A RAND NOTE

THE HEALTH INSURANCE EXPERIMENT'S GUIDELINES FOR ABSTRACTING HEALTH SERVICES RENDERED BY GROUP HEALTH COOPERATIVE OF PUGET SOUND

George A. Goldberg

February 1983

N-1948-HHS

Prepared for

The U.S. Department of Health and Human Services

35th Year

Rand
SANTA MONICA, CA. 90406

The research reported herein was performed pursuant to Grant No. 016B-7903-P2021 from the U.S. Department of Health and Human Services, Washington, D. C.

Published by The Rand Corporation

A RAND NOTE

THE HEALTH INSURANCE EXPERIMENT'S GUIDELINES FOR ABSTRACTING HEALTH SERVICES RENDERED BY GROUP HEALTH COOPERATIVE OF PUGET SOUND

George A. Goldberg

February 1983

N-1948-HHS

Prepared for

The U.S. Department of Health and Human Services

35th Year

Rand
SANTA MONICA, CA. 90406

PREFACE

This Note reproduces the abstraction guidelines developed for and adhered to during the abstraction of outpatient and inpatient records of more than 1800 Health Insurance Experiment (HIE) participants who were enrolled in a well-known prepaid group practice (Health Maintenance Organization, HMO), Group Health Cooperative of Puget Sound, Seattle, Washington. Records of these participants (approximately 23.9% of all HIE participants) were abstracted in order to ascertain the kinds and quantity of health services utilized during the course of a three- or five-year period, 1976-1979 or 1976-1981.

This document will be of interest to those wishing to understand how the Health Insurance Experiment abstracted information from Group Health Cooperative's records. In view of the overwhelming likelihood that much future health services research will require obtaining similar information from Health Maintenance Organizations for comparison with the fee-for-service sector, this document should also prove useful to all researchers embarking on comparative studies of fee-for-service and prepaid-group-practice health care.

Readers who are unfamiliar with the HIS are referred to two companion reports: R-1987/1-HEW, Conceptualization and Measurement of Health for Adults in the Health Insurance Study: Vol. 1, Model of Health and Methodology, by J. E. Ware et al., May 1980; and R-2847-HHS, Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance, by J. P. Newhouse et al., January 1982.

SUMMARY

This Note reproduces the abstraction guidelines developed for and adhered to during the abstraction of outpatient and inpatient records of more than 1800 Health Insurance Experiment participants who were enrolled in a well-known prepaid group practice, Group Health Cooperative of Puget Sound, Seattle, Washington.

In the fee-for-service sector, claim forms submitted for reimbursement permit collection of data on services utilized; but because a prepaid organization generally has no need to submit claim forms for reimbursement purposes, it is necessary to abstract from within-organization records in order to acquire comparable data on services utilized. The objectives of the Health Insurance Experiment required that the abstraction of health service utilization data from Group Health Cooperative's records be as precise and complete as possible, and that such abstraction be carried out in a standardized, unarbitrary way; hence the need for abstraction guidelines.

ACKNOWLEDGMENTS

The author would like to thank Group Health Cooperative abstractors JoAnn Habakangas, Jayne Moeller, Valerie Nayematsu, and Ellen Skinner for their outstanding work and their many questions which served to sharpen these abstraction guidelines. Marge Andrich, Ed Emerson, Judith Fiedler, Sandra Guerra, Faith Korner, Sue Madsen, and Lillie Peterson were prominent among those who provided important administrative support over the years of exemplary cooperation between Group Health Cooperative and Rand's Health Insurance Experiment (HIE). Joseph P. Newhouse, Rand's Project Leader for the HIE, kindly provided timely and careful review of these guidelines during their developmental stage. I am particularly grateful for the invaluable guidance and assistance of Richard Handschin, M.D., Director of Research at Group Health Cooperative.

CONTENTS

PREFACE iii

SUMMARY v

ACKNOWLEDGMENTS vii

FOREWORD 1

Section I. THE HEALTH INSURANCE EXPERIMENT'S ABSTRACTION GUIDELINES FOR OUTPATIENT SERVICES AT GROUP HEALTH COOPERATIVE OF PUGET SOUND, SEATTLE, WASHINGTON

INTRODUCTION 12
Sources 12
Information Sought 14
NAME OF PATIENT 15
PATIENT'S FAMILY NUMBER 15
PATIENT'S INDIVIDUAL NUMBER 15
NAME OF PROVIDER(S) AND AREA LOCATION 15
RN Services 17
RN Refill Service 18
AREA LOCATION 18
REFERRAL 19
REASON FOR VISIT 20
ACCIDENT OR INJURY 21
PLAN 21
PRIMARY PROBLEM OR DIAGNOSIS 22
Abstractor's Inference Box for Diagnosis or Problem 24
TYPE OF PROBLEM 25
Acute 26
Well Care 26
Flare-up of Chronic 27
Chronic 27
Abstractor's Inference Box for Type of Problem 28
TREATMENT HISTORY 28
Abstractor's Inference Box for Treatment History 30
DATE SYMPTOMS FIRST OCCURRED 30
DATE OF SERVICE 31
PLACE OF SERVICE 32
SERVICES 32
Laboratory Work, Including X-ray 33
Obstetrics-Gynecology Services 36
Ophthalmological Services 37
Physical Medicine Services 39
Drugs and Supplies Services 39
Mental Health Services 40
Surgical Services 41
Other Services 42
TYPE OF OFFICE VISIT 42
RELATION OF TREATMENT TO PROBLEM ('LINKAGE') 45
Abstractor's Inference Box for Linkage of Treatment to Problem 45

DRUGS AND DIETS PRESCRIBED OR SUGGESTED..... 45
Supplies Suggested or Prescribed..... 47
Abstractor's Inference Box for Linkage of Therapy to Problem..... 47
SPECIAL CONSIDERATIONS..... 48
To SERR or Not to SERR..... 48
Laboratory, X-ray, and Physical Therapy Visits..... 50
Emergency Room..... 51
Outpatient Surgery..... 51
Home Health Services..... 51
Ambulance Services..... 52
"Missing" Visits..... 52
Completing the Health Insurance Experiment (Termination)... 53

Section II: THE HEALTH INSURANCE EXPERIMENT'S ABSTRACTION GUIDELINES FOR INPATIENT SERVICES AT GROUP HEALTH COOPERATIVE, OF PUGET SOUND, SEATTLE, WASHINGTON

INTRODUCTION..... 58
IDENTIFYING HOSPITALIZATIONS..... 59
INITIATING A GHC HOSPITALIZATION ABSTRACT..... 59
WHO IS LISTED AS A PROVIDER..... 59
TYPES OF VISITS..... 63
Initial Care..... 63
Admissions Through the Emergency Room..... 64
Transfer from Another Hospital..... 65
Followup Care (Progress Visits)..... 65
Critical Care..... 66
Consultation..... 67
NON-SURGICAL PROCEDURES..... 68
SURGERY..... 69
ANESTHESIA..... 71
OBSTETRICS..... 73
Therapeutic Abortion..... 74
Newborns..... 75
PCF (PROGRESSIVE CARE FACILITY) UTILIZATION..... 75
REVIEWING AND ANNOTATING THE 'LEDGER BILL'..... 76
END OF THE HEALTH INSURANCE EXPERIMENT (TERMINATION)..... 78

Appendices

Usually Acute Conditions--Outpatient..... 81
Usually Preventive/Well Care Conditions--Outpatient..... 84
Usually Chronic Conditions--Outpatient..... 85
Drugs Needing Strength Indicated..... 87
Abbreviations Used at GHC..... 89
Procedure for Requesting GHC Charts..... 92
Procedure for Abstracting GHC Outpatient Encounters onto SERRs..... 93
Physicians, Doctors, Suppliers and Outpatient SERR..... 95
Emergency Room Services Sheet..... 96
Further Guidelines for Coding the Treatment History..... 97
Coding List..... 99
Hospital/PCF SERR..... 100
Physician's SERR for Hospitalization..... 101

FOREWORD

This document is not analytical; it is descriptive and procedural. It reproduces the outpatient and inpatient guidelines developed by the author (a physician) for use by abstractors who were obtaining health service utilization information from records of Health Insurance Experiment (HIE) participants enrolled in Group Health Cooperative of Puget Sound, Seattle, Washington,a prepaid group practice (Health Maintenance Organization, HMO), during their three or five years of participation in the HIE. This Introduction exists to orient the reader to the reasons why the following abstraction guidelines required development.

The Rand Health Insurance Experiment (HIE), funded by a grant from the U.S. Department of Health and Human Services, was a large-scale social experiment designed to vary the patient's cost of health services and thereafter to assess how this deliberate variation affected use of services, quality of care, patient satisfaction, and health status. The HIE was also designed to study how the provision of services in either the fee-for-service system or a prepaid group practice affected those same variables.

Nearly 8000 people in 2750 families were enrolled in the Experiment in six sites across the United States: Dayton, Ohio; Seattle, Washington; Fitchburg, Massachusetts; Franklin County, Massachusetts; Charleston, South Carolina; and Georgetown County, South Carolina. The sites were chosen to represent the four Census regions of the country and an urban-rural mix, and to reflect variation in the amount of stress on the ambulatory medical care system (as expressed by long or short delay for new and return appointments).

Families were enrolled in the HIE for either three or five years (approximately 70 and 30 percent, respectively). Except in Seattle, low-income families were oversampled. Eligibility for participation in the HIE was broad; ineligible persons were mainly heads of households 61 years of age and older at the time of enrollment, members of the military, people confined to various institutions, and people eligible for Medicare. When families were enrolled, they agreed to assign their own health insurance benefits (if they were previously covered) to the HIE for the duration of their enrollment. Their health insurance policies were held in escrow and returned at the end of their period of participation. For people who had not been previously insured, some coverage was obtained during the HIE and made available to them at the end of their participation.

The families were assigned to one of 16 different insurance plans. For this purpose, a complex, unbiased allocation model was used to ensure that the assortment of families in each plan closely resembled that in every other plan, as reflected by 24 different demographic and socioeconomic variables. The 16 experimental plans were as follows:

- One plan in which care was free to the family (i.e., 0-percent coinsurance).
- Three plans with 25-percent coinsurance (i.e., the family paid 25 percent of its medical bills).
- Three plans with 50-percent coinsurance.
- Three plans with 50-percent coinsurance for dental and outpatient mental health services and 25-percent coinsurance for all other services.

- Three plans with 95-percent coinsurance.
- One plan with 95-percent coinsurance on outpatient expenditures only, up to a maximum out-of-pocket expenditure of $150 per individual ($450 per family) per year and no coinsurance above that; all hospital care was free on this plan.
- One plan that assigned some Seattle participants to the prepaid group practice, Group Health Cooperative of Puget Sound.
- One plan (a control group) that consisted of a random sample of people already enrolled in the Seattle prepaid group practice, Group Health Cooperative of Puget Sound, and who also met the HIE eligibility requirements.

It was for these last two groups, the "experimental" and the "control" group at Group Health Cooperative of Puget Sound (GHC), Seattle, Washington, the prepaid group practice, that the abstraction guidelines presented here were developed. However, we will continue with further general background on the HIE before returning to focus on the HIE/GHC population.

All plans except the first one and the last three had a ceiling on annual out-of-pocket expenditures by the family amounting to 5, 10, or 15 percent of annual family income-- the so-called "catastrophic insurance" feature. The maximum out-of-pocket expenditure per year per family was $1000 for the 50- and 95-percent coinsurance plans and $750 for the 25-percent plans. All plans including the GHC "experimental" plan (but with the sole exception of the GHC "control" plan) had an identical, very comprehensive benefits package that covered ambulatory and hospital care, preventive services, all dental services except

orthodontia, prescription drugs, certain over-the-counter drugs, most supplies and durable medical equipment, psychiatric and psychological services, and almost all other personal medical services, including those delivered by chiropractors and Christian Science healers. Enrollees in the GHC "control" plan were previously enrolled at GHC, and they retained whatever benefit package they already had by virtue of their prior enrollment at GHC.

Over the span of the HIE, data were collected on demographic and socioeconomic variables, health status, use of health services, satisfaction with and attitudes toward health care, and types of providers seen. The sources of health data included baseline interviews before enrollment, self-administered (or parent-completed) Medical History Questionnaires, biweekly Health Reports, annual Health Questionnaires, and medical screening examinations. Data on use of health services were obtained in the fee-for-service sector from claims submitted (chiefly by providers) for reimbursement for services rendered; and at Group Health Cooperative, comparable data on use of health services were obtained by abstraction from enrollees' records.

As noted, a major HIE objective was to study how the provision of services in either the fee-for-service system or a prepaid group practice affected use of services, quality of care, patient satisfaction, and health status.

In one of the HIE's sites, Seattle, Washington, the Group Health Cooperative of Puget Sound, a well-known, well-established prepaid group practice, agreed to cooperate with Rand's Health Insurance Experiment by allowing us to (1) enroll an "experimental" group of previously nonenrolled people into GHC, and (2) select a "control" group randomly

from among people enrolled for at least one year at GHC in a number of different GHC plans, none of which had any connection with the HIE. The Experimentals were drawn from the same population and assigned to GHC by the same, unbiased allocation model as was the population enrolled in the HIE's various fee-for-service insurance plans; while the Controls, drawn as a random sample from the GHC population, were not and were not meant to be directly comparable to the HIE fee-for-service population.

Experimentals and Controls together constituted slightly more than 1800 people, or slightly less than 24% of all HIE participants. Experimentals alone made up approximately 14.4% of the HIE population; Controls alone accounted for approximately 9.5% of the population. Experimentals accounted for approximately 36.7% of the total Seattle sample, while Controls represented another approximately 24.1%, for a total of around 60% of the total Seattle sample of slightly more than 3100 people. Half of the Experimentals remained in the HIE for three years, and the remaining half for five years, whereas all the Controls were enrolled in the HIE for five years. The words "approximately," "slightly," and "about" abound purposely, because percentages shifted continually during the years of the HIE as the various HIE plans experienced gains (for example, through births) and losses (for example, through attritions or deaths).

Experimentals were provided a package of benefits within GHC that matched as closely as possible the benefits available to the HIE's fee-for-service enrollees. When services covered by the HIE were not available at GHC (for example, dental and chiropractic services), these services were covered in full by the HIE for Experimentals obtaining them in the fee-for-service sector. In other words, the HIE/GHC

Experimentals had "free" care comparable to the "free" (0-percent coinsurance) fee-for-service plan. However, if an Experimental participant chose to go to the fee-for-service system for services which were in fact available at GHC, the HIE reimbursed only 5% of the charge for those services. Our reason for reimbursing even 5% was to encourage the Experimental participant to file a claim with the HIE for such services, so that we could measure out-of-GHC utilization.

Controls were not provided a benefit package by the HIE, because they retained whichever benefit package they had purchased by themselves or through an employer at GHC. Controls were reimbursed 5% of all charges they incurred, both outside GHC in the fee-for-service sector and inside GHC, if they brought the charges to the HIE's attention. A more lengthy explanation of HIE rules vis-a-vis Experimentals and Controls lies beyond the scope of this document.

Record abstraction was needed at GHC to be able to compare health services utilization by HIE/GHC participants with the utilization information flowing in on claim forms from the fee-for-service sector for other HIE participants. Information on outpatient (ambulatory) care, inpatient (hospital and nursing facility) care, laboratory services, drugs, and ancillary services was required. Outpatient record abstraction took place by calling for each HIE/GHC participant's medical chart (record) annually, and searching it thoroughly for evidence of all health services utilization not previously abstracted. Inpatient record abstraction took place by checking master inpatient files semiannually to learn of all admissions of Experimentals and Controls, after which the inpatient charts (kept separately at GHC) of the admitted participants were abstracted. Information on drugs obtained within the

GHC Pharmacy system by participants was sent directly on computer tape by GHC to a Rand data-coding and -processing subcontractor (Glen Slaughter and Associates, Oakland, California) from the GHC Pharmacy's data tapes, without any intermediate abstracting step.

