



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Referred Care Information System (RCIS)

(BMC)

User Manual

Version 4.0
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Preface

The Referred Care Information System (RCIS) is a group of computer programs that automate the clinical and administrative management of all referred care, including in-house referrals, referrals to other IHS facilities, and referrals to outside contract providers. Information entered to the system provides timely and accurate referral data on individuals and groups of patients for the key clinical and administrative managers at care delivery sites, IHS Areas, and IHS Headquarters. By tracking this information, RCIS helps ensure that referred care services are appropriate, effective, of high quality, and provided at fair and reasonable prices.

Security

This package does not impose any additional legal requirements, nor does it relieve the use of any legal requirements.

This package requires the use of *access* and *verify* codes in order to access the system. These can be obtained from your supervisor or site manager. In addition, security keys are assigned with your access codes. They are required to perform certain options in the Referred Care Information System application. Some options within the application are “locked”, i.e. you are unable to access the option without the appropriate security key.

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1.0 Overview

The new IHS RCIS is a group of computer programs created to assist you with clinical and administrative management of all referred care, including in-house referrals, referrals to other IHS facilities, and referrals to outside contract providers. The system is designed to automate the referral process within a facility. Essential information is gathered to provide timely and accurate referral data on individuals and groups of patients for the key clinical and administrative managers at care delivery sites, IHS Areas, and IHS Headquarters. By tracking information in referred care, RCIS helps IHS provide appropriate, effective, and high-quality referred care services to American Indian/Alaska Native people at fair and reasonable prices.

RCIS contains many features that facilitate the entry, management, and retrieval of referred care data; some of these features are listed below:

- Tracks information on all types of referred care, including care provided by Contract Health Services (CHS), non-CHS, IHS facilities, and Tribal sites
- Allows for either direct data entry at a terminal by a provider or later data entry by a clerk from a handwritten referral form
- Automates data entry for common referrals specific to your facility; e.g., screening mammography, audiology, or prenatal care
- Categorizes care in clinically defined “episodes” rather than individual purchase orders
- Minimizes redundant data entry by linking with the CHS system and the Patient Care Component (PCC) to share information
- Allows for data collection and recording before, during, and after referred care is provided
- Records clinical and administrative information
- Functions in a “bare bones” form as well as in its fullest implementation
- Allows exporting data to the Area office for Area-wide analyses

Numerous outputs are available from the RCIS that facilitate data retrieval and administrative tasks, such as:

- Automated e-mail messages to mail groups, primary care providers, and referring providers regarding information related to the referral.
- Printed referral forms that referred patients take from the IHS facility to the referred provider. Each referral form contains all of the necessary administrative and clinical data for referred care services to the extent that this information has been entered into the system.

- Standard sets of administrative reports, including reports on high-cost management, utilization, quality of care, contract management, and third-party utilization.
- An ad-hoc retrieval system, both within the RCIS itself and by transferring data to the PCC where it is accessible by Q-Man, the more powerful ad-hoc search tool.

The RCIS was initially developed jointly by the ISD/OHPRD development team in Tucson, the IHS Managed Care Committee, and field clinical and administrative managers involved in providing and managing direct patient care. The Contract Health workgroup has been responsible for enhancements to the package since 2003.

2.0 Introduction

The RCIS provides a standard tool for automating the referral process and maintaining records on referred care services. There are four main modules specific to the RCIS that are accessible from the main menu of the system:

- Data Entry
- Print Reports
- RCIS Management
- RCIS Special Print Menu

All of the data entry, management, and retrieval for the RCIS are performed with these four menu options. This user manual presents descriptions of these options and their submenus and provides detailed instructions for using all aspects of the system. It is recommended that you read the entire manual before using the RCIS.

2.1 The Data Entry Module

Most referral processing work is handled in the Data Entry module on the RCIS main menu. Initial referral information can be directly entered by a provider at a terminal. Additional referral information can then be added as needed by a scheduling clerk and staff in the CHS, Business, and Managed Care offices. Once the initial data has been entered in the system, an RCIS-generated referral letter that contains only the clinical and administrative information needed by the patient and the referred care provider can be printed and forwarded or hand-carried by the patient to the referred provider.

Alternatively, information can be progressively added to a standard, handwritten referral form. The final cumulative information can then be entered into the RCIS by a staff member in the CHS, Business, or Managed Care office. The handwritten referral form may be taken by the patient to the outside provider or a letter may be printed after the data entry is complete and then forwarded to the outside provider.

After a patient has received services from an outside provider, the referral may be closed via the RCIS Data Entry module or the link with the CHS system, if enabled.

2.2 The Print Reports Module

A set of predefined reports is available from the RCIS for administration and analysis of referred care data. Three report categories are available in the Print Reports option on the RCIS main menu:

- Administrative Reports

- Case Management Reports
- Utilization Reports

General Retrieval Reports: In addition to the predefined reports, the RCIS provides a general retrieval report option that allows for the creation of custom reports to meet the needs of your facility. Version 4.0 allows users to add Case Review Comments and Discharge Comments to a selection. This option is available from the Print Reports menu.

PCC Interface: When the PCC interface is enabled, all referred care data in the RCIS is shared with the PCC in an automated fashion. The PCC then becomes a much more complete repository of all patient care information, direct and referred, allowing managers to utilize the power search engine Q-Man on this more complete information system for extensive and detailed report outputs.

2.3 The RCIS Management Module

The RCIS Management module allows the Site Manager to set the special parameters for this software, customizing its features to meet the specific needs of your site. You can perform the following actions from the Management Menu:

- Enable the interface between RCIS and PCC or CHS
- Create site-specific local table files
- Enter full ICD diagnostic and CPT procedure codes
- Utilize email alert bulletins for potential high-cost cases, cosmetic procedures, experimental procedures, and cases with third-party liability
- Indicate a contact person and phone number that will be printed on all referral letters
- Create customized referral templates to minimize data entry for common referrals
- Identify special default entries to minimize data entry
- Manage MailMan groups

Note: You must set the RCIS site parameters before using the system for the first time. You may modify these parameters at a later time, as needed.

3.0 Using the Data Entry Module

The Data Entry module, accessible from the RCIS main menu, provides functions for initiating referrals, modifying referral information, reviewing patient insurance coverage, closing referrals, viewing patient referral records, and printing referral forms.

```

*****
*                INDIAN HEALTH SERVICE                *
*   REFERRED CARE INFORMATION SYSTEM                   *
*   VERSION 4.0, Oct 20, 2005                          *
*****
                UNSPECIFIED SERVICE UNIT
                Data Entry

ADD    Add Referral
RFY    Add a Referral for a Previous Fiscal Year
EDIT   Edit Referral Options ...
ALT    Check Alternate Resources
DSP    Display Referral Record
NDA    Number of Days Authorized Modifications
SAS    Quick Inquiry to Appointment Scheduling Status
SEC    Secondary Referrals ...
LTRS   Print RCIS Letter Types ...

Select Data Entry Option:
    
```

Figure 3-1: Data entry menu

3.1 Moving around the Module

Many of the options in the Data Entry menu present screens in which data can be entered and modified. The following commands are useful for navigating these screens and entering data.

Command/Key	Function
Tab key	To move your cursor from one field to another
Return key	To move your cursor from one field to another and to select fields that have additional screens
^	To move your cursor to a selected field. You must type the up-hat (^) and the first few letters of the field. For example, ^PRIO will move your cursor to the Priority field. Also, the up-hat (^) followed by the Return key will move the cursor to the Command line.
?	For assistance with the type of data that needs to be entered in a particular field, type a question mark (?) and press the Return key. If it's available, help text will appear at the very bottom of the screen.
<F1>H	To view a list of commands for navigating the data entry screens
<F1>C	To close a pop-up screen and return to the primary data entry screen
<F1>E	To exit a data entry screen and save your changes

Command/Key	Function
<F1>Q	To exit a data entry screen without saving your changes

For a more detailed list of data entry commands and other introductory information on using the system, please refer to Appendix A: Data Entry Screen Help.

3.2 Adding a New Referral (ADD)

New referrals may be entered directly into the system upon initiation or recorded manually on a printed form and entered into the system at a later time.

To add data to the RCIS for a new referral, select the Add Referral option on the Data Entry menu. You will be prompted for a patient name. You can select a patient by entering the patient's name (last name then first name or initial, separated by a comma), social security number, health record number, or ward number if the patient is an inpatient. The patient must be registered at your facility prior to initiating a referral. If you enter the name of a patient who is not registered, the system will respond with two question marks (??) and a beep. To register a patient, follow the standard registration procedures at your site.

If the patient you enter has prior referrals that have been recorded in the system, the five most recent referrals for the patient within the current fiscal year will be displayed on the screen. The information displayed includes the initiation date, referral number, patient name, actual or estimated date of service, referred provider, and purpose of referral. You will then have the option to continue adding a referral or return to the *Data Entry* menu. By displaying the most recent referrals that have been initiated, this feature prevents the duplicate entry of referrals for a patient. If the patient does not have any recorded referrals, the message No Existing Referrals will appear (Figure 3-2).

Next you will enter the date on which the referral was initiated. Note that the date you enter at this prompt is not necessarily the same as the current date. For instance, if you are entering data from handwritten referral forms generated during the previous week, you would enter the date that was recorded on the referral form, not the current date. The default value for the date prompt is the current date. If you are entering a referral directly into the system upon initiation, just press the Return key at the prompt to accept the default value.

After you have entered the referral date, you will be presented with a list of referral forms. The first four choices are standard referral forms that are distributed with the package. Each of the following standard forms is described in detail in this manual:

- Mini Referral
- Complete Referral (all referral data)
- Call In Notification by Outside Facility

- Abbreviated Entry for Clinicians

Subsequent forms on the selection list (if available) are referral templates that have been created specifically by your facility. The locally defined forms are referral types that are frequently initiated at your site. These templates minimize the amount of data entry required by incorporating data that will remain constant for these referral types. For instance, if you refer all routine mammograms to one provider, you would probably use a custom template for generating those referrals. See section 5.2.6 for instructions on creating custom referral types.

Next you will enter the name of the provider who requested the referral. You can identify the provider by full name (last name then first name, separated by a comma) or initials. The “Requesting Provider:” prompt will not appear if you have selected a referral initiated by an outside facility.

Once you have entered all of the initial data requested, the system automatically assigns a referral number and the form you have chosen will appear on your screen for entering data.

An example of the first three steps in the process of adding a new referral is presented in Figure 3-2. These steps will be the same for each type of referral that you enter into the system. User responses and instructions are in bold type.

```

*****
*                INDIAN HEALTH SERVICE                *
*      REFERRED CARE INFORMATION SYSTEM      *
*                VERSION 4.0, Oct 20, 2005        *
*****
                                UNSPECIFIED HOSP
                                Add Referral

Select PATIENT NAME: PATIENT,LONA
                                F 07-14-1980
                                128935
                                PAH
16869
                                5426
                                PIMC
128935

                                *****
                                **LAST 5 REFERRALS**
                                *****

                                **--NO EXISTING REFERRALS--**

DATE INITIATED: TODAY// JUNE 10,2005 (JUN 10, 2005)

Please select the referral form you wish to use.
  1. Mini Referral
  2. Complete Referral (all referral data)
  3. Referral initiated by outside facility
  4. Abbreviated entry for clinicians

Locally-defined Routine Referral Templates:
  5) 9553
  6) Acc labor/del
  7) Acc shipaway

Enter REFERRAL FORM: (1-7): 2// 2
Enter REQUESTING PROVIDER: PROVIDER,ADAM

REFERRAL number : 555555500049

```

Figure 3-2: Add a new referral

3.2.1 Using the Complete Referral Form

The Complete Referral form is a comprehensive format for entering patient referral data. It is typically used when referral data is entered from a handwritten form. The complete referral screen (Figure 3-3) prompts you for almost every piece of referral information that is entered into the RCIS.

Not all the data items that appear on the form are required; the required data items are underlined. If you have not entered data into all of the required fields and try to exit the screen, the system will alert you and return you to the data entry screen. Referral data will not be entered into the system without all of the required data items.

Some of the fields shown in the Complete Referral form have pop-up screens that request additional information, depending on the data that you have entered. None of the information prompted for with a pop-up screen is required.

Patient information and help tips are displayed below the line at the bottom of the Complete Referral form. The information displayed varies according to the field in which you are entering data. For instance, if your cursor is at the Referral Type field, information on the patient's insurance displays below the line. If you need assistance with entering data into a field and are unsure of what to enter, type a question mark (?) and press the Return key to see help screens displayed below the line.

Each piece of information collected from the Complete Referral form is defined and described in detail in the order in which it appears on the form.

RCIS REFERRAL RECORD	
DATE: JUN 23,2004	NUMBER: 2021000400022 PATIENT: LOPEZ,EDWIN J

REQUESTING FACILITY: GET WELL SOON FACILI	Display Face Sheet? N
REQUESTING PROVIDER:	
REFERRAL TYPE: CHS	PRIMARY PAYOR: IHS
INPATIENT/OUTPATIENT: OUTPATIENT	CASE MANAGER:
GERBER, SPECIALIST	
APPT/ADM DATE&TIME:	
PROVISIONAL DRG: DRG25	
ESTIMATED TOTAL REFERRAL COST: 500	ESTIMATED IHS REFERRAL COST: 400
Do you want to enter CHS Eligibility Factors?: N	
PURPOSE/SERVICES REQUESTED: Rehabilitation	
PRIORITY: 3	
ARE YOU SENDING ADDITIONAL MEDICAL INFORMATION WITH THE PATIENT? NO	
ICD DIAGNOSTIC CATEGORY: MUSCULOSKELETAL AND CONNECTIVE TI	
CPT PROCEDURE CATEGORY: NONSURGICAL PROCEDURES	

Figure 3-3: Using the complete referral form

Date: The date at the top of the referral form refers to the date that the referral was initiated. This date is entered prior to selecting a referral form for data entry. The date you enter is automatically incorporated into the data entry screen and cannot be edited from this screen.

Number: The referral number is automatically generated for each new referral that is entered into the system. Entering a patient name, date, provider name, and referral form for data entry initiates the referral number assignment. The number assigned is included at the top of the referral form for data entry; you do not need to enter it. This generated number consists of your 6-digit facility code, 2-digit calendar or fiscal year (entered in the site parameters), and a 5-digit referral number. In the example in Figure 3-3, the number is 001019500455; 000101 is the Sells Hospital facility number, 95 is the fiscal year specified in the site parameters, and 00455 is the number for the referral. This field cannot be edited from this screen.

Patient: The name of the patient for whom you are entering referral data is included at the top of the data entry screen and does not need to be reentered.

Requesting Facility: Enter into this field the facility from which the referral is made. The default for this field will be your facility. Press the Return key or the Tab key to accept the default value. This field cannot be edited from this screen.

Display Face Sheet: The Face Sheet is a summary of the patient's registration data. You may browse or print the patient's face sheet while entering referral data. To do so, type **Y** at the prompt and then select print or browse. The default value for this field is *No*. Press the Return key to accept the default value.

Requesting Provider: Provider that requested the referral for the patient.

Referral Type: This is the type of referral that you are generating. You must select one of the following types:

IHS: A referral to another IHS facility

CHS: A referral to an outside facility that will be paid for with CHS funds

In-house: A referral to another clinical area within your facility

Other: Any other type of referral that will be paid for with funds other than CHS; for example, Medicaid or private insurance

If you are not sure of the referral type, enter CHS. If the CHS office determines that the patient is not eligible for CHS services, the referral record can be changed accordingly.

Note: if CHS is entered at the referral type and a CHS authorization is entered for the referral, the type cannot be changed. This field defaults to CHS. Press the Return key to accept the default value or type the first letter of the correct referral type.

When a referral type is entered, an alert message may appear at the bottom of the screen to convey pertinent information about the patient. For instance, if you entered CHS, you may see the message Patient Registration indicates that this patient is Not Eligible for CHS care. Be aware of these alerts and direct any questions about them to your Patient Registration Manager.

After you have entered a referral type, a pop-up screen will display, prompting you for the specific facility to which you are referring the patient. The following screens display for each of the referral types. Sample entries are in bold type.

IHS

Enter the IHS facility to which the patient is being referred. This is a required field.

```
TO IHS FACILITY: PHOENIX INDIAN MED CENTER
```

CHS and Other

In the *Primary Vendor* field, enter the facility to which the patient is being referred. The facility you enter must be a service provider that has already been entered into the vendor file. To enter a service provider that is not already in your facility's system, contact your CHS or Site Manager.

```
TO PRIMARY VENDOR: UNIVERSITY MEDICAL CENTER
SPECIFIC PROVIDER: PROVIDER,MARTY
```

In the *Other Provider* field, type the name of the specific provider, if needed. If you type the name of a provider who has not already been entered into your system, a message will appear on the screen asking if you want to add the provider to your RCIS-specific provider list. Typing **Y** will add the new provider to your site's list; typing **N** will display a list of providers from which to choose. To bypass the Other Provider field, press the Return key.

```
Are you adding 'PROVIDER,MARTY' as
a new RCIS SPECIFIC PROVIDER (the 11th)?
```

Note: The Other Provider field is a learn-as-you-go (LAYGO) field. All entries should be consistent and be entered using all capital letters to avoid the addition of duplicate entries into this local table file. You will want to establish a standard format for entering these names. For example, always use last name then first name, separated by a comma, as shown above.

If you do not know the Primary Vendor at the time of the referral entry, type **Unspecified** in the field. Press the Return key to bypass entering a provider. This entry can be modified at a later date.

```
TO PRIMARY VENDOR: UNSPECIFIED
SPECIFIC PROVIDER: [RET]
```

In-House

Type in the name or code of the in-house clinic to which the patient is referred at the "Clinic Referred To (In-House):" prompt.

```
Clinic Referred To (In-House): PHYSICAL THERAPY
```


Primary Payor: The primary payor is the party who is responsible for payment of the referred service. You must enter one of the following choices:

- IHS
- Medicare
- Medicaid
- Private
- Patient
- VA
- Other
- Workman's Compensation

You can make your selection by typing the name of your choice or the selection number and pressing the Return key. If you are not certain of the responsible party, enter IHS. The referral record can be modified later, if needed.

Inpatient/Outpatient: The Inpatient/Outpatient field is used to indicate whether the referral for care is for an inpatient or outpatient visit. Type an **I** or **O** in this field to make your selection.

Case Manager: Type the name of the case manager who is assigned to this referral. If your site has only one case manager or a primary case manager who handles most of the referred care services, you can set the name of this person as the default entry for this field by using the RCIS Management option *Edit Site Parameters* (section 5.1).

Actual Appointment/Admission Date: This field is used for entering the appointment date and time for an outpatient referral and the admission date for an inpatient referral.

If you know the actual admission date or the appointment date and time, enter it in this field. You will then be prompted for additional information with a pop-up screen. The information requested will vary, depending on whether the referral is for an inpatient or outpatient visit. Each screen is described and shown below. Sample entries and instructions are in bold type.

Inpatient

For an inpatient referral, you will be prompted for an estimated length of stay. It is important that you enter this information if you will be generating reports that identify patients who have exceeded their anticipated length of stay (to perform utilization reviews and more closely monitor these patients).

Estimated Length of Stay: 3

Outpatient

For an outpatient referral, you will be prompted for the expected end date of service and the estimated number of visits. If the patient will have only one visit, press the Return key at the first prompt to bypass the expected end date of service and press the Return key at the “Estimated number of visits.” prompt to accept one visit as the default value.

Outpatient referrals sometimes require multiple visits over a period of time. For a patient who will have multiple visits, enter the estimated date that services will be completed. You can type dates in this field with shortcuts, such as T+14 (14 days from today) or T+3M (3 months from today). Then enter the estimated number of visits. Entering a value for number of visits will allow you to print this information on the referral sheet that is sent to the outside provider. You will also be able to print reports on patients who exceed or have fewer than the number of visits authorized.

By entering an expected end date of services, you will be able to print a report of patients whose visits with an outside provider are presumed completed (even if you do not have any actual ending date of service) but for whom you have not yet received a consultation or discharge letter.

```
EXPECTED END DATE OF SERVICE: DEC 30, 2005  
ESTIMATED # OF OUTPATIENT VISITS: 4
```

Actual Admission/Appointment Date: If you do not know the actual appointment or admission date, you will be prompted with pop-up screens to provide estimated information and enter notes to the person who will be scheduling the appointment or admission. As described above, the information requested will vary depending on whether the referral is for an inpatient or outpatient visit. The estimated appointment/admission date should be entered if you will be extracting data from the system for a group of referrals that includes appointments/admissions that are not yet scheduled but for which you know the approximate date the service will be provided. If you do not enter an estimated date, referrals that are not yet scheduled may be unintentionally omitted from your reports. The pop-up screens are described and shown below with sample user entries.

Inpatient

For inpatient visits, you will be prompted to enter the expected admission date and the estimated length of stay. You will also be able to note how soon the admission should be scheduled (any number between 0 and 365) and add notes (2-100 characters) for the person who will be scheduling the admission.

```
EXPECTED ADMISSION DATE: JUL 1, 2005
ESTIMATED LENGTH OF STAY: 3
Schedule within N # Days: 2
Notes to the Appointment Scheduler: SCHEDULE A.M. ADMISSION
```

Outpatient

For outpatient visits, you will be prompted to enter the expected begin date of service, expected end date of service, and expected number of outpatient visits. You may also indicate the time frame for scheduling the visit (any number 0-365) and add notes (2-100 characters) for the person who will be scheduling the appointment. The expected number of outpatient visits defaults to 1.

```
EXPECTED BEGIN DATE OF SERVICE: JUL 15, 2005
EXPECTED END DATE OF SERVICE: SEP 15, 2005
EXPECTED # OF OUTPATIENT VISITS: 5
Schedule within N # Days: 7
Notes to Scheduler/ Appointment Clerk: MAKE AFTERNOON APPT.
```

Provisional DRG: If the Provisional diagnostic-related group (DRG) is known, enter it in this field. Otherwise, press the Return key to bypass this optional field.

Estimated Total Referral Cost: Enter in this field an estimate of the total cost of this referral for all payors. Prior to the development of the RCIS, even estimates for CHS costs were not available until all services were provided. Also, referred care costs that were not funded by IHS (Type = Other) or other IHS facilities (Type = IHS) were not available. These figures can be very important for measuring how effectively alternative resources are employed and for negotiating contracts. By entering this information, these figures will be available in a more timely fashion.

Estimated IHS Referral Cost: Enter the estimated cost to IHS for the referred care. Be sure that you are entering only the portion of the total cost for which IHS is responsible.

Purpose/Services Requested: Enter a narrative (1-80 characters) that describes the purpose of this referral. Similar to the purpose of visit on the PCC, this entry should be a concise statement that can be used for reference wherever a brief statement of purpose is needed (e.g. on the PCC Health Summary). The following are sample purposes of referral:

- Evaluation and treatment of dysfunctional uterine bleeding
- Perform colposcopy to evaluate abnormal pap
- Provide active-assistive range-of-motion treatment to left shoulder

Priority: Enter the appropriate *Medical Priority* from the list provided on the help screen. (Remember, to view the help screen you must type a question mark (?))

followed by the Return key.) The system is distributed with the following IHS standard priority list:

Level I— Emergent/Acutely Urgent Care Services: Diagnostic/therapeutic services that are necessary to prevent the immediate death/serious impairment of the health of the individual, and if left untreated, would result in uncertain but potentially grave outcomes.

Level II— Preventive Care Services: Primary health care aimed at the prevention of disease/disability, such as on urgent preventive ambulatory care, screening for known disease entities, and public health intervention.

Level III— Primary and Secondary Care Services: Inpatient and outpatient care services that involve the treatment of prevalent illnesses/conditions that have a significant impact on morbidity and mortality.

Level IV— Chronic Tertiary and Extended Care Services: Inpatient and outpatient care services that (1) are not essential for initial/emergent diagnosis/therapy; (2) have less impact on mortality than morbidity; or (3) are high cost, elective, and often require tertiary care facilities.

Level V— Excluded Services: Services and procedures that are considered purely cosmetic in nature, experimental or investigational, or have no proven medical benefit.

Alternatively, your site can substitute its own site-specific narrative description for the above standards by using the RCIS Management option Edit Site Parameters (section 5.1).

Note: The Priority Code may be a required field depending on the site parameter specifications for your facility and the type of referral you are entering. Even if required, the Priority prompt will not be underlined as are other required fields. When the priority is required and has not been entered upon your exiting the screen, an alert message will display and prompt you to return to the data entry screen and fill in the field.

When additional medical information is sent with the patient: This field allows you to indicate to the referral agency and provider whether you are sending additional medical information relevant to the patient's care. For example, you may be sending the patient's most recent lab results, x-rays, or a more complete record of the patient's condition. This indication will be noted on the referral sheet printed by the system. At the prompt, type a **Y** or **N**.

If you respond *Yes* to this prompt, the following pop-up screen displays for you to specify the specific items that you are sending with the patient.

```

INCLUDE WHICH OF THE FOLLOWING ITEMS?
PCC VISIT FORM:                MOST RECENT EKG:
SPECIALTY CLINIC NOTES:       HISTORY AND PHYSICAL:
PRENATAL RECORD(S):           X-RAY/ REPORT:
SIGNED TUBAL CONSENT:         X-RAY FILM:
FACE SHEET:                   CONSULTATION REPORT:
HEALTH SUMMARY:               MOST RECENT LAB REPORT:

ADDITIONAL DOCUMENTS:

```

Figure 3-4: Sending additional medical information

At each of the prompts, enter a **Y** or **N**. Alternatively, you can bypass the fields that are not applicable. The Additional Documents field is a word processing function that allows you to add notes to specify the documents being sent with the patient. Press the Return key at the Additional Documents prompt to use the word processing screen.

To enter CHS Eligibility Factors: This option allows for the historical capture of CHS Regulatory Requirements at the time of the referral creation. The date of capture and the user who entered these fields displays on the *Display a Referral* option and in the General Retrieval Report.

If you answer **Yes**, a pop-up screen displays (Figure 3-5). If you answer **No**, the pop-up screen will not display.

```

*****CHS ELIGIBILITY FACTORS*****
CHS INDIAN DESCENT: YES
CHS RESIDENCY: YES
CHS ALTERNATE RESOURCE: YES
CHS 72 HOUR NOTIFICATION: YES
BUSINESS OFFICE/CHS COMMENTS:

MGD CARE COMMITTEE ACTION:HOLD

```

Figure 3-5: Entering CHS eligibility factors

At each of the first four prompts, type **Y** or **N**. If you wish to add *Business Office/CHS Comments* regarding the patient's eligibility, press the Return key at the "Business Office/CHS Comments:" prompt and type your comments in the word processing box that displays. If the Managed Care Committee has determined an action for this referral, enter it at the "MGD Care Committee Action:" prompt. Once you have finished answering the prompts, you will be returned to the Add Referral screen.

Business Office/CHS Comments: You can use this field to enter any pertinent notes for the Business Office or CHS staff. Press the Return key at the prompt to display the word processing field for entering your comments.

ICD Diagnostic Category: Choose the most appropriate diagnostic category from the list that follows. You may also view the list on your screen by typing a question mark (?) and pressing the Return key at this prompt. Data must be entered in this field. If you are not entering full ICD-9 codes for all referrals, the Diagnostic Category will be the only mechanism available for grouping referrals into diagnostic categories for reports.

Below are the ICD Diagnostic Categories

- Cardiovascular Disorders
- Musculoskeletal and Connective Tissue Disorders
- Cerebrovascular Disorders
- Neoplasms
- Congenital Anomalies
- Nephrological and Urological Disorders
- Dental and Oral Surgical Disorders
- Neurological Disorders
- Dermatologic Disorders
- Obstetrical Care
- Endocrine, Nutritional, and Metabolic Diseases and Immune Disorders
- Other Symptoms, Signs, and Ill-Defined Conditions
- Female Breast and Genital Tract Disorders
- Ophthalmologic Disorders
- Gastrointestinal Disorders
- Other Perinatal Conditions
- Hematological Disorders
- Other Vascular Disorders
- Infectious and Parasitic Diseases
- Otolaryngologic Disorders
- Injuries and Poisonings
- Preventive Health Care

- Male Genital Organ Disorders
- Respiratory Disorders
- Mental Disorders

CPT Procedure Category: Choose the most appropriate service category from the list below. To view this list on the screen, type a question mark (?) and press the Return key. If your site is not entering full CPT codes for all referrals, the Procedures Category will be the only mechanism available for grouping referrals for reports.

Below are the CP Procedure Categories

- Diagnostic Imaging
- Non-surgical Procedures
- Pathology and Laboratory
- Evaluation and/or Management
- Operations/Surgery

You may also create a list of local service categories at your site by using the Add/Edit Local Category option in the RCIS Management module (section 5.2.1). Upon pressing the Return key at the CPT Procedure Category prompt, a pop-up screen displays that allows you to enter these local service categories. Note that these categories must be defined before you can enter them in a referral record. Some examples of local categories that you might include are air transport or ambulance.

```
Enter all appropriate LOCAL SERVICE CATEGORIES
CATEGORY:
CATEGORY:
CATEGORY:
CATEGORY:
CATEGORY:
```

Figure 3-6: Add/edit local categories

Completing the Referral Form

After you have finished entering data on the Complete Referral form, press the <PF1>+E keys to exit and type **Y** at the next prompt to save and file the data. If you have not entered data into all of the required fields, a warning message will display that identifies which of the required fields are missing data, as shown in Figure 3-7. Press the Return key at the next prompt to return to the data entry screen and enter the missing data.

```

Verifying...
THE DATA COULD NOT BE FILED.
Page 1, CPT PROCEDURE CATEGORY is a required field
Page 1.2, TO PRIMARY VENDOR is a required field

```

Figure 3-7: Missing data warning message

When you have saved and exited the completed referral form, you will be prompted to enter Pertinent Medical History and Findings. This is a word processing field in which you can enter a long narrative that describes any pertinent medical history; for example, lab values, examination results, and other tests performed. The RCIS will print this information on the referral letter that can be sent to the outside provider. Press the Return key at the prompt to bring up the word processing field for entering your comments. See Appendix B: Word Processing Screen Help for tips on using the word processing field.

```

You may edit one of the existing Medical HX/Findings Comments or add a new
one

No entries to edit

Select one of the following:

      A          ADD a new Medical HX/Findings Comments
      Q          QUIT

Do you wish to: A//

```

Figure 3-8: Entering/adding medical hx/findings comments

When all of the required fields have been completed, the following message displays.

```

Entry of Referral 25555555522 is complete.

