



**DEFENSE HEALTH AGENCY**  
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*DHA-IPM 18-016*  
*October 19, 2018*

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (MANPOWER AND RESERVE AFFAIRS)  
ASSISTANT SECRETARY OF THE NAVY (MANPOWER AND RESERVE AFFAIRS)  
ASSISTANT SECRETARY OF THE AIR FORCE (MANPOWER AND RESERVE AFFAIRS)  
DEPUTY ASSISTANT SECRETARY OF DEFENSE (HEALTH READINESS POLICY AND OVERSIGHT)  
DEPUTY ASSISTANT SECRETARY OF DEFENSE (HEALTH SERVICES POLICY AND OVERSIGHT)  
DEPUTY ASSISTANT SECRETARY OF DEFENSE (HEALTH RESOURCES MANAGEMENT AND POLICY)

SUBJECT: Interim Procedures Memorandum 18-016, Medical Coding of the DoD Health Records

References: See Attachment 1.

Purpose. This Defense Health Agency-Interim Procedures Memorandum (DHA-IPM), based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (s):

- Establishes the Defense Health Agency's (DHA) procedures for centralized oversight, standardized operations, and ensured quality and performance for the coding of DoD Health Records.
- This DHA-IPM is effective immediately; it will be converted into a DHA-Procedural Instruction. This DHA-IPM will expire 12 months from the date of issue.

Applicability. This DHA-IPM applies to OSD, the Military Departments (MILDEPs), the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of DoD, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD (referred to collectively in this DHA-IPM as the "DoD Components").

Policy Implementation. It is DHA's instruction, pursuant to References (d) through (m), that:

- In accordance with Reference (b), the Director, DHA, has the authority to develop and issue implementation and procedural guidance, specify procedures, requirements, rules, and standards for ensuring accurate, complete, and prompt

coding of the Military Health System (MHS) patient services, adhering to industry-established, legal, and MHS-specific guidelines and criteria, (as permitted by MHS data collection systems), to ensure accuracy and consistency of code assignment, proper code sequence, valid data reporting, and authorized exchange of data with non-MHS organizations. This supports the continuity of patient care, MHS resource allocation, the integrity of MHS information, performance measurement, data quality management, provider readiness currency, provider productivity, research, and MHS cost recovery programs.

- In accordance with Reference (d), in coordination with the MILDEPs, all Medical Treatment Facilities (MTFs) within the MHS whether under Service command or Director, DHA, administration and management; will be required to adhere to the same policies, procedures, and standard clinical and business processes. Development of these system-wide standards, policies, and procedures will be the responsibility of the Director, DHA.
- In accordance with Reference (h), the Director, DHA, will manage all data obtained from coding activity of the DoD Health Records in accordance with its data management plans and make such data available to the MILDEPs and the Transitional Intermediary Management Organization (tIMO) in support of their responsibilities.
- The DoD has transitioned much of its healthcare documentation processes into an Electronic Health Record (EHR) system. Due to unique operational mission requirements, the DoD will use a hybrid record consisting of electronic and traditional paper-based records and forms.
- The DHA, MILDEPs, and tIMO are collectively responsible for ensuring that all DoD Health Records are accessible for complete and timely coding in order to facilitate appropriate medical care and legal and administrative proceedings and to optimize cost recovery.
- The DHA and the MILDEPs routinely collect, aggregate, and analyze sufficient data to manage and promote the quality of coding operations. Coding quality performance is monitored routinely against MHS and DHA data collection and reporting requirements by the DHA and MILDEPs. This supports the MHS' overall mission of providing quality health care and preventing health care billing fraud, waste, abuse, or mismanagement of government resources.
- In the absence of published DHA guidance, current MILDEP policies and procedures will remain in effect until superseded by the appropriate DHA guidance.

Responsibilities. Attachment 2.

Procedures. Attachments 3 through 7.

Releasability

- **Cleared for public release.** This DHA-IPM is available on the Internet from the Health.mil site at: [www.health.mil/DHAPublications](http://www.health.mil/DHAPublications).



R. C. BONO  
VADM, MC, USN  
Director

Attachments:

As stated

cc:

Principal Deputy Assistant Secretary of Defense (Health Affairs)

