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DEPLOYMENT HEALTH CODING AND DOCUMENTATION
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We are here today to discuss Coding and Documentation as it relates to the Post-Deployment Health Clinical Practice Guideline and the Pre- and Post-Deployment Health Assessment Process.

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The objectives of this presentation include identifying

1. The coding and documentation reasons important for post-deployment health concerns.
2. The proper use of ICD-9 coding in relation to post-deployment health concerns.
3. The proper use of E & M coding for post-deployment health care visits; and,
4. The forms and documentation procedures for post-deployment health care.

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Proper coding and documentation have become critical elements of the Guideline because they provide the best method of tracking patients with deployment-related health problems. Electronic coding of "deployment-related visits" provides a type of "registry" of those with deployment-related concerns. It is the centerpiece for deployment health surveillance; providing population health information about military members and families in service to our nation.

Proper coding is also critical to successful implementation of the Guideline. It provides a method to identify and analyze trends and best practices so that they can be captured and disseminated for improvement of healthcare delivery for those affected by deployments.

After the first Gulf War, the Comprehensive Clinical Evaluation Program (or CCEP) was established with its Gulf War registry. This centralized patient call-in type registry and its associated specialized care program has been transformed by the Post-Deployment Health Clinical Practice Guideline. The Guideline repositions deployment-related care in Primary Care rather than in a specialty care setting, integrating deployment-related concerns into a complete continuum of care for the patient. The Gulf War call-in registry has largely been replaced by the Coding and Documentation process implemented by the providers who deliver deployment-related healthcare. For the most part, this shifts the responsibility for identifying deployment-related health concerns to the healthcare system and away from a patient call-in process. The patient is relieved of the responsibility and hassle of knowing that there is a registry, finding the right telephone number, and taking the time to call. At the same time, the completeness and quality of our data are improved. The process also provides expanded information and enhances our tracking capability by adding diagnosis and follow-up information into the surveillance system. That simply wasn't the case with the old system.

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People often ask, "Why should I bother with all the administrivia of coding? " While coding is not fun, it really is an important aspect of all healthcare, and especially guideline-based deployment healthcare. In effect, unless care is coded and documented, it simply doesn't exist in the healthcare system, and even the highest quality care can be overlooked. Coding allows us to analyze health concerns and disease trends so that we can better plan for future needs or conduct proactive prevention. Not only do service members and their families deserve to know their health concerns are being addressed and taken seriously, the information gleaned from coding and documentation can be used to help convey credibility to beneficiaries by

communicating to them that the military healthcare system is making every effort to meet their needs.

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Data analysis of deployment-related health concerns provides a mechanism for tracking care and ultimately provides data with which to compare the best practices identified in the Guideline with actual clinical practices.

Through proper coding and documentation we create a “population registry” that allows for analysis and trending of multiple deployment health concerns. All of these quality improvement activities work together to provide optimal care for our primary customer, the war fighter and his or her family.

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Two types of coding systems form “the essentials” for the deployment-related visit. Both types are important and are required for adequate tracking of deployment-related concerns and for documentation of the patient encounter.

The first system of coding is the International Classification of Diseases system or ICD-9 Coding. The ninth edition of this international reference is currently in use. ICD-9 codes document diagnoses according to the categories of diseases and injuries, and tell us the “why” of provider intervention. ICD-9 coding is done in CHCS in the ADM section for each patient encounter under the ICD-9 code section. The list of ICD-9 codes is extensive, and providers are certainly not expected to know them all. And the list is so long, they couldn’t possibly all be listed on a single choice list. To assist providers in the coding process, each MTF has a CHCS consultant available. This consultant can help set up a “pick list” or paper-based “super bill” of the most commonly used codes in your specific clinic and include the deployment-related codes on the list, to make it as easy as possible to find and use the right codes.

Second, the E & M, or Evaluation and Management, coding system has its own series of numbers that are used in a different section of CHCS, under E& M codes, for each patient contact in the ADM system. E & M codes document in what context we delivered care. By that I mean, they document the office setting such as an outpatient clinic visit or a preventive medicine visit and the nature of the visit.

Another term we will come across in this area is the term “CPT” which stands for Current Procedural Terminology. A coding resource, available to providers, was originally developed by HCFA, the old Healthcare Finance Administration, which is now called the Centers for Medicare and Medicaid Services (CMS). This book is called the Healthcare Common Procedure Coding System (or HCPS) and is a valuable resource for assisting with ICD-9 coding selection for procedures.

