



RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS PCC Suite

(BJPC)

Data Entry Mnemonics

Version 2.0 Patch 10
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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 Goal – 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.

```

MNEMONIC: ACPT Anesthesia CPT ALLOWED VISIT-RELATED-ONLY
Select V CPT: 42825 REMOVAL OF TONSILS
      TONSILLECTOMY, PRIMARY OR SECONDARY; YOUNGER THAN AGE 12
...OK? Yes// (Yes)
QUANTITY: 1
MODIFIER: MODIFIER 2:
ANESTHESIA ADMINISTERED?: Y//
ASA-PS CLASS: P1
  1 P1 HEALTHY PATIENT
  2 P1E HEALTHY PATIENT-EMERGENC
CHOOSE 1-2: 1 P1 HEALTHY PATIENT
ANESTHESIA START DATE/TIME: T@0800 (MAR 06, 2008@08:00:00)
ANESTHESIA STOP DATE/TIME: T@1000 (MAR 06, 2008@10:00:00)
ELAPSED TIME (ANESTHESIA): 120//
ANESTHESIOLOGIST: ETEST,JENNIFER J

```

Figure 3-3: Example of using the ACPT mnemonic

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:

```

MNEMONIC: ACTH ANTI-COAGULATION THERAPY ALLOWED VISIT RELATED ONLY
Select V ANTICOAGULATION WARFARIN INDICATED?: Y (YES) INR GOAL: ??

```

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:

```

Figure 3-4: Example of using the ACTH mnemonic

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.

```

MNEMONIC: ADA ADA Code Entry ALLOWED VISIT-RELATED-ONLY Select V DENTAL
SERVICE CODE: 7110 EXTRACTION, SIMPLE (ANY REASON)
NO. OF UNITS: 1
OPERATIVE SITE: 17 PERMANENT THIRD MOLAR,MAND LEFT 17

```

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
VALUE:
```

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
```

```
APPOINTMENT LENGTH: 30
```

Figure 3-10: Example of using the AL mnemonic

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                7. HIVES
  2. ITCHING,WATERING EYES  8. DRY MOUTH
  3. HYPOTENSION           9. ANAPHYLAXIS
  4. DROWSINESS            10. RASH
  5. NAUSEA,VOMITING       11. OTHER SIGN/SYMPTOM
  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:
  Signs/Symptoms                Date Observed
-----
  1 HIVES

Select Action (A)DD, (D)ELETE OR <RET>:
  Choose one of the following:
    A - ALLERGY
    P - PHARMACOLOGICAL
    U - UNKNOWN

MECHANISM: UNKNOWN// P PHARMACOLOGIC

COMMENTS:
  1>
  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
```

```

ORIGINATOR: DATA ENTRY   ORIGINATED: MAR 04, 2008@11:48
SIGN OFF: NO              OBS/HIST: HISTORICAL

ID BAND MARKED:          CHART MARKED:
SIGNS/SYMPTOMS: HIVES
Change status of this allergy/adverse reaction to verified? Y (Yes)

...updating Omnicell data base...
Enter another Causative Agent? YES// NO
This session you have CHOSEN:
    SULFAMETHOXAZOLE
Have the Chart(s) been marked for this CAUSATIVE AGENT? N (No)
CALL IRM AND HAVE USERS ASSIGNED TO THE GMRA MARK CHART MAIL GROUP

```

Figure 3-11: Example of using the ALG mnemonic

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.

```

MNEMONIC: ALR Allergy List Review ALLOWED VISIT RELATED ONLY

Did the Provider indicate that he/she Reviewed the Allergy List? (Y/N): Y
Allergy List Review Date/Time: Oct 26, 2010// (OCT 26, 2010)
Provider who Reviewed the the Allergy List: SMITH BTPROVIDER,WENDY C

```

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.

```

MNEMONIC: AOP Anesthesia Operation ALLOWED VISIT-RELATED-ONLY
Enter OPERATION/PROCEDURE: 28.3
  1 28.3 TONSILLECTOMY/ADENOIDEC TONSILLECTOMY WITH ADENOIDECTOMY
  2 28.31 TONSILLECTOMY W/ADENOIDECTOMY FOR MALIGNANCY
CHOOSE 1-2: 1 28.3 TONSILLECTOMY/ADENOIDEC TONSILLECTOMY
WITH ADENOIDECTOMY
PROVIDER NARRATIVE: TONSILLECTOMY TONSILLECTOMY

```

```

OPERATING PROVIDER: SIGMA,JOHN
DIAGNOSIS: 472.1 472.1 CHRONIC PHARYNGITIS
...OK? Yes//
ANESTHESIA ADMINISTERED: Y// YES
ASA-PS CLASS: P1
  1 P1 HEALTHY PATIENT
  2 P1E HEALTHY PATIENT-EMERGENCY
CHOOSE 1-2: 1 P1 HEALTHY PATIENT
ANESTHESIA START DATE/TIME: T@0800 (MAR 06, 2008@08:00:00)
ANESTHESIA STOP DATE/TIME: T@1000 (MAR 06, 2008@10:00:00)
ELAPSED TIME (ANESTHESIA): 120//
ANESTHESIOLOGIST: SIGMA,JANE
Enter OPERATION/PROCEDURE:

```

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 (APO) 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.

```

MNEMONIC: APO    Activate an Inactive Problem    ALLOWED
NON-VISIT/VISIT
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
***** INACTIVE PROBLEMS AND NOTES *****
  CI4    11/02/2010    TESTING PO (ONSET: 11/02/2010) Status: INACTIVE
  CI4CI1 11/02/2010    TEST

Enter Problem Number: CI4
Activating Problem CI4 ...
Enter the Date the Problem List was Updated by the Provider: Nov
02, 2010// (

```

```
NOV 02, 2010)
Enter the PROVIDER who Updated the Problem List: IWPROVIDER,MARY
ANNE
```

Figure 3-14: Example of using the AOP mnemonic

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.

```
MNEMONIC: APPT Appointment Date&Time ALLOWED VISIT-RELATED-ONLY
APPT DATE&TIME: MAY 31,1997@2:30
```

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.

```
MNEMONIC: ASFD Asthma Symptom Free Days ALLOWED VISIT-RELATED- ONLY
VALUE: 10
```

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.

```
MNEMONIC: AT Activity & Travel Time ALLOWED VISIT-RELATED-ONLY Enter
ACTIVITY TIME (in Minutes): 30
TRAVEL TIME (in minutes): 15
```