Surgeon General of the Army

Surgeon General of the Navy

Surgeon General of the Air Force

Medical Officer of the Marine Corps

Joint Staff Surgeon

Director of Health, Safety, and Work-Life, U.S. Coast Guard

Surgeon General of the National Guard Bureau

Director, National Capital Region

ATTACHMENT 1

REFERENCES

- (a) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, as amended
- (b) DoD Directive 5136.13, "Defense Health Agency," September 30, 2013
- (c) DHA-Procedural Instruction 5025.01, "Publication System," August 21, 2015, as amended
- (d) United States Code, Title 10, Section 1073c (2017)
- (e) DoD Instruction 6040.45, "DoD Health Record Life Cycle Management," November 16, 2015, as amended
- (f) DoD Instruction 6040.40, "Military Health System Data Quality Management Control Procedures," November 26, 2002
- (g) DoD Instruction 6025.18, "Privacy for Individually Identifiable Health Information in DoD Health Care Programs," December 2, 2009
- (h) DoD Instruction 6040.42, "Management Standards for Medical Coding of DoD Health Records," June 8, 2016
- (i) Military Health System Specific Coding Guidelines Version 1, as amended
- (j) DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 24, 2003
- (k) Assistant Secretary of Defense for Health Affairs Memorandum, "Approval for Interim Guidance for use of the Healthcare Artifact and Image Management Solution-Service Treatment Record and Clinical use," July 24, 2013
- (l) DoD Manual 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," October 29, 2013
- (m) DHA-Procedural Instruction 6025.06 "Standardized Templates for Primary Care Clinical Encounter Documentation," May 16, 2018
- (n) Centers for Medicare and Medicaid Services, Documentation Guidelines for Evaluation and Management Services, 1995
- (o) Centers for Medicare and Medicaid Services, Documentation Guidelines for Evaluation and Management Services, 1997
- (p) United States Code, Title 5, Section 552a (1974)
- (q) DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007
- (r) DoD Directive 5400.11, "DoD Privacy Program," October 29, 2014
- (s) Public Law 104-191, "Health Insurance Portability and Accountability Act (HIPAA)," August 21, 1996

ATTACHMENT 2

RESPONSIBILITIES

1. DIRECTOR, DHA. The Director, DHA, in coordination with the MILDEPs and the tIMO, will:

a. Establish and resource an office to implement and oversee the formal DoD Medical Coding Program to develop procedural guidance and monitor performance and compliance with this DHA-IPM and all other applicable guidance.

b. Ensure availability of training opportunities for health information management workforce development in the areas of clinical documentation improvement (CDI), coding, auditing, compliance, Charge Description Master management, revenue cycle activities, and performance management.

c. Publish procedural and clarifying guidance and serve as the proponent for enterprise manuals that specify procedures for clinical documentation, abstraction, coding, auditing and performance management measures, and improvement.

d. Ensure that the bidirectional exchange of health information is maintained in a secure manner in order to protect beneficiaries' Personally Identifiable Information (PII) and/or Protected Health Information.

e. Ensure that data developed from a health record coding activity is managed in compliance with applicable statutes and regulations and is made available to support MHS missions, as needed.

f. Ensure the assigned MTF Directors comply with, oversee, and execute the procedures outlined in this DHA-IPM.

2. DHA MEDICAL CODING PROGRAM OFFICE (MCPO). The DHA MCPO will:

a. Establish and manage the DHA Coding Work Group (CWG).

b. Publish MHS coding procedural instructions and operational guidance and will be responsible for the following functions:

(1) Health Record Abstraction. Manual process for collection of clinically relevant coded data elements from a patient's health record and entered into another system.

(2) Coding Research and Assignment. Review of health record documentation for assignment of proper diagnosis and procedure codes utilizing system edits, MHS specific, and commercial coding guidance.

(3) Coding Compliance and Auditing. Examination of medical documentation and coding to ensure accurate, ethical coding practices, and documentation that supports the diagnoses and services reported.

(4) Coding Education and Training. Periodic interval training provided to coders and other staff to ensure knowledge and skills are current and continuously improving.

(5) Workforce Design. Build and maintain an adequate and proficient clinical documentation and coding workforce that meets workload requirements across the MHS.

3. CWG MEMBERS. The CWG Members will be the DHA MCPO functional proponent for coding compliance guidance and policy. This includes establishing, monitoring, evaluating, and reporting health records processing policies, procedures, rules, and standards for: CDI, health record abstraction, coding research, and assignment, coding workforce, Coding Education and Training, auditing and coding compliance.

4. THE MILDEPS SURGEONS GENERAL (SGs) AND DIRECTOR, tIMO. The MILDEPs SGs and Director, tIMO, within and for their respective MILDEPs are responsible for accurate, comprehensive, and complete coding, and will:

a. Promptly forward deficiencies and findings to the Director, DHA, as directed in additional organization guidance.

b. Monitor health records documentation and coding operations.

c. Include effectiveness in meeting coding accuracy standards in military and civilian performance reports as appropriate.

d. Arrange for random and targeted external audits of MTFs to:

(1) Identify compliance/noncompliance with DHA clinical documentation and coding standards, policy, procedural and clarifying enterprise guidance, including enterprise manuals.

(2) Identify improvement opportunities for clinical documentation and coding quality.

(3) Monitor and identify improvement opportunities in workflow management of process and quality controls and feedback mechanisms involving coding and documentation to improve revenue, workload capture and provider readiness currency.

(4) Verify compliance with DHA coding compliance plans, policies, and procedures, including review of the MTF coding compliance plan.

(5) Identify and report provider readiness currency issues arising from medical coding and documentation problems to the DHA MCPO for resolution.

e. Develop, adequately provision, and maintain a MILDEP MCPO to support the SG (or Director) in fulfilling their responsibilities in this DHA-IPM and serve as the primary advisor and Office of Primary Responsibility to the SG (or Director, tIMO) on functions described in this DHA-IPM.

f. Provide a Primary and Alternate Service Coding Representative appointed by the SG to serve on the CWG.

