



RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS PCC Suite

(BJPC)

Data Entry Supervisor's Manual

Version 2.0 Patch 11
June 2015

Office of Information Technology (OIT)
Division of Information Technology

Table of Contents

1.0	PCC Manager Menu	1
1.1	Data Entry Utilities (DEU)	2
1.2	Overview of Using the Prompts	3
1.2.1	Entering Patient Name	3
1.2.2	Enter Dates.....	3
1.2.3	Accessing the Help Screen	4
2.0	Release Notes	5
3.0	Uncoded Diagnoses	6
3.1	Fix Uncoded Purpose of Visit Diagnoses (POV).....	7
3.2	Fix Uncoded PROBLEM File Diagnoses (PRB).....	9
3.3	Fix Uncoded PERSONAL HISTORY Diagnoses (PER).....	10
3.4	Fix Uncoded FAMILY HISTORY Diagnoses (FAM).....	11
3.5	Fix Uncoded V PROCEDURE Operation Codes (OPS)	12
3.6	Print a List of All Uncoded Diagnoses/Operations (PPV).....	13
4.0	Link In-Hospital to Hospitalizations	15
4.1	Link In-Hospital Visits to Hospitalizations (AUT).....	16
4.2	Manually Link In-Hospital to Hospitalizations (MAN)	17
5.0	Display PCC Data Entry Site Parameters	19
6.0	Process Accept Commands	21
6.1	List Records with ACCEPT Command (ACC)	22
6.2	Assign the ACCEPT Command to a V Record (EAC)	23
6.3	Remove the Accept command from a Visit Record (RAC)	24
7.0	Delete Duplicate Primary Providers from Visits	26
8.0	DX Coding Audit for Selected Set of Visits (DXV)	27
9.0	Enter/Edit PCC Data Entry Site Parameters	28
10.0	Auto Merge Event Visits on Same Day	39
11.0	Forms/Data Entry Tracking Menu	41
11.1	Report a Count of Forms Processed (CNT).....	42
11.2	DX ICD Coding QA Audit (DXA)	44
11.3	Operation/Procedure ICD Coding QA Audit (OPA).....	45
11.4	Purge Entries in Forms Tracking File (PRG)	47
11.5	Display Operator Who Entered a Particular Visit (DOP).....	47
11.6	Report of Number of Tran Codes Entered By Operator (TCC)	48
11.7	Forms Tracking Summary Report (TSR)	49
12.0	Complete Orphaned Lab Menu	52
12.1	Complete 'Orphaned' Lab Visits (COL).....	52

12.2	Queue 'Orphaned' Lab Linker (QCL)	53
12.3	Queue Orphaned Pharmacy Linker (CRX)	53
12.4	Queue 'Orphaned' Radiology Visits (CRAD)	53
12.5	Queue Orphaned Radiology Linker (QRAD).....	54
12.6	Completed 'Orphaned' Visits Report (ROL).....	54
12.7	Purge 'Orphaned' Lab Visit Log (PUR)	55
12.8	Complete 'Orphaned' Blood Bank Visits (BB).....	55
12.9	Complete 'Orphaned' Immunization Visits (IM).....	56
12.10	Complete 'Orphaned' Microbiology Visits (MIC)	56
13.0	Visit Log Reports.....	58
13.1	List of Visits Modified by the Visit Re-linker (VRLR)	59
13.2	Purge Visit Re-linker Log (PVRL)	60
13.3	Print List of Visit Deleted/Merged (PVDM).....	60
13.4	Purge Visit Delete/Merge Log (PUDM)	61
13.5	Display a Visit by Visit IEN (VIEN)	62
14.0	Data Entry Mnemonics	64
14.1	Print List of Data Entry Mnemonics (PMN)	64
14.2	Update PCC Mnemonics Allowed/Not Allowed (MNE)	66
15.0	Other PCC Data Entry Reports	67
15.1	Chart Review and Telephone Calls with Ancillary Data (CTA)	68
15.2	Visits with a Returned to Stock Medication (VRTS).....	69
16.0	Reports Listing Allergies on Problem List	70
16.1	List All Patients with Allergies / NKA on Problem List (PWA)	70
16.2	List Pts seen in N yrs w/Problem List Allergies (SALP)	72
16.3	List Patients w/Allergies entered in a Date Range (NALP)	73
17.0	Re-Submit a Visit to the Data Center	75
18.0	Table Maintenance	77
18.1	Physical Therapy Modality Enter/Edit (PHY)	78
18.2	Treatment Enter/Edit (TRT)	78
18.3	Print Table Listings (PRT).....	79
18.3.1	Provider Listing (PRVL)	80
18.3.2	Print ACTIVE Providers (APA).....	82
18.3.3	Print Providers by Provider Classification (APC)	82
18.3.4	Print INACTIVE Providers (API)	83
18.3.5	Print Area Table (ARE).....	84
18.3.6	Print Provider List by Discipline (DIS).....	85
18.3.7	Print Education Topics List (EDU)	85
18.3.8	Print CHS Vendor List by EIN Number (EVN)	86
18.3.9	Print Insurer List (INS)	87
18.3.10	Print Location Table (LOC)	87
18.3.11	Print CHS Vendor List by Name (NVE)	88
18.3.12	Print Physical Therapy List (PHY)	89

18.3.13	Print Provider List by Name (PPN)	89
18.3.14	Print Immunization Table (PRI).....	90
18.3.15	Print Skin Test Table (PST)	90
18.3.16	Print Relationship List (REL).....	91
18.3.17	Print Service Unit Table (SUP)	91
18.3.18	Print Treatment List (TRT).....	92
18.4	List Clinics (CL).....	93
18.5	Inactivate/Reactivate Persons & Providers (INA)	94
18.6	Add/Edit Providers (PRV)	94
19.0	Update ICD-10 Diagnosis from SNOMED Concept ID	98
20.0	Update PCC Master Control File	99
21.0	Coding Queue.....	100
21.1	EHR/PCC Coding Audit for Visits in Date Range (EHRD).....	101
21.2	Using the PCC/EHR VISIT AUDIT Screen	105
21.2.1	Display Visit (D)	107
21.2.2	Note Display (N)	108
21.2.3	Modify Visit (M).....	108
21.2.4	Append to Visit (A).....	109
21.2.5	Visit Merge (G)	110
21.2.6	Status Update (S).....	112
21.2.7	Resort List (R)	113
21.2.8	Chart Audit History (C)	114
21.2.9	Health Summary (H).....	114
21.2.10	One Patient's Visit (O)	115
21.2.11	Visit Delete (X).....	116
21.2.12	B Merge 2 Diff Date (B)	116
21.2.13	F Move V File (F).....	117
21.2.14	E Move V File 2 Dates (E)	117
21.2.15	Change Date/Time (T).....	117
21.2.16	Resequence POVs (U)	117
21.2.17	View BH Note (J).....	117
21.2.18	View Any Visit (Y)	118
21.2.19	Add a Visit (Z).....	119
21.2.20	Chart Deficiency (I).....	120
21.2.21	Change Patient (K)	121
21.3	Adding Chart Deficiency Reasons	121
21.4	Update PCC Master Control File	122
21.5	Tally Reviewed/Completed Visits (Last Operator)	125
Appendix A:	Rules of Behavior	126
A.1	All RPMS Users	126
A.1.1	Access.....	126
A.1.2	Information Accessibility	127
A.1.3	Accountability	127

A.1.4	Confidentiality.....	128
A.1.5	Integrity.....	128
A.1.6	System Logon.....	128
A.1.7	Passwords.....	129
A.1.8	Backups.....	130
A.1.9	Reporting.....	130
A.1.10	Session Timeouts.....	130
A.1.11	Hardware.....	130
A.1.12	Awareness.....	131
A.1.13	Remote Access.....	131
A.2	RPMS Developers.....	132
A.3	Privileged Users.....	132
	Glossary.....	135
	Acronym List.....	141
	Contact Information.....	142

Preface

The Patient Care Component (PCC) Supervisor/Manager is the key to PCC's success or failure. The supervisor/manager must be knowledgeable in both the Resource and Patient Management System (RPMS) and medical records. A thorough working knowledge in the International Classification of Disease (ICD) coding system and PCC data entry are mandatory. This can be accomplished through one or several people, depending on the resources at your site. The PCC supervisor is ultimately responsible for making sure data is as accurate as possible and accessible in a timely and reasonable manner.

This manual demonstrates the supervisory functions that are performed in the PCC Data Entry Module. In addition to this manual, refer to the PCC Data Entry Operator, PCC Data Entry Mnemonics, and PCC Transmission manuals for more details regarding the role of the PCC Supervisor. The following topics are discussed in this manual:

- Customizing the data entry operations
- Quality control of data entry operators
- Quantity control of data entry operators
- Resolving uncoded diagnoses
- IHS edits on ICD codes

1.0 PCC Manager Menu

The PCC Manager Menu, shown below, contains options that will be performed by the PCC supervisor and/or site manager.

```

PCC  Patient Care Data Entry Menu ...
UTIL Utilities For Auto-Coding System ...
      **> Out of order: Disabled with distribution of AICD v4.
HSM  Health Summary ...
QMGR Q-Man Site Manager's Utilities
TX   PCC Data Transmission Menu ...

Select PCC Manager Menu Option: PCC

```

Figure 1-1: Options on PCC Manager Menu

Each option is described in detail in standalone PCC manuals. See your Area Information Systems Coordinator (ISC) to order copies, or check the IHS web site <http://www.ihs.gov>, because many RPMS manuals are now downloadable in .PDF format.

The PCC Manager Menu is discussed in detail in the PCC Data Entry Operator's manual.

The PCC Data Transmission Menu (PCCX) menu is not covered in this manual. These reports are part of the PCC Data Transmission and are discussed in detail in the Transmission manual. The Visit Review Report (VRR) has been placed on the Supervisor menu for easy access purposes only.

The following screens display the sequence of menus necessary to access the PCC Supervisor menu. Your site manager or area might have customized other means to access these features.

To access the supervisor's responsibilities menu, type **PCC** at the "Select PCC Manager Menu Option" prompt to display the PCC Data Entry Module, shown below.

```

*****
**   PCC Data Entry Module   **
*****

          Version 2.0
        DEMO INDIAN HOSPITAL

ENT  Enter/Modify/Append PCC Data ...
DSP  Display Data for a Specific Patient Visit
PEF  Print a PCC Visit in Encounter Form format
UPD  Update Patient Related/Non Visit Data ...
DEU  Data Entry Utilities ...
GHS  Generate Health Summary
BHS  Browse Health Summary

```

```

DVB   Display a PCC Visit w/limited Lab Display
PDV   Print a PCC Visit Display to a Printer

Select Patient Care Data Entry Menu Option: DEU

```

Figure 1-2: PCC Data Entry Module

1.1 Data Entry Utilities (DEU)

The DEU option displays the following menu:

```

*****
**   PCC Data Entry Module   **
** Data Entry Utilities Menu **
*****

                          Version 2.0
                          DEMO INDIAN HOSPITAL

LST   List Visits for a Patient in a Date Range
AUN   Find CHS Entry for a Given Authorization Number
MRG   Merge two Visits on Same Date
DEL   Delete All Data For A Visit
SUP   Data Entry SUPERVISORY Options and Utilities...
GC    Pediatric Growth Charts
MR2   Merge 2 Visits on 2 Different Dates
MV2D  MV2D Move Data from one visit to a different date
MVD   Move Data Items from One Visit to Another
RGF   Reprint Group PCC Visit Forms

Select Data Entry Utilities Option: SUP

```

Figure 1-3: Options for DEU

The SUP option (on the Data Entry Utilities Menu) displays the following menu:

```

*****
**           PCC Data Entry Module           **
** Data Entry SUPERVISOR Options and Utilities **
*****

                          Version 2.0
                          DEMO INDIAN HOSPITAL

ICD   Fix UNCODED ICD Diagnoses/Operations ...
VRR   Visit Review Report ...
INP   Link In-Hospital Visits to Hospitalizations ...
DSP   Display PCC Data Entry Site Parameters
ACC   Process ACCEPT Commands ...
DDPR  Delete Duplicate Primary Providers from Visits
DXV   DX Coding Audit for Selected Set of Visits
ESP   Enter/Edit PCC Data Entry Site Parameters
EVM   Auto Merge Event Visits on Same Day
FTM   Forms/Data Entry Tracking Menu ...
LAB   Complete Orphaned Visits Menu ...
MDL   Visit Re-linker/Merge/Delete Log Reports ...
MNE   Update PCC Mnemonic's Allowed/Not Allowed
OTH   Other PCC Data Entry Reports ...
PLAL  Reports Listing Allergies recorded on PROBLEM LIST ...

```

```

PMN    Print list of Data Entry Mnemonics
RET    Re-Submit PCC Visit to the IHS Data Center
TAB    PCC Local Table Maintenance ...
UIFS   Update ICD-10 Diagnoses from SNOMED Concept ID
UPMC   Update PCC Master Control File

```

Select Data Entry SUPERVISOR Options and Utilities Option:

Figure 1-4: Supervisor options

The Visit Review Report (VRR) has been placed on the Supervisor menu for easy access purposes only. This option will not be reviewed in this manual.

1.2 Overview of Using the Prompts

Below is information about entering or using the prompts.

1.2.1 Entering Patient Name

Many of the prompts ask you to enter the patient name.

Identify the patient in one of the following ways:

- Type the Patient's NAME or a portion of the NAME in the following format: HORSECHIEF,JOHN DOE or HORSECHIEF,JOHN. Use the following guidelines:
 - Use from 3 to 30 letters.
 - A comma must follow the last name.
 - If 'JR' or 'II', etc., is included, follow the form SMITH,JOHN MARK,JR.
 - NO SPACES after commas.
 - Type the patient's IHS chart number.
 - Type the patient's date of birth (DOB) in one of the following forms:
 - B012266
 - Any valid date, such as 01/22/66, 01-22-66, or JAN 22,1966.
 - Type the Patient's social security number (SSN) or the last 4 digits of the SSN.
 - If the patient is an inpatient enter the ward or room-bed number in the following form: 66-2 PEDIATRICS
- Otherwise, type two question marks (??) to view a list of valid entries.

1.2.2 Enter Dates

Many of the prompts ask you to enter a date. The following are examples of valid dates:

- JAN 20 1957 or 20 JAN 57 or 1/20/57 or 012057.

- T (for TODAY), T+1 (for TOMORROW), T+2, T+7, etc.
- T-1 (for YESTERDAY), T-3W (for 3 WEEKS AGO), etc.
- If the year is omitted, the computer assumes a date in the past.
- You can omit the precise day (for example, JAN, 1957).

1.2.3 Accessing the Help Screen

To access the help screen for many of the prompts, type two question marks (??) and press the Return key. For example, if the prompt is “Enter Clinic” and you want to know the available clinics, type two questions marks (??) to list the clinics.

2.0 Release Notes

Detailed information listing the modifications and enhancements for BJPC v2.0 patch 11 is provided in the Indian Health Service Office of Information Technology Release Announcement. All software release announcements are available on the IHS website with the software files

3.0 Uncoded Diagnoses

The options and utilities on the Supervisor menu are shown below:

```

*****
**                PCC Data Entry Module                **
** Data Entry SUPERVISOR Options and Utilities **
*****

                          Version 2.0
                          DEMO INDIAN HOSPITAL

ICD   Fix UNCODED ICD Diagnoses/Operations ...
VRR   Visit Review Report ...
INP   Link In-Hospital Visits to Hospitalizations ...
DSP   Display PCC Data Entry Site Parameters
ACC   Process ACCEPT Commands ...
DDPR  Delete Duplicate Primary Providers from Visits
DXV   DX Coding Audit for Selected Set of Visits
ESP   Enter/Edit PCC Data Entry Site Parameters
EVM   Auto Merge Event Visits on Same Day
FTM   Forms/Data Entry Tracking Menu ...
LAB   Complete Orphaned Visits Menu ...
MDL   Visit Re-linker/Merge/Delete Log Reports ...
MNE   Update PCC Mnemonic's Allowed/Not Allowed
OTH   Other PCC Data Entry Reports ...
PLAL  Reports Listing Allergies recorded on PROBLEM LIST ...
PMN   Print list of Data Entry Mnemonics
RET   Re-Submit PCC Visit to the IHS Data Center
TAB   PCC Local Table Maintenance ...
UIFS  Update ICD-10 Diagnoses from SNOMED Concept ID
UPMC  Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 3-1: Options on the Supervisor's menu

Use the ICD option to correct diagnoses containing an Uncoded Diagnoses code entered by operators during PCC data entry.

The Uncoded Diagnoses code is entered when an operator cannot obtain the correct code during initial entry of the diagnoses. Because an Uncoded Diagnoses code can prevent a visit from transmitting to the Data Center, a routine clean-up is required. These options should be run regularly (at least once a week) when starting PCC. Later, monthly runs as part of the PCC transmission process should be sufficient. Frequency will vary and depend on the data entry staff and their knowledge of ICD coding and provider documentation.

The PCC supervisor uses the ICD printouts when customizing local ICD files in the Utilities for Auto-Coding. Numerous instances and/or consistent patterns of an Uncoded Diagnoses code might indicate that an operator requires training in one or more areas of ICD coding.

The samples that follow are examples of using the Fix option. The computer continues to loop with the question “CONTINUE Y//” after each Uncoded Diagnoses code entry, but you can get out of the Fix menus at any time by typing N.

After selecting ICD at the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt, the application displays the Fix UNCODED ICD Diagnoses/Operation Codes menu:

```

*****
**          PCC Data Entry Module          **
**  Fix UNCODED ICD Diagnoses/Operation Codes  **
*****
                IHS PCC Suite Version 2.0
                DEMO INDIAN HOSPITAL

POV    Fix Uncoded Purpose of Visit Diagnoses
PRB    Fix Uncoded PROBLEM File Diagnoses
PER    Fix Uncoded PERSONAL HISTORY Diagnoses
FAM    Fix Uncoded FAMILY HISTORY Diagnoses
OPS    Fix Uncoded V PROCEDURE Operation Codes
PPV    Print a list of all Uncoded Diagnoses/Operations

Select Fix UNCODED ICD Diagnoses/Operations Option:

```

Figure 3-2: Options on the Fix UNCODED ICD Codes menu

The application allows searching for uncoded diagnoses or codes beginning at any date. To retrieve all uncoded diagnoses or codes, use a very early date like 01/01/1930. To review data for visits in the past week only, use T-7.

3.1 Fix Uncoded Purpose of Visit Diagnoses (POV)

Use the POV option to access all purpose of visits containing an Uncoded Diagnoses code.

- An ambulatory visit containing an Uncoded Diagnoses code in the Primary and/or Secondary Purpose of Visit field excludes that entire visit record from transmitting to the Data Center.
- An inpatient visit containing an Uncoded Diagnoses code in any of the 1-6 Purpose of Visits fields excludes that entire visit record from transmitting to the Data Center.
- The data entry operator must maintain the Provider Narrative verbatim. The narrative is a guide in determining the proper code.

Follow these steps:

1. At the “Select Fix UNCODED ICD Diagnoses/Operations Option” prompt, type **POV**.

2. At the “Enter the Beginning Date to Search for Uncoded V POV’s” prompt, type the beginning date for the search.
3. At the “Enter code indicating what LOCATIONS/FACILITIES are of interest” prompt, type one of the following:
 - A** ALL Locations/Facilities
 - S** One SERVICE UNIT’s Locations/Facilities
 - O** One Location/Facility
 - a. If S is used, type the name of the service unit at the “Which SERVICE UNIT” prompt.
 - b. If O is used, type the name of the location at the “Which LOCATION” prompt.
4. The system asks if you want to continue. Type **Y** and the output begins. Type **N** and the focus returns to the “Select UNCODED ICD Diagnoses/Operations Option” prompt.

Below is a sample output. Note: If the diagnosis was entered through the EHR application and Map Advice site parameter is set to Y, you are given the option to view map advice and update the ICD code as appropriate.

```

NAME: TEST,DONNA DOB: FEB 28,1980 SEX: F HRN: 13976
DATE OF VISIT: JAN 28,2016 12:00 LOC: 2013 DEMO HOSPITAL
POV: ZZZ.999 PATIENT NAME: TEST,DONNA
VISIT: JAN 28, 2016@12:00 PROVIDER NARRATIVE: TEST FOR UNCODED DX
ICD-9 CODE: .9999 PRIMARY SNOMED: 63161005
ENCOUNTER PROVIDER: ST CYR,DONNA DATE/TIME ENTERED: JAN 28, 2016@11:39:42
ENTERED BY: ST CYR,DONNA
DATE/TIME LAST MODIFIED: APR 02, 2016@13:06:09
LAST MODIFIED BY: ST CYR,DONNA

```

```

PROVIDER NARRATIVE: TEST FOR UNCODED DX
POV: ZZZ.999//
Continue? Y// Y YES

```

```

NAME: Test,KRISTINA LORRAINE DOB: DEC 18,1985 SEX: F HRN: 109415
DATE OF VISIT: MAR 12,2016 17:13 LOC: 2013 DEMO HOSPITAL
POV: ZZZ.999 PATIENT NAME: Test,KRISTINA LORRAINE
VISIT: MAR 12, 2016@17:13
PROVIDER NARRATIVE: Fracture of lower leg |
PRIMARY/SECONDARY: PRIMARY PROBLEM LIST ENTRY: ZZZ.999
SNOMED CONCEPT ID: 414292006 SNOMED DESCRIPTION ID: 2533504018
PRIMARY SNOMED: 63161005
EVENT DATE AND TIME: MAR 12, 2016@17:22:06
ENCOUNTER PROVIDER: BISHOP,BRADLEY M DATE/TIME ENTERED: MAR 12, 2016@17:22:06
ENTERED BY: BISHOP,BRADLEY M
DATE/TIME LAST MODIFIED: MAR 12, 2016@17:22:06
LAST MODIFIED BY: BISHOP,BRADLEY M

```

```

This POV has been SNOMED coded and there is map advice available.
Do you wish to see the Map Advice? Y//N
PROVIDER NARRATIVE: Fracture of lower leg |

```

```
POV: ZZZ.999//
```

Figure 3-3: Sample POV output

3.2 Fix Uncoded PROBLEM File Diagnoses (PRB)

Use the PRB option to access all active and inactive problems containing an Uncoded Diagnoses code in the Problem file. These codes do not affect the data transmission process; however, research, output, and future data entry on your local computer will be affected if these codes are not corrected.

Follow these steps:

1. At the “Select Fix UNCODED ICD Diagnoses/Operations Option” prompt, type **PRB**.
2. At the “Enter the Beginning Date to Search for Uncoded PROBLEM’s” prompt, type the beginning date for the search.
3. At the “Enter code indicating what LOCATIONS/FACILITIES are of interest” prompt, type one of the following:
 - A** ALL Locations/Facilities
 - S** One SERVICE UNIT’s Locations/Facilities
 - O** One Location/Facility
 - a. If S is used, type the name of the service unit at the “Which SERVICE UNIT” prompt.
 - b. If O is used, type the name of the location at the “Which LOCATION” prompt.
4. The system asks if you want to continue. Type **Y** and the output begins. Type **N** and the focus returns to the “Select UNCODED ICD Diagnoses/Operations Option” prompt.

Below is a sample output (at the beginning):

```
NAME: BIRD,JIM DOB: SEP 15,1945 SEX: M HRN: 103145
DIAGNOSIS: ZZZ.999 PATIENT NAME: BIRD,JIM
DATE LAST MODIFIED: AUG 17, 2006 PROVIDER NARRATIVE: *ULCERATIVE COLITIS
FACILITY: 2011 DEMO INDIAN HOSPITAL NMBR: 3
DATE ENTERED: DEC 15, 1987 STATUS: CHRONIC
USER LAST MODIFIED: KESSLER,SONYA A
NOTE FACILITY: 2011 DEMO INDIAN HOSPITAL
NOTE NMBR: 1 NOTE NARRATIVE: COLONOSCOPY 10/86
STATUS: ACTIVE
NOTE FACILITY: 2011 DEMO HOSPITAL
NOTE NMBR: 1 NOTE NARRATIVE: colonoscopy 7/06
DATE NOTE ADDED: AUG 17, 2006 AUTHOR: KESSLER,SONYA A
```

```
DIAGNOSIS: ZZZ.9999//
```

Figure 3-4: Sample PRB output

3.3 Fix Uncoded PERSONAL HISTORY Diagnoses (PER)

Use the PER option to access all ZZZ.999, Uncoded Diagnoses codes in the Personal History file. These codes do not affect the data transmission process; however, research, output, and future data entry on your local computer will be affected if these codes are not corrected.

Follow these steps:

1. At the “Select Fix UNCODED ICD Diagnoses/Operations Option” prompt, type **PER**.
2. At the “Enter the Beginning Date to Search for Uncoded PERSONAL HISTORY’s” prompt, type the beginning date for the search.
3. At the “Enter code indicating what LOCATIONS/FACILITIES are of interest” prompt, type one of the following:
 - A** ALL Locations/Facilities
 - S** One SERVICE UNIT’s Locations/Facilities
 - O** One Location/Facility
 - a. If S is used, type the name of the service unit at the “Which SERVICE UNIT” prompt.
 - b. If O is used, type the name of the location at the “Which LOCATION” prompt.
4. The system asks if you want to continue. Type **Y** and the output begins. Type **N** and the focus returns to the “Select UNCODED ICD Diagnoses/Operations Option” prompt.

Below is a sample output:

```
NAME: LINDSAY,FAITH ANN DOB: MAY 25,1979 SEX: F HRN: 119956
DIAGNOSIS: ZZZ.9999 PATIENT NAME: LINDSAY,FAITH ANN
DATE NOTED: SEP 23, 2004@14:13:08 PROVIDER NARRATIVE: ABNORMAL 1 HR GTT

PROVIDER NARRATIVE: ABNORMAL 1 HR GTT
DIAGNOSIS: ZZZ.9999//

Continue? Y// ES

NAME: WILLIAMS,FELICIA KAY DOB: JUN 25,1933 SEX: F HRN: 129466
DIAGNOSIS: ZZZ.9999 PATIENT NAME: WILLIAMS,FELICIA KAY
DATE NOTED: OCT 11, 2004@10:15:16
PROVIDER NARRATIVE: HISTORY OF ATRIAL FIBRILLATION
```

```
PROVIDER NARRATIVE: HISTORY OF ATRIAL FIBRILLATION
DIAGNOSIS: ZZZ.9999//
```

Figure 3-5: Sample PER output

3.4 Fix Uncoded FAMILY HISTORY Diagnoses (FAM)

Use the FAM option to access all ZZZ.9999, Uncoded Diagnoses codes in the Family History file. These codes do not affect the data transmission process; however, research, output, and future data entry on your local computer will be affected if these codes are not corrected.

Follow these steps:

1. At the “Select Fix UNCODED PERSONAL HISTORY Diagnoses/Operations Option” prompt, type **FAM**.
2. At the “Enter the Beginning Date to Search for Uncoded FAMILY HISTORY’s” prompt, type the beginning date for the search.
3. At the “Enter code indicating what LOCATIONS/FACILITIES are of interest” prompt, type one of the following:
 - A** ALL Locations/Facilities
 - S** One SERVICE UNIT’s Locations/Facilities
 - O** One Location/Facility
 - a. If S is used, type the name of the service unit at the “Which SERVICE UNIT” prompt.
 - b. If O is used, type the name of the location at the “Which LOCATION” prompt.
4. The system asks if you want to continue. Type **Y** and the output begins. Type **N** and the focus returns to the “Select UNCODED ICD Diagnoses/Operations Option” prompt.

Below is a sample output:

```
AME: BRADLEY,SHASTINA DOB: JAN 5,1957 SEX: F HRN: 169707
DIAGNOSIS: ZZZ.9999 PATIENT NAME: BRADLEY,SHASTINA
DATE NOTED: FEB 09, 2005@15:03:08 PROVIDER NARRATIVE: *Tonsillectomy
RELATION/FAMILY MEMBER: UNKNOWN
DATE LAST MODIFIED: FEB 09, 2005@15:03:08
AGE RANGE MOVED (PATCH): YES

PROVIDER NARRATIVE: *Tonsillectomy
DIAGNOSIS: ZZZ.9999//
```

```

Continue? Y// y YES

NAME: WACHACHA,HOLLY DOB: FEB 26,1972 SEX: F HRN: 126222
DIAGNOSIS: ZZZ.9999 PATIENT NAME: WACHACHA,HOLLY
DATE NOTED: AUG 12, 2005@11:00:22
PROVIDER NARRATIVE: *Positive hx of breast cancer--mother age 55
RELATION/FAMILY MEMBER: UNKNOWN
DATE LAST MODIFIED: AUG 12, 2005@11:00:22
AGE RANGE MOVED (PATCH): YES

PROVIDER NARRATIVE: *Positive hx of breast cancer--mother age 55
DIAGNOSIS: ZZZ.9999//

```

Figure 3-6: Sample FAM output

3.5 Fix Uncoded V PROCEDURE Operation Codes (OPS)

Use the OPS option to access all Uncoded Diagnoses codes in the Operation/Procedure file.

- An ambulatory visit containing an Uncoded Diagnoses code in the first procedure field excludes that entire visit record from transmitting to the Data Center.
- An inpatient visit containing an Uncoded Diagnoses code in any of the 1-3 Procedure fields excludes that entire visit record from transmitting to the Data Center.

Follow these steps:

1. At the “Select Fix UNCODED V PROCEDURE Operations Option” prompt, type **OPS**.
2. At the “Enter the Beginning Date to Search for UNCODED V PROCEDURE’s” prompt, type the beginning date for the search.
3. At the “Enter code indicating what LOCATIONS/FACILITIES are of interest” prompt, type one of the following:
 - A** ALL Locations/Facilities
 - S** One SERVICE UNIT’s Locations/Facilities
 - O** One Location/Facility
 - a. If S is used, type the name of the service unit at the “Which SERVICE UNIT” prompt.
 - b. If O is used, type the name of the location at the “Which LOCATION” prompt.
4. The system asks if you want to continue. Type **Y** and the output begins. Type **N** and the focus returns to the “Select UNCODED ICD Diagnoses/Operations Option” prompt.

3.6 Print a List of All Uncoded Diagnoses/Operations (PPV)

Use the PPV option to print hardcopies of all of the reports in the uncoded diagnoses and codes options. As stated above, they can be used for customizing your local ICD files and critiquing the ICD training requirements of the data entry staff.

To print reports, follow these steps:

1. At the “Select Fix UNCODED ICD Diagnoses/Operations Option” prompt, type **PPV**.
2. At the “Enter a code indicating what LOCATIONS/FACILITIES are of interest” prompt, type one of the following codes:
 - A** ALL Locations/Facilities
 - S** One SERVICE UNIT’S Locations/Facilities
 - O** One SERVICE UNIT’S Location/Facility
 - a. If S is used, type the name of the service unit at the “Which SERVICE UNIT” prompt.
 - b. If O is used, type the name of the location at the “Which LOCATION” prompt.
3. At the “Enter the Beginning Date to Search for Uncoded entries” prompt, type the beginning date for the search.
4. At the “Enter the Ending Date to Search for Uncoded entries” prompt, type the ending date for the search.
5. At the “Enter a code indicating what LOCATIONS/FACILITES are of interest” prompt, type one of the following codes:
 - A** for ALL Providers (PRIMARY)
 - S** for One Provider (PRIMARY)

If S is used, type the name of the provider at the “Which Provider” prompt.
6. At the “Which File would like to print from” prompt, type one of the following codes:
 - POV** VPOV
 - PRB** PROBLEM LISY
 - PRC** V PROCEDURE
 - FH** FAMILY HISTORY
 - PHX** PERSONAL HISTORY
 - A** ALL OF THE ABOVE
7. At the “Enter device for printing” prompt, specify the device to output the report.

Below is an example output:

```

                                PCC Data Entry Module
*****
* LISTING OF UNCODED DIAGNOSES AND PROCEDURES *
*****

V POV uncoded entries:

HRN: 108903      DOB: OCT 4,1961      SEX: M
POV: ZZZ.999
VISIT: JUL 01, 2002@10:50
PROVIDER NARRATIVE: RECURRENT DEEP VEIN THROMBOSIS
FIRST/REVISIT: REVISIT
OPERATOR FROM FORMS TRACKING OR CREATED BY: KNABENSHUE,CINDY
LOCATION OF ENCOUNTER: 2011 DEMO INDIAN HOSPITAL
PROVIDER: WILLIAMS,BETTY L

HRN: 130363      DOB: MAY 30,1960      SEX: F
POV: ZZZ.999
VISIT: FEB 24, 2004@10:00
PROVIDER NARRATIVE: BIP[OLAR
OPERATOR FROM FORMS TRACKING OR CREATED BY: MICKENS,ROSE MARIE
LOCATION OF ENCOUNTER: 2011 DEMO SGI
PROVIDER: MICKENS,ROSE MARIE

Enter RETURN to continue or '^' to exit:

```

Figure 3-7: Sample report for PPV option

To review the next page of information, press Enter at the last prompt.

Type a caret (^) at the last prompt and the focus returns to the “Select UNCODED ICD Diagnoses/Operations Option” prompt.

4.0 Link In-Hospital to Hospitalizations

The options and utilities on the Supervisor menu are shown below:

```

*****
**          PCC Data Entry Module          **
** Data Entry SUPERVISOR Options and Utilities **
*****

                IHS PCC SUITE  Version 2.0
                DEMO INDIAN HOSPITAL

ICD    Fix UNCODED ICD Diagnoses/Operations ...
VRR    Visit Review Report ...
INP    Link In-Hospital Visits to Hospitalizations ...
DSP    Display PCC Data Entry Site Parameters
ACC    Process ACCEPT Commands ...
DDPR   Delete Duplicate Primary Providers from Visits
ESP    Enter/Edit PCC Data Entry Site Parameters
EVM    Auto Merge Event Visits on Same Day
FTM    Forms/Data Entry Tracking Menu ...
LAB    Complete Orphaned Visits Menu ...
MDL    Visit Re-linker/Merge/Delete Log Reports ...
MNE    Update PCC Mnemonic's Allowed/Not Allowed
OTH    Other PCC Data Entry Reports ...
PLAL   Reports Listing Allergies recorded on PROBLEM LIST ...
PMN    Print list of Data Entry Mnemonics
RET    Re-Submit PCC Visit to the IHS Data Center
TAB    PCC Local Table Maintenance ...
UIFS   Update ICD-10 Diagnoses from SNOMED Concept ID
UPMC   Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 4-1: Options on the Supervisor's menu

Use the INP option to link visits containing a service category of I (In-hospital) to visits with a service category of H (Hospitalization). This must be done on a regular basis in order to internally connect these visits for future output purposes.