```

Optional ICD/CPT Coding

If the ICD/CPT Coding option in the RCIS site parameters has been set to *Yes*, you will be prompted to enter a provisional diagnosis and a provisional procedure (section 5.1). These data fields, if used at your facility, are optional.

Note: The procedure must be entered in all capital letters. If it is not, two question marks (??) will display and you will hear a beep. There will be no other indication that your entry was not accepted.

If you are entering diagnoses and procedures for referrals, several screen alert messages have been built into the system that will alert you during data entry to the following categories. The alert messages are based upon taxonomies that have been created for each category of alert. The criteria for generating these alerts and the

warning messages that appear for each are described below. The screen alerts will appear for all referral types except in-house referrals.

Note: Bulletins have been removed MailMan bulletins are also available for the following categories. See section 5.3 for instructions on using them.

Cosmetic: This warning displays when a cosmetic procedure is entered.

You are entering a cosmetic procedure that may require CMO approval.

Experimental: This warning displays when a procedure that is considered experimental is entered.

You are entering a procedure that indicates this may be an Experimental Procedure. If so, CHS funds cannot be used to pay for this procedure.

High Cost: This warning displays when a procedure or diagnosis is entered that has the potential for high costs.

You are entering a procedure/diagnosis that indicates this may be a high cost case. You may want to carefully explore alternative resources and alert your case manager.

Third-Party Liability: This warning displays when a diagnosis is entered that indicates a third party may be liable for the cost of care.

You are entering a diagnosis that indicates this may involve third-party liability. You may want to investigate this possibility in order to recover costs.

To enter a provisional diagnosis and/or procedures, enter the data requested at the prompts, as in Figure 3-9. User entries are in bold type and instructions are in brackets.

If you do not know or are unsure of the specific code for the provisional diagnosis or procedure, you have the option of using an uncoded entry (.9999 for the diagnosis code or 00099 for the procedure code). You must enter a specific diagnosis or procedure narrative with the uncoded entry so that a coder can enter the appropriate code for the referral record at a later time. See sections 3.4.9 and 3.4.10 for details on adding codes to uncoded referral records.

```
Do you want to enter a Provisional Diagnosis? N// YES
Select RCIS DIAGNOSIS: 578.9          GASTROINTEST HEMORR NOS
      ...OK? Yes// YES
Are you adding '578.9' as a new RCIS DIAGNOSIS? No// Y
DIAGNOSIS: 578.9// [press the Return key]
PRI/SEC: P PRIMARY
DIAGNOSIS NARRATIVE: GASTROINTESTINAL BLEEDING
Select RCIS DIAGNOSIS: [RET]

Do you want to enter a Provisional Procedure? N// YES
Select RCIS PROCEDURE: 43259          ENDOSCOPIC ULTRASOUND EXAM
      Upper gastrointestinal endoscopy including esophagus,
      stomach, and either the duodenum and/or jejunum as
      appropriate; with endoscopic
      ...OK? Yes// Yes
PROCEDURE: 43259// [RET]
PRI/SEC: P PRIMARY
PROCEDURE NARRATIVE: GASTROINTESTINAL ENDOSCOPY
Select RCIS PROCEDURE: [RET]

Do you want to enter Case Review Comments? N// NO
Storing static fields....

Entry of Referral 5555555550 is complete.

A Message has NOT been sent for this referral.

Do you wish to send a message? Y// ES
  1. BMC CHS ALERT
  2. BMC IHS ALERT
  3. BMC INHOUSE ALERT

To select recipient group(s) enter a list or range of numbers: (1-3): 1
***MESSAGE SENT***
Enter RETURN to continue or '^' to exit:
```

Figure 3-9: Entering a provisional diagnosis

When the referral is complete, a confirmation message will display (Figure 3-9).

If the Send MailMan message Site parameter is set to Yes, the prompt to send a message will be displayed. You have the option to send a message to a mail group previously set up. See section 5.3 for additional details.

3.2.2 Using the Mini Referral Form

The Mini Referral form is a shortened version of the Complete Referral form. This referral type is most often used for data entry when providers are entering referral information directly into the system upon initiation. The Mini Referral form facilitates the initiation of patient referrals by minimizing the amount of data entry required to generate a referral form for sending a patient to another provider. Additional referral data can be entered at a later date by data entry, business office, or CHS staff when it becomes available.

To use the Mini Referral form, you will follow the same process for selecting a patient and entering the data that was described in section 3.2.1. You will then be presented with a list of referral types. Select number **1** to enter data in to the Mini Referral Form.

The fields used in the Mini Referral form are the same as those in the Complete Referral form. For descriptions of these fields and detailed instructions on entering data into each, refer to the list in section 3.2.1.

A sample Mini Referral form can be seen in Figure 3-10. As with the Complete Referral form, data fields that are underlined are required items and must be completed for the referral to be entered into the system.

```

                                RCIS REFERRAL RECORD
DATE: JUN 22,2004  NUMBER: 2021000400004  PATIENT: PATIENT,BOB
-----
REQUESTING FACILITY:  GET WELL SOON FACILITY
REQUESTING PROVIDER:  PROVIDER,ADAM
Do you wish to view a FACE SHEET?  N           View Health Summary?  N
REFERRAL TYPE:  CHS                           INPATIENT/OUTPATIENT:
PRIMARY PAYOR:  IHS
PURPOSE OF REFERRAL:

Are you sending additional medical information with the Patient?
Do you want to enter CHS Eligibility Factors?:  N
PRIORITY:
ICD DIAGNOSTIC CATEGORY:
CPT PROCEDURE CATEGORY:
Notes to Appointment Scheduler:
Schedule Patient Appointment within          Days

```

Figure 3-10: Mini referral form (sample)

After you have entered data on the first screen of the Mini Referral form, you will be prompted to enter medical hx/findings comments, a provisional diagnosis, and a provisional procedure if the ICD/CPT Coding option in the RCIS site parameters has been set to *Yes*. Descriptions of these optional fields and instructions for entering data into them are included in section 3.2.1.

3.2.3 Entering a Referral Initiated by an Outside Facility

The data entry form for a referral initiated by an outside facility (option 3 on the referral form selection list) is used when a patient has received services at an outside facility without prior authorization from your facility (e.g. if a patient was involved in a weekend accident and required emergency medical care at the nearest hospital, not an IHS facility.) Such visits must be reported within 72 hours of the visit. In order for IHS to cover the cost of those services, a referral record must be generated for the

patient. In cases such as these, the Outside Facility referral form would be used for entering the referral data.

The Outside Facility referral form (Figure 3-11) is exactly the same as the Complete Referral form. The only difference with using this form is that after you have selected the Outside Facility referral form from the selection list, you will not be prompted to enter the name of the requesting provider. In the case of a referral initiated by an outside facility, the patient has already received services at another facility, so the "Requesting Provider:" prompt is not applicable.

RCIS REFERRAL RECORD	
DATE: JUN 23, 2004	NUMBER: 25555555522 PATIENT: PATIENT, EDWIN J

REQUESTING FACILITY: GET WELL SOON FACILI	Display Face Sheet? N
REFERRAL TYPE: CHS	PRIMARY PAYOR: IHS
INPATIENT/OUTPATIENT: OUTPATIENT	CASE MANAGER:
GERBER, SPECIALIST	
APPT/ADM DATE&TIME:	
PROVISIONAL DRG: DRG25	
ESTIMATED TOTAL REFERRAL COST: 500	ESTIMATED IHS REFERRAL COST: 400
Do you want to enter CHS Eligibility Factors?: N	
PURPOSE/SERVICES REQUESTED: Rehabilitation	
PRIORITY: 3	
ARE YOU SENDING ADDITIONAL MEDICAL INFORMATION WITH THE PATIENT? NO	
ICD DIAGNOSTIC CATEGORY: MUSCULOSKELETAL AND CONNECTIVE TI	
CPT PROCEDURE CATEGORY: NONSURGICAL PROCEDURES	

Figure 3-11: Outside Facility Referral form (sample)

For descriptions of the data fields in this form and detailed instructions on entering data, refer to section 3.2.1 of this guide.

3.2.4 Using the Abbreviated Entry for Clinicians Referral Form

The purpose of this option is to allow for quick creation of a referral without prompting for non-required fields. Like the Mini Referral form, the Abbreviated Entry for Clinicians Referral is a shortened version of the Complete Referral form. The primary difference between these shortened form options is that the Abbreviated Entry for Clinicians Referral option does not prompt you with as many fields, accepting the defaults automatically instead. This option is more efficient for providers who already accept the default on all or most of the Mini Referral fields and do not wish to spend the time pressing the Return key to move through all of the defaults. Just as with the other shortened referral forms, additional referral data can be entered at a later date by data entry, business office, or CHS staff when it becomes available. Three basic fields are non-editable, automatically being set to the following defaults:

- Referral type = CHS

- Primary payor = IHS
- Primary vendor = Unspecified

A sample of the Abbreviated Entry for Clinicians Referral option is seen in Figure 3-12.

```

Select Data Entry Option: ADD Add Referral

*****
*                INDIAN HEALTH SERVICE                *
*    REFERRED CARE INFORMATION SYSTEM                  *
*                VERSION 4.0, Oct 20, 2005            *
*****
                GET WELL SOON FACILITY
                Add Referral

Select PATIENT NAME: PATIENT,JOSE E                M 09-07-1948
555004444          109951

*****
**LAST 5 REFERRALS**
*****

**--NO EXISTING REFERRALS--**

DATE INITIATED: TODAY// JUN 22, 2004

Please select the referral form you wish to use.

1. Mini Referral
2. Complete Referral (all referral data)
3. Call In Notification by outside facility
4. Abbreviated entry for clinicians

Locally-defined Routine Referral Templates:

Enter REFERRAL FORM: (1-4): 2// 4
Enter REQUESTING PROVIDER: PROVIDER,ADAM

REFERRAL number : 555555550005

                RCIS REFERRAL RECORD
DATE: JUN 22,2004  NUMBER: 5555555500005  PATIENT: PATIENT,JOSE E
-----
REQUESTING FACILITY: GET WELL SOON FACILITY
REQUESTING PROVIDER: PROVIDER,ADAM
REFERRAL TYPE: CHS                PRIMARY PAYOR: IHS
TO PRIMARY VENDOR:
Do you wish to view a Face Sheet?  N    View Health Summary?  N
INPATIENT/OUTPATIENT: OUTPATIENT

PURPOSE OF REFERRAL: RADIOLOGY
PRIORITY: HI
Are You Sending Additional Medical Information With Patient? YES
ICD DIAGNOSTIC CATEGORY: RESPIRATORY DISORDERS
CPT PROCEDURE CATEGORY: DIAGNOSTIC IMAGING
Notes to Appointment Scheduler: HAVE HIM REMOVE ALL JEWELRY
    
```

Figure 3-12: Abbreviated entry for clinician's referral option

3.3 Add a Referral for a Previous Fiscal Year (RFY)

This function allows you to add a referral for a previous fiscal year. This is extremely useful in entering prior year referral backlogs (after the Site Parameters have been changed to the current Fiscal Year). You are provided a list of the last ten referrals entered for a selected Fiscal Year and prompted to enter the desired referral number.

3.4 Edit Referral Options (EDIT)

```

*****
*                INDIAN HEALTH SERVICE                *
*      REFERRED CARE INFORMATION SYSTEM      *
*                VERSION 4.0, Oct 20, 2005        *
*****
                UNSPECIFIED SERVICE UNIT
                Edit Referral Options

MOD    Modify Referral - Current Fiscal Year
MR     Modify Referral - All Fiscal Years
MCR    Modify Closed Referral - All Fiscal Years
BOC    Enter Business Office/CHS Comments
MSD    Enter or Edit Scheduling Data
URMD   Utilization Review by MD/Managed Care Comm Action
CAS    Enter or Edit Case Review Comments
ECHS   Add/Edit CHS Data
FDX    Fix Uncoded DX Codes
FPX    Fix Uncoded Procedure Codes

Select Edit Referral Options Option:

```

Figure 3-13: Edit referral options menu

3.4.1 Modify Referral - Current Fiscal Year (MOD)

While a referral remains active, the information in a referral record may require updating or additional data may need to be added. For example, the Case Manager or Utilization Review Nurse may want to enter case review comments or discharge notes, the Business Office staff may need to update the patient's third-party eligibility information, or a data entry clerk may need to record the date on which a discharge letter was received from the referred provider.

Note: Closed referrals created in previous fiscal years cannot be modified with this menu option. In order to modify the information for a closed referral or a referral created in a previous fiscal year, you must use the corresponding options on the Supervisor's Utility menu, which can be accessed from the Data Entry menu. A restricted security key is required to use the supervisor's utilities. Please see your Site Manager for assistance.

The Modify Referral option on the RCIS Data Entry menu allows you to modify the active referral record or add information to it. To do so, select the *Modify* option and identify the referral at the first prompt. You can enter the referral number, the patient's name, or the data on which the referral was initiated.

You will then be presented with the following list of options for entering or modifying data.

```
Select one of the following:
0      QUIT
1      MINI MOD
2      ALL DATA
3      DATE/COUNTS
4      COSTS
5      ICD9 DX
6      CPT PROCEDURES
7      CASE REVIEW
8      PURPOSE/MED HX/OTHER DX INFO
9      BUSINESS OFFICE
10     DISCHARGE NOTES
11     ADD DOCUMENTATION
12     CHS ELIG FACTORS
13     OTHER REFERRALS
14     SEND GROUP MESSAGE
15     SEND MESSAGE TO PROVIDERS
EDIT Which Data Type: 0//
Select one of the following:
```

Figure 3-14: Data modification list

These options simplify the data entry task by prompting you for only the fields that are of interest to you instead of every item in the referral record. For instance, if you will be entering only the referred care cost figures, you would select option **4**. If you were interested in modifying the Business Office notes, you would select option **9**. Each of these data entry options is described in the following sections.

Quit

To return to the Data Entry menu at any time, choose **0** to quit. Each time you enter data using one of the 11 other selections under the Modify Referral option, you will return to the selection list. When you have finished entering or modifying data in the selected referral record and want to choose another referral record for modification or wish to return to the Data Entry menu, choose **Quit**. The Quit option will always be the default value for the selection prompt.

Mini Mod

The Mini Mod option displays the Mini Referral form used for data entry. All information entered for the referral to date displays on the screen. Previously made entries can be changed and new data can be added, as applicable. Refer to the *Adding a New Referral* section of this manual for instructions on using the data entry screen and the data to be entered into each field (section 3.2).

All Data

The option to modify all data will allow you to enter or modify data for each item of the RCIS. The following screen displays upon selection of the All Data option. Data that has been previously entered for the referral also displays. This screen works the same way as the Data Entry screens. For more detailed instructions, see section 3.2.1 of this guide.

```

                                RCIS REFERRAL RECORD
DATE: NOV 29,2001  NUMBER: 555555550050  PATIENT: PATIENT,LONA
-----
REQUESTING FACILITY: UNSPEC HOSP      CASE MANAGER: DOCTOR,ONE
REQUESTING PROVIDER: PROVIDER,ADAM    INPT OR OUTPT: INPATIENT
Do you wish to view a FACE SHEET?  N
REFERRAL TYPE: CHS                    PRIMARY PAYOR: IHS
Provider OR Facility Referred To:
Do you want to change the above Referral Provider/Facility? N

      PURPOSE OF REFERRAL: EVALUATION
              PRIORITY: 3
ACTUAL APPT/BEGIN DOS:

***Press return at any of the following to edit the data items***
      SERVICE DATES/COUNTS:          COST DATA:
DIAGNOSTIC/PROCEDURAL/MED HX:      STATUS INFORMATION:

```

Figure 3-15: Modify Referral – all data option

There are four categories of data items at the bottom of the screen:

- Service Dates/Counts
- Cost Data
- Diagnostic/Procedural/Med HX
- Status Information

Data can be entered or changed for these items by pressing the Return key at any of the prompts. A pop-up screen displays, allowing you to enter and modify data. More detailed information about each of these pop-up screens is provided in the following sections. Descriptions and data entry instructions for many of these items are also provided in section 3.2.1.

Service Dates/Counts

While the referral remains active, you may need to revise the expected dates of service. If the services have been provided, you will want to enter the actual visit dates, number of visits, and length of stay, as applicable.

Note: If the referral is a CHS type and the CHS link is active, the beginning and ending service dates and length of stay will be automatically entered into the RCIS via the CHS link. You will need to enter the final dates and counts for all other referral types.

The Service Date/Counts option displays two different screens, depending on whether the patient referral is for an outpatient visit or an inpatient visit. Each screen allows you to enter estimated and actual dates for the visit type. Figure 3-16 is an example of the outpatient pop-up screen and Figure 3-17 is an example of the inpatient pop-up screen.

```

RCIS REFERRAL RECORD
DATE: JUN 22,2004  NUMBER: 2021000400015  PATIENT: ADAMS,BOB
-----
Expected Begin Date of Service: JUL 15,2004
Actual Begin Date of Service:

Expected End Date of Service: JUL 30,2004
Actual End Date of Service:

Outpatient # of Visits: 7

Next Review Date:

Notes to scheduler: None
Schedule Appointment within: 4 Days

```

Figure 3-16: Modify Referral – Service dates and counts – outpatient visit

```

RCIS REFERRAL RECORD
DATE: JUN 22,2004  NUMBER: 2021000400020  PATIENT: PATIENT,BYRON
-----
Expected Admission Date: JUL 15,2004
Actual Admission Date:

Inpatient Estimated LOS:1
Inpatient Actual LOS:

Expected Discharge Date: JUL 16,2004
Actual Discharge Date:

Next Review Date:
Notes to Scheduler: None
Schedule Appointment within: 2 Days

```

Figure 3-17: Modify Referral – Service dates and counts—inpatient visit

Cost Data

Actual costs may be entered and estimated costs may be added or modified using this option. If the referral is a CHS type and the CHS link is active, actual cost

information will be automatically provided by the CHS. For all other referral types, you must enter actual cost data manually. For these other types, entering the actual cost data will provide more accurate and timely information.

RCIS REFERRAL RECORD		
DATE: JUN 6, 1996	NUMBER: 555555500480	PATIENT: PATIENT, BECKY

*****	ACTUAL TOTAL COST INFORMTION	*****
	Estimated Cost: 6000	
	Actual Cost:	
*****	IHS TOTAL COST INFORMTION	*****
	Estimated Ihs Cost: 6000	
	Actual Ihs Cost:	

Figure 3-18: Modify Referral – Cost Data

In the Actual Cost field, enter the total cost of the referred care for all payors. In the Actual IHS cost field, enter only the portion of the total cost for which IHS is responsible.

ICD-9 Diagnoses

If you are entering ICD-9 diagnoses at your facility, you may use this option to add, change, or delete the diagnoses that have been entered on a referral record.

The following example shows the addition of hypertension as a patient's primary diagnosis for this referral. If the patient does not have any diagnoses entered, you have the choice of adding a new diagnosis or quitting. Once one or more diagnoses have been added, you will be presented with four options:

- Edit an Existing Diagnosis
- Add a New Diagnosis
- Delete an Existing Diagnosis
- Quit

When adding a new diagnosis, you will be prompted for the diagnosis type (provisional or final), whether it is primary or secondary, and a narrative. Note that you can enter only one primary diagnosis in a referral record.

If you do not know the correct ICD-9 diagnosis code, you can enter .9999 (uncoded) and include a detailed diagnosis narrative. Later, a coder can enter the appropriate code into the referral record based on the narrative that was entered. For instructions on using the option to update uncoded diagnoses in referral records, see section 3.4.9.

```

You may edit one of the existing Diagnoses or add a new one

No entries to edit

    Select one of the following:

        A          ADD a new Diagnoses
        Q          QUIT

Do you wish to: Q// ADD a new Diagnoses

Adding a NEW Diagnoses...

Select RCIS DIAGNOSIS: 401.9          HYPERTENSION NOS
    ...OK? Yes// YES
DIAGNOSIS: 401.9// [RET]
TYPE: P PROVISIONAL
PRI/SEC: P PRIMARY
DIAGNOSIS NARRATIVE:

You may edit one of the existing Diagnoses or add a new one

    1) 401.9  ENTER A NARRATIVE HERE          (Provisional)

    Select one of the following:

        E          EDIT one of the above Diagnoses
        A          ADD a new Diagnoses
        D          DELETE one of the above Diagnoses
        Q          QUIT

Do you wish to: Q//

```

Figure 3-19: Modify Referral – ICD-9 Diagnoses

To edit a diagnosis, type **E** to select the Edit option. Select the diagnosis to edit by entering the diagnosis line number shown on the screen. You will then be prompted for each of the data items (diagnosis, type, primary/secondary, narrative). The default values for the prompts will be the data that has already been entered. Press the Return key at each field that should remain unchanged and enter the new data at each field that should be modified.

If you want to delete a diagnosis, type **D** to select the Delete option. Select the diagnosis to delete by entering the line number shown on the screen. You will then see the “Are you sure you want to delete this Diagnosis?” prompt. Type **Y** to delete the selected diagnosis, or type **N** to return to the previous selection menu.

CPT Procedures

If you are entering CPT procedures at your facility, you may use this option to add, change, or delete the procedures that have been entered on a referral record.

The process for adding the CPT procedures is the same as adding the ICD-9 diagnoses. Figure 3-20 illustrates how to add a new procedure.

```

You may edit one of the existing Procedures or add a new one

1) No entries to edit

    Select one of the following:

        A          ADD a new Procedures
        Q          QUIT

Do you wish to: Q// ADD a new Procedures

Adding a NEW Procedures...

Select RCIS PROCEDURE: 33322    REPAIR MAJOR BLOOD VESSEL(S)
    Suture repair of aorta or great vessels; with cardiopulmonary
    bypass
    ...OK? Yes// YES
    PROCEDURE: 33322// [RET]
You are entering a procedure that indicates this may be a high cost case.
You may want to carefully explore alternative resources and alert your
case
manager.
    TYPE: P    PROVISIONAL
    PRI/SEC: P    PRIMARY
    PROCEDURE NARRATIVE:

You may edit one of the existing Procedures or add a new one

1) 33322    ENTER A NARRATIVE HERE                (Provisional)

    Select one of the following:

        E          EDIT one of the above Procedures
        A          ADD a new Procedures
        D          DELETE one of the above Procedures
        Q          QUIT

Do you wish to: Q//

```

Figure 3-20: Modify Referral – CPT Procedures

The procedures for editing and deleting a procedure are the same as for editing and deleting a diagnosis (section 3.4.9).

Case Review Comments

This option allows you to add, edit, or delete the case review comments on a patient's referral record. A date for each separate comment must be entered. When prompted, enter the date on which the comment was written. Note that the default value for the date field is the current date. If comments are entered into the system on a date other than when they were recorded, be sure to enter the date on which they were recorded, not the current date. Figure 3-21 shows the addition of a new case review comment. When finished, you are prompted to enter a date for the next case review, as applicable. Comments are automatically date and user stamped by person entering the comment.

```

You may edit one of the existing Case Review Comments or add a new one

1) JAN 30, 2001
   PATIENT HAD SURGERY YESTERDAY AND IS DOING WELL.  SHOULD
   RETURN FOR FOLLOW-UP IN 6 MONTHS.

   Select one of the following:
   E          EDIT one of the above Case Review Comments
   A          ADD a new Case Review Comments
   D          DELETE one of the above Case Review Comments
   Q          QUIT

Do you wish to: E// ADD a new Case Review Comments

Adding a NEW Case Review Comments...

Select RCIS CASE REVIEW COMMENTS DATE: JUN 12,2001   JUN 12, 2001
Are you adding 'JUN 12, 2001' as
a new RCIS CASE REVIEW COMMENTS? No// Y (Yes)
DATE: JUN 12,2001// [RET]
COMMENTS:
  No existing text

You may edit one of the existing Case Review Comments or add a new one

1) JAN 30, 2001          Jackson, Fonda
   PATIENT HAD SURGERY YESTERDAY AND IS DOING WELL.  SHOULD
   RETURN FOR FOLLOW-UP IN 6 MONTHS.
2) JUN 12, 2001          Jackson, Fonda
   PATIENT FOLLOW-UP SATISFACTORY.  NO FURTHER VISITS
   REQUIRED.

   Select one of the following:
   E          EDIT one of the above Case Review Comments
   A          ADD a new Case Review Comments
   D          DELETE one of the above Case Review Comments
   Q          QUIT

Do you wish to: Q//

```

Figure 3-21: Modify Referral – Case Review Comments

Purpose of Referral/Med Hx/Other Diagnostic Information

Selecting this option allows you to modify diagnostic information on the referral record. Figure 3-22 shows the screen used for entering data. You can change, add, or delete data on this screen in the same way that you that you entered data using the other data entry screens.

```

                                RCIS REFERRAL RECORD
DATE: JAN 18,2002  NUMBER: 5555555002  PATIENT: PATIENT,CHARLENE
-----
                PROVISIONAL DRG:
                  FINAL DRG:
DATE DSCH SUMM/CONS LTR RCVD:

                PURPOSE OF REFERRAL: EXAM

WAS ADDITIONAL MEDICAL INFORMATION SENT WITH THE PATIENT?

ICD DIAGNOSTIC CATEGORY: ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES
CPT PROCEDURE CATEGORY: OPERATIONS/SURGERY

EDIT EXISTING DIAGNOSES:
EDIT EXISTING PROCEDURES:

```

Figure 3-22: Modify referral – purpose, med hx, other dx information

The data modification screen also allows you to edit existing diagnoses and procedures. By pressing the Return key at either the “Edit Existing Diagnoses:” or “Edit Existing Procedures:” prompt, an additional screen will display and contain all of the diagnoses or procedures that have been entered for the referral record. To modify the diagnoses and procedures, review sections 3.4.9 and 3.4.10. You may also setup the system to automatically populate the diagnosis and procedure codes (see section 5.1).

After closing the data modification screen, you will be prompted to edit the Medical HX/Findings Comments or add a new one

```

You may edit one of the existing Medical HX/Findings Comments or add a new
one

No entries to edit

Select one of the following:

      A          ADD a new Medical HX/Findings Comments
      Q          QUIT

Do you wish to: Q//

```

Figure 3-23: Modify referral – editing/adding medical hx/findings

Business Office Notes

You can use this option to add information pertaining to the Business Office. As illustrated in the following sample, you will be prompted to add a new business office comment. You will then be prompted to add comments in a word processing field. Please see Appendix B: Word Processing Screen Help for tips on using the word processing field. You will not be able to edit or delete these comments using this option. There is an option under the Referral Management Menu that allows you to

perform those actions. Comments are automatically date and user stamped when entered.

```

You may add a new Business Office Comment

      Select one of the following:

          A          ADD a new Business Office Comment
          Q          QUIT

Do you wish to: Q// ADD a new Business Office Comment

Adding a NEW Business Office Comment...

COMMENTS:
  No existing text
  Edit? NO// [RET]
    
```

Figure 3-24: Modify Referral - Business Office Notes

Diagnoses

To modify a diagnosis, press the Return key at the diagnostic code that you want to modify. A pop-up screen containing the information for the diagnosis will appear. The data in this screen can be modified or deleted. Note that you cannot add a diagnosis with this option — for that, you must use option 5, ICD-9 Diagnosis.

```

                                RCIS REFERRAL RECORD
DATE: JUN 6, 1996  NUMBER: 5555555480  PATIENT: PATIENT, BECKY
-----
DX: 543.9 NARR: ACUTE APPENDICITIS TYPE: PROVISIONAL PRI/SEC: PRIM
DX: 567.9 NARR: PERITONITIS          TYPE: FINAL       PRI/SEC: SECO
DX:      NARR:                      TYPE:           PRI/SEC:
DX:      NARR:                      TYPE:           PRI/SEC:
DX:      NARR:                      TYPE:           PRI/SEC:
DX:      NARR:                      TYPE:           PRI/SEC:
DX:      NARR:                      TYPE:           PRI/SEC:
    
```

Figure 3-25: Modify a diagnosis

Diagnosis pop-up screen for second diagnosis:

```

                                DIAGNOSIS: 567.9
                                TYPE: FINAL
                                PRIMARY/ SECONDARY: SECONDARY
                                DIAGNOSIS NARRATIVE: PERITONITIS
    
```

Figure 3-26: Secondary diagnosis pop-up screen

Procedures

To modify a procedure, press the Return key at the procedure code that you wish to modify. A pop-up screen containing the information for the procedure displays. The data in this screen can be modified or deleted. Note that you cannot add a procedure with this option — you must use option 6, CPT Procedures.

