Cheat Sheet for PCC Documentation and Data Entry for CRS Version 23.1
Last Updated May 2023

Data Entry Best Practices to Meet Measures

The following items detail the recommended use for this material. Each facility should:

1. Identify their three or four key clinical problem areas.
2. Review the attached information.
3. Customize the provider documentation and data entry instructions, if necessary.
4. Train staff on appropriate documentation.
5. Post the applicable pages of the Cheat Sheet in exam rooms.

The purpose of this document is to provide information to both providers and data entry personnel on the most appropriate way to document key clinical procedures in the Resource and Patient Management System (RPMS). It does not include all the codes the Clinical Reporting System (CRS) checks when determining if a performance measure is met. To review that information, view the CRS short version logic at: https://www.ihs.gov/sites/crs/themes/responsive2017/display_objects/documents/crsv23/GPRAMeasuresV230.pdf.

Note: Government Performance and Results Act (GPRA) measures do not include refusals.

Table 1: Performance measures, standards, provider documentation, and how to enter data in PCC

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Diabetes Prevalence **Note**: This is not a GPRA measure; however, it is used in determining patients that have been diagnosed with diabetes.		Standard PCC documentation for tests performed at the facility. Ask about off-site tests and record historical information in PCC: • Date received • Location • Results	**Diabetes Prevalence Diagnosis POV** *Mnemonic PPV enter* Purpose of Visit: ICD-10: E10.*-E13.* Provider Narrative: Modifier: Cause of DX:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Diabetes: Glycemic Control	User Population Patients DX with diabetes and with an A1c: • Greater than (>) 9 (Poor Glycemic Control)	Standard PCC documentation for tests performed at the facility. Ask about off-site tests and record historical information in PCC: • Date received • Location • Results	**Standard PCC data entry:** **A1c Lab Test** *Mnemonic LAB enter* Enter Lab Test Type: [Enter site's defined A1c Lab Test] Results: [Enter Results] Units: Abnormal: Site: [Blood, Plasma] **Historical A1c Lab Test** *Mnemonic HLAB enter* Date of Historical Lab Test: Type: Location Name: Enter Lab Test: [Enter site's defined A1c Lab Test] Results: **CPT Entry** *Mnemonic CPT enter* Enter CPT: 83036, 83037, 3044F-3046F, 3051F, 3052F Quantity: Modifier: Modifier 2:
Diabetes: Blood Pressure Control	User Population Patients DX with diabetes and with controlled blood pressure: • Less than (<) 140/90 (mean systolic less than [<] 140, mean diastolic less than [<] 90)	Standard PCC documentation for tests performed at the facility. Ask about off-site tests and record historical information in PCC: • Date received • Location • Results	**Standard PCC data entry:** **Blood Pressure Data Entry** Value: [Enter as Systolic/Diastolic (e.g., 140/90)] Select Qualifier: Date/Time Vitals Taken:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes	User Population Patients DX with diabetes age 40-75 or any age with documented CVD or age 20 and older with LDL greater than or equal to (≥) 190 or hypercholesterolemia who have statin therapy.	Standard PCC documentation for medication dispensed at the facility. Ask about off-site medication and record historical information in PCC: • Date received • Location • Dosage	**Standard PCC data entry:** **Statin Therapy Medication** *Mnemonic RX enter* Select Medication: [Enter Statin Therapy Prescribed Medication] Outside Drug Name (Optional): [Enter any additional name for the drug] SIG Quantity: Day Prescribed: Event Date & Time: Ordering Provider: **Historical Statin Therapy Medication** *Mnemonic HRX enter* Date of Historical Medication: Type: Location Name: Enter Medication: [Enter Statin Therapy Prescribed Medication] Name of Non-Table Drug: SIG: Days Prescribed: Date Discontinued: Date Dispensed (If Known): Outside Provider Name: **Statin Therapy CPT** Mnemonic CPT enter Enter CPT Code: 4013F Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Diabetes: Nephropathy Assessment	User Population Patients DX with diabetes with a Nephropathy assessment: • Estimated GFR with result during the Report Period • Urine Albumin-to-Creatinine Ratio during the Report Period • End Stage Renal Disease diagnosis/treatment	Standard PCC documentation for tests performed at the facility. Ask about off-site tests and record historical information in PCC: • Date received • Location • Results	**Standard PCC data entry:** **Estimated GFR Lab Test** *Mnemonic LAB enter* Enter Lab Test Type: [Enter site's defined Est GFR Lab Test] Results: [Enter Results] Units: Abnormal: Site: [Blood] **Historical GFR Lab Test** *Mnemonic HLAB enter* Date of Historical Lab Test: Type: Location Name: Enter Lab Test: [Enter site's defined Est GFR Lab Test] Results: **Urine Albumin-to-Creatinine Ratio CPT** Mnemonic CPT enter Enter CPT: 82043 AND 82570 Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Diabetes: Nephropathy Assessment (cont.)			**ESRD CPT** *Mnemonic CPT enter* Enter CPT: 36147, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90935, 90937, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512, 3066F, G0257, G9231, M1187, M1188, S2065 or S9339 Quantity: Modifier: Modifier 2: **ESRD POV** *Mnemonic PPV enter* Purpose of Visit: ICD-10: I12.0, I13.11, I13.2, N18.5, N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2 Provider Narrative: Modifier: Cause of DX: **ESRD Procedure** *Mnemonic IOP enter* Operation/Procedure: ICD-10: 5A1D70Z, 5A1D80Z, 5A1D90Z Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX (ESRD)]

