



# **Quality Audiology and Speech Analysis and Reporting (QUASAR)**

## **USER MANUAL**

Version 3.0  
February 2000

(Updated November 2010)

Department of Veterans Affairs  
*Vista* Health System Design and Development (HSD&D)



## Revision History

Date	Description	Page	Author/Manager
February 2000	QUASAR 3.0: original version		
January 2001	ACKQ*3.0*1 <ul style="list-style-type: none"> <li>• Update the PCE problem list when sending encounter data to PCE</li> <li>• Suppress PCE credit encounters for telephone clinics</li> <li>• Correct display of V codes with QUASAR's Capitation report</li> <li>• Incorporate military sexual trauma functionality</li> <li>• Warning if a QUASAR staff member's USR membership entry has been deleted</li> <li>• Warning if running PCE Exception report prior to install of version 3.0</li> <li>• Send examining physician to AMIE when adequating QUASAR visits</li> <li>• Add ability to choose between event capture codes and CPT codes</li> </ul>		
April 2001	ACKQ*3.0*2 <ul style="list-style-type: none"> <li>• Remove integer only check of DFN within new clinic visit option</li> <li>• Convert A&amp;SP staff members' IEN to corresponding IEN in file #200</li> <li>• Clear completed adequated visits from waiting adequation list</li> </ul>		
November 2003	ACKQ*3.0*3 Release of the GUI interface, Audiogram Module with two components: Audiogram Edit and Audiogram Display		Denver ALC
March 2003	ACKQ*3.0*4 <ul style="list-style-type: none"> <li>• File internal value of CPT code (not external)</li> <li>• Allow users to edit site parameters for the entry of event capture codes</li> </ul>		

Date	Description	Page	Author/Manager
March 2003	ACKQ*3.0*5 <ul style="list-style-type: none"> <li>• Corrected the updating of patient diagnostic histories when using the inquire-A&amp;SP patient option</li> <li>• Stopped sending students as secondary providers - PCE rejected students because of a missing person class</li> </ul>		
September 2003	ACKQ*3.0*6 <ul style="list-style-type: none"> <li>• Only allow the correct version of CPT codes (ACKQAS VISIT ENTRY and ACKQAS VISIT EDIT)</li> <li>• Only allow the entry of the correct version of ICD codes (ACKQAS VISIT ENTRY and ACKQAS VISIT EDIT)</li> <li>• Only allow the correct version of CPT codes (ACKQAS VACO DIRECTIVE)</li> <li>• Only allow the entry of the correct version of ICD codes (ACKQAS VACO DIRECTIVE)</li> <li>• Do not allow the entry of EC codes that have invalid CPT counterparts (ACKQAS VISIT ENTRY and ACKQAS VISIT EDIT)</li> </ul>		
July 2003	ACKQ*3.0*7 Fixed problems related to the updating of the PCE problem list with diagnosis codes when entering or editing A&SP clinic visits		
October 2004	ACKQ*3.0*8 <ul style="list-style-type: none"> <li>• Only allow the display of the correct version of ICD-9 and CPT modifiers code descriptions</li> <li>• Display the correct version of ICD-9 code description (ACKQAS PAT INQ)</li> <li>• Send the correct version of ICD-9 code description (ACKQAS VISIT ENTRY and ACKQAS VISIT EDIT)</li> <li>• Display the correct version of ICD-9 code description (ACKQAS VISITS BY DIAG)</li> </ul>		

Date	Description	Page	Author/Manager
	<ul style="list-style-type: none"> <li>• Display the correct version of CPT code description (ACKQAS PRINT COST COMPARE)</li> <li>• Display the correct version of CPT code description (ACKQAS PROC STATS)</li> <li>• Display the correct version of the CPT modifier code description (ACKQAS UPDATE CPT MODIFIERS)</li> <li>• Display the correct version of CPT code description (ACKQAS COST ENTRY)</li> </ul>		
February 2006	ACKQ*3.0*10 New message, <i>Patient died on mm/dd/yy</i> , prevents creating a new clinic visit for a deceased patient		
November 2005	ACKQ*3.0*12 Updates to the Audiogram Module		Denver ALC Pam Urrutia
July 2007	Combine, format, and update the QUASAR and the Audiogram Module User Manuals. Historical version: Quality: Audiology and Speech Analysis Reporting (QUASAR) GUI version: QUASAR Audiogram Module		Christine Beynon
July 2007	ACKQ*3.0*13 <ul style="list-style-type: none"> <li>• Removed Sections IX, X, and XI from the historical version of the user manual.</li> <li>• Configure one of three audiometric instruments, GSI61 (Grason-Stadler), Madsen-Aurical (GN Otometrics), and AC40 (Interacoustics).</li> <li>• Check and monitor the status of the audiometer connection.</li> <li>• Import audiometric data from the audiometer to the Audiogram Module, point by point or batch mode.</li> <li>• Reset values in audiometers capable of being reset and clear any buffers or memory used in the construction or passing of information.</li> </ul>	77 89 92 102 106 99 103	Christine Beynon

Date	Description	Page	Author/Manager
	<ul style="list-style-type: none"> <li data-bbox="415 260 1019 443">• Incorporate the graph (Audiogram Display component) as a tab in the Audiogram Edit window. The graphic display is updated in real time with data from the device. 111</li> <li data-bbox="415 464 1019 779">• The following items are added or modified to display within the surrounding area of the audiogram display (graph). 113 114 <ul style="list-style-type: none"> <li data-bbox="461 625 1019 657">a. Air Conduction averages</li> <li data-bbox="461 678 1019 779">b. Audiogram symbol key, No Response, Rollover Index text boxes, and SRT, IAR, and CAR grids</li> </ul> </li> <li data-bbox="415 800 1019 982">• Desktop access to the application is removed. The Audiogram Module can be configured and accessed only through the Computerized Patient Record System (CPRS) Tools menu. 83</li> <li data-bbox="415 1003 1019 1104">• The algorithm for <i>points to plot on the graph</i> uses the Retest value if there is no Final value. 125</li> <li data-bbox="415 1125 1019 1199">• The third row label on the Pure Tones tab changed from Final or Masked to Masked. 99</li> <li data-bbox="415 1220 1019 1293">• The Flip Tabs option is removed from the File menu. 85</li> <li data-bbox="415 1314 1019 1377">• A 1500 Hz column is added to the Pure Tones tab for Bone Conduction. 99</li> <li data-bbox="415 1398 1019 1472">• VA form 10-2364 is modified to conform to VA standards. 115</li> </ul>		
July 2007	<ul style="list-style-type: none"> <li data-bbox="415 1499 1019 1671">• ACKQAG03 is modified to suppress the MailMan notification sent to the user when an AUDIOMETRIC EXAM DATA file (#509850.9) record is transmitted to the Denver ALC.</li> <li data-bbox="415 1692 1019 1875">• ACKQAG05 is modified to replace DDC with DALC in the subject of the MailMan message that confirms the deletion of an AUDIOMETRIC EXAM DATA file (#509850.9) record from the local and</li> </ul>		



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# Quality: Audiology and Speech Analysis and Reporting (QUASAR) V 3.0

## Introduction

Quality: Audiology and Speech Analysis and Reporting (QUASAR) is a VISTA software package written for the Audiology and Speech Pathology Service. QUASAR is used to enter, edit, and retrieve data for each episode of care.

- QUASAR provides transmission of visit data to the Patient Care Encounter (PCE) program in order to incorporate QUASAR Visit Data in ACRP Workload Reporting, as well as to the Decision Support System (DSS).
- QUASAR produces a variety of reports useful to local managers, medical center management, and central planners.
- QUASAR contains a VA FileMan function that permits users to generate customized reports using data from QUASAR's A&SP Clinic Visit file (#509850.6) or A&SP Patient file (#509850.2).
- QUASAR produces an automated Cost Distribution RCS 10-0141 Report (CDR) and has an option for generating and processing audiology compensation and pension examinations through an agreement with the Automated Medical Information Exchange (AMIE) package.
- For current coding guidance, refer to the Audiology website: [VA Speech Pathology Services - Audiology and Speech Pathology Service](#)

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# Implementing & Maintaining the QUASAR Package

## ***Implementation Checklist (Virgin Installations Only)***

Each of the following steps is described in greater detail within this chapter.

- Assign menu options to users.
- Assign the ACKQ ADHOC key to those users who will be designing reports using the Tailor-Made A&SP Reports option.
- Add appropriate A&SP staff to the USR Class Membership file # 8930.3 and assign a User Class to each. After staff is added to the USR Class Membership file, add the same A&SP staff to the A&SP Staff file #509850.3. Also ensure that each A&SP staff member has an appropriate Person Class entry within the New Person file #200.
- Define site parameters using the A&SP Site Parameters option.
- (Optional) Use the Update Files per CO Directive to add diagnoses to the A&SP Diagnostic Condition file and procedures to the A&SP Procedure Code file.
- (Optional) Apply local cost amounts to each procedure using the Enter Cost Information Procedure option. You may use locally developed cost data, DSS product costs, community fees, insurance reasonable rates, or Medicare reasonable rates.

## ***Implementation Checklist (Installations over V. 2.0)***

- Define site parameters using the A&SP Site Parameters option.
- Make sure each entry in the A&SP Staff file #509850.3 also has an appropriate Person Class entry within the New Person file #200.
- (Optional) Use the Update Files per CO Directive to make any required changes to the A&SP Diagnostic Condition file and the A&SP Procedure Code file.
- (Optional) Apply local cost amounts to each procedure using the Enter Cost Information Procedure option.

## ***Menu Option Assignment***

### **A&SP Supervisor Menu**

The A&SP Supervisor Menu [ACKQAS SUPER] option is assigned to supervisory personnel. It is the main menu and contains options for setting up and maintaining the QUASAR package, entering clinic visit data, generating management reports, and adequating Compensation and Pension (C&P) exams.

## **1. Set Up/Maintenance**

- Staff (Enter/Edit)
- A&SP Site Parameters
- Update Files per CO Directive
- Print A&SP File Entries
- Enter Cost Information for Procedures
- Update CPT Modifiers per CO Directive

## **2. Audiology & Speech Visit Tracking System**

- New Clinic Visits
- Edit an Existing Visit
- Inquire - A&SP Patient
- A&SP Reports
  - i. Visits by Diagnosis
  - ii. Patients by City
  - iii. Statistics by Procedure
  - iv. Cost Comparison Report
  - v. Tailor-Made A&SP Reports **\*\*Locked: ACKQ ADHOC\*\***
  - vi. PCE Exception Report
  - vii. Workload Report

## **3. Management Reports A&SP**

- Generate A&SP Service CDR
- Print A&SP Service CDR
- Compile A&SP Capitation Data
- Print A&SP Capitation Report

## **4. C&P Exam Adequation**

## **5. Delete an A&SP Clinic Visit**

## **Audiology & Speech Visit Tracking System**

The Audiology & Speech Visit Tracking System [ACKQAS MASTER] menu option is assigned to personnel who will be entering clinic visit data and generating reports.

- New Clinic Visits
- Edit an Existing Visit
- Inquire - A&SP Patient
- A&SP Reports
  - a. Visits by Diagnosis
  - b. Patients by City
  - c. Statistics by Procedure
  - d. Cost Comparison Report
  - e. Tailor-Made A&SP Reports **\*\*Locked: ACKQ ADHOC\*\***
  - f. PCE Exception Report
  - g. Workload Report

### **A&SP Reports**

The A&SP Reports [ACKQAS REPORTS] menu contains only report options. This menu can be assigned to users who may not enter or modify any of the data, but need to be able to see the data generated by these reports.

- Visits by Diagnosis
- Patients by City
- Statistics by Procedure
- Cost Comparison Report
- Tailor-Made A&SP Reports **\*\*Locked: ACKQ ADHOC\*\***
- PCE Exception Report
- Workload Report

### ***Key Assignment***

Give the **ACKQ ADHOC** key to all users who will be creating/designing reports using the option Tailor-Made A&SP Reports. This option uses VA FileMan to sort and print data from the A&SP Clinic Visit (#509850.6) and A&SP Patient (#509850.2) files.

## ***Options for Implementing and Maintaining the Package***

### **Set Up/Maintenance Menu**

The Set Up/Maintenance menu [ACKQAS SET UP MENU] can be accessed by anyone assigned the A&SP Supervisor menu. It contains the options needed to implement the package and maintain or update the data used by the package.

- Staff (Enter/Edit) [ACKQAS CLINICIAN ENTRY]
- A&SP Site Parameters [ACKQAS SITE PARAMS]
- Enter Cost Information for Procedures [ACKQAS COST ENTRY] (Only A&SP staff designated as supervisors can access this option.)
- Update Files per CO Directive [ACKQAS VACO DIRECTIVE] (Only A&SP staff designated as supervisors can access this option.)
- Print A&SP File Entries [ACKQAS FILE PRINT]
- Update CPT Modifiers per CO Directive [ACKQAS UPDATE CPT MODIFIERS]

### ***Staff (Enter/Edit)***

[ACKQAS CLINICIAN ENTRY]

The Staff (Enter/Edit) option allows you to enter data for clinicians, fee-basis personnel, other providers (e.g., health technicians), and students into the A&SP STAFF file (#509850.3). The information includes the staff person's name, activation and inactivation dates, status, an ID number for sites that choose to use code numbers, and whether or not the person is designated as a supervisor. Entering this option will automatically synchronize the A&SP STAFF file (#509850.3) member's NAME with their NEW PERSON file (#200) NAME.

**Note:** Staff members should never be deleted because entries in the A&SP Clinic Visit file (#509850.6) reference them. This option is used to activate and inactivate staff members as appropriate.

**A&SP Staff Name:** Names added to the A&SP STAFF file (#509850.3) must be in the New Person file (#200). The A&SP Service Chief should contact IRM if an entry needs to be made to the New Person file.

**Status:** Assign one of the following statuses to each staff member entry:

- S    STUDENT
- C    CLINICIAN
- F    FEE BASIS CLINICIAN
- O    OTHER PROVIDER

**Activation Date:** An activation date is required to associate the staff member with a clinic visit. The activation date is the date the staff member became an active member. For the staff



member to receive credit for a patient visit, he or she must have been active on or before the visit date.

**Inactivation Date:** Enter a date when the staff member is no longer active.

**ID Number:** The ID Number field is used at stations that use code numbers in lieu of provider names. QUASAR provides a sequential default number starting with 0001, but any unique four digit number is accepted.

**Supervisor:** Selected clinicians can be designated as supervisors. Supervisors have access to certain functionality that is not available to other staff members (e.g., adequating any C&P exam).

### **A&SP Site Parameters**

[ACKQAS SITE PARAMS]

The A&SP Site Parameters option allows you to enter data into the A&SP Site Parameters file (#509850.8). The parameters define how you want the program to run at your site and at each division within your site.

**Site Name:** Enter your station name or number. Only one entry is allowed in the A&SP Site Parameters file.

**Interface with PCE:** If you want QUASAR to send visit data to PCE, answer YES. If you check out patients via PCE and wish to continue to do so, answer NO. This parameter determines whether or not to activate the interface with PCE. If this parameter is set to NO, data will not be sent to PCE. If set to YES, visit data will be transmitted to PCE for each division that has its Send To PCE parameter also set to YES.

**Division:** Even if you are a single division site, enter that division here. This allows for workload crediting by division. At this point, you need to define all the following parameters for each Division using this program.

**Division Status:** Enter ACTIVE. If the division should become inactive, change the status at that time to INACTIVE. No new visits can be added to an Inactive division.

**Send to PCE:** If you want data for this division sent to PCE, the INTERFACE TO PCE parameter for the Site (see above) must be set to YES and you must also set this parameter (SEND TO PCE) for the division to YES. When a new visit is entered, or an existing visit is edited or deleted, the system looks at the SEND TO PCE parameter for the division to determine whether the visit data should be transmitted to PCE. A multi-divisional site has the choice of sending visit data to PCE for some divisions and not for others.

**Note:** Data is transmitted to PCE as soon as you exit the record.

**PCE Interface Start Date:** Enter the first Visit Date to be sent to PCE. QUASAR will only send Visits for this Division if the Visit Date falls on or after the PCE INTERFACE START DATE.

If you enter the 1st of the next calendar month for instance, you may continue to enter, edit, or delete visits for the current calendar month and QUASAR will not transmit them to PCE. Once new Visits are entered for the new month they will automatically be transmitted to PCE.

If you enter a date in the past, QUASAR will not automatically transmit visits that are already on file, even if their Visit Date is after the PCE INTERFACE START DATE. These visits will be reported on the PCE Exception Report and must be edited in QUASAR to initiate transfer to PCE.

**Update PCE Problem List: No//:**<sup>1</sup> This is a new field within the A&SP Site Parameters file (509850.8). This field can be edited.

The default setting is No. If you answer with a No, there are no changes to the prompts that you will view. You will continue with the “Use ASP Clinic File Number” prompt. The PCE Problem list is not updated.

If you answer with a Yes, a Diagnosis Code will be sent to PCE. This prompt occurs in the New Visit and Edit Visit options for each Diagnostic code that is entered, but only if the PCE Interface is active for the Division.

If you select to update the PCE Problem List, you will be asked who the Diagnosis Provider was. Currently, when data is transferred to PCE, a PCE Encounter is created using the QUASAR visit data. However, if you answer Yes to the “Update the PCE Problem List” prompt, the system will also attempt to update the PCE Problem List with all selected Diagnosis Codes and their associated Providers.

**Use ASP Clinic File Number:** For those sites that have existing LOCAL (not medical center) file numbers associated with their Audiology and Speech Pathology patients and wish to continue using these numbers, answer YES. By doing this, you can cross-reference QUASAR visit entries to your current file numbering system.

**Use C&P:** Answer YES if you wish to use QUASAR’s AMIE/C&P interface. If you use a different reporting procedure and do not wish to use the AMIE/C&P interface, answer NO.

If you answer YES to use the AMIE/C&P interface, staff involved must have an electronic signature. An electronic signature can be established using the Edit Electronic Signature Code option in the User’s Toolbox menu.

The AMIE linkage feature allows:

- Entry of text and audiometric data in the AMIE format,
- Adequation of the results, and
- Hand-off of the report to the AMIE Compensation and Pension package.

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<sup>1</sup> This is a new field contained in Patch ACKQ\*3.0\*1.

If this functionality is enabled, QUASAR checks to see if an audiology C&P exam is scheduled. When an entry is made for the patient, the user is asked “Is this a C&P exam?” If the user responds yes, in addition to the usual QUASAR information, narrative data is requested for generating the AMIE report.

If the C&P exam prompt does not appear:

1. The patient entered is not a C&P patient,
2. Veterans Affairs Regional Office (VARO) did not request an AUDIO exam (see Form 2507),
3. The patient’s C&P claim has been closed by the C&P Unit. Users should contact their C&P Unit.

See Forcing the C&P Prompt for procedure to force the C&P prompt.

**Bypass Audiometrics:** Certain diagnosis codes (i.e., hearing loss codes) are flagged to require audiometric data to be entered when those codes are used for a visit. By answering YES for the Bypass Audiometrics field, you allow users to bypass the entry of that data. If you answer NO, users are not allowed to bypass the entry of audiometric data.

**Event Capture Codes<sup>1</sup>:** Supervisors can set up a Division to use Event Capture Codes instead of the Procedure Codes (CPT) as a prompt to be displayed for the coming DSS extract period. In the Event Capture mode, answer “Yes” if you want the Division to use Event Capture Codes or “No” if you want this Division to use CPT codes.

The Division can be set up with this option to change the mode in Site Parameters within a two-week window from September 17-30 each year. The last day to change the mode is September 30 at midnight. Supervisors can re-edit this field within this time period, but all values after September 30 will be final for the approaching Fiscal Year.

When a mode has been changed to use the Event Capture Code field, an automatic MailMan message is sent to all active Supervisors within the Division.

**Clinic Location:** The only clinics that may be entered for a division are clinics for Audiology (Stop Code 203), Speech Pathology (Stop Code 204), and Telephone/Rehab and Support (Stop Code 216) that reside in the Hospital Location file (#44) at your site. There must be at least one clinic entered for this field.

**Audiology DSS Unit Link and Speech Pathology DSS Unit Link:** The last two fields are pointers to the DSS Unit file (#724) from Event Capture. These fields create linkage between QUASAR and a specific DSS unit in order to define data needed by the QUASAR/DSS extract. Enter the DSS units for these links.

**Note:** These are not division specific.

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<sup>1</sup> This is a new field contained in Patch ACKQ\*3.0\*1.

## ***Enter Cost Information for Procedures***

[ACKQAS COST ENTRY]

The Enter Cost Information for Procedures option allows you to enter cost data for each procedure code in the A&SP Procedure Code file (#509850.4). You can select a single CPT-4 code, or you can edit all procedure codes. If you choose to edit all procedures, each procedure is displayed consecutively, and the current approximate private sector cost can be entered. You can obtain fee schedules from public or private sector clinics and hospitals, calculate their real costs, or use insurance reimbursement rates (e.g., Medicare/Medicaid or insurance UCRs).

Procedure cost information is used in generating the Cost Comparison Report on the A&SP Reports menu.

## ***Update Files per CO Directive***

[ACKQAS VACO DIRECTIVE]

**Note:** In order to use this option, you must be designated as an active supervisor in the A&SP Staff file (#509850.3). Use the Staff (Enter/Edit) option to make this designation.

The Update Files per CO Directive option is to be used with extreme caution. Data in the CDR Account file (#509850), the A&SP Diagnostic Condition file (#509850.1), and the A&SP Procedure Code file (#509850.4) are standardized for roll-up to central data bases (e.g., DSS). File entries should be added or modified **ONLY** by directive from the Director, Audiology and Speech Pathology Service (VAHQ).

After selecting the file you wish to edit, you can choose to inactivate selected entries or add data for a new entry. When a new entry is added, all fields for that entry must be answered in order to maintain database integrity. If data is incomplete, the entry is automatically deleted.

## ***Print A&SP File Entries***

[ACKQAS FILE PRINT]

The Print A&SP File Entries option lists the file entries from the CDR Account file, the A&SP Procedure Code file, or the A&SP Diagnostic Condition file. Select the file you want to print and enter a printer name.

### Example

A&SP	PROCEDURE CODE LIST PAGE 1	OCT 14,1999	09:53
CODE	PROCEDURE MODIFIER DESCRIPTION	COST	ACTIVE
-----			
NNNNN	PROCEDURE	\$\$00	ACTIVE
NNNNN	PROCEDURE	\$\$00	INACTIVE
...			

### ***Update CPT Modifiers per CO Directive***

[ACKQAS UPDATE CPT MODIFIERS]

This option allows you to select any modifier already defined in the A&SP Procedure Modifier file (#509850.5) and either activate or inactivate it. The option also allows you to add active CPT or HCPCS modifiers from the CPT Modifier file (#81.3) to the A&SP Procedure Modifier file. Modifiers cannot be deleted from the A&SP Modifier file; a modifier is removed from user selection lists by setting the status of the modifier to Inactive.

The following modifiers were exported with this release:

- 22 UNUSUAL PROCEDURAL SERVICES
- 26 PROFESSIONAL COMPONENT
- 50 BILATERAL PROCEDURE
- 51 MULTIPLE PROCEDURES
- 52 REDUCED SERVICES
- 53 DISCONTINUED PROCEDURE
- 59 DISTINCT PROCEDURAL SERVICE
- 76 REPEAT PROCEDURE BY SAME PHYSICIAN
- 77 REPEAT PROCEDURE BY ANOTHER PHYSICIAN
- 99 MULTIPLE MODIFIERS
- TC TECHNICAL COMPONENT

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## Entering and Viewing Clinic Visit Data

The main function of the package is to add visit information to the program. This is done using options from the Audiology & Speech Visit Tracking System menu. Visit data can be viewed using the A&SP Reports menu.

### ***Audiology & Speech Visit Tracking System***

[ACKQAS MASTER]

- New Clinic Visits [ACKQAS VISIT ENTRY]
- Edit an Existing Visit [ACKQAS VISIT EDIT]
- Inquire - A&SP Patient [ACKQAS PAT INQ]
- A&SP Reports [ACKQAS REPORTS]
  - a. Visits by Diagnosis [ACKQAS VISITS BY DIAG]
  - b. Patients by City [ACKQAS PAT BY CITY]
  - c. Statistics by Procedure [ACKQAS PROC STATS]
  - d. Cost Comparison Report [ACKQAS PRINT COST COMPARE]
  - e. Tailor-Made A&SP Reports [ACKQAS ADHOC]
  - f. PCE Exception Report [ACKQAS PCE EXCEPTION REPORT]
  - g. Workload Report [SDCLINIC WORKLOAD]

### **Appointment Management and PCE Interfaces**

#### ***How Does It Work?***

After entering the clinic, date and patient name in the **New Clinic Visits** option, the program searches Appointment Management, QUASAR, and PCE to see if there is already a visit/appointment on file. The following discusses how the program works under different circumstances (no existing QUASAR visits as opposed to existing visits). This discussion assumes PCE is active.

#### **No Existing QUASAR Visits**

The following assumes there are no existing visits in QUASAR for the clinic, date, and patient entered.

1. First, QUASAR checks for matching appointments in Appointment Management. If there are none, the program drops immediately to the Patient Inquiry screen and you may add new visit data.

**Note:** Sites are strongly warned not to enter encounter data for appointments that do not exist in Appointment Management. If a patient presents to the clinic without a scheduled appointment (walk-ins), the patient **MUST** be entered into Appointment Management in accordance with the facility's policy prior to entering encounter data for the patient into QUASAR.

If Appointment Management is not used and a visit is added in QUASAR, it will not appear in Appointment Management, although it will exist in PCE. The data will transmit to the NPCDB. However, if there is a problem with the data, the clinic will not know that the encounter is in ACTION REQUIRED status. An incomplete encounter warning will come back to MAS, but they will not be able to find the offending encounter since it does not appear in Appointment Management. This is not strictly a QUASAR problem. Any appointment generated outside Appointment Management (e.g., CPRS, ECS) will not appear in Appointment Management.

2. If there are existing appointments in Appointment Management, then they are displayed.

**Example**

- APPOINTMENT LIST -		
Name : QUASARPATIENT,ONE		SSN : 000-00-0001
Date : 11/03/99		Clinic : AUDIOLOGY
Appt Date/Time	Status	Appointment Type
1. NOV 3,1999 08:00	NO ACTION TAKEN	REGULAR
Select Appointment (1-1) or (N)ew Visit : 1//		

- a. If you select an existing appointment, then you are returned to QUASAR and shown the Patient Inquiry screen. You may begin entering visit data. The Appointment Time will be the same as that in Appointment Management and it is not editable in QUASAR.
- b. If you select New Visit, a warning message displays.

**Example**

WARNING - You are Creating a Visit that does not exist within Appointment Management. This Visit will not be displayed within Appointment Management.  Do you want to Continue ? NO//
---

**Note:** Data should **NOT** be entered into QUASAR without having an appointment in the Appointment Management package. If, however, you should still



elect to continue, you must enter a time different from that in Appointment Management.

### Existing QUASAR Visits

Regardless of whether or not the appointment is already in Appointment Management, if there is an existing QUASAR visit for the clinic, date, and patient entered, the program displays that QUASAR visit for selection first.

### Example

```
One visit has already been entered for this date and patient.

1. NOV 19, 1999  9:35 AM  AUDIOLOGY

Is the appointment shown here the one you wish to edit? No//
```

1. If the existing QUASAR visit is selected, then you are dropped immediately to the Patient Inquiry screen and may edit the existing visit data.
2. If the existing QUASAR visit is not selected, then you are shown any existing encounters in PCE which should include the visit already displayed from the QUASAR package and any others that may have been added to PCE through the Scheduling package.