RCIS REFERRAL RECORD			
DATE: JUN 6, 1996	NUMBER: 5555555500480	PATIENT: PATIENT, BECKY	

PRC: 56315	NARR: APPENDECTOMY	TYPE: PROVISIONAL	PRI/SEC: PRIMARY
PRC:	NARR:	TYPE:	PRI/SEC:
PRC:	NARR:	TYPE:	PRI/SEC:

Figure 3-27: Modifying a procedure

Procedure pop-up screen for first procedure:

Procedure:	56315
TYPE:	FINAL
PRIMARY/ SECONDARY:	SECONDARY
PROCEDURE NARRATIVE:	APPENDECTOMY

Figure 3-28: First procedure pop-up screen

Discharge Notes

This option allows you to enter, edit, or delete any discharge notes on the referral record. Selecting this option displays a word processing field for entering notes. Use the standard word processing options to add, enter, or delete comments. Comments are automatically user and date stamped. See Appendix B: Word Processing Screen Help, section 8.5 for a list of commands.

You may edit one of the existing Discharge Notes Comments or add a new one	
1) JUN 23, 2004	Jackson, Fonda
Sample discharge notes	
Select one of the following:	
E	EDIT one of the above Discharge Notes Comments
A	ADD a new Discharge Notes Comments
D	DELETE one of the above Discharge Notes Comments
Q	QUIT
Do you wish to: Q//	

Figure 3-29: Modify Referral - Discharge Notes

Additional Documentation

The Additional Documentation option can be used to add, modify, or delete the specific items that are sent with the patient's referral record. If you are sending additional items, be sure that you have typed **Y** at the "Was Additional Medical Information sent with the Patient?" prompt. This prompt can be accessed with modify options 1, 2, and 8.

```

                                RCIS REFERRAL RECORD
DATE: JUN 6, 1996  NUMBER: 555555500480  PATIENT: PATIENT, BECKY
-----
INCLUDE WHICH OF THE FOLLOWING ITEMS?

PCC VISIT FORM:                MOST RECENT EKG:
SPECIALTY CLINIC NOTES:        HISTORY AND PHYSICAL:
PRENATAL RECORD(S):            X-RAY / REPORT:
SIGNED TUBAL CONSENT:          X-RAY FILM:
FACE SHEET:                    CONSULTATION REPORT:
HEALTH SUMMARY:                MOST RECENT LAB REPORT:

ADDITIONAL DOCUMENTS:

```

Figure 3-30: Modify Referral – Additional Documentation

CHS Eligibility Factors

This option allows the user to edit the historical capture of CHS Regulatory Requirements that was entered at the time of the referral. The date of capture and the user who entered these fields is also displayed on the Display a Referral option and the new items in the General Retrieval Report.

```

EDIT Which Data Type: 0// 12  CHS ELIGIBIILTY FACTORS

*****CHS ELIGIBILITY FACTORS*****
CHS INDIAN DESCENT: YES
CHS RESIDENCY: YES
CHS ALTERNATE RESOURCE: YES
CHS 72 HOUR NOTIFICATION: YES
BUSINESS OFFICE/CHS COMMENTS:

MGD CARE COMMITTEE ACTION: APPEAL

```

Figure 3-31: Modify Referral – CHS Eligibility Factors

Other Referrals: This allows the user to select a different referral without having to exit the option.

```

EDIT Which Data Type: 0// 13 OTHER REFERRALS
REFERRED CARE INFORMATION SYSTEM
                                DEMO DATABASE
                                Modify Referral - Current Fiscal Year
Select RCIS REFERRAL by Patient or by Referral Date or #:

```

Figure 3-32: Other Referrals

Send Group Message: This allows the user to send a message to a group. If additional information was added to the Business Office notes the information will be added to the mailman message. If a message has already been sent the date, sent by and sent to information will be displayed.

```

EDIT Which Data Type: 0// 14          SEND GROUP MESSAGE
A Message has NOT been sent for this referral.
Do you wish to send a message? Y//
OR
A Message has already been sent for this referral:
  DATE                SENT BY                GROUP/PROV
OCT 25, 2005@15:26:42    JACKSON,FONDA C    BMC CHS ALERT
Do you wish to send a message? Y// ES
  1. BMC CHS ALERT
  2. BMC IHS ALERT
  3. BMC INHOUSE ALERT
To select recipient group(s) enter a list or range of numbers: (1-3): 2
***MESSAGE SENT***

```

Figure 3-33: Send Group Message

MailMan Messages:

```

Subj: REFERRAL ALERT [#5939] 07 Oct 05 14:32 22 Lines
From: <JACKSON,FONDA C.> in 'IN' basket. Page 1
-----
----
Patient name: CARD,JOE Date Referral Initiated: OCT 06, 2005
Referral #: 5059010600001
Requesting Provider: JACKSON,FONDA C.

Purpose: TEST FOR SENDING MESSAGES
Referred To: SMITH AMBULANCE SERVICE
Notes to Scheduler:
Priority Rating: 2

Referral Type: CHS
Comments:
  Date: 10/6/2005 By: JACKSON,FONDA C.
  TEST FOR MESSAGES
  Date: 10/5/2005 By: JACKSON,FONDA C.
  TEST FOR SENDING BO MESSAGE

```

Figure 3-34: MailMan Messages

Send Message to Providers: This option allows the user to send a message to the Patient's Primary Care Provider and to the Referring Provider. The user cannot select to whom the message will be sent. All comments regarding the referral are contained within the message, such as Medical Hx and findings, or Case Review Comments. The Primary care provider is defined in PCC.

```

EDIT Which Data Type: 0// 15          SEND MESSAGE TO PROVIDERS
A Message has NOT been sent for this referral.
Do you wish to send a message? Y//
OR
A Message has already been sent for this referral:
  DATE                SENT BY                GROUP/PROV
OCT 25, 2005@15:26:42    JACKSON,FONDA    BMC CHS ALERT
Do you wish to send a message? Y// ES

***MESSAGE SENT***

```

Figure 3-35: Send Message to Providers

3.4.2 Modify Referral - All Fiscal Years (MR)

To modify a referral that was initiated in a previous fiscal year, you will need to use the MR option on the edit menu. Only referrals within the current fiscal year can be modified with the Modify Referral option on the edit menu. The process for modifying a referral from a previous fiscal year is identical to modifying a current fiscal year referral. For detailed instructions, please refer to the Modifying a Referral section of this manual (section 3.4.1).

3.4.3 Modify Closed Referral - All Fiscal Years (MCR)

To modify data for a closed referral, you must use the MCR option on the edit menu; the MOD option on the edit menu allows you to modify data only for active referrals within the current fiscal year. The process of modifying a closed referral is identical to modifying an active referral. For details instructions, please refer to the Modifying a Referral section of this manual (section 3.4.1).

3.4.4 Enter Business Office/CHS Comments (BOC)

The Enter or Edit Business Office/CHS Comments option allows the appropriate individual in the Business or CHS Office to add comments pertaining to the referral record. This option is also used to enter a Referred Care Committee Action if your facility is entering them into the referral record. Note that the Referred Care Committee Action field in the Site Parameters file must be set to *Yes* in order for the prompt to appear when entering and editing Business Office/CHS comments.

After selecting the Enter or Edit Business Office/CHS Comments option from the Data Entry main menu, you will be prompted to identify the referral for which you will be entering comments. You can select the referral by typing the patient's name, referral data, or referral number.

You will only be able to add new comments to the referral record. You can edit the comments only from the Management Menu (see section 5.5.1). The standard word processing screen will display that allows you to add comments. If you are not entering comments, type **Q** to bypass this field.

```

Select Edit Referral Options Option: BOC Enter Business Office/CHS Comments

*****
*          INDIAN HEALTH SERVICE          *
*    REFERRED CARE INFORMATION SYSTEM    *
*    VERSION 4.0, Oct 20, 2005          *
*****
          UNSPECIFIED SERVICE UNIT
          Enter Business Office/CHS Comments

Select RCIS REFERRAL by Patient or by Referral Date or #: 070103 JUL 01, 2003
20555555504 PATIENT,BOB                      3M DENTAL PRODUCTS DIVISI
07/01/03 E - 1 Services not available

You may add a new Business Office Comment

1) JUN 23, 2004 Jackson,Fonda
   Sample business office comments

Select one of the following:

A          ADD a new Business Office Comment
Q          QUIT

Do you wish to: A//

```

Figure 3-36: Modify Referral – Enter Business Office/CHS Comments

3.4.5 Enter or Edit Scheduling Data (MSD)

The Enter or Edit Scheduling Data option on the edit menu allows quick access to the scheduling data in order to enter notes for the appointment clerk and indicate a scheduling time frame. At the prompts, enter the requested information as shown in Figure 3-37. If data has already been entered, it will appear on the screen as the default value. Press the Return key to accept the previous entry or type the text to be replaced followed by the new entry.

```

Select REFERRAL by Patient or Referral Date or #: PATIENT, BECKY
10-1-1996 555555500635 PATIENT, BECKY UNSPECIFIED HOSPITAL
UNKNOWN SERVICE DATE ROUTINE MAMMOGRAPHY

Schedule within N # Days: 30

Notes to Scheduler: CONTACT PT FOR SCHEDULING PREFERENCE

Select REFERRAL by Patient or Referral Date or #: [RET]

```

Figure 3-37: Modify Referral – Enter or edit scheduling data

3.4.6 Utilization Review by MD/Managed Care Comm Action (URMD)

This option on the Data Entry menu is used to enter the utilization review decision by a physician and the Managed Care Committee Action. The items that may be entered

for each of these fields are developed by each site. (See the instructions for creating these categories in section 5.2.4).

You will be prompted to bring up the referrals by Patient, Referral Number or Referral Date. The complete record for the referral will then display. After quitting the display screen, you will be prompted for the Referred Care Committee action, date, and the utilization review decision. Note that the Managed Care Committee Action prompt does not appear unless your site has chosen to utilize this field. At each field, enter the appropriate response, as defined by your facility. To see a complete list of the choices available, type a question mark (?) and press the Return key at the prompt. To bypass any of the prompts without entering data, press the Return key. After you have entered the requested data, you will be prompted to review the next referral record, if more than one referral for that date exists. Otherwise, you will be returned to the Data Entry menu.

```
Select RCIS REFERRAL by Patient or by Referral Date or #: Oct 1, 2005
REFERRED CARE COMMITTEE ACTION: SCHEDULE AS REQUESTED

DATE MCC ACTION RECORDED: OCT 2, 1996// SEPTEMBER 15, 1996

UTILIZATION REVIEW BY MD: APPROVED

Continue with next referral?? Y// YES
```

Figure 3-38: Modify Referral – Utilization review

3.4.7 Enter or Edit Case Review Comments (CAS)

This option allows you to add, edit, or delete the case review comments on a patient's referral record. The date of the comment will default to the current date. If comments are entered into the system on a date other than when they were recorded, be sure to enter the date on which they were recorded, not the current date.

After selecting to add a case review comment, a word processing screen will display in which to enter your comments. Once you have entered your comments and exited the word processing screen, you will be prompted to enter a date for the next review. Please see Appendix B: Word Processing Screen Help for tips on entering data in word processing screens.

```

Select Edit Referral Options Option: CAS Enter or Edit Case Review Comments

*****
* INDIAN HEALTH SERVICE *
* REFERRED CARE INFORMATION SYSTEM *
* VERSION 4.0, Oct 20, 2005 *
*****
GET WELL SOON FACILITY
Enter or Edit Case Review Comments

Select RCIS REFERRAL by Patient or by Referral Date or #: PATIENT,ALEX LEE
M 04-13-1965 7777777 106352 6-23
-2004 2555555555555 J C HESTER CO INC
07/30/04 E - 5 Rehabilitation

You may edit one of the existing Case Review Comments or add a new one

No entries to edit

Select one of the following:

A ADD a new Case Review Comments
Q QUIT

Do you wish to: A// ADD a new Case Review Comments
Adding a NEW Case Review Comments...

COMMENTS:
No existing text
Edit? NO// Y YES

==[ WRAP ]==[ INSERT ]===== < COMMENTS >===== [ <PF1>H=Help ]====
06/23/04 - Sample case review comments

=====T=====T=====T=====T=====T=====T=====T=====T=====T=====

NEXT REVIEW DATE: 06/28/04 (JUN 28, 2004)

You may edit one of the existing Case Review Comments or add a new one

1) JUN 23, 2004 Bunny,Bugs
06/23/04 - Sample case review comments

Select one of the following:

E EDIT one of the above Case Review Comments
A ADD a new Case Review Comments
D DELETE one of the above Case Review Comments
Q QUIT

Do you wish to: A// Q
    
```

Figure 3-39: Enter or edit case review comments

3.4.8 Add/Edit CHS Data (ECHS)

This menu option is available primarily for sites that are not using the link with the CHS system. The Add/Edit CHS Data option allows you to enter and modify CHS

data that would otherwise be added to referral records automatically via the CHS system interface.

After selecting the ECHS menu option from the RCIS Supervisory Utilities sub-menu, you will be prompted to enter a referral initiation date. If more than one referral was initiated on that date, you will need to select the referral of interest from the list of referrals displayed. A screen, like the example in Figure 3-40, displays for entering and modifying data. To enter or edit data, follow the same procedures as for all other data entry screens in the RCIS. Several of the CHS Authorization fields are required entries. If you have any questions regarding the information to be entered in each field, contact a staff member at your local CHS office.

```

RCIS REFERRAL RECORD
DATE: OCT 11,2001  NUMBER: 55555555200003  PATIENT: PATIENT,GEENA
-----
*****CONTRACT HEALTH SERVICES INFORMATION*****

      CHS APPROVAL STATUS:  APPROVED
CHS APPROVAL/DENIAL DATE:
      CHS DENIAL REASON:
CHS AUTHORIZATION DEC STAFF:  MGR,FOUR
CHS AUTHORIZATION DEC REV DT:  NOV 27,2001

AUTHORIZATION #:  1356
AUTHORIZATION #:
AUTHORIZATION #:
AUTHORIZATION #:
AUTHORIZATION #:

```

Figure 3-40: Add/Edit CHS Data

CHS Approval Status: Enter the status of this referral. You have the choice of Pending, Approved, or Denied.

CHS Approval/Denial Date: Enter the date on which the CHS decision was made.

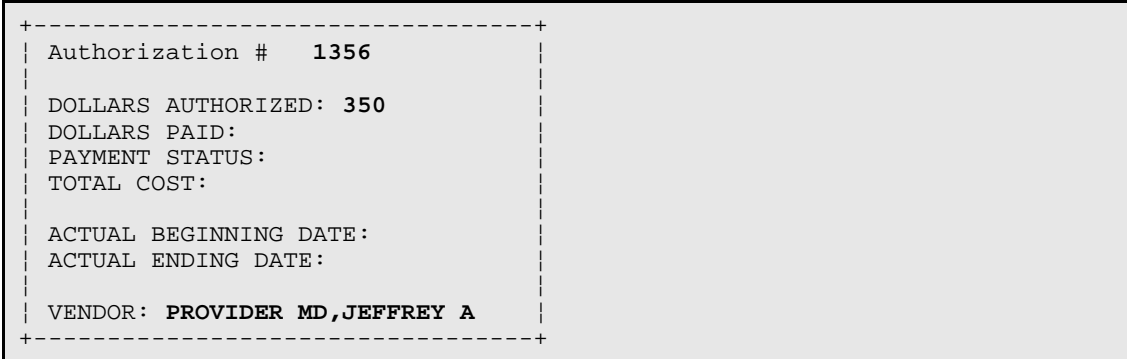
CHS Denial Reason: For a denied referral, specify the reason for the denial. To see a list of the locally defined selections for this field, type a question mark (?) and press the Return key.

CHS Authorization Decision Staff: Enter the name of the person who made the CHS authorization decision. This field is a required entry.

CHS Authorization Decision Review Date: Enter the date on which the referral was reviewed. This field is a required entry.

Authorization Number: Indicate the CHS authorization number for the referral.

For referrals that have been approved and an authorization number has been entered, a pop-up screen appears for entering additional information. Note that the Dollars Authorized field is required.



A screenshot of a pop-up window with a dashed border. The text inside is as follows:

```
Authorization # 1356  
  
DOLLARS AUTHORIZED: 350  
DOLLARS PAID:  
PAYMENT STATUS:  
TOTAL COST:  
  
ACTUAL BEGINNING DATE:  
ACTUAL ENDING DATE:  
  
VENDOR: PROVIDER MD,JEFFREY A
```

Figure 3-41: Authorization Number

Note: It is recommended that you not use this menu option for entering or modifying CHS data if your site has enabled the link with the CHS system. This data should be entered from the CHS Office when the interface is enabled.

3.4.9 Fix Uncoded DX Codes (FDX)

The Fix Uncoded Diagnosis Codes option (FDX) was designed to expedite the entry of diagnostic codes for those sites that have elected to enable ICD-9 coding for referrals. As previously mentioned in the Data Entry section, the provider entering the initial referral data may not know the correct diagnostic code for the patient. In this case, the provider can enter .9999 or Uncoded for the diagnosis and include a diagnostic narrative in the referral record. At a later time, an experienced ICD-9 coder can use this option to quickly add the correct codes to the referral records.

Once this menu option is selected, the referral database will be searched for records with uncoded diagnosis. Each of these records will display on the screen, one at a time, with the diagnostic narrative, as shown in the following sample dialog. The coder will then enter the appropriate ICD diagnostic code number or description. After each entry, the coder has the option of continuing to the next uncoded record or exiting. When all of the referrals with uncoded diagnoses have displayed, a message will appear indicating that the coding process is complete.

```
Searching the RCIS DIAGNOSIS File
Continue? Y// YES

Name: PATIENT,BARNEY   DOB: AUG 8, 1989   SEX: M   Ref#: 555558
REFERRAL #: 55555550091

DIAGNOSIS: .9999// DIABETES
250.00 (DM UNCOMPL/T-II/NIDDM,NS UNCON) DIABETES MELLITUS WITHOUT MENTION
OF COMPLICATION/TYPE II/ NON-INSULIN *DEPENDENT/ ADULT-ONSET, OR
UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED

OK? Y// YES
CONTINUE? Y// YES

NAME: PATIENT,BECKY   DOB: JAN 1, 1933   SEX: F   HRN: 55555256
PROVIDER NARRATIVE: PANIC ATTACK
REFERRAL #: 555555500636

DIAGNOSIS: .9999// 300.01
PANIC DISORDER

CONTINUE? Y// YES

All done with the RCIS DIAGNOSIS file
```

Figure 3-42: Fix Uncoded Dx Codes

3.4.10 Fix Uncoded Procedure Codes (FPX)

The Fix Uncoded Procedure Codes option (FPX) was designed to expedite the entry of CPT codes for those sites that have elected to enable CPT coding for referrals. As previously mentioned in the Data Entry section, the provider entering the initial referral data may not know the correct CPT code for the patient. In this case, the provider can enter 00099 or Uncoded for the procedure and include a procedural narrative in the referral record. At a later time, an experienced coder can use this option to quickly add the correct codes to the referral records.

Once this menu option is selected, the referral database will be searched for records with uncoded diagnoses. Each of these records will display on the screen one at a time with the diagnostic narrative, as show in Figure 3-43. The coder will then enter the appropriate CPT procedural code number or description. After each entry, the coder has the option of continuing to the next uncoded record or exiting. When all the referrals with uncoded procedures have displayed a message will appear indicating that the coding process is complete.

```

Searching the RCIS PROCEDURE File

Continue? Y// YES

NAME: PATIENT,ANITA   DOB: OCT 12, 1968   SEX: F   Ref#: 66666625
PROCEDURE NARRATIVE: EVALUATION
REFERRAL #: 55555500384
PROCEDURE: 00099/ ROUTINE VISIT
SITING/VISITINTERMED/VISITOR/VISITS )

The following 2 matches were found:

1: 99213 (99213)
OFFICE/ OUTPATIENT VISIT EST
    OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND
    MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT
    LEAST TWO OR THESE THREE

2: 99214 (99214)
OFFICE/ OUTPATIENT VISIT, EST
    OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND
    MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT
    LEAST TWO OF THESE THREE

Press <RET> or Select 1-2: 1

Continue? Y//YES

NAME: PATIENT, DIANE   DOB: DEC 3, 1941   SEX: F   Ref#: 55555579
PROCEDURE NARRATIVE: TOTAL HYSTERECTOMY
REFERRAL #: 55555500311
PROCEDURE: 00099// 58150           TOTAL HYSTERECTOMY
    TOTAL ABDOMINAL HYSTERECTOMY (CORPUS AND CERVIX), WITH OR WITHOUT
    REMOVAL OF TUBE(S), WITH OUR WITHOUT REMOVAL OF OVARY(S);
    . . . OK? YES// YES

CONTINUE? Y// YES

```

Figure 3-43: Fix Uncoded Procedure Codes

3.5 Check Alternate Resources (ALT)

The Check Alternate Resources option provides a means for quickly checking a patient's eligibility for services and any third-party insurance they may have. After selecting the Check Alternative Resources option, you will enter a patient's name at the prompt. Information on the patient's classification, eligibility, and insurance will display. Any comments in the Additional Registration Information field of the patient registration record will also display. A sample output is shown in Figure 3-44.

```

CLASSIFICATION/ BENEFICIARY IS: INDIAN/ ALASKA NATIVE
ELIGIBILITY STATUS IS: CHS & DIRECT
NO THIRD PARTY COVERAGE RECORDED

ADDITIONAL REGISTRATION INFORMATION:
Patient's chart is in temporary storage.
Need to check on status of old material.

```

Figure 3-44: Check Alternate Resources

3.6 Display Referral Record (DSP)

The DSP option on the Data Entry menu is used to obtain a detailed display of a referral record. All of the information that has been entered into the referral record is displayed. The information shown for each referral will differ depending on the type of referral, whether it is for an inpatient or outpatient visit, and the status of the referral (i.e. more data is likely to have been entered for a closed referral than for one that has just been initiated).

You will select the referral record by entering the patient's name, referral data, or referral number. This menu also provides an option that allows the display of a secondary referral. The referral record will then display on the screen (Figure 3-45).

```

Patient Name:          PATIENT,ELIZABETH M
Chart #:               8888
Date of Birth:        JUL 02, 1961
Sex:                  F

===== Referral Record =====
DATE INITIATED:      SEP 21, 2005
REFERRAL #:          55555500126
PATIENT:             PATIENT,ELIZABETH M
TYPE:                CHS
REQUESTING FACILITY: WHITE EARTH HEALTH CENTER
REQUESTING PROVIDER: PROVIDER,LAVONNE
TO PRIMARY VENDOR:   UNSPECIFIED FACILITY
TO OTHER PROVIDER:   DUCK,DONALD MD
FACILITY REFERRED TO (COM: UNSPECIFIED FACILITY
PRIMARY PAYOR:       IHS
ICD DIAGNOSTIC CATEGORY: NEPHROLOGICAL AND UROLOGICAL DISORDERS
CPT SERVICE CATEGORY:  EVALUATION AND/OR MANAGEMENT
INPATIENT OR OUTPATIENT: OUTPATIENT
DAYS SINCE BEGIN DOS: 33
STATUS OF REFERRAL:  ACTIVE
CREATED BY USER:     USER,TERESTIA
DATE CREATED:         SEP 21, 2005
DATE LAST MODIFIED:   SEP 21, 2005
PRIORITY:             I

PURPOSE OF REFERRAL: CONSULT HEMODIALYSIS

NOTES TO SCHEDULER:  PLEASE SCHEDULE A.M. APPOINTMENT

EXPECTED BEGIN DOS:   SEP 21, 2005
EXPECTED END DOS:     OCT 30, 2005
OUTP NUMBER OF VISITS: 2
CHS APPROVAL STATUS:  DENIED
CHS APPROVAL/DENIAL DATE: SEP 21, 2005
CHS DENIAL REASON:    Lives Outside Local CHS Service Area
CHS AUTHORIZATION DEC STA: CITIZEN,TERESITA
CHS AUTHORIZATION DEC REV: SEP 21, 2005
OUTPT VISIT NUMBER USER: CITIZEN,TERESITA

ALTERNATE RESOURCE LETTER:

LOCAL CATEGORIES:

CHS AUTHORIZATONS:

CHS APPROVAL STATUS LOG:

DATE/TIME CHANGED:    SEP 21, 2005@12:45:11
USER UPDATED:         CITIZEN,TERESITA
OPTION USED:          BMC ADD REFERRAL
OLD VALUE:
NEW VALUE:            PENDING

DATE/TIME CHANGED:    SEP 21, 2005@13:51:36
USER UPDATED:         CITIZEN,TERESITA
OPTION USED:          BMC EDIT CHS DATA
OLD VALUE:            PENDING
NEW VALUE:            DENIED
REVIEWER:             CITIZEN,TERESITA
CRF, CONSULT FOR VASCULAR ACCESS FOR HEMODIALYSIS.

===== Business/CHS Comments =====

DATE:                 SEP 21, 2005
REVIEWER:             CITIZEN,TERESITA

```

```

A/R: PI COVERAGE. CHS INTELIG.

===== Secondary Referrals =====

DATE INITIATED:          SEP 21, 2005
USER:                   CITIZEN, TERESITA
PROVIDER VENDOR:       UNSPECIFIED FACILITY
EXP APPT DATES:
PURPOSE OF REFERRAL:   SURGERY/VASCULAR ACCESS PLACEMENT
SUFFIX:                 A1
OUTP VISITS LEFT:      1
    
```

Figure 3-45: Display referral record

3.7 Number of Days Authorized Modifications (NDA)

When a referral is created as an outpatient referral, the default number of days authorized is one day, but this number can be modified if necessary. The NDA report will display a list of referrals for which those days have been modified/increased. This report assists the scheduler in determining which referrals to follow-up with for appointment scheduling and status.

A sample report is provided in Figure 3-46.

# DAYS AUTHORIZED LISTING				DEC 7, 2001	08:52	PAGE 1
INITIATED	BEGIN				DAYS	
REFERRAL	D.O.S.	# DAYS AUTHORIZED	TYPE	DATE	MODIFIED	
00/10/00 555555800002	11/15/97 (A)	PATIENT, CLARISSA 2	CHS	UNSPECIFIED GROUP PC 04/15/98		
04/30/98 555555800539	11/12/97 (E)	PATIENT, KATHERINE 5	CHS	UNSPECIFIED SURGERY PC 04/30/98		
05/05/98 555555800621	05/04/98 (E)	PATIENT, SAMUEL P 5	CHS	UNSPECIFIED SPECIALISTS 05/05/98		

Figure 3-46: Number of days authorized modifications

3.8 Quick Inquiry to Appointment Scheduling Status (SAS)

This report displays a quick view of a specific patient’s current scheduled appointments for a particular referral. To print/browse the SAS report, select the SAS option from the *Data Entry* menu and type the name of the device you wish to print to at the “Device:” prompt. A sample report is provided in Figure 3-47.