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Diabetic Retinopathy	Patients with diabetes and no bilateral blindness or bilateral eye enucleation will have a qualified* retinal examination during the report period. *Qualified retinal exam: The following methods are qualifying for this measure: • Dilated retinal evaluation by an optometrist or ophthalmologist • Seven standard fields stereoscopic photos (ETDRS) evaluated by an optometrist or ophthalmologist • Any photographic method formally validated to seven standard fields (ETDRS) **Note**: Refusals are not counted toward the GPRA measure but should still be documented.	Standard PCC documentation for tests performed at the facility. Ask about off-site tests and record historical information in PCC: • Date received • Location • Results Exams: • Diabetic Retinal Exam – Dilated retinal eye exam – Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist – Eye imaging validated to match the diagnosis from seven standard field stereoscopic photos – Routine ophthalmological examination including refraction (new or existing patient) – Diabetic indicator: retinal eye exam, dilated, bilateral • Other Eye Exams – Non-DNKA (did not keep appointment) visits to ophthalmology or optometry clinics with an optometrist or ophthalmologist, or visits to formally validated tele-ophthalmology retinal evaluation clinics	**Standard PCC data entry:** **Diabetic Retinopathy Exam** *Mnemonic EX enter* Select Exam: 03 Result: [Enter Results] Comments: Provider Performing Exam: **Historical Retinopathy Exam** *Mnemonic HEX enter* Date of Historical Exam: Type: Location Name: Exam Type: 03 Result Comments Encounter Provider **Retinal Exam CPT** *Mnemonic CPT enter* Enter CPT: 2021F, 2022F-2025F, 2026F, 2033F, G2102-G2104, S0620, S0621, S3000 Quantity: Modifier: Modifier 2: **Other Eye Exam CPT** *Mnemonic CPT enter* Enter CPT: 67028, 67039, 67040, 92002, 92004, 92012, 92014, 92018, 92019 Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Diabetic Retinopathy (cont.)			**Other Eye Exam Clinic** *Mnemonic CL enter* Clinic: A2, 17, 18, 64 Was this an appointment or walk in?
Access to Dental Service	Patients should have annual dental visits/exams. **Note**: Refusals are not counted toward the GPRA measure but should still be documented.	Standard PCC documentation for tests performed at the facility. Ask about off-site tests and record historical information in PCC: • Date received • Location • Results	**Standard PCC data entry:** **Visit for Dental Exam** *Mnemonic EX enter* Select Exam: 30 Result: [Enter Results] Comments: Provider Performing Exam: **Historical Dental Exam** *Mnemonic HEX enter* Date of Historical Exam: Type: Location Name: Exam Type: 30 Result: Comments: Encounter Provider:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Access to Dental Service (cont.)			**Dental Visit (ADA code)** *Mnemonic ADA enter* Dental Service Code: 0000, 0007, 0110-0390, 0415-0471, 0601-0603, 0999-9974, 9995, 9996, 9999 Type: No. Of Units: Operative Site: **Historical Dental Visit (ADA code)** *Mnemonic HADA enter* Date of Historical ADA: Type: Location Name: ADA Code: 0000, 0007, 0110-0390, 0415-0471, 0601-0603, 0999-9974, 9999 Units: **Dental Visit CPT** *Mnemonic CPT enter* Enter CPT: D0110-D0390, D0415-D9952, D9970-D9974, D9995, D9996, D9999 Quantity: Modifier: Modifier 2: **Dental Visit POV** *Mnemonic PPV enter* Purpose of Visit: ICD-10: Z01.20, Z01.21, Z13.84, Z29.3 Provider Narrative: Modifier: Cause of DX:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Dental Sealants	Patients should have one or more intact dental sealants. **Note**: Refusals are not counted toward the GPRA measure but should still be documented.	Standard PCC documentation for tests performed at the facility. Ask about off-site tests and record historical information in PCC: • Date received • Location • Results	**Standard PCC data entry:** **Dental Sealants (ADA)** *Mnemonic ADA enter* Dental Service Code: 1351, 1352, 1353 Type: No. Of Units: Operative Site: **Historical Dental Sealants** *Mnemonic HADA enter* Date of Historical ADA: Type: Location Name: ADA Code: 1351 Units: **Dental Sealants CPT** *Mnemonic CPT enter* Enter CPT: D1351, D1352, D1353 Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Topical Fluoride	Patients should have one or more topical fluoride applications. **Note**: Refusals are not counted toward the GPRA measure but should still be documented.	Standard PCC documentation for tests performed at the facility. Ask about off-site tests and record historical information in PCC: • Date received • Location • Results	**Standard PCC data entry:** **Topical Fluoride (ADA code)** *Mnemonic ADA enter* Dental Service Code: 1206, 1208, 5986 Type: No. Of Units: Operative Site: **Historical Fluoride (ADA code)** *Mnemonic HADA enter* Date of Historical ADA: Type: Location Name: ADA Code: 1206, 1208, 5986 Units: **Topical Fluoride CPT** *Mnemonic CPT enter* Enter CPT: D1206, D1208, D5986, 99188 Quantity: Modifier: Modifier 2: **Topical Fluoride POV** *Mnemonic PPV enter* Purpose of Visit: ICD-10: Z29.3 Provider Narrative: Modifier: Cause of DX:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Influenza	All patients ages 6 months and older should have an annual influenza (flu) shot. Refusals should be documented. **Note**: Only Not Medically Indicated (NMI) refusals are counted toward the GPRA Measure.	Standard PCC documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in PCC: • IZ type • Date received • Location Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include: Immunization Package of "Egg Allergy" or "Anaphylaxis" NMI Refusal	**Standard PCC data entry:** **Influenza Vaccine** *Mnemonic IM enter* Select Immunization Name: 140, 141, 144, 149, 150, 151, 153, 155, 158, 161, 166, 168, 171, 185, 186, 194, 197, 200-202, 205 (other options are 111, 15, 16, 88) Lot: VFC Eligibility: **Historical Influenza Vaccine** *Mnemonic HIM enter* Date of Historical Immunization: Type: Location: Immunization Type: 140, 141, 144, 149, 150, 151, 153, 155, 158, 161, 166 (other options are 111, 15, 16, 88) Series:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Influenza (cont.)			**Influenza Vaccine CPT** *Mnemonic CPT enter* Enter CPT: 90630, 90654-90662, 90672-90674, 90682, 90685-90689, 90694, 90756, G0008, Q2034-Q2039 Quantity: Modifier: Modifier 2: **NMI Refusal of Influenza** *Mnemonic NMI enter* Patient Refusals For Service/NMI Refusal Type: Immunization Immunization Value: [See codes above] Date Refused: Provider Who Documented: Comment: **Immunization Package Contraindication Influenza** (Assumes you are in the IMM Pkg for Single Patient Record for your site) Select Action: C (Contraindications) Select Action: A (Add Contraindication) Vaccine: [See codes above] Reason: Anaphylaxis Date Noted: Command: Save Select Action: Quit

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Adult Immunizations	All adults ages 19 and older will have age appropriate vaccines. • Ages 19–50: 1 Tdap/Td in the past 10 years, 1 Tdap ever • Ages 51–65: 1 Tdap/Td in the past 10 years, 1 Tdap ever, 2 doses of Shingrix ever • Ages 66+: 1 Tdap/Td in the past 10 years, 1 Tdap ever, 2 doses of Shingrix ever, 1 up-to-date Pneumococcal vaccine Refusals should be documented. **Note**: Only NMI refusals are counted toward the GPRA Measure.	Standard PCC documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in PCC: • IZ type • Date received • Location Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include: Immunization Package of "Immune Deficiency" or "Anaphylaxis" NMI Refusal	**Standard PCC data entry:** **Adult Immunizations** *Mnemonic IM enter* Select Immunization Name: Tdap: 115; Td: 9, 113, 138, 139, 196; Shingrix: 187; PPSV23: 33, 109; PCV13: 100, 133, 152; PCV20: 216; PCV15: 215 Lot: VFC Eligibility: **Historical Adult Immunizations** *Mnemonic HIM enter* Date of Historical Immunization: Type: Location: Immunization Type: Tdap: 115; Td: 9, 113, 138, 139, 196; Shingrix: 187; PPSV23: 33, 109; PCV13: 100, 133, 152; PCV20: 216; PCV15: 215 Series: **Adult Immunizations CPT** *Mnemonic CPT enter* Enter CPT: Tdap: 90715; Td: 90714, 90718; Shingrix: 90750; PPSV23: 90732, G0009, G9279; PCV13: 90669, 90670; PCV20: 90677; PCV15: 90671 Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Adult Immunizations (cont.)			**NMI Refusal of Adult Immunizations** *Mnemonic NMI enter* Patient Refusals For Service/NMI Refusal Type: Immunization Immunization Value: [See codes above] Date Refused: Provider Who Documented: Comment: **Immunization Package Contraindication Adult Immunizations** (Assumes you are in the IMM Pkg for Single Patient Record for your site) Select Action: C (Contraindications) Select Action: A (Add Contraindication) Vaccine: [See codes above] Reason: [See Contraindications section under the Provider Documentation column] Date Noted: Command: Save Select Action: Quit