### Example

```
Ok, adding another visit for this patient/date.

No. DATE          TIME          HOSPITAL LOCATION      CATEGORY  UNIQUE I D
                                     END OF LIST

PAT/SEX/AGE/SSN: QUASARPATIENT,ONE  MALE 86 Years          000-00-0001
ENCOUNTERS: ...Select an ENCOUNTER .....
                                     -- 1 ENCOUNTERS --
No. DATE          TIME          HOSPITAL LOCATION      CATEGORY  UNIQUE I D
1  NOV 19, 1999  09:35        AUDIOLOGY              PRIMARY   14GG-TEST
2  NOV 19, 1999  07:00        AUDIOLOGY              PRIMARY   14CW-TEST
                                     END OF LIST

'RETURN' to continue or '-' for previous screen
Select ITEM No. or 'A' to ADD an Encounter:
```

You may select one of these encounters, add a new encounter, or press the <ret> key.

- a. If an encounter is selected from this screen that is not already in QUASAR, then QUASAR will copy the Visit Time Eligibility data and all Diagnosis, Procedure and Provider information from PCE and you will be presented with the Patient Inquiry screen.

If you select the same visit that is already in QUASAR, then you will receive an Error message.

**Example**

ERROR - A visit already exists in QUASAR with the following details.

Visit Date: NOV 19, 1999 Appointment Time: 9:35 AM  
Clinic: AUDIOLOGY  
Patient: QUASARPATIENT,TWO

If you choose to continue you must enter a different Appointment Time.

**Note:** QUASAR will not allow two visits for the same Patient and Clinic to have the exact same date and time. Also, since duplicate entry of workload data will affect the Capitation Statistics, DSS Extract, and ACRP Workload Reports, it is important that the same visit is not entered twice.

- b. If you elect to ADD an Encounter and there are no existing appointments, you get a warning message.

**Example**

WARNING –

You are Creating a Visit that does not exist within Appointment Management.  
This Visit will not be displayed within Appointment Management.

Do you want to Continue ? NO//

- c. If you press the <ret> key and there are appointments in Appointment Management, then you get one last chance to select an appointment in Appointment Management.

**Example**

– APPOINTMENT LIST –

Name : QUASARPATIENT,ONE  
Date : 11/19/99

SSN : 000-00-0001  
Clinic : AUDIOLOGY

Appt Date/Time	Status	Appointment Type
1. NOV 19,1999 07:00	NO ACTION TAKEN	REGULAR
2. NOV 19,1999 09:35	NO ACTION TAKEN	REGULAR

Select Appointment (1-2) or (N)ew Visit : 1//

- If you do not select an existing QUASAR visit, PCE encounter, or Appointment or add a new encounter, then you are returned to the beginning of the option.

## Avoiding Mismatches between QUASAR and PCE

### When is PCE Interface Active?

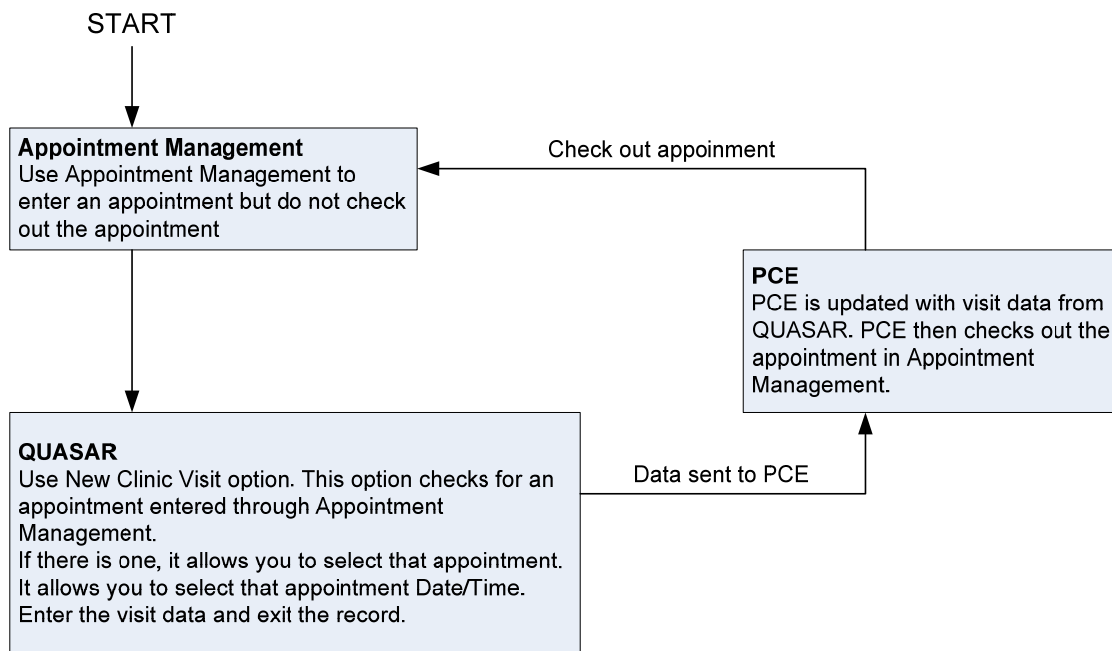
The PCE Interface is considered Active for the current Visit if all the following are true:

- The PCE Interface parameter for the Site is set to YES.
- The Send to PCE parameter for the Division is set to YES.
- The Visit Date falls on or after the PCE Interface Start Date for the Division.

**Note:** If data is entered or edited in QUASAR for a date which is PRIOR to the PCE INTERFACE START DATE initially set in the site parameters, data mismatches will be reported in the PCE exception report.

### Preferred Workflow

The general workflow should be from Appointment Management to QUASAR to PCE and back to Appointment Management to check out the appointment. If this workflow pattern is followed, you will have few or no instances of mismatched data between PCE and QUASAR.



## Data Mismatch between PCE and QUASAR

**Note:** Any data entered into QUASAR is automatically transmitted to PCE when the interface is Active; data entered first into QUASAR assumes the same data in PCE.

If there is mismatched data:

- The data in PCE was entered before that in QUASAR through Scheduling or Progress Notes.
- The data was altered in PCE following transmission of the data from QUASAR.
- The PCE interface was not active when the visit was entered into QUASAR and different values were entered into QUASAR and PCE.

If there is a mismatch, the fields with mismatches are displayed whenever you select a record to edit. The mismatch check is done on the Clinic Location, Visit Date, Appointment Time, and Patient Name fields. If there is a mismatch, only the mismatched fields display.

### Example

The following fields within the PCE Visit entry linked to this Quasar visit no longer match.

CLINIC LOCATION  
PATIENT  
VISIT DATE

Due to this mismatch the link between this Quasar visit and the PCE visit will be broken.

**Note:** You should routinely run the PCE Exception Report and correct any problems found.

## New Clinic Visits

[ACKQAS VISIT ENTRY]

The New Clinic Visits option allows you to enter A&SP clinic visits into the computer.

### Required Data

When entering a new visit, if all required information is not typed in, the entire visit is deleted. This is done to eliminate errors caused by incomplete data. Each of the following six fields must contain data for the visit to be filed in QUASAR:

1. DIVISION
2. CLINIC
3. VISIT DATE
4. PATIENT NAME
5. APPOINTMENT TIME
6. CDR ACCOUNT

If all the above are present, the program checks for data in the following additional fields that are considered required but do not prevent the visit from being filed in QUASAR.

If the PCE interface is not active for the visit:

7. PRIMARY DIAGNOSIS                      8. PROCEDURE                      9. PRIMARY PROVIDER

If the PCE interface is active for the visit:

7. VISIT ELIGIBILITY                      10. RADIATION EXPOSURE\*\*                      12. PRIMARY DIAGNOSIS  
8. SERVICE CONNECTED\*                      11. ENVIRONMENTAL CONTAMINANTS\*\*                      13. PRIMARY PROVIDER  
9. AGENT ORANGE\*\*                      14. PROCEDURE

\* field required only if it applies to the Patient

\*\* field required only if it applies to the Patient and the Visit is NOT Service Connected

The following prompts may or may not appear depending on the patient and the way the site parameters are defined:

**Division:** If this is a multi-divisional site and there is more than one Active Division defined in the A&SP Site Parameters, select the Division associated with the visit. If there is only one active Division, you will not see this prompt.

**Clinic:** If there is more than one Clinic location for the Division, identify the Clinic location for this visit.

**Visit Date:** Enter the visit date. QUASAR defaults to today's date and will accept any date format except a future date.

**Patient Name:** Enter the patient's name. If a new name is entered (i.e., a name not previously in the A&SP Patient file (#509850.2)), QUASAR asks if you want to add the new patient to the file.

Once you select a clinic, date, and patient, the program searches QUASAR, Appointment Management, and PCE for existing visits/appointments.

**Note:** For more information, refer to *Appointment Management and PCE Interfaces* on page 13.

[Display of patient details]

Next, the system displays a Patient Inquiry summary/screen of the Patient you selected. The display includes the Division and Clinic selected for this visit, the Patient Name, Date of Birth, Social Security Number, Eligibility, and Initial Visit Date. If the patient is currently an Inpatient, the patient's ward, room and treating specialty also display.

**Example**

QUASAR V.3    NEW VISIT ENTRY
-------------------------------

CLINIC: AUD CLINIC 1	DIVISION: HINES ISC
PATIENT: QUASARPATIENT,THREE	DOB: NOV 11,1959    SSN: 000-00-0003
ELIGIBILITY:	INITIAL VISIT DATE: 08/19/99
Patient is not currently an inpatient.	
Patient Diagnostic History	
Mr. QUASARPATIENT,THREE has been seen for the following:	
DIAGNOSIS	DATE ENTERED
-----	
141.9    MALIG NEO TONGUE NOS	09/12/99
V41.6    PROBLEM W SWALLOWING	08/19/99

If there have been previous visits, the patient's A&SP problem list will also be displayed.

**Appointment Time:** You are asked for an Appointment Time if an appointment or PCE visit was not selected or if there is a mismatch in appointment times between PCE and QUASAR. If this is the first recorded visit for the patient, you are also asked to enter the Initial Visit Date.

If the Use ASP Clinic File Number site parameter is set to YES, you will get the following prompt next:

**ASP File Number:** Enter the patient's ASP File Number or press the <ret> key to accept the default.

If you are using QUASAR's AMIE/C&P interface and an Audiology C&P exam is scheduled through AMIE for the patient, the following appears:

**Is this a C&P Visit?:** Answer YES to this prompt to link the QUASAR clinic visit to the appropriate AMIE entry.

If the C&P exam prompt does not appear:

- The patient entered is not a C&P patient.
- Veterans Affairs Regional Office (VARO) did not request an AUDIO exam (see Form 2507).
- The patient's C&P claim has been closed by the C&P Unit. Contact your C&P Unit if necessary.

It is permissible to force the "Is this a C&P exam?" prompt and there are occasions when this is acceptable. To force the C&P prompt, enter "^C AND P" after the patient identifying information (e.g., at the "Select DIAGNOSTIC CODE:" prompt). A facility not using the AMIE/C&P interface might force the prompt to keep an accurate count of C&P exams. A facility using the AMIE/C&P interface might force the prompt in order to produce the C&P report for an allied

war veteran with a C&P appointment. The allied war veteran's report would be signed manually, because only C&P exams requested through VARO can be adequated through QUASAR.

**Diagnostic Code:** Enter a diagnostic code (ICD-9-CM code).

**Evaluations:** The disease codes are those conditions found to exist after evaluation or are determined to exist based on observation or case history. Previously noted conditions are not listed unless they are relevant to the management of the patient.

**Treatment and Therapy Visits:** The disease codes are those conditions which are treated. Conditions previously noted to exist but are not relevant to the management of the patient or are not treated during the visit are not entered. Disease codes are added to the A&SP problem list for the patient.

**Note:** To see a list of previously entered diagnostic codes, enter a ? at the "Select DIAGNOSTIC CODE:" prompt.

**Is this the Primary Diagnosis ? : YES:** This prompt appears until one of the Diagnostic Codes entered is designated as the Primary Diagnosis. If you don't define a Primary Diagnosis, the program will remind you and send you back to designate one as the primary.

**Update PCE Problem List with Diag. Code?:<sup>1</sup>** This is a new conditional field within the New Visit option. This prompt displays only when you answer Yes to the "Update PCE Problem List?" prompt. This prompt exists for the Diagnosis Provider prompt, which displays after this prompt.

**Diagnosis Provider:<sup>2</sup>** If you select to update the PCE Problem List, you will be asked who the Diagnosis Provider was. For each diagnosis added, you will need to add a Provider. The valid providers are also the same providers as on the "Secondary Provider" prompt.

Currently, when data is transferred to PCE, a PCE Encounter is created using the QUASAR visit data. However, if you answer Yes to the "Update the PCE Problem List" prompt, the system will also attempt to update the PCE Problem List with all selected Diagnosis Codes and their associated Providers.

**Eligibility for this Appointment:** This prompt only appears if the patient is Service Connected. The classification is displayed and you are asked to select the eligibility for the appointment. NSC is always a possible selection because the eligibility for the appointment might not be covered by the patient's service classification.

### Example

Service Classifications SERVICE-CONNECTED
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<sup>1</sup> This is a new field contained in Patch ACKQ\*3.0\*1.

<sup>2</sup> This is a new field contained in Patch ACKQ\*3.0\*1.

This Patient has other Entitled Eligibilities  
NSC NON-SERVICE CONNECTED  
PRISONER OF WAR PRISONER OF WAR

Enter the Eligibility for this Appointment: SERVICE CONNECTED 50% to 100%

// ??

Only Eligibilities associated with the visit are valid for entry.

Choose from:

NSC  
PRISONER OF WAR  
SERVICE CONNECTED 50% to 100%

Enter the Eligibility for this Appointment: SERVICE CONNECTED 50% to 100%

//

If the patient is Service Connected and has been exposed to Agent Orange, Environmental Contaminants, and/or Radiation, then the service connection and all exposures are listed and you are asked to enter the eligibility for the appointment.

### Example

Service Classifications

SERVICE-CONNECTED AGENT-ORANGE

This Patient has other Entitled Eligibilities

NSC NON-SERVICE CONNECTED  
PRISONER OF WAR PRISONER OF WAR

Enter the Eligibility for this Appointment: SERVICE CONNECTED 50% to 100%

//

**Was the Care for a SC Condition?:** If the patient is Service Connected, this prompt also appears. Indicate here whether or not the visit is Service Connected.

The next prompt, "Was care related to ... Exposure", only appears:

- If you answer NO at the "Was the Care for a SC Condition?" prompt, and the patient has been exposed to Agent Orange, Radiation or Environmental Contaminants, or
- If the patient is not service connected but has been exposed to Agent Orange, Radiation, or Environmental Contaminants.

**Was care related to ... Exposure:** If the patient is not Service Connected but has been exposed to Agent Orange, Environmental Contaminants, and/or Radiation, then the classification is not displayed but you are asked to designate whether or not the care given during the visit was related to the exposure(s). This prompt does not appear if:

- The patient is Service Connected



- The patient is not service connected and has not been exposed to Agent Orange, Environmental Contaminants, or Radiation.

**Was care related to Head and/or Neck Cancer ?:** This prompt indicates whether the patient's visit was related to Head and/or Neck Cancer. This prompt will only appear if the patient is classified with Environment Factors: (4) N/T Radium (VERIFIED).

**Was care related to COMBAT ?:** This prompt indicates whether the patient's visit was related to Combat. This prompt will only appear if the patient is classified with combat related information.

**Was care related to MST?<sup>1</sup>** This prompt indicates whether the patient's visit was related to Military Sexual Trauma. This prompt displays because the patient is registered on the MST file and the QUASAR Visit Date falls after the MST Active date.

If the Division is set up in Site Parameters to transmit data to PCE, and the above conditions exist and the answer of Yes or No to this prompt is included in the data that gets sent to PCE.

If the Division is not set up in Site Parameters to transmit data to PCE, then this prompt will not display.

**CDR Account:** QUASAR determines the CDR cost account. The program checks for inpatient/outpatient status and treating specialty to determine the CDR cost account. All outpatient workload is distributed to CDR account 2611.00 (Rehabilitative and Supportive Services). If the CDR account presented is correct, accept the default answer by pressing the return key (<RET>).

Audiometric Scores and the associated word processing fields (Review of Medical Records, Medical History, Physical Examination, Diagnostic and Clinical Tests, and Diagnosis) only appear when entering C&P Exam data. At least one of the diagnostic codes entered for the visit must be related to hearing loss.

**Note:** If the patient is found to have normal hearing, use ICD9-CM code V65.5 in addition to the code for the patient's chief complaint.

**Audiometric Scores:** The program displays the patient's previous audiometric scores if either of the following conditions is true:

- The visit is a C&P Exam and the patient has previous audiometric scores.
- At least one of the diagnostic codes entered for the visit is defined as being Hearing Loss, the Bypass Audiometric site parameter is set to NO for the division, and the patient has previous audiometric scores.

If one of the above conditions is met, the program displays the patient's previous scores and asks if you want to use those scores. If not, prompts appear for audiometric

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<sup>1</sup> This is a new field contained in Patch ACKQ\*3.0\*1.

thresholds and word recognition scores. Enter a whole number between -10 and 105. No response at the limits of the audiometer is coded as 105.

**Note:** The A&SP Program Office prohibits presentation of audiometric stimuli exceeding 105 dB HL.

Audiometric scores are required if one of the following conditions is met:

- The visit is a C&P exam and the patient does not have previous scores.
- The visit is a C&P exam and the patient has previous scores but you have chosen not to use them.
- One or more of the diagnosis codes for the visit is defined as constituting hearing loss, the Bypass Audiometric site parameter for the division is set to NO, and the patient does not have previous scores.
- One or more of the diagnosis codes for the visits is defined as constituting hearing Loss, the Bypass Audiometric site parameter for the division is set to NO, the patient has previous scores, but you have chosen not to use them.

**Review of Medical Records:** Indicate whether the C-file was reviewed. You should state that the C-file was not reviewed or was not available for review.

**Medical History:** Comment on:

1. Chief complaint.
2. Situation of greatest difficulty.
3. Pertinent service history.
4. History of military, occupational, and recreational noise exposure.
5. Tinnitus - If present, state:
  - a. Date and circumstances of onset.
  - b. Whether it is unilateral or bilateral.
  - c. Whether it is recurrent (indicate frequency and duration).
  - d. The most likely etiology of the tinnitus, and specifically, if hearing loss is present, whether the tinnitus is due to the same etiology (or causative factor) as the hearing loss.

**Physical Examination:** Enter the Objective Findings.

1. Measure pure tone thresholds in decibels at the indicated frequencies (air conduction):

	=====RIGHT EAR=====					=====LEFT EAR=====					
A*	B	C	D	E	**	A*					
	B	C	D	E	**	**					
500	1000	2000	3000	4000	average	500	1000	2000	3000	4000	average

\* The pure tone threshold at 500 Hz is not used in determining the evaluation but is used in determining whether or not a ratable hearing loss exists.

\*\* The average of B, C, D, and E.

2. Speech Recognition Score:

Maryland CNC word list \_\_\_\_\_% right ear \_\_\_\_\_% left ear

3. When only pure tone results should be used to evaluate hearing loss, the examiner, who must be a state-licensed audiologist, should certify that language difficulties or other problems (specify what the problems are) make the combined use of pure tone average and speech discrimination inappropriate.

**Diagnostic and Clinical Tests:**

1. Report middle-ear status, confirm type of loss, and indicate need for medical follow-up. In cases where there is poor inter-test reliability and/or positive Stenger test results, obtain and report estimates of hearing thresholds using a combination of behavioral testing, Stenger interference levels, and electrophysiological tests.
2. Include results of all diagnostic and clinical tests conducted in the examination report.

**Diagnosis:**

1. Summary of audiologic test results. Indicate type and degree of hearing loss for the frequency range from 500 to 4000 Hz. For type of loss, indicate whether it is normal, conductive, sensorineural, central, or mixed. For degree, indicate whether it is mild (26-40 dB HL), moderate (41-54 dB HL), moderately-severe (55-69 dB HL), severe (70-89 dB HL), or profound (90+ dB HL). For VA purposes, impaired hearing is considered to be a disability when the auditory threshold in any of the frequencies 500, 1000, 2000, 3000, and 4000 Hz is 40 dB HL or greater; or when the auditory thresholds for at least three of these frequencies are 26 dB HL or greater; or when speech recognition scores are less than 94%.
2. Note whether, based on audiologic results, medical follow-up is needed for an ear or hearing problem, and whether there is a problem that, if treated, might cause a change in hearing threshold levels.

**Primary Provider, Secondary Provider, Student:** Next, you are prompted for Primary Provider, Secondary Provider, and Student.

1. The Primary Provider field is required and contains the name of the primary A&SP clinician who participated in the exam.
2. You may enter more than one Secondary Provider. This is the same as a Diagnosis Provider prompt. If more than one provider was involved in the exam, the name(s) of the Secondary Provider should be entered here. In order to enter a provider in this field, the provider must already exist in the A&SP Staff file (#509850.3) and the Activation Date and the Inactivation Date must indicate that the selected provider is active on the date of the exam. This field can also be left blank.
3. You can only select providers and students who are active on the exam visit date.

**Event Capture Codes:**<sup>1</sup> Conditional prompt that displays only if Event Capture Codes was set up in Site Parameters for a Division. You can enter Event Capture Codes instead of the Procedure Codes (CPT) for the Division at this prompt. A list will display for you to select an Event Capture Code. Multiple entries can be made.

**Volume:**<sup>2</sup> Conditional prompt that displays only if Event Capture Codes was set up in the Site Parameters for the Division. This prompt denotes the number of times that the procedure was performed with the visit.

**EC Procedure Provider:**<sup>3</sup> Conditional prompt that displays only if Event Capture Codes was set up in the Site Parameters for the Division. You can select a provider/clinician that performed the procedure at this prompt. The selection defaults to the same person as the “Primary Provider” if they were selected for the Encounter. It is also the same person as the CPT Procedure Provider and Diagnosis Provider.

**Procedure Code:** Enter all applicable procedure codes (CPT-4 codes).

**Note:** There are times when the same procedure is done more than once during a visit. In that case, enter the procedure once and at the next Procedure Code prompt, enter the same procedure in quotes.

#### Example

Select PROCEDURE CODE: 92565 <RET>	STENGER TEST, PURE TONE
Select CPT MODIFIER: <RET>	
VOLUME: 1// <RET>	
PROCEDURE PROVIDER: QUASARPROVIDER1,SIX// <RET>	JS
Select PROCEDURE CODE: "92565" <RET>	STENGER TEST, PURE TONE

<sup>4</sup>If a Supervisor answers “No” to the Event Capture Code prompt for a Division, then the Procedure Codes (CPT) prompt will be displayed instead of the Event Capture Codes. This prompt contains CPT procedure codes for this exam. QUASAR accepts multiple CPT-4 codes to be entered more than once if the second and subsequent codes are enclosed in quotation marks (e.g., “92507”). If this is not done, QUASAR assumes that the entry is a mistake and displays the entered code followed by double slant bars (e.g., 92507//). This is a signal that this code has already been entered for this visit.

**CPT Modifier:** You are prompted for modifiers when a modifiable CPT code is entered. Enter as many as apply.

**Volume:** The default volume is one because most Audiology and Speech Pathology procedures are complexity-based, not time-based.

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<sup>1</sup> This is a new field contained in Patch ACKQ\*3.0\*1.

<sup>2</sup> This is a new field contained in Patch ACKQ\*3.0\*1.

<sup>3</sup> This is a new field contained in Patch ACKQ\*3.0\*1.

<sup>4</sup> This is an updated field contained in Patch ACKQ\*3.0\*1.

**Complexity-Based Procedures:** The volumes for codes that are complexity-based are always "one". For example, if you provide treatment (92507), one code is entered regardless of how much time is spent with the patient. If the time spent exceeds the typical time for that procedure, you should enter CPT Modifier 22 to show that the complexity of procedure was unusual.

**Time-Based Procedures:** Some procedure (CPT) codes are time-based (e.g., 97703, 96105). One code is entered for each specified time period. For example, code 97703 has a period of 15 minutes. If the procedure was performed for 30 minutes, then a volume of "two" would be entered.

**Repeated Procedures:** If a procedure is repeated, the volume is not entered as "two". When the procedure is repeated by the same provider, modifier 76 is entered. If the procedure is repeated by another provider, modifier 77 is used.

The typical times associated with various procedures can be found in the A&SP Product Code Manual, on the A&SP Website at <http://vaww1.va.gov/audiospeech/> or from your local DSS Office.

**Procedure Provider:** The default is the Primary Provider. You may accept the default entry or enter a new provider.

**Time Spent (minutes):** Enter the total time spent during the clinic visit. Time is recorded in minutes and is to include direct (e.g., face-to-face) and indirect time (e.g., report writing, progress note writing, decision making, record review, and/or coordination of care). The chief use of procedure time data is the CDR. You can sort, tabulate, and print procedure time by clinic or provider using the Tailor-Made A&SP Reports option.

If all the required data has been entered and you are using the AMIE/C&P interface, the program allows you to sign off on the exam.

Are you ready to sign off this exam? No// **y** (Yes)  
SIGNATURE CODE: (Enter your signature code)  
Ok...

### ***Entering Visit Data for a New QUASAR Patient***

In this example:

- The Send to PCE site parameter is set to **YES**.
- The patient is Service Connected.
- The patient has been exposed to Agent Orange and Radiation.
- The **Use ASP Clinic File Number** site parameter is set to **YES**.

#### **Example**

New Clinic Visits

This option is used to enter new A&SP clinic visits. Existing clinic visits should be updated with the Edit an Existing Visit option.

Select DIVISION                  **CIOFO HINES DEV**                  Station Number : 14100  
Select CLINIC:                   **AUDIOLOGY**

Clinic: AUDIOLOGY    Stop Code: 203  
Enter Visit Date: TODAY// <RET> (OCT 26, 1999)  
Select A&SP PATIENT NAME: **QUASARPATIENT,FOUR**   01-10-44       321456733       YES  
SC VETERAN

- APPOINTMENT LIST -

Name : QUASARPATIENT,FOUR	SSN : 000-00-0004
Date : 10/26/99	Clinic : AUDIOLOGY

Appt Date/Time	Status	Appointment Type
1. OCT 26,1999 09:35	NO ACTION TAKEN	REGULAR

Select Appointment (1-1) or (N)ew Visit : 1// <RET>

QUASAR V.3. NEW VISIT ENTRY

Patient Inquiry

CLINIC: AUDIOLOGY	DIVISION: CIOFO HINES DEV
PATIENT: QUASARPATIENT,FOUR	DOB: JAN 10,1944   SSN: 000-00-0004
ELIGIBILITY: SC LESS THAN 50%	INITIAL VISIT DATE:

Patient is currently an inpatient.

WARD: 4AS	ROOM/BED:	TREATING SPEC:NEUROLOGY
-----------	-----------	-------------------------

This visit's Treatment:

-----

Related to AGENT ORANGE ? : UNKNOWN	Service Connected ? : UNKNOWN
Related to RADIATION EXPOSURE ? : UNKNOWN	

Patient Diagnostic History

Ms. QUASARPATIENT,FOUR has been seen for the following:

DIAGNOSIS	DATE ENTERED
-----------	--------------

-----  
No A&SP Diagnostic Data for this Patient

APPOINTMENT TIME: 9:35 AM (Uneditable)

INITIAL VISIT DATE: OCT 26, 1999// <RET> (OCT 26, 1999)

ASP FILE NUMBER: **TINY123**

^

Select DIAGNOSTIC CODE: **784.3**      APHASIA

...OK? Yes// <RET> (Yes)

784.3      APHASIA

We have no previous record of diagnostic condition 784.3 for Ms. QUASARPATIENT,FOUR.  
Ok, I've added this code to her permanent record !

Is this the Primary Diagnosis ? : **Y** YES

Select DIAGNOSTIC CODE: <RET>

Service Classifications

SERVICE-CONNECTED AGENT-ORANGE RADIATION

This Patient has other Entitled Eligibilities

NSC NON-SERVICE CONNECTED

PRISONER OF WAR PRISONER OF WAR

Enter the Eligibility for this Appointment: SC LESS THAN 50%

// **NSC**

Was care for SC Condition ? : **N** NO

Was care related to AO Exposure ? : **N** NO

Was care related to IR Exposure ? : **Y** YES

Suggested CDR Account :1111.00 NEUROLOGY

CDR ACCOUNT: 1111.00// <RET>      NEUROLOGY

PRIMARY PROVIDER: **QUASARPROVIDER,ONE**    AG    AUDIOLOGY AND SPEECH PATH

SECONDARY PROVIDER: <RET>

STUDENT: <RET>

Select PROCEDURE CODE: **92506**

SPEECH & HEARING EVALUATION

Select CPT MODIFIER: ?