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ICD-9 coding for the diagnosis associated with deployment-related visits uses a standard approach for coding.

The ICD-9 code V70 point 5 space 6 is used to identify a deployment-related visit. This code is always used in the primary position, or picked first on your list, and conveys the importance of the patient’s perception that this visit was “deployment-related”. The standard diagnostic coding using ICD-9 codes associated with the visit are always used in the secondary position, or picked after the deployment-related code. Using this approach, electronic queries can identify patients with deployment-related concerns and analyze what the specific concerns were as designated by the ICD-9 codes used for diagnosis.

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The V70 point 5 code is specifically used to code a visit related to deployment. This code is used whenever documentation needs to show that a patient was evaluated, educated or treated for a deployment-related concern. You should bear in mind that the use of this code is not intended to convey that you think there is necessarily a causal relationship between a specific medical diagnosis and a particular deployment. It does document however, the patient's perception that the current visit or their associated health concern is related to a deployment.

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So when is the V70 point 5 code used? The answer is simply whenever a patient responds positively to the military unique vital sign screening question, " Is your visit today related to a deployment?" The Code is also used during the pre- and post- deployment process when a service member is provided a Post-Deployment Health Assessment using the DD Form 2796, which requires an evaluation through a face-to-face encounter with a credentialed provider.

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The next logical question is: "Do I always put the ICD-9 diagnostic coding for specific diseases or conditions in the secondary position?" Current guidance from the coding experts tells us that the answer is "Yes," the specific diagnostic codes are always placed in the secondary position. This coding documentation identifies accompanying diseases or patient sub-groups. For the code used in this regard, the Guideline provides three groups of diagnostic categories that follow the three categories outlined in the Clinical Practice Guideline : The first coding group is for the Asymptomatic Concerned and the code used for this group is V65 point 5. The second category, and the second algorithm of the Guideline, represents those with specific, identifiable diseases that happen to be deployment-related. For this group, you use the same specific medical diagnosis as you would in usual standard of care. Third is the medically unexplained symptom arm of the Guideline. For this category, you use the code 799 point 8.

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The Asymptomatic Concerned code V65 point 5 is used when a patient has no medical complaints or symptoms or signs but is merely seeking information or answers to questions about a deployment or deployments. These patients may answer "yes" or "maybe" to the military unique vital sign question, " Is your visit today related to a deployment?" but have only questions and no physical or psychological complaints. The questions can be about a past, present or future deployment for themselves or for a family member. In these cases, a comprehensive health risk communication approach is important for establishing trust with the beneficiary. In the past, many veterans had negative experiences with the military healthcare system when it came to post-deployment health concerns. The congressional and media attention that followed helped point to a need for change. Addressing the needs of Asymptomatic Concerned patients gives the provider an opportunity to foster trust and establish a positive collaborative relationship with the patient.

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The 799 point 8 code is used for the patient presenting with "medically undiagnosed physical symptoms". Generally speaking, this diagnosis is reserved for patients with chronic conditions when a diagnosis cannot be made. Use of the 799.8 code is only made after several visits to the primary care provider have revealed no medical diagnosis. The code 799 point 8 officially designates "ill-defined or unknown causes of morbidity or mortality" and was chosen as the code for the Guideline to identify those that fall into the Medically Unexplained Symptom algorithm.

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Selection of a specific ICD-9 code for an identified disease follows the standard diagnostic approach. Placing the V70 point 5 6 code for a post-deployment concern in the primary coding position with the diagnostic code placed in the secondary position represents a change to the original Clinical Practice Guideline. This revision was made during the second year review and reflects the guidance from military medical coding community experts.

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Evaluation and Management, or E &M, codes also must be recorded electronically in CHCS or on bubble sheets, in places where electronic versions of CHCS are not available. The Evaluation and Management codes tell us what the provider did during the visit. Two types of E& M codes are used most often in the primary care clinic setting: New Patient code numbers 99201 through 99205 and Established Patient code numbers 99212 through 99214 are the most common. New Patient codes are used, obviously, for patients coming for their first visit to the clinic for this problem, and Established Patient codes are used for their associated follow-up visits.

