CDC 4A051

Health Services Management Journeyman

Volume 2. Patient Administration

Air Force Career Development Academy

The Air University

Air Education and Training Command

Z4A051 02, 1504, Edit Code 04

AFSC 4A051

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THIS SECOND volume of the Z4A051, Health Services Management (HSM) Journeyman CDC, takes a close look at the various functions involved with Patient Administration within a military treatment facility (MTF). Some of the specific duties in this volume are *not* accomplished on a routine basis by many 4A0s. Fewer HSMs carry out these roles as compared to working in an outpatient records section or on a Primary Care Optimization (PCO) team. But you want to be prepared when you get the opportunity! Also, note that failure to carry out these duties properly can cause undue hardship to many personnel. Therefore, it is paramount you pay close attention to detail while learning these functions.

Unit 1 focuses on Records Management. Each 4A0 will, at one time or another, use the Composite Health Care System (CHCS). This computer system is crucial to the new 4A0, as this is the most widely used computer application system in the military health services. CHCS is beneficial to the seasoned veteran 4A0 as well, given that it discusses many management tools. Pay particular attention to the information which pertains to the outpatient and inpatient records section. As a young HSM you will likely get the opportunity to spend most of your formative years in this section of the MTF. Whether you work in a decentralized records section or a centralized records section, most HSMs get the chance to work in a records section as a technician and later as a supervisor. Unit 1 also focuses on the terminal digit filing system and filing electronic health information.

Unit 2 provides valuable information on verifying eligibility and on many important programs such as the Secretary of the Air Force Designee, Special Needs Identification and Assignment Coordination (SNIAC) process, and Sensitive Duties. You will discover how to perform Line of Duty (LOD) determinations and why that job is important to those who have experienced *in line of duty* incidents while on active duty.

Unit 3 covers two different areas of inpatient administration. You will learn how to admit and discharge a patient, how to make special notifications, and what your job entails as far as working the inpatient side of the MTF.

A glossary is included for your use.

Code numbers on figures are for preparing agency identification only.

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To get a response to your questions concerning subject matter in this course, or to point out technical errors in the text, unit review exercises, or course examination, call or write the author using the contact information on the inside front cover of this volume.

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This volume is valued at 18 hours and 6 points.

ACKNOWLEDGEMENT

The following individuals are acknowledged for their assistance in the technical input of this course.

SMSgt Nicole McClain

SMSgt Jessica Slaughter

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THE DUTIES DISCUSSED in this unit are performed by many health services managers (HSM), and each function is important to the success of the Air Force mission. For instance, as the HSM in charge of your military treatment facility (MTF) Release of Information program, you will need in depth knowledge of the different acts and laws that govern this program. One wrong decision could be very costly to you and the MTF.

Included in this unit is information on the Composite Health Care System (CHCS). Health services managers use the system to help locate and checkout outpatient medical records. Medical technicians and HSMs working on the primary care optimization (PCO) teams operate the system to help manage the appointment system and document patient related data. Providers use the medical system to order laboratory, radiology and pharmaceutical support. In turn, ancillary services personnel use the system to retrieve requests that are electronically sent by providers. As you can see, CHCS is used in many different capacities throughout our MTFs to help better manage patient data and expedite care. For these reasons, it is pivotal that all HSMs have a good understanding of its many features.

Last, but not least, maintaining an outpatient or inpatient records section is one of the most important roles you will have as a 4A0. Patients do not want to hear that you cannot find their records or paperwork; they want to know that you, the person on the other side of the counter, will be able to take care of them. When you operate a records section, it’s your job to ensure that records are sent to

their respective appointments, filed back properly, and that paperwork is filed as quickly as possible. Someone's life could actually depend on you doing your job correctly.

1–1. Release of Medical Information

How should you handle an insurance company's request for medical information on a dependent husband involved in a motor vehicle accident? Who, if anyone, must consent to the release of medical information? Do you need written or verbal consent from the patient, or can you release the information without the patient's consent? What information should you release to the insurance company, and how do you document the release? There are many things you must know the answer to before you can release medical information. These are just a few of the questions that we address in the following paragraphs.

201. Laws affecting maintenance and disclosure

Medical personnel must comply with the Privacy Act, Freedom of Information Act, Health Insurance Portability and Accountability Act (HIPAA), Drug Abuse Offense and Treatment Act, and the Comprehensive Alcohol Abuse amendments. Each of these laws must be complied with regarding maintenance, access, and disclosure of information from health records and related documentation. Personnel must periodically contact the Staff Judge Advocate's (SJA) office concerning changes to directives.

Privacy Act of 1974 (PL 93–579 and 5 U.S.C. 552a)

Medical records are maintained within a system of records protected by the privacy act. Hard copy records are covered by the system notice "Medical Record System" (F044 AF SG E), which identifies the records, including secondary files, as inpatient and outpatient records of care received in Air Force medical facilities. Automated records are covered by the "Automated Medical/Dental Record System" (F044 AF SG D). Disclosure to third parties is prohibited, except pursuant to the written consent of the individual to whom the record pertains, or in specified, limited circumstances.

Informing the patient

The DD Form 2005, Privacy Act Statement—Health Records, is used to inform patients of their rights under the Privacy Act of 1974. This single form eliminates the need for a separate PA statement for each medical or dental document. The form applies to all medical and dental forms, as well as any related documents required in providing health care. Remember, most 2100A series record jackets will have the Privacy Act Statement located on the outside (back) cover of the folder. Patient records maintained in these jackets do not require a DD 2005 placed in section three.

The DD Form 2005 is not a consent form. It serves as evidence that, as prescribed by the privacy act, the individual was informed of the purpose and uses of the information collected and was advised of his/her rights and obligations with respect to supplying the data.

NOTE: The signature of the patient on the DD Form 2005 is not mandatory. The individual requesting the patient's signature should in no way coerce or even imply that the signature is necessary before treatment is given. If a patient refuses to sign, the requesting individual should note such a refusal on the DD Form 2005 and sign it.

Privacy Act statement in outpatient records

The patient signs and dates DD Form 2005 only once for each outpatient health record, regardless of the time covered. The nonmilitary patient completes a DD Form 2005 at the time of his or her first clinic visit. Military members complete the form at the time of entry into service. If the form is not in the military member's outpatient record or preprinted on the reverse of the patient's outpatient record jacket, it is prepared at the time of his or her first clinic visit. A completed DD Form 2005 is placed in records filed at other locations, such as occupational health clinics, environmental health services, or family practice clinics.

Privacy Act statement in inpatient records

Place a signed copy of the DD Form 2005 in the inpatient record. For newborns, either parent can sign the Privacy Act statement.

The Health Insurance Portability and Accountability Act (Public Law 104–191, 45 CFR, parts 160 and 164)

The Health Insurance Portability and Accountability Act (HIPPA) was enacted on August 21, 1996. The purpose of the Act is to improve the portability and continuity of health insurance coverage, improve access to long term care services and coverage, and to simplify the administration of healthcare. A primary component of HIPAA administrative simplification provisions is the protection and privacy of individually identifiable health information. The HIPAA privacy rule governs this component and DOD 6025.18-R implements the requirements of the HIPAA privacy rule as listed below.

1. *Use of information.* Patient's protected health information can only be used for treatment, payment and health care operations without written authorization from the patient or other disclosures required by law.
2. *Acknowledgement of notice of privacy practices.* Each patient or guardian will receive a copy of the Military Health System (MHS) notice of privacy practices. Documentation must be entered on the HIPAA acknowledgement label that is placed on the bottom middle exterior of the health records jacket.
3. *Disclosure or release.* Records can be disclosed for various reasons without authorization by the patient. Complying with subpoena, court order, or public health requirement, as well as specific national security requirements are among the allowed disclosures.
4. *Patient rights to access.* Patients have the right to access their health record information. The health record is the property of the United States Government; the information contained in the record belongs to the patient. Patients can request copies of information in their record just as allowed in the privacy act.
5. *Accounting of disclosure.* The patient can request an accounting of every disclosure for the previous 6-year period back to 14 April 2003. This is limited to disclosures that are not part of treatment, payment, health care operations or disclosures authorized by the patient. Authorized disclosures must be tracked using a locally generated form until DOD implements the use of an automated accounting of disclosure tracking system.
6. *Restrictions on information.* According to HIPAA and the MHS notice of privacy practices, a patient has the right to request restrictions of uses and disclosures of their medical or dental information. Requests for restrictions must be made in writing. However, it does not mandate that the MTF is required to agree to the restriction. The restriction should be denied if the MTF couldn't reasonably accommodate the request, if it conflicts with this instruction or any other applicable DOD or Air Force directive, or for other appropriate reasons. See DOD 6025.18-R paragraph C10.1 for more information. The medical group (MDG) commander, or designee, must act on requests to restrict information in a timely manner and do so in writing. No restriction shall be effective above the management authority level that an authorized person agreed to it. No restriction shall be effective unless the person agreeing to the restriction is actually authorized to agree to it and establishes a written record of the restriction. The needs of the patient should be weighted with the burden that would be put on the facility to comply with the request. If granted, the patient should be informed that the restriction is not permanent and only applies to the individual or MTF that grants the request for which it is requested and does not transfer to another individual or MTF.

Drug Abuse Offense and Treatment Act, and Comprehensive Alcohol Abuse Amendments

You must know the laws governing these acts because they contain very specific instructions pertaining to the confidentiality of information in drug and alcohol abuse records. The drug and

alcohol laws take precedence over other directives pertaining to access and release of medical information. Health records (inpatient and outpatient) that contain reference to drug or alcohol abuse or rehabilitation are reviewed by the SJA for a determination of releasability and for guidance on the nature of the reply.

If it is determined that the record is not releasable under the drug and alcohol abuse acts, the requester is informed that release of the requested record is prohibited by law. If only a portion of the record is not releasable, that portion which can be released is provided, and the requester is informed that the records released are all that are allowed to be released under the law. The patient or his or her legal representative must give specific authorization in writing before information pertaining to drug and alcohol abuse or rehabilitation can be released from a health record. To comply with the federal laws, consent for the release of information must include the following:

- Name of facility to release information.
- Name and title of person or organization to receive information.
- Name of patient.
- Purpose or need for information.
- Extent or nature of information to be released (for example, narrative summary or outpatient notes and time period to be covered).
- Statement that the consent can be revoked at any time (except for that information which has already been released), and the specification of the data, event, or condition on which the consent will expire if revoked.
- Date consent signed.
- Signature of patient or person authorized to sign for the patient.
- Statement that future disclosure of the information without written consent of the person is prohibited.

The following sample format includes all of the necessary information to allow for the release of drug or alcohol abuse or rehabilitation information. Check with your supervisor for the specific release form your MTF uses for this purpose.

AUTHORITY TO RELEASE INFORMATION UNDER
TITLE 42, CODE OF FEDERAL REGULATIONS, PART 2

1. I understand the information to be released from my medical record includes information regarding:

a. _____ Drug abuse, treatment, or rehabilitation.

b. _____ Alcoholism, alcohol abuse, treatment, or rehabilitation.

2. I request and authorize (Name of Facility) to furnish (Name and Title of Person, Agency, or Organization) the following information: (specify extent or nature of information: such as hospital summary, outpatient notes and dates) contained in the medical record of (Name of Patient and SSN).

3. The above information is to be released for the following purpose only:

_____

_____

_____.

4. I understand that I may revoke this authorization at any time except for that action which has already been taken to comply with it. Without my express revocation, this will automatically expire (a) on satisfaction of the need for this disclosure; or (b) on (date supplied by the patient), or (c) under the following condition(s):

_____

_____.

5. Future disclosure of the information without my written consent is prohibited.

Exceptions

Once again, there are some exceptions to these restrictions. Information in drug and alcohol abuse related records may be released under the following conditions:

- Within the armed forces or between the Air Force and those components of the Veterans Administration furnishing health care to veterans.
- To medical personnel to the extent necessary to meet a bona fide emergency.
- To qualified persons for specific research, management, and financial audits or program evaluation.
- By an appropriate court order of competent jurisdiction after application showing good cause. On the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, imposes appropriate safeguards against unauthorized disclosure.

Prohibited redisclosure

Whenever information is released under the guidelines of the drug and alcohol abuse acts, the disclosure must be accompanied by the following statement:

> "Prohibition on redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of the medical or other information is not sufficient for this purpose."

202. Safeguarding and releasing medical information

Information in the health record is personal to the individual and must be safeguarded properly. Take every precaution to avoid compromise of medical information during the movement of patient records within your medical facility, such as during the records run or from the facility to any person authorized to receive them. Access to health records is restricted to authorized medical service personnel except in certain situations discussed in this lesson. Before releasing information to medical personnel, be sure their access to those records is authorized and necessary in the performance of their duties. For instance, your suspicions should be aroused if an airman from the medical equipment repair section requests a patient's medical record. If a request seems out of the ordinary or unrelated to the requester's normal duties, ask the person some questions and refer any suspicions you have to your supervisor.

Safeguarding practices

Limit access to all open record storage areas and to electronic records to authorized personnel only. Authorized personnel are defined as personnel who, through a verification process, have presented a valid requirement to access said records. Personnel granted access must be fully aware of the requirements on safeguarding protected health information (PHI) maintained in the MTF.

Establish procedures to ensure highly sensitive records and sensitive medical information are safeguarded. This includes copying electronic records for inclusion into the hard-copy record, safeguarding x-rays and fetal monitoring strips. Drug and alcohol abuse, rape, child or adult abuse and possible claims against the government are examples of highly sensitive records. Information which may affect the patient's morale, character, medical progress or mental health is considered sensitive. To protect the sensitive nature of the information, ensure that sensitive records or documents are only handled directly by medical personnel when advised by the attending physician or MDG commander.

Except under certain conditions (identified later), do not release information from medical records to any person or agency without the written consent of the person concerned (patient) or the patient's legal representative. A written request signed only by the husband for medical information from a wife's medical record is not releasable under these guidelines. The wife must sign her own request unless circumstances do not permit her to sign.

For example, the wife may be in a coma or have some other medical condition that does not allow her to sign the request. Questionable cases regarding release of information that cannot be resolved within your MTF should be referred to the base SJA.

Confidentiality

Information in a patient's health record is personal and considered confidential. Medical records must be handled in confidence so that personal information is not made known to unauthorized persons. This does not, however, prevent you from:

- releasing information on the current health and welfare of individual patients to appropriate persons, or releasing vital statistical data, such as proof of birth or death;
- complying with court orders or subpoenas to produce health records for law suits or criminal prosecutions; or
- releasing information from health records according to current law. This includes county, state, or federal (US or foreign) laws that have authority over those particular medical records.

Sensitive medical information

Information that may affect the patient's morale, character, medical progress, or mental health is considered sensitive. Drug and alcohol abuse, rape, child or adult abuse, and possible claims against the government are examples of highly sensitive records. To protect the sensitive nature of the information, stamp records or documents **"SENSITIVE MEDICAL INFORMATION"** before release or referral outside the medical facility. Then, place them in a sealed envelope stamped **"MEDICAL INFORMATION—FOR USE BY AUTHORIZED PERSONNEL ONLY."**

Records are hand-carried by trustworthy personnel only. For example, if a child is being treated for suspected child abuse injuries, it would not be appropriate for the parents to hand-carry the child's records to and from clinics and ancillary services when these records may contain possible incriminating evidence. In cases like this, the provider must inform outpatient records personnel that the records contain sensitive medical information and should be safeguarded. Otherwise, medical records are no longer hand carried.

When it is considered advisable by the physician or medical facility commander, sensitive medical records are only sent directly through medical channels. In other words, medical personnel will hand-carry these records between the records section and the appropriate clinics within the MTF.

Releasing medical information

As you are well aware by now, almost every activity in your career field has a set of procedures for you to follow. Releasing medical information is no exception. Because this is a very sensitive area, with implications for legal issues, you need to be very familiar with the guidelines. In the following paragraphs, you will study the process used to release medical information.

Nonmilitary sources

Information obtained from nonmilitary sources, such as civilian providers and hospitals, is for the purpose of further diagnosis and treatment of the patient or other official Air Force uses. Although this information is filed in the patient's medical record, it is not considered a part of the Air Force health record. Therefore, information that originated in a nonmilitary facility is not released any further by the Air Force. This information remains the property of the originating nonmilitary facility

or provider and can only be released by that facility or provider. You must inform the patient or other requester that additional information is contained in the medical record and that, if desired, it may be requested from the originating facility.

Honoring requests for medical information

The MDG commander reviews and approves the requests for release of medical information. The MDG commander has the authority to designate responsibility for these duties to another official. If the information or access to health records is to be provided to nonmedical personnel with a proper and legitimate need, such as Air Force Office of Special Investigations (AFOSI) agents, the MDG commander or his or her representative determines what information is pertinent to the request. It is also decided at this time whether or not the requester should receive professional medical assistance during the review of the records.

Medical facilities must comply with laws regarding the maintenance, use, and release of information. As a member of the health care team, you must also comply with these laws. When you receive a request for information, provide only enough information to accomplish the purpose for which the information is requested. For example, if an insurance company specifically requests information on an injury a patient received in a car accident last week, you do not release information from that patient's record concerning a hair transplant performed at a civilian facility five years ago!

Original health record documents are not released to any person or agency outside the executive branch of the US Government. Copies of pertinent pages of the record can be released as long as the requirements of such a release are met. If the patient is seeing a civilian provider in the local area, you may sign the record out to the patient; it is the patient's responsibility to return the record to the facility after the appointment.

When information is released to a third party (such as insurance companies, civilian physicians, etc.), further release is not authorized without the consent of the patient, his or her legal representative, or the agency having records responsibility. This is where it's important for you to understand the laws, policies, and procedures governing the maintenance use, and release of health records and medical documents. The details of this subject should be included in an ongoing training program for personnel working in outpatient records, as well as for HSMs throughout the entire clinic.

If there is any doubt as to whether the requester has proper or legitimate need for the information, ask the person to state the purpose for which the medical information is to be used. In certain cases, the requester is informed that information is being withheld until written consent of the person concerned is furnished. Remember, only the information that has been requested is released.

When you receive a request for records no longer at the medical facility, send the request to the activity to which the records were transferred and tell the requester of your action. If there is no indication that the record was ever in your file, complete the appropriate block in item 12 of DD Form 877, Request for Medical/Dental Records or Information, and return the form to the requesting facility (fig. 1–1).

REQUEST FOR MEDICAL/DENTAL RECORDS OR INFORMATION

REQUESTING ACTIVITY - Complete Items 1 through 10 (Except 8b), also complete Item 19.
ADDRESSEE - Complete Items 8b, 11 to 14 or 15 to 18, as appropriate, final referrer shall return to requester.

DATE: 1 Mar 2014

1. PATIENT (Last Name - First Name - Middle Name): SMITH, SAUL P.

2. ORGANIZATION AND PLACE OF TREATMENT: 359th Medical Group, 221 3rd Street Randolph AFB, TX 78148

3. STATUS: [X] MILITARY [ ] VA BENEFICIARY [ ] DEPENDENT [ ] FEDERAL EMPLOYEE [ ] OTHER (Specify)

3a. NAME OF SPONSOR (If dependent):

4. TO (Include ZIP Code): 74th Medical Group, 4881 Sugar Maple Drive, Wright Patterson, AFB, OH 45433

5. IDENTIFYING INFORMATION
a. SERVICE NUMBER: 123-45-6789
b. GRADE/RATE: E-7
c. SOCIAL SECURITY ACCOUNT NO.:
d. VA CLAIM NUMBER:
e. DATE OF BIRTH (If Federal employee):

6. DATES OF TREATMENT (Inclusive): 1 May 2002-1 July 2006

7. DISEASE OR INJURY:

8. a. RECORDS REQUESTED / b. RECORDS FORWARDED

MIL	VA		MIL (b)	VA (b)
[ ]	[ ]	CLINICAL	[ ]	[ ]
[X]	[ ]	OUTPATIENT	[ ]	[ ]
[ ]		HEALTH RECORD	[ ]	
[ ]	[ ]	DENTAL RECORD	[ ]	[ ]
[X]	[ ]	X-RAY	[ ]	[ ]
[ ]		MEDICAL REPORT CARDS, EMERGENCY MEDICAL TAGS, FIELD MEDICAL CARDS	[ ]	
	[ ]	ABSTRACT OF RATING SHEET		[ ]
[ ]	[ ]	REPORT OF PHYSICAL EXAMINATION	[ ]	[ ]
[ ]		ALL AVAILABLE RECORDS (Except X-rays unless specifically requested)	[ ]	
[ ]	[ ]	OTHERS (List under remarks)	[ ]	[ ]

9. REMARKS:

10. SIGNATURE: Saul Smith

REPLY/REFERRAL

11. TO:

12. REMARKS
[ ] RECORDS CHECKED IN 8b FORWARDED.
[ ] NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.
[ ] MORE INFORMATION NEEDED. FURNISH FOLLOWING:

13. SIGNATURE

14. DATE

REPLY/SECOND REFERRAL

15. TO:

16. REMARKS
[ ] RECORDS CHECKED IN 8b FORWARDED.
[ ] NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.
[ ] MORE INFORMATION NEEDED. FURNISH FOLLOWING:

17. SIGNATURE

18. DATE

19. RETURN TO: (Include ZIP Code): 359th Medical Group, 221 3rd Street, Randolph AFB, TX 78148

REQUESTING ACTIVITY WILL ENTER COMPLETE ADDRESS TO WHICH RECORDS OR FINAL REPLY SHOULD BE MAILED.

DD FORM 877, SEP 67 — REPLACES EDITION OF 1 JAN. 60. — Adobe Professional 7.0

Figure 1–1. DD Form 877, Request for Medical/Dental Records

Responding to requests for medical information

Use a locally developed transmittal letter or the form furnished by the requester when an insurance company or other agency requests information. Prepare the transmittal letter or form in three copies—

send the original to the requester, file the second copy in the health record with the authorization for release of information, and forward the third copy to the medical service account (MSA) officer.

When answering requests for information on injury cases, which appear to involve third party liability action, send a copy of the letter or form to the SJA. When answering requests referencing pending litigation or contemplated litigation send a copy of the request to the SJA. When information is released to a third party liability action, send a copy of the letter or form to the SJA. When information is released to a third party, such as an insurance company, the transmittal letter must include the statement; **"You are not authorized subsequent release of this information without the permission of the patient, his/her legal representative, or this medical facility."**

Other DOD medical facilities may use DD Form 877 to request medical information or records. The DD Form 2138, Request for Transfer of Outpatient Record (fig. 1–2), is used to request a permanent transfer of outpatient records. The DD Form 877 is a much more detailed form, and can be used for either a permanent or a temporary transfer of information. It can be used to request all types of medical information (inpatient, outpatient, or dental records; x-rays; tests; etc.). If you receive a DD Form 877, send the record and the original and one copy of the DD Form 877 back to the requesting MTF (follow the instructions for "addressee" preprinted on the back of the form), then file a copy of DD Form 877 in the folder pocket of a charge-out guide in place of the record.

(To mail, address and send through the Base Distribution System)

REQUEST FOR TRANSFER OF OUTPATIENT RECORD

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - Use Blanket PAS - DD FORM 2005)
(This form may be used only when requesting records from US Military Medical and Dental facilities)

I. REQUEST THAT THE OUTPATIENT RECORD(S) OF INDIVIDUAL(S) LISTED BELOW BE TRANSFERRED TO THIS TREATMENT FACILITY	INSTRUCTIONS TO SPONSOR Complete Sections I and II of form. Deliver form to U.S. Military outpatient clinic which will next provide outpatient care for the dependents.
PRINT NAME *(Last, First, Middle Initial)* **AND RELATIONSHIP TO SPONSOR** *(Family member prefix code)*. **EMBOSSED PATIENT'S CARD MAY BE USED.**	**II. SPONSOR INFORMATION**
	GRADE / **NAME** *(Last, First, Middle Initial)*
	DEPT / **SSAN**
	III. REQUESTING FACILITY
	FROM: *(Complete mailing address of requesting facility)*
	DATE / **REQUESTER** *(Signature, grade, title)*

DD Form 2138, JAN 78 **REPLACES AF FORM 275, MAR 71, WHICH IS OBSOLETE.**

Figure 1–2. DD Form 2138, Request for Transfer of Outpatient Record

Filing correspondence related to the release

File all correspondence relating to the release of information in the patient's health record folder for permanent retention. Include the request for information, signed consent of the patient or guardian when required, and a copy of the information released or a statement of the specific documents released. When you send copies of these documents make sure you document (on a transmittal letter) exactly what documents you did release, and file the letter and the release correspondence in the patient's record.

Releasing medical information electronically

Although most regulatory and accreditation requirements do not specifically address the use of Telefax in relation to the transmission of health information, you must be aware of any specific state laws and regulations, including hospital licensure laws, which address requirements for original records or facsimile transmission.

To protect patient privacy, only use facsimile transmission when the original record or mail-delivered copies will not meet requirements for immediate patient care. Only send sensitive information when urgently needed for patient care or when required by a third-party payer for ongoing certification of payment for a hospitalized patient.

Limit facsimile transmission to the documents required to meet the requester's needs. Use regular mail or messenger service for routine disclosure of information to insurance companies, attorneys or other legitimate users.

The cover letter sent with the documentation transferred will include the following:

- Date and time of facsimile transmission.
- Sending facility's name, address, telephone number, and facsimile numbers.
- Sender's name.
- Receiving facility's name, address, telephone and facsimile numbers.
- Authorized receiver's name.
- Number of pages transmitted including cover page.
- Confidentiality notice, including instructions on redisclosure and destruction.

Maintain the signed release authorization and the original cover letter with a notation of the disclosed information, data, and identity of the employee making the disclosure. File these in the patient's health record.

203. Specific requests and laws governing requests

It is important to become familiar with some of the more common situations that may arise if and/or when you become responsible for the release of information at your MTF. If you work with release of information long enough, situations will arise that you have not encountered. Always remember to research the facts before you release medical information. Discuss the situation with your chain of command, research the directives or call your base legal office. Complying with Air Force directives and laws are of critical importance! Here are some of the more common scenarios you may be faced with.

Replying to specific requests

The following paragraphs provide you with background information and guidelines you can use when replying to specific requests for information. It takes a topical approach by discussing how to provide information to the patient at his or her request and how to release information on adopted infants. In addition, we provide guidelines on responding to requests for information from the public, including the news media, OSI, the courts, other governmental departments and agencies, and medical and scientific agencies. Let's begin by discussing the release of information to a patient in response to his or her request.

Release of information to a patient

Information in the health record or a copy of pertinent pages can be released directly to the patient. Information can also be released to authorized representatives of the patient when a written request is received from the patient or a legal representative. However, if a physician determines that a direct disclosure of the information to the patient could have an adverse effect on the physical or mental health or safety and welfare of the individual, or other persons with whom he or she may have

contact, only release the information to a physician named by the patient or to a person qualified to make psychiatric or mental determinations. The physician or qualified individual can then determine what information, if any, may be disclosed to the patient. If the patient's records involve a potential claim, the original records must not be given to the patient.

DOD investigative agencies

Special agents are granted access to health records when proper identification is provided. The agent must sign a dated statement which contains the identity of the record to be examined, the identity (file number) of the investigation for which the record is being examined, a certification by the examiner that the examination is required as part of the official investigation, identification of any copies of material furnished to or copied by the agent, and a signed receipt.

NOTE: Do not file the statement in the patient's health record. Maintain the statement in a separate folder in the general correspondence files until the investigation is concluded. At that time, annotate disclosure in the disclosure accounting system.

Before providing investigative agencies access to the records, the request and the records will be reviewed by the MTF commander or designee. Special agents should seek an interview with a health care provider when clarification or interpretation of medical documentation is necessary. These actions are taken as quickly as practical so as not to delay the investigation.

Although the OSI has the right to seize government records for investigation, OSI agents will not seize original medical records without SJA written approval. If such approval is received, copies of the seized records will be left with the medical facility. In all but very few exceptions, giving the OSI a certified true copy of the original records will suffice. Consult with the SJA if questions arise.

Release to US Government branches

Regarding release of information to US Government entities, you most likely will receive requests from courts and other administrative bodies, first sergeants and commanders, as well as other departments or agencies. Because there is a difference in the way you respond, we will discuss each of these situations separately.

Other departments or agencies

Medical information is released upon request, to other departments and agencies, both Federal and State, that have a proper and legitimate need for the information. For example:

- Release protected health information to the Department of Veterans Affairs (DVA) to process a claim in which the person's medical history is relevant or upon the separation or discharge of the individual from uniformed service for the purpose of a determination by DVA of the individual's eligibility for or entitlement to benefits.
- Release protected health information to Federal and State hospitals and prisons for further medical treatment of a person in their custody. Give the First Sergeant or prisoner escort the original health records of active duty members when processing a patient to go to a corrections facility.
- Release protected health information to the Occupational Safety and Health Administration (OSHA) to help detect, treat, and prevent occupational injuries and diseases.
- Release protected health information to the Air Force Reserve or Air National Guard, Air Reserve Component (ARC) medical personnel when required to determine the medical qualification for continued military duty of a spouse or other beneficiary who is a Reservist or Guardsmen.
- Release the protected health information of foreign military personnel to their appropriate foreign military authority.

- Release protected health information upon the request of medical research or scientific organizations or other qualified researchers when, in the opinion of the releasing authority, its release is legal and in the public interest. This also includes release of information to present or former members of the uniformed services who need it for private study or research to advance their professional standing. Where possible, de-identify the records by removing names and SSNs of individuals and other unnecessary demographic information. Counsel the researcher that the information must be held in confidence and that any published reports must not identify, in any way, the individuals whose health records were examined. Do not release the information when reproducing the information would be a burden or if it violates existing laws.

All disclosures of information must be documented in the medical record or the automated disclosure tracking system.

Access may be granted to review records for research purposes in MTFs and facilities of the General Services Administration (e.g., National Personnel Record Center [NPRC]). Hard copy medical records will not be removed from the MTF or other facility. Space will be furnished to review the medical record.

MDG commanders, with concurrence of an Institutional Review Board (IRB) or Privacy Board, will approve requests from personnel under their command whose research projects involve medical records maintained at that facility when individual patient authorizations are not practical.

Submission of research requests

All requests from outside and within the Department of the Air Force will be made through channels to:

AFMSA/SG6H
2261 Hughes Dr Ste 158
JBSA Lackland AFB TX 78236–9856

Requests will include the following:

- Name and address of researcher and any assistants.
- List of the professional qualifications of the researcher and any assistants.
- Description of the researcher’s project or field of study.
- Reason for requesting the use of Air Force records.
- Identification of the specific records required and their location.
- Provide inclusive dates when access is desired.
- Signed agreement from each person named in the request listing the following conditions:
  a. Information taken from Air Force medical records will be treated according to the ethics of the medical and dental profession.
  b. Identities of people mentioned in the records will not be divulged without their written authorization, and no photographs of a person or of any exterior portion of his or her body will be released without his or her written consent.
  c. The researcher understands that permission to study the records does not imply approval of the project or field of study by the Air Force Surgeon General.
  d. All identifying entries concerning a person will be deleted from abstracts or reproduced copies of the records. Published reports will not identify in any way individuals whose health records were examined.

e. Any published material or lectures on the particular project or study will contain the following statement: "The use of Air Force medical records in the preparation of this material is acknowledged, but it is not to be construed as implying official Department of the Air Force approval of the conclusions presented."

Sequestering medical records

The MTF may sequester the original medical record or a certified copy when the situation warrants. If a certified copy is made for sequestering, return the original record to the file room and suspense it for periodic updates. Some recommendations on when to sequester the original outpatient record are as follows:

1. When a claim has actually been filed.
2. When the patient has tried to tamper, alter, or illegally remove a record from the facility.
3. When a request is received from an attorney under circumstances indicating a claim is being considered.
4. When the patient has initiated an IG (Inspector General), Congressional Inquiry, or Investigation.
5. When the record becomes relevant to an OSI or Security Forces investigation. Annotate sequestered record form with the OSI/Security Forces agents name and case number for annual review process.

It is the MDG commander's responsibility (with Quality Services Manager and/or SJA's advice) to establish local operating instructions on how to sequester medical records for safekeeping. As a minimum, the records will be kept in a separate, locked location with limited access. If the patient is actively being seen at the MTF, copy the original record for the outpatient records room and annotate on the jacket "Clinic Copy." Create the "Clinic Copy" in Composite Health Care System (CHCS) as a unique record type for tracking purposes in the Medical Records Tracking (MRT) module.

Place a cover sheet on the original medical record stating the record has been sequestered. Maintain a separate file on why the record has been sequestered, and the date (or occurrence of an event) when the record should be reviewed to determine the need for continued sequestering. Place a charge out in appropriate records room with a statement that the record has been sequestered. If a "Clinic Copy" is made, ensure the original documentation is forwarded to the sequestered file and a copy is placed in the "Clinic Copy."

Coordinate an annual review of sequestered records with the base claims officer to determine whether the records should continue to be sequestered. In addition, ensure records are reviewed before patient relocation to see if sequestering is still applicable. If sequestering is still required, mail the outpatient records to the gaining MTF. The losing MTF will make a certified true copy of the record before mailing for the cases identified in recommendations 1, 3, 4, and 5 above. Maintain the copy until the claim is resolved with the base claims officer.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

201. Laws affecting maintenance and disclosure

1. What acts and amendments must medical personnel comply with?

2. Medical records are maintained within a system of records protected by which act?

3. What single form eliminates the need for a separate privacy act statement for each medical or dental document?

4. Relative to the release of medical information, what is the purpose of the DD Form 2005?

5. Is the signature of the patient mandatory on the DD Form 2005? Explain.

6. What is the purpose of the Health Insurance Portability and Accountability Act?

202. Safeguarding and releasing medical information

1. Explain the policy of releasing information to *medical personnel*.

2. Questionable cases regarding the release of medical information are referred to what office?

3. How much information should be provided when answering a request for medical information?

4. If your MTF receives a DD Form 877 from another MTF and the records have been transferred to another base, what procedure should you follow?

203. Specific requests and laws governing requests

1. If a physician feels that the release of medical information to the patient will have an adverse effect on the physical or mental health of the patient, what procedures should you follow in answering a request for medical information?

2. What must a special agent provide to be granted access to health records?

3. What should you tell medical research or scientific organizations when releasing medical information?

4. When may the MTF sequester the original medical record or a certified copy of the medical record?

5. How often must you coordinate a review of sequestered records with the base claims officer to determine whether the records should continue to be sequestered?

1–2. The Composite Health Care System

What patient care computer system is used most often in a MTF? Give up? Let me give you a couple of hints. Health services managers (HSM) use the system to help locate and checkout outpatient medical records. Medical technicians and HSMs working on the primary care optimization teams operate the system to help manage the appointment system and document patient related data. Providers use the medical system to order laboratory, radiology and pharmaceutical support. In turn, ancillary services personnel use the system to retrieve requests electronically sent by providers. Now, do you think you know the answer? It's called the Composite Health Care System (CHCS) of course! As you can see, CHCS is used in many different capacities throughout our MTFs to help better manage patient data and expedite care. For these reasons, it is pivotal that all HSMs have a good understanding of its many features.

204. CHCS pre-registration procedures

The Composite Health Care System allows MTF personnel to track patient care and related administrative activities on a daily basis. When CHCS is fully activated, all subsystems work together to assist MTF personnel in providing quality patient care. CHCS also interfaces with the Defense Enrollment Eligibility Reporting System (DEERS), which allows for automatic DEERS checks to be accomplished for patients.

No single aspect of CHCS is more crucial than the initial registration of a patient. For that reason a great deal of emphasis has been placed on that subject. Many other commonly used automated data functions will be discussed at length as well. As you know, not a single function can be accomplished without knowing how to properly log on to the system. Most of you probably remember learning this task during your Health Services Management Apprentice Course. For that reason, this lesson briefly describes the proper sign on procedures before delving into the initial registration of patients as well as the other commonly used CHCS functions. Do you feel overwhelmed? Don't! We are going to cover these topics point by point and also explain how to access the ever-important HELP menu whenever you may need assistance.

Logging on to CHCS

The procedures to log on to CHCS are quite simple, but may vary depending on your starting point and how your terminal is connected to the system. You will need a username and access/verify codes to log on to the system. To begin the process, you will have to respond to the following prompts:

- Username:
- ACCESS CODE:
- VERIFY CODE:

Remember, these steps may vary depending on your starting point and how your terminal is connected.

Let's discuss a few of the prompts and clarify their roles. The access and verify codes establish your identity to CHCS and authenticates your use of the system. Your user record lets the system know who you are and how you can use the system. Personnel assigned to your MTF's systems flight will be able to assign these codes to you or give directions as to how to receive them. They are also an excellent resource to use if you have difficulty accessing the system.

Each time you use your access and verify codes, your actions are noted by the system audit mechanisms. The system tracks log on attempts, menu access, file access, record access and log off. If you make a mistake when entering your access and verify codes, you may try again. Your site determines the number of attempts permitted. After an excessive number of attempts, your terminal will lock up for a set amount of time.

Once you are logged on to CHCS, your primary menu is displayed. This is the user's starting point. Different users will have different primary menus depending on the nature of the work to be accomplished. It's as simple as that! Now that you have an understanding of the log on process, let's continue this lesson by explaining the ever-important function of accessing the CHCS HELP feature.

Accessing help

CHCS provides help throughout the entire system. You can use question marks (?, ??, ???) to access help at any menu, prompt or field.

- Entering ? accesses a message that tells you how to get additional help.
- Entering ?? displays the secondary menu.
- Entering ??? displays a brief description of each option on the menu.
- Entering ?OPTION or ?OPTION SYNONYM displays the section of the OLUM that discusses that option. Enter OLUM to access the Online User's Manual Menu.

Remember, the various HELP options will save you time and unwanted frustrations when working with CHCS. Now you know how to log on to the system, as well as access HELP when working within CHCS. Our next step deals with one of the most vital aspects of the CHCS process—patient registration.

205. Patient registration and eligibility

As the MHS has deployed AHLTA, the initialization of the electronic health record is accomplished the first time a patient is registered in DEERS and CHCS. Therefore, patient registration, if not completed properly, can cause patient duplication within AHLTA and can lead to demographic data errors. A single patient registration error has the potential to cause significant patient safety and records management problems, extending beyond the patient's primary MTF to other MTFs via AHLTA. As such, it is imperative that strict attention to detail be followed during patient registration and that current MHS demographic error (including FMP and SSN error) correction guidelines are followed when addressing registration errors and inconsistencies within and between AHLTA and CHCS, as well as other interfaced systems. For more information on Patient Registration, refer to AFI 41–210, Chapter 4.

The Patient Administration function has direct oversight of MTF patient registration. MTF clinical work centers such as the pharmacy, laboratory, emergency department, and the local TRICARE Service Center may also require the ability to register patients in CHCS. To ensure a balanced and responsible registration process throughout the MTF, Patient Administration personnel, in partnership with CHCS System Administrators and Information Management officials, provide user training and are the only MTF approval authorities authorized to grant registration access and/or similar capabilities. Registration capabilities are only to be granted to authorized MTF staff members who have demonstrated the correct registration procedures and have received documented patient registration training validated by the MTF Tricare Operations and Patient Administration (TOPA) or Patient Administration function or Flight Commander. Requests for CHCS registration training are coordinated and approved by the flight superintendent or flight commander before submitting requests to the MTF TOPA Flight Commander, Patient Administration Officer, Systems or Information Management Flight Commander. Training requests submitted by individual users seeking CHCS registration training, without documented flight level approval, are not accepted.

At MTF point of service locations, such as outpatient clinic reception or customer service front desk, laboratory front desk, radiology department reception desk, etc., only supervisors and personnel that regularly receive patients and confirm appointments are authorized CHCS registration keys. CHCS registration capabilities or the CHCS File Man code with the appropriate CHCS registration related security keys will not be automatically granted or added to any MTF staff member's CHCS user profile without flight commander justification. The MTF TOPA Flight Commander, Patient Administration Officer, Systems Flight Commander and/or designated Information Management Officer have shared approval authority to grant training permission. TOPA officials are responsible for conducting periodic reviews of all MTF personnel with CHCS registration capabilities to verify training requirements have been met and registration capabilities remain valid.

Performing a patient look-up

It is critical to key patient information into CHCS correctly. Small differences in the entry of a patient's name or social security number (SSN) can be the cause of a duplicate patient record. PLEASE BE CAREFUL! Adding a duplicate patient to the database can have a significant impact on patient safety. To avoid confusion and duplication, before registering a new patient you must accomplish a "Patient Lookup."

To perform a patient lookup, you must have been assigned the ampersand (&) Fileman access code. The following is the preferred method and must be followed closely to ensure accuracy. When the **Select Patient** prompt is displayed, accomplish the following:

1. Enter the first letter of the patient's name and last four digits of the patient's SSN. (i.e., Select Patient: **G9999**) Check the display closely. If the patient information matches, verify the selection. Go to the second step if no match is found.
2. Enter the patient's full SSN (i.e., **999–99–9999**). Check the display closely. If the patient information matches, verify the selection. Go to the third step if no match is found.
3. Enter the patient's last name (i.e., **GRAY**). Check the display closely; look for the listing that matches the patient information you have.
4. If there is no match, you may register the patient as a new patient using the following convention: **LAST NAME,FIRST NAME MI** , pay special attention to the following:
   - There is no space between the last and first name (GRA**Y,A**NDREW).
   - There is one space between first name and middle initial (GRA**Y,A**NDREW **F).**
   - There is no period after middle initial. Press <Return> after typing.

Person or personal identifiers

Most patients treated in the Air Force Medical Service (AFMS) possess a SSN. Individual identification using a person's unique Social Security Number provides a solid framework from which to build a personal eligibility profile in DEERS and within the MTF. SSNs are considered Person or Personal Identifiers and are used as the default numeric "account number" for which CHCS partly bases individual identification. Some patients, however, may not possess a SSN for various reasons. Frequently, alternative Person or Personal Identifiers are used to reduce the use of SSNs or identify patients as individuals who may not possess a SSN. There are multiple alternative Person Identifiers issued, used, and/or created depending on the patient's particular situation.

Foreign Identification Numbers

Foreign Identification Numbers (FIN) are issued to foreigners who are eligible for healthcare but who are not eligible to obtain a SSN. The FIN takes the place of a SSN. The FIN begins with the number "9", e.g., 9XX-XX-XXXX and is issued by DEERS. An example of someone who may be issued a FIN: A military service member from a participating SOFA country here in the United States enrolled in a pilot training program.

Temporary Identification Number

The Temporary Identification Number (TIN) is an ID number issued by DEERS to patients who are eligible for SSNs but who either do not possess an issued SSN or those who have been issued a SSN but have not reported the SSN to DEERS. The TIN takes the place of a SSN. The TIN begins with the number "8", e.g., 8XX-XX-XXXX. The TIN resembles a "Pseudo" SSN which is generated only in CHCS. Although the TIN begins with the number "8", it is different from the "Pseudo" SSN (which will be discussed later in this section). A TIN should appear on the beneficiaries ID card and remain constant between different CHCS computer server hosts. Pseudo SSNs are only relevant or applicable to the local CHCS host computer server (at the MTF where the number was created) and are based on the patient's date of birth or date of emergency medical treatment when a Patient Identifier is not known. Patients can legitimately have different Pseudo SSNs on different CHCS host computer servers.

Individual Taxpayer Identification Number

According to the Internal Revenue Service (IRS), the definition of an Individual Taxpayer Identification Number (ITIN) is, "A tax processing number issued by the IRS. It is a nine-digit number that always begins with the number 9 and has a range of 70–88 in the fourth and fifth digit, example 9XX–70-XXXX. The IRS issues ITINs to individuals who are required to have a US taxpayer identification number but who do not have, and are not eligible to obtain a SSN from the Social Security Administration (SSA)."

Other alternative Personal Identifiers do exist but the three previous examples are the most common forms for which an MTF will be presented. If the patient is eligible for an SSN and does not yet possess the official number, encourage the patient or sponsor to provide the SSN to the local DEERS office following SSN issuance from the SSA. The new SSN will replace the alternative Personal Identifier in DEERS and CHCS.

Patients with multiple-eligibility

Beneficiaries are registered according to the highest level of eligibility. However, patients may be eligible for medical and dental care under more than one FMP/SSN and patient category (PATCAT). These patients pose a unique problem and careful management of this issue must be fulfilled to prevent cascading effects that may negatively impact patient safety, continuity of care, medical records tracking, and financial reimbursement processes, as well as other MHS systems that use CHCS for registration and identity (for example, AHLTA). Currently, CHCS is not designed to support patients that have multiple concurrent (or historic) eligibility categories, e.g., patients who are eligible or who once were eligible for care under another or multiple FMPs, SSNs, or PATCATs. Key patient identifiers (the patient SSN and DOD ID Number) are only allowed to be used one time on any CHCS host computer server—this means, the local CHCS can only "see" a patient in one status. However, to work around this restriction, patients with dual or multiple-healthcare eligibility have been historically registered more than once using a "Pseudo" SSN. The entry of more than one SSN into CHCS (for the same patient) fools the system by inaccurately identifying the patient according to two different patient identity registration profiles. Unfortunately, this created many identification issues.

The practice of inserting or creating a "Pseudo" or manufactured SSN into any CHCS patient registration data entry, so that a patient's healthcare may be differentiated according to different beneficiary categories for which the patient may be eligible, may temporarily solve an immediate records management, records tracking requirement, or third party insurance payer reimbursement requirement. This practice however, places the patient's safety at risk by fragmenting their medical history, to include medication and allergy profiles, into separate records. The "splitting" or division of the patient's record within CHCS, AHLTA, etc. affects interfaced systems. FOR THIS REASON, NO PATIENT (TO INCLUDE DUAL OR MULTIPLE HEALTHCARE ELIGIBILITY PATIENTS) SHOULD BE PURPOSEFULLY DUPLICATED WITHIN CHCS; PATIENTS SHOULD BE

REGISTERED ONE TIME UNDER THEIR HIGHEST LEVEL OF ELIGIBILITY. This mandate will certainly cause confusion in terms of records tracking/filing paperwork and billing, but the safety of the patient must be considered above all other factors. When a patient is identified with more than one eligibility account, profile, or record, and/or if clinical data has been entered under more than one record, FMPs, or SSNs, MTF TOPA staff or system managers are authorized to merge the duplicate records and "alias" the surviving record using the Former Patient Name functionality within CHCS. Changes must be processed in accordance with (IAW) current MHS merge/unmerge guidelines. While this practice successfully merges or identifies duplicate multiple-eligibility patient accounts or records, this action does not correct duplicate records or entries already documented in AHLTA and other associated MHS automated systems. Providers and MTF staff must be aware of the potential problems associated with dual or multiple-eligibility patients and how to implement corrective measures and alternative processes to ensure the patient's healthcare is properly documented. With greater emphasis placed upon training and identification of multiple-eligible patients during the initial CHCS registration training course and through the practice of limiting CHCS registration keys to users who truly need access, future occurrences of PIT errors and/or record/account linking or "aliasing" problems associated with accidental or purposeful registration of patients with more than one eligibility level, are expected to significantly decrease.

Securing the correct patient identity for patients with multiple healthcare eligibility categories remains a noteworthy AFMS and MHS challenge. Significant issues related to dual or multiple eligibility (to include maintaining multiple hardcopy records for the same patient while having one electronic record), or resolving data alignment problems between different medical systems (such as FMP/SSN discrepancies between CHCS, AHLTA, and DEERS using different identifiers for patient status) have not yet been resolved. The medical facility's TOPA and MTF systems (IM/IT) personnel are responsible for ensuring all MTF personnel are aware of current policies and procedures designed to mitigate these problems, and how new systems or procedures may impact the overall patient identity process. The TOPA and systems offices must also ensure that any and all MTF staff members, who possess CHCS registration capabilities, are aware of the problems associated with multi-eligible patients and other current patient identity problems. Actions that may lessen the confusion associated with these particular patients are: aliasing a patient within CHCS registration, noting a patient's multiple eligibility within CHCS registration, and placing records aside that cannot be retired properly (patient is active duty, but a dependent child record exists that needs to be retired to the National Personnel Records Center (NPRC); collect these records for later resolution). Other actions include cross-referencing physical records when the patient has more than one physical record within the MTF (e.g., when the patient's highest level of eligibility is a dependent family member but he or she also has a Reserve Component health record within the MTF). MTF records managers should take necessary steps to identify as many of their dual or multiple eligibility patients and keep track of their records for resolution when an acceptable "work around" solution is identified. These actions may lessen, but will not completely eliminate the confusion caused by current system design deficiencies. Instructions on how to manage two paper records for Dual Eligible patients is discussed in the Medical Records section.

No available SSN

A pseudo-SSN is created for beneficiaries without an SSN. This process occurs in the DEERS when the personnel technician issues an ID card or enrolls the beneficiary. Either a foreign identification number (FIN) or a temporary identification number (TIN) is generated. When issuing an ID card, the DEERS gives the personnel technician a choice to enter an SSN, FIN or TIN. When FIN is selected, DEERS automatically assigns a 900–00–000F. This number is assigned to categories of eligible NATO and non-NATO foreign military members, their family members, for foreign nationals employed in positions overseas that result in DOD benefits and entitlements, and for authorized non-US personnel who are not under our Social Security Administration System, and will not receive an SSN.

A TIN is assigned and automatically generated by the DEERS (800–00–000D) for categories of beneficiaries who are awaiting an SSN (such as newborns) or for those who do not have a SSN. The TIN is used as a method to record the beneficiary as a potential patient on DEERS while awaiting a SSN. Foreign nationals who are the spouse of a US citizen will be issued a TIN if they are awaiting or will be receiving an SSN. If they are not required to have an SSN, they are issued a FIN.

SSN reduction

In an effort to reduce the unnecessary use of SSNs, DOD has begun the use of alternative Personal Identifiers in place of the SSN. The alternative Personal Identifiers include the DOD Identification (ID) Number, which uniquely identifies individuals, and the DOD Benefits Number that identifies individuals eligible to receive DOD benefits such as commissary, exchange, and TRICARE benefits. The Military Health System, when feasible, will limit the use and display of SSNs while migrating systems and business processes to use the DOD ID Number. While the security of SSNs is at the forefront of MHS concern, the process of converting all paper medical record jackets across the DOD has proved to be an unrealistic task.

The mini registration function

As stated earlier, one of the most important functions of CHCS is patient registration. In fact, registration must take place before any other automated action can be accomplished. For example, a patient must be registered before they can be admitted, schedule an outpatient appointment or utilize ancillary services. In the CHCS database, patient demographics (personal information that does not change because of a specific episode of patient care) is entered into an automated patient record, similar to registering for a club membership. Patient records are also updated in the same manner. This information is critical because it is used by every CHCS user within the MTF including doctors, laboratory technicians, and appointment schedulers, etc. If the patient registration is incomplete or inaccurate, every user has inaccurate and incomplete information. Under most circumstances, mini registration takes place when a patient or family member is newly assigned to the base (when the records are being turned in to the outpatient records section after PCS), or the first time they make an outpatient appointment, or are seen on an outpatient basis. The mini registration option allows selected personnel to perform four different functions:

1. Add a new patient as his/her own sponsor.
2. Add a new patient with an existing sponsor.
3. Add a new patient with a new sponsor.
4. Update an existing patient registration.

To register a new patient, you must be assigned the ampersand (&) Fileman access code by your information systems office. Without this code, you cannot register a new patient into CHCS. This restriction ensures only those individuals with the proper training and expertise can register a patient. However, even without the Fileman access code you can use the Mini Registration option to update an existing patient’s record. The system will prompt you for the name of the individual you want to register. As stated in the patient look-up section, the name must be typed precisely in order to alleviate the chance of a duplicate record. The correct way to enter a patient’s name is as follows: **LAST NAME(comma)FIRST NAME(space) MIDDLE INITIAL (e.g. SMITH,JOHN S)**

The demographic information gathered during mini registration includes the following:

- Name
- FMP (family member prefix)
- DOB
- Sponsor’s SSN
- Patient Category
- Home Phone/Work Phone
- Security Clearance
- Rank
- Station/Unit
- Duty Address
- Duty Zip Code
- Duty Phone/DSN (Defense Switch Network)

- Patient Address
- Sex
- Zip Code
- Outpatient Records Location
- Primary Physician
- Registration Comments

All of this information is extremely important because it is used by all CHCS users. The old adage, “garbage in, garbage out” applies to entering and using CHCS data! Are you getting the hint? It is extremely important that the information stored in CHCS is accurate!

That’s all there is to it! You have just registered your first patient. Now, let’s look at the difference between mini registration and full registration.

The full registration function

Normally, full registration is only accomplished if a patient is being admitted to the MTF; however, each MTF will have guidelines established to dictate when full registration is appropriate. Full registration is very similar to mini registration except that more information is entered (such as next of kin and emergency contact information) so it takes a little more time to accomplish. As with the mini registration, you will still need the ampersand (&) FileMan access code to complete full registration for a patient.

DEERS check

Both full and mini registration includes a DEERS check to verify the patient’s eligibility for care at the MTF. A perpetual link exists between CHCS and DEERS systems. CHCS stores the results of the eligibility check in the patient file. Eligibility information is assumed valid for 120 hours.

Post registration options

After registering the patient, you will be prompted to complete one or more post registration options. Although the options vary according to the MTF’s CHCS capabilities, the four most commonly used options are as shown in the following table:

Option	Results in
Create Medical Record?	An electronic entry used to track the physical patient record.
Print Registration Form?	A hard copy of the registration information.
Emboss Card?	The patient identification card used to stamp patient information on medical forms.
Enter/Edit Allergy Information?	Updated allergy data for the registered patient.

You have now successfully completed a mini and full patient registration. In our next lesson, we will learn some of the more common functions such as the record tracking system and the automated record charge-out.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

204. Composite Health Care System pre-registration procedures

1. Match each definition in column A with its corresponding term in column B. Each term in column B will be used only once or not at all.

Column A	*Column B*
____ (1) Establishes your identity to CHCS and authenticates your use of the system.	a. Primary Menu.
____ (2) Let's the system know who you are and how you can use the system.	b. Help Menu.
____ (3) Notes your actions each time you use your access and verify codes.	c. User Record.
____ (4) This is the user's starting point once logged on to CHCS.	d. Online User's Manual.
	e. System Audit Mechanism.
	f. Access and Verify Codes.

2. SrA Rose is having trouble performing a patient look-up on CHCS. What input can he enter at any menu, prompt or field to learn how to get additional help?

205. Patient registration

1. What must be assigned to you before you can accomplish a patient look up in the CHCS?

2. What is the proper way to insert a patient's name in CHCS?

3. What are the four different functions the mini registration option allows users to accomplish?

4. Normally, when is a full registration accomplished?

5. How long is the DEERS eligibility information assumed valid?

1–3. Automated Medical Functions and Processes

In years gone by, most of the functions described in this section were done using paper and pen. Automated systems like CHCS helped to revolutionize healthcare management. But, like any new process or system, it's only as good as the user sitting in front of the keyboard. By gaining the required knowledge and skills necessary to successfully operate CHCS, you are accomplishing two important functions: (1) You are making the job of the HSM more efficient, while (2) ensuring our

customers receive the best care possible. In this section we are going to discuss the CHCS medical record tracking system and its associated functions.