5. MILDEP AND tIMO MCPOs. MILDEP and tIMO MCPOs will provide support to their respective SG by:

a. Developing, adequately provisioning, and maintaining a MILDEP MCPO to support the SG (or Director, tIMO) in fulfilling their responsibilities in this DHA-IPM and serve as the primary advisor to the SG (or Director, tIMO).

b. Advising and serving the SG as a subject matter expert on coding and documentation matters described in this DHA-IPM impacting the data accuracy, quality, and reporting of their MILDEP from the revenue and provider readiness currency perspectives.

c. Providing the technical knowledge, skills, and abilities required to perform the random and focused audits of their MTFs as described in this DHA-IPM.

d. Monitoring, analyzing, reporting, and making recommendations to the SG and the DHA MCPO on civilian industry developments in regard to coding reference changes, coding compliance, Coding Education and Training, revenue cycle, revenue integrity, and coding workforce design and development.

e. Collaborating with MILDEP Clinical Consultants to identify and advocate appropriate courses of action for creating, changing, or improving capture of military medical services targeted in provider readiness currency.

f. Reviewing and analyzing DHA and Department coding data to identify improvement opportunities for capturing revenue, healthcare quality, and/or provider readiness currency.

6. MTF DIRECTORS. MTF Directors will:

a. Implement a DoD Health Records control process, which must include procedures to achieve a 97 percent availability of complete health records for coding while striving for 100 percent, in accordance with Reference (h).

b. Ensure a coding compliance plan is current, available, and used at their MTFs.

c. Incorporate DHA and/or Service-level audits as part of their compliance plans.

d. Provide internal auditors and/or trainers or instructors functioning in accordance with DHA or MILDEP organizational guidance until the requirement is transitioned to the DHA MCPO.

e. Provide coding staff with appropriate, available resources, including coding references materials in either hard copy or electronic form.

f. Ensure availability of coders as advisors or coaches to clinical staff.

g. Ensure coding staff is current in MHS coding guidance and coding industry standards.

h. Ensure that all coding staff are trained to a level sufficient to meet accuracy standards, preferably with an approved coding certification.

i. Ensure that individuals who document in the health record are available and responsive to coders when the coders have questions or when the coders need to clarify the documentation to assign the most correct code.

j. Incorporate coding accuracy and coding productivity standards in coder performance reviews.

ATTACHMENT 3

HEALTH RECORD ABSTRACTION

1. OVERVIEW. An efficient and comprehensive health records retrieval process is essential to complete coding accurately and ensure coding is standardized and comparable across the MHS. The MTF coder will only code documentation that was part of the DoD Health Record during the inpatient visit or outpatient encounter.
  
2. ABSTRACTION GUIDANCE. The DHA MCPO will publish and maintain abstraction guidance, including; source data across multiple systems, abstraction instructions, decision-making tools, operational definitions, a description of defined data elements, their allowable values, and their location; inclusionary or exclusionary variable information, guidelines for recording the data, and timeliness.
  
3. ABSTRACTION CODING EDUCATION AND TRAINING. The DHA MCPO will provide ongoing abstraction training to educate members of the patient care team and health record staff on compliant abstraction practices.
  
4. PERFORMANCE STANDARDS. MTF performance will be evaluated on the effectiveness of its document management system, as required by Reference (h). Coding must be compliant with both MHS coding and ethics guidelines and Reference (e), performance measures. MTF Directors must ensure that coding within their facilities meets the established standard of 97 percent records availability set by the Medical Business Operations Group for DoD Health Records, with a goal of 100 percent.

ATTACHMENT 4

CODING RESEARCH AND ASSIGNMENT

1. OVERVIEW. The MHS medical coding program encompasses review of documentation and other supporting reports to facilitate accurate assignment of medical codes (i.e., International Classification of Diseases (ICD), the American Medical Association's Current Procedural Terminology (CPT), the Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS), the American Dental Association's Current Dental Terminology, and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders).

2. CODING WORKLOAD. MHS medical coding workload is categorized as the following types of medical services:

- a. Inpatient Professional Services;
- b. Inpatient Facility Services;
- c. Ambulatory Professional Surgical Services;
- d. Ambulatory Facility Surgical Services;
- e. Observation Professional Services;
- f. Observation Facility Services;
- g. Emergency Department (ED) Professional Services;
- h. ED Facility Services; and
- i. Outpatient Professional Services.

(1) Outpatient Primary Care. In accordance with Reference (m), clinics include family medicine; internal medicine; pediatrics; adolescent medicine; general primary care; trainee and student health; medical readiness/operational medicine; executive medicine; aviation/flight medicine; women's health and ancillary providers integrated into the primary care team (e.g., clinical pharmacists and behavioral health).

(2) Outpatient Specialty Care. All other outpatient clinics not identified as Outpatient Primary Care in Reference (m).

