



RESOURCE AND PATIENT MANAGEMENT SYSTEM

# **IHS PCC Suite**

(BJPC)

## **Data Entry Supervisor's Manual**

Version 2.0 Patch 7  
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## Preface

The Patient Care Component (PCC) Supervisor/Manager is the key to PCC's success or failure. The supervisor/manager must be knowledgeable in both the Resource and Patient Management System (RPMS) and medical records. A thorough working knowledge in the International Classification of Disease (ICD) coding system and PCC data entry are mandatory. This can be accomplished through one or several people, depending on the resources at your site. The PCC supervisor is ultimately responsible for making sure data are as accurate as possible and accessible in a timely and reasonable manner.

This manual demonstrates the supervisory functions that are performed in the PCC Data Entry Module. In addition to this manual, refer to the PCC Data Entry Operator, PCC Data Entry Mnemonics, and PCC Transmission manuals for more details regarding the role of the PCC Supervisor. The following topics are discussed in this manual:

- Customizing the data entry operations
- Quality control of data entry operators
- Quantity control of data entry operators
- Resolving uncoded diagnoses
- IHS edits on ICD codes

## 1.0 PCC Manager Menu

The PCC Manager Menu, shown below, contains options that will be performed by the PCC supervisor and/or site manager. Each is described in detail in standalone PCC manuals. See your Area Information Systems Coordinator (ISC) to order copies, or check the IHS web site <http://www.ihs.gov>, because many RPMS manuals are now downloadable in .PDF format.

```
PCC  Patient Care Data Entry Menu ...
UTIL Utilities For Auto-Coding System ...
HS   Health Summary ...
PCCX PCC Data Transmission Menu ...
```

```
Select PCC Manager Menu Option: PCC
```

This menu is discussed in detail in the PCC Data Entry Operator's manual.

The PCC Data Transmission Menu (PCCX) menu is not covered in this manual. These reports are part of the PCC Data Transmission and are discussed in detail in the Transmission manual. The Visit Review Report (VRR) has been placed on the Supervisor menu for easy access purposes only.

The following screens display the sequence of menus necessary to access the PCC Supervisor menu. Your site manager or area might have customized other means to access these features.

To access the supervisor's responsibilities menu, type PCC at the "Select PCC Manager Menu Option" prompt to display the PCC Data Entry Module, shown below.

```
*****
**   PCC Data Entry Module   **
*****
Version 2.0
```

```
DEMO INDIAN HOSPITAL
```

```
ENT  Enter/Modify/Append PCC Data ...
DSP  Display Data for a Specific Patient Visit
PEF  Print a PCC Visit in Encounter Form format
UPD  Update Patient Related/Non Visit Data ...
DEU  Data Entry Utilities ...
GHS  Generate Health Summary
BHS  Browse Health Summary
DVB  Display a PCC Visit w/limited Lab Display
PDV  Print a PCC Visit Display to a Printer
```

```
Select Patient Care Data Entry Menu Option: DEU
```

### 1.1 Data Entry Utilities (DEU)

The DEU option displays the following menu:

```

*****
**      PCC Data Entry Module      **
** Data Entry Utilities Menu **
*****

Version 2.0

DEMO INDIAN HOSPITAL

LST      List Visits for a Patient in a Date Range
GHS      Generate Health Summary
AUN      Find CHS Entry for a Given Authorization Number
MRG      Merge two Visits on Same Date
DEL      Delete All Data For A Visit
SUP      Data Entry SUPERVISORY Options and Utilities ...
BHS      Browse Health Summary
COD      Display IHS Coding Guidelines
GC       Pediatric Growth Charts
MR2      Merge 2 Visits on 2 Different Dates
MV2D     MV2D Move Data from one visit to a different date
MVD      Move Data Items from One Visit to Another
RGF      Reprint Group PCC Visit Forms

Select Data Entry Utilities Option: SUP

```

The SUP option (on the Data Entry Utilities Menu) displays the following menu:

```

*****
**      PCC Data Entry Module      **
** Data Entry SUPERVISOR Options and Utilities**
*****

Version 2.0

DEMO INDIAN HOSPITAL

ICD      Fix UNCODED ICD9 Diagnoses/Operations ...
VRR      Visit Review Report ...
INP      Link In-Hospital Visits to Hospitalizations ...
DSP      Display PCC Data Entry Site Parameters
ACC      Process ACCEPT Commands ...
DDPR     Delete Duplicate Primary Providers from Visits
ESP      Enter/Edit PCC Data Entry Site Parameters
EVM      Auto Merge Event Visits on Same Day
FTM      Forms/Data Entry Tracking Menu ...
LAB      Complete Orphaned Visits Menu ...
MDL      Visit Re-linker/Merge/Delete Log Reports ...
MNE      Update PCC Mnemonic's Allowed/Not Allowed
OTH      Other PCC Data Entry Reports ...
PLAL     Reports Listing Allergies recorded on PROBLEM LIST ...
PMN      Print list of Data Entry Mnemonics
RET      Re-Submit PCC Visit to the IHS Data Center
TAB      PCC Local Table Maintenance ...

UPMC     Update PCC Master Control File

```

Select Data Entry SUPERVISOR Options and Utilities Option:

The Visit Review Report (VRR) has been placed on the Supervisor menu for easy access purposes only. This option will not be reviewed in this manual.

## 1.2 Overview of Using the Prompts

Below is information about entering or using the prompts.

### 1.2.1 Entering Patient Name

Many of the prompts ask you to enter the patient name.

Identify the patient in one of the following ways:

- Type the Patient's NAME or a portion of the NAME in the following format: HORSECHIEF,JOHN DOE or HORSECHIEF,JOHN. Use the following guidelines:
    - Use from 3 to 30 letters.
    - A comma must follow the last name.
    - If 'JR' or 'II', etc, is included, follow the form SMITH,JOHN MARK,JR.
    - NO SPACES after commas.
  - Type the patient's IHS chart number.
  - Type the patient's date of birth (DOB) in one of the following forms:
    - B012266
    - Any valid date, such as 01/22/66, 01-22-66, or JAN 22,1966.
  - Type the Patient's social security number (SSN) or the last 4 digits of the SSN.
  - If the patient is an inpatient enter the ward or room-bed number in the following form: 66-2 PEDIATRICS
- Otherwise, type ?? to view a list of valid entries.

### 1.2.2 Entering Dates

Many of the prompts ask you to enter a date. The following are examples of valid dates:

- JAN 20 1957 or 20 JAN 57 or 1/20/57 or 012057.
- T (for TODAY), T+1 (for TOMORROW), T+2, T+7, etc.
- T-1 (for YESTERDAY), T-3W (for 3 WEEKS AGO), etc.
- If the year is omitted, the computer assumes a date in the past.
- You can omit the precise day (for example, JAN, 1957).

### 1.2.3 Accessing the Help Screen

To access the help screen for many of the prompts, type ?? and press the Return key. For example, if the prompt is “Enter Clinic,” and you want to know the available clinics, use the ?? method to list the clinics.

## 2.0 Release Notes

BJPC v2.0 patch 7 contains the following modifications and enhancements.

### 2.1 PCC Data Entry (APCD)

The following changes apply to the APCD application.

#### 2.1.1 New Patient Goal Component

Added the new option, PATG Patient Goals Update, to the UPD Update Patient Related/Non-Visit Data menu. The option is in List Manager format. The user can enter, modify, and delete patient goals and steps along with progress notes.

#### 2.1.2 Mnemonic Changes

- EX: result is now required on all exam entries
- ER: urgency levels have been modified to include the following:
  - R Resuscitation (1)
  - E Emergent (2)
  - U Urgent (3)
  - L Less Urgent (4)
  - N Routine (5)
- PED: Patient education topics can now be added using CPT codes.
- BM: Birth Length field added.
- RF: Added new fields; DES Daughter?, Age at First Menses, Age at First Vaginal Intercourse, Age at Onset of Menopause
- FP: Added the new fields below.
  - DES DAUGHTER?
  - AGE at FIRST MENSES
  - AGE at FIRST VAGINAL INTERCOURSE
  - AGE at ONSET of MENOPAUSE
  - CURRENTLY PREGNANT?
  - PROVIDER WHO UPDATED CURRENTLY PREGNANT
  - EDD (METHOD UNKNOWN)
  - PROVIDER WHO DOCUMENTED EDD (METHOD UNKNOWN)
  - EDD (METHOD UNKNOWN) COMMENT
  - EDD (LMP)
  - PROVIDER WHO UPDATED EDD (LMP)

- EDD (LMP) COMMENT
- EDD (ULTRASOUND)
- PROVIDER WHO UPDATED EDD (ULTRASOUND)
- EDD (ULTRASOUND) COMMENT
- EDD (CLINICAL PARAMETERS)
- PROVIDER WHO UPDATED EDD (CLINICAL PARAMETERS)
- EDD (CLIN PARAMETERS) COMMENT
- DEFINITIVE EDD
- PROVIDER WHO UPDATED DEFINITIVE EDD
- DEFINITIVE EDD COMMENT
- LACTATION STATUS
- Added the option to add, edit or delete a contraceptive method. The ability to record multiple contraceptive methods for a patient is available and the list of contraceptive methods available to choose is expanded.
- PV, IPV, PPV, and SPV: Modified these mnemonics to prompt for a First/Revisit entry when an injury is added. When the user is in Modify (MOD) mode the First/Revisit prompt displays for injury and non-injury entries.
- Added an encounter provider prompt to the following mnemonics:
  - Any measurement (BP, WT, HT, etc)
  - Any Purpose of Visit (PV, IPV, PPV, SPV, UPV)
  - Any CPT entry (ACPT, CPT, PCPT)
  - ADA codes (ADA)
  - Operation entry (OP, AOP, UOP)
  - Diagnostic procedure entry (DXP)
  - Elder care entry (EL)
  - Eye Glass entry (GP)
  - Health Factor entry (HF)
  - Infant Feeding Choice (IF)
  - Lab entry (LAB)
  - Physical Therapy entry (PT)
  - Radiology Exam entry (RAD)
  - Skin Test entry (ST, STP)
  - Immunization entry (IM)
  - Medication (RX)
  - Emergency Room (ER)

### 2.1.3 Mnemonics: New

- PTG: Patient Goal mnemonic which allows access to the new Patient Goal component
- EGA: New Estimated Gestational Age measurement
- MMSE: New Mini Mental Status Exam measurement

### 2.1.4 Health Factors: New and Modified

- Category Health Literacy and its associated factors are inactivated.
- Category Barriers to Learning:
  - Factors Childhood Development, Learning Disability, Developmental Delay, <6<sup>th</sup> Grade Education, and Social Stressors are inactivated.
  - Renamed factor Emotional Stressors to Stressors.
  - Added factors Low Health Literacy and Cognitive Impairment.

### 2.1.5 Coding Queue Changes

- EHRD/PEHR: added View Any Visit and View BH Note actions.
- EHRD/PEHR: added Status Update action prompt that allows users to edit or delete chart audit notes when a visit is marked as Reviewed/Complete.
- EHRD: added No Primary Visit Provider and No Clinic Assigned to the selection list of visit choices.
- PEHR: added Change Patient action to allow the user to switch patients without going back to the menu.

## 2.2 PCC Health Summary (APCH)

The following modification applies to the APCH application.

### 2.2.1 Health Summary Modifications

- Added Lactation Status, Current Contraception Methods and EDD information to the Reproductive History - Brief and Reproductive History – All EDDs components.
- Modify Health Summary: added a health summary definition parameter “Display Comments w/Reasons Service Not Done:” under the General Info selection option. Enter “Yes” to allow refusal comments to display in the refusal components.
- Added a Patient Goal Component.
- Added the new option, Generate a Health Summary Supplement, to the Health Summary Menu. The option allows a user to print or view a supplement without a summary type defined.

## 2.2.2 Health Maintenance Reminders

- Removed V72.31 from the Pap Smear reminder logic.

## 2.2.3 Patient Wellness Handout

- The following new components are available:
  - Anticoagulation
  - Appointments
  - Diabetes Screening
  - Education Forms
  - Family History
  - Intake Forms
  - Pediatric Screening
  - Procedures
  - Recent BP History
  - Recent Weight History
- The Patient Goal component is modified to include goals from the new Patient Goals functionality.
- The Quality of Care Transparency Report Card is inactivated.

## 2.3 PCC Management Reports (APCL)

The following changes apply to the APCL application.

### 2.3.1 PGEN/VGEN

- The following data elements have been added to PGEN as search items:
  - Contraception Method
  - EDD (Any/All types)
  - Definitive EDD
  - EDD (LMP)
  - EDD (Ultrasound)
  - EDD (Clinical Parameters)
  - EDD (Method Unknown)
  - EDD (Last Documented)
- The following data elements have been added to VGEN as search items:
  - Visit Auditor
  - Any Immunization Administered?

- EDD (Any/All types)
- Definitive EDD
- EDD (LMP)
- EDD (Ultrasound)
- EDD (Clinical Parameters)
- EDD (Method Unknown)
- EDD (Last Documented)
- Contraceptive Methods

### 2.3.2 QMAN (AMQQ)

The following have been added to QMAN as search attributes:

- Hospital Location
- Patient Registration Inactivation Date
- IMM Patient Active
- IMM Patient Inactive
- VFC Eligibility

### 2.3.3 Management Report Changes

- RTI Returns to Clinic w/in 72 hours report: Added two new prompts:
  - Ask for same diagnosis - if the user answers yes,
  - only visits with the same primary diagnosis are listed.
  - Include Incomplete Visits? If the user answers yes, incomplete visits will be listed.
- Added totals to reports, DP Patient Listing by Primary Care Provider and VDP Pts by Designated Primary Care Prov w/Visit Counts.
- Added the ability to run the reports CH Community Health Profile Summary and PPDS Provider Practice Description Report using a search template of patients.
- PCCV reports: Added ability to print totals for all visits, regardless of encounter location.

## 2.4 Other

DM Data Entry Option: Added the message “the data you enter for the above patient will be updated in the PCC database. Do you wish to continue? Y/N.”

## 2.5 Designated Specialty Provider Management

A new report, “NODP List of Patients with No,” is available.

### 3.0 Uncoded Diagnoses

The options and utilities on the Supervisor menu are shown below:

```

*****
**                               PCC Data Entry Module                               **
** Data Entry SUPERVISOR Options and Utilities**
*****
                               IHS PCC Suite Version 2.0

                               DEMO HOSPITAL

ICD   Fix UNCODED ICD9 Diagnoses/Operations ...
VRR     Visit Review Report ...
INP     Link In-Hospital Visits to Hospitalizations ...
DSP     Display PCC Data Entry Site Parameters
ACC     Process ACCEPT Commands ...
DDPR    Delete Duplicate Primary Providers from Visits
ESP     Enter/Edit PCC Data Entry Site Parameters
EVM     Auto Merge Event Visits on Same Day
FTM     Forms/Data Entry Tracking Menu ...
LAB     Complete Orphaned Visits Menu ...
MDL     Visit Re-linker/Merge/Delete Log Reports ...
MNE     Update PCC Mnemonic's Allowed/Not Allowed
OTH     Other PCC Data Entry Reports ...
PLAL    Reports Listing Allergies recorded on PROBLEM LIST ...
PMN     Print list of Data Entry Mnemonics
RET     Re-Submit PCC Visit to the IHS Data Center
TAB     PCC Local Table Maintenance ...
UPMC    Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 3-1: Data Entry SUPERVISOR Options and Utilities menu

The PCC supervisor uses the Fix Uncoded ICD9 Diagnoses/Operations (ICD) option to correct diagnoses containing the .9999 Uncoded diagnoses code entered by operators during data entry.

The .9999 is entered when an operator cannot obtain the correct code during initial entry of the diagnoses. Because a .9999 can prevent a visit from transmitting to the Data Center, a routine clean-up is required. These options should be run regularly (at least once a week) when starting PCC. Later, monthly runs as part of the PCC transmission process should be sufficient. Frequency will vary and depend on the data entry staff and their knowledge of ICD coding and provider documentation.

The PCC supervisor uses the ICD9 printouts when customizing local ICD files in the Utilities for Auto-Coding. Numerous instances and/or consistent patterns of the .9999 code might indicate that an operator requires training in one or more areas of ICD coding.

The samples that follow display examples of using the Fix option. The computer continues to loop with the question “CONTINUE Y//” after each .9999 entry, but you can get out of the Fix menus at any time by typing N.

After selecting ICD at the “Select Data Entry SUPERVISOR Options and Utilities Option” prompts, the following menu is displayed:

```

*****
**                PCC Data Entry Module                **
**  Fix UNCODED ICD9 Diagnoses/Operation Codes  **
*****
                IHS PCC Suite Version 2.0

                DEMO INDIAN HOSPITAL

POV  Fix Uncoded Purpose of Visit Diagnoses
PRB  Fix Uncoded PROBLEM File Diagnoses
PER  Fix Uncoded PERSONAL HISTORY Diagnoses
FAM  Fix Uncoded FAMILY HISTORY Diagnoses
OPS  Fix Uncoded V PROCEDURE Operation Codes
PPV  Print a list of all Uncoded Diagnoses/Operations

Select Fix UNCODED ICD9 Diagnoses/Operations Option:

```

Figure 3-2: Options on the Fix Uncoded ICD9 Codes menu

You can search for uncoded diagnoses or codes beginning at any date. To retrieve all uncoded diagnoses or codes, use a very early date like 01/01/1930. To review data for visits in the past week only, enter T-7.

## 3.1 Overview of Uncoded Diagnoses and Codes Options

This section provides an overview of the uncoded diagnoses and codes options (POV, PRB, PER, FAM, OPS).

### 3.1.1 Fix Uncoded Purpose of Visit Diagnoses (POV)

Use the POV option to access all purpose of visits containing the .9999, Uncoded Diagnoses code.

- An ambulatory visit containing the .9999 code in the Primary and/or Secondary Purpose of Visit field excludes that entire visit record from transmitting to the Data Center.
- An inpatient visit containing the .9999 code in any of the 1-6 Purpose of Visits fields excludes that entire visit record from transmitting to the Data Center.

Also, the data entry operator must maintain the Provider Narrative verbatim. This is your guide in determining the proper code.

### 3.1.2 Fix Uncoded Problem File Diagnoses (PRB)

Use the PRB option to access all active and inactive problems containing the .9999, Uncoded Diagnoses code in the Problem file. These codes do not affect the data transmission process; however, research, output, and future data entry on your local computer will be affected if these codes are not corrected.

### 3.1.3 Fix Uncoded Personal History Diagnoses (PER)

Use the PER option to access all .9999, Uncoded Diagnoses codes in the Personal History file. These codes do not affect the data transmission process; however, research, output, and future data entry on your local computer will be affected if these codes are not corrected.

### 3.1.4 Fix Uncoded Family History Diagnoses (FAM)

Use the FAM option to access all .9999, Uncoded Diagnoses codes in the Family History file. These codes do not affect the data transmission process; however, research, output, and future data entry on your local computer will be affected if these codes are not corrected.

### 3.1.5 Fix Uncoded V Procedure Operation Codes (OPS)

Use the OPS option to access all .9999, Uncoded Diagnoses codes in the Operation/Procedure file.

- An ambulatory visit containing the .9999 code in the first procedure field excludes that entire visit record from transmitting to the Data Center.
- An inpatient visit containing the .9999 code in any of the 1-3 Procedure fields excludes that entire visit record from transmitting to the Data Center.

## 3.2 Prompts for Uncoded Diagnoses and Codes Options

The prompts for the POV, PRB, PER, FAM, and OPS options are the same, as shown below.

1. At the “Enter the Beginning Date to Search for Uncoded V POV’s” prompt, specify the beginning date for the search. (The words “V POV’s” will vary according to the option you are using.)
2. At the “Enter code indicating what LOCATIONS/FACILITIES are of interest” prompt, type one of the following:
  - A - ALL Locations/Facilities
  - S - One SERVICE UNIT’S Locations/Facilities
  - O - ONE Location/Facility

If you type **S** or **O**, other prompts will be displayed.

- The system asks if you want to continue. If you type **Y**, the output begins. If you type **N**, you return to the “Select UNCODED ICD9 Diagnoses/Operations Option” prompt.

Below is a sample output using the VPOV option.

```

Searching the V POV File

Continue? Y// y YES

NAME: CARRICK,DAVID PAUL DOB: SEP 4,1944 SEX: M HRN: 110051
DATE OF VISIT: MAR 6,2001 10:30 LOC: HOME

PROVIDER NARRATIVE: S/P STROKE
POV: .9999//

Continue? Y// y YES

NAME: GOLDEN,JEFFERY SCOTT DOB: JAN 24,1935 SEX: M HRN: 131899
DATE OF VISIT: APR 17,2001 13:00 LOC: DEMO INDIAN HOSPITAL

PROVIDER NARRATIVE: ILLEGIBLE TO BE ADDED LATER
POV: .9999//

Continue? Y//

```

Figure 3-3: Prompts for All Locations

If you respond **Y** to the “Continue” prompt, the next set of records will be displayed. If you respond **N**, you will return to the “Select UNCODED ICD9 Diagnoses/Operations Option” prompt.

### 3.3 Print a List of All Uncoded Diagnoses/Operations (PPV)

Use the PPV option to print hardcopies of all of the reports in the uncoded diagnoses and codes options. As stated above, they can be used for customizing your local ICD files and critiquing the ICD training requirements of the data entry staff.

To print reports, follow these steps:

- At the “Enter a code indicating what LOCATIONS/FACILITIES are of interest” prompt, type one of the following codes:
  - A** - ALL Locations/Facilities
  - S** - One SERVICE UNIT’S Locations/Facilities
  - O** - ONE Location/Facility

If you type **S** or **O**, other prompts will display.
- At the “Enter the Beginning Date to Search for Uncoded V POV” prompt, specify the beginning date for the search.

3. At the “Enter the Ending Date to Search for Uncoded V POV” prompt, specify the ending date for the search.
4. At the “Enter a code indicating what LOCATIONS/FACILITES are of interest” prompt, type one of the following codes:
  - **A** for ALL Providers (PRIMARY)
  - **O** for One Provider (PRIMARY)
 If you type **O**, other prompts will be displayed.
5. At the “Enter device for printing” prompt, specify the device to use for printing or displaying.

After responding to the prompts, information will be displayed or printed. An example is below:

```

SEP 5,2008                                                    Page: 1
                                PCC Data Entry Module
*****
* LISTING OF UNCODED DIAGNOSES AND PROCEDURES *
*****

V POV entries that need coded:

HRN: 110051      DOB: SEP 4,1944      SEX: M
POV: .9999      PATIENT NAME: THETA,DAVID PAUL
VISIT: MAR 06, 2001@10:30      PROVIDER NARRATIVE: S/P STROKE
FIRST/REVISIT: REVISIT
OPERATOR FROM FORMS TRACKING OR CREATED BY: NOFIRE,SANDRA D
LOCATION OF ENCOUNTER: HOME
PROVIDER: SEIB,KATE S

HRN: 131899      DOB: JAN 24,1935      SEX: M
POV: .9999      PATIENT NAME: GAMMA,JEFFERY SCOTT
VISIT: APR 17, 2001@13:00
PROVIDER NARRATIVE: ILLEGIBLE TO BE ADDED LATER
FIRST/REVISIT: REVISIT
OPERATOR FROM FORMS TRACKING OR CREATED BY: POITRA,SHONDA L
LOCATION OF ENCOUNTER: DEMO INDIAN HOSPITAL
PROVIDER: WESTON,MISTY R

Enter RETURN to continue or '^' to exit:

```

Figure 3-4: Sample report for PPV option

To review the next page of information, press Enter.

If you type ^ at the last prompt, you will return to the “Select UNCODED ICD9 Diagnoses/Operations Option” prompt.

## 4.0 Link In-Hospital to Hospitalizations

The options and utilities on the Supervisor menu are shown below:

```

*****
**                               PCC Data Entry Module                               **
** Data Entry SUPERVISOR Options and Utilities**
*****
                               IHS PCC Suite Version 2.0

                               DEMO HOSPITAL

ICD   Fix UNCODED ICD9 Diagnoses/Operations ...
VRR   Visit Review Report ...
INP  Link In-Hospital Visits to Hospitalizations ...
DSP   Display PCC Data Entry Site Parameters
ACC   Process ACCEPT Commands ...
DDPR  Delete Duplicate Primary Providers from Visits
ESP   Enter/Edit PCC Data Entry Site Parameters
EVM   Auto Merge Event Visits on Same Day
FTM   Forms/Data Entry Tracking Menu ...
LAB   Complete Orphaned Visits Menu ...
MDL   Visit Re-linker/Merge/Delete Log Reports ...
MNE   Update PCC Mnemonic's Allowed/Not Allowed
OTH   Other PCC Data Entry Reports ...
PLAL  Reports Listing Allergies recorded on PROBLEM LIST ...
PMN   Print list of Data Entry Mnemonics
RET   Re-Submit PCC Visit to the IHS Data Center
TAB   PCC Local Table Maintenance ...
UPMC  Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 4-1: Data Entry SUPERVISOR Options and Utilities menu

Use the INP option to link visits containing a service category of I (In-hospital) to visits with a service category of H (Hospitalization). This must be done on a regular basis in order to internally connect these visits for future output purposes.

Type **INP** at the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt to display the In-Hospital Link Menu.

```

*****
**                               PCC Data Entry Module                               **
** Data Entry SUPERVISOR Options and Utilities**
**                               In-Hospital Link Menu                               **
*****
                               IHS PCC Suite Version 2.0

                               DEMO HOSPITAL

AUT   Link In-Hospital Visits to Hospitalizations

MAN   Manually Link In-Hospital to Hospitalization

```

```
Select Link In-Hospital Visits to Hospitalizations Option:
```

Figure 4-2: Options on the In-Hospital Link menu

## 4.1 Link In-Hospital Visits to Hospitalizations (AUT)

The AUT option looks at the admission and discharge date for each H visit, and then searches for any I visit containing a visit date in that range. If an I visit is found, an internal link is automatically made; however, no visit records are deleted or merged. It is reasonable to have multiple I visits linked to one H visit. It is also reasonable to have I visits with no H visit linkage. Once AUT is complete, it's possible to determine cost or extract information regarding a patient's full hospitalization stay.