Type **INP** at the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt to display the In-Hospital Link Menu.

```

*****
**          PCC Data Entry Module          **
** Data Entry SUPERVISOR Options and Utilities **
**          In-Hospital Link Menu          **
*****

                IHS PCC Suite Version 2.0
                2011 DEMO HOSPITAL

AUT    Link In-Hospital Visits to Hospitalizations
MAN    Manually Link In-Hospital to Hospitalization

```

```
Select Link In-Hospital Visits to Hospitalizations Option:
```

Figure 4-2: Options on the In-Hospital Link menu

4.1 Link In-Hospital Visits to Hospitalizations (AUT)

The AUT option looks at the admission and discharge date for each H visit, and then searches for any I visit containing a visit date in that range. If an I visit is found, an internal link is automatically made; however, no visit records are deleted or merged. It is reasonable to have multiple I visits linked to one H visit. It is also reasonable to have I visits with no H visit linkage. Once AUT is complete, it is possible to determine cost or extract information regarding a patient's full hospitalization stay.

All facilities should be running AUT on a regular basis, at least once a month. Hospitals and outpatient facilities should perform this function for Contract and non-Contract data purposes. When AUT is run a printout is generated stating what visits were linked and what visits were not. This consists of two to four reports, depending on the existing data. AUT will not link visits with a visit date greater than one year but will generate a report stating which visits were not linked.

This routine will find all in-hospital visits that are not linked to a hospitalization and link them if possible.

This process could take some time; consider queuing the report to print after hours.

Specify the device for printing at the "DEVICE" prompt.

The report is divided into the following parts, as in the example below.

- The following In-Hospital Visits are over one year old and are not linked to a Hospitalization. These visits will not be displayed on future reports.
- The following In-Hospital Visits could be linked to two or more Hospitalizations. These visits must be linked manually.
- The following In-Hospital Visits were linked to the Hospitalizations listed.

An example, below, shows In-Hospital Visits Linked to Hospitalizations.

```
JUL 15,2014                                     Page: 2
                                     PCC Data Entry Module
*****
* REPORT OF IN-HOSPITAL VISITS LINKED TO HOSPITALIZATIONS *
*****

-----
The following In-Hospital Visits could be linked to two or more
Hospitalizations. They must be linked manually.
-----

IN-HOSP:  DATE: [JAN 20,1989@12:00] NAME: [KALONAHESKIE,SAMMY JACKSON] TYPE: [C
]
```

```

LOCATION: [UNDESIG LOCS] DEPENDENT ENTRY CNT: [3]
HOSPITALIZATION: DATE: [JAN 20,1989@12:00] NAME: [KALONAHESKIE,SAMMY JACKSON] T
YPE: [C]
LOCATION: [UNDESIG LOCS] DISCH DATE: [JAN 21,1989]
HOSPITALIZATION: DATE: [JAN 20,1989@12:00] NAME: [KALONAHESKIE,SAMMY JACKSON] T
YPE: [C]
LOCATION: [UNDESIG LOCS] DISCH DATE: [JAN 21,1989]
Enter RETURN to continue or '^' to exit:

```

Figure 4-3: Sample In-House Visits Linked to Hospitalization

To review the next page of information, press Enter at the last prompt.

Type a caret (^) at the last prompt and the focus returns to the “Select Link In-Hospital Visits to Hospitalizations Option:” prompt.

4.2 Manually Link In-Hospital to Hospitalizations (MAN)

Use the MAN option for visits that did not automatically link. In some cases, AUTO does not know which I visit(s) correspond to an H visit. In this case, the PCC supervisor must investigate each visit by pulling the chart and performing the linkage using the MAN option and the appropriate H visit.

To manually link I visits to H visits, follow these steps:

1. At the “Select Link In-Hospital Visits to Hospitalizations Option” prompt, type **MAN**.
2. At the “Select PATIENT NAME” prompt, type the name of the patient.
3. At the “Enter IN-HOSPITAL Visit date” prompt, type the date.

If you entered an invalid date, the application displays the “No IN-HOSPITAL Visit selected!” message. In this case, the focus returns to the “Select Link In-Hospital Visits to Hospitalizations Option” prompt.

4. At the “Enter HOSPITALIZATION Admission date” prompt, type the admission date.

Below is a sample of this prompt:

```

Enter HOSPITALIZATION Admission date: 01132008@12:00
DATE VISIT CREATED: JAN 16, 2008 TYPE: CONTRACT
PATIENT NAME: ALPHA,PATIENT LOC OF ENCOUNTER:
TUCSON MEDICAL CENTER
SERVICE CATEGORY: HOSPITALIZATION DEPENDENT ENTRY COUNT: 3
DATE LAST MODIFIED: MARCH 3, 2008

Do you want to see the Entire Visit (V FILE entries)?? NO//

```

```
Do you want to continue (Y/N)  N//  Y
```

Figure 4-4: Sample prompts

5. The application displays this message: “In-Hospital Visit Linked!!”

When you display a visit, look at the in-hospital visit and visit file information. The Parent Visit Link field should give you the date of admission for the hospitalization. At this point, the visit should not appear on any error reports.

5.0 Display PCC Data Entry Site Parameters

The options and utilities on the Supervisor menu are shown below:

```

*****
**                PCC Data Entry Module                **
** Data Entry SUPERVISOR Options and Utilities **
*****

                IHS PCC SUITE  Version 2.0
                DEMO INDIAN HOSPITAL

ICD    Fix UNCODED ICD Diagnoses/Operations ...
VRR    Visit Review Report ...
INP    Link In-Hospital Visits to Hospitalizations ...
DSP    Display PCC Data Entry Site Parameters
ACC    Process ACCEPT Commands ...
DXV    DX Coding Audit for Selected Set of Visits
DDPR   Delete Duplicate Primary Providers from Visits
ESP    Enter/Edit PCC Data Entry Site Parameters
EVM    Auto Merge Event Visits on Same Day
FTM    Forms/Data Entry Tracking Menu ...
LAB    Complete Orphaned Visits Menu ...
MDL    Visit Re-linker/Merge/Delete Log Reports ...
MNE    Update PCC Mnemonic's Allowed/Not Allowed
OTH    Other PCC Data Entry Reports ...
PLAL   Reports Listing Allergies recorded on PROBLEM LIST ...
PMN    Print list of Data Entry Mnemonics
RET    Re-Submit PCC Visit to the IHS Data Center
TAB    PCC Local Table Maintenance ...
UIFS   Update ICD-10 Diagnoses from SNOMED Concept ID
UPMC   Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 5-1: Data Entry SUPERVISOR Options and Utilities menu

Use the DSP option to display or print the Data Entry Site parameters of a specified site.

Follow these steps:

1. At the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt, type **DSP**.
2. At the “Select PCC DATA ENTRY SITE PARAMETERS SITE NAME” prompt, type the name of the site.
3. At the “Do you want to” prompt, type one of the following **B** (BROWSE Output on Screen or **P** (PRINT Output to Printer).

The application displays the Data Entry Site parameters for the particular site.

```

OUTPUT BROWSER                Jul 11, 2014 10:09:38                Page:    1 of    3
Patient Care Component Site Parameter Display

```

```
PATIENT CARE COMPONENT DATA ENTRY SITE PARAMETERS

                SITE NAME:  2011 DEMO HOSPITAL
                  LOOKUP:  UNIVERSAL
ASK YES ON VISIT CREATION:  YES
DISPLAY PROBLEM LIST ON PO/NO:  YES
                  FORMS TRACKING:  YES
    DEFAULT VALUES DISPLAYED:  YES
    DISPLAY FAMILY/PERSONAL HX:  YES
DISPLAY SURGICAL HISTORY (SHX):  YES
    DEFAULT LOCATION:  2011 DEMO HOSPITAL
    DEFAULT VISIT TYPE:  TRIBE-NON 638/NON COMPACT
    DEFAULT SERVICE CATEGORY:  AMBULATORY
    DEFAULT CLINIC:  GENERAL
    HEALTH SUMMARY TYPE FOR DHS:  ADULT REGULAR
+      Enter ?? for more actions                                >>>
+  NEXT SCREEN          -  PREVIOUS SCREEN          Q  QUIT
Select Action: +//
```

Figure 5-2: Sample output of the Data Entry Site parameters

Perform any one of the following on this report screen:

- Type + to display the next screen (does not apply to the last page).
- Type - to display the previous screen (does not apply to the first page).
- Type **Q** to exit the output screen.

6.0 Process Accept Commands

The options and utilities on the Supervisor menu are shown below:

```

*****
**          PCC Data Entry Module          **
** Data Entry SUPERVISOR Options and Utilities **
*****
                IHS PCC SUITE  Version 2.0
                DEMO INDIAN HOSPITAL

ICD    Fix UNCODED ICD Diagnoses/Operations ...
VRR    Visit Review Report ...
INP    Link In-Hospital Visits to Hospitalizations ...
DSP    Display PCC Data Entry Site Parameters
ACC    Process ACCEPT Commands ...
DDPR   Delete Duplicate Primary Providers from Visits
ESP    Enter/Edit PCC Data Entry Site Parameters
EVM    Auto Merge Event Visits on Same Day
FTM    Forms/Data Entry Tracking Menu ...
LAB    Complete Orphaned Visits Menu ...
MDL    Visit Re-linker/Merge/Delete Log Reports ...
MNE    Update PCC Mnemonic's Allowed/Not Allowed
OTH    Other PCC Data Entry Reports ...
PLAL   Reports Listing Allergies recorded on PROBLEM LIST ...
PMN    Print list of Data Entry Mnemonics
RET    Re-Submit PCC Visit to the IHS Data Center
TAB    PCC Local Table Maintenance ...
UIFS   Update ICD-10 Diagnoses from SNOMED Concept ID
UPMC   Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 6-1: Data Entry SUPERVISOR Options and Utilities menu

Use the ACC option to assign an ICD code to a diagnosis based on several criteria. In addition to the internationally recognized criteria, the IHS requires specific edits to several diagnoses as well. These edits have been programmed into PCC and are subsequently checked on data that is transmitted to the Data Center. If an edit is not allowed for a particular diagnosis, the visit will be rejected at the Data Center.

Type **ACC** at the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt to access the PCC Data Entry Module screen.

```

*****
**          PCC Data Entry Module          **
*****
                IHS PCC Suite Version 2.0
                2011 DEMO HOSPITAL

ACC    List Records with ACCEPT Command
EAC    Assign the ACCEPT Command to a V Record
RAC    Remove the Accept command from a Visit Record

```

```
Select Process ACCEPT Commands Option:
```

Figure 6-2: Options on the PCC Data Entry Module menu

6.1 List Records with ACCEPT Command (ACC)

Use the ACC option to obtain a hardcopy printout of visit records containing an ACC command. This list should be thoroughly reviewed and verified. When appropriate, the ACC can be removed and the ICD code changed.

This option prints all the Purpose of Visit, Procedures, and/or Hospitalization records to which the ACCEPT command has been applied. The ACCEPT command is used to override an edit in the IHS Direct Inpatient and/or PCIS Systems.

To print a list of records, follow these steps:

1. At the “Select Process ACCEPT Commands Option” prompt, type **ACC**.
2. At the “Run Report by” prompt, type the report type to be used: **1** (Posting Date) or **2** (Visit Date).
3. At the “Enter beginning Visit Date for Search” prompt, type the beginning date of the date range.
4. At the “Enter ending Visit Date for Search” prompt, type the ending date of the date range.
5. At the “LIST ACCEPT commands for which of the above” prompt, type one of the following record types:
 - 1** Purpose of Visit Record
 - 2** Operations/Procedure Records
 - 3** V Hospitalization Records
 - 4** All of the Above
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I** Include ALL Patients
 - E** Exclude ALL Patients
 - O** Include ONLY DEMO Patients
7. At the “DEVICE” prompt, specify the device to output the report.

Below is a sample ACC report.

```
PCC DATA ENTRY ACCEPT COMMAND REPORT
```

```
Page: 1
```

```
REPORT OF POV'S FOR POSTING DATE RANGE: JUL 11,2013 THROUGH JUL 11,2014
```

```

Date: [NOV 21,2013@12:00] Name: [FORBES,GARLAND J] Sex: M]
HRN: [172420] Date of Birth: [NOV 19,1958] Age in Days: [20091]
POV Code: [296.32] ICD Narrative: [RECURR DEPR PSYCHOS-MOD]
Overridden By: [GARCIA,RYAN]

Enter RETURN to continue or '^' to exit:

```

Figure 6-3: Sample ACC report

To review the next page of information, press Enter at the last prompt.

Type a caret (^) at the last prompt and the focus returns to the “Select Link In-Hospital Visits to Hospitalizations Option:” prompt.

6.2 Assign the ACCEPT Command to a V Record (EAC)

Use the EAC option to assign the ACCEPT command to a V record.

Follow these steps:

1. At the “Select Process ACCEPT Commands Option” prompt, type **EAC**. The application displays the following message:

```

PLEASE NOTE: THE ACCEPT COMMAND IS NO LONGER NECESSARY TO BE ENTERED TO
OVERRIDE AN EDIT. THIS OPTION WILL BE ELIMINATED IN A FUTURE PATCH. VISITS
WILL EXPORT TO THE DATA WAREHOUSE AND WILL NOT BE REJECTED IF THE ACCEPT
COMMAND IS NOT PRESENT.

```

Figure 6-4: Message about EAC

2. At the “Enter Patient Name” prompt, type the patient name.
3. At the “Enter VISIT date” prompt, type the date of the visit.

The report is shown below:

```

VISIT IEN: 1725808

HRN: WW 113487
----- VISIT FILE -----
VISIT/ADMIT DATE&TIME: FEB 11, 2002@06:05
DATE VISIT CREATED: FEB 11, 2002 TYPE: IHS
THIRD PARTY BILLED: PRIVATE INSURANCE; VISIT OUTSIDE ELIGIBILITY DATES
(NE)
PATIENT NAME: TONAHCOT,REBECCA LEE LOC. OF ENCOUNTER: DEMO INDIAN
HOSPITAL
SERVICE CATEGORY: HOSPITALIZATION DEPENDENT ENTRY COUNT: 10
DATE LAST MODIFIED: APR 10, 2002 DATE VISIT EXPORTED: OCT 29, 2002
CREATED BY USER: HAMILTON,DEBRA DEE USER LAST UPDATE: GILLIAM,CHRISTINE
B
NDW UNIQUE VISIT ID (DBID): 102320001725808

----- V HOSPITALIZATION -----
DATE OF DISCHARGE: FEB 13, 2002@11:40 PATIENT NAME: TONAHCOT,REBECCA LEE

```

```

VISIT: FEB 11, 2002@06:05      ADMITTING SERVICE: GYNECOLOGY
DISCHARGE SERVICE: GYNECOLOGY  DISCHARGE TYPE: REGULAR DISCHARGE
ADMISSION TYPE: DIRECT         ADMITTING DX: 233.1
LENGTH OF STAY (c): 2

Enter to continue, '^' to halt

```

Figure 6-5: Sample report

Type a caret (^) at the last prompt and the focus returns to the “Select Process ACCEPT Commands Option” prompt.

To review the next page of information, press Enter.

At the end of the visit display, the following message is displayed:

```

End of visit display, <ENTER> to Continue
Select one of the following:
1. Purpose of Visit (V POV)
2. Procedure/Operation (V PROCEDURE)
3. Inpatient Record (V HOSPITALIZATION)

```

Figure 6-6: Message at end of report

Identify the item to which to apply the ACCEPT command. When you type the appropriate number, the following message is displayed:

```

Accept Command has been set for Purpose of Visit (V POV) XXXX (If the
Purpose of Visit had the Accept Command applied).

```

Figure 6-7: Sample message

6.3 Remove the Accept command from a Visit Record (RAC)

Note: The IHS Direct Inpatient System no longer requires the use of the ACCEPT command. This option is no longer necessary and will be eliminated.

Use the RAC option to remove an ACC flag that has previously been applied to an ICD code. However, removing the ACC flag does not change the code; you must manually change the ICD code to an appropriate code for the diagnoses according to the patient age and/or sex. This is accomplished through the data entry menu using Modify or the MOD mnemonic.

To remove an ACC flag, follow these steps:

1. At the “Select Process ACCEPT Commands Option” prompt, type **RAC**.
2. At the “Enter Patient Name” prompt, type the patient name.

3. At the “Enter VISIT date” prompt, type the date of the visit.

After entering the date, the report displays:

```
VISIT IEN: 1725808

HRN: WW 113487
----- VISIT FILE -----
VISIT/ADMIT DATE&TIME: FEB 11, 2002@06:05
DATE VISIT CREATED: FEB 11, 2002 TYPE: IHS
THIRD PARTY BILLED: PRIVATE INSURANCE; VISIT OUTSIDE ELIGIBILITY DATES
(NE)
PATIENT NAME: TONAHCOT,REBECCA LEE LOC. OF ENCOUNTER: DEMO INDIAN
HOSPITAL
SERVICE CATEGORY: HOSPITALIZATION DEPENDENT ENTRY COUNT: 10
DATE LAST MODIFIED: APR 10, 2002 DATE VISIT EXPORTED: OCT 29, 2002
CREATED BY USER: HAMILTON,DEBRA DEE USER LAST UPDATE: GILLIAM,CHRISTINE
B
NDW UNIQUE VISIT ID (DBID): 102320001725808

----- V HOSPITALIZATION -----
DATE OF DISCHARGE: FEB 13, 2002@11:40 PATIENT NAME: TONAHCOT,REBECCA LEE
VISIT: FEB 11, 2002@06:05 ADMITTING SERVICE: GYNECOLOGY
DISCHARGE SERVICE: GYNECOLOGY DISCHARGE TYPE: REGULAR DISCHARGE
ADMISSION TYPE: DIRECT ADMITTING DX: 233.1
LENGTH OF STAY (c): 2

Enter to continue, '^' to halt
```

Figure 6-8: Sample report

Type a caret (^) at the last prompt and the focus returns to the “Select Process ACCEPT Commands Option” prompt.

To review the next page of information, press Enter.

At the end of the visit display, the following message appears:

```
End of visit display, <ENTER> to Continue
Select one of the following:
1. Purpose of Visit (V POV)
2. Procedure/Operation (V PROCEDURE)
3. Inpatient Record (V HOSPITALIZATION)
```

Figure 6-9: Sample message

Identify the item from which to remove the ACCEPT command. When you type the appropriate number, the application displays the following message:

```
Accept Command has been removed for POV XXXXX (if the Purpose of Visit had
the Accept Command removed).
```

Figure 6-10: Sample message

7.0 Delete Duplicate Primary Providers from Visits

The options and utilities on the Supervisor menu are shown below:

```

*****
**          PCC Data Entry Module          **
** Data Entry SUPERVISOR Options and Utilities **
*****

IHS PCC SUITE Version 2.0
DEMO INDIAN HOSPITAL

ICD    Fix UNCODED ICD Diagnoses/Operations ...
VRR    Visit Review Report ...
INP    Link In-Hospital Visits to Hospitalizations ...
DSP    Display PCC Data Entry Site Parameters
ACC    Process ACCEPT Commands ...
DDPR   Delete Duplicate Primary Providers from Visits
ESP    Enter/Edit PCC Data Entry Site Parameters
EVM    Auto Merge Event Visits on Same Day
FTM    Forms/Data Entry Tracking Menu ...
LAB    Complete Orphaned Visits Menu ...
MDL    Visit Re-linker/Merge/Delete Log Reports ...
MNE    Update PCC Mnemonic's Allowed/Not Allowed
OTH    Other PCC Data Entry Reports ...
PLAL   Reports Listing Allergies recorded on PROBLEM LIST ...
PMN    Print list of Data Entry Mnemonics
RET    Re-Submit PCC Visit to the IHS Data Center
TAB    PCC Local Table Maintenance ...
UIFS   Update ICD-10 Diagnoses from SNOMED Concept ID
UPMC   Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 7-1: Data Entry SUPERVISOR Options and Utilities menu

Use the DDPR option to find all visits in a specified date range that have duplicate primary providers and delete one of the primary provider entries.

1. At the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt, type **DDPR**.
2. At the “Enter Beginning Visit Date” prompt, type the beginning date of the date range.
3. At the “Enter Ending Visit Date” prompt, type the ending date of the date range.
4. The application asks if you want to continue. Type **Y** to continue the process. Type **N** to not continue.

```

Enter Beginning Visit Date: t-365 (OCT 18, 2007)
Enter Ending Visit Date: t (OCT 17, 2008)
Do you want to continue? N// y YES

```

Figure 7-2: Prompts displayed after using the DDPR option

8.0 DX Coding Audit for Selected Set of Visits (DXV)

The DXV option allows a PCC supervisor or an area office to perform routine and random checks on a selected data entry operator's ICD coding. This report should be used in place of the DXA report by sites that have implemented the EHR.

1. The report checks the V CHART/AUDTI file and determines the last person who entered a chart audit status of Reviewed/Complete for a visit.
2. The report checks the V POV file and determines the last user to modify the visit POV.

You can select visits based on:

1. Visit date or date last modified
2. Service category
3. Clinic
4. Operator who last marked the visit as reviewed complete or modified the POV
5. Visits marked as reviewed/complete or all visits

Select all visits if you want to include hospital, telephone or chart review visits. These visit types do not require a reviewed/complete status in the coding queue.

6. Visit by ICD diagnosis code

HR#	Visit Date/Time	Clinic	SC	Reviewed/Completed By
2013 DEMO HOSPITAL Last Modified Dates: NOV 25, 2015 - SEP 20, 2016 Data Entry Operator: ST CYR,DONNA Service Categories: All Clinic: ALL Only visit marked reviewed/complete are included Total Visits Found: 81				
ICD DX	ICD-9	Provider Narrative [ICD Description]		

TST 298378	DEC 25, 2015@12:09	GENERAL	A	ST CYR,DONNA
Z00.01	V70.9	Last Modified By: ST CYR,DONNA		
Evaluation and management of new outpatient in office or other outpatient facility Enlarged Thyroid				
[Encounter for general adult medical exam w abnormal findings]				
E04.9	240.9	Last Modified By: ST CYR,DONNA		
Goiter Enlarged Thyroid				

Figure 8-1: Sample ICD Diagnosis Coding Audit for Selected Set of Visits Report

9.0 Enter/Edit PCC Data Entry Site Parameters

The options and utilities on the Supervisor menu are shown below:

```

*****
**          PCC Data Entry Module          **
** Data Entry SUPERVISOR Options and Utilities **
*****

          IHS PCC SUITE  Version 2.0
          DEMO INDIAN HOSPITAL

ICD      Fix UNCODED ICD Diagnoses/Operations ...
VRR      Visit Review Report ...
INP      Link In-Hospital Visits to Hospitalizations ...
DSP      Display PCC Data Entry Site Parameters
ACC      Process ACCEPT Commands ...
DDPR     Delete Duplicate Primary Providers from Visits
DXV      DX Coding Audit for Selected Set of Visits
ESP      Enter/Edit PCC Data Entry Site Parameters
EVM      Auto Merge Event Visits on Same Day
FTM      Forms/Data Entry Tracking Menu ...
LAB      Complete Orphaned Visits Menu ...
MDL      Visit Re-linker/Merge/Delete Log Reports ...
MNE      Update PCC Mnemonic's Allowed/Not Allowed
OTH      Other PCC Data Entry Reports ...
PLAL     Reports Listing Allergies recorded on PROBLEM LIST ...
PMN      Print list of Data Entry Mnemonics
RET      Re-Submit PCC Visit to the IHS Data Center
TAB      PCC Local Table Maintenance ...
UIFS     Update ICD-10 Diagnoses from SNOMED Concept ID
UPMC     Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 9-1: Data Entry SUPERVISOR Options and Utilities menu

Prior to data entry, the PCC manager/supervisor must establish the site file. This option allows specific parameters to be set or changed that affect how the data entry staff enters data. Rather than the traditional 'Roll and Scroll' display, this option makes use of the VA ScreenMan to display the editable fields in the site file.

For help with ScreenMan, press the <PF1> key if using a Wyse or IBM 3151 terminal, or F1 on a standard PC keyboard, followed by an action key such as 'H' to obtain the on-screen help. Once in ScreenMan, press the Tab key to move from field to field; the UP/DOWN RIGHT/LEFT arrow keys will also work in many cases. Because ScreenMan makes use of reverse video in places, parts of the display might be difficult to read. If the color settings cause problems in reading parts of the ScreenMan display, contact your site manager for assistance.

Many of the editable fields in the ScreenMan display have a question followed by the current setting. To change the value in a field, you must move to the field using Tab or the arrow keys, and then type the desired value or type a question mark (?) to obtain help for that parameter. For example, in the example shown above, PROMPT FOR MODIFIER ON POV is currently turned on, and to turn that parameter off, move to that field and type N to change the value to N (no).

Some of the fields displayed by ScreenMan are not in the form of a question, but end with the “(press Enter):” prompt. These parameters contain multiple values; when Enter is pressed at the prompt; a new screen opens containing the parameters that can be edited. Pressing Enter at the “UPDATE DEFAULT PARAMETERS (press enter):” prompt will display the following:

```
*****Update Default Site Parameters*****
Do you want the DEFAULT VALUES displayed?(Y/N):
DEFAULT LOCATION:
DEFAULT VISIT TYPE:
DEFAULT SERVICE CATEGORY:
DEFAULT CLINIC:
HISTORICAL VISIT TYPE:
DEFAULT HEALTH SUMMARY TYPE for DHS
```

Figure 9-2: Sample Update Default Site Parameters display

This screen is reviewed in a section below.

Follow these steps to update PCC data entry parameters:

1. At the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt type **ESP**.
2. At the “Select PCC DATA ENTRY SITE PARAMETERS SITE NAME” prompt, type the name of the site.

The application verifies the name of the site. Type **Y** to accept the name. Otherwise, type **N** and the prompt repeats.

