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Army Regulation 40-66

Medical Services

**Medical
Record
Administration
and Health
Care
Documentation**

Headquarters
Department of the Army
Washington, DC
21 June 2006

UNCLASSIFIED

SUMMARY of CHANGE

AR 40-66

Medical Record Administration and Health Care Documentation

This administrative revision dated 21 June 2006-

- o Replaces figure 6-1, page 2 (page 67).
- o Corrects typographical errors throughout.

This rapid action revision dated 22 May 2006-

- o Substitutes DD Form 2870 (Authorization for Disclosure of Medical or Dental Information) for DA Form 5006 (Authorization for Disclosure of Information) (throughout).
- o Outlines a cultural change whereby outpatient medical records are not transported by patients (para 1-4d, 1-5a, 1-5b, 5-28c(1), 6-4a(1), and 6-8).
- o Requires that original outpatient documentation stay at the medical treatment facility where it was created (para 1-4e(3)).
- o References DODI 6040.43 (para 1-5).
- o Adds provision for clinical use of electronic mail (para 2-8).
- o Requires that all medical records entries be timed (as well as dated) (para 3-4d).
- o Adds a provision for reporting detainee documentation (para 3-13d).
- o Provides new guidance on the procedures for inpatient and outpatient treatment record retirement (para 4-4a(5)).
- o Provides guidance on the Medical Registry System for accessioning, retiring, and retrieving inpatient and outpatient records (para 4-4c(4)).
- o Adds a requirement to print out laboratory and radiology reports before the record is retired (para 4-4c(5) and 9-25b).
- o Updates figures 5-1, pages 1 and 3; 5-2, pages 1 and 6; 6-1, pages 1 and 3; 6-2, pages 1 and 5; 7-1, pages 1 and 3; 9-1, pages 1 and 5; and 10-1, page 5.
- o Includes a requirement to send a copy or electronic version of the health record to the patient's ward (para 5-2c).
- o Adds a requirement to mail or courier the health record after a patient is released (para 5-2c(3)).

- o Requires the use of DD Form 2882 (Pediatric and Adolescent Preventive and Chronic Care Flow Sheet) instead of the DA Form 5571 (Master Problem List) for pediatric patients (para 5-10).
- o Includes instructions for filing the most recent Flying Duty Medical Examination (para 5-13b(1)).
- o Allows SF 600 entries to be typed, electronically entered, written in ink, or printed (para 5-18).
- o Requires an unremarried former spouse to use his/her own social security number for medical record identification (para 6-1).
- o Provides new guidance for initiating and keeping outpatient treatment records (para 6-3).
- o Updates guidance for family health center outpatient treatment records (para 6-4e).
- o Requires loose documents to be retired through Composite Health Care System or Composite Health Care System II medical records tracking (para 6-6a).
- o States that x-rays stored on electronic media are not eligible for retirement to National Personnel Records Center in outpatient treatment record folders (para 6-6c).
- o Adds new guidance on behavioral health records (para 6-7h).
- o Addresses retention requirements for civilian employee health records (para 7-2d).
- o Adds additional countries to the North Atlantic Treaty Organization listing (table 9-1).
- o Refers to appendix D of the Medical Record Tracking, Retirement, Retrieval User Guide for guidance on retirement of fetal monitors (para 9-3).
- o Provides new guidance on disposition of extended ambulatory records (para 10-6).
- o Adds the health record, outpatient treatment record, and civilian employee medical record to the list of those medical record delinquencies that are reported on a quarterly basis (para 12-3c).
- o Deletes SF 536 (Medical Record -- Pediatric Nursing Notes).

This revision, dated 20 July 2004--

- o Implements DOD 6025.18-R, Department of Defense Health Information Privacy Regulation.

- o Updates the responsibilities of military and dental treatment facility commanders to ensure compliance with the Privacy Rule of the Health Insurance Portability and Accountability Act (Public Law 104-191) and DOD 6025.18-R (para 1-4a(6)).
- o Adds a requirement to conduct an annual risk assessment to ensure compliance with the protected health information provisions outlined in DOD 6025.18-R (para 1-4e(4)).
- o Modifies the procedures for disclosure of protected health information, including psychotherapy notes (paras 2-3, 2-4, and 2-5).
- o Outlines the process by which individuals may file complaints when they believe that protected health information relating to them has been used or disclosed improperly (para 2-5).
- o Updates information concerning requested amendments to protected health information (para 3-4).
- o Adds a requirement to attach the Notice of Privacy Practices acknowledgement label to treatment folders (paras 4-4 and 7-4a).
- o Updates instructions regarding the disposal of health records for veterans who are filing medical claims (para 5-29a).
- o Updates instructions for filing inpatient treatment records for previous admissions and extended ambulatory records (paras 9-2b(1), 10-6a, and 10-7a(2)).
- o Adds permission for qualified podiatrists to perform admission histories and physical examinations (para 9-12a(3)).
- o Updates the management control evaluation checklist (app C).

This revision, dated 10 March 2003--

- o Reiterates the use of DA Form 4 (Department of the Army Certification for Authentication of Records) in certifying copies of medical records (para 2-5g).
- o Authorizes the filing of photographs in medical and dental records (para 3-1b).
- o Adds a requirement for countersignatures in cases of therapeutic abortions (para 3-16c).
- o Adds guidelines for recording videotaped documentation of episodes of medical care (para 3-18).
- o Revises the requirement to prepare carded-for-record-only cases to include only the deaths of active duty military personnel (para 3-19).

- o Prescribes the use of two new forms: DD Form 2766 (Adult Preventive and Chronic Care Flowsheet) and DD Form 2766C (Adult Preventive and Chronic Care Flowsheet--Continuation) (paras 5-13, 5-19, 5-32a, and 5-36a).
- o Updates the instructions for the use of a revised form, SF 602 (Medical Record--Serology Record) (paras 5-18g, 5-21b(10), and 5-26b(2)(1)).
- o Adds the filing of DA Form 4466 (Patient Progress Report) to the health record (para 5-21b(4)).
- o Adds the requirement to transfer the health record of a retiring member to the Veterans Affairs Records Management Center rather than to the National Personnel Records Center (para 5-29).
- o Authorizes the filing of DD Form 2341 (Report of Animal Bite--Potential Rabies Exposure) in various records (figs 5-1, 5-2, 6-1, 6-2, 7-1, 9-1, and 10-1).
- o Authorizes the filing of the Occupational Safety and Health Administration Respirator Medical Evaluation Questionnaire in several records (para 7-4b(8) and figs 5-1, 5-2, and 7-1).
- o Allows the option of filing DA Form 3666 (Department of the Army Nonappropriated Funds Statement of Physical Ability for Light Duty Work) in the Civilian Employee Medical Record (para 7-4b(11)(b)).
- o Prescribes the use of the Extended Ambulatory Record (chap 10).
- o Adds the definitions of an attending physician, a preceptor physician, and a senior resident to the glossary.
- o Rescinds the use of DA Form 5128 (Clinical Record--Visual Field Examination), DA Form 5694 (Denver Developmental Screening Test), DA Form 8007-R (Individual Medical History), and SF 556 (Immunochemistry).

Effective 21 July 2006

Medical Services

Medical Record Administration and Health Care Documentation

By Order of the Secretary of the Army:

PETER J. SCHOOMAKER
General, United States Army
Chief of Staff

Official:


JOYCE E. MORROW
Administrative Assistant to the
Secretary of the Army

History. This publication is an administrative revision. The portions affected by this administrative revision are listed in the summary of change.

Summary. This regulation prescribes policies for preparing and using medical reports and records in accordance with North Atlantic Treaty Organization Standardization Agreements 2348 ED.3(1), 2132 ED.2, and American-British-Canadian-Australian Quadripartite Standardization Agreement 470 ED.1.

Applicability. This regulation applies to the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve unless

otherwise stated. Also it applies to other members of the uniformed services of Allied nations who receive medical treatment or evaluation in an Army military treatment facility. This publication is applicable during mobilization.

Proponent and exception authority. The proponent of this regulation is The Surgeon General. The proponent has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25-30 for specific guidance.

Army management control process.

This regulation contains management control provisions and identifies key management controls that must be evaluated.

Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from the Office of The Surgeon General, ATTN: DASG-HS AP, 5109 Leesburg Pike, Falls Church, VA 22041-3258.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to the Office of The Surgeon General, ATTN: DASG-HS-AP, 5109 Leesburg Pike, Falls Church, VA 22041-3258.

Distribution. This publication is available in electronic media only and is intended for command levels A, B, C, D, and E for the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve.

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Glossary



Chapter 1 Introduction

1-1. Purpose

a. This regulation sets policies and procedures for the preparation, disposition, and use of Army electronic and paper medical records and other health care documentation discussed in the following chapters.

b. The purpose of a medical record is to provide a complete medical and dental history for patient care, medicolegal support (for example, reimbursement and tort claims), research, and education. A medical record also provides a means of communication, where necessary, to fulfill other Army functions (for example, identification of remains).

c. The following types of health-care records will be used to document medical and dental care. All care provided to beneficiaries as hospital inpatients will be recorded in an inpatient treatment record (ITR). Outpatient care on a military member will be recorded in either the member's treatment record or dental record. Combined, the treatment record and dental record are considered a health record (HREC). Care provided to nonmilitary beneficiaries will be documented in an outpatient treatment record (OTR) that includes a separate dental record. Both military and nonmilitary personnel enrolled in the Army Substance Abuse Program (ASAP) will have an ASAP outpatient medical record (ASAP-OMR). Occupational and nonoccupational outpatient care provided to a civilian employee will be recorded in a civilian employee medical record (CEMR).

d. The ability to retrieve the documentation of care provided to patients is paramount. The original documentation of outpatient care will be maintained at the medical treatment facility (MTF) where it was created. These documents will be maintained separately from health records (HREC), outpatient treatment records (OTR), and civilian employee medical records (CEMR). The MTFs which currently have access to electronic records documentation generating and storage systems may continue their use until the Composite Health Care System II (CHCS II) is implemented at that MTF. The MTFs that do not have access to electronic information systems must implement a paper medical document storage and retrieval system (see DODI 6040.43).

1-2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

1-3. Explanation of abbreviations and terms

a. Abbreviations and special terms used in this regulation are explained in the glossary.

b. Abbreviations and symbols authorized for use in medical records are explained in appendix B. Dental terminology, abbreviations, and symbols are provided in TB MED 250. The use of locally approved abbreviations and symbols is authorized if the conditions in paragraph 3-8 of this regulation are met. When electronic systems are utilized, users must resolve any inconsistencies concerning local abbreviations and capitalization.

1-4. Responsibilities

a. *Military treatment facility (MTF) and dental treatment facility (DTF) commanders.* The MTF or DTF commanders will—

- (1) Be the official custodians of the medical or dental records at their facilities.
- (2) Ensure that policies and procedures of this regulation are followed.
- (3) Issue local rules to enforce the policies and procedures stated in this regulation.
- (4) Ensure that an adequate and timely ITR is prepared for each patient who must have one.
- (5) Ensure that a blood sample for deoxyribonucleic acid (DNA) identification is on file with the Armed Forces Repository of Specimen Samples for the Identification of Remains for all military members and deploying civilians.
- (6) Ensure compliance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) (Public Law (PL) 104-191), DOD 6025.18-R, and with the process of investigations of privacy violations.

b. *Unit commanders.* If a commander acquires HRECs or documents belonging in HRECs, the commander will ensure that the documents are properly secured and sent to the proper HREC custodian without delay. As an exception to e(1), below, if no Army medical department (AMEDD) or MTF personnel are available to act as the custodian of unit HRECs, a unit commander may act as the custodian of his or her unit's HRECs, or, as an alternative, appoint a competent person of the unit as the custodian. Unit commanders will also ensure that information in HRECs is kept private and confidential in accordance with law and regulation. Examples of situations in which unit HRECs may be maintained centrally at a unit in the custody of the unit commander or competent designee include those units located away from an MTF, to include recruiting stations, Reserve Officers' Training Corps detachments, professors of military science, and Reserve Component (RC) units receiving medical or dental care from civilian facilities. HRECs maintained at such units must be managed in accordance with this regulation. Such units must place special emphasis on compliance with chapter 2 of this regulation. Questions about centralized HREC maintenance in isolated units will be referred to the Army Regional Medical Command with administrative responsibility for that geographic area. OTRs for family members accompanying those active duty military members assigned to isolated units will not be maintained at the unit. In accordance with paragraph 6-4 of this regulation, a copy of an OTR may be furnished to a pertinent family

member. However, the original record will be returned, along with an explanatory letter, to the MTF that last provided medical care to that family member.

c. RC specific commanders.

(1) State adjutants general will initiate, maintain, and dispose of Army National Guard of the United States (ARNGUS) HRECs.

(2) The Commander, HRC-Stl will initiate, maintain, and dispose of HRECs for Individual Ready Reserve (IRR) members.

(3) The Commanding General, Army Reserve Personnel Command (AR-PERSCOM), will initiate and dispose of HRECs for Individual Ready Reserve (IRR) members.

(4) The commander or assigned agency head will maintain and dispose of HRECs for Individual Mobilized Augmentees (IMAs).

d. Military personnel officers. Military personnel officers will—

(1) Initiate HRECs and send them to the proper HREC custodian.

(2) Ensure that the records of personnel who are changing stations are sent to the next duty station.

(3) Tell the HREC custodian of impending unit or personnel movements 1 month prior to movement or as soon as possible.

(4) Provide, on a quarterly basis, rosters that identify personnel for whom MTF and DTF commanders are medical record custodians.

(5) Keep secure any defense information in HRECs (para 2-7). When military personnel officers acquire HRECs or documents belonging in HRECs, they will ensure that the records are maintained confidentially (chap 2) and sent to the proper HREC custodian without delay.

e. AMEDD officers. AMEDD officers will—

(1) Serve as custodians of HRECs, except in those instances where exception is granted as outlined in *b* and *c*, above, and in paragraph 5-26b(1). AMEDD officers are in charge of the HRECs for members of the units to which they supply primary medical and dental care. They are also in charge of the HRECs of other individuals they are currently treating.

(2) Use HRECs for diagnoses and treatment. HRECs are important for the conservation and improvement of patient health. Therefore, AMEDD officers will ensure that all pertinent information is promptly entered in the HRECs in their custody. If any such pertinent information has been omitted, AMEDD officers will take immediate action to obtain such information from the proper authority and include it in the HREC.

(3) Send the appropriate records to the military member's HREC custodian when an AMEDD officer examines or treats a person whose HREC is not in his or her custody. Original outpatient documentation stays at the MTF where it was created. These records will be sent sealed in an envelope that is stamped or plainly marked "Health (or Dental) Records." In addition to the address, the envelope will also be plainly marked "Health (or Dental) Record of (person's name, grade, and Social Security number (SSN))." The person's unit of assignment will also be shown. If the HREC custodian is not known, the document will be sent to the medical department activity (MEDDAC), U.S. Medical Center (MEDCEN), or dental activity (DENTAC) commander of the person's assigned installation.

(4) At least annually, conduct risk assessments. Consistently, throughout the year, monitor internal policies to ensure compliance with the HIPAA Privacy Rule provisions outlined in DOD 6025.18-R.

f. Chief, Patient Administration Division. The Chief, Patient Administration Division of an MTF, will act for the commander in matters pertaining to medical records management and information. The office of patient administration will keep the professional staff informed of the requirements for medical records and related health care documentation.

g. Medical and dental officers. Medical and dental officers will ensure that—

(1) Information is promptly and accurately recorded on medical and dental forms.

(2) Records prepared and received from other MTFs and DTFs are promptly reviewed and filed in the medical record.

h. Health-care providers. Health-care providers will promptly and correctly record all patient observations, treatment, and care.

i. Chaplains. Hospital chaplains are allowed access to medical records subject to standards contained in the American Hospital Association Guidelines for Recording Chaplains' Notes in Medical Records. Visiting clergy will not have access to ITRs. Chaplains enrolled as students in clinical pastoral education courses will be afforded the same privileges as hospital chaplains. Chaplains assigned to a residential treatment facility (RTF) will be allowed, but not required, to document information in medical records. The RTF chaplain will document the factual and observational information called for in the American Hospital Association Guidelines. As a team member in an RTF, the chaplain is encouraged to include additional information that would be helpful for the total care and treatment of the patient. Such information is considered observational.

j. Persons within Department of the Army (DA) agencies. Persons within DA agencies who use protected health

information (PHI) for official purposes must protect the privacy and confidentiality of that information in accordance with law and regulation.

k. Research personnel. Research personnel will ensure that data collected from medical records are within guidelines of human use committees and maintain the confidentiality of patients. See AR 40-38 and paragraph 2-8 of this regulation.

1-5. Record ownership

a. Army medical records are the property of the Government. Thus, the same controls that apply to other Government documents apply to Army medical records. (See DODI 6040.43, AR 25-55, AR 25-400-2, and AR 340-21 for policies and procedures governing the maintenance and release of Government documents.)

b. Army medical records, other than those of RCs, will remain in the custody of the MTFs at all times. RC records will remain in the custody of the appointed HREC custodian. The medical records of special operations forces will also remain in the custody of the MTFs at all times. This medical record is the Government's record of the medical care that it has rendered and must be protected. The patient will not transport the HREC, OTR, or CEMR. Upon request, the patient may be provided with a copy of his or her record, but not the original record. Only one free copy may be provided to the patient. Procedures should ensure conscientious Government control over medical records for good medical care, performance improvement, and risk management. Limit access to all open record storage areas and to electronic records to authorized personnel only.

1-6. International standardization agreements

Some provisions of this regulation are covered by North Atlantic Treaty Organization (NATO) Standardization Agreements (STANAGs) 2348 ED.3(1) and 2132 ED.2 and American-British-Canadian-Australian (ABCA) Quadripartite Standardization Agreement (QSTAG) 470 ED.1. These parts are annotated to show the related agreement. Any proposed changes or cancellations of these provisions must be approved through international standardization channels.

Chapter 2

Confidentiality of PHI

2-1. General

This chapter explains DA policies and procedures governing the release of PHI pertaining to individual patients. The policies expressed in this chapter will be used in coordination with those expressed in AR 25-55, AR 340-21, and DOD 6025.18-R. Note that no information pertaining to the identity, treatment, prognosis, diagnosis, or participation in the ASAP will be released, except in accordance with AR 600-85, chapter 6, and chapter 8 of this regulation. Refer to AR 40-68, paragraph 2-5, for information pertaining to the confidentiality of medical quality assurance records.

2-2. Policies governing PHI

DA policy mandates that the confidentiality of PHI of both living and deceased individuals will be ensured to the fullest extent possible. PHI will be disclosed only if authorized by law and regulation.

a. Within DA, PHI may be used for treatment, payment, health care operations, and preventive care of patients. PHI may also be used within DA to monitor the delivery of health-care services, to conduct medical research, to provide medical education, to facilitate hospital accreditation, and to satisfy other official purposes.

b. Each Army MTF/DTF will give patients a copy of the Notice of Privacy Practices (NOPP). The NOPP explains to beneficiaries how their PHI may be used as well as their patient rights concerning PHI. Beneficiaries will sign the NOPP acknowledgment (para 4-4) showing that they received this notice. Note: A military prison inmate does not complete the NOPP acknowledgment.

c. Unless authorized by law or regulation, no person or organization will be granted access to PHI.

d. Any person who, without proper authorization, discloses PHI may be subject to adverse administrative action or disciplinary proceedings. Under HIPAA, penalties for misuse or misappropriation of PHI include both civil monetary penalties and criminal penalties. Civil penalties range from \$100 for each violation to a maximum of \$25,000 per year for the same violations. Criminal penalties vary from \$50,000 and/or 1-year imprisonment to \$250,000 and/or 10-years imprisonment (Sections 1320d-5 and 1320d-6, Title 42, United States Code). Report all possible violations of this regulation to the Privacy Officer and/or the commander, who will consult with the servicing legal office to determine a proper disposition for the reported violation.

e. PHI is often viewed by clerical and administrative personnel, such as secretaries, transcriptionists, and medical specialists. This access is authorized and necessary in order for an MTF to properly process and maintain information and records. However, the MTF commander will ensure that all persons with access to PHI are trained in their obligation to maintain the confidentiality and privacy of PHI. Required training includes web-based program modules covering health information privacy laws and procedures for using or disclosing PHI.

f. When PHI is officially requested for a use other than patient care, only enough information will be provided to satisfy the request.

g. All business associate arrangements in the form of contracts or other more informal memoranda involving PHI will establish satisfactory assurances to—

- (1) Ensure that the information is used only for intended purposes.
- (2) Safeguard the information from misuse.

h. The policy and the procedures contained herein do not apply specifically when members of the workforce exercise their right to—

- (1) File a complaint with the Department of Health and Human Services (HHS).
- (2) Testify, assist, or participate in an investigation, compliance review, proceeding, or hearing under the Social Security Act.

(3) Oppose any act made unlawful by the privacy laws, provided the individual or person has a good faith belief that the act opposed is unlawful, and the manner of the opposition is reasonable and does not involve a disclosure of PHI in violation of the privacy laws.

(4) Disclose PHI as a whistleblower and the disclosure is to a health oversight agency, public health authority, or an attorney retained by the individual for purposes of determining the individual's legal options with regard to the whistleblower activity.

(5) Disclose PHI to a law enforcement official if the employee is a victim of a crime and provided that the PHI is about a suspected perpetrator of the criminal act and is only limited to identification information. In response to law enforcement requests for limited information for identification and location purposes, the MTF may disclose only items listed in (a) through (h) below. (Note: PHI for the purpose of identification or location does not include DNA or DNA analysis, dental records or typing, samples or analysis of body fluids or tissue (see DOD 5025.18-R, para C.7.6.2.2).)

(a) Name and address.

(b) Date and place of birth.

(c) Social Security number.

(d) ABO blood type and Rh factor.

(e) Type of injury.

(f) Date and time of treatment.

(g) Date and time of death, if applicable.

(h) A description of distinguishing physical characteristics, including height, weight, gender, race, and eye color; presence or absence of facial hair (beard or mustache); scars; and tattoos.

(i) All sanctioning of employees, business associates, and limited data set recipients will be documented and retained for at least six years from the date of its creation.

(j) Individuals may file a complaint when they believe that PHI relating to them has been used or disclosed improperly; that an employee has improperly handled the information; that they have wrongfully been denied access to or opportunity to amend the information; or that the entity's notice does not accurately reflect its information practices. All such complaints must be in writing.

(k) The Freedom of Information Act/Privacy Official is the primary point of contact for individuals to file complaints pursuant to this policy.

(l) As stated in the NQPP, individuals may also complain to the HHS if they believe their privacy rights have been violated. If an individual chooses to file a complaint with HHS, the complaint must—

1. Be filed in writing, either on paper or electronically;

2. Name the entity that is the subject of the complaint and describe the actions that have allegedly been violations of the privacy standards; and

3. Be filed within 180 days of when the complainant knew or should have known that the violation occurred.

(m) All workforce members are prohibited from retaliating against individuals filing a complaint or requiring individuals to waive their rights to file a complaint with the HHS as a condition of the provision of treatment, payment, enrollment, or eligibility for benefits.

2-3. Release of information when the patient consents to disclosure

a. *Requests from patients.* If a patient requests information from his or her medical record or copies of documents in the record, the information or record will be provided to the patient.

