RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS PCC Suite

(BJPC)

Data Entry Mnemonics

Version 2.0 Patch 5
February 2011

Office of Information Technology (OIT)
Division of Information Resource Management
Albuquerque, New Mexico

Preface

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

Table of Contents

1.0   Introduction

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

The following RPMS components comprise the PCC suite:

- IHS Dictionaries (AUPN)

- Standard Tables

- PCC Health Summary, including Health Maintenance Reminders (APCH)

- PCC Data Entry (APCD)

- PCC Management Reports, including PGEN/VGEN (APCL)

- Designated Specialty Provider Management (DP)

- Q-Man (Query Manager) (AMQQ)

- Taxonomy Management (ATX)

Mnemonics permit the user to enter data from a variety of PCC forms, and to do so in whatever entry order is easiest or most efficient. Mnemonics eliminate the requirement to "space through" fields on a form that contains no data.

2.0   Release Notes

BJPC v2.0 p5 contains the following modifications and enhancements.

2.1   PCC Data Entry (APCD)

The following changes apply to the APCD application.

2.1.1   Problem Deletion

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

2.1.2   Problem-Related Mnemonics: Modified

- PL–Two action items have been added to the list manager display when using the PL mnemonic: NP–No Active Problems; LR–Problem List Reviewed.

- All Problem List-related mnemonics (PO, APO, IPO, PPV, NO, RNO, MNN, MPO, RPO) prompt the operator for the provider who made the Problem List update and the date the update was made.

- PO, MPO, and PL: Modified the Problem Add and Modify mnemonics (PO, MPO) and the PL mnemonic when used to add or modify a problem to prompt for the three new E code fields when the problem diagnosis is an injury diagnosis. When adding a problem, the fields will only be prompted for if the diagnosis is an injury diagnosis; however, when modifying a problem, they will always be prompted for so that they can be deleted if needed.

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

2.1.3   Mnemonics: New

The following Clinical Action Review Item mnemonics were added:

- PLR–Problem List Reviewed

- ALR–Allergy List Review

- MLR–Medication List Review

- NAP–No Active Problems

- NAM–No Active Medications

- NAA–No Active Allergies

2.1.4   Health Factors: New and Modified

- The TOBACCO category has been reorganized into three categories: TOBACCO (SMOKING), TOBACCO (SMOKELESS–CHEWING/DIP), and TOBACCO (EXPOSURE).

- Inactivated the following Health Factors: TOBACCO (category), CURRENT SMOKER & SMOKELESS, and NEVER USED TOBACCO

- Renamed the following Health Factors:

  – CURRENT SMOKER is now CURRENT SMOKER, STATUS UNKNOWN
  – PREVIOUS SMOKER is now PREVIOUS (FORMER) SMOKER
  – PREVIOUS SMOKELESS is now PREVIOUS (FORMER) SMOKELESS

- Added six new Health Factors

  – CURRENT SMOKER, EVERY DAY
  – CURRENT SMOKER, SOME DAY
  – NEVER SMOKED
  – SMOKING STATUS UNKNOWN
  – SMOKELESS TOBACCO, STATUS UNKNOWN
  – NEVER USED SMOKELESS TOBACCO

2.2   PCC Health Summary (APCH)

The following modifications apply to the APCH application.

2.2.1   TOBACCO Health Factor Category

- If the health summary type had TOBACCO in the definition of which health factors would display on the health summary, the health summary type was changed to include the three new categories: TOBACCON (SMOKING), TOBACCO (SMOKELESS–CHEWING/DIP), and TOBACCO (EXPOSURE).

2.2.2   Date of Death or Cause of Death

- When there is data in *either* the Date of Death *or* Cause of Death field in the patient's file, both fields display on the health summary.

2.2.3   Problem/Medication/Allergy List-Related Items

- Problems–Active and Problems–Inactive components: added the date of the last problem list review, Problem List update, date of the last documented "No Active Problems," and the name of the provider who updated the list.

- All medication components: added the date of the last medication review, last medication update, and last documented "No Active Medications."

- Allergies/Adverse Reactions components: added date of last allergy list review, provider conducting the review, and last documented "No Active Allergies."

- The following Health Summary-related reports/displays ignore all problems with a status of Deleted:

  - Allergies from the Problem List component
  - Patient Wellness Handout when checking to see if diabetes is on the problem list
  - Asthma Supplement when determining if asthma is on the problem list
  - Various Health Maintenance reminders when checking to see if a particular problem is on the problem list
  - The 1999 through 2008 Diabetes Audits

2.2.4   Health Maintenance Reminders: Modified

The TOBACCO SCREENING Health Maintenance Reminder was modified to include any of the three new tobacco categories: TOBACCO (SMOKING), TOBACCO (SMOKELESS–CHEWING/DIP), and TOBACCO (EXPOSURE).

2.2.5   Demographics-Related Components

Added a patient's preferred language and preferred method of receiving reminders to the Demographic Section of the health summary.

2.3   PCC Management Reports (APCL)

The following changes apply to the APCL application.

2.3.1   Problem List-Related Displays and Reports

Modified the following displays/reports to ignore problems with a status of Deleted:

- PWA: List all patients with Allergies/NKA on Problem List

- SALP: List patients seen in N yrs with Problem List Allergies

- NALP: List Patients with Allergies entered in a Date Range

- PL: Problem List Update

- "Report Patients with No Diagnosis on the Problem List" (Diabetes report)

2.3.2   PGEN/VGEN

- The following data elements have been added to PGEN as search items:
    - Ethnicity
    - Preferred Language
    - Preferred Reminder Method
    - Date PL Last Reviewed
    - Date PL Last Updated
    - No Active Problems (Date Last)
    - PL Review Provider (Last)
    - Prov No Active Prob (Last)
    - Date Med Last Reviewed
    - Date Med Last Updated
    - No Active Meds (Date Last)
    - Med Review Provider (Last)
    - Med Update Provider (Last)
    - Prov No Active Med (Last)
    - Date Allergy List Reviewed
    - Allergy List Rev Prov
- The following data elements have been added to VGEN as search items:
    - Ethnicity
    - Preferred Language
    - Preferred Reminder Method
    - Problem List Reviewed?
    - Problem List Updated
    - No Active Problems?
    - Prov Rev Prob List
    - Prov Updating PL
    - Prov Updating NAP
    - Med List Reviewed?
    - Medication List Updated?
    - No Active Medications?
    - Prov Rev Med List
    - Prov Updating Med List
    - Prov Updating NAM
    - Allergy List Reviewed?

     – Prov Rev Allergy List

2.3.3 Cause of Death Item in VGEN

The Cause of Death item on the Patient Selection Menu in VGEN now displays the ICD9 code *and* the description on the report.

2.3.4 QMAN (AMQQ)

- The following tobacco-related Health Factor categories have been added to QMAN as search items:
  - TOBACCO (SMOKING)
  - TOBACCO (SMOKELESS–CHEWING/DIP)
  - TOBACCO (EXPOSURE)
- The following search items were added:
  - Ethnicity
  - Preferred Language
  - Preferred Reminder Method
- Modified QMAN queries involving the Problem List to ignore problems with a status of Deleted status.
- The Cause of Death attribute in QMAN displays the ICD9 code *and* the description on the report.

2.3.5 Other

- Removed the Diabetes Program Audit submenu from PCC Management Reports. The Diabetes Program Audit menu is now a part of the Diabetes Management System Application (BDM).
- Added a new set of options under PCC Management Reports that allow the site to export their ILI surveillance data and selected lab result data to the EPI Program in HL7 format. This addition supports meaningful use. The options are locked with a key–APCSZ EPI EXPORTS–and should only be run when requested to do so by the EPI Program. The options are:
  - HLIL Export my H1N1/ILI data
  - HLLB Export Lab Data

2.4 General Database (AUPN)

The following changes apply to AUPN.

- V UPDATED/REVIEWED: Created new file with the following fields:

- Clinical Action
- Patient Name
- Visit
- Date/Time Entered
- Entered By
- Deleted/Entered in Error
- Deleted/Entered in Error By
- Reason Deleted
- Reason If Other
- Event Date and Time
- Ordering Provider
- Clinic
- Encounter Provider
- Parent Assessment
- External Key
- Outside Provider Name
- Ordering Location
- V HEALTH FACTOR: Converting the following data:
  - If a visit had the CURRENT SMOKER & SMOKELESS health factor recorded, the new health factors of CURRENT SMOKER, STATUS UNKNOWN and CURRENT SMOKELESS were automatically appended to the visit if those health factors were not already documented on the visit.
  - If the a visit had the NEVER USED TOBACCO health factor recorded, then the NEVER SMOKED and NEVER USED SMOKELESS TOBACCO health factors were automatically appended to the visit.
  - If the visit has the NON-TOBACCO USER health factor documented, then the NEVER SMOKED and NEVER USED SMOKELESS TOBACCO health factors were automatically appended to the visit.
- PROBLEM: Added three ICD E Code fields to the PROBLEM file:
  - .16 E Code
  - .17 E Code 2
  - .18 E Code 3
- Added/Modified the following fields in the PROBLEM file:
  - .12 STATUS: Added DELETED As a choice
  - 2.01 PROBLEM DELETED BY: New field
  - 2.02 DATE/TIME PROBLEM DELETED: New field
  - 2.03 REASON PROBLEM DELETED: New field

- 2.04 REASON IF OTHER: New field

3.0   PCC Data Entry Mnemonics

3.1   Definition of PCC Data Entry Mnemonics

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

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

3.2   Historical Mnemonics

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

3.3   Online Documentation

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

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

3.4   Entry of Incorrect Mnemonics

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

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

3.5   Mnemonic Codes, Descriptions, and Instructions

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

3.5.1   3M Coder Interface (3M)

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

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

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

3.5.2   Asthma Control (ACON)

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

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

Figure 3-2: Sample of using the ACON mnemonic

3.5.3   Anesthesia CPT (ACPT)

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

Quantity is the number of times this procedure was done to the patient during the encounter.

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

Figure 3-3: Example of using the ACPT mnemonic

3.5.4   Anti-Coagulation Therapy (ACTH)

Use mnemonic ACTH to enter Anticoagulation Therapy data. The user is prompted for V Anti-Coagulation Warfarin Indicated, INR Goal, Duration of Anti-Coagulation Therapy, and Anti-Coagulation Start Date.

```
MNEMONIC: ACTH    ANTI-COAGULATION THERAPY   ALLOWED   VISIT RELATED
ONLY
Select V ANTICOAGULATION WARFARIN INDICATED?: Y (1  YES)
 INR GOAL: ??

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

   Choose from:
    1    2.0 - 3.0
    2    2.5 - 3.5
    3    Other
 INR GOAL: 1 2.0 - 3.0
 DURATION OF ANTI-COAGULATION THERAPY: ??

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

   Choose from:
```

```
     1     3 MONTHS
     2     6 MONTHS
     3     12 MONTHS
     4     INDEFINITELY
 DURATION OF ANTI-COAGULATION THERAPY: 3 12 MONTHS
 ANTI-COAGULATION THERAPY START DATE: JAN 14,2010
     //  (JAN 14, 2010)
```

Figure 3-4: Example of using the ACTH mnemonic

3.5.5   ADA Code Entry (ADA)

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

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

Figure 3-5: Example of using the ADA mnemonic

3.5.6   Asthma Work/School Days Missed (ADM)

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

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

Figure 3-6: Example of using the ADM mnemonic

3.5.7   Admitting Diagnosis (ADX)

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

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

Switching to Modify Mode for ONE Mnemonic ONLY!
MNEMONIC:  ADX  Admitting Diagnosis  ALLOWED  VISIT-RELATED-ONLY
```

```
1  2970529  SIGMA,BOB MAY 26,1997@10:00
    ADMITTING DX: 251.0// 250.00 250.00  DM UNCOMPL/T-II/NIDDM,NS
UNCON
    ...OK? Yes//  (Yes)
Switching back to ENTER Mode!
```

Figure 3-7: Example of using Admitting Diagnosis mnemonic

3.5.8   Abdominal Girth (AG)

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

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

Figure 3-8: Example of using the AG mnemonic

3.5.9   Ankle BP (AKBP)

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

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

Figure 3-9: Sample of using the AKBP mnemonic

3.5.10   Appointment Length (AL)

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

```
MNEMONIC: AL Appointment Length   ALLOWED   VISIT-RELATED-ONLY
APPOINTMENT LENGTH: 30
```

Figure 3-10: Example of entering appointment length values

3.5.11   Allergy Tracking Entry (ALG)

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

```
MNEMONIC: ALG   Allergy Tracking Entry  ALLOWED  NON-VISIT/VISIT
MNEMONIC
Does this patient have any known allergies or adverse reactions? :
Yes
     This patient has no allergy/adverse reaction data.
Enter Causative Agent: SULFAMETHOXAZOLE
  SULFAMETHOXAZOLE  OK? Yes//
(O)bserved or (H)istorical Allergy/Adverse Reaction: H HISTORICAL
No signs/symptoms have been specified. Please add some now.
The following are the top ten most common signs/symptoms:
 1. ANXIETY             7. HIVES
 2. ITCHING,WATERING EYES      8. DRY MOUTH
 3. HYPOTENSION             9. ANAPHYLAXIS
 4. DROWSINESS           10. RASH
 5. NAUSEA,VOMITING        11. OTHER SIGN/SYMPTOM
 6. DIARRHEA
Enter from the list above : 7

