RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS PCC Suite

(BJPC)

Data Entry Supervisor's Manual

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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
   GHS    Generate Health Summary
   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 ...
   BHS    Browse Health Summary
   COD    Display IHS Coding Guidelines
   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 ICD9 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 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

BJPC v2.0 contains the following modifications and enhancements.

The user cannot delete a visit in the following conditions:

- With a V Referral attached in the coding queue
- In the Delete All Data for A Visit menu option

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 ICD9 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 3-1: Options on the Supervisor's menu

Use the ICD option to correct diagnoses containing an Uncoded Diagnoses code entered by operators during 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 ICD9 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 ICD9 Diagnoses/Operation Codes menu:

```
             ************************************************
             **              PCC Data Entry Module          **
             **  Fix UNCODED ICD9 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 ICD9 Diagnoses/Operations Option:
```

Figure 3-2: Options on the Fix UNCODED ICD9 Codes menu

The application allowing 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 ICD9 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 ICD9 Diagnoses/Operations Option” prompt.

Below is a sample output (at the beginning):

```
NAME: TESTER,ERICA  DOB: MAR 25,1977  SEX: F  HRN: 117493
DATE OF VISIT: APR 23,2014  01:00  LOC: 2011 DEMO HOSPITAL
POV: .9999                              PATIENT NAME: TESTER,ERICA
  VISIT: APR 23, 2014@01:00             PROVIDER NARRATIVE: NARRATIVE FOR .9999
  EXTERNAL CAUSE: E888.8                PLACE OF ACCIDENT: STREET/HIGHWAY
  PRIMARY/SECONDARY: SECONDARY          DATE OF INJURY: APR 23, 2014
  PRESENT ON ADMISSION?: NO             DATE/TIME ENTERED: APR 23, 2014@07:22:47
  ENTERED BY: EVERETT,BRIAN E
  DATE/TIME LAST MODIFIED: APR 23, 2014@07:22:50
  LAST MODIFIED BY: EVERETT,BRIAN E


PROVIDER NARRATIVE:  NARRATIVE FOR .9999
POV: .9999//


Continue? Y// y  YES

NAME: DEMO,PATIENT BOY  DOB: JAN 1,2009  SEX: M  HRN: 789321
DATE OF VISIT: APR 23,2014  11:04  LOC: 2011 DEMO HOSPITAL
POV: .9999                              PATIENT NAME: DEMO,PATIENT BOY
  VISIT: APR 23, 2014@11:04
  PROVIDER NARRATIVE: Testing THERB 04/23/2014 after Brian fixed the issue with
Dx                                      PRIMARY/SECONDARY: PRIMARY
  PRIMARY SNOMED: 63161005              DATE/TIME ENTERED: APR 23, 2014@11:07:22
  ENTERED BY: HESS,BARBARA
  DATE/TIME LAST MODIFIED: APR 23, 2014@11:07:22
  LAST MODIFIED BY: HESS,BARBARA


PROVIDER NARRATIVE:  Testing THERB 04/23/2014 after Brian fixed the issue with D
x
POV: .9999//
```

```
Continue? Y// y  YES

NAME: DEMO,PATIENT CURRENTPREG  DOB: JAN 1,1975  SEX: F  HRN: 11
DATE OF VISIT: APR 23,2014  10:17  LOC: 2011 DEMO HOSPITAL
POV: .9999                              PATIENT NAME: DEMO,PATIENT CURRENTPREG
  VISIT: APR 23, 2014@10:17
  PROVIDER NARRATIVE: A/N care: elderly primiparous | testing testing testing
  FIRST/REVISIT: FIRST VISIT            EXTERNAL CAUSE: E826.1
  PRIMARY/SECONDARY: SECONDARY          DATE OF INJURY: APR 18, 2014
  PROBLEM LIST ENTRY: .9999             SNOMED CONCEPT ID: 169588002
  SNOMED DESCRIPTION ID: 263129013
  EVENT DATE AND TIME: APR 27, 2014@10:29:45
  ENCOUNTER PROVIDER: HESS,BARBARA      DATE/TIME ENTERED: APR 24, 2014@10:22:47
  ENTERED BY: HESS,BARBARA
  DATE/TIME LAST MODIFIED: APR 27, 2014@10:29:45
  LAST MODIFIED BY: HESS,BARBARA


PROVIDER NARRATIVE:  A/N care: elderly primiparous | testing testing testing
POV: .9999//
```

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 ICD9 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 ICD9 Diagnoses/Operations Option” prompt.

Below is a sample output (at the beginning):

```
NAME: BIRD,JIM  DOB: SEP 15,1945  SEX: M  HRN: 103145
DIAGNOSIS: .9999                          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: .9999//
```

Figure 3-4: Sample PRB output

3.3 Fix Uncoded PERSONAL HISTORY Diagnoses (PER)

Use the PER option to access all .9999, 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 ICD9 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 ICD9 Diagnoses/Operations Option" prompt.

Below is a sample output:

```
NAME: LINDSAY,FAITH ANN  DOB: MAY 25,1979  SEX: F  HRN: 119956
DIAGNOSIS: .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: .9999//


Continue? Y// ES

NAME: WILLIAMS,FELICIA KAY  DOB: JUN 25,1933  SEX: F  HRN: 129466
DIAGNOSIS: .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: .9999//
```

Figure 3-5: Sample PER output

3.4 Fix Uncoded FAMILY HISTORY Diagnoses (FAM)

Use the FAM option to access all .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 ICD9 Diagnoses/Operations Option” prompt.