If Y was used, the application displays the ScreenMan window:

```
UPDATE PCC DATA ENTRY PARAMETERS   SITE NAME:  2011 DEMO HOSPITAL
*****
UPDATE DEFAULT PARAMETERS (press enter):          FORMS TRACKING? (Y/N) Y
UPDATE DISPLAY PARAMETERS (press enter):          ASK OUTSIDE LOCATION? (Y/N) Y
Prompt for VISIT CREATION? (Y/N) Y                ASK PROVIDER EVENT TIME? (Y/N) Y
Turn on ICD-9 coding: YES, TURN ON DUAL CODI     MAP ADVICE DEFAULT RESPONSE: YES
PROMPT FOR MODIFIERS WITH CPT ENTRY? YES        PROMPT FOR MODIFIER ON POV? N
ASK WALK-IN/APPT FOR CLINIC? (Y/N) Y           Require AT on PHN Visits?  N
UNIVERSAL or SITE SPECIFIC LOOKUPS? UNIVERSAL
Exclude Inactive Patients in Patient Lookup when entering new data?  NO
TYPE OF PROCEDURE CODING: CPT PROCEDURE CODING
REQUIRE ENCOUNTER PROVIDER AND DIAGNOSIS ON CPE MNEMONIC:
Require Present on Admission (POA) for Hospital Stays?
```

```

Keep a log of orphaned lab visits that are re-linked? YES
Select PERSON TO RECEIVE IN-HOSPITAL LINK MESSAGE: MARFISEE,ELIZABETH ELLEN
Update Locations with Charts (press enter):
Update Auto Prompting of Mnemonics (press enter):

Exit      Save      Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

```

Figure 9-3: Display from ScreenMan

3. At the “Update Default Parameters” prompt, press Enter to display the Update Default Site Parameters pop-up window.

```

*****Update Default Site Parameters*****

Do you want the DEFAULT VALUES displayed?(Y/N): Y
DEFAULT LOCATION: 2011 DEMO HOSPITAL
DEFAULT VISIT TYPE: TRIVE-NON 6
DEFAULT SERVICE CATEGORY: AMBULATORY
DEFAULT CLINIC: GENERAL
HISTORICAL VISIT TYPE: IHS
DEFAULT HEALTH SUMMARY TYPE for DHS: ADULT REGULAR

```

Figure 9-4: Sample Update Default Parameters pop-up window

As the cursor moves through the prompts, you can change (edit) the value for each particular prompt.

- a. At the “Do you want the DEFAULT VALUES displayed?” prompt, type **Y** (yes) or **N** (no) depending on the preference of the data entry operators.

Use Y (yes) to allow the application to automatically display the default values at the Location, Visit Type, Service Category, and Clinic when creating visits in PCC data entry. However, a default value is not required at all items.

When using default values at Location, Visit Type and/or Service Category, the data entry operator must type a caret (^) to back out of the data entry menu.

Use N (no) if the default values are not preferred.
- b. At the “DEFAULT LOCATION” prompt, consider the following:

If a location is stored in this parameter, it is automatically entered when creating visits during data entry. A different location can be entered during data entry because the operator is not required to accept the default. Any default value in this parameter must first exist in the Location File before it can be selected.

If data is entered for more than one location, this should not be used because visits can more easily be created in error.

- c. At the “DEFAULT VISIT TYPE” prompt, type any valid visit type to store the visit type as a default for data entry. However, it need not be accepted during the data entry process. Type one of following:
- I** (IHS)
 - C** (Contract)
 - T** (Tribe-Non 638/Non Compact)
 - O** (Other)
- d. At the “DEFAULT SERVICE CATEGORY” prompt, type **A** for ambulatory. If **AMBULATORY** is stored as the default category, it will be used when creating visits during PCC data entry; however, the data entry operator can change the Service Category as needed. Ambulatory is the only Service Category that can be stored as a default.
- e. At the “DEFAULT CLINIC” prompt, type the clinic stop name or code. A default clinic is specified when a facility does not hold a large number of organized clinics but usually conducts General (01) clinic throughout the day. This is the most common clinic used here; however, any IHS standard clinics can be used as a default.

If your facility holds several different types of organized clinics, a default clinic would not be advantageous to the data entry operator and should be left blank.

Once the default clinic is specified, the application automatically enters this clinic when using the CL mnemonic; however, a different Clinic can be entered because the operator is not required to accept the default.

- f. At the “HISTORICAL VISIT TYPE” prompt, type one of the following:
- I** (IHS)
 - C** (Contract)
 - 6** (638 Program)
 - T** (Tribal)
 - O** (Other)
 - V** (VA)

The Historical Visit Type is used when the data entry staff enters historical information and one visit type is specified more frequently than another.

This visit type is then automatically entered when creating visits during data entry using the Historical mnemonics: HBS, HCBC, HHCT, HEKG, HEX, HIM, HLAB, HMSR, HPAP, HRAD, HS, HUA, SHX.

A different visit type can be entered during data entry because the operator is not required to accept the default.

- g. At the “DEFAULT HEALTH SUMMARY TYPE for DHS” prompt, type the default health summary type to be used with the DHS mnemonic. This default health summary is entered by the application when the data entry person is at the MNEMONIC prompt. However, the data entry operator can display a list of valid entries (and not use the default value).

The most common choice is the Adult Regular Health Summary; however, any standard or customized health summary can be identified.

Press Tab at the last prompt to exit the pop-up window and return to the Update PCC Data Entry Parameters form.

4. At the “Forms Tracking” prompt, type **Y** (yes) or **N** (no).

YES enables the use of the Forms/Data Entry Tracking features located in the Supervisory options. Use Y (yes) during implementation of PCC because Forms Tracking begins counting on the day Y (yes) is set; it cannot track data entered retrospectively.

NO causes the Forms Tracking to not function and reports cannot be generated.

5. At the “Update Display Parameters” prompt, press Enter to update the display values. The application displays the following pop-up window:

```

*****Update Display Values*****

DISPLAY PROBLEM LIST ON PO/NO? (Y/N)
DISPLAY FAMILY/PERSONAL HISTORY? (Y/N)
DISPLAY SURGICAL HISTORY? (Y/N)
DISPLAY VISIT AFTER SELECTING? (Y/N)

```

Figure 9-5: Sample Update Display Parameter Values pop-up window

This option allows updating the display parameter of the Patient Care Component Data Entry screen.

- a. At the “DISPLAY PROBLEM LIST ON PO/NO?” prompt, always type **Y** (yes) so that a patient’s active and inactive problems display on the screen during the data entry process. This affects all the data entry Problem mnemonics: PO, NO, PPV, MPO, APO, IPO, RPO, RNO, MNN.
- b. At the “DISPLAY FAMILY/PERSONAL HISTORY?” prompt, type **Y** (yes) or **N** (no).

Use YES if the data entry staff is new to PCC. The Visit File will be displayed after the initial visit criteria have been entered: Location, Visit Type, Service Category, Date, Time, and Health Record Number (HRN).

Use NO only when the data entry operators are knowledgeable in PCC data entry and no longer require an automatic display of the Visit File. The N option is not advised if your facility is capturing information for multiple disciplines and locations.

- c. At the “DISPLAY SURGICAL HISTORY” prompt, type **Y** (yes) or **N** (no). If Y is used, the patient’s surgical history is displayed on the screen during the data entry process.
- d. At the “DISPLAY VISIT AFTER SELECTING?” prompt, type **Y** (yes) or **N** (no).

Use Y (Yes) if the data entry staff is new to PCC. The Visit File will be displayed after the initial visit criteria have been entered: Location, Visit Type, Service Category, Date, Time, and Health Record Number (HRN).

Use N (No) only when the data entry operators are knowledgeable in PCC data entry and no longer require an automatic display of the Visit File. The N option is not advised if your facility is capturing information for multiple disciplines and locations.

Press Tab at the last prompt to exit the pop-up window and return to the Update PCC Data Entry Parameters form.

- 6. At the “ASK OUTSIDE LOCATION?” prompt, type **Y** (yes) or **N** (no).

Use YES if the facility is using generic, undesignated locations when creating visits in data entry. The operator is then allowed to add a descriptive line about the generic location using 2-50 characters after the Visit File is created during data entry. This parameter corresponds with the OLOC mnemonic, which will prompt the operator while in the data entry menu and when appropriate. The OLOC or VST mnemonics can be used to modify an error while in a visit.

Use NO if the facility does not use generic, undesignated locations and data entry does not want to see the prompt appear.

- 7. At the “Prompt For VISIT CREATION?” prompt, type **Y** (yes) or **N** (no).

Use YES if you do want the question “OK YES//” after each HRN is entered and prior to the creation of a visit while in the PCC data entry.

Use NO if you do not want the question “OK? YES//” after each HRN is entered and prior to the creation of a visit while in the PCC data entry. If N (no) is used, the operator is not allowed to verify that the patient and a visit are created immediately.

8. At the “ASK PROVIDER EVENT TIME?” prompt, type **Y** (yes) or **N** (no).

Use YES to give the data entry operator the opportunity to enter the date and time that the provider saw the patient. This feature is particularly useful if the site is interested in conducting waiting time studies. Also see waiting time mnemonics in the PCC Data Entry Mnemonic manual.

9. At the “Turn on ICD-9 coding” prompt, type **1** (YES, TURN ON DUAL CODING), or **2** (NO TURN OFF DUAL CODING).

Use YES to turn on dual coding. Otherwise, use NO.

10. At the “MAP ADVICE DEFAULT RESPONSE?” prompt, type **Y** (yes) or **N** (no).

Use YES if you think your coding staff will want to see the Map Advice associated with POVs which are SNOMED coded a majority of the time.

11. At the “PROMPT FOR MODIFIERS WITH CPT ENTRY” prompt, type **Y** (yes) or **N** (no).

Use YES to allow the data entry operator to enter a modifier whenever CPT code information is entered during the data entry process, and that information will be passed to the Third Party Billing package.

Many sites will use NO when the billing personnel are responsible for determining what, if any, modifiers should be utilized on the third party claim.

12. At the “PROMPT FOR MODIFIER ON POV” prompt, type **Y** (yes) or **N** (no).

Use YES to have the data entry operator see the MODIFIER prompt with each POV.

Use NO to have the MODIFIER prompt not appear during entry of the Purpose of Visit; however, the operator can enter a modifier (e.g., RULE OUT, SUSPECT, etc.) by utilizing the MOD mnemonic and selecting the PV action. At that time, the operator will have the opportunity to step through all fields in the POV just as if the parameter had been set to Yes to allow automatic prompting of MODIFIER.

13. At the “ASK WALK-IN/APPT FOR CLINIC?” prompt, type **Y** (yes) or **N** (no).

Use YES to cause the operator to be prompted at the beginning of the visit with the “WAS THIS AN APPOINTMENT OR WALK-IN?” prompt. If the operator answers “A” for appointment, the application will ask for the appointment date and appointment time.

14. At the “Require AT on PHN Visits?” prompt, type **1** (yes) or **0** (no).
15. At the “UNIVERSAL or SITE SPECIFIC LOOKUPS?” prompt, type **U** (UNIVERSAL) or **S** (SITE SPECIFIC).

SITE SPECIFIC is primarily used for a single site with no health centers subordinate to it or when data is being entered for one site only. When set to Site Specific, the HRN will only access the patient with that site’s HRN, e.g., Betty Ann Miller will only appear when her San Xavier Health Center HRN, SX054666, is entered.

UNIVERSAL is used at the Area Office level and/or when a site enters data for multiple facilities and more than one HRN is on file for the patients. Access to a patient might be available regardless of which site’s HRN is entered, e.g., SE088888 or SX054666 or SR9012 will access Betty Ann Miller when any one of these numbers is entered, or when patients have the same number but different locations. For example, when HRN 088888 is entered, two patients, Sells-Betty Ann Miller (SE088888) and San Xavier-Lucy Mae Jones (SX088888), are listed and the computer waits for the operator to choose the appropriate HRN.

16. At the “Exclude Inactive Patients in Patient Lookup when entering new data?” prompt, type **1** (yes) or **0** (no). Use NO to view inactive patients during patient lookup. Otherwise, use YES.
17. At the “TYPE OF PROCEDURE CODING” prompt, type one of the following codes:

C CPT PROCEDURE CODING
I ICD OPERATION CODING
B PROMPT FOR BOTH CODES

When entering procedures under the OP mnemonic, the operator will be prompted for either the ICD-9 procedure code, CPT code, or both depending on how it is set up in this parameter.

18. At the “REQUIRE ENCOUNTER PROVIDERS AND DIAGNOSIS ON CPE MNEMONIC?” prompt, type **1** (for yes) or **2** (for no). The CPE mnemonic captures the CPT or HCPCS code, Quantity, at least two modifiers, a diagnosis/reason for service (medical necessity/medical significance), the event date & time, and Encounter Provider (who provided the service).

Below is an example of CPE:

```

MNEMONIC: CPE          Cpt Entry with Enc Prov    ALLOWED    VISIT RELATED ONLY
Select V CPT: 10040    ACNE SURGERY
          ACNE SURGERY (EG, MARSUPIALIZATION, OPENING OR REMOVAL OF
          MULTIPLE MILIA, COMEDONES, CYSTS, PUSTULES)
          ...OK? Yes//    (Yes)
QUANTITY: 1
MODIFIER:
MODIFIER 2:
DIAGNOSIS: ACNE
706.1 (ACNE NEC)
OTHER ACNE

OK? Y//
EVENT DATE AND TIME: NOW    (JUN 16, 2008@10:36:20)
ENCOUNTER PROVIDER: DP    Demo, Provider 100 DP

```

Figure 9-6: Sample CPE

19. At the “Require Present on Admission (POA) for Hospital Stay?” prompt, type **1** (Do NOT REQUIRE POA - CRITICAL ACCESS HOSPITAL) or **0** (REQUIRE POA). Present on Admission is a requirement that must be reported on all hospital admissions, except Critical Access Hospitals, per CMS. The system will prompt the operator to indicate whether a final documented diagnosis was present on admission. The POA guidelines are available in the Coding Guidelines.

20. At the “Keep a Log of Orphaned Lab Visits That Are Re-Linked?” prompt, type **Y** (yes) or **N** (no).

There is an option that attempts to link lab visits that have no purpose of visit or provider to the original visit on which the lab was ordered. If no original visit exists, it adds a provider or lab technician and a POV of lab draw to the visit. If a log should be kept of all visits that had a provider and POV attached to them, answer YES here.

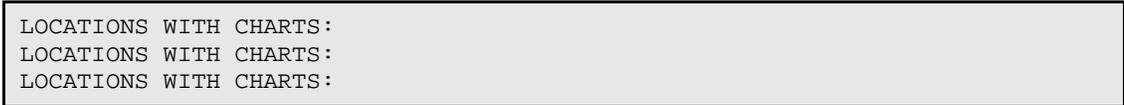
Setting this parameter to Y (yes) will create a log of lab-generated visits that were automatically re-linked to a PCC visit. Review of the log can reveal instances where a second visit should have been created rather than having the lab test linked to an existing PCC visit.

21. At the “Select PERSON TO RECEIVE IN-HOSPITAL LINK MESSAGE” prompt, type one of the following:

NEW PERSON NAME
 INITIAL
 SSN
 VERIFY CODE
 NICK NAME
 SERVICE/SECTION
 DEA#
 VA#
 CODE
 IHS LOCAL CODE
 IHS ADC INDEX
 ALIAS

For inpatient facilities, this field contains the name of the RPMS user that should receive a MailMan message when the option to link in-hospital visits with hospitalizations cannot resolve which visits to link. When this happens, the option to manually link the visits should be used to link them correctly. Section 4.2 provides information about manual links.

22. At the “Update Locations with Charts” prompt, press Enter to display the following pop-up window:



```

LOCATIONS WITH CHARTS:
LOCATIONS WITH CHARTS:
LOCATIONS WITH CHARTS:
  
```

Figure 9-7: Sample pop-up window

Type one or more locations, or type a new location at the prompt.

To change a field, type a caret (^) followed by a caption to move to a specific field.

When you have completed the locations entry, use Close to dismiss the pop-up. Otherwise, use Refresh to refresh the display.

This parameter should only be used if your facility is entering visits for more than one IHS/638/Compacted Tribal Location. Those locations, with the exception of your location, would then be identified here.

This feature enables the data entry operator to create visits for multiple locations without logging off and on after each location change. The computer then checks to see if the patient contains an HRN (chart) at the location of encounter as identified in this parameter. If no HRN is found for the location, a message will appear warning the operator of a location-chart conflict. When a HRN does not exist for the location of encounter in a patient’s record, the visit will be rejected at the Data Center. This parameter is designed to avoid those rejections.

23. At the “Update Auto Prompting of Mnemonics” prompt, press Enter to update the auto prompting for mnemonics. The following pop-up window displays:

```
Any mnemonics entered here will automatically be prompted for
in Mini Data Entry. These mnemonics will be prompted for
in addition to the CL, PRV and PV that are already displayed.
Mnemonic:
Mnemonic:
Mnemonic:
Mnemonic:
Mnemonic:
```

Figure 9-8: Sample pop-up window

This site parameter allows for the storage of a list of mnemonics (in addition to the standard CL, PRV, and PV mnemonics) for which the MIN data entry option will automatically prompt the operator on every visit entered using MIN. Any allowed mnemonic can be entered in the list; however, Measurement Mnemonics (e.g., BP, WT) should not be listed because the operator will not be able to bypass the mnemonic and go on to complete the visit.

Specify the mnemonic to use, or type a new mnemonic for which to prompt.

When the mnemonic entry is complete, use Close to dismiss the pop-up. Otherwise, use Refresh to refresh the display.

To change a field, type a caret (^) followed by a caption to move to a specific field.

When the UPDATE PCC DATA ENTRY PARAMETERS window is complete, do one of the following:

- To change a field, type a caret (^) followed by a caption to move to a specific field.
- Use Save to save any changes you made. If there is any missing data, the system displays the field names; for example, Prompt for VISIT CREATION? (Y/N) is a required field. At this point, press Enter to return to the form.
- Use Refresh to refresh the display.
- Use Exit to leave the window. If you have unsaved changes, the system will prompt you to save. If you type **N** (no), the system displays “Changes not saved!” as you leave the form. If you type **Y** (yes), the system checks for required fields. If there is any missing data, the names are displayed. For example, Prompt for VISIT CREATION? (Y/N) is a required field. At this point, press Enter to return to the form.

After you leave the form, focus returns to the first prompt (to enter the name of the PCC site).

10.0 Auto Merge Event Visits on Same Day

The options and utilities on the Supervisor menu are shown below:

```

*****
**          PCC Data Entry Module          **
** Data Entry SUPERVISOR Options and Utilities **
*****

IHS PCC SUITE  Version 2.0
DEMO INDIAN HOSPITAL

ICD    Fix UNCODED ICD Diagnoses/Operations ...
VRR    Visit Review Report ...
INP    Link In-Hospital Visits to Hospitalizations ...
DSP    Display PCC Data Entry Site Parameters
ACC    Process ACCEPT Commands ...
DDPR   Delete Duplicate Primary Providers from Visits
DXV    DX Coding Audit for Selected Set of Visits
ESP    Enter/Edit PCC Data Entry Site Parameters
EVM    Auto Merge Event Visits on Same Day
FTM    Forms/Data Entry Tracking Menu ...
LAB    Complete Orphaned Visits Menu ...
MDL    Visit Re-linker/Merge/Delete Log Reports ...
MNE    Update PCC Mnemonic's Allowed/Not Allowed
OTH    Other PCC Data Entry Reports ...
PLAL   Reports Listing Allergies recorded on PROBLEM LIST ...
PMN    Print list of Data Entry Mnemonics
RET    Re-Submit PCC Visit to the IHS Data Center
TAB    PCC Local Table Maintenance ...
UIFS   Update ICD-10 Diagnoses from SNOMED Concept ID
UPMC   Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 10-1: Data Entry SUPERVISOR Options and Utilities menu

The EVM option locates all instances in the visit file where there are two ‘E - Historical Event’ visits on the same day to the same location and automatically merge them together.

You must enter a date range for which to run this report.

This process could take some time; consider queuing the report to print after hours. A report can be generated detailing which visits were merged together.

To merge event visits that occurred on the same day, follow these steps:

1. At the “Select Data Entry SUPERVISOR Options and Utilities Option:” prompt, type **EVM**.
2. At the “Run Report” prompt, type one of the following:
 - 1 Posting Date
 - 2 Visit Date

If 1 is used, the application asks to enter the Beginning Posting Date for Search and to enter the Ending Posting date for Search.

If 2 is used, the application asks to enter the Beginning Visit Date for Search and to enter the Ending Visit date for Search.

3. At the “Would you like a report of those visits that were merged?” prompt, type **Y** or **N**.
4. At the “Device” prompt, specify the device to output the report.

Below is a sample report:

```

ST                               Jul 11, 2014                Page 1

                                PCC Data Entry Module
                                *****
                                *   VISIT REVIEW ERROR REPORT   *
                                *****
                                PCC DATA ENTRY AUTO MERGE EVENT VISIT REPORT

Report of Visits Merged for VISIT Date Range: 7/10/2013 through 7/11/2014
-----
FROM VISIT:  8/2/2013    DB 148916    DB    test                SKIN TEST
TO VISIT:    8/2/2013    DB 148916    DB    test

FROM VISIT:  8/2/2013    DB 148916    DB    test                PATIENT ED
TO VISIT:    8/2/2013    DB 148916    DB    test

FROM VISIT:  8/2/2013    DB 148916    DB    test                EXAM
TO VISIT:    8/2/2013    DB 148916    DB    test

FROM VISIT:  9/11/2013   DB 116405   DB    2011 DEMO CLINIC EXAM
TO VISIT:    9/11/2013   DB 116405   DB    2011 DEMO CLINIC

Enter RETURN to continue or '^' to exit:

```

Figure 10-2: Sample EVM report

To review the next page of information, press Enter at the last prompt.

Type a caret (^) at the last prompt and the focus returns to the “Select Data Entry SUPERVISORY Options and Utilities Option” prompt.

11.0 Forms/Data Entry Tracking Menu

The options and utilities on the Supervisor menu are shown below:

```

*****
**          PCC Data Entry Module          **
** Data Entry SUPERVISOR Options and Utilities **
*****

          IHS PCC SUITE  Version 2.0
          DEMO INDIAN HOSPITAL

ICD      Fix UNCODED ICD Diagnoses/Operations ...
VRR      Visit Review Report ...
INP      Link In-Hospital Visits to Hospitalizations ...
DSP      Display PCC Data Entry Site Parameters
ACC      Process ACCEPT Commands ...
DDPR     Delete Duplicate Primary Providers from Visits
DXV      DX Coding Audit for Selected Set of Visits
ESP      Enter/Edit PCC Data Entry Site Parameters
EVM      Auto Merge Event Visits on Same Day
FTM      Forms/Data Entry Tracking Menu ...
LAB      Complete Orphaned Visits Menu ...
MDL      Visit Re-linker/Merge/Delete Log Reports ...
MNE      Update PCC Mnemonic's Allowed/Not Allowed
OTH      Other PCC Data Entry Reports ...
PLAL     Reports Listing Allergies recorded on PROBLEM LIST ...
PMN      Print list of Data Entry Mnemonics
RET      Re-Submit PCC Visit to the IHS Data Center
TAB      PCC Local Table Maintenance ...
UIFS     Update ICD-10 Diagnoses from SNOMED Concept ID
UPMC     Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 11-1: Data Entry SUPERVISOR Options and Utilities menu

The Forms Tracking parameter in the Site File must be set to YES before the Forms/Data Entry Tracking Menu (FTM) option can be used. FORM is designed specifically for maintaining quality of data entry and ICD coding and quantity of visit file entries. Reports are generated to assist with personnel rating and staffing requirements. These reports should be run more frequently (once a week) during the onset of PCC and less frequently (once a month) later on.

Type **FTM** at the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt to display the Data Entry Forms Tracking Menu:

```

*****
**          PCC Data Entry Module          **
** Data Entry Forms Tracking Menu **
*****

          IHS PCC Suite Version 2.0
          2011 DEMO HOSPITAL

CNT      Report on Counts of Forms Processed
DXA      DX ICD Coding QA Audit

```

OPA	Operation/Procedure ICD Coding QA Audit
PRG	Purge Entries in Forms Tracking File
DOP	Display Operator who Entered a Particular Visit
TCC	Report of Number of Tran Codes Entered by Operator
TSR	Forms Tracking Summary Report

Select Forms/Data Entry Tracking Menu Option:

Figure 11-2: Options on the Data Entry Forms Tracking menu

11.1 Report a Count of Forms Processed (CNT)

This report will generate a count of visits entered by a particular data entry operator or for ALL data entry operators for a date range that you specify.

The report can be subtotaled by CLINIC TYPE, SERVICE CATEGORY OR BY VISIT TYPE.

The CNT option counts the dependent entries for visits entered by the data entry staff. This is useful for checking the quantity of data processed by staff if more than one person is responsible for data entry at a facility. Checks can be made to determine whether one operator is entering easier forms and another is entering more difficult forms. The numbers on this report should be fairly well distributed among all operators.

For each 20,000 visits, one full-time data entry operator is required. The skill level of an operator will vary for each facility. The 20,000 figure is reached by calculating approximately 87 forms per day times 230 working days. All too often, a site will place a medical record staff member into the data entry position and expect both responsibilities to be maintained by that same person. This is only possible if the facility is very small and less than 87 visits per day are generated.

You can specify a time frame, a particular operator or operators, and varying visit information whenever you choose as long as no PURGE (PRG) has been done. Section 11.4 provides information on PRG. The frequency at which this report is run will vary depending on the data entry staff.

To run the CNT report, follow these steps:

1. At the “Select Forms/Data Entry Tracking Menu Option” prompt, type **CNT**.
2. At the “Enter beginning Posting Date” prompt, type the beginning date of the date range.
3. At the “Enter ending Post Date” prompt, type the ending date of the date range.
4. At the “Report on ALL Operators” prompt, type **Y** for all operators or **N** for only one operator.

- If N is used, type the name of the operator at the “Which Operator” prompt.
5. At the “Count number of Forms Processed by” prompt, type one of the following codes:

- 1 CLINIC TYPE
- 2 SERVICE CATEGORY
- 3 VISIT TYPE
- 4 INCLUDE ALL VISITS

At the “Subtotal by Visit Date?” prompt, type Y (Yes) or N (no).

6. At the “DEVICE” prompt, specify the device to output the report.

2011 DEMO HOSPITAL NUMBER OF FORMS KEYED			
Jul 11, 2014 Page 1			
DATE ENTRY OPERATOR: EVERETT,BRIAN E			
VISIT POSTING DATES: MAY 12, 2014 TO JUL 11, 2014			
POSTING DATE	# FORMS	# DEP ENT	AVG # DEP ENT

JUN 03, 2014	1	3	3
Visit Dates Processed:			
Jun 02, 2014	1		

Totals for EVERETT,BRIAN E	1	3	3.0
Enter RETURN to continue or '^' to exit:			

Figure 11-3: Sample report

Below is a sample summary report:

SUMMARY OF FORMS KEYED BY ALL OPERATORS						
Jul 15, 2014 Page 3						
VISIT POSTING DATES: MAY 31, 2014 TO JUL 15, 2014						
Operator	# days of D/E	# of forms	% workload	Avg # forms/day	Avg # dep ent/day	Avg # dep ent/form

EVERETT,BRIAN E	1	1	50.0	1.0	3.0	3.0
MICHAEL,SARAH	1	1	50.0	1.0	6.0	6.0

		2				
RUN TIME (H.M.S): 0.0.0						
Enter RETURN to continue or '^' to exit:						

Figure 11-4: Sample summary report

To review the next page of information, press Enter.

Type a caret (^) at the last prompt and the focus returns to the options on the Forms/Data Entry Tracking Menu.

11.2 DX ICD Coding QA Audit (DXA)

The DXA option is based on PCC Form Data Entry and should NOT be used at sites which have the EHR implemented. The option allows a PCC supervisor or an area office to perform routine and random checks on a selected data entry operator's ICD coding. This report displays the provider narrative and the code that was entered by the operator. This is especially useful for monitoring operators new to coding or operators who might have problems with a particular code.

This report lists visits (by posting date with an option of random samples) for a selected data entry operator. The Purpose of Visit ICD diagnosis code and provider narrative are also listed for each visit.

To perform a DX ICD coding QA audit, follow these steps:

1. At the "Select Forms/Data Entry Tracking Menu Option" prompt, type **DXA**.
2. At the "Enter Beginning Posting Date" prompt, type the beginning date of the date range.
3. At the "Enter Ending Post Date" prompt, type the ending date of the date range.
4. At the "Enter DATA Entry Operator" prompt, type the operator name.
5. At the "Include ALL Visit Service Categories" prompt, type **Y** (Yes) or **N** (no).
 - a. If **N** is used, type the service category at the "Enter SERVICE CATEGORY" prompt.
 - b. At the "Enter ANOTHER SERVICE CATEGORY" prompt, type the name of another service category, if needed.
6. At the "Want to limit search by CLINIC TYPE" prompt, type **Y** (Yes) or **N** (no).
 - If **Y** is used, type the name of the clinic at the "Clinic" prompt.
7. At the "Do you wish to include only a subset of ICD Diagnoses" prompt, type **Y** (Yes) or **N** (no).
 - If **Y** is used, type the coding system from which you want to enter a code or range of codes at the "Select ICD CODING SYSTEMS ICD CODING SYSTEM NOMENCLATURE" prompt.
 - Press Enter at the prompt to select all of the ICD ranges.
8. At the "Enter Diagnosis (or range of DX codes)" prompt, type the ICD diagnosis code or narrative.

You can enter a range of codes by placing a "-" between two codes. Codes in a range will include the first and last codes indicated and all codes that fall between. Only one code or one range of codes at a time.

To select all codes in a set you can use a '*' wildcard. E.g. E11*, 250*.

You can also "de-select" a code or range of codes by placing a "-" in front of it. (e.g. '-250.00' or '-250.01-250.91') Type two question marks (??) to see code ranges selected so far.

9. At the "Do you want ALL Visits Selected?" prompt, type **Y** (Yes) or **N** (no).
 - If N is used, type the number of randomized visits at the "How many randomized visits do you want: (1-100)" prompt.
10. At the "DEVICE" prompt, specify the device to output the report.