### 3. CODING SOURCE GUIDANCE

a. The MHS Coding Guidelines are developed and maintained by the CWG to provide specific guidance for military unique services and requirements that are not adequately addressed in industry coding guidance. The MHS guidelines are derived from the following source documents, and take precedence over them:

(1) ICDs, 10th Revision, Clinical Modification (ICD-10-CM), or current coding classification system;

(2) ICDs, 10th Revision, Procedural Coding System (ICD-10-PCS), or current coding classification system;

(3) CPT;

(4) HCPCS;

(5) Current Dental Terminology;

(6) The American Hospital Association Coding Clinic;

(7) The American Medical Association CPT Assistant;

(8) The Coding Clinic for HCPCS; and

(9) CMS regulations and guidelines, including References (n) and (o).

b. Any specialty group-specific coding guidance will not be disseminated as guidance without prior concurrence of the DHA MCPO and CWG.

c. Any MILDEP or tIMO-specific coding guidance will not override MHS coding guidance except where specifically issued or approved by the DHA MCPO.

d. In the absence of specific MHS, MILDEP, or tIMO MCPOs coding guidance, coders should refer to the appropriate industry standard coding conventions.

e. Requests from clinical or other communities for specific usage should be submitted to the DHA MCPO no later than August 1st of each year for disposition and, if applicable, inclusion in the next version of the MHS Coding Guidelines. Urgent requests may be submitted, a determination made, and interim guidance published on a case-by-case basis.

f. The DHA CWG will issue an annual update each year to the MHS Coding Guidelines. The CWG may issue quarterly updates when necessary to address capture of new military medical services or requirements.

g. Conflicting interpretations of the MHS Coding Guidelines will be submitted to the DHA CWG for final interpretation that will be binding on all parties.

4. CODING REFERENCES. Coding personnel must use these reference and coding tools, to include the full spectrum of encoder reports, to expedite the coding process and ensure all billable and non-billable encounters are coded in a timely manner. The following guidance is provided in order to ensure consistent coding practices in the MHS:

a. The MHS Coding Guidelines and the references described in Reference (h), are considered official coding references. The MHS Coding Guidelines take precedence over all other official coding references.

b. Coding reference books, MHS coding guidelines, and encoder software will be updated annually, or as necessary, as the classification systems are revised. DHA will also provide an electronic encoder software program that includes and will maintain the current versions of the coding industry references in Reference (h). MTFs will also be required to ensure that hard copy current versions of the coding industry references listed in Reference (h) are available for their onsite General Schedule (GS) coding staff.

c. All contractors performing on an MHS awarded coding contract will be required to provide their contract employees updates to coding reference books annually, or as necessary, to maintain availability to current code sets.

d. DoD presentations containing coding guidance will not be considered official coding references unless previously approved by the DHA MCPO and the CWG.

e. MHS Specialty manuals containing coding guidance will not be considered official coding references unless previously approved by the DHA MCPO and the CWG.

f. Civilian medical specialty academy, association, college, organization, society, or consultant or other types of civilian presentations containing coding guidance or instruction will not be considered official coding references unless previously approved by the DHA MCPO.

g. Coding “tip sheets” or coding tools must be approved by the Director, DHA, or Service MCPO and CWG for use in the MTF.

#### 5. PRODUCTION CODING REQUIREMENTS

a. The DHA MCPO will publish, in accordance with legal and medical coding practices, and system limitations, minimum expected coding productivity standards for experienced professional coders at the target-grade level performing the coder scope of work requirements or performance work statement for contract coders.

Table 1. MHS Coding Productivity Standards

Type of Record/Encounter	MHS Standard Per Day
Outpatient Primary Care	100–120
Outpatient Specialty Care and/or ED	80–100
Ambulatory Procedure Visits	35–40
Inpatient Professional Service	80–100
Inpatient Facility	20–25

b. Processes, including coding department oversight, must be in place to validate the accuracy of coded encounters, monitor diagnosis and procedure coding, and ensure the complete and accurate description of services.

c. MTFs will establish policies and procedures in accordance with DHA MCPO guidance for obtaining provider clarification, such as allowing the coder to directly contact the provider about a record being coded.

d. Coding supervisors and MTF coding staff will review assigned codes by manual or automated methods.

e. Coding supervisors will produce and review reports daily, to ensure all billable cases are coded in a timely manner, per the coding standards listed below.

f. In accordance with legal and medical coding practices, MTFs will use the following guidelines to code minimum standard targets for Data Quality Management Control reporting, as specified in Reference (h):

(1) 100 percent of outpatient encounters, other than ambulatory procedure visits, must be coded within 3 business days of the encounter.

(2) 100 percent of ambulatory procedure visits must be coded within 15 days of the encounter.

(3) 100 percent of inpatient records must be coded within 30 days after discharge.

g. In accordance with legal and medical coding practices, the minimum expected coding accuracy standard for all types of work for experienced professional coders at the target-grade level is 97 percent. Accuracy reviews will follow auditing procedures in accordance with DHA MCPO guidelines and standards. Appropriate modified standards may be set for coders in developmental positions. The DHA MCPO also will publish MHS-suggested quality indicators for measuring accuracy. All contractors performing on an MHS awarded coding contract will develop and conduct their quality assurance reviews on productivity and accuracy in accordance with DHA MCPO auditing guidelines and standards.

ATTACHMENT 5

CODING COMPLIANCE AND AUDITING

1. OVERVIEW. Auditing is a systematic, unbiased, independent examination of medical documentation and coding to validate that all codes entered into the MHS systems are accurate. Coder review of professional or clinical staff coding of encounters is not considered to be “auditing” for purposes of this attachment. All levels of the MHS will use compliance to adhere to policy and guidance, identify high-risk areas, and ensure that the DHA MCPO takes appropriate corrective actions.