Below is a sample output:

```
AME: BRADLEY,SHASTINA  DOB: JAN 5,1957  SEX: F  HRN: 169707
DIAGNOSIS: .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: .9999//


Continue? Y// y  YES

NAME: WACHACHA,HOLLY  DOB: FEB 26,1972  SEX: F  HRN: 126222
DIAGNOSIS: .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: .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 ICD9 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 ICD9 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: .9999                              PATIENT NAME: COLEMAN,BENJAMIN III
  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: .9999                              PATIENT NAME: HERRING,AMANDA
  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 ICD9 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 ICD9 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 ICD9 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 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 ICD9 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. Section Appendix A: provides a listing of the IHS edits. 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 against those in Appendix A: (the IHS Edits). 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 ICD9 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

If Y is used, the system displays the number of primary providers that were deleted.

8.0 The Site 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 ICD9 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 8-1: 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 8-2: 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:                         MAP ADVICE DEFAULT RESPONSE:
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 8-3: 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 8-4: 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 ^ 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 8-5: 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).

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 8-6: 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 8-7: 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 8-8: 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).

9.0 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 ICD9 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 9-1: 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 9-2: 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.

10.0 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 ICD9 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 10-1: 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 ICD9 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 10-2: Options on the Data Entry Forms Tracking menu

10.1 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 10.4 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.

```
                                                        Jul 11, 2014   Page 1
                              2011 DEMO HOSPITAL
                             NUMBER OF FORMS KEYED
                      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 10-3: Sample report

Below is a sample summary report:

```
                                                        Jul 15, 2014   Page 3
                     SUMMARY OF FORMS KEYED BY ALL OPERATORS
               VISIT POSTING DATES:  MAY 31, 2014  TO  JUL 15, 2014
                      # days # of   %        Avg #      Avg # dep   Avg # dep
     Operator         of D/E forms  workload forms/day  ent/day     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 10-4: 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.

10.2 DX ICD Coding QA Audit (DXA)

The DXA 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:  JAN 22, 2008 and MAY 21, 2008
                   Data Entry Operator:  BETA,LA
                            Clinic:  ALL

Total Visits Found: 7     Total Number of Random Visits Selected:  7

  HR#       Visit Date         ICD9   Provider Narrative
-------------------------------------------------------------------

WW 106735  DEC 05, 2007@12:00  401.9  HTN
                                     [HYPERTENSION NOS]
WW 143670  MAR 13, 2007@12:00  250.00 DM
                                     [DIABETES II/UNSPEC NOT UNCONTR]

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

Figure 10-5: 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.

10.3 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, 2008 and MAY 21, 2008
                Data Entry Operator:  BETAAA,LAMBDA
                          Clinic:  ALL

Total Visits Found: 0     Total Number of Random Visits Selected:  0

                                ICD O/P   Provider Narrative
  HR#     Visit Date            Code   [ICD O/P NARRATIVE]
-------------------------------------------------------------------
100010   JUN 26, 1998@14:22   47.19   APPENDECTOMY
                                      [OTHER INCIDENTAL APPENDECTOMY]
101846   JUL 28, 1998@14:22   51.22   CHOLECYSTECTOMY
                                      [CHOLECYSTECTOMY]
```

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

Figure 10-6: 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.

10.4 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.”

10.5 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 10-7: Sample information from DOP option

