



RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS PCC Suite

(BJPC)

Documentation Guide for RPMS Health Factor and Exam Codes

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1.0 Health Factors

Health Factors describe a component of the patient's health and wellness not documented elsewhere or as an International Classification of Disease (ICD) or Current Procedural Terminology (CPT) code. Health factors are not visit specific and relate to the patient's overall health status. Reassess health factors at least once yearly.

The Indian Health Service (IHS) offers the following guidance for assessing health factors and documenting the results. The Resource and Patient Management System (RPMS) does not include these tools, but the results are mapped to the health factor responses that are provided.

1.1 Tobacco Use and Exposure

1.1.1 Factor A: Smoking Assessment

Use this health factor to document whether the patient smokes tobacco (cigarettes, pipe, or cigars) or has a history of smoking.

To use the Smoking Assessment Health Factor:

1. Ask the patient if he or she smokes tobacco or has smoked tobacco in the past (cigarettes, pipe, or cigars).
2. Ask the patient if he or she smokes tobacco products for cultural or religious purposes.
3. Document the Smoking Assessment factor screening results using the values in Table 1-1.

Table 1-1: Smoking assessment health factors

Health Factor	Definition
Current every day smoker	Currently smokes tobacco (cigarettes, cigars, pipe, etc.) every day.
Current some day smoker	Currently smokes tobacco (cigarettes, cigars, pipe, etc.) on some days (but not every day)
Current smoker, status unknown	Currently smokes tobacco (cigarettes, cigars, pipe, etc.) but the amount smoked is unknown.
Cessation smoker	Is transitioning from a Current Smoker to a Previous Smoker. The time period between the stop date and the present date is less than six months.
Previous (former) smoker	Has quit smoking tobacco for six months or more.

Health Factor	Definition
Ceremonial Use	Uses tobacco for ceremonial or religious purposes only.
Never smoked	Does not and has never smoked tobacco products.
Smoking status unknown	Unable to assess the patient's smoking status (patient may be unconscious or unresponsive).

1.1.2 Factor B: Smokeless Tobacco (Chewing/Snuff/Dip) Assessment

Use this health factor to document whether the patient uses smokeless tobacco (chewing tobacco, dip) or has a history of using smokeless tobacco.

To use the Smokeless Tobacco Use Health Factor:

1. Ask the patient if he or she uses smokeless tobacco products (Chewing tobacco, snuff, dip, etc.).
2. Document the health factor screening results using the values in Table 1-2.

Table 1-2: Smokeless tobacco assessment health factors

Health Factor	Definition
Current Smokeless	Currently uses smokeless tobacco (chew, dip, snuff, etc.).
Cessation smokeless	Is transitioning from a Current Smokeless tobacco user to a Previous Smokeless tobacco user. The time period between stopping smokeless tobacco and the present date is less than six months.
Previous (former) smokeless	Has quit smokeless tobacco for six months or more.
Never used smokeless tobacco	Does not and has never used smokeless tobacco products.
Smokeless tobacco status unknown	Unable to assess the patient's smokeless tobacco use status (they may be unconscious or unresponsive).

1.1.3 Factor C: Exposure to Environmental Tobacco Smoke

Use this health factor to document whether the patient is exposed to tobacco smoke at home or work.

To use the Tobacco Use and Exposure Health Factor:

1. Ask the patient if he or she is exposed to tobacco smoke at work.
2. Ask the patient if anyone uses tobacco products at home.
3. Document the health factor screening results using the values in Table 1-3.

Table 1-3: Tobacco use and exposure health factor

Health Factor	Definition
Exposure to Environmental Tobacco Smoke	Is exposed to secondhand smoke at work or outside the home.
Smoker in Home	Is exposed to secondhand smoke at home.
Smoke Free Home	There is no exposure to tobacco smoke at home.