Reports of laboratory and ancillary services are filed inside the outpatient and inpatient records at GHC. The HIE carried out a validation study on 554 tests to discover whether reasonably complete information regarding the services performed actually reached the outpatient and inpatient records. Missing rates for laboratory results were: bacteriology, 1.6%; chemistry, 3.4%; hematology, 8.5%; and radiology, 3.1%. The overall missing rate for laboratory results was 4.0%. The problem area was mental health services, where 20.6% of visits were not recorded in the "complete" GHC outpatient chart. We therefore established a special yearly abstraction procedure for GHC's mental health records, which are kept separately at GHC.

We believe we succeeded in abstracting essentially all care provided in the prepaid-group-practice setting, GHC. It is of course unknown how many services provided in the fee-for-service sector go unreported on health insurance claim forms. In the fee-for-service sector, the positive incentive to file claims for all reimbursable services must be balanced against (1) internal administrative inefficiencies and (2) failure to report certain services that the provider may think are not reimbursable. The HIE has carried out a major Utilization Verification effort, to be reported elsewhere, that will shed light on this issue in the fee-for-service sector. It seemed plain to us that we needed to do our utmost to achieve as close to a complete count of services rendered at GHC as possible.

The abstractor abstracted from each outpatient chart once per year--always at least 4 months after the completion of the year to be abstracted, and in many instances substantially longer. Thus, there was little chance that the abstractor might miss a service because its documentation had not yet reached the chart by the time of abstraction. Furthermore, the next annual abstraction provided an additional opportunity for the abstractor to ascertain that she had missed no utilizations recorded in the chart for any of the previous years. The annual abstraction cycle had several advantages. In view of the fact that each chart-pull costs money and requires employee effort, more frequent chart-pulling was desired neither by Rand nor GHC. The annual chart-pull permitted the abstractor to "get to know" the high utilizers, as multiple visits required abstraction; it is probable (but cannot be shown) that more accurate abstraction was thus achieved. The annual cycle also permitted us to recognize a missing chart before more than one year's worth of data had been lost. In fact, lost charts were extraordinarily rare at GHC, although a number of hard-to-find charts took considerable time to retrieve. Among the HIE/GHC participants, there were no lost charts during the first two years; only one chart lost for the third year only, because GHC established a substitute chart by the time the fourth year began; and only two charts lost for the fourth and fifth years.

Administrative oversight regarding the abstractor's productivity and progress-to-date was provided by her completion of a monthly Abstraction Status Report, which stated the number of outpatient charts reviewed, the number of people with and without at least one

utilization, the mean number of utilizations per person having any utilizations, and how far along the list of approximately 1800 names the abstractor had proceeded during the then-current abstraction year. A similar Report was completed for inpatient utilizations.

Abstractors were selected on the basis of educational background, experience, interviews by GHC and Rand personnel, and a practical test of abstraction ability. All these factors proved to contribute to the hiring decision. Our first abstractor left the project during the organizational phase of activity, so in fact there were three abstractors working during the lifetime of the HIE, each working for approximately two years. Abstractors were trained internally by GHC, and also by a Rand/HIE physician with extensive experience in chart review. The abstraction guidelines presented here were important training and standardization tools. Of course, these guidelines became progressively more detailed, due in substantial measure to the questions raised by our abstractors as they performed their tasks.

Another facet of training and quality control was the visits (at least one per quarter-year) by the Rand/HIE physician to GHC. During these visits, intensive, visit-by-visit, line-by-line review of recently completed abstractions was carried out. Problem abstractions were saved by the abstractor for the physician's visits; and abstractions from recent, "non-problem" charts were also reviewed. This was another mechanism for improving abstraction guidelines, ensuring a high-quality level of abstraction, and instilling understanding of the importance of the HIE. Finally, frequent telephone calls took place between the physician and the abstractor, and the abstractor and the data-coding subcontractor. This contact provided further support and quality

control, and enhanced a cooperative, team effort which we believe was crucial in maintaining high abstractor morale in what was by nature an isolated, lonely job. Also important was the fact that each abstractor was a GHC employee and therefore could feel more at home in the organization within which she was working.

Formal, independent repeat abstraction of records was carried out only once during the abstraction period. The Rand/HIE physician abstracted some visits, and his work was compared with the work of the abstractor. Results were highly satisfactory.

Further formal, independent record abstraction was eschewed because of time constraints during the physician's visits to GHC. However, much of the physician's routine review of the abstractor's work was in fact independent: The physician would hold the chart and state out loud what he would have written for a given visit, while the abstractor was watching her already-completed abstraction form for that visit. The two would then huddle over the chart and abstraction form to resolve discrepancies, if any. Thus, the physician did not look at the abstraction form until after his abstraction decisions had been verbally stated. It will be plausible to any reader with medical record abstraction experience that it was not always the physician who was right and the GHC abstractor who was wrong in these interchanges. From this procedure came careful attention to detail and expanded, more explicit abstraction guidelines.

The Health Insurance Experiment's Abstraction Guidelines for Outpatient Services at Group Health Cooperative of Puget Sound, Seattle, Washington

INTRODUCTION

Sources

To assist you in your abstraction of outpatient (ambulatory) utilization information from several Group Health Cooperative (GHC) sources onto the Services Rendered Report (SERR), you have two references aside from the original source material.

(1) You will receive Encounter Logs from Glen Slaughter and Associates (GS&A) in Oakland, California. GS&A is the Health Insurance Experiment's subcontractor responsible for claims processing, payment, and coding. Encounter Logs are kept by GS&A; GS&A obtains information on recent encounters from Health Reports submitted by most Health Insurance Experiment (HIE) participants, and adds this information to each individual's Encounter Log, which is therefore cumulative. Thus, when you receive an updated Encounter Log for any HIE participant, you can discard the earlier Log. GS&A has also sent you identifying information for those few HIE participants who do not fill out Health Reports; thus, you will not "lose" any HIE participants who are using GHC. Note that Health Reports were discontinued in summer, 1978, and reinstituted in autumn, 1979.

Encounter Logs are helpful because they provide you with some reasons for visit, thus making it easier to identify in a record an encounter (utilization) reported in the Encounter Log. More importantly, although you will attempt to find all utilizations (whether mentioned in the Encounter Log or not), you will make certain that you find, at minimum, every encounter listed in the Encounter Log. (This is the equivalent of what we call "claim form tracking" in the

fee-for-service system. In the rare event that you are unable to discover any evidence of a utilization that was reported in the Encounter Log, even after attempting to confirm the utilization by contacting a provider, notify GS&A by written memorandum (but do not fill out a SERR).

Please note that GS&A will not send you the entire set of Encounter Logs automatically, because that would result in your use of outdated Logs, if (for example) you received Logs in January for participants whose records you did not get to examine until April. Instead, you should request from GS&A the Encounter Logs of those enrollees whose records you will be looking at during the next month or so, so that the Encounter Logs you are using are always reasonably up to date.

(2) You yourself will maintain a reference, the History Card, aside from the original source material. Each utilization abstracted onto a SERR is recorded by you on your own History Card (one for each HIE enrollee), which becomes a complete though undetailed summary of all utilizations of each participant, as well as a record of all encounters you have previously abstracted. It should also contain the participant's HIE plan (experimental or control), and the effective date of enrollment. The History Card functions as a Problem List, as well as a utilization summary--and is thus a reference and aid in filling out subsequent SERRs. The History Card is especially helpful in deciding on diagnosis and on treatment history.

Information Sought

Once you have pulled a participant's record, be sure to examine it thoroughly for all possible utilizations. For example, there may be out-of-order visits to providers or to the Emergency Room (left side of GHC record), there may be "unattached" lab slips or x-rays, evidence of visits for an injection only (see the very back of right side of GHC record) or for immunization (especially for children), or even evidence of an inpatient stay. Record all utilizations. This procedure will enable us to capture utilizations not reported by HIE participants on Health Reports mailed to GS&A. (Health Reports were not in use between summer, 1978, and autumn, 1979.)

Note that we are interested in listing all "encounters" or "services" received by HIE participants. Thus, a "visit", in the sense of an office visit, is only one type of encounter or service that can be received. (For example, a patient can visit GHC and receive a laboratory test without having a "visit".) Your task is to report on all outpatient (and inpatient--see the inpatient abstraction guidelines) services received by HIE participants, and not only on office visits. Office visits are, of course, a very common type of service or encounter, and they are defined operationally as encounters to which GHC assigns an office visit code. Rand memoranda SM-3283 of 21 September 1976 and SM-5171 of 6 March 1978 provide a listing of such codes, both for non-mental health visits and for mental health visits (and services). For mental health services, the memorandum is supplemented by information listed on the GHC mental health charge slip.

On a periodic basis, you will be checking the regular outpatient, mental health outpatient, and inpatient records of all GHC HIE participants in sequential manner.

Information on the use of the GHC Pharmacy by GHC/HIE participants comes to the HIE directly on tape (requested by you once a year, in September), so guidelines of abstraction for records from the pharmacy are unnecessary, and have purposely not been developed.

Whenever you have doubt concerning the type, amount or format of information that you should enter on the SERR, please feel free to discuss any question with the claims coder (adjuster) or her supervisor at GS&A in Oakland, or with your GHC supervisor, or with Rand's medical consultant.

Throughout the SERR, use "Z" for "not available," "?" for "questionable," and "NA" for "not applicable." Also, in these guidelines, the titles "provider" and "practitioners" are used interchangeably.

NAME OF PATIENT

Include middle initial, if given.

PATIENT'S FAMILY NUMBER

Enter the LB number.

PATIENT'S INDIVIDUAL NUMBER

Enter the RB number.

NAME OF PROVIDER(S) AND AREA LOCATION

Where a practitioner on the medical staff (including medex and nurse practitioner) has provided care, list the practitioner's name with corresponding area location (Ex: Dr. X-Central).

If a medex/NP provided care, and the note is merely countersigned

by the physician, enter the medex/NP alone as the provider. An informal "curbside" consult or quick review of x-rays by a physician does not constitute reason to enter the physician's name as a second practitioner. If, however, the handwriting or the text from the record indicates that the physician did more than countersign the medex/NP's work, or informally consult, then include (on one SERR) both the medex/NP and the physician as providers. Of course, if the patient was seen by a medex/NP for one problem, and a physician for a second problem (or at a different time or location), then complete two SERRs, one for each utilization.

If a medical student under the supervision of a physician saw the patient, list the physician as the sole provider of care.

A GHC housestaff provider is listed under his/her own name for outpatient services (unlike the procedure for inpatient services). A resident from the University of Washington who is rotating through GHC for training should be designated only as "U. of W. resident."

For a Home Health Visit made by other than a physician, enter the name of the type of professional making the visit, not the name of the physician under whose auspices the visit was made. However, if a medical student, under the supervision of a physician, saw the patient, list the physician as the sole provider of care.

It is highly important to link the services ordered with the provider who ordered them. A great effort should be made to discover and record the linkage. Whenever possible, a medical staff member should be the provider, rather than a lab, x-ray department, etc. Therefore, combine, as much as is logical, lab and x-ray on a SERR which includes the

medical staff member visit. You will, in fact, almost always be able to accomplish this.

In the rare event that a SERR does record a laboratory, x-ray or special procedure provided without an associated visit (which need not necessarily occur on the same day) with a practitioner, enter the name of the requesting practitioner, if known, in the "referred from" box. Leave the provider box blank, but write in the area location where the service was performed.

If the SERR records a service for which a dietician or physical therapist is the provider, enter "dietician" or "P.T." (not the specific name of the dietician or physical therapist) in the provider box, enter his/her area location, and write the requesting practitioner's name in the "referred from" box. If there are repetitive visits for P.T. or dietary consultation, continue to write the requesting practitioner's name in the "referred from" box on each SERR.

For a service provided outside of GHC, enter the name and address of the provider (and the dollar amount), and specify whether the provider is located inside or outside of the GHC service area (Ex: ABC Labs inside GHC area). See the section, To SERR or Not To SERR, below, for further instructions.

RN Services

When an injection (e.g., allergy or immunization) given by a registered nurse is the only service provided on a given date, write in the practitioner's name as the provider (not the RN's name), if it is available. If you cannot determine who was the provider who ordered the injection, then write in the name of the clinic (e.g., allergy clinic)

as the provider. Give the area location (Ex: Dr. M-BN). Fill out the entire SERR, and pay particular attention to describing the substance injected as completely possible in the Services box. For other, simple RN-only services (e.g., "VM" visits) such as "blood pressure check" or liquid nitrogen treatment of a wart, follow the analogous procedure.

If the RN handles simple office visits (a "V1" visit such as a nurse's screening exam, a well-baby check, or an upper respiratory infection) or emergency room visits, nevertheless write in the practitioner's name as the provider (not the RN's name). In contrast, note that if a medex or nurse practitioner were to provide exactly the same service, you would write in the particular name of the medex or nurse practitioner.

RN Refill Service

Put "RN" and clinic location (Ex: RN-Northgate). This official service was not available after 1977. If, however, you see a note written by a physician's nurse (underneath the physician's name-stamp) that records a visit by a patient where only the nurse was seen, and only for a refill, then use the physician's name as provider, and code a "VM" visit.

AREA LOCATION

Feel free to use the standard one-letter or two-letter abbreviations (attached) to designate the area location. For Eastside, be certain to distinguish Eastside Family Care (ES) from Eastside Specialty Care (E).

For home health services, write in the name of the GHC area location (usually Central) which is overseeing the home health services.

The information, "H" (home visit), will be entered under "place of service," rather than here.

When a service, whether furnished by GHC or not, is provided at a place which is not an area location, enter "inside GHC area" or "outside GHC area" in this box. In this case, you are specifying inside or outside the service area.

REFERRAL

If one practitioner (a physician, a Medex, a PA, a nurse practitioner, etc.) clearly (a) had a patient sent by a previous practitioner, or (b) sent a patient to a subsequent practitioner (whether or not the patient ever saw the subsequent practitioner), enter the full name in the (a) referred from or (b) referred to box. Note if the referred-to practitioner is outside of GHC. A patient can also be referred to a laboratory or special facility, so if a laboratory or other test or procedure is separated from a visit (i.e., appears on a separate SERR, a rare occurrence), be sure to enter the name of the referring practitioner who ordered the test or procedure. That name may appear on the laboratory or x-ray slip. If there is apparently no referral, simply draw a line, which will signify "none". (Of course, if the patient is requested by a practitioner to return to him/herself, that is not a referral.)

If possible, for a referral, give the specific name of the practitioner or lab; if it is not available, then write in the specialty name and/or location. For example, if a practitioner wrote, "Refer to Dr. G," and the appointment was kept or not, enter Dr. G in the "referring to" box; if the practitioner wrote Dr. G but the patient saw Dr. F

instead, enter Dr. F in the "referring to" box; if the practitioner wrote, "Refer to GI," and the patient saw Dr. G, enter Dr. G's name; and if the practitioner wrote "Refer to GI" but the patient did not go to GI, enter "GI" in the "referring to" box.

If one practitioner writes, "Check with Dr.---- as needed," that is not a referral; however, a definite followup visit to another practitioner is a referral.

If one physician (e.g., an internist) forwards x-rays or laboratory reports to a second physician (e.g., an orthopedist or endocrinologist), so that the second physician (without seeing the patient in question) can review the results and decide if the patient should be seen in consultation, the sending of the results alone does not constitute a referral. There is no referral unless the second physician is (or was to be) actually visited by the patient.

If a patient is referred from the ER to his/her own practitioner (who did not attend the patient in the ER), that is a referral, so long as an appointment was specifically made or requested (in writing). However, if only a phone call is "scheduled" (e.g., "Call back to primary MD in 7 days"), that is not a referral.

"Dental referral suggested" is not a referral; "refer to dentist" or "refer to DDS" is a referral.

