RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS RPMS Dictionaries (Patient)

(AUPN)

Technical Manual

Version 99.1
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Preface

The AUPN Package contains all dictionaries that comprise the 'clinical repository' or Patient Care Component (PCC). The dictionaries in this package are the primary files in which patient medical and registration data is housed. This package also contains various utilities and routines called from these dictionaries.

This manual contains the technical documentation for the IHS DICTIONARIES (AUPN) package, V. 99.1. Included here are a system description, routine descriptions, option descriptions, and a variety of other information necessary for use by IRM personnel to operate and maintain the PCC IHS Patient Medical Dictionaries software.

1.0 Introduction

This package contains IHS Standard patient and medical dictionaries. It also contains the following utilities:

- IHS Patient Lookup
- AUPNPAT utility routines that contain many function calls for retrieving patient data, Other utility routines called by these dictionaries.

2.0 Implementation and Maintenance

2.1 General Information

The AUPN package occupies the AUPN namespace. There are only data dictionaries and routines distributed with this package. There are no templates, options, or forms. This package is distributed in conjunction with V. 2.0 of PCC Data Entry. The two packages must be installed together and should not be installed one without the other.

2.2 System Requirements

- Kernel V. 8.0 or higher
- FileMan V. 21 or higher
- PCC Data Entry V. 2.0

3.0 Routine Descriptions

3.1 Callable Routines/Functions

This package has many published entry points. They are described below:

3.1.1 Routine - AUPNPAT

Data for the following function calls come from the PATIENT file, file 9000001, and from the Medicare Eligible, Medicaid Eligible, and Private Insurance Eligible files.

SEX(p) Returns SEX of patient p

arguments

p - patient ien (DFN)

examples

W $$SEX^AUPNPAT(234) => F

DOB(p,f) Returns DATE OF BIRTH of patient p in format f

arguments

p - patient ien (DFN)
f - optional format; if null, returns internal FileMan format of DOB
E - external written-out format (MAR 05, 1995)

examples

W $$DOB^AUPNPAT(1234) => 2950305
W $$DOB^AUPNPAT(1234,“E”) => MAR 05,1995

SSN(p) Returns SSN of patient

arguments

p - patient ien (DFN)

examples

W $$SSN^AUPNPAT(234) => 123456789

AGE(p,d,f) Returns AGE of patient p on date d in format f

arguments

p - patient ien (DFN)
d - optional date in internal FileMan format; if null, will default to DT
f - optional format; if null, returns age in years null - age in years
R - age in readable format

examples

```
W $$AGE^AUPNPAT(1234)          => 32
W $$AGE^AUPNPAT(1234,"R")      => 32 YRS
```

DOD(p,f) Returns DATE OF DEATH of patient p in format f

arguments

p - patient ien (DFN)
f - optional format; if null, returns internal FileMan format of DOD E - external written-out format (MAR 05, 1995)

examples

```
W $$DOD^AUPNPAT(1234)          => 2950305
W $$DOD^AUPNPAT(1234,"E")      => MAR 05,1995
```

TRIBE(p,f) Returns TRIBE OF MEMBERSHIP of patient p in format f

arguments

p - patient ien (DFN)
f - optional format; if null, returns tribe code
I - internal format of tribe (tribe ien)
E - external written-out format of tribe
C - tribe code

examples

```
W $$TRIBE^AUPNPAT(1234,"I")    => 31
W $$TRIBE^AUPNPAT(1234,"E")    => CHOCTAW NATION OF OK
W $$TRIBE^AUPNPAT(1234,"C")    => 031
```

COMMRES(p,f) Returns COMMUNITY OF RESIDENCE of patient p in format f

arguments

p - patient ien (DFN)
f - optional format; if null, returns STCTYCOM COMMUNITY code
I - internal format of COMMUNITY (community ien)
E - external written-out format of COMMUNITY
C - STCTYCOM code

examples

W $$COMMRES^AUPNPAT(1234,“I”) => 31
W $$COMMRES^AUPNPAT(1234,“E”) => PRINCESS BAY
W $$COMMRES^AUPNPAT(1234,“C”) => 0210019

HRN(p,l,f) Returns HEALTH RECORD NUMBER of patient p at location l in format f

arguments

p - patient ien (DFN)
l - must be valid ien of location
f - optional, 2–HRN will have prefix of site abbreviation

examples

W $$HRN^AUPNPAT(1234,4585) => 3456
W $$HRN^AUPNPAT(1234,4585,2) => SE3456

ELIGSTAT(p,f) Returns ELIGIBILITY STATUS of patient p in format f

arguments

p - patient ien (DFN)
f - optional format; if null, returns internal format
I - internal format of eligibility status (set of codes)
E - external written-out format of eligibility status

examples

W $$ELIGSTAT^AUPNPAT(1234,“I”) => D
W $$ELIGSTAT^AUPNPAT(1234,“E”) => DIRECT ONLY

BEN(p,f) Returns CLASSIFICATION/BENEFICIARY of patient p in format f

arguments

p - patient ien (DFN)
f - optional format; if null, returns classification/beneficiary code
I - internal format of classification/beneficiary (pointer value)
E - external written-out format of classification/beneficiary
C - classification/beneficiary code

examples

W $$BEN^AUPNPAT(1234,“I”) => 1
W $$BEN^AUPNPAT(1234,“E”) => INDIAN/ALASKA NATIVE
W $$BEN^AUPNPAT(1234,“C”) => 01

MCR(p,d) Returns 1 or 0: Is Patient p eligible for Medicare on date d?

arguments

p - patient ien (DFN)
d - required date in internal FileMan format

examples

W $$MCR^AUPNPAT(1234,2950601) => 1
Is patient 1234 eligible for Medicare on 6/1/95? => yes

PI(p,d) Returns 1 or 0: Is Patient p eligible for private insurance on date d?

arguments

p - patient ien (DFN)
d - required date in internal FileMan format

examples

W $$PI^AUPNPAT(1234,2950601) => 1
Is patient 1234 eligible for private insurance on 6/1/95? => yes

MCD(p,d) Returns 1 or 0: Is Patient p eligible for Medicaid on date d?

arguments

p - patient ien (DFN)
d - required date in internal FileMan format

examples

W $$MCD^AUPNPAT(1234,2950601) => 1
Is patient 1234 eligible for Medicaid on 6/1/95? => yes

MCDPN(p,d,f) Returns Medicaid plan name for patient p on date d in format f

arguments

p - patient ien (DFN)
d - required date in internal FileMan format
f - format, optional; if null, returns internal ien of insurer I

examples

W $$MCDPN^AUPNPAT(1234,2950601,“I”) => 1
W $$MCDPN^AUPNPAT(1234,2950601,“E”) => CARONDELET

PIN(p,d,f) Returns private insurance plan name for patient p on date d in format f

arguments

p - patient ien (DFN)
d - required date in internal FileMan format
f - format, optional; if null, returns internal ien of insurer

examples

W $$PIN^AUPNPAT(1234,2950601,“I”) => 1
W $$PIN^AUPNPAT(1234,2950601,“E”) => BLUE CROSS/BLUE SHIELD

CDEATH(p,f) Returns CAUSE OF DEATH of patient p in format f

arguments

p - patient ien (DFN)
f - optional format; if null, returns Cause of Death ICD9 code
I - internal format ICD9 ien
E - external written-out format (ICD9 TEXT) C - ICD9 code

examples

W $$CDEATH^AUPNPAT(1234,“I”) => 31
W $$CDEATH^AUPNPAT(1234,“E”) => DIABETES MELLITUS
W $$CDEATH^AUPNPAT(1234,“C”) => 250.00

ENC(p) Returns an encrypted patient identifier 12 bytes long. The entry-point DEC reverses the process and returns the decoded output in a 27-byte-long string.

arguments

p - patient ien (DFN)

examples

W $$ENC^AUPNPAT(1) => V46332UMH763

DEC(p) Reverses the process of ENC^AUPNPAT and returns the decoded output in a 27-byte-long string.

arguments

p - patient ien (DFN)

examples

W $$DEC^AUPNPAT(V46332UMH763) =>[THA,B JAN 01,1933 0001]

3.1.2 Routine - AUPNPAT1

Data for the following functions comes from the PATIENT file, file 9000001.

BEN(p) Returns Beneficiary/Non-Beneficiary Status

arguments

p - patient ien (DFN)

examples

W $$BEN^AUPNPAT1(1) =>1

OUTPUT:

1 = yes
0 = no
-1 = no/old tribe or unable

3.2 Routines with Description

Grouped Routines	Description
AUPNCASE	Upper cases a string - called from .01 of file 2.
AUPNCIX*	Sets/kills QMAN cross references
AUPNCPT	Extrinsic call to pass back array of all CPT codes available in PCC for one visit.
AUPNELIG	Input transforms on insurer fields in eligibility files.
AUPNHLP	Executable help call for railroad retirement.
AUPNLBCK	Back billing check.
AUPNLK*	Patient lookup routines.
AUPNOHRW	Offspring history birth weight calculation.
AUPNPAT*	Function calls to retrieve patient data. They are all described following this routine list.
AUPNPC	Return HT or WT percentile based on sex and age.
AUPNPCT	Cross reference on value field of V Measurement.
AUPNPCTR	Cross reference trigger on #1117 of patient file.
AUPNPED	Edits on fields in Patient file.
AUPNPOST	Post init routine.
AUPNPOUT	Output transforms on fields in Patient file.
AUPNPRE	Environment check routine.
AUPNPREI	Pre initialization routine.
AUPNSICD	Screen on .01 of V POV and other pointers to ICD Diagnosis.
AUPNVDX*	Called from V Diagnostic Procedure Result.
AUPNVEYE	Called from V EYEGLASS file.
AUPNVLI	Called from V Line Item file.

Grouped Routines	Description
AUPNVMS*	Input transforms and help on measurement types/values.
AUPNVSIT	Called from cross references and input transforms on visit file.
AUPNXFRC	Trigger on #1117 on patient file.

4.0 Files

4.1 File List

This file is the primary patient data file. The NAME (.01) field of this file is a backward pointer to the VA's patient file (#2). Fields in common between the two dictionaries actually exist only in the VA patient file and are referenced by the IHS patient file as computed fields. All other files containing patient data have backward pointers linking them to this file. The linkage is by patient name and the internal FileMan generated number of the ancillary file is the same number used in this file.

All applications developed for the RPMS which require patient data will point to this file.

FILE SCREEN (SCR-node) : I '$P(^DPT(Y,0),U,19)
SPECIAL LOOKUP ROUTINE : AUPNLK
POST-SELECTION ACTION : D ^AUPNPAT

GLOBAL: ^AUPNPAT(
FILE #: 9000001

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	NAME	D0,0	1	P
.02	DATE ESTABLISHED	"	2	D
.03	DATE OF LAST REG. UPDATE	"	3	D
.04	OUTPT MED/RR RELEASE DATE	"	4	D
.05	MED/RR RELEASE REVOKED DATE	"	5	D
.06	PCIS ID NO.	"	6	F
.07	TRIBAL ENROLLMENT NO.	"	7	F
.08	MFI MEDICAL	"	8	S
.09	CHS TRIBAL AFFILIATION	"	9	P
.11	ESTABLISHING USER	"	11	P
.12	USER-LAST UPDATE	"	12P	P
.13	BLOOD TYPE	"	13	S
.14	PRIMARY CARE PROVIDER	"	14	P
.15	CHS TX DATE	"	15	D
.16	DATE OF LAST UPDATE	"	16	D
.17	ASSIGN BENEFITS OBTAINED DATE	"	17	D
.18	ASSIGN BENEFITS EXPIRED DATE	"	18	D
.19	EMPLOYER NAME	"	19	P

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.21	EMPLOYMENT STATUS	"	21	S
.22	SPOUSE'S EMPLOYER NAME	"	22	P
.23	SSN VERIFICATION STATUS	"	23	P
.24	REASON FOR NO SSN	"	24	S
.25	PRIMARY INSURER	"	25	P
.31	PRINTABLE NAME	D0,3	1	F
.32	REFERRING PCP	"	2	F
1101.2	SEX	COMPUTED		
1102.2	DOB	COMPUTED (DATE)		
1102.98	PRINTABLE AGE	COMPUTED		
1102.99	AGE	"		
1103.2	CITY OF BIRTH	"		
1104.2	STATE OF BIRTH	"		
1105	BIRTH CERTIFICATE NO.	D0,11	5	F
1106.2	RELIGION	COMPUTED		
1107.2	SSN	"		
1108	TRIBE OF MEMBERSHIP	D0,11	8	P
1109	TRIBE QUANTUM	"	9	F
1109.9	TRIBE QUANTUM DECIMAL	COMPUTED		
1110	INDIAN BLOOD QUANTUM	D0,11	10	F
1110.9	INDIAN QUANTUM DECIMAL	COMPUTED		
1111	CLASSIFICATION/BENEFICIARY	D0,11	11	P
1112	ELIGIBILITY STATUS	"	12	S
1113	CURRENT RESIDENCE DATE	"	13	D
1113.2	DATE OF DEATH	COMPUTED (DATE)		
1114	UNDERLYING CAUSE OF DEATH	D0,11	14	P
1115	STATE OF DEATH	"	15	P

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
1116	DEATH CERTIFICATE NO.	"	16	F
1117	CURRENT RESIDENCE PTR	"	17	P
1118	CURRENT COMMUNITY	"	18	F
1119	TRIBE MEMBERSHIP VERIFIED FLAG	"	19	S
1121	RESIDENCE VERIFIED FLAG	"	21	S
1122	PREV HSDA RES (VER) FLAG	"	22	S
1123	DATE ELIGIBILITY DETERMINED	"	23	D
1124	BIC ELIGIBILITY STATUS	"	24	P
1125	ELIGIBILE MINOR CHILD	"	25	S
1126	BIC PRINTED FLAG	"	26	S
1127	PRE-BIC TRIBE	“	27	P
1201	LOCATION OF HOME (9000001.12)			
.01	LOCATION OF HOME	D0,12,D1,0	1	W
1301	ADDITIONAL REGISTRATION INFO	(9000001.13)		
.01	ADDITIONAL REGISTRATION INFO	D0,13,D1,0		
1401	REMARKS (9000001.14)			
.01	REMARKS	D0,14,D1,0	1	W
1501	ALERTS (9000001.15)			
.01	ALERTS	D0,15,D1,0	1	W
1602.2	MAILING ADDRESS-STREET	COMPUTED		
1603.2	MAILING ADDRESS-CITY	"		
1604.2	MAILING ADDRESS-STATE	"		
1605.2	MAILING ADDRESS-ZIP	"		
1606.2	HOME PHONE	"		
1607.2	OFFICE PHONE	"		
2101.2	LEGAL RESIDENCE-STREET	"		
2102.2	LEGAL RESIDENCE-CITY	"		
2103.2	LEGAL RESIDENCE-COUNTY	"		
2104.2	LEGAL RESIDENCE-STATE	"		
2105.2	LEGAL RESIDENCE-ZIP	"		
2601.2	FATHER'S NAME	"		
2602	FATHER'S CITY OF BIRTH	D0,26	2	F
2603	FATHER'S STATE OF BIRTH	"	3	P
2604.2	MOTHER'S MAIDEN NAME	COMPUTED		
2605	MOTHER'S CITY OF BIRTH	D0,26	5	F
2606	MOTHER'S STATE OF BIRTH	D0,26	6	P

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
2801.2	NEXT OF KIN	COMPUTED		
2802	NOK RELATIONSHIP	D0,28	2	P
2803.2	NOK ADDRESS-STREET	COMPUTED		
2804.2	NOK ADDRESS-CITY	"		
2805.2	NOK ADDRESS-STATE	"		
2806.2	NOK ADDRESS-ZIP	"		
2807.2	NOK PHONE	"		
3101.2	EMERGENCY CONTACT	"		
3102	EC RELATIONSHIP	D0,31	2	P
3103.2	EC ADDRESS-STREET	COMPUTED		
3104.2	EC ADDRESS-CITY	"		
3105.2	EC ADDRESS-STATE	"		
3106.2	EC ADDRESS-ZIP	"		
3107.2	EC PHONE	"		
4101	HEALTH RECORD NO. (9000001.41)			
.01	HEALTH RECORD FAC	D0,41,D1,0	1	P
.02	HEALTH RECORD NO.	"	2	F
.0299	TERMINAL DIGITS	COMPUTED		
.03	DATE INACTIVATED/DELETED	D0,41,D1,0	3	D
.04	RECORD DISPOSITION	"	4	P
.05	RECORD STATUS	"	5	S
.06	STOP INTEGRATION	"	6	S
4301	OTHER TRIBE	(9000001.43)		
.01	OTHER TRIBE	D0,43,D1,0	1	P
.02	QUANTUM	"	2	F
4601.2	OTHER NAME	COMPUTED		
5101	PREVIOUS COMMUNITY (9000001.51)			
.01	DATE MOVED	D0,51,D1,0	1	D
.02	DATE ADDED TO FILE	"	2	D
.03	COMMUNITY OF RESIDENCE	"	3	P
6101	MFI SITE (9000001.61)			
.01	MFI SITE	D0,61,D1,0	1	P
9999	LOOKUP	COMPUTED		
9999999	9 FREE TEXT NAME	D0,99999999	1	F

4.2 FILE: MEDICARE ELIGIBLE

This file contains information on patients who are eligible for Medicare. The PATIENT NAME field of this file (.01) is a backward pointer to the IHS PATIENT file. A patient must exist in the IHS PATIENT file before data can be added here.

