather than selects and sorts
SPECIAL FEATURES:	EXAMPLES:	EXPLANATIONS:	
@	at START WITH prompt	SORT BY: DATE SIGNED START WITH DATE SIGNED: @	Prints all entries with a value in the DATE SIGNED field first followed by null values for that field
@	at the START WITH and GO TO prompt	SORT BY: DATE SIGNED START WITH DATE SIGNED: @ GO TO DATE SIGNED: @	Prints only entries with null values in the DATE SIGNED field
TEMPLATES:	EXAMPLES:	EXPLANATIONS:	
]	Forces FileMan to offer a template prompt	SORT BY:] FIRST PRINT FIELD:]	Forces FileMan to offer you a template
[Used to call a template	SORT BY: [A&SP ... FIRST PRINT FIELD: [A&SP ...	Calls a previously created template; ie sort or print template named A&SP ...
[?	Will show all templates available to the user	SORT BY: [? FIRST PRINT FIELD: [?	Shows all sort or print templates
^	Inserts	THEN PRINT FIELD: PATIENT NAME//^SSN THEN PRINT FIELD: PATIENT NAME//	Inserts a field before another field
@	Deletes	THEN PRINT FIELD: SSN//@	Deletes a field

BOOLEAN LOGIC:	EXAMPLES:	EXPLANATIONS:
= Equal	SORT BY: PROCEDURE CODE=92507	Finds all instances of PROCEDURE CODE equal to 92507
> Greater Than	SORT BY: TIME SPENT>30	Finds all instances where TIME SPENT was greater than 30 minutes
< Less Than	SORT BY: TIME SPENT<30	Finds all instances where TIME SPENT was less than 30 minutes
[Contains	SORT BY: PATIENT NAME["AR"	Finds all patients with AR in their names
] Follows	SORT BY: PATIENT NAME]"ST"	Finds all patients whose names begin with ST to the end of the alphabet
! OR	SORT BY: TIME SPENT<10!(TIME SPENT>60)	Finds all instances where TIME SPENT was less than 10 minutes OR greater than 60 minutes
& AND	SORT BY: PRIMARY PROVIDER="GLAD,JAMES C"&(TIME SPENT>120)	Finds all instances where PRIMARY PROVIDER GLAD,JAMES C spent greater than 2 hours on a visit.
' NEGATE	SORT BY: 'TIME SPENT>30	Finds all instances where TIME SPENT is NOT greater than 30

Writing Your Own Tailor-Made Reports

Tailor-Made A&SP Reports is an option on the A&SP Reports menu in the Audiology & Speech Visit Tracking System menu. The option prompts you to sort from the A&SP Patient file (#905850.2) or the A&SP Clinic Visit file (#905850.6). VA FileMan defaults are always followed by the // symbol. The default file is the A&SP CLINIC VISIT file. See [Data Dictionaries](#) for a listing of the fields in the two files.

You can enter the field name or number in sort or print logic. When performing some arithmetic operations, you must specify the field name. For example, if you want to convert TIME SPENT (minutes) into hours, you would write TIME SPENT/60. Dividing the field number (.07) by 60 will not work.

Tailor-Made A&SP Reports allows you to store your sort logic in templates. VA FileMan prompts you for a template name when you enter new sorting logic. The saved template can be called up by entering the template name enclosed in brackets (e.g., [PATIENT LIST]) at the first "SORT BY:" prompt. The list of stored templates can be called up by entering [?. Print logic cannot be stored by the Tailor-Made A&SP Reports option. Print logic must be entered each time the report is run. Neither the sort logic nor the print logic can be edited. If you make a mistake while entering sort logic, exit by pressing the ^ key (shift-6). If you want to change the sort logic after you have saved a template, a new template can be saved with the same or a different template name. If you save a template with a template name that already exists, VA FileMan will warn you that the template exists and will ask if you wish to overwrite the existing template.

VA FileMan also allows you to specify ranges for sorted data. Ranges permit flexibility and repeated use of the same sort logic when using templates. VA FileMan will prompt you for those data fields for which you want to enter ranges. For example, if you sort by DATE, you will be asked:

```
SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO//
```

In most cases, you should enter a range for each sort value during the initial run of the sorting routine. This will force VA FileMan to ask if you want the user to be asked a 'From – To' range" when using the template. If you want a range for the data, answer YES to the prompt; otherwise answer NO.

Examples of Tailor-Made A&SP Reports

This section contains some examples of tailor-made reports. In the following examples, text to be entered is highlighted in boldface type. Explanatory information is italicized and enclosed in brackets []. Data fields followed by slant bars // are defaults. The symbol <RET> means press the return or enter key. If you specify visit date by its field name, DATE, you will be shown four date fields from which to select. DATE is the clinic visit date. The visit date is uniquely specified by its field number, .01.

Note:

1. **With this release there are several fields for capturing provider (Primary Provider, Secondary Provider, Student, and Procedure Provider). Keep in mind that if you want the Primary Provider for the visit, use the Primary Provider field. If you want to capture discrete data on providers for each procedure done during the visit, use the Procedure Provider field found under the Procedure multiple. There are examples of the use of providers from both fields in the following pages.**
2. **Also with this release, data can be obtained by Division if your site parameters are set up by Division. You may want to sort by Division at the beginning of each report to get only data from your Division.**
3. **Please keep in mind that some fields have been changed or added since the last release. If you created any sort or print templates, you should review those for any necessary changes following the installation of this release.**

Report #1: Student Cost Distribution Report

Objective: To print out procedure time by CDR account for each student. This program returns the procedure time by date and student for each CDR account and totals the procedure time. You must calculate subtotals of CDR accounts (e.g., 1100-series, 1200-series) for entry into the QUASAR A&SP Service CDR.

```
Select A&SP Reports Option: Tailor-Made A&SP Reports
Print From Which File: (P/V): V// <RET>isit
SORT BY: DATE// +CDR ACCOUNT
START WITH CDR ACCOUNT: FIRST// <RET>
    WITHIN CDR ACCOUNT, SORT BY: STUDENT
    START WITH STUDENT: FIRST// <RET>
        WITHIN STUDENT, SORT BY: DATE
            1 DATE
            2 DATE ADEQUATED
            3 DATE OF AUDIOMETRIC TESTING
            4 DATE SIGNED
CHOOSE 1-4: 1 DATE
    START WITH DATE: FIRST// [Enter beginning date of range]
    GO TO DATE: LAST// [Enter ending date of range]
    WITHIN DATE, SORT BY: <RET>
STORE IN 'SORT' TEMPLATE: [Enter a name for your template]
    Are you adding 'TEMPLATE NAME' as
    a new SORT TEMPLATE? No// <RET> (Yes)
DESCRIPTION:
    1> You may enter a description of the template here.

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO// YES
FIRST PRINT FIELD: CDR ACCOUNT;C1;L10;N
THEN PRINT FIELD: STUDENT;C13;L15;N
THEN PRINT FIELD: .01;C31;L12;N DATE
THEN PRINT FIELD: +(TIME SPENT/60);C46;L6;"TIME (HRS)"
THEN PRINT FIELD: <RET>
DEVICE: [Select a print device]
```

Notes:

- If you want to display procedure time in minutes, the last print command should be entered as: **+.07;C46;L6;"TIME (MIN)"**.
- A&SP Service CDR requires that you add all student hours for each of the 1100-series, 1200-series, 1300-series, 1400-series, 1600-series, and 2800-series accounts. The cost account totals are the training (.12) data required by the QUASAR A&SP Service CDR.
- The Student CDR assumes 100% supervision.

A&SP CLINIC VISIT STATISTICS			NOV 13,1995	13:27	PAGE 1
CDR			TIME		
ACCOUNT	STUDENT	DATE	(HRS)		
1110.00	BROWN, STUDE	OCT 6, 1995	.25		
		OCT 14, 1995	.75		
		OCT 21, 1995	1.5		
		OCT 30, 1995	.5		
	CARTER, STUDE	OCT 13, 1995	1		
		OCT 14, 1995	.5		
		OCT 17, 1995	.5		
		OCT 23, 1995	1		
		OCT 26, 1995	.5		
	KELLY, STUDE	OCT 6, 1995	2		
		OCT 13, 1995	.5		
		OCT 14, 1995	.5		
		OCT 17, 1995	.75		
		OCT 18, 1995	.5		
		OCT 23, 1995	1.5		

	SUBTOTAL		13		
	SUBCOUNT		16		
	SUBMEAN		0.81		
1111.00	BROWN, STUDE	OCT 19, 1995	.75		

	SUBTOTAL		.75		
	SUBCOUNT		1		
	SUBMEAN		0.75		
1211.00		OCT 15, 1995	1		
	CARTER, STUDE	OCT 5, 1995	.5		
			.5		
		OCT 7, 1995	2		
		OCT 9, 1995	.75		
		OCT 10, 1995	2		
			.75		
		OCT 12, 1995	.75		

	SUBTOTAL		8.25		
	SUBCOUNT		8		
	SUBMEAN		1.03		

	TOTAL		22		
	COUNT		25		
	MEAN		0.88		

Report #2: Patient Addresses

Objective: To print names and addresses of patients for database or mailing purposes.

```
Select A&SP Reports Option:  Tailor-Made A&SP Reports
Print From Which File:  (P/V):  V//  <RET>isit
SORT BY:  DATE//  @DATE
      1  DATE
      2  DATE ADEQUATED
      3  DATE OF AUDIOMETRIC TESTING
      4  DATE SIGNED
CHOOSE 1-4:  1  DATE
START WITH DATE:  FIRST//  [Instead of accepting the default, specify a date
range if you always would like to be asked for a range]
GO TO DATE:  LAST//  [Enter an ending date]
WITHIN DATE, SORT BY:  @CLINIC STOP CODE

      START WITH CLINIC STOP CODE:  FIRST//  ??
The CLINIC STOP CODE field contains A for Audiology, S for Speech
Pathology, AT for an Audiology Telephone visit and ST for Speech
Telephone visit.
      Choose from:
      A  AUDIOLOGY
      S  SPEECH
      AT TELEPHONE AUDIOLOGY
      ST TELEPHONE SPEECH
START WITH CLINIC STOP CODE:  FIRST//  A  AUDIOLOGY
GO TO CLINIC STOP CODE:  LAST//  A  AUDIOLOGY
WITHIN CLINIC STOP CODE, SORT BY:
STORE IN 'SORT' TEMPLATE:  [Enter a name for your template]

DESCRIPTION:
      1>  Enter a description.

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO//  <RET>YES

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'CLINIC STOP CODE'? NO//
<RET>YES
FIRST PRINT FIELD:  PATIENT NAME:
      THEN PRINT A&SP PATIENT FIELD:  NAME:
      THEN PRINT PATIENT FIELD:  NAME;S1;"";C35
      THEN PRINT PATIENT FIELD:  STREET ADDRESS [LINE 1];C35;"
      THEN PRINT PATIENT FIELD:  CITY ", "_STATE_" "_ZIP CODE;C35;"
      THEN PRINT PATIENT FIELD:  <RET>
      THEN PRINT A&SP PATIENT FIELD:  <RET>
THEN PRINT FIELD:  <RET>
DEVICE:  [Select Print Device]
```

Note:

- This routine makes use of forward pointing commands to extract patient data from the MAS Patient file(#2). Because the patient's name is identified, some patient data not entered into QUASAR may be accessed, sorted, and printed.

```
A&SP CLINIC VISIT LIST                                NOV 13,1995 13:12  PAGE 1
-----
                                ZIFFEL, PATIENT
                                666 ELM DRIVE
                                ANYWHERE, ILLINOIS 60611

                                ZOOM, PATIENT
                                10 LAKE SHORE DRIVE
                                SOMEWHERE, ILLINOIS 60623
```

Report #3: Visit Report (Provider/Time Spent/Diagnostic Code)

Objective: To print a list of patient names, primary provider, procedure times, and ICD9-CM codes by visit date.

```
Select A&SP Reports Option:  Tailor-Made A&SP Reports
Print From Which File:  (P/V): V// <RET>isit
SORT BY: DATE// <RET>
START WITH DATE: FIRST// [Enter a beginning date]
GO TO DATE: LAST// [Enter an ending date]
  WITHIN DATE, SORT BY: PATIENT NAME
  START WITH PATIENT NAME: FIRST// <RET>
  WITHIN PATIENT NAME, SORT BY: <RET>
FIRST PRINT FIELD: PATIENT NAME;L20;S1
THEN PRINT FIELD: .01;C24;L15  DATE
THEN PRINT FIELD: PRIMARY PROVIDER;C42;L20
THEN PRINT FIELD: TIME SPENT;C65;L3 (minutes)
THEN PRINT FIELD: DIAGNOSTIC CODE (multiple)
  THEN PRINT DIAGNOSTIC CODE SUB-FIELD: DIAGNOSTIC CODE;C71;L8
  THEN PRINT DIAGNOSTIC CODE SUB-FIELD: <RET>
THEN PRINT FIELD: <RET>
DEVICE: [Select Print Device]
```

A&SP CLINIC VISIT LIST		NOV 22,1999	13:22	PAGE 1
PATIENT NAME	DATE	PRIMARY PROVIDER	TIME SPENT (minutes)	CODE
PATIENT,BJ	AUG 16,1999	PROVIDER,ANN E	30	388.12
PATIENT,K G	AUG 16,1999	PROVIDER,ANN E	25	388.12

Report #4: Visit Report (Procedure Code/Cost)

Objective: To print a list of patient names, CPT-4 codes, and costs by clinic stop and date. Report also calculates the total cost, number of procedures, and the mean procedure cost.

```
Select A&SP Reports Option:  Tailor-Made A&SP Reports
Print From Which File:  (P/V): V// <RET>isit
SORT BY: DATE// <RET>
START WITH DATE: FIRST// [Enter a beginning date]
GO TO DATE: LAST// [Enter an ending date]
  WITHIN DATE, SORT BY: PROCEDURE CODE (multiple)
  PROCEDURE CODE SUB-FIELD: PROCEDURE CODE:
  A&SP PROCEDURE CODE FIELD: CLINIC STOP
  START WITH CLINIC STOP: FIRST// <RET>
    WITHIN CLINIC STOP, SORT BY: PATIENT NAME
    START WITH PATIENT NAME: FIRST// <RET>
      WITHIN PATIENT NAME, SORT BY: <RET>
STORE IN 'SORT' TEMPLATE: [Enter a template name]
  Are you adding 'TEMPLATE NAME' as
  a new SORT TEMPLATE? No// Y (Yes)
DESCRIPTION:
  1><RET>

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO// <RET>YES
FIRST PRINT FIELD: PROCEDURE CODE (multiple)
  FIRST PRINT PROCEDURE CODE SUB-FIELD: PROCEDURE CODE:
    THEN PRINT A&SP PROCEDURE CODE FIELD: CLINIC STOP;N
    THEN PRINT A&SP PROCEDURE CODE FIELD: <RET>
    THEN PRINT PROCEDURE CODE SUB-FIELD: <RET>
  THEN PRINT FIELD: PATIENT NAME;C20;L20
  THEN PRINT FIELD: DATE;C43;L14
    1  DATE
    2  DATE ADEQUATED
    3  DATE OF AUDIOMETRIC TESTING
    4  DATE SIGNED
  CHOOSE 1-4: 1 DATE
  THEN PRINT FIELD: PROCEDURE CODE (multiple)
    THEN PRINT PROCEDURE CODE SUB-FIELD: PROCEDURE CODE;C60;L7
    THEN PRINT PROCEDURE CODE SUB-FIELD: PROCEDURE CODE:
      THEN PRINT A&SP PROCEDURE CODE FIELD: +COST;C70
      THEN PRINT A&SP PROCEDURE CODE FIELD: <RET>
    THEN PRINT PROCEDURE CODE SUB-FIELD: <RET>
  THEN PRINT FIELD: <RET>
  DEVICE: [Enter a device]
```

A&SP CLINIC VISIT STATISTICS			NOV 13,1995	15:15	PAGE 1
CLINIC STOP	PATIENT NAME	DATE	PROCEDURE CODE	COST	
AUDIOLOGY	ZIFFEL,PATIEN	OCT 5,1995	92557	80.00	
			92599	20.00	
	FIRPO,PATI	OCT 6,1995	92557	80.00	
			92567	30.00	
			92568	30.00	
SPEECH	GULCH,PATIEN	OCT 20,1995	92507	75.00	
	BERRY,PATIE	OCT 10,1995	74230	225.00	
TOTAL				540.00	
COUNT				7	
MEAN				77.14	

Report #5: Visit Report (Procedure Time)