2. CODING AUDITING

a. General Audit Policies

(1) Personnel performing coding audits should be experienced in auditing and the type of coding being audited (For example, an outpatient professional services coder may not perform an audit involving inpatient facility encounters). The Services and tIMO may require completion of one or more coding certifications for specific auditing positions within defined timeframes, until such time as DHA provides definitive guidance on certification requirements.

(2) Medical coding professionals performing audits shall not audit records they have personally coded, edited, or already reviewed. Due to contractual requirements, contract auditors may not audit another contract auditors work.

(3) Each auditor will exercise reasonable care and diligence and observe the principles of serving the public interest and maintain the highest degree of integrity, objectivity, and independence in applying professional judgment to all aspects of his/her work.

b. Audit Process. The audit process will follow a disciplined, defined process to provide a systematic, unbiased, and independent examination. The audit process will consist of the following components:

(1) Scope Document. Each audit performed must be described and defined as to the scope of work. The scope document is to include the following:

(a) Identification. The individual, clinic, hospital, MTF, or other entity to be audited is clearly identified. The individuals, agencies, or other entities to whom the audit report will be provided must also be identified.

(b) Purpose. Why the audit is being conducted, to include specific goals and objectives. The purpose should also identify what is excluded from the audit.

(c) Timeline. Each audit is essentially a project, with a defined start date, phases, milestones, and end date. The timeline must clearly define when phases of the audit process are expected to be started and finished.

(d) Documentation or Items to be Reviewed. The scope document should specifically describe what documentation, data, information, or other specific items are required to conduct the audit.

(e) Audit Methodology. The sample universe/population must be defined, as well as the sampling methodology (e.g., random sample). In the case of coding audits, the type of audit (professional versus (vs.) facility, inpatient vs. outpatient, prospective vs. retrospective, etc.), must be defined. Additionally, the DHA MCPO and Service MCPOs may develop and implement specific audit methodologies for mandated monitoring and reporting.

(f) Time Frame. The time frame defines the period (fiscal year, calendar year, month, etc.), from which the sample population is defined.

(2) Binding Guidance. Binding guidance, to include appropriate industry standard coding conventions and/or MHS Coding Guidelines, defines what specific guidance, policies, rules, or standards will be used to determine if an audit item is correct or in error. The reference(s) used will vary depending on the services being audited. The binding guidance must be referenced in the audit methodology and have been active, or in force during the defined time frame of the sample.

(3) Audit Scoring. The definition and type of errors to be reported in audit findings are to be clearly described. The scoring criteria for the audit and errors must be well-defined and support development of actionable findings. Any coding errors must be supported by one or more references in the binding guidance. Errors without documented reference(s) to binding coding guidance will not be allowed to be scored against the audited individual/clinic/entity.

(4) Coordination and Communications Plan. A coordination and communications plan for the audit should be developed and executed, to include the following elements:

(a) Pre-notification to the individual, clinic, or other entity to be audited, to include providing the scope of the audit. Pre-notification may only be waived in the following cases:

1. Cases of investigating potential coding compliance issues, and rationale for waiving pre-notification must be clearly documented.

2. "Standing" audits, or audit required on a recurring or regular basis in which the scope of the audit does not change. In the case of standing audits, an initial scope document with coordination and communication instructions is sufficient, as long as the scope document is in accordance with DHA MCPO auditing guidance and standards and is updated annually or as necessary.

(b) Requests for documentation or other information.

(c) Description of how patient identifying information will be protected in transmission. The audit process must ensure that the policies and procedures in this DHA-IPM are implemented to protect the privacy of individuals in the collection, use, maintenance, and dissemination of PII, as required by Reference (p) and implemented by References (p) and (r).

(d) Pre-report Notification of Findings. This step is to provide the individual, clinic, or other entity to be audited with the preliminary findings.

(e) Appeals Process and Coordination.

(f) Distribution of Final Audit Report.

(5) Preliminary Findings. The process for developing/presenting preliminary findings must be described, to include the content of findings presented. For coding audits, the minimum required documentation for preliminary findings must include:

(a) Encounter identifying information;

(b) The original codes assigned to the encounter;

(c) Specific error or error code assigned; and

(d) The auditor's codes assigned, the auditor's scoring of the encounter, and the auditor's rationale with official references supporting their findings, if different from the original codes.

(6) Appeals

(a) Each coding audit scope document will have a defined and documented appeals process. The process will define what constitutes an appealable item, how an appeal will be documented and presented, how an appeal will be decided, and how the appeal decision is documented and reported.

(b) The audit scope document is required to include deadlines for submission of preliminary findings, review and appeal. No appeals should be allowed after the defined deadline to appeal has passed.

(c) Official coding references listed in the binding guidance of the scope document and in accordance with Attachment 5, Section 2, of this DHA-IPM are required for all appeals in coding audits; appeals without coding references will automatically be denied.

(d) The audit process is required to include a time limit for adjudicating appeals (example, 5 duty days).

(e) The individual tasked with adjudicating the appeal in a coding audit must be a certified coding professional.