1.2 CAGE Questionnaire

CAGE is a screening tool for alcohol abuse. It can be modified for drug use by substituting “drug use” for “drinking” and replacing the fourth question of “Do you ever use drugs first thing in the morning” to ‘take the edge off?’

To use the CAGE health factor:

- Ask the patient the following four questions:
 - Have you ever felt you ought to *Cut* down on your alcohol intake?
 - Have people *Annoyed* you by criticizing your drinking?
 - Have you ever felt bad or *Guilty* about your drinking?
 - Have you ever had a drink first thing in the morning (*Eye-opener*) to steady your nerves or get rid of a hangover?

Note: Two or more “Yes” answers are considered indicative of probable alcohol dependence. One “Yes” answer indicates that the patient’s alcohol use deserves further evaluation.

- Document the health factor screening results using the values in Table 1-4.

Table 1-4: CAGE health factors

Health Factor	Definition
CAGE 0/4	Answers NO to all four questions
CAGE 1/4	Answers YES to one of the four questions
CAGE 2/4	Answers YES to two of the four questions
CAGE 3/4	Answers YES to three of the four questions
CAGE 4/4	Answers YES to all four questions

1.3 Activity Level

Use Activity level to document the average amount of physical activity in which the patient engages.

To use the Activity Level health factor:

1. Ask the patient if he or she engages in physical activity.
2. Ask the patient in what activities he or she is engaged.
3. Ask the patient how much time he or she spends engaging in this activity.
4. Document the health factor screening results using the values in Table 1-5.

Table 1-5: Activity level health factors

Health Factor	Definition
Inactive	Engages in little or no physical activity
Some Activity	Engages in < 150 minutes (approximately 30 minutes four or fewer times a week) of physical activity per week
Active	Engages in 150–299 minutes of physical activity per week
Very Active	Engages in 300 or more minutes of physical activity per week to achieve and maintain a healthy body weight and reduce body fat

1.4 Occupation

Use Occupation to identify various qualities of the patient's occupation that may influence health outcomes.

To use the Occupation health factor:

1. Ask the patient what type of job he or she does.
2. Ask the patient what hours he or she works.
3. Ask the patient if there are any risks involved with his or her work.
4. Document the health factor screening results using the values in Table 1-6. More than one health factor can be documented for the patient.

Table 1-6: Occupation health factors

Health Factor	Definition
Dayshift	Works predominantly during daylight hours
Nightshift	Works predominantly during nighttime hours
Mixed Shift	Works during different hours of the day

Health Factor	Definition
Manager or Administrator	Works in an administrative capacity
Staff Employee	Works under an administrator or other supervisor
Desk Job	Works predominantly at a desk with little activity involved during the workday
Lifting	Actively involved in lifting objects and physical activity during the workday
Risky work	Works in a job that is considered to possess some degree of danger to health and safety
Outdoor job	Works in an outside environment
Works with food	Works with food preparation or raw meats
Works with animals	Works with animals
Unemployed	Currently not employed
Retired	Currently retired and not working

1.5 Diabetes Self-Monitoring

Use Diabetes self-monitoring to document whether patient perform self-monitoring of blood glucose (blood sugar testing) at home.

To use the Diabetes Self-Monitoring health factor:

1. Ask whether the patient checks blood glucose at home
2. Document the health factor screening results using the values in Table 1-7.

Table 1-7: Diabetes self-monitoring health factors

Health Factor	Definition
Yes	Patient performs self-monitoring of blood glucose
No	Patient does not perform self-monitoring of blood glucose
Refused	Patient refuses to perform self-monitoring of blood glucose

1.6 Tuberculosis Treatment Status

Use Tuberculosis treatment status to document TB treatment status in affected patients.

To use the Tuberculosis Treatment Status health factor:

1. Evaluate patient for history of TB or positive PPD test.
2. Determine if the patient has active or a history of infection or exposure.

