



DEPARTMENT OF THE ARMY
HEADQUARTERS, U. S. ARMY MEDICAL COMMAND
2050 WORTH ROAD, SUITE 10
FORT SAM HOUSTON, TEXAS 78234-6010

REPLY TO
ATTENTION OF

MCHS-IS

31 December 2001

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Minutes of the Medical Command Data Quality for AMEDD
Success Team (DQFAST)

1. The DQFAST met in Room 107, Patient Administration Systems
and Biostatistics Activity (PASBA) Conference Room,
Building 126, at 0900 on 18 December 2001.

a. Members Present:

COL Halvorson, Team Leader, PASBA
LTC Starcher, PASBA
Ms. Bacon, AMPO
Ms. Bowman, TRICARE Operations Division
Ms. Leaders, TRICARE Operations Division
Ms. Mandell, PASBA
Mr. Padilla, RM
Ms. Robinson, PASBA
Mr. Thompson, Internal Review

b. Members Absent:

COL Jones, ACofS (HP&S)
LTC Dolter, Outcomes Management
MAJ Wesloh, PASBA
MAJ Burzynski, OTSG (IMD)
MAJ Shahbaz, OTSG (Decision Support Cell)
MAJ Griffith, RM
MAJ Stewart, MEDCOM PAS
Ms. Cyr, ACofS (PA&E)
Ms. Enloe, PASBA
Mr. James, PASBA
ACofS Personnel Representative

c. Others Present:

Mr. Hale, Representing ACofS (PA&E)

MCHS-I

SUBJECT: Minutes of the Medical Command Data Quality for AMEDD
Success Team (DQFAST)

LTC Patrin, MEDCOM Clinical Services
Mr. Ashby, HP&S (PAD)
Ms. Lundberg, PASBA
Mr. Bacon, PASBA

2. Opening Remarks. There were no opening remarks.

3. Old Business.

a. Approval of Minutes. The November minutes were approved as written.

b. DQFAST Metrics (exceptions only). There was one exception to report, the Standard Ambulatory Data Record (SADR) Timeliness Metric ([enclosure 1](#)). For the report month of November, the overall compliance percentage for the Army dropped to 91 percent primarily due to Fort Gordon apparently having a system/automation problem. Recent transmissions indicate that the problem may have been corrected. **Decision: Item will remain on the agenda for the next meeting. This will allow more time to research the issue.**

c. Data Quality Management Control Program (DQMCP) Pending Issues.

(1) Impact of Coders on Uniform Business Office Collections, Third Party Collections ([enclosure 2](#)). There was a discussion on how to justify the expenditure of 7.1 million dollars on coders and billers. To help gain better insight into how funding was determined, a representative from the Health Policy and Services Directorate, Patient Administration Division, spoke about the impact of coders on Third Party Collections. Medical treatment facilities (MTFs) will go from an all-inclusive rate of billing to an itemized billing rate for outpatient care. This will allow for a rate structure that more closely reflects actual cost. This will also bring the military in line with private sector billing and improve collections by facilitating electronic billing and expediting payments. The expectation is to collect a higher percentage on billings, since the itemized billing methodology more closely meets payers' requirements. The projected increase in collections should be approximately 30 percent per claim or 16.6 million dollars. It

MCHS-I

SUBJECT: Minutes of the Medical Command Data Quality for AMEDD Success Team (DQFAST)

should take about 1 year to reach this projection. To achieve this, 175 additional coders were funded. Without additional coders, the transition to outpatient itemized billing is infeasible. Coding directly impacts itemized billing, and coding compliance and the quality of coding becomes a much more critical issue.

(2) Inpatient/Outpatient Records Coding Issues.

(a) The International Classification of Diseases-9th Revision (ICD-9) updates were distributed in October, a great improvement over previous years. There has been an ongoing standardization process between the ICD-9 tables and encoder groupers. When the new ICD-9 tables were loaded this standardization process caused the Ambulatory Data Module or Ambulatory Data System templates to show invalid codes. This necessitated much work on the part of facilities to correct the problem. The problem has been corrected. In the future, an automated program will prevent this type of error from affecting templates.

(b) There has been much effort through video teleconferencing to educate facilities on itemized billing. Facilities are being informed to pay special attention to certain areas that may present a problem.

(c) It appears that funding will be available for physicians to take Internet training on Evaluation and Management codes. Coders will also be able to take some training via the Internet.

(d) A representative from the Army Medical Command introduced himself. He is involved in the marketing of the Composite Health Care System II (CHCS II) and the education of physicians. He is interested in any changes/updates that will have an impact on physicians.

(3) Medical Expense and Performance Reporting System (MEPRS) Expense Assignment System (EAS) IV Update. There has been an overall increase in MEPRS compliance, except for the 11 percent decrease on comparison of workload between EAS and Worldwide Workload Report visits. The Army MEPRS Program Office

MCHS-I

SUBJECT: Minutes of the Medical Command Data Quality for AMEDD Success Team (DQFAST)

(AMPO) is researching this decrease. Seventy-five percent of the sites have submitted data for the month of September. The AMPO representative wanted to make sure the committee was aware that the October Army's suspense is 25 December. Starting with November data MEPRS will be back on the 45-day suspense timeline.

(4) In January 2002, the committee chairman will make a concerted effort to have MTF representatives present at the DQMCP briefings to The Surgeon General.

d. DQMCP, New Issues.

