Documentation for Ambulatory Care

Revised Edition

Ambulatory Care Section

American Health Information Management Association

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Preface

Robbyn Lessig, RHIA

Why are ambulatory care services flourishing? The same research that led to medical science's increased understanding of disease processes has led to changes in the patterns of medical practice and the settings of patient care. The use of advanced technology such as endoscopes and lasers has decreased the trauma associated with surgical procedures and has shortened the postoperative recovery period. Complex procedures that a decade ago required long hospital stays now are performed routinely in the ambulatory care setting.

Moreover, the use of ambulatory services has grown, in part, in response to the public's demand for high-quality, convenient healthcare. Today, patients and physicians alike emphasize the importance of preventive medicine, which is delivered almost entirely within the ambulatory setting.

In the decades after World War Two, the Hill–Burton Act stimulated federal spending on healthcare facilities. New hospitals were built and older facilities were modernized to make hospital care more widely available to Americans. In 1965, Title XVIII of the Social Security Act mandated the creation of Medicare, the federally funded health insurance program for people over 65 years old. Medicaid, a similar program targeting the poor, followed. These government programs stimulated spending on healthcare, and by the 1980s, it had become obvious that healthcare spending would continue to escalate if left unchecked.

The cost of healthcare services continues to be a national concern. The implementation of a prospective payment system for Medicare and the growth of managed care represent efforts by the federal government, private insurers, and employers to curb healthcare spending. The movement of services from the acute care setting to ambulatory settings had resulted in lower costs for some services, but the overall demand for healthcare services continues to grow.

Accurate and complete health record documentation is critical to the quality of ambulatory care services and the economic viability of ambulatory care providers. This edition of *Ambulatory Care Documentation* brings new information, particularly with regard to the impact on health record documentation of the new regulations promulgated by the Health Insurance Portability and Accountability Act (HIPAA), to help guide health information managers in their efforts to maintain accurate, complete patient documentation and to make that documentation accessible to those who need it in the most timely manner possible.

Ambulatory Care Documentation, Revised Edition, is divided into nine chapters. Chapter 1 discusses health record documentation in the different types of ambulatory care settings and identifies the principal regulatory agencies that accredit ambulatory care facilities. Chapter 2 reviews the components of the basic patient record and the advantages and disadvantages of the different patient record formats. Chapter 3 provides a list of general guidelines for creating

health records in the ambulatory care setting and explains how to conduct a health record deficiency analysis. Chapter 4 focuses on all aspects of health record security and discusses the HIPAA information security provisions. Chapter 5 identifies different methods for storing patient information and how patient information can be most efficiently organized for easy retrieval. It also describes the technologies available for purging files. Chapter 6 compares the computer-based and paper-based systems and outlines the planning stages in implementing a CPR system. This chapter also offers insight into how CPR implementation will be affected by the new HIPAA regulations. Chapter 7 describes the benefits of accreditation and examines the standards used by three accreditation agencies in particular: the Joint Commission on Accreditation of Healthcare Organizations, the Accreditation Association for Ambulatory Health Care, and the National Committee for Quality Assurance. Chapter 8 reviews the format and conventions of the ICD-9-CM, CPT, and HCPCS coding systems and assesses the impact on ambulatory care facilities of the ambulatory payment classification system. Finally, chapter 9 identifies the different agencies involved in investigating fraud and abuse activities and describes how ambulatory care facilities can set up an effective compliance program.

In addition, the book includes a number of appendixes that provide health record documentation guidelines, examples of documentation forms, and various sources of health record documentation information.

Chapter 1
Overview

Robbyn Lessig, RHIA

The Subcommittee on Ambulatory Statistics of the National Committee on Vital and Health Statistics (NCVHS) defines *ambulatory care* as the healthcare services provided to patients who are neither hospitalized nor institutionalized as inpatients in the facility that is the site of the service encounter. The two principal categories of ambulatory care are hospital-based ambulatory care and community-based ambulatory care. In addition, a variety of healthcare organizations offer specialized ambulatory services.

This chapter defines hospital- and community-based ambulatory care and describes the different types of healthcare organizations that offer ambulatory care services. It also identifies the different regulatory agencies that accredit ambulatory care facilities and describes the types and purposes of patient documentation in the ambulatory care setting.