3. Document health factor screening results using the values in Table 1-8.

Table 1-8: Tuberculosis treatment status health factors

Health Factor	Definition
TB-TX In Progress	Patient is currently receiving TB treatment
TB-TX Complete	Patient has completed a course of TB treatment
TB-TX Incomplete	Patient has not completed a course of TB treatment
TB-TX Untreated	TB has not been treated
TB-TX Unknown	Status of TB treatment is uncertain

1.7 Barriers to Learning

Barriers to learning are patient specific. They usually are not visit specific, but rather relate to the patient's overall health status. Assess barriers by observation and interview, and then document them to alert other healthcare providers who may provide education. It is important to accommodate and overcome barriers to enhance patient learning. Assess barriers annually or any time the situation warrants assessment.

To use the Barriers to Learning health factor:

1. Observe and question the patient for any barriers to learning.
2. Document the health factor screening results using the values in Table 1-9.

Table 1-9: Barriers to learning health factors

Health Factor	Definition	Assessment
No Barriers (NONE)	The patient has no apparent barriers to learning	
Visually Impaired (VISI)	The patient has difficulty seeing even with best corrected vision. The difficulty can be compensated with the use of other measures, devices, or both to improve vision (large print, better lighting, magnifying glasses).	The patient may divert the eyes, squint, or state his or her difficulty seeing.

Health Factor	Definition	Assessment
Blind (BLND)	The patient is blind and cannot compensate with low vision devices.	The patient may divert the eyes, wear sunglasses inside, state his or her inability to see, or is diagnosed with blindness (best corrected vision is $\leq 20/200$ or ≤ 20 degrees of visual field in the better eye).
Hard of Hearing (HEAR)	The patient has a problem hearing that can be compensated with increased volume or hearing devices.	The patient may not respond to questions initially and may ask for things to be repeated, may speak loudly, bend ear or lean toward the speaker, or wear a hearing device.
Deaf (DEAF)	The patient is deaf and cannot compensate with increased volume or hearing devices.	The patient may not respond to questions, may look intently at your lips as you speak, may motion to communicate by writing, may use sign language to indicate deafness, or may have a diagnosis of deafness.
Does Not Read English (DNRE)	The patient is unable to read English.	Ask the patient or the patient's family about his or her ability to read English. The patient may be embarrassed to admit he or she cannot read English or may make excuses such as "I forgot my glasses." This is a sensitive subject and must be treated accordingly. Stress "English" in this evaluation and acknowledge that the patient's primary language may be unwritten. Another technique is to have the patient read a sentence that could be interpreted in different ways and ask the patient how he or she interprets the sentence. If the patient is unable, state that reading English can be hard for people who learned another language first and ask if this applies to him or her.
Speaks English as a second language (ESLA)	The patient's primary language is not English.	The patient speaks English fluently, but may have minor barriers due to differences in primary language.
Interpreter needed (INTN)	The patient does not readily understand spoken English.	The patient may verbalize the need for an interpreter, answer questions inappropriately, or answer or nod "yes" to all questions. These actions could also imply hearing difficulty and may require further assessment.

Health Factor	Definition	Assessment
Fine Motor Skills Deficit (FIMS)	The patient has fine motor skills impairment which can interfere with tasks requiring manual dexterity.	The patient may have difficulty or lack the physical control to direct or manage body movement, such as paralysis, arthritis, amputation, unable to handle testing supplies (for example checking blood sugars or measuring medications).
Dementia (DEMN)	The patient may have difficulty learning because of impaired thought processes.	The patient may answer questions inappropriately, behave inappropriately, or display symptoms of confusion or forgetfulness. The patient may have a documented diagnosis of dementia.
Values or Beliefs (VALU)	The patient has values or beliefs that may impact learning; this may also include traditional Native American/Alaska Native values or beliefs that may impact the medical or clinical aspects of healthcare.	The patient may comment or be asked about values or beliefs in relation to health information or medical or clinical aspects of health care.
Stressors (STRESS)	The patient's ability to learn is limited due to emotional stressors.	The patient may appear distraught, avoid eye contact, or show anger. The emotional stressors may be acute or ongoing. e.g., personal issues (marital/relationship problems, unemployment/financial stress, lack of housing, problems with children/family members) or behavioral issues (mood, anxiety, grief). Emotional stressors are internal while social stressors are external.
Low Health Literacy (LOHL)	The patient does not demonstrate the ability to obtain, process, and understand basic health information.	Assessment is made by a low score on a health literacy screening tool or observation.
Cognitive Impairment (COGI)	The patient demonstrates cognitive impairment	The patient may be unable to give return demonstration, fails to understand simple information despite multiple attempts to teach, or has a diagnosis of cognitive impairment.