206. Creating a medical record tracking record

The purpose of the CHCS Medical Record Tracking System is to electronically track patient records, medical or dental, their location and availability to be charged out. The system is specifically designed to track the location of a record and its availability to be charged out. The tracking is achieved through the creation of an electronic record and printed labels that identify records by patient name or identification number (ID#) (fig. 1–3).

These medical record tracking labels are human and machine readable through the use of bar codes. Medical Record Tracking (MRT) functions provide all of the following:

- Loan control.
- Record transfer and retirement.
- Data and statistics necessary for record management.
- Create records and print labels, both automatically and manually.
- Generate pull lists.
- Check-in and charge-out records.
- Track individual record statuses, locations, and pending requests.
- Flag records that are missing or are inactivated for various reasons.
- Generate lists of those records eligible for transfer and/or retirement.
- Generate the reports necessary to manage department activities.
- Generate electronic messages to notify tracking system users of information concerning specific patient records.

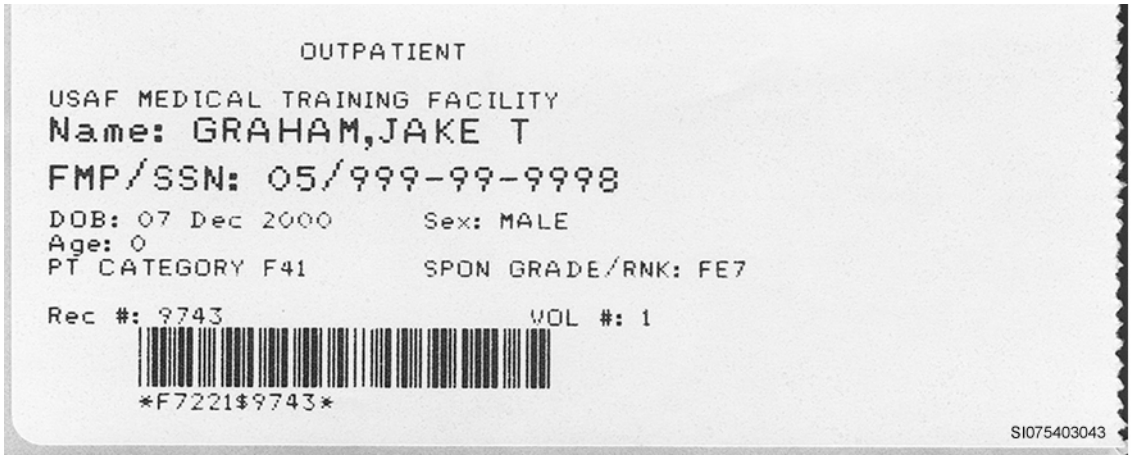

Figure 1–3. Label with Bar Code

The MRT system responds to a series of triggers generated by any or all of the following:

- Patient Administration Division (PAD).
- Patient Appointment and Scheduling (PAS).
- Radiology (RAD) subsystems.

Batch List and Pull List entries are available to be initialized when a patient appointment is scheduled, record request notices are generated when patients check-in for unscheduled appointments, mail messages are generated when patient records are identified as missing, found or deleted (this is an optional feature on the system), an entry is generated on the pending request list when a requested

record is currently charged out, or when entries are generated on the overdue list when a current borrower has not returned a record within an MTF-specified time.

An MRT record label consists of the following minimum patient identification:

- Patient's name.
- FMP.
- Sponsor's SSN.
- Record type.
- Volume Number (used when a patient has more than one record volume).
- Record Number.
- Current Location.
- Home Location.
- Status.

When the label is printed a bar code will also appear on the label that can be used by the appropriate equipment. This label will be placed in the Patient Identification block of the AF Form 2100A, Health Record—Outpatient (Orange), series health record.

Data is collected and entered into the system, which defines the Patient Administration Medical Record Tracking (Inpatient and Outpatient Records), and the Radiology Image Tracking applications. This data collection defines the file rooms, record types, and the parameters under which record tracking applications are operated (i.e., the number of days a borrowed record is out before it is tagged as overdue).

Borrowers are established in the system set up for record tracking, and establish the entities that may borrow records. The borrower may be a provider, a hospital location such as a clinic, ward, or file room, a medical treatment facility, NON-DOD MTF, or other specific locations. For example, a record can be charged to the Cardiology clinic with the associated borrower being Dr. Caldwell.

The two CHCS record tracking applications are a vital aspect of our daily job as a HSM. It is pivotal that medical personnel have easy, swift access to patient information. CHCS provides the tools necessary to ensure medical information can be provided on a moment's notice!

The automated record charge out process

When medical personnel in a clinic, ward, or other borrower need an outpatient record, you will use the "Charge-Out" option on CHCS. This option is used to charge-out a record as a single transaction. You will either key information into the system using the keyboard, or scan the bar code on the MRT, provided your facility has the necessary automated scanning equipment. Borrowers can be providers, wards, clinics, other MTFs, or non-DOD MTFs.

What happens if a medical record needs to be transferred from one clinic to another before it makes its way back to the records section? For instance, SrA Smith has an appointment at 0900 in primary care and another appointment in the obstetrics clinic at 1000. How would CHCS track the record from one clinic to the next? Simple! The "Recharge Records" CHCS option would be used to indicate that the record has been transferred from the first clinic (primary care) to the next borrower (obstetrics). This function is accomplished without having to process the medical record into the file storage area in the medical records section.

The facility transfer process

At times, as the outpatient records technician, you will be confronted with personnel who are either PCSing to a new duty assignment or embarking on an extended TDY. In these cases, rather than utilizing the CHCS record charge out option, you will use the facility transfer CHCS option. This

CHCS function gives you the ability to check out a medical record on a temporary or a permanent basis (depending on the situation) to another MTF. By accomplishing a temporary or permanent facility transfer you are effectively “freezing” the automated medical record. No CHCS updates or transactions will be possible on this medical record until it is checked back in to your MTF using the CHCS transfer in function. CHCS makes the distinction between medical records staying within your MTF as opposed to those leaving your MTF. Used properly, the facility transfer function provides an organizational tool for the records section to better manage the many records within their control.

Patient record inquiry

CHCS enables users to inquire as to the location of a record, as well as a history of the record’s movements. You have four different types of inquiries to choose from depending upon the amount and type of information you need. The four inquiries are

1. Combination Data Trace,
2. Record Inquiry,
3. Short Record Inquiry, and
4. Trace Movement History.

Check-in a record

The check-in record option is used to record the return of borrowed records to their home location file room. The system records the record being returned, as well as the date and time of return. The check-in procedure is very similar to that of charging-out records.

207. Composite Health Care System provider templates

CHCS designed a tool capable of efficiently managing a provider’s/clinic’s schedule. Provider templates, as they are called, enable HSMs to easily and quickly create and/or adjust a schedule to properly reflect a provider’s time slots. To understand the benefits and capabilities of this tool, let’s take a closer look at some of the terminology associated with the templates.

Scheduling terminology

If this is your first encounter with CHCS provider templates or if it has been quite a while since you last performed this function, you may not be very familiar with the terminology. Therefore, we will do a quick review to make sure you understand the scheduling lingo!

A schedule is composed of timeslots that have been assigned appropriate appointment types, durations, and a maximum number of patients per slot. Once a schedule is created, you can do the following:

- Copy and/or transfer one schedule to another provider within the same clinic.
- Open the schedules for immediate booking, or allow the system to open the schedule at a later date that you specify.
- Reserve the schedule for automatic, interactive, or future Wait List processing.
- Freeze appointment slots from further booking.
- Cancel slots with or without booked appointments.
- Modify slots within a schedule by changing the appointment type or number of patients allowed per slot.
- Add or delete slots to a schedule.

A profile is a collection of administrative, scheduling, and appointment information applicable to a specific MTF, division, clinic and provider. It defines the basic rules and instructions by which the facility, division, clinic and provider will provide care. For example, a clinic profile may specify that

the system will automatically check the “Holiday File” in CHCS when a schedule is being created. This ensures the schedules for clinic providers are not created on holidays.

A template is a pattern of time slots that is specific to a provider, but is not linked to any particular date. It is governed by the rules entered in the MTF’s profiles. Using options in the Templates MENU, you can create a daily or weekly template. Either way, once you assign a specific date range to the template, you create a schedule.

Template procedures

You must create profiles before you can create templates; likewise, you must create templates before you can create schedules. If you think about it, this is the only logical way to proceed. Let me explain:

First, clinic profiles must first be established to set guidelines to determine the parameters for an MTF. Next, templates must be created that are specific to each provider to give boundaries as to when patients can be scheduled for appointments. Finally, schedules are produced and then opened. Now you can appoint patients into specific schedule time slots.

After a schedule is created, it can be assigned one of three statuses:

- Open for booking.
- Hold for future booking.
- Reserve for processing Wait List requests.

The option to reserve a schedule for processing (Wait List requests) is only available when Wait List requests currently exist for the MTF with the newly created schedule. The Wait List Hold/Release Schedules (WSCH) option is used to reserve appointment slots in existing schedules for processing Wait List requests or to release them from the Wait List reserved status.

In order for a clinic to have a Wait List you must (1) set the Wait List Activated field in the clinic profile to *YES*; (2) reserve the schedule for Wait Lists requests; and (3) enter the number of days from today to automatically change the wait slots to open slots. You must then select one of the following three actions from the Wait List action bar:

1. *Interactive:* This action processes Wait List requests manually, notifying the patient either by telephone that an appointment is available, or by mail that an appointment has been booked.
2. *Automatic Wait List:* This action permits the system to process current Wait List requests for the clinic/provider, book the schedule time slot on the schedule, and automatically generate the notification mailer.
3. *Quit:* The Quit action is selected if the reserved Wait List slots are not to be processed at this time.

Now that the profiles, templates and schedules have been created, what tools do you, as an HSM, have to help you adjust and modify the existing information?

208. Template management

The tools that CHCS has to offer are far too many to list in this lesson. Therefore, here we will take a closer look at some of the more common functions that are bound to help you in your template management endeavors.

The Replicate Schedule option

As an HSM, if you work with templates at all, you will soon discover that the Replicate Schedules option on CHCS is a time saver. This option allows you to copy an existing schedule to another provider.

Say, for example, a new provider has been assigned to your clinic beginning next Monday. The new provider’s schedule is very similar to a physician already assigned to your work center. Rather than

creating a schedule from scratch, you can simply replicate the schedule of the physician already in existence (fig. 1–4).

Figure 1–4. Sample CHCS template management screen

The Maintain/Cancel Schedules option

No matter how precise you are at creating schedules, there will always be changes that need to be made. The Maintain/Cancel Schedules CHCS option makes it simple for you to add, delete, cancel, freeze and release schedule time slots for specific days within any provider's schedule.

For instance, a provider at your work center has been called out of town unexpectedly. A colleague at the clinic can take over the remainder of the schedule from the departing physician. To accomplish this, you will need to transfer the schedule to the provider who will take over the remainder of the schedule. This can easily be accomplished by using the Maintain/Cancel Schedules CHCS option rather than building a brand new schedule.

The Cancellation by Facility option

The Cancellation by Facility CHCS option allows you to cancel all or part of an existing schedule at the request of the provider or other agency at the MTF. If the schedule slots that you are canceling have booked appointments, the system allows you to access the Cancellation Processing (Mail/Phone) option of the Notify Patient Menu so you can notify the patients by phone or mail.

The Freeze/Release Schedules option

The Freeze/Release Schedules CHCS option of the Maintain/Cancel Schedules CHCS menu allows you to manually or automatically freeze and release schedule time slots or daily schedules. Freezing a schedule *does not* cancel slots; it prevents any further appointment booking. These slots, although listed, are labeled frozen when the schedule is displayed or printed. However, they will not be displayed during appointment searches (except in Browse mode) or on the Provider Schedule Summary Report.

Frozen slots may be released automatically at a date determined by a parameter in the clinic profile, or manually through the same option. If you choose to let the system release the slots automatically, the system calculates the release date based upon the Schedule Hold Duration parameter in the clinic profile. This parameter defines how much time will elapse before the system automatically releases

the frozen slots. If frozen slots are to be released manually, release them by using the Freeze/Release Schedule CHCS option.

So, can you think of a scenario when you might have to use these functions? Let's give it a try:

Dr Black, a provider in your clinic, thought that she would be attending a medical conference on Wednesday, 3 Jul 2015 from 0800 through 1130. Therefore, you, being the professional HSM that you are, froze the appropriate appointment slots during the allotted conference times. Dr Black just briefed you that the meeting has been changed from 3 Jul to 2 Jul and the new times are 1200 through 1600. You must now freeze the appropriate slots on 2 Jul and manually release the previously frozen slots on the third. It's as simple as that!

The Modify/Add/Delete Schedule option

The Modify/Add/Delete Schedule CHCS option allows you to do just that: modify, add and delete slots from a provider's schedule. You can modify schedule slots by changing the appointment type or number of patients per slot and by entering or editing comments. If you change the appointment type of the slot, you can only change to another valid appointment type for this clinic and provider. If you change the number of patients per slot, you can only enter a number that will not cause the schedule for that day to exceed the maximum number of patients per day defined in the provider's profile.

Modify/Add/Delete Schedule option should not be confused with canceling appointments. This option does not permit you to delete slots with booked appointments. If you try to delete booked slots, you are warned with a message and no change is made to the schedule. If you want to delete the booked slots, you must first cancel the appointment slots using the Cancellation by Facility CHCS option. Once the slots have been cancelled, you can delete the slots using the Modify/Add/Delete option.

Here's an example to illustrate when the use of this option would be required:

Dr Hines is going to begin seeing "RETURN" patients between 0730 and 0900 every day during his schedule. Previously, he only saw "NEW" patients during this time frame. To accurately reflect this change, you will need to change the appointment type for the slots during this time period from NEW to RETURN patients.

All of these CHCS options have been created to help HSMs effectively manage provider schedules. The better you understand CHCS and what it has to offer, the better it will work for you. I encourage each HSM to aggressively seek out other avenues for learning the many capabilities of CHCS. Talk to your supervisor and systems representatives to explore all of the learning opportunities offered in your area! Again, as stated at the beginning of this section, by gaining the required knowledge and skills necessary to successfully operate CHCS, you are (1) making the job of the HSM more efficient, while (2) ensuring our customers receive the best care possible. These are two very important functions that you will be responsible to help maintain as an HSM.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

206. Creating a medical records tracking record

1. What is the purpose of the CHCS Record Tracking System?

2. Medical record tracking provides 11 important functions. Name five of these functions.

3. What is the minimum patient identification information found on a medical record tracking record label?

4. What CHCS option is used if a medical record needs to be transferred from one clinic to another before it makes its way back to the records section?

5. What information does CHCS record when using the check-in record option?

207. Composite Health Care System provider templates

1. What is a schedule composed of?

2. Name four tasks that can be accomplished once a schedule is created.

3. What defines the basic rules and instructions by which the facility, division, clinic and provider will provide care?

4. What is a provider template?

5. Once you've assigned a specific date range to a template, what have you created?

6. Prior to a schedule being produced what two items must be created?

7. After a schedule is created, what three statuses can it be assigned?

8. Which CHCS option is used to reserve appointment slots in existing schedules for processing Wait List requests, or to release them from the Wait List reserved status?

9. List and briefly describe the three actions that can be performed from the Wait List action bar.

208. Template management (edits & changes)

1. Match each CHCS option in column A with the appropriate response in column B. Each answer in column B will only be used once.

Column A

____ (1) Using this option, slots will not be displayed during appointment searches (except in Browse mode) or on the Provider Schedule Summary Report.

____ (2) This option allows you to adjust schedule slots by changing the appointment type or number of patients per slot and by entering or editing comments.

____ (3) This option allows you to cancel all or part of an existing schedule at the request of a provider or other agency at an MTF.

____ (4) This option makes it simple for you to add, delete, cancel, freeze and release schedule time slots for specific days within any providers' schedule.

____ (5) This option allows you to copy an existing schedule to another provider.

Column B

a. The Modify/Add/Delete Schedules option.
b. The Cancellation by Facility option.
c. The Maintain/Cancel Schedules option.
d. The Replicate Schedule option.
e. The Freeze/Release Schedules option.

1–4. Preparing and Maintaining Outpatient Health Records

The primary purpose of the medical record is to document the course of patient's illness and treatment during a particular period and during any subsequent periods as an inpatient or an outpatient. It serves as a basis for the planning and evaluation of individual patient care. It also provides a communication link between the physician and other professionals contributing to the patient's care. The medical record also meets legal requirements imposed on hospitals and physicians, and provides clinical data of interest to researchers and higher authorities at the Air Staff (HQ USAF) and Department of Defense (DOD). The best place to start our discussion is with the initial creation of the medical record and the types of entries used to identify the record.

When we refer to the Outpatient Medical Record, it is important to note that this designated record set consists of not only the paper record but all applicable outpatient electronic medical record data that provides a permanent record of a patient's medical care as well. The majority of the outpatient electronic medical record information is maintained and documented in AHLTA; the DOD's approved Electronic Health Record (EHR). Until we transition to a completely electronic health record, the AFMS will continue to use a "hybrid" record consisting primarily of the EHR, and including traditional paper-based records and forms to meet unique operational mission requirements. As AHLTA is operational at all Active Duty Military MTFs, the combination of the EHR and the paper record constitute a complete health record for a beneficiary. Both the EHR and the paper record must be available for inspection, review, copying and disposition when required.

All outpatient records must contain enough information to identify the patient, support the diagnosis given by the health care providers (practitioners), justify the treatment, and accurately document the results of care rendered. The visits a patient makes to your facility are documented on a variety of different forms that become part of this record. The text that follows takes you through the process of creating a medical record and how these forms become part of the outpatient health record. Also, keep in mind, when you see or hear the terms "charge-out," "pull," or "checkout," they refer to the removal of a medical record from the file.

There are only two types of Outpatient Records:

- Service Treatment Records (STR)—the outpatient medical record and dental treatment record for a member of the US Military. It is made up of the patient's medical and dental encounters throughout the course of their military career.
- Non-Service Treatment Records (NSTR)—outpatient medical records for patients in ALL other categories (dependents, civilians, foreign military, retirees, etc.

209. Prepare, update, and maintain outpatient medical records

The Outpatient Medical Record is vital when it comes to patient care. The record holds the significant health history for that patient. It is important to keep the record up to date since you would not want to give a patient a medication that they are allergic to. In this objective, we will discuss how to build, and properly identify an outpatient medical record.

Preparing AF Form 2100A

The AF Form 2100A is a four-part folder, and is the only AF Form in use as an outpatient health record "jacket." The 2100A series folders are created for enlisted active duty personnel at Lackland AFB, TX. In fact, you may remember creating your own during basic training. These same folders are used for family members and other non-military patients, and are usually prepared during their first visit to an Air Force MTF. For retirees, these same folders are used, and should be prepared during their first visit to the MTF following their retirement.

Selecting the form number and color of outpatient health records

Creation of folders, arrangement of content and record filing methodology is consistent throughout Air Force MTFs. There are 10 different colors of outpatient health records. The different colors aid in filing and charging-out records. We discuss this in more detail later in this lesson. For now, it is important for you to know how to properly choose the correct folder in relation to the sponsor's SSN. As with all things military, there is a definite process involved in the selection of the correct folder for each patient.

Form number selection

The sponsor's SSN determines the AF Form 2100A series record you will use for the sponsor and their dependents. Each record cover contains a place to write the applicable SSN. It is of primary importance that the folder be properly numbered and then verified using the patient's military identification card (ID).

If a beneficiary has received medical care under a previous SSN, as a result of remarriage to another military sponsor, record forms filed under the former SSN should be consolidated under the current sponsor SSN. Once the patient has been registered in CHCS under the current sponsor's SSN, merge the old and new patient file. For future inquiries, a cross-reference from the old number to the new number should be indicated in the outpatient files as well as in the current automated system.

If a dependent spouse or child has received medical care under the SSN of a different sponsor (i.e. divorce, re-marriage to another sponsor), the record and forms filed under the former SSN should be consolidated and merged into a new record jacket reflecting the new sponsor's SSN. If a beneficiary has received medical care under multiple SSNs as the result of dual eligibility status (i.e. a dependent spouse who is also an ARC member, or a retiree), then a CROSS-REFERENCE of the SSNs should be annotated on the outpatient record jacket, as well as an "ALIAS" created in CHCS, to assist with identification. Dual Status records maintenance will be discussed in further detail later in this section.

No available SSN

A pseudo-SSN is created for beneficiaries without an SSN. This process occurs in the DEERS when the personnel technician issues an ID card or enrolls the beneficiary. Either a Foreign Identification Number (FIN) or a Temporary Identification Number (TIN) is generated.

When issuing an ID card, the DEERS gives the personnel technician a choice to enter an SSN, FIN or TIN. When FIN is selected, DEERS automatically assigns a 900–00–000F. This number is assigned to categories of eligible NATO and non-NATO foreign military members, their family members, for foreign nationals employed in positions overseas that result in DOD benefits and entitlements, and for authorized non-US personnel who are not under our Social Security Administration System, and will not receive a SSN.

A TIN is assigned and automatically generated by the DEERS (800–00–000D) for categories of beneficiaries who are awaiting an SSN (such as newborns) or for those who do not have a SSN. The TIN is used as a method to record the beneficiary as a potential patient on DEERS while awaiting a SSN. Foreign nationals who are the spouse of a US citizen will be issued a TIN if they are awaiting or will be receiving an SSN. If they are not required to have an SSN, they are issued a FIN. Foreign National spouses who have been issued an Individual Taxpayer Identification Number (ITIN) by the Social Security Administration will be able to use those numbers.

Color selection

Select an AF Form 2100A series folder (whatever is on hand locally) according to the second to last digit of the sponsor's SSN. For example, if the SSN is 539–60–54**2**7, the second to last digit is a "2." This corresponds to a yellow AF Form 2100A. The following table lists the range of SSN digits used to select a folder, the form number, and the color of the folder.

If the second to last SSN digit is:	Use AF Form	Color
00–09	2100A	Orange
10–19	2110A	Green
20–29	2120A	Yellow
30–39	2130A	Gray
40–49	2140A	Tan
50–59	2150A	Blue
60–69	2160A	White
70–79	2170A	Brown
80–89	2180A	Pink
90–99	2190A	Red

Over time you will become acquainted with the folder color system and how to select the proper folder based on the SSN. Once you memorize this color coding system, you can select the proper folder for the job in an instant. Here is a little word association sentence that may help you memorize the different colors:

> **O**nly **g**ood **y**oung **g**entlemen **t**hink to **b**ring **w**omen **b**eautiful **p**ink **r**oses.

Compare the highlighted letters with the ten colors in the 2100 A series table. The highlighted letters represent the first letter of each color in order. Okay, so it's a little silly! But it may help you remember the different color schemes on the various folders. Good luck!

Preparing the folder

Figures 1–5 and 1–6 are examples of AF Form 2100A series record jackets. Figure 1–4 displays the correct way to complete an AF Form 2100A for active duty members, while figure 1–5 shows a correctly completed AF Form 2100A for a family member. Throughout this lesson, we will use these figures to illustrate how to correctly complete the identification section of outpatient records.

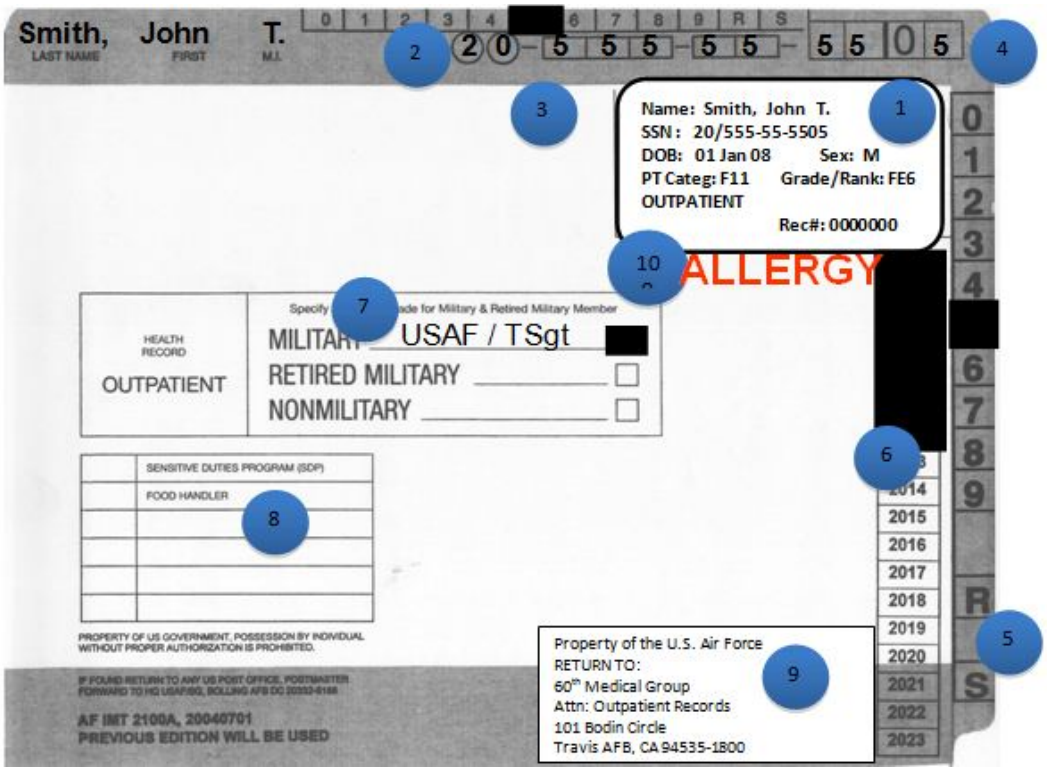

Figure 1–5. Outpatient record for military member

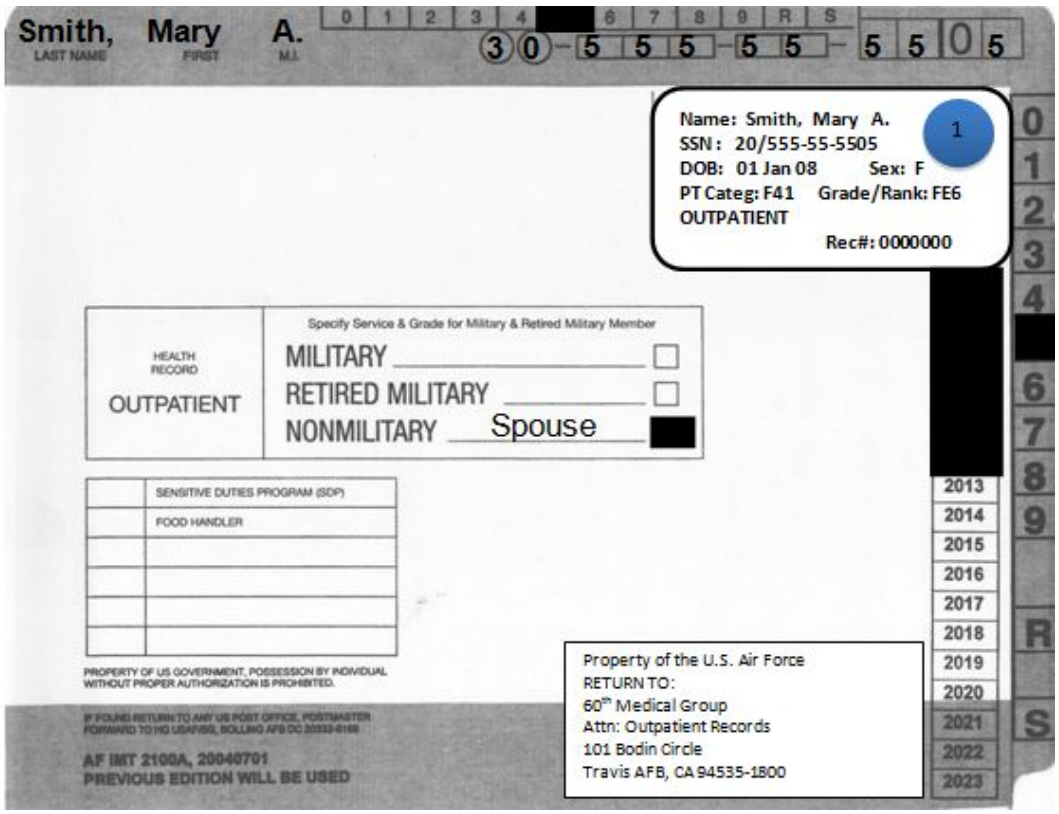

Figure 1–6. Outpatient record for family member

Patient identification

The patient identification block is located on the upper right hand corner of the outpatient record cover (figs. 1–5 and 1–6, item 1). Using a black pen or felt-tip marker enter the first name, middle initial, and last name of the patient. If you are handwriting this information, ensure it is legible. An emboss card or a CHCS medical records tracking (MRT) label may also be used. Today, most HSMs will be using the functions featured in CHCS.

As stated earlier, automated records and printed labels for tracking patient medical records will be created when a patient is registered through CHCS PAD registration options, or a patient is admitted to the hospital. An MRT record label consists of the following minimum patient identification:

- Patient's name.
- FMP.
- Sponsor's SSN.
- Record type.
- Volume Number (used when a patient has more than one record volume).
- Record Number.
- Status.
- Date of Birth.
- MTF DMIS ID or MTF Code, name and location.
- Additional information at the discretion of the MTF.

When the label is printed, a bar code will also appear on the label that can be used by the appropriate equipment. This label will be placed on the front cover in the patient identification block of the AF Form 2100A series health record.

Sponsor's SSN

In the single space immediately to the right of the preprinted digit, located in the upper right-hand corner of the folder, place the last digit of the applicable SSN. In the seven spaces to the left of the preprinted digit, enter the remaining numbers of the SSN. Remember, use ballpoint pen, felt-tip marker, or any other permanent means. **Do not use a pencil!** These nine numbers constitute the complete SSN of the sponsor.

Sponsor/Family member prefix

Depending on the type of record you are creating, enter either sponsor's prefix, or the family member's prefix in the two circles immediately to the left of the SSN. On the family member's record, this prefix denotes the relationship of the member to the sponsor. Check the TRICARE DEERS website for the DEERS Dependent Suffix (DDS) for the patient or if not available, number in birth date order for family member children.

The most commonly used prefixes are listed in the following table:

Family Member Prefix (FMP)	Relationship Description
20	Sponsor
01–19	Sponsor's children
30	Sponsor's first spouse (current or former)
31–39	Each additional spouse (current or former)
40	Mother or Step-Mother of Sponsor
45	Father or Step-Father of Sponsor
50	Mother-in-Law of Sponsor

Family Member Prefix (FMP)	Relationship Description
55	Father-in-Law of Sponsor
60–69	Other authorized dependents of Sponsor
90–95	Beneficiaries authorized by Statute
98	Civilian Emergency
99	All Others, Not Elsewhere Classified

Once an FMP has been assigned to an individual, the number will not change as long as the patient is still associated with the same sponsor and SSN. When a military member marries a person with children, assign family member prefix numbers in sequence following the last family member prefix already assigned to children of the sponsor (if any). Assign the oldest child the next number in numerical sequence.

Spouse prefix assignment

Assign the family member prefix “30” to the first spouse authorized care. If the member remarries due to spousal death, divorce, etc., assign the number “31” to the next authorized current spouse. Increase prefix numbers by 1 (e.g., 32, 33) for any additional dependent spouse authorized care. Only one current dependent spouse is authorized medical care.

Un-remarried former spouses

Certain former spouses of active duty or retired service members may be eligible for medical care (including TRICARE) if a DEERS-Uniformed Services issuing ID card office has certified the un-remarried, former spouse’s eligibility. All un-remarried former spouses are now self-sponsored. Un-remarried former spouses who have met the requirements IAW AFI 36–3026V1_IP are treated in the MTF as their own sponsor. As such, medical records are created for these patients using a “20” FMP their own SSN. If the patient’s previous record, filed under the deceased sponsor’s SSN, is still in the file, remove the documents and place in this new record. Annotate previous folder with cross reference to new folder. If the patient is still in CHCS under the deceased sponsor’s SSN, work with the Systems Office to correct this.

Right side blocking

Using black tape or black marker, block out the last character of the sponsor’s SSN. Red tape or marker can be used to denote individuals assigned to the Sensitive Duties Program (SDP); green tape or marker may be used to denote individuals assigned to mobility positions. If an individual is assigned to both SDP duties and mobility, SDP (red) will take priority. If an individual is removed from either of these programs, simply cover the previous marker or tape with black marker or tape.

Records maintained in aerospace medicine for flying personnel contain additional markings.

- Mark these folders with a strip of black tape on the side of the folder, extending from immediately below block to the bottom of the folder. If file cabinets are used, apply another strip of black tape to top of folder, immediately to the left of the last four digits of the SSN. Never cover the prefix or SSN.
- Use black ink or a suitable marking device if black tape is not available. Stamp “FLY” in two-inch block letters in the upper left-hand corner of the front of the folder.

Health record year grid

Mark through the current year of nonmilitary records with a felt-tip marker or pen to indicate the latest year non-active duty patients were treated. Affix an AF Form 2700L, Year List Label for AF 2100, and AF 788, & AF 2100B Series, to extend the number of years and to extend the life of an outpatient record folder. Do not accomplish a new AF Form 2100A series folder just to extend the year grid of a record.

Status

Indicate the patient's status in the box located in the center of the front cover of the record jacket. Enter the service and rank for extended active duty and retired personnel. Enter the country for non-US military personnel. Use pencil entries for items that change, such as rank. Blacken in the "military" block for active duty military personnel. Enter an "R" in the military block for air reserve component (ARC) personnel not on active duty. For family members who are also members of an ARC, enter the family member's SSN here, as well as their status as a member of the Air Force Reserve or Air National Guard as appropriate. Blacken in the "Retired Military" block for retired personnel. Annotate the person's service and rank. Blacken in the "Nonmilitary" block for all others.

Sensitive duties program/food handler

If the patient is a member of the personnel reliability program (PRP) program, stamp "PRP" in two-inch block letters on the left-hand side of the front of the folder.

If the person is a food handler, the Force Health Management section enters the date of the current food handler examination in pencil on the appropriate line of the preprinted format.

MTF identification

Identify the MTF having custodial responsibility for the outpatient record with a self-adhesive label affixed to the health record folder in the lower right-hand corner.

Allergies

If the patient has a known allergy to medication(s), this information will be displayed prominently under the patient identification data on the right-hand side of the folder.

NOTE: All remaining areas on the AF Form 2100A are optional or as determined necessary by each MTF.

Acknowledgement of Notice of Privacy Practices procedures

The Health Insurance Portability and Accountability Act of 1996 require all patients to be informed of their rights in regards to their protected health information. Each patient must receive the MHS Notice of Privacy Practices and acknowledgement of receipt must be documented in the outpatient record.

Medical records technicians and/or clinic check-in personnel check the back outside cover of outpatient health record to see if the acknowledgement label is present and signed. If none present, place the label centered near the bottom on the outside of the record. Ask the patient or their representative if they have received the MHS Notice of Privacy Practices in the mail, and ask patient or representative to fill out the Name, Date, and FMP/SSN sections and sign the document. Have MHS Notice of Privacy Practices available to give to patient if they did not receive or do not remember receiving it in the mail. If the patient or their representative refuses to sign for any reason, fill in the date, Patient Name, FMP and SSN, check the block that the patient/representative declined to sign, and initial the label.

Acknowledgement of Military Health System
Notice of Privacy Practices

The signature below only acknowledges receipt of the Military Heath System Notice of Privacy Practices, effective date __14 April 2003__.

_____
Signature of Patient/Patient Representative date

_____
Name of Patient/Representative relationship to patient (if applicable)

FMP/SSN: _____/_____-_____-_____

☐ Patient/Representative declined to sign _____ MTF staff initials

210. Maintenance and quality management of outpatient records

Maintenance of outpatient records is a very important task. In keeping with its importance, this lesson discusses some major aspects of maintenance and quality management-proper identification, arrangement of forms in the 2100A series records, updating records, and quality management. Let's begin with a look at how to identify the forms.

Proper identification

As a minimum, each form and document filed in a patient's records *must* contain with the following:

- Patient's name.
- Family member prefix.
- Sponsor's SSN.
- Facility providing treatment.
- Name of the facility maintaining the records.

Return all documents with incomplete patient identification to the originating clinic for proper completion. An exception to the (minimum identification) rule is the laboratory display sheet. Since the individual slips contain the necessary data, it is not necessary to repeat identification information on this sheet. Another exception is the AF Form 745**,** Sensitive Duties Program Record Identifier, which only requires the appropriate program (PRP or PS) be circled in pencil. And finally, the AF 966, Registry Record, used to identify tumor registry patients is also an exception. The patient's mailing address can be added on any form. This information may help a physician or other health care provider manage the patient's case.

Arrangement of the AF Form 2100A series folder

Now let's look at the filing arrangement in the AF Form 2100A series (see figs. 1–5 and 1–6), which is divided into four sections. Section 1 is located on the left side of the folder immediately inside the front cover. Sections 2 and 3 are located on the middle flap of the folder, and section 4 is located inside the back cover. New folders are prepared for new patients or when the present folder no longer protects the contents.

Section 1

Arrange forms in chronological sequence with the most recent action on top. The exception to this rule is the AF Form 1480A or DD Form 2766A, which will be the top form in section 1. File the following forms in order as listed after the AF Form 1480A or DD Form 2766.

1. DD Form 2766C or AF Form 1480B, Adult Preventive and Chronic Care Flowsheet—Continuation Sheet.
2. DD Form 2796, Post-Deployment Health Assessment.
3. DD 2569, Third Party Collection Program—Insurance Information—original.
4. Health Enrollment Assessment Review for Primary Care Managers (HEAR PCM)—original.
5. Results from HEAR.
6. AF Form 1480, Summary of Care—original.
7. AF Form 3922, Adult Preventive Care—Flow Sheet—original.
8. AF Form 3923, Child Preventive Care—Flow Sheets—original.
9. Copies of *inpatient* forms filed in chronological order.

Section 2

Primarily, this section contains the documentation related to outpatient care and is much like the right side of the AF Form 2100 series folder except for the laboratory, x-ray, and ECG Reports. Health care providers use this part to document a patient's visit to an outpatient clinic. The forms are filed in the following order, from the top down:

1. AF Form 745, Sensitive Duties Program Record Identifier—This form is used to identify health records of patients in the Sensitive Duties Program. If used, it is the top form on the right side. Individuals may participate in more than one program. Facilities will circle the initials of the appropriate program on an AF Form 745 (PRP and Presidential Support Program [PSP]). Removal of the AF Form 745 depends on the number of programs with which the individual is associated.
2. AF Form 966, Registry Record—is placed on top of the right-hand documents and under AF Form 745, if used.
3. Patient signed informed consent to the use of an electronic mail (e-mail) format of communication with his/her provider.
4. SF 600, Medical Record—Chronological Record of Medical Care, is filed in date order. This form AF Form 745, Sensitive Duties Program Record Identifier, when applicable. This will be interfiled with SF 558s, Medical Record–Emergency Care and Treatment, chronologically, most recent on top. As with the two-part folder, file the DD Form 2161, Referral for Civilian Medical Care and/or SF 513, Medical Record–Consultation Sheet on top of the SF 600 to which it was ordered.
5. AF Form 1352, Hyperbaric Patient Information and Therapy Record—original if treatment was on an outpatient basis.
6. AF Form 1446, Medical Examination—Flying Personnel—signed original.
7. SF 88, Medical Record—Report of Medical Examination—signed copy of each report. When DD Form 2161 or any other form is prepared in conjunction with the SF 88, it is filed with the SF 88.
8. SF 93, Report of Medical History—signed copy of each report. File civilian employee's SF 93 in his/her health record.

Section 3

With the exception of forms related to inpatient care, (which we file in section 1), this section is much like the left side of the AF Form 2100 series folder. File the forms in the following order:

1. DD Form 2005 and AF Form 137, Footprint Record, directly above the Disclosure Accounting Record. Most 2100A series record jackets will have the Privacy Act Statement located on the outside cover on the back of the folder. Patients utilizing these jackets do not require a DD 2005 placed in section three.
2. File all other forms, unless specifically designated elsewhere, in chronological order, with the most recent form or report on top. This may include consent forms or letters and copies of reports of care from civilian sources (reports from civilian sources should be reviewed by the military health care provider responsible for the patient's case prior to filing).

Section 4

This section is where most of the diagnostic test reports are filed. Arrange forms in the following order, from top to bottom, chronologically with the most recent report on the top of each group.

1. Laboratory forms are stapled individually to the bond paper as described earlier. Approved computer-generated reports are grouped together and filed above everything else in section 4.

2. SFs 519B, Radiological Consultation Request/Review.
3. OF 520, Medical Record–Electrocardiograph (ECG) Record. ECG records are filed directly below the radiographic reports.
4. Other diagnostic test reports are filed here.
5. Place advanced directives (Self-Determination Acts or Living Wills) in an envelope and file behind all other test reports.

Updating outpatient health records

Updating records involves different tasks, depending on what forms or other material you receive to post to the patient's file. Generally, you are involved with four types of actions:

- Updating folders.
- Adding documents.
- Withdrawing documents.
- Filing documents with the same treatment dates.

The following paragraphs discuss what you do in each of these situations.

Folders

Update the information on the outpatient record folder when changes in a patient's identification or status occur. Some examples include a name change due to marriage or divorce or a change in rank for an active duty patient. Create a new record folder *only* when the existing folder no longer protects the contents of the record. DO NOT add or remove from the list of sensitivities (allergies) identified on the cover of the medical record. The patient's physician is responsible for making changes to this list. If a new record folder is created, be sure to transfer all the sensitivity information (as well as all other information) from the previous folder to the new folder.

Adding documents

Ancillary services (laboratory, radiology, etc.) should forward all completed medical documentation to the outpatient records section by the close of business each day. Clinic personnel ensure that medical documentation is complete and legible for accurate filing. Make sure all documents and forms are added to records immediately after receipt. Temporarily place documents and reports received while the record is charged out in the charge-out guide, which is filed in place of the record until it is returned. The charge-out guide is discussed in the next section of this unit.

Daily filing of outpatient test results is no longer a requirement as the result of on-line capability through clinical results retrieval. MTFs will develop local policies and procedures to ensure complete cumulative test results are printed and inserted in the outpatient records upon referral of a patient to a civilian provider for medical care, on PCS of individual, and in other appropriate instances where necessary. Develop methods to ensure all test results (including archived results) are retrieved and filed when the record is retired to the National Personnel Records Center, the Department of Veterans Affairs, or the MTF deems it necessary for the record to contain the hard copy test results.

Withdrawing documents

When material in an outpatient record is particularly relevant to further treatment of the patient as an inpatient, the material can be withdrawn and inserted in the inpatient record. Note the withdrawals on an SF 600, Medical Record–Chronological Record of Medical Care. For example, a patient is admitted to the hospital for surgery and relevant documents are removed from the outpatient file. In this case, the entry on SF 600 reads "29 Jun 98, consultation sheets, dated 16 and 17 May 98, withdrawn and placed in the inpatient record on admission of this patient to the hospital for a partial gastrectomy. Thomas Edwards, A1C, USAF." Anytime you remove a document, annotate the SF 600

with the reason why you removed it and the new location of the document; then print your name and sign above it.

Documents with the same date of treatment

What happens when you have several documents with the same date of treatment? If there is no particular sequence to file the forms, look to see if there is a time of treatment. File the documents with the latest time on top of those with an earlier treatment time. You may receive three lab slips; for example, all of which were done on the same day. Most lab slips have a test time on them. This helps you arrange them on the lab display mount in the record. If there is no time on the document to help you, just file them in any order you feel is appropriate.

Electronically-generated forms

Use only the AF-approved forms package. Word processing packages are directly forbidden because there is no method of locking the form so that the user cannot change it; see AFI 33–360, *Publications and Forms Management*. Most Air Force (AF), Standard (SF) and Optional Forms (OP) can be obtained from the Air Force e-Publishing website at http://www.e-publishing.af.mil

Additionally, DOD forms may be retrieved at the Department of Defense site: http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm

Both websites have links to Standard, Optional, DOD, and other federal agency electronic forms. The only exception is forms for which AFMOA/SGAT has identified standard data elements. For these forms, the standard elements are required but mirror imaging of the paper form is no longer required. Additional data elements that would change the meaning of the form cannot be added. Standard patient information is required on these forms.

Legal correction of erroneous data or information in the electronic health record of a patient encounter

Since these legal corrections of erroneous data may involve sensitive situations and require Tier III Help Desk Support, TRICARE Management Activity has developed a specific process to request the legal correction of erroneous PHI. All provider SSNs must be redacted so as to be unreadable prior to issuing a copy of any health record (including, but not limited to, the outpatient medical, dental treatment, inpatient, ambulatory procedure visit, and extended ambulatory record). Specifically, the MTF will make an initial copy of the record(s), then within the copy, sanitize the entire SSN, and then recopy the health record(s) before releasing a copy to the requestor. This policy applies to copies for any purpose, to include individual's requesting copies of his/her own records for any reason. Original medical records should remain intact. The original provider's SSN must never be deleted from the original health record.

Research and filing of loose medical documentation

There will be times when you attempt to file back loose paperwork and will not immediately locate a medical record. The following is an example of steps that may be taken to locate the original record or create a temporary file.

1. Use the CHCS/DEERS screen and Mini Registration to determine if the patient has a PCM assigned to your facility. The Defense Medical Information System (DMIS) code will assist you. If the patient has your DMIS code, determine if the patient's medical records are maintained in a different record room. If so, send the paperwork to the appropriate record room.
2. If CHCS/DEERS gives your facility as a DMIS, go through the medical record menu, IN (Record Info), and RI (Record Inquiry). If no record is found, initiate a new record in CHCS and make a folder.

3. If the patient is assigned to a different DMIS code than your facility, check your DMIS code book to find the location and mail the paperwork to that location. Print a copy of the DEERS CHCS screen to accompany the paperwork.
4. If the patient already has a medical record established, research the current location of that record using CHCS. Using CHCS record menu, IN (Record Info), and TM (Trace Movement) should give you an indication of the current location. If the previous volumes have been retired to the archive or sent to retirement and separation, make a new volume 2, 3, etc., whichever is appropriate.
5. If the patient has been identified through CHCS/DEERS as a reserve or guard member assigned to a unit identification code (UIC), use the world wide locator disk to find the Personnel Accounting Symbol (PAS) code, UIC, and the name of the unit assigned. Then send the paperwork to the members unit.
6. If the patient does not have a military PCM, make a temporary manila or brown folder medical record with label for the patient. Do not send the paperwork to another MTF near the patient's home address. If the patient tries to receive copies of the documentation, he or she will not be able to locate the information. Your facility will have no documentation on where the medical information was mailed. If the record contains more than 5 sheets of paper, make a four part folder with the appropriate label.
7. If the patient has separated or retired from the military within the last 30 days, send the paperwork to the Military Personnel Squadron to be merged with their active duty record. This is IAW AFI 41–210. If it is over 30 days, send the paperwork to Veterans Association in St Louis, MO. The addresses can be found in AFI 41–210.

When tasked to handle loose medical paperwork, it is your responsibility to ensure the medical documentation ends up at the right location so it may be filed into the appropriate medical record in a timely manner.

Scanning documents

You may ask, "If we have an EHR, can we scan documents into it so we don't have to file them?" Unfortunately, the answer to this question is both YES and NO.

Scanning into AHLTA

A scanned document, file, or image may be uploaded or imbedded into an AHLTA patient encounter note, provided the document or image a) is directly related to the current patient encounter, b) will not delay the coding of the patient encounter note, and c) can be uploaded into the patient encounter note before the provider electronically signs the encounter. By signing the encounter, the provider is acknowledging that the scanned/uploaded image or document was acceptable for its intended purpose. If the document cannot be imbedded into the note before the provider electronically signs, or if an image is captured, or scanned and uploaded in support of a previous episode of care, the document or image should be "appended" to the desired note. This action will generate an automatic notification to the provider/user that created the original encounter note. The notification mechanism lets the original creator know that someone has "appended" his or her original patient encounter note.

Appending a previously closed encounter with an uploaded image will not change the original encounter information. The user adding the additional image or document must also electronically sign appended patient encounter notes. Appending a note is a permanent action and cannot be reversed. Appended documentation is not searchable. Without prior knowledge that a specific encounter note has been appended with an image, subsequent users may have significant difficulty finding the appended image or they may not even know of its existence. Until potential future document filing policies allow, any paper document, normally required to be filed into either the paper outpatient medical or dental treatment record, which has been scanned and the electronic copy uploaded into AHLTA (not including documents created in AHLTA), must also be filed into the outpatient medical or dental treatment record according to standard filing requirements. If a particular

type of paper document is regularly reviewed and signed (by hand) by a provider, before filing into the outpatient medical or dental treatment record, the same document must still be signed (by hand) no matter if the document was scanned and uploaded into AHLTA.

So, you may now be asking, where the YES is. Specialty care and urgent primary care results, emergency room notes, discharge summary reports, laboratory results, and radiology reports generated by providers and health care organizations external to the MTF shall be scanned and imported into AHLTA using the following mandatory/standardized instructions. Users must have AHLTA 3.3.6 Special Package 1 and Windows 7 installed (at a minimum) before scanning into AHLTA.

There are two parts to scanning results/reports into AHLTA:

- First, create an AHLTA Clinical Note with the result/reports. You will need the Clinical Note date and title to reference in the Telephone Consult (T-Con) that corresponds to the specific Clinical Note. You will need the date, time, and title of the T-Con generated to reference in the Clinical Note. See section II and III below for detailed instructions.
- Second, create an AHLTA T-Con to notify the referring provider, PCM or surrogate of the pending result/report. The receiving provider will document his/her review in the generated T-Con. Reference the corresponding Clinical Note's date and title in the T-Con.

For both parts, a mandatory standard naming convention will be used: Network Results—Specialty MM/YY where the MM/YY is the date the patient was seen. For example, Network Results—Cardiology 04/12.

All staff generating T-Cons must have a profile in the same clinic that the receiving provider is assigned to with only a T-CON* appointment type to allow them to create T-Cons. AHLTA will only allow T-Cons to be shared with members of the same clinic and not across clinics. Use ONLY the following electronic file types when importing into AHLTA: TXT, RTF, HTML, TIF, JPG, BMP, and DOC. PDF files cannot be directly uploaded into AHLTA; however, the information contained within a PDF file may be copied and pasted into "Clinical Notes" using the Adobe Reader Snapshot tool. Use a minimum resolution of 75 percent in Adobe Reader Snapshot to ensure readability of the uploaded document. Adjust as needed to ensure legibility of CLR. If using JPG or TIF, ensure resolution that meets file size and legibility. Document file sizes shall NOT exceed 500kb. Any existing shared folders used for the purpose of storing temporary results or other Protected Health Information may be maintained for 30 calendar days following the date of the original image upload. Thereafter, the electronic folder and documents must be deleted. For translated results/reports, both the original foreign language and the English translated result/report must be uploaded into AHLTA. The un-translated result/report does not have to be signed by the referring provider if the translated result/report was already signed. The reviewing provider is not required to handwrite or "wet" sign the hard copy result/report. The paper copy of the result/report is not required to be filed into the paper outpatient medical record. However wet signatures and filing of paper copy may be required for special programs (e.g. PRP) or payment issues. Before destroying the original hard copy or electronic result/report, ensure the scanned document is legible by the provider. Ensure you have a quality check process in place. Incorrect documents scanned into AHLTA must be redacted per "Legal Correction of Erroneous Data Policy."

Quality management of health records

As a member of the outpatient records team, your external customers are the patients and your internal customers are the staff of the medical facility. Providing services that satisfy your customers does not happen by accident—it takes a lot of hard work, careful planning, listening to your customers, teamwork (with everyone in the process involved), and always looking for ways to improve.

Doing something right the first time requires you to focus on what tasks you do (work processes) and seek ways to improve these processes. For instance, after several days as a newly assigned records clerk, you notice that when records are brought back to your records section, they are placed in a large bin and eventually returned to the file. Since you are always looking for ways to improve, you decide to put together a collection center where clinic personnel return records by placing records in separate bins based on the folder color. This small but significant improvement will decrease the amount of time it takes you and your coworkers to file the records. Improvements like this will make your job much easier.

Whether you are managing records in a decentralized PCO or in a centralized records section, improving the quality of health record maintenance is a major step in the right direction for delivering total quality health care. In addition to meeting the regulatory requirements for quality control of health records, work with the others in your organization to develop plans and improvement strategies that strive for customer satisfaction.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

209. Preparing AF Forms 2100A

1. You have just been asked to make a record jacket for SrA Lynn N. James, 999–99–9972. SrA James is on active duty in the Air Force and his record is maintained at your current medical facility. What entry would you make in the area marked ① in figure 1–4?

2. What entry would be appropriate in the area marked ② in figure 1–4?

3. What entry would be appropriate in the area marked ③ in figure 1–4?

4. What entry would be appropriate in the area marked ④ in figure 1–4?

5. What entry would be appropriate in the area marked ⑤ in figure 1–4?

6. What entry would be appropriate in the area marked ⑥ in figure 1–4?

7. What entry would be appropriate in the area marked ⑦ in figure 1–4?

210. Maintenance and quality management of outpatient records

1. What minimum identification is placed on each document filed in the outpatient record?

2. What will be placed in the health record in place of the AF Form 1480 or DD Form 2766A?

3. What type of documentation is filed in Section 1, AF Form 2100A series health record?

4. What forms may be filed in Section 2, AF Form 2100A series health record?

5. What forms may be filed in Section 4, AF Form 2100A series health record?

6. When should a new health record be created for a patient?

7. What website can most Air Force, Standard, and Optional Forms be obtained from?

1–5. Outpatient Records Section Functions

Now that you've studied how to build a record and how forms are filed and maintained, let's look at several functions you are likely to perform in the outpatient records section and how these functions affect each outpatient record. These functions include filing the record, charge-out to patients or staff members, transfer to other medical facilities, and inventory and retirement procedures. Don't forget, HSMs working in a PCO environment, as well as HSMs working in a centralized records section, can accomplish these functions.

211. Terminal digit filing system and location of special files

Up to this point, you have studied record types and the materials contained in outpatient records. In passing, we also mentioned filing the records. As I'm sure you can imagine, filing is a critical area for outpatient—or any other—records; if you can't find the records, they can't serve the purpose for which they were created. In this lesson, we introduce you to the filing system for patient records and discuss filing procedures, the centralized file, and special categories of records. However, before discussing these elements we need to consider the subject of records ownership.

Ownership of outpatient records

Health records are the property of the United States Government. The information contained in the record belongs to the patient. IAW the Privacy Act of 1974 and HIPAA of 1996, the patient has the right to the information in the record. However, the maintenance of the record at the MTF is a legal requirement and there is an increasing requirement that these records be available to the many accrediting and auditing agencies who review records. The lack of medical records and medical record documentation may adversely impact Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation. In any case, record availability is paramount to facilitate the most appropriate health care for patients.

Establish custody of the health record upon the patient's initial visit. Implement a system to retrieve health records, when possible, from those patients who hand carry them and verify where the record should be maintained. Effort should be made to ensure patients do not leave the MTF with their

records. Patients may request a copy of pertinent sections of their records; however, the original should not be relinquished except in rare occasions when an exception is required. Establish a system that allows for delivery of records to clinics for scheduled appointments, and for walk-ins to the greatest extent possible. Staff members will not return the record to the patient's control after the visit unless the record label states that it is maintained at another MTF or deployable unit and is verified that this is the records file location.