All facilities should be running AUT on a regular basis, at least once a month. Hospitals and outpatient facilities should perform this function for Contract and non-Contract data purposes. A printout is generated when AUT is run stating what visits were linked and what visits were not. This consists of two to four reports, depending on the data in your computer. AUT will not link visits with a visit date greater than one year but will generate a report stating which visits were not linked.

This routine will find all in-hospital visits that are not linked to a hospitalization and link them if possible.

This process could take some time; consider queuing the report to print after hours.

Specify the device for printing or displaying at the "DEVICE" prompt.

The report is divided into the following parts, as in the example below.

- In-Hospital Visits over one year old not linked to a Hospitalization. These visits will not be displayed on future reports.
- In-Hospital Visits could be linked to two or more Hospitalizations. These visits must be linked manually.
- In-Hospital Visits were linked to the Hospitalizations listed.

An example, below, shows In-Hospital Visits Linked to Hospitalizations:

```
MAY 21, 2008
Page: 2
PCC Data Entry Module
*****
* REPORT OF IN-HOSPITAL VISITS LINKED TO HOSPITALIZATIONS *
*****

-----

The following In-Hospital Visits were linked to the Hospitalization
listed
-----
```

```

IN-HOSP: DATE: [AUG 28,2007@09:10] NAME: [ALPHA,ALICE ROCHELLE]
TYPE: [I]
        LOCATION: [DEMO INDIAN HOSPITAL] DEPENDENT ENTRY CNT: [1]

IN-HOSP: DATE: [AUG 28,2007@10:19] NAME: [ALPHA,GERALDINE] TYPE:
[I]
        LOCATION: [DEMO INDIAN HOSPITAL] DEPENDENT ENTRY CNT: [1]

IN-HOSP: DATE: [SEP 19,2007@12:00] NAME: [SIGMA,ALBERT TILLMAN]
TYPE: [I]
        LOCATION: [DEMO INDIAN HOSPITAL] DEPENDENT ENTRY CNT: [3]

IN-HOSP: DATE: [MAR 6,2008@01:00] NAME: [ALPHA,ALICE ROCHELLE]
TYPE: [I]
        LOCATION: [DEMO INDIAN HOSPITAL] DEPENDENT ENTRY CNT: [3]

Enter RETURN to continue or '^' to exit:

```

Figure 4-3: Sample In-House Visits Linked to Hospitalization

To review the next page of information, press Enter.

If you type ^ at the last prompt, you will return to the “Select Link In-Hospital Visits to Hospitalizations Option:” prompt.

## 4.2 MAN – Manually Link In-Hospital to Hospitalizations

Use the MAN option for visits that did not automatically link. In some cases, AUTO does not know which I visit(s) correspond to an H visit. In this case, the PCC supervisor would investigate each visit by pulling the chart and performing the linkage using the MAN option and the appropriate H visit.

To manually link I visits to H visits, follow these steps:

1. At the “Select PATIENT NAME” prompt, specify the name of the patient.
2. At the “Enter IN-HOSPITAL Visit date” prompt, specify the date.

If you entered an invalid date, the “No IN\_HOSPITAL Visit selected!” message is displayed. In this case, you return to the “Select Link In-Hospital Visits to Hospitalizations Option” prompt.

```

VISIT ADMIT DATE^TIME: 01152008@12:00
DATE VISIT CREATED: JAN 17, 2008 TYPE: CONTRACT
PATIENT NAME: ALPHA,PATIENT LOC OF ENCOUNTER:
CHS OTHER, 000197
SERVICE CATEGORY: IN HOSPITAL DEPENDENT ENTRY: 4
DATE LAST MODIFIED: MAR 3, 2008

Do you want to see the Entire Visit (V FILE entries)?? NO//

```

Figure 4-4: Sample prompts

3. At the “Enter HOSPITALIZATION Admission date” prompt, specify the admission date.

```
Enter HOSPITALIZATION Admission date: 01132008@12:00
      DATE VISIT CREATED:  JAN 16, 2008           TYPE:  CONTRACT
      PATIENT NAME:  ALPHA,PATIENT                LOC OF
ENCOUNTER:  TUCSON MEDICAL CENTER
      SERVICE CATEGORY:  HOSPITALIZATION          DEPENDENT ENTRY COUNT:  3
      DATE LAST MODIFIED:  MARCH 3, 2008

Do you want to see the Entire Visit (V FILE entries)?? NO//

Do you want to continue (Y/N)  N//  Y
```

Figure 4-5: Sample prompts

4. The application displays this message: “In-Hospital Visit Linked!!”

When you display a visit, look at the in-hospital visit and visit file information. The Parent Visit Link field should give you the date of admission for the hospitalization. At this point, the visit should not appear on any error reports.

## 5.0 Display PCC Data Entry Site Parameters

The options and utilities on the Supervisor menu are shown below:

```

*****
**                               PCC Data Entry Module                               **
** Data Entry SUPERVISOR Options and Utilities**
*****
                               IHS PCC Suite Version 2.0

                               DEMO HOSPITAL

ICD   Fix UNCODED ICD9 Diagnoses/Operations ...
VRR   Visit Review Report ...
INP   Link In-Hospital Visits to Hospitalizations ...
DSP Display PCC Data Entry Site Parameters
ACC   Process ACCEPT Commands ...
DDPR  Delete Duplicate Primary Providers from Visits
ESP   Enter/Edit PCC Data Entry Site Parameters
EVM   Auto Merge Event Visits on Same Day
FTM   Forms/Data Entry Tracking Menu ...
LAB   Complete Orphaned Visits Menu ...
MDL   Visit Re-linker/Merge/Delete Log Reports ...
MNE   Update PCC Mnemonic's Allowed/Not Allowed
OTH   Other PCC Data Entry Reports ...
PLAL  Reports Listing Allergies recorded on PROBLEM LIST ...
PMN   Print list of Data Entry Mnemonics
RET   Re-Submit PCC Visit to the IHS Data Center
TAB   PCC Local Table Maintenance ...
UPMC  Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 5-1: Data Entry SUPERVISOR Options and Utilities menu

Use the DSP option to display or print the Data Entry Site parameters of a specified site.

Type **DSP** at the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt to display the following:

```

Select PCC DATA ENTRY SITE PARAMETERS SITE NAME: demo indian
hospital          TUCS
ON              NON SVC UNIT          01   NM          1601

      Select one of the following:

              B          BROWSE Output on Screen
              P          PRINT Output to Printer

Do you want to: B// b BROWSE Output on Screen

OUTPUT BROWSER          Oct 17, 2008 12:42:32          Page:          2 of          2

```

```

Patient Care Component Site Parameter Display
+
          ASK OUTSIDE LOCATION:   YES
DEFAULT HISTORICAL VISIT TYPE:   IHS
DISPLAY VISIT AFTER SELECTING:   NO
          ASK WALK-IN/APPT FOR CLINIC: YES
          TYPE OF PROCEDURE CODING:  ICD OPERATION CODING
          ASK PROVIDER EVENT TIME:  YES
PERSON TO REC INHOSP LINK MSG:   NAKASHIMA, TONYA LYNN
          ORPHAN LAB LOG KEPT:     YES
          PROMPT FOR MODIFIER ON POV?: NO
          PROMPT FOR MODIFIERS WITH CPT: YES
USE CLINIC TO LINK IN RELINKER:
          CODING AUDIT INCOMPLETE?:
          DEFAULT PROMPT CODING COMPL:
          REQUIRE PROVIDER/DX ON CPE?:
          REQ CHART DEFICIENCY REASON:
          DO NOT REQUIRE POA - CAH:
          EXCLUDE INACTIVE PATIENTS: NO
Acceptable Patient CHART LOCATIONS: DEMO INDIAN HOSPITAL

          Enter ?? for more actions                                >>>
+   NEXT SCREEN          -   PREVIOUS SCREEN          Q   QUIT
Select Action: +//

```

Figure 5-2: Prompts for DSP option

You can do one of the following on this report screen:

- If you are not on the last page, type + to display the next screen.
- If you are not on the first page, type - to display the previous screen.
- Type **Q** to exit the report screen.

## 6.0 Process Accept Commands

The options and utilities on the Supervisor menu are shown below:

```

*****
**          PCC Data Entry Module          **
** Data Entry SUPERVISOR Options and Utilities**
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

ICD   Fix UNCODED ICD9 Diagnoses/Operations ...
VRR   Visit Review Report ...
INP   Link In-Hospital Visits to Hospitalizations ...
DSP   Display PCC Data Entry Site Parameters
ACC  Process ACCEPT Commands ...
DDPR  Delete Duplicate Primary Providers from Visits
ESP   Enter/Edit PCC Data Entry Site Parameters
EVM   Auto Merge Event Visits on Same Day
FTM   Forms/Data Entry Tracking Menu ...
LAB   Complete Orphaned Visits Menu ...
MDL   Visit Re-linker/Merge/Delete Log Reports ...
MNE   Update PCC Mnemonic's Allowed/Not Allowed
OTH   Other PCC Data Entry Reports ...
PLAL  Reports Listing Allergies recorded on PROBLEM LIST ...
PMN   Print list of Data Entry Mnemonics
RET   Re-Submit PCC Visit to the IHS Data Center
TAB   PCC Local Table Maintenance ...
UPMC  Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 6-1: Data Entry SUPERVISOR Options and Utilities menu

Use the **ACC** option to assign an ICD code to a diagnosis based on several criteria. In addition to the internationally recognized criteria, the IHS requires specific edits to several diagnoses as well. These edits have been programmed into PCC and are subsequently checked on data that is transmitted to the Data Center. Refer to Appendix B: , for a listing of the IHS edits. If an edit is not allowed for a particular diagnosis, the visit will be rejected at the Data Center.

After you type **ACC** at the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt, the PCC Data Entry Module screen is displayed.

```

*****
**          PCC Data Entry Module          **
*****
          IHS PCC Suite, Version 2.0

          DEMO INDIAN HOSPITAL

```

```

ACC      List Records with ACCEPT Command
EAC      Assign the ACCEPT Command to a V Record
RAC      Remove the Accept command from a Visit Record

Select Process ACCEPT Commands Option:

```

Figure 6-2: Options on the PCC Data Entry Module menu

## 6.1 List Records With Accept Command (ACC)

Use the ACC option to obtain a hardcopy printout of visit records containing an ACC command. This list should be thoroughly reviewed and verified against the IHS Edits in Appendix B: . When appropriate, the ACC can be removed and the ICD code changed.

This option will allow you to print all the Purpose of Visit, Procedures, and/or Hospitalization records to which the ACCEPT command has been applied. The ACCEPT command is used to override an edit in the IHS Direct Inpatient and/or PCIS Systems.

To print a list of records, follow these steps:

1. Select the type of date: either the Posting Date or the Visit Date.
2. At the “Enter beginning Visit Date for Search” prompt, specify the beginning date of the date range.
3. At the “Enter ending Visit Date for Search” prompt, specify the ending date of the date range.
4. Select one of the following record types:
  - 1 - Purpose of Visit Records
  - 2 0 Operations/Procedure Records
  - 3 - V Hospitalization Records
  - 4 - All of the Above
5. Specify the device to print or display the information.

Below is a sample ACC report:

```

PCC DATA ENTRY ACCEPT COMMAND REPORT                               Page: 1
REPORT OF POV'S FOR VISIT DATE RANGE: JAN 2002 THROUGH MAY 21,2008

Date: [JAN 12,2002@03:16] Name: [RAMSEY,DANIEL]      Sex: F]
HRN:  [102062] Date of Birth: [NOV 11,1985] Age in Days: [5906]

POV Code: [637.11] ICD Narrative: [ABORT NOS W HEMORR-INC]
      Overridden By: [NOFIRE,SANDRA D]

Date: [JAN 25,2002@14:24] Name: [LEE,CAROL LEE]      Sex: F]

```

```

HRN: [202395] Date of Birth: [DEC 23,2001] Age in Days: [33]
POV Code: [763.82] ICD Narrative: [ABN FETAL HEART R/R DUR LABOR]
      ICD Lower Age: [0] ICD Upper Age: [28]
      Overridden By: [TUTT,THOMAS R]

Date: [JAN 15,2002@16:08] Name: [RAGAN,SONNY JAMES] Sex: M]
HRN: [202129] Date of Birth: [DEC 1,2001] Age in Days: [45]
POV Code: [787.03] ICD Narrative: [VOMITING ALONE]
      ICD Lower Age: [28] ICD Upper Age: [99999]
      Overridden By: [YEAHQQUO,MELISSA]

Enter RETURN to continue or '^' to exit:

```

Figure 6-3: Sample ACC Report

To review the next page of information, press Enter.

If you type ^ at the last prompt, you will return to the “Select Process ACCEPT Commands Option” prompt.

## 6.2 Assign Accept Command to a V Record (EAC)

Use the EAC option to assign an ACCEPT command to a Purpose of Visit, Procedure, or Inpatient record. The ACCEPT command is used by the IHS Inpatient and PCIS systems to override an age edit on diagnoses or procedures or to override some other IHS Inpatient edits.

Some ICD codes have limits on whether they can be used for a given patient based on age and sex. Before using this option, verify that the code to which the ACC is being applied will be allowed based on the IHS standard edits. If the IHS edit states that a given code cannot apply an ACC, another code might have to be used for the diagnosis, or the form might have to be returned to the provider for clarification of the purpose of visit or operation.

When you select EAC, the following message is displayed:

```

PLEASE NOTE: THE ACCEPT COMMAND IS NO LONGER NECESSARY TO BE ENTERED
TO OVERRIDE AN EDIT. THIS OPTION WILL BE ELIMINATED IN A FUTURE
PATCH. VISITS WILL EXPORT TO THE DATA WAREHOUSE AND WILL NOT BE
REJECTED IF THE ACCEPT COMMAND IS NOT PRESENT.

```

To assign an ACCEPT command, follow these steps:

1. At the “Enter Patient Name” prompt, specify the patient name.
2. At the “Enter VISIT date” specify the date of the visit.

After entering the date, the report is displayed on your monitor as shown below:

```

VISIT IEN: 1725808

HRN: WW 113487

```

```

----- VISIT FILE -----
VISIT/ADMIT DATE&TIME: FEB 11, 2002@06:05
  DATE VISIT CREATED: FEB 11, 2002      TYPE: IHS
  THIRD PARTY BILLED: PRIVATE INSURANCE; VISIT OUTSIDE ELIGIBILITY
DATES (NE)
  PATIENT NAME: TONAHCOT,REBECCA LEE    LOC. OF ENCOUNTER: DEMO
INDIAN HOSPITAL
  SERVICE CATEGORY: HOSPITALIZATION      DEPENDENT ENTRY COUNT: 10
  DATE LAST MODIFIED: APR 10, 2002      DATE VISIT EXPORTED: OCT 29,
2002
  CREATED BY USER: HAMILTON,DEBRA DEE   USER LAST UPDATE:
GILLIAM,CHRISTINE B
  NDW UNIQUE VISIT ID (DBID): 102320001725808

----- V HOSPITALIZATION -----
DATE OF DISCHARGE: FEB 13, 2002@11:40  PATIENT NAME:
TONAHCOT,REBECCA LEE
  VISIT: FEB 11, 2002@06:05            ADMITTING SERVICE: GYNECOLOGY
  DISCHARGE SERVICE: GYNECOLOGY        DISCHARGE TYPE: REGULAR DISCHARGE
  ADMISSION TYPE: DIRECT                ADMITTING DX: 233.1
  LENGTH OF STAY (c): 2

Enter to continue, '^' to halt

```

Figure 6-4: Sample report

If you type ^ at the last prompt, you will return to the “Select Process ACCEPT Commands Option” prompt.

To review the next page of information, press Enter.

At the end of the visit display, the following message is displayed:

```

End of visit display, <ENTER> to Continue
Select one of the following:
1. Purpose of Visit (V POV)
2. Procedure/Operation (V PROCEDURE)
3. Inpatient Record (V HOSPITALIZATION)

```

Figure 6-5: Message at end of report

Identify the item you want the ACCEPT command applied to. When you type the appropriate number, the following message is displayed:

```

Accept Command has been set for Purpose of Visit (V POV) XXXX (If
the Purpose of Visit had the Accept Command applied).

```

Figure 6-6: Sample message

### 6.3 Remove Accept Command from a Visit Record (RAC)

**Note:** The IHS Direct Inpatient System no longer requires the use of the ACCEPT command. This option is no longer necessary and will be eliminated.

Use the RAC option to remove an ACC flag that has previously been applied to an ICD code. However, removing the ACC flag does not change the code; you must manually change the ICD code to an appropriate code for the diagnoses according to the patient age and/or sex. This is accomplished through the data entry menu using Modify or the MOD mnemonic.

To remove an ACC flag, follow these steps:

1. At the “Enter Patient Name” prompt, specify the patient name.
2. At the “Enter VISIT date” prompt, specify the date of the visit.

After entering the date, the report is displayed on your monitor as shown below:

```
VISIT IEN: 1725808

HRN: WW 113487
----- VISIT FILE -----
VISIT/ADMIT DATE&TIME: FEB 11, 2002@06:05
  DATE VISIT CREATED: FEB 11, 2002      TYPE: IHS
  THIRD PARTY BILLED: PRIVATE INSURANCE; VISIT OUTSIDE ELIGIBILITY
  DATES (NE)
  PATIENT NAME: TONAHCOT,REBECCA LEE    LOC. OF ENCOUNTER: DEMO
  INDIAN HOSPITAL
  SERVICE CATEGORY: HOSPITALIZATION      DEPENDENT ENTRY COUNT: 10
  DATE LAST MODIFIED: APR 10, 2002      DATE VISIT EXPORTED: OCT 29,
  2002
  CREATED BY USER: HAMILTON,DEBRA DEE   USER LAST UPDATE:
  GILLIAM,CHRISTINE B
  NDW UNIQUE VISIT ID (DBID): 102320001725808

----- V HOSPITALIZATION -----
DATE OF DISCHARGE: FEB 13, 2002@11:40  PATIENT NAME:
TONAHCOT,REBECCA LEE
  VISIT: FEB 11, 2002@06:05            ADMITTING SERVICE: GYNECOLOGY
  DISCHARGE SERVICE: GYNECOLOGY        DISCHARGE TYPE: REGULAR DISCHARGE
  ADMISSION TYPE: DIRECT                ADMITTING DX: 233.1
  LENGTH OF STAY (c): 2

Enter to continue, '^' to halt
```

Figure 6-7: Sample report

If you type ^ at the last prompt, you will return to the “Select Process ACCEPT Commands Option” prompt.

To review the next page of information, press Enter.

At the end of the visit display, the following message appears:

```
End of visit display, <ENTER> to Continue
Select one of the following:
1. Purpose of Visit (V POV)
2. Procedure/Operation (V PROCEDURE)
```

```
3. Inpatient Record (V HOSPITALIZATION)
```

Figure 6-8: Sample message

Identify the item you want the ACCEPT command removed from. When you type the appropriate number, the following message is displayed:

```
Accept Command has been removed for POV XXXXX (if the Purpose of  
Visit had the Accept Command removed).
```

Figure 6-9: Sample message

## 7.0 Delete Duplicate Primary Providers from Visits

The options and utilities on the Supervisor menu are shown below:

```

*****
**                PCC Data Entry Module                **
** Data Entry SUPERVISOR Options and Utilities**
*****
                IHS PCC Suite Version 2.0

                DEMO HOSPITAL

ICD   Fix UNCODED ICD9 Diagnoses/Operations ...
VRR   Visit Review Report ...
INP   Link In-Hospital Visits to Hospitalizations ...
DSP   Display PCC Data Entry Site Parameters
ACC   Process ACCEPT Commands ...
DDPR Delete Duplicate Primary Providers from Visits
ESP   Enter/Edit PCC Data Entry Site Parameters
EVM   Auto Merge Event Visits on Same Day
FTM   Forms/Data Entry Tracking Menu ...
LAB   Complete Orphaned Visits Menu ...
MDL   Visit Re-linker/Merge/Delete Log Reports ...
MNE   Update PCC Mnemonic's Allowed/Not Allowed
OTH   Other PCC Data Entry Reports ...
PLAL  Reports Listing Allergies recorded on PROBLEM LIST ...
PMN   Print list of Data Entry Mnemonics
RET   Re-Submit PCC Visit to the IHS Data Center
TAB   PCC Local Table Maintenance ...
UPMC  Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 7-1: Data Entry SUPERVISOR Options and Utilities menu

Use the **DDPR** option to find all visits in a specified date range that have duplicate primary providers and delete one of the primary provider entries.

When you type **DDPR** at the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt, the following prompts are displayed:

```

Enter Beginning Visit Date: t-365 (OCT 18, 2007)
Enter Ending Visit Date: t (OCT 17, 2008)
Do you want to continue? N// y YES

```

Figure 7-2: Prompts displayed after using the **DDPR** option

After the process finishes, the system displays the number of primary providers that were deleted.

## 8.0 The Site File

The options and utilities on the Supervisor menu are shown below:

```

*****
**                               PCC Data Entry Module                               **
** Data Entry SUPERVISOR Options and Utilities**
*****
                               IHS PCC Suite Version 2.0

                               DEMO HOSPITAL

ICD   Fix UNCODED ICD9 Diagnoses/Operations ...
VRR   Visit Review Report ...
INP   Link In-Hospital Visits to Hospitalizations ...
DSP   Display PCC Data Entry Site Parameters
ACC   Process ACCEPT Commands ...
DDPR  Delete Duplicate Primary Providers from Visits
ESP Enter/Edit PCC Data Entry Site Parameters
EVM   Auto Merge Event Visits on Same Day
FTM   Forms/Data Entry Tracking Menu ...
LAB   Complete Orphaned Visits Menu ...
MDL   Visit Re-linker/Merge/Delete Log Reports ...
MNE   Update PCC Mnemonic's Allowed/Not Allowed
OTH   Other PCC Data Entry Reports ...
PLAL  Reports Listing Allergies recorded on PROBLEM LIST ...
PMN   Print list of Data Entry Mnemonics
RET   Re-Submit PCC Visit to the IHS Data Center
TAB   PCC Local Table Maintenance ...
UPMC  Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option: ESP

```

Figure 8-1: Data Entry SUPERVISOR Options and Utilities menu

Prior to data entry, the PCC manager/supervisor must establish the site file. This option allows specific parameters to be set or changed that affect how the data entry staff enters data. Rather than the traditional 'Roll and Scroll' display, this option makes use of the VA ScreenMan to display the editable fields in the site file.

For help with ScreenMan, the user should press the <PF1> key if using a Wyse or IBM 3151 terminal, or F1 on a standard PC keyboard, followed by an action key such as 'H' to obtain the on-screen help. Once in ScreenMan, you can move around using the Tab key to move from field to field; the UP/DOWN RIGHT/LEFT arrow keys will also work in many cases. Because ScreenMan makes use of reverse video in places, parts of the display might be difficult to read. If the color settings on your PC cause problems in reading parts of the ScreenMan display, contact your site manager for assistance.

## 8.1 ESP - Enter/Edit PCC Data Entry Site Parameters

After selecting ESP from the SUPERVISOR menu and entering the name of the PCC site, ScreenMan will display the following:

```

                                UPDATE PCC DATA ENTRY PARAMETERS
                                SITE NAME:  ATKA

*****

    UPDATE DEFAULT PARAMETERS (press enter):          FORMS TRACKING?
(Y/N)
    UPDATE DISPLAY PARAMETERS (press enter):          ASK OUTSIDE LOCATION?
(Y/N)
        Prompt for VISIT CREATION? (Y/N)    ASK PROVIDER EVENT TIME?
(Y/N)
PROMPT FOR MODIFIERS WITH CPT ENTRY?          PROMPT FOR MODIFIER ON POV?
Y
        ASK WALK-IN/APPT FOR CLINIC? (Y/N)
        UNIVERSAL or SITE SPECIFIC LOOKUPS?
        TYPE OF PROCEDURE CODING:
REQUIRE ENCOUNTER PROVIDER AND DIAGNOSIS ON CPE MNEMONIC?:
Require Present on Admission (POA) for Hospital Stays?
Keep a log of orphaned lab visits that are re-linked?
Select PERSON TO RECEIVE IN-HOSPITAL LINK MESSAGE:
Update Locations with Charts (press enter):
Update Auto Prompting of Mnemonics (press enter):

-----

COMMAND:                                     Press <PF1>H for help
Insert

```

Figure 8-2: Display from ScreenMan

Many of the editable fields in the ScreenMan display have a question followed by the current setting. To change the value in a field, you must move to the field using Tab or the arrow keys, and then type the desired response or type “?” to obtain help for that parameter. For example, in the example shown above, PROMPT FOR MODIFIER ON POV is currently turned on, and to turn that parameter off, move to that field and type N to change the value to N (no).

Some of the fields displayed by ScreenMan are not in the form of a question, but end with the “(press Enter):” prompt. These parameters contain multiple values; when Enter is pressed at the prompt, a new screen opens containing the parameters that can be edited. Pressing Enter at the “UPDATE DEFAULT PARAMETERS (press enter):” prompt will display the following:

```

*****Update Default Site Parameters*****

Do you want the DEFAULT VALUES displayed?(Y/N):