FILE: PATIENT
FILE: MEDICARE ELIGIBLE

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	PATIENT NAME	D0,0	1	P
.02	INSURER POINTER	"	2	P
.03	MEDICARE NUMBER	"	3	F
.04	SUFFIX	"	4	P
.05	MEDICARE SECONDARY PAYER	"	5	D
1101	ELIGIBILITY (9000003.11)			
.01	ELIG. DATE	D0,11,D1,0	1	D
.02	ELIG. END DATE	"	2	D
.03	COVERAGE TYPE	"	3	S
2101	MEDICARE NAME	D0,21	1	F
2102	MEDICARE DATE OF BIRTH	"	2	D

4.3 FILE: MEDICARE CLAIMS

This file contains claims and payment information for Medicare eligible encounters, the file links to the 9000003 file and subsequently to the Patient file. Data cannot be added if these links are not complete.

GLOBAL: ^AUPNMCRC(
FILE #: 9000003.01

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	CLAIM	D0,0	1	D
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
.04	CLAIM AMOUNT	"	4	N
.05	FACILITY	"	5	P
.06	SETTLEMENT DATE	"	6	D
.07	SETTLEMENT AMOUNT	"	7	N
.08	DENIAL CODE	"	8	F

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.09	BEGIN CLAIM DATE	"	9	D
.11	END CLAIM DATE	"	11	D
.12	TYPE OF CLAIM	"	12	S
.13	DRG CODE	"	13	N
.14	DRG AMOUNT	"	14	N
.15	TRANSMITTAL NUMBER	"	15	N
.16	REBILL FLAG	"	16	S

4.4 File: POLICY HOLDER

This file contains the information on the Patient Policy holders used in the Third Party Billing system.

GLOBAL: ^AUPN3PPH(
FILE #: 9000003.1

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	NAME OF POLICY HOLDER	D0,0	1	F
.02	PATIENT POINTER	"	2	P
.03	INSURANCE COMPANY	"	3	P
.04	POLICY NUMBER	"	4	F
.05	COVERAGE TYPE	"	5	P
.06	GROUP NAME	"	6	P
.08	POLICY HOLDER'S SEX	"	8	S
.09	HOLDER'S ADDRESS - STREET	"	9	F
.11	HOLDER'S ADDRESS - CITY	"	11	F
.12	HOLDER'S ADDRESS - STATE	"	12	P
.13	HOLDER'S ADDRESS - ZIP	"	13	F
.14	HOLDER'S TELEPHONE NUMBER	"	14	F
.15	HOLDER'S EMPLOYMENT STATUS	"	15	S
.16	EMPLOYER	"	16	P
.17	EFFECTIVE DATE	"	17	D
.18	EXPIRATION DATE	"	18	D
.19	DATE OF BIRTH	"	19	D

4.5 FILE: MEDICAID ELIGIBLE

This file contains information on patients who are eligible for Medicaid. The PATIENT NAME field of this file (.01) is a backward pointer to the IHS PATIENT file. A patient must exist in the IHS PATIENT file before data can be added here.

1-8-87 This file cannot currently be RE-INDEXED. To do so creates residual "AA" cross-reference entries.

GLOBAL: ^AUPNMCD(
FILE #: 9000004

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	PATIENT NAME	D0,0	1	P
.02	INSURER POINTER	"	2	P
.03	MEDICAID NUMBER	"	3	F
.04	STATE	"	4	P
.05	NAME OF INSURED	"	5	F
.06	RELATIONSHIP TO INSURED	"	6	P
.07	SEX OF INSURED	"	7	S
.08	DATE OF LAST UPDATE	"	8	D
.09	POLICY HOLDER	"	9	P
.11	PLAN NAME	"	10	P
.12	RATE CODE	"	11	F
.13	CASE NUMBER	"	13	F
1101	ELIGIBILITY DATES	(9000004.11)		
.01	ELIG. DATE	D0,11,D1,0	1	D
.02	ELIG. END DATE	"	2	D
.03	COVERAGE TYPE	"	3	F
2101	MEDICAID NAME	D0,21	1	F
2102	MEDICAID DATE OF BIRTH	"	2	D

4.6 File: MEDICAID CLAIMS

This file contains claims and payment information for Medicaid eligible encounters, the file links to the 9000004 file and subsequently to the Patient file. Data cannot be added if these links are not complete.

GLOBAL: ^AUPNMCDC(
FILE #: 9000004.01

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	CLAIM	D0,0	1	D
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
.04	CLAIM AMOUNT	"	4	N
.05	FACILITY	"	5	P
.06	SETTLEMENT DATE	"	6	D
.07	SETTLEMENT AMOUNT	"	7	N
.08	DENIAL CODE	"	8	F
.09	BEGIN CLAIM DATE	"	9	D
.11	END CLAIM DATE	"	11	D
.12	TYPE OF CLAIM	"	12	S
.13	DRG CODE	"	13	N
.14	DRG AMOUNT	"	14	N
.15	TRANSMITTAL NUMBER	"	15	N
.16	REBILL FLAG	"	16	S

4.7 File: RAILROAD ELIGIBLE

This file contains information on patients who are eligible for Railroad. The PATIENT NAME field of this file (.01) is a backward pointer to the IHS PATIENT file. A patient must exist in the IHS PATIENT file before data can be added here.

GLOBAL: ^AUPNRRE
FILE #: 9000005

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	PATIENT NAME	D0,0	1	P
.02	INSURER POINTER	"	2	P
.03	PREFIX	"	3	P
.04	RAILROAD NUMBER	"	4	F
1101	ELIGIBILITY (9000005.11)			
.01	ELIG. DATE	D0,11,D1,0	1	D
.02	ELIG. END DATE	"	2	D
.03	COVERAGE TYPE	"	3	S
2101	RAILROAD NAME	D0,21	1	F
2102	RAILROAD DATE OF BIRTH	"	2	D

4.8 FILE: RAILROAD CLAIMS

This file contains claims and payment information for Railroad eligible encounters, the file links to the 9000005 file and subsequently to the Patient file. Data cannot be added if these links are not complete.

GLOBAL: ^AUPNRREC(
FILE #: 9000005.01

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	CLAIM	D0,0	1	D
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
.04	CLAIM AMOUNT	"	4	N
.05	FACILITY	"	5	P
.06	SETTLEMENT DATE	"	6	D
.07	SETTLEMENT AMOUNT	"	7	N
.08	DENIAL CODE	"	8	F
.09	BEGIN CLAIM DATE	"	9	D
.11	END CLAIM DATE	"	11	D
.12	TYPE OF CLAIM	"	12	S
.13	DRG CODE	"	13	N
.14	DRG AMOUNT	"	14	N
.15	TRANSMITTAL NUMBER	"	15	N
.16	REBILL FLAG	"	16	S

4.9 FILE: PRIVATE INSURANCE ELIGIBLE

This file contains information on patients who are eligible for private insurance. The PATIENT NAME field of this file (.01) is a backward pointer to the IHS PATIENT file. A patient must exist in the IHS PATIENT file before data can be added here.

GLOBAL: ^AUPNPRVT(
FILE #: 9000006

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	PATIENT NAME	D0,0	1	P
1101	INSURER (9000006.11)			
.01	INSURER	D0,11,D1,0	1	P
.02	*POLICY NUMBER	"	2	F

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.03	*COVERAGE	"	3	P
.04	*NAME OF INSURED	"	4	F
.05	RELATIONSHIP	"	5	P
.06	ELIG. DATE	"	6	D
.07	ELIG. END DATE	"	7	D
.08	POLICY HOLDER	"	8	P
.09	VERIFIED COVERAGE DATE	"	9	D
.11	VERIFIED BY	"	11	P

4.10 FILE: PRIVATE INSURANCE CLAIMS

This file contains claims and payment information for private insurance eligible encounters, the file links to the 9000006 file and subsequently to the Patient file. Data cannot be added if these links are not complete.

GLOBAL: ^AUPNPRVC(
FILE #: 9000006.01

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	CLAIM	D0,0	1	D
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
.04	CLAIM AMOUNT	"	4	N
.05	FACILITY	"	5	P
.06	SETTLEMENT DATE	"	6	D
.07	SETTLEMENT AMOUNT	"	7	N
.08	DENIAL CODE	"	8	F
.09	BEGIN CLAIM DATE	"	9	D
.11	END CLAIM DATE	"	11	D
.12	TYPE OF CLAIM	"	12	S
.13	DRG CODE	"	13	N
.14	DRG AMOUNT	"	14	N
.15	TRANSMITTAL NUMBER	"	15	N
.16	REBILL FLAG	"	16	S

4.11 FILE: SCHEDULED ENCOUNTER

This file contains patient's future scheduled encounters. The PATIENT NAME field of this file (.01) is a backward pointer to the IHS PATIENT file and must exist there before data can be added here. There is one record in this file for each scheduled encounter for each patient, therefore, the KEY field (.01) is duplicated. This file is used by the PCC, and is not part of the VA Clinical Scheduling system.

GLOBAL: ^AUPNFSE(
FILE #: 9000007

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	DATE/TIME NEXT VISIT	D0,0	1	D
.02	PATIENT NAME	"	2	P
.03	SCHED ON DATE	"	3	D
.04	PRIORITY	"	4	S
.05	SCHED BY FACILITY	"	5	P
.06	SCHED BY PROVIDER	"	6	P
.07	SCHED FOR FACILITY	"	7	P
.08	SCHED FOR PROVIDER	"	8	P
.09	NARRATIVE	"	9	F

4.12 FILE: SURVEILLANCE

This file contains surveillance procedures due for each patient. The PATIENT NAME field of this file (.01) is a backward pointer to the IHS PATIENT file and must exist there before data can be added here. This file contains one record for each surveillance procedure for each patient, therefore, the KEY field (.01) is duplicated. The surveillance procedures include immunizations, skin tests, laboratory tests and physical exams, and a due date is calculated for each patient based on the patient age, sex and date of the previous procedure.

GLOBAL: ^AUPNSURV(
FILE #: 9000008

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	PATIENT NAME	D0,0	1	P
.02	CODE	"	2	P
.03	DATE LAST GIVEN	"	3	D
.04	DATE NEXT DUE	"	4	D
.05	PROCEDURE CODE	"	5	P

4.13 FILE: CLINICAL REMINDER

This file contains clinical reminders for patients. The PATIENT NAME field of this file (.01) is a backward pointer to the IHS PATIENT file and must exist there before data can be added here. There is one record in this file for each clinical reminder for each patient, therefore, the PATIENT NAME field of this file (.01) is duplicated. Data in this file is generated by software.

GLOBAL: ^AUPNCR(
FILE #: 9000009

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	PATIENT NAME	D0,0	1	P
.02	CODE	"	2	P
.03	DATE OF TRIGGER	"	3	D

4.14 FILE: VISIT

This file contains a record of all patient visits at health care facilities or by health care providers, including direct outpatient and clinic visits, as well as inpatient encounters with providers of care. All other visit related files, such as purpose of visit (diagnoses), operative procedures, immunizations, examinations, etc., will point to a visit in this file. The records are maintained by date/time of visit, and the patient name field is a pointer to the IHS Patient file, where the patient must exist before data can be added here.

Cross References:

("AA",<patient pointer>,<9's-visit date+time>,IEN)=<eligibility pointer>
("AAH",<patient pointer>,<9's-visit date+time>,IEN)=""
set conditional SERVICE CATEGORY = Hospitalization
("ABILL",<date visit created>, IEN)="" set conditional to site parameter
("AC",<patient pointer>,IEN)=""
("AD", <parent visit pointer>,IEN)=""
("ADEL",<visit date&time>,IEN)=""
set conditional DEPENDENT ENTRY COUNT '> 0
("AI",IEN)=""
set conditional SERVICE CATEGORY = In hospital
("AMRG",<date visit created>,IEN)=""
("APCIS",<date visit created>,IEN)=""

GLOBAL: ^AUPNVSIT(
FILE #: 9000010

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	VISIT/ADMIT DATE&TIME	D0,0	1	D
.02	DATE VISIT CREATED	"	2	D
.03	TYPE	"	3	S
.04	THIRD PARTY BILLED	"	4	P
.05	PATIENT NAME	"	5	P
.06	LOC. OF ENCOUNTER	"	6	P
.07	SERVICE CATEGORY	"	7	S
.08	CLINIC	"	8	P
.09	DEPENDENT ENTRY COUNT	"	9	N
.11	DELETE FLAG	"	11	S
.12	PARENT VISIT LINK	"	12	P
.13	DATE LAST MODIFIED	"	13	D
.14	DATE VISIT EXPORTED	"	14	D
.15	MFI STATUS	"	15	S
.16	WALK IN/APPT	"	16	S
.17	EVALUATION AND MANAGEMENT CODE	"	17	P
.18	CHECK OUT DATE&TIME	"	18	D
.19	LEVEL OF SERVICE (PCC FORM)	"	19	S
.21	ELIGIBILITY	"	21	P
.22	HOSPITAL LOCATION	"	22	P
.23	CREATED BY USER	"	23	P
.24	OPTION USED TO CREATE	"	24	P
.25	PROTOCOL	"	25	P
.26	APPT DATE&TIME	"	26	D
.27	USER LAST UPDATE	"	27	P
.28	BILLING LINK	"	28	P
.29	LEVEL OF DECISION MAKING	"	29	S
.31	APPOINTMENT LENGTH	"	31	N
.32	TYPE OF APPOINTMENT (S/M/L)	"	32	S
1101	AMOUNT BILLED	D0,11	1	N
1102	AMOUNT PAID	"	2	N
1209	EXTERNAL KEY	D0,12	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F
1601	FLAG	D0,16	1	N
2101	OUTSIDE LOCATION	D0,21	1	F
9999	LOOKUP	COMPUTED		

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
15001	SERVICE PROVIDED	D0,150	1	P
15002	PATIENT STATUS IN/OUT	"	2	S
15003	PRIMARY	"	3	S
80001	SERVICE CONNECTED	D0,800	1	S
80002	AGENT ORANGE EXPOSURE	"	2	S
80003	IONIZING RADIATION EXPOSURE	"	3	S
80004	PERSIAN GULF EXPOSURE	"	4	S
81101	COMMENTS	D0,811	1	F

4.15 FILE: V MEASUREMENT

This file has been designed for joint use by the Indian Health Service and the Department of Veteran Affairs.