APPOINTMENT STATUS LIST	DEC 7, 2001 08:55	PAGE 1
PATIENT	CHART	EXPECTED ACTUAL BEG DATE BEG DATE

PATIENT, LONA	16869	
REFERRING IHS PHYSICIAN: PROVIDER, ADAM		PRIMARY PAYOR: IHS
FACILITY REFERRED TO:		
PURPOSE: EVALUATION		

Figure 3-47: Quick inquiry to appointment scheduling status

3.9 Secondary Referrals (SEC)

Select Data Entry Option: SEC Secondary Referrals

* INDIAN HEALTH SERVICE *
* REFERRED CARE INFORMATION SYSTEM *
* VERSION 4.0, Oct 20, 2004 *

UNSPECIFIED SERVICE UNIT
Secondary Referrals
ASEC Add Secondary Referral
ESEC Edit Secondary Referral Data
DSEC Delete Secondary Referral
SPIQ Display Secondary Providers for a Specific Patient
Select Secondary Referrals Option:

Figure 3-48: Secondary referral menu

3.9.1 Add Secondary Referral (ASEC)

This option allows the user to add a new secondary referral for a different provider (other than the Primary Provider/Vendor) entered on the initial Referral. You are first prompted to select the referral, then to verify whether or not the referral type is a call-in, appointment date, primary payor, number of visits, purpose of appointment, ICD9 category, and CPT procedure category. Some of the information defaults from the primary referral, but it can be changed (with the exception of the number of visits). That number must be changed through the primary referral. Using the secondary referral option assists in tracking episodes of care for the patient. If the CHS link is turned on then the user will be able to select the secondary referral during entry of a PO or Denial.

```

*****
*           INDIAN HEALTH SERVICE           *
*   REFERRED CARE INFORMATION SYSTEM       *
*   VERSION 4.0, Oct 25, 2005             *
*****
                DEMO DATABASE
                Add Secondary Referral

Select REFERRAL by Patient or by Referral Date or #:   14
Is this a Call-in Secondary Referral? NO//
    
```

Figure 3-49: Add secondary referral

```

Select REFERRAL by Patient or by Referral Date or #: 070103   JUL 01, 2003
                55555500004 PATIENT,BOB                        3M DENTAL PRODUCTS
DIVISI
                07/01/03 E - 1                                Services not
available
                REFERRAL #: 5555550004
                RCIS SECONDARY REFERRAL RECORD
DATE: JUN 14,2004   Referral Suffix: A1   PATIENT: ADAMS,BOB
-----
REQUESTING FACILITY: WHITE EARTH HEALTH C   Display Face Sheet? N
REQUESTING PROVIDER: PROVIDER,SHIRLEY E
Referral Type: CHS                           PRIMARY PAYOR: IHS
INPATIENT OR OUTPATIENT: OUTPATIENT
APPT/ADM DATE&TIME:                            Number of remaining visits: 0

PURPOSE OF REFERRAL:
PRIORITY: 1

ICD Diagnostic Category:
CPT Procedure Category:
    
```

Figure 3-50: Add secondary referral

3.9.2 Edit Secondary Referral Data (ESEC)

This option allows you to edit an existing Secondary Referral and/or Secondary Referral element. After editing the Secondary Referral data through this option, you will need to use the Print New Secondary Provider Letter option (PRFS) to print an updated letter.


```

                                REFERRAL #: 255555555004
                                RCIS SECONDARY REFERRAL RECORD
DATE: JUN 17,2004   Referral Suffix: A1   PATIENT: PATIENT,CHERYL LYNN
-----
REQUESTING FACILITY: WHITE EARTH HEALTH C   DISPLAY FACE SHEET? N
REQUESTING PROVIDER: PROVIDER,COLLEEN
Referral Type: CHS                               PRIMARY PAYOR: VA
INPATIENT OR OUTPATIENT: OUTPATIENT
APPT/ADM DATE&TIME: MAY 17,2002               Number of remaining visits: 4

PURPOSE OF REFERRAL: Follow-up
PRIORITY: 2

ICD Diagnostic Category: INJURIES AND POISONINGS
CPT Procedure Category: EVALUATION AND/OR MANAGEMENT
-----
Exit      Save      Refresh
Enter a command or '^' followed by a caption to jump to a specific field.
    
```

Figure 3-51: Edit secondary referral data

3.9.3 Delete Secondary Referral Data (DSEC)

This option allows you to delete an existing Secondary Provider letter and/or Secondary Provider element.

```

*****
                                SECONDARY REFERRAL: 202100000004A1
PATIENT: PATIENT,CHERYL LYNN           Appointment Date: MAY 17, 2002
Requesting Provider: PROVIDER,COLLEEN
Purpose of Visit: Follow-up
*****
Sure you want to delete? No//
    
```

Figure 3-52: Delete secondary referral data

3.9.4 Display Secondary Providers for a Specific Patient (SPIQ)

This report was designed to provide a quick listing (by patient) for all Secondary Provider Letters that were printed using the Print RCIS Letter Types menu options on the LTRS menu. You are prompted for the patient name and then provided a list of all referrals for which Secondary Provider letters were printed. A sample report is provided in Figure 3-53.

```

DATE: SEP 25, 2001                PATIENT: PATIENT,ANITA
REFERRAL DATE: JAN 26, 1999      USER: PATIENT,ADAM
SECONDARY PROVIDER: PROVIDER DDS,STEVEN  EXP APPT DATE: SEP 25, 2001
PURPOSE OF APPT: THIS IS A TEST
REFERRAL NUMBER (c): 5555555500003
PRIMARY VENDOR (c): VENDOR RPH,JARJORIE S
PRIMARY PURPOSE (c): EVALUATION OF CHEST PAIN

DATE: SEP 25, 2001                PATIENT: PATIENT,ANITA
REFERRAL DATE: JAN 26, 1999      USER: PROVIDER,ADAM
SECONDARY PROVIDER: PROVIDER DDS,STEVEN  EXP APPT DATE: OCT 31, 2001
PURPOSE OF APPT: THE REALLY FINAL TEST
REFERRAL NUMBER (c): 5555555500003
PRIMARY VENDOR (c): VENDOR RPH,JARJORIE S
PRIMARY PURPOSE (c):
    
```

Figure 3-53: Display secondary providers for a specific patient

3.10 Print RCIS Letter Types (LTRS)

This menu option houses all the editing and printing of the RCIS Letter types. There are five letter options available from this menu, each of which is detailed in this section:

```

Select Data Entry Option: LTRS  Print RCIS Letter Types

*****
*                INDIAN HEALTH SERVICE                *
*   REFERRED CARE INFORMATION SYSTEM                   *
*   VERSION 4.0, Oct 20, 2005                          *
*****
                UNSPECIFIED SERVICE UNIT
                Print RCIS Letter Types

PCHS  Print Referral Letters (CHS Approval Status)
PARL  Print Alternate Resource Application Letter
PRF   Print Referral Letter (All types of letters)
PRS   Print Routing Slips
PRFS  Print Secondary Provider Letter

Select Print RCIS Letter Types Option:
    
```

Figure 3-54: Print RCIS letter types

3.10.1 Print Referral Letters (CHS Approval Status) (PCHS)

This option is controlled by the BMCZCHS security key and allows you to change the existing CHS Approval Status Field and print a new referral letter with the changed approval status. Changing the CHS Approval Status Field changes the text that appears at the bottom on the Referral and delineates payment of services party. An

audit of the CHS Approval is also displayed on the Display a Referral Menu option, listing the user and date the approval status was changed.

To change a patient's CHS approval status and print a new referral letter, follow these steps:

1. Type **PCHS** at the "Select Print RCIS Letter Types Option:" prompt.
2. At the "Select Type of Letter to be Printed:" prompt, type the name of the letter type you wish to print or type two question marks (??) to see a list of options first.
3. At the "Select Referral by Patient Name, date of referral or referral #:" prompt, type the name, referral date, or referral number for the patient you wish to refer. The patient's basic information and current CHS status will display on the screen.
4. At the "Do you wish to Change the Existing CHS Approval Status?" prompt, type **Y** if you wish to change the patient's CHS Approval Status or type **N** if you want to leave the CHS Approval Status as it is. If you choose not to change the status, jump to step 6.
5. At the "CHS Approval Status:" prompt, type the approval status you wish the referral to have or type a question mark (?) to see a list of options first.
6. At the "Device:" prompt, type the name of the device to which the letter prints.

```

***** REFERRAL FORM PRINT*****
This report will produce a hard copy computer generated referral letter.
Select Type of letter to be printed: STANDARD IHS REFERRAL LETTER
Select Referral by Patient Name, date of referral or referral #: 8-18-1997
0001019700390  PATIENT,C          CARONDLELET HEALTH SERVICE
                UNKNOWN SERVICE DATE          DIALYSIS

** CHS APPROVAL STATUS**: PENDING

Do you wish to Change the Existing CHS Approval Status? N// YES

CHS APPROVAL STATUS: PENDING// A APPROVED

DEVICE: HOME//

```

Figure 3-55: Print referral letters

A sample of the referral letter is provided in Figure 3-56.

```

Referral for Contract Professional Services      NOV 29, 2001
*****
Patient Identification, Address, Phone
Patient Name:  PATIENT,LONA                    ID Number:  PAH 55555
              SSN:                               Sex:  FEMALE
              Address:  PO BOX 8                 DOB:  JUL 17, 1984
                      ANYTOWN, ARIZONA 88888   Phone:
-----
Referred to:      BETHANY GENERAL HOSPITAL
Mailing: 7600 N.W. 23RD           Physical:
              BETHANY, OK 73008

5059010600008
INPATIENT Services                    Admission Date:
Priority Rating: 3                     Expected Ending Date:
-----
Purpose/Services Requested: EVALUATION

Additional Medical Information Attached: Not Documented by Provider
-----
If you have any questions concerning this referral, please contact:
UNSPEC HOSP (contact: MRS. JUDY STAFF)
RT. 5, BOX 55
ANYTOWN, ARIZONA 88888 (phone: (602) 364-5319)
Referring Provider (ELECTRONIC SIGNATURE): PROVIDER,ADAM
Case Manager: DOCTOR,ONE              Veteran:
Our records indicate that the patient has no third party coverage as of
today.
*****
To the contract provider: CHS funds are authorized as specified above,
subject to the conditions below:

* The provider shall submit a consultation report or discharge summary to
the Indian Health Service prior to reimbursement by IHS Contract Health
Services or the IHS's Fiscal Intermediary.

* This patient must apply for any alternative resouces for which he/she is
entitled. Failure to do so by the patient will result in denial of
payment by IHS and the patient would then be responsible for the entire
bill.

* This referral does not authorize transfer of this patient to any other
provider or the provision of services not requested without prior
approval. Provision of unauthorized services may result in denial of
payment without recourse to the patient.

This referral is valid for 30 days from the date of issue for the above
specified services, unless otherwise specified.

* This referral is a request for health services, not a guarantee of
payment.

Contract Health Service Office
    
```

Figure 3-56: Referral letter (sample)

3.10.2 Print Alternate Resource Application Letter (PARL)

This option will produce a hard copy computer generated Alternate Resource Application Letter. If the patient has possible Third Party alternate resources, then a letter must be sent to the patient asking them to apply to that Alternate Resource.

Pursuant to IHS Regulations, 42 CFR Part C, a patient is required to make a good faith effort to complete an application for alternate resources. This letter is addressed to the patient with all pertinent referral information and requirements needed for the patient to comply. The date the letter was printed, the user who printed it, and the type of letter disseminated are also stored with the other referral information. In addition, the General Retrieval Lister Items allow the retrieval of these specific elements.

You are prompted for the Contact Point, documentation needed for proof of identity, how the letter was delivered to that patient (and if certified mail, the mail certification number). This information (along with the user who printed the letter and the date printed) is stored with the Referral and is displayed under the Display a Referral Menu option.

A sample of the patient letter is provided in Figure 3-57.

```

DEC 06, 2001

**TO THE PARENTS OF PATIENT,LONA:
LONA PATIENT
PO BOX 555
ANYTOWN, ARIZONA 88888

Admit Date: #999555888777330
Services: EVALUATION
Est. Amount: $70.00

Dear Patient:
The information that has been provided to the CHS Office indicates that
you may be qualified for an alternate resource. Pursuant to IHS
Regulations, 42 CFR Part C (attached), you are required to make a good
faith effort to complete an application for alternate resources. You must
provide this facility with a copy of the alternate resource program's
eligibility determination.

THE APPLICATION PROCESS REQUIRES YOU TO DO THE FOLLOWING:

___A. You must contact STATE MEDICAID to schedule an appointment
to complete an application. It is very important that you keep your
scheduled appointment.

___B. You will need to bring the following documentation with you to your
appointment:

You might also have to provide the alternate resource program with
additional documentation specially requested prior to or during your
appointment.

IF YOU ARE UNABLE TO APPLY FOR AN ALTERNATE RESOURCE OR ARE HAVING
DIFFICULTY APPLYING, THE CHS OFFICE IS AVAILABLE TO ASSIST YOU. IF AN
ALTERNATE RESOURCE APPLICATION IS NOT COMPLETED, OR IF YOU DO NOT CONTACT
THE CHS OFFICE FOR ASSISTANCE IN COMPLETING AN APPLICATION, WITHIN 30 DAYS
OF THE DATE OF THIS NOTICE, A CHS DENIAL LETTER WILL BE ISSUED. PLEASE
CALL TELEPHONE NUMBER - (602) 364-5319.

Sincerely,
Mrs. Toni Staff

cc: file

_____  

PATIENT SIGNATURE DATE

```

Figure 3-57: Alternate Resource Application Letter (sample)

3.10.3 Print Referral Letter (All Types of Letters) (PRF)

Once you have entered data for a referral, you will be able to generate a printed referral letter to send with the patient or forward to the referred provider. The referral letter that prints for the referral record you select differs according to the referral type and status. For instance, a CHS referral contains information that is unnecessary for an in-house referral.

To print a referral letter, select the Print Referral Letter option on the Data Entry menu and then identify the type or referral to be printed. The RCIS package is designed to print the referral letter in a standard format. You may also want a letter that meets the requirements of your state health care program or the specific needs of

other providers. Please contact the IHS ITSC developers if you are interested in a site-specific referral letter.

To print the standard form, type **Standard** at the prompt and identify the referral record. You can make your selection by typing the patient’s name, the referral number, or the date the referral was initiated. At the “Device:” prompt, enter the device for printing the form.

3.10.4 Print Routing Slips (PRS)

Computer-generated routing slips for the referrals can be printed with the PRS option on the Data Entry menu. A sample routing slip for a patient referral is shown in Figure 3-58. Basic referral visit information and patient identification data display at the top, followed by the facility to which the patient was referred. The additional documentation specified during data entry to be sent with the patient is marked with an X in the left hand column with the item name in the center column and a space to the right of each item for initials or signature.

```

          Routing Slip for Contract Health
*****
Patient Name:  PATIENT,JOEL G.           ID Number:  WE 99999
Referral Number:  55555555700133       Date Initiated:  SEP 22, 2005
                                           Appointment Date:  9/23/05

Referred to:  UNM HOSPITAL (505-555-4422)
              2211 LOMAS BLVD NE
              ALBUQUERQUE, NEW MEXICO 87107
-----
_____ PCC Visit Form                    _____
  X _____ Specialty Clinic Notes       _____
_____ Prenatal Record(s)                _____
_____ Signed Tubal Consent               _____
_____ Face Sheet                          _____
  X _____ Health Summary                _____
_____ Most Recent EKG                     _____
  X _____ History and Physical          _____
_____ X-Ray/ Report                       _____
_____ X-Ray/ Film                         _____
_____ Consultation Report                 _____
_____ Most Recent Lab Report              _____

Additional Documentation:
Disposition: _____
_____
_____
    
```

Figure 3-58: Printing Routing Slips

3.10.5 Print Secondary Provider Letter (PRFS)

Computer-generated secondary provider letters for the referrals can be printed with the PRFS option on the Data Entry menu. The user has the option to print the

Primary Referral Medical History and Findings on the Secondary referral letter. If the referral is a CHS type, the option allows the user to change the existing CHS Approval Status Field and print a referral letter with the changed approval status. Changing the CHS Approval Status Field changes the text that appears at the bottom on the Referral and delineates payment of services party. An example of the prompts is shown in figure 3-50. An audit of the CHS Approval is also displayed on the Display a Referral Menu option, listing the user and date the approval status was changed.

A sample secondary provider letter for a patient referral is shown in Figure 3-59.


```

Select Print RCIS Letter Types Option: PRFS Print Secondary Provider Letter

*****
* INDIAN HEALTH SERVICE *
* REFERRED CARE INFORMATION SYSTEM *
* VERSION 4.0, Oct 20, 2005 *
*****
UNSPECIFIED SERVICE UNIT
Print Secondary Provider Letter

***** REFERRAL FORM PRINT-SECONDARY PROVIDER *****

Select one of the following:

1 STANDARD
2 AHCCCS

Enter Secondary Letter Type: STANDARD// [RET]

Do you want to include Primary referral History and Findings? Y// ES

Select REFERRAL by Patient or by Referral Date or #: BIRD,TWEETY
F 07-25-1965 777228888 1333330 6-17
-2004 BIRD,TWEETY 55555555000004 A1
**CHS APPROVAL STATUS**: APPROVED

Do you wish to Change the Existing CHS Approval Status? N// 0

DEVICE: HOME// [RET] Right Margin: 80// [RET]

Referral for Contract Professional Services JUN 17, 2004
*****
Patient Identification, Address, Phone
Patient Name: BIRD,TWEETY ID Number: WE 91001
SSN: 456963357 Sex: FEMALE
Address: 1545 ROSE FIELD RD DOB: 07/25/1969
ALBUQUERQUE, NEW MEXICO 87114 Hm Phone: (505)896-4321

Referred to: ABGINTON MEMORIAL HOSPITAL
Mailing: 1200 OLD YORK RD Physical:
Abington , PA 19001 Referral: 1135100500045 A1
OUTPATIENT SERVICES Appointment Date: 9/24/05
# of Outpatient Visits: 0 Expected Ending Date: SEP 24, 2005
Priority Rating: 1

Purpose/Services Requested: chest pain

Additional Medical Information Attached: No

If you have any questions concerning this referral, please contact:
PINE POINT HEALTH STATION (contact: MICKEY MOUSE))

Referring Provider (ELECTRONIC SIGNATURE): PROVIDER, COLLEEN
Case Manager: STAFF, BILL G Veteran:
Our records, as of 6/17/2004 indicate that this patient has the following
third party coverage:
MEDICARE: - 555555592A
NO PRIVATE INSURANCE COVERAGE

*****
To the contract provider: CHS funds are authorized as specified above, subject
to the conditions below:
    
```

* The provider shall submit a consultation report or discharge summary to the Indian Health Service prior to reimbursement by IHS Contract Health Services or the IHS's Fiscal Intermediary.

* This patient must apply for any alternative resources for which he/she is entitled. Failure to do so by the patient will result in denial of payment by IHS and the patient would then be responsible for the entire bill.

* This referral does not authorize transfer of this patient to any other provider or the provision of services not requested without prior approval. Provision of unauthorized services may result in denial of payment without recourse to the patient.

* This referral is valid for 30 days from the date of issue for the above specified services, unless otherwise specified.

* This referral is a request for health services, not a guarantee of payment.

Contract Health Service Office

Figure 3-59: Print secondary provider letter

4.0 Print Reports (RPT)

A number of predefined reports can be generated from the Print Reports Module of the RCIS to help with the tracking and management of referred care at your facility. Reports in a variety of general categories are available as well as a very flexible report option that allows you to create customized reports with minimum effort.

The following menu displays the different report categories that are available to you. Each of the categories include a submenu of reports except the RCIS General Retrieval option and the Delete General Retrieval Report Definition option, which are used for creating and deleting customized reports.

```

*****
*                INDIAN HEALTH SERVICE                *
*      REFERRED CARE INFORMATION SYSTEM      *
*                VERSION 4.0, Oct 20, 2005        *
*****
                                UNSPECIFIED HOSP
                                Print Reports

ADM   Administrative Reports ...
CM    Case Management Reports ...
UTIL  Utilization Reports ...
GEN   RCIS General Retrieval
DGR   Delete General Retrieval Report Definition

Select Print Reports Option:

```

Figure 4-1: Print Reports Menu

This section of the manual includes detailed instructions for using all of the report options and presents a sample of each. It is helpful to review all of the report options available and their capabilities before generating any reports.

For many of the reports, you have the option of printing the output or browsing it on the screen. When browsing output on the screen, the following commands are available for reviewing the output:

- + Next Screen
- - Previous Screen
- Q Quit
- ?? More Actions

Note: All reports in this module exclude in-house referrals except those specifically designed for the reporting of in-house referral data.

4.1 Administrative Reports (ADM)

The Administrative Reports option provides a means for tracking active referrals, checking the status of CHS referrals, looking at the patterns of in-house referrals, and reviewing referrals for a particular time period. The menu below shows the reports that are available from this category.

```

Select Print Reports Option: ADM Administrative Reports

*****
*                INDIAN HEALTH SERVICE                *
*      REFERRED CARE INFORMATION SYSTEM      *
*                VERSION 4.0, Oct 20, 2005        *
*****
                UNSPECIFIED SERVICE UNIT
                Administrative Reports

ARD   Active Referrals by Date
ARR   Active Referrals by Referred To
ARP   Active Referrals by Requesting Provider
CHPD  CHS Paid
CHSR  CHS Status Report for Referrals
INHC  Tally of In-House Referrals by Clinic
INHP  Tally of In-House Referrals by Requesting Provider
INHR  In-House Report for Active Referrals
OUT   Referrals Initiated at an Outside Facility
RRR   Referral Review Report - By Time Period
RRRF  Referral Review Report - By Facility/Time Period
SRR   Secondary Referral Report

Select Administrative Reports Option:

```

Figure 4-2: Administrative Reports Menu

4.1.1 Active Referrals by Date (ARD)

The ARD report lists all active referrals ordered by date. Active referrals are those that have not yet been closed. You may choose to list the referrals by the date they were initiated or the best available beginning date of service. The date initiated is the actual date on which the referral was generated. The best available beginning date of service is the actual beginning date of service, if available. If the actual date is not available, the expected beginning date of service is displayed. If you are generating a report by best available beginning date of service, an *A* or *E* displays after each date of service to indicate whether the date is actual or estimated. You may print the report or browse the output on the screen.

The sample report in Figure 4-3 lists referrals by beginning date of service. Note the *A* and *E* printed after each date of service.

```

*****CONFIDENTIAL PATIENT INFORMATION *****
                UNSPECIFIED HOSPITAL/CLINIC
                ACTIVE REFERRALS BY BEGIN DATE OF SERVICE
                PAGE 1

```

BEGIN DOS	REFERRAL #	PATIENT NAME	REF PROV	TYPE	FACILITY REFERRED TO
02/26/05(E)	0001019500141	PATIENT,DOREEN	EDE	CHS	UNSPECIFIED CLINIC
03/01/05(E)	0001019500116	PATIENT,ABE	EDE	IHS	UNSPECIFIED CLINIC
03/04/05(E)	0001019500229	PATIENT,DOREEN	EDE	CHS	UNSPECIFIED CLINIC
03/04/05(E)	0001019500232	PATIENT,GREGORY	EDE	IHS	UNSPECIFIED CLINIC
03/04/05(E)	0001019500236	PATIENT,JENNIFEREDE	EDE	CHS	UNSPECIFIED CLINIC
03/07/05(A)	0001019500269	PATIENT,MEGAN	EDE	CHS	UNSPECIFIED CLINIC
03/09/05(E)	0001019500234	PATIENT,DON	EDE	IHS	UNSPECIFIED CLINIC
03/14/05(E)	0001019500218	PATIENT,BECKY	EDE	IHS	UNSPECIFIED CLINIC
03/15/05(E)	0001019500197	PATIENT,ROBIN	ACC	IHS	UNSPECIFIED CLINIC
03/19/05(E)	00010195000271	PATIENT,ANITA	SPG	CHS	UNSPECIFIED CLINIC
03/20/05(A)	0001019500242	PATIENT,MELANIE	EDE	CHS	UNSPECIFIED CLINIC
03/20/05(E)	0001019500285	PATIENT,JENNIFEREDE	EDE	CHS	UNSPECIFIED CLINIC
03/22/05(E)	0001019500287	PATIENT,JEAN	EDE	CHS	UNSPECIFIED CLINIC
03/29/05(A)	0001019500276	PATIENT,DON	EDE	IHS	UNSPECIFIED CLINIC DR. SMITH
04/01/05(A)	0001019500288	PATIENT,FRED	GIS	CHS	UNSPECIFIED CLINIC
04/01/05(E)	0001019500290	PATIENT,ANITA	EDE	CHS	UNSPECIFIED CLINIC
04/01/05(E)	0001019500294	PATIENT,HANNAH	ACC	CHS	UNSPECIFIED CLINIC
04/01/05(A)	0001019500303	PATIENT,BECKY	EDE	CHS	UNSPECIFIED CLINIC DR. JONES
04/18/05(A)	0001019500305	PATIENT,MARTHA	EDE	CHS	UNSPECIFIED CLINIC DR. SMITH
04/23/05(A)	0001019500309	PATIENT,BEA	EDE	CHS	UNSPECIFIED CLINIC
04/24/05(E)	0001019500311	PATIENT,ANDY	ACC	CHS	UNSPECIFIED CLINIC

RUN TIME (H.M.S.): 0.0.0
End of report. HIT RETURN:

Figure 4-3: Active Referrals by Date (sample report)

4.1.2 Active Referrals by Referred To (ARR)

This report lists all active referrals and totals by the provider to which the patient was referred. Active referrals are those that have not yet been closed. The user is requested to enter a beginning and ending date. The report may be printed or browsed on the screen. You may elect to print each facility on a separate page.

```

*****CONFIDENTIAL PATIENT INFORMATION *****
                UNSPECIFIED CLINIC                PAGE 1
        ACTIVE REFERRALS BY FACILITY REFERRED TO

REF
BEGIN DOS  REFERRAL #      PATIENT NAME          PROV TYPE PRIM PAYOR
-----
FACILITY REFERRED TO: <UNKNOWN>
                5059010500018A1  PATIENT,PATIENT      FCJ  OTH   IHS
TOTAL = 1

FACILITY REFERRED TO:  AMBULATORY ANESTHESIA
10/24/05 A 5059010600008A1  BUNNY,JACQUELIN      FCJ  CHS   IHS
TOTAL = 1

FACILITY REFERRED TO:  BARTLESVILLE UROLOGY
01/06/05 E 5059010400142    PATIENT,DEMO         JM   CHS   IHS
12/11/04 A 5059010400144    DEMO,PATIENT         JM   CHS   IHS
TOTAL = 2

RUN TIME (H.M.S.): 0.0.0
End of report.  HIT RETURN:
    
```

Figure 4-4: Active Referrals by Referred To (sample report)

4.1.3 Active Referrals by Requesting Provider (ARP)

This report will list all active referrals at your facility sorted by the requesting provider. Active referrals are those that have not yet been closed. You may list the referrals by a single provider that you specify or by all providers. The user is asked to enter a beginning and ending date for the report. An *A* or *E* following each date of service indicates whether the date is actual or estimated. You may print the output or browse it on the screen.

```

*****CONFIDENTIAL PATIENT INFORMATION *****
                UNSPECIFIED HOSPITAL/CLINIC
                ACTIVE REFERRALS BY REQUESTING PROVIDER
                PAGE 1
-----
BEGIN DOS   REFERRAL #   PATIENT NAME   REF
                PROV   TYPE   FACILITY REFERRED TO
-----
REQUESTING PROVIDER:   PROVIDER, MARTY
01/06/96(A) 0001019500143 PATIENT,DOREEN MAJ   CHS   UNSPECIFIED CLINIC
02/20/96(E) 0001019500173 PATIENT,DANIELLE MAJ   CHS   UNSPECIFIED CLINIC
02/21/96(E) 0001019500179 PATIENT,MEGAN MAJ   CHS   UNSPECIFIED CLINIC
05/12/96(E) 0001019500180 PATIENT,LOURDES MAJ   IHS   UNSPECIFIED CLINIC
05/28/96(A) 0001019500201 PATIENT,MITCHELL MAJ   CHS   UNSPECIFIED CLINIC C
                DR. JONES
                0001019500204 PATIENT,JOSEPH MAJ   IHS   <UNKNOWN>
03/19/96(A) 0001019500275 PATIENT,ANITA MAJ   CHS   UNSPECIFIED CLINIC
                DR. JONES
05/20/96(E) 0001019500352 PATIENT,DON MAJ   CHS   UNSPECIFIED CLINIC
05/20/96(A) 0001019500354 PATIENT,JENNIFER MAJ   IHS   UNSPECIFIED CLINIC
05/20/96(E) 0001019500361 PATIENT,MELANIE MAJ   CHS   UNSPECIFIED CLINIC
05/22/96(A) 0001019500380 PATIENT,IRENE MAJ   CHS   UNSPECIFIED CLINIC
                RADIOLOGY
REQUESTING PROVIDER:   PROVIDER, ARTHUR NP
06/01/96(E) 0001019500095 PATIENT,KELSEY ACC   IHS   UNSPECIFIED CLINIC
                NEW, OTHER PROVIDER
05/01/96(A) 0001019500220 PATIENT,LOIS ACC   CHS   UNSPECIFIED CLINIC
REQUESTING PROVIDER:   PROVIDER, CLAYTON
11/14/96(E) 0001019500075 PATIENT,JOANNE CC   IHS   UNSPECIFIED CLINIC
02/01/96(A) 0001019500093 PATIENT,ROBERT CC   CHS   UNSPECIFIED CLINIC
02/14/96(E) 0001019500135 PATIENT,DIANE M CC   CHS   UNSPECIFIED CLINIC
                DR. JOE
02/14/96(E) 0001019500192 PATIENT,DOREEN CC   CHS   UNSPECIFIED CLINIC
                DR. JONES
03/15/96(E) 0001019500197 PATIENT,ROBIN CC   IHS   UNSPECIFIED CLINIC
RUN TIME (H.M.S.): 0.0.0
End of report. HIT RETURN:

```

Figure 4-5: Active Referrals by Requesting Provider (sample report)

4.1.4 Removed Report: CHS Denied Still Active (CHD)

This report has been removed from v.4. It is no longer available. The option printed a list of all referrals that were denied by CHS but are still active. The same information can be extracted by using the CHS Status Report (including referrals that have been or should be referred under some other mechanism (e.g., using alternative resources or referred to another IHS facility).

*****CONFIDENTIAL PATIENT INFORMATION *****				
UNSPECIFIED CLINIC				PAGE 1
CHS REFERRALS DENIED STILL ACTIVE				
REF DATE	PATIENT NAME	Ref#	PROV	FACILITY REFERRED TO

12/04/95	PATIENT, KELSEY SURGERY	SE100119	EDE	UNSPECIFIED CLINIC
01/14/96	PATIENT, MARTIN EVALUATION	SE179585	SPG	UNSPECIFIED CLINIC
02/10/96	PATIENT, MARTHA ROUTINE EXAM	SE100857	DEM	UNSPECIFIED CLINIC
02/15/96	PATIENT, BECKY SCAR REMOVAL	SE109375	MCR	UNSPECIFIED CLINIC
03/12/96	PATIENT, TOM INITIAL EVALUATION	SE105924	LEU	UNSPECIFIED CLINIC
03/15/96	PATIENT, KAREN ROUTINE VISIT	SE101456	ROC	UNSPECIFIED CLINIC
05/18/96	PATIENT, DIANE CONTINUING THERAPY	SE1098456	EDE	UNSPECIFIED CLINIC
06/30/96	PATIENT, NICH REHABILITATION SERVICES	SE1034545	SPG	UNSPECIFIED CLINIC

Figure 4-6: CHS Denied Still Active (sample of removed report)

4.1.5 CHS Paid (CHPD)

This report lists all active CHS referrals for which one or more authorization have already been paid. Both Primary and Secondary referrals are included in the report. Beginning and ending dates are requested. Then the report can be printed or browsed on the screen.