1.8 Learning Preferences

List Learning Preference in the medical record as a health factor. Although a patient may have a predominant way of learning, it is important to use a variety of teaching methods to optimize an educational encounter. Evaluate learning preference whenever it seems necessary.

To use the Learning Preferences health factor:

1. Review the most common styles of adult learning (talking and asking questions, group discussion, videos, reading).
2. Explain that every individual is unique and has his or her own preference(s) in how they receive new information.
3. Ask the patient, or the patient's family, "How do you learn best?"
4. Document the health factor screening results using the values in Table 1-10.

Table 1-10: Learning preferences health factor

Health Factor	Definition
Do or Practice	The patient states that doing or practicing a new skill is the preferred style of learning new information.
Read	The patient, or the patient's family, states that reading is a preferred style of learning.
Small Group	The patient, or the patient's family, states that participating in small groups is a preferred style of learning.
Talk	The patient, or the patient's family, states that talking and asking questions is a preferred style of learning.
Media	The patient, or the patient's family, states that media (kiosk, videos, interactive displays) is a preferred style of learning.

1.9 Asthma Triggers

To use the Asthma Triggers health factor:

1. Ask the patient if exposure to any of the factors listed below worsens asthma symptoms.
2. Document the asthma trigger health factors using the values in Table 1-11. When necessary, add multiple health factors (to document that the patient has more than one asthma trigger: mold, dust mites, and animals).

Table 1-11: Asthma trigger health factors

Health Factor	Definition
Animal	The patient's asthma status worsens when around animals and pets including rodents and birds.
Dust Mites	The patient's asthma status worsens when exposed to dust and dust mites.
Cockroaches	The patient's asthma status worsens when exposed to cockroaches.
Mold	The patient's asthma status worsens when exposed to mold and/or mildew.
Air Pollutants	The patient's asthma status worsens when exposed to air pollutants or when the air quality index is low.
Pollen	The patient's asthma status worsens when exposed to pollen or other seasonal triggers.
Tobacco Smoke	The patient's asthma status worsens when exposed to tobacco smoke.
Exercise	The patient's asthma status worsens when exercising/cold.
Viral Infection	Viral infections worsen the patient's asthma status.
Change in Weather	The patient's asthma status worsens with changes in weather such as cold air, high humidity, or heat.
Menses	The female patient's asthma status worsens during menses.
Strong Emotional Expression	Strong emotional expressions cause worsening of the patient's asthma status.
Other Trigger	Use only if no other trigger is appropriate; enter the specific asthma trigger in the comments section.

2.0 Exam Codes

Exam Codes are an assessment of a specific component of the patient's health at a point in time. Exam codes are not documented elsewhere or as an ICD or CPT code.

The IHS offers following guidance for assessing and documenting results for the various exam codes. RPMS does not include these tools, however, the results map to the exam code responses that are provided.

2.1 Intimate Partner Violence/Domestic Violence

Used to document results of screening for current and lifetime exposure to Intimate Partner Violence/Domestic Violence (IPV/DV).