REASON FOR VISIT

Fill in this box on the basis of information found in the Encounter Log sent to you by GS&A, never on the basis of information written in the record. If the reason for visit is not available from the Log, circle this box. If the enrollee is one of the few who does

not have an Encounter Log (because there is no Health Report filled out), write N.A. (not applicable) in this box. GS&A may telephone you from time to time, to discuss problems arising from the completion of this box. (Between summer, 1978, and autumn, 1979, there was no Encounter Log to provide reasons for visit. During that time, the box was left blank for all enrollees.)

ACCIDENT OR INJURY

Was the injury or illness accident-related? Interpret "accident-related" to mean "injury-related." Any injury that is not intentionally self-inflicted (including strains, sprains, involved in fight, lacerations, concussion, fractures unless caused by disease, burns, rape, dislocations, bites, stratches, abrasions) means you should check "yes" for accident-related. If a child ingests a toxic substance, checking "yes" or "no" depends on age and intent. If an adult attempts suicide, do not label it an accident.

PLAN

For your information, the type of HIE plan is found under "Plan Type No." on the Registration Card, which was provided to you by GS&A in 1976. However, you need not enter the plan number on the SERR.

30 = Experimental. If a Plan 30 participant remains in GHC after the effective date of termination, be sure not to fill out SERRs for utilizations after that date.

98 = Control (member of GHC previously). For Plan 98 participants, be sure not to fill out SERRs for utilizations occurring prior to the effective date of enrollment (that date is listed on the Registration Card) or after the effective date of termination.

PRIMARY PROBLEM OR DIAGNOSIS

- Use the practitioner's diagnosis/problem, if it is found in the chart. It may also be found in previous visits or on a Problem List, and can be used if it is apparent that the previous and current diagnosis/problem are one and the same. Try to avoid giving symptoms or a practitioner's comments on progress, if you can possibly find or infer a more substantial diagnosis or problem. For example, "slow, rather poor progress of left ear" should be eschewed in favor of using "left otitis media" which diagnosis had been made on a recent, previous visit. Or, if the diagnosis is "allergic reaction," and you can specify the type (e.g., hives, anaphylaxis) of reaction from information available in the record, please do so. Or, if the physician employs vague language such as "viral syndrome" or "virus" or "flu syndrome," use the physician's language, but in parentheses provide further information (if available) about the involved area(s) of the body or some of the symptoms mentioned, so that GS&A can code the condition as specifically as possible.
- List all the diagnoses/conditions that the practitioner specifically listed, as well as any other diagnoses/conditions (not listed by the practitioner) for which there is evidence that the problem was considered or acted upon by the practitioner. For example, if the practitioner does not list diabetes as a diagnosis (during a visit for upper respiratory

infection), but the text of the progress note shows that he considered the diagnosis (for example, he asked questions about its control), then include diabetes as a diagnosis (and mark the abstractor's inference box as 1) (AI=1) even if no action was performed because of the diabetes.

- o Generally, each diagnosis/problem should be listed on a separate line.
- o If a practitioner lists more than four diagnoses/conditions, select for inclusion on the SERR the four for which there is the most evidence of action taken or consideration given. In case of doubt, discuss the question with your medical consultant.
- o Write "with" between two diagnoses, only if the practitioner used the word, "with," even if the two diagnoses are related. Conversely, it is not required (although it is acceptable) to use "with" when "with" is written, if you think that the practitioner was merely indicating an additional diagnosis, not a related one.
- o Include "Rule out," "Probable," "?", etc., with the diagnosis, if written by the practitioner. GS&A can code these qualifiers (and you will rarely find a long list of "Rule Outs" in these outpatient charts).
- o Use the practitioner's sequence of diagnoses, in the case of multiple diagnoses. Do not attempt to enter the "most important" diagnosis first. Any inferred diagnoses added by the abstractor are written after those listed by the practitioner.

- List a diagnosis for lab, x-ray, or physical therapy, if available--otherwise, write "Z."
- When applicable, and if available, enter "left" or "right" or "bilateral" along with the diagnosis/problem. For example, if a laceration, say where; if a lesion, say where; if cellulitis, say where.
- If the diagnosis is "muscle strain," record the involved part of the body.
- If the diagnosis is listed as "recovery from viral illness," give the specific type of viral illness, if such information is available in the chart.
- If an entire visit consisted of nothing but an immunization of any type (and the visit code is VM), then list the "diagnosis" as "Immunization NEC," rather than as "Well Care," with AI=2. Of course, the treatment history code is well care.
- If a well-baby examination included immunizations, there is no need to enter "immunizations" as a second, separate diagnosis. Of course, the immunizations will appear as services rendered.

Abstractor's Inference Box for Diagnosis or Problem

Use this box if you are inferring any diagnosis or problem. Inference means that you could not find the diagnosis/problem in an encounter being abstracted. If you find the diagnosis/problem in a Problem List or in a recent previous encounter, enter "1." If you had to formulate the diagnosis/problem without help from a Problem List or recent previous encounter, enter "2."

Concerning well care, if you infer that well care was given, enter "2" in the AI box as you record this (or any other) additional diagnosis. If a visit was recorded on one of GHC's Physical Examination Forms, thus implying a routine well care visit, then you can enter "1" in the AI box, if you need to write in "well care" as a diagnosis.

Obviously, you may be inferring one diagnosis, but not inferring another; use the AI box next to your inferred diagnosis only.

TYPE OF PROBLEM

No entry is needed for lab, x-ray, or physical therapy, if one of these services appears alone (without a staff member visit) on a SERR.

Type of Problem and Treatment History (see below) are closely connected. You should decide if the condition is acute, well care, flare-up of chronic or chronic (not flare-up), as you also decide if this is an initial or repeat visit for an episode. Attached you will find lists of conditions which are usually acute, usually chronic and usually well care, as well as further discussion of treatment history. Coders at GS&A have a great deal of experience, and will be glad to advise you, as will the medical consultant. Note that the SERR is organized so that a different Type of Problem and Treatment History can be assigned to each diagnosis/condition you list on the SERR. Type of Problem and Treatment History are assigned to mental health visits, too.

In determining the dividing line between acute and chronic designation of a condition that could be either, or could change from being acute to chronic (because the condition unexpectedly did not

respond to treatment and disappear), it may help to consider if services for the illness were foreseen or unforeseen, from the participant's point of view. If the participant cannot foresee the pattern of future utilization (i.e., visits or laboratory tests are unforeseen), then the condition is still acute. If a point is reached at which you surmise that the participant now can indeed foresee a pattern of future utilization, then at that point the condition has become chronic.

- o Acute = self-limited illnesses of usually sudden onset (also generally includes pre-op and post-op visits). For a laceration, fracture, etc., where no symptom date appears, assume that the visit date and symptom date are identical, unless written information is to the contrary. Certain illnesses not acute in onset, may nonetheless be acute, so long as they had a "start" and have an expected "stop" (ex: wart, cyst).
- o If a final diagnosis is "No x," that does not mean that the visit was well care: "No ingrown toenail" is an acute visit (from the point of view of both the patient and provider).
- o If the "problem" is "Abnormal HIE Test Result," then the type of problem is acute, not well care.
- o Well Care = physical examinations, routine gyn examinations, routine eye examinations, normal pregnancy visits, etc. As a guide, see the well care diagnosis list.
- - Use well care for a clearly quiescent infectious disease (implication of checking on disease activity for a disease

whose acute episode ended more than or equal to one year ago, and no activity is expected). An example is rheumatic fever follow-up (in certain cases).

- Use well care for routine eye examinations, though abnormality (e.g., myopia, hyperopia, presbyopia) may exist.
- If an illness is discovered and/or dealt with during a well care examination, it will be entered on a separate line on the SERR and assigned its suitable Type of Problem.
- Flare-up of Chronic = flare-up of chronic condition. As a guide, see the chronic conditions list. Flare-up might be used if symptoms exacerbated, or if a chronic condition entered a temporary acute phase, or if treatment for a chronic condition began to produce problems. If a chronic problem flares up, but the participant had never been seen for the problem at GHC before, that is still a flare-up of chronic: What matters is the medical condition.
- Chronic (not flare-up) = routine chronic conditions. As a guide, see the chronic conditions list.

For a visit made to discuss a surgical procedure that may be carried out in the future, code initial acute if the surgery was eventually performed, but well care if the surgery under consideration was not performed.

Abstractor's Inference Box for Type of Problem

Enter a checkmark (not a "1") in this box if you are inferring the type of problem.

TREATMENT HISTORY

Consult previous visits or your History Card, if the treatment history is not clear from the current visit. See the Appendix, Further Guidelines for Coding the Treatment History.

Initial includes a pre-op visit, and the first visit when a chronic condition flares up. Use initial for the first time the patient visits for a condition, whether acute or chronic.

Repeat includes a post-op visit, and a repeat visit for a condition whether acute or chronic. Referrals and consultations are usually repeat visits, even if the participant is seeing a particular practitioner for the first time: what counts is the "old" illness episode, not the "new" practitioner. Similarly, if a participant was seen at GHC for a problem prior to starting with the HIE, and then seen again after the HIE effective date for the same problem, the visit occurring after the effective date (although "first" in the HIE) is still a repeat visit.

For episodes, think medically by illness, not by a particular practitioner. When the illness leaves the question of episode ambiguous, look at the time course, to determine if this is the same, or a new episode.

For treatment histories related to pregnancy and delivery, see "Ob-Gyn Services" under "Services."

If the treatment history is needed, but is unknown and cannot be

inferred, enter "Z" which will mean that is unavailable. If you do not do this, GS&A will assume that you forgot to fill in the box, and will telephone you.

A visit at which performing surgery is either considered or decided upon should be coded with the treatment history of initial acute, if the surgery was eventually performed. If this initial acute visit was followed by a visit or consultation with a surgeon, the visit to the surgeon is repeat acute, if the surgery was eventually performed. If the surgery under consideration was never actually performed, then designate the treatment history as is appropriate.

For routine visits occurring to check on a condition which has been quiescent for at least one year (e.g., routine visits for post-hysterectomy or for long-ago rheumatic fever or tuberculosis), code the treatment history as well care, rather than chronic repeat. Well care is used only with no evidence of active disease, no complications which are being followed because they might get worse, and only if the visit is perfectly routine. If in doubt, use chronic repeat as the treatment history code.

For an office visit generated because of an abnormal finding on the HIE entry screening examination, the treatment history is initial acute, and the symptom date is "Z".

If abnormal lab results are unexpectedly found on routine lab work, the return visit caused by the new finding should be initial acute, and the symptom date is the date the laboratory specimen was taken.

If the diagnosis being "ruled out" is acute, use initial acute as

the treatment history code. If the diagnosis being "ruled out" is chronic, use initial chronic as the treatment history code.

Abstractor's Inference Box for Treatment History

Enter a checkmark (not a "1") in this box if you are inferring whether this is an initial or repeat visit, for this particular episode of this particular diagnosis/problem. This AI box is for the Treatment History only, not for the Date Symptoms First Occurred information.

DATE SYMPTOMS FIRST OCCURRED

For pregnancy, give the date of the last menstrual period (LMP); use the same date for post-partum visits, as well.
Note that there is no entry necessary for repeat chronic (not flare-up) conditions and well care, which is logical; however, symptom date is necessary for initial chronic (not flare-up), as well as for acute conditions. If the symptom date is needed but not available, enter "Z". If a range of dates is given, i.e., "cough started 6-7 days ago," write down the maximum length of time mentioned.

For the removal of warts, moles, cysts, or other cysts, or other surface lesions, choose as the symptom date the date of appearance (most preferable, but rarely available) or the date of the pre-op visit (second most preferable) or the date of removal (least preferable, but still acceptable). Do not record "Z" as the symptom date. Also, record the number of warts or moles; and the size of excised surface lesions such as lipomas or cysts.

For lacerations and fractures, assume that the symptom date is the same as the date of service, unless the note contains information to the contrary.

For surgical procedures such as operations, the symptom problem date is generally the date of the visit at which the performance of surgery was decided upon. The date may be even earlier, if symptoms plainly preceded the date of the visit when surgery was decided upon. Occasionally, unclear notes may compel you to select the date of surgery itself as the symptom problem date.

DATE OF SERVICE

It is not necessary for all services reported on one SERR to have been rendered on the same day, so long as there is a logical, medical connection among them.

If a service was ordered on a date different from the date the patient received the service, use the date the patient received the service. For bacteriology, use the date the culture was started, rather than completed.

If there is a procedure for which you cannot find the date of service on the report slip or in the record, then try to find the date of service elsewhere (for example, in a laboratory's logbook of procedures). If the date of service is just plain irretrievable, then select the date of the nearest or most logical visit to a provider, and use that date.

If there is an undated visit to a provider, then try to ascertain the date of the visit by other means (for example, by telephoning the provider's office staff and seeing if they have a record of the visit). If the date of the visit is just plain irretrievable, then look at the surrounding visits which "bracket" the undated visit. Be as logical as possible, and give at least the year, and whenever at all possible, the

month. If there is information available from the Health Report (via the Encounter Log) which matches the information found in the record, then you may use the date of visit (if present) specified in the Encounter Log. (Health Reports were discontinued between summer, 1978, and autumn, 1979.)

From time to time, GS&A coders may telephone you, in search of a "missing" utilization, that is, a utilization which GS&A has learned about, yet for which GS&A received no SERR from you. See page 42, "Missing Visits," for further informaion.

PLACE OF SERVICE

Use place of service codes listed on the SERR.

Note that "L" is used only for lab or x-ray services rendered "outside of GHC". Use "O" for any (central or area clinic location) internal GHC lab or x-ray, as well as for outpatient visits to providers.

SERVICES

Here is an example of how a portion of the SERR would look upon completion:

DIAGNOSIS

A. Sore Throat
B. Diabetes

	SERVICES	Office Visit Type	Relate Treatment To Problem
1/3/79	OV	V2	A B
1/3/79	Throat Culture		A
1/3/79	SMA-6		B

Write OV (office visit) for each visit except for emergency room visits, in which case write "ERV."

Laboratory Work, Including X-ray

It is not enough that a note says that a lab test/x-ray/etc. was ordered or even done: there must be evidence (a returned slip) that the text/x-ray was performed. If the result of a test is written in a note, then the written result should also be considered as evidence of performance, even in the absence of a returned slip.

For every visit, even well care, be sure to record all tests, procedures, etc., rendered. If, for a given procedure or test, you are not certain what degree of specificity is required, consult the CRVS book to see what distinction it makes. If there is still a question, telephone GS&A or write in the most specific information and let GS&A decide on the necesssary degree of specificity.

If a participant is scheduled for a complete physical examination, and that physical exam is preceded by a "visit" whose only purpose is ordering and/or obtaining pre-exam laboratory work (e.g., an LPN writes in the chart which tests were ordered), the pre-examination lab work should not be listed as a visit. Record the lab work on the same SERR as the complete physical examination that follows.

For x-rays, lab tests, etc., give the specific test. For example, say bilirubin, SGOT, SGPT, instead of "liver function tests."

- If the practitioner ordered just a few chemistry tests, but the laboratory performed an entire SMA-18 (or -12 or -6) on its own, and wrote in extra results in addition to the ones the practitioner ordered, then you should record only the specific tests that the practitioner ordered (checked off on the lab slip).
- If the practitioner ordered a "culture and sensitivity," but the laboratory performed only the culture, then record only the culture. In general, whenever there is a discrepancy between what appears to have been ordered, and what appears to have been done, record what was done.
- If a cervical culture is ordered only "for GC" and not for "all pathogens," then write "cervical culture for GC," rather than "cervical culture--all pathogens."
- If a quantitative platelet count was done (rather than just a qualitative description of platelets), please note this.
- If a stool sample was checked for occult blood (O.B. or hema-test or guaiac), note this. A rectal examination without a stool check should also be noted. The "physical examination" section of the printed GHC Medical Questionnaire Form contains a line entitled, "rectum"; if it is checked, do not assume that a rectal examination was done--there must be positive assurance that a rectal examination was done (e.g., rectal showed..., prostate was...).