*****CONFIDENTIAL PATIENT INFORMATION *****				
UNSPECIFIED CLINIC				PAGE 1
ACTIVE CHS REFERRALS WHERE ALL AUTHORIZATIONS PAID				
REF DATE	PATIENT NAME	Ref#	PROV	FACILITY REFERRED TO

12/14/95	PATIENT, JIM EVALUATION	SE555156	CCC	UNSPECIFIED CLINIC
01/28/96	PATIENT, JAMES OUTPATIENT SURGERY	SE555145	COT	UNSPECIFIED CLINIC
02/12/96	PATIENT, BERNARD EVALUATION	SE555957	MED	UNSPECIFIED CLINIC
02/18/96	PATIENT, MARTHA ALLERGY TREATMENT	SE555375	MCR	UNSPECIFIED CLINIC
03/24/96	PATIENT, ALEXANDER SURGERY	SE555547	LUT	UNSPECIFIED CLINIC
03/25/96	PATIENT, MELINDA COUNSELING SESSION	SE555498	MLE	UNSPECIFIED CLINIC
05/4/96	PATIENT, MELANIE REHAB AFTER ACCIDENT	SE555265	KTY	UNSPECIFIED CLINIC
06/21/96	PATIENT, WAYNE	SE5558326	SPG	UNSPECIFIED CLINIC

Figure 4-7: CHS Paid (sample report)

4.1.6 CHS Status Report for Active Referrals (CHSR)

This report prints out a list of all CHS referrals. You can select a date range by Date Initiated. The Status of Referral can be Active, Closed or Both. The CHS Status of Referral can be Approved, Pending, Denied, or All. The report can be printed or browsed on screen.

```

Select Administrative Reports Option: CHSR CHS Status Report for Referrals

*****
* INDIAN HEALTH SERVICE *
* REFERRED CARE INFORMATION SYSTEM *
* VERSION 4.0, Oct 20, 2005 *
*****
UNSPECIFIED SERVICE UNIT
CHS Status Report for Referrals

Enter beginning Referral Date: 01/01/2000 (JAN 01, 2000)
Enter ending Referral Date: 12/31/2002 (DEC 31, 2002)

Select one of the following:

P Pending
A Approved
D Denied
AL All

Enter the CHS status of the Referral for the Report: P// Pending

Select one of the following:

A Active
C Closed
B Both

Enter the Status of the Referral for the Report: A// A

Select one of the following:

P PRINT Output
B BROWSE Output on Screen

Do you wish to: P// BROWSE Output on Screen
...HMMM, THIS MAY TAKE A FEW MOMENTS...
OUTPUT BROWSER Jun 17, 2004 15:25:14 Page: 1 of 1

***** CONFIDENTIAL PATIENT INFORMATION *****
UNSPECIFIED SERVICE UNIT Page 1
CHS REFERRALS: PENDING APPROVAL
REFERRALS STATUS: ACTIVE AND CLOSED

REF DATE PATIENT NAME Ref# STATUS PROV FACILITY REF TO
-----
10/16/2000 PATIENT,KENNARD J ???? P/A PB FEDERAL MARKETING COMPANY
GET BRAIN SCAN
6/7/2001 PATIENT,MERLIN T ???? P/A FLA ORTHOPEDICS INC
deadly sick
    
```

Figure 4-8: CHS status report for active referrals (set-up and sample report)

4.1.7 Tally of In-House Referrals by Clinic (INHC)

The INHC report provides a count and totals of all in-house referrals by the clinic to which the patient was referred. You will enter a beginning and ending referral date for

the report. Data can be generated for one specific clinic that you specify or for all clinics at your facility. The report includes both Primary and Secondary referrals. The user has the ability to browse or print the report.

IN-HOUSE REFERRALS BY CLINIC		
REFERRAL DATE RANGE: JUN 01, 2005 TO JUN 06, 2005		
CLINIC REFERRED TO	PROVIDER REFERRED FROM	NUMBER

GENERAL	DOCTOR, DON	3
	DOCTOR, THOMAS	4
Total Secondary Referrals = 2		
Total Primary Referrals = 5		
Total for GENERAL		7
OBESITY		
	DOCTOR, LORI ANN	1
Total for OBESITY		1
DIABETES		
	DOCTOR, SANDRA	6
	DOCTOR, JERRY	4
Total Secondary Referrals = 3		
Total Primary Referrals = 7		
Total for DIABETES		10
DENTAL		
	DOCTOR, DEAN	1
Total for DENTAL		1
RUN TIME (H.M.S): 0.0.1		
End of report. HIT RETURN:		

Figure 4-9: Tally of In-House Referrals by Clinic (sample report)

4.1.8 Tally of In-House Referrals by Requesting Provider (INHP)

This report displays a count of all in-house referrals by provider of service. You will enter a beginning and ending referral date for this report. Then you will select to print referrals for all providers or a single provider that you specify.

IN-HOUSE REFERRALS BY CLINIC		
REFERRAL DATE RANGE: JAN 01, 2005 TO JUN 06, 2005		
PROVIDER	CLINIC REFERRED TO	NUMBER

Doctor, LORI ANN	OBESITY	1
Total Secondary Referrals = 0		
Total Primary Referrals = 1		
TOTAL FOR Doctor, LORI ANN		1
DOCTOR, DON	GENERAL	3
Total Secondary Referrals = 2		
Total Primary Referrals = 1		
TOTAL FOR DOCTOR, DON		3
RUN TIME (H.M.S): 0.0.2		
End of report. HIT RETURN:		

Figure 4-10: Tally of In-House Referrals by Requesting Provider (sample report)

4.1.9 In-House Report for Active Referrals (INHR)

This report prints out a list of all active in-house referrals. You can select a date range in which to search for active referrals.

```

Select Administrative Reports Option: INHR In-House Report for Active Referrals

*****
*          INDIAN HEALTH SERVICE          *
*    REFERRED CARE INFORMATION SYSTEM    *
*      VERSION 4.0, Oct 20, 2005        *
*****
          UNSPECIFIED SERVICE UNIT
          In-House Report for Active Referrals

Enter beginning Referral Date:  01/01/2003 (JAN 01, 2003)
Enter ending Referral Date:    12/31/2005 (DEC 31, 2005)

Select one of the following:

      P          PRINT Output
      B          BROWSE Output on Screen

Do you wish to: P// B BROWSE Output on Screen

***** CONFIDENTIAL PATIENT INFORMATION *****
                      DEMO DATABASE
ACTIVE IN HOUSE REFFERALS BY CLINIC REFERRED TO
BEG DATE: JAN 01, 2005 END DATE: OCT 26, 2005
Page 1

REF DATE      DOS          REFERRAL #      PATIENT                                HRN      PROV
-----
CLINIC REFERRED TO:  EMERGENCY MEDICINE
1/10/2005  1/10/2005  5059010400145  RICE JR,AMBER TIF                      77       _  JM
6/6/2005   6/6/2005   5059010400164  BUNNY,BENJAMIN                        1119    _  KLW
6/6/2005   6/6/2005   5059010400160A1 JONES,DELORES                          10      _  FCJ
6/6/2005   6/6/2005   5056100200161A1 MEYERS,UNKNOWN                        2356    _  RFC

RUN TIME (H.M.S): 0.0.12
End of report. HIT RETURN:
    
```

Figure 4-11: In-house report for active referrals

4.1.10 Referrals at an Outside Facility (Call In's) (OUT)

The OUT report lists all referrals that were initiated at an outside facility. You will be prompted to enter the Facility and the beginning and ending dates of referral initiation for the report. The sample in Figure 4-12 lists referrals initiated from an outside facility for the period July 1 to July 31, 1997.

```
***** CONFIDENTIAL PATIENT INFORMATION *****
                        DEMO DATABASE
Page 1
                        OCT 26, 2005
**REFERRALS INITIATED AT OUTSIDE FACILITY (CALL'ins)**
                        BEG DATE: JAN 01, 2005
                        END DATE: OCT 26, 2005
-----
MOUSE,MICKEY          7777          DOB: Jul 04, 1944  61 YRS 444556666
Referral #: 5059010400163    Date Init: 06/01/05  Tribe: CHEROKEE NATION
SEC A1 06/01/2005 DOS 06/01/2005 TEST                                BETHANY MEDICAL
CLINIC A
Priority: 1  CHS Auth Dec: PENDING  MCC Action:
Alternate Resource Letter Date:
```

Figure 4-12: Referrals at an Outside Facility (sample report)

4.1.11 Referral Review Report - By Time Period (RRR)

The Referral Review report (RRR) displays a list of referrals that were initiated within a specified time frame. Detailed information about each of the referrals is included in the report. Both ICD-9 and DX categories can be printed on the report. This report is useful for the CHS or Managed Care Committee to review referrals initiated at your facility.

You will enter a date range indicating the dates on which the referrals were generated. The selected date range will appear in the header display. You can print the output or browse it on the screen.

```

*****CONFIDENTIAL PATIENT INFORMATION*****
                WHITE EARTH HEALTH CENTER
                PAGE 1
OCT 21, 2005
                **WEEKLY CHS REVIEW LISTING BY DATE**
BEG DATE: JAN 01, 2004      END DATE: OCT 01, 2005
-----
PATIENT,ETHEL                WE117000      DOB: JUN 04,1989  16 YRS
Tribe: INDIAN NON-TRIBAL ME  Req Provider: PROVIDER,ADAM
Referral #: 11135100200000  Date Referral Initiated: 06/14/04
Eligibility: DIRECT ONLY
3RD party:
Refer To: WHITE EARTH HEALTH C
Primary Payor: IHS                Referral Type: IHS
Inpatient Admission Date: 6/14/04 A      LOS: 1 E
Purpose: TEST
Dx Cat: CARDIOVASCULAR DISORDERS
Dx: .9999 - THIS IS A TEST
Srv Cat: NONSURGICAL PROCEDURES
Priority: 1 CHS Auth Dec: PENDING  MCC Action:
Utilization Review by MD:
Alternate Resource Date:
Business Office Comments:
-----

PATIENT,ANITA                WE90800  DOB: JUN 25, 1963  42 YRS  555555612
Tribe: ACOMA PUEBLO, NM      Req Provider: PROVIDER,DONALD L
Referral #: 11135100200001  Date Referral Initiated: 09/08/04
Eligibility: CHS & DIRECT
3RD Party:
Refer To: RADIOLOGY ASSOCIATES
Primary Payor: IHS                Referral Type: CHS
Outpatient Services requested for: 09/08/04 A # of Visits: 1
Purpose: hip pain
Dx Cat: OTHER SYMPTOMS, SIGNS, AND ILL-DEFINED CONDITIONS
Srv Cat: DIAGNOSTIC IMAGING
Priority: 1 CHS Auth Dec: APPORVED  MCC Action:
Utilization Review by MD:
Alternate Resource Date:
-----

```

Figure 4-13: Referral Review by Time Period (sample report)

4.1.12 Referral Review Report - By Facility/Time Period (RRRF)

The Referral Review by Facility/Time Period report is the same as the Referral Review by Time Period report except that this report allows extraction of a specific IHS Facility. See section 4.1.11 for more information on the Referral Review reports.

4.1.13 Secondary Referral Report (SRR)

This report prints a list of all Secondary Provider Letters initiated in a selected date range. This report allows you to select and report for an individual facility only. This report also allows you to select a particular user who created the letter. In-house Referrals are not included in this report.

```

Select Administrative Reports Option: srr Secondary Referral Report
***** SECONDARY PROVIDER LETTERS BY DATE OF RECORDING *****

Enter Facility Name: UNSPECIFIED MEMORIAL HOSPITAL

Restrict Report to a particular User Who Created the Letter? NO// [RET]

Enter beginning Letter Date Range: 01/01/1996 (JAN 01, 1996)

Enter ending Letter Date Range: (1/1/1996 - 12/31/2699): 12/31/2003 (DEC 31, 2003)

Select one of the following:

C          CHS
I          IHS (ANOTHER FACILTIY)
O          OTHER
A          ALL (Excluding IN-HOUSE Referrals)

Enter the Referral type or A for All: C// CHS

Select one of the following:

P          PRINT Output
B          BROWSE Output on Screen

Do you wish to: P// B BROWSE Output on Screen
***** CONFIDENTIAL PATIENT INFORMATION *****
                TAOS-PICURIS HEALTH CENTER
                OCT 26, 2005
                **SECONDARY PROVIDER LETTER BY DATE**
-----
BUNNY,BUGS          XXX4602    DOB: JAN 30, 1963  42 YRS 555667777
Referral #: 2024129800034 A1 Date Init: 09/06/98  Tribe: TAOS PUEBLO, NM
Refferal Type: OTHER
LETTER DATE: MAY 04, 2005          USER CREATED: ADAM,ADAM2

Expected Appoinment Date: MAY 04, 2005
Purpose of Appointment: TEST FOR REF
Contract Vendor: BUGSBUNNY MD, STANLEY E.
IHS Facility:
Alternate Resource Letter Date:

```

Figure 4-14: Secondary referral report

4.2 Case Management Reports (CM)

The Case Management Reports group included report options for reviewing records of patients who are currently receiving referred services, identifying patients with high and potentially high costs of care, and tracking the receipt of discharge and consultation summaries.

The following reports are available from the Case Management Reports menu.


```

*****
*          INDIAN HEALTH SERVICE          *
*    REFERRED CARE INFORMATION SYSTEM    *
*    VERSION 4.0, Oct 20, 2005          *
*****
                UNSPECIFIED HOSP
                Case Management Reports

ILOG  Inpatient Log
AHDC  Area Hospital Discharges
OLOG  Outpatient Referral Log
HCU   List of High Cost Users
HCTX  Potential High Cost Cases
TDL   Timeliness of Receiving Disch/Consult Summary
DCNR  Patients for Whom Disch/Consult Summary Not Rec'd
TLOG  Transfer Log
CRD   Print Case Review Comments (By Date/Facility)
OTL   Outlier Report
RNK   Reasons Not Completed Report

Select Case Management Reports Option:

```

Figure 4-15: Case Management Reports Menu

4.2.1 Inpatient Log (ILOG)

The Inpatient Log lists patients who are currently receiving inpatient treatment at outside facilities to which they were referred. To be included on this list, the patient's referral must meet the following criteria:

- It is an inpatient referral
- The beginning date of service is today's date or earlier
- The actual end date of service is blank, today's date, or later than today's date
- The status of the referral is active

You may elect to sort the output by the facility to which the patient was referred, case manager, or patient name. You have the option of printing a separate page for each category. A detailed report or a summary report can be printed. A sample of the detailed report is shown in Figure 4-16. The summary report prints only the patient's name, health record number, date of birth, facility referred to, provider, admit date, and purpose of referral for each patient.

The report may be printed or reviewed on the screen. Note that if you select the summary report, it should be printed on a printer capable of producing condensed print. The sample report in Figure 4-16 is a detailed report that lists patients by the facility to which they were referred.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
                                UNSPECIFIED HOSP
                                INPATIENT REFERRAL LOG
                                Page 1
-----
FACILITY REFERRED TO:  <UNKNOWN>

Name:          PATIENT,AVONNELLE   HRN: WE7461   DOB: Mar 12, 1913 92 YRS
Tribe:         AKUTAN NATIVE VILLAG3RD Party Elig:MEDICARE  MEDICARE
Case Man:      BUGGS, BUNNY        Nxt Rev Dt:
Referral #:    1135100500123      Ref Phy:
Facility:      AMERICAN COLLEGE OF Provider:
Adm Date:      09/20/05 E          LOS: 7 E      LOS to date: 31
Purpose:       emergency OB patient
Dx:            OBSTETERICAL CARE
Srv Cat:       EVALUATION AND/OR MANAGEMENT
-----
Name:          PATIENT,CAROL E     HRN: WE776   DOB: Jan 16, 1972 29 YRS
Tribe:         UNSPECIFIED PIMA    3RD Party Elig: PRVT INS
Case Man:      NRD:
Referral #:    1135100500567      Ref Phy:
Facility:      <UNKNOWN>          Provider:
Adm Date:      11/12/97 (E)       LOS: 5 (E)   LOS to date: 1477
Purpose:       PYSCHIATRIC EVALUATION
Dx:            292.11 - DRUG PARANOID STATE
Srv Cat:       EVALUATION AND/OR MANAGEMENT
-----

```

Figure 4-16: Inpatient Log (sample report)

4.2.2 Area Hospital Discharges (AHDC)

This discharge report prints a list of discharged patients by the ending date of service for all inpatient referrals. You will enter a beginning and ending date of discharge for the report and then select the detailed or summary report. The detailed report, shown below, prints a separate page for each referral and includes any discharge comments that have been entered. The summary report prints a continuous list with the same information as the detailed report except the discharge comments are excluded.

Note: The summary report should only be printed on a printer capable of producing condensed print.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
                UNSPECIFIED HOSP
Page 1
                **AREA HOSPITAL DISCHARGES BY DATE**
Pt Name/Purpose      Rec #      Age      Referral #      Community      Fac. Ref
To
-----
---
BIRD, TWEETY          WE91001      36 YRS  1135100400018  SANDIA          ST JOSEPH
WEST
KNEE SUGERY          Admit Dt:   09/30/04 (A)-Disch Dt: 10/01/04 A LOS: 1 A
Discharge Comments: 11/30/04 By: MARTINEZ, BERTHA
                PATIENT DISCHARGED ON 10/01/04 @ 10:30AM..BBM

```

Figure 4-17: Area Hospital Discharges (sample report)

4.2.3 Outpatient Referral Log (OLOG)

This report prints a list of patients who are currently referred for outpatient services at an outside referral facility. Only those referrals for which services are not yet complete are included. For a referral to be considered currently referred, it must meet the following criteria:

- It is an outpatient referral
- The actual or estimated beginning date is today or earlier
- The actual end date of service is blank, today's date, or later than today's date
- The status of the referral is active

You may sort the report by the facility to which the patient was referred, case manager, or patient name. If desired, each sort category can be printed on a separate page. The sample report in Figure 4-18 lists patients by case manager.

```

***** CONFIDENTIAL PATIENT INFORMATION ***** Referral Summary (TLOG) Page
1
Report Run Date: Oct 26, 2005 3:17:58 pm
-----
Name: SIMPSON,BART D          7/4/1928 77 YRS 777777777 Ref:5056109900088
AKA'S: SMITH,BART
Tribe: OSAGE TRIBE OF OKLAH Tribal #: < ? > HOMINY
#: 44444 #: 44444
Referred To: <UNKNOWN>           Attending:
Referred By: SMITH,PHIL M. M.D.
Case Manager:
Beg DOS: 1/8/99   Date Discharge Consult Rec'd:
Purpose: OV
Primary Payor: MEDICARE
Case Review Comments: 1/11/1999 By: JACKSON,FONDA C.
TEST
1/11/1999 By: JACKSON,FONDA C.
REFERRAL

Name: LEWIS,JERRY LEE        12/10/1974 31 YRS 444334444 Ref:5059010300089
Tribe: CHEROKEE NATION Tribal #: < ? > BARNSDALL
#: 33333 #: 33333

Enter RETURN to continue or '^' to exit:

```

Figure 4-18: Outpatient Referral Log (sample report)

4.2.4 List of High Cost Users (HCU)

The HCU report option lists all patients who have incurred costs from referrals that exceed the amount you specify during a selected time period. This report includes the number of referrals that each of these patients has received and the total cost of service for those referrals during the time period. You will be prompted to specify a beginning and ending referral date range. Then you will enter a minimum dollar amount for the cost of services. Any patient whose total service costs equal or exceed the amount you have specified will be considered a high-cost patient and will be included in the report.

You may choose to evaluate patients based on IHS cost or total cost of care. In cases where actual costs are available, those costs will be reported. If actual costs are unavailable, the estimated costs entered will be used. You may print the output or browse it on the screen.

The sample report in Figure 4-19 lists patients whose IHS costs for referred services are equal to or greater than \$1,000.

*****CONFIDENTIAL PATIENT INFORMATION*****					
UNSPECIFIED CLINIC					
Page 1					
HIGH COST USERS- using IHS COST					
PATIENT NAME	HRN	DOB	SEX	# REFS	TOTAL COST
PATIENT, ANDY	SE999926	01/03/89	F	2	\$4,000.00
PATIENT, DEE	SE999572	02/27/63	F	1	\$10,000.00
PATIENT, JENNIFER	SE999044	04/19/31	F	9	\$2,000.00
PATIENT, LORI ANN	SE999907	06/21/57	F	1	\$2,000.00
PATIENT, HANNAH	SE999150	01/03/23	F	2	\$2,000.00
PATIENT, MEGAN	SE999117	03/18/52	F	6	\$6,000.00
PATIENT, DON	SE999041	03/05/41	F	13	\$20,400.00
PATIENT, ABE	SE999770	05/24/86	M	11	\$8,499.00
PATIENT, DOREEN	SE999321	01/01/21	F	7	\$8,900.00
RUN TIME (H.M.S): 0.0.0					
End of report. HIT RETURN:					

Figure 4-19: List of High Cost Users (sample report)

4.2.5 Potential High Cost Cases (HCTX)

The HCTX report lists patients who potentially have a high cost of care. Taxonomy of potentially high-cost diagnoses and procedures in the RCIS determines which patients appear in this report. Since no taxonomy can accurately identify all cases that are going to incur high costs, many of the cases in the report will not result in high costs.

You will enter beginning and ending referral dates that indicate when the referrals were initiated. You may print the output or browse it on the screen.

Note: This report is not available to facilities that do not enter full diagnosis coding for referrals.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
                                UNSPECIFIED CLINIC
                                POTENTIAL HIGH COST CASES - BASED ON DIAGNOSIS
                                Page 1
-----
BEGIN D.O.S. ST  HRN      PATIENT NAME      REF
                                PROV   TYPE  FACILITY REFERRED TO
-----
10/10/01 (A) A   PAH99970  PATIENT,BETSY      ML   CHS   UNSPECIFIED CLINIC

Purpose:  PATIENT HAS FAMILY HISTORY OF HEART DISEASE.
Dx:       996.01 - MALFUNC CARDIAC PACEMAKE
          250.00 - DM UNCOMPL/T-II/NIDDM,NS UNCON
Srv Cat:  EVALUATION AND/OR MANAGEMENT

CLASSIFICATION/BENEFICIARY IS: INDIAN/ALASKA NATIVE
ELIGIBILITY STATUS IS: CHS & DIRECT
NO THIRD PARTY COVERAGE RECORDED
-----

05/22/01 (A) C1  PAH99910  PATIENT,B.J.      MD1  CHS   A O ORTHOPEDIC SPECI
Purpose:  FAMILY HX OF RHEUMATROID ARTHRITIS.  DFJA;LDSF SDFJA;LFJD
          SDJA;JDA
Dx:       996.02 - MALFUNC PROSTH HRT VALVE
          996.01 - MALFUNC CARDIAC PACEMAKE
Proc:     27447 - TOTAL KNEE REPLACEMENT

CLASSIFICATION/BENEFICIARY IS: INDIAN/ALASKA NATIVE
ELIGIBILITY STATUS IS: DIRECT ONLY
PATIENT HAS MEDICARE
PATIENT HAS MEDICAID-PLAN NAME: UNKNOWN
PATIENT HAS INSURANCE-INSURER: UNSPECIFIED OKLAHOMA INC

ADDITIONAL REGISTRATION INFORMATION:
SUBMITTED TPQY CARD 12-1-92
-----

RUN TIME (H.M.S): 0.0.3
End of report. HIT RETURN:
    
```

Figure 4-20: Potential High Cost Cases (sample report)

4.2.6 Timeliness of Receiving Disch/Consult Summary (TDL)

The TDL report tabulates the timeliness with which discharge letters are received from facilities to which patients have been referred. The report includes the total number of referrals to each outside provider and the number of discharge summaries received within the date range you specify. This report also tabulates the number of discharge summaries/letters received within 1 month of discharge, within 2-3 months, within 4-6 months, and more than 6 months.

You will enter a beginning and ending date range for the referral activity. You may print the report or browse the output on the screen.

UNSPECIFIED CLINIC										Page 1
TIMELINESS OF RECEIPT OF DISCHARGE LETTERS										
BY REFERRAL FACILITY										
REFERRAL INITIATED DATE RANGE: Nov 29, 2000 to Nov 29, 2001										
*any referral with an ending service date of less than 31 days ago is excluded.										
REFERRAL FACILITY	TOTAL	NOT YET		RECEIVED WITH (#MONTHS)						
	REFS	RECD*		<1	1-3		4-6		>6	
	N	N	N	%	N	%	N	%	N	%
A O ORTHOPEDIC SPECIALI	3	3	0	0	0	0	0	0	0	0
BROWN, JAMES MD	2	2	0	0	0	0	0	0	0	0
UNSPECIFIED PODIATRIST P	1	0	1	100	0	0	0	0	0	0
GOOD SAM MED CTR/RADIOL	1	1	0	0	0	0	0	0	0	0
GOOD SAMARITAN TRAUMA S	1	1	0	0	0	0	0	0	0	0
UNSPECIFIED MEDICAL	1	1	0	0	0	0	0	0	0	0

RUN TIME (H.M.S): 0.0.0
End of report. HIT RETURN:

Figure 4-21: Timeliness of Receipt of Discharge Letters (sample report)

4.2.7 Patients for Whom Discharge/Consult Summary Not Received (DCNR)

This report lists all referrals for which a discharge letter or consultation summary has not been received. All referral records (with or without an actual end date of service) with no discharge letter/consultation summary received are included in the report.

You will be prompted to specify the amount of time considered overdue for the discharge report. Enter the time in number of days. You can sort the report by the facility to which the patient was referred or by the amount of time that the discharge letter/consult summary is overdue. The user will also be prompted to select a specific IHS Facility on which to report. The output may be printed or browsed on the screen.

The sample report in Figure 4-22 lists the referral by the facility to which the patient was referred.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
                                UNSPECIFIED HOSP
                                REFERRALS FOR WHICH MEDICAL/COST DATA HAS NOT BEEN RECEIVED
                                Page 1
REF DATE   PATIENT NAME           HRN       PROV   FACILITY REF TO   BEG DOS.
-----
FACILITY REFERRED TO:   UNSPECIFIED MDS

5/18/1999  PATIENT,GERTRUDE           PAH999968   ML     UNSPECIFIED MDS
Ending Date of Service: UNKNOWN           Time Lapsed: UNKNOWN
Case Manager:
ICD Diagnosis Category:  CARDIOVASCULAR DISORDERS
CPT Service Category:   EVALUATION AND/OR MANAGEMENT

FACILITY REFERRED TO:   UNSPECIFIED LABORATORY
5/5/1998   PATIENT,CONSTANCE           PAH9997     AA     UNSPECIFIED 5/5/1998 (A)
Ending Date of Service: May 05, 1998      Time Lapsed: 3 YRS
Case Manager: DOCTOR,ONE
ICD Diagnosis Category:  CEREBROVASCULAR DISRDRERS
CPT Service Category:   DIAGNOSTIC IMAGING

FACILITY REFERRED TO:   UNSPECIFIED LABORATORIES

9/29/1999  PATIENT,KATHERINE           PAH9998     ML     UNSPECIFIED 9/29/1999 (E)
Ending Date of Service: Oct 29, 1999      Time Lapsed: 25 MOS
Case Manager:
ICD Diagnosis Category:  MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS
CPT Service Category:   OPERATIONS/SURGERY

RUN TIME (H.M.S): 0.0.0
End of report.  HIT RETURN:

```

Figure 4-22: Patients for Which Medical/Cost Data Has Not Been Received (sample report)

4.2.8 Transfer Log (TLOG)

This report lists detailed information for patients who are currently receiving treatment at outside referral facilities. To be included in this report, the referral must meet the following criteria:

- It is an inpatient referral
- The beginning date of service is today or earlier
- The expected end date of service is blank, or on or after today's date
- The status of the referral is active

The TLOG report prints a one to two page detailed summary record display for each referral. The TLOG report displays the specific IHS Facility in the header and allows for sorting output by either vendor or patient. You may print the report or browse the output on the screen.


```

***** CONFIDENTIAL PATIENT INFORMATION ***** Referral Summary (TLOG) Page 1
RCIS RUN SITE: PINE POINT HEALTH STATION
Report Run Date: Oct 21, 2005 9:39:41 am
-----
Name: PATIENT,JUSTIN      6/01/1965 40 YRS 888884576   Ref #:5555555550005
Tribe: JEMEZ PUEBLO, NM  Tribal #: <?> JEMEZ PUEBLO
WE#: 92200
Referred To: GARY L. PROVIDER, M.D.      Attending: BILL PROVIDER
Referred By: PROVIDER,FRANCES M
Beg DOS: 9/30/04   Est LOS: 2   LOS to Date: 386
Purpose: CHEST PAIN
Primary Payor: IHS
Business Office Notes: 2/24/05 By: MARTINEZ,BERTHA
      Test
2/24/05 By: MARTINEZ,BERTHA
      BMM

***** CONFIDENTIAL PATIENT INFORMATION ***** Referral Summary (TLOG) Page 2
RCIS RUN SITE: UNSPECIFIED SERVICE UNIT
Report Run Date: Oct 20, 2005 5:31:15 pm
-----
Name: PATIENT,BLUES      7/09/1984 21 YRS 501444500   Ref #:5555555550001
AKA'S: PATIENT, LUCILLE M
Tribe: INDIAN NON-TRIBAL ME  Tribal #: < ? > NORTH DAKOTA UNK
WE#: 15400
Referred To: ALBUQUERQUE AMBULANCE EMS      Attending:
Referred By: PROVIDER,PAUL
Beg DOS: 9/19/05   Est LOS: 1   LOS to Date: 32
Purpose: transportation to hospital
Primary Payor: IHS
Case Manager: BUGGS, BUNNY

```

Figure 4-23: Transfer Log (sample report)

4.2.9 Print Case Review Comments (By Date/Facility) (CRD)

This report allows you to enter a specified date range and print all case review comments entered for the review(s) at a single facility within that given date range. It is very useful when entering Managed Care Committee meeting minutes for that day and all action and decisions made on these referrals. The report can also be printed for a specific Case Reviewer for a specific date range. In-house referrals are not included in this report.

To print case review comments, follow these steps:

1. Type **CRD** at the Administrative Report Menu.
2. Type the name of the facility from which to print the report at the “Enter Facility Name:” prompt.
3. Type **Y** or **N** at the “Would you like to Restrict Report to a particular Case Reviewer?” prompt. If you typed **N**, continue to step 5. If you typed **Y**, you will first be prompted for the Case Reviewer’s name.