You may enter a new CPT MODIFIER, if you wish

Enter a Modifier code(s) for the selected Procedure.

Only valid Modifiers for the selected Procedure that are marked as active on the A&SP CPT Modifiers File are available for selection.

Answer with A&SP PROCEDURE MODIFIER

Do you want the entire A&SP PROCEDURE MODIFIER List? **Y** (Yes)

Choose from:

22	UNUSUAL PROCEDURAL SERVICES	CPT
26	PROFESSIONAL COMPONENT	CPT
51	MULTIPLE PROCEDURES	CPT
52	REDUCED SERVICES	CPT
53	DISCONTINUED PROCEDURE	CPT
59	DISTINCT PROCEDURAL SERVICE	CPT
76	REPEAT PROCEDURE BY SAME PHYSICIAN	CPT
77	REPEAT PROCEDURE BY ANOTHER PHYSICIAN	CPT
99	MULTIPLE MODIFIERS	CPT
TC	TECHNICAL COMPONENT	HCPCS

Select CPT MODIFIER: **<RET>**

VOLUME: 1// **<RET>**

PROCEDURE PROVIDER: QUASARPROVIDER,ONE// **<RET>**

Select PROCEDURE CODE: **<RET>**

TIME SPENT (minutes): **30**

### ***Entering Audiometry Scores***

If the USE C&P site parameter is answered YES, you are utilizing the AMIE/C&P interface. Staff involved in the C&P process must have an electronic signature. An electronic signature can be established using the Edit Electronic Signature Code option in the User's Toolbox menu.

The AMIE linkage feature allows entry of text and audiometric data in the AMIE format, adequation of the results, and hand-off of the report to the AMIE Compensation and Pension package. When an entry is made for the patient, you are asked "Is this a C&P exam?" If you respond YES, in addition to the usual QUASAR information, narrative data is requested for generating the AMIE report. When the exam is signed and adequated, the rating narrative, and audiometric data are transmitted to the AMIE system.

The C&P exam prompt may not appear for the following reasons:

1. The patient is not a C&P patient. The chief reason for this event is that VARO did not request an AUDIO exam (see Form 2507) or the examining physician requests an audiological assessment not requested by VARO. You should contact the C&P Unit to have AUDIO added to the selected exam list.



2. The patient's C&P claim has been closed by the C&P Unit. This event occurs when users do not use QUASAR to process rating summaries (i.e., the AMIE link is disabled) and QUASAR visit data are entered significantly after the visit date. You should contact your C&P Unit to see if the exam has been closed out.

If you are using the AMIE/C&P interface, QUASAR prompts for the AMIE rating summary fields. These fields may be filled by entering text through the line or text editor or by pasting text into the summary field from commercial word-processing software. If the AMIE/C&P interface is not enabled, the text fields do not appear.

**Note:** Procedures differ from clinic to clinic. The example below is for demonstration purposes only and is not intended to represent the official format for rating summaries.

.....

Is this a C&P Visit ?: YES// <RET> YES

Select DIAGNOSTIC CODE: **388.2** SUDDEN HEARING LOSS NOS

388.2 SUDDEN HEARING LOSS NOS

We have no previous record of diagnostic condition 388.2 for Mr. QUASARPATIENT,FIVE.

Ok, I've added this code to his permanent record !

Is this the Primary Diagnosis ?: **Y** YES

Select DIAGNOSTIC CODE: <RET>

Service Classifications

SERVICE-CONNECTED

This Patient has other Entitled Eligibilities

NSC NON-SERVICE CONNECTED

Enter the Eligibility for this Appointment: SERVICE CONNECTED 50% to 100%

// **NSC**

Was care for SC Condition ?: **N** NO

Suggested CDR Account :2611.00 REHABILITATIVE & SUPPORTIVE SERVICES

CDR ACCOUNT: 2611.00// <RET> REHABILITATIVE & SUPPORTIVE SERVICES

Enter Audiometrics :

TONE R500: **30**

TONE R1000: **35**

TONE R2000: **75**

TONE R3000: **75**

TONE R4000: **75**  
TONE L500: **30**  
TONE L1000: **30**  
TONE L2000: **75**  
TONE L3000: **75**  
TONE L4000: **75**  
CNC R: **85**  
CNC L: **80**  
W22 R: **1**  
W22 L: **1**

Compensation and Pension Examination  
For AUDIO  
#1305 Worksheet

An examination of hearing impairment must be conducted by a state-licensed audiologist and must include a controlled speech discrimination test (specifically, the Maryland CNC recording) and a pure tone audiometry test in a sound isolated booth that meets American National Standards Institute standards (ANSI S3.1.1991) for ambient noise.

Measurements will be reported at the frequencies of 500, 1000, 2000, 3000, and 4000 Hz. The examination will include the following tests: pure tone audiometry by air conduction at 250, 500, 1000, 2000, 3000, 4000 Hz, and 8000 Hz; and by bone conduction at 250, 500, 1000, 2000, 3000, and 4000 Hz; spondee thresholds; speech recognition using the recorded Maryland CNC Test; tympanometry; and acoustic reflex tests, and, when necessary, Stenger tests. Bone conduction thresholds are measured when the air conduction thresholds are poorer than 15 dB HL. A modified Hughson-Westlake procedure will be used with appropriate masking. A Stenger test must be administered whenever pure tone air conduction thresholds at 500, 1000, 2000, 3000, and 4000 Hz differ by 20 dB or more between the two ears.

Press RETURN to continue:

Compensation and Pension Examination  
For AUDIO  
#1305 Worksheet (Continued)

Maximum speech recognition will be reported with the 50-word VA-approved recording of the Maryland CNC test. When speech recognition is 92% or less, a performance intensity function will be obtained with a starting presentation level of 40dB re SRT. If necessary, the starting level will be

adjusted upward to obtain a level at least 5 dB above the threshold at 2000 Hz. The examination will be conducted without the use of hearing aids. Both ears must be examined for hearing impairment even if hearing loss in only one ear is at issue.

REVIEW OF MEDICAL RECORDS: Indicate whether the C-file was reviewed. If the C-file was not reviewed or was not available for review, the examiner should so state.

REVIEW OF MEDICAL RECORDS:

1>ENTER THE TEXT.

2> <RET>

EDIT Option: <RET>

MEDICAL HISTORY (SUBJECTIVE COMPLAINTS):

Comment on:

1. Chief Complaint.
2. Situation of greatest difficulty.
3. Pertinent service history.
4. History of military, occupational, and recreational noise exposure.
5. Tinnitus - If present, state:
  - a. date and circumstances of onset
  - b. whether it is unilateral or bilateral
  - c. whether it is recurrent (indicate frequency and duration)
  - d. State the most likely etiology of the tinnitus, and specifically, if hearing loss is present, whether the tinnitus is due to the same etiology (or causative factor) as the hearing loss.

MEDICAL HISTORY:

1>ENTER THE TEXT

2> <RET>

EDIT Option: <RET>

PHYSICAL EXAMINATION (OBJECTIVE FINDINGS):

1. Measure pure tone thresholds in decibels at the indicated frequencies (air conduction):

=====RIGHT EAR=====										=====LEFT EAR=====				
A*	B	C		D		E	**					A*	B	
		C	D			E	**							
500	1000	2000	3000	4000	average			500	1000	2000	3000	4000		
		average												

\*The pure tone threshold at 500 Hz is not used in determining the evaluation but is used in determining whether or not a ratable hearing loss exists.

\*\*The average of B, C, D, and E.

2. Speech Recognition Score:

Maryland CNC word list \_\_\_\_\_% right ear \_\_\_\_\_% left ear

3. When only pure tone results should be used to evaluate hearing loss, the examiner, who must be a state-licensed audiologist, should certify that language difficulties or other problems (specify what the problems are) make the combined use of pure tone average and speech discrimination inappropriate.

PHYSICAL EXAMINATION:

1>ENTER THE TEXT.

2> <RET>

EDIT Option: <RET>

DIAGNOSTIC AND CLINICAL TESTS:

1. Report middle-ear status, confirm type of loss, and indicate need for medical follow-up. In cases where there is poor inter-test reliability and/or positive Stenger test results, obtain and report estimates of hearing thresholds using a combination of behavioral testing, Stenger interference levels, and electrophysiological tests.

2. Include results of all diagnostic and clinical tests conducted in the examination report.

DIAGNOSTIC AND CLINICAL TESTS:

1>ENTER THE TEXT

2> <RET>

EDIT Option: <RET>

DIAGNOSIS:

1. Summary of audiologic test results. Indicate type and degree of hearing loss for the frequency range from 500 to 4000 Hz. For type of loss, indicate whether it is normal, conductive, sensorineural, central, or mixed. For degree, indicate whether it is mild (26-40 dB HL), moderate (41-54 dB HL), moderately-severe (55-69 dB HL), severe (70-89 dB HL), or profound (90+ dB HL). For VA purposes, impaired hearing is considered to be a disability when the auditory threshold in any of the frequencies 500, 1000, 2000, 3000, and 4000 Hz is 40 dB HL or greater; or when the auditory thresholds for at least three of

these frequencies are 26 dB HL or greater; or when speech recognition scores are less than 94%.

2. Note whether, based on audiologic results, medical follow-up is needed for an ear or hearing problem, and whether there is a problem that, if treated, might cause a change in hearing threshold levels.

DIAGNOSIS:

1>ENTER THE TEXT

2> <RET>

EDIT Option: <RET>

### ***Forcing the C&P Prompt***

(Not Using the AMIE/C&P Interface or Audiometric Data for Hearing Loss Codes).

It is permissible to force the "Is this a C&P exam?" prompt and there are occasions when this is acceptable. To force the C&P prompt, enter "^C AND P" after the patient identifying information (e.g., at the "Select DIAGNOSTIC CODE:" prompt). A facility not using the AMIE/C&P interface might force the prompt to keep an accurate count of C&P exams. A facility using the AMIE/C&P interface might force the prompt in order to produce the C&P report for an allied war veteran with a C&P appointment. The allied war veteran's report would be signed manually, because only C&P exams requested through VARO can be adequated through QUASAR.

If your facility uses the AMIE/C&P interface, you must keep in mind that forcing the "Is this a C&P exam?" prompt DOES NOT create the required linkage information between QUASAR and AMIE. If the C&P question does not appear during data input, you should confer with your C&P Unit to determine the cause.

**Note:** Exams with forced C&P prompts cannot be adequated and may not be available to the AMIE package.

The example below presumes the AMIE/C&P interface is inactivated and the facility has the BYPASS AUDIOMETRICS site parameter set to YES. The facility uses QUASAR to track the number of C&P exams.

[Patient Inquiry screen]

Select DIAGNOSTIC CODE: ^C

1 C AND P

2 CDR ACCOUNT

3 CLINICIAN

4 CNC L

5 CNC R

CHOOSE 1-5: 1

Is this a C&P visit? : YES// <ret> YES

## ***Deleting a Non-Hearing Loss Code to Obtain Audiometric Display***

Certain diagnosis codes (i.e., hearing loss codes) are flagged to require audiometric data to be entered when those codes are used for a visit. If the Bypass Audiometrics site parameter is answered NO, you are asked to enter audiometric data.

After audiometric data is entered for a patient's visit, you may wish to edit the audiometric fields. When a non-hearing loss code is the last ICD9-CM code entered, the audiometric fields are not displayed for editing. In order to edit, follow these steps.

1. Delete the non-hearing loss code from the record.
2. Edit the audiometric data field(s).
3. Re-enter the deleted non-hearing loss code using the ^ (shift-6) key to skip to the diagnostic code field.

### **Delete the non-hearing loss code:**

```
Select DIAGNOSTIC CODE: 388.9// @
  SURE YOU WANT TO DELETE THE ENTIRE DIAGNOSTIC CODE? Y (Yes)
Select DIAGNOSTIC CODE: 389.10// <ret>
  DIAGNOSTIC CODE: 389.10// <ret>
Select DIAGNOSTIC CODE: <ret>
```

Suggested CDR Account: 2611.00 REHABILITATIVE & SUPPORTIVE SERVICES

CDR ACCOUNT: 2611.00// <ret>

Audiometric testing for this patient last completed 09/17/94.

#### **PURE TONE RESULTS:**

R500:	30	L500:	30
R1000:	35	L1000:	30
R2000:	75	L2000:	75
R3000:	75	L3000:	75
R4000:	75	L4000:	75
R AVG:	65	L AVG:	63
CNC R:	85	CNC L:	80
W22 R:	10	W22 L:	10

### **Edit the audiometric data field(s):**

Do you wish to use these scores? **NO**

Enter Audiometrics:

TONE R500: 30// ^TONE L1000  
TONE L1000: 30// 35  
TONE L2000: 75// ^DIAGNOSTIC CODE

### Re-enter the deleted non-hearing loss code:

Select DIAGNOSTIC CODE: 389.10// **388.9**      DISORDER OF EAR NOS  
...OK? Yes// <ret> (Yes)  
Are you adding '388.9' as a new DIAGNOSTIC CODE (the 2ND for this A&SP CLINIC VISIT)? Y (Yes)  
Select DIAGNOSTIC CODE: ^

### Edit an Existing Visit

[ACKQAS VISIT EDIT]

The Edit an Existing Visit option is used to modify an existing clinic visit when the data is incorrect, incomplete, or needs to be updated. This option is not to be used to enter a new visit. Fields in this option appear as shown in the New Clinic Visits option.

#### Notes:

1. If you want to delete a visit entered in error, use the option: Delete an A&SP Clinic Visit.
2. The "Appointment Time" prompt is NOT an editable field.

### Inquire - A&SP Patient

[ACKQAS PAT INQ]

The Inquire - A&SP Patient option displays demographic information for an A&SP patient which includes date of birth, social security number, eligibility, service connected status, and initial visit date. Additionally the option shows inpatient status and diagnostic history. Output can be sent to a printer.

After selecting the A&SP patient's name, you are given an opportunity to update the diagnostic history. The problem list is recompiled using this logic: All clinic visits for the patient are examined. Unique diagnostic codes and the earliest date for each code are determined. The A&SP Patient file is updated with these codes and dates. Also, the earliest diagnostic date found becomes the Initial Visit Date.

### A&SP Reports

[ACKQAS REPORTS]

The A&SP Reports menu contains options to print Audiology and Speech Pathology reports. This menu can be assigned to users who do not enter or modify A&SP data, but require read only access.

Visits by Diagnosis [ACKQAS VISITS BY DIAG]  
 Patients by City [ACKQAS PAT BY CITY]  
 Statistics by Procedure [ACKQAS PROC STATS]  
 Cost Comparison Report [ACKQAS PRINT COST COMPARE]  
 Tailor-Made A&SP Reports [ACKQAS ADHOC] **\*\*Locked with ACKQ ADHOC\*\***  
 PCE Exception Report [ACKQAS PCE EXCEPTION REPORT]  
 Workload Report [SDCLINIC WORKLOAD]

**Visits by Diagnosis**

[ACKQAS VISITS BY DIAG]

The Visits by Diagnosis report is printed by selected Division(s) and a date range. You can print the report for Audiology (includes Telephone Audiology) only, Speech Pathology (includes Telephone Speech) only, or both Audiology and Speech Pathology.

You can choose to print the report for one or all clinician(s), other provider(s), or student(s).

The report lists clinic visits for the date range and selected Division(s) sorted by ICD-9CM diagnostic codes. Since the diagnostic code field is a multiple field, the visit shows up once under each diagnostic code entered for that visit.

**Example**

Audiology & Speech Pathology Diagnostic Code Statistics For Provider, QUASARPROVIDER,ONE Covering Visits from 11/28/99 to 11/29/99 For Division: CIOFO HINES DEV	
-----	
STOP CODE: SPEECH TELEPHONE	
CLINIC: SPEECH TELEPHONE	
CLINICIAN: PROVIDER, QUASARPROVIDER,ONE	
141.9 MALIG NEO TONGUE NOS	COUNT: 1
...	

**Patients by City**

[ACKQAS PAT BY CITY]

The Patients by City option generates a patient count report by selected Division(s) and date range. The report shows the number of patients seen, sorted by city of residence.



## Example

Audiology & Speech Pathology	
Unique Patients by City	
Visits from 11/01/99 to 11/30/99	
For Division: CIOFO HINES DEV	
-----	
CLINIC: AUDIOLOGY	
STOP CODE: AUDIOLOGY	
CHICAGO, IL:	13 patients
MAYWOOD, IL:	4 patients
MELROSE PARK, IL:	2 patients
...	

## Statistics by Event Capture Procedure

[ACKQAS EC PROC STATS]

The Statistics by Event Capture Procedure<sup>1</sup> report is printed by selected Division(s) and a date range. You can print the report for Audiology (includes Telephone Audiology) only, Speech Pathology (includes Telephone Speech Pathology) only, or both Audiology and Speech Pathology.

You can choose to print the report for one or all clinician(s), other provider(s), or student(s).

The report lists clinic visits for the date range and selected Division(s) sorted by Event Capture codes.

## Example

Audiology & Speech Pathology	
EC Procedure Statistics	
for	
All Clinicians	
Covering Visits from 10/02/00 to 11/21/00	
For Division: CIOFO HINES DEV	
-----	
STOP CODE: AUDIOLOGY	
CLINIC: AUDIOLOGY AND SPEECH PATHOLOGY	
CLINICIAN: QUASARPROVIDER1,SIX	
SP002 SPCH LOUDNESS TOLERANCE TEST	COUNT: 2

<sup>1</sup> New Report included in Patch ACKQ\*3.0\*1.

SP010	SPEECH/LANGUAGE SCREENING	COUNT: 2
SP025	HEARING TREATMENT NEC	COUNT: 1
SP053	INSTRUM STUDY OF NASAL FUNCTION	COUNT: 1
SP104	HEARING AID EVALUATION BIN	COUNT: 1
SP106	HEARING AID CHECK/REPAIR/ADJUST, BIN	COUNT: 3
SP110	EAR CANAL PROBE MEASUREMENT, BIN	COUNT: 1
SP128	SPECIAL SUPPLIES	COUNT: 44
...		

**Statistics by Procedure**

[ACKQAS PROC STATS]

The Statistics by Procedure report is printed by selected Division(s) and a date range. You can print the report for Audiology (includes Telephone Audiology) only, Speech Pathology (includes Telephone Speech Pathology) only, or both Audiology and Speech Pathology.

You can choose to print the report for one or all clinician(s), other provider(s), or student(s).

The report lists clinic visits for the date range and selected Division(s) sorted by CPT-4 procedure codes. Since the procedure code field is a multiple field, the visit shows up once under each procedure code entered for that visit.

**Example**

Audiology & Speech Pathology Procedure Statistics for Provider, QUASARPROVIDER,ONE Covering Visits from 11/27/99 to 11/29/99 For Division: CIOFO HINES DEV		
-----		
STOP CODE: SPEECH PATHOLOGY		
CLINIC: SPEECH		
CLINICIAN: PROVIDER, QUASARPROVIDER,ONE		
31505	DIAGNOSTIC LARYNGOSCOPY	COUNT: 1
...		

## Cost Comparison Report

[ACKQAS PRINT COST COMPARE]

The Cost Comparison Report option produces a report of all CPT-4 procedure codes and their associated costs used within a selected date range. The cost linked to a CPT code is based upon approximate private sector cost. Cost is entered by local A&SP supervisors using the Enter Cost Information for Procedures option on the Set Up/Maintenance menu.

The following example is for demonstration purposes only and is not meant to reflect actual costs.

### Example

Procedure Cost Comparison for Date Range 08/21/99 to 11/29/99 For Division: CIOFO HINES DEV				
QUAN	CODE	DESCRIPTION	COST	TOTAL
-----				
STOP CODE: Speech Pathology				
1	31505	DIAGNOSTIC LARYNGOSCOPY	\$ 60.00	\$ 60.00
1	31575	DIAGNOSTIC LARYNGOSCOPY	\$ 60.00	\$ 60.00
2	92506	SPEECH & HEARING EVALUATION	\$ 60.00	\$ 120.00
7	92508	SPEECH/HEARING THERAPY	\$ 60.00	\$ 420.00
5	92511	NASOPHARYNGOSCOPY	\$100.00	\$ 500.00
3	92512	NASAL FUNCTION STUDIES	\$ 60.00	\$ 180.00
Speech Pathology Total:				\$1340.00
...				

## Tailor-Made A&SP Reports

[ACKQAS ADHOC] \*\*Locked: ACKQ ADHOC\*\*

The Tailor-Made A&SP Reports option allows you to design reports using the VA FileMan sort and print functionality. Reports can be generated from the A&SP Clinic Visit file (#509850.6) or the A&SP Patient file (#509850.2). You must be familiar with VA FileMan's Print and Sort functions as well as the structure of the file from which the data is printed.

Access to this option is controlled by the ACKQ ADHOC security key. Allocation of this key is at the discretion of the IRM chief. The option may not be available at all sites. If available, this option can provide various statistical reports from the QUASAR package. However, its indiscriminate use could have a negative impact on system performance. Complicated sorts or

reports that could be expected to impact system performance should be queued to run during off-hours.

Refer to the chapter, [Creating Tailor-Made Reports](#), for additional information. This section contains tips and examples on how to generate your own tailor-made reports.

**Note:** Check all sort and print routines created in the previous version for field name changes.

### ***PCE Exception Report***

[ACKQAS PCE EXCEPTION REPORT]

This report lists all A&SP Clinic Visits from the date range selected for the Division that have not been successfully updated in PCE. See [Required Data](#), for those fields that pass data to PCE.

#### **Reasons for Exceptions**

A Visit will be included on the report if it falls into one of the following categories:

1. The last time QUASAR attempted to send the Visit to PCE, the Visit was rejected. In this case, the report will include the error messages returned by the PCE Interface.

#### **Example**

Audiology & Speech Pathology PCE Exception Report For Division: CIOFO HINES DEV	
-----	
Clinic: SPEECH PATHOLOGY	
Visit Date: MAY 01, 1999 Appnt. Time: 5:00 AM PRIMARY PROVIDER – QUASARPROVIDER,TWO <b>The Provider does not have an ACTIVE person class!</b>	Patient: QUASARPATIENT,SIX SSN: 000-00-0006
Visit Date: AUG 30, 1999 Appnt. Time: 8:00 PM PCE VISIT - <b>Unable to Delete PCE Visit</b>	Patient: QUASARPATIENT,SEVEN SSN: 000-00-0007
Visit Date: SEP 30, 1999 Appnt. Time: 12:00 AM ENC D/T - SEP 30, 1999 <b>You are missing the TIME of the visit in FileManager internal format. Unless this is an HISTORICAL encounter, you must have the time.</b>	Patient: QUASARPATIENT,EIGHT SSN: 000-00-0008

- The Visit was edited in QUASAR but the new Visit data was not sent to PCE because the PCE Interface was switched off. In this case the report will show the date/time of the last QUASAR update versus the date/time of the last time the Visit was sent to PCE.

**Example**

Audiology & Speech Pathology PCE Exception Report For Division: CIOFO HINES DEV	
Visit Date: SEP 22, 1999	Patient: QUASARPATIENT,NINE
Appnt. Time: 2:00 PM	SSN: 000-00-0009
Last Edit in <b>QSR: SEP 22, 1999@16:35:22</b>	PCE time is before QSR time
Last Sent to <b>PCE: SEP 22, 1999@14:00:20</b>	
Visit Date: SEP 23, 1999	Patient:
Appnt. Time: 12:00 AM	SSN:
Last Edit in <b>QSR: SEP 23, 1999@10:46:49</b>	No PCE time
Last Sent to <b>PCE:</b>	

To remove a Visit from the Exception report, the PCE Interface must be activated for the Site, and for the Division in which the Visit took place, and then correct the error.

- Errors may include data missing in non QUASAR files such as the New Person file #200 or the USR Class Membership file # 8930.3. In that situation, you may need to contact IRM for assistance. Once corrected, you must edit the visit again using the option Edit an Existing Visit to send the corrected data to PCE.
- If the errors are in QUASAR:
  - In files other than the A&SP Clinic Visit file, make the corrections and then use the option Edit an Existing Visit to send the corrected data to PCE.
  - In the A&SP Clinic Visit file, use the option Edit an Existing Visit to edit the data and send the corrected information to PCE.
- If you delete a visit and it still exists in PCE ("Unable to Delete PCE Visit"), use PCE to delete the visit.

Once the Visit data is the same in both systems (QUASAR and PCE), the visit is removed from the PCE Exception Report.

**Warning Message:<sup>1</sup>**

You will be prompted to enter a Beginning Date and Ending Date for the PCE Exception Report date range. When entering a Beginning Date prior to March 17, 2000, which was the date that Version 3.0 of QUASAR was installed, a WARNING message will display.

---

<sup>1</sup> New Warning Message included in Patch ACKQ\*3.0\*1.

## Example

QUASAR - PCE Exception Report

This option produces a report listing all the A&SP Clinic Visits that have been reported as an exception by PCE.

Select DIVISION: ALL

Beginning Date: T-2000 (MAY 27, 1995)  
Ending Date: T

**Warning - You are running a report using a start date that falls either on or before the installation of Version 3.0 of Quasar.**

**Quasar Version 3.0 was installed on - MAR 17, 2000**

**Note that all PCE related functionality was developed within Quasar version 3.0. It is recommended that this report be run using start dates that fall after the installation date.**

Do you want to Continue ? NO//

## Workload Report

### [SDCLINIC WORKLOAD]

The Workload Report is not a QUASAR option. It is on the A&SP Reports menu with permission from the Scheduling package. This option displays daily patient appointment transactions by division for a selected date range. It allows you to determine the relative activity within a clinic during specified periods and allows you to compare activity for selected clinics for the previous year. You may want to print the report only for Audiology (203), Speech Pathology (204), and/or Telephone/Rehab and Support (216) Stop Code.

**Caution:** The default Stop Code for this report is ALL. This means that all Stop Codes will be reported. Be careful to enter only Stop Code/DSS identifier 203, 204, or 216. See example below:

Select division: ALL// HINES ISC 578

Select another division:

\*\*\*\* Date Range Selection \*\*\*\*

Beginning DATE : **9/1/99** (SEP 01, 1999)

Ending DATE : **9/30/99** (SEP 30, 1999)

Will now check if outpatient encounter dates have been updated...

.....

Note: To obtain accurate statistics, this workload report should be run again after the outpatient encounter status update process has been completed for these dates.

Totals by (C)LINIC or (S)TOP CODE?: C//STOP CODE

Enter Stop Code: ALL//**203**

AUDIOLOGY 203

Enter Stop Code: **204**

SPEECH PATHOLOGY 204

Enter Stop Code: **216**

TELEPHONE/REHAB AND SUPPORT 216

Enter Stop Code: **<RET>**

Do you want to include add/edits? No// **<RET>** (No)

Brief or Expanded Report? E// **<RET>** EXPANDED

(D)ETAIL BY DAY or (S)UMMARY BY MONTH?: D// **<RET>** DETAIL BY DAY

Do you want to see patient names? No// **<RET>** (No)

Do you want to compare this data to the same period in the previous year? No//

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# Generating Management Reports

## ***Management Reports A&SP***

### [ACKQAS MANAGEMENT REPORTS]

The Management Reports A&SP menu allows you to generate the Audiology and Speech Pathology CDR, and to compile and print the A&SP Capitation report. This data is stored in the A&SP Workload file (#509850.7).

- Generate A&SP Service CDR [ACKQAS CDR]
- Print A&SP Service CDR [ACKQAS CDR PRINT]
- Compile A&SP Capitation Data [ACKQAS WKLD GEN MAN]
- Print A&SP Capitation Report [ACKQAS WKLD VERIFY]

### **Generate A&SP Service CDR**

#### [ACKQAS CDR]

The Generate A&SP Service CDR option generates and prints the RCS 10-0141 report for Audiology and Speech Pathology by Division.