Hospital-Based Ambulatory Care

When an individual who is not an inpatient receives healthcare services in a hospital department (for example, radiology, laboratory, cardiology, or physical therapy), the services are categorized as ambulatory services and he or she is considered a hospital outpatient. In hospital-based ambulatory care, the hospital is responsible for both the administrative and the clinical aspects of the delivery of healthcare services. This category of ambulatory care includes preventive, diagnostic, and therapeutic services provided through a comprehensive outpatient program. Services may be provided in the hospital or in a satellite facility owned and operated by the hospital.

Hospital outpatients may be classified further by the type of service they receive and the location in which they receive the service (Youmans 2000):

- Emergency outpatients are admitted to the hospital's emergency or trauma care department for the diagnosis and treatment of a condition that requires immediate medical care.
- Clinic outpatients are admitted to a clinical department of the hospital for diagnostic testing or treatment on an ambulatory basis.
- Referral outpatients are provided special diagnostic or therapeutic services in the hospital on an ambulatory basis. Responsibility for the medical care remains with the referring physician.

Hospitals offer two kinds of programs exclusively for ambulatory patients (Youmans 2000):

- *Partial hospitalization:* This program is for patients who spend a limited amount of time (a few days or nights) in the hospital setting, typically as part of a transitional program from acute care to a less intensive level of service. Psychiatric and substance abuse facilities frequently offer partial hospitalization programs.
- *Ambulatory surgery:* This program is for the performance of elective surgical procedures on patients who are classified as outpatients and typically are released from the surgery center on the same day the procedure is performed.

Community-Based Ambulatory Care

Community-based ambulatory care is provided in freestanding facilities that are not owned by, or directly affiliated with, a hospital. These types of facilities offer a variety of nonacute healthcare services and range in size from single-physician practices to large healthcare clinics with organized medical staffs. Several types of community-based facilities are discussed below.

Community Health Centers

Community health centers, sometimes called neighborhood health centers, usually are located in low-income areas. They offer comprehensive, primary healthcare services (both therapeutic and preventive) to patients who otherwise would have limited access to healthcare. Community health centers frequently are operated by local and state public health departments, and most of the services are provided by public health nurses. Patients pay for services either on a sliding scale based on income or according to a flat-rate, discounted fee schedule supplemented by public funding.

Industrial Health Centers

Often located in areas that are easily accessible to industrial sites, industrial health centers offer treatment for workers who are affected by work-related injuries and illnesses. Usually, these centers are financed through the employer's workers' compensation insurance plan. Sometimes they also provide preemployment physicals and testing, which are paid for directly by the potential employers. Finally, many industrial health centers collect data on patterns of work-related illness and injury and provide the information to employers on a contract basis.

Ambulatory Surgery Centers

Freestanding ambulatory surgery centers are not directly affiliated with a hospital and are located in separate facilities. Most ambulatory surgery centers are operated on a for-profit basis and may be owned by physicians, managed care organizations (MCOs), or entrepreneurs.

Surgical procedures performed in a freestanding facility are scheduled in advance and usually take from 5 to 90 minutes. In addition, such procedures must require less than a four-hour recovery period so patients can leave the facility on the same day their procedures are performed. Because freestanding ambulatory surgery centers have lower overhead expenses than hospital-based ambulatory surgery facilities do, they are able to provide surgical services at a

lower cost. However, patients who develop surgical complications must be transported to a local inpatient facility.

Private Medical Practices

Physicians who provide medical care in an office setting may work alone in a solo practice, in a limited partnership with one or more other physicians, or in a group practice with a number of other physicians. Physicians in a group practice share office space, equipment, records, and personnel, and usually employ an office manager. Some group practices provide medical services in a single specialty, for example, internal medicine. A multispecialty group practice includes providers who represent a variety of medical specialties.

Health Maintenance Organizations

Health maintenance organizations (HMOs) offer a wide range of healthcare services, including acute care and ambulatory care. They provide health coverage to voluntarily enrolled individuals in return for prepayment of a fixed fee, regardless of the services the individual enrollees actually use.

Under the federal HMO Act, an entity must have three characteristics to call itself an HMO: (1) an organized system for providing healthcare or otherwise ensuring healthcare delivery in a specific geographic area; (2) an agreed set of basic and supplemental health maintenance and treatment services; and (3) a voluntarily enrolled group of people. In addition, HMOs must follow a number state-legislated rules and regulations.