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

The following is the list of reported signs/symptoms for this
reaction:
   Signs/Symptoms                 Date Observed
----------------------------------------------------------------------
 1 HIVES

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

MECHANISM: UNKNOWN// P PHARMACOLOGIC

COMMENTS:
 1>
Currently you have verifier access.
Would you like to verify this Causative Agent now? Yes//
CAUSATIVE AGENT: SULFAMETHOXAZOLE
      TYPE: DRUG
  INGREDIENTS: SULFAMETHOXAZOLE
VA DRUG CLASSES: AM650 - SULFONAMIDE/RELATED ANTIMICROBIALS
    OBS/HIST: HISTORICAL
 SIGNS/SYMPTOMS: HIVES
   MECHANISM: PHARMACOLOGIC
Would you like to edit any of this data? N (No)
    PATIENT: SIGMA,DEMO       CAUSATIVE AGENT: SULFAMETHOXAZOLE
  INGREDIENTS: SULFAMETHOXAZOLE    VA DRUG CLASSES:
SULFONAMIDE/RELATED A
  ORIGINATOR: DATA ENTRY        ORIGINATED: MAR 04, 2008@11:48
   SIGN OFF: NO                 OBS/HIST: HISTORICAL

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

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

Figure 3-11: Example of using the ALG mnemonic

3.5.12   Allergy List Review (ALR)

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

```
MNEMONIC: ALR        Allergy List Review      ALLOWED      VISIT RELATED ONLY

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

Figure 3-12: Example of using the ALR mnemonic

3.5.13   Asthma Management Plan (AMP)

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

3.5.14   Anesthesia Operation (AOP)

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

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

 OPERATING PROVIDER: SIGMA,JOHN
 DIAGNOSIS: 472.1 472.1   CHRONIC PHARYNGITIS
     ...OK? Yes//
 ANESTHESIA ADMINISTERED: Y//  YES
 ASA-PS CLASS: P1
   1  P1    HEALTHY PATIENT
```

```
    2  P1E    HEALTHY PATIENT-EMERGENCY
CHOOSE 1-2: 1 P1   HEALTHY PATIENT
 ANESTHESIA START DATE/TIME: T@0800 (MAR 06, 2008@08:00:00)
 ANESTHESIA STOP DATE/TIME: T@1000 (MAR 06, 2008@10:00:00)
 ELAPSED TIME (ANESTHESIA): 120//
 ANESTHESIOLOGIST: SIGMA,JANE
Enter OPERATION/PROCEDURE:
```

Figure 3-13: Example of using the AOP mnemonic

3.5.15   Activate an Inactive Problem (APO)

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

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

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

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

```
MNEMONIC: APO       Activate an Inactive Problem    ALLOWED
NON-VISIT/VISIT
Problem List Reviewed On:                      By:
Problem List Updated On:          Nov 02, 2010  By:
ADPROVIDER,RAY
No Active Problems Documented On:              By:
*****************  ACTIVE PROBLEMS AND NOTES  ********************
  CI1      11/02/2010  TESTING PROBLEM NOTES  (ONSET: 11/02/2010)
  CI2      11/02/2010  NONE  (ONSET: 11/02/2010)
  CI3      11/02/2010  TESTING
  CI3CI1   11/02/2010  TEST
*****************  INACTIVE PROBLEMS AND NOTES
******************
  CI4      11/02/2010  TESTING PO  (ONSET: 11/02/2010)
                       Status: INACTIVE
  CI4CI1   11/02/2010  TEST

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

```
Enter the PROVIDER who Updated the Problem List: IWPROVIDER,MARY
ANNE
```

Figure 3-14: Example of typing mnemonics to activate an inactive problem

3.5.16   Appointment Date and Time (APPT)

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

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

Figure 3-15: Example of entering mnemonics for appointment date and time

3.5.17   Asthma Symptom Free Days (ASFD)

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

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

Figure 3-16: Example of using the ASFD mnemonic

3.5.18   Activity and Travel Time (AT)

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

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

Figure 3-17: Example of typing mnemonics for activity and travel time

3.5.19 Audiometry (AUD)

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

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

Figure 3-18: Example of entering mnemonics for recording results of hearing exams

3.5.20 AUDIT-C (AUDC)

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

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

Figure 3-19: Example of using the AUDC mnemonic

3.5.21 Audit (AUDT)

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

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

Figure 3-20: Sample of using the AUDT mnemonic

3.5.22 Birth Measurement (BM)

Use the Birth Measurement (BM) mnemonic to document a patient's birth weight for non-visit- or visit-related encounters. The measurement is in pounds and ounces, the APGAR in one and five minutes, gestational age in weeks, delivery type, and any complications.

```
MNEMONIC: BM    Birth Measurement   ALLOWED    NON-VISIT/VISIT
MNEMONIC
Patient Name: SMITH,JANE
 BIRTH WEIGHT LBS: 6
 BIRTH WEIGHT OZS: 10
 APGAR 1 MINUTE: 1
 APGAR 5 MINUTE: 2
 GESTATIONAL AGE WKS: 34
 DELIVERY TYPE: C
 COMPLICATIONS: NONE
 BW GRAMS: 3005//
```

Figure 3-21: Example of using the BM mnemonic

3.5.23 Blood Pressure (BP)

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

```
MNEMONIC: BP BLOOD PRESSURE VALUE: 120/80
```

Figure 3-22: Sample of entering blood pressure measurements

3.5.24 Best Peak Flow (BPF)

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

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

Figure 3-23: Example of typing the BPF mnemonic

3.5.25 Blood Sugar (BS)

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

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

Figure 3-24: Example of typing mnemonics to order a glucose laboratory test

3.5.26 Blood Type Entry (BT)

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

```
MNEMONIC: BT BLOOD TYPE ENTRY
BLOOD TYPE: O+
```

Figure 3-25: Example of typing patient blood type

3.5.27 CBC Ordered (CBC)

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

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

Figure 3-26: Example of typing mnemonics to record the ordering of a CBC laboratory test

3.5.28 Chief Complaint (CC)

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

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

Figure 3-27: Example of using the CC mnemonic

3.5.29 Cardiac Ejection Fraction (CEF)

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

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

Figure 3-28: Example of using the CEF mnemonic

3.5.30 CHS–Outpatient Form (CHA)

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

Follow these steps:

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

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

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

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

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

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

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

3.5.31 Centimeter Head Circumference (CHC)

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

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

Figure 3-29: Example of typing mnemonics for centimeter head circumference

3.5.32 CHS–Hospitalization Form (CHH)

Use the Hospitalization Form (CHH) mnemonic to type contract healthcare hospitalization data from the HRSA 43-CHS PO for Hospital Services Rendered (for visit-related-only encounters). In order to use the CHH mnemonic Contract as the

visit type and Hospital as the service category must be selected. If Contract and Hospital have not been selected, a warning message displays indicating that the values need to change.

Follow these steps:

1. At the "Authorizing facility" prompt, type the facility name.

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

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

4. At the "Date of Discharge" prompt, type the date of discharge

5. At the "Discharge Type" prompt, type one of the following:

   - 1–Discharge

   - 2–Irregular Discharge

   - 3–Died within 48 hours

   - 4–Died after 48 hours

   - 5–Transferred

6. After typing the discharge type the following prompts display: "Newborn Diagnosis" and "Stillborn." Type data in these fields, if applicable; or press ENTER to bypass them.

7. At the "Total Charges" prompt, specify the dollar amount, if known.

8. At the "Pay Status" prompt, indicate whether the pay status is full pay or partial pay.

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

3.5.33   CHS–In-Hospital Form (CHI)

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

Follow these steps:

1. At the "Authorizing facility" prompt, type the facility name.

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

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

4. At the "Vendor" prompt, type the name of the contract service provider.

5. At the "Hospital Voucher No." prompt, type the hospital voucher number, if any, using 10 to 15 characters in length.

6. At the "Number of Visits" prompt, type the appropriate value.

7. At the "Total charges" prompt, type the dollar amount, if known.

8. At the Pay Status, indicate whether the pay status is full pay or partial pay.

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

3.5.34   Centimeter Height (CHT)

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

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

Figure 3-30: Example of typing mnemonics for height measurement in centimeters

3.5.35   Check Out Date and Time (CKO)

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

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

```
APPOINTMENT LENGTH: 30//
```

Figure 3-31: Example of entering mnemonics for checkout information

3.5.36   Clinic Type (CL)

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

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

Figure 3-32: Example of entering mnemonics for clinic types

3.5.37   Coded Chief Complaint (COC)

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

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

Figure 3-33: Example of using COC mnemonic

3.5.38   Coding Guidelines Display (CODE)

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

```
OUTPUT BROWSER       Feb 09, 2009 14:18:47    Page: 1 of 7


NAME: IHSCODINGGUIDELINES
 TEXT:

   Official Coding Guidelines
   Coding Clinic for ICD-9-CM

   1. General Coding Guidelines

 Use of Both Alphabetic Index and Tabular List

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

+     Enter ?? for more actions    >>>
```

```
+  NEXT SCREEN    -  PREVIOUS SCREEN   Q  QUIT
Select Action: +//
```

Figure 3-34: Example using the CODE mnemonic

At the "Select Action" prompt, do one of the following:

- Type **Q** (Quit) to quit the screen.

- Type a plus sign (+) to display the next screen. This option is not available for the last screen.

- Type a minus sign (–) to display the previous screen. This option is not available for the first screen.

3.5.39 CPT Codes with Entry of Encounter Provider (CPE)

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

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

Figure 3-35: Example of entering mnemonics for CPT codes

3.5.40 CPT Codes (CPT)

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

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

The following word was not used in this search:
    OF

The following 2 matches were found:

1: 50360 (50360)
```

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

Press <RET> or Select 1-2: 1

QUANTITY: 1
Enter CPT code:
```

Figure 3-36: Example of entering CPT codes

3.5.41   CRAFFT (CRFT)

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

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

Figure 3-37: Example of using the CRFT mnemonic

3.5.42   CAN TRAN CODE ENTRY (CTC)

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

3.5.43   CAN TRAN CODE ENTRY TE (CTE)

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

3.5.44   Cervix Dilation (CXD)

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

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

```
VALUE: 3
```

Figure 3-38: Example of using the CXD mnemonic

3.5.45   Disposition of Care (DC)

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

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

Figure 3-39: Example of using the DC mnemonic

3.5.46   Dental–Direct Services (DDS)

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

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

```
MNEMONIC: DDS Dental Direct Service ALLOWED  VISIT-RELATED-ONLY
Select V PROVIDER: BLACK,HAROLD C      DENTIST  IHS   207   152207
Select V DENTAL SERVICE CODE: 2330 COMPOSITE RESIN, ONE SURFACE,
ANTERIOR
 QUANTITY: 1

 OPERATIVE SITE:

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

Figure 3-40: Example of entering mnemonic for dental data

3.5.47   Data Entry Health Summary (DHS)

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

```
MNEMONIC: DHS Data Entry Health Summary ALLOWED NON-VISIT/VISIT
MNEMONIC ...SORRY, LET ME PUT YOU ON 'HOLD' FOR A SECOND...

OUTPUT BROWSER       Jun 18, 1997 08:07:09    Page: 1 of 9 PCC
Health Summary for SMITH,GRANT

******* CONFIDENTIAL PATIENT INFORMATION -- JUN 18,1997 8:07 AM [CC]
****** ************* SMITH,GRANT 100243 (ADULT REGULAR SUMMARY) pg 1
************

--------------------- DEMOGRAPHIC DATA ------------------------
SMITH,GRANT            DOB: JUL 2,1957 39 YRS MALE no blood type
TOHONO O'ODHAM NATION, OF, ARIZON SSN: 007-30-0073
                MOTHER'S MAIDEN NAME: MARTIN,MARY ELLEN
(H) 602-555-0073        FATHER'S NAME: SMITH,DOUGLAS
BIG FIELDS (55 5TH ST.,SAFFORD,AZ,88776)

LAST UPDATED: MAR 28,1997    ELIGIBILITY: CHS & DIRECT
HEALTH RECORD NUMBERS: 100241 PHOENIX HOSP
        100242 IHS IID
        100243 SELLS HOSPITAL/CLINIC
        100244 SAN XAVIER HEALTH CENTER

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

Figure 3-41: Example of entering mnemonic for Health Summary from within the Data Entry system

3.5.48   Visit Display (DISP)

Use the Visit Display (DISP) mnemonic to display all data that has been typed for a patient for the visit with which the user is working (for non-visit- or visit-related encounters). Brief patient demographics display along with the Visit file. Note that historical and non-visit related entries do not display in the active visit file. To browse through the information, use the commands listed at the bottom of the screen.

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

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

Patient Name:       RHORHO,BRANDY
Chart :           100105
Date of Birth:      SEP 05, 1949
Sex:          F
=============== VISIT FILE ===============
VISIT/ADMIT DATE&TIME: JUN 14, 1997@15:21
DATE VISIT CREATED:    JUN 18, 1997
TYPE:          IHS
PATIENT NAME:       RHORHO,BRANDY
LOC. OF ENCOUNTER:    SELLS HOSPITAL/CLINIC
SERVICE CATEGORY:     AMBULATORY
CLINIC:          GENERAL
```

```
DEPENDENT ENTRY COUNT:   5
DATE LAST MODIFIED:     JUN 18, 1997
WALK IN/APPT:        UNSPECIFIED
CREATED BY USER:        CHVATAL,CHRISTINE


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

Figure 3-42: Example of a visit display screen

3.5.49   Designated Provider (DP)

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

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

Figure 3-43: Example of capturing a provider name with the DP mnemonic

3.5.50   DRG (DRG)

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

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

Figure 3-44: Example of using the DRG mnemonic

3.5.51   Diagnostic Procedure Tran Code (DTC)

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

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

Figure 3-45: Example of typing mnemonic for Chargemaster transaction codes

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

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

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

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

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

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

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

Figure 3-46: Example of appending an E code

3.5.55   Edema Measurement (ED)

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