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.

```
MNEMONIC: AUD AUDIOMETRY VALUE:
100/100/100/95/90/90/85/80/105/105/105/105/100/100/95/90/
```

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.

```

MNEMONIC: BM Birth Measurement ALLOWED NON-VISIT/VISIT MNEMONIC
Patient Name: SMITH,JANE
BIRTH WEIGHT LBS: 6
BIRTH WEIGHT OZS: 10
APGAR 1 MINUTE: 1
APGAR 5 MINUTE: 2
GESTATIONAL AGE WKS: 34
DELIVERY TYPE: C
COMPLICATIONS: NONE
BW GRAMS: 3005//
When entering Birth Length, use the following format:
  - to enter the value in inches, just enter the # of inches
  - to enter the value in centimeters type a C and the value,
    e.g. C55
BIRTH LENGTH: BIRTH ORDER:

MNEMONIC:

```

Figure 3-21: Example of using the BM mnemonic

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.

```
MNEMONIC: BS 11 BLOOD SUGAR ORDERED
```

Figure 3-24: Example of using the BS mnemonic

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-.

```
MNEMONIC: BT BLOOD TYPE ENTRY
BLOOD TYPE: 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.

```
MNEMONIC: CBC CBC Ordered ALLOWED VISIT-RELATED-ONLY
```

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).

```
MNEMONIC: CC Chief Complaint ALLOWED VISIT-RELATED-ONLY
CHIEF COMPLAINT: SORE THROAT
```

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).

```
MNEMONIC: CEF Cardiac Ejection Fraction ALLOWED VISIT-RELATED- ONLY
VALUE: 10
```

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).

MNEMONIC: CHC Centimeter Head Circumference ALLOWED VISIT-RELATED- ONLY
VALUE: 35

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

<p>Note: After making entries for the CHA mnemonic, type the provider (PRV) and purpose of visit (PV) to complete this visit record.</p>

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.

```

MNEMONIC: CPE   Cpt Entry with Enc Pro  ALLOWED  VISIT-RELATED- ONLY
Enter CPT Code: 10140 DRAINAGE OF HEMATOMA/FLUID
                INCISION AND DRAINAGE OF HEMATOMA, SEROMA, OR FLUID COLLECTION
                ...OK? YES//  YES)
QUANTITY: 1
EVENT DATE AND TIME: T@345  (NOV 28, 1998@15:45:00)
ENCOUNTER PROVIDER: ACC  CURITIS,PATIENT  ACC

```

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.

```

MNEMONIC: CPT Enter CPT Code: TRANSPLANTATION OF KIDNEY
(KIDNEY/KIDNEYS/KIDNEYSKIN/KIDNEYURETER
TRANSPLANTATION/TRANSPLANTATIONS )

The following word was not used in this search: OF

```

```

The following 2 matches were found:

1: 50360 (50360)
TRANSPANTATION OF KIDNEY RENAL ALLOTRANSPLANTATION, IMPLANTATION OF
GRAFT; EXCLUDING DONOR AND RECIPIENT NEPHRECTOMY
2: 50365 (50365)
TRANSPANTATION 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.

```
MNEMONIC: CXD Cervix Dilatation ALLOWED VISIT-RELATED-ONLY
VALUE: 3
```

Figure 3-38: Example of using the CXD mnemonic

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.

```
MNEMONIC: CDR          CUP TO DISC RATIO      ALLOWED      VISIT RELATED ONLY
VALUE: .56
Select QUALIFIER: LEFT
      ...OK? Yes//   (Yes)

Select QUALIFIER: LEFT//
Select QUALIFIER:
Date/Time Vitals Taken:
Date/Time Vitals Taken: 10-11-13   (OCT 11, 2013)
Encounter Provider: DEMO,LISA M RN      DEM          PHYSICIAN
```

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.

```
MNEMONIC: DC Disposition of Care ALLOWED VISIT-RELATED-ONLY
DISPOSITION: ADMIT
```

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:
```

```

TOOTH SURFACE:
Select V DENTAL SERVICE CODE:
Now generating V POV entry!
DENTAL/ORAL HEALTH VISIT

```

Figure 3-41: Example of using the DDS mnemonic

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.

```

MNEMONIC: DHS Data Entry Health Summary ALLOWED NON-VISIT/VISIT

OUTPUT BROWSER          Jan 19, 2015 13:54:48          Page:    1 of    11
PCC Health Summary for DEMO,BERNADINE MARIA

***** CONFIDENTIAL PATIENT INFORMATION -- 1/19/2015  1:54 PM [st] *****
***** DEMO,BERNADINE MARIA #140558 <D>    (ADULT REGULAR SUMMARY)  pg 1 *****

----- DEMOGRAPHIC DATA -----

DEMO,BERNADINE MARIA          DOB: NOV 11,1992 22 YRS  FEMALE  no blood type
SANTA ROSA COMM, SANTA ROSA RANCH  SSN: XXX-XX-9580
                                MOTHER'S MAIDEN NAME: LEWIS,JULIA MOLINA
(H) 555-555-8023              FATHER'S NAME: DEMO,LARENZO JAMES

RIVERSIDE (P. O. BOX 414,ALB,NM,87119)

LAST UPDATED:  OCT 5,2007          ELIGIBILITY:  CHS & DIRECT

NOTICE OF PRIVACY PRACTICES REC'D BY PATIENT?  YES
                                DATE RECEIVED BY PATIENT:  Oct 05, 2007
                                WAS ACKNOWLEDGEMENT SIGNED?  YES

HEALTH RECORD NUMBERS:  140558  2013 DEMO HOSPITAL
                                140559  2013 DEMO-3 TRIBAL CLINIC
                                DESIGNATED PROVIDERS
                                DESIGNATED PRIMARY CARE PROVIDER:  EVANS,BARBARA A R N

----- ALLERGIES/ADVERSE REACTIONS (FROM ALLERGY TRACKING) -----

                                NO ALLERGY INFORMATION RECORDED

Allergy List Reviewed On:          By:
Allergy List Updated On:          By:
No Active Allergies Documented On:  By:

```

```

----- ALLERGIES (FROM PROBLEM LIST) -----

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

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

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:

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

          HT      WT      BP      BMI      %RW      VU      VC
12/11/08
10/18/07      218
*** 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:  By:

----- 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:  By:

----- 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:  By:

----- 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 day

----- 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 -----
                LAST          NEXT
BLOOD PRESSURE      12/11/08  12/11/10
HEIGHT              11/11/92
WEIGHT              10/18/07  10/17/08
PAP SMEAR          11/11/10
PELVIC EXAM        11/11/10
BREAST EXAM        11/11/12

IMMUNIZATIONS DUE * BICALL Error: -4;Cannot find, open, load Live Vaccine Table

PHYSICAL EXAM      11/11/10
TD-ADULT           11/11/04

ALCOHOL USE SCREENING 11/11/05
TOBACCO USE SCREENING 11/11/05

*** 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.

```

MNEMONIC: DISP Visit Display ALLOWED NON-VISIT/VISIT MNEMONIC

PCC VISIT DISPLAY Jun 18, 1997 08:22:21 Page 1 of 3

Patient Name: DEMO,BERNADINE MARIA
Chart : 140558
Date of Birth: NOV 11, 1992
Sex: F
===== VISIT FILE =====
VISIT/ADMIT DATE&TIME: DEC 11, 2008@12:00
DATE VISIT CREATED: JAN 26, 2009
TYPE: IHS
THIRD PARTY BILLED: VISIT DATE PRIOR TO BACKBILLING LIMIT
PATIENT NAME: DEMO,BERNADINE MARIA
LOC. OF ENCOUNTER: 2013 DEMO-3 TRIBAL CLINIC
SERVICE CATEGORY: AMBULATORY
CLINIC: GENERAL
DEPENDENT ENTRY COUNT: 12
DATE LAST MODIFIED: JAN 19, 2015
WALK IN/APPT: APPOINTMENT

```

```

EVALUATION AND MANAGE: 99212
HOSPITAL LOCATION:     SH CLINICS
CREATED BY USER:      DUPREE,BEVERLY
OPTION USED TO CREATE: PSO LM BACKDOOR ORDERS
PROTOCOL:             IHS PS HOOK
USER LAST UPDATE:     THETA,SHIRLEY
OLD/UNUSED UNIQUE VIS: 6064010001440284
ORIGINAL DATA ENTRY D: FEB 06, 2009
DATA WAREHOUSE EXPORT: FEB 09, 2009
DATE/TIME LAST MODIFI: JAN 19, 2015@11:51:02
CHART AUDIT STATUS:   REVIEWED/COMPLETE
NDW UNIQUE VISIT ID (: 163450001440284
WHERE SEEN SNOMED CT: 255327002
WHERE SEEN PREFERRED : Ambulatory
WHERE SEEN SNOMED CT: 440655000
WHERE SEEN PREFERRED : Outpatient environment
FACE TO FACE SNOMED C: 308335008
FACE TO FACE PREFERRE: Patient encounter procedure
VISIT ID:             162MH-PAH

+ Next screen   - Previous screen   Q  QUIT
Select Action: +//

```

Figure 3-43: Example of using the DISP mnemonic

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.)

```

MNEMONIC: DP Designated Provider ALLOWED NON-VISIT/VISIT MNEMONIC PERSONAL
PHYSICIAN: RBW WIRTH,ROBERT INTERNAL MEDICINE IHS RBW
171RBW

```

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).

```

MNEMONIC: DRG   DRG   ALLOWED   VISIT-RELATED-ONLY
DRG: DRG1

```

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.

```
MNEMONIC: DTC Diagnostic Procedure Tran Code ALLOWED VISIT-RELATED- ONLY
Enter (DTC) TRANSACTION CODE: 10100330 X-RAY, FOREARM, AP/LAT
ORDERING DATE: T-1 (NOV 28, 1998)
ORDERING PROVIDER: ACC CHI,CLAYTON ACC
```

Figure 3-46: Example of using the DTC mnemonic

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.

```
MNEMONIC: ECOD Append an E-Code to a POV ALLOWED VISIT-RELATED- ONLY
1 821.00 VON BRAUN,DON JUN 18,1997@12:00
Enter E-CODE: E818.0 E818.0 MV TRAFF ACC NEC-DRIVER
...OK? Yes// (Yes)
```

Figure 3-47: Example of using the ECOD mnemonic

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+.

```
MNEMONIC: ED EDEMA Measurement ALLOWED VISIT-RELATED-ONLY
```

```
VALUE: 1+
```

Figure 3-48: Example of using the ED mnemonic

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.

```
MNEMONIC: EDD Expected Date of Delivery ALLOWED NON-VISIT/VISIT
MNEMONIC
CURRENTLY PREGNANT?: Yes
PROVIDER WHO UPDATED CURRENTLY PREGNANT: Test, Provider
EDD (Method Unknown):
EDD (LMP):
EDD (ULTRASOUND): T+150 (APR 26, 2012)
PROVIDER WHO UPDATED EDD (ULTRASOUND): Test, Provider
EDD (ULTRASOUND) COMMENT:
EDD (CLINICAL PARAMETERS):
DEFINITIVE EDD:
```

Figure 3-49: Example of using the EDD mnemonic

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.

```
MNEMONIC: EFF Effacement ALLOWED VISIT-RELATED-ONLY
VALUE: 45
```

Figure 3-50: Example of using the EFF mnemonic

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.

```
MNEMONIC: EKG EKG Diagnostic Procedure ALLOWED VISIT-RELATED-ONLY
VALUE: NORMAL
```

Figure 3-51: Example of using the EKG mnemonic

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.

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

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.

```
MNEMONIC: EM Evaluation&Management (CPT) ALLOWED VISIT-RELATED-
ONLY EVALUATION AND MANAGEMENT CODE: 99201 OFFICE/OUTPATIENT
VISIT, NEW
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)
```

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.

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

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 s 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 - UNKNOWNR - 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      TK
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

          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: +//

```

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

```

```

D      DECEASED
U      UNKNOWN
R      PT REFUSED TO ANSWER
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:
APPROXIMATE AGE?: 35??
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)   430727006      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:
Contraceptive Method          Start Date      End Date
-----
1) EMERGENCY CONTRACEPTION    Oct 25, 2011
   Comment: NONE
2) MENOPAUSE                   Oct 25, 2011

Select one of the following:

A   ADD a new Contraceptive Method
E   Edit an Existing Contraceptive Method

```

```

D      Delete an Existing Contraceptive Method
Q      QUIT

Which action: Q// Q QUIT

MNEMONIC:

```

Figure 3-66: Example of using the FP mnemonic

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

```

Figure 3-67: Example of using the FT mnemonic

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

```

Figure 3-68: Example of using the FVFC mnemonic

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

```

MNEMONIC: F10R      FRAMINGHAM 10 YEAR RISK      ALLOWED      VISIT RELATED
ONLY
VALUE: 4
Select QUALIFIER:

```

Date/Time Vitals Taken: 12-15-08 (DEC 15, 2008)
Encounter Provider: TEST, KATHLEEN TK

Figure 3-69: Example of using the F10R mnemonic

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.