Once each month you should run and save a CDR report. It is saved in the A&SP Workload file (#509850.7). If you choose to save the CDR, it must be run for a single entire month. If you choose not to save the report, you can run the CDR for any date range.

You must enter the month for which the report is to be generated. The total number of clinic visit hours and instructional support (.12) hours for the month is displayed. You are prompted for the total number of paid hours.

You can enter a flat number of hours to be distributed among all administrative support (.13), continuing education (.14), and research (.21 and .22) accounts or you can enter hours for each account individually. You are then asked for pass through account hours. When entering hours for these accounts, keep in mind the number of clinic visit hours. Do not let the number of hours remaining go below the total number of clinic visit hours.

The A&SP CDR is an 80-column report which displays only the CDR accounts with activity during the date range.

### **Print A&SP Service CDR**

#### [ACKQAS CDR PRINT]

The Print A&SP Service CDR option prints the RCS 10-014 report for Audiology and Speech Pathology. Use this option to reprint the CDR report that you created using the Generate A&SP Service CDR option. If your CDR is reported by Division, you must select the Division(s) to be

printed. Then enter the month that you wish to print. The report will print the CDR for the month and Divisions that have been generated.

### **Compile A&SP Capitation Data**

[ACKQAS WKLD GEN MAN]

The Compile A&SP Capitation Data option is used to generate capitation data by Division for a selected month. If data has previously been compiled for the month selected, you are asked if you wish to continue. If you do so, the previously compiled data is deleted and the information is recalculated. The compilation takes place in the background, and you are notified by an e-mail message when the task is finished. You can use the Print A&SP Capitation Report to review the data.

### **Print A&SP Capitation Report**

[ACKQAS WKLD VERIFY]

When the Compile A&SP Capitation Data option has generated information for selected Division(s) and a selected month, you are notified by an e-mail message. You can then use the Print A&SP Capitation Report to review the data. This option produces a three-part report by Division that includes demographic, diagnostic, procedure data. This is followed by a summary (not separated by Division) that includes demographic, diagnostic and procedure data.

# Adequating a C&P Exam

## ***C&P Exam Adequation***

[ACKQAS CP ADEQ]

This option allows you to adequate a C&P exam. Only exams that are complete (i.e., having a status of AWAITING ADEQUATION) and signed off on can be adequated.

When an audiologist provides his or her electronic signature to a C&P exam, the chief adequator sees a list of exams waiting to be adequated. He or she can review, print, or edit the report using the Edit an Existing Visit option. Finally, he or she can provide an electronic signature using the C&P Exam Adequation option to release the report to the AMIE package. Entering the electronic signature to adequate an exam causes all exam results to be transferred to the AMIE C&P package and the exam is marked CLOSED. The results are made available to the regional office. Non-supervisory clinicians can adequate their own C&P exams. A clinician designated as a supervisor in the A&SP Staff file (#509850.3) can adequate other clinicians' C&P exams.

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## Deleting a Clinic Visit

### *Delete an A&SP Clinic Visit*

[ACKQAS DELETE VISIT]

This option allows you to delete an A&SP Clinic Visit that has been entered in error. If the selected visit was sent to PCE, then this function will also attempt to delete the visit from PCE. If the PCE deletion fails, you will see a warning message displayed.

Warning - This QUASAR Visit is linked to a PCE Visit but the PCE Interface is not active. If you delete this visit, it will be deleted from QUASAR but the corresponding PCE VISIT will remain. To delete the visit from PCE you must use the PCE package options.

**or**

ERROR: The PCE Visit linked to this QUASAR Visit could not be deleted.

If you choose to continue, the QUASAR visit will be deleted but the PCE Visit will remain. Corrective action to the PCE Visit will be required using the PCE system.

You may then choose to continue or abort the deletion. If you continue, the Quasar Visit will be deleted but you will have to use the PCE package to delete the same visit from PCE.

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# Creating Tailor-Made Reports

## Introduction

This appendix provides instruction on sorting data and printing reports using the option Tailor-Made A&SP Reports. Any of the QUASAR data fields and some of the data fields contained in the patient file # 2 can be sorted and printed. The Tailor-Made A&SP Reports option is a restricted version of VA FileMan. It permits sorting, basic arithmetic operations, Boolean logic, saving of sort logic, and customized formatting of reports. Users are encouraged to contact their IRM Service to obtain training and training materials on VA FileMan report generation.

Access to the Tailor-Made A&SP Reports option is controlled by the ACKQ ADHOC security key. Allocation of this key is at the discretion of the IRM Chief. Therefore, Tailor-Made A&SP Reports may not be available at all sites.

**Important:** Indiscriminate use of VA FileMan may have a negative impact on system performance. Complicated sorting routines or reports should be queued to run during off-hours.

VA FileMan functions like an index card filing system. Any data entered in QUASAR data fields can be accessed, sorted, and printed as can data in any "pointed to" file (e.g., Patient file #2).

## Data Dictionaries

### A&SP Patient file #509850.2

The A&SP Patient file contains identifying, demographic, and other clinical information for all patients seen in the Audiology and Speech Pathology clinics.

Field #	Label	Description
.01	Name	The NAME field contains the name of the patient seen in the Audiology and Speech Pathology clinics.
.03	ASP File Number	The ASP FILE NUMBER field contains an existing LOCAL file number associated with this Audiology and Speech Pathology patient.
1	Initial Visit Date	The INITIAL VISIT DATE field contains the date (if known) of this patient's first visit to the Audiology and/or Speech Pathology clinic at this site. This field can be left blank.
2	Diagnostic Condition	The DIAGNOSTIC CONDITION field contains the ICD-9CM diagnostic condition code for the A&SP patient. Disease codes listed in this field appear in the A&SP Problem List.
	.01 Diagnostic Condition	The DIAGNOSTIC CONDITION field contains the ICD-9CM diagnostic condition code for the A&SP patient. Disease

Field #	Label	Description
		codes listed in this field appear in the A&SP Problem List.
	1 Date Condition Entered	The DATE CONDITION ENTERED field contains the date the DIAGNOSTIC CONDITION was entered for the A&SP patient. This field appears in the A&SP Problem List.

### A&SP Clinic Visit file #509850.6

The A&SP Clinic Visit file contains all data specific to each patient encounter. This includes the patient, the providers and students involved, the diagnostic and procedure codes, the date of the visit, procedure time, and the CDR cost account.

Field #	Label	Description
.01	Name	The DATE field contains the encounter date or date and time.
.07	Time Spent (minutes)	The TIME SPENT field is used to record the TOTAL number of minutes that were used during this clinic visit.
.08	Linked C&P Exam	For C&P exams, the LINKED C&P EXAM field is automatically filled in by the QUASAR package. It provides a means of linking this QUASAR visit with a specific AMIE C&P request. If the visit is not a C&P exam this field is left blank.
.09	C and P Status	The C AND P STATUS field indicates the status of the C&P exam (if any). 0 stands for NOT A C&P EXAM, 1 stands for NOT SIGNED OFF, 2 stands for AWAITING ADEQUATION, and 3 stands for COMPLETE.
.25	Secondary Provider	This is a multiple. If more than one provider was involved in this exam, the name(s) of the SECONDARY PROVIDER should be entered here. The SECONDARY PROVIDER field can be left blank.
.27	*Lead Role	This field is starred for deletion.
1	Patient Name	The PATIENT NAME field contains the name of the patient seen during this clinic visit. This is a pointer to the Patient file #2.
1.5	Age on Appointment	This is the patient's age.
2	Patient Eligibility Code	This is the Primary Eligibility of the patient.



<b>Field #</b>	<b>Label</b>	<b>Description</b>
2.5	C and P	The C AND P field contains 0 or NO if this is not a C&P exam. The field contains 1 or YES if this is a C&P exam.
2.6	Clinic Location	The CLINIC LOCATION field is a pointer to the HOSPITAL LOCATION file (#44).
2.7	Secondary Provider	This is the provider(s) not considered the primary provider.
3	Diagnostic Code  .01 Diagnostic Code  .12 Primary Diagnosis  .15 *Modifier	The DIAGNOSTIC CODE field is a pointer to the A&SP DIAGNOSTIC CONDITION file (#509850.1).  YES or NO  This field starred for deletion.
4	Clinic Stop Code	The CLINIC STOP CODE field contains A for Audiology, S for Speech Pathology, AT for an Audiology Telephone visit and ST for Speech Telephone visit.
4.01	Tone R500	The TONE R500 field indicates the patient's pure tone threshold at 500Hz.
4.02	Tone R1000	The TONE R1000 field indicates the pure tone threshold (Right) at 1000Hz for this patient.
4.03	Tone R2000	The TONE R2000 field indicates the pure tone threshold (Right) at 2000Hz for this patient.
4.04	Tone R3000	The TONE R3000 field indicates the pure tone threshold (Right) at 3000Hz for this patient.
4.05	Tone R4000	The TONE R4000 field indicates the pure tone threshold (Right) at 4000Hz for this patient.
4.06	Tone R Average	The TONE R AVERAGE field is the average pure tone threshold for this patient's right ear.
4.07	Tone L500	The TONE L500 field indicates the patient's pure tone threshold at 500Hz.
4.08	Tone L1000	The TONE L1000 field indicates the pure tone threshold (Left) at 1000Hz for this patient.
4.09	Tone L2000	The TONE L2000 field indicates the pure tone threshold (Left) at 2000Hz for this patient.
4.1	Tone L3000	The TONE L3000 field indicates the pure tone threshold (Left) at 3000Hz for this patient.
4.11	Tone L4000	The TONE L4000 field indicates the pure tone threshold

<b>Field #</b>	<b>Label</b>	<b>Description</b>
		(Left) at 4000Hz for this patient.
4.12	Tone L Average	The TONE L AVERAGE field is the average pure tone threshold for this patient's left ear.
4.13	CNC R	The CNC R field contains the patient's (Right) word recognition score for Maryland CNC material. This score is a percentage between 0 and 100.
4.14	CNC L	The CNC L field contains the patient's (Left) word recognition score for Maryland CNC material. This score is a percentage between 0 and 100.
4.15	W22 R	The W22 R field contains the patient's (Right) word recognition score for CID W-22 material. This score is a percentage between 0 and 100.
4.16	W22 L	The W22 L field contains the patient's (Left) word recognition score for CID W-22 material. This score is a percentage between 0 and 100.
4.17	Signature	For C&P exams, the SIGNATURE field contains the electronic signature of the audiologist who completed the exam. When the exam is signed, it is released for adequation by the supervisor.
4.18	Date Signed	For C&P exams, the DATE SIGNED field contains the date that the electronic signature was entered, thereby releasing the C&P exam for adequation.
4.19	Adequated By	The ADEQUATED BY field contains the electronic signature of the audiologist who adequated the clinic visit.
4.2	Date Adequated	The DATE ADEQUATED field contains the date that the electronic signature was entered for the adequation of this C&P exam.
4.23	Date of Audiometric Testing	When audiometric data are pulled from a past visit (i.e., testing is not done on the current date), the DATE OF AUDIOMETRIC TESTING field is filled with the date when actual testing was done.
4.24	Completer Title	For C&P exams, the COMPLETER TITLE field contains the title of the audiologist who completed the exam.
4.25	Adequator Title	For C&P exams, the ADEQUATOR TITLE field contains the title of the audiologist who adequated the clinic visit.
5	CDR Account	The CDR ACCOUNT field contains the CDR account number to be credited with this clinic visit.
6	Primary Provider	The PRIMARY PROVIDER field contains the name of the

<b>Field #</b>	<b>Label</b>	<b>Description</b>
		primary A&SP Provider who participated in this exam.
6.5	PCE Error  .01 PCE Error .02 PCE Field Name .03 PCE Field Internal Value .04 PCE Field External Value 1 PCE Error Message	This multiple contains any error messages returned by PCE when this visit was transmitted via the Interface to PCE.
7	Student	If a student or trainee participated in this exam, the name of the STUDENT should be entered here.
8	*Other Provider	This field is starred for deletion.
8	*Disposition	This field is starred for deletion.
10	Procedure Code  .01 Procedure .02 *Modifier .03 Volume .04 CPT Modifier .05 Procedure Provider	The PROCEDURE CODE field contains CPT-4 procedure codes and modifiers, if any, for this exam.  Starred for deletion.
20	Service Connected	This prompt allows the user to indicate if the visit is Service Connected or not.
25	Agent Orange	Y or N indicates whether the visit is related to Agent Orange Exposure.
30	Radiation	Y or N indicates whether the visit is related to Radiation Exposure.
35	Environmental Contaminants	Y or N indicates whether the visit is related to Environmental Contaminants Exposure.
55	Appointment Time	The time the visit took place.
60	Division	This is the division at which the visit took place.
80	Visit Eligibility	Only Eligibilities associated with the visit are valid for entry.

Field #	Label	Description
100	Review of Medical Records	Word Processing field.
101	Medical History	Word Processing field.
102	Physical Examination	Word Processing field.
103	Diagnostic and Clinical Tests	Word Processing field.
104	Diagnosis	Word Processing field.
125	PCE Visit IEN	This is the IEN of the PCE visit passed back by the send to PCE processing.
135	Last Sent to PCE	The Date/Time that the system last attempted to send this data to PCE.
140	Last Edited in QUASAR	This date is the date when the visit record was last edited in Quasar.
900	Exception Date	Set to NOW whenever the system determines that the Visit has become a PCE Exception.

## ***VA FileMan Sort and Print Options***

### ***Print Options***

Formatting Codes		Examples	Explanations
C	Column Assignment	FIRST PRINT FIELD: NAME;C10	Print NAME starting in Column 10
S	Skip Lines	FIRST PRINT FIELD: NAME;S1	Skip 1 line before printing the next NAME
L	Left Justify	FIRST PRINT FIELD: PROVIDER;L8	Print only the first 8 characters of the PROVIDER name.
R	Right Justify	FIRST PRINT FIELD: DATE;R30	Right justify the DATE 30 columns from the end of the last value plus 2 column spacers
W	Word Wrap	FIRST PRINT FIELD: MEDICAL HISTORY;W20	Wrap after 20 columns of text but will not split words
D	Decimal Points	FIRST PRINT FIELD: COST;D2	Use two decimal places

<b>Formatting Codes</b>		<b>Examples</b>	<b>Explanations</b>
N	No Repeat	FIRST PRINT FIELD: NAME;N	Will not repeat consecutive occurrence of the same name
Y	Start at Row	FIRST PRINT FIELD: NAME;Y10	Start printing 10 rows from top of page
		FIRST PRINT FIELD: NAME;Y-10	Start printing 10 rows from bottom of page
@	Suppress Heading	HEADING: A&SP... Replace @	Suppress the entire Heading (from the dash line up)
X	Suppress Spacing	FIRST PRINT FIELD: .01 NAME  THEN PRINT FIELD: SSN;X	Suppress spacing between the name and the SSN
T	Print Title	FIRST PRINT FIELD: TIME SPENT;T	Print title (Time Spent in Minutes) as column header instead of label
"	Print Different Header	FIRST PRINT FIELD: TIME SPENT;"Time"	Print Time as a column header rather than TIME SPENT
_	Concatenate (Join)	FIRST PRINT FIELD: ADEQUATED BY_", "_ADEQUATOR TITLE	Joins field values with literals or other fields, i.e.... JOHN DOE, CHIEF
:	Forward Pointing	FIRST PRINT FIELD: NAME:  THEN PRINT PATIENT FIELD: SSN	Follows the NAME pointer field from the A&SP Patient File to the Patient File to get the SSN
<b>Arithmetic Operators</b>		<b>Examples</b>	<b>Explanations</b>
!	Counts Any Field	FIRST PRINT FIELD: !NAME	Counts the entries that have values in the NAME field
&	Totals Numerics	FIRST PRINT FIELD: &TIME SPENT/60;D1	Totals numeric fields; totals TIME SPENT and divides by 60 with 1 decimal place
+	Totals, Count & Mean	FIRST PRINT FIELD: +TIME SPENT	Totals and Counts fields and provides a mean value
#	Totals, Count, Mean, Minimum, Maximum, & Standard Division	FIRST PRINT FIELD: #TIME SPENT	Totals and Counts fields and provides a minimum value and a maximum value found with the average value and standard deviation
<b>Binary Operators</b>		<b>Examples</b>	<b>Explanations</b>
+	Addition	FIRST PRINT FIELD:	Add 10 hours to the total TIME SPENT

Formatting Codes		Examples	Explanations
		&TIME SPENT+600	
-	Subtract	FIRST PRINT FIELD: &TIME SPENT-600	Subtract 10 hours from total TIME SPENT
*	Multiply	FIRST PRINT FIELD: &TIME SPENT*.25	Multiply total TIME SPENT by .25
/	Divide	FIRST PRINT FIELD: &TIME SPENT/60;D1	Divide total TIME SPENT by 60 to get total hours to 1 decimal place
\	Integer Division	FIRST PRINT FIELD: &TIME SPENT\60	Divide the TIME SPENT by 60 leaving off all remainders

### **Sort Options**

Formatting Codes		Examples	Explanations
C	Column Assignment	SORT BY: DATE;C30	Print DATE sub-header in column 30
S	Skip Lines	SORT BY: DATE;S2	Skip 2 lines before printing the next DATE sub-header
L	Left Justify	SORT BY: PRIMARY PROVIDER;L10	Print only the first 10 characters of the PRIMARY PROVIDER as the sub-header
"	Print Your Header	SORT BY: PRIMARY PROVIDER;"Provider: "	Prints Provider: as a sub-header rather than PRIMARY PROVIDER
@	Suppress Sub-Header	SORT BY: @DATE	Sorts by the selected Field (DATE) but suppresses the sub-header

<b>Sort Functions</b>		<b>Examples</b>	<b>Explanations</b>
!	Ranking Numbers	SORT BY: !DATE	Items printed under DATE sub-header will have ranking numbers
+	Sub Totals	SORT BY: +NAME	All print fields with !,&,+,or # will be sub-totaled at each new NAME
#	Form Feed	SORT BY: #PRIMARY PROVIDER	A form feed will be generated for each new PRIMARY PROVIDER
-	Reverse Order	SORT BY: -DATE	Will reverse order of print from lowest-highest to highest-lowest order
'	Select Entries	SORT BY: 'DATE	Select items only, rather than selects and sorts
<b>Special Features</b>		<b>Examples</b>	<b>Explanations</b>
@	at START WITH prompt	SORT BY: DATE SIGNED START WITH DATE SIGNED: @	Prints all entries with a value in the DATE SIGNED field first followed by null values for that field
@	at the START WITH and GO TO prompt	SORT BY: DATE SIGNED START WITH DATE SIGNED: @ GO TO DATE SIGNED: @	Prints only entries with null values in the DATE SIGNED field

<b>Templates</b>		<b>Examples</b>	<b>Explanations</b>
]	Forces FileMan to offer a template prompt	SORT BY: ] FIRST PRINT FIELD: ]	Forces FileMan to offer you a template
[	Used to call a template	SORT BY: [A&SP ... FIRST PRINT FIELD: [A&SP ...	Calls a previously created template; i.e. sort or print template named A&SP ...
[?	Will show all templates available to the user	SORT BY: [? FIRST PRINT FIELD: [?	Shows all sort or print templates
^	Inserts	THEN PRINT FIELD: PATIENT NAME//^SSN THEN PRINT FIELD: PATIENT NAME//	Inserts a field before another field
@	Deletes	THEN PRINT FIELD: SSN//@	Deletes a field
<b>Boolean Logic</b>		<b>Examples</b>	<b>Explanations</b>
=	Equal	SORT BY: PROCEDURE CODE=92507	Finds all instances of PROCEDURE CODE equal to 92507
>	Greater Than	SORT BY: TIME SPENT>30	Finds all instances where TIME SPENT was greater than 30 minutes
<	Less Than	SORT BY: TIME SPENT<30	Finds all instances where TIME SPENT was less than 30 minutes
[	Contains	SORT BY: PATIENT NAME["AR"	Finds all patients with AR in their names
]	Follows	SORT BY: PATIENT NAME]"ST"	Finds all patients whose names begin with ST to the end of the alphabet
!	OR	SORT BY: TIME SPENT<10!(TIME SPENT>60)	Finds all instances where TIME SPENT was less than 10 minutes OR greater than 60 minutes
&	AND	SORT BY: PRIMARY PROVIDER="ACKQ,PROVIDER1"&(TIME SPENT>120)	Finds all instances where PRIMARY PROVIDER ACKQ, PROVIDER1 spent greater than 2 hours on a visit.
'	NEGATE	SORT BY: 'TIME SPENT>30	Finds all instances where TIME SPENT is NOT greater than 30



## ***Writing Your Own Tailor-Made Reports***

Tailor-Made A&SP Reports is an option on the A&SP Reports menu in the Audiology & Speech Visit Tracking System menu. The option prompts you to sort from the A&SP Patient file (#905850.2) or the A&SP Clinic Visit file (#905850.6). VA FileMan defaults are always followed by the // symbol. The default file is the A&SP CLINIC VISIT file. See [Data Dictionaries](#) for a listing of the fields in the two files.

You can enter the field name or number in sort or print logic. When performing some arithmetic operations, you must specify the field name. For example, if you want to convert TIME SPENT (minutes) into hours, you would write TIME SPENT/60. Dividing the field number (.07) by 60 will not work.

Tailor-Made A&SP Reports allows you to store your sort logic in templates. VA FileMan prompts you for a template name when you enter new sorting logic. The saved template can be called up by entering the template name enclosed in brackets (e.g., [PATIENT LIST]) at the first "SORT BY:" prompt. The list of stored templates can be called up by entering [?. Print logic cannot be stored by the Tailor-Made A&SP Reports option. Print logic must be entered each time the report is run. Neither the sort logic nor the print logic can be edited. If you make a mistake while entering sort logic, exit by pressing the ^ key (shift-6). If you want to change the sort logic after you have saved a template, a new template can be saved with the same or a different template name. If you save a template with a template name that already exists, VA FileMan will warn you that the template exists and will ask if you wish to overwrite the existing template.

VA FileMan also allows you to specify ranges for sorted data. Ranges permit flexibility and repeated use of the same sort logic when using templates. A FileMan will prompt you for those data fields for which you want to enter ranges. For example, if you sort by DATE, you will be asked:

```
SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO//
```

In most cases, you should enter a range for each sort value during the initial run of the sorting routine. This will force VA FileMan to ask if you want the user to "be asked a 'From – To' range" when using the template. If you want a range for the data, answer YES to the prompt; otherwise answer NO.

## ***Examples of Tailor-Made A&SP Reports***

This section contains some examples of tailor-made reports. In the following examples, text to be entered is highlighted in boldface type. Explanatory information is italicized and enclosed in brackets [ ]. Data fields followed by slant bars // are defaults. The symbol <RET> means press the return or enter key. If you specify visit date by its field name, DATE, you will be shown four date fields from which to select. DATE is the clinic visit date. The visit date is uniquely specified by its field number, .01.

## Notes:

1. There are several fields for capturing provider (Primary Provider, Secondary Provider, Student, and Procedure Provider). If you want the Primary Provider for the visit, use the Primary Provider field. If you want to capture discrete data on providers for each procedure done during the visit, use the Procedure Provider field found under the Procedure multiple. Examples of the use of providers from both fields follow.
2. Data can be obtained by Division if your site parameters are set up by Division. You may want to sort by Division at the beginning of each report to get only data from your Division.
3. Some fields have been changed or added since the last release. If you created any sort or print templates, you should review those for any necessary changes.

## Report #1: Student Cost Distribution Report

**Objective:** To print out procedure time by CDR account for each student. This program returns the procedure time by date and student for each CDR account and totals the procedure time. You must calculate subtotals of CDR accounts (e.g., 1100-series, 1200-series) for entry into the QUASAR A&SP Service CDR.

```
Select A&SP Reports Option: Tailor-Made A&SP Reports
Print From Which File: (P/V): V// <RET>isit
SORT BY: DATE// +CDR ACCOUNT
START WITH CDR ACCOUNT: FIRST// <RET>
  WITHIN CDR ACCOUNT, SORT BY: STUDENT
START WITH STUDENT: FIRST// <RET>
  WITHIN STUDENT, SORT BY: DATE
    1 DATE
    2 DATE ADEQUATED
    3 DATE OF AUDIOMETRIC TESTING
    4 DATE SIGNED
CHOOSE 1-4: 1 DATE
  START WITH DATE: FIRST// [Enter beginning date of range]
  GO TO DATE: LAST// [Enter ending date of range]
  WITHIN DATE, SORT BY: <RET>
STORE IN 'SORT' TEMPLATE: [Enter a name for your template]
Are you adding 'TEMPLATE NAME' as
  a new SORT TEMPLATE? No// <RET> (Yes)
DESCRIPTION:
  1> You may enter a description of the template here.
```

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO// YES

FIRST PRINT FIELD: **CDR ACCOUNT;C1;L10;N**

THEN PRINT FIELD: **STUDENT;C13;L15;N**

THEN PRINT FIELD: **.01;C31;L12;N DATE**

THEN PRINT FIELD: **+(TIME SPENT/60);C46;L6;"TIME (HRS)"**

THEN PRINT FIELD: **<RET>**

DEVICE: [Select a print device]

**Notes:**

1. If you want to display procedure time in minutes, the last print command should be entered as: **+.07;C46;L6;"TIME (MIN)"**.
2. A&SP Service CDR requires that you add all student hours for each of the 1100-series, 1200-series, 1300-series, 1400-series, 1600-series, and 2800-series accounts. The cost account totals are the training (.12) data required by the QUASAR A&SP Service CDR .
3. The Student CDR assumes 100% supervision.

**Example**

A&SP CLINIC VISIT STATISTICS		NOV 13,1995	13:27	PAGE 1
CDR			TIME	
ACCOUNT	STUDENT	DATE	(HRS)	
1110.00	QUASARPROVIDER,THREE	OCT 6,1995	.25	
		OCT 14,1995	.75	
		OCT 21,1995	1.5	
		OCT 30,1995	.5	
	QUASARPROVIDER,FOUR	OCT 13,1995	1	
		OCT 14,1995	.5	
		OCT 17,1995	.5	
		OCT 23,1995	1	
	QUASARPROVIDER,FIVE	OCT 26,1995	.5	
		OCT 6,1995	2	
		OCT 13,1995	.5	
		OCT 14,1995	.5	
		OCT 17,1995	.75	
		OCT 18,1995	.5	
			.75	
		OCT 23,1995	1.5	
		-----		
SUBTOTAL			13	
SUBCOUNT			16	
SUBMEAN			0.81	

1111.00	QUASARPROVIDER,THREE	OCT 19,1995	.75
			-----
SUBTOTAL			.75
SUBCOUNT			1
SUBMEAN			0.75
1211.00		OCT 15,1995	1
	QUASARPROVIDER,FOUR	OCT 5,1995	.5
			.5
		OCT 7,1995	2
		OCT 9,1995	.75
		OCT 10,1995	2
			75
		OCT 12,1995	.75
			-----
SUBTOTAL			8.25
SUBCOUNT			8
SUBMEAN			1.03
			-----
TOTAL			22
COUNT			25
MEAN			0.88

## Report #2: Patient Addresses

**Objective:** To print names and addresses of patients for database or mailing purposes.

Select A&SP Reports Option: **Tailor-Made A&SP Reports**

Print From Which File: (P/V): V// <RET>isit

**SORT BY: DATE// @DATE**

- 1 DATE
- 2 DATE ADEQUATED
- 3 DATE OF AUDIOMETRIC TESTING
- 4 DATE SIGNED

CHOOSE 1-4: **1 DATE**

START WITH DATE: FIRST// [Instead of accepting the default, specify a date range if you always would like to be asked for a range]

GO TO DATE: LAST// [Enter an ending date]

WITHIN DATE, SORT BY: **@CLINIC STOP CODE**

START WITH CLINIC STOP CODE: FIRST// ??