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Childhood Immunizations	Children age 19–35 months will be up to date for all ACIP recommended immunizations. This is the 4313*314 combo: 4 DTaP 3 IPV 1 MMR 3 Hepatitis B 3 or 4 Hib 1 Varicella 4 Pneumococcal Refusals should be documented. **Note**: Only NMI refusals are counted toward the GPRA Measure.	Standard PCC documentation for immunizations performed at the facility. Ask about off-site tests and record historical information in PCC: • IZ type • Date received • Location Because IZ data comes from multiple sources, any IZ codes documented on dates within 10 days of each other will be considered as the same immunization Contraindications should be documented and are counted toward the GPRA Measure. Contraindications include Immunization Package of "Anaphylaxis" for all childhood immunizations. The following additional contraindications are also counted: • **DTaP**: Encephalopathy due to vaccination with a vaccine adverse-effect • **IPV**: Immunization Package: "Neomycin Allergy" • **OPV**: Immunization Package: "Immune Deficiency" • **MMR**: Immunization Package: "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy"; Immunodeficiency; Lymphoreticular cancer, multiple myeloma or leukemia • **Varicella**: Immunization Package: "Hx of Chicken Pox" or "Immune", "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy"; Immunodeficiency; HIV; Lymphoreticular cancer, multiple myeloma or leukemia • **Pneumococcal:** Immunization Package: "Anaphylaxis"	**Standard PCC data entry:** **Childhood Immunizations** *Mnemonic IM enter* Select Immunization Name: DTaP: 20, 50, 102, 106, 107, 110, 120, 130, 146; DTP: 1, 22, 102, 198; Tdap: 115; DT: 28; Td: 9, 113, 138, 139, 196; Tetanus: 35, 112; Acellular Pertussis: 11; OPV: 2, 89; IPV: 10, 89, 110, 120, 130, 146; MMR: 3, 94; M/R: 4; R/M: 38; Measles: 5; Mumps: 7; Rubella: 6; Hepatitis B: 8, 42-45, 51, 102, 104, 110, 146, 189, 193, 198, 220; HIB: 17, 22, 46-49, 50, 51, 102, 120, 146, 148, 198; Varicella: 21, 94; Pneumococcal: 33, 100, 109, 133, 152 Lot: VFC Eligibility: **Historical Childhood Immunizations** *Mnemonic HIM enter* Date of Historical Immunization: Type: Location: Immunization Type: DTaP: 20, 50, 102, 106, 107, 110, 120, 130, 146; DTP: 1, 22, 102, 198; Tdap: 115; DT: 28; Td: 9, 113, 138, 139; Tetanus: 35, 112; Acellular Pertussis: 11; OPV: 2, 89; IPV: 10, 89, 110, 120, 130, 146; MMR: 3, 94; M/R: 4; R/M: 38; Measles: 5; Mumps: 7; Rubella: 6; Hepatitis B: 8, 42-45, 51, 102, 104, 110, 146, 189, 193, 198, 220; HIB: 17, 22, 46-49, 50, 51, 102, 120, 146, 148, 198; Varicella: 21, 94; Pneumococcal: 33, 100, 109, 133, 152 Series:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Childhood Immunizations (cont.)		Dosage and types of immunization definitions: 4 doses of DTaP: • 4 DTaP/DTP/Tdap • 1 DTaP/DTP/Tdap and 3 DT/Td • 1 DTaP/DTP/Tdap and 3 each of Diphtheria and Tetanus • 4 DT and 4 Acellular Pertussis • 4 Td and 4 Acellular Pertussis • 4 each of Diphtheria, Tetanus, and Acellular Pertussis 3 doses of IPV: • 3 OPV • 3 IPV • Combination of OPV and IPV totaling 3 doses 1 dose of MMR: • MMR • 1 M/R and 1 Mumps • 1 R/M and 1 Measles • 1 each of Measles, Mumps, and Rubella 3 doses of Hepatitis B • 3 doses of Hep B 3 or 4 doses of HIB, depending on the vaccine administered 1 dose of Varicella 4 doses of Pneumococcal	**Childhood Immunizations Evidence of Disease POV** *Mnemonic PPV enter* Purpose of Visit: IPV: ICD-10: M89.6*; Measles: ICD-10: B05.*; Mumps: ICD-10: B26.*; Rubella: ICD-10: B06.*; Hepatitis B: ICD-10: B16.*, B19.1*; Varicella: ICD-10: B01.*-B02.* **Childhood Immunizations CPT** *Mnemonic CPT enter* Enter CPT: DTaP: 90696-90698, 90700, 90721, 90723; DTP: 90701, 90720; Tdap: 90715; DT: 90702; Td: 90714, 90718; Diphtheria: 90719; Tetanus: 90703; OPV: 90712; IPV: 90696-90698, 90713, 90723; MMR: 90707, 90710; M/R: 90708; Measles: 90705; Mumps: 90704; Rubella: 90706; Hepatitis B: 90636, 90697, 90723, 90740, 90743-90748, 90759, G0010; HIB: 90644-90648, 90697, 90698, 90720-90721, 90748; Varicella: 90710, 90716; Pneumococcal: 90669, 90670, 90732, G0009, G9279 Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Childhood Immunizations (cont.)			**NMI Refusal of Childhood Immunizations** *Mnemonic NMI enter* Patient Refusals For Service/NMI Refusal Type: Immunization Immunization Value: [See codes above] Date Refused: Provider Who Documented: Comment: **Immunization Package Contraindication Childhood Immunizations** (Assumes you are in the IMM Pkg for Single Patient Record for your site) Select Action: C (Contraindications) Select Action: A (Add Contraindication) Vaccine: [See codes above] Reason: [See Contraindications section under the Provider Documentation column] Date Noted: Command: Save Select Action: Quit

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Cervical Cancer Screening	Women ages 24–64 should have a Pap Smear every 3 years, or if patient is 30 to 64 years of age, either a Pap Smear documented in the past 3 years, or a Pap Smear and an HPV DNA documented on the same day in the past 5 years or an HPV Primary in the past 5 years. **Note**: Refusals of any above test are not counted toward the GPRA measure but should still be documented.	Standard PCC documentation for tests performed at the facility. Ask about off-site tests and record historical information in PCC: • Date received • Location • Results	**Data entry through Women's Health program or standard PCC data entry for tests performed at the facility.** **Pap Smear V Lab** *Mnemonic LAB enter* Enter Lab Test Type: Pap Smear Results: [Enter Results] Units: Abnormal: Site: **Pap Smear POV** *Mnemonic PPV enter* Purpose of Visit: ICD-10: R87.61*, R87.810, R87.820, Z01.42, Z12.4 Provider Narrative: Modifier: Cause of DX: **Pap Smear CPT** *Mnemonic CPT enter* Enter CPT: 88141-88154, 88160-88167, 88174-88175, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091 Quantity: Modifier: Modifier 2: **Historical Pap Smear** *Mnemonic HPAP enter* Date Historical Pap Smear: Type of Visit: Location Name: Enter Outside Location: [(if "Other" was entered for Location Name:)] Select V Lab Test: Pap Smear Results: [Enter Results]