(1) Any request from a patient for disclosure of information or documents from his or her own medical record must be in writing. The patient may complete DD Form 2870 (Authorization for Disclosure of Medical or Dental Information); if the form is not available to the patient, he or she may submit a letter detailing the request for information or documents. This form is available at the Department of Defense Forms Management Program Web site (www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm). If the patient is requesting information from his or her own record or a document from that record, the patient is not required to disclose the use of medical information. Accordingly, that

part of DD Form 2870 need not be completed by a patient who is requesting information or documents from his or her own record.

(2) If a physician or dentist determines that a patient's access to his or her own medical record could adversely affect the patient's physical, mental, or emotional health, the patient will be asked to designate a physician or dentist to receive the record. Such a determination, together with the rationale for such, should be documented by the determining physician or dentist in a memorandum for record to be forwarded with the record to a physician or dentist chosen by the patient. However, the failure or refusal of a patient to designate a physician to receive information from his or her health record does not relieve the Army of the obligation to eventually provide the requested information to the patient. In this circumstance, competent medical authority will institute and adhere to appropriate procedures to ensure that the actual or perceived harm to the patient by disclosure of the health record is minimized. All such medical records will be identified with a conspicuous strip of tape. (See para 4-4a(10).) Direct access of an identified patient to his or her original record will be allowed only in the presence of the patient administrator or his or her designee.

(3) PHI obtained from nonmilitary sources will be filed with the patient's medical record. Such information is available for further diagnosis and treatment of the patient and for other official DA uses. The MTF will release a copy of the information to the individual if requested to do so but will caution the patient that the copy is not certified as a correct and true copy. The patient or other requester will be told that the original PHI is the property of the nonmilitary facility and may be requested from the originating facility. This does not apply to PHI on patients treated under supplemental care. Such information may be released as a part of the patient's medical record.

b. Requests from third parties when patient consents to disclosure.

(1) PHI pertaining to a particular patient may be disclosed to a third party provided that the third party has obtained the prior written consent of the patient concerned. Whenever possible, DD Form 2870 will be completed by a patient to document the patient's consent to disclose PHI; if the form is not available to the patient, a letter may be used. The original DD Form 2870 or patient letter must be submitted by the third party with that party's request for a patient's PHI. In all cases, the DD Form 2870 or letter must—

(a) Be submitted in writing.

(b) Contain the patient's original signature and must be dated by the patient.

1. If the patient is a minor child, a parent or legal guardian must sign the consent form on behalf of the child. A minor child is any person who has not attained the age of 18 years and who is not emancipated as determined by the law of the State in which the MTF is located. (See the definition of a "patient with decision making capacity" in AR 40-3, glossary.)

2. If the patient has been determined to be mentally incompetent by a court of competent jurisdiction, the person who has been appointed as the legal guardian of that patient may sign the consent form on behalf of the incompetent patient. A copy of the court order appointing the legal guardian must accompany the signed consent form.

(c) Be submitted to the MTF for processing within one year from the date on which the form was signed by the patient. Consent forms older than one year are not valid.

(d) State the specific PHI for which the patient has consented to release. Only the specific information or medical record for which the patient has consented to release will be released.

(e) Name the individual or organization to whom the patient has authorized release of PHI. PHI will be released only to those persons or organizations named.

(f) State the purpose(s) for which the patient has consented for his or her PHI to be used upon disclosure to a third party.

(2) Consult with the local judge advocate to determine the validity of the information provided on a DD Form 2870.

(3) DA Form 4876 (Request and Release of Medical Information to Communications Media) will be used for release of PHI to communications media. This form is available on the AEL CD-ROM and at the USAPD Web site (www.apd.army.mil). (See AR 25-55, paragraph 3-200.)

2-4. Disclosure without consent of the patient

a. Requests from personnel within the Department of Defense (DOD).

(1) PHI may be disclosed to officers and employees of the DOD who have an official need for access in the performance of their duties; patient consent is not required.

(2) The MTF/DTF may, subject to specific terms and conditions addressed in DOD 6025.18-R, chapter 7, use or disclose PHI in the following situations without the individual's authorization or opportunity to object:

(a) When required by law or Government regulation.

(b) For public health purposes.

(c) About victims of abuse or neglect.

(d) For health oversight activities authorized by law.

(e) For judicial or administrative proceedings.

(f) For law enforcement purposes.

(g) Concerning decedents in limited circumstances.

~~(h) For cadaveric organ, eye, or tissue donation purposes.~~

~~(i) For research involving minimal risk.~~

(j) To avert a serious threat to health or safety.

(k) For specialized Government functions, including certain activities relating to Armed Forces personnel. Part 164, Title 45, Code of Federal Regulations (45 CFR 164) and DOD 6025.18-R allow a covered entity (including a covered entity not part of or affiliated with the DOD) to use and disclose the PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission. The purposes for which any and all of the PHI of an individual who is a member of the Armed Forces may be used or disclosed are the following:

1. To determine the member's fitness for duty, including but not limited to the member's compliance with standards and all other activities carried out under the authority of AR 40-501, AR 50-5, AR 635-40, and similar requirements.

2. To determine the member's fitness to perform any particular mission, assignment, order, or duty, including compliance with any actions required as a precondition to performance of such mission, assignment, order, or duty.

3. To carry out activities under the authority of DOD Directive (DODD) 6490.2.

4. To report on casualties in any military operation or activity according to applicable military regulations or procedures.

5. To carry out any other activity necessary to the proper execution of the mission of the Armed Forces.

(l) For workers' compensation programs. PHI may be disclosed to comply with workers' compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.

(3) DOD personnel will submit requests for PHI on DA Form 4254 (Request for Private Medical Information) (available on the AEL CD-ROM and at the Army Publishing Directorate Web site (www.apd.army.mil)). Ordinarily, direct access to medical records will not be permitted. Only the minimum necessary PHI will be provided to satisfy the intended purpose. When requesting disclosure of a patient's PHI, DA personnel will present their official credentials and document their official need to know the requested information.

(4) The receiving MTF will file all DA Forms 4254 received according to AR 25-400-2.

b. *Requests from the Defense Security Service (DSS).* DSS agents are required to provide the following appropriate release form(s) before they are provided the requested information.

(1) A completed DSS Form 40 (Alcohol and Drug Abuse Information Release and Consent to Rediscovery) is required for release of ASAP records to DSS agents.

(2) A completed "Authorization for Release of Medical Information" included in Standard Form (SF) 86 (Questionnaire for National Security Positions) is required for release of information from HRECs.

(3) A completed DSS Form 16 (Doctor/Patient Release Statement) is required before releasing general records maintained by doctors, hospitals, and other institutions pertaining to medical or psychiatric examinations or treatment. This form should also be used if the DSS agent desires to interview a physician for evaluation or opinion of the individual's case.

c. *Other requests.* All other requests for disclosure of PHI will be analyzed and processed according to AR 25-55 and AR 340-21.

2-5. Processing requests for PHI, restrictions, and revocations

a. The MTF commander is responsible for the management and oversight of this program. The patient administrator, as the representative of the MTF commander, is responsible for the processing of requests for patient PHI. In the absence of the patient administrator, the acting patient administrator will assume this responsibility.

b. All requests for patient PHI must be submitted in writing using DD Form 2870; if the form is unavailable to the patient, a letter may be submitted instead. Requests will be acted on within 30 days. In urgent situations, facsimile requests for disclosure may be accepted. In some situations (for example, cases of emergency, rape, assault, child abuse, or death), the need for information may be extremely urgent. In such cases, a verbal request for disclosure of medical information or medical records may be submitted and acted on. The requester will be informed that the verbal request must be supplemented by the submission of a written request according to law and regulation, at the first available opportunity.

c. Authorization for the release of PHI will normally be documented in writing. However, in certain emergency situations, the MTF commander or patient administrator may verbally authorize the release of PHI, provided that such release is otherwise authorized by law and regulation. Immediately after granting verbal authorization for disclosure, the authorizing official will prepare a memorandum for record, documenting the release and the reasons for the use of emergency procedures.

d. Usually, copies of PHI authorized for release must be picked up, in person, by the requester or other person to whom disclosure has been authorized. In emergency situations, facsimile transmission of released PHI is authorized, provided that appropriate measures are taken to ensure that the information is delivered to the correct party. A cover letter, including a confidentiality notice, will accompany each such facsimile transmission. The confidentiality notice will include instructions on redisclosure and destruction of the disclosed information. A sample is shown in figure 2-1.

e. MTF commanders or patient administrators will determine the legitimacy of the request for patient PHI. MTF commanders or patient administrators are encouraged to seek the advice and assistance of their servicing judge advocate in determining the legitimacy of a request for disclosure and in authorizing release of PHI.

****CONFIDENTIALITY NOTICE****

The documents accompanying this facsimile transmission contain confidential information, belonging to the sender, that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for return of these documents.

Figure 2-1. Sample confidentiality notice accompanying facsimile transmissions

f. Only that specific PHI required to satisfy the terms of a request will be authorized for disclosure. If the request is for psychotherapy notes, the patient administrator or his/her representative will obtain an authorization for use or disclosure except—

(1) To carry out the following treatment, payment, or health care operations:

(a) Use by the originator of the psychotherapy notes for treatment.

(b) Use or disclosure by the covered entity for its own training programs that students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.

(c) Use or disclosure by the covered entity to defend itself (or to defend the United States in a claim or action brought under the Federal Tort Claims Act or Military Claims Act, in a legal action, or other proceeding brought by the individual).

(2) A use or disclosure that is—

(a) Required by the Secretary of HHS in relation to compliance activities of the Secretary of HHS.

(b) Required by law.

(c) Pertaining to uses and disclosures for health oversight activities, with respect to the oversight of the originator of the psychotherapy notes.

(d) Pertaining to uses and disclosures about decedents to coroners and medical examiners.

(e) Pertaining to uses and disclosures to avert a serious and imminent threat to health or safety of a person or the public, which may include a serious and imminent threat to military personnel or members of the public or a serious or imminent threat to a specific military mission or national security under circumstances which in turn create a serious and imminent threat to a person or the public.

g. If a request for certified disclosure of all or part of the request for patient PHI is approved, certified copies of that information or record will be released. (See AR 27-40 and paragraph 12-4b(3) of this regulation for the use of DA Form 4 (Department of the Army Certification for Authentication of Records) to certify records.) If the requester seeks disclosure of the original records, the requester must justify, in writing, why certified copies are not adequate to fulfill the purpose for which the records are being sought. Advice of the local judge advocate should be sought in determining the legitimacy of a request for disclosure of an original record.

h. A copy of the request for disclosure of PHI, a copy of any consent form, together with copies of the disclosure authorization and a notation of which records have been disclosed, will be filed in the patient's medical record. If these copies cannot be made, the request will be annotated to reflect the specific information disclosed. When requests are made for information from both inpatient and outpatient records at the same time, the request and an annotation of which copies were disclosed will be filed in the inpatient record. The outpatient record will be properly cross-referenced.

i. A patient has the right to request restrictions on the uses and disclosures of their medical record.

(1) The MTF/DTF is not required to agree to the restriction. The restriction should be denied if the MTF/DTF

cannot reasonably accommodate the restriction, if it conflicts with this regulation or any other applicable DOD or DA directive, or for any other appropriate reason. A response to a request for restriction should be provided to the individual requesting it as soon as practicable and should include the rationale for denying it, if the request is denied in whole or part.

(2) The MTF/DTF commander or designee must act on requests to restrict information in a timely manner and do so in writing. No restriction will be effective above the management authority level that agreed to the restriction. No restriction will be effective unless the person agreeing to the restriction is actually authorized to agree to it and establishes a written record of the restriction.

(3) The needs of the patient should be weighed against the burden that would be put on the facility to comply with the request. If the restriction is granted, the patient should be informed that the restriction is not permanent, that it only applies to the individual or MTF that granted the restriction, and that it does not transfer to another individual or MTF.

j. An individual may revoke an authorization provided under this section at any time, if the revocation is in writing, except if the MTF/DTF has already taken action on the authorization. The MTF/DTF will document and retain any signed authorization and/or revocation.

k. An individual has a right to receive an accounting of PHI disclosures made by a covered entity in the six years prior to the date that the accounting is requested, except for disclosures—

(1) To carry out treatment, payment, and health care operations as provided in DOD 6025.18-R, chapter 4.

(2) To individuals of PHI about themselves.

(3) Pursuant to an authorization under DOD 6025.18-R, chapter 5.

(4) For the facility's directory or to persons involved in the individual's care or other notification purposes as provided in DOD 6025.18-R, chapter 6.

(5) For national security or intelligence purposes as provided in DOD 6025.18-R, paragraph C7.11.4.

(6) To correctional institutions or law enforcement officials as provided in DOD 6025.18-R, paragraph C7.11.6.

(7) As part of a limited data set according to DOD 6025.18-R, section C8.3.

(8) Incident to a use or disclosure otherwise permitted or required by DOD 6025.18-R, section C8.4.

(9) That occurred prior to 14 April 2003.

l. Information for each disclosure will include—

(1) The date of the disclosure.

(2) The name of the entity or person who received the PHI and, if known, the address of such entity or person.

(3) A brief description of the PHI disclosed.

(4) A brief statement that reasonably informs the individual of the basis for the disclosure; or, in lieu of such statement, a copy of a written request for disclosure under DOD 6025.18-R, section C2.5, or chapter 8, if any.

m. The covered entity will provide the first accounting to an individual in any 12-month period without charge. The covered entity may impose a reasonable, cost-based fee according to AR 25-55 for each subsequent request for an accounting by the same individual within the 12-month period, if the covered entity informs the individual in advance of the fee and provides the individual with an opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.

n. Fees and charges for copying, certifying, and searching records will be calculated and imposed according to AR 25-55, chapter 6.

o. Continued coordination with a judge advocate is encouraged on all matters pertaining to the request for and disclosure of patient PHI.

2-6. Medical records of teenage family members

a. Disclosure of information.

(1) Minors have rights to access under the Privacy Act, Section 552a, Title 5, United States Code (5 USC 552a). Parents or guardians have a right to access the medical records of their minor children under the Privacy Act, 5 USC 552a(h). The law of the State in which the minor is located determines whether, for the purposes of the Privacy Act, the child is a minor. If not a minor, the teenager can act on his or her own behalf and the parent or guardian does not have a right to access. If, however, the teenager is a minor under the State law where he or she resides, then the law of the State in which the medical record is maintained governs the disclosure of information from that record. Patient administrators must be especially sensitive to restrictions contained in statutory or regulatory programs for—

(a) Drug and alcohol abuse.

(b) Venereal disease control.

(c) Birth control.

(d) Abortion.

(2) For overseas installations, the opinion from the DOD Privacy Board Legal Committee (23 September 1998) will be used. (See fig 2-2.)

The Privacy Act applies to any "individual" which is defined as "a citizen of the United States or an alien lawfully admitted for permanent residence" (5 USC section 552a(a)(2)). With respect to any rights granted the individual, no restriction is imposed on the basis of age; therefore, minors have the same rights and protections under the Privacy Act as do adults.

The Privacy Act provides that "the parent of any minor . . . may act on behalf of the individual" (5 USC section 552a(h)). This subsection ensures that minors have a means of exercising their rights under the Privacy Act (Office of Management and Budget Privacy Act Guidelines (OMB Guidelines), 40 Federal Register 28949, 28970 (July 9, 1975)). It does not preclude minors from exercising rights on their own behalf, independent of any parental exercise. Parental exercise of the minor's Privacy Act rights is discretionary. A Department of Defense (DOD) component may permit parental exercise of a minor's Privacy Act rights at its discretion, but the parent has no absolute right to exercise the minor's rights absent a court order or the minor's consent. See OMB Guidelines, 40 Federal Register 56741, 56742 (December 4, 1975). Further, the parent exercising a minor's rights under the Privacy Act must be doing so on behalf of the minor and not merely for the parent's benefit (DePlanche v. Califano, 549 F. Supp. 685 (W.D. Mich. 1982)).

The age at which an individual is no longer a minor becomes crucial when an agency must determine whether a parent may exercise the individual's Privacy Act rights. With respect to records maintained by DOD components, the age of majority is 18 years unless a court order states otherwise or the individual, at an earlier age, marries, enlists in the military, or takes some other action that legally signifies attainment of majority status. Once an individual attains the age of majority, Privacy Act rights based solely on parenthood cease.

Figure 2-2. Defense Privacy Board Advisory Opinion—the Privacy Act and Minors, 23 September 1998

b. Medical confidentiality. So that medical confidentiality will not be compromised, medical records of minors that contain information mentioned in *a(1)(a)* through *a(1)(d)*, above, will be maintained as "Mental Health Records (Minors)." Because PHI in these records may be an important part of continued and follow-up care, SF 600 (Medical Record—Chronological Record of Medical Care) will note "Patient seen, refer to file number 40-216k2" and will be filed in the patient's OTR. Disposition of these records will be in accordance with AR 25-400-2, file number 40-216k2, (mental health records (minors)). (See table 3-1 and para 6-7h of this regulation.)

2-7. Disclosure of medical records containing classified defense information

a. Medical records will not usually contain classified defense information. The entry of such information should be avoided unless doing so jeopardizes the interests of the patient or of the Government. If entered, the documents containing classified defense information will be safeguarded and transferred according to AR 380-5. The custodian of the record will state on SF 600 that the record has a classified portion. Such documents will be screened often to see whether declassification is possible. When declassified, a note will be made on SF 600, and the documents will be returned to the custodian of the record.

b. Before records are sent to the Department of Veterans Affairs (VA), any separate file of documents bearing defense information will be reviewed for possible declassification. Documents that cannot be declassified will not be sent to the VA. Those documents in records of officers and warrant officers will be sent to the Commander, USA HRC—Alexandria, ATTN: AHRC—MSO, Alexandria, VA 22332-0002. Those documents in records of enlisted personnel will be sent to the Commander, AHRC—RP, 8899 56th Street, Indianapolis, IN 46249.

2-8. Research using military medical records

Qualified people may have access to Army medical records—electronic or paper—and biostatistical information for research and study. Access may be granted to records in MTFs and DTFs, Army record centers, and facilities of the General Services Administration. Medical records used for research will not be removed from the MTF or DTF or the center; space and facilities will be furnished by the custodian. Further, commanders of MTFs and DTFs will not borrow retired records for researchers. The Surgeon General will approve any exception.

a. Approval of requests.

- (1) The Surgeon General will approve all requests for research. An exception to this is given in (2), below.
- (2) The MTF/DTF commanders will approve requests from personnel under their command whose research projects

involve medical records at that facility. Researchers will abide by applicable portions of AR 49-38 and 32 CFR 219 and obtain approval from the Institutional Review Board.

b. Submission of requests. With the exception of those requests falling under *a*(2), above, all requests from outside and within DA will be made through channels to U.S. Patient Administration Systems and Biostatistics Activity, ATTN: MCHS-IN, 1216 Stanley Rd., Ste. 25, Fort Sam Houston, TX 78234-6000. Such requests will—

- (1) Provide the names and addresses of the researcher and of any assistants.
- (2) List the professional qualifications of the researcher and of any assistants.
- (3) Describe the researcher's project or field of study.
- (4) Provide the reason for requesting the use of Army records.
- (5) Name the particular records needed (for example, the historical range for which records are desired) and their location.

(6) Give inclusive dates when access is wanted.

(7) Attach evidence of institutional approval (training director) for residency training projects.

(8) Have each person named in the request sign an agreement that lists the following conditions:

(a) Information taken from Army medical records will be treated according to the ethics of the medical and dental profession.

(b) The identities of people mentioned in the records will not be divulged without their permission, and photographs of a person or of any exterior portion of his or her body will not be released without his or her consent.

(c) The researcher understands that permission to study the records does not imply approval of the project or field of study by The Surgeon General.

(c) All identifying entries about a person will be deleted from abstracts or reproduced copies of the records. Health information that does not identify an individual and there is no reasonable basis to believe that the information can be used to identify an individual is not considered individually identifiable health information.

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

c. Access authorization proof. Any approval letter from The Surgeon General allowing access to records will be shown to the proper authority (Chief, Patient Administration Division; health information administrator) when requesting access to records at the MTF level.

d. Clinical use of electronic mail. Clinical use of electronic mail in provider-to-patient communications will be in accordance with MEDCOM guidance.

Chapter 3

Preparation of Medical Records

Section I

Forms and Documents

3-1. Authorized forms and documents

a. The forms authorized for use in medical and dental records are listed in the figures in chapters 5, 6, 7, 8, 9, and 10. Unless authorized by this regulation, only documents prepared by authorized AMEDD personnel will be filed in Army medical records. (This restriction does not prohibit the use of other documents created by attending physicians and dentists outside the AMEDD (Navy, Air Force, civilian, and so forth), or the filing of other documents as summaries or brief extracts. If such documents are filed, their source, and the physician or dentist under whom they were prepared, must be identified.)

b. Photographs may be mounted on authorized forms and filed in medical and dental records. They may be mounted on various forms, depending on the size of the photo and the interpretation location. Examples of forms that may be used for this purpose are DA Form 4700 (Medical Record—Supplemental Medical Data), Department of Defense (DD) Form 2161 (Referral for Civilian Medical Care), SF 513 (Medical Record—Consultation Sheet), and SF 600.

c. Recordkeeping requirements (file numbers) required by this regulation are listed in table 3-1.

3-2. Filing electronic/computerized forms

a. Electronic/computerized medical reports may be filed in Army medical records. Examples of such reports are electrocardiograms, coronary care unit or intensive care unit vital-sign-monitoring records, scans, anesthesia monitoring records, commercially available emergency room charting systems, and laboratory test results. Such reports will be filed with the SFs, DD forms, or DA forms to which they most closely relate (for example, electrocardiogram and cardiac monitoring with Optional Form (OF) 520 (Clinical Record—Electrocardiographic Record) (formerly SF 520),

anesthesia monitoring with DA Form 7389 (Medical Record—Anesthesia) (formerly SF 517 and OF 517), commercially available emergency room charting systems with SF 558 (Medical Record — Emergency Care and Treatment), and laboratory test results with SF 545 (Laboratory Report Display). Undersized reports, such as monitoring strips, will be mounted on DA Form 4700 overprints identified as display sheets, except for cardiac rhythm strips, which may be mounted on the corresponding SF 510 (Medical Record—Nursing Notes). When DA Form 4700 is used, it should be referenced on SF 600. (Also see paras 3-3, 9-2, and 12-4 for information on DA Form 4700.)

b. When a computerized or electronic summary of all previous laboratory (lab) tests is provided, only the cumulative final report will be filed. All other results will be discarded. For this reason, it is vital that health-care providers not document PHI or opinions on the daily lab reports because they will not be retained.

c. Computerized or electronic versions of recognized forms will include reference to “electronic version of (form number)” in the lower-left corner and must be mirror images of DOD or DA forms.

d. The Interagency Committee on Medical Records, with approval of the General Services Administration, has eliminated the requirement that every electronic version of a medical standard or optional form be reviewed and granted an exception. The elements required for electronic versions of these forms have been published in the Federal Register. These elements must be included in any electronic versions of these forms.

e. MTFs may discontinue the daily filing of laboratory and radiology results in the medical record and maintain these results electronically within the Composite Health Care System (CHCS), CHCS II, or clinical information system (CIS). MTFs planning to implement this practice will develop a migration plan before converting to the electronic storage of test results. These plans will include the following, at a minimum:

(1) Procedures for ensuring laboratory and radiology reports will be properly authenticated in CHCS, CHCS II, or CIS by authorized MTF staff members according to CHCS, CHCS II, or CIS functionality and business rules.