To use the IPV/DV exam code:

1. Talk to the patient alone in a safe, private environment.
2. Know the reporting requirements in your state and inform patients about any limits of confidentiality prior to conducting screening.
3. Ask the patient simple, direct questions; such as:
 - Are you in a relationship with a person who physically hurts or threatens you?
 - Did someone cause these injuries? Was it your partner or spouse?
 - Has your partner or ex-partner ever hit you or physically hurt you?
 - Do you (or did you ever) feel controlled or isolated by your partner?
 - Has your partner ever forced you to have sex when you didn't want to? Has your partner ever refused to practice safe sex?
 - Has any of this happened to you in a previous relationship?
4. Document IPV/DV screening results using the values in Table 2-1.

Note: If the IPV/DV screen is positive, a health and safety assessment should be performed and findings documented. Refer to a social worker or domestic violence advocate, if possible.

Table 2-1: Intimate partner violence or domestic violence exam results

Exam Result	Definition
Negative	Denies being a current or past victim of IPV/DV

Exam Result	Definition
Past	Denies being a current victim, but discloses being a past victim of IPV/DV
Present	Discloses current IPV/DV
Present and Past	Discloses past victimization and current IPV/DV victimization
Unable to screen	Unable to screen patient (partner or verbal child present, unable to secure an appropriate interpreter, etc.)
Refused	Patient declined exam or screening

2.2 Alcohol Screening

Use Alcohol screening to document risky alcohol drinking habits. Various exams are recommended in different settings.

To use the Alcohol Screening Exam code for adults in the outpatient setting:

1. Ask the patient:
 - On average, how many days per week do you drink alcohol?
 - On a typical day when you drink, how many drinks do you have?
 - What's the maximum number of drinks you have had on a given occasion in the last month?

Table 2-2: At-risk drinking definition

	Per Week	Per Occasion
Men	> 14 Drink	> 4 Drinks
Women	> 7 Drinks	> 3 Drinks
Age > 65	> 7 Drinks	> 1 Drink

2. Document the exam code screening results using the values in Table 2-3.

Table 2-3: Alcohol screening exam codes

Exam Result	Definition
Normal or Negative	The patient's screening exam does not indicate risky alcohol use.
Abnormal	The patient's screening exam indicates potential risky alcohol use.
Refused	Patient declined exam or screening.

2.3 Fall Risk

Use Fall risk to document fall risk in patients, especially those patients age 65 or older.

To use the Fall Risk exam code:

1. Ask the patient if they have fallen in the past year or identify a fall with presentation for medical attention from the health record.
2. Document the screening results using the values in Table 2-4.
3. Provide, or refer for, a full Fall Evaluation if the result is either Positive or Abnormal.

Table 2-4: Fall risk exam codes

Exam Result	Definition
Positive or Abnormal	History of fall with presentation for medical attention. History of multiple (two or more) falls or history of fall and abnormality on brief, office-based assessment of gait and balance.
Negative or Normal	Denies falling in the past year; no impairment in strength, balance, or gait.
Refused	Patient declined exam or screening.

2.4 Depression Screening

Use Depression screening to document the results of a brief screening for depression. A positive result does not equal a diagnosis of depression. It is an indication that further evaluation is warranted.

To use the Depression Screening exam code:

1. Administer the PHQ-2 Questionnaire and assign the appropriate values to the responses:

“Over the last two weeks, how often have you been bothered by any of the following problems?”

Table 2-5: Depression screening exam codes

Problem	Frequency	Rating
a) Little interest or pleasure in doing things	Not at all	0
	Several days	1
	More than half the days	2
	Nearly every day	3
b) Feeling down, depressed, or hopeless	Not at all	0
	Several days	1
	More than half the days	2
	Nearly every day	3
Total PHQ-2 Score Range: 0-6		

- Score the results of the PHQ-2 and document results using the depression screening exam code in Table 2-6 and Table 2-7.