Health maintenance organizations can be categorized into one of four models:

1. *Staff model:* In the staff model, physicians are hired and paid by the HMO and are considered employees.
2. *Independent practice association model:* In the independent practice association model, also called the individual practice association or independent practitioner association model, the HMO contracts with a group of physicians who come together for contracting purposes but retain their individual practices. The HMO pays the physicians on a discounted fee-for-service basis. They are not considered employees of the HMO and are paid from a fund designated for physician compensation. The physicians provide care to HMO members from their private offices and continue to treat their regular patients on a fee-for-service basis.
3. *Group model:* In the group model, the HMO contracts with a multispecialty group practice to provide services to HMO enrollees. The physicians usually agree to devote a fixed percentage of their time to the HMO.
4. *Network model:* The network model is similar to the group model, except that the HMO contracts for services with two or more physician groups instead of just one.

The HMO arranges to provide healthcare for its members and manages the payment process for all services provided. Many HMOs base reimbursement on a per member per month (PMPM) payment rate, which represents a capitation mechanism for paying providers a set rate for each member for a specified period of time, usually one month. In capitated arrangements, providers share the risk of providing all the necessary care to those members within the set payment.

Other Organizations That Provide Ambulatory Care Services

Ambulatory services also are provided by a number of specialized treatment facilities. Examples of such facilities and the services they provide are discussed in the following subsections.

Birthing Centers

Freestanding birthing centers are for-profit facilities owned by physicians, nurse-midwives, MCOs, and/or entrepreneurs. Usually staffed by nurse-midwives, these centers provide delivery services for women who plan to have normal deliveries. A patient must be screened for medical acceptability before she can be scheduled to deliver her child at a birthing center. Some hospitals also offer ambulatory obstetric services for women who are expected to have normal deliveries.

Cancer Treatment Centers

Cancer treatment centers specialize in providing comprehensive cancer treatment, including radiation and chemotherapy. Many of them also offer patient education and family counseling services.

Renal Dialysis Centers

Freestanding renal dialysis centers offer various treatment options for patients with renal disease. Services include traditional hemodialysis and education and support for patients who perform continuous peritoneal dialysis at home.

Rehabilitation Centers

Rehabilitation centers provide physical, occupational, and speech therapy on an ambulatory basis when such services are ordered by a physician. Staffed by therapists, the centers are usually for-profit facilities that may be owned by therapists or physicians, entrepreneurs, or managed care networks.

Home Care and Hospice Programs

Home care and hospice programs offer a variety of ambulatory care services. Record maintenance practices in these settings differ from those in the typical ambulatory setting and are beyond the scope of this publication.

Correctional Facilities

Ambulatory care services also are provided to prisoners confined to correctional facilities.

Influence of Managed Care

Managed care is a generic term for a healthcare reimbursement system that manages the cost and quality of, and access to, healthcare services. (HMOs are one type of MCO.) Managed care systems control costs by presetting allowable reimbursement levels and controlling patient access to healthcare services. The goal is to deliver value by providing only medically necessary,

cost-effective healthcare in the most appropriate setting. Managed care networks integrate the financial, administrative, and clinical aspects of care over a full range of healthcare facilities, many of which are ambulatory facilities. One effect of managed care has been a decline in the amount of healthcare provided in hospitals and an expansion in the amount of healthcare provided in ambulatory care facilities.

Regulation and Accreditation of Ambulatory Care Facilities

Ambulatory care facilities are subject to a number of regulations and accreditation standards. The principal accrediting bodies and the types of organizations for which they have created standards are discussed below. (See appendix A for a listing of ambulatory care documentation standards.)

Joint Commission on Accreditation of Healthcare Organizations

Established in 1951, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) was originally called the Joint Commission on Accreditation of Hospitals. Today, the JCAHO has established accreditation standards for psychiatric facilities, home care programs, long-term care facilities, healthcare networks, pathology and clinical laboratory services, and ambulatory care facilities, in addition to acute care hospitals. JCAHO standards are updated yearly by a board of commissioners representing the American Hospital Association, the American Medical Association, the American College of Surgeons, the American College of Physicians, and the American Dental Association.