(2) Procedures for providing information during CHCS, CHCS II, or CIS unavailability and for entering any results obtained if or when the system is unavailable.

(3) Mechanism for retrieval of archived information.

(4) Procedures for ensuring cumulative laboratory and radiology results are filed in medical records upon permanent change of station (PCS), referral for treatment to other facilities, record retirement, and valid request.

(5) Procedures for ensuring test results for active duty members assigned to deployable units are included in DD Form 2766 (Adult Preventive and Chronic Care Flowsheet), or other applicable documents created during a deployment, and ultimately placed in the active duty member's OTR/HREC.

3-3. Guidelines for local forms and overprints

The approval of overprinted medical forms and proposed forms using the DA Form 4700 overprint not listed in figures in chapters 5, 6, 7, 8, 9, and 10 is delegated to MEDCEN and MEDDAC or DENTAC commanders, using the guidelines described in *a* through *r*, below.

a. Local forms and proposed overprints will be well thought out in content and design; be well identified with a title, heading, and or subject; and present data in a neat and organized format. The MTF or DENTAC overprint number will appear under the form number and edition date on each form or overprint. On SF overprints, the entry “approved by U.S. Army Publishing Directorate” must be printed under the overprint number.

b. All overprinting of SFs, OFs, DD forms, and DA forms must be processed and approved before implementation. Overprinting of these forms is limited to items that specifically pertain to the form on which they are printed (for example, admission note overprint on SF 509 (Medical Record—Progress Notes) and nursing history and assessment overprint on DA Form 3888-2 (Medical Record—Nursing Care Plan)). Other overprints should be printed on DA Form 4700.

c. The MTF or DENTAC group that reviews medical records is directly responsible for review and approval of local forms and overprints.

d. Local forms and overprints submitted to the MTF or DENTAC for review and approval as in *c*, above, will be accompanied by written justification.

e. Creation of a form for which a higher echelon form exists (for example, creation of a local form as a substitute for an SF) is prohibited.

f. Titles of overprints should be printed inside the border of the form because titles printed at the top of the page between hole perforations are obscured when the forms are fastened in the records. OF 275 (Medical Record Report) may be used in ITRs, HRECs, and OTRs. OF 275 may be used for the transcription of dictated reports, or it may replace approved overprints on DA Form 4700. When OF 275 is used, the title and number of the form that it replaces are noted in the bottom part of the form. All standard information needed on the report form replaced by OF 275 will be entered on OF 275, including subtitles and name and address of MTF. OF 275 will be filed in the ITR, HREC, or OTR, according to the number of the form that it replaces. (Also see para 9-12 for information to be included on OF 275.)

g. Overprints on SFs, OFs, DD forms, and DA forms (other than DA Form 4700) must facilitate completion of subject forms, not provide “substitute” information.

h. Overprints that contain fill-in lines and or lined charts or graphs must be printed on DA Form 4700, rather than

~~lined SFs, GFs, DD forms, or DA forms. Lined overprints superimposed on lined SFs, GFs, DD forms, and DA forms create serious printing and user problems.~~

- i. Overprinting on nonstandard-size DA Forms 4700 (for example, 8-inch by 13-inch overprints) will not be approved.
- j. Multi-page forms and overprints should be printed on both sides of the paper (head to foot) and indicate "page 1 of 3," "page 2 of 3," and so on if they consist of more than two pages.
- k. Overprints on SF 509 and SF 600 should not extend over into the "Date" column, except for data pertaining specifically to the date and or time entry.
- l. Ward policies and procedures should not be included in forms and overprints because they do not belong in the patient's medical record.
- m. Worksheets should not be overprinted on SFs, DD forms, and DA forms (including DA Form 4700) because these documents will not be permanently filed in medical records.
- n. When preprinted instructions are given to the patient and family, the patient's record will so indicate, and a sample of the instruction sheet will be retained in the ITR, HREC, or OTR on a DA Form 4700 overprint. Local policy will dictate how classes, videos, and other types of learning activities are documented. (Also see para 3-18.)
- o. Preprinted instructions to the health-care provider do not belong in the patient's record and therefore should not be included in local forms and overprints.
- p. Approval for entering doctors' orders on DA Form 4256 (Doctor's Orders) and DA Form 4700 is not required, including orders that are handwritten, taken over the phone by authorized personnel, or overprinted as standing orders. (See para 9-26.)
- q. OF 522 (Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures) (formerly SF 522) or a State-mandated consent form will be used to meet the requirements of counseling and authorization required for consent to inpatient or outpatient medical or dental care. Local consent forms will not be used in place of these forms.
- r. Use of abbreviations on forms and overprints should be in strict compliance with those included in appendix B or locally approved in accordance with paragraph 3-3c. Otherwise the abbreviations must be spelled out.

Section II Medical Record Entries

3-4. General

a. *Content.* Entries will be made in a record by the health-care provider who observes, treats, or cares for the patient and in accordance with the locally defined patient assessment policy. No health-care practitioner is permitted to complete the documentation for a medical record on a patient unfamiliar to him or her. In unusual extenuating circumstances (for example, death of a provider), local policy will ensure that all means have been exhausted to complete the record. If this action is impossible, the medical staff may vote to file the incomplete record as is. Documentation summarizing the reason for the action will be filed with the record.

b. *Legibility.* All entries must be legible. Entries should be typed, but they may be handwritten. (However, radiology, pathology, and operative reports, as well as narrative summaries, will be typewritten.) Handwritten entries will be made in permanent black or blue-black ink, except when pencil entries are either directed or necessary under field conditions. Erasable ink and felt tip pens will not be used. Rubber stamps may be used only for standardized entries, such as routine orders.

~~Signatures.~~ All entries must be signed or electronically authenticated.

(1) Electronic signatures on a medical record are usually admissible and will not normally jeopardize the admissibility of the record in court. However, courts address this issue on a case-by-case basis. (See the definition of "electronic signature" in the glossary, sec II.)

(2) The first entry made by a person will be signed (first and last name); later entries on the same page by that person will be signed or initialed. (A military member must add grade and corps; a civilian must add his or her title or certification.) To verify initials that are on ITR documents, a DA Form 4700 with the typed name of each staff member, their payroll signature, and their initials must be placed in each ITR. Initials must be legible and correspond to the individual's name.

(3) Rubber-stamped signatures will not be used in place of written signatures, initialing, or electronic authentication. However, the use of (rubber) block stamps or handprinted or typed names under written signatures is recommended because it establishes a method to identify the authors of entries. Block stamps for military members will contain printed name, grade, and corps (officers), or military occupational specialty (enlisted); block stamps for civilians will contain printed name and title or certification or professional licensure (such as registered nurse (RN) or licensed practical nurse (LPN)).

d. *Dating and timing entries.* All entries must be dated and timed. Dates will be written in the day-month-year sequence; months will be stated by name, not by number. For example, a correct entry is 17 Jun 2005 @ 1400 hours.

e. *Corrections to entries.* To correct an entry, a single line is drawn through the incorrect information, and it is

noted as "error," then dated and initialed. This information must remain readable. Deletion, obliteration, or destruction of medical record information is not authorized. The new information is then added, with the reason for the change (for example, "wrong patient's chart"); the date; and signature (with title) of the person making the change. Electronic corrections to entries must show a complete audit trail.

f. Amendment to medical records.

(1) Under HIPAA, individuals have the right to request an amendment or correction to their PHI. MTFs/DTFs will have procedures in place to address this issue.

(2) MTFs/DTFs may deny any individual's request for amendment, if they determine that the PHI that is subject to the request—

(a) Was not created by the covered entity, unless the individual provides a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment.

(b) Would not be available for inspection under DOD 6025.18-R, chapter 11; or

(c) Is accurate and complete.

(3) If the MTF/DTF denies the requested amendment, in whole or in part, they will provide the individual with a timely, written denial, written in plain language, that will contain—

(a) The basis for the denial.

(b) A statement of the individual's right to submit a written statement disagreeing with the denial.

(c) A description of how the individual may file such a statement.

(d) A description of how the individual may complain to the MTF/DTF, to include the name, title, and telephone number of the contact person or office designated to receive such complaints.

(e) A description of how the individual may file a complaint with the HHS.

(f) A statement that, if the individual does not submit a statement of disagreement, he or she may request that the MTF/DTF provide his or her request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment.

(4) Medical records will be amended according to AR 340-21, paragraph 2-10.

g. Use of rubber stamps. Rubber stamp entries constitute overprints only when they are used to collect clinical data, not when used to document administrative data, such as the name of a specialty clinic, time and date of clinic visit, or signature block.

3-5. Patient identification

The patient identification section will be completed when each record document is begun. The patient's recording card will be used for the HREC and OTR; the inpatient identification plate will be used for the ITR. When mechanical imprinting is not available, patient identification will be typed, computer-generated, or handwritten in black or blue-black ink. Patient identification must include at least the patient's name; his or her rank, grade, or status; his or her family member prefix (FMP) and sponsor's SSN (para 4-1); the patient's SSN; date of birth; code for MTF that maintains records; and his or her register number (if any).

a. Patient's recording card. This card is used to enter identifying data on forms filed in the OTR and HREC; it is used with the ward or clinic identification plate. (See *b*, below.) The card also may be used as an appointment card. An adhesive-backed paper appointment notice may be attached to the back. The clinic receptionist or appointment clerk fills in the date, time, and clinic name on the blank lines of the notice. (The notice also has space for the name, location, and telephone number of the MTF.) This information is then available to the patient and to clinical personnel during the patient's next visit.

(1) The patient's recording card should be prepared when the patient is first examined or treated in a troop medical clinic, health clinic, or MTF. The patient's DD Form 1173 (Uniformed Services Identification and Privilege Card) or DD Form 2(ACT) (Armed Forces of the United States Identification Card (Active)), DD Form 2(RES) (Armed Forces of the United States Identification Card (Reserve)), or DD Form 2(RET) (United States Uniformed Services Identification Card (Retired)) will be used to prepare the card; these forms contain all the information needed to prepare the patient's recording card.

(2) The information that may be embossed on the patient's recording card is given below. Format may vary at MTFs using the CHCS, CHCS II, or CIS. The optical card reader font will be used for the FMP and SSN to make the filing of records easier. The suggested format for this card is described in (a) through (e), below.

(a) *Line 1.* Spaces 1 through 14—FMP and SSN (para 4-1). Spaces 15 through 22—Blank.

(b) *Line 2.* All spaces—Blank.

(c) *Line 3.* Spaces 1 through 22—Patient's name (last, first, and middle initial).

(d) *Line 4.* Spaces 1 through 4—Year of birth. Space 5—Blank. Space 6—Sex (M—male, F—female). Spaces 13 through 16—Status of patient and of sponsor if patient is a family member (for example, AD equals active duty). Space 17—Blank. Spaces 18 through 22—Department of patient or of sponsor (Army, Navy, Air Force, and so forth.).

(e) *Line 5.* Spaces 1 through 3—Three-character abbreviation of grade or rank of patient or of sponsor if patient is a

family member; otherwise, blank. Space 4—Blank. Spaces 5 through 22—Sponsor's name, if patient is a family member; otherwise, blank.

(3) Because patients may be treated at several MTFs, information identifying the MTF that is the custodian of the patient's record, as well as any other locally required information, may be imprinted on the card.

(4) The patient's recording card is designed only to make the printing of identification data on records easy. It is not used to determine eligibility of care. Such determinations are made in accordance with AR 40-400.

b. Ward or clinic identification plate. This plate is used to identify the MTF and the nursing unit or clinic. It will also be used to identify the Uniformed Chart of Accounts code. This plate is used with the inpatient identification plate and the patient's recording card. Suggested format for this plate is as follows:

- (1) *Lines 1 and 2.* Name and location of MTF and Uniformed Chart of Accounts code.
- (2) *Line 3.* Name of the nursing unit or clinic.

c. Inpatient identification plate. This plate is used to imprint patient identification information on all forms in the ITR; it is used with the ward or clinic identification plate.

(1) Format may vary at CHCS, CHCS II, or CIS facilities. The suggested format for this plate is as follows:

(a) *Lines 1 and 2.* All spaces—Blank.

(b) *Line 3.* Spaces 8 through 23—Patient's name (last, first, and middle initial). Space 24—Blank. Spaces 25 through 29—Rank, grade, or status.

(c) *Line 4.* Spaces 8 through 15—Register number. Space 16—Blank. Spaces 17 through 29—FMP and sponsor's SSN (para 4-1).

(d) *Line 5.* Space 8—Sex (M—male, F—female). Space 9—Blank. Spaces 10 through 12—Age. Spaces 13 through 29—Blank.

(2) The patient's identification plate will accompany the medical record. When the patient is ready for final disposition, local procedure will cover the use of the plate.

d. Patient bed card. This card will be prepared on a plain 3- by 5-inch card. The format for the information on the card is—

(1) Patient's first name, middle initial, and last name.

(2) Rank, grade, or status.

(3) Service affiliation (Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service, or National Oceanic and Atmospheric Administration).

(4) Date of admission.

3-6. Facility identification

The MTF or DTF providing care will be clearly named in all medical records and reports. (Such entries on SF 600 will be made by rubber stamp when possible.) Because patients are often treated at several MTFs, the MTF that is custodian of the patient's records will also be named. For OTRs and HRECs, this identification may be accomplished using the patient recording card.

3-7. Destruction of unidentifiable medical documents

An unidentifiable document is one that contains either no identifying data or such a small amount that it is impossible to identify the person to whom it belongs. Destruction of unidentifiable documents will follow instructions outlined in the MTF Information Management Plan.

Section III

Recording Diagnoses and Procedures

3-8. Nomenclature used in recording diagnoses

a. Acceptable diagnostic nomenclature will be used. Vague and general expressions will be avoided.

b. The affected body part will always be stated when relevant to the condition and when not given in the name of the condition. In addition, the body part will be described in as much detail as is needed (for example, "skin of," "tissue of," or "region of"). Terms such as "right," "left," "bilateral," "posterior," and "anterior" will also be added when applicable.

c. Few abbreviations should be used in medical records. Those abbreviations and symbols listed in appendix B, as well as locally approved abbreviations and symbols, are authorized if the following conditions are met:

(1) Local abbreviations and symbols will not delete or alter the meaning of those listed in appendix B.

(2) A copy of locally approved abbreviations and symbols will be readily available to those authorized to make entries in the medical record and to those who must interpret them.

(3) This exception to policy applies to all MTFs. However, each treatment facility will be responsible for altering its approved lists as new additions or deletions are made to appendix B. It is recommended that abbreviations not listed in

appendix B or not locally approved be used in long narratives only if they are defined in the text. For example: "Nerve conduction time (NCT) is changed by many factors. NCT varies with electrolytes. NCT varies with temperature."

d. Instructions for recording dental diagnoses and procedures, to include abbreviations and symbols, are provided in TB MED 250.

3-9. Special instructions for certain diseases

(See Tri-Service Disease and Procedure ICD-9-CM Coding Guidelines (app A) for details on coding specific diseases.)

3-10. Special instructions for certain diagnoses

Information on, and results of, Human Immunodeficiency Virus (HIV) testing will be entered in individual medical records, as follows, (in accordance with AR 600-110, para 2-10):

a. For force surveillance testing, an entry will be made on SF 600 that will include the date and location of testing. Recording of test results in the medical record of Active Duty Soldiers is required when the Soldier is being processed for overseas PCS. (See AR 600-110 for complete testing requirements.) HIV test results for the ARNGUS and USAR will be annotated on SF 600, which will be posted in the medical record. The HIV test date and result will be annotated on DD Form 2808 (Report of Medical Examination), item 49, if the test was performed in conjunction with a physical exam.

b. Results of routine adjunct testing will always be recorded in the medical record using SF 557 (Miscellaneous) or electronic version. The slip will be clearly stamped either "HIV positive" or "HIV negative." Specimens which are enzyme-linked immunosuppressant assay (ELISA) positive by local testing only will not be reported as HIV positive. These specimens will be reported as "pending results" to the ordering physician, and finally reported as HIV positive or negative only after receipt of confirmatory test results (Western Blot or other supplementary tests).

c. The medical and dental record jacket for all HIV-infected Soldiers will be marked only by affixing a DA Label 162 (Emergency Medical Identification Symbol) in accordance with chapter 14 of this regulation. DD Form 2766 will be annotated "Donor Ineligible-V72.62."

d. The losing HIV program point of contact will ensure that copies of medical records pertaining to the patient's diagnosis and evaluation of the HIV infection are forwarded by mail or courier. Care will be taken to protect the confidentiality of the records by sealing them in an envelope marked "Sensitive Medical Records—To Be Opened by Addressee Only," and then inserting the envelope into a carrier addressed directly to the attention of the receiving HIV program point of contact, by name when known.

3-11. Recording psychiatric conditions

Psychiatric conditions will be recorded using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised (or current edition), as nomenclature (app A).

3-12. Recording injuries

a. Details to be recorded.

(1) The same details will be given and the same terms used when both battle and nonbattle injuries are recorded. To be complete, the recording of an injury must include the details given in (a) through (g) below. (For information needed for proper coding, see Tri-Service Disease and Procedure ICD-9-CM Coding Guidelines (app A).) Record on DA Form 3647 (Inpatient Treatment Record Cover Sheet), item 33, CHCS, CHCS II, or CIS electronic equivalent, the details listed in (c) through (g) below.

(a) *The nature of the injury.* Record the exact nature of the injury as well as the medical condition caused by it. Explain conditions, such as traumatic bursitis, traumatic neuritis, traumatic myositis, or traumatic synovitis, by describing the original injury. For example, record a contused wound resulting in bursitis as bursitis due to contusion.

(b) *The part or parts of the body affected.* In the case of fractures and wounds, state whether any nerves or arteries were involved; name major nerves or blood vessels.

(c) *The external causative agent.* In the case of acute poisoning, name the poison.

(d) *How the injury occurred.* State what the person was doing when injured (for example, in action against the enemy, work detail, marching, drilling, or motor vehicle accident, etc.). For motor vehicle accidents, state the kinds of vehicles involved and whether military owned or otherwise.

(e) *Whether the injury was self-inflicted.* If the injury was deliberately self-inflicted, state whether it was an act of misconduct (to avoid duty) or an act of the mentally unsound (a suicide or attempted suicide).

(f) *The location where the person was injured.* If on post, state the building or area (for example, barracks, mess, or motor pool); if off post, state the exact location where the accident occurred (such as name of business, city, State) or location of motor vehicle accident (city, State, etc.), and the person's status (for example, home or leave or in transit while absent without leave (AWOL)).

(g) *The date of the injury.*

(2) Examples of properly recorded diagnoses are provided in (a) and (b), below.

(a) "Fracture, open comminuted, upper third of shaft of femur, left; no nerve or artery involvement; bullet entering anterior upper portion of left thigh and lodging in femur. Caused by rifle bullet, accidentally incurred when patient's rifle discharged while he was cleaning it in Barracks A, Fort Hood, TX, 8 Jul 98."

(b) "Bursitis, acute, knee, right, due to contusion, anterior aspect. Accidentally incurred when patient tripped and fell, striking knee on floor while entering Barracks 26, Fort Lewis, WA, 2 Dec 98."

b. *Wound or injury incurred in combat.*

(1) In addition to the details described in *a*, above, records on wounds or injuries incurred in combat must state—

(a) Whether the wound resulted from enemy action. The abbreviation "WIA" will be used; however, "WIA" by itself is not acceptable as a diagnosis.

(b) The kind of missile or other agent that caused the wound.

(c) The time that the wound occurred.

(d) The general geographic location where the person was wounded. Entries such as "near Taegu, Korea" are sufficient; map coordinates alone are not.

(2) The following example is a correctly recorded WIA case: "WIA wound, penetrating, left arm; entrance, posterior lateral, proximal third, severing brachial artery without nerve involvement. Incurred during search and destroy mission when struck by enemy mortar shell fragments, 16 Dec 69 near Kon Found, Republic of Vietnam."

c. *Injuries or diseases caused by chemical or biological agents or by ionizing radiation.*

(1) For these injuries, record the name of the agent or type of ionizing radiation (if known). If the agent or radiation is not recognized, record any known properties of it (for example, odor, color, or physical state).

(2) Record the date, time, and place where contamination took place.

(3) Estimate and record the time that lapsed between contamination and self-decontamination or first aid (if any). Describe the procedure used.

(4) For injury by ionizing radiation, estimate and record the distance from the source. If the exposure is to external gamma radiation, state the dosage (for example, "measured 200r"). If not known, the dosage should be estimated (for example, "est 150r").

(5) State, if known, whether exposure was through airburst, ground burst, water surface burst, or underwater burst.

d. *Occupational injury and illness.* This term includes all injury or illness incurred as the result of performance of duty for military and civilian personnel, including those identified in *c*, above. In addition to the details in *a*, above, identify the injury or illness as "occupational."

3-13. Recording deaths

a. *Recording deaths of unknown cause.* The following terms will be used to record deaths when the cause is unknown:

(1) "Sudden death." Used in the case of sudden death known not to be violent.

(2) "Died without sign of disease." Used in the case of death other than sudden death known not to be violent.

(3) "Found dead." Used in cases not covered by (2) above when a body is found.

b. *Recording underlying cause of death.* The underlying cause of death is a disease, abnormality, injury, or poisoning that began the train of morbid events leading to death. For example, a fatal case with a diagnosis of cerebral hemorrhage, hypertension, and myocarditis would have hypertension as the underlying cause. The diagnosis that describes the underlying cause of death should be identified as the underlying cause on DA Form 3647, CHCS, CHCS II, or CIS electronic equivalent.

(1) The train of events leading to death will be recorded in items 7a and b of DA Form 3894 (Hospital Report of Death). The immediate cause will be entered in item 7a, and the underlying cause will be entered in item 7b. Only one cause should be entered on each line of items 7a and b; no entry is needed in 7b if the immediate cause of death given in 7a describes completely the train of events. To record the example given in *b*, above, cerebral hemorrhage would be entered in 7a as the condition directly leading to death; hypertension would be entered in 7b(1) as the antecedent cause or condition leading to the immediate cause; and myocarditis would be entered in 8a as the condition contributing to death but not related to the cause.

(2) The diagnosis given as the underlying cause of death on DA Form 3647, CHCS, CHCS II, or CIS electronic equivalent should be the same as the diagnosis given on DA Form 3894 and on the Certificate of Death. On the Certificate of Death, the underlying cause of death is shown on line c. If line c has no entry, it is on line b; and if lines b and c are blank, it is on line a. (For more information, see the Physicians' Handbook on Medical Certification of Death (app A).)

c. *Recording neonatal deaths.* When recording deaths of infants under 28 days of age, use the term "neonatal death," and state the infant's age at death. For deaths in the first 24 hours of life, state the age in number of hours lived; for deaths after the first day of life, state the number of days lived. Examples of these entries are "Neonatal death less than one hour after birth," "Neonatal death, age 22 hours," and "Neonatal death, age 26 days." (For more information, see the Hospitals' and Physicians' Handbook on Birth Registration and Fetal Death Reporting (app A).)

d. *Detainee documentation.*

(1) Accurate and complete outpatient and, when required, inpatient medical records on each detainee shall be created and maintained according to the provisions of this regulation and AR 190-8. The detainee identification number will be used as the patient identification number. Medical records will be maintained at the MTF with responsibility for the detainee's health care. If a detainee is transferred to another U.S. Armed Forces detention facility, the medical records will be forwarded to the appropriate depository for MTF. All detainee medical records remain the property of the U.S. Army. An appropriate depository for inactive detainee medical records will be established.