Measurements, such as weight, height, blood pressure, etc., taken by a health professional at an outpatient encounter, will be stored in this file. The patient name is a pointer to the Patient/IHS file, and the visit is a pointer to the Visit file. Both of these must exist before data can be entered in this record. This file contains one record for each measurement for a patient for each visit; therefore the key field (.01) will be duplicated.

GLOBAL: ^AUPNVMSR(
FILE #: 9000010.01

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	TYPE	D0,0	1	P
.011	CPT CODE	COMPUTED		
.02	PATIENT NAME	D0,0	2	P
.03	VISIT	"	3	P
.04	VALUE	"	4	F
.05	PERCENTILE	"	5	N
.06	NUMERATOR ON VC/VU	"	6	N
1201	EVENT DATE AND TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
80101	EDITED FLAG	D0,801	1	S
80102	DATA SOURCE	"	2	F
81101	COMMENTS	D0,811	1	F

4.16 FILE: V HOSPITALIZATION

This file contains administrative information for each inpatient admission at an IHS facility or CHS facility. This record will be generated automatically at time of discharge for those facilities running the Admission, Discharge and Transfer (ADT) system. It contains a backward pointer to the visit file, and the IHS Patient file. Data must be in both of those files for this visit before data can be entered here.

GLOBAL: ^AUPNVINP(
FILE #: 9000010.02

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	DATE OF DISCHARGE	D0,0	1	D
.019	LENGTH OF STAY	COMPUTED		
.02	PATIENT NAME	D0,0	2	P
.03	VISIT	"	3	P
.04	ADMITTING SERVICE	"	4	P
.05	DISCHARGE SERVICE	"	5	P
.06	DISCHARGE TYPE	"	6	P
.07	ADMISSION TYPE	"	7	P
.08	NUMBER OF CONSULTS	"	8	N
.09	TRANSFERRED TO	"	9	V
.11	MEDICARE RELEASE	"	11	S
.12	ADMITTING DX	"	12	P
.13	ASSIGNMENT OF BENEFITS	"	13	S
.14	OVERRIDE/ACCEPT IHS INPT EDIT	"	14	P
.15	CODING COMPLETE	"	15	S
5101	CERTIFIED PERIOD (9000010.0251)			
.01	BEGIN DATE	D0,51,D1,0	1	D
.02	END DATE	"	2	D
5301	U/R ACUTE CARE PERIOD(S) (9000010.0253)			
.01	U/R ACUTE CARE BEGIN DATE	D0,53,D1,0	1	D
.02	U/R ACUTE CARE END DATE	"	2	D

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
5401	U/R NON-ACUTE CARE PERIOD(S) (9000010.0254)			
.01	U/R NON-ACUTE CARE BEGIN DATE	D0,54,D1,0	1	D
.02	U/R NON-ACUTE CARE END DATE	"	2	D
.03	U/R DENIAL REASON	"	3	P
5501	DISCHARGE PLAN INITIATION DATE	D0,55	1	D
6101	ADMISSION TYPE (UB-82)	D0,61	1	S
6102	ADMISSION SOURCE (UB-82)	"	2	S
6103	DISCHARGE STATUS (UB-82)	"	3	S
6104	BILLING RELEASE FLAG	"	4	S
6105	PRO APPROVAL CODE	"	5	S
6106	PRO AUTHORIZATION NUMBER	"	6	F

4.17 FILE: V CHS

This file contains contract health care information for each CHS inpatient visit for each patient. The VISIT field of this file (.03) is a backward pointer to the VISIT file. The current thinking is this field will not be duplicated but the dictionary does not prohibit duplication. The PATIENT NAME field of this file (.02) is a backward pointer to the IHS PATIENT file. Eventually the facility CHS/MIS will generate this record automatically from the CHS/MIS at time of discharge, but currently this is not being done.

GLOBAL: ^AUPNVCHS(
FILE #: 9000010.03

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	AUTHORIZING FACILITY	D0,0	1	P
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
.04	AUTHORIZATION NO.	"	4	F
.05	PAY STATUS	"	5	S
.06	TOTAL CHARGES	"	6	N
.07	DATE OF DISCHARGE	"	7	D
.0791	COMP LOS	COMPUTED		
.0792	LENGTH OF STAY	"		
.08	DISCHARGE TYPE	D0,0	8	S
.09	NEWBORN DX	"	9	P

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.11	STILLBORN	"	11	S
.12	NO OF VISITS	"	12	N
.13	HOSPITAL VOUCHER NO.	"	13	F
.14	VENDOR	"	14	P

4.18 FILE: V EYE GLASS

This file contains eye glass prescription information specific to a particular visit for a particular patient. The VISIT field of this file (.01) is a backward pointer to the VISIT file. This file contains one record for each eye glass prescription for each visit, therefore, the KEY field (.01) may be duplicated.

GLOBAL: ^AUPNVEYE(
FILE #: 9000010.04

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	NAME	D0,0	1	N
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
1201	EVENT DATE&TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F
1901	READING ONLY	D0,19	1	S
1902	DRE SPHERE	"	2	F
1903	DRE CYLINDER	"	3	F
1904	RE AXIS	"	4	N
1905	DLE SPHERE	"	5	F
1906	DLE CYLINDER	"	6	F
1907	LE AXIS	"	7	N
1908	READING ADD. R	"	8	F
1909	READING ADD. L	"	9	F
1910	*EYE SIZE	"	10	N

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
1911	*BRIDGE	"	11	N
1912	*TEMPLE	"	12	F
1913	PUP. DIST. NEAR	"	13	N
1914	PUP. DIST. FAR	"	14	N
1915	RE PRISM	"	15	F
1916	LE PRISM	"	16	F

4.19 FILE: V DENTAL

This file contains dental information specific to a particular visit. The VISIT field of this file (.01) is a backward pointer to the VISIT file and data must exist there before data can be entered here. This file contains one record for each service code for each visit for each patient, therefore, the KEY field (.01) may be duplicated.

GLOBAL: ^AUPNVDEN(
FILE #: 9000010.05

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	SERVICE CODE	D0,0	1	P
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
.04	NO. OF UNITS	"	4	N
.05	OPERATIVE SITE	"	5	P
.06	TOOTH SURFACE	"	6	F
1201	EVENT DATE&TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F

4.20 FILE: V PROVIDER

This record, along with a purpose of visit, is required for each patient encounter, whether at an IHS, tribal or CHS facility, or at a visit in the home or other field location. It has backward pointers to the IHS Patient file, and the visit file, and data must exist in both of these files for this visit before data can be entered here. There can be multiple providers for a given visit. The primary/secondary field identifies which provider is considered the primary provider for this visit. The provider must exist in the Provider File (#6). data can be entered here. There can be multiple providers for a given visit. The primary/secondary field identifies which provider is considered the primary provider for this visit. The only providers that can be entered in the file, are those providers who have the "AK.PROVIDER" key.

In the VA, providers without the security key can be entered in the V-files Encounter Provider field.

GLOBAL: ^AUPNVPRV(
FILE #: 9000010.06

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	PROVIDER	D0,0	1	P
.019	AFF.DISC.CODE	COMPUTED		
.02	PATIENT NAME	D0,0	2	P
.03	VISIT	"	3	P
.04	PRIMARY/SECONDARY	"	4	S
.05	PROVIDER STATUS	"	5	S
.06	PROVIDER TYPE	"	6	F
1201	EVENT DATE AND TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F
80101	EDITED FLAG	D0,801	1	S
80102	DATA SOURCE	"	2	F
81101	COMMENTS	D0,811	1	F

4.21 FILE: V POV

This file has been designed for joint use by the Indian Health Service and the Department of Veteran Affairs. POV is an abbreviation for “Purpose of Visit” (descriptive name used by IHS) or “Problem of Visit” (descriptive name used by VA).

The V POV file is used to store clinical data related to the “purpose of visit” or “problem of visit” (POV). This is the provider’s definition of what diagnosis to use to represent the patient care given at the visit. The POV entry is not the patient's “Chief Complaint” text. It is the diagnosis as defined by the provider which will have an ICD Diagnosis code related to it to support Clinical needs and additionally support Administrative functions too such as Billing, Workload, and DSS.

There should be at least one “purpose of visit” (descriptive name used by IHS) or one “problem of visit” (descriptive name used by the VA) in the V POV file for each patient visit whether it is an inpatient, outpatient or field visit, and regardless of the discipline of the provider (i.e., dental, CHN, mental health, etc.). There is no limit to the number of POVs that can be entered for a patient for a given encounter.

At IHS facilities, POVs are generated automatically for this file at time of discharge from the Admission, Discharge and Transfer (ADT) system. POVs are entered in narrative form, and coded automatically to the appropriate ICD9 code. Physician entered narrative which modifies the diagnosis, such as “doubtful, suspect, resolved” are entered by the data entry person in the MODIFIER field. Narrative qualifiers, such as “not healing well,” “date of onset,” “severe” etc., are stored in the NARRATIVE QUALIFIER field. STAGE is used only as a local option. The file contains pointers to the IHS Patient file, and visit file, and data must exist in both of these files for this visit before a POV can be entered here.

At VA facilities, POV is used as an abbreviation for “Problem of Visit,” or the problem treated at the visit. POVs are primarily created for clinic visits from 3 sources:

1. The scheduling checkout process, in which case the information collected about the POV is limited to the ICD Diagnosis code. The provider narrative becomes the ICD narrative from the ICD Diagnosis file.

2. The Encounter Form automated data scanning (AICS package). In this case the provider narrative is the terminology defined by the clinician to represent the diagnosis on the encounter form. The AICS package, or other automated data capture tool, is able to pass the narrative and the ICD Diagnosis. If the problem treated at the visit was a pre-existing problem from \the patient’s “Problem List,” the related problem entry is also stored in the POV record. (The Problem List orientation is not utilized by IHS.)

3. The manual data entry process for encounter form data not collected via automated data capture. This process is the most like the process IHS uses.

   GLOBAL: ^AUPNVPOV(
   FILE #: 9000010.07

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	POV	D0,0	1	P
.019	ICD NARRATIVE	COMPUTED		
.02	PATIENT NAME	D0,0	2	P
.03	VISIT	"	3	P
.04	PROVIDER NARRATIVE	"	4	P
.05	STAGE	"	5	N
.06	MODIFIER	"	6	S
.07	CAUSE OF DX	"	7	S
.08	FIRST/REVISIT	"	8	S
.09	CAUSE OF INJURY	"	9	P
.11	PLACE OF ACCIDENT	"	11	S
.12	PRIMARY/SECONDARY	"	12	S
.13	DATE OF INJURY	"	13	D
.14	OVERRIDE/ACCEPT	"	14	P
.15	CLINICAL TERM	"	15	P
.16	PROBLEM LIST ENTRY	"	16	P
.17	DATE OF ONSET	"	17	D
.18	3M SENT	"	18	D
1201	EVENT DATE AND TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC STOP	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F
80001	SERVICE CONNECTED	D0,800	1	S
80002	AGENT ORANGE EXPOSURE	"	2	S
80003	IONIZING RADIATION EXPOSURE	"	3	S
80004	PERSIAN GULF EXPOSURE	"	4	S
80101	EDITED FLAG	D0,801	1	S
80102	DATA SOURCE	"	2	F

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
80201	PROVIDER NARRATIVE CATEGORY	D0,802	1	P
81101	COMMENTS	D0,811	1	F

4.22 FILE: V PROCEDURE

This file contains all operative procedures performed on a patient at an inpatient, outpatient or field visit, either through direct care, tribal program or CHS. Data is generated in this file automatically from the ADT system at time of discharge. Eventually data will also be generated automatically from the CHS/MIS, but this is not being done currently. Data is generally entered in narrative form, and coded to the ICD9 operative procedures automatically. The file contains backward pointers to the IHS Patient file, and visit file, and data must exist in both of these files for this visit before data can be entered here.

GLOBAL: ^AUPNVPRC(
FILE #: 9000010.08

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	PROCEDURE	D0,0	1	P
.019	PROCEDURE NARRATIVE	COMPUTED		
.02	PATIENT NAME	D0,0	2	P
.03	VISIT	"	3	P
.04	PROVIDER NARRATIVE	"	4	P
.05	DIAGNOSIS	"	5	P
.06	PROCEDURE DATE	"	6	D
.07	PRINCIPLE PROCEDURE	"	7	S
.08	INFECTION	"	8	S
.09	OVERRIDE/ACCEPT	"	9	P
.11	OPERATING PROVIDER	"	11	P
.12	ANESTHESIOLOGIST	"	12	P
.13	ELAPSED TIME (ANESTHESIA)	"	13	N
.14	ANESTHESIA ADMINISTERED	"	14	S
.15	ASA-PS CLASS	"	15	P
.16	CPT CODE	"	16	P
.1609	CPT SHORT NAME	COMPUTED		
1201	EVENT DATE&TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F

4.23 FILE: V LAB

This file contains all lab tests ordered, with results being entered optionally for selected tests. The file does not currently interface with the VA Radiology system. The file contains backward pointers to the IHS Patient file, and visit file, and data must exist in both of these files for a visit for before data can be entered here. There will be one record for each type lab test ordered for the patient on a given visit; the .01 record may therefore be duplicated. On a given visit, the .01 record may, therefore, be duplicated.

GLOBAL: ^AUPNVLAB(
FILE #: 9000010.09

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	LAB TEST	D0,0	1	P
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
.04	RESULTS	"	4	F
.05	ABNORMAL	"	5	F
.06	LR ACCESSION NO.	"	6	F
.07	*PROVIDER	"	7	P
1101	UNITS	D0,11	1	F
1102	ORDER	"	2	N
1103	SITE	"	3	P
1104	REFERENCE LOW	"	4	F
1105	REFERENCE HIGH	"	5	F
1106	THERAPEUTIC LOW	"	6	F
1107	THERAPEUTIC HIGH	"	7	F
1108	SOURCE OF DATA INPUT	"	8	S
1109	CURRENT STATUS FLAG	"	9	S
1110	LAB TEST COST	"	10	N
1111	BILLABLE ITEM	"	11	S
1112	LAB POV	"	12	P

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
1201	COLLECTION DATE AND TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F
1211	ORDERING DATE	"	11	D
1301	COMMENT1	D0,13	1	F
1302	COMMENT2	"	2	F
1303	COMMENT3	"	3	F
1401	CPT PTR	D0,14	1	P
1402	CPT - BILLABLE ITEMS	"	2	F

4.24 FILE: V IMMUNIZATION

This file has been designed for joint use by the Indian Health Service and the Department of Veteran Affairs.

This file contains immunizations specific to a particular visit for a particular patient. This file contains one record for each immunization.

In the VA, if a CPT code is entered into PCE that represents an immunization, than an immunization will automatically be entered in the V Immunization file. And vice versa, if an immunization is entered into PCE that has a related CPT code, then a V CPT entry will automatically be created with the CPT code for the immunization. The PCE Code Mapping file contains the definitions of what immunization is related to what CPT code, and vice versa.