- If a CBC has a differential, write "CBC with diff.," not just "CBC."
- When a glucose tolerance test is done, record both the number of blood specimens drawn and the number of hours (3 or 5) the test lasted.
- For pulmonary function tests (PFTs), state if they were performed with and without, or just without bronchodilator (aerosol). Arterial blood gases, if performed concurrently, should be listed separately.
- A "pure T3" (T3 by RIA) is reported as a decimal (.62), and is different from a "T3 uptake," which is reported as a percentage (usually between 25 percent and 35 percent).
- For each x-ray requisition, write in the number of films exposed (see second line, second box of the x-ray requisition and report form), e.g., sinus series (4). In the case of a chest x-ray, if only one view of the chest was obtained, be sure to specify "one view"; otherwise, two views will be assumed. In addition, be as specific as possible about the portion of the body that underwent x-ray.
- Always write "left" or "right" or "bilateral", if applicable, when recording an x-ray (Ex: ankle).
- For echography (ultrasound) procedures, specify the part(s) of the body which was examined.

Obstetrics-Gynecology Services

Be sure to specify every Pap smear, pelvic exam, fern test, and/or cervical culture, etc. It is not necessary to record staining of the cervix with Lugol's solution. For a cervical culture, specify (if available) if the culture was for gonorrhea (GC) or not. When both colposcopy and cervical biopsy were performed, list the two procedures separately.

When is a "pelvic" not a pelvic examination?--when only a Pap (and/or cervical culture and/or wet mount) was done, and there is no specific evidence of a general examination of the internal organs.

Include diaphragm fitting and IUD (intrauterine device) insertion as Services.

For a routine pregnancy, four or five SERRs will usually be needed:

- First Prenatal Visit (new obstetrics visit)--Fill out a SERR for this first visit, including the prenatal lab panel (be specific as to which tests are included, and which nonroutine tests, if any, were also performed), cervical culture, Pap, and pelvic examination. If this "first visit" was really two visits (one to the nurse for routine lab, and a second to the obstetricians for Pap, pelvic, and confirmation of pregnancy), then two SERRs will be needed.
- Prenatal Visits--One SERR can be used for all routine prenatal visits (excluding the first visit). Each routine prenatal visit date should be noted separately, although a different line is not needed for each one. Record all lab tests performed (and dates of performance) during the prenatal visits:

include ordinary blood work such as hematocrit/hemoglobin, and also include the "urine screen" (the in-the-office urine dipstick check for protein and/or sugar). If a separate urinalysis was ordered from the regular laboratory and was reported on a standard lab slip, be sure to record the complete urinalysis. Also record (and date) any non-routine procedures (e.g., ultrasound). If you find that you are abstracting a chart while the enrollee is in the midst of a pregnancy, go ahead and abstract all prenatal visits that are currently in the chart, without waiting for the delivery to take place.

- o Delivery--A hospitalization abstract will be needed. The treatment history code for delivery is "initial acute." Consult your inpatient abstraction guidelines.
- o After Delivery--Fill out a separate SERR for any postnatal visits. The treatment history code for routine postnatal visits is "repeat acute." Include all laboratory tests performed, without exception.

For non-routine pregnancy care (abnormal pregnancy), fill out a separate SERR for each utilization as it occurs. Also, for care given during pregnancy but not related to the pregnancy, fill out a separate SERR each time a utilization occurs.

Ophthalmological Services

For eye examinations, refraction or tonometry (a glaucoma screening test) must be listed specifically, if done. Write one or both of them in parentheses if they were only a part of an eye examination you are

recording, so that it will be clear to GS&A that they were not independent procedures. If they are not written down, GS&A will assume they were not done.

If glasses or contact lenses were prescribed, note that under "supplies." For glasses, specify if clear or tinted, and if bi-, tri-, or monofocal lenses. For contact lenses, specify whether hard or soft.

For the furnishing of eyeglasses or of contact lenses, fill out a SERR for each pair of glasses (or contact lenses) obtained from GHC Optical, whether or not any charge was made. If regular lenses were dispensed without accompanying frames, make that clear. Because the actual provision of glasses is usually noted on a special slip which includes only the lens fee, frame fee, sales tax and total, assume for purposes of SERR completion that the lenses furnished (whether regular or contact) are the same as those prescribed during the most recent previous examination. When recording information about purchase of glasses, give separate charges for frames and lenses.

For contact lens visits, there are no special type-of-visit codes. Instead, list the various kinds of contact lens visits as follows:

Central Contact Lens Department's Designation	What You Write On the SERR
Contact lens fitting exam (not currently a C.L. wearer)	Contact lens exam
Initial GHC exam (a C.L. wearer)	Eye exam (C.L. dept.)

Annual exam (established patient)	Eye exam (C.L. dept.)
Follow-up exam	Contact lens check
Diagnostic fitting exam	Contact lens check

Indicate that the service was provided by the contact lens department, how much the patient was charged, and what was prescribed or suggested. There is no need to enter a type-of-visit code. When you fill out a SERR for an initial or annual contact lens exam, you should also telephone the optometrist's assistant and ask for the dates of all subsequent visits and charges to the patient.

Physical Medicine Services

For physical medicine, write out each procedure or modality performed (including manipulation, orthotics training, prosthetic training, etc.). Include the GHC code (#1, #2, #3, or #4) for the type of physical medicine visit, as well. If available, also enter the amount of time spent in treatment.

Drugs and Supplies Services (Provided During a Visit)

Include medicines and supplies actually given in the office. For medicines, specify dosage information and route (oral, intramuscular, etc.). However, if a prescription is to be filled later, do not enter the medicine or supply under Services; put it under the "prescribed or suggested" section.

It is important to distinguish a procedure performed from a supply provided, and from a supply prescribed. The use of the word, "splint," is particularly problematic, because "splint" can be either a noun or a verb. If a splint is applied (a procedure), write "splinted" or "splint

applied" in the Services box. If a splint is sold or given to the patient, write "a splint" in the Services box. For a splint that has been prescribed or suggested, write "a splint suggested" in the Supplies Prescribed or Suggested box.

- o Include Ace bandages, crutches, and splints under Services, only if they were provided at the time of the visit.

Mental Health Services

For each mental health visit, determine and list the type of therapy, duration of therapy, number of patients involved and number of therapists involved. At least annually, check the names of all GHC/HIE participants (experimentals and controls) against the Central Master File which is located at GHC's Central Mental Health Center. For all those participants with active folders, check the utilizations listed in their folders against the utilizations noted in the main outpatient record, and fill out a SERR for each utilization which, because it is in the folder but not in the record, you have not already reported to GS&A on a SERR. Do the same at Eastside Center.

For family therapy, fill out an individual SERR for each family member. On each one of the SERRs, be certain to write very clearly that family therapy is involved, and state the total number of family members taking part so that GS&A will be able to divide the CRVS units by the number of individuals obtaining therapy and to assign the resulting value to each person. If a GHC/HIE participant attends family therapy with a "significant other" who is not a person covered by GHC, write in the name of relationship (e.g., "boyfriend," "fiancee"), so GS&A will understand why no SERR is being filled out for the person not covered by GHC.

Surgical Services

Having a consent form signed should not be included as a service rendered.

When a SERR is filled out for a post-operative visit, be sure to specify the date of surgery and the operation performed, even though a separate (inpatient) SERR has been completed and describes the surgery in greater detail.

See the Type of Problem Section for a discussion of appropriate designations for pre-operative visits.

If the diagnosis is listed as "status-post some kind of operation" then give the date of the operation, and the type of surgery performed.

For a laceration and suture: Give the length of the laceration, and its location. Be as specific as possible. List any special techniques used or complications listed (for example, if tendons were involved in the injury).

For fracture care, it is important to be as specific as possible about the specific bone(s) fractured, particularly for fractures involving the extremities. Give not only the side of the fracture, but also the specific bone(s) fractured. This information may appear either in the progress notes, or on the x-ray report. If the specific bone cannot be identified in the chart, write "bone NOS" or "bone unspecified" to indicate that you tried to identify the specific fracture site, but could not find the information.

Other Services

If the patient was instructed in a procedure (e.g., correct nail cutting, how to administer insulin), or there is indication of time devoted to education about a disease (e.g., "We discussed complications and need for compliance re HBP,"), note this as a service. However, if the patient was only given an instruction sheet (e.g., head injury sheet), do not record this fact as a service on the SERR.

For audiologic (ear) testing, specify if air conduction only was performed, or if bone conduction was also tested. List if threshold and discrimination were tested. If a tympanogram was performed (tympanometry), list it separately.

For electromyography (EMG), specify the number of extremities. (See CRVS 94860-95869.)

TYPE OF OFFICE VISIT

Note the red-inked number in the chart margin, next to each visit (Ex: #1 PE, #2 Consult); it is written in by the GHC chart reader. Refer to the substance of the visit as well as to the red-inked number; then, assign and enter a "revised GHC code" as listed in Rand memo SM-3283 of 21 September 1976.

If there is no number, assume it is a #1 visit, unless it is clearly a visit in which a physician, medex or NP did not take part, in which case, it will sometimes be a "minimal visit." (See RN Services, page 6.)

- o For mental health visits, enter the type of therapy (individual, family, group), the number of minutes for the session (see mental health charge slip for code definition) and, if

available, the number of therapists and number of patients taking part. Ex: 52/90 = 90 minutes of family therapy; 50/60 = 60 minutes of individual therapy.

- o For alcoholism treatment visits, provide the same information as for mental health visits.

Coding "Type of Office Visit" for prenatal and postpartum visits will be different from office visits not connected with pregnancy, if the visits are routine. The first prenatal visit to the physician (for confirmation of pregnancy, and initial examination) is not a routine visit (code it V1), nor are visits for specific problems of pregnancy. For routine prenatal visits, including the initial routine visit (with lab work) to the nurse, code the office visit as VP1 (or VP2, VP3, VP4), rather than V1 (or V2, V3, V4). Routine postpartum visit(s) should also be coded as VP1 rather than V1. (Note that if ultrasound was performed, the visit is not routine; ultrasound is not considered to be a routine procedure. When ultrasound was performed, be certain to link it to a diagnosis or condition which explains why it was done.)

Coding "Type of Office Visit" for pre-operative (pre-surgery) visits will be different from office visits not connected with surgery. Treat inpatient surgery and outpatient surgery in the same way. There may be more than one pre-op visit--for example, one visit at which the decision is made to perform surgery, and a second visit at which a pre-op examination is performed. Pre-op office visits should be coded as VSB1 (or VSB2, VSB3, VSB4; VSB implies "visit for surgery, before"), rather than V1 (or V2, V3, V4). This guideline takes precedence over

calling a pre-op visit a consultation, in the case where a regular physician sends the patient for consultation to a surgeon, and that consultation is in fact the pre-op visit: Code VSB1, not C1.

However, if the pre-op visit takes place at GHC, but the operation is performed elsewhere (e.g., University of Washington), use the V1 series for the GHC pre-op visit.

Post-operative office visits should be coded as usual, with V1, (or V2, V3, V4), although GS&A will assign a special code to post-op visits (GS&A memo SR-1517 is reference) if the post-op visit(s) occurs within the standard number of CRVS follow-up days.

For a pre-op or post-op visit, also write "pre-op" or "post-op", if you know such was the case. State the condition for which the surgery is being (was) done. In addition, list the name of the surgical procedure (even though it was performed on a different day) to which the pre-op or post-op visit is connected. If there were two pre-op visits, one from the patient's usual physician and one from the pre-operative surgeon, write "pre-op" on both of these SERRs. The first post-op visit is always a V1 unless another visit type is specified. Check the CRVS surgical procedure code, "following days" column, to see if subsequent visits qualify as post-op visits by virtue of the fact that they fall within the specified period of followup. Also see the Type of Problem Section.

If a pre-op visit took place but was never followed by an operation, code the pre-op visit as a standard office visit, not as a pre-op visit.

RELATION OF TREATMENT TO PROBLEM ('LINKAGE')

Relate each service furnished to one or more diagnoses/problems listed, by writing the corresponding letter(s) A, B, C, D, located in front of the diagnosis/problem. You may use more than one letter per procedure; you will certainly use more than one letter for the "office visit" procedure, in the case of multiple diagnosis/problems.

The attached memo, "Guidelines for Linking Procedures and Drugs to Diagnosis/Problems," provides guidelines for linking procedures and drugs or supplies to diagnosis/problems. The linkages "allowed" or "not allowed" do not imply good or bad medical practice per se, but they do set forth relationships which are either medically possible, or which would generally be considered most unlikely. Of course, you need not make your own decision about linkage when the practitioner has indicated the connection between the service and the diagnosis/problem. Questions about linkage should be discussed with your medical consultant.

On occasion, in order to link service to diagnosis/problem, you will need to "add" a diagnosis/problem, which will often be a "well care" diagnosis.

Abstractor's Inference Box for Linkage of Treatment to Problem

Enter a checkmark (not a "1") in this box if you are inferring a relationship between treatment and problem. Consult the linkage guidelines that have been developed.

DRUGS AND DIETS PRESCRIBED OR SUGGESTED

Enter all prescription and non-prescription drugs suggested or prescribed. However, do not include dosage changes of a drug, and likewise do not include ordinary continuation of a drug. However, if the

provider had listed a drug in such a way that it is obviously a refill (a new prescription was written), instead of just a re-listing, do enter the refill. If a drug is being resumed after a hiatus, list it. Also, if a drug was apparently started during a hospitalization, and the progress note from the post-hospitalization visit states, "Continue drug so-and-so," then do enter that drug, because this is the first time the drug has been given in the outpatient setting. When in doubt, list the drug.

For drugs, generally write only the name(s). We do not usually need to know the quantity or strength on the outpatient SERR. The sole exception comes for a small number of drugs, such as birth control pills and narcotic-containing compounds (e.g., Empirin #3), which routinely are compounded in several different standard fixed combinations (strengths). See the attached list (or GS&A memo SR-554 or 20 August 1976) for a complete list of drugs for which the strength should be indicated. If the provider's note fails to indicate the particular strength for such a compound, enter the strength most commonly prescribed at GHC. For assistance in deciphering drug abbreviations (of both generic and trade names), refer to the official GHC drug formulary, as well as to the PDR and to clinic personnel (on rare occasions). Maintain and expand the attached list of common abbreviations used at GHC.

If a provider mentions gargles, be as specific as you can regarding the type of gargle (which may have a bearing upon whether or not a purchase will be required). For example, if a provider wrote, "salt water gargle" or "gargle with XYZ, 1 teaspoon in 1 glass hot water QID," you

should write: "salt water gargle" or "XYZ gargle," rather than "gargle."

If a practitioner prescribes/suggests a diet, the following guideline applies: If the diagnosis is obesity, then omit the dietary instruction unless more has been written than simply, "told to lose weight." However, if a diet is prescribed, or if dietary instruction is given by a practitioner for any condition other than obesity, then the word, "diet," should be entered in the drug/supply box, and related to the appropriate diagnosis/problem(s). It is not necessary to specify the particular type of diet.

Supplies Suggested or Prescribed

If an item is mentioned that the patient might have to go and buy, but might also have at home (e.g., Ace bandage, vaporizer), list it. Among supplies, include:

- o Glasses prescribed (But refraction for glasses, or inside-GHC "selling" of a pair of glasses, goes under Services.);
- o Diaphragm prescribed or suggested. (But note that the fitting, if done, appears under Services.)

Abstractor's Inference Box for Linkage of Therapy to Problem

For linkage of drug or supply to diagnosis, accept the physician's linkage whenever available. Otherwise, link to the most reasonable one or more of current diagnoses/problems, and check the AI box. Consult the linkage guidelines that have been developed. Occasionally, you will need to "add" a diagnosis/problem, which will often be a "well care" diagnosis. Birth control pills prescribed can often be related to a Gyn examination visit.

