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|  |  | **Organizational Identifiers** |  |  |
|  | VAMCCONTROLQICBEGDTEREVDTE | Facility IDControl NumberAbstractor IDAbstraction Begin DateAbstraction End Date | Auto-fillAuto-fillAuto-fillAuto-fillAuto-fill |  |
|  |  | Patient Identifiers |  |  |
|  | SSNPTNAMEFPTNAMELBIRTHDTSEXMARISTATRACE | Patient SSNFirst NameLast NameBirth DateSexMarital StatusRace | Auto-fill: no changeAuto-fill: no changeAuto-fill: no changeAuto-fill: no changeAuto-fill: **can change**Auto-fill: no changeAuto-fill: no change |  |
|  |  | **Administrative Data** |  |  |
| 1 | telencdt | Enter the date of the telephone encounter. | mm/dd/yyyy**Will auto-fill from pull list and cannot be modified**

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| --- |
| >= stdybeg and <= stdyend |

 | **The telephone encounter date will auto-fill from the pull list and cannot be modified.** **A telephone contact** between a practitioner and a patient is only considered an encounter if the telephone contact is documented and that documentation includes the appropriate elements of a face-to-face encounter.  |
| 2 | telenctm | Enter the time of the telephone encounter. | \_\_\_\_**Will auto-fill from pull list and cannot be modified** | **The telephone encounter time will auto-fill from the pull list and cannot be modified.** |
| 3 | provtype | Enter the provider type for the telephone encounter.1. LIP2. Non-LIP | **1,2****Will auto-fill as 1= LIP or 2=Non-LIP from pull list and cannot be modified** | **The provider type (1=LIP or 2=Non-LIP) will auto-fill from the pull list and cannot be modified.** |
| 4 | cptcode | Enter the CPT code for the telephone encounter. | \_ \_ \_ \_ \_Will auto-fill from pull list and cannot be modified | **The CPT code will auto-fill from the pull list and cannot be modified.** |
| 5 | enchx | For the telephone encounter on (computer to display telencdt) did the provider document the history and assessment findings in the note?1. Yes2. No | 1,2 | **A telephone contact** between a practitioner and a patient is only considered an encounter if the telephone contact is documented and that documentation includes the appropriate elements of a face-to-face encounter.**History/assessment:** Documentation must include, but is not limited to:Reason for telephone encounter or patient’s chief complaint/problem; including but not limited to elements such as when problem started, duration, signs/symptoms, what has been done for the problem so far. **Example Note:** Telephone Contact - RN called to follow up on new diagnosis of depression. Veteranseen in Clinic 6 days ago with complaints of low motivation, feeling “down” all the time, crying frequently. Newly diagnosed with Depression, referred to Behavioral Health Clinic and started on anti-depressant. Today states feeling about the same; taking medication with no apparent problems; has been to BH Clinic 2 times and likes the counselor. No evidence of crying heard; sounded positive about seeking help; no physical complaints voiced. Denied suicidal ideation. Indicated compliance with new med. If the record has addendum/addenda to the telephone encounter within 30 days of the telephone encounter date, review the addendum/addenda for any applicable information. If there are two telephone encounter notes on the same date, but only one telephone encounter in CVP (Clinic Visits Past), then you may use the information from both notes to answer the question. |
| 6 | encdx | For the telephone encounter on (computer to display telencdt), did the provider document the diagnosis/diagnoses in the note?1. Yes2. No | 1,2 | **Diagnosis:** Documentation must include, but is not limited to: Provider’s identification of the problem(s), reason for the call and/or diagnosis/diagnoses that relate to the encounter. A minimum of one problem/diagnosis is required. **Example**: Problem: New Dx - Depression. Indicated compliance with new med. If the record has addendum/addenda to the telephone encounter within 30 days of the telephone encounter date, review the addendum/addenda for any applicable information. If there are two telephone encounter notes on the same date, but only one telephone encounter in CVP (Clinic Visits Past), then you may use the information from both notes to answer the question. |
| 7 | encplan | For the telephone encounter on (computer to display telencdt), did the provider document the plan of care in the note?1. Yes2. No | 1,2 | **Plan of Care:** Documentation must include, but is not limited to: Provider’s description of the plan of treatment based on assessment during the telephone encounter and the diagnosis/diagnoses. **Example:****Plan:** Provide counseling - encouraged Veteran to continue anti-depressant and follow up in BH Clinic; encouraged to call if new S/S develop and/or go to ED if thinking of harming self or others. If the record has addendum/addenda to the telephone encounter within 30 days of the telephone encounter date, review the addendum/addenda for any applicable information. If there are two telephone encounter notes on the same date, but only one telephone encounter in CVP (Clinic Visits Past), then you may use the information from both notes to answer the question. |
| 8 | enctime | For the telephone encounter on (computer to display telencdt), select the time spent on the encounter that is documented in the provider’s note.1. 5 to 10 minutes2. 11 to 20 minutes3. 21 to 30 minutes99. Unable to determine or time spent not documented | 1,2,3,99 | **Time spent:** The provider is required to document the amount of time spent on the telephone encounter within the note regarding the encounter. **Examples:** “Time spent 15 minutes.” “20 minutes spent on this call.”If documentation states, “More than 30 minutes spent on this encounter,” select option “3”.If time spent is not documented or otherwise not specific to options 1, 2, or 3, select option “99”.**Information Only****Correct CPT code for time spent:****99441 and 98966 - 5 to 10 minutes****99442 and 98967 - 11 to 20 minutes****99443 and 98968 - 21 to 30 minutes** |