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Cervical Cancer Screening (cont.)			**HPV V Lab** *Mnemonic LAB enter* Enter Lab Test Type: HPV Results: [Enter Results] Units: Abnormal: Site: **HPV POV** *Mnemonic PPV enter* Purpose of Visit: ICD-10: B97.7, R85.618, R85.81, R85.82, R87.628, R87.810, R87.811, R87.820, R87.821, Z11.51 Provider Narrative: Modifier: Cause of DX: **HPV CPT** *Mnemonic CPT enter* Enter CPT: 87623-87625, G0476 Quantity: Modifier: Modifier 2: **HPV Primary V Lab** *Mnemonic LAB enter* Enter Lab Test Type: HPV Primary Results: [Enter Results] Units: Abnormal: Site: **HPV Primary CPT** *Mnemonic CPT enter* Enter CPT: 87624 Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Cancer Screening: Mammogram Rates	Women ages 52–74 should have a mammogram every 2 years **Note**: Refusals of any above test are not counted toward the GPRA measure but should still be documented.	Standard PCC documentation for Radiology performed at the facility. Ask and record historical information in PCC: • Date received • Location • Results Telephone visit with patient Verbal or written lab report Patient's next visit	**Data entry through Women's Health program or standard PCC data entry for tests performed at the facility.** **Mammogram Radiology Procedure** *Mnemonic RAD enter* Enter Radiology Procedure: 77046-77049, 77052-77059, 77061-77063, 77065-77067, G0206; G0204, G0202, G0279 Impression: [Enter Results] Abnormal: Modifier: Modifier 2: **Historical Mammogram Radiology** *Mnemonic HRAD enter* Date of Historical Radiology Exam: Type: Location Name: Enter Outside Location: [(if "Other" was entered for Location Name:)] Radiology Exam: 77046-77049, 77052-77059, 77061-77063, 77065-77067, G0206; G0204, G0202, G0279 Impression: Abnormal:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Cancer Screening: Mammogram Rates (cont.)			**Mammogram POV** *Mnemonic PPV enter* Purpose of Visit: ICD-10: R92.0, R92.1, R92.8, Z12.31 Provider Narrative: Modifier: Cause of DX: **Mammogram CPT** *Mnemonic CPT enter* Enter CPT: 77046-77049, 77052-77059, 77061-77063, 77065-77067, G0206; G0204, G0202, G0279 Quantity: Modifier: Modifier 2: **Mammogram Procedure** *Mnemonic IOP enter* Operation/Procedure: ICD-10: BH00ZZZ, BH01ZZZ, BH02ZZZ Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX]