DEFAULT LOCATION:

```

```

DEFAULT VISIT TYPE:
DEFAULT SERVICE CATEGORY:
DEFAULT CLINIC:
HISTORICAL VISIT TYPE:
DEFAULT HEALTH SUMMARY TYPE for DHS

```

Figure 8-3: Sample Update Default Site Parameters display

This screen is reviewed in the Update Default Parameters section below.

When you have completed the UPDATE PCC DATA ENTRY PARAMETERS window, do one of the following:

- To change a field, type ^ followed by a caption to move to a specific field.
- Use Save to save any changes you made. If there is any missing data, the system displays the field names; for example, Prompt for VISIT CREATION? (Y/N) is a required field. At this point, press Enter to return to the form.
- Use Refresh to refresh the display.
- Use Exit to leave the window. If you have unsaved changes, the system will prompt you to save. If you type **N** (no), the system displays “Changes not saved!” as you leave the form. If you type **Y** (yes), the system checks for required fields. If there is any missing data, the names are displayed. For example, Prompt for VISIT CREATION? (Y/N) is a required field. At this point, press Enter to return to the form.

After you leave the form, you return to the first prompt to enter the name of the PCC site.

## 8.2 Editable Fields

The editable fields on the Update PCC Data Entry Parameters form are reviewed in the following sections.

### 8.2.1 Update Default Parameters

To update the default site parameters, press Enter at the UPDATE DEFAULT PARAMETERS prompt to display the Update Default Site Parameters pop-up, as shown below:

```

*****Update Default Site Parameters*****

Do you want the DEFAULT VALUES displayed?(Y/N):
DEFAULT LOCATION:
DEFAULT VISIT TYPE:

DEFAULT SERVICE CATEGORY:
DEFAULT CLINIC:
HISTORICAL VISIT TYPE:
DEFAULT HEALTH SUMMARY TYPE for DHS

```

Figure 8-4: Sample Update Default Parameters pop-up

As the cursor moves through the prompts, you can change (edit) the value for each particular prompt.

The prompts for updating default parameters are:

### **Do you want the DEFAULT VALUES displayed?**

Type Y (Yes) or N (No), depending on the preference of the data entry operators. Yes allows default values to be entered automatically at the Location, Visit Type, Service Category, and Clinic when creating visits in PCC data entry. Y (Yes) must be entered if you want to display a default value at any one of the above items; however, a default value is not required at all items. N (No) is entered if default values are not preferred.

When using default values at Location, Visit Type and/or Service Category, the data entry operator must type ^ to back out of the data entry menu.

### **DEFAULT LOCATION**

If a location is stored in this parameter, it is automatically entered when creating visits during data entry. A different location can be entered during data entry because the operator is not required to accept the default. Any default value in this parameter must first exist in the Location File before it can be selected.

If data is entered for more than one location on your computer, this should not be used because visits can more easily be created in error.

### **DEFAULT VISIT TYPE**

Any legitimate visit type can be stored here as a default for data entry, although it need not be accepted during the data entry process. Use one the following:

- I (IHS)
- C (Contract)
- T (Tribe-Non 638/Non Compact)
- O (Other)

### **DEFAULT SERVICE CATEGORY**

Use A for ambulatory. If AMBULATORY is stored as the default category, it will be used when creating visits during PCC data entry; however, the data entry operator can change the Service Category as needed. Ambulatory is the only Service Category that can be stored as a default.

### **DEFAULT CLINIC**

Specify the clinic stop name or code. A default clinic is specified when a facility does *not* hold a large number of organized clinics but usually conducts General (01) clinic throughout the day. This is the most common clinic entered here;

however, any IHS standard clinics can be used as a default. If your facility holds several different types of organized clinics, a default clinic would not be advantageous to the data entry operator and should be left blank. Once specified, this clinic is automatically entered when the CL mnemonic is used during data entry; however, a different Clinic can be entered because the operator is not required to accept the default.

## **HISTORICAL VISIT TYPE**

Historical Visit Type is used when the data entry staff at your facility enter historical information and one visit type is specified more frequently than another. Use one of the following:

- I (IHS)
- C (Contract)
- 6 (638 Program)
- T (Tribal)
- O (Other)
- V (VA)

This visit type is then automatically entered when creating visits during data entry using the Historical mnemonics: HBS, HCBC, HHCT, HEKG, HEX, HIM, HLAB, HMSR, HPAP, HRAD, HS, HUA, SHX. A different visit type can be entered during data entry because the operator is not required to accept the default.

## **DEFAULT HEALTH SUMMARY TYPE for DHS**

Answer with the Health Summary Type Name. Enter the default health summary type to be used with the DHS mnemonic that allows the user to display a health summary at the MNEMONIC prompt. The system then displays a list of valid entries. This parameter specifies which health summary will display on the screen when using the DHS mnemonic in data entry. The most common choice is the Adult Regular Health Summary; however, any standard or customized health summary can be identified.

Press Tab at the last prompt to exit the pop-up and return to the Update PCC Data Entry Parameters form.

### **8.2.2 Forms Tracking**

Type **Y** (Yes) to enable the use of the Forms/Data Entry Tracking features located in the Supervisory options. If you use **N** (No), Forms Tracking will not function and reports cannot be generated. Use **Y** (Yes) during implementation of PCC because Forms Tracking begins counting on the day **Y** (Yes) is set; it cannot track data entered retrospectively.

### 8.2.3 Update Display Parameters

To update the display parameters, press Enter to display the following pop-up:

```
*****Update Display Values*****
```

```
DISPLAY PROBLEM LIST ON PO/NO? (Y/N)  
DISPLAY FAMILY/PERSONAL HISTORY? (Y/N)  
DISPLAY SURGICAL HISTORY? (Y/N)  
DISPLAY VISIT AFTER SELECTING? (Y/N)
```

Figure 8-5: Sample Update Display Values pop-up

The prompts to update the display parameters are:

#### **DISPLAY PROBLEM LIST ON PO/NO?**

This parameter should always be set to **Y** (Yes) so that a patient's active and inactive problems display on the screen during the data entry process. This affects all the data entry Problem mnemonics: PO, NO, PPV, MPO, APO, IPO, RPO, RNO, MNN.

#### **DISPLAY FAMILY/PERSONAL HISTORY?**

Type **Y** (Yes) to display a patient's family history and personal history on the screen during the data entry process.

#### **DISPLAY SURGICAL HISTORY?**

Type **Y** (Yes) to display a patient's surgical history on the screen during the data entry process.

#### **DISPLAY VISIT AFTER SELECTING?**

This parameter should be set to **Y** (Yes) if your data entry staff is new to PCC. The Visit File will be displayed after the initial visit criteria have been entered: Location, Visit Type, Service Category, Date, Time, and Health Record Number (HRN). This parameter is set to **N** (No) only when you are absolutely sure the data entry operators are knowledgeable in PCC data entry and no longer require an automatic display of the Visit File. The N option is not advised if your facility is capturing information for multiple disciplines and locations.

Press Tab at the last prompt to exit the pop-up and return to the Update PCC Data Entry Parameters form.

### 8.2.4 Ask Outside Location

Use **Y** (Yes) if your facility is using generic, undesignated locations when creating visits in data entry. The operator is then allowed to add a descriptive line about the generic location using 2-50 characters after the Visit File is created during data entry. This parameter corresponds with the OLOC mnemonic, which will prompt the operator while in the data entry menu and when appropriate. The OLOC or VST mnemonics can be used to modify an error while in a visit. Use **N** (No) if your facility does not use generic, undesignated locations and data entry does not want to see the prompt appear.

### 8.2.5 Prompt For Visit Creation

Use **N** (No) if you do not want the question “OK? YES//” after each HRN is entered and prior to the creation of a visit while in the PCC data entry. Use **Y** (Yes) if you *do* want the question “OK YES//” after each HRN is entered and prior to the creation of a visit while in the PCC data entry. If **N** (No) is used for this parameter, the operator is not allowed to verify that the patient and a visit are created immediately.

### 8.2.6 Ask Provider Event Time

If this parameter is set to **Y** (Yes), the data entry operator will be given the opportunity to enter the date and time that the provider saw the patient. This feature is particularly useful if the site is interested in conducting waiting time studies. Also see waiting time mnemonics in the PCC Data Entry Mnemonic manual.

### 8.2.7 Prompt For Modifiers with CPT Entry

Set this parameter to **Y** (Yes) to allow the data entry operator to enter a modifier whenever CPT code information is entered during the data entry process, and that information will be passed to the Third Party Billing package. Many sites will answer this parameter with **N** (No) so that billing personnel will be responsible for determining what, if any, modifiers should be utilized on the third party claim.

### 8.2.8 Prompt For Modifier on POV

If this parameter is set to **Y** (Yes), the data entry operator will see the MODIFIER prompt with each POV. If set to **N** (No), the MODIFIER prompt will not appear during entry of the Purpose of Visit; however, the operator can enter a modifier (e.g., RULE OUT, SUSPECT, etc.) by utilizing the MOD mnemonic and selecting the PV action. At that time, the operator will have the opportunity to step through all fields in the POV just as if the parameter had been set to **Yes** to allow automatic prompting of MODIFIER.

### 8.2.9 Ask Walk-In/Appt for Clinic

Setting this parameter to **Y** (Yes) will cause the operator to be prompted at the beginning of the visit with the “WAS THIS AN APPOINTMENT OR WALK-IN?”

prompt. If the operator answers “A” for appointment, the appointment date and appointment time will also be asked.

### 8.2.10 Universal or Site Specific Lookups

SITE SPECIFIC is primarily used for a single site with no health centers subordinate to it or when data is being entered for one site only. When set to Site Specific, the HRN will only access the patient with that site’s HRN, e.g., Betty Ann Miller will only appear when her San Xavier Health Center HRN, SX054666, is entered.

UNIVERSAL is used at the Area Office level and/or when a site enters data for multiple facilities and more than one HRN is on file for patients. Access to a patient might be available regardless of which site’s HRN is entered, e.g., SE088888 or SX054666 or SR9012 will access Betty Ann Miller when any one of these numbers is entered, or when patients have the same number but different locations. For example, when HRN 088888 is entered, two patients, Sells-Betty Ann Miller (SE088888) and San Xavier-Lucy Mae Jones (SX088888), are listed and the computer waits for the operator to choose the appropriate HRN.

### 8.2.11 Exclude Inactive Patients in Patient Lookup when entering new data?

Enter **N** (No) if you would like to view inactive patients during patient lookup. Enter **Y** if you do not want to view inactive patients during patient lookup.

### 8.2.12 Type of Procedure Coding

When entering procedures under the OP mnemonic, the operator will be prompted for either the ICD-9 procedure code, CPT code, or both depending on how this is set up in the parameters. Choose from the following:

- C (CPT Procedure Coding)
- I (ICD Operation Coding)
- B (prompt for both codes)

### 8.2.13 Require Encounter Providers and Diagnosis on CPE Mnemonic

Use **1** for YES or **0** for No. The CPE mnemonic captures the CPT or HCPCS code, Quantity, at least two modifiers, a diagnosis/reason for service (medical necessity/medical significance), the event date & time, and Encounter Provider (who provided the service).

Below is an example of CPE:

MNEMONIC: CPE	Cpt Entry with Enc Prov	ALLOWED	VISIT
RELATED ONLY			
Select V CPT: 10040	ACNE SURGERY		

```

ACNE SURGERY (EG, MARSUPIALIZATION, OPENING OR REMOVAL OF
MULTIPLE MILIA, COMEDONES, CYSTS, PUSTULES)
...OK? Yes// (Yes)
QUANTITY: 1
MODIFIER:
MODIFIER 2:
DIAGNOSIS: ACNE
706.1 (ACNE NEC)
OTHER ACNE

OK? Y//
EVENT DATE AND TIME: NOW (JUN 16, 2008@10:36:20)
ENCOUNTER PROVIDER: DP Demo, Provider 100 DP

```

Figure 8-6: Sample CPE

### 8.2.14 Require Present on Admission (POA) for Hospital Stay

Use **1** (Do NOT REQUIRE POA - CRITICAL ACCESS HOSPITAL) or **0** (REQUIRE POA). Present on Admission is now a requirement that must be reported on all hospital admissions, except Critical Access Hospitals, per CMS. The system will prompt the operator to indicate whether a final documented diagnosis was present on admission. The POA guidelines are available in the Coding Guidelines.

### 8.2.15 Keep a Log of Orphaned Lab Visits That Are Re-Linked

There is an option that attempts to link lab visits that have no purpose of visit or provider to the original visit on which the lab was ordered. If no original visit exists, it adds a provider of lab technician and a POV of lab draw to the visit. If you are using this option and would like a log kept of all visits that had a provider and POV attached to them, answer YES here. Choose from **Y** (Yes) or **N** (No).

Setting this parameter to **Y** (Yes) will create a log of lab-generated visits that were automatically re-linked to a PCC visit. Review of the log can reveal instances where a second visit should have been created rather than having the lab test linked to an existing PCC visit.

### 8.2.16 Select Person to Receive In-Hospital Link Message

For inpatient facilities, this field contains the name of the RPMS user that should receive a MailMan message when the option to link in-hospital visits with hospitalizations cannot resolve which visits to link. When this happens, the option to manually link the visits should be used to link them correctly.

Answer with NEW PERSON NAME, or INITIAL, or SSN, or VERIFY CODE, or NICK NAME, or SERVICE/SECTION, or DEA#, or VA#, or CODE, or IHS LOCAL CODE, or IHS ADC INDEX, or ALIAS.

### 8.2.17 Update Locations with Charts

If you press Enter the following pop-up is displayed:

```
LOCATIONS WITH CHARTS :
LOCATIONS WITH CHARTS :
LOCATIONS WITH CHARTS :
```

Figure 8-7: Sample pop-up

Type one or more locations, or type a new location at the prompt.

To change a field, type ^ followed by a caption to move to a specific field.

When you have completed the locations entry, use Close to dismiss the pop-up. Otherwise, use Refresh to refresh the display.

This parameter should only be used if your facility is entering visits for more than one IHS/638/Compacted Tribal Location. Those locations, with the exception of your location, would then be identified here. This feature enables the data entry operator to create visits for multiple locations without logging off and on after each location change. The computer then checks to see if the patient contains an HRN (chart) at the location of encounter as identified in this parameter. If no HRN is found for the location, a message will appear warning the operator of a location-chart conflict. When a HRN does not exist for the location of encounter in a patient's record, the visit will be rejected at the Data Center. This parameter is designed to avoid those rejects.

## 8.2.18 Update Auto Prompting Of Mnemonics

To update the autoprompting of mnemonics, press Enter to display the following pop-up:

```
Any mnemonics entered here will automatically be prompted for
in Mini Data Entry. These mnemonics will be prompted for
in addition to the CL, PRV and PV that are already displayed.
Mnemonic:
Mnemonic:
Mnemonic:

Mnemonic:
Mnemonic:
```

Figure 8-8: Sample pop-up

This site parameter allows for the storage of a list of mnemonics (in addition to the standard CL, PRV, and PV mnemonics) for which the MIN data entry option will automatically prompt the operator on every visit entered using MIN. Any allowed mnemonic can be entered in the list; however, Measurement Mnemonics (e.g., BP, WT) should *not* be listed because the operator will not be able to bypass the mnemonic and go on to complete the visit.

Specify the mnemonic you want to use, or type a new mnemonic to prompt for.

When you have completed the mnemonic entry, use Close to dismiss the pop-up. Otherwise, type Refresh to refresh the display.

To change a field, type ^ followed by a caption to move to a specific field.

## 9.0 Auto Merge Event Visits On Same Day

The options and utilities on the Supervisor menu are shown below:

```

*****
**                PCC Data Entry Module                **
** Data Entry SUPERVISOR Options and Utilities**
*****
                IHS PCC Suite Version 2.0

                DEMO HOSPITAL

ICD   Fix UNCODED ICD9 Diagnoses/Operations ...
VRR   Visit Review Report ...
INP   Link In-Hospital Visits to Hospitalizations ...
DSP   Display PCC Data Entry Site Parameters
ACC   Process ACCEPT Commands ...
DDPR  Delete Duplicate Primary Providers from Visits
ESP   Enter/Edit PCC Data Entry Site Parameters
EVM Auto Merge Event Visits on Same Day
FTM   Forms/Data Entry Tracking Menu ...
LAB   Complete Orphaned Visits Menu ...
MDL   Visit Re-linker/Merge/Delete Log Reports ...
MNE   Update PCC Mnemonic's Allowed/Not Allowed
OTH   Other PCC Data Entry Reports ...
PLAL  Reports Listing Allergies recorded on PROBLEM LIST ...
PMN   Print list of Data Entry Mnemonics
RET   Re-Submit PCC Visit to the IHS Data Center
TAB   PCC Local Table Maintenance ...
UPMC  Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 9-1: Data Entry SUPERVISOR Options and Utilities menu

The EVM option locates all instances in the visit file where there are two 'E - Historical Event' visits on the same day to the same location and automatically merge them together.

You must enter a date range for which to run this report.

This process could take some time; consider queuing the report to print after hours. A report can be generated detailing which visits were merged together.

To merge event visits that occurred on the same day, follow these steps:

1. At the "Run Report" prompt, type one of the following:

- 1 - Posting Date
- 2 - Visit Date

If you type **1**, you are asked to enter the Beginning Posting Date for Search and to enter the Ending Posting date for Search.

If you type **2**, you are asked to enter the Beginning Visit Date for Search and to enter the Ending Visit date for Search.

- At the “Would you like a report of those visits that were merged?” prompt, type **Y** or **N**.
- At the “Device” prompt, select the device to print/view the report. Below is a sample report:

```

ST                               May 21, 2008                               Page 1

                                PCC Data Entry Module
                                *****
                                *   VISIT REVIEW ERROR REPORT   *
                                *****
                                PCC DATA ENTRY AUTO MERGE EVENT VISIT REPORT

Report of Visits Merged for Posting Date Range: 3/22/2008 through
5/21/2008
-----
FROM VISIT:   8/27/2007   WW 204188   WW                PROCEDURE
TO VISIT:    8/27/2007   WW 204188   WW

FROM VISIT:   10/2/2007  WW 204188   WW                MEASUREMENT
TO VISIT:    10/2/2007  WW 204188   WW

FROM VISIT:   10/19/2007 WW 193574   WW                RADIOLOGY
TO VISIT:    10/19/2007 WW 193574   WW

FROM VISIT:   9/26/2007  WW 111855   WW                PROCEDURE
TO VISIT:    9/26/2007  WW 111855   WW

Enter RETURN to continue or '^' to exit: ^

FROM VISIT:   10/22/2007 WW 114975   WW                IMMUNIZATION
TO VISIT:    10/22/2007 WW 114975   WW

Enter RETURN to continue or '^' to exit: ^

FROM VISIT:   9/3/2007   WW 114975   WW                IMMUNIZATION
TO VISIT:    9/3/2007   WW 114975   WW

Enter RETURN to continue or '^' to exit:

```

Figure 9-2: Sample report

To review the next page of information, press Enter.

If you type **^** at the last prompt, you return to the “Select Data Entry SUPERVISORY Options and Utilities Option” prompt.

## 10.0 Forms/Data Entry Tracking Menu

The options and utilities on the Supervisor menu are shown below:

```

*****
**                PCC Data Entry Module                **
** Data Entry SUPERVISOR Options and Utilities**
*****
                IHS PCC Suite Version 2.0

                DEMO HOSPITAL

ICD   Fix UNCODED ICD9 Diagnoses/Operations ...
VRR   Visit Review Report ...
INP   Link In-Hospital Visits to Hospitalizations ...
DSP   Display PCC Data Entry Site Parameters
ACC   Process ACCEPT Commands ...
DDPR  Delete Duplicate Primary Providers from Visits
ESP   Enter/Edit PCC Data Entry Site Parameters
EVM   Auto Merge Event Visits on Same Day
FTM  Forms/Data Entry Tracking Menu ...
LAB   Complete Orphaned Visits Menu ...
MDL   Visit Re-linker/Merge/Delete Log Reports ...
MNE   Update PCC Mnemonic's Allowed/Not Allowed
OTH   Other PCC Data Entry Reports ...
PLAL  Reports Listing Allergies recorded on PROBLEM LIST ...
PMN   Print list of Data Entry Mnemonics
RET   Re-Submit PCC Visit to the IHS Data Center
TAB   PCC Local Table Maintenance ...
UPMC  Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 10-1: Data Entry SUPERVISOR Options and Utilities menu

The Forms Tracking parameter in the Site File must be set to **Yes** before the Forms/Data Entry Tracking Menu (FTM) option can be used. FORM is designed specifically for maintaining quality of the data entry operators ICD9 coding and quantity of visit file entries. Reports are generated to assist with personnel rating and staffing requirements. These reports should be run more frequently (once a week) during the onset of PCC and less frequently (once a month) later on.

Type **FTM** at the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt to display the following:

```

*****
**                PCC Data Entry Module                **
** Data Entry Forms Tracking Menu **
*****
                PCC IHS Suite Version 2.0

                DEMO INDIAN HOSPITAL

```

CNT	Report on Counts of Forms Processed
DXA	DX ICD Coding QA Audit
OPA	Operation/Procedure ICD Coding QA Audit
PRG	Purge Entries in Forms Tracking File
DOP	Display Operator who Entered a Particular Visit
TCC	Report of Number of Tran Codes Entered by Operator
TSR	Forms Tracking Summary Report

Select Forms/Data Entry Tracking Menu Option:

Figure 10-2: Options on Data Entry Forms Tracking menu

## 10.1 Report a Count of Forms Processed (CNT)

This report will generate a count of visits entered by a particular data entry operator or for ALL data entry operators for a specified date range. It can be subtotaled by clinic type, service category, or visit type.

The CNT option counts the dependent entries for visits entered by the data entry staff. This is useful for checking the quantity of data processed by staff if more than one person is responsible for data entry at a facility. Checks can be made to determine whether one operator is entering easier forms and another is entering more difficult forms. The numbers on this report should be fairly well distributed among all operators.

For each 20,000 visits, one full-time data entry operator is required. The skill level of an operator will vary for each facility. Twenty thousand is reached by calculating approximately 87 forms per day times 230 working days. All too often, a site will place a medical record staff member into the data entry position and expect both responsibilities to be maintained by that same person. This is only possible if the facility is very small and less than 87 visits per day are generated.

You can specify a time frame, a particular operator or operators, and varying visit information whenever you choose as long as no PURGE (PRG) has been done. Refer to the section on PRG. The frequency at which this report is run will vary depending on the data entry staff.

To run the CNT report, follow these steps:

1. At the “Enter beginning Posting Date” prompt, specify the beginning date of the date range.
2. At the “Enter ending Post Date” prompt, specify the ending date of the date range.
3. At the “Report on ALL Operators” prompt, type **Y** for all operators or **N** for only one operator. If you type **N**, other prompts will be displayed.
4. At the “Count number of Forms Processed by” prompt, use one of the following:
  - 1 - CLINIC TYPE
  - 2 - SERVICE CATEGORY

- 3 - VISIT TYPE  
4 - INCLUDE ALL VISITS
5. At the “Subtotal by Visit Date?” prompt, type **Y** or **N**.
6. At the “DEVICE” prompt, specify the type of device you want to use to print/view the report.

A sample report is below.

				May 21, 2008	Page 1
DEMO INDIAN HOSPITAL					
NUMBER OF FORMS KEYED					
DATE ENTRY OPERATOR: BETA,LA					
VISIT POSTING DATES: JAN 22, 2008 TO MAY 21, 2008					
POSTING DATE	# FORMS	# DEP ENT	AVG # DEP ENT		
-----					
FEB 29, 2008	1	5	5		
-----					
Totals for BETA,LA	1	5	5.0		
Enter RETURN to continue or '^' to exit:					

Figure 10-3: Sample report

Below is a sample summary report.

							May 21, 2008	Page 11
SUMMARY OF FORMS KEYED BY ALL OPERATORS								
VISIT POSTING DATES: JAN 22, 2008 TO MAY 21, 2008								
Operator	# days of D/E	# of forms	% workload	Avg # forms/day	Avg # dep ent/day	Avg # dep ent/form		
-----								
BURERER,LYY	2	2	0.7	1.0	3.5	3.5		
IRZZZ,MOI M	22	153	54.8	7.0	29.6	4.3		
KLRRR,STTHE	7	11	3.9	1.6	6.9	4.4		
TCCEE,ARR C	19	109	39.1	5.7	17.1	3.0		
-----								
275								
RUN TIME (H.M.S): 0.0.2								
Enter RETURN to continue or '^' to exit								

Figure 10-4: Sample summary report

To review the next page of information, press Enter.

If you type ^ at the last prompt, you return to options on the Forms/Data Entry Tracking Menu.

## 10.2 DX ICD Coding QA Audit (DXA)

The DXA option allows a PCC supervisor or an area office to perform routine and random checks on a selected data entry operator’s ICD coding. This report displays

the provider narrative and the code that was entered by the operator. This is especially useful for monitoring operators new to coding or operators who might have problems with a particular code.

This report lists visits (by posting date with an option of random samples) for a selected data entry operator. The Purpose of Visit ICD diagnosis code and provider narrative are also listed for each visit.

To perform a DX ICD coding QA audit, follow these steps:

1. At the “Enter beginning Posting Date” prompt, specify the beginning date of the date range.
2. At the “Enter ending Post Date” prompt, specify the ending date of the date range.
3. At the “Enter DATA Entry Operator” prompt, specify the operator name.
4. At the “Include ALL Visit Service Categories” prompt, type **Y** or **N**. If you type **Y**, other prompts will be displayed.
5. At the “Want to Limit search by CLINIC TYPE” prompt, type **Y** or **N**. If you type **Y**, other prompts will be displayed.
6. At the “Do you wish to include only a subset of ICD Diagnoses” prompt, type **Y** or **N**. If you type **Y**, other prompts will be displayed.
7. At the “Do you want ALL Visits Selected?” prompt, type **Y** or **N**. If you type **Y**, other prompts will be displayed.
8. At the “DEVICE” prompt, specify the type of device you want to use to print or view the report.

Below is a sample report:

ICD DIAGNOSIS CODING AUDIT				Page 1
DEMO INDIAN HOSPITAL				
Visit POSTING Dates: JAN 22, 2008 and MAY 21, 2008				
Data Entry Operator: BETA,LA				
Clinic: ALL				
Total Visits Found: 7		Total Number of Random Visits Selected: 7		
HR#	Visit Date	ICD9	Provider Narrative	
-----				
WW 106735	DEC 05, 2007@12:00	401.9	HTN	
			[HYPERTENSION NOS]	
WW 143670	MAR 13, 2007@12:00	250.00	DM	
			[DIABETES II/UNSPEC NOT UNCONTR]	

```
Enter RETURN to continue or '^' to exit: Enter RETURN to continue or
'^' to exit:
```

Figure 10-5: Sample Report

To review the next page of information, press Enter.

If you type ^ at the last prompt, you return to options on the Forms/Data Entry Tracking Menu.

### 10.3 Operation/Procedure ICD Coding QA Audit (OPA)

The OPA option functions exactly like the previous example (DX ICD Coding QA Audit), except that it finds only visits where ICD procedure codes were entered and reports the procedure codes and narratives entered.

This report lists visits by POSTING date, with an option of random samples, for a selected data entry operator. Purpose of Visit ICD OPERATION/PROCEDURE Code and Provider Narrative will also be listed.

To perform an operation/procedure ICD coding QA audit, follow these steps:

1. At the “Enter beginning Posting Date” prompt, specify the beginning date of the date range.
2. At the “Enter ending Post Date” prompt, specify the ending date of the date range.
3. At the “Enter DATA Entry Operator” prompt, specify the operator name.
4. At the “Want to Limit search by CLINIC TYPE” prompt, type **Y** or **N**. If you type **N**, other prompts will be displayed.
5. At the “Do you wish to include only a subset of ICD OPERATION/PROCEDURE Codes” prompt, type **Y** or **N**. If you type **N**, other prompts will be displayed.
6. At the “Do you want ALL Visits Selected?” prompt, type **Y** or **N**. If you type **N**, other prompts will be displayed.
7. At the “DEVICE” prompt, specify the type of device you want to use to print or view the report.

Below is a sample report.