Objective: To print a list of procedure times by provider and date. Report also calculates total procedure time for all providers.

```
Select A&SP Reports Option: Tailor-Made A&SP Reports
Print From Which File: (P/V): V// <RET>isit
SORT BY: DATE// PROCEDURE CODE (multiple)
PROCEDURE CODE SUB-FIELD: PROCEDURE PROVIDER;S
START WITH PROCEDURE PROVIDER: FIRST// <RET>
  WITHIN PROCEDURE PROVIDER, SORT BY: DATE
    1 DATE
    2 DATE ADEQUATED
    3 DATE OF AUDIOMETRIC TESTING
    4 DATE SIGNED
CHOOSE 1-4: 1 DATE
  START WITH DATE: FIRST// [Enter a beginning date]
  GO TO DATE: LAST// [Enter an ending date]
  WITHIN DATE, SORT BY: <RET>
STORE IN 'SORT' TEMPLATE: [Enter a template name]
Are you adding 'TEMPLATE NAME' as a new SORT TEMPLATE? No// Y (Yes)
DESCRIPTION:
  No existing text
  Edit? NO// <RET>

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO// YES
FIRST PRINT FIELD: PROCEDURE CODE (multiple)
  FIRST PRINT PROCEDURE CODE SUB-FIELD: PROCEDURE PROVIDER;N
  THEN PRINT PROCEDURE CODE SUB-FIELD: <RET>
THEN PRINT FIELD: DATE
  1 DATE
  2 DATE ADEQUATED
  3 DATE OF AUDIOMETRIC TESTING
  4 DATE SIGNED
CHOOSE 1-4: 1 DATE
THEN PRINT FIELD: &TIME SPENT;"TIME" (minutes)
THEN PRINT FIELD: <RET>
DEVICE: [Enter a device]
```

A&SP CLINIC VISIT STATISTICS		NOV 23,1999	10:18	PAGE 1
PROCEDURE PROVIDER	DATE		TIME	
PROVIDER, KYLE	NOV 10,1999		30	
	NOV 10,1999		30	
	NOV 10,1999		30	
	NOV 15,1999		30	
	NOV 18,1999		90	
	NOV 22,1999		60	
PROVIDER, JON L.	NOV 19,1999		30	
PROVIDER, ANDY	NOV 10,1999		30	
	NOV 10,1999		30	
	NOV 22,1999		60	
PROVIDER, STEPHEN	NOV 18,1999		60	
	NOV 18,1999		90	
PROVIDER, BRENT	NOV 22,1999		60	
TOTAL			630	

Report #6: C&P Examinations

Objective: To provide a list of patients seen for C&P exams by date and primary provider.

```

Select A&SP Reports Option: Tailor-Made A&SP Reports
Print From Which File: (P/V): V// <RET>isit
SORT BY: DATE// C AND P
  1  C AND P
  2  C AND P STATUS
CHOOSE 1-2: 1 C AND P
START WITH C AND P: FIRST// <RET>
  WITHIN C AND P, SORT BY: DATE
    1  DATE
    2  DATE ADEQUATED
    3  DATE OF AUDIOMETRIC TESTING
    4  DATE SIGNED
CHOOSE 1-4: 1 DATE
  START WITH DATE: FIRST// [Enter a beginning date]
  GO TO DATE: LAST// [Enter an ending date]
  WITHIN DATE, SORT BY: PATIENT NAME
  START WITH PATIENT NAME: FIRST// <RET>
    WITHIN PATIENT NAME, SORT BY: PRIMARY PROVIDER
    START WITH PRIMARY PROVIDER: FIRST// <RET>
      WITHIN PRIMARY PROVIDER, SORT BY: <RET>
STORE IN 'SORT' TEMPLATE: [Enter a template name]
  Are you adding 'TEMPLATE NAME' as a new SORT TEMPLATE? No// Y (Yes)
DESCRIPTION:
  1><RET>

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO// <RET>YES
FIRST PRINT FIELD: PRIMARY PROVIDER;L20;N
THEN PRINT FIELD: .01;C25 DATE
THEN PRINT FIELD: PATIENT NAME;C40;L25
THEN PRINT FIELD: !C AND P;C70;"C&P"
THEN PRINT FIELD: <RET>
DEVICE: [Enter a device]

```

A&SP CLINIC VISIT STATISTICS		NOV 23,1999	12:20	PAGE 1
PRIMARY PROVIDER	DATE	PATIENT NAME	C&P	
PROVIDER, ANDY	AUG 16,1999	PATIENT, TO	YES	
	AUG 31,1999	PATIENT, EARLY	YES	
	OCT 7,1999	PATIENT, SCARL	YES	
PROVIDER, DON	OCT 12,1999	PATIENT, TO	YES	
PROVIDER, ANDY	OCT 22,1999	PATIENT, DANIEL	YES	
	NOV 18,1999	PATIENT, CEER	YES	
	NOV 18,1999	PATIENT, TO	YES	

COUNT			7	

Report #7: Visit Report (Procedure Codes/Date and Provider)

Objective: To print patient names, primary providers, and procedure code by date. This report is useful for validating data and for searching the QUASAR database for procedure codes or patients which were entered in error or missed.

```
Select A&SP Reports Option:  Tailor-Made A&SP Reports
Print From Which File:  (P/V): V// <RET>isit
SORT BY: DATE// <RET>
START WITH DATE: FIRST// [Enter a beginning date]
GO TO DATE: LAST// [Enter an ending date]
  WITHIN DATE, SORT BY: PATIENT NAME
  START WITH PATIENT NAME: FIRST// <RET>
    WITHIN PATIENT NAME, SORT BY: PRIMARY PROVIDER
    START WITH PRIMARY PROVIDER: FIRST// <RET>
      WITHIN PRIMARY PROVIDER, SORT BY: <RET>
STORE IN 'SORT' TEMPLATE: [Enter a template name]
Are you adding 'TEMPLATE NAME' as a new SORT TEMPLATE? No// Y (Yes)
DESCRIPTION:
  1><RET>

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO// <RET>YES
FIRST PRINT FIELD: PATIENT NAME;C1;S1;L20
THEN PRINT FIELD: PRIMARY PROVIDER;C25;L20;N
THEN PRINT FIELD: .01;C50;N DATE
THEN PRINT FIELD: PROCEDURE CODE (multiple)
  THEN PRINT PROCEDURE CODE SUB-FIELD: PROCEDURE CODE;C70
  THEN PRINT PROCEDURE CODE SUB-FIELD: <RET>
THEN PRINT FIELD: <RET>
DEVICE: [Enter a device]
```

A&SP CLINIC VISIT LIST			NOV 23,1999 12:31	PAGE 1
PATIENT NAME	PRIMARY PROVIDER	DATE		PROCEDURE CODE

ARMSTRONG, PT	PROVIDER, ANN E	AUG 16,1999		92511
BIRD, PATIENT				92511
BORIS, PAT				92511
CAMPBELL, PATI				92511
CHRISTMAS, PATIE				92511
DRG, PATI				92511
EARLY, PATIENT	PROVIDER, ANDY			92506

Report #8: ASHA Data on Trainees

Objective: To print a list of procedure times by student and date.

```

Select A&SP Reports Option:  Tailor-Made A&SP Reports
Print From Which File: (P/V): V// <RET>isit
SORT BY: DATE// #STUDENT
START WITH STUDENT: FIRST// <RET>
  WITHIN STUDENT, SORT BY: DATE
    1  DATE
    2  DATE ADEQUATED
    3  DATE OF AUDIOMETRIC TESTING
    4  DATE SIGNED
CHOOSE 1-4: 1  DATE
  START WITH DATE: FIRST// [Enter a beginning date]
  GO TO DATE: LAST// [Enter an ending date]
    WITHIN DATE, SORT BY: <RET>
STORE IN 'SORT' TEMPLATE: [Enter a template name]
  Are you adding 'TEMPLATE NAMES' as a new SORT TEMPLATE? No// Y (Yes)
DESCRIPTION:
  1><RET>

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO// <RET>YES
FIRST PRINT FIELD: STUDENT;C1;N;L20
THEN PRINT FIELD: .01;C25  DATE
THEN PRINT FIELD: DIAGNOSTIC CODE (multiple)
  THEN PRINT DIAGNOSTIC CODE SUB-FIELD: DIAGNOSTIC CODE;C40
  THEN PRINT DIAGNOSTIC CODE SUB-FIELD: <RET>
THEN PRINT FIELD: PROCEDURE CODE (multiple)
  THEN PRINT PROCEDURE CODE SUB-FIELD: PROCEDURE CODE;C50
  THEN PRINT PROCEDURE CODE SUB-FIELD: <RET>
THEN PRINT FIELD: TIME SPENT;C65 (minutes)
THEN PRINT FIELD: <RET>
DEVICE: [Enter a device]
  
```

A&SP CLINIC VISIT LIST		NOV 13,1995 09:54		PAGE 1	
STUDENT	DATE	DIAGNOSTIC CODE	PROCEDURE CODE	TIME SPENT (minutes)	
STUDE, JENNY	OCT 6, 1995	389.10	92557 92567 92568 92599	90	

Report #9: Procedure Time Report

Objective: To print a list of procedure times for a specified procedure. The report also provides descriptive statistics on procedure times. This report is useful for analyzing product lines and standardizing procedure times for DSS. Note: This report is designed to analyze procedure time for a single specified procedure code. It uses the Primary Provider instead of the Procedure Provider field.

```
Select A&SP Reports Option:  Tailor-Made A&SP Reports
Print From Which File:  (P/V): V// <RET>isit
SORT BY: DATE//  @DATE
    1  DATE
    2  DATE ADEQUATED
    3  DATE OF AUDIOMETRIC TESTING
    4  DATE SIGNED
CHOOSE 1-4:  1  DATE
  START WITH DATE: FIRST// [Enter a beginning date]
  GO TO DATE: LAST// [Enter an ending date]
  WITHIN DATE, SORT BY:  PROCEDURE CODE      (multiple)
  PROCEDURE CODE SUB-FIELD:  PROCEDURE CODE
  START WITH PROCEDURE CODE: FIRST// [Enter code to be sorted]
  GO TO PROCEDURE CODE: LAST// [Enter same code]
  WITHIN PROCEDURE CODE, SORT BY:  START WITH DATE: FIRST// [Enter a
beginning date]
  GO TO DATE: LAST// [Enter an ending date]

STORE IN 'SORT' TEMPLATE: [Enter a template name]
Are you adding 'TEMPLATE NAMES' as a new SORT TEMPLATE? No//  Y  (Yes)
DESCRIPTION:
  1><RET>

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO//  YES

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'PROCEDURE CODE'? NO//  YES
FIRST PRINT FIELD:  PROCEDURE CODE (multiple)
  FIRST PRINT PROCEDURE CODE SUB-FIELD:  PROCEDURE CODE;C1
  THEN PRINT PROCEDURE CODE SUB-FIELD:  <RET>
THEN PRINT FIELD:  PRIMARY PROVIDER;C20;N
THEN PRINT FIELD:  #TIME SPENT;C40 (minutes)
THEN PRINT FIELD:  <RET>
DEVICE: [Enter a device]
```

A&SP CLINIC VISIT STATISTICS			NOV 13,1995 10:28	PAGE 1
PROCEDURE CODE	PRIMARY PROVIDER	TIME SPENT (minutes)		
92507	PROVID, DON	30		
92507		30		
92507		30		
92507		45		
92507		45		
92507	PROVI, JAMES	45		
92507		45		

TOTAL		270		
COUNT		7		
MEAN		39		
MINIMUM		30		
MAXIMUM		45		
DEV.		8		

Report #10: Clinic Management Report

Objective: To provide a report of patient names, procedures, and procedure times by provider.

```
Select A&SP Reports Option:  Tailor-Made A&SP Reports
Print From Which File:  (P/V): V// <RET>isit
SORT BY: DATE// @DATE
      1  DATE
      2  DATE ADEQUATED
      3  DATE OF AUDIOMETRIC TESTING
      4  DATE SIGNED
CHOOSE 1-4:  1  DATE
START WITH DATE: FIRST// {Enter a beginning date}
GO TO DATE: LAST// [Enter an ending date]
  WITHIN DATE, SORT BY: @CLINIC LOCATION
  START WITH CLINIC LOCATION: FIRST// [Enter a clinic location]
  GO TO CLINIC LOCATION: LAST// [Enter the same clinic location]
  WITHIN CLINIC LOCATION, SORT BY: <RET>
STORE IN 'SORT' TEMPLATE: [Enter a template name]
Are you adding 'TEMPLATE NAME' as a new SORT TEMPLATE? No// Y  (Yes)
DESCRIPTION:
  1><RET>

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO// YES

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'CLINIC LOCATION'? NO// YES
FIRST PRINT FIELD:  PRIMARY PROVIDER;C1;L20
THEN PRINT FIELD:  PATIENT NAME;C30
THEN PRINT FIELD:  PROCEDURE CODE (multiple)
  THEN PRINT PROCEDURE CODE SUB-FIELD:  PROCEDURE CODE;C55
  THEN PRINT PROCEDURE CODE SUB-FIELD:  <RET>
THEN PRINT FIELD:  TIME SPENT;C65  TIME SPENT (minutes)
THEN PRINT FIELD:  <RET>
DEVICE: [Enter a device]
```

A&SP CLINIC VISIT LIST		NOV 23,1999	13:51	PAGE 1
PRIMARY PROVIDER	PATIENT NAME	PROCEDURE CODE	TIME SPENT (minutes)	
PROVIDER, ANDY	SMITH, PATIEN	92506	30	
PROVIDER, NORMAN	GIBSON, PAT	92506	100	
	GIBSON, PAT	92506	120	
PROVIDER, ANDY	TART, PATIE	92511	10	

IX. GUIDE TO PROCEDURE CODES

The following codes and descriptions were extracted from the *Current Procedural Terminology* (CPT™). In some cases the descriptions have been modified to clarify their use in audiology practice. Code descriptions may therefore differ from the *Current Procedural Terminology* and the VISTA descriptors.

The procedure modifiers included in Version 2.0 have been inactivated but remain in the file for archival purposes. QUASAR will no longer prompt users for these modifiers. QUASAR modifiers have been replaced by a set of CPT Modifiers. These CPT modifiers are intended to alter the procedure in a specific way without changing the code definition. Users will be prompted for a CPT modifier for each CPT code entered. When circumstances warrant the use of a modifier, the user may enter the appropriate modifier at the prompt. If no modifier is appropriate, the user may skip the CPT modifier field.

Evaluation and management codes (CPT 99201-99499) are no longer available for use by non-physicians. The exceptions are minimal outpatient care for established patients (99211), telephone codes (99371-99373) and disability exams (99456).

CPT codes change annually. The procedure code file may be updated by using the Update Files per CO Directive option in the Set Up/Maintenance menu.

The codes, definitions, and guidance contained herein are intended for instructional purposes only. This addendum does not substitute for effective and appropriate use of official code references such as the *Current Procedural Terminology, Fourth Edition* and the *International Classification of Diseases, Ninth Edition, with Clinical Modification* (ICD-9CM). The authors, the national Audiology and Speech Pathology Service and the Department of Veterans Affairs make no representation, warranty, or guarantee that the codes, definitions, or guidance contained herein conform with authoritative coding conventions or that use of the codes, definitions, or guidance contained herein will conform to local coding or billing decisions or result in reimbursement by third-party payers. The authors, the national Audiology and Speech Pathology Service, or the Department of Veterans Affairs is not responsible for any liability related to the use of the codes, definitions, or guidance contained herein. Users are strongly advised to follow national coding conventions and local coding and billing rules.

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Procedure Codes and Descriptions-Audiology

The following descriptions are based on the *Current Procedural Terminology* (CPT™).
Audiological procedures are assumed to be bilateral, unless otherwise noted.

69210 CERUMEN MANAGEMENT

Removal of cerumen, one or both ears. Procedure includes external ear canal and tympanic membrane inspection by otoscopy. For video-otoscopy, see CPT 92599.

92270 ELECTRO-OCULOGRAPHY

Measurement of oculomotor function, brief. Calibration and simple saccades or measurements of saccades in horizontal and vertical planes, pursuit tracking, and gaze nystagmus in horizontal and

vertical planes with electro-oculography, infrared oculography, or video infrared oculoscopy, with interpretation.

92506 SPEECH/LANGUAGE/HEARING EVALUATION

Evaluation of speech, language, voice, communication, or auditory disorder including aural rehabilitation, individual, with interpretation.

92507 SPEECH/LANGUAGE/HEARING TREATMENT

Treatment of speech, language, voice, communication, and/or auditory disorder including aural rehabilitation, individual, with interpretation.

92508 GROUP EVALUATION/TREATMENT/ACTIVITY

Speech, language, dysphagia, or hearing evaluation or treatment with two or more patients

92510 COCHLEAR IMPLANT REHABILITATION

Assessment of cochlear implant function, adjustment for optimum performance, reprogramming, training, and/or follow-up after implantation. To report benefit or outcome measures, use CPT 92506.

92516 FACIAL NERVE FUNCTION STUDIES

Electroneurographic measurement and interpretation of facial nerve function

92531 SPONTANEOUS NYSTAGMUS OBSERVATION W/O RECORDING

Observation and evaluation of spontaneous nystagmus including gaze without electrical recording (e.g. direct observation or use of Frenzel lenses), with interpretation

92532 POSITIONAL NYSTAGMUS OBSERVATION W/O RECORDING

Observation and evaluation of positional nystagmus, minimum of four positions, without electrical recording (e.g. direct observation or use of Frenzel lenses), with interpretation

92533 CALORIC TEST OBSERVATION W/O RECORDING

Observation and evaluation of vestibular function, each irrigation, without electrical recording (e.g. direct observation or use of Frenzel lenses), with interpretation

92534 OPK NYSTAGMUS OBSERVATION W/O RECORDING

Observation and evaluation of optokinetic nystagmus without electrical recording (e.g. direct observation or use of Frenzel lenses), with interpretation

92541 SPONTANEOUS NYSTAGMUS WITH RECORDING

Measurement and evaluation of spontaneous nystagmus including gaze and fixation with electro-oculography, infrared reflection oculography, or video infrared oculoscopy recording and interpretation

92542 POSITIONAL NYSTAGMUS WITH RECORDING

Measurement and evaluation of positional nystagmus, minimum of four positions, with electro-oculography, infrared reflection oculography, or video infrared oculoscopy recording and interpretation

92543 CALORIC VESTIBULAR TEST, EACH

Measurement and evaluation of vestibular function with caloric stimulus with electro-oculography, infrared reflection oculography, or video infrared oculoscopy recording and interpretation. Binaural, bithermal stimulation counts as four tests. Use this code to document an

ice water caloric test in one ear.