GLOBAL: ^AUPNVIMM(
FILE #: 9000010.11

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	IMMUNIZATION	D0,0	1	P
.011	CPT CODE	COMPUTED		
.02	PATIENT NAME	D0,0	2	P
.03	VISIT	"	3	P
.04	SERIES	"	4	S
.05	LOT	"	5	P

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.06	REACTION	"	6	S
.07	*CONTRAINDICATED	"	7	S
.12	DATE OF VAC INFO STATEMENT	"	12	D
1101	REMARKS (9000010.1111)			
.01	REMARKS	D0,11,D1,0	1	W
1201	EVENT DATE AND TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F
80101	EDITED FLAG	D0,801	1	S
80102	DATA SOURCE	"	2	F
81101	COMMENTS	D0,811	1	F

4.25 FILE: V SKIN TEST

This file has been designed for joint use by the Indian Health Service and the Department of Veteran Affairs. There will be one record for each type of skin test given to a patient on a given visit. Data must exist for a patient and a visit before data can be entered here. The record is normally created when a skin test is given, and the results, if available, are entered at a later date and matched to the original record. If results are entered and a skin test given does not exist, a new record is created.

In the VA, If a CPT code is entered into PCE that represents a skin test, then a skin test entry will automatically be entered into the V Skin Test file. And vice versa, if a skin test is entered into PCE that represents a CPT code, then a CPT entry will automatically be entered into the V CPT file. This supports getting workload credit from clinical activities. The PCE Code Mapping file defines the relationships between Skin Tests and CPT codes.

GLOBAL: ^AUPNVSK(
FILE #: 9000010.12

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	SKIN TEST	D0,0	1	P
.011	CPT CODE	COMPUTED		
.02	PATIENT NAME	D0,0	2	P

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.03	VISIT	"	3	P
.04	RESULTS	"	4	S
.05	READING	"	5	N
.06	DATE READ	"	6	D
1201	EVENT DATE AND TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1205	HOSPITAL LOCATION	"	5	P
1206	SERVICE CREDIT STOP	"	6	P
1207	SECONDARY VISIT	"	7	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F
80101	EDITED FLAG	D0,801	1	S
80102	DATA SOURCE	"	2	F
81101	COMMENTS	D0,811	1	F

4.26 FILE: V EXAM

This file contains exam information specific to a particular visit for a particular patient. This file contains one record for each exam for each visit. For each visit, therefore, the VISIT field (.03) will be duplicated.

GLOBAL: ^AUPNVXAM(
FILE #: 9000010.13

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	EXAM	D0,0	1	P
.011	CPT CODE	COMPUTED		
.019	EXAM CODE	"		
.02	PATIENT NAME	D0,0	2	P
.03	VISIT	"	3	P
.04	RESULT	"	4	S
1201	EVENT DATE AND TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F
80101	EDITED FLAG	D0,801	1	S
80102	DATA SOURCE	"	2	F
81101	COMMENTS	D0,811	1	F

4.27 FILE: V MEDICATION

This file currently contains a record for each prescription given to a patient on a given visit for PCC Areas. At the current time there is no interface between this file and the O/P or Inpatient Pharmacy system. Multiple records will exist for a given medication (.01) field based on the dates on which they were prescribed. The file contains backward pointers to the IHS Patient file, and visit file, and data must exist in these files for a visit before data can be entered here.

GLOBAL: ^AUPNVMED(
FILE #: 9000010.14

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	MEDICATION	D0,0	1	P
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
.04	NAME OF NON-TABLE DRUG	"	4	F
.05	SIG	"	5	F
.06	QUANTITY	"	6	N
.07	DAYS PRESCRIBED	"	7	N
.08	DATE DISCONTINUED	"	8	D
1101	COMMENT	D0,11	1	F
1201	EVENT DATE&TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F
1211	ORDERING DATE	"	11	D

4.28 FILE: V TREATMENT

This file has been designed for joint use by the Indian Health Service and the Department of Veteran Affairs.

This file contains a record for each treatment provided to a patient on a given patient visit. There will be multiple treatment records for the same treatment (.01) field based on the date on which it was given. Data must exist in the Patient/IHS file and visit file for the patients' visit before data can be entered in the V Treatment file.

GLOBAL: ^AUPNVTRT(
FILE #: 9000010.15

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	TREATMENT	D0,0	1	P
.011	CPT CODE	COMPUTED		
.019	TREATMENT CODE	"		
.02	PATIENT NAME	D0,0	2	P
.03	VISIT	"	3	P
.04	HOW MANY	"	4	N
.05	PROVIDER	"	5	P
.06	PROVIDER NARRATIVE	"	6	P
1201	EVENT DATE AND TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F
80101	EDITED FLAG	D0,801	1	S
80102	DATA SOURCE	"	2	F
80201	PROVIDER NARRATIVE CATEGORY	D0,802	1	P
81101	COMMENTS	D0,811	1	F

4.29 FILE: V PATIENT ED

This file has been designed for joint use by the Indian Health Service and the Department of Veteran Affairs.

This is the file which stores the patient education given to a patient or his responsible care giver. Data must exist in the Patient/IHS file and Visit file for a patient visit before data can be entered in the V Patient Ed File.

GLOBAL: ^AUPNVPED(
FILE #: 9000010.16

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	TOPIC	D0,0	1	P
.011	CPT CODE (computed)	COMPUTED		
.02	PATIENT NAME	D0,0	2	P
.03	VISIT	"	3	P
.05	PROVIDER	"	5	P
.06	LEVEL OF UNDERSTANDING	"	6	S
.07	INDIVIDUAL/GROUP	"	7	S
.08	LENGTH OF EDUC (MINUTES)	"	8	N
.09	CPT CODE	"	9	P
.11	COMMENT	"	11	F
1201	EVENT DATE AND TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F
80101	EDITED FLAG	D0,801	1	S
80102	DATA SOURCE	"	2	F
81101	COMMENTS	D0,811	1	F

4.30 FILE: V PHYSICAL THERAPY

This file contains physical therapy information specific to a particular visit for a particular patient. The VISIT field of this file is a backward pointer to the VISIT file. This file contains one record for each physical therapy procedure for each visit.

GLOBAL: ^AUPNVPT(
FILE #: 9000010.17

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	PT TREATMENT	D0,0	1	P

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.011	CPT CODE	COMPUTED		
.02	PATIENT NAME	D0,0	2	P
.03	VISIT	"	3	P
.04	QUANTITY	"	4	N
1201	EVENT DATE&TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F

4.31 FILE: V CPT

The V CPT file has been defined for joint use by the Indian Health Service and the Department of Veteran Affairs. This is the file used to store CPT related services performed at a visit. Data must exist for a patient and a visit before data can be entered in the V CPT file.

This file is used in the VA to identify procedures that were done to a patient at an encounter or occasion of service. The procedures may have been performed by a primary or secondary provider of patient care. Procedures checked off and scanned from ambulatory care encounter forms are stored here to record that they were done. Results of procedures are not included.

This file is restricted to procedures that have a CPT code. The V Treatment file is used to store procedures without CPT codes that do not fit into any other V-file category.

The Provider Narrative field represents the preferred text for this procedure as defined by the clinician.

GLOBAL: ^AUPNVCPT(
FILE #: 9000010.18

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	CPT	D0,0	1	P
.019	CPT SHORT NAME	COMPUTED		
.02	PATIENT NAME	D0,0	2	P
.03	VISIT	"	3	P

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.04	PROVIDER NARRATIVE	"	4	P
.05	DIAGNOSIS	"	5	P
.07	PRINCIPAL PROCEDURE	"	7	S
.16	QUANTITY	"	16	N
1201	EVENT DATE AND TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F
80101	EDITED FLAG	D0,801	1	S
80102	DATA SOURCE	"	2	F
81101	COMMENTS	D0,811	1	F

4.32 FILE: V ACTIVITY TIME

This file contains one record per visit. It contains the amount of time spent on the visit, the amount of travel time and a computed value with total time.

GLOBAL: ^AUPNVTM(
FILE #: 9000010.19

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	ACTIVITY TIME			
.02	PATIENT NAME			
.03	VISIT			
.04	TRAVEL MINUTES	D0,0	1	N
.049	TOTAL TIME	COMPUTED		
1201	EVENT DATE&TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER KEY	"	10	P

4.33 FILE: V DIAGNOSTIC PROCEDURE RESULT

This file contains one entry for each diagnostic procedure done (e.g., EKG).

GLOBAL: ^AUPNVDXP(
FILE #: 9000010.21

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	TYPE	D0,0	1	P
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
.04	VALUE	"	4	F
.05	ABNORMAL	"	5	F
.06	PARAMS	"	6	F
.07	*PARENT	"	7	P
1201	EVENT DATE&TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F

4.34 FILE: V RADIOLOGY

This file contains radiology information specific to a particular visit for a particular patient. This VISIT field of this file (.03) is a backward pointer to the VISIT file. This file contains one record for each radiology procedure done for each visit, therefore, the VISIT field (.03) will be duplicated. This file is populated by the Radiology Package link or by use of the RAD mnemonic in PCC.

GLOBAL: ^AUPNVRAD(
FILE #: 9000010.22

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	RADIOLOGY PROCEDURE	D0,0	1	P
.019	CPT CODE	COMPUTED		
.02	PATIENT NAME	D0,0	2	P
.03	VISIT	"	3	P
.05	ABNORMAL	"	5	S

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.06	DIAGNOSTIC CODE	"	6	P
1101	IMPRESSION	D0,11	1	F
1201	EVENT DATE&TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F
1211	ORDERING DATE	"	11	D

4.35 FILE: V HEALTH FACTORS

This file has been defined for joint use by the Indian Health Service and the Department of Veteran Affairs.

This is the file used for storing patient health factors identified at a visit. Data must exist in the Patient/IHS and Visit file for a patient's visit before data can be entered in the V Health Factor file.

GLOBAL: ^AUPNVHF(
FILE #: 9000010.23

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	HEALTH FACTOR	D0,0	1	P
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
.04	LEVEL/SEVERITY	"	4	S
.05	PROVIDER	"	5	P
.06	QUANTITY	"	6	N
1201	EVENT DATE AND TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F
80101	EDITED	D0,801	1	S

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
80102	DATA SOURCE	"	2	F
81101	COMMENTS	D0,811	1	F

4.36 FILE: V PATHOLOGY

This file is populated by the Laboratory System with Pathology data.

GLOBAL: ^AUPNVPTH(
FILE #: 9000010.24

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	TYPE	D0,0	1	S
.019	SNOMED CODE	COMPUTED		
.02	PATIENT NAME	D0,0	2	P
.03	VISIT	"	3	P
.04	SPECIMEN	"	4	P
.05	ORGAN/TISSUE	"	5	P
.06	LR ACCESSION NO.	"	6	F
1101	UNITS	D0,11	1	N
1102	ORDER	"	2	N
1109	CURRENT STATUS FLAG	"	9	S
1110	LAB TEST COST	"	10	N
1111	BILLABLE ITEM	"	11	S
1112	LAB POV	"	12	P
1201	DATE&TIME SPECIMEN TAKEN	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F
1401	CPT	D0,14	1	P
1402	CPT - BILLABLE ITEMS	"	2	F
2101	DISEASE (9000010.2421)			
.01	DISEASE	D0,21,D1,0	1	P
.019	SNOMED CODE	COMPUTED		

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
2201	MORPHOLOGY (9000010.2422)			
.01	MORPHOLOGY	D0,22,D1,0	1	P
2301	ETIOLOGY (9000010.2423)			
.01	ETIOLOGY	D0,23,D1,0	1	P
.019	SNOMED CODE	COMPUTED		
2401	FUNCTION (9000010.2424			
.01	FUNCTION	D0,24,D1,0	1	P
.019	SNOMED CODE	COMPUTED		
2501	FUNCTION (9000010.2425)			
.01	PROCEDURE	D0,25,D1,0		
.019	SNOMED CODE	COMPUTED		

4.37 FILE: V MICROBIOLOGY

This file contains all lab tests ordered, with results being entered optionally for selected tests. The file contains backward pointers to the IHS Patient file, and visit file, and data must exist in both of these files for a visit for before data can be entered here. There will be one record for each type lab test ordered for the patient on a given visit; the .01 record may therefore be duplicated.

GLOBAL: ^AUPNVMIC(
FILE #: 9000010.25

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	CULTURE	D0,0	1	P
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
.04	ORGANISM	"	4	P
.05	ANTIBIOTIC	"	5	P
.06	LR ACCESSION NO.	"	6	F
.07	RESULT	"	7	F
.08	COLLECTION SAMPLE	"	8	P
.09	COMPLETE DATE	"	9	D
1101	UNITS	D0,11	1	F
1102	ORDER	"	2	N
1103	SITE	"	3	P
1104	REFERENCE LOW	"	4	F

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
1105	REFERENCE HIGH	"	5	F
1106	THERAPEUTIC LOW	"	6	F
1107	THERAPEUTIC HIGH	"	7	F
1108	SOURCE OF DATA INPUT	"	8	S
1109	CURRENT STATUS FLAG	"	9	S
1110	LAB TEST COST	"	10	N
1111	BILLABLE ITEM	"	11	S
1112	LAB POV	"	12	P
1201	COLLECTION DATE AND TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F
1301	COMMENT1	D0,13	1	F
1302	COMMENT2	"	2	F
1303	COMMENT3	"	3	F
1401	CPT PTR	D0,14	1	P
1402	CPT - BILLABLE ITEMS	"	2	F

4.38 FILE: V NOTE

This file contains each progress note, discharge summary, and operative report for a particular patient and visit.