(2) Entries should be made into detainee medical records as they would for any other patient. Detainees are entitled to copies of their medical records upon release from detention. Before copies of records are released, all health care provider information, including names of all who provided care of any nature, and other identification must be stricken from the copied medical records.

3-14. Recording cases observed without treatment, undiagnosed cases, and causes of separation

a. Observation without need for further medical care. A record must be made when a patient shows a symptom of an abnormal condition but study reveals no need for medical care. That is, observation reveals no condition related to the symptom that would warrant recording and no need for any treatment. In such a case, the proper diagnosis entry is "Observation." After this entry, give the name of the suspected disease or injury; after this entry, enter either "No disease found" or "No need for further medical care."

(1) A diagnosis of "Observation" is used even when a condition unrelated to the one suspected is diagnosed and recorded. For example, a patient is admitted for possible cardiac disease, but a specific cardiac diagnosis is not made. While in the hospital, however, the patient is also treated for arthritis. In such a case, "Observation, suspected..." is entered as the cause of admission; arthritis is given as the second diagnosis.

(2) A diagnosis of "Observation" is not used for patients lost to observation before a final diagnosis is made, and it is not used for a medical examination of a well person who has no complaint and who shows no need for observation or medical care.

b. "Undiagnosed" or "undetermined diagnosis" (nonfatal cases). When a patient is admitted or transferred and an immediate diagnosis is not possible, give the symptoms or the name of the suspected condition. Replace these terms with a more definitive diagnosis as soon as possible. When a final or more definitive diagnosis cannot be made, use the condition or manifestation causing admission.

c. Recording cause of separation. For a noninjury patient separated or retired for physical disability, the cause must be recorded. If there is more than one diagnosis, select the one that is the principal cause of separation, and enter after it "principal cause." For an injury patient, the residual disability (the condition causing separation) must be recorded. If there is more than one residual disability, the one that is the principal cause of separation must be stated. The diagnosis that is the "underlying cause" must also be recorded, that is, the injury causing the residual disability. For example, if a leg injury leads to amputation, the leg injury is stated as the underlying cause.

3-15. Recording surgical, diagnostic, and therapeutic procedures

Principles for coding and sequencing surgical, diagnostic, and therapeutic procedures are found in the Tri-Service Disease and Procedure ICD-9-CM Coding Guidelines (app A).

3-16. Recording therapeutic abortions

10 USC 1093 states that funds available to DOD may not be used to perform abortions except when the mother's life would be endangered if the fetus were carried to term. To ensure compliance with 10 USC 1093, the following are required:

a. Before the procedure, physicians performing therapeutic abortions in Army hospitals will document in the clinical record that the abortion is being performed because the mother's life would be endangered if the fetus were carried to term.

b. The same documentation will be placed in the medical record of a patient referred out on supplemental care.

c. As an added control, the chief of obstetrics and gynecology, deputy commander for clinical services, or the hospital commander must countersign the physician's statement before the procedure is performed. The legal advice of a judge advocate will be solicited if deemed necessary.

d. For guidance on all other categories of abortion, see AR 40-400, paragraph 2-18.

3-17. Recording use of restraints/seclusion

Documentation of the use of restraints/seclusion will conform to local policy and the current Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards.

3-18. Recording videotaped documentation of episodes of medical care

a. When an episode of health care (for example, surgical procedures, medical evaluation, telemedicine consultation, and so forth) is to be documented on videotape, the patient must provide written consent for the taping (unless the taping is for the documentation of neglect or abuse). The patient (if identifiable) must provide written consent.

Consent will be recorded on an OF 522 or a State-mandated consent form in accordance with paragraph 3-3g.

c. The episode of health care will be documented in the medical record as is normally done. Written documentation of the consultation will be done by providers on both ends of a telemedicine encounter. The videotape will be erased after standard documentation is complete, unless the videotape is required for a specified interval for a specific reason, such as documentation of neglect, abuse, or possible criminal activity. In cases where adverse administrative, nonjudicial, or judicial proceedings may be contemplated because of possible criminal activity, consult with the local judge advocate before erasing the videotape. The provider will indicate in the final documentation whether or not the image was erased, or where the videotape will be maintained. The videotape will not become part of the medical record.

d. Exceptions to the prohibition against retaining videotapes may be permitted for cases with exceptional educational value or cases where adverse administrative, nonjudicial, or judicial proceedings may be contemplated because of possible criminal activity. Tapes are not usually filed by any type of personal identifier. If they are, then all Privacy Act regulations must be followed. Any MTF which chooses to keep such images on file for educational purposes must develop appropriate policies and standing operating procedures and review them periodically.

Section IV

Records for Carded-for-Record-Only Cases and Absent-Sick Status

3-19. Carded-for-record-only cases

a. Certain cases not admitted to an MTF will be carded-for-record-only (CRO) cases and will be documented both in the medical record and through the Standard Inpatient Data Record (SIDR). This includes only the deaths of active duty military personnel. These deaths will be reported in one of the following ways:

(1) If an active duty Soldier dies during a hospital stay, it is considered a hospital death and is reported through the SIDR.

(2) If the Soldier dies while hospitalized in a civilian hospital, it is reported as an absent-sick death and reported through the SIDR.

(3) If the Soldier is dead on arrival (DOA), it is reported as a CRO through the SIDR.

(4) If the Soldier dies in the emergency room, it is reported as a CRO through the SIDR.

b. The MTF with geographic control is responsible for initiating the CRO and is required to monitor and coordinate with the civilian facilities in that geographic area. Coordination must occur through the respective command surgeon's office.

c. For these cases, DA Form 3647, CHCS, CHCS II, or CIS electronic equivalent; or DD Form 1380 (U.S. Field Medical Card) will be prepared. A register number will be assigned to each CRO case. When DA Form 3647 is used, items 7, 10, 14, 24, 27, and 30 and the name of the admitting officer do not need to be completed. When DD Form 1380 is used, block 17 does not need to be completed.

d. Deaths of other than active duty military personnel may be CRO if they are considered to have medical, legal, or other significance. However, they are CRO cases only if an ITR has not already been prepared for them.

3-20. Absent-sick status

An Army patient admitted to a nonmilitary treatment facility is in an absent-sick status. (See AR 40-400, para 10-11a.)

a. Only Active Army members, RC members in the Active Guard/Reserve program, RC members on tours of duty for 30 days or more, and U.S. Military Academy cadets can be classified in an absent-sick status.

b. DA Form 3647, CHCS, CHCS II, or CIS electronic equivalent; and DA Form 2985 (Admission and Coding Information) for absent-sick status are prepared much the same as for a direct admission but with the exceptions noted in the Individual Patient Data System (IPDS) User's Manual (app A). Additional information on absent-sick patients placed in quarters by civilian physicians is given in DA Form 3647 and DA Form 2985 do not need to be completed for these cases.

Table 3-1
AR 25-400-2, Army Records Information Management System (ARIMS)
File numbers, record keeping requirements

File number	Title
11-9	Personnel dosimetry files
40	General medical services correspondence files
40-5h	Civilian Employee Medical Files
40-66a	Health records
40-66b	Dental health records
40-66c	Register number files
40-66e	Foreign national inpatient treatment records
40-66f	Military inpatient treatment records
40-66g	Civilian inpatient treatment records
40-66i	NATO personnel inpatient treatment records
40-66j	Military outpatient records
40-66k	Civilian outpatient records
40-66m	Foreign national outpatient records
40-66p	Army Reserve and ROTC outpatient records
40-66q	NATO personnel outpatient records
40-66s	Field medical cards
40-66u	Medical care inquiries
40-66v	USMA applicant x rays
40-66w	Installation x-ray indices
40-66x	Troop and health clinic clinical record cover sheets
40-66y	Photograph and duplicate medical files
40-66z	Procurement and separation x rays
40-66aa	Applicant and registrant x-ray film
40-66bb	Patient treatment film
40-66cc	Occupational health surveillance x rays
40-66ee	Medical records access files
40-66ff	PHI releases
40-66gg	Nominal indexes
40-66hh	Tubercular applicant and registrant x rays
40-66ii	Military dental files
40-66jj	Civilian dental files
40-66kk	Foreign national dental files
40-66mm	American Red Cross dental files
40-66pp	Army Substance Abuse Program outpatient records
40-216h	Electroencephalographic tracings
40-216i	NATO consultation service cases
40-216k1	Mental Health Records (Adults)
40-216k2	Mental Health Records (Minors)
40-407f	Register of operations

Chapter 4

Filing and Requesting Medical Records

4-1. Filing by Social Security number and family member prefix

An 11-digit number is used to identify and file medical records under the terminal digit filing system. This number consists of the sponsor's SSN and an FMP:

- a. The first two digits of the file number are the FMP. These digits identify the patient, as shown in table 4-1.
- b. The other nine digits of the file number are the sponsor's SSN broken into three groups. The first group is the first five digits of the SSN; the second group is the next two digits of the SSN; and the third group is the last two digits of the SSN. For example, PFC Ernie Jones's SSN: 390-22-3734, would be identified as 20 39022 37 34; his wife's number would be 30 39022 37 34; his third oldest child's number would be 03 39022 37 34. As shown in the example, the sponsor's SSN will be used for beneficiaries. When both parents are on active duty, a newborn child's number will be the same SSN as that used on the mother's records. When a newborn infant has no entitlement to continued medical care (for example, a newborn infant of a daughter family member or of a civilian emergency patient), the FMP assigned to the infant will be 90-95, and the SSN will be the one that the mother uses.
- c. Pseudo or artificial 11-digit numbers will be given to patients not described in *b*, above and in table 4-1. These numbers will also be given to patients who do not have an SSN. The pseudo or artificial SSN will be constructed according to the patient's date of birth. The following format will be employed: (80 +(0-9) + YYMMDD), where 80 is constant in every case, and the third digit is used for sequencing of multiple same birthdate admissions. For example, a birthdate of 21 Sep 46 is formed 800-46-0921; a second patient requiring a pseudo SSN with the same birthdate is distinguished by the third digit, 801-46-0921. (Civilian emergency patients who have an SSN are described in rule 13 of table 4-1 and will not be given an artificial number.)



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Other medical or dental records important to the patient's care, including advance directives (durable powers of attorney for health care, living wills, etc.). (See paras 6-2i, 9-2c(2), and 10-3a(4).)

DD Form 2005¹

Privacy Act Statement—Health Care Records. DA Form 2005 is always the bottom form or is printed on the folder. (See paras 4-4a(9), 5-27a, 7-4a, and 10-3a(1).)

Notes:

¹This form must be included in all nonmilitary dental records.

²Instructions for completing this form are self-explanatory.

Figure 6-3. Forms and documents of the nonmilitary dental record—Continued

Chapter 7 Occupational Health Program Civilian Employee Medical Record

Section I General

7-1. Compliance

The purpose of this chapter is to explain how the initiation, maintenance, and disposition of CEMRs will meet the requirements of DODI 6055.5, the Occupational Safety and Health Administration (OSHA) (29 CFR 1904, 29 CFR 1910, and 29 CFR 1960), and regulations of the Office of Personnel Management (5 CFR 293.501, Subpart E).

7-2. Definition and purpose of the civilian employee medical record

a. The CEMR is defined as a chronological, cumulative record of both occupational and non-occupational information about health status developed on an employee during the course of employment. It includes personal and occupational health histories, exposure records, medical surveillance records, Office of Workers' Compensation Programs (OWCP) records, and the written opinions and evaluations generated by health-care providers in the course of examinations, treatment, and counseling.

b. The purpose of the CEMR is to provide a complete medical and occupational exposure history for employee care, medicolegal support, research, and education.

c. CEMRs are not maintained on Soldiers. Occupational health-related documentation, such as exposure records, medical surveillance records, x-ray reports, and so forth, are filed in the OTR.

d. The original documentation will be retained at the MTF where the treatment was rendered. Continue to maintain an additional legible, chronological, longitudinal record copy of all treatment episodes.

7-3. For whom prepared

A CEMR will be prepared for each permanent civilian employee upon employment. A medical record will be prepared for all nonpermanent employees who receive any type of occupational health services.

7-4. Civilian employee medical records folder and forms

a. The CEMR may be maintained either in the terminal digit filing system DA Form 3444-series or the SF 66D during the course of employment. When the DA Form 3444-series folders are used, they will be prepared and filed according to chapter 4. When the SF 66D folders are used, they will be filed alphabetically by last name. The name (last, first, middle initial), date of birth, and SSN of the employee will be typed on a label and affixed to the SF 66D on the indicated space on the folder. Attach an NOPP acknowledgment label to the center of the back outside cover of the SF 66D. Ensure the civilian employee completes a separate DD Form 2005 regardless of the type folder used. The CEMR will be retired or transferred in the SF 66D folder; therefore the employee does not need to complete the preprinted DD Form 2005 on the inside of the folder when the DD Form 3444-series is used.

b. The forms authorized for use in CEMRs are listed in figure 7-1. These forms will be filed from top to bottom in the order they are listed in the figure. Copies of the same form will be grouped and filed in reverse chronological order (the latest on top). Specialized occupational health forms may be maintained in CEMRs, but they must have prior approval by the supporting MEDDAC/MEDCEN (chap 3, sec I). When it is necessary to use a DD form, DA form, or

SF that is not listed in figure 7-1 but is listed in this regulation, file it in the order listed in the relevant figure shown in chapter 5 or chapter 6.

(1) SF 78 (U.S. Civil Service Commission, Certificate of Medical Examination) will be used to record preemployment physical examination results for appropriated fund employees, and it may be used to record periodic job-related physical examination results. Parts A, B, and C of the SF 78 are authorized for filing in the CEMR, and parts D, E, and F are forwarded to the Civilian Personnel Office (CPO).

(2) DD Form 2807-1 will be used to obtain a health history from civilian workers and to initiate a medical record on employment and subsequent job-related medical surveillance or other purposes, as required.

(3) DA Form 3437 (Department of the Army Nonappropriated Funds Certificate of Medical Examination), will be used to record preemployment physical examination results for nonappropriated funds employees and may be used to record periodic job-related physical examination results. DA Form 3437 is authorized for filing in the CEMR.

(4) DD Form 2766 and DD Form 2766C provide a summary of known past and current diagnoses or problems, and currently or recently used medications. (See paras 5-13 and 5-32a for instructions on completing and using these forms.)

(5) DD Form 2795, DD Form 2796, and DD Form 2844 (TEST) may be used to record the results of pre- and post-deployment health assessments for civilians who are deployed. (See paras 5-32a, 5-35, and 5-36a for instructions on using these forms.)

(6) DD Form 1141 or ADR is used to record results of all personal monitoring, to include film badge readings for each person occupationally exposed to ionizing radiation. DD Form 1141 or ADR is a medical record and is filed in the CEMR (para 5-21b(5)).

(7) DA Form 4515 and DA Form 3180 are used according to AR 50-5 and AR 50-6 to identify and evaluate all individuals working in the nuclear or chemical surety programs.

(8) The mandatory OSHA Respirator Medical Evaluation Questionnaire will be used according to 29 CFR 1910.134. The use of this questionnaire (or medical examination that obtains the same information as the OSHA questionnaire) is used to determine an employee's ability to use a respirator.

(9) Copies of the following OWCP medical forms are authorized to be maintained in the CEMR:

(a) Department of Labor (DOL) Form CA-16 (Authorization for Examination and or Treatment).

(b) DOL Form CA-17 (Duty Status Report).

(c) DOL Form CA-20 (Attending Physician's Report).

(10) In addition, a copy of DOL Form CA-1 (Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation) is maintained in the CEMR when the employee files a claim with OWCP for an occupational traumatic injury, but the original DOL Form CA-1 is placed in the medical record if a claim is not filed. A copy of DOL Form CA-2 (Federal Employee's Notice of Occupational Disease and Claim for Compensation) is authorized to be maintained in the CEMR when the employee is claiming an occupational disease (5 CFR 293.501).

(11) Copies of the following nonmedical forms may be filed in the CEMR to provide supplementary medical data:

(a) OF 345 (Physical Fitness Inquiry for Motor Vehicle Operators).

(b) DA Form 3666 (Department of the Army Nonappropriated Funds Statement of Physical Ability for Light Duty Work).

Section II

Maintaining, Transferring, and Disposing of Civilian Employee Medical Records and Retention of Job-Related X-Ray Films

7-5. Custody and maintenance of civilian employee medical records

The MTF commander is the official custodian of all medical records, including CEMRs, at his or her facility. The Chief, Patient Administration Division, of an MTF will act for the commander to handle medical records. The CEMRs will usually be maintained in the outpatient record room of the MTF when the occupational health service/clinic is collocated with a hospital. The CEMRs will be maintained in the U.S. Army Health Clinic or Occupational Health Clinic or Occupational Health Nursing Office when the clinic is not collocated with a hospital.

7-6. Medical record entries

Medical record entries in the CEMR will be made in accordance with paragraph 3-4.

7-7. Recording occupational injuries and illnesses

a. Record all injury or illness incurred as the result of performance of duty by individual personnel. Identify the injury or illness as "occupational." The recording of an occupational injury must include the following details:

(1) The exact nature of the injury.

(2) The part or parts of the body affected.

(3) The external causative agent. In the case of acute poisoning, the poison must be named.

- (4) How the injury occurred.
- (5) The place where injured. State the building and or area.
- (6) The date of the injury.

b. For the recording of injuries or diseases caused by chemical or biological agents or by ionizing radiation, see paragraph 3-12c.

7-8. Cross-coding of medical records

a. Civilian employees who are military medical beneficiaries will have two medical records, the CEMR and the OTR. These records will be cross-indexed to identify the dual status, to facilitate care, and to ensure appropriate identification and reporting of occupational illnesses and injuries.

b. In those facilities using the Pharmacy Data Transaction Service, the CEMRs of civilian employees who are also family member beneficiaries will be electronically merged with the family member record in the CHCS, CHCS II, or CIS. This will result in one CHCS, CHCS II, or CIS record for these patients, which will be identified under the sponsor's SSN. A paper CEMR will continue to be maintained under the civilian employee's SSN or name.

7-9. Transferring and retiring civilian employee medical records

The CEMR of an employee transferring to another Federal agency or separating from Federal service will be forwarded to the CPO identified in the SF 66D within 10 days of transfer or separation (AR 25-400-2). The CPO will forward the CEMR to the appropriate custodian.

7-10. Retention of job-related x-ray films

a. Legal and regulatory requirements dictate that x-ray films performed for exposure to work place hazards must be preserved and maintained for at least the duration of employment plus 30 years, or for 40 years, whichever is greater (29 CFR 1910.20, 5 CFR 293.501, and DODI 6055.5).

b. Civilian employee x-ray films performed for exposures to work place hazards are part of the CEMR. X-ray films 8 1/2- by 11-inches or smaller will fit within the CEMR file folder and will be transferred to another Federal employing agency or retired with the medical record. Oversized chest/torso x-ray films cannot fit into the CEMR and will not be sent with the record to storage; however, they will be sent with the CEMR to a new Federal employing agency. When the CEMR is sent to storage, oversized films must be retained in their original state by the last MTF that provided occupational health services to the employee until such time as they may be destroyed. (See a, above.) Radiographic results will be included in the CEMR and a notation will be entered on the SF 600 and include the location of any film not present in the record and how it can be obtained. A microfiche copy of any type x ray except chest may be placed in the CEMR instead of the original x ray. 29 CFR 1910.20(d)(2) requires that chest x-ray films be preserved in their original state.

c. See paragraphs 6-4d(2) and 6-6c for transfer and retention of x-ray films taken for medical surveillance purposes on military members exposed to toxic substances or harmful physical agents in their work environment.

Section III

Confidentiality of PHI, Access to Civilian Employee Medical Records, and Performance Improvement

7-11. Protection of confidentiality and disclosure procedures

a. All CEMRs and PHI pertaining to civilian employees will be treated as private information. The provisions of chapter 2 of this regulation will be followed in protecting the confidentiality of PHI contained in CEMRs and in responding to requests for the disclosure of such information. In addition, OSHA and OPM rules (29 CFR 1910.20, 5 CFR 293.504, 5 CFR 297.204-205, and 5 CFR 297.401(c)) provide for access by the employee or his or her representative as designated in writing, and by OSHA representatives (compliance officers and National Institute for Occupational Safety and Health personnel) to examine or copy PHI that bears directly on the employee's exposure to toxic materials and harmful physical agents. The employee or his or her designated representative must be provided one copy of this data upon request without cost to the employee or his or her representative. The information must be provided within 15 working days of the employee's request.

b. Workers' compensation claims directly involve the employer and all facts relevant to the case become the concern of management. All medical records relating to the injury, illness, or death of an employee entitled to Federal Employee Compensation Act benefits are the official records of the Office of Personnel Management and are not the records of any agency having the care or use of such records (5 CFR 293.506). For all OWCP cases that are treated by a physician, a medical report is required. This report may be made on DOL Forms CA-16, CA-17, or CA-20; a narrative report on the physician's letterhead stationery; or in the form of an EC/ED summary. A copy of these reports is maintained in the CEMR.

c. When required, with the knowledge and permission of the employee, an interpretation of medical findings may be given to the CPO or responsible management personnel to assure safe and effective use of manpower.

7-12. Civilian employee medical record review

CEMRs will be included in the Patient Administration Division performance improvement processes. Medical records will be reviewed for accuracy, timeliness, completeness, clinical pertinence, and adequacy as medicolegal documents. All guidance and standards in paragraph 12-3 that are applicable to the CEMR will be used in this review.



All forms should be filed in an upright position on both sides of the folder. Order given below is from top to bottom of the record.

LEFT SIDE OF FOLDER

DD Form 2766²

Adult Preventive and Chronic Care Flowsheet (cut sheet construction). (See paras 3-10c, 4-4d, 5-13, 5-19, 5-26b(2), 5-32a, 5-36a, 6-7f, 7-4b(4), 10-7b, and 12-3a(9).)

DD Form 2766C, SF 601¹

Adult Preventive and Chronic Care Flowsheet-Continuation Sheet; Health Record-Immunization Record. If using the folder construction of DD Form 2766 (deployable civilians), attach DD form 2766C, SF 601, and any automated immunization tracking system printout to the inside fastener of DD Form 2766. If using the cut sheet construction of DD Form 2766 (nondeployable civilians), place DD Form 2766C below DD Form 2766 and place SF 601 and any automated immunization tracking system printout where noted below. (See paras 5-13a(2), 5-13b(3)(b), 5-13c(10), 5-13d, 5-19, 5-27c(1), 5-32a, 5-36a, and 6-7b.)

DA Form 5571

Master Problem List. This form is obsolete; use for file purposes only if already in existence.

DA Form 8007-R

Individual Medical History. This form is obsolete; use for file purposes only if already in existence. (See para 5-13b.)

DA Form 3180

Personnel Screening and Evaluation Record. (See AR 50-5, AR 50-6, and paras 5-21b(8), 5-30a, 5-31c, and 7-4b(8) of this regulation.)

DA Form 4186

Medical Recommendation for Flying Duty. (See AR 40-501 and para 5-21b(6) of this regulation.)

Documents and correspondence on flying status; that is, restrictions, removal of restrictions, suspensions, and termination of suspensions. (See AR 600-105.)

DD Form 1141; ADR

Record of Occupational Exposure to Ionizing Radiation; Automated Dosimetry Record. (See paras 5-21b(5) and 7-4b(6) of this regulation.)