```
MNEMONIC: ED EDEMA Measurement ALLOWED VISIT-RELATED-ONLY
VALUE: 1+
```

Figure 3-47: Example of typing mnemonic for edema measurement

3.5.56   Expected Date of Confinement (EDC)

Use the Expected Date of Confinement (EDC) mnemonic to capture the expected date of confinement for non-visit- or visit-related encounters. The user will be prompted to confirm the patient's name, type a confinement date, and the determination method. The choices for how the EDC was determined are shown as follows:

- 0: Unknown Method

- 1: Sonogram

- 2: Dates

- 3: Clinical Parameters

```
MNEMONIC: EDC Expected Date of Confinement ALLOWED NON-VISIT/VISIT
MNEMONIC
 NAME: SIGMA,JANE//
 EDC: MAR 12,2008//
 HOW EDC DETERMINED: CLINICAL PARAMETERS//
```

Figure 3-48: Example of using the EDC mnemonic

3.5.57   Effacement (EFF)

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

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

Figure 3-49: Example of typing EFF mnemonic to record effacement

3.5.58   EKG Diagnostic Procedure (EKG)

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

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

Figure 3-50: Example of typing EKG mnemonic to record procedures

3.5.59   Elder Care (EL)

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

```
MNEMONIC: EL    Elder Care   ALLOWED   VISIT-RELATED-ONLY
 TOILETING: I INDEPENDENT
 BATHING: I INDEPENDENT
 DRESSING: I INDEPENDENT
 TRANSFERS: I INDEPENDENT
 FEEDING: I INDEPENDENT
 CONTINENCE: I INDEPENDENT
```

```
FINANCES: N NEEDS HELP
COOKING: N NEEDS HELP
SHOPPING: N NEEDS HELP
HOUSEWORK/CHORES: N NEEDS HELP
MEDICATIONS: N NEEDS HELP
TRANSPORTATION: N NEEDS HELP
CHANGE IN FUNCTIONAL STATUS: S SAME
IS PATIENT A CAREGIVER: N NO
```

Figure 3-51: List of Elder Care data elements

3.5.60 Evaluation and Management (CPT) (EM)

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

```
MNEMONIC: EM  Evaluation&Management (CPT) ALLOWED VISIT-RELATED-
ONLY EVALUATION AND MANAGEMENT CODE: 99201      OFFICE/OUTPATIENT
VISIT, NEW
OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT
OF
A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A PROBLEM
 ...OK? Yes//  (Yes)
```

Figure 3-52: Example of using the EM mnemonic to capture an Evaluation and Management CPT

3.5.61 Emergency Visit Record (EVR)

This mnemonic is not used by all sites.

3.5.62 Emergency Room Visit Record (ER)

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

Follow these steps:

1. At the "Urgency" prompt, type one of the following:

   - E–Emergent

   - U–Urgent

   - N–Non Emergent

2. At the "Means of Arrival" prompt, type one of the following:

- A–Ambulance
- P–Police
- POV–POV
- T–Taxi
- W–Walked
- O–Other
- R–Air
- M–Medivac from village

3. At the "Enter ER by" prompt, type one of the following:

- A–Ambulatory
- W–Wheelchair
- C–Carried

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

5. At the "Notified" prompt, type one of the following:

- R–Relative
- P–Police
- C–Coroner

6. At the "Disposition of Care" prompt, type one of the following:

- A–Admit
- T–Transfer
- D–Discharge
- O–Other
- M–Medivac Transfer
- L–Lifeguard
- E–Died/Expired
- L–Left AMA

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

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

3.5.63   Examinations (EX)

Use the Examinations (EX) mnemonic to record the type of exam performed during a patient visit (for visit-related-only encounters). The specific results of the exam are not recorded, but a choice of Normal or Abnormal can be typed. Some of the exam types are reported in the Health Summary in the Health Maintenance Reminders component, along with the date on which the exam was performed and a due date for the next exam. The following list shows available exam types.

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

The following is an example of using the EX mnemonic:

```
MNEMONIC: EX     Examinations    ALLOWED    VISIT-RELATED-ONLY
Select V EXAM: 05 NECK EXAM    05
 RESULT: N NORMAL/NEGATIVE
 COMMENTS:
 PROVIDER PERFORMING EXAM: SIGMA,JOHN
```

Figure 3-53: Example of using the EX mnemonic

3.5.64   24-Hour Fluid Balance, Positive/Negative (FBPN)

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

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

  VALUE: 2000
```

Figure 3-54: Example of using the FBPN mnemonic

3.5.65   FEF 25-75 (FEF)

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

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

Figure 3-55: Example of using the FEF mnemonic

3.5.66   Fundal Height (FH)

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

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

Figure 3-56: Sample of entering FH mnemonic

3.5.67   Family History (FHX)

Use the FHX mnemonic to type medical data concerning family members that can be pertinent to the patient's healthcare (for visit-related-only encounters). Family History does not allow a duplicate relation to be entered. The user can type either a complete or partial V code or the related ICD Narrative. The health history is restricted to the V16*, V17*, V18*, and V19* ICD codes.

```
MNEMONIC: FHX  Family History   ALLOWED   NON-VISIT/VISIT

Add/Edit Family History   Jun 18, 2008 12:31:26    Page: 1 of 2

Name: LASTNAME,FIRST M DOB: JUL 13, 19 Sex: F HRN:

1) Aug 24, 2006 Relation: UNKNOWN        Status:
   Dx: V16.3 FAMILY HX OF BREAST CANCER-MAT AUNTS
   Age at Onset: Age Unknown
2) Aug 24, 2006 Relation: UNKNOWN         Status:
   Dx: V16.49 FAMILY HX OF CERVICAL CANCER
```

```
  Age at Onset: Age Unknown
3) Aug 24, 2006 Relation: UNKNOWN          Status:
  Dx: V18.0 FAMILY HX OF DM-SIBLINGS
  Age at Onset: Age Unknown
4) Jul 31, 2001 Relation: UNKNOWN          Status:
  Dx: 414.9 CAD
  Age at Onset: Age Unknown


    Q - Quit/?? for more actions/+ next/- previous

A  Add Family Hx    X  Delete Family Hx   Q  Quit
E  Edit Family Hx    HS  Health Summary

Select Action: +// A  Add Family Hx
```

Figure 3-57: Example of using FHX mnemonic

At the "Select Action" prompt, do one of the following:

- Type **Q** (Quit) to quit the screen.

- Type a plus sign (+) to display the next screen. This option is not available for the last screen.

- Type a minus sign (–) to display the previous screen. This option is not available for the first screen.

The following actions are available on the FHX screen:

- Type **A** (Add Family HX) to add a family relation type.

- Type **E** (Edit Facility Hx) to edit an existing family relation type.

- Type **X** (Delete Facility Hx) to remove an existing family relation type.

- Type **HS** (Health Summary) to display a Health Summary for a specified patient.

- Type **Q** (Quit) to exit the screen.

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

```
Enter Relation: Father (Biological)
RELATION DESCRIPTION:
STATUS: ??
   Choose from:
    L    LIVING
    D    DECEASED
    U    UNKNOWN
    R    PT REFUSED TO ANSWER

STATUS: D DECEASED

AGE AT DEATH: ?
   I - In Infancy
   1 - Before age 20
   2 - At age 20-29
```

```
    3 - At age 30-39
    4 - At age 40-49
    5 - At age 50-59
    6 - 60 and older
    U - Age Unknown
AGE AT DEATH: 4 At age 40-49
CAUSE OF DEATH: ?
    Enter a brief description of this family member's cause of death.
CAUSE OF DEATH: HEART DISEASE

MULTIPLE BIRTH?: Y YES
MULTIPLE BIRTH TYPE: T
    1  TWIN, UNSPECIFIED
    2  TRIPLET
Choose 1-2: ??
    Select the type of multiple birth for the family member.
    Choose from:
     TU     TWIN, UNSPECIFIED
     IT     IDENTICAL TWIN
     FT     FRATERNAL TWIN
     TR     TRIPLET
     OTH    OTHER MULTIPLE
MULTIPLE BIRTH TYPE: IT IDENTICAL TWIN
```

Figure 3-58: Example of adding data about a relation

To add data for the first condition for this relation:

```
Add a Condition for FATHER (BIOLOGICAL) ? Y// ES

Enter Condition: V17
    1  V17.0    FAM HX-PSYCHIATRIC COND
    2  V17.1    FAMILY HX-STROKE
    3  V17.2    FAM HX-NEUROLOG DIS NEC
    4  V17.3    FAM HX-ISCHEM HEART DIS
    5  V17.41   FAM HIST SUDDEN CARDIA DEATH
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 2 V17.1   FAMILY HX-STROKE


PROVIDER NARRATIVE: STROKE TEST NARRATIVE

PROVIDER: PROVIDER,MARY S

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

```
Family History added.
```

Figure 3-59: Example of typing data for the first condition for this relation

To add data for a second condition for this relation, if any:

```
Add Another Condition for FATHER (BIOLOGICAL) ? N// Y YES

Enter Condition: ?
   1  V19.0    FAMILY HX-BLINDNESS
   2  V19.1    FAMILY HX-EYE DISORD NEC
   3  V19.2    FAMILY HX-DEAFNESS
   4  V19.3    FAMILY HX-EAR DISORD NEC
   5  V19.4    FAMILY HX-SKIN CONDITION
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 5 V19.4   FAMILY HX-SKIN CONDITION
PROVIDER NARRATIVE:  FAMILY HX-SKIN CONDITION FAMILY HX-SKIN
CONDITION
PROVIDER:
AGE AT ONSET:?
     I  In Infancy
     1  Before age 20
     2  At age 20-29
     3  At age 30-39
     4  At age 40-49
     5  At age 50-59
     6  60 and older
     U  Age Unknown
AGE AT ONSET:

Family History added.

Add Another Condition for FATHER (BIOLOGICAL)? N// NO
```

Figure 3-60: Example of adding data for a second condition for this relation

```
Add/Edit Family History   Jun 18, 2008 12:31:26   Page: 1 of 2

Name: LASTNAME,FIRST M DOB: JUL 13, 19 Sex: F HRN:

1) Jun 18, 2008 Relation: FATHER (BIOLOGICAL)  Status: UNKNOWN
  Multiple Birth: UNKNOWN
  Dx: V17.1 Stroke Test Narrative
  Age at Onset: 60 and older
  Provider who Documented: PROVIDER,MARY S
2) Jun 18, 2008 Relation: FATHER (BIOLOGICAL)  Status: UNKNOWN
  Multiple Birth: UNKNOWN
  Dx: V19.4 FAMILY HX-SKIN CONDITION
  Age at Onset:
3) Aug 24, 2006 Relation: UNKNOWN        Status:
  Dx: V16.3 FAMILY HX OF BREAST CANCER-MAT AUNTS
  Age at Onset: Age Unknown
4) Aug 24, 2006 Relation: UNKNOWN        Status:
```

```
  Dx: V16.49 FAMILY HX OF CERVICAL CANCER
  Age at Onset: Age Unknown
5) Aug 24, 2006 Relation: UNKNOWN        Status:
  Dx: V18.0 FAMILY HX OF DM-SIBLINGS


+    Q - Quit/?? for more actions/+ next/- previous
A  Add Family Hx    X  Delete Family Hx   Q   Quit
E  Edit Family Hx    HS  Health Summary25h

Select Action: +//
```

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

3.5.68   24-Hour Fluid Input (FI24)

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

```
MNEMONIC: FI24     24 HOUR FLUID INPUT    ALLOWED    VISIT RELATED ONLY

 VALUE: 5000
```

Figure 3-62: Example of using FI24 mnemonic

3.5.69   Flag Field (FL)

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

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

Figure 3-63: Example of typing FL mnemonic

3.5.70   Family Planning Method (FM)

Use the Family Planning Method (FM) mnemonic to type the family planning method (only) for non-visit- or visit-related encounters. To type additional female reproductive factors, use the FP mnemonic. The user will be prompted to confirm the patient's name then type the contraception method and date begun, if known. For a list of methods that can be entered, see the description of the FP mnemonic that follows.