The CLINIC STOP CODE field contains A for Audiology, S for Speech Pathology, AT for an Audiology Telephone visit and ST for Speech Telephone visit.

Choose from:

- A AUDIOLOGY
- S SPEECH
- AT TELEPHONE AUDIOLOGY
- ST TELEPHONE SPEECH

START WITH CLINIC STOP CODE: FIRST// A AUDIOLOGY  
GO TO CLINIC STOP CODE: LAST// A AUDIOLOGY  
WITHIN CLINIC STOP CODE, SORT BY:  
STORE IN 'SORT' TEMPLATE: [Enter a name for your template]

DESCRIPTION:

1> Enter a description.

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO// <RET>YES

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'CLINIC STOP CODE'? NO//  
<RET>YES

FIRST PRINT FIELD: **PATIENT NAME:**

THEN PRINT A&SP PATIENT FIELD: **NAME:**

THEN PRINT PATIENT FIELD: **NAME;S1;"";C35**

THEN PRINT PATIENT FIELD: **STREET ADDRESS [LINE 1];C35;""**

THEN PRINT PATIENT FIELD: **CITY\_ " " \_STATE\_ " " \_ZIP CODE;C35;""**

THEN PRINT PATIENT FIELD: **<RET>**

THEN PRINT A&SP PATIENT FIELD: **<RET>**

THEN PRINT FIELD: **<RET>**

DEVICE: [Select Print Device]

**Note:** This routine makes use of forward pointing commands to extract patient data from the MAS Patient file (#2). Because the patient's name is identified, some patient data not entered into QUASAR may be accessed, sorted, and printed.

### Example

A&SP CLINIC VISIT LIST	NOV 13,1995 13:12	PAGE 1
-----		
	QUASARPATIENT,TEN	
	666 ANY DRIVE	
	ANYWHERE, ILLINOIS 60611	
	QUASARPATIENT1,ONE	
	10 ANY LANE	
	SOMEWHERE, ILLINOIS 60623	

### Report #3: Visit Report (Provider/Time Spent/Diagnostic Code)

**Objective:** To print a list of patient names, primary provider, procedure times, and ICD9-CM codes by visit date.

Select A&SP Reports Option: **Tailor-Made A&SP Reports**  
 Print From Which File: (P/V): V// <RET>isit  
 SORT BY: DATE// <RET>  
 START WITH DATE: FIRST// [Enter a beginning date]  
 GO TO DATE: LAST// [Enter an ending date]  
 WITHIN DATE, SORT BY: **PATIENT NAME**  
 START WITH PATIENT NAME: FIRST// <RET>  
 WITHIN PATIENT NAME, SORT BY: <RET>  
 FIRST PRINT FIELD: **PATIENT NAME;L20;S1**  
 THEN PRINT FIELD: **.01;C24;L15** DATE  
 THEN PRINT FIELD: **PRIMARY PROVIDER;C42;L20**  
 THEN PRINT FIELD: **TIME SPENT;C65;L3** (minutes)  
 THEN PRINT FIELD: **DIAGNOSTIC CODE** (multiple)  
 THEN PRINT DIAGNOSTIC CODE SUB-FIELD: **DIAGNOSTIC CODE;C71;L8**  
 THEN PRINT DIAGNOSTIC CODE SUB-FIELD: <RET>  
 THEN PRINT FIELD: <RET>  
 DEVICE: [Select Print Device]

#### Example

A&SP CLINIC VISIT LIST		NOV 22,1999 13:22	PAGE 1	
PATIENT NAME	DATE	PRIMARY PROVIDER	TIME SPENT (minutes)	DIAGNOSTIC CODE
QUASARPATIENT1,TWO	AUG 16,1999	QUASARPROVIDER,SIX	30	388.12
QUASARPATIENT1,THREE	AUG 16,1999	QUASARPROVIDER,SIX	25	388.1

### Report #4: Visit Report (Procedure Code/Cost)

**Objective:** To print a list of patient names, CPT-4 codes, and costs by clinic stop and date. Report also calculates the total cost, number of procedures, and the mean procedure cost.

Select A&SP Reports Option: **Tailor-Made A&SP Reports**

Print From Which File: (P/V): V// <RET>isit  
 SORT BY: DATE// <RET>  
 START WITH DATE: FIRST// [Enter a beginning date]  
 GO TO DATE: LAST// [Enter an ending date]  
 WITHIN DATE, SORT BY: **PROCEDURE CODE** (multiple)  
 PROCEDURE CODE SUB-FIELD: **PROCEDURE CODE:**  
 A&SP PROCEDURE CODE FIELD: **CLINIC STOP**  
 START WITH CLINIC STOP: FIRST// <RET>  
 WITHIN CLINIC STOP, SORT BY: **PATIENT NAME**  
 START WITH PATIENT NAME: FIRST// <RET>  
 WITHIN PATIENT NAME, SORT BY: <RET>  
 STORE IN 'SORT' TEMPLATE: [Enter a template name]  
 Are you adding 'TEMPLATE NAME' as  
 a new SORT TEMPLATE? No// Y (Yes)  
 DESCRIPTION:  
 1><RET>

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO// <RET>YES  
 FIRST PRINT FIELD: **PROCEDURE CODE** (multiple)  
 FIRST PRINT PROCEDURE CODE SUB-FIELD: **PROCEDURE CODE:**  
 THEN PRINT A&SP PROCEDURE CODE FIELD: **CLINIC STOP;N**  
 THEN PRINT A&SP PROCEDURE CODE FIELD: <RET>  
 THEN PRINT PROCEDURE CODE SUB-FIELD: <RET>  
 THEN PRINT FIELD: **PATIENT NAME;C20;L20**  
 THEN PRINT FIELD: **DATE;C43;L14**  
 1 DATE  
 2 DATE ADEQUATED  
 3 DATE OF AUDIOMETRIC TESTING  
 4 DATE SIGNED  
 CHOOSE 1-4: 1 DATE  
 THEN PRINT FIELD: **PROCEDURE CODE** (multiple)  
 THEN PRINT PROCEDURE CODE SUB-FIELD: **PROCEDURE CODE;C60;L7**  
 THEN PRINT PROCEDURE CODE SUB-FIELD: **PROCEDURE CODE:**  
 THEN PRINT A&SP PROCEDURE CODE FIELD: **+COST;C70**  
 THEN PRINT A&SP PROCEDURE CODE FIELD: <RET>  
 THEN PRINT PROCEDURE CODE SUB-FIELD: <RET>  
 THEN PRINT FIELD: <RET>  
 DEVICE: [Enter a device]

### Example

A&SP CLINIC VISIT STATISTICS		NOV 13,1995	15:15	PAGE 1	
CLINIC				PROCEDURE	
STOP	PATIENT NAME	DATE		CODE	COST
-----					
AUDIOLOGY	QUASARPATIENT1,FOUR	OCT 5,1995		92557	80.00
				92599	20.00
	QUASARPATIENT1,FIVE	OCT 6,1995		92557	80.00
				92567	30.00
				92568	30.00
SPEECH	QUASARPATIENT1,SIX	OCT 20,1995		92507	75.00
	QUASARPATIENT1,SEVEN	OCT 10,1995		74230	225.00
-----					
TOTAL					540.00
COUNT					7
MEAN					77.14

### Report #5: Visit Report (Procedure Time)

**Objective:** To print a list of procedure times by provider and date. Report also calculates total procedure time for all providers.

Select A&SP Reports Option: **Tailor-Made A&SP Reports**  
Print From Which File: (P/V): V// <RET>isit  
SORT BY: DATE// **PROCEDURE CODE** (multiple)  
PROCEDURE CODE SUB-FIELD: **PROCEDURE PROVIDER;S**  
START WITH PROCEDURE PROVIDER: FIRST// <RET>  
WITHIN PROCEDURE PROVIDER, SORT BY: **DATE**  
1 DATE  
2 DATE ADEQUATED  
3 DATE OF AUDIOMETRIC TESTING  
4 DATE SIGNED  
CHOOSE 1-4: **1 DATE**  
START WITH DATE: FIRST// [Enter a beginning date]  
GO TO DATE: LAST// [Enter an ending date]  
WITHIN DATE, SORT BY: <RET>  
STORE IN 'SORT' TEMPLATE: [Enter a template name]  
Are you adding 'TEMPLATE NAME' as a new SORT TEMPLATE? No// **Y** (Yes)  
DESCRIPTION:



No existing text  
Edit? NO// <RET>

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO// YES

FIRST PRINT FIELD: **PROCEDURE CODE** (multiple)

FIRST PRINT PROCEDURE CODE SUB-FIELD: **PROCEDURE PROVIDER;N**

THEN PRINT PROCEDURE CODE SUB-FIELD: <RET>

THEN PRINT FIELD: **DATE**

- 1 DATE
- 2 DATE ADEQUATED
- 3 DATE OF AUDIOMETRIC TESTING
- 4 DATE SIGNED

CHOOSE 1-4: **1** DATE

THEN PRINT FIELD: **&TIME SPENT;"TIME"** (minutes)

THEN PRINT FIELD: <RET>

DEVICE: [Enter a device]

**Example**

A&SP CLINIC VISIT STATISTICS	NOV 23,1999 10:18	PAGE 1
PROCEDURE PROVIDER	DATE	TIME
-----		
QUASARPROVIDER,SEVEN	NOV 10,1999	30
	NOV 10,1999	30
	NOV 10,1999	30
	NOV 15,1999	30
	NOV 18,1999	90
	NOV 22,1999	60
QUASARPROVIDER,EIGHT	NOV 19,1999	30
QUASARPROVIDER,NINE	NOV 10,1999	30
	NOV 10,1999	30
	NOV 22,1999	60
QUASARPROVIDER,TEN	NOV 18,1999	60
	NOV 18,1999	90
QUASARPROVIDER1,ONE	NOV 22,1999	60
		----
TOTAL		630

## Report #6: C&P Examinations

**Objective:** To provide a list of patients seen for C&P exams by date and primary provider.

Select A&SP Reports Option: **Tailor-Made A&SP Reports**

Print From Which File: (P/V): V// <RET>isit

**SORT BY: DATE// C AND P**

1 C AND P

2 C AND P STATUS

CHOOSE 1-2: 1 C AND P

START WITH C AND P: FIRST// <RET>

WITHIN C AND P, SORT BY: **DATE**

1 DATE

2 DATE ADEQUATED

3 DATE OF AUDIOMETRIC TESTING

4 DATE SIGNED

CHOOSE 1-4: 1 DATE

START WITH DATE: FIRST// [Enter a beginning date]

GO TO DATE: LAST// [Enter an ending date]

WITHIN DATE, SORT BY: **PATIENT NAME**

START WITH PATIENT NAME: FIRST// <RET>

WITHIN PATIENT NAME, SORT BY: **PRIMARY PROVIDER**

START WITH PRIMARY PROVIDER: FIRST// <RET>

WITHIN PRIMARY PROVIDER, SORT BY: <RET>

STORE IN 'SORT' TEMPLATE: [Enter a template name]

Are you adding 'TEMPLATE NAME' as a new SORT TEMPLATE? No// Y (Yes)

DESCRIPTION:

1><RET>

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO// <RET>YES

FIRST PRINT FIELD: **PRIMARY PROVIDER;L20;N**

THEN PRINT FIELD: **.01;C25 DATE**

THEN PRINT FIELD: **PATIENT NAME;C40;L25**

THEN PRINT FIELD: **!C AND P;C70;"C&P"**

THEN PRINT FIELD: <RET>

DEVICE: [Enter a device]

### Example

A&SP CLINIC VISIT STATISTICS	NOV 23,1999 12:20	PAGE 1	
PRIMARY PROVIDER	DATE	PATIENT NAME	C&P
-----			
QUASARPROVIDER,NINE	AUG 16,1999	QUASARPATIENT2,EIGHT	YES
	AUG 31,1999	QUASARPATIENT2,NINE	YES
	OCT 7,1999	QUASARPATIENT2,TEN	YES
QUASARPROVIDER1,TWO	OCT 12,1999	QUASARPATIENT2,EIGHT	YES
QUASARPROVIDER,NINE	OCT 22,1999	QUASARPATIENT3,ONE	YES
	NOV 18,1999	QUASARPATIENT3,TWO	YES
	NOV 18,1999	QUASARPATIENT2,EIGHT	YES
			---
COUNT			7

### Report #7: Visit Report (Procedure Codes/Date and Provider)

**Objective:** To print patient names, primary providers, and procedure code by date. This report is useful for validating data and for searching the QUASAR database for procedure codes or patients which were entered in error or missed.

Select A&SP Reports Option: **Tailor-Made A&SP Reports**

Print From Which File: (P/V): V// <RET>isit

SORT BY: DATE// <RET>

START WITH DATE: FIRST// [Enter a beginning date]

GO TO DATE: LAST// [Enter an ending date]

WITHIN DATE, SORT BY: **PATIENT NAME**

START WITH PATIENT NAME: FIRST// <RET>

WITHIN PATIENT NAME, SORT BY: **PRIMARY PROVIDER**

START WITH PRIMARY PROVIDER: FIRST// <RET>

WITHIN PRIMARY PROVIDER, SORT BY: <RET>

STORE IN 'SORT' TEMPLATE: [Enter a template name]

Are you adding 'TEMPLATE NAME' as a new SORT TEMPLATE? No// Y (Yes)

DESCRIPTION:

1><RET>

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO// <RET>YES

FIRST PRINT FIELD: **PATIENT NAME;C1;S1;L20**

THEN PRINT FIELD: **PRIMARY PROVIDER;C25;L20;N**

THEN PRINT FIELD: **.01;C50;N DATE**

THEN PRINT FIELD: **PROCEDURE CODE** (multiple)  
 THEN PRINT PROCEDURE CODE SUB-FIELD: **PROCEDURE CODE;C70**  
 THEN PRINT PROCEDURE CODE SUB-FIELD: **<RET>**  
 THEN PRINT FIELD: **<RET>**  
 DEVICE: [Enter a device]

**Example**

A&SP CLINIC VISIT LIST		NOV 23,1999 12:31		PAGE 1
PATIENT NAME	PRIMARY PROVIDER	DATE	PROCEDURE CODE	
-----				
QUASARPATIENT1,EIGHT	QUASARPROVIDER,SIX	AUG 16,1999	92511	
QUASARPATIENT1,NINE			92511	
QUASARPATIENT1,TEN			92511	
QUASARPATIENT2,ONE			92511	
QUASARPATIENT2,TWO			92511	
QUASARPATIENT2,THREE			92511	
QUASARPATIENT2,FOUR	QUASARPROVIDER,NINE		92506	

**Report #8: ASHA Data on Trainees**

**Objective:** To print a list of procedure times by student and date.

Select A&SP Reports Option: **Tailor-Made A&SP Reports**  
 Print From Which File: (P/V): V// **<RET>**isit  
 SORT BY: DATE// **#STUDENT**  
 START WITH STUDENT: FIRST// **<RET>**  
 WITHIN STUDENT, SORT BY: **DATE**  
 1 DATE  
 2 DATE ADEQUATED  
 3 DATE OF AUDIOMETRIC TESTING  
 4 DATE SIGNED  
 CHOOSE 1-4: **1 DATE**  
 START WITH DATE: FIRST// [Enter a beginning date]  
 GO TO DATE: LAST// [Enter an ending date]

WITHIN DATE, SORT BY: <RET>  
 STORE IN 'SORT' TEMPLATE: [Enter a template name]  
 Are you adding 'TEMPLATE NAMES' as a new SORT TEMPLATE? No// Y (Yes)  
 DESCRIPTION:  
 1><RET>  
  
 SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO// <RET>YES  
 FIRST PRINT FIELD: **STUDENT;C1;N;L20**  
 THEN PRINT FIELD: **.01;C25 DATE**  
 THEN PRINT FIELD: **DIAGNOSTIC CODE** (multiple)  
 THEN PRINT DIAGNOSTIC CODE SUB-FIELD: **DIAGNOSTIC CODE;C40**  
 THEN PRINT DIAGNOSTIC CODE SUB-FIELD: <RET>  
 THEN PRINT FIELD: **PROCEDURE CODE** (multiple)  
 THEN PRINT PROCEDURE CODE SUB-FIELD: **PROCEDURE CODE;C50**  
 THEN PRINT PROCEDURE CODE SUB-FIELD: <RET>  
 THEN PRINT FIELD: **TIME SPENT;C65** (minutes)  
 THEN PRINT FIELD: <RET>  
 DEVICE: [Enter a device]

**Example**

A&SP CLINIC VISIT LIST		NOV 13,1995 09:54	PAGE 1	
STUDENT	DATE	DIAGNOSTIC CODE	PROCEDURE CODE	TIME SPENT (minutes)
QUASARPROVIDER1,THREE	OCT 6,1995	389.10	92557 92567 92568 92599	90

**Report #9: Procedure Time Report**

**Objective:** To print a list of procedure times for a specified procedure. The report also provides descriptive statistics on procedure times. This report is useful for analyzing product lines and standardizing procedure times for DSS.

**Note:** This report is designed to analyze procedure time for a single specified procedure code. It uses the Primary Provider instead of the Procedure Provider field.

Select A&SP Reports Option: **Tailor-Made A&SP Reports**

Print From Which File: (P/V): V// <RET>isit

**SORT BY: DATE// @DATE**

- 1 DATE
- 2 DATE ADEQUATED
- 3 DATE OF AUDIOMETRIC TESTING
- 4 DATE SIGNED

**CHOOSE 1-4: 1 DATE**

START WITH DATE: FIRST// [Enter a beginning date]

GO TO DATE: LAST// [Enter an ending date]

WITHIN DATE, SORT BY: **PROCEDURE CODE** (multiple)

PROCEDURE CODE SUB-FIELD: **PROCEDURE CODE**

START WITH PROCEDURE CODE: FIRST// [Enter code to be sorted]

GO TO PROCEDURE CODE: LAST// [Enter same code]

WITHIN PROCEDURE CODE, SORT BY: START WITH DATE: FIRST// [Enter a beginning date]

GO TO DATE: LAST// [Enter an ending date]

STORE IN 'SORT' TEMPLATE: [Enter a template name]

Are you adding 'TEMPLATE NAMES' as a new SORT TEMPLATE? No// **Y** (Yes)

DESCRIPTION:

1><RET>

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO// **YES**

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'PROCEDURE CODE'? NO//  
**YES**

FIRST PRINT FIELD: **PROCEDURE CODE** (multiple)

FIRST PRINT PROCEDURE CODE SUB-FIELD: **PROCEDURE CODE;C1**

THEN PRINT PROCEDURE CODE SUB-FIELD: <RET>

THEN PRINT FIELD: **PRIMARY PROVIDER;C20;N**

THEN PRINT FIELD: **#TIME SPENT;C40** (minutes)

THEN PRINT FIELD: <RET>

DEVICE: [Enter a device]

### Example

PROCEDURE CODE	PRIMARY PROVIDER	TIME SPENT (minutes)
92507	QUASARPROVIDER1,FOUR	30
92507		30
92507		30

92507		45
92507		45
92507	QUASARPROVIDER1,FIVE	45
92507		45
		----
TOTAL		270
COUNT		7
MEAN		39
MINIMUM		30
MAXIMUM		45
DEV.		8

## Report #10: Clinic Management Report

**Objective:** To provide a report of patient names, procedures, and procedure times by provider.

Select A&SP Reports Option: **Tailor-Made A&SP Reports**

Print From Which File: (P/V): V// <RET>isit

SORT BY: DATE// @DATE

- 1 DATE
- 2 DATE ADEQUATED
- 3 DATE OF AUDIOMETRIC TESTING
- 4 DATE SIGNED

CHOOSE 1-4: **1** DATE

START WITH DATE: FIRST// {Enter a beginning date}

GO TO DATE: LAST// [Enter an ending date]

WITHIN DATE, SORT BY: @CLINIC LOCATION

START WITH CLINIC LOCATION: FIRST// [Enter a clinic location]

GO TO CLINIC LOCATION: LAST// [Enter the same clinic location]

WITHIN CLINIC LOCATION, SORT BY: <RET>

STORE IN 'SORT' TEMPLATE: [Enter a template name]

Are you adding 'TEMPLATE NAME' as a new SORT TEMPLATE? No// **Y** (Yes)

DESCRIPTION:

1><RET>

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE'? NO// **YES**

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'CLINIC LOCATION'? NO// **YES**

FIRST PRINT FIELD: **PRIMARY PROVIDER;C1;L20**

THEN PRINT FIELD: **PATIENT NAME;C30**

THEN PRINT FIELD: **PROCEDURE CODE** (multiple)

THEN PRINT PROCEDURE CODE SUB-FIELD: **PROCEDURE CODE;C55**  
 THEN PRINT PROCEDURE CODE SUB-FIELD: **<RET>**  
 THEN PRINT FIELD: **TIME SPENT;C65** TIME SPENT (minutes)  
 THEN PRINT FIELD: **<RET>**  
 DEVICE: [Enter a device]

**Example**

A&SP CLINIC VISIT LIST	NOV 23,1999 13:51		PAGE 1
PRIMARY PROVIDER	PATIENT NAME		
		PROCEDURE CODE	TIME SPENT (minutes)
-----			
QUASARPROVIDER,NINE	QUASARPATIENT2,FIVE	92506	30
QUASARPROVIDER1,EIGHT	QUASARPATIENT2,SIX	92506	100
	QUASARPATIENT2,SIX	92506	120
QUASARPROVIDER,NINE	QUASARPATIENT2,SEVEN	92511	10



# QUASAR Audiogram Module

## Introduction

**QUASAR** (Quality: Audiology and Speech Analysis and Reporting) is a VistA software package written for the Audiology and Speech Pathology Service (ASPS). QUASAR is used to enter, edit, and retrieve data for each audiometric exam of a patient and provides for the transmission of this data to various programs.

Patch ACKQ\*3.0\*13 adds the ability to retrieve data directly from certain audiometric devices, and combines the Edit and Display components into one application. Recommended users (not doing data entry or capture), can use the Graph Display tab to view a graphic display of a record.

The **QUASAR Audiogram Module** is a Windows-based GUI interface, developed to simplify and enhance the entry, display, and use of information obtained during an audiometric exam of a patient.

The Audiogram Edit component (ACKQROES3E.exe) is a Windows-based software application that allows clinicians to enter, edit, and view a patient's audiometric exam record and a patient's audiogram graph. You access the component from the Computerized Patient Record System (CPRS) Tools menu.

The **QUASAR Audiogram Module** includes components that reside on two systems: the local facility VistA system and the Denver Acquisition & Logistics Center (Denver ALC) system. The local facility components include a VistA file, 'M' routines and options, remote procedure calls, and a Delphi executable. The Denver ALC ROES\*3.0 (Remote Order Entry System) order processing application incorporates patient-specific audiometric information that is taken from data transmitted to a national database from the QUASAR Audiogram Module. The information is used by vendors to produce customized hearing related items.

## ***Related Documentation***

Related documentation is located in the VistA Document Library:

<http://www.va.gov/vdl/>

*QUASAR Audiogram Module Release Notes for Patch ACKQ\* 3.0\*13*

*QUASAR Audiogram Module Installation and Implementation Guide for Patch ACKQ\* 3.0\*13*

*QUASAR Audiogram Module Technical Manual and Package Security Guide for Patch ACKQ\* 3.0\*13*

## ***Conventions Used***

The QUASAR GUI uses a Microsoft Windows-style graphical interface with typical navigation and conventions<sup>1</sup>.

- Altered data is used in all screen captures in the user manual; this includes the names of patients and providers, patient information, and audiometric test results. The examples are representative of the features of the application.
- Use the Tab-key, right and left arrows, or mouse point/click to navigate the fields on each tab.
- You can access editable fields, tab pages and menu options using shortcut key combinations, such as Alt +, Ctrl +, and F-key + in combination with an additional key.
- The slide bar on the right side of the window allows you to adjust the view of the screen.
- The Audiogram Edit window includes five tabs: Audiogram Entry, Pure Tones, Speech Audiometry, Acoustic Immittance, and Graph Display.
- Disabled fields cannot be edited.
- Tab-key moves through the editable fields in a logical sequence, from left to right, and right-ear fields first and left-ear fields second.
- To bypass the Tab-key sequence, click the mouse in a specific field.
  - Note:** The Tab key and the mouse do not allow access to the disabled fields.
- Calculated fields display as disabled, because the system automatically populates them.
- A hint with acceptable values displays when you pause the cursor over an editable field.
  - a. To enable/disable the hints, click **File** and select **Enable/No Hints**.
  - b. Hints are not available, once the record is signed.

## ***Monitor/Keyboard Placement***

Patch ACKQ\*3.0\*13 requires attention be given to the placement of the keyboard and monitor<sup>2</sup>.

- PC keyboard and PC monitor must be connected (cable) to the PC running the Audiogram Module.
- Locate the keyboard adjacent to or directly below the audiometer device controls.
- Locate the PC monitor in a physical position, so that the clinician can comfortably view and analyze the data imported to the Audiogram Module.

---

<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 Modified conventions used in the Audiogram Module.

<sup>2</sup>Patch ACKQ\*3.0\*13 July 2007 Section added on the placement of the monitor and keyboard.

## What's New in Audiogram Module Patch ACKQ\*3.0\*13

Patch ACKQ\*3.0\*13 enhances the functionality of the Audiogram Module<sup>1</sup>.

- Audiogram Display is integrated into Audiogram Edit as a new tab, Graph Display.
- The Audiogram Module Interface allows the transfer of data, point by point, from the audiometer device to the grids in the Pure Tones and Speech Audiometry tabs of the Audiogram Edit window.
- A black box audiometer transfers all data at once (dump) from its associated software to the Audiogram Module at the end of a testing session. The Madsen Aurical is an example of a black box audiometer. For information regarding the use of the Audiogram Module with a black box audiometer, refer to Appendix A: Black Box Audiometer, page 121.
- To pass data from an audiometer to the Audiogram Module, an audiometer must be configured for the first time, **Configure Audiometer**. Each ensuing time the Audiogram Module is started, the configured audiometer is *remembered*. You can import data from the audiometer for all subsequent sessions.
- During subsequent uses of an audiometer, you can verify connection without reconfiguring, **Check Audiometer**.
- Within the Pure Tones tab, all **Final or Masked** field labels are changed to **Masked**.
- Within the Speech Audiometry tab under Rollover, **Applied Max** drop-down list boxes are added for the left and right ear. You can select the Word Recognition test (default, 1, 2, 3, 4, or 5) to use to calculate the PB Max value.
- For an audiometer capable of being reset, each time the Audiogram Module is opened, the data stored in the audiometer's local repository is cleared or set to default, in preparation for a new patient. For an audiometer not capable of being reset, you must manually reset it.
- The graph display reflects imported data dynamically.
- Value boundary validation is part of data imports. When a value is outside the upper range of acceptable, valid values, the highest permitted value for a field displays with + (plus sign) to the right of it.
- On the Graph Display tab, for the Overlap and Separate views of the audiogram, Rollover Index for R and L, and Pure Tone Averages for R and L/Two/Three/Four are added to the display.
- On the Graph Display tab, for the Overlap view of the audiogram, IAR and CAR for R and L, and Right and Left for SRT-1 and 2, Mask-1 and 2, MCL, and UCL are added to the display.

---

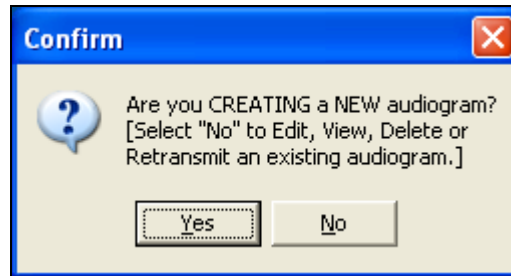
<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 List of enhancements associated with the Audiogram Module GUI.

- To import data from an audiometer successfully with **F10**, the Audiogram Edit window must be in focus and active.
- Frequency 1500 is added to the Pure Tones tab in the Bone Conduction section.
- To indicate no response (NR), add the + to the right of the no response (NR) data when the system does not automatically place it.