10.6 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 10-8: Sample report

Below is a summary of forms keyed by all operators.

```
                                          May 21, 2008   Page 6
            SUMMARY OF FORMS KEYED BY ALL OPERATORS
       VISIT POSTING DATES:  JAN 22, 2008  TO  MAY 21, 2008

                        No. of  Forms     % of        Avg # of
Operator                Forms   per day   Workload    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 10-9: Sample summary of forms keyed by all operators

10.7 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 10-10 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


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.

There were a total of 10 visits processed during the time period.
specified.  Below is a further breakdown of these visits.



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 10-10: Sample pages of the report

11.0 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 11-1: 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.

11.1 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.

11.2 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.

11.3 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.

11.4 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 11-2: Sample message

Press Enter and the focus returns to the menu options.

11.5 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.

11.6 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 11-3: 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.

11.7 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.

11.8 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.

11.9 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.

11.10 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.

12.0 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 ICD9 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 12-1: 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 12-2: 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.

The Visit Delete/Merge Log option creates a log of all visits that were deleted or merged. A report will list all of these visits, and there is also an option to purge the log. The visit delete option prompts for a reason for the visit deletion. This prompt is not required. This is a prospective change meaning that only visits deleted or merged after the installation date of this version (v2.0) of the IHS PCC Suite will be logged and reported on with these options.

12.1 List of Visits Modified by the Visit Re-linker (VRLR)

Use the VRLR option to print a list of visits on which a V File (ancillary data item) was ‘moved’ or ‘re-linked’ from one visit to another during the nightly visit re-linker process or during the post-data-entry visit re-linking process.

To print a list of modified visits, follow these steps:

1. At the “Select Visit Re-linker/Merge/Delete Log Reports Option” prompt, type **VRLR**.
2. At the “Enter beginning Date” prompt, type the beginning date of the date range. This date range specifies the dates on which the re-linking occurred.
3. At the “Enter ending Date” prompt, type the ending date of the date range.
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 “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 09:40:38     Page:    1 of    1




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

    Visits for which an Ancillary Data Item was 're-linked' to another visit
        Relinking Dates:  APR 15, 2014 and JUL 14, 2014
-------------------------------------------------------------------
                         TO VISIT                     FROM VISIT
HRN    PATIENT           DATE/TIME (IEN)              DATE/TIME (IEN)
-------------------------------------------------------------------
```

```
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 12-3: Sample information

12.2 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 12-4: Sample Purge Visit Re-linker Log prompts

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

12.3 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
-------------------------------------------------------------------
                          DELETED/MERGED VISIT        MERGED TO VISIT
HRN    PATIENT            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 12-5: Sample Output Browser window

12.4 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 12-6: Prompts for the PUDM option

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

12.5 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,DNNNNNNNNNNNNN
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,DNNNNNNNNNNNNN
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 12-7: 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.

13.0 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 ICD9 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 13-1: 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.

13.1 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
          ALLOWED/NOT
MNEMONIC  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 13-2: 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.

13.2 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.

14.0 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 ICD9 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 14-1: 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 14-2: The choices for the OTH option

14.1 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 14-3: Sample CTA report

14.2 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 14-4: Sample VRTS report

15.0 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 ICD9 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 15-1: 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 15-2: Options for PLAL

15.1 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 15-3: 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.

15.2 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,PCCCCC 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 15-4: 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.

15.3 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 15-5: 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.

16.0 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 ICD9 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 16-1: 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

-----------------------------     V PROVIDER     -----------------------------
PROVIDER: MYERS,JUDY G                  PATIENT NAME: BROOKS,LAWANDA
  VISIT: JUN 29, 1988@23:30             PRIMARY/SECONDARY: PRIMARY
  AFF.DISC.CODE (c): 980080
PROVIDER: COSNER,RHONDA C               PATIENT NAME: BROOKS,LAWANDA
  VISIT: JUN 29, 1988@23:30             PRIMARY/SECONDARY: SECONDARY
  AFF.DISC.CODE (c): 901106
-----------------------------        V POV       -----------------------------
POV: 883.0                              PATIENT NAME: BROOKS,LAWANDA
  VISIT: JUN 29, 1988@23:30
  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 16-2: Sample Visit File information

17.0 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 ICD9 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 17-1: 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 17-2: Options on PCC Local Table Maintenance menu

17.1 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).

17.2 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.

17.3 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 17-3: Options on the PCC Local Table Maintenance Print Menu

17.3.1 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
      NTL 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 17-4: 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.

17.3.2 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
                           DISCIPLINE
NAME                       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 17-5: Sample APA report

17.3.3 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 17-6: Sample APC report

17.3.4 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
                           DISCIPLINE                   INACTIVE
NAME                       CODE        PROVIDER CLASS   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,JENNIFER H        00          MD               JAN 12,2005
ANDERSON,SHERRI            80          FAMILY PRACTICE  MAR  7,2003
ANTICOAGULATION,TOM S LCS  52          DENTIST          MAY 20,1997
```

Figure 17-7: Sample API report

17.3.5 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
                                                       CAN
                                                       NUMBER
NAME                            CODE  PREFIX/REGION  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 17-8: Sample ARE report

17.3.6 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
                                                            INACTIVE
NAME                                 INITIAL  AFFL  ADC     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 17-9: Sample DIS report

17.3.7 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 17-10: Sample EDU report

17.3.8 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                154106319
400 BURWELL STREET              SALEM                 VA


THOMAS CLAYTON                  156158949
WEST MAIN STREET                ANDREWS               NC
  NOV 25,1997

PD CARDIOLOGY ASSOCIATES        157079823   00
500 SOUTH COIT ST               FLORENCE              SC
  NOV 25,1997

PEE DEE CARDIOLOGY ASSOC        157079823   00
500 S. COIT STREET              FLORENCE              SC
  NOV 25,1997
```

Figure 17-11: Sample EVN report

17.3.9 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 17-12: Sample INS report

17.3.10 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
                                ASUFAC
NAME                            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 17-13: Sample LOC report

17.3.11 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 17-14: Sample NVE report

17.3.12 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 17-15: Sample PHY report

17.3.13 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
                                                            INACTIVE
NAME                                  INITIAL  AFFL  ADC     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 17-16: Sample PPN report

17.3.14 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.

17.3.15 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 shorted 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
                                       INACTIVE
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 17-17: Sample PST report

17.3.16 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 17-18: Sample REL report

17.3.17 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
                                                              AREA        ASU
NAME                            AREA                          CODE  CODE  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 17-19: Sample SUP report

17.3.18 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
CATHETHERIZATION                000134
```

Figure 17-20: Sample TRT report

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

17.4 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
[temple 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 17-21: Sample CL report

17.5 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 an at sign (**@**) 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.

17.6 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.

18.0 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 ICD9 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 18-1: 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.

19.0 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 ICD9 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 19-1: 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 19-2: 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.

20.0 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 19.0 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.

20.1 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
   INCV   List Visits Marked as Incomplete
   LIR    List Unreviewed/Incomplete Visits
   TRV    Tally of Reviewed/Completed Visits by Operator
   VNR    Tally/List of Visits not Reviewed in N Days


Select EHR/PCC Coding Audit Menu Option:
```

Figure 20-1: 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
- 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 LOATION” 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 the 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
    R Chart Deficiency Reason (Last one entered)
    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    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 20-2: Sample EHRD report

Section 20.2 provides more information about the PCC/EHR VISIT AUDIT screen.

20.2 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.

```
PCC/EHR VISIT AUDIT     Sep 11, 2008 10:36:22     Page:   1 of    1
Visit Dates:  Sep 07, 2008 to Sep 11, 2008
* an asterisk beside the visit number indicates the visit has an error
#  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    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 20-3: 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

Code	Name	Functionality
K	Change Patient	Changes the patient for subsequence activities

20.2.1 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 date 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 20-4: 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.