```

                                ICD OPERATION/PROCEDURE CODING AUDIT                Page 1
                                DEMO INDIAN HOSPITAL

Visit POSTING Dates:  JAN 22, 2008 and MAY 21, 2008
Data Entry Operator:  BETAAA,LAMBDA
Clinic:  ALL

Total Visits Found:  0      Total Number of Random Visits Selected:  0

```

HR#	Visit Date	ICD O/P Code	Provider Narrative [ICD O/P NARRATIVE]
100010	JUN 26, 1998@14:22	47.19	APPENDECTOMY [OTHER INCIDENTAL APPENDECTOMY]
101846	JUL 28, 1998@14:22	51.22	CHOLECYSTECTOMY [CHOLECYSTECTOMY]

Enter RETURN to continue or '^' to exit:

Figure 10-6: Sample report

To review the next page of information, press Enter.

If you type ^ at the last prompt, you return to options on the Forms/Data Entry Tracking Menu.

## 10.4 Purge Entries in Forms Tracking File (PRG)

Use the PRG option to delete TRACKING information. Patient visit information remains untouched, but forms tracking (CNT and QA) data generated before using PRG is no longer available. Always be certain hard copy reports are generated on all operators prior to the purge. The computer will continue generating forms tracking data as long as the site file parameter is set to Y (Yes).

The data is purged from the Forms Tracking file.

To purge forms tracking entries, follow these steps:

1. At the “Purge forms up to and including what POSTING DATE” prompt, specify the posting date.
2. At the DEVICE prompt, specify the device you want to use to print or view the report.

The system purges the files and indicates how many were purged, e.g., “A Total of 2902 Dates Purged.”

## 10.5 Display Operator Who Entered a Particular Visit (DOP)

The DOP option displays the name of the data entry operator who entered a selected visit.

To display an operator name, follow these steps:

1. At the “Select Patient Name” prompt, specify the name of the patient.
2. At the “Enter Visit Date” prompt, specify the date of the visit.

The following shows information from the DOP option:

```

Visit date/time: FEB 11,2002@12:00    [internal entry# 1725765]
Posting date: NOV 29,2002
Data entry operator: OPER,F
Date Last Modified: NOV 29, 2002
User Last Modified: OPER,J

```

Figure 10-7: Sample information from DOP option

## 10.6 Report of Number of Tran Codes Entered By Operator (TCC)

The TCC option will generate a count of visits entered by a particular data entry operator or for ALL data entry operators for a date range that you specify.

This report lists operators who have entered tran codes using either of the two options for entering these codes on outpatient and in-hospital visits.

To generate a TCC report, follow these steps:

1. At the “Enter beginning Posting Date” prompt, specify the beginning date of the date range.
2. At the “Enter ending Posting Date” prompt, specify the ending date of the date range.
3. At the “Report on ALL Operators” prompt, type **Y** to tabulate visits entered by all operators, or type **N** to tabulate visits for only one operator. If you type **N**, other prompts will be displayed.
4. At the “Count number of Forms Processed by” prompt, type one of the following options:
  - 1 - CLINIC TYPE
  - 2 - SERVICE CATEGORY
  - 3 - VISIT TYPE
  - 4 - INCLUDE ALL VISITS
5. At the “DEVICE” prompt, specify the device you want to use to print or view the report.

A sample report is shown below:

```

                                                                    May 21, 2008   Page 1
                DEMO INDIAN HOSPITAL
                NUMBER OF FORMS KEYED
                DATE ENTRY OPERATOR:  ADAM,ADAM
                VISIT POSTING DATES:  JAN 22, 2008  TO  MAY 21, 2008

                POSTING DATE          # FORMS      # TRANS      AVG # TRAN ENT
                -----

```

MAY 05, 2008	1	1	1
Totals for ADAM,ADAM	1	1	1.0
Enter RETURN to continue or '^' to exit:			

Figure 10-8: Sample report

Below is a summary of forms keyed by all operators.

		May 21, 2008	Page 6
SUMMARY OF FORMS KEYED BY ALL OPERATORS			
VISIT POSTING DATES: JAN 22, 2008 TO MAY 21, 2008			
Operator	No. of Forms	Forms per day	% of Workload
ADAM, ADAM	1	1.0	1.4
BETZZA, LZZZZ	1	1.0	1.4
IRCCC, MNNNNNNNNN	34	3.8	49.3
TAZZZZZZZZZ	33	2.8	47.8
69			
Enter RETURN to continue or '^' to exit:			

Figure 10-9: Sample summary of forms keyed by all operators

## 10.7 Forms Tracking Summary Report (TSR)

The TSR option produces a summary count of visits processed by data entry personnel during the time frame specified. It excludes data that was entered via the Enter Non-Visit Data option because no visit file is created for these entries. In order for this option to function, the forms tracking site parameter must be set to Y (yes).

This report uses the forms tracking data to summarize the forms that have been processed by PCC data entry operators.

You must specify the date range for which you would like the summary report.

To generate a TSR report, follow these steps:

1. At the “Enter beginning Posting Date” prompt, specify the beginning date of the date range.
2. At the “Enter ending Post Date” prompt, specify the ending date of the date range.
3. At the “DEVICE” prompt, specify the device to use to print or view the report.

Below is a sample Forms Tracking Summary report:

Report Run Date: MAY 21, 2008	Page 1
-------------------------------	--------

```

                SUMMARY COUNT OF VISITS PROCESSED BY DATA ENTRY
                FOR:  JAN 22, 2008  TO  MAY 21, 2008
                DEMO INDIAN HOSPITAL

This report will include counts on Visits created or appended to
during the data entry process.  Data entered via the option ENTER
NON-VISIT DATA are not counted because no visit file is created.
The count of these forms must be tallied manually.  The counts are
taken from the forms tracking file.  Therefore, you must be running
forms tracking for this report to have any data.

There were a total of 285 visits processed during the time period
specified.  Below is a further breakdown of these visits.

HOSPITALIZATIONS (HSA-44)

There were 27 hospitalization documents during this period.

Enter RETURN to continue or '^' to exit:

```

Figure 10-10: Sample Forms Tracking Summary report, page 1

If you press Enter, the next page displays, as shown below:

```

                Data Entry Forms Summary  Page 2

By TYPE:
  IHS                                27

By LOCATION:
  DEMO INDIAN HOSPITAL              27

IN-HOSPITAL VISITS (NON-CHS):

There were 2 in-hospital documents during this period.

By TYPE:
  IHS                                2

By LOCATION:
  DEMO INDIAN HOSPITAL              2

Enter RETURN to continue or '^' to exit:

```

Figure 10-11: Sample Forms Tracking Summary report, page 1

The following page shows a summary by clinic.

```

                Data Entry Forms Summary  Page 4

<none>                                2
ALCOHOL AND SUBSTANCE                  2
BEHAVIORAL HEALTH                      3
CANCER SCREENING                       3

```

CARDIOLOGY	1
DAY SURGERY	1
DAY TREATMENT PROG	1
DENTAL	6
DERMATOLOGY	16
DIABETIC	4
EMERGENCY MEDICINE	11
ENDOCRINOLOGY	1
FAMILY PRACTICE	114
GENERAL	37
GENERAL PREVENTIVE	1
GYNECOLOGY	4
IMMUNIZATION	1

Enter RETURN to continue or '^' to exit:

Figure 10-12: Sample summary by clinic

One of the pages provides information about the report.

#### DEPENDENT ENTRY COUNT

There were 1048 visit related data items entered during this period. They are broken down below by data type. Labs, Medications, Dental and Radiology data items are excluded because in general, these are entered through the ancillary package.

#### V ACTIVITY TIME

Enter RETURN to continue or '^' to exit:

Figure 10-13: Sample information about report

## 11.0 Complete Orphaned Lab Menu

**Note:** The complete orphaned visit options use a generic provider; add the appropriate V Code for Lab, X-ray, Immunization, Blood Bank, Microbiology, and Med Refill. However, it does *not* add a diagnosis to justify for services, does *not* use exact codes for immunizations, and does *not* allow for CPT/HCPCS codes. The diagnosis/reason for the service is needed for billing and reporting purposes.

Type **LAB** at the “Select Data Entry Supervisor Options and Utilities Options” prompt to display the following:

```
COL    Complete 'Orphaned' Lab Visits
QCL    Queue Orphaned Lab Linker
CRX    Complete 'Orphaned' Pharmacy Visits
QRX    Queue Orphaned Pharmacy Linker
CRAD   Complete 'Orphaned' Radiology Visits
QRAD   Queue Orphaned Radiology Linker
ROL    Completed 'Orphaned' Visits Report
PUR    Purge Orphaned Visit Log
BB     Complete 'Orphaned' Blood Bank Visits
IM     Complete 'Orphaned' Immunization Visits
MIC    Complete 'Orphaned' Microbiology Visits
```

Select Complete Orphaned Visits Menu Option:

Figure 11-1: Options for LAB

This menu allows a site to manage “orphaned” lab visits that are created by the Laboratory module or by PCC data entry using the LOG data entry menu option to enter laboratory tests and results. Orphaned labs are incomplete visits that were created by one of these methods and do not contain a primary provider, purpose of visit, or clinic. Normally, these incomplete visits are linked to the medical part of the visit when PCC data entry takes place and the operator is given the opportunity to merge the lab tests with the remainder of the visit. Orphaned labs can also be automatically linked to a complete PCC visit by the nightly re-linker program which looks for incomplete visits more than 60 days old and attempts to link the partial visit with a complete visit on the same day and location for the patient.

### 11.1 Complete ‘Orphaned’ Lab Visits (COL)

Use the COL option to complete lab tests that did not get merged or linked to a complete visit at data entry time, or by the re-linker. The user is asked for a beginning and ending date for the visit search and whether the visits should be transmitted to the Data Center. Answer **Yes** if the visit date range is within the current fiscal year and **No** if the range is prior to the beginning of the current fiscal year. The ending date must be prior to the date set by the PCC delay factor. This option will not run unless the visit re-linker has also been run at least once.

To complete orphaned lab visits, follow these steps:

1. At the “Enter Beginning Date for Search” prompt, specify the beginning date of the date range.
2. At the “Enter ending Date for Search” prompt, specify the ending date of the date range.
3. At the “Do you want these visits transmitted to the Data Center” prompt, type **Y** if the selected date range is within the current fiscal year. You will want those visits to DDPS. Otherwise, type **N** if you are running this option for past fiscal years.

The system indicates that it is searching the data. When the search is complete, the system displays how many visits were fixed.

## 11.2 Queue ‘Orphaned’ Lab Linker (QCL)

This is a non-interactive option that queues the lab linker to be run in the background. A beginning date of T-60 is used and the ending date will be 7 days earlier than the date set by the PCC delay factor.

## 11.3 Queue Orphaned Pharmacy Linker (CRX)

This is a non-interactive option that queues the pharmacy linker to be run in the background. A beginning date of T-60 is used and the ending date will be 7 days earlier than the date set by the PCC delay factor.

## 11.4 Queue ‘Orphaned’ Radiology Visits (CRAD)

This option fixes the unlinked radiology visits.

If you do not have a generic X-Ray Technician provider, the following message is displayed:

```
You do not have a generic X-Ray Technician provider entry in your
database. Cannot run fix for unlinked rads.
Press ENTER:
```

Figure 11-2 Sample message

Press Enter to return to the menu options.

## 11.5 Queue Orphaned Radiology Linker (QRAD)

This is a non-interactive option which queues the radiology linker to be run in the background. A beginning date of T-60 is used and the ending date will be 7 days earlier than the date set by the PCC delay factor.

## 11.6 Completed ‘Orphaned’ Visits Report (ROL)

This report lists all visits that were completed using the options to complete orphaned lab, radiology, or pharmacy visits.

To generate a report of completed orphaned visits, follow these steps:

1. At the “Which type of Completed Visits do you wish to list” prompt, type one of the following:

L - Lab Visits  
 R - Radiology Visits  
 P - Pharmacy Visits  
 I - Immunization  
 B - Blood Bank  
 M - Microbiology  
 A - All Completed Visits

2. Type the date range for which you would like to see a list of completed LAB/RAD/RX/IMM/BB/MICRO visits at the following prompts:

- Type beginning date for the report.
- Type ending date for the report.

3. At the “Do you wish to” prompt, select one of the following:

P - PRINT Output  
 B - BROWSE Output on Screen

Below is a sample orphaned visit report.

```

OUTPUT BROWSER      May 21, 2008 18:15:28      Page:      1 of 34

***** CONFIDENTIAL PATIENT INFORMATION *****
                DEMO INDIAN HOSPITAL                        Page 1
ANCILLARY VISITS FOR WHICH A PROVIDER AND POV WERE APPENDED
                Dates range: Jan 22, 2008-May 21, 2008

VISIT DATE/TIME    HRN  LOCATION  TYPE  SC  #  ENT  BILLING LINK DATE
-----
Date 'Orphan' Visit Completed: May 21, 2008
Jan 02, 2004@12:00 152567 DEMO INDIA I A LAB 30  JAN 01, 2004@23:28
Jan 02, 2004@12:00 155593 DEMO INDIA I A LAB 39
Jan 02, 2004@12:00 102493 DEMO INDIA I A LAB 2

Jan 02, 2004@12:00 143948 DEMO INDIA I A LAB 34  DEC 18, 2003@09:00
Jan 04, 2004@12:00 115900 DEMO INDIA I A LAB 28  JAN 03, 2004@22:42
Jan 05, 2004@12:00 160887 DEMO INDIA I A LAB 6
Jan 05, 2004@12:00 103070 DEMO INDIA I A LAB 23
Jan 06, 2004@12:00 117080 DEMO INDIA I A LAB 47  DEC 30, 2003@08:07
Jan 06, 2004@12:00 107210 DEMO INDIA I A LAB 28

+          Enter ?? for more actions                                >>>
+   NEXT SCREEN          -   PREVIOUS SCREEN          Q   QUIT
Select Action: +//
  
```

Figure 11-3: Sample report

You can do one of the following at the “Select Action” prompt:

- If you are not on the last page, type + to display the next screen.
- If you are not on the first page, type - to display the previous screen.
- Type **Q** to exit the report screen.

## 11.7 Purge ‘Orphaned’ Lab Visit Log (PUR)

If the orphaned lab log site parameter is set to Yes, this option can be used to purge the log of entries no longer needed. The user will be prompted to enter an ending date for visits to be purged as well as a device to display or print the results.

After you enter the date at the “Purge log up to and including what Posting Date” prompt, the system purges the entries and displays the total.

## 11.8 Complete ‘Orphaned’ Blood Bank Visits (BB)

Use this option to fix unlinked blood bank visits.

Follow these steps:

1. At the “Enter Beginning Date for Search” prompt, specify the beginning date of the date range.
2. At the “Enter Ending Date for Search” prompt, specify the ending date of the date range.
3. At the “Do you want these visits transmitted to the Data Center” prompt, type **Y** if the data range you have selected is for the current fiscal year. You will want those visits transmitted to DDPS. Otherwise, type **N** if you are running this for past fiscal years.

The system indicates that it is searching the data. When it is finished, it will display how many visits were fixed.

## 11.9 Complete ‘Orphaned’ Immunization Visits (IM)

Use this option to fix unlinked immunization visits.

Follow these steps:

1. At the “Enter Beginning Date for Search” prompt, specify the beginning date of the date range.
2. At the “Enter Ending Date for Search” prompt, specify the ending date of the date range.

3. At the “Do you want these visits transmitted to the Data Center” prompt, type **Y** if the data range you have selected is for the current fiscal year. You will want those visits transmitted to DDPS. Otherwise, type **N** if you are running this for past fiscal years.

The system indicates that it is searching the data. When it is finished, it will display how many visits were fixed.

## 11.10 Complete ‘Orphaned’ Microbiology Visits (MIC)

Use this option to fix unlinked microbiology visits.

Follow these steps:

1. At the “Enter Beginning Date for Search” prompt, specify the beginning date of the date range.
2. At the “Enter Ending Date for Search” prompt, specify the ending date of the date range.
3. At the “Do you want these visits transmitted to the Data Center” prompt, type **Y** if the data range you have selected is for the current fiscal year. You will want those visits transmitted to DDPS. Otherwise, type **N** if you are running this for past fiscal years.

The system indicates that it is searching the data. When it is finished, it will display how many visits were fixed.

## 12.0 Visit Log Reports

The options and utilities on the Supervisor menu are shown below:

```

*****
**                               PCC Data Entry Module                               **
** Data Entry SUPERVISOR Options and Utilities**
*****
                               IHS PCC Suite Version 2.0

                               DEMO HOSPITAL

ICD   Fix UNCODED ICD9 Diagnoses/Operations ...
VRR   Visit Review Report ...
INP   Link In-Hospital Visits to Hospitalizations ...
DSP   Display PCC Data Entry Site Parameters
ACC   Process ACCEPT Commands ...
DDPR  Delete Duplicate Primary Providers from Visits
ESP   Enter/Edit PCC Data Entry Site Parameters
EVM   Auto Merge Event Visits on Same Day
FTM   Forms/Data Entry Tracking Menu ...
LAB   Complete Orphaned Visits Menu ...
MDL  Visit Re-linker/Merge/Delete Log Reports ...
MNE   Update PCC Mnemonic's Allowed/Not Allowed
OTH   Other PCC Data Entry Reports ...
PLAL  Reports Listing Allergies recorded on PROBLEM LIST ...
PMN   Print list of Data Entry Mnemonics
RET   Re-Submit PCC Visit to the IHS Data Center
TAB   PCC Local Table Maintenance ...
UPMC  Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 12-1: Data Entry SUPERVISOR Options and Utilities menu

Use the MDL option to re-link, merge, or delete visit log reports.

Type **MDL** at the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt to display the following:

```

VRLR  List of Visits Modified by the Visit Re-Linker
PVRL  Purge Visit Re-linker Log
PVDM  Print List of Visits Deleted/Merged
PUDM  Purge Visit Delete/Merge Log
VIEN  Display a Visit by Visit IEN

Select Visit Re-linker/Merge/Delete Log Reports Option:

```

Figure 12-2: Options for MDL

The Visit Re-linker Log option creates a log of all visits that were modified through the visit re-linker process. These visits have had one or more V File entries moved or “re-linked” to another visit. A report will list all visits that were modified by the re-linker process, and there is also an option to purge the log.

The Visit Delete/Merge Log option creates a log of all visits that were deleted or merged. A report will list all of these visits, and there is also an option to purge the log. The visit delete option prompts for a reason for the visit deletion. This prompt is not required. This is a prospective change meaning that only visits deleted or merged after the installation date of this version (v2.0) of the IHS PCC Suite will be logged and reported on with these options.

## 12.1 List of Visits Modified by the Visit Re-linker (VRLR)

Use the VRLR option to print a list of visits on which a V File (ancillary data item) was 'moved' or 're-linked' from one visit to another during the nightly visit re-linker process or during the post-data-entry visit re-linking process.

To print a list of modified visits, follow these steps:

1. At the "Enter Beginning Date for Search" prompt, specify the beginning date of the date range. This date range specifies the dates on which the re-linking occurred.
2. At the "Enter Ending Date for Search" prompt, specify the ending date of the date range.
3. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:
  - I - Include All patients
  - E - Exclude Demo patients
  - O - Include only demo patients
4. At the "Do you wish to" prompt, indicate one of the following:
  - P - PRINT Output
  - B - BROWSE Output on Screen

Below is a sample report.

```

OUTPUT BROWSER          Oct 14, 2008 09:40:38          Page:    1 of    1
***** CONFIDENTIAL PATIENT INFORMATION *****
                        DEMO HOSPITAL                               Page 1

  Visits for which an Ancillary Data Item was 're-linked' to
  another visit
  Relinking Dates:  OCT 15, 2007 and OCT 14, 2008
-----
HRN      PATIENT                TO VISIT                      FROM VISIT
                        DATE/TIME (IEN)                DATE/TIME (IEN)
-----
There are no visits in the Visit Relinker Log for that time period.

          Enter ?? for more actions                                >>>
+  NEXT SCREEN          -  PREVIOUS SCREEN          Q  QUIT
  
```

```
Select Action: +//
```

Figure 12-3: Sample information

If there were visits listed on this screen:

- If you are not on the last page, type + to display the next screen.
- If you are not on the first page, type - to display the previous screen.
- Type **Q** to exit the screen.

## 12.2 Purge Visit Re-linker Log (PVRL)

Use the PVRL option to purge data from the Visit Relinker Log up to and including a specified run date.

```
Purge Data from Visit Relinker Log!

Purge data up to and including what RELINKER RUN DATE? ??
  Examples of Valid Dates:
    JAN 20 1957 or 20 JAN 57 or 1/20/57 or 012057
    T   (for TODAY), T+1 (for TOMORROW), T+2, T+7, etc.
    T-1 (for YESTERDAY), T-3W (for 3 WEEKS AGO), etc.
    If the year is omitted, the computer assumes a date in the
    PAST.
Purge data up to and including what RELINKER RUN DATE?
```

Figure 12-4: Sample Purge Visit Re-linker Log

After the process ends, the system displays the number of entries purged.

## 12.3 Print List of Visit Deleted/Merged (PVDM)

Use the PVDM option to print a list of visits that were merged into another visit or deleted. If a reason for the deletion/merge can be determined it will be displayed. The first part of the Print List of Visit Deleted/Merged report is shown below.

Follow these steps:

1. At the “Which set of Visits” prompt, type one of the following:
  - 1 - Deleted/Merged Visits by Visit Date Range
  - 2 - Deleted/Merged Visits by Date Visit Deleted/Merged
2. At the “Enter Beginning Date” prompt, specify the beginning date of the date range.
3. At the “Enter Ending Date for Search” prompt, specify the ending date of the date range.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

- I - Include All patients
- E - Exclude Demo patients
- O - Include only demo patients

5. At the “Do you wish to” prompt, indicate one of the following:

- P - PRINT Output
- B - BROWSE Output on Screen

Below is a sample report.

```

OUTPUT BROWSER      Oct 14, 2008 09:56:39      Page:    1 of    5

      ***** CONFIDENTIAL PATIENT INFORMATION *****
                    DEMO HOSPITAL                      Page 1

                    DELETED/MERGED VISITS
      Deletion/Merge Dates:  OCT 15, 2007 and OCT 14, 2008
-----
      HRN      PATIENT                DELETED/MERGED VISIT      MERGED TO VISIT
      DATE/TIME (IEN)                DATE/TIME (IEN)
-----
124682 SMXXX,ALPHAM      10/9/08@09:00 (2522097)
      User who Updated:  FXMEM,LRESERT  Date/Time Deleted:  Oct 09,
2008@09:28:12
      Reason for deletion/merge:  DATA ENTRY EXITED VISIT/DELETED

+          Enter ?? for more actions                                >>>
+  NEXT SCREEN      -  PREVIOUS SCREEN      Q  QUIT
Select Action:  +//

```

Figure 12-5: Sample Output Browser window

You can do the following at the “Select Action” prompt:

- If you are not on the last page, type + to display the next screen.
- If you are not on the first page, type - to display the previous screen.
- Type Q to exit the screen.