```
MNEMONIC: FM Family Planning Method ALLOWED NON-VISIT/VISIT MNEMONIC
NAME: MPATIENT,ANITA//
CONTRACEPTION METHOD: 11 HORMONE INJECTION
CONTRACEPTION BEGUN: JAN 1995 (JAN 1995)
```

Figure 3-64: Example of typing FM mnemonic

3.5.71   24-Hour Fluid Output (FO24)

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

```
MNEMONIC: FO24     24 HOUR FLUID INPUT    ALLOWED    VISIT RELATED ONLY

 VALUE: 3000
```

Figure 3-65: Example of using FO24 mnemonic

3.5.72   Family Planning (FP)

Use the Family Planning (FP) mnemonic to capture female reproductive factors and family planning data for non-visit- or visit-related encounters. The reproductive factors include Last Menstrual Period (LMP), Family Planning (FP) Method, and Date Begun for that method.

The reproductive history is typed in the following fields:

- Gravida (number of pregnancies)
- Full Term Births
- Premature Births
- Therapeutic Abortions (TA)
- Spontaneous Abortions (SA)
- Ectopic Pregnancies
- Multiple Births
- Living Children
- Last Menstrual Period
- EDC
- How EDC Determined
- Contraceptive Method
- Contraception Begun

The "EDC" and "EDC Determined" prompts can be bypassed by pressing ENTER, as needed. If typing data into these fields, type a date at the "EDC" prompt and then select one of the following choices for entry in the "How EDC Determined" field:

- 0–Unknown METHOD

- 1–Sonogram

- 2–Dates

- 3– Clinical Parameters

When typing the type of contraception currently used, choose from the list below. Type the choice by code or by name.

Code	Meaning
0	Education Only
1	Oral Contraceptives
2	Intrauterine Device (IUD)
3	Surgical Sterilization
4	Barrier Methods
5	Partner Sterilized
6	Natural Techniques
7	Menopause
8	None
9	Other
10	Hormonal Implant
11	Hormone Injection
12	Abstinence

The following shows an example of typing the FP mnemonic:

```
MNEMONIC: FP     Family Planning   ALLOWED    NON-VISIT/VISIT MNEMONIC
GRAVIDA: 5//
FULL TERM BIRTHS: 3//
PREMATURE BIRTHS: 0//
THERAPEUTIC ABORTIONS (TA): 0//
SPONTANEOUS ABORTIONS (SA): 0//
ECTOPIC PREGNANCIES: 2//
MULTIPLE BIRTHS: 3//
LIVING CHILDREN: 1//
LAST MENSTRUAL PERIOD: JUN 1,2007//
EDC: MAR 12,2008//
HOW EDC DETERMINED: CLINICAL PARAMETERS//
CONTRACEPTIVE METHOD: ORAL CONTRACEPTIVES//
```

```
CONTRACEPTION BEGUN:
```

Figure 3-66: Example of typing FP mnemonic

3.5.73   Future Scheduled Encounter

This mnemonic is not used by all sites.

3.5.74   Fetal Heart Tones (FT)

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

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

Figure 3-67: Example of typing FT mnemonic

3.5.75   FEV1/FVC (FVFC)

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

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

Figure 3-68: Example of using the FVFC mnemonic

3.5.76   Generate Health Summary (GHS)

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

3.5.77   Eyeglass Prescription (GP)

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

```
      Sphere    Cylinder     Axis
RX)  +1.25     -2.50       X5      for the right eye
     +1.50     -3.50       X175    for the left eye
Frame Consensus BLSL 50/22/5-1/4
Add)  +1.00 +0.50    (This is a trifocal reading
      -0.75 -0.30     and will not be entered.)    P.D. 6059
```

Figure 3-69: Example of a complete prescription

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

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

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

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

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

- **Sphere**: A number between -28.00 and +16.00, include the + or – or plano

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

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

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

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

- **Pup. Dist**.: A whole number between 40 and 80

```
MNEMONIC:     GP       Eyeglass Prescription ALLOWED VISIT-RELATED-
ONLY
READING ONLY:  NO
DRE SPHERE:   +1.25
DRE CYLINDER: -2.50
RE AXIS:      5
RE PRISM:     5 BD
DLE SPHERE:   +1.50
DLE CYLINDER: -3.50
LE AXIS:      175
```

```
LE PRISM:    5 BD
READING ADD.   R: 1.00
READING ADD.   L: .75
PUP.  DIST.  FAR:  59
PUP.  DIST.  NEAR:  60
```

Figure 3-70: Example of entering GP mnemonic

3.5.78 Gram Weight (GWT)

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

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

Figure 3-71: Example of entering GWT mnemonic

3.5.79 Historical ADA Code Entry (HADA)

Use the Historical ADA Code Entry (HADA) mnemonic to type historical ADA information (for non-visit- or visit-related encounters).

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

Figure 3-72: Example of typing HADA mnemonic

3.5.80 Historical Barium Enema (HBE)

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

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

```
Updating V CPT file...


   QUANTITY: 1
```

Figure 3-73: Example of typing HBE mnemonic

3.5.81   Historical Blood Sugar Entry (HBS)

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

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

Figure 3-74: Example of entering HBS mnemonic

3.5.82   Head Circumference (HC)

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

```
MNEMONIC: HC VALUE: 15
```

Figure 3-75: Example of entering HC mnemonic

3.5.83   Historical CBC Entry (HCBC)

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

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

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

Figure 3-76: Example of typing HCBC mnemonic

3.5.84 Historical Colonoscopy (HCOL)

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

```
MNEMONIC: HCOL  Historical Colonoscopy ALLOWED  NON-VISIT/VISIT
MNEMONIC
Enter Date of Historical COLONOSCOPY: T-30 (FEB 05, 2008) (FEB 05,
2008@12:00)
PATIENT: SIGMA,JANE has one or more VISITs on this date.
1 TIME: 08:00 LOC: DH  TYPE: I CAT: S CLINIC: <NONE>  DEC: 5
Select one: 1
 COLONOSCOPY PROVIDER NARRATIVE: NONE NONE
```

Figure 3-77: Example of typing HCOL mnemonic

3.5.85 Historical CPT (HCPT)

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

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

Figure 3-78: Example of entering HCPT mnemonic

3.5.86 20 Hematocrit Ordered (HCT)

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

```
MNEMONIC: HCT  20 Hematocrit Ordered ALLOWED  VISIT-RELATED-ONLY
```

Figure 3-79: Example of entering HCT mnemonic

3.5.87   Hearing (HE)

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

```
MNEMONIC:  HE
VALUE:     N
```

Figure 3-80: Example of typing HE mnemonic

3.5.88   Historical EKG (HEKG)

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

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

Figure 3-81: Example of typing HEKG mnemonic

3.5.89   Historical Examination (HEX)

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

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

ENCOUNTER PROVIDER: SIGMA,JOHN
```

Figure 3-82: Example of typing HEX mnemonic

3.5.90   Health Factors (HF)

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

Below is a list of the available health factor categories:

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

The choices for the "Level/Severity" prompt are:

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

```
MNEMONIC: HF
     1   HF        Health Factors     ALLOWED     VISIT RELATED ONLY
     2   HFOB        Historical FOBT (GUAIAC)      ALLOWED      NON-
VISIT/VISIT MNEMONIC
CHOOSE 1-2: 1  HF     Health Factors     ALLOWED     VISIT RELATED
ONLY

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

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

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

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

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

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

Figure 3-83: Example of typing HF mnemonic

3.5.91   Historical FOBT (GUAIAC) (HFOB)

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

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

Figure 3-84: Example of typing HFOB mnemonic

3.5.92   Historical Hematocrit (HHCT)

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

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

Figure 3-85: Example of entering HHCT mnemonic

3.5.93   Historical Health Factor (HHF)

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

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

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

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

Enter HEALTH Factor: READINESS
   1  READINESS TO LEARN-NOT READY
   2  READINESS TO LEARN-PAIN
   3  READINESS TO LEARN-RECEPTIVE
   4  READINESS TO LEARN-SEVERITY OF ILLNESS
   5  READINESS TO LEARN-UNRECEPTIVE
CHOOSE 1-5: 3 READINESS TO LEARN-RECEPTIVE
 LEVEL/SEVERITY: ??
   Choose from:
    M    MINIMAL
    MO    MODERATE
    H    HEAVY/SEVERE
 LEVEL/SEVERITY: MO MODERATE
 PROVIDER: SIGMA,JANE
 QUANTITY: 1
```

Figure 3-86: Example of typing HHF mnemonic

3.5.94   Historical Immunizations (HIM)

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

- Date of Immunization (the month and year if the exact date is not available)

- Immunization Type, Series (for OPV and DPT)

- Name of the facility where the immunization was administered, if known.

To modify or correct a historical immunization, switch to Modify (MOD) mode and then use the HIM mnemonic.

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

Figure 3-87: Example of modifying a mnemonic

3.5.95   Hospital Location (HL)

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

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

Figure 3-88: Example of using the HL mnemonic

3.5.96   Historical Lab Test (HLAB)

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

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

Figure 3-89: Example of typing the HLAB mnemonic

3.5.97 Health Status (HLST)

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

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

Figure 3-90: Example of using the HLST mnemonic

3.5.98 Historical Measurement (HMSR)

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

```
MNEMONIC: HMSR  Historical Measurement  ALLOWED  NON-VISIT/VISIT
MNEMONIC

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

Figure 3-91: Example of typing the HMSR mnemonic

3.5.99 Historical Pap Smear (HPAP)

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

```
MNEMONIC: HPAP   Historical PAP Smear   ALLOWED  NON-VISIT/VISIT
MNEMONIC
PAP SMEAR RESULTS
Patient Name: SIGMA,JANE      Patient Age:  28.6 years
Date/Time of Visit        Pap Smear Result
--------------------------------
APR 02, 2007@12:00        WNL
Enter Date of Historical PAP SMEAR: APR 02, 2006
TYPE: I// IHS
Select LOCATION NAME: DEMO
Select V LAB LAB TEST: PAP SMEAR, CONVENTIONAL
 RESULTS: N
```

Figure 3-92: Example of typing the HPAP mnemonic

3.5.100 Historical Radiology (HRAD)

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

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

ABNORMAL: A  ABNORMAL
Enter RADIOLOGY PROCEDURE Type:
```

Figure 3-93: Example of using the HRAD mnemonic

3.5.101 Historical RX (HRX)

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

```
MNEMONIC: HRX  Historical RX  ALLOWED   NON-VISIT/VISIT MNEMONIC
Enter Date of Historical Medication: T-7 (NOV 22, 2007@12:00)
TYPE: I// IHS
Select LOCATION NAME: DEMO HOSPITAL
Enter MEDICATION: OUTSIDE DRUG
NAME OF NON-TABLE DRUG: MODURETIC 25MG TAB
SIG: T1TD AT BEDTIME
```

```
QUANTITY: 90
DAYS PRESCRIBED: 90
DATE DISCONTINUED:
DATE DISPENSED (IF KNOWN): T-7
OUTSIDE PROVIDER NAME: DR. GAMMA
```

Figure 3-94: Example of typing the HRX mnemonic

3.5.102 Historical Skin Test (HS)

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

- Date of skin test(s) reading

- Skin test type; for example, PPD, Cocci, etc.

