IHS PCC Suite

(BJPC)

Data Entry Mnemonics

Version 2.0 Patch 10
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# Table of Contents

## 1.0 Introduction

## 2.0 Release Notes

2.1 PCC Data Entry (APCD) .......................... 2
2.1.1 Mnemonics: New ............................. 2
2.1.2 Mnemonics Modified ...................... 2
2.2 PCC Health Summary (APCH) ...... 2
2.2.1 Health Summary Modifications .... 2
2.2.2 Patient Wellness Handout .......... 2
2.3 PCC Management Reports (APCL) ........ 2
2.3.1 VGEN ........................................ 3
2.3.2 V Files ....................................... 3

## 3.0 PCC Data Entry Mnemonics

3.1 Definition of PCC Data Entry Mnemonics .................. 4
3.2 Historical Mnemonics ...................................... 4
3.3 Online Documentation ...................................... 4
3.4 Entry of Incorrect Mnemonics ............................. 4
3.5 Mnemonic Codes, Descriptions, and Instructions ......... 5
3.5.1 3M Codes Interface (3M) ..................... 5
3.5.2 Asthma Control (ACON) ..................... 5
3.5.3 Anesthesia CPT (ACPT) ..................... 5
3.5.4 Anti-Coagulation Therapy (ACTH) .......... 6
3.5.5 ADA Code Entry (ADA) ..................... 7
3.5.6 Asthma Work/School Days Missed (ADM) ..... 7
3.5.7 Admitting Diagnosis (ADX) .................. 8
3.5.8 Abdominal Girth (AG) ....................... 8
3.5.9 Ankle BP (AKBP) .............................. 8
3.5.10 Appointment Length (AL) ................... 8
3.5.11 Allergy Tracking Entry (ALG) ............... 9
3.5.12 Allergy List Review (ALR) ................ 10
3.5.13 Asthma Management Plan (AMP) .......... 10
3.5.14 Anesthesia Operation (AOP) .............. 10
3.5.15 Activate an Inactive Problem (AOP) ..... 11
3.5.16 Appointment Date and Time (APPT) ...... 12
3.5.17 Asthma Symptom Free Days (ASFD) .... 12
3.5.18 Activity and Travel Time (AT) .......... 12
3.5.19 Audiometry (AUD) ......................... 13
3.5.20 AUDIT-C (AUDC) ......................... 13
3.5.21 Audit (AUDT) ............................... 13
3.5.22 Birth Measurement (BM) ................. 13
3.5.23 Blood Pressure (BP) ....................... 14
3.5.24 Best Peak Flow (BPF) ..................... 14
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5.25</td>
<td>Blood Sugar (BS) .................................................. 14</td>
</tr>
<tr>
<td>3.5.26</td>
<td>Blood Type Entry (BT) .................................................. 15</td>
</tr>
<tr>
<td>3.5.27</td>
<td>CBC Ordered (CBC) .................................................. 15</td>
</tr>
<tr>
<td>3.5.28</td>
<td>Chief Complaint (CC) .................................................. 15</td>
</tr>
<tr>
<td>3.5.29</td>
<td>Cardiac Ejection Fraction (CEF) ........................................... 15</td>
</tr>
<tr>
<td>3.5.30</td>
<td>CHS–Outpatient Form (CHA) .................................................. 16</td>
</tr>
<tr>
<td>3.5.31</td>
<td>Centimeter Head Circumference (CHC) ............................................... 16</td>
</tr>
<tr>
<td>3.5.32</td>
<td>CHS–Hospitalization Form (CHH) .................................................. 17</td>
</tr>
<tr>
<td>3.5.33</td>
<td>CHS–In-Hospital Form (CHI) .................................................. 18</td>
</tr>
<tr>
<td>3.5.34</td>
<td>Centimeter Height (CHT) .................................................. 18</td>
</tr>
<tr>
<td>3.5.35</td>
<td>Check Out Date and Time (CKO) .................................................. 19</td>
</tr>
<tr>
<td>3.5.36</td>
<td>Clinic Type (CL) .................................................. 19</td>
</tr>
<tr>
<td>3.5.37</td>
<td>Coded Chief Complaint (COC) .................................................. 19</td>
</tr>
<tr>
<td>3.5.38</td>
<td>Coding Guidelines Display (CODE) .................................................. 19</td>
</tr>
<tr>
<td>3.5.39</td>
<td>CPT Codes with Entry of Encounter Provider (CPE) .......................... 20</td>
</tr>
<tr>
<td>3.5.40</td>
<td>CPT Codes (CPT) .................................................. 20</td>
</tr>
<tr>
<td>3.5.41</td>
<td>CRAFFT (CRFT) .................................................. 21</td>
</tr>
<tr>
<td>3.5.42</td>
<td>CAN TRAN CODE ENTRY (CTC) .................................................. 21</td>
</tr>
<tr>
<td>3.5.43</td>
<td>CAN TRAN CODE ENTRY TE (CTE) .................................................. 21</td>
</tr>
<tr>
<td>3.5.44</td>
<td>Cervix Dilation (CXD) .................................................. 21</td>
</tr>
<tr>
<td>3.5.45</td>
<td>Cup to Disk (CDR) .................................................. 22</td>
</tr>
<tr>
<td>3.5.46</td>
<td>Disposition of Care (DC) .................................................. 22</td>
</tr>
<tr>
<td>3.5.47</td>
<td>Dental–Direct Services (DDS) .................................................. 22</td>
</tr>
<tr>
<td>3.5.48</td>
<td>Data Entry Health Summary (DHS) .................................................. 23</td>
</tr>
<tr>
<td>3.5.49</td>
<td>Visit Display (DISP) .................................................. 26</td>
</tr>
<tr>
<td>3.5.50</td>
<td>Designated Provider (DP) .................................................. 27</td>
</tr>
<tr>
<td>3.5.51</td>
<td>DRG (DRG) .................................................. 27</td>
</tr>
<tr>
<td>3.5.52</td>
<td>Diagnostic Procedure Tran Code (DTC) .................................................. 28</td>
</tr>
<tr>
<td>3.5.53</td>
<td>Append a 2nd E-Code to a POV (ECO2) .................................................. 28</td>
</tr>
<tr>
<td>3.5.54</td>
<td>Append a 3rd E-Code to a POV (ECO3) .................................................. 28</td>
</tr>
<tr>
<td>3.5.55</td>
<td>Append an E-Code to a Purpose of Visit (ECOD) .................................................. 28</td>
</tr>
<tr>
<td>3.5.56</td>
<td>Edema Measurement (ED) .................................................. 28</td>
</tr>
<tr>
<td>3.5.57</td>
<td>Expected Date of Delivery (EDD) .................................................. 29</td>
</tr>
<tr>
<td>3.5.58</td>
<td>Effacement (EFF) .................................................. 29</td>
</tr>
<tr>
<td>3.5.59</td>
<td>EKG Diagnostic Procedure (EKG) .................................................. 29</td>
</tr>
<tr>
<td>3.5.60</td>
<td>Elder Care (EL) .................................................. 30</td>
</tr>
<tr>
<td>3.5.61</td>
<td>Evaluation and Management (CPT) (EM) .................................................. 30</td>
</tr>
<tr>
<td>3.5.62</td>
<td>Emergency Visit Record (EVR) .................................................. 30</td>
</tr>
<tr>
<td>3.5.63</td>
<td>Emergency Room Visit Record (ER) .................................................. 30</td>
</tr>
<tr>
<td>3.5.64</td>
<td>Examinations (EX) .................................................. 32</td>
</tr>
<tr>
<td>3.5.65</td>
<td>24-Hour Fluid Balance, Positive/Negative (FBPN) .................................................. 33</td>
</tr>
<tr>
<td>3.5.66</td>
<td>FEF 25-75 (FEF) .................................................. 33</td>
</tr>
<tr>
<td>3.5.67</td>
<td>Fundal Height (FH) .................................................. 33</td>
</tr>
<tr>
<td>3.5.68</td>
<td>Family History (FHX) .................................................. 33</td>
</tr>
<tr>
<td>3.5.69</td>
<td>24-Hour Fluid Input (FI24) .................................................. 38</td>
</tr>
<tr>
<td>3.5.70</td>
<td>Flag Field (FL)</td>
</tr>
<tr>
<td>3.5.71</td>
<td>Family Planning Method (FM)</td>
</tr>
<tr>
<td>3.5.72</td>
<td>24-Hour Fluid Output (FO24)</td>
</tr>
<tr>
<td>3.5.73</td>
<td>Family Planning (FP)</td>
</tr>
<tr>
<td>3.5.74</td>
<td>Future Scheduled Encounter</td>
</tr>
<tr>
<td>3.5.75</td>
<td>Fetal Heart Tones (FT)</td>
</tr>
<tr>
<td>3.5.76</td>
<td>FEV1/FVC (FVFC)</td>
</tr>
<tr>
<td>3.5.77</td>
<td>FRAMINGHAM 10 YEAR RISK (F10R)</td>
</tr>
<tr>
<td>3.5.78</td>
<td>Generate Health Summary (GHS)</td>
</tr>
<tr>
<td>3.5.79</td>
<td>Eyeglass Prescription (GP)</td>
</tr>
<tr>
<td>3.5.80</td>
<td>Gram Weight (GWT)</td>
</tr>
<tr>
<td>3.5.81</td>
<td>Historical ADA Code Entry (HADA)</td>
</tr>
<tr>
<td>3.5.82</td>
<td>Historical Barium Enema (HBE)</td>
</tr>
<tr>
<td>3.5.83</td>
<td>Historical Blood Sugar Entry (HBS)</td>
</tr>
<tr>
<td>3.5.84</td>
<td>Head Circumference (HC)</td>
</tr>
<tr>
<td>3.5.85</td>
<td>Historical CBC Entry (HCBC)</td>
</tr>
<tr>
<td>3.5.86</td>
<td>Historical Colonoscopy (HCOL)</td>
</tr>
<tr>
<td>3.5.87</td>
<td>Historical CPT (HCPT)</td>
</tr>
<tr>
<td>3.5.88</td>
<td>20 Hematocrit Ordered (HCT)</td>
</tr>
<tr>
<td>3.5.89</td>
<td>Hearing (HE)</td>
</tr>
<tr>
<td>3.5.90</td>
<td>Historical EKG (HEKG)</td>
</tr>
<tr>
<td>3.5.91</td>
<td>Historical Examination (HEX)</td>
</tr>
<tr>
<td>3.5.92</td>
<td>Health Factor (HF)</td>
</tr>
<tr>
<td>3.5.93</td>
<td>Historical FOBT (GUAIC) (HFOB)</td>
</tr>
<tr>
<td>3.5.94</td>
<td>Historical Hematocrit (HHCT)</td>
</tr>
<tr>
<td>3.5.95</td>
<td>Historical Health Factor (HHF)</td>
</tr>
<tr>
<td>3.5.96</td>
<td>Historical Immunizations (HIM)</td>
</tr>
<tr>
<td>3.5.97</td>
<td>Hospital Location (HL)</td>
</tr>
<tr>
<td>3.5.98</td>
<td>Historical Lab Test (HLAB)</td>
</tr>
<tr>
<td>3.5.99</td>
<td>Health Status (HLST)</td>
</tr>
<tr>
<td>3.5.100</td>
<td>Historical Measurement (HMSR)</td>
</tr>
<tr>
<td>3.5.101</td>
<td>Historical Pap Smear (HPAP)</td>
</tr>
<tr>
<td>3.5.102</td>
<td>Historical Radiology (HRAD)</td>
</tr>
<tr>
<td>3.5.103</td>
<td>Historical RX (HRX)</td>
</tr>
<tr>
<td>3.5.104</td>
<td>Historical Skin Test (HS)</td>
</tr>
<tr>
<td>3.5.105</td>
<td>Historical Sigmoidoscopy (HSIG)</td>
</tr>
<tr>
<td>3.5.106</td>
<td>Height (HT)</td>
</tr>
<tr>
<td>3.5.107</td>
<td>Historical UA (HUA)</td>
</tr>
<tr>
<td>3.5.108</td>
<td>Infant Feeding Choices (IF)</td>
</tr>
<tr>
<td>3.5.109</td>
<td>In-Hospital Immunization Entry (IIM)</td>
</tr>
<tr>
<td>3.5.110</td>
<td>Immunizations (IM)</td>
</tr>
<tr>
<td>3.5.111</td>
<td>ICD Operation Narrative (IOP)</td>
</tr>
<tr>
<td>3.5.112</td>
<td>Hospitalization Information (IP)</td>
</tr>
<tr>
<td>3.5.113</td>
<td>Inactive Problem (IPO)</td>
</tr>
<tr>
<td>3.5.114</td>
<td>ICD Narrative Purpose of Visit (IPV)</td>
</tr>
<tr>
<td>Mnemonic</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>3.5.115</td>
<td>Kilogram Weight (KWT)</td>
</tr>
<tr>
<td>3.5.116</td>
<td>Lab Test (LAB)</td>
</tr>
<tr>
<td>3.5.117</td>
<td>Line Item Entry for Billing (LI)</td>
</tr>
<tr>
<td>3.5.118</td>
<td>Last Known Well (LKW)</td>
</tr>
<tr>
<td>3.5.119</td>
<td>Last Menstrual Period (LMP)</td>
</tr>
<tr>
<td>3.5.120</td>
<td>Level of Care (LOC)</td>
</tr>
<tr>
<td>3.5.121</td>
<td>Level of Service (LS)</td>
</tr>
<tr>
<td>3.5.122</td>
<td>Measurement Entry (MEAS)</td>
</tr>
<tr>
<td>3.5.123</td>
<td>Medication List Review (MLR)</td>
</tr>
<tr>
<td>3.5.124</td>
<td>Change Note Narrative (MNN)</td>
</tr>
<tr>
<td>3.5.125</td>
<td>Switch to Modify Mode (MOD)</td>
</tr>
<tr>
<td>3.5.126</td>
<td>Modify Problem Narrative (MPO)</td>
</tr>
<tr>
<td>3.5.127</td>
<td>No Active Allergies (NAA)</td>
</tr>
<tr>
<td>3.5.128</td>
<td>No Active Medications (NAM)</td>
</tr>
<tr>
<td>3.5.129</td>
<td>No Active Problems (NAP)</td>
</tr>
<tr>
<td>3.5.130</td>
<td>Not Medically Indicated (NMI)</td>
</tr>
<tr>
<td>3.5.131</td>
<td>Note (NO)</td>
</tr>
<tr>
<td>3.5.132</td>
<td>No Response to Followup (NRF)</td>
</tr>
<tr>
<td>3.5.133</td>
<td>Nutritional Risk Screening (NRS)</td>
</tr>
<tr>
<td>3.5.134</td>
<td>Narrative Text (NT)</td>
</tr>
<tr>
<td>3.5.135</td>
<td>NIHS Stroke Scale Total Score (NSST)</td>
</tr>
<tr>
<td>3.5.136</td>
<td>O2 Saturation (O2)</td>
</tr>
<tr>
<td>3.5.137</td>
<td>Offspring History (OHX)</td>
</tr>
<tr>
<td>3.5.138</td>
<td>Outside Location (OLOC)</td>
</tr>
<tr>
<td>3.5.139</td>
<td>Operations (OP)</td>
</tr>
<tr>
<td>3.5.140</td>
<td>Outside RX (Historical)</td>
</tr>
<tr>
<td>3.5.141</td>
<td>Other Items for List Manager (OT)</td>
</tr>
<tr>
<td>3.5.142</td>
<td>Health Reminder Override (OVR)</td>
</tr>
<tr>
<td>3.5.143</td>
<td>Pain (PA)</td>
</tr>
<tr>
<td>3.5.144</td>
<td>31 Pap Smear Ordered (PAP)</td>
</tr>
<tr>
<td>3.5.145</td>
<td>PCC+ Form (PCF)</td>
</tr>
<tr>
<td>3.5.146</td>
<td>Primary Care Provider (PCP)</td>
</tr>
<tr>
<td>3.5.147</td>
<td>Procedure Entry (CPT) (PCPT)</td>
</tr>
<tr>
<td>3.5.148</td>
<td>Patient Education (PED)</td>
</tr>
<tr>
<td>3.5.149</td>
<td>Peak Flow (PF)</td>
</tr>
<tr>
<td>3.5.150</td>
<td>Public Health Nursing Form (PHN)</td>
</tr>
<tr>
<td>3.5.151</td>
<td>PHQ2 (PHQ2)</td>
</tr>
<tr>
<td>3.5.152</td>
<td>PHQ9 (PHQ9)</td>
</tr>
<tr>
<td>3.5.153</td>
<td>PHQT (PHQ-9 Modified for Teens)</td>
</tr>
<tr>
<td>3.5.154</td>
<td>Personal History (PHX)</td>
</tr>
<tr>
<td>3.5.155</td>
<td>Infant Feeding Patient Data (PIF)</td>
</tr>
<tr>
<td>3.5.156</td>
<td>Problem List (PL)</td>
</tr>
<tr>
<td>3.5.157</td>
<td>Problem List Reviewed (PLR)</td>
</tr>
<tr>
<td>3.5.158</td>
<td>Problem Only (PO)</td>
</tr>
<tr>
<td>3.5.159</td>
<td>POV and Problem Entry (PPV)</td>
</tr>
<tr>
<td>Mnemonic</td>
<td>Page</td>
</tr>
<tr>
<td>------------------------</td>
<td>------</td>
</tr>
<tr>
<td>3.5.160 Presentation (Pregnancy) (PR)</td>
<td>84</td>
</tr>
<tr>
<td>3.5.161 Provider Discontinued Service (PRD)</td>
<td>84</td>
</tr>
<tr>
<td>3.5.162 Providers (Primary/Secondary) (PRV)</td>
<td>85</td>
</tr>
<tr>
<td>3.5.163 Prescription RX (PRX)</td>
<td>85</td>
</tr>
<tr>
<td>3.5.164 VA Mobile Cln Prescription Act</td>
<td>85</td>
</tr>
<tr>
<td>3.5.165 Physical Therapy (PT)</td>
<td>86</td>
</tr>
<tr>
<td>3.5.166 Patient Goals (PTG)</td>
<td>86</td>
</tr>
<tr>
<td>3.5.167 Pulse (PU)</td>
<td>88</td>
</tr>
<tr>
<td>3.5.168 Purpose of Visit (PV)</td>
<td>88</td>
</tr>
<tr>
<td>3.5.169 Radiology (RAD)</td>
<td>91</td>
</tr>
<tr>
<td>3.5.170 Refusal for Service (REF)</td>
<td>91</td>
</tr>
<tr>
<td>3.5.171 Add Patient to a Register (REG)</td>
<td>91</td>
</tr>
<tr>
<td>3.5.172 Reproductive Factors (RF)</td>
<td>91</td>
</tr>
<tr>
<td>3.5.173 Remove Note Narrative (RNO)</td>
<td>92</td>
</tr>
<tr>
<td>3.5.174 VA Mobile Clinic REFER OUPT (RO)</td>
<td>93</td>
</tr>
<tr>
<td>3.5.175 Remove Problem Entry (RPO)</td>
<td>93</td>
</tr>
<tr>
<td>3.5.176 Respiration (RS)</td>
<td>94</td>
</tr>
<tr>
<td>3.5.177 Medications (RX)</td>
<td>94</td>
</tr>
<tr>
<td>3.5.178 Suicide Form Entry (SF)</td>
<td>95</td>
</tr>
<tr>
<td>3.5.179 History of Surgery (SHX)</td>
<td>95</td>
</tr>
<tr>
<td>3.5.180 Purpose of Visit with Stage Prompt (SPV)</td>
<td>96</td>
</tr>
<tr>
<td>3.5.181 VA Mobile Clinic Refer Spec (SR)</td>
<td>96</td>
</tr>
<tr>
<td>3.5.182 Skin Test (ST)</td>
<td>97</td>
</tr>
<tr>
<td>3.5.183 Stage in Purpose of Visit (STG)</td>
<td>97</td>
</tr>
<tr>
<td>3.5.184 Station (Pregnancy) (STN)</td>
<td>97</td>
</tr>
<tr>
<td>3.5.185 Skin Test Placed (No Reading) (STP)</td>
<td>98</td>
</tr>
<tr>
<td>3.5.186 Type of Appointment (S/M/L) (TA)</td>
<td>98</td>
</tr>
<tr>
<td>3.5.187 Chargemaster Transaction Code (TC)</td>
<td>98</td>
</tr>
<tr>
<td>3.5.188 Type of Decision Making (TD)</td>
<td>99</td>
</tr>
<tr>
<td>3.5.189 Chargemaster Transaction Code with Enc Prov (TE)</td>
<td>99</td>
</tr>
<tr>
<td>3.5.190 Time of Visit (TM)</td>
<td>99</td>
</tr>
<tr>
<td>3.5.191 Temperature (TMP)</td>
<td>100</td>
</tr>
<tr>
<td>3.5.192 Tonometry (TON)</td>
<td>100</td>
</tr>
<tr>
<td>3.5.193 Treatments Provided (TP)</td>
<td>100</td>
</tr>
<tr>
<td>3.5.194 Treatment Contracts (TRC)</td>
<td>101</td>
</tr>
<tr>
<td>3.5.195 49 Urinalysis Order–No Results (UA)</td>
<td>101</td>
</tr>
<tr>
<td>3.5.196 Unable to Screen (UAS)</td>
<td>101</td>
</tr>
<tr>
<td>3.5.197 Underlying Cause of Death (UCD)</td>
<td>101</td>
</tr>
<tr>
<td>3.5.198 Auditory Evoked Potential Exam (UNH)</td>
<td>102</td>
</tr>
<tr>
<td>3.5.199 Uncoded Procedure (UOP)</td>
<td>102</td>
</tr>
<tr>
<td>3.5.200 Uncoded Purpose of Visit (UPV)</td>
<td>102</td>
</tr>
<tr>
<td>3.5.201 Vision Corrected (VC)</td>
<td>103</td>
</tr>
<tr>
<td>3.5.202 VA Mobile Clinic Visits Data (VR)</td>
<td>103</td>
</tr>
<tr>
<td>3.5.203 Visit File Data Modify (VST)</td>
<td>103</td>
</tr>
<tr>
<td>3.5.204 VA Mobile Clinic Visit Type</td>
<td>103</td>
</tr>
</tbody>
</table>
3.5.205 Vision Uncorrected (VU) ............................................................................. 104
3.5.206 Waist Measurement (WC) ............................................................................. 104
3.5.207 Well Child Exam (WCE) .................................................................................. 104
3.5.208 Demographic and Visit Display (WHAT) ......................................................... 107
3.5.209 Information on Patient (WHO) ........................................................................ 107
3.5.210 Weight (WT) .................................................................................................... 107
3.5.211 Quick Out (XIT) ............................................................................................. 108

Appendix A:  Data Entry Mnemonics Grouped by Type ............................................. 109
Appendix B:  Rules of Behavior .................................................................................. 115
  B.1 All RPMS Users .................................................................................................... 115
    B.1.1 Access ............................................................................................................. 115
    B.1.2 Information Accessibility .............................................................................. 116
    B.1.3 Accountability ............................................................................................... 116
    B.1.4 Confidentiality ............................................................................................. 117
    B.1.5 Integrity .......................................................................................................... 117
    B.1.6 System Logon ............................................................................................... 118
    B.1.7 Passwords ....................................................................................................... 118
    B.1.8 Backups ........................................................................................................... 119
    B.1.9 Reporting ......................................................................................................... 119
    B.1.10 Session Timeouts ......................................................................................... 119
    B.1.11 Hardware ....................................................................................................... 119
    B.1.12 Awareness ..................................................................................................... 120
    B.1.13 Remote Access ............................................................................................. 120
  B.2 RPMS Developers ............................................................................................... 121
  B.3 Privileged Users ................................................................................................. 122

Contact Information ................................................................................................. 124
Preface

The purpose of this manual is to provide technical information specific to the Patient Care Component (PCC) package and data entry mnemonics. This Data Entry Mnemonics manual provides comprehensive information regarding the use of mnemonics with the Resource and Patient Management System PCC, including correct entry, description, and abbreviation of mnemonics.
1.0 Introduction

The Patient Care Component (PCC) database is the central repository for data in the Resource and Patient Management System (RPMS).

The following RPMS components comprise the PCC suite:

- IHS Dictionaries (AUPN)
- Standard Tables
- PCC Health Summary, including Health Maintenance Reminders (APCH)
- PCC Data Entry (APCD)
- PCC Management Reports, including PGEN/VGEN (APCL)
- Designated Specialty Provider Management (BDP)
- Q-Man (Query Manager) (AMQQ)
- Taxonomy Management (ATX)

Mnemonics permit the user to enter data from a variety of PCC forms, and to do so in whatever entry order is easiest or most efficient. Mnemonics eliminate the requirement to “space through” fields on a form that contains no data.
2.0 Release Notes
BJPC v2.0 Patch 10 contains the following modifications and enhancements.

2.1 PCC Data Entry (APCD)
The following changes apply to the APCD applications.

2.1.1 Mnemonics: New
NSST – NIH Stroke Scale Total
F104 – Framingham 10 Year Risk
CDR – Cup to Disk Ratio

2.1.2 Mnemonics Modified
• EX Examinations
  – Suicide Risk Assessment
  – Added result options:
    • High
    • Moderate
    • Low
• ACTH Anti-Coagulation Therapy
  – INR Goad – added selection option N/A
• FHX – Family History
  – Family History now required SNOMED selection

2.2 PCC Health Summary (APCH)
The following modifications apply to the APCH application.

2.2.1 Health Summary Modifications

2.2.2 Patient Wellness Handout

2.3 PCC Management Reports (APCL)
The following changes apply to the Patient Management Report application.
2.3.1 VGEN

2.3.2 V Files
   Added four new fields to each V File.
3.0 PCC Data Entry Mnemonics

3.1 Definition of PCC Data Entry Mnemonics

PCC Data Entry mnemonics are two- to four-character abbreviations of the types of data typed into the PCC via the PCC Data Entry system. When a mnemonic is typed, the system is alerted that a particular type of data is about to be entered. For example, by typing the mnemonic BP, the system is alerted that the data that follows will be a blood pressure entered in the format 140/88.

Mnemonics are abbreviations usually recognizable for the data items that they represent. For example, WT represents weight, IM represents immunization, PV represents purpose of visit, PRV represents provider, and so on.

3.2 Historical Mnemonics

When a mnemonic begins with the letter H, it usually stands for historical data that occurred on a previous visit. For example, HEX represents historical exam, HPAP represents historical Pap smear, HLAB represents historical laboratory data, etc. When a historical mnemonic is used, the PCC Data Entry System temporarily shifts from the date of the visit being typed and prompts the operator to create a separate visit for the date of the historical event. Following entry of a historical mnemonic and the associated data for that visit, the system shifts back to the visit being typed prior to use of the historical mnemonic.

3.3 Online Documentation

In addition to the material included in this user’s guide, help screens are available online. To access these help screens, type a question mark (?) at the prompt and press Enter. If more help is needed, typing two or three question marks at the prompt generates more detailed help screens, when available.

A complete list of the mnemonics can be viewed by typing two question marks (??) and pressing Enter at the “Mnemonic” prompt.

3.4 Entry of Incorrect Mnemonics

If a mnemonic is typed in error, type a caret (^) by pressing Shift+6 and then press Enter. This usually allows the user to exit the erroneous mnemonic and choose the correct one.

Some mnemonics do not permit using a caret (^) to exit. In this case, type a value to return to the mnemonic prompt, and then type the MOD (Modify) mnemonic to delete the data typed in error.
3.5 Mnemonic Codes, Descriptions, and Instructions

The PCC data entry mnemonics are presented here in alphabetical order by mnemonic. For each mnemonic, a detailed description and instructions are provided.

3.5.1 3M Codes Interface (3M)

Use the 3M Coder Interface (3M) mnemonic to send the visit information to 3M for coding (for visit-related-only encounters). The workstation ID can be free text, must be one–two characters, and must not contain an embedded up-arrow.

MNEMONIC: 3M  3M Coder Interface  ALLOWED  VISIT-RELATED-ONLY
Are you ready to send the visit information to 3M for coding? Y// YES
Enter your 3M Workstation ID: 22
Now Sending to 3M
Visit information has been passed to 3M, switch screens, code the visit and then press enter below when you are finished coding.
Are you done with the coding of the POV's on the 3M coder? N// YES

Figure 3-1: Example of using the 3M mnemonic

3.5.2 Asthma Control (ACON)

The Asthma Control (ACON) mnemonic populates the V Asthma, Asthma Control field for visit-related-only encounters. Asthma control is defined as: Well Controlled, Not Well Controlled, or Very Poorly Controlled, based on the patient’s current and recent symptoms, and the need for oral steroid treatment.