GLOBAL: ^AUPNVNOT(
FILE #: 9000010.28

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	DOCUMENT TITLE	D0,0	1	P
.02	PATIENT	"	2	P
.03	VISIT	"	3	P
1201	EVENT DATE&TIME	D0,12	1	D
1202	AUTHOR	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F

4.39 FILE: V EMERGENCY VISIT RECORD

This file contains one entry for each emergency room visit. Data items unique to the emergency room form are entered in this file

GLOBAL: ^AUPNVER(
FILE #: 9000010.29

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	FORM ID	D0,0	1	F
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
.04	URGENCY	"	4	S
.05	MEANS OF ARRIVAL	"	5	S
.06	OTHER MEANS OF ARRIVAL	"	6	F
.07	ENTERED ER BY	"	7	S
.08	INFORMANT	"	8	F
.09	NOTIFIED	"	9	S
.11	DISPOSITION OF CARE	"	11	S
.12	DISPOSITION IF OTHER	"	12	F
.13	DEPARTURE DATE&TIME	"	13	D
.14	LEFT AREA	"	14	D
.15	CONDITION ON DEPARTURE	"	15	F
1201	EVENT DATE AND TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F

4.40 FILE: V BLOOD BANK

GLOBAL: ^AUPNVBB(
FILE #: 9000010.31

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	LAB TEST	D0,0	1	P
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
.04	RESULTS	"	4	F
.05	ANTIBODY	"	5	P
.06	LR ACCESSION NO.	"	6	F
.07	BB TEST NAME	"	7	F
1101	UNITS	D0,11	1	F
1102	ORDER	"	2	N
1103	SITE	"	3	P
1104	REFERENCE LOW	"	4	F
1105	REFERENCE HIGH	"	5	F
1106	THERAPEUTIC LOW	"	6	F
1107	THERAPEUTIC HIGH	"	7	F
1108	SOURCE OF DATA INPUT	"	8	S
1109	CURRENT STATUS FLAG	"	9	S
1110	LAB TEST COST	"	10	N
1111	BILLABLE ITEM	"	11	S
1112	LAB POV	"	12	P
1201	COLLECTION DATE AND TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F
1301	COMMENT1	D0,13	1	F
1302	COMMENT2	"	2	F
1303	COMMENT3	"	3	F
1401	CPT PTR	D0,14	1	P
1402	CPT - BILLABLE ITEMS	"	2	F

4.41 4.41 FILE: V PHN

GLOBAL: ^AUPNVPHN(
FILE #: 9000010.32

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	FORM ID	D0,0	1	F
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
.04	RESULT	"	4	S
.05	LEVEL OF INTERVENTION	"	5	S
.06	TYPE OF DECISION MAKING	"	6	S
1201	EVENT DATE AND TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F
2101	PSYCHO/SOCIAL/ENVIRON	D0,21	1	F
2201	NSG DX	D0,22	1	F
2301	SHORT TERM GOALS	D0,23	1	F
2401	LONG TERM GOALS	D0,24	1	F

4.42 FILE: V TRANSACTION CODES

GLOBAL: ^AUPNVTC(
FILE #: 9000010.33

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	TRANSACTION CODE	D0,0	1	P
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
.04	CAN #	"	4	P
.05	SERVICE CLASSIFICATION CODE	"	5	P
.06	CHARGE	"	6	N
.07	HCPCS	"	7	P
.08	MODIFIER	"	8	F
.09	REVENUE CODE	"	9	P

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.11	DESCRIPTION	"	11	F
1201	EVENT DATE AND TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1211	ORDERING DATE	"	11	D
1301	FILE CREATED FROM	D0,13	1	P
1302	IEN OF ENTRY CREATED BY	"	2	N

4.43 FILE: V NARRATIVE TEXT

GLOBAL: ^AUPNVNT(
FILE #: 9000010.34

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	TEXT TYPE	D0,0	1	P
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
1100	TEXT	(9000010.3411)		
.01	TEXT	D0,11,D1,0	1	W
1201	EVENT DATE AND TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1209	EXTERNAL KEY	"	9	F
1210	OUTSIDE PROVIDER NAME	"	10	F

4.44 FILE: V VA MOBILE VISIT RELATED

This file was developed to assist the VA Mobile clinic sites in collecting certain visit related data. The data items are found on the Ambulatory Encounter record form used by the VA Mobile clinics.

GLOBAL: ^AUPNVMVR(
FILE #: 9000010.701

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	CLINIC (LOCATION)	D0,0	1	P
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
.04	ARRIVAL MODE	"	4	S
.05	LEVEL OF SERVICE	"	5	S
.06	CLINIC STATUS	"	6	S
.07	REFERRAL STATUS	"	7	S
.08	REFER FOR HOSPITALIZATION	"	8	S

4.45 FILE: V VA MOBILE VISIT TYPES

This file was developed to assist the VA Mobile clinic sites in collecting certain visit related data. The data items are found on the Ambulatory Encounter record form used by the VA Mobile clinics. The specific data item housed in this file is visit type at the top right hand corner of the form.

GLOBAL: ^AUPNVMVT(
FILE #: 9000010.702

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	VISIT TYPE	D0,0	1	S
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P

4.46 FILE: V VA MOBILE PRES ACTIONS

This file was developed to assist the VA Mobile clinic sites in collecting certain visit related data. The data items are found on the Ambulatory Encounter record form used by the VA Mobile clinics. The specific data item housed in this file is prescription action in the visit conclusion section of the form.

GLOBAL: ^AUPNVMPA(
FILE #: 9000010.703

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	PRESCIPTION ACTION	D0,0	1	S
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P

4.47 FILE: V VA MOBILE REFER FOR OUTPATIENT

This file was developed to assist the VA Mobile clinic sites in collecting certain visit related data. The data items are found on the Ambulatory Encounter record form used by the VA Mobile clinics. The specific data item housed in this file is refer for outpatient in the visit conclusion section of the form.

GLOBAL: ^AUPNVMRO(
FILE #: 9000010.704

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	REFER FOR OUTPATIENT CARE	D0,0	1	S
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P

4.48 FILE: V VA MOBILE SPECIALTY OF REFER

This file was developed to assist the VA Mobile clinic sites in collecting certain visit related data. The data items are found on the Ambulatory Encounter record form used by the VA Mobile clinics. The specific data item housed in this file is specialty of referral in the visit conclusion section of the form.

GLOBAL: ^AUPNVMSP(
FILE #: 9000010.705

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	SPECIALTY OF REFERRAL	D0,0	1	P
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P

4.49 FILE: V VA MOBILE EXAMS ORDERED

GLOBAL: ^AUPNVMEO(
FILE #: 9000010.706

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	EXAM/TEST	D0,0	1	P
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
.04	WHERE ORDERED	“	4	

4.50 FILE: V LINE ITEM (GOODS&SERVICES)

This file contains exam information specific to a particular visit for a particular patient. This file contains one record for each exam for each visit. for each visit, therefore, the VISIT field (.03) will be duplicated.

GLOBAL: ^AUPNVLI(
FILE #: 9000010.99

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	TYPE OF ITEM	D0,0	1	P
.02	PATIENT NAME	"	2	P
.03	VISIT	"	3	P
.04	GOOD/SERVICE	"	4	F
.05	IEN OF ITEM	"	5	N
.06	DESCRIPTION	"	6	F
.07	REVENUE CODE	"	7	P
.08	COST (TRUE COST)	"	8	N
.09	CHARGE (FROM 3PB)	"	9	N
.11	AMT COLLECTED	"	11	N
.12	COST CENTER	"	12	P
.13	COST (NOT BUNDLED)	"	13	N
.14	QUANTITY	"	14	N
.15	HCPCS	"	15	P
.16	CAN #	"	16	F
1101	TOOTH NUMBER	D0,11	1	P
1102	TOOTH SURFACE	"	2	F
1103	NDC #	"	3	F
1104	PRESCRIPTION #	"	4	F
1105	START TIME FOR ANESTHESIOLOGY	"	5	D
1106	STOP TIME FOR ANESTHESIOLOGY	"	6	D
1201	EVENT DATE AND TIME	D0,12	1	D
1202	ORDERING PROVIDER	"	2	P
1203	CLINIC	"	3	P
1204	ENCOUNTER PROVIDER	"	4	P
1208	PARENT	"	8	P
1301	FILE CREATED FROM	D0,13	1	P
1302	IEN OF ENTRY CREATED BY	"	2	N
4100	CPT MODIFIER (9000010.9941)			

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	CPT MODIFIER	D0,41,D1,0	1	F
8000	CPT MODIFIER	D0,80	1	F
9000	CORRESPONDING DIAGNOSIS (MULT)	D0,90	1	P

4.51 FILE: PROBLEM

This file contains patient specific problems entered by the various providers of service. The PATIENT NAME field (.02) is a backward pointer to the IHS PATIENT file. This file contains one record for each problem for each patient, therefore, the KEY field (.01) is duplicated.

As of March 17, 1986, the FACILITY must be entered prior to the NUMBER. If the NUMBER is entered without previously entering the FACILITY the "AA" index is created with no FACILITY pointer.

GLOBAL: ^AUPNPROB(
FILE #: 9000011

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	DIAGNOSIS	D0,0	1	P
.02	PATIENT NAME	"	2	P
.03	DATE LAST MODIFIED	"	3	D
.04	CLASS	"	4	S
.05	PROVIDER NARRATIVE	"	5	P
.06	FACILITY	"	6	P
.07	NMBR	"	7	N
.08	DATE ENTERED	"	8	D
.12	STATUS	"	12	S
.13	DATE OF ONSET	"	13	D
.14	USER LAST MODIFIED	"	14	P
1.01	PROBLEM	D0,1	1	P
1.02	CONDITION	"	2	S
1.03	ENTERED BY	"	3	P
1.04	RECORDING PROVIDER	"	4	P
1.05	RESPONSIBLE PROVIDER	"	5	P
1.06	SERVICE	"	6	P
1.07	DATE RESOLVED	"	7	D
1.1	SERVICE CONNECTED	"	10	S

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
1.11	AGENT ORANGE EXPOSURE	"	11	S
1.12	IONIZING RADIATION EXPOSURE	"	12	S
1.13	PERSIAN GULF EXPOSURE	"	13	S
1101	NOTE FACILITY (9000011.11)			
.01	NOTE FACILITY	D0,11,D1,0	1	P
1101	NOTE (9000011.1111)			
.01	NOTE NMBR	D0,11,D1,11,D2,0	1	N
.03	NOTE NARRATIVE	"	3	F
.04	STATUS	"	4	S
.05	DATE NOTE ADDED	"	5	D
.06	AUTHOR	"	6	P

4.52 FILE: OFFSPRING HISTORY

The Offspring History file is used in connection with a prenatal program in place in some PCC Areas. Each record contains birth data about a specific child that is gathered as part of a prenatal visit. The file contains backward pointers to the mother's Patient file, and visit file, and data must be in these files for a visit before data can be entered here. A separate record is maintained for each child by date of the child's birth.

GLOBAL: ^AUPNOFFH(
FILE #: 9000012

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	DATE OF OFFSPRING BIRTH	D0,0	1	D
.02	PATIENT NAME	"	2	P
.04	FIRST NAME	"	4	F
.05	SEX	"	5	S
.06	BIRTH WEIGHT	"	6	F
.07	GESTATIONAL AGE	"	7	N
.08	APGAR SCORE 1 MIN	"	8	N
.09	APGAR SCORE 5 MIN	"	9	N
.11	DATE OF DEATH	"	11	D
.12	CAUSE OF DEATH	"	12	F
2101	PERINATAL (9000012.21)			
.01	PERINATAL COMPLICATION	D0,21,D1,0	1	F
3101	NEONATAL (9000012.31)			

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	NEONATAL COMPLICATION	D0,31,D1,0	1	F

4.53 FILE: PERSONAL HISTORY

*** WARNING *** ... The .05 field requires programmer access for delete. The field is optional. Once data is entered it may be changed, but never deleted. The affect of overriding this protection and deleting the field would be to leave a residual entry in the "AA" index pointing to the PERSONAL HISTORY entry from which the field was deleted. The Personal History file contains information on a patient's past health problems that is gathered retroactively at a patient visit. Since the data is the patient's view of his/her problems, not necessarily substantiated by a confirmed physician's diagnosis, the information is stored here rather than in the POV record. There will be a separate record for each health problem for a patient. The file contains backward pointers to the IHS Patient file and visit file, and data must exist in both of these files for the patient and visit before data can be entered here.

GLOBAL: ^AUPNPH(
FILE #: 9000013

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	DIAGNOSIS	D0,0	1	P
.02	PATIENT NAME	"	2	P
.03	DATE NOTED	"	3	D
.04	PROVIDER NARRATIVE	"	4	P
.05	DATE OF ONSET	"	5	D

4.54 FILE: FAMILY HISTORY

This file contains a history of family health problems for a given patient. These are not the patient's problems, but those of some immediate member of the family. The information is gathered as a result of a patient visit at which the patient provides the history. The file contains backward pointers to the IHS Patient file and visit file, and data must exist in both of these files for the patient and visit before data can be entered here.

GLOBAL: ^AUPNFH(
FILE #: 9000014

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	DIAGNOSIS	D0,0	1	P
.02	PATIENT NAME	"	2	P

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.03	DATE NOTED	"	3	D
.04	PROVIDER NARRATIVE	"	4	P

4.55 FILE: *UNMET SURGICAL NEED

GLOBAL: ^AUPNUMS(FILE #: 9000015

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	OPERATION	D0,0	1	P
.02	PATIENT NAME	"	2	P
.03	DATE NOTED	"	3	D
.04	NARRATIVE QUALIFIERS	"	4	P

4.56 FILE: *HISTORY OF PROCEDURES

GLOBAL: ^AUPNHOS(
FILE #: 9000016

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	OPERATION	D0,0	1	P
.02	PATIENT NAME	"	2	P
.03	DATE NOTED	"	3	D
.04	NARRATIVE QUALIFIERS	"	4	P
.05	DATE OF SURGERY	“	5	D

4.57 FILE: REPRODUCTIVE FACTORS

This file is used to maintain information on reproductive factors for women of reproductive age. It points to the PATIENT file (9000001) and is DINUM to it. Associated files include PRENATAL (9000002) and OFFSPRING HISTORY (9000012).

GLOBAL: ^AUPNREP(
FILE #: 9000017

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	NAME	D0,0	1	P
1	REPRODUCTIVE HISTORY	"	2	F
1.1	DATE REPRO HX OBTAINED	"	3	D

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
2	LAST MENSTRUAL PERIOD	"	4	D
2.1	DATE LMP HX OBTAINED	"	5	D
3	CONTRACEPTION METHOD	"	6	S
3.05	CONTRACEPTION BEGUN	"	7	D
3.1	DATE METHOD HX OBTAINED	"	8	D
4	EDC	"	9	D
4.05	HOW EDC DETERMINED	"	10	S
4.1	DATE EDC DETERMINED	"	11	D

4.58 FILE: HEALTH STATUS

This file contains the latest of each Health Factor by category.

GLOBAL: ^AUPNHF(
FILE #: 9000019

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	HEALTH FACTOR	D0,0	1	P
.02	PATIENT NAME	"	2	P
.03	DATE NOTED	"	3	D
.04	LEVEL/SEVERITY	"	4	P
.06	QUANTITY	“	6	N

4.59 FILE: PT LAB RELATED DATA

This file contains patient related lab data. For example, ABO Group, RBC Antigens, etc. This data will originate in the Lab package and be passed over to this file.

GLOBAL: ^AUPNLABR(
FILE #: 9000020

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.01	NAME	D0,0	1	P
.02	ABO GROUP	"	2	S
.03	DATE LAST MODIFIED	"	3	D
.04	RH TYPE	"	4	S
.05	DO NOT TRANSFUSE	"	5	S
.06	RBC ANTIGENS	"	6	S

FIELD #	FIELD NAME	SUBSCRIPT	PIECE	TYPE
.07	ANTIBODIES IDENTIFIED	"	7	S

5.0 Cross-References

JUN 2,1997@10:40 FILE XREF LIST

PATIENT 9000001

NAME (.01)
1 B REGULAR

DATE ESTABLISHED (.02)
1 ADTE REGULAR

PCIS ID NO. (.06)
1 AZZ REGULAR

PRIMARY CARE PROVIDER (.14)
1 AK REGULAR
Provides a PRIMARY CARE PROVIDER sorting index.

EMPLOYER NAME (.19)
1 AF REGULAR

SPOUSE'S EMPLOYER NAME (.22)
1 AG REGULAR

SSN VERIFICATION STATUS (.23)
1 AS REGULAR
This cross reference is used by the SSN Matching Processes and reports.