- Readings and/or result

- Facility name where the skin test was read, if known

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

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

Figure 3-95: Example of typing the HS mnemonic

3.5.103 Historical Sigmoidoscopy (HSIG)

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

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

Figure 3-96: Example of typing the HSIG mnemonic

3.5.104 Height (HT)

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

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

Figure 3-97: Example of typing the HT mnemonic

3.5.105 Historical UA (HUA)

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

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

Figure 3-98: Example of typing the HUA mnemonic

3.5.106 Infant Feeding Choices (IF)

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

- 1–Exclusive breastfeeding

- 2–Mostly breastfeeding

- 3–½ formula and ½ breast

- 4–Mostly formula

- 5–Formula only

```
MNEMONIC: IF    Infant Feeding Choices   ALLOWED    VISIT-RELATED-
ONLY
Enter FEEDING CHOICE: 4 (4  MOSTLY FORMULA)
```

Figure 3-99: Example of typing the IF mnemonic

3.5.107 In-Hospital Immunization Entry (IIM)

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

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

Figure 3-100: Example of using the IIM mnemonic

3.5.108 Immunizations (IM)

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

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

Figure 3-101: Example of typing the IM mnemonic

3.5.109 ICD Operation Narrative (IOP)

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

```
MNEMONIC: IOP  ICD Operation Narrative   ALLOWED   VISIT-RELATED-
ONLY
```

```
This is the MNEMONIC which will automatically stuff the ICD
Operation
Narrative into the Provider Narrative field!

Enter OPERATION/PROCEDURE: 10.32 10.32 DESTRUCT CONJUNC LES NEC
DESTRUC
TION OF LESION OF CONJUNCTIVA
...OK? Yes// (Yes)
OPERATING PROVIDER: SMITH,CARL R
  DIAGNOSIS: 873.50     OPEN WND FACE NOS-COMPL
...OK? Yes// (Yes)
```

Figure 3-102: Example of typing the IOP mnemonic

3.5.110 Hospitalization Information (IP)

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

Admission type:

- Direct Admission 1

- Trans-Non IHS Hospital Admission 2

- Trans-IHS Hospital Admission 3

- Referred From IHS Clinic Admission 4

- Other Admission 5

Admitting Service/Discharge Service	Mnemonic	
• Alcoholism	Al	15
• Dental	Den	01
• Dental Observation	Deno	01o
• ENT	Ent	02
• ENT Observation	Ento	02o
• Family Practice	Fam	17
• Family Practice Observation	Fampo	17o
• General Medicine	Gms	03
• GYN Observation	Gyno	05o
• Gynecology	Gyn	05

Admitting Service/Discharge Service	Mnemonic
• Internal Med Observation	Imedo 06o
• Internal Medicine	Int 06
• Medicine Observation	Medo 03o
• Mental Health	Men 12
• Mental Health Observation	Mho 12o
• Neurology	Neuro 20
• Neurology Observation	Neuob 20o
• Neuropsychiatric	Np 00
• Newborn	Nb 07
• Nurse-Midwifery Observation	Nrsob 22o
• Nurse-Midwifery Service	Nrsse 22
• Obstetrics	Ob 08
• Obstetrics Observation	Obo 08o
• Ophthalmology	Eye 09
• Ophthalmology Observation	Eyeo 09o
• Orthopedics	Ort 10
• Orthopedics Observation	Orto 10o
• Other	Hosp 14
• Pediatrics	Ped 11
• Pediatrics Observation	Pedo 11o
• Plastic Surgery	Psur 16
• Plastic Surgery Observation	Psuro 16o
• Podiatry	Pod 19
• Podiatry Observation	Podo 19o
• Substance Abuse Observation	Alcoo 15o
• Surgery	Sur 04
• Surgery Observation	Suro 04o
• Swing Bed	Swi 21
• TB	Tb 13

Admitting Service/Discharge Service	Mnemonic	
• Tuberculosis Observation	Tbo	13o
• Urology	Uro	18
• Urology Observation	Uroo	18o

Discharge Type	Mnemonic		
• Regular Discharge	Discharge	Active	1
• Transferred	Discharge	Active	2
• Irregular Discharge	Discharge	Active	3
• Death W/I 48 Hrs W Autopsy	Discharge	Active	4
• Death W/I 48 Hrs W/O Autopsy	Discharge	Active	5
• Death After 48 Hrs W Autopsy	Discharge	Active	6
• Death After 48 Hrs W/O Autopsy	Discharge	Active	7

```
MNEMONIC: IP
1 IP  Hospitalization Information  ALLOWED  VISIT-RELATED-ONLY
2 IPO  Inactivate a Problem  ALLOWED   NON-VISIT/VISIT MNEMONIC
3 IPV  ICD Narrative Purpose of Visit ALLOWED  VISIT-RELATED-ONLY
CHOOSE 1-3: 1
Enter Date of Discharge: T-1 (JUN 11, 1997) JUN 11, 1997

ADMISSION TYPE: 1  DIRECT  ADMISSION  1
ADMITTING SERVICE: INTERNAL MEDICINE  06
DISCHARGE TYPE: REGULAR DISCHARGE     DISCHARGE 1
NUMBER OF CONSULTS: 3
ADMITTING DX: DIABETIC NEPHRITIS ( DIABETIC|DIABETES NEPHRITIS )

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

OK? Y//
```

Figure 3-103: Example of using the IP mnemonic

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

3.5.111 Inactive Problem (IPO)

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

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

```
MNEMONIC: IPO       Inactivate a Problem     ALLOWED      NON-
VISIT/VISIT MNEMONIC
Problem List Reviewed On:                              By:
Problem List Updated On:              Nov 02, 2010   By:
ADPROVIDER,RAY
No Active Problems Documented On:                     By:
*****************  ACTIVE PROBLEMS AND NOTES  ********************
  CI1        11/02/2010   TESTING PROBLEM NOTES  (ONSET: 11/02/2010)
  CI2        11/02/2010   NONE  (ONSET: 11/02/2010)
  CI3        11/02/2010   TESTING
  CI3CI1     11/02/2010   TEST
  CI4        11/02/2010   TESTING PO  (ONSET: 11/02/2010)
  CI4CI1     11/02/2010   TEST

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

Enter Problem Number: CI4

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

Figure 3-104: Example of using the IPO mnemonic

3.5.112 ICD Narrative Purpose of Visit (IPV)

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

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

Enter PURPOSE of VISIT: DIABETES MELLITUS
```

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

Figure 3-105: Example of using the IPV mnemonic

3.5.113 Kilogram Weight (KWT)

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

```
MNEMONIC: KWT Kilogram Weight  ALLOWED  VISIT-RELATED-ONLY
VALUE: 125
```

Figure 3-106: Example of using the KWT mnemonic

3.5.114 Lab Test (LAB)

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

```
MNEMONIC: LAB  Lab Test  ALLOWED  VISIT-RELATED-ONLY
Enter LAB TEST: CREATININE
1   CREATININE
2   CREATININE CLEARANCE
3   CREATININE, FLUID
CHOOSE 1-3: 1
RESULTS:
UNITS: 1
ABNORMAL: N
SITE:
Enter LAB TEST:
```

Figure 3-107: Example of using the LAB mnemonic

3.5.115 Line Item Entry for Billing (LI)

This mnemonic is not used by all sites.

3.5.116 Last Known Well (LKW)

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

Document the Date/Time Last Known Well as follows:

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

```
MNEMONIC: LKW      Last Known Well ALLOWED   VISIT RELATED ONLY
Enter date/time patient was last known to be without signs/symptoms
of current stroke.  When onset is witnessed, the last known well
is identical to time of symptoms onset.
  Date/Time Last Known Well: T@07:00
  ENCOUNTER PROVIDER: Test, Provider
```

Figure 3-107: Example of using the LKW mnemonic.

3.5.117 Last Menstrual Period (LMP)

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

```
MNEMONIC: LMP  Last Menstrual Period  ALLOWED NON-VISIT/VISIT
MNEMONIC
 NAME: SIGMA,TESS//
 LAST MENSTRUAL PERIOD: 6/12/07 (JUN 12, 2007)
```

Figure 3-108: Example of typing the LMP mnemonic

3.5.118 Level of Care (LOC)

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

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

```
Enter CPT Code: 71120   71120 X-RAY EXAM OF BREASTBONE
    RADIOLOGIC EXAMINATION; STERNUM, MINIMUM OF TWO VIEWS
      ...OK? Yes//

 PROVIDER NARRATIVE: NONE NONE
EVENT DATE AND TIME: T-20 (FEB 15, 2008)
ORDERING PROVIDER: SIGMA,JOHN
```

Figure 3-109: Example of typing the LOC mnemonic

3.5.119 Level of Service (LS)

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

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

```
MNEMONIC: LS  Level of Service   ALLOWED    VISIT-RELATED-ONLY
LEVEL OF SERVICE (PCC FORM): INTER   INTERMEDIATE
```

Figure 3-110: Example of typing the LS mnemonic

3.5.120 Measurement Entry (MEAS)

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

Measurement types are listed as follows:

Type	Description
ADM	Asthma Work/School Days Missed
AG	Abdominal Girth
AKBP	Ankle Blood Pressure
ASFD	Asthma Symptom Free Days
ASQF	ASQ - Fine Motor
ASQG	ASQ - Gross Motor
ASQL	ASQ - Language
ASQM	ASQ Questionnaire (Mos)
ASQP	ASQ - Problem Solving
ASQS	ASQ - Social

Type	Description
AUD	Audiometry
AUDC	Audit-C
AUDT	Audit
BP	Blood Pressure
BPF	Best Peak Flow
CEF	Cardiac Ejection Fraction
CRFT	CRAFFT
CXD	Cervix Dilatation
ED	Edema
EF	Effacement
FBPN	24-hour fluid balance, pos/neg
FEF	FEF 25-75
FH	Fundal Height
FI24	24-hour fluid intake
FO24	24-hour fluid output
FT	Fetal Heart Tones
FVFC	FEV1/FVC
HC	Head Circumference
HE	Hearing
HT	Height
LKW	Last Known Well
O2	O2 Saturation
PA	Pain
PF	Peak Flow
PHQ2	PHQ2
PHQ9	PHQ9
PR	Presentation
PU	Pulse
RS	Respirations
SN	Station (Pregnancy)
TMP	Temperature
TON	Tonometry
VC	Vision Corrected
VU	Vision Uncorrected
WC	Waist Circumference
WT	Weight

The following shows an example of using the MEAS mnemonic.

```
MNEMONIC: MEAS  Measurement Entry  ALLOWED  VISIT-RELATED-ONLY
Select V MEASUREMENT TYPE: BP  BLOOD PRESSURE
```

```
VALUE: 120/80
```

Figure 3-111: Example of using the MEAS mnemonic

3.5.121 Medication List Review (MLR)

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

```
MNEMONIC: MLR       Medication List Review    ALLOWED    VISIT RELATED
ONLY

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

Figure 3-112: Example of using the MLR mnemonic

3.5.122 Change Note Narrative (MNN)

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

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

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


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



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

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

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

Enter Problem Number: CI1
  Select NOTE FACILITY: 2010 DEMO HOSPITAL//
```

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

Figure 3-113: Example of using the MNN mnemonic

3.5.123 Switch to Modify Mode (MOD)

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

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

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

Figure 3-114: Example of using the MOD mnemonic

3.5.124 Modify Problem Narrative (MPO)

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

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

```
MNEMONIC: MPO        Correct/Modify Problem    ALLOWED    NON-VISIT/VISIT
MNEMO

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


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

  CI1      11/02/2010  TESTING PROBLEM NOTES  (ONSET: 11/02/2010)
  CI2      11/02/2010  NONE  (ONSET: 11/02/2010)
  CI3      11/02/2010  TESTING
  CI3CI1   11/02/2010  TEST
  CI4      11/02/2010  TESTING PO  (ONSET: 11/02/2010)
  CI4CI1   11/02/2010  TEST

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

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

Figure 3-115: Example of using the MPO mnemonic

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

```
Enter Problem Diagnosis: INJURY

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

 OK? Y//

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

Figure 3-116: Example of E Code prompts.

3.5.125 No Active Allergies (NAA)

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

```
MNEMONIC: NAA        No Active Allergies    ALLOWED    VISIT RELATED ONLY

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

Figure 3-117: Example of using the NAA mnemonic

3.5.126 No Active Medications (NAM)

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

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

This patient has active medications in their record.


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

Figure 3-118: Example of using the NAM mnemonic

3.5.127 No Active Problems (NAP)

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

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


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

Figure 3-119: Example of using the NAP mnemonic

3.5.128 Not Medically Indicated (NMI)

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

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

Figure 3-120: Example of using the NMI mnemonic

3.5.129 Note (NO)

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

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

```
MNEMONIC: NO      Note      ALLOWED     NON-VISIT/VISIT MNEMONIC


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


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

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

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

Enter Problem Number: CI1

Problem Number: CI1                     Diagnosis: 493.90

Add a new Problem Note for this Problem? N// YES

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


Enter the Date the Problem List was Updated by the Provider:  Nov
10, 2010//   (
NOV 10, 2010)
Enter the PROVIDER who Updated the Problem List: BLPROVIDER,DAVID
P// BLPROVIDER ,DAVID P

Problem Number: CI1                     Diagnosis: 493.90
Problem Notes:
     2010 DEMO HOSPITAL
          Note#1 11/10/2010 USE OF INHALER

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

Figure 3-121: Example of adding notes

3.5.130 No Response to Followup (NRF)

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

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

Figure 3-122: Example of using NRF mnemonic

3.5.131 Nutritional Risk Screening (NRS)

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

```
MNEMONIC: NRS    NUTRITIONAL RISK SCREENING    ALLOWED    VISIT
RELATED ONLY

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

Nutritional Risk Screening Factors
    - Age 70+

    - Nutrition Support
    - High Risk Weight Issue
    - High Risk Diagnosis
    - Poor Appetite
    - Difficulty Chewing
 Nutritional Risk (Low/High): H HIGH
 Nutritional Risk Comment:
 Recommend RD Referral (Yes/No): Y YES
 Referral Comment: REFER TO DR. SMITH
```

Figure 3-123: Example of Using Nutritional Risk Screening Mnemonic

3.5.132 Narrative Text (NT)

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

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

```
Enter Type of TEXT: CHIEF COMPLAINT
 TEXT:
 1>SORE THROAT
 2>
EDIT Option:
```

Figure 3-124: Example of using NT mnemonic

3.5.133 O2 Saturation (O2)

Use the O2 Saturation (O2) mnemonic to enter O_2 saturation levels for a patient for visit-related-only encounters. The range is a range between 50% and 100%.

