



PATIENT FINANCIAL SERVICES SYSTEM (PFSS) – SURGERY

RELEASE NOTES

SR*3*142

SR*3*146

Version 3.0

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Introduction

Patch SR*3*142 is part of the Patient Financial Services System (PFSS) project. PFSS patches are being released on various schedules. PFSS will initially be implemented at select pilot sites ONLY, and some patch functionality will be available only with the initiation of the PFSS On/Off switch. The functionality in this patch, SR*3*142, is activated immediately upon installation, and the features are not controlled by the PFSS On/Off Switch.

Patch SR*3*146 is also included as a part of the release of SR*3*142, and provides a new option for Risk Assessment Nurse Reviewers to alert the coder if there is a question on the Current Procedural Terminology (CPT) or International Classification of Diseases (ICD) codes on a Surgery case.

The following are acronyms that are used in this document:

Acronym	Name
CPT	Current Procedural Terminology
ICD	International Classification of Diseases
PCE	Patient Care Encounter
PFSS	Patient Financial Services System

Overview of Project Enhancements

The software patch SR*3*142 provides the following enhancements:

- The *Update/Verify Procedure/Diagnosis Codes* [SRCODING EDIT] option is modified to represent the final procedure and diagnosis codes.
- A new file, the SURGERY PROCEDURE/DIAGNOSIS CODES file (#136), is created to store coded procedure and coded diagnosis data for a Surgery case, in support of the modified *Update/Verify Procedure/Diagnosis Codes* [SRCODING EDIT] option.
- A post-installation process converts coding data in the SURGERY file (#130) to the new SURGERY PROCEDURE/DIAGNOSIS CODES file (#136) for all completed cases.
- Updates are made to the Surgery/PCE interface to send coding data from the SURGERY PROCEDURE/DIAGNOSIS CODES file (#136), entered through the enhanced *Update/Verify Procedure/Diagnosis Codes* [SRCODING EDIT] option.
- Several Surgery reports and options are modified to use the coder-entered CPT and/or ICD codes from the SURGERY PROCEDURE/DIAGNOSIS CODES file (#136).
- Several Risk Assessment reports and options are modified to use the coder-entered CPT and/or ICD codes from the SURGERY PROCEDURE/DIAGNOSIS CODES file (#136).
- The *Surgery Nightly Cleanup and Updates* [SRTASK-NIGHT] option is modified to remove the background PCE data.

The software patch SR*3*146 provides the following enhancements:

- The *Alert Coder Regarding coding Issues* [SROA CODE ISSUE] option is a new option allowing Nurse Reviewers the opportunity to ask questions regarding possible coding issues.

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Project Enhancements

This section describes the new features, as well as changes to existing functionality, that are included in the patch SR*3*142 and SR*3*146.

Prior to patch SR*3*142, coders used the *Update/Verify Procedure/Diagnosis Codes* [SRCODING EDIT] option, which updated coded data directly in the SURGERY file (#130). However, the SURGERY file (#130) does not currently make a distinction between procedure and diagnosis data entered by clinicians and that data entered by coders. With the existing design, coding a surgical case impacts the clinical data for the patient and may require the coder to create an addendum because each code is directly associated with a free-text procedure or diagnosis entry. The redesign provided by patch SR*3*142 separates final coded procedures and diagnoses from the clinically captured procedures and diagnoses. The final CPT and ICD codes no longer have a one-to-one relationship with the clinically entered free-text information. As a by-product, coders will no longer be required to create an addendum when updating codes.

Modified Surgery Coding Option

The *Update/Verify Procedure/Diagnosis Codes* [SRCODING EDIT] option is modified to allow entry of final billing CPT codes for surgical and non-OR procedures and ICD codes in the SURGERY PROCEDURE/DIAGNOSIS CODES file (#136).



A post-installation process converts coding data in the SURGERY file (#130) to the new SURGERY PROCEDURE/DIAGNOSIS CODES file (#136) for all completed cases. This process is run only once, and will not run again if the patch is re-installed.