SPECIAL CONSIDERATIONS

To SERR or Not to SERR

- o Fill out a SERR for any outside-GHC utilization (whether within the area or out of the area) if it was paid for by GHC, including charge(s) made for procedures, supplies, etc. Be certain to write the charge next to each procedure, supply, etc. For outside emergency services which are paid for by GHC, see the section on emergency services.
- o Fill out a SERR for inside-GHC utilizations not covered by GHC (e.g., certain contact lens examinations). If you find evidence of an uncovered, within-GHC service, fill out a SERR for the service and indicate that the service is not covered. Show the amount that GHC charged, and write the words, "non-covered inside-GHC," at the top of the SERR and also in the procedures section, along with the service provided and the charge for it. For purchase of glasses, give separate charges for frames and lenses.
- o For questions about filling out a SERR for certain services delivered partly before and partly after an enrollee's effective date of termination of participation in the Health Insurance Experiment, consult the section entitled "Completing the Health Insurance Experiment (Termination)."
- o Do not fill out a SERR for the following:
  1. If the only reason for a visit is to get a refill written, and the refill is given unaccompanied by any other interaction, do not fill out a SERR. In other words, a

refill does not need a SERR unless a practitioner (other than a pharmacist) was seen. (Also see page 7, RN Refill Service.)

2. Telephone calls, even if to request a new prescription or a refill, even if the doctor or nurse wrote a chart note documenting the by-telephone new prescription or refill;

3. A canceled appointment (DNK = did not keep), even when "DNK" is written in the chart;

4. Outside utilizations rejected by, or not paid for by GHC. When, in the GHC record, you find evidence of any utilization outside of GHC which was not paid for by GHC, and for which the enrollee should be expected to file a regular claim form (known as a MER, or Medical Expense Report), then notify GS&A to check that they have received a MER (Ex: A GHC member, when already a member, had gall bladder and upper GI x-rays done outside GHC, even though these x-rays would have been covered if performed at GHC--and a courtesy letter was sent by the private radiologist to GHC with a description of the tests and their results.)

5. Occasionally, you will find a dated note which refers back to a very recent (1-2 days earlier) visit during which a bacteriological culture was obtained. The note will document the results of the culture, and may outline the (new) therapeutic plan. The note does not reflect a

service, and a SERR should not be filled out. You may use the information contained in the note, however, to help you complete a SERR for the earlier visit during which the culture was obtained.

6 The Seattle-King County Health Department's post-partum nurse's visit to the home;

7. If a GHC physician makes a legal deposition, or if there is an entry recording that a patient came to request information related to legal action.

Laboratory, X-ray, and Physical Therapy Visits

1. Fill in the provider and location boxes (as per instructions above).
2. Fill in the provider's diagnosis, if available.
3. Check AI boxes, if necessary.
4. Fill in the date of service.
5. Fill in the place of service.
6. List all procedures done.
7. Relate treatment/procedure to problem diagnosis.
8. Do not fill in the type of office visit for laboratory and X-ray. (It is logically missing.) However, fill in type of office visit for physical therapy.
9. Do not fill in type of problem or treatment history or date of onset of symptoms. (All of these are logically missing.)

Emergency Room

For all emergency room (ER) visits, whether leading to an admission or not, fill out an outpatient SERR completely, with all procedures listed. Be certain to enter the type of visit, too.

As explained in GS&A memo SGH-30 (Emergency Room Services, January 10, 1977), we also need to code whether or not certain services and facilities were utilized. Therefore, a specially-designed "Emergency Room Slip" should be completed and attached to each SERR made out for an emergency room utilization. The Emergency Room Slip (attached to these guidelines) is a yes/no checklist for the services and facilities for which we do not require more detailed information.

If the ER visit led to an admission, write "admitted to hospital" on the SERR.

Outpatient Surgery

List each procedure done with a separate SERR for every surgeon involved (and the specific role of each, e.g., primary, assistant) and anesthetist (if any, with duration of anesthesia and surgical procedure) involved. Write "outpatient surgery" on the SERR.

Home Health Services

For home health services, the following rules apply for filling out the SERR:

Generally, the name of the type of provider (rather than the provider's personal name) who visited the home is filled in: that is, an MD, RN, dietician, physical therapist, social worker, etc. GS&A can enter any of these professionals as a provider of care. If the provider is a nurse, specify the type--RN, LPN, or PHN. The personal name of a

physician should be given.

The service is briefly described. GS&A has invented additional procedure codes to describe a social worker's service, a dietician's service, a nurse's service, etc.

Place of service is identified as "H" = patient's home. For area location, write in the name of the area location which is overseeing the home health services.

The Seattle-King County Health Department's post-partum nurse's visit to the home is not to be considered a visit (See "To SERR or not to SERR," above).

Ambulance Services

If an ambulance company bills GHC for ambulance service, and GHC has paid, then fill out a SERR for the ambulance service. Be sure to include the diagnosis, and the amount charged.

If GHC has rejected payment for an ambulance service, do not fill out a SERR; instead, notify GS&A that the service was provided, so that GS&A will expect to receive a claim form (MER) from the HIE participant.

"Missing" Visits

A "missing" visit is a service listed by the participant on the Health Report (and therefore seen by you on the Encounter Log received from Oakland) but not found by you in the GHC chart; or a service on a laboratory report which implies that a visit should have occurred previously, but that visit cannot be found by you in the GHC chart. When you realize that there is a "missing" visit, attempt to determine whom the participant saw (or might have seen), and then telephone the provider (or provider's secretary or nurse) to try and discover if the visit was

actually made. If the provider can confirm that a visit was made, fill out a SERR as completely as possible; the type of visit should be designated as MM. It is recognized that there will be many "Z's" on such a SERR. If the provider cannot confirm that a visit was made, do not fill out a SERR, but do notify GS&A by a written memorandum. (Health Reports were discontinued between summer, 1978, and autumn, 1979.)

Completing the Health Insurance Experiment (Termination)

It may not be clearcut whether (and how) certain services should be abstracted on or around a participant's effective date of termination of participation in the Health Insurance Experiment, because certain services may be delivered partly before and partly after the effective date of termination. This section provides guidelines for unusual circumstances encountered when abstracting charts of participants who have completed their enrollment period.

- Obstetrics - For women who become pregnant while they are enrolled in the Experiment, and continue to be pregnant past their completion date, continue to prepare a SERR for all visits pertaining to the pregnancy, i.e., regular obstetrics visits and other obstetrics-related visits.
- Labor and Delivery - The HIE will usually pay the hospital charges for delivery of women who became pregnant while enrolled in the Experiment but ended their pregnancy after their completion date. Therefore, prepare a regular inpatient SERR, with true dates of service recorded, for labor-and-delivery-related hospitalization(s). Include any related procedures, e.g., tubal ligation, that may

have been performed in association with delivery. However, do not abstract any baby-related expenses if the baby was born after the mother completed her enrollment in the Health Insurance Experiment, and check the mother's "ledger "bill" to be certain that any baby-related expenses are deleted from it.

- o Newborns born before the mother's completion of enrollment in the Health Insurance Experiment are considered to be valid enrollees. All their services should be recorded on SERRs, as long as they were born before midnight on the date of termination of the mother's participation in the Experiment.
- o For a participant who was hospitalized while enrolled in the Experiment and who continued the hospitalization after the completion date, abstract the entire hospitalization. Write the effective termination date prominently on the SERR.
- o Tests and Procedures - If a test or procedure is ordered before the effective date of completion of participation, but is not performed until after that date, do not prepare a SERR for the test or procedure performed after the effective termination date.
- o Some enrollees will order glasses or contact lenses before their effective termination date, but will receive them after that date. If the date of pickup falls after they have completed their enrollment period, fill out a SERR for the glasses or contact lenses. When filling out the SERR, artificially assign the last date of enrollment as

the "Date of Service," rather than the date when the glasses or contact lenses were really received.

The Health Insurance Experiment's Abstraction Guidelines for Inpatient Services at Group Health Cooperative of Puget Sound, Seattle, Washington

INTRODUCTION

A complete Group Health Cooperative (GHC) hospitalization abstract provides information equivalent to that received from the fee-for-service sector from both the hospital (brown HIE claim form plus attached hospital bill) and from the provider(s) of care (blue HIE claim form(s) received from physicians and/or others). The complete GHC hospitalization abstract consists of three parts:

1) The hospital/PCF SERR, the top portion of which is filled out by you and the bottom portion of which is completed by the GHC Business Office;
2) The "ledger bill," analogous to a hospital's bill in the fee-for-service sector, which is prepared entirely by the Business Office and attached to the hospital/PCF SERR, but which you must review and sometimes annotate; and
3) A "physicians, doctors, suppliers and outpatient SERR," which is filled out by you in a special way so as to document the professional services rendered to the enrollee during hospitalization.

The attached example of a "physician SERR" demonstrates how it is to be filled out when it is submitted as part of a GHC hospitalization abstract. Note that some sections are filled in as usual, while for other sections, no information is needed. In the "Names of Provider(s)" box, write: "Inpatient-see below", and in the "Area Location" box, write in the name of the GHC facility where the enrollee was hospitalized. In the "Problem or Diagnosis" box, it is enough to write, "See inpatient SERR," because the attached inpatient

SERR will contain the hospital's discharge diagnosis(es), as listed by the Business Office. For "Place of Service," it is enough to write "IH" (inpatient hospital) just once. Box C, "Services," and Box D, "Type of Visit," are discussed in detail below.

IDENTIFYING HOSPITALIZATIONS

In identifying hospitalizations, the inpatient master files (one at Central and a second at Eastside) should be reviewed at regular intervals, no less than twice yearly.

INITIATING A GHC HOSPITALIZATION ABSTRACT

Wait at least six weeks after the date a GHC/HIE enrollee (control or experimental) is discharged from the hospital. Any time thereafter, complete the top portion of the hospital/PCF SERR, using the Treatment History Card. Deliver the SERR to the Central or Eastside Business Office, where the bottom portion of the SERR will be filled in, and an accompanying "ledger bill" will be prepared. Obtain the completed hospital/PCF SERR and the "ledger bill" from the Business Office, and retrieve the chart from the hospital's record room. Now you are ready to abstract the professional services rendered during hospitalization. (You must have the "ledger bill" before you abstract professional services from the chart, so that you can check the "ledger bill" entries against the information you find in the chart.)

WHO IS LISTED AS A PROVIDER

The listing of professional services which you are abstracting from the inpatient record should be as analogous as possible to what would appear on claim forms received from one or more private

physicians (and other providers of care) in the fee-for-service sector. The following guidelines are designed to achieve the highest possible degree of comparability.

-Name the attending staff physician, then list the dates and type of visit for each progress note found in the record.

-If the admitting and attending staff physician are different people, name both of them, and specify which is which, in the "Name of Admitting Physician" box (#13) on the hospital/PCF SERR.

-If a second staff physician appears to be covering the attending staff physician (e.g., for a weekend, or for an evening), use the second physician's name when the second physician writes a progress note--do not assign that second physician's documented visit to the attending physician's name.

-If two staff physicians both write admission workups, list both workups. Be aware that one of the workups may well be a brief admission note (entered as HAB) rather than a complete admission workup (entered as HAN or HAC).

-If a resident or student writes one admission workup, and an attending physician writes another workup (whether a brief admission note or a more complete workup), list only one admission workup, describe it as the most complete one present (regardless of who performed it), and assign it to the attending physician (even if the resident or student wrote the complete admission workup while the attending physician wrote only a brief admission note).

-For housestaff (GHC residents), do not use individual names

(unlike your procedure for outpatient visits). Say that the provider is "GHC housestaff," and list all the visits from different housestaff members together, under the one "GHC housestaff" provider heading. GS&A has a special provider code for "GHC housestaff." Give separate dates for the various visits. Show when more than one visit occurred on the same date. Also, use the different, special codes provided to document services rendered by housestaff.

-For externs' (medical students') notes, which are countersigned by any level of physician, use guidelines for the countersigning physician. In the absence of any countersignature by any physician of a medical student's note, disregard the note, even if it is the only admission workup in the chart.

-For Medex or nurse practitioners, use individual names and use the same visit codes that apply to physicians. However, as regards the admission workup, follow the guidelines (above) given for residents or students.

-If you cannot read a physician's signature, and there are no clues in the record as to who the physician is, then ask the inpatient medical record room chart readers for help. If all of you are absolutely stuck, then call the provider, "GHC inpatient physician, unidentifiable." GS&A has a special provider code which, we hope, will rarely be needed.

-If a physician has signed orders on the order sheet, but has not written any progress notes, do not assume that the physician saw the patient. Therefore, do not record a physician's visit on the

basis of the presence of orders alone. This guideline is in accord with the general policy of insurance intermediaries.

-Although there is usually only one attending staff physician, it is possible to record more than one physician as the attending physician. Do not record more than three names. In the rare event when more than one physician's name will be recorded, designate which physician was the admitting physician.

-For nonphysician providers of care, such as social workers, dieticians, home health care nurses, psychologists, and hospital-employed physician therapists, occupational therapists, and respiratory (inhalation) therapists, you should not use individual names, but you do need to include the general provider title (e.g., psychologist) and services rendered (including dates) as part of the SERR hospitalization abstract. However, if their services are included and clearly identified on the "ledger bill," there is no need to write in the information. This guideline parallels fee-for-service procedures. See the section, "Reviewing and Annotating the 'Ledger Bill,'" below.

-Notes written by nurses (e.g., CCU nurses' notes, which are written in the regular progress note section of the record) are not recorded on the SERR. In rare instances, registered nurses may be making inpatient visits in cooperation with an attending physician. For registered nurses, do not use individual names. Say that the provider is "registered nurse." However, use the same visit codes which apply to physicians. The presence or absence of the physician's countersignature has no bearing on this guideline.

-In obstetrics, do not list different physicians as "admitting" and "attending." The physician recorded as "doctor" on the GHC admission and discharge record should be designated as the "admitting" physician in SERR box #13.

TYPES OF VISITS

An attached sheet gives the abbreviations you should use for various types of visits, together with their fee-for-service CRVS code equivalents. Note that GHC arbitrarily and routinely calls each initial hospital care service a 90200 (brief) and each followup hospital care service a 90240 (brief). However, you should make more distinctions, to give HIE analysts the opportunity to examine the data in more than one way.

Initial Care

Initial care is not to be confused with the concept of "new" versus "established" patient. Instead, it represents the baseline care provided in the hospital by a physician, whether the patient is new or established. In general, an initial "workup" should be coded as HAN or HAC. Use HAN for the usual pre-surgery workup (which covers all the major headings of a workup, but is generally less comprehensive than the initial workup of a patient being admitted to the medical service), and use HAC for the usual workup done upon admission to the medical or pediatric service. HAB and HAU will be only rarely used: Do not use them, except in the extremely rare situation when the workup differs strikingly in length and complexity from both HAN and HAC. In cases where you just cannot decide which

level of complexity to assign, enter HAX to describe the attending physician's initial care.

We have introduced the code, HAS, especially for the initial workup for ambulatory ("in-and-out") surgery or a "short stay". The ambulatory surgery or short stay type of workup covers the major workup categories, but is extremely brief, and is usually written on GHC's especially printed "short form."

When the same physician has written a full admitting note (history and physical examination) and a short note (holding note, often written until the full note has been transcribed and placed in the chart) on admission, record the full note, but do not record the short note. Also, do not assume that the short note represents a followup note written later. Check the text of the short note, to determine if it is a holding note on admission or a followup note bearing the same date.

Admissions Through The Emergency Room

Whenever a patient is admitted from the emergency room, write "admitted from E.R." prominently on the SERR. GS&A will later check the inpatient SERR against outpatient SERRs and will make sure that the E.R. services are not double-counted.