Table 2-6: Depression screening exam code results

Score	Result
Rating 0-2	Depression screening exam code result: NEGATIVE
Rating 3-6	Depression screening exam code result: POSITIVE

Note: If the patient declines the screening or the provider is unable to conduct the screening, record the results as Refused or Unable to Screen. If the screening is positive, further evaluation for depression is indicated. Conduct such evaluation in the primary care or behavioral health setting using a diagnostic instrument.

Table 2-7: Depression screening exam results

Exam Result	Definition
Normal or Negative	Denies symptoms of depression
Abnormal or Positive	Provides positive answers to the depression screen; further evaluation is warranted
Refused	Patient declined exam or screening
Unable to Screen	Unable to administer the screening

2.5 Diabetic Eye Exam

Use Diabetic eye exam to document the administration and results of a diabetic eye exam.

To use the Diabetic Eye Exam code:

1. Administer a diabetic eye exam.
2. Document the exam results using the values in Table 2-8.

Table 2-8: Diabetic eye exam results

Exam Result	Definition
Normal	Normal result to eye exam
Abnormal	Abnormal result to eye exam—address abnormal findings in the patient's note
Refused	Patient declined exam screening

2.6 Diabetic Foot Exam

Use Diabetic foot exam to document the administration and results of a formal diabetic foot exam.

Examination should include assessment of protective sensation, foot structure and biomechanics, vascular status, and skin integrity. Test sensation with the 10g monofilament on the plantar aspect of the first, third, and fifth digits and metatarsal heads of each foot. If the patient has no sensation on one or more of the tested sites, he or she is at high risk of developing an ulcer. Inspect the foot for deformities and altered biomechanics including hammer or claw toe deformities, bunions, Charcot foot, any bony prominence, and excessive pronation. Additionally, patients with a history of prior non-traumatic ulceration or amputation are at high risk.

Conduct a vascular assessment by feeling for dorsalis pedis and posterior tibial pulses on each foot. Alternatively, assess vascular status with an ankle brachial index (ABI). An absent pulse or ABI ratio of <0.9 on either foot confers high risk. Keep in mind these results may be falsely elevated in diabetics.

To use the Diabetic Foot Exam code:

1. Administer a complete diabetic foot exam.
2. Document the exam results using the values in Table 2-9.

Table 2-9: Diabetic foot exam results

Exam Result	Definition
Normal	Normal result to diabetic foot exam
Abnormal	Abnormal result to diabetic foot exam - address abnormal findings in the patient's note
Refused	Patient declined exam or screening

2.7 Foot Inspection (formerly Diabetic Foot Check)

Use Foot inspection to document the administration and results of a simple foot check or inspection.

Shoes should be removed and feet inspected for acute problems at each visit.

To use the Foot Inspection Exam code:

1. Administer a foot inspection.
2. Document the exam results using the values in Table 2-10.

Table 2-10: Foot inspection exam results

Exam Result	Definition
Normal	Normal result to simple foot exam
Abnormal	Abnormal result to simple foot exam - address abnormal findings in the patient's note
Refused	Patient declined exam or screening

2.8 Dental Exam

Use Dental exam to document a dental exam.

To use the Dental Exam code:

1. Administer a dental exam.
2. Document the exam results using the values in Table 2-11.

Table 2-11: Dental exam results

Exam Result	Definition
Normal	Normal result to dental exam
Abnormal	Abnormal result to dental exam - address abnormal findings in the patient's note

Exam Result	Definition
Refused	Patient declined exam or screening

3.0 Inactive Health Factors and Exam Codes

3.1 Reasons for Inactivating Health Factors and Exam Codes

The Office of Information Technology (OIT), on the recommendation of multiple subject matter experts, has inactivated certain health factors and physical examination exam codes. Data regarding the Staged Diabetes Management health factors are no longer used or recommended by the IHS Division of Diabetes Treatment and Prevention for the purposes of national collection data for the treatment of patients with Type 2 diabetes. The table in Section 3.2.1 lists the inactive Staged Diabetes Management health factors. Many physical examination exam codes were developed to capture data elements in the RPMS system that were not captured through other, more universal, documentation and coding methods. Today, many exam codes that are available are obsolete, unused, or can be replaced by more conventional and universal coding systems such as the ICD codes or CPT codes.