Terminal digit filing

Outpatient records are filed according to a special system called the "terminal digit filing system." As the name implies, the records are filed according to the terminal digit of the sponsor's SSN using a color-coded and blocked filing system. Under this system, the central files are divided into 100 approximately equal sections, which are identified by a minimum of 100 file guides bearing the 100 primary numbers, "00" consecutively through "99."

Each of these 100 sections contain all records whose primary digit (last two numbers) correspond to that section's primary number. For example, every record with a SSN ending "53" is filed in section "53." Within each of these 100 sections, folders are filed in numerical sequence according to their secondary numbers. The secondary number is the pair of digits immediately to the left of the primary number.

In a properly developed and maintained terminal digit, color-coded and blocked filing system, it is almost impossible to misfile a record. Any folder misfiled with respect to the left digit of its primary number (e.g., a "45" that was inserted among the "55s") attracts attention because of the color differences between the folders. A folder misfiled with respect to the right digit of its primary number (e.g., a "45" that was inserted among the "42s"), causes a break in the diagonal pattern formed by the blocking (of the last number of the sponsor's SSN) within a color group.

An example of the breakdown is the SSN 20/987–65–4321. Read in terminal digit fashion:

Family prefix filing order

Now that you have some background information on the terminal digit filing system, let's try to take it a step further. When filing a family's outpatient records, in which order do you think they should be filed? For instance, CMSgt Smith has just dropped off her records, as well as her family's records to you at the outpatient records window. She brought her own record, which carries the family prefix of "20", her husband's record which carries the family prefix "30" and their three children's records whose family prefixes are "01, 02 and 03." In what order would you file the Smith family's records? The answer to this question is a little tricky. Let me explain. There are no directives in our medical AFIs stipulating the order of filing records by family prefixes.

Terminal Digit Group:
20
987
65
43
21

Therefore, it is imperative that you learn the local MTF procedures when you are first assigned the task of working in a records section.

Generally, there are two methods used by most MTFs. The first is called the "sandwich" method. Using this approach, the sponsor's record would be filed first and the spouse's record would be last. Then, the children's records would be "sandwiched" in-between the two parents in numerical sequence. The second method calls for the sponsors record to be filed first followed by the spouse's

record—the children's records would follow in numeric sequence. There is no fancy catch phrase for this method but it is a practical way to consistently file records within your system.

There are numerous other beneficiaries such as a sponsor's parents or parents-in-law that will require investigation to reveal the proper order for filing. The important word here is *consistency*! It is imperative that all HSMs be aware of the procedures for filing records within your MTF. It may be a good idea to post the order for filing family prefixes in the records room to guard against misfiles and maintain consistency!

Exceptions for special files

There are a few authorized exceptions from the requirements to file outpatient records in the centralized files.

1. Small facilities may maintain separate files for active duty and family members, if they so desire.
2. Group records may be filed by organization for units that frequently transfer as a group.
3. Air Reserve Component (ARC) units will maintain records for their members unless a local agreement exists with the co-located active duty MTF to maintain the records. File the records separately when maintained by the MTF.
4. Maintain records for individual mobilization augmentees (IMA) (Cat B) as follows:
   - Maintain records for centrally managed IMAs (HC, JA, SG) with active duty unit of attachment MTF.
   - Maintain records of non-centrally managed IMAs with active duty unit of assignment MTF.
   - Maintain records of IMAs without unit of attachment/assignment MTF at HQ ARPC/SGP, Denver, CO, 80280–5000.
   - Maintain records for participating individual ready reserve (IRR) (Cat E) at HQ ARPC/SGP, Denver, CO, 80280–5000.
5. Mental health records are a separate category of records containing detailed psychiatric notations. Do not use the AF Form 2100A series. These records are usually maintained in the mental health clinic.
6. Prenatal records are maintained separately by the prenatal clinic. They must be incorporated into the inpatient record at the time of delivery, if the delivery occurs at the MTF. Provide copies of the prenatal record if the patient does not expect to deliver in a military MTF. The original documents will be filed in the outpatient record.
7. Family advocacy records are maintained by the family advocacy officer for each child in the program. These files are separate from the outpatient record and are secured. Do not use the AF Form 2100A series records.

Multiple volumes

If an additional record volume is needed or to separate the current volume from older volumes, records personnel will mark on the front cover of the new outpatient record volume jacket cover, in the upper left corner or in another area where other identifying record information is not obscured, in 2″ capital letters, with bold, black marker, the appropriate volume number, e.g., "Volume 2, 3, or 4" or "Volume II, III, or IV," etc. Login to CHCS and from the MRT module, verify that the multi-volume record is properly referenced, and if not, create a new electronic volume reference, print a new bar-scan ID label and affix to the new record volume jacket in the upper right corner. Place the new record volume back into main file and relocate older volume(s) to a designated location within the secure records department. Label older volume(s) with the same type of bold, black marker,

clearly indicating the volume number and be sure the bar-scan ID label reflects the older volume number(s).

"Splitting" records aka closing record volumes

In order to optimize file space for current and future outpatient records, it is permissible to "split" or separate outpatient records that consist of more than one volume.

Deceased patients

Place outpatient records of deceased patients in a separate, secured file location within the records department. Retire the non-Active Duty medical record (NSTR) to the NPRC IAW with established record retirement procedures, discussed later in this section. For records of deceased Active Duty and RCSMs, refer to the Sequestered/Deceased Member's Records section.

As stated above, there are few authorized exceptions from the requirements to file outpatient records in the centralized files. Only the MTF Commander may grant/authorized exceptions. Some examples of exceptions frequently used in MTFs were discussed above in the *Adding or Filing Documents* section.

212. Charge-out and transfer procedures

This function usually involves the most direct contact with patients in the outpatient records section. Patients seeking care in your medical facility regularly visit outpatient records for your assistance.

Records needed for clinic appointments

The outpatient records section and clinic personnel will ensure the outpatient record is available prior to patient's appointment. If the record is not present at the clinic when the patient arrives, an AF Form 250 Health Record Charge Out Request (fig. 1–7) or other appropriate form is prepared and entered into the MRT module in CHCS. This completed form is presented to the Records Section and the patient's record is removed from the file, charged out to the destination clinic in the MRT module and sent to the clinic. Do *not* allow the patient to hand carry the record. If the record is not available, the provider should make an entry on the form used to document care stating the record was not available for review.

FMP CODE			SSN (If Depn give Sponsor's)									
NAME (Last, First, Middle Initial)						STATUS (OPT)			ACTIVE DUTY			
							Air Force		RETIRED			
GRADE (If AD or Ret)			DATE				Army		AD DEPENDENT			
							NAVY/MARINE		RET/DECD/DEPN			
							OTHER		OTHER			
	AEROSPACE MEDICINE		MENTAL HEALTH		UROLOGY							
	DERMATOLOGY		NEUROLOGY/NEUROSURG		OTHER (SPECIFY)							
	DIET CLINIC		OB & GYN									
	EMERGENCY		OPHTHALMOLOGY		INPATIENT RECORDS							
	ENT		OPTOMETRY		PATIENT ADMINISTRATION							
	FAMILY PRACTICE		ORTHOPEDIC		PHYSICAL EXAMS							
	GENERAL SURGERY		PEDIATRICS		SECURITY CLEARANCE/PRP							
	INTERNAL MEDICINE		PRIMARY CARE		WARD NO.							

AF Form 250 AUG 91 PREVIOUS EDITION WILL BE USED HEALTH RECORD CHARGE OUT REQUEST

Figure 1–7. Sample, AF Form 250

Using charge-out storage guides

AF Forms 885, 886, and 887, Medical Record Charge Out Guides, are used as charge-outs and temporary storage guides when individual outpatient records are removed from open shelf files for short periods of time. They are not designed for use in files maintained in filing cabinets and must not be cut or otherwise changed to fit such a system. If your records are in filing cabinets, use the AF Form 614, Charge Out Record. If the supply of AF Forms 885, 886, and 887 becomes a problem, you can use AF Forms 614 for the daily checkout of records. If your facility uses commercially purchased out guides, you may continue their use.

Enter the record identification data on AF Form 250 or other appropriate form and then place the slip in the small pocket on the charge out guide. Insert the guide into the file in the same place the health record was filed. If you receive any forms to file in a charged out record, place the forms in the charge out guide.

When the record is returned, remove any loose filing from the charge-out guide and file it in the record. Then, remove the charge out guide and destroy the request slip. The charge out guide is then available for reuse.

These guides come in different colors to assist you in managing and controlling outpatient records files effectively. For example, one color could be used to identify the records pulled the first week, another color for the second week, etc. Color can also be used to identify records of patients who are sent to another facility for an appointment or consultation. Regardless of the system, the goal is to solve the problems associated with filing, suspensing, and controlling records.

Transfer of military outpatient records

Field personnel records are transferred when personnel are reassigned permanent change of station (PCS) or terminate service. The outpatient health record and dental records are part of the field personnel records.

Handling loose medical documentation

The outpatient records section maintains a CD-ROM that provides a directory of all active duty and retired personnel. To ensure you are placed on the requirements list to receive the CD ROM, send an e-mail request to tab@randolph.af.mil. Provide the name of the product requested and a valid mailing address including applicable suite/room number and a 9-digit zip code. Review the list and if the person is included, forward the documents to the new unit servicing MTF or MPF at the base to which the patient is assigned. Send any documents or records for separating or retiring Air Force personnel to the local MPF no later than five duty days after the member's date of separation (DOS). If more than five duty days, send the health records and/or loose documentation for members not filing a claim to the Department of Veterans Affairs, 4300 Goodfellow, Building 104, St. Louis, MO 63115–0020. Send health records and/or loose documentation for members who are filing a claim to the VA Regional Office (VARO) where the member has filed for compensation or pension. Prepare DD Form 675, Receipt for Records and Patients Property, to forward records and loose documents to the VARO or VA Records Management Center. Coordinate with the MPF to determine where health records and/or loose documents are to be sent. The Department of Veterans Affairs requires that when sending loose documentation it must be filed in an outpatient health record folder before it is sent to them.

Records of Air Force active duty family members are usually maintained at the MTF where the sponsor is assigned, unless they are performing an unaccompanied tour. Check the CD-ROM Personnel Locator to ascertain where the sponsor is assigned. If it can be determined whether the sponsor's family members receive care at the MTF, forward the loose documents for inclusion in the outpatient record. In all other cases where the record cannot be located, file the loose documents in a charge-out guide. If the record is not located within three months, place the documents in a manila

folder annotated with the patient's identification, and file in place of the charge out guide. These records will be retired IAW AFI 37–138.

Transfer of nonmilitary and retired military records

When patients change their residence, their records should be transferred to the nearest MTF to avoid loss of records or unauthorized access. However, the health care provider can authorize copies of pertinent medical documents be given to the patient, or the clinician can prepare an abstract.

Packaging the record

When the AF Form 1942, Clinic Index, is properly completed, place the health record in a sealed envelope addressed to the gaining medical facility. Mark the sealed envelope HEALTH RECORDS FOR MEDICAL USE ONLY, PROPERTY OF US GOVERNMENT.

Mailing outpatient records to another MTF

Medical records are mailed to another facility when a DD Form 2138, Request for Transfer of Outpatient Record (fig. 5), DD Form 877, Request for Medical/Dental Records or Information; or other legal request is received. The DD Form 2138 is a postcard-style form that is routinely used for transferring records. Put the name and complete address of your MTF in the center of the "address" side of the DD Form 2138. You may use a rubber stamp or other preprinting/automated device. The sponsor or spouse completes the identification data (name, SSN, etc.) on the form. After arrival at the new location, the sponsor or spouse delivers the DD Form 2138 to the medical facility that is responsible for providing outpatient care. The remaining section of the form is completed by the receiving medical facility. Then the form is mailed back to the MTF at the sponsor's previous duty assignment. When the form is received by the sponsor's previous MTF, records personnel remove the record or records from the file, annotated AF Forms 1942 as to the place and date of transfer, and then place the AF Forms 1942 in an alphabetical file for six months. At the end of the 6-month period, the AF Form 1942 is destroyed.

A copy of the PCS orders and the DD Form 877 or 2138 along with an AF Form 614, Charge Out Record, is placed in a folder, and then placed in the central record file where the record you are transferring out was located. All loose medical documents received after the record is removed are filed in the folder until the documents can be mailed to the receiving MTF. No loose documents are stored in this folder over 90 days. At the end of the 90-day period, all remaining loose documents are mailed, and the PCS orders, DD Forms 877 or 2138, and the charge-out guide are removed from the central file.

The outpatient record is mailed to the requesting facility in a timely manner. Use the address block of DD Form 2138 as a mailing label.

The DD Form 2138 can be initiated by any MTF to request outpatient records from another MTF. It cannot be used to request records that have been retired to the records center; another form, DD Form 877 is used for this type of request.

If you receive a request from a civilian practitioner or facility, be sure a signed release from the patient, parent, or legal guardian is enclosed. Copy the pertinent parts of the record, or request that a practitioner prepare a synopsis of care, whichever is your facility's policy. Never release the original outpatient record to a civilian source unless you are directed to do so by a valid court order. Each MTF has established policy, depending on the local and state requirements.

213. Outpatient records inventory and retirement

As the lesson title states, the subject we discuss here is inventorying and the procedures for retiring outpatient records. Inventorying is an important part of the process in maintaining a record section. This process is spelled out for you to ensure you conduct your inventory properly and timely. As a Health Services Management Journeyman, you will play a crucial role in outpatient records retirement. It is an important process that involves more than just the task at hand. We will discuss the

process of retiring records, exceptions to retiring instructions, valuable references available, how to package the records, and how to request information from records that were retired. Ready, set, go! Let's become experts at tackling outpatient records inventory and retirement.

Records of personnel assigned to the base

Outpatient records inventories are only performed on records of active duty personnel. The records of active duty personnel assigned to the base are inventoried at least once a year. This inventory must be completed by 31 March of each year. Local policy dictates how your MTF accomplishes this task.

Records of personnel not assigned to the base

When individuals who are not assigned to the local Air Force organization receive medical care on base (e.g., AFIT (Air Force Institute of Technology) students), their records must be individually identified by entering their status on the health record folder, in pencil. Do not forward these records (ex.) civilian emergencies.

Managing reserve component outpatient records

STRs for members of the RC (Category A) and ANG/AGR are normally maintained with their respective medical units, unless a local agreement or MOU exists between the MTF and the RC/ANG unit(s) requires the MTF to maintain them. The MTF may maintain STRs for members of the RC (Category A) and ANG who:

- Are placed on active duty orders for more than 30 days.
- Are currently empanelled to an MTF primary care manager.
- Have provided the MTF records department with the original health record and a copy of the member's activation orders (the service member or the unit can provide the records).

In these instances, the member is required to notify the MTF records department upon completion or removal from active duty and/or removal from active MTF enrollment. If the Service Member's Reserve/ANG unit does not provide the outpatient medical records to the MTF during the RCSM's period of active duty activation and/or empanelment, the missing outpatient record will not negatively count against the MTF's paper records availability and accountability percentages (availability and accountability metric percentages will be discussed in further detail below in the *Medical Records Review Function* section).

Dual or multiple eligibility

Maintain separate paper-based health records for dual or multiple healthcare eligibility patients, (e.g., a patient who is a family member husband and a RCSM). See the *Dual Status* Section above for additional guidance regarding dual or multiple eligibility patient record maintenance. Medical and dental records for Category B individual mobilization augmentee (IMA) and E (PIRR) are maintained at the IMA Service Member's servicing USAF MTF usually co-located at or near the Service Member's unit of attachment.

IMAs

Maintain STRs for IMAs (Cat B) according to the following instructions:

- Maintain records for centrally managed IMAs (HC, JA, and SG) with the active duty MTF unit of attachment.
- Maintain records of non-centrally managed IMAs with the active duty MTF unit of assignment.
- Complete an annual inventory of all RC health records on file as of 31 March.
- RMG/IRMS maintains a registry of IMA/PIRR records/locations, and can furnish a list of the IMA records you should have on file at your MTF.

- Notify HQ AFRC/SGP if records are not located or if a records transfer (due to reassignment, retirement) is required.

Mental health records

Mental health records are a separate category of records that contain detailed psychiatric notations of evaluations, consultations, tests, and treatment provided on an outpatient or inpatient status. Do not use AF Form 2100A series record jackets for records kept in the mental health clinic. These records must be kept in properly secured files in the mental health clinic. See AFI 44–109 and AFI 44–172, Chapter 4, for details on mental health records and records management.

Family Advocacy Program patient records

The Family Advocacy clinic or office maintains the original Family Advocacy Program (FAP) patient record. The FAP record contains detailed, confidential information regarding alleged or verified family maltreatment. These files are separate from the outpatient record and are secured. Do not use the AF Form 2100A series records jackets.

Prenatal records

Prenatal records may be maintained separately by the prenatal clinic and then must be incorporated, as a package into the inpatient record at the time of delivery, if the delivery occurs at the MTF. see the *Section 1* filing table for instructions. For exceptions, see the following:

- If a patient is transferred or relocates before delivery, the prenatal record should be given to the patient to hand-carry to the next MTF. If the patient does not expect to deliver in an MTF, copies of the prenatal record should be given to the patient and the original documents filed in the patient's outpatient record.
- Prenatal records should be screened quarterly. When the expected date of delivery has passed or there is no indication that the patient is being followed, the prenatal record should be withdrawn from the prenatal file and forwarded to the outpatient records department for inclusion in the patient's outpatient record. If no outpatient record is available, prepare one.

Flight and operational medicine records

If authorized by the MTF Commander, outpatient records for Airmen and family members empanelled to the Flight and Operational Medicine Clinic may be maintained in the Flight and Operational Medicine Clinic. Flight and Operational Medicine records are usually maintained on individuals assigned to air crew duty, missile launch duty, air traffic control duty, physiological training duty, parachute duty, and weapons control duty, and on the family members of Airmen on flight status who are empanelled to the Flight Clinic.

PRP, PSP, FLY, and other sensitive duties programs records

Outpatient medical and dental treatment records for personnel assigned to the PRP, PSP, or any other sensitive duty program will be maintained in a separate, secured location. Proper use and management of the CHCS MRT module is mandatory and will provide MTF personnel with the mechanism to determine where a "paper" medical record is located. Remember, Service Members assigned to Sensitive Duties Programs, like the PRP, PSP, or other sensitive duty National Security program(s), may be temporarily or permanently decertified, suspended, or removed from their duty position(s) based on their medical, dental, or mental health status or the type of medications prescribed. The current DOD EHR cannot automatically provide for the mandatory notification and receipt confirmation documentation (between the MTF competent medical authority and individual unit commanders or installation operational assurance officials) of a Service Member's health status, operational capabilities/limitations, or his/her fitness for duty following each patient encounter. Because of this limitation, MTF personnel will print each patient encounter form(s) following each episode of care so that all administrative notifications regarding the patient's operational capability/reliability may be recorded (by hand) on the same document. Following notification

documentation, any forms printed from the EHR will be filed into the Service Member's paper outpatient medical or dental treatment record.

Records for personnel from the US Army and US Navy

Record custodians will comply with Air Force records management and maintenance instructions when maintaining Army and Navy records. When Army and Navy members are attached to an Air Force facility for medical care, the Air Force assumes custody of their health records. When patients from other Services are treated in Air Force facilities and require certain Service specific forms be completed and filed in the records, the documents will be filed in their record. The documents will be placed in the appropriate section of their outpatient record based on the type of form. Interfile Army and Navy records with Air Force records. Replace folders with the AF Form 2100A series only if the color and blocking do not permit interfiling.

Geographically separated units outpatient records management

Active duty service members, and their family members, assigned to a geographically separated units (GSU) (with no on-site military medical support), and/or those who reside more than 50 miles or approximately one hour of driving time from the nearest MTF may be eligible for care through TRICARE Prime Remote (TPR). Reference the TPR website at http://www.tricare.osd.mil/tpr. These beneficiaries are often assigned to:

- USAF Recruiting Service posts.
- ROTC units.
- GSUs.
- Authorized TRICARE Prime Remote locales.
- TRICARE Prime Remote family members enrolled to civilian PCMs.

These STRs and NSTRs will be maintained at the nearest MTF to the member/sponsor's remote assignment location or home address, whichever is more advantageous to the sponsor and family member(s). There may be instances when the responsible AF MTF is not the nearest MTF to where the member is assigned or the family member is enrolled. In these instances, the responsible AF MTF must coordinate with the nearest MTF maintaining the records to ensure the records are correctly processed when the member retires, separates, PCS's to another location or enrolls to another MTF. The original health records of GSU Service Members and their family members (if family members accompany the sponsor) will NOT be maintained by the sponsor, his or her family members, or provided to the sponsor or family members' civilian PCM office. As previously stated, the records will be maintained at the Air Force MTF nearest to where the sponsor and/or family members reside. Affix the following statement to the outside of each original health record(s) using an address label (see fig. 1–8):

> "Assigned to a GSU at or near (enter city, state, territory, or Province name here). IAW AFI 41–210, Section 5B, DO NOT RETIRE THIS OUTPATIENT RECORD."

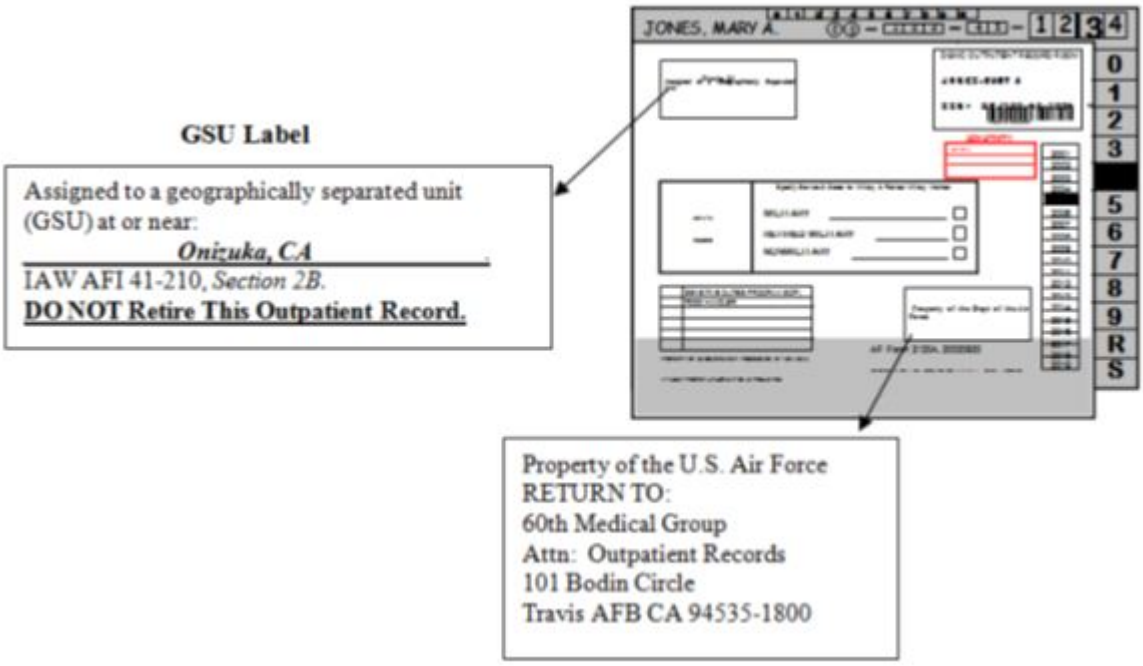

Figure 1–8. GSU Record Copy

EXCEPTION: For sensitive duties program participants or flight status personnel

The original Service Treatment Records (STR) of service members assigned to a GSU may be required to be maintained or stored at the unit to maintain sensitive duties program participation, flight status, or individual or overall program certification. If the original STR is required to be kept at the unit, the outpatient medical and dental records will be maintained by the unit commander, and secured in a locked container behind at least one locked door during non-duty hours. Access is restricted to the unit PRP, PSP, of flight status certification or program reporting official. A good example of this type of scenario would apply to service members assigned to remote munitions sites (MUNS) GSUs in USAFE. The nearest Air Force MTF Commander and Service Member's GSU commander will ensure mechanisms are in place to ensure all medical documentation generated from civilian medical facilities are added into the Service Member's STR and that all health records are maintained IAW AFI 41–210. When health record copies are provided, Air Force MTF records personnel will place a "Property of the US Air Force" label containing the appropriate MTF address on the record jacket. See Figure 1–8, GSU Record Copy.

Miscellaneous or "loose" medical documents generated by an MTF for GSU members and/or their family members will be forwarded to the MTF or GSU that maintains the individual's health record. Upon reassignment from the GSU to a military installation and subsequent MTF PCM assignment, the gaining MTF will send a DD Form 877 or DD Form 2138 so that the member's original outpatient medical record(s) are forwarded to the new location. Upon receipt of the original health record, cover the GSU label with a blank label, create a new facility location label, and remove the PCS order to the previous GSU location. The gaining MTF/PCM should complete a release of information authorization for the patient to request copies of medical record documentation from their civilian provider to be added into the official medical record. Transferring records for PCS and in-processing records will be discussed further in the applicable sections below.

Missing and lost health records

Health records, both in electronic and paper form are considered PHI and PII subject to the provisions of the Privacy Act. Once a medical record is deemed "lost", specific steps must be taken in order to

report the information and notify the affected beneficiary or party. There are several instances when a health record may be considered "missing." Here are some of the most common examples:

- A health record may be considered "missing" immediately following a record room supervisor's investigation of the circumstances surrounding the record's disappearance.
- When a health record is discovered missing from the main Record File with no documented borrower location or date.
- When a record is discovered missing from the main Record File (with a documented) borrower location and date, but the physical record has not returned to the Main File following a period of 30 calendar days or more without a documented explanation.

MTFs must exhaust all reasonable means to locate a missing health record. When missing records are discovered, each MTF staff member is responsible for searching their immediate work area(s). All MTF personnel will mobilize and help search for a missing record. The following procedures are required after discovering a record is missing:

- Check to identify possible borrower charge-out locations in the automated MRT module.
- Check for record misfiles in each record storage room.
- Search provider offices and exam rooms.
- Ensure the record has not been forwarded to a peer review or clinical review committee, meeting, or function.
- Verify the record has not been sequestered from main file.
- Verify the record has not been temporarily separated from the main file for any other official review function; if known, contact the previous MTF responsible for maintaining the beneficiary's health records.

If the record still has not been located following the preceding minimum search requirements, submit or add the missing record to the next quarterly AFMS "Global" Records Search.

AFMS global records search

If, after an extensive internal MTF search is completed, including contacting the patient's previous MTF, the investigation has not yielded the recovery of the missing record(s), MTF health records officials may request an Air Force Medical Service-wide search for the missing health records. This AFMOA/SGAT sponsored service provides MTF, RCMU, and GSU health records custodians, with an opportunity to broadcast their missing paper outpatient medical and/or dental records to other MTF records managers throughout the AFMS. Each quarter, AFMOA officials solicit all MTFs, RCMUs, and GSUs to submit their lists of missing medical and dental records to the San Antonio AFMOA office via secure, encrypted e-mail message. This quarterly missing record "data call" includes a pre-formatted data collection spreadsheet that each MTF completes when documenting their missing record(s). Before the missing record data/request is submitted to AFMOA, the TOPA flight commander or patient administration flight commander will verify that all MTF records personnel have exhausted every possible research mechanism for every identified missing record. The TOPA flight commander or the patient administration flight commander will include the following statement in either the body of an encrypted e-mail message to AFMOA or typed and included in the faxed report:

> "I certify an extensive investigation has concluded the identified missing record(s) cannot be located within this MTF. All reasonable records research efforts have been exhausted. All necessary communications with records management officials at other potential MTF and/or record maintenance and storage sites have not contributed to the successful recovery of the missing record(s)."

The information listed below will be e-mailed or faxed to the AFMOA/SGAT, Health Benefits Office. Forwarding the missing record information via e-mail message is the preferred

communication method. However, fax requests may be accepted but prior coordination with AFMOA is required. Fax requests must also include the standard HIPAA warning advisory. E-mail messages will ONLY be forwarded to AFMOA using Common Access Card (CAC) digital signature and encryption protocols verified using registered Air Force Public Key Infrastructure (PKI) identification/security certificates. Simply assigning a document password and forwarding the information unencrypted to higher headquarters is not authorized. The message must be digitally signed and encrypted. No exceptions. Include the following information:

- CHCS MRT Record Tracking Number.
- Patient's Last Name, Patient's First Name, Middle Initial.
- Sponsor's Full Name (Last Name, First Name, Middle Initial).
- Sponsor's SSN.
- Patient FMP (20, 30, 01, 02, etc.).
- Patient's PAT CAT.
- Sponsor's Pay Grade and Rank.
- Patient Status (AD/AF; Dep Son Ret/USN, Retired USA, etc.).
- Location and date where record was last seen. **NOTE:** List MTF name only. Due to federal privacy laws, specific references to the name of the last known outpatient clinic or clinical work center will not be forwarded to the AFMS, e.g., do not include the Urology Clinic, 19 Sep 2010 as the last known record location.
- Identify a POC for each missing record. Include name, rank, telephone number, and e-mail address.

If after all preceding research actions have completed, and still the missing record(s) has not been recovered, the squadron commander responsible for the records room reporting the loss is responsible for informing the MTF Commander. Only the MTF Commander may deem a missing health record as "lost." After all efforts to find the lost health record(s) are exhausted, MTF personnel must follow the guidelines and procedures identified in DOD 5400.11-R in consultation with the installation Public Affairs Officer and available installation legal staff and/or the Medical Legal Committee (MLC). MTF personnel should be aware that Public Affairs reporting and notification procedures often require disclosing the paper or electronic breech to the US Computer Emergency Response Team (USCERT) within one hour of the "lost" determination.

Retiring outpatient records

At the end of each calendar year, outpatient records for nonmilitary, dependents, and retired military personnel are retired in accordance with AFI 37–138, *Records Disposition Policies and Procedures* and AFMAN 37–139, *Records Disposition Schedule*. The general rule is that records are retired at the end of the year, two years after the last date of treatment recorded in the record. There are several exceptions and conditions that may affect this rule and AFI 41–210 must be consulted during the records retirement process.

Identifying and processing records for retirement

All MTFs will utilize the step-by-step instructions provided in the Medical Record Tracking, Retirement, and Retrievel (MRTR2) User Guide to set up the CHCS record rooms, create pull lists of retirement eligible records, and to create the final shipment index. A copy of this user guide can be obtained from the patient administration website: https://kx.afms.mil/patientadmin. MTFs with CHCS must create a records retirement list by using the Medical Records Menu to enter record selection criteria including record room, record type, and retirement year. A CHCS batch job selects the records, and downloads the electronic list to a subfile for use specifically for the records retirement process. The subfile is the records retirement index file, which is printed and used as the pull list to retrieve the records eligible for retirement.

Non-NATO foreign military personnel outpatient records

Retire outpatient records for non-NATO foreign military personnel to NPRC two years after the end of the calendar year of the last date of treatment, IAW AFRIMS Records Disposition Schedule, Series 41 Internet website, accessible via the Air Force Portal website and the Medical Record Tracking, Retirement and Retrieval (MRTR2) System located at the AFMS KX Knowledge Exchange, Patient Administration website.

Federal civilian employee outpatient records

The civilian employee medical folder (EMF) is a chronological, cumulative record of occupational and non-occupational information pertaining to the health of a civilian employee during the course of employment. This record consists of personal and occupational health histories, exposure records, medical surveillance records, Office of Worker's Compensation Programs (OWCP) records, and the documented notes, evaluations and tests results generated by healthcare providers in the course of examination, treatment and counseling. Maintain outpatient records of civilian Air Force employees until the employee is transferred to another activity within the Federal government or is separated from the Federal Service. Upon employee transfer or separation, place the record in SF 66D, Employee Medical Folder, and forward to the MPS, Civilian Personnel Section within 10 days of transfer or separation. It is the responsibility of the MPS to forward the EMF to the appropriate custodian. However, federal civilian employees must complete installation and unit and/or installation out-processing checklists similar to their active duty counterparts (as applied to MTF out-processing requirements). Typically, active duty members are required to visit the installation OPR department to make sure their record(s) and the record(s) of their family members will be forwarded to the next base, regardless of any pre-arranged MPS-MTF transfer process. Federal civilian employees are also required to visit the local servicing MTF OPR department where their EMF is maintained. This process will ensure that the MTF receives notice from the civilian employee of an upcoming transfer or retirement, regardless of any MPS records relocation/retirement notification.

If however, civilian employee records are found years after the employee has relocated or retired, then accomplish the following items to disposition the records:

- Ensure records are in a SF 66D. Each employee will have his own folder.
- Annotate the SF 66D with the employee's last name, first name, middle initial and SSN on the upper right hand corner—preferably typed on a white folder tab.
- Box the records in a container that will safely make it through the USPS mailing process.
- Create a shipping list for each container. Detail the contents by name and SSN of each employee's record
- Mail the container(s) to:

  National Personnel Record Center
  111 Winnebago Street
  St. Louis, MO 63118–4126

Mail the record containers using standard first class mail, certified mail, or other available option. If standard first class USPS is used, return receipt confirmation is required.

Editing the records retirement index

The records retirement index will need to be modified according to what records are or are not available for pull. This includes removing records unavailable for pull from the retirement index and adding records eligible for retirement to the retirement index. The specific instructions in the MRTR2 guide must be followed to ensure it is done properly. Accuracy of the record retirement index is critical because it is the document later used to locate any medical records previously retired.

Boxing the records

As mentioned in the previous section, the records retirement index is used as the pull list to retrieve the eligible records from the file room. The records must be placed in the exact order as they are listed on the records retirement index. Once all records are retrieved and placed in boxes, the user adds the box numbers to the electronic records index. The records index will then be printed and placed in the first box of the shipment and copies will be retained at the MTF for future reference. A shipment receipt acknowledgement form is also included in the first shipment box.

Shipping the records

Prior to shipping, the records index and shipment data files will need to be transmitted electronically to the National Personnel Records Center (NPRC). The MRTR2 guide provides specific instructions on completing this step. After receiving the information from the MTF, NPRC will send accession numbers to the MTF. The medical records cannot be shipped until accession numbers are received. Now, you are ready to palletize and ship the medical records to NPRC. NPRC set forth guidance to assist with the proper build of the pallets. You will coordinate with the local TMO on base to ship the medical records. This will require completion of DD Form 1149, Requisition and Invoice/Shipping Document, upon receipt of the shipment at NPRC, NPRC personnel unload the boxes from the carrier, move them to the processing area, open the boxes and prepare them for review. The NPRC personnel sign and date the shipment receipt acknowledgement form and mail it back to the MTF. In general, if the physical records in the boxes do not match the index or were not prepared IAW the retirement instructions, the NPRC personnel send an e-mail message and notifies the MTF that the error exists. If necessary, the NPRC returns the shipment at MTF expense.

As you work in an outpatient records setting, you will soon discover that many questions are bound to arise that haven't been answered in this short unit. Remember to find the experts for advice—your supervisor or NCOIC is a great place to start. If you are really motivated, find a copy of AFI 41–210, *Patient Administration Functions.* This instruction is a wealth of knowledge and will certainly be able to answer some of your more complex questions.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

211. Terminal digit filing system and location of special files

1. Who owns all of the military health records?

2. What system is used to file outpatient records?

3. Using the social security number "20/000–12–3456," break down the number into the following categories:

   a. 1st part tertiary:

   b. FMP:

   c. Primary number:

d. 2nd part tertiary:

e. Secondary number:

212. Charge-out and transfer procedures

1. What type of documentation must be received by the sending MTF before medical records are mailed to another medical facility?

2. How are AF Forms 1942 filed, and for how long are they maintained?

213. Outpatient records retirement and inventory

1. What category of records is inventoried?

2. How often are outpatient records inventoried?

3. When are outpatient records for nonmilitary, dependents, and retired military personnel retired?

4. What is used as a pull list to retrieve medical records eligible for retirement?

5. What can happen if the physical records sent to NPRC do not match the records retirement index?

1–6. In and Out-Processing Outpatient Medical Records

The DOD has established policy that all military service members will be apprised of their healthcare benefits as they move from one assignment to another. Specifically, members must be informed of the scope of their benefits; how to access healthcare in their local community; how to access healthcare while away from home or in route to a new duty station; and how to get problems resolved during this transitional period should they arise. Furthermore, medical in/out-processing appointments, briefings, and meetings offer MTF providers and preventative healthcare specialists with an opportunity to collect, review, and assess a Service Member and his/her family members' health status to identify significant medical or dental conditions or complications that may have otherwise gone unnoticed or untreated if the medical in/out-processing review had not been completed. You should have a basic understanding of TRICARE benefit options and be able to clearly communicate these options to beneficiaries when required. You may also be asked to provide health benefits briefings at other

installation information briefings normally provided to arriving and departing service members. A good example of an in-processing briefing opportunity is the "base newcomer's" briefing or Right Start Program briefing. Although not specifically limited as an exclusive TOPA obligation, generally, MTF staff members assigned to the TOPA functions are responsible for providing the healthcare benefits portion of each in/out-processing function.

214. In-processing outpatient medical records

One of the first places people will visit when they come into the MTF is the outpatient records window. When they come to the outpatient records window, we want to ensure we have their outpatient medical record. This is why it is important that all outpatient medical records have been in-processed correctly through outpatient records.

Methods for in-processing outpatient medical records

As stated earlier, there is no standardized written method for in-processing outpatient medical records into the MTF. Therefore, MTF's use many different methods. The next several paragraphs identify some of the methods used throughout the United States Air Force to in-process records.

Active duty member in-processing

There are several ways members' records are delivered to MTFs. Three of those are identified below:

1. Active Duty member in-processes at the squadron. If members are assigned to the Personnel Reliability Program (PRP), the squadron generates the AF Form 286, Personnel Reliability Program (PRP) Qualification/Certification Action, and takes appropriate steps to in-process the member through PRP.
2. Active Duty member in-processes at the military personnel flight (MPF) and hand delivers records at that time.
3. Active Duty member attend the finance briefing, and a 4A0 picks up all medical records from the finance briefing.

Command support staff in-processing

Command support staff (CSS) personnel open all envelopes containing the medical records of active duty members. Then, they schedule active duty members for a mass medical briefing, which is given once a week. This mass briefing has many names; some MTFs call it "Right Start." This briefing is given once a week. During the briefing, the members fill out appropriate forms and are "checked into" the CHCS. They are then given information to help them alleviate any concerns they might have about the MTF. Finally, an active duty member and their family members (beneficiaries) are assigned to a Primary Care Optimization (PCO) team.

Military personnel flight in-processing

Personnel in the Military Personnel Flight (MPF) open all envelopes containing outpatient medical record(s). The Outpatient Records section sends a 4A0 over to the MPF to pick up all outpatient medical records. **NOTE:** It is recommended this be done daily.

MTF procedures for in-processing outpatient records

The 4A0 in-processes all medical records, loads the demographic roster, and then gives the records to the appropriate PCO team for screening. Outpatient records section or PCO team registers patients into CHCS, if required. In addition, other information is updated to ensure all information in CHCS is accurate. The 4A0 generates a computer charge-out and then delivers the records to the primary care manager (PCM) for review. The PCM then returns all records to 4A0 for filing.

215. Out-processing outpatient medical records

When active duty members and dependents are transferring, retiring, or being discharged/or separated, you can use the following guidelines to properly process their record and their dependents' records.

Transferring members

1. Verify eligibility/identity of the patients by checking their ID cards.
2. Obtain a copy of the sponsor's orders.
3. Be sure the sponsor's record is maintained at your MTF. For example, the MTF does not maintain records for anyone on flying status; those records are maintained by Flight Medicine.
4. If the sponsor's record is maintained at your MTF, place a copy of the orders in an AF Form 885 (red), Medical Record Charge Out Guide; AF Form 886 (yellow), Medical Record Charge Out Guide; or AF Form 887 (blue), Medical Record Charge Out Guide and file in place of the record. The NCOIC, Outpatient Records, will decide which color to use for quality control purposes. One color should be used for one month and then alternate colors for subsequent months through the year. If the record is not maintained at the MTF, use the CHCS or personnel locator CD-ROM to determine where the record is being maintained.
5. Pull the sponsor's medical records. If they have any dependents, pull their records also. If any of the dependents are over the age of 18, be sure there is written consent in their records authorizing someone else to pick them up. If there is no consent, those dependents must return with a copy of the sponsor's orders to pick up their own records.
6. When all of the records for a sponsor and family members have been pulled, you must then transfer them in the computer.
7. Print out any lab slips or x-rays that the patient may have in the computer system and file them in the appropriate records.
8. Place the dependents' records in a separate envelope from the sponsor's.
9. Seal both envelopes with tape and stamp with the statement "To Be Opened By Medical Group Personnel (Outpatient Records)."
10. If for some reason the sponsor's medical record is unavailable at the time of out-processing, give them a "Letter of Non-Availability" (locally developed form). When the record has been located, let the individual know and indicate when it will be transferred to their next base.
11. If any dependent's records could not be located, the requester fills out a tracer (a locally developed form) and a DD Form 2138, Request for Transfer of Outpatient Record. Attach the DD Form 2138 to the tracer, and notify patients that when their records are located they will be transferred to their next base.

Retiring members

1. Verify eligibility/identity of the patient by checking the member's identification card.
2. Obtain a copy of the members' orders.
3. The sponsor's outpatient medical record will be the only record released.
4. If the record is maintained at your MTF, place a copy of the orders in an AF Form 885 (red), AF Form 886 (yellow), or AF Form 887 (blue) Medical Record Charge Out Guides (the color of the month) and file in place of the record.
5. The records must be transferred and updated in the computer.
6. Place the sponsor's record in a sealed envelope and forward the record to the MPF within 5 duty days of final outprocessing appointment.

7. If the sponsor is retiring in the local area, the retiree and the family members' records will remain on the shelf for continued care.
8. If the sponsor is not retiring in the local area, the family member's records may be transferred to the closest MTF where they will reside. To do this, a DD Form 2138 may be filled out at the originating or destination MTF. The sponsor may fill out a DD form 2138 for any children they have under the age of 18. Anyone over the age of 18 must come in and fill out this form to have their records transferred, unless there is a consent letter in the medical record authorizing the sponsor to do so for them.
9. If there is no MTF close to their residence, retirees and their dependents will need to request copies of their medical information.

Discharged or separated members

If a member is being discharged and needs to obtain his or her medical records but they do not have any type of orders, they must provide a memorandum from their squadron stating that discharge/separation is pending and their records are needed for the discharge review board to review. If you receive a copy of this type of memorandum, then you can release the member's medical records. Family members, however, are only authorized to request a copy of their own medical records.

Providing copies for the benefits delivery at discharge program

The benefits delivery at discharge (BDD) Program is a joint initiative between the DVA and the DOD. This program enables DVA representatives to help transitioning Airmen assemble and prepare their disability claim packages for DVA disability compensation and benefits review prior to their service separation or retirement. The original STR is not provided to the BDD office. Instead, the MTF will provide the member with a paper copy of the STR at the member's request. The BDD office will only accept a paper record copy at this time. **NOTE:** this copy is counted as the member's one complete copy free of charge.

Collecting and preparing STRs for shipment

Once the LOSS rosters are obtained, retrieve the applicable outpatient medical records and place them in a staging area separate from the main file located within a secure, limited access room. File the STRs in chronological order according to the Loss Roster shipment date. This will help ensure the STRs are mailed to AFPC by the deadline (i.e., no earlier than 30 days after and no later than 35 days after the member's final date of separation). No later than 20 calendar days after the Airman's date of separation, MTF and dental treatment facility (DTF) records personnel will ensure the dental treatment records for each separating and retiring Airman are forwarded to a central MTF location where they will be bundled with the outpatient medical record and staged until ready for mailing to AFPC. The outpatient medical and dental records for each Airman must be "bundled" together before shipping to the AFPC Records Disposition Center. DO NOT MAIL THE OUTPATIENT AND DENTAL RECORDS SEPARATELY.

Missing records

With the DOD-wide implementation of AHLTA, almost all active duty service members (ADSM) have patient medical encounters documented electronically. If after an exhaustive MTF-wide search either the original paper outpatient medical or original dental record(s) cannot be located, there will likely still be at least a few electronically stored AHLTA patient medical encounter documents. In this scenario, MTF records managers are required to locate and print the AHLTA patient medical encounter documents and file in a new outpatient medical record jacket. The record jacket should be labeled "Volume II" and a record of the new volume must be documented in the CHCS MRT module. Records managers must flag the original paper record volume as "missing" in the same CHCS MRT module. The process of identifying and printing AHLTA dental patient encounter information and filing the printed documents in a new dental record jacket is required for all DTFs with operational

AHLTA dental modules. A letter of non-availability must be included in the STR package for the missing original volume.

Non-availability statement for missing original paper records

If after due diligence, to include contacting the patient's previous MTF, either the original paper dental or original paper outpatient medical record(s) are missing and absolutely cannot be located, then include in the bundled package, a letter of non-availability indicating one or more original records are missing. A template for the letter of non-availability is available on the AF/SG Community of Practice (CoP). See Attachment 32 for the authorized format. It is important to note; two letters of Non-Availability will not clear the STR from the missing roster, as the DVA will not accept two letters of Non-Availability for one individual. The squadron commander or flight commander responsible for the operational day-to-day maintenance and storage of the dental and/or outpatient medical records, as applicable, must wet sign the letter of non-availability. Signature delegation is not authorized.

As previously stated, MTF records managers are required to print all patient encounters from AHLTA and add to the existing outpatient and/or dental treatment record at the time of the Airman's separation or retirement. If either the original outpatient medical or dental records are missing, create a new AF Form 2100A series record and add the printed documents to the paper record aka record jacket. Since this new jacket constitutes another record volume, MTF records personnel must create another medical volume in the CHCS MRT menu and record the transfer to the AFPC Records Disposition Center just as they would for the original record. The letter of non-availability must be completed to reflect that the original paper record volume is missing.

Air Force members empanelled to other-service MTFs

STRs for ADSMs are normally maintained at the MTF where the member receives his primary care, regardless of service affiliation. The health record management officials at the Air Force MTF located nearest to the member's Other-Service PCM/MTF location should establish a local STR support agreement (see Attachment 33 for example) with the Other-Service MTF. As this is DOD policy, Memorandum of Understanding (MOU) verbiage should include both service processes. The agreement should identify how the STRs will be transferred from the Other-Service MTF. How this is accomplished is jointly decided by the MTFs, but acceptable methods include:

- The Other-Service MTF may mail the STR to the nearest AF MTF for subsequent mailing to AFPC.
- The Other-Service MTF may forward the STR directly to AFPC if they do so using the instructions outlined in this document. Include a copy of the STR disposition instructions with the agreement if this method is chosen.

There may be instances when the member is assigned to a GSU and the responsible Air Force MTF is not the nearest MTF to the member's Other-Service PCM/MTF location. In these cases, if the MTF identified on the Loss Roster is not the MTF that maintains the retiring/separating member's STR, the Loss-Roster-named MTF must coordinate with the MTF where the record is regularly maintained in order to ensure the STRs are mailed to AFPC or RCMU by the deadline. Once contacted, the MTF maintaining the STR mails the STR to AFPC.

Non-Air Force service members empanelled to Air Force MTFs

Service Treatment Records for non-AF service members are normally maintained at the MTF where the member is empanelled and enrolled, regardless of Service affiliation. Unless there is a local STR Support Agreement stating otherwise, STRs for Other-Service members should be mailed to the Service specific address identified on the SG CoP. If a local STR Support Agreement is established with another Service, the agreement should identify how the STR will be transferred to the applicable Service. DO NOT FORWARD HEALTH RECORDS FOR UNIFORMED SERVICE MEMBERS

OTHER THAN AIR FORCE SERVICE MEMBERS TO THE AFPC RECORDS DISPOSITION CENTER. FORWARD AIR FORCE STRs ONLY.

STR Bundles should include:

- Outpatient medical record and/or letter of non-availability.
- Dental record and/or letter of non-availability.
- Retirement/separation or discharge order in each record or memo regarding missing orders.
- DVA claim application (VA Form 21–526, Veteran's Application for Compensation and/or Pension) or Memorandum for Retiring/Separating or Discharging Service Members Intent to File DVA Claim (if applicable).

Items Included in Shipment Boxes:

- STR Bundles by chronological shipment date as identified by the DOS on the Loss Roster and/or orders.
- AF Form 330, Record Transmittal/Request, in each shipped box.
- A copy of the LOSS roster.

The downloaded LOSS roster has 3 additional columns on the right-hand side titled, "Date Record Mailed", "Remarks", and "NCOIC Signature." The NCOIC or records department supervisor must sign off the roster stating they have quality checked or "QC'd" the shipment, annotate the mailing date, and annotate any remarks needed. This is a communication tool for the MTF to AFPC. Due to the size of the LOSS roster, when printing only certain columns are required to be included. The following columns are required. All other columns can be "hidden" prior to printing:

- SSN.
- Name.
- DOS.
- Medical Records (Yes/No).
- Dental Records (Yes/No).
- Date Record Mailed.
- Remarks.
- NCOIC Signature.

MTF records management personnel are required to keep a copy of the AF Form 330 and LOSS roster permanently or until the Office of the Undersecretary of Defense for Personnel and Readiness (OUSD (P&R)) and the Services establish a disposition rule for active duty records. Place together with the postage tracking/arrival confirmation notice in a central location within the Outpatient Records department.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

214. In-processing outpatient medical records

1. Under a CSS in-processing system, to what type of medical team are active duty members and their family members assigned?

2. After members' records are in-processed through the MTF, to whom does the 4A0 charge them out for review?

215. Out-processing outpatient medical records

1. When an active duty member is transferring and a dependent's record cannot be found, what two documents must the requester fill out so the records can be forwarded to the active duty member's next base of assignment once recovered?

2. When an active duty member is retiring and has a dependent over the age of 18, who must fill out the DD Form 2138 for the dependent?

3. If an active duty member needs medical records for the discharge review board, but does not have any orders, what must he or she provide before you can release the records?

1–7. Maintaining Inpatient Records and Files

Inpatient records complement the outpatient records so that a complete picture of a patient's medical history and treatment is documented properly and thoroughly. Throughout the patient's hospitalization, many healthcare providers come in contact with the inpatient record. When the patient is discharged, the inpatient records section is responsible for consolidating the information, analyzing and coding the data, inputting (entering the information) into the CHCS, quality control of the documents, filing, retrieval (when needed) and the eventual retirement of the inpatient record.

On many occasions, health care providers will use the information found from a patient's previous admission to help answer medical questions or uncertainties regarding a current admission. The health services manager working in the inpatient records section plays a crucial role in ensuring health care providers have the information they need to make the right call! Paying attention to detail when filing records and ensuring loose medical documentation is properly filed may seem monotonous or boring at times. Remember, these tasks are critical elements needed for the successful treatment of our patients/customers.

216. Reviewing and finalizing inpatient records

As an inpatient records technician, you are responsible for assembling the inpatient record and reviewing the documentation before filing. You must ensure the records meet the JCAHO standards of:

- Completeness.
- Accuracy.
- Promptness.
- Clinical pertinence.

Ensuring the records meet the highest possible standards also includes reviewing documents for improper use of medical abbreviations and medical care not correctly documented in the record. If anything appears to be incomplete, or incorrectly documented, you must refer the record back to the provider.

Generating an inpatient record

Inpatient records are prepared under the following circumstances:

- Patients admitted to an inpatient unit of an Air Force facility, including patients admitted and discharged before 2400 hours on the day of admission regardless of the type of discharge.

- Reactivate the record of hospitalization if the patient is readmitted before midnight on the same day as discharged for the same reason as the first admission. The attending provider annotates the reason for readmission and the hospitalization is considered as one continuous period.
- Active duty personnel admitted to non-Federal hospitals and others records, responsibility is assumed.
- Live births occurring in Air Force MTFs.

  NOTE: Do not create a separate record on stillbirths.

- Patients who die in transit. The MTF receiving the remains processes the records and administrative data as if the patient had transferred-in.

There are some circumstances where a "canceled admission" is appropriate. Annotate the admission work sheet with the reason for cancellation and place all paperwork generated by the admission (e.g., history and physical, progress notes, laboratory and x-ray reports, etc.) in the patient's outpatient record folder. Record and code the episode as an outpatient visit.

Extended ambulatory records

The extended ambulatory records (EAR) is a folder that contains information on treatment received during an ambulatory procedure visit (APV), an observation stay, emergency room death (ERD), dead on arrival (DOA), or other similar status. Maintain each occasion of treatment as a separate episode within the EAR similar to the way multiple admissions are maintained within a single inpatient record folder. Starting 1 Jan 15 create a separate folder for each episode of care.

NOTE: There is no requirement to re-folder episodes created before 1 January 2004.

Maintain the EAR folder in a method similar to the inpatient record, using the inpatient record folder (AF Form 788A-J). Annotate the folder with the patient's name, Family Member Prefix (FMP), and sponsor's SSN. Attach the CHCS MRT bar code label to the folder. The EAR will be filed by the sponsor's SSN (same as the outpatient and inpatient records). The EAR will be maintained in a limited access area to allow for risk management and quality improvement purposes.

Although the paperwork for these cases is filed in the EAR folder, these episodes are actually coded as an outpatient episode in the appropriate ambulatory data collection system.

Ambulatory procedure visit and observation case records

File original documentation on a patient seen during an ambulatory procedure visit (APV) episode in the EAR folder. Create an APV record for those cases when a patient is seen in the Emergency Room or specialty procedure room, an APV procedure is performed, and the patient is discharged within 23 hours and 59 minutes of the time the patient was checked in by the nurse for preliminary work-up for the procedure.

Observation patients are outpatients with acute or chronic medical problems who require assessment monitoring or diagnostic evaluation in order to determine final disposition. The decision to place a patient in observation status is based upon the complexity, intensity, and duration of care required. Outpatient observation stays generally should not exceed 23 hours and 59 minutes. However, up to 48 hours may be authorized when medical necessity has been clearly demonstrated.

Emergency room deaths and dead-on-arrival cases

Code these records in the current ambulatory system. Maintain the documentation in the EAR folder.

Inpatient record file

After a patient has been discharged, the information in the patient's chart (located on the unit) is assembled into the proper order. Eventually, the patient information will make its way to the inpatient records section. The inpatient information is filed in an AF Form 788 series (A-J), Inpatient Record,

folder. The inpatient record uses a color-coded, terminal digit filing system based on the sponsor's SSN, the same system used in outpatient records. Construct a pseudo SSN whenever the actual SSN cannot be determined.

Preparing the folder

Folders are prepared and maintained by the inpatient record section technicians. Select the appropriate color based on the second to last digit of the sponsor's SSN. Enter the patient identification data in the same manner (using a pen) as you would the outpatient record identification label. Attach the CHCS generated MRT label. Blot out the square block along the right edge of the back leaf of the folder corresponding to the last digit of the SSN with a black felt-tip marker or black tape. Enter the FMP and sponsor's SSN along the top in the spaces provided.