MNEMONIC: ACON  Asthma Control ALLOWED VISIT-RELATED-ONLY
ASTHMA CONTROL: ?
Asthma 'Control' is assessed at each visit and determines ongoing management. Asthma control is defined as: a) well controlled, b) not well controlled, or c) very poorly controlled, based on the patient’s current and recent symptoms, and the need for oral steroid treatment.
Choose from:
W  WELL CONTROLLED
N  NOT WELL CONTROLLED
V  VERY POORLY CONTROLLED

ASTHMA CONTROL: N NOT WELL CONTROLLED

Figure 3-2: Example of using the ACON mnemonic

3.5.3 Anesthesia CPT (ACPT)

Use the Anesthesia CPT (ACPT) mnemonic to type an anesthesia CPT for visit-related-only encounters. The system prompts for the V CPT code, the quantity, two modifiers, and whether anesthesia was administered. The system also prompts for the anesthesia start date/time, the stop date/time, and then calculates the elapsed time.

Quantity is the number of times this procedure was done to the patient during the encounter.
3.5.4 Anti-Coagulation Therapy (ACTH)

Use mnemonic ACTH to enter Anticoagulation Therapy data. The user is prompted to enter data in the following fields:

- **V Anti-Coagulation Warfarin Indicated**: Y/N
- **INE Goal**:
  - Choose from:
    - 1 2.0 – 3.0
    - 2 2.5 – 3.5
    - 3 Other
    - 4 N/a
- **Duration of Anti-Coagulation Therapy**
  - Choose from:
    - 1 3 Months
    - 2 6 Months
    - 3 12 Months
    - 4 Indefinitely
- **Anti-Coagulation Start Date**:
- **Comment**:
- **Encounter Provider**:

The INR Goal indicates the ratio at which anticoagulation therapy is directed. The INR goal is defined as a minimum INR value (range 2-3) and maximum INR value (range 304). You can use .5 integers, such as...
2, 2.5, 3, 3.5, and 4. An example is 2.5/4.

Choose from:
1 2.0 - 3.0
2 2.5 - 3.5
3 Other
4 N/A

INR GOAL: 1 2.0 - 3.0
DURATION OF ANTI-COAGULATION THERAPY: ??

Indications for warfarin often have explicit durations of therapy that occur at 3 months, 6 months, or 1 year. The duration can also be indefinite. You can enter 3, 6, or 1, which indicates t+91d, t+182d, t+365d. Enter IND or leave this field blank to indicate an indefinite time period.

Choose from:
1 3 MONTHS
2 6 MONTHS
3 12 MONTHS
4 INDEFINITELY

DURATION OF ANTI-COAGULATION THERAPY: 3 12 MONTHS
ANTI-COAGULATION THERAPY START DATE: JAN 14, 2010
// (JAN 14, 2010)

COMMENT:

ENCOUNTER PROVIDER:

---

**3.5.5 ADA Code Entry (ADA)**

Use the ADA Code Entry (ADA) mnemonic to type dental-related codes for visit-related-only encounters. The system prompts for the V Dental service code, number of units, and operative site.

<table>
<thead>
<tr>
<th>MNEMONIC: ADA ADA Code Entry ALLOWED VISIT-RELATED-ONLY</th>
<th>Service code: 7110 EXTRACTION, SIMPLE (ANY REASON)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO. OF UNITS: 1</td>
<td>OPERATIVE SITE: 17 PERMANENT THIRD MOLAR, MAND LEFT 17</td>
</tr>
</tbody>
</table>

Figure 3-5: Example of using the ADA mnemonic

---

**3.5.6 Asthma Work/School Days Missed (ADM)**

Use the Asthma Work/School Days Missed (ADM) mnemonic to type the number of work or school days missed related to asthma in the past two weeks (for visit-related-only encounters). Type a value from 0 to 14 (the units of measure is days).

| MNEMONIC: ADM Asthma Work/School Days Missed ALLOWED VISIT-RELATED-ONLY | VALUE: 2 |

Figure 3-6: Example of using the ADM mnemonic
3.5.7 Admitting Diagnosis (ADX)

Use the Admitting Diagnosis (ADX) mnemonic to modify the diagnosis for a hospitalization visit for visit-related-only encounters. To use the mnemonic, the visit must be a hospitalization and the user must be in Modify mode. In the following example, a warning message displays when using the ADX mnemonic in Enter mode.

```
MNEMONIC: ADX Admitting Diagnosis ALLOWED VISIT-RELATED-ONLY
You must specify MODIFY mode in order to use the Admitting DX mnemonic!

MNEMONIC: MOD Switch to Modify Mode ALLOWED VISIT-RELATED-ONLY
Switching to Modify Mode for ONE Mnemonic ONLY!
MNEMONIC: ADX Admitting Diagnosis ALLOWED VISIT-RELATED-ONLY
1 2970529 SIGMA,Bob May 26,1997@10:00
   ADMITTING DX: 251.0// 250.00 250.00 DM UNCOMPL/T-II/NIDDM,NS
   UNCON
...OK? Yes// (Yes)
Switching back to ENTER Mode!
```

Figure 3-7: Example of using ADX mnemonic

3.5.8 Abdominal Girth (AG)

Abdominal girth (AG) is a measurement around the abdominal area that is recorded in centimeters for visit-related-only encounters. At the “Value” prompt, type the measurement, within the range 0 to 150.

```
MNEMONIC: AG Abdominal Girth ALLOWED VISIT-RELATED-ONLY VALUE: 50
```

Figure 3-8: Example of using the AG mnemonics

3.5.9 Ankle BP (AKBP)

Use the Ankle BP (AKBP) mnemonic to type ankle blood pressure for visit-related-only encounters. The systolic must be between 20 and 275 and the diastolic must be between 20 and 200.

```
MNEMONIC: AKBP Ankle BP ALLOWED VISIT-RELATED-ONLY VALUE: 120/80
```

Figure 3-9: Example of using the AKBP mnemonic

3.5.10 Appointment Length (AL)

Use the Appointment Length (AL) mnemonic to identify the length of a scheduled appointment (for visit-related-only encounters). The AL mnemonic is used for sites involved in Waiting Time studies.

```
MNEMONIC: AL Appointment Length ALLOWED VISIT-RELATED-ONLY
```
3.5.11 Allergy Tracking Entry (ALG)

Use the Allergy Tracking Entry (ALG) mnemonic to type allergies, signs, and symptoms, and to verify the causative agent (for non-visit- or visit-related encounters). To leave the ALG mnemonic, type N (No) at the “Does this patient have any known allergies or adverse reactions?” prompt.

**MNEMONIC:** ALG Allergy Tracking Entry ALLOWED NON-VISIT/VISIT MNEMONIC

Does this patient have any known allergies or adverse reactions? : Yes

This patient has no allergy/adverse reaction data. Enter Causative Agent: SULFAMETHOXAZOLE

SULFAMETHOXAZOLE OK? Yes/

(O)bserved or (H)istorical Allergy/Adverse Reaction: H HISTORICAL

No signs/symptoms have been specified. Please add some now. The following are the top ten most common signs/symptoms:

1. ANXIETY
2. ITCHING, WATERING EYES
3. HYPOTENSION
4. DROWSINESS
5. NAUSEA, VOMITING
6. DIARRHEA

Enter from the list above: 7

Date (Time Optional) of appearance of Sign/Symptom(s):

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

<table>
<thead>
<tr>
<th>Signs/Symptoms</th>
<th>Date Observed</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIVES</td>
<td></td>
</tr>
</tbody>
</table>

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

Choose one of the following:

A - ALLERGY
P - PHARMACOLOGICAL
U - UNKNOWN

MECHANISM: UNKNOWN// P PHARMACOLOGIC

COMMENTS:

Currently you have verifier access.

Would you like to verify this Causative Agent now? Yes//

CAUSATIVE AGENT: SULFAMETHOXAZOLE

TYPE: DRUG

INGREDIENTS: SULFAMETHOXAZOLE

VA DRUG CLASSES: AM650 - SULFONAMIDE/RELATED ANTIMICROBIALS

OBS/HIST: HISTORICAL

SIGNS/SYMPTOMS: HIVES

MECHANISM: PHARMACOLOGIC

Would you like to edit any of this data? N (No)

PATIENT: SIGMA, DEMO CAUSATIVE AGENT: SULFAMETHOXAZOLE

INGREDIENTS: SULFAMETHOXAZOLE VA DRUG CLASSES: SULFONAMIDE/RELATED A
3.5.12 Allergy List Review (ALR)

Use to document when a provider indicates on the PCC or PCC+ Form that he/she reviewed the allergy list. This mnemonic will prompt for the provider who reviewed the allergy list and the date/time reviewed. If the time is not known, the date alone is sufficient and will default to the visit date.

Figure 3-12: Example of using the ALR mnemonic

3.5.13 Asthma Management Plan (AMP)

The Asthma Management Plan (AMP) is documented with the PED mnemonic using education topic ASM-SMP.

3.5.14 Anesthesia Operation (AOP)

Use the Anesthesia Operation (AOP) mnemonic to type the operation and procedure code, provider narrative, operating provider, and diagnosis data for visit-related-only encounters. The system also prompts for the anesthesia start date/time, the stop date/time, and then calculates elapsed time.

Figure 3-11: Example of using the ALG mnemonic
Figure 3-13: Example of using the AOP mnemonic

3.5.15 Activate an Inactive Problem (AOP)

In order to use the Activate an Inactive Problem (AOP) mnemonic, an active problem must already exist in the patient’s Problem List for non-visit- or visit-related encounters. The instructions on the PCC encounter form must specify the exact problem number and indicate that the status of that problem is to be changed from inactive to active.

After typing the APO mnemonic, the patient’s active and inactive problems display. Type the problem number exactly as it displays on the list and the PCC encounter form. The number consists of a location code and a problem number. A confirmation message displays to indicate that the selected problem has been activated.

If the patient has no problems on file, the system displays a related message.

The APO mnemonic prompts for the provider who added the problem list update and the date the update was made. This enables the creation of a V Updated/Reviewed entry with a clinical action of Problem List Updated.
3.5.16 Appointment Date and Time (APPT)

Use the Appointment Date and Time (APPT) mnemonic to type the patient’s appointment date and time (in a single prompt) for visit-related-only encounters. Type the date and time using standard RPMS conventions. Type the date followed by the at sign (@) and the time, as shown in the example. If a time is entered, the system automatically enters the current date. Time is a required response for this mnemonic.

<table>
<thead>
<tr>
<th>MNEMONIC: APPT Appointment Date&amp;Time</th>
<th>ALLOWED VISIT-RELATED-ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPT DATE&amp;TIME: MAY 31, 1997@2:30</td>
<td></td>
</tr>
</tbody>
</table>

Figure 3-15: Example of using the APPT mnemonic

3.5.17 Asthma Symptom Free Days (ASFD)

Use the Asthma Symptom Free Days (ASFD) mnemonic to document the patient’s asthma symptom free day for visit-related-only encounters. This includes the number of days a patient has been free of asthma symptoms, such as chest tightness, cough, shortness of breath, or wheezing in the past two weeks.

<table>
<thead>
<tr>
<th>MNEMONIC: ASFD Asthma Symptom Free Days</th>
<th>ALLOWED VISIT-RELATED-ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>VALUE: 10</td>
<td></td>
</tr>
</tbody>
</table>

Figure 3-16: Example of using the ASFD mnemonic

3.5.18 Activity and Travel Time (AT)

The Activity and Travel Time (AT) mnemonic is primarily used for Public Health Nurses (PHNs) and Community Health Nurses (CHNs) to record activity and travel times when visiting patients at their homes or outside the healthcare facility (for visit-related-only encounters). Staff from other disciplines can record activity and travel times as well. The times are entered in minutes and must be in the range of 0 to 9999 with no decimals.

<table>
<thead>
<tr>
<th>MNEMONIC: AT Activity &amp; Travel Time</th>
<th>ALLOWED VISIT-RELATED-ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIVITY TIME (in Minutes): 30</td>
<td></td>
</tr>
<tr>
<td>TRAVEL TIME (in minutes): 15</td>
<td></td>
</tr>
</tbody>
</table>

Figure 3-17: Example of using the AT mnemonic
3.5.19  Audiometry (AUD)

Use the Audiometry (AUD) mnemonic to record the results of hearing exams, which are typically performed by an audiologist (for visit-related-only encounters). At the value prompt, type eight readings for the right ear followed by eight readings for the left ear. The values should be separated by slash marks (/). Each value must be in the range of 0 to 110.

<table>
<thead>
<tr>
<th>MNEMONIC: AUD AUDIOMETRY VALUE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>100/100/100/95/90/85/80/105/105/105/105/100/100/95/90/</td>
</tr>
</tbody>
</table>

Figure 3-18: Example of using the AUD mnemonic

3.5.20  AUDIT-C (AUDC)

The AUDIT-C (AUDC) mnemonic is one of several Audit questions that focus on alcohol consumption for visit-related-only encounters. It is scored on a scale of 0–12 (score of zero reflects no alcohol use). In men, a score of four or more is considered positive; in women, a score of three or more is considered positive. A positive score means the patient is at increased risk for hazardous drinking or active alcohol abuse or dependence.

| MNEMONIC: AUDC AUDIT-C ALLOWED VISIT-RELATED-ONLY VALUE: 2 |

Figure 3-19: Example of using the AUDC mnemonic

3.5.21  Audit (AUDT)

The Audit (AUDT) mnemonic is one of several Audit questions that focus on alcohol consumption for visit-related-only encounters. It is based on a scale of zones, which range from 0–40. Zone I is a score of 0–7, which indicates low risk drinking or abstinence. Zone II is a score of 8–15, which indicates alcohol use in excess of low-risk guidelines. Zone III is a score of 16–19, which indicates harmful and hazardous drinking. Zone IV is a score of 20–40, which indicates a referral to specialist for diagnostic evaluation and treatment should be made.

| MNEMONIC: AUDT AUDIT ALLOWED VISIT-RELATED-ONLY VALUE: 7 |

Figure 3-20: Sample of using the AUDT mnemonic

3.5.22  Birth Measurement (BM)

Use the Birth Measurement (BM) mnemonic to document a patient’s birth weight and associated birth data for non-visit- or visit-related encounters. The birth weight measurement is in pounds and ounces, the APGAR in one and five minutes, gestational age in weeks, and birth length in centimeters or inches.
3.5.23 Blood Pressure (BP)

The Blood Pressure (BP) mnemonic consists of a systolic (contraction of the heart) and a diastolic (dilatation of the heart) reading for visit-related-only encounters. Each of the readings will be recorded on the PCC encounter form and should be typed as indicated on the PCC encounter form and separated by a slash mark (/). The systolic measurement must be between 20 and 275. The diastolic measurement must be between 20 and 200.

MNEMONIC: BP BLOOD PRESSURE VALUE: 120/80

Figure 3-22: Sample of using the BP mnemonic

3.5.24 Best Peak Flow (BPF)

The Best Peak Flow (BPF) is also called “personal best” peak flow recorded during periods of symptom control for visit-related-only encounters. Use BPF mnemonic to document this value. It is often recorded from home and self-reported. The value range is 50-1000 L/min.

MNEMONIC: BPF BEST PEAK FLOW ALLOWED VISIT-RELATED-ONLY VALUE: 200

Figure 3-23: Example of using the BPF mnemonic

3.5.25 Blood Sugar (BS)

Use the Blood Sugar (BS) mnemonic to record the ordering of a glucose laboratory test for visit-related-only encounters. This mnemonic should be used only if the Laboratory System is not operational at a facility. The BS mnemonic indicates only that the test was ordered. Results are not typed.
3.5.26 Blood Type Entry (BT)

The Blood Type (BT) entry mnemonic allows for the entry of a patient’s blood type for non-visit- or visit-related encounters. After selecting this mnemonic, type one of the following blood types listed as follows: A+, A-, B+, B-, AB+, AB-, O+, and O-.

Figure 3-25: Example of using the BT mnemonic

3.5.27 CBC Ordered (CBC)

Use the CBC Ordered (CBC) mnemonic to record that a CBC laboratory test was ordered for a patient for visit-related-only encounters. This mnemonic is to be used only if the laboratory package is not operational at the user’s facility. The mnemonic records only that the test was ordered. Results are not typed.

Figure 3-26: Example of using the CSC mnemonic

3.5.28 Chief Complaint (CC)

Use the Chief Complaint (CC) mnemonic to type free text about the patient’s chief complaint, using 2–240 characters (for visit-related-only encounters).

Figure 3-27: Example of using the CC mnemonic

3.5.29 Cardiac Ejection Fraction (CEF)

The Cardiac Ejection Fraction (CEF) value must be within the range of 5–99 (for visit-related-only encounters).

Figure 3-28: Example of using the CEF mnemonic
3.5.30 CHS–Outpatient Form (CHA)

Use the Outpatient Form (CHA) mnemonic to type Contract Health Care ambulatory data from the HRSA 64-PO for CHS visits other than hospital or dental for visit-related-only encounters. In order to use this mnemonic, Contract must have been selected as the visit type. If Contract was not selected, a warning message displays indicating that the user needs to change the visit type.

Follow these steps:

1. At the “Select V CHS Authorizing Facility” prompt, type the facility name.

2. At the “Authorization No.” prompt, type the authorization number, which is a 10-character number beginning with the two-digit fiscal year, followed by the three-digit location code and a five-digit number for the authorization. No dashes (-) are required.

3. At the “Vendor” prompt, type the name of the contract service provider.

4. At the “No. of Visits” prompt, type the number of visits.

5. At the “Total Charges” prompt, type the dollar amount, if known.

6. At the “Pay Status” prompt, type either full pay or partial pay.

**Note:** After making entries for the CHA mnemonic, the provider (PRV) and purpose of visit (PV) will need to be typed to complete this visit record.

3.5.31 Centimeter Head Circumference (CHC)

Use the Centimeter Head Circumference (CHC) mnemonic to enter the head circumference measurement in centimeters for visit-related-only encounters. Before using this mnemonic, be sure that the provider has indicated centimeters as the unit of measure. The entry must be within the range of 26 to 76. Decimals and fractions can be used. The fractional/decimal portion of the entry must be a multiple of 1/8 (0.125).

Figure 3-29: Example of using the CHC mnemonic
3.5.32 CHS–Hospitalization Form (CHH)

Use the Hospitalization Form (CHH) mnemonic to type contract healthcare hospitalization data from the HRSA 43-CHS PO for Hospital Services Rendered (for visit-related-only encounters). In order to use the CHH mnemonic Contract as the visit type and Hospital as the service category must be selected. If Contract and Hospital have not been selected, a warning message displays indicating that the values need to change.

Follow these steps:

1. At the “Authorizing facility” prompt, type the facility name.
2. At the “Authorization No.” prompt, type a 10-character number beginning with the two-digit fiscal year, followed by the three-digit location code, and a five-digit number for the authorization. No dashes (-) are required.
3. At the “Vendor” prompt, type the name of the contract service provider.
4. At the “Date of Discharge” prompt, type the date of discharge
5. At the “Discharge Type” prompt, type one of the following:
   • 1–Discharge
   • 2–Irregular Discharge
   • 3–Died within 48 hours
   • 4–Died after 48 hours
   • 5–Transferred
6. After typing the discharge type the following prompts display: “Newborn Diagnosis” and “Stillborn.” Type data in these fields, if applicable; or press ENTER to bypass them.
7. At the “Total Charges” prompt, specify the dollar amount, if known.
8. At the “Pay Status” prompt, indicate whether the pay status is full pay or partial

Note: After making entries for the CHA mnemonic, type the provider (PRV) and purpose of visit (PV) to complete this visit record.
3.5.33  CHS–In-Hospital Form (CHI)

Use the In-Hospital Form (CHI) mnemonic to type Contract Health Care in-hospital data from the HRSA 64-PO for CHS Other than Hospital or Dental for visit-related-only encounters. To use the CHI mnemonic, a visit type of Contract and a service category of In-Hospital must be selected. If Contract and In-Hospital have not been selected and the user tries to use this mnemonic, a warning message displays indicating the changes required.

Follow these steps:

1. At the “Authorizing facility” prompt, type the facility name.
2. At the “Authorization No.” prompt, type a 10-character number beginning with the two-digit fiscal year, followed by the three-digit location code, and a five-digit number for the authorization. No dashes (-) are required.
3. At the “Vendor” prompt, type the name of the contract service provider.
4. At the “Vendor” prompt, type the name of the contract service provider.
5. At the “Hospital Voucher No.” prompt, type the hospital voucher number, if any, using 10 to 15 characters in length.
6. At the “Number of Visits” prompt, type the appropriate value.
7. At the “Total charges” prompt, type the dollar amount, if known.

**Note:** After making entries for the CHI mnemonic, type the provider (PRV) and purpose of visit (PV) to complete this visit record.

3.5.34  Centimeter Height (CHT)

Use the Centimeter Height (CHT) mnemonic to enter the height measurement in centimeters for visit-related-only encounters. Be sure that the provider has indicated on the PCC Encounter form that the measurement has been recorded in centimeters. The entry must be in the range of 10 to 80 centimeters. Decimals or fractions can be used.

**MNEMONIC:** CHT Centimeter Height ALLOWED VISIT-RELATED-ONLY
**VALUE:** 28

Figure 3-30: Example of using the CHT mnemonic
3.5.35 Check Out Date and Time (CKO)

Use the Check Out Date and Time (CKO) to identify the time the patient’s visit was concluded for visit-related-only encounters. This information is typed when the user’s site is involved in Waiting Time studies.

MNEMONIC: CKO  Checkout Date & Time  ALLOWED  VISIT-RELATED-ONLY
Enter the Checkout Date: Sep 21,1998//@14:33  (Sep 21, 1998)
Enter CHECKOUT TIME: 233
Sep 21, 1998@233 (SEP 21, 1998@14:33)
APPOINTMENT LENGTH: 30//

Figure 3-31: Example of using the CKO mnemonic

3.5.36 Clinic Type (CL)

Use the Clinic Type (CL) mnemonic to type the clinic type for visit-related-only encounters. Clinic Type is a required data item for an ambulatory care visit record when the visit type is IHS, 638, or Tribal. The facility (location) code is between 0 and 49. Clinic Type can be typed by code or name.

MNEMONIC: CL  Clinic Type  ALLOWED  VISIT-RELATED-ONLY
CLINIC: GENERAL//WELL CHILD      24
WAS THIS AN APPOINTMENT OR A WALK IN? : WALK IN// W WALK IN

Figure 3-32: Example of using the CL mnemonic

3.5.37 Coded Chief Complaint (COC)

Use the Coded Chief Complaint (COC) mnemonic to type the code of the patient’s chief complaint for visit-related-only encounters.

CODED CHIEF COMPLAINT: 472.1 472.1  CHRONIC PHARYNGITIS
...OK? Yes//

Figure 3-33: Example of using COC mnemonic

3.5.38 Coding Guidelines Display (CODE)

Use the Coding Guidelines Display (CODE) mnemonic to display the general coding guidelines for data entry operators (for non-visit- or visit-related encounters).

OUTPUT BROWSER  Feb 09, 2009 14:18:47  Page: 1 of 7
NAME: IHSCODINGGUIDELINES
TEXT:

Official Coding Guidelines
Coding Clinic for ICD-9-CM

1. General Coding Guidelines
Use of Both Alphabetic Index and Tabular List

A. Use both the Alphabetic Index and the Tabular List when locating and assigning a code. Reliance on only the Alphabetic Index or the Tabular List leads to errors in code assignments and less specificity code selection.

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

Figure 3-34: Example using the CODE mnemonic

At the “Select Action” prompt, do one of the following

- Type Q (Quit) to quit the screen.
- Type a plus sign (+) to display the next screen. This option is not available for the last screen.
- Type a minus sign (–) to display the previous screen. This option is not available for the first screen.

3.5.39 CPT Codes with Entry of Encounter Provider (CPE)

Use the CPT Codes with Entry of Encounter Provider (CPE) mnemonic to type CPT codes for a visit including typing of the provider for the encounter (for visit-related-only encounters). The CPT code can be typed by numerical code (as shown below) or by description. To type CPT codes without entering the encounter provider, use the CPT mnemonic.

Figure 3-35: Example of using the CPE mnemonic

3.5.40 CPT Codes (CPT)

Use the CPT mnemonic to record CPT codes for a visit (for visit-related-only encounters). The CPT code can be entered by numerical code (if known) or by description, as shown below.

The following word was not used in this search: OF
The following 2 matches were found:

1: 50360 (50360)
TRANSPLANTATION OF KIDNEY RENAL ALLOTRANSPLANTATION, IMPLANTATION OF GRAFT; EXCLUDING DONOR AND RECIPIENT NEPHRECTOMY

2: 50365 (50365)
TRANSPLANTATION OF KIDNEY RENAL ALLOTRANSPLANTATION, IMPLANTATION OF GRAFT; WITH RECIPIENT NEPHRECTOMY

Press <RET> or Select 1-2: 1

QUANTITY: 1
Enter CPT code:

Figure 3-36: Example of using the CPE mnemonic

3.5.41 CRAFFT (CRFT)

Use the CRAFFT (CRFT) mnemonic to enter a rating of alcohol or drug-related disorder (for visit-related-only encounters). Positive answers to two or more of the questions are highly predictive of a disorder and further assessment is indicated. The range is from zero to six.

MNEMONIC: CRFT CRFT CRAFFT ALLOWED VISIT-RELATED-ONLY
VALUE: 3

Figure 3-37: Example of using the CRFT mnemonic

3.5.42 CAN TRAN CODE ENTRY (CTC)

Use the Can Tan Code Entry (CTC) mnemonic to type the CAN number to be processed (for visit-related-only encounters). This mnemonic is used by sites with the Monsalve Chargemaster (all seven Aberdeen hospitals and about eight other hospitals). When Chargemaster is installed, sites with the Monsalve Chargemaster are trained on these mnemonics. No other sites use this mnemonic.

3.5.43 CAN TRAN CODE ENTRY TE (CTE)

Use the Can Tan Code Entry Te (CTE) mnemonic to type the CAN number to be processed (for visit-related-only encounters). This mnemonic is used by sites with the Monsalve Chargemaster (all seven Aberdeen hospitals and about eight other hospitals). When Chargemaster is installed, sites with the Monsalve Chargemaster are trained on these mnemonics. No other sites use this mnemonic.

3.5.44 Cervix Dilation (CXD)

Use the Cervix Dilation (CXD) mnemonic to type the cervix dilatation measurement for a patient in visit-related-only encounters. The value entered must be in the range 0 to 10.
3.5.45  Cup to Disk (CDR)

Use the Cup to Disk (CDR) mnemonic to enter the Cup to Disc Ratio. The value must be between 0 and 1, up to 2 decimal digits.

Figure 3-39: Example of using the CDR mnemonic

3.5.46  Disposition of Care (DC)

Use the Disposition of Care (DC) mnemonic to specify the disposition of care type for visit-related-only encounters. The options are: Admit, AMA, Death, Discharged, Follow up appointment, Observation, Other, PRN, and Transferred.

Figure 3-40: Example of using the DC mnemonic

3.5.47  Dental–Direct Services (DDS)

Use the Dental–Direct Services (DDS) mnemonic to capture dental data only if the IHS Dental Module is not currently operating at the user’s facility (for visit-related-only encounters). The system automatically creates a Purpose of Visit, as well as the designation of Primary for the provider entered. The user will be prompted for the dental service code, quantity, operative site, and tooth surface.

Note: The help screens are lengthy and might require a great deal of processing time.

MNEMONIC: DDS Dental Direct Service ALLOWED VISIT-RELATED-ONLY
Select V PROVIDER: BLACK,HAROLD C DENTIST IHS 207 152207
Select V DENTAL SERVICE CODE: 2330 COMPOSITE RESIN, ONE SURFACE, ANTERIOR
QUANTITY: 1
OPERATIVE SITE:
3.5.48 Data Entry Health Summary (DHS)

Use the DHS mnemonic to display a Health Summary from within the Data Entry system for non-visit- or visit-related encounters. The type of Health Summary that displays is defined in the Site Parameter file. After the Health Summary displays, the commands at the bottom of the screen are used to browse through the patient information. For more information on Health Summaries, refer to the Health Summary system user’s manual.
-------------------- ALLERGIES (FROM PROBLEM LIST) --------------------

***** NONE RECORDED *****

Allergy List Reviewed On:  
Allergy List Updated On:  
No Active Allergies documented On:  

Problem List Reviewed On:  Dec 06, 2014  By: WHITE, LESLIE R  
Problem List Updated On:  Dec 15, 2014  By: TEST, KATHLEEN  
No Active Problems Documented On:  

------- MEASUREMENT PANELS (OUTPATIENT) (max 5 visits or 2 years)-------

<table>
<thead>
<tr>
<th>HT</th>
<th>WT</th>
<th>BP</th>
<th>BMI</th>
<th>%RW</th>
<th>VU</th>
<th>VC</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/11/08</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10/18/07</td>
<td>218</td>
<td></td>
<td>***</td>
<td>***</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*** NO HEIGHT FOR PATIENT.  