DD Form 2493-1

Asbestos Exposure Part I-Initial Medical Questionnaire. (See AR 40-5 and para 5-21b(9) of this regulation.)

DD Form 2493-2

Asbestos Exposure Part II-Periodic Medical Questionnaire. (See AR 40-5 and para 5-21b(9) of this regulation.)

OF 345

Physical Fitness Inquiry for Motor Vehicle Operators. (See AR 40-5 and para 7-4b(11)(a) of this regulation.)

DA Form 3666

Department of the Army Nonappropriated Funds Statement of Physical Ability for Light Duty Work. (See AR 215-3 and para 7-4b(11)(b) of this regulation.)

Figure 7-1. Forms and documents of the CEMR using DA Form 3444-series jackets or SF 66D folders

SF 177

Statement of Physical Ability for Light Duty Work. This form is obsolete; use for file purposes only if already in existence.

SF 601¹

Health Record—Immunization Record. Place this form here only if using the cut sheet construction of DD Form 2766. File any automated immunization tracking system printout here. (See paras 5–19, 5–25e(3), 5–27c(1), and 6–7b.)

Automated laboratory report forms. File like forms in reverse chronological order. (See paras 3–2, 5–15, and 9–25.)

SF 512¹

Clinical Record—Plotting Chart. (See para 5–15.)

SF 545¹

Laboratory Report Display. (See paras 3–2 and 9–25.) Instructions for completing this form are provided in tables 9–2 and 9–3.

SF 546; SF 547; SF 548; SF 549; SF 550; SF 551; SF 552; SF 553; SF 554; SF 555; SF 557
Chemistry I; Chemistry II; Chemistry III (Urine); Hematology; Urinalysis; Serology; Parasitology; Microbiology I; Microbiology II; Spinal Fluid; Miscellaneous. Attach to SF 545 in reverse chronological order. (See para 9–25.) Instructions for completing these forms are provided in tables 9–2 and 9–3.

SF 556

Immunohematology. SF 556 is obsolete; use for file purposes only if already in existence.

SF 507¹

Medical Record—Report on or Continuation of SF. File with the standard form being continued.

SF 519-B¹

Radiographic Consultation Request/Report. (See para 9–37.)

SF 519; SF 519A

Medical Record—Radiographic Report. SF 519 and SF 519A are obsolete; use for file purposes only if already in existence.

QF 520¹

Clinical Record—Electrocardiographic Record (formerly SF 520). Reports of electrocardiograph examinations with adequate representative tracings should be attached to the back of QF 520 or on another attached sheet of paper. CAPOC or other automated tracings may substitute for the QF 520.

DA Form 5551-R

Spirometry Flow Sheet. (See TB MED 509.)

DA Form 4060

Report of Optometric Examination. DA Form 4060 is obsolete; use for file purposes only if already in existence.

DD Form 741¹

Eye Consultation.

Figure 7–1. Forms and documents of the CEMR using DA Form 3444-series jackets or SF 66D folders—Continued

DD Form 771
Eyewear Prescription. (See AR 40-63/NAVMEDCOMINST 6810.1/AFR 167-3 and para 5-21b(2) of this regulation.)

DD Form 2215¹
Reference Audiogram. (See AR 40-5 and DA Pam 40-501.)

DD Form 2216
Hearing Conservation Data. Also file any correspondence on hearing aids here. (See AR 40-5 and DA Pam 40-501.)

Reports of certificates prepared by neuropsychiatric consultation services or psychiatrists.

DA Form 3365
Authorization for Medical Warning Tag. (See paras 6-7f, 14-1, 14-3c, and 14-5.)

DA Form 4254¹
Request for Private Medical Information. (See para 2-4a.)

DA Form 4876¹
Request and Release of Medical Information to Communications Media. (See para 2-3b(3).)

DD Form 2870
Authorization for Disclosure of Medical or Dental Information. (See paras 2-3a(1) and 2-3b(1) and figs 5-1, 5-2, 6-1, 6-2, 7-1, 9-1, and 10-1.)

DA Form 5006
Medical Record-Authorization for Disclosure of Information. File any other authorization for release of medical information and related correspondence here. This form is obsolete; use for file purposes only if already in existence. File DA Form 5006 after DD form 2870.

Administrative documents and other correspondence, including advance directives (durable powers of attorney for health care, living wills, and so forth). (See paras 6-2i, 9-2c(2), and 10-3a(4).)

DA Form 4410-R²
Disclosure Accounting Record. The DA Form 4410-R is printed on the DA Form 3444-series folder. The separate form is obsolete, use for file purposes only if already in existence.

RIGHT SIDE OF FOLDER

DA Form 4516
Personnel Reliability Program Record Identifier. (See AR 50-5, AR 50-6, and paras 5-21b(8), 5-31c, and 7-4b(8) of this regulation.)

Interfile the following four forms in reverse chronological order with the most recent on top.

SF 600^{1,2}, DD Form 2844 (TEST); SF 558¹, SF 513¹, DD Form 2161¹
Medical Record-Chronological Record of Medical Care; Medical Record-Post Deployment Medical Assessment; Medical Record-Emergency Care and Treatment; Medical Record-Consultation Sheet; Referral for Civilian-Medical Care. If DD Form 2844 (TEST) is present, file it with the associated SF 600; include any associated patient questionnaires. File any other basic chronological medical care records here, for example, commercially available emergency room charting systems, AMOSIST or other forms completed at civilian facilities. (See paras 5-7, 5-16, 5-18, 5-35b, 9-12, and 10-3b(6)(b).)

DD Form 2341
Report of Animal Bite-Potential Rabies Exposure. File behind corresponding SF 558. (See AR 40-905/SECNAVINST 6401.1A/AFI 48-131.)

Figure 7-1. Forms and documents of the CEMR using DA Form 3444-series jackets or SF 66D folders—Continued

DA Form 5008

Telephone Medical Advice Consultation Record. Attach to and file with SF 600 in chronological order. (See paras 5-6 and 10-3b(6)(a).)

Other SF 500-series forms. File here in numerical sequence with like form numbers together in reverse chronological order.

DA Form 4700¹

Medical Record—Supplemental Medical Data. When DA Form 4700 is used, it should be referenced on SF 600. Undersized reports should be mounted on DA Form 4700 display sheets and filed with reports to which they most closely relate. (See paras 3-2a, 3-3, 5-21b(7), 9-2b, and 12-4b(4).) File here any other forms used to record the results of atmospheric sampling.

DD Form 2808

Report of Medical Examination. (See AR 40-501 and paras 3-10g, 5-18d, 5-21b(1), and 5-25e(5) of this regulation.)

SF 88

Report of Medical Examination. This form is obsolete; use for file purposes only if already in existence.

DD Form 2795; DD Form 2796

Pre-Deployment Health Assessment; Post-Deployment Health Assessment. File any DD Form 2795 and the associated DD Form 2796 as a set. (See paras 5-32a, 5-35a, 5-36a(2), and 7-4b(5).)

OSHA Respirator Medical Evaluation Questionnaire. (See para 7-4b(8).)

SF 78

U.S. Civil Service Commission, Certificate of Medical Examination. (See para 7-4b(1).)

DA Form 3437

Department of the Army Nonappropriated Funds Certificate of Medical Examination. (See para 7-4b(3).)

DD Form 2807-1²

Report of Medical History. File any other medical history form here. (See AR 40-501 and paras 5-21b(1), 5-25e(5), and 7-4b(2) of this regulation.)

SF 93

Report of Medical History. This form is obsolete; use for file purposes only if already in existence.

DOL Form CA-1

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation. (See para 7-4b.)

DOL Form CA-2

Federal Employee's Notice of Occupational Disease and Claim for Compensation. (See para 7-4b.)

DOL Form CA-16

Authorization for Examination and/or Treatment. (See para 7-4b.)

DOL Form CA-17

Duty Status Report. (See para 7-4b.)

Figure 7-1. Forms and documents of the CEMR using DA Form 3444-series jackets or SF 66D folders—Continued

DOL Form CA-20
Attending Physician's Report. (See para 7-4b.)

DD Form 2005²

Privacy Act Statement—Health Care Records. DD Form 2005 is always the bottom form in the CEMR. (See paras 4-4a(9), 5-27a, 7-4a, and 10-3a(1).) A separate DD Form 2005 must be in the CEMR as the CEMR must be retired or transferred in SF 66D folder, which does not have a preprinted DD Form 2005.

Notes:

¹Instructions for completing this form are self-explanatory.

²This form must be included in all CEMRs.

Figure 7-1. Forms and documents of the CEMR using DA Form 3444-series jackets or SF 66D folders—Continued

Chapter 8 Army Substance Abuse Program Outpatient Medical Record

Section I General

8-1. For whom prepared

An ASAP-OMR will be prepared for each patient enrolled in the ASAP.

8-2. Access

All personnel having access to ASAP-OMRs will protect the privacy of PHI. Care will be taken to prevent unauthorized release of any information on the treatment, identity, prognosis, or diagnosis for substance abuse patients. Requests for release of information will be handled in accordance with chapter 2 of this regulation and AR 600-85, chapter 6, using DA Form 5018-R (Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) Client's Consent Statement for Release of Treatment Information).

8-3. Disclosure of information

a. Requests for release of information from ASAP-OMRs will be handled by the Patient Administration Division in accordance with AR 600-85 and chapter 2 of this regulation. DA Form 5018-R must be completed. Information will be released only under the authority of the Patient Administration Division.

b. The following drug and alcohol laws take precedence over other directives pertaining to access to drug and alcohol rehabilitation information.

(1) 42 USC 290dd-2 prohibits the disclosure of records of the identity, diagnosis, prognosis, or treatment of any patient maintained in connection with a Federal substance abuse program, except under the following circumstances:

(a) The patient consents in writing;

(b) The disclosure is allowed by a court order; or

(c) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

(2) 42 USC 290dd-2 provides no exceptions for civilian employees participating in the Nuclear or Chemical Surety Personnel Reliability Programs (AR 50-5 and AR 50-6), or any DOD or Army personnel security program (AR 380-67).

(3) A "patient" is defined in 42 CFR 2.11 as "any individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a Federally-assisted program and includes any individual who, after arrest on a criminal charge, is identified as an alcohol or drug abuser in order to determine that individual's eligibility to participate in a program." An employee does not have to be enrolled in the program in order to be protected by the provisions of 42 USC 290dd-2, so long as the employee falls within this definition of patient.

(4) During the initial screening, or as soon thereafter as possible, the patient will be notified of the Federal confidentiality requirements and will be given a summary in writing of the Federal laws and regulations. A sample notice is contained in 42 CFR 2.22.

(5) A patient may have access to his or her own records, including the opportunity to inspect and copy any records



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34

Medical Services

Quality Assurance Administration

Headquarters
Department of the Army
Washington, DC
20 December 1989

UNCLASSIFIED

SUMMARY of CHANGE

AR 40-68

Quality Assurance Administration

This new regulation--

- o Adds the confidentiality statute and the table of organization and equipment treatment facilities (chap 1).
- o Adds the impaired provider ad hoc committee (chap 2).
- o Expands assessment of patient care, utilization management, and risk management (chap 3).
- o Expands privileging and reporting of privileging actions (chap 4).
- o Deletes the requirement for a 305-day conditional privileges period for practitioners initially coming on active duty (chap 4).
- o Adds dental Activity Quality Assurance Program (chap 5).
- o Expands the Quality Assurance Program for Reserve Components (chap 6).
- o Adds the quality assurance policies within the Alcohol and Drug Abuse Prevention and Control Program Community Counseling Center Quality Assurance Program (chap 8).
- o Adds the preselection procedures for nonmilitary health care providers (app B).
- o Adds department of Nursing Quality Assurance Program (app C).
- o Adds Nutrition Care Division or Directorate (app D).
- o Adds occupational therapy and physical therapy activities (app E).
- o Modifies licensure requirements (chap 9).

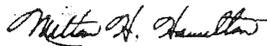
Medical Services

Quality Assurance Administration

By Order of the Secretary of the Army:

CARL E. VUONO
General, United States Army
Chief of Staff

Official:



MILTON H. HAMILTON
Administrative Assistant to the
Secretary of the Army

History. This UPDATE printing publishes a new Army regulation. This publication has been reorganized to make it compatible with the Army electronic publishing database. No content has been changed.

Summary. This regulation is a consolidation. It prescribes policy and procedures for the Army Medical Department's Quality Assurance Program which includes—

- a. The Impaired Health Care Provider Program.
- b. The Alcohol and Drug Abuse

Prevention and Control Program Community Counseling Center Quality Assurance Program.

c. Professional licensure.

Applicability. This regulation applies to the Active Army, the Army National Guard (ARNG), and the U.S. Army Reserve (USAR). It also applies to Medical Department activities, medical centers, dental activities, and organizations for which the Army Medical Department is the executive agent.

Proponent and exception authority. Not applicable.

Committee establishment approval. The DA Committee Management Officer concurs in the establishment of the impaired provider ad hoc committee.

Army management control process. This regulation is subject to the requirements of AR 11-2. It contains internal control provisions but does not contain checklists for conducting internal control reviews. These checklists have been developed and will be published at a later date.

Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited without prior

approval from HQDA (SGPS-PSQ), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

Interim changes. Interim changes to this regulation are not official unless they are authenticated by the Administrative Assistant to the Secretary of the Army. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

Suggested Improvements. The proponent of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (SGPS-PSQ), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

Distribution. Distribution of this publication is made in accordance with the requirements on DA Form 12-09-E, block number 5027, intended for command level B for Active Army, and A for ARNG and USAR.

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*This regulation supersedes AR 40-66, chapters 9 and 10, 31 January 1985.

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Chapter 1 Introduction

1-1. Purpose

This regulation establishes policies, procedures, and responsibilities for the administration of the Army Medical Department's (AMEDD) Quality Assurance Program (QAP). The purpose of quality assurance (QA) is to—

- a. Provide quality care and treatment to all beneficiaries in their need for health services, subject to the availability of space and facilities and the capabilities of the medical and dental staff.
- b. Make improvements resulting in higher quality health care.
- c. Promote the professional development and enhance the capabilities of the military and civilian members of the AMEDD.

1-2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

1-3. Explanation of abbreviations and terms

Abbreviations and special terms used in this regulation are explained in the glossary.

1-4. Responsibilities

a. *The Surgeon General (TSG)*. TSG will establish policy concerning the QAP to include reporting requirements.

b. *Commanders of major medical commands (MEDCOMs)*. These commanders are responsible for administration of policies in this regulation, the effectiveness of QAPs in their subordinate units, and for tables of organization and equipment (TOE) units under their command. They will control the extent of patient treatment in the TOE treatment facilities.

c. *Commanders of medical department activities (MEDDACs), medical centers (MEDCENs), and dental activities (DENTACS)*. These commanders will—

- (1) Ensure that a comprehensive QAP is established in compliance with this regulation.
- (2) Appoint a QA coordinator (QAC) and risk manager. (See chap 5 for DENTAC.)
- (3) Ensure development of a prevention, identification, and procedural plan for impaired health care providers (HCPs).
- (4) Ensure coordination of actions under appropriate regulations and the Uniform Code of Military Justice (UCMJ) when necessitated by findings under this regulation.
- (5) Ensure that the credentials committee reviews Reserve Component (RC) Army National Guard (ARNG), and U.S. Army Reserve (USAR) practitioner credentials files (PCFs) and takes action per paragraphs 6-4 and 6-5.

d. *Chiefs of departments, services, or clinics*. In their areas of responsibility, these chiefs will at least—

- (1) Retain accountability for all professional and administrative functions.
- (2) Develop criteria for granting clinical privileges.
- (3) Provide recommendations for granting and renewing clinical privileges based upon the performance of each practitioner who practices in that department.
- (4) Evaluate and document the credentials and current competence of HCPs not individually privileged.
- (5) Evaluate causes for, and participate in response to, untoward incidents.
- (6) Serve as a coordinating point by providing information about hospital and patient care affairs to members of the department.
- (7) With the help of relevant support personnel, plan and conduct QA meetings of the department.
- (8) Provide for reports to hospital or dental committees as follows:

(a) *Quality assurance committee*. Data concerning clinical QA issues to include monitoring and evaluation of quality and appropriateness of patient care. (See also para 2-1a.)

(b) *Credentials committee*. Recommendations concerning clinical practice or conduct problems of practitioners.

(c) *Others as appropriate*.

(9) Counsel and advise individuals and initiate administrative action on questions about clinical competence or performance, disregard for reasonable rules, lack of respect for coworkers, suspected impairment, or practicing outside the scope of clinical privileges that have been granted.

(10) Establish a systematic program for recognizing those within the service or department who make exceptional contributions to the care of patients through clinical competence and/or leadership in the provision of such care.

e. *RC commanders*. RC commanders are responsible for the administration of policies in this regulation. They are responsible for the effectiveness of QAPs within their commands to include—

- (1) Establishing a credentials committee.
- (2) Appointing a QAC.
- (3) Establishing, reviewing, and maintaining PCFs.
- (4) Providing updated PCFs for review by each serviced MEDDAC, MEDCEN, or DENTAC. (See chap 6.)
- (5) Approval of privileging actions for assigned or attached practitioners engaged in providing health care during unit controlled activities (for example, physical examinations, immunizations, dental examinations, field exercises, medical support missions, and so forth).

f. *MEDDAC or MEDCEN QAC*. The QAC is the overall manager of the MEDDAC or MEDCEN QA activities who plans, organizes, coordinates, and evaluates QAP functions outlined in the QA plan. (See para 3-6.)

g. *MEDDAC or MEDCEN risk manager*. The risk manager is the overall manager of the MEDDAC or MEDCEN risk management (RM) program who plans, organizes, coordinates, and evaluates the risk management functions (para 3-5). The risk manager will also incorporate quality control procedures for medical materiel as part of the overall RM program. (The dissemination of medical materiel quality control information per AR 40-61 is the responsibility of the chief, medical treatment facility (MTF), logistics division.) (See para 3-7.)

h. *MEDDAC or MEDCEN credentials specialist*. Where this is a separate function (not performed by the QAC), the credentials specialist will initiate and maintain the provider activity files (PAFs) and the PCFs for all MEDDAC or MEDCEN practitioners. There will be coordination with the QAC and risk manager to assure proper information flow. Upon transfer or permanent change of station (PCS) of the practitioner, there will be a timely mailing of the PCF (para 4-3a).

i. *Community counseling center clinical director*. The clinical director carries out the QAP within the community counseling center. (See para 8-2.)

j. *The community counseling center (CCC) clinical consultant*. The CCC clinical consultant will—

- (1) Assist the CCC clinical director in the development of the CCC QA plan.
- (2) In coordination with the clinical director, assist in the coordination of the CCC QA plan with the MEDDAC, MEDCEN, or DENTAC QA committee.
- (3) Develop criteria for clinical privileges of CCC HCPs with the department, service, or clinic chief appropriate to the profession of the person applying for privileges.

1-5. Objectives of the QAP

The objectives of the QAP are to assure that personnel of MEDDAC, MEDCEN, or DENTAC—

- a. Deliver quality patient care subject to the availability of space and facilities and the capabilities of the medical and dental staff.
- b. Reduce risk-creating incidents and adverse effects to patients.
- c. Improve provider-patient communication and patient satisfaction.
- d. Enhance coordination and communication among HCPs and clinical and ancillary services.
- e. Improve the HCP screening, selection, and accession process.

f. Objectively evaluate practitioner performance through performance-based criteria and other QA information as defined in this regulation.

g. Educate MEDDAC, MEDCEN, and DENTAC personnel on QAP requirements.

h. Enhance the skills and knowledge of practitioners.

i. Consolidate QA efforts into one comprehensive program.

j. Reduce medical malpractice cases and claims to the maximum extent possible.

1-6. Quality assurance education

Education not only improves the MEDDAC, MEDCEN, or DENTAC clinical, administrative, and ancillary services personnel's understanding of QAP objectives and requirements, it also provides a forum for multidisciplinary discussion of and education on QA issues. Both successful QA efforts and identified problem areas should be communicated to all elements of the activity. Results of QA evaluations will be discussed in department, service, and clinic meetings. Identified areas for improvement will be presented. Trends having educational value or showing a need for changes in policies or procedure should be presented.

1-7. Confidentiality statute

a. *Statute.* The National Defense Authorization Act for Fiscal Year 1987 (Public Law No. 99-661 (PL 99-661), section 1102, title 10, United States Code (10 USC 1102)) provides that records created by or for the Department of Defense (DOD) in a medical or dental QAP are confidential and preclude disclosure of or testimony about any records or findings, recommendations, evaluations, opinions, or actions taken by the QA activity except in limited situations. These records include any proceedings, minutes, reports, or other records emanating from DOD QA program activities that are produced or compiled by DOD as part of a medical QAP. The statutory privilege is designed to improve the quality of medical care by encouraging a thorough and candid medical peer review process.

b. *Statute provisions.* The statute—

(1) Establishes the confidential and privileged nature of QA information.

(2) Prohibits disclosure of records and testimony concerning the records except in certain circumstances. (See *e* below.)

(3) Establishes penalties for unauthorized disclosure. (See *g* below.)

(4) Provides immunity from civil liability for anyone who, in good faith, participates in or provides information to a person or body engaged in creating or reviewing medical QA records. (The law specifically provides that QA records may not be "subject to discovery or admitted into evidence. . ." except as provided by statute.) The law does not limit access to information in a record created and maintained outside a DOD medical or dental QA program even though it may be presented to a peer review body and become incorporated into a QA record—for example, a patient's medical or dental record.

c. *Inclusion.* To receive coverage under this statute, QA and RM activities will be clearly identified. For example, a commander's investigation under AR 15-6 would not normally be a QA function while a QA investigation using for convenience the format of an AR 15-6 investigation would be.

d. *QA record.* A medical or dental QA record is defined as "the proceedings, records, minutes, and reports that emanate from" QAP activities. A medical or dental QAP is "any activity carried out before, on, or after the date of enactment of this section by or for the DOD to assess the quality of patient care. . ." The statute specifically includes within the definition of QAP any activity designed to assess the quality of patient care carried out or conducted by individuals; MEDDAC, MEDCEN, or DENTAC committees; or other review bodies responsible for credentialing, infection control, patient care assessment, medical and dental records, health resources

management review, and identification and prevention of medical or dental incidents and risks.

e. *Exceptions to nondisclosure.* The statute allows disclosure of record or testimony to—

(1) Federal or private agencies performing licensing or accreditation functions regarding DOD health care facilities or conducting required monitoring of an MTF or a dental treatment facility (DTF).

(2) An administrative or judicial proceeding commenced by a current or former DOD practitioner concerning the revocation, restriction, or suspension of the practitioner's clinical privileges.

(3) Governmental boards, agencies, or professional health care societies or organizations if needed to perform licensing, credentialing, or monitoring of the professional standards of any present or former member or employee of DOD.

(4) A hospital, MEDDAC, MEDCEN, or DENTAC, or other health care facility to assess the professional qualifications of a current or former DOD practitioner who has applied for or has been granted authority or employment to provide health care services in or on behalf of such institution.

(5) Officers, employees, or contractors of DOD who have need for QA information in the performance of their official duties; including, but not limited to, claims attorneys, claims officers, claims investigators, criminal investigators, and The Inspector General.

(6) Criminal or civil law enforcement agencies or instrumentalities if—

(a) They are charged under applicable law with the protection of the public health or safety.

(b) A government representative of such agencies or instrumentalities makes a written request that such record or testimony be provided for a purpose authorized by law.