20.2.2 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.

20.2.3 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 20.2.16 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.

20.2.4 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)ELETE OR <RET>:
```

Figure 20-5: 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.

20.2.5 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 20-6: Sample output for G

20.2.6 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, type the deficiency reason at the "CHART DEFICIENCY REASON" prompt.

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.

20.2.7 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
R	Chart Deficiency Reason (Last one entered)
I	Has Medicare/Medicaid or PI

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

Below is a new sort of the records by HRN:

```
PCC/EHR VISIT AUDIT           Jul 16, 2014 16:24:06          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@15:55 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/PTETER,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 20-7: Sample report for Resort List action

20.2.8 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 20-8: Sample chart audit history

20.2.9 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 20-9: 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.

20.2.10 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 20-10: Sample report

20.2.11 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. Otherwise, type **Y** to remove it.

20.2.12 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.

20.2.13 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.

20.2.14 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.

20.2.15 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.

20.2.16 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.

20.2.17 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.

> **Note**: The AMHZ CODING QUEUE security key is required to use this action.

20.2.18 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 20-11: Sample data for Y action

20.2.19 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 20-12: Prompts for Add a Visit

The prompts vary according to the mnemonic used in the process.

20.2.20 Change Patient (K)

This option is available when using PEHR EHR/PCC Coding Audit for One Patient. The option allows you to change patient's 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.

20.3 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 20-13: 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 20-14: 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.

20.4 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 ICD9 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 20-15: 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 20-16: 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.

If needed, type Refresh at the COMMAND prompt.

Appendix A: IHS Edits

Inpatient Edit C2	These V codes cannot be used as principal DX
V01.O CHOLERA CONTACT	V01.1 TUBERCULOSIS CONTACT
V01.2 POLIOMYELITIS CONTACT	V01.3 SMALLPOX CONTACT
V01.4 RUBELLA CONTACT	V01.7 RABIES CONTACT
V01.6 VENEREAL DIS CONTACT	V01.7 VIRAL DIS CONTACT NEC
V01.8 COMMUNIC DIS CONTACT NEC	V01.9 COMMUNIC DIS CONTACT NOS
V02.0 CHOLERA CARRIER	V02.1 TYPHOID CARRIER
V02.2 AMEBIASIS CARRIER	V02.3 GI PATHOGEN CARRIER NEC
V02.4 DIPHTHERIA CARRIER	V02.5 CARRIER/SUSP/OTR/SPEC BACT
V02.6 VIRAL HEPATITIS CARRIER	V02.7 GONORRHEA CARRIER
V02.8 VENEREAL DIS CARRIER NEC	V02.9 CARRIER NEC
V03.0 VACCIN FOR CHOLERA	V03.I VACC-TYPHOID-PARATYPHOID
V03.2 VACCIN FOR TUBERCULOSIS	V03.3 VACCIN FOR PLAGUE
V03.4 VACCIN FOR TULAREMIA	V03.5 VACCIN FOR DIPHTHERIA
V03.6 VACCIN FOR PERTUSSIS	V03.7 TETANUS TOXOID INOCULAT
V03.8 VACCIN FOR BACT DIS NEC	V03.9 VACCIN FOR BACT DIS NOS
V04.0 VACCIN FOR POLIOMYELITIS	V04.1 VACCIN FOR SMALLPOX
V04.2 VACCIN FOR MEASLES	V04.3 VACCIN FOR RUBELLA
V04.4 VACCIN FOR YELLOW FEVER	V04.5 VACCIN FOR RABIES
V04.6 VACCIN FOR MUMPS	V04.7 VACCIN FOR COMMON COLD
V04.8 VACCIN FOR INFLUENZA	V05.0 ARBOVIRUS ENCEPH VACCIN
V05.1 VACC ARBOVIRAL DIS NEC	V05.2 VACCIN FOR LEISHMANIASIS
V05.8 VACCIN FOR DISEASE NEC	V05.9 VACCIN FOR SINGL DIS NOS
V06.0 VACCIN FOR CHOLERA + TAB	V06.1 VACCIN FOR DTP
V06.2 VACCIN FOR DIP + TAB	V06.3 VACCIN FOR DTP + POLIO
V06.4 VAC-MEASLE-MUMPS-RUBELLA	V06.8 VAC-DIS COMBINATIONS NEC
V06.9 VAC-DIS COMBINATIONS NOS	V07.2 PROPHYLACT IMMUNOTHERAPY
V07.3 PROPHYL CHEMOTHERAPY NEC	V07 9 PROPHYLACTIC MEASURE NOS
V10.00 HX OF GI MALIGNANCY NOS	V10.01 HX OF TONGUE MALIGNANCY
V10.02 HX-ORAL/PHARYNX MALG NEC	V10.03 HX-ESOPHAGEAL MALIGNANCY
V10.04 HX OF GASTRIC MALIGNANCY	V10.05 HX OF COLONIC MALIGNANCY
V10.06 HX-RECTAL ANAL MALIGN	V10.07 HX OF LIVER MALIGNANCY
V10.09 HX OF GI MALIGNANCY NEC	V10.11 HX-BRONCHOGENIC MALIGNAN
V10.12 HX-TRACHEAL MALIGNANCY	V10.20 HX-RESP ORG MALIGNAN NOS
V10.21 HX-LARYNGEAL MALIGNANCY	V10.22 HX-NOSE/EAR/SINUS MALIG
V10.29 HX-INTRATHORACIC MAL NEC	V10.3 HX OF BREAST MALIGNANCY
V10.40 HX-FEMALE GENIT MALG NOS	V10.41 HX-CERVICAL MALIGNANCY
V1O.42 HX-UTERUS MALIGNANCY NEC	V10.43 HX OF OVARIAN MALIGNANCY
V10.44 HX-FEMALE GENIT MALG NEC	V10.45 HX-MALE GENIT MALIG NOS
V10.46 HX-PROSTATIC MALIGNANCY	V10.47 HX-TESTICULAR, MALIGNANCY