If the same physician performs an examination documented on the emergency room sheet, and then performs an admission history and physical examination, record only one examination: the admission examination. Ignore the emergency room visit in this case, because you will be completing an outpatient SERR for treatment rendered in the emergency room; GS&A will reconcile a physician's services

rendered on the admission day, according to practices followed in the fee-for-service sector. If one physician performs an emergency room examination, the patient is then admitted, and a second physician performs the admission history and physical examination, record the second physician's admission history and physical examination as part of the hospital stay. Fill out a separate outpatient SERR to document the first physician's work in the emergency room. If the first physician merely signed an emergency room form or wrote a brief holding note as the patient was "passed through" the emergency room into the hospital, but did not perform an examination, then no separate outpatient SERR need be completed for the first physician.

Transfer From Another Hospital

If the patient was transferred from another hospital (whether within GHC or not), write "This patient was transferred to ------- from ------ Hospital" at the top of the physician SERR. Make sure that every procedure listed on the hospital/PCF SERR is marked to show at which hospital it was carried out.

Followup Care (Progress Visits)

The visits made by an attending physician (or by someone else covering for the attending physician) are coded with followup codes. Show when more than one visit occurred on the same date. The CRVS designates the "limited" visit as "characteristic of the usual hospital visit," and you should follow this rule. Thus HFL should be used to designate the typical inpatient progress visit. When the progress note clearly shows a more extensive involvement/activity, then use HFN for the progress visit. A really complete re-evaluation,

which is rare, should be coded as HFE. Use HFB (brief) only when there is specific notation, in some way, of the brevity of the visit. HFF, "final hospital care for discharge of a patient including final examination of the patient, discussion of the hospital stay, prognosis, instructions to the patient for continuing care, and preparation of discharge records," (quoted from "California Relative Value Studies," 1974 Revision, page 23) will not routinely be used to code the last ("final") progress note: The last visit will also usually be coded as HFL. Only when the final note makes it plain that, in fact, most or all of the description quoted above has been carried out, should HFF be used. HNF, routine newborn care, is well described in the CRVS manual. In cases where you just cannot decide which level of complexity to assign, enter HNX to describe the attending physician's followup care.

If the patient left against medical advice, and a note was written to document that fact, do not record the note as a "visit."

Critical Care

According to CRVS, "critical care includes the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician at the bedside (cardiac arrest, shock, bleeding, respiratory failure, post-operative complications, critically ill neonate). Critical care is usually, but not always, given in a critical care area...." HCA is used for the initial period of critical care, the usual followup visit in a critical care area should be designated as HCL, and you can use HCX in situations where you just cannot decide which level of complexity to assign.

Critical care codes are used depending on the criticality of the level of care used, not on the location of the patient in a unit. Thus, a patient can be located in an intensive care unit of any type, but if physician visits have become routine and are not made for the purpose of dealing with a critical emergency situation, then the regular inpatient visit series should be used to describe the physician's visit. You will have to follow the substance of the physician's progress notes, in order to determine if visits are still related to a critical situation or not.

Consultation

Consultation(s) may be carried out during a hospitalization. A consultation is usually easy to recognize in the chart, because it usually appears on a GHC Consultation Sheet, or follows a standard format. It often is headed "Consultation," or will start with the sentence, "I have been asked by Dr. ---- to see ----...," or will conclude with a sentence such as "Thank you for allowing me to see this interesting (or fascinating, or pleasant, or seriously ill) patient," or "I will follow with you," or "I will follow with interest." Use the comprehensive designation, HSC, only when it is clear that the consultant has done what amounts to a complete workup. Most consultations should be designated as HSL (limited consultation) or HSN (intermediate consultation), when the consultation has been limited to a given system, and no comprehensive history and examination has been performed. HSN is used when it is clear from the note that the consultant had to review partially the general history and examination, rather than limit him/herself to one quite isolated

system or question. If the consultant did limit him/herself to one quite isolated system or question, use HSL. Use HSX in situations where you just cannot decide which level of complexity to assign. Consultative followup visits should generally be designated as HEL (limited); see the discussion of followup care by the attending physician for further guidelines. In cases where you just cannot decide which level of complexity to assign, enter HEX to describe consultative followup care.

An initial consultation should be described by using the consultation series of codes. In some cases, followup visits by the consultant will be described by continued use of the consultation series of codes. However, in many cases, a physician who originally served only as a consultant takes over some or all of the responsibility for management of the patient. When the consultant assumes some primary responsibility for the patient, start using the regular inpatient visit series of codes.

NON-SURGICAL PROCEDURES

Procedures other than surgery (and accompanying anesthesia) which are performed by physicians should also be listed as part of the inpatient SERR. For example, endoscopy (such as colonoscopy or gastroscopy), bone marrow aspiration or biopsy, lumbar puncture, and thoracentesis, should be listed along with the name of the physician (as well as any assistants) who performed the procedure, and the date the procedure was performed. Note the location where endoscopy was performed.

If a radiologist visits a patient before or after a procedure

(e.g., cerebral arteriogram or myelogram) which he/she performs, do not list those "visits" as visits. Similarly, if he writes the results of a procedure in the progress note section, his written report does not constitute a visit.

SURGERY (FOR OBSTETRICS, SEE SEPARATE SECTION BELOW)

List the date of (each) surgery, the name of the surgeon, the name of the anesthetist (whether a physician or a nurse), the total number of minutes of anesthesia (this information is always available in the operative notes), and the type of anesthesia.

If a staff physician serves as a surgical assistant during an operation, record the physician's name. If a housestaff physician, or a nurse, or surgical assistant (SA), or certified operating room technician (CORT) serves as surgical assistant, record "housestaff M.D. assisted" or "RN assisted" or "SA assisted" or "CORT assisted," without recording the individual's name. If there was more than one assistant, list each assistant to the surgeon. Write "unassisted" if there was no surgical assistant for the procedure.

When recording the name of the operation performed, use the language specified by the physician on the official operative report or operating room record. Alternative sources, in order of preference, are the physician's discharge summary, and the physician's brief operative note, appearing in the progress notes.

-When a housestaff member performs an operation under the supervision of a staff physician, assign the operation to the staff physician.

-It is not necessary to note the total number of minutes of surgery.

-It is not necessary to note whether a recovery room was used (except for obstetrics-- see below).

-It is not necessary to supply any specific information from the pathology report, or to record that a specimen was sent to pathology. Do not record the pathologist's service as a separate service on the SERR, because the pathologist's service (i.e., "fee") is included in laboratory "charges" on the "ledger bill."

-Be sure to record the number of hospital visits (pre-operative, recovery room, and post-operative) made by the surgeon. The operative note written in the progress notes section should not be recorded as a visit.

Indicate, as an adjunct to the diagnosis(es), any surgical complications which have been listed on the hospital's front sheet or by the physician in the discharge summary; however, do not seek out surgical complications from within the progress notes themselves. This guideline is designed to achieve high compatibility with procedures followed in the fee-for-service sector.

If surgery was performed at Group Health by an "outside physician," you need only write "outside physician" next to the physician's name under services. The IH place of service will indicate that the surgery was done at Group Health.

ANESTHESIA

-Only one anesthetist (or anesthesiologist) should be designated for an operation. If, in rare instances, you note that two anesthetists of the same training level participated in an operation, select the one who appears to have been more involved (e.g., the one who wrote the pre-operative anesthesia note). If there is no way of determining which was more involved, then list the anesthetist whose name appears first on the operative report sheet.

-The anesthetist's name may sometimes be found written on the back of the anesthesia record; this will help to determine who actually provided the anesthetic services.

-For SERR purposes, when a nurse-anesthetist furnished anesthesia instead of an anesthesiologist, treat the nurse-anesthetist just like an anesthesiologist.

-When the certified registered nurse anesthetist (CRNA) actually administered anesthesia, record the CRNA as the provider of anesthesia. In other words, do not record the name of the physician-anesthesiologist if the anesthesiologist countersigned the record, rather than provided primary attention during the operation. If both the physician and CRNA actually participated in an operation, record the physician as the sole provider of anesthesia.

-If a student and anesthetist provided the anesthesia, enter the name of the anesthetist (whether physician or CRNA) on the SERR.

-For type of anesthesia, it is enough to specify: local, regional, spinal (caudal), epidural or general.

-Length of anesthesia is needed only for general, spinal and epidural anesthesia, not for pudendal or local. In determining length of anesthesia, use the times written on the operative room record (anesthesia start and stop) when they appear there. If one or both of these times are not written on the operative room record, turn to the anesthesia record, and look for a total time figure written there (lower right-hand corner). If no more exact information is available, take the starting time as the time when vital signs started to be recorded, and take the ending time as the time of entry into the recovery room (assuming no special anesthesia problems or care in the recovery room).

-Do not record any pre-operative or post-operative visits which may have been made by the anesthetist during the hospitalization, even if the post-operative visit occurred later than the actual date of the operation.

-If the physician administered the (local) anesthesia, and the anesthesiologist was only on standby and was not used, do not record the presence (or name) of the anesthesiologist. This is also true for obstetrical cases.

-If no anesthesia was used during a procedure, note "no anesthetic agent used" on the SERR.

-As a general rule, record the professional title (e.g., MD,

CRNA) of the designated anesthetist when you list his or her name.

OBSTETRICS

-For a history and physical examination performed on a woman admitted to obstetrics at the time of labor, code the workup as HAB (code HAH if house staff).

-When a resident has delivered a baby under the supervision of a staff physician, assign the delivery to the staff physician, and do not note the participation of the resident. If one staff physician supervised and assisted, and a different staff physician provided a countersignature, list the name of the staff physician who actually supervised and assisted.

-There is no need to record that the labor room was used, or for how long it was used. This is true both for women who delivered during the present admission, and for women who were in labor but did not deliver during the present admission.

-"Visits" in the labor room should not be recorded as visits.

-During a saline abortion, "visits" to comment on progress should not be recorded as visits.

-The delivery note should not be recorded as a visit.

-If there is internal fetal monitoring, note it.

-There is no need to mention the use of induction (with pitocin). However, do note the presentation of the fetus, if complex, or any other complications which ensue during labor.

-There is no need to record the length of time in the delivery room.

-Length of obstetrical anesthesia is needed only for general spinal, or epidural anesthesia (not for pudendal or local). For length of anesthesia, first look for information on the anesthesia record. If information is not available there, then, for starting time, consult the labor record in the "second stage" section; for ending time, consult the labor record in the "third stage" section, under "placenta."

-When an obstetrician administers obstetrical anesthesia (e.g., pudendal, local), record that information on the SERR. The type of anesthesia will be listed under "anesthesia" in the second stage section of the labor record sheet. It may also be found in the nurses' notes (labor and delivery). Do not record the name of an anesthesiologist on standby, if (s)he was not used.

-Be certain to record whether or not the obstetrical recovery room was used.

Therapeutic Abortion

A therapeutic abortion using saline should be abstracted as follows:

-List the admission workup as an HAB (shortstay).

-Write the name of the procedure, Saline Abortion, with the date on which the abortion was initiated.

-Do not list any of the visits made by the physician prior to

expulsion of uterine contents. (This convention is analogous to the situation in the labor room.)

-List the discharge note as an HFL.

-If any unusual events occur, revert to normal inpatient abstracting guidelines.

See also the section entitled "End of the Health Insurance Experiment (Termination)", below.

Newborns

For newborns, code the newborn's initial examination as HNA (HAH if housestaff), any routine newborn care as HNF (HFH if housestaff), and the discharge examination as an HNF (HFH if housestaff); name the physician(s). If a newborn is sent to a special nursery/unit, note that fact, and record associated diagnoses. If a circumcision was done, record the circumcision and the name of the staff physician who performed or supervised it. If circumcision was not done, and the newborn was male, state that a circumcision was not done.

See also the section entitled "End of the Health Insurance Experiment (Termination)," below.

PCF (PROGRESSIVE CARE FACILITY) UTILIZATION

When a patient has used the PCF, follow the same procedures as have been outlined for completion of an abstract of hospitaliziation. Mark very clearly that the stay was in the PCF, and not in a hospital.

Even in the PCF setting, notes written by nurses are not recorded on the SERR.

REVIEWING AND ANNOTATING THE 'LEDGER BILL'

Check the "ledger bill" to make sure that various items are recorded in the correct columns. Do not worry about E.R. charges on the "ledger bill." GS&A routinely compares the inpatient SERR with outpatient SERRs and makes sure that the E.R. services are not double-counted.

If there has been an incorrect or incomplete transcription of diagnosis or operation from the medical record to the hospital/PCF SERR, then lightly cross out any incorrect information, and write in the correction or addition. When there is a discrepancy, the physician's diagnoses listed in the physician's discharge summary are given preference over the diagnoses recorded on the front sheet.

When rendered, physical therapy (inpatient) and respiratory therapy (inpatient) should appear as a charge on the "ledger bill." Check to see if they are there. If they are not there, add them to the inpatient SERR. If they are there, check to see that they can be identified as such and, if not, annotate the "charge." The same guidelines apply to dietician services (inpatient), which should appear as a charge on the "ledger bill." Social work (inpatient) or home health cae assessment (inpatient) may or may not appear as a charge on the "ledger bill." Again, follow the same guidelines.

The "ledger bill" records pharmacy charges only for those drugs which are administered parenterally--there is "no charge" (at least on the "ledger bill") for oral or topical medications. This GHC custom is acceptable, and you need not attempt to note the provision

of oral and topical medications in a more explicit way.

Infrequently, the "ledger bill" will fail to distinguish a pharmacy "charge" from a central supply "charge." That is, the "charges" entered in column 2 will not be annotated with either a "1" (pharmacy) or a "2" (central supply). When this occurs, it will not be necessary to obtain additional information. Merely send the "ledger bill" with the pharmacy-central supply ambiguity, as is, to GS&A. Of course, if this problem is encountered frequently, then talk to the GHC employee who is preparing the "ledger bill" in order to correct the omission.

Occasionally, the "ledger bill" contains a "charge" that has been "billed" in error--for example, a "charge" for laboratory work which was performed in a clinic prior to admission to the hospital (and a duplicate copy of the laboratory results was sent to the hospital record). In such a case, cross out the "charge" recorded in error, and subtract the crossed-out "charge" from the total "charge" listed on the "ledger bill."

Annotate the "ledger bill" to specify the use of any type of special unit (e.g., coronary care unit), if such use occurred.

On the "ledger bill," scans appear in the x-ray column. Annotate the "bill": designate each scan as such, and show the "charge" for it. Specify the type of scan, also (e.g., liver-spleen). For invasive procedures such as lumbar myelograms, angiograms, and so forth, annotate the "ledger bill," and be certain to record the number of films taken and the "charge." Also annotate the "ledger bill" for echography (ultrasound), electroencephalogram (EEG), and treadmill

testing (stress EKG). Do not annotate the "ledger bill" for pelvimetry or an intravenous pyelogram (IVP).

See also the section entitled "End of the Health Insurance Experiment (Termination)," below.

END OF THE HEALTH INSURANCE EXPERIMENT (TERMINATION)

Labor and Delivery - Rand will be paying the hospital charges for delivery of women who became pregnant while enrolled in the Experiment but ended their pregnancy after their completion date. Therefore, prepare a regular inpatient SERR, with true dates of service recorded, for labor-and-delivery-related hospitalization(s). Include any related procedures, e.g., tubal ligation, that may have been performed in association with delivery. However, do not abstract any baby-related expenses if the baby was born after the mother completed her enrollment in the Health Insurance Experiment, and check the mother's "ledger bill" to be certain that any baby-related expenses are deleted from it.

Newborns born before the mother's completion of enrollment in the Health Insurance Experiment are considered to be valid enrollees. All their services should be recorded on SERRs, as long as they were born before midnight on the date of termination of the mother's participation in the Experiment.

For a participant who was hospitalized while enrolled in the Experiment and who continued the hospitalization after the completion date, abstract the entire hospitalization. Write the effective termination date prominently on the SERR.