(1) The Great Plains Regional Medical Center (GPRMC) submitted an Executive Summary ([enclosure 3](#)) as part of their November DQMCP input.

a. The GPRMC identified no new issues. However; they are monitoring several issues for resolution, to include: "daily" end-of-day processing, availability of FY 02 MEPRS and coding software tables, the loss of the reporting tool for ADS version 2.3, coding, telephone consult tracking, conflicting metrics, and EAS IV conversion.

b. The GPRMC provided additional information on the "daily" end-of-day processing. They stated that after-hour care and weekend clinics do not necessarily have clerical support or daily management oversight to validate end-of-day processing. These after-hour clinics are minimally staffed, because GPRMC MTFs were never provided resources to complete primary care optimization.

c. The GPRMC will monitor the outcome of monthly coding audits on inpatient and outpatient records, question four of the DQMCP, and will conduct some on-site audits/assistance visits to aid the MTFs in their pursuit of quality coding.
Decision: The committee request that the GPRMC keep them updated about the impact of additional coders on coding quality.

(2) October Summary of the Summary Review

MCHS-I

SUBJECT: Minutes of the Medical Command Data Quality for AMEDD Success Team (DQFAST)

([enclosure 4](#)). If any committee member requires the most current version of this summary, or any other metric, they are posted on the PASBA website.

e. DQMCP Trends, [enclosures 5,6 & 7](#). With the conversion to the Green-Amber-Red (GAR) scale percentages used by the TriCare Management Activity (TMA), there should be an overall improvement in the GAR representations for facilities.

(1) For question one, end-of-day processing, there was a decrease in compliance for three facilities. Next month the question converts from a yes or no response to a cumulative percentage. This should be reflected as an improvement on this GAR.

(2) For question two, part a, compliance with Tri-service policies for timely submission of data, MEPRS shows an overall increase. The AMPO previously indicated that the Army MTFs have been granted a 10-day extension to the submission suspense date, for the report month of October. It was noted that this submission date extension did not change the suspense date established by TMA.

(3) For question two, part b, Fort Eustis experienced an electronic transmission utility (ETU) problem.

(4) For question two, part c, Fort Belvoir has consistently had problems; apparently this involves the National Capital Region I CHCS. Compliance was also affected by the ETU problems of Fort Eustis.

(5) For question four, outcome of monthly coding audits, all areas appear to be leveling out to between 1 and 5 percent variations.

(6) For question five, percentage of outpatient records located in a monthly review of CHCS visits, there has been an overall increase in compliance of 4 percent.

(7) For question six, implementation of EAS/MEPRS data validation and reconciliation, there was an improvement with

MCHS-I

SUBJECT: Minutes of the Medical Command Data Quality for AMEDD
Success Team (DQFAST)

6 MTFs for financial data and 3 MTFs improved their workload data.

(8) For question seven there was a general increase in compliance.

f. DQMCP Update.

(1) The Department of Defense Inspector General's office has requested additional information on the following: the process for briefing The Surgeon General and what actions he takes after the briefing, how the information is forwarded to TMA, copies of briefing charts, and minutes of any DQMCP briefings.

(2) The committee chairman would like information on how the other services are going about their DQMCP briefings, their process and timelines for completing their DQMCP reports.

(3) For the October reporting period, the form used for the Commander's Data Quality Statement will be Version 6.1. The minimum sample size of records should be 30. The GAR chart percentages for the DQMCP will be TMA's standard; 100 percent-95 percent will be green, 94 percent-80 percent will be amber, 79 percent and below will be red.

g. DQMCP Best Business Practices. There were no recommendations from committee members. This area will be addressed again at the next DQFAST meeting.

h. Data Quality in the Balkans. There were some minor problems with Standard Inpatient Data Records received from a Fort Hood unit, but this was corrected.

4. New Business.

a. Encoder/Grouper Issues. Previously discussed in paragraph 3c(2)(a).

b. New Metric Proposals.

MCHS-I

SUBJECT: Minutes of the Medical Command Data Quality for AMEDD Success Team (DQFAST)

(1) The DQMCP Metric versus the SADR Compliance Metric ([enclosure 8](#)). This metric compares the results from the DQFAST SADR Compliance Metric and the responses provided on the Commander's Data Quality Statement. **Decision: The committee agreed to include this metric with the other DQFAST metrics currently being done.**

(2) The DQMCP versus MEPRS Timeliness Metric ([enclosure 9](#)). This metric compares the results from the MEPRS Currency Metric, and the responses provided on the Commander's Data Quality Statement. Due to incorrect responses on the Commander's Data Quality Statement being corrected by PASBA, at the direction of The Office of The Surgeon General, this metric no longer serves a useful purpose. **Decision: The committee decided not to include this metric with the other DQFAST metrics currently being done.**

d. Other New Issue Discussion.

(1) The committee member from Internal Review related that an audit had been conducted to match Third Party Collections on patients with those patients SADR records. The question under consideration was if the facility billed for care on a particular patient was there a matching SADR record with the same date of care, diagnosis, treatment, etc. Four MTFs had matches between 45 and 50 percent. Criteria for auditing a facility were to have between 2 and 3 million dollars in billing for a given year.

5. Deferred Issue--None.

6. The meeting adjourned at 1045. The next meeting date will be 15 January 2002.

9 Encls
as

JAMES A. HALVORSON
COL, MS
DQFAST Team Leader

DISTRIBUTION:

MCHS-I

SUBJECT: Minutes of the Medical Command Data Quality for AMEDD
Success Team (DQFAST)

1-Each Committee Member