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Colorectal Cancer Screening	Adults ages 50–75 should be screened for CRC (HEDIS). For GPRA, IHS counts any of the following: • Annual fecal occult blood test (FOBT) or fecal immunochemical test (FIT) • FIT-DNA in the past 3 years • Flexible sigmoidoscopy or CT colonography in the past 5 years • Colonoscopy every 10 years **Note**: Refusals of any above test are not counted toward the GPRA measure but should still be documented.	Standard PCC documentation for procedures performed at the facility (Radiology, Lab, or provider). Guaiac cards returned by patients to providers should be sent to Lab for processing. Ask and record historical information in PCC: • Date received • Location • Results Telephone visit with patient Verbal or written lab report Patient's next visit	**Standard PCC data entry process for procedures, Lab or Radiology** **Colorectal Cancer POV** *Mnemonic PPV enter* Purpose of Visit: ICD-10: C18.*, C19, C20, C21.2, C21.8, C78.5, Z85.030, Z85.038, Z85.048 Provider Narrative: Modifier: Cause of DX: **Total Colectomy CPT** *Mnemonic CPT enter* Enter CPT: 44150-44151, 44155-44158, 44210-44212 Quantity: Modifier: Modifier 2: **Total Colectomy Procedure** *Mnemonic IOP enter* Operation/Procedure: ICD-10: 0DTE*ZZ Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX] **FOBT or FIT CPT** *Mnemonic CPT enter* Enter CPT: 82270, 82274, G0328 Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Colorectal Cancer Screening (cont.)			**FIT-DNA CPT** *Mnemonic CPT enter* Enter CPT: 81528, G0464 Quantity: Modifier: Modifier 2: **Flexible Sigmoidoscopy CPT** *Mnemonic CPT enter* Enter CPT: 45330-45347, 453349, 45350, G0104 Quantity: Modifier: Modifier 2: **Flexible Sigmoidoscopy Procedure** *Mnemonic IOP enter* Operation/Procedure: ICD-10: 0DJD8ZZ Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX] **CT Colonography CPT** *Mnemonic CPT enter* Enter CPT: 74261-74263 Quantity: Modifier: Modifier 2: **Colon Screening CPT** *Mnemonic CPT enter* Enter CPT: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398, G0105, G0121, G2204, G9252, G9253 Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Colorectal Cancer Screening (cont.)			**Colon Screening Procedure** *Mnemonic IOP enter* Operation/Procedure: ICD-10: (see logic manual for codes) Provider Narrative: Operating Provider: Diagnosis: [Enter appropriate DX] **Historical CRC** *Mnemonic [from the following list] enter:* HCOL - Historical Colonoscopy HFOB - Historical FOBT (Guaiac) HSIG - Historical Sigmoidoscopy HBE - Historical Barium Enema Date: Type: Location of Encounter: Quantity:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Tobacco Use and Exposure Assessment **Note**: This is not a GPRA measure; however, it will be used for reducing the incidence of Tobacco Use.	Ask all patients age five and over about tobacco use at least annually.	Standard PCC documentation for tests performed at the facility. Ask and record historical information in PCC: • Date received • Location • Results Document on designated Health Factors section of form: • HF–Current Smoker, every day • HF–Current Smoker, some day • HF–Current E-cigarette user w/nicotine • HF–Current E-cig user w/other substance(s) • HF–Heavy Tobacco Smoker • HF–Light Tobacco Smoker • HF–Current Smoker, status unknown • HF–Current Smokeless • HF–Previous (Former) Smoker [or –Smokeless or –E-cigarette] (quit greater than (>) 6 months) • HF–Smoker in Home • HF–Ceremonial Use Only • HF–Exp to ETS (Second Hand Smoke) • HF–Smoke Free Home **Note**: If your site uses other expressions (e.g.," Chew" instead of "Smokeless;" "Past" instead of "Previous"), be sure Data Entry staff knows how to "translate" Tobacco Patient Education Codes: • Codes will contain "TO-", "-TO", "-SHS"	**Standard PCC data entry** **Tobacco Screening Health Factor** *Mnemonic HF enter* Select V Health Factor: [Enter HF (See the Provider Documentation column)] Level/Severity: Provider: Quantity: **Historical Tobacco Health Factor** *Mnemonic HHF enter* Date Historical Health Factor: Type of Visit: Location Name: Enter Health Factor: [Enter HF (See the Provider Documentation column)] Level/Severity: Provider: Quantity:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Tobacco Use and Exposure Assessment (cont.)		**Note**: Ensure you update the patient's health factors as they become nontobacco users. Patients who have quit tobacco should have their health factor updated to "Former Smoker", "Former Smokeless", or "Former E-cigarette user."	**Tobacco Screening PED - Topic** *Mnemonic PED enter* Enter Education Topic: [Enter Tobacco Patient Education Code (See the Provider Documentation column)] Readiness to Learn: Level of Understanding: Provider: Length of Education (Minutes): Comment Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: **Tobacco Users Health Factor** *Mnemonic HF enter* Select V Health Factor: Current Smoker (every day, some day, or status unknown), Current Smokeless, Current E-cigarette user w/nicotine, Current E-cig user w/other substance(s) Level/Severity: Provider: Quantity: **Smokers Health Factor** *Mnemonic HF enter* Select V Health Factor: Current Smoker (every day, some day, or status unknown) Level/Severity: Provider: Quantity:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Tobacco Use and Exposure Assessment (cont.)			**Smokeless Health Factor** *Mnemonic HF enter* Select V Health Factor: Current Smokeless Level/Severity: Provider: Quantity: **E-Cigarette User Health Factor** *Mnemonic HF enter* Select V Health Factor: Current E-cigarette user w/nicotine, Current E-cig user w/other substance(s) Level/Severity: Provider: Quantity: **ETS Health Factor** *Mnemonic HF enter* Select V Health Factor: Exp to ETS Level/Severity: Provider: Quantity:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Tobacco Cessation	User Population patients identified as current tobacco users prior to report period and who have received tobacco cessation counseling or a Rx for smoking cessation aid or quit tobacco use. **Note**: Refusals are not counted toward the GPRA measure but should still be documented.	Standard PCC documentation for tests performed at the facility. Ask and record historical information in PCC: • Date received • Location • Results Current tobacco users are defined by having any of the following documented prior to the report period: • Last documented Tobacco Health Factor Health factors considered to be a tobacco user: • HF–Current Smoker, every day • HF–Current Smoker, some day • HF–Current E-cigarette user w/nicotine • HF–Heavy Tobacco Smoker • HF–Light Tobacco Smoker • HF–Current Smoker, status unknown • HF–Current Smokeless Tobacco Patient Education Codes: • Codes will contain "TO-", "-TO", "-SHS" Prescribe Tobacco Cessation Aids: • Predefined Site-Populated Smoking Cessation Meds • Meds containing: – “Nicotine Patch” – “Nicotine Polacrilex” – “Nicotine Inhaler” – “Nicotine Nasal Spray”	**Standard PCC data entry** **Tobacco Cessation PED - Topic** *Mnemonic PED enter* Enter Education Topic: [Enter Tobacco Patient Education Code (See the Provider Documentation column)] Readiness to Learn: Level of Understanding: Provider: Length of Education (Minutes): Comment **Tobacco Cessation PED - Diagnosis** *Mnemonic PED enter* Select ICD Diagnosis Code Number or SNOMED code Category: Readiness to Learn: Level of Understanding: Provider: Length of Education (Minutes): Comment Provider’s Narrative:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Tobacco Cessation (cont.)		**Note**: Ensure you update the patient's health factors as they become nontobacco users. Patients who have quit tobacco should have their health factor updated to "Former Smoker", "Former Smokeless", or "Former E-cigarette user."	**Tobacco Cessation Clinic** *Mnemonic CL enter* Clinic: 94 Was this an appointment or walk in?: Tobacco Cessation Dental (ADA) Mnemonic ADA enter Select V Dental Service Code: 1320 No. Of Units: Operative Site: **Tobacco Cessation CPT** *Mnemonic CPT enter* Enter CPT Code: D1320, 99406, 99407, 4000F, G0030,G9016, G9458 Quantity Modifier: Modifier 2: **Tobacco Cessation Medication** *Mnemonic RX enter* Select Medication: [Enter Tobacco Cessation Prescribed Medication] Outside Drug Name (Optional): [Enter any additional name for the drug] SIG Quantity: Day Prescribed: Event Date & Time: Ordering Provider:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Tobacco Cessation (cont.)			**Historical Tobacco Cessation Medication** *Mnemonic HRX enter* Date of Historical Medication: Type: Location Name: Enter Medication: [Enter Tobacco Cessation Prescribed Medication] Name of Non-Table Drug: SIG: Days Prescribed: Date Discontinued: Date Dispensed (If Known): Outside Provider Name: **Tobacco Cessation Prescription CPT** *Mnemonic CPT enter* Enter CPT Code: 4001F Quantity Modifier: Modifier 2: **Quit Tobacco Health Factor** *Mnemonic HF enter* Select V Health Factor: Former Smoker, Former Smokeless, Former E-cigarette user Level/Severity: Provider: Quantity:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Alcohol Screening	User Population patients ages 9 through 75 should be screened for alcohol use at least annually. **Note**: Refusals are not counted toward the GPRA measure but should still be documented.	Standard PCC documentation for tests performed at the facility. Ask and record historical information in PCC: • Date received • Location • Results Alcohol screening may be documented with either an exam code or the CAGE health factor in PCC. Medical Providers: EXAM—Alcohol Screening • **Negative**–Patient's screening exam does not indicate risky alcohol use. • **Positive**–Patient's screening exam indicates potential risky alcohol use. • **Refused**–Patient declined exam/screen • **Unable to screen** - Provider unable to screen **Note**: Recommended Brief Screening Tool: SASQ (below). *Single Alcohol Screening Question (SASQ)* *For Women:* • When was the last time you had more than 4 drinks in one day? *For Men:* • When was the last time you had more than 5 drinks in one day?	**Standard PCC data entry** **Alcohol Screening Exam** *Mnemonic EX enter* Select Exam: 35, ALC Result: A–Abnormal N–Normal/Negative PR–Present PAP–Present and Past PA–Past PO–Positive Comments: SASQ Provider Performing Exam: **Historical Alcohol Screen Exam** *Mnemonic HEX enter* Date of Historical Exam: Type: Location Name: Exam Type: 35, ALC Result: Comments: Encounter Provider:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Alcohol Screening (cont.)		Any time in the past 3 months is a positive screen and further evaluation indicated; otherwise, it is a negative screen: • Alcohol Screening Exam Code Result: Positive The patient may decline the screen or "Refuse to answer": • Alcohol Screening Exam Code Result: Refused The provider is unable to conduct the screen: • Alcohol Screening Exam Code Result: Unable To Screen **Note**: Provider should note the screening tool used was the SASQ at the Comment Mnemonic for the Exam code. All Providers: Use the CAGE questionnaire: • Have you ever felt the need to Cut down on your drinking? • Have people Annoyed you by criticizing your drinking? • Have you ever felt bad or Guilty about your drinking? • Have you ever needed an Eye-opener the first thing in the morning to steady your nerves or get rid of a hangover? • Tolerance: How many drinks does it take you to get high? Based on how many YES answers were received, document Health Factor in PCC: • HF–CAGE 0/4 (all No answers) • HF–CAGE 1/4 • HF–CAGE 2/4 • HF–CAGE 3/4 • HF–CAGE 4/4	**Cage Health Factor** *Mnemonic HF enter* Select Health Factor: CAGE 1 CAGE 0/4 (all No answers) 2 CAGE 1/4 3 CAGE 2/4 4 CAGE 3/4 5 CAGE 4/4 Choose 1-5: [Number from above] Level/Severity: Provider: Quantity:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Alcohol Screening (cont.)		Optional values: • **Level/Severity**: Minimal, Moderate, or Heavy/Severe • **Quantity**: # of drinks daily *or* T (Tolerance) – # drinks to get high (e.g., T-4) • **Comment**: used to capture other relevant clinical info e.g., “Non-drinker” Alcohol-Related Patient Education Codes: Codes will contain "AOD-", "-AOD", "CD-" AUDIT Measurements: • **Zone I**: Score 0–7 Low-risk drinking or abstinence • **Zone II**: Score 8–15 Alcohol use in excess of low-risk guidelines • **Zone III**: Score 16–19 Harmful and hazardous drinking • **Zone IV**: Score 20–40 Referral to Specialist for Diagnostic Evaluation and Treatment AUDIT-C Measurements: How often do you have a drink containing alcohol? • (0) Never (Skip to Questions 9–10) • (1) Monthly or less • (2) 2 to 4 times a month • (3) 2 to 3 times a week • (4) 4 or more times a week	**Alcohol Screening CPT** *Mnemonic CPT enter* Enter CPT Code: 99408, 99409, G0396, G0397, G0442, G0443, G2011, G2196, G2197, H0049, H0050 Quantity: Modifier: Modifier 2: **Alcohol-Related Diagnosis POV** *Mnemonic PPV enter* Purpose of Visit: ICD-10: F10.1*, F10.20, F10.220-F10.29, F10.920-F10.982, F10.99, G62.1 Provider Narrative: Modifier: Cause of DX: Alcohol-Related Diagnosis BHS POV data entry Enter BHS POV 10, 27, 29 Enter BHS problem code 10, 12.1, 14.2, 17.1, 18.1, 20.1, 22.1