92544 OPTOKINETIC NYSTAGMUS WITH RECORDING

Measurement and evaluation of optokinetic nystagmus using bi-directional, foveal, or peripheral stimulation with electro-oculography, infrared reflection oculography, or video infrared oculoscopy recording and interpretation

92545 OSCILLATING TRACKING TRACKING TEST

Measurement and evaluation of oculomotor function using pendular tracking with electro-oculography, infrared reflection oculography, or video infrared oculoscopy recording and interpretation

92546 SINUSOIDAL VERTICAL AXIS ROTATION

Measurement and evaluation of vestibular function using rotating chair, with interpretation

92547 VERTICAL ELECTRODE RECORDING

Use of vertical channel for any ENG procedure with electrical recording and interpretation. This is an add-on code to be used in conjunction with other ENG procedures.

92548 COMPUT DYNAMIC POSTUROGRAPHY

Measurement and evaluation of balance disorders, dysequilibrium, or unsteadiness using computer-controlled assessment of sensory organization and coordination

92551 HEARING SCREENING, AIR ONLY

Screening test with interpretation, pure tone air only. For threshold testing, use CPT 92552.

92552 PURE TONE AUDIOMETRY, AIR ONLY

Pure tone audiometry (threshold), air conduction only, with interpretation. Procedure includes otoscopic inspection of external ear canal and tympanic membrane.

92553 PURE TONE AUDIOMETRY, AC/BC

Pure tone audiometry (threshold), air and bone conduction with interpretation. Procedure includes otoscopic inspection of external ear canal and tympanic membrane.

92555 SPEECH THRESHOLD TESTING

Measurement of speech reception threshold (SRT) or speech awareness threshold (SAT) with interpretation

92556 SPEECH/WORD RECOGNITION TESTING

Speech audiometry, speech reception threshold and word recognition testing with interpretation. Includes aided speech recognition tests with or without competing message. For PI/PB functions, use CPT 92506.

92557 COMPREHENSIVE AUDIOMETRY

Comprehensive audiometric assessment with interpretation. Includes pure tone testing (CPT 92553), speech reception threshold (CPT 92555), and word recognition testing (CPT 92556). Use bundled code when all component procedures are performed. Otherwise, code procedures separately. Otosopic inspection of external ear canal and tympanic membrane is included in the examination and is not reported separately. For PI/PB, use CPT 92506.

- 92559 AUDIOMETRIC TESTING OF GROUPS
Threshold or Bekesy tracking in a group testing situation
- 92560 BEKESY AUDIOMETRY, SCREENING
Use of Bekesy tracking for screening or non-threshold testing, fixed or sweep frequency with interpretation. Enter code once when more than one sweep or frequency is done.
- 92561 BEKESY AUDIOMETRY, DIAGNOSTIC
Use of Bekesy tracking for diagnostic purposes, fixed frequency or sweep frequency with interpretation. Enter code once when more than one sweep or frequency is done.
- 92562 LOUDNESS BALANCE TEST
Use of alternate binaural , monaural bi-frequency loudness tests to evaluate loudness growth, with interpretation.
- 92563 TONE DECAY TEST
Tone decay test, any method, with interpretation. Enter code once when more than one frequency is done. For reflex decay, use CPT 92569.
- 92564 SISI
Short increment sensitivity index with interpretation. Enter one code when more than one level or frequency is done.
- 92565 STENGER, PURE TONE
Use of pure tone Stenger to assess non-organicity, with interpretation. Includes contralateral interference levels. Enter code once for each procedure even when more than frequency is tested.
- 92567 ACOUSTIC IMMITTANCE
Acoustic immittance (static, dynamic, or multi-frequency), impedance or admittance, with interpretation. Enter one code for each procedure even when more than probe frequency is used. Static and dynamic immittance (tympanometry) count as one procedure. For Eustachian tube function, use CPT 92599.
- 92568 ACOUSTIC REFLEX THRESHOLDS
Measurement and or recording of acoustic reflexes, with interpretation. Includes recording of reflex patterns. Enter one code for measurement of ipsilateral and contralateral reflexes.
- 92569 ACOUSTIC REFLEX DECAY TESTING
Observation or recording of acoustic reflex decay, with interpretation. Enter one code for measurement in ipsilateral and/or contralateral condition.
- 92571 DISTORTED SPEECH TEST
Assessment of auditory function using any filtered, distorted, or degraded speech materials, with interpretation
- 92572 SSW
Administration and interpretation of staggered spondaic word test
- 92575 SENSORINEURAL ACUITY LEVEL TEST
Administration and interpretation of the SAL
- 92576 SSI (ICM/CCM)

Administration and interpretation of synthetic sentence index using ipsilateral or contralateral competing message. Enter one code when more than one test or MCR is used.

92577 STENGER, SPEECH

Assessment of non-organicity using speech Stenger test, with interpretation.

92579 VISUAL REINFORCEMENT AUDIOMETRY (VRA)

Administration and interpretation of VRA

92582 CONDITIONING PLAY AUDIOMETRY

Administration and interpretation of audiometry using conditioned play techniques

92583 SELECT PICTURE AUDIOMETRY

Administration and interpretation of audiometry using picture stimuli

92584 ELECTROCOCHLEOGRAPHY

Recording and interpretation of extra-tympanic or transtympanic recordings

92585 AUDITORY EVOKED POTENTIALS

Recording and interpretation of auditory evoked potentials (ABR, MLR, P300, etc.)

92587 OTOACOUSTIC EMISSIONS, LIMITED

Recording and interpretation of TOAE or DPOAE using single stimulus level.

92588 OTOACOUSTIC EMISSIONS, DIAGNOSTIC

Recording and interpretation of TOAE or DPOAE at multiple frequencies, levels, or conditions.

92589 CENTRAL AUDITORY FUNCTION TEST

Assessment and interpretation of auditory function including but not limited to competing or degraded speech tasks, dichotic tasks, or masking level differences. Enter one code for each distinct test performed. CPT users should enter code 92589 for any kind of central auditory function test.

92590 HEARING AID ASSESSMENT, MONAURAL

Selection or evaluation of hearing aid, monaural. Use code only once for each issue. Includes needs assessment, loudness tolerance measurements, and product/circuit selection. For device ordering, processing, and shipping, use CPT 99002. For audiometric assessment, use appropriate audiometric codes. For ear impressions, use CPT 92599.

92591 HEARING AID ASSESSMENT, BINAURAL

Selection or evaluation of hearing aid, binaural. Use code only once for each issue. Includes needs assessment, loudness tolerance measurements, and product/circuit selection. For device ordering, processing, and shipping, use CPT 99002. For audiometric assessment, use appropriate audiometric codes. For ear impressions, use CPT 92599.

92592 HEARING AID CHECK/REPAIR/ADJUST, MONAURAL

Non-electroacoustic check, repair, modification, adjustment, or reprogramming of hearing aid, monaural. For electroacoustic measurements, use CPT 92594.

92593 HEARING AID CHECK/REPAIR/ADJUST, BINAURAL

Non-electroacoustic check, repair, modification, adjustment, or reprogramming of hearing aid,

binaural. For electroacoustic measurements, use CPT 92595.

92594 ELECTROACOUSTIC HEARING AID TEST, MONAURAL
Measurement of hearing aid function in accordance with ANSI S3.22 specifications, monaural. Measurement of REUR, REAR, REIR, target insertion gain (any formula) and/or target 2cc prescription (SSPL90 and FOG), monaural

92595 ELECTROACOUSTIC HEARING AID TEST, BINURAL
Measurement of hearing aid function in accordance with ANSI S3.22 specifications, binaural. Measurement of REUR, REAR, REIR, target insertion gain (any formula) and/or target 2cc prescription (SSPL90 and FOG), binaural

92596 EAR PROTECT ATTENUATION
Measurement of attenuation characteristics of hearing protection devices, any method

92599 UNLISTED ENT PROCEDURE
Used to document any audiology or speech procedure not elsewhere classified.

95920 INTRAOPERATIVE MONITORING, PER HR
Intraoperative neurophysiological testing, per hour, with interpretation. Enter one code for each hour of care. Use in addition to the code for the evoked potential measured (e.g. CPT 92585).

97703 SPEECH/HEAR PROSTH DEVICE ORIENTATION, 15 MIN
Patient education, device orientation, and verification of readiness to use speech, hearing, alternative, or augmentative communication prosthetic devices and hearing aids, each 15 minutes. Includes device fitting, adjustment, orientation, and measurement of benefit or outcome. Enter one code for each 15 minutes of care.

99002 PRODUCT DISPENSING/HANDLING
Handling, conveyance, and/or any other service connecting with the implementation of an order involving devices (e.g. designing, fitting, packaging, handling, delivery or mailing) when devices such as orthotics, protective devices, or prosthetics are fabricated by an outside laboratory or shop but are to be fitted and adjusted by the provider. Includes electronic ordering and processing or prosthetic orders (e.g. ROES).

99070 SPECIAL SUPPLIES
Supplies and materials dispensed over and above those normally included with an office visit (e.g. batteries, hearing parts and accessories, TEP supplies). For ordering, shipping, and handling, use CPT 99002.

99071 EDUCATIONAL SUPPLIES
Educational supplies such as books, tapes, or pamphlets provided for patient education. Does not include instructions or pamphlets provided by the manufacturer packaged with items such as hearing aids or assistive, augmentative, or alternative speech or hearing devices.

99075 EXPERT TESTIMONY/OPINION
Research, preparation and presentation of aural or written testimony or expert opinion in legal or adjudication proceedings (e.g. court testimony or affidavits).

99078 GROUP PATIENT EDUCATION
Patient education rendered in a group situation. This code is used when patients have established symptoms or illnesses. For education of patients without established illness, use preventive

medicine codes.

99080 SPECIAL REPORTS/CHART REVIEW

Review of chart beyond normal documentation (e.g. certification of disability, case management, or care plan oversight)

99211 E&M, OUTPATIENT EST

Use to document professional services to outpatients who have been seen by the provider or the provider's group practice within the past three (3) years. Office or outpatient visit, established patient. Problem of minimal complexity. Non-physician code.

99371 TELEPHONE CALL, BRIEF

Telephone contact with patient or for consultation or management or for coordinating management with other providers, simple or brief (e.g. report on tests findings, to clarify or alter patient instructions, to integrate new information from other providers into treatment plan, or to adjust therapy). Any procedures or activities that directly result from a telephone encounter should also be documented.

99372 TELEPHONE CALL, INTERMEDIATE

Telephone contact with patient or for consultation or management or for coordinating management with other providers, intermediate (e.g. to provide advice to established patients on a new problem, to initiate therapy over the telephone, discuss test findings in detail, to coordinate management of new problem on established patient, to discuss and evaluate new information and details, or to initiate new plan of care). Any procedures or activities that directly result from a telephone encounter should also be documented.

99373 TELEPHONE CARE, COMPLEX

Telephone contact with patient or for consultation or management or for coordinating management with other providers, complex or lengthy (e.g. lengthy counseling with patient, detailed/prolonged discussion with family members, lengthy communication with providers for coordination of care). Any procedures or activities that directly result from a telephone encounter should also be documented.

99456 DISABILITY EXAMINATION

Disability assessment (e.g. compensation and pension exam) including history, examination, diagnosis, assessment of capabilities, calculation of impairment, development of treatment plan, expert opinion, and completion of documentation or report.

Procedure Codes and Descriptions-Speech Pathology

The following descriptions are based on the *Current Procedural Terminology* (CPT™).

31505 LARYNGOSCOPY, INDIRECT
Assessment of laryngeal function using indirect laryngoscopy, with interpretation. Use in addition to CPT 92590.

31575 LARYNGOSCOPY, FIBEROPTIC
Assessment of laryngeal function using flexible endoscope, with interpretation. Use this code when speech pathologist actually inserts the endoscope. Use in addition to CPT 92520.

31579 LARYNGOSCOPY, FIBEROPTIC W/ STROBE
Assessment of laryngeal function using flexible or rigid endoscope with stroboscopy, with interpretation. Use this code when speech pathologist actually inserts the endoscope. Use in addition to CPT 92520.

92506 SPEECH/LANGUAGE/HEARING EVALUATION
Evaluation of speech, language, voice, communication, or auditory disorder including aural rehabilitation, individual, with interpretation.

92507 SPEECH/LANGUAGE/HEARING TREATMENT
Treatment of speech, language, voice, communication, and/or auditory disorder including aural rehabilitation, individual, with interpretation.

92508 GROUP EVALUATION/TREATMENT/ACTIVITY
Speech, language, dysphagia, or hearing evaluation or treatment with two or more patients

92511 NASOPHARYNGOSCOPY
Nasopharyngoscopy with fiberoptic endoscope (e.g. VPI, FEES), with interpretation. Procedure may be used only when speech pathologist inserts the endoscope. For instrumental assessment of swallowing disorders, report both the instrument code and the instrumental swallowing assessment code (CPT 92525). If another provider inserts the endoscope, report only the interpretation (CPT 92525).

92512 INSTRUM STUDY OF NASAL FUNCTION
Measurement and interpretation of nasal function using airflow pressure, rhinometry, or nasometry

92520 LARYNGEAL FUNCTION STUDIES
Assessment and interpretation of laryngeal function using aerodynamic, glottographic, or other instrumental means

92525 SWALLOWING EVALUATION
Assessment and interpretation of swallowing function associated with instrumental and non-instrumental (bedside) exam, with interpretation. Use to document interpretation of video-fluoroscopy or endoscopic evaluation of swallowing function (FEES), or electromyographic measurements of swallowing function.

92526 SWALLOWING TREATMENT
Treatment or therapy for swallowing disorders, any method

- 92597 AUGM/ALTERN/PROSTH DEVICE EVAL**
Evaluation for use and/or fitting of voice prosthesis, augmentative or alternative communication devices, prosthetic speech devices, tracheo-esophageal puncture voice prostheses, or electrolarynges. Includes needs assessment, device selection, and ordering, processing, and shipping. For check out for prosthetic use and device orientation for speech prosthetic devices, use CPT 97703.
- 92598 MODIFY AUGM/ALTERN/PROSTH DEVICE**
Modification or adjustment of voice prosthesis, augmentative or alternative communication device, or other prosthetic speech device. Includes modification, adjustment, or replacement of tracheo-esophageal puncture voice prosthesis.
- 92599 UNLISTED ENT PROCEDURE**
Used to document any audiology or speech procedure not elsewhere classified.
- 96105 APHASIA ASSESSMENT, PER HOUR**
Assessment of expressive and receptive aphasia, language function, language comprehension, speech production, reading, spelling, writing, etc. using diagnostic aphasia test with interpretation and report. Enter one code for each hour of care provided.
- 97703 SPEECH/HEAR PROSTH DEVICE ORIENTATION, 15 MIN**
Patient education, device orientation, and verification of readiness to use speech, hearing, alternative, or augmentative communication prosthetic devices and hearing aids, each 15 minutes. Includes device fitting, adjustment, orientation, and measurement of benefit or outcome. Enter one code for each 15 minutes of care.
- 99002 PRODUCT DISPENSING/HANDLING**
Handling, conveyance, and/or any other service connecting with the implementation of an order involving devices (e.g. designing, fitting, packaging, handling, delivery or mailing) when devices such as orthotics, protective devices, or prosthetics are fabricated by an outside laboratory or shop but are to be fitted and adjusted by the provider. Includes electronic ordering and processing or prosthetic orders (e.g. ROES).
- 99070 SPECIAL SUPPLIES**
Supplies and materials dispensed over and above those normally included with an office visit (e.g. batteries, hearing parts and accessories, TEP supplies). For ordering, shipping, and handling, use CPT 99002.
- 99071 EDUCATIONAL SUPPLIES**
Educational supplies such as books, tapes, or pamphlets provided for patient education. Does not include instructions or pamphlets provided by the manufacturer packaged with items such as hearing aids or assistive, augmentative, or alternative speech or hearing devices.
- 99075 EXPERT TESTIMONY/OPINION**
Research, preparation and presentation of aural or written testimony or expert opinion in legal or adjudication proceedings (e.g. court testimony or affidavits).
- 99078 GROUP PATIENT EDUCATION**
Patient education rendered in a group situation. This code is used when patients have established symptoms or illnesses. For education of patients without established illness, use preventive medicine codes.