4. Type the case reviewer's name at the "Case Reviewer:" prompt.
5. Type the start date at the "Enter beginning Case Review Date:" prompt.
6. Type the end date at the "Enter ending Case Review Date:" prompt.
7. Type **P** (print) or **B** (browse) at the "Do you wish to:" prompt. If you typed **P**, your report will print on the default printer. If you typed **B**, your report will appear on the screen.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
                                UNSPECIFIED HOSP
Page1                               DEC 11, 2001
                                **CASE REVIEW COMMENTS BY DATE**
-----
PATIENT,CHARLENE                PAH999990   DOB: Jul 06, 1986   15 YRS 5555551103
Referral #: 6999999100053        Date Referral Initiated: 03/27/01
  SEC A1 06/07/2005 DOS 06/07/2005 TEST OF ILOG          BETHANY MEDICAL
CLINIC
CASE REVIEW DATE: MAR 01, 2001    CASE REVIEWER: PROVIDER,ADAM
CASE REVIEW COMMENTS:
  The Committee met and we are going to pay for these services.
  The patient is doing well in hospital today.
-----
PATIENT,CHARLENE                PAH999990   DOB: Jul 06, 1986   15 YRS 5555551103
Referral #: 6999999900265        Date Referral Initiated: 05/23/01

CASE REVIEW DATE: MAY 23, 20      CASE REVIEWER: MGR,EIGHTEEN
CASE REVIEW COMMENTS:
  ELDERLY WOMAN WITH PROLAPSED UTERUS AND LONG STANDING PROBLEM
  WITH BLADDER INCONTINENCE.
-----
RUN TIME (H.M.S): 0.0.0

```

Figure 4-24 Print Case Review Comments (sample report)

4.2.10 Outlier Report (OTL)

The Outlier Report generates a list of inpatients who have been hospitalized at facilities to which they were referred for a longer period of time than their estimated length of stay. The report includes any referral that meets the following criteria:

- It is an inpatient referral
- The referral has a date of admission of today or earlier
- The actual discharge date is blank
- The status of the referral is active
- The actual length of stay to date is greater than the estimated length of stay

You may choose to sort the report by the facility to which the patient was referred, case manager, or patient name. The output may be printed or browsed on the screen.

Note: If the estimated length of stay for a referral has not been entered into the database, the referral will not display on this report.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
                                UNSPECIFIED HOSP
                                OUTLIER REPORT
                                ICD-9CM  ADM DATE  ACTUAL LOS  OUTLIER
-----
PATIENT NAME:  PATIENT,JOANN
1122  PREVENTIVE HEALTH CARE          02/11/00 (E)  657      655
Purpose: INPATIENT SPECIALTY AT IHS FAC.

      REVIEWED  BY  CASE REVIEW COMMENTS          3RD PARTY:  PRVT  ELIG: C
      -----
                <No comments on file.>

PATIENT NAME:  PATIENT,JAMES WILSON
653214  DM UNCOMPL/T-II/NIDDM,NS U  250.00  11/12/97 (E)  1478      1471
        BENIGN HYPERTENSION          401.1
Purpose: CANCER OF LIVER

      REVIEWED  BY  CASE REVIEW COMMENTS          3RD PARTY:  0    ELIG: C
      -----
                <No comments on file.>

PATIENT NAME:  PATIENT,CONSTANCE
10584  NORMAL DELIVERY                650.    05/23/01 (E)  4        2
Purpose: LABOR & DELIVERY

      REVIEWED  BY  CASE REVIEW COMMENTS          3RD PARTY:  MCD  ELIG: C
      -----
                <No comments on file.>

RUN TIME (H.M.S): 0.0.3
End of report.  HIT RETURN:
    
```

Figure 4-25: Outlier Report (sample report)

4.2.11 Reasons Not Completed Report (RNK)

The Reasons Not Completed option creates a listing of referrals that have not been completed for a given date range. The user is asked to select a specific reason not completed or list all reasons completed. This report is useful for printing a concise list of referrals that have not been completed. The user is prompted for a specified date range and asked whether a particular reason not completed is desired.

To print the Reasons Not Completed report, follow these steps:

1. Type **RNK** at the Case Management menu.
2. Type the date you wish to start the date range with at the “Enter beginning Referral Initiation Date:” prompt.

3. Type the date you wish to end the date range with at the “Enter ending Referral Initiation Date:” prompt.
4. Type **Y** or **N** at the “Would you like to INCLUDE ONLY a particular Reason NOT Completed? NO//” prompt.
5. Type the name of the device on which you wish to print/browse the report at the “DEVICE:” prompt.

RCIS-REASON NOT COMPLETED		OCT 21, 2005 13:59		PAGE 1
DT				
INITIATED REFERRAL #	PATIENT	PRI	STATUS/REASON	

09/14/05	1135110100114	PATIENT, CATHERINE	I	CLOSED-NOT COMPLETED OTHER
09/22/05	1135110100225	PATIENT, MARGARET M	II	CLOSED-NOT COMPLETED OTHER

Figure 4-26: Reasons Not Completed (sample report)

4.3 Utilization Reports (UTIL)

Utilization reports provide a means for tracking the number of referrals initiated and the costs associated with those referrals. This information is presented by provider or facility for identifying the source of high referral rates and costs.

```

*****
*                INDIAN HEALTH SERVICE                *
*   REFERRED CARE INFORMATION SYSTEM                   *
*   VERSION 4.0, Oct 20, 2005                          *
*****
                UNSPECIFIED HOSP
                Utilization Reports

RFP  Referral Patterns by Provider or Facility
CHSC CHS Referral Costs By Requesting Prov/Facility
TTDX Top Ten Diagnosis Report
TTPX Top Ten Procedure Report

Select Utilization Reports Option:
    
```

Figure 4-27: Utilization Report Menu

4.3.1 Referral Patterns by Provider or Facility (RFP)

This report displays referral patterns for each provider at your facility or for your entire facility. The report tabulates the total number of referrals initiated, the total number of each type of referral, and the rate of referrals per 100 PCC visits. Secondary referrals will not be included in the count. Note that the rate of referral will

be included only if you are utilizing the PCC. Cancelled referrals are excluded from the report.

You will specify a date range during which the referrals were initiated. You may have the results reported by requesting provider or by requesting facility. The output may be printed or browsed on screen.

The sample report in Figure 4-28 shows referral patterns by the requesting provider.

***** CONFIDENTIAL PATIENT INFORMATION *****							
UNSPECIFIED HOSP							
REFERRAL PATTERNS BY REQUESTING PROVIDER							
PROVIDER	REFS INITIATED	IHS REFS	OTHER REFS	CHS REFS	# PCC VISITS	TOTAL REF PER 100	RATE PCC VISITS
PROVIDER, ADAM	10	1	1	8	27		37
PROVIDER, LYDIA	1			1	0		
PROVIDER, USER	1			1	0		
PROVIDER, GARY	1			1	0		
PROVIDER, TEST	5			5	0		
PROVIDER, BRIAN R	11	1		10	569		2
PROVIDER, CONTRACT	4			4	0		
PROVIDER, MARY	61		2	59	0		
PROVIDER, JACK	1			1	0		
RUN TIME (H.M.S.): 0.0.9							
End of report. HIT RETURN:							

Figure 4-28: Referral Patterns by Provider or Facility (sample report)

4.3.2 CHS Referral Costs by Requesting Provider/Facility (CHSC)

The CHSC report displays CHS referral costs by requesting provider or referring facility. The report will include the total number of referrals, total number of CHS referrals, total cost of CHS referrals, number of PCC visits, and CHS referral cost per 100 PCC visits. Note that the number of PCC visits and the referral cost per 100 PCC visits will be included only if you are utilizing the PCC interface. Cancelled referrals are excluded from this report.

You will enter a beginning and ending referral date range and indicate whether the data is to be reported by requesting provider or requesting facility. You will also elect to include either actual CHS costs or best available CHS costs. If you select actual costs, be aware that the costs are only those known to date. As subsequent bills are received and paid, the cost figures will increase. The best available CHS costs are based upon actual costs incurred plus estimated figures. The output may be printed or browsed on the screen.

The sample report in Figure 4-29 lists the best available CHS referral costs by requesting provider.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
                                UNSPECIFIED HOSP
                                Page 1

CHS REFERRAL COSTS** BY REQUESTING PROVIDER
PROVIDER          # REFS      # CHS   TOTAL CHS   # PCC   CHS REF COST
                   INITIATED  REFS   REF COST   VISITS  PER 100 PCC VISITS
-----
PROVIDER,ADAM      10           8     $2,150      27       7963
PROVIDER,LYDIA     1            1     $2,500       0
PROVIDER,USER      1            1         $0         0
PROVIDER,GARY      1            1         $0         0
PROVIDER,TEST      5            5    $755,000     0
PROVIDER,BRIAN R   11           10    $23,100     569       4060
PROVIDER,CONTRACT  4            4       $500        0
PROVIDER,MARY     61           59    $23,819     0
PROVIDER,JACK      1            1         $0         0

** These costs are based on best available data (actual or estimates).
Actual completed costs may vary from this.

RUN TIME (H.M.S): 0.0.2
End of report. HIT RETURN:

```

Figure 4-29: CHS Referral Costs by Requesting Provider (sample report)

4.3.3 Top Ten Diagnosis Report (TTDX)

This report displays the top ten to top 100 ICD-9 Diagnosis Codes and APC Diagnostic Groupings for referrals for a given date range. The report allows for screening on all items in the General Retrieval Search screen. For instance, you can find the top ten diagnoses for a specific Vendor, community, Tribe, IHS Referral Physician, etc.

To print or view the top ten diagnosis report, follow these steps:

1. Type **TTDX** at the Utilization Report menu.
2. Type the start date at the "Enter beginning Referral Date:" prompt.
3. Type the end date at the "Enter ending Referral Date:" prompt.
4. Type the number of the items to see on the report at the "How many entries do you want in the list:" prompt. For example, if you want a top 10 list, type **10**. If you want a top 50 list, type **50**.
5. Select the referral screening item(s) you wish to use from the General Retrieval screen(s). Referrals can be screened based upon any of the listed items. Select as many as you wish, in any order or combination. An asterisk (*) indicates items already selected. To bypass screens and select all referrals, type **Q**.

6. Type **P** (Primary Diagnosis of Referral) or **A** (All diagnoses of Referral) at the “Report should include:” prompt. If you type **P**, the report will only include primary diagnoses. If you type **A**, the report will include all primary and secondary diagnoses.
7. Type **L** (List of items with counts) or **B** (Bar Graph) at the “Select Type of Output:” prompt. If you type **B**, you must have a printer capable of printing 132-character lines.
8. Type the name of the device you wish to print to at the “Device:” prompt.

```

***** RCIS FREQUENCY OF DIAGNOSES REPORT *****
No. REFERRALS: 77   No. DXs: 89           DX/REFERRAL ratio: 1.16 (min. std.
> 1.6)

TOP 10 DX's =>
 1. 650.   NORMAL DELIVERY (21)
 2. 696.1  OTHER PSORIASIS (13)
 3. 250.00 DM UNCOMPL/T-II/NIDDM,NS UNCON (10)
 4. 311.   DEPRESSIVE DISORDER NEC (10)
 5. 996.01 MALFUNC CARDIAC PACEMAKE (4)
 6. V58.1  CHEMOTHERAPY (4)
 7. 618.3  UTEROVAG PROLAPS-COMPLET (3)
 8. V76.1  SCREEN MAL NEOP-BREAST (3)
 9. V07.39 PROPHYLACTIC CHEMOTHERAPY,NEC (3)
10. 401.9  HYPERTENSION NOS (2)

TOP 10 DIAGNOSTIC CATEGORIES =>
 1. PREGNANCY,CHLDBRTH,PUERPERIUM (21)
 2. SKIN,BREAST,SUBCUTANEOUS T (15)
 3. MENTAL DISEASES & DISORDERS (11)
 4. ENDOCRINE,NUTRIT,METABOLIC (10)
 5. CIRCULATORY SYSTEM (9)
 6. HEALTH STATUS FACTORS (9)
 7. FEMALE REPRODUCTIVE SYSTEM (4)
 8. MYELOPROLIFERATIVE,NEOPLASIA (4)
 9. MUSCULOSKELETAL & CONNECTIVE T (2)
10. EYE (1)

RUN TIME (H.M.S): 0.0.1
End of report. HIT RETURN:

```

Figure 4-30: Top Ten Dx (sample report)

4.3.4 Top Ten Procedure Report (TTPX)

The Top Ten Procedure Report displays the top ten to top 100 CPT Procedure Codes for referrals for a given date range. The report allows for screening on all items listed in the General Retrieval Search Screen. For instance, you can find the top ten procedures for a specific Vendor, community, Tribe, IHS Referral Physician, etc.

To print/view the top ten procedure report, follow these steps:

1. Type **TTPX** at the Utilization Report menu.

2. Type the start date at the “Enter beginning Referral Date:” prompt.
3. Type the end date at the “Enter ending Referral Date:” prompt.
4. Type the number of the items to see on the report at the “How many entries do you want in the list:” prompt. For example, if you want a top ten list, type **10**. If you want a top 50 list, type **50**.
5. Select the referral screening item(s) you wish to use from the General Retrieval screen(s). Referrals can be screened by any of the listed items. Select as many as you wish, in any order or combination. An asterisk (*) indicates items already selected. To bypass screens and select all referrals, type **Q**.
6. Type the name of the device you wish to print to at the “Device:” prompt.

```

***** FREQUENCY OF RCIS PROCEDURES REPORT *****
No. REFERRALS: 76   No. PRCs: 77           PRC/REFERRAL ratio: 1.01 (min.
std. > 1.
6)

TOP 10 PRC's =>
1. 00955 ANALGESIA, VAGINAL DELIVERY (20)
2. 27447 TOTAL KNEE REPLACEMENT (20)
3. 10060 DRAINAGE OF SKIN ABSCESS (17)
4. 56420 DRAINAGE OF GLAND ABSCESS (4)
5. 19100 BX BREAST PERCUT W/O IMAGE (3)
6. 76091 MAMMOGRAM, BOTH BREASTS (3)
7. 00103 ANESTH, BLEPHAROPLASTY (1)
8. 19120 REMOVAL OF BREAST LESION (1)
9. 19272 EXTENSIVE CHEST WALL SURGERY (1)
10. 33322 REPAIR MAJOR BLOOD VESSEL(S) (1)

RUN TIME (H.M.S): 0.0.1
End of report. HIT RETURN:

```

Figure 4-31: Top Ten Procedures (sample report)

4.4 RCIS General Retrieval (GEN)

The RCIS General Retrieval is a very flexible report option that lists and/or counts patient referrals. This report option enables you to select which patients to include in the report, which data items to print, and how the data is sorted. Depending on the choices you make, you can generate a very specific report or a very general report. You may also save the logic used to produce the report for future use.

If you design a report that is 80 characters or fewer in width, it can be displayed on your screen or printed. If your report is 81-132 characters wide, it must be printed and can only be printed on a printer capable of producing 132 character lines. Each report includes a cover page that details the user-defined criteria.

To begin generating a report using the General Retrieval option, you will need to indicate whether you are creating a new report or using logic that you saved from a previous report. You will select one of the following:

- P A Previously Defined Report
- N Create a New Report

If you are using a previously defined report, you will first be prompted for the name of the report. Enter the name of the report and the system will first prompt you with the option to change the name of the report, then you can select to print or browse the output.

If you are creating a new report, you will be presented with a referral selection menu. You will be prompted to select the type of referrals to be included in the report:

- P Primary Referrals
- S Secondary Referrals
- B Both

After you enter the *referral type*, you will reach the *Referral Selection Menu*. Type a plus sign (+) and a dash (–) at the “Select Action:” prompt to review the selection items in the list. When you are ready to select items, press the Return key at the prompt to accept Select Items as the default value or type **S**. You can select patient referrals based on any combination of the data items in the list. Enter a list or a range of numbers at the next prompt; for example, 1-4, 5, 20 or 10, 12, 20, 30. Then you will be prompted to define values for the items you chose, as applicable. For instance, if you selected age, you would be prompted to enter an age range.

After you have selected and defined referral selection items, you will be returned to the referral selection item list. The items that you selected will be marked with an asterisk (*). You can add or remove items at this point, if needed, by typing **S** or **R**. If you are finished marking your selections, type **Q** to leave this screen and continue creating your report.

Next you will need to choose a report output. The following five output formats are available:

- Total Count Only
- Sub-counts and Total Count
- Detailed Referral Listing
- Numeric Item Basic Statistics
- Referral Record Display

Total Count Only

This format displays only the counts for the information you select from the referral. For example, if you only select the date a referral was initiated for a particular time frame, this format will only give you the number of referrals initiated in that time frame.

Sub-counts and Total Count

This format displays subtotals for all the search criteria you select in a report and the total referral counts found.

Detailed Referral Listing

This format displays more detailed information for the referrals you select. Once you have selected the search criteria for the referrals you want, you will be prompted to select the information from those referrals that you want to print. Version 4 includes a new option for “Call-In’s.” The system will also prompt you to select the field widths for the printed report. Then you will be prompted to select one of the selection criteria on which to sort the report. A summary of the all the selections you have made will display before the report prints.

Numeric Item Basic Statistics

This format will provide basic statistics (sum, count, mean, maximum, minimum) on any one of the “Numeric Items” listed below. Upon selection of a “Numeric Item” a list of “Sort” Choices will also be displayed. This *Sort* Choice is provided for the purpose of Totaling and/or Sub-totaling all records selected.

Numeric Item Selection Menu:

- 1 Age
- 2 Actual Total Cost
- 3 Best Avail Total Cost
- 4 Actual IHS Cost
- 5 Best Avail IHS Cost
- 6 CHS Amt Auth to Date
- 8 CHS FI Total to Date
- 9 Best Avail Inpt LOS
- 10 Actual Inpt LOS

For example, choosing “Actual Cost” as the Numeric Item and, then, choosing Primary Vendor as the “Sort” Choice would produce a report of Actual Cost statistics (Sub-totaled by Vendor). If you choose *not* to select a “Sort” Item, the report would

produce only one Grand Total (sum, count, mean, max, and min, etc.) for all “Actual Cost” statistics.

Referral Record Display

This format will display the entire referral for all of the referrals that meet the search criteria you select. You can print the referral listing to a specific device or view it onscreen.

4.5 Delete General Retrieval Report Definition (DGR)

This option on the Reports menu allows you to delete any report types that have been saved using the General Retrieval Report Generation tool. It is recommended that you delete saved report types that are no longer used.

As shown in Figure 4-32, you will be prompted to enter the name of the saved report type and then confirm the deletion. Remember that once a report type has been deleted, it can no longer be retrieved. A confirmation message appears after the report has been deleted.

```
This option enables the user to delete an RCIS General Retrieval report
definition.
REPORT NAME: CKC TEST REPORT PATIENT,CHRISTINE-SEP 11,1997@10:18:45
Are you sure you want to delete the CKC TEST REPORT report definition? N// YES
Report Definition PATIENT,CHRISTINE- SEP 11,1997@10:18:45 deleted.
```

Figure 4-32: Delete General Retrieval Report Definition

5.0 RCIS Management (MGT)

The RCIS system provides functions that allow each facility to customize options to meet its needs. For example, each facility can set the system parameters as needed, create local procedure categories, develop referral templates for frequently initiated referrals, and specify Managed Care Committee actions. These options are available on the RCIS Management Menu

```

Select Referred Care Information System Option: MGT RCIS Management

*****
*                INDIAN HEALTH SERVICE                *
*   REFERRED CARE INFORMATION SYSTEM                   *
*   VERSION 4.0, Oct 20, 2005                          *
*****
                UNSPECIFIED SERVICE UNIT
                RCIS Management

ESP   Edit Site Parameters
TAB   Table and Template Updates ...
EMAL  Manage Mail Menu ...
DISP  Print Parameters and Tables ...
RMM   Referral Management Menu ...

Select RCIS Management Option:).

```

Figure 5-1: RCIS management menu

Access to the Management Module menu options requires the manager's security key. This section of the manual describes each of the RCIS Management menu options in detail and provides instructions on using them.

Note: Before using the system for the first time, the Site Manager or Referred Care Coordinator will need to set the initial parameters. These parameters can be changed at a later time, if needed. See section 5.1 for instructions on setting the site parameters.

5.1 Edit Site Parameters (ESP)

You can use the Edit Site Parameters option to customize the RCIS at your facility. This option allows you to elect whether to use various options and to specify the default value for others. This option is also used for designating the type of IHS MailMan messages that are generated for each referral, if any, and to whom they will be sent.

Upon selecting the Edit Site Parameters option, you will be prompted to enter the name of your facility. The entry screen for customizing the parameters displays.

Figure 5-2 shows the entry screen used to customize the RCIS parameters. Each of the parameters that may be set at your facility is described below along with details on the responses to be entered.

```

UPDATE REFERRED CARE INFORMATION SYSTEM (RCIS) PARAMETERS
*****
REFERRAL YEAR: 04 STATE:
ACTIVATE CHS LINK? YES ACTIVATE PCC LINK? YES
PROMPT FOR MGED CARE COM ACTION? YES PROMPT FOR LOCAL CATEGORIES? ASK
PROMPT FOR ICD AND CPT CODES? YES SSN LETTER DISPLAY:
ENTER YOUR SITE'S 'OTHER' LOCATION: UNSPECIFIED ADMINISTRATION
DEFAULT CASE MANAGER:
CHS SUPERVISOR: STAFF,ART
BUSINESS OFFICE SUPERVISOR: STAFF,ART
REFERRAL FACILITY ADDRESS (return):
REFERRAL CONTACT NAME: STA,A
REFERRAL CONTACT PHONE: (999) 999-9999 THIRD PARTY SIGNATURE:
RCIS ACTIVATION DATE: MAY 15,1999 BENEFITS COORDINATOR:
BULLETIN/MESSAGE PARAMETERS (return): UNIVERSAL OR SITE SPEC. LOOKUP: U
REQUIRE PRIORITY ENTRY ON ALL REFERRALS? YES MCC ACTION HS DISPLAY:
PRESS RETURN TO ENTER HELP TEXT THAT WILL APPEAR WHEN ENTERING PRIORITY:
PRESS RETURN TO EDIT SITE-SPECIFIC REFERRAL LETTER TEXT:
    
```

Figure 5-2: Edit site parameters

Referral Year: Type into this field the last two digits of the referral processing year (i.e. enter 05 for 2005). The referral processing year may be the fiscal year or the calendar year. All assigned referral numbers include the two digits of the corresponding referral year.

State: Type the name of the state in which your facility resides.

CHS Interface: If you are using the CHS package at your facility, you can link it to work in conjunction with the RCIS. This interface allows the CHS office to enter information in the RCIS referral records and to close records after services have been received. Activating this link will eliminate redundant data entry at your facility. Information that is entered on the Referral will default during the data entry of POs and Denials. Data is then passed back to the referral during PO payment and during the entry of the Denial data. Note that the link affects CHS referrals only. Type **Y** to use the interface, or **N** if your site does not use the CHS, or if you do not want to use the interface. If you entered *yes* a pop up screen will appear. If you require a referral for every PO, you should answer **yes** to the Require a Referral on All POs prompt.

The Denial will close the outpatient referral if this parameter is set to *yes*. The Denial will never close an inpatient referral, due to follow-up reasons with the visit.

```

Require a Referral on All CHS PO's? NO
CHS Denial will close outpatient referrals? NO
    
```

Figure 5-3: CHS Interface parameters

PCC Interface: If the PCC is used at your facility, you have the option of linking the RCIS with the PCC. To enable this interface, type **Y**. Type **N** if your site does not use the PCC or if you do not want to enable the interface. Data passes from the RCIS to the PCC and creates a PCC Visit only after a referral is closed. Data for open referrals is also passed to the PCC and available for retrieval and display on the Health Summary, but a PCC Visit is not created for the referral until it is closed.

ICD/CPT Coding: This field controls whether the system will prompt for ICD and CPT codes during the referral data entry process. Type **Y** to enable the prompts or **N** if you do not want ICD and CPT codes entered into the system for referrals.

If you respond **Y**, the following pop-up box will appear, prompting you to specify whether you want to automatically stuff the uncoded ICD9 and CPT codes. Responding **Y** to this subsequent prompt means that the user is prompted only for the narrative and the code field is stuffed with the unspecified code (.9999 for diagnoses and 0999 for procedures). A data entry or medical records staff person will add the correct codes at a later date based upon the provider narrative that has been entered. Responding **N** will prompt the user for both the code and the narrative.

```
Enter Yes if you wish to automatically stuff
UNCODED ICD9 & CPT Codes.
** User will be prompted for Provider Narrative Only **

STUFF ICD/CPT CODES: N
```

Figure 5-4: ICD/CPT coding field

Local Category: Your response in this field indicates whether the system prompts for local site categories during the referral data entry process, and if so, whether the response is required. Select one of the following options:

Do Not Ask — the system does not prompt for local categories

Ask but Optional — the system prompts for local categories, but the response is optional

Ask and Required — the system prompts for local categories and the response is required

If you select 1 or 2, you must define the local categories using the Add/Edit Local Category option (LC) on the RCIS Management menu. (See section 5.2.1 for instructions).

Managed Care Committee Action: This field allows you to specify whether Managed Care Committee Actions are entered into the database. These actions are

developed locally to meet the needs of your site. Type **Y** to utilize this field or **N** if you do not want to record this information.

Other Location: This field contains the entry in the Location file to be used by the PCC link for the Location of Encounter for all outside referrals. This entry should point to the generic location *Other* for your local Service Unit.

Default Case Manager: You can use this field to enter a particular Case Manager whose name will appear as the default for Case Manager during the referral data entry process. If you have only one or a primary Case Manager who handles referrals at your facility, entering the Case Manager's name in this field helps minimize data entry. You may leave this field blank and no default name will display at the Case Manager prompt.

CHS Supervisor: Enter in this field the name of the CHS staff member responsible for reviewing CHS referrals. The CHS Supervisor named in the field receives a mail bulletin if the CPT category and CPT procedure codes entered for a referral are not logically consistent.

Business Office Supervisor: This field contains the name of the Business Office staff member responsible for reviewing referrals. The Business Office Supervisor named in this field receives a mail bulletin if the CPT category and CPT procedure codes entered for a referral are not logically consistent.

Referral Facility Address (return): This is the mailing address that will print on the referral letters. It will default to the location file, so address is not required.

```
***** Referring Facility *****  
  
MAILING ADDRESS-STREET:  
MAILING ADDRESS-CITY:  
MAILING ADDRESS-STATE:  
MAILING ADDRESS-ZIP CODE:
```

Figure 5-5: Mailing address information

Referral Contact Name: The name entered into this field is printed on all referral forms as the contact person for any inquiries that referred providers might have about the referral. This entry is required.

Referral Contact Phone: Type the phone number of the referral contact person. This number will appear on all of the printed referral forms. It is a required entry and must be 13-15 characters in length (e.g., (520) 295-2533).

A pop-up screen containing the mailing address of your facility appears after you have entered the phone number for the referral contact person. A sample screen is shown below. Verify that your site's mailing address is correct. If it is incorrect, contact your site manager who can make the necessary corrections.

```

** Contact Site Manager to Change Address- If incorrect **
Mailing Address-Street: PO Box 555
Mailing Address- City: ANYTOWN
Mailing Address- State: ARIZONA
Mailing Address- Zip: 88888

```

Figure 5-6: Facility mailing address

RCIS Activation Date: Type the date that the RCIS “went live,” or started processing actual patient data. Do not use the date on which the RCIS was installed at your site. Once the RCIS has been active for 6 months (i.e. 6 months after the activation date); referral numbers will be required on all CHS Purchase Orders. When entering the activation date, you may omit the exact day (e.g., July 2005).

Universal/Site-Specific Lookup: This field specifies how the system looks up patients in the database. Type **U** for universal lookup, or **S** for site-specific lookup. For multi-facility sites, the universal lookup will display a list of patients regardless of the HRN prefix. The site-specific lookup will display only those patients who have an HRN with the prefix of your site. For example, if a user at the San Xavier (SX) clinic entered John Smith as the patient, the site-specific lookup would display all patients named John Smith who had a record at the San Xavier clinic.

MailMan Alerts: *Feature has been disabled and will be removed in the next version. This option has been replaced by send MailMan feature.* When certain types of referrals have been initiated and entered into the system, you are prompted whether you want to send an alert to a particular mail group. You may elect whether to use these alerts and which ones to use. Four mail groups are already included in the system to which these bulletins are sent; however, you must specify who is included in each one. The referral types and their corresponding mail groups are listed below.

Referral Type	Mail Group Name
IHS	BMC IHS Alert
OTHER	BMC Other Alert
CHS	BMC CHS Alert
In-House	MBC In-House Alert

In addition, you may activate mail bulletins for the following special referrals. These bulletins are available only if you are entering ICD-9 Diagnosis and CPT Procedure Codes at your facility.

High-Cost Diagnosis: sent when a diagnosis previously classified as “high cost” is entered in a patient’s referral record

High-Cost Procedure: sent when a procedure previously classified as “high cost” is entered in a patient’s referral record

Cosmetic Procedure: sent when a cosmetic procedure is entered in a patient’s referral record

Experimental Procedure: sent when a procedure previously classified as “experimental” is entered in a patient’s referral record.

Third Party Liability: sent when a diagnosis that indicates a third party may be liable for patient care is entered in a patient’s referral record (e.g., auto accident).

You will need to specify which individuals will receive the mail bulletins pertaining to each of the special referral categories listed above.

To define or edit the mail bulletin parameters, press the Return key at the Update Bulletin Parameters prompt on the *Edit Site Parameters* screen, as indicated. A pop-up screen will display for entering mail bulletin data (see Figure 5-7).