	Sphere	Cylinder	Axis	
RX)	+1.25	-2.50	X5	for the right eye
	+1.50	-3.50	X175	for the left eye
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	

Figure 3-70: Example of 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).

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

- **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.

```
MNEMONIC: GWT Gram Weight   ALLOWED   VISIT-RELATED-ONLY
VALUE: 1500
```

Figure 3-72: Example of using the GWT mnemonic

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).

```
MNEMONIC: HADA Historical ADA Code entry  ALLOWED NON-VISIT/VISIT MNEMONIC
Enter Date of Historical ADA: T-1 (MAR 05, 2008) (MAR 05,
2008@12:00)
PATIENT: SIGMA,JANE has one or more VISITs on this date.
1 TIME: 09:00 LOC: DH  TYPE: T CAT: A CLINIC: GENERAL DEC: 0
Select one: 1
Select V DENTAL SERVICE CODE: 7110  EXTRACTION, SIMPLE (ANY
REASON)
NO. OF UNITS: 1
```

Figure 3-73: Example of using the HADA mnemonic

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).

```
MNEMONIC: HBE Historical Barium Enema  ALLOWED NON-VISIT/VISIT MNEMONIC
Enter Date of Historical BARIUM ENEMA: T-30 (FEB 05, 2008@12:00)
PATIENT: SIGMA,JANE has one or more VISITs on this date.
1 TIME: 08:00 LOC: DH  TYPE: I CAT: S CLINIC: <NONE>  DEC: 4
Select one: 1

Updating V CPT file...

QUANTITY: 1
```

Figure 3-74: Example of using the HBE mnemonic

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.

```
MNEMONIC: HBS Historical Blood Sugar Entry  ALLOWED NON-VISIT/VISIT MNEMONIC
Enter Date of Historical Blood Sugar: 5/1/07 (MAY 01, 2007@12:00)
TYPE: O//
LOC. OF ENCOUNTER: 000000 DEMO HOSPITAL
```

```
OUTSIDE LOCATION: Updating V Lab file...
```

Figure 3-75: Example of using the HBS mnemonic

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 3-76: Example of using the HC 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 3-77: Example of using the HCBC 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: T-30 (FEB 05, 2008) (FEB 05,
2008@12:00)
PATIENT: SIGMA,JANE has one or more VISITs on this date.
1 TIME: 08:00 LOC: DH TYPE: I CAT: S CLINIC: <NONE> DEC: 5
Select one: 1
COLONOSCOPY PROVIDER NARRATIVE: NONE NONE
```

Figure 3-78: Example of using the HCOL 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 (GUAIAAC)   ALLOWED   NON-VISIT/VISIT MNEMONIC
CHOOSE 1-2: 1 HF Health Factors   ALLOWED   VISIT RELATEDONLY
```

```

***** PCC HEALTH FACTORS (LAST ONE FOR EACH CATEGORY) *****

-- ALCOHOL/DRUG --
08/26/2008 CAGE 0/4

-- TOBACCO (SMOKING) --
11/14/2008 NEVER SMOKED
NON-TOBACCO USER

-- TOBACCO (SMOKELESS - CHEWING/DIP) --
11/14/2008 NEVER USED SMOKELESS TOBACCO

-- TOBACCO (EXPOSURE) --
08/26/2008 SMOKE FREE HOME

Select V HEALTH FACTORS: TOBACCO
  1 TOBACCO SMOKE ASTHMA TRIGGERS
  2 TOBACCO (EXPOSURE) SMOKE FREE HOME TOBACCO (EXPOSURE)
  3 TOBACCO (EXPOSURE) SMOKER IN HOME TOBACCO (EXPOSURE)
  4 TOBACCO (EXPOSURE) EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE
TOBACCO (EXPOSURE)
  5 TOBACCO (SMOKELESS - CHEWING/DIP) CURRENT SMOKELESS
TOBACCO (SMOKELESS - CHEWING/DIP)
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 3 SMOKER IN HOME TOBACCO (EXPOSURE)
LEVEL/SEVERITY: MO MODERATE
PROVIDER: BVPROVIDER, PROVIDER
QUANTITY:

```

Figure 3-84: Example of using the HF mnemonic

3.5.93 Historical FOBT (GUAIAAC) (HFOB)

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

```

MNEMONIC: HFOB Historical FOBT (GUAIAAC) ALLOWED NON-VISIT/VISIT MNEMONIC
Enter Date of Historical FOBT - GUAIAAC: T-30 (FEB 05, 2008@12:00)
QUANTITY: 1

```

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.

```

MNEMONIC: HHCT Historical Hematocrit (HCT) ALLOWED NON-VISIT/VISIT MNEMONIC
Enter Date of Historical Hematocrit (HCT): 5/15/07 (MAY 15, 2007@12:00)
TYPE: O// I IHS
LOC. OF ENCOUNTER: DEMO HOSPITAL

```

```
Updating V Lab file...
```

Figure 3-86: Example of using the HHCT mnemonic

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.

```
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:
O// 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
```

```

Date/Time of Visit      Pap Smear Result
-----
APR 02, 2007@12:00      WNL
Enter Date of Historical PAP SMEAR: APR 02, 2006
TYPE: I// IHS
Select LOCATION NAME: DEMO
Select V LAB LAB TEST: PAP SMEAR, CONVENTIONAL
RESULTS: N

```

Figure 3-93: Example of using the HPAP mnemonic

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: T1TD 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.

```
MNEMONIC: HT Height in Inches ALLOWED VISIT-RELATED-ONLY
VALUE: 69
```

Figure 3-98: Example of using the HT mnemonic

3.5.107 Historical UA (HUA)

Use the Historical US (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.