Blot out the appropriate box on the front cover signifying the appropriate patient's status. Blot out the appropriate year in the year grid on the cover of the folder for all patients.

Multiple admissions

For discharges in CY 03 and earlier, records of previous admissions may be brought forward and filed, as a separate entity, in the folder of the current admission record. With the implementation of the Electronic Medical Records Retirement System in CHCS, beginning with discharges as of 1 January 2004 each admission must be filed in a separate folder to allow for the proper retirement of the record. There is no requirement to re-file admissions in a separate folder for discharges occurring prior to 1 January 04.

217. Update and maintain inpatient records folders and contents

Inpatient records consist of the original medical forms generated while a patient is admitted to an MTF. At a minimum, each form must contain the following:

- Patient's name.
- Register number.
- Family member prefix (FMP).
- Sponsor's social security number.
- Name of treating facility (and the name of facility maintaining the outpatient record if different).

Electronically-generated forms (when used in place of SF, DD, or AF Forms) must be a mirror image of the non-automated form and contain the statement: "SF, DD, or AF Form XXXX (EF) [names and producer/vendor (if any) of the software used]."

Optional Form (OF) 275, Medical Record Report, may be used in place of standard forms, Air Force forms, and DOD forms. When OF 275 is used, it must show the form number and title of the form being replaced. Information entered on the form must include all of the same information as the form it represents. The OF 275 is then filed in the same location as the form it replaces.

Record contents

Inpatient records consist of the medical forms and other information used to document a patient's case. Although there are many forms that could be filed in an inpatient record, let's look at the most common.

Cover sheet

The record of inpatient treatment (automated AF Form 565, Record of Inpatient Treatment), produced by the CHCS, is filed as the top form for each inpatient episode in the inpatient record. It provides a quick summary of diagnoses, procedures, and other administrative data.

Narrative summary

A concise clinical summary is dictated by a physician, dentist, or certified nurse midwife (CNM), and must be typed (not handwritten) on SF 502, Medical Record-Narrative Summary, for patients who:

1. Die after admission.
2. Are received by transfer for further treatment.
3. Remain in the hospital, as a bed occupant, for eight days or more.

The transcription of the SF 502 is completed within seven workdays after the patient is discharged. Forward the SF 502 as follows:

- File a copy in the patient's outpatient record.
- Send a copy to the attending health care provider of each referring MTF upon discharge.
- Ensure a copy is also sent to the outpatient records section of each referring MTF.

Final progress notes

Final progress notes on SF 509, Medical Record—Progress Report, may be substituted for narrative summaries for patients with minor problems requiring less than a 48-hour admission and for normal newborn infants or uncomplicated obstetrical deliveries. Include any instructions given to the patient or family in the final progress note and insert a copy in the patient's outpatient record.

Records on transfer patients

All inpatient records prepared for a patient, before transfer to your MTF, are to be maintained as a component part of, and attached to, the current inpatient record. Do not break up the transfer record and interfile its forms among the forms of the current inpatient record.

Arrangement of forms

As discussed earlier, while the patient is admitted to the unit the chart is maintained in a manner that best facilitates patient care. The forms should be arranged in the order specified in AFI 41–210. Figure 1–9 is a guide to help in the process. Don't let that long list scare you! There's no reason to memorize every form. But you should be familiar with the more common forms that inpatient records technicians' deal with on a daily basis such as the forms discussed above. If you work with inpatient records, you may want to make a copy of this figure and use it as a tool or "cheat sheet" to ensure you file all of the many, many forms in the proper order.

Contents & Arrangement of Inpatient Record			
Form No.	Form Title	Form No. Cont.	Form Title Continued
AF 565	Record of Inpatient Treatment	AF 1412	Occupational Therapy Treatment Record
AF 560	Authorization & Treatment Statement	AF 1535	Physical Therapy Consultation
SF 569	Patient's Absence Record	AF 1536	Physical Therapy Consultation Continuation Sheet Record
AF 618	Medical Board Report	SF 521	Medical Record-Dental
SF 502	Medical Record-Narrative Summary	SF 524	Medical Record-Radiation Therapy
SF 503	Medical Record-Autopsy Protocol	SF 525	Medical Record-Radiation Therapy Summary
DD 1322	Aircraft Accident Autopsy Report	SF 526	Medical Record-Interstitial/Intercavity Therapy
SF 504	Clinical Record History Parts I & II	SF 527	Medical Record-Group Muscle Strength Joint R.O.M., Girth & Length Measurements
SF 505	Clinical Record History Parts II & III	SF 528	Medical Record-Muscle Function by Nerve Distrbution: Face, Neck & Extremity
SF 506	Clinical Record-Physical Examination	SF 529	Medical Record-Muscle Function by Nerve Distrbution: Trunk & Lower Extremity
SF 539 or DD 2770	Medical Record-Abbreviated Medical Record	SF 530	Medical Record-Neurological Examination
SF 558	Medical Record-Emergency Care & Treatment	SF 531	Medical Record-Anatomical Figure
SF 507	Clinical Record Report On__or Continuation of SF Report__	AF 3066	Doctor's Orders
OF 275	Medical Record Report	AF 3069	Medication Examination Record
SF 535	Clinical Record-Newborn	AF 3068	PRN Medication Administration Record
SF 509	Medical Record Progress Note	AF 3067	Intravenous Record
DD 2161	Referral for Civilian Medical Care	AF 3241	Adult Admission Note
SF 515	Medical Record-Tissues Examination	AF 3242	Adult Patient Care Plan
SF 516	Clinical Record Operation Report	AF 3244	Pediatric Admission Note
OF 517	Medical Record-Anesthesia Recovery Room Record	AF 3245	Pediatric Patient Care Plan
AF 1864	Perioperative Nursing Record	AF 3247	Neonatal Admission Note
OF 522	Medical Record Request for Administration of Anesthesia and for Performance of Operations & Other Procedures	AF 3248	Neonatal Patient Care Plan
SF 533	Medical Record-Prenatal & Pregnancy	AF 3250	Obstetric Patient care Plan
AF 3915	Labor & Delivery Flowsheet	AF 3252	Mental Health Patient Care Plan
AF 1302	Request & Consent for Sterilization	AF 3254	Patient Care Plan
AF 1225	Informed Consent for Blood Transfusion	AF 3256	Patient/Family Teaching Flow Sheet
SF 523	Medical Record Authorization for Autopsy	AF 3257	ADL/Treatment Flow Sheet
OF 523B	Medical Record-Authorization for Tissue Donation	AF 3258	Generic Flow Sheet
SF 518	Medical Record-Blood or Blood Component	AF 3260	Discharge/Transport Summary
SF 519B	Medical Record-Radiological Consultation Request Report	SF 511	Medical Record-Vital Signs Record
OF 520	Medical Record-Electrocardiograph Record	SF 512	Medical Record Plotting Chart
SF 546	Chemistry I	SF 512A	Medical Record-Plotting Chart Blood Pressures
SF 541	Medical Record-Gynecologic Cytology	DD 792	Twenty-Four-Hour Patient Intake & Output Worksheet
SF 547	Chemistry II	AF 570	Notification of Patient's MedicalStatus
SF 548	Chemistry III (urine)	AF 1122	Personal Property Inventory
SF 549	Hematology	AF 1122A	Personal Property Inventory Continuation Sheet
SF 550	Urinalysis		Birth Certificate and Worksheet
SF 551	Serology		Death Certificate
SF 552	Parasitology	AF 438	Medical Care-Third Party Liability Notification
SF 553	Microbiology I		Other command & local administrative forms
SF 554	Microbiology II		Other release of information forms
SF 555	Spinal Fluid		Correspondence records received with transferred patients
SF 557	Miscellaneous (Note: laboratry reports may be automated)	DD 602	Patient Evacuation Tag
DD 741	Eye Consultation		

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Figure 1–9. Inpatient records tool.

Symbols and abbreviations

Do not use symbols or abbreviations when recording final diagnoses on the AF Form 560, Authorized and Treatment Statement, and avoid using them in other parts of the inpatient record. When you must use abbreviations, each abbreviation must have only one meaning and be a nationally recognized

standard abbreviation (or authorized for use in military records). The medical records review committee of each MTF monitors the use of abbreviations in both inpatient and outpatient records.

218. Maintaining inpatient record files

All inpatient services provided by the professional staff are adequately documented in the patient's inpatient record. The medical staff, through one of its authorized committees, reviews records to ensure sufficient information is documented to

- substantiate the diagnosis,
- justify the treatment, and
- warrant the end result.

Whichever forms are used, the record must include pertinent history, physical examination, laboratory reports, progress notes, doctor's orders, and work with the provider staff to ensure all required forms and reports are present, complete, signed, and filed in the order prescribed.

Safeguarding

Inpatient records, like outpatient records, are the property of the Department of Defense, not of the individual's concerned. They are maintained for the benefit of the patient and the Air Force. They should be safeguarded to protect the record itself and its contents against loss, defacement, tampering, or use by unauthorized individuals.

Loan of inpatient records

When transferring a patient to another military MTF, send a complete and legible copy of the current inpatient record, original outpatient records, and any copies of previous admissions that are pertinent to the patient's current condition. If complete and legible copies cannot be made in time for the patient's transfer, send the original and current inpatient record.

NOTE: The receiving MTF returns original records to the transferring MTF once they have served their purpose.

When transferring patients to nonmilitary medical treatment facilities, a transcript or copies of pertinent pages may accompany the patient. Keep in mind—you must never release the original record.

Quality control

Each MTF is responsible for establishing a medical record review function. This committee is responsible for reviewing records to ensure

- quality,
- clinical pertinence, and
- timely completion of records.

The medical records review function should also ensure records are prepared and kept according to Air Force directives and JCAHO standards. During the review, representative samples of every provider's records are examined to ensure compliance with standards.

Inpatient record library

Authority to set up or close down an inpatient record library is granted by the Air Force Medical Support Agency, (AFMSA/SGOI). MTFs request this authority through their major command (MAJCOM). The inpatient record library should be in an area of the MTF convenient to the medical staff. It should be supervised by a civilian rated eligible by the Office of Personnel Management, or an Air Force officer with equivalent record of education and experience.

There are several purposes of an inpatient record library:

1. Make records readily retrievable.
2. Provide resources for clinical reference and research.
3. Support specialty training and postgraduate programs.
4. Provide the essential tools and services for improvement of the quality of health records and reports.
5. Provide the means for accomplishing analysis and professional review of records and patient care.

Fetal monitor strip filing procedures

Fetal monitor strips are sent to the inpatient record section when the newborn infant is discharged from the MTF. The strips are maintained as a separate file. Fetal monitor strips are maintained in SSN order the same as the inpatient record. Place the sponsor's SSN at the top of each envelope to be clearly visible when records are filed in boxes for retirement. When an expecting mother is transferred to another MTF, all fetal monitor strips that have been prepared are sent with the inpatient records of the mother. However, if the mother delivers and the newborn infant is transferred during initial hospitalization, the fetal monitor strips are forwarded with the newborn. If the infant is stillborn, the fetal monitor strips are filed under the SSN of the sponsor (mother).

When it cannot be determined that prenatal care terminated in hospitalization or delivery, the outpatient fetal monitor strips are sent to the inpatient medical records section. These strips are filed by the sponsor's SSN and retired accordingly.

Disposition of inpatient records

When transferring patients to another MTF; send a complete and legible copy of the current inpatient record and pertinent copies of the patient's current condition.

Inpatient records of US military personnel, retirees, and nonmilitary personnel are eventually retired from the MTF files and sent to the NPRC. By retiring records, you avoid having an excessive number of records in file; yet, an accessible archive for inpatient records is available at the NPRC. Inpatient records, EAR records, and Fetal Monitoring Strips of all personnel are retired to NPRC in St. Louis, MO according to the year of patient disposition, with the cutoff being 31 December of each year. MTFs without established medical record libraries retire records two-years after the year of last discharge. MTFs with established medical record libraries retire records five years after the year of last discharge, unless a waiver has been granted by the National Archives and Records Administration.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

216. Reviewing and finalizing inpatient records

1. Where is documentation generated by a canceled admission filed?

2. Where are APV records filed?

217. Updating inpatient records folders and contents

1. What minimum patient identification information is required when filling out inpatient forms?

2. When is a narrative summary prepared?

3. When may a final progress note substitute for a narrative summary?

218. Maintaining inpatient record files

1. Who owns the inpatient records of a family member of a retired Air Force CMSgt?

2. Why are inpatient records safeguarded?

3. What are the responsibilities of an MTF's medical record review function committee?

4. Who grants the authority to set up or close down an inpatient record library?

5. What is the cutoff date for inpatient record retirement?

Answers to Self-Test Questions

201

1. Medical personnel must comply with the Privacy Act, Freedom of Information Act, Health Insurance Portability and Accountability Act (HIPAA), Drug Abuse Offense and Treatment act, and Comprehensive Alcohol Abuse amendments.
2. Privacy Act.
3. Use a DD Form 2005.
4. It serves as evidence that, as prescribed by the privacy act, the individual was informed of the purpose and uses of the information collected and was advised of his/her rights and obligations with respect to supplying the data.
5. The signature of the patient on the DD Form 2005 is not mandatory. The individual requesting the patient's signature should in no way coerce or even imply that the signature is necessary before treatment is given. If a patient refuses to sign, the requesting individual should note such a refusal on the DD Form 2005 and sign it.
6. The purpose of the act is to improve the portability and continuity of health insurance coverage, improve access to long term care services and coverage, and to simplify the administration of healthcare.

202

1. Ensure that their access to those records is authorized and necessary in the performance of their duties.
2. SJA.
3. Only the information requested.
4. Send the request to the activity to which the records were transferred and tell the requester of your action.

203

1. Only release the information to a physician named by the patient or to a person qualified to make psychiatric or mental determinations.
2. When proper identification is provided and written approval by SJA.
3. Tell the requester that the information must be held in confidence and that any published reports resulting from the study must not identify, in any way, those whose health records were examined.
4. When the situation warrants.
5. Coordinate an annual review of sequestered records with the base claims officer to determine whether the records should continue to be sequestered.

204

1. (1) f.
   (2) c.
   (3) e.
   (4) a.
2. Entering ? accesses a message that tells you how to get additional help.

205

1. Ampersand (&) Fileman Access code.
2. LAST NAME,FIRST NAME MI (No space between last and first name; one space between first name and MI; and no period after MI).
3. Add a new patient as his/her own sponsor, Add a new patient with an existing sponsor, Add a new patient with a new sponsor, Update an existing patient registration.
4. If a patient is being admitted to the hospital; however each MTF will have guidelines established to dictate when full registration is appropriate.
5. 120 hours.

206

1. To electronically track patient records, medical or dental, their location and availability to be charged out. The system is specifically designed to track the location of a record and its availability to be charged out.
2. Any five of the following are correct:
   (1) Loan control,
   (2) Record transfer and retirement,
   (3) Data and statistics necessary for record management,
   (4) Create records and print labels, both automatically and manually,
   (5) Generate pull lists,
   (6) Check-in and charge-out records,
   (7) Track individual record statuses, locations, and pending requests,
   (8) Flag records that are missing or are inactivated for various reasons,
   (9) Generate lists of those records eligible for transfer and/or retirement,
   (10) Generate the reports necessary to manage department activities,
   (11) Generate electronic messages to notify tracking system users of information concerning specific patient records.
3. Patient’s name, FMP, Sponsor’s SSN, Record type, Volume Number (used when a patient has more than one record volume), Record Number, Current Location, Home Location, and Status.
4. Recharge Records.
5. The record being returned, as well as the date and time of return.

207

1. Timeslots that have been assigned appropriate appointment types, durations and a maximum number of patients per slot.

2. Any four of the following:
   (1) Copy and/or transfer one schedule to another provider within the same clinic.
   (2) Open the schedules for immediate booking, or allow the system to open the schedule at a later date that you specify.
   (3) Reserve the schedule for automatic, interactive, or future Wait List processing.,
   (4) Freeze appointment slots from further booking.
   (6) Cancel slots with or without booked appointments.
   (5) Modify slots within a schedule by changing the appointment type or number of patients allowed per slot.
   (7) Add or delete slots to a schedule.
3. A profile.
4. A pattern of time slots that is specific to a provider but is not linked to any particular date. It is governed by the rules entered in the MTF's profiles. Using options in the Templates MENU, you can create a daily or weekly template.
5. A schedule.
6. A profile and a template.
7. (1) Open for booking.
   (2) Hold for future booking,,
   (3) Reserve for processing Wait List requests.
8. The Wait List Hold/Release Schedules option.
9. (1). **Interactive:** This action processes Wait List requests manually, notifying the patient either by telephone that an appointment is available, or by mail that an appointment has been booked,
   (2). **Automatic Wait List:** This action permits the system to process current Wait List requests for the clinic/provider, book the schedule time slot on the schedule, and automatically generate the notification mailer.
   (3). **Quit:** The Quit action is selected if the reserved Wait List slots are not to be processed at this time.

208

1. (1) e.
   (2) a.
   (3) b.
   (4) c.
   (5) d.

209

1. Lynn N. James.
2. 999–99–9972.
3. 20.
4. Block the number "2."
5. Block "S."
6. Enter "AD AF SrA" and block the box on the "military" line.
7. MTF address.

210

1. Patient's name, family member prefix, sponsor's SSN, facility name, and name of MTF maintaining the records.
2. Copy of the AF Form 1480 or DD Form 2766A.
3. AF Forms 1480/B or DD Forms 2766/C, 2796, 2569, HEAR PCM, result from HEAR, AF Forms 1480, 3922, 3922, and copies of inpatient forms.

4. AF Form 745 when applicable; AF Form 966, if used; patient signed informed consent, SF 600 interfiled with SF 558s; DD Form 2161 on top of the SF 600 to which it was ordered, AF Forms 1352, 1446, and SFs 88 and 93.
5. Diagnostic test reports such as lab forms, SFs 519B, OFs 520, other diagnostic test reports, and advanced directives (self-determined acts or living wills).
6. When the existing folder no longer protects the contents of the record.
7. The Air Force e-Publishing website at: http://www.e-publishing.af.mil

211

1. US Government.
2. Terminal digit filing system.
3. (a) 12.
   (b) 20.
   (c) 56.
   (d) 000.
   (e) 34.

212

1. DD Form 2138; DD Form 877; or other legal request.
2. Alphabetically; 6 months.

213

1. Active duty personnel records.
2. Annually.
3. At the end of each calendar year.
4. Records retirement index.
5. NPRC can return the shipment at MTF expense.

214

1. PCO team.
2. PCM.

215

1. A tracer (a locally developed form) and a DD Form 2138.
2. The dependent over the age of 18.
3. A memorandum from their squadron stating that discharge/separation is pending and their records are needed for the discharge review board to review.

216

1. Annotate the admission worksheet with the reason for cancellation and place a copy in the outpatient record. File all other paperwork generated by the admission in the inpatient record's folder.
2. File original documentation on a patient seen during an APV episode in the EAR folder.

217

1. Patient's name, register number, FMP, sponsor's social security number, and name of treating MTF.
2. For patients who die after admission; who are received by transfer for further treatment; and who remained in the hospital as a bed occupant for 8 days or more.
3. For patients with minor problems requiring less than a 48-hour stay, normal newborn infants or uncomplicated obstetrical deliveries.

218

1. Department of Defense.
2. To protect against loss, defacement, tampering, or use by unauthorized individuals.

3. For reviewing records to ensure quality, clinical pertinence and the timely completion of records and compliance with AF directives and JCAHO standards.
4. Air Force Medical Support Agency (AFMSA/SGOI).
5. 31 December of each year.

Complete the unit review exercises before going to the next unit.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter. When you have completed all unit review exercises, transfer your answers to the Field-Scoring Answer Sheet.

Do not return your answer sheet to the Air Force Career Development Academy (AFCDA).

1. (201) Medical personnel must comply with the Privacy Act, Freedom of Information Act, Health Insurance Portablility and Accountability Act, Drug Abuse Offense and Treatment Act, and
   a. Insurance Claims Amendments.
   b. Disability of Americans Amendments.
   c. Comprehensive Alcohol Abuse Amendments.
   d. Medical Release of Information Amendments.

2. (201) Which laws take precedence over other directives pertaining to access and release of medical information?
   a. Drug and alcohol.
   b. Adoptions and abortions.
   c. Sexual assault and abuse.
   d. Child molestation and endangerment.

3. (202) Which of the following is a valid consent authorizing the release of a dependent husband's medical record information to an insurance company?
   a. No consent necessary for member's own insurance company.
   b. Verbal consent from the husband.
   c. Written consent from husband.
   d. Verbal consent from wife.

4. (203) If a physician determines that a direct disclosure of medical information to the patient could have an adverse effect on the physical or mental health or safety and welfare of the individual,
   a. only release the information to the staff judge advocate (SJA).
   b. release a copy of the record to the next of kin (NOK).
   c. send the record to the military treatment facility (MTF) commander or his designee
   d. only release the information to a physician named by the patient or to a person qualified to make psychiatric or mental determinations.

5. (203) An individual's medical record information is *not* released to medical research or scientific organizations when
   a. the information concerns patients treated in a medical treatment facility (MTF) within the past five-years.
   b. reproducing the information would be a burden or it is contrary to existing laws.
   c. the patient does not want his or her records released.
   d. the request concerns active duty members.

6. (204) The Composite Health Care System (CHCS) allows military treatment facility (MTF) personnel to track patient care and
   a. ICDM–9 (automated coding).
   b. related administrative activities.
   c. AF Forms 542, Subsistence Stock Records.
   d. War Reserve Material (WRM) requirements.

7. (204) What two purposes does the user record serve?
   a. Allows access to the system and lets the system know who you are.
   b. Lets the system know who you are and how you can use the system.
   c. Allows you access to the system and establishes how you can use the system.
   d. Establishes how you can use the system and ensures your actions are noted by the system audit mechanism.

8. (204) Which of the following is *not* an input used for accessing help in the Composite Health Care System (CHCS)?
   a. ???.
   b. OLUM.
   c. ??OLUM.
   d. ?OPTION.

9. (205) To avoid confusion and duplication, what action should be taken prior to registering a new patient in the Composite Health Care System?
   a. Accomplish a “Patient lookup”.
   b. Access On Line User’s Manual by entering ??OLUM.
   c. Create medical record using post registration options.
   d. Compare patient documentation with a Defense Enrollment Eligibility System (DEERS) RIP from military personnel flight (MPF).

10. (205) What mini-registration task requires the user to possess a *Fileman* access code?
    a. Registering a spouse whose sponsor has already been registered.
    b. Making a system inquiry concerning upcoming appointments.
    c. Updating a home address for an active duty member.
    d. Running (printing) a pull list.

11. (205) Which example shows the correct way to enter a patient’s name during Composite Health Care System (CHCS) Registration?
    a. Lastname(space)(comma)Firstname(space)Middle Initial(period).
    b. Lastname(comma)Firstname(space)Middle Initial(period).
    c. Lastname(comma)Firstname(space)Middle Initial.
    d. Lastname(space)First Initial.

12. (205) A perpetual link exists between the Composite Health Care System (CHCS) and the Defense Enrollment Eligibility Reporting System (DEERS) to accomplish what task?
    a. Verify the patient’s eligibility for care.
    b. Ensure the patient’s CHCS data is comparable to his or her DEERS data.
    c. Provide a tool for commander’s to keep abreast of unit’s manning strength.
    d. Provides interface for military personnel flight (MPF) to update active duty information.

13. (206) What information does the Composite Health Care System (CHCS) record when using the check-in record option?
    a. Clinic returning record.
    b. Provider who checked-out the record.
    c. Date and time of record being returned.
    d. Highlights records charged-out more than 72-hours.

14. (207) Which Composite Health Care System (CHCS) component is a pattern of timeslots that is specific to a provider but is not linked to any particular date?
    a. Capacity appointment slots.
    b. Template.
    c. Schedule.
    d. Profile.

15. (207) What is the proper sequence for setting up a provider's schedule in the Composite Health Care System (CHCS)?
    a. Profile first, template second, and schedule last.
    b. Template first, profile second, and schedule last.
    c. Schedule first, template second, and profile last.
    d. Schedule first, profile second, and template last.

16. (208) What Composite Health Care System (CHCS) option makes it simple for the user to add, delete, and cancel schedule timeslots for specific days within any provider's schedule?
    a. Maintain/Cancel Schedule.
    b. Cancellation by Facility.
    c. Freeze/Release Schedule.
    d. Modify/Add/Delete Schedule.

17. (208) The schedule hold duration parameter (located in the clinic profile) defines how much time will elapse before
    a. the system automatically freezes slots.
    b. the system automatically releases frozen slots.
    c. the appointment technician can manually freeze slots.
    d. the appointment technician can manually release frozen slots.

18. (209) Where is the medical records tracking (MRT) label placed on the AF Form 2100 or 2100A?
    a. Back cover, in the status box in the center of the record jacket.
    b. Front cover, in the patient identification block.
    c. Back cover, in the lower right hand corner.
    d. Front cover, in the lower left hand corner.

19. (209) If a sponsor with two children (ages 5 and 8) marries an individual with one child (age 10), the step child's family member prefix (FMP) will be
    a. 01.
    b. 03.
    c. 60.
    d. 90.

20. (209) If a divorced sponsor remarries, the new spouse's family member prefix (FMP) will be
    a. 20.
    b. 21.
    c. 30.
    d. 31.

21. (209) Which number is blocked on the right hand side of the AF Form 2100A series health record for a sponsor whose social security number is 987–65–4321?
    a. 4.
    b. 3.
    c. 2.
    d. 1.

22. (209) Where is allergy information displayed on a patient's health record?
    a. Below the "Food Handler" line on the bottom left hand corner of the record jacket.
    b. Above the patient's name, in the patient identification block.
    c. Anywhere on the front cover of the record jacket in red ink.
    d. Under the patient identification block of the record jacket.

23. (210) What should outpatient records personnel do with medical paperwork missing the required minimum identification documentation?
    a. Place the documentation in the research file.
    b. Annotate the correct identification to save time.
    c. Return documents to the originating clinic for proper completion.
    d. Annotate identification and then call clinic personnel to brief proper requirements.

24. (210) Copies of inpatient care documents are filed in what section of the AF Form 2100A, Health Record–Outpatient?
    a. Section 1.
    b. Section 2.
    c. Section 3.
    d. Section 4.

25. (210) In which section of the AF Form 2100A, Health Record–Outpatient, is the DD Form 2005, Privacy Act Statement filed?
    a. Section 1.
    b. Section 2.
    c. Section 3.
    d. Section 4.

26. (210) Which section of AF Form 2100A, Health Record–Outpatient, are living wills (Self-Determination Act forms) filed?
    a. Section 1.
    b. Section 2.
    c. Section 3.
    d. Section 4.

27. (210) Where is the withdrawal of material from an outpatient medical record to an inpatient record recorded?
    a. No notation is required, as long as it is returned to the outpatient record.
    b. On SF 600, Health Record—Chronological Record of Medical Care.
    c. On AF Form 1480, Summary of Care, in the outpatient record.
    d. In the inpatient record.

28. (211) Outpatient records are the property of the
    a. United States Government.
    b. medical treatment facility.
    c. records custodian.
    d. patient.

29. (211) Which statement *best* describes the outpatient records filing system?
    a. Tertiary number, color-coded and blocked filing system.
    b. Terminal digit, color-coded and blocked filing system.
    c. Tertiary number filing system.
    d. Terminal digit filing.

30. (211) A properly developed and maintained terminal digit (color-coded and blocked) filing system makes it easier to
    a. group records according to primary borrower.
    b. file the forms in an outpatient record.
    c. identify a misfiled record.
    d. distribute the workload.

31. (212) If a record must be transferred from one clinic to another, whose responsibility is it to change the location of the record on the AF Form 250, Health Record Charge Out Request?
    a. The clinic that originally transferred the record.
    b. The clinic receiving the transferred record.
    c. Outpatient records personnel.
    d. The patient.

32. (213) How often are active duty records inventoried?
    a. Never, if the facility has CHCS.
    b. At least semiannually.
    c. Whenever necessary.
    d. At least once a year.

33. (213) When are outpatient records for nonmilitary, dependents, and retired military members retired?
    a. End of each calendar year.
    b. End of each fiscal year.
    c. Semiannually.
    d. Quarterly.

34. (213) What reference provides step-by-step instructions for completing records retirement?
    a. Military Record Tracking, Retirement, and Retrieval Users Guide (MRTR2).
    b. AFI 37–138, *Records Disposition Policies and Procedures*.
    c. AFMAN 37–139, *Records Disposition Schedule*.
    d. Records retirement list.

35. (214) What type of team are active duty members and their beneficiaries assigned to after the mass medical in-processing briefing?
    a. TRICARE team.
    b. Alternative care team.
    c. Health care optimization team.
    d. Primary care optimization team.

36. (214) When you in-process a medical record and then generate a computer charge-out, to whom do you deliver the records?
    a. Acute care manager.
    b. Health care manager.
    c. Primary care manager.
    d. Family practice manager.

37. (215) If for some reason the sponsor’s medical record is not present at the time of out-processing, give the individual a
    a. letter of non-availability.
    b. letter of justification.
    c. letter of reason.
    d. waiver letter.

38. (215) When an active duty sponsor is retiring and they have a dependent over the age of 18, who must fill out the DD Form 2138, Request for Transfer of Outpatient Record, for the dependent?
    a. The sponsor.
    b. The dependent.
    c. The gaining unit.
    d. The primary care manager.

39. (216) For which of the following would you *not* create an inpatient record?
    a. Active duty personnel admitted to a non-Federal hospital.
    b. Patients admitted and dispositioned on the same day.
    c. Patients admitted to a tactical medical facility.
    d. Stillbirths.

40. (216) The AF Form 788 (series), Inpatient Record, is filed using which filing system?
    a. Terminal digit (by patient's inpatient register number).
    b. Terminal digit (by sponsor's social security number).
    c. Numerically, by inpatient unit.
    d. Alphabetically, by inpatient unit.

41. (216) Who prepares AF form 788 (series) folders for filing inpatient documentation?
    a. Unit inpatient records technician.
    b. Inpatient records section technician.
    c. Admission and disposition technician.
    d. Military personnel flight (MPF) personnel during basic military training.

42. (217) A concise clinical summary is dictated and typed on SF 502, Medical Record—Narrative Summary, for
    a. all inpatients unless treated by a tactical medical treatment facility.
    b. patients remaining in the hospital as bed occupants for 48 hours or less.
    c. inpatients received by transfer for further treatment.
    d. cases involving communicable diseases.

43. (217) Final progress notes on SF 509 may be substituted for narrative summaries for all of the following patients *except*
    a. patients with minor problems requiring less than a 48-hour stay.
    b. uncomplicated obstetrical deliveries.
    c. patients treated at a tactical military treatment facility (MTF).
    d. normal newborn infants.

44. (218) How are fetal monitor strips filed?
    a. In SSN terminal digit order interfiled with outpatient medical records.
    b. In SSN terminal digit order the same as inpatient records.
    c. In SSN terminal digit order interfiled with inpatient records.
    d. In alphabetical order.

45. (218) An inpatient record of an Air Force Staff Sergeant admitted on 28 Dec 98 and dispositioned on 4 Jan 99 (no other inpatient episodes) at a facility with an inpatient records library is
    a. eligible for retirement 31 Dec 2001.
    b. eligible for retirement 31 Dec 2003.
    c. eligible for retirement 31 Dec 2004.
    d. never retired as long as the patient remains on active duty.

Please read the unit menu for unit 2 and continue ➔

Student Notes

Unit 2. Outpatient Administration

2–1. Eligibility for Outpatient Care and Special Needs Programs 2–1
219. Evidence of beneficiary status 2–1
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222. Special needs identification and assignment coordination 2–10
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THE DUTIES DISCUSSED in this unit are not performed by many Health Service Management (HSM) personnel when compared to outpatient records, primary care optimization (PCO) or other 4A0 functions. Yet, their importance to the success of the Air Force mission is extremely important. For instance, it is important for you and your staff to know how and why we verify eligibility for medical care. The Secretary of the Air Force (SAF) designee program allows personnel otherwise not eligible to receive medical care to receive certain types of care in your military treatment facility (MTF). In these financially difficult times, it is imperative that MTF commanders make the right decisions. And you, as the SAF designee program manager will be in the position to ensure your commander is on track. As a family member relocation clearance (FMRC) coordinator working with the special needs identification and assignment coordination (SNIAC) program, you will be in the position to help ensure only qualified personnel and their families are allowed to embark on a permanent change of station (PCS). Nothing is more important than ensuring dependents of active duty personnel attempting to move overseas have the appropriate medical and educational needs at their new location. As the HSM in charge of your MTF's line of duty (LOD) program, you play a pivotal role in deciding the fate of many Air Force personnel. Mismanaging the Sensitive Duties Program (personnel reliability program [PRP]) can have a catastrophic effect on your MTF. A PRP failure during a nuclear surety inspection can cause the entire wing to receive an unsatisfactory rating! Many members will depend on you to research their medical evaluation board (MEB) issues or possible disabilities. How their package is put together and submitted to an MEB is critical to all parties involved. And finally, you will come to understand what referral management is and how it benefits your facility.

2–1. Eligibility for Outpatient Care and Special Needs Programs

The local military personnel flight (MPF) establishes an individual's eligibility for medical care. Medical service personnel then confirm the patient's identity and verify entitlements. It will be your responsibility as a HSM craftsman to know and understand every aspect of this part of the job, from training your personnel to conducting record audits. You must know and understand your workers, and you must be able to react to any situation that may arise.

219. Evidence of beneficiary status

Patients requesting care at a MTF must present satisfactory evidence of their beneficiary status, even when they are in uniform. The two best pieces of evidence you can check to ensure beneficiary status are (1) a valid identification (ID) card, and (2) enrollment in the Defense Enrollment Eligibility Reporting System (DEERS). Routine care is usually not provided to patients with questionable

eligibility until eligibility has been determined. However, in emergency situations, care is always provided first, and eligibility determined later.

ID cards

The first step in verifying a patient's eligibility is to check the ID card. MTF personnel must ensure each patient shows a valid ID card before receiving routine care, ancillary care, or administrative services. It is your responsibility as a manager to ensure each person in the MTF knows and understands why and when eligibility should be verified.

There are various types of uniformed services ID cards. The following cards are the ones you'll see most often:

- DD Form 2ACT, Armed Forces of the United States Geneva Convention Identification Card (Active). These cards are green and identify active duty members.
- DD Form 2RES, Armed Forces of the United States Geneva Convention Identification Card (Reserve). These cards are either red or green and identify USAF Reserve (USAFR) or Air National Guard (ANG) personnel.
- DD Form 2RET, United States Uniformed Services Identification Card (Retired). These cards are blue and identify retirees.
- DD Form 2RESRET, United States Uniformed Services Identification Card (Reserve Retired). These cards are either red or green and identify retired reserve and guard personnel.
- DD Form 1173, US Uniformed Services Identification and Privilege Card. These cards are tan and identify family members of active and retired personnel.
- DD Form 1173–1, Department of Defense Guard and Reserve Family Member Identification Card. These cards are red and identify family members of reserve and guard personnel.

You also may see the United States Public Health Service ID cards: PHS 1866–1 for active duty public health personnel and PHS 1866–2 for reserve public health personnel. Individuals possessing these cards are authorized users of DOD medical facilities.

Some separating personnel and their family members are eligible for medical benefits under the Transition Assistance Management Program (TAMP); they will have DD Form 1173. And, there are other beneficiaries who may have different organizational identification. If an organization doesn't issue ID cards, its members must show you proof of organizational affiliation and personal identification.

http://www.cac.mil/common-access-card/

DD Form 2765

DD Form 1173-1

DD Form 1173

Figure 2–1. ID cards

DEERS

The second step in verifying a person's eligibility status is to search the DEERS database. The categories of patients you should check in DEERS include active duty, retirees, family members of active duty and retirees, TAMP-eligible personnel, and survivors. (**NOTE:** Not all beneficiaries are enrolled in DEERS.)

If a child who is 10 years of age (or older) and without an ID card seeks medical care, perform a DEERS check. If the child is in DEERS and accompanied by the sponsor or parent who has a valid ID card, you don't have to require the sponsor or parent to return within 30 days with the child's ID card. However, you should inform the sponsor or parent that all children 10 years of age (or older) need ID cards to continue to receive authorized military medical services. Children under age 10 must be enrolled in DEERS, but they don't need their own ID card.

Failing a DEERS check

There are times when a patient may receive routine care in an MTF, even though they fail a DEERS eligibility check. If patients present an appropriate type of ID card and/or documents, care will be provided. The following list identifies circumstances when a patient is eligible to receive care after failing a DEERS check, and some of the types of evidence you can use to verify eligibility when patients are not registered in DEERS:

1. The patient presents an ID card that was received within the last 120 days.
2. The patient presents a DD Form 1172, Application for Uniformed Services Identification and Privilege Card, which the Air Force issued or re-verified within the last 120 days.

The DD Form 1172 must be dated and certified by a verifying authority from the MPF. This certification includes an original signature in ink with the rank, position, and phone number of the verifying official.

3. The patient's sponsor is a member of the Reserve or National Guard ordered to federal active duty (within the last 120 days) for more than 30 days and the patient has a copy of such orders.
4. The patient is less than 1 year old.
5. The patient is a child who is under 10 years old and the sponsor is a reservist or guardsman called to duty (within the last 120 days) for more than 30 days. The child may use a copy of the orders to verify eligibility.
6. The patient is a SAF designee. Use the designee letter to verify eligibility and benefits (discussed further in the next lesson).
7. The patient is a foreign military sponsor or family member.
8. The sponsor is on overseas assignment or afloat, or has an Army or Air Force Post Office (APO) or Fleet Post Office (FPO) address. The patient should present some documentation (e.g., temporary duty or permanent change-of-station orders) to indicate the sponsor's status.

Questionable eligibility

Routine care is normally denied when the verification process results in questionable eligibility. In these situations, a competent medical authority performs a risk assessment. If there is a possibility of risk to either the patient or the Air Force, the patient can be treated; however, he or she must first sign a statement agreeing to prove eligibility within 30 days. After the 30th day, if the patient has not proved eligibility, the information is forwarded to the medical resource management office for billing. This procedure applies to actual medical treatment, as well as to ancillary services such as filling prescriptions from non-Federal civilian providers.

MTF procedures

Each MTF must have written instructions on how to handle patients with questionable eligibility. These instructions or procedures should outline the process of verifying eligibility with a valid ID card and a DEERS check. Also, procedures should be established to verify the eligibility of all beneficiaries who have prescriptions from non-federal providers, and to allow adult family members or friends to pick up prescriptions from the pharmacy for an eligible beneficiary.

220. Quarters program

A quarter's patient is treated on an outpatient basis, and is to remain in their home during the quarters period. Quarters periods generally last 24–72 hours depending on the providers prescribed rest/recovery period. In the paragraphs below, we will look at who manages the program as well as quarters notifications.

Quarters management

Quarters is a full duty excuse provided to active duty uniformed service members receiving medical or dental treatment for a disease or injury that, based on sound professional judgment, does not require inpatient care. A quarter's patient is treated on an outpatient basis, and is to remain in their home during the quarters period. Quarters periods generally last 24–72 hours depending on the providers prescribed rest/recovery period.

NOTE: Physician assistants/nurse practitioners may not place a patient on quarters for longer than 48 hours without approval by a physician.

Unit commanders and supervisors have the authority to grant up to 24 hours sick status at their discretion if a member's illness/injury does not require MTF intervention. If the illness/injury persists

beyond 24 hours, then the commander or supervisor must refer the member to the MTF for treatment and subsequent clinical examination.

Obstetrical quarters

As a general rule, obstetrical (OB) quarters should be the primary method for managing OB patients with prenatal medical issues when continued duty must be temporarily limited or suspended. The use of OB quarters is designed for on-going medical issues that may require medical re-evaluation, not convalescence, which implies a period of recovery. For ongoing medical problems during pregnancy, providers are encouraged to use quarters and the profile system rather than recommending convalescent leave.

Quarters notification procedures

The provider or support staff will notify the member's unit commander or commander's designee regarding the patient's quarter's status. Command authority notification must be documented on a DD Form 689, Individual Sick Slip, or a locally created form. Disclose only the minimum information necessary and account for the disclosure in the PHIMT or MTF approved centralized disclosure accounting tool. Notwithstanding any other installation document creation and approval mechanism, the health records review committee must approve locally created clinical forms. Forward a copy of the quarters notification or sick slip to the member's unit commander or authorized representative to receive quarters information. Provide a second copy to the member so he/she may give it (quarters sick slip) to their supervisor. Develop local procedures for program management, including, but not limited to:

- Notifying public health for communicable disease tracking.
- Mechanism for extending quarters past the initial rest period.

Complete quarters notifications

After the healthcare provider completes the quarters notification form, the current manual notification process requires clinical or support personnel to call and/or fax a copy of the quarters notification form to the member's unit (usually the member's CSS) to make the quarters notification. Once received by the member's unit, the medical quarters data in manually entered into the AFPC Military Personnel Data System (MilPDS) to update the member's duty status. Another copy of the quarters notification form is provided to the member.

However, your facility may be using an automated process to make quarters notifications. As of this publication, this process is not mandatory however future policy decisions mandating its use are forthcoming. The automated quarters notification process improves timeliness, accuracy and the reliability of the notification by providing near real-time information to commanders, CSS and AFPC personnel. It also reduces man-hours spent on the manual notification process and makes it easier to track and analyze trends.

In the automated process, the medical staff inputs the quarters authorization into the automated system and the provider e-signs the form. Once the provider e-signs the form, the automated system automatically sends an email notification to the commander/designated unit monitor. The member can obtain a copy of his/her signed quarters notification form from the MyIMR page (accessed through the Air Force Portal). Medical staff can also print a copy and give it to the member.

221. SAF designee program

The SAF designee program allows for certain individuals, who would not otherwise be eligible for medical care, to receive care in an MTF. Patients who qualify under this program may be designated by the Secretary of Defense; Secretary of Commerce; Secretary of Transportation; Secretary of Health and Human Services; or the Secretary of the Army, Navy, and Air Force, for care in MTFs. Under Section 8013 of 10 United States Code, the SAF has delegated authority and oversight responsibility for this program to the Secretary of the Air Force Administrative Assistant (SAF/AA).

Program guidelines

Secretarial designees from all uniformed services except the Army may receive treatment in Air Force MTFs. These designees normally receive space-available care at the commander's discretion; however, a higher priority of care may be given to the extent appropriate to the context in which Secretarial designee status is given. The authorization for care includes supplemental care for diagnostic procedures, but does not entitle an individual to receive medical care in Army medical treatment facilities or civilian medical care using TRICARE standard. Each individual designated by the SAF/AA must have a signed letter from that office establishing eligibility for care. The letter will include the following:

- Effective date.
- Period covered.
- A determination as to whether the Air Force is providing transportation on aeromedical evacuation aircraft and the rate (charges) for care.
- Period of time the letter will remain in effect (maximum of two years).

Individuals may request renewal of designee status and reapply for designation if continued care is still necessary. Normally, individuals (a primary and alternate) will manage the SAF Designee Program in the MTF. For the purpose of this lesson, we'll call them the program managers.

Air Force secretarial designee criteria

Individuals seeking to apply for Air Force secretarial designee status must meet one or more of the following criteria:

Preadoptive wards

This category of designees includes individuals who are undergoing adoption and who are placed with a family for that purpose.

Military is only source of care

This category consists of people for whom the military is the only source of care, for example, hyperbaric medicine.

Teaching case

When a medical case presents a unique teaching opportunity for the MTF staff or residency programs, the patient may apply for designee status.

Best interest of the Air Force

This category of designee includes those for whom it is in the best interest of the Air Force to provide continued care.

Continuity of care

If continuity of care is a significant clinical issue in the individual's course of treatment and civilian medical care is not available or appropriate; individuals in this category may receive designee status.

Medical evaluations for foreign nationals

Foreign governments may request designee status for their military members in order to receive medical evaluations at the San Antonio Military Medical Center. The US Embassy in the member's country will assist in processing the designee request through the State Department.

In addition to the information required on all designee letters, a request for this type of designee must also contain nationality, service affiliation, age, aeronautical rating, type of aircraft flown and total number of flying hours, date for which the applicant is requesting service, where to report the results of the evaluation or test, and billing information.

Involuntary separation

If a sponsor is involuntarily separated for medical reasons under honorable conditions and the sponsor's wife is pregnant, the wife may request designee status.

Abused family members

If the sponsor was discharged or separated from service for dependent abuse, the abused individuals or those affected by the knowledge of the abuse, may request care for associated problems. By law, medical care ends one year after the sponsor's discharge. This provision applies to individuals whose sponsor the Air Force discharged/separated on or after 14 November 1986 (the date the law became effective). These designees may obtain care in MTFs and through TRICARE. When an individual meets the criteria of this paragraph, the MTF commander approves the request.

Former spouses

Former spouses are individuals who possess an ID card from one of the uniformed services, and have been certified (by a military personnel office) as meeting the following criteria: (1) they are not remarried and (2) they have no employer-sponsored health insurance. In addition, individuals must meet one of these three conditions:

1. Married 20 years to the same sponsor who had 20 years of creditable service for retired pay and the 20 years overlap (20/20/20).
2. Married 20 years to the same sponsor who had 20 years of creditable service for retired pay and at least 15 years overlap (20/20/15).
3. Period of overlap of marriage and the member's creditable service was at least 10 years and the former spouse is in receipt of an annuity as a result of the member being separated from the service due to misconduct involving dependent abuse and a divorce, dissolution, or annulment occurred on or after 23 October 1992.

Former spouses are eligible for medical care in military treatment facilities for 12 months. If eligible, they can obtain from the MPF an ID card that is valid for the initial 12 months.

Application procedures

Although there are exceptions, most applications for designee status will be submitted through the command surgeon office to HQ USAF/SGMA. The application should contain the following information:

- The patient's full name and relationship to sponsor.
- Sponsor's full name, rank, branch of service, SSN, and status (active duty, retired, deceased) and reason for discharge or separation.
- The exact date designee status should begin and recommendation for length of designation.
- Whether the patient requesting designee status might require transportation on aeromedical evacuation. If so, include patient's home address.
- Reason for designation: for example, age (specify date of birth), marriage, sponsor leaving the service.
- Justification for the request using the previously stated criteria. For cases when the justification is in the best interest of the government, include a letter addressing the effects of denying designee status (for example, litigation risk, cost, negative press coverage). Cases should be reviewed by the MTF law consultant or base SJA. For cases when the justification is continuity of care, the case must be medically supportable. Include a statement on the impact, if the Air Force were to deny the individual designee status. If submitting the case for teaching purposes, include an endorsement from the department chief and the director of education verifying the teaching significance. At MTFs without a director of education or

formal internship or residency program, the chief of hospital/clinic services provides verification that the case has a significant teaching value.

- Diagnosis. The application should include a diagnosis in laymen's terms. An example would be pregnancy.
- Case history. The application needs a brief one- or two-paragraph case history. For complex cases, attach a separate letter with additional details. Include a long-term prognosis, the patient's age when medical providers first diagnosed the problem, and when and where DOD-sponsored care began. Histories must be understandable to nonmedical personnel.
- Name of attending physician.
- Medical specialty. Application should specify the type of medical specialist (orthopedics, pediatrics, etc.) who would provide care for the patient.
- Name, rank, and duty phone (DSN and commercial) for the beneficiary services caseworker.

Disapproval authority for requests rests with MTF commander and the major command (MAJCOM) surgeon general for requests that do not meet the criteria in AFI 41–115, *Authorized Health Care and Health Care Benefits in the Military Health Services System (MHSS)*. The MTF commander signs the application and makes specific recommendation as to whether designee status is appropriate. Applications that the MTF commander or MAJCOM disapproves will not go to HQ USAF/SGMA. Submit requests only if the MTF commander determines there are facilities and professional capability to provide the care.

HQ USAF/SGMA returns application results to the requesting MTF commander or MAJCOM so that the individual can be notified. A copy of the letter is filed in the individual's outpatient records.

Preadoptive ward designee application procedures

MTF commanders have the authority to approve requests for this category of designees. These applicants are children undergoing adoption and living with a family who is planning to adopt. This category does not include foster children or court-appointed wards, unless the family with whom these children reside plan to adopt them. DOD civilians stationed overseas on official orders may apply for designee status for these children under the preadoptive wards program. When you are in-processing applications for preadoptive wards, follow these guidelines:

1. Apply to the beneficiary services office. Beneficiary services personnel obtain an endorsement from the base staff judge advocate. This endorsement is not an approval or disapproval, but a coordination that helps determine if the family has taken the appropriate steps consistent with laws of the state or country to adopt the child in question.
2. Use the date of placement in the home as the exact date that designee status should begin.
3. Use the expected final adoption date as the recommended length of designation.
4. Include a statement signed by the sponsor that no other civilian organization is obligated to furnish medical care for the child.

MTFs must add the preadoptive designees to the calendar year log of designated individuals (RCS: HAF-SGH(A) 9474, Secretary of the Air Force Designee Log). Send the log to the MAJCOM by 15 January for consideration and transmittal to HQ USAF/SGHA by 31 January of the following year. This report is designated emergency status code C3. Continue reporting during emergency conditions, delayed precedence. Submit data requirements as prescribed, but they may be delayed to allow the submission of higher precedence reports. Submit by nonelectronic means, if possible.

Charges for preadoptive wards of civilians are at full reimbursement rate. Charges for preadoptive wards of active duty or retired members are at the dependent rate.

Former Air Force females

In most MTFs, the majority of requests for SAF designee status are from former Air Force females that were discharged under other than honorable conditions and pregnant at the time of discharge. Care is authorized under limited approval authority granted by the SAF to the general court-martial convening authority. The convening authority grants the individual the privilege of applying to the MTF commander for obstetrical care. This limited approval authority is provided to help discharge authorities separate individuals from active duty who might be kept on active duty solely because of pregnancy and in the face of evidence that would otherwise result in separation. The MTF commander should provide supporting information to the convening authority to assist in deliberations.

The care is granted only as an exception, not as a general rule. The MTF commander considers whether medical continuity of care is an issue (i.e., the same facility providing prenatal care will also perform delivery) and the general health of the mother. Another consideration is whether the individual has alternate resources for providing the care (child's father, court order for payment of maternity care, major medical coverage, other government benefits program, other family members, etc.).

Care is limited to prenatal and delivery, as well as follow-up care not to exceed six weeks. Supplemental care is limited to diagnostic tests associated with maternity care when not available in the MTF and the Air Force maintains case management. Postpartum sterilization is authorized when performed during the obstetrical admission. In those cases, where complications arise and the patient requires definitive inpatient care after delivery, the care is provided. Care is terminated or the patient is transferred to an appropriate civilian MTF at the six-week point. If complications were the result of MTF intervention in the treatment of the patient, SAF designee status may be applied under the provisions of "Best Interest of the Air Force." The MTF commander is responsible for seeing that this extended care provision is not abused.

Care for the newborn is only authorized in conjunction with delivery to include a postpartum well-baby check and related immunizations. Aeromedical evacuation, and transfer to another MTF is not authorized.

Applying for designee status

The request for designee status must include a copy of the individual's discharge or separation papers. If approved, the individual is informed that any maternity care in a civilian medical facility is at her own expense. Further, if at any time during the management of her maternity care it becomes necessary to transfer to a civilian MTF because the care required is beyond the capability of the MTF, all costs, to include aeromedical evacuation, are at the individual's expense. Before providing care, the individual must acknowledge receipt and understanding of these provisions by signing a statement explaining these facts. A copy of the signed statement is filed in the individual's inpatient health record. The patient must be advised that she should apply for Secretarial Designee status for her newborn, otherwise the newborn becomes a pay patient at the full reimbursement rate.

Aeromedical evacuation of designees

The SAF has authorized aeromedical evacuation for these Secretary of Defense designees (family members are not included):

- The President and Vice President.
- Members of Congress.
- Members of the Cabinet, as well as deputy secretary and the assistant secretaries of defense.
- The Under Secretary of Defense for Policy.
- The Under Secretary of Defense for Research and Engineering.

- The secretaries, the under secretaries, the assistant secretaries, and the general counsels of the military departments.
- Article III federal judges. Article III federal judges have an identification card proving their association with one of the courts.

NOTE: Notify USAF/SGH immediately if you treat an Article III federal judge.

- Judges of the US Court of Military Appeals.
- Members who require alcohol rehabilitation treatment.

NOTE: Alcohol treatment often requires that members of the family support the active duty member receiving treatment at an authorized DOD MTF. These family members may receive transportation to the treatment facility via aeromedical evacuation aircraft at no costs. However, these individuals must cover the costs of their transportation from their homes to the pickup point that the Aeromedical Evacuation Control Center designates. The Aeromedical Evacuation Control Center makes all reasonable attempts to keep ground travel times and distances to a minimum. Only two individuals may receive transportation under this authority, and exceptions require approval from HQ AMC/SG or designated representative.

Charges for care under the SAF designee program

The SAF has authorized that the individuals receiving medical care and emergency dental care within the United States be charged as follows:

- Outpatient charges within the national capital region (Andrews and Bolling AFB). All charges are waived.
- Outpatient charges outside the national capital region. Members of Congress pay full reimbursement rate; all others pay interagency rate.
- Inpatient charges anywhere. Members of Congress pay full reimbursement rate; all others pay interagency rate.

222. Special needs identification and assignment coordination

Special needs identification is mandatory for active duty sponsors whose family members meet identification criteria established by the DOD. The FMRC process, a component of the SNIAC program, is critical for determining the availability of services for family members with special needs when relocating. The goal is to provide a consistent process for all customers, to clearly delineate responsibilities within each military treatment facility, and to support personnel actions.

Mission of SNIAC

The mission of the SNIAC program is to (1) identify active duty service members with family members who have special medical and/or educational needs, (2) help those families to obtain information on required services, and (3) ensure they have access to necessary services if reassigned. The process also assists the MPF in updating the assignment limitation “Code Q” that is assigned to the sponsor for the purpose of ensuring service availability upon PCS.

Importance of SNIAC

Why is it necessary to have a SNIAC program? Let me give you an example: Major Smith along with his wife and two children PCS to Kenya, Africa, where he will work as a defense attaché in the American Embassy. This was a chance of a lifetime for Maj Smith and he accepted the assignment and left for Africa on a moment’s notice. When he arrived, he soon encountered a few problems. First, he discovered the nearest MTF to adequately care for his wife’s chronic reactive airway disease was a six-hour, aeromedical evacuation flight to Landstuhl and Germany. Furthermore, one of his children requires special education classes not offered anywhere in the entire country! His dream assignment has turned into a nightmare! This *(fictional*) scenario causes three very serious actions:

1. Maj Smith's family **will** return to CONUS costing the Air Force thousands of dollars.
2. The situation placed the well being of Maj Smith's family in serious jeopardy.
3. Most important, the Air Force mission is needlessly hampered!

This scenario borders on outrageous and would probably never happen in today's Air Force. However, the example does paint a clear picture in your mind as to the importance of SNIAC.

SNIAC program components

There are two components to the SNIAC program; the special needs coordinator and the FMRC process. Let's take a look at each of these components.