TRIBE OF MEMBERSHIP (1108)
1 AE REGULAR

TRIBE QUANTUM (1109)
1 AZ1 MUMPS
2 AQ2 MUMPS

INDIAN BLOOD QUANTUM (1110)
1 AZ2 MUMPS
2 AQ1 MUMPS

CLASSIFICATION/BENEFICIARY (1111)
1 AD REGULAR

CURRENT RESIDENCE DATE (1113)
1 AJ MUMPS

CURRENT RESIDENCE PTR (1117)
1 AH MUMPS

CURRENT COMMUNITY (1118)
1 AC REGULAR

NOK RELATIONSHIP (2802)
1 TRIGGER

EC RELATIONSHIP (3102)
1 TRIGGER

MEDICARE ELIGIBLE 9000003

PATIENT NAME (.01)
1 B REGULAR

MEDICARE CLM*S* 9000003.01

CLAIM (.01)
1 B REGULAR

PATIENT NAME (.02)
1 AC REGULAR

VISIT (.03)
1 AD REGULAR

TYPE OF CLAIM (.12)
1 C REGULAR

POLICY HOLDER 9000003.1

NAME OF POLICY HOLDER (.01)
1 B REGULAR
2 TRIGGER

PATIENT POINTER (.02)
1 C REGULAR

INSURANCE COMPANY (.03)
1 E REGULAR

POLICY NUMBER (.04)
1 D REGULAR

GROUP NAME (.06)
1 AG REGULAR

EMPLOYER (.16)
2 AE REGULAR

MEDICARE ELIGIBLE 9000004

PATIENT NAME (.01)

1 B REGULAR
2 AD MUMPS

MEDICAID NUMBER (.03)
1 AB MUMPS

STATE (.04)
1 AB-TOO MUMPS

POLICY HOLDER (.09)
1 C REGULAR

MEDICARE CLAIMS 9000004.01

CLAIM (.01)
1 B REGULAR

PATIENT NAME (.02)
1 AC REGULAR

VISIT (.03)
1 AD REGULAR

RAILROAD ELIGIBLE 9000005

PATIENT NAME (.01)
1 B REGULAR

RAILROAD CLAIMS 9000005.01

CLAIM (.01)
1 B REGULAR

PATIENT NAME (.02)
1 AC REGULAR

VISIT (.03)
1 AD REGULAR

PRIVATE INSURANCE ELIGIBLE 9000006

PATIENT NAME (.01)
1 B REGULAR

PRIVATE INSURANCE CLAIMS 9000006.01

CLAIM (.01)
1 B REGULAR

PATIENT NAME (.02)
1 AC REGULAR

VISIT (.03)

1 AD REGULAR

SCHEDULED ENCOUNTER 9000007

DATE/TIME NEXT VISIT (.01)
1 B REGULAR
2 AZ9 MUMPS

PATIENT NAME (.02)
1 AC REGULAR
2 AA MUMPS

SURVEILLANCE 9000008

PATIENT NAME (.01)
1 B REGULAR

CODE (.02)
1 AA MUMPS

CLINICAL REMINDER 9000009

PATIENT NAME (.01)
1 B REGULAR

CODE (.02)
1 AA MUMPS

VISIT 9000010

VISIT/ADMIT DATE&TIME (.01)
1 B REGULAR
Regular B cross reference on .01 Visit/Admit Date&Time
^AUPNVSIT("B",Visit/Admit Date&Time,ien)=""
2 AAHTOO MUMPS
This cross reference indexes Hospitalization visits (#.07=H) by patient and inverse visit date. Used to get at the last n Hospitalizations. Used by PCC Health Summary.
3 AA-TOO MUMPS
This cross reference indexes the visits by patient and inverse date. It is used to find the last n visits by a particular patient. Used by PCC Q-Man, PCC Health Summary, PCC Management Reports, etc. The name AA-TOO signifies that the cross reference used several field values and therefore the index AA is set on all of the fields.
4 AV9 MUMPS
The AV9 cross reference is used to set DIC("DR")="" in order to suppress the asking of identifiers during a file shift from visit to a V File. When adding data to V Files using input templates starting in the Visit file this suppressing the asking of identifiers in the V File.
5 ADEL2 MUMPS

This sets the "delete" flag based upon the Dependent Entry Count.

6 AE MUMPS
Cross reference for hospital location.

7 AAAP1 MUMPS
This is a cross reference for OE 3 and CPRS. It is made on the patient, visit date/time, hospital location, primary type of visit, visit IEN.

DATE VISIT CREATED (.02)

1 APCIS MUMPS
Flag for IHS data center transmission. DIU(0) prevents user re-indexing through direct fileman, DUZ(AG) selectively sets the index for IHS sites.

2 AMRG MUMPS
If there is not a merge for this date - the first visit for this day, set this x-ref. This tells the merge where to start looking.

3 TRIGGER
Triggers the setting of DT into field #13.

4 ABILL MUMPS
Flag for IHS Billing System. Set only if running the IHS Billing Package.

5 TRIGGER

PATIENT NAME (.05)

1 AC REGULAR
Regular cross reference of Patient field.

2 AA MUMPS
Indexes visits by patient and inverse visit date. Used to find the last n visits made by a patient. Used by PCC Q-Man, PCC Health Summary, etc.

3 AAHTOO2 MUMPS
Indexes HOSPITALIZATION visits by patient, inverse visit date. Used to find the last n Hospitalizations for a given patient. Used by PCC Health Summary.

4 AAAP2 MUMPS
This is a cross reference for OE 3 and CPRS. It is made on the patient Visit date/time, hospital location, primary type of visit, visit IEN.

SERVICE CATEGORY (.07)

1 AAH MUMPS
Indexes Hospitalization visits by patient and inverse visit date. Used to find the last n Hospitalizations for a given patient.

2 AI MUMPS

DEPENDENT ENTRY COUNT (.09)

1 ADEL MUMPS

PARENT VISIT LINK (.12)

1 AD REGULAR PARENT VISIT LINK

2 AITOO MUMPS
This cross reference is set only for main visits and killed for secondary visits.

3 APV MUMPS
THIS UPDATES THE DEPENDENT ENTRY COUNT WHEN A CHILD VISIT IS CREATED.

DATE LAST MODIFIED (.13)
1 APCISTOO MUMPS
APCIS X-REF FOR IHS FOR DATA CENTER TRANSMISSION.
2 ABILLTOO MUMPS IHS BILLING X-REF.
3 TRIGGER
4 AQAJ2 MUMPS
UPDATES QI JCAHO IMS FILE If a facility is running the QI Linkages-JCAHO package, this xref will update the QI JCAHO IMS file for hospitalizations only that have been modified after the coding is complete.

MFI STATUS (.15)
1 AMFI MUMPS

ELIGIBILITY (.21)
1 AVAA2 MUMPS
Set the "AA" cross reference equal to the pt's eligibility (pointer).

HOSPITAL LOCATION (.22)
1 AHL MUMPS
Hospital Location inverse date x-ref.
2 AAAP3 MUMPS
This is a cross reference for OE 3 and CPRS. It is made on the patient, visit date/time, hospital location, primary type of visit, visit IEN.

BILLING LINK (.28)
1 ABP REGULAR

SERVICE PROVIDED (15001)
1 AOS MUMPS
Service Provided CROSS REFERENCE USING PATIENT,VISIT,TYPE OF SERVICE PROVIDED.
3 TRIGGER

PRIMARY (15003)
1 AAAP MUMPS
Cross reference for OE 3 and CPRS this gives the patient, visit date/time, hospital location, primary type of visit, visit IEN.

V MEASUREMENT 9000010.01

TYPE (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO MUMPS

This cross reference is used for searches in sequence by patient, measurement type, inverted visit date, and internal entry number.
"AA",PATIENT,TYPE,VISIT,DA

4 AQTOO MUMPS

5 AQPCTOO MUMPS
"AQ" xref for %iles. If change type to not Ht or Wt, and was previously a Ht or Wt, will delete the "AQ" xref for %iles and the .05 field value. If change type to Ht or Wt, will set "AQ" xref and .05 %ile field value.

PATIENT NAME (.02)

1 AC REGULAR

2 AATOO2 MUMPS

VISIT (.03)

1 AD REGULAR
This is used for programmed lookup by visit internal entry number.

2 AA MUMPS
This cross-reference is used for searches in sequence by patient, measurement type, inverted visit date, and internal entry number.
"AA",PATIENT,TYPE,VISIT,DA

3 AV10 MUMPS
This cross reference is used to add "1" to the Dependent Entry Count field (#.09) of the related Visit file (9000010) entry to indicate that there is a file (in this case measurement) pointing to the Visit. When the measurement entry is deleted, this cross reference is used to subtract "1" from the Dependent Entry Count field (#.09) of the related Visit file (9000010) entry.

VALUE (.04)

1 AQPC MUMPS
If patient under age 18, measurement a height or weight will set a value in the .05 percentile field of this file and then execute all xrefs and set the "AQ" compound x-ref on the .05 field directly prefacing the %ile value with HPC for ht %ile and WPC for wt %ile.

2 AQ REGULAR

V HOSPITALIZATION 9000010.02

DATE OF DISCHARGE (.01)

1 B REGULAR

2 AV9 MUMPS

3 AATOO MUMPS

PATIENT NAME (.02)

1 AC REGULAR

2 AA MUMPS

VISIT (.03)

1 AD REGULAR
2 AV10 MUMPS

DISCHARGE TYPE (.06)
1 TRIGGER

CODING COMPLETE (.15)
1 AQAJ1 MUMPS
If a facility is running the QI LINKAGES-JCAHO package, this xref will update the QI JCAHO IMS file for this hospitalization as it is completed. This update may include additional clarification questions needed by JCAHO software.

V CHS **9000010.03**

AUTHORIZING FACILITY (.01)
1 B REGULAR
2 AV9 MUMPS

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO MUMPS

VISIT (.03)
1 AD REGULAR
2 AV10 MUMPS
3 AA MUMPS

AUTHORIZATION NO. (.04)
1 AUTHNO REGULAR

V EYE GLASSES **9000010.04**

NAME (.01)
1 B REGULAR
2 AV9 MUMPS

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO MUMPS

VISIT (.03)
1 AD REGULAR
2 AA MUMPS
3 AV10 MUMPS

DRE SPHERE (1902)
1 AV1 MUMPS

DRE CYLINDER (1903)

1 AV2 MUMPS

DLE SPHERE (1905)
1 AV3 MUMPS

DLE CYLINDER (1906)
1 AV4 MUMPS

V DENTAL **9000010.05**

SERVICE CODE (.01)
1 B REGULAR
2 AV9 MUMPS
3 AZ8 MUMPS

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO MUMPS

VISIT (.03)
1 AD REGULAR
2 AA MUMPS
3 AV10 MUMPS

OPERATIVE SITE (.05)
1 AO REGULAR

V PROVIDER **9000010.06**

PROVIDER (.01)
1 B REGULAR
2 AV9 MUMPS

PATIENT NAME (.02)
1 AC REGULAR

VISIT (.03)
1 AD REGULAR
This is used for programmed lookup by visit internal entry number.
2 AV10 MUMPS
This cross reference is used to add "1" to the Dependent Entry Count field (#.09) of the related Visit file (9000010) entry to indicate that there is a file (in this case V Provider) pointing to the Visit. When the measurement entry is deleted, this cross reference is used to subtract "1" from the Dependent Entry Count field (#.09) of the related Visit file (9000010) entry.

V POV **9000010.07**

POV (.01)

1 B REGULAR
2 AV9 MUMPS
3 AE MUMPS

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO MUMPS

VISIT (.03)
1 AD REGULAR
This cross-reference is used for searches by the visit pointer and internal entry number. "AD",VISIT pointer value, DA
2 AA MUMPS
This cross reference is used for searches in sequence by patient, inverted visit date (from the Visit file) and the internal entry number. "AA",PATIENT,inverted VISIT, DA
3 AV10 MUMPS
This cross-reference adds and subtracts from the dependent entry count in the VISIT file.

V PROCEDURE 9000010.08

PROCEDURE (.01)
1 B REGULAR
2 AV9 MUMPS

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO MUMPS

VISIT (.03)
1 AD REGULAR
2 AA MUMPS
3 AV10 MUMPS

OPERATING PROVIDER (.11)
1 AE REGULAR

V LAB 9000010.09

LAB TEST (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO2 MUMPS
4 AETOO MUMPS
5 AQTOO MUMPS Q-MAN XREF

PATIENT NAME (.02)
1 AC REGULAR

2 AATOO MUMPS
3 AETOO2 MUMPS
4 AOP2 MUMPS

VISIT (.03)
1 AD REGULAR
2 AA MUMPS
3 AV10 MUMPS
4 AE MUMPS
5 AOP3 MUMPS

RESULTS (.04)
1 AR MUMPS
2 AQ MUMPS
Sets and kills "AQ" index used by the QUERY MANAGER

LR ACCESSION NO. (.06)
1 ALR MUMPS
2 ALR0 REGULAR

ORDERING PROVIDER (1202)
1 AOP MUMPS

V IMMUNIZATIONS 9000010.11

IMMUNIZATION (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO MUMPS
This cross reference is used for searches in sequence by patient, immunization internal entry, inverted visit date, and internal entry number. "AA",PATIENT,IMMUNIZATION,VISIT,DA
4 AQTOO MUMPS Q-MAN XREF

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO2 MUMPS

VISIT (.03)
1 AD REGULAR
This cross reference is used for searches by the visit pointer and internal entry number. "AD",VISIT pointer, DA
2 AA MUMPS
This cross-reference is used for searches in sequence by patient, Immunization pointer, inverted visit date, and internal entry number. "AA",PATIENT,IMMUNIZATION,VISIT,DA
3 AV10 MUMPS

This cross-reference adds and subtracts from the dependent entry count in the VISIT file.
4 ADT MUMPS

SERIES (.04)
1 AQMUMPS Q-MAN XREF

V SKIN TEST 9000010.12

SKIN TEST (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO MUMPS
This cross reference is used for searches in sequence by patient, Skin test pointer, inverted Visit date, and internal entry number.
"AA",PATIENT,SKIN TEST,VISIT,DA
4 AQTOO MUMPS
This is a "Q-Man" cross-reference.

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO2 MUMPS
This is a Health Summary cross-reference. "AA",PATIENT,SKIN TEST, VISIT,DA

VISIT (.03)
1 AD REGULAR
This cross reference allows look-up of entries by patient name.
2 AA MUMPS
This cross reference is used for searches in sequence by patient, skin test pointer, inverted visit date, and internal entry number.
"AA",PATIENT,SKIN TEST,VISIT,DA
3 AV10 MUMPS
This cross-reference is for adding and subtracting from the dependent entry count in the VISIT file.

RESULTS (.04)
1 AZ1 MUMPS

READING (.05)
1 AZ2 MUMPS
2 AE REGULAR
This cross-reference searches on the results of skin tests across all patients.
"AE",READING,DA
3 AQ MUMPS
This is a "Q-Man" cross-reference.

SECONDARY VISIT (1207)

1 AS REGULAR

PARENT (1208)
1 APT REGULAR
This is a regular cross reference on the PARENT field. It is used by QMAN.

V EXAM **9000010.13**

EXAM (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO MUMPS
This cross reference is used for searches in sequence by patient, Exam pointer, inverted visit date, and internal entry number.
"AA",PATIENT,EXAM,VISIT,DA
4 AQTOO MUMPS QMAN XREF

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO2 MUMPS

VISIT (.03)
1 AD REGULAR
This cross reference is used for searches by the visit pointer and internal entry number. "AD",VISIT,DA
2 AA MUMPS
This cross reference is used for searches in sequence by patient, exam pointer, inverted visit, internal entry number.
"AA",PATIENT,EXAM,VISIT,DA
3 AV10 MUMPS
This cross-reference adds and subtracts from the dependent entry count in the VISIT file.

RESULT (.04)
1 AQ MUMPS

V MEDICATION **9000010.14**

MEDICATION (.01)
1 B REGULAR
2 AV9 MUMPS

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO MUMPS

VISIT (.03)
1 AD REGULAR

2 AAMUMPS
3 AV10 MUMPS

EXTERNAL KEY (1209)
1 AXK REGULAR

V TREATMENT 9000010.15

TREATMENT (.01)
1 B REGULAR
2 AV9 MUMPS

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO MUMPS

VISIT (.03)
1 AD REGULAR
This cross reference is used for searches by the visit pointer and internal entry number.
2 AAMUMPS
This cross reference is used for searches in sequence by patient, inverted visit date, and the internal entry number.
"AA",PATIENT,VISIT,DA
3 AV10 MUMPS
This cross-reference adds and subtracts from the dependent entry count in the VISIT file.