Below is a sample report.

ICD DIAGNOSIS CODING AUDIT				Page 1
DEMO INDIAN HOSPITAL				
Visit POSTING Dates: OCT 22, 2015 and DEC 01, 2015				
Data Entry Operator: BETA,LA				
Total Visits Found: 1				
HR#	Visit Date	ICD	ICD-9	Provider Narrative
TST 445577	OCT 23, 2016@08:00	M84.30XA	733.98	STRESS FRACTURE [Stress fracture, unspecified s]
		S00.01XA	767.19	SCALP FRACTURE [Abrasion of scalp, initial

Figure 11-5: Sample report

To review the next page of information, press Enter at the last prompt.

Type a caret (^) at the last prompt and the focus returns to the options on the Forms/Data Entry Tracking Menu.

11.3 Operation/Procedure ICD Coding QA Audit (OPA)

The OPA option functions exactly like the previous example (DX ICD Coding QA Audit), except that it finds only visits where ICD procedure codes were entered and reports the procedure codes and narratives entered.

This report lists visits by POSTING date, with an option of random samples, for a selected data entry operator. Purpose of Visit ICD OPERATION/PROCEDURE Code and Provider Narrative will also be listed.

To perform an operation/procedure ICD coding QA audit, follow these steps:

1. At the “Select Forms/Data Entry Tracking Menu Option” prompt, type **OPA**.
2. At the “Enter Beginning POSTING Date” prompt, type the beginning date of the date range.
3. At the “Enter Ending POSTING Date” prompt, type the ending date of the date range.
4. At the “Enter DATA Entry Operator” prompt, type the operator name.
5. At the “Want to Limit search by CLINIC TYPE” prompt, type **Y** (Yes) or **N** (no).
 - If Y is used, type the name of the clinic at the “Clinic” prompt.
6. At the “Do you wish to include only a subset of ICD OPERATION/PROCEDURE Codes” prompt, type **Y** (Yes) or **N** (no).
 - a. If Y is used, type the coding system from which you want to enter a code or range of codes at the “Select ICD CODING SYSTEMS ICD CODING SYSTEM NOMENCLATURE” prompt.
 - b. Type another procedure at the “Enter another Procedure (or range of procedure codes)” prompt, if needed.
7. At the “Enter Procedure (or range of procedure codes) prompt, type the code range.
8. At the “Do you want ALL Visits Selected?” prompt, type **Y** (Yes) or **N** (no).

If N was used, type now many randomized visits you want at the “How many randomized visits do you want: (1-100)” prompt.
9. At the “DEVICE” prompt, specify the device to output the report.

Below is a sample report.

ICD OPERATION/PROCEDURE CODING AUDIT		Page 1		
DEMO INDIAN HOSPITAL				
Visit POSTING Dates: JAN 22, 2016 and MAY 21, 2016				
Data Entry Operator: BETAAA,LAMBDA				
Clinic: ALL				
Total Visits Found: 6				
HR#	Visit Date	ICD O/P Code	ICD-9 Code	Provider Narrative [ICD O/P NARRATIVE]

```

-----
13976   FEB 28, 2016@08:00 0DQJ8ZZ  47.01  APPENDECTOMY
                                             [Repair Appendix, Endo]

445577  MAR 11, 2016@08:00 021L0ZW  35.93  Bypass Left ventricle
                                             [Bypass Left Ventricle to Aorta,
O]
Enter RETURN to continue or '^' to exit:

```

Figure 11-6: Sample report

To review the next page of information, press Enter at the last prompt.

Type a caret (^) at the last prompt and the focus returns to the options on the Forms/Data Entry Tracking Menu.

11.4 Purge Entries in Forms Tracking File (PRG)

Use the PRG option to delete TRACKING information. Patient visit information remains untouched, but forms tracking (CNT and QA) data generated before using PRG is no longer available. Always be certain hard copy reports are generated on all operators prior to the purge. The computer will continue generating forms tracking data as long as the site file parameter is set to Y (Yes).

The data is purged from the Forms Tracking file.

To purge forms tracking entries, follow these steps:

1. At the “Select Forms/Data Entry Tracking Menu Option” prompt, type **PRG**.
2. At the “Purge forms up to and including what POSTING DATE” prompt, type the posting date.
3. At the DEVICE prompt, specify the device to output the report.

The system purges the files and indicates how many were purged, e.g., “A Total of 2902 Dates Purged.”

11.5 Display Operator Who Entered a Particular Visit (DOP)

The DOP option displays the name of the data entry operator who entered a selected visit.

To display an operator name, follow these steps:

1. At the “Select Forms/Data Entry Tracking Menu Option” prompt, type **DOP**.
2. At the “Select Patient Name” prompt, type the name of the patient.
3. At the “Enter Visit Date” prompt, type the date of the visit.

The following shows information from the DOP option:

```

Visit date/time: FEB 11,2002@12:00   [internal entry# 1725765]
Posting date: NOV 29,2002
Data entry operator: OPER,F
Date Last Modified: NOV 29, 2002
User Last Modified: OPER,J

```

Figure 11-7: Sample information from DOP option

11.6 Report of Number of Tran Codes Entered By Operator (TCC)

The TCC option will generate a count of visits entered by a particular data entry operator or for ALL data entry operators for a date range that you specify.

This report lists operators who have entered tran codes using either of the two options for entering these codes on outpatient and in-hospital visits.

To generate a TCC report, follow these steps:

1. At the “Select Forms/Data Entry Tracking Menu Option” prompt, type **TCC**.
2. At the “Enter beginning Posting Date” prompt, type the beginning date of the date range.
3. At the “Enter ending Posting Date” prompt, type the ending date of the date range.
4. At the “Report on ALL Operators” prompt, type **Y** to tabulate visits entered by all operators, or type **N** to tabulate visits for only one operator.
 - If **N** is used, type the name of the operator at the “Which operator” prompt.
5. At the “Count number of Forms Processed by” prompt, type one of the following codes:
 - 1 CLINIC TYPE
 - 2 SERVICE CATEGORY
 - 3 VISIT TYPE
 - 4 INCLUDE ALL VISITS
6. At the “DEVICE” prompt, specify the device to output the report.

A sample report is shown below:

```

May 21, 2008   Page 1
DEMO INDIAN HOSPITAL
NUMBER OF FORMS KEYED
DATE ENTRY OPERATOR:  ADAM,ADAM

```

VISIT POSTING DATES: JAN 22, 2008 TO MAY 21, 2008			
POSTING DATE	# FORMS	# TRANS	AVG # TRAN ENT
MAY 05, 2008	1	1	1

Totals for ADAM,ADAM	1	1	1.0

Enter RETURN to continue or '^' to exit:

Figure 11-8: Sample report

Below is a summary of forms keyed by all operators.

SUMMARY OF FORMS KEYED BY ALL OPERATORS				
VISIT POSTING DATES: JAN 22, 2008 TO MAY 21, 2008				
Operator	No. of Forms	Forms per day	% of Workload	Avg # of tran codes ent
ADAM,ADAM	1	1.0	1.4	1.0
BETZZA,LZZZZ	1	1.0	1.4	1.0
IRCCC,MNNNNNNNNN	34	3.8	49.3	2.2
TAZZZZZZZZZZ	33	2.8	47.8	2.1

	69			

Enter RETURN to continue or '^' to exit:

Figure 11-9: Sample summary of forms keyed by all operators

11.7 Forms Tracking Summary Report (TSR)

The TSR option produces a summary count of visits processed by data entry personnel during the time frame specified. It excludes data that was entered via the Enter Non-Visit Data option because no visit file is created for these entries. In order for this option to function, the forms tracking site parameter must be set to Y (yes).

This report uses the forms tracking data to summarize the forms that have been processed by PCC data entry operators.

The date range for the summary report is required.

To generate a TSR report, follow these steps:

1. At the “Select Forms/Data Entry Tracking Menu Option” prompt, type **TSR**.
2. At the “Enter beginning Posting Date” prompt, type the beginning date of the date range.
3. At the “Enter ending Post Date” prompt, type the ending date of the date range.

4. At the “DEVICE” prompt, specify the device to output the report.

Figure 11-10 is an example of a few pages from the Forms Tracking Summary report:

Report Run Date: JUL 11, 2014	Page 1
SUMMARY COUNT OF VISITS PROCESSED BY DATA ENTRY FOR: JUL 11, 2013 TO JUL 11, 2014 2011 DEMO HOSPITAL	
<p>This report will include counts on Visits created or appended to during the data entry process. Data entered via the option ENTER NON-VISIT DATA are not counted because no visit file is created. The count of these forms must be tallied manually. The counts are taken from the forms tracking file. Therefore, you must be running forms tracking for this report to have any data.</p> <p>There were a total of 10 visits processed during the time period specified. Below is a further breakdown of these visits.</p>	
HOSPITALIZATIONS (HSA-44)	
There were 1 hospitalization documents during this period.	
Data Entry Forms Summary Page 2	
By TYPE: TRIBE-NON 638/NON-COMPACT	1
By LOCATION: 2011 DEMO HOSPITAL	1
IN-HOSPITAL VISITS (NON-CHS):	
There were 0 in-hospital documents during this period.	
AMBULATORY CARE VISITS (non-chs, excludes events, hospitalizations,in-hosp)	
There were 9 ambulatory documents during this period.	
By TYPE:	
Enter RETURN to continue or '^' to exit:	
Data Entry Forms Summary Page 2	
By TYPE: TRIBE-NON 638/NON-COMPACT	1
By LOCATION: 2011 DEMO HOSPITAL	1
IN-HOSPITAL VISITS (NON-CHS):	

```

There were 0 in-hospital documents during this period.

AMBULATORY CARE VISITS (non-chs, excludes events, hospitalizations,in-hosp)
There were 9 ambulatory documents during this period.

By TYPE:

                                     Data Entry Forms Summary   Page 2

By TYPE:
  TRIBE-NON 638/NON-COMPACT           1

By LOCATION:
  2011 DEMO HOSPITAL                   1

IN-HOSPITAL VISITS (NON-CHS):
There were 0 in-hospital documents during this period.

AMBULATORY CARE VISITS (non-chs, excludes events, hospitalizations,in-hosp)
There were 9 ambulatory documents during this period.

By TYPE:

                                     Data Entry Forms Summary   Page 5

  V HOSPITALIZATION                     1
  V MEASUREMENT                          3
  V POV                                  12
  V PROVIDER                             19
  V TREATMENT CONTRACT                   1
  V UPDATED/REVIEWED                     3

                                FORMS PROCESSED BY EACH OPERATOR

OPERATOR:  EVERETT,BRIAN E
TOTAL Number of Forms Processed:         2

By TYPE:
  TRIBE-NON 638/NON-COMPACT           2

By LOCATION:

Enter RETURN to continue or '^' to exit:

```

Figure 11-10: Sample pages of the report

12.0 Complete Orphaned Lab Menu

Note: The complete orphaned visit options use a generic provider; add the appropriate V Code for Lab, X-ray, Immunization, Blood Bank, Microbiology, and Med Refill. However, it does not add a diagnosis to justify for services, does not use exact codes for immunizations, and does not allow for CPT/HCPCS codes. The diagnosis/reason for the service is needed for billing and reporting purposes.

Type **LAB** at the “Select Data Entry Supervisor Options and Utilities Options” prompt to display the following options:

```
COL      Complete 'Orphaned' Lab Visits
QCL      Queue Orphaned Lab Linker
CRX      Complete 'Orphaned' Pharmacy Visits
QRX      Queue Orphaned Pharmacy Linker
CRAD     Complete 'Orphaned' Radiology Visits
QRAD     Queue Orphaned Radiology Linker
ROL      Completed 'Orphaned' Visits Report
PUR      Purge Orphaned Visit Log
BB       Complete 'Orphaned' Blood Bank Visits
IM       Complete 'Orphaned' Immunization Visits
MIC      Complete 'Orphaned' Microbiology Visits
```

Select Complete Orphaned Visits Menu Option:

Figure 12-1: Options for LAB

This menu allows a site to manage “orphaned” lab visits that are created by the Laboratory module or by PCC data entry using the LOG data entry menu option to enter laboratory tests and results. Orphaned labs are incomplete visits that were created by one of these methods and do not contain a primary provider, purpose of visit, or clinic. Normally, these incomplete visits are linked to the medical part of the visit when PCC data entry takes place and the operator is given the opportunity to merge the lab tests with the remainder of the visit. Orphaned labs can also be automatically linked to a complete PCC visit by the nightly re-linker program which looks for incomplete visits more than 60 days old and attempts to link the partial visit with a complete visit on the same day and location for the patient.

12.1 Complete ‘Orphaned’ Lab Visits (COL)

Use the COL option to complete lab tests that did not get merged or linked to a complete visit at data entry time, or by the re-linker.

The application asks for a beginning and ending date for the visit search and whether the visits should be transmitted to the Data Center. Answer **Yes** if the visit date range is within the current fiscal year and **No** if the range is prior to the beginning of the current fiscal year. The ending date must be prior to the date set by the PCC delay factor. This option will not run unless the visit re-linker has also been run at least once.

To complete orphaned lab visits, follow these steps:

1. At the “Select Complete Orphaned Visits Menu Option” prompt, type **COL**.
2. At the “Enter Beginning Date for Search” prompt, type the beginning date of the date range.
3. At the “Enter ending Date for Search” prompt, type the ending date of the date range.
4. At the “Do you want these visits transmitted to the Data Center” prompt, type **Y** (yes) **N** (no).

Use YES if the selected date range is within the current fiscal year. These visits should be sent to DDPS.

Use NO if running this option for past fiscal years.

The system indicates that it is searching the data. When the search is complete, the system displays how many visits were fixed.

12.2 Queue ‘Orphaned’ Lab Linker (QCL)

The QCL option is a non-interactive option that queues the lab linker to be run in the background. A beginning date of T-60 is used and the ending date will be 7 days earlier than the date set by the PCC delay factor.

12.3 Queue Orphaned Pharmacy Linker (CRX)

The CRS option is a non-interactive option that queues the pharmacy linker to be run in the background. A beginning date of T-60 is used and the ending date will be 7 days earlier than the date set by the PCC delay factor.

12.4 Queue ‘Orphaned’ Radiology Visits (CRAD)

The CRAD option fixes the unlinked radiology visits.

If you do not have a generic X-Ray Technician provider, the application displays the following message:

```
You do not have a generic X-Ray Technician provider entry in your database.
Cannot run fix for unlinked rads.
Press ENTER:
```

Figure 12-2: Sample message

Press Enter and the focus returns to the menu options.

12.5 Queue Orphaned Radiology Linker (QRAD)

The QRAD option is a non-interactive option which queues the radiology linker to be run in the background. A beginning date of T-60 is used and the ending date will be 7 days earlier than the date set by the PCC delay factor.

12.6 Completed 'Orphaned' Visits Report (ROL)

This report lists all visits that were completed using the options to complete orphaned lab, radiology, or pharmacy visits.

To generate a report of completed orphaned visits, follow these steps:

1. At the "Select Complete Orphaned Visits Menu Option" prompt, type **ROL**.
2. At the "Which type of Completed Visits do you wish to list" prompt, type one of the following:
 - L** Lab Visits
 - R** Radiology Visits
 - P** Pharmacy Visits
 - I** Immunization
 - B** Blood Bank
 - M** Microbiology
 - A** All Completed Visits
3. Type the date range to show a list of completed LAB/RAD/RX/IMM/BB/MICRO visits at the following prompts:
 - Type beginning date for the report
 - Type ending date for the report
4. At the "Do you wish to" prompt, select one of the following:
 - P** PRINT Output
 - B** BROWSE Output on Screen

Below is a sample orphaned visit report.

```

OUTPUT BROWSER      May 21, 2008 18:15:28      Page:      1 of      34

***** CONFIDENTIAL PATIENT INFORMATION *****
                DEMO INDIAN HOSPITAL                Page 1
ANCILLARY VISITS FOR WHICH A PROVIDER AND POV WERE APPENDED
                Dates range: Jan 22, 2008-May 21, 2008

VISIT DATE/TIME    HRN  LOCATION  TYPE  SC  # ENT  BILLING LINK DATE
-----
Date 'Orphan' Visit Completed: May 21, 2008
Jan 02, 2004@12:00 152567 DEMO INDIA I A LAB 30  JAN 01, 2004@23:28
Jan 02, 2004@12:00 155593 DEMO INDIA I A LAB 39
Jan 02, 2004@12:00 102493 DEMO INDIA I A LAB 2
Jan 02, 2004@12:00 143948 DEMO INDIA I A LAB 34  DEC 18, 2003@09:00
Jan 04, 2004@12:00 115900 DEMO INDIA I A LAB 28  JAN 03, 2004@22:42
Jan 05, 2004@12:00 160887 DEMO INDIA I A LAB 6
Jan 05, 2004@12:00 103070 DEMO INDIA I A LAB 23
Jan 06, 2004@12:00 117080 DEMO INDIA I A LAB 47  DEC 30, 2003@08:07
Jan 06, 2004@12:00 107210 DEMO INDIA I A LAB 28
+           Enter ?? for more actions                >>>
+   NEXT SCREEN          -   PREVIOUS SCREEN          Q   QUIT
Select Action: +/-

```

Figure 12-3: Sample report

The following actions are available at the “Select Action” prompt:

- Type a plus sign (+) to display the next screen (does not apply to the last screen).
- Type a minus sign (-) to display the previous screen (does not apply to the first screen).
- Type **Q** to exit the report screen.

12.7 Purge ‘Orphaned’ Lab Visit Log (PUR)

If the orphaned lab log site parameter is set to Yes, use the PUR option to purge the log of entries no longer needed. The application prompts for an ending date for visits to be purged as well as a device to display or print the results.

After you enter the date at the “Purge log up to and including what Posting Date” prompt, the system purges the entries and displays the total.

12.8 Complete ‘Orphaned’ Blood Bank Visits (BB)

Use the BB option to fix unlinked blood bank visits.

Follow these steps:

1. At the “Select Complete Orphaned Visits Menu Option” prompt, type **BB**.

2. At the “Enter Beginning Date for Search” prompt, type the beginning date of the date range.
3. At the “Enter Ending Date for Search” prompt, type the ending date of the date range.
4. At the “Do you want these visits transmitted to the Data Center” prompt, type **Y** if the selected data range is for the current fiscal year. You will want those visits transmitted to DDPS. Otherwise, type **N** to run this for past fiscal years.

The system indicates that it is searching the data. When it is finished, it will display how many visits were fixed.

12.9 Complete ‘Orphaned’ Immunization Visits (IM)

Use the IM option to fix unlinked immunization visits.

Follow these steps:

1. At the “Select Complete Orphaned Visits Menu Option” prompt, type **IM**.
2. At the “Enter Beginning Date for Search” prompt, type the beginning date of the date range.
3. At the “Enter Ending Date for Search” prompt, type the ending date of the date range.
4. At the “Do you want these visits transmitted to the Data Center” prompt, type **Y** if the selected data range is for the current fiscal year. Those visits should be transmitted to DDPS. Otherwise, type **N** to run this for past fiscal years.

The system indicates that it is searching the data. When it is finished, it will display how many visits were fixed.

12.10 Complete ‘Orphaned’ Microbiology Visits (MIC)

Use the MIC option to fix unlinked microbiology visits.

Follow these steps:

1. At the “Select Complete Orphaned Visits Menu Option” prompt, type **MIC**.
2. At the “Enter Beginning Date for Search” prompt, type the beginning date of the date range.
3. At the “Enter Ending Date for Search” prompt, type the ending date of the date range.

4. At the “Do you want these visits transmitted to the Data Center” prompt, type **Y** if the selected data range is for the current fiscal year. Those visits should be transmitted to DDPS. Otherwise, type **N** to run this for past fiscal years.

The system indicates that it is searching the data. When it is finished, it will display how many visits were fixed.

13.0 Visit Log Reports

The options and utilities on the Supervisor menu are shown below:

```

*****
**          PCC Data Entry Module          **
** Data Entry SUPERVISOR Options and Utilities **
*****

          IHS PCC SUITE  Version 2.0
          DEMO INDIAN HOSPITAL

ICD      Fix UNCODED ICD Diagnoses/Operations ...
VRR      Visit Review Report ...
INP      Link In-Hospital Visits to Hospitalizations ...
DSP      Display PCC Data Entry Site Parameters
ACC      Process ACCEPT Commands ...
DDPR     Delete Duplicate Primary Providers from Visits
DXV      DX Coding Audit for Selected Set of Visits
ESP      Enter/Edit PCC Data Entry Site Parameters
EVM      Auto Merge Event Visits on Same Day
FTM      Forms/Data Entry Tracking Menu ...
LAB      Complete Orphaned Visits Menu ...
MDL      Visit Re-linker/Merge/Delete Log Reports ...
MNE      Update PCC Mnemonic's Allowed/Not Allowed
OTH      Other PCC Data Entry Reports ...
PLAL     Reports Listing Allergies recorded on PROBLEM LIST ...
PMN      Print list of Data Entry Mnemonics
RET      Re-Submit PCC Visit to the IHS Data Center
TAB      PCC Local Table Maintenance ...
UIFS     Update ICD-10 Diagnoses from SNOMED Concept ID
UPMC     Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 13-1: Data Entry SUPERVISOR Options and Utilities menu

Use the MDL option to re-link, merge, or delete visit log reports.

Type **MDL** at the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt to display the following options:

```

VRLR     List of Visits Modified by the Visit Re-Linker
PVRL     Purge Visit Re-linker Log
PVDM     Print List of Visits Deleted/Merged
PUDM     Purge Visit Delete/Merge Log
VIEN     Display a Visit by Visit IEN

Select Visit Re-linker/Merge/Delete Log Reports Option:

```

Figure 13-2: Options for MDL

The Visit Re-linker Log option creates a log of all visits that were modified through the visit re-linker process. These visits have had one or more V File entries moved or “re-linked” to another visit. A report will list all visits that were modified by the re-linker process, and there is also an option to purge the log.


```

Date of Visit Relinker: Jun 24, 2014

126858 ABERNATHY,EMILIE D6/23/14@22:17 (3733008)      6/23/14@12:00 (3733007)
Providers-To Visit: RICHARDS,SUS
Data re-linked: V MEDICATION Ordering Prv: RICHARDS,SUSAN P      # 1

Total # of Visits: 1

```

Figure 13-3: Sample information

13.2 Purge Visit Re-linker Log (PVRL)

Use the PVRL option to purge data from the Visit Relinker Log up to and including a specified run date.

```

Purge Data from Visit Relinker Log!

Purge data up to and including what RELINKER RUN DATE? ??
Examples of Valid Dates:
    JAN 20 1957 or 20 JAN 57 or 1/20/57 or 012057
    T (for TODAY), T+1 (for TOMORROW), T+2, T+7, etc.
    T-1 (for YESTERDAY), T-3W (for 3 WEEKS AGO), etc.
    If the year is omitted, the computer assumes a date in the PAST.
Purge data up to and including what RELINKER RUN DATE?

```

Figure 13-4: Sample Purge Visit Re-linker Log prompts

After the process ends, the system displays the number of entries purged.

13.3 Print List of Visit Deleted/Merged (PVDM)

Use the PVDM option to print a list of visits that were merged into another visit or deleted. If a reason for the deletion/merge can be determined it will be displayed. The first part of the Print List of Visit Deleted/Merged report is shown below.

Follow these steps:

1. At the “Select Visit Re-linker/Merge/Delete Log Reports Option” prompt, type **PVDM**.
2. At the “Which set of Visits” prompt, type one of the following:
 - 1** Deleted/Merged Visits by Visit Date Range
 - 2** Deleted/Merged Visits by Date Visit Deleted/Merged
3. At the “Enter beginning Date” prompt, type the beginning date of the date range.
4. At the “Enter ending Date” prompt, type the ending date of the date range.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I** Include All patients
 - E** Exclude Demo patients

O Include only demo patients

6. At the “Do you wish to” prompt, indicate one of the following:

P PRINT Output

B BROWSE Output on Screen

Below is a sample report:

```

OUTPUT BROWSER      Oct 14, 2008 09:56:39      Page:    1 of    5

***** CONFIDENTIAL PATIENT INFORMATION *****
                DEMO HOSPITAL                        Page 1

                DELETED/MERGED VISITS
Deletion/Merge Dates:  OCT 15, 2007 and OCT 14, 2008
-----
HRN      PATIENT                DELETED/MERGED VISIT          MERGED TO VISIT
                DATE/TIME (IEN)                DATE/TIME (IEN)
-----
124682 SMXXX,ALPHAM      10/9/08@09:00 (2522097)
  User who Updated: FXMEM,LRESERT Date/Time Deleted: Oct 09, 2008@09:28:12
  Reason for deletion/merge: DATA ENTRY EXITED VISIT/DELETED
148916 SCOTT,EDITH EYELYN8/2/13@12:00 (3732267)      8/2/13@12:00 (3732264)
  User who Updated: TETER,SHIRLEY Date/Time Deleted: Jul 11, 2014@16:20:12
  Reason for deletion/merge: AUTO EVENT VISIT MERGE

116405 AALVIK,BETH      9/11/13@12:00 (3732354)      9/11/13@12:00 (3732353)
  User who Updated: TETER,SHIRLEY Date/Time Deleted: Jul 11, 2014@16:20:13
  Reason for deletion/merge: AUTO EVENT VISIT MERGE

147482 MAGERS,CHARLOTTE 9/23/13@15:32 (3732392)      9/23/13@15:26 (3732391)
  User who Updated: TETER,SHIRLEY Date/Time Deleted: Jul 11, 2014@16:20:17
  Reason for deletion/merge: AUTO EVENT VISIT MERGE

Total # of Visits: 4

```

Figure 13-5: Sample Output Browser window

13.4 Purge Visit Delete/Merge Log (PUDM)

Use the PUDM option to purge data up to and including a delete/merge date from the visit log. Below is the first part of the PUDM process:

```

Purge Data from Visit Delete/Merge Log!

Purge data up to and including what DELETE/MERGE DATE? ??
Examples of Valid Dates:
  JAN 20 1957 or 20 JAN 57 or 1/20/57 or 012057
  T (for TODAY), T+1 (for TOMORROW), T+2, T+7, etc.
  T-1 (for YESTERDAY), T-3W (for 3 WEEKS AGO), etc.

```

If the year is omitted, the computer assumes a date in the PAST.
Purge data up to and including what DELETE/MERGE DATE?

Figure 13-6: Prompts for the PUDM option

After the process ends, the system displays the number of visits purged.

13.5 Display a Visit by Visit IEN (VIEN)

Use the VIEN option to show visit file data for a specified IEN number.

Below is a sample of Display a Visit by Visit IEN:

```

Visit display by IEN
Enter the VISIT IEN: (1-99999999999): 6745

PCC VISIT DISPLAY      Oct 14, 2008 10:14:21      Page:    1 of    2

Patient Name:          SXXX,DNNNNNNNNNNNNNNN
Chart #:               1XXXXX
Date of Birth:         APR 05, 1965
Sex:                   M
Visit IEN:             6745

===== VISIT FILE =====
VISIT/ADMIT DATE&TIME: DEC 28, 1987@01:55
DATE VISIT CREATED:   DEC 30, 1987
TYPE:                  IHS
PATIENT NAME:         SXXX,DNNNNNNNNNNNNNNN
LOC. OF ENCOUNTER:    DEMO INDIAN HOSPITAL
SERVICE CATEGORY:    AMBULATORY
CLINIC:                EMERGENCY MEDICINE
DEPENDENT ENTRY COUNT: 8

===== MEASUREMENTs =====
TYPE:                  TMP
VALUE:                 97

TYPE:                  PU
VALUE:                 68

TYPE:                  BP
VALUE:                 128/80

===== PROVIDERs =====
PROVIDER:              VACANT,LORI LYNN
AFF.DISC.CODE:         980077
PRIMARY/SECONDARY:     PRIMARY

===== POVs =====
POV:                   873.42
ICD NARRATIVE:         OPEN WOUND OF FOREHEAD
PROVIDER NARRATIVE:    FOREHEAD LACERATION

```

```
Enter ?? for more actions
+   Next Screen           -   Previous Screen   Q   Quit
Select Action: +//
```

Figure 13-7: Sample report

Do one of the following at the “Select Action” prompt:

- Type + to display the next screen (does not apply to the last screen).
- Type - to display the previous screen (does not apply to the first screen).
- Type **Q** to exit the screen.

14.0 Data Entry Mnemonics

The options and utilities on the Supervisor menu are shown below:

```

*****
**          PCC Data Entry Module          **
** Data Entry SUPERVISOR Options and Utilities **
*****
                IHS PCC SUITE  Version 2.0
                DEMO INDIAN HOSPITAL

ICD    Fix UNCODED ICD Diagnoses/Operations ...
VRR    Visit Review Report ...
INP    Link In-Hospital Visits to Hospitalizations ...
DSP    Display PCC Data Entry Site Parameters
ACC    Process ACCEPT Commands ...
DDPR   Delete Duplicate Primary Providers from Visits
DXV    DX Coding Audit for Selected Set of Visits
ESP    Enter/Edit PCC Data Entry Site Parameters
EVM    Auto Merge Event Visits on Same Day
FTM    Forms/Data Entry Tracking Menu ...
LAB    Complete Orphaned Visits Menu ...
MDL    Visit Re-linker/Merge/Delete Log Reports ...
MNE    Update PCC Mnemonic's Allowed/Not Allowed
OTH    Other PCC Data Entry Reports ...
PLAL   Reports Listing Allergies recorded on PROBLEM LIST ...
PMN    Print list of Data Entry Mnemonics
RET    Re-Submit PCC Visit to the IHS Data Center
TAB    PCC Local Table Maintenance ...
UIFS   Update ICD-10 Diagnoses from SNOMED Concept ID
UPMC   Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 14-1: Data Entry SUPERVISOR Options and Utilities menu

Mnemonics are used for quick entry of information into the Patient Care Component by the data entry operator. The supervisor is responsible for maintaining the list of mnemonics to be used or not used by data entry. Changes might have to be made periodically.

14.1 Print List of Data Entry Mnemonics (PMN)

You can obtain a list of all PCC data entry mnemonics through this menu option. Prior to any changes, this should be reviewed.