------------------------ CHRONIC PROBLEMS ------------------------

ENT.    MODIFIED  
TST2    12/15/14 12/15/14  E10.622-Type 1 diabetes mellitus with other skin ulcer; *diabetes date on onset (onset 12/12/13)(Status: CHRONIC)  
TST3    12/15/14 12/15/14  G57.71-Causalgia of right lower limb; *problem #! (onset 01/06/15)(Status: CHRONIC)  
TST4    12/15/14 12/15/14  A01.00-Typhoid fever, unspecified; *diagnosis positive (Status: CHRONIC)  

Problem List Reviewed On:  Dec 06, 2014  By: WHITE, LESLIE R  
Problem List Updated On:  Dec 15, 2014  By: TEST, KATHLEEN  
No Active Problems Documented On:  

------------------ SUB ACUTE PROBLEMS ------------------

Problem List Reviewed On:  Dec 06, 2014  By: WHITE, LESLIE R  
Problem List Updated On:  Dec 15, 2014  By: TEST, KATHLEEN  
No Active Problems Documented On:  

------------------- EPISODIC PROBLEMS -------------------

ENT.    MODIFIED  
TST1    12/06/14 12/06/14  -<DIAGNOSIS field missing>; Pain |  (Status: EPISODIC)  

Problem List Reviewed On:  Dec 06, 2014  By: WHITE, LESLIE R  
Problem List Updated On:  Dec 15, 2014  By: TEST, KATHLEEN  
No Active Problems Documented On:  

-------------------- SOCIAL/ENVIRONMENTAL PROBLEMS --------------------
Problem List Reviewed On: Dec 06, 2014 By: WHITE, LESLIE R
Problem List Updated On: Dec 15, 2014 By: TEST, KATHLEEN
No Active Problems Documented On: By:

----------------------------- INACTIVE PROBLEMS -----------------------------

Problem List Reviewed On: Dec 06, 2014 By: WHITE, LESLIE R
Problem List Updated On: Dec 15, 2014 By: TEST, KATHLEEN
No Active Problems Documented On: By:

----------------------------- HISTORY OF SURGERY -----------------------------

Minor procedures are on file but have not been displayed.

SCHEDULED ENCOUNTERS (INCLUDES CHART REQ AND WALK INS) (max 10 visits or 90 days)

--------------- IN HOSPITAL VISITS (max 10 visits or 2 years) --------------

--------------- OUTPATIENT/FIELD VISITS (max 10 visits or 2 years) ------------

12/15/14  2013 DEMO HO CHR  Z02.9-Encounter for administrative examinations, unspecified; iCare Chart Review
            <none>  A01.00-Typhoid fever, unspecified; diagnosis positive
12/08/14  GWC          GEN   <purpose of visit not yet entered>; <purpose of visit not yet entered>
11/10/14  GWC          GEN   S32.613G-Displaced avulsion fx unsp ischium, subs for fx w delay heal; Pain |
07/09/13  2013 DEMO HO CMS <purpose of visit not yet entered>; <purpose of visit not yet entered>

<<< RCIS ACTIVE REFERRALS >>>

No Referred Care Referral records on file.

--------------- MOST RECENT PATIENT EDUCATION (max 5 visits or 2 years) ------------

------------------------- MOST RECENT EXAMINATIONS -------------------------

NECK EXAM       12/04/08  HILLSTROM, DELON
HEART EXAM      12/11/08  HILLSTROM, DELON
EYE EXAM - GENERAL 12/04/08  HILLSTROM, DELON

----------------------------- IMMUNIZATIONS -----------------------------

IMMUNIZATION FORECAST:
*BICALL Error: -4; Cannot find, open, load Live Vaccine Table file.
IMMUNIZATION HISTORY:
--------------- HEALTH MAINTENANCE REMINDERS ---------------

<table>
<thead>
<tr>
<th>LAST</th>
<th>NEXT</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLOOD PRESSURE</td>
<td>12/11/08</td>
</tr>
<tr>
<td>HEIGHT</td>
<td>11/11/92</td>
</tr>
<tr>
<td>WEIGHT</td>
<td>10/18/07</td>
</tr>
<tr>
<td>PAP SMEAR</td>
<td>11/11/10</td>
</tr>
<tr>
<td>PELVIC EXAM</td>
<td>11/11/10</td>
</tr>
<tr>
<td>BREAST EXAM</td>
<td>11/11/12</td>
</tr>
<tr>
<td>IMMUNIZATIONS DUE * BICALL Error: -4;Cannot find, open, load Live Vaccine Table</td>
<td></td>
</tr>
<tr>
<td>PHYSICAL EXAM</td>
<td>11/11/10</td>
</tr>
<tr>
<td>TD-ADULT</td>
<td>11/11/04</td>
</tr>
<tr>
<td>ALCOHOL USE SCREENING</td>
<td>11/11/05</td>
</tr>
<tr>
<td>TOBACCO USE SCREENING</td>
<td>11/11/05</td>
</tr>
</tbody>
</table>

*** END * CONFIDENTIAL PATIENT INFORMATION -- 1/19/2015 1:54 PM [st] ********

Figure 3-42: Example of using the DHS mnemonic

3.5.49 Visit Display (DISP)

Use the Visit Display (DISP) mnemonic to display all data that has been typed for a patient for the visit with which the user is working (for non-visit- or visit-related encounters). Brief patient demographics display along with the Visit file. Note that historical and non-visit related entries do not display in the active visit file. To browse through the information, use the commands listed at the bottom of the screen. The visit display displays SNOMED-preferred terms if the topic is a SMOMED topic. In addition the Visit Display handles LOINC and other new fields.
3.5.50 Designated Provider (DP)

Use the DP mnemonic when a patient is assigned a specific designated provider for all visits and to capture this provider’s name (for non-visit or visit-related encounters). The provider’s name will display in the Adult Regular Health Summary in the Demographics section. DP will rarely be used and should not be confused with the provider entry, which is required for all visits. (Note that this mnemonic is the same as the PCP – Primary Care Provider. Only the terminology is different.)

Figure 3-44: Example of using the DRG mnemonic

3.5.51 DRG (DRG)

Use the DRG mnemonic to enter the DRG number or name (for visit-related-only encounters).

Figure 3-45: Example of using the DRG mnemonic
3.5.52 **Diagnostic Procedure Tran Code (DTC)**

Use the DTC mnemonic to type Chargemaster Transaction Codes for diagnostic procedures in visit-related-only encounters. Other Chargemaster Tran Codes not for diagnostic procedures are typed utilizing the TC mnemonic. The codes are usually recorded on a special-purpose billing form such as a Superbill. A Chargemaster Transaction File must be loaded at the user’s site in order to use this mnemonic.

![Example of using the DTC mnemonic](image)

3.5.53 **Append a 2nd E-Code to a POV (ECO2)**

Use the Append a 2nd E-Code to a POV (ECO2) mnemonic to append a second E code to a purpose of visit for visit-related-only encounters. See ECOD below for more information.

3.5.54 **Append a 3rd E-Code to a POV (ECO3)**

Use the Append a 3rd E-Code to a POV (ECO3) mnemonic to append a third E code to a purpose of visit for visit-related-only encounters. See ECOD below for more information.

3.5.55 **Append an E-Code to a Purpose of Visit (ECOD)**

Use the ECOD mnemonic to append an E code to a purpose of visit (for visit-related-only encounters). The E code allows a cause of injury to be recorded along with the visit diagnosis. For a visit with more than one purpose of visit, specify to which purpose of visit the E code should be appended. At the “Enter E-code” prompt, type the name or numerical code for entry.

![Example of using the ECOD mnemonic](image)

3.5.56 **Edema Measurement (ED)**

Use the Edema Measurement (ED) mnemonic to type the edema measurement for visit-related-only encounters. The value typed must be one of the following: 0, 1+, 2+, 3+, or 4+.
3.5.57 Expected Date of Delivery (EDD)

Use the Expected Date of Delivery (EDD) mnemonic to capture the expected date of delivery for non-visit or visit-related encounters. If the answer to the first prompt, “Currently Pregnant?:” is N (No), you are returned to the Mnemonic prompt. If the answer is Y (Yes), the EDD prompts follow.

The EDD choices are: EDD (Method Unknown), EDD (LMP), EDD (Ultrasound), EDD (Clinical Parameters), DEFINITIVE EDD. You have the option to enter a comment after you enter a date at an EDD prompt.

3.5.58 Effacement (EFF)

Use the Effacement (EFF) mnemonic to record effacement for visit-related-only encounters. The value typed must be within the range 0 to 100.

3.5.59 EKG Diagnostic Procedure (EKG)

Use the EKG Diagnostic Procedure (EKG) mnemonic to type EKG procedures for visit-related-only encounters. Results are recorded at the “Value” prompt and can be designated only as normal or abnormal.
3.5.60 Elder Care (EL)

Use the Elder Care (EL) mnemonic to type data about elder care for visit-related-only encounters. The value options are Independent, Needs Help, and Totally Dependent. The options for Change in Functional Status are Same, Improvement, and Decline. The options for “Is Patient a Caregiver” prompt are Yes or No.

<table>
<thead>
<tr>
<th>MNEMONIC: EL</th>
<th>Elder Care</th>
<th>ALLOWED</th>
<th>VISIT-RELATED-ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOILETING:</td>
<td>I INDEPENDENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BATHING:</td>
<td>I INDEPENDENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRESSING:</td>
<td>I INDEPENDENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRANSFERS:</td>
<td>I INDEPENDENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FEEDING:</td>
<td>I INDEPENDENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONTINENCE:</td>
<td>I INDEPENDENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FINANCES:</td>
<td>N NEEDS HELP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COOKING:</td>
<td>N NEEDS HELP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHOPPING:</td>
<td>N NEEDS HELP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HOUSEWORK/CHORES:</td>
<td>N NEEDS HELP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MEDICATIONS:</td>
<td>N NEEDS HELP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRANSPORTATION:</td>
<td>N NEEDS HELP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHANGE IN FUNCTIONAL STATUS:</td>
<td>S SAME</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IS PATIENT A CAREGIVER:</td>
<td>N NO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 3-52: Example of using the EL mnemonic

3.5.61 Evaluation and Management (CPT) (EM)

Use the Evaluation and Management CPT (EM) mnemonic to capture evaluation and management CPT data for visit-related-only encounters. An entry can be created by name or numerical code. Note that the code typed must be within the range of 99201 to 99499.

<table>
<thead>
<tr>
<th>MNEMONIC: EM</th>
<th>Evaluation&amp;Management (CPT) ALLOWED</th>
<th>VISIT-RELATED-ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>VISIT, NEW:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A PROBLEM ...OK? Yes// (Yes)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 3-53: Example of using the EM mnemonic

3.5.62 Emergency Visit Record (EVR)

This mnemonic is not used by all sites.

3.5.63 Emergency Room Visit Record (ER)

Use the ER mnemonic to type patient data for an emergency room visit in visit-related-only encounters. Before using this mnemonic, Emergency must have been selected as the clinic type. If Emergency has not been selected, modify the clinic with the CL mnemonic.

Follow these steps:
1. At the “Urgency” prompt, type one of the following:
   - R Resuscitation (1)
   - E Emergent (2)
   - U Urgent (3)
   - L Less Urgent (4)
   - Routine (5)

2. At the “Means of Arrival” prompt, type one of the following:
   - A–Ambulance
   - P–Police
   - POV–POV
   - T–Taxi
   - W–Walked
   - O–Other
   - R–Air
   - M–Medivac from village

3. At the “Enter ER by” prompt, type one of the following:
   - A–Ambulatory
   - W–Wheelchair
   - C–Carried

4. At the “Informant” prompt, specify the information using up to 30 characters.

5. At the “Notified” prompt, type one of the following:
   - R–Relative
   - P–Police
   - C–Coroner

6. At the “Disposition of Care” prompt, type one of the following:
   - A–Admit
   - T–Transfer
   - D–Discharge
   - O–Other
• M–Medivac Transfer
• L–Lifeguard
• E–Died/Expired
• L–Left AMA

7. At the “Departure Date&Time” prompt, type the date and time of the departure.

8. At the “Left Area” prompt, type the date and time of the patient left the area.

3.5.64 Examinations (EX)

Use the Examinations (EX) mnemonic to record the type of exam performed during a patient visit (for visit-related-only encounters). Some of the exam types are reported in the Health Summary in the Health Maintenance Reminders component, along with the date on which the exam was performed and a due date for the next exam. The following list shows available exam types.

<table>
<thead>
<tr>
<th>Exam</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Screening</td>
<td>35</td>
</tr>
<tr>
<td>Color Blindness</td>
<td>41</td>
</tr>
<tr>
<td>Dental Exam</td>
<td>30</td>
</tr>
<tr>
<td>Depression Screening</td>
<td>36</td>
</tr>
<tr>
<td>Diabetic Eye Exam</td>
<td>03</td>
</tr>
<tr>
<td>Diabetic Foot Exam, Complete</td>
<td>28</td>
</tr>
<tr>
<td>Fall Risk</td>
<td>37</td>
</tr>
<tr>
<td>Foot Inspection</td>
<td>29</td>
</tr>
<tr>
<td>Intimate Partner Violence</td>
<td>34</td>
</tr>
<tr>
<td>Newborn Hearing Screen (Right)</td>
<td>38</td>
</tr>
<tr>
<td>Newborn Hearing Screen (Left)</td>
<td>39</td>
</tr>
<tr>
<td>Suicide Risk Assessment</td>
<td>43</td>
</tr>
<tr>
<td>VTE Risk Assessment</td>
<td>42</td>
</tr>
</tbody>
</table>

The following is an example of using the EX mnemonic:

```
MNEMONIC: EX Examinations ALLOWED VISIT-RELATED-ONLY
Select V EXAM: FALL RISK 37
RESULT: N NORMAL/NEGATIVE COMMENTS:

PROVIDER PERFORMING EXAM:
```

Figure 3-54: Example of using the EX mnemonic
3.5.65 24-Hour Fluid Balance, Positive/Negative (FBPN)

Use the FBPN mnemonic to enter the patient’s fluid balance within a 24-hour period. Subtract the 24-hour fluid output from the 24-hour fluid input for the value. This value can be either positive or negative. Use this information in conjunction with the 24-Hour Fluid Input (FI24) and 24-Hour Fluid Output (FO24) mnemonics.

```
MNEMONIC: FBPN  FLUID BALANCE POS/NEG ALLOWED VISIT RELATED ONLY
VALUE: 2000
```

Figure 3-55: Example of using the FBPN mnemonic

3.5.66 FEF 25-75 (FEF)

Use the FEF 25-75 (FEF) mnemonic to type the average flow of air during the middle portion of expiration (the unit of measure is percent) for visit-related-only encounters. The value range is any integer between 0–150.

```
MNEMONIC: FEF   FEF 25-75   ALLOWED   VISIT-RELATED-ONLY
VALUE: 50
```

Figure 3-56: Example of using the FEF mnemonic

3.5.67 Fundal Height (FH)

Use the Fundal Height (FH) mnemonic to type the Fundal height measurement (for visit-related-only encounters). This measurement is recorded in centimeters and must be in the range 0 to 100. Note that when entering the FH mnemonic, the user will always be prompted to choose between FH and FHX, as shown below.

```
MNEMONIC: FH
VALUE: 15
```

Figure 3-57: Sample of entering FH mnemonic

3.5.68 Family History (FHX)

Use the FHX mnemonic to type medical data concerning family members that can be pertinent to the patient’s healthcare (for visit-related-only encounters). Family History does not allow a duplicate relation to be entered. The user is prompted to select SNOMED terms from a list of valid family history terms that have the mapped ICD code display next to the term description.

Add/Edit Family History       Jan 19, 2015 14:24:04          Page:    1 of    1
Name: DEMO,BERNADINE MARIA  DOB: NOV 11, 1992  Sex: F  HRN: 140558
1)  Dec 11, 2008  Relation: SISTER
   Status: LIVING
   Multiple Birth: NO
Dx:  
SNOMED:  
Age at Onset:  
Q - Quit/?? for more actions/+ next/- previous  
A    Add Family Hx    X    Delete Family Hx    Q    Quit  
E    Edit Family Hx    HS    Health Summary  
Select Action: +//  
e    Edit Family Hx  
Select :  (1-1): 1  
RELATIONSHIP: SISTER//  
RELATION DESCRIPTION:  
L - LIVING  
D - DECEASED  
U - UNKNOWN  
R - PT REFUSED TO ANSWER  
STATUS: LIVING//  
MULTIPLE BIRTH?: NO//  
Add a Condition for SISTER ? Y//  
SNOMED SELECTION  
Jan 19, 2015 14:27:01  
Page:    2 of   23  
SELECT FAMILY HISTORY SNOMED TERM  
+  
18)  430552005       Family history of benign prostatic hyperplasia (V19.8)  
19)  433491003       Family history of bilateral hip replacements (.9999)  
20)  431330007       Family history of breast cancer 1 gene mutation (V16.3)  
21)  431331006       Family history of breast cancer 2 gene mutation (V16.3)  
22)  266899005       FH: Bronchitis/COAD (V17.6)  
23)  433277006       Family history of bulimia nervosa (V19.8)  
24)  275937001       Family history of cancer (V16.9)  
25)  312824007       Family history of cancer of colon (V16.0)  
26)  430331003       Family history of cancer of the esophagus (V16.0)  
27)  438825005       Family history of cardiovascular disease in first degree f  
28)  439724007       Family history of cardiovascular disease in first degree m  
29)  433448008       Family history of carotid endarterectomy (.9999)  
30)  430329007       Family history of celiac disease (V18.59)  
31)  266891008       FH: CNS disorder (V17.2)  
32)  430674005       Family history of cerebral artery occlusion (V17.1)  
33)  440697006       Family history of cerebral infarction (V17.3)  
34)  429970002       Family history of Charcot-Marie-Tooth disease (V17.2)  
+         Enter ?? for more actions                                          >>>  
S    Select Snomed: 19  
This is the ICD code that the SNOMED maps to, you can change it if needed.  
DIAGNOSIS: .9999//  
PROVIDER NARRATIVE:  UNCODED DIAGNOSIS  
PROVIDER: PROVIDER: test TEST,KATHLEEN  
DIAGNOSIS ONSET AGE:  
DIAGNOSIS ONSET AGE: 23  
APPROXIMATE AGE?:  
34??  
Choose from:  
  1        YES, APPROXIMATE AGE  
  0        NO  
APPROXIMATE AGE?:  
Family History added.  
Add Another Condition for SISTER ? N//  
Add/Edit Family History  
Jan 19, 2015 14:30:01  
Page:    1 of   1  
Name: DEMO,BERNADINE MARIA  DOB: NOV 11, 1992  Sex: F HRN: 140558  
1)  Jan 19, 2015  Relation: SISTER  
Status: LIVING
Multiple Birth: NO
Dx: .9999  Family history of bilateral hip replacements | UNCODED DIAGNOSIS
SNOMED: 433491003
Age at Onset: 23
Provider who Documented: TEST,KATHLEEN

Figure 3-58: Example of using FHX mnemonic

At the “Select Action” prompt, do one of the following:

- Type Q (Quit) to quit the screen.
- Type a plus sign (+) to display the next screen. This option is not available for the last screen.
- Type a minus sign (–) to display the previous screen. This option is not available for the first screen.

The following actions are available on the FHX screen:

- Type A (Add Family Hx) to add a family relation type.
- Type E (Edit Facility Hx) to edit an existing family relation type.
- Type X (Delete Facility Hx) to remove an existing family relation type.
- Type HS (Health Summary) to display a Health Summary for a specified patient.

To add data about the relation, use the following example:

Enter RELATION: father (BIOLOGICAL)  NATURAL FATHER  18
Enter NATURAL FATHER Relation Description:
RELATION DESCRIPTION: ??

RELATION DESCRIPTION:

L - LIVING
D - DECEASED
U - UNKNOWN
R - PT REFUSED TO ANSWER
STATUS: STATUS: ??

Choose from:
L   LIVING
<table>
<thead>
<tr>
<th>Status</th>
<th>Mnemonic</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>DECEASED</td>
</tr>
<tr>
<td>U</td>
<td>UNKNOWN</td>
</tr>
<tr>
<td>R</td>
<td>PT REFUSED TO ANSWER</td>
</tr>
</tbody>
</table>

**STATUS:** 1

**MULTIPLE BIRTH?:** N  NO

**Add a Condition for NATURAL FATHER ?** Y//

**SNOMED SELECTION** Jan 19, 2015 14:36:42  Page: 2 of 23

**SELECT FAMILY HISTORY SNOMED TERM**

`+` 18) 430552005  Family history of benign prostatic hyperplasia (V19.8)
19) 433491003  Family history of bilateral hip replacements (.9999)
20) 431330007  Family history of breast cancer 1 gene mutation (V16.3)
21) 431331006  Family history of breast cancer 2 gene mutation (V16.3)
22) 266899005  FH: Bronchitis/COAD (V17.6)
23) 433277006  Family history of bulimia nervosa (V19.8)
24) 275937001  Family history of cancer (V16.9)
25) 312824007  Family history of cancer of colon (V16.0)
26) 430331003  Family history of cancer of the esophagus (V16.0)
27) 438825005  Family history of cardiovascular disease in first degree f
28) 439724007  Family history of cardiovascular disease in first degree m
29) 433448008  Family history of carotid endarterectomy (.9999)
30) 430329007  Family history of celiac disease (V18.59)
31) 266891008  FH: CNS disorder (V17.2)
32) 430674005  Family history of cerebral artery occlusion (V17.1)
33) 440697006  Family history of cerebral infarction (V17.3)
34) 429970002  Family history of Charcot-Marie-Tooth disease (V17.2)

`Enter ?? for more actions`[>]

**S** Select Snomed

**Select Action:** [+] S

Enter 1-365: 24

This is the ICD code that the SNOMED maps to, you can change it if needed.

**DIAGNOSIS:** V16.9/

**PROVIDER NARRATIVE:** FAMILY HX-MALIGNANCY NOS

**PROVIDER:** test TEST, KATHLEEN TK

**DIAGNOSIS ONSET AGE:**

Choose from:

1  YES, APPROXIMATE AGE
0  NO

**APPROXIMATE AGE?:** 1

Family History added.

**Add Another Condition for NATURAL FATHER ?** N//

---

**Figure 3-59: Example of adding data about a relation**

To add data for the first condition for this relation:

---

**Add a Condition for Father (BIOLOGICAL)?** Y// ES

**SNOMED SELECTION** Jan 19, 2015 14:40:30  Page: 1 of 23

**SELECT FAMILY HISTORY SNOMED TERM**

1) 441120009  Family history of acquired immune deficiency syndrome (V19
2) 160953001  Family history of acute medical disorder (V19.8)
3) 266890009  Family history of alcoholism (V19.8)
4) 431912005  Family history of alpha-1-antitrypsin deficiency (V19.8)
5) 430728001  Family history of amnesia (V19.8)
6) 430720006  Family history of amyotrophic lateral sclerosis (V17.2)
7) 430102007  Family history of aneurysm of artery (V19.8)
8) 430753003  Family history of aneurysm of thoracic aorta (V17.49)
9) 315626001       FH angina female first degree age known (V17.49)
10) 315623009       FH angina male first degree age known (V17.49)
11) 433306000       Family history of anorexia nervosa (V19.8)
12) 433276002       Family history of atrial fibrillation (V17.49)
13) 429950008       Family history of attention deficit hyperactivity disorder
14) 433380009       Family history of attention deficit hyperactivity disorder
15) 412750001       Family history of autism (V17.0)
16) 429976008       Family history of backache (V17.89)
17) 433442009       Family history of bariatric operative procedure (.9999)

+ Enter ?? for more actions

S Select Snomed
Select Action:+// s   Select Snomed

Which SNOMED Term:  (1-376): 22
This is the ICD code that the SNOMED maps to, you can change it if needed.

DIAGNOSIS: V17.6//
PROVIDER NARRATIVE: FAM HX-CHR RESP COND NEC
PROVIDER: test TEST,KATHLEEN TK
DIAGNOSIS ONSET AGE: 55
APPROXIMATE AGE?:
y YES, APPROXIMATE AGE

Family History added.
Add Another Condition for NATURAL FATHER ? N//

Figure 3-60: Example of typing data for the first condition for this relation

To add a new relation and conditions:

Select Action: +// e   Edit Family Hx
Select : (1-3): 2

The relation associated with this Family History condition is:
NATURAL FATHER
Do you wish to CHANGE the relation associated with this condition? N// y  YES

Enter RELATION: Enter RELATION: mother (BIOLOGICAL)  NATURAL MOTHER  18
Enter NATURAL MOTHER Relation Description:

RELATION DESCRIPTION:
L - LIVING
D - DECEASED
U - UNKNOWN
R - PT REFUSED TO ANSWER
STATUS: d  DECEASED

I - In Infancy
1 - Before age 20
2 - At age 20-29
3 - At age 30-39
4 - At age 40-49
5 - At age 50-59
6 - 60 and older
U - Age Unknown
AGE AT DEATH:
5 At age 50-59

CAUSE OF DEATH:
ULTIPLE BIRTH?: n  NO

SNOMED: FH: Bronchitis/COAD (266899005)
DX: V17.6
Do you wish to CHANGE the SNOMED or Diagnosis? N//
PROVIDER: TEST,KATHLEEN//
DIAGNOSIS ONSET AGE: 55//
APPROXIMATE AGE?: YES, APPROXIMATE AGE//

Figure 3-61: Example of data display of the new relation and conditions typed

3.5.69 24-Hour Fluid Input (FI24)

Use the FI24 mnemonic to enter the patient’s fluid input within a 24-hour period. The value range is 0–10000 mls. Use this information in conjunction with the 24-Hour Fluid Output (FO24) and 24-Hour Fluid Balance, Positive/Negative (FBPN) mnemonics.

MNEMONIC: FI24  24 HOUR FLUID INPUT  ALLOWED  VISIT RELATED ONLY
VALUE: 5000

Figure 3-62: Example of using FI24 mnemonic

3.5.70 Flag Field (FL)

Use the Flag Field (FL) mnemonic to type a numeric code between 1 and 99 into a special Flag Field of the PCC Visit Record for keeping track of locally relevant data (for visit-related-only encounters). For example, a facility might want to gather workload data about a designated special area within their outpatient clinic. These special clinic areas can be identified in each visit by an entry in the Flag Field of the Visit Record.

MNEMONIC: FL Flag Field ALLOWED VISIT-RELATED-ONLY
FLAG: 5

Figure 3-63: Example of using the FL mnemonic

3.5.71 Family Planning Method (FM)

Use the Family Planning Method (FM) mnemonic to type the family planning method (only) for non-visit- or visit-related encounters. You are given the option to add a new contraceptive method or quit and return to the mnemonic prompt. Type two question marks (??) at the “ADD a new Contraceptive Method” prompt to see a list of the contraceptive methods available.

MNEMONIC: FM Family Planning Method ALLOWED NON-VISIT/VISIT MNEMONIC
Contraceptive Methods currently recorded: None recorded
Select one of the following:

A  ADD a new Contraceptive Method
Q  QUIT

Which action: Q// Q QUIT

Figure 3-64: Example of using the FM mnemonic

To type additional female reproductive factors, use the FP mnemonic. A list of contraceptive methods currently on file for the patient displays.

3.5.72 24-Hour Fluid Output (FO24)

Use the FO24 mnemonic to enter the patient’s fluid output within a 24-hour period. The value range is 0–10000 mls. Use this information in conjunction with the 24-Hour Fluid Input (FI24) and 24-Hour Fluid Balance, Positive/Negative (FBPN) mnemonics.

MNEMONIC: FO24  24 HOUR FLUID INPUT ALLOWED VISIT RELATED ONLY
VALUE: 3000

Figure 3-65: Example of using FO24 mnemonic

3.5.73 Family Planning (FP)

Use the Family Planning (FP) mnemonic to capture female reproductive factors and family planning data for non-visit or visit-related encounters.

The reproductive history data fields are:

- Total # Pregnancies
- Full Term Births
- Premature Births
- Abortions, # Induced
- Abortions, # Spontaneous
- Ectopic Pregnancies
- Multiple Births
- Living Children
- DES Daughter?
- Age at First Menses
- Age at First Vaginal Intercourse
- Age at Onset of Menopause
- Last Menstrual Period
- Currently Pregnant?
- EDD (Method Unknown)
- EDD (LMP)
- EDD (Ultrasound)
- EDD (Clinical Parameters)
- Definitive EDD
- Lactation Status
- Provider who documented Lactation
- Contraceptive Method
- Contraception Begun
- Contraception Ended

The user is given the option to add, edit or delete a contraceptive method. Type two question marks (??) to see a list of the contraceptive methods available.

```
MNEMONIC: FP  Family Planning  ALLOWED  NON-VISIT/VISIT MNEMONIC TOTAL #
PREGNANCIES: 0//
FULL TERM BIRTHS: 0//
PREMATURE BIRTHS: 0// ABORTIONS, # INDUCED: 0// ABORTIONS, # SPONTANEOUS: 0//
ECTOPIC PREGNANCIES: 0// MULTIPLE BIRTHS: 0//
LIVING CHILDREN: 0//
DES DAUGHTER?: UNKNOWN//
AGE at FIRST MENSES: 12//
AGE at FIRST VAGINAL INTERCOURSE: 15//
AGE at ONSET of MENOPAUSE:
LAST MENSTRUAL PERIOD: MAR 31, 2011// CURRENTLY PREGNANT?: YES//
PROVIDER WHO UPDATED CURRENTLY PREGNANT: EDD (Method Unknown):
EDD (LMP): OCT 5, 2011//
PROVIDER WHO UPDATED EDD (LMP): EDD (LMP) COMMENT:
EDD (ULTRASOUND):
PROVIDER WHO UPDATED EDD (ULTRASOUND):

EDD (ULTRASOUND) COMMENT: EDD (CLINICAL PARAMETERS):
PROVIDER WHO UPDATED EDD (CLINICAL PARAMETERS): EDD (CLIN PARAMETERS) COMMENT:
DEFINITIVE EDD: U//
PROVIDER WHO UPDATED DEFINITIVE EDD: DEFINITIVE EDD COMMENT:
LACTATION STATUS:
PROVIDER WHO DOCUMENTED LACTATION STATUS:

Contraceptive Methods currently recorded:

<table>
<thead>
<tr>
<th>Contraceptive Method</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)  EMERGENCY CONTRACEPTION</td>
<td>Oct 25, 2011</td>
<td></td>
</tr>
<tr>
<td>2)  MENOPAUSE</td>
<td>Oct 25, 2011</td>
<td></td>
</tr>
</tbody>
</table>

Select one of the following:
A  ADD a new Contraceptive Method
E  Edit an Existing Contraceptive Method
```
Delete an Existing Contraceptive Method
Q QUIT

Which action: Q// Q QUIT

3.5.74 Future Scheduled Encounter
This mnemonic is not used by all sites.

3.5.75 Fetal Heart Tones (FT)
Fetal Heart Tones is a measurement of the fetal heart rate per minute. This measurement is usually found on a prenatal encounter form. The value for this measurement must be in the range of 0 to 400. This mnemonic is used for visit-related-only encounters.