99080 SPECIAL REPORTS/CHART REVIEW

Review of chart beyond normal documentation (e.g. certification of disability, case management, or care plan oversight)

99211 E&M, OUTPATIENT EST

Use to document professional services to outpatients who have been seen by the provider or the provider's group practice within the past three (3) years. Office or outpatient visit, established patient. Problem of minimal complexity. Non-physician code.

99371 TELEPHONE CALL, BRIEF

Telephone contact with patient or for consultation or management or for coordinating management with other providers, simple or brief (e.g. report on tests findings, to clarify or alter patient instructions, to integrate new information from other providers into treatment plan, or to adjust therapy). Any procedures or activities that directly result from a telephone encounter should also be documented.

99372 TELEPHONE CALL, INTERMEDIATE

Telephone contact with patient or for consultation or management or for coordinating management with other providers, intermediate (e.g. to provide advice to established patients on a new problem, to initiate therapy over the telephone, discuss test findings in detail, to coordinate management of new problem on established patient, to discuss and evaluate new information and details, or to initiate new plan of care). Any procedures or activities that directly result from a telephone encounter should also be documented.

99373 TELEPHONE CARE, COMPLEX

Telephone contact with patient or for consultation or management or for coordinating management with other providers, complex or lengthy (e.g. lengthy counseling with patient, detailed/prolonged discussion with family members, lengthy communication with providers for coordination of care). Any procedures or activities that directly result from a telephone encounter should also be documented.

99456 DISABILITY EXAMINATION

Disability assessment (e.g. compensation and pension exam) including history, examination, diagnosis, assessment of capabilities, calculation of impairment, development of treatment plan, expert opinion, and completion of documentation or report.

CPT Modifiers

CPT modifiers are used to indicate that a procedure or service has been altered in some way but the basic definition of the procedure or service is not changed. Modifiers are used in the following circumstances: (1) a procedure or service has both a professional and technical component and one or the other is reported, (2) the procedure was performed by more than one provider, (3) the procedure or service was performed more than once (for procedures that are not time-based), (4) the procedure or service was increased or reduced, (5) only part of the procedure was performed, or (6) when unusual events occur. The following CPT Modifiers are mapped to each CPT code.

22 UNUSUAL PROCEDURAL SERVICES

Enter this modifier when the service is greater than typically required for the procedure.

26 PROFESSIONAL COMPONENT

Some procedures have a professional and technical component. When the professional component is reported separately, enter this modifier. Use the TC modifier when reporting the technical component.

50 BILATERAL PROCEDURE

Unless otherwise noted, indicate a bilateral procedure with this modifier. For example, most audiometric procedures are assumed to be bilateral.

51 MULTIPLE PROCEDURES

When multiple procedures are performed during the same encounter by the same provider, the primary procedure is entered as listed. Additional procedures are entered along with this modifier. If the same procedure is repeated by the same provider, use modifier -76.

52 REDUCED SERVICES

Enter this modifier if a procedure is reduced or partially eliminated at the provider's discretion without changing the code definition. For example, enter this modifier if an audiometric procedure is done on one ear only.

53 DISCONTINUED PROCEDURE

Enter this modifier if a procedure is terminated at the provider's discretion.

59 DISTINCT PROCEDURE

Enter this modifier to indicate services or procedures are distinct from or independent of other procedures performed the same day. This modifier may be used to identify procedures that are not normally reported together, to indicate a separate session, or to evaluate or treat a separate organ system or condition on the same day.

76 REPEAT PROCEDURE BY SAME PROVIDER

Enter this modifier when a procedure is repeated by the same provider. For example, if a procedure is repeated, one does not enter a volume of two. One enters the original code followed by the same code and the -76 modifier. This modifier is used to indicate volumes greater than one for non time-based procedures. Some procedures (e.g. 97703 or 96105) are time-based, i.e. one code is entered for each specified block of time. Most A&SP procedures are not time-based.

77 REPEAT PROCEDURE BY ANOTHER PROVIDER

Enter this modifier when a procedure is repeated by a separate provider.

99 MULTIPLE MODIFIERS

Enter this modifier to indicate multiple modifiers. The 99 modifier is added to the original code. Additional modifiers are entered as appropriate.

TC TECHNICAL COMPONENT

Enter this code when reporting only the technical component of a procedure. For example, when the results are interpreted by a physician, the procedure itself is reported as a technical component.

HCPCS Level II Codes

Note: HCPCS Level II, or national, codes are published annually by the Health Care Financing Administration (HCFA). Because CPT codes do not describe many non-physician services and supplies, or devices, HCFA lists these codes to supplement CPT codes. Each level II code consists of a letter and four digits (e.g., V5008). Audiology and Speech pathology products and services start with the letter "V". Some speech pathology devices are found in the orthotic and prosthetic devices (Section L) or medical and surgical supplies (Section A).

V5008	Hearing screening
V5010	Assessment for hearing aid
V5011	Fitting/orientation/checking of hearing aid
V5014	Repair/modification of hearing aid
V5020	Real-ear measurements
V5030	Hearing aid, monaural, body, air
V5040	Hearing aid, monaural, body, bone
V5050	Hearing aid, monaural, ITE
V5060	Hearing aid, monaural, BTE
V5070	Hearing aid, eyeglass, air
V5080	Hearing aid, eyeglass, bone
V5090	Dispensing fee, unspecified hearing aid
V5100	Hearing aid, bilateral, body
V5110	Dispensing fee, bilateral
V5120	Hearing aid, binaural, body
V5130	Hearing aid, binaural, ITE
V5140	Hearing aid, binaural, BTE
V5150	Hearing aid, binaural, eyeglass
V5160	Dispensing fee, binaural
V5170	Hearing aid, CROS, ITE
V5180	Hearing aid, CROS, BTE
V5190	Hearing aid, CROS, eyeglass
V5200	Dispensing fee, CROS
V5210	Hearing aid, BICROS, ITE
V5220	Hearing aid, BICROS, BTE
V5230	Hearing aid, BICROS, eyeglass
V5240	Dispensing fee, BICROS
V5299	Hearing service, miscellaneous
V5336	Repair/modification of augmentative/communication device
V5362	Speech screening
V5363	Language screening
V5364	Dysphagia screening
L8501	Speaking valve
A4625	Tracheostomy care kit, new patient
A4629	Tracheostomy care kit, established patient
A4481	Tracheostomy filter
A4621	Tracheostomy mask
A4622	Tracheostomy or laryngectomy tube
A4623	Tracheostomy inner cannula replacement

HCPCS Level II Code Book. ©1999 St. Anthony Publishing, Inc.

Problem CODES

Audiology

<u>ICD-9CM Code</u>	<u>Descriptor</u>
380.4	Impacted cerumen
381.60	Obstructed Eustachian tube
381.7	Patulous Eustachian tube
384.20	Perforation of tympanic membrane NOS
384.21	Central perforation of tympanic membrane
384.22	Attic perforation of tympanic membrane
384.25	Total perforation of tympanic membrane
384.81	Healed tympanic membrane perforation
385.23	Ossicular discontinuity
386.0	Meniere's Disease NOS
386.11	Benign paroxysmal positional vertigo
386.12	Vestibular neuronitis
386.2	Vertigo, central
386.53	Hypoactive labyrinth, unilateral
386.54	Hypoactive labyrinth, bilateral
386.55	Loss of labyrinthine reactivity, unilateral
386.56	Loss of labyrinthine reactivity, bilateral
387.9	Otosclerosis, unspecified
388.01	Presbycusis
388.12	Noise-induced hearing loss
388.2	Sudden hearing loss, unspecified
388.31	Tinnitus, subjective
388.43	Impairment of auditory discrimination
388.44	Recruitment
388.71	Otalgia
388.9	Other disorder of ear
389.01	Conductive hearing loss, external ear
389.02	Conductive hearing loss, tympanic membrane
389.03	Conductive hearing loss, middle ear
389.04	Conductive hearing loss, inner ear
389.08	Conductive hearing loss, combined type
389.11	Sensory hearing loss
389.12	Neural hearing loss
389.13	Central hearing loss
389.18	Sensorineural hearing loss, combined type
389.2	Mixed hearing loss
389.8	Other hearing loss
780.4	Dizziness

Speech Pathology

<u>ICD9-CM Code</u>	<u>Descriptor</u>
290.0	Senile dementia, uncomplicated
290.10	Presenile dementia, uncomplicated
290.40	Atherosclerotic dementia, uncomplicated

291.1	Alcohol amnestic syndrome
291.2	Other alcohol dementia
292.83	Drug-induced amnestic syndrome
293.0	Confusional state, acute delirium
293.1	Confusional state, subacute delirium
294.0	Amenstic syndrome
294.1	Dementia in conditions classified elsewhere
310.0	Stuttering
310.1	Cognitive change, non-psychotic
310.1	Mild memory disturbance
315.0	Reading disorder
315.1	Dyscalculia
315.01	Alexia
315.02	Developmental dyslexia
315.31	Developmental aphasia
315.31	Expressive aphasia
315.32	Receptive language disorder
315.4	Dyspraxia
438.0	Late effects of CV disease, cognitive
438.11	Late effects of CV disease, aphasia
438.12	Late effects of CV disease, dysphasia
438.19	Late effects of CV disease, other speech/language
438.81	Late effects of CV disease, apraxia
438.82	Late effects of CV disease, dysphagia
478.3	Vocal fold paralysis
478.31	Vocal fold paralysis, unilateral partial
478.32	Vocal fold paralysis, unilateral complete
478.33	Vocal fold paralysis, bilateral partial
478.34	Vocal fold paralysis, bilateral complete
478.4	Vocal fold polyp
507.0	Aspiration pneumonia
783.0	Anorexia
783.3	Abnormal weight loss
784.3	Aphasia
784.4	Voice disturbance
784.41	Aphonia
784.49	Hoarseness
784.5	Dysarthria
784.5	Speech disturbance, acquired dysfluency
784.61	Symbolic dysfunction, alexia and dyslexia
784.69	Symbolic dysfunction, acalculia
784.69	Symbolic dysfunction, apraxia
784.69	Symbolic dysfunction, agnosia
787.2	Dysphagia

Supplemental Codes

<u>ICD9-CM Code</u>	<u>Descriptor</u>
V19.2	Family history of hearing loss
V40.1	Problem with communication (speech)
V41.2	Problems with hearing

V41.3	Other hearing problems
V41.4	Problems with voice production
V41.6	Problems swallowing or mastication
V52.8	Fitting AND adjustment of OTHER SPECIFIED prosthetic device
V53.2	Hearing aid adjustment
V55.0	Tracheostomy care
V57.3	Speech therapy
V65.2	Non-organic condition
V65.5	Normal function
V70.5	Occupational hearing screening
V70.5	C&P exam

St. Anthony's ICD-9-CM Code Book for Physician Payment. ©1997 St. Anthony Publishing Company, Inc.

X. Using CPT Modifiers

This chapter contains examples of the use of the CPT modifiers.

Example #1-Repeat Procedure by Same Provider (Modifier 76)

Modifier 76 is used to indicate that a procedure is repeated by the same provider. This modifier applies to codes that are not time-based. A time-based code is one which has a specified time period (e.g., 15 minutes). The volume of the procedure indicates how much time was spent with the patient. For example, 97703 is time-based with a period of 15 minutes. If the patient was seen for 30 minutes, the volume of two would be entered. Most Audiology and Speech Pathology procedures are *complexity-based*. In other words, it is not appropriate to enter a volume greater than one for a complexity-based code. If circumstances warrant, modifiers are used to indicate that the procedure was repeated, increased in complexity, decreased in complexity, or discontinued.

```
Select DIAGNOSTIC CODE: 389.18 <RET>
  ..OK? Yes// <RET> YES
Is this the Primary Diagnosis ?: Y <RET> YES
Select DIAGNOSTIC CODE: <RET>

Service Classifications
AGENT-ORANGE RADIATION ENVIRONMENTAL-CONTAMINANTS

Was care related to AO Exposure ?: N <RET> NO
Was care related to IR Exposure ?: N <RET> NO
Was care related to EC Exposure ?: N <RET> NO

Suggested CDR Account :2611.00 REHABILITATIVE & SUPPORTIVE SERVICES

CDR ACCOUNT: 2611.00// <RET> REHABILITATIVE & SUPPORTIVE SERVICES

PRIMARY PROVIDER: SMITH, JOHN <RET> JS
Select SECONDARY PROVIDER: <RET>
STUDENT: <RET>
Select PROCEDURE CODE: 92557 <RET> COMPREHENSIVE HEARING TEST
  Select CPT MODIFIER: <RET>
  VOLUME: 1// <RET>
```

Note: The volume has a default of one. This procedure is not time based; therefore the volume is always one. Only time-based codes (e.g. 97703) have volumes greater than one. When a procedure is repeated, a modifier is necessary. See below:

```
PROCEDURE PROVIDER: SMITH, JOHN// <RET> JS
Select PROCEDURE CODE: 92565 <RET> STENGER TEST, PURE TONE
  Select CPT MODIFIER: <RET>
  VOLUME: 1// <RET>
PROCEDURE PROVIDER: SMITH, JOHN// <RET> JS
Select PROCEDURE CODE: "92565" <RET> STENGER TEST, PURE TONE
```

Note: The procedure code is repeated and must be placed inside quotation marks.

```
Select CPT MODIFIER: 76 <RET> REPEAT PROCEDURE BY SAME PHYSICIAN
```

Modifier 76 is used to indicate that the procedure is repeated by the same provider. If the procedure is repeated by another provider, use modifier 77.

```
CPT MODIFIER: 76// <RET>
Select CPT MODIFIER: <RET>
VOLUME: 1// <RET>
PROCEDURE PROVIDER: SMITH, JOHN// <RET>
Select PROCEDURE CODE: <RET>
TIME SPENT (minutes): 60 <RET>
```

Example #2-Repeat Procedure by Other Provider (Modifier 77)

Modifier 77 is used to indicate that a procedure is repeated by another provider. This modifier applies to codes that are not time-based. A time-based code is one which has a specified time period (e.g., 15 minutes). The volume of the procedure indicates how much time was spent with the patient. For example, 97703 is time-based with a period of 15 minutes. If the patient was seen for 30 minutes, the volume of two would be entered. Most Audiology and Speech Pathology procedures are *complexity-based*. In other words, it is not appropriate to enter a volume greater than one for a complexity-based code. If circumstances warrant, modifiers are used to indicate that the procedure was repeated, increased in complexity, decreased in complexity, or discontinued.

```
Select DIAGNOSTIC CODE:      389.18 <RET>
      ...OK? Yes// <RET> YES
Is this the Primary Diagnosis ?: Y <RET> YES
Select DIAGNOSTIC CODE: <RET>

Service Classifications
AGENT-ORANGE RADIATION ENVIRONMENTAL-CONTAMINANTS

Was care related to AO Exposure ?: N <RET> NO
Was care related to IR Exposure ?: N <RET> NO
Was care related to EC Exposure ?: N <RET> NO

Suggested CDR Account :2611.00 REHABILITATIVE & SUPPORTIVE SERVICES

CDR ACCOUNT: 2611.00// <RET> REHABILITATIVE & SUPPORTIVE SERVICES
PRIMARY PROVIDER: SMITH, JOHN <RET> JS
Select SECONDARY PROVIDER: JONES, ANDREA <RET> AJ
Select SECONDARY PROVIDER: <RET>
STUDENT: <RET>
Select PROCEDURE CODE: 92557 <RET> COMPREHENSIVE HEARING TEST
      Select CPT MODIFIER: <RET>
      VOLUME: 1// <RET>
```

Note: The volume has a default of one. This procedure is not time based; therefore the volume is always one. Only time-based codes (e.g. 97703) have volumes greater than one. When a procedure is repeated, a modifier is necessary. See below:

```
PROCEDURE PROVIDER: SMITH, JOHN// <RET> JS
Select PROCEDURE CODE: 92565 <RET> STENGER TEST, PURE TONE
      Select CPT MODIFIER: <RET>
      VOLUME: 1// <RET>
PROCEDURE PROVIDER: SMITH, JOHN// <RET> JS
Select PROCEDURE CODE: "92565" <RET> STENGER TEST, PURE TONE
```

Note: The procedure code is repeated and must be placed inside quotation marks.

```
Select CPT MODIFIER: 77 <RET> REPEAT PROCEDURE BY ANOTHER PHYSICIAN
```

Modifier 77 is used to indicate that the procedure is repeated by another provider. If the procedure is repeated by the same provider, use modifier 76.

```
CPT MODIFIER: 77// <RET>
Select CPT MODIFIER: <RET>
VOLUME: 1// <RET>
PROCEDURE PROVIDER: SMITH, JOHN// JONES, ANDREA <RET> AJ
Select PROCEDURE CODE: <RET>
TIME SPENT (minutes): 60 <RET>
```

Example #3-Reduced Services (Modifier 52)

Modifier 52 is used to indicate that a procedure has decreased complexity. The most common usage of this modifier is in audiological procedures done on one ear only. Audiology CPT codes assume that procedures are done on both ears, unless otherwise noted.

```
Select DIAGNOSTIC CODE: 389.18 <RET>
  ..OK? Yes// <RET> YES
Is this the Primary Diagnosis ?: Y <RET> YES
Select DIAGNOSTIC CODE: <RET>

Service Classifications
AGENT-ORANGE RADIATION ENVIRONMENTAL-CONTAMINANTS

Was care related to AO Exposure ?: N <RET> NO
Was care related to IR Exposure ?: N <RET> NO
Was care related to EC Exposure ?: N <RET> NO

Suggested CDR Account :2611.00 REHABILITATIVE & SUPPORTIVE SERVICES

CDR ACCOUNT: 2611.00// <RET> REHABILITATIVE & SUPPORTIVE SERVICES
PRIMARY PROVIDER: SMITH, JOHN <RET> JS
Select SECONDARY PROVIDER: <RET>
STUDENT: <RET>
Select PROCEDURE CODE: 92557 <RET> COMPREHENSIVE HEARING TEST
  Select CPT MODIFIER: 52 <RET>

Note: Modifier 52 is used when a procedure or service is partially reduced or
eliminated at the provider's discretion. For example, audiometric procedures
assume that both ears are evaluated. If only one ear is tested, modifier 52 is entered
to reflect the reduced level of service.
  CPT MODIFIER: 52// <RET>
  Select CPT MODIFIER: <RET>
  VOLUME: 1// <RET>
  PROCEDURE PROVIDER: SMITH, JOHN// <RET> JS
Select PROCEDURE CODE: <RET>
TIME SPENT (minutes): 60 <RET>
```

Example #4-Unusual Procedural Services (Modifier 22)

Modifier 22 is used to indicate increased complexity. Users should refer to the relative value unit (RVU) for the procedure before using this modifier. For example, if the listed RVU is 30 minutes but the complexity of history, assessment, decision making, coordination of care, counseling, or interpretation significantly exceeded the recommended RVU, then modifier 22 should be entered.