To list all PCC data entry mnemonics, follow these steps:

1. At the “Data Entry SUPERVISOR Options and Utilities Option” prompt, type **PMN**.
2. At the “Sort By” prompt, use the default (mnemonic), or type one of the following:

```

.01          MNEMONIC
.02          MODE
.03          FILE
.04          TEMPLATE
.05          KEY VALUE
.06          DESCRIPTION
.07          ALLOWED/NOT ALLOWED
.08          VISIT RELATED
.09          V FILE UPDATED
.11          PRIMARY LIST ORDER
.12          MENU TEXT
.13          SECONDARY LIST ORDER
.14          ASSOCIATED FILE
.15          HISTORICAL LIST ORDER
.16          NON-VISIT DATA ITEM ORDER
.17          COHORT ENTRY LIST ORDER 1
.18          COHORT ENTRY LIST ORDER 2
.999999901  PATCH ADDED

```

- Type **a** in front of a numeric-valued field to sort from high to low.
 - Type a plus sign (+) in front of a field name to get subtotals by that field.
 - Type # to page-feed on each field value.
 - Type '!' to get ranking number.
 - Type @ to suppress subheader.
 - Type ']' to force saving sort template.
 - Type **TXT** after Free Text fields to sort numbers as text.
 - Type [**TEMPLATE NAME**] in brackets to sort by previous search results.
3. At the “START WITH MNEMONIC” prompt, press Enter to select the default **FIRST**. This field contains the data entry mnemonic or a pseudo **INPUT TEMPLATE** for entering data from the various logs. If the **MNEMONIC** name is 2–3 characters long it is considered a **MNEMONIC** (e.g., 'BP' or 'TON'). If the **MNEMONIC** name is 4 or more characters long it is considered a pseudo-**INPUT TEMPLATE**.
 4. At the “Device” prompt, specify the device to output the report.

A sample report is shown below

RPMS PCC DATA ENTRY CONTROL LIST			MAY 22, 2008 10:43	PAGE 1
MNEMONIC	ALLOWED/NOT ALLOWED	DESCRIPTION		
3M	NOT ALLOWED	3M Coder Interface		
ADA	ALLOWED	ADA Code Entry		

ADM	ALLOWED	Asthma Work/School Days Missed
ADX	ALLOWED	Admitting Diagnosis
AL	ALLOWED	Appointment Length
ALG	ALLOWED	Allergy Tracking Entry
AOP	ALLOWED	Anesthesia Operation
APO	ALLOWED	Activate an Inactive Problem
APPT	ALLOWED	Appointment Date&Time
ASEV	ALLOWED	Asthma Severity
ASFD	ALLOWED	Asthma Symptom Free Days

Figure 14-2: Sample report

Notice that there are no commands to move from one page to another. Currently, press Enter to move to the next page. Otherwise, type ^ to exit the report.

14.2 Update PCC Mnemonics Allowed/Not Allowed (MNE)

Use the MNE option to specify which mnemonics can be used by PCC Data Entry. Changes are made here when a means other than PCC Data Entry is used to track a specific data type. For example, Lab tests ordered data is initially captured through PCC Data Entry using the UA, BS, and HCT mnemonics. After PCC is running smoothly and problems have been resolved, a facility might choose to capture results using the LAB mnemonic, therefore UA, BS, and HCT are set to NOT ALLOWED. A facility might choose to capture results via the RPMS Laboratory module, in which case the LAB, UA, BS, and HCT should be set to NOT ALLOWED.

To update the list of allowed/not allowed mnemonics, follow these steps:

1. At the “Data Entry SUPERVISOR Options and Utilities Option” prompt, type **MNE**.
2. At the “Select RPMS PCC DATA ENTRY CONTROL MNEMONIC” prompt, type the control mnemonic you want to update.
3. At the “Is Date Entry Allowed/Not Allowed to use this Mnemonic” prompt, type **0** (for ALLOWED) or **1** (for NOT ALLOWED).
4. The prompts in steps 1 and 2 repeat until you type **1** (not allowed) at the second prompt. In this case, focus returns to the “Select Data Entry SUPERVISORY Options and Utilities Option” prompt.

15.0 Other PCC Data Entry Reports

The options and utilities on the Supervisor menu are shown below:

```

*****
**          PCC Data Entry Module          **
** Data Entry SUPERVISOR Options and Utilities **
*****
          IHS PCC SUITE  Version 2.0
          DEMO INDIAN HOSPITAL

ICD      Fix UNCODED ICD Diagnoses/Operations ...
VRR      Visit Review Report ...
INP      Link In-Hospital Visits to Hospitalizations ...
DSP      Display PCC Data Entry Site Parameters
ACC      Process ACCEPT Commands ...
DDPR     Delete Duplicate Primary Providers from Visits
DXV      DX Coding Audit for Selected Set of Visits
ESP      Enter/Edit PCC Data Entry Site Parameters
EVM      Auto Merge Event Visits on Same Day
FTM      Forms/Data Entry Tracking Menu ...
LAB      Complete Orphaned Visits Menu ...
MDL      Visit Re-linker/Merge/Delete Log Reports ...
MNE      Update PCC Mnemonic's Allowed/Not Allowed
OTH      Other PCC Data Entry Reports ...
PLAL     Reports Listing Allergies recorded on PROBLEM LIST ...
PMN      Print list of Data Entry Mnemonics
RET      Re-Submit PCC Visit to the IHS Data Center
TAB      PCC Local Table Maintenance ...
UIFS     Update ICD-10 Diagnoses from SNOMED Concept ID
UPMC     Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 15-1: Data Entry SUPERVISOR Options and Utilities menu

Use the OTH option to display one of two reports: (a) Chart Review and Telephone Calls with ancillary data, or (b) Visits with a Returned to Stock Medication.

Follow these steps:

1. At the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt, type **OTH**.

The application displays the following choices:

```

CTA      Chart Review and Telephone Calls w/ancillary data
VRTS     Visits with a Returned to Stock Medication

```

Figure 15-2: The choices for the OTH option

15.1 Chart Review and Telephone Calls with Ancillary Data (CTA)

Use the CTA option to list all visits within a specified date range with a service category of T (telecommunications), C (Chart Review), clinic code 51 (TELEPHONE), clinic code 52 (CHART REVIEW) that have ancillary data items attached to them. The ancillary data items are any of the following: medication, radiology, microbiology, lab, or blood bank.

To list these visits, follow these steps:

1. At the “Enter beginning Visit Date” prompt, type the beginning date of the date range.
2. At the “Enter ending Visit Date” prompt, type the ending date of the date range.
3. At the “Sort the report by” prompt, use one of the following:
 - T** Terminal Digit Order
 - H** Health Record Number Order
 - D** Visit Date Order
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I** Include All patients
 - E** Exclude Demo patients
 - O** Include only demo patients
5. At the “Device” prompt, specify the device to output the output.

Below is a sample report.

SJT		Feb 13, 2009			Page 1		
		DEMO HOSPITAL					
Chart Review and Telephone Call visits with ancillary data							
PATIENT NAME	HRN	VISIT DATE	SC	CL	DATA	ORDER PROV	ORDER DATE
MBETA, KRISTA	103700	08/01/2007	T	50	MED's	CWPROVIDER, RENE	
BETA, DOROTHY	104600	01/05/2007	T	50	LAB's	XEPROVIDER, FELI	01/05/2007
BETA, DOROTHY	104600	01/23/2007	T	50	LAB's	XEPROVIDER, FELI	01/23/2007
					MED's	CPPROVIDER, MARG	
BETA, DOROTHY	104600	02/06/2007	T	50	LAB's	XEPROVIDER, FELI	02/06/2007
BBETA S, OLIVE	105300	01/03/2007	T	77	MED's	MUPROVIDER, TAMM	
GAMA, LAWRENCE	166601	01/08/2007	T	77	MED's	SBPROVIDER, MAND	

Enter RETURN to continue or '^' to exit:

Figure 15-3: Sample CTA report

15.2 Visits with a Returned to Stock Medication (VRTS)

Use the VRTS option to list all non-chart review/telephone call visits with a V Medication that is flagged as RETURN TO STOCK.

To list these visits, follow these steps:

1. At the “Enter beginning Visit Date” prompt, type the beginning date of the date range.
2. At the “Enter ending Visit Date” prompt, type the ending date of the date range.
3. At the “Sort the report by” prompt, use one of the following:
 - T** Terminal Digit Order
 - H** Health Record Number Order
 - D** Visit Date Order
4. At the “Device” prompt, specify the device to output the report.

The following shows the display when the Visits with a Returned to Stock Medication option is selected at the “Select Other PCC Data Entry Reports Option” prompt.

xxx		Feb 13, 2009		Page 1		
DEMO HOSPITAL						
Chart Review and Telephone Call visits with ancillary data						
PATIENT NAME	HRN	VISIT DATE	SC CL	DATA	ORDER PROV	ORDER DATE
MOOOO, KRISTA	103700	08/01/2007	T 50	MED's	CWPROVIDER, RENE	
SAAA, DOROTHY	104600	01/05/2007	T 50	LAB's	XEPROVIDER, FELI	01/05/2007
SAAA, DOROTHY	104600	01/23/2007	T 50	LAB's	XEPROVIDER, FELI	01/23/2007
				MED's	CPPROVIDER, MARG	
SAAA, DOROTHY	104600	02/06/2007	T 50	LAB's	XEPROVIDER, FELI	02/06/2007
BETAA, OLIVE G	105300	01/03/2007	T 77	MED's	MUPROVIDER, TAMM	
MUUU, LAWRENCE	166601	01/08/2007	T 77	MED's	SBPROVIDER, MAND	
GAMA, BESSIE G	104402	07/25/2007	T 77	MED's	NPROVIDER, ERIN	
CHI, BRANDIE L	107902	02/23/2007	T 39	MED's	FTPROVIDER, NANC	
THHH, CLAUDIA	112703	03/23/2007	C 77	MED's	FNPROVIDER, CLAU	
MBETAAAA, NATA	124103	07/25/2007	T 77	MED's	EFPROVIDER, STEP	
DELTA, HEATHER	166503	06/08/2007	T 39	MED's	SBPROVIDER, MAND	
CHIII, FELICIA	111704	02/21/2007	T 77	MED's	NPROVIDER, ERIN	
PBETA, JAYLYNN	128004	01/12/2007	C 52	LAB's	BUPROVIDER, RENE	01/12/2007
LAMBDAH, SIERA	100205	03/02/2007	T 77	MED's	NPROVIDER, ERIN	

Enter RETURN to continue or '^' to exit:

Figure 15-4: Sample VRTS report

16.0 Reports Listing Allergies on Problem List

The options and utilities on the Supervisor menu are shown below:

```

*****
**          PCC Data Entry Module          **
** Data Entry SUPERVISOR Options and Utilities **
*****

IHS PCC SUITE  Version 2.0
DEMO INDIAN HOSPITAL

ICD    Fix UNCODED ICD Diagnoses/Operations ...
VRR    Visit Review Report ...
INP    Link In-Hospital Visits to Hospitalizations ...
DSP    Display PCC Data Entry Site Parameters
ACC    Process ACCEPT Commands ...
DDPR   Delete Duplicate Primary Providers from Visits
DXV    DX Coding Audit for Selected Set of Visits
ESP    Enter/Edit PCC Data Entry Site Parameters
EVM    Auto Merge Event Visits on Same Day
FTM    Forms/Data Entry Tracking Menu ...
LAB    Complete Orphaned Visits Menu ...
MDL    Visit Re-linker/Merge/Delete Log Reports ...
MNE    Update PCC Mnemonic's Allowed/Not Allowed
OTH    Other PCC Data Entry Reports ...
PLAL   Reports Listing Allergies recorded on PROBLEM LIST ...
PMN    Print list of Data Entry Mnemonics
RET    Re-Submit PCC Visit to the IHS Data Center
TAB    PCC Local Table Maintenance ...
UIFS   Update ICD-10 Diagnoses from SNOMED Concept ID
UPMC   Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 16-1: Data Entry SUPERVISOR Options and Utilities menu

Use the **PLAL** option to display the options for listing allergy reports.

Type **PLAL** at the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt to display the following options:

```

PWA    List All Patients w/Allergies / NKA on Problem List
SALP   List Pts seen in N yrs w/Problem List Allergies
NALP   List Patients w/Allergies entered in a Date Range

Select Reports Listing Allergies recorded on PROBLEM LIST Option:

```

Figure 16-2: Options for PLAL

16.1 List All Patients with Allergies / NKA on Problem List (PWA)

Use the **PWA** option to list patients who have an allergy or NKA entered on the PCC Problem List.

The pharmacy staff can use this list to add these allergies into the Allergy Tracking module. When you have finished processing this list, run the option “List Patients w/Allergies entered in a Date Range” to pick up any allergies entered onto the Problem list after you ran this report. Deceased patients and patients with inactive charts are not included on this list.

The list can be very long at sites with many patients and providers who have been maintaining up-to-date problem lists. To make the list more manageable at those sites, the application prompts for the beginning and ending first character of the patient’s last name. This allows printing all patients, for example, whose last name begins with A through C the first time, D through H the second time, etc. To print all patients, use A and Z as the beginning and ending characters.

1. At the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt, type **PLAL**.
2. At the “Select Reports Listing Allergies recorded on PROBLEM LIST Option” prompt, type **PWA**.
3. At the “Start with last names beginning with” prompt, type the letter of the beginning last name.
4. At the “End with last names beginning with” prompt, type the letter of the ending last name.
5. At the “DEVICE” prompt, specify the device to output the data.

The report contains the following information:

2011 DEMO HOSPITAL		
PATIENTS WITH ALLERGIES OR DOCUMENTED NO KNOWN ALLERGIES ON PCC PROBLEM LIST		
PATIENTS WITH LAST NAMES BEGINNING WITH A through B		
PATIENT NAME	CHART #	DOB

BROOKS, LAWANDA	100008	Mar 22, 1956
DATE ADDED	DX	PROVIDER NARRATIVE
-----	---	-----
JUN 29, 1988	995.3	*ALLERGIC PENICILLIN & COEDINE
APR 15, 1989	V14.0	*PENICILLIN ALLERGY
MAY 31, 1994	995.2	*POSSIBLE DRUG REACTION TO BACTRIM / ALLERGIC TO SULFA
BUCHANAN, RONALD STEVE	100135	Apr 24, 1956
DATE ADDED	DX	PROVIDER NARRATIVE
-----	---	-----
NOV 10, 1999	995.2	*ALLERGIC PCN
ALLEY, HELEN	100159	May 04, 1956
DATE ADDED	DX	PROVIDER NARRATIVE
-----	---	-----
MAR 01, 2002	V14.5	*ALLERGY: CODEINE
ARKANSAS, BARBARA	100354	Jul 02, 1911

DATE ADDED	DX	PROVIDER NARRATIVE
-----	--	-----
JUN 07, 1999	995.2	*PENICILLIN ALLERGY
ARMACHAIN, MAMIE		
		100402 Oct 10, 1946
DATE ADDED	DX	PROVIDER NARRATIVE
-----	--	-----
FEB 28, 2000	995.2	*ALLERGY: CODEINE
BURKS, SHERRY L		
		100553 Jun 02, 1948
DATE ADDED	DX	PROVIDER NARRATIVE
-----	--	-----
MAR 16, 1993	995.2	*ECZEMA OF HANDS 3
AUG 09, 1996	995.2	*KEFLEX ALLERGY
MAR 12, 2004	995.2	*ALLERGY-IBUPROFEN-SOB, EDEMA OF FACE
Enter RETURN to continue or '^' to exit:		

Figure 16-3: Sample information for PWA option

Press Enter to view the next page of data (does not apply to the last page of data).

Otherwise, type a caret (^) to exit the screen.

16.2 List Pts seen in N yrs w/Problem List Allergies (SALP)

Use the SALP option to display the list of patients seen in a specified number of years who have an allergy on the Problem List.

The pharmacy staff can use this list to add these allergies into the Allergy Tracking module. When you have finished processing this list, run the option “List Patients w/Allergies entered in a Date Range” to pick up any allergies entered onto the Problem list after you ran this report. Deceased patients and patients with inactive charts are not included on this list.

To make the list more manageable, use a smaller number of years. The default is three years.

To show a report containing a list these patients, follow these steps:

1. At the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt, type **PLAL**.
2. At the “Select Reports Listing Allergies recorded on PROBLEM LIST Option” prompt, type **SALP**.
3. At the “Enter the number of years: (1-99)” prompt, type the number of years to be reported on.
4. At the “DEVICE” prompt, specify the device to output the report.

The following shows a sample report:

```

SJT
                                                    Page 1
                DEMO HOSPITAL
PATIENTS WITH ALLERGIES OR DOCUMENTED NO KNOWN ALLERGIES ON PCC PROBLEM LIST
PATIENTS SEEN BETWEEN VISIT DATES:  OCT 24, 1983  TO  OCT 17, 2008
PATIENT NAME                CHART #        DOB
-----
YXXX,LAAAAAA C                100002      Jul 29, 1986
  DATE ADDED      DX      PROVIDER NARRATIVE
  -----
  NOV 24, 2000   799.9   NKA

BXXXXXXXXX,LZZZ NSSSSSS      100008      Mar 22, 1956
  DATE ADDED      DX      PROVIDER NARRATIVE
  -----
  JUN 29, 1988   995.3   ALLERGIC PENICILLIN & COEDINE
  APR 15, 1989   V14.0   PENICILLIN ALLERGY
  MAY 31, 1994   995.2   POSSIBLE DRUG REACTION TO BACTRIM / ALLERGIC TO SULFA

CVVVVV,PCCCC LXXX                100017      Jan 17, 1940
  DATE ADDED      DX      PROVIDER NARRATIVE
  -----
  APR 06, 1992   995.2   ALLERGIC REACTION TO CIPRO
  APR 04, 1997   995.2   GI UPSET WITH KEFLEX

Enter RETURN to continue or '^' to exit:

```

Figure 16-4: Sample report for SALP option

Press Enter to view the next page of data (does not apply to the last page of data).

Otherwise, type a caret (^) to exit the screen.

16.3 List Patients w/Allergies entered in a Date Range (NALP)

Use the NALP option to list patients with allergies within a specified date range.

This report will produce a list of patients who have had allergies entered onto their problem list in a specified date range. If you are using this list to populate the Allergy Tracking module, first run the 'List all patients with Allergies on their problem list' option. Use that report to enter the allergies into the Allergy tracking module. When you have finished that list, use this list (for the NALP option) to pick up any allergies entered onto the problem list after you have ran and processed that list.

To show a report containing a list these patients, follow these steps:

1. At the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt, type **PLAL**.
2. At the “Select Reports Listing Allergies recorded on PROBLEM LIST Option” prompt, type **NALP**.
3. At the “Enter beginning Date” prompt, type the beginning date of the date range.

4. At the “Enter ending Date” prompt, type the ending date of the date range.
5. At the “DEVICE” prompt, specify the device to output the report.

The following shows a sample report:

```

SJT                                     Page 1
                                DEMO HOSPITAL
PATIENTS WITH ALLERGIES OR DOCUMENTED NO KNOWN ALLERGIES ON PCC PROBLEM LIST
  ALLERGIES ADDED TO THE PROBLEM:  OCT 18, 2007 TO  OCT 17, 2008
PATIENT NAME                        CHART #      DOB
-----
SXXXX,ADDDDD                        124682     Jul 01, 1987
  DATE ADDED      DX      PROVIDER NARRATIVE
  -----      --      -----
  OCT 14, 2008   995.3   ALLERGY TO DUST

SHHHH,ABBBBB D SR                    165110     Mar 23, 2002
  DATE ADDED      DX      PROVIDER NARRATIVE
  -----      --      -----
  FEB 04, 2008   995.3   ALLERGIC TO SEPTRA

Enter RETURN to continue or '^' to exit:

```

Figure 16-5: Sample report for NALP option

Press Enter to view the next page of data (does not apply to the last page of data).

Otherwise, type a caret (^) to exit the screen.

17.0 Re-Submit a Visit to the Data Center

The options and utilities on the Supervisor menu are shown below:

```

*****
**          PCC Data Entry Module          **
** Data Entry SUPERVISOR Options and Utilities **
*****

IHS PCC SUITE  Version 2.0
DEMO INDIAN HOSPITAL

ICD    Fix UNCODED ICD Diagnoses/Operations ...
VRR    Visit Review Report ...
INP    Link In-Hospital Visits to Hospitalizations ...
DSP    Display PCC Data Entry Site Parameters
ACC    Process ACCEPT Commands ...
DDPR   Delete Duplicate Primary Providers from Visits
DXV    DX Coding Audit for Selected Set of Visits
ESP    Enter/Edit PCC Data Entry Site Parameters
EVM    Auto Merge Event Visits on Same Day
FTM    Forms/Data Entry Tracking Menu ...
LAB    Complete Orphaned Visits Menu ...
MDL    Visit Re-linker/Merge/Delete Log Reports ...
MNE    Update PCC Mnemonic's Allowed/Not Allowed
OTH    Other PCC Data Entry Reports ...
PLAL   Reports Listing Allergies recorded on PROBLEM LIST ...
PMN    Print list of Data Entry Mnemonics
RET    Re-Submit PCC Visit to the IHS Data Center
TAB    PCC Local Table Maintenance ...
UIFS   Update ICD-10 Diagnoses from SNOMED Concept ID
UPMC   Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 17-1: Data Entry SUPERVISOR Options and Utilities menu

Use the RET option when a visit was rejected by the Data Center. Be absolutely sure the problem has been resolved before using this option.

To resubmit a visit to the Data Center, follow these steps:

1. At the “Select Patient Name” prompt, type the name of the patient.
2. At the “Enter VISIT date” prompt, type the date of the visit.

The following Visit File information is displayed:

```

VISIT IEN: 45609

HRN: DB 100008

----- VISIT FILE -----
VISIT/ADMIT DATE&TIME: JUN 29, 1988@23:30
DATE VISIT CREATED: JUN 30, 1988      TYPE: IHS
THIRD PARTY BILLED: VISIT DATE PRIOR TO BACKBILLING LIMIT
PATIENT NAME: BROOKS,LAWANDA
LOC. OF ENCOUNTER: 2011 DEMO INDIAN HOSPITAL

```

```

SERVICE CATEGORY: AMBULATORY          CLINIC: CHEST AND TB
DEPENDENT ENTRY COUNT: 3

-----
PROVIDER: MYERS,JUDY G                 V PROVIDER
VISIT: JUN 29, 1988@23:30              PATIENT NAME: BROOKS,LAWANDA
AFF.DISC.CODE (c): 980080              PRIMARY/SECONDARY: PRIMARY
PROVIDER: COSNER,RHONDA C              PATIENT NAME: BROOKS,LAWANDA
VISIT: JUN 29, 1988@23:30              PRIMARY/SECONDARY: SECONDARY
AFF.DISC.CODE (c): 901106

-----
POV: 883.0                             V POV
VISIT: JUN 29, 1988@23:30              PATIENT NAME: BROOKS,LAWANDA
PROVIDER NARRATIVE: LACERATION L INDEX FINGER
ICD NARRATIVE (c): OPEN WOUND OF FINGER

-----

End of visit display, <ENTER> to Continue
Are you sure this is the visit to re-transmit? No// yes
I will re-set the Data Warehouse flag to re-send this visit as of today's
Posting Date.
Do you want to continue? N//

```

Figure 17-2: Sample Visit File information

18.0 Table Maintenance

The options and utilities on the Supervisor menu are shown below:

```

*****
**          PCC Data Entry Module          **
** Data Entry SUPERVISOR Options and Utilities **
*****

          IHS PCC SUITE  Version 2.0
          DEMO INDIAN HOSPITAL

ICD      Fix UNCODED ICD Diagnoses/Operations ...
VRR      Visit Review Report ...
INP      Link In-Hospital Visits to Hospitalizations ...
DSP      Display PCC Data Entry Site Parameters
ACC      Process ACCEPT Commands ...
DDPR     Delete Duplicate Primary Providers from Visits
DXV      DX Coding Audit for Selected Set of Visits
ESP      Enter/Edit PCC Data Entry Site Parameters
EVM      Auto Merge Event Visits on Same Day
FTM      Forms/Data Entry Tracking Menu ...
LAB      Complete Orphaned Visits Menu ...
MDL      Visit Re-linker/Merge/Delete Log Reports ...
MNE      Update PCC Mnemonic's Allowed/Not Allowed
OTH      Other PCC Data Entry Reports ...
PLAL     Reports Listing Allergies recorded on PROBLEM LIST ...
PMN      Print list of Data Entry Mnemonics
RET      Re-Submit PCC Visit to the IHS Data Center
TAB      PCC Local Table Maintenance ...
UIFS     Update ICD-10 Diagnoses from SNOMED Concept ID
UPMC     Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 18-1: Data Entry SUPERVISOR Options and Utilities menu

Use the TAB option to locally maintain several data tables (files) used in PCC and in other RPMS applications. These lookup tables will occasionally need to be updated or enhanced. This set of menu options provides the ability to do the initial building and subsequent update of these tables. The responsibility for updating tables will vary, depending on the size of your facility. In many cases, responsibility might be split between several people and offices.

Every effort should be made to keep duplicate entries out of these tables. In many instances only the RPMS site manager or PCC manager has been given authority to add new entries to the locally maintained tables, and in particular, the Provider File. Entries added to the tables via the Table Maintenance Menu cannot be easily removed. If duplicates are noted in these tables, the site manager or area RPMS support personnel should be notified to resolve the problem.

In addition to the menu options to edit the various tables, menu options are provided to print table listings (PRT) as well as to inactivate or reactivate providers (INA).

Type **TAB** at the “Select Data Entry Supervisor Options and Utilities Option” prompt to display the following options:

```

*****
**          PCC Data Entry Module          **
**      PCC Local Table Maintenance      **
*****
                IHS PCC Suite, Version 2.0
                DEMO INDIAN HOSPITAL

PHY      Physical Therapy Modality Enter/Edit
TRT      Treatment Enter/Edit
PRT      Print Table Listings ...
CL       List Clinics
INA      Inactive/Reactivate Persons & Providers
PRV      Add/Edit Providers

Select PCC Local Table Maintenance Option:

```

Figure 18-2: Options on PCC Local Table Maintenance menu

18.1 Physical Therapy Modality Enter/Edit (PHY)

Use the PHY option to enter or edit physical therapy modalities into the Physical Therapy file. These entries can never be deleted.

To work with physical therapy modalities, follow these steps:

1. At the “Select PCC Local Table Maintenance Option” option, type **PHY**.
2. At the “Select PHYSICAL THERAPY CODE” prompt, type the code you want to enter/edit. If you enter a new code, the system will create it (must be 6 numeric characters in length).
3. At the “Code” prompt, the default code for an existing therapy is displayed. Press Enter to accept it, or type a new code (must be 6 numeric characters in length).
4. At the “Name” prompt, the default name for an existing therapy is displayed. Press Enter to accept it, or type a name for the new code (limited to between 3 and 30 characters in length).

18.2 Treatment Enter/Edit (TRT)

Use the TRT option to enter or edit treatments in the Treatment file.

To work with treatments in the Treatment file, follow these steps:

1. At the “Select PCC Local Table Maintenance Option” option, type **TRT**.
2. At the “Select TREATMENT NAME” option, type an existing treatment to display the treatment name, or enter a new treatment name (must be 3–30 characters in length).

3. At the “Code” prompt, the default code for an existing treatment is displayed. Press Enter to accept it, or type a new code (must be six characters in length).
4. At the “Summary Flag” prompt, the default flag for an existing treatment is displayed. Press Enter to accept it, or type an integer (only one in length) specifying the summary flag for the new treatment.
5. At the “Inactive Flag” prompt, type **1** to inactivate the treatment, or press Enter to leave the field blank.
6. At the “CPT Code” prompt, type the CPT code (or short name or CPT category) that identifies the treatment, or press Enter to leave the field blank.
7. At the “Mnemonic” prompt, type the mnemonic to be used (must be 1–6 characters in length), or press Enter to leave the field blank.

The focus returns to the “Select TREATMENT NAME” prompt. Type another treatment name, or press Enter and the focus returns to the “Select PCC Local Table Maintenance option” prompt.

18.3 Print Table Listings (PRT)

Use the PRT option to print a listing of all items in a selected table. A submenu allows the user to choose which tables to print.

1. At the “Select PCC Local Table Maintenance Option” prompt, type **PRT**.
2. The application displays the following menu:

```

*****
**          PCC Data Entry Module          **
**    PCC Local Table Maintenance Print Menu    **
*****
          IHS PCC Suite Version 2.0
          DEMO HOSPITAL

APA    Print ACTIVE Providers
APC    Print Providers by Provider Classification
API    Print INACTIVE Providers
ARE    Print Area Table
DIS    Print Provider List by Discipline
EDU    Print Education Topics List
EVN    Print CHS Vendor List by EIN Number
INS    Print Insurer List
LOC    Print Location Table
NVE    Print CHS Vendor List by Name
PHY    Print Physical Therapy List
PPN    Print Provider List by Name
PRI    Print Immunization Table
PST    Print Skin Test Table
REL    Print Relationship List
SUP    Print Service Unit Table
TRT    Print Treatment List

```

Select Print Table Listings Option:

Figure 18-3: Options on the PCC Local Table Maintenance Print Menu

18.3.1 Provider Listing (PRVL)

Use the PRVL option to produce a report of all entries in File 200. The report can be sorted by name, affiliation, discipline, active/inactive status or division.

1. At the “PCC Local Table Maintenance Option” prompt, type **PRVL**.
2. At the “List which set of entries” prompt, type **A** (All Users) or **P** (Providers Only – defined by having the PROVIDER key). The default is P.
3. At the “List which set of providers” prompt, type one of the following:
 - A** Active Providers
 - I** Inactive Providers
 - B** Both Active and Inactive Providers
4. At the “Include Providers with which Affiliation” prompt, type **O** (one or a set of Affiliations) or **A** (Any/All Affiliations).
 - a. If O is used, type the affiliation at the “Enter AFFILIATION” prompt. Type one of the following:
 - IHS**
 - CONTRACT**
 - TRIBAL**
 - STATE**
 - MUNICIPAL**
 - NTH HLTH SRV CORP**
 - OTHER**
 - VOLUNTEER**
 - 638 PROGRAM**
 - b. Type another affiliation at the “Type ANOTHER AFFILIATION” prompt, if needed. Otherwise, leave it blank.