MNEMONIC: FT Fetal Heart Tones ALLOWED VISIT-RELATED-ONLY VALUE: 90

3.5.76 FEV1/FVC (FVFC)
Use the FEV1/FVC (FVFC) mnemonic to type a ratio of FEV1/FVC. FEV1 is the maximum amount of air exhaled in one second. The range is 0–10 liters. The Forced Vital Capacity (FVC) is the maximum amount of air inhaled and exhaled. The range is 0–10 liters. The mnemonic is used for visit-related-only encounters.

MNEMONIC: FVFC FEV1/FVC ALLOWED VISIT-RELATED-ONLY VALUE: 5/10

3.5.77 FRAMINGHAM 10 YEAR RISK (F10R)
Use the Framingham 10 Year Risk (F10R) mnemonic to enter a numeric percentage from the following allowable values:

For women: <1, 1, 2, 3, 4, 5, 6, 8, 11, 14, 17, 22, 27, >30

For men: <1, 1, 2, 3, 4, 5, 6, 8, 10, 12, 16, 20, 25, >30
3.5.78 Generate Health Summary (GHS)

The Generate Health Summary (GHS) mnemonic is used to display a particular patient’s Health Summary (for non-visit- or visit-related encounters).

3.5.79 Eyeglass Prescription (GP)

Use the Eyeglass Prescription (GP) mnemonic to type eyeglass prescription data for visit-related-only encounters. The data includes measurements for the sphere, cylinder, axis, and eyeglass frame, as well as the papillary distance in the eye. If eyeglass prescription data is typed at the user’s facility, each prescription must contain at least a sphere, cylinder, and axis reading. The form will record the prescription for the right eye first and the reading for left eye directly below it. An example of a complete prescription follows.

<table>
<thead>
<tr>
<th>Sphere</th>
<th>Cylinder</th>
<th>Axis</th>
</tr>
</thead>
<tbody>
<tr>
<td>RX)</td>
<td>+1.25</td>
<td>-2.50</td>
</tr>
<tr>
<td>+1.50</td>
<td>-3.50</td>
<td>X175 for the left eye</td>
</tr>
</tbody>
</table>

Frame Consensus BLSL 50/22/5-1/4
Add) +1.00 +0.50 (This is a trifocal reading -0.75 -0.30 and will not be entered.) P.D. 6059

The following parameters apply to the prompts that appear when using the GP mnemonic:

- **Sphere:** The words “plano” and “sphere” are sometimes typed as a measurement. “Plano” is the only word acceptable for coding the eyeglass prescription. If the word “sphere” is used, press ENTER at the appropriate field.

- **Axis:** The axis measurement consists of three digits. When typing the value, disregard the any leading zeroes and the X before the digits.

- **Add:** There might also be a section of measurements that are prefaced with “Add.”

- **Frame Measurements:** The frame measurements can also be recorded on the encounter form identifying the style and color of the frame to be used. These measurements are usually recorded as 50/22/5-1/4, representing the eye, bridge, and temple sizes of the frame for the glasses. The eye and bridge measurements are typed in millimeters and should be recorded as such; the temple size is entered in inches. Press ENTER if no measurements have been recorded. If the temple measurement has been recorded in millimeters, it must be converted to inches by dividing the last three digits by 25.4; e.g., 50/22/140 (140 divided by 25.4 = 5.50).
• **Sphere**: A number between -28.00 and +16.00, include the + or – or plano

• **Cylinder**: A number between -9.50 and +9.50

• **Axis**: A whole number between 0 and 180

• **RE Prism H**: A number between .25 and 50 followed by a prism base direction: BU (base up), BD (base down), BI, or BO

• **LE Prism H**: A number between .25 and 50 followed by a prism base direction: BU (base up), BD (base down), BI, or BO

• **R Prism V**: A number between .25 and 50 followed by a prism base direction: BU (base up), BD (base down), BI, or BO

• **LE Prism V**: A number between .25 and 50 followed by a prism base direction: BU (base up), BD (base down), BI, or BO

• **Reading Add**: A number between .74 and 9.99 (decimal point is required)

• **PD (NEAR)**: A whole number between 40 and 80

• **PD (DISTANCE)**: A whole number between 40 and 80

• **PD (LEFT)**: A whole number between 25 and 40

• **PD (RIGHT)**: A whole number between 25 and 40

```
MNEMONIC: GP   Eyeglass Prescription ALLOWED VISIT-RELATED-ONLY
READING ONLY: NO
DRE SPHERE: +1.25
DRE CYLINDER: -2.50
RE AXIS: 5
RE PRISM H: 5 BD
RE PRISM V:
DLE SPHERE: +1.50
DLE CYLINDER: -3.50
LE AXIS: 175
LE PRISM H: 5 BD
LE PRISM V: 4 BD READING ADD. R: 1.00
READING ADD. L: .75
PD (DISTANCE): 50
PD (NEAR): 60
PD (LEFT): 30
PD (RIGHT): 35
COMMENT:
ENCOUNTER PROVIDER:
```

Figure 3-71: Example of using the GP mnemonic

### 3.5.80 Gram Weight (GWT)

Use the Gram Weight (GWT) mnemonic to type a patient’s weight in grams for visit-related-only encounters. Be sure that the provider has specified grams as the unit of measure on the encounter form before using this mnemonic. The value entered must be in the range 1000 to 340000. Fractions and decimals are allowed.
3.5.81 Historical ADA Code Entry (HADA)
Use the Historical ADA Code Entry (HADA) mnemonic to type historical ADA information (for non-visit- or visit-related encounters).

3.5.82 Historical Barium Enema (HBE)
Use the Historical Barium Enema (HBE) mnemonic to type historical barium enema data (for non-visit- or visit-related encounters).

3.5.83 Historical Blood Sugar Entry (HBS)
Use the Historical Blood Sugar Entry (HBS) mnemonic to record a past blood sugar test (for non-visit- or visit-related encounters). The mnemonic records only that the test was performed on the date specified. Test results are not captured. The location of the test can be recorded also. The information entered will be included in the patient’s V Lab file.
3.5.84 **Head Circumference (HC)**

Use the Head Circumference (HC) mnemonic to type the head circumference measurement for visit-related-only encounters. The value must be in the range 10 to 30, and inches are the understood units of measure. Decimals and fractions can be used and must be a multiple of 1/8th (.125).

**MNEMONIC:** HC **VALUE:** 15

Figure 3-75: Example of using the HBS mnemonic

3.5.85 **Historical CBC Entry (HCBC)**

Use the Historical CBC Entry (HCBC) mnemonic to type historical CBC laboratory tests for a patient in non-visit- or visit-related encounters. No results are recorded; type only that the patient had the laboratory test and the approximate date of the test.

**MNEMONIC:** HCBC Historical CBC Entry ALLOWED NON-VISIT/VISIT MNEMONIC
Enter Date of Historical CBC: JAN 2007 (JAN 01, 2007@12:00)
TYPE: O// OTHER
LOC. OF ENCOUNTER: 000000 DEMO HOSPITAL
OUTSIDE LOCATION: Updating V Lab file...

Figure 3-76: Example of using the HC mnemonic

3.5.86 **Historical Colonoscopy (HCOL)**

Use the Historical Colonoscopy (HCOL) mnemonic to type historical colonoscopy data (for non-visit or visit encounters).

**MNEMONIC:** HCOL Historical Colonoscopy ALLOWED NON-VISIT/VISIT MNEMONIC
Enter Date of Historical COLONOSCOPY: FEB 05, 2008 (FEB 05, 2008@12:00)
PATIENT: SIGMA, JANE has one or more VISITs on this date.
TIME: 08:00 LOC: DH TYPE: I CAT: S CLINIC: <NONE> DEC: 5
Select one: 1
COLONOSCOPY PROVIDER NARRATIVE: NONE NONE

Figure 3-77: Example of using the HCBC mnemonic

3.5.87 **Historical CPT (HCPT)**

Use the Historical CPT (HCPT) mnemonic to type historical CPT data (for non-visit- or visit-related encounters).

**MNEMONIC:** HCPT Historical CPT ALLOWED NON-VISIT/VISIT MNEMONIC
Enter Date of Historical CPT: T-30 (FEB 05, 2008) (FEB 05, 2008@12:00)
PATIENT: SIGMA, JANE has one or more VISITS on this date.
1 TIME: 09:00 LOC: DH TYPE: I CAT: S CLINIC: <NONE> DEC: 4
Select one: 1
Select V CPT: 42700
MODIFIER: MODIFIER 2: QUANTITY: 1

Figure 3-79: Example of using the HCPT mnemonic

3.5.88 20 Hematocrit Ordered (HCT)

Hematocrit is a laboratory test and should only be typed using the Data Entry system if the laboratory package is not in use at the user’s site. If the laboratory package is not in use, the HCT mnemonic records that a hematocrit test was ordered (for visit-related-only encounters). Results of the test are not captured.

Mnemonic: HCT 20 Hematocrit Ordered ALLOWED VISIT-RELATED-ONLY

Figure 3-80: Example of using the HCT mnemonic

3.5.89 Hearing (HE)

Use the Hearing (HE) mnemonic to type hearing test results for visit-related-only encounters. The Value can be recorded only as normal (N) or abnormal (A).

Mnemonic: HE
Value: N

Figure 3-81: Example of using the HE mnemonic

3.5.90 Historical EKG (HEKG)

Use the Historical EKG (HEKG) mnemonic to type Historical EKG procedures (for non-visit- or visit-related encounters).

Mnemonic: HEKG Historical EKG ALLOWED NON-VISIT/VISIT MNEMONIC
Enter Date of Historical EKG: JUNE 1996 (JUN 01, 1996@12:00)
TYPE: O// OTHER
LOC. OF ENCOUNTER: 000199 SELLS UNDES TUCSON SELLS 99
OUTSIDE LOCATION: TUCSON MEDICAL CENTER
Updating V Diagnostic Procedure file...
Value: NORMAL

Figure 3-82: Example of using the HEKG mnemonic
3.5.91 Historical Examination (HEX)

Use the Historical Examination (HEX) mnemonic to record past examinations for a patient (for non-visit- or visit-related encounters). Various types of examinations can be typed. If a visit does not exist for the date specified for the exam, a visit will be created.

MNEMONIC: HEX   Historical Examination   ALLOWED NON-VISIT/VISIT MNEMONIC
Enter Date of Historical Exam: 2/1/05 (FEB 01, 2005@12:00) Enter EXAM Type: VISION EXAM 19
RESULT: A ABNORMAL COMMENT:

Figure 3-83: Example of using the HEX mnemonic

3.5.92 Health Factor (HF)

Various factors that have an impact on a patient’s health can be recorded in the patient’s record. Use the HF mnemonic to enter these factors (for visit-related-only encounters), which are displayed on the Adult Regular Health Summary. The level/severity, quantity, and provider can also be typed, as applicable.

Below is a list of the available health factor categories:

- Activity Level
- Alcohol/Drug
- Asthma Triggers
- Barriers to Learning
- Confidence in Managing Health Problems
- Diabetes Self Monitoring
- Learning Preference
- Occupation
- TB Status
- Tobacco (Exposure)
- Tobacco (Smoking)
- Tobacco (Smokeless–Chewing/Dip)

The choices for the “Level/Severity” prompt are:

- M–Minimal
- MO–Moderate
- H–Heavy/Severe

MNEMONIC: HF
1  HF  Health Factors ALLOWED VISIT RELATED ONLY
2  HFOB  Historical FOBT (GUAIAC) ALLOWED NON-VISIT/VISIT MNEMONIC
CHOOSE 1-2: 1  HF  Health Factors ALLOWED VISIT RELATEDONLY
Figure 3-84: Example of using the HF mnemonic

3.5.93 Historical FOBT (GUAIAC) (HFOB)

Use the Historical FOBT (HFOB) mnemonic to type historical FOBT data for non-visit- or visit-related encounters.

Figure 3-85: Example of using the HFOB mnemonic

3.5.94 Historical Hematocrit (HHCT)

Use the Historical Hematocrit (HHCT) mnemonic to type a Hematocrit test performed in the past for non-visit- or visit-related encounters. This mnemonic records only that the test was performed, not the test results. The date that the test was performed as well as the location can be recorded. This data is recorded in the patient’s V Lab file.
3.5.95 Historical Health Factor (HHF)

Use the Historical Health Factor (HHF) mnemonic to type data about a past health factor for non-visit- or visit-related encounters.

Figure 3-86: Example of using the HHCT mnemonic

MNEMONIC: HHF Historical Health Factor ALLOWED NON-VISIT/VISIT MNEMONIC

******* PCC HEALTH FACTORS (LAST ONE FOR EACH CATEGORY) *******
- TOBACCO --
  02/06/2007 NON-TOBACCO USER
- ALCOHOL/DRUG --
  11/06/2006 CAGE 0/4

Enter Date of Historical HEALTH FACTOR: 2/4/2008 (FEB 04, 2008 @12:00)

Enter HEALTH Factor: READINESS
- 1 READINESS TO LEARN-NOT READY
- 2 READINESS TO LEARN-PAIN
- 3 READINESS TO LEARN-RECEPTIVE
- 4 READINESS TO LEARN-SEVERITY OF ILLNESS
- 5 READINESS TO LEARN-UNRECEPTIVE

CHOOSE 1-5: 3 READINESS TO LEARN-RECEPTIVE
LEVEL/SEVERITY: ??
Choose from:
- M MINIMAL
- MO MODERATE
- H HEAVY/SEVERE

LEVEL/SEVERITY: MO MODERATE

PROVIDER: SIGMA, JANE

QUANTITY: 1

Figure 3-87: Example of using the HHF mnemonic

3.5.96 Historical Immunizations (HIM)

Use the Historical Immunizations (HIM) mnemonic to record a patient’s immunization record (for non-visit- or visit-related encounters). These are past immunizations not previously recorded or immunizations administered at another facility. An event visit for the immunization date typed is automatically created if no visit exists for that date. The patient’s immunization history is displayed, which allows the operator to verify the data and avoid duplicate entries. The following items are required entries and must be identified when using this mnemonic:

- Date of Immunization (the month and year if the exact date is not available)
- Immunization Type, Series (for OPV and DPT)
- Name of the facility where the immunization was administered, if known.
To modify or correct a historical immunization, switch to Modify (MOD) mode and then use the HIM mnemonic.

```
MNEMONIC: HIM Historical Immunization ALLOWED NON-VISIT/VISIT MNEMONIC
Immunization Record
TD-ADULT 2 01/02/95 DEMO HOSPITAL/CLINIC
INFLUENZA 11/02/88 DEMO HOSPITAL/CLINIC
12/24/86 DEMO HOSPITAL/CLINIC
PNEUMO-VAC 03/27/97 DEMO HOSPITAL/CLINIC
Enter Date of Historical Immunization: 5/1/96 (MAY 01, 1996@12:00)
TYPE: O// I IHS
LOC. OF ENCOUNTER: DEMO HOSPITAL
Enter IMMUNIZATION Type: MMR MEASLES,MUMPS,RUBELLA (MMR) MMR 17
SERIES: 1 SERIES 1
Enter IMMUNIZATION Type:
```

Figure 3-88: Example of using the HIM mnemonic

### 3.5.97 Hospital Location (HL)

Use the Hospital Location (HL) mnemonic to specify the location within a hospital where a visit occurred (for visit-related-only encounters). The list of choices available is locally defined and maintained.

```
MNEMONIC: HL Hospital Location ALLOWED VISIT-RELATED-ONLY
HOSPITAL LOCATION: GENERAL
```

Figure 3-89: Example of using the HL mnemonic

### 3.5.98 Historical Lab Test (HLAB)

Use the Historical Lab Test (HLAB) mnemonic to record any historical laboratory test for a patient for non-visit- or visit-related encounters. The date of the test, test type, location given, results, and site can be recorded, if known. If the exact date is not known, the year is required as a minimum entry.

```
MNEMONIC: HLAB Historical Lab Test ALLOWED NON-VISIT/VISIT MNEMONIC
Enter Date of Historical Lab Test: 4/1/96 (APR 01, 1996@12:00)
TYPE: O// OTHER
LOC. OF ENCOUNTER: 000000 DEMO HOSPITAL
OUTSIDE LOCATION:
Enter LAB TEST Type: CREATININE
1 CREATININE
2 CREATININE CLEARANCE
3 CREATININE, FLUID CHOOSE 1-3: 1
RESULTS: SITE:
Enter LAB TEST Type:
```

Figure 3-90: Example of using the HLAB mnemonic
3.5.99 **Health Status (HLST)**

Use the Health Status (HLST) mnemonic to type factors that affect a patient’s health (for non-visit- or visit-related encounters). The factors that have already been added display for reference prior to entering new items. For a list of the items that can be used, refer to the HF - Health Factors mnemonic description. The HF mnemonic is identical to the HLST mnemonic; only the terminology is different.

```
MNEMONIC: HLST  Health Status  ALLOWED NON-VISIT/VISIT MNEMONIC
*****************************************************************************
PCC HEALTH FACTORS******************
-- TOBACCO --
05/23/95 CURRENT SMOKER (MINIMAL)
Select HEALTH STATUS HEALTH FACTOR: TB - TX COMPLETE
DATE NOTED: T (JUN 19, 2007) LEVEL/SEVERITY:
QUANTITY:
```

Figure 3-91: Example of using the HLST mnemonic

3.5.100 **Historical Measurement (HMSR)**

Use the Historical Measurement (HMSR) mnemonic to add historical measurements (for non-visit- or visit-related encounters). When typing measurements, once the measurement type has been specified, the value is a required response and must be typed before continuing. The date is also a required response, but if the exact date is unknown, the month and year or year only can be typed. For a list of the measurement types, refer to the description of the MEAS mnemonic.

```
MNEMONIC: HMSR  Historical Measurement  ALLOWED NON-VISIT/VISIT MNEMONIC
Enter Date of Historical Measurement: JAN 1997 (JAN 01, 1997@12:00) TYPE:
0// OTHER
LOC. OF ENCOUNTER: 000000 DEMO HOSPITAL
OUTSIDE LOCATION: MEDICAL CENTER
Enter MEASUREMENT Type: BP BLOOD PRESSURE
VALUE: 120/80
Enter MEASUREMENT Type:
```

Figure 3-92: Example of using the HMSR mnemonic

3.5.101 **Historical Pap Smear (HPAP)**

Use the Historical Pap Smear (HPAP) mnemonic to type a pap smear that was performed on a previous date (for non-visit- or visit-related encounters). Unlike other mnemonics used for typing historical data, the HPAP mnemonic records that a pap smear was performed and allows results to be typed into a free-text field. The date and location can also be recorded. The information is typed into a patient’s V Lab File.

```
MNEMONIC: HPAP  Historical PAP Smear  ALLOWED NON-VISIT/VISIT MNEMONIC
PAP SMEAR RESULTS
Patient Name: SIGMA,JANE     Patient Age:  28.6 years
```

Data Entry Mnemonics  PCC Data Entry Mnemonics
October 2014
3.5.102 Historical Radiology (HRAD)

Use the Historical Radiology (HRAD) mnemonic to type historical radiology procedures for non-visit- or visit-related encounters. The date, location, and impression, as well whether the result is normal or abnormal, can be recorded. At the Date field, type at least the year if the exact date is unknown.

MNEMONIC: HRAD Historical Radiology Procedure ALLOWED NON-VISIT/VISIT MNEMONIC
Enter Date of Historical Radiology Procedure: 2/15/97 (FEB 15, 1997@12:00)
TYPE: O// OTHER
SELECT LOCATION NAME: 000000 DEMO HOSPITAL
Enter RADIOLOGY EXAM: ANKLE 2 VIEWS (Detailed) CPT:73600
IMPRESSION:
ABNORMAL: A ABNORMAL
Enter RADIOLOGY PROCEDURE Type:

Figure 3-94: Example of using the HRAD mnemonic

3.5.103 Historical RX (HRX)

Use the Historical RX (HRX) mnemonic to type a medication prescribed or dispensed on a date prior to the date of the visit being processed (for non-visit- or visit-related encounters). The medication might have been prescribed and dispensed at the user’s facility, but not typed into the computer at that time, or it might have been prescribed and dispensed by an outside provider and pharmacy.

MNEMONIC: HRX Historical RX ALLOWED NON-VISIT/VISIT MNEMONIC Enter Date of Historical Medication: T-7 (NOV 22, 2007@12:00) TYPE: I// IHS
Select LOCATION NAME: DEMO HOSPITAL
Enter MEDICATION: OUTSIDE DRUG
NAME OF NON-TABLE DRUG: MODURETIC 25MG TAB
SIG: TID AT BEDTIME
QUANTITY: 90
DAYS PRESCRIBED: 90
DATE DISCONTINUED:
DATE DISPENSED (IF KNOWN): T-7
OUTSIDE PROVIDER NAME: DR. GAMMA

Figure 3-95: Example of using the HRX mnemonic
3.5.104 Historical Skin Test (HS)

Use the Historical Skin Test (HS) mnemonic to type a skin test that was performed on a previous visit or at another facility (for non-visit- or visit-related encounters). In addition to the date of the test and the location where it was performed, the reading/result can be typed. An event visit file for the skin test read date is automatically created if there is no existing visit for that date. The following items are required:

- Date of skin test(s) reading
- Skin test type; for example, PPD, Cocci, etc.
- Readings and/or result
- Facility name where the skin test was read, if known

```
MNEMONIC: HS  Historical Skin Test   ALLOWED   NON-VISIT/VISIT MNEMONIC
Skin Test Record
SMITH, JANE  Aug 29 1946  FEMALE
Date  Skin Test  Reading  Result  Date Read
------------  ------------ ------------ ----------- --------
Apr 15 2007  PPD 2    0
Press 'RETURN' To Continue:
Enter Date of Historical Skin Test: 3/14/07 (MAR 14, 2007@12:00)
TYPE: O// I IHS
Select LOCATION NAME: DEMO HOSPITAL
Enter SKIN TEST Type: COCCI
READING: 3
RESULTS: N  NEGATIVE
DATE READ: 4/30/07  (APR 30, 2007)
Enter SKIN TEST Type:
```

Figure 3-96: Example of using the HS mnemonic

To modify or correct a historical skin test, select the option MOD (Modify Data) and type the ST mnemonic. Like the Immunization Record, the system displays the patient’s skin test history, which should be verified by the operator to avoid duplication of entry.

3.5.105 Historical Sigmoidoscopy (HSIG)

Use the Historical Sigmoidoscopy (HSIG) mnemonic to type historical sigmoidoscopy data (for non-visit- or visit-related encounters).

```
MNEMONIC: HSIG  Historical Sigmoidoscopy ALLOWED NON-VISIT/VISIT MNEMONIC
Enter Date of Historical SIGMOIDOSCOPY: T-30 (FEB 05, 2008)
SIGMOIDOSCOPY PROVIDER NARRATIVE: 209
```

Figure 3-97: Example of using the HSIG mnemonic
3.5.106 Height (HT)

Use the Height (HT) mnemonic to type the height measurement in inches (for visit-related-only encounters). The value must be in the range of 10 to 90. Fractions and decimals are allowed.

<table>
<thead>
<tr>
<th>MNEMONIC: HT</th>
<th>Height in Inches</th>
<th>ALLOWED</th>
<th>VISIT-RELATED-ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>VALUE:</td>
<td>69</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 3-98: Example of using the HT mnemonic

3.5.107 Historical UA (HUA)

Use the Historical UA (HUA) mnemonic to type a urinalysis test performed on a previous date for a patient (for non-visit- or visit-related encounters). Results are not captured, only that the test was given on a particular date. The location can be recorded also.

<table>
<thead>
<tr>
<th>MNEMONIC: HUA</th>
<th>Historical UA entry</th>
<th>ALLOWED</th>
<th>NON-VISIT/VISIT MNEMONIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Date of Historical UA:</td>
<td>1/1/07 (JAN 01, 2007@12:00)</td>
<td>TYPE:</td>
<td>C CONTRACT</td>
</tr>
<tr>
<td>LOC. OF ENCOUNTER:</td>
<td>DEMO HOSPITAL OUTSIDE LOCATION: CLINIC</td>
<td>Updating V Lab file...</td>
<td></td>
</tr>
</tbody>
</table>

Figure 3-99: Example of using the HUA mnemonic

3.5.108 Infant Feeding Choices (IF)

Use the Infant Feeding Choices (IF) mnemonic to document the feeding method of an infant patient for visit-related-only encounters. The options are:

- 1–Exclusive breastfeeding
- 2–Mostly breastfeeding
- 3–½ formula and ½ breast
- 4–Mostly formula
- 5–Formula only
- 6–Mostly breastfeeding, some formula
- 7–Mostly formula, some breast milk

If the feeding choice is 2, 4, 6 or 7 then the user is prompted for additional feeding choices (Milk, Fruit juice, Carbonated drink, sports drink, Glucose, Water).

<table>
<thead>
<tr>
<th>MNEMONIC: IF</th>
<th>Infant Feeding Choices</th>
<th>ALLOWED</th>
<th>VISIT-RELATED ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select V INFANT FEEDING CHOICES:</td>
<td>1 (1 EXCLUSIVE BREASTFEEDING)</td>
<td>ENCOUNTER PROVIDER:</td>
<td></td>
</tr>
</tbody>
</table>

Figure 3-100: Example of using the IF mnemonic
3.5.109 In-Hospital Immunization Entry (IIM)

Use the In-Hospital Immunization Entry (IIM) mnemonic to enter immunization data for a specific date for non-visit- or visit-related encounters.

| MNEMONIC: IIM In-Hospital Immunization Entry ALLOWED NON-VISIT/VISIT MNEMONIC |
| Enter Date of Historical IMMUNIZATION: T-5 |
| ENTER IMMUNIZATION Type: RUB |
| 1  RUBELLA           RUBELLA       6 |
| 2  RUBELLA/MUMPS     RUBELLA/MU   38 |
| CHOOSE 1-2: 1 RUBELLA RUBELLA       6 |
| SERIES: C COMPLETE |

Figure 3-101: Example of using the IIM mnemonic

3.5.110 Immunizations (IM)

Use the Immunizations (IM) mnemonic to enter immunizations that were given during a patient’s visit (for visit-related-only encounters) and recorded on the Encounter form.

| MNEMONIC: IM  Immunizations ALLOWED VISIT-RELATED-ONLY Enter IMMUNIZATION |
| Given: OPV     SABIN TRIVALENT (OPV)   OPV   06 |
| SERIES: 1 SERIES 1 |
| LOT: |

Figure 3-102: Example of typing the IM mnemonic

3.5.111 ICD Operation Narrative (IOP)

Use the ICS Operation Narrative (IOP) mnemonic to indicate that the standard ICD-9 code operation narrative will be automatically entered for the provider narrative (for visit-related-only encounters). The operator does not have to retype the narrative, thereby saving data entry time. Caution is advised because provider narratives should always be typed exactly as the provider recorded them on the Encounter Form.

| MNEMONIC: IOP  ICD Operation Narrative ALLOWED VISIT-RELATED- ONLY |
| This is the MNEMONIC which will automatically stuff the ICD Operation Narrative into the Provider Narrative field! |
| Enter OPERATION/PROCEDURE: 10.32 10.32 DESTRUCT CONJUNC LES NEC DESTRUCTION OF LESION OF CONJUNCTIVA |
| ...OK? Yes// (Yes) |
| OPERATING PROVIDER: SMITH, CARL R |
| DIAGNOSIS: 873.50 OPEN WND FACE NOS-COMPL |
| ...OK? Yes// (Yes) |

Figure 3-103: Example of using the IOP mnemonic
3.5.112 Hospitalization Information (IP)

Use the Hospitalization Information (IP) mnemonic to type data from IHS form HRSA 44-1 Clinical Record Brief-IHS Inpatient Services for visit-related-only encounters. This requires that the Service Category be set to H for “hospitalization;” if the Service Category is not set to H, correct the record using the VST mnemonic.