APPENDICES

USUALLY ACUTE CONDITIONS--OUTPATIENT

H-ICDA, Second Edition

Food poisoning (bacterial) 005
Gastroenteritis, infectious 008
Plague 020
Diphtheria 032, Whooping cough 033
Streptococcal sore throat and scarlet fever 034
Meningococcal infection 036 (excluding meningococcal carrier state)
Septicemia 038
Gas gangrene 039.0
Acute polio 040, 041, 042, 043
Enterovirus CNS diseases 045, 046
Viral diseases accompanied by exanthem 050-057 (excluding 053.9
055.9
056.2-056.9)
Arbovirus diseases 060-068 (excludes 066)
Hepatitis (if labeled acute) 070
Rabies 071
Other viral diseases (selected) 071-075
Trachoma, active 077.0
Conjunctivitis 078
Rickettsioses, etc. 080-083 (excluding 081.1)
Early syphilis, symptomatic 091.0-091.9
Gonococcal infections 098.0-098.9 (excluding 098.1 and 098.9)
Trichomoniasis 131
Pediculosis 132
Acute neoplasms
Thyroid crisis 242.3
Acute thyroiditis 245.0
Acute psychoses 296, 298, 300, 303
Acute alcoholic disorder 302.0-302.4
Acute nonpsychotic organic brain syndrome 304
Acute paranoid reaction 309.4
Infectious meningitis 320.0-320.4
Conjunctivitis and ophthalmia 360
Acute primary glaucoma 375.0
Acute otitis media 381.0-381.2
Acute mastoiditis 383.0
Acute rheumatic fever 390, 391
Acute pericarditis 420.-420.9
Acute and subacute endocarditis 421
Acute and subacute myocarditis 422
Cerebrovascular hemorrhage (when it happens) 430-431
Cerebrovascular occlusion (when it happens) 432-434
Dissecting aneurysm 441.0
Acute thrombophlebitis 451 (when acute)
Acute upper respiratory infections 460-470

Infectious pneumonia 480-486
Acute bronchitis and bronchiolitis 489
Status asthmaticus 493
Pleurisy 511.0-511.1
Spontaneous pneumothorax 512
Acute pulmonary edema 519.1
Acute gingivitis 523.0
Oral aphthous ulcerations 528.2
Esophageal rupture 530.4
Ulcers with hemorrhage and/or perforation (when occurring) 531.1-531.3
532.1-532.3
533.1-533.3
534.1-534.3

Acute appendicitis 540
Hernia with obstruction 552-553
Intestinal obstruction 560
Peritonitis 567
Acute and subacute cirrhosis of liver 570
Acute cholecystitis 575.0
Acute pancreatitis 577.0
Acute glomerulonephritis 580
Acute renal failure 585.0-585.1
Acute pyelonephritis 590.1
Acute cystitis 595.0
Acute urethritis (if acute) 597
Acute salpingitis and oophoritis 612
Acute parametritis and pelvic peritonitis 616.0-616.2
Ectopic pregnancy 631
Pre-eclampsia 637.0
Abortion 640-646
Delivery 650-664
Puerperial complications 670, 677-678
Acute lymphadenitis 683
Impetigo 684
Erysipelas 686.3
Acute arthritis due to pyogenic organisms 710
Acute or subacute osteomyelitis 720.0
Hemolytic disease of newborn 762
Cardiovascular shock 775.0-775.2
Syncope and collapse 775.5
Acute epistaxis 776.1
Fractures (current) 800-829
Dislocation (current) 830-839
Other musculoskeletal injuries (current) 840-848 (excluding late effects)
Intracranial injury (current) 850-854 (excluding late effects)
Injuries to chest, abdomen, pelvis (current) 860-869
Laceration and open wound (current) 870-897
Injury to blood vessels (current) 900-904
Superficial injury (current) 910-918
Unspecified injury (current) 919.0-919.8
Contusion (current) 920-925
Crush injury (current) 926-929

Foreign body entry (unless chronic) 930-939 (excluding IUD)
Burn (current) 940-949 (excluding late effects)
Nerve/spinal cord injury (current) 950-959 (excluding late effects)
Toxic effect of noxious foodstuffs 988
Toxic effect of other substances 989
Heat effects 992
Effects of air pressure 993
Effects of lightning 994.0
Effects of submersion 994.1
Asphyxiation and strangulation 994.7
Effects of electric current 994.8
Early complications of trauma 995
Spinal headache 997.0
Other complications 999
Contacts with infective and parasitic diseases YO3
External cause accidents (if current) E807-E845, E859, E869, E887-E899, E904-E976 (excludes E903 & E964)

USUALLY PREVENTIVE/WELL CARE CONDITIONS--OUTPATIENT

H-ICDA, Second Edition

*Check procedures performed to make sure this was only well care.

Annual exam	Y00.1
Birth	Y20-Y29
Cancer screening	Y80.1
Contact lens check	Y17.7
Diagnostic skin tests	Y02.0, Y02.2 (Diphtheria, Tuberculosis)
Employment exam	Y00.0
Eye exam*	Y01.0
Family planning	Y83.0-Y83.9
Follow-up (status post)*	Y12.0-Y12.9, Y15.4, Y15.8 (more than one year after illness, injury, surgery)
Gynecological exam	Y01.3
Hearing test	Y01.1
Immunizations	Y81.0-Y81.8
Multiparity	Y86.4
Newborn exam	Y20-Y29
Pap smear	Y01.3
Physical exam*	Y00.1
Pregnancy test	Y01.5
Premarital exam	Y00.0
Prenatal care	Y06.0, Y06.1
Preventive medicine	Y87.1
Refractive error	370.0-370.9
School exam	Y00.0
Screening	Y80.1-Y80.9 (e.g., VD, PKU, diabetes)
Vaccinations	Y81.0-Y81.8
Vision check*	Y01.0
Well baby check	Y00.1

USUALLY CHRONIC CONDITIONS--OUTPATIENT

H-ICDA, Second Edition

*After reference to History Card, to determine if the diagnosis is chronic (as it often will be), or acute (as it sometimes will be).

Acne
Adjustment Reactions
Alcoholism*
Allergic Bronchitis
Allergic Dermatitis*
Allergic Rhinitis
Allergies, NOS
Amblyopia
Anemia
Angina Pectoris
Arthritis, Rheumatoid (not traumatic)
ASHD, ASCVD
Asthma
Asthmatic Bronchitis*
BHP (benign prostatic hypertrophy)
Bursitis
Cancer
Cardiomegaly
Carpal Tunnel Syndrome*
Cataract
Cerebral Palsy
Cerebral Paralysis
Cirrhosis
Congenital Anomalies
Corneal Opacities
Hypotension
Hypothyroidism
Irritable Bowel Syndrome
Ischemic Heart Disorder
Leprosy
Leukemia
Lordosis
Malaria*
Marpan's Syndrome
Menopausal Syndrome
Mental Retardation
Metabolic Dysfunction
Migraine
Morton's Toe*
Muscular Dystrophy
Musculo-Skeletal Deformities
Neuroses
CVA, Post-CVA
Diabetes
Disc Degeneration
Diverticulitis, Diverticulosis
Eczema
Endocrine Disorders
Epilepsy
Estrogen Deficiency
Fibrocystic Breast Disease*
Glaucoma
Goiter
Gout
Hansen's Disease
Hemiplegia
Hemophilia
Hereditary Neuro-Muscular Disorders
Herpes Simplex*
Hodgkin's Disease
Hyperkinetic Reaction of Childhood
Hyperlipoproteinemia
Hypertension
Hypertensive Heart Disease
Hyperthyroidism
Hypoglycemia
Hypo-Ovarianism
Post MI
Premenstrual Tension
Psoriasis
Psychoses
Psychosomatic Disorders
Radicular Syndrome
Renal Disease, NOS
Retroverted Uterus
Rheumatic Heart Disease
Schizophrenia*
Sciatica*
Scoliosis
Seborrheic Dermatitis
Sickle Cell Anemia
Somatic Dysfunction
Strabismus
Tenosynovitis*

Obesity
Osteoarthritis
Osteoporosis
Paranoia*
Paraplegia
Peripheral Neuropathy*
Personality Disorders
Pes Planus
Thrombophlebitis*
Tuberculosis
Ulcer, GI Tract
Uterine Fibroid
Varicose Veins

DRUGS NEEDING STRENGTH INDICATED

(These drugs exist as multiple standard fixed combinations at GHC)

Aldochlor
Antivert
APC with Codeine
Belap
Berocca-C
Biphetamine
Buffadyne
Combipres
Cor Tar Quin
Desquam
Dexamyl
Diupres
Emersert
Empirin with Codeine
Enarax
Enovid
Eppy
Etrafon
Fiorinal with Codeine
Gentlax
Heb-cort
Hydrelt
Hydromax
Hydropres
Iberet
Lextron
Menrium
Milpath
Neo Cortef
Neo Delta Cortef
Neosporin
Norinyl
Norlestrin
Novahistine
Ortho Novum
Pathibamate
Phenaphen with Codeine
Principen
RHI-LIEF (come in childs and super)
Rondec
Ru-Tuss
Triavil
Tuinal
Tylenol with Codeine
Vicon
Zorane

Abbreviations Used at GHC

AB	Abortion
AC	Air conduction in audiometry
AC	Axiocervical (shoulder injuries)
ADA	Alcohol and Drug Abuse Center at GHC
ADA Diet	American Diabetes Association Diet
ANJ	A New Jersey
AOB	Alcohol on breath
AODM	Adult-onset diabetes mellitus
ARD	Acute respiratory disease
ARP	Ano-rectoplasty
AS	Left ear
ASA	Aspirin
ATL	Atypical lymphocytes
ATS	Anxiety tension state
AVC	Sulfanilamide-Allantoin-Aminoacridine or Sulfanil-A-A
AVic	A Victoria
BBT	Basal body temperature
BC	Bone conduduction in audiometry
BCM	Birth control method
BN	Burien Clinic

BNP	Bacitracin-Neomycin-Polymixin Ointment
BOM	Bilateral otitis media
BPH	Benign prostatic hypertrophy
BRB	Bright red blood
BS	Breath sounds
BT	Bowel tones
BTB	Break-through bleeding
BTL	Bilateral tubal ligation
BTZ	Butazolidine or Phenylbutazone
BZP	Benzoyl peroxide
C	Central Clinic
CF	Cystic fibrosis
CH	Capitol Hill Clinic
CHI	Cyto-hormonal index (maturation status)
CIN	Cervical intraepithelial neoplasm
COP,COPV,OPV	Oral polio vaccine (combined)
CQ	Cold quartz - ultra violet (dermatology)
C&S	Culture and sensitivity
CTM	Chlorpheniramine
CTS	Chronic tension state
DBS	Dysfunctional bowel syndrome
DC	Discharge or discontinue
DIFF	Differential
DJD	Degenerative joint disease
DM	Diabetes mellitus
DMAO	Diabetes mellitus, adult-onset
DTB	Diphtheria-tetanus booster
DTR	Deep tendon reflex
DU	Duodenal ulcer
DUB	Dysfunctional uterine bleeding
E	Eastside Specialty clinic
EA	Earache
EMG	Electromyogram
EOS Test	Test for eosinophilia (may indicate asthma)
ER-WIE	Walk-in at Central Emergency Room
ES	Eastside Clinic
ET	Eustachian tube
ETH-C	Elixir of terpin hydrate with codeine
FC	Fibrocystic (Dr. Wallach)
FRPM	Full range painless motion
FSH	Follicle stimulating hormone
FUB	Functional uterine leeding
FW	Federal Way Clinic
GB	Gall bladder
GC	Gonorrhea
GC Test	Test for gonorrhea, cervical culture
GG or 2G	Glyceryl quaiacolate expectorant
H	Hyperopia
HC	Central Hospital
HC	Hydrocortisone
HCM	Health care maintenance
HCT	Hematocrit

ABBREVIATIONS USED AT GHC

HCTZ	Hydrochlorothiazide
HCVD	Hypertensive cardiovascular disease
HE	Eastside Hospital
HGA1C	Hemoglobin A1C (test related to diabetes)
HGB	Hemoglobin
HMS	Hot moist soaks
HS	Hysterical syndrome
HVV	Hemophilus vaginalis vaginitis
I&O	In and out (i.e. one-day surgery), standard procedure followed for pre-surgery exam
IBD	Inflammatory bowel disease
IDA	Iron deficiency anemia
IHSS	Idiopathic hypertrophic subaortic stenosis
IM	Intramuscular
IMB	Intermenstrual bleeding
ISG	Injection: immune serum globulin
IV	Intravenous
KOH	Potassium hydroxide (to reveal fungal skin infection)
LBP	Low back pain
LW	Lynnwood Clinic
LFT's	Liver function tests
Lemon Custard	Ampicillin and probenecid
LH	Luteinizing hormone
LTL	Laparoscopic tubal ligation
MD	Madrona Clinic
MI	Maturation index (status) or myocardial infarction
MOM	Milk of Magnesia
MT	Tympanic membrane
NCR	Evidence of eyeglass prescription, when handwritten
NG	Northgate Clinic
NKA	No known allergies
NKDA	No known drug allergies
NR IRRIT	Nerve root irritation
NS	Normal saline
NSD	Nasal septal deformity
NSND	Neosynephrine nose drops
NSU	Non-specific urethritis
OL	Olympia Clinic
OM	Otitis media
OW	Olive Way or Downtown Clinic
OW	Observation ward of ER Department
P & P	Pelvic & Pap
PAR	Perennial allergic rhinitis
PB	Phenobarbital
PBZ	Phenylbutazone or Pyribenzamine
PCN	Penicillin
PEN	Penicillin
PID	Pelvic inflammatory disease
PND	Post-nasal drip or paroxysmal nocturnal dyspnea
PO	Port Orchard Clinic
POC	Products of conception
PP	Post-prandial (after eating)

PR	Pityriasis rosea
PROM	Premature rupture of membranes
PT	Physical therapy
PT I	CRVS 97000
PT II	CRVS 97050
PT III	CRVS 97100
PT IV	CRVS 97200-97541
PTU	Propylthiouracil
PVC	Premature ventricular contraction
PWB	Partial weight bearing
RBC	Red blood cell count
RN	Renton Clinic
ROM Exercise	Range of motion exercise, CRVS 97100
SAC	Short arm cast
SAR	Seasonal allergic rhinitis
SBE	Self breast exam or subacute bacterial endocarditis
SG	Saline gargle
SOM	Serous otitis media
SP, S/P	Status post
SR	Suture removal
S&S Snuff	Salt and soda (salt and soda in warm water, to be snorted)
S&S Gargle	Salt and soda gargle
STI	Strep throat infection
SWD	Diathermy
TBG	Thyroxine-binding globulin
TC	Throat culture or Tacoma (Cushman) Clinic
TCN	Tetracycline
TCNS	Transcutaneous neuro-stimulator
TIA	Transient ischemic attack
TIBC	Total iron binding capacity
TMC	Triamcinolone
TMJ	Temporomandibular joint
TMS	Tympanic membrane
TO Syndrome	Thoracic outlet syndrome
TOP	Termination of pregnancy
UA	Urinalysis
URI	Upper respiratory infection
USI	Urinary stress incontinence
UTI	Urinary tract infection
UVL	Ultra violet light
VSD	Ventriculoseptal defect
WBC	White blood cell count
WIE	Walk-in emergency

GHC Locations

BN	Burien
C	Central
CH	Capitol Hill
E	Eastside Specialty
ES	Eastside
FW	Federal Way

LW	Lynnwood
NG	Northgate
OL	Olympia
OW	Olive Way
PO	Port Orchard Clinic
RN	Renton
TC	Tacoma (Cushman) Clinic

PROCEDURE FOR REQUESTING GHC CHARTS

a. Fill out request form from Treatment History card (list of participants);

b. Determine chart location by working at the computer;

c. Check all requests against Central files, to ascertain that charts are not temporarily checked out to Central;

d. Pull Central charts, and send out requests for area charts;

e. Send out a second request slip if the area chart has not arrived within three weeks.