Special needs coordinator

This is a medical officer appointed by the MTF commander. Opens special needs assignment coordination records and initiates Assignment Limitation "Code Q" after identifying that a special medical and/or educational need exists. The special needs coordinator provides oversight of the FMRC process. AF Form 1466, Request for Family Member's Medical and Education Clearance for travel, AF Form 1466D Dental Health Summary, and DD Form 2792, Addendum B, Special Education/Early Intervention Summary, are processed by the special needs coordinator and FMRC coordinator. In addition, the coordinator refers active duty service members to the MPF for information on the Exceptional Family Member Program (EFMP) assignment or deferment process IAW AFI 36–2110, attachment 7.

The FMRC process

This is a process used to coordinate and determine whether family member needs can be met at a projected location prior to the sponsor receiving PCS orders. Military members who have children and spouses with special needs cannot receive approval for government travel until their educational and medical service needs have been determined and addressed. All family member children who are eligible to attend DODDS must have an educational clearance as part of the FMRC process. Required educational services are coordinated with the Pacific and Europe Special Education Area Coordinators by the installation processing the facility determination inquiry. FMRC will be conducted IAW AFMOA/SGZF standards and guidance.

The process

To ensure program effectiveness, the following key features will exist as a part of each installation's SNIAC process:

1. MTF instruction, which details client-focused, process to accomplish the FMRC.
2. A memorandum of understanding (MOU) developed between SNIAC process and key civilian agencies, which specify interagency client-focused processes that ensure the safety of service members and their families, and enhances access to community resources.
3. SNIAC process records created for each family with special medical and/or educational needs. These records will be maintained IAW SNIAC process standards.
4. Electronic data submitted to AFMOA/SGZF using the Q-Base Manual and system.
5. The FMRC coordinator (4A, 4C, or 4N) is assigned by the MTF/CC and provides administrative functions along with forms and record management for the SNIAC process.
6. All family members of active duty Air Force sponsors with an OCONUS assignment requesting travel will be screened within 6 months of Permanent Change of Station (PCS) for special medical and educational needs. The appropriate AF Form 1466, Request for Family Member's Medical/Education Clearance for Travel, AF Form 1466D, Dental Health Summary, DD Form 2792, Exceptional Family Member Medical and Education Summary, and Addenda are used.

7. For CONUS travel, only those family members with special medical and educational needs must be screened for travel. The appropriate forms are used.
8. For sponsors on unaccompanied assignments, family member clearance screening is accomplished by the MTF in closest proximity to the family. When special needs exist, the FMRC voordinator at the MTF in closest proximity to the family assists with coordination of the AF Form 1466, 1466DO, and appropriate DD Form 2792 and Addenda for completion by the MTF or family members' physician, dentist, and/or school. Completed and signed AF and DD Forms and Addenda are forwarded to the sponsors' assigned MTF FMRC Coordinator. The sponsor's MTF FMRC coordinates with the gaining MTF to complete the AF Form 1466, Section VII.

FMRC Coordinator responsibilities

You may be appointed as the FMRC Coordinator for your MTF. The FMRC Coordinator plays an important role in the SNIAC process. They are responsible for the following:

1. Using the automated, on-line tool (Q-Base) to develop a chronological log of "Q-coded" sponsors and special needs family members.
2. Compiling the special needs assignment coordination record (SNACR), a secondary medical record.
3. Coordinating conjoint medical appointments for the sponsor, family members, Medical Review Officer, and Special Needs Coordinator.
4. Coordinating with the local school system or Department of Defense Dependent Schools (DODDS) representative at the gaining base for Individualized Education Plans (IEP) or Early Intervention Services representative for Individualized Family Service Plans.
5. Initiating, reviewing, completing, forwarding, and tracking Facility Determination Inquiries (FDI) package (AF 1466, AF Form 1466 DO, DD Form 2792 and appropriate addenda) for all family members with special needs whose sponsors are in the PCS cycle.
6. Coordinating with the MAJCOM behavioral health consultants on all disapproved FMRC submissions.
7. Processing delayed FMRC submissions.
8. Notifying the sponsor of FDI status and approval or disapproval.
9. Processing an FMRC submission received from a losing MTF.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

219. Evidence of beneficiary status

1. What are the two best checks you can perform to obtain evidence of a patients' eligibility for medical care in the MTF?

2. In which category of patients will each member possess a blue ID card? What is the name and form number of this card?

3. What color is the ID card for family members of active and retired members? What is the name and form number of this card?

4. DEERS checks should be performed on what categories of patients?

5. Which beneficiary category doesn't need an ID card, but must be enrolled in DEERS to receive medical care?

6. If a patient fails a DEERS check and wants to use a DD Form 1172 to verify eligibility, who certifies the DD Form 1172 to verify the patient is eligible to receive medical care at a military facility?

7. What is used to verify eligibility and benefits for a SAF designee?

8. Who performs a risks assessment when the eligibility for a patient to receive medical care at a military facility is questionable?

9. How long (days) after receiving medical care is the patient given to provide evidence of eligibility before they are billed?

10. In addition to written instructions outlining the process used to determine patient eligibility for medical care at an MTF, what other procedures should be established in the MTF verification procedures?

220. Quarters Program

1. What basis is a quarters patient treated on?

2. What purpose does the quarters authorization form serve?

221. SAF designee program

1. Personnel from which US uniformed service *cannot* receive care in an *Air Force* MTF under the SAF designee program?

2. What is the maximum amount of time an SAF designee letter can remain in effect?

3. How long are perspective designees under the abused family members criteria entitled to medical care?

4. When completing an application for SAF designee status, if the justification for designee status is *under the best interest of the government* criteria, what information should be addressed?

5. Who has disapproval authority for request for designee status?

6. When are applications for SAF designee status *not* forwarded to HQ USAF/SGMA?

7. Under the SAF designee program, what type of care is provided to former Air Force females that were discharged under other than honorable conditions and pregnant at the time of discharge?

8. What type of care is authorized for the newborns of former Air Force females under the SAF designee program?

222. SNIAC

1. What is the mission of the SNIAC program?

2. Name the two components of the SNIAC program.

3. What forms are processed by the special needs coordinator and FMRC coordinator?

4. Who must have an educational clearance as part of the FMRC process?

5. What part of the SNIAC program ensures the safety of service members and their families?

6. Who accomplishes family member clearance screenings for sponsors that are on unaccompanied assignments?

7. What automated on-line tool is used to develop a chronological log?

2–2. Performing Line of Duty Determination Functions

While assigned to a patient administrative area, you may one day find yourself in charge of the line of duty (LOD) program. When there is a possibility of misconduct on the part of a military member, an investigation is conducted as much to protect the member as to ensure that US Government benefits are awarded with justice. If the facts are assembled with care, they will include all of the information needed to judge claims arising immediately, or even years after, the incident. Keep in mind, the investigation is separate and distinct from any judicial process or disciplinary measures. Any adverse finding regarding LODs or a finding of misconduct is not used as punishment (we often use LOD in this section to mean LOD and misconduct determination, not just LOD). We begin this section by discussing the terms that you'll need to know continue our discussion of LOD and misconduct determinations. Then we explain why and by whom LOD and misconduct determinations are used, for whom the determinations are made, when they are required, and the prevalent situations for which determinations are made. The LOD program is very important to the Air Force, the member, and occasionally, his or her surviving family members. Your role as the LOD technician is a crucial piece of the puzzle.

223. LOD and misconduct determination terminology and fundamental elements

At first glance, the LOD program may appear complex and a little overwhelming. Once you master the basics, everything will become crystal clear! It is important that you are familiar with the terms associated with the LOD program. Knowledge of these terms will help you in the study of this section and, more importantly, in your job—if ever called upon to run the LOD program. Let's get started with the common terms associated with the LOD program.

Substances

The following is a list of terms related to the abuse or misuse of either legal or illegal substances:

Alcohol abuse

Alcohol abuse is the use of alcoholic beverages leading to a person's misconduct, or to impairment of duty performance, or physical and mental health. It is an excessive use of alcoholic beverages under any circumstances. Consideration should be given, but not limited to, the amount, type, and intoxicating effect of the alcoholic beverage used, the period of time over which it was used, and the physical condition of the user. It is the same as "intemperate use of alcohol."

Alcoholism

A psychological or physical dependence on alcohol.

Drugs

Substances identified as controlled substances by the Attorney General of the United States.

Habit forming drugs

The term "habit forming" refers to drugs that can lead to either physical or psychological dependence.

Drug abuse

Intentional use of drugs in any amount when usage has not been authorized by qualified medical authority for specific medical treatment or for other legitimate purposes. It is the same as "intemperate use of drugs".

LOD and misconduct determining variables (terms and descriptions)

A LOD is the process the Air Force uses to determine if an injury or illness happened while a member was in a duty status, absent from duty, or due to member's misconduct or willful neglect.

Absent without authority

A member is "absent without authority" (AWA) if he or she is voluntarily absent without leave (AWOL) for more than 24 hours, or was voluntarily absent from a scheduled duty or formation, a restriction, or an arrest. Scheduled duty or formation means a specified task to be done at a specified time and place for a specified purpose. It is not the same as regularly scheduled duty. A member is also "absent without authority" if he or she is absent from duty in civil confinement for more than 24 hours and the absence is not excused. The term "absent without authority" is the same as an "unauthorized absence."

Disease

A condition of an organ, part, structure, or system of the body in which there is an incorrect function resulting from the effect of heredity, infection, diet, or environment. It is the same as illness, sickness, or ailment.

Injury

Injury includes such conditions as fractures, wounds, strains, sprains, dislocations, concussions, and compressions. In addition, it includes conditions resulting from extremes of temperature or prolonged exposure. Acute poisonings (except those due to contaminated food) resulting from exposure to a toxic or poisonous substance, are also classified as injuries.

Intentional conduct

An act, by commission or omission, done on purpose.

Lost time

Time (if more than 24 hours) which must be made up (served) by an enlisted member who is unable to perform military duties because of intemperate use of drugs or alcohol, or because of disease or injury resulting from misconduct.

Mental responsibility

We presume that all members are mentally responsible for their acts, unless there is contrary evidence. This presumption usually means it's not necessary to pursue the issue of mental responsibility. However, when there is credible evidence of lack of mental responsibility, the issue must be resolved. The evidence may consist of the circumstances surrounding a diagnosed disease, injury, death, previous abnormal or irrational behavior, expert opinion, or other evidence directly or indirectly pointing toward lack of mental responsibility. Members may not be held responsible for their misconduct and its foreseeable consequence if, as a result of mental disease or defect, they lack substantial capacity either to appreciate the wrongfulness of their conduct or to conform their conduct to the requirements of law. The term "mental disease or defect" does not include an abnormality manifested only by repeated or otherwise antisocial behavior. Members whose mental faculties are impaired as a result of their own prior misconduct, such as by taking a hallucinogen, other illegal (controlled substance), or deliberately ingesting any harmful/dangerous substances, are mentally responsible.

Proximate cause

The cause that, in a natural and continuous sequence, unbroken by an independent and unforeseeable new cause, results in the disease, injury, or death and without which the disease, injury, or death would not have occurred. Proximate cause may also be described as the primary moving cause or predominating cause. It is the connecting relationship between the intentional misconduct, or willful negligence of the member, and the disease, injury, or death that results as a natural, direct, and

immediate consequence that supports a "not in line of duty," due to own misconduct determination. As a general rule, to warrant a finding that an act of misconduct was the proximate cause of disease, injury, or death, it must appear that, in light of all attending circumstances, it could reasonably have been anticipated by the member that disease, injury, or death might result from misconduct.

Preponderance of the evidence

Preponderance of the evidence can be defined as the greater weight of credible evidence. Evidence that, when fairly considered produces the stronger impression and is more convincing as to its truth when weighed against the opposing evidence.

Under the influence of alcohol or drugs

Any intoxication caused by alcohol or drugs that is sufficient to impair sensibly the rational and full exercise of the mental or physical faculties.

Willful neglect

An act (or acts) of omission or commission that evidences a reckless or wanton disregard for its attendant consequences. It is conduct indicating a member exhibited a reckless or wanton disregard for his or her own personal well being or for the well being of another. It's the same as gross negligence.

LOD and misconduct determinations

Misconduct is basically in one word WRONG! We will discuss in this section the different types of neglect and their severity.

In line of duty

This determination is made unless a preponderance of the evidence supports the finding that the member's disease, injury, or death was incurred while the member was absent without authority or was proximately caused by the member's own misconduct. Here are some examples:

- A member becomes a hostile casualty.
- A member is injured or dies, leaving surviving family members, while present for duty. The injury was not proximately caused by the member's own misconduct.
- A USAFR or ANG member is injured while performing inactive duty training or while traveling to or from inactive duty training. The injury was not proximately caused by the member's own misconduct.

Misconduct

Misconduct is defined as intentional conduct that is wrongful or improper. Also, willful neglect.

Not in line of duty, due to own misconduct

This determination is made when a preponderance of the evidence supports the finding that the member's disease, injury, or death was proximately caused by the member's own misconduct, regardless of whether the member was absent without authority.

- A member is injured or dies leaving surviving family members while present for duty. The injury or death was proximately caused by the member's own misconduct.
- A member is injured or dies leaving surviving family members while AWOL. The injury or death was proximately caused by the member's own misconduct.
- A USAFR or ANG member is injured while performing inactive duty training. The injury was proximately caused by the member's own misconduct.

Not in line of duty, not due to own misconduct

This determination is made when a preponderance of the evidence supports the finding that the member's disease, injury, or death was incurred when absent without authority, and the disease, injury, or death was not proximately caused by the member's own misconduct.

This determination is also made in the following special cases even if the member was not "absent without authority" at the time:

- A regular Air Force member, USAFR or ANG member was injured or contracted a disease while traveling to or from active duty and had materially deviated from the "authorized" travel route.
- A USAFR or an ANG member was injured or aggravated an injury while traveling either to or from inactive duty training, or to or from a period of active duty for 30 days or less, and had deviated from the "authorized" travel route.

If the known facts raise a question whether the member materially deviated from the authorized travel route, an LOD and misconduct determination must be made. Here are some examples of not in line of duty, not due to own misconduct:

- A member is injured or dies leaving surviving family members while AWOL. The injury or death was not proximately caused by the member's own misconduct.
- A USAFR or ANG member incurs an injury while returning home after performing inactive duty training. The accident occurred at a time and place constituting a material deviation from the member's authorized travel route. The injury was not proximately caused by the member's own misconduct.
- A member is AWA or AWOL at the time of being captured or taken hostage by a hostile group and, thereafter, is injured, becomes ill, or dies, leaving surviving family members, while being detained in a captive status. The injury, disease, or death was not proximately caused by the member's own misconduct.

Existed prior to service

This phrase is added to a medical diagnosis where there is clear evidence that a disease or injury, or the underlying condition causing it, existed before the member's entry into military service or between periods of service, and was not aggravated by service.

Existed prior to service (EPTS) diseases include chronic diseases, and diseases with an incubation period that rules out a finding that they started during inactive duty training, active duty training, or tours of active duty. Here are two examples of EPTS, LOD not applicable:

- After enlisting, a member suffers a recurrence of malaria that was contracted before enlisting and was not aggravated by military service.
- A USAFR or ANG member becomes ill during a 3-day tour of active duty for training. The illness is medically diagnosed as a disease that was contracted before the start of the 3-day tour of active duty for training at a time when the member was not serving on any tour of active duty, active duty for training, or inactive duty training. Also, it is determined that the disease was not aggravated by military service.

LOD program basics and fundamentals

You may be asking yourself "why do we perform LODs?" Federal laws require the Air Force to determine whether certain diseases, injuries, or even deaths are suffered by military members while in the line of duty status or are the result of the member's own misconduct. The following table identifies what agencies use LOD findings and for what purpose.

Agency	Purpose
Air Force	Eligibility for physical disability retirement or separation. Lost time required to be made good (paid back). Forfeiture of pay when absent from duty due to disease caused by intemperate (unrestrained) use of alcohol or habit forming drugs. Eligibility of certain members of the USAFR and of the ANG for medical care and for pay and allowances. Eligibility for surviving family members of a deceased active duty person, to continue living in military family housing for up to 90 days after the member's death or continued payment of the deceased's quarters allowance for up to 90 days following death.
Department of Veterans Affairs	Determine eligibility for disability compensation and hospitalization benefits.
Office of Personnel Management	Determine eligibility for Civil Service preference.
Department of Labor	Eligibility of an Air Force Reserve Officer Training Corps (AFROTC) cadet for compensation for injuries sustained while training.

Persons for whom LOD and misconduct determinations are made

Members of the Air Force (regular or reserve) who incur or aggravate an injury, illness, or disease, or who die leaving family member beneficiaries while on active duty or traveling to or from such duty need an LOD determination. Also, an LOD determination is needed for:

1. Members of the USAFR and the ANG who incur or aggravate an injury, illness, or disease while:
   a. Performing active duty for training for any period of time, or while on inactive duty training.
   b. Traveling to or from the place the member performs active duty or active duty for training for more than 30 days.
   c. Traveling directly to or from the place the member will perform, or has performed active duty or inactive duty training for more than 30 days.
   d. Die on active duty while serving under conditions that make them eligible to receive basic housing allowance (BAH) or an overseas housing allowance (OHA), and who leave surviving family members qualifying for benefits.
2. AFROTC cadets injured while flying or while in flight instruction, or injured while traveling to or from, or attending, field training. AFROTC cadets who acquire a disease or illness that is the proximate result of the performance of the training specified earlier are considered to have been injured during the period.
3. Cadets of the United States Air Force Academy (USAFA).
4. Military members of the other United States Armed Forces attached or assigned to an Air Force unit. This includes those treated at an Air Force medical facility.

NOTE: If there is a question about the circumstances of a given case (such as determining when a disease or illness was contracted, or aggravated as an incident of inactive duty training, or whether the injury occurred while a member on inactive duty for training was traveling directly to or directly from the member's duty location), an LOD and misconduct determination should be made. This may happen when determining whether a disease or illness was contracted or aggravated as an incident of inactive duty training.

When determinations are made

An LOD and misconduct determination is needed when a member, whether hospitalized or not, has a disease or injury that results in

- the inability to do military duties for more than 24 hours;
- the likelihood of a permanent disability;
- death when there are surviving family members; and
- medical treatment for reserve members regardless of the ability to perform military duties.

Determinations for various situations

Disease, injury, or death suffered by military members requires the health care provider to complete a line of duty and misconduct determination. Let's review some of the more prevalent situations.

Fights

Aggression or voluntary participation in a fight or similar encounter, where a member is at least equally at fault with the adversary in starting or continuing the fight, is evidence of misconduct. Additional evidence of misconduct includes provocative actions or language taken or uttered under circumstances where a reasonable person would anticipate retaliation. There is no misconduct if a member is a victim of an unprovoked assault or acts in self-defense. Misconduct may not always be the proximate cause of injury or death caused by excessive means—for example, where a fight is underway and an adversary uses an excessive means that, under the circumstances, could not reasonably be foreseen. However, there can be a causal connection between the misconduct and the injury or death where a member persists in a fight or other encounter knowing that an adversary has produced a dangerous weapon. Each case is determined on its own facts.

Alcohol abuse

A member may accrue lost time because of the inability to do military duties for more than 24 hours as a result of intemperate use of alcohol whether or not there is a resulting disease or injury. Alcohol abuse is not a disease or an injury for the purpose of requiring an LOD determination.

Make an LOD determination when, as a result of diseases secondary to alcohol abuse, the member is unable to do his or her duty for more than 24 hours or there is the likelihood of a permanent disability. These diseases may be organic and chronic or they may be acute and transient. Generally, do not determine misconduct in cases involving a disease that is secondary to alcohol abuse and which is organic and chronic; however, consider misconduct in cases involving a secondary disease that is acute and transient and which is directly caused by and immediately follows alcohol abuse.

The ultimate determination is whether the member's misconduct is the proximate cause of the disease, injury, or death.

Drug abuse

A member may accrue lost time because of inability to do military duty for more than 24 hours as a result of drug abuse whether or not there is a resulting disease or injury. Drug abuse is not a disease or an injury for the purpose of requiring an LOD determination. Make an LOD determination only when a condition relating to drug abuse results in some identifiable disease or results in an injury or in the death of a member leaving surviving family members.

Drug abuse is evidence of misconduct. Disease, injury, or death proximately resulting from drug abuse may be considered the result of misconduct. This includes the debilitating effect the drug has on the body and the effect the drug has in impairing the member's mental or physical faculties affecting his or her actions. Do not excuse from resulting misconduct a member with a preexisting physical condition, which causes him or her to be more susceptible to the effects of the drug. You can determine misconduct through information from the limited privilege communication program,

identification through urinalysis, or incident to medical care for other than drug abuse. The ultimate determination is whether the member's misconduct is the proximate cause of the disease, injury, or death.

Explosives, firearms, and dangerous substances

Unexploded ammunition or other objects, firearms, and highly flammable liquids are inherently dangerous and their handling necessitates a high degree of care. Tampering with, attempting to ignite, or otherwise handling such objects in disregard of their dangerous qualities is strong evidence of misconduct.

Extended treatment for secondary conditions

In the process of treatment for a medical condition that would not require an LOD and misconduct determination, a member may also receive treatment or undergo observation for a different (secondary) condition which does cause an inability to perform military duty for more than 24 hours. The condition may itself be a disease or injury, or it may manifest itself as a mental condition or as incapacitation resulting from intemperate use of drugs or alcohol requiring a lost time determination. Make an LOD determination in these cases.

One example would be treatment for a superficial self-inflicted injury that is insufficient to require hospitalization for more than 24 hours. However, the member remains hospitalized in excess of 24 hours for observation of his or her mental condition. You do not need an LOD determination for the injury itself. The provider needs to decide if the reason for the extended hospitalization (for example, observation of the member's mental status) is due to the member's own misconduct (for example, drug abuse) or is it due to an EPTS condition.

Findings of in line of duty or EPTS are appropriate when the misconduct requiring initial hospitalization is unrelated to the condition requiring hospitalization in excess of 24 hours—for example, a member's mental state which naturally develops some time before a suicidal gesture. Make these findings by an administrative determination if possible.

Joint ventures; imputed misconduct

The Air Force can hold a member responsible for the misconduct of another if the member exercises control over, and is responsible for, the conduct of the principal actor, or if the circumstances demonstrate coordinated action sufficient to establish a joint enterprise. Mere presence of the member is not sufficient to establish a joint enterprise or to give a basis for holding the member responsible for the misconduct of another. There is no obligation to exert a positive or constructive influence over the conduct of the principal actor.

Motor vehicle accidents

The provider can find misconduct when a member who knows, or should reasonably know, of his or her unfitness of driving a motor vehicle and injury or death results. Voluntary intoxication, use of drugs, or other circumstances that affect the member's mental or physical faculties cause a member to be unfit. It is not necessarily misconduct when a member has a motor vehicle accident because he or she fell asleep while driving. The test for misconduct is whether a reasonable person, under the circumstances and conditions similar to those under which the member is driving, would or would not have undertaken to drive and whether, having elected to drive, the member's actions constitute intentional misconduct or willful neglect. It is also possible to find misconduct when a member, who is otherwise fit to drive, operates a motor vehicle in an intentionally wrongful or negligent manner.

Injury or death incurred while not wearing safety devices such as seat belts or safety helmets is one factor to consider. Standing alone, the violation of a safety standard or regulation constitutes only simple negligence. The violation must, under the circumstances, amount to gross, willful, or wanton carelessness to constitute misconduct. The failure to use safety devices may have nothing to do with the proximate cause of the injury or death. For example, the failure to wear a safety helmet may have

nothing to do with a motorcyclist who breaks a leg. In other cases, failure to use safety devices can aggravate the injuries, but will not be the proximate cause of the injuries or death. Do not focus solely upon whether or not the member was wearing seat belts or other protective devices at the time of the accident, instead, carefully examine the facts and circumstances of each case.

Participation in inherently hazardous off-duty activities

The provider determines the LOD status of members participating in inherently hazardous off-duty activities the same way you would determine any other case. The providers consider the nature of the activity, its inherent hazards, and the prior training and experience of the member.

Pregnant members

Do not perform an LOD determination for pregnancy or for any diagnosis associated with pregnancy. Make an LOD determination if the member is unable to do her duties for more than 24 hours; or there is the likelihood of a permanent disability, or in the case of death, or in cases involving an induced abortion in violation of the law of the location of the abortion.

Refusal of or failure to seek medical or dental treatment

When a member does not submit to medical, surgical, or dental treatment, which proximately causes disease, injury, or death, even though misconduct did not cause the original condition, consider misconduct, unreasonable refusing, or failing through willful neglect or by design.

Residual effects of surgery or treatment

Normal disability resulting from the surgery or treatment of a disease or injury incurred “not in line of duty” is likewise “not in line of duty.” However, you may find unanticipated residuals from the surgery or treatment, as incurred “in line of duty.”

Resisting arrest, escape from custody

Consider any injury or death suffered while resisting arrest or trying to escape from custody a result of the member’s own misconduct. The member can reasonably anticipate the use of necessary force, even excessive force, to restrain him or her. One who engages in such activities acts in disregard of personal safety.

Suicide attempts and suicide of members leaving surviving family members

A bona fide suicide attempt, in the absence of any intervening misconduct, raises a strong inference of lack of mental responsibility because of the instinct for self-preservation. A bona fide suicide attempt is sufficient evidence to rebut the presumption that the member was mentally responsible. In such cases, obtain evidence bearing on the suicide or suicide attempt including evidence on the person’s social background, his or her actions immediately before the suicide or suicide attempt, and any problems that might serve as motivation for the incident.

Intentionally self-inflicted injury or disease, not prompted by a bona fide suicide attempt, is at most a suicidal gesture. Such disease or injury may be the result of the member’s own misconduct, unless you can show a lack of mental responsibility. Where the suicide attempt or suicidal gesture occurred while the member was absent without authority, mental responsibility at the beginning of the absence without authority, must be determined in addition to mental responsibility at the time of the suicide attempt.

Venereal disease

Such diseases are not ordinarily considered to have been incurred as a result of the member’s misconduct, unless the member has failed to comply with regulations requiring him or her to report for and receive treatment.

224. Processing LOD and misconduct determinations

The overall LOD process does not rest on the shoulders of one individual. It is a team effort where many individuals and base agencies play a part. As you continue on with your reading, you will become familiar with the entire process and the roles of the various agencies and personnel involved.

Determining LOD status

Now that we have some idea of when we conduct LODs and on whom an LOD applies, let's look at the actual LOD process. We include the three types of LODs:

1. Administrative.
2. Informal.
3. Formal.

Administrative LOD

This type of determination is made by a medical officer, and should be made only in the following cases:

1. Hostile casualties.
2. Injuries, or death of members leaving surviving family members, incurred while a passenger in a common commercial carrier or a military aircraft.
3. Diseases, injuries, or death of members leaving surviving family members, not included in paragraphs 1 or 2, if:
   a) The disease or death is of natural origin that does not involve misconduct, drug or alcohol abuse.
   b) The injury is a simple injury (sprain, contusion, or minor fracture) not likely to result in a permanent disability.
   c) The disease, injury, or death did not happen while the member was AWA and was clearly not caused by the member's own misconduct.
   d) Diseases or injuries existed prior to service. The medical officer makes an entry in the member's medical records when a member dies leaving surviving family members or for USAFR members when required for medical care and pay purposes.

Presume all other cases to be "in line of duty" if an AF Form 348, Line of Duty Determination, is not initiated. You do not have to make an entry in the member's medical records.

Informal LOD

The member's immediate commander normally makes and records informal determinations on the AF Form 348 when:

- An administrative determination cannot be made; and the disease, injury, or death of member leaving surviving family members did not happen while the member was AWA or due to the member's own misconduct.
- Reserve members are unable to perform duties for more than 24 hours, when the member's tour of duty is expiring and there is a requirement for continued medical care, when the disease or injury is likely to result in partial or permanent disability, or if the disease or injury could result in a request for incapacitation benefits.

Formal LOD

The purpose of an LOD and misconduct investigation is to protect the interests of the member being investigated and to ensure government benefits are awarded justly and according to law. It is primarily a fact-finding process. The formal determination is required when neither an administrative

determination nor an informal determination can be made. Formal determinations are recorded on DD Form 261, Report of Investigation Line of Duty and Misconduct Status.

The report of investigation consists of a DD Form 261 as a cover sheet and forwarding document, an index of exhibits, a summary prepared by the investigating officer, and the documents collected by the investigating officer during the course of the investigation. Some of these latter documents can consist of a copy of the investigating officer's appointing documents; a copy of the AF Form 348; a sworn statement by the subject of the investigation or the certificate of the investigating officer describing his or her attempts to get a statement, and stating the reasons why it could not be obtained; statements of witnesses; and medical records relevant to determining the LOD and misconduct determination. All documents are sent by the investigation officer to the staff judge advocate (SJA) serving as the appointing authority for legal review.

The final decision must be supported by a preponderance of evidence (the greater weight of credible evidence) in the case file. All matters in the file that have rational probative value may be considered, whether or not that evidence may be inadmissible in a criminal or civil trial under the formal rules of evidence applicable to such a trial.

NOTE: Nothing in the discussion of administrative and informal determinations above, is intended to preclude a formal determination in any case where such action is deemed necessary to protect the interests of the member or of the United States.

Interim LOD for reserve members

The appointing authority, at the request of the member's commander may issue an interim LOD determination if an LOD determination cannot be finalized within seven days of notification and it is possible that the member may be entitled to incapacitation benefits. The interim LOD is valid for no more than 90 days.

An interim LOD is not made if there is clear and convincing evidence showing an EPTS condition or it appears that misconduct was the proximate cause of the incapacitation.

Record the interim LOD in a memorandum, containing a description of the injury, illness, or disease, the date it occurred, the type of military status the member was in at the time, and the current status of the final LOD determination, signed by the appointing authority, and data fax to HQ AFRES/DPPAS for a control number. Also send a copy to the servicing MPF/MSPPA or Reserve MPFO Quality Force Career Enhancement Section for processing.

Preparing AF Form 348

It is very important to know what entries are completed on AF Form 348 and who is authorized to sign the form. Refer to figures 2–2 and 2–3 as you study the following information on completing the form.

Items 1 through 14—MTF (front)

The medical officer will complete all items in three copies.

1. Enter the organization and location of the member's immediate commander in the *TO* block.
2. Enter the location of the MPF/MSPPA in the *THRU* block.
3. Enter the organization and location of the MTF preparing the form in the *FROM* block.
4. Items 1–4. These items are self-explanatory.
5. Item 5. If the member is regular Air Force, AFROTC cadet, or United States Air Force Academy (USAFA) cadet, check the appropriate block in item 5A. If the member is ANG, check the appropriate block in item 5B indicating who has strength accountability. If the member is USAFR, check the appropriate block in item 5C telling who has strength accountability. Then, if strength accountability is with the USAFR, check the appropriate

block in item 5D, stating whether or not the member is assigned to an active duty unit for training.

6. Item 6. Check the appropriate block and give details. If the cause of the injury resulted in the death of a member leaving surviving family members, none of the blocks should be checked. The word *death* should be written in item 6 along with a short description of the cause of death.
7. Item 7. Check the appropriate block to indicate whether the member was initially provided treatment at a military or civilian facility. Enter the name and location of the MTF first providing treatment.
8. Item 8. Enter the hour and date when treatment was provided.
9. Item 9. You may have to check one, two, or all three blocks depending on the circumstances of the case. If none of these blocks can be checked, no LOD and misconduct determination is required.
10. Items 10 and 11. The provider should complete information in items 10 and 11. If the member was first seen by a civilian physician or by a medical officer of another military service, get the necessary information from the civilian physician's records or from the records of the medical facility of the military service where treatment was first provided.
11. Item 12. Give as complete a description of the alleged circumstances as the available information permits. In the case of death of a member leaving surviving family members, the medical officer will provide the presumptive medical cause of death.
12. Item 13. It is not necessary to give names and address if the source of the information is the member or the police.
13. Item 14—Signature. The Air Force medical officer who provided the treatment or the hospital or facility commander must sign the form. At some remote locations, only a medical technician is in attendance at the Air Force unit. The technician may sign the medical officer's part of the form in such circumstances, but must note below his or her signature that no medical officer is assigned to the remote location.

Items 15 through 22—Action of approving authority (back)

The patient's immediate commander completes the reverse side of AF Form 348. Again, all items must be completed.

1. Enter the organization and location of the appointing authority in the *TO* block.
2. Enter the organization and location of the immediate commander in the *FROM* block.
3. Item 15. This item refers to the actual duty status of the member at the time the disease or injury was incurred. A member who performs duty or who is on the installation in an off-duty status is *present for duty.* A member who is away from the installation and not performing assigned duty is either *absent with authority* (this authority may be written, oral, or implied); *absent without authority*; or the member fits one of the special situations which apply only to USAFR and ANG members. Commanders of newly arriving members with treatment for a disease or injury prior to the move, but before the initiation of an AF Form 348, may have to consult with the member's former organization to determine the member's duty status at the time.
4. Item 16. Record completely and concisely the circumstances surrounding the disease, injury, or death, based on the immediate commander's information investigation. DO NOT STATE, "See Item 12". Include the names and addresses of civilians involved in the same incident, if any. If more space is required, use plain bond paper and identify item 16 as being continued. Include the type of tour and the inclusive tour dates for USAFR and ANG members.

5. Item 17. Check the appropriate block. If intentional misconduct or willful neglect of the member was not the proximate cause, check “neither of these” and specify the proximate cause.
6. Item 18. It is not necessary to give names and address if the source of the information is the member or the police, nor is it necessary to repeat names and addresses already appearing in item 13.
7. Items 19 or 20. The immediate commander completes either Item 19 or 20.
   a) Check Item 19 if the commander finds that the member was not absent without authority when the disease, injury, or death happened; that none of the special situations relating to not in line of duty, not due to own misconduct (NLOD/NDOM) apply; and that the disease, injury, or death was not proximately caused by the member’s own misconduct.
   b) The immediate commander finalizes in line of duty findings for members whose strength accountability is with the active duty force where there exists clear and convincing evidence supporting that finding and the SJA concurs in the finding. The immediate commander will delete the word recommended in Item 19.
   c) Check Item 20 in all cases where Item 19 does not apply. The member’s immediate commander signs the AF Form 348.
8. Item 21. Enter the SJA concurrence for those cases where the immediate commander finalizes the “in line of duty” finding on AF Form 348, block 21.
9. Item 22. The appointing authority checks and signs the appropriate block.

LINE OF DUTY DETERMINATION

TO: *(Immediate Commander)*	THRU:	FROM:
6TH AMXS/CC	6TH MSSO	39TH MDG

1. NAME *(Last, First, Middle Initial)*	2. SSN	3. GRADE	4. ORGANIZATION
Witt, Charlie E.	123-45-6789	E-5	6TH AMXS

5. MEMBER'S STATUS: [X] AD AF [ ] ARC [ ] AFROTC Cadet [ ] USAFA Cadet

6. NATURE AND EXTENT OF [ ] DISEASE [X] INJURY [ ] DEATH

1. Fracture, right radius
2. Broken left femur

7. NAME AND LOCATION OF [X] MILITARY [ ] CIVILIAN HOSPITAL OR TREATMENT FACILITY FIRST PROVIDED TREATMENT

123 Spring Rd
MacDill AFB, Florida

8. TREATMENT PROVIDED: HOUR 23:00 DATE 2014-06-10

9. MEDICAL OPINION OF MEMBER'S CONDITION WHEN FIRST TREATED:

A. [ ] WAS [ ] WAS NOT UNDER THE INFLUENCE OF ALCOHOL. *(See AFI 36-2910, Explanation of Terms)*

B. [ ] WAS [X] WAS NOT UNDER THE INFLUENCE OF A DRUG-INDUCING MARIJUANA (See AFI 36-2910, *Explanation of Terms*)

IF MEMBER WAS UNDER THE INFLUENCE OF A DRUG, SPECIFY WHAT KIND _____

C. [ ] UNABLE TO DETERMINE BECAUSE OF PHYSICAL CONDITION

D. [ ] WAS [ ] WAS NOT MENTALLY RESPONSIBLE

E. SPECIFY ANY OTHER CONDITION DEEMED RELEVANT

10. TESTS

A. BLOOD ALCOHOL TEST [ ] WAS [X] WAS NOT MADE. IF MADE, STATE RESULTS: _____

B. PSYCHIATRICAL EVALUATION [ ] HAS [ ] HAS NOT BEEN CONDUCTED.

C. ANY OTHER TESTS AND RESULTS *(Specify)*: _____

11. DETAILS OF ACCIDENT OR HISTORY OF DISEASE:

At approximately 2300, on 10 Jun 2014 at the block of Spring Rd, the patient was waiting for the traffic signal to change when a vehicle hit the members vehicle from the rear. The patients injuries stated above were sustained during the accident.

12. SOURCES OF INFORMATION

A. [X] MEMBER [ ] POLICE [ ] WITNESS(ES)
[ ] OTHER *(Specify)*:

B. NAME(S) AND ADDRESS(ES) OF WITNESS(ES)

DATE	TYPED NAME AND GRADE OF MEDICAL OFFICER	SIGNATURE
2014-06-15	G.E. Rose, Col, USAF, MC, SFS Chief, Emergency Medical Department	

AF IMT 348, 20020220, V1 PREVIOUS EDITION IS OBSOLETE

Figure 2–2. Sample, AF Form 348 (front)

TO: (Appointing Authority)	THRU: (SJA)	FROM: (Immediate Commander)
SSgt Witt	6TH FW/JA	6TH AMXS/CC

13. AT THE TIME OF THIS OCCURRENCE, THE MEMBER WAS:
A. [X] PRESENT FOR DUTY
B. [ ] ABSENT WITH AUTHORITY
C. [ ] ABSENT WITHOUT AUTHORITY FOR MORE THAN 24 HOURS
D. [ ] ABSENT WITHOUT AUTHORITY FROM *(HOUR AND DATE)* _____ / _____ TO *(HOUR AND DATE)* _____ / _____
E. NEITHER PRESENT FOR DUTY, ABSENT WITH AUTHORITY NOR ABSENT WITHOUT AUTHORITY BUT WAS:
[ ] ARC ONLY, TRAVELING TO OR FROM INACTIVE DUTY TRAINING.
[ ] TRAVELING TO OR FROM DUTY OR TRAINING AND HAD MATERIALLY DEVIATED FROM AUTHORIZED TRAVEL ROUTE.

14. AS A RESULT OF MY INVESTIGATION, I HAVE DETERMINED THE CIRCUMSTANCES TO BE AS FOLLOWS: (Who, how, when, where, why)

SSgt Witt was stopped at a traffic light when another vehicle approached at a high rate of speed. Due to heavy congestion, SSgt Witt was unable to take evasive action to avoid the accident. The other vehicle driven by Mr. Maney, collided with SSgt Witt's vehicle causing injuries to both parties. Both vehicles were totaled in the mishap. Mr. Maney was apprehended by authorities for driving under the influence of alcohol.

15. THE PROXIMATE CAUSE OF THE MEMBER'S DEATH, DISEASE OR INJURY WAS
[ ] INTENTIONAL MISCONDUCT [ ] WILLFUL NEGLECT [ ] BOTH OF THESE [ ] NEITHER OF THESE BUT *(Specify)*

16. SOURCES OF INFORMATION:
A. [ ] MEMBER [ ] OSI
[X] POLICE [ ] WITNESS(ES)
[ ] OTHER *(Specify)*
Police Report

B. STATE NAME(S) AND ADDRESS(ES) OF WITNESS(ES):

17. AS A RESULT OF MY INVESTIGATION,
A. [ ] THE RECOMMENDED FINDING IS *"IN LINE OF DUTY."*
B. [ ] RECOMMEND A FORMAL INVESTIGATION.
C. [ ] ARC ONLY - THE RECOMMENDED FINDING IS *"EPTS-LOD Not Applicable."*
D. [ ] ARC ONLY - THE RECOMMENDED FINDING IS *"EPTS-Service Aggravated."*

DATE	TYPED NAME AND GRADE OF IMMEDIATE COMMANDER	SIGNATURE
2014-06-19	STEVEN MANN, Major, USAF Commander	

18. [X] CONCUR [ ] NONCONCUR
(ACTIVE DUTY. If concur with recommendation of "In Line of Duty," file this form in Master Personnel Records, AFI 36-2910 *(Line of Duty (Misconduct) Determination)*. Otherwise, forward to Appointing Authority.)

DATE	TYPED NAME AND GRADE OF STAFF JUDGE ADVOCATE	SIGNATURE
2014-06-25	JASON G. PHILLIPS, Major, USAF Commander	

19. ACTION OF THE APPOINTING AUTHORITY:
A. [X] THE FINDING IS *"IN LINE OF DUTY."*
B. [ ] APPOINT INVESTIGATING OFFICER.
C. [ ] ARC ONLY, *"EPTS - LOD Not Applicable."*
D. [ ] ARC ONLY, *"EPTS - Service Aggravated."*

DATE	TYPED NAME AND GRADE OF APPOINTING AUTHORITY	SIGNATURE
2014-06-30	KEVIN EDMUND TOWNSEND, Colonel, USAF	

AF IMT 348, 20020220, V1 *(REVERSE)* PREVIOUS EDITION IS OBSOLETE.

Figure 2–3. Sample, AF Form 348 (back)

Responsibilities of the MTF, MPF, immediate commander, and others

Identifying cases in which LOD and misconduct determinations are required is an indispensable link in implementing the policies and procedures of the LOD program. When a disease, injury, or death of a member leaving surviving family members is involved, the task of determining the LOD status should, and does fall on the Air Force MTF. However, if this identification should inadvertently not

be made by the MTF, then commanders, SJAs, and staff officials at all levels are expected to assist by calling the oversight to the attention of the MTF commander. Now, let's take a look at the responsibilities of the MTF staff, the SJA, and the rest of the agencies who play a part in the LOD process.

Role of the medical facility

Identifying the cases in which LOD and misconduct determinations are required is a must! Since a disease, injury, or death of a member leaving surviving family members is involved in each case, this job falls on the staff of the Air Force MTF. Each medical facility commander (MFC) appoints a Line of Duty Medical Focal Point (LOD-MFP).

Usually, the responsibility for identifying cases in which an LOD and misconduct determination is required rests with the medical officer assigned to the medical facility that first provides treatment or has administrative control of the patient. The admitting health care provider decides whether an LOD determination is required.

When a health care provider decides an LOD and misconduct determination and investigation are required for a patient being admitted to the MTF, you, as the admissions clerk, obtain from the patient or other witnesses the time, place, and manner of occurrence of the incident. You record this information on the reverse side of AF Form 560, and help the attending medical officer prepare the AF Form 348.

Let's take a look at guidelines for initiating an LOD and misconduct determination in unusual circumstances.

Air Force members may be treated first at a place other than at their home bases, including treatment at other than Air Force MTFs and treatment by civilian physicians. In these cases, the Air Force MTF that first gives treatment is responsible for ensuring the LOD and misconduct determination process starts.

Air Force members may be treated first at their home bases, but may then be transferred by PCS, either as a hospital patient or otherwise, before the LOD and misconduct determination process starts. In these cases, the MTF that initiated treatment remains responsible for starting the process.

A member of another service may be treated first at an Air Force MTF. When this occurs, the MTF will advise the member's commander or the commander of the nearest installation of the service, in writing, of the need for an LOD and misconduct determination. The responsibility for processing the determination then goes to that service, but Air Force agencies will provide all reasonable assistance. An MTF takes action when a member or cadet gets a disease or injury resulting in an inability to do military duties for more than 24 hours, or the likelihood of a permanent disability. This applies to members of the Regular Air Force, USAFR, or ANG (on active duty, active duty for training, or inactive duty training); an AFROTC cadet on flight training or on field training; or an Air Force Academy Cadet.

When the case cannot be resolved by an administrative determination, prepare an AF Form 348 for the responsible medical officer to sign. AF Form 348 actions must be completed within 4 workdays. These time standards don't apply to USAFR member determinations being processed through USAFR channels. However, USAFR action agencies are expected to complete the actions as soon as possible.

When a member is initially treated at an MTF of another armed service, that service's LOD form may be used to start the LOD process. AF Form 348 may be attached to the other service's form and processed as usual.

Complete AF Form 348 in triplicate copies (original and two copies), ensure the appropriate medical officer signs it, and distribute as follows:

1. Send the original to the special actions section (DPMPEP) of the MPF that services the immediate commander (shown in the “TO” block of the form).
2. File a copy in the member’s medical records. For inpatients, file a copy in the member’s inpatient (clinical) records. For outpatients, or when treated at another military service’s MTF or at a civilian MTF, file the copy in the member’s outpatient records.
3. File a copy in the LOD-MTF office.

There are special procedures that apply to processing LOD and misconduct determinations following the death of a member who leaves surviving family members. Upon notification of the death, contact the supporting MPF to determine whether the deceased member has surviving family members who qualify for benefits. Family members who are authorized military medical care will, in most situations, qualify as beneficiaries. The deceased’s immediate commander and the casualty assistance representative (CAR) at the customer support section (DPMPSC) in the MPF should be contacted when necessary to clarify the status of the deceased’s surviving family members. Information from the DEERS or other automated systems capability may be reviewed to verify whether or not the deceased had surviving beneficiaries. When surviving family members have been identified, initiate an LOD and misconduct determination. When the case cannot be resolved by an administrative determination, initiate an AF Form 348 for the responsible medical officer’s completion.

Complete AF Form 348 in four copies and distribute as follows:

- Send the original to the (DPMPEP of the MPF that serves the immediate commander (shown in the “TO” block of the form).
- File a copy in the member’s medical records. For inpatients, file a copy in the member’s inpatient (clinical) records. For outpatients, or when treated at another military service’s MTF or at the civilian MTF, file the copy in the member’s outpatient records.
- File a copy in the LOD-MTF office.
- Forward a copy to the CAR, MPF/MSPPA.

Responsibilities of the MPF

After you initiate an AF Form 348, and the medical officer makes the appropriate entries and signatures, send the form to the member’s unit commander through the appropriate MPF/DPMPEP. When we speak of MPF/DPMPEP, we refer to the Special Actions section that serves the immediate commander of the member who is the subject of the determination. MPF/DPMPEP has the overall responsibility for ensuring the LOD and misconduct determination are processed correctly. Upon receiving an AF Form 348 from the MTF, MPF/DPMPEP does the following:

- Acts on behalf of the appointing authority.
- Monitors the progress of the determination by setting up controls and suspenses.
- Sends AF Form 348 to the immediate commander.
- Ensures the responsible officials complete the actions on time.

Immediate commander’s action of AF Form 348

The commander of the lowest unit where the member is assigned for strength accounting purposes at the time an AF Form 348 is initiated by the MTF, acts as the immediate commander. The immediate commander:

1. Investigates the circumstances of the case.
2. Fills out the applicable portion of the reverse of AF Form 348.
3. Finalizes findings of “in line of duty” for members whose strength accountability is with the active duty force and the SJA concurs with the finding. AF Form 348 is forwarded through the SJA to MPF/DPMPEP for final processing.

4. If the finding of “in line of duty” is not supported by clear and convincing evidence, or if the SJA does not concur with the “in line of duty” finding, AF Form 348 is forwarded to the appointing authority through the SJA.

SJA responsibilities

Review and coordination of AF Forms 348 by the SJA ensures formal investigations are conducted in appropriate cases. The SJA must concur or nonconcur with the recommendation of the immediate commander. The SJA should also take an active role to ensure an AF Form 348 is properly initiated by reviewing AF Form 53, Security Police Desk Blotter; incident reports; and potential hospital recovery claims on AF Form 438, Medical Care Third Party Liability Notification, and AF Form 1488, Daily Log of Patients Treated for Injuries. AF Form 1488 entries should be annotated when a line of duty determination is required. One copy of the AF Form 1488 is returned by the SJA to the MTF and one copy is retained in the claims office. Close coordination between the SJA, the claims officer, and the MTF should identify cases in which LOD and misconduct determinations are required.

When AF Form 348 is received, the SJA may conclude that an administrative determination rather than an informal determination is required. When this occurs, the SJA returns the AF Form 348 with recommendations, through MPF/DPMPEP, to the LOD-MFP, for further action. If the case could have been resolved by an administrative determination, the medical officer annotates the medical record by entering an administrative finding of “in line of duty.” In these cases, ensure that all copies of the AF Form 348 are destroyed.

If it is determined that an informal determination is required, return AF Form 348 to the SJA, through MPF/DPMPEP, for continued processing.

The immediate commander may finalize an “in line of duty” finding for members whose strength accountability is with the active duty force, where there exists clear and convincing evidence supporting that finding, and the SJA concurs with the finding. The SJA’s concurrence must appear on the AF Form 348. If the SJA does not concur, he or she sends the AF Form 348 to the appointing authority for action.

Appointing authority

The officer exercising special court-martial jurisdiction over the immediate commander acts as the appointing authority. If an appointing authority exercises both special and general court-martial jurisdiction, authority to act as appointing authority must be delegated to a member of the commander’s staff who is in the grade of colonel or higher. In no case may the same officer act as both appointing authority and as reviewing authority. If an appointing authority is also the immediate commander, that authority may act in both capacities.

The special court-martial convening authority may delegate the responsibilities of appointing authority no lower than the group commander. This does not apply to ANG or USAFR members.

The appointing authority reviews the AF Form 348 and takes action. Coordination with the SJA prevents delays by ensuring formal investigations are accomplished in appropriate cases.

If the immediate commander recommends an “in line of duty” finding and the SJA does not concur with the finding, the appointing authority may either concur with that finding or may direct that a formal investigation be conducted and appoint an investigating officer.

If the immediate commander recommends a formal investigation, the appointing authority may either concur and direct that an investigating officer be appointed or may direct the case be closed without further investigation with an “in line of duty” finding.

If an “in line of duty” finding results from the appointing authority’s action, the appropriate block in AF Form 348 (item 21) is checked. The entry is otherwise filled out, signed by the appointing authority, and sent to MPF/DPMPEP.

If an investigating officer is appointed as a result of the appointing authority's action, the appropriate block in AF Form 348 (item 21) is checked. The entry is otherwise completed and signed by the appointing authority, and the following actions are taken:

- Appoint an investigating officer.
- Give the investigating officer copies of the appointing order, the original AF Form 348 and a copy of AFI 36–2910, Line of Duty (Misconduct) Determination.
- Advise the investigating officer to contact the SJA for a briefing on his or her duties.
- Send copies of the appointing order to MPF/DPMPEP and to the custodian of the member's health records for filing. Set up typing and administrative support for the investigating officer.

Investigating officer

Investigating officers are appointed either by letter or by special orders according to AFI 37–128, *Administrative Orders*. The appointing document cites AFI 36–2910 as the authority, states the reason for the appointment, and designates a suspense date for submission of the investigating officer's report, which is usually 14 workdays from the date of the order. If circumstances warrant, the appointing authority may extend the period of investigation.

Investigating officers are disinterested officers in the grade of captain and above who are senior in date of rank to the member being investigated. If an officer is appointed who does not meet these criteria, the appointing authority prepares a memorandum justifying the appointment made. This memorandum is placed with the appointing orders when they become a part of the investigative file.

When determinations of the LOD and misconduct status of more than one member arising from a single incident are necessary, one investigating officer should be appointed to do all of the investigations. Separate investigative files are created on each subject.

When an incident occurs at a location remote from the appointing authority, an investigating officer from the installation nearest to where the incident occurred should be appointed with the concurrence of the commander concerned. Alternatively, the commander of the installation nearest to where the incident occurred may appoint the investigating officer, based on the request of the appointing authority. The request will be cited in the appointing document. Direct communication between the commands is encouraged.

Reinvestigation of the final findings

Final findings can be reinvestigated at the request of the member or at the direction of the appointing authority or higher authority, including HQ AFMPC/JA. The approving authority is the only official who has the authority to deny a request for reinvestigation.

Reinvestigation at the request of the member

A member who is the subject of a final LOD and misconduct determination may ask for reinvestigation by:

1. Applying, in writing, to the appointing authority that directed the first investigation within 45 calendar days after the member gets a copy of the formal determination.
2. Attaching new and significant evidence not previously considered, plus the member's copy of the formal report of investigation.
3. Sending a copy of only the written application to the final custodian of the original investigation for filing with that original, pending resolution of the request.

Reinvestigation of death cases

Family members of deceased military personnel not qualifying for benefits due to an adverse LOD and misconduct determination can request a reinvestigation. Usually, the requester is the surviving

spouse. When the surviving family member is a minor child or children, or an adult judged incompetent to manage his or her own affairs, the legal guardian appointed to represent that person's interests may submit a written request for reinvestigation in the minor's or incompetent's behalf. Evidence (such as a court order) must be submitted showing that he or she has been duly appointed as that person's guardian. The SJA should be consulted by the appointing authority to answer questions and review documentation establishing guardianship.

Reinvestigation at the direction of the Air Force

When new or significant evidence shows the chance of an error in a final LOD and misconduct determination—whether adverse to the member or not—the appointing or higher authority, including the Air Force Military Personnel Center, Judge Advocate (AFMPC/JA), may direct a reinvestigation.

In this case, the appointing authority directs the investigation be reopened either on his or her own initiative or as a result of being instructed to do so.

Procedures for reinvestigation

The appointing authority obtains the original report of investigation, gives all documentation to the investigating officer, and directs reopening of the case. If necessary, a new investigating officer may be appointed. The appointing authority also advises AFMPC Disability Retirements Branch (DPMADS) that the case is being reinvestigated.

The case is investigated and processed in the same way as previously discussed.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

223. LOD and misconduct determination fundamentals

1. Match the definitions in column A with the term or phrase in column B. Items in column B may be used only once.

Column A	*Column B*
____ (1) Substances identified as controlled substances by the Attorney General of the United States.	a. Alcoholism.
____ (2) A psychological or physical dependence on alcohol.	b. Alcohol abuse.
____ (3) The use of alcoholic beverages leading to a person's misconduct.	c. Drugs.
____ (4) Drugs that can lead to either physical or psychological dependence.	d. Habit forming drugs.
____ (5) Intemperate use of drugs.	e. Drug abuse.

2. Match the definitions in column A with the term or phrase in column B. Items in column B may be used only once.

Column A

____ (1) Fractures, wounds, concussions, and conditions resulting from extremes of temperature or prolonged exposure.

____ (2) Condition that existed prior to member's entry into military service.

____ (3) Illness, sickness, or ailment.

____ (4) Member is voluntarily away from duty without leave for more than 24 hours.

____ (5) Presumption that all members are mentally responsible for their acts.

____ (6) Primary moving cause or predominating cause.

____ (7) An act that evidences a reckless or wanton disregard for their attendant consequences.

____ (8) Intentional conduct that is wrongful or improper.

____ (9) Greater weight of credible evidence.

____ (10) An act done on purpose.

Column B

a. Absent without authority.
b. Injury.
c. Mental responsibility.
d. Existed prior to service.
e. Proximate cause.
f. Preponderance of the evidence.
g. Misconduct.
h. Intentional conduct.
i. Willful neglect.
j. Disease.

3. How does the Department of Veterans Administration use LOD findings?

4. How does the Office of Personnel Management use LOD findings?

5. How does the Department of Labor use LOD findings?

6. For whom are LOD and misconduct determinations made?

7. When is an LOD and misconduct determination needed?

8. When is a condition relating to alcohol abuse considered to be a disease or injury for the purpose of requiring an LOD and a misconduct determination?