5. At the “Include Providers with which Provider Class” prompt, type **O** (one or a set of Disciplines/Provider Classes) or **A** (Any/All Disciplines/Provider Classes).

If O was used, the following prompts displays:

- a. At the “Enter Class” prompt, type the class.
 - b. After typing the class, the “Enter ANOTHER CLASS” prompt displays where you can type another class or leave the prompt blank.
6. At the “Include Providers with which division” prompt, type either **O** (one or a set of Divisions/Locations) or **A** (Any/All Divisions/Locations).

If O was used, the following prompts displays:

- a. At the “Enter ENCOUNTER LOCATION” prompt, type the name of the encounter location.
 - b. At the “Enter ANOTHER ENCOUNTER LOCATION” prompt, type the name of another encounter location or leave it blank.
7. At the “Sort the list by” prompt, type one of the following codes:

- N** Provider Name
- A** Affiliation
- D** Discipline/Provider Class
- S** Active and Inactive Status

8. At the “DEVICE” prompt, specify the device to output the report.

Below is a sample of the beginning of the report:

Affiliations: All Affiliations				
Affiliations: All AffiliationsAll Disciplines/Provider Classes				
NAME	AFFL	PROV CLASS	ADC	INACTIVE
-----	-----	-----	-----	-----
ABERNETHY, LAURA	TRIBAL	CLINIC RN	301CAF	DB
ABU-HATAB, CARL	IHS	OTHER	115MJK	ADB
				SB
				CCH
				CLB
				CPRX
				DB
				THC
				SBC
				CMC
				WW
				CDM
				DNH
				URA
				CDS
				CBL
				CWC

```
Enter RETURN to continue or '^' to exit:
```

Figure 18-4: Sample report

Do one of the following at the last prompt:

- Press Enter to display the next screen (does not apply to the last page).
- Type a caret (^) to exit.

18.3.2 Print ACTIVE Providers (APA)

Use the APA option to print active providers.

Following these steps:

1. At the “Select Print Table Listings Option” prompt, type **APA**.
2. At the “DEVICE” prompt, specify the device to output the report.

Below is a sample of the report.

LIST OF ALL ACTIVE PROVIDERS				JUL 14, 2014	15:30	PAGE 1
NAME	DISCIPLINE CODE	AFFILIATION	PROVIDER CLASS			
ABERNETHY, LAURA	01	TRIBAL	CLINIC RN			
ABU-HATAB, CARL	15	IHS	OTHER			
ACORD, CARRIE A	00	OTHER	MD			
ADAMS, REGINA N	00	OTHER	MD			
ADAMS, VICTORIA	48	OTHER	ALCOHOLISM/SUB ABUSE COUN			
ADEKANMBI, CRAIG A	21	OTHER	NURSE PRACTITIONER			
ADKINS, REVA D	PS	OTHER	PHYSICAL THERAPY STUDENT			
ADRIANCE, SHANNON E	66	TRIBAL	CASE MANAGERS			
AHUJA, PATRICK	11	OTHER	PHYSICIAN ASSISTANT			
AHUJA, TERESA M	C1	OTHER	PHARMACY STUDENT			
AIELLO, BRIAN C	C1	OTHER	PHARMACY STUDENT			
AIELLO, JASON D	00	CONTRACT	MD			
AIREE, AMANDA	00	OTHER	MD			
AIREE, JONEE C	PS	OTHER	PHYSICAL THERAPY STUDENT			
AIREE, LON	10	OTHER	PHYSICAL THERAPIST			

Figure 18-5: Sample APA report

18.3.3 Print Providers by Provider Classification (APC)

Use the APC option to print the providers by provider classification.

1. At the “Select Print Table Listings Option” prompt, type **APC**.
2. At the “DEVICE” prompt, specify the device to output the report.

Below is a sample of the report that lists providers by provider classification.

LIST OF PROVIDERS BY PROVIDER CLASSIFICATION		JUL 14, 2014	15:38	PAGE 1
NAME	PROVIDER CLASS			
ABBOTT, JAMES B	PUBLIC HEALTH NURSE			
ABERNETHY, LAURA	CLINIC RN			
ABU-HATAB, CARL	OTHER			
ACORD, CARRIE A	MD			
ADAMS, REGINA N	MD			
ADAMS, SHERRI	PHARMACIST			
ADAMS, VICTORIA	ALCOHOLISM/SUB ABUSE COUNSELOR			
ADEKANMBI, CRAIG A	NURSE PRACTITIONER			
ADKINS, MARY	FAMILY PRACTICE			
ADKINS, REVA D	PHYSICAL THERAPY STUDENT			
ADRIANCE, SHANNON E	CASE MANAGERS			
AHEARNE, JOSHUA	DENTAL HYGIENIST			
AHUJA, PATRICK	PHYSICIAN ASSISTANT			
AHUJA, TERESA M	PHARMACY STUDENT			
AIELLO, BRIAN C	PHARMACY STUDENT			
AIELLO, JASON D	MD			

Figure 18-6: Sample APC report

18.3.4 Print INACTIVE Providers (API)

Use the API option to print the inactive providers.

1. At the “Select Print Table Listings Option” prompt, type **API**.
2. At the “DEVICE” prompt, specify the device to output the report.

Below is a sample of the report that lists inactive providers.

LIST OF INACTIVE PROVIDERS		JUL 14, 2014	15:40	PAGE 1
NAME	DISCIPLINE CODE	PROVIDER CLASS	INACTIVE DATE	
ABBOTT, JAMES B	13	PUBLIC HEALTH N	APR 29, 2003	
ADAMS, SHERRI	09	PHARMACIST	MAR 9, 2005	
ADKINS, MARY	80	FAMILY PRACTICE	MAY 1, 2003	
AHEARNE, JOSHUA	46	DENTAL HYGIENIS	MAR 7, 2003	
ALBEA, TED	00	MD	MAY 1, 2003	
ALLEN, ERIN K	00	MD	JAN 12, 2005	
ALLEN, SHERYL	11	PHYSICIAN ASSIS	JUN 11, 2004	
ALLEN, SOPHIE	00	MD	MAY 1, 2003	
ALMOND, JONATHAN	73	ORTHOPEDIST	JAN 12, 2005	
AMAN, KARA S	00	MD	JAN 12, 2005	
AMBLER, BRIDGET H	53	COMMUNITY HEALT	JAN 12, 2005	
ANAAA, PURVI R	70	CARDIOLOGIST	JAN 12, 2005	
ANDERSON, JEN NIFER H	00	MD	JAN 12, 2005	
ANDERSON, SHERRI	80	FAMILY PRACTICE	MAR 7, 2003	
ANTICOAGULATION, TOM S	LCS 52	DENTIST	MAY 20, 1997	

Figure 18-7: Sample API report

18.3.5 Print Area Table (ARE)

Use ARE option to print a report that lists the area table.

1. At the “Select Print Table Listings Option” prompt, type **ARE**.
2. At the “SORT BY” prompt, type one of the following:

```
.01      NAME
.02      CODE
.03      PREFIX/REGION
.04      CAN NUMBER PREFIX
.05      INACTIVE DATE
.06      INACTIVE FLAG
```

What you type determines which column will be sorted. For example, if you typed CODE, the Code column would be sorted.

If you used the default NAME, the prompts continue:

3. At the “START WITH NAME: FIRST//” prompt, press enter to use “FIRST” – the default. This means that the first column (NAME) will be sorted by area name.
4. At the “DEVICE” prompt, specify the device to output the report.

Below is a sample report using NAME as the sort item.

AREA LIST		JUL 14, 2014 15:58		PAGE 1
NAME	CODE	PREFIX/REGION	CAN NUMBER PREFIX	
ABERDEEN	10	ABERDEEN	345	
ABERDEEN NON-IHS	19	ABERDEEN		
ABERDEEN TRIBE/638	15	ABERDEEN	345	
ABERDEEN URBAN	17	ABERDEEN	345	
ALASKA	30	ALASKA	359	
ALASKA NON-IHS	39	ALASKA	J59	
ALASKA TRIBE/638	35	ALASKA	359	
ALBUQUERQUE	20	ALBUQUERQUE	353	
ALBUQUERQUE NON-IHS	29	ALBUQUERQUE		
ALBUQUERQUE TRIBE/638	25	ALBUQUERQUE	353	
ALBUQUERQUE URBAN	27	ALBUQUERQUE	J53	
BEMIDJI	11	BEMIDJI	346	
BEMIDJI NON-IHS	18	BEMIDJI	346	
BEMIDJI TRIBE/638	16	BEMIDJI	346	

Figure 18-8: Sample ARE report

18.3.6 Print Provider List by Discipline (DIS)

Use the DIS option to the provider list by discipline

1. At the “Select Print Table Listings Option” prompt, type **DIS**.
2. At the “DEVICE” prompt, specify the device to output the report.

Below is a sample of the report that lists providers by discipline.

NEW PERSON LIST		JUL 14, 2014		16:01	PAGE 1
NAME	INITIAL	AFFL	ADC	INACTIVE DATE	

AIREE, LON	AIR	9	910931		
ANDERSON, WILLIAM L	AND	2	210802		
BARLOW, EUDEMA P	BAR	9	910649		
BIRDWELL, ALLYSON KOSTERMAN	BIR	9	910463	JAN 12, 2005	
BRIDGES, MARK E	BRI	9	910779	MAR 9, 2005	
BURRIS, LOREN A	BUR	9	910RA1		
CATTERSON, AMANDA M	CAT	3	310AAD		
CLABO, FRANK B	CLA	3	310AFV		
HAYS, DON MELVIN	HAY	9	910508		
HILL, LINDSAY R	HIL	9	910888		
HOPKINS, DIANE	HOP	9	910553	APR 30, 2003	

Figure 18-9: Sample DIS report

18.3.7 Print Education Topics List (EDU)

Use EDU option to print a report that lists the area table.

1. At the “Select Print Table Listings Option” prompt, type **EDU**.
2. At the “START WITH NAME: FIRST//” prompt, press enter to indicate that the education topic name will display in the first column. This column will be sorted by education topic name.
 - a. If you type the name of education topic at the “START WITH NAME” prompt, that education topic will be the first one in the education topics list.
 - b. At the “GO TO NAME: LAST//” prompt, type the education topic name to be the last in the list of education topics.
3. At the “DEVICE” prompt, specify the device to output the report.

Below is a sample report (using FIRST in the START WITH NAME).

EDUCATION TOPICS LIST		JUL 14, 2014		16:02	PAGE 1
NAME	MNEMONIC				

-COMPLICATIONS 2006	-C
-DISEASE PROCESS 2005	-DP
-LITERATURE	-L
-MEDICATIONS 2005	-M
-NUTRITION 2005	-N
-PROCEDURES 2005	-PRO
.0871-NUTRITION 2005	.0871-N
.9999-HOME MANAGEMENT 2005	
0-EQUIPMENT 2006	-EQ
0-HOME MANAGEMENT 2006	-HM
0-TREATMENT 2006	-TX
011.90-COMPLICATIONS 2005	011.90-C
034.0-FOLLOW UP	034.0-FU
034.0-HOME MANAGEMENT	034.0-HM
034.0-MEDICATIONS	034.0-M
034.0-MEDICATIONS 2005	034.0-M

Figure 18-10: Sample EDU report

18.3.8 Print CHS Vendor List by EIN Number (EVN)

Use the EVN option to produce a report that shows CHS vendor list by EIN number.

1. At the “Select Print Table Listings Option, type **EVN**.”
2. At the “START WITH EIN NO.” prompt, press Enter to select **FIRST**, the default. This means the EIN NO. items will be displayed under the first column and the list will be sorted by those items.
3. At the “DEVICE” prompt, specify the device to output the report.

Below is a sample report.

CHS VENDOR LISTING BY EIN NUMBER		JUL 15, 2014	15:37	PAGE 1
NAME	EIN NO.	EIN SUFFIX		
STREET	CITY	ST		
DATE INACT.	-----			
SALEM EYE CENTER 400 BURWELL STREET	154106319 SALEM			VA
THOMAS CLAYTON WEST MAIN STREET NOV 25, 1997	156158949 ANDREWS			NC
PD CARDIOLOGY ASSOCIATES 500 SOUTH COIT ST NOV 25, 1997	157079823 FLORENCE	00		SC
PEE DEE CARDIOLOGY ASSOC 500 S. COIT STREET NOV 25, 1997	157079823 FLORENCE	00		SC

Figure 18-11: Sample EVN report

18.3.9 Print Insurer List (INS)

Use the INS option to produce a report that shows the Insurer List.

1. At the “Select Print Table Listings Option” prompt, type **INS**.
2. At the “START WITH NAME.” prompt, press enter to select **FIRST**, the default. This means that the first column will be sorted by the insurer name.
3. At the “DEVICE” prompt, specify the device to output the report.

Below is a sample report.

INSURER LIST		JUL 14, 2014	16:11	PAGE 1
NAME	CONTROL NUMBER			

3M MEDICAL PLAN				
AAA LIFE INSURANCE COMPANY				
AAG				
AAG BENEFIT PLAN				
AARP				
AARP				
AARP - COMPLETE PLUS				
AARP CLAIM UNIT				
AARP EXPRESS SCRIPT				
AARP HEALTH CARE OPTIONS				
AARP HEALTHCARE OPTIONS				
AARP OF PA				
ABINGTON COS GROUP	60			
ABS, CORPORATE				
ACCEPTANCE INS GRP	3298			

Figure 18-12: Sample INS report

18.3.10 Print Location Table (LOC)

Use the LOC option to produce a report of locations of the insurers.

1. At the “Select Print Table Listings Option” prompt, type **LOC**.
2. At the “START WITH AREA: A” prompt, press Enter to accept A as the default for the starting location.
3. At the “GO TO AREA: Z” prompt, press Enter to accept Z as the default ending location.
4. At the “DEVICE” prompt, specify the device to output the report.

The following is a sample report.

LOCATION LIST		JUL 15, 2014 15:43		PAGE 1
NAME	ASUFAC INDEX	ABBRV	AREA	SU
AMBULANCE	101077		ABERDEEN	CHEYENNE R
BEAR CREEK	101080		ABERDEEN	CHEYENNE R
BRIDGER SCH	101050		ABERDEEN	CHEYENNE R
CHERRY CR HS	101031		ABERDEEN	CHEYENNE R
CHERRY CR SC	101051		ABERDEEN	CHEYENNE R
CHS HOSPITAL	101082		ABERDEEN	CHEYENNE R
CHS OTHER	101097		ABERDEEN	CHEYENNE R
CHS PHYSICIAN OFFICE	101088		ABERDEEN	CHEYENNE R
DUPREE	101081		ABERDEEN	CHEYENNE R
EAGLE BU SCH	101052		ABERDEEN	CHEYENNE R
EAGLE BUTTE	101001		ABERDEEN	CHEYENNE R
FIRESTEEL	101083		ABERDEEN	CHEYENNE R
GLAD VALLEY	101084		ABERDEEN	CHEYENNE R
GLENCROSS	101085		ABERDEEN	CHEYENNE R
HOME	101089		ABERDEEN	CHEYENNE R

Figure 18-13: Sample LOC report

18.3.11 Print CHS Vendor List by Name (NVE)

Use the CHS option to produce a report that shows the CHS vendor list by name.

1. At the “Select Print Table Listings Option” prompt, type **NVE**.
2. At the “START WITH NAME” prompt, press enter to select **FIRST**, the default. This means the VHS Venter List names will appear in the first column.
3. At the “DEVICE” prompt, specify the device to output the report.

Below is a sample report.

CHS VENDOR LISTING BY NAME		JUL 15, 2014 15:44		PAGE 1
NAME	EIN NO.	EIN SUFFIX		
STREET	CITY	ST		
DATE INACT.				
1520595110	1520595110			
PO BOX 64478	BALTIMRE	MD		
1621113167				
MARVIN L. MILLS, MD	1581337219			
102 GROSS CRESCENT	FT. OGLETHO	GA		

Figure 18-14: Sample NVE report

18.3.12 Print Physical Therapy List (PHY)

Use the PHY option to produce a report that shows the physical therapy list by name.

1. At the “Select Print Table Listings Option” prompt, type **PHY**.
2. At the “START WITH NAME.” prompt, press enter to select **FIRST**, the default. This means the physical therapy names will appear in the first column.
3. At the “DEVICE” prompt, specify the device to output the report.

Below is a sample report.

PHYSICAL THERAPY LIST		JUL 14, 2014	16:21	PAGE 1
NAME	CODE			
ADL INSTRUCTION	975304			
ALT HOT/COLD	975001			
AMB-CANE	975005			
AMB-CRUTCHES	975004			
AMB-FITTING	975006			
AMB-GAIT TRNG	975008			
AMB-INDEPENDENT	975009			
AMB-INSTRUCT	975007			
AMB-PARRAL. BAR	975002			
AMB-WALKER	975003			
AMPUTEE REHAB	975015			
APPT-S OTHER	975308			
BACK EVALUATION	975205			
BED TRACT-ORTHO	975113			
BED TRACT-S CER	975114			
BED TRACT-S PEL	975115			

Figure 18-15: Sample PHY report

18.3.13 Print Provider List by Name (PPN)

Use the PPN option to print the provider list by name.

1. At the “Select Print Table Listings Option” prompt, type **PPN**.
2. At the “DEVICE” prompt, specify the device to output the report.

Below is a sample of the report that lists the providers by name.

NEW PERSON LIST		JUL 14, 2014	16:23	PAGE 1
NAME	INITIAL	AFFL	ADC	INACTIVE DATE
ABBOTT, JAMES B	ABB	9	913033	APR 29, 2003
ABERNETHY, LAURA	ABE	3	301CAF	
ABU-HATAB, CARL	ABU	1	115MJK	
ACORD, CARRIE A	ACO	9	900MD	

ADAMS, REGINA N	ADA	9	900856		
ADAMS, SHERRI	ADA	9	909449	MAR	9, 2005
ADAMS, VICTORIA	ADA	9	948KH		
ADEKANMBI, CRAIG A	ADE	9	921ANP		
ADKINS, MARY	ADK	9	980704	MAY	1, 2003
ADKINS, REVA D	ADK	9	9PSADQ		
ADRIANCE, SHANNON E	ADR	3	366AFC		
AHEARNE, JOSHUA	AHE	9	946133	MAR	7, 2003
AHUJA, PATRICK	AHU	9	911PAC		
AHUJA, TERESA M	AHU	9	9C1715		
AIELLO, BRIAN C	AIE	9	9C1715		

Figure 18-16: Sample PPN report

18.3.14 Print Immunization Table (PRI)

Use the PRI option to produce a report that shows the immunization list by name.

1. At the “P Select Print Table Listings Option” prompt, type **PRI**.
2. At the “START WITH NAME: FIRST//” prompt, type the first name to start the list.
3. At the “GO TO NAME: LAST//” prompt, type the last name to end the list.
4. At the “DEVICE” prompt, specify the device to output the report.

18.3.15 Print Skin Test Table (PST)

Use the PST option to produce a report that shows the skin test list by name.

1. At the “Print Table Listings Option” prompt, type **PST**.
2. At the “START WITH NAME.” prompt, press enter to select **FIRST** to indicate the skin test name is in the first column (NAME). This means that the list will be sorted by skin test name.
3. At the “DEVICE” prompt, specify the device to output the report.

Below is a sample report.

SKIN TEST LIST		JUL 14, 2014 16:28		PAGE 1
NAME	CODE	FLAG	CPT CODE	
CANDIDA	26	INACTIVE		
CHLAMYDIA	27	INACTIVE		
COCCI	23	INACTIVE	86490	
MONO-VAC	24	INACTIVE	86585	
MUMPS	28	INACTIVE		
PPD	21		86580	
SCHICK	22	INACTIVE		
TETANUS	25			

TINE	20	INACTIVE	86585
------	----	----------	-------

Figure 18-17: Sample PST report

18.3.16 Print Relationship List (REL)

Use the REL option to produce a report that shows the relationship list by name.

1. At the “Select Print Table Listings Option” prompt, type **REL**.
2. At the “START WITH RELATIONSHIP:” prompt, press Enter to select FIRST to indicate the relationship name is in the first column.
3. At the “DEVICE” prompt, specify the device to output the report.

Below is a sample report.

RELATIONSHIP LIST	JUL 14, 2014	16:33	PAGE 1
RELATIONSHIP	MNEMONIC		

ADOPTED CHILD			
ADOPTED DAUGHTER			
ADOPTED SON			
AUNT			
BOSS			
BROTHER			
BROTHER-IN-LAW			
CADAVER DONOR			
CADEVER DONOR			
CHILD			
CHILD IN-LAW			
CHILD WHERE INSURED HAS NO FINANCIAL RESPONSIBILITY			
COMMON-LAW SPOUSE			
COUSIN			
COUSIN (FEMALE)			
COUSIN (MALE)			

Figure 18-18: Sample REL report

18.3.17 Print Service Unit Table (SUP)

Use the SUP option to produce a report showing the service unit by name.

1. At the “Select Print Table Listings Option” prompt, type **SUP**.
2. At the “START WITH AREA” prompt, type the area name to start with.
3. At the “GO TO AREA” prompt, type the area name to end with.
4. At the “DEVICE” prompt, specify the device to output the report.

Below is a sample report using Phoenix as the Start With Area and Zuni as the Go To Area.

SERVICE UNIT LIST		JUL 15, 2014	16:07	PAGE 1	
NAME	AREA	AREA CODE	ASU CODE	ASU CODE	
NON SERVICE UNIT	TUCSON	00	00	0000	
SELLS	TUCSON	00	01	0001	
YAQUI CHS	TUCSON	00	02	0002	
SELLS, NON-IHS	TUCSON NON-IHS	09	01	0901	
YAQUI	TUCSON NON-IHS	09	02	0902	
SELLS/638	TUCSON TRIBE/638	05	01	0501	
YAQUI	TUCSON TRIBE/638	05	02	0502	
TUCSON URBAN	TUCSON URBAN	07	01	0701	

Figure 18-19: Sample SUP report

18.3.18 Print Treatment List (TRT)

Use the TRT option to produce a report that shows the treatment list by name.

1. At the “Select Print Table Listings Option” prompt, type **TRT**.
2. At the “START WITH NAME.” prompt, press enter to select **FIRST** to indicate the treatment name is in the first column.
3. At the “DEVICE” prompt, specify the device to output the report.

Below is a sample report.

TREATMENT LIST		JUL 14, 2014	16:40	PAGE 1	
NAME	CODE				
ACOUSTIC REFLEX DECAY TEST	AUD020				
ACOUSTIC REFLEX TEST	AUD019				
ACTIVITIES OF DAILY LIVING	000520				
ADMINISTRATION OF MEDICINE	000131				
AMBULATION	000521				
APPLY/REMOVE BRACE-SLING, CAST	000132				
AREA, SU, MTNGS OR COMMITTEES	000028				
ARRANGING TRANSPORTATION	000050				
ASSESSMENT	000101				
BASIC COMPREHENSIVE AUD EVAL	AUD014				
BATH	000133				
BINOCULAR MICROSCOPY	AUD055				
CALORIC VESTIBULAR TESTS(4)	AUD005				
CASE CONFERENCE	000001				
CASTING	000542				
CATHETERIZATION	000134				

Figure 18-20: Sample TRT report

Each option will ask you to select the device to display or browse the report.

18.4 List Clinics (CL)

Use the CL option to show a report that lists the clinics.

To list the clinics, follow these steps:

1. At the “Select PCC Local Table Maintenance Option” option, type **CL**.
2. At the “Sort by” prompt, specify the sort criteria for the report. The response determines which column will be sorted. Type one of the following options:

```

01          NAME
1           CODE
90000.01    1A WORKLOAD CLINIC
90000.02    MEDICARE BILLABLE
90000.03    MEDICAID BILLABLE
999999901  ABBREVIATION
999999902  PRIMARY CARE CLINIC

```

The following table provides information about other items to type:

Type	Results
- in front of a numeric-valued field	Sort from high to low
+ in front of field name	Get subtotals by that field
#	Page feed on each field value
‘!	Get ranking number
@	Suppress a sub-header
]	Force saving sort template
;txt after Free-Text fields	Sort numbers as text
[template name] in brackets	Sort by previous search results
By (0)	Define record selection and sort order

The following prompts will display if you selected NAME in the first step:

3. At the “Start With Name” prompt, type the name to start the name range. If you leave this prompt blank, then the “Go to Name” prompt will not display.
4. At the “Go to Name” prompt, type the name to end the name range.
5. At the “DEVICE” prompt, specify the device to output the report.

Below is a sample report.

CLINIC STOP LIST	JUL 14, 2014 16:45	PAGE 1
	PRIM	
	CARE	
NAME	CODE 1A?	CLINIC

ALCOHOL AND SUBSTANCE	43	YES
AMBULANCE	0	YES
ANESTHESIOLOGY	0	YES
ANTICOAGULATION THERAPY	0	YES
AUDIOLOGY	35	YES
BEHAVIORAL HEALTH	0	YES
CANCER CHEMOTHERAPY	62	YES
CANCER SCREENING	58	YES
CARDIOLOGY	2	YES
CASE MANAGEMENT SERVICES	77	NO
CAST ROOM	55	YES
CHART REV/REC MOD	52	NO
CHEST AND TB	3	YES
CHIROPRACTIC	0	YES

Figure 18-21: Sample CL report

18.5 Inactivate/Reactivate Persons & Providers (INA)

Use the INA option to enter an inactive date for a person or provider. To deactivate a user, please use the option on the USER EDIT menu. To reactivate a person or provider, type @ at the Inactivate Date prompt. Then proceed to the Add/Edit Providers option to ensure all the data is current.

Follow these steps to inactivate a person:

1. At the “Select PCC Local Table Maintenance Option” option, type **INA**.
2. At the “Select NEW PERSON NAME” prompt, type the name of the person to inactivate.
3. At the “INACTIVE DATE” prompt, type the date to inactivate the person.

18.6 Add/Edit Providers (PRV)

Use the PRV option to add new providers to your system OR to edit those already in the system. You do NOT need to enter the provider as a person first. Just use this option.

Below are the prompts:

1. At the “Select PCC Local Table Maintenance Option” option, type **PRV**.
2. At the “Enter NEW PERSON’s name (Family, Given middle Suffix)” prompt, type the person’s name.

If the person is inactive, then the application displays a message stating this and telling you to use the INACTIVATE/REACTIVATE option (for that particular person).

3. At the “INITIAL” prompt, type the person’s initials.
4. At the “SEX” prompt, type the person’s sex. Use M (male) or F (female).
5. At the “DOB” prompt, type the person’s date of birth.
6. At the “TITLE” prompt, type the person’s title.
7. At the “SSN” prompt, type the person’s social security number.
8. At the “SERVICE/SECTION” prompt, type the name of the service or section for the person. Other options are to type the abbreviation, mail symbol, type of service, or MIS costing code. (This prompt is required.)
9. At the “STREET ADDRESS 1” prompt, type the street address of the person.
10. At the “STREET ADDRESS 2” prompt, type the second line of the street address, if needed. Otherwise, leave blank. Sometimes this line is used to specify the PO Box number.
11. At the “STREET ADDRESS 3” prompt, type the third line of the street address, if needed. Otherwise, leave blank.
12. At the “CITY” prompt, type the name of the city in which the person resides.
13. At the “STATE” prompt, type the name of the state in which the person resides.
14. At the “ZIP CODE” prompt, type the zip code of the person’s address.
15. At the “PHONE (HOME)” prompt, type the phone number the person’s home phone.
16. At the “OFFICE PHONE” prompt, type the phone number the person’s office phone.
17. At the “FAX NUMBER” prompt, type the fax number at the person’s office.
18. At the “EMAIL ADDRESS” prompt, type the person’s e-mail address.
19. At the “PROVIDER CLASS” prompt, type the person’s provider class (required).
20. At the “AFFILIATION” prompt, type the person’s affiliation (required), which can be one of the following:
 - 1 IHS
 - 2 CONTRACT
 - 3 TRIBAL
 - 4 STATE
 - 5 MUNICIPAL
 - 7 NTL HLTH SRV CORP

- 9 OTHER
- 6 VOLUNTEER
- 8 638 PROGRAM

21. At the “CODE” prompt, type the person’s code, using 1–3 characters in length.
22. At the “IHS LOCAL CODE” prompt, type the person’s IHS local code.
23. At the “MEDICARE PROVIDER NUMBER” prompt, type the person’s Medicare provider number.
24. At the “MEDICAID PROVIDER NUMBER” prompt, type the person’s Medicaid provider number.
25. At the “UPIN NUMBER” prompt, type the person’s unique physician identification number.
26. At the “AUTHORIZED TO WRITE MED ORDERS” prompt, type **1** to indicate that the provider is authorized to write orders.
27. At the “DEA#” prompt, type the person’s DEA number. This can be two upper case letters followed by 7 digits. A suffix of up to two alphanumeric characters can be appended (optional). This field is used to enter the drug enforcement agency number.
28. At the “DEA EXPIRATION DATE” prompt, type the expiration date of the DEA.
29. At the “SPI” prompt, type the person’s SureScript Provider ID.
30. At the “PROVIDER TYPE” prompt, type one of the following:
 - 1** FULL TIME
 - 2** PART TIME
 - 3** C & A
 - 4** FEE BASIS
 - 5** HOUSE STAFF
31. At the “REQUIRES COSIGNER” prompt, type **1** (YES) if medication orders written by this person must be cosigned by another provider of care.
32. At the “USUAL COSIGNER” prompt, type the name of the usual cosigner, if any.
33. At the “REMARKS” prompt, type remarks and/or comments about the provider.
34. At the “Select STATE OF LICENSURE” prompt, type the state of licensure for the person. If you respond to this prompt, then the next prompt will display.
35. At the “LICENSE NUMBER” prompt, type the license number of the person.

After the prompts are complete, the focus returns to the “Enter NEW PERSON's name (Family,Given Middle Suffix)” prompt.