V PATIENT ED 9000010.16

TOPIC (.01)
1 B REGULAR
2 AV9 MUMPS

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO MUMPS

VISIT (.03)
1 AD REGULAR
2 AAMUMPS
This is a Health Summary cross-reference. "AA",PATIENT,VISIT,DA
3 AV10 MUMPS
This cross-reference adds and subtracts from the dependent entry count in the VISIT file.

V PHYSICAL THERAPY 9000010.17

PT TREATMENT (.01)
1 B REGULAR

2 AV9 MUMPS

PATIENT NAME (.02)
1 AC REGULAR

VISIT (.03)
1 AD REGULAR
2 AV10 MUMPS

V CPT **9000010.18**

CPT (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO MUMPS
This cross reference is used for searches in sequence by Patient, CPT internal entry number, inverted visit date, and internal entry number. "AA",PATIENT,CPT,VISIT,DA

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO2 MUMPS
This cross reference is used for searches in sequence by patient, CPT internal entry number, inverted visit date, and internal entry number. "AA",PATIENT,CPT,VISIT,DA
3 C REGULAR
This field allows look-up on the file by the patient's name.

VISIT (.03)
1 AD REGULAR
This cross reference is used for searches by the visit pointer and internal entry number. "AD",VISIT,DA
2 AA MUMPS
This cross reference is used for searches in sequence by patient, CPT internal entry number, inverted visit date, and internal entry number. "AA",PATIENT,CPT,VISIT,DA
3 AV10 MUMPS
This cross-reference adds and subtracts from the dependent entry count in the VISIT file.

V ACTIVITY TIME **9000010.19**

ACTIVITY TIME (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO MUMPS

PATIENT NAME (.02)
1 AC REGULAR

2 AATOO2 MUMPS

VISIT (.03)
1 ADREGULAR
2 AAMUMPS
3 AV10 MUMPS

V DIAGNOSTIC PROCEDURE RESULT 9000010.21

TYPE (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO MUMPS
4 AE MUMPS
5 APTOO MUMPS
6 AQTOO MUMPS

PATIENT NAME (.02)
1 ACREGULAR
2 AATOO2 MUMPS

VISIT (.03)
1 ADREGULAR
2 AAMUMPS
3 AV10 MUMPS

VALUE (.04)
1 TRIGGER
TRIGGERS 'ABNORMAL' FIELDS BASED ON VALUE OF X AND PARAMS
2 AQMUMPS

PARAMS (.06)
1 TRIGGER

*PARENT (.07)
1 AP MUMPS
Index to find non-value attribute given the parent

V RADIOLOGY 9000010.22

RADIOLOGY PROCEDURE (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO MUMPS
4 AQMUMPS
Sets the "AQ" xref reference; a compound xref that has both the dfn of the V RAD entry and the value of the .05 abnormal field.

PATIENT NAME (.02)

1 AC REGULAR
2 AATOO2 MUMPS

VISIT (.03)
1 AD REGULAR
2 AA MUMPS
3 AV10 MUMPS

ABNORMAL (.05)
1 AQTOO MUMPS

V HEALTH FACTORS 9000010.23

HEALTH FACTOR (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO1 MUMPS
This cross reference is used for searches in sequence by patient, health factor internal entry number, inverted visit date, and internal entry number. "AA",PATIENT,HEALTH FACTORS,VISIT,DA

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO MUMPS

VISIT (.03)
1 AD REGULAR
2 AA MUMPS
3 AV10 MUMPS

V PATHOLOGY 9000010.24

TYPE (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO MUMPS
4 AQTOO MUMPS QMAN XREF

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO2 MUMPS

VISIT (.03)
1 AD REGULAR
2 AA MUMPS
3 AV10 MUMPS

SPECIMEN (.04)
1 AQ MUMPS

V MICROBIOLOGY 9000010.25

CULTURE (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO2 MUMPS
4 AETOO MUMPS

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO MUMPS
3 AETOO2 MUMPS
4 AOP2 MUMPS

VISIT (.03)
1 AD REGULAR
2 AA MUMPS
3 AV10 MUMPS
4 AE MUMPS

LR ACCESSION NO. (.06)
1 ALR MUMPS
2 ALR0 REGULAR

ORDERING PROVIDER (1202)
1 AOP MUMPS

V NOTE 9000010.28

DOCUMENT TITLE (.01)
1 B REGULAR
2 AV9 MUMPS

PATIENT (.02)
1 AC REGULAR
2 AATOO MUMPS

VISIT (.03)
1 AD REGULAR
2 AA MUMPS
3 AZ10 MUMPS

V EMERGENCY VISIT RECORD 9000010.29

FORM ID (.01)
1 B REGULAR
2 AV9 MUMPS

PATIENT NAME (.02)
1 AC REGULAR

VISIT (.03)
1 ADREGULAR
This cross reference is used for searches by the visit pointer and internal entry number. "AD",VISIT,DA
3 AV10 MUMPS
This cross-reference adds and subtracts from the dependent entry count in the VISIT file.

V BLOOD BANK 9000010.31

CULTURE (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO2 MUMPS
4 AETOO MUMPS

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO MUMPS
3 AETOO2 MUMPS
4 AOP2 MUMPS

VISIT (.03)
1 ADREGULAR
2 AA MUMPS
3 AV10 MUMPS
4 AE MUMPS

LR ACCESSION NO. (.06)
1 ALR MUMPS
2 ALR0 REGULAR

ORDERING PROVIDER (1202)
1 AOP MUMPS

V PHN 9000010.32

FORM ID (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO MUMPS
This cross reference is used for searches in sequence by patient, Exam pointer, inverted visit date, and internal entry number.
4 AQTOO MUMPS QMAN XREF

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO2 MUMPS

VISIT (.03)
1 ADREGULAR
This cross reference is used for searches by the visit pointer and internal entry number. "AD",VISIT,DA
2 AAMUMPS
This cross reference is used for searches in sequence by patient, exam pointer, inverted visit, internal entry number.
"AA",PATIENT,EXAM,VISIT,DA
3 AV10 MUMPS
This cross-reference adds and subtracts from the dependent entry count in the VISIT file.

RESULT (.04)
1 AQMUMPS

V TRANSACTION CODES 9000010.33

TRANSACTION CODE (.01)
1 B REGULAR
2 AV9 MUMPS
3 TRIGGER
4 TRIGGER
5 TRIGGER
6 TRIGGER
7 TRIGGER
8 TRIGGER
9 TRIGGER

PATIENT NAME (.02)
1 AC REGULAR

VISIT (.03)
1 ADREGULAR
This cross reference is used for searches by the visit pointer and internal entry number. "AD",VISIT,DA
2 AV11 MUMPS
3 AV10 MUMPS
This cross-reference adds and subtracts from the dependent entry count in the VISIT file.

V VA MOBILE VISIT RELATED 9000010.701

CLINIC (LOCATION) (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO MUMPS

PATIENT NAME (.02)
1 AC REGULAR

2 AATOO2 MUMPS

VISIT (.03)
1 AD REGULAR
2 AA MUMPS
3 AV10 MUMPS

V VA MOBILE VISIT TYPES 9000010.702

VISIT TYPE (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO MUMPS

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO2 MUMPS

VISIT (.03)
1 AD REGULAR
2 AA MUMPS
3 AV10 MUMPS

V VA MOBILE PRES ACTIONS 9000010.703

PRESCIPTION ACTION (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO MUMPS

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO2 MUMPS

VISIT (.03)
1 AD REGULAR
2 AA MUMPS
3 AV10 MUMPS

V VA MOBILE REFER FOR OUTP 9000010.704

REFER FOR OUTPATIENT CARE (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO MUMPS

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO2 MUMPS

VISIT (.03)
1 ADREGULAR
2 AAMUMPS
3 AV10 MUMPS

V VA MOBILE SPECIALTY OF REFER 9000010.705

SPECIALTY OF REFERRAL (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO MUMPS

PATIENT NAME (.02)
1 ACREGULAR
2 AATOO2 MUMPS

VISIT (.03)
1 ADREGULAR
2 AAMUMPS
3 AV10 MUMPS

V VA MOBILE EXAMS ORDERED 9000010.706

EXAM/TEST (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO MUMPS

PATIENT NAME (.02)
1 ACREGULAR
2 AATOO2 MUMPS

VISIT (.03)
1 ADREGULAR
2 AAMUMPS
3 AV10 MUMPS

V LINE ITEM (GOODS&SERVICES) 9000010.99

TYPE OF ITEM (.01)
1 B REGULAR
2 AV9 MUMPS
3 TRIGGER
Clears out the #.04 field value when the .01 is changed.
4 TRIGGER
Clears out the #.05 field when the .01 is edited/deleted.
5 TRIGGER
Clears out the .06 value when the .01 is edited/deleted.

PATIENT NAME (.02)

1 AC REGULAR

VISIT (.03)
1 AD REGULAR
This cross reference is used for searches by the visit pointer and internal entry number. "AD",VISIT,DA
3 AV10 MUMPS
This cross-reference adds and subtracts from the dependent entry count in the VISIT file.

IEN OF ITEM (.05)
1 TRIGGER
2 TRIGGER

PROBLEM 9000011

DIAGNOSIS (.01)
1 B REGULAR
2 AZ9 MUMPS
Controls the behavior of the input templates used by IHS to populate and maintain this file.

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO MUMPS
Allows problem retrieval by patient, facility, and problem number (Nmbr); the number is used as a string in "000.00" format to assure a consistent ordering.
3 ACTIVE1 MUMPS
Allows problem retrieval by patient and status, in order of entry.

FACILITY (.06)
1 AV1 MUMPS No longer in use.
2 AATOO2 MUMPS
Allows problem retrieval by patient, facility, and problem number (Nmbr); the number is used as a string in "000.00" format to assure a consistent ordering.

NMBR (.07)
1 AA MUMPS
Allows problem retrieval by patient, facility, and problem number (Nmbr); the number is used as a string in "000.00" format to assure a consistent ordering.

STATUS (.12)
1 ACTIVE MUMPS
Allows problem retrieval by patient and status, in order of entry.

PROBLEM (1.01)

1 C REGULAR

OFFSPRING HISTORY 9000012

DATE OF OFFSPRING BIRTH (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO MUMPS

PATIENT NAME (.02)
1 AC REGULAR
2 AA MUMPS

PERSONAL HISTORY 9000013

DIAGNOSIS (.01)
1 B REGULAR
2 AV9 MUMPS

PATIENT NAME (.02)
1 AC REGULAR
2 AATOO MUMPS

DATE NOTED (.03)
1 AD REGULAR

DATE OF ONSET (.05)
1 AA MUMPS

FAMILY HISTORY 9000014

DIAGNOSIS (.01)
1 B REGULAR
2 AV9 MUMPS

PATIENT NAME (.02)
1 AC REGULAR

DATE NOTED (.03)
1 AD REGULAR

REPRODUCTIVE FACTORS 9000017

NAME (.01)
1 B REGULAR

HEALTH STATUS 9000019

HEALTH FACTOR (.01)
1 B REGULAR
2 AV9 MUMPS
3 AATOO MUMPS

PATIENT NAME (.02)
1 AC REGULAR
2 AA MUMPS

DATE NOTED (.03)
2 AATOO2 MUMPS

PT LAB RELATED DATA 9000020

NAME (.01)
1 B REGULAR

6.0 Exported Options

There are no options in this package.

7.0 Menu Diagram

There are no options in this package.

8.0 Arching and Purging

There is no archiving and purging in this package.

9.0 External Relations

This package calls the following documented entry points:

Routine is Invoked by:

^%DT AUPNLK1I,AUPNLK2B,|dd9000001,|dd9000001.41,|dd9000001.51
|dd9000003,|dd9000003.01,|dd9000003.1,|dd9000003.11
|dd9000004,|dd9000004.01,|dd9000004.11,|dd9000005
|dd9000005.01,|dd9000005.11,|dd9000006.01,|dd9000006.11
|dd9000007,|dd9000008
|dd9000009,|dd9000010,|dd9000010.01,|dd9000010.02
|dd9000010.0251,|dd9000010.0253,|dd9000010.0254,|dd9000010.03
|dd9000010.04,|dd9000010.05,|dd9000010.06,|dd9000010.07
|dd9000010.08,|dd9000010.09,|dd9000010.11,|dd9000010.12
|dd9000010.13
|dd9000010.14,|dd9000010.15,|dd9000010.16,|dd9000010.17
|dd9000010.18,|dd9000010.19,|dd9000010.21,|dd9000010.22
|dd9000010.23,|dd9000010.24,|dd9000010.25,|dd9000010.28
|dd9000010.29,|dd9000010.31,|dd9000010.32,|dd9000010.33
|dd9000010.34
|dd9000010.99,|dd9000011,|dd9000011.1111,|dd9000012
|dd9000013,|dd9000014,|dd9000015,|dd9000016,|dd9000017
|dd9000019,|dd9000020
DD^%DT AUPNINIS,AUPNPCTR
^%DTC AUPNPAT,|dd9000001,|dd9000010.02,|dd9000010.03
NOW^%DTC AUPNINI1,AUPNINIS,AUPNINIT
%XY^%RCR AUPNINI2,AUPNINI3,AUPNINI4
^%ZTLOAD AUPNPOST UPDATE1^AGED |dd9000006.11
QXR^AMQQLXR |dd9000001
UPDATE^AQAJUPD|dd9000010,|dd9000010.02
KILLNM^AQAJUTIL |dd9000010,|dd9000010.02
^ATXPOV |dd9000010.07
^AUFMLK AUPNPED VLAB04^AUPNCIX |dd9000010.09
VMSR01^AUPNCIX |dd9000010.01
VMSR04^AUPNCIX |dd9000010.01
VMSRPCT^AUPNCIX |dd9000010.01
AQ^AUPNCIXL |dd9000010.09
AQ1^AUPNCIXL|dd9000010.09
AQE^AUPNCIXL |dd9000010.13,|dd9000010.24
AQE1^AUPNCIXL |dd9000010.13,|dd9000010.24,|dd9000010.34
AQEKILL^AUPNCIXL |dd9000010.13,|dd9000010.24
AQEKILL1^AUPNCIXL |dd9000010.13,|dd9000010.24,|dd9000010.34
AQKILL^AUPNCIXL |dd9000010.09
AQKILL1^AUPNCIXL |dd9000010.09