Admission type:

- Direct Admission 1
- Trans-Non IHS Hospital Admission 2
- Trans-IHS Hospital Admission 3
- Referred From IHS Clinic Admission 4
- Other Admission 5

<table>
<thead>
<tr>
<th>Admitting Service/Discharge Service</th>
<th>Mnemonic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholism</td>
<td>Al 15</td>
</tr>
<tr>
<td>Dental</td>
<td>Den 01</td>
</tr>
<tr>
<td>Dental Observation</td>
<td>Deno 01o</td>
</tr>
<tr>
<td>ENT</td>
<td>Ent 02</td>
</tr>
<tr>
<td>ENT Observation</td>
<td>Ento 02o</td>
</tr>
<tr>
<td>Family Practice</td>
<td>Fam 17</td>
</tr>
<tr>
<td>Family Practice Observation</td>
<td>Fampo 17o</td>
</tr>
<tr>
<td>General Medicine</td>
<td>Gms 03</td>
</tr>
<tr>
<td>GYN Observation</td>
<td>Gyno 05o</td>
</tr>
<tr>
<td>Gynecology</td>
<td>Gyn 05</td>
</tr>
<tr>
<td>Internal Med Observation</td>
<td>Imedo 06o</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Int 06</td>
</tr>
<tr>
<td>Medicine Observation</td>
<td>Medo 03o</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Men 12</td>
</tr>
<tr>
<td>Mental Health Observation</td>
<td>Mho 12o</td>
</tr>
<tr>
<td>Neurology</td>
<td>Neuro 20</td>
</tr>
<tr>
<td>Neurology Observation</td>
<td>Neuob 20o</td>
</tr>
<tr>
<td>Neuropsychiatric</td>
<td>Np 00</td>
</tr>
<tr>
<td>Newborn</td>
<td>Nb 07</td>
</tr>
<tr>
<td>Admitting Service/Discharge Service</td>
<td>Mnemonic</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>• Nurse-Midwifery Observation</td>
<td>Nrsob 22o</td>
</tr>
<tr>
<td>• Nurse-Midwifery Service</td>
<td>Nrsse 22</td>
</tr>
<tr>
<td>• Obstetrics</td>
<td>Ob08</td>
</tr>
<tr>
<td>• Obstetrics Observation</td>
<td>Obo 08o</td>
</tr>
<tr>
<td>• Ophthalmology</td>
<td>Eye 09</td>
</tr>
<tr>
<td>• Ophthalmology Observation</td>
<td>Eyeo 09o</td>
</tr>
<tr>
<td>• Orthopedics</td>
<td>Ort10</td>
</tr>
<tr>
<td>• Orthopedics Observation</td>
<td>Orto 10o</td>
</tr>
<tr>
<td>• Other</td>
<td>Hosp 14</td>
</tr>
<tr>
<td>• Pediatrics</td>
<td>Ped 11</td>
</tr>
<tr>
<td>• Pediatrics Observation</td>
<td>Pedo 11o</td>
</tr>
<tr>
<td>• Plastic Surgery</td>
<td>Psur 16</td>
</tr>
<tr>
<td>• Plastic Surgery Observation</td>
<td>Psuro 16o</td>
</tr>
<tr>
<td>• Podiatry</td>
<td>Pod 19</td>
</tr>
<tr>
<td>• Podiatry Observation</td>
<td>Podo 19o</td>
</tr>
<tr>
<td>• Substance Abuse Observation</td>
<td>Alcoo 15o</td>
</tr>
<tr>
<td>• Surgery</td>
<td>Sur 04</td>
</tr>
<tr>
<td>• Surgery Observation</td>
<td>Suro 04o</td>
</tr>
<tr>
<td>• Swing Bed</td>
<td>Swi 21</td>
</tr>
<tr>
<td>• TB</td>
<td>Tb 13</td>
</tr>
<tr>
<td>• Tuberculosis Observation</td>
<td>Tbo 13o</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discharge Type</th>
<th>Mnemonic</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Urology</td>
<td>Uro 18</td>
</tr>
<tr>
<td>• Urology Observation</td>
<td>Uroo 18o</td>
</tr>
<tr>
<td>• Regular Discharge</td>
<td>Discharge Active 1</td>
</tr>
<tr>
<td>• Transferred</td>
<td>Discharge Active 2</td>
</tr>
<tr>
<td>• Irregular Discharge</td>
<td>Discharge Active 3</td>
</tr>
<tr>
<td>• Death W/I 48 Hrs W Autopsy</td>
<td>Discharge Active 4</td>
</tr>
<tr>
<td>Discharge Type</td>
<td>Mnemonic</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Death W/I 48 Hrs W/O Autopsy</td>
<td>Discharge Active 5</td>
</tr>
<tr>
<td>Death After 48 Hrs W Autopsy</td>
<td>Discharge Active 6</td>
</tr>
<tr>
<td>Death After 48 Hrs W/O Autopsy</td>
<td>Discharge Active 7</td>
</tr>
</tbody>
</table>

**Mnemonic: IP**
1. Hospitalization Information ALLOWED VISIT-RELATED-ONLY
2. Inactivate a Problem ALLOWED NON-VISIT/VISIT MNEMONIC
3. ICD Narrative Purpose of Visit ALLOWED VISIT-RELATED-ONLY

Choose 1-3: 1

Enter Date of Discharge: T-1 (JUN 11, 1997) JUN 11, 1997

Admission Type: 1 DIRECT ADMISSION
Admitting Service: INTERNAL MEDICINE 06
Discharge Type: REGULAR DISCHARGE
Number of Consults: 3
Admitting Dx: DIABETIC NEPHRITIS (DIABETIC DIABETES NEPHRITIS)

583.81 (NEPHRITIS NOS IN OTH DIS)
NEPHRITIS AND NEPHROPATHY, NOT SPECIFIED AS ACUTE OR CHRONIC, IN DISEASES CLASSIFIED ELSEWHERE

OK? Y/

**Note:** After making entries for the IP mnemonic, type the provider (PRV) and purpose of visit (PV) to complete this visit record.

**3.5.113 Inactive Problem (IPO)**

Use the Inactive Problem (IPO) mnemonic to change the status of a problem from Active to Inactive for non-visit- or visit-related encounters. The patient’s Problem List displays on the screen for the operator to verify the correct problem number.

The IPO mnemonic prompts for the provider who added the problem list update and the date the update was made. This enables the creation of a V Updated/Reviewed entry with a clinical action of Problem List Updated.

**Mnemonic: IPO**

Inactivate a Problem ALLOWED NON-VISIT/VISIT MNEMONIC

Problem List Reviewed On: By: Problem List Updated
On: Nov 02, 2010 By: ADPROVIDER, RAY
No Active Problems Documented On: By:

*************** ACTIVE PROBLEMS AND NOTES ***************
CI1 11/02/2010 TESTING PROBLEM NOTES (ONSET: 11/02/2010)
CI2 11/02/2010 NONE (ONSET: 11/02/2010) CI3 11/02/2010 TESTING
CI3CI1 11/02/2010 TEST
CI4 11/02/2010 TESTING PO (ONSET: 11/02/2010)
CI4CI1 11/02/2010 TEST
3.5.114 ICD Narrative Purpose of Visit (IPV)

Use the ICD Narrative Purpose of Visit (IPV) mnemonic as an alternative to the PV Purpose of Visit mnemonic (for visit-related-only encounters). This mnemonic allows the standard ICD-9 code narrative to automatically be entered for the provider narrative. The operator does not have to retype the narrative, thereby saving data entry time. Caution is advised as provider narratives should always be typed exactly as the provider stated on the form.

MNEMONIC: IPV
This is the MNEMONIC that automatically stuffs the ICD Narrative in the Provider Narrative field!!

Enter PURPOSE of VISIT: DIABETES MELLITUS

250.00 (DM UNCOMPL/T-II/NIDDM, NS UNCON)
DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION/TYPE II/NON-INSULIN DEPENDENT/ADULT-ONSET, OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED
OK? Y/
DM UNCOMPL/T-II/NIDDM, NS UNCON ***ICD****
CAUSE OF DX:
Enter PURPOSE of VISIT:

When adding a diagnosis, if the diagnosis is an injury, the IPV mnemonic will prompt for three E Code fields and for an entry of First Visit or Revisit. These prompts will always display in MOD (modification) mode so they can be deleted, if appropriate.

3.5.115 Kilogram Weight (KWT)

Use the Kilogram Weight (KWT) mnemonic to type a patient’s weight in kilograms for visit-related-only encounters. Before using the KWT mnemonic, be sure that the provider has indicated kilograms as the unit of measure for the patient’s weight. The value typed must be in the range of 1 to 340. Fractions and decimals are allowed.

MNEMONIC: KWT Kilogram Weight ALLOWED VISIT-RELATED-ONLY
VALUE: 125
3.5.116 Lab Test (LAB)

Laboratory tests and results can be typed from within the Data Entry system for visit-related-only encounters. However, laboratory tests should only be entered with this mnemonic if the laboratory system is not being used at the user’s facility. If using this mnemonic, it is recommended that laboratory personnel type the laboratory tests to ensure accurate entry of results.

<table>
<thead>
<tr>
<th>MNEMONIC: LAB</th>
<th>Lab Test</th>
<th>ALLOWED</th>
<th>VISIT-RELATED-ONLY Select V LAB LAB</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEST:</td>
<td>CREATININE</td>
<td></td>
<td>1 CREATININE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2 CREATININE CLEARANCE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3 CREATININE, FLUID</td>
</tr>
<tr>
<td>CHOOSE 1-3:</td>
<td>1</td>
<td></td>
<td>RESULTS:</td>
</tr>
<tr>
<td>UNITS:</td>
<td>1</td>
<td></td>
<td>ABNORMAL: N</td>
</tr>
<tr>
<td>SITE:</td>
<td></td>
<td></td>
<td>ENCOUNTER PROVIDER: Enter LAB TEST:</td>
</tr>
<tr>
<td>CURRENT STATUS</td>
<td></td>
<td></td>
<td>FLAG: ORDERING PROVIDER:</td>
</tr>
</tbody>
</table>

Figure 3-108: Example of using the LAB mnemonic

3.5.117 Line Item Entry for Billing (LI)

This mnemonic is not used by all sites.

3.5.118 Last Known Well (LKW)

This measurement is specific to the onset of stroke symptoms. Use the Last Known Well mnemonic to enter the time the patient was last known to be without the signs and symptoms of the current stroke or at his or her prior baseline. The value “Well” is automatically recorded in the V Measurement file when you enter the mnemonic, date last known well, and encounter provider.

Document the Date/Time Last Known Well as follows:

If provider witnessed onset, document the date/time of onset of stroke symptoms. When the onset of symptoms is clearly witnessed, then the time last known well is identical to the time of symptom onset. If date/time of onset was not witnessed, document date/time the patient was without stroke symptoms. Example: A nurse in the hospital takes vital signs at 8 AM. Patient was at baseline. Nurse returns at 10 AM and notes facial droop and unilateral weakness. Onset was not witnessed. Nurse would then enter 8 AM for last known well since this was the last time the patient was known to be without the signs or symptoms.

<table>
<thead>
<tr>
<th>MNEMONIC: LKW</th>
<th>Last Known Well</th>
<th>ALLOWED</th>
<th>VISIT RELATED ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter date/time patient was last known to be without signs/symptoms of current stroke. When onset is witnessed, the last known well is identical to time of symptoms onset.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.5.119 Last Menstrual Period (LMP)

Use the Last Menstrual Period (LMP) mnemonic to record the date of a female patient’s last menstrual period for non-visit- or visit-related encounters. The user is prompted to confirm the patient’s name and then type the date.

**MNEMONIC:** LMP  Last Menstrual Period  ALLOWED NON-VISIT/VISIT MNEMONIC

**NAME:** SIGMA,TESS//

**LAST MENSTRUAL PERIOD:** 6/12/07 (JUN 12, 2007)

Figure 3-110: Example of using the LMP mnemonic

3.5.120 Level of Care (LOC)

Use the Level of Care (LOC) mnemonic to type level of care information (for visit-related-only encounters), including CPT code, provider narrative, event date and time, and the ordering provider.

**MNEMONIC:** LOC  LEVEL OF CARE  ALLOWED  VISIT-RELATED-ONLY

Enter CPT Code: 71120  71120 X-RAY EXAM OF BREASTBONE

RADIOLOGIC EXAMINATION; STERNUM, MINIMUM OF TWO VIEWS

...OK? Yes//

**PROVIDER NARRATIVE:** NONE NONE

**EVENT DATE AND TIME:** T-20 (FEB 15, 2008)

**ORDERING PROVIDER:** SIGMA,JOHN

Figure 3-111: Example of using the LOC mnemonic

3.5.121 Level of Service (LS)

Use the Level of Service (LS) mnemonic to type data checked in the Level of Service box in the lower right area of the PCC Ambulatory Encounter form (for visit-related-only encounters). The choice of entries consists of: Brief, Limited, Intermediate, Extended, and Comprehensive.

**Note:** With Data Entry Version 2.0, most facilities will begin typing the Evaluation and Management CPT code for each visit. When the Evaluation and Management CPT code is typed, there is no need to use the LS mnemonic to type Level of Service.

**MNEMONIC:** LS  Level of Service  ALLOWED VISIT-RELATED-ONLY

**LEVEL OF SERVICE (PCC FORM):** INTER  INTERMEDIATE
3.5.122 Measurement Entry (MEAS)

Use the Measurement Entry (MEAS) to type any measurement for visit-related-only encounters. The user will be prompted for the measurement type and value. The value is a required field and must be completed before continuing.

Measurement types are listed as follows:

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADM</td>
<td>Asthma Work/School Days Missed</td>
</tr>
<tr>
<td>AG</td>
<td>Abdominal Girth</td>
</tr>
<tr>
<td>AKBP</td>
<td>Ankle Blood Pressure</td>
</tr>
<tr>
<td>ASFD</td>
<td>Asthma Symptom Free Days</td>
</tr>
<tr>
<td>ASQA</td>
<td>ASQ-Autism Screen</td>
</tr>
<tr>
<td>ASQF</td>
<td>ASQ - Fine Motor</td>
</tr>
<tr>
<td>ASQG</td>
<td>ASQ - Gross Motor</td>
</tr>
<tr>
<td>ASQL</td>
<td>ASQ – Language</td>
</tr>
<tr>
<td>ASQM</td>
<td>ASQ Questionnaire (Mos)</td>
</tr>
<tr>
<td>ASQP</td>
<td>ASQ - Problem Solving</td>
</tr>
<tr>
<td>ASQS</td>
<td>ASQ - Social</td>
</tr>
<tr>
<td>AUD</td>
<td>Audiometry</td>
</tr>
<tr>
<td>AUDC</td>
<td>Audit-C</td>
</tr>
<tr>
<td>AUDT</td>
<td>Audit</td>
</tr>
<tr>
<td>BP</td>
<td>Blood Pressure</td>
</tr>
<tr>
<td>BPF</td>
<td>Best Peak Flow</td>
</tr>
<tr>
<td>CEF</td>
<td>Cardiac Ejection Fraction</td>
</tr>
<tr>
<td>CRFT</td>
<td>CRAFFT</td>
</tr>
<tr>
<td>CXD</td>
<td>Cervix Dilatation</td>
</tr>
<tr>
<td>ED</td>
<td>Edema</td>
</tr>
<tr>
<td>EF</td>
<td>Effacement</td>
</tr>
<tr>
<td>EGA</td>
<td>Estimated Gestational Age</td>
</tr>
<tr>
<td>FBPN</td>
<td>24-hour fluid balance, pos/neg</td>
</tr>
<tr>
<td>FEF</td>
<td>FEF 25-75</td>
</tr>
<tr>
<td>FH</td>
<td>Fundal Height</td>
</tr>
<tr>
<td>FI24</td>
<td>24-hour fluid intake</td>
</tr>
<tr>
<td>FO24</td>
<td>24-hour fluid output</td>
</tr>
<tr>
<td>FT</td>
<td>Fetal Heart Tones</td>
</tr>
<tr>
<td>Type</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>FVFC</td>
<td>FEV1/FVC</td>
</tr>
<tr>
<td>HC</td>
<td>Head Circumference</td>
</tr>
<tr>
<td>HE</td>
<td>Hearing</td>
</tr>
<tr>
<td>HT</td>
<td>Height</td>
</tr>
<tr>
<td>LKW</td>
<td>Last Known Well</td>
</tr>
<tr>
<td>MMSE</td>
<td>Mini-Mental Status Exam</td>
</tr>
<tr>
<td>O2</td>
<td>O2 Saturation</td>
</tr>
<tr>
<td>PA</td>
<td>Pain</td>
</tr>
<tr>
<td>PF</td>
<td>Peak Flow</td>
</tr>
<tr>
<td>PHQ2</td>
<td>PHQ2</td>
</tr>
<tr>
<td>PHQ9</td>
<td>PHQ9</td>
</tr>
<tr>
<td>PHQT</td>
<td>PHQ-9 Modified for Teens</td>
</tr>
<tr>
<td>PR</td>
<td>Presentation</td>
</tr>
<tr>
<td>PU</td>
<td>Pulse</td>
</tr>
<tr>
<td>RS</td>
<td>Respirations</td>
</tr>
<tr>
<td>SN</td>
<td>Station (Pregnancy)</td>
</tr>
<tr>
<td>TMP</td>
<td>Temperature</td>
</tr>
<tr>
<td>TON</td>
<td>Tonometry</td>
</tr>
<tr>
<td>VC</td>
<td>Vision Corrected</td>
</tr>
<tr>
<td>VU</td>
<td>Vision Uncorrected</td>
</tr>
<tr>
<td>WC</td>
<td>Waist Circumference</td>
</tr>
<tr>
<td>WT</td>
<td>Weight</td>
</tr>
</tbody>
</table>

The following shows an example of using the MEAS mnemonic.

```
MNEMONIC: MEAS Measurement Entry ALLOWED VISIT-RELATED-ONLY
Select V MEASUREMENT TYPE: BP BLOOD PRESSURE
VALUE: 120/80
Select QUALIFIER: Date/Time Vitals Taken: ENCOUNTER PROVIDER:

MNEMONIC:
```

Figure 3-113: Example of using the MEAS mnemonic

### 3.5.123 Medication List Review (MLR)

Use to document when a provider indicates on the PCC or PCC+ Form that he/she reviewed the medication list. This mnemonic will prompt for the provider who reviewed the medication list and the date/time reviewed. If the time is not known, the date alone is sufficient and will default to the visit date.
MNEMONIC: MLR  Medication List Review  ALLOWED VISIT RELATED ONLY

Did the Provider indicate that he/she Reviewed the Medication List? (Y/N): Y
Provider who Reviewed the Medication List: SMITH BTPROVIDER,WENDY C

Figure 3-114: Example of using the MLR mnemonic

3.5.124 Change Note Narrative (MNN)

Use the Change Note Narrative (MNN) mnemonic to make changes to the narrative portion of a note (for non-visit- or visit-related encounters). Before using this mnemonic, the problem number that corresponds to the note must be clearly identified on the encounter form, as shown in the following example.

The MNN mnemonic prompts for the provider who added the problem list update and the date the update was made. This enables the creation of a V Updated/Reviewed entry with a clinical action of Problem List Updated.

MNEMONIC: MNN  Change Note Narrative  ALLOWED NON- VISIT/VISIT MNEMONIC

Problem List Reviewed On: By:
Problem List Updated On: Nov 10, 2010 By:
BLPROVIDER,DAVID P
No Active Problems Documented On: By:

*************** ACTIVE PROBLEMS AND NOTES ***************

CI1 11/10/2010 ASTHMA (ONSET: 08/10/2010)
CI1CI1 11/10/2010 USES INHALER THREE A TIMES

********** No INACTIVE Problems on file for this Patient

Enter Problem Number: CI1
Select NOTE FACILITY: 2010 DEMO HOSPITAL//
Select NOTE NMBR: 1//
NOTE NARRATIVE: USES INHALER THREE A TIMES
Replace A With TIMES PER DAY
Replace USES INHLER THREE A TIMES PER DAY
STATUS: ACTIVE//
Select NOTE FACILITY:
Enter the Date the Problem List was Updated by the Provider:
Nov 10, 2010// (NOV 10, 2010)
Enter the PROVIDER who Updated the Problem List: BLPROVIDER,DAVID P// BLPROVIDER ,DAVID P

Figure 3-115: Example of using the MNN mnemonic
3.5.125 Switch to Modify Mode (MOD)

To change an entry, use the MOD mnemonic to switch from Enter mode to Modify mode for visit-related-only encounters. This mnemonic applies to visit-related-only encounters.

Note that typing the mnemonic that requires modification prior to selecting MOD to switch to Modify mode, will not allow the user to correct the error. Instead, the user might be typing new data or overwriting previously entered data. MOD can only be used for one mnemonic at a time. To modify data for another mnemonic, the user will need to use the MOD mnemonic again. A warning message indicates when the user is switching between Enter and Modify modes, as shown in the following example.

```
MNEMONIC: MOD  Switch to Modify Mode  ALLOWED  VISIT-RELATED-ONLY
Switching to Modify Mode for ONE Mnemonic ONLY!
MNEMONIC: MEAS  Measurement Entry  ALLOWED  VISIT-RELATED-ONLY
  1 BP  THETA,EVA  JUN 19,1997@12:25  120/80
  2 WT  THETA,EVA  JUN 19,1997@12:25  185
Choose: 2
  TYPE: WT//
  VALUE: 185// 158
Switching back to ENTER Mode!
```

Figure 3-116: Example of using the MOD mnemonic

3.5.126 Modify Problem Narrative (MPO)

Use the Modify Problem Narrative (MPO) mnemonic to change a patient’s active or inactive problem narrative for non-visit- or visit-related encounters. Other problem item fields can be changed when using the MPO mnemonic, as shown in the example that follows. Before using this mnemonic, be sure that the problem number and facility codes have been clearly identified on the encounter form in the Purpose of Visit or the Problem List Update section. The patient’s Problem List displays to assist with verifying the correct problem for modification.

The PO mnemonic prompts for the provider who added the problem list update and the date the update was made. This enables the creation of a V Updated/Reviewed entry with a clinical action of Problem List Updated. Please note the following example.

```
MNEMONIC: MPO  Correct/Modify Problem  ALLOWED  NON-VISIT/VISIT MNEMO
Problem List Reviewed On:  By:
Problem List Updated On:  Nov 02, 2010  By: ADPROVIDER,RAY No Active
Problems Documented On:     By:

**************************  ACTIVE PROBLEMS AND NOTES  **************************
   CI1  11/02/2010  TESTING PROBLEM NOTES  (ONSET: 11/02/2010)
   CI2  11/02/2010  NONE  (ONSET: 11/02/2010)
   CI3  11/02/2010  TESTING CI3CI1  11/02/2010  TEST
```

Data Entry Mnemonics
October 2014

PCC Data Entry Mnemonics

65
When adding a problem, if the diagnosis is an injury, the PO mnemonic will prompt for three E Code fields. When modifying any problem, however, these prompts will always display so they can be deleted, if appropriate.

3.5.127 No Active Allergies (NAA)

Use to document when a provider indicates on the PCC or PCC+ Form that he/she reviewed allergy list and there are No Active Allergies. This mnemonic will prompt for the provider who documented No Active Allergies and the date/time documented. If the time is not known, the date alone is sufficient and will default to the visit date. Please note that if you choose mnemonic NAA and there are active allergies in the allergy tracking system, you will be warned and prompted as to whether you want to continue.

Figure 3-119: Example of using the NAA mnemonic

Did the Provider indicate there are No Active Allergies? (Y/N): Y
Date/Time Provider documented 'No Active Allergies': Oct 26, 2010
// (OCT 26, 2010)
Provider who Documented 'No Active Allergies': BTPROVIDER, WENDY C
3.5.128 No Active Medications (NAM)

Use to document when a provider indicates on the PCC or PCC+ Form that he/she reviewed the medication list and there are No Active Medications. This mnemonic will prompt for the provider who documented No Active Medications and the date/time documented. If the time is not known, the date alone is sufficient and will default to the visit date. Please note that if you choose mnemonic NAM and there are active medications on the medication list, you will be warned and prompted as to whether you want to continue.

<table>
<thead>
<tr>
<th>MNEMONIC: NAM  No Active Medications  ALLOWED VISIT RELATED ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>This patient has active medications in their record.</td>
</tr>
<tr>
<td>Are you sure you want to document 'No Active Medications'?  (Y/N): Y</td>
</tr>
<tr>
<td>Date/Time Provider documented 'No Active Medications': Oct 26, 2010</td>
</tr>
<tr>
<td>// (OCT 26, 2010)</td>
</tr>
<tr>
<td>Provider who Documented 'No Active Medications': BTPROVIDER,WENDY C</td>
</tr>
</tbody>
</table>

Figure 3-120: Example of using the NAM mnemonic

3.5.129 No Active Problems (NAP)

Use to document when a provider indicates on the PCC or PCC+ Form that he/she reviewed the problem list and there are No Active Problems. This mnemonic will prompt for the provider who documented No Active Problems and the date/time documented. If the time is not known, the date alone is sufficient and will default to the visit date. Please note that if you choose mnemonic NAP and there are active problems on the problem list, you will not be able to continue with the mnemonic.

<table>
<thead>
<tr>
<th>MNEMONIC: NAP  No Active Problems  ALLOWED VISIT RELATED ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the Provider indicate there are No Active Problems? (Y/N): Y</td>
</tr>
<tr>
<td>Date/Time Provider documented 'No Active Problems': Nov 10, 2010</td>
</tr>
<tr>
<td>// (NOV 10, 2010)</td>
</tr>
<tr>
<td>Provider who Documented 'No Active Problems': XCPROVIDER,SHARON R</td>
</tr>
</tbody>
</table>

Figure 3-121: Example of using the NAP mnemonic

3.5.130 Not Medically Indicated (NMI)

Use the Not Medically Indicated (NMI) mnemonic to type a new patient refusals for service/NMI (for non-visit- or visit-related encounters). The options are: ADA Code, CPT, Education Topics, EKG, Exam, ICD Operation/Procedure, Immunization, Lab, Mammogram, Measurements, Medication/Drug, Pap Smear, Radiology Exam, and Skin Test. The user is prompted to enter the type of refusal, the date declined/not indicated, and the provider who documented the refusal.

| MNEMONIC: NMI  Not Medically Indicated ALLOWED NON-VISIT/VISIT MNEMONIC |
3.5.131 Note (NO)

Use the Note (NO) mnemonic to add notes to an existing problem for non-visit- or visit-related encounters. Providers often record treatment plans or notes on a patient’s Problem List. Before adding a note, be sure that the problem number has been clearly identified on the encounter form. The patient’s problem displays so that the problem number can be verified.

The NO mnemonic prompts for the provider who added the problem list update and the date the update was made. This enables the creation of a V Updated/Reviewed entry with a clinical action of Problem List Updated.

MNEMONIC: NO  Note  ALLOWED  NON-VISIT/VISIT MNEMONIC

Problem List Reviewed On:  By:
Problem List Updated On:  Nov 10, 2010  By:
BVPROVIDER, PROVIDER
No Active Problems Documented On:  By:

*************** ACTIVE PROBLEMS AND NOTES *******************

CI1  11/10/2010  ASTHMA  (ONSET: 08/10/2010)

********** No INACTIVE Problems on file for this Patient

Enter Problem Number: CI1
Problem Number: CI1  Diagnosis: 493.90
Add a new Problem Note for this Problem? N// YES

Adding 2010 DEMO HOSPITAL Note #1
NOTE NARRATIVE: USE OF INHALER

Enter the Date the Problem List was Updated by the Provider:  Nov 10, 2010// (Nov 10, 2010)
Enter the PROVIDER who Updated the Problem List:  BLPROVIDER, DAVID P// BLPROVIDER, DAVID P
Problem Number: CI1  Diagnosis: 493.90
Problem Notes:
2010 DEMO HOSPITAL Note#1 11/10/2010 USE OF INHALER
3.5.132 No Response to Followup (NRF)

Use the No Response to Followup (NRF) mnemonic to document that the patient has not responded to follow up (for non-visit- or visit-related encounters).

MNEMONIC: NRF  No Response to Followup ALLOWED NON-VISIT/VISIT MNEMONIC
Select PATIENT REFUSALS FOR SERVICE/NMI SERVICE TYPE: MAMMOGRAM
Enter the RAD/NUC MED PROCEDURES value: BREAST SPECIMEN (RAD Detailed)
CPT:76098
DATE DECLINED/NOT INDICATED: T-5 (MAR 01, 2008)
PROVIDER WHO DOCUMENTED: SIGMA,JOHN

3.5.133 Nutritional Risk Screening (NRS)

A Nutritional Risk Screening can be added using the NRS mnemonic. The screening captures nutritional risk factors. The Nutritional Risk Screening component in the Health Summary displays the patient’s last three nutritional risk screenings.