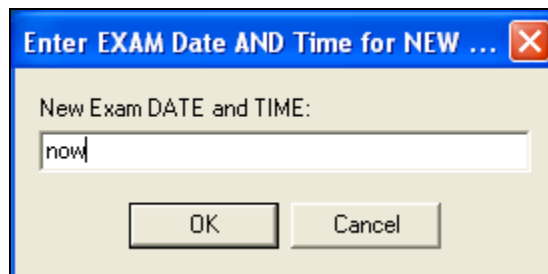
## Accessing the Audiogram Module

You access the Audiogram Module<sup>1</sup> through CPRS.

1. From the Patient Selection pop-up, select a patient and click **OK**.
2. Click **Tools** and select **Audiogram Edit**. The Confirm pop-up displays.



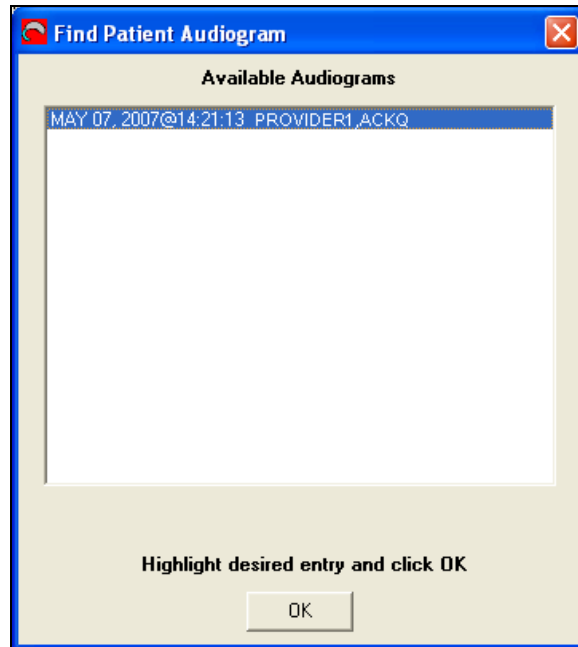
3. To create a new audiogram, click **Yes**. The Enter EXAM Date AND Time for NEW entry pop-up displays.



4. Type the date and time that the exam takes place in the New Exam Date and Time: text box and click **OK**.  
A new record is set up in the file and the age of the patient is calculated.
  - a. You can type **Now** or **n** in the **New Exam Date and Time:** text box and the current date and time displays.
  - b. Use any of the standard VA FileMan date/time formats. For more information, refer to Appendix G on page 133.
5. Click **OK**. The Audiogram Edit for <patient> as seen on <date> window displays with the Audiogram Entry tab open.
6. Continue with steps for the Audiogram Entry tab on page 95.
7. To edit, view, or delete an audiogram (signed or unsigned), click **No**. The Find Patient Audiogram pop-up displays.

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<sup>1</sup> Patch ACKQ\*3.0\*13 July 2007 Audiogram Module is accessed through CPRS only. Access steps are updated to reflect this.

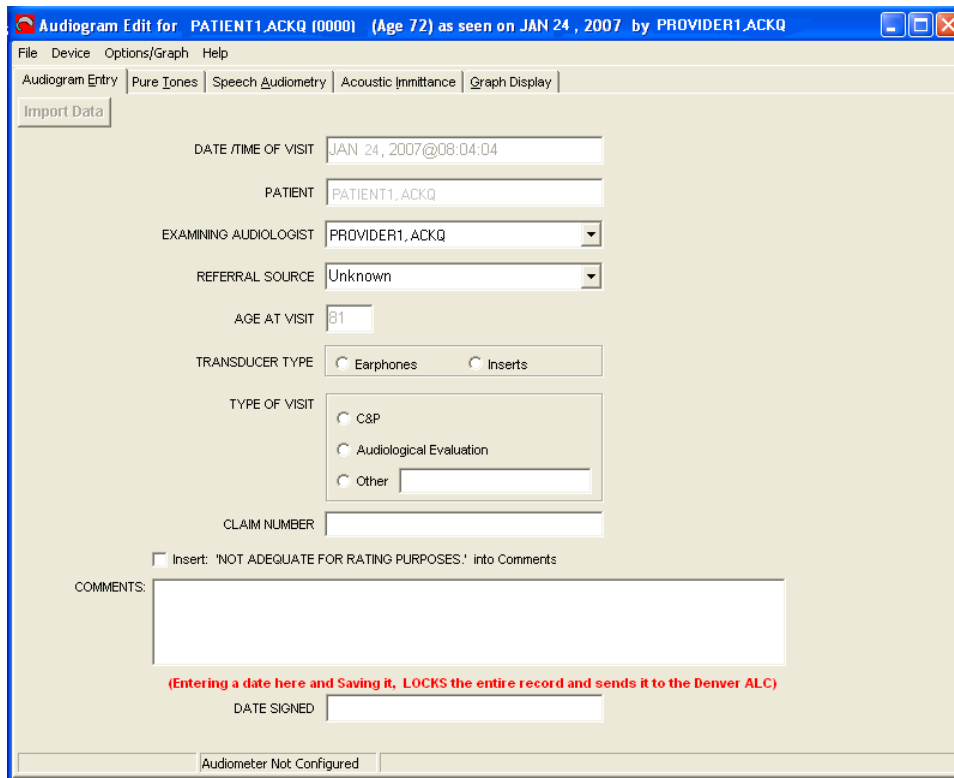


8. Select an audiogram from the list box and click **OK**. The Audiogram Edit for <patient> as seen on <date> window displays with the Audiogram Entry tab open.
9. Continue with steps for the Audiogram Entry tab on page 95.

# Audiogram Edit Window

The Audiogram Edit window contains the procedures and functional features applying to the navigation and data entry of a patient's audiometric exam readings; it is where you create a new audiometric record or edit an existing audiometric record for a patient.

The Audiogram Edit window has four menus: File, Device, Options/Graph, and Help. The window has five tabs: Audiogram Entry, Pure Tones, Speech Audiometry, Acoustic Immittance, and Graph Display. The Audiogram Edit window displays with the Audiogram Entry tab open.

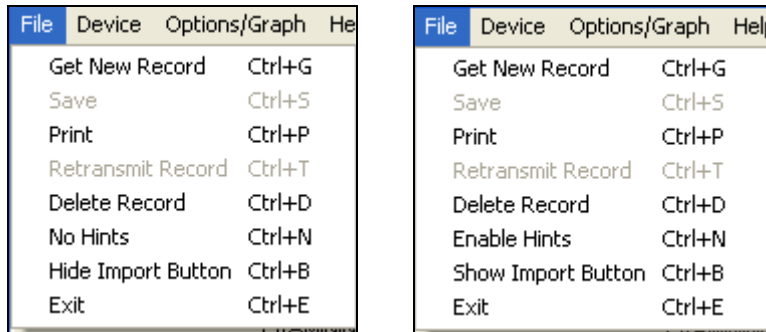


## File Menu

The File drop-down menu allows you to get a new record, save data, print the screen, view an audiogram, retransmit a record, delete a record, enable/disable hints, hide/show the Import Data button<sup>1</sup>, and exit the module.

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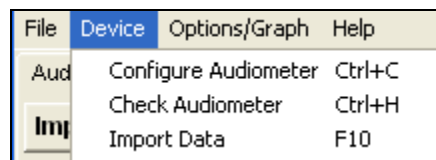
<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 Import Data button is added to the File menu; Flip Tabs is removed from the File menu.



- Use **Get New Record** to loop through existing audiometric records without re-entering codes and to go to another record for a patient, if accessing through CPRS or select a new patient/record, if accessing from the desktop.
- Use **Save** to retain data. Save is disabled until a value is added or changed.
- Use **Delete Record** to flag a local, signed audiogram for deletion (flag an erroneous record) and automatically send a message to the Denver ALC to delete the signed audiogram from the national database. You receive a confirmation message.
- Use **No/Enable Hints** to disable/enable the acceptable values displayed when you pause your cursor over an editable field.
- Use **Hide/Show Import Button** to enable/disable the import data button on the Audiogram Edit window.
- Use **Retransmit Record** to resend signed records transmitted only with air and speech results or for some reason did not make it to the Denver ALC. The retransmission date displays on the Audiogram Entry tab. When the original record is sent to the Denver ALC, the **Retransmit Record** is enabled.

## Device Menu

The Device drop-down menu<sup>1</sup> allows you to configure an audiometer, check an audiometer, and import data. All of the options of which the device is capable, display enabled when a device is configured, bidirectional and connected.



**Configure Audiometer** is used to:

- Set up an audiometer for the first time.

<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 Device menu is added to the Audiogram Edit window.



- Disconnect an audiometer (None).
- Change the audiometer used for importing data.

**Check Audiometer** is used subsequently to:

- Connect to an audiometer.
- Verify connection status.
- Check for a dropped connection.

Use **Import Data** to transfer data from the audiometer to the Audiogram Module.

- Click the **Device** menu and select **Import Data**,
- Press **F10** on the PC keyboard (the Audiogram Edit window must be in focus and active), or
- Click the **Import Data** button on the Audiogram Edit window.

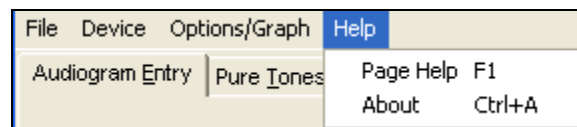
## Options/Graph Menu

The Options/Graph menu<sup>1</sup> allows you to view the audiometric data in a graph or tabular format. As a data point is imported, it displays on the graph in the appropriate location and with the proper symbol. The test results are viewed as a single graph with the left ear and right ear results overlapping or as separate graphs, one graph for the left ear and one graph for the right ear. The VA form 10-2364 is a standard tabular form and displays only the last saved test data from the file.

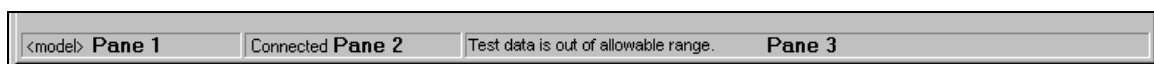


## Help Menu

The Help menu<sup>2</sup> displays at the top of all tabs. The Page Help option display tab-specific Help text.



## Status Bar



<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 Options/Graph menu is added to the Audiogram Edit window.

<sup>2</sup>Patch ACKQ\*3.0\*13 July 2007 Options in the Help menu are rearranged.

The status bar<sup>1</sup> displays at the bottom of each tab and shows information about the audiometer:

**Pane 1** – displays the model of the configured audiometer.

**Pane 2** – displays the connection status of the configured audiometer: audiometer not configured, connected, or not connected.

**Pane 3** – displays messages regarding the configured audiometer, such as indicating the data is out of range for the selected frequency. The message displays only for a few seconds. Also, an audible sound is produced for a message.

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<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 Status Bar is added to the Audiogram Edit window.

## Configuration of the Audiometer

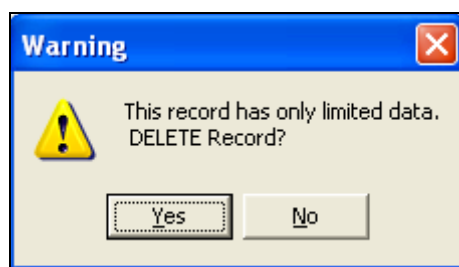
In order to import data from the device to the Audiogram Module, the audiometer must be configured in the Audiogram Module<sup>1</sup>.

### ***Configure the Audiometer for the First Time***

The first time you use an audiometer, you must configure it in the Audiogram Module.

1. From the Patient Selection pop-up, select a patient and click **OK**.
2. Click **Tools** and select **Audiogram Edit**. The Confirm pop-up displays.
3. To create a new audiogram, click **Yes**. The Enter EXAM Date AND Time for NEW... pop-up displays.

**Note:** When you open Audiogram Edit and click **Yes** to create a new audiogram, QUASAR creates a *skeleton* record in the QUASAR file for the previously selected patient in CPRS. If you do not add or change the patient's record in the Audiogram Edit window, when you exit Audiogram Edit, a warning pop-up displays.



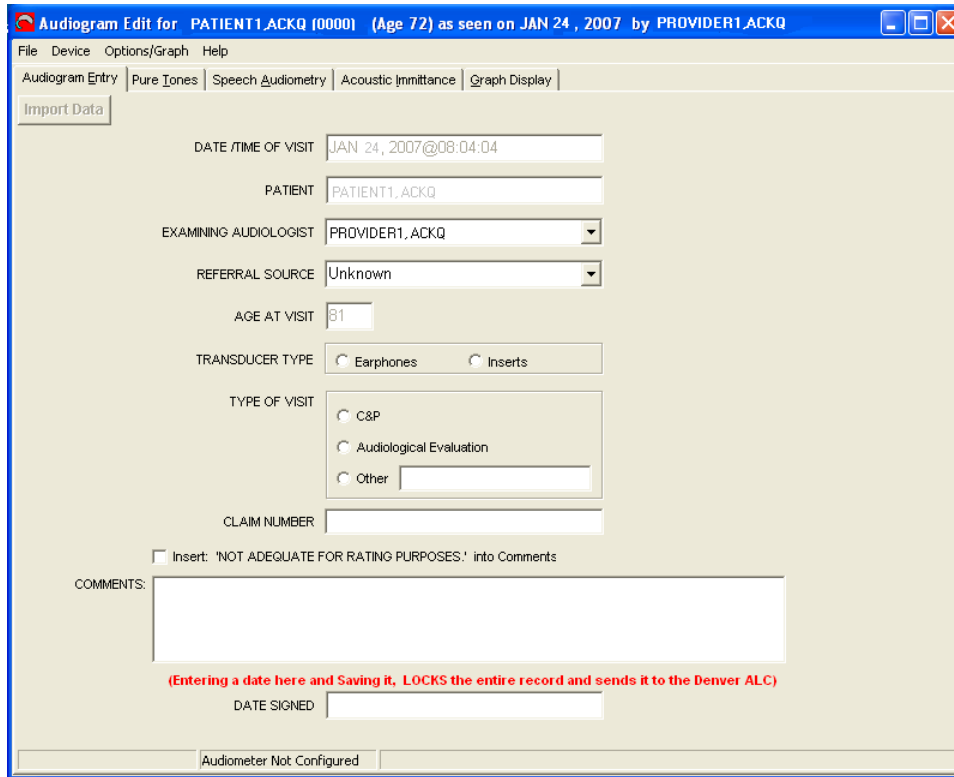
- a. Click **Yes**, to remove the *skeleton* record from the QUASAR file.
  - b. Click **No**, to retain the *skeleton* record.
4. Type the date and time of the appointment and click **OK**.

**Note:** Type **Now (n)** to use the current date and time.

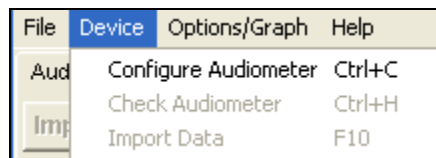
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<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 Section added for configuring an audiometer.

The Audiogram Edit window displays with the Audiogram Entry tab open. The message in the status bar indicates the audiometer is not configured. (The Import Data button is disabled.)



5. Click **Device**. The Device drop-down menu displays with only the **Configure Audiometer** option enabled.



6. Select **Configure Audiometer**. The Select Audiometer window displays.



**Note:** The list of available audiometers varies, depending on the models used at your site.

7. Select an audiometer and click **Select**.

The Audiogram Edit window displays with the Audiogram Entry tab open. The message in the status bar indicates the audiometer is connected. (The Import Data button is enabled.)

The screenshot shows the 'Audiogram Edit' window for patient PATIENT1.ACKQ (Age 72) as seen on JAN 24, 2007 by PROVIDER1.ACKQ. The window has a menu bar with 'File', 'Device', 'Options/Graph', and 'Help'. Below the menu bar are tabs for 'Audiogram Entry', 'Pure Tones', 'Speech Audiometry', 'Acoustic Immittance', and 'Graph Display'. The 'Audiogram Entry' tab is active, showing an 'Import Data' button. The form contains the following fields and options:

- DATE /TIME OF VISIT: JAN 24, 2007@15:50:53
- PATIENT: PATIENT1.ACKQ
- EXAMINING AUDIOLOGIST: PROVIDER1.ACKQ
- REFERRAL SOURCE: Unknown
- AGE AT VISIT: 72
- TRANSDUCER TYPE:  Earphones  Inserts
- TYPE OF VISIT:  C&P  Audiological Evaluation  Other
- CLAIM NUMBER: (empty)
- Insert: 'NOT ADEQUATE FOR RATING PURPOSES.' into Comments
- COMMENTS: (empty text area)
- DATE SIGNED: (empty)

At the bottom of the window, the status bar shows 'Model A' and 'Connected'.

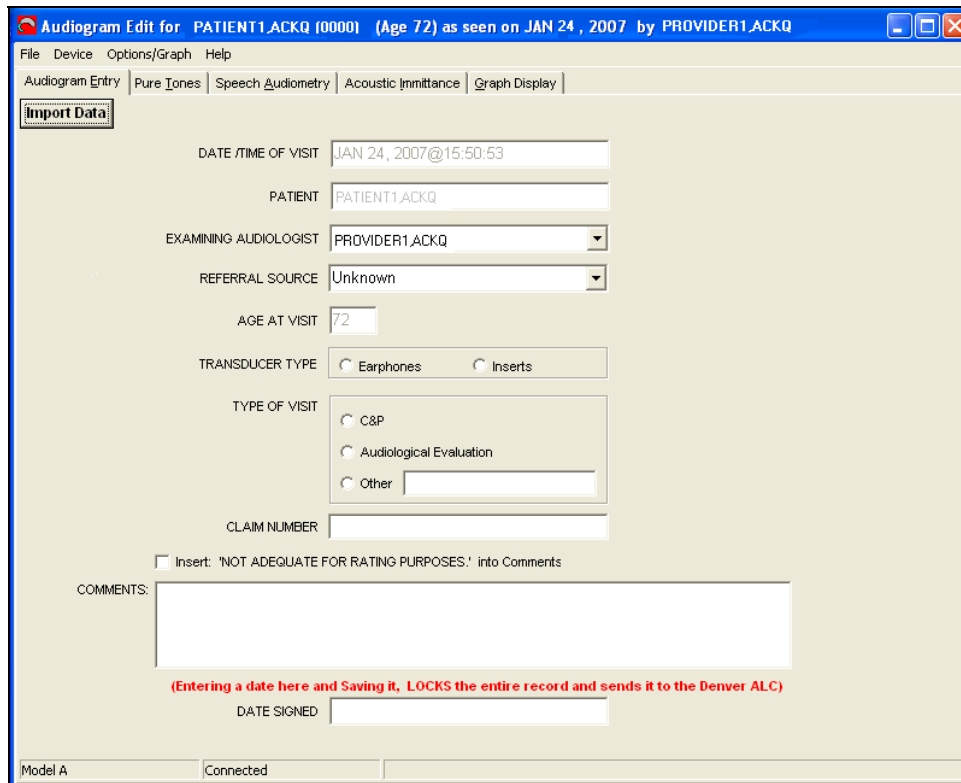
8. Click **Device**. The Device menu drop-down displays with options enabled for the specific configured and connected audiometer.

File	Device	Options/Graph	Help
	Aud	Configure Audiometer	Ctrl+C
		Check Audiometer	Ctrl+H
	Imp	Import Data	F10

## Verify the Connection of the Audiometer

You can verify the connection<sup>1</sup> of the audiometer at any time.

1. In the Audiogram Module, the Audiogram Edit window displays with the Audiogram Entry tab open. The message in the status bar indicates the audiometer is connected. (The Import Data button is enabled.)

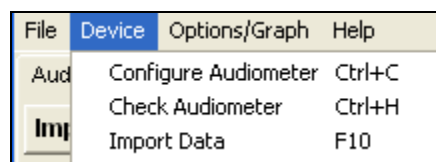


The screenshot shows the 'Audiogram Edit for PATIENT1.ACKQ (0000) (Age 72) as seen on JAN 24, 2007 by PROVIDER1.ACKQ' window. The 'Audiogram Entry' tab is active. The 'Import Data' button is highlighted. The form contains the following fields and options:

- DATE /TIME OF VISIT: JAN 24, 2007@15:50:53
- PATIENT: PATIENT1.ACKQ
- EXAMINING AUDIOLOGIST: PROVIDER1.ACKQ
- REFERRAL SOURCE: Unknown
- AGE AT VISIT: 72
- TRANSDUCER TYPE:  Earphones  Inserts
- TYPE OF VISIT:  C&P  Audiological Evaluation  Other
- CLAIM NUMBER: (empty)
- Insert: 'NOT ADEQUATE FOR RATING PURPOSES.' into Comments
- COMMENTS: (empty text area)
- DATE SIGNED: (empty)

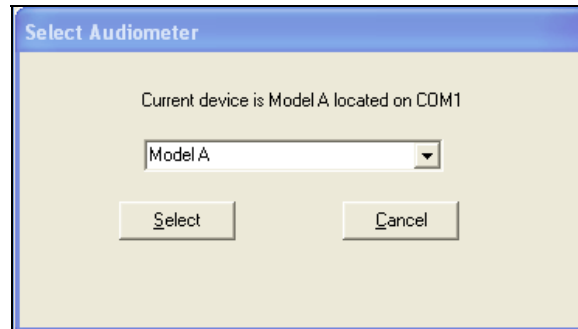
At the bottom, the status bar shows 'Model A' and 'Connected'.

2. Click **Device**. The Device drop-down menu displays with only Configure Audiometer, Check Audiometer, and Import Data enabled.



<sup>1</sup> Patch ACKQ\*3.0\*13 July 2007 Section added on verifying the connection of an audiometer.

3. Select **Configure Audiometer**. The Select Audiometer pop-up displays and indicates the current audiometer connected to a specific port.



**Note:** The port number (COM1) may vary.

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## Audiogram Entry

The Audiogram Entry tab allows you to collect and display basic patient and visit information. After the **Date Signed** is entered and saved, the data is transmitted to the Denver ALC and can no longer be edited.

If a patient is registered in the Denver ALC ROES system, audiometric data transmitted to the Denver ALC is available for viewing, in a tabular format, from the Denver ALC ROES Patient Information screen.

### Audiogram Entry Fields

Field	Description
Date/Time of Visit	Date and time of visit are recorded when the patient record is created. This field cannot be edited.  <b>Note:</b> The date and time entered in the Enter EXAM Date AND Time for NEW... pop-up, automatically populate the <b>Date/Time of Visit</b> text box of the Audiogram Entry tab.
Patient	The patient name automatically populates the <b>Patient</b> text box from CPRS (current patient selected).  You cannot edit the patient field. If the wrong patient is selected, you must delete the record and repeat the process of creating a new record.

<b>Field</b>	<b>Description</b>
Examining Audiologist	Type the first few characters of the person's last name or select from the drop-down list box.  Examining Audiologist is taken from the NEW PERSON file (#200).
Referral Source	For referral source, type the first few letters of the location or select from the drop-down list box. <ul style="list-style-type: none"> <li>• Referral source pulls from the local HOSPITAL LOCATION file (#44).</li> <li>• Names for the locations vary from facility to facility.</li> </ul>
Age at Visit	The age of the patient <b>at the time of the visit</b> is calculated by the system, which looks at the date of birth in the Patient file when the record is created. This field cannot be edited.
Transducer Type	Method by which the sounds are transmitted: <ul style="list-style-type: none"> <li>• Earphones</li> <li>• Inserts</li> </ul>
Type of Visit	Three types of visits: C&P (Compensation and Pension), Audiologist Referral, and Other.  <b>Note:</b> Select <b>Other</b> and you can enter free text of 2-26 characters in the <b>Other</b> text box. The text is stored in the record and displays on VA form 10-2364.
Claim Number	Type a number in the <b>Claim Number</b> text box.  <b>Note:</b> The number is saved in the record and displays on VA form 10-2364.
<input type="checkbox"/> NOT ADEQUATE FOR RATING PURPOSES' into Comments check box	Select the <b>NOT ADEQUATE FOR RATING PURPOSES' into Comments</b> check box when: <ul style="list-style-type: none"> <li>• Thresholds cannot be used for rating C&amp;P claims.</li> <li>• Testing was not done according to C&amp;P protocols.</li> <li>• Thresholds are not reliable for a C&amp;P exam.</li> </ul>

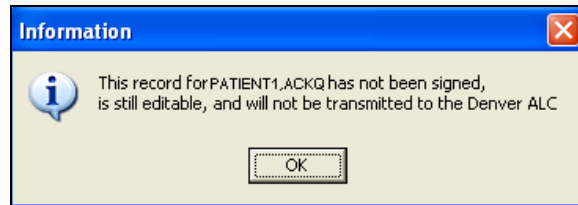
Field	Description
Comments	<p>Type a comment in the <b>Comments</b> text box. Up to 300 characters (approximately three lines of text).can be saved to appear in the national record and on the VA form 10-2364.</p> <ul style="list-style-type: none"> <li>• If the form is not saved, you can use the check box to insert the phrase: NOT ADEQUATE FOR RATING PURPOSES. Once the phrase is inserted, the check box is disabled.</li> <li>• The phrase is the first 33 characters of your 300-character <b>Comments</b>.</li> <li>• To remove the phrase, highlight it, press <b>Delete</b>, and exit the Comments text box. This also removes the check from the check box.</li> <li>• To wrap the text in the Comments text box to accommodate 300 characters, press <b>Ctrl + Enter</b>.</li> </ul>
Date Signed	<p>The date the information is verified as accurate.</p> <ul style="list-style-type: none"> <li>• Once a date is entered in the <b>DATE SIGNED</b> text box, the record is considered final and approved; the values are transmitted to the Denver ALC national database.</li> <li>• Once the record is sent to the Denver ALC, the <b>Retransmit</b> option is activated. Records at the Denver ALC are updated with additional information.</li> <li>• Once retransmitted, the retransmission date displays next to the date signed; a message displays if you try to retransmit a second time.</li> </ul>

### ***Audiogram Entry/Date Signed***

After a date is entered and saved in the DATE SIGNED text box, all fields are locked and you cannot make any changes to the record. If after signing, you find the data was entered for the wrong patient or the wrong data was entered for a patient, delete the record and repeat the process for creating a new record.

- To delete an audiogram containing erroneous data, after a date is entered and saved in the **DATE SIGNED** text box, click **File** and select **Delete Record**.
- A deletion message is transmitted to the Denver ALC (Denver Acquisition & Logistics Center), if the record was signed, and it is removed from the national database. You receive a confirmation message.
- Completed and signed records are stored in a local QUASAR global. They are transmitted to the Denver ALC through the VistA MailMan system for inclusion with orders for hearing aids and repairs, when ordered through the VistA Remote Order Entry System (ROES) package.

- If you Exit without signing the audiogram, a pop-up displays reminding you that the audiogram is not signed and will not be sent to the Denver ALC.



## Pure Tones

The Pure Tones tab allows you to enter pure tone threshold values across a standard range of frequencies, as a measure of hearing loss. For an audiometer capable of being reset, each time the Audiogram Module is opened, the data stored in the audiometer's repository is reset, in preparation for a new patient. For an audiometer not capable of being reset, you must manually reset it.

The audiogram (graphic display) is constructed with appropriate symbols, based on the data entered into the Pure Tones fields. Review the imported data to make sure that the fields are appropriately populated before saving.