## 12.4 Purge Visit Delete/Merge Log (PUDM)

Use the PUDM option to purge data up to and including a delete/merge date from the visit log. Below is the first part of the PUDM process:

```

Purge Data from Visit Delete/Merge Log!

Purge data up to and including what DELETE/MERGE DATE?  ??
Examples of Valid Dates:
      JAN 20 1957 or 20 JAN 57 or 1/20/57 or 012057
      T (for TODAY), T+1 (for TOMORROW), T+2, T+7, etc.
      T-1 (for YESTERDAY), T-3W (for 3 WEEKS AGO), etc.

```

```

If the year is omitted, the computer assumes a date in the
PAST.
Purge data up to and including what DELETE/MERGE DATE?

```

Figure 12-6: Sample first part of PUDM process

After the process ends, the system displays the number of visits purged.

## 12.5 Display a Visit by Visit IEN (VIEN)

Use the VIEN option to show visit file data for a specified IEN number. For example:

```

Visit display by IEN
Enter the VISIT IEN: (1-9999999999): 6745

PCC VISIT DISPLAY      Oct 14, 2008 10:14:21      Page:      1 of      2

Patient Name:          SXXX,DNNNNNNNNNNNNNNN
Chart #:                1XXXXX
Date of Birth:         APR 05, 1965
Sex:                   M
Visit IEN:             6745

===== VISIT FILE =====
VISIT/ADMIT DATE&TIME: DEC 28, 1987@01:55
DATE VISIT CREATED:   DEC 30, 1987
TYPE:                 IHS
PATIENT NAME:         SXXX,DNNNNNNNNNNNNNNN
LOC. OF ENCOUNTER:    DEMO INDIAN HOSPITAL
SERVICE CATEGORY:    AMBULATORY
CLINIC:               EMERGENCY MEDICINE
DEPENDENT ENTRY COUNT: 8

===== MEASUREMENTS =====
TYPE:                 TMP
VALUE:                97

TYPE:                 PU
VALUE:                68

TYPE:                 BP
VALUE:                128/80

===== PROVIDERS =====
PROVIDER:             VACANT,LORI LYNN
AFF.DISC.CODE:        980077
PRIMARY/SECONDARY:    PRIMARY

===== POVs =====
POV:                  873.42
ICD NARRATIVE:        OPEN WOUND OF FOREHEAD
PROVIDER NARRATIVE:   FOREHEAD LACERATION

Enter ?? for more actions

```

```
+      Next Screen      -      Previous Screen      Q      Quit
Select Action: +//
```

Figure 12-7: Sample report

You can do the following at the “Select Action” prompt:

- If you are not on the last page, type + to display the next screen.
- If you are not on the first page, type - to display the previous screen.
- Type **Q** to exit the screen.

## 13.0 Data Entry Mnemonics

The options and utilities on the Supervisor menu are shown below:

```

*****
**                PCC Data Entry Module                **
** Data Entry SUPERVISOR Options and Utilities**
*****
                IHS PCC Suite Version 2.0

                DEMO HOSPITAL

ICD   Fix UNCODED ICD9 Diagnoses/Operations ...
VRR   Visit Review Report ...
INP   Link In-Hospital Visits to Hospitalizations ...
DSP   Display PCC Data Entry Site Parameters
ACC   Process ACCEPT Commands ...
DDPR  Delete Duplicate Primary Providers from Visits
ESP   Enter/Edit PCC Data Entry Site Parameters
EVM   Auto Merge Event Visits on Same Day
FTM   Forms/Data Entry Tracking Menu ...
LAB   Complete Orphaned Visits Menu ...
MDL   Visit Re-linker/Merge/Delete Log Reports ...
MNE  Update PCC Mnemonic's Allowed/Not Allowed
OTH   Other PCC Data Entry Reports ...
PLAL  Reports Listing Allergies recorded on PROBLEM LIST ...
PMN  Print list of Data Entry Mnemonics
RET   Re-Submit PCC Visit to the IHS Data Center
TAB   PCC Local Table Maintenance ...
UPMC  Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 13-1: Data Entry SUPERVISOR Options and Utilities menu

Mnemonics are used for quick entry of information into the Patient Care Component by the data entry operator. The supervisor is responsible for maintaining the list of mnemonics to be used or not used by data entry. Changes might have to be made periodically.

### 13.1 Print List of Data Entry Mnemonics (PMN)

You can obtain a list of all PCC data entry mnemonics through this menu option. Prior to any changes, this should be reviewed.

To list all PCC data entry mnemonics, follow these steps:

1. At the “Sort By” prompt, use the default (mnemonic), or choose one of the following:
  - .01 - MNEMONIC
  - .02 - MODE

.03 - FILE  
.04 - TEMPLATE  
.05 - KEY VALUE  
.06 - DESCRIPTION  
.07 - ALLOWED/NOT ALLOWED  
.08 - VISIT RELATED  
.09 - V FILE UPDATED  
.11 - PRIMARY LIST ORDER  
.12 - MENU TEXT  
.13 - SECONDARY LIST ORDER  
.14 - ASSOCIATED FILE  
.15 - HISTORICAL LIST ORDER  
.16 - NON-VISIT DATA ITEM ORDER  
.17 - COHORT ENTRY LIST ORDER 1  
.18 - COHORT ENTRY LIST ORDER 2  
.999999901 - PATCH ADDED

- Type **a** in front of a numeric-valued field to sort from high to low.
  - Type **+** in front of a field name to get subtotals by that field.
  - Type **#** to page-feed on each field value.
  - Type **!** to get ranking number.
  - Type **@** to suppress subheader.
  - Type **]** to force saving sort template.
  - Type **TXT** after free-text fields to sort numbers as text.
  - Type **[TEMPLATE NAME]** in brackets to sort by previous search results.
2. At the “START WITH MNEMONIC” prompt, use the default FIRST. This field contains the data entry mnemonic or a pseudo-INPUT TEMPLATE for entering data from the various logs. If the MNEMONIC name is 2-3 characters long it is considered a MNEMONIC (e.g., 'BP' or 'TON'). If the MNEMONIC name is 4 or more characters long it is considered a pseudo-INPUT TEMPLATE.
  3. At the “Device” prompt, specify the device to use to view or print the information.

A sample report is shown below.

RPMS PCC DATA ENTRY CONTROL LIST			MAY 22, 2008	10:43	PAGE 1
MNEMONIC	ALLOWED/NOT ALLOWED	DESCRIPTION			
3M	NOT ALLOWED	3M Coder Interface			
ADA	ALLOWED	ADA Code Entry			
ADM	ALLOWED	Asthma Work/School Days Missed			
ADX	ALLOWED	Admitting Diagnosis			
AL	ALLOWED	Appointment Length			
ALG	ALLOWED	Allergy Tracking Entry			
AOP	ALLOWED	Anesthesia Operation			
APO	ALLOWED	Activate an Inactive Problem			
APPT	ALLOWED	Appointment Date&Time			
ASEV	ALLOWED	Asthma Severity			
ASFD	ALLOWED	Asthma Symptom Free Days			

Figure 13-2: Sample report

Notice that there are no commands to move from one page to another. Currently, press Enter to move to the next page. Otherwise, type ^ to exit the report.

## 13.2 Update PCC Mnemonics Allowed/Not Allowed (MNE)

Use the MNE option to specify which mnemonics can be used by PCC Data Entry. Changes are made here when a means other than PCC Data Entry is used to track a specific data type. For example, Lab tests ordered data is initially captured through PCC Data Entry using the UA, BS, and HCT mnemonics. After PCC is running smoothly and problems have been resolved, a facility might choose to capture results using the LAB mnemonic, therefore UA, BS, and HCT are set to NOT ALLOWED. A facility might choose to capture results via the RPMS Laboratory module, in which case the LAB, UA, BS, and HCT should be set to NOT ALLOWED.

To update the list of allowed/not allowed mnemonics, follow these steps:

1. At the “Select RPMS PCC DATA ENTRY CONTROL MNEMONIC” prompt, specify the control mnemonic you want to update.
2. At the “Is Date Entry Allowed/Not Allowed to use this Mnemonic” prompt, type **0** (for ALLOWED) or **1** (for NOT ALLOWED).
3. The prompts in steps 1 and 2 repeat until you type **1** (not allowed) at the second prompt. In this case, you return to the “Select Data Entry SUPERVISORY Options and Utilities Option” prompt.

## 14.0 Other PCC Data Entry Reports

The options and utilities on the Supervisor menu are shown below:

```

*****
**                PCC Data Entry Module                **
** Data Entry SUPERVISOR Options and Utilities**
*****
                        Version 2.0

                        DEMO INDIAN HOSPITAL

ICD   Fix UNCODED ICD9 Diagnoses/Operations ...
VRR   Visit Review Report ...
INP   Link In-Hospital Visits to Hospitalizations ...
DSP   Display PCC Data Entry Site Parameters
ACC   Process ACCEPT Commands ...
DDPR  Delete Duplicate Primary Providers from Visits
ESP   Enter/Edit PCC Data Entry Site Parameters
EVM   Auto Merge Event Visits on Same Day
FTM   Forms/Data Entry Tracking Menu ...
LAB   Complete Orphaned Visits Menu ...
MDL   Visit Re-linker/Merge/Delete Log Reports ...
MNE   Update PCC Mnemonic's Allowed/Not Allowed
OTH  Other PCC Data Entry Reports ...
PLAL  Reports Listing Allergies recorded on PROBLEM LIST ...
PMN   Print list of Data Entry Mnemonics
RET   Re-Submit PCC Visit to the IHS Data Center
TAB   PCC Local Table Maintenance ...
UPMC  Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 14-1: Data Entry SUPERVISOR Options and Utilities menu

Use the OTH option to display one of two reports: (a) Chart Review and Telephone Calls with ancillary data, or (b) Visits with a Returned to Stock Medication.

Use OTH at the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt to display the following:

```

Select Data Entry SUPERVISORY Options and Utilities Option: oth
Other PCC Data
Entry Reports

    CTA   Chart Review and Telephone Calls w/ancillary data
    VRTS  Visits with a Returned to Stock Medication

Select Other PCC Data Entry Reports Option:

```

Figure 14-2: Options for OTH

## 14.1 Chart Review and Telephone Calls with Ancillary Data (CTA)

Use the CTA option to list all visits within a specified date range with a service category of T (telecommunications), C (Chart Review), or clinic code 52 (Chart Review) that have ancillary data items attached to them. The ancillary data items are any of the following: medication, radiology, microbiology, lab, or blood bank.

To list these visits, follow these steps:

1. At the “Enter beginning Visit Date” prompt, specify the beginning date of the date range.
2. At the “Enter ending Visit Date” prompt, specify the ending date of the date range.
3. At the “Sort the report by” prompt, use one of the following:
  - T - Terminal Digit Order
  - H - Health Record Number Order
  - D - Visit Date Order
4. At the “Demo Patient Inclusion/Exclusion” prompt, use one of the following:
  - I - Include All patients
  - E - Exclude Demo patients
  - O - Include only demo patients
5. At the DEVICE prompt, specify the type of device you want to use to print/view the report.

Below is a sample report:

SJT		Feb 13, 2009				Page 1	
DEMO HOSPITAL							
Chart Review and Telephone Call visits with ancillary data							
PATIENT NAME	HRN	VISIT DATE	SC	CL	DATA	ORDER	PROV
ORDER DATE							
MBETA, KRISTA	103700	08/01/2007	T	50	MED'S	CWPROVIDER,	RENE
BETA, DOROTHY	104600	01/05/2007	T	50	LAB'S	XEPROVIDER,	FELI
01/05/2007							
BETA, DOROTHY	104600	01/23/2007	T	50	LAB'S	XEPROVIDER,	FELI
01/23/2007							
					MED'S	CPPROVIDER,	MARG
BETA, DOROTHY	104600	02/06/2007	T	50	LAB'S	XEPROVIDER,	FELI
02/06/2007							
BBETA S, OLIVE	105300	01/03/2007	T	77	MED'S	MUPROVIDER,	TAMM
GAMA, LAWRENCE	166601	01/08/2007	T	77	MED'S	SBPROVIDER,	MAND

Enter RETURN to continue or '^' to exit:

Figure 14-3: Sample CTA report

## 14.2 Visits with a Returned to Stock Medication (VRTS)

Use the VRTS option to list all nonchart review/telephone call visits with a V Medication that is flagged as RETURN TO STOCK.

To list these visits, follow these steps:

1. At the “Enter beginning Visit Date” prompt, specify the beginning date of the date range.
2. At the “Enter ending Visit Date” prompt, specify the ending date of the date range.
3. At the “Sort the report by” prompt, type one of the following:
  - T - Terminal Digit Order
  - H - Health Record Number Order
  - D - Visit Date Order
4. At the DEVICE prompt, specify the device to use to print or view the report.

The following shows the display when the Visits with a Returned to Stock Medication option is selected at the “Select Other PCC Data Entry Reports Option” prompt.

xxx		Feb 13, 2009				Page 1	
DEMO HOSPITAL							
Chart Review and Telephone Call visits with ancillary data							
PATIENT NAME	HRN	VISIT DATE	SC	CL	DATA	ORDER	PROV
ORDER DATE							
-----							
MOOOO, KRISTA	103700	08/01/2007	T	50	MED 's	CWPROVIDER,	RENE
SAAA, DOROTHY	104600	01/05/2007	T	50	LAB 's	XEPROVIDER,	FELI
01/05/2007							
SAAA, DOROTHY	104600	01/23/2007	T	50	LAB 's	XEPROVIDER,	FELI
01/23/2007							
					MED 's	CPPROVIDER,	MARG
SAAA, DOROTHY	104600	02/06/2007	T	50	LAB 's	XEPROVIDER,	FELI
02/06/2007							
BETAA, OLIVE G	105300	01/03/2007	T	77	MED 's	MUPROVIDER,	TAMM
MUUU, LAWRENCE	166601	01/08/2007	T	77	MED 's	SBPROVIDER,	MAND
GAMA, BESSIE G	104402	07/25/2007	T	77	MED 's	NPROVIDER,	ERIN
CHI, BRANDIE L	107902	02/23/2007	T	39	MED 's	FTPROVIDER,	NANC
THHH, CLAUDIA	112703	03/23/2007	C	77	MED 's	FNPROVIDER,	CLAU
MBETAAAA, NATA	124103	07/25/2007	T	77	MED 's	EFPROVIDER,	STEP
DELTA, HEATHER	166503	06/08/2007	T	39	MED 's	SBPROVIDER,	MAND
CHIII, FELICIA	111704	02/21/2007	T	77	MED 's	NPROVIDER,	ERIN
PBETA, JAYLYNN	128004	01/12/2007	C	52	LAB 's	BUPROVIDER,	RENE
01/12/2007							
LAMBDAAH, SIERA	100205	03/02/2007	T	77	MED 's	NPROVIDER,	ERIN
Enter RETURN to continue or '^' to exit:							

Figure 14-4: Sample VRTS report

## 15.0 Reports Listing Allergies on Problem List

The options and utilities on the Supervisor menu are shown below:

```

*****
**                               PCC Data Entry Module                               **
** Data Entry SUPERVISOR Options and Utilities**
*****
                               IHS PCC Suite Version 2.0

                               DEMO HOSPITAL

ICD   Fix UNCODED ICD9 Diagnoses/Operations ...
VRR   Visit Review Report ...
INP   Link In-Hospital Visits to Hospitalizations ...
DSP   Display PCC Data Entry Site Parameters
ACC   Process ACCEPT Commands ...
DDPR  Delete Duplicate Primary Providers from Visits
ESP   Enter/Edit PCC Data Entry Site Parameters
EVM   Auto Merge Event Visits on Same Day
FTM   Forms/Data Entry Tracking Menu ...
LAB   Complete Orphaned Visits Menu ...
MDL   Visit Re-linker/Merge/Delete Log Reports ...
MNE   Update PCC Mnemonic's Allowed/Not Allowed
OTH   Other PCC Data Entry Reports ...
PLAL Reports Listing Allergies recorded on PROBLEM LIST ...
PMN   Print list of Data Entry Mnemonics
RET   Re-Submit PCC Visit to the IHS Data Center
TAB   PCC Local Table Maintenance ...
UPMC  Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 15-1: Data Entry SUPERVISOR Options and Utilities menu

Use the **PLAL** option to display the options for listing allergy reports.

Typing **PLAL** at the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt displays the following:

```

*****
**                               PCC Data Entry Module                               **
** Data Entry SUPERVISOR Options and Utilities **
*****
                               IHS PCC Suite Version 2.0

                               DEMO HOSPITAL

PWA   List All Patients w/Allergies / NKA on Problem List
SALP  List Pts seen in N yrs w/Problem List Allergies
NALP  List Patients w/Allergies entered in a Date Range

Select Reports Listing Allergies recorded on PROBLEM LIST Option:

```

Figure 15-2: Options for PLAL

The following is an overview of each of the options:

- **PWA:** This report lists patients who have an allergy or NKA entered on the PCC Problem List.
- **SALP:** This report lists patients who have allergies on the PCC Problem list within a specified number of years.
- **NALP:** This report lists patients with allergies within a specified date range

## 15.1 List All Patients with Allergies / NKA on Problem List (PWA)

Use the PWA option to list patients who have an allergy or NKA entered on the PCC Problem List.

The pharmacy staff uses the PWA option to add these allergies into the Allergy Tracking module. When you have finished processing this list you can run the List Patients w/Allergies entered in a Date Range option to pick up any allergies entered onto the Problem list after you ran this report. Deceased patients and patients with inactive charts are not included on this list.

The list can be very long at sites with many patients and providers who have been maintaining up-to-date problem lists.

To make the list more manageable at those sites, you will be prompted to enter the beginning and ending first character of the last name the patient. You can then print all patients whose last name begins with A through C the first time, D through H the second time, etc. To print all patients, enter A and Z as the beginning and ending characters.

The list contains the following information:

SJT		Page 1
DEMO HOSPITAL		
PATIENTS WITH ALLERGIES OR DOCUMENTED NO KNOWN ALLERGIES ON PCC PROBLEM LIST		
PATIENTS WITH LAST NAMES BEGINNING WITH a through z		
PATIENT NAME	CHART #	DOB
-----		

Figure 15-3: Sample information for PWA option

## 15.2 List Pts seen in N yrs w/Problem List Allergies (SALP)

You use the SALP option to display the list of patients seen in a specified number of years with an allergy on the Problem List.

To make the list more manageable, use a smaller number of years. The default is three years.

To list these patients, follow these steps:

1. At the “Enter the number of years: (1-99)” prompt, enter the number of years to be reported on.
2. At the “DEVICE” prompt, specify the type of device to use to print/view the report.

The following shows a sample report:

SJT		Page 1	
DEMO HOSPITAL			
PATIENTS WITH ALLERGIES OR DOCUMENTED NO KNOWN ALLERGIES ON PCC PROBLEM LIST			
PATIENTS SEEN BETWEEN VISIT DATES: OCT 24, 1983 TO OCT 17, 2008			
PATIENT NAME	CHART #	DOB	
-----			
YXXX,LAAAAA C	100002	Jul 29, 1986	
DATE ADDED	DX	PROVIDER NARRATIVE	
-----	--	-----	
NOV 24, 2000	799.9	NKA	
BXXXXXXXXX,LZZZ NSSSSSS	100008	Mar 22, 1956	
DATE ADDED	DX	PROVIDER NARRATIVE	
-----	--	-----	
JUN 29, 1988	995.3	ALLERGIC PENICILLIN & COEDINE	
APR 15, 1989	V14.0	PENICILLIN ALLERGY	
MAY 31, 1994	995.2	POSSIBLE DRUG REACTION TO BACTRIM / ALLERGIC TO SULFA	
CVVVVV,PCCCC LXXX	100017	Jan 17, 1940	
DATE ADDED	DX	PROVIDER NARRATIVE	
-----	--	-----	
APR 06, 1992	995.2	ALLERGIC REACTION TO CIPRO	
APR 04, 1997	995.2	GI UPSET WITH KEFLEX	
Enter RETURN to continue or '^' to exit:			

Figure 15-4: Sample report for SALP option

### 15.3 List Patients w/Allergies entered in a Date Range (NALP)

Use the NALP option to list patients with allergies within a specified date range.

To list these patients, follow these steps:

1. At the “Enter beginning Date” prompt, specify the beginning date of the date range.
2. At the “Enter ending Date” prompt, specify the ending date of the date range.

3. At the “DEVICE” prompt, specify the type of device to use to print/view the report.

The following shows a sample report:

SJT		Page 1	
DEMO HOSPITAL			
PATIENTS WITH ALLERGIES OR DOCUMENTED NO KNOWN ALLERGIES ON PCC			
PROBLEM LIST			
ALLERGIES ADDED TO THE PROBLEM: OCT 18, 2007 TO OCT 17, 2008			
PATIENT NAME	CHART #	DOB	
-----			
SXXXX,ADDDDD	124682	Jul 01, 1987	
DATE ADDED	DX	PROVIDER NARRATIVE	
-----	--	-----	
OCT 14, 2008	995.3	ALLERGY TO DUST	
SHHHH,ABBBBB D SR	165110	Mar 23, 2002	
DATE ADDED	DX	PROVIDER NARRATIVE	
-----	--	-----	
FEB 04, 2008	995.3	ALLERGIC TO SEPTRA	

Figure 15-5: Sample report for NALP option

## 16.0 Resubmit a Visit to the Data Center

The options and utilities on the Supervisor menu are shown below:

```

*****
**                PCC Data Entry Module                **
** Data Entry SUPERVISOR Options and Utilities**
*****
                IHS PCC Suite Version 2.0

                DEMO HOSPITAL

ICD   Fix UNCODED ICD9 Diagnoses/Operations ...
VRR   Visit Review Report ...
INP   Link In-Hospital Visits to Hospitalizations ...
DSP   Display PCC Data Entry Site Parameters
ACC   Process ACCEPT Commands ...
DDPR  Delete Duplicate Primary Providers from Visits
ESP   Enter/Edit PCC Data Entry Site Parameters
EVM   Auto Merge Event Visits on Same Day
FTM   Forms/Data Entry Tracking Menu ...
LAB   Complete Orphaned Visits Menu ...
MDL   Visit Re-linker/Merge/Delete Log Reports ...
MNE   Update PCC Mnemonic's Allowed/Not Allowed
OTH   Other PCC Data Entry Reports ...
PLAL  Reports Listing Allergies recorded on PROBLEM LIST ...
PMN   Print list of Data Entry Mnemonics
RET Re-Submit PCC Visit to the IHS Data Center
TAB   PCC Local Table Maintenance ...
UPMC  Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 16-1: Data Entry SUPERVISOR Options and Utilities menu

Use the RET option only if you have discovered that a visit was rejected by the Data Center. You must be absolutely sure you have resolved the problem before using this option.

To resubmit a visit to the Data Center, follow these steps:

1. At the “Select Patient Name” prompt, specify the name of the patient.
2. At the “Enter VISIT date” prompt, specify the date of the visit.