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

Figure 3-125: Example of using O2 mnemonic

3.5.134 Offspring History (OHX)

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

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

Figure 3-126: Example of using OHX mnemonic

3.5.135 Outside Location (OLOC)

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

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

Figure 3-127: Example of using OLOC mnemonic

3.5.136 Operations (OP)

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

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

CARDIAC DYSRHYTHMIA, UNSPECIFIED
Select 1-2: 2
Enter CPT CODE:
```

Figure 3-128: Example of using OP mnemonic

3.5.137 Outside RX (Historical)

This mnemonic is not used by all sites.

3.5.138 Other Items for List Manager (OT)

This mnemonic is not used by all sites.

3.5.139 Health Reminder Override (OVR)

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

```
MNEMONIC: OVR Health Reminder Override  ALLOWED   NON-VISIT/VISIT
MNEMONIC

Select HEALTH REMINDER OVERRIDE HEALTH MAINTENANCE REMINDER: WEIGHT
 PROVIDER REQUESTING OVERRIDE: SMITH,JOHN
```

```
DUE DATE: T
PROVIDER COMMENTS: OVERRIDE
```

Figure 3-129: Example of using OVR mnemonic

3.5.140 Pain (PA)

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

```
MNEMONIC: PA
   VALUE: 5
```

Figure 3-130: Example of using PA mnemonic

3.5.141 31 Pap Smear Ordered (PAP)

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

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

Figure 3-131: Example of using PAP mnemonic

3.5.142 PCC+ Form (PCF)

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

3.5.143 Primary Care Provider (PCP)

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

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

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

Figure 3-132: Example of using PCP mnemonic

3.5.144 Procedure Entry (CPT) (PCPT)

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

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

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

Figure 3-133: Example of using PCPT mnemonic

3.5.145 Patient Education (PED)

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

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

- Distraction

- Eager to Learn

- Intoxication

- Not Ready

- Pain

- Receptive

- Severity of Illness

- Unreceptive

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

- Poor

- Fair

- Good

- Group–No Assessment

- Refused

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

```
MNEMONIC: PED  Patient Education  ALLOWED  VISIT-RELATED-ONLY
You can enter education topics in 2 ways:
  - using the name of the topic (e.g. DM-DIET)
  - using an ICD Diagnosis for the topic diagnosis and enter a topic
category

   Select one of the following:
     T     EDUCATION TOPIC

     D     DIAGNOSIS
Do you wish to enter a: T//  EDUCATION TOPIC
Enter EDUCATION Topic: DEP-EXERCISE
 READINESS TO LEARN: EAGER TO LEARN
 LEVEL OF UNDERSTANDING: GOOD
 PROVIDER: SIGMA,JANE
 LENGTH OF EDUC (MINUTES): 30
 COMMENT:
 GOAL CODE: GS GOAL SET
 GOAL COMMENT:
```

Figure 3-134: Example of using PED mnemonic

3.5.146 Peak Flow (PF)

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

```
MNEMONIC: PF     Peak Flow   ALLOWED   VISIT-RELATED-ONLY
 VALUE: 500
```

Figure 3-135: Example of using PF mnemonic

3.5.147 Public Health Nursing Form (PHN)

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

Code	Level of Intervention
P	Primary
S	Secondary
T	Tertiary

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

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

The following shows an example of using the PHN mnemonic:

```
MNEMONIC: PHN  Public Health Nursing Form  ALLOWED  VISIT-RELATED-
ONLY
LEVEL OF INTERVENTION: P PRIMARY

TYPE OF DECISION MAKING: S STRAIGHTFORWARD
PSYCHO/SOCIAL/ENVIRON: PT IS DEPRESSED SECONDARY TO OTHER MEDICAL
PROBLEMS
NSG DX: DEPRESSION, DIABETES, HYPERTENSION
SHORT TERM GOALS: CONTINUE TO MONITOR MEDICATION
LONG TERM GOALS: ADMISSION TO NURSING HOME
```

Figure 3-136: Example of using PHN mnemonic

3.5.148 PHQ2 (PHQ2)

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

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

Figure 3-137: Example of using PHQ2 mnemonic

3.5.149 PHQ9 (PHQ9)

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

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

Figure 3-138: Example of using PHQ9 mnemonic

3.5.150 Personal History (PHX)

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

```
 MNEMONIC: PHX     Personal History   ALLOWED   NON-VISIT/VISIT
 MNEMONIC
 ********************* PERSONAL HISTORY *********************

 03/30/1988 C-SECTION, BW 7-11,APGARS 7/9 (onset 10/08/1987)


 Enter PERSONAL HISTORY Diagnosis: 977.9 977.9   POISON-MEDICINAL AGT
 NOS
      ...OK? Yes//  (Yes)

  DATE NOTED: OCT 7,2008//  (No Editing)
  PROVIDER NARRATIVE: SUICIDE ATTEMPT--DRUG OVERDOSE
  DATE OF ONSET: 2008 (2008)
  MULTIPLE BIRTH?: Y YES
  MULTIPLE BIRTH TYPE: ??
    Choose from:
     TU    TWIN, UNSPECIFIED
     IT    IDENTICAL TWIN
     FT    FRATERNAL TWIN
     TR    TRIPLET
     OTH   OTHER MULTIPLE
```

```
   MULTIPLE BIRTH TYPE: FT FRATERNAL TWIN
 MNEMONIC:
```

Figure 3-139: Example of using PHX mnemonic

3.5.151 Infant Feeding Patient Data (PIF)

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

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

Figure 3-140: Example of using PIF mnemonic

3.5.152 Problem List (PL)

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

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

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

```
Problem List Update           Nov 02, 2010 10:30:16        Page:   1 of   1
-----------------------------------------------------------------------------
Patient Name: DEMO,CHARLES   DOB: AUG 25, 1937   Sex: M   HRN: 167260
```

```
--------------------------------------------------------------------------------

Problem List Updated On: Nov 02, 2010  By: IWPROVIDER,MARY ANNE

   1) Problem ID:   CI1    DX: .9999   Status: ACTIVE Onset: 11/2/2010
      Provider Narrative:  none
        Notes:
          CI Note#1 11/2/2010  testing for pl menu list


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

Select Action: +// AP

Adding a new problem for SIGMA,JOHN.

Enter Problem Diagnosis: DIABETES MELLITUS
250.00 (DM UNCOMPL/T-II/NIDDM,NS UNCON)
DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION/TYPE II/NON-INSULIN
DEPENDENT/ADULT-ONSET,OR UNSPECIFIED TYPE,NOT STATED AS UNCONTROLLED
 OK? Y//
PROVIDER NARRATIVE: = DIABETES MELLITUS
DATE OF ONSET:
NMBR: 4//
CLASS:
STATUS: A//   ACTIVE
Add a new Problem Note for this Problem? N//
Enter the Date the Problem List was Updated by the Provider:  Nov 02, 2010//   (
NOV 02, 2010)
Enter the PROVIDER who Updated the Problem List: // SMITH, BESSIE
```

Figure 3-141: Example of updating a Problem List

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

> **Note:** Remember to type **Q** to quit the Problem List menu and
> return to the "Mnemonic" prompt.

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

```
Enter Problem Diagnosis: INJURY

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

 OK? Y//

  PROVIDER NARRATIVE: INJURY  INJURY
  E CODE (CAUSE OF INJURY):
```

```
   E CODE 2:
   E CODE 3:
```

Figure 3-142: Example of E Code prompts.

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

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

3.5.153 Problem List Reviewed (PLR)

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

```
MNEMONIC: PLR       Problem List Reviewed     ALLOWED     VISIT RELATED
ONLY

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

Figure 3-143: Example of using the PLR mnemonic

3.5.154 Problem Only (PO)

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

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

```
MNEMONIC: PO  Problem Only  ALLOWED  NON-VISIT/VISIT MNEMONIC

Problem List Reviewed On: Nov 02, 2010            By: EDEMO,ARLENE
F
Problem List Updated On:          Nov 02, 2010   By:
IWPROVIDER,MARY ANNE
No Active Problems Documented On:                By:
```

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

  CI1       11/02/2010  none  (ONSET: 11/02/2010)
  CI1CI1    11/02/2010  testing for pl menu list
  CI2       11/02/2010  none

********** No INACTIVE Problems on file for this Patient
Enter Problem Number: CI2

Activating Problem CI2 ...
Enter the Date the Problem List was Updated by the Provider:  Nov
02, 2010//   (
NOV 02, 2010)
Enter the PROVIDER who Updated the Problem List: IWPROVIDER,MARY
ANNE
```

Figure 3-144: Example of using PO mnemonic

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

```
Enter Problem Diagnosis: INJURY

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

 OK? Y//

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

Figure 3-145: Example of E Code prompts.

3.5.155 POV and Problem Entry (PPV)

Use the POV and Problem Entry (PPV) mnemonic to automatically generate a
problem in the Problem List for visit-related-only encounters. Use the PV mnemonic
to type POVs only.

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

```
MNEMONIC: PPV        P O V and PROBLEM entry      ALLOWED      VISIT
RELATED ONLY

This mnemonic will automatically generate a PROBLEM on the PROBLEM
```

```
LIST.  Use the PV mnemonic to enter POV's only!

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

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

  CI1        11/02/2010  TESTING PROBLEM NOTES  (ONSET: 11/02/2010)
  CI2        11/02/2010  NONE  (ONSET: 11/02/2010)
  CI3        11/02/2010  TESTING
  CI3CI1     11/02/2010  TEST
  CI4        11/02/2010  TESTING PO  (ONSET: 11/02/2010)
  CI4CI1     11/02/2010  TEST

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

Enter PURPOSE of VISIT: .9999   .9999     UNCODED DIAGNOSIS
         ...OK? Yes//   (Yes)

  PROVIDER NARRATIVE: TESTING PPV
  MODIFIER:
  CAUSE OF DX:

Now creating PROBLEM on PROBLEM LIST ...
    NMBR: 5//
    CLASS:
    DATE OF ONSET: T  (NOV 02, 2010)
    STATUS: A//   ACTIVE

Add a new Problem Note for this Problem? N// O
Enter the Date the Problem List was Updated by the Provider:  Nov
02, 2010//   (NOV 02, 2010)
Enter the PROVIDER who Updated the Problem List: IWPROVIDER,MARY
```

Figure 3-146: Example of using PPV mnemonic

3.5.156 Presentation (Pregnancy) (PR)

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

Number	Name	Abbreviation
1	Vertex	VT
2	Complete Breach	CB
3	Double Footling	DF
4	Single Footling	SF
5	Frank Breach	FB
6	Face	FA

Number	Name	Abbreviation
7	Unspecified Breach	UB
8	Transverse	TR
9	Other	OT
10	Unknown	UNK

The following shows using the PR mnemonic:

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

Figure 3-147: Example of using PR mnemonic

3.5.157 Providers (Primary/Secondary) (PRV)

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

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

Figure 3-1481: Example of using PRV mnemonic

3.5.158 Prescription RX (PRX)

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

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

Figure 3-149: Example of using PRX mnemonic

3.5.159 VA Mobile Cln Prescription Act

This mnemonic is not used by all sites.

3.5.160 Physical Therapy (PT)

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

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

Figure 3-150: Example of using PT mnemonic

3.5.161 Pulse (PU)

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

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

Figure 3-151: Example of using PU mnemonic

3.5.162 Purpose of Visit (PV)

The purpose of visit is the most important data item recorded for a patient's visit. Every encounter form must have a purpose of visit recorded before it can be processed by the data entry staff. This data item is typed in the Purpose of Visit

section on the encounter form in a narrative format by the provider. This section is also used to create and update a patient's Problem List. The purpose of visit is entered in two parts: (1) to obtain the ICD-9 code, and (2) to maintain the provider's narrative verbatim. The second entry, the provider's narrative, displays in the Adult Regular Health Summary. For more information on the purpose of visit or the Problem List, refer to the PCC Forms manual. This mnemonic applies to visit-related-only encounters.

During entry of the purpose of visit, the user will be prompted for a modifier and a cause of diagnosis. These optional fields are used as needed, depending on the provider's diagnosis. The choices available for entry at each of these prompts are listed in the following table.

Modifier	Description
C	Consider
D	Doubtful
F	Follow Up
M	Maybe, Possible, Perhaps
O	Rule Out
P	Probable
R	Resolved
S	Suspect, Suspicious
T	Status Post

Cause of DX:

- Hospital Acquired

- Alcohol Related

- Battered Child

- Employment Related

- Domestic Violence Related

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

Figure 3-152: Example of using PV mnemonic

> **Note:** At the "Provider Narrative" prompt, if the narrative from the encounter form is identical to the text typed at the

> "Purpose of Visit" prompt to obtain the ICD code, then type an equal sign (=) to duplicate the text typed in at the Purpose of Visit prompt. This will save keystrokes.