Modified features of the *Update/Verify Procedure/Diagnosis Codes* [SRCODING EDIT] option include:

- After a Surgery case is completed (e.g., the Time Pat Out OR field is entered or the Time Proc Ended field is entered), the user can access the case using the *Update/Verify Procedure/Diagnosis Codes* [SRCODING EDIT] option. When the option is first selected for a case, the planned codes entered by clinicians will be auto-populated from the SURGERY file (#130). The coder can then accept or modify the planned codes.
- A principal ICD code and a principal CPT code are required for coding a surgical case, and sending the data to PCE.
- An unlimited number of ICD codes may be entered for other diagnoses and an unlimited number of CPT codes may be entered for other procedures performed.
- Each CPT code entered must be assigned the associated ICD code(s) related to the procedure performed.
- An unlimited number of CPT modifiers may be entered for each CPT code entered.

- For every ICD code entered, the following questions must be answered as appropriate for the patient based upon enrollment indicators:
 - Treatment related to Service Connected condition?
 - Treatment related to Agent Orange Exposure?
 - Treatment related to Ionizing Radiation Exposure?
 - Treatment related to Environmental Contaminant Exposure?
 - Treatment related to Military Sexual Trauma?
 - Treatment related to Head and/or Neck Cancer?
 - Treatment related to Combat?
- Upon completion of coding for a case, the coder is allowed to mark the record as complete and to send the record immediately to PCE. The case is only sent to PCE when flagged as complete within this option.

Modified Surgery Reports and Other Options

The following Surgery reports and options are modified to use the coder-entered CPT and/or ICD codes from the SURGERY PROCEDURE/DIAGNOSIS CODES file (#136):

- *Cumulative Report of CPT Codes* [SROACCT] option
- *List Completed Cases Missing CPT Codes* [SRSCPT] option
- *PCE Filing Status Report* [SRO PCE STATUS] option
- *Report of CPT Coding Accuracy* [SR CPT ACCURACY] option
- *Annual Report of Surgical Procedures* [SROARSP] option
- *Annual Report of Non-OR Procedures* [SRNOP-ANNUAL] option
- *List of Invasive Diagnostic Procedures* [SROQIDP] option
- *Quarterly Report - Surgical Service* [SRO QUARTERLY REPORT] option
- *Report of Missing Quarterly Report Data* [SROQ MISSING DATA] option



The Other CPT Codes field no longer affects the Report of Missing Quarterly Report Data, and references to this field are removed. The display of “I” in the footer of this report is also removed.

The following Surgery reports and options are modified to remove CPT and/or ICD codes from the display:

- *Update Status of Returns within 30 Days* [SRO UPDATE RETURNS] option
- *Update Operations as Unrelated/Related to Death* [SRO DEATH RELATED] option
- *Non-OR Procedure Information* [SR NON-OR INFO] option
- *Deaths Within 30 Days of Surgery* [SROQD] option
- *Admissions Within 14 Days of Outpatient Surgery* [SROQADM] option
- *List of Operations Included on Quarterly Report* [SROQ LIST OPS] option

Modified Risk Assessment Options

The following options are modified to display CPT and ICD codes from the SURGERY PROCEDURE/DIAGNOSIS CODES file (#136):

- *Print a Surgery Risk Assessment* [SROA PRINT ASSESSMENT] option
 - *List of Surgery Risk Assessments* [SROA ASSESSMENT LIST] option
 - *Exclusion Criteria (Enter/Edit)* [SR NO ASSESSMENT REASON] option
 - *Update 1-Liner Case* [SROA ONE-LINER UPDATE] option
 - *Queue Assessment Transmissions* [SROA TRANSMIT ASSESSMENTS] option
-



The new CPT code fields will not be editable from these options:
Exclusion Criteria (Enter/Edit) [SR NO ASSESSMENT REASON] and
Update 1-Liner Case [SROA ONE-LINER UPDATE].

The following options are modified to remove the CPT codes from the screen headings:

- *Preoperative Information (Enter/Edit)* [SROA PREOP DATA] option
 - *Laboratory Test Results (Enter/Edit)* [SROA LAB] option
 - *Operation Information (Enter/Edit)* [SROA OPERATION DATA] option
-



The Principal CPT code and Postoperative Diagnosis fields will not be editable from the
Operation Information (Enter/Edit) [SROA OPERATION DATA] option.