Inpatient Edit C2	These V codes cannot be used as principal DX
V10.49 HX-MALE GENIT MALIG NEC	V10.50 HX-URINARY MALIGNAN NOS
V10.51 HX OF BLADDER MALIGNANCY	V10.52 HX OF KIDNEY MALIGNANCY
V10.59 HX-URINARY MALIGNAN NEC	V10.60 HX OF LEUKEMIA NOS
V10.61 HX OF LYMPHOID LEUKEMIA	V10.62 HX OF MYELOID LEUKEMIA
V10.63 HX OF MONOCYTIC LEUKEMIA	V10.69 HX OF LEUKEMIA NEC
V10.71 HX-LYMPHOSARCOMA	V10.72 HX-HODGKIN1S DISEASE
V10.79 HX-LYMPHATIC MALIGN NEC	V10.81 HX OF BONE MALIGNANCY
V10.82 HX-MALIG SKIN MELANOMA	V10.83 HX-SKIN MALIGNANCY NEC
V10.84 HX OF EYE MALIGNANCY	V10.85 HX OF BRAIN MALIGNANCY
V10.86 HX-MALIGN NERVE SYST NEC	V10.87 HX OF THYROID MALIGNANCY
V10.88 HX-ENDOCRINE MALIGN NEC	V10.89 HX OF MALIGNANCY NEC
V10.9 HX OF MALIGNANCY NOS	V11.0 HX OF SCHIZOPHRENIA
V11.1 HX OF AFFECTIVE DISORDER	V11.2 HX OF NEUROSIS
V11.3 HX OF ALCOHOLISM	V11.8 HX-MENTAL DISORDER NEC
V11.9 HX-MENTAL DISORDER NOS	V12.0 HX-INFECT/PARASITIC DIS
V12.1 HX-NUTRITION DEFICIENCY	V12.2 HX-ENDOCR/META/IMMUN DIS
V12.3 HX-BLOOD DISEASES	V12.4 HX-NERV SYS/SENS ORG DIS
V12.5 HX-DISEASES CIRCULATORY SYSTEM	V12.6 HX-RESPIRATORY SYS DIS
V12.7 HX OF GI DISORDER	V13.0 HX-URINARY SYSTEM DISORD
V13.I HX-TROPHOBLASTIC DISEASE	V13.2 HX-GENITAL/OBSTETRIC DIS
V13.3 HX-SKIN/SUBCUTAN TIS DIS	V13.4 HX OF ARTHRITIS
V13.5 HX-MUSCULOSKELET DIS NEC	V13.6 PERS HX CONGENIT MALFORMATION
V13.7 HX-PERINATAL PROBLEMS	V13.8 HX OF DISEASES NEC
V13.9 HX OF DISEASE NOS	V14.0 HX-PENICILLIN ALLERGY
V14.1 HX-ANTIBIOT ALLERGY NEC	V14.2 HX-SULFONAMIDES ALLERGY
V14.3 HX-ANTI-INFECT ALLERGY	V14.4 HX-ANESTHETIC ALLERGY
V44.8 ARTIF OPEN STATUS NEC	V44.9 ARTIF OPEN STATUS NOS
V45 0 CARDIAC PACEMAKER STATUS	V45.1 RENAL DIALYSIS STATUS
V45.2 VENTRICULAR SHUNT STATUS	V45.3 INTESTINAL BYPASS STATUS
V45.4 ARTHRODESIS STATUS	V45.5 PRESENCE OF IUD
V45.6 POSTSURGICAL STATE, EYE	V45.81 AORTOCORONARY BYPASS
V45.89 POSTSURGICAL STATES NEC	V46.0 DEPENDENCE ON ASPIRATOR
V46.1 DEPENDENCE ON RESPIRATOR	V46.8 MACHINE DEPENDENCE NEC
V46.9 MACHINE DEPENDENCE NOS	V47.0 INTERN ORGAN DEFICIENCY
V47.1 MECH PROB W INTERNAL ORG	V47.2 CARDIORESPIRAT PROBL NEC
V47.3 DIGESTIVE PROBLEMS NEC	V47.4 URINARY PROBLEMS NEC
V47.5 GENITAL PROBLEMS NEC	V47.9 PROBL W INTERNAL ORG NOS
V48.0 DEFICIENCIES OF HEAD	V48.1 DEFICIENCIES NECK/TRUNK
V48.2 MECHANICAL PROB WHEAD	V48.3 MECH PROB WNECK TRUNK
V48.4 SENSORY PROBLEM WHEAD	V48.5 SENSOR PROB WNECK/TRUNK
V48.6 DISFIGUREMENTS OF HEAD	V48.7 DISFIGUREMENT NECK/TRUNK
V48.8 PROB-HEAD/NECK/TRUNK NEC	V48.9 PROB-HEAD/NECK/TRUNK NOS
V49.0 DEFICIENCIES OF LIMBS	V49.1 MECHANICAL PROB W LIMBS