MNEMONIC: NRS  NUTRITIONAL RISK SCREENING ALLOWED VISIT RELATED ONLY
Date and Time Performed: T (JAN 14, 2010)
Nutritional Risk Screening Provider: ST CYR, DONNA  DS
Age 70+? (Yes/No): Y YES
Nutrition support? (Yes/No): Y YES
High risk weight issue? (Yes/No): Y YES
High risk diagnosis? (Yes/No): Y YES
Poor appetite? (Yes/No): Y YES
Difficulty chewing? (Yes/No): Y YES
Food Allergies/Intolerances (Yes/No): N NO
Recent vomiting or diarrhea? (Yes/No): N NO
Other Risk Factor? (Yes/No): N NO

Nutritional Risk Screening Factors
- Age 70+
- Nutrition Support
- High Risk Weight Issue
- High Risk Diagnosis
- Poor Appetite
- Difficulty Chewing
Nutritional Risk (Low/High): H HIGH
Nutritional Risk Comment:
Recommend RD Referral (Yes/No): Y YES
Referral Comment: REFER TO DR. SMITH
3.5.134 Narrative Text (NT)

Use the Narrative Text (NT) mnemonic to enter narrative information into the V Narrative Text File of PCC (for visit-related-only encounters).

![Figure 3-126: Example of using NT mnemonic](image)

3.5.135 NIHS Stroke Scale Total Score (NSST)

Use the NIHS Stroke Scale Total Score Mnemonic to enter a valid NIH Stroke Scale Total. The value must be a whole number between 0 and 42.

![Figure 3-127: Using the NSST mnemonic](image)

3.5.136 O2 Saturation (O2)

Use the O2 Saturation (O2) mnemonic to enter O2 saturation levels for a patient for visit-related-only encounters. The range is a range between 50% and 100%.

![Figure 3-128: Example of using the O2 mnemonic](image)
3.5.137 Offspring History (OHX)

Use the Offspring History (OHX) mnemonic to enter female patient information about offspring births and deaths for non-visit- or visit-related encounters. Although offspring history does not display on the standard Adult Regular Health Summary, it can be displayed on a locally defined custom Health Summary. A warning message displays if attempting to use this mnemonic with a male patient’s record.

```
MNEMONIC: OHX  Offspring History  ALLOWED  NON-VISIT/VISIT MNEMONIC
Select OFFSPRING HISTORY DATE OF OFFSPRING BIRTH: 5/1/96  MAY 01, 1996
FIRST NAME: JANE
SEX: F  FEMALE BIRTH WEIGHT: 7.5
GESTATIONAL AGE: 38
APGAR SCORE 1 MIN: 9
APGAR SCORE 5 MIN: 9
DATE OF DEATH: CAUSE OF DEATH:
Select PERINATAL COMPLICATION:
Select NEONATAL COMPLICATION:
```

Figure 3-129: Example of using the OHX mnemonic

3.5.138 Outside Location (OLOC)

Use the Outside Location (OLOC) mnemonic to type an outside location for a patient’s visit. Outside Location is a free-text field for a minimum of two to a maximum of 50 characters.

```
MNEMONIC: OLOC  Outside Location  ALLOWED  VISIT-RELATED-ONLY
OUTSIDE LOCATION: DEMO HOSPITAL
```

Figure 3-130: Example of using OLOC mnemonic

3.5.139 Operations (OP)

Use the Operations (OP) mnemonic to type procedures performed on a patient for visit-related-only encounters. Only critical procedures are captured for display on the patient’s Health Summary.

```
MNEMONIC: OP Operations  ALLOWED  VISIT-RELATED-ONLY
Enter CPT CODE: 33200   INSERTION OF HEART PACEMAKER
INSERTION OF PERMANENT PACEMAKER WITH EPICARDIAL ELECTRODE(S); BY THORACOTOMY
...OK? Y
PROVIDER NARRATIVE: HEART PACEMAKER INSERTION  HEART PACEMAKER INSERTION
OPERATING PROVIDER: SIGMA,JOHN  PHYSICIAN IHS
DIAGNOSIS: CARDIAC DYSRHYTHMIA  (CARDIAC|HEART/HEARTBURN DYSRHYTHMIAS/DYSRHYTHMIAS)
The following matches were found:
1: 427.89 (CARDIAC DYSRHYTHMIAS NEC)
OTHER SPECIFIED CARDIAC DYSRHYTHMIAS
2: 427.9 (CARDIAC DYSRHYTHMIA NOS)
CARDIAC DYSRHYTHMIA, UNSPECIFIED Select 1-2: 2
```
Enter CPT CODE:

Figure 3-131: Example of using the OP mnemonic

3.5.140 Outside RX (Historical)
This mnemonic is not used by all sites.

3.5.141 Other Items for List Manager (OT)
This mnemonic is not used by all sites.

3.5.142 Health Reminder Override (OVR)
Use the Health Reminder Override (OVR) mnemonic to override a health reminder for a specific patient in non-visitor visit-related encounters.

MNEMONIC: OVR Health Reminder Override  ALLOWED  NON-VISIT/VISIT MNEMONIC
Select HEALTH REMINDER OVERRIDE HEALTH MAINTENANCE REMINDER: WEIGHT
   PROVIDER REQUESTING OVERRIDE: SMITH, JOHN
   DUE DATE: T
   PROVIDER COMMENTS: OVERRIDE

Figure 3-132: Example of using the OVR mnemonic

3.5.143 Pain (PA)
Use the Pain (PA) mnemonic to enter perceived pain level, with a range of zero to ten for visit-related-only encounters.

MNEMONIC: PA
   VALUE: 5

Figure 3-133: Example of using the PA mnemonic

3.5.144 31 Pap Smear Ordered (PAP)
Use the 31 Pap Smear Ordered (PAP) mnemonic to record that a pap smear was ordered for a female patient for visit-related-only encounters. This entry indicates only that a Pap was ordered. Results are not captured. This mnemonic should be used only if the user’s facility is not using the laboratory or women’s health package.

MNEMONIC: PAP  31 PAP Smear Ordered  ALLOWED  VISIT-RELATED-ONLY

Figure 3-134: Example of using the PAP mnemonic
3.5.145 PCC+ Form (PCF)

The PCC+ Form (PCF) mnemonic flags a visit as being created from a PCC+ form (for visit-related-only encounters).

3.5.146 Primary Care Provider (PCP)

Use the Primary Care Provider (PCP) mnemonic to indicate that a patient is assigned a specific provider for all visits for non-visit or visit-related encounters. The provider’s name displays on the Adult Regular Health Summary in the Demographics section. PCP will rarely be used and should not be confused with the PRV mnemonic that is required for all visits.

**Note:** This mnemonic is the same as the DP – Designated Provider. Only the terminology is different.

```
MNEMONIC: PCP  Primary Care Provider  ALLOWED  NON-VISIT/VISIT MNEMONIC
PERSONAL PHYSICIAN: SIGMA, JANE  PHYSICIAN  IHS  TAC  100TAC
```

Figure 3-135: Example of using the PCP mnemonic

3.5.147 Procedure Entry (CPT) (PCPT)

Use the Procedure Entry (PCPT) mnemonic to type a procedure CPT code for visit-related-only encounters. The CPT code can be typed by using the name, as shown in the example below, or the numerical code.

```
MNEMONIC: PCPT  Procedure Entry (CPT)  ALLOWED  VISIT-RELATED-ONLY Enter
CPT CODE: DTP IMMUNIZATION
( DTP/DTPHIB IMMUNIZATION/IMMUNIZATIONS )
The following 3 matches were found:
1: 90701 (90701) DTP IMMUNIZATION
   IMMUNIZATION, ACTIVE; DIPHTHERIA AND TETANUS TOXOIDS AND PERTUSSIS
   VACCINE (DTP)
2: 90711 (90711) COMBINED VACCINE
   IMMUNIZATION, ACTIVE; DIPHTHERIA, TETANUS TOXOIDS, AND PERTUSSIS
   (DTP) AND INJECTABLE POLIOMYELITIS VACCINE
3: 90720 (90720) DTP/HIB VACCINE
   IMMUNIZATION, ACTIVE; DIPHTHERIA, TETANUS TOXOIDS, AND PERTUSSIS
   (DTP) AND HEMOPHILUS INFLUENZA B (HIB) VACCINE
Press <RET> or Select 1-3: 1

PROVIDER NARRATIVE: DTP IMMUNIZATION
OPERATING PROVIDER: SIGMA, JOHN  PHYSICIAN  IHS DIAGNOSIS:
Enter CPT CODE:
```

Figure 3-136: Example of using the PCPT mnemonic
3.5.148 Patient Education (PED)

Use the Patient Education (PED) mnemonic to record the health education received by a patient for visit-related-only encounters. The education topic should be noted on the Encounter Form and will display on the Adult Regular health summary. This data should not be entered unless the education topic has been initialized by the provider in the Patient Education section of the form. Each facility is responsible for establishing and maintaining its own database of patient education topics.

The patient’s readiness to learn can be typed, with the following choices:

- Distraction
- Eager to Learn
- Intoxication
- Not Ready
- Pain
- Receptive
- Severity of Illness
- Unreceptive

The patient’s level of understanding can be entered, as well as CPT codes. The choices available for patient’s level of understanding shown as follows:

- Poor
- Fair
- Good
- Group – No Assessment
- Refused

Education topics can be entered in one of three ways: (1) use the name of the topic (e.g., DM-DIET), (2) use an ICD Diagnosis for the topic diagnosis and type a topic category or (3) use a CPT Code and type a topic category.

---

**MNEMONIC: PED Patient Education ALLOWED VISIT-RELATED-ONLY**

You can enter education topics in 2 ways:
- using the name of the topic (e.g. DM-DIET)
- using an ICD Diagnosis for the topic diagnosis and enter a topic category

Select one of the following:
- T EDUCATION TOPIC
- D DIAGNOSIS
- C CPT CODE

Do you wish to enter a: T// EDUCATION TOPIC

Enter EDUCATION Topic: DEP-EXERCISE
READINESS TO LEARN: EAGER TO LEARN
LEVEL OF UNDERSTANDING: GOOD
PROVIDER: SIGMA, JANE
LENGTH OF EDUC (MINUTES): 30
COMMENT:
### 3.5.149 Peak Flow (PF)

Use the Peak Flow (PF) mnemonic to document a patient’s peak flow measurement for visit-related-only encounters. The value range is 50 to 1000.

**Mnemonic:** PF Peak Flow  Allowed  Visit-Related-Only  
**Value:** 500

Figure 3-138: Example of using the PF mnemonic

### 3.5.150 Public Health Nursing Form (PHN)

Use the Public Health Nursing (PHN) mnemonic to type patient data resulting from public health nursing visits (for visit-related-only encounters). The user is prompted to enter data in several fields. The choices for the Level of Intervention and Type of Decision Making prompts are listed below. The remaining fields are free-text fields. The entry can be a maximum of 200 characters in length for each.

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Primary</td>
</tr>
<tr>
<td>S</td>
<td>Secondary</td>
</tr>
<tr>
<td>T</td>
<td>Tertiary</td>
</tr>
</tbody>
</table>

The following shows the type of decision making for each code.

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Straightforward</td>
</tr>
<tr>
<td>L</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>M</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>H</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

The following shows an example of using the PHN mnemonic:

**Mnemonic:** PHN Public Health Nursing Form  Allowed  Visit-Related-Only  
**Level of Intervention:** P Primary  
**Type of Decision Making:** S Straightforward  
**Psychosocial/Environment:** PT is depressed secondary to other medical problems  
**NSG DX:** Depression, Diabetes, Hypertension  
**Short Term Goals:** Continue to monitor medication  
**Long Term Goals:** Admission to nursing home

Figure 3-139: Example of using the PHN mnemonic
3.5.151 PHQ2 (PHQ2)

Use the PHQ2 mnemonic as a depression screen (for visit-related-only encounters). A score of three or higher is considered a positive screen and further evaluation is indicated. The value range is zero to six.

<table>
<thead>
<tr>
<th>MNEMONIC:</th>
<th>PHQ2</th>
<th>PHQ2</th>
<th>ALLOWED</th>
<th>VISIT-RELATED-ONLY</th>
<th>VALUE: 5</th>
</tr>
</thead>
</table>

Figure 3-140: Example of using the PHQ2 mnemonic

3.5.152 PHQ9 (PHQ9)

Use the PHQ9 mnemonic as a depression screen (for visit related encounters). The value range is 0 to 27. A value of zero to four indicates no depression. A value of five to nine indicates minimal symptoms. A value of 10 to 14 indicates mild symptoms. A value of 15 to 19 indicates moderate symptoms. A value of 20 or more indicates severe symptoms.

<table>
<thead>
<tr>
<th>MNEMONIC:</th>
<th>PHQ9</th>
<th>PHQ9</th>
<th>ALLOWED</th>
<th>VISIT-RELATED-ONLY</th>
<th>VALUE: 10</th>
</tr>
</thead>
</table>

Figure 3-141: Example of using the PHQ9 mnemonic

3.5.153 PHQT (PHQ-9 Modified for Teens)

Use the PHQT mnemonic as a depression screen for teens (for visit related encounters). The value range is 0 to 27. A positive score is a total score equal to or greater than 11 OR a positive response to questions 12 or 13. Depression Severity: 1 – 4: Minimal depression; 5 – 9: Mild depression; 10 – 14: Moderate depression; 15 – 19: Moderately severe depression; 20 – 27: Severe depression. Suicidality: Regardless of the PHQ-9 Modified total score, endorsement of serious suicidal ideation OR past suicide attempt (a “Yes” response to questions 12 or 13) should be considered a positive screen.

<table>
<thead>
<tr>
<th>MNEMONIC:</th>
<th>PHQT</th>
<th>PHQ-9 Modified for Teens</th>
<th>VALUE: 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select QUALIFIER:</td>
<td></td>
<td>Date/Time Vitals Taken: T@13:40  (MAY 04, 2012@13:40:00)</td>
<td></td>
</tr>
<tr>
<td>ENCOUNTER PROVIDER:</td>
<td>TEST,PCC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 3-142: Example of using the PHQT mnemonic
3.5.154 Personal History (PHX)

When a provider wants to capture data that is pertinent to the patient’s health but has not otherwise been recorded, use the PHX mnemonic to capture personal history data (for non-visit or visit-related encounters). Many times judgment calls will be required by the data entry operator based on the narrative that has been written on the encounter form; for example, the notation “Attempted suicide 1993” indicates a personal history item with the date of onset as 1993. Although personal history items do not display in the Adult Regular Health Summary, they can be displayed in a locally defined custom Health Summary.

```
MNEMONIC: PHX Personal History ALLOWED NON-VISIT/VISIT MNEMONIC
**************************** PERSONAL HISTORY **********************
03/30/1988 C-SECTION, BW 7-11, APGARS 7/9 (onset 10/08/1987)
Enter PERSONAL HISTORY Diagnosis: 977.9 977.9 POISON-MEDICINAL AGT NOS ...
OK? Yes// (Yes)
DATE NOTED: OCT 7, 2008// (No Editing)
PROVIDER NARRATIVE: SUICIDE ATTEMPT--DRUG OVERDOSE
MULTIPLE BIRTH?: Y YES MULTIPLE BIRTH TYPE: ??
  Choose from:
  TU TWIN, UNSPECIFIED
  IT IDENTICAL TWIN
  FT FRATERNAL TWIN
  TR TRIPLET
  OTH OTHER MULTIPLE
MULTIPLE BIRTH TYPE: FT FRATERNAL TWIN
MNEMONIC:
```

Figure 3-143: Example of using the PHX mnemonic

3.5.155 Infant Feeding Patient Data (PIF)

Use the Infant Feeding Patient Data (PIF) mnemonic to type infant feeding patient data for non-visit or visit-related encounters. This includes data about the birth weight, birth order, formula started, breast stopped, solids started, and mother’s name.

```
MNEMONIC: PIF Infant Feeding Patient Data ALLOWED NON-VISIT/VISIT MNEMONIC
Patient Name: SIGMA, BABY
***** PLEASE NOTE ****
For BIRTH WEIGHT the system assumes you are entering lbs and ozs, if you are entering kilograms (kg) please enter a K after the value. If you are entering grams please enter a G after the value.
Examples: 7 2 for 7 lbs 2 ozs
  3.2K for 3.2 kilograms
  3200G for 3200 grams
BIRTH WEIGHT: 7 1
BIRTH ORDER: 2
FORMULA STARTED: 1Y
BREAST STOPPED: 1Y
SOLIDS STARTED: 1Y
MOTHER: SIGMA, MOTHER
```
Figure 3-144: Example of using the PIF mnemonic

3.5.156 Problem List (PL)

Use the Problem List (PC) mnemonic to access a Problem List update menu (for non-visit or visit-related encounters). The patient’s Problem List displays on the screen with action commands listed across the bottom. A patient’s Problem List is updated in the same way that the problem list mnemonics are used, with text prompts. Only the method of selecting action items is different. The Problem List Narrative can be up to 160 characters.

Additional features available from this menu include a Health Summary and face sheet display from within this menu. The detailed display shows the complete data for the problem selected. An example of adding a problem is shown in the following example.

Two action items have been added to the List Manager display when using the PL mnemonic: NP (No Active Problems), and LR (Problem List Reviewed).

```
Problem List Update           Jan 19, 2015 12:26:52          Page:    1 of    1
--------------------------------------------------------------------------------
Patient Name: DEMO,BERNADINE MARIA   DOB: NOV 11, 1992   Sex: F   HRN: 14
--------------------------------------------------------------------------------
Problem List Reviewed On: Dec 06, 2014  By: WHITE,LESLIE R
Problem List Updated On: Dec 06, 2014  By: WHITE,LESLIE R

1) Problem ID:  TST1    DX: -1    Status: EPISODIC    Onset:
   Provider Narrative:  Pain |
   SNOMED CONCEPT ID: 22253000

Enter ?? for more actions                                          >>>
AP   Add Problem          DD   Detail Display       NP   No Active Problems
EP   Edit Problem         NO   Add Note             LR   Problem List Reviewed
DE   Delete Problem       MN   Edit Note            HS   Health Summary
CS   Change Status        RN   Remove Note          FA   Face Sheet
Select Action: +//
```

Adding a new problem for DEMO,BERNADINE MARIA.

```
Enter PROBLEM Diagnosis: Type 1 Diabetes Mellitus with other Skin Ulcer (ICD-10-CM E10.622)
   PROVIDER NARRATIVE: diabetes date on onset
   DATE OF ONSET: 12-12-2013  (DEC 12, 2013)
   NMBR: 2//
   CLASS:                  
   STATUS: CHRONIC//
   Severity: None recorded
```
Select one of the following:

A        Add a Severity
N        No Change

Which action: N//

Add a new Problem Note for this Problem? N//
Enter the Date the Problem List was Updated by the Provider: Dec 15, 2014//
Enter the individual that updated the problem list. If you are transcribing an update from a PCC Provider, then enter the individual who requested the change. If you are data entry/coder correcting the problem entry such as correcting the ICD9 code, then enter yourself.
Enter the INDIVIDUAL who Updated the Problem List: DEMO, DR

Figure 3-145: Example of using the PL mnemonic

The Problem List Update menu will display again after you press the Enter key.

Note: Remember to type Q to quit the Problem List menu and return to the “Mnemonic” prompt.

When adding a problem, if the diagnosis is an injury, the PL mnemonic will prompt for three E Code fields. When modifying any problem, however, these prompts will always display so they can be deleted, if appropriate.

Enter Problem Diagnosis: INJURY

959.9 (INJURY SITE NOS)
OTHER AND UNSPECIFIED INJURY TO UNSPECIFIED SITE

OK? Y//

PROVIDER NARRATIVE: INJURY INJURY
E CODE (CAUSE OF INJURY):
E CODE 2:
E CODE 3:

Figure 3-146: Example of E Code prompts

Problems can no longer be deleted from the Problem List; instead, they will be updated with a status of Deleted. The status values are now Active, Inactive, or Deleted.

The PL mnemonic has been modified so that when you delete a problem, you are prompted for a reason and for who documented the deletion. Instead of deleting the problem, as was done in the past, the status field is set to D for Deleted.

If the problem does have a SNOMED code, then the user can only edit the status and ICD code.
3.5.157 Problem List Reviewed (PLR)

Use to document when a provider indicates on the PCC or PCC+ Form that he/she reviewed the problem list. This mnemonic will prompt for the provider who reviewed the problem list and the date/time reviewed. If the time is not known, the date alone is sufficient and will default to the visit date.

Did the Provider indicate that he/she Reviewed the Problem List? (Y/N): Y
Problem List Review Date/Time: Oct 26, 2010/ (OCT 26, 2010)
Provider who Reviewed the Problem List: SMITH BTPROVIDER,WENDY C
Figure 3-148: Example of using the PLR mnemonic

3.5.158 Problem Only (PO)

Use the Problem Only mnemonic to add new active or inactive problems to a patient’s Problem List for non-visit-or visit-related encounters. Problems to be added to a patient’s Problem List will be written in the Purpose of Visit section of the encounter form with the problem status marked as A (Active) I (Inactive), or D (Deleted). For more information on the Problem List, refer to the PCC Forms and Health Summary manuals.

The PO mnemonic prompts for the provider who added the problem list update and the date the update was made. This enables the creation of a V Updated/Reviewed entry with a clinical action of Problem List Updated.

```
MNEMONIC: PO Problem Only ALLOWED NON-VISIT/VISIT MNEMONIC
Problem List Reviewed On: Dec 06, 2014 By: WHITE, LESLIE R
Problem List Updated On: Dec 15, 2014 By: DEMO, LISA M RN
No Active Problems Documented On: By:

******************** ACTIVE (ALL) PROBLEMS AND NOTES ********************
TST1 12/06/2014 Pain |
      Status: EPISODIC
TST2 12/15/2014 *diabetes date on onset (ONSET: 12/12/2013) |
      Status: CHRONIC

********** No INACTIVE Problems on file for this Patient

Enter PROBLEM Diagnosis: Enter PROBLEM Diagnosis: CI2

347 term matches found.

1) Cauda equina syndrome (ICD-10-CM G83.4)
2) Cauliflower Ear, left Ear (ICD-10-CM M95.12)
3) Cauliflower Ear, right Ear (ICD-10-CM M95.11)
4) Causalgia of left upper Limb (ICD-10-CM G56.42)
5) Causalgia of left lower Limb (ICD-10-CM G57.72)

Type "^" to STOP or SELECT 1-5: (1-5):

6) Causalgia of right upper Limb (ICD-10-CM G56.41)
7) Causalgia of right lower Limb (ICD-10-CM G57.71)
8) Injury of Cauda Equina, Sequela (ICD-10-CM S34.3XXS)
9) Cauliflower Ear, unspecified Ear (ICD-10-CM M95.10)
10) Cardiac Arrest, Cause unspecified (ICD-10-CM I46.9)

Type "^" to STOP or SELECT 1-10: (1-10):7

PROVIDER NARRATIVE: problem #!
DATE OF ONSET: t-13 (JAN 06, 2015)
NMBR: 3/
CLASS:
STATUS: CHRONIC/

Severity: None recorded
```
Select one of the following:

A   Add a Severity
N   No Change

Which action: N//

Add a new Problem Note for this Problem? N//
Enter the Date the Problem List was Updated by the Provider: Dec 15, 2014//
Enter the individual that updated the problem list.
If you are transcribing an update from a PCC Provider, then enter
the individual who requested the change. If you are data
tentry/coder correcting the problem entry such as correcting the
ICD9 code, then enter yourself.
Enter the INDIVIDUAL who Updated the Problem List: // dr. ATEST

Enter the provider that made the assessment
Answer with NEW PERSON NAME, or INITIAL, or SSN, or VERIFY CODE, or
   NICK NAME, or SERVICE/SECTION, or DEA#, or VA#, or CODE, or
   IHS LOCAL CODE, or IHS ADC INDEX, or ALIAS, or NPI
Do you want the entire NEW PERSON List? N
Enter the Date the Problem List was Updated by the Provider: Dec 15, 2014// (DEC 15, 2014)
Enter the individual that updated the problem list. // adam, adam ADAM, ADAM AXA

Figure 3-149: Example of using the PO mnemonic

When adding a problem, if the diagnosis is an injury, the PO mnemonic will prompt
for three E Code fields. When modifying any problem, however, these prompts will
always display so they can be deleted, if appropriate.

Enter Problem Diagnosis: INJURY
959.9 (INJURY-SITE NOS)
OTHER AND UNSPECIFIED INJURY TO UNSPECIFIED SITE
OK? Y//

   PROVIDER NARRATIVE: INJURY INJURY
   E CODE (CAUSE OF INJURY):
   E CODE 2:
   E CODE 3:

Figure 3-150: Example of E Code prompts

3.5.159 POV and Problem Entry (PPV)

Use the POV and Problem Entry (PPV) mnemonic to automatically generate a
problem in the Problem List for visit-related-only encounters. Use the PV mnemonic
to type POVs only.
The PO mnemonic prompts for the provider who added the problem list update and the date the update was made. This enables the creation of a V Updated/Reviewed entry with a clinical action of Problem List Updated.

```
MNEMONIC: PPV       P O V and PROBLEM entry     ALLOWED     VISIT RELATED ONLY
Enter PURPOSE OF VISIT:
Enter an active ICD-10-CM diagnosis code or descriptive text.
DO NOT enter a code that begins with V, W, X or Y (these are External cause of Morbidity codes).
Do you want the entire ICD DIAGNOSIS List? N/
Enter PURPOSE OF VISIT: A01.00

1 term matches found.
1) Typhoid Fever, unspecified (ICD-10-CM A01.00)
Type "^" to STOP or SELECT 1-1: (1-1): 1

PROVIDER NARRATIVE: diagnosis positive
CAUSE OF DX: ??
Choose from:
1 HOSPITAL ACQUIRED
2 ALCOHOL RELATED
3 BATTERED CHILD
4 EMPLOYMENT RELATED
5 DOMESTIC VIOLENCE RELATED
6 DRUG RELATED
CAUSE OF DX: 2 ALCOHOL RELATED
ENCOUNTER PROVIDER: test TEST,KATHLEEN TK

Now creating PROBLEM on PROBLEM List...
NMBR: 4/
CLASS:
DATE OF ONSET:
STATUS: CHRONIC/

Add a new Problem Note for this Problem? N/
Enter the Date the Problem List was Updated by the Provider: Dec 15, 2014/
Enter the individual that updated the problem list.
If you are transcribing an update from a PCC Provider, then enter the individual who requested the change. If you are data entry/coder correcting the problem entry such as correcting the ICD9 code, then enter yourself.
Enter the INDIVIDUAL who Updated the Problem List: test TEST,KATHLEEN TK
```

**Figure 3-151: Example of using the PPV mnemonic**

When adding a problem, if the diagnosis is an injury, the PPV mnemonic will prompt for three E Code fields and for an entry of First Visit or Revisit. When modifying any problem, however, these prompts will always display so they can be deleted, if appropriate.
3.5.160 Presentation (Pregnancy) (PR)

Use the Presentation (PR) mnemonic to capture a female patient’s pregnancy presentation for visit-related-only encounters. The choices for entry are listed below. They can be typed by number, name, or abbreviation, as shown in the following table.

<table>
<thead>
<tr>
<th>Number</th>
<th>Name</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Vertex</td>
<td>VT</td>
</tr>
<tr>
<td>2</td>
<td>Complete Breach</td>
<td>CB</td>
</tr>
<tr>
<td>3</td>
<td>Double Footing</td>
<td>DF</td>
</tr>
<tr>
<td>4</td>
<td>Single Footing</td>
<td>SF</td>
</tr>
<tr>
<td>5</td>
<td>Frank Breach</td>
<td>FB</td>
</tr>
<tr>
<td>6</td>
<td>Face</td>
<td>FA</td>
</tr>
<tr>
<td>7</td>
<td>Unspecified Breach</td>
<td>UB</td>
</tr>
<tr>
<td>8</td>
<td>Transverse</td>
<td>TR</td>
</tr>
<tr>
<td>9</td>
<td>Other</td>
<td>OT</td>
</tr>
<tr>
<td>10</td>
<td>Unknown</td>
<td>UNK</td>
</tr>
</tbody>
</table>

The following shows using the PR mnemonic:

MNEMONIC: PR Presentation (Pregnancy) ALLOWED VISIT-RELATED-ONLY
VALUE: 2 COMPLETE BREACH

Figure 3-152: Example of using the PR mnemonic

3.5.161 Provider Discontinued Service (PRD)

Use the Provider Discontinued Service (PRD) mnemonic to record that a service, such as a medication or drug has been stopped by a provider.