RVUs are available in the *A&SP Product Code Manual* which can be accessed on the A&SP Website at [VA National Audiology & Speech Pathology Service](http://152.128.6.2/audio-speech/index.htm) (<http://152.128.6.2/audio-speech/index.htm>) or obtained from your local DSS Office.

```
Select DIAGNOSTIC CODE: 438.82 <RET> OTH LATE EFFECT CEREB DIS DYSPHAGIA
..OK? Yes// <RET> YES
Is this the Primary Diagnosis ?: Y <RET> YES
Select DIAGNOSTIC CODE: <RET>
```

```
Service Classifications
AGENT-ORANGE RADIATION ENVIRONMENTAL-CONTAMINANTS
```

```
Was care related to AO Exposure ?: N <RET> NO
Was care related to IR Exposure ?: N <RET> NO
Was care related to EC Exposure ?: N <RET> NO
```

```
Suggested CDR Account :2611.00 REHABILITATIVE & SUPPORTIVE SERVICES
```

```
CDR ACCOUNT: 2611.00// <RET> REHABILITATIVE & SUPPORTIVE SERVICES
PRIMARY PROVIDER: SMITH, JOHN <RET> JS
Select SECONDARY PROVIDER: <RET>
STUDENT: <RET>
Select PROCEDURE CODE: 92525 <RET> ORAL FUNCTION EVALUATION
Select CPT MODIFIER: 22 <RET>
```

Note: Modifier 22 is used to indicate a level of service greater than normally associated with the procedure. For example, if the complexity of the evaluation and/or interpretation significantly exceeded the relative value for the procedure, modifier 22 may be used.

```
CPT MODIFIER: 22// <RET>
Select CPT MODIFIER: <RET>
VOLUME: 1// <RET>
PROCEDURE PROVIDER: SMITH, JOHN// <RET> JS
Select PROCEDURE CODE:<RET>
TIME SPENT (minutes): 90 <RET>
```

Example #5-Multiple Procedures (Modifier 51)

Modifier 51 is used to indicate that multiple procedures, other than evaluation and management services, are performed by the same provider during the same encounter. This modifier should not be used with procedures that are normally reported together. For example, in an audiological test battery, one would not use this modifier. In this example, modifier 51 is used to show that aphasia assessment and treatment were performed during the encounter.

```
Select DIAGNOSTIC CODE: 784.3 <RET> APHASIA
...OK? Yes// <RET> YES
Is this the Primary Diagnosis ?: Y <RET> YES
Select DIAGNOSTIC CODE: <RET>
```

```
Service Classifications
AGENT-ORANGE RADIATION ENVIRONMENTAL-CONTAMINANTS
```

```
Was care related to AO Exposure ?: N <RET> NO
Was care related to IR Exposure ?: N <RET> NO
Was care related to EC Exposure ?: N <RET> NO
```

```
Suggested CDR Account :2611.00 REHABILITATIVE & SUPPORTIVE SERVICES
```

```
CDR ACCOUNT: 2611.00// <RET> REHABILITATIVE & SUPPORTIVE SERVICES
PRIMARY PROVIDER: SMITH, JOHN <RET> JS
Select SECONDARY PROVIDER: <RET>
STUDENT: <RET>
Select PROCEDURE CODE: 92507 <RET> SPEECH HEARING THERAPY
Select CPT MODIFIER: <RET>
VOLUME: 1// <RET>
```

Note: The volume has a default of one. This procedure is not time based; therefore the volume is always one. If the procedure is repeated by the same provider, modifier 76 is entered (example #1). If the procedure is repeated by another provider, modifier 77 is used (example #2).

```
PROCEDURE PROVIDER: SMITH, JOHN// <RET> JS
Select PROCEDURE CODE: 96105 <RET> APHASIA ASSESSMENT
Select CPT MODIFIER: 51 <RET> MULTIPLE PROCEDURES
CPT MODIFIER: 51// <RET>
Select CPT MODIFIER: <RET>
VOLUME: 1// 2 <RET>
```

Note: The volume may be greater than one since 96105 is a time-based code. This code is entered for each 60 minutes of care. In this case, the aphasia assessment took two hours. Modifier 51 is used to show that multiple procedures were done, in this case both aphasia treatment and assessment. Note that the modifier is added to the second and all subsequent procedures.

```
PROCEDURE PROVIDER: SMITH, JOHN// <RET> JS
Select PROCEDURE CODE: <RET>
TIME SPENT (minutes): 180 <RET>
```

Example #6-Distinct Procedural Service (Modifier 59)

Modifier 59 is used only when other modifiers are not appropriate. The most common usage of modifier 59 is to indicate that two or more procedures that are not normally reported together were performed during the same encounter. The procedures may represent a different session on the same day, a different procedure, or a different organ system. Modifier 59 is used only when no other modifier is appropriate.

```
Select DIAGNOSTIC CODE: 784.3 <RET> APHASIA
...OK? Yes// <RET> YES
Is this the Primary Diagnosis ?: Y <RET> YES
Select DIAGNOSTIC CODE: 784.41 <RET> APHONIA
...OK? Yes// <RET> YES
```

```
Service Classifications
AGENT-ORANGE RADIATION ENVIRONMENTAL-CONTAMINANTS
```

```
Was care related to AO Exposure ?: N <RET> NO
Was care related to IR Exposure ?: N <RET> NO
Was care related to EC Exposure ?: N <RET> NO
```

```
Suggested CDR Account :2611.00 REHABILITATIVE & SUPPORTIVE SERVICES
```

```
CDR ACCOUNT: 2611.00// <RET> REHABILITATIVE & SUPPORTIVE SERVICES
PRIMARY PROVIDER: SMITH, JOHN <RET> JS
Select SECONDARY PROVIDER: <RET>
STUDENT: <RET>
Select PROCEDURE CODE: 92507 <RET> SPEECH HEARING THERAPY
Select CPT MODIFIER: <RET>
VOLUME: 1// <RET>
```

Note: The volume has a default of one. This procedure is not time based; therefore the volume is always one. If the procedure is repeated by the same provider, modifier 76 is entered (example #1). If the procedure is repeated by another provider, modifier 77 is used (example #2).

```
PROCEDURE PROVIDER: SMITH, JOHN// <RET> JS
Select PROCEDURE CODE: 92598 <RET> MODIFY VOICE PROSTHESIS
Select CPT MODIFIER: 59 <RET> DISTINCT PROCEDURAL SERVICE
CPT MODIFIER: 59// <RET>
Select CPT MODIFIER: <RET>
VOLUME: 1// <RET>
```

Note: Modifier 59 is used to indicate that a procedure used distinct from or independent of another procedure performed the same day by the same provider. This modifier usually indicates that two or more procedures that are not normally performed together were performed. This may represent a different session, a different procedure, or evaluation or assessment of a different organic system. Modifier 59 should not be used when other more appropriate modifiers apply .

```
PROCEDURE PROVIDER: SMITH, JOHN// <RET> JS
Select PROCEDURE CODE: <RET>
TIME SPENT (minutes): 180 <RET>
```

Example #7-Discontinued Procedure (Modifier 53)

Modifier 53 is used to indicate that a procedure was terminated or discontinued at the provider's discretion. Procedures may be discontinued because the patient cannot tolerate the procedure or the procedure cannot be completed due to technical difficulties.

```
Select DIAGNOSTIC CODE: 389.18 <RET>
...OK? Yes// <RET> YES
Is this the Primary Diagnosis ?: Y <RET> YES
Select DIAGNOSTIC CODE: <RET>

Service Classifications
AGENT-ORANGE RADIATION ENVIRONMENTAL-CONTAMINANTS

Was care related to AO Exposure ?: N <RET> NO
Was care related to IR Exposure ?: N <RET> NO
Was care related to EC Exposure ?: N <RET> NO

Suggested CDR Account :2611.00 REHABILITATIVE & SUPPORTIVE SERVICES

CDR ACCOUNT: 2611.00// <RET> REHABILITATIVE & SUPPORTIVE SERVICES
PRIMARY PROVIDER: SMITH, JOHN <RET> JS
Select SECONDARY PROVIDER: <RET>
Select SECONDARY PROVIDER: <RET>
STUDENT: <RET>
Select PROCEDURE CODE: 92557 <RET> COMPREHENSIVE HEARING TEST
Select CPT MODIFIER: <RET>
VOLUME: 1// <RET>
PROCEDURE PROVIDER: SMITH, JOHN// <RET> JS
Select PROCEDURE CODE: 92567 <RET>
Select CPT MODIFIER: 53 <RET>

Note: Modifier 53 is used to show that the procedure was terminated at the
provider's discretion. For example, if a procedure was not tolerated by the patient,
one would enter the procedure code followed by modifier 53.
CPT MODIFIER: 53// <RET>
Select CPT MODIFIER: <RET>
VOLUME: 1// <RET>
PROCEDURE PROVIDER: SMITH, JOHN// <RET> JS
Select PROCEDURE CODE: <RET>
TIME SPENT (minutes): 60 <RET>
```

Example #8-Multiple Modifiers (Modifier 99)

Modifier 99 is used to indicate that multiple modifiers are used to describe a procedure. In this example, a procedure required an unusual degree of complexity but was terminated at the provider's discretion.

```
Select DIAGNOSTIC CODE: 438.82 <RET> OTH LATE EFFECT CEREB DIS DYSPHAGIA
...OK? Yes// <RET> YES
Is this the Primary Diagnosis ?: Y <RET> YES
Select DIAGNOSTIC CODE: <RET>
```

```
Service Classifications
AGENT-ORANGE RADIATION ENVIRONMENTAL-CONTAMINANTS
```

```
Was care related to AO Exposure ?: N <RET> NO
Was care related to IR Exposure ?: N <RET> NO
Was care related to EC Exposure ?: N <RET> NO
```

```
Suggested CDR Account :2611.00 REHABILITATIVE & SUPPORTIVE SERVICES
```

```
CDR ACCOUNT: 2611.00// <RET> REHABILITATIVE & SUPPORTIVE SERVICES
PRIMARY PROVIDER: SMITH, JOHN <RET> JS
Select SECONDARY PROVIDER: <RET>
STUDENT: <RET>
Select PROCEDURE CODE: 92525 <RET> ORAL FUNCTION EVALUATION
Select CPT MODIFIER: 99 <RET>
```

Note: Modifier 99 is added to the basic procedure.

```
CPT MODIFIER: 99// <RET>
Select CPT MODIFIER: 22 <RET>
```

Note: Modifier 22 is used to indicate a level of service greater than normally associated with the procedure. For example, if the complexity of the evaluation and/or interpretation significantly exceeded the relative value for the procedure, modifier 22 may be used.

```
CPT MODIFIER: 22// <RET>
Select CPT MODIFIER: 53 <RET>
```

Note: Modifier 53 is used to show that the procedure was terminated at the provider's discretion. For this example, an unusually complex procedure was not tolerated by the patient. Modifier 99 and 53 are entered.

```
CPT MODIFIER: 53// <RET>
Select CPT MODIFIER: <RET>
VOLUME: 1// <RET>
PROCEDURE PROVIDER: SMITH, JOHN// <RET> JS
Select PROCEDURE CODE:<RET>
TIME SPENT (minutes): 90 <RET>
```

Example #9-Professional Component (Modifier 26)

Modifier 26 is used only for codes that have technical and professional components. The following CPT codes have professional and technical components: 92541, 92542, 92543, 92544, 92545, 92546, 92548, 92585, 92587, 92588, 95920. When the technical component of the procedure is performed by one provider (e.g. a technician) but the interpretation of the results is performed by another provider, the interpretation is indicated using modifier 26. The technical component of the procedure is indicated by modifier TC.

```
Select DIAGNOSTIC CODE:      389.18 <RET>
      ...OK? Yes// <RET> YES
Is this the Primary Diagnosis ?: Y <RET> YES
Select DIAGNOSTIC CODE: <RET>

Service Classifications
AGENT-ORANGE  RADIATION  ENVIRONMENTAL-CONTAMINANTS

Was care related to AO Exposure ?: N <RET> NO
Was care related to IR Exposure ?: N <RET> NO
Was care related to EC Exposure ?: N <RET> NO

Suggested CDR Account :2611.00  REHABILITATIVE & SUPPORTIVE SERVICES

CDR ACCOUNT: 2611.00// <RET>      REHABILITATIVE & SUPPORTIVE SERVICES
PRIMARY PROVIDER: SMITH, JOHN <RET>      JS
Select SECONDARY PROVIDER: <RET>
Select SECONDARY PROVIDER: <RET>
STUDENT: <RET>
Select PROCEDURE CODE: 92585 <RET>      AUDITORY EVOKED POTENTIALS
      Select CPT MODIFIER: 26 <RET>

Note: Modifier 26 is used to indicate that the professional component of a procedure is reported separately. Some procedures (e.g., 92585) have both technical and professional components. For example, if a technician performed the actual recordings but the audiologist interpreted the results, the interpretation would be entered with modifier 26. The technical component would be entered with the TC modifier with the technician as the provider.
      CPT MODIFIER: 26// <RET>
VOLUME: 1// <RET>
      PROCEDURE PROVIDER: SMITH, JOHN// <RET>      JS
Select PROCEDURE CODE: <RET>
TIME SPENT (minutes): 60 <RET>
```

XI. Guide to Cost Distribution Reporting

A. Algorithm

There is substantial variability from station to station in the way in which the Cost Distribution (RCS 10-0141) Report is prepared. The method by which the QUASAR RCS 10-0141 Report is prepared herein will foster greater uniformity in cost distribution reporting.

The algorithm implemented in this package is as follows:

1. User is prompted to enter TOTAL PAID HOURS.
2. User is prompted to enter HOURS to be credited to ADMINISTRATIVE SUPPORT and CONTINUING EDUCATION (subaccounts .13 and .14) and to RESEARCH (subaccounts .21 and .22). Please note that the user may optionally choose to enter a TOTAL number of hours to be credited to these subaccounts and then let the computer equally distribute those hours across the various cost accounts OR the user may choose to enter the number of hours to be assigned to each of the pertinent cost accounts. Usually, the equal distribution method is used only when there are no hours to be distribution in Administrative Support, Continuing Education, or Research accounts.
3. User is prompted to enter HOURS to be credited to the various PASS-THROUGH ACCOUNTS.
4. The computer TOTALS pass-through hours, research hours, administrative support, and continuing education hours.
5. The computer SUBTRACTS the total in STEP 4 from TOTAL PAID HOURS which the user entered in STEP 1.
6. That is, the computer sums the PROCEDURE TIME for patient visits which have been entered during the reporting period and then computes the percentage of the total patient care hours (in proportion to the total hours of patient care) associated with each of the CDR cost centers.

B. Explanation of CDR Codes

For guidance, the following narrative was excerpted from the *CDR Handbook--A Guide for Preparing the Cost Distribution Report* (April 1996 revision).

The cost accounting system in the VA is designed to produce cost information on a functional or organizational level. However, management requires a further distribution to reflect the cost of patient care provided through the VA medical system. This information has, in the past, been used as backup data for budget support to the Congress and for developing interagency and tort reimbursement rates for inpatient and outpatient services furnished by the VA. The source of this patient care cost data is the RCS 10-0141.

Additional uses have been found for the CDR data, the most recent being as a cost base for Resource Allocation. The Resource Planning and Management (RPM) process is designed to fully integrate VHA planning, management, and budget. Although not yet fully implemented, RPM data is reflected in the Fiscal year 1995 facility Target Allowance. When fully implemented, RPM will be used both in the facility Target Allowances and in the actual budget submission to OMB (Office of Management and Budget) and the Congress.