(f) The individual tasked with adjudicating the appeal in a coding audit cannot be the coder being reviewed or the auditor performing the review. In situations involving contract coding personnel, the individual tasked with adjudicating the appeal cannot be an employee of the same contract or the same task order as the auditor.

(g) If an appeal is adjudicated locally and still cannot be resolved, the appeal will be submitted to the MILDEP MCPO or Service MCPO for a decision. All appeal decisions made by the DHA MCPO for a decision will be final.

(h) Audit findings should not be made final until after all appeals have been resolved.

(7) Audit Report. The process, format, and distribution of the audit report are described in the audit scope document.

(8) Action Plan. An action plan to correct identified errors is to be developed at the MTF or audited entity based on the audit report results.

c. Random and Targeted External Audits

(1) The DHA MCPO will perform random and targeted external audits of provider documentation and provider or coder coding accuracy and of MHS data monitors implemented to track key indicators of patient mix and coding practices. Such indicators may include case mix index, complication rates, and reporting of potentially problematic diagnoses and procedures. External auditors include, but are not limited to, DHA MCPO, contract personnel, inspectors general, and MILDEP audit agencies.

(2) The Services or tIMO MCPOs may perform random and targeted external audits. Audits of provider documentation and provider or coder coding accuracy as described in this DHA-IPM could aid the DHA MCPO in advising his/her respective SG or Director in regard to coding compliance issues within their Department, and track provider readiness currency coding capture and accuracy.

(3) DHA MCPO and all other external auditors performing random and targeted external audits for the benefit of the DHA Coding Program will be expected to perform the audits in accordance with the provisions of this enclosure and DHA MCPO auditing guidance and standards.

### 3. CODING AUDITORS

a. Coding auditors external to the MTF (including, but not limited to, DHA, contract personnel, inspectors general, and MILDEP audit agencies) for official use may perform review, evaluation, and audit functions.

b. To the greatest extent possible, all MHS coding auditing should be performed by DoD GS, active duty military personnel, or reservists who have been trained and received certification from a certified organization accepted by the DHA MCPO. The auditors should also possess and maintain in good standing coding certifications in facility and professional services coding from the American Academy of Professional Coders (AAPC), or American Health Information Management Association (AHIMA), or other national professional organizations as approved and recognized by the DHA MCPO.

c. In the use of contract auditors, the contractor may not be an awardee or performing on any MHS production coding or training contract. Any contract personnel performing MHS coding auditing will be required to have been trained and certified in good standing as medical coding auditors from a certified organization accepted by the DHA MCPO, in addition to possessing and maintaining in good standing coding certifications in facility and professional services coding from the AAPC or AHIMA, or other national professional organizations as approved and recognized by the DHA MCPO.

4. CODING COMPLIANCE. The DHA MCPO will develop a mandatory minimum standard compliance policy and template applicable to all active duty, DoD GS, and contractor personnel that will include these requirements:

a. A written coding compliance plan must be current, available, and used at each MTF to prevent, detect, and mitigate fraud, waste, and abuse. The coding compliance plan must contain, at a minimum:

- (1) Written policies and procedures;
- (2) Designation of a compliance officer and compliance committee;
- (3) Risk assessment;
- (4) Training and education;
- (5) Open lines of communication;
- (6) Enforcement and discipline;
- (7) Auditing and monitoring; and
- (8) Investigation and response.

b. Coding metrics that are gathered, reported, and monitored monthly to ensure optimal health record coding program performance. At a minimum, metrics will cover timeliness of record completion, availability of records, quality of documentation, and accuracy of coding.

c. Internal reviews that are conducted in collaboration with other program areas (e.g., providers, CDI) and results communicated to the patient care team and medical coding staff. Reviews will be used to determine patterns of claims, denials, and other factors that may suggest inappropriate coding. Results will be provided to Director, DHA, in the DHA specified format.

d. The DHA MCPO will compile the results of requested internal coding reviews, independent external coding audit work, and corrective action plans annually. The DHA MCPO will review these results and collaborate with the DHA Data Quality Management Control Program in determining items for an annual audit work plan for the upcoming year, if coders require further education or training, or if additional corrective action is required.

e. The Services and tIMO will continue their respective coding compliance programs until such time as DHA has developed a coding compliance plan.

ATTACHMENT 6

CODING EDUCATION AND TRAINING

1. OVERVIEW. To ensure coder knowledge and skills are current and continuously improving, coding staff must receive Continuing Education Units through the MHS and, to the extent authorized, industry sponsored educational activities, such as webinars, conferences, and online coding educational tools. Coder education assists coders in improving coding accuracy, promotes consistency in practice, and ensures current knowledge of coding rules and regulations. Coding supervisors must assess and address the educational needs and knowledge deficits of each member of the coding staff annually.

2. OVERALL GOALS AND OBJECTIVES

- a. To structure training needs, training needs will be identified and categorized.
- b. Provide training through the appropriate training mechanism for the identified need.
- c. Tailor training content to the needs of the training audience to bring the best value of the training to the audience.
- d. Provide clear, consistent communication of training content and objectives to training audiences.
- e. Demonstrate a positive return on investment for training initiatives executed to improve coding accuracy, revenue, workload, and provider readiness currency capture.
- f. The Services and tIMO will continue to define and use their current position descriptions for Coding Education and Training personnel until such time as DHA has developed a coding training plan.