(7) Protect the public health or safety but only with respect to the subject in an administrative or judicial proceeding brought by a criminal or civil law enforcement agency.

f. *Secondary disclosure.* The records of the QA activity or testimony given concerning the QA process remain confidential and further disclosure may be made only as specifically provided. This extends to any person or entity having possession of or access to QA records or testimony.

g. *Deletion of names.* All names included in a QA record, except for the name of the subject of a QA action, will be deleted from the record before disclosure outside DOD. The requirement does not apply to releases under the Privacy Act.

h. *Penalty provisions.* Penalties range from a \$3,000 fine for a first offense of willful and knowing disclosure of a QA record to \$20,000 for subsequent violations. The penalty provisions apply to any person who makes an unauthorized disclosure of both authorized and unauthorized releases or who makes further disclosure of the privileged information.

i. *Disclosure.* In no instance will QA records or information be released to anyone other than AMEDD personnel in the performance of their duties without the written approval of the MEDDAC, MEDCEN, or DENTAC commander. (The commander should consult with a judge advocate or civilian legal adviser concerning questions of releasability.) The following will be included on the transmittal of any QA document: "Quality Assurance Document under 10 USC 1102. Copies of this document, enclosures thereto, and information therefrom will not be further released under penalties of the law. Unauthorized disclosure carries a minimum \$3,000 fine."

j. *Processing of requests under The Freedom of Information Act (FOIA).* While QA records are exempt from access under FOIA, processing of these requests (with legible copies of requested records) to the appropriate initial denial authority (IDA) is required. The IDA for these records is TSG.

1-8. TOE treatment facilities

This paragraph applies to TOE facilities not operating as a fixed, permanent MTF in peacetime.

a. Patient treatment in TOE hospital units not operating with their complete authorization of TOE personnel and equipment will

be permitted to the extent authorized by major MEDCOM commanders.

b. The commander of the TOE unit will propose a scope of practice for the unit, specifying the extent to which the facility will be operational including proposed staffing during its operation. This will be submitted to the director of health services (DHS) for the area of operations.

c. The DHS and the TOE commander will provide a plan that will include the scope of practice and the professional support and backup required from the fixed MTF. This specific plan will be forwarded for approval to the major MEDCOM commander, addressed to the attention of the deputy chief of staff for clinical services. The major MEDCOM commander will approve, modify, or correct the plan. The major MEDCOM may delegate approval authority to the DHS.

Chapter 2 MEDDAC and MEDCEN Quality Assurance Program committees

2-1. Committees

The complexity of committee organization will depend upon the size and composition of the medical staff and the size and mission of the MEDDAC or MEDCEN. Each separate activity with a Medical Corps (MC) officer commanding will have a QAP. The following QA committees, at least, will be formed:

a. *MEDDAC or MEDCEN QA committee.*

(1) The QA committee (the executive committee of the clinical staff) will actively participate in the QAP, assuring that quality care is being delivered within the MTF and by the separate activities under its command. Table 2-1 will be used as a guideline for a calendar of reports. Separate activities will also report on a regular basis.

(2) The QA committee will—

(a) Evaluate all practitioners who provide the same patient care service using the same standards to ensure that care will be of the same level of quality.

(b) Approve the MTF written QA plan.

(c) Review patient care evaluation, utilization management, and RM activities to include followup carried out in the MTF.

(d) Have the authority to require corrective action within the parameters of the MTF's mission, policies, and programs.

(e) Notify the MTF executive committee when action is not implemented within a reasonable time.

(f) Integrate and coordinate QA findings, recommendations, and actions. When problems or opportunities to improve patient care involve more than one department or service, the committee will communicate information among departments or services. (See para 3-6c.)

(g) Report pertinent findings to the credentials committee.

(h) Determine the overall effectiveness of the QAP at least annually.

(i) Identify resources to implement an effective QAP.

(j) Perform executive committee of the medical staff functions per Joint Commission on Accreditation of Healthcare Organizations (JCAHO) medical staff standards.

(3) The exact composition of the committee should be determined by the commander. However, the committee will consist of a majority of physicians; the chief, department of nursing or representative; the chief, patient administration division (PAD), and/or the medical record administrator; and the QAC. A physician will serve as chairperson. This committee minus those not privileged may, based on individual facility needs, act as the credentials committee (see b below).

(4) Copies of all minutes and reports from all QAP activities will be submitted to the MTF QA committee for review, analysis, and further action as necessary. These minutes will contain findings from ongoing monitoring and evaluation of the appropriateness of

care and treatment provided to patients. Table 2-1 will be used as a guideline for frequency of reporting. (The QAC will contact departments and services not submitting minutes and reports in a timely manner.)

(5) Problems that are identified and resolutions or opportunities to improve care will be reported as well as the results of activities undertaken to improve that care. Problems and issues requiring further action, together with recommendations, will be reported. Identification of issues not within the province of the reporting entity, including logistical and administrative matters, will also be reported. The minutes, summarizing the MTF QAP activities, to include conclusions, recommendations, and actions taken, will be sent to the MTF's executive committee.

Table 2-1 Calendar of QA review and evaluation reports to the MEDDAC or MEDCEN QA committee

Unit: Alcohol and Drug Abuse Prevention and Control Program (ADAPCP)
Submit: Feb, May, Aug, Nov.

Unit: Ambulatory care
Submit: Jan, Apr, Jul, Oct.

Unit: Anesthesia
Submit: Jan, Apr, Jul, Oct.

Unit: Blood utilization
Submit: Jan, Apr, Jul, Oct.

Unit: Drug usage
Submit: Jan, Apr, Jul, Oct.

Unit: Emergency medicine service
Submit: Monthly.

Unit: Intensive Care Unit, Coronary Care Unit, and special care units
Submit: Feb, May, Aug, Nov.

Unit: Infection control
Submit: Feb, Apr, Jun, Aug, Oct.

Unit: Laboratory/pathology
Submit: Mar, Jun, Sep, Dec.

Unit: Medical record
Submit: Feb, May, Aug, Nov.

Unit: Medical staff clinical department
Submit: Monthly.

Unit: Nursing department
Submit: Feb, Apr, Jun, Aug, Oct, Dec.

Unit: Nutrition care
Submit: Mar, Oct.

Unit: Occupational therapy
Submit: Jan, Apr, Jul, Oct.

Unit: Physical therapy
Submit: Jan, Apr, Jul, Oct.

Unit: Radiology/nuclear medicine
Submit: Feb, May, Aug, Nov.

Unit: Respiratory therapy
Submit: Mar, Jun, Sep, Dec.

Unit: Safety
Submit: Mar, Sep.

Unit: Social work service
Submit: Feb, Aug.

Unit: Surgical case review
Submit: Monthly.

Unit: Utilization management
Submit: Monthly.

b. *Credentials committee.*



will be referred to the QA committee for review and followup action. (Careful analysis will be accomplished prior to initiating adverse privileging action on the basis of an isolated occurrence. On the other hand, repeated occurrences by a practitioner or particular department or service must receive scrutiny and positive action in order to protect patients from harm.)

d. Occurrence screening applies to all military and civilian practitioners as well as interns, residents, and fellows who, under regulations of the AMEDD, provide medical treatment in Army MTFs. The screening will also be used to identify institutional problems.

e. Occurrence screening does not negate the completion of DA Form 4106 per paragraph 3-5b.

3-8. Emergency medical services occurrence screening

Emergency medical services (EMS) occurrence screening will be used. Until necessary personnel are available, the criteria will be used on a rotating basis; that is, one or two per month. Implementation of the AQCESS EMS module is recommended but not required.

3-9. Inpatient discharge survey

Every inpatient will be given the opportunity to complete, at discharge, an evaluation of care received. The locally developed questionnaires will address the following:

- a. Promptness of the admission process.
- b. Courtesy and friendliness of the admissions staff.
- c. Respect for patient privacy.
- d. How well staff members identified themselves and explained their purpose.
- e. Satisfaction with HCPs, nursing staff, dietary services, and housekeeping services.
- f. Experiences with laboratory tests and x-ray or radiology procedures.
- g. Whether it is clear that there was a primary care practitioner.
- h. Overall rating of patient care received.
- i. How well the staff members explained conditions, treatment options, and expected results of the treatments.

Chapter 4 Credentials Review, Privileging, and Proceedings

4-1. General

a. Credentials review and clinical privileging must be effective in order to maintain quality health care. Credentials review includes verification of current licensure, certification, registration (as appropriate), education, training, experience, and current competence. The privileging process is directed solely and specifically to the provision of quality patient care and is not a disciplinary or personnel management mechanism. Privileging actions may, however, accompany actions of an administrative or judicial nature or may engender such actions. In any event, they require independent judgment and fairness.

b. Privileging provides for processing through credentials committee channels those practitioners given the authority and responsibility for making independent decisions to diagnose, initiate, alter, or terminate a regimen of medical or dental care. This includes physicians, dentists, nurse practitioners, nurse anesthetists, nurse midwives, podiatrists, optometrists, clinical social workers, clinical psychologists, and physician assistants. Also included will be personnel from the following professions when given individual clinical privileges:

- (1) Physical therapists.
- (2) Occupational therapists.
- (3) Audiologists.
- (4) Clinical dietitians.
- (5) Clinical pharmacists.
- (6) Speech pathologists.

c. Other HCPs who function under a standard job description,

protocol, or policies and procedures will not be privileged. Department or service chiefs may develop an internal certification mechanism to perform these functions. However, any HCP may be privileged when deemed appropriate by the MEDDAC, MEDCEN, or DENTAC commander. Where full performance of a civil service position requires the incumbent to be privileged, privileging is a condition of employment.

d. Recommendations for granting of clinical privileges will be made by the department or service chief, acted on by the credentials committee, and forwarded to the commander for approval or disapproval. No actions of the credentials committee will be considered final until approved and signed by the commander. In the case of nonphysician practitioners, peer recommendations normally will be obtained in addition to department or service chief recommendations.

e. Practitioners will be granted privileges in the departments, services, and clinics in which they practice, including the emergency room. The clinical director of the Alcohol and Drug Abuse Prevention and Control program (ADAPCP) will be privileged.

f. Granting of clinical privileges will be based on education, specific training, experience, and current competence, taking into account the limitations of the MTF support staff, equipment, capability, and so forth, which may limit a practitioner from carrying out some health care activities. Inquiry will also be made to the National Practitioner Data Bank (para 4-13f) prior to initial granting of clinical privileges. In no instance may a person be assigned or privileged to perform professional duties unless qualified by education, training, and experience to perform them. Behavioral competence and health status are also elements in this decision-making process.

g. Reappraisal of defined clinical privileges will be completed at least every 2 years and when a practitioner changes station. (For RCs, see chap 6.)

h. Clinical privileges may be ignored only in the case of an emergency. An emergency is a condition in which the life of the patient is in immediate danger or he or she may be permanently injured if treatment is delayed. In such cases HCPs will be expected to do all in their power to save the patient's life or prevent injury. This includes calling for available consultations.

i. Each department, service, or clinic will develop criteria for granting clinical privileges in that department, service, or clinic.

4-2. Clinical privileges

Clinical privileges are the type of practice activities permitted in the granting MEDDAC, MEDCEN, or DENTAC, within defined limits, based on the practitioner's education; professional license, as appropriate; experience; current competence; ability; judgment; and health status.

a. Staff privileges

(1) *Courtesy privileges.* These are clinical privileges given to practitioners assigned to the MEDDAC, MEDCEN or DENTAC for short periods; that is, temporary duty (TDY) of 180 days or less. They may also apply to a practitioner located in geographic proximity to an MTF or DTF during military training exercises but not assigned to the facility. These privileges may be granted by the commander of the receiving facility after written or telephonic communication with the practitioner's commander or commander's representative, if appropriate. Courtesy privileges do not apply to ARNG or USAR practitioners.

(2) *Consultant privileges.* These are advisory clinical privileges given to military or civil service practitioners designated as consultants or experts. A PCF will be initiated per paragraph 4-6. The PCF for the civilian consultant or expert will include, as a minimum, DA Form 4691-R (Initial Application for Clinical Privileges); board certification, updated curriculum vitae, letters of recommendation, and verification documentation. DA Form 4691-R is located at the back of this regulation and may be reproduced on 8½- by 11-inch paper. Consultants or experts who provide direct patient care must have formal privileging (para 4-8).

(3) Temporary privileges.

(a) These are clinical privileges given to active duty practitioners

when reporting to a new duty station with an incomplete PCF or without a PCF. When a practitioner requests clinical privileges by letter at the gaining MTF without a completed PCF (or the PCF has not yet arrived), the practitioner may be granted temporary privileges by the commander or the recommendation of the chief of the applicable department or service or the DCCS. Temporary privileges do not require review or recommendation by the credentials committee.

(b) The practitioner will sign an acknowledgement of having received and read the MTF medical staff's current rules and regulations and an agreement to be bound by their rules and regulations pertaining to temporary privileges. Temporary privileges may be granted for a stated time not to exceed 30 days. Information on available items of education, training, licensure, and so forth will be obtained from the QA Provider Actions Branch, Quality Assurance Division, Directorate of Professional Services (SGPS-PSQ), 5109 Leesburg Pike, Falls Church, VA 22041-3258, AUTOVON 289-0088 or commercial (703) 756-0088.

(c) A practitioner with temporary privileges will be supervised by a designated MTF staff member. This supervisor must be privileged and of the same specialty area in which clinical privileges are requested (or any other privileged member of the staff when a specialist in the same discipline is not available). The supervising member must be designated in writing.

(d) Temporary privileges will be used for active duty military practitioners only and will not be granted pending the processing of clinical privileges applications for RC or civilian practitioners. After the temporary period, the practitioner will be placed on provisional status in accordance with (4)(a) below. At DTFs, the DENTAC will place the practitioner on temporary status, arrange for supervision, and approve provisional status.

(4) *Provisional (conditional) privileges.* Provisional clinical privileges are given to practitioners newly assigned to a facility or discipline; for example, when they first come on active duty or become employed by the AMEDD, change duty stations, or complete a Graduate Health Professions Education (GHPE) program in a different specialty area. Practitioners who return to clinical practice after serving in a nonclinical capacity (for example, in an administrative or leadership role) for more than 1 year will be given only provisional privileges, regardless of the reason for the nonclinical service, to permit an evaluation of their current clinical competence. Action pertaining to civil service employees regarding performance, training, conduct, and probationary periods will be coordinated with the appropriate civilian personnel office (CPO).

(a) The period of provisional privileges will be 365 days (para 4-4a). However, the provisional privileges may be reviewed by the commander and defined privileges granted or other action taken, if appropriate, based on the review. The risks associated with the activities for which privileges are sought and the frequency with which procedures are performed should be taken into consideration.

(b) Failure to attain and retain required proficiency levels for defined privileges by the end of the provisional period will require an evaluation as to whether revocation or permanent restriction of privileges is appropriate. For practitioners completing a GHPE program in a different specialty area and failing to attain proficiency levels, an evaluation to determine privileging in his or her prior credentialed specialty area will also be accomplished. A decision whether to separate the practitioner will be made by the commander following the privileging action (AR 635-100).

(c) During the provisional period, practitioners will be supervised directly or indirectly depending on the recommendations of the credentials committee. The appointed supervisor will submit monthly reports to the credentials committee; however, quarterly reports will be acceptable after three successive satisfactory monthly reports.

(d) RC practitioners whose professional credentials have been reviewed and accepted by the credentials committee for a period of active duty at the MEDDAC, MEDCEN, or DENTAC will be given provisional privileges at each facility where active duty for training (ADT) is conducted. Repetitive ADT at the same facility may result

in the facility granting defined privileges based upon credentials committee review and the commander's approval.

(5) *Defined privileges.* These are clinical privileges given the individual by the commander upon recommendation of the credentials committee after completion of a satisfactory provisional period.

b. *Privileging actions.* Several privileging actions are available to the credentials committee and the commander. (Individuals enrolled in GHPE are controlled by AR 351-3.) (See para 4-8h.) The following are privileging actions that may be taken after performances are documented:

(1) *Privilege reappraisal.* (See para 4-8e and f.)

(2) *Abeance.* This is the temporary assignment of a practitioner to nonclinical duties while an internal or external peer review is conducted. This period will not exceed 14 days except that the MTF may grant a single additional 14 days by order of the commander. Such abeyance periods are not considered adverse actions with regard to privilege sanctions or reporting requirements.

(3) *Augmentation.* This is the addition of clinical privileges not previously held by the practitioner. Augmentation is based on additional training, sustained superior performance, correction of previously demonstrated deficiencies, or other objective evidence of increased expertise. Reappraisal per paragraph 4-8e is required.

(4) *Suspension.* This is temporary removal of all or part of a practitioner's privileges based on incompetence, negligence, or unprofessional conduct, or other factors that do or may affect the appropriateness of the practitioner's privileges.

(5) *Restriction (limitation).* This is permanent removal of a portion of a practitioner's clinical privileges based on incompetence, unprofessional conduct, or other factors affecting the activities restricted.

(6) *Revocation.* This is permanent removal of all clinical privileges. In most cases, such action will be followed by action to terminate the practitioner's DCD service (para 4-4).

4-3. Transfer

a. *Practitioner change of station or employment.* The credentials committee of the losing MEDDAC, MEDCEN, or DENTAC will send the PCF by certified mail, return receipt requested, to the commander of the receiving facility. The PCF will be forwarded far enough in advance to ensure that it arrives at the receiving facility no later than 15 days before the practitioner's reporting date. If the gaining facility has not received the PCF upon the practitioner's arrival, the facility will take immediate steps to locate the missing PCF. Temporary privileges may be granted to the active duty practitioner (para 4-2a(3)).

b. *Administrative position or school.* If the practitioner changes station to a position involving no clinical practice or attends a civilian or military school (other than graduate medical or dental education), the PCF will be sent to HQDA (SGPS-PSQ), 5109 Leesburg Pike, Falls Church, VA 22041-3258. These files will be held until requested. (The PCF may be requested by a collocated MEDDAC, MEDCEN, or DENTAC if the practitioner engages in clinical practice while attending school.) For those attending military graduate medical or dental education, the PCF will be forwarded to the military facility conducting the internship, residency, or fellowship training.

4-4. Practitioner's separation

a. *Military.*

(1) A military practitioner who is not in compliance with this regulation may be eliminated from the service under the provisions of AR 635-100 or AR 135-175.

(2) Active duty members leaving the service in a less than fully privileged status will not receive an appointment or assignment in an AMEDD branch of the RCs.

b. *Civilian practitioners.* A civilian employee's failure to attain or to maintain the required proficiency levels and the ability to practice may be a basis for separation since the employee is not qualified to retain his or her appointment to the position. Commanders may consider separation under three approaches, each of which requires close consultation with the servicing CPO.

(1) *Separation during probation.* If the practitioner is serving under a probationary appointment (initial competitive appointment, typically a 365-day period), the practitioner may be separated under the provisions of Federal Personnel Manual (FPM), chapter 315. Such an action must be completed before the end of the last duty day prior to the practitioner's 365th day after appointment. For practitioners who are under probation, this is the preferred route, and warrants close scrutiny of employees during their first year of employment.

(2) *Separation based on performance.* This approach is based on poor performance of one or more critical elements in a practitioner's performance plan, and need not include a loss of privileges. This action is taken under the provisions of section 4303, title 5, United States Code and FPM, chapter 432. There are significant rights to notice, opportunity to improve, and to seek external review.

(3) *Separation based on loss of qualifications.* This approach is based on the fact that the practitioner is no longer qualified to perform the duties of the position to which he or she was appointed, or when misconduct or malfeasance serve as a basis. (The misconduct must be related to the practitioner's ability to perform the duties of the position—the "nexus" requirement.) There are significant rights to notice, hearing, representation, and appeals beyond the agency.

4-5. Cross-servicing of practitioners' credentials files

PCFs will be provided as supporting documentation for those practitioners who request interservice transfers. These files will be certified copies and will be added to the transfer request by the practitioner's MEDDAC, MEDCEN, or DENTAC commander. Credentials files of applicants not selected for AMEDD service (preselection credential review) will be made available to recruiting agencies of the other Services on request.

4-6. Preselection credential review

a. Verification. Prior to appointment to the military, civil service, consultant status, foreign national local hire, or as a contract practitioner, a verification of education, training, experience, licensure and/or certification and/or registration, and current competence will be completed. (See para 4-13f.)

b. PCF. Information will be obtained so that a PCF can be initiated. (This information will serve as the basis of the PCF throughout that practitioner's service career, or for nonmilitary health care practitioners the entire period they work within the AMEDD.) Following is the information needed:

(1) Copies of qualifying education degrees (including diplomas) needed for the performance of clinical privileges and verification of the authenticity of these documents (para 4-6c).

(2) Copies of required postgraduate training certificates for the privileges in the area of work; for example, internship, residency, fellowship, nurse anesthesia school, and verification of the authenticity of these documents.

(3) Copies of State licenses and current renewal certificates, and Educational Commission for Foreign Medical Graduates (ECFMG) certification when applicable. A list of all licenses ever held will be provided along with an explanation of any that are not current or that have ever been subjected to disciplinary action, and a statement that this list with explanations is complete and accurate. There will be verification of licenses and certificates.

(4) Copies of specialty board certificates and fellowship certificates and verification.

(5) A curriculum vitae to account for all periods of time subsequent to obtaining the initial qualifying degree.

(6) Proof of current (within 1 year) competence (letters of reference and a recent description of clinical privileges as concurred in by the supervisors of the practitioner per c(5) below).

(7) A statement of involvement in malpractice cases and claims to include a brief description of the facts of each claim settled on the behalf of the practitioner.

(8) Any history of disciplinary action by hospitals, State licensure boards, or other government agency.

(9) A statement regarding physical and mental health to include any history of drug or alcohol abuse.

(10) An interview summary by at least one Medical Corps (MC) officer on active duty (applies to MC only).

(11) All current and prior Drug Enforcement Agency (DEA) numbers, as appropriate.

(12) National Practitioner Data Bank query.

c. Verification.

(1) Preselection verification of military (para 4-6b) will be completed by the AMEDD Officer Procurement Division, U.S. Army Health Professional Support Agency (SGPS-PD). Verified copies of all the documents along with DA Form 71 (Oath of Office—Military Personnel) and a copy of orders will be sent to the first MEDDAC, MEDCEN, or DENTAC to which the practitioner is assigned. A duplicate packet will be given to the appointee. (These documents will serve as the basis of the PCF throughout the practitioner's service career.)

(2) Before selection of Civil Service, civilian consultants (experts), and foreign national local hires, there will be a preselection verification of education, training, experience, licensure and/or certification and/or registration, and current competence. (See para B-5.)

(3) For verification of education; training; licensure and/or registration, and/or certification; ECFMG; and board certification, if applicable, either an original letter from the educational institution or certifying body, attesting to successful completion of specialty training, or verification by telephone communication between the recruiter and the education institution or specialty board will be used. Telephone verification will be recorded on the document itself and on official letterhead and signed and dated by the individual making the phone call. These letters will be placed in section VI of the PCF.

(4) If the medical or dental diploma has been issued by a foreign medical school in a country that has no diplomatic relations with the United States, the MEDDAC, MEDCEN, or DENTAC will contact HQDA (SGPS-PSQ) (AUTOVON 289-8000; commercial (703) 756-8000) for verification.

(5) For verification of experience and current competence at least two letters of recommendation from appropriate sources in (a), (b), and (c) below are required. The letters will be mailed by the author directly to the recruiting agency, MEDDAC, MEDCEN, or DENTAC. These descriptions of recent clinical privileges will be verified.