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

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).

```
MNEMONIC: IF Infant Feeding Choices ALLOWED VISIT-RELATED ONLY
Select V INFANT FEEDING CHOICES: 1 (1 EXCLUSIVE BREASTFEEDING)
ENCOUNTER PROVIDER:
```

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 DESTRUC
TION 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

Admitting Service/Discharge Service	Mnemonic
• Alcoholism	Al 15
• Dental	Den 01
• Dental Observation	Deno 01o
• ENT	Ent 02
• ENT Observation	Ento 02o
• Family Practice	Fam 17
• Family Practice Observation	Fampo 17o
• General Medicine	Gms 03
• GYN Observation	Gyno 05o
• Gynecology	Gyn 05
• Internal Med Observation	Imedo06o
• Internal Medicine	Int 06
• Medicine Observation	Medo 03o
• Mental Health	Men 12
• Mental Health Observation	Mho 12o
• Neurology	Neuro 20
• Neurology Observation	Neuob 20o
• Neuropsychiatric	Np 00
• Newborn	Nb 07

Admitting Service/Discharge Service	Mnemonic
• Nurse-Midwifery Observation	Nrsob 22o
• Nurse-Midwifery Service	Nrsse 22
• Obstetrics	Ob08
• Obstetrics Observation	Obo 08o
• Ophthalmology	Eye 09
• Ophthalmology Observation	Eyeo 09o
• Orthopedics	Ort10
• Orthopedics Observation	Orto 10o
• Other	Hosp 14
• Pediatrics	Ped 11
• Pediatrics Observation	Pedo 11o
• Plastic Surgery	Psur 16
• Plastic Surgery Observation	Psuro 16o
• Podiatry	Pod 19
• Podiatry Observation	Podo 19o
• Substance Abuse Observation	Alcoo 15o
• Surgery	Sur 04
• Surgery Observation	Suro 04o
• Swing Bed	Swi 21
• TB	Tb 13
• Tuberculosis Observation	Tbo 13o

Discharge Type	Mnemonic
• Urology	Uro 18
• Urology Observation	Uroo 18o
• Regular Discharge	Discharge Active 1
• Transferred	Discharge Active 2
• Irregular Discharge	Discharge Active 3
• Death W/I 48 Hrs W Autopsy	Discharge Active 4

Discharge Type	Mnemonic
• Death W/I 48 Hrs W/O Autopsy	Discharge Active 5
• Death After 48 Hrs W Autopsy	Discharge Active 6
• Death After 48 Hrs W/O Autopsy	Discharge Active 7

```

MNEMONIC: IP
1 IP Hospitalization Information ALLOWED VISIT-RELATED-ONLY
2 IPO Inactivate a Problem ALLOWED NON-VISIT/VISIT MNEMONIC
3 IPV 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 1
ADMITTING SERVICE: INTERNAL MEDICINE 06
DISCHARGE TYPE: REGULAR DISCHARGE DISCHARGE 1
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//

```

Figure 3-104: Example of using the IP mnemonic

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

```

```

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

Enter Problem Number: CI4

Inactivating Problem CI4 ...
Enter the Date the Problem List was Updated by the Provider: Nov
02, 2010// (NOV 02, 2010)
Enter the PROVIDER who Updated the Problem List: IWPROVIDER,MARY ANNE

```

Figure 3-105: Example of using the IPO mnemonic

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:

```

Figure 3-106: Example of using the IPV mnemonic

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

```

Figure 3-107: Example of using the KWT mnemonic

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.

```
MNEMONIC: LAB Lab Test ALLOWED VISIT-RELATED-ONLY Select V LAB LAB
TEST:CREATININE
1 CREATININE
2 CREATININE CLEARANCE
3 CREATININE, FLUID
CHOOSE 1-3: 1
RESULTS:
UNITS: 1
ABNORMAL: N
SITE:
ENCOUNTER PROVIDER: Enter LAB TEST: CURRENT STATUS FLAG: ORDERING PROVIDER:
```

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.

```
MNEMONIC: LKW Last Known Well ALLOWED VISIT RELATED ONLY
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.
```

```
Date/Time Last Known Well: T@07:00
ENCOUNTER PROVIDER: Test, Provider
```

Figure 3-109: Example of using the LKW mnemonic

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
```

Figure 3-112: Example of using the LS mnemonic

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:

Type	Description
ADM	Asthma Work/School Days Missed
AG	Abdominal Girth
AKBP	Ankle Blood Pressure
ASFD	Asthma Symptom Free Days
ASQA	ASQ-Autism Screen
ASQF	ASQ - Fine Motor
ASQG	ASQ - Gross Motor
ASQL	ASQ – Language
ASQM	ASQ Questionnaire (Mos)
ASQP	ASQ - Problem Solving
ASQS	ASQ - Social
AUD	Audiometry
AUDC	Audit-C
AUDT	Audit
BP	Blood Pressure
BPF	Best Peak Flow
CEF	Cardiac Ejection Fraction
CRFT	CRAFFT
CXD	Cervix Dilatation
ED	Edema
EF	Effacement
EGA	Estimated Gestational Age
FBPN	24-hour fluid balance, pos/neg
FEF	FEF 25-75
FH	Fundal Height
FI24	24-hour fluid intake
FO24	24-hour fluid output
FT	Fetal Heart Tones

Type	Description
FVFC	FEV1/FVC
HC	Head Circumference
HE	Hearing
HT	Height
LKW	Last Known Well
MMSE	Mini-Mental Status Exam
O2	O2 Saturation
PA	Pain
PF	Peak Flow
PHQ2	PHQ2
PHQ9	PHQ9
PHQT	PHQ-9 Modified for Teens
PR	Presentation
PU	Pulse
RS	Respirations
SN	Station (Pregnancy)
TMP	Temperature
TON	Tonometry
VC	Vision Corrected
VU	Vision Uncorrected
WC	Waist Circumference
WT	Weight

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
Medication List Review Date/Time: Oct 26, 2010// (OCT 26, 2010)
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  Replace TIMES 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
```

```

CI4      11/02/2010  TESTING PO  (ONSET: 11/02/2010)
CI4CI1  11/02/2010  TEST

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

Enter Problem Number: CI4
DIAGNOSIS: .9999// CLASS:
PROVIDER NARRATIVE: TESTING PO//
E CODE (CAUSE OF INJURY):
E CODE 2:
E CODE 3:
DATE OF ONSET: NOV 2,2010//
STATUS: ACTIVE//
Enter the Date the Problem List was Updated by the Provider: Nov 02,
2010// (NOV 02, 2010)
Enter the PROVIDER who Updated the Problem List: IWPROVIDER, MARY ANNE

```

Figure 3-117: Example of using the MPO 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 3-118: Example of E Code prompts

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.