224. Processing LOD and misconduct determinations

1. Who makes the determination concerning an administrative LOD?

2. An administrative LOD may be made under what conditions?

3. What type of determination is normally made by the member's unit commander?

4. When is a formal LOD determination required?

5. What form is used to record a formal determination?

6. An interim LOD applies to what category of individuals?

7. When can an interim LOD be issued?

8. How long is an interim LOD valid?

9. Who is responsible for completing the front side of the AF Form 348?

10. Who is responsible for the reverse side of the AF Form 348?

11. Who is responsible for identifying cases which require LOD misconduct determinations?

12. What organization is responsible for establishing suspenses and ensuring the responsible officials complete actions associated with informal LOD and misconduct determinations?

13. If the SJA determines an administrative LOD is more appropriate, where will the AF Form 348 be sent?

14. Where is the AF Form 348 sent if the SJA does *not* agree with the unit commander's findings on an "LOD" determination?

2–3. Referral Management

Taking care of our enrolled population in the best manner possible will enable the Air Force Medical Service (AFMS) to meet the Surgeon Generals (SG) charge for efficient, effective, customer-centric health care. This means being able to provide the right care, at the right time, at the right place, by the right provider, and at the right cost, while at the same time being able to train and sustain our capabilities. Referral management (RM), a process for managing and tracking patient referrals, is just one of the key processes in this endeavor.

As stated by the AF SG we have a contractual commitment to those who enroll with us in TRICARE Prime. Beyond the commitment to getting the best possible health care to these people, we have agreed to provide or arrange care by 1–7–28: urgent care within 1 day, routine care in 7 days, and referral/preventive appointments in 28 days. This defines the platform for our clinical practice. Our practices need to be both efficient and effective, not only to create a healthy, fit, and resilient population but also to train and sustain our capabilities. The job of every manager and every leader is to keep our environment one of calm, collected, confident competence for our Air Force. We are one team, taking care of the mission. We are also one family, taking care of each other. You deserve, and our Air Force deserves, no less.

Referral management is vital because it provides a patient-centered approach by ensuring the patient receives the best possible, timely, and cost effective specialty care while at the same time optimizing the MTF's clinical specialty capabilities. By optimizing its clinical specialty capabilities, the MTF is not only ensuring a patient-focused approach to its services but also guaranteeing that its personnel maintain the critical expeditionary medicine skills.

225. Referral management benefits

Establishing some form of referral management (RM) allows each MTF to better position itself for successful operations under the TRICARE managed care support contracts (MCSC). Under TRICARE revised financing, the Air Force SG will be at risk for millions of dollars in private sector care costs. Likewise all medical group (MDG) commanders will be held financially accountable for all care delivered to their enrollees, both within and outside of their facility. To flourish under TRICARE and revised financing rules of engagement, each MTF must find ways to fully optimize its capabilities, to maximize the recapture of specialty care from the private sector.

TRICARE "at risk" financing requires each MTF commander to be responsible for taking care of their enrolled patients and financially accountable for this care regardless of where it is delivered. Claims for network care by MTF enrolled patients will be paid by the MCSC, who will then be reimbursed from MTF operating funds on a monthly basis. Therefore the financial incentive for the MTF is to retain as much specialty care within the MTF as capability and capacity will allow.

Each MTF will need to carefully analyze its enrollment capacity, and primary and specialty care capabilities to perform well under TRICARE and its "at risk" financing rules of engagement. The more these functions stay in-house, the better off financially the MTF will be. MTFs will have to find better ways to partner with their MCSC. Referral management activities include rapidly completing the MTF's right of first refusal, screening of all MTF and network specialty care referrals, sustaining up-to-date service availability listings, establishing MTF/MCSC memorandums of understanding that optimize MTF capabilities, implementing RM standard business rules and responsibilities that allow for the constant tracking and resulting of referrals, continuous partnering with other local MTFs, and appropriately using information management systems. These activities allow the MTF to flourish under TRICARE in order to provide the right care, with the right provider, at the right time, at the right place, at the right cost.

226. Referral management center roles and responsibilities

RM is a process for managing and tracking patient referrals, both internal and external to the MTF, in order to identify trends, recapture care, and promote continuity of care. It provides a mechanism for

determining patient access to specialty clinics based on standardized criteria and pre-determined clinical/business outcomes. As the AFMS postures itself for TRICARE, recapturing patient care from the private sector is a key strategy to maximize the MTF's specialty care capability while simultaneously recapturing specialty care being done in the private sector for care, which could be done in the MTF or Direct Care system.

The RMC is a "One-Stop Shop" where patients go to process specialty referrals requested by their primary care manager (PCM). When a patient arrives at the RMC, the RMC staff will adhere to the following:

- Cordially greet and introduce himself or herself to the patient.
- Obtain electronic or in a very limited case, paper copy of the referral and review it for suitability, administrative and medical completeness, and determine if it is a covered benefit.
- Determine where the referral will go based on rule sets, memorandums of understanding, service availability listings (SAL), local market conditions, and MTFs availability and capacity. It is at this point the staff will review the referral for the right of first refusal. This means the staff will determine if the MTF has the specialty capability as reflected in the SAL, has an available specialty care appointment, and can make that appointment within the access to care standards which state that specialty care must be appointed within 28 days or sooner if so requested by the PCM or requesting provider. This right of first refusal must be completed within 24 hours. It is recommended that MOUs be reviewed annually or more frequently if needed, and that SALs be reviewed every 30 days to ensure MTF capabilities are fully and accurately defined.
- Provide the patient with advice concerning referral and treatment options, travel requirements, and answer questions the patient may have concerning his or her care.
- Provide the patient with a specialty care appointment. If the MTF has the specialty capability and the patient can be appointed within Access To Care (ATC) standards, the patient will be given an appointment to the MTF's specialty clinic. If the MTF does not have the capability or if an appointment cannot be given within ATC standards, the patient will be appointed to another MTF or Network/non-network provider within ATC standards in collaboration with the TRICARE service center (TSC). This process should preferably be completed before the patient leaves the MTF.
- Be customer focused throughout the process, both for the patient and for the referring provider, to relieve him/her from as many administrative burdens as possible.
- Track all referral requests and results going out of/into the MTF within prescribed timelines and follow-up to obtain results as necessary. Legible specialty care results from the MTF and other direct care specialists are to be provided to the PCM or requesting provider within 72 hours of the specialty care encounter. Network providers are expected to provide the PCM or requesting provider with specialty care results within 10 working days of the appointment.

Since the RMC is considered as a "one-stop shop" for all specialty referral and consult needs, it should be located in a convenient and accessible location for patient access. Ideally, the RMC and TRICARE TSC should be co-located or adjacent to each other to promote patient convenience and staff communication. Signage should be conducive to ease of wayfinding. In addition, according to forthcoming AFMS guidance, the RMC should be aligned under the patient administration function.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

225. Referral management benefits

1. Establishing some form of RM allows each MTF to better position itself for successful operations under what program?

2. The financial incentive for the MTF is to retain what type of care within the MTF as capability and capacity will allow?

226. Referral management center roles and responsibilities

1. What key strategy is used to maximize the MTF's specialty care capability while simultaneously recapturing specialty care being done in the private sector, for care which could be done in the MTF or Direct Care system?

2. What is a "One-Stop Shop" where patients go to process specialty referrals requested by their PCM?

3. Legible specialty care results from the MTF and other direct care specialists are to be provided to the PCM or requesting provider within how many hours of the specialty care encounter?

Answers to Self-Test Questions

219

1. A valid ID card and DEERS.
2. Uniformed services retirees; DD Form 2RET.
3. Tan; DD Form 1173, US Uniformed Services Identification and Privilege Card.
4. Children under age 10 must be enrolled in DEERS, but they don't need their own ID card.
5. Children *under* the age of 10.
6. MPF.
7. The designee letter to verify eligibility and benefits.
8. A competent medical authority performs a risk assessment.
9. Within 30 days.
10. Procedures should be established to verify the eligibility of all beneficiaries who have prescriptions from non-federal providers, and to allow adult family members or friends to pick up prescriptions from the pharmacy for an eligible beneficiary.

220

1. Outpatient.
2. As notification to the patient, the patient's commander, and Public Health.

221

1. Army.
2. Two years.
3. One year after sponsor's discharge.
4. The effects of denying designee status (for example, litigation cost, negative press coverage).
5. MTF commander and MAJCOM surgeon general for requests not meeting the criteria in AFI 41–115.
6. Those that the MTF commander or MAJCOM disapproves.
7. Care is limited to prenatal and delivery, as well as follow-up care not to exceed six weeks. Supplemental care is limited to diagnostic tests associated with maternity care. Postpartum sterilization is authorized when performed during the obstetrical admission.
8. Care is authorized in conjunction with delivery to include postpartum well-baby check and related immunizations.

222

1. The mission of the SNIAC process is to
   (1) identify active duty service members with family members who have special medical and/or educational needs,
   (2) help those families to obtain information on required services, and
   (3) ensure they have access to necessary services if reassigned. The process also assists the MPF in updating the Assignment Limitation "Code Q" that is assigned to the sponsor for the purpose of ensuring service availability upon PCS.
2. Special needs coordinator and the FMRC process.
3. The appropriate AF Form 1466, AF Form 1466D, DD Form 2792, and Addendum B.
4. All family member children who are eligible to attend DODDS.
5. A MOU developed between SNIAC process and key civilian agencies, which specify interagency client-focused processes that ensure the safety of service members and their families, and enhances access to community resources.
6. The MTF in closest proximity to the family.
7. Q-base.

223

1. (1) c.
   (2) a.
   (3) b.
   (4) d.
   (5) e.
2. (1) b.
   (2) d.
   (3) j.
   (4) a.
   (5) c.
   (6) e.
   (7) i.
   (8) g.
   (9) f.

(10) h.

3. To determine eligibility for disability compensation and hospitalization benefits.
4. To determine eligibility for civil service preference.
5. To determine eligibility of an AFROTC cadet for compensation for injuries sustained while training.
6. Members of the Air Force (regular or reserve) who incur or aggravate an injury, illness, or disease, or who die leaving family member beneficiaries while on active duty or traveling to or from such duty need an LOD determination.
7. When a member, whether hospitalized or not, has a disease or injury that results in the inability to do military duties for more than 24 hours, the likelihood of a permanent disability, death, when there are surviving family members and medical treatment for reserve members regardless of the ability to perform military duties.
8. Make an LOD determination when alcohol abuse causes the death of a member leaving surviving family members, or an injury that results in a member's inability to perform duty for more than 24 hours, or results in the likelihood of a permanent disability. The ultimate determination is whether the member's misconduct is the proximate cause of the disease, injury, or death.

224

1. Medical officer.
2. (1) Hostile casualties.
   (2) Injuries, or death of members leaving surviving family members, incurred while a passenger in a common commercial carrier or a military aircraft.
   (3) Diseases, injuries, or death of members leaving surviving family members if
      (a) the disease or death is of natural origin that does not involve misconduct, drug or alcohol abuse,
      (b) or the injury is a simple injury (sprain, contusion, or minor fracture) not likely to result in a permanent disability, and
      (c) the disease, injury, or death did not happen while the member was absent without authority and was clearly not caused by the member's own misconduct or
      (d) disease or injury existed prior to service.
3. Informal LOD.
4. When neither an administrative nor an informal determination can be made.
5. DD Form 261.
6. Reserve members.
7. The appointing authority, at the request of the member's commander may issue an interim LOD determination if an LOD determination cannot be finalized within seven days of notification and it is possible that the member may be entitled to incapacitation benefits.
8. The interim LOD is valid for no more than ninety days.
9. Medical officer.
10. The patient's immediate commander.
11. Medical treatment facility.
12. Military Personnel Flight.
13. The SJA returns the AF Form 348 with recommendations, through MPF/MSPPA, to the LOD-MFP, for further action.
14. If the SJA does not concur, he or she sends the AF Form 348 to the appointing authority for action.

225

1. The TRICARE and MCSC.
2. Each MTF will need to carefully analyze their enrollment capacity, and primary and specialty care capabilities to perform well under T-Nex and its "at risk" financing rules of engagement. The more these functions stay in-house, the better off financially the MTF will be.

226

1. Recapturing patient care from the private sector.
2. The RMC.
3. 72 hours.

Complete the unit review exercises before going to the next unit.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter.

46. (219) Routine care is *usually not* provided to patients with questionable eligibility until the
    a. patient provides other identification.
    b. patient provides proof of insurance.
    c. patient's eligibility is determined.
    d. patient pays for treatment.

47. (219) Which patient would still receive routine medical care, even if they failed a Defense Enrollment Eligibility System (DEERS) eligibility check?
    a. A patient issued an identification card within the last 120 days.
    b. A patient issued an identification card within the last 60 days.
    c. A patient returned from overseas within the last 120 days.
    d. A returned from overseas within the last 60 days.

48. (219) After the risk assessment, what determines if a patient with questionable eligibility is treated in the military treatment facility?
    a. If it is determined that the patient has sufficient insurance.
    b. If there is a possibility of risk to the Air Force or patient.
    c. If the patient has other forms of identification.
    d. If the patient need only minimal medical care.

49. (220) What is the *final step* of completing the quarters notification form?
    a. Establish a follow up appointment.
    b. Fax/e-mail a copy to the member's unit.
    c. Update medical treatment facility (MTF) records.
    d. Update the member's duty status in the Military Personnel Data System (MilPDS).

50. (221) A Secretary of the Air Force designee letter must contain the effective date, period covered and
    a. the specific provider who will follow the designee.
    b. the specific primary care optimization team the designee is assigned to.
    c. determination as to whether the Air Force is providing aeromedical evacuation.
    d. confirmation that the designee is either a TRICARE prime, extra or standard member.

51. (221) When can patients request for a renewal of their Secretary of the Air Force designee status?
    a. The Judge Advocate General determines that continued status may thwart possible litigation.
    b. A teaching case that is still producing benefits for the Air Force residency program.
    c. Military treatment facility commander approves the continuation.
    d. Continued care is still necessary.

52. (221) When an abused family member applies for Secretary of the Air Force designee status after the sponsor was discharged from the service, the approval authority is the
    a. medical group commander.
    b. Secretary of the Air Force.
    c. wing commander.
    d. unit commander.

53. (221) Generally how are the applications for designee status submitted?
    a. Through the command surgeon general's office to HQ USAF/SGMA.
    b. Through the wing commander to the command surgeon general's office.
    c. Through the military treatment facility commander to HQ USAF/SGMA.
    d. Through the chief of hospital or clinic services to the command surgeon's office.

54. (222) Which of the following *is not* part of the mission of the special needs identification and assignment coordination (SNIAC) process?
    a. Identify active duty service members with family members with special educational needs.
    b. Locates providers and establishes the consults for care.
    c. Help families obtain information on required services.
    d. Ensures access to necessary services if reassigned.

55. (222) For sponsors on unaccompanied assignments, a family member clearance screening is accomplished by the
    a. military training facility (MTF) in closest proximity to the family.
    b. military personnel flight (MPF) in closest proximity to the family.
    c. MTF in closest proximity to the member.
    d. MPF in closest proximity to the member.

56. (223) Which agency uses line of duty (LOD) determinations to determine eligibility for physical disability retirement?
    a. Office of Personnel Management.
    b. Department of Veterans' Affairs.
    c. Department of Labor.
    d. Air Force.

57. (223) Which agency uses line of duty (LOD) determinations to determine eligibility for disability compensation and hospital benefits?
    a. Office of Personnel Management.
    b. Department of Veterans' Affairs.
    c. Department of Labor.
    d. Air Force.

58. (223) Which agency uses line of duty (LOD) determinations to evaluate the eligibility of an Air Force Reserve Officer Training Corps (AFROTC) cadet for compensation for injuries sustained while training?
    a. Office of Personnel Management.
    b. Department of Veterans' Affairs.
    c. Department of Labor.
    d. Air Force.

59. (224) The three types of line of duty determinations are informal, formal, and
    a. administrative.
    b. associative.
    c. disease/injury.
    d. general.

60. (224) The interim line of duty (LOD) for reserve members is valid for no more than how many days?
    a. 30.
    b. 60.
    c. 90.
    d. 180.

61. (224) If the Staff Judge Advocate (SJA) determines an administrative line of duty (LOD) is more appropriate after an AF Form 348 has been completed, the SJA will return the AF Form 348 through the military personnel flight (MPF)/DFMPEP to the
    a. appointing authority.
    b. investigating officer.
    c. unit commander.
    d. LOD-MFP.

62. (224) The only individual who has the authority to deny a request for reinvestigation of line of duty (LOD) findings is the
    a. investigating authority.
    b. staff judge advocate.
    c. approval authority.
    d. unit commander.

63. (225) Who is held financially accountable for care regardless of where it is delivered?
    a. Nurse.
    b. Member.
    c. Supervisor.
    d. Military treatment facility (MTF) commander.

64. (225) Who pays for claims for network care by military treatment facility (MTF) enrolled patients?
    a. MCSC.
    b. TRICARE.
    c. RMC.
    d. PAD.

65. (226) Which office is the “one stop shop” where patients go to process specialty referrals requested by their PCM?
    a. TRICARE.
    b. Family practice.
    c. Referral management center.
    d. Resource management office.

Please read the unit menu for unit 3 and continue ➔

Unit 3. Inpatient Administration

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MOST OF THIS UNIT concentrates on the inpatient aspects of medical care. The logical approach is to start with the admissions process and work our way through to the disposition process. We will also discuss some of the major steps in between such as notifying the appropriate agencies when personnel are admitted and the transfer process. Like most health services manager (HSM) positions, the admissions and dispositions (A&D) technician is a customer-oriented position that requires excellent communicative skills, a caring attitude, and thorough knowledge of the A&D process. When a health care provider orders a patient to be admitted to the hospital, you know the patient's medical condition is in question. In many cases, the patient is feeling very poorly and is probably quite frightened. Working as an A&D technician, you must know how to communicate with the patient, as well as with concerned family members—skills that you should remember from your 3-level training. The key word here is *empathy*. You are the individual that the wards look to for assistance in admitting or discharging patients, upkeep and turn-in of the inpatient records, and many other taskings. Patients and staff will be depending on you to know your job and to ensure their inpatient records are being properly maintained.

3–1. Admitting Patients to the Hospital

If a health care provider determines that a patient's condition requires inpatient medical care, the patient is admitted to the hospital for a specific plan of care (regimen). The physician administers this care, with the assistance of other medical staff members, while the patient occupies a bed in the hospital.

You have a challenging position as the admissions point of contact. You must "try" to place the patient at ease and make their transition to the inpatient unit (sometimes referred to as the ward) as quick and as smooth as possible. Concerned family members or other individuals may also require

your assistance. Your training in anatomy and physiology, and medical terminology, will be a great help to you when working in A&D. You must be able to relate the diagnosis of the patient to the specialty of care provided on each inpatient unit in your MTF. For instance, if the diagnosis is pregnancy, you need to know that the patient should be admitted to the obstetrics unit and not the orthopedics unit.

Other areas of knowledge you may rely on are patient eligibility, line of duty and misconduct determinations, and third party liability and the collection programs. Now it's time to dive right into the admission process and find out how our customers become inpatients.

227. The admission process

At first glance, admitting patients to the hospital may seem to be primarily a physician-patient interaction; however, throughout the entire process it takes a team of highly qualified medical personnel. The best place for us to begin our journey through the world of A&D is at the very beginning with common terms.

Common A&D terms

Before you can walk you must first learn how to crawl. A&D uses many terms that are closely related. For instance, subsisting out as opposed to convalescent leave or inter-service and interward transfer. Until you begin using these terms frequently it may be hard to remember their meanings. As you're studying the rest of this unit, remember to refer back to these terms to help clarify their definitions.

Admission

Admission is the act of placing a patient under treatment or observation in a MTF.

Carded for record only

Carded for record only (CRO) refers to a patient who is dead on arrival to the MTF.

Change of status

Change of status is a change which may occur between the time of admission and the disposition of a military patient. Subsisting out and convalescent leave are two such examples.

Subsisting out

Subsisting out is a military patient who has been a bed occupant and has reached a point of recovery, where the doctor considers it more desirable for the patient to continue treatment and live and eat at their home or dorm room. The patient is excused from duty; however, he or she is required to visit the physician frequently during this period of time.

Convalescent leave

Convalescent leave is a military patient, who has been a bed occupant and has reached a point of recovery, where the physician considers it more desirable for the patient to have a period of recuperation and relaxation outside the MTF. The patient does not have to return to the MTF until the leave ends. This leave is not charged against the patient's annual accrued leave.

Emergency room death

This refers to a patient who is alive upon arriving at the MTF, but dies before being admitted to an inpatient unit.

Inpatient

Inpatient is an individual, other than a transient patient, who is admitted to a bed in a MTF. Inpatients are also referred to as bed occupants.

Inter-service transfer

Inter-service transfer is the movement of an inpatient from one clinic service to another.

Inter-unit (inpatient unit) transfer

Inter-unit transfer is the movement of an inpatient from one unit (ward) to another.

Outpatient

An Outpatient is an individual receiving medical or dental care and DOES NOT require admission to the MTF.

Patient

A patient is an individual who is examined and treated for an illness or injury; to include a physical examination (can be categorized as inpatient or outpatient).

Transient patient

Transient patient is a patient being evacuated from overseas or from one MTF to another.

Responsibility

All patients admitted to an MTF are processed through the MTF's admissions function. Most of the admissions procedures are established locally, yet there are still some general guidelines that are all encompassing throughout the Air Force.

Admitted from the clinic

Most patients are admitted to the inpatient unit from the clinic. In these situations, the health care provider initiates an AF Form 560, Authorization and Treatment Statement (the form is a four-part carbon set), (fig. 3–1). The completion of the AF 560 is a team effort between the admitting health care provider and the HSM working in the A&D office. The health care provider has the ultimate responsibility to ensure the AF 560 is accurate. This is accomplished by authenticating the entries and identifying themselves by signature, initials or use of a name stamp. If the AF Form 560 shows that the clinic has not assigned the patient to an inpatient unit, the A&D technician must make the appropriate assignment in item 22 (as mentioned earlier, this is where you reap the benefits of your anatomy and physiology training). This decision depends on the service for which the patient is being admitted, and availability of beds within that service. Enter the inpatient unit on *all* copies of the AF Form 560.

Explain to all patients the purpose of the Privacy Act Statement (PAS) and be sure to explain, to any patient not on active duty, the purpose of the disengagement statement; both are located on the reverse of the AF Form 560 (fig. 3–2). The disengagement statement simply informs the patient that their admission to the MTF is subject to the availability of space and capabilities of the staff. When the patient signs in item 36B, they are acknowledging they have read the disengagement statement and the privacy act statement.

USE BALL POINT PEN
PRESS HARD

AUTHORIZATION AND TREATMENT STATEMENT

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - See Reverse)

I. ADMISSION *(CLINIC PERSONNEL OR PROVIDER FILLS IN CIRCLED ITEMS)*

1. REGISTER NO. 12345	NBSUF	(2.) NAME (Last, First, Middle Initial) Brown, Thomas					3. RELIGION NRP	
4. FACILITY CODE	5. MEDICAL TREATMENT FACILITY San Antonio Military Medical Center					6. TIME OF ADM 1200	(7.) DATE OF ADM 20140201	8. TYPE OF CASE INJ
9. FMP 20	SSN 123-45-6789	10. BENEF TYPE F11	11. GRADE E-5	12. AFSC 4A0	13. AVIATION SVC CODE	14. RATING	15. LENGTH OF SVC 12 Yrs	16. AGE 28
17. SEX M	18. MARITAL STATUS M	19. RACE/ COLOR W	20. ZIP CODE 78234	21. CURRENT ORGANIZATION 359 Medical Group				(22.) INPATIENT UNIT 3A
23. FAC INT ADM CODE	24. FACILITY OF INITIAL ADMISSION SAMMC				25. DATE INITIAL ADM 20140201		26. ROOM 2	27. BED 2A
28. PRIOR ADM ☑ YES ☐ NO	29. CLINIC SERVICE(S) BDAA						30. ADMISSION CLERK SW	

31. EMERGENCY ADDRESSEE/RELATIONSHIP Jane Brown	32. NAME AND ADDRESS OF SPONSOR Self
(33.) PRIMARY ADMISSION DIAGNOSIS Appendicitis	(34.) SECONDARY ADMISSION DIAGNOSIS
35. CAUSE OF INJURY	

36A. DEPOSIT VALUABLES FOR SAFEKEEPING ☐ YES ☑ NO	36B. I have read and understand the Privacy Act and Disengagement Statements on the reverse of this form.	SIGNATURE OF PATIENT OR SPONSOR	(37.) ADMITTING PROVIDER Dr. J. Mark

II. TREATMENT

38. DIAGNOSES - PROCEDURES	39. PROVIDERS OF CARE
LOD: ☐ YES ☐ EPTS, LOD not applicable ☐ AF Form 348 (Check ☐ if continued on reverse)	(Check ☐ if continued on reverse)

40. ADMINISTRATIVE DATA *(Change in physical profile required* ☐ *YES (Prepare AF Form 422)* ☐ *NO)* *(Meal Card* ☐ *YES* ☐ *NO)*

(Check ☐ *if continued on reverse)*

41. DISPOSITION	42. DATE OF DISPOSITION	43. TIME OF DISPOSITION	44. CC OF WHOLE BLOOD	45. CC OF PACKED CELLS	46. CONVALESCENT LEAVE TAKEN	RECOMMENDED

47. SIGNATURE OF ATTENDING HEALTH CARE PROVIDER	48. SIGNATURE OF PATIENT AFFAIRS OFFICIAL

AF IMT 560, 19870101, V2 PREVIOUS EDITION WILL BE USED.

Figure 3–1. Sample, AF Form 560 Authorization and Treatment Statement (front).

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU

1. *AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)*
   Section 133, 1071-87, 3012, 5031, and 8012, Title 10, United States Code and Executive Order 9397.

2. *PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED*
   This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

3. *ROUTINE USES*
   The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignment; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

4. *WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION*
   In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.

   This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

   YOUR SIGNATURE ON THE FRONT OF THE FORM ACKNOWLEDGES THAT YOU HAVE BEEN ADVISED OF THE ABOVE. IF REQUESTED, A COPY OF THIS FORM WILL BE FURNISHED TO YOU.

DISENGAGEMENT STATEMENT

I Hereby acknowledge that my admission to this medical facility is subject to the availability of space and capabilities of the medical staff. I further acknowledge that, upon determination by the Commander of this hospital that space is no longer available or that the medical staff is no longer capable of providing me the required care, I may be discharged or transferred to a civilian source of care under the COST-SHARING PROVISIONS OF CHAMPUS, OR AT MY OWN EXPENSE (active duty personnel are excepted). In such event, if time and circumstances permit, either I or my next of kin will be consulted concerning my options prior to my discharge or transfer.

AF IMT 560, 19870101, V2

Figure 3–2. Sample, AF Form 560 Authorization and Treatment Statement (back).

Patients who die

The administrative requirements are similar for patients who die en route or those who die in the emergency room. When a patient is dead on arrival, the case is referred to as a “carded for record only” or “*CRO*” case. You may also hear CRO referred to as “dead on arrival” or “DOA.” A patient

who arrives at the MTF alive, but dies in the emergency room or prior to admission is considered an "emergency room death" or "ERD" case.

Emergency room deaths or DOAs will be coded in the KG-Ambulatory Data System (KG-ADS) as opposed to Composite Health Care System (CHCS). A separate folder similar to the ambulatory procedure visit (APV) record will be created and all documentation will be filed in this folder. This record will be filed in the inpatient records area or other limited access area.

Active duty in a nonmilitary hospital

The MTF commander at the nearest Air Force MTF, including clinics, assumes administrative responsibility upon notification that an Air Force active duty member is hospitalized in a nonmilitary medical facility. An AF Form 560 is completed as if the active duty member were being directly admitted to a MTF. We will discuss this process in more detail in a later lesson.

Transfer patients

A patient received by transfer from another MTF presents the inpatient record and transfer orders to you in the admissions office (when possible). In an MTF where transfer patients are not first processed through a clinic, the admissions technician prepares four copies of AF Form 560. At other MTFs, the clinic (health care provider) may prepare this form and send it to the admissions technician with the patient.

The admission diagnosis information located in items 33 and 34 of the AF Form 560 is taken from the record of inpatient treatment (automated version of AF Form 565 with the same title), or the inpatient record, which was prepared by the transferring facility.

Direct to inpatient unit

Sometimes the patient being admitted cannot visit the Admissions office upon arrival. This occurs when a patient is sent directly to the inpatient unit without stopping at the admissions office. Inpatient unit personnel or clinical staff complete as much of the admission process as possible, and then forwards the AF Form 560 to the admissions office for completion.

Register of patients

Each patient admission is assigned a register number. This number is used to identify a patient's case from beginning to end. A new register number is assigned automatically by the CHCS each time a patient is admitted to an MTF (use a manual method or other computer generated form when CHCS is not available).

To manually register patients, use a register of patient's form (fig. 3–3). At the start of each day, the admissions technician enters the date on the first blank line of the register. Register numbers begin with number "1" for the first patient admitted on the first day of operation of the facility. Use only whole numbers, in numerical sequence, until the facility is closed down, regardless of any change in its status or designation. If you happen to deploy to a tactical MTF, such as an Expeditionary Medical Service (EMEDS) your deployed facility will use its own set of register numbers for each patient admitted.

If a register number must be assigned after the date of admission, assign the next whole number in the current numerical sequence and annotate the correct date of admission on the same line in the register of patients. Under the actual date of admission, enter the date the number is assigned. Do not omit any number. Therefore, a MTFs register of patients, must be kept readily accessible, maintained and disposed of IAW AFM 37–139, *Disposition of Air Force Records—Records Disposition Standards*. Regardless of whether your MTF utilizes manual (DD Form 739) or automated (CHCS) methods to register patients, you must keep a historical records file on hand.

REGISTER OF PATIENTS (NUMERIC)

1. MEDICAL FACILITY	2. YEAR	3. PAGE NUMBER

4. REGISTER NUMBER	5. PATIENT'S NAME (Last, First, Middle Initial)	6. SPONSOR'S SOCIAL SECURITY NUMBER

DD Form 739, JAN 82 (EG) PREVIOUS EDITION IS OBSOLETE

Reset

Figure 3–3. Register of Patients

Register births in CONUS

A birth certificate will be prepared for each infant born in an Air Force MTF. Follow state laws with regard to the forms used, format, and number of copies required. File a work copy in the infant's inpatient record. Advise parents to report to the Military Personnel Flight (MPF) to update personnel records and register the child in the DEERS as part of birth registration. This must be accomplished within 120 days or the member will receive a bill for care. When both parents are active duty, recommend that the same sponsor be identified in CHCS and DEERS to eliminate confusion with the records. Refer parents to the TRICARE service center for TRICARE options, including TRICARE prime enrollment.

Register births overseas

Overseas Air Force MTFs must cooperate with consular officers in registering births of infants born to US citizens in areas overseas. **EXCEPTIONS:** Register births in American Samoa, Guam, Puerto Rico, the Trust Territories, and the US Virgin Islands through the special offices of the Vital Statistics Division, Public Health Services, US Department of Health and Human Services, or specified local US Government offices. Births are reported to local authorities on the forms provided by US Consular Offices. Notify the US Consular Office where the Air Force MTF is located no later than 10 days after the birth of an infant whose parent or parents are US citizens. Advise DOD personnel whose children are born overseas to report to the Military Personnel Flight to update personnel records and register the child in the DEERS and passport application as part of birth registration in an overseas area.

Assigning patients to an inpatient unit

It is very important to always have an accurate count of available beds. This can be done in a couple of different ways. You may use a manual method or an automated method to provide a snap shot view of the number of beds available on each inpatient unit.

Each morning, the total number of available beds on each inpatient unit is provided to the admissions office, or it may be your job to call each inpatient unit for this information. As patients are admitted, discharged, or transferred to other inpatient units, the balance of available beds is adjusted. When units reach their full capacity, inform the medical staff that no beds are available on those units. Do not send patients to an inpatient unit that does not have available beds and do not direct them to another unit until the admitting provider of care has been notified.

Manual method

One manual method that may be utilized is a simple status board. The bed status board as it is commonly referred is a wallboard on which a copy of each inpatient locator card is mounted. The cards are mounted under the unit headings, so that the cards for all patients assigned beds on a given unit appear under that unit. Cards for patients on leave, AWOL, or PCS awaiting discharge from the service, are mounted under an appropriate heading.

Automated method

Facilities using CHCS have the ability to determine bed availability using the “Bed Status Menu” under the patient administration division (PAD) subsystem. The last page of this report is titled the Ward Nursing Report (figs. 3–4). By viewing this document, you can get a summary of the counts of each inpatient unit broken down by the following topics:

- Ward.
- Beds in ward.
- Patients in ward.
- Blocked beds in ward.
- Preadmits in ward.
- Beds available.

These are an example of a useful management tool offered by CHCS.

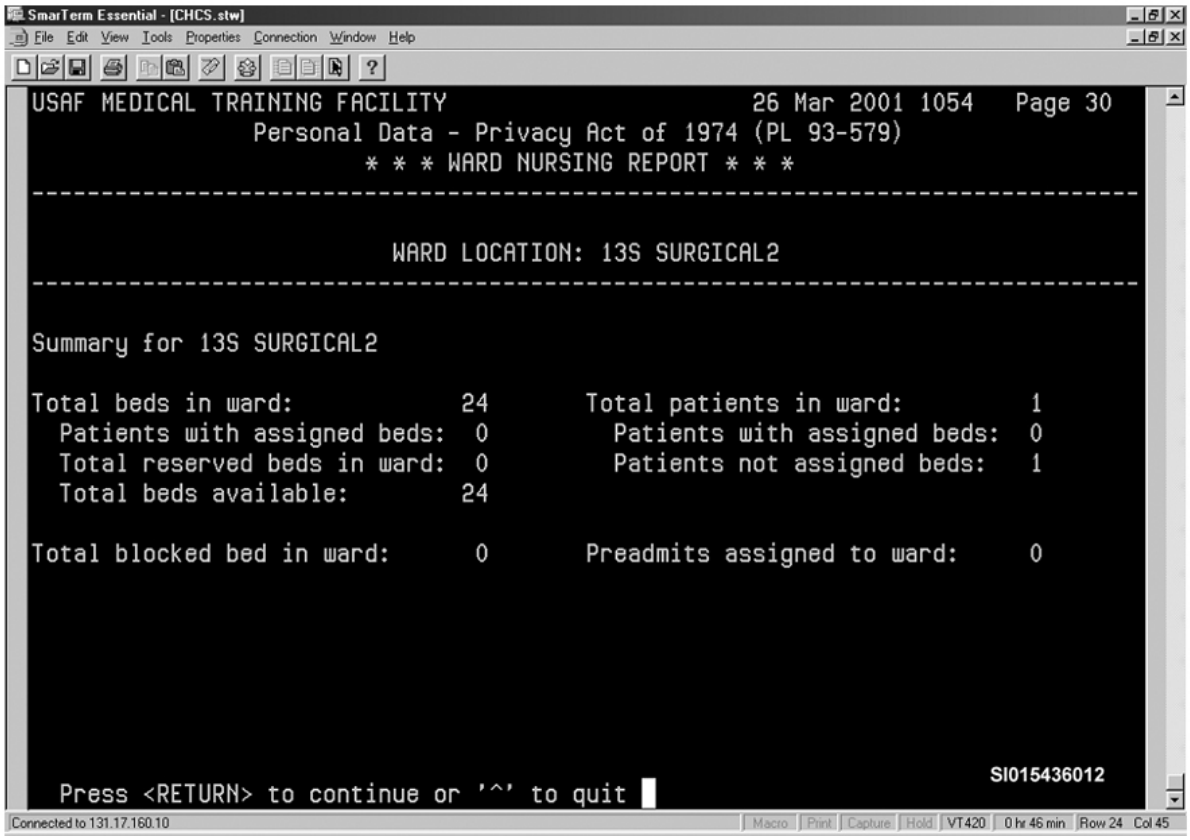

Figure 3–4. Ward nursing report.

228. Completing AF Form 560

Regardless of the specific type of admission, paperwork is necessary to start the administrative process. In this lesson, we are going to look at the entries required on the primary admission document—the AF Form 560, Authorization and Treatment Statement.

Source document

An AF Form 560 is completed for every patient admitted to your MTF and military patients admitted to nonmilitary (civilian) hospitals.

NOTE: Emergency room deaths or DOAs will be coded in the (KG-ADS) as opposed to CHCS. Emergency room deaths or CROs were once admitted through CHCS. This practice is no more!

MTFs using the CHCS may use AF Form 560 as a source document for entering information into the system. Most admissions technicians write the information on AF Form 560 just as it will be keyed in to the CHCS (which is how we will present most of the items in this lesson). Remember, if you forget what information should be entered into a CHCS field, simply type “??” to view the onscreen help menu.

AF Form 560

When patients are admitted, the (admitting) health care providers (physicians, dentists, or certified nurse midwives) complete the circled items of the AF Form 560; the admissions technician completes the remaining entries (items 2 through 32 that are not circled). As we discuss the entries refer back to figures 3–1 and 3–2 for a sample AF Form 560.

Item Number	Title	Explanation
1	Register Number	Leave this item blank until you are provided a register number by the CHCS. Enter the register number assigned by the CHCS to this particular patient. If the register number is assigned manually, take the next available number from the DD Form 739.
2	Name	The patient's name (last, first, and middle initial) should be entered by the health care provider.
3	Religion	Enter the patient's religious preference. You may use an abbreviation or enter "NRP" if no preference.
4	MTF Code	Enter the code that identifies your MTF.
5	MTF	Enter the name and location of your MTF.
6	Time of Admission	Enter the time you admit the patient using the standard 24-hour military clock—e.g., 0220 or 2200. Do not enter the time for preadmissions until they are actually admitted to the MTF.
7	Date of Admission	The day, month, and year of admission should be entered by the health care provider (e.g., 1 Jan 02). Do not enter a date for pre-admissions until they are actually admitted to the MTF.
8	Type Case	Enter the type of case, The two most common entries are "INJ" and "DIS." *INJ—Injury.* A person sustaining an injury by accident, violence, or poisoning. This category excludes a person suffering from: An injury previously recorded in Armed Forces inpatient medical records. Residuals of an injury. An injury incurred before the person entered into active service. *DIS—Disease.* Any person not classified as INJ. For example, a female admitted for pregnancy would be classified as a DIS It may sound funny, but the definition stipulates any person not classified as INJ. When a patient is admitted for both a nonbattle injury and a disease, classify according to the principal cause of admission.
9	FMP and SSN	There must be an entry in both of these items. Enter the appropriate family member prefix (FMP) and Social Security Number (SSN) for this patient. The FMP is assigned based on the relationship the patient has to the sponsor (selection of the FMP was covered in volume 2 of this CDC). Use the sponsor's SSN for nonmilitary patients.
10	Beneficiary Type/ Command of Assignment	Enter the appropriate beneficiary code listed in fig. 1–3 for the patient (e.g., F11, A41, etc.).
11	Grade	Enter the grade of active duty or retired members of the uniformed services. You may wish to write the pay grade (E3, E–5, O–4, etc.) or, to ease transfer of this information into the CHCS, enter the three major letters used to describe the patient's rank. For example, "TSG" identifies the admission of a TSgt, and "COL" identifies a Colonel. For OSI agents enter the rank for Airman Basic regardless of the agent's actual rank.
12	Duty Air Force Specialty Code (DAFSC)	For Air Force active duty and Air Reserve Forces, enter the first three digits of the individual's DAFSC. For all others leave blank.
13 and 14	Aviation Service Code/Rating	Enter "Y" in one of these items, if the active duty patient is on flying status. If the patient is not on flying status, enter "N." These are the only entries required when you enter this data in the CHCS.

Item Number	Title	Explanation
15	Length of Service	For active duty military personnel, enter the total amount of all active duty service at time of admission. Service of less than 1 month is shown in days, such as “25D” for an individual with 25 days total active service. Less than 1 year is shown in months, such as “03M” for an individual with 3 months total active service. An individual with more than 1 year is shown in completed years (i.e., an individual with 7 years and 2 months service would be seven “07Y” years.) Leave blank for all others.
16	Age	Enter the patient’s age at the time of the admission. Age is entered in years as of the last birthday (except for children under 2 years old). Enter “NB” for an infant, which includes newborn infants born in your MTF, born at home or on the way to your MTF, and admitted immediately thereafter. For an infant born in a civilian facility and admitted to your facility on day of birth, enter “00D.” For other infants under 30 days old, enter the age in days using a two digit display; for example, “22D” for a 22 day old child. For a child between 2 months and 2 years old, enter the age in completed months; for example, “09M”, meaning a 9-month-old child.
17	Sex	Enter M or F.
18	Marital Status	Enter appropriate code: A–Annulled D–Divorced I–Interlocutory L–Legally separated M–Married S–Single, never married W–Widowed Z–Unknown
19	Race/Color	Enter C = White (Caucasian) N = Black M = Asian R = Western Hemisphere Indian X = Other Z = Unknown
20	Zip Code	For active duty military patients, enter the 9-digit zip code of the member’s present duty station. For all others, enter the 9-digit zip code of residence. In overseas areas, use APO or FPO numbers.

Item Number	Title	Explanation
21	Current Organization	Enter the designation of the unit of assignment for patients on active duty with the US Armed Forces (i.e., 384 TRS). For other patients, enter their appropriate status. Here are some examples: *OSI Agents.* Enter “OSI Agent.” *Retired uniform service personnel.* Make an entry regarding their branch of service and rank (i.e., “RET USAF E–7”). If the patient is on the temporary duty retired list (TDRL) at time of admission, note this information (i.e., “USAF RET/TDRL”). *Dependents of active duty, retired, or deceased uniformed service personnel.* Specify relationship and status of sponsor (i.e., “Son, AD AF E–2”, “Dau, Army 03.” If the sponsor is retired, specify that fact (i.e., “Wife, Army 05 (Ret).” If sponsor is deceased, specify whether active duty or retired at time of death (i.e., “Daughter, AF AD E–8 (Decd)”, or “Son, AF Ret E–9 (Decd).” *Civilian employees of the United States Government.* Show the Government department in which they are employed; for example, Govt Empl-State Dept, Govt Empl-Air Force. Overseas, if employee is a citizen of another country, specify that fact; for example: Govt Empl-Air Force-Germany. *Other status.* Give a brief description of each; for example, “civilian emergency”, “diplomat (specify what country)”, or “POW (specify nationality).” For foreign military personnel, enter the name of the country and the department; for example, “Belgian Air Force.” For female personnel discharged because of pregnancy, enter “discharged,” the branch of service from which she was discharged, and pay grade at the time of discharge; for example, “discharged/USN/E5.”
22	Inpatient Unit	The health care provider should enter the designation of the inpatient unit to which the patient is to be admitted. For example, 2E for inpatient unit 2 East. Enter CRO for carded for record only cases and ERD for patients that are emergency room deaths.
23	Facility of Initial Admission Code	If a patient is transferred to your MTF from another facility, enter the code of the facility that transferred the patient to your MTF. If the patient is not a transfer, leave blank.
24	Facility of Initial Admission	Enter the name or designation of medical treatment facility of initial admission (by transfer). Leave blank if the same as item 5.
25	Date of Initial Admission	Enter the day, month, and year of the first admission if the admission to your MTF is a continuation of treatment (by transfer) provided by another MTF. Leave blank if the same as item 7.
22	Room	Enter the room number of the inpatient unit to which the patient is admitted. If a room is not assigned, leave blank.
27	Bed	Enter the bed number to which the patient is assigned when specific bed assignments are made. If beds are not assigned, leave blank.
28	Prior Admission	Enter “yes” if patient has been admitted previously to your MTF; otherwise enter “no.”
29	Clinic Service(s)	Enter clinic service(s) responsible for the management of the patient. If transfers occur between clinic services prior to discharge, unit technician or nursing personnel write the new clinic service and date of transfer next to the previous clinic service entry. For example, “To Family Practice Services and transferred to Mental Health on 25 Apr 98.” This entry indicates that the patient was admitted to family practice and transferred to mental health on 25 Apr 98 for continuation of treatment. If you need more room, continue in item 40.
30	Admission Technician	Place your rank and name in this item.

Item Number	Title	Explanation
31	Emergency Addressee/ Relationship	Enter the complete name, address, phone number, and relationship of the individual(s) the patient wishes to be notified in case of emergency.
32	Name and Address of Sponsor	Self-explanatory. Leave blank if information is the same as in item 32.
33	Primary Admission Diagnosis	The health care provider places the diagnosis considered principally responsible for the patient's admission in this item.
34	Secondary Admission Diagnosis	The health care provider indicates, in this item, other diagnoses considered secondarily responsible for the patient's admission.
35	Cause of Injury	If the patient is treated for an injury or for any remaining effects of an injury, state the circumstances under which the injury was incurred, including intentionally self-inflicted injuries. In addition, include information on whether or not the patient was engaged in assigned duties. If the patient was engaged in assigned duties, state the nature of these duties in this item. If the patient was in an aircraft or motor vehicle accident, indicate the kind of aircraft or vehicle involved and the ownership (military or private). If you need additional space, continue in item 40.
36A and 36B	Personal Valuables/Privacy Act	The patient or sponsor must sign to indicate his or her desire to deposit valuables for safekeeping, and that the Privacy Act Statement (as shown in fig. 1–2) has been read and explained. This must be completed for all inpatients.
37	Name of Admitting Health Care Provider	The health care provider places his or her name in this item to authorize the admission.
40	Administrative Data	The entry in this area will be a matter of local policy. Many MTFs enter the patient's date of birth (DOB) and ID card expiration date in this area. You may use this item to indicate whether or not the patient or sponsor has third party (private) health insurance coverage.

If using CHCS, you may not remember the proper code or valid entry when completing the AF 560. That's okay; write down the information on the AF Form 560 to the best of your ability. When you key the information into CHCS remember the help option that we covered in volume 2 of the CDC. You can type "??" at any field and the CHCS help option will guide you along in the process.

229. Processing inpatients using the Composite Health Care System

As you may recall from Unit 1, the CHCS is an automated information system designed to support the administration and delivery of health care in MTFs including hospitals, outlying medical clinics, and selected outlying dental clinics. The CHCS supports most functions of the numerous administrative, patient care, and ancillary work centers of the MTF. It also facilitates the communication of information among the departments within each MTF.

An authorized user may perform functions from any CHCS terminal with the benefit of immediate access to shared integrated information accumulated by the CHCS from all of the work centers of the MTF. Using the CHCS, authorized users may communicate automatically with selected external computer systems such as DEERS to verify patient eligibility for care. Let's look at some Patient Administration Directory (PAD) options you would find helpful when admitting a patient. The PAD subsystem supports admissions functions through CHCS.

Bed status menu

The bed status menu (BSM) contains options allowing personnel to check bed availability on either a particular inpatient unit or all inpatient units. CHCS also enables users to reserve beds for incoming casualties. Once again, refer to figure 3–4 for a sample of the Ward Nursing Report.

Admissions, dispositions, and transfers

CHCS supports processing of inpatients through the use of options on the admissions, dispositions, and transfers (ADT) menu available in the PAD subsystem. Generally, when admitting a patient, the admissions technician will use the full registration option. Under certain circumstances the mini registration would be used during a mass casualty situation or in wartime scenarios.

The *admissions* option is used to admit individuals as inpatients to either activated or inactivated inpatient units. An activated inpatient unit is one where CHCS clinical (CLN) software has been enabled and patient orders are entered via the *Enter and Maintain Orders (ORE)* option. On the other hand, an inactive inpatient unit is a unit that is not clinically activated and requires PAD office personnel to write and activate inpatient ADT orders.

NOTE: Remember, a patient must be registered in CHCS before they can be admitted in CHCS.

Use the *interward transfers* option to process transfers to other inpatient units within the same facility. A clinically entered transfer order is required to transfer a patient to or from an active inpatient unit. Use the dispositions CHCS function to process dispositions. We will look at this in greater detail in a later unit.

Review pending ADT actions

Orders which have been clinically activated can be reviewed and processed by A&D personnel using the *review pending ADT actions* option.

Cancel ADT transactions

The cancel ADT transactions option is used to cancel admissions to, and transfers or dispositions from, inpatient units. Transfers and dispositions for active inpatient units can be canceled if the order has not been clinically activated. Admissions can be canceled as long as there are no active orders on the patient.

Corrections and ADT view

The *corrections and ADT view* option is used to view and correct current and historical data.

Reports

Within the PAD subsystem, there are various reports available for both on-screen viewing and for printing purposes. The ADT Processing Output Menu (AOUT) contains options that allow you to select and print diverse types of ADT reports while the Medical Expense and Performance Reporting System (MEPRS) Reports Menu (MOUT) contains options that allow you to choose among a list of MEPRS report outputs. Reports can be scheduled to print given any parameters you wish. For example, you can request a specific report be run (printed) on demand, nightly, weekly, or even on a monthly basis. The chart below shows the most commonly requested reports.

AOUT reports	***MOUT reports***
Admission and Disposition Recap by PATCAT	Clinical Record Cover Sheet
Admission and Disposition Report	Death Report
Admission by Diagnosis Report	Display Patient Diagnoses and Procedures
Admission Cover Worksheet	Disposition MEPRS Report
Admission Notification to Unit	Inpatient History Summary
Alpha Roster	Inpatients by MEPRS Report
Batch Consolidated Edits Report	MEPRS/Provider Days

AOUT reports	*MOUT reports*
Disposition Notice to Unit	Monthly MEPRS Detail Report
Emboss Card	Patient Category Billing Table
Future Dated Admissions Report	Patient Inactive MEPRS Summary
Inpatient Index Card	Monthly MEPRS Report
Medical Inpatient Treatment Recording Card	
Print Patient ID Label	
RON Roster	
TPC Insurance Worksheet	
Transfer Notice to Unit	
Ward Nursing Report	
Ward Roster	

If you have a need for additional information, or information presented in a different format, your information systems office can program CHCS to run what is known as "AD HOC" reports. AD HOC reports are reports tailored to meet a specific purpose.

CHCS admission notification letter

One of the most common documents printed in CHCS is the Admission Notification Letter. This letter serves as written notification that an active duty patient has been admitted. This letter is automatically generated every time a beneficiary code for an active duty person (F11, A11, N11, etc.) is entered for a patient admitted through CHCS and is sent to the patient's unit commander.

Admission and disposition report

Another report that is commonly used by MTFs and other base agencies is the admission and disposition (A&D) report. The A&D report is a daily report listing:

- admissions,
- dispositions,
- change of status,
- newborns, and
- interward transfers occurring in a given 24-hour period.

The A&D report is considered final when produced after midnight of the date of the report. The report itself has many headings and sub headings, depending on the military department and the activity that occurred. How the A&D report is distributed will be a matter of local policy, but in many instances it is reviewed by not only hospital personnel but also the patient's commanders, the MPF and others.

Note the signature block located at the bottom of the report. Amn Jones prepared and validated the information on the A&D Report. As stated previously, this document will ultimately be reviewed by the MTFs internal customers (MDG commander, MDG flight chiefs, etc) as well as our external customers (commanders of active duty patients, MPF personnel etc). This large responsibility usually falls on the shoulders of a junior HSM. Ensuring the information is correct is crucial to the success of the A&D office, as well as the success of the medical group.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

227. The admission process

1. Match each term in column B with its corresponding definition in column A. Each term may be used once or not at all.

____ (1) Column A

____ (1) Patients being evacuated from overseas or from one MTF to another.

____ (2) Individual receiving medical or dental care who do not require admission to an MTF.

____ (3) Change which may occur between the time of admission and disposition of a military patient

____ (4) Refers to a patient who is dead on arrival to the MTF.

____ (5) Military patient who has been a bed occupant and has reached a point of recovery where the physician considers it more desirable for the patient to have a period of recuperation and relaxation outside the MTF. The patient does not have to return to the MTF until this leave ends. This leave is not chargeable.

____ (6) Military patient who has been a bed occupant and has reached a point of recovery where the physician considers it more desirable for the patient to continue treatment at the MTF yet can live and eat outside the MTF. The patient is excused from duty, yet is required to meet with the physician frequently for continued care.

____ (7) Patient is alive upon arriving at the MTF, but dies before being admitted.

____ (8) Individual, other than a transient patient, who is admitted to a bed in the MTF. Also referred to as bed occupant.

____ (9) Movement of an inpatient from one clinic service to another.

____ (10) Movement of an inpatient from one unit (ward) to another.

____ (2)

Column B

a. Transient patient.
b. Carded for record only.
c. Outpatient.
d. Change of status.
e. Inter-unit (ward) transfer.
f. Subsisting out.
g. Inter service transfer.
h. Convalescent leave.
i. Inpatient.
j. Emergency room death.

2. What is the purpose of the disengagement statement on AF Form 560, Authorization and Treatment Statement?

3. What is another term used for a patient who is CRO?

4. Who assumes administrative responsibility for an active duty Air Force patient admitted to a non-military facility?

5. For what purpose is a register number used?

6. How are register numbers assigned to each inpatient case?

7. What directive guides medical facilities on the proper maintenance and disposition of a MTFs register of patients?

8. List the two methods used to identify the number of beds available on each inpatient unit?

9. What topics can the ward nursing report be broken down into?

228. Completing AF Form 560

1. What is used as the source document for entering admission information into the CHCS?

2. Match the description of items from part 2 of AF Form 560 listed in column A with the item listed in column B. Column B items may be used once or not at all.

Column A	*Column B*
____ (3)	a. Grade.
____ *(1) Leave this item blank until provided an appropriate entry by the CHCS.*	b. Type of case.
____ *(2) Enter "NB" for an infant born in your MTF.*	c. Register number.
____ *(3) Enter whether or not the patient has private insurance coverage.*	d. Length of service.
____ *(4) The term "DIS" (Disease) is used in this item.*	e. Age.
____ (4)	f. Administrative data.

3. Who completes the circled items found on the AF Form 560?

4. What type of case should be entered in item 8 of the AF Form 560 for a female patient being admitted for pregnancy?

5. What rank should be entered into item 11 of the AF Form 560 for an OSI agent?

6. The following letters in column A are valid entries placed in items 18 and 19 on the AF Form 560. Letters placed in item 18 represent a patient's marital status and letters place in item 19 represent a patient's race/color. Match each letter in column A with the item it represents in column B. Each answer item in column B may be used only once.

	Column A	*Column B*
____ *(1)*	*C*	a. Annulled.
____ *(2)*	*N*	b. Black.
____ *(3)*	*M*	c. White.
____ *(4)*	*R*	d. Divorced.
____ *(5)*	*X*	e. Western Hemisphere Indian
____ *(6)*	*Z*	f. Widowed.
____ *(7)*	*A*	g. Single, never married.
____ *(8)*	*D*	h. Asian.
____ *(9)*	*I*	i. Interlocutory.
____ *(10)*	*L*	j. Unknown.
____ *(11)*	*S*	k. Other.
____ *(12)*	*W*	l. Legally separated.