- *Patient Demographics (Enter/Edit)* [SROA DEMOGRAPHICS] option
- *Intraoperative Occurrences (Enter/Edit)* [SRO INTRAOP COMP] option
- *Postoperative Occurrences (Enter/Edit)* [SRO POSTOP COMP] option
- *Clinical Information (Enter/Edit)* [SROA CLINICAL INFORMATION] option
- *Laboratory Test Results (Enter/Edit)* [SROA LAB-CARDIAC] option
- *Enter Cardiac Catheterization & Angiographic Data* [SROA CATHETERIZATION] option

- *Operative Risk Summary Data (Enter/Edit)* [SROA CARDIAC OPERATIVE RISK] option
-



The Principal CPT code and Other CPT Code fields will not be editable from the *Operative Risk Summary Data (Enter/Edit)* [SROA CARDIAC OPERATIVE RISK] option.

- *Cardiac Procedures Operative Data (Enter/Edit)* [SROA CARDIAC PROCEDURES] option
- *Outcome Information (Enter/Edit)* [SROA CARDIAC-OUTCOMES] option
- *Resource Data* [SROA CARDIAC RESOURCE] option

The *Update Assessment Status to 'COMPLETE'* [SROA COMPLETE ASSESSMENT] option is modified to remove the ability to edit CPT and ICD codes.

New Risk Assessment Option

At many sites the Risk Assessment Nurse Reviewers are involved with the HIMS staff in determining the final codes for a Surgery case. A new option allows the Risk Assessment Nurse Reviewer to alert the coder if there is a question on the CPT or ICD codes on a Surgery case.

- The *Alert Coder Regarding Coding Issues* [SROA CODE ISSUE] option displays on both the *Non-Cardiac Assessment Information (Enter/Edit)* [SROA ENTER/EDIT] and *Cardiac Risk Assessment Information (Enter/Edit)* [SROA CARDIAC ENTER/EDIT] menu options.
- This option displays basic surgery case information including Patient, Case Number, Surgery Date, and Procedure and allows the Nurse Reviewer to enter a free text comment field to send coding concerns to the coder, as well as to members of a predefined mail group identified in the CODE ISSUE MAIL GROUP parameter.
- The message will not be sent if there is no coder, or if the mail group is not defined.

Surgery to PCE Interface

The Surgery to PCE interface is modified to send coding data from the SURGERY PROCEDURE/DIAGNOSIS CODES file (#136). The interface now passes data to PCE in real time when the coder completes the coding process for a case.

After a case is filed with PCE, if certain data passed to PCE is changed within the Surgery software, the Surgery to PCE interface sends an update to PCE immediately.

Updates to these fields in the SURGERY file (#130) will send an update to PCE:

- SURGEON
- ATTEND SURG
- PROVIDER
- ATTEND PROVIDER
- TIME PAT IN OR
- TIME PAT OUT OR
- TIME PROCEDURE BEGAN
- TIME PROCEDURE ENDED
- IN/OUT-PATIENT STATUS
- SURGERY SPECIALTY
- NON-OR LOCATION
- OPERATING ROOM
- ASSOCIATED CLINIC
- SERVICE CONNECTED
- AGENT ORANGE EXPOSURE
- IONIZING RADIATION EXPOSURE
- ENVIRONMENTAL CONTAMINANTS
- MILITARY SEXUAL TRAUMA
- HEAD AND/OR NECK CANCER
- COMBAT VET

Because only the data from the SURGERY PROCEDURE/DIAGNOSIS CODES file (#136) is used to update PCE, modifying the following fields, stored in the SURGERY file (#130), does not send an update to PCE.

- PLANNED OTHER PROC CPT CODE
- OTHER ASSOC DIAGNOSIS
- OTHER PREOP DIAGNOSIS
- OTHER POSTOP DIAGS
- PLANNED ICD DIAGNOSIS CODE
- PLANNED PRINCIPAL PROCEDURE CODE
- PRIN ASSOC DIAGNOSIS
- PRIN PRE-OP ICD DIAGNOSIS CODE
- PLANNED PRIN DIAGNOSIS CODE

Other Updates

The *Surgery Nightly Cleanup and Updates* [SRTASK-NIGHT] option is modified as follows:

- Functions that are currently part of the Store Operation Times feature have been updated to use the CPT code fields in the SURGERY PROCEDURE/DIAGNOSIS CODES file (#136).
- The *Surgery Nightly Cleanup and Updates* [SRTASK-NIGHT] option is modified to remove the background PCE data.