```

MNEMONIC: NAA No Active Allergies ALLOWED VISIT RELATED ONLY

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

```

Figure 3-119: Example of using the NAA mnemonic

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.

```
MNEMONIC: NAM No Active Medications ALLOWED VISIT RELATED ONLY

This patient has active medications in their record.

Are you sure you want to document 'No Active Medications'? (Y/N): Y
Date/Time Provider documented 'No Active Medications': Oct 26, 2010
// (OCT 26, 2010)
Provider who Documented 'No Active Medications': BTPROVIDER,WENDY C
```

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.

```
MNEMONIC: NAP No Active Problems ALLOWED VISIT RELATED ONLY

Did the Provider indicate there are No Active Problems? (Y/N): Y
Date/Time Provider documented 'No Active Problems': Nov 10, 2010
// (NOV 10, 2010)
Provider who Documented 'No Active Problems': XCPROVIDER,SHARON R
```

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
```

```
Select PATIENT REFUSALS FOR SERVICE/NMI SERVICE TYPE: EXAM
Enter the EXAM value: 19 VISION EXAM 19
DATE REFUSED/NOT INDICATED: T-10 (FEB 25, 2008)
PROVIDER WHO DOCUMENTED: SMITH,JOHN
COMMENT: REFUSED
```

Figure 3-122: Example of using the NMI 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
```

```
Add a new Problem Note for this Problem? N// O
```

Figure 3-123: Example of using the NO mnemonic

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 COMMENT:
```

Figure 3-124: Example of using the NRF mnemonic

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
```

Figure 3-125: Example of using the NRS mnemonic

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).

```
MNEMONIC: NT Narrative Text ALLOWED VISIT-RELATED-ONLY
Enter Type of TEXT: ?
Answer with V NARRATIVE TEXT TYPE
    You may enter a new V NARRATIVE TEXT, if you wish
Answer with NARRATIVE TEXT TYPE
Choose from:
CHIEF COMPLAINT
OBJECTIVE SUBJECTIVE
Enter Type of TEXT: CHIEF COMPLAINT
TEXT:
1>SORE THROAT
2>
EDIT Option:
```

Figure 3-126: Example of using NT mnemonic

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.

```
MNEMONIC: NSST          NIHS STROKE SCALE TOTAL SCORE    ALLOWED    VISIT
RELATED
ONLY
VALUE: 34
Select QUALIFIER: 3 MONTHS
    ...OK? Yes//    (Yes)

    QUALIFIER: 3 MONTHS//
Select QUALIFIER:
Date/Time Vitals Taken: 12-16-2014@12:00 (DEC 16, 2014@12:00:00)
Encounter Provider: test    TEST,KATHLEEN    TK
```

Figure 3-127: Using the NSST mnemonic

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%.

```
MNEMONIC: O2    O2 Saturation    ALLOWED    VISIT-RELATED-ONLY
VALUE: 65
```

Figure 3-128: Example of using the O2 mnemonic

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
DYSRHYTHMIA/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:
```

```
GOAL CODE: GS GOAL SET
GOAL COMMENT:
```

Figure 3-137: Example of using the PED mnemonic

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.

Code	Level of Intervention
P	Primary
S	Secondary
T	Tertiary

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

Code	Type of Decision Making
S	Straightforward
L	Low Complexity
M	Moderate Complexity
H	High Complexity

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
PSYCHO/SOCIAL/ENVIRON: 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.

```
MNEMONIC: PHQ2 PHQ2 ALLOWED VISIT-RELATED-ONLY
VALUE: 5
```

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.

```
MNEMONIC: PHQ9 PHQ9 ALLOWED VISIT-RELATED-ONLY
VALUE: 10
```

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.

```
MNEMONIC: PHQT PHQ-9 Modified for Teens
VALUE: 20
Select QUALIFIER:
Date/Time Vitals Taken: T@13:40 (MAY 04, 2012@13:40:00)
ENCOUNTER PROVIDER: TEST,PCC
```

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
DATE OF ONSET: 2008 (2008)
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.

```

Problem List Update           Jan 19, 2015 14:14:17           Page:    1 of    2
-----
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 15, 2014   By: TEST,KATHLEEN

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

2) Problem ID:  TST2    DX: E10.622   Status: CHRONIC           Onset: 12/12/13
   Provider Narrative: *diabetes date on onset

3) Problem ID:  TST3    DX: G57.71    Status: CHRONIC           Onset: 1/6/15
   Provider Narrative: *problem #!
+       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: +/-

Editing Problem Number:  TST1

This problem has been SNOMED coded, you can only edit the Status.

STATUS: EPISODIC// ??

Enter a code from the list.

Select one of the following:

    A      CHRONIC
    I      INACTIVE
    S      SUB-ACUTE
    E      EPISODIC
    O      SOCIAL

STATUS: EPISODIC//

```

Figure 3-147: Example of editing problem with SNOMED 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.

```

MNEMONIC: PLR  Problem List Reviewed  ALLOWED  VISIT RELATED ONLY

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
entry/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//
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.

Number	Name	Abbreviation
1	Vertex	VT
2	Complete Breach	CB
3	Double Footling	DF
4	Single Footling	SF
5	Frank Breach	FB
6	Face	FA
7	Unspecified Breach	UB
8	Transverse	TR
9	Other	OT
10	Unknown	UNK

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
MNEMONIC
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)rietary 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
REG ISTERED 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 CIn 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.

```
MNEMONIC: PT Physical Therapy ALLOWED VISIT-RELATED-ONLY
Enter PHYSICAL THERAPY CPT Code: 975006      AMB-FITTING
QUANTITY: 1
Enter PHYSICAL THERAPY CPT Code:
```

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.

GOAL List Update	Dec 12, 2011 11:17:48	Page: 1 of 1

Patient Name: TEST,PATIENT DOB: AUG 01, 1980 Sex: F HRN: 7543		
'Active Goals are listed first followed by Goals not set. Inactive goals are not listed.		

```

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

```

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.

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

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

```

MNEMONIC: RF Reproductive Factors ALLOWED NON-VISIT/VISIT MNEMONIC
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:

MNEMONIC:

```

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.