229. Processing inpatients using the Composite Health Care System

1. What is CHCS?

2. What external computer system does CHCS communicate with to process patient eligibility inquiries?

3. What CHCS subsystem supports admissions, dispositions, and transfers?

4. What is the purpose of the "Cancel ADT transactions" option?

5. What is an "AD HOC" report?

6. What letter does the CHCS produce each time an active duty patient is admitted as an inpatient?

7. Who receives the CHCS admission notification letter?

8. Which CHCS report lists admissions, dispositions change of status, newborns, and interward transfers occurring in a given 24-hour period?

3–2. Completing the Admission Process

Fortunately for us, most HSMs use an automated process to admit patients. The CHCS prints many of the required admission documents based on the information entered while admitting the patient. In this section, we will discuss some of the documents, files, and procedures involved in the admission process and some special notifications you *may* be required to make when admitting certain categories of patients.

230. Additional admission documentation

When you admit a patient, you will be required to generate numerous documents. Some will go to the inpatient unit with the patient; others will remain in the A&D office while still others are necessary for MTF personnel in other sections to accomplish their job.

Admission package

When the admission process is complete and the patient has had an opportunity to deposit funds, valuables, and store clothing or baggage that will not be stored on the inpatient unit, the patient is then referred to the appropriate inpatient unit. The following documents may be included in the admission package (you may have others depending on local policy), and accompany the patient to the inpatient unit along with any other pertinent documentation:

- AF Form 560.
- Pertinent admission records from clinic services (example: OB records).
- One index (locator) card. *
- AF Form 577, Patient's Clearance Record.
- Outpatient record.
- Other pertinent records as requested.
- Pertinent inpatient records of a patient who is transferred from another hospital.
- Emboss card.*
- Patient ID bracelet.*

*Indicates documents normally generated by CHCS.

Patient suspense file

The admissions and dispositions office normally maintains an administrative file on each patient. This file is commonly referred to as a *patient suspense file* and serves as a working site for all documents, communications, or administrative actions affecting the patient. It serves as a file for inpatient records while patients are absent from the hospital as part of their treatment, on leave, and so forth, and as a follow-up file to ensure administrative actions are carried out promptly when required.

The *suspense file* is generally maintained in a plain (manila type) folder or in a permanent-type cardboard folder with a visible cardholder and a movable signal on one edge.

Follow-up

After the patient's suspense file is established, determine whether any documents need to be sent to the MPF responsible for the patient's field personnel records. Also, review AF Form 560 for any line of duty status notations. If there is any indication that an investigation may be required, prepare a suspense for action to be taken as part of this program.

Disposition of the patient suspense file

When the patient is discharged, any information or material in the file is transferred to the inpatient record or to the field personnel record, or disposed of according to appropriate directives.

Master index of patients (MPI)

The MPI serves as an alphabetical index of all hospital patients and patients for whom administrative responsibility is assumed (e.g., active duty military in nonfederal MTFs). MTFs with CHCS may establish an automated MPI for new patients.

Composition

The master index is a 3×5–inch index card file containing two sections—the active section and inactive section. Each section is arranged alphabetically according to the patient last name. The active section contains cards for all hospital patients currently under treatment, or for patients for whom the facility has assumed administrative responsibility. The inactive section contains cards for patients no longer under treatment as an inpatient in your MTF (discharged).

Keeping the index current

When a patient's locator card is received from admissions, the inactive section is checked to determine whether a card is present from a previous admission of this patient. If a card is found, it is removed and information including all previous registration numbers, dates, admissions, and departures, are posted to the new card and the old card is destroyed. The card is then filed in the proper alphabetical sequence in the active section of the file.

When the patient is discharged, the card is removed from the active section, annotated to show the disposition, and filed in the proper alphabetic sequence in the inactive section of the index.

Information file

If your facility maintains a separate information section (information desk), maintain a separate alphabetical locator file using an imprinted index card. The admission office promptly sends a copy of a patient locator card to the information section after the admission of each patient.

The information section uses the daily admissions and dispositions report to update and maintain the file. Upon notification of the patient's disposition or change of status, move the appropriate locator card to an inactive file.

Patient control file

The patient control file is an inventory of patients covering a 24-hour period (0001 through 2400 hours), indicating which patients are bed occupants, subsisting out, on leave, AWOL, nonmilitary hospital patients, etc.

Divide the file into sections and subsections that include patient groups you used in preparing the A&D report. Large hospitals may find it desirable to further subdivide these sections, while small hospitals may find that only a few of the sections or subsections are sufficient.

If you have several patient locator cards in any one section or subsection, you may find it easier to locate the patient card by filing it in alphabetical order.

231. Special admissions procedures

Under certain circumstances, you will find additional steps in the admissions process may be required. Some patients must be processed differently because of their status, duty requirements, or duty location.

Military patient admission

When an active duty member is admitted to a military MTF or any civilian hospital, the member's unit commander must be informed of the admission. This is done by contacting the squadron or unit of assignment by telephone and CHCS admission notification letter or priority electrical message (military electrical messages can be compared to sending a telegram in the civilian community). Documentation of the telephone call or a copy of the message is placed in the active duty member's

suspense file. The patient's unit commander may also be notified, in writing, using the admission notification letter generated by CHCS.

Active duty in a nonmilitary hospital

When an Air Force active duty member is hospitalized in a nonmilitary MTF (except in those cases where the active duty member elects to obtain civilian care at his or her own expense), the commander of the nearest Air Force MTF assumes medical administrative responsibility for the patient. You will find yourself working closely with the resource management office (RMO) and the patient's physician to keep track of the patient's status. For example, it might be necessary to aeromedically evacuate the patient from the nonmilitary facility to an Air Force MTF (we will discuss this more in a later unit). Inform the civilian physician that it is Air Force policy to transfer any active duty member to a military hospital as soon as possible without endangering the life or adversely affecting the prognosis. Remind the physician that you need a complete summary of the patient's treatment from the civilian provider. The RMO needs to be aware of the patient's status at all times. Once the patient is transferred from the nonmilitary facility, it is your job (along with the RMO) to ensure the medical documentation related to the hospitalization is forwarded to your office.

As the admissions and dispositions technician, you will also be the focal point to bridge the gap between the civilian provider and a military provider assigned to your MTF. When discussing such topics as when a military member should be transferred via aeromedical evacuation or when medical treatments are to be performed, you will need to ensure a physician to physician link is established. In many MTFs this is accomplished through the chief of medical services.

Information needed

When you are notified that an active duty member is admitted to a nonmilitary hospital, obtain the following information by telephone:

- Information on the patient's diagnoses, any procedures performed and prognosis.
- Full patient identification (name, grade, SSN, duty station) from the facility and promptly notify the patient's unit commander.
- Name/telephone number of civilian attending physician.

The civilian hospital is reimbursed for the patient's care based on the Diagnosis Related Group (DRG). A complete summary of the patient's treatment while under the care of the civilian health care provider is required after the patient has been discharged. A Standard Inpatient Data Record (SIDR) will be transmitted. However, the complete summary is not required before the SIDR can be transmitted.

Advise the health care provider that a complete summary of the patient's treatment while under their care is required and how and where to submit bills.

The Military Medical Support Office (MMSO) is responsible to notify the MTF with geographic responsibility of all unscheduled admissions of TRICARE Prime Remote (TPR)/Geographical Separated Unit (GSU) personnel admitted to non-federal medical facilities so that facility may assume administrative and clinical oversight of that patient's care.

AF Form 560

Admission to a nonmilitary hospital still requires completion of section I of the AF Form 560. If the MTF utilizes CHCS then the information must be input into the system.

Information plate

Although the active duty patient was admitted to a civilian MTF, you must still prepare one 5-line plate (plastic card) with the information from the AF Form 560 for use in the A&D office.

Patient suspense file work sheet

When locally desired, a patient's suspense file work sheet is prepared for the patient's suspense file. This may be used to note specific events of an administrative nature that may affect the patient's case.

Other procedures

Be sure to accomplish the following procedures, as necessary:

- Ensure prompt notification of the member's unit commander.
- In case of serious illness or death, make appropriate notifications.
- Arrange for movement of the patient to a military hospital when movement can be made without endangering life or adversely affecting the prognosis.
- Obtain a medical summary of patient's treatment from the nonmilitary MTF or attending physician.
- Initiate AF Form 348, Line of Duty Determination, when necessary.
- Initiate AF Form 438, Medical Care—Third Party Liability Notification, if applicable.
- Enter the information into the CHCS, print the appropriate documents and reports, and be sure that the patient is reflected on the CHCS admissions and dispositions report.
- Complete vouchers for payment of civilian medical bills.
- Ensure appropriate entries are made in the patient's military medical records.

Generals, colonels, and other prominent persons

Notification procedures for generals, colonels and other prominent persons can be divided into two sections. The first is *local procedures*. Locally, the admission technician must notify the MDG/CC when the following personnel are admitted to an MTF:

1. General Officer (GO): Includes all Active Duty, ARC, and Foreign General/Flag Officers (grade 07 and above).
2. Colonel: Includes Air Force active duty that are very seriously ill (VSI), seriously ill (SI), expected to be hospitalized greater than 10 days, or given a profile change because of any medical or surgical condition affecting the member's assignment availability. Also includes any colonel that is a member of the Air Force Medical Service (AFMS) that has been admitted as an inpatient.
3. Prominent Persons: Includes Senior Executive Staff (SES), political officials, high-ranking public officials, and current Chief Master Sergeant of the Air Force (CMSAF). Notifications for this category other than the CMSAF require the patient's authorization.
4. The admissions technician will provide sanitized information by telephone. This information should be made within 12 hours after admission. Sanitized information can be described as patient's name, rank, age, unit of assignment, and date of admission or treatment.

The MDG commander will notify the Installation commander via appropriate information conduits, keeping release to the minimum necessary.

The second type of notification is *HQ AF notification* when a general/flag officer, colonel or prominent person is admitted. Comprehensive (as opposed to sanitized) information will be provided by telephone to HQ AF/SGXO-MOC by 0600 eastern standard time (EST) following admission. Comprehensive information can be described as patient's name, rank, age, status, unit of assignment, date of admission/treatment, diagnosis, current medical status, and projected length of stay

Updates as to the status of the patient will occur daily and be submitted by 0600 EST to HQ AF/SGXO-MOC. Medical staff personnel familiar with the patient's case (nurse manager or attending physician) should present these updates.

Preadmissions

Preadmission of patients is recommended whenever practical. There are three distinct advantages of using preadmissions:

1. It reduces patient waiting time
2. Reduces patient stress on the day of admission
3. Admissions personnel can process patients more effectively.

A health care provider may see a patient in the outpatient clinic and plan to admit the patient at a later date (i.e., a patient scheduled for surgery). To help speed up the process and reduce the amount of stress to the patient, the physician may complete the admission paperwork in advance.

For preadmission cases, the patient presents four copies of AF Form 560 to the A&D technician. Complete section I of AF Form 560, *except* for the:

- register number,
- date, and
- time of admission.

Keep the patient's preadmission forms in a suspense "reminder" file in your admissions section. Use local procedures in completing the record and monitoring the file. When the patient returns for hospitalization, complete the record IAW the standard admissions process.

Return to hospital from leave, AWOL, subsistence out

The patient reports to the A&D section. The admissions technician completes two copies of AF Form 564, Return of Patient Record, attaches the original copy to the inpatient record, and hand carries the duplicate copy to the inpatient unit.

The duplicate of this form is given to the patient control technician to keep the patient control file current; it is then forwarded to the dispositions section for file in the patient's suspense file. The inpatient record of a patient on leave, AWOL, or subsisting out, is held in the patient's suspense file during their absence.

Inpatient records of subsisting-out patients may be held in clinic services during the patient's absence, if locally desired. If using this approach, the records are obtained from the clinic by the admissions section when the patient reverts back to a hospital bed status or is discharged from treatment.

From nonmilitary hospital to military MTF

The patient transferring in to your MTF reports to the admissions section (if possible, if not unit personnel will complete appropriate procedures). The admissions technician updates the AF Form 560 to indicate the status change and completes other forms required to complete the admission as necessary. The patient is then processed as an initial admission to your hospital.

Army and Navy personnel

Upon notification that an Army or Navy active duty member is hospitalized in a nearby nonmilitary medical facility, the commander (or authorized representative) of the Air Force MTF accomplishes the following:

- Obtains the patient's diagnosis and prognosis; informs the attending health care provider that it is Air Force policy to transfer Air Force patients to a military hospital as soon as possible without endangering the life of the patient or adversely affecting the prognosis.
- Advises the health care provider that a complete summary of the patient's treatment while under their care is required and how and where to submit bills.
- Obtains full patient identification from the facility and promptly notifies the patient's unit commander.

These are the same procedures as described for Air Force active duty members admitted to non-military facilities. The Air Force MDG/CC is responsible for ensuring the nearest Army or Navy MTF is notified. If requested by another service, the AF MTF can assume medical administrative responsibility for the patient and keep the designated parent service representative informed as to the status of the patient.

USTF or VA hospital

When notified of an active duty Air Force member hospitalized in a Uniformed Service Treatment Facility (USTF) or VA hospital, the commander of the nearest Air Force MTF assumes medical administrative responsibility for the member and arranges transfer to a military hospital (preferably Air Force). Although USTF and VA hospitals are federal medical facilities, they are *not* military hospitals and, because of military control factors, active duty Air Force members should be transferred to military hospitals as available space and facilities permit.

Exception: All continental US (CONUS) medical facilities and selected overseas facilities are authorized to transfer drug and alcohol abuse patients to VA hospitals pending administrative separation.

Air Force personnel admitted in an Army or Navy hospital

When notified that Air Force members have been admitted to an Army or Navy hospital, the nearest Air Force MDG/CC assumes medical administrative responsibility and ensures the following procedures are completed:

- Maintain liaison with the Army or Navy hospital on behalf of Air Force patients.
- Keep rosters and pertinent data on hospitalized Air Force patients and ensures notification of the Air Force member's unit of assignment.
- Initiates AF Form 348 on potential line of duty cases.
- In seriously ill or death cases, makes appropriate notifications.
- In cases of prior civilian hospitalization, ensures compliance with appropriate provisions of current Air Force directives.
- Makes notification to wing safety officer in accident cases.
- If the patient is to be hospitalized 90 days or more, initiates reassignment to the patient squadron of the responsible Air Force MTF.

Infants

Infants born outside the MTF (i.e., at home or en route to the hospital) are admitted as "liveborn" when admitted with the mother for post-partum care. Admission must occur within a reasonable period after the birth. Verify the delivery in the military hospital was intended and process the same as for infants born in the hospital.

If the admission and birth occurred in a civilian hospital and the mother and baby are later transferred to the military MTF, admit the infant as a direct admission (not a "liveborn"). When a newborn infant is transferred to another military MTF, the receiving MTF admits the infant as a direct admission (tranfer-in).

Military patients hospitalized in excess of 90 days

When a patient is expected to be hospitalized over 90 days, notify the individual's servicing military personnel flight (MPF) as quickly as possible. If reassignment occurs due to hospitalization in excess of 90 days, the MPF will be notified to allow them ample time to swiftly issue PCS orders and have personnel records, military pay records, and so forth, sent to the appropriate base.

232. Patient valuables

Each inpatient is given an opportunity to deposit their valuables for safekeeping with the custodian of patient valuables. The patient (or sponsor) signs the AF Form 560, and indicates whether or not they desire to deposit valuables. If a patient remains in your hospital for any significant period, you can be sure that they will want to either withdraw part or all of their valuables at one time or another. The system used at your facility must be flexible enough to permit these types of transactions. Remember, flexibility and convenience should be directed towards our patients schedule and not the medical staff. We are employed to serve our customers and should make every attempt (within reason) to make their stay as pleasant as possible!

Responsibilities

The MDG/CC has the authority and responsibility for accepting patient valuables for storage and safekeeping. However, the MTF commander normally delegates this authority in writing to a custodian of patient valuables and an alternate custodian. The custodian or their alternate performs the actual duties associated with patient valuables. The appointment as a custodian or alternate custodian of patient valuables is not restricted to rank or grade.

Accepting valuables

The term “valuables” refers to cash, jewelry, and other articles of a similar nature. The phrase “other articles of a similar nature” indicates that the patient and the custodian may use their judgment in determining what patient items or personal property are valuable. A patient’s personal property, other than valuables (such as clothing), is normally stored either on the patient’s unit or even in a centralized baggage/clothing room (depending upon the space available on the inpatient unit). But, there may be certain property you would not accept for storage in the medical facility. Check with your MTF’s local procedures to identify what items are not accepted (normally firearms and other weapons), and what procedures to follow to safeguard those items.

Inspecting

Each month the MDG/CC appoints a “disinterested” officer, NCO (E–5 or above), or a civilian with comparable grade, to perform an inspection of patient valuables. In almost all instances you will find this task falls on the shoulders of the NCOs. The term “disinterested” means the individual is not involved in accepting and protecting patient valuables. During this assessment, the inspector audits and checks patient valuables, related records and forms to ensure they are being adequately controlled and protected.

NOTE: According to AF directives, officers and civilian equivalents may accomplish this task, yet rarely do.

Documentation

There are three forms commonly used in safeguarding and controlling patient valuables:

1. AF Form 1052, Envelope for Storing Patient’s Valuables.
2. AF Form 1053, Record of Patients Storing Valuables.
3. DD Form 599, Patient’s Effects Storage Tag.

AF Form 1052

The AF Form 1052 is an envelope used to store smaller valuables such as money, watches jewelry etc. It is also used as a record of each patient’s valuables deposited at your MTF. The form can be broken down into three different sections:

1. The top section contains MTF, and patient identification information.
2. The middle section is a record of monetary transactions (similar to a checkbook ledger).

3. The bottom section is a record of transactions for other valuables (other than money) that will be stored in the MTF. Let's take a closer look at the completion of the AF Form 1052.

Number

The resource manager or other specified individual will issue a serial number on each AF Form 1052. The numbering format of the AF Form 1052 will be based on your local procedures.

Medical facility

Enter the name of the admitting MTF.

Last Name, First Name, Middle Initial

Enter the patient's name, in the format requested.

Register number

Enter the register number from item #1, AF Form 560.

Date column

Enter the date the transaction is taking place.

Deposit column

Enter the monetary deposit the patient is making for safekeeping.

Withdrawal column

Enter the monetary withdrawal the patient is making.

Balance

Enter the balance after the deposit or withdrawal is complete.

Signature (Depositor/Withdrawer) column

Ask the patient or his or her designee to sign for the transaction.

Initials of custodian column

The patient valuables custodian should place their initials in this column for the transaction.

Valuables (In/Out) column

Indicate on the first line the date the first valuable is being deposited (The second line is completed when the patient is withdrawing the first valuable).

Description

Enter a brief description of the valuable being deposited. Try to stay away from using terms such as gold ring, silver bracelet, diamond earrings and so forth. Instead, describe valuables using terms such as "gold-toned ring, diamond-like earrings," and so on. Since most of us are not experienced jewelers we cannot determine the authenticity of jewelry. If the item is a piece of electronic equipment such as a camera, camcorder, or radio, enter a description of the item and serial number.

Once each item has been identified on the AF Form 1052, the top copy is torn off and given to the patient or patient's representative for safekeeping. When the patient wishes to withdraw some or all of their valuables, he or she should give you the top copy of the AF Form 1052. You should then place the top copy over the carbon paper, and make the appropriate entry. After each transaction, give the top copy back to the patient for either the next withdrawal or final withdrawal.

DD Form 599, Patient's Effects Storage Tag

You may be thinking, "How can a radio or a camcorder fit into a 6½ ×9 inch envelope like the AF Form 1052?" Unless the item is very small, it cannot. That is why we use the next form, a DD Form

599. The DD Form 599 is a small tag that is completed, and attached to each item that cannot be placed in an AF Form 1052. Let's take a look at each item on this form.

Name

Enter the patient's name.

Service No., SSN, or Cat of Personnel

Enter the sponsor's social security number.

Date Received

Enter the date the valuable was deposited with you.

Rack or Bin

Enter the number from the upper right hand corner of the AF Form 1052.

Hospital

Enter the hospital's name where the patient is being admitted.

Signature of Patient (Upon Withdrawal)

This area is left blank until the patient withdraws the item from you.

Patient's Stub

The bottom portion is completed as above and given to the patient.

Once the DD Form(s) 599 is completed, annotate the DD Form 599 number (located in the upper right hand corner) on the AF Form 1052 on the Description/DD Form 599 line. By doing so, you have a cross-reference between the DD Form 599 and the AF Form 1052.

NOTE: Remember, every time a DD Form 599 is used, you must also use an AF Form 1052 (even if it is empty).

AF Form 1053

The last form we will discuss is the AF Form 1053, (fig. 3–5). This form serves as a log of each patient who has deposited valuables in your facility.

RECORD OF PATIENTS STORING VALUABLES
(All entries are to be made in ink.)

MEDICAL FACILITY: San Antonio Military Medical Center | FY: 15 | PAGE: 1 of

DATE OF DEPOSIT	SIGNATURE OF PATIENT	ENVELOPE NUMBER	INITIALS OF RECIPIENT	DATE RELEASE	SIGNATURE OF PATIENT OR DESIGNATED REPRESENTATIVE	INITIALS AND DATE: CUSTODIAN	INITIALS AND DATE: INSPECTOR
20150601	[illegible]	15 06 101	SR	150601	[illegible]	SR	CR 15 Jun 15

AF IMT 1053, 19750801, V1 PREVIOUS EDITION WILL BE USED

Figure 3–5. Record of Patient Storing Valuables

Medical Facility

Enter the medical facility's name.

FY

Enter the current fiscal year.

Page

Enter the page number. For example, if you have already completed three AF Forms 1053 this fiscal year the correct entry would be "13."

Date of Deposit column

Enter the date the patient is depositing their valuables with you.

Signature of Patient column

Ask the patient or his or her representative to sign, indicating they are depositing valuables with you.

Envelope Number column

Enter the number from the upper right hand corner of the AF Form 1052.

Initials of Recipient column

The patient valuables custodian should enter his or her initials.

NOTE: This is the last entry made when a patient is depositing valuables. The following columns are completed when the patient is withdrawing all of their valuables from you.

Date Released column

Enter the date the patient is withdrawing all of their valuables.

Signature of Patient or Designated Representative column

Ask the patient to sign when they are withdrawing their valuables from you.

Initials and Date columns

The custodian enters their initials when the patient has withdrawn their valuables. The second subcolumn, "Inspector" is completed upon the monthly inspection of the patient valuables program.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

230. Additional admission documentation

1. What items in the admission package may accompany the patient to the inpatient unit?

2. What is the purpose of the patient suspense file?

3. Describe the contents of the master index of patients.

4. What is the patient control file?

231. Special admissions procedures

1. Who must be notified whenever a military patient is admitted to the hospital? How is this notification made?

2. Who assumes medical administrative responsibility of an active duty Air Force member admitted to a nonmilitary hospital?

3. What information is needed when an active duty member is admitted to a nonmilitary hospital?

4. On preadmission cases, which blocks are left blank when completing part 1 of AF Form 560?

5. When an active duty patient is to be hospitalized over 90 days, what organization should be notified?

232. Patient valuables

1. Who has the responsibility for accepting patient valuables?

2. Who normally performs the actual duties associated with patient valuables?

3. What does the term “valuables” mean?

4. How often is an inspection of patient valuables conducted?

5. What criteria does the MDG/CC use to appoint an individual to perform an inspection of patient valuables?

6. For what purposes are the following forms used:

   (1) AF Form 1052.

   (2) AF Form 1053.

   (3) DD Form 599.

3–3. The Disposition Process & Special Notifications

It is recommended that patients should be discharged on normal duty days (Monday through Friday), during normal duty hours. This allows the patient to clear through all appropriate offices that may be closed otherwise. If a patient is discharged after normal duty hours, the inpatient record should still be completed by the appropriate personnel on the inpatient unit and sent to the disposition technician as soon as possible.

Some MTFs allow patients to do a pre-discharge clearance when it is known that the patient is being discharged after duty hours, or on weekends or holidays. This process allows the patient to perform most of the clearance process before the end of the duty day or on the last duty day before the weekend or holiday.

233. Patient dispositions

The health services management journeyman in the dispositions office usually is the last contact the patient will have with a member of the hospital staff. As such, you must ensure the inpatient record is complete and the patient is processed quickly and efficiently.

It is important for you to remember that the patient is probably very eager to get out of the hospital and you must do what you can to make the disposition process as smooth as possible. Keep in mind that the patient's last interaction with the medical staff will be based (in part) on their (the patient's) interface with the dispositions technician. This is where your interpersonal relations training received in technical school and in volume 1 of your CDCs, coupled with your professionalism, will pay dividends to the entire medical staff!

Categories of disposition

The removal of a patient from inpatient treatment is termed a disposition or discharge. A patient removed from care in an Air Force MTF may be discharged to duty or home, transferred to another MTF, separated or retired from military service (for active duty), or possibly, died. Some examples of patient dispositions include the following:

Disposition	Applies to
Return to duty.	Military patients only.
Discharge from treatment.	Nonmilitary patients only.
Evacuate to US.	All patients returning from an overseas MTF.
Separate or retire due to physical disability.	Military patients only.
Transfer out by aeromedical evacuation or other means to another military, government, or civilian MTF.	All patients.

Military in a nonmilitary hospital

Active duty members hospitalized in nonmilitary (civilian) hospitals must be returned to a military MTF when the patient's condition allows such a move. When a military patient is moved to a military MTF from a civilian MTF, this transaction is considered a change of status, *in*. When the patient is ready to be discharged from the MTF, the transaction is treated like a normal disposition.

Closing the suspense file

The dispositions office technician will enter the time and date of discharge, and place their initials on the AF Form 560. Once these actions are complete, the patient may be released.

Pertinent information is removed from the patient suspense file and placed in the inpatient record, which is then sent to the inpatient records section for review and final action. For active duty military personnel, information relating to personnel actions is sent to the MPF for inclusion in the patient's field personnel records. Other extraneous information is destroyed.

Completion of AF Form 560

In the previous unit, we discussed the completion of items 1 through 37 of AF Form 560 for admission of patients to the hospital. When the patient is discharged, the health care provider must complete the remaining entries on the form to reflect the diagnoses, treatment, and other data related to the patient's case. You will be required to check the AF Form 560 for completeness and may be asked to assist the provider with the completion of the form.

The AF Form 560 is primarily a worksheet and a source of information for entry of data into the CHCS. Once the provider has completed the AF Form 560, inpatient records personnel use the form to complete the remaining contents of the inpatient record and to code the patient's record using a classification system that we will discuss in the next unit. Let's review items 38 through 48 so you know what entries are needed and how the information is obtained.

Item 38, Diagnosis—Procedures

The primary health care provider should write in all diagnoses and surgical procedures related to the patient's hospitalization. The principal diagnosis should be listed first, followed by any secondary diagnoses. Surgical procedures are also identified. Surgical procedures should be numbered with the principle procedure listed first, and then those that are associated procedures. Inpatient records

personnel enter the International Classification of Diseases–9th Revision Clinical Modification (ICD–9 CM) code that corresponds with the diagnoses and procedures listed by the provider. These numeric codes are used to enter the diagnoses and procedures into the CHCS. Here are some helpful hints to ensure conformity is used when listing diagnoses and procedures:

1. A battle injury always takes precedence over any other condition.
2. If two or more unrelated conditions were present at the time of admission, designate as the principal diagnosis the condition that caused the patient's admission.
3. If a surgical procedure is performed immediately prior to admission to the hospital, record on AF Form 560 the diagnosis and procedure responsible for the patient's admission to the hospital. Indicate where the procedure was performed (for example, "Impacted teeth, 1. Extraction of teeth, 22 Sep 2013, in dental clinic").
4. Below the diagnoses present on admission, record any diagnoses for conditions arising after admission.
5. *Do not* list diagnoses that relate to an earlier episode that *do not* affect the management or treatment of the patient during this hospital stay.
6. Be sure to list any history of organ transplant, personal history of malignant tumors, or presence of a cardiac pacemaker.

Item 39, Providers of care

The primary provider of care is the person signing the AF Form 560 in item 47, Signature of Attending Health Care Provider, unless the person specifies in item 39 that someone else should be given primary credit for the case. If other providers participated in this case, the method listed below should be followed to ensure they receive proper credit. If entries are not made in this item, other providers that participated in the case will not receive credit. The primary provider or other providers who shared in the responsibility for the case make entries in this item. The SF 516, Medical Record–Operation Report (fig. 3–6), may be reviewed to determine the surgeon and assisting surgeon for cases involving surgical procedures. However, it is the responsibility of the health care providers to make the identification of shared responsibility. Consultants are generally not considered to have shared responsibility unless they participated in providing care for the patient. Here are some tips on the identification of providers in item 39:

1. If any procedures were performed, list the number of each procedure in item 39 and then the provider's name. If more than one provider is listed for a procedure, the first provider is considered the primary surgeon for the procedure and the other providers listed will be given credit as assistant surgeons. Anesthesiologists are listed last for each procedure.
2. After the procedures and providers are listed, other providers who shared nonsurgical responsibility in the case are listed. It is not necessary to list providers who have already been listed under at least one procedure.
3. If there are no procedures in the case and no other providers are listed in item 39, it is assumed that the primary provider (the person that signs item 47) is the only provider on the case. (see fig. 3–6)

NSN 7540-00-634-4150

MEDICAL RECORD	OPERATION REPORT

PREOPERATIVE DIAGNOSIS

Progressive Abdominal, oliguria and tachycardia of sepsis

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
ANESTHETIST	ANESTHETIC		TIME BEGAN: 0835
Maj Colin Cape	GETT		TIME ENDED: 1057
CIRCULATING NURSE	SCRUB NURSE	TIME OPERATION BEGAN	TIME OPERATION COMPLETED
Capt T. Mann	MSgt A. Williams		1045

OPERATIVE DIAGNOSES

1) Omental Necrosis
2) Ascites

DRAINS (Kind and number)	SPONGE COUNT VERIFIED
16-FR Foley, NG Tube, 16 FR Tube	Correct

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

1) Omentum

OPERATION PERFORMED

1) Exploratory Laparotomy
2) Excision of necrosed omentum
3) Placement of jejunostomy feeding tube

DESCRIPTION OF OPERATION (Typeset of suture used, gross findings, etc.)	PROSTHETIC DEVICES (Lot no.)	DATE OF OPERATION
	None	04/01/2013

35 YO black male approximately five-days ago underwent right hemicolectomy for treatment of colon cancer. Post operatively the patient underwent procedure without complications. Patient began having abdominal pain on day three after procedure. Radiologic procedure identified possible small bowel obstruction with no distal air.

Description of Operation: After consent, patient was brought to operating room and placed in supine fashion. Abdominal wall was prepped for procedure after GETT anesthesia was administered. Incision was then extended to cephalad for approximately 8 cm. A Bookwalter retractor was them used to place self retaining retractors for exposure of abdominal cavity.

Abdominal exploratory was performed. A large amount of fluid was discovered. A feeding jejunostomy tube proceeded a significant amount of inflammation within the abdominal cavity gave the impression that this would be quite prolonged ileus, and the patient had already been without nutrition for close to one-week.

Staples and retention sutures were then secured. Area was cleaned and dried. Sterile dressing were applied and the patient was taken to the recovery room in stable condition.

Complications: None

SIGNATURE OF SURGEON	DATE
[redacted]	04/03/2013

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date hospital or medical facility)	REGISTER/I.D. NO.	WARD NO.
Witt, Scott 20/123-45-6789 12345 San Antonio Military Medical Center San Antonio, Texas	12345	2B

OPERATION REPORT
Medical Record

STANDARD FORM 516 (REV. 5-62)
Prescribed by GSA/OMR
FPMR (41 CFR) 101-46.505

Figure 3–6. SF 516, Operation Report

Item 40, Administrative data

This item is used to record various types of data that relate to the patient's case and are not recorded elsewhere. The following describes the type of information that may be recorded in this block:

1. The primary provider enters a statement regarding the change or lack of change in physical profile of active duty patients, when applicable.
2. The nature and date of medical or physical evaluation board proceedings.
3. Dates of changes in patient status such as leave, subsisting out, AWOL, etc.
4. If the patient was discharged to duty to await final action on Physical Evaluation Board (PEB) recommendation, enter this fact and any limitations or restrictions concerning performance of duty. The inpatient record is then completed in the CHCS. Upon receipt of the final PEB results, the record is updated in the CHCS and a new record of inpatient treatment (cover sheet) is printed containing the results of the PEB.
5. Summary of movement of patient. For a patient admitted by transfer, enter a summary of patient movement during the current continuous period of treatment. Include the designations and locations of all places of treatment, with dates and statements of the methods of transportation employed. For example:

   "Initial Admission 15 Apr 2011—Mather AFB CA.
   Trf. by Ambulance 16 Apr 2012—Travis AFB CA.
   Trf. by Air 19 May 2013—Lackland AFB TX."
6. For cases in which third party liability is involved, enter the statement: "Third Party Liability."
7. Use when patients are classified as:
   - emergency room death or CRO (patients brought to the MTF alive but die prior to admission), or
   - outpatients, who die in an outpatient clinic.

   Record the above information in item 40 for example, "ERD at 0927 on 1 May 12."
8. Other information. Enter supplemental information to prevent misinterpretation of entries or omissions. Note the following examples:
   - Infant died on (date).
   - Mother previously discharged on (date).
   - Patient was treated as an outpatient from date of injury until date of admission.
   - Newborn infant transferred unaccompanied by mother, or mother transferred unaccompanied by infant.
9. If a discharged patient returns the same day for further inpatient care, the patient is *not* readmitted. The disposition is canceled, the inpatient record is reopened using the same register number, and the case is handled as a continuation of hospitalization. Make certain this fact is recorded in item 40.

Item 41, Disposition

The nature of the patient's disposition is entered this item. For example, "Duty" or "Transfer." If you need additional space, continue in item 40.

1. When a patient is transferred to another MTF, show the disposition as "*Transfer to _____Hospital*."
2. When a patient who is not on active duty is discharged from inpatient treatment, show the disposition as "*discharge*" *or* "*home*."

3. When a patient is retired or separated for physical disability, state whether the retirement is *permanent* or *temporary*, or whether the separation is *with* or *without* severance pay**.**
4. If a patient (other than active duty) leaves the hospital against medical advice, record that fact with the date and time for example: *Patient discharged against the advice of primary health care provider (Dr Smith) on 3 Jun 12 @ 0715.*
5. For a case terminating in death, record that fact and indicate whether or not an autopsy was done. For example, "*Died 1600 hrs, 4 Jul 13, Autopsy: No*."

Items 42 through 48

The following table describes the entries you make in the remaining items on AF Form 560.

Item No.	Title	Entries
42	Date of disposition	Enter the day, month, and year of disposition from your medical treatment facility; for example 11 Jan 02.
43	Time of disposition	Enter the time of disposition from the medical treatment facility. For example, "1355", or "0023."
44	CC of whole blood	The physician will make an entry as to how many CCs of whole blood were administered to the patient.
45	CC of packed cells	The physician will make an entry as to how many CCs of packed cells were administered to the patient.
46	Convalescent leave	Enter the number of days of convalescent leave actually taken by an active duty military patient prior to discharge from patient status. Also enter the number of days of convalescent leave that the attending physician recommended be given to military patients upon discharge from patient status. There is no requirement to check whether the leave was actually granted.
47	Signature of attending health care provider	The provider primarily responsible for the patient's case signs item 47. Records prepared for military personnel treated in nonmilitary facilities must be signed by a physician designated by the commander. This physician ensures that necessary profile changes, convalescent leave requests, Medical Evaluation Board (MEB) or PEB actions, and other physical standard actions are taken as required.
48	Signature of TRICARE services official	This signature is not required on AF Form 560.

Disposition data in the CHCS

Patient dispositions are also recorded in the CHCS using the completed AF Form 560 and the inpatient record as source documents. By following the "ADT" menu followed by the "DIS" or dispositions menu you will be able to access the disposition processing features of the CHCS. These features allow the user to

- enter information about a patient's discharge from your MTF;
- view or update disposition data; and
- cancel a previous disposition, if necessary.

The disposition technician is the patient's last contact prior to disposition and they are responsible for consolidating all of the inpatient record documents prior to submission to the inpatient records section. The disposition technician also ensures the disposition information is entered into the CHCS.

234. Special notifications

While working in the A&D office, you will (at times) be required to make special notifications as to the condition of certain patients admitted to your MTF. Wing, group and squadron commanders alike must always be aware of the status of their human resources. If you are serving in the capacity of the casualty assistance representative this task will be yours. Commanders are not the only personnel

outside of the MTF who should be informed in these situations. Local policy may dictate others such as the base chaplain or the MPF are contacted. Additionally, civilian authorities may need to be contacted in certain death cases. The information provided below will serve as a road map to these sensitive yet ever-important tasks.

Reporting casualties and deaths

Because of their condition, special notification and reporting is required when patients are admitted for serious conditions or when a patient's condition changes after admission. The MDG/CC relies on the judgment of the provider staff and the health services management team, to ensure these notifications are made. The focal point for casualty status notifications is usually a health services management specialist in the admissions and dispositions office or on the inpatient unit. This program requires a considerable amount of coordination with individuals outside of your MTF.

Patient categories

Patients requiring special casualty reporting fit into several categories (as determined by a health care provider). A patient is reported as:

- *Very seriously ill (VSI)* when the patient's physical condition, whether due to illness or injury is so severe that there is imminent danger to life.
- *Seriously ill (SI)* when the patient's is one whose illness or injury is so severe that there is cause for immediate concern but there is no imminent danger to life.
- *Incapacitating illness or injury (III)* when the hospitalized patient is not classified as VSI or SI by competent medical personnel, but whose illness or injury have the following characteristics:
    1. Involves serious disfigurement.
    2. Results in loss of a major extremity.
    3. Causes major loss of sight or hearing.
    4. Renders the patient physically or mentally incapable of communicating with the next of kin (NOK).

When a health care provider makes the decision to report a patient in SI, VSI, or III status, they will make the appropriate entry in the patient's inpatient record on AF Form 3066, Doctor's Orders.

Unit personnel

Unit personnel are responsible for preparing an original and one copy of AF Form 570, Notification of Patient's Medical Status. The original is sent to the casualty affairs liaison (CAL) so the appropriate notifications may be made, and the copy is placed in the patient's inpatient record.

CAL

When notified (by receipt of an AF Form 570) of a SI, VSI, III or a deceased patient, notify all interested persons within the MTF and on the installation. Local policy should identify all of the required notifications you must make for casualty notifications. This list usually includes the following:

- Installation commander.
- MDG/CC.
- MDG administrator.
- Chief of hospital/clinic services.
- Chief of nursing services.
- Base chaplain.
- Patient's commander.

- Personnel responsible for casualty notification on your base (as designated by the installation commander).

The notifications that you make are recorded in section V of AF Form 570. In this block, state the individual contacted and the date and hour notified. Once notifications are complete, copies of AF Form 570 are distributed as local policy dictates.

When you (the CAR) receive an AF Form 570, it is your responsibility to update the CHCS (if your facility has CHCS capabilities). It is also your responsibility to print a Casualty Status Report (discussed below) from the reports menu daily. To update the CHCS, simply follow the specified menu path:

- PAM or Patient Affairs/Administrative Menu.
- CST or Casualty Status.
- Patient Name.

If your MTF does not use CHCS, you must complete an AF Form 1403, Roster of Seriously Ill/Very Seriously Ill. This form serves as a tool to help (those few) MTFs properly manage the VSI/SI/III program when CHCS in not available. Although rare, it is important to learn and understand the manual method as well as the automated process. At times, CHCS may not be available at your MTF due to the primitive working conditions such as those you may be faced with during some deployments. Even in the most “high tech” environment occasionally computer network problems arise, which force us to reach back to the old “brown shoe days” when tasks were accomplished with pen and paper!

Changes in casualty status

When the provider determines that a patient’s status has changed or is no longer in VSI, SI, or III status, they should annotate the inpatient record to reflect the change or removal and another AF Form 570 is initiated by the unit personnel. The form is, once again, sent to the CAL for appropriate notifications. Usually, the same personnel are notified of changes in patient casualty status. Again, these notifications are recorded in section V of the AF Form 570.

Preparing AF Form 1403

Air Force Form 1403, Roster of Seriously Ill/Very Seriously Ill, or the automated Casualty Status Report available through the CHCS reports menu may be used to provide a list of patients and their casualty status. To view or print the CHCS report you must first access the following CHCS menu options:

- ORM or Out Reports Menu.
- POUT or Patient Affairs/Administrative Output Menu.
- 2 or Casualty Status Report.

If your facility does not have CHCS capabilities, you will be required to prepare an AF Form 1403 manually each day. Prepare enough copies to distribute as local policies dictate. Be cognizant of the sensitive information listed on the AF Form 1403. The information on the form contains Privacy Act data and should be handled appropriately. Only authorized personnel should have access.

Let me explain: The AF Form 1403 may have patient information on numerous patients throughout your MTF. The form is constructed to give a running tally of VSI, SI, and III patients admitted at your MTF on a 24-hour basis. Working as the CAR, you are responsible for providing this data to numerous personnel within the MTF, as well as to certain agencies outside of your MTF. Your local policy may dictate that squadron commanders receive a copy of this form if any of their personnel have been identified as VSI, SI or III. It is important they receive this information, but it is also important to protect the information of all the patients on this form.

The AF Form 1403 is prepared as of midnight and shows the name of each patient that was added to or removed from SI, VSI, or III status on the previous day. The list also reflects those patients that remain unchanged from previous days.

NOK travel arrangements

In certain cases, the physician may determine that it is medically advisable for a relative to be present at the bedside during a critical period in the patient's hospitalization. The attending physician provides a recommendation to the MTF commander that the presence of the NOK is considered beneficial to the patient's recovery. If the MTF commander approves the request, they will document the approval on the AF Form 570. With some restrictions, each military branch is allowed to pay for travel of NOK for SI or VSI active duty military patients.

The NOK is defined as the following patient's relations:

1. Spouse.
2. Children (includes natural offspring, step, adopted and illegitimate).
3. Siblings of the member.
4. Parents of the member, who include adoptive parents and persons who have stood *in loco parentis* (a term used to describe those who perform the duties and responsibilities as a parent for a period of time) to the member for a period of *not* less than 1 year immediately before the member entered the uniformed service. However, only one mother and father or their counterparts may be recognized in any one case.

235. Reporting deaths in the military treatment facility

Just as in the civilian population, a physician is responsible for verifying deaths that occur in an MTF and on Air Force installations. When a member of the active duty Armed Forces dies outside the limits of an Air Force installation, Air Force personnel must not remove the remains (body) without the permission of civil authorities. The installation commander must consult with local civil authorities in developing procedures to be followed when Armed Forces personnel die within or beyond installation limits.

For the most part, civilian authorities have no jurisdiction when active duty Armed Forces personnel die on an Air Force installation. However, the remains cannot be removed from an Air Force base for shipment or burial until the proper civil authority issue a transient or burial permit.

Remains

The remains are released to mortuary personnel within 24 hours after death, unless special circumstances exist. You must ensure the death certificate is completed and signed by the responsible medical officer before releasing the remains. The releasing officer ensures that the remains present a clean appearance. Remains are not released unless wrapped in suitable covering. The mortuary representative, military or civilian, who takes custody of the remains, signs a receipt. This receipt is filed in the inpatient record of the deceased.

DOD policy requires that when a military member or dependent dies outside the US, the death must be officially recorded with the local civil authorities.

Disposition of personal effects

The CAL or their representative is notified immediately when the physician verifies the death. The physician initiates an AF Form 570 to report the death to the CAL who, in turn, makes all the required notifications IAW Air Force publications and local policy. If this is your function, you must collect and inventory all personal property of the deceased (including funds, valuables, clothing, and baggage) as soon as possible following the death of a military or civilian patient.

- Personal effects of a military patient are sent to the appointed summary court officer (an officer in charge of coordinating the settlement of the deceased military member's affairs).

- Personal effects of civilians (for instance, family members, retired, etc.) are inventoried and sent to an executor or administrator, or if none is appointed, to the nearest NOK.
- A copy of the inventory should be signed, as a receipt, by the executor, administrator, or nearest NOK, as appropriate. File this receipt in the deceased patient's inpatient record.

Death certificate

The physician in attendance completes the inpatient record and makes all required entries. The physician is responsible for the completion of the death certificate; however, you will be called upon to assist the physician with this task. There are specific requirements for the completion of the death certificate, and the requirements vary with each state and country. Once the death certificate is prepared, submit it to the proper authorities according to state and civil requirements. File a copy of the death certificate in the inpatient record of the deceased.

Reporting stillbirths

Prepare a certificate of fetal death and submit it as required by state and civil law. File one copy of the fetal death certificate in the mother's inpatient record. Handle the remains the same as for other deaths. If an autopsy is requested, ensure a permit is completed and signed.

Performing postmortem (autopsy)

If the surviving spouse, NOK, or person having right of burial, requests (in writing) a post-mortem examination, make every reasonable effort to comply with such a request. File the authorization to perform a post-mortem examination in the deceased's inpatient record. Except for the cases identified in the next paragraph, a post-mortem may be performed *only* with the consent of the surviving spouse, NOK, person having right of burial, or at the request of the local coroner or medical examiner.

When a member of the Armed Forces (called or ordered into active military service for a period of *more than* 90 days) dies on an Air Force installation, a complete post-mortem will be performed if any of the following applies:

1. The death occurred under circumstances suggesting crime, suicide, or other appearances requiring investigation. *Do not* exclude a postmortem merely because a superficial examination may suggest a conclusion as to cause of death.
2. The cause of death might constitute a menace to public health.
3. The cause of traumatic death is other than as a result of a military accident, but physiological or pathological changes may have precipitated the events that led to death and this cannot be determined without a post-mortem.
4. The death occurred while the person was serving as an aircrew member in a military aircraft.
5. The physician is unable to establish the cause of death.
6. Death occurred while the person was confined in disciplinary custody but had *not* been punitively discharged from the military service.
7. The commanding officer of an installation or command, of their own volition, requires the post-mortem to determine the true cause of death, secure information for the completion of military records, or protect the welfare of the military community.

The installation commander is the approving authority for a postmortem examination. The installation commander may delegate approving authority to the MDG/CC. This delegation must be in writing and remain current at all times. This is true also in overseas areas, including US possessions where the US has jurisdiction. In areas outside the US and its territories, existing Status of Forces Agreements apply.

Completion of inpatient record

The inpatient records of patients that die *during* hospitalization are completed much the same way as patients that are routinely discharged: The AF Form 560 is completed, the proper disposition entries are made in CHCS, the physician and inpatient unit personnel ensure the inpatient record is complete, inpatient records personnel enter the appropriate coding of diagnoses and procedures, and a record of inpatient treatment is printed for the inpatient record folder.

Patients classified as CRO or an ERD are also entered into CHCS (we covered CRO and ERD patients earlier in this volume). An AF Form 560 is prepared indicating the time, date, place of death, and any other pertinent information. As with any other AF Form 560 or episode in CHCS, the physician completes the portion of the AF Form 560 that requires medical input (i.e., diagnoses, cause of death, etc.). A record of inpatient treatment is printed and filed with the AF Form 560 in the deceased inpatient record folder.

NOTE: CRO does *not* include patients who die in transit (while either in flight or in an ambulance between MTFs), or while being staged (processed) through an aeromedical staging facility (ASF).

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

233. Patient dispositions

1. Define disposition or discharge.

2. According to the text, what are some examples of patient dispositions?

3. When completing an AF Form 560, in which item would you document all diagnoses and procedures of a patient's case?

4. How are surgical procedures entered on AF Form 560?

5. In which item of AF Form 560 is the *nature* of a patient's disposition recorded?

6. What source documents do you use to input information about a patient's discharge into the CHCS?

234. Special notifications

1. Match the casualty status in Column B with the applicable description in Column A.

____ (5) Column A	*Column B*
1. A patient with an illness that is severe, but there is no imminent danger to the patient's life.	a. Incapacitating illness or injury.
2. A patient's injuries resulted in serious disfigurement	b. Very seriously ill.
3. A condition so severe that there is imminent danger to the patient's life.	c. Seriously ill.

2. On what form does the health care provider annotate the decision to report a patient in SI, VSI, or III status?

3. On what form, does the casualty affairs liason (CAL) annotate individuals who are notified of a patient's casualty status?

4. For what purpose is the AF Form 1403, used?

5. Who approves an attending physician's recommendation for the presence of the NOK when it would be beneficial to the patient's recovery?

6. Under what circumstances is each military branch allowed to pay for the travel of a patient's NOK?

235. Reporting deaths in the military treatment facility

1. Who is responsible for verifying deaths that occur in an MTF and on Air Force installations?

2. Within how many hours after death are remains released to mortuary personnel?

3. To whom is the personal property of an active duty deceased forwarded?

4. To whom are the personal effects of civilians forwarded?

5. Who is responsible for the completion of the death certificate?

6. Where is a copy of the death certificate filed?

7. Who is the approval authority for a postmortem examination?

3–4. Inpatient Records Responsibilities

Health services managers assigned to inpatient units act as administrators for the professional staff on that unit. The physicians, dentists, nurses, and the medical service technicians look to you for guidance and expertise relating to health care management issues, and they rely on your ability to assist in the recovery of each patient. In this section, we will look at some of the administrative functions performed within the unit that supports the patients and staff of the hospital.

236. Health services management responsibilities

As stated earlier, there are many HSM functions and working on the inpatient unit may be one of them. The health services management journeyman assigned to the unit, works with, and directly supports the patients and staff on the inpatient unit.

Patient support

Nursing functions are performed by nursing services personnel. As you know, generally, HSMs are not trained in most nursing functions. Therefore, by accomplishing these tasks you may be doing the following:

- Placing the AF in jeopardy of facing possible legal actions.
- Placing the MTF in jeopardy of facing possible Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Health Services Inspection (HSI) write-ups/discrepancies.
- Doing harm to the well-being of the patient (our customers, are the reason for our existence).

Remember, you should be properly trained in the tasks that you perform and that training should be documented in your six-part on-the-job training folder. Contact your health services management functional manager and/or supervisor to learn more about this critical training function.

Doing more with less is a reality in the Air Force Medical Service. With the new Patient Centered Medical Home system being implemented throughout the Air Force, HSMs may find themselves performing certain nursing functions just as nursing services personnel may begin to play a more prominent role in traditional HSM functions. The key here is to remember the three important steps to effectively utilizing HSMs in non-traditional roles: *Training, training, and more training!* That's right, we must ensure that HSMs who perform other than HSM functions are properly trained and that training is properly reflected in our on the job training folders.

Maintenance of inpatient records

As a health services management journeyman, the nursing staff will look to you as the focal point for the maintenance of each patient's inpatient record (normally referred to as a "chart" while on the unit) while the patient is in the hospital. The provider and nursing staff rely on your expertise to ensure the patient's medical documentation is maintained properly. Some of these inpatient record or chart functions may include the following:

- Preparing and quality control for all patient admission, transfer, and disposition records. This includes ensuring all forms and information is complete and accurate.

- Maintaining each patient's inpatient record while it is on the inpatient unit. You must review each record to ensure that required documents are completed and filed.
- Preparing inpatient records for MEBs and PEBs.
- Ensuring preparation and completeness of inpatient records for those patients going to surgery, specialized clinics, or other treatment outside the inpatient unit.
- Preparing and finalizing inpatient records for patients being released from the hospital.
- Preparing medication and treatment cards for each patient.
- Preparing requests for diagnostic laboratory tests, x-ray examinations, and consultations.
- Documenting temperature, pulse, respiration, and blood pressure data on each inpatient. This information is obtained from the nursing service staff and is entered into each patient's chart. Prepare daily worksheets to monitor these items.
- Notifying nursing staff of new physician's orders, when applicable.
- Acting as liaison for the scheduling and preparation of patients for aeromedical evacuation.

Administrative support

You may also provide administrative support to the patients and staff on the inpatient unit. This support could include the following duties:

- Request and obtain necessary health records.
- Prepare necessary paperwork and assist with the arrangements for movement of patients when requested by the health care provider. Even though you may be asked to make the arrangements, nursing personnel remain responsible for the actual (physical) movement of the patient.
- Prepare, coordinate, and process forms for patients authorized convalescent leave, pass, or to subsist out (we will talk about these later in this unit). Maintain nursing unit status board.
- Advise nutritional medicine service of all new admissions and the type of diet needed for each patient or any change in a patient's diet needs. Processing emergency direct admissions to the inpatient unit. This involves completing the AF Form 560, obtaining a register number from the A&D section, and processing the necessary forms to complete the admission.
- Preparing administrative data for birth certificates.
- Assisting in the processing of administrative requirements relating to deceased patients.
- Initiating the administrative portion of AF Form 570, Notification of Patient's Medical Status, in support of the casualty reporting program.
- Establish requirements, ordering, and receiving all forms and publications for the nursing unit. This includes keeping publications current by making required changes when needed. Today, most publications can be found electronic means, yet due to requirements, local policy and convenience some are still filed the old fashion way (hard copy).
- As we stated earlier, performing nursing unit duties that consist of receiving and coordinating various requests and inquiries by patients, visitors, and staff.

Other related duties

As if the responsibilities just mentioned are not enough, you may also be responsible for many services that directly impact the quality of care provided to the patient, such as:

- Arranging transportation for patients requiring diagnostic tests away from the inpatient unit.
- Completing requests for laboratory tests or x-rays.
- Receiving results of tests accomplished.
- Making sure patients have deposited their valuables in the RMO for safeguarding.

As you can see, working on the ward involves a myriad of tasks and requires flexibility and dependability.

Inpatient records and documenting care

The treatment each patient receives is documented in the patient's health record. Inpatient care can sometimes be quite extensive. Accurate documentation is vital to the success of the patient's recovery. If a diagnostic test or examination is not documented correctly, or is poorly documented, the physician may not be able to administer an adequate treatment plan. As a health services management journeyman assigned to the inpatient unit, you are in a position to assist the health care provider staff with the proper documentation and provide quality control of each patient's care. You are looked upon as the medical records expert and must be sure to maintain that expertise through constant training and research.

Health care providers are responsible for *all* health record entries regarding the diagnosis and treatment of a patient, and indicating specific orders. While on the unit, you will be responsible for the maintenance, care, and protection of the health record while it is maintained on the unit.

Entries and corrections

All entries must be in *reproducible* black or blue-black ink. Entries must be legibly written or lettered. When incorrect entries in a medical record are discovered, corrections to the medical record must be made. The rule is, if the error is identified *soon* after the date of the erroneous entry, and the practitioner that made the entry remembers the circumstances involved, use the following guidelines:

- Line through the incorrect data with *one* straight line. *Do not* erase or "scratch out" the information
- If space permits, enter the correct data next to the erroneous data.
- If there is *not* enough room to make the correction, draw one straight line through the erroneous data, initial and place the *current date* next to the entry.
- Make a note that refers the reader to the corrected entry (i.e., "see correction, 1 Nov 98").
- Go to the location on the medical record form where the next entry can be made and enter the correction using the *current date*.

The practitioner who originally entered the incorrect data should accomplish corrections. If this is not practical, enter a brief explanation of why the original entrant did not make the correction. The person making the correction must sign and date the entry.

Inpatient record forms

During the period of hospitalization, forms are located in record folders, clipboards, or other containers, in an order that allows for ease of use by the medical staff. Local policies may be initiated to dictate the location and order of forms in the chart on the inpatient unit.