Inpatient Edit C2	These V codes cannot be used as principal DX
V49.2 MOTOR PROBLEMS W LIMBS	V49.3 SENSORY PROBLEMS W LIMBS
V49.4 DISFIGUREMENTS OF LIMBS	V49.5 LIMB PROBLEMS NEC
V49.8 PROBL INFLU HEALTH NEC	V49.9 PROBL INFLU HEALTH NOS
V57.0 BREATHING EXERCISES	V57.4 ORTHOPTIC TRAINING
V58.2 BLOOD TRANSFUSION, NO DX	V58.5 ORTHODONTICS AFTERCARE
V68.0 ISSUE MEDICAL CERTIFICAT	V68.1 ISSUE REPEAT PRESCRIPT
V68.2 REQUEST EXPERT EVIDENCE	V68.89 ADMINISTRTVE ENCOUNT NEC
V68.81 REFERRAL-NO EXAM/TREAT	V37.00 OTH MULT,UNSPEC-IN HOSP,NO C-S
V37.01 OIH MULT,UNSPEC-IN HOS,DEL C-S	V39.00 LB-IN HOSP,UNSPEC,NO C-S
V39.01 LB-IN HOSP, DEL C-S	V68.9 ADMINISTRTVE ENCOUNT NOS
V23.7 INSUFFICIENT PRENATAL CARE	V25.8 CONTRACEPTIVE MANGMT NEC
V25.9 CONTRACEPTIVE MANGMT NOS	V07.4 POSTMENOPAUSAL HORMONE REPLACE
V25.43 SURV SUBDERMAL CONTRACEPTIVE	V25.5 INSERT SUBDERMAL CONTRACEPTIVE
V03.81 VACC FOR H INFLUENZA,TYPE B	V03 82 VACC FOR STREPTOCOCCUS PNEUMON
V03.89 OTH SPEC VACC SINGLE BACT DIS	V06.5 VACC TETANUS-DIPHTHERIA [Td)
V06.6 VACC STREP PNEUMONIAE,INFLUENZ	V07.31 PROPHY FLUORIDE ADMINISTRATION
V07.39 PROPHYLACTIC CHEMOTHERAPY,NEC	V12.00 HX-INFECT/PARASITIC DIS,NOS
V12.01 HX-TUBERCULOSIS	V12.02 HX-POLIOMYELITIS
V12.03 HX-MALARIA	V12.09 HX-INFECT/PARASITIC DIS,NEC
V12.70 HX-DIGESTIVE DIS,NOS	V12.71 HX-PEPTIC ULCER DISEASE
V12.72 HX-COLONIC POLYPS	V12.79 HX-DIGESTIVE SYSTEM DIS,NEC
V13.00 HX-URINARY DISORDER,NOS	V13.01 HX-URINARY CALCULI
V13.09 HX-URINARY SYSTEM DISORDER,NEC	V15.82 HX-TOBACCO USE
V43.60 JOINT REPLACEMENT STATUS,NOS	V43.61 SHOULDER JT REPLACEMENT STATUS
V43.62 ELBOW JT REPLACEMENT STATUS	V43.63 WRIST JT REPLACEMENT STATUS
V43.64 HIP JT REPLACEMENT STATUS	V43 65 KNEE JT REPLACEMENT STATUS
V43.66 ANKLE JT REPLACEMENT STATUS	V43.69 JOINT REPLACEMENT STATUS,NEC
V45.00 CARDIAC DEVICE IN SITU.NOS	V45.01 CARDIAC PACEMAKER IN SITU
V45.09 CARDIAC DEVICE IN SITU,NEC	V45.51 PRESENCE OF IUD
V45.52 PRES-SUBDERM CONTRACEPT IMPLNT	V45 59 PRES-CONTRACEPTIVE DEVICE,NEC
V45.82 PERCUT/TRANSLUM COR/ANGIO STAT	V49.60 UPPER LIMB AMP STATUS,NOS
V49.61 THUMB AMPUTATION STATUS	V49 62 FINGER(S) AMPUTATION STATUS
V49.63 HAND AMPUTATION STATUS	V49.64 WRIST AMPUTATION STATUS
V49.65 BELOW ELBOW AMPUTATION STATUS	V49.66 ABOVE ELBOW AMPUTATION STATUS
V49.67 SHOULDER AMPUTATION STATUS	V49.70 LOWER LIMB AMP STATUS,NOS
V49.71 GREAT TOE AMPUTATION STATUS	V49.72 OTHER TOE(S) AMPUTATION STATUS
V49.73 FOOT AMPUTATION STATUS	V49.74 ANKLE AMPUTATION STATUS
V49.75 BELOW KNEE AMPUTATION STATUS	V49.76 ABOVE KNEE AMPUTATION STATUS
V49.77 HIP AMPUTATION STATUS	V15.41 HISTORY OF PHYSICAL ABUSE
V15.42 HISTORY OF EMOTIONAL ABUSE	V15.49 PSYCHOLOGICAL TRAUMA,NEC
V66.7 ENCOUNTER FOR PALLIATIVE CARE	V02.60 VIRAL HEPATITIS CARRIER,UNSPEC