### Pure Tones Fields – Right and Left Ears

Field	Description	Valid Values
<b>Air Conduction</b>		<b>250 Hz-8000 Hz</b>
Initial	First data value obtained during testing for Air Conduction, unmasked.	-10 to 105dB +, NR, CNT, DNT, blank

<b>Field</b>	<b>Description</b>	<b>Valid Values</b>
Retest	Only <i>unmasked</i> threshold for retested (second, third, fourth, and so on) frequencies.	-10 to 105dB +, NR
Masked <sup>1</sup>	Masked threshold.	-10 to 105dB +, NR
Masking Level	Masking level value.	0 to 105dB CNM, blank
<b>Bone Conduction</b>	Frequency 1500 is added to the Pure Tones tab. <sup>2</sup>	<b>250 Hz-4000 Hz</b>
Initial	First data value obtained during testing for Bone Conduction, unmasked.	-10 to 80dB +, NR, CNT, DNT, blank
Retest	Only <i>unmasked</i> threshold for retested (second, third, fourth, and so on) frequencies.	-10 to 80dB +, NR
Masked	Masked threshold.	-10 to 80dB +, NR
Masking Level	Masking level value.	0 to 105dB CNM, blank
<b>Inter Test Consistency</b>	Select a description from each drop-down list box, one for the right ear and one for the left ear.	Good, Fair, Poor
<b>Pure Tone Averages</b>	Automatically calculated when sufficient information is entered. For more information, refer to Appendix F: Calculation of Pure Tone Averages on page 131.	Read-only fields
<b>SRT (Masking Level)</b>		
Initial	First data value obtained during testing for Speech Reception Threshold.	-10 to 100dB CNT, DNT, blank
(Masking Level 1)	Masking level value for initial SRT.	0 to 105dB CNM, blank

<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 On the Pure Tones tab, Final or Masked is changed to Masked.

<sup>2</sup>Patch ACKQ\*3.0\*13 July 2007 On the Pure Tones tab, a column for frequency 1500 is added.

Field	Description	Valid Values
Final	Last data value obtained during testing for Speech Reception Threshold.	-10 to 100dB
(Masking level 2)	Masking level value for final SRT.	0 to 105dB CNM, blank

## **Pure Tones - Air and Bone Conduction Values**

- You can edit any data manually. After the data is edited, it can be overwritten by a new reading imported from the audiometer.
- Duplicate data entry text boxes exist for both the right and left ears. Keyboard navigation moves first through all of the right ear text boxes, then through all of the left ear text boxes.
- If a data point is outside the upper range of acceptable, valid values for a field, the system enters the highest permitted value for the field followed by the + sign, such as 105+.
- **Masking** values below the acceptable minimum are converted to zero for Air and Bone Conduction. A message displays in Pane 3.
- Manual entry is required for Could Not Test (CNT/c/C), Did Not Test (DNT/d/D), Could Not Mask (CNM/c/C), and No Response (n/N) values.<sup>1</sup>
- When **CNT** (Could Not Test), **DNT** (Did Not Test), or **NR** (No Response) is entered in an **Initial** field, the Retest field for that frequency and ear is disabled.
- All fields are considered **unmasked**, unless a non-zero numeric value is entered in the **Masking Level** text box; CNM (Could Not Mask) is a valid response.
- When you **retest without masking**, the value from the retest is stored in the **Retest** text box. Values for subsequent retests overwrite the value stored in the **Retest** text box, as long as the **Initial** text box is populated.
- For each frequency, values for masked pure tones are stored in the **Masked** text box and the masking levels are stored in the **Masking Level** text box for the associated frequency.
- When you **retest with masking**, the subsequent masked data imported, overwrites the previous data in the **Masked** text box and the **Masking Level** text box with the new threshold dB and masking level.
- Indicate **No Response** by manually entering + with the numeric value or N. This is converted to the highest acceptable value followed by the + sign.
- Type + and it converts to maximum value for the frequency with a +.

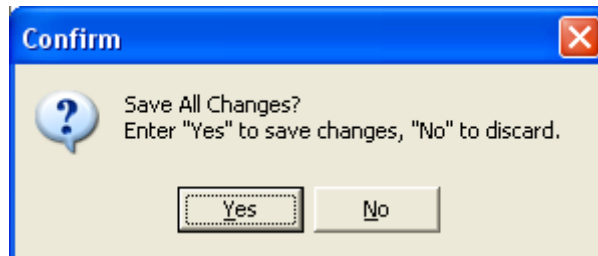
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<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 Abbreviations are acceptable for could not test, did not test, and no response, such as CNT/c/C for could not test.

## Importing Pure Tones Data Points

You can import values<sup>1</sup> from the audiometer to the Audiogram Module. Values can be imported point by point or all at once (data dump), depending on the device configured. The clinician can transfer the data values appropriately without having the specific tab for that test open, as long as the Audiogram Module has the appropriate focus.

1. In the Audiogram Module, click the Pure Tones tab.
2. Set your audiometer: Air Conduction or Bone Conduction and Right or Left ear.
3. Set the decibel threshold level (Hz) on the audiometer.
4. Set the masking level, if masking is required.
5. Conduct the testing.
6. To pass the dB value:
  - Press **F10** on the PC keyboard,
  - Press the **Import Data** button on the Audiogram Edit window, or
  - Click the **Device** menu and select **Import Data**.
7. Complete importing all test data collected in the Pure Tones, Speech Audiometry, and Acoustic Immittance tabs.
8. Complete viewing, editing, and confirming the imported data.
9. Save the data to the QUASAR file, click **File** and select **Save**. Save All Changes pop-up displays.



- Click **Yes** to save changes
- Click **No** to discard changes.

---

<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 Section added for importing pure tones data points.



# Speech Audiometry

The Speech Audiometry tab allows you to enter Speech Reception Threshold (SRT) values for comfort levels, effective masking levels, and Word Recognition information. Calculated pure tone averages display automatically and are read-only. For an audiometer capable of being reset, each time the Audiogram Module is opened, the data stored in the audiometer's local repository is reset, in preparation for a new patient. For audiometers not capable of being reset, you must manually reset it.

For information (including word lists) about the VA Speech Recognition & Identification Materials CD version 2.0, refer to the website: <http://vaww.mtn-home.med.va.gov/>

The screenshot shows the 'Audiogram Edit' window for patient PATIENT1.ACKQ (Age 72) as seen on JAN 24, 2007. The 'Speech Audiometry' tab is active. The interface includes sections for 'SPEECH COMFORT LEVELS', 'PURE TONE AVERAGES', 'Initial SRT', 'Masking Level', 'Final SRT', 'ROLLOVER', and 'WORD RECOGNITION TESTING'. The 'WORD RECOGNITION TESTING' section is further divided into 'RIGHT EAR WORD RECOGNITION' and 'LEFT EAR WORD RECOGNITION' with columns for percentage, HL, EM, and List across five trials.

## Speech Audiometry Fields: Right and Left Ears

Field	Description	Valid Values
<b>Speech Comfort Levels</b>		
MCL (Most Comfortable Level)	Manual entry	50 to 105dB

<b>Field</b>	<b>Description</b>	<b>Valid Values</b>
UCL (Uncomfortable Level)	Manual entry	50 to 105dB
Initial SRT (Speech Reception Threshold)	First data value obtained during testing for Speech Reception Threshold (SRT)	-10 to 100dB CNT, DNT, blank
Masking Level	Masking level for the Initial SRT.	0 to 105dB CNM, blank
Final SRT	Last data value obtained during testing for Speech Reception Threshold (SRT)	-10 to 100dB
Masking Level	Masking level for the Final SRT.	0 to 105dB CNM, blank
<b>Pure Tone Averages</b>		
Two, Three, Four	Automatically calculated	Read-only fields
<b>Rollover</b>		
PB Max (Phonetically-balanced Maximum)	Automatically populated Refer to Appendix D: Calculation of PB Max and RI (or PI/PB) on page 127 for PB Max information.	Read-only fields
RI (Rollover Index)	Automatically calculated Refer to Appendix D: Calculation of PB Max and RI (or PI/PB) on page 127 for the RI formula.	Read-only fields
Applied Max <sup>1</sup>	Select a test series to use for the Applied Max.	Default, Test 1, Test 2, Test 3, Test 4, Test 5
<b>Word Recognition</b>	1, 2, 3, 4, 5	
Material	Most commonly used lists, both 25- and 50-word, which apply to all the word tests.  Select a material for both ears from the <b>Material</b> drop-down list box.	NU6-25/NU6-50 W22-25/W22-50 CNC-25/CNC-50 Other

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<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 Applied Max is added to the Rollover section to allow the user to select a WRT test to use for PB Max.

<b>Field</b>	<b>Description</b>	<b>Valid Values</b>
Presentation	Delivery method of the material, which apply to all word tests.  Select a delivery method for both ears from the <b>Presentation</b> drop-down list box.	Recorded (CDs and tapes) and MLV (Monitored Live Voice)
% (Percent Correct)	Percent of words correctly recognized.	0 to 100 %, CNT, DNT, blank
HL (Hearing Level)		0 to 100, blank
EM (Effective Masking)		0 to 105 dB CNM, blank
List	Manual Entry	Maryland CNC: 1, 3, 4, 6, 7, 9, 10; 1-1, 1-3, 1-4, 1-6, 1-7, 1-9, 1-10; blank  CID W-22: 1A to 4A, 1B to 4B, 1C to 4C, 1D to 4D, 1E to 4E, 1F to 4F, blank  NU-6: 1A to 4A, 1B to 4B, 1C to 4C, 1D to 4D, blank

### ***Speech Audiometry - Speech Reception and Word Recognition Values***

- If a data point is outside the upper range of acceptable, valid values for a field, the system enters the highest permitted value for the field followed by the + sign, such as 105+.
- You can edit any data manually and the data is not be overwritten by data imported from the audiometer; unless the imported data is the result of a new reading after the data was edited. The system ensures that the most recent value displays.
- The PB Max and RI fields are automatically populated when sufficient information is entered. For more information, refer to Appendix D: Calculation of PB Max and RI (or PI/PB) on page 127.
- You can select the Word Recognition test (default, 1, 2, 3, 4, or 5) to use for the PB Max value.
- You can import the Word Recognition HL, EM, and % values from audiometers capable of collecting these values.
- Manual entry is required for Could Not Test (CNT/c/C), Did Not Test (DNT/d/D), and Could Not Mask (CNM/c/C) values.<sup>1</sup>

---

<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 Abbreviations are accepted for could not test, did not test, and no response, such as CNT/c/C for could not test.

- **Initial SRT** is the first SRT value obtained during testing.
- CNT (Could Not Test) or DNT (Did Not Test) can only be entered in an **Initial SRT** text box. The **Masking** and **Final SRT** fields are disabled for that ear, when you enter CNT or DNT in the **Initial SRT** field.
- Type + and converts to maximum value with a +.
- If there is data in both the **Initial** and **Final** fields, the Final SRT value displays on the audiogram (graph display) data is in both fields, the final data displays on the graphic audiogram.
- Place values obtained after masking, re-instructing the patient, or retesting for reliability, in the **Final SRT** text box.
- The masking level value for a masked SRT test is stored in the **Masking Level** text box of the SRT test.
- The masking level value for a masked Word Recognition test is stored in the **EM** text box.
- When you **retest SRT without masking**, the value from the retest is stored in the **Final SRT** text box with no value in the **Masking Level** text box. Values for subsequent retests overwrite the value stored in the **Final SRT** text box.
- When you **retest SRT with masking**, the retest masked data is stored in the **Final SRT** text box and the **Final Masking Level** text box. Values for subsequent retests, overwrite the values stored in the **Final SRT** text box and the **Final Masking Level** text box.
- The first Word Recognition test series populates column 1. As you retest, values populate column 2, then column 3, then column 4, and last column 5. For retest 6 and up, the values overwrite the values in column 5.
- For **WRT** the first **CNT/DNT** value the system finds is replaced moving from Test 1 through Test 5.
- Selections in **Material** apply to all of the word tests and include both the 25- and 50- word lists that are most commonly used.
- Selections in the **Presentation** drop-down list box apply to all of the word tests and include Recorded (CD or tape recordings) and MLV (Monitored Live Voice).

### ***Importing SRT and WRT Data Points***

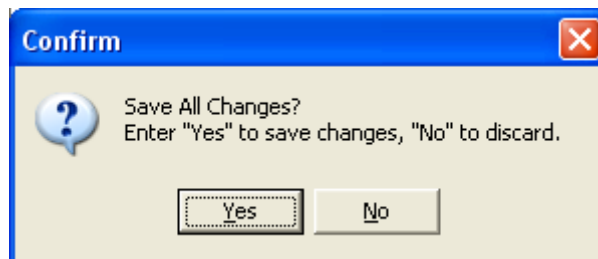
You can import values<sup>1</sup> from the audiometer to the Audiogram Module, point by point. Values can be imported to the SRT (Speech Reception Threshold) and WRT (Word Recognition Testing) grids while one of the other tabs is open.

---

<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 Section added for importing SRT and WRT data points.

## Speech Reception Threshold

1. In the Audiogram Module, click the Speech Audiometry tab.
2. Set your audiometer: Speech Reception Threshold and Right or Left ear.
3. Set the decibel threshold level (Hz) on the audiometer.
4. Set the masking level, if masking is required.
5. To pass the dB value:
  - Save the reading on the audiometer.
  - Press **F10** on the PC keyboard,
  - Press the **Import Data** button on the Audiogram Edit window, or
  - Click the **Device** menu and select **Import Data**.
6. Complete importing the test data collected in the Pure Tones and Speech Audiometry tabs, and enter data in the Acoustic Immittance tab.
7. Complete viewing, editing, and confirming the imported data.
8. Save the data to the QUASAR file, click **File** and select **Save**. Save All Changes pop-up displays.

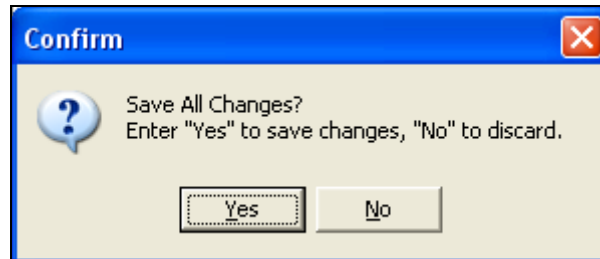


- Click **Yes** to save changes
- Click **No** to discard changes.

## Word Recognition Testing

1. In the Audiogram Module, click the Speech Audiometry tab.
2. Set your audiometer: Word Recognition and Right or Left ear.
3. Perform your Word Recognition testing
4. To pass the dB value to the Audiogram Module:
  - Save the reading on the audiometer.
  - Press **F10** on the PC keyboard,
  - Press the **Import Data** button, or
  - Click the **Device** menu and select **Import Data**.

5. Complete importing the test data collected in the Pure Tones and Speech Audiometry tabs, and enter data in the Acoustic Immittance tab.
6. Complete viewing, editing, and confirming the imported data.
7. Save the data to the QUASAR file, click **File** and select **Save**. Save All Changes pop-up displays.

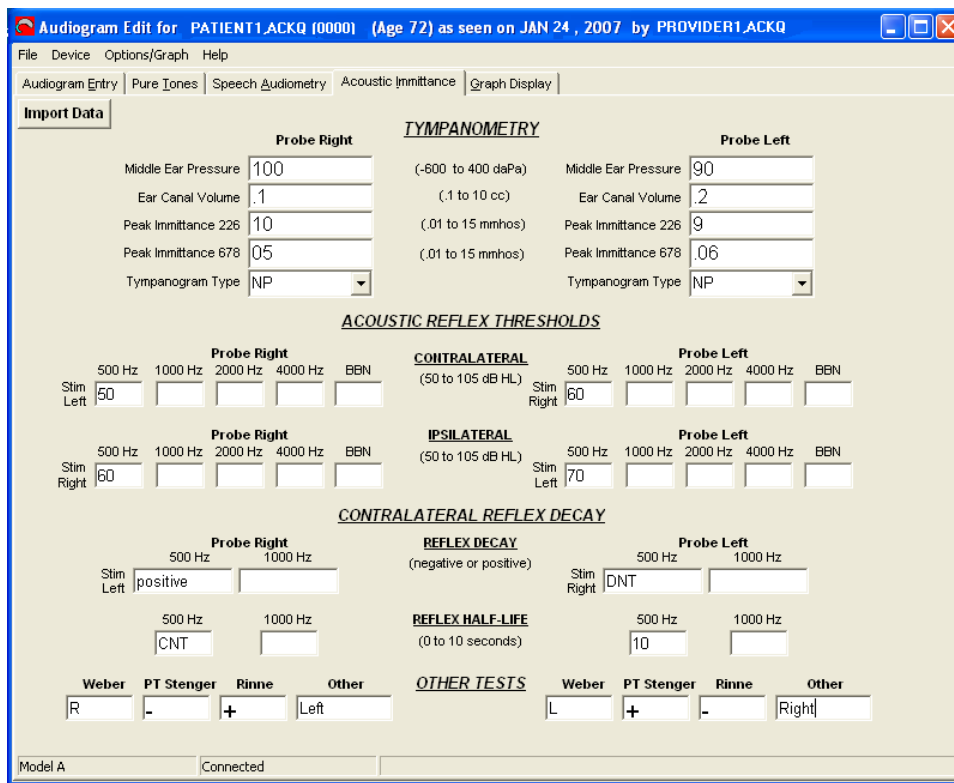


- Click **Yes** to save changes
- Click **No** to discard changes.

# Acoustic Immittance

The Acoustic Immittance tab allows you to enter values for Tympanometry, Acoustic Reflex Thresholds, Contralateral Reflex Decay, and Other Tests, such as, Weber, Rinne, Stenger. All values collected for the Acoustic Immittance tab must be entered manually.

**Note:** Some audiologists use A (absent) or NR (no response). Because this does not indicate the level used, the audiologist is not protected from accusations by the patient that the presentation level was injurious. The level must be documented on the Audiogram Module screen. When there is no response at the maximum permissible level or the patient's comfort level, enter the value followed by +, (105+).



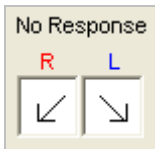
## Acoustic Immittance Fields: Right and Left Ears

Field	Description	Valid Values
<b>Tympanometry</b>		
Middle Ear Pressure		-600 to +400 daPa CNT, DNT, blank
Ear Canal Volume		.1 to 10 cc
Peak Immittance 226		.01 to 15.00 mmhos blank

Field	Description	Valid Values
Peak Immittance 678		.01 to 15.00 mmhos blank
Tympanogram Type	Drop-down list box	As, Ad, A, B, C, Flat (no peak), blank
<b>Acoustic Reflex Thresholds</b>		<b>Probe Right, Probe Left: 500 Hz to 4000 Hz and BBN</b>
Stm Left/Stm Right	Contralateral	50 to 105 dB HL CNT, DNT, blank
Stm Right/Stm Left	Ipsilateral	50 to 105 dB HL CNT, DNT, blank
<b>Contralateral Reflex Decay</b>		<b>Probe Right, Probe Left: 500 Hz and 1000 Hz</b>
Stm Left/Stm Right	Reflex Decay	+ (positive) or – (negative) CNT, DNT, blank
	Reflex Half-life	0 to 10 seconds CNT, DNT, blank
<b>Other Tests</b>		
Weber		R, L, ML, CNT, DNT, blank
PT Stenger	Pure Tones Stenger	+, -, CNT, DNT, blank
Rinne		+, -, CNT, DNT, blank
Other		10-character limit or blank

### ***Acoustic Immittance Values***

- The maximum allowed hearing level for an acoustic reflex threshold, both the probe ear and stimulus ear, is 105 dB.
- When **CNT** (Could Not Test) or **DNT** (Did Not Test) is entered in a **Middle Ear Pressure** field, the Retest field for that frequency and ear is disabled.
- On the audiogram (graphic display) for no response (NR), the no response reflex symbol



, displays at the specified frequency level.

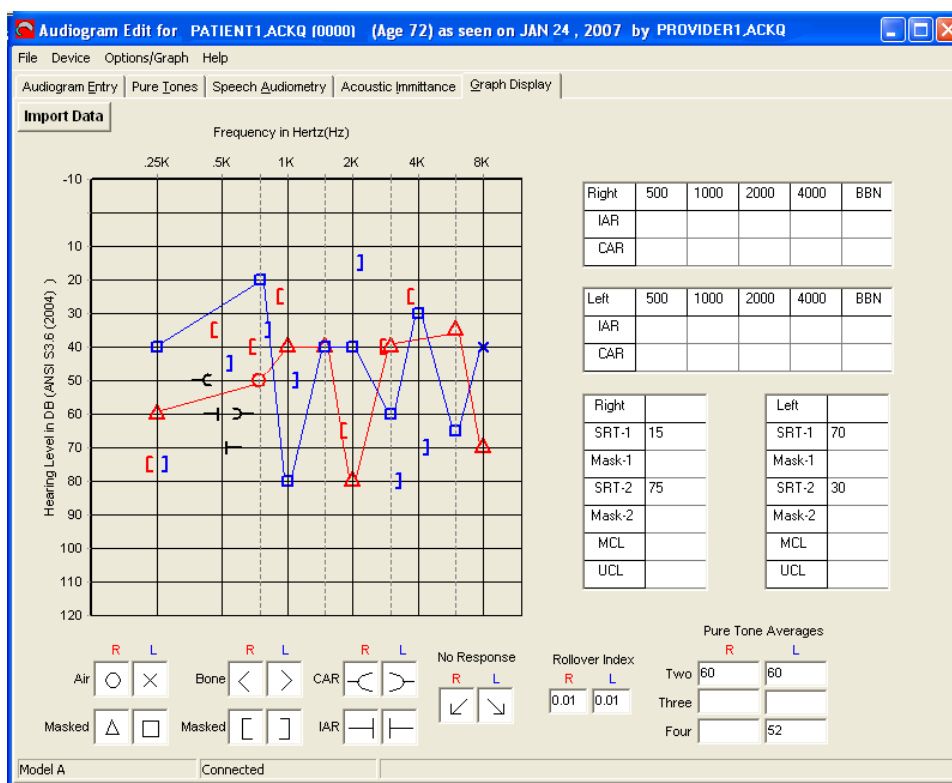
- On the tabular audiogram, VA form 10-2364, the numeric value displays as well as, **CNT** (Could Not Test) and **DNT** (Did Not Test).



## Graph Display

The Graph Display<sup>1</sup> tab allows you to view procedures and functional features applying to the patient's audiometric exam readings in graph format. Graph Display displays audiometric data for both ears in a graphic format and a tabular format (VA form 10-2364, version 2005). The default view is data overlapping for the right and left ears.

The graph in the Audiogram Module reflects the data most recently transferred from the audiometer or data manually entered. Graph Display displays values before they are saved in the QUASAR file. You collect a data point, import it, and view the data point on the Graph Display. Graph Display automatically refreshes to reflect the most recent data.

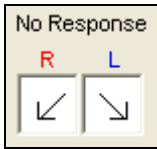


### Graph Display Values

- Data on the graph display is read-only; the data cannot be edited on the graph.
- The frequency is represented in Hertz (Hz).
- Frequency displays logarithmically on the horizontal axis (abscissa) in values from 125 to 8000 Hz.
- The dashed lines for 750, 1500, 3000, and 6000 Hz are placed logarithmically on the graph.

<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 Section added on the Graph Display tab.

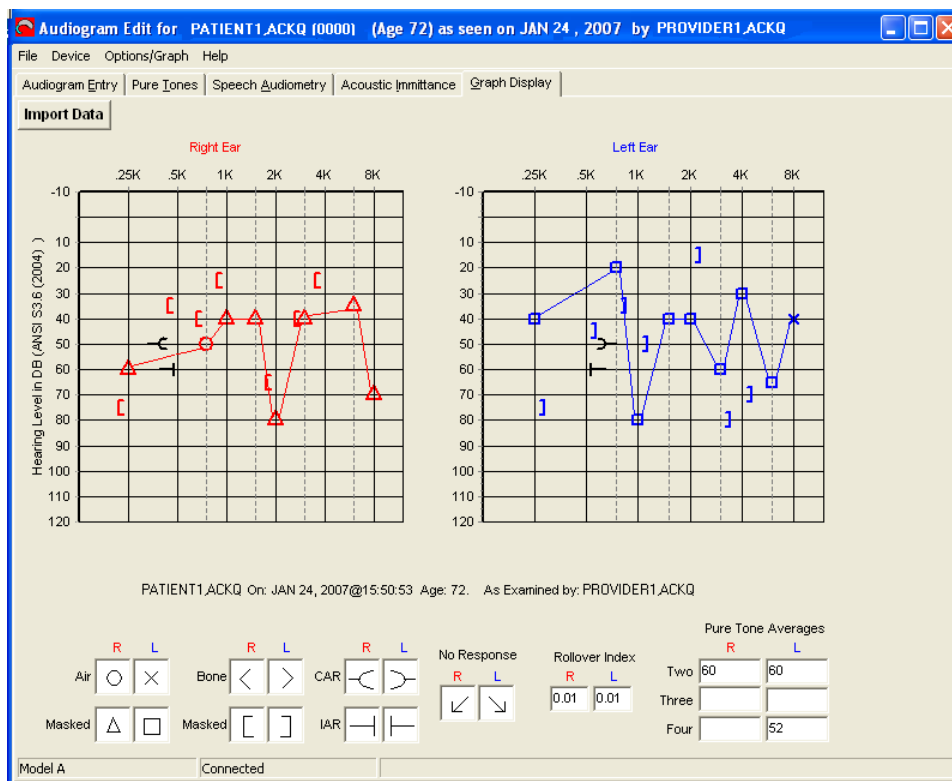
- The hearing level (HL) is represented in decibels (dB). Hearing level displays on the vertical axis (ordinate) in values from -10 to 120 dB.
- Values entered in the Pure Tones **Masked** fields display on the audiogram graph.
- When there is data in both Speech Audiometry SRT text boxes, the **retest** data displays on the audiogram graph.
- If a **Masking Level** field is enabled and a value is entered in that text box, the final value on the audiogram graph displays as *masked*.
- If a final value is not entered and a value for Masking Level is entered, the lower non-zero value in the **Initial** and **Retest** text boxes displays as *masked*.
- On the audiogram (graphic display) for no response (NR), the no response reflex symbol



- displays at the specified frequency level.
- Pure Tone symbols display so that the midpoint of the symbol centers on the vertical ruling and the horizontal axis are at the appropriate hearing level. Additional symbols are offset from the Pure Tone symbols.
- Bone Conduction symbols display adjacent to, but not touching the frequency coordinate ruling, and centered vertically at the hearing level.
- The symbol for the **left ear** is placed to the *right* of the vertical ruling and the symbol for the **right ear** is to the *left* of the vertical ruling.
- NR (No Response) values do not connect on the graph.
- Appendix C: Determining Series Values to Place on the Graph on page 125, explains how values from an audiometric record are selected to display on the audiogram graph when more than one reading is entered for a field, such as, Initial, Retest and Final.
- Appendix F: Calculation of Pure Tone Averages on page 131, provides additional information about the automatic calculation of pure tone averages.

## Graph Display in Separate View

The right ear and left ear graphs can be viewed separately<sup>1</sup> for each ear. The left ear graph displays on the right side and the right ear graph displays on the left side, consistent with the tabular format (VA Form 10-2364) audiogram. The Graph Display tab with the Separate view of the audiogram displayed includes the Rollover Index for R and L, and Pure Tone Averages for R and L/Two/Three/Four.



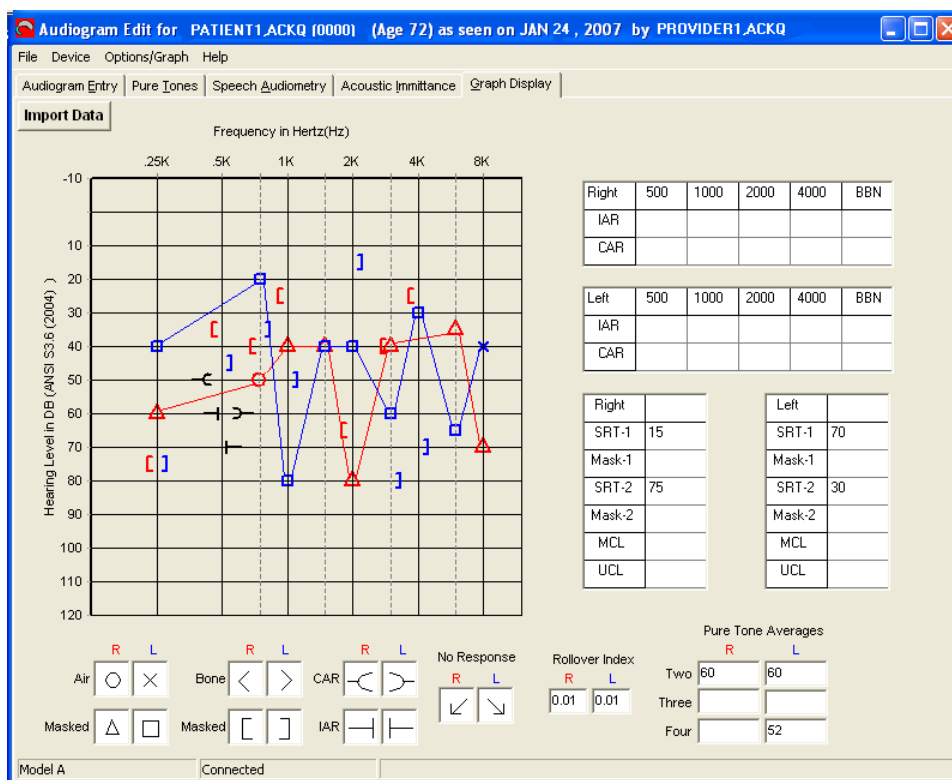
Use the Options/Graph menu to select **Separate** to view the graphs of the right and left ears separately, select **VA form 10-2364** to view a tabular format (VA Form 10-2364) audiogram, and select **Overlap** to return to the default view.