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

- "Cause of Injury"
- "Place of Accident"
- "Date of Injury"

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

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

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

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

```
MNEMONIC: PV  Purpose of Visit  ALLOWED  VISIT-RELATED-ONLY
Enter PURPOSE of VISIT: LACERATION HAND
882.0 (OPEN WOUND OF HAND)
OPEN WOUND OF HAND EXCEPT FINGERS ALONE, WITHOUT MENTION OF
COMPLICATION
  OK? Y//
PROVIDER NARRATIVE: = LACERATION HAND
MODIFIER:
CAUSE OF INJURY: DOG BITE( BITE/BITEMPORAL/BITES DOG )
```

```
E906.0 (DOG BITE)
DOG BITE
  OK? Y//
PLACE OF ACCIDENT: B  HOME-OUTSIDE
DATE OF INJURY: T    (JUN 13, 1998)
CAUSE OF DX:>
Enter PURPOSE of VISIT:
```

Figure 3-153: Example of an injury-related visit entry

3.5.163 Radiology (RAD)

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

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

Figure 3-154: Example of using RAD mnemonic

3.5.164 Refusal for Service (REF)

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

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

Figure 3-155: Example of using REF mnemonic

3.5.165 Add Patient to a Register (REG)

This mnemonic is not used by all sites.

3.5.166 Reproductive Factors (RF)

Use the Reproductive Factors (RF) mnemonic to enter reproductive factors for a female patient for non-visit- or visit-related encounters. The data entered includes gravidity, full-term births, premature births, therapeutic abortions, spontaneous abortions, ectopic pregnancies, multiple births, and living children.

```
MNEMONIC: RF  Reproductive Factors   ALLOWED    NON-VISIT/VISIT
MNEMONIC
GRAVIDA: 5//
FULL TERM BIRTHS: 3//
PREMATURE BIRTHS: 0//
THERAPEUTIC ABORTIONS (TA): 0//
SPONTANEOUS ABORTIONS (SA): 0//

ECTOPIC PREGNANCIES: 2//
MULTIPLE BIRTHS: 3//
LIVING CHILDREN: 1// /
```

Figure 3-156: Example of using RF mnemonic

3.5.167 Remove Note Narrative (RNO)

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

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

```
MNEMONIC: RNO         Remove Note from Problem      ALLOWED      NON-
VISIT/VISIT MNE
Problem List Reviewed On:                            By:
Problem List Updated On:              Nov 02, 2010   By:
ADPROVIDER,RAY
No Active Problems Documented On:                    By:
*****************   ACTIVE PROBLEMS AND NOTES   *******************
  CI1        11/02/2010   TESTING PROBLEM NOTES   (ONSET: 11/02/2010)
  CI2        11/02/2010   NONE   (ONSET: 11/02/2010)
  CI3        11/02/2010   TESTING
  CI3CI1     11/02/2010   TEST
  CI4        11/02/2010   TESTING PO   (ONSET: 11/02/2010)
  CI4CI1     11/02/2010   TEST
  CI5        11/02/2010   TESTING PPV   (ONSET: 11/02/2010)
********** No INACTIVE Problems on file for this Patient
```

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

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

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

Figure 3-157: Example of using RNO mnemonic

3.5.168 VA Mobile Clinic REFER OUPT (RO)

This mnemonic is not used by all sites.

3.5.169 Remove Problem Entry (RPO)

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

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

```
 MNEMONIC: RPO        Remove Problem entry      ALLOWED      NON-
VISIT/VISIT MNEMONIC

Problem List Reviewed On:                        By:
Problem List Updated On:            Nov 02, 2010   By:
ADPROVIDER,RAY
No Active Problems Documented On:                By:
*****************  ACTIVE PROBLEMS AND NOTES  *******************
  CI1       11/02/2010  TESTING PROBLEM NOTES  (ONSET: 11/02/2010)
  CI2       11/02/2010  NONE  (ONSET: 11/02/2010)
  CI3       11/02/2010  TESTING
  CI3CI1    11/02/2010  TEST
  CI4       11/02/2010  TESTING PO  (ONSET: 11/02/2010)
  CI5       11/02/2010  TESTING PPV  (ONSET: 11/02/2010)
********** No INACTIVE Problems on file for this Patient
Enter Problem Number: CI3

Please Note:  You are NOT permitted to delete a problem without
```

```
entering a reason for the deletion.
Are you sure that you want to remove Problem Number CI3 ? (Y/N) Y

Removing Problem CI3 ...
  Provider who deleted the problem: ADPROVIDER,RAY
  REASON PROBLEM DELETED: D  DUPLICATE

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

MNEMONIC:
```

Figure 3-158: Example of using RPO mnemonic

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

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

3.5.170 Respiration (RS)

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

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

Figure 3-159: Example of using RS mnemonic

3.5.171 Medications (RX)

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

```
MNEMONIC: RX  Medications  ALLOWED  VISIT-RELATED-ONLY
Select V MEDICATION: IBUPROFEN
1  IBUPROFEN 400MG TAB MS102
2  IBUPROFEN 400MG TAB U/D
3  IBUPROFEN 800MG TAB
CHOOSE 1-3: 3
 Outside Drug Name (OPTIONAL):
```

```
 SIG: TAKE EVERY 6 HOURS FOR PAIN AS NEEDED
 QUANTITY: 60
 DAYS PRESCRIBED: 15
 EVENT DATE&TIME:
 ORDERING PROVIDER: SIGMA,JOHN PHYSICIAN   IHS
 CLINIC: 01   GENERAL   01
 ENCOUNTER PROVIDER:
```

Figure 3-160: Example of using RX mnemonic

3.5.172 Suicide Form Entry (SF)

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

```
MNEMONIC: SF  Suicide Form Entry   ALLOWED   NON-VISIT/VISIT
MNEMONIC
Enter the Provider who completed the Form: SIGMA,JOHN //
Enter the DATE of the SUICIDE ACT: T (MAR 06, 2008)
Please note: If while entering the data from the suicide form you
make a mistake, you can edit the field by '^' jumping to that field.
For example: to go back to edit EMPLOYMENT STATUS after you have
passed That field, type ^EMPLOY and you will be taken back to that
field to edit it.


LOCAL CASE : 11


COMMUNITY WHERE ACT OCCURRED: SPRINGFIELD
EMPLOYMENT STATUS: UNEMPLOYED
RELATIONSHIP STATUS: SINGLE
EDUCATION LEVEL: HIGH SCHOOL GRADUATE/GED
SUICIDAL BEHAVIOR: ATTEMPT
LOCATION OF ACT: HOME HOME OR VICINITY
PREVIOUS ATTEMPTS: 1 1
Select METHOD: STABBING/LACERATION
Select METHOD:
SUBSTANCE INVOLVED: NONE


Please enter any documented CONTRIBUTING FACTORS


Select FACTOR: VICTIM OF ABUSE (CURRENT)   3


Select FACTOR:
LETHALITY: M MEDIUM
DISPOSITION: UNKNOWN     UNK
NARRATIVE:
```

Figure 3-161: Example of using SF mnemonic

3.5.173 History of Surgery (SHX)

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

```
MNEMONIC: SHX  History of Surgery  ALLOWED  NON-VISIT/VISIT MNEMONIC
*********************** SURGICAL HISTORY *********************
01/31/97  APPENDECTOMY
Enter Date of Historical Procedure/Operation:  1986  (JAN 01,
1986@12:00)
 TYPE: O//   OTHER
 LOC. OF ENCOUNTER: 000198  SELLS OTHER  TUCSON  SELLS  98
 OUTSIDE LOCATION:
Enter CPT CODE:  SPLENECTOMY
The following matches were found:
  1: 41.43 (PARTIAL SPLENECTOMY)
    PARTIAL SPLENECTOMY
  2: 41.5 (TOTAL SPLENECTOMY)
TOTAL SPLENECTOMY
Select 1-2: 2
PROVIDER NARRATIVE: REMOVAL OF SPLEEN
```

Figure 3-162: Example of using SHX mnemonic

3.5.174 Purpose of Visit with Stage Prompt (SPV)

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

```
MNEMONIC: SPV  POV with Stage Prompted  ALLOWED  VISIT-RELATED-ONLY
Enter PURPOSE of VISIT: MALIGNANT NEOPLASM OF ENDOCERVIX
( ENDOCERVIX MALIGNANT NEOPLASM/NEOPLASMS )
The following word was not used in this search:
OF

180.0 (MALIG NEO ENDOCERVIX)
MALIGNANT NEOPLASM OF ENDOCERVIX
 OK? Y//
   PROVIDER NARRATIVE: =
Enter the STAGE: 6
MODIFIER:
CAUSE OF DX:
Enter PURPOSE of VISIT:
```

Figure 3-163: Example of using SPV mnemonic

3.5.175 VA Mobile Clinic Refer Spec (SR)

This mnemonic is not used by all sites.

3.5.176 Skin Test (ST)

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

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

Result	Description
P	Positive
N	Negative
D	Doubtful
O	No Take

The following shows using the ST mnemonic:

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

Figure 3-164: Example of using ST mnemonic

3.5.177 Stage in Purpose of Visit (STG)

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

> **Note**: Decimals are not allowed.

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

Figure 3-165: Example of using STG mnemonic

3.5.178 Station (Pregnancy) (STN)

Use the Station (STN) mnemonic to type the station measurement for a pregnancy for visit-related-only encounters. The value typed must be between negative six and four.

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

Figure 3-166: Example of using STN mnemonic

3.5.179 Skin Test Placed (No Reading) (STP)

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

- Cocci

- Mono-Vac

- PPD

- Schick

- Tine

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

Figure 3-167: Example of using STP mnemonic

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

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

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

Figure 3-168: Example of using TA mnemonic

3.5.181 Chargemaster Transaction Code (TC)

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

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

Figure 3-169: Example of using TA mnemonic

3.5.182 Type of Decision Making (TD)

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

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

The following shows using the TD mnemonic:

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

Figure 3-170: Example of using TD mnemonic

3.5.183 Chargemaster Transaction Code with Enc Prov (TE)

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

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

Figure 3-171: Example of using TE mnemonic

3.5.184 Time of Visit (TM)

Use the Time of Visit (TM) mnemonic to correct a visit time for visit-related-only encounters. Time is a required entry for a patient visit and is typed at the "Time of

Visit" prompt when a visit is created. If the user has entered an incorrect time, use TM to make the change.

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

Figure 3-172: Example of using TM mnemonic

3.5.185 Temperature (TMP)

Use the Temperature (TMP) mnemonic to type the patient's temperature at the time of the visit for visit-related-only encounters. The value is entered in degrees Fahrenheit and must be in the 94 to 109.9 range. The patient's temperature will not display in the Adult Regular Health Summary, but can be selected to display in a locally defined custom Health Summary.

```
MNEMONIC: TMP   Temperature  ALLOWED  VISIT-RELATED-ONLY
VALUE: 99.3
```

Figure 3-173: Example of using TMP mnemonic

3.5.186 Tonometry (TON)

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

```
MNEMONIC: TON  Tonometry  ALLOWED  VISIT-RELATED-ONLY
VALUE: 20/21
```

Figure 3-174: Example of using TON mnemonic

3.5.187 Treatments Provided (TP)

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

and maintaining this list of codes for treatments provided (for visit-related-only encounters).

```
MNEMONIC: TP  Treatments Provided  ALLOWED  VISIT-RELATED-ONLY
Enter TREATMENT Type: RA-PAIN MANAGEMENT  000918 1
HOW MANY: 1//
PROVIDER: JS SIGMA,JANE  REGISTERED NURSE  IHS
```

Figure 3-175: Example of using TP mnemonic

3.5.188 Treatment Contracts (TRC)

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

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

Figure 3-176: Example of using TRC mnemonic

3.5.189 49 Urinalysis Order–No Results (UA)

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

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

Figure 3-177: Example of using UA mnemonic

3.5.190 Unable to Screen (UAS)

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

```
MNEMONIC: UAS  Unable to Screen   ALLOWED   NON-VISIT/VISIT MNEMONIC

Select PATIENT REFUSALS FOR SERVICE/NMI REFUSAL TYPE: EXAM
 Enter the EXAM value: 08 HEART EXAM   08
 DATE REFUSED/NOT INDICATED: T (MAR 06, 2008)
 PROVIDER WHO DOCUMENTED: SIGMA,JOHN
```

```
COMMENT:
```

Figure 3-178: Example of using UAS mnemonic

3.5.191 Underlying Cause of Death (UCD)

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

```
MNEMONIC: UCD  Underlying Cause of Death  ALLOWED  NON-VISIT/VISIT
MNEMONIC
UNDERLYING CAUSE OF DEATH: RENAL FAILURE
586.  (RENAL FAILURE NOS)
RENAL FAILURE, UNSPECIFIED
 OK? Y//
```

Figure 3-179: Example of using UCD mnemonic

3.5.192 Auditory Evoked Potential Exam (UNH)

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

3.5.193 Uncoded Procedure (UOP)

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

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

Figure 3-180: Example of using UOP mnemonic

3.5.194 Uncoded Purpose of Visit (UPV)

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

```
MNEMONIC: UPV  Uncoded Purpose of Visits  ALLOWED  VISIT-RELATED-
ONLY
PROVIDER NARRATIVE: RECURRENT BLEEDING ULCER
MODIFIER:
CAUSE OF DX:

Enter another Diagnosis/POV? No//  (No)
```

Figure 3-181: Example of using UPV mnemonic

3.5.195 Vision Corrected (VC)

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

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

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

Figure 3-182: Example of using VC mnemonic

3.5.196 VA Mobile Clinic Visits Data (VR)

This mnemonic is not used by all sites.