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Alcohol Screening (cont.)		How many drinks containing alcohol do you have on a typical day when you are drinking? • (0) 1 or 2 • (1) 3 or 4 • (2) 5 or 6 • (3) 7, 8, or 9 • (4) 10 or more How often do you have 6 or more drinks on one occasion? • (0) Never • (1) Less than monthly • (2) Monthly • (3) Weekly • (4) Daily or almost daily The AUDIT-C (the first three AUDIT questions which focus on alcohol consumption) is scored on a scale of 0–12 (scores of 0 reflect no alcohol use). • In men, a score of 4 or more is considered positive • In women, a score of 3 or more is considered positive. A positive score means the patient is at increased risk for hazardous drinking or active alcohol abuse or dependence.	**Alcohol-Related PED - Topic** *Mnemonic PED enter* Enter Education Topic: [Enter Alcohol-Related Education Code (See the Provider Documentation column)] Readiness to Learn: Level of Understanding: Provider: Length of Education (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: **Alcohol-Related PED - Diagnosis** *Mnemonic PED enter* Select ICD Diagnosis Code Number: F10.1*, F10.20, F10.220-F10.29, F10.920-F10.982, F10.99, or G62.1 Category: Readiness to Learn: Level of Understanding: Provider: Length of Education (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Provider's Narrative:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Alcohol Screening (cont.)		CRAFFT Measurements: • C–Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs? • R–Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? • A–Do you ever use alcohol/drugs while you are by yourself, ALONE? • F–Do you ever FORGET things you did while using alcohol or drugs? • F–Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use? • T–Have you gotten into TROUBLE while you were using alcohol or drugs? Total CRAFFT score (Range: 0–6). A positive answer to two or more questions is highly predictive of an alcohol or drug-related disorder. Further assessment is indicated. Standard PCC documentation for tests performed at the facility. Ask and record historical information in PCC: • Date received • Location • Results	**Alcohol Screen AUDIT Measurement** *Mnemonic AUDT enter* Value: [Enter 0-40] Select Qualifier: Date/Time Vitals Taken: **Alcohol Screen AUDIT-C Measurement** *Mnemonic AUDC enter* Value: [Enter 0-40] Select Qualifier: Date/Time Vitals Taken: **Alcohol Screen CRAFFT Measurement** *Mnemonic CRFT enter* Value: [Enter 0-6] Select Qualifier: Date/Time Vitals Taken: **Unable to Perform Alcohol Screen** *Mnemonic UAS enter* Patient Refusals For Service: Exam Exam Value: 35, ALC Date Refused: Provider Who Documented: Comment:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	User Population patients age 9 through 75 who screened positive for risky or harmful alcohol use should receive a Brief Negotiated Interview (BNI) or Brief Intervention (BI) within 7 days of the positive screen.	Standard PCC documentation for tests performed at the facility. Ask and record historical information in PCC: • Date received • Location • Results	**BNI/BI CPT** *Mnemonic CPT enter* Enter CPT Code: G0396, G0397, G2011, G2200, H0050, 96150-96155, 99408, 99409 Quantity Modifier: Modifier 2: **BNI/BI PED - Topic** *Mnemonic PED enter* Enter Education Topic: AOD-BNI Readiness to Learn: Level of Understanding: Provider: Length of Education (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Intimate Partner (Domestic) Violence Screening (IPV/DV)	Adult females should be screened for domestic violence at new encounter and at least annually Prenatal once each trimester (Source: Family Violence Prevention Fund National Consensus Guidelines) **Note**: Refusals are *not* counted toward the GPRA measure but should be documented.	Standard PCC documentation for tests performed at the facility. Ask and record historical information in PCC: • Date received • Location • Results Medical and Behavioral Health Providers: EXAM—IPV/DV Screening • **Negative**–Denies being a current or past victim of IPV/DV • **Past**–Denies being a current victim, but discloses being a past victim of IPV/DV • **Present**–Discloses current IPV/DV • **Present and Past**–Discloses past victimization and current IPV/DV victimization • **Refused**–Patient declined exam/screen • **Unable to screen**–Unable to screen patient (partner or verbal child present, unable to secure an appropriate interpreter, etc.) IPV/DV Patient Education Codes: • Codes will contain "DV-" or "-DV"	**Standard PCC data entry** **IPV/DV Screening Exam** *Mnemonic EX enter* Select Exam: 34, INT Result: A–Abnormal N–Normal/Negative PR–Resent PAP–Present and Past PA–Past PO–Positive Comments: Provider Performing Exam: **Historical IPV/DV Screen Exam** *Mnemonic HEX enter* Date of Historical Exam: Type: Location Name: Exam Type: 34, INT Result: Comments: Encounter Provider: Standard BHS data entry Enter BHS problem code Narrative "IPV/DV exam"

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Intimate Partner (Domestic) Violence Screening (IPV/DV) (cont.)			**IPV/DV Diagnosis POV** *Mnemonic PPV enter* Purpose of Visit: ICD-10: T74.11XA, T74.21XA, T74.31XA, T74.91XA, T76.11XA, T76.21XA, T76.31XA, T76.91XA, Z91.410; IPV/DV Counseling: ICD-10: Z69.11 Provider Narrative: Modifier: Cause of DX: IPV/DV Diagnosis BHS POV data entry Enter BHS problem code 43.*, 44.* **IPV/DV–Topic** *Mnemonic PED enter* Enter Education Topic: [Enter IPV/DV Patient Education Code (See the Provider Documentation column)] Readiness to Learn: Level of Understanding: Provider: Length of Education (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: **IPV/DV PED–Diagnosis** *Mnemonic PED enter* Select ICD Diagnosis Code Number: T74.11XA, T74.21XA, T74.31XA, T74.91XA, T76.11XA, T76.21XA, T76.31XA, T76.91XA, or Z91.410