PROCEDURE FOR ABSTRACTING GHC OUTPATIENT ENCOUNTERS ONTO SERRS

1) Obtain chart of GHC/HIE participant.

2) Pull participant's Treatment History (TH) card.

    a) Make sure chart tab information agrees with personal information on the TH card.
    b) Notice date participant joined Rand study.
    c) Enter date participant joined GHC on TH card, or, if already recorded, check to make sure participant has not changed his standing with GHC since the last chart review.

3) Read progress notes in chart, and also review the right-hand side of the patient's folder (chart) for utilizations falling after the study-joining date.

    a) Note significant past history on TH card.
    b) Enter dates of encounters falling after study-joining date in chronological order on the TH card. Integrate encounters reported on both sides of the chart.

4) Abstract encounters onto SERRs, according to the GH Abstractor's Guidelines.

    a) After abstracting or noting each encounter on a SERR, enter the diagnosis (Ex: on TH card beside the correct date).
    b) Check to make sure the dates on the TH card and the SERRs match and that there is a SERR and a notation on the TH card for each encounter.

5) Using the GS&A Encounter Log, enter "reason for visit" in the appropriate box on the SERR and note on the Encounter Log that a SERR was filled out.

    a) For participants not submitting Health Reports, enter N.A. (Not Applicable) in the "reason for visit" box.
    b) For participants submitting Health Reports, but not reporting an encounter, write "none given" in the "reason for visit" box and note the date and type of visit on the Encounter Log for control purposes.
    c) For participants submitting Health Reports, if no reason for visit is given because the encounter falls after the last date listed on the Encounter Log, circle "reason for visit" on the SERR, so coders at GS&A will look for the reason for visit before coding. Note date of visit on the Encounter Log.
    d) For participants submitting Health Reports, if an

encounter is reported but there is no GHC record:

1) Check chart to make sure the encounter is really unrecorded.
2) Check dates of encounter on the Encounter Log and recorded visits; perhaps the participant or GHC personnel entered an incorrect date.
3) If the reported encounter is missing and occurred two months or more before the chart is abstracted, note that the encounter is unrecorded on a memo for GS&A, circle the reason for visit on the Encounter Log, and note that the visit is missing and reported to GS&A as missing on the Encounter Log.
   If the reported encounter occurred less than two months before the chart is abstracted, circle the reason for visit on the Encounter Log, and make a note to look for the encounter next time the chart is reviewed.
4) If, for any reason, it is not appropriate to abstract a reported encounter onto a SERR, note circumstances and identifying information on a memo for GS&A (e.g., if a participant reports an encounter and chart documentation indicates an appointment was canceled or rescheduled because the participant was late).

6) Note any GHC hospitalization and any outside-GHC emergency use of services (outpatient or inpatient) which occurred after the joining date, on a separate list for later "billing."

7) Attach Emergency Room Services supplement sheets as ER visits are abstracted. Attach two copies of the sheet to the SERR.

8) Reassemble chart.

9) Remove chart request from front pocket. For counting purposes, save one complete slip of the chart request for chart requests made from Central; and only the end tab, after entering request date on the tab, for chart requests made from the areas. Draw a red "X" on the chart request and return to the pocket, for chartroom control purposes. Put the chart in the Out Box for pick-up by chartroom personnel.

10) Repeat procedure with the next chart.

PHYSICIANS, DOCTORS, SUPPLIERS AND OUTPATIENT SERR

Last Name of Patient	First Name	MI	Patient's Individual Number	Patient's Family Number

Name(s) of Provider(s)	Area Location	Referred From:	Referring To:

Reason for Visit	Was Illness or Injury Employment Related?	Was Illness or Injury Accident Related?	Date of Injury or Accident	Describe how and where accident occurred:
	YES ☐ NO ☐	YES ☐ NO ☐	/ /	

Describe the Primary Problem or Diagnosis That Brought the Patient to GHC and Any Other Problem(s) for Which Treatment Was Supplied. Please List Primary Problem or Diagnosis on Line A.	AI	Type of Problem (check one)		Treatment History (omit if well care or pregnancy) Date Symptoms First Occurred this Episode (for pregnancy, give LMP) (omit for well care or chronic - not flare-up)	AI
A.		☐ Acute ☐ Well Care (or pregnancy) ☐ Flare-up of Chronic ☐ Chronic (not flare-up)		☐ Initial Visit for this episode ☐ Repeat Visit for this episode Symptom Date / /	
B.		☐ Acute ☐ Well Care (or pregnancy) ☐ Flare-up of Chronic ☐ Chronic (not flare-up)		☐ Initial Visit for this episode ☐ Repeat Visit for this episode Symptom Date / /	
C.		☐ Acute ☐ Well Care (or pregnancy) ☐ Flare-up of Chronic ☐ Chronic (not flare-up)		☐ Initial Visit for this episode ☐ Repeat Visit for this episode Symptom Date / /	
D.		☐ Acute ☐ Well Care (or pregnancy) ☐ Flare-up of Chronic ☐ Chronic (not flare-up)		☐ Initial Visit for this episode ☐ Repeat Visit for this episode Symptom Date / /	

Place of Visit Codes: O = Outpatient Clinic (Includes Laboratory or X-ray Inside GHC); L = Outside X-ray or Laboratory; H = Patient's Home; IH = Inpatient Hospital; NH = Nursing Home, PCF or SNF; ER = Emergency Room; OL = Other Location

AI = Abstractor's Inference

	A. Date Of Service	B. Place of Service Use code above	C. Services Describe Each Medical or Surgical Procedure and Other Service or Supplies Furnished For Each Date, Including Specific Lab Tests and the Specific Name of Any Drug Injected.	D. Type of Office Visit (GHC Code)	E. Relate Treatment to Problem by Ref. to A, B, C or D above	AI	Were Any Drugs Prescribed? Were any Supplies Prescribed or Suggested? ☐ Yes ☐ No A. If yes, specify drug(s) and/or supply(ies):	B. Relate to Problem by Reference to 17 A, B, C or D above	AI
1									
2									
3									
4									
5									
6									

ABSTRACTOR _____ **DATE** _____

FORM HIEI-100 1M Rev 1-81 5M, 9-81 5M

EMERGENCY ROOM SLIP FOR_____ DATE_____

		Yes	No
1.	Walk in emergency (? after hours)	☐	☐
2.	Hospital emregency (? after hours)	☐	☐
3.	Minor operating room	☐	☐
4.	Observation room	☐	☐
5.	Cast room	☐	☐
6.	Supplies	☐	☐
7.	Lab surcharge (after hours)	☐	☐
8.	X-ray surcharge (after hours)	☐	☐
9.	Other_____	☐	☐

FURTHER GUIDELINES FOR CODING THE TREATMENT HISTORY

What is the proper treatment history for the diagnosis, "Rule out hypothyroidism," or "Rule out diabetes," or "Rule out infectious mononucleosis"?

a. If the physician's diagnosis deals with ruling out an acute disease, the visit is called initial acute.

b. If the diagnosis deals with ruling out a chronic disease (e.g., diabetes, hypothyroidism), the first visit is called initial chronic.

   Subsequent visits may, however, receive different treatment history codes, depending on the circumstances. For example, an initial visit to rule out a chronic disease like diabetes may result in the making of the diagnosis, in which case, future visits for that problem will be routine chronic (or occasionally, flare-up of chronic). Or, an initial visit may result in definitely discarding the diagnosis (perhaps a patient was anxious, and simply requested a check to know if diabetes or anemia was present or not), with no further visits for the same problem. There is a third possibility: that the physician and patient, on a "fishing expedition," are searching for a diagnosis that will explain the patient's problem(s)----in which case, the first visit's diagnosis might be R/O (rule out) diabetes, the next visit might show R/O hypothyroidism, and a third visit might have R/O brucellosis (!), when in reality, all these visits concern the

same problem, and really are parts of the same episode of illness. An arbitrary but reasonable rule is needed to decide when multiple claims forms carrying "Rule out" diagnoses represent the same episode of illness, and when they represent different episodes of illness, and here it is:

c. If two claim forms appear, both of which carry the diagnosis "Rule out a disease," whether or not it is the same or different diseases, check to see how far apart the visits were. If the two visits occurred within one month of each other, then the second is chronic routine (repeat chronic), because we suspect that the physician is working on one problem. If the two visits occur with a longer time interval between them, then the second visit will be coded as initial chronic again (if the diagnosis mentioned as a rule-out is a chronic problem) or initial acute (if the diagnosis mentioned as a rule-out is an acute problem).

d. Be flexible, make the maximum possible use of information available on the History Card, and ask questions of your HIE medical consultant.

PROFESSIONAL HOSPITAL SERVICES

GHC Abstractor's Code				
Initial Hospital Care	Title	GHC Unit Value	Fee-For-Service CRVS	1974 Unit Value
HAB	Brief	18.5	90200	10.5
HAN	Intermediate	18.5	90215	15.5
HAC	Comprehensive	18.5	90220	18.5
HAU	Unusually complex	18.5	90230	0.0 †
HAX	Cannot be determined	18.5	90201*	0.0
HAS	Ambulatory surgery or short-stay form	0.0	90202*	0.0
HAH	Performed by housestaff	0.0	90203*	0.0
Established Patient, Followup Hospital Care				
HFB	Brief	3.9	90240	3.9
HFL	Limited (usual visit)	3.9	90250	5.2
HFN	Intermediate	3.9	90260	6.5
HFE	Extended	3.9	90270	8.7
HFF	Final for discharge	3.9	90275	8.7
HNA	Routine newborn care admission	0.0	90285	15.5
HNF	Routine newborn care followup	0.0	90286*	0.0
HFX	Cannot be determined	3.9	90251*	0.0
HFH	Performed by housestaff	0.0	90252*	0.0
Critical Care Services				
HCA	Initial, prolonged presence	3.9	90290	0.0 †
HCB	Brief followup	3.9	90294	0.0 †
HCL	Limited followup	3.9	90295	0.0 †
HCN	Intermediate followup	3.9	90296	0.0 †
HCE	Extended followup	3.9	90297	0.0 †
HCX	Cannot be determined	3.9	90291*	0.0
HCH	Initial by housestaff	0.0	90292*	0.0
HCR	Followup by housestaff	0.0	90298*	0.0
Consultations				
HSL	Initial limited	15.5	90600	9.9
HSN	Initial intermediate	15.5	90605	13.0
HSE	Initial extended	15.5	90610	15.5
HSC	Initial comprehensive	15.5	90620	22.0
HSM	Initial complex	15.5	90625	29.0
HSU	Initial unusually complex	15.5	90630	0.0 †
HSX	Initial cannot be determined	15.5	90601*	0.0
HEB	Followup brief	15.5	90640	0.0 †
HEL	Followup limited	15.5	90641	0.0 †
HEN	Followup intermediate	15.5	90642	0.0 †
HEE	Followup extended	15.5	90643	0.0 †
HEX	Followup cannot be determined	15.5	90645*	0.0
HSH	Initial by housestaff	0.0	90602*	0.0
HEH	Followup by housestaff	0.0	90644*	0.0

* Unofficial CRVS code developed by the Health Insurance Experiment

† "By Report," or "Relativity Not Established"

HOSPITAL/PCF SERR

1. Last Name of Patient	First Name	MI	2. GHC Medical History Number

3. HIS Plan	4. Patient Family No.	5. Patient Individual No.	6. Hospital Location

7. Was illness or injury employment-related? Yes ☐ No ☐ 8. Was illness or injury accident-related? Yes ☐ No ☐ 9. Date of Injury/or Accident_____	10. Discharged to: ☐ Home ☐ _____	11. Date of Admission	12. Date of Discharge

GHC Business Office Will Complete the Items Below and Will Attach a Ledger "Bill"

13. Name of Admitting Physician:	14. Patient Status: ☐ Discharged ☐ Deceased	15. If patient was in a private room, state whether private room was: ☐ The patient's choice ☐ The only type of room available ☐ Medically necessary

16. Final Diagnosis(es):

17. Operations or Summary of Treatment:

PLEASE ATTACH

LEDGER "BILL"

18. This form completed by:

_____

Date completed:

_____

PHYSICIANS, DOCTORS, SUPPLIERS AND OUTPATIENT SERR

Last Name of Patient	First Name	MI	Patient's Individual Number	Patient's Family Number
Fill in	Fill in		Fill in	Fill in

Name(s) of Provider(s)	Area Location	Referred From:	Referring To:
INPATIENT-See Below	Central Hosp. or Eastside	Omit	Omit

Reason for Visit	Was Illness or Injury Employment Related?	Was Illness or Injury Accident Related?	Date of Injury or Accident	Describe how and where accident occurred:
Omit	YES ☐ NO ☐ Omit	YES ☐ NO ☐ Omit	/ /	Omit

Describe the Primary Problem or Diagnosis That Brought the Patient to GHC and Any Other Problem(s) for Which Treatment Was Supplied. Please List Primary Problem or Diagnosis on Line A.	AI	Type of Problem (check one)		Treatment History (omit if well care or pregnancy) Date Symptoms First Occurred this Episode (for pregnancy, give LMP) (omit for well care or chronic - not flare-up)	AI
A. See attached inpt. SERR		☐ Acute ☐ Well Care (or pregnancy) ☐ Flare-up of Chronic ☐ Chronic (not flare-up) Omit		☐ Initial Visit for this episode ☐ Repeat Visit for this episode Symptom Date Omit / /	
B.		☐ Acute ☐ Well Care (or pregnancy) ☐ Flare-up of Chronic ☐ Chronic (not flare-up)		☐ Initial Visit for this episode ☐ Repeat Visit for this episode Symptom Date / /	
C.		☐ Acute ☐ Well Care (or pregnancy) ☐ Flare-up of Chronic ☐ Chronic (not flare-up)		☐ Initial Visit for this episode ☐ Repeat Visit for this episode Symptom Date / /	
D.		☐ Acute ☐ Well Care (or pregnancy) ☐ Flare-up of Chronic ☐ Chronic (not flare-up)		☐ Initial Visit for this episode ☐ Repeat Visit for this episode Symptom Date / /	

Place of Visit Codes: O = Outpatient Clinic (Includes Laboratory or X-ray Inside GHC); L = Outside X-ray or Laboratory; H = Patient's Home; IH = Inpatient Hospital; NH = Nursing Home, PCF or SNF; ER = Emergency Room; OL = Other Location

AI = Abstractor's Inference

	A. Date Of Service	B. Place of Service Use code above	C. Services Describe Each Medical or Surgical Procedure and Other Service or Supplies Furnished For Each Date, Including Specific Lab Tests and the Specific Name of Any Drug Injected.	D. Type of Office Visit (GHC Code)	E. Relate Treatment to Problem by Ref. to A, B, C or D above	AI	Were Any Drugs Prescribed? Were any Supplies Prescribed or Suggested? ☐ Yes ☐ No A. If yes, specify drug(s) and/or supply(ies):	B. Relate to Problem by Reference to 17 A, B, C or D above	AI
1	Omit	IH	Welby: HAN on 11/15/76						
2			Surgery on 11/16 HFL on 11/16-11/19, 11/22,						
3			11/24-11/25 Kildare: Assistant in surgery 11/16						
4			Morton: Anesthesia on 11/16: 205 minutes. Surgery was partial gastrectomy with Billroth II						
5			anastomosis, General anesthesia. Recovery room was used.						
6			Osler: HFL on 11/20-21, 11/23 XYZ EMI Service, CAT Scan on 11/23, GHC paid $400 for Scan & $50 for interpretation by Dr. Harvey Cushing (employed by XYZ)						

ABSTRACTOR AP **DATE** 1/6/77

RAND/N-1948-HHS

THE HEALTH INSURANCE EXPERIMENT'S GUIDELINES FOR ABSTRACTING HEALTH SERVICES RENDERED BY GROUP HEALTH COOPERATIVE OF PUGET SOUND

G. A. Goldberg