Inpatient Edit C2	These V codes cannot be used as principal DX
V02.61 HEPATITIS B CARRIER	V02.62 HEPATITIS C CARRIER
V02.69 OTHER VIRAL HEPATITIS CARRIER	V12.40 HX-NERV SYS/SENS ORG DIS,UNSP
V12.41 HX BENIGN BRAIN NEOPLASM	V12.49 HX OTH DIS NERV SYS/SENS ORG
V16.40 FAN HX MALIG GENITAL ORG,UNSP	V16.41 FAM HX MALIG NEOPLASM OVARY
V16.42 FAM HX MALIG NEOPLASM PROSTATE	V16.43 FAM HX MALIG NEOPLASM TESTIS
V16.49 FAN HX OTHER MALIG NEOPLASM	V42.81 ORG/TISS REPL TRANS,BMARROW
V42.82 ORG/TISS REPL TRANS,STEMCELLS	V45.69 OTH STATES P SURG EYE/ADNEXA
V45.71 ACQUIRED ABSENSE OF BREAST	V45.72 ACQUIRED ABSENSE OF INTESTINE
V45.73 ACQUIRED ABSENCE OF KIDNEY	V64.4 LAPROSCOP CONV TO OPEN PROC
V76.10 SCREEN FOR MALIG/BREAST,UNSPEC	V76.11 MAMMOGRAM HI-RISK MALIG BREAST
V76.12 OTH MAMMOGRAM MALIG BREAST	
V14.5 HX-NARCOTIC ALLERGY	V14.6 HX-ANALGESIC ALLERGY
V14.7 HX-VACCINE ALLERGY	V14.8 HX-DRUG ALLERGY NEC
V14.9 HX-DRUG ALLERGY NOS	V15.O HX OF ALLERGY NEC
V15.1 HX-MAJOR CARDIOVASC SURG	V15.2 HX-MAJOR ORGAN SURG NEC
V15.3 HX OF IRRADIATION	V15 4 PSYCHOLOGICAL TRAUMA
V15.5 HX OF INJURY	V15.6 HX OF POISONING
V15.7 HX OF CONTRACEPTION	V15.81 HX OF PAST NONCOMPLIANCE
V15.89 HEALTH HAZARDS NEC	V15.9 HX-HEALTH HAZARD NOS
V16.0 FAMILY HX-GI MALIGNANCY	V16.1 FM HX-TRACH/BRONCHOG MAL
V16.2 FAM HX-INTRATHORACIC MAL	Vl6 3 FAMILY HX-BREAST MALIG
V16.4 FAMILY HX-GENITAL MALIG	V16.5 FM HX MALIG NP URINARY
V16.6 FAMILY HX-LEUKEMIA	V16.7 FAM HX-LYMPH NEOPLAS NEC
V16.8 FAMILY HX-MALIGNANCY NEC	V16.9 FAMILY HX-MALIGNANCY NOS
V17.0 FAM HX-PSYCHIATRIC COND	V17.1 FAMILY HX-STROKE
V17.2 FAM HX-NEUROLOG DIS NEC	V17.3 FAM HX-ISCHEM HEART DIS
V17.4 FAM HX-CARDIOVAS DIS NEC	V17.5 FAMILY HX-ASTHMA
V17.6 FAM HX-CHR RESP COND NEC	V17.7 FAMILY HX-ARTHRITIS
V17.8 FAM HX-MUSCLOSKL DIS NEC	V18.0 FAM HX-DIABETES MELLITUS
V18.1 FM HX-ENDO/METAB DIS NEC	V18.2 FAMILY HX-ANEMIA
V18.3 FAM HX-BLOOD DISORD NEC	V18.4 FAM HX-MENTAL RETARDAT
V18.5 FAMILY HX-GI DISORDERS	V18.6 FAMILY HISTORY KIDNEY DISEASE
V18.7 FAMILY HX-GU DISEASE NEC	V18.8 FM HX-INFECT/PARASIT DIS
V19.0 FAMILY HX-BLINDNESS	V19.1 FAMILY HX-EYE DISORD NEC
V19.2 FAMILY HX-DEAFNESS	V19.3 FAMILY HX-EAR DISORD NEC
V19.4 FAMILY HX-SKIN CONDITION	V19.5 FAM HX-CONGEN ANOMALIES
V19.6 FAMILY HX-ALLERGIC DIS	V19.7 CONSANGUINITY
V19.8 FAMILY HX-CONDITION NEC	V22.2 PREG STATE, INCIDENTAL
V23.0 PREG WHX OF INFERTILITY	V23.1 PREG W HX-TROPHOBLAS DIS
V23.2 PREG WHX OF ABORTION	V23.3 GRAND MULTIPARITY
V23.4 PREG W POOR OBSTETRIC HX	V23.5 PREG W POOR REPRODUCT HX
V23.8 SUPV OTHER HR PREGNANCY	V23.9 SUPRV HIGH-RISK PREG NOS
V25.01 PRESCRIP-ORAL CONTRACEPT	V25.02 INITIATE CONTRACEPT NEC