19.0 Update ICD-10 Diagnosis from SNOMED Concept ID

The options and utilities on the Supervisor menu are shown below:

```

*****
**          PCC Data Entry Module          **
** Data Entry SUPERVISOR Options and Utilities **
*****
                IHS PCC SUITE  Version 2.0
                DEMO INDIAN HOSPITAL

ICD    Fix UNCODED ICD Diagnoses/Operations ...
VRR    Visit Review Report ...
INP    Link In-Hospital Visits to Hospitalizations ...
DSP    Display PCC Data Entry Site Parameters
ACC    Process ACCEPT Commands ...
DDPR   Delete Duplicate Primary Providers from Visits
DXV    DX Coding Audit for Selected Set of Visits
ESP    Enter/Edit PCC Data Entry Site Parameters
EVM    Auto Merge Event Visits on Same Day
FTM    Forms/Data Entry Tracking Menu ...
LAB    Complete Orphaned Visits Menu ...
MDL    Visit Re-linker/Merge/Delete Log Reports ...
MNE    Update PCC Mnemonic's Allowed/Not Allowed
OTH    Other PCC Data Entry Reports ...
PLAL   Reports Listing Allergies recorded on PROBLEM LIST ...
PMN    Print list of Data Entry Mnemonics
RET    Re-Submit PCC Visit to the IHS Data Center
TAB    PCC Local Table Maintenance ...
UIFS   Update ICD-10 Diagnoses from SNOMED Concept ID
UPMC   Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 19-1: Data Entry SUPERVISOR Options and Utilities menu

Use the UIFS option to update the diagnosis on the Problem List and family history when a DIKS upgrade with updated mappings is received or when you first switch to ICD-10 from ICD-9.

This option should only be run after the ICD-10 implementation date. The ICD-10 implementation date for your system is Oct. 01, 2015.

20.0 Update PCC Master Control File

The options and utilities on the Supervisor menu are shown below:

```

*****
**          PCC Data Entry Module          **
** Data Entry SUPERVISOR Options and Utilities **
*****

                IHS PCC SUITE  Version 2.0
                DEMO INDIAN HOSPITAL

ICD    Fix UNCODED ICD Diagnoses/Operations ...
VRR    Visit Review Report ...
INP    Link In-Hospital Visits to Hospitalizations ...
DSP    Display PCC Data Entry Site Parameters
ACC    Process ACCEPT Commands ...
DDPR   Delete Duplicate Primary Providers from Visits
DXV    DX Coding Audit for Selected Set of Visits
ESP    Enter/Edit PCC Data Entry Site Parameters
EVM    Auto Merge Event Visits on Same Day
FTM    Forms/Data Entry Tracking Menu ...
LAB    Complete Orphaned Visits Menu ...
MDL    Visit Re-linker/Merge/Delete Log Reports ...
MNE    Update PCC Mnemonic's Allowed/Not Allowed
OTH    Other PCC Data Entry Reports ...
PLAL   Reports Listing Allergies recorded on PROBLEM LIST ...
PMN    Print list of Data Entry Mnemonics
RET    Re-Submit PCC Visit to the IHS Data Center
TAB    PCC Local Table Maintenance ...
UIFS   Update ICD-10 Diagnoses from SNOMED Concept ID
UPMC   Update PCC Master Control File

Select Data Entry SUPERVISOR Options and Utilities Option:

```

Figure 20-1: Data Entry SUPERVISOR Options and Utilities menu

Use the UPMC option to update the PCC master control file.

Type **UPMC** at the “Select Data Entry SUPERVISOR Options and Utilities Option” to display the following:

```

                PCC DATA ENTRY SUPERVISOR MENU

                UPDATE PCC MASTER CONTROL FILE and ANCILLARY TO PCC LINKS
                This option is used to update the PCC Master Control file and the
                Ancillary to PCC link status for ancillary packages.
                You should be very careful when using this option.

                Do you want to continue? N//

```

Figure 20-2: Information displayed for the UPMC option

Type **N** at the last prompt and the focus returns to the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt.

21.0 Coding Queue

In order to use the coding queue, the EHR/PCC Coding Audit Start Date needs to be set in the PCC Master Control file. Section 20.0 provides for more information about updating the PCC Master Control File.

There should be adequate staff to manage the coding queue daily and it should not exceed more than seven days. If you exceed seven days, however, you may encounter problems such as slowness when running it. Turning the queue on and then turning it off again will not create a problem.

The coding queue list can be used to audit visits that are created by EHR users. The visits displayed in the list are those with an INCOMPLETE or blank chart audit status. The object is to review these visits and update their status so that the chart audit status is updated to Reviewed / Complete. Consider the following:

- Billable visits that are *not* flagged as “reviewed” will not generate a claim in Third Party Billing (TPB).
- Nonbillable visits that are *not* flagged as “reviewed” will be exported via NDW.
- *All* visits, whether they are billable or not, should be reviewed and flagged as reviewed. A visit will not pass to Billing until it is marked as Reviewed/Completed.
- Incomplete/orphan ancillary visits do not appear on this list. These visits appear on the LIR and PPPV reports and will need to be completed and flagged as complete through the normal data entry process.

The following visits are excluded from the list:

- Contract Health visits
- Visits that do not have a primary provider

Visits with the following service categories are included in the list:

- A Ambulatory
- S Day Surgery
- O Observation
- T Telecommunications
- C Chart Review
- R Nursing Home
- I In Hospital

This list can be sorted by date, primary provider, clinic code, hospital location (scheduling clinic), and facility. Once the visit has been reviewed, the review status can be set as reviewed/complete or incomplete. All visits set as reviewed/complete will be passed to the IHS/RPMS billing package.

We recommend that the lists be run daily with TPB priority. The ultimate goal is to review 100% of all visits. When performing the review, run the list first and then display it to make sure the service category, clinic code, location, coding, and other information is coded correctly.

The Coding Audit Menu is accessed by using the EHRC option on Select Enter/Modify/Append PCC Data Menu Option menu.

21.1 EHR/PCC Coding Audit for Visits in Date Range (EHRD)

```

*****
**          PCC Data Entry Module          **
**          EHR/PCC Coding Audit Menu      **
*****
          IHS PCC Suite, Version 2.0
          DEMO INDIAN HOSPITAL

EHRD  EHR/PCC Coding Audit for Visits in Date Range
PEHR  EHR/PCC Coding Audit for One Patient
ACRD  Add new Chart Deficiency Reason to Table
TUR   Count Unreviewed Visits by Date/Service Category
ACCL  Auto Mark Visits as Reviewed/Complete by Clinic
ACRX  Auto-Complete Pharmacy Education Only Visits
CASP  Update EHR Coding Audit Site Parameters
ICPD  Incomplete Charts by Provider w/Deficiencies
INCV  List Visits Marked as Incomplete
LIR   List Unreviewed/Incomplete Visits
TRV   Tally of Reviewed/Completed Visits by Operator
TRVL  Tally Reviewed/Completed Visits (Last Operator)
VNR   Tally/List of Visits not Reviewed in N Days

Select EHR/PCC Coding Audit Menu Option:

```

Figure 21-1: Options on EHR/PCC Coding Audit Menu

Use the EHRD option to audit visits created by EHR users.

The visits displayed in the list are those with an INCOMPLETE or blank chart audit status. This list can be sorted by date, primary provider clinic code, hospital location (scheduling clinic), and facility.

Once the visit has been reviewed, the review status can be set as reviewed/complete or incomplete. All visits set as reviewed/complete will be passed to the IHS/RPMS billing package.

The following are excluded:

- Contract Health visits
- Visits that do not have a primary provider (If Site Parameter “Include all visits in the coding queue list?” is set to “No.”)
- Visits with the following service categories:
 - Event (Historical)
 - Hospitalization
 - In Hospital
 - Observation

Visits with the following service categories are included in the list:

- A Ambulatory
- S Day Surgery
- O Observation
- T Telecommunications
- C Chart Review
- R Nursing Home
- I In Hospital

Notes: A visit will NOT pass to Billing until it is marked as reviewed/completed.

Incomplete/orphan ancillary visits do not appear on this list. These visits appear on the LIR and PPPV reports and need to be completed and flagged as complete through the normal data entry process.

To list these visits, follow these steps:

1. At the “Select EHR/PCC Coding Audit Menu Option” prompt, type **EHRD**.
2. At the “Enter Beginning Visit Date” prompt, type the beginning date of the date range. You should limit your date range to no more than seven days, because viewing more than seven days could take a while to process.
3. At the “Enter Ending Visit Date” prompt, type the ending date of the date range.
4. At the “Enter a code indicating what LOCATIONS/FACILITIES are of interest” prompt, type one of the following:

- A** ALL Locations/Facilities
- S** Selected set or Taxonomy of Locations
- O** ONE Location/Facility

IF S or O is used, other prompts will display:

- a. Type the encounter location at the “Enter ENCOUNTER LOCATION” prompt.
 - b. Type another encounter location, if needed, at the “Enter ANOTHER ENCOUNTER LOCATION” prompt.
5. At the “Enter a code indicating what CLINICS (IHS clinic code) are of interest” prompt, type one of the following:

- A** ALL Clinics
- S** Selected set or Taxonomy of Clinics
- O** ONE Clinic
- X** No Clinic Assigned

Your selection indicates the clinics (IHS clinic code) visits that will be included in the list. If S or O was used, other prompts will be displayed.

- a. Type a clinic at the “Enter CLINIC” prompt.
 - b. Type another clinic at the “Enter ANOTHER CLINIC” prompt.
6. At the “Enter a code indicating which HOSPITAL LOCATIONS are of interest” prompt, type one of the following:

- A** ALL Hospital Locations
- S** Selected set or Hospital Locations
- O** ONE Hospital Location

Your selection indicates which HOSPITAL LOCATIONS will be included in the list. If you type S or O, another prompt will be displayed.

- At the “Which HOSPITAL LOCATIONS” prompt, type the hospital location.

7. At the “Enter a code indicating which providers are of interest” prompt, type one of the following:

- A** ALL Providers
- S** Selected set or Taxonomy of Providers
- O** ONE Provider
- X** No Visit Primary Provider Assigned

Your selection indicates which providers will be included in the list. If you type S or O, another prompt will be displayed.

- At the “Enter PROVIDER” prompt, type the name of the provider.

8. At the “Select visits based on chart deficiency reason” prompt, type either **D** (Do NOT screen on Chart Deficiency Reason) or **S** (Screen on Chart Deficiency Reason).

A chart deficiency reason might have been previously entered for a visit. If you want to display only visits whose LAST chart deficiency reason matches one or more that you select, type the reason or reasons.

If **S** is used, other prompts will display.

- a. At the “Which CHART DEFICIENCY REASON” prompt, type the chart deficiency reason.
 - b. After entering a chart deficiency reason, the prompt repeats. Type another chart deficiency reason, if needed. Otherwise, leave it blank.
9. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

- I** Include All patients
- E** Exclude Demo patients
- O** Include only demo patients

The application displays the criteria for the visits.

10. At the “Do you wish to continue?” prompt, type **Y** (Yes) or **N** (no).

If **N** is used, you leave the process.

If **Y** is used, the next prompt is displayed.

11. At the “How would you like the list of visits sorted” prompt, type one of the following options:

- N** Patient Name
- H** HRN
- D** Date of Visit
- T** Terminal Digit of HRN
- S** Service Category
- L** Location of Encounter
- C** Clinic
- O** Hospital Location
- P** Primary Provider
- A** Chart Audit Status
- I** Has Medicare/Medicaid or PI

The following shows a sample report.

PCC/EHR VISIT AUDIT	Jul 16, 2014 11:38:49	Page:	1 of	4
Visit Dates: Jun 21, 2014 to Jul 16, 2014				
* an asterisk beside the visit number indicates the visit has an error				

#	VISIT DATE	PATIENT NAME	HRN	FAC	HOSP LOC	S	CL	INS	PRIM PROV	STATU
1)*	06/24/14@15:14	ABBOTT, RAMONA	103447	CDM	ACUPUNCT	A	06	P	RICHARDS,	NO
2)*	06/24/14@15:55	ABBOTT, RAMONA	103447	DB	PHARMACY	A	39	P	RICHARDS,	NO
3)	06/23/14@12:34	RUSSELL, HEIDI	105309	DB	TOEDT FP	A	01	P	RUSLAVAGE	
4)	06/23/14@20:44	RUSSELL, HEIDI	105309	DB	AAA DEMO	A	28	P	RUSLAVAGE	
5)*	06/26/14@14:17	CHEKELELEE, RO	112414	DB	BRIDGES	A	64	M/C/PTETER, SHI		NO
6)*	06/26/14@15:33	ABRAMS, BETTY	114685	CDM	CDP Phys	A	06	P	TETER, SHI	NO
7)*	06/23/14@12:04	AALVIK, BETH	116405	DB	ALEXANDE	A	20		RICHARDS,	.99
8)*	06/23/14@12:04	AALVIK, BETH	116405	DB	ALEXANDE	A	20		RICHARDS,	NO
9)*	06/23/14@11:04	AALVIK, BETH	116405	DB	PHARMACY	A	39		RICHARDS, I	.99
10)*	06/24/14@16:08	AALVIK, BETH	116405	DB	PHARMACY	A	39		BISHOP, BR	.99
+ Q - Quit/?? for more actions/+ next/- previous >>>										
D	Display Visit	C	Chart Audit History	T						Change Date/Time
N	Note Display	H	Health Summary	U						Resequenece POVS
M	Modify Visit	O	One Patient's Visits	J						View BH Note
A	Append to Visit	X	Visit Delete	Y						View Any Visit
G	Visit Merge	B	B Merge 2 Diff Dates	Z						Add a Visit
S	Status Update	F	F Move V File	I						Chart Deficiency
R	Resort List	E	E Move V File 2 Dates	K						Change Patient
Select Action: D//										

Figure 21-2: Sample EHRD report

Section 21.2 provides more information about the PCC/EHR VISIT AUDIT screen.

21.2 Using the PCC/EHR VISIT AUDIT Screen

The PCC/EHR VISIT AUDIT screen displays the visits that were retrieved and put into the queue for review.

#	VISIT DATE	PATIENT NAME	HRN	FAC	HOSP LOC	CL	INS	PRIM PROV	STATU	
1)	09/08/08@09:00	PATIENT, CRSFO	999807	WW		A	16	KAPPAAAA,		
2)	09/08/08@09:00	PATIENT, CRSFO	999815	WW		A	12	KAPPAAAA,		
Q - Quit/?? for more actions/+ next/- previous >>>										
D	Display Visit	C	Chart Audit History	T						Change Date/Time
N	Note Display	H	Health Summary	U						Resequenece POVS
M	Modify Visit	O	One Patient's Visits	J						View BH Note
A	Append to Visit	X	Visit Delete	Y						View Any Visit
G	Visit Merge	B	B Merge 2 Diff Dates	Z						Add a Visit
S	Status Update	F	F Move V File	I						Chart Deficiency
R	Resort List	E	E Move V File 2 Dates	K						Change Patient
Select Action: D//										

Figure 21-3: PCC/EHR VISIT AUDIT screen

The following can be used at the “Select Action” prompt:

- Type a plus sign (+) to display the next page of information (does not apply to the last page).
- Type a minus sign (-) to display the previous page of information (does not apply to the first page).
- Type **Q** to leave the screen.

The following table provides an overview of the actions that can be performed at the “Select Action” prompt:

Code	Name	Functionality
D	Display Visit	Displays the PCC Visit Data screen for a specified visit
N	Note Display	Displays any notes associated with the visit
M	Modify Visit	Allow adding a mnemonic to the specified visit
A	Append to Visit	Allows appending a mnemonic to the specified visit
G	Visit Merge	Allows merging visits on the same visit date
S	Status Update	Allows changing the chart audit status to either R (Reviewed / Complete) or I (Incomplete)
R	Resort List	Allows changing the sort order of the list in the queue by selecting new sort criteria
C	Chart Audit History	Displays the Chart Audit History for a specified visit
H	Health Summary	Displays the specified health summary type about a selected visit
O	One Patient's Visit	Displays all visits for a patient on the same date as the visit you select from the list
X	Visit Delete	Removes a specified visit from the visit queue
B	B Merge 2 Diff Dates	Allows Pharmacy to add a medication to a physician visit (for example, over the weekend)
F	F Move V File	Moves the V file data for a visit record that has more than 1 visit on the particular day
E	E Move V File 2 Dates	Similar to F Move V File but moves visits on different days
T	Change Date/Time	Changes the date or time of a specified visit
U	Resequence POVS	Resequence the POVS for a specified visit.
J	View BH Note	Views any behavioral health note associated with a visit
Y	Views Any Visit	Views the Visit File associated with a visit
Z	Add a Visit	Adds a visit to the visit queue
I	Chart Deficiency	Adds, Edits, Resolves Chart Deficiencies
K	Change Patient	Changes the patient for subsequence activities

21.2.1 Display Visit (D)

Use the D action to display ancillary data about a specified visit.

Display the visit for which to verify PCC reporting requirements (service category, clinic, location, visit type, etc.) and coding requirements. Note that the display shows visits that are EHR created. Record any deficiencies and coding changes to be communicated to the provider via e-mail or person-to-person. If you need to document the discussion with the provider, use the coding template to document the interaction in writing.

Type **D** at the “Select Action” prompt and select the visit of interest. The application displays a message that it’s looking for ancillary data to merge into the visit.

The following is a sample report:

```

PCC VISIT DISPLAY                Jul 16, 2014 11:40:33                Page:    1 of    3

Patient Name:                    CHEKELELEE,ROBERT
Chart #:                          112414
Date of Birth:                    DEC 06, 1969
Sex:                               M
Visit IEN:                        3733026

===== VISIT FILE =====
VISIT/ADMIT DATE&TIME: JUN 26, 2014@14:17
DATE VISIT CREATED:              JUN 26, 2014
TYPE:                             TRIBE-NON 638/NON-COMPACT
PATIENT NAME:                     CHEKELELEE,ROBERT
LOC. OF ENCOUNTER:                2011 DEMO HOSPITAL
SERVICE CATEGORY:                AMBULATORY
CLINIC:                           RETINOPATHY
DEPENDENT ENTRY COUNT:            2
DATE LAST MODIFIED:              JUN 26, 2014
HOSPITAL LOCATION:                BRIDGES
CREATED BY USER:                 THETA,SHIRLEY
OPTION USED TO CREATE:            CIAV VUECENTRIC

USER LAST UPDATE:                 THETA,SHIRLEY
OLD/UNUSED UNIQUE VIS:            5851010003733026
DATE/TIME LAST MODIFI:            JUN 26, 2014@14:23:12
NDW UNIQUE VISIT ID (:            160610003733026
WHERE SEEN SNOMED CT:             255327002
WHERE SEEN PREFERRED :            Ambulatory
WHERE SEEN SNOMED CT:             440655000
WHERE SEEN PREFERRED :            Outpatient environment
WHERE SEEN SNOMED CT:             33022008
WHERE SEEN PREFERRED :            Hospital-based outpatient department
FACE TO FACE SNOMED C:            308335008
FACE TO FACE PREFERRE:            Patient encounter procedure
VISIT ID:                          3M336-CIX

===== PROVIDERs =====
PROVIDER:                          THETA,SHIRLEY
AFF.DISC.CODE:                     200abc
PRIMARY/SECONDARY:                 PRIMARY

```



```
Select Action: +//
```

Figure 21-4: Sample information using D

The following can be performed at the “Select Action” prompt:

- Type a plus sign (+) to display the next screen of data (does not apply to the last screen of data).
- Type a minus sign (-) to display the previous screen of data (does not apply to the first screen of data).
- Type a caret (^) to and the focus returns to the PCC/EHR VISIT AUDIT screen.

21.2.2 Note Display (N)

Use the **N** action to display notes about a selected visit (if permitted). Some BH visits might not allow this display. You will be prompted to select the visit to use.

21.2.3 Modify Visit (M)

Use the **M** action to modify a selected visit.

1. At the “Select Action” prompt, type **M**.
2. At the “Modify which Visit” prompt, type the number of the visit to modify. The application displays the “Looking for ancillary data to merge into this visit” message.
3. At the “MNEMONICS” prompt, type the mnemonic to use.

The remaining prompts will vary, depending on the mnemonic used.

4. At the “Chart Audit Status” prompt, type one of the following:

R (reviewed/complete)

I (Incomplete)

If **I** is used, the application asks for a chart deficiency reason.

You can add a new deficiency to the list. Section 21.2.16 provides more information about adding a chart deficiency reason.

5. The last prompt asks if you want to (A)DD or (D)ELETE. Otherwise, press Enter.

If you type **A**, the prompts will be repeated so you can add another option associated with the mnemonic. For example, if you entered the allergy (ALG) mnemonic, you will be asked to enter another causative agent.

If you type **D**, you will be asked which sign or symptom you want to delete.

If you press Enter, various prompts will display, depending on the mnemonic used.

During the update process, if you answer I to the “CHART AUDIT STATUS” prompt, the visit will be flagged as Incomplete and the system will ask for a reason. Type two question marks (??) at the prompt to view a list of deficiencies reasons to choose from, or choose Other. You can also add a note to the visit; notes are displayed in the Visit File information with the Chart Audit Notes label.

21.2.4 Append to Visit (A)

Use the A action to append a visit (add another mnemonic) to the visit queue.

1. Type **A** at the “Select Action” prompt.
2. At the “Append to which visit” prompt, type the visit to use.
3. At the “MNEMONICS” prompt, type the mnemonic to use.

The remaining prompts will vary, depending on the entered mnemonic.

4. The last prompt asks if you want to (A)DD or (D)ELETE. Otherwise, press Enter.

If **A** is used, the prompts will be repeated so you can add another option associated with the mnemonic. For example, if you entered the allergy (ALG) mnemonic, you will be asked to enter another causative agent. ALG requires that at least one causative agent be entered.

If **D** is used, you will be asked which sign or symptom you want to delete.

If you press Enter, the following screen is displayed (in this example, the ALG mnemonic was entered).

```

COMMENTS:
  No existing text
  Edit? NO//
Complete the observed reaction report? Yes//   (Yes)
DATE/TIME OF EVENT: SEP 9,2008//
OBSERVER: TESTER,ALPHA//
SEVERITY:
DATE MD NOTIFIED: Sep 9,2008//   (SEP 09, 2008)
Complete the FDA data? Yes//   (Yes)

Indicate which FDA Report Sections to be completed:
1. Reaction Information
2. Suspect Drug(s) Information
3. Concomitant Drugs and History

```

```

4. Initial Reporter
Choose number(s) of sections to be edited: (1-4): 1-4//

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

    Signs/Symptoms
-----
1  DIARRHEA
2  ITCHING

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

```

Figure 21-5: Sample information

Other prompts will be displayed depending on your response to the “Select Action” prompt.

During the update process, if you answer NO to the “Coding Complete...” prompt, this visit will be flagged as Incomplete and the system will ask for a reason; Type two question marks (??) at the prompt to view a list of deficiencies to choose from or choose Other. You can also add a note to the visit; notes are displayed in the Visit File information with the Chart Audit Notes label.

21.2.5 Visit Merge (G)

Use the G action to merge data when a patient has more than one visit on the date of the selected visit.

Use this option, for example, when the patient was seen by a physician and ordered medications, and the pharmacist filled the medication by creating another visit file. The pharmacist should have added to the physician visit instead.

1. Type **G** at the “Select Action” prompt.
2. At the “Modify which Visit” prompt, type the number of the visit to be merged. (If this process is not possible, the system displays the “Patient only has 1 visit on that day, cannot do merge” message.)

If the patient has one or more visits for the date, below is a sample of what displays:

```

PATIENT: ABBOTT,RAMONA has one or more VISITs on this date.

1  TIME: 15:14 LOC: CDM  TYPE: T CAT: A CLINIC: DIABETIC DEC: 1
   Hospital Location: ACUPUNCTURE CLINIC CDP
   Primary Provider: RICHARDS,SUSAN P
2  TIME: 15:55 LOC: DB   TYPE: T CAT: A CLINIC: PHARMACY DEC: 1
   Hospital Location: PHARMACY
   Primary Provider: RICHARDS,SUSAN P

Select one: 1

```

Select 'To' visit.

PATIENT: ABBOTT,RAMONA has one or more VISITs on this date.

1 TIME: 15:14 LOC: CDM TYPE: T CAT: A CLINIC: DIABETIC DEC: 1
Hospital Location: ACUPUNCTURE CLINIC CDP
Primary Provider: RICHARDS,SUSAN P
2 TIME: 15:55 LOC: DB TYPE: T CAT: A CLINIC: PHARMACY DEC: 1
Hospital Location: PHARMACY
Primary Provider: RICHARDS,SUSAN P

Select one: 2

VISIT IEN: 3733015

HRN: DB 103447

VISIT FILE

VISIT/ADMIT DATE&TIME: JUN 24, 2014@15:14

DATE VISIT CREATED: JUN 24, 2014 TYPE: TRIBE-NON 638/NON-COMPACT

PATIENT NAME: ABBOTT,RAMONA

LOC. OF ENCOUNTER: 2011 DEMO DIABETES CLINIC

SERVICE CATEGORY: AMBULATORY CLINIC: DIABETIC

DEPENDENT ENTRY COUNT: 1 DATE LAST MODIFIED: JUN 24, 2014

HOSPITAL LOCATION: ACUPUNCTURE CLINIC CDP

CREATED BY USER: RICHARDS,SUSAN P OPTION USED TO CREATE: CIAV

VUECENTRIC

USER LAST UPDATE: RICHARDS,SUSAN P

OLD/UNUSED UNIQUE VISIT ID: 5851010003733015

DATE/TIME LAST MODIFIED: JUN 24, 2014@15:14:44

NDW UNIQUE VISIT ID (DBID): 160610003733015

WHERE SEEN SNOMED CT: 255327002

WHERE SEEN SNOMED CT: 440655000

FACE TO FACE SNOMED CT: 308335008

VISIT ID: 3M32R-CIX

Enter to continue, '^' to halt

V PROVIDER

PROVIDER: RICHARDS,SUSAN P

PATIENT NAME: ABBOTT,RAMONA

VISIT: JUN 24, 2014@15:14

PRIMARY/SECONDARY: PRIMARY

ENCOUNTER PROVIDER: RICHARDS,SUSAN P DATE/TIME ENTERED: JUN 24,

2014@15:14:44

ENTERED BY: RICHARDS,SUSAN P

DATE/TIME LAST MODIFIED: JUN 24, 2014@15:14:44

LAST MODIFIED BY: RICHARDS,SUSAN P

End of visit display, <ENTER> to Continue

Do you want to merge the two visits? (Y/N) Y//

VISIT IEN: 3733017

```

HRN: DB 103447
----- VISIT FILE -----
---
VISIT/ADMIT DATE&TIME: JUN 24, 2014@15:55
  DATE VISIT CREATED: JUN 24, 2014      TYPE: TRIBE-NON 638/NON-COMPACT
  PATIENT NAME: ABBOTT,RAMONA           LOC. OF ENCOUNTER: 2011 DEMO
HOSPITAL
  SERVICE CATEGORY: AMBULATORY           CLINIC: PHARMACY
  DEPENDENT ENTRY COUNT: 2              DATE LAST MODIFIED: JUL 16, 2014
  HOSPITAL LOCATION: PHARMACY           CREATED BY USER: RICHARDS,SUSAN P
  OPTION USED TO CREATE: CIAV VUECENTRIC
  USER LAST UPDATE: TETER,SHIRLEY
  OLD/UNUSED UNIQUE VISIT ID: 5851010003733017
  DATE/TIME LAST MODIFIED: JUL 16, 2014@16:16:31
  NDW UNIQUE VISIT ID (DBID): 160610003733017
  WHERE SEEN SNOMED CT: 255327002
  WHERE SEEN SNOMED CT: 440655000
  WHERE SEEN SNOMED CT: 33022008
  FACE TO FACE SNOMED CT: 308335008
  VISIT ID: 3M32V-CIX

Enter to continue, '^' to halt
----- V PROVIDER -----
---
PROVIDER: RICHARDS,SUSAN P              PATIENT NAME: ABBOTT,RAMONA
  VISIT: JUN 24, 2014@15:55            PRIMARY/SECONDARY: PRIMARY
  ENCOUNTER PROVIDER: RICHARDS,SUSAN P DATE/TIME ENTERED: JUN 24,
2014@15:14:44
  ENTERED BY: RICHARDS,SUSAN P
  DATE/TIME LAST MODIFIED: JUN 24, 2014@15:14:44
  LAST MODIFIED BY: RICHARDS,SUSAN P

PROVIDER: RICHARDS,SUSAN P              PATIENT NAME: ABBOTT,RAMONA
  VISIT: JUN 24, 2014@15:55            PRIMARY/SECONDARY: PRIMARY
  ENCOUNTER PROVIDER: RICHARDS,SUSAN P DATE/TIME ENTERED: JUN 24,
2014@16:55:12
  ENTERED BY: RICHARDS,SUSAN P
  DATE/TIME LAST MODIFIED: JUN 24, 2014@16:55:12
  LAST MODIFIED BY: RICHARDS,SUSAN P

~~~~~
~~~~~

End of visit display, <ENTER> to Continue

```

Figure 21-6: Sample output for G

21.2.6 Status Update (S)

Use the S action to change the status of a specified visit.

1. Type **S** at the “Select Action” prompt, and then type the number of the visit to use.
2. At the “CHART AUDIT STATUS” prompt, type **R** (reviewed) or **I** (incomplete).

- Type **R** to cause the specified visit to no longer be in the queue.
 - Type **I** to cause the specified visit to remain in the queue.
- a. If **I** is used, the Outpatient Chart Deficiency window displays. You may add one or multiple deficiencies.
 - b. At the “Do you want to update the Chart Audit Notes for this visit?” prompt, type **Y** (yes) or **N** (no).
 - c. Type the audit notes at the number (like 1). Another note can be types at the next number (like 2).
 - d. At the “EDIT Option” prompt, type a Line Number to edit that line, if needed.

21.2.7 Resort List (R)

Use the **R** action to determine the sort order of the visits.

1. Type **R** at the “Select Action” prompt.
2. At the “How would you like the list of visits sorted” prompt, type one of the following options:

N Patient Name
H HRN
D Date of Visit
T Terminal Digit of HRN
S Service Category
L Location of Encounter
C Clinic
O Hospital Location
P Primary Provider
A Chart Audit Status
I Has Medicare/Medicaid or PI

3. After the sort criteria has been selected, the system redisplay the records using the specified criteria.

Below is a new sort of the records by HRN:

#	VISIT DATE	PATIENT NAME	HRN	FAC	HOSP	LOC	S	CL	INS	PRIM	PROV	STATU
1)*	06/24/14@15:55	ABBOTT, RAMONA	103447	DB	PHARMACY	A	39	P		RICHARDS,		NO
2)	06/23/14@12:34	RUSSELL, HEIDI	105309	DB	TOEDT FP	A	01	P		RUSLAVAGE		
3)	06/23/14@20:44	RUSSELL, HEIDI	105309	DB	AAA DEMO	A	28	P		RUSLAVAGE		
4)*	06/26/14@14:17	CHEKELELEE, RO	112414	DB	BRIDGES	A	64	M/C/PT	TETER, SHI			NO
5)*	06/26/14@15:33	ABRAMS, BETTY	114685	CDM	CDP Phys	A	06	P		TETER, SHI		NO
6)*	06/23/14@12:04	AALVIK, BETH	116405	DB	ALEXANDE	A	20			RICHARDS,		.99
7)*	06/23/14@12:04	AALVIK, BETH	116405	DB	ALEXANDE	A	20			RICHARDS,		NO

```

8)* 06/23/14@11:04 AALVIK,BETH 116405 DB PHARMACY A 39 RICHARDS, I .99
9)* 06/24/14@16:08 AALVIK,BETH 116405 DB PHARMACY A 39 BISHOP,BR .99
10) 07/16/14@08:51 AALVIK,BETH 116405 DB AAA DEMO A 28 RICHARDS,
+ Q - Quit/?? for more actions/+ next/- previous >>>
D Display Visit C Chart Audit History T Change Date/Time
N Note Display H Health Summary U Resequence POVS
M Modify Visit O One Patient's Visits J View BH Note
A Append to Visit X Visit Delete Y View Any Visit
G Visit Merge B B Merge 2 Diff DatesZ Add a Visit
S Status Update F F Move V File K Change Patient
R Resort List E E Move V File 2 Dates
Select Action: D//

```

Figure 21-7: Sample report for Resort List action

21.2.8 Chart Audit History (C)

Use the C action to display the chart audit history for a specified visit.

1. Type **C** at the “Select Action” prompt.
2. At the “Display Chart Audit History for which Visit” prompt, type the number of the visit.

The following shows the information about the selected visit:

```

Chart Audit History for VISIT:
Visit Date: JAN 26, 2007@09:57 Patient Name: ALPHA,GAMMA
Hospital Location: FAMILY MED primary Provider: XDOCT,MD
DATE OF AUDIT STATUS USER WHO AUDITIED CHART DEFICIENCY

Mar 19, 2007@10:37 INCOMPLETE USER,BSTUDENT

NOTES:

Waiting for provider to add his note changes before completing the visit

```

Figure 21-8: Sample chart audit history

21.2.9 Health Summary (H)

Use the H action to display the specified health summary type about a selected visit.

1. Type **H** at the “Select Action” prompt.
2. At the “Select Health Summary Type Name” prompt, type the health summary type to use.
3. At the “Select HEALTH SUMMARY TYPE NAME: ADULT REGULAR//” prompt, press Enter to accept the default or type the type name to be used.

Below is a sample report for the All Reminders health summary type.