The JCAHO conducts accreditation surveys of hospital-based ambulatory care facilities on the basis of the *Accreditation Manual for Hospitals.* Freestanding ambulatory care centers are accredited on the basis of the standards in the *Accreditation Manual for Ambulatory Health Care.*

Accreditation Association for Ambulatory Health Care

The Accreditation Association for Ambulatory Health Care (AAAHC) was established in 1979 in response to organizational changes that took place within the JCAHO in 1978. As a result of those changes, a group of organizations interested primarily in ambulatory care established an accreditation organization independent of the JCAHO. The six organizations included:

- American College Health Association (ACHA)
- American Group Practice Association (AGPA)
- Federated Ambulatory Surgery Association (FASA)
- Group Health Association of America, Inc. (GHAA)
- Medical Group Management Association (MGMA)
- National Association of Community Health Centers, Inc. (NACHC)

The AAAHC surveys physician-based services, freestanding ambulatory surgery centers, and student health clinics on the basis of the *Accreditation Handbook for Ambulatory Health Care.*

National Committee for Quality Assurance

Founded in 1979 by the Group Health Association of America and the American Managed Care and Review Association, the National Committee for Quality Assurance (NCQA) is the primary accreditation association for all types of MCOs. Many HMOs consider the NCQA the accreditation association of choice. Group practices that participate in one or more MCOs also work to meet NCQA standards.

Commission for the Accreditation of Freestanding Birth Centers

The Commission for the Accreditation of Freestanding Birth Centers (CAFBC) administers the accreditation process for freestanding birthing centers and uses *Standards for Freestanding Birth Centers* written by the National Association of Childbearing Centers (NACC). The NACC also publishes the *Protocols for Management of Care Manual* for use in birthing centers.

Government Regulation

To participate in the Medicare program, ambulatory care facilities must meet the specific conditions outlined in the *Code of Federal Regulations.* Similar requirements restrict participation in Medicaid (Title XIX of the Social Security Act), which was created to provide medical care for the poor and disabled. Medicaid is funded jointly by federal and state governments and administered by individual state governments.

Like other healthcare organizations, ambulatory care organizations will be required to meet the provisions of the Health Insurance Portability and Accountability Act of 1996. The new regulations pertain to all patient-identifiable healthcare information created, maintained, communicated, or stored in electronic media. The regulations, however, do not apply to health information stored in nonelectronic media such as paper-based medical records. Because virtually all ambulatory care organizations use computer-based systems for at least some of their information management functions (for example, laboratory databases and master patient indexes), physicians' offices and other ambulatory organizations will need to take steps to meet the HIPAA requirements. HIPAA is discussed in more detail in later chapters of this book.

Individual physicians and other healthcare providers are licensed by state governments, which are responsible for ensuring that providers have received proper training and have passed the appropriate examinations.

Patient Care Documentation in the Ambulatory Setting

Careful documentation is critical whatever the ambulatory care setting. The instrument of this documentation is the health record. By providing documentation of elements such as patient and provider demographics, reason for visit, results of physical examinations and diagnostic lists, treatment rendered, and plans for follow-up care, the health record answers questions about the who, what, when, where, why, and how of patient care. In addition, it is used to substantiate claims for payment and serves as the legal record of the healthcare services provided to individual patients.

In recognition of the need for a common core of standard data items, the U.S. Department of Health and Human Services (DHHS) published the first Uniform Ambulatory Care Data Set

in 1976. All ambulatory data collectors—including clinical providers, third-party payers, and professional organizations—use this data set to make management and policy decisions, enhance research, and facilitate comparison of data. The data set has been revised three times since 1976. Prepared in 1996 by the Subcommittee on Ambulatory and Hospital Care Statistics of the National Committee on Vital and Health Statistics (NCVHS), the current version added three data elements: socioeconomic indicator (years of education completed by the patient), injury code, and site of encounter/place of service. (See appendix B for the complete text of the most current version.)

With the proliferation of managed care plans, large employers have sought a way to evaluate the care that different plans provide. In response, several large health plans and employers collaborated on a second data set—the Health Plan Employer Data and Information Set (HEDIS) report card (discussed further in chapter 7). Although it is still being refined, this reporting system already is helping employers evaluate and compare managed care plans. The full HEDIS data set is available from the NCQA. (The NCQA's Web site address is www.NCQA.org.)