```

MNEMONIC: RNO Remove Note from Problem ALLOWED NON- VISIT/VISIT MNE
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
CI5     11/02/2010  TESTING PPV  (ONSET: 11/02/2010)
***** No INACTIVE Problems on file for this Patient

Enter Problem Number: CI4
Select NOTE FACILITY: 2010 DEMO HOSPITAL//
Select NOTE NMBR: 1//

Are you sure you want to remove Note Number 1?  (Y/N) Y

Removing Note Number 1
Select NOTE FACILITY:
Enter the Date the Problem List was Updated by the Provider:  Nov
02, 2010//  ( NOV 02, 2010)
Enter the PROVIDER who Updated the Problem List: IWPROVIDER,MARY
ANNE

```

Figure 3-164: Example of using the RNO mnemonic

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.

```

MNEMONIC: RPO  Remove Problem entry  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)
CI5  11/02/2010  TESTING PPV  (ONSET: 11/02/2010)
***** No INACTIVE Problems on file for this Patient
Enter Problem Number: CI3

Please Note:  You are NOT permitted to delete a problem without entering a
reason for the deletion.
Are you sure that you want to remove Problem Number CI3 ? (Y/N) Y

Removing Problem CI3 ...
Provider who deleted the problem: ADPROVIDER,RAY

```

```

REASON PROBLEM DELETED: D  DUPLICATE

Enter the Date the Problem List was Updated by the Provider: Nov
02, 2010// (
NOV 02, 2010)
Enter the PROVIDER who Updated the Problem List: ADPROVIDER,RAY//
ADPROVIDER,RAY

MNEMONIC:

```

Figure 3-165: Example of using the RPO mnemonic

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 RPO 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.

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.

```

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 METHOD:
SUBSTANCE INVOLVED: NONE

Please enter any documented CONTRIBUTING FACTORS

Select FACTOR: VICTIM OF ABUSE (CURRENT) 3

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.

```

MNEMONIC: SHX  History of Surgery  ALLOWED  NON-VISIT/VISIT MNEMONIC
***** SURGICAL HISTORY *****
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 NEOPLASM/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.

Result	Description
P	Positive
N	Negative
D	Doubtful
O	No Take

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.

```
MNEMONIC: STN Station (Pregnancy Meas) ALLOWED VISIT-RELATED-ONLY
VALUE: 3
```

Figure 3-173: Example of using the STN mnemonic

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

```
MNEMONIC: STP Skin Test Placed (No Reading) ALLOWED VISIT- RELATED-ONLY
Enter SKIN TEST Type: PPD 21
```

Figure 3-174: Example of using the STP mnemonic

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).

```
MNEMONIC: TA Type of Appointment (S/M/L) ALLOWED VISIT-RELATED- ONLY
TYPE OF APPOINTMENT (S/M/L): M MEDIUM
```

Figure 3-175: Example of using the TA mnemonic

3.5.187 Chagemaster Transaction Code (TC)

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

```
MNEMONIC: TC Chagemaster Transaction Code ALLOWED VISIT- RELATED-ONLY
Enter (TC) TRANSACTION CODE: 10100095 X-R, TMJ, OPEN/CLSD MOUTH;BI
Enter (TC) TRANSACTION CODE: 10100110 X-R, PHARYNX, LARYNX, W/FLUO Enter
(TC) TRANSACTION CODE: 10100055 X-RAY, ORBITS, COMP, MIN 4VS
```

Figure 3-176: Example of using the TC 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:

Type	Description
S	Straightforward
L	Low Complexity
M	Moderate Complexity
H	High Complexity

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
```

```

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.

```
MNEMONIC: VST Visit File Data Modify ALLOWED VISIT-RELATED- ONLY
LOC. OF ENCOUNTER: SELLS HOSPITAL/CLINIC//
SERVICE CATEGORY: AMBULATORY// TYPE: IHS//
CLINIC: GENERAL// DIABETIC
WALK IN/APPT: APPOINTMENT//
APPT DATE&TIME: JUN 1,1997@10:00// 6/17/97@1030
EVALUATION AND MANAGEMENT CODE: CHECK OUT DATE&TIME:
HOSPITAL LOCATION:
LEVEL OF DECISION MAKING:
```

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.

```
MNEMONIC: VU Vision Uncorrected  ALLOWED  VISIT-RELATED-ONLY
VALUE: 30/40
NUMERATOR ON VC/VU: 20//
```

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.

```
MNEMONIC: WC
  1 WC  Waist Measurement  ALLOWED  VISIT-RELATED-ONLY
  2 WCE WELL CHILD EXAM  ALLOWED  VISIT-RELATED-ONLY
Choose: 1-2 1 WC  Waist Measurement  ALLOWED  VISIT-RELATED-ONLY
VALUE: 35
```

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.

```
MNEMONIC: WCE WELL CHILD EXAM  ALLOWED  VISIT-RELATED-ONLY
*** DATA ENTRY - WELL CHILD EXAM ***
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: 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 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: 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 ALLOWED NON-VISIT/VISIT
MNEMONIC
You are currently processing the following Patient Visit:
  Patient Name:  SIGMA,JANE Chart :  000000
  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 ALLOWED NON-VISIT/VISIT MNEMONIC
You are currently processing the following Patient Visit:
Patient Name:  SIGMA,JANE Chart : 000000
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).

```
MNEMONIC: WT Weight in lbs/ozs  ALLOWED  VISIT-RELATED-ONLY
VALUE: 125
```

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:

```
MNEMONIC: XIT Quick Out  ALLOWED  VISIT-RELATED-ONLY
This is the 'Quick Exit' from Data Entry Enter Mode.  This visit
will be deleted and you will be returned to the 'VISIT/DATE TIME'
prompt. Do you wish to Proceed with the Deletion? Y// NO
Do you still wish to EXIT this Visit? Y//  ES
WARNING - You may be leaving an INCOMPLETE VISIT!!
Looking for ancillary data to merge into this visit...
```

Figure 3-197: Example of saving a visit

Deleting a visit:

```
MNEMONIC: XIT Quick Out  ALLOWED  VISIT-RELATED-ONLY
This is the 'Quick Exit' from Data Entry Enter Mode.  This visit
will be deleted and you will be returned to the 'VISIT/DATE TIME'
prompt. Do you wish to Proceed with the Deletion? Y//  ES..
Looking for ancillary data to merge into this visit...
```

Figure 3-198: Example of deleting a visit

Appendix A: Data Entry Mnemonics Grouped by Type

Administrative Data

Mnemonic	Meaning
AT	Activity and Travel Time
ER	Emergency Visit Record
FL	Flag Field
HL	Hospital Location
IP	Inpatient
PHN	Public Health Nursing