Inpatient Edit C2	These V codes cannot be used as principal DX
V25.09 CONTRACEPTIVE MANGMT NEC	V25.1 INSERTION OF IUD
V25.3 MENSTRUAL EXTRACTION	V25.40 CONTRACEPT SURVEILL NOS
V25.41 CONTRACEPT PILL SURVEILL	V25.42 IUD SURVEILLANCE
V25.49 CONTRACEPT SURVEILL NEC	V26.3 GENETIC COUNSELING
V26.4 PROCREATIVE MGMT-COUNSEL	V26.8 PROCREATIVE MANGMT NEC
V26.9 PROCREATIVE MANGMT NOS	V27.0 DELIVER-SINGLE LIVEBORN
V27.1 DELIVER-SINGLE STILLBORN	V27.2 DELIVER-TWINS, BOTH LIVE
V27.3 DEL-TWINS, 1 NB, I SB	V27.4 DELIVER-TWINS, BOTH SB
V27.5 DEL-MULT BIRTH, ALL LIVE	V27.6 DEL-MULT BRTH, SOME LIVE
V27.7 DEL-MULT BIRTH, ALL SB	V27.9 OUTCOME OF DELIVERY NOS
V28.0 SCREENING-CHROMOSOM ANOM	V28.1 SCREEN-ALPHAFETOPROTEIN
V28 2 SCREEN BY AMNIOCENT NEC	V28.3 SCREEN-FETAL MALFORM
V28.4 SCREEN-FETAL RETARDATION	V28.5 SCREEN-ISOIMMUNIZATION
V28.8 ANTENATAL SCREENING NEC	V28.9 ANTENATAL SCREENING NOS
V37.0 MULT BIRTH NOS-IN HOSP	V37.1 MULT BRTH NOS-BEFORE ADM
V37.2 MULT BIRTH NOS-NONHOSP	V39.0 LIVEBORN NOS-IN HOSP
V39.1 LIVEBORN NOS-BEFORE ADM	V39.2 LIVEBORN NOS-NONHOSP
V40.0 PROBLEMS WITH LEARNING	V40.1 PROB WITH COMMUNICATION
V40.2 MENTAL PROBLEMS NEC	V40.3 BEHAVIORAL PROBLEMS NEC
V40.9 MENTAL/BEHAVIOR PROB NOS	V41.0 PROBLEMS WITH SIGHT
V41.1 EYE PROBLEMS NEC	V41.2 PROBLEMS WITH HEARING
V41.3 EAR PROBLEMS NEC	V41.4 VOICE PRODUCTION PROBLEM
V41.5 SMELL AND TASTE PROBLEM	V41.6 PROBLEM W SWALLOWING
V41.7 SEXUAL FUNCTION PROBLEM	V41.8 PROBL WSPECIAL Flmc NEC
V41.9 PROBL W SPECIAL FUNC NOS	V42.0 KIDNEY TRANSPLANT STATUS
V42.1 HEART TRANSPLANT STATUS	V42.2 HEART VALVE TRANSPLANT
V42.3 SKIN TRANSPLANT STATUS	V42.4 BONE TRANSPLANT STATUS
V42.5 CORNEA TRANSPLANT STATUS	V42.6 LUNG TRANSPLANT STATUS
V42.7 LIVER TRANSPLANT STATUS	V42.8 TRANSPLANT STATUS NEC
V42.9 TRANSPLANT STATUS NOS	V43.0 EYE REPLACEMENT NEC
V43.1 LENS REPLACEMENT NEC	V43.2 HEART REPLACEMENT NEC
V43.3 HEART VALVE REPLAC NEC	V43.4 BLOOD VESSEL REPLAC NEC
V43.5 BLADDER REPLACEMENT NEC	V43.6 JOINT REPLACEMENT NEC
V43.7 LIMB REPLACEMENT NEC	V43.8 OTH ORGAN/TISS REPL BY OTH MEANS
V44.0 TRACHEOSTOMY STATUS	V44.1 GASTROSTOMY STATUS
V44.2 ILEOSTOMY STATUS	V44.3 COLOSTOMY STATUS
V44.4 ENTEROSTOMY STATUS NEC	V44.5 CYSTOSTOMY STATUS
V44.6 URINOSTOMY STATUS NEC	V44.7 ARTIFICIAL VAGINA STATUS

Appendix B: Rules of Behavior

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

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

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

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

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

B.1 All RPMS Users

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

B.1.1 Access

RPMS users shall

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or nonpublic agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions *Indian Health Manual* Part 8, "Information Resources Management," Chapter 6, "Limited Personal Use of Information Technology Resources."

RPMS users shall not

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

B.1.2 Information Accessibility

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

RPMS users shall

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

B.1.3 Accountability

RPMS users shall

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

- Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and information technology (IT) information processes.

B.1.4 Confidentiality

RPMS users shall

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

RPMS users shall not

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

B.1.5 Integrity

RPMS users shall

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

RPMS users shall not

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

B.1.6 System Logon

RPMS users shall

- Have a unique User Identification/Account name and password.
- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after five successive failed login attempts within a specified time period (e.g., one hour).

B.1.7 Passwords

RPMS users shall

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha-numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts or batch files).
- Change passwords immediately if password has been seen, guessed, or otherwise compromised, and report the compromise or suspected compromise to their ISSO.
- Keep user identifications (IDs) and passwords confidential.

RPMS users shall not

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per eight characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.

- Give a password out over the phone.

B.1.8 Backups

RPMS users shall

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

B.1.9 Reporting

RPMS users shall

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

RPMS users shall not

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

B.1.10 Session Timeouts

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

RPMS users shall

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

B.1.11 Hardware

RPMS users shall

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.

- Keep records of maintenance/repairs performed on system equipment.

RPMS users shall not

- Eat or drink near system equipment.

B.1.12 Awareness

RPMS users shall

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

B.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, and intrusion detection, and provide physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote RPMS users shall

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

Remote RPMS users shall not

- Disable any encryption established for network, internet, and Web browser communications.

B.2 RPMS Developers

RPMS developers shall

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Not access live production systems without obtaining appropriate written access, and shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Observe separation of duties policies and procedures to the fullest extent possible.
- Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change, and reason for the change.
- Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Follow industry best standards for systems they are assigned to develop or maintain, and abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available.

RPMS developers shall not

- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

B.3 Privileged Users

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

Privileged RPMS users shall

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

- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator’s database.
- Shall follow industry best standards for systems they are assigned to, and abide by all Department and Agency policies and procedures.

Privileged RPMS users shall not

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

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

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/

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