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Depression Screening	All patients 12 years of age and older should be screened for depression at least annually. (Source: United States Preventive Services Task Force) **Note**: Refusals are *not* counted toward the GPRA measure but should be documented.	Standard PCC documentation for tests performed at the facility. Ask and record historical information in PCC: • Date received • Location • Results Medical Providers: EXAM—Depression Screening • **Normal/Negative**–Denies symptoms of depression • **Abnormal/Positive**–Further evaluation indicated • **Refused**–Patient declined exam/screen • **Unable to screen**–Provider unable to screen **Note**: Refusals are not counted toward the GPRA measure but should be documented. Mood Disorders: Two or more visits with POV related to: • Major Depressive Disorder • Dysthymic Disorder • Depressive Disorder NOS • Bipolar I or II Disorder • Cyclothymic Disorder • Bipolar Disorder NOS • Mood Disorder Due to a General Medical Condition • Mood Disorder NOS	**Standard PCC data entry** **Depression Screening Exam** *Mnemonic EX enter* Select Exam: 36, DEP Result: • A–Abnormal • N–Normal/Negative • PR–Present • PAP–Present and Past • PA–Past • PO–Positive Comments: PHQ-2 Scaled, PHQ9, PHQT Provider Performing Exam: **Historical Depression Screen Exam** *Mnemonic HEX enter* Date of Historical Exam: Type: Location Name: Exam Type: 36, DEP Result: Comments: PHQ-2 Scaled, PHQ9 (If Known), PHQT Encounter Provider:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Depression Screening (cont.)		**Note**: Recommended Brief Screening Tool: PHQ-2 Scaled Version (below). Patient Health Questionnaire (PHQ-2 Scaled Version) Over the past two weeks, how often have you been bothered by any of the following problems? Little interest or pleasure in doing things • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly Value: 3 Feeling down, depressed, or hopeless • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 PHQ-2 Scaled Version (continued) Total Possible PHQ-2 Score: Range: 0-6 • 0–2: Negative Depression Screening Exam: – Code Result: **Normal or Negative** • 3–6: Positive; further evaluation indicated Depression Screening Exam – Code Result: **Abnormal or Positive** The patient may decline the screen or "Refuse to answer" Depression Screening Exam • Code Result: **Refused** The provider is unable to conduct the Screen Depression Screening Exam • Code Result: **Unable To Screen** Provider should note the screening tool used was the PHQ-2 Scaled at the Comment Mnemonic for the Exam Code.	**Depression Screening CPT** *Mnemonic CPT enter* Enter CPT: 1220F, 3725F, G0444 Quantity: Modifier: Modifier 2: Standard BHS POV data entry **Unable to Screen for Depression** *Mnemonic UAS enter* Patient Refusals For Service: Exam Exam Value: 36, DEP Date Refused: Provider Who Documented: Comment:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Depression Screening (cont.)		PHQ9 Questionnaire Screening Tool Little interest or pleasure in doing things? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Feeling down, depressed, or hopeless? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Trouble falling or staying asleep, or sleeping too much? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Feeling tired or having little energy? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Poor appetite or overeating? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3	**Mood Disorder Diagnosis POV** *Mnemonic PPV enter* Purpose of Visit: ICD-10: F01.51, F06.31-F06.34, F1*.*4, F10.159, F10.180, F10.181, F10.188, F10.259, F10.280, F10.281, F10.288, F10.959, F10.980, F10.981, F10.988, F30.*, F31.0-F31.71, F31.73-F31.75, F31.77, F31.81-F31.9, F32.*-F39, F43.21, F43.23 Provider Narrative: Modifier: Cause of DX: Standard BHS Mood Disorder POV data entry Enter BHS problem code: 14, 15

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Depression Screening (cont.)		Feeling bad about yourself—or that you are a failure or have let yourself or your family down? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Trouble concentrating on things, such as reading the newspaper or watching television? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3 Thoughts that you would be better off dead, or of hurting yourself in some way? • Not at all Value: 0 • Several days Value: 1 • More than half the days Value: 2 • Nearly every day Value: 3	

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Depression Screening (cont.)		Total Possible PHQ-2 Score: Range: 0–27: • 0–4 Negative/None Depression Screening Exam: Code Result: **None** • 5–9 Mild Depression Screening Exam: Code Result: **Mild depression** • 10–14 Moderate Depression Screening Exam: Code Result: **Moderate depression** • 15–19 Moderately Severe Depression Screening Exam: Code Result: **Moderately Severe depression** • 20–27 Severe Depression Screening Exam: Code Result: **Severe depression** Provider should **note** the screening tool used was the PHQ9 Scaled at the Comment Mnemonic for the Exam Code.	
Childhood Weight Control	Patients ages 2–5 at the beginning of the report period whose BMI could be calculated and have a BMI equal to or greater than (≥) 95%. Height and weight taken on the same day. Patients that turn 6 years old during the report period are not included in the GPRA measure.	Standard PCC documentation to obtain height and weight during visit and record information in PCC: • Height • Weight • Date Recorded BMI is calculated using NHANES II Age in the age groups is calculated based on the date of the most current BMI found. Example: a patient may be 2 at the beginning of the time period but is 3 at the time of the most current BMI found, patient will fall into the age 3 group. The BMI values for this measure are reported differently than in the Obesity Assessment measure as they are Age-Dependent. The BMI values are categorized as Overweight for patients with a BMI in the 85th to 94th percentile and Obese for patients with a BMI at or above the 95th percentile (GPRA).	**Standard PCC data entry** **Height Measurement** *Mnemonic HT enter* Value: Select Qualifier: Actual Estimated Date/Time Vitals Taken: **Weight Measurement** *Mnemonic WT enter* Value: Select Qualifier: Actual Bed Chair Dry Estimated Standing Date/Time Vitals Taken:

<table>
<tr><th>Performance Measure</th><th>Standard</th><th>Provider Documentation</th><th>How to Enter Data in PCC</th></tr>
<tr><td>Childhood Weight Control (cont.)</td><td></td><td>Patients with BMI either greater or less than the Data Check Limit range shown below will not be included in the report counts for Overweight or Obese.
<table>
<tr><th>Low-High</th><th>Sex</th><th>BMI ≥ 85</th><th>BMI ≥ 95</th><th>Data Check Limits</th><th>Data Check Limits</th></tr>
<tr><td>Ages</td><td>Sex</td><td>Over Weight</td><td>Obese</td><td>BMI ></td><td>BMI <</td></tr>
<tr><td>2–2</td><td>M
F</td><td>17.7
17.5</td><td>18.7
18.6</td><td>36.8
37.0</td><td>7.2
7.1</td></tr>
<tr><td>3–3</td><td>M
F</td><td>17.1
17.0</td><td>18.0
18.1</td><td>35.6
35.4</td><td>7.1
6.8</td></tr>
<tr><td>4–4</td><td>M
F</td><td>16.8
16.7</td><td>17.8
18.1</td><td>36.2
36.0</td><td>7.0
6.9</td></tr>
<tr><td>5–5</td><td>M
F</td><td>16.9
16.9</td><td>18.1
18.5</td><td>36.0
39.2</td><td>6.9
6.8</td></tr>
</table></td><td></td></tr>
<tr><td>Controlling High Blood Pressure - Million Hearts</td><td>User Population patients ages 18 through 85 diagnosed with hypertension and no documented history of ESRD or current diagnosis of pregnancy who have BP less than (<) 140/90 (mean systolic less than (<) 140, mean diastolic less than (<) 90).</td><td>Standard PCC documentation for tests performed at the facility. Ask about off-site tests and record historical information in PCC:
• Date received
• Location
• Results</td><td>Standard PCC data entry
Blood Pressure Data Entry
Mnemonic BP enter
Value: [Enter as Systolic/Diastolic (e.g., 140/90)]
Select Qualifier:
Date/Time Vitals Taken:</td></tr>
</table>