It is not unusual for physicians and other health care providers to ask you to assist in the preparation of some forms for their signature. When you know what information is required on each form, you will be able to identify incomplete forms that may be filed in the patient's record and work with the nursing staff to ensure they understand the procedures for completion of each form. So why do we stress the importance of minimum patient information on all medical forms? Here are some of those reasons:

- Loose medical paperwork will get filed in the patients' charts and/or inpatient record much quicker. Without the required patient data, HSMs are forced to research loose documentation to match the paperwork with the correct record. This task (researching paperwork) can be very time consuming. Ask any inpatient record's technician and they will tell you—it's hard enough staying a step ahead of all of the work within inpatient records without having to needlessly research large amounts of paperwork.

- Patient care may suffer. If medical paperwork isn't readily available when health care providers need immediate access, the patient may suffer the consequences.
- Failure to do so will place the MTF in jeopardy of facing possible JCAHO and HSI write-ups/discrepancies.

Each form placed in the medical record must contain at least the following *minimum* identification:

- Patient's name.
- Register number.
- Name of the treating MTF (and the name of MTF maintaining the outpatient record if different from the treating MTF).
- Family member prefix (FMP).
- Sponsor's Social Security Number.

There are two patient forms where the minimum identification rule does not apply:

1. Laboratory and x-ray *display* sheets, or the AF Form 745. Each laboratory or x-ray test result contains patient identification. Further identification on the display sheet would be redundant.
2. As discussed in Volume 3 of your CDC, minimum patient identification is not necessary on the AF Form 745.

Now that we know the minimum identification necessary on inpatient forms, let's look at some of the forms you may commonly see in the inpatient chart or record.

AF Form 745

Use AF Form 745, Sensitive Duties Program Identifier, to identify records of individuals identified as being on the Personnel Reliability Program (PRP) or Presidential Support Program (PSP). File this form so that it is *always* the uppermost item in the record while on the unit.

SFs 504, 505, and 506

SF 504, Clinical Record—History, Part I, SF 505, Clinical Record—History, Parts 2 and 3, and SF 506, Clinical Record—Physical Examination, are used to document the medical history and current physical status of a patient. Within the first 24 hours of a patient's admission, the responsible health care provider must complete the medical history and physical examination. The nursing staff reviews these forms and uses them to assist in the patient's plan of care. If a patient is readmitted to the same medical facility within a month for the same condition, an interval note and reference to the previous history and physical examination is annotated. Also, a copy of the previous history and physical is placed in the current record.

SF 509

The SF 509, Medical Record—Progress Notes, is used by the physician, dentist, or certified nurse midwife (CNM) and nurses to chronologically document the patient's progress while in the hospital. The condition of the patient determines how often the SF 509 is annotated.

AF Form 3066

The physician, dentist, or CNM uses AF Form 3066 (fig. 3–7) to transmit written orders for patient care and treatment to the nursing staff. The original stays in the inpatient record, and the pharmacy staff uses a perforated copy to establish and maintain drug profiles on each patient. The provider's SSN is required in the provider's stamp on prescriptions for controlled substances.

NOTE: This is the only instance where the provider's SSN is required in the stamp in the inpatient record.

Telephone and verbal orders normally are used for emergency situations, and may be accepted only by a registered nurse. The registered nurse, signs verbal and telephone orders using the requesting

physician, dentist, or CNM's name followed by the nurse's signature. The responsible provider must countersign these orders within 24 hours.

Laboratory and radiology reports

When a computerized or automated summary of all laboratory and radiology report results are compiled during the patient's hospitalization, file only the cumulative final report. Destroy all previous computerized/automated report results.

SF 516

Report surgical operations, including those performed in the ambulatory surgery unit, on SF 516, Medical Record—Operation Report (fig. 3–6, refer to page 3–33).

Dictate the report immediately following surgery. Annotate the date and time of dictation and transcription on the form. Include in the report a description of the findings, the technique used, the tissue removed or altered, the postoperative diagnosis and the condition of the patient at the end of the operation.

SF 535

A SF 535, Clinical Record—Newborn in duplicate is prepared for all newborn infants (figs. 3–8 and 3–9). Include the original in the newborn's inpatient record. The copy will be filed in the outpatient record.

SF 539

The SF 539, Abbreviated Medical Record may be used under the following circumstances:

1. Hospitalizations of five days or less for minor medical conditions normally treated on an ambulatory basis when care in the patient's residence is inadequate.
2. Hospitalizations of two days or less for minor surgical procedures performed under local or peripheral nerve block anesthesia.
3. Hospitalizations of five days or less for delivering obstetric patients whose intrapartum and postpartum course is uncomplicated, provided that a complete prenatal record is included in the inpatient record.
4. Hospitalizations of 48 hours or less for surgeries when the patient is clearly anesthesia Class I or II, regardless of type of anesthesia used.

DOCTOR'S ORDERS- *(SIGN ALL ORDERS)*

For Each Set of Orders, Record the Date and Time, Sign, and Cross Out the Unused Lines

PATIENT IDENTIFICATION	DATE OF ORDER / TIME	NURSE'S SIGNATURE
Mann, Carter 20/123-45-6789	15 Apr 2014 / 8:00 AM	
	T3 every 4-6 hrs	
	Liquid Diet	
NURSING UNIT: 3A / ROOM NO.: 2 / BED NO.: 5		
PATIENT IDENTIFICATION	DATE OF ORDER / TIME	
Mann, Carter 20/123-45-6789		
NURSING UNIT / ROOM NO. / BED NO.		
PATIENT IDENTIFICATION	DATE OF ORDER / TIME	
NURSING UNIT / ROOM NO. / BED NO.		
PATIENT IDENTIFICATION	DATE OF ORDER / TIME	

Figure 3–7. Sample, AF Form 3066, Doctor's Order.

CLINICAL RECORD — **NEWBORN**

MOTHER'S LAST NAME - FIRST NAME - MIDDLE NAME	AGE	RACE	REGISTER NO.	FATHER'S LAST NAME - FIRST NAME - MIDDLE NAME	AGE
Evans, Tara	28	C	12345	Evans, Ed	30

EXPECTED DATE OF CONFINEMENT	MOTHER'S HEALTH PRIOR TO PREGNANCY	ABNORMALITIES OF PREVIOUS PREGNANCIES
25 Dec 2013	Good	None

GRAVIDA	PARA	STILLBIRTHS	ABORTIONS	LIVING CHILDREN	FATHER'S Rh	MOTHER'S BLOOD GROUP	ANTI Rh	Rh	PAST TRANSFUSION HISTORY
2	1	0	0	1	A+	O+			None

PRENATAL CARE BY (Name of Physician)	LAST MENSTRUAL PERIOD	SEROLOLGY - TREATMENT IF POSITIVE	VIT. K	COMPLICATIONS OF DELIVERY
Dr. Davis	29 Mar 2012	NR		

PRENATAL COURSE: (Include illnesses, contacts with diseases. Details under remarks)
Uneventful

ANALGESIA (State whether scopolamine, barbiturate or opiate; dosage and hours of administration)
2mg SIVP@0330

ANESTHESIA (Length of administration, kind, and amount)
Epidural

DATE OF BIRTH — TIME

METHOD OF DELIVERY	LENGTH OF FIRST STAGE	LENGTH OF SECOND STAGE	INFANT'S CONDITION AT BIRTH
Vaginal	17 HRS 20 MIN.	2 HRS. 0 MIN.	Resp 2/2 Tone 2/2

CHARACTER OF CRY	RESUSCITATION USED (Type)	SUCTION USED (Type)	RESPIRATORY STIMULANT USED (Type)
Lusty	Stimulation	Bulb	Tactile

RESPIRATION ESTABLISHED IN	RESPIRATION NORMAL IN	OXYGEN IN DELIVERY ROOM	DURATION	EYE PROPHYAXIS (State type)
21 MIN.	1 MIN.	☐ YES ☑ NO	HRS.	

REMARKS (Summary of complications, etc., of pregnancy and birth, and nature of therapy)

Allergies: NKDA
Vessels 3vc

SIGNATURE OF OBSTETRICIAN — DATE

INITIAL PHYSICAL EXAMINATION — **To be completed within twenty-four hours of birth:** Note especially sutures, hemorrhage, clavicles, cephalhematoma, fontanelles, cleft palate, heart rate and rhythm, anus, skin blemishes, jaundice, sternocleidomastoid, umbilicus, hernia, clubfoot, fingers, tumors, mongolism, character of cry, other deformities. Use progress sheet for abnormalities, description, and elaboration.

GEN. APPEARANCE	FACIES	BIRTH WEIGHT	TEMPERATURE	CHARACTER OF CRY	MEASUREMENTS: LENGTH	HEAD	CHEST	ABDOMEN
Vigorous	0	8lbs 8oz	99.0	Lusty	49	34	30	31

BREATHING	CYANOSIS	SKIN	VERNIX	SUBCUT. TISSUE	PALLOR	ICTERUS
Unlabor	0	Pink			0	0

HEAD	FONTANELLES	SUTURES	EYES	EARS	NOSE	MOUTH
		Opposed	TRR			

THROAT	NECK	CHEST	LUNGS	HEART	MURMURS
	0 Mass	Sum	CTA	RRV	0

ABDOMEN	LIVER	SPLEEN	CORD	GENITALS	ANUS	MECONIUM
Soft	MP	MP	3V	WNL		Positive

SPINE	EXTREMITIES	MUSCLE TONE	PARALYSES	REFLEXES	MORO	JOINTS
No defects		Good	N/A			

ABNORMAL FINDINGS ON PHYSICAL EXAMINATION

V. Davis, Lt Col, USAF, MC
OB/GYN Dept.

SIGNATURE OF PHYSICIAN	DATE	SEX	RACE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.	WARD NO.

Evans, Tara
30/123-45-6789
Reg No. 12345
SAMMC, San Antonio, TX

NEWBORN
Standard Form 535
(IMT-V1)

General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.808-8
October 1975 535-104

Figure 3–8. Sample SF 535 Clinical Record—Newborn (front page).

CONDITION ON DISCHARGE: *(Record any significant physical findings and summarize any unusual observations or therapy during hospitalization.)*

DISCHARGE FEEDING: *(Use progress notes to record unusual feeding behavior)*

- [x] BREAST
- [ ] BREAST AND COMPLEMENT
- [ ] FORMULA _____ *(Amount)* _____ *(Number of feedings)*

SPECIFY FORMULA:

FOLLOW-UP

- [ ] NURSING VISIT ORDERED
- [ ] OFFICE OF PRIVATE PHYSICIAN _____ *(Location)* _____ *(Date)*
- [ ] REFERRED TO CLINIC _____ *(Location)* _____ *(Date)*
- [ ] SOCIAL SERVICE FOLLOW-UP ADVISED. REFERRED TO _____ *(Name of social service agency)*

SIGNATURE OF PHYSICIAN	DATE	WEIGHT ON DISCHARGE

PROGRESS NOTES *(Sign and date all notes)*

(IMT-V1)

Figure 3–9. Sample SF 535, Clinical Record—Newborn (back page).

237. Managing patient absences

Under certain circumstances, patients may be allowed to leave the inpatient unit on a temporary pass or leave. You will assist the charge nurse in monitoring the status of these patients.

Departure authority

Patients are only released from the MTF when authorized by their health care provider. Active duty patients that leave the hospital without proper authorization are considered AWOL. Nonmilitary patients that leave the hospital without authorization are administratively discharged from the hospital.

Patient sign-out register

To help monitor patient absences, a patient sign-out register is maintained on each inpatient unit. Patients who are given permission to leave the unit must sign-out before leaving and sign-in upon their return.

Patient pass

A pass is a temporary (usually a few hours) absence that normally is requested by the patient. The physician or dentist authorizes a pass when the patient's condition allows for such an absence without danger to the patient's well being.

Departing on pass

A patient desiring a pass completes two copies of AF Form 569, Patient's Absence Record, Section I. If the physician or dentist approves the pass, he or she will sign both the original and copy and make an annotation on the AF Form 3066, Doctor's Orders. Give the original AF Form 569 to the patient, at the time of their departure, and file the carbon copy in the patient's chart.

The nursing staff makes a notation of the patient's departure on SF 509, Progress Notes, in the patient's inpatient record. The unit's inpatient status board must also be updated to reflect the patient's absence. Be sure to notify nutritional medicine services so that meals are not prepared for patients who will be out on pass during food service hours. Read the two scenarios below to get a better understanding:

1. A1C Thomas is on pass from 1430 until 1930. There is no reason to prepare a supper meal for A1C Jones since she will be out of the MTF during the meal hours.
2. CMSgt Owens will be on pass from 1300 until 1530. The chief will be in the MTF for both lunch and supper. Therefore it behooves you to ensure both meals are prepared for the chief. In this case, you would make *no* notification to nutritional medicine services.

Some patients are authorized hospitalization or subsistence (meals) at government expense; some patients are not and must pay charges upon discharge. If a patient is *not* authorized hospitalization or subsistence at government expense, inform the patient that daily charges for hospitalization and/or subsistence continue even when they are out of the MTF on pass.

Returning from pass

Patients returning from a temporary pass turn in their copy of the AF Form 569 to an inpatient unit staff member. The nursing staff will annotate the patient's return on an SF 509 located in the patient's chart. If needed, don't forget to notify nutritional medicine services of the patient's return so that the appropriate number of meals are prepared. A1C Thomas may get pretty upset if you forget to re-order her meal!

Convalescent leave

This form of authorized absence is granted to active duty members receiving medical care and is part of the treatment prescribed for recuperation and convalescence. This leave is not charged to the member's annual leave account. Convalescent leave is limited to the minimum amount of time essential to meet the patient's medical needs. Members placed in convalescent leave status have the same entitlements and privileges as those on ordinary leave, so this authority is used only when continued medical supervision is not required. Convalescent leave is *not* used as an alternative to placing a member in an excused from duty status, or when an individual could be temporarily

returned to limited duties without adversely affecting their full recovery. Convalescent leave can be either directed or recommended.

Directed

If the patient is to depart on convalescent leave while remaining an inpatient in the hospital, the attending physician requests convalescent leave on an AF Form 988, Leave Request/Authorization, and the chief of service reviews and approves the leave by signing in the Remarks section. The patient squadron unit commander then completes blocks 23 through 25. The inpatient record remains open and in the suspense file in the A&D office until the patient returns from directed convalescent leave. The record is then returned with the patient to the assigned unit or forwarded to the inpatient records department if the patient is dispositioned.

Recommended

At the time of a patient's discharge, the provider may *recommend* convalescent leave to the patient's unit commander by completing block 7, Recommend Convalescent Leave, of the AF Form 988, The key word here is *recommend*. The final approval authority for the leave is the patient's unit commander not the attending health care provider. For these types of requests, the AF Form 988 is hand-carried, by the patient after he or she is dispositioned, to his or her unit commander for approval.

Recommendations for convalescent leave are also used for outpatients (without a related inpatient episode) when the medical condition warrants it.

Patients subsisting out

Like convalescent leave, this status only applies to *active duty military*. Subsisting out is a nonleave status assigned to an inpatient that is no longer assigned to a hospital bed. *Inpatients* authorized to subsist out are not medically able to return to duty, but their condition and treatment does *not* require bed occupancy in the hospital. During this time, the patient may reside in their quarters. If the patient is to live in the dormitory or temporary billeting, the health care provider must have consent from the patient's unit commander prior to releasing the patient to subsisting out status.

The attending physician or dentist places the patient in subsisting out status by completing the identification portion and section I of AF Form 569 (this is the same form used for patient pass status). The AF Form 569 and the patient's inpatient record are sent to the disposition technician.

Like convalescent leave, the patient clears the hospital as though being discharged to duty (this includes paying any charges they may have incurred). The disposition technician maintains the inpatient record in the patient suspense file until the patient returns or is discharged.

While a patient is subsisting out, they are *not* charged for hospitalization. A physician or dentist will continue to see the patient frequently during the subsisting out period and the patient's progress is documented in their inpatient record. The procedures for returning subsisting out patients is the same as those patients returning from convalescent leave.

238. Preparing for patient disposition

When the patient's condition improves and the physician determines that hospitalization is no longer needed, the patient is discharged from the hospital. The unit staff begins the administrative process of discharging a patient by acting upon the orders of the health care provider.

Authorization

Only a provider (physician, dentist, or CNM) may authorize the disposition of a patient. The provider identifies the discharge order on the patient's AF Form 3066.

Compiling the inpatient record

Before the disposition of a patient occurs, the inpatient record is assembled, completed, and verified for accuracy by the primary or designated health care provider. The primary health care provider completes section II and signs in block 47 of AF Form 560. The provider also completes and signs SF 502, Medical Record—Narrative Summary, if the form was prepared on the case.

The inpatient record staff should assemble the inpatient record while it is on the inpatient unit. The completed AF Form 560 should be the uppermost form in the record (exception: active duty personnel assigned to a sensitive duty position will *always* have the AF Form 745 as the upper most form). Then the 4A should review the record to ensure all necessary paperwork is included and all items are completed. After all required disposition procedures have been completed on the inpatient unit, the inpatient record is sent to the disposition office or to the inpatient records section (as determined by local policy) for further review and action.

Patient clearance from the hospital

Local policy will dictate the clearance process for patients being discharged from your MTF. Normally, every effort is made to discharge patients during normal duty hours. By doing so, the patient does not need to return to the facility to pay a bill, pick up prescriptions and so forth. Another point to remember—the patients being dispositioned from your facility will probably not be as familiar with the layout of the MTF as you are. Therefore, when developing a plan for patient clearance, patient convenience is extremely important and must *always* be considered. Whenever possible, telephone clearance should be used.

AF Form 577

Once the patient has been cleared for discharge by the provider, the AF Form 577 is annotated indicating the offices or locations to be cleared (if not already on the form) and the expected time of departure (if transportation arrangements have been made). The final point of clearance on the AF Form 577 is the disposition office.

Other considerations

If the patient stored funds or valuables during their stay in your MTF, the custodian of patient valuables should be one of the clearance stops on the AF Form 577. The custodian returns the items or ensures none were deposited and initials the AF Form 577.

If the patient has received a modified diet or was served meals while on the inpatient unit, notify the nutritional medicine service as soon as possible. This will prevent the preparation of an excessive number of patient meals. Your MTF should also have procedures established to ensure the patient's mail is forwarded to his or her home address for a reasonable period of time after discharge.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

236. Health services management responsibilities

1. What type of duties can you expect to perform while assigned to an inpatient unit?

2. Who is responsible for all health record entries regarding diagnoses and procedures?

3. How are corrections to inpatient records made?

4. What *minimum* information is required on each form in the inpatient record?

5. How are medical records-progress notes used?

6. What form is used by a physician to transmit written orders for patient care to the nursing staff?

237. Managing patient absences

1. Who authorizes patient absences from the hospital?

2. What happens when an active duty member leaves the hospital without proper authorization?

3. What form is used to authorize a patient pass?

4. What patient absence is granted to active duty members and is considered part of the patient's treatment?

5. What is the difference between *directed* and *recommended* convalescent leave?

238. Preparing for patient disposition

1. How does the administrative process of a patient discharge begin?

2. When all required disposition procedures have been completed on the inpatient unit, where is the patient's inpatient record sent?

3. What form is used, by the patient, to clear the appropriate sections within the MTF?

4. What is the final point of clearance listed on the patient clearance record?

3–5. Coding of Records

In the simplest sense, coding is the numeric or alphanumeric representation of written descriptions. It allows standardized, efficient data gathering for a variety of purposes. While it can provide a detailed clinical picture of a patient population, it can also be useful in overseeing population health, anticipating demand, assessing quality outcomes and standards of care, managing business activities, and receiving reimbursements for services.

239. Diagnostic coding

Diagnostic coding began as a means of gathering statistical information to track mortality and morbidity. Subsequent changes to add clinical information resulted in a coding structure that describes the clinical picture of a patient, as well as non-medical reasons for seeking care and causes of injury. Diagnosis codes are listed in the International Classification of Diseases, 9th revision, Clinical Modifications or, ICD–9-CM.

Procedural coding

Healthcare Common Procedure Coding System (HCPCS) codes are grouped in two levels:

Level I HCPCS are commonly referred to as Current Procedural Terminology (CPT).

Form the major portion of the HCPCS coding system, covering most services and procedures. CPT codes supersede Level II codes when the verbiage is identical.

Level II codes supersede level I codes for similar encounters, when the verbiage of the level II code is more specific. HCPCS includes evaluation and management services, other procedures, supplies, materials, injectables, and dental codes. Having a code number listed in a specific section of HCPCS does not usually restrict its use to a specific profession or specialty.

HCPCS level I and level II codes, except for codes 99201–99499, are collected in the third data collection screen of the Ambulatory Data Module of the MHSS computer system.

Other specifics regarding HCPCS Level II codes

Equipment and durable supplies will only be coded if the equipment or supply item is issued to the patient without the expectation that the patient will return the item when no longer needed. For instance, if the patient is issued a C-PAP machine with the expectation the machine will be returned when it is no longer needed, issuance of the machine would not be coded. However, the personalized facemask would be issued with no expectation of return, and so would be coded.

Pharmaceuticals and injectables

HCPCS Level II codes will only be used when the pharmaceutical or injectable is paid for directly from the clinic’s funds, and is not a routine supply item. If a drug is issued by the pharmacy to the patient, and the patient brings the drug to the clinic for administration, the drug will not be coded, as the pharmacy was the service issuing the drug. Inpatient ward stock will not be coded, as it is part of the institutional component and part of the diagnosis-related group (DRG).

C-Codes

These codes are commonly referred to as pass-through codes. They are usually only available for a few years at which time the item is included in a procedure or no longer used. These tend to be for high-cost items. The item must be coded if it is paid for out of clinic funds. As with other drugs, do not code it if the pharmacy issued it to the patient. Frequently, coders will need to query the provider or the clinic supply custodian on the method of acquisition.

V-Codes

DOD extender codes have been paired with selected V-codes to further specify military unique services. The addition of DOD extender codes to the root code enables differentiation of the types of

health assessments. The V-codes are used to identify circumstances (diagnoses) other than disease, symptom, or injury that are the reason for an encounter, or that explain why a service or procedure was furnished. V-codes are used to classify a patient in the following circumstances:

When a person is not currently or acutely ill, but requires healthcare services for some purpose, such as preventive education and counseling or prophylactic vaccinations.

Examples: V04.2 would be used for the child receiving a measles vaccination in a pediatric clinic; V65.3 would be used for the diabetic patient who receives dietary counseling.

Evaluation and management codes

In the DOD, the term evaluation and management codes refers to the CPT codes inclusive of 99201–99499. These codes describe the non-procedural portion of services furnished during a healthcare encounter. They classify services provided by a healthcare provider and indicate the level of service. Evaluation and management codes (E&M) codes are a subset of CPT codes (Level I HCPCS), yet are referred to as an E&M instead of as a CPT code to distinguish between E&M services and procedural coding.

The three key elements in selecting the appropriate complexity of the E&M code are:

- History.
- Examination.
- Medical decision making.

These components must meet or exceed the minimum requirements specified in the E&M guidance of CPT. More E&M documentation guideline information is on the CMS website at http://www.cms.hhs.gov/.

240. Coding manuals

Coding manuals are used to classify a wide variety of diseases and anything that can cause injury or disease. A few examples are: symptoms, external causes, abnormal findings and external causes. Just about every diagnosis and procedure can be assigned a code from a coding manual.

International Classification of Diseases, 9th Revision, Clinical Modification

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9-CM) is the official system used in the United States to classify and assign codes to health conditions and related information. The use of standardized codes improves consistency among physicians in recording patient symptoms and diagnoses.

ICD–9-CM codes are used to describe diseases, conditions, symptoms, and other reasons for seeking healthcare services. The ICD–9-CM contains a list of alphanumeric codes which correspond to diagnoses and procedures recorded in conjunction with hospital care in the United States.

The United States Department of Health & Human Services and the Centers for Medicare and Medicaid Services created ICD–9-CM as an extension of the Ninth Revision, International Classification of Diseases (ICD–9), which the World Health Organization (WHO) established to track mortality statistics across the world.

International Classification of Diseases, 10th Revision, Clinical Modification

The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD–10-CM) is a revision to the ICD–9-CM system used by physicians and other health care providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care in the United States.

Like ICD–9-CM, the ICD–10-CM is based upon the International Classification of Diseases, which is published by the World Health Organization (WHO) and which uses unique alphanumeric codes to

identify known diseases and other health problems. According to WHO, the ICD assists in the storage and retrieval of diagnostic information and in the compilation of national mortality and morbidity statistics. ICD–10-CM includes twice as many categories as the ICD–9-CM and it introduces alphanumeric category classifications for the first time.

Current procedural terminology

A medical code set developed, maintained and copyright protected by the American Medical Association. The CPT code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes. New editions are released each October.

CPT coding is similar to ICD–9 and ICD–10 coding, except that it identifies the services rendered rather than the diagnosis on the claim. ICD code sets also contain procedure codes but these are only used in the inpatient setting.

CPT is currently identified by the Centers for Medicare and Medicaid Services (CMS) as Level 1 of the Health Care Procedure Coding System.

The CPT manual contains three categories:

Category I codes

Procedure and service codes, organized into the following categories:

- Evaluation and Management.
- Anesthesia.
- Surgery.
- Radiology.
- Pathology and Laboratory.
- Medicine.

Category II codes

- These codes are used to track performance and have four numbers followed by a letter: *7890A*.
- Use of these codes is optional.

Category III codes

- These codes are temporary codes for new technology and have four numbers followed by the letter “T”: *7890T*.
- After five years, these codes are moved to Category I or removed from the CPT, depending on their usefulness.

The Healthcare Common Procedural Coding System

A set of health care procedure codes based on the American Medical Association’s Current Procedural Terminology (CPT). Healthcare Common Procedural Coding System (HCPCS) provide a standardized coding system for describing the specific items and services provided in the delivery of health care. Such coding is necessary for Medicare, Medicaid, and other health insurance programs to ensure insurance claims are processed in an orderly and consistent manner.

HCPCS includes two levels of codes:

Level I codes consist of the American Medical Association’s CPT and is numeric.

Level II codes are alphanumeric and primarily include non-physician services such as ambulance services and prosthetic devices. Level II codes represent services, supplies and equipment not covered by Level I codes.

It is often pronounced by its acronym as “hick pick”, when referring to a singular code, or “hick-picks” when referring to multiple HCPCS codes.

Diagnostic and Statistical Manual

Mental health diagnoses are based on terminology and codes in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV). Although the terminology in ICD–9-CM or CHCS does not always match the terminology in DSM IV, use the mental health codes in the 290–320 range in ICD–9-CM.

241. Coding taxonomy (structure)

International Classification of Diseases, 9th Revision, Clinical Modification (ICD–9-CM)

ICD–9-CM codes are 3- to 5-digit numeric and alphanumeric codes. Some codes are modified for special use in the DOD. The first three digits usually represent a single disease entity, or a group of similar or closely related conditions. The fourth digit subcategory provides more specificity on the etiology (cause), site, or manifestation. In some cases, fourth-digit subcategories have been expanded to the fifth-digit level to provide even greater specificity.

International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10-CM)

On January 16, 2009, the Department of Health and Human Services (HHS) published a Final Rule for the adoption of ICD–10-CM and ICD–10-PCS code sets to replace the currently used ICD–9-CM code sets under rules 45 CFR Parts 160 and 162, of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Here are some highlights of the final rule

ICD–10-CM (diagnoses) adoption will affect all components of the healthcare industry that currently utilize ICD–9-CM volume 3-inpatient procedures.

ICD–10-PCS (procedures) will only affect those components of the healthcare industry that currently utilize ICD–9-CM volume 3-inpatient procedures.

HHS concluded that the provisions in the Final Rule are the most cost-effective alternative for implementing HHS’ statutory objectives of administrative simplification.

As per all medical code sets under HIPAA, compliance date requires services performed on and after that date be coded using the new codes.

ICD–9 Limitations	ICD–10 Advantages
Terminology and classification of some conditions are outdated and obsolete	Modernized terminology
Outdated codes produce imprecise and limited data	Increased information to public health, surveillance, research, quality measurement
Lacks specificity	Increased specificity, e.g. laterality
13,000 codes; has reached its maximum capacity of codes	68,000 available codes; more room to expand
Generic terms used for body parts	Definitive code choices
Lacks interoperability, not used by most other countries	Ultimately less billing denials
Limits Diagnostic Related Group (DRG) assignment	Allows DRG definitions for recognition of new technologies and devices

The Military Health System (MHS) will transition on 1 October 2014 to using the ICD–10-CM for healthcare encounter diagnoses, conditions, factors and causes of injury. All codes in ICD–10-CM are alphanumeric as opposed to the strictly numeric characters in the main classification of ICD–9-CM.

All the letters of the alphabet are utilized with the exception of the letter "U."

Though the use of alpha characters "I" and "O" may be confused with numbers "1" and "0", coders should remember that the first character in ICD–10-CM is always a letter.

242. Coding patient encounters

Most coding in the MTF is performed by civilians and contractors. However, you may be asked to perform this duty depending on your MTFs local policies and procedures.

Coding patient encounters is the means by which providers and facilities receive reimbursement for their services. All coding must be supported by documentation found in the patient's medical records (paper and electronic).

ICD–9-CM is used in both the inpatient and outpatient settings to code diagnoses and in the inpatient setting to code procedures. CPT codes are used to code procedures in the outpatient setting.

To code a patient encounter, you must first review the medical documentation to determine the diagnosis and course of care provided/recommended. In the inpatient setting the diagnosis is usually the reason for admission. In the outpatient setting, the diagnosis may not be clearly stated. You should review the Symptom Observation Assessment Plan (*SOAP)* note written by the provider to help you determine the diagnosis (i.e urinary tract infection), or if no diagnosis is provided then you would code symptoms the patient presented to the clinic with (i.e lower back pain).

ICD–9-CM

This system codes procedures associated with hospital procedures and diagnoses. Some examples are: Therapeutic procedures, diagnostic procedures as well as surgical. Below are some of the terms used when coding these encounters:

Factors influencing health status and contact with health services

ICD–9-CM codes beginning with the letter V are used when the patient seeks healthcare for reasons other than illness or injury. Examples include a well-baby exam or a physical.

External causes of injury

ICD–9-CM codes beginning with the letter E describe external causes of injury, poisoning and adverse reactions. They are used to describe where, why, and how an injury occurred.

Not otherwise specified

Only use not otherwise specified (NOS) codes when the documentation is insufficient to use a more specific code. This is synonymous with unspecified.

Example: A provider note indicates the patient has otitis media. Code 382.9, unspecified otitis media, is the appropriate code if the diagnostic statement or record lacks additional information, such as purulent or serous.

Not elsewhere classifiable

Use not elsewhere classifiable (NEC) codes when there is no specific code in the classification system for the condition, even though the diagnosis may be very specific.

Example: 008.67 Enteritis due to Enterovirus NEC (Coxsackie virus, echovirus; excludes poliovirus). In this example, this code would be reported even if a specific enterovirus, such as echovirus, had been identified, because ICD–9-CM does not provide a specific code for echovirus.

Specificity in coding classification

Specificity in coding is assigning all the available digits for a code. Diagnostic codes should be assigned at the highest level of specificity. If a code has five digits, all five digits must be used.

Assign three-digit codes only if there are no four-digit codes within that code category.

Assign four-digit codes only if there is no fifth-digit sub-classification for that category.

Assign the fifth-digit sub-classification code for those categories where it exists.

Assign a DOD extender code if one exists.

Example: A patient is seen for abdominal pain in the upper right quadrant; no specific cause has been determined. The appropriate diagnostic code would be the five-digit code 789.01—other symptoms involving abdomen and pelvis, right upper quadrant—as opposed to the four-digit code 789.0 (other symptoms involving abdomen and pelvis, unspecified site).

ICD–10-CM

Code	Gout Type	Gout Location	Gout Laterality
M10-Gout	M10.0 (idiopathic)	M10.07 (ankle and foot)	M10.071 (right)
	0 idiopathic	1 shoulder	1 right
	1 lead-induced	2 elbow	2 left
	2 drug induced	3 wrist	3 unspecified
	3 due to renal impairment	4 hand	
	4 other secondary gout	5 hip	
	5 gout unspecified	6 knee	
		7 ankle and foot	
		8 vertebrae	
		9 multiple sites	

Demand management

MTFs should conduct ongoing analysis for the daily, monthly and seasonal healthcare needs to their enrolled patient population and its applicable non-enrolled beneficiaries (i.e. students) to facilitate future demand needs.

- Be proactive and aggressive.
- Manage Surges.
  - Sports Physicals.
  - Deployments.
  - Exercises.
  - Flu Season.

Capacity management

There are many variables that will affect how each MTF manages its capacity. Capacity is the “supply” when you think of “supply and demand.” Some of these variables include:

- Provider availability.
- Support staff availability.
- Appointment availability.
- Facility availability.
- Acuity of caseload.
- Staff productivity strategy.

- Be proactive and aggressive.
- Clinic staffing strategies.
  - Use of a spreadsheet/staffing grid.
  - Identify projected gains and losses.
  - Work to fill losses.
    - Identify impact.

Align available staffing appropriately

When you align demand and capacity management together, you can see trends in the facility and will know how to better place your personnel. As stated above, flu season may be a busy time in your facility as well as school physicals. This may vary from clinic to clinic.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

239. Diagnostic coding

1. What are C-Codes commonly referred to?

2. What do V-codes usually identify?

240. Coding manuals

1. What are coding manuals primarily used for?

2. What does a CPT code describe?

241. Coding taxonomy (structure)

1. What are ICD–9-CM codes?

2. When was the final rule for adoption of ICD–10-CM put into use?

242. Coding patient encounters

1. Most of the coding in the MTF is done by whom?

2. What must be done first before coding a patient encounter?

Answers to Self-Test Questions

227

1. (1) a.
   (2) c.
   (3) d.
   (4) b.
   (5) h.
   (6) f.
   (7) j.
   (8) i.
   (9) h.
   (10) g.
2. To inform the patient that his or her admission is subject to the availability of space and capabilities of the staff.
3. Dead on arrival.
4. MTF commander at the nearest Air Force MTF.
5. To identify a patient's case from beginning to end.
6. The CHCS assigns the numbers automatically. When manual methods are used, the admissions technician assigns the numbers in numeric sequence on the DD Form 739.
7. AFM 37–139.
8. Bed status board, or CHCS.
9. Inpatient ward.
   Beds in ward.
   Patients in ward.
   Blocked beds in ward.
   Preadmits in ward.
   Beds available in ward.

228

1. AF Form 560.
2. (1) c.
   (2) e.
   (3) f.
   (4) b.
3. Admitting health care provider.
4. DIS.
5. AB.
6. (1) c.
   (2) b.
   (3) h.
   (4) e.
   (5) k.
   (6) j.
   (7) a.
   (8) d.
   (9) i.

(10) l.

(11) g.

(12) f.

229

1. An automated information system designed to support the administration and delivery of health care.
2. DEERS.
3. PAD.
4. To cancel admissions to, and transfers or dispositions from, inpatient units.
5. Reports tailored to meet a specific purpose.
6. CHCS admission notification letter.
7. Active duty patients' commander.
8. Admissions and dispositions report.

230

1. The AF Form 560; pertinent information from clinic services, one index card, AF Form 577, the patient's outpatient record, embossed card, other pertinent information as requested, inpatient records from the previous MTF when the patient is admitted by transfer and a patient ID bracelet.
2. It is a working file for all documents, communications, or administrative actions affecting the patient during their hospitalization. It serves as a file for inpatient records while patients are absent from the MTF as part of their treatment, on leave, etc., and as a follow-up file to ensure administrative actions are carried out promptly when required.
3. It's an index card file containing an active and inactive section. The active section contains cards for all hospital patients currently under treatment; the inactive section contains cards on patients that are no longer under treatment in the MTF (discharged).
4. It serves as an inventory of patients covering a 24-hour period (0001 through 2400) and indicates which patients are bed occupants, subsisting out, on leave, AWOL, nonmilitary hospital patients etc.

231

1. The member's unit commander; contacting the member's squadron by telephone or priority electrical message or by sending the CHCS generated notification letter.
2. The commander of the nearest Air Force MTF.
3. The patient's full name, grade, SSN, unit, duty station, and exact location; the name and telephone number of the attending physician; date and time of admission; status (leave, pass, etc.); circumstances surrounding the admission; diagnosis, present condition, and prognosis; the earliest date that the patient may be transferred to a military MTF.
4. The register number, time, and date of admission.
5. The individual's MPF.

232

1. MDG/CC.
2. Patient valuables custodian (primary and/or alternate).
3. Cash, jewelry, and other articles of a similar nature.
4. Monthly.
5. NCO in the grade of E–5 or above, a civilian with comparable grade, or an officer.
6. (1) To store small valuables such as jewelry, or cash etc. that will fit into it and a record of all valuables being deposited.

   (2) Used as a log of each patient who has deposited valuables.

   (3) A tag attached to each item that cannot be placed in the AF Form 1052.

233

1. The removal of a patient from inpatient treatment.
2. Return to duty; discharge from treatment; evacuate to US; separate or retire due to physical disability; transfer out.
3. Item 38, Diagnosis–Procedures.
4. Numbered with the principal procedure listed first, and then those that are associated procedures.
5. Item 41, Disposition.
6. AF Form 560 and the inpatient record.

234

1. (1) c.
   (2) a.
   (3) b.
2. AF Form 3066, Doctor's Orders.
3. AF Form 570.
4. To list patients on casualty status.
5. MTF commander.
6. For military VSI and SI active duty military patients.

235

1. Physician.
2. 24.
3. Appointed summary court officer.
4. Executor or administration, or, if none is appointed, to the nearest NOK.
5. Physician.
6. Inpatient record.
7. Installation commander.

236

1. Health services management duties.
2. Health care providers.
3. Line through incorrect data, do not erase or scratch out. If space permits enter correct data next to erroneous data, if not draw a line through erroneous data, initial and place the correct date next to the entry. Make a note that refers the reader to the correct entry. Go to the location on the inpatient form where the next entry can be made and enter the information using the current date.
4. Patient's name, register number, name of MTF providing treatment, name of MTF maintaining records if different than admitting MTF, family member prefix and SSN.
5. Used by the physician, dentist, and/or certified nurse midwife to chronologically document the patient's progress while admitted to the hospital.
6. AF Form 3066.

237

1. Health care provider.
2. They are considered AWOL.
3. AF Form 569.
4. Convalescent leave.
5. *Directed* refers to active duty patient's still admitted to the MTF. The chief of service approves these cases. *Recommended* refers to active duty patients being discharged. The patient's unit commander approves these cases.

238

1. The unit staff acts upon the order provided by the health care provider.
2. It is sent to the disposition office or inpatient records section (as determined by local policy).
3. AF Form 577.
4. The disposition office.

239

1. Pass through codes.
2. Diagnoses other than disease.

240

1. To classify a wide variety of disease that can cause injury or disease.
2. Medical, surgical, and diagnostic services.

241

1. A 3–5 digit numeric and alphanumeric codes.
2. January 16, 2009.

242

1. Civilians and contractors.
2. Review the medical documentation to determine the diagnosis and course of care provided/recommended.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter. When you have completed all unit review exercises, transfer your answers to the Field-Scoring Answer Sheet.

Do not return your answer sheet to the Air Force Career Development Academy (AFCDA).

66. (227) A patient who is alive when he or she reaches the hospital, but dies prior to admission is considered
    a. an emergency room death.
    b. a carded for record only.
    c. a dead on arrival.
    d. an outpatient.

67. (227) For which patient would an Air Force commander at the nearest medical treatment facility (MTF) accept administrative responsibility?
    a. Active duty Staff Sergeant admitted to a nearby civilian hospital while on leave status.
    b. Temporary Duty Retirement Listing (TDRL) patient admitted to a civilian facility.
    c. A retired Master Sergeant when referred to a civilian facility in the local area.
    d. A civilian emergency care patient admitted to the Air Force MTF.

68. (227) Patient register numbers are assigned in numerical sequence
    a. until the facility is closed down.
    b. on a calendar year basis.
    c. based on local policy.
    d. on a fiscal year basis.

69. (228) When patients are admitted from the clinic, who completes the circled items of an AF Form 560?
    a. NCOIC, Admissions and Dispositions office.
    b. Admissions technician.
    c. Attending physician.
    d. Head nurse.

70. (228) Who completes the remaining blocks of the AF Form 560 once the health care provider has completed his or her entries?
    a. NCOIC, Admissions and Dispositions office.
    b. Admitting physician.
    c. Admissions clerk.
    d. Charge nurse.

71. (228) Which entry is *not* acceptable for block 21 (Current Organization) of AF Form 560?
    a. Son, USAF E7 (Ret).
    b. Civilian emergency.
    c. AD E6 OSI Agent.
    d. Wife, AD AF 0–3.

72. (229) Use the *interward transfer* Composite Health Care System (CHCS) function to
    a. move a patient from one unit to another within the military treatment facility (MTF).
    b. update a remaining overnight (RON) patient's location.
    c. move a patient from one MTF to another MTF.
    d. correct a previous ward assignment error.

73. (229) Composite Health Care System (CHCS) reports designed for a specific purpose by military treatment facility (MTF) personnel are called
    a. special reports.
    b. AD HOC reports.
    c. customized reports.
    d. Patient Administration Directory (PAD) reports.

74. (229) A Composite Health Care System (CHCS) admission notification letter is generated each time
    a. a patient with private insurance is admitted to the military treatment facility (MTF).
    b. an active duty patient is admitted to the MTF.
    c. an SI/VSI or III patient admitted to the MTF.
    d. an 0–6 or above is admitted to the MTF.

75. (229) The admissions and dispositions report is a daily report of
    a. admissions, dispositions, change of status, newborns, and interward transfers.
    b. *all* transactions taking place in the admissions and dispositions (A&D) office.
    c. admissions, dispositions, and newborns *only*.
    d. admissions and dispositions *only*.

76. (230) Which of the following is *not* included in the admission package that accompanies a patient to the inpatient unit?
    a. AF Form 560.
    b. AF Form 577.
    c. The outpatient record.
    d. Patient suspense file.

77. (230) What serves as a working site for all documents, communications, or administrative actions affecting a patient?
    a. Inpatient record.
    b. Patient control file.
    c. Patient suspense file.
    d. Master index of patients.

78. (231) When a military patient is admitted to a military treatment facility (MTF), the patient's unit commander should be notified by
    a. admission notification letter and telephone or priority message.
    b. electronic message or telephone.
    c. admission notification letter only.
    d. telephone only.

79. (231) When must notification to HQ AF/SGXO be accomplished for active duty flag officers admitted to a military treatment facility (MTF)?
    a. Immediately, following admission.
    b. When requested by the flag officer.
    c. By 0600 hours eastern standard time following admission.
    d. When expected hospital stay is more than seven days.

80. (232) An inventory of patient valuables is conducted
    a. annually.
    b. quarterly.
    c. monthly.
    d. daily.

81. (232) Which of the following individuals would *not* be eligible to perform an inventory of patient valuables?
    a. Staff Sergeant Jones, NCOIC, outpatient records.
    b. Captain Smith, director, medical logistics.
    c. Senior Airman Hill, pharmacy technician.
    d. Mrs. Lee (GS–6), DBMS' secretary.

82. (233) When a patient's clearance is complete, the AF Form 577, Patient Clearance Record, is turned into the
    a. medical service account office.
    b. disposition office.
    c. clinical records.
    d. inpatient unit.

83. (233) In which block of AF Form 560, Authorization and Treatment Statement, does the health care provider identify the surgical procedures performed during a patient's hospitalization?
    a. Block 33, Primary admission diagnosis.
    b. Block 38, Diagnoses–Procedures.
    c. Block 40, Administrative data.
    d. Block 41, Disposition.

84. (234) When a patient's physical condition is so severe that there is imminent danger to life, the patient category reported is
    a. Incapacitating illness or injury.
    b. Very seriously ill.
    c. Seriously ill.
    d. Critically ill.

85. (234) When a health care provider makes the decision to report a patient in a casualty status, he or she makes the appropriate entry on
    a. AF Form 1403, Roster of Seriously Ill/Very Seriously Ill.
    b. the Composite Health Care System (CHCS).
    c. AF Form 3066, Doctor's Orders.
    d. SF 509, Progress Notes.

86. (234) Which form is used to document dates and times of casualty status notifications made to outside organizations and individuals?
    a. AF Form 1403.
    b. AF Form 560.
    c. AF Form 570.
    d. SF 509.

87. (234) When a patient's physician determines it medically advisable, each military branch may pay for the travel of the patient's next of kin (NOK) for
    a. terminally ill family members of active duty personnel.
    b. SI, VSI, and III active duty military patients.
    c. SI and VSI active duty military patients.
    d. all military patients.

88. (235) When must the military treatment facility (MTF) release a deceased patient's remains to mortuary personnel?
    a. Within 24 hours after death.
    b. After a complete and thorough investigation has been conducted.
    c. When approved by the medical group commander or a designated representative.
    d. When approved by the wing commander or a designated representative.

89. (236) The *minimum* identification required on forms placed in the inpatient record includes the patient's name, family member prefix (FMP), sponsor's social security number, register number, and the
    a. name of the military treatment facility (MTF).
    b. name of the attending physician.
    c. patient's social security number.
    d. inpatient unit.

90. (236) When must the attending physician accomplish the medical history and physical examination?
    a. Prior to admission to the inpatient unit.
    b. Within 24 hours after admission.
    c. Within 7 days of admission.
    d. Prior to discharge.

91. (236) Which inpatient record form is used to transmit the physician's instructions to the nursing staff?
    a. SF 506.
    b. SF 509.
    c. SF 539.
    d. AF Form 3066.

92. (236) A provider's verbal or telephone orders may be taken by
    a. the unit inpatient records technician (UIRT) or nurse only.
    b. a nurse or medical technician only.
    c. anyone assigned to the ward.
    d. a registered nurse only.

93. (237) Nonmilitary patients who leave the hospital without authorization are
    a. considered to be on "pass" until they return to the ward.
    b. administratively discharged from the hospital.
    c. reported to the sponsor's commander.
    d. considered AWOL.

94. (237) To monitor patient absences, use
    a. updates on the inpatient unit nursing status board.
    b. AF Form 569, Patient's Absence Record.
    c. notes on the AF Form 560.
    d. a patient sign-out register.

95. (237) If convalescent leave is *directed*, the inpatient record is
    a. maintained on the ward until the patient returns to the ward or is discharged.
    b. forwarded to the clinic for reference during follow-up outpatient visits.
    c. forwarded to the disposition office and filed in the suspense file.
    d. forwarded to the inpatient records section for coding and filing.

96. (237) *Recommended* convalescent leave must be approved by the
    a. medical squadron section commander.
    b. attending physician's supervisor.
    c. patient's unit commander.
    d. MDG/CC.

97. (238) Of the following, who may authorize a patient disposition?
    a. Dentist.
    b. Registered nurse.
    c. Physician assistant.
    d. Medical service corps officer.

98. (238) What will dictate the clearance process for patients being discharged from your military treatment facility (MTF)?
    a. DOD policy.
    b. Local policy.
    c. Air Force policy.
    d. Military personnel flight (MPF) policy.

99. (239) Level 1 Healthcare Common Procedure Coding System (HCPCS) are commonly referred to as
    a. common procedure terminology.
    b. common patient terminology.
    c. current procedural terminology.
    d. current patient terminology.

100. (239) What are the three key elements in selecting the appropriate complexity of the evaluation and management (E&M) codes?
    a. History, test, and medical decision making.
    b. History, physical, and decision making.
    c. History, lab, and decision making.
    d. History, examination, and medical decision making.

101. (240) What code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information?
    a. Military Health Service System.
    b. Current Procedural Terminology.
    c. Evaluation and Management Codes.
    d. International Classification of Diseases.

102. (240) How many years do category III codes remain in the Current Procedural Terminology Manual?
    a. One
    b. Three.
    c. Five.
    d. Seven.

103. (241) All codes in the International Classification of Diseases, 10th Revision, Clinical Modification are:
    a. alphanumeric.
    b. numeric.
    c. alpha.
    d. either alpha or numeric.

104. (242) According to the International Classification of Diseases, 9th Revision, Clinical Modification, what does a code beginning with the letter "*E*" mean?
   a. There is no specific code in the classification system.
   b. External causes of injury.
   c. Type of examination.
   d. Echovirus.

Abbreviations and Acronyms

A&D	admissions and dispositions
ADS	active duty support
ADSM	active duty service member
ADT	active duty for training/admissions, dispositions and transfers
AFI	Air Force Instruction
AFIT	Air Force Institute of Technology
AFMS	Air Force Medical Service
AFMSA	Air Force Medical Support Agency
AFOSI	Air Force Office of Special Investigations
AFROTC	Air Force Reserve Officer Training Corps
AFS	Air Force Specialty
AFSC	Air Force Specialty Code
AGR	Air guard & reserve
ALC	assignment limitation code
ANG	Air National Guard
AOUT	ADT Processing Output Menu
APO	Army or Air Force Post Office
APV	Ambulatory Procedure Visit
APV	ambulatory procedure visit
ARC	air reserve component
ARPC	Air Reserve Personnel Center
ASD	Assistant Secretary of Defense
ASF	aeromedical staging facility
AT	Annual Training
ATC	Access To Care
AWA	absent without authority
AWOL	absent without leave
BAH	basic housing allowance
BDD	benefits delivery at discharge
BSM	bed status menu
CAC	common access card
CAL	casualty affairs liaison

CAR	casuality assistance representative
CHCS	Composite Health Care System
CLN	clinical
CMS	Centers for Medicare and Medicaid Services
CMSAF	Chief Master Sergeant of the Air Force
CNM	certified nurse midwife
CONUS	continental US
CPT	current procedural terminology
CRO	carded for record only
CSS	command support staff
CST	casualty status
DDS	DEERS dependent suffix
DEERS	Defense Enrollment Eligibility Reporting System
DIS	disease
DOA	dead on arrival
DOD	Department of Defense
DODDS	Department of Defense Dependent Services
DOS	date of separation
DPMADS	AFMPC Disability Retirement Branch
DRG	Diagnosis Rebated Group
DSMIV	Diagnostic and Statistical Manual of Mental Disorders
DSN	Defense Switch Network
DTF	dental treatment facility
DVA	Department of Veterans Affairs
E&M	evaluation and management codes
EAD	extended active duty
EAR	extended ambulatory records
ECG or EKG	electrocardiograph
EFMP	Exceptional Family Member Program
EFMPO	Exceptional Family Member Program Officer
EHR	Electronic Health Record
EMEDS	Expeditionary Medical Service
EMF	employee medical folder
EPTS	existed prior to service
ERD	emergency room death

EST	eastern standard time
FDI	Facility Determination Inquiries
FIN	Foreign Identification Numbers
FMP	family member prefix
FMRC	family member relocation clearance
FPO	fleet post office
GO	General Officer
GSU	geographically separated units
HA	Health Affairs
HCPCS	Healthcare Common Procedural Codes System
HEAR PCM	Health Enrollment Assessment Review for Primary Care Managers
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HSI	Health Services Inspection
HSM	health services manager/health service management
IADT	initial active duty for training
IAW	in accordance with
ICD–10-CM	International Classification of Diseases—Tenth Revision, Clinical Modification
ICD–9	International Classification of Diseases
ICD–9-CM	International Classification of Diseases–9th Revision Clinical Modification
ID	identification
IEP	Individual Education Plans
IG	Inspector General
III	Incapacitating illness or injury
IMA	individual mobilization augmentees
IMET	International Military Education & Training Program
IN	Record Info
IRB	Institutional Review Board
IRR	individual ready reserve
IRS	Internal Revenue Service
ITIN	Individual Taxpayer Identification Number
JCAHO	Joint Commission on Accredition of Healthcare Organizations
KG-ADS	KC Ambulatory Data System
LOD	line of duty
MAJCOM	major command

MBO	Management by Objective
MCM	Manual for Courts Martial
MCSC	managed care support contracts
MDG	medical group
MEB	medical evaluation board
MEPRS	Medical Expense and Performance Reporting System
MFC	medical facility commander
MFP	medical focal point
MHS	Military Health System
MHSS	Military Health Service System
MilPDS	Military Personnel Data Systems
MLC	Medical Legal Committee
MMSO	Military Medical Support Office
MOU	Memorandum of Understanding
MOUT	MEPRS Reports Menu
MPF	Military Personnel Flight
MRT	Medical Record Tracking
MRTR2	Medical Record Tracking, Retirement, and Retrievel User Guide
MSA	Medical service account
MTF	military treatment facility
MUNS	munite site
NDOM	not due to own misconduct
NEC	not elsewhere classified
NLOD	not in line of duty
NOK	next of kin
NOS	not otherwise specified
NPRC	National Personnel Records Center
NSTR	Non-Service Treatment Records
OB	obstetrical
OF	Optional Form
OHA	overseas housing allowance
OI	operating instruction
OLUM	On Line Users Manual
OMCP	Overseas Medical Clearance Program
OP	optional

ORM	Output Reports menu
OSHA	Occupational Safety and Health Administration
OSI	Office of Special Investigations
OWCP	Office of Worker's Compensation
PAD	patient administration division/Patient Administrative Directory
PAM	Patient Affairs/Administrative Menu
PAS	Personnel Accounting Symbol
PAS	Patient Appointment and Scheduling
PAS	Privacy Act System
PATCAT	patient category
PCM	primary care managers
PCMHO	Patient Centered Medical Home
PCO	primary care optimization
PCS	permanent change of station
PEB	Physical Evaluation Board
PEBLO	Physical Evaluation Board Liaison Officer
PES	Physical Evaluation Section
PHI	protected health information
PHS	Public Health Service
PII	personally identifiable information
PKI	Air Force Key Infrastructure
POUT	Patient Affairs/Administrative Output Menu
PRP	personnel reliability program
PSP	Patient Safety Program
PSP	Presidential Support Program
QAF	Quality Air Force
RAD	radiology
RI	record injury
RM	referral management
RMC	referral management center
RMO	resource management office
SAF	Secretary of the Air Force
SATP	Security Assistance Training Program
SDP	Sensitive Duties Program
SES	Senior Executive Staff

SF	standard form
SG	Surgeon General
SI	seriously ill
SIDR	Standard Inpatient Data Record
SJA	Staff judge advocate
SNIAC	special needs identification and assignment coordinator/coordination
SSB	Special Separation Benefit
SSN	social security number
STR	Service Treatment Records
TAMP	Transition Assistance Management Program
TDRL	Temporary Duty Retired List
TIN	Temporary Identification Number
TM	Trace Movement
TOPA	Tricare Operations and Patient Administration
TPR	TRICARE Prime Remote
TQM	Total Quality Management
TSC	TRICARE service center
TTAD	tempoary tour of active duty
TTAT	tempoary tour of active training
USAFA	Unites States Air Force Academy
USAFR	United States Air Force Reserve
USCERT	US Computer Emergency Response Team
USHBP	Uniform Services Health Benefits Program
USPHS	United States Public Health Service
USTF	Uniformed Service Treatment Facility
VSI	Voluntary Separation Incentive
VSI	very seriously ill
WHO	World Health Organization
WSCH	Wait List Hold/Release Schedule

Student Notes

AFSC 4A051
Z4A051 02 1504
Edit Code 04