The following Visit File information is displayed:

```

VISIT IEN: 1725808

HRN: WW 113487
----- VISIT FILE -----
VISIT/ADMIT DATE&TIME: FEB 11, 2002@06:05
  DATE VISIT CREATED: FEB 11, 2002      TYPE: IHS
  THIRD PARTY BILLED: PRIVATE INSURANCE; VISIT OUTSIDE ELIGIBILITY
DATES (NE)
  PATIENT NAME: TONAHCOT,REBECCA LEE    LOC. OF ENCOUNTER: DEMO
INDIAN HOSPITAL
  SERVICE CATEGORY: HOSPITALIZATION      DEPENDENT ENTRY COUNT: 10
  DATE LAST MODIFIED: APR 10, 2002      DATE VISIT EXPORTED: OCT 29,
2002
  CREATED BY USER: HAMILTON,DEBRA DEE   USER LAST UPDATE:
GILLIAM,CHRISTINE B
  NDW UNIQUE VISIT ID (DBID): 102320001725808

----- V HOSPITALIZATION -----
DATE OF DISCHARGE: FEB 13, 2002@11:40  PATIENT NAME:
TONAHCOT,REBECCA LEE
  VISIT: FEB 11, 2002@06:05            ADMITTING SERVICE:
GYNECOLOGY
  DISCHARGE SERVICE: GYNECOLOGY        DISCHARGE TYPE: REGULAR
DISCHARGE
  ADMISSION TYPE: DIRECT                ADMITTING DX: 233.1
  LENGTH OF STAY (c): 2

Enter to continue, '^' to halt

```

Figure 16-2: Sample Visit File information

Near the end of the file, the following will be displayed: The responses are in bold.

```

----End if visit display, <RETURN> to Continue:
Are you sure this is the visit to re-transmit? NO// Y YES

This visit has already been transmitted to the IHS Data Center once.
This will cause the visit to be re-transmitted to the Data Center.

Have all corrections to the visit been made through modify or append
mode so that the visit will now be accepted by the Data Center
(either APC or the IHS Inpatient System)?

Enter Yes or No? N// Y YES
Visit will be re-sent as of Today's Date

```

Figure 16-3: Prompts near end of process

## 17.0 Table Maintenance

The options and utilities on the Supervisor menu are shown below:

```

*****
**                               PCC Data Entry Module                               **
** Data Entry SUPERVISOR Options and Utilities**
*****
                               IHS PCC Suite Version 2.0

                               DEMO HOSPITAL

ICD   Fix UNCODED ICD9 Diagnoses/Operations ...
VRR   Visit Review Report ...
INP   Link In-Hospital Visits to Hospitalizations ...
DSP   Display PCC Data Entry Site Parameters
ACC   Process ACCEPT Commands ...
DDPR  Delete Duplicate Primary Providers from Visits
ESP   Enter/Edit PCC Data Entry Site Parameters
EVM   Auto Merge Event Visits on Same Day
FTM   Forms/Data Entry Tracking Menu ...
LAB   Complete Orphaned Visits Menu ...
MDL   Visit Re-linker/Merge/Delete Log Reports ...
MNE   Update PCC Mnemonic's Allowed/Not Allowed
OTH   Other PCC Data Entry Reports ...
PLAL  Reports Listing Allergies recorded on PROBLEM LIST ...
PMN   Print list of Data Entry Mnemonics
RET   Re-Submit PCC Visit to the IHS Data Center
TAB PCC Local Table Maintenance ...
UPMC  Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 17-1: Data Entry SUPERVISOR Options and Utilities menu

Use the TAB option to locally maintain several data tables (files) used in PCC and in other RPMS applications. These lookup tables will occasionally need to be updated or enhanced. This set of menu options provides the ability to do the initial building and subsequent update of these tables. The responsibility for updating tables will vary, depending on the size of your facility. In many cases, responsibility might be split between several people and offices.

Every effort should be made to keep duplicate entries out of these tables. In many instances only the RPMS site manager or PCC manager has been given authority to add new entries to the locally maintained tables, and in particular, the Provider File. Entries added to the tables via the Table Maintenance Menu cannot be easily removed. If duplicates are noted in these tables, the site manager or area RPMS support personnel should be notified to resolve the problem.

In addition to the menu options to edit the various tables, menu options are provided to print table listings (PRT) as well as to inactivate or reactivate providers (INA).

Type TAB at the “Select Data Entry Supervisor Options and Utilities Option” prompt to display the following:

```

*****
**          PCC Data Entry Module          **
**          PCC Local Table Maintenance    **
*****
          IHS PCC Suite, Version 2.0

          DEMO INDIAN HOSPITAL

PHY   Physical Therapy Modality Enter/Edit
TRT   Treatment Enter/Edit
PRT   Print Table Listings ...
CL    List Clinics

Select PCC Local Table Maintenance Option:

```

Figure 17-2: Options on PCC Local Table Maintenance menu

Below is an overview of the options:

- **Physical Therapy Modality Enter/Edit:** used to enter or edit physical therapy modalities in the Physical Therapy file. These entries can never be deleted.
- **Treatment Enter/Edit:** used to enter or edit treatments in the Treatment file.
- **Print Table Listings:** used to print a listing of all items in a selected table. A submenu allows the user to choose which tables to print.
- **List Clinics:** used to list the clinics.

## 17.1 Physical Therapy Modality Enter/Edit (PHY)

Use the PHY option to enter or edit physical therapy modalities.

To work with physical therapy modalities, follow these steps:

1. At the “Select Physical Therapy Code” prompt, specify the code you want to enter/edit. If you enter a new code, the system will create it.
2. At the “Code” prompt, the default code for an existing therapy is displayed. Press Enter to accept it, or enter a new code.
3. At the “Name” prompt, the default name for an existing therapy is displayed. Press Enter to accept it, or enter a name for the new code.

You are returned to the “Select PCC Local Table Maintenance option” prompt.

## 17.2 Treatment Enter/Edit (TRT)

Use the TRT option to enter or edit treatments in the Treatment file.

To work with treatments in the Treatment file, follow these steps:

1. At the “Select Treatment Name” option, type an existing treatment to display the treatment name, or enter a new treatment name.
2. At the “Code” prompt, the default code for an existing treatment is displayed. Press Enter to accept it, or enter a new code.
3. At the “Summary Flag” prompt, the default flag for an existing treatment is displayed. Press Enter to accept it, or enter an integer specifying the summary flag for the new treatment.
4. At the “Inactive Flag” prompt, type **1** to inactivate the treatment, or press Enter to leave the field blank.
5. At the “CPT Code” prompt, type the CPT code that identifies the treatment, or press Enter to leave the field blank.
6. At the “Mnemonic” prompt, specify the mnemonic to be used, or press Enter to leave the field blank.

You are returned to the “Select Treatment Name” prompt. You can enter another treatment name, or press Enter to return to the “Select PCC Local Table Maintenance option” prompt.

### 17.3 Print Table Listings (PRT)

Use the PRT option to print a listing of all items in a selected table. A submenu allows the user to choose which tables to print.

After you type **PRT**, the following menu is displayed:

```

*****
**                PCC Data Entry Module                **
**      PCC Local Table Maintenance Print Menu      **
*****
                IHS PCC Suite Version 2.0

                DEMO HOSPITAL

PRVL  Provider Listing
APA   Print ACTIVE Providers
APC   Print Providers by Provider Classification
API   Print INACTIVE Providers
ARE   Print Area Table
DIS   Print Provider List by Discipline

EDU   Print Education Topics List
EVN   Print CHS Vendor List by EIN Number
INS   Print Insurer List
LOC   Print Location Table
NVE   Print CHS Vendor List by Name
PHY   Print Physical Therapy List
PPN   Print Provider List by Name
PRI   Print Immunization Table

```

PST	Print Skin Test Table
REL	Print Relationship List
SUP	Print Service Unit Table
TRT	Print Treatment List

Select Print Table Listings Option:

Figure 17-3: Options on the PCC Local Table Maintenance Print Menu

Each option will ask you to select the device to display or browse the report.

## 17.4 List Clinics (CL)

Use the CL option to show a report that lists the clinics.

To list the clinics, follow these steps:

1. At the “Sort by” prompt, specify the sort criteria for the report. Use any **one** of the following options:
  - 01 - NAME
  - 1 - CODE
  - 90000.01 - 1A WORKLOAD CLINIC
  - 90000.02 - MEDICARE BILLABLE
  - 90000.03 - MEDICAID BILLABLE
  - 999999901 - ABBREVIATION
  - 999999902 - PRIMARY CARE CLINIC
    - Type - in front of a numeric-valued field to sort from high to low.
    - Type + in front of a field name to get subtotals by that field.
    - Type # to page-feed on each field value, '!' to get ranking number.
    - Type @ to suppress a subheader.
    - Type ] to force saving sort template.
    - Type ;**txt** after free-text fields to sort numbers as text.
    - Type [template name] in brackets to sort by previous search results.
    - Type **by(0)** to define record selection and sort order.

The following prompts display if NAME is selected in the first step:

- At the “Start With Name” prompt, specify the name to start the name range.
- At the “Go to Name” prompt, specify the name to end the name range.

## 18.0 Update PCC Master Control File

The options and utilities on the Supervisor menu are shown below:

```

*****
**                PCC Data Entry Module                **
** Data Entry SUPERVISOR Options and Utilities**
*****
                IHS PCC Suite Version 2.0

                DEMO HOSPITAL

ICD   Fix UNCODED ICD9 Diagnoses/Operations ...
VRR   Visit Review Report ...
INP   Link In-Hospital Visits to Hospitalizations ...
DSP   Display PCC Data Entry Site Parameters
DDPR  Delete Duplicate Primary Providers from Visits
ESP   Enter/Edit PCC Data Entry Site Parameters
EVM   Auto Merge Event Visits on Same Day
FTM   Forms/Data Entry Tracking Menu ...
LAB   Complete Orphaned Visits Menu ...
MDL   Visit Re-linker/Merge/Delete Log Reports ...
MNE   Update PCC Mnemonic's Allowed/Not Allowed
OTH   Other PCC Data Entry Reports ...
PLAL  Reports Listing Allergies recorded on PROBLEM LIST ...
PMN   Print list of Data Entry Mnemonics
RET   Re-Submit PCC Visit to the IHS Data Center
TAB   PCC Local Table Maintenance ...
UPMC Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 18-1: Data Entry SUPERVISOR Options and Utilities menu

Use the UPMC option to update the PCC master control file.

Type **UPMC** at the “Select Data Entry SUPERVISOR Options and Utilities Option” to display the following:

```

                PCC DATA ENTRY SUPERVISOR MENU

                UPDATE PCC MASTER CONTROL FILE and ANCILLARY TO PCC LINKs
                This option is used to update the PCC Master Control file and the
                Ancillary to PCC link status for ancillary packages.
                You should be very careful when using this option.

                Do you want to continue? N//

```

Figure 18-2: Information displayed for the UPMC option

If you type **N** at the last prompt, you return to the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt.

## 19.0 Coding Queue

In order to use the coding queue, the EHR/PCC Coding Audit Start Date needs to be set in the PCC Master Control file. Refer to section 19.4 Update PCC Master Control File for more information.

There should be adequate staff to manage the coding queue daily and it should not exceed more than seven days. If you exceed seven days, however, you may encounter problems such as slowness when running it. Turning the queue on and then turning it off again will not create a problem.

The coding queue list can be used to audit visits that are created by EHR users. The visits displayed in the list are those with an INCOMPLETE or blank chart audit status. The object is to review these visits and update their status so that the chart audit status is updated to Reviewed / Complete. Consider the following:

- Billable visits that are *not* flagged as “reviewed” will *not* generate a claim in Third Party Billing (TPB).
- Nonbillable visits that are *not* flagged as “reviewed” will be exported via NDW.
- *All* visits, whether they are billable or not, should be reviewed and flagged as reviewed. A visit will *not* pass to Billing until it is marked as Reviewed/Completed.
- Incomplete/orphan ancillary visits do not appear on this list. These visits appear on the LIR and PPPV reports and will need to be completed and flagged as complete through the normal data entry process.

The following visits are excluded from the list:

- Contract Health visits
- Visits that do not have a primary provider

Visits with the following service categories are included in the list:

- A – Ambulatory
- S - Day Surgery
- O – Observation
- T – Telecommunications
- C - Chart Review
- R - Nursing Home
- I - In Hospital

This list can be sorted by date, primary provider, clinic code, hospital location (scheduling clinic), and facility. Once the visit has been reviewed, the review status can be set as reviewed/complete or incomplete. All visits set as reviewed/complete will be passed to the IHS/PPMS billing package.

We recommend that the lists be run daily with TPB priority. The ultimate goal is to review 100% of all visits. When performing the review, run the list first and then display it to make sure the service category, clinic code, location, coding, and other information is coded correctly.

## 19.1 EHR/PCC Coding Audit for Visits in Date Range (EHRD)

```

*****
**          PCC Data Entry Module          **
**          EHR/PCC Coding Audit Menu      **
*****
          IHS PCC Suite, Version 2.0

          DEMO INDIAN HOSPITAL

EHRD  EHR/PCC Coding Audit for Visits in Date Range
PEHR    EHR/PCC Coding Audit for One Patient
TUR     Count Unreviewed Visits by Date/Service Category
ACRX    Auto-Complete Pharmacy Education Only Visits
CASP    Update EHR Coding Audit Site Parameters
INCV    List Visits Marked as Incomplete
LIR     List Unreviewed/Incomplete Visits
TRV     Tally of Reviewed/Completed Visits by Operator
VNR     Tally/List of Visits not Reviewed in N Days

Select EHR/PCC Coding Audit Menu Option:

```

Figure 19-1: Options on EHR/PCC Coding Audit menu

Use the EHRD option to audit visits created by EHR users.

The visits displayed in the list are those with an incomplete or blank chart audit status. This list can be sorted by date, primary provider clinic code, hospital location (scheduling clinic), and facility.

Once the visit has been reviewed, the review status can be set as reviewed/complete or incomplete. All visits set as reviewed/complete will be passed to the IHS/RPMS billing package.

Contract Health visits are excluded. Visits that do not have a primary provider are also excluded.

Visits with the following service categories are included in the list:

- A – Ambulatory
- S - Day Surgery
- O – Observation

- T – Telecommunications
- C - Chart Review
- R - Nursing Home
- I - In Hospital

**Note:** A visit will NOT pass to Billing until it is marked as reviewed/completed.

**Note:** Incomplete/orphan ancillary visits do not appear on this list. These visits appear on the LIR and PPPV reports and need to be completed and flagged as complete through the normal data entry process.

To list these visits, follow these steps:

1. At the “Enter Beginning Visit Date” prompt, specify the beginning date of the date range. You should limit your date range to no more than seven days, as viewing more than seven days could take a while to process.
2. At the “Enter Ending Visit Date” prompt, specify the ending date of the date range.
3. At the “Enter a code indicating what LOCATIONS/FACILITIES are of interest” prompt, type one of the following:
  - A - ALL Locations/Facilities
  - S - Selected set or Taxonomy of Locations
  - O - ONE Location/Facility

Your selection indicates the locations and facilities that will be included in the list. If you type S or O, other prompts will be displayed.

4. At the “Enter a code indicating what CLINICS (IHS clinic code) are of interest” prompt, type one of the following:
  - A - ALL Clinics
  - S - Selected set or Taxonomy of Clinics
  - O - ONE Clinic
  - X - No Clinic Assigned

Your selection indicates the clinics (IHS clinic code) visits that will be included in the list. If you type S or O, other prompts will be displayed.

5. At the “Enter a code indicating which HOSPITAL LOCATIONS are of interest” prompt, type one of the following:

- A - ALL Hospital Locations
- S - Selected set of Hospital Locations
- O - ONE Hospital Location

Your selection indicates which HOSPITAL LOCATIONS will be included in the list. If you type S or O, other prompts will be displayed.

6. At the “Enter a code indicating which providers are of interest” prompt, type one of the following:

- A - ALL Providers
- S - Selected set or Taxonomy of Providers
- O - ONE Provider
- X - No Visit Primary Provider Assigned

Your selection indicates which providers will be included in the list. If you type S or O, other prompts will be displayed.

7. At the “Select visits based on chart deficiency reason” prompt, use either D (Do NOT screen on Chart Deficiency Reason) or S(Screen on Chart Deficiency Reason).

A chart deficiency reason might have been previously entered for a visit. If you want to display only visits whose LAST chart deficiency reason matches one or more that you select, type the reason or reasons.

8. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

- I - Include All patients
- E - Exclude Demo patients
- O - Include only demo patients

9. The system displays the criteria for the visits.

10. At the “Do you wish to continue?” prompt, type **Y** or **N**. If you type **N**, you leave the process. If you type **Y**, the next prompt is displayed.

11. At the “How would you like the list of visits sorted” prompt, type one of the following options:

- N - Patient Name
- H - HRN
- D - Date of Visit
- T - Terminal Digit of HRN
- S - Service Category

- L - Location of Encounter
- C - Clinic
- O - Hospital Location
- P - Primary Provider
- A - Chart Audit Status
- R - Chart Deficiency Reason (Last one entered)
- I - Has Medicare/Medicaid or PI

The following shows a sample report.

```

PCC/EHR VISIT AUDIT      Feb 06, 2009 15:28:30      Page:    1 of    1
Visit Dates:  Jan 30, 2009 to Feb 06, 2009
* an asterisk beside the visit number indicates the visit has an
error

# VISIT DATE   PATIENT NAME  HRN   FAC  HOSP LOC   CL INS  PRIM
PROV STATU

1)* 01/30/09@12:00 BROWN,LATITIA 104177 DH  A 01 P   ARPROVIDE I .99
2)* 02/04/09@12:00 SMITH,CARLA M 107847 DH  A 01   JKPROVIDE I .99
3)* 02/03/09@12:00 BROWN,CARL WE 164432 DH  A 30 P   JKPROVIDE I .99

      Q - Quit/?? for more actions/+ next/- previous      >>>
D Display Visit      C Chart Audit History      T Change Date/Time
N Note Display      H Health Summary          U Resequence POVS
M Modify Visit      O One Patient's Visits    J View BH Note
A Append to Visit   X Visit Delete            Z Add a Visit
G Visit Merge      B Merge 2 Diff Dates      Y View Any Visit
S Status Update    F F Move V File          K Change Patient
R Resort List      E E Move V File 2 Dates
Select Action: D//

```

Figure 19-2: Sample EHRD data

See Section 19.2 Using the PCC/EHR VISIT AUDIT Screen for more information about this window.

## 19.2 Using the PCC/EHR VISIT AUDIT Screen

The PCC/EHR VISIT AUDIT screen displays the visits that were retrieved and put into the queue for review.

```

PCC/EHR VISIT AUDIT      Sep 11, 2008 10:36:22      Page:    1 of    1
Visit Dates:  Sep 07, 2008 to Sep 11, 2008
* an asterisk beside the visit number indicates the visit has an
error

# VISIT DATE   PATIENT NAME  HRN   FAC  HOSP LOC   CL INS  PRIM PROV
STATU

```

```

1) 09/08/08@09:00 PATIENT,CRSFO 999807 WW      A 16      KAPPAAAA,
2) 09/08/08@09:00 PATIENT,CRSFO 999815 WW      A 12      KAPPAAAA,

          Q - Quit/?? for more actions/+ next/- previous      >>>
D  Display Visit      R  Resort List
N  Note Display      C  Chart Audit History      T  Change Date/Time
M  Modify Visit      H  Health Summary      U  Resequence POVS
A  Append to Visit  O  One Patient's Visits      J  View BH Note
G  Visit Merge      X  Visit Delete      Y  View Any Visit
S  Status Update    B  B Merge 2 Diff Date      Z  Add a Visit
R  Resort List      F  F Move V File      K  Change Patient
                          E  E Move V File 2 Dates

Select Action: D//

```

Figure 19-3: PCC/EHR VISIT AUDIT screen

You can do the following at the “Select Action” prompt:

- If you are not on the last page of the report, type + to display the next page of information.
- If you are not on first page of the report, type - to display the previous page of information.
- Type **Q** to leave the screen.

Below is an overview of the actions that you can perform at the “Select Action” prompt.

- **D - Display Visit:** displays the PCC Visit Data screen for a specified visit.
- **N - Note Display:** displays any notes associated with the visit.
- **M - Modify Visit:** allows you to add a mnemonic to the specified visit.
- **A - Append to Visit:** allows you to append a mnemonic to the specified visit.
- **G - Visit Merge:** allows you to merge visits on the same visit date.
- **S - Status Update:** allows you to change the chart audit status to either R (Reviewed / Complete) or I (Incomplete).
- **R - Resort List:** allows you to change the sort order of the list in the queue by selecting new sort criteria.
- **C - Chart Audit History:** displays the Chart Audit History for a specified visit.
- **H - Health Summary:** displays the specified health summary type about a selected visit.
- **O - One Patient’s Visit:** displays all visits for a patient on the same date as the visit you select from the list.
- **X - Visit Delete:** removes a specified visit from the visit queue.
- **B - B Merge 2 Diff Dates:** used by Pharmacy, for example, to add a medication to a physician visit (for example, over the weekend).

- **F - F Move V File:** move the V file data for a visit record that has more than 1 visit on the particular day.
- **E - E Move V File 2 Dates:** similar to F Move V File but moves visits on different days.
- **T - Change Date/Time:** changes the date or time of a specified visit.
- **U - Resequence POVS:** allows the user to change the POV sequence for a visit.
- **J - View BH Note:** displays a Behavioral Health Note for a visit.
- **Y- View any Visit:** allows user to view any visit on a patient in the list.
- **Z - Add a Visit:** adds a visit to the visit queue.
- **K – Change Patient:** allows users to switch patients when in PEHR option.

### 19.2.1 Display Visit (D)

Use the D action to display ancillary data about a specified visit.

Display the visit for which to verify PCC reporting requirements (service category, clinic, location, visit type, etc.) and coding requirements. Note that the display shows visits that are EHR created. Record any deficiencies and coding changes to be communicated to the provider via email or person-to-person. If you need to document the discussion with the provider, use the coding template to document the interaction in writing.

If you type **D** at the “Select Action” prompt and select the visit of interest, the system displays a message that it’s looking for ancillary data to merge into the visit.

```

PCC VISIT DISPLAY      Feb 06, 2009 16:05:40      Page:    1 of    3

Patient Name:          BROWN,LATITIA
Chart #:                104177
Date of Birth:         NOV 08, 1956
Sex:                   F
Visit IEN:             2522248

===== VISIT FILE =====
VISIT/ADMIT DATE&TIME: JAN 30, 2009@12:00
DATE VISIT CREATED:   JAN 30, 2009
TYPE:                 TRIBE-NON 638/NON-COMPACT
PATIENT NAME:         BROWN,LATITIA
LOC. OF ENCOUNTER:    DEMO HOSPITAL
SERVICE CATEGORY:    AMBULATORY
CLINIC:               GENERAL
DEPENDENT ENTRY COUNT: 3
DATE LAST MODIFIED:   JAN 30, 2009
WALK IN/APPT:         WALK IN
CREATED BY USER:     BETHEA,LINZA
USER LAST UPDATE:     BETHEA,LINZA

+           Enter ?? for more actions

```

+    Next Screen	-    Previous Screen	Q    Quit
Select Action: +//		

Figure 19-4: Sample information using D

You can enter the following at the “Select Action” prompt:

- If you are not on the last screen of data, type + to display the next screen of data.
- If you are not on the first screen of data, type - to display the previous screen of data.
- Type **Q** to return to the PCC/EHR Visit Audit screen.

### 19.2.2 Note Display (N)

Use the **N** action to display notes about a selected visit (if permitted). Some BH visits might not allow this display. You will be prompted to select the visit you want to use.

### 19.2.3 Modify Visit (M)

Use the **M** action to modify a selected visit.

1. At the “Select Action” prompt, type **M**.
2. At the “Modify which Visit” prompt, specify the number of the visit you want to modify.
3. At the “MNEMONICS” prompt, specify the mnemonic you want to use.
4. The remaining prompts will vary, depending on the mnemonic you enter.
5. At the “Chart Audit Status” prompt, type one of the following:
  - R (reviewed/complete)
  - I (Incomplete)

If you use **I**, the system will ask for a chart deficiency reason.

You can add a new deficiency to the list. See section 19.3 Adding Chart Deficiency Reasons for more information.

6. The last prompt asks if you want to (A)DD or (D)ELETE. Otherwise, press Enter.

If you type **A**, the prompts will be repeated so you can add another option associated with the mnemonic. For example, if you entered the allergy (ALG) mnemonic, you will be asked to enter another causative agent. ALG requires that at least one causative agent be entered.

If you type **D**, you will be asked which sign or symptom you want to delete.

If you press Enter, the following screen is displayed (in this example, the ALG mnemonic was entered).

```

COMMENTS:
  No existing text
  Edit? NO//
Complete the observed reaction report? Yes//   (Yes)
DATE/TIME OF EVENT: SEP 9,2008//
OBSERVER: TESTER,ALPHA//
SEVERITY:
DATE MD NOTIFIED: Sep 9,2008//   (SEP 09, 2008)
Complete the FDA data? Yes//   (Yes)

Indicate which FDA Report Sections to be completed:

1.  Reaction Information
2.  Suspect Drug(s) Information
3.  Concomitant Drugs and History
4.  Initial Reporter

Choose number(s) of sections to be edited:   (1-4): 1-4//

The following is the list of reported signs/symptoms for this
reaction:

      Signs/Symptoms
-----
1  DIARRHEA
2  ITCHING

Select Action (A)DD, (D)ELETE OR <RET>:

```

Figure 19-5: Sample prompts

Other prompts will be displayed depending on your response to the “Select Action” prompt.

During the update process, if you answer NO to the “Coding Complete...” prompt, this visit will be flagged as Incomplete and the system will ask for a reason. Type ?? at the prompt to view a list of deficiencies to choose from, or choose Other. You can also add a note to the visit; notes are displayed in the Visit File information with the Chart Audit Notes label.

#### 19.2.4 Append to Visit (A)

Use the A action to append a visit to the visit queue.

1. Type A at the “Select Action” prompt and answer the prompts accordingly.
2. At the “Append to which visit” prompt, specify the visit you want to append.
3. At the “MNEMONICS” prompt, specify the mnemonic you want to use.
4. The remaining prompts will vary, depending on the entered mnemonic.

5. The last prompt asks if you want to (A)DD or (D)ELETE. Otherwise, press Enter.

If you type **A**, the prompts will be repeated so you can add another option associated with the mnemonic. For example, if you entered the allergy (ALG) mnemonic, you will be asked to enter another causative agent. ALG requires that at least one causative agent be entered.

If you type **D**, you will be asked which sign or symptom you want to delete.

If you press Enter, the following screen is displayed (in this example, the ALG mnemonic was entered).

```

COMMENTS:
  No existing text
  Edit? NO//
Complete the observed reaction report? Yes//   (Yes)
DATE/TIME OF EVENT: SEP 9,2008//
OBSERVER: TESTER,ALPHA//
SEVERITY:
DATE MD NOTIFIED: Sep 9,2008//   (SEP 09, 2008)
Complete the FDA data? Yes//   (Yes)

Indicate which FDA Report Sections to be completed:
1.  Reaction Information
2.  Suspect Drug(s) Information
3.  Concomitant Drugs and History
4.  Initial Reporter
Choose number(s) of sections to be edited:   (1-4): 1-4//

The following is the list of reported signs/symptoms for this
reaction:

      Signs/Symptoms
-----
1  DIARRHEA
2  ITCHING

Select Action (A)DD, (D)ELETE OR <RET>:

```

Figure 19-6: Sample information

Other prompts will be displayed depending on your response to the “Select Action” prompt.

During the update process, if you answer NO to the “Coding Complete...” prompt, this visit will be flagged as Incomplete and the system will ask for a reason; Type ?? at the prompt to view a list of deficiencies to choose from or choose Other. You can also add a note to the visit; notes are displayed in the Visit File information with the Chart Audit Notes label.

## 19.2.5 Visit Merge (G)

Use the **G** action to merge data when a patient has more than one visit on the date of the selected visit.

1. Type **G** at the “Select Action” prompt and respond to the subsequent prompts.
2. At the “Modify which Visit” prompt, specify the number of the visit to be merged. (If this process is not possible, the system displays the “Patient only has 1 visit on that day, cannot do merge” message.)

Use this option, for example, when the patient was seen by a physician and ordered medications, and the pharmacist filled the medication by creating another visit file. The pharmacist should have added to the physician visit instead.

### 19.2.6 Status Update (S)

Use the **S** action to change the status of a specified visit.