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	User Population Patients age 40–75 with diabetes or any age with documented CVD or age 20 and older with LDL greater than or equal to (≥) 190 or hypercholesterolemia who have statin therapy.	Standard PCC documentation for medication dispensed at the facility. Ask about off-site medication and record historical information in PCC: • Date received • Location • Dosage	**Standard PCC data entry:** **Statin Therapy Medication** *Mnemonic RX enter* Select Medication: [Enter Statin Therapy Prescribed Medication] Outside Drug Name (Optional): [Enter any additional name for the drug] SIG Quantity: Day Prescribed: Event Date & Time: Ordering Provider: **Historical Statin Therapy Medication** *Mnemonic HRX enter* Date of Historical Medication: Type: Location Name: Enter Medication: [Enter Statin Therapy Prescribed Medication] Name of Non-Table Drug: SIG: Days Prescribed: Date Discontinued: Date Dispensed (If Known): Outside Provider Name: **Statin Therapy CPT** Mnemonic CPT enter Enter CPT Code: 4013F Quantity: Modifier: Modifier 2:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
HIV Screening	Patients should be tested for HIV at least once; education and follow-up provided as appropriate. **Note**: Refusals are not counted toward the GPRA measure but should still be documented.	Standard PCC documentation for tests performed at the facility. Ask and record historical information in PCC: • Date received • Location • Results	**Standard PCC data entry** **HIV Screen CPT** *Mnemonic CPT enter* Enter CPT Code: 80081, 86689, 86701-86703, 87389-87391, 87534-87539, 87806, 87901, 87906 Quantity: Modifier: Modifier 2: **HIV Diagnoses POV** *Mnemonic PPV enter* Purpose of Visit: ICD-10: B20, B97.35, Z21, O98.711-O98.73 Provider Narrative: Modifier: Cause of DX: **HIV Lab Test** *Mnemonic LAB enter* Enter Lab Test Type: [Enter site's defined HIV Screen Lab Test] Results: [Enter Results (e.g., Negative, Positive, Indeterminate)] Units: Abnormal: Site: [Blood, Serum] **Historical HIV Screen** *Mnemonic HLAB enter* Date of Historical Lab Test: Type: Location Name: Enter Lab Test: Results:

<table>
<tr><th>Performance Measure</th><th>Standard</th><th>Provider Documentation</th><th>How to Enter Data in PCC</th></tr>
<tr>
<td>Breastfeeding Rates
The information is included here to inform providers and data entry staff of how to collect, document, and enter the data.</td>
<td>All providers should assess the feeding practices of all newborns through age 1 year at all well-child visits.</td>
<td>The following grid is designed to be used on PCC and PCC+. It was successfully field tested at Phoenix Indian Medical Center (PIMC) for pediatric clinic visits. See the next page for definitions of each feeding choice.
<table>
<tr><th>Feeding Choice (today) X</th></tr>
<tr><td>Exclusive Breastfeeding</td></tr>
<tr><td>Mostly Breastfeeding</td></tr>
<tr><td>½ Breastfeeding
½ Formula feeding</td></tr>
<tr><td>Mostly Formula feeding</td></tr>
<tr><td>Only Formula feeding</td></tr>
<tr><th>One-time data fields</th></tr>
<tr><td>Mom’s name or chart #:</td></tr>
<tr><td>Birth order:</td></tr>
<tr><td>Birth wt.:</td></tr>
<tr><td>Started formula: ____wks/mth</td></tr>
<tr><td>Stopped breastfeeding: ____wks/mth</td></tr>
<tr><td>Started solids: ____wks/mth</td></tr>
</table>
Exclusive Breastfeeding. Breastfed or expressed breast milk only, no formula
Mostly Breastfeeding: Mostly breastfed or expressed breast milk, with some formula feeding (1 time per week or more, but less than half the time formula feeding.)
½ Breastfeeding, ½ Formula Feeding: Half the time breastfeeding/expressed breast milk, half formula feeding
Mostly Formula: The baby is mostly formula fed, but breastfeeds at least once a week
Formula Only: Baby receives only formula</td>
<td>Standard PCC data entry
Infant Breastfeeding
Mnemonic IF enter
Enter Feeding Choice:
1. Exclusive Breastfeeding
2. Mostly Breastfeeding
3. Mostly Breastfeeding, Some Formula
4. 1/2 & 1/2 Breast and Formula
5. Mostly Formula
6. Mostly Formula, Some Breastfeeding
7. Formula Only</td>
</tr>
</table>

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Breastfeeding Rates (cont.)		The additional one-time data fields (e.g., birth weight, formula started, and breast stopped) may also be collected and may be entered using the data entry Mnemonic PIF. However, this information is not used or counted in the CRS logic for Breastfeeding Rates.	

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Patient Education Measures (Patient Education Report) **Note**: This is not a GPRA measure; however, the information is being provided because there are several GPRA measures that do include patient education as meeting the numerator (e.g., alcohol screening). Providers and data entry staff need to know they need to collect and enter all components of patient education.	N/A	*All providers should document all 5 patient education elements and elements #6–7 if a goal was set for the patient:* 1. Education Topic/Diagnosis 2. Readiness to Learn 3. Level of Understanding (see below) 4. Initials of Who Taught 5. Time spent (in minutes) 6. Goal Not Set, Goal Set, Goal Met, Goal Not Met 7. Text relating to the goal or its status Readiness to Learn: • Distraction • Eager To Learn • Intoxication • Not Ready • Pain • Receptive • Severity of Illness • Unreceptive Levels of Understanding: • P–Poor • F–Fair • G–Good • GR–Group-No Assessment • R–Refused Goal Codes: • GS–Goal Set • GM–Goal Met • GNM–Goal Not Met • GNS–Goal Not Set	**Patient Education Topic** Topic: [Enter Topic] Readiness to Learn: D, E, I, N, P, R, S, U Level of Understanding: P, F, G, GR, R Provider: Length of Education (minutes): Comment: Goal Code: GS, GM, GNM, GNS Goal Comment: **Patient Education Diagnosis** Select ICD Diagnosis Code Number: Category: [Enter Category] Readiness to Learn: D, E, I, N, P, R, S, U Level of Understanding: P, F, G, GR, R Provider: Length of Education (Minutes): Comment: Goal Code: [(Objectives Met) (if a goal was set, not set, met, or not met, enter the text relating to the goal)] Goal Comment: Provider's Narrative:

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Patient Education Measures (Patient Education Report) (cont.)		An example of how this would look on the PCC form for Topic is: DM-N-E-G-DU-15 MIN-GS-Patient will eat more fruits and vegetables and less sugar: DM-N = Diabetes Mellitus -Nutrition (Topic) E = Eager to Learn (Readiness to Learn) G = Good (Level of Understanding) DU = Initials of Provider 15 MIN = 15 minutes spent providing education to the patient (Time Spent) GS = A goal was set Patient will… = The goal set for the patient Diagnosis Categories: • Anatomy and Physiology • Complications • Disease Process • Equipment • Exercise • Follow-up • Home Management • Hygiene • Lifestyle Adaptation • Literature • Medical Nutrition Therapy • Medications • Nutrition • Prevention • Procedures • Safety • Tests • Treatment	

Performance Measure	Standard	Provider Documentation	How to Enter Data in PCC
Patient Education Measures (Patient Education Report) (cont.)		An example of how this would look on the PCC form for Diagnosis is: V65.3-N-E-G-DU-15 MIN-GS-Patient will eat more fruits and vegetables and less sugar: V65.3 = Dietary Surveil/Counsel (Diagnosis) N = Nutrition (Category) E = Eager to Learn (Readiness to Learn) G = Good (Level of Understanding) DU = Initials of Provider 15 MIN = 15 minutes spent providing education to the patient (Time Spent) GS = A goal was set Patient will… = The goal set for the patient	

Contact Information

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