

# Medical Documentation

## Gastroenterology Procedures

### Quick Reference Guide – All Regions

#### Key Points:

- ➔ Medical documentation/records are required for services provided to a Veteran under the Department of Veterans Affairs (VA) Community Care programs.
- ➔ VA requires providers to submit medical documentation directly to the Veteran's authorizing VA Medical Center (VAMC).
- ➔ VA may reach out for additional medical documentation for care coordination purposes.
- ➔ Providers should submit medical documentation to the authorizing VAMC as soon as possible, but no later than 30 days following the date of service.

#### General Medical Documentation Content Requirements:

VA's Community Care programs require medical documentation for the initial appointment evaluation and end-of-episode/end-of-care summary records. Some specialties may have additional documentation requirements.

VA requires providers to submit all medical documentation directly to the Veteran's authorizing VAMC. Records should include Veteran identification, including at minimum:

- ➔ Veteran's name
- ➔ Veteran's date of birth
- ➔ Last four digits of Veteran's Social Security number
- ➔ Authorization number

For more detailed information on timelines for document submission, please read TriWest's [Quick Reference Guide on Medical Documentation](#).

## Additional Documentation for Gastroenterology Procedures:

Medical documentation for gastroenterology procedures (e.g., colonoscopy, sigmoidoscopy, esophagogastroduodenoscopy [EGD], endoscopic retrograde cholangiopancreatography [ERCP] and endoscopic ultrasonography [EUS]) must submit to the authorizing VAMC and must include the following:

- ➔ Procedure performed (e.g. colonoscopy with biopsy)
- ➔ Procedural indication
- ➔ Sedation medications and doses
- ➔ Description of the quality of the bowel preparation (for colonoscopy or sigmoidoscopy)
- ➔ Depth of insertion of the endoscope/completeness of the procedure
  - ➔ If the procedure is incomplete, an explanation must be provided
- ➔ Description of all relevant findings, for example:
  - ➔ Number and size of polyps
  - ➔ Presence of hemorrhoids, diverticulosis, colitis, stricture, etc.
- ➔ Full description of all interventions
- ➔ If polypectomy is performed, the provider must indicate whether or not the lesion was completely removed
- ➔ Description of any unanticipated events or adverse events
- ➔ If specimens were removed for pathologic assessment, then a copy of the pathology results must be included
- ➔ Summary assessment and recommendations, including any recommended follow-up.
- ➔ If specimens were removed for pathologic assessment, then final recommendations taking into account the pathology results must be included.

Please note that abnormal or critical findings should also be reported within 48 hours. For additional details on Medical Documentation, please refer to our Quick Reference Guide.

**The prompt return of medical documentation is crucial for care coordination. To ensure Veterans can receive timely care, VA may call to request status updates and additional or expedited medical documentation.**