3.5.197 Visit File Data Modify (VST)

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

```
MNEMONIC: VST   Visit File Data Modify   ALLOWED   VISIT-RELATED-
ONLY
LOC.  OF ENCOUNTER: SELLS HOSPITAL/CLINIC//
SERVICE CATEGORY: AMBULATORY//
```

```
TYPE: IHS//
CLINIC: GENERAL// DIABETIC
WALK IN/APPT: APPOINTMENT//
APPT DATE&TIME: JUN 1,1997@10:00//  6/17/97@1030
EVALUATION AND MANAGEMENT CODE:
CHECK OUT DATE&TIME:
HOSPITAL LOCATION:
LEVEL OF DECISION MAKING:
```

Figure 3-183: Example of using VST mnemonic

3.5.198 VA Mobile Clinic Visit Type

This mnemonic is not used by all sites.

3.5.199 Vision Uncorrected (VU)

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

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

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

Figure 3-184: Example of using VU mnemonic

3.5.200 Waist Measurement (WC)

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

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

Figure 3-185: Example of using WC mnemonic

3.5.201 Well Child Exam (WCE)

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

```
MNEMONIC: WCE WELL CHILD EXAM   ALLOWED   VISIT-RELATED-ONLY
        *** DATA ENTRY - WELL CHILD EXAM ***
   Select one of the following:
      1     Clinic
      2     Provider
      3     POV
      4     Development/Autism Screen comments
      5     Patient education
      6     Nutrition
      7     Screening exams
      8     ASQ score
      A     ALL items
      Q     QUIT THIS MNEMONIC
Your choice: A//
CLINIC: GENERAL// >


Provider: SIGMAH,JOHN
PRIMARY/SECONDARY: PRIMARY//
Another provider:
*** WELL CHILD EXAM (V20.2) has been automatically added as a POV
***
Add additional POV's using the PV mnemonic
Want to enter Development or Autism screen comments? No//
Select from the list of standard patient education topics:
  1. Set reasonable expectations
  2. Know child's friends and their families
  3. Ensure adequate sleep (bed by 8-9??)
  4. Limit TV, computer, video time (2 hours a day)
  5. Promote physical activity
  6. Use belt-positioning booster seat in back seat
  7. NEVER put booster seat in front seat with air bag
  8. Reinforce home safety rules (matches, poisons, tools)
  9. Provide safe after-school care
  10. Teach stranger, neighborhood safety
  11. Supervise tooth brushing
  12. Answer questions, normal curiosity
  13. Praise child, encourage talking about activities and feelings
  14. Read interactively with child; listen as he reads aloud
  15. Set appropriate limits, establish consequences
Select ITEMS by number: 2

  1. Set reasonable expectations
  2. Know child's friends and their families [SELECTED]
  3. Ensure adequate sleep (bed by 8-9??)
  4. Limit TV, computer, video time (2 hours a day)
  5. Promote physical activity
  6. Use belt-positioning booster seat in back seat
```

```
   7. NEVER put booster seat in front seat with air bag
   8. Reinforce home safety rules (matches, poisons, tools)
   9. Provide safe after-school care
   10. Teach stranger, neighborhood safety
   11. Supervise tooth brushing
   12. Answer questions, normal curiosity
   13. Praise child, encourage talking about activities and feelings
   14. Read interactively with child; listen as he reads aloud

   15. Set appropriate limits, establish consequences
Want to make any additional changes? No//


Name of educator: SIGMA,JOHN
If possible, record the level of understanding and duration of
patient education session
    Select one of the following:
      1      POOR
      2      FAIR
      3      GOOD
      5      REFUSED
Level of understanding: 3 GOOD


Total patient education time (min): (1-100): 30
Was an Infant Feeding Choice recorded? No//
No nutrition topics are required for this visit!!
Select EXAM TYPE
    Select one of the following:

      1      General health screening
      2      Age-specific physical exam
      3      Special risk screening
      4      Behavioral health screening
      A      ALL OF ABOVE
      Q      QUIT ENTERING EXAMS
Your choice: 4 Behavioral health screening
No behavioral health screening exam items are available for this
visit

Select EXAM TYPE
    Select one of the following:
      1      General health screening
      2      Age-specific physical exam
      3      Special risk screening
      4      Behavioral health screening
      A      ALL OF ABOVE
      Q      QUIT ENTERING EXAMS
Your choice: 2 Age-specific physical exam

Select age-specific physical exam(s)
  1. Teeth
  2. Signs of possible abuse or neglect
Select ITEMS by number: 2
  1. Teeth
  2. Signs of possible abuse or neglect [SELECTED]
Want to make any additional changes? No//
```

```
Signs of possible abuse or neglect
Exam result (N or A): N NORMAL
Select EXAM TYPE
   Select one of the following:
      1      General health screening
      2      Age-specific physical exam
      3      Special risk screening
      4      Behavioral health screening
      A      ALL OF ABOVE
      Q      QUIT ENTERING EXAMS
Your choice: QUIT ENTERING EXAMS


No ASQ scores should be entered on this visit!!
  Select one of the following:
      1      Clinic
      2      Provider
      3      POV
      4      Development/Autism Screen comments
      5      Patient education
      6      Nutrition
      7      Screening exams
      8      ASQ score
      A      ALL items
      Q      QUIT THIS MNEMONIC
Your choice: QUIT THIS MNEMONIC
```

Figure 3-186: Example of using WCE mnemonic

3.5.202 Demographic and Visit Display (WHAT)

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

```
MNEMONIC: WHAT Demographic and Visit Display ALLOWED NON-VISIT/VISIT
MNEMONIC
You are currently processing the following Patient Visit:
 Patient Name:   SIGMA,JANE Chart :  000000
 Date of Birth:  AUG 21, 1976 Sex:      F
 Visit Date:     JUN 23, 2007@08:00:00
 Location:       DEMO HOSPITAL/CLINIC
 Type:        I   Service Category: A
 Clinic:       GENERAL
============== MEASUREMENT's ==============
TYPE: TMP   VALUE: 101.2
TYPE: BP    VALUE: 120/30
============== PROVIDER's ==============
PROVIDER: SIGMA,JOHN   PRIMARY/SECONDARY: PRIMARY
EVENT DATE AND TIME: JUN 23, 2007@08:15
PROVIDER: SIGMA,JOHN   PRIMARY/SECONDARY: SECONDARY
EVENT DATE AND TIME: JUN 23, 2007@09:00
```

```
=============== POV's    ==============
POV: 460. PROVIDER NARRATIVE: COLD WITH COUGH
FIRST/REVISIT: REVISIT
```

Figure 3-187: Example of using WHAT mnemonic

3.5.203 Information on Patient (WHO)

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

```
MNEMONIC: WHO  Information on Patient  ALLOWED  NON-VISIT/VISIT
MNEMONIC
You are currently processing the following Patient Visit:
 Patient Name: SIGMA,JANE   Chart : 000000
 Date of Birth: NOV 18, 1970  Sex: F
 Visit Date: JUN 23, 2007@08:00 Location: DEMO HOSPITAL/CLINIC
 Type: I  Service Category: A
 Clinic: GENERAL
```

Figure 3-188: Example of using WHO mnemonic

3.5.204 Weight (WT)

Use the Weight (WT) mnemonic to enter a patient's weight in pounds and ounces (for visit-related-only encounters).

> **Note:** Be sure that the provider has specified pounds as the unit of measure in the weight (WT) section of the encounter form before using this mnemonic.

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

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

Figure 3-189: Example of using WT mnemonic

3.5.205 Quick Out (XIT)

The XIT mnemonic allows the user to leave the data entry process from the "Mnemonic" prompt, regardless of whether the visit data entry is complete (for visit-related-only encounters). The user is prompted to determine whether the visit information entered so far is to be deleted or saved. Remember that exiting an

incomplete visit will result in an error that must be corrected prior to the data transmission process. Two sample dialogs are shown below. In the first example, the visit is saved. The visit is deleted in the second example.

Saving the visit:

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

Figure 3-190: Example of saving a visit

Deleting the visit:

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

Figure 3-191: Example of deleting a visit

Appendix A: Data Entry Mnemonics Grouped by Type

Administrative Data

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

Billing/Chargemaster

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

Contract Health Service

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

Data Entry Utilities

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

Diagnosis/Purpose of Visit

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

Examination

Mnemonic	Meaning
HE	Hearing
WCE	Well Child Exam

Historical Data

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

Immunization/Skin Tests

Mnemonic	Meaning
IM	Immunization
ST	Skin Test
STP	Skin Test Placed

Laboratory

Mnemonic	Meaning
CBC	CBC Ordered
HBS	Historical Blood Sugar Entry
HCBC	Historical CBC Entry
HCT	Hematocrit Ordered
LAB	Lab Test Entry
PAP	Pap Smear Ordered
UA	Urinalysis Order–No Results

Measurements

Mnemonic	Meaning
AUD	Audiometry
BM	Birth Measurement
BP	Blood Pressure
BPF	Best Peak Flow
CHC	Centimeter Head Circumference
CHT	Centimeter Height
FEF	FEF 25-75
FEV1	FEV1 - LITERS
FV1P	FEV1 %
FVC	Forced Vital Capacity (Liters)
FVCP	Forced Vital Capacity - %
GWT	Gram Weight
HC	Head Circumference
HT	Height
MEAS	Measurement Entry
O2	O2 Saturation
PF	Peak Flow
PU	Pulse
RS	Respiration
TMP	Temperature
TON	Tonometry
VC	Vision Corrected
VU	Vision Uncorrected
WC	Waist Measurement
WT	Weight

Medication

Mnemonic	Meaning
RX	Medications

Operation/Procedure

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

Other Clinical Data

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

Patient Related

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

Prenatal

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

Problem List

Mnemonic	Meaning
IPO	Inactivate Problem
MNN	Modify Note Narrative
MPO	Modify Problem Narrative
NO	Note
PL	Problem List

Mnemonic	Meaning
PO	Problem Only
PPV	POV and Problem Entry
RNO	Remove Note Narrative
RPO	Remove Problem Entry

Visit related data

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

Waiting time studies

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

Appendix B: RPMS Rules of Behavior

The information in this required section was written by the IHS Office of Information Technology. It does not contain any information about the functionality of the software.

B.1   All RPMS Users

In addition to these rules, each application may include additional Rules of Behavior (RoBs), which may be defined within the individual application's documentation (e.g., PCC, Dental, and Pharmacy).

B.1.1   Access

RPMS users shall:

- Only use data for which they 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 Chapter 6 OMS Limited Personal Use of Information Technology Resources TN 03-05," August 6, 2003.

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 job or by divulging information to anyone not authorized to know that information

B.1.2   Logging On To The System

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.1.3   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.

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 function 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.

- Behave in an ethical, technically proficient, informed, and trustworthy manner.

- Log out of the system whenever they leave the vicinity of their PC.

- 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 IT information processes

B.1.4   Accountability

Users shall:

- Behave in an ethical, technically proficient, informed, and trustworthy manner.

- Log out of the system whenever they leave the vicinity of their PC.

- Be alert to threats and vulnerabilities in the security of the system.

- Report all security incidents to their local 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 IT information processes.

B.1.5   Confidentiality

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 HIPAA regulations to ensure patient confidentiality

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.1.6   Integrity

Users shall:

- Protect their system 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.

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.1.7   Passwords

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

- Keep user identifications (ID) and passwords confidential

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

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

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.1.9   Reporting

Users shall:

- Contact and inform their ISSO that they have identified an IT security incident and will begin the reporting process by providing an IT Incident Reporting Form regarding this incident.

- Report security incidents as detailed in IHS SOP 05-03, Incident Handling Guide

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 Time Outs

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

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 screen after some period of inactivity.

B.1.11   Hardware

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

Users shall not:

- Eat or drink near system equipment

B.1.12   Awareness

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, intrusion detection, and provides physical security for government equipment and sensitive data.

- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote 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 users shall not:

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

B.2   RPMS Developers

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 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, 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; abide by all Department and Agency policies and procedures.

- Document and implement security processes whenever available

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 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, 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 back up 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.

- Follow industry best standards for systems they are assigned to; abide by all Department and Agency policies and procedures

Privileged users shall not:

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

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

- Release any sensitive agency or patient information.

Contact Information

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

Phone: (505) 248-4371 or (888) 830-7280 (toll free)

Fax: (505) 248-4363

Web: http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm

E-mail: support@ihs.gov