Each Service Chief is responsible for developing a percentage distribution of his/her Service's costs. A Service may have more than one cost center. Each Service Chief must make a conscientious effort to provide the most accurate distribution data possible for each cost center for which they have responsibility. Designated responsible officials should develop percentage distributions of time spent and all other costs pertinent to each bed section and outpatient care area. The official RCS 10-0141 Handbook is available from Fiscal Service at each medical center. The Handbook is composed of Chapter One which contains general instructions as well as account definitions, and cost center specific instructions in the remaining chapters. Additional guidance is available from the facility CDR Coordinator or the CDR Liaison Group via FORUM mail group G.CDRTS as well as VA Central Office Program Officials.

Baseline reporting, where appropriate, is the recommended method for developing distribution percentages. A yearly sampling should be performed, with periodic reviews and adjustments to update program and staffing information if required throughout the fiscal year. The most accurate method for developing that information would be to make a name listing of each employee in the cost center and distribute his/her time actually spent in the various categories.

C. Definitions

1. **COST CENTER:** A functional or organizational level of responsibility used for classifying and accumulating costs, e.g., Medical Service, Surgical Service, Sanitation Operations. The 200 series of cost centers are assigned to direct medical care-- VA facilities; 400 series are assigned to administrative services; 500 series are assigned to Engineering and Building Management; and 600 series are assigned to miscellaneous benefits. All costs are reported in the CALM 830 Report by cost center. It should be pointed out that cost centers are not synonymous with fund control points.
2. **COSTS:** The dollar amount of goods and services received and/or expended during the report month.
3. **CALM 830 REPORT:** A Fiscal Service report which captures, on a cumulative basis, personal service and all other costs by cost center.
4. **DISTRIBUTION CATEGORIES:** These are specific categories in the RCS 10-0141 which are designed to measure the treatment cost of inpatient and outpatient care, both VA and non-VA. The distribution accounts identify the major categories of cost.

(1) Major Cost Categories:

<u>Category</u>	<u>Account Series</u>
Inpatient-VA	1000.00
Outpatient-VA	2000.00
Inpatient-Non-VA	3000.00

Outpatient-Non-VA	4000.00
Off-facility Programs-VA	5000.00
Miscellaneous Benefits & Services	6000.00
Interstation Transfers	7000.00
Services Furnished Other Than VHA	8000.00

(2) Subdivisions of Inpatient-VA:

<u>Category</u>	<u>Account Series</u>
Medical Bed Section	1100.00
Surgical Bed Section	1200.00
Psychiatric Bed Section	1300.00
VA Nursing Home Care Bed Section	1400.00
Domiciliary Care Bed Section	1500.00
Intermediate Care Bed Section	1600.00
Psychiatric Residential Rehabilitation Treatment Program	1700.00

(3) Account Suffix Codes:

Unassigned	.00
Satellite Outpatient Clinics	.01
Community-Based Clinics	.02
Outreach & Mobile Outreach Clinics	.03
Education and Training	
Trainee Payroll (includes contract)	.11
Instructional Support - Trainees	.12
Administrative Support - Trainees	.13
Continuing Education	.14
Research Support	
Medical Research	.21
Prosthetic Research	.22
Administrative Support	.30
Building Management Support	.40
Engineering Support	.50
Equipment Depreciation	.70
Building Depreciation	.80

D. Inpatient-VA

1110.00 General Medicine

All costs incurred in the examination, diagnosis, and treatment of diseases/disorders of inpatients admitted to a general medical bedsection, including cardiology, gastroenterology, immunology, dermatology, endocrinology, infectious diseases, pulmonary diseases, etc., as well as the costs of other medical disorders. (Excludes the costs associated with those bed sections designated by accounts 1111.00 through 1120.00 and 1610.00 and 1620.00)

1111.00 Neurology

All costs incurred in the examination, diagnosis, and treatment of diseases/disorders of inpatients admitted to the neurology bed section, including strokes, aphasia, multiple sclerosis, etc.

1113.00 Rehabilitation

All costs incurred in the evaluation and treatment of diseases/disorders of inpatients admitted to the rehabilitation medicine beds section.

1114.00 Epilepsy Center

All costs incurred in the diagnosis, treatment, and medical intervention of inpatients admitted to an epilepsy bed section/center. This account is restricted to VACO-approved sites.

1115.00 Blind Rehabilitation

All costs incurred in the diagnosis, treatment and medical intervention of inpatients admitted to a blind rehabilitation bedsection, including the costs incurred in providing personal and social adjustment training/services to the blind in adapting to their environments. This account is restricted to VACO approved Blind Rehabilitation Center and Blind Clinic sites.

1116.00 Spinal Cord Injury

All costs incurred in the diagnosis, treatment, and medical intervention of inpatients admitted to a spinal cord injury bedsection, including treatments/services such as intensive rehabilitation care, sustaining care, and long-term care.

1116.01 SCI Substance Abuse (Inpatient)

All costs incurred in the evaluation and treatment for substance abuse among spinal cord injury patients. This account is restricted to VAMC Bronx.

1117.00 Medical Intensive Care Units

All costs incurred for inpatients admitted to a medical and/or coronary intensive care unit as well as a general purpose intensive care unit. A general intensive care unit is defined as a unit using designated intensive care beds interchangeably for more than one type of patient (e.g., medical, coronary, surgical).

1118.00 Inpatient Dialysis

Includes all direct costs incurred for inpatient dialysis treatments associated with acute or chronic renal failure. The treatment counts are limited to one per day per patient; units are entered through on-line entry into Austin. Treatments include peritoneal dialysis, hemodialysis, and other hemoperfusion. Does include all dialysis treatments for poisons/overdoes. Does not include therapeutic plasma exchange (plasmapheresis) treatments for non renal-related conditions.

Direct costs for this account include all medications related to the dialysis treatment (i.e., saline, heparin, albumin) and other issued to the dialysis unit. Does not include prescriptions/medications specifically issued to individual patients (i.e., vancomycin, EPO, TPN). Does not include laboratory cost for individual patients.

Cost distribution to this account is limited to the following cost centers:

- 201 Medicine
- 211 Dialysis
- 221 Social Work
- 224 Pharmacy
- 241 Nursing Service
- 243 Dietetic
- 281 Supply Processing & Distribution
- 285 Ward Administration

1119.00 Inpatient AIDS

All costs incurred for inpatients admitted to an AIDS bed section. This account is only applicable to New York, Miami, and West Los Angeles VAMCs.

1120.00 Geriatric Evaluation and Management (GEM) Unit - Medical Beds

All costs incurred in the diagnosis, treatment, and medical intervention of GEM inpatients admitted to acute medicine, neurology, and rehabilitation; patient treating specialty codes 31, 34, and 35.



Note: Units for GEM - Medical Beds may be identified as acute medicine, neurology, or rehabilitation days of care. It will be necessary to adjust units for CDR accounts 1100.00, 1111.00, and 1113.00 to prevent duplicate reporting of days of care. The On-line Units screen will display accounts 1121.00, 1122.00, and 1123.00 in place of GEM account 1120.00. Enter units for acute medicine GEM into account 1121.00; units for rehabilitation into account 1122.00; and units for neurology GEM into account 1123.00.

1121.00 Geriatric Evaluation and Management (GEM) Unit - Acute Medicine

1122.00 Geriatric Evaluation and Management (GEM) Unit - Rehabilitation

1123.00 Geriatric Evaluation and Management (GEM) Unit - Neurology

1130.00 Primary Care - Medicine

All costs incurred in the examination, diagnosis, and treatment of diseases/disorders of inpatients admitted to general medicine bed sections, including cardiology, gastroenterology, immunology, dermatology, endocrinology, infectious disease, pulmonary diseases, etc., as well as the costs of other medical disorders, if the admission is a result of or, in conjunction with outpatient Primary Care. (Excludes the costs associated with those bed sections designated by accounts 1100.00 through 1120.00 and 1610.00.) The PTF Code number related to this account is 23.

1210.00 Surgical Ward Cost

All costs incurred in the examination, diagnosis and treatment of diseases/disorders of inpatients admitted to a surgical bed section, including general surgery, urology, orthopedics, vascular, neurosurgery, plastic, thoracic, transplantation, etc.

1211.00 Surgical Intensive Care Unit

All costs incurred for inpatients admitted to an approved and designated surgical intensive care unit. (Excludes the costs incurred for surgical patients admitted/transferred to a general purpose unit- refer to account 1117.00.)

1212.00 Operating/Recovery Room

All costs incurred in the operative treatment of disease, performed in the operating room as well as the costs provided to patients in the recovery room. (Excludes the costs of pre/post operative treatment and services provided on a general ward, as well as the operating/recovery room costs incurred for procedures involving open heart surgery.) Also excludes the cost of ambulatory procedures performed in the operating room. Workload equates to one unit per patient procedures in the Operating Room. This account is for reporting inpatient workload only.

1213.00 Open Heart Surgery

All direct care costs incurred in the operating room and the recovery room for open heart surgical procedures. (Excludes the costs of pre/post operative treatment and services provided on a general ward, as well as the operating/recovery room costs incurred for procedures other than open heart surgery and cardiac catheterization.) Only inpatient cost and workload are to be reported to this account.

1230.00 Primary Care - Surgery

All costs incurred in the examination, diagnosis and treatment of diseases/disorders of inpatients admitted to a surgical bed section, including general surgery, urology, orthopedics, vascular, neurosurgery, plastic, thoracic, transplantation, etc., if the admission is a result of or, in conjunction with outpatient Primary Care. (Excludes the costs associated with accounts 1210.00 through 1213.00.) The PTF Code number related to this account is 64.

1310.00 High Intensity General Psychiatric Inpatient Unit

All direct care costs incurred in the diagnosis and treatment of psychiatric diseases/disorders for inpatients admitted to a high intensity psychiatry inpatient unit with workload not

reported elsewhere in the Psychiatric inpatient unit with workload not reported elsewhere in the Psychiatric inpatient accounts.

1311.00 General Intermediate Psychiatry

All direct care costs incurred in the care, treatment and support of inpatients in locally designated subacute psychiatry beds other than substance abuse. The length of stay is expected to be under 90 days.

1312.00 Substance Abuse Intermediate Care

All direct care costs incurred in the care, treatment and support of inpatients in a locally designated subacute substance abuse psychiatry bed. The length of stay is expected to be under 90 days.

1313.00 Substance Abuse Treatment Program - High Intensity

All direct care costs incurred in the diagnosis and treatment of inpatients admitted to a VACO approved (reporting on an inpatient substance abuse AMIS segment) drug, alcohol, or combined alcohol and drug treatment unit.

1314.00 Specialized Inpatient PTSD (SIPU) - Intermediate Care

All direct care costs incurred in a VACO approved SIPU which provides comprehensive treatment for PTSD.

1315.00 Evaluation/Brief Treatment PTSD Unit (EBTPU) - High Intensity

All direct care costs incurred in a VACO approved EBTPU unit providing short-term PTSD care.

1316.00 STAR I, II, & III Programs Sustained Treatment and Rehabilitation

All direct care costs incurred in the care, treatment and support of inpatients in a locally designated sustained treatment and rehabilitation psychiatric bed, other than substance abuse. The length of stay is usually greater than 90 days.

1317.00 Substance Abuse STAR I, II, & III Programs Sustained Treatment and Rehabilitation

All direct care costs incurred in the care, treatment and support of inpatients in a locally designated substance abuse sustained treatment and rehabilitation psychiatric bed. These programs will usually involve patients with significant psychiatric and/or medical comorbidities. The length of stay is usually greater than 90 days.

1320.00 Geriatric Evaluation and Management (GEM) Unit - Psychiatry Beds

All costs incurred in the diagnosis, treatment, and medical intervention of GEM inpatients admitted to psychiatry; patient treating specialty code 33.

1330.00 Primary Care - Psychiatric

All costs incurred in the examination, diagnosis and treatment of disease/disorders of inpatients admitted to a psychiatric bed section. (Excludes the costs associated with accounts 1310.00 through 1320.00.) The PTF Code number related to this account is 78.

1410.00 VA Nursing Home Care

All costs incurred in the care and treatment of inpatients in VA nursing home care units.

1420.00 Geriatric Evaluation and Management (GEM) Unit - VA Nursing Home

All costs incurred in the diagnosis, treatment, and medical intervention of GEM inpatients admitted to VA Nursing home care; patient treating specialty code 81.

1510.00 Domiciliary Bed Section

All costs incurred in the care and treatment of inpatients in VA domiciliaries. Costs of special programs for Domiciliary patients will be reported to the appropriate 1511.00 or 1512.00 account. Cost of care provided to Domiciliary patients in an outpatient setting will be charged to the appropriate Ambulatory Care distribution account. All domiciliary patient days will be included as work units for this account. Total work units for the Domiciliary account section will be the units for this account.

1511.00 Domiciliary Substance Abuse

A VACO approved Domiciliary program funded with Mental Health & Behavior Sciences Service (MH&BSS) enhancement funds to provide substance abuse treatment and rehabilitation on a designated number of Domiciliary beds. Only substance abuse treatment costs provided by enhancement moneys or staffing enhancements provided locally should be costed to this account. The patient days will be included in CDR account 1510.00 as domiciliary days and also reported in 1511.00.

1512.00 Domiciliary - PTSD

A VACO approved Domiciliary program funded with MH&BSS enhancement funds to provide PTSD treatment and rehabilitation on a designated number of Domiciliary beds. Only PTSD services rendered by enhancement staff or local staffing enhancements should be costed to this account. The patient days will be included in CDR account 1510.00 as domiciliary days and also reported in 1511.00.

1520.00 Geriatric Evaluation and Management (GEM) Unit - Domiciliary

All costs incurred in the diagnosis, treatment, and medical intervention of GEM inpatients admitted to the domiciliary; patient treating specialty code 87.

1610.00 Intermediate Care

All direct care costs incurred in the care, treatment, and support of inpatients in VACO approved intermediate medicine beds.

1620.00 Geriatric Evaluation and Management (GEM) Unit - Intermediate Care

All costs incurred in the diagnosis, treatment, and medical intervention of GEM inpatients admitted to intermediate care; patient treating specialty code 32.

1711.00 PR RTP (PTSD Residential Rehabilitation Treatment Program)

A VACO approved PR RTP focusing on the treatment and rehabilitation of PTSD patients.

1712.00 PR RTP (PTSD Residential Rehabilitation Program)

A VACO approved PR RTP focusing on the treatment and rehabilitation of PTSD patients.

1713.00 SAR RTP (Substance Abuse Residential Rehabilitation Treatment Program)

A VACO approved PR RTP focusing on the treatment and rehabilitation of substance abuse patients.

1714.00 HCM I CWT/TR (Homeless Chronically Mentally Ill Compensated Work Therapy/Transitional Residences)

A VACO approved PR RTP focusing on patients suffering from homelessness and chronic mental illness. All services provided, including CWT, must be costed to this account.

1715.00 SA CWT/TR (Substance Abuse Compensated Work Therapy/Transitional Residences)

A VACO approved PR RTP focusing on patients with substance abuse problems. All services provided, including CWT, must be costed to this account.

E. Outpatient - VA

General Comments: The distribution accounts listed below should be utilized to report direct costs associated with outpatient care provided at VA facilities (.00); VA satellite outpatient clinics (.01); VA community-based clinics (.02); outreach and mobile outreach clinics (.03). With the exception of Domiciliary patients, a facility cannot receive workload credit for any inpatient care provided in an outpatient setting); therefore, costs should be charged to the appropriate bed section. Any questions concerning the appropriateness of distributing costs to these accounts should be referred to the Facility CDR Coordinator or the CDR Liaison Group via FORUM mail group G.CDRTS.

 **Note:** All CPT codes have been activated for national use. This will require all cost associated with CPTs to be distributed to account 2211.xx. If your VAMC does not chose to use the full range of CPTs, then the cost of clinic stops that do not result in reported CPTs will continue to be distributed to the appropriate CDR outpatient account while the cost of clinic stops that result in reported CPTs will be distributed to CDR account 2211.xx.

2110.00 Medicine
2110.01 Medicine - SOC
2110.02 Medicine - CBC
2110.03 Medicine - ORC

The cost of diagnostic and/or therapeutic care related to general medicine and provided in the clinic stoops listed below. (Excludes the costs incurred for ambulatory special procedures which are reported in account 2211.00.)

301 - General Internal Medicine
302 - Allergy Immunology
303 - Cardiology
304 - Dermatology
305 - Endocrinology/Metabolic
306 - Diabetes
307 - Gastroenterology
308 - Hematology
309 - Hypertension
310 - Infectious Disease
311 - Pacemaker
312 - Pulmonary/Chest
313 - Renal/Nephrology
314 - Rheumatology/Arthritis
315 - Neurology
316 - Oncology/Tumor
317 - Coumadin Clinic
318 - Geriatric Clinic
319 - Geriatric Evaluation & Management (GEM) Clinic
320 - Alzheimer's/Dementia Clinic
321 - GI Endoscopy
322 - Women's Clinic

2111.00 Admitting/Screening
2111.01 Admitting/Screening - SOC
2111.02 Admitting/Screening - CBC
2111.03 Admitting/Screening - ORC

All costs incurred in the admitting and/or screening of patients. Includes the following clinic stops:

101 - Emergency Unit
102 - Admitting/Screening

2130.00 Outpatient Primary Care - Medicine
2130.01 Outpatient Primary Care - Medicine - SOC
2130.02 Outpatient Primary Care - Medicine - CBC
2130.03 Outpatient Primary Care - Medicine - ORC

All costs of diagnostic and therapeutic care related to general medicine and provided in the clinic listed below. (Excludes the costs incurred for ambulatory special procedures which are reported in account 2211.00.)