File and Field Updates

This section lists the file, field, and input template updates to the Surgery software.

SURGERY PROCEDURE/DIAGNOSIS CODES File (#136) Updates

A new file, the SURGERY PROCEDURE/DIAGNOSIS CODES file (#136), is created to store coded procedure and coded diagnosis data for a Surgery case. Data entered into this file will be the new source of coding data sent by the Surgery package to PCE. Access to this file is restricted and updates should only be made using the *Update/Verify Diagnosis/Procedure Codes* [SRCODING EDIT] option.

SURGERY File (#130) Updates

The following are changes made to the SURGERY file (#130):

- The PRINCIPAL CPT CODE field (#27) and the OTHER CPT CODE field (#3, sub-file #130.16) are modified to include the word 'PLANNED'.
- The PRIN DIAGNOSIS CODE field (#66) and the OTHER POSTOP ICD DIAGNOSIS CODE field (#3 of sub-file #130.18) are modified to include the word 'PLANNED'.

The following fields in the SURGERY file (#130) are modified for data dictionary updates:

- PATIENT field (#.01)
- IN/OUT-PATIENT STATUS field (#.011)
- SERVICE CONNECTED field (#.016)
- AGENT ORANGE EXPOSURE field (#.017)
- IONIZING RADIATION EXPOSURE field (#.018)
- ENVIRONMENTAL CONTAMINANTS field (#.019)
- OPERATING ROOM field (#.02)
- ASSOCIATED CLINIC field (#.021)
- MILITARY SEXUAL TRAUMA field (#.022)
- HEAD AND/OR NECK CANCER field (#.023)
- COMBAT VET field (#.024)
- SURGERY SPECIALTY field (#.04)
- SURGEON field (#.14)
- ATTEND SURG field (#.164)
- TIME PAT IN OR field (#.205)
- TIME PAT OUT OR field (#.232)
- PRIN PRE-OP ICD DIAGNOSIS CODE field (#32.5)
- PRIN DIAGNOSIS CODE field (#66)
- NON-OR LOCATION field (#119)
- TIME PROCEDURE BEGAN field (#121)
- TIME PROCEDURE ENDED field (#122)
- PROVIDER field (#123)
- ATTEND PROVIDER field (#124)
- OTHER ASSOC DIAGNOSIS field (#.01 of sub-file #130.165)
- OTHER POSTOP DIAGS field (#.01 of sub-file #130.18)
- ICD DIAGNOSIS CODE field (#3 of sub-file #130.18)
- PRIN ASSOC DIAGNOSIS field (#.01 of sub-file #130.275)

SURGERY SITE PARAMETERS File (#133) Updates

The following field is added to the SURGERY SITE PARAMETERS file (#133):

- CODE ISSUE MAIL GROUP field (#43)

Input Template Updates

The following input templates are modified to remove the PRIN DIAGNOSIS CODE field (#66):

<u>Template</u>	<u>Option Affected</u>
SREQUEST	<i>Make Operation Request</i> <i>Make a Request for Concurrent Cases</i>
SROMEN-OPER	<i>Operation</i>
SROMEN-OUT	<i>Operation Short Screen</i>
SROMEN-POST	<i>Post operation</i>
SRSCHED-UNREQUESTED	<i>Schedule Unrequested</i>
SRSREQV	<i>Operation Menu</i>
SRSRES1	<i>Operation</i>
SRSRES-ENTRY	<i>Operation Menu</i> <i>Make Operation Request</i> <i>Make a Request for Concurrent Cases</i> <i>Delete or Update Operation Requests</i>
SRSRES-SCHED	<i>Schedule Requested Operations</i> <i>Schedule Unrequested Operations</i> <i>Schedule Unrequested Concurrent Cases</i> <i>Reschedule or Update a Scheduled Operation</i>

The following input template is modified to add the CODE ISSUE MAIL GROUP:

<u>Template</u>	<u>Option Affected</u>
SRPARAM	<i>Surgery Site Parameters (Enter/Edit)</i>



Installation of these templates overwrites any local modifications previously made to the templates.