Billing/Chargemaster

Mnemonic	Meaning
CPE	CPT Codes with Entry of Encounter Provider
CPT	CPT Codes
DTC	Diagnostic Procedure Tran Code (Chargemaster)
EM	Evaluation and Management (CPT)
LS	Level of Service
PCPT	Procedure Entry (CPT)
TC	Tran Code (Chargemaster)
TD	Type of Decision Making
TE	Tran Code with Entry of Encounter Provider (Chargemaster)

Contract Health Service

Mnemonic	Meaning
CHH	CHS – Hospitalization Form
CHI	CHS – In-Hospital Form

Data Entry Utilities

Mnemonic	Meaning
DHS	Display Health Summary
DISP	Visit Display
GHS	Generate Health Summary
MOD	Switch to Modify Mode
PCF	PCC+ Form
VST	Modify Visit File Information
WHAT	Demographic and Visit Display
WHO	Information on Patient
XIT	Quick Out

Diagnosis/Purpose of Visit

Mnemonic	Meaning
ECOD	Append an E-Code to a Purpose of Visit
IPV	ICD Narrative Purpose of Visit
PV	Purpose of Visit
SPV	Purpose of Visit with Stage Prompt
STG	Stage in Purpose of Visit
UPV	Uncoded Purpose of Visit

Historical Data

Mnemonic	Meaning
HBE	Historical Barium Enema
HCOL	Historical Colonoscopy
HCPT	Historical CPT
HFOB	Historical FOBT (GUAIAc)
HHF	Historical Health Factor
HSEV	Historical Asthma Severity
HSIG	Historical Sigmoidoscopy
HEKG	Historical EKG
HEX	Historical Examination
HIM	Historical Immunizations
HHCT	Historical Hematocrit
HLAB	Historical Lab Test
HMSR	Historical Measurement
HPAP	Historical Pap Smear
HRAD	Historical Radiology
HRX	Historical Prescription
HS	Historical Skin Test
HUA	Historical UA

Immunization/Skin Tests

Mnemonic	Meaning
IM	Immunization
ST	Skin Test
STP	Skin Test Placed

Laboratory

Mnemonic	Meaning
CBC	CBC Ordered
HBS	Historical Blood Sugar Entry
HCBC	Historical CBC Entry

Mnemonic	Meaning
HCT	Hematocrit Ordered
LAB	Lab Test Entry
PAP	Pap Smear Ordered
UA	Urinalysis Order–No Results
IM	Immunization

Mnemonic	Meaning
AUD	Audiometry
BM	Birth Measurement
BP	Blood Pressure
BMI	Body Mass Index
BMIP	BMI Percentile
BPF	Best Peak Flow
CDR	Cup to Disc Ratio
CHC	Centimeter Head Circumference
CHT	Centimeter Height
EGA	Estimated Gestational Age
FEF	FEF 25-75
FEV1	FEV1 – LITERS
F10R	Framingham 10 Year Risk
FV1P	FEV1 %
FVC	Forced Vital Capacity (Liters)
FVCP	Forced Vital Capacity - %
GWT	Gram Weight
HC	Head Circumference
HT	Height
MEAS	Measurement Entry
MME	Mini-Mental Status Exam
NSST	NIH Stroke Scale Total
O2	O2 Saturation
PF	Peak Flow
PU	Pulse
RS	Respiration
TMP	Temperature
TON	Tonometry
VC	Vision Corrected
VU	Vision Uncorrected
WC	Waist Measurement
WT	Weight

Medication

Mnemonic	Meaning
RX	Medications
MLR	Medication List Review
NAM	No Active Medications

Operation/Procedure

Mnemonic	Meaning
AOP	Anesthesia Operation
IOP	ICD Operation Narrative
OP	Operations
UOP	Uncoded Procedure

Other Clinical Data

Mnemonic	Meaning
ADA	ADA Code Entry
ADM	Asthma Work/School Days Missed
ALG	Allergy Tracking Entry
ASEV	Asthma Severity
ASFD	Asthma Symptom-Free Days
CC	Chief Complaint
CEF	Cardiac Ejection Fraction
COC	Coded Chief Complaint
DC	Disposition of Care
DRG	DRG
DDS	Dental – Direct Services
EL	Elder Care
EKG	EKG Diagnostic Procedure
GP	Eyeglass Prescription
IF	Infant Feeding Choices
NT	Narrative Text
LOC	Level of Care
NMI	Not Medically Indicated
NRF	No Response to Followup
OVR	Health Reminder Override
PA	Pain
PED	Patient Education
PT	Physical Therapy
PTG	Patient Goals
RAD	Radiology
REF	Refusal for Service

Mnemonic	Meaning
TP	Treatments Provided
TRC	Treatment Contracts
UAS	Unable to Screen
UNH	Auditory Evoked Potential Exam

Patient Related

Mnemonic	Meaning
AUDIT	AUDIT
BT	Blood Type Entry
CRFT	CRAFFT
DP	Designated Provider
FS	Future Scheduled Encounter
FHX	Family History
FM	Family Planning Method
FP	Family Planning
HF	Health Factors
HLST	Health Status
FP	Family Planning
OHX	Offspring History
PCP	Primary Care Provider
PHQ2	PHQ2
PHQ9	PHQ9
PHX	Personal History
PIF	Infant Feeding Patient Data
RF	Reproductive Factors
SF	Suicide Form Entry
SHX	History of Surgery
UCD	Underlying Cause of Death

Prenatal

Mnemonic	Meaning
CXD	Cervix Dilation
ED	Edema Measurement
EDD	Expected Date of Delivery
EFF	Effacement
FH	Fundal Height
FT	Fetal Heart Tones
LMP	Last Menstrual Period
PR	Presentation (Pregnancy)
STN	Station (Pregnancy)

Problem List

Mnemonic	Meaning
IPO	Inactivate Problem
MNN	Modify Note Narrative
MPO	Modify Problem Narrative
NAP	No Active Problems
NO	Note
PL	Problem List Update Menu
PLR	Problem List Reviewed
PO	Problem Only
PPV	POV and Problem Entry
RNO	Remove Note Narrative
RPO	Remove Problem Entry

Visit-related data

Mnemonic	Meaning
OLOC	Outside Location
PRV	Providers (Primary/Secondary)
TM	Time of Visit

Waiting-time studies

Mnemonic	Meaning
AL	Appointment Length
CKO	Check Out Date and Time
TA	Type of Appointment

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 policies 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