```

+-----+
+
+          *****  UPDATE BULLETIN RELATED RCIS SITE PARAMETERS  *****
+
+
+          Referral Type
+
+ SEND BULLETIN ON CHS REFERRALS?  YES
+ SEND BULLETIN ON IHS REFERRALS?
+ SEND BULLETIN ON OTHER REFERRAL TYPE?
+ SEND BULLETIN ON IH-HOUSE REFERRALS?
+
+ Hit return at each item below to ADD/EDIT/DELETE users who should
+ receive each bulletin type.
+
+ HIGH COST DIAGNOSIS BULLETIN:          EXPERIMENTAL PROCEDURE BULLETIN:
+ HIGH COST PROCEDURE BULLETIN:          THIRD PARTY LIABILITY BULLETIN:
+ COSMETIC PROCEDURE BULLETIN:
+
+-----+
+

```

Figure 5-7: Update Bulletin Related Parameters

The first four prompts on the pop-up screen allow you to specify whether you want mail bulletins sent for each of the referral types (CHS, IHS, Other, In-house). Type **Y** at the prompt for each mail bulletin desired and type **N** at the prompt for each mail bulletin type you do not want sent. Remember that you will need to define the membership for each mail group. To do so, contact your Site Manager.

To use the mail bulletins for special referrals listed at the bottom of the Update Bulletin pop-up screen, press the Return key at the designated prompt to see another pop-up screen that allows you to specify this information. The following pop-up screen is for the High-Cost Diagnosis bulletins. All of the pop-up screens for the special bulletin types are similar to this one and function identically.

```

** UPDATE USERS WHO RECEIVE HIGH COST DIAGNOSIS BULLETIN **
|
| Person to Receive Bulletin          Receive for Referral Types
|
| PROVIDER,SUSAN                     CI
| PROVIDER,DON                       I
| PROVIDER,ANTHONY                   CION
| PROVIDER,DIANA                     CIN
|
    
```

Figure 5-8: Mail Bulletins (sample pop-up screen)

On the left side of this screen, type the name of the person to receive the bulletin. Then, to the right of each person’s name, enter the following codes to indicate the specific referral types for which mail bulletins will be sent:

C	CHS	O	Other
I	IHS	N	In-House

For instance, in the example above, Susan Smith will receive bulletins on high-cost diagnoses for CHS and IHS referrals only. Don Martin will receive bulletins on high-cost diagnoses for IHS referrals only. You may enter up to 4 codes for each person.

Message Parameters: These parameters control the display to request a message during Adding a Referral. The mail group can be added through the Add/Edit the Groups receiving bulletins option under the Management Menu, but only mail groups that start with BMC will be displayed. If they are set to *Yes*, then the following prompts will appear:

```

A Message has NOT been sent for this referral.
Do you wish to send a message? Y// ES
  1. BMC CHS ALERT
  2. BMC IHS ALERT
To select recipient group(s) enter a list or range of numbers: (1-2): 1
***MESSAGE SENT***
Enter RETURN to continue or '^' to exit:
    
```

Figure 5-9: Message parameters

Site Parameter Screen:

```

***** UPDATE BULLETIN/MESSAGE RELATED RCIS SITE PARAMETERS***** |
|           WHEN ADDING A NEW REFERRAL
| PROMPT TO SEND MESSAGE FOR CHS REFERRALS?  YES
| PROMPT TO SEND MESSAGE FOR IHS REFERRALS?  YES
| PROMPT TO SEND MESSAGE FOR OTHER REFERRAL TYPE?  YES
| PROMPT TO SEND MESSAGE FOR IN-HOUSE REFERRALS?  YES
|
| Note: Option below are not active and will be removed in next version.
| Hit return at each item below to ADD/EDIT/DELETE users who should
| receive each bulletin type.
|
| HIGH COST DIAGNOSIS BULLETIN:                EXPERIMENTAL PROCEDURE BULLETIN:
| HIGH COST PROCEDURE BULLETIN:                THIRD PARTY LIABILITY BULLETIN:
| COSMETIC PROCEDURE BULLETIN:

```

Figure 5-10: Site parameters screen

Require Priority Entry: Type **Y** or **N** in this field to indicate whether a priority ranking will be required for each referral record entered into the system. The priority ranking system is required for each CHS referral, regardless of your choice for this parameter. If you type **N**, the system will prompt the user for a priority ranking for CHS Referrals only.

Help for Priority System: The RCIS package contains the standard CHS priority rating system. The Help for Priority System field can be used for creating local priority definitions to be used instead of the standard rating system at your facility. The definitions that you create will then be displayed as a help screen if a user types a question mark at the priority ranking prompt during the data entry process.

To define a local priority-ranking system, press the Return key at the prompt. A pop-up word-processing screen will appear. Type the new priority categories.

```

COMMAND:                                     Press <PF1>H for help
Insert

1>
2>

EDIT option:

```

Figure 5-11: Define a local priority-ranking system (sample pop-up screen)

Site-Specific Referral Text: You can customize the referral text to print for CHS and Other referral types. Text for CHS letters can be specific to the approval status as well. Press the **Return** key at the prompt to display the following pop-up screen, then press the Return key at the specific letter for which you want to enter or edit text.

```

PRESS RETURN TO EDIT CHS APPROVED TEXT:
PRESS RETURN TO EDIT CHS DENIED TEXT:
PRESS RETURN TO EDIT CHS PENDING OR UNKNOWN TEXT:
PRESS RETURN TO EDIT OTHER REFERRAL TEXT:

```

Figure 5-12: Site-Specific Referral Letter Text (sample pop-up screen)

After you have selected the specific letter for customizing text, the following word-processing screen appears. Enter the specific text you want to appear on the referral letter, as shown in Figure 5-13.

```

COMMAND:                                     Press <PF1>H for help
Insert

1>This is site-specific text for SELLS where the CHS has authorized
payment for this referral.
2>
3>

EDIT option:

```

Figure 5-13: Customizing Referral Letter Text (sample pop-up screen)

5.2 Table and Template Updates (TAB)

```

Select RCIS Management Option: TAB  Table and Template Updates

*****
*                INDIAN HEALTH SERVICE                *
*      REFERRED CARE INFORMATION SYSTEM      *
*                VERSION 4.0, Oct 20, 2005          *
*****
                UNSPECIFIED SERVICE UNIT
                Table and Template Updates

LC      Add/Edit Local Category
ASP     Add Specific Provider
EAR     Add/Edit Alternate Resource
LUV     Add/Edit Local Utilization Review By MD Codes
MCC     Add/Edit Local Managed Care Committee Action
AERR    Add/Edit Routine Referral Template Form
DRR     Delete Routine Referral Template Form

Select Table and Template Updates Option:

```

Figure 5-14: Unspecified Service Unit table and template updates menu

5.2.1 Add/Edit Local Category (LC)

If you are entering local CPT procedure categories at your facility, you will need to define the categories to be used. The Add/Edit Local Category option on the RCIS Management menu allows for the creation and modification of these categories.

To add a new category, enter the name of the category at the first prompt. The name may be 3-30 characters in length and must not be numeric or begin with punctuation. At the "Name:" prompt, press the **Return** key to add the new category name. If you

have accidentally mistyped the category name, type the correct name at this prompt and press the Return key.

Next you have the option of selecting a mnemonic for the category. Selecting a mnemonic for each category facilitates the data entry process by reducing the number of keystrokes required for entry. The mnemonic you select may be 1 to 3 characters long. For ease of use, it should be a logical abbreviation of the category. The following sample shows the addition of a new category. User responses and instructions are in bold type.

```
Select RCIS LOCAL SERVICE CATEGORY NAME: X-RAY
Are you adding 'X-RAY' as
a new RCIS LOCAL SERVICE CATEGORY (the 6th)? Y

NAME: X-RAY// [Press the Return key to accept the default or type a new
name]
Mnemonic: XR
```

Figure 5-15: Add Local Category

You can also use this option to modify already existing local categories; for instance, you may want to rename a category or select a new mnemonic. The process is very similar to creating a new category. First, select the category you want to edit. Then enter the new name at the Name prompt that appears next. Finally, enter a new mnemonic or press return to keep the previous one. The former name and mnemonic for the category will be replaced with your new entries. A sample of this process is show below.

```
Select RCIS LOCAL SERVICE CATEGORY NAME: X-RAY
NAME: X-RAY// RADIOLOGY
MNEMONIC: X1// RD
```

Figure 5-16: Edit Local Category

5.2.2 Add Specific Provider (ASP)

Specific providers can be added with the Add Specific Provider option on the RCIS Management menu. When adding the specific providers with this option, a mnemonic can be assigned to each to speed the selection of the provider during the data entry process. An example of adding a new provider is shown below.

```
Select RCIS SPECIFIC PROVIDER NAME: MARTIN,ROBERT
Are you adding 'Martin,Robert' as
a new RCIS SPECIFIC PROVIDER (the 16th)? YES
RCIS SPECIFIC PROVIDER MNEMONIC: RM
MNEMONIC: RM// [RET]
```

Figure 5-17: Add Specific Provider

Note that the specific providers can also be added during the data entry process.

5.2.3 Add/Edit Alternate Resource (EAR)

This Table File entry is used when printing Alternate Resource letters. The user can only select an Alternate Resource entry that resides in this table file. These entries include third party alternate resources such as Medicaid, Medicare, and State/Federal programs.

To add/edit an alternate resource for use in the Alternate Resource letters, follow these steps:

1. Type **EAR** at the *MGT* menu.
2. Type the name of the Alternate Resource that you wish to add/edit at the “Select RCIS Alternate Resource Name:” prompt. You will be presented with a “Name: AlternateResourceName//” prompt. If the entry is restricted, a (No Editing) message will appear after the two slashes (//) and the “Select RCIS Alternate Resource Name:” prompt will reappear (Figure 5-18). If you are adding a new alternate resource entry, the “Are you adding “AlternateResourceName” as a new RCIS Alternate Resource (the #TH)? No//” prompt will appear before allowing you to edit the entry name (Figure 5-18).

```

*****
*                INDIAN HEALTH SERVICE                *
*          REFERRED CARE INFORMATION SYSTEM          *
*                VERSION 4.0, Oct 20, 2005          *
*****
                UNSPECIFIED HOSP
                Add/Edit Alternate Resource

Select RCIS ALTERNATE RESOURCE NAME: STATE MEDICAID
NAME: STATE MEDICAID//      (No Editing)

Select RCIS ALTERNATE RESOURCE NAME: KIDSCARE
  Are you adding 'KIDSCARE' as a new RCIS ALTERNATE RESOURCE (the 7TH)?
No// Y
    (Yes)
NAME: KIDSCARE//      (No Editing)

Select RCIS ALTERNATE RESOURCE NAME:

```

Figure 5-38: Add/edit alternate resource

5.2.4 Add/Edit Local Utilization Review by MD Codes (LUV)

If your facility will be entering codes for utilization reviews by physicians, these codes must be predefined prior to entry. The Add/Edit Local Utilization Review by MD Codes option allows your site to enter the codes that will be used locally. The codes

that you define must be 3 to 30 characters in length and may not be numeric or begin with punctuation.

The following sample dialog shows how to add a new code. If you are editing a code, you will select the code first and then enter the new text that you want to replace the previous code. This process is the same as creating and editing other local categories in the RCIS.

```
Select RCIS LOCAL UTIL REV BY MD CODES ACTION: APPROVED

Are you adding 'APPROVED' as a new RCIS LOCAL UTIL REV BY MD CODES (the
2nd)? YES

ACTION: APPROVED// [RET]
```

Figure 5-49: Add/Edit Local Utilization Review by MD Codes

5.2.5 Add/Edit Local Managed Care Committee Action (MCC)

This option allows for the creation of site-specific Managed Care Committee actions. Before entering any Managed Care Committee decisions into patients' referral records, the decision codes must be defined for your facility. After these actions have been defined and entered into the RCIS, they may be added to referral records as needed to track Managed Care Committee decisions regarding referred care.

Action items developed by the Managed Care Committee may consist of text or numeric codes. There are no restrictions on the format of the actions and as many actions as needed may be entered in the RCIS. For instance, one facility developed the following actions based upon the decisions typically made by the Managed Care Committees:

- Deferred Service
- Hold, To Be Determined
- Schedule as Requested
- Schedule at San Xavier Clinic

To enter a Managed Care Committee action into the system, select the Add/Edit Managed Care Committee action on the RCIS Management menu (MCC). You will be prompted to type an action item. Your response must be 3 to 30 characters in length. The next prompt allows you to add the action item or return to the previous prompt. Respond **Y** to add the item or **N** to return to the previous prompt.

```
Select RCIS MANAGED CARE COMM ACTION ITEM: HOLD, TO BE DETERMINED
Are you adding 'HOLD, TO BE DETERMINED' as
a new RCIS MANAGED CARE COMM ACTION (the 3rd)? YES
```

Figure 5-20: Add/Edit Local Managed Care Committee Action

Continue adding Managed Care Committee action items in this manner until finished.

5.2.6 Add/Edit Routine Referral Template Form (AERR)

As mentioned in the data entry section of this manual, you can create routine referral templates for your site. Routine referral templates are typically created for the most common referrals initiated at your facility. These templates minimize the amount of data entry required by providing default values for many of the fields on the data entry screen. The default values are used whenever one of the routine referrals is generated. Referral templates allow for faster and easier data entry into the system and printed referral forms can be quickly prepared and sent with the patient to the referred provider.

To create a routine referral template, select the *Add/Edit Routine Referral Template Form* on the RCIS Management menu. You will be prompted to enter a name for the routine referral. The name may be 3 to 30 characters in length. You will then be asked if you want to create a new template with the name you entered. If you want to change the name, type **N** and you will be returned to the first prompt. Type **Y** to add the template and continue.

```
Enter NAME of Routine Referral: ROUTINE X-RAY
Are you adding 'ROUTINE X-RAY' as
A new RCIS ROUTINE REFERRAL DEF (the 8th)? Y
```

Figure 5-21: Add/Edit Routine Referral Template Form

Next, the following screen will display for entering the template default data. Remember that the data you enter will appear each time the referral form is selected for data entry. Enter data into each of the fields, as needed, in the same way that you enter data for a new referral. The only pop-up screen that appears is for the CPT Service Category screen that allows you to enter local categories if they are used at your facility. For more detailed instructions on entering data and descriptions of each field, see section 3.2.1.


```

UPDATE ROUTINE REFERRAL INFORMATION
*****
NAME OF ROUTINE REFERRAL: ROUTINE X-RAY
REQUESTING FACILITY: UNSPECIFIED HOSP
      TYPE of REFERRAL:                PRIMARY PAYOR:

Refer To - CHS Referrals:  PRIMARY VENDOR:
           IHS Referrals:   IHS FACILITY:
           Any Referral:    OTHER PROVIDER:

INPT/OUTPT:      INPT-EST LOS:          OUTPT # OF VISITS:
EST. COST:       EST. IHS COST:        PRIORITY:

      PURPOSE OF REFERRAL:
      ICD DIAGNOSTIC CATEGORY:
      CPT SERVICE CATEGORY:
      PROVISIONAL DRG:

```

Figure 5-22: Update Routine Referral Information

After you have entered data on the data entry screen and have saved the changes, you will be prompted for entering ICD-9 Diagnosis codes and CPT Service Category codes that will be the default codes used when this custom referral is selected. Note that these prompts will appear only if the ICD/CPT site parameter has been set to *Yes*. You may enter codes or bypass the prompts by pressing the Return key.

Once you have finished adding the template, it will now appear on the list of referral types you can select from when using the *Add Referral* option on the Data Entry menu.

```

Please select the referral form you wish to use.
  1. Mini Referral
  2. Complete Referral (all referral data)
  3. Call In Notification by outside facility
  4. Abbreviated entry for clinicians

Locally-defined Routine Referral Templates:
  4. Routine mammogram
  5. Routine prenatal care
  6. Routine x-ray
  7. Dental Visit

```

Figure 5-23: Referral types (added template sample)

When adding a new referral, selecting the referral template that you created will then display the data entry screen with all of the default values that were specified during the template creation process. If using the following sample template, for instance, the person entering data will need to add information only in the fields without default information. In this case, the appointment date and time would be entered as well as any other information needed in the optional fields, such as pertinent medical history and lab data or Business Office comments. The person entering data may change any of the default data, if needed.

```

                                RCIS REFERRAL RECORD
DATE: JUN 25, 1996 NUMBER: 5555555000509 PATIENT: PATIENT, ROBERT
-----
REQUESTING FACILITY: UNSPECIFIED HOSPITAL/CLINI   Display Face Sheet? N
REFERRAL TYPE: CHS FACILITY                       PRIMARY PAYOR: IHS
INPATIENT/OUTPATIENT: OUTPATIENT                 CASE MANAGER: PROVIDER,DON
ACTUAL APPT/ADM DATE&TIME:

PROVISIONAL DRG:
ESTIMATED COSE: 50                               ESTIMATED IHS COST: 50

PURPOSE/ SERVICES REQUESTED: X-RAY
ARE YOU SENDING ADDITIONAL MEDICAL INFORMATION WITH THE PATIENT?
BUSINESS OFFICE/CHS COMMENTS:
ICD DIAGNOSTIC CATEGORY:
CPT PROCEDURE CATEGORY:

```

Figure 5-24: Customized Referral Form (sample)

5.2.7 Delete Routine Referral Template Form (DRR)

Routine referrals that have been entered into the system and are no longer used can be deleted with the Delete Routine Referral Template Form option on the RCIS Management menu. Select the menu option and enter the name of the template to be deleted. You will then be prompted to confirm the deletion. A message appears indicating that the template has been removed from the system. Remember that once a template is deleted, it can no longer be retrieved.

```

ROUTINE REFERRAL TEMPLATE NAME: PRENATAL
Are you sure you want to delete the PRENATAL Routine Referral? N// YES
Routine Referral PRENATAL deleted.

```

Figure 5-25: Delete Routine Referral Template

5.3 Manage Mail Menu (EMAL)

This option is used to create and manage mail groups within the RCIS system.

```
Select RCIS Management Option: EMAL Manage Mail Menu

*****
*                INDIAN HEALTH SERVICE                *
*   REFERRED CARE INFORMATION SYSTEM                   *
*   VERSION 4.0, Oct 20, 2005                          *
*****
                UNSPECIFIED SERVICE UNIT
                Manage Mail Menu

GRP   Add/Edit the Groups receiving bulletins
MRG   Purge Mail Messages

Select Manage Mail Menu Option:
```

Figure 5-26: Manage mail menu

5.3.1 Add/Edit the Groups Receiving Bulletins (GRP)

You can add and/or edit mail groups using this option. The fields that are required will be listed and discussed in this section. If you would like further descriptions of the other fields please refer to the MailMan section of the VA Kernel Manual.

Select the mail group you want to add/edit. In this case, the group name must begin with *BMC*. The system will prompt you to confirm your selection. You will then be prompted to select the members of the mail group. Type the names of the members you want to add or ?? to view a list from which to choose. However, the member must have an access code and a mailbox. The “Select Member:” prompt will display and you can select more members, or press the Return key to continue the add/edit mail group process. This field is also used to remove a person from the mail group with the delete key, “@”.

```

*****
*                INDIAN HEALTH SERVICE                *
*      REFERRED CARE INFORMATION SYSTEM      *
*                VERSION 4.0, Oct 20, 2005        *
*****
                UNSPECIFIED SERVICE UNIT
                Manage Mail Menu

GRP      Add/Edit the Groups receiving bulletins
MRG      Purge Mail Messages

Select Manage Mail Menu Option: GRP Add/Edit the Groups receiving
bulletins

        Group names must start with BMC!

Select MAIL GROUP NAME: BMCSAMPLE
Are you adding 'BMCSAMPLE' as a new MAIL GROUP? No// Y (Yes)
NAME: BMCSAMPLE// [RET]
Select MEMBER: STAFF,ADAM      AA
Are you adding 'STAFF,ADAM' as a new MEMBER (the 1ST for this MAIL
GROUP)? No// Y (Yes)
Select MEMBER:

```

Figure 5-57: Add/edit mail groups – creating/selecting a group

You will then be prompted to add the mail group description. This is an optional field, but is useful to describe the members of the mail group.

You will then be prompted to assign a type to the mail group. The type of mail group determines who can send mail to it. The two types of mail groups are *public* and *private*. Provided there are no Authorized Senders specified, anyone can send mail to a public group and only its members can send mail to a private group. If there are Authorized Senders specified, only those users can address the group. You should enter Public.

Next, you will be prompted to verify the group organizer. This field defaults to the person creating the group. An organizer can add new members to a private mail group. The system will now prompt you to select a group coordinator. This field is used as a screen when you try to edit a mail group for which you are a coordinator. If the screen fails and you do not hold the XMMGR key, you cannot edit the mail group. Even if the coordinator is removed from the Mail System, this field will remain to indicate who created the Mail Group and if others can use it. If it is a Personal Group, it will be deleted.

```

DESCRIPTION: (optional)
  No existing text
  Edit? NO// [RET]

TYPE: ??
  Choose from:
    PU      public
    PR      private
TYPE: PU public

ORGANIZER: USER,GRETA// [RET]
COORDINATOR: USER,GRETA      GU

```

Figure 5-68: Add/edit mail groups – mail group type

You can now enter a new Authorized Sender, if you wish. This option should not be used unless you want to restrict who can send a message to the group.

Warning: If a group has authorized senders, then remote users will not be able to send messages to it. Any messages sent by a remote user to a group with authorized senders will be rejected.

The system will now prompt you to select whether you want to allow self-enrollment. This field should be set to “No” because the messages will contain confidential patient information. Otherwise users may use the Join option to make themselves members of the group or to drop their names from the group. This option is only operative with public groups.

Now you are prompted to select a member group name. This is an optional field. It allows you to combine groups of users, such as a CHS group and a Managed care group. Instead of adding all of the members above you can list the groups and the message would be sent to both groups.

```

Select AUTHORIZED SENDER: (Optional)
ALLOW SELF ENROLLMENT?: No

Select MEMBER GROUP NAME: TEST
  Are you adding 'TEST' as a new MEMBER GROUPS (the 1ST for this MAIL
  GROUP)? No// Y (Yes)

Select MEMBER GROUP NAME: [RET]

```

Figure 5-79: Add/edit mail groups – member group name

The following prompts are optional and for additional information refer to the Mailman VA Kernel Manual. Most IHS systems do not have remote mail setup.

```
Select REMOTE MEMBER: [RET]
Select DISTRIBUTION LIST: [RET]
Select FAX RECIPIENT: [RET]
Select FAX GROUP: [RET]
Select MAIL GROUP NAME: [RET]
```

Figure 5-30: Add/edit the groups receiving bulletins

5.3.2 Purge Mail Messages (MRG)

This option will merge data from the RCIS Messages File. This file holds the date and group(s) messages were sent for a specific Referral. This will not remove the message from the Mail box.

Select the Purge Mail Messages option from the Manage Mail menu. Type in the beginning and end dates you want to purge the mail messages. The system prompts you to confirm your selection. The system will display a message stating how many messages were removed.

```
Select Manage Mail Menu Option: MRG Purge Mail Messages

Enter the beginning date for purging messages, earliest date: //
01/01/2002
Enter the ending date for purging messages: 12/31/2002

Message will be purged beginning with JAN 1,2002 THRU DEC 31,2002.

Enter Yes to continue, No to exit? N// Y YES
REMOVING ENTRIES
TOTAL REMOVED = 0
```

Figure 5-31: Purge mail messages

5.4 Print Parameters and Tables (DISP)

```

Select RCIS Management Option: DISP Print Parameters and Tables

*****
*                INDIAN HEALTH SERVICE                *
*      REFERRED CARE INFORMATION SYSTEM      *
*                VERSION 4.0, Oct 20, 2005        *
*****
                UNSPECIFIED SERVICE UNIT
                Print Parameters and Tables

DSP      Display Site Parameters
PLC      Print Local Categories Listing
PMC      Print MGD Care Committee Action Listing
PSP      Print Specific Provider Listing
PUR      Print Utilization Review/MD Listing

Select Print Parameters and Tables Option:

```

Figure 5-32: Print parameters tables

5.4.1 Display Site Parameters (DSP)

This option allows you to view the parameters that have been set for a facility. After selecting this option on the RCIS Management menu, you will specify the facility for which you want the parameters displayed, then enter a device for printing or viewing the parameters. Figure 5-33 shows the site parameters that have been set for the Sells Hospital/Clinic. Read the following section for descriptions of each parameter.

RCIS SITE PARAMETERS

FACILITY: UNSPECIFIED
 REFERRAL YEAR: 95
 PCC INTERFACE: YES
 CHS INTERFACE: NO
 REFERRAL #: 504
 ICD/CPT CODING: YES
 LOCAL CATEGORY: ASK BUT OPTIONAL
 OTHER LOC: UNSPECIFIED OTHER
 DEFAULT MGR: PROVIDER,DON
 CHS SUPERVISOR: STAFF,LORI ANN
 BUSINESS OFFICE SUPERVISOR: STAFF,TONI M
 CHS ALERT: YES
 REQUIRE PRIORITY RANK ON ALL: YES
 REFERRAL CONTACT NAME: JOHN STAFF
 REFERRAL CONTACT PHONE: (520) 555-2533
 STATE: ARIZONA
 IHS ALERT: YES
 OTHER ALERT: YES
 IN-HOUSE ALERT: YES
 RCIS ONLINE START DATE: JUN 11, 1996
 UNIVERSAL OR SITE SPEC. LOOKUP: UNIVERSAL
 MANAGED CARE COMMITTEE ACTION: YES

HELP PROMPT FOR PRIORITY SYSTEM:

LEVEL I. EMERGENT/ ACUTELY URGENT CARE SERVICES
 LEVEL II. PREVENTIVE CARE SERVICES
 LEVEL III. PRIMARY AND SECONDARY CARE SERVICES
 LEVEL IV. CHRONIC TERTIARY AND EXTENDED CARE SERVICES
 LEVEL V. EXCLUDED SERVICES

HIGH COST DIAGNOSES BULLETINS:

Person Receiving Bulletin: STAFF,LORI ANN Types: C
 Person Receiving Bulletin: STAFF,TONI M Types: CIO

HIGH COST PROCEDURES BULLETINS:

Person Receiving Bulletin: STAFF,DIANA Types: CION

COSMETIC PROCEDURE BULLETINS:

Person Receiving Bulletin: STAFF,DON Types: CION

EXPERIMENTAL PROCEDURE BULLETINS:

Person Receiving Bulletin: STAFF,LORI ANN Types: CIO
 Person Receiving Bulletin: STAFF,TONI M Types: CIO
 Person Receiving Bulletin: STAFF,DON Types: CN

THIRD PARTY LIABILITY BULLETINS:

Person Receiving Bulletin: STAFF,TONI M Types: CIO
 Person Receiving Bulletin: STAFF,LORI ANN Types: CIO
 Person Receiving Bulletin: STAFF,DON Types: C

CHS APPROVED TEXT:

The site-specific text for UNSPECIFIED where the CHS has authorized payment for the referral displays here.

CHS DENIED TEXT:

The site-specific text for UNSPECIFIED where the CHS has denied payment for the referral displays here.

CHS PENDING OR UNKNOWN TEXT:

The site-specific text for UNSPECIFIED where the CHS authorization status is pending or unknown displays here.

OTHER REFERRAL TEXT:

The site-specific text for UNSPECIFIED for non-CHS, non-IHS, and non-IHS in-house referrals displays here.

Figure 5-33: Display Site Parameters

5.4.2 Print Local Categories Listing (PLC)

A list of the local service categories developed at your site can be printed with this option. Select the PLC option from the management menu and the output device at the “Device:” prompt and the list will print/display. Below is a sample of the printed list.

RCIS LOCAL SERVICE CATEGORY LIST		SEP 3, 1997	09:30	PAGE 1
NAME	MNEMONIC			

AMBULANCE	AMB			
CAT SCAN	CS			
RADIOLOGY	RD			

Figure 5-34: Print Local Categories Listing

5.4.3 Print MGD Care Committee Action Listing (PMC)

A list of the managed care committee actions developed at your site can be printed with this option. Select the PMC option from the management menu and the output device at the “Device:” prompt and the list will print/display. A sample list is shown below.

RCIS MANAGED CARE COMM ACTION LIST		SEP 3, 1997	09:30	PAGE 1
ITEM	CODE			

APPROVED				
DENIED				
HOLD, TO BE DETERMINED				
SCHEDULE AS REQUESTED				

Figure 5-35: Print MGD Care Committee Action Listing

5.4.4 Print Specific Provider Listing (PSP)

A list of the specific providers and the corresponding mnemonics that have been entered at your site can be printed with this option. Select the PSP option from the management menu and the output device at the “Device:” prompt and the list will print/display. A sample is shown below.

RCIS SPECIFIC PROVIDER LIST NAME	SEP 3, 1997 MNEMONIC	09:30	PAGE 1

JOHNSON, ROBERT	RJ		
MARTIN, ROBERT	RM		
MEDLIN, JOHN	MED		

Figure 5-36 Print Specific Provider Listing

5.4.5 Print Utilization Review/MD Listing (PUR)

The site-specific utilization review decisions developed locally can be printed using the Print Utilization Review/MD Listing. Select the PUR option from the Management menu and the output device at the “Device:” prompt and the list will print/display. A sample list is displayed here.

RCIS LOCAL UTIL REV BY MD CODES LIST ACTION	SEP 3, 1997	09:30	PAGE 1

APPROVED			
REVIEWED/ NOT APPROVED			
REVIEWED/ PENDING			

Figure 5-37: Print Utilization Review/MD Listing

5.5 Referral Management Menu

Select RCIS Management Option: RMM Referral Management Menu

* INDIAN HEALTH SERVICE *
* REFERRED CARE INFORMATION SYSTEM *
* VERSION 4.0, Oct 20, 2005 *

UNSPECIFIED SERVICE UNIT
Referral Management Menu
BOCE Enter/Edit Business Office/CHS Comments Supervisor
DELR Delete Referral Entered in Error
CLO Close Out Referral - Current Fiscal Year
COR Close Out Referral - All Fiscal Years
ACLO Automatic Referral Closure***WARNING***
Select Referral Management Menu Option:

Figure 5-88: Referral management menu

5.5.1 Enter or Edit Business Office/CHS Comments (BOCE)

The Enter or Edit Business Office/CHS Comments is the only option that will allow the appropriate individual in the business or CHS office to edit or delete previously entered comments pertaining to the referral record.