Various ICD and CPT codes exist to replace the inactivated exam codes and are listed in Section 3.3.1 Record and document physical examinations as part of the patient's note. Examination codes are not sufficient documentation elements when used alone as they do not provide the clinician with the ability to expand upon their findings as is necessary for providing appropriate patient care. Further, they cannot be individually used in the calculation of evaluation and management (E&M) codes.

There are some misconceptions regarding the use of physical examination exam codes in RPMS applications and reports. This has led to inappropriate documentation. Inactive codes are not used by RPMS applications. Examples include the following:

- Breast exam is not included in the logic for the Clinical Reporting System (CRS) or Government Performance and Results Act (GPRA) outcome measure for breast cancer screening. The United States Preventive Services Task Force (USPSTF) recommends screening mammography with or without clinical breast examination (CBE). There is insufficient data to recommend CBE alone as a screening method for breast cancer. The appropriate documentation for breast exam consists of a description of the examination and results in the provider's narrative and use of appropriate procedure codes.
- Rectal exam is not included in the logic for the CRS or GPRA outcome measure for colorectal cancer. The USPSTF recommends fecal occult blood testing (FOBT), colonoscopy, or sigmoidoscopy. Documentation of rectal exam is insufficient to address this measure. Rectal exams are performed by some clinicians to screen patients for prostate cancer. The appropriate documentation for this screening consists of a description of the examination and results in the provider's narrative, and a digital rectal exam documented using procedure codes.

Results of prostate specific antigen (PSA) screening, if performed, should be documented as well. The USPSTF states that there is insufficient data to recommend prostate cancer screening.

- Pelvic exam is not included in the logic for the CRS or GPRA outcome measure for ovarian cancer. The USPSTF states that there is no existing evidence that any screening test (CA125, ultrasound, or pelvic exam) reduces mortality from ovarian cancer. Additionally, pelvic exam is not included in the logic for cancer screening Pap smear rate. The appropriate documentation for pelvic exam consists of a description of the examination and results in the provider's narrative and use of appropriate procedure codes.

3.2 Inactive Health Factors

3.2.1 Staged Diabetes Management

- Food and Exercise
- Oral Agents
- Oral Agent Combination
- Oral/Insulin Combination
- Insulin Stage 2
- Insulin Stage 3
- Insulin Stage 4
- Food and Exercise (Maintain)
- Oral Agents (Maintain)
- Insulin (Maintain)

3.2.2 Health Literacy

- Health Literate

3.2.3 Barriers to Learning

- Childhood Development
- Developmental Delay
- Learning Disability
- Social Stressors
- <6th Grade Education

3.2.4 Rubella Immunity

- Rubella Immune
- Rubella Non-Immune
- Rubella Status Indeterminate

3.3 Inactive Physical Exam Codes

3.3.1 Inactive Exam Codes and Recommended Conversions

Disclaimer: The codes in Table 3-1 are suggested codes for use; however, a coder should code to the highest specificity according to documentation.

