Health Care Agency	Section Name:	Information Management
Behavioral Health Services	Sub-section:	IRIS
Policies and Procedures	Section Number:	05.03.01
	Policy Status:	☐New ☒Revised

	SIGNATURE	DATE APPROVED
Chief of Operations Behavioral Health Service	_____	_____

SUBJECT:	IRIS Entry of Encounter Document Information by Office Support Staff – For Non-Electronic Health Record Clinics

PURPOSE:

To establish a uniform procedure for entering information on services provided to clients into the existing Behavioral Health Services (BHS) Integrated Record Information System (IRIS).

POLICY:

For non-Electronic Health Record clinics, office support staff shall have the responsibility of verifying and entering specified information obtained from the Encounter Document (ED) into the IRIS.

SCOPE:

All BHS County and Contract service locations that are utilizing the ED.

REFERENCES:

BHS P&P # 05.01.02 Use and Flow of the Encounter Document

FORMS:

Encounter Document, BHS Form F346-682 (R-1/9/13)

Children, Youth & Prevention Behavioral Health Programs:
http://www1.ochca.com/ochealthinfo.com/training/bhs/apt/cys/attachments/

Adult and Older Adult Behavioral Health Services Programs:
For Encounter Documents or Progress Notes, please contact your Service Chief or Program Manager.

DEFINITIONS:

CPT: Current Procedural Terminology:

Descriptive term for medical (including psychiatric/psychological/counseling) procedures which have a specific five digit number that is published by the American Medical Association. It is the national coding standard for use in billing.

IRIS: Integrated Record Information System:

The Health Care Agency's computer system currently used for recording and storing services rendered within BHS for purposes of reporting, data management, management of billing information and historical data.

Progress Note/Encounter Document (PNED):

This document is used by clinicians to record detailed service encounters along with billing code, time and provider information.

Service Function Codes:

The codes used for the State Departments of Mental Health and Alcohol and Drug Program (ADP) to categorize services provided. These are general codes as set and recognized by both Short Doyle and ADP Medi-Cal.

PROCEDURE:

I.   Only the clinician providing the service shall complete the Encounter Document (ED) portion of the Progress Note/Encounter Document (PNED).

   A.   Under certain circumstances described below, office support staff may fill in specified blanks on the ED portion of the PNED.

II.   Office Support Staff Responsibility

   A.   Office Support staff shall verify and enter information only related to services provided and documented.

      1.   Only the information documented on the ED portion of the PNED shall be entered into IRIS.

   B.   Office Support staff shall:

      1.   Verify that all required information on the ED portion of the PNED is completed:

         a)   Clinic Address

      b)   Client Label

      c)   Encounter type

      d)   Date of Service

      e)   Diagnosis Treated Today

      f)   Service Minutes

      g)   Clinician Name/signature and professional license

2. Return the PNED to the clinician if one of the required data points is missing from the list in 1.

3. Not return the PNED to the clinician if:

      a)   The date of service was left blank on the ED portion of the PNED but is clear in the progress note section, then fill in the date of service in the ED section.

      b)   The clinician's <u>printed</u> name has been left blank in the ED section of the PNED but is clear in the progress note section.

      c)   The clinician's <u>printed</u> license type has been left blank in the ED section but is noted in the progress note section.

4. When the ED portion of the PNED indicates a number greater than "0" for the face-to-face minutes, check "Yes" for face-to-face if not completed. **This only applies to AOABH**.

5. Note the date of documentation on the ED portion of the PNED when the clinician has noted different day documentation in the progress note section.

6. Place an "S", if not noted, in the designated area on the ED portion of the PNED if the date of documentation is noted in the progress note section.

7. Initial and date any item added to the ED portion of the PNED.

8. Not change any information that has been completed by the clinician on the ED portion of the PNED being reviewed.

9. Add the modifier for repeat services to the ED portion of the PNED when crediting and re-dropping a service that has appeared on the duplicate services report. Initial, in the appropriate box, on the ED portion of the PNED when doing so.

10. Enter service information into IRIS when all the required information is completed on the ED portion of the PNED and as instructed in the IRIS training.

11. Once posted, file into the client's chart:

   a) If the chart resides in another clinic location, then send the PNED to that clinic for office staff at that location to file into the chart.

III. Summary of Steps:

A. Office Support staff shall ensure the required items for billing are noted on the ED portion of the PNED.

   1. If not, complete those items permitted in this Policy and Procedure.

   2. Any items missing that are not noted within this P&P, return the PNED to the clinician for correction/completion.

B. Any questions shall be referred to the appropriate Service Chief or the Office Staff Operations Manager and/or the Authority and Quality Improvement Services Division Manager.