To change the status of a visit, type **S** at the “Select Action” prompt and respond to the subsequent prompts.

```
Update Chart Audit Status for which visit:   (1-98): 92

CHART AUDIT STATUS: ?

Choose from:
R           REVIEWED/COMPLETE
I           INCOMPLETE
```

Figure 19-7: Sample prompts

- If you type **R** at the “CHART AUDIT STATUS” prompt, the specified visit will no longer be in your queue.
- If you type **I** at the “CHART AUDIT STATUS” prompt, the specified visit will remain in your queue.

### 19.2.7 Resort List (R)

Use the **R** action to specify the sort order of the visits.

1. Type **R** at the “Select Action” prompt and respond to the subsequent prompts.
2. At the “How would you like the list of visits sorted” prompt, type one of the following options:
  - N - Patient Name
  - H - HRN
  - D - Date of Visit
  - T - Terminal Digit of HRN

- S - Service Category
  - L - Location of Encounter
  - C - Clinic
  - O - Hospital Location
  - P - Primary Provider
  - A - Chart Audit Status
  - R - Chart Deficiency Reason (Last one entered)
  - I - Has Medicare/Medicaid or PI
3. After the sort criteria have been selected, the system redisplay the records using the specified criteria.

Below is a new sort of the records:

```

PCC/EHR VISIT AUDIT      Sep 11, 2008 16:19:44      Page:      1 of      1
Visit Dates:  Sep 03, 2008 to Sep 11, 2008
* an asterisk beside the visit number indicates the visit has an
error

#   VISIT DATE      PATIENT NAME  HRN      FAC  HOSP LOC  CL  INS
PRIM PROV STATU

1)* 09/03/08@12:00 GAMMA,MISTY1  106735 WW   PHARMACY A 39 M
NO
2)* 09/03/08@12:00 DEMO,AUSTIN W 192640 WW   PHARMACY A 39
NO
3)* 09/03/08@12:00 SAM,ALPHA WAY 197800 WW   PHARMACY A 39
NO
4)* 09/04/08@12:00 SAM,ALPHA WAY 197800 WW   PHARMACY A 39
NO
5)* 09/04/08@12:00 KAPPA,FAYY ER 135297 WW   PHARMACY A 39 M/C
NO
6) 09/05/08@10:45 ALPHAB,CHELSE 116431 WW   BJB SOCS A 48 M
BETA,B
7) 09/08/08@09:00 PATIENT,CRSFO 999807 WW           A 16  KAPPA1,
8) 09/08/08@09:00 PATIENT,CRSFO 999815 WW           A 12  KAPPA,
I

          Q - Quit/?? for more actions/+ next/- previous      >>>
D Display Visit      R Resort List          F F Move V File
N Note Display      C Chart Audit History E E Move V File 2 Dates
M Modify Visit      H Health Summary      T Change Date/Time
A Append to Visit   O One Patient's Visits Z Add a Visit
G Visit Merge      X Visit Delete
S Status Update    B B Merge 2 Diff Dates
Select Action: D//

```

Figure 19-8: Sample report for Resort List action

## 19.2.8 Chart Audit History (C)

Use the C action to display the chart audit history for a specified visit.

Type **C** at the “Select Action” prompt and respond to the subsequent prompts.

```
Select Action: D//C

    1 Chart Audit History
    2 Change Date/Time
CHOOSE 1-2: 1 Chart Audit History
Display Chart Audit History for which Visit (1-5): 3
Chart Audit History for VISIT:
  Visit Date: JAN 26, 2007@09:57 Patient Name: ALPHA,GAMMA
Hospital Location: FAMILY MED primary Provider: XDOCT,MD
DATE OF AUDIT          STATUS          USER WHO AUDITIED CHART
DEFICIENCY

Mar 19, 2007@10:37    INCOMPLETE    USER,BSTUDENT

NOTES:
Waiting for provider to add his note changes before completing the
visit
```

Figure 19-9: Sample prompts

## 19.2.9 Health Summary (H)

Use the H action to display the specified health summary type about a selected visit.

1. Type **H** at the “Select Action” prompt.
2. At the “Select Health Summary Type Name” prompt, specify the health summary type you want to use.

Below is a sample report for the All Reminders health summary type.

```
OUTPUT BROWSER          Sep 11, 2008 16:30:39      Page:    1 of    2
PCC Health Summary for PATIENT,CRSFORG

** CONFIDENTIAL PATIENT INFORMATION -- 9/11/2008  4:30 PM  [ST] **
** PATIENT,CRSFORG #999807 <A>    (ALL REMINDERS SUMMARY)  pg 1 **

----- HEALTH MAINTENANCE REMINDERS -----

                                LAST          NEXT

BREAST EXAM                      MAY BE DUE NOW
DIABETES SCREENING                MAY BE DUE NOW

BLOOD PRESSURE                    MAY BE DUE NOW
PAP SMEAR                          MAY BE DUE NOW

PELVIC EXAM                       MAY BE DUE NOW
HEIGHT                             MAY BE DUE NOW
```

```

WEIGHT                                MAY BE DUE NOW
+          Enter ?? for more actions          >>>

+   NEXT SCREEN          -   PREVIOUS SCREEN   Q   QUIT
Select Action: +//

```

Figure 19-10: Sample prompts

Use one of the following options at the “Select Action” prompt:

- If you are not on the last screen of information, type + to view the next screen.
- If you are not on the first screen of information, type - to view the previous screen.
- Type **Q** to return to the PCC/EHR Visit Audit screen.

### 19.2.10 One Patient’s Visit (O)

Use the **O** action to display all visits for a patient on the same date as the visit you select from a list.

Type **O** at the “Select Action” prompt and respond to the subsequent prompts.

```

Which Visit: (1-8): 7
Looking for ancillary data to merge into this visit...

PCC/EHR VISIT AUDIT      Sep 11, 2008 16:40:18      Page:      1 of      1
* an asterisk beside the visit number indicates the visit has an
error
# VISIT DATE    PATIENT NAME    HRN  FAC  HOSP  LOC    CL  PRIM  PROV
STATUS

1)  09/08/08@09:00  PATIENT,CRSFORG 999807  WW          A 16  KAPPA,S

          Q - Quit/?? for more actions/+ next/- previous

>>>
D Display Visit          G Visit Merge          X Visit Delete
N Note Display          S Status Update        B B Merge 2 Dates
M Modify Visit          C Chart Audit History  F F Move V File
A Append to Visit       H Health Summary       Z Add a Visit
Select Action: D//

```

Figure 19-11: Sample information

### 19.2.11 Visit Delete (X)

Use the **X** action to remove a specified visit from the queue.

Type **X** at the “Select Action” prompt and respond to the subsequent prompts.

```

Which Visit: (1-8): 7

~~~~~

VISIT IEN: 2561722

HRN: WW 999807

----- VISIT FILE -----
VISIT/ADMIT DATE&TIME: SEP 08, 2008@09:00
  DATE VISIT CREATED: SEP 08, 2008      TYPE: IHS
  PATIENT NAME: PATIENT,CRSFORG        LOC. OF ENCOUNTER: DEMO
INDIAN HOSPITAL
  SERVICE CATEGORY: AMBULATORY          CLINIC: OBSTETRICS
  DEPENDENT ENTRY COUNT: 2             DATE LAST MODIFIED: SEP 11,
2008
  WALK IN/APPT: UNSPECIFIED            CREATED BY USER: KAPPA,SIGMA
  USER LAST UPDATE: THETA,SIGMA
  OLD/UNUSED UNIQUE VISIT ID: 5059010002561722
  ORIGINAL DATA ENTRY DATE: SEP 08, 2008
  DATE/TIME LAST MODIFIED: SEP 11, 2008@13:52:37
  NDW UNIQUE VISIT ID (DBID): 102320002561722
  VISIT ID: 366M-WWX

Enter to continue, '^' to halt

----- V PROVIDER -----
PROVIDER: KAPPA,SIGMA                PATIENT NAME:
PATIENT,CRSFORG
  VISIT: SEP 08, 2008@09:00          PRIMARY/SECONDARY: PRIMARY
  AFF.DISC.CODE (c): 1001

----- V POV -----
POV: 651.00                          PATIENT NAME:
PATIENT,CRSFORG
  VISIT: SEP 08, 2008@09:00
  PROVIDER NARRATIVE: TWIN PREGNANCY-UNSPEC
  FIRST/REVISIT: REVISIT
  ICD NARRATIVE (c): TWIN PREGNANCY-UNSPEC

~~~~~

End of visit display, <ENTER> to Continue

THE ABOVE VISIT AND RELATED V FILE ENTRIES WILL BE REMOVED FOREVER
!!!
Sure you want to delete? No//

```

Figure 19-12: Sample prompts

If you type **N** at the “Sure you want to delete?” prompt, the visit remains in the queue. Otherwise, type **Y** to remove it.

### 19.2.12 B Merge 2 Diff Date (B)

There are times when the pharmacy staff are close to the end of the day and enter the medications the day later (or the following Monday), if it is an emergency room visit. When the pharmacists go in on Monday, they need to go back to the visit created by the physician the day before (or the Friday, Saturday, or Sunday before) to add the medication to the physician visit.

Type **B** at the “Select Action” prompt and respond to the subsequent prompts.

```
Which visit: (1-97): 90
Select 'From' visit.
Enter VISIT date: 011707 (Jan 17, 2007)
PATIENT: ALPHA,GAMMA has one or more visits on this visit.
1  TIME: 12:00 LOC: CI  TYPE: T CAT: A CLINIC: PHARMACY DEC: 31
   Hospital Location: PHARMACY
   Primary Provider: USER,DEMO1
2  TIME: 12:00 LOC: CI  TYPE: T CAT: A CLINIC: PHARMACY DEC: 1
   Hospital Location: PHARMACY
   Primary Provider: USER,DEMO31
3  TIME: 13?21 LOC: CI  TYPE: T CAT: A CLINIC: GENERAL  DEC: 13
   Hospital Location: GENERAL
   Primary Provider: USER,DOC
Select one:
```

Figure 19-13: Sample prompts

### 19.2.13 F Move V File (F)

To save time, the ancillary staff may create a single V File even though some of the information belongs to separate visits in multiple clinics on the same day. The data entry staff can use this option to move multiple medications, labs, or X-rays to the correct physician visits.

Type **F** at the “Select Action” prompt and respond to the subsequent prompts.

### 19.2.14 E Move V File 2 Dates (E)

Like the F Move V File option, this option moves multiple medications, labs, or X-rays to the correct physician visits, but for V Files created on different days. The data entry staff must verify which parts of the V files belong to which dates.

Type **E** at the “Select Action” prompt and respond to the subsequent prompts.

### 19.2.15 Change Date/Time (T)

Use this option to change the date and time of a specified visit in the queue.

Type **T** at the “Select Action” prompt and respond to the subsequent prompts.

```
Which Visit: (1-8): 7

NDW UNIQUE VISIT ID (DBID): 102320002561721
VISIT ID: 366K-WWX

The date and time of the VISIT is SEP 05, 2008@10:45

Enter new date and time:
```

Figure 19-14: Sample prompts

### 19.2.16 Resequence POVS (U)

Use this option to Resequence the POVs in the audit list.

### 19.2.17 View BH Note (J)

Type **J** at the “Selection Action” prompt to view a Behavioral Health TIU or SOAP note entered into the behavioral health module.

**Note:** The AMHZ CODING QUEUE security is required to use this action.

### 19.2.18 View Any Visit (Y)

Use this option to view patient visits that are not in the current view visit list. Type **Y** at the “Selection Action” prompt and enter the patient name and visit date.

### 19.2.19 Add a Visit (Z)

Use this option to add a visit to the visit queue.

Type **Z** at the “Select Action” prompt and respond to the subsequent prompts. The system will enter the ENTER Mode.

### 19.2.20 Change Patient (K)

This option is available when using PEHR EHR/PCC Coding Audit for One Patient. The option allows you to change patient’s without having to exit.

## 19.3 Adding Chart Deficiency Reasons

You can add a deficiency reason by using the ACDR option on the EHR.PCC Coding Audit Menu. This option requires that the APCDZ ADD CDR key is assigned to the user.

\*\*\*\*\*

```

**          EHR/PCC Coding Audit Menu          **
*****
                IHS PCC Suite Version 2.0

                DEMO INDIAN HOSPITAL

EHRD   EHR/PCC Coding Audit for Visits in Date Range
PEHR   EHR/PCC Coding Audit for One Patient
ACDR  Add new Chart Deficiency Reason to Table
TUR    Count Unreviewed Visits by Date/Service Category
ACRX   Auto-Complete Pharmacy Education Only Visits
CASP   Update EHR Coding Audit Site Parameters
INCV   List Visits Marked as Incomplete
LIR    List Unreviewed/Incomplete Visits
TRV    Tally of Reviewed/Completed Visits by Operator

You have 32 PENDING ALERTS
      Enter "VA to jump to VIEW ALERTS option

There is PRIORITY Mail!

Select EHR/PCC Coding Audit Menu Option:

```

Figure 19-15: EHR/PCC Coding Audit Menu options

After you type **ACRD** at the “Select EHR/PCC Coding Audit Menu Option” prompt, the following message is displayed. This example uses “Physical” as the new deficiency reason.

```

Select OUTPATIENT CHART DEFICIENCY REASONS: physical
Are you adding 'physical' as
a new OUTPATIENT CHART DEFICIENCY REASONS (the 45TH)? No//

```

Figure 19-16: Sample prompts

The name of the new deficiency reason must be 3-35 characters in length.

If you type **Yes** at the last prompt, the new deficiency reason will be displayed on the list of reasons.

If you type **No** at the last prompt, the new deficiency reason will not be displayed on the list of reasons.

## 19.4 Update PCC Master Control File

To use the coding queue, the EHR/PCC Coding Audit Start Date must be set in the PCC Master Control file.

The options and utilities on the Supervisor menu are shown below:

```

*****
**          PCC Data Entry Module          **
** Data Entry SUPERVISOR Options and Utilities**

```

```

*****
IHS PCC Suite Version 2.0

DEMO INDIAN HOSPITAL

ICD   Fix UNCODED ICD9 Diagnoses/Operations ...
VRR   Visit Review Report ...
INP   Link In-Hospital Visits to Hospitalizations ...
DSP   Display PCC Data Entry Site Parameters
ACC   Process ACCEPT Commands ...
DDPR  Delete Duplicate Primary Providers from Visits
ESP   Enter/Edit PCC Data Entry Site Parameters
EVM   Auto Merge Event Visits on Same Day
FTM   Forms/Data Entry Tracking Menu ...

LAB   Complete Orphaned Visits Menu ...
MNE   Update PCC Mnemonic's Allowed/Not Allowed
OTH   Other PCC Data Entry Reports ...
PLAL  Reports Listing Allergies recorded on PROBLEM LIST ...
PMN   Print list of Data Entry Mnemonics
RET   Re-Submit PCC Visit to the IHS Data Center
TAB   PCC Local Table Maintenance ...
UPMC Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 19-17: Data Entry SUPERVISOR Options and Utilities menu

Use the UPMC option to update the PCC Master Control file and Ancillary to PCC link status for ancillary packages.

After you type **UPMC** at the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt, the following is displayed after you enter the facility name:

```

***** Update PCC Master Control *****
Location/Division: DEMO INDIAN HOSPITAL
-----

Default Type of Visit: IHS
Default Health Summary Type: ADULT REGULAR
Type of PCC Link (old mode): TIME REQUIRED
Beginning FISCAL YEAR Month:

Pass PAP Smears from V LAB to WH?

EHR Chart Audit Start Date: SEP 1,2008

Default Directory for DM Audit EPI output file:
FACILITY PRINT NAME for Patient Handout:
Prompt to Print Patient Health Handout at Check-In?