Selection of appropriate E& M Codes is based on three components: first, patient history; second, the type of examination (for example, if it is a problem focused visit versus a full review of systems); and third, the complexity of the decision making process.

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E & M codes are also used to document post-deployment health assessment visits. Many times, these PDHA exams are administered to members of a unit returning from deployment who are going through the post-deployment process together. The Army, for example, refers to this as the Demobilization or DEMOB process, while other services use different terminology. Regardless of the setting, whether the process is completed for a unit or for an individual returning, the Post-Deployment Health Assessment must be completed within 5 days of return or redeployment. This five-day period can be before or after the actual return. Some service members actually complete the PDHA in theater before exiting. In all cases, the exam must be completed by a credentialed provider during a face-to-face encounter with each returning service member.

The Preventive Medicine Counseling E&M Codes are to be used to document the PDHA, either electronically in CHCS or in paper format on bubble sheets or in a superbill. The series of code numbers used for this purpose are 99401 through 99420. The Preventive Medicine Counseling code selection is based on different criteria than the Primary Care Clinic E& M codes. The Preventive Medicine Counseling codes are based entirely on the amount of time spent with the patient and not on the patient history, examination elements or the complexity of decision-making.

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Just to muddy the waters and make things more confusing, there is one situation where the Primary Care Clinic codes for New Patients, the E & M series numbered 99201 through 99205, are always used for the Post-Deployment Health Assessment. This is when the service member has deployment-related concerns and requires a follow-up referral. In this context, a referral includes an appointment with the service members' health care provider in a primary care setting and not just referrals for specialty care such as dermatology or ortho**.** In this situation, the Post-Deployment Health Assessment is always coded as a New Patient visit, just as it would be if the patient were being seen in primary care, because the visit must contain all of the elements of the new patient visit. History, examination and complexity of decision-making are factors to be considered in this examination.

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The CHCS system is available in most military settings. Patient encounters are coded in the ADM section of CHCS. Both ICD-9 codes and E& M codes are to be used for each patient encounter. Most Medical Treatment Facilities, or MTFs, have a CHCS point of contact available to assist each clinic in setting up customized pick lists. Adding the V70 point 6 space 5 Post Deployment visit code in the Primary position on the pick list is ideal and easily accomplished.

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Because the selection process can be confusing, there are several resources for clarifying which codes to be used and when to use it.. The ICD-9 handbook is the official medical classification text used in the United States. Printed versions are available from a number of commercial publishers.

The official version of the ICD-9 is also available on CD-ROM from the US Government Printing Office.

Official coding advice and guidelines approved by the agencies responsible for administering the ICD-9 in the United States are published quarterly in the " Coding Clinic for ICD-9". This is published by the Central Office of the American Hospital Association. The Coding Clinic 4th Quarter, 2003 on page 86 and 87 has guidance on proper use of the ICD-9 and E& M codes for Post-Deployment Health. Additionally, Faye Brown's 2003 version of the book, "ICD-9 Coding Handbook with Answers" is especially helpful and an easy to understand resource.

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Each service provides assistance with coding to all who have questions. You can reach them using the contact information on the slide. That information can also be found through the pdhealth website or DHCC's toll-free helpline.

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It cannot be stressed enough, if care is not documented, it is as if it didn't happen in the healthcare system. Proper documentation is vitally important for monitoring the extent to which deployment-related health concerns are present in the military and for monitoring the care given to address these concerns. Documentation shows that the military unique vital sign screening question has been asked. It shows that the patient's concerns were listened to and that a collaborative effort between the provider and the patient resulted in a plan of care. Coding and documentation are the only available means for determining that outcomes have been established and measured.

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Documentation by the local MTF provides proof that the Post-Deployment Health Guideline is implemented in the clinic and that post-deployment healthcare is provided to all patients with concerns that fall under this guideline. The military unique vital sign question is placed on the SF 600 either through use of a clinic stamp or through an SF 600 overprint.

The "yes" and "maybe" responses are reviewed by the provider who then further screens and evaluates the patient's post-deployment concerns. The provider then documents the findings in narrative form on the SF 600. The optional DD Form 2844, the Post Deployment Medical Assessment form, is available and can be used as an alternative to the SF 600.