<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 Section added on the separate view of the graph display.

## Graph Display in Overlap View

The Graph Display default view is right ear and left ear series overlapping<sup>1</sup> on a graph. The right ear series displays in red and the left ear series displays in blue. The Graph Display tab with the Overlap view of the audiogram displayed includes R and L values for IAR and CAR, and Right and Left values for SRT-1 and 2, Mask-1 and 2, MCL, and UCL, as well as R and L values for Rollover Index and Pure Tone Averages, Two/Three/Four.

Use the Options/Graph menu to select **Separate** to view the graphs of the right and left ears separately and select **VA form 10-2364** to view a tabular format (VA Form 10-2364) audiogram.



<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 Section added on the overlap view of the graph display.

## Graph Display in Tabular View

The tabular view<sup>1</sup> presents a computer-generated VA Standard form 10-2364 (version 2005), containing only the saved values from the selected audiogram. The values on the form are intended only for printing or viewing.

Use the Options/Graph menu to select **Separate** to view the graphs of the right and left ears separately and select **Overlap** to return to the default view.

The screenshot shows a software window titled "Department of Veterans Affairs" containing a form for "AUDIOLOGICAL EVALUATION". The form is organized into several sections:

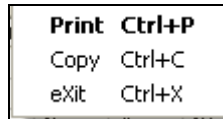
- Header:** DEPARTMENT OF VETERANS AFFAIRS, AUDIOLOGICAL EVALUATION. Fields for Referral Reason and Referral Source.
- AIR CONDUCTION:** Two columns for Right and Left ears. Fields for Examiner Initials, Masking, and Pure Tone Averages (2 FA, 3 FA, 4 FA). A Transducer Type section with checkboxes for Earphone and Insert.
- BONE CONDUCTION:** Two columns for Right and Left ears. Fields for Examiner Initials, Masking, and Pure Tone Averages (2 FA, 3 FA, 4 FA).
- ACOUSTIC IMMITTANCE:** Two columns for Right and Left ears. Fields for Probe (Right/Left), Peak daPa, Weber, Peak Immittance (226 Hz, 678 Hz), Tympanogram Type, Stimulus (Contra AR Thresholds, Reflex Decay, Ipsi AR Thresholds, Half-Life), and Other Tests (WEBER, PT STENGER, RINNE, OTHER).
- SPEECH AUDIOMETRY:** Two columns for Right and Left ears. Tables for RIGHT SRT and LEFT SRT, and RIGHT SPEECH RECOGNITION and LEFT SPEECH RECOGNITION. Includes checkboxes for INTER-TEST CONSISTENCY (GOOD, POOR, FAIR), MATERIAL (MARYLAND CNC, CIDW-22, NU-6, OTHER, SPECIFY), and PRESENTATION (RECORDED, MLV).
- Footer:** Patient Name (Last, First MI), Age, Claim Number, SSN, Examining Station or Clinic, Examining Audiologist, Date of Exam. A note at the bottom states "Computer generated VA form 10-2364 (2005) AUDIOLOGICAL EVALUATION".

<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 Section added on the tabular view (VA form 10-2364) of the graph display. The form is modified to conform with VA standards.

## **VA form 10-2364 Fields**

The VA form 10-2364 is the summation of all the tests performed with patient information. The audiogram must be saved, in order for the current data to display on the VA form 10-2364.

- The **Comment** is pulled from the database to the database and you cannot edit it on VA form 10-2364.
- The **Referral Reason** is pulled from the **Type of Visit** field on the Audiogram Entry tab.
- CNT (Could Not Test) and DNT (Did Not Test) are not used in the VA form 10-2364.
- With the cursor over the form, press the right button on the mouse. A pop-up displays allowing you to print, copy, or exit VA form 10-2364.



## Glossary

<b>Word/Acronym</b>	<b>Definition</b>
API	Application Programmer Interface
Application/Package	Computer programs, files, and documentation developed specifically to meet the requirements of a user or a group of users and support a specific function within VistA: software and documentation that support the automation of a service, such as ROES.
AC	Air Conduction
AR	Acoustic Reflex
ARD	Acoustic Reflex Decay
ASPS/A&SP	Audiology and Speech Pathology Service
BBN	Broad Band Noise
BC	Bone Conduction
Black Box Audiometer	Audiometer that requires proprietary software for conducting audiometric measurements. It lacks physical buttons, sliders, and dials. It relies on proprietary software to accomplish control and interfacing tasks.
C&P	Compensation and Pension
CAPRI	Compensation and Pension Records Interchange
CAR	Contralateral Acoustic Reflex
cc	Cubic Centimeter
CDR	Cost Distribution Report
CNC	Consonant Nucleus Consonant
CNM	Could Not Mask
CNT	Could Not Test
CPRS	Computerized Patient Record System
CPT Codes	Codes listed in the Physicians Current Procedural Terminology Handbook
daPa	decaPascal
dB	Decibel
Denver ALC	Denver Acquisition & Logistics Center A part of the Department of Veteran's Affairs, Office of Acquisition and Logistics, located in Denver, Colorado.

<b>Word/Acronym</b>	<b>Definition</b>
DFN	The internal number of the patient in the PATIENT file (#2).
DLL	Dynamic Link Library
DNT	Did Not Test
DSS	Decision Support System
EM	Effective Masking
FA	Frequency Average
GUI	Graphical User Interface A Windows environment that allows users to interact using a mouse or keyboard.
HCFA	Health Care Financing Administration
HCPCS	HCFA Common Procedure Coding System
HL	Hearing Level
Hz	Hertz
IAR	Ipsilateral Acoustic Reflex
ICD-9-CM	International Classification of Diseases, Ninth Edition, with Clinical Modifications
IRM	Information Resource Management
KERNEL	A set of VistA software routines that function as an intermediary between the host operating system and the VistA application package, such as ROES.
Listener	In ROES, it is the RPC Broker on the workstation and the server.
MCL	Most Comfortable Loudness
ML	Masking Level
MMHO	Millimho mho is a measure of acoustic admittance
Module	GUI part of QUASAR, covering a single topic.
NR	No Response
Package/Application	Computer programs, files, and documentation developed specifically to meet the requirements of a user or a group of users and support a specific function within VistA: software and documentation that support the automation of a service, such as ROES.
PB	Phonetically Balanced
pc	Piece



<b>Word/Acronym</b>	<b>Definition</b>
PCE	Patient Care Encounter
PCMM	Patient Care Management Module
PI/PB	Performance Intensity-Phonetically Balanced
Pr-L	Probe Left
Pr-R	Probe Right
PSAS	Prosthetics and Sensory Aids Service
PTA	Pure Tone Average
QUASAR	Quality: Audiology and Speech Analysis and Reporting
RI	Rollover Index
ROES	Remote Order Entry System A package for ordering various supplies from the Denver ALC.
SAT	Speech Awareness Threshold
SRT	Speech Reception Threshold
SSN	Social Security Number
UCL	Uncomfortable Loudness
UNC	Universal Naming Convention
VACO	Veterans Affairs Central Office
VARO	Veterans Affairs Regional Office
Vea	Acoustic Equivalent Volume Same as Equivalent Ear Canal Volume Vec)
VHA	Veterans Health Administration
VistA	Veterans Health Information Systems and Technology Architecture

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## Appendix A: Black Box Audiometer

The import of data from the software of a black box audiometer<sup>1</sup> to the QUASAR Audiogram Module occurs at the completion of a testing session. The data points collected during the testing assessment are imported all at once into the QUASAR Audiogram Module as a data dump. Information provided in the User Manual applies to the placement and display of the testing data.

The DLL file for the audiometer must be installed in the appropriate directory.

For assistance with the black box audiometer software, refer to the reference guide of the audiometer.

### Importing Data

1. Open CPRS.
2. Select a patient from the Patients list box and click **OK**.
3. Click **Tools** and select **ROES Audiogram Enter/Edit**.
4. Create a new audiogram. Click **Yes**.
5. Type **Now** in the New Exam DATE and TIME text box and click **OK**. In ROES Audiogram Enter/Edit, the Audiogram Edit window displays with the Audiogram Entry tab open.
6. Click **Device**
7. Select **Check Audiometer**.
8. Click **Cancel**.

**Note:** The port number (COM1) may vary. In ROES Audiogram Enter/Edit, the status bar indicates that the black box audiometer is connected.

9. Open the black box audiometer software and perform your testing.
10. Continue collecting data points, until you complete your testing session.
11. In ROES Audiogram Enter/Edit, press **Import Data**. All the data points transfer to the appropriate fields in the Audiogram Module—data dump is complete.
12. Manually edit any necessary fields.
13. In ROES Audiogram Enter/Edit, on the Audiogram Entry tab
  - a. Enter the date in the **DATE SIGNED** text box.
  - b. Save and send the record to the Denver ALC. The record is sent to the Denver ALC.

(Entering a date here and Saving it, LOCKS the entire record and sends it to the Denver ALC)

DATE SIGNED

---

<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 Appendix added about the black box audiometer.

14. Exit the Audiogram Module.

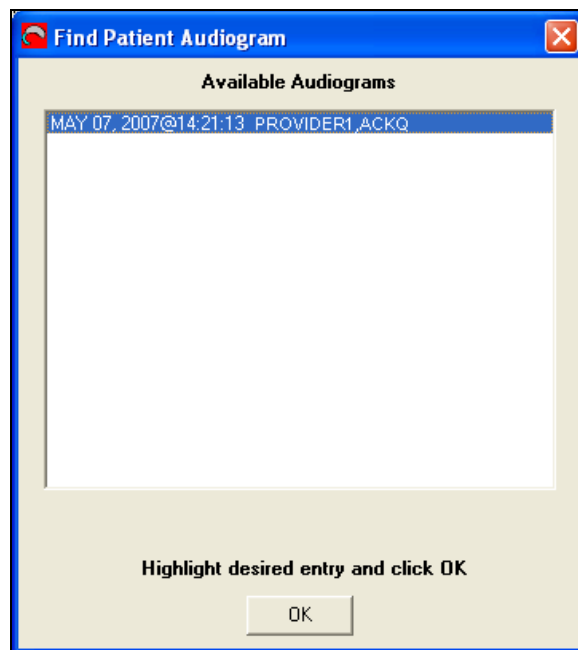
15. Exit CPRS.

## Appendix B: Accessing Audiogram Display

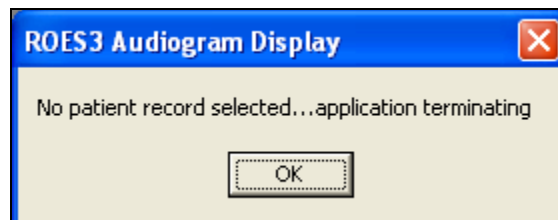
Any doctor with access to the local system can view the Audiogram Display within the application to aid in treatment and diagnosis decisions. They can continue to view the display as assigned in patch ACKQ\*3.0\*12. For information on Audiogram Display, refer to *User Manual - Audiometric Exam Module*, November 2005 in the VistA Document Library.

[http://www.va.gov/vdl/documents/Clinical/Qual\\_Audio\\_Speech\\_Anal\\_\(QUASAR\)/ackq3\\_0\\_p12um.pdf](http://www.va.gov/vdl/documents/Clinical/Qual_Audio_Speech_Anal_(QUASAR)/ackq3_0_p12um.pdf)

1. From the Patient Selection pop-up, select a patient and click **OK**.
2. Click **Tools** and select **Audiogram Display**. The Find Patient Audiogram window displays with a list of audiograms available for the patient.
3. Select an audiogram and click **OK**. The Audiogram Display window displays with the selected audiogram for the patient  
Lookup for exams for the patient is done in the AUDIOMETRIC EXAM DATA file (#509850.9).



4. If no audiogram is available and you click **OK**, the ROES3 Audiogram Display message pop-up displays.



5. Click **OK**. Audiogram Display closes.

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## Appendix C: Determining Series Values to Place on the Graph

There are some key rules for preparing series values for display on the audiogram graph.

The *initial*, *retest* and *final* thresholds, as well as the *final masking* level are obtained, using these rules.

The rules are checked in the following order, until a point is obtained.

Only the final reading contains the *masking* level, if one exists.

1. If the *initial* value is **CNT** (Could Not Test) or **DNT** (Did Not Test), there is no point on the graph.
2. If the *final* reading has a value including +, it is used.
3. If the *retest* value is “”, the *initial* value is used.
4. If the *initial* value is “”, the *retest* value is used.
5. If the *initial value* contains + and the *retest* value does not, the *retest* value is used.
6. If the *initial* value does not contain + and the *retest* value does, the *initial* value is used.
7. If the *initial* value is less than the *retest* value, the *initial* value is used.
8. If a value is in a *retest* field, it is used.
9. If the selected point indicates a *No Response* (+), the symbol appears but does not connect to adjoining values on the display.

The Points to Plot on the Graph<sup>1</sup> flowchart indicates the how-to of determining the points to plot on the audiogram graph. It follows on the next page.

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<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 Added the Points to Plot on the Graph flowchart to *Determining Series Values to Place on the Graph*.

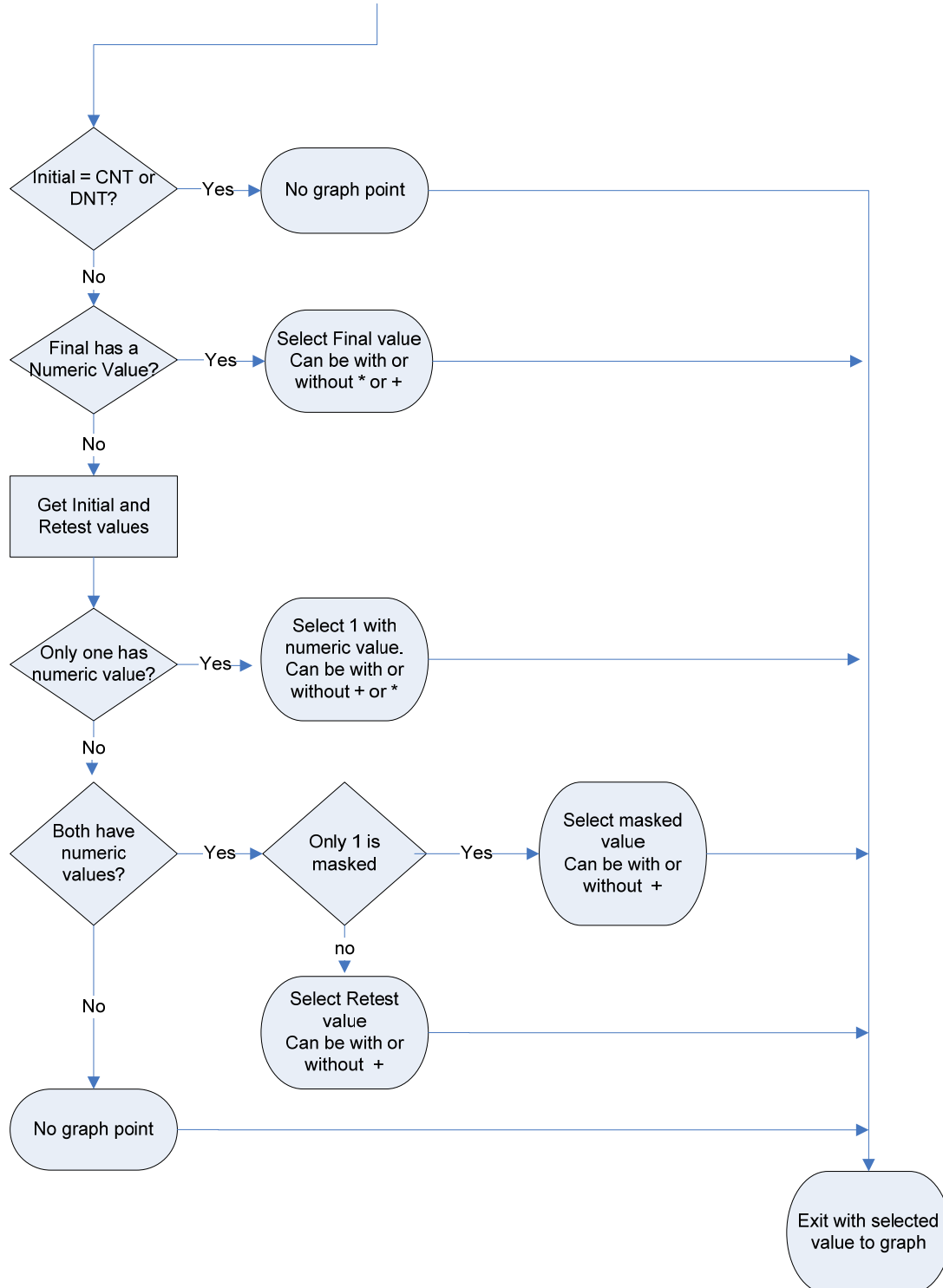
## Points to Plot on the Graph

**Enter** with Initial, Retest, and Final Thresholds and a final Masking Level.

**Exit** with Point to graph.

+ indicates no response (NR).

\* indicates masked value.





## Appendix D: Calculation of PB Max and RI (or PI/PB)

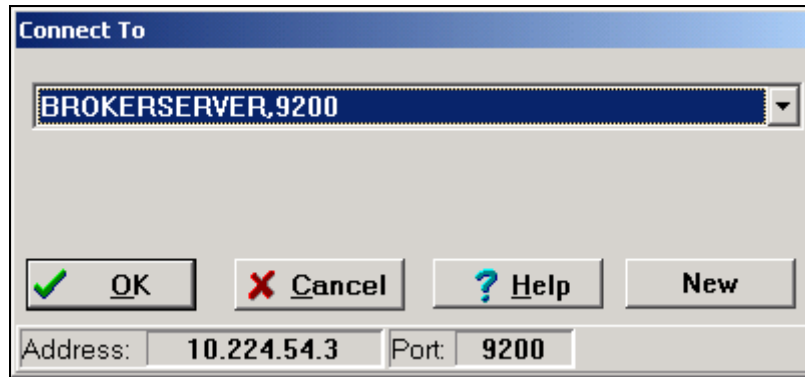
Calculation of the Rollover Index (RI), or Performance Intensity-Phonetically Balanced (PI/PB), value in the Audiogram Module is based on specific profession-standard formulas established for these measurements. Basic descriptions of some of these formulas are as follows:

- PB Max is the default maximum percentage from the word recognition testing. In patch ACKQ\*3.0\*13 the ability to select a PB Max was added for the display of PB Max only. The default PB Max is always used in the RI calculation.
- PB Min is the minimum percentage from the word recognition testing.
- RI or PI/PB is an indicator of possible retrocochlear pathology.  
$$\text{RI or PI/PB} = (\text{PB Max} - \text{PB Min}) / (\text{PB Max})$$
  
The Rollover Index is significant when it exceeds .40.
- The RI or PI/PB index assesses multiple scores and levels in one ear. The calculation occurs only when a second score obtained at a higher presentation level, is poorer than a prior score at a lower presentation level. The result is always a value less than 1.0.

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## Appendix E: Access to Multiple Broker Environments

If you have access to multiple broker environments, (such as, training and development), you need to select an environment on the Connect To pop-up. Your local IRM or ADPAC can provide you with the correct server name.



Select the correct environment from the **Connect To** drop-down list box and click **OK**.

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## Appendix F: Calculation of Pure Tone Averages

Pure Tone Averages (PTA) displayed in the Audiogram Module are automatically calculated and supplied when sufficient information is entered. At each level, the numbers used are the ones that display on the graph for that level. There are three Frequency Average (FA) formulas.

### Frequency Average (FA) Formulas

- 2FA (PTA2) = average of the lowest two readings from 500, 1000, and 2000 Hz
- 3FA (PTA3) = average of the readings from 500, 1000 and 2000 Hz
- 4FA (PTA4) = average of the readings from 1000, 2000, 3000 and 4000 Hz

### Rounding Fives

When a result is exactly midway between two whole numbers (such as, 3.5 is exactly half way between 3.0 and 4.0), it makes just as much sense to round down as it does to round up. Usually there is no harm in using the *always round up* rule, which is often taught in schools and used by computer programs. However, this rounding rule can cause problems when adding a very large number of values (such as, in accounting). The sum can be a little bigger than it ought to be.

The Audiogram Module uses the *odd-even* rule.

- If the five is the last significant digit and the round-off digit (digit to the left of the .5) is odd, round up.
- If the five is the last significant digit and the round-off digit (digit to the left of the .5) is even, do not round up.

**Note:** The Audiogram Module and the CPRS audiogram use the same rounding rules for decimal fractions 0-4 and 6-9. The two systems differ on rounding decimals exactly equal to .5. The rounding rule used in this program is: if the average is exactly halfway between two whole numbers, the result rounds to the even number. This method of rounding is often called *Banker's Rounding*.

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## Appendix G: VA FileMan Date/Time Formats

Examples of valid dates:

JAN 20 1957 or 20 JAN 57 or 1/20/57 or 012057

T (TODAY), T+1 (TOMORROW), T+2, T+7, and so on

T-1 (YESTERDAY), T-3W (3 WEEKS AGO), and so on

- If the year is omitted, the system uses current year.
- A two-digit year assumes no more than 20 years in the future or 80 years in the past.
- If only the time is entered, the system assumes current date.
- The date is followed by a time, such as JAN 20@10, T@10AM, 10:30, and so on.
- Enter time as NOON, MIDNIGHT or NOW.
- Enter NOW+3' for current date and time plus 3 (minutes apostrophe).

**Note:** Time is REQUIRED for the **Date/Time of Exam** field in order to establish the entry.

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## Appendix H: Message Box Errors

The following is a list of error messages<sup>1</sup> that display for the listed reason.

<b>Error</b>	<b>Reason</b>
<i>A needed RPC XXXXXXXXX is not available.</i>	Contact your IRM. The 'XWB IS RPC AVAILABLE' remote procedure call returned FALSE for RPC XXXXXXXXX. IRM needs to install this RPC in order for the action to be workable.
<i>A problem was encountered accessing Vista, RPC XXXXX.</i>	Contact your IRM Service. The Broker call to remote procedure XXXXX failed.
<i>A problem was encountered communicating with the server.</i>	The RPCBroker call to the server was tried for a remote procedure, but it failed.
<i>A problem with the RPC call - no data to graph.</i>	The expected data for the selected entry was not returned by the remote procedure call.
<i>Application Canceled. Or unable to access RPCBroker.</i>	Broker.Connected returned False.
<i>Cannot continue without Patient.</i>	Patient identification number DFN is undefined or nil.
<i>Broker Server could not be determined.</i>	The program did not pick up the name of the broker server or the port.
<i>Connection to Broker Server could not be established.</i>	The server and port selected could not be activated.
<i>No Charts to Show! Audiogram Terminating.</i>	Called the View Audiogram option for a patient that has no data in file 509850.9.
<i>No Patient to lookup.</i>	An attempt was made to continue without a patient selected. (DFN undefined or nil).
<i>Patient not selected.</i>	An attempt was made to continue without a patient selected.
<i>Problem encountered in setting up message - no data sent!</i>	XMZ < 1 was returned from the MailMan setup call.
<i>Problem saving entries for Acoustic Immittance!</i>	A change on the Acoustic Immittance tab was not saved because the database would not accept it. Exiting and coming back to the page causes the faulty entry to be missing.

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<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 Message Box Errors appendix is moved from the technical manual to the user manual.

<b>Error</b>	<b>Reason</b>
<i>Problem saving entries for Left Ear!</i>	A change to the Left Ear was not saved because the database would not accept it. Exiting and coming back to the page causes the faulty entry to be missing.
<i>Problem saving entries for Right Ear!</i>	A change to the Right Ear was not saved because the database would not accept it.
<i>Record NOT sent to Denver ALC.</i>	The setup of the transfer message failed after entering a DATE SIGNED. Another attempt could be made by having IRM remove the entry in the DATE SIGNED field in 509850.9. Then use the GUI again to sign the audiogram edit.
<i>The Audiogram Option is not approved for this user.</i>	Someone is attempting to access option ACKQROES3E when it is not on their menu tree.
<i>The XXXXXXXX program[option name] could not be accessed.</i>	Terminating application. The CreateContext for the application failed - not in user's menu tree.
<i>There was a problem deleting the record.</i>	The delete button was pressed, but the DIK call returned an error.
<i>User identification could not be established.</i>	The DUZ was not defined, or the XUS GET USER INFO RPC returned an error
<i>You are not authorized to use the Audiogram Enter/Edit program [ACKQROES3E]. Terminating application...</i>	Someone is attempting to access option ACKQROES3E when it is not on their menu tree.
<i>Users station not added. Station in record is blank.</i>	The program picked up an invalid pointer to the Institution file.

## Appendix I: Shortcut Keys

The following is a list of shortcut keys<sup>1</sup> for the QUASAR Audiogram Module GUI.

Window	Option/Text	Shortcut	Action/Opens
<b>Audiogram Edit</b>	<b>File</b> menu	Alt, F	Opens the File menu
	Get New Record	Ctrl, G	
	Save	Ctrl, S	
	Print	Ctrl, P	
	Retransmit Record	Ctrl, T	
	Delete Record	Ctrl, D	
	No Hints/Enable Hints	Ctrl, N	
	Hide Import Button/ Show Import Button	Ctrl, B	
	Flip Tabs	Ctrl, F	
	Exit	Ctrl, E	
	<b>Device</b> menu	Alt, D	Opens the Device menu
	Configure Audiometer	Ctrl, C	
	Check Audiometer	Ctrl, H	
	Import Data	F10 or Ctrl, I	
	<b>Options/Graph</b> menu	Alt, O	Opens the Options/Graph menu
	Overlap	Ctrl, O	
	Separate	Ctrl, S	
	VA form 10-2364	Ctrl, V	
	<b>Help</b> menu	Alt, H	Opens the Help menu

<sup>1</sup>Patch ACKQ\*3.0\*13 July 2007 Section added on shortcut keys.

Window	Option/Text	Shortcut	Action/Opens
	About	Ctrl, A	
	Page Help	Ctrl, H	Click a tab and press F1
<b>Audiogram Entry</b> tab		Click Tab Ctrl, E Alt + E	
		Tab	Move from field to field
<b>Pure Tones</b> tab		Click Tab Ctrl, T Alt + T	
		Tab	Move from field to field
<b>Speech Audiometry</b> tab		Click Tab Ctrl, A Alt + A	
		Tab	Move from field to field
<b>Acoustic Immittance</b> tab		Click Tab Ctrl + I Alt + I	
		Tab	Move from field to field
<b>Graph Display</b> tab		Click Tab Ctrl, G Alt + G	
		Tab	
	<b>VA form 10-2364</b>	Right-click mouse on form to access options	Opens the VA form 10-2364

<b>Window</b>	<b>Option/Text</b>	<b>Shortcut</b>	<b>Action/Opens</b>
	Print	Ctrl + P	
	Copy	Ctrl + C	
	Exit	Ctrl + X	Close the VA form 10-2364

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