```

Select Referral Management Menu Option: BOCE Enter/Edit Business
Office/CHS Comments Supervisor

*****
*                INDIAN HEALTH SERVICE                *
*   REFERRED CARE INFORMATION SYSTEM                   *
*   VERSION 4.0, Oct 20, 2005                          *
*****
                UNSPECIFIED SERVICE UNIT
Enter/Edit Business Office/CHS Comments Supervisor

Select RCIS REFERRAL by Patient or by Referral Date or #: PATIENT, MAGDALE

You may edit one of the existing Business Office Comment or add a new one

1) OCT 27, 2005          JACKSON, FONDA C.
   test for bo comments

Select one of the following:

E          EDIT one of the above Business Office Comment
A          ADD a new Business Office Comment
D          DELETE one of the above Business Office Comment
Q          QUIT

Do you wish to: A//

```

Figure 5-99: Enter/edit business office/CHS comments

5.5.2 Delete Referral Entered in Error (DELR)

This option is provided for deleting referrals that have been entered in error. Once a referral has been deleted, the entire referral record and related entries are not recoverable. If a referral is a CHS type and has been modified by the CHS office through the CHS system link, you will not be able to delete the referral record.

To delete a referral, select the Delete Referral Entered in Error option on the *Referral Management menu*. At the first prompt, select the referral record you want to delete by entering the patient's name, the referral date, or the referral number. The referral record you select will then be displayed on the screen for browsing so that you can verify that it is the record that you want to delete. After you have reviewed the record, type **Q** at the prompt to quit the browsing mode. You are then presented with the option of deleting the referral, as shown below. Type **Yes** to delete the referral record, or press the return key to accept the default value, **No**, and not delete the record.

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

Figure 5-40: Delete a referral entered in error

If the referral has been deleted from the system, a confirming message will appear on the screen. If the referral record you selected to delete is a CHS referral and has been modified by the CHS office, a message will appear indicating that the referral may not be deleted.

Select Referral Management Menu Option: **DELR** Delete Referral Entered in Error

Select RCIS REFERRAL by Patient or by Referral Date or #:
PATIENT,MAGDALENA 4-16-1996 0001019600046 PATIENT,MAGDALENA <UNKNOWN>
 04/20/96 A - 1 F/U HOSPITALIZATION

RCIS Referral Display Jun 14, 2004 14:04:16 Page: 4 of 4

User: LINCOLN,GRETA
 Patient Name: PATIENT,MAGDALENA
 +hart #: None

RCIS Referral Display Jun 17, 2004 08:49:15 Page: 1 of 4

User: USER,GRETA

Patient Name: PATIENT,MAGDALENA
 Chart #: None
 Date of Birth: AUG 07, 1986
 Sex: F

===== REFERRAL RECORD =====

DATE INITIATED: APR 16, 1996
 REFERRAL #: 555555500046
 PATIENT: PATIENT,MAGDALENA
 TYPE: CHS
 REQUESTING FACILITY: SHORT VISIT HEALTH STATION
 REQUESTING PROVIDER: GUEST,JIM
 FACILITY REFERRED TO (COM: <UNKNOWN>
 PRIMARY PAYOR: IHS
 ICD DIAGNOSTIC CATEGORY: RESPIRATORY DISORDERS
 CPT SERVICE CATEGORY: EVALUATION AND/OR MANAGEMENT
 INPATIENT OR OUTPATIENT: OUTPATIENT

DAYS SINCE BEGIN DOS: 2980
 STATUS OF REFERRAL: ACTIVE
 CREATED BY USER: USER,PAUL
 DATE CREATED: APR 16, 1996
 DATE LAST MODIFIED: APR 16, 1996
 PRIORITY: 5

PURPOSE OF REFERRAL: F/U HOSPITALIZATION

NOTES TO SCHEDULER:

ESTIMATED TOTAL REFERRAL : 500
 ESTIMATED IHS REFERRAL CO: 250
 ACTUAL APPT/BEGIN DOS: APR 20, 1996
 EXPECTED END DOS: APR 20, 1996
 OUTP NUMBER OF VISITS: 1
 CHS APPROVAL STATUS: APPROVED
 CHS APPROVAL/DENIAL DATE: MAY 08, 1996
 CHS AUTHORIZATION COUNT: -1
 UPDATED ESTIMATED IHS COS: -78
 CHS AMOUNT AUTHORIZED TO : -77
 CHS AUTHORIZATION DEC STA: STAFF,CAL
 CHS AUTHORIZATION DEC REV: MAY 31, 1996

ALTERNATE RESOURCE LETTER:

LOCAL CATEGORIES:

```
CHS AUTHORIZATIONS:
CHS APPROVAL STATUS AUDIT LOG:

===== Business/CHS Comments =====

DATE:                JUN 14, 2004
REVIEWER:            LINCOLN,GRETA

THE ABOVE REFERRAL AND RELATED ENTRIES WILL BE REMOVED FOREVER !!!
Sure you want to delete? No// Y (Yes)..

Referral Record Deleted - 73
```

Figure 5-41: Deleting a referral record

5.5.3 Close Out Referral – Current Fiscal Year (CLO)

Ultimately, all referrals will be closed, either automatically or manually. The only referrals that will be closed automatically are CHS referrals, provided that the link with the CHS is enabled. When all purchase orders in the CHS system referencing a CHS referral have been paid, the referral will be automatically closed. Also if the *auto close outpatient denials* parameter is turned on CHS denied referrals will be closed. If your site is not using the link with the CHS, you must close CHS referrals manually using the *Closing Out a Referral* menu option (CLO).

Referral types other than CHS must be closed manually after the referred care services have been provided. You may also need to manually close referrals of all types if they are deemed canceled or it is determined that all information that will be obtained has already been entered into the system.

The Close Out a Referral Option (CLO) on the RCIS Data Entry menu is used to manually close referrals from the RCIS that were created during the current fiscal year. For all referrals originating in another fiscal year, a separate option on the Supervisor's Utilities menu must be used. To close a referral, you will add the final data to the referral record, including:

- Diagnosis
- Procedures
- Costs
- Appointment/ Admission Dates
- Length of Stay/ Number of Visits

- Comments
- Status

Once a referral is closed, modification can be made to the referral record only with the Modify a Closed Referral option (see section 3.4.3 for instructions). You must have a security key to access this option.

To begin the process, select the Close Out Referral option from the Data Entry menu and indicate the file that you wish to close by entering the patient's name, referral date, or referral number at the "Select RCIS Referral by Patient or by Referral Date or #:" prompt. Type **Y** or **N** at the "Do you want to enter final values?" prompt. If you know that the final data has already been entered into the file, type **N** to continue. If you have not entered the final data, press the return key to accept the default value of Yes.

If you have opted to enter final values, you will be presented with the same selections that were available from the Modify Referral option. You will enter the final values the same way that you entered or edited data using the Modify Referral option. After you have entered the final referral data, press the Return key at the "Edit Which Data Type:" prompt to quit the selection list and continue the close out process.

```
Select RCIS REFERRAL by Patient or by Referral Date or #: Patient, Becky

Do you want to enter final values? Y// Y or N

Select one of the following:
0      QUIT
MINI MOD
ALL DATA
DATE/COUNTS
COSTS
ICD9 DIAGNOSIS
CPT PROCEDURES
CASE REVIEW COMMENTS
PURPOSE OF REFERRAL/MED HX/OTHER DIAGNOSTIC INFO
BUSINESS OFFICE NOTES
DISCHARGE NOTES
ADDITIONAL DOCUMENTATION

EDIT Which Data Type: 0// [Enter your selection here.]
```

Figure 5-42: Closing out a referral – entering final data

Whether or not you have chosen to enter final data, the next prompt will request the final status of the referral. Note that if you have entered final data, this prompt appears after you choose *Quit* from the Edit Data Type menu; otherwise, the prompt appears after choosing not to enter final data. At the status prompt, enter one of the following codes. Each category is described below:

- C1 - Closed- Completed
- X - Closed- Not Completed

Closed- Completed

If you know the referral was completed and you have all of the final data, select Closed- Completed. This is the default value for the prompt. In order to select this status, you must have entered data into all of the required fields. If data is missing in one or more of the required fields, you will be notified onscreen and asked if you want to enter the missing data. If you respond Yes, you will then be prompted to enter data in those incomplete fields only. To complete the closure, you will enter the date on which the referral was closed and the date on which the discharge summary or consultation letter was received. If no discharge summary or consultation letter has been received, you can press the Return key to bypass the prompt since this entry is optional.

The example in Figure 5-43 shows the process of entering data into the incomplete fields and closing the referral.

```
Enter Final Status: C1// C1 Closed-Completed
Required fields missing. Do you want to enter them? Y// Y
ACTUAL COST: 500
ACTUAL IHS COST: 350
ACTUAL END DOS: JUN 01, 1996
DATE CLOSED: JUN 20, 1996// [RET]
DATE DSCH SUMM/CONS LTR RCVD: JUN 15, 1996
```

Figure 5-43: Closing a referral – Closed-completed

Note: If you respond *No* at the Required Fields Missing message, the referral will not be closed and you will be returned to the Data Entry menu.

Closed- Not Completed

Select the Closed-Not Completed option if you know the referral was not completed. You will then be prompted to enter a reason why the referral was not completed. You must select an option from the following list:

- 5 Failed to Apply for Alternative Resources
- 6 Failed to Keep Appointment
- 7 Condition Resolved
- 8 Administrative Error
- 9 CHS Denial
- 10 Unknown
- 11 Need Additional Information
- 12 Other

If *Other* is selected, you will be prompted to enter notes regarding the referral. This however is optional. At your final prompt, enter the date on which the referral was closed to complete the closure.

If your facility is using the interface with the PCC, when a referral is designated as Closed-Completed the referral data pass to the PCC visit update module and are added to the PCC Visit, Diagnosis, Procedure, and Provider files. In turn, the PCC visit IEN is stored in the referral file. An example follows in figure 5-44.

```

*****
*                INDIAN HEALTH SERVICE                *
*      REFERRED CARE INFORMATION SYSTEM      *
*                VERSION 4.0, Oct 25, 2005        *
*****
                DEMO DATABASE
                Close Out Referral - Current Fiscal Year

Select RCIS REFERRAL by Patient or by Referral Date or #:   10-27-2005
                    5059010600017 BUNNY III,JACK                UNSPECIFIED
                                                10/27/05 E - 1        TEST

Do you want to enter final values? Y// NO
Enter Final Status: C1// ?
Choose from:
A          ACTIVE
C1         CLOSED-COMPLETED
X          CLOSED-NOT COMPLETED
Enter Final Status: C1// X  CLOSED-NOT COMPLETED
REASON NOT COMPLETED: ?
Choose from:
1          FAILED TO APPLY FOR ALTERNATIVE RESOURCES
2          FAILED TO KEEP APPOINTMENT
3          CONDITION RESOLVED
4          ADMINISTRATIVE ERROR
5          CHS DENIAL
6          UNKNOWN
7          NEED ADDITIONAL INFORMATION
8          OTHER
REASON NOT COMPLETED: O  OTHER
NOT COMPLETED NOTES:
No existing text
Edit? NO//

```

Figure 5-44: Closing a referral – Closed-Not Completed

5.5.4 Close Out Referral – All Fiscal Years (COR)

Referrals can be closed automatically through the link with the CHS package or manually with the CLO option on the *Data Entry menu*. However, to close referrals from previous fiscal years, you must use the *Close Out Referral* option. The closing process for referrals from previous fiscal years is identical to closing a referral in the current fiscal year. Please refer to the Closing Out a Referral section of this manual (section 5.5.3).

5.5.5 Automatic Referral Closure ***WARNING*** (ACLO)

This function allows the user to loop through and automatically close a selected group of old referrals. The user is prompted for the facility name, type of referral, inpatient or outpatient status, any exclusion of a specific local category, and selected date range. This option will close the referral with a close completed status.

```

Select Referral Management Menu Option: ACLO Automatic Referral
Closure***WARNING***

*****
*          INDIAN HEALTH SERVICE          *
*    REFERRED CARE INFORMATION SYSTEM    *
*          VERSION 4.0, Oct 20, 2005     *
*****
          UNSPECIFIED SERVICE UNIT
          Automatic Referral Closure***WARNING***

***** AUTOMATIC CLOSE OF REFERRALS *****

*****WARNING*****

This routine will LOOP through all referrals that were initiated in a date
range entered by the User --
*****AUTOMATIC CLOSURE OF REFERRAL*****
This Routine allows User to Select a specific INDIVIDUAL FACILITY Only!
This Routine also allows the User to EXCLUDE a particular Local Category
This Routine allows the User to Select INPATIENT or OUTPATIENT Referrals Only!
This Routine allows the User to Select TYPE of Referral (CHS,IHS,OTHER) Only!

Enter Facility Name: UNSPECIFIED SERVICE UNIT      HEADQUARTERS WEST      01
NM

      Select one of the following:

          C          CHS
          O          OTHER
          I          IHS

Enter Type of Referral:: CHS//[RET]

Would you like to EXCLUDE a particular Local Category in this report? NO//[RET]

      Select one of the following:

          I          INPATIENT
          O          OUTPATIENT

Select Inpatient or Outpatient: I// I INPATIENT

Enter beginning Referral Initiated Date: 010196 (JAN 01, 1996)

Enter ending Referral Initiation Date: (1/1/1996 - 12/31/2699): 123196 (DEC 31,
1996)
End of Auto Close of Referrals - Total Number of Referrals Closed = 0

```

Figure 5-45: Auto-closing referrals

6.0 RCIS Special Print Menu (SPEC)

```

Select Referred Care Information System Option: SPEC RCIS Special Print
Menu

*****
*                INDIAN HEALTH SERVICE                *
*    REFERRED CARE INFORMATION SYSTEM                *
*                VERSION 4.0, Oct 20, 2005            *
*****
                UNSPECIFIED SERVICE UNIT
                RCIS Special Print Menu

BOC    Enter Business Office/CHS Comments
DSP    Display Referral Record
PRS    Print Routing Slips
RPT    Print Reports ...

Select RCIS Special Print Menu Option:

```

Figure 6-1: RCIS special print menu

6.1 Enter Business Office/CHS Comments (BOC)

The Enter Business Office/CHS Comments option allows the appropriate individual in the Business or CHS Office to add comments pertaining to the referral record.

After selecting the Enter Business Office/CHS Comments option from the Data Entry main menu, you will be prompted to identify the referral for which you will be entering comments. You can select the referral by typing the patient's name, referral data, or referral number.

For more information, see section 3.4.4.

6.2 Display Referral Record (DSP)

The DSP option on the Data Entry menu is used to obtain a detailed display of a referral record. The information shown for each referral will differ depending on the type of referral, whether it is for an inpatient or outpatient visit, and the status of the referral (i.e. more data is likely to have been entered for a closed referral than for one that has just been initiated).

You will select the referral record by entering the patient's name, referral data, or referral number. This menu also provides an option that allows the display of a secondary referral. The referral record will then display on the screen (Figure 3-45).

For more information, see section 3.6.

6.3 Print Referral Letter (All Types of Letters) (PRF)

Once you have entered data for a referral, you will be able to generate a printed referral letter to send with the patient or forward to the referred provider.

The date the letter was printed, the user who printed it, and the type of letter disseminated are also stored with the other referral information. In addition, the General Retrieval Lister Items allow the retrieval of these specific elements.

You are prompted for the Contact Point, documentation needed for proof of identity, how the letter was delivered to that patient (and if certified mail, the mail certification number). This information (along with the user who printed the letter and the date printed) is stored with the Referral and is displayed under the *Display a Referral Menu* option.

A sample of the patient letter is provided in Figure 3-57. For more information, see section 3.10.2

6.4 Print Routing Slips (PRS)

Computer-generated routing slips for the referrals can be printed with the PRS option on the Data Entry menu. Basic referral visit information and patient identification data display at the top, followed by the facility to which the patient was referred. The additional documentation specified during data entry to be sent with the patient is marked with an *X* in the left hand column with the item name in the center column and a space to the right of each item for initials or signature.

A sample routing slip for a patient referral is shown in Figure 3-58. Refer to section 3.10.4 for additional details.

6.5 Print Reports (RPT)

The following menu displays the different report categories that are available to you. Each of the categories include a submenu of reports except the RCIS General Retrieval option and the Delete General Retrieval Report Definition option, which are used for creating and deleting customized reports.

```

Select RCIS Special Print Menu Option: RPT Print Reports

*****
*                INDIAN HEALTH SERVICE                *
*   REFERRED CARE INFORMATION SYSTEM                   *
*   VERSION 4.0, Oct 20, 2005                          *
*****
                UNSPECIFIED SERVICE UNIT
                Print Reports

ADM   Administrative Reports ...
CM    Case Management Reports ...
UTIL  Utilization Reports ...
GEN   RCIS General Retrieval
DGR   Delete General Retrieval Report Definition

Select Print Reports Option:

```

Figure 6-2: Print reports menu

6.5.1 Administrative Reports (ADM)

The Administrative Reports option provides a means for tracking active referrals, checking the status of CHS referrals, looking at the patterns of in-house referrals, and reviewing referrals for a particular time period.

For more information, see section 4.1.

6.5.1.1 Active Referrals by Date (ARD)

The ARD report lists all active referrals ordered by date. Active referrals are those that have not yet been closed.

For more information, see section 4.1.1. The sample report in Figure 4-3 lists referrals by beginning date of service.

6.5.1.2 Active Referrals by Referred To (ARR)

This report lists all active referrals by the provider to which the patient was referred.

For more information, see section 4.1.2.

6.5.1.3 Active Referrals by Requesting Provider (ARP)

This report will list all active referrals at your facility sorted by the requesting provider.

For more information, see section 4.1.3.

6.5.1.4 CHS Paid (CHPD)

This report lists all active CHS referrals for which one or more authorization have already been paid.

For more information, see section 4.1.5.

6.5.1.5 CHS Status Report for Active Referrals (CHSR)

This report prints out a list of all Active CHS referrals. You can select a date range by Date initiated, Status of Referral, and CHS status of Referral.

See section 4.1.6.

6.5.1.6 Tally of In-House Referrals by Clinic (INHC)

The INHC report provides a count of all in-house referrals by the clinic to which the patient was referred.

For more information, see section 4.1.7.

6.5.1.7 Tally of In-House Referrals by Requesting Provider (INHP)

This report displays a count of all in-house referrals by provider of service.

For more information, see section 4.1.8.

6.5.1.8 In-House Report for Active Referrals (INHR)

This report prints out a list of all active in-house referrals. You can select a date range in which to search for active referrals.

See section 4.1.9

6.5.1.9 Referrals at an Outside Facility (Call In's) (OUT)

The OUT report lists all referrals that were initiated at an outside facility.

For more information, see section 4.1.10.

6.5.1.10 Referral Review Report - By Time Period (RRR)

The Referral Review report (RRR) displays a list of referrals that were initiated within a specified time frame.

For more information, see section 4.1.11.

6.5.1.11 Referral Review Report - By Facility/Time Period (RRRF)

The Referral Review by Facility/Time Period report is the same as the Referral Review by Time Period report except that this report allows extraction of a specific IHS Facility. See section 4.1.11 for more information on the Referral Review reports.

6.5.1.12 Secondary Provider Workload (SWK)

This report prints a list of all Secondary Provider Letters initiated in a selected date range.

For more information, see section 4.1.13.

6.5.2 Case Management Reports (CM)

The Case Management Reports group included report options for reviewing records of patients who are currently receiving referred services, identifying patients with high and potentially high costs of care, and tracking the receipt of discharge and consultation summaries.

For more information, see section 4.2.

6.5.2.1 Inpatient Log (ILOG)

The Inpatient Log lists patients who are currently receiving inpatient treatment at outside facilities to which they were referred.

For more information, see section 4.2.1.

6.5.2.2 Area Hospital Discharges (AHDC)

This discharge report prints a list of discharged patients by the ending date of service for all inpatient referrals.

For more information, see section 4.2.2.

6.5.2.3 Outpatient Referral Log (OLOG)

This report prints a list of patients who are currently referred for outpatient services at an outside referral facility.

For more information, see section 4.2.3.

6.5.2.4 List of High Cost Users (HCU)

The HCU report option lists all patients who have incurred costs from referrals that exceed the amount you specify during a selected time period.

For more information, see section 4.2.4.

6.5.2.5 Potential High Cost Cases (HCTX)

The HCTX report lists patients who potentially have a high cost of care.

For more information, see section 4.2.5.

6.5.2.6 Timeliness of Receiving Disch/Consult Summary (TDL)

The TDL report tabulates the timeliness with which discharge letters are received from facilities to which patients have been referred.

For more information, see section 4.2.6.

6.5.2.7 Patients for Whom Disch/Consult Summary Not Rec'd (DCNR)

This report lists all referrals for which a discharge letter or consultation summary has not been received.

For more information, see section 4.2.7.

6.5.2.8 Transfer Log (TLOG)

This report lists detailed information for patients who are currently receiving treatment at outside referral facilities.

For more information, see section 4.2.8.

6.5.2.9 Print Case Review Comments (By Date/Facility) (CRD)

This report allows you to enter a specified date range and print all case review comments entered for the review(s) at a single facility within that given date range.

For more information, see section 4.2.9.

6.5.2.10 Outlier Report (OTL)

The Outlier Report generates a list of inpatients who have been hospitalized at facilities to which they were referred for a longer period of time than their estimated length of stay.

For more information, see section 4.2.10.

6.5.2.11 Reasons Not Completed Report (RNK)

The Reasons Not Completed option creates a listing of referrals that have not been completed for a given date range.

For more information, see section 4.2.11

6.5.3 Utilization Reports (UTIL)

Utilization reports provide a means for tracking the number of referrals initiated and the costs associated with those referrals. This information is presented by provider or facility for identifying the source of high referral rates and costs.

For more information on this report, see section 4.3.

6.5.3.1 Referral Patterns by Provider or Facility (RFP)

This report displays referral patterns for each provider at your facility or for your entire facility.

For more information on this report, see section 4.3.1.

6.5.3.2 CHS Referral Costs by Requesting Prov/Facility (CHSC)

The CHSC report displays CHS referral costs by requesting provider or referring facility.

For more information on this report, see section 4.3.2.

6.5.3.3 Top Ten Diagnosis Report (TTDX)

This report displays the top ten to top 100 ICD9 Diagnosis Codes and APC Diagnostic Groupings for referrals for a given date range.

For more information on this report, see section 4.3.3.

6.5.3.4 Top Ten Procedure Report (TTPX)

The Top Ten Procedure Report displays the top ten to top 100 CPT Procedure Codes for referrals for a given date range.

For more information on this report, see section 4.3.4.

6.5.4 RCIS General Retrieval (GEN)

The RCIS General Retrieval is a very flexible report option that lists and/or counts patient referrals.

For more information on this report, see section 4.4.

6.5.5 Delete General Retrieval Report Definition (DGR)

This option on the Reports menu allows you to delete any report types that have been saved using the General Retrieval report generation tool.

For more information on this option, see section 4.5.

7.0 Glossary

Term	Definition
Access Code	A password used along with the verify code to provide secure user access. The access code must be entered by the user prior to using the RPMS.
Browser	An interactive application that displays text on a terminal in a scrolling format. The user is allowed to navigate freely within the text displayed using the specified commands.
Bulletin	An email message automatically delivered by MailMan under certain conditions. For example, a bulletin can be set to generate when a particular type of referral is entered into the system.
CHS	Contract Health Services; Services not directly available from IHS that are purchased under contract from community hospitals and practitioners.
CPT	Current Procedural Terminology; coding system for medical procedures
Field	In a record, a specified area used for a category of data. Specifications as to the type of data that can be entered apply to each field. These specifications are accessible on the Help screens throughout the program.
File	A set of related records or entries treated as a single unit.
ICD	International Classification of Diseases; coding system for medical diagnoses.
IHS	Indian Health Service
LAYGO Access:	User authorization to create a new entry when editing a computer file. Learn As You Go (LAYGO) provides the ability to create new entries. An example of LAYGO is the Specific Provider field of the RCIS.
Local	The facility system that a user is currently signed on to.
MailMan	An email system that allows users to send and receive messages via the RPMS computer. Email messages received via MailMan may also be bulletins that are automatically generated.
Menu	A list of choices for computing activity. A menu is a type of option designed to identify a series of items (other options) for presentation to the user for selection. When displayed, menu-type options are preceded by the word "select" and followed by the word "option," as in "Select the Menu Management option:" (the menu's select prompt).
Option	An entry in the Option file. As an item on a menu, an option provides an opportunity for users to select it, thereby invoking the associated computing activity. Options may also be scheduled to run in the background, non-interactively, by TaskMan.
PCC	Patient Care Component; the central repository of data for the RPMS.
Prompt	A question or message issued interactively that requires a response.
Queuing	Requesting that a job be processed at a later time rather than within the current session.
RCIS	Referred Care Information System
Record	A set of related data treated as a unit

Term	Definition
RPMS	Resource and Patient Management System; A suite of software applications used at IHS facilities to support administrative, clerical, and clinical functions
Return Key	The Enter key on the computer keyboard
Security Key	A means of safeguarding options that are used by managerial staff only; for example, a security key is required to modify a closed referral. Security keys are assigned to appropriate personnel by the local Site Manger.
Service Unit	An administrative unit of the Indian Health Service.
Spacebar/Return	The use of the key combination Spacebar/Return at a prompt to retrieve the user's last response to that prompt.
Template	A means of storing report formats, data entry formats, and sorted entry sequences. A template is a permanent place to store selected field specifications for use at a later time.
Up-Arrow Jump	In the menu system, entering a circumflex or up-hat (^) followed by an option name accomplishes a jump to the target option without needed to take the usual steps through the menu pathway.
Up-Hat	A circumflex, also known as a "hat" or "caret," that is used primarily for exiting functions and jumping to options in the RCIS. The up-hat is denoted at "^" and is entered by simultaneously pressing the shift key and the 6 key on the keyboard.
User:	A person who interacts with the computer application.
Verify Code	A secret password used with the access code to provide secure user access. The verify code must be entered by the user after entering the access code to log on to the RPMS.

8.0 Appendix A: Data Entry Screen Help

When entering and modifying data, the following commands allow you to navigate through the data entry screens:

8.1 Cursor Movement

Move right one character	<Right>
Move left one character	<Left>
Move right one word	<Ctrl-L> or <PF1><Space>
Move left one word	<Ctrl-J>
Move to right of window	<PF1><Right>
Move to left of window	<PF1><Left>
Move to end of field	<PF1><PF1><Right>
Move to beginning of field	<PF1><PF1><Left>

8.2 Modes

Insert/Replace toggle	<PF3>
Zoom (invoke multiline editor)	<PF1>Z

8.3 Deletions

Character under cursor	<PF2> or <Delete>
Character left of cursor	<Backspace>
From cursor to end of word	<Ctrl-W>
From cursor to end of field	<PF1><PF2>
Toggle null/last edit/default	<PF1>D or <Ctrl-U>

8.4 Macro Movements

Field below	<Down>
Field above	<Up>
Field to right	<Tab>
Field to left	<PF4>
Pre-defined order	<Return>
Next Page	<PF1><Down> or <Page Down>
Previous Page	<PF1><Up> or <Page Up>
Next block	<PF1><PF4>
Jump to next field	^caption
Go to command line	^
Go into multiple or word processing field	<Return>

8.5 Command Line Options

Enter the up-hat (^) at any field to jump to the command line.

COMMAND	SHORTCUT	DESCRIPTION
Exit	<PF1>E	Exit form (asks whether changes should be saved)
Close	<PF1>C	Close window and return to previous level
Save	<PF1>S	Save changes
Next page	<PF1> <Down>	Go to next page
Refresh	<PF1>R	Repaint screen

8.6 Other Shortcut Keys

Exit form and save changes	<PF1>E
Quit form without saving changes	<PF1>Q
Invoke Record Selection Page	<PF1>L

9.0 Appendix B: Word Processing Screen Help

The following options are helpful for using the word-processing screens in the RCIS.

9.1 Edit Options

The options below are available for editing text that has been entered into a word-processing field. To use one of the options, type the first letter of the command at the EDIT prompt.

Add Lines to End of Text (A)

Break a Line into Two (B)

Change Every String to Another in a Range of Lines (C)

Delete Lines (D)

Edit a Line (Replace ____ with ____) (E)

Insert Line(s) After An Existing Line (I)

Join Line to the One Following (J)

List a Range of Lines (L)

Move Lines to New Location Within Text (M)

Print Lines as Formatted Output (P)

Repeat Lines at a New Location (R)

Search for a String (S)

Transfer Lines from Another Document (T)

Utility Sub-Menu (U)

9.2 Utility Sub-Menu

The options below are available from the utility sub-menu. To use one of these options, type the first letter of the command.

Editor Change (E)

File Transfer from Foreign CPU (F)

Text-Terminator-String Change (T)

10.0 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