MNEMONIC: PRD Provider Discontinued Service ALLOWED NON-VISIT/VISIT

Select PATIENT REFUSALS FOR SERVICE/NMI SERVICE TYPE: MEDICATION/DRUG
Enter the DRUG value: SERTRALINE 100MG TAB U/D
DATE DECLINED/NOT INDICATED: T PROVIDER WHO DOCUMENTED: Test, User
COMMENT:

Figure 3-153: Example of using the PRD mnemonic
3.5.162 Providers (Primary/Secondary) (PRV)

Use the Providers (PRV) mnemonic to record each person who provides healthcare services to a patient during a visit (for visit-related-only encounters). A primary provider is required for each patient visit and must be recorded on the encounter form. Secondary providers are optional and can be typed with the PRV if written on the encounter form. The user can type the provider’s code, initials, or entire name. The date and time that the provider saw the patient can also be typed utilizing the PRV mnemonic. These data fields are typed only at facilities that are conducting Waiting Time studies. The PCC Data Entry Site Parameters determine whether or not the data entry operator is prompted for Date and Time when using this mnemonic.

```
MNEMONIC: PRV  Providers (Primary/Secondary)  ALLOWED  VISIT-RELATED-ONLY
Enter PROVIDER (code/initials or name): TAC  COOPER, TERI  PHYSICIAN
IHS
TAC 100TAC
P)rimary or S)econdary: P PRIMARY
Date Provider Seen: Jun 13, 2007//  (JUN 13, 2007)
Time Provider Seen: 1:45 Jun 13, 2007@1:45  (JUN 13, 2007@13:45)
Enter a SECONDARY PROVIDER (code/initials or name): SJ  SIGMA, JANE
REGISTERED NURSE  IHS  SJ  101SJ
Date Provider Seen: Jun 13, 2007//  (JUN 13, 2007)
Time Provider Seen: 2:00  Jun 13, 2007@2:00  (JUN 13, 2007@14:00)
Enter a SECONDARY PROVIDER (code/initials or name):  
```

Figure 3-154: Example of using the PRV mnemonic

3.5.163 Prescription RX (PRX)

Use the Prescription RX (PRX) mnemonic at sites that either do not have a pharmacy or are not utilizing an automated pharmacy system for entry of medications for visit-related-only encounters. Data entry staff use this mnemonic to type medications directly into the PCC V-Medication File. This mnemonic is similar to the RX mnemonic but fewer data fields are typed using PRX.

```
MNEMONIC: PRX  Prescription RX  ALLOWED  VISIT-RELATED-ONLY
Select V MEDICATION: GLIPIZIDE
  1 GLIPIZIDE 10MG TAB
  2 GLIPIZIDE 5MG TAB CHOOSE 1-2: 1
Outside Drug Name (OPTIONAL): SIG: T2TD WITH MEALS
QUANTITY: 60
DAYS PRESCRIBED: 30
```

Figure 3-155: Example of using the PRX mnemonic

3.5.164 VA Mobile Cln Prescription Act

This mnemonic is not used by all sites.
### 3.5.165 Physical Therapy (PT)

Facilities that have a therapist on staff and use form HRSA 464–PCIS Brief Visit Record for documenting physical therapy visits should use the PT mnemonic to capture the physical therapy treatment provided (for visit-related-only encounters). The physical therapist will type the appropriate code for data entry in the box on the right side of the form labeled Coding. The physical therapist is responsible for establishing and maintaining the list of physical therapy codes.

<table>
<thead>
<tr>
<th>MNEMONIC: PT Physical Therapy ALLOWED VISIT-RELATED-ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter PHYSICAL THERAPY CPT Code: 975006 AMB-FITTING</td>
</tr>
<tr>
<td>QUANTITY: 1</td>
</tr>
<tr>
<td>Enter PHYSICAL THERAPY CPT Code:</td>
</tr>
</tbody>
</table>

Figure 3-156: Example of using the PT mnemonic

### 3.5.166 Patient Goals (PTG)

Use the Patient goals Mnemonic to document patient goals, steps taken to meet the goals and monitor and update goal progression and status. The PTG mnemonic takes you to the Goal List Update screen which is in list manager format. The list manager is also accessible through option PATG Patient Goals Update under the UPD Update Patient Related/Non-visit Data menu. A brief description of the list manager options is below.

**AG – Add Goal**

Enter a goal by first establishing a goal setting. Options are: “S Goal Set” and” N Goal Not Set.” Choose a predefined goal type, or choose “Other.” Prompts for Goal Number, Goal Name, Reason for Goal, Provider, Goal Start and Follow-up Dates follow. Multiple goal types and multiple steps can be added. The available goal types are:

- ALCOHOL OR OTHER DRUGS
- DIABETES CURRICULUM
- MEDICATIONS
- MONITORING
- NUTRITION
- OTHER
- PHYSICAL ACTIVITY
- STRESS AND COPING
- TOBACCO
- WELLNESS AND SAFETY
**RV – Review a Goal**

You can select one of the following:

- ME – Goal Met
- MA – Maintenance Goal
- S – Goal Stopped
- – No Change

After you choose a review option, previously entered progress notes display. You can add, edit or delete a progress note or return to the previous screen.

- DE – Delete Goal
  Goals should not be deleted unless they were entered in error. You are prompted to enter the goal you want to delete. Answer “No” to the verification prompt “Do you wish to continue to delete a Goal?” if you wish to leave the option without deleting a goal.

- AS – Add Step
  Enter text that describes the step; enter the step type, start date, follow-up date and the provider. You can enter multiple steps for each goal.

- ES – Review Step
  You can select one of the following:
  
  - ME – Step Met
  - MA – Maintenance Step
  - S – Step Stopped

- RS – Remove Step
  Steps should not be removed unless they were entered in error. You are prompted to enter the goal and step you want to delete. Answer “No” to the verification prompt “Are you sure you want to delete this STEP?” if you wish to leave the option without removing a step.

- IG – Display Inactive Goals
  Goals are considered inactive if the goal status is “Goal Met” or “Goal Stopped.”

- DD – Detail Display
  Choose a goal from the list. Detailed data entered for the goal and associated steps displays.
1) GOAL ID: CI1 Status: GOAL SET - ACTIVE
   Goal Start Date: 12/05/11 Goal Follow up Date: 01/04/12
   Goal Name: Stop Drinking
   Goal Reason: Liver Disease
   Provider: TEST, USER ONE
   Steps:
   CI Step#1 Join AA
   Status: MAINTAINING STE Start Date: 12/12/11 F/U Date: 01/04/12

Enter ?? for more actions >>>
AG Add GOAL AS Add Step FS Face Sheet
RV Review Goal ES Review Step IG Display Inactive Goals
DE Delete GOAL RS Remove Step
DD Detail Display HS Health Summary
Select Action: +/

Figure 3-157: Goal List Update Example

3.5.167 Pulse (PU)

This is an optional data item that does not print on the Adult Regular Health Summary although it can be used in a customized Health Summary. The value typed must be in the range 30 to 250. The mnemonic applies to visit-related-only encounters.

| MNEMONIC: PU Pulse ALLOWED VISIT-RELATED-ONLY |
| VALUE: 75 |

Figure 3-158: Example of using PU mnemonic

3.5.168 Purpose of Visit (PV)

The purpose of visit is the most important data item recorded for a patient’s visit. Every encounter form must have a purpose of visit recorded before it can be processed by the data entry staff. This data item is typed in the Purpose of Visit section on the encounter form in a narrative format by the provider. This section is also used to create and update a patient’s Problem List. The purpose of visit is entered in two parts: (1) to obtain the ICD-9 code, and (2) to maintain the provider’s narrative verbatim. The second entry, the provider’s narrative, displays in the Adult Regular Health Summary. For more information on the purpose of visit or the Problem List, refer to the PCC Forms manual. This mnemonic applies to visit-related-only encounters.

During entry of the purpose of visit, the user will be prompted for a modifier and a cause of diagnosis. These optional fields are used as needed, depending on the provider’s diagnosis. The choices available for entry at each of these prompts are listed in the following table.
### Modifier | Description
--- | ---
C | Consider
D | Doubtful
F | Follow Up
M | Maybe, Possible, Perhaps
O | Rule Out
P | Probable
R | Resolved
S | Suspect, Suspicious
T | Status Post

#### Cause of DS:
- Hospital Acquired
- Alcohol Related
- Battered Child
- Employment Related
- Domestic Violence Related

### Example of using the PV mnemonic

**MNEMONIC:** PV  Purpose of Visit  ALLOWED  VISIT-RELATED-ONLY  
Enter PURPOSE of VISIT: PNEUMONIA  
486. (PNEUMONIA, ORGANISM NOS)  
PNEUMONIA, ORGANISM UNSPECIFIED OK? Y//  
PROVIDER NARRATIVE: PNEUMONIA  PNEUMONIA  
MODIFIER: CAUSE OF DX:  
Enter PURPOSE of VISIT:

**Figure 3-159: Example of using the PV mnemonic**

**Note:** At the “Provider Narrative” prompt, if the narrative from the encounter form is identical to the text typed at the “Purpose of Visit” prompt to obtain the ICD code, then type an equal sign (=) to duplicate the text typed in at the Purpose of Visit prompt. This will save keystrokes.

If the diagnosis is an injury, several different prompts will appear requesting specific information about the injury. It is very important that these fields get completed in order to maintain records and generate statistical reports on accidents in the user’s area. The three additional prompts that display are as follows:

- “Cause of Injury”
- “Place of Accident”
- “Date of Injury”
The Cause of Injury field allows an E code to be recorded for the visit. Data for each of these items should be recorded on the encounter form by the provider and then typed into the system by data entry staff using the PV mnemonic.

If the diagnosis is an injury, the PV mnemonic will prompt for three E Code fields and for an entry of First Visit or Revisit. When modifying (MOD) any diagnosis, these prompts will always display so they can be deleted, if appropriate.

For the “Place of Accident” prompt, choose from the following table.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Home–Inside</td>
</tr>
<tr>
<td>B</td>
<td>Home–Outside</td>
</tr>
<tr>
<td>C</td>
<td>Farm</td>
</tr>
<tr>
<td>D</td>
<td>School</td>
</tr>
<tr>
<td>E</td>
<td>Industrial Premises</td>
</tr>
<tr>
<td>F</td>
<td>Recreational Area</td>
</tr>
<tr>
<td>G</td>
<td>Street/Highway</td>
</tr>
<tr>
<td>H</td>
<td>Public Building</td>
</tr>
<tr>
<td>I</td>
<td>Resident Institution</td>
</tr>
<tr>
<td>J</td>
<td>Hunting/Fishing</td>
</tr>
<tr>
<td>K</td>
<td>Other</td>
</tr>
<tr>
<td>L</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

An example of an injury-related visit follows. Notice the use of the equal sign (=) at the “Provider Narrative” prompt to duplicate the text used at the “Purpose of Visit” prompt.

```
MNEMONIC: PV Purpose of Visit ALLOWED VISIT-RELATED-ONLY
Enter PURPOSE of VISIT: LACERATION HAND
882.0 (OPEN WOUND OF HAND)
OPEN WOUND OF HAND EXCEPT FINGERS ALONE, WITHOUT MENTION OF COMPLICATION
  OK? Y//
PROVIDER NARRATIVE: = LACERATION HAND
MODIFIER:
CAUSE OF INJURY: DOG BITE( BITE/BITEMPORAL/BITES DOG )
E906.0 (DOG BITE) DOG BITE
  OK? Y//
PLACE OF ACCIDENT: B HOME-OUTSIDE
DATE OF INJURY: T (JUN 13, 1998)
FIRST/REVISIT:
CAUSE OF DX:
ENCOUNTER PROVIDER:
Enter PURPOSE of VISIT:
```

Figure 3-160: Example of using the PV mnemonic
3.5.169 Radiology (RAD)

Use the Radiology (RAD) mnemonic to enter radiology procedures into the system for visit-related-only encounters. The impression and an indication of whether or not the result is normal/abnormal can be recorded. It is recommended that radiology staff enter this data to ensure that the procedures and impressions are input accurately. This mnemonic should not be used if the radiology package is operational at the user’s facility.

```
MNEMONIC: RAD  Radiology  ALLOWED  VISIT-RELATED-ONLY
Enter Radiology Procedure: MAMMOGRAM BILATERAL(BILATERAL MAMMOGRAM )
76091 (76091)
   MAMMOGRAM, BOTH BREASTS
MAMMOGRAPHY; BILATERAL
   OK? Y// ES MAMMOGRAM BILAT
(Detailed) CPT:76091
IMPRESSION: NORMAL
ABNORMAL: N NORMAL
```

Figure 3-161: Example of using the RAD mnemonic

3.5.170 Refusal for Service (REF)

Use the Refusal for Service (REF) mnemonic to document the service that the patient refused for non-visit- or visit-related encounters.

```
MNEMONIC: REF  Refusal for Service  ALLOWED  NON-VISIT/VISIT MNEMONIC
Select PATIENT REFUSALS FOR SERVICE/NMI SERVICE TYPE: EXAM
Enter the EXAM value: PELVIC EXAM  15
DATE DECLINED/NOT INDICATED: T-2
PROVIDER WHO DOCUMENTED: SIGMA,JOHN
COMMENT:
```

Figure 3-162: Example of using the REF mnemonic

3.5.171 Add Patient to a Register (REG)

This mnemonic is not used by all sites.

3.5.172 Reproductive Factors (RF)

Use the Reproductive Factors (RF) mnemonic to enter reproductive factors for a female patient for non-visit or visit-related encounters. The following fields are available for data entry:

- Total # Pregnancies
- Full Term Births
- Premature Births
- Abortions, #Induced
- Abortions,, #Spontaneous
• Ectopic Pregnancies
• Multiple Births
• Living Children
• DES Daughter?
• Age at First Menses
• Age at First Vaginal Intercourse
• Age at Onset of Menopause

<table>
<thead>
<tr>
<th>MNEMONIC: RF Reproductive Factors ALLOWED NON-VISIT/VISIT MNEMONIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL # PREGNANCIES:</td>
</tr>
<tr>
<td>FULL TERM BIRTHS:</td>
</tr>
<tr>
<td>PREMATURE BIRTHS:</td>
</tr>
<tr>
<td>ABORTIONS, # INDUCED:</td>
</tr>
<tr>
<td>ABORTIONS, # SPONTANEOUS:</td>
</tr>
<tr>
<td>ECTOPIC PREGNANCIES: MULTIPLE BIRTHS:</td>
</tr>
<tr>
<td>LIVING CHILDREN:</td>
</tr>
<tr>
<td>DES DAUGHTER?:</td>
</tr>
<tr>
<td>AGE at FIRST MENSES:</td>
</tr>
<tr>
<td>AGE at FIRST VAGINAL INTERCOURSE:</td>
</tr>
<tr>
<td>AGE at ONSET of MENOPAUSE:</td>
</tr>
</tbody>
</table>

Figure 3-163: Example of using the RF mnemonic

3.5.173 Remove Note Narrative (RNO)

When a provider indicates on the encounter form that a problem note should be removed, use the RNO mnemonic (for non-visit- or visit-related encounters). Notes are linked to problems and must be clearly identified by number in the top section of the Encounter Form under “Problem List Update - Remove” before a delete is performed by the data entry operator. The provider uses the patient’s Health Summary to identify the entire problem number and note to be deleted; for example, SX1SX1. For reference, the patient’s Problem List displays prior to deletion of the note.

The PO mnemonic prompts for the provider who added the problem list update and the date the update was made. This enables the creation of a V Updated/Reviewed entry with a clinical action of Problem List Updated.

<table>
<thead>
<tr>
<th>MNEMONIC: RNO Remove Note from Problem ALLOWED NON-VISIT/VISIT MNE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem List Reviewed On:</td>
</tr>
<tr>
<td>Problem List Updated On:</td>
</tr>
<tr>
<td>No Active Problems Documented On:</td>
</tr>
</tbody>
</table>

*************** ACTIVE PROBLEMS AND NOTES ***********************

CI1      11/02/2010 TESTING PROBLEM NOTES (ONSET: 11/02/2010)
CI2      11/02/2010 NONE (ONSET: 11/02/2010)
CI3      11/02/2010 TESTING
CI3CI1    11/02/2010 TEST
CI4      11/02/2010 TESTING PO (ONSET: 11/02/2010)
3.5.174 VA Mobile Clinic REFER OUPT (RO)

This mnemonic is not used by all sites.

3.5.175 Remove Problem Entry (RPO)

Use the Remove Problem Entry (RPO) mnemonic when a provider indicates that an active or inactive problem is to be removed from the patient’s Problem List for non-visit- or visit-related encounters. The provider must write the entire problem number from the Health Summary in the “Remove” box under the Problem List Update section at the top of the encounter form.

The PO mnemonic prompts for the provider who added the problem list update and the date the update was made. This enables the creation of a V Updated/Reviewed entry with a clinical action of Problem List Updated.
3.5.176 Respiration (RS)

Use the Respiration (RS) mnemonic to record the patient’s respiration rate for visit-related-only encounters. The value entered must be in the range 8 to 90.

MNEMONIC: RS  Respiration  ALLOWED  VISIT-RELATED-ONLY
VALUE: 40

Figure 3-166: Example of using the RS mnemonic

3.5.177 Medications (RX)

Use the Medications (RX) mnemonic to record medications dispensed only if the Pharmacy module is not in use at the user’s facility (for visit-related-only encounters). The provider notes the prescription name, SIG, quantity, and days under the Medications section on the lower portion of the encounter form. Medications display in the Adult Regular Health Summary.

MNEMONIC: RX  Medications  ALLOWED  VISIT-RELATED-ONLY
Select V MEDICATION: IBUPROFEN
1  IBUPROFEN 400MG TAB MS102
2  IBUPROFEN 400MG TAB U/D
3  IBUPROFEN 800MG TAB CHOOSE 1-3: 3
Outside Drug Name (OPTIONAL):
SIG: TAKE EVERY 6 HOURS FOR PAIN AS NEEDED
QUANTITY: 60
DAYS PRESCRIBED: 15
EVENT DATE&TIME:
ORDERING PROVIDER: SIGMA, JOHN PHYSICIAN
IHS CLINIC: 01 GENERAL 01
ENCOUNTER PROVIDER:

Figure 3-167: Example of using RX mnemonic
3.5.178 Suicide Form Entry (SF)

Use the Suicide Form Entry (SF) mnemonic to enter information about a patient’s suicide attempt for non-visit or visit-related encounters. The data fields included are: Provider Completing The Form, Date Of Suicide Act, Local Case Number, Community, Employment Status, Relationship Status, Education Level, Suicidal Behavior, Location Of Act, Previous Attempts, Method, Substance Involved, Factor, Disposition, and Narrative.

Example of the SF mnemonic:

**MNEMONIC:** SF  Suicide Form Entry  ALLOWED NON-VISIT/VISIT MNEMONIC

Enter the Provider who completed the Form: SIGMA, JOHN //

Enter the DATE of the SUICIDE ACT: T (MAR 06, 2008)

Please note: If while entering the data from the suicide form you make a mistake, you can edit the field by '^' jumping to that field. For example: to go back to edit EMPLOYMENT STATUS after you have passed that field, type ^EMPLOY and you will be taken back to that field to edit it.

LOCAL CASE : 11

COMMUNITY WHERE ACT OCCURRED: SPRINGFIELD

EMPLOYMENT STATUS: UNEMPLOYED

RELATIONSHIP STATUS: SINGLE

EDUCATION LEVEL: HIGH SCHOOL GRADUATE/GED

SUICIDAL BEHAVIOR: ATTEMPT

LOCATION OF ACT: HOME HOME OR VICINITY

PREVIOUS ATTEMPTS: 1 1

Select METHOD: STABBING/LACERATION

Select FACTOR:

DISPOSITION: UNKNOWN UNK

NARRATIVE:

Figure 3-168: Example of using the SF mnemonic

3.5.179 History of Surgery (SHX)

Use the SHX mnemonic when a provider documents a past surgical procedure in the Purpose Of Visit section of the encounter form (for non-visit- or visit-related encounters). This mnemonic is used for historical procedures only. Type the provider’s narrative and date for the procedure. If the exact date is unknown, type the year the procedure was performed for an entry. These historical surgeries display in the Adult Regular Health Summary.

Example of the SHX mnemonic:

**MNEMONIC:** SHX  History of Surgery  ALLOWED NON-VISIT/VISIT MNEMONIC

01/31/97  APPENDECTOMY

Enter Date of Historical Procedure/Operation:  1986  (JAN 01, 1986@12:00)

TYPE: O//  OTHER
LOC. OF ENCOUNTER: 000198 SELLS OTHER TUCSON SELLS 98
OUTSIDE LOCATION:
Enter CPT CODE: SPLENECTOMY
The following matches were found:
1: 41.43 (PARTIAL SPLENECTOMY)
   PARTIAL SPLENECTOMY
2: 41.5 (TOTAL SPLENECTOMY)
TOTAL SPLENECTOMY
Select 1-2: 2
PROVIDER NARRATIVE: REMOVAL OF SPLEEN

Figure 3-169: Example of using the SHX mnemonic

3.5.180 Purpose of Visit with Stage Prompt (SPV)

The Purpose of Visit with Stage Prompt (SPV) mnemonic is identical to the PV mnemonic except that an additional prompt, “Stage,” is included (for visit-related-only encounters). The entry for Stage must be a number between zero and nine. No decimals are allowed. For more information on purpose of visit, see the description of the PV mnemonic. The mnemonic applies to visit-related-only encounters.

MNEMONIC: SPV  POV with Stage Prompted  ALLOWED VISIT-RELATED-ONLY Enter PURPOSE of VISIT: MALIGNANT NEOPLASM OF ENDOCERVIX ( ENDOCERVIX MALIGNANT NEOPLASMS/NEOPLASMS )
The following word was not used in this search: OF
180.0 (MALIG NEO ENDOCERVIX) MALIGNANT NEOPLASM OF ENDOCERVIX
OK? Y/
   PROVIDER NARRATIVE: =
Enter the STAGE: 6
MODIFIER:
CAUSE OF DX:
Enter PURPOSE of VISIT:

Figure 3-170: Example of using the SPV mnemonic

If the diagnosis is an injury, the SPV mnemonic will prompt for three E Code fields and for an entry of First Visit or Revisit. When modifying any diagnosis (MOD), these prompts will always display so they can be deleted, if appropriate.

3.5.181 VA Mobile Clinic Refer Spec (SR)

This mnemonic is not used by all sites.
3.5.182 Skin Test (ST)

Use the Skin Test (ST) mnemonic to type skin tests reading(s) and results for visit-related-only encounters. A reading and/or results is required before an entry is made. Provider initials do not indicate a reading or results. To record only that a skin test was placed, use the STP mnemonic. The PPD readings and/or results are written on the last line of the Orders/Initials column. All other skin tests are written on the last line of the Medications/Treatments Procedures/Patient Education section.

At the “Reading” prompt, the value typed must be in the 0 to 40 range. Select from choices in the following table for an entry at the “Results” prompt.

<table>
<thead>
<tr>
<th>Result</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Positive</td>
</tr>
<tr>
<td>N</td>
<td>Negative</td>
</tr>
<tr>
<td>D</td>
<td>Doubtful</td>
</tr>
<tr>
<td>O</td>
<td>No Take</td>
</tr>
</tbody>
</table>

The following shows using the ST mnemonic:

```
MNEMONIC: ST  Skin Test  ALLOWED VISIT-RELATED-ONLY
Enter SKIN TEST Type: PPD 21
READING: 0
RESULTS: N  NEGATIVE
DATE READ: Jun 16, 1997//  (JUN 16, 1997)
```

Figure 3-171: Example of using the ST mnemonic

3.5.183 Stage in Purpose of Visit (STG)

Use the Stage in Purpose of Visit (STG) mnemonic to record the stage only for a Purpose Of Visit (for visit-related-only encounters). After typing the STG mnemonic, all purposes of visit typed display. In the case of multiple purposes for a single visit, type the stage for only one purpose of visit at a time. At the “Stage” prompt, type a number between zero and nine.

**Note:** Decimals are not allowed.

```
MNEMONIC: STG  Stage in Purpose of Visit  ALLOWED VISIT-RELATED-ONLY
1  174.3  SIGMA,JANE  JUN 23,2007@09:00
STAGE: 4
```

Figure 3-172: Example of using the STG mnemonic

3.5.184 Station (Pregnancy) (STN)

Use the Station (STN) mnemonic to type the station measurement for a pregnancy for visit-related-only encounters. The value typed must be between negative six and four.
3.5.185 Skin Test Placed (No Reading) (STP)

Use the Skin Test Placed (STP) mnemonic to record that a skin test was placed during a visit (for visit-related-only encounters). No results or reading are typed when using this mnemonic. Choose from the following skin test types:

- Cocci
- Mono-Vac
- PPD
- Schick
- Tine

3.5.186 Type of Appointment (S/M/L) (TA)

Use the Type of Appointment (TA) mnemonic to type whether the patient’s appointment was Short, Medium, or Long (for visit-related-only encounters).

3.5.187 Chargemaster Transaction Code (TC)

Use the TC mnemonic to enter one or more Chargemaster Transaction Codes from a Superbill or other form of billing document (for visit-related-only encounters). A Chargemaster Transaction File must be loaded at the user’s site in order use this mnemonic.
3.5.188 Type of Decision Making (TD)

The type of decision making is recorded primarily for public health nursing visits (for visit-related-only encounters). The prompt displays when using the PHN mnemonic. To record only the type of decision making, use the TD mnemonic. The entry choices are the following:

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Straightforward</td>
</tr>
<tr>
<td>L</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>M</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>H</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

The following shows using the TD mnemonic:

MNEMONIC: TD Type of Decision Making ALLOWED VISIT-RELATED-ONLY
LEVEL OF DECISION MAKING: S STRAIGHTFORWARD

Figure 3-177: Example of using the TD mnemonic

3.5.189 Chargemaster Transaction Code with Enc Prov (TE)

Use the TE mnemonic to enter one or more Chargemaster Transaction Codes, including the identification of the Ordering Provider, from a Superbill or other form of billing document for visit-related-only encounters. A Chargemaster Transaction File must be loaded at the user’s site in order to use this mnemonic.

MNEMONIC: TE Chargemaster TC with Enc Prov ALLOWED VISIT-RELATED-ONLY
Enter (TE) TRANSACTION CODE: 26000800 IPECAC ADMINISTRATION
EVENT DATE AND TIME: T-1 (NOV 28, 1998)
ENCOUNTER PROVIDER: GM SIGMA, JANE

Figure 3-178: Example of using the TE mnemonic

3.5.190 Time of Visit (TM)

Use the Time of Visit (TM) mnemonic to correct a visit time for visit-related-only encounters. Time is a required entry for a patient visit and is typed at the “Time of Visit” prompt when a visit is created. If the user has entered an incorrect time, use TM to make the change.

MNEMONIC: TM Time of Visit ALLOWED VISIT-RELATED-ONLY
Enter new time: 1130/1145
Now changing time... (JUN 16, 1997@11:45)

Figure 3-179: Example of using the TM mnemonic
3.5.191 Temperature (TMP)

Use the Temperature (TMP) mnemonic to type the patient’s temperature at the time of the visit for visit-related-only encounters. The value is entered in degrees Fahrenheit and must be in the 70 to 120 range. The patient’s temperature will not display in the Adult Regular Health Summary, but can be selected to display in a locally defined custom Health Summary.

Mnemonic: TMP Temperature Allowed Visit-Related-Only
Value: 99.3

Figure 3-180: Example of using TMP mnemonic

3.5.192 Tonometry (TON)

Use the Tonometry (TON) mnemonic to record the intraocular tension of a patient’s eyes for visit-related-only encounters. Tonometry is rarely entered into the system because only facilities with an optometrist use this data. The tonometry reading is recorded in the Medications/Treatments/Procedures/Patient Education section of the encounter form. The reading is entered with the right eye measurement first, followed by a slash, and then the reading for the left eye, as shown in the following example. The values must be between 0 and 80.

Mnemonic: TON Tonometry Allowed Visit-Related-Only
Value: 20/21

Figure 3-181: Example of using TON mnemonic

3.5.193 Treatments Provided (TP)

This optional data item is located in the Medications/Treatments/Procedures/Patient Education section of the ENCOUNTER FORM. The treatment provided is recorded on the form with a three-digit code for visit-related-only encounters. Because this section of the encounter form is used for multiple purposes, providers must indicate “TP” next to the code for the treatment to be captured; for example, TP 906. Because the PCC requires this data to be entered as a six-digit code, three zeroes must precede the three-digit code; in the example above, 000906 would be typed. Treatments provided are primarily used by CHNs. Each facility is responsible for establishing and maintaining this list of codes for treatments provided (for visit-related-only encounters).