```

OUTPUT BROWSER Jul 16, 2014 16:32:58 Page: 3 of 20

```

```

PCC Health Summary for OTTER,TRIGGER JAMES
+
Allergy List Updated On:                               By:
No Active Allergies Documented On:  Jul 18, 2011    By: CARLTON,GREGRITA LYNN

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

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

Allergy List Reviewed On:           Jul 18, 2011    By: CARLTON,GREGRITA LYNN
Allergy List Updated On:           By:
No Active Allergies documented On:  Jul 18, 2011    By:  CARLTON,GREGRITA LYNN

Problem List Reviewed On:           Jul 18, 2011    By: CARLTON,GREGRITA LYNN
Problem List Updated On:           By:
No Active Problems Documented On:  Jul 18, 2011    By: CARLTON,GREGRITA LYNN

----- MEASUREMENT PANELS (OUTPATIENT) (max 5 visits or 2 years) -----
+           Enter ?? for more actions                                     >>>
+   NEXT SCREEN           -   PREVIOUS SCREEN           Q   QUIT
Select Action: +//

```

Figure 21-9: Sample report

The following can be performed at the “Select Action” prompt:

- Type a plus sign (+) to display the next screen of data (does not apply to the last screen of data).
- Type a minus sign (-) to display the previous screen of data (does not apply to the first screen of data).
- Type **Q** and the focus returns to the PCC/EHR VISIT AUDIT screen.

21.2.10 One Patient’s Visit (O)

Use the O action to display all visits for a patient on the same date as the visit you select from a list.

1. Type **O** at the “Select Action” prompt.
2. At the “Which Visit” prompt, type the number of the visit to be used.

The application displays the “Looking for ancillary data to merge into this visit” message.

Below is a sample report:

```

PCC/EHR VISIT AUDIT      Sep 11, 2008 16:40:18    Page:    1 of    1
* an asterisk beside the visit number indicates the visit has an error
# VISIT DATE    PATIENT NAME    HRN    FAC    HOSP LOC    CL PRIM PROV    STATUS

```

```

1) 09/08/08@09:00 PATIENT,CRSFORG 999807 WW A 16 KAPPA,S

      Q - Quit/?? for more actions/+ next/- previous          >>>
D   Display Visit      S   Status Update      F   F   Move V File
N   Note Display      C   Chart Audit History  Z   Add a Visit
M   Modify Visit      H   Health Summary      J   View BH Note
A   Append to Visit   X   Visit Delete      Y   View Any Visit
G   Visit Merge      B   B   Merge 2 Dates
Select Action: D//

```

Figure 21-10: Sample report

21.2.11 Visit Delete (X)

Use the X action to remove a specified visit from the queue.

1. Type **X** at the “Select Action” prompt.
2. At the “Which Visit” prompt, type the number of the visit to use.

The application displays the visit data about the particular visit.

At the end of the display, the application displays the “End of visit display, <ENTER> to Continue” and “THE ABOVE VISIT AND RELATED V FILE ENTRIES WILL BE REMOVED FOREVER !!!” messages.

3. Type **N** at the “Sure you want to delete?” prompt and the visit remains in the queue.
4. Type **Y** at the “Sure you want to delete?” prompt and the “REASON FOR DELETION:” prompt displays. Type text describing the reason you are deleting the visit.

21.2.12 B Merge 2 Diff Date (B)

There are times when the pharmacy staff are close to the end of the day and enter the medications the day later (or the following Monday), if it is an emergency room visit. When the pharmacists go in on Monday, they need to go back to the visit created by the physician the day before (or the Friday, Saturday, or Sunday before) to add the medication to the physician visit.

1. Type **B** at the “Select Action” prompt.
2. At the “Which Visit” prompt, type the number of the visit to use.

The application displays “Select ‘From’ visit.

3. At the “Enter VISIT date” prompt, type the visit date.

21.2.13 F Move V File (F)

To save time, the ancillary staff may create a single V File even though some of the information belongs to separate visits in multiple clinics on the same day. The data entry staff can use this option to move multiple medications, labs, or X-rays to the correct physician visits.

Type **F** at the “Select Action” prompt and respond to the subsequent prompts.

21.2.14 E Move V File 2 Dates (E)

Like the F Move V File option, this option moves multiple medications, labs, or X-rays to the correct physician visits, but for V Files created on different days. The data entry staff must verify which parts of the V files belong to which dates.

Type **E** at the “Select Action” prompt and respond to the subsequent prompts.

21.2.15 Change Date/Time (T)

Use this option to change the date and time of a specified visit in the queue.

1. Type **T** at the “Select Action” prompt.
2. At the “Which Visit” prompt, type the number of the visit to be used.

The application displays the date and time of the visit.

3. At the “Enter new date and time” prompt, type the new date and time of the visit.

21.2.16 Resequence POVs (U)

Use this option to resequence the POVS for a specified visit.

1. Type **U** at the “Select Action” prompt.
2. At the “Resequency POVS for which visit” prompt, type the number of the visit to be used.

The application displays the Visit Information. Then respond to the prompts.

21.2.17 View BH Note (J)

Use this option to view the behavioral note associated with a particular visit.

1. Type **J** at the “Select Action” prompt.
2. At the “Which Visit” prompt, type the number of the visit to be used.

The application will display the behavioral note associated with the visit, if any exist.

Note: The AMHZ CODING QUEUE security key is required to use this action.

21.2.18 View Any Visit (Y)

Use this option to view any visit.

1. Type **Y** at the “Select Action” prompt.
2. At the “Enter PATIENT NAME” prompt, type the name of the patient whose visit you want to view.
3. At the “Enter VISIT date” prompt, type the date of the visit.

The application displays the PCC visit data.

```

PCC VISIT DISPLAY                Jul 16, 2014 17:01:31                Page:    1 of    3

Patient Name:                    BROOKS,LAWANDA
Chart #:                         100008
Date of Birth:                   MAR 22, 1956
Sex:                             F
Visit IEN:                       47059

===== VISIT FILE =====
VISIT/ADMIT DATE&TIME: JUN 29, 1988@12:00
DATE VISIT CREATED:             JUL 07, 1988
TYPE:                           IHS
THIRD PARTY BILLED:             VISIT DATE PRIOR TO BACKBILLING LIMIT
PATIENT NAME:                   BROOKS,LAWANDA
LOC. OF ENCOUNTER:              2011 DEMO INDIAN HOSPITAL
SERVICE CATEGORY:              AMBULATORY
CLINIC:                         DENTAL
DEPENDENT ENTRY COUNT:          6

===== DENTALS =====

SERVICE CODE:                   9110
NO. OF UNITS:                    1

SERVICE CODE:                   0140
NO. OF UNITS:                    1

SERVICE CODE:                   0190
NO. OF UNITS:                    1

SERVICE CODE:                   0330
NO. OF UNITS:                    1

```

```

===== PROVIDERs =====
PROVIDER:                PIKUS,DUFFEY A
AFF.DISC.CODE:           952016
PRIMARY/SECONDARY:       PRIMARY

===== POVs =====
POV:                      V72.2

SERVICE CODE:           9110
NO. OF UNITS:            1

SERVICE CODE:           0140
NO. OF UNITS:            1

SERVICE CODE:           0190
NO. OF UNITS:            1

SERVICE CODE:           0330
NO. OF UNITS:            1

===== PROVIDERs =====
PROVIDER:                PIKUS,DUFFEY A
AFF.DISC.CODE:           952016
PRIMARY/SECONDARY:       PRIMARY

===== POVs =====
POV:                      V72.2

Select Action: +//

```

Figure 21-11: Sample data for Y action

21.2.19 Add a Visit (Z)

Use this option to add a visit to the visit queue.

Type **Z** at the “Select Action” prompt. The application will enter the ENTER Mode.

```

                                PCC Data Entry Module

                                *****
                                * ENTER Mode *
                                *****

Select LOCATION NAME: 2011 DEMO HOSPITAL//          HEADQUARTERS WEST          ALBUQU
ERQUE                01                          NM HOSPITAL  8999
TYPE: T// TRIBE-NON 638/NON-COMPACT
SERVICE CATEGORY: A// AMBULATORY

VISIT/ADMIT DATE: t-13 (JUL 03, 2014)
TIME OF VISIT: 13:00 (JUL 03, 2014@13:00)

Select PATIENT NAME: kelly
 1  KELLY,ARRON LEE                                M 07-18-1960 XXX-XX-6000  ADB 149623
                                                DB 149624(I)
                                                URA 149625(I)
 2  KELLY,BECKY NICOLA  SMOKER,TALASHOMA<W>      F 12-12-1987 XXX-XX-4489  ADB 12

```

```

5975
                                     DB 125976
                                     URA 125977
3  KELLY,EMMA L  LONG,ALLISON      F 01-08-1943 XXX-XX-5703  ADB 104179(I)
                                     DB 104180(I)
                                     URA 104181(I)
4   KELLY,JOSHUA JAY              M 10-27-1938 XXX-XX-3368  ADB 124891(I)
                                     DB 124892(I)
                                     URA 124893(I)
5  KELLY,JUANTIA  ROBERTS,GLENDA A<A>  F 08-22-1981 XXX-XX-8506  ADB 119109
                                     DB 119110
                                     URA 119111

ENTER '^' TO STOP, OR
CHOOSE 1-5: 3
LONG,ALLISON              F 01-08-1943 XXX-XX-5703  ADB 104179(I)
                                     DB 104180(I)
                                     URA 104181(I)

Ok? Yes//

MNEMONIC:
    
```

Figure 21-12: Prompts for Add a Visit

The prompts vary according to the mnemonic used in the process.

21.2.20 Chart Deficiency (I)

Use this option to add/edit deficiencies, change the deficiency provider, add/edit a chart audit note, edit tracking dates, display a visit, and mark a visit as completed.

1. Type **I** at the “Select Action” prompt.
2. At the “Which Visit” prompt, type the number of the visit to be used.
3. The application displays visit information and deficiency data.

```

Outpatient Chart Deficiency   Jul 17, 2016 10:35:27   Page 1 of 1
TEST,PM                       #837786
Visit Date: MAY 28, 2016@11:20   Service Category: AMBULATORYHospital
Location: DEMO CLINIC           Clinic: GENERAL
Primary Provider: ST CYR,DONNA

Date Chart Tagged: JUN 11, 2016

Provider           Deficiencies           Status
=====
ST CYR,DONNA      HISTORY & PHYSICAL           Pending
Entered by: ST CYR,DONNA           Date Entered: JUN 11, 2016
Chart Audit Notes
=====
Enter ?? for more actions
E Edit Tracking Dates      A Add/Edit Deficiencies  P Change Provider for Defiy
C Chart Audit Note Edit   M Mark as Completed      D Display Visit
Select Action: Quit//
    
```

Figure 21-13: Chart Deficiency Window

1. Type **E** or **Edit** to access the “Edit Tracking Dates” action. This is the date that a user has tagged, or reviewed, the chart. Update the dates as appropriate. The Date Chart Tagged field in the window will update when the date is changed.
2. Type **C** or **Chart to access** “The Chart Audit Note Edit” action. You can add a new note or edit an existing note.
3. Type **A** or **Add** to access the “Add/Edit Deficiencies” action. You can add multiple deficiencies, edit, resolve or delete deficiencies for a provider.
4. Type **M** or **Mark** to access the “Mark as Completed” action. If the visit has unresolved errors a message displays indicating which errors need to be resolved before the visit can be marked reviewed/completed.
5. Type **P** or **Change** to access the “Change Provider for Deficiency” action. If the provider you enter has multiple deficiencies attributed, you are asked to select the deficiency for which you would like to change the provider.
6. Type **D** or **Display** to access the “Display visit” action.

21.2.21 Change Patient (K)

This option is available when using PEHR EHR/PCC Coding Audit for One Patient. The option allows you to change to a different patient without having to exit. Use this option to change to another patient.

1. Type **K** at the “Select Action” prompt.
2. At the “Enter PATIENT NAME” prompt, type the name of the patient to be used in the change process.

21.3 Adding Chart Deficiency Reasons

You can add a deficiency reason by using the ACDR option on the EHR PCC Coding Audit Menu. This option requires that the APCDZ ADD CDR security key.

```

*****
**          PCC Data Entry Module          **
**          EHR/PCC Coding Audit Menu      **
*****
          IHS PCC Suite, Version 2.0
          DEMO INDIAN HOSPITAL

EHRD  EHR/PCC Coding Audit for Visits in Date Range
PEHR  EHR/PCC Coding Audit for One Patient
ACRD  Add new Chart Deficiency Reason to Table
TUR   Count Unreviewed Visits by Date/Service Category
ACRX  Auto-Complete Pharmacy Education Only Visits
CASP  Update EHR Coding Audit Site Parameters
INCV  List Visits Marked as Incomplete
LIR   List Unreviewed/Incomplete Visits

```

```

TRV      Tally of Reviewed/Completed Visits by Operator

Select EHR/PCC Coding Audit Menu Option:

```

Figure 21-14: Options on EHR/PCC Coding Audit Menu

After you type **ACRD** at the “Select EHR/PCC Coding Audit Menu Option” prompt, the application displays the following message. This example uses “Physical” as the new deficiency reason.

```

Select OUTPATIENT CHART DEFICIENCY REASONS: physical
Are you adding 'physical' as
a new OUTPATIENT CHART DEFICIENCY REASONS (the 45TH)? No//

```

Figure 21-15: Sample prompts

The name of the new deficiency reason must be 3-35 characters in length.

Type **Yes** at the last prompt and the new deficiency reason will be displayed on the list of reasons.

Type **No** at the last prompt and the new deficiency reason will not be displayed on the list of reasons.

21.4 Update PCC Master Control File

To use the coding queue, the EHR/PCC Coding Audit Start Date must be set in the PCC Master Control file.

The options and utilities on the Supervisor menu are shown below:

```

*****
**          PCC Data Entry Module          **
** Data Entry SUPERVISOR Options and Utilities **
*****
                IHS PCC SUITE  Version 2.0
                DEMO INDIAN HOSPITAL

ICD      Fix UNCODED ICD Diagnoses/Operations ...
VRR      Visit Review Report ...
INP      Link In-Hospital Visits to Hospitalizations ...
DSP      Display PCC Data Entry Site Parameters
ACC      Process ACCEPT Commands ...
DDPR     Delete Duplicate Primary Providers from Visits
DXV      DX Coding Audit for Selected Set of Visits
ESP      Enter/Edit PCC Data Entry Site Parameters
EVM      Auto Merge Event Visits on Same Day
FTM      Forms/Data Entry Tracking Menu ...
LAB      Complete Orphaned Visits Menu ...
MDL      Visit Re-linker/Merge/Delete Log Reports ...
MNE      Update PCC Mnemonic's Allowed/Not Allowed
OTH      Other PCC Data Entry Reports ...
PLAL     Reports Listing Allergies recorded on PROBLEM LIST ...

```

```

PMN    Print list of Data Entry Mnemonics
RET    Re-Submit PCC Visit to the IHS Data Center
TAB    PCC Local Table Maintenance ...
UIFS   Update ICD-10 Diagnoses from SNOMED Concept ID
UPMC   Update PCC Master Control File

```

```
Select Data Entry SUPERVISOR Options and Utilities Option:
```

Figure 21-16: Data Entry SUPERVISOR Options and Utilities menu

Use the UPMC option to update the PCC Master Control file and Ancillary to PCC link status for ancillary packages. Be very careful when using this option.

Follow these steps:

1. At the “Select Data Entry SUPERVISOR Options and Utilities Option” prompt, type **UPMC**.
2. At the “Enter your SITE name” prompt, type the name of the site.

The application displays the following is displayed after you enter the facility name:

```

***** Update PCC Master Control *****
Location/Division: 2011 DEMO HOSPITAL
-----
Default Type of Visit: TRIBE-NON 638/NON -COMPACT
Default Health Summary Type: ADULT REGULAR
Type of PCC Link (old mode): TIME REQUIRED
Beginning FISCAL YEAR Month: OCTOBER
Pass PAP Smears from V LAB to WH? YES
EHR Chart Audit Start Date: JUL 1,2005
Default Directory for DM Audit EPI output file: F:\PUB\
FACILITY PRINT NAME for Patient Handout: CHEROKEE INDIAN HOSPITAL
FACILITY ADDRESS:
FACILITY ADDRESS CITY:
FACILITY ADDRESS STATE:
FACILITY ADDRESS ZIP:
Prompt to Print Patient Health Handout at Check-In? NO
Update Package PCC Linkages? Y
-----
COMMAND:                                     Press <PF1>H for help   Insert

```

Figure 21-17: Prompts for UPMC

3. At the “Default Type of Visit” prompt, type the default visit type for the site. Type one of the following:

```

I    IHS
C    Contract
O    Other
T    TRIBE-NON 638/NON-COMPACT

```

6 TRIBE-638
U VA
P TRIBE-COMPACTED TRIBAL PROGRAM
U URBAN CLINIC
S STATE

4. At the “Default Health Summary Type” prompt, type the name of the default health summary type for the site.
5. At the “Type of PCC Link (old mode)” prompt, type one of the following:

0 DATE ONLY REQUIRED
1 TIME REQUIRED
6. At the “Beginning FISCAL YEAR Month” prompt, type the month for the beginning fiscal year.
7. At the “Pass PAP Smears from V LAB to WH?” prompt, type **Y** (yes) or **N** (no).
8. At the “EHR Chart Audit Start Date” prompt, type the start date for the EHR chart audit.
9. At the “Default Directory for DM Audit EPI output file” prompt, type the location of the directory.
10. At the “FACILITY PRINT NAME for Patient Handout” prompt, type the name of the facility.
11. At the “FACILITY ADDRESS” prompt, type the address.
12. At the “FACILITY ADDRESS CITY” prompt, type the name of the city.
13. At the “FACILITY ADDRESS STATE” prompt, type the name of the state.
14. At the “FACILITY ADDRESS ZIP” prompt, type the zip code.
15. At the “Prompt to Print Patient Health Handout at Check-In?” prompt, type **Y** (yes) or **N** (no).
16. At the “Updated Package PCC linkages?” prompt, **Y** (yes) or **N** (no).

When the prompt are complete, type Save at the COMMAND prompt. Then type Exit.

21.5 Tally Reviewed/Completed Visits (Last Operator)

This report counts audits by checking the V CHART/AUDIT file to determine the last user who reviewed the visit and marked the visit incomplete or reviewed/complete. A visit must be reviewed at least once to be counted in this report. If a visit has been reviewed and marked as either Reviewed/Complete or incomplete multiple times, the LAST user is displayed on the report.

The system prompts the user for the following information when generating the report.

1. Enter a Beginning Review Date
2. Enter an Ending Review Date
3. Report on ALL Operators? (if No entered, the user is prompted to specify which operator.)
4. Do you wish to see a subtotal by REVIEW Date?

Sep 20, 2015	PCC Data Entry Module		Page: 1

* COUNT OF VISITS REVIEWED/COMPLETED BY OPERATOR *			
* COUNTS LAST REVIEW ONLY *			

REVIEW Date Range: Mar 04, 2016 through Sep 20, 2016			
Operator	# of visits reviewed	# of visits marked as complete	

User,Test	40	12	
Total Number of Visits:	40	12	
End of report. PRESS ENTER:			

Figure 21-18: Sample Report

Appendix A: 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.

A.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).

A.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.

A.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.

A.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.

A.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.

A.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.

A.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).

A.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.

A.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.

A.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.

A.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.

A.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.

A.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.

A.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.

A.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.

A.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.

Glossary

@ symbol

This symbol (key combination of Shift+2) has two functions: (1) to delete an entry and (2) to separate a date and time.

Acute

Used to describe a condition that lasts for a short time. Used in contrast to *chronic*.

Append

To add additional data items to an existing visit, usually at the end of entering the data.

Best Practice Prompts

Best Practice Prompts are a set of clinical messages related to procedures such as lab tests, immunizations, procedures etc. that are generally recommended for a subset of the population who share a common diagnosis (e.g. Asthma, CVD). They are displayed in a variety of places including the Health Summary, Supplements, and the Patient Record in both EHR and iCare.

Users can turn on (activate) and display BP Prompts on Health Summaries, similar to the Health Maintenance Reminder function.

Billable Visit

A visit from a patient that has third party insurance coverage to which a hospital/clinic can then bill for services.

Caret

The symbol ^ obtained by using the key combination Shift+6. Commonly used in RPMS character-based interfaces to exit out of a routine or to back up from the previous field.

Chart Number

A unique numerical identifier assigned to each patient. This is also referred to as Health Record Number.

Chronic

Used to describe a condition that has an indefinite duration or with a frequent occurrence. Used in contrast to *acute*.

Clinical

To do with treatment in or as a clinic: involving or concerned with direct observation and treatment of patients.

Command

The instructions you give the computer to record a certain transaction. For example, selecting “Payment” or “P” at the command prompt tells the computer you are applying a payment to a chosen bill.

Community of Service

The community where the encounter took place.

Community of Residence

The community where the patient resides.

CPT Code

Current Procedural Terminology code. Used to identify procedures provided during an encounter and for billing outpatient services provided.

Database

A database is a collection of files containing information that may be used for many purposes. Storing information in the computer helps in reducing the user’s paperwork load and enables quick access to a wealth of information. Databases are comprised of fields, records, and files.

Default Response

Many of the prompts in the RPMS applications contain responses that can be activated simply by pressing the Return key . For example: “Do you really want to quit? No//.” Pressing the Return key tells the system you do not want to quit. “No//” is considered the default response. The default is generally set to the most frequently used response for the prompt.

Designated Primary Care Provider (DPCP)

The primary care provider designated for the patient. This is distinguished from a primary or secondary visit provider for a specific visit.

Device

The name of the printer you want the system to use when printing information. *Home* means the computer screen.

Export

To format data so it can be used by another application.

Fields

Fields are a collection of related information that makes up a database record. Fields on a display screen function like blanks on a form. Each field has a prompt that requests a specific type of data. There are nine basic field types in RPMS programs; each collects a specific type of information.

Free Text Field

This field type will accept numbers, letter, and most of the symbols on the keyboard. There may be restrictions on the number of characters that can be entered.

Health Factors

Health factors are data elements utilized by RPMS to record health status information about the patient. “Current smoker” is an example of a health factor in the Tobacco category. Health factor data are recorded in the PCC V Health Factor file. For a current list of health factors, see the Health Summary User Manual.

Health Maintenance Reminders (HMRs)

Health Maintenance Reminders are a set of clinical reminders related to procedures such as lab tests, immunizations, procedures etc. that are generally recommended for a subset of the population. They are displayed in a variety of places including the Health Summary, Supplements, and the Patient Record in both EHR and iCare.

Health Record Number (HRN)

A unique numerical identifier assigned to each patient. This is also referred to as a “chart number”.

Health Summary

The Health Summary is a summary report of a patient’s medical care drawn from V files such as Laboratory and Pharmacy. The RPMS PCC is distributed with several standard health summaries, and summaries can also be customized or designed on the fly using available components. Examples of standard health summaries are: Adult Regular, Behavioral Health, CHR, and Dental.

Interfaces

A boundary where two systems can communicate. RPMS applications contain both character-based (“roll-and-scroll”) and graphical user (GUI) interfaces. PCC Data Entry is an example of a character-based interface; RPMS EHR is an example of a GUI.

International Classifications of Diseases

This is a national coding system primarily used for: (1) classifying morbidity and mortality information for statistical purposes, (2) indexing of hospital records by disease and operations, and (2) data storage and retrieval. In addition, this is the coding system physicians must use to bill Medicare, Medicaid, and private insurance for services rendered.

Menu

The menu is a list of options that can be selected at a given time. To choose a task, select an item from the list by entering the established abbreviation or synonym at the prompt. A menu option followed by the ellipsis (...) indicates there are submenus.

Mnemonic

An abbreviation used to name a menu option or report used in the RPMS character-based packages. RPMS PCC data entry mnemonics used to enter a data type can be two, three, or four characters, such as BP (blood pressure).

Narrative Description

A detailed description using words rather than codes.

Patient Care Component (PCC)

PCC is the core of the RPMS applications and functions as a clinical data repository. Most RPMS applications “pass” key data elements to PCC, stored in V (visit) files, e.g., V Lab. Other data is entered directly into V files, e.g., V Patient Education, BP (blood pressure), WT (weight), HT (height), HC (head circumference) etc.

Patient Wellness Handout

The Patient Wellness Handout is a health summary created for the patient. It displays personal medical information in easy-to-interpret language.

PGEN Report

The PGEN report is located in PCC Management Reports. General retrieval reports are on-the-fly reports created by choosing specific data elements to select, print, and sort by.

Problem List

A list of important/chronic medical, social, or psychiatric problems, related notes, and treatment plans recorded and updated as part of the patient’s health record. The Health Summary has two categories: Active and Inactive.

Prompt

Text displayed onscreen indicating that the system is waiting for input to a field. When the system displays a prompt, it waits for you to enter some specific information.

Provider

One who provides direct medical care to a patient i.e., physician, nurse, mid-level provider).

Provider Narrative

A detailed description of the patient's conditions using words rather than codes.

QMan

Short for Query Manager, QMan is a VA-based search utility that allows users to construct detailed searches of the RPMS database. QMan is part of the integrated PCC suite.

Retrieval

The process of obtaining data from another location.

Roll-and-Scroll

The roll-and-scroll (character-based) data entry format captures the same information as the screen format but uses a series of prompts for recording data. This is typically the most efficient method for data entry.

Secondary Providers

A provider for a patient's visit other than the patient's primary visit provider. A patient visit might have multiple secondary providers, depending on the services provided.

Security Key

A means of securing menus to limit accessibility. To use certain functions, such as those on a manager's menu, you must be assigned the appropriate key by the site manager.

Select

To choose an option from a list of options.

Site Manager

The person in charge of setting up and maintaining the technical aspects of RPMS at the facility or area level.

Specialty Providers

Defined through the Designated Specialty Provider Management (BDP) application.

Submenu

A menu that is accessed through another menu. A menu option followed by the ellipsis (...) indicates there are submenus.

Supplement

A modified health summary related to a specific condition such as diabetes or HIV/AIDS. It displays personal medical information related to that condition.

Tally

To count, total, or subtotal a collection of items.

VGEN Search Utility

VGEN is one of the search utilities used to construct searches of the RPMS database. General retrieval reports are on-the-fly reports created by choosing specific data elements to select, print, and sort by.

Acronym List

Acronym	Term Meaning
DOB	Date of Birth
DOD	Date of Death
DOS	Date of Service
DCPC	Designated Primary Care Provider
DX	Common abbreviation for diagnosis
EDC	Expected/estimated date of confinement, that is the expected/estimated due or delivery date for a pregnancy.
EDD	Expected/estimate date of delivery
HRN#	Health record number, also referred to as a "chart number"
HS	Health Summary
HX	Common abbreviation for history; an event that occurred in the past, such as surgery, immunizations, etc.
ICD	International Classifications of Diseases
IHS	Indian Health Service
PGEN	Abbreviation for Patient General Retrieval Report
POV	Purpose of Visit: one or more diagnoses (ICD codes) that are identified as the reason for a patient's visit, recorded in the PCC V POV file.
RPMS	Resource and Patient Management System
VGEN	Abbreviation for Visit General Retrieval Report

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