Update Package PCC Linkages? Y

```

Figure 19-18: Sample prompts

Set the EHR/PCC Coding Audit Start Date at the “EHR Chart Audit Start Date” prompt.

We suggest that the date be the beginning of the fiscal year or the beginning of a month or quarter.

## Appendix A: RPMS Rules of Behavior

The information in this required section was written by the IHS Office of Information Technology. It does not contain any information about the functionality of the software.

### A.1 All RPMS Users

In addition to these rules, each application may include additional RoBs, which may be defined within the individual application's documentation (e.g., PCC, Dental, Pharmacy).

#### A.1.1 Access

RPMS users shall:

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer *before* providing any type of information system access, sensitive information, or non-public agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions Indian Health Manual Chapter 6 OMS Limited Personal Use of Information Technology Resources TN 03-05," August 6, 2003.

Users shall not:

- Retrieve information for someone who does not have authority to access the information.
- Access, research, or change any user account, file, directory, table, or record not required to perform your OFFICIAL duties.
- Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.
- Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their job or by divulging information to anyone not authorized to know that information

#### A.1.2 Logging On To The System

RPMS users shall:

- Have a unique User Identification/Account name and password.

- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after 5 successive failed login attempts within a specified time period (e.g., one hour).

### A.1.3 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

Users shall

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the function they perform such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS policies and procedures prior to interconnection to or transferring data from RPMS.
- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their PC.
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.
- Shall abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior and IT information processes

### A.1.4 Accountability

Users shall:

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their PC.
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)

- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.
- Abide by all department and agency policies and procedures and guidelines related to ethics, conduct, behavior and IT information processes.

### A.1.5 Confidentiality

Users shall:

- Be aware of the sensitivity of electronic and hardcopy information, and protect it accordingly.
- Store hardcopy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media, prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all HIPAA regulations to ensure patient confidentiality

Users shall not:

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting

### A.1.6 Integrity

Users shall:

- Protect your system against viruses and similar malicious programs.
- Observe all software license agreements.
- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

Users shall not:

- Violate Federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware or public domain software on/with the system without your manager's written permission and without scanning it for viruses first

### A.1.7 Passwords

Users shall:

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha, numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts, or batch files).
- Change password immediately if password has been seen, guessed or otherwise compromised; and report the compromise or suspected compromise to your ISSO.
- Keep user identifications (ID) and passwords confidential

Users shall not:

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per 8 characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.
- Give a password out over the phone.

### A.1.8 Backups

Users shall:

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment

Users shall not:

- Violate Federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware or public domain software on/with the system without your manager's written permission and without scanning it for viruses first.

### A.1.9 Reporting

Users shall:

- Contact and inform your ISSO that you have identified an IT security incident and you will begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in IHS SOP 05-03, Incident Handling Guide

Users shall not:

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

### A.1.10 Session Time Outs

RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

Users shall:

- Utilize a screen saver with password protection set to suspend operations at no greater than 10-minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on your screen after some period of inactivity.

### A.1.11 Hardware

Users shall:

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.
- Keep records of maintenance/repairs performed on system equipment

Users shall not:

- Eat or drink near system equipment

### A.1.12 Awareness

Users shall:

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS Manuals for the applications used in their jobs.

### A.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that:

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal and non-recovery of temporary files created in processing sensitive data, virus protection, intrusion detection, and provides physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote users shall:

- Remotely access RPMS through a virtual private network (VPN) whenever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures

Remote users shall not:

- Disable any encryption established for network, internet, and web browser communications

## A.2 RPMS Developers

Developers shall:

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.

- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Observe separation of duties policies and procedures to the fullest extent possible.
- Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change and reason for the change.
- Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Follow industry best standards for systems they are assigned to develop or maintain; abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available

Developers shall not:

- Access live production systems without obtaining appropriate written access, shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

### A.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators have added responsibilities to ensure the secure operation of RPMS.

Privileged users shall:

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.

- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need to know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, CISO, and systems owner.
- Protect the supervisor, superuser or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.
- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords, and delete or reassign related active and back up files.
- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator's database.
- Follow industry best standards for systems they are assigned to; abide by all Department and Agency policies and procedures

Privileged users shall not:

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.

- Release any sensitive agency or patient information.

## Appendix B: IHS Edits

Inpatient Edit C2	These V codes cannot be used as principal DX
V01.0 CHOLERA CONTACT	V01.1 TUBERCULOSIS CONTACT
V01.2 POLIOMYELITIS CONTACT	V01.3 SMALLPOX CONTACT
V01.4 RUBELLA CONTACT	V01.7 RABIES CONTACT
V01.6 VENEREAL DIS CONTACT	V01.7 VIRAL DIS CONTACT NEC
V01.8 COMMUNIC DIS CONTACT NEC	V01.9 COMMUNIC DIS CONTACT NOS
V02.0 CHOLERA CARRIER	V02.1 TYPHOID CARRIER
V02.2 AMEBIASIS CARRIER	V02.3 GI PATHOGEN CARRIER NEC
V02.4 DIPHTHERIA CARRIER	V02.5 CARRIER/SUSP/OTR/SPEC BACT
V02.6 VIRAL HEPATITIS CARRIER	V02.7 GONORRHEA CARRIER
V02.8 VENEREAL DIS CARRIER NEC	V02.9 CARRIER NEC
V03.0 VACCIN FOR CHOLERA	V03.1 VACC-TYPHOID-PARATYPHOID
V03.2 VACCIN FOR TUBERCULOSIS	V03.3 VACCIN FOR PLAGUE
V03.4 VACCIN FOR TULAREMIA	V03.5 VACCIN FOR DIPHTHERIA
V03.6 VACCIN FOR PERTUSSIS	V03.7 TETANUS TOXOID INOCULAT
V03.8 VACCIN FOR BACT DIS NEC	V03.9 VACCIN FOR BACT DIS NOS
V04.0 VACCIN FOR POLIOMYELITIS	V04.1 VACCIN FOR SMALLPOX
V04.2 VACCIN FOR MEASLES	V04.3 VACCIN FOR RUBELLA
V04.4 VACCIN FOR YELLOW FEVER	V04.5 VACCIN FOR RABIES
V04.6 VACCIN FOR MUMPS	V04.7 VACCIN FOR COMMON COLD
V04.8 VACCIN FOR INFLUENZA	V05.0 ARBOVIRUS ENCEPH VACCIN
V05.1 VACC ARBOVIRAL DIS NEC	V05.2 VACCIN FOR LEISHMANIASIS
V05.8 VACCIN FOR DISEASE NEC	V05.9 VACCIN FOR SINGL DIS NOS
V06.0 VACCIN FOR CHOLERA + TAB	V06.1 VACCIN FOR DTP
V06.2 VACCIN FOR DIP + TAB	V06.3 VACCIN FOR DTP + POLIO
V06.4 VAC-MEASLE-MUMPS-RUBELLA	V06.8 VAC-DIS COMBINATIONS NEC
V06.9 VAC-DIS COMBINATIONS NOS	V07.2 PROPHYLACT IMMUNOTHERAPY
V07.3 PROPHYL CHEMOTHERAPY NEC	V07.9 PROPHYLACTIC MEASURE NOS
V10.00 HX OF GI MALIGNANCY NOS	V10.01 HX OF TONGUE MALIGNANCY
V10.02 HX-ORAL/PHARYNX MALG NEC	V10.03 HX-ESOPHAGEAL MALIGNANCY
V10.04 HX OF GASTRIC MALIGNANCY	V10.05 HX OF COLONIC MALIGNANCY
V10.06 HX-RECTAL ANAL MALIGN	V10.07 HX OF LIVER MALIGNANCY
V10.09 HX OF GI MALIGNANCY NEC	V10.11 HX-BRONCHOGENIC MALIGNAN
V10.12 HX-TRACHEAL MALIGNANCY	V10.20 HX-RESP ORG MALIGNAN NOS
V10.21 HX-LARYNGEAL MALIGNANCY	V10.22 HX-NOSE/EAR/SINUS MALIG
V10.29 HX-INTRATHORACIC MAL NEC	V10.3 HX OF BREAST MALIGNANCY
V10.40 HX-FEMALE GENIT MALG NOS	V10.41 HX-CERVICAL MALIGNANCY
V10.42 HX-UTERUS MALIGNANCY NEC	V10.43 HX OF OVARIAN MALIGNANCY
V10.44 HX-FEMALE GENIT MALG NEC	V10.45 HX-MALE GENIT MALIG NOS
V10.46 HX-PROSTATIC MALIGNANCY	V10.47 HX-TESTICULAR, MALIGNANCY

<b>Inpatient Edit C2</b>	<b>These V codes cannot be used as principal DX</b>
V10.49 HX-MALE GENIT MALIG NEC	V10.50 HX-URINARY MALIGNAN NOS
V10.51 HX OF BLADDER MALIGNANCY	V10.52 HX OF KIDNEY MALIGNANCY
V10.59 HX-URINARY MALIGNAN NEC	V10.60 HX OF LEUKEMIA NOS
V10.61 HX OF LYMPHOID LEUKEMIA	V10.62 HX OF MYELOID LEUKEMIA
V10.63 HX OF MONOCYTIC LEUKEMIA	V10.69 HX OF LEUKEMIA NEC
V10.71 HX-LYMPHOSARCOMA	V10.72 HX-HODGKIN1S DISEASE
V10.79 HX-LYMPHATIC MALIGN NEC	V10.81 HX OF BONE MALIGNANCY
V10.82 HX-MALIG SKIN MELANOMA	V10.83 HX-SKIN MALIGNANCY NEC
V10.84 HX OF EYE MALIGNANCY	V10.85 HX OF BRAIN MALIGNANCY
V10.86 HX-MALIGN NERVE SYST NEC	V10.87 HX OF THYROID MALIGNANCY
V10.88 HX-ENDOCRINE MALIGN NEC	V10.89 HX OF MALIGNANCY NEC
V10.9 HX OF MALIGNANCY NOS	V11.0 HX OF SCHIZOPHRENIA
V11.1 HX OF AFFECTIVE DISORDER	V11.2 HX OF NEUROSIS
V11.3 HX OF ALCOHOLISM	V11.8 HX-MENTAL DISORDER NEC
V11.9 HX-MENTAL DISORDER NOS	V12.0 HX-INFECT/PARASITIC DIS
V12.1 HX-NUTRITION DEFICIENCY	V12.2 HX-ENDOCR/META/IMMUN DIS
V12.3 HX-BLOOD DISEASES	V12.4 HX-NERV SYS/SENS ORG DIS
V12.5 HX-DISEASES CIRCULATORY SYSTEM	V12.6 HX-RESPIRATORY SYS DIS
V12.7 HX OF GI DISORDER	V13.0 HX-URINARY SYSTEM DISORD
V13.1 HX-TROPHOBLASTIC DISEASE	V13.2 HX-GENITAL/OBSTETRIC DIS
V13.3 HX-SKIN/SUBCUTAN TIS DIS	V13.4 HX OF ARTHRITIS
V13.5 HX-MUSCULOSKELET DIS NEC	V13.6 PERS HX CONGENIT MALFORMATION
V13.7 HX-PERINATAL PROBLEMS	V13.8 HX OF DISEASES NEC
V13.9 HX OF DISEASE NOS	V14.0 HX-PENICILLIN ALLERGY
V14.1 HX-ANTIBIOT ALLERGY NEC	V14.2 HX-SULFONAMIDES ALLERGY
V14.3 HX-ANTI-INFECT ALLERGY	V14.4 HX-ANESTHETIC ALLERGY
V44.8 ARTIF OPEN STATUS NEC	V44.9 ARTIF OPEN STATUS NOS
V45 0 CARDIAC PACEMAKER STATUS	V45.1 RENAL DIALYSIS STATUS
V45.2 VENTRICULAR SHUNT STATUS	V45.3 INTESTINAL BYPASS STATUS
V45.4 ARTHRODESIS STATUS	V45.5 PRESENCE OF IUD
V45.6 POSTSURGICAL STATE, EYE	V45.81 AORTOCORONARY BYPASS
V45.89 POSTSURGICAL STATES NEC	V46.0 DEPENDENCE ON ASPIRATOR
V46.1 DEPENDENCE ON RESPIRATOR	V46.8 MACHINE DEPENDENCE NEC
V46.9 MACHINE DEPENDENCE NOS	V47.0 INTERN ORGAN DEFICIENCY
V47.1 MECH PROB W INTERNAL ORG	V47.2 CARDIORESPIRAT PROBL NEC
V47.3 DIGESTIVE PROBLEMS NEC	V47.4 URINARY PROBLEMS NEC
V47.5 GENITAL PROBLEMS NEC	V47.9 PROBL W INTERNAL ORG NOS
V48.0 DEFICIENCIES OF HEAD	V48.1 DEFICIENCIES NECK/TRUNK
V48.2 MECHANICAL PROB WHEAD	V48.3 MECH PROB WNECK TRUNK
V48.4 SENSORY PROBLEM WHEAD	V48.5 SENSOR PROB WNECK/TRUNK
V48.6 DISFIGUREMENTS OF HEAD	V48.7 DISFIGUREMENT NECK/TRUNK
V48.8 PROB-HEAD/NECK/TRUNK NEC	V48.9 PROB-HEAD/NECK/TRUNK NOS

<b>Inpatient Edit C2</b>	<b>These V codes cannot be used as principal DX</b>
V49.0 DEFICIENCIES OF LIMBS	V49.1 MECHANICAL PROB W LIMBS
V49.2 MOTOR PROBLEMS W LIMBS	V49.3 SENSORY PROBLEMS W LIMBS
V49.4 DISFIGUREMENTS OF LIMBS	V49.5 LIMB PROBLEMS NEC
V49.8 PROBL INFLU HEALTH NEC	V49.9 PROBL INFLU HEALTH NOS
V57.0 BREATHING EXERCISES	V57.4 ORTHOPTIC TRAINING
V58.2 BLOOD TRANSFUSION, NO DX	V58.5 ORTHODONTICS AFTERCARE
V68.0 ISSUE MEDICAL CERTIFICAT	V68.1 ISSUE REPEAT PRESCRIPT
V68.2 REQUEST EXPERT EVIDENCE	V68.89 ADMINISTRTVE ENCOUNT NEC
V68.81 REFERRAL-NO EXAM/TREAT	V37.00 OTH MULT, UNSPEC-IN HOSP,NO C-S
V37.01 OIH MULT, UNSPEC-IN HOS,DEL C-S	V39.00 LB-IN HOSP, UNSPEC,NO C-S
V39.01 LB-IN HOSP, DEL C-S	V68.9 ADMINISTRTVE ENCOUNT NOS
V23.7 INSUFFICIENT PRENATAL CARE	V25.8 CONTRACEPTIVE MANGMT NEC
V25.9 CONTRACEPTIVE MANGMT NOS	V07.4 POSTMENOPAUSAL HORMONE REPLACE
V25.43 SURV SUBDERMAL CONTRACEPTIVE	V25.5 INSERT SUBDERMAL CONTRACEPTIVE
V03.81 VACC FOR H INFLUENZA,TYPE B	V03.82 VACC FOR STREPTOCOCCUS PNEUMON
V03.89 OTH SPEC VACC SINGLE BACT DIS	V06.5 VACC TETANUS-DIPHThERIA [Td]
V06.6 VACC STREP PNEUMONIAE,INFLUENZ	V07.31 PROPHY FLUORIDE ADMINISTRATION
V07.39 PROPHYLACTIC CHEMOTHERAPY,NEC	V12.00 HX-INFECT/PARASITIC DIS,NOS
V12.01 HX-TUBERCULOSIS	V12.02 HX-POLIOMYELITIS
V12.03 HX-MALARIA	V12.09 HX-INFECT/PARASITIC DIS,NEC
V12.70 HX-DIGESTIVE DIS,NOS	V12.71 HX-PEPTIC ULCER DISEASE
V12.72 HX-COLONIC POLYPS	V12.79 HX-DIGESTIVE SYSTEM DIS,NEC
V13.00 HX-URINARY DISORDER,NOS	V13.01 HX-URINARY CALCULI
V13.09 HX-URINARY SYSTEM DISORDER,NEC	V15.82 HX-TOBACCO USE
V43.60 JOINT REPLACEMENT STATUS,NOS	V43.61 SHOULDER JT REPLACEMENT STATUS
V43.62 ELBOW JT REPLACEMENT STATUS	V43.63 WRIST JT REPLACEMENT STATUS
V43.64 HIP JT REPLACEMENT STATUS	V43.65 KNEE JT REPLACEMENT STATUS
V43.66 ANKLE JT REPLACEMENT STATUS	V43.69 JOINT REPLACEMENT STATUS,NEC
V45.00 CARDIAC DEVICE IN SITU.NOS	V45.01 CARDIAC PACEMAKER IN SITU
V45.09 CARDIAC DEVICE IN SITU,NEC	V45.51 PRESENCE OF IUD
V45.52 PRES-SUBDERM CONTRACEPT IMPLNT	V45.59 PRES-CONTRACEPTIVE DEVICE,NEC
V45.82 PERCUT/TRANSLUM COR/ANGIO STAT	V49.60 UPPER LIMB AMP STATUS,NOS
V49.61 THUMB AMPUTATION STATUS	V49.62 FINGER(S) AMPUTATION STATUS
V49.63 HAND AMPUTATION STATUS	V49.64 WRIST AMPUTATION STATUS
V49.65 BELOW ELBOW AMPUTATION STATUS	V49.66 ABOVE ELBOW AMPUTATION STATUS
V49.67 SHOULDER AMPUTATION STATUS	V49.70 LOWER LIMB AMP STATUS,NOS
V49.71 GREAT TOE AMPUTATION STATUS	V49.72 OTHER TOE(S) AMPUTATION STATUS
V49.73 FOOT AMPUTATION STATUS	V49.74 ANKLE AMPUTATION STATUS
V49.75 BELOW KNEE AMPUTATION STATUS	V49.76 ABOVE KNEE AMPUTATION STATUS
V49.77 HIP AMPUTATION STATUS	V15.41 HISTORY OF PHYSICAL ABUSE
V15.42 HISTORY OF EMOTIONAL ABUSE	V15.49 PSYCHOLOGICAL TRAUMA,NEC

<b>Inpatient Edit C2</b>	<b>These V codes cannot be used as principal DX</b>
V66.7 ENCOUNTER FOR PALLIATIVE CARE	V02.60 VIRAL HEPATITIS CARRIER,UNSPEC
V02.61 HEPATITIS B CARRIER	V02.62 HEPATITIS C CARRIER
V02.69 OTHER VIRAL HEPATITIS CARRIER	V12.40 HX-NERV SYS/SENS ORG DIS,UNSP
V12.41 HX BENIGN BRAIN NEOPLASM	V12.49 HX OTH DIS NERV SYS/SENS ORG
V16.40 FAM HX MALIG GENITAL ORG,UNSP	V16.41 FAM HX MALIG NEOPLASM OVARY
V16.42 FAM HX MALIG NEOPLASM PROSTATE	V16.43 FAM HX MALIG NEOPLASM TESTIS
V16.49 FAM HX OTHER MALIG NEOPLASM	V42.81 ORG/TISS REPL TRANS,BMARROW
V42.82 ORG/TISS REPL TRANS,STEMCELLS	V45.69 OTH STATES P SURG EYE/ADNEXA
V45.71 ACQUIRED ABSENSE OF BREAST	V45.72 ACQUIRED ABSENSE OF INTESTINE
V45.73 ACQUIRED ABSENCE OF KIDNEY	V64.4 LAPROSCOP CONV TO OPEN PROC
V76.10 SCREEN FOR MALIG/BREAST, UNSPEC	V76.11 MAMMOGRAM HI-RISK MALIG BREAST
V76.12 OTH MAMMOGRAM MALIG BREAST	
V14.5 HX-NARCOTIC ALLERGY	V14.6 HX-ANALGESIC ALLERGY
V14.7 HX-VACCINE ALLERGY	V14.8 HX-DRUG ALLERGY NEC
V14.9 HX-DRUG ALLERGY NOS	V15.0 HX OF ALLERGY NEC
V15.1 HX-MAJOR CARDIOVASC SURG	V15.2 HX-MAJOR ORGAN SURG NEC
V15.3 HX OF IRRADIATION	V15.4 PSYCHOLOGICAL TRAUMA
V15.5 HX OF INJURY	V15.6 HX OF POISONING
V15.7 HX OF CONTRACEPTION	V15.81 HX OF PAST NONCOMPLIANCE
V15.89 HEALTH HAZARDS NEC	V15.9 HX-HEALTH HAZARD NOS
V16.0 FAMILY HX-GI MALIGNANCY	V16.1 FM HX-TRACH/BRONCHOG MAL
V16.2 FAM HX-INTRATHORACIC MAL	V16.3 FAMILY HX-BREAST MALIG
V16.4 FAMILY HX-GENITAL MALIG	V16.5 FM HX MALIG NP URINARY
V16.6 FAMILY HX-LEUKEMIA	V16.7 FAM HX-LYMPH NEOPLAS NEC
V16.8 FAMILY HX-MALIGNANCY NEC	V16.9 FAMILY HX-MALIGNANCY NOS
V17.0 FAM HX-PSYCHIATRIC COND	V17.1 FAMILY HX-STROKE
V17.2 FAM HX-NEUROLOG DIS NEC	V17.3 FAM HX-ISCHEM HEART DIS
V17.4 FAM HX-CARDIOVAS DIS NEC	V17.5 FAMILY HX-ASTHMA
V17.6 FAM HX-CHR RESP COND NEC	V17.7 FAMILY HX-ARTHRITIS
V17.8 FAM HX-MUSCLOSCL DIS NEC	V18.0 FAM HX-DIABETES MELLITUS
V18.1 FM HX-ENDO/METAB DIS NEC	V18.2 FAMILY HX-ANEMIA
V18.3 FAM HX-BLOOD DISORD NEC	V18.4 FAM HX-MENTAL RETARDAT
V18.5 FAMILY HX-GI DISORDERS	V18.6 FAMILY HISTORY KIDNEY DISEASE
V18.7 FAMILY HX-GU DISEASE NEC	V18.8 FM HX-INFECT/PARASIT DIS
V19.0 FAMILY HX-BLINDNESS	V19.1 FAMILY HX-EYE DISORD NEC
V19.2 FAMILY HX-DEAFNESS	V19.3 FAMILY HX-EAR DISORD NEC
V19.4 FAMILY HX-SKIN CONDITION	V19.5 FAM HX-CONGEN ANOMALIES
V19.6 FAMILY HX-ALLERGIC DIS	V19.7 CONSANGUINITY
V19.8 FAMILY HX-CONDITION NEC	V22.2 PREG STATE, INCIDENTAL
V23.0 PREG WHX OF INFERTILITY	V23.1 PREG W HX-TROPHOBLAS DIS
V23.2 PREG WHX OF ABORTION	V23.3 GRAND MULTIPARITY
V23.4 PREG W POOR OBSTETRIC HX	V23.5 PREG W POOR REPRODUCT HX

<b>Inpatient Edit C2</b>	<b>These V codes cannot be used as principal DX</b>
V23.8 SUPV OTHER HR PREGNANCY	V23.9 SUPRV HIGH-RISK PREG NOS
V25.01 PRESCRIP-ORAL CONTRACEPT	V25.02 INITIATE CONTRACEPT NEC
V25.09 CONTRACEPTIVE MANGMT NEC	V25.1 INSERTION OF IUD
V25.3 MENSTRUAL EXTRACTION	V25.40 CONTRACEPT SURVEILL NOS
V25.41 CONTRACEPT PILL SURVEILL	V25.42 IUD SURVEILLANCE
V25.49 CONTRACEPT SURVEILL NEC	V26.3 GENETIC COUNSELING
V26.4 PROCREATIVE MGMT-COUNSEL	V26.8 PROCREATIVE MANGMT NEC
V26.9 PROCREATIVE MANGMT NOS	V27.0 DELIVER-SINGLE LIVEBORN
V27.1 DELIVER-SINGLE STILLBORN	V27.2 DELIVER-TWINS, BOTH LIVE
V27.3 DEL-TWINS, 1 NB, 1 SB	V27.4 DELIVER-TWINS, BOTH SB
V27.5 DEL-MULT BIRTH, ALL LIVE	V27.6 DEL-MULT BRTH, SOME LIVE
V27.7 DEL-MULT BIRTH, ALL SB	V27.9 OUTCOME OF DELIVERY NOS
V28.0 SCREENING-CHROMOSOM ANOM	V28.1 SCREEN-ALPHAFETOPROTEIN
V28.2 SCREEN BY AMNIOCENT NEC	V28.3 SCREEN-FETAL MALFORM
V28.4 SCREEN-FETAL RETARDATION	V28.5 SCREEN-ISOIMMUNIZATION
V28.8 ANTENATAL SCREENING NEC	V28.9 ANTENATAL SCREENING NOS
V37.0 MULT BIRTH NOS-IN HOSP	V37.1 MULT BRTH NOS-BEFORE ADM
V37.2 MULT BIRTH NOS-NONHOSP	V39.0 LIVEBORN NOS-IN HOSP
V39.1 LIVEBORN NOS-BEFORE ADM	V39.2 LIVEBORN NOS-NONHOSP
V40.0 PROBLEMS WITH LEARNING	V40.1 PROB WITH COMMUNICATION
V40.2 MENTAL PROBLEMS NEC	V40.3 BEHAVIORAL PROBLEMS NEC
V40.9 MENTAL/BEHAVIOR PROB NOS	V41.0 PROBLEMS WITH SIGHT
V41.1 EYE PROBLEMS NEC	V41.2 PROBLEMS WITH HEARING
V41.3 EAR PROBLEMS NEC	V41.4 VOICE PRODUCTION PROBLEM
V41.5 SMELL AND TASTE PROBLEM	V41.6 PROBLEM W SWALLOWING
V41.7 SEXUAL FUNCTION PROBLEM	V41.8 PROBL WSPECIAL Flmc NEC
V41.9 PROBL W SPECIAL FUNC NOS	V42.0 KIDNEY TRANSPLANT STATUS
V42.1 HEART TRANSPLANT STATUS	V42.2 HEART VALVE TRANSPLANT
V42.3 SKIN TRANSPLANT STATUS	V42.4 BONE TRANSPLANT STATUS
V42.5 CORNEA TRANSPLANT STATUS	V42.6 LUNG TRANSPLANT STATUS
V42.7 LIVER TRANSPLANT STATUS	V42.8 TRANSPLANT STATUS NEC
V42.9 TRANSPLANT STATUS NOS	V43.0 EYE REPLACEMENT NEC
V43.1 LENS REPLACEMENT NEC	V43.2 HEART REPLACEMENT NEC
V43.3 HEART VALVE REPLAC NEC	V43.4 BLOOD VESSEL REPLAC NEC
V43.5 BLADDER REPLACEMENT NEC	V43.6 JOINT REPLACEMENT NEC
V43.7 LIMB REPLACEMENT NEC	V43.8 OTH ORGAN/TISS REPL BY OTH MEANS
V44.0 TRACHEOSTOMY STATUS	V44.1 GASTROSTOMY STATUS
V44.2 ILEOSTOMY STATUS	V44.3 COLOSTOMY STATUS
V44.4 ENTEROSTOMY STATUS NEC	V44.5 CYSTOSTOMY STATUS
V44.6 URINOSTOMY STATUS NEC	V44.7 ARTIFICIAL VAGINA STATUS

## 20.0 Glossary

### @ symbol

This symbol (key combination of Shift+2) has two functions: (1) to delete an entry and (2) to separate a date and time.

### Acute

Used to describe a condition that lasts for a short time. Used in contrast to *chronic*.

### Append

To add additional data items to an existing visit, usually at the end of entering the data.

### Best Practice Prompts

Best Practice Prompts are a set of clinical messages related to procedures such as lab tests, immunizations, procedures etc. that are generally recommended for a subset of the population who share a common diagnosis (e.g. Asthma, CVD). They are displayed in a variety of places including the Health Summary, Supplements, and the Patient Record in both EHR and iCare.

Users can turn on (activate) and display BP Prompts on Health Summaries, similar to the Health Maintenance Reminder function.

### Billable Visit

A visit from a patient that has third party insurance coverage to which a hospital/clinic can then bill for services.

### Caret (“Up Hat”)

The symbol ^ obtained by using the key combination Shift+6. Commonly used in RPMS character-based interfaces to exit out of a routine or to back up from the previous field.

### Chart Number

A unique numerical identifier assigned to each patient. This is also referred to as Health Record Number.

### Chronic

Used to describe a condition that has an indefinite duration or with a frequent occurrence. Used in contrast to *acute*.

### Clinical

To do with treatment in or as a clinic: involving or concerned with direct observation and treatment of patients.

**Command**

The instructions you give the computer to record a certain transaction. For example, selecting “Payment” or “P” at the command prompt tells the computer you are applying a payment to a chosen bill.

**Community of Service**

The community where the encounter took place.

**Community of Residence**

The community where the patient resides.

**CPT Code**

Current Procedural Terminology code. Used to identify procedures provided during an encounter and for billing outpatient services provided.

**Database**

A database is a collection of files containing information that may be used for many purposes. Storing information in the computer helps in reducing the user’s paperwork load and enables quick access to a wealth of information. Databases are comprised of fields, records, and files.

**Default Response**

Many of the prompts in the RPMS applications contain responses that can be activated simply by pressing the Return key . For example: “Do you really want to quit? No//.” Pressing the Return key tells the system you do not want to quit. “No//” is considered the default response. The default is generally set to the most frequently used response for the prompt.

**Designated Primary Care Provider (DPCP)**

The primary care provider designated for the patient. This is distinguished from a primary or secondary visit provider for a specific visit.

**Device**

The name of the printer you want the system to use when printing information. *Home* means the computer screen.

**DOB**

Date of Birth

**DOD**

Date of Death

**DOS**

Date Of Service

**DX**

Common abbreviation for diagnosis

**EDC**

Expected/estimated date of confinement, that is the expected/estimated due or delivery date for a pregnancy.

**EDD**

Expected/estimated date of delivery.

**Export**

To format data so it can be used by another application.

**Fields**

Fields are a collection of related information that makes up a database record. Fields on a display screen function like blanks on a form. Each field has a prompt that requests a specific type of data. There are nine basic field types in RPMS programs; each collects a specific type of information.

**Free Text Field**

This field type will accept numbers, letter, and most of the symbols on the keyboard. There may be restrictions on the number of characters that can be entered.

**Health Factors**

Health factors are data elements utilized by RPMS to record health status information about the patient. "Current smoker" is an example of a health factor in the Tobacco category. Health factor data are recorded in the PCC V Health Factor file. For a current list of health factors, see the Health Summary User Manual.

**Health Maintenance Reminders (HMRs)**

Health Maintenance Reminders are a set of clinical reminders related to procedures such as lab tests, immunizations, procedures etc. that are generally recommended for a subset of the population. They are displayed in a variety of places including the Health Summary, Supplements, and the Patient Record in both EHR and iCare.

**Health Record Number (HRN)**

A unique numerical identifier assigned to each patient. This is also referred to as a "chart number".

**Health Summary**

The Health Summary is a summary report of a patient's medical care drawn from V files such as Laboratory and Pharmacy. The RPMS PCC is distributed with several standard health summaries, and summaries can also be customized or designed on the fly using available components. Examples of standard health summaries are: Adult Regular, Behavioral Health, CHR, and Dental.

**HRN#**

Health record number, also referred to as a "chart number"

**HS**

Health Summary: a summary report of a patient's medical care drawn from V files such as Laboratory and Pharmacy. The RPMS PCC is distributed with several standard health summaries, and summaries can also be customized or designed on the fly using available components. Examples of standard health summaries are: Adult Regular, Behavioral Health, CHR, and Dental.

**HX**

Common abbreviation for history; an event that occurred in the past, such as surgery, immunizations, etc.

**ICD**

International Classifications of Diseases. This is a national coding system primarily used for: (1) classifying morbidity and mortality information for statistical purposes, (2) indexing of hospital records by disease and operations, and (2) data storage and retrieval. In addition, this is the coding system physicians must use to bill Medicare, Medicaid, and private insurance for services rendered.

**Interfaces**

A boundary where two systems can communicate. RPMS applications contain both character-based ("roll-and-scroll") and graphical user (GUI) interfaces. PCC Data Entry is an example of a character-based interface; RPMS EHR is an example of a GUI.

**Menu**

The menu is a list of options that can be selected at a given time. To choose a task, select an item from the list by entering the established abbreviation or synonym at the prompt. A menu option followed by the ellipsis (...) indicates there are submenus.

**Mnemonic**

An abbreviation used to name a menu option or report used in the RPMS character-based packages. RPMS PCC data entry mnemonics used to enter a data type can be two, three, or four characters, such as BP (blood pressure).

**Narrative Description**

A detailed description using words rather than codes.

**Patient Care Component (PCC)**

PCC is the core of the RPMS applications and functions as a clinical data repository. Most RPMS applications “pass” key data elements to PCC, stored in V (visit) files, e.g., V Lab. Other data is entered directly into V files, e.g., V Patient Education, BP (blood pressure), WT (weight), HT (height), HC (head circumference) etc.

**Patient Wellness Handout**

The Patient Wellness Handout is a health summary created for the patient. It displays personal medical information in easy-to-interpret language.

**PGEN**

Abbreviation for Patient General Retrieval Report. The PGEN report is located in PCC Management Reports. General retrieval reports are on-the-fly reports created by choosing specific data elements to select, print, and sort by.

**POV**

Purpose of Visit: one or more diagnoses (ICD codes) that are identified as the reason for a patient’s visit, recorded in the PCC V POV file.

**Problem List**

A list of important/chronic medical, social, or psychiatric problems, related notes, and treatment plans recorded and updated as part of the patient’s health record. The Health Summary has two categories: Active and Inactive.

**Prompt**

Text displayed onscreen indicating that the system is waiting for input to a field. When the system displays a prompt, it waits for you to enter some specific information.

**Provider**

One who provides direct medical care to a patient i.e., physician, nurse, mid-level provider).

**Provider Narrative**

A detailed description of the patient’s conditions using words rather than codes.

**QMan**

Short for Query Manager, QMan is a VA-based search utility that allows users to construct detailed searches of the RPMS database. QMan is part of the integrated PCC suite.

**Retrieval**

The process of obtaining data from another location.

**Roll-and-Scroll**

The roll-and-scroll (character-based) data entry format captures the same information as the screen format but uses a series of prompts for recording data. This is typically the most efficient method for data entry.

**RPMS**

Resource and Patient Management System; a suite of integrated software packages used by IHS

**Secondary Providers**

A provider for a patient's visit other than the patient's primary visit provider. A patient visit might have multiple secondary providers, depending on the services provided.

**Security Key**

A means of securing menus to limit accessibility. To use certain functions, such as those on a manager's menu, you must be assigned the appropriate key by the site manager.

**Select**

To choose an option from a list of options.

**Site Manager**

The person in charge of setting up and maintaining the technical aspects of RPMS at the facility or area level.

**Specialty Providers**

Defined through the Designated Specialty Provider Management (BDP) application.

**Submenu**

A menu that is accessed through another menu. A menu option followed by the ellipsis (...) indicates there are submenus.

**Supplement**

A modified health summary related to a specific condition such as diabetes or HIV/AIDS. It displays personal medical information related to that condition.

**Tally**

To count, total, or subtotal a collection of items.

**VGEN**

Abbreviation for Visit General Retrieval Report. VGEN is one of the search utilities used to construct searches of the RPMS database. General retrieval reports are on-the-fly reports created by choosing specific data elements to select, print, and sort by.

## 21.0 Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

**Phone:** (505) 248-4371 or (888) 830-7280 (toll free)

**Fax:** (505) 248-4363

**Web:** <http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm>

**Email:** [support@ihs.gov](mailto:support@ihs.gov)