ATTACHMENT 7

WORKFORCE DESIGN

1. OVERVIEW

a. It is essential to build and maintain an adequate and proficient clinical documentation and coding workforce that meets workload requirements across the MHS.

b. Specialized training, education, skills, and resources are necessary to ensure proper documentation and code assignment, sequencing, and reporting of the DoD Health Record. To ensure that coded data accurately reflects the documented diagnoses and services provided to patients, it is essential to recruit, hire, and retain experienced and preferably-credentialed coding staff. The number of and level of credentials will vary according to specific positions.

c. As the MHS moves towards a commercial EHR and more closely mirrors civilian industry, specialized training, education, skills, and resources will be necessary to ensure accurate professional and facility coding in the outpatient, ambulatory, and inpatient environments.

2. WORKFORCE COMPOSITION

a. Overreliance on any single type of workforce resource places enterprise coding operations at risk. For example, if the bulk of coding personnel are contract, there is significant risk to coding operations if the contract is terminated for cause and a gap is created due to contracting timelines for advertising and award of a new contract. Certain MHS MTFs are in particularly remote areas where it is difficult to recruit and retain qualified coding personnel for contract or GS positions. Such problems become particularly acute when the positions involve complex functions, such as ambulatory surgery, ED, observation, inpatient coding, auditing, training, and compliance.

b. The DHA and Service or tIMO MCPOs will monitor and assess, at least quarterly, coding recruitment, and retention of all coding staff, so that recommendations can be made for MHS coding workforce management and allocation around predicted workload.

c. The DHA and Service or tIMO MCPOs will undertake studies and business case analyses to determine the feasibility and courses of action to improve the GS qualification and classification standards of GS coding personnel, to include:

- (1) Requiring medical coding certifications, as appropriate, for specific coding positions;
- (2) Developing GS coding personnel development tracks;

(3) Improving GS classifications to make coding positions more competitive with the civilian market in recruitment and retention; and

(4) Increase in number of GS coding personnel in complex functions, such as ambulatory surgery, ED, observation, inpatient coding, auditing, training, and compliance to achieve necessary staffing levels for performing these functions.

d. The DHA and Service or tIMO MCPOs will undertake studies and business case analyses to determine the feasibility and course of actions to integrate selected active duty medical administration personnel in upgrade training from basic to complex coding functions such as ambulatory surgery, ED, observation, inpatient coding, auditing, training, and compliance. The goal of such studies and course of actions will be to determine how to best utilize trained and certified active duty medical administration personnel to:

(1) Provide contingency coding support by temporary duty assignment or remote access to MTFs experiencing unexpected coding manpower shortages;

(2) Identify remote or hard to fill locations and coordinate with the Services to create specific active duty assignments for personnel identified as certified coders; and

(3) Develop selected active duty coding personnel to fill some of the required auditing, training, and compliance full-time equivalent requirements to reduce number of GS personnel required, avoid contracting for these levels of coding professionals, and develop, enhance, and maintain corporate knowledge of these functions in the MHS.

e. The DHA and Service or tIMO MCPOs will develop standardized performance work statement requirements to be used in any MHS coding contracts. Contract strategy should be to secure contract support as necessary to ensure coding workload (as defined by systems capabilities and requirements) is met.

3. CODING COMPLIANCE. All levels of the MHS will use compliance to adhere to policy and guidance; identify high-risk areas DHA and the Service or tIMO MCPOs will define; develop and monitor the list and description of Coding Education and Training required for coding positions, including the type of medical coding certifications required and acceptable certifying organizations. Until such time as revision of GS qualifications and classification allows requiring coding certifications as a condition of employment, Individual Development Plans and annual performance plans should be used to promote acquisition of coding certifications identified as requirements. The DHA and Service or tIMO MCPOs will also work with the appropriate Government contracting point of contact to acquire contracts with the major U.S. certified organizations (AAPC and AHIMA), to secure Continuing Education certification testing, and training for GS and active duty military coding personnel. As an industry coding certification is recognition given to an individual who has met predetermined qualifications set by an industry organization, the Services and tIMO may require completion of one or more of the following coding certifications for specific coding positions within defined timeframes, until such time as DHA provides definitive guidance on certification requirements:

a. Professional Services Coding

(1) AAPC: Certified Professional Coder; and

(2) AHIMA: Certified Coding Specialist-Physician; Registered Health Information Technician, Registered Health Information Administrator.

b. Institutional (Facility) Coding

(1) AAPC: Certified Outpatient Coder (outpatient facility only), Certified Inpatient Coder (inpatient facility only); and

(2) AHIMA: Certified Coding Specialist; Registered Health Information Technician, Registered Health Information Administrator.

4. CODING POSITIONS. The Services and tIMO will continue to define and use their current position descriptions for coding personnel until such time as MHS has developed a workforce plan.