AQR^AUPNCIXL |dd9000010.22
AQR1^AUPNCIXL |dd9000010.22
AQRKILL^AUPNCIXL |dd9000010.22
AQRKILL1^AUPNCIXL |dd9000010.22
AQS^AUPNCIXL |dd9000010.12
AQS1^AUPNCIXL |dd9000010.12
AQSKILL^AUPNCIXL |dd9000010.12
AQSKILL1^AUPNCIXL |dd9000010.12
$$EDUCCPT^AUPNCPT |dd9000010.16
$$EXAMCPT^AUPNCPT |dd9000010.13
$$IMMCPT^AUPNCPT |dd9000010.11
^AUPNINI1 AUPNINIT
^AUPNINI2 AUPNINIT REP^AUPNINI2 AUPNINIT
^AUPNINI3 AUPNINIT EN^AUPNINI4 AUPNINI3
PAC^AUPNINIS AUPNINIT MCD^AUPNLBCK |dd9000004.11
MCR^AUPNLBCK |dd9000003.11
PI^AUPNLBCK |dd9000006.11
RR^AUPNLBCK |dd9000005.11
^AUPNLK1 AUPNLKB
^AUPNLK1I AUPNLK1
^AUPNLK2 AUPNLKB
^AUPNLK2B AUPNLK2
^AUPNLK3 AUPNLK2B ADDPAT^AUPNLKB AUPNLK
LOOKUPS^AUPNLKB AUPNLK
^AUPNLKD AUPNLK3
^AUPNLKH AUPNLK
^AUPNLKI AUPNLK PRTAUP^AUPNLKUT
AUPNLK1,AUPNLKB
SETAUP^AUPNLKUT AUPNLK1,AUPNLK1I,AUPNLKB RESET^AUPNLKZ
AUPNLK
SET^AUPNLKZ AUPNLK,AUPNLKI CONT^AUPNNTE0 AUPNNTEG
^AUPNOHBW |dd9000012
^AUPNPAT AUPNVSIT
$$AGE^AUPNPAT AUPNCPT
$$DOB^AUPNPAT AUPNPAT3,AUPNPAT4
$$SSN^AUPNPAT AUPNPAT4
$$BEN^AUPNPAT1 AUPNPAT
$$MCD^AUPNPAT2 AUPNPAT
$$MCDPN^AUPNPAT2 AUPNPAT
$$MCR^AUPNPAT2 AUPNPAT
$$PI^AUPNPAT2 AUPNPAT
$$PIN^AUPNPAT2 AUPNPAT
$$AGE^AUPNPAT3 AUPNPAT
$$BEN^AUPNPAT3 AUPNPAT
$$CDEATH^AUPNPAT3 AUPNPAT

$$COMMRES^AUPNPAT3 AUPNPAT
$$DOB^AUPNPAT3 AUPNPAT
$$DOD^AUPNPAT3 AUPNPAT
$$ELIGSTAT^AUPNPAT3 AUPNPAT
$$HRN^AUPNPAT3 AUPNPAT
$$SEX^AUPNPAT3 AUPNPAT
$$SSN^AUPNPAT3 AUPNPAT
$$TRIBE^AUPNPAT3 AUPNPAT DEC^AUPNPAT4 AUPNPAT
ENC^AUPNPAT4 AUPNPAT
$$AUHTWT^AUPNPC AUPNPCT
^AUPNPCT AUPNCIX K^AUPNPCTR |dd9000001.51
MFI^AUPNPCTR |dd9000001
S^AUPNPCTR |dd9000001.51
NAME^AUPNPED AUPNLK2B,|dd9000003.1,|dd9000004,|dd9000006.11
PAT1109^AUPNPED |dd9000001
PAT1110^AUPNPED |dd9000001
PAT4302^AUPNPED |dd9000001.43
PAT5101^AUPNPED |dd9000001.51
^AUPNPOST AUPNINIT PAT11099^AUPNPOUT |dd9000001
PAT11109^AUPNPOUT |dd9000001
^AUPNPRE AUPNINIT
^AUPNPREI AUPNINI1
^AUPNVDXP |dd9000010.21
HELP^AUPNVDXP |dd9000010.21
AQ^AUPNVDXQ AUPNVDXP AQ1^AUPNVDXQ AUPNVDXP
AQKILL^AUPNVDXQ AUPNVDXP AQKILL1^AUPNVDXQ AUPNVDXP
^AUPNVDXT |dd9000010.21
VEYE1902^AUPNVEYE |dd9000010.04
VEYE1903^AUPNVEYE |dd9000010.04
VEYE1905^AUPNVEYE |dd9000010.04
VEYE1906^AUPNVEYE |dd9000010.04
$$VAL^AUPNVLI |dd9000010.99
^AUPNVMS2 AUPNVMSR
^AUPNVMSR |dd9000010.01
$$OUT^AUPNVMSR |dd9000010.01
HELP^AUPNVMSR |dd9000010.01
ADD^AUPNVSIT |dd9000010,|dd9000010.01,|dd9000010.02,|dd9000010.03
|dd9000010.04,|dd9000010.05,|dd9000010.06,|dd9000010.07
|dd9000010.08,|dd9000010.09,|dd9000010.11,|dd9000010.12
|dd9000010.13,|dd9000010.14,|dd9000010.15,|dd9000010.16
|dd9000010.17
|dd9000010.18,|dd9000010.19,|dd9000010.21,|dd9000010.22
|dd9000010.23,|dd9000010.24,|dd9000010.25,|dd9000010.28
|dd9000010.29,|dd9000010.31,|dd9000010.32,|dd9000010.33

```
                    |dd9000010.34,|dd9000010.701,|dd9000010.702,|dd9000010.7
                        03
                    |dd9000010.704
                    |dd9000010.705,|dd9000010.706,|dd9000010.99
SUB^AUPNVSIT        |dd9000010,|dd9000010.01,|dd9000010.02,|dd9000010.03
                    |dd9000010.04,|dd9000010.05,|dd9000010.06,|dd9000010.07
                    |dd9000010.08,|dd9000010.09,|dd9000010.11,|dd9000010.12
                    |dd9000010.13,|dd9000010.14,|dd9000010.15,|dd9000010.16
                    |dd9000010.17
                    |dd9000010.18,|dd9000010.19,|dd9000010.21,|dd9000010.22
                    |dd9000010.23,|dd9000010.24,|dd9000010.25,|dd9000010.28
                    |dd9000010.29,|dd9000010.31,|dd9000010.32,|dd9000010.33
                    |dd9000010.34,|dd9000010.701,|dd9000010.702,|dd9000010.7
                        03
                    |dd9000010.704
                    |dd9000010.705,|dd9000010.706,|dd9000010.99
VSIT01^AUPNVSIT |dd9000010
^BLRENPUT  AUPNCIX
^BLRHELP    |dd9000010.09
EN^DDIOL
    AUPNCIX,AUPNLK,AUPNLKB,AUPNLKH,AUPNLKI,AUPNLKID,AUPNL
    KUT
EN^DDSZ AUPNINI3
^DIC  AUPNELIG,AUPNINI2,AUPNINI3,AUPNINIT,AUPNPCTR,AUPNVMSR
    |dd9000001,|dd9000001.43,|dd9000003,|dd9000003.1
    |dd9000004,|dd9000005,|dd9000006.11,|dd9000010,|dd9000010.01
    |dd9000010.02,|dd9000010.03,|dd9000010.04,|dd9000010.05
    |dd9000010.06
^DIC        |dd9000010.07,|dd9000010.08,|dd9000010.09,|dd9000010.11
            |dd9000010.12,|dd9000010.13,|dd9000010.14,|dd9000010.15
            |dd9000010.16,|dd9000010.18,|dd9000010.19,|dd9000010.21
            |dd9000010.22,|dd9000010.23,|dd9000010.24,|dd9000010.25
            |dd9000010.28
            |dd9000010.29,|dd9000010.31,|dd9000010.32,|dd9000010.33
            |dd9000010.34,|dd9000010.701,|dd9000010.702,|dd9000010.703
            |dd9000010.704,|dd9000010.705,|dd9000010.706,|dd9000010.99
            |dd9000011,|dd9000013,|dd9000014,|dd9000017,|dd9000019
$$FIND1^DIC     |dd9000010.99
IX^DIC      |dd9000010.01,|dd9000010.07,|dd9000010.11,|dd9000010.12
            |dd9000010.13,|dd9000010.15,|dd9000010.16,|dd9000010.18
            |dd9000010.23,|dd9000010.29,|dd9000010.32,|dd9000010.33
            |dd9000010.34,|dd9000010.99
DO^DIC1  AUPNLKI WAIT^DICD  AUPNINI1
FILE^DICN    AUPNELIG,AUPNINI4,AUPNLK2
YN^DICN AUPNELIG,AUPNINI1,AUPNLK,AUPNLK2B,AUPNLK3
```

DQ^DICQ AUPNLKH
^DICR |dd9000001,|dd9000003.1,|dd9000006.11,|dd9000010
|dd9000010.02,|dd9000010.21,|dd9000010.33,|dd9000010.99
DT^DICRW AUPNINI1
^DIE AUPNELIG,AUPNINI2,AUPNPCTR,AUPNVSIT Q^DIFROM0
AUPNINIT
$$VAL^DIFROMSS AUPNINI3
OS^DII AUPNINI3
^DIK AUPNINI4,AUPNLK2,AUPNPCTR DD^DIK AUPNVSIT
ENALL^DIK AUPNPOST
IX1^DIK AUPNINI2,AUPNINI3,AUPNINI4
IXALL^DIK AUPNINI1,AUPNINIT
1^DIK1 AUPNVSIT EN^DIKZ AUPNINIT EN1^DIP AUPNVDXP
Y^DIQ |dd9000003.1,|dd9000010,|dd9000010.17,|dd9000010.28
|dd9000011
^DIR AUPNINI2,AUPNINIT,AUPNPOST I^DITR AUPNINI1
EN^DIU2 AUPNINI1
$$DIC^XBDIQ1 AUPNVMSR
$$VAL^XBDIQ1 AUPNCPT,AUPNVLI,|dd9000010.99
ENP^XBDIQ1 AUPNPAT1
$$EXTSET^XBFUNC AUPNPAT3
^XBGXREFS AUPNPCT EN2^XBKD AUPNPREI EN^XBNEW
AUPNVMSR
$$FMDIFF^XLFDT AUPNINIS,AUPNPAT3

10.0 Internal Relations

This package is a set of standard data dictionaries and utilities.

11.0 How to Generate On-Line Documentation

The file number range for this package is 9000001-9000099. The namespace is AUPN. All globals, routines, screen forms, etc. begin with AUPN.

This section describes some of the methods by which users can generate IHS Patient Medical Dictionaries system technical documentation. Online technical documentation pertaining to the IHS Patient Medical Dictionaries software, in addition to that which is located in the help prompts and on the help screens throughout the IHS Patient Medical Dictionaries package, can be generated through the use of several Kernel options. These include, but are not limited to, the following:

- %INDEX
- Menu Management
- Inquire Option Print Option File VA FileMan
- Data Dictionary Utilities
- List File Attributes

Entering question marks at the "Select...Option" prompts can also provide users with valuable technical information. For example, a single question mark (?) lists all options that can be accessed from the current option. Entering two question marks (??) lists all options accessible from the current one, showing the formal name and lock for each. Three question marks (???) displays a brief description for each option in a menu, whereas an option name preceded by a question mark (?OPTION) shows extended help, if available, for that option.

For a more exhaustive option listing and further information about other utilities that supply online technical information, please consult the DHCP Kernel Reference manual.

11.1 %INDEX

This option analyzes the structure of a routine to determine in part, if the routine adheres to RPMS programming standards. The %INDEX output can include the following components:

- Compiled list of errors and warnings
- Routine listing
- Local variables
- Global variables
- Naked globals

- Label references
- External references

By running %INDEX for a specified set of routines allows users to discover any deviations from RPMS programming standards that exist, and to see how routines interact with one another (i.e., which routines call or are called by other routines).

To run %INDEX for the IHS Patient Medical Dictionaries package, specify the AUPN namespace at the Routine(s)?> prompt.

> **Note**: IHS Patient Medical Dictionaries initialization routines that reside in the UCI in which %INDEX is being run, compiled template routines, and local routines found within the APCH namespace should be omitted at the Routine(s)?> prompt. To omit routines from selection, preface the namespace with a minus sign (-).

11.2 Inquire Options

This menu management option provides the following information about a specified option:

- Option name
- Menu text
- Option description
- Type of option
- Lock (if any)

In addition, all items on the menu are listed for each menu option. To secure information about IHS Patient Medical Dictionaries options, you must specify the AUPN namespace.

11.3 Print Option File

This VA FileMan option File utility generates a listing of options from the Option file (#19). Users can print all of the entries or a single option or range of options.

11.3.1 List File Attributes

This VA FileMan option allows you to generate documentation pertaining to files and file structure. Using the Standard format of this option yields the following data dictionary information for a specified file:

- File name and description

- Identifiers
- Cross-references
- Files pointed to by the file specified
- Files that point to the file specified
- Input, print, and sort templates

In addition, the following applicable data is supplied for each field in the file:

- Field name, number, title, and description
- Global location
- Help prompt
- Cross-references
- Input transform
- Date last edited
- Notes

Using the Global Map format of this option generates an output that lists the following information:

- All cross-references for the file selected
- Global location of each field in the file
- Input, print, and sort templates

For a comprehensive listing of IHS Patient Medical Dictionaries package files, please refer to the Files section of this manual.

12.0 SAC Requirements and Exemptions

There were no exemptions necessary for this package.

Glossary

Archiving

The storing of historical or little-used data off-line (often on tape).

Banner

A line of text with a user's name and domain.

Browser

An interactive application that displays ASCII text on a terminal that supports a scroll region. The text can be in the form of a word-processing field or sequential local or global array. The user may navigate freely within the document.

Callable Entry Points

Places in a routine that can be called from an application program.

Component

A segment of the IHS Patient Medical Dictionaries that provides a mechanism for grouping data into sections.

Cross-reference

An indexing method whereby files can include pre-sorted lists of entries as part of the stored database. Cross-references (x-refs) facilitate look-up and reporting.

Entry Point

Entry point within a routine that is referenced by a "DO" or "GOTO" command from a routine internal to a package.

File

A set of related records or entries treated as a single unit.

FileMan

The database management system for RPMS.

Flowsheet

A tabular format for organizing and displaying data in a special section of the health summary.

Global

In MUMPS, global refers to a variable stored on disk (global variable) or the array to which the global variable may belong (global array).

Health Summary

A summary of a patient's demographic and clinical information compiled from information in the Patient Care Component (PCC) database of the Resource and Patient Management System (RPMS).

ICD

International Classification of Diseases.

Index (%Index)

A Kernel utility used to verify routines and other MUMPS code associated with a package. Checking is done according to current ANSI MUMPS standards and RPMS programming standards. This tool can be invoked through an option or from direct mode (>D ^%INDEX).

Init

Initialization of an application package. The initialization step in the installation process builds files from a set of routines (the init routines). Init is a shortened form of initialization.

Internal Entry Number (IEN)

The number used to identify an entry within a file. Every record has a unique internal entry number.

IRM

Information Resource Management. The IHS personnel responsible for information systems management and security.

Kernel

The set of MUMPS software utilities that function as an intermediary between the host operating system and application packages, such as Laboratory and Pharmacy. The Kernel provides a standard and consistent user and programmer interface between application packages and underlying MUMPS implementation. These utilities provide the foundation for RPMS.

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 Menu Management option: (the menu's select prompt).

Namespace

A unique set of 2 to 4 alpha characters that are assigned by the database administrator to a software application.

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.

Panel

A tabular format for presenting a series of clinical measurements or results in the health summary.

Patient Care Component (PCC)

The central repository for data in the Resource and Patient Management System (RPMS).

Queuing

Requesting that a job be processed at a later time rather than within the current session.

Routine

A program or sequence of instructions called by a program that may have some general or frequent use. MUMPS routines are groups of program lines saved, loaded, and called as a single unit via a specific name.

UCI

User Class Identification: a computing area.

Up-Hat (^)

A circumflex, also know as a "hat" or "caret," that is used as a piece delimiter in a global. The up-hat is denoted as "^" and is typed by pressing Shift+6 on the keyboard.

Utility

A callable routine line tag or function. A universal routine usable by anyone.

Variable

A character or group of characters that refers to a value. MUMPS recognizes three types of variables: local, global, and special. Local variables exist in a partition of the main memory and disappear at sign-off. A global variable is stored on disk, potentially available to any user. Global variables usually exist as parts of global arrays.

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