323 - Primary Care/Medicine

2210.00 Surgery
2210.01 Surgery - SOC
2210.02 Surgery - CBC
2210.03 Surgery - ORC

The cost of diagnostic and/or therapeutic care related to surgical outpatients and provided in the clinics listed below. (Excludes the costs incurred for ambulatory special procedures which are reported in account 2211).

401 - General Surgery
402 - Cardiac Surgery
403 - ENT
404 - Gynecology
405 - Hand Surgery
406 - Neurosurgery
407 - Ophthalmology
408 - Optometry
409 - Orthopedics
410 - Plastic Surgery
411 - Podiatry
412 - Proctology
413 - Thoracic Surgery
414 - Urology
415 - Vascular Surgery
416 - Ambulatory Surgery Office
419 - Anesthesia Pre-Op Consult
420 - Pain clinic
421 - Vascular Lab
422 - Cast Clinic

426 - Women Surgery

- 2211.00 Ambulatory Special Procedures
- 2211.01 Ambulatory Special Procedures - SOC
- 2211.02 Ambulatory Special Procedures - CBC
- 2211.03 Ambulatory special Procedures - ORC

All costs of diagnostic and therapeutic care related to surgery and provided in the clinic listed below. (Excludes the costs incurred for ambulatory special procedures that are reported in account 2211.00.)

427 - Primary Care/Surgery

- 2310.00 Special Psychiatry
- 2310.01 Special Psychiatry - SOC
- 2310.02 Special Psychiatry - CBC
- 2310.03 Special Psychiatry - ORC

The cost of diagnostic and/or therapeutic care related to special psychiatric outpatient activity and provided in the clinic stops listed below.

- 516 - PTSD - Group
- 521 - Long-Term Enhancement - Group
- 550 - Mental Health Clinic - Group
- 553 - Day Treatment - Group
- 554 - Day Hospital - Group
- 557 - Psychiatry - Group
- 558 - Psychology - Group
- 573 - Incentive Therapy
- 574 - Compensated Work Therapy
- 575 - Vocational Assistance

- 2311.00 General Psychiatry
- 2311.01 General Psychiatry - SOC
- 2311.02 General Psychiatry - CBC
- 2311.03 General Psychiatry - ORC

The cost of diagnostic and/or therapeutic care related to general psychiatric outpatient activity and provided in the clinic stops listed below.

- 502 - Mental Health Clinic - Individual
- 505 - Day Treatment - Individual
- 506 - Day Hospital - Individual
- 509 - Psychiatry - Individual
- 510 - Psychology - Individual
- 512 - Psychiatry Consultation
- 515 - CWT/TR-HCMI
- 520 - Long-Term Enhancement - Individual
- 524 - sexual Trauma Counseling - Women Veterans
- 525 - Women's Stress Disorder Treatment Teams
- 529 - HCHV/HMI
- 562 - PTSD - Individual

2313.00 PTSD Clinical Team
2313.01 PTSD Clinical Team - SOC
2313.02 PTSD Clinical Team - CBS
2316.03 PTSD Clinical Team - ORC

This account is restricted to VACO approved sites. Includes all direct care costs associated with a facility's post traumatic stress disorder clinical care provided in the following clinic:

540 - PCT-Post Traumatic Stress

2316.00 Substance Abuse Dependence - OP
2316.01 Substance Abuse Dependence - OP - SOC
2316.02 Substance Abuse Dependence - OP - CBC
2316.03 Substance Abuse Dependence - OP - ORC

All direct costs associated with an outpatient substance abuse program. All Services providing care in the following clinics should distribute FTEE and costs to this account.

507 - Drug Dependence - Individual
508 - Alcohol Treatment - Individual
513 - Substance Abuse - Individual
514 - Substance Abuse - Home Visit
517 - CWT/Substance Abuse
518 - CWT/TR - Substance Abuse
522 - HUD-VASH
523 - Methadone Maintenance
555 - Drug Dependence - Group
556 - Alcohol Treatment - Group
560 - Substance Abuse - Group

2317.00 Substance Abuse Disorder (SUPS)
2317.01 Substance Abuse Disorder (SUPS) - SOC
2317.02 Substance Abuse Disorder (SUPS) - CBC
2317.03 Substance Abuse Disorder (SUPS) - ORC

This account is restricted to VACO approved sites. Includes the cost of diagnostic and/or therapeutic care related to substance abuse disorder and provided by a PTSD Team in the following clinic stop:

519 - Substance Use Disorder/PTSD Teams

2330.00 Outpatient Primary Care - Special Psychiatric Treatment
2330.01 Outpatient Primary Care - Special Psychiatric Treatment - SOC
2330.02 Outpatient Primary Care - Special Psychiatric Treatment - CBC
2331.03 Outpatient Primary Care - Special Psychiatric Treatment -ORC

All costs of diagnostic and therapeutic care related to special psychiatric outpatient activity and provided in the clinic listed below. (Excludes the costs incurred for ambulatory special procedures which are reported in account 2211.00.)

563 - Primary Care/Spec.Psy

2331.00 Outpatient Primary Care - General Psychiatric Treatment
2331.01 Outpatient Primary Care - General Psychiatric Treatment -SOC
2331.02 Outpatient Primary Care - General Psychiatric Treatment -CBC
2331.03 Outpatient Primary Care - General Psychiatric Treatment -ORC

All costs of diagnostic and therapeutic care related to general psychiatric outpatient activity and provide in the clinic listed below. (Excludes the costs incurred for ambulatory special procedures which are reported in account 2211.00.)

531 - Primary Care/General Psy

2410.00 Dialysis
2410.10 Dialysis - SOC

Includes all direct costs of outpatient dialysis treatment for the clinic stops listed below:

602 - Chronic Assisted Hemodialysis Treatment
603 - Limited Self Care Hemodialysis Treatment
604 - Home/Self Hemodialysis Treatment
606 - Chronic Assisted Peritoneal Dialysis
607 - Limited Self Care Peritoneal Dialysis
608 - Home/Self Peritoneal Dialysis Training

The treatment counts will be one for each hemodialysis treatment and one for each day of dialysis for peritoneal dialysis. Exclude the costs of dialysis treatment for inpatients (reported to CDR account 1118.00.)

Direct costs for this account include dialysis staff, all medications related to the dialysis treatment (i.e., saline, lidocaine, heparin) and supplies issued to the dialysis unit. does not include prescriptions/medications specifically issued to individual patients (these costs reported in the CDR account 2613.00 series). Includes dialysis-related, patient-specific, laboratory costs and other laboratory costs for the unit (i.e., bacteriologic test on water).

Cost distribution to this account is limited to the following cost centers:

201 - Medicine
211 - Dialysis
221 - Social Work
223 - Laboratory
224 - Pharmacy
241 - Nursing Service
243 - Dietetic
281 - Supply Processing & Distribution
285 - Ward Administration
286 - Ambulatory Care Administration

2510.00 Adult Day Health Care
2510.01 Adult Day Health Care - SOC
2510.02 Adult Day Health Care - CBC
2510.03 Adult Day Health Care - ORC

All direct costs associated with the VA staff care and treatment of the Adult Day Health Care (ADHC) patients and provided in the following clinic:

190 - Adult Day Health Care

2610.00 Ancillary Services

2610.01 Ancillary Services - SOC

2610.02 Ancillary Services - CBC

2610.03 Ancillary Services - ORC

The cost of ancillary services in support of diagnosis and/or treatment of outpatients provided in the following clinic stops:

117 - Nursing

120 - Health Screening

122 - Public Health Nursing

123 - Nutrition/Dietetics/Individual

124 - Nutrition/Dietetics/Group

125 - Social Work Service

160 - Clinical Pharmacy

165 - Bereavement Counseling

166 - Chaplain Service - Individual

167 - Chaplain Service - Group

168 - Chaplain Service - Collateral

999 - Employee Health

2611.00 Rehabilitative and Supportive Services

2611.01 Rehabilitative and Supportive Services - SOC

2611.02 Rehabilitative and Supportive Services - CBC

2611.03 Rehabilitative and Supportive Services - ORE

The cost of rehabilitation services in support of the diagnosis and/or treatment of outpatients provided in the following clinic stops:

201 - Rehabilitative Medicine

202 - Recreation Therapy Service

203 - Audiology

204 - Speech Pathology

205 - Physical Therapy

206 - Occupational Therapy

207 - PM&RS Incentive Therapy

208 - PM&RS Compensated Work Therapy

209 - VIST Coordinator

210 - Spinal Cord Injury

211 - Amputation Follow-up Clinic

212 - EMG - Electromyogram

213 - PM&RS Vocational Assistance

214 - Kinesiotherapy

2612.00 Diagnostic Services

2612.01 Diagnostic Services - SOC

2612.02 Diagnostic Services - CBC

2612.03 Diagnostic Services - ORC

The cost of diagnostic services in support of the diagnosis and/or treatment of outpatients provided in the following clinic stops:

- 104 - Pulmonary Function
- 105 - X-Ray
- 106 - EEG
- 107 - EKG
- 108 - Laboratory
- 109 - Nuclear Medicine
- 115 - Ultrasound
- 126 - Evoked Potential
- 127 - Topographical Brain Mapping
- 128 - Prolonged Video EEG Monitoring
- 144 - Radionuclide Therapy
- 145 - Pharmacology/Physiologic Nuclear Myocardial Perfusion Studies
- 146 - PET

2613.00 Pharmacy

- 2613.01 Pharmacy - SOC
- 2613.02 Pharmacy - CBC
- 2613.03 Pharmacy - ORC

The costs of pharmacy services incurred in the diagnosis and/or treatment of outpatients (Excludes the costs of staff/FTEE assigned to a clinical pharmacy outpatient clinic--clinic stop 160 which is reported to account 2610.)

2614.00 Prosthetics/Orthotics

- 2614.01 Prosthetics/Orthotics -SOC
- 2614.02 Prosthetics/Orthotics - CBC
- 2614.03 Prosthetics/Orthotics - ORC

The cost of prosthetic/orthotic services in support of the diagnosis and/or treatment of outpatients provided in the following clinic stops:

- 417 - Prosthetic/Orthotics
- 418 - Amputation Clinic
- 423 - Prosthetic Services

2616.00 SCI Substance Abuse (Outpatient)

All costs incurred in the evaluation and treatment for substance abuse among spinal cord injury patients. This account is restricted to VAMC Bronx, NY.

2710.00 Dental Procedures

- 2710.01 Dental Procedures - SOC

The total costs of all outpatient examination and treatment procedures (other than those procedures which produce a CPT code) performed by Dental staff. For CDR purposes the units are CTVs from the DAS 270 report. Dental visits are captured in stop code 180 and telephone dental in stop code 181. The stop count, instead of the CTVs, is used in the total outpatient units.

2750.00 Domiciliary Aftercare - VA

The total costs of all visits of discharged domiciliary patients to a VA domiciliary follow-up clinic for care as part of a domiciliary discharge plan.

Includes the following clinic stop:

727 - Domiciliary Aftercare - VA

2780.00 Telephone Contacts

Includes all direct costs associated with telephone consultation between the patient and VA clinical/professional staff regarding case management, advice, referral, etc., for the following clinic stops:

- 103 - Telephone/Triage
- 147 - Telephone/Ancillary
- 148 - Telephone/Diagnostic
- 169 - Telephone/Chaplain
- 178 - HBHC/Telephone
- 181 - Telephone/Dental
- 216 - Telephone/Rehab & Support
- 324 - Telephone/Medicine
- 325 - Telephone/Neurology
- 326 - Telephone/Geriatrics
- 424 - Telephone/Surgery
- 425 - Telephone/Prosthetics/Orthotics
- 526 - Telephone/Special Psychiatry
- 527 - Telephone/General - Psychiatry
- 528 - Telephone/Homeless Mentally Ill
- 530 - Telephone/HUD - VASH
- 542 - Telephone/PTSD
- 546 - Telephone/IPCC
- 611 - Telephone/Dialysis
- 729 - Telephone/Domiciliary

F. Inpatient - Non-VHA

General Comments: The accounts listed below should be utilized to report the costs of non-VA inpatient activity in which no RPM reportable workload is generated/received by the VA facility. Because these services are provided in non-VA facilities, there should be minimal direct care (i.e., 200 cost centers) costs associated or reported to these accounts. Provided below are a few examples of inclusions/exclusions of direct care costs which can and cannot be distributed to these accounts. Any questions concerning the appropriateness of distributing costs to these accounts should be referred to the Facility CDR Coordinator or the CDR Liaison Group via FORUM mail group G.CDRTS.

Inclusions:

- Visits made by VA staff to the non-VA facility to review the patient's condition, treatment, or arrange further placement.
- Review of the patient's bill as part of contract/fee program evaluation.
- Visits made by VA staff to inspect, negotiate, etc., non-VA facilities and services.

Exclusions:

Any activity or service performed in which the patient is an active inpatient at a VA facility (i.e., includes such services and functions as discharge planning coordinating, arranging, scheduling placement/transfer to a non-VA facility; telephone contacts with staff at non-VA facilities; review of medical information pertinent to treatment and services received at non-VA facilities; etc.).

3110.00 Contract Hospital - Medical

All usual and customary charges paid for medical (i.e., cardiology, dermatology, metabolic, infectious diseases, pulmonary, etc.) and other non-surgical inpatient care received by veterans at non-VA hospitals.

3210.00 Contract Hospital - Surgical

All usual and customary charges paid for surgical inpatient care (i.e., ENT, gynecologic, ophthalmologic, orthopedic, proctologic, urologic, surgical, etc.) received by veterans at non-VA hospitals.

3310.00 Contract Hospital - Psychiatric

All usual and customary charges paid for psychiatric inpatient care received by veterans at non-VA hospitals.

3410.00 Community Nursing Home Care

All costs of diagnostic and treatment of patients in contract community nursing homes. Also includes the costs of follow-up visits by VA staff for clinic stop 119 - Community Nursing home Follow-up. Cost center 342 - Nursing Home Care - Community Homes - should distribute 100% to this account.

3411.00 State Home Nursing Home Care

All costs incurred in the care of patients in state home domiciliaries. Cost center 331 - Domiciliary Care - State Homes - should distribute 100% to this account.

3520.00 Contract Homeless Chronically Mentally Ill

Includes all direct care staff and contract costs associated with the contract HCMI program. For CDR purposes, units are locally supplied bed days of care.

3521.00 Contract Alcohol and Drug Treatment and Rehabilitation

Includes all direct care staff and contract costs associated with the Alcohol and Drug Contract Residential Treatment Program (Contract Halfway House). Cost center 361 - Alcohol and Drug Treatment and Rehabilitation - should distribute 100% to this account.

3610.00 State Home Hospital Care

All costs incurred in the care of patients in state home hospitals.

Cost Center 332 - Hospital Care - State Homes - should distribute 100% to this account.

3611.00 Civilian Health and Medical Program (CHAMPVA)

All costs paid by the VA to non-VA institutions for inpatient care provided to VA beneficiaries under the CHAMPVA program.

G. Outpatient - Non-VA

General Comments: The accounts listed below should be utilized to report the costs of non-VA outpatient activity in which no RPM reportable workload is generated/received by the VA facility. Because these services are provided in non-VA facilities, there should be minimal direct care (i.e., 200 cost series) costs associated or reported to these accounts. Two exceptions are account 4111.00 Other Non-VA Outpatient Care which may have substantial radiation therapy charges and account 4613.00 Fee Tests Performed by VA laboratories which covers services provided in VA facilities. Provided below are a few examples of inclusions and exclusions of direct care costs which can and cannot be distributed to these accounts. Any questions concerning the appropriateness of distributing costs of these accounts should be referred to the Facility CDR Coordinator or the CDR Liaison Group via FORUM mail group G.CDRTS.

Inclusions:

- Visits made by VA staff to the non-VA facility to review the patient's condition, treatment, or arrange further placement.
- Costs of contract special services such as radiation therapy, chemotherapy, CAT scans, ambulatory surgery services, blood/blood products trans., nuclear magnetic resonance.
- Review of the patient's medical status/bill as part of contract/fee program evaluation.
- Visits by VA staff to inspect, negotiate, etc., non-VA facilities and services.

Exclusions:

- Any activities or service, performed at the VA medical center, which is considered a cost of doing business such as scheduling, arranging, or coordinating a patient's visit to a non-VA outpatient facility/provider.
- Review of medical information pertinent to treatment and services received at non-VA facilities which is relevant to a patient's visit to an outpatient VA clinic.
- Cost of fee or contract tests which are incident to the treatment of the patient for which outpatient workload credit is taken.

4110.00 Outpatient Care - Fee Medical

All usual and customary charges paid for outpatient fee medical services provided to veterans at non-VA facilities. Cost center 363 (2561) - Outpatient Fee-Basis Medical and Nursing Services - should be distributed 100% to this account.