Table 3-1: Inactive exam codes

Exam Code	Purpose Of Visit Or Diagnosis Code	Procedure Codes (ICD-9, CPT, or HCPCS)
General Exam (01)	V70.0; V70.3; V70.9	99391 to 99397; G0344 (Medicare–Initial Preventative)
Ear Exam (02)	V72.1; V72.19; V80.3	18.11 (otoscopy); 92700 (unlisted service or procedure)
Mouth Exam (04)	V76.42 (screening for malignant neoplasms, oral cavity)	89.31 (dental exam)
Neck Exam (05)	NA	NA
Breast Exam (06)	V76.10; V76.12; V76.19	89.36; G0101 (Medicare Screening Breast and Pelvic)
Chest Exam (07)	V72.82 (Pre-op)	NA
Heart Exam (08)	V72.81 (Pre-op); V81.0; V81.2	G0367 (Medicare Screening EKG)
Abdomen Exam (09)	NA	NA
Hernia Exam (10)	NA	NA
Neurological Exam (11)	V80.0	89.13
Ortho Exam (12)	NA	89.39; 95851
Rectal Exam (14)	V76.41 (rectum) V76.44 (prostate)	89.34 G0102 (Medicare screening prostate); S0601; S0605
Pelvic Exam (15)	V72.31; V72.32	G0101 (Medicare screening breast or pelvic)
General Development Exam (16)	V20.2; V79.3	NA
Hearing Exam (17)	V72.11; V72.19	NA
Eye Muscle Balance Exam (18)	NA	NA

Exam Code	Purpose Of Visit Or Diagnosis Code	Procedure Codes (ICD-9, CPT, or HCPCS)
Vision Exam (19)	V72.0	95.09 (Eye) 95.05 (Visual field) 99172; 99173
Sex Development Exam (20)	NA	NA
Oto Exam (21)	V72.1; V72.19; V80.3 [See Ear Exam (02)]	18.11 (otoscopy); 92700 (unlisted service or procedure)
Audiometric Screening (22)	NA	92551 (bilateral)
Audiometric Threshold (24)	NA	92552; 92553; 92555; 92556
Tympanogram (25)	NA	95.41; 92567
Tonometry (26)	NA	89.11; 95.26; S0620; S0621; 92100; 92120; 92499 (unlisted service or procedure)
Scoliosis Screening (27)	NA	NA

Note: NA signifies an exam without a matching ICD, CPT, or HCPCS code.

4.0 Comparison of Old and New Tobacco Health Factors

Tobacco use and assessment is the primary screening tool used by the IHS to document the patient's use of smoke or smokeless tobacco as well as exposure to environmental tobacco smoke. In 2010, the Office of the National Coordinator developed criteria for EHRs that classify the terminology and categories for documenting smoking use and assessment. The RPMS has realigned the health factors to match these recommendations. Patients who have a health factor documented in the RPMS system will be transitioned to new categories based on Table 4-1, Table 4-2, and Table 4-3:

Table 4-1: Tobacco use health factors

If the patient has this Health Factor	It will become this Health Factor	CRS Category
NA	Current every day smoker	Current tobacco user
NA	Current some day smoker	Current tobacco user
Current Smoker	Current smoker, status unknown	Current tobacco user
Current Smoker and Smokeless*	Current smoker, status unknown	Current tobacco user
Cessation smoker	Cessation smoker	Current tobacco user
Previous smoker	Previous (former) smoker	Non-tobacco user
Ceremonial Use	Ceremonial Use	Non-tobacco user
Never Used Tobacco*	Never smoked	Non-tobacco user
NA	Smoking status unknown	Undocumented

4.1 Health Factor–Smokeless (Chewing/Snuff/Dip)

Table 4-2: Smokeless tobacco health factors

If the patient has this Health Factor	It will become this Health Factor	CRS Category
Current smokeless	Current Smokeless	Current tobacco user
Current Smoker and Smokeless*	Current Smokeless	Current tobacco user

If the patient has this Health Factor	It will become this Health Factor	CRS Category
Cessation smokeless	Cessation smokeless	Current tobacco user
Previous (former) smokeless	Previous (former) smokeless	Non-tobacco user
Never Used Tobacco*	Never used smokeless tobacco	Non-tobacco user
NA	Smokeless tobacco status unknown	Undocumented

4.2 Health Factor–Tobacco Exposure

Table 4-3: Tobacco exposure health factors

If the patient has this Health Factor	It will become this Health Factor
Smoker in the Home	Smoker in the Home
Smoke Free Home	Smoke Free Home
Environmental exposure	Environmental exposure

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