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The DD Form 2844 Post Deployment Medical Assessment form provides a comprehensive format for documenting post-deployment health concerns. The front of the form is a patient self-

report area with five sections including: demographics, a symptom check-off list, deployment history, deployment concerns and medications. The backside of the form is for the provider assessment and contains sections on : history of present illness, physical exam, review of labs and ancillary tests, review of patient questionnaires, diagnosis and treatment plan. This form can be used to document a thorough assessment of a post-deployment concern. The form is then filed in the patient's permanent medical record as a baseline. Follow-up care for post-deployment concerns is then documented on a subsequent SF 600.

The use of the DD Form 2844 follows Service-specific and local MTF policies.

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The DD Form 2796, Post-Deployment Health Assessment Form, is mandated for use in screening service members upon redeployment. It provides a first glance look at a service member's reported health status at the point of their return. The form is four pages long. It was expanded from the two-page form in response to Operation Iraqi Freedom. The service member fills out the self-report sections, which then are reviewed by a credentialed provider during a face-to-face healthcare encounter.

The form may be temporarily filed in the DD Form 2766, the Preventive Medicine Chronic Care Flowsheet, also commonly known as the Deployable Medical Record. The DD Form 2766 is the temporary medical record that the service member takes when he goes on deployment. Sometimes the DD 2796 is filled out prior to the service member arriving back at their home MTF in which case it must be filed in the Deployable Medical Record until the service member can bring it home for filing in their permanent medical record. As soon as possible (and within 30 days of return), the completed original DD 2796, along with the deployable medical record itself, is placed in the permanent medical record.

A copy of the 2796 is sent to the Army Medical Surveillance Activity (or AMSA) for entry into a central database. This form can be completed electronically through the MODS/MEDPROS system or it can be mailed to AMSA. Contact information for AMSA is included on the slide and can be found at their website or the PDHealth.mil website. It cannot be stressed enough that submission of this completed form to AMSA is critically important. And, by the way, it is a DoD and Service requirement.

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The Pre-Deployment Health Assessment form, DD Form 2795, is a self-report of the service member's health status prior to deployment. This form is to be completed within 30 days of departure and is reviewed during a face-to-face with a credentialed provider if there are any positive responses or health issues. The original form is also to be filed in the service member's permanent record at completion and a copy is placed in the Deployable Medical Record for the service member to take along. This form is used as a baseline for the service member's health status prior to deployment and is compared to the DD Form 2796 Post-Deployment Health Assessment upon return.

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Just as with the 2796, a copy of this form is also to be sent to AMSA for entry into the central medical surveillance database. It can also be completed electronically through the MODS/MEDPROS system.

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Taken together, the DD Form 2795, Pre-Deployment Health Assessment form and the DD Form 2796, Post-Deployment Assessment form, provide a record of the service member's health status

before and immediately after deployment. Both forms are to be filed in the service member's permanent record where they can be viewed whenever appropriate. It is well known that post-deployment health concerns may not surface for months or even years after a deployment. However, it is invaluable for providers to be able to look back and review the service member's health screenings at pre- and post-deployment. In situations where post-deployment concerns emerge after the DD Form 2796 is completed, the Post-Deployment Health Clinical Practice Guideline takes over for ongoing management of deployment-related concerns.

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The main form for the Guideline in primary care clinics is the Standard Form 600. I'm sure you are all more than familiar with this very commonly used form. The military unique vital sign is available through applying a clinic stamp that includes the guideline question along with other vital sign questions, such as pain rating and tobacco use. Or, the question can be added electronically to an SF 600 overprint. Clinicians should check with their local MTFs to find out which way you're doing it. Step-by-step instructions for adding the question to an SF600 overprint can be found, of course, at PDHealth.mil.

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The DD Form 2795 and the DD Form 2796 are available on the following PDHealth website as well as the general DoD forms electronic library.

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In conclusion, coding and documentation is critical. Without coding, we can't track deployment-related health concerns. We owe it to our servicemen and women to monitor and address their deployment-related concerns properly.

Even though it's not fun, and it's certainly not glamorous, coding and documentation are important. We know we need an accurate method of tracking deployment-related concerns. By knowing the extent of deployment health issues and what kind of issues are emerging, we can begin to address the health needs of our service members in the most effective ways possible.

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If you have questions or need further information, don't hesitate to call DHCC on their provider helpline or visit the website. We definitely appreciate your conscientious service to our troops and their families and your attention to this presentation.