4111.00 Other Non-VA Outpatient Care

The cost of outpatient services purchased on a contract/fee service basis when the care or service cannot be provided by the VA facility. These services should not generate any reportable RPM workload. This account also includes the costs of various outpatient services not appropriate for distribution to any of the other 4000 series accounts. Examples of expenditures appropriate for distribution to this account include:

- Home Oxygen
- ID Card prosthetic Repair and Replacement
- Contract/Fee for Service Procedures (CAT Scans, Chemotherapy, Radiation Therapy, etc.)

- Non-VA Post-hospital/Outpatient Care for Contract Inpatients (Cost Center 351 - Post-hospital Care - should distribute 100% to this account)

4120.00 Contract Adult Day Health Care

Includes all direct staff and contract costs associated with the Contract Adult Day Health Care Program.

4130.00 Fee Prescriptions Filled by VA Pharmacies

The cost of new and refills of patient prescriptions written by off-station, non-VA physicians which are dispensed by VA pharmacies. Includes prescriptions for non-formulary items dispensed by VA pharmacies.

4610.00 CHAMPVA - OP

All costs paid by the VA to non-VA institutions for outpatient medical care provided to VA beneficiaries under the CHAMPVA program.

4612.00 Non-VA Pharmacies

All costs of authorized prescriptions written by off-station, non-VA physicians for drugs, medications and other medical requisites and tests which are dispensed by non-VA pharmacies directly to the patient. Cost Center 363 (2636) - Outpatient Fee Prescriptions - should distribute 100% to this account. Pharmacy time used to review the billings for these prescriptions is appropriate for distribution to this account.

4613.00 Fee Tests Performed by VA Laboratories

The cost of diagnostic tests requested by off-station, non-VA physicians and performed in VA laboratories.

4710.00 Dental Services - Fee

The actual dollars expended for payment of fee-basis dental examinations and treatment services performed in non-VA facilities during the reporting period. Cost center 363 (2571) - Outpatient Fee Dental Service should be distributed 100% to this account. Dental time used to review the billings for these services is appropriate for distribution to this account.

H. Off-Facility Programs - VA

General Comments: The accounts listed below should be utilized to distribute costs associated with Hospital Based Home Care as well as other various types of home based programs. It should be noted that accounts 51100.00 - Hospital Based Home Care and 5111.00 - Home Dialysis are restricted to VACO approved programs only; however, the other 5000 series accounts may be utilized to distribute costs incurred in these as appropriate.

5110.00 Hospital Based Home Care

All direct care cost (200 series cost centers) of care and treatment furnished to the Hospital Based Home Care (HBHC) patient in the home setting, plus the HBHC coordinators and secretary time required to administer the program. Clinic stop 170 - HBHC records staff visits to the patient at their residence. However, for CDR purposes, the units are bed days of care and are reported through the Austin HBHC program.

 **Note:** Indirect costs associated with the HBHC program are to be distributed to the 5110.30, 5110.40, and 5110.50 accounts rather than the 5000.30, 5000.40, or 5000.50 accounts where other home programs' indirect costs are reported.

5111.00 Home Dialysis

All costs incurred in the home treatment of patients requiring removal of toxic wastes from patients with diseases of the kidneys, or acute poisonings or other toxic or metabolic diseases.

5112.00 Spinal Cord Injury Home Care

Includes all costs of direct patient care provided in the SCI patient's home under the authority of the Spinal Cord Injury Home Care Program. Excludes all costs of care provided the patient as an inpatient or in the outpatient clinics. Also excludes the costs of wheelchairs, special beds, etc., ordered as part of the discharge planning process for an inpatient (chargeable to 1116.00 Spinal Cord Injury) or as the result of an outpatient clinic visit (account 2611.xx Rehabilitative and Supportive Services or 2614.xx Prosthetics/Orthotics).

5113.00 Residential Care Home Program

Includes all authorized patient care expenses incurred by the VA for patients in the Residential Care Home Program. Does not include the expense of the patient staying in the home or the care provided at the VA facility or through any of the fee programs. For CDR purposes, units are locally supplied bed days of care. Staff visits in the community are recorded under the following clinic stops:

- 121 - Residential Care Home Program
- 503 - Residential Care - Individual

5114.00 Other Home Based Programs

All costs of direct patient care provided in a patient's home setting for a home program not specifically identified by another account. Example: the Independent Living Program. No units are reported due to the mixture of programs. Staff visits are recorded in the following clinic stops:

- 118 - Home Treatment Services
- 504 - Community Clinic - Individual
- 551 - Community Clinic - Group
- 552 - Community Day Program

5115.00 Community Based Domiciliary Aftercare/Outreach

All costs relating to case-finding/contact services to homeless veterans and all costs of direct patient care provided to discharged domiciliary patients in the community as part of a domiciliary discharge plan. Includes the following clinic stops:

- 725 - Domiciliary Outreach Services
- 726 - Domiciliary Aftercare - Community

5116.00 Homemaker/Home Health Aide Program

The costs of purchased homemaker/health aide services provided in the patient's home. Units are locally supplied contract homemaker/aide visits to the patient's residence.

Cost Center 343 should be distributed 100% to this account.

5117.00 Intensive Psychiatric Community Care (effective for FY95)

All costs of direct patient care provided by Intensive Psychiatric Community Care (IPCC) programs (specialized interdisciplinary teams to maintain severely psychiatrically disabled veterans in the community). Only VA medical facilities approved to participate in the IPCC program may use this account. Care may be provided at the medical center, a community clinic day program, or in other community sources and localities.

The workload units for this accounts are the following clinic stops:

- 504 - IPCC Medical Center Visit
- 551 - IPCC Community Clinic/Day Program Visit
- 552 - IPCC Community Visit

I. Miscellaneous Benefits and Services

Costs distributed to the miscellaneous accounts (i.e., 6000/7000/8000) are restricted solely for direct and indirect care costs associated with the programs and services listed in the CDR account definitions. Costs reported/distributed to these accounts should not generate any reportable workload for resource allocation purposes. Any questions pertaining to the utilization of these accounts should be referred to the Facility CDR Coordinator or the CDR Liaison Group via FORUM mail group G.CDRTS.

Exclusion List:

An exclusion list of services and activities felt to be inappropriate for distribution to the miscellaneous and non-VHA accounts is provided below. The costs associated with these activities are considered to be a part of a facility's overhead cost of doing business and should be distributed to the appropriate 1000-2000 CDR accounts. The list is not intended to be all inclusive but rather to serve as a reference for clarifying and identifying certain activities inappropriate for distribution to these accounts. Therefore, the omission of an activity from the below list does not necessarily indicate that the cost distribution to these accounts is appropriate.

- Projects, studies, reports, etc., applicable to the operation of the facility (i.e., AMIS, Questionnaires, Pre/Post survey reports, Region required reports, etc.)
- JCAHO, External Peer Review Process (EPRP), IG, and other surveys/audits/reviews
- Preparation and attendance of meetings relevant to the operation of the facility (i.e., all facility committee meetings, Regional Planning Board meetings, TQI/QA meetings, Education meetings, etc.)
- Blood drives, food drives, bond campaigns, CFC, Federal Women's Program, or other such activities
- Community services/activities (i.e., working with local schools, organizations, etc.)
- Support provided to and/or meetings with veteran organizations
- Time in support of VA Regional Offices (i.e., eligibility, means test, C&P exams, processing of correspondence requests, etc.)
- Attendance to workshops, seminars, or other training programs
- Sick leave pending retirement, sabbatical leave, military leave, court leave, etc.
- Time associated with Relocation Expense Program
- On station EEO investigations
- Time in support of Tumor Registry
- Time and costs associated with Employee Health, Employee Assistance, Employee Wellness programs
- Bereavement counseling and the attending of funeral/memorial services of patients
- Other activities associated with care of dead (i.e., autopsies, transcription services, medical media, etc.)
- Coordination/administrative processing of patient transfers and records to both VA and non-VA facilities
- Responding/answering congressional inquiries
- Time spent with visitors, dignitaries. etc.
- Costs and time in support of affiliations (i.e., attending meetings, training of students, etc.)
- Gratuitous meals, meal tickets, etc., for volunteers, WOC trainees, etc.

- Support to non-VA libraries (i.e., ILL and local consortium)

Account Definitions:

6010.00 Other Miscellaneous Benefits and Services

Includes direct and indirect costs associated with the following miscellaneous services and activities. (Note: where referenced, the cost center listed after the program/activity should distribute 100% of their costs to this account; however, this does not preclude other cost centers in support of these activities/programs from utilizing this account.)

- Home Improvement & Structural Alterations - Cost Center 601
- Beneficiary Travel - Cost Center 602
- Care of the Dead - Cost Center 603 only
- Operation & Maintenance of Cemeteries -Cost Center 604 only
- Housekeeping Quarters - Cost Center 621
- Non Housekeeping Quarters - Cost Center 622
- Garages & Parking Facilities - Cost Center 623
- Insurance Claims & Indemnities - Cost Center 631
- Canteen Services - Cost Center 632
- Readjustment Counseling Program (Off-Station)
- Repair of Equipment in a Veteran's home (i.e., only in support of HISA program, includes both VA/contract support)

6011.00 District/Regional/National Support

Includes direct and indirect costs incurred by VAMC in support of the following district, regional, and national programs and offices. Examples of regional support include the current region offices as well as those on a level of the current regional division offices, networks and the former medical district offices. At a minimum, VAMCs with a medical district and/or regional office should distribute the FTTE and salaries of assigned staff to this account.



Note: Where referenced, the cost center listed after the program should distribute 100% of their costs to this account; however, this does not preclude other cost centers in support of these activities/programs from utilizing this account.)

- Prosthetic Distribution Center - Cost Center 265
- Regional Information Systems Center (ISCs) - Cost Center 610
- Administrative Programs - Cost Center 615
- Regional Directors Office - Cost Center 651
- District Directors Office - Cost Center 655

Also includes costs incurred in support of:

- Visual Impairment Services Team (VIST) program where no reportable workload is generated
- EEO investigations performed off station (i.e., includes pre/post administrative review relevant to the investigation)

- Reviews/Audits/Investigations performed by medical center staff off station at the request of District, Region, and/or VACO (i.e., EPRP reviewer, special program investigations, etc.)
- Special task force/committee appointments by the Region and/or VACO which are not considered a part of the facility's operations (i.e., Technical Advisory Groups, CMD's Field Advisory Committee, Data Validation Task Force, CDR Task Force, etc.)
- Time of staff serving as a chairperson for any Regional and/or VACO meeting; however, only the costs and time that are a direct result of the chairperson's duties and responsibilities (i.e., scheduling/coordination of meetings, preparing agendas and minutes, coordinating and arranging meeting accommodations, etc.)
- VACO approved special projects and/or alpha-beta test sites for costs incurred above the normal cost of doing business

6013.00 Continuing Education and Training Programs

Includes the direct and indirect costs associated with or incurred in the support of the following continuing education and training programs. (Note: where referenced, the cost centers listed after the program should distribute 100% of their costs to this account; however, this does not preclude other cost centers in support of these activities/programs from utilizing this account, such as faculty participation or host VAMC support cost.)

- Operation of Regional Medical Education Centers-Cost Center 605
- Regional Police Training Centers-Cost Center 606
- Learning Resources Center-Cost Center 607
- Cooperative Health Manpower Education Programs
- Dental Education Centers
- Engineering Training Centers

As referenced in the exclusion list, the costs of travel, tuition, and time of staff for attendance at one of the above programs should not be reported under this account. These costs should be reported to the .14-continuing education suffix for the appropriate 1000/2000 CDR account.

6015.00 National Center on PTSD

Includes the direct and indirect costs incurred in support of the National Center on PTSD. (Applicable only to VACO approved facilities.)

J. Interstation Transfers

The 7000 accounts listed below are interstation transfer balancing accounts for the costs and FTEE incurred by a VAMC on behalf of another medical center in which there was no transfer of the patient and no workload generated for resource allocation purposes, and/or reimbursement received for the services provided. Examples of services appropriate for cost transfer include but are not limited to the following:

- General Reference Labs
- Central Dental Labs
- Consolidated Mail-Out Pharmaceuticals
- Medical Media Support
- Provision of clinical services by loan or rotation (both recurring and nonrecurring) such as staff which rotate to other facilities (e.g., Chaplain who rotates to other centers to provide Chaplain support)
- Dietetic Services performed for another station

7000.30 Administrative Services

Includes all costs of administering services (i.e., Supply Services, Medical Administration Services, etc.) except those listed below, which are performed for another VAMC.

7000.40 Laundry and Linen Service

Includes all costs of services performed for another VAMC by laundry and linen activities.

7000.50 Engineering Service

Includes the costs of services performed for another VAMC by Engineering Service.

K. Services Furnished Other Than VHA

General Comments: The 8000 series accounts listed below have been established to report the costs of services incurred in support of non-VHA activities. Refer to the general comments and exclusion list, referenced under the miscellaneous benefits and services accounts, for services and activities inappropriate for distribution to these accounts. Any questions concerning the utilization of these accounts should be referred to the Facility CDR Coordinator or the CDR Liaison Group via FORUM mail group G.CDRTS.

8021.00 Services Furnished to Veterans Benefits Admin.(VBA)

This includes administrative, environmental management, and engineering support to field VBA activities. (Excludes the costs of services or C&P exams, veteran service organizations, employee health--refer to exclusion list). Facilities should locally input work units for this account. Work units represent the number of cumulative FTEE on-board at the supported VBA activity through the report period.

8022.00 Services to the National Cemetery System (NCS)

This includes administrative, environmental management, and engineering support to field NCS activities. It does not include the cost of employee health services which should be reported in account 2610.00, Ancillary Services.

8023.00 Services to Other Non-VHA Activities

This includes the support provided other VA and non-VA elements not represented elsewhere. It does not include support costs to Veterans Canteen Service activities which should be distributed to CDR account 6010.00.

There are no work units for account 8023.00.

8024.00 DOD Sharing

This includes the cost of services furnished to DOD under formal sharing agreements pursuant to 38 USC 5011. Services for patients who are entered into the PTF, OPC, and RUGII databases are not included. However, it does include services for lab tests and similar work for which no patient entries to PTF, etc., result.

Facilities should locally input work units for this account. Work units represent the amount of funds billed (not necessarily collected) to DOD for these services rendered during the current fiscal year.

8025.00 Other Sharing

This includes the cost of services furnished to other Federal and non-Federal institutions under the authority of 38 USC 5053 or 5054. It also includes the cost of joint venture agreements completed under the authority of 38 USC. Services for patients who are entered into the PTF, OPC, and RUGII databases are not included.

Facilities should locally input work units for this account. Work units represent the amount of funds billed (not necessarily collected) for services rendered during the current fiscal year.

H. Education and Training

Education and Training cost has four parts: Trainee Salary, Instructional Costs, Administrative Support, and Continuing Education.

.11 Trainee Salary:

The salary cost of the Central Office approved .26 Trainees, or the contract cost of Central Office approved staff contracts.

.12 Instructional:

The salary and other costs of the VA staff that are the instructors for the trainees who make up the Trainee Salary cost plus any WOC trainee of Central Office approved training programs. Contractual services of consultants and lecturers who teach classes for the trainees will also be charged to this account.

.13 Administrative Support:

Refers to the same Central Office approved training programs covered by Trainee Salary and Instructional Cost and inches such support as personnel actions, payroll, books, uniforms, coordination of the program, etc.

.14 Continuing Education:

All costs of travel, tuition, registration, contracts and supplies associated with provision of continuing education to VA staff. Includes the time and supplies used by VA staff to prepare and present a formal class, i.e., an activity where there is a teacher/student relationship. On-the-job training and periodic orientation of new personnel does not qualify as continuing education for RCS 10-0141 purposes, nor does the time of the student attending the formal classroom presentation.

I. Research Support

.21 Medical Research Support

.22 Prosthetic Research Support

Research support is that cost the Medical Care appropriation incurs in support of the Research program. Personnel who spend part of their VA time working on a research project are usually on the Medical Care rolls. If these employees use a portion of their normal duty tour to work on a research project, the cost of that time should be reported as Research Support. Patients may be research subjects and therefore some of the services provided the patient may be required only because of the research project. Administrative support such as personnel, fiscal, supply, maintenance and repair, etc., are provided to the Research program. The cost of this time, supplies, and services should be charged on the RCS 10-0141 as research support.

Research projects may be funded by the Research appropriation, through grants such as NIH, through the General Post Fund. or unfunded. Unfunded does not necessarily mean that the project has no funding. Central Office approves projects as funded, partially funded or unfunded. For the unfunded project to be active, the R&E Committee must fund the project from available funds either by reducing the funding provided projects identified as fully funded or partially funded projects or through savings accrued from funded projects. Another form of unfunded projects is one which requires no funding other than some administrative support like duplication and tabulation of survey forms. After identifying the research projects and the investigators, it is necessary to accurately allocate the investigators time to research support. An investigator on the Medical Care rolls has as their first responsibility the care of the patients. Therefore, a full time physician working 90 hours during the pay period and spending 30 of these hours on a research project would show only 25% of his time as research support rather than 33 1/3%. The reason being that FTEE is calculated on a basis of 80 hours per pay period regardless of how much time is actually worked. The difference between the hours the employee should work and the hours spent in patient care, if due to research, will determine the percentage for research support.

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