(a) A letter from either the chief of staff of the hospital, the clinic administrator, the professional supervisor, or the department head, if the appointee has professional or clinical privileges or is associated with a hospital or clinic.

(b) A letter from the director or a faculty member of the appointee's training program, if the appointee has been in a training program within the last 5 years.

(c) A letter from a practitioner (in the appointee's discipline) who is in a position to evaluate the appointee's professional standing, character, and ability; for example, a peer or a president or secretary of the local professional society. A letter from a peer and a professional association or society association is mandatory if the appointee is self-employed.

(6) A copy of the appointee's Federal narcotics license, if applicable, will be submitted and verified with the DEA. The capability of prescribing unrestricted drugs will be determined.

d. Contract practitioners. Civilian contract practitioners must meet the same requirements as civil service practitioners (c(2) above). For verification of education, training, and experience, see paragraph B-4.

e. Privileging. Granting of clinical privileges will be withheld until sufficient verified data to document training, experience, and current competence is available.

4-7. Preselection experience and reference checks

a. The following are general guidelines for HCP experience or reference checks:

(1) Always verify by telephone any reference information obtained in writing.

(2) In general, do not limit reference checks to those given by the provider on the application form. Providers must be notified that other individuals may be contacted.

(3) If possible, ask current MEDDAC, MEDCEN, or DENTAC staff and/or peers members to make telephonic calls to other HCPs or peers for reference checks.

b. The following are physician applicant contacts for reference (comparable contacts can be made for other HCPs):

(1) For physician applicants now in practice—

(a) Start with the names specified by the applicant on the application form.

(b) Call the chief of staff of the present hospital where the applicant holds staff privileges and previous hospitals where the applicant held staff privileges.

(c) Call the chief of the department of the present hospital where the applicant practices, if appropriate.

(d) If the physician applicant is a member of a medical staff with fewer than five members, call the president of the local medical society. Ask the president for another reference.

(e) If the applicant has been in practice less than 5 years and the previous information is not satisfactory, contact the director of the applicant's residency program.

(f) If problems regarding the physician's relationship with other professionals are suspected, contact the director of nursing of the present hospital or a nursing supervisor of the unit most frequently used by the applicant.

(2) For physician applicants completing residency programs—

(a) Use the names specified by the applicant on the application form.

(b) Always call the director of the residency program.

(c) Ask the director for one faculty person and one attending physician not recommended by the applicant.

c. Use the following questions for experience and competence checks as appropriate (comparable questions can be asked for HCPs other than physicians):

(1) Did you personally ever have reason to question the physician's medical or surgical competence? If yes, ask for an explanation.

(2) Are you aware of committees of the medical staff ever considering or actually taking action against this physician for poor medical practice?

(3) Have you heard concerns expressed by the medical staff over the quality of this physician's practice? If yes, ask for an explanation.

(4) Does the physician work well with other members of the medical staff? If no, ask for an explanation.

(5) Do you and other members of the medical community consider this physician a medical staff leader? If no, ask for an explanation.

(6) Does the physician relate well and in a professional manner with members of the hospital employee staff? If no, ask for an explanation.

(7) Does the physician have, or has he or she had in the past, any personal problems (for example, alcoholism or drug abuse) that have interfered with the professional practice? If yes, ask for an explanation.

(8) Has the physician ever lost admitting privileges because of failure to comply with medical staff bylaws or rules and regulations? If yes, ask for an explanation.

(9) Does the physician complete medical records in a timely and careful manner? If no, ask for an explanation.

d. Records for each contact must be maintained, including names of all parties to the call, date, and summary of the call. OF 271 (Conversation Record) may be used. Contacts should be advised that the practitioner may be provided with this information.

4-8. Clinical privileging

a. Initial application for privileges.

(1) DA Form 4691-R and DA Form 5440-R-series (Delineation

of Privileges—Specialty) will be completed upon arrival at the initial duty station or place of employment. The forms will be completed in duplicate. The originals will be given to the PCF custodian and the copies to the practitioner. The specialties listed below are applicable. (See app A for the corresponding DA Form 5440-R-series number.) DA form 5440-R-series will be reproduced locally on 8½- by 11-inch paper; copies for reproduction are located at the back of this regulation.

(a) Anesthesia.

(b) Dentistry.

(c) Family practice.

(d) Internal medicine and subspecialty.

(e) Neurology.

(f) Obstetrics and gynecology.

(g) Optometry.

(h) Pathology.

(i) Pediatrics.

(j) Podiatry.

(k) Psychiatry.

(l) Psychology.

(m) Radiology/nuclear medicine

(n) Surgery.

(o) Nurse anesthetists.

(p) Nurse midwives.

(q) Nurse practitioners (adult).

(r) Obstetrics/Gynecology (OB/GYN) nurse practitioner.

(s) Physician assistants.

(t) Dietetics.

(u) Occupational therapy.

(v) Physical therapy.

(w) Emergency medicine.

(x) Aviation medicine.

(y) General medical officer.

(z) Troop medical clinic physicians.

(aa) Troop medical clinic dentists.

(ab) Troop medical clinic physician assistants.

(2) Prior to the granting of provisional clinical privileges at the appointee's first duty station or place of employment, the MEDDAC, MEDCEN, or DENTAC credentials committee will review the preselection validated documents (para 4-6) and completed DA Forms 4691-R and DA Form 5440-R-series. Based on this review, the credentials committee will forward its recommendation for clinical privileges to the facility commander.

(3) If the appointee disagrees with the MEDDAC, MEDCEN, or DENTAC commander on the initial privileges to be granted, he or she may appeal per paragraph 4-10. Pending appeal findings, the privileges, if any, will be as granted by the MEDDAC, MEDCEN, or DENTAC commander.

b. DA Form 4691-R. DA Form 4691-R provides a synopsis of education and experiential background of each practitioner at the time of initial application for clinical privileges. It includes professional education, postgraduate training, previous hospital assignments, certification and professional society membership, and credentials action history. Form 4691-R is completed only at the practitioner's initial duty station or place of employment.

c. DA Form 5440-R-series.

(1) DA Form 5440-R-series will be used for granting of clinical privileges for practitioners in one of the specialties listed in a above. These forms combine a categorical (patient risk and training of practitioner) and disease and procedure-based (listed specifically) approach by discipline.

(2) For the nonphysician practitioner serving in an expanded role, only the disease and procedure approach is used. When using this disease or procedure-based method, care must be taken to ensure that the practitioner has credentials to perform each function or procedure and that he or she recognizes every hazard or complication for the condition or procedure. The practitioner will complete the left-hand column, initialing the category and privileges requested. The department, service, or clinic chief will initial the right-hand column. The credentials committee chairperson will complete the "Recommendations" portion on the last page. The last page

will be dated and signed by the department, service, or clinic chief; the credentials committee chairperson; and the MEDDAC, MEDCEN, or DENTAC commander.

(3) For practitioners who are assigned to one department or service and request privileges in another, appropriate chiefs in both departments or services will be named and will initial on the last page. The practitioner will document any education or training that was taken since completion of DA Form 4691-R or the last DA Form 5440-R-series. This education or training will be verified by the credentials specialist (para 1-4h). (See para 4-11a(4)(a).) When privileges are modified from those requested, state the reason under "Remarks." (Examples of such reasons are lack of technological resources (will be included on updated DA Form 5440-R-series), lack of ancillary staff, AMEDD unauthorized privileges, lack of practitioner credentials, and professional performance.) When appropriate, only the last page of DA Form 5440-R-series will be completed for a privilege status change; that is, provisional to defined status.

d. DA Form 5440-22 (Delineation or Privileges). This form is completed for those specialties and expanded role functions not otherwise included in the DA Form 5440-R-series; for example, for a dermatologist. This group of practitioners includes all of those identified in paragraph 4-1 but not specifically listed in *a* above. This is a special form and whenever used a copy will be forwarded through the next higher medical headquarters to HQDA (SGPS-PSQ), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

e. Periodic clinical privileges reappraisal (renewal).

(1) Practitioners will be continuously monitored to ensure that quality patient care is given. It is the responsibility of each practitioner to request, in writing, the renewal of his or her privileges every 2 years. The request for renewal must be submitted far enough in advance to permit an evaluation of clinical privileges. Thorough reappraisal will be based on education, training, experience, appraisals of clinical performance, PAF data, professional conduct, and health status. Failure to request renewal in a timely fashion will result in the expiration of prior privileges granted, effective on the date that is 2 years from the date the earlier privileges were granted. (See para 4-13f.)

(a) DA Forms 5441-R-series (Evaluation of Privileges—(Specialty)) and DA Form 5374-R (Performance Assessment) will be used for the reappraisal of clinical performance. (See app A for a complete listing of the DA Form 5441-R-series.) DA Form 5374-R and DA Form 5441-R-series forms will be reproduced locally on 8½- by 11-inch paper; copies of these forms for reproduction are located at the back of this regulation.

(b) The "privileges performed" on DA Form 5441-R-series (including DA Form 5441-23-R) must be identical to the "privileges delineated" on DA Form 5440-R-series. (See *a*(1) and *d* above.)

(c) When privileges are modified because of the reappraisal, state the reason under "Comments" on DA Form 5441-R-series.

(2) DA Form 5374-R will be used to evaluate clinical and interpersonal professional skills. It will be completed by the chief of the department, service, or clinic. It will include documentation of the results of peer review especially with regard to superior or substandard performance.

(3) At the time of privilege reappraisal, the current PAF data may be removed and destroyed only after the credentials committee judges that the data are reflected accurately and completely in the current reappraisal and privilege delineation. (In no case will data, documents, or other materials placed by another MEDDAC, MEDCEN, or DENTAC be deleted from the PCF. No material relating to a command reprimand, privilege restriction, suspension, or revocation will be deleted.)

(4) If the practitioner disagrees with privileges granted, he or she may appeal per paragraph 4-10.

(5) For the practitioner changing from provisional to defined privileges, a summary of the appointed supervisor's reports (para 4-2a(4)(c)) will be documented in the "Remarks" section of the appropriate DA Form 5440-R-series.

(6) RC. (See chap 6.)

(7) DA Forms 5440-R-series, 5441-R-series, and 5374-R will be completed in duplicate. The originals will be kept in the practitioner's PCF and copies given to the practitioner.

f. Modification of privileges at the request of the practitioner.

(1) When the practitioner requests modification of his or her clinical privileges for the upcoming period, this fact will be documented in the "Remarks" section of the DA Form 5440-R-series prepared for the period. Practitioners who request privileges substantially less than those that would be expected from members of their specialty area of concentration (AOC) or skill identifier (SI) will be referred to the commander for appropriate administrative action; for example, change in AOC or SI, change in special pays, or separation. (Practitioners who refuse to request privileges within 5 duty days of reappraisal date, PCS, and so forth will be referred to the credentials committee for recommendation of action to the commander.)

(2) If the modification reduces his or her privileges, the credentials committee will—

(a) Determine whether the request is warranted.

(b) Determine whether the practitioner will undergo a period of training. If the training is approved, the modification of privileges (temporary) will not result in an adverse privileging action.

(c) Determine whether a recommendation should be made to change the practitioner's AOC or SI.

(3) Consider recommending processing for separation in a less than fully privileged status.

g. Practitioners changing duty station or transferred employed civilian practitioner.

(1) When practitioners change stations or transfer, they will submit the appropriate DA Form 5440-R-series to the receiving credentials committee. The losing MEDDAC, MEDCEN, or DENTAC will complete a new DA Form 5441-R-series and DA Form 5374-R. If the biennial appraisal was completed by the losing facility within 6 months of PCS, it will be considered to be current. The credentials committee of the losing facility will send these forms together with the PCF by certified mail, return receipt requested, to the receiving facility. (See para 4-3a.)

(2) The gaining facility will use this file as a basis on which to grant provisional privileges. Even if practitioners change stations to leadership or administrative positions involving no clinical practice or become school attendees (para 4-3b), the PCFs will include current reappraisals (DA Forms 5441-R-series and 5374-R).

h. GHPE.

(1) Interns, residents, and fellows will be supervised by practitioners who have defined privileges in their AOC or SI. The degree of supervision (direct or indirect) will be appropriate to the individual's level of progress, the risk of the procedure, and the seriousness of the patient's illness. Concurrent consultation should be obtained for all patients where a substantial risk is implied or where the diagnosis is obscure. This consultation will be documented on SF 509 or SF 513 (Medical Record—Consultation Sheet). Situations that require mandatory direct supervision will be identified by the program director in writing, and the documentation will be given to those involved.

(2) Training credentials files (TCFs) and PAFs will be developed and maintained for all practitioners during GHPE training. The TCFs will be initiated during the first year of training and contain verified copies of diplomas, licenses, clearinghouse reports, training certificates, practice experience documents (curriculum vitae) and other documents as appropriate. The TCFs will be maintained by the director of education or as directed by the commander. Performance assessments will be made at least every 6 months and a specific recommendation from the department chief for or against promotion to the next year's training level will be made yearly. These will be placed in the PAFs.

(3) Prior to completion of the training program, trainees will submit applications for clinical privileges (DA Form 5440-R-series) through the service chief and the department chief to the professional education committee. One month prior to completion of the training, the education committee will complete DA Form 5441-R-series in response to the application and DA Form 5374-R, which

will show clinical privileges warranted at the resident's first assignment, based on performance during training. The DA Forms 5440-R-series, 5441-R-series, and 5374-R will become permanent parts of the TCFs and sent by certified mail, return receipt requested, to the gaining facility to arrive 15 days prior to PCS. The education committee will decide which, if any, of the interval performance assessments and PAF data from the training period will remain in the TCFs.

(4) In any case where a practitioner is held back or removed from a program for lack of competence or disciplinary reasons, the facts will be reported per paragraph 4-9k.

(5) Reporting requirements concerning substandard performance or unprofessional conduct will be made per paragraph 4-9k.

i. *Formal on-the-job training (OJT)*. OJT programs consist of formal training to provide expertise in an AOC or SI to individuals who are expected to receive limited privileges in an AOC or SI. The commander will require a written program of instruction, specifying the objectives of the program.

(1) OJT trainees will be supervised by practitioners who have defined privileges in their AOC or SI. The degree of supervision will be appropriate to each individual's level of progress, the risk of the procedure, and the seriousness of the patient's illness. Concurrent consultation should be obtained by the trainee for all patients where a substantial risk is implied or where the diagnosis is obscure. Situations that require mandatory direct supervision will be identified by the program director in writing, and the documentation will be given to those involved.

(2) Individuals progressing unsatisfactorily will be processed per the training program procedure.

(3) One month prior to completion of training, the preceptor will complete DA Forms 5441 R-series and 5374-R, which will show those clinical privileges warranted at the individual's next assignment, based on performance during training. These forms will be forwarded through the education committee where one exists, otherwise through the credentials committee, to the gaining facility. They will be sent by certified mail to arrive 15 days prior to PCS. The gaining facility will use this information as a basis on which to grant provisional privileges. These forms will become a permanent part of the individual's PCF.

j. *Privileging for new medical procedures and technology*. The privileging process remains the same. Particular attention will be given to the details of training, experience, competence, and MTF or DTF capabilities in granting privileges in the use of recent technologies and equipment.

(1) *New procedure*. Prior to the introduction of a substantially new and innovative procedure into an MTF or DTF, the commander will ensure that criteria are developed at the department level and approved by the credentials committee. The criteria will include the specific preparatory training that practitioners must have completed prior to being granted the privilege. The privileging process for a new procedure will be accomplished prior to its introduction.

(2) *New technology*. MTFs and DTFs will ensure that their technology; for example, lasers, and magnetic resonance imaging (MRI) devices, does not surpass the staff's abilities. MTFs will establish safety protocols for an instrument's use and provide for proper privileging procedures. Adverse outcomes involving equipment malfunction will be reported immediately to the risk manager (para 3-5j).

k. *Musculoskeletal manipulations*. Musculoskeletal manipulations consist of palpation and other manual techniques used predominantly by osteopathic physicians. These manipulations are used to evaluate and correct somatic dysfunctions that impair or alter functions of the somatic systems. These include the skeletal, arthrodial, myofascial, vascular, lymphatic, and neural systems. This policy does not provide guidance on joint mobilization that physical therapists commonly use and that do not exceed the normal range of motion of joints. The following policy guidance applies to musculoskeletal manipulation procedures:

(1) Graduates of accredited colleges of osteopathic medicine may provide musculoskeletal manipulations. Possession of the Doctor of

Osteopathy (D.O.) degree implies adequate education and training for initial privileging.

(2) MTFs may privilege allopathic physicians, physician assistants, and physical therapists to perform musculoskeletal manipulations provided they can provide evidence of appropriate training or experience acceptable to the credentials committee. (Physician assistants and physical therapists will have a named physician supervisor who is similarly privileged.)

(3) Practitioners performing manipulative procedures will explain to the patient the nature and purpose of the procedure, its anticipated risks, benefits, and alternative treatments with their risks and benefits. This will be documented on SF 509 or SF 600, as appropriate.

(4) Only specifically privileged physicians (D.O. or Doctor of Medicine (M.D.)) may perform manipulation procedures of the lower back when using general anesthesia or intravenous medications. The general anesthesia will be administered by appropriately privileged anesthesiologists or anesthesiologists.

4-9. Suspension, restriction, or revocation of clinical privileges

a. *Action processes*. These actions are taken for health care activity incompetence or unprofessional conduct. Actions taken may be summary (immediate) or routine. QA investigations may be immediate (medical incident or significant unprofessional conduct) or routine (provider competence or professional behavior). In any case involving privileging action, the practitioner will be advised of his or her hearing rights (see below). No punishment or any form of retaliatory action will be taken against an informant providing information concerning a practitioner unless it is later determined that the information was false and the informant acted maliciously. Action to withdraw clinical privileges will be taken promptly when there is reasonable cause to doubt the practitioner's competence to practice or for any other cause affecting patient safety. Reasonable cause includes—

- (1) A single incident of gross negligence.
- (2) A pattern of inappropriate prescribing.
- (3) A pattern of substandard care.
- (4) An act of incompetence or negligence causing death or serious bodily injury.
- (5) Abuse of legal or illegal drugs or diagnosis of alcohol dependence. (See chap 7.)
- (6) Practitioner disability (physical and psychiatric).
- (7) Significant practitioner unprofessional conduct (k(5)below).

b. Summary action.

(1) Steps involved.

(a) Summary action will be taken for cause by the commander or the chairperson of the credentials committee of a MEDDAC, MEDCEN, or DENTAC. It immediately details the practitioners involved to nonclinical duties. (If necessary, the commander may allow the practitioner to continue essential patient care under supervision, such as care of inpatients with whom only he or she is familiar.) Causes for this action are as follows:

1. A practitioner's conduct (or allegations thereof) that requires immediate action to protect the health or safety of patients, employees, or others in the MTF or DTF.

2. A practitioner's involvement in (or alleged involvement in) an incident of gross negligence or acts of incompetence or negligence causing death or serious bodily injury.

(b) If a patient's welfare is immediately threatened, the chief of the department or service in which the practitioner is assigned has the same authority as the commander or chairperson to take summary action. In unusual situations, for example, inebriation or bizarre behavior, the senior medical officer available, of whatever grade, will have authority to act summarily.

(c) The commander (or DCCS, if the commander is not readily available) will review the action at the first available opportunity. Such action (abeyance) will become effective immediately and will not exceed 14 days except that the commander may extend the action for an additional 14 days.

(2) *Immediate notification*. Immediate telephonic notification to the next higher headquarters and to SGPS-PSQ (AUTOVON

289-0088 or commercial (703) 756-0088) will be made of any incident of gross negligence and acts of incompetence or negligence causing death or serious bodily injury, or allegations thereof. Written confirmation of telephonic notification will be per *k* below:

(3) *QA investigation.*

(a) In cases of summary action (medical incident or significant unprofessional conduct) there will be an immediate investigation. The chairperson of the credentials committee will appoint an officer, pursuant to the authority of this regulation, to conduct an informal investigation and report to the credentials committee. The MTF commander may request that an officer with the appropriate specialty be made available from another command; that is, the regional Army MEDCEN for U.S. Army Health Services Command (HSC) MEDDACs and clinics, or Headquarters (HQ), HSC for HSC MEDCENS; HQ, 7th MEDCOM for MTFs in Europe; the 18th MEDCOM for Japan and outlying MTFs in Korea; and Tripler Army MEDCEN for the 121st EVAC hospital.) To maximize objectivity, a recognized, unaffiliated civilian specialist may be requested to actively participate in the investigation wherever practical.

(b) The investigation may include voluntary consultation with the practitioner; review of any relevant documents; or discussions with other persons having knowledge of the conduct involved. When the investigation is complete, the report should present factual findings of the investigation and may include conclusions or recommendations. The commander need not await the conclusion of the investigation prior to returning the practitioner to clinical duties. When early phases of the investigation clearly indicate the absence of substandard performance, the credentials committee should meet, review the preliminary details of the investigation and advise the commander without delay. At the conclusion of the investigation, the credentials committee will review the full report and make recommendations concerning the practitioner's clinical privileges. The practitioner will be notified of his or her hearing rights.

c. Routine action. When adverse information is submitted to the credentials committee and summary action is not necessary, the action to be taken may include—

(1) *Investigation.* If more information or background concerning the practitioner's conduct is necessary, the credentials committee chairperson may investigate further per *b*(3) above, or may designate an investigating officer to do so. In designating an investigating officer, it should be remembered that while such officer is usually available to testify at any hearing after the investigation, he or she is disqualified from participation in or voting as a member of the credentials committee on this matter.

(2) *Credentials committee chairperson action.* After reviewing the investigation report and/or other pertinent information, the chairperson may—

(a) Recommend that no action be taken;

(b) Initiate summary action.

(c) Determine that the information warrants review by a hearing committee for recommendations as to whether the practitioner's privileges should be suspended, restricted, or revoked.

(3) *Collateral actions.* In the case of suspected drug or alcohol involvement, a member of the impaired provider committee will be appointed to the hearing committee. (See chap 7.) If a hearing is required, the chairperson will give the practitioner written notice of it per *f* below. In the event the practitioner waives the hearing, the credentials committee will send its recommendations to the MTF commander. It will also deliver a copy of its recommendation to the practitioner. A notice of the commander's decision will be delivered to the practitioner with a copy placed in the PCF (para 4-11).

d. Suspension or restriction of clinical privileges. In any case involving actions other than total suspension of privileges, the commander will designate by name a supervisor or peer who will submit progress reports to the credentials committee at specified dates (internal determination) documenting current performance.

(1) Where the MTF commander has restricted a practitioner's privileges and he or she is no longer performing the full range of normal duties in his or her specialty practice, consideration will be given to separation in a less than fully privileged status (military) or

taking actions for failure to maintain conditions of employment (civilian). If the practitioner remains on active duty, consideration will be given to changes in AOC or SI and specialty pays. The commander will make a recommendation through the major MEDCOM to the U.S. Total Army Personnel Command, (TAPC-OPH—appropriate career branch), 200 Stovall Street, Alexandria, VA 22332-0417, with an information copy to HQDA (SGPS-PSQ), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

(2) A suspension period will not ordinarily exceed 60 days and can only be extended by the commander for good cause; for example, investigation, completion of appeal, or illness of any necessary participant.

e. Hearing rights.