All ambulatory health records or databases should include the items in the Uniform Ambulatory Care Data Set. However, the content and complexity of the remainder of the health record depend on the provider's information requirements and the reason for the patient's visit. For example, a prophylactic flu shot may require no more than a brief notation, whereas the diagnostic workup and consultation needed to determine the etiology of abdominal pain would require extensive documentation.

For a solo practice provider, health record documentation in its simplest form consists of patient and provider data recorded on a registration form. Each encounter requires a single blank sheet or progress note form, which is used to record data such as date of service, vital signs, reason for visit, symptoms, assessment, orders, and diagnostic test results. The documentation for the encounter also may include a problem list and a medication list. Information can run in reverse chronological order, with data for subsequent visits simply added at the top of the list. The back of the record folder can be reserved for outside records pertaining to the patient's previous medical care.

In contrast, a large group practice may arrange its health record into a predetermined format with a specific section for each specialty and for ancillary departments such as laboratory, radiology, and physical therapy. Each service uses customized forms to meet its specific data collection needs. Some practices use color-coded dividers to organize different forms and sections of the record.

Purposes of Documentation

Regardless of the complexity of the documentation, ambulatory care records must be comprehensive enough to serve five different purposes: patient care, research, legal proceedings, accreditation and licensing, and reimbursement.

Patient Care

Because more and more patients are receiving sophisticated healthcare services in ambulatory care facilities, the coordination of treatment has become increasingly important. The health record serves as a vital communication link among the various clinicians providing patient care. By clearly and completely reflecting the care provided at each step, documentation in the health record reduces the duplication of diagnostic tests and the risk of treatment errors.

Research

Data gathered for healthcare research are used in a variety of ways: to evaluate and improve treatment methods, to forecast community healthcare needs, to track resource usage, to develop patient care criteria, to evaluate quality of care, and to predict the incidence of disease. In the case of an epidemic of infectious disease, for example, epidemiologists and public health professionals can use healthcare data to determine where to focus scarce resources and to indicate what preventive measures are needed to stop the spread of disease. The better the documentation, the more accurate the treatment plan.

Legal Proceedings

The documentation in the health record protects the legal interests of the patient, the physician, and the healthcare facility. For example, the health record must accurately show the extent of the injuries of a patient involved in an automobile accident in order to ensure appropriate compensation. In another example, an accurate and complete health record may help establish the defense for the physician and/or facility named in a malpractice suit, and, conversely, a poorly documented health record can shatter even the most compelling defense.

Accreditation and Licensing

To receive approval to operate, healthcare facilities must comply with the licensing requirements of the states in which they operate. In addition, accrediting agencies ensure the quality of healthcare through a voluntary evaluation process built on a predetermined set of performance standards. By conforming to the standards and receiving accreditation from the agency, the ambulatory care facility tells the public that it is able to deliver high-quality care. On-site surveys are used to determine facility compliance with accreditation and licensing standards, and because the surveys include a review of patient care documentation, the quality and the quantity of documentation are central to a facility's licensure and accreditation status.

Reimbursement

In processing reimbursement claims, health insurance companies and other third-party payers often look to the health record for proof that services were provided as billed. Further, Medicare, Medicaid, private insurers, and employers sometimes review health records to determine the medical necessity and appropriateness of the care provided.

Developed, published, and copyrighted by the American Medical Association (AMA), Current Procedural Terminology (CPT) is a coding system used to communicate the nature of physician services to insurance companies and other third-party payers. The CPT coding system is used as one part of the Health Care Financing Administration's Common Procedure Coding System (HCPCS), which is required for reimbursement under Medicare and Medicaid. The system includes a series of codes for office visits known as the evaluation and management (E/M) codes. In 2000, a new prospective payment system for outpatient care services—ambulatory payment classifications—was implemented for hospital-based ambulatory services. (See chapter 8.)

Conclusion

With new treatments emerging all the time, ambulatory care is still a work in progress. Computer-based patient records, as well as medical outcomes and guidelines and integrated care, are

among the new systems undergoing early testing by facilities. The community health record already has become a part of many large, integrated healthcare delivery systems. In light of such developments, the role of patient care documentation promises to grow even more in the future.

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