5. LOCATION OF CODING PERSONNEL

a. Workforce design and resource allocation depends on logistical support, workforce management and oversight activities. Locating qualified staff in a setting with access to providers allow for easy communication with providers to facilitate clinical documentation and coding education. Coding staff may be located on site in a centralized area, or they may be decentralized throughout the medical facility or clinic, in a remote centralized coding unit, or any combination of locations.

b. The Services and tIMO may continue to determine coding staffing for their MTFs until the DHA MCPO has developed and approved a standardized policy.

c. Remote production coding personnel must follow all DoD and DHA directives, guidance, instructions, policies, procedures, rules, and standards relating to protection of patient information and privacy practices.

d. All remote production coding must have and maintain updated information systems contingency plans, to include both hardware and software issues.

e. Contract coding services may provide time-limited documentation and coding support to assist with backlogs or cover regular coding duties if within the scope of work. The contractor

must ensure that contract staff are sufficiently trained, credentialed, and eligible to obtain access to all relevant DoD Health Record data and MHS systems necessary to perform their duties.

f. The MTF must monitor all coding contract services work for quality, timeliness, and appropriate coding. The Services and tIMO may continue to determine staffing and assignment of coding auditing, training, and compliance personnel located at and supporting their MTFs until such time as the DHA MCPO has developed and approved a standardized policy.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

AAPC	American Academy of Professional Coders
AHIMA	American Health Information Management Association
CDI	clinical documentation improvement
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CWG	Coding Work Group
DHA	Defense Health Agency
DHA-IPM	Defense Health Agency-Interim Procedures Memorandum
ED	Emergency Department
EHR	Electronic Health Record
GS	General Schedule
HCPCS	Healthcare Common Procedure Coding System
ICD	International Classification of Diseases
MCPO	Medical Coding Program Office
MHS	Military Health System
MILDEP	Military Department
MTF	Medical Treatment Facility
PII	Personally Identifiable Information
SG	Surgeon General
tIMO	Transitional Intermediary Management Organization
vs	versus

## PART II. DEFINITIONS

ambulatory procedure visits. Formerly referred to as “same day surgery.” A type of outpatient visit in which immediate pre-procedure and post-procedure care requires an unusual degree of intensity and is provided in an ambulatory procedure unit. Care is required in the facility for less than 24 hours.

Bidirectional Health Information Exchange. Used to exchange healthcare information between Department of Veterans Affairs healthcare facilities nationwide and between VA healthcare facilities and DoD healthcare facilities.

CDI. A program that improves the quality of clinical documentation, regardless of its impact on revenue. CDI programs facilitate accurate representation of health care services through complete and accurate reporting of diagnoses and procedures. This can have an impact on CMS quality measures, present on admission, pay-for-performance, value-based purchasing, data used for decision making in health care reform, and other national reporting initiatives that require the specificity of clinical documentation. Improving the accuracy of clinical documentation can reduce compliance risks, minimize a health care facility’s vulnerability during external audits, and provide insight into quality of care issues.

Charge Description Master. The database of all billable items that go on a patient’s account. It contains all the descriptions, revenue codes, department associations, and alternate CPT/HCPCS codes for different payors and prices. Used in the MHS primarily as a method of cost allocation.

CPT. A listing of descriptive terms and identifying codes for reporting medical services and procedures. The purpose of CPT is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby serves as an effective means for reliable nationwide communication among physicians and other health care providers, patients, and third parties. CPT codes are established and maintained by the American Medical Association.

EHR. Enterprise-wide clinical information management system used to collect and share patient care related data.

HCPCS. Standardized coding system comprising Levels I and II. Level I HCPCS codes are CPT codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals and maintained by the American Medical Association. Level II HCPCS are used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies when used outside a provider’s office. CMS maintains Level II codes.

ICD. A Health Insurance Portability and Accountability Act standard code set used in Reference (s) standard electronic transactions to describe the medical indication for the services provided. The code set, based on the World Health Organization code set, as used in the United States includes diagnoses, symptoms, external causes of morbidity, and factors influencing health status

and contact with health services. Standard diagnostic code set tool for epidemiology, health management and clinical purposes. The US proponent is the Centers for Disease Control and Prevention, National Center for Health Statistics.

Individual Development Plans. A tool to help individuals develop their skills, further their unit's mission, and achieve their career goals.

Knowledge, Skills, and Abilities. Factors used to identify individuals qualified to be assigned to a duty position.

Medical coding. The transformation of healthcare terms, diagnosis, symptoms, procedures, medical services, and equipment into medical alphanumeric codes used in the U.S. The diagnoses and procedure codes are taken from health record documentation, such as transcription of physician's notes, laboratory and radiologic results.

PII. Information which can be used to distinguish or trace an individual's identity.

Procedure Coding System. Classification system used to identify specific surgical, medical, or diagnostic interventions.

Protected Health Information. U.S. law is any information about health status, provision of health care, or payment for health care that is created or collected by a "Covered Entity" (or a Business Associate of a Covered Entity) and can be linked to a specific individual.

Revenue Integrity. The basis of revenue integrity is to prevent recurrence of issues that can cause revenue leakage and/or compliance risks through effective, efficient, replicable processes and internal controls across the continuum of patient care, supported by the appropriate documentation and the application of sound financial practices that are able to withstand audits at any point in time.