Mnemonic: TP Treatments Provided Allowed Visit-Related-Only Enter Treatment Type: RA-PAIN MANAGEMENT 000918 1
How many: 1 //
Provider: JS SIGMA, JANE REGISTERED NURSE IHS

Figure 3-182: Example of using the TP mnemonic
3.5.194 Treatment Contracts (TRC)

Use the Treatment Contracts (TRC) mnemonic to enter a new mental health (M) or pain (P) contract and the date for visit-related-only encounters. The user can also enter a new V Treatment Contract. This is the entry in the Exam file that represents which type of exam was done at the encounter (for visit-related-only encounters).

```
MNEMONIC: TRC  Treatment Contracts  ALLOWED  VISIT-RELATED-ONLY
Enter TREATMENT CONTRACT Type: P (P  PAIN)
  DATE INITIATED: T (MAR 06, 2008)
  PROVIDER: SIGMA, JOHN
```

Figure 3-183: Example of using the TRC mnemonic

3.5.195 49 Urinalysis Order–No Results (UA)

Use the UA mnemonic to record the order for a urinalysis test for visit-related-only encounters. This mnemonic is used only if the Laboratory module is not in use at the user’s facility. The UA mnemonic should not be used unless the second box under the Orders/Initials on the encounter form is checked and initialed. The Adult Regular Health Summary contains a section called Most Recent Laboratory Data under which the UA test order displays.

```
MNEMONIC: UA  49 Urinalysis Ordered  ALLOWED  VISIT-RELATED-ONLY
```

Figure 3-184: Example of using UA mnemonic

3.5.196 Unable to Screen (UAS)

Use the Unable to Screen (UAS) mnemonic to document the service/NMI refusal type that the provider was not able to perform (for non-visit- or visit-related encounters).

```
MNEMONIC: UAS  Unable to Screen  ALLOWED  NON-VISIT/VISIT MNEMONIC
Select PATIENT REFUSALS FOR SERVICE/NMI REFUSAL TYPE: EXAM
Enter the EXAM value: 08 HEART EXAM 08
  DATE REFUSED/NOT INDICATED: T (MAR 06, 2008)
  PROVIDER WHO DOCUMENTED: SIGMA, JOHN
  COMMENT:
```

Figure 3-185: Example of using the UAS mnemonic

3.5.197 Underlying Cause of Death (UCD)

Use the Underlying Cause of Death (UCD) mnemonic to capture the underlying cause of death of a patient for non-visit- or visit-related encounters. At the prompt, enter the narrative for lookup, as shown below, or the ICD diagnostic code, if known.

```
MNEMONIC: UCD  Underlying Cause of Death  ALLOWED  NON-VISIT/VISIT MNEMONIC
```

Data Entry Mnemonics
October 2014
UNDERLYING CAUSE OF DEATH: RENAL FAILURE
586. (RENAL FAILURE NOS) RENAL FAILURE, UNSPECIFIED
OK? Y//

Figure 3-186: Example of using the UCD mnemonic

3.5.198 Auditory Evoked Potential Exam (UNH)

Use the Auditory Evoked Potential Exam (UNH) mnemonic to type data related to potential exam (for visit-related-only encounters).

3.5.199 Uncoded Procedure (UOP)

Use the Uncoded Procedure (UOP) mnemonic to enter an uncoded procedure for visit-related-only encounters. The provider narrative, operating provider, and diagnosis will be entered with this mnemonic.

MNEMONIC: UOP Uncoded Procedure ALLOWED VISIT-RELATED-ONLY
Entering Uncoded Procedure, please enter a narrative describing the PROCEDURE
PROVIDER NARRATIVE: SUTURE LACERATION OF RIGHT UPPER ARM
OPERATING PROVIDER: JCS SIGMA, JANE PHYSICIAN IHS JAS 100JCS
DIAGNOSIS: 880.03 880.03 OPEN WOUND OF UPPER ARM
...OK? Yes// (Yes)
Enter another Uncoded PROCEDURE? No// (No)

Figure 3-187: Example of using the UOP mnemonic

3.5.200 Uncoded Purpose of Visit (UPV)

Use the Uncoded Purpose of Visit (UPV) mnemonic to enter an uncoded Purpose Of Visit for visit-related-only encounters. The user is prompted for provider narrative, modifier, and cause of diagnosis. Multiple Purposes Of Visit can be entered for a single visit.

MNEMONIC: UPV Uncoded Purpose of Visits ALLOWED VISIT-RELATED-ONLY
PROVIDER NARRATIVE: RECURRENT BLEEDING ULCER
MODIFIER: CAUSE OF DX:
Enter another Diagnosis/POV? No// (No)

Figure 3-188: Example of using UPV mnemonic
3.5.201 Vision Corrected (VC)

Use the Vision Corrected (VC) mnemonic to enter vision data located in the Vision Corrected box on the right column of the encounter form (for visit-related-only encounters). This box is divided into a R (Right) and L (Left) eye reading. Usually two numbers are entered in each half; for example, 20/30 and 20/40. Only the second number (denominator) in each half of the box is picked up and combined for one entry into the system; for example, 30/40 would be entered for the previous example.

If one of the boxes on the form does not contain a reading, type only one value. To type the reading for the right eye only, type the number without a slash: 30. To type the left eye only, type a slash followed by the reading: /40. The values must be between 10 and 999. The numerator can differ from the assumed value of 20. If so, the second prompt “Numerator on VC/VU” allows the user to change the numerator value.

| MNEMONIC: VC  Vision Corrected ALLOWED VISIT-RELATED-ONLY VALUE: 40/50 NUMERATOR ON VC/VU: 20// |

Figure 3-189: Example of using the VC mnemonic

3.5.202 VA Mobile Clinic Visits Data (VR)

This mnemonic is not used by all sites.

3.5.203 Visit File Data Modify (VST)

Use the Visit File Data Modify (VST) mnemonic to correct the visit file (for visit-related-only encounters) after the visit is created and the mnemonic prompt has been reached. The data already entered displays as the default values for the prompts. To change any data previously entered, type the corrected information at the prompt, as shown in the example below.


Figure 3-190: Example of using the VST mnemonic

3.5.204 VA Mobile Clinic Visit Type

This mnemonic is not used by all sites.
3.5.205 Vision Uncorrected (VU)

Use the Vision Uncorrected (VU) mnemonic to enter the patient’s uncorrected vision measurement (which is found in the Vision-Uncorrected box on the right column of the encounter form). This box is divided into an R (Right) and L (Left) eye reading. Usually two numbers are entered in each half of the box; for example, 20/30 and 20/40. Only the second number (denominator) in each half of the box is picked up and combined as one entry; for example, 30/40 for the sample given above. This mnemonic applies to visit-related-only encounters.

It is assumed that the first number (numerator) is 20. In instances where the numerator is a number other than 20, enter the correct value at the “Numerator” prompt. If one box on the form does not have a reading, only the reading recorded is typed. If the reading is for the right eye only, enter the reading without the slash: 30. If the reading is for the left eye only, precede the value with the slash: /40.

Figure 3-191: Example of using the VU mnemonic

3.5.206 Waist Measurement (WC)

Use the Waist Measurement (WC) mnemonic to document the waist circumference for visit-related-only encounters.

Figure 3-192: Example of using the WC mnemonic

3.5.207 Well Child Exam (WCE)

Use the Well Child Exam (WCE) mnemonic to enter data about a well-child exam for visit-related-only encounters. The user can enter patient education data and data gathered during a general health screening, age-specific physical exam, special risk screening, and a behavioral health screening.

Figure 3-193: Example of using the WCE mnemonic
7 Screening exams
8 ASQ score
A ALL items
Q QUIT THIS MNEMONIC

Your choice: A//

CLINIC: GENERAL/> 

Provider: SIGMAH, JOHN PRIMARY/SECONDARY: PRIMARY/ Another provider:

*** WELL CHILD EXAM (V20.2) has been automatically added as a POV
***

Add additional POV's using the PV mnemonic

Want to enter Development or Autism screen comments? No//

Select from the list of standard patient education topics:
1. Set reasonable expectations
2. Know child's friends and their families
3. Ensure adequate sleep (bed by 8-9??)
4. Limit TV, computer, video time (2 hours a day)
5. Promote physical activity
6. Use belt-positioning booster seat in back seat
7. NEVER put booster seat in front seat with air bag
8. Reinforce home safety rules (matches, poisons, tools)
9. Provide safe after-school care
10. Teach stranger, neighborhood safety
11. Supervise tooth brushing
12. Answer questions, normal curiosity
13. Praise child, encourage talking about activities and feelings
14. Read interactively with child; listen as he reads aloud
15. Set appropriate limits, establish consequences

Select ITEMS by number: 2

1. Set reasonable expectations
2. Know child's friends and their families [SELECTED]
3. Ensure adequate sleep (bed by 8-9??)
4. Limit TV, computer, video time (2 hours a day)
5. Promote physical activity
6. Use belt-positioning booster seat in back seat
7. NEVER put booster seat in front seat with air bag
8. Reinforce home safety rules (matches, poisons, tools)
9. Provide safe after-school care
10. Teach stranger, neighborhood safety
11. Supervise tooth brushing
12. Answer questions, normal curiosity
13. Praise child, encourage talking about activities and feelings
14. Read interactively with child; listen as he reads aloud
15. Set appropriate limits, establish consequences

Want to make any additional changes? No//

Name of educator: SIGMA, JOHN

If possible, record the level of understanding and duration of patient education session

Select one of the following:
1 POOR
2 FAIR
3 GOOD
5 REFUSED

Level of understanding: 3 GOOD

Total patient education time (min): (1-100): 30

Was an Infant Feeding Choice recorded? No//

No nutrition topics are required for this visit!!
Select one of the following:

1. General health screening
2. Age-specific physical exam
3. Special risk screening
4. Behavioral health screening
   A. ALL OF ABOVE
   Q. QUIT ENTERING EXAMS

Your choice: 4 Behavioral health screening
No behavioral health screening exam items are available for this visit

Select EXAM TYPE
Select one of the following:

1. General health screening
2. Age-specific physical exam
3. Special risk screening
4. Behavioral health screening
   A. ALL OF ABOVE
   Q. QUIT ENTERING EXAMS

Your choice: 2 Age-specific physical exam

Select age-specific physical exam(s)
1. Teeth
2. Signs of possible abuse or neglect
Select ITEMS by number: 2
1. Teeth
2. Signs of possible abuse or neglect [SELECTED]

Want to make any additional changes? No/

Signs of possible abuse or neglect
Exam result (N or A): N NORMAL

Select EXAM TYPE
Select one of the following:

1. General health screening
2. Age-specific physical exam
3. Special risk screening
4. Behavioral health screening
   A. ALL OF ABOVE
   Q. QUIT ENTERING EXAMS

Your choice: QUIT ENTERING EXAMS

No ASQ scores should be entered on this visit!!

Select one of the following:

1. Clinic
2. Provider
3. POV
4. Development/Autism Screen comments
5. Patient education
6. Nutrition
7. Screening exams
8. ASQ score
   A. ALL items
   Q. QUIT THIS MNEMONIC

Your choice: QUIT THIS MNEMONIC

Figure 3-193: Example of using the WCE mnemonic
3.5.208 Demographic and Visit Display (WHAT)

Use the WHAT mnemonic to view the current patient’s demographics and visit data already entered (for non-visit or visit-related encounters). This mnemonic is similar to DISP, but displays the data in a different format. No dependent entry count is provided with WHAT.

Mnemonic: WHAT Demographic and Visit Display

You are currently processing the following Patient Visit:
- Patient Name: SIGMA, JANE
- Date of Birth: AUG 21, 1976
- Sex: F
- Visit Date: JUN 23, 2007@08:00:00
- Location: DEMO HOSPITAL/CLINIC
- Type: I
- Service Category: A
- Clinic: GENERAL

=============== MEASUREMENT's ===============
- Type: TMP  Value: 101.2
- Type: BP  Value: 120/30

=============== PROVIDER's ================
- Provider: SIGMA, JOHN  Primary/Secondary: PRIMARY
  - Event Date and Time: JUN 23, 2007@08:15
- Provider: SIGMA, JOHN  Primary/Secondary: SECONDARY
  - Event Date and Time: JUN 23, 2007@09:00

=============== POV's ================
- pov: 460. Provider Narrative: COLD WITH COUGH
- First/Revisit: REVISIT

Figure 3-194: Example of using the WHAT mnemonic

3.5.209 Information on Patient (WHO)

Use the Information on Patient (WHO) mnemonic to view information about the current patient (for non-visit or visit-related encounters). This mnemonic provides a quick way to verify the patient for whom the user is entering information and some brief visit items that have already been entered.

Mnemonic: WHO Information on Patient

You are currently processing the following Patient Visit:
- Patient Name: SIGMA, JANE
- Date of Birth: NOV 18, 1970
- Sex: F
- Visit Date: JUN 23, 2007@08:00
- Location: DEMO HOSPITAL/CLINIC
- Type: I
- Service Category: A
- Clinic: GENERAL

Figure 3-195: Example of using the WHO mnemonic

3.5.210 Weight (WT)

Use the Weight (WT) mnemonic to enter a patient’s weight in pounds and ounces (for visit-related-only encounters).
Note: Be sure that the provider has specified pounds as the unit of measure in the weight (WT) section of the encounter form before using this mnemonic.

The value entered must be in the range of 2 to 750 pounds. Ounces can be entered by leaving a space between the pounds and ounces; for example: 10 6 for 10 pounds 6 ounces. Fractions and decimals are allowed in multiples of 1/16 (.0625).

Figure 3-196: Example of using the WT mnemonic

3.5.211 Quick Out (XIT)

The XIT mnemonic allows the user to leave the data entry process from the “Mnemonic” prompt, regardless of whether the visit data entry is complete (for visit-related-only encounters). The user is prompted to determine whether the visit information entered so far is to be deleted or saved. Remember that exiting an incomplete visit will result in an error that must be corrected prior to the data transmission process. Two sample dialogs are shown below. In the first example, the visit is saved. The visit is deleted in the second example.

Saving the visit:

Figure 3-197: Example of saving a visit

Deleting a visit:

Figure 3-198: Example of deleting a visit
# Appendix A: Data Entry Mnemonics Grouped by Type

## Administrative Data

<table>
<thead>
<tr>
<th>Mnemonic</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT</td>
<td>Activity and Travel Time</td>
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<tr>
<td>ER</td>
<td>Emergency Visit Record</td>
</tr>
<tr>
<td>FL</td>
<td>Flag Field</td>
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<tr>
<td>HL</td>
<td>Hospital Location</td>
</tr>
<tr>
<td>IP</td>
<td>Inpatient</td>
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<tr>
<td>PHN</td>
<td>Public Health Nursing</td>
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</table>

## Billing/Chargemaster

<table>
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<tr>
<th>Mnemonic</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>CPE</td>
<td>CPT Codes with Entry of Encounter Provider</td>
</tr>
<tr>
<td>CPT</td>
<td>CPT Codes</td>
</tr>
<tr>
<td>DTC</td>
<td>Diagnostic Procedure Tran Code (Chargemaster)</td>
</tr>
<tr>
<td>EM</td>
<td>Evaluation and Management (CPT)</td>
</tr>
<tr>
<td>LS</td>
<td>Level of Service</td>
</tr>
<tr>
<td>PCPT</td>
<td>Procedure Entry (CPT)</td>
</tr>
<tr>
<td>TC</td>
<td>Tran Code (Chargemaster)</td>
</tr>
<tr>
<td>TD</td>
<td>Type of Decision Making</td>
</tr>
<tr>
<td>TE</td>
<td>Tran Code with Entry of Encounter Provider (Chargemaster)</td>
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## Contract Health Service

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<th>Meaning</th>
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<tbody>
<tr>
<td>CHH</td>
<td>CHS – Hospitalization Form</td>
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<tr>
<td>CHI</td>
<td>CHS – In-Hospital Form</td>
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## Data Entry Utilities

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<td>DHS</td>
<td>Display Health Summary</td>
</tr>
<tr>
<td>DISP</td>
<td>Visit Display</td>
</tr>
<tr>
<td>GHS</td>
<td>Generate Health Summary</td>
</tr>
<tr>
<td>MOD</td>
<td>Switch to Modify Mode</td>
</tr>
<tr>
<td>PCF</td>
<td>PCC+ Form</td>
</tr>
<tr>
<td>VST</td>
<td>Modify Visit File Information</td>
</tr>
<tr>
<td>WHAT</td>
<td>Demographic and Visit Display</td>
</tr>
<tr>
<td>WHO</td>
<td>Information on Patient</td>
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<td>XIT</td>
<td>Quick Out</td>
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## Diagnosis/Purpose of Visit

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<thead>
<tr>
<th>Mnemonic</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>ECOD</td>
<td>Append an E-Code to a Purpose of Visit</td>
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<tr>
<td>IPV</td>
<td>ICD Narrative Purpose of Visit</td>
</tr>
<tr>
<td>PV</td>
<td>Purpose of Visit</td>
</tr>
<tr>
<td>SPV</td>
<td>Purpose of Visit with Stage Prompt</td>
</tr>
<tr>
<td>STG</td>
<td>Stage in Purpose of Visit</td>
</tr>
<tr>
<td>UPV</td>
<td>Uncoded Purpose of Visit</td>
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## Historical Data

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<td>HCOL</td>
<td>Historical Colonoscopy</td>
</tr>
<tr>
<td>HCPT</td>
<td>Historical CPT</td>
</tr>
<tr>
<td>HFOB</td>
<td>Historical FOBT (GUAIAC)</td>
</tr>
<tr>
<td>HHF</td>
<td>Historical Health Factor</td>
</tr>
<tr>
<td>HSEV</td>
<td>Historical Asthma Severity</td>
</tr>
<tr>
<td>HSIG</td>
<td>Historical Sigmoidoscopy</td>
</tr>
<tr>
<td>HEKG</td>
<td>Historical EKG</td>
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<td>HEX</td>
<td>Historical Examination</td>
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<td>HIM</td>
<td>Historical Immunizations</td>
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<tr>
<td>HHCT</td>
<td>Historical Hematocrit</td>
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<tr>
<td>HLAB</td>
<td>Historical Lab Test</td>
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<td>HMSR</td>
<td>Historical Measurement</td>
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<td>HPAP</td>
<td>Historical Pap Smear</td>
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<td>HRAD</td>
<td>Historical Radiology</td>
</tr>
<tr>
<td>HRX</td>
<td>Historical Prescription</td>
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<tr>
<td>HS</td>
<td>Historical Skin Test</td>
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<td>HUA</td>
<td>Historical UA</td>
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## Immunization/Skin Tests

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<tr>
<td>IM</td>
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<tr>
<td>ST</td>
<td>Skin Test</td>
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<tr>
<td>STP</td>
<td>Skin Test Placed</td>
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## Laboratory

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<td>Historical Blood Sugar Entry</td>
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<tr>
<td>HCBC</td>
<td>Historical CBC Entry</td>
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<tr>
<td>Mnemonic</td>
<td>Meaning</td>
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<tr>
<td>----------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>HCT</td>
<td>Hematocrit Ordered</td>
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<tr>
<td>LAB</td>
<td>Lab Test Entry</td>
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<tr>
<td>PAP</td>
<td>Pap Smear Ordered</td>
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<tr>
<td>UA</td>
<td>Urinalysis Order–No Results</td>
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<tr>
<td>IM</td>
<td>Immunization</td>
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<td>AUD</td>
<td>Audiometry</td>
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<tr>
<td>BM</td>
<td>Birth Measurement</td>
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<td>Blood Pressure</td>
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<td>BMI</td>
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<td>BMIP</td>
<td>BMI Percentile</td>
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<td>BPF</td>
<td>Best Peak Flow</td>
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<tr>
<td>CDR</td>
<td>Cup to Disc Ratio</td>
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<tr>
<td>CHC</td>
<td>Centimeter Head Circumference</td>
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<td>CHT</td>
<td>Centimeter Height</td>
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<td>EGA</td>
<td>Estimated Gestational Age</td>
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<td>FEV1 %</td>
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<td>FVC</td>
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<td>FVCP</td>
<td>Forced Vital Capacity - %</td>
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<td>Head Circumference</td>
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<td>HT</td>
<td>Height</td>
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<td>Measurement Entry</td>
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<tr>
<td>MME</td>
<td>Mini-Mental Status Exam</td>
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<td>NSST</td>
<td>NIH Stroke Scale Total</td>
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<td>O2</td>
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<td>Peak Flow</td>
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<td>TON</td>
<td>Tonometry</td>
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<td>Vision Uncorrected</td>
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### Medication

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<td>Medications</td>
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<tr>
<td>MLR</td>
<td>Medication List Review</td>
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<td>NAM</td>
<td>No Active Medications</td>
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### Operation/Procedure

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<tr>
<td>AOP</td>
<td>Anesthesia Operation</td>
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<td>IOP</td>
<td>ICD Operation Narrative</td>
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<td>OP</td>
<td>Operations</td>
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### Other Clinical Data

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<td>ADM</td>
<td>Asthma Work/School Days Missed</td>
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<td>ALG</td>
<td>Allergy Tracking Entry</td>
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<td>ASEV</td>
<td>Asthma Severity</td>
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<td>ASFD</td>
<td>Asthma Symptom-Free Days</td>
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<td>CC</td>
<td>Chief Complaint</td>
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<td>CEF</td>
<td>Cardiac Ejection Fraction</td>
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<tr>
<td>COC</td>
<td>Coded Chief Complaint</td>
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<td>DC</td>
<td>Disposition of Care</td>
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<td>DRG</td>
<td>DRG</td>
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<tr>
<td>DDS</td>
<td>Dental – Direct Services</td>
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<td>EL</td>
<td>Elder Care</td>
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<tr>
<td>EKG</td>
<td>EKG Diagnostic Procedure</td>
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<td>GP</td>
<td>Eyeglass Prescription</td>
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<td>IF</td>
<td>Infant Feeding Choices</td>
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<tr>
<td>NT</td>
<td>Narrative Text</td>
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<td>LOC</td>
<td>Level of Care</td>
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<td>NRF</td>
<td>No Response to Followup</td>
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<td>OVR</td>
<td>Health Reminder Override</td>
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<td>PA</td>
<td>Pain</td>
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<td>PED</td>
<td>Patient Education</td>
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<td>PT</td>
<td>Physical Therapy</td>
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<td>PTG</td>
<td>Patient Goals</td>
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<tr>
<td>RAD</td>
<td>Radiology</td>
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<td>REF</td>
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### Mnemonic Grouped by Type

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<th>Meaning</th>
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<tr>
<td>TP</td>
<td>Treatments Provided</td>
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<tr>
<td>TRC</td>
<td>Treatment Contracts</td>
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<tr>
<td>UAS</td>
<td>Unable to Screen</td>
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<tr>
<td>UNH</td>
<td>Auditory Evoked Potential Exam</td>
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#### Patient Related

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<tr>
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<td>AUDIT</td>
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<td>Blood Type Entry</td>
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<td>Future Scheduled Encounter</td>
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<td>RF</td>
<td>Reproductive Factors</td>
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<td>SF</td>
<td>Suicide Form Entry</td>
</tr>
<tr>
<td>SHX</td>
<td>History of Surgery</td>
</tr>
<tr>
<td>UCD</td>
<td>Underlying Cause of Death</td>
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#### Prenatal

<table>
<thead>
<tr>
<th>Mnemonic</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>CXD</td>
<td>Cervix Dilation</td>
</tr>
<tr>
<td>ED</td>
<td>Edema Measurement</td>
</tr>
<tr>
<td>EDD</td>
<td>Expected Date of Delivery</td>
</tr>
<tr>
<td>EFF</td>
<td>Effacement</td>
</tr>
<tr>
<td>FH</td>
<td>Fundal Height</td>
</tr>
<tr>
<td>FT</td>
<td>Fetal Heart Tones</td>
</tr>
<tr>
<td>LMP</td>
<td>Last Menstrual Period</td>
</tr>
<tr>
<td>PR</td>
<td>Presentation (Pregnancy)</td>
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<tr>
<td>STN</td>
<td>Station (Pregnancy)</td>
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Problem List

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<tr>
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<tr>
<td>IPO</td>
<td>Inactivate Problem</td>
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<tr>
<td>MNN</td>
<td>Modify Note Narrative</td>
</tr>
<tr>
<td>MPO</td>
<td>Modify Problem Narrative</td>
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<tr>
<td>NAP</td>
<td>No Active Problems</td>
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<tr>
<td>NO</td>
<td>Note</td>
</tr>
<tr>
<td>PL</td>
<td>Problem List Update Menu</td>
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<tr>
<td>PLR</td>
<td>Problem List Reviewed</td>
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<tr>
<td>PO</td>
<td>Problem Only</td>
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<tr>
<td>PPV</td>
<td>POV and Problem Entry</td>
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<tr>
<td>RNO</td>
<td>Remove Note Narrative</td>
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<tr>
<td>RPO</td>
<td>Remove Problem Entry</td>
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Visit-related data

<table>
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<td>OLOC</td>
<td>Outside Location</td>
</tr>
<tr>
<td>PRV</td>
<td>Providers (Primary/Secondary)</td>
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<td>TM</td>
<td>Time of Visit</td>
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Waiting-time studies

<table>
<thead>
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<tr>
<td>AL</td>
<td>Appointment Length</td>
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<tr>
<td>CKO</td>
<td>Check Out Date and Time</td>
</tr>
<tr>
<td>TA</td>
<td>Type of Appointment</td>
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</table>
Appendix B: Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is FOR OFFICIAL USE ONLY. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (RoB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general ROB for all users, see the most recent edition of IHS General User Security Handbook (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the IHS Technical and Managerial Handbook (SOP 06-11b).

Both documents are available at this IHS Web site: http://security.ihs.gov/.

The ROB listed in the following sections are specific to RPMS.

B.1 All RPMS Users

In addition to these rules, each application may include additional RoBs that may be defined within the documentation of that application (e.g., Dental, Pharmacy).

B.1.1 Access

RPMS users shall

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller’s identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or nonpublic agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions Indian Health Manual Part 8, “Information Resources Management,” Chapter 6, “Limited Personal Use of Information Technology Resources.”
RPMS users shall not

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

B.1.2 Information Accessibility

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

RPMS users shall

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the functions they perform, such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS polices and procedures prior to interconnection to or transferring data from RPMS.

B.1.3 Accountability

RPMS users shall

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their personal computers (PCs).
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.
• Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and information technology (IT) information processes.

B.1.4 Confidentiality

RPMS users shall

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

RPMS users shall not

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

B.1.5 Integrity

RPMS users shall

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

RPMS users shall not

• Violate federal copyright laws.
• Install or use unauthorized software within the system libraries or folders.
• Use freeware, shareware, or public domain software on/with the system without their manager’s written permission and without scanning it for viruses first.
B.1.6 System Logon

RPMS users shall

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

• Be granted access based on authenticating the account name and password entered.

• Be locked out of an account after five successive failed login attempts within a specified time period (e.g., one hour).

B.1.7 Passwords

RPMS users shall

• Change passwords a minimum of every 90 days.

• Create passwords with a minimum of eight characters.

• If the system allows, use a combination of alpha-numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.

• Change vendor-supplied passwords immediately.

• Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts or batch files).

• Change passwords immediately if password has been seen, guessed, or otherwise compromised, and report the compromise or suspected compromise to their ISSO.

• Keep user identifications (IDs) and passwords confidential.

RPMS users shall not

• Use common words found in any dictionary as a password.

• Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user’s name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).

• Share passwords/IDs with anyone or accept the use of another’s password/ID, even if offered.

• Reuse passwords. A new password must contain no more than five characters per eight characters from the previous password.

• Post passwords.

• Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.
• Give a password out over the phone.

B.1.8 Backups
RPMS users shall
• Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
• Make backups of systems and files on a regular, defined basis.
• If possible, store backups away from the system in a secure environment.

B.1.9 Reporting
RPMS users shall
• Contact and inform their ISSO that they have identified an IT security incident and begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
• Report security incidents as detailed in the *IHS Incident Handling Guide* (SOP 05-03).

RPMS users shall not
• Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

B.1.10 Session Timeouts
RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

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

B.1.11 Hardware
RPMS users shall
• Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
• Keep an inventory of all system equipment.
• Keep records of maintenance/repairs performed on system equipment. RPMS users shall not
• Eat or drink near system equipment.

B.1.12 Awareness
RPMS users shall
• Participate in organization-wide security training as required.
• Read and adhere to security information pertaining to system hardware and software.
• Take the annual information security awareness.
• Read all applicable RPMS manuals for the applications used in their jobs.

B.1.13 Remote Access
Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that
• Are in writing.
• Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
• Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
• Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, and intrusion detection, and provide physical security for government equipment and sensitive data.
• Establish mechanisms to back up data created and/or stored at alternate work locations.

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

Remote RPMS users shall not
• Disable any encryption established for network, internet, and Web browser communications.
B.2 RPMS Developers

RPMS developers shall

• Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.

• Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.

• Only access information or code within the namespaces for which they have been assigned as part of their duties.

• Remember that all RPMS code is the property of the U.S. Government, not the developer.

• Not access live production systems without obtaining appropriate written access, and shall only retain that access for the shortest period possible to accomplish the task that requires the access.

• Observe separation of duties policies and procedures to the fullest extent possible.

• Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer’s initials, date of change, and reason for the change.

• Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.

• Follow industry best standards for systems they are assigned to develop or maintain, and abide by all Department and Agency policies and procedures.

• Document and implement security processes whenever available.

RPMS developers shall not

• Write any code that adversely impacts RPMS, such as backdoor access, “Easter eggs,” time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.

• Grant any user or system administrator access to RPMS unless proper documentation is provided.

• Release any sensitive agency or patient information.
B.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators, have added responsibilities to ensure the secure operation of RPMS.

Privileged RPMS users shall

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, Chief Information Security Officer (CISO), and systems owner.
- Protect the supervisor, superuser, or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.
• Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords, and delete or reassign related active and backup files.

• Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.

• Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator’s database.

• Shall follow industry best standards for systems they are assigned to, and abide by all Department and Agency policies and procedures.

Privileged RPMS users shall not

• Access any files, records, systems, etc., that are not explicitly needed to perform their duties

• Grant any user or system administrator access to RPMS unless proper documentation is provided.

• Release any sensitive agency or patient information.
Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone:  (888) 830-7280 (toll free)
Web:  http://www.ihs.gov/helpdesk/
Email:  support@ihs.gov