(1) As soon as practicable (but in no case later than 14 days) after action affecting a practitioner's privileges is taken, or after an investigation when the investigation provides reasonable cause, a written notice of the privileging action will be delivered to the practitioner personally or by certified mail, return receipt requested (fig 4-1). A separate page endorsement (receipt acknowledgment) will accompany the written notice (fig 4-2). The written notice of the privileging action will specify the deficiencies, suspension, restrictions, and duration, and the right to a hearing before a hearing committee.

(2) The practitioner will have 10 duty days to give written notice to the credentials committee chairperson requesting a hearing. Upon receipt of the request for a hearing, the hearing will be scheduled per *f* below. Failure to request a hearing or failure to appear at the hearing, absent good cause, constitutes waiver of a hearing and appeal rights. The commander will determine, if requested by the practitioner, whether good cause existed. This decision is final and not subject to appeal. In the event of a waiver, the committee's recommendation will be forwarded to the MTF commander for review and final action. The final action along with the notice of action will become a part of the PCF (para 4-11).

f. Hearing committee procedures.

(1) The senior member of the hearing committee will be designated as the chairperson. The hearing is administrative in nature. Therefore, the rules of evidence prescribed for trials by courts-martial or for court proceedings are not applicable. The committee must be fully informed of the facts so that it may make an intelligent, reasonable, good-faith judgment. To become informed, the committee may question witnesses and examine documents as necessary. The procedures in AR 15-6 should be consulted for procedural guidance in conducting the hearing; however, they are not binding on proceedings under this regulation.

(2) The chairperson of the hearing committee will advise the practitioner in writing (fig 4-3), delivered personally with a memorandum for acknowledgment (fig 4-4), or by certified mail, return receipt requested, of the following:

(a) The specific concerns that led to the need for the hearing (including dates and pertinent documents where appropriate).

(b) The time and location of the hearing (which will be 10 duty days from the receipt of the notification unless extended by the hearing committee chairperson for good cause). For RC practitioners, the hearing will be within 30 calendar days of the notification.

(c) The names of the witnesses to be called to testify to the hearing committee.

(d) The right to be present, to present evidence, to question witnesses called, and to call witnesses in his or her behalf. The practitioner should be advised that he or she is responsible for arranging the presence of his or her witnesses and failure of such witnesses to appear will not constitute a procedural error or basis for delay of the proceedings.

(e) The right to consult legal counsel. (See (3) below.)

(3) The practitioner is free to consult with legal counsel or any other representative. While such representatives may attend the hearing and advise the practitioner during the hearing, such representatives will not be allowed to participate directly in the hearing (for example, they will not be permitted to ask questions, respond to questions on behalf of the practitioner, or seek to enter material into the record).

(4) During an investigation or hearing under this regulation and if requested by the employee, the exclusive representative of an appropriate bargaining unit has the right to be present under the following conditions:

(a) Whenever a civilian employee of the unit is the subject, practitioner, or witness during the proceedings.

(b) If the employee reasonably believes that the inquiry could lead to disciplinary action against him or her. Unless required by the collective bargaining agreement, there is no requirement to advise the employee of this right. If the employee requests the presence of the exclusive representative, a reasonable amount of time will be allowed to obtain him or her. The servicing civilian personnel office and labor counselor will be consulted before denying such a request. The role of the union representative is not wholly passive, although he or she will not be permitted to make the proceedings adversarial. Subject to the direction of the hearing committee chairperson, the union representative may be permitted to explain the employee's position (if the employee agrees) or to persuade the employee to cooperate in the proceedings.

(5) The committee will review all the material presented, including that provided by the practitioner. If criminal misconduct, including dereliction of duty, is known or suspected, the chairperson of the hearing committee will advise the practitioner of his or her rights, using DA Form 3881 (Rights Warning Procedure/Waiver Certificate). The chairperson will arrange for the orderly presentation of information. If an investigating officer was designated per (4) above, he or she may present exhibits and testimony to the hearing committee. The investigating officer will not participate in committee deliberations. Any objections made by the practitioner will be ruled on by the chairperson. A summarized record of the proceedings will be made, although in rare cases the chairperson may have the proceedings recorded in verbatim form if approved by the MTF commander. (If a verbatim record is requested, the chairperson should ascertain from the servicing judge advocate office whether a Department of the Army (DA) court reporter (military or civilian) is available and provide this information to the commander. Funds may not be expended to hire a contract reporter.) Because these proceedings are covered by 10 USC 1102, no recording devices, other than that used by the reporter or secretary to prepare the record, will be permitted in the hearing.

(6) At the close of the presentation, the practitioner being examined will be excused, and the hearing committee will determine, by majority vote ((8) below), the recommendations to be made. They may include (but are not limited to)—

(a) Reinstating privileges.

(b) Setting terms of limitations such as requirements for consultation and identifying deficiencies that require improvement. (The committee should not make recommendations involving the reassignment of a practitioner.)

(c) Suspending or limiting clinical privileges and specifying the length of time. (The hearing committee should also recommend whether a practitioner should be released from active duty or employment (para 4-4a).)

(d) Revoking clinical privileges.

(e) Reconvening the hearing, after appropriate notice to the practitioner, to consider additional relevant evidence.

(7) The hearing committee should bear in mind the gravity of its responsibilities and the need to clearly document the basis for its findings and recommendations. General statements should be supported by specifically identified incidents or situations. Case histories relied on should be tabbed as exhibits to the record and documented by copies of pertinent medical records where feasible.

(8) Each member of the committee must either vote yes or no. No abstentions are permitted. Voting will be done by secret ballot.

(9) The members of the credentials committee may act as the hearing committee (g below). A member of the practitioner's discipline should also be a member of the hearing committee.

(10) The hearing will be closed to the public. However, the

practitioner may request that observers be permitted. The chairperson will normally grant the request. The chairperson may limit the number of observers and exclude those who are disruptive.

(11) The hearing committee may obtain advice concerning legal questions from the servicing judge advocate office. The practitioner should be advised of legal questions and answers.

g. Action on hearing recommendations.

(1) After the record of the hearing has been prepared, the hearing committee will forward the record, including findings and recommendations, to the MTF commander. (See (2) below.) A copy of the findings and recommendations (and, if requested, a copy of the hearing record) will also be delivered to the practitioner. If all qualified members of the credentials committee did not act as the hearing committee, then the record, including findings and recommendations, should be forwarded by the hearing committee through the credentials committee to the commander. The qualified members of the full credentials committee (excluding any hearing committee members or member having acted as the investigation officer) must either concur by endorsement with the recommendations or may submit separate recommendations. If a member of the credentials committee is absent (for example, through TDY or illness) when the report is forwarded, such absence will be noted by the credentials committee chairperson, and the case forwarded to the commander without action by the absent member.

(2) Prior to action by the commander, the record, including findings and recommendations, will be reviewed by a judge advocate or DA civilian attorney for legal sufficiency. Where practicable, this review will not be conducted by the CJA.

(3) The commander will review the hearing record, including findings and recommendations. The findings and recommendations are advisory only and not binding on the commander. The commander will then make a decision regarding the practitioner's privileges. Written notice of the decision with the date of delivery noted on it will be delivered to the practitioner. A copy of the notice will be placed in the individual's PCF. The appropriate department, service, or clinic chiefs will also be advised of the decision. If the decision includes suspension, restriction, or revocation of privileges, the notice should advise the practitioner of the right of appeal. (See e above.) For a contract practitioner, there is no right of appeal beyond the MEDDAC, MEDCEN, or DENTAC level.

h. Separation.

(1) The loss of clinical privileges of an AMEDD practitioner may be the basis for separation from military or civilian service (see AR 635-100 and AR 135-175). When clinical privileges of an AMEDD military or civilian practitioner are suspended, restricted, or revoked, a local command review will be held to determine whether the practitioner should be considered for separation.

(a) For practitioners separating in a less than fully privileged status, information will be released to appropriate professional regulating authorities only by TSG. The practitioner will be informed of the effects of leaving the service in a less than fully privileged status.

(b) For a practitioner with a service obligation, consideration must then be given to branch transfer or reclassification action or, as an exception to policy, elimination from the service.

(2) The facility that initiated adverse privileging actions will be responsible for finalizing privileging actions. This includes actions when a practitioner has been sent to another facility for evaluation and found unfit for duty. In this case the practitioner must also be advised of his or her rights of due process.

i. Civilian training. If subsequent to an adverse privileging action the practitioner is not separated and seeks remedial training at a civilian institution, that institution will be notified of the adverse privileging action.

j. Off-duty employment. In the event of suspension or loss of clinical privileges by a military practitioner who has permission to engage in remunerative professional civilian employment at a hospital, medical center, or other institution providing health care services, action will ordinarily be taken to withdraw permission for continued employment per AR 40-1. Such civilian employer will be notified of all privileging actions by the MTF commander as they

occur, if the practitioner continues employment. This is the only exception to TSG as the information releasing authority.

k. Reporting requirements.

(1) *Clinical privileges changes.* When an MTF commander suspends, restricts, or revokes clinical privileges of a practitioner, the commander will complete DD Form 2499 (Health Care Provider Adverse Clinical Privileges Action Report (RCS DD-HA(AR)1611)). One copy will be submitted within 3 workdays following each adverse privileging action through the next higher headquarters to HQDA (SGPS-PSQ), 5109 Leesburg Pike, Falls Church, VA 22041-3258. For a supply of blank DD Forms 2499, see appendix A. For preparation of DD Form 2499, see 1 below.

(2) *QA investigations.*

(a) The beginning of an investigation will be reported within 2 workdays to the next higher headquarters.

(b) If an allegation is not substantiated, the commander will send a report within 7 workdays of the completion of the investigation through the next higher headquarters to HQDA (SGPS-PSQ), 5109 Leesburg Pike, Falls Church, VA 22041-3258. The report will provide the following:

1. A summary of the information giving rise to the investigation.
2. The rationale for the commander's decision.
3. A notation signifying level of confidence in the practitioner's performance.

(c) Status reports (status changes) using DD Form 2499 will be provided through the next higher headquarters to HQDA (SGPS-PSQ) until final action has been completed and so indicated on a DD Form 2499. This form should have the date mailed from the MTF in the top right corner.

(3) *Hearing decision.* Copies of the written notice of the commander's decision (g above) will be sent to the next higher headquarters along with DD Form 2499 upon completion of the privileging action if there was a restriction or revocation of privileges.

(4) *Restoration of privileges.* When the MTF commander approves total or partial restoration of clinical privileges previously removed, DD Form 2499 will be submitted per (1) above.

(5) *Reportable actions for unprofessional conduct.* Practitioners charged with any of the actions below will be evaluated by the credentials committee and privileging recommendations, if any, will be made to the commander. Although the credentials committee is not a criminal investigative body, it can and will consider all evidence from such investigations in its deliberations. Whenever any of the following occur, a DD Form 2499 will be submitted per (1) above. Any privileging actions will be noted. The commander will also notify any civilian facilities in which the practitioner is engaged in off-duty employment. An act is deemed to have "occurred" when the practitioner is indicted or titled for an offense (if applicable), or after completion of applicable proceedings and command action.

(a) Fraud or misrepresentation involving application for DOD service that results in discharge from the service.

(b) Fraud or misrepresentation involving renewal of contract for professional employment, application for or renewal of clinical privileges, or extension of service obligation.

(c) Cheating on a qualifying examination.

(d) Commission of a serious misdemeanor, defined as an action punishable by a fine or forfeiture of pay greater than \$1000, confinement greater than 30 days, or punitive separation, whether under civilian or military jurisdiction.

(e) Entry of guilty, nolo contendere plea, or request for discharge in lieu of court-martial while charged with a serious misdemeanor or felony.

(f) Abrogating professional responsibility through any of the following actions:

1. Making false or misleading statements to patients regarding clinical skills and/or clinical privileges.
2. Willfully or negligently violating the confidentiality between practitioner and patient except as required by civilian or military law.

3. Being found impaired by reason of drug or alcohol abuse or alcoholism.

4. Intentionally aiding or abetting the practice of medicine or dentistry by obviously incompetent or impaired persons.

(g) Commission of an act of sexual abuse, misconduct, or exploitation related to the practice of medicine or dentistry.

(h) Possessing, prescribing, selling, administering, giving, or using any drug legally classified as a controlled substance for other than medically acceptable therapeutic purposes.

(i) Prescribing, selling, administering, or providing a controlled substance for use by the practitioner or a family member of the practitioner without prior waiver of policy.

(j) Violating Federal, State, or military laws or regulations on controlled substances.

(k) Fraud under dual compensation provisions of Federal statutes relating to directly or indirectly receiving a fee, commission, rebate, or other compensation for the treatment of patients eligible for care in DOD MTFs.

(l) Failure to report to the privileging authority—

1. Any disciplinary action taken by professional or governmental organization reportable under this regulation.

2. Malpractice awards, judgments, or settlements occurring outside DOD facilities.

3. Any sanction taken by a civilian licensing agency or health care facility.

(6) *Charged practitioner separation.* A practitioner (military or civilian) will not be allowed to separate from DOD service until criminal investigations and resultant privileging actions are final unless the Secretary of the Army authorizes earlier separation.

(7) *Reporting authority.* TSG is the reporting authority to State regulatory authorities, the Federation of State Medical Boards, the National Practitioner Data Bank, and/or other appropriate central clearinghouses regarding adverse privileging actions, unprofessional conduct ((5) above), and any charges of which the practitioner is found guilty, pleads guilty, pleads nolo contendere, or requests discharge in lieu of court-martial.

(8) *Late charges.* Charges of substandard performance and misconduct that are filed up to 12 months following separation from DOD service will be investigated and reported per (1) above. Such practitioners will be notified of the charges and of their rights.

1. *DD Form 2499, completion instructions.* Check the appropriate box for each numbered item on initial or first-time actions. When updating an action, as a minimum, respond to items 1 through 7 and 10 through 14.

(1) *Item 1.* Enter the fiscal year and the date of the report.

(2) *Items 2 and 3.* Enter the Service filing the report. If the practitioner is on active duty at the time of the privileging action, indicate the Service; otherwise check civilian.

(3) *Items 4 and 5.* Indicate whether this is an initial report or an update of a previously filed report. The date requested is the date of the action being reported.

(4) *Item 6a.* Enter the name of the MTF.

(5) *Item 6b.* Enter the Health Affairs Defense Medical Information System (DMIS) code for the facility responsible for maintaining and reviewing the PCF of the practitioner. The DMIS number is available from AQCESS or the patient administration division of the MTF.

(6) *Item 7.* Enter the HCP's SSN.

(7) *Item 8.* Enter the profession of the practitioner. If the practitioner is a physician or a dentist, enter also the highest level of education (specialization) and the primary specialty.

(8) *Item 9.* Self-explanatory.

(9) *Item 10a.* This block requires a brief description of the type of action taken. Examples: Required to have consultation on all inpatients; operative surgery only with supervision, no emergency call, may not prescribe third generation cephalosporins, American Society of Anesthesiology Class I patients only.

(10) *Item 10b.* If the action is a suspension, enter duration. If permanent, also enter whether a restriction or a revocation.

(11) *Item 10c.* Enter all applicable actions.

(12) *Item 11.* Enter all applicable reasons for the adverse action. Circle the primary reason in cases involving more than one reason.

(13) *Item 12.* List the States in which the practitioner is known to be currently licensed.

(14) *Item 13.* Do not complete. Notification and completion of item 13 will be done by the Office of The Surgeon General.

4-10. Appeal process

a. Where the MTF commander has decided to suspend, restrict, or revoke clinical privileges, the practitioner will be granted 10 duty days (extendable in writing by the commander) to send a written appeal by certified mail to the next higher commander as follows:

(1) Continental United States (CONUS): Commander, Health Services Command (includes Alaska, Hawaii, and Panama).

(2) Outside continental United States (OCONUS):

(a) Commander, 7th MEDCOM—Europe.

(b) Commander, 18th MEDCOM—Korea and Japan.

b. The appropriate major MEDCOM commander in *a* above will establish a committee of at least three senior physicians (MC officers), one of whom will be of the same discipline as the practitioner being reviewed to act as the appeal committee. Other corps will each be represented when privileges in their respective disciplines are reviewed. If the practitioner is a dentist with no hospital privileges, the appropriate major medical commander may appoint a committee of three dental officers to act as the appeal committee. If the dentist has hospital privileges, the committee will consist of at least two physicians and one dental officer.

c. The appeal committee will review all information furnished by the practitioner as well as the hearing record, findings, and recommendations. After considering the information, the committee will advise the major MEDCOM commander of the decision of the committee concerning the appeal, and the committee's recommendations as to the commander's action on the appeal. The findings and recommendations of the committee are advisory in nature, and do not bind the commander.

d. A copy of the decision on appeal will be forwarded by the major MEDCOM commander (HQDA (SGPS-PSQ), 5109 Leesburg Pike, Falls Church, VA 22041-3258, within 7 working days following the decision. This information should include a copy of the credentials committee minutes at which the original action was taken to modify privileges, a copy of the hearing proceedings and evidentiary material, and a copy of the decision on appeal.

e. The practitioner may appeal the decision of the major MEDCOM commander to the Office of The Surgeon General (HQDA (SGPS-PSQ), 5109 Leesburg Pike, Falls Church, VA 22041-3258). This final written appeal must be sent by certified mail, return receipt requested, within 10 duty days after the practitioner receives notice of the MEDCOM commander's findings. If the practitioner appeals, TSG will be the final appellate authority for suspending, restricting, or revoking clinical privileges.

f. Administrative action to separate the practitioner as a result of a privileging action under paragraph 4-4 will normally be deferred pending appeal resolution. Practitioners who separate prior to resolution of their appeal will be informed in writing that the process will be completed as though they were still on active duty or employed. Special considerations such as extensions of time for appeal will not be granted.

g. For nonprivileged licensed practitioners, pending reporting to the National Practitioner Data Bank (para 4-13), appeal of notification to the data bank may be made to the MTF commander, who is the final authority.

4-11. Practitioner's credentials file

a. The PCF maintained for practitioners (para 4-1) will contain the documentation listed below. The PCF will be a six-part file (National Stock Number 7530-00-990-8884) with like documents grouped together and filed in reverse chronological order (most current on top).

(1) *Section I.*

(a) Identification photo (official military or passport photo).

(b) DA Form 4691-R.

(c) DA Form 5440-R-series (current and past).

(d) DA Form 5441-R-series (current and past).

(e) DA Form 4692-R (Clinical Privileges Annual Evaluation) (past).

(f) DA Form 5753-R (USAR/ARNG Application for Clinical Privileges to Perform Active/Inactive Duty Training) (for RC practitioners).

(2) *Section II.*

(a) DA Form 5374-R (current and past).

(b) Provider activity profile data as determined by the credentials committee and commander per paragraph 4-8e(3) (in summary form).

(c) Credentials and privileges granted (scope of practice) from civilian MTFs or DTFs where the member is employed or practicing (for RC practitioners).

(3) *Section III.* Documents of adverse action by Army MEDDAC, MEDCEN, or DENTAC:

(a) Letters of notification.

(b) Letters of acknowledgment.

(c) Hearing summary or minutes.

(d) Investigations.

(e) Adverse statements, to include National Practitioner Data Bank reports.

(f) Letters of decision.

(g) Malpractice claims together with the peer review determination whether the standard of care was met, and National Practitioner Data Bank reports.

(h) Copies of any other adverse information.

(4) *Section IV.*

(a) Medical continuing education (CE) summary, which includes a 3-year history of courses, sponsors, locations (city and State), dates (start/end), and CE hours/units (AQ/ESS summary). This education or training will be validated.

(b) Lectures given, papers published, and special activities (for example, research).

(5) *Section V.* DA Forms 5440-R-series, 5441-R-series, and 5374-R from previous MTFs or privileges granted at civilian agencies, if applicable.

(6) *Section VI.*

(a) Copies of diplomas, certification, licenses, and so forth.

(b) Verification documentation (para 4-6c).

b. The PCF will be released only to the MEDDAC, MEDCEN, or DENTAC commander; the credentials committee; and reviewing authorities or officially appointed auditors or inspectors. The practitioner may, however, authorize release to others; for example, drafting letters of recommendation. (See para 4-9h on separation.)

c. The PCF will be kept for the entire service career of the military practitioner to include active and inactive service in the ARNG or USAR. For civilians, it will be kept for the entire period of work within the AMEDD. For the active duty practitioner who joins the ARNG or USAR, the gaining RC unit will request the PCF from the last MEDDAC, MEDCEN, or DENTAC of appointment.

d. PCFs of personnel attending schools or changing duty stations will be forwarded per paragraph 4-3.

e. Disposition of PCFs is as follows:

(1) Copies of PCFs and PAFs of practitioners containing any permanent adverse privileging actions will be sent to HQDA (SGPS-PSQ), 5109 Leesburg Pike, Falls Church, VA 22041-3258, at the time of separation.

(2) Copies of PCFs of practitioners who have separated in good standing with defined privileges will be maintained by the MTF of last assignment or employment for at least 1 year.

(3) For disposition of the original PCF after a practitioner separates or retires from service or, if civilian, ends his or her employment with the AMEDD, see AR 25-400-2, FN 40-66d.

4-12. Practitioner activity file

a. A PAF will be maintained for each practitioner; it is a peer review working file. Material to be kept in the PAF will reflect the following in semiannual increments:

(1) *Practice profile, for practitioners with admission privileges.* AQCESS Practice Profile reports providing number of discharges, procedures (by procedure), deliveries, intensive care unit admissions, and inpatient deaths.

(2) *Practice profile, for primary care practitioners without admission privileges.* Average daily patient load, number of times assigned emergency services, percentage of time in deployed status, and name of supervising physician, as appropriate (AR 40-48).

(3) *Outcome.*

(a) Cases of superior care with appropriate documentation.

(b) Number of cases referred to the credentials committee regarding possible substandard care. (AQCESS Provider Profile reports showing variations; that is, surgical case, transfusion and drug usage reviews, and occurrence screens may be used.)

(4) *Malpractice.* RM data relating to filed or settled malpractice cases together with peer review findings. Claims reported to the risk manager identifying practitioner involvement will be posted to that practitioner's PCF, together with the peer review determination as to whether the standard of care was met.

(a) The chairperson of the RM committee, using military memorandum format, will forward to the credentials committee chairperson his or her statement that further assessment by the credentials committee is requested. Subsequent to credentials committee review and determination that the standard of care was or was not met, the original memorandum, together with committee findings or action, will be placed in section II of the PCF. The credentials committee will document the committee action in its minutes.

(b) It is expected that most malpractice claims will have been reviewed as PCEs or adverse events and, therefore, resolved by the RM program or referred to the credentials committee for its assessment. When this review has occurred and a claim arises after previously being reviewed as a PCE, the risk manager will forward a formal statement to the credentials committee indicating either that no further action is required or the claim requires further assessment.

(c) Claims identified by the MTF on practitioners who have departed on PCS or separation will be reviewed as above. Findings and committee minutes will be forwarded through the next higher headquarters to HQDA (SGPS-PSQ), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

(d) Claims will be reviewed by the RM committee in an attempt to identify those practitioners who provided the patient care that formed the basis for the claim and, when identified, the above procedures will apply.

(5) *Administrative.*

(a) AQCESS Provider Profile reports providing expiration dates of basic cardiac life support (BCLS), advanced trauma life support (ATLS), and advanced cardiac life support (ACLS) training certificates.

(b) Reports on medical record deficiencies and delinquencies. At a minimum, the following medical record deficiencies will be identified and recorded:

1. History and physical not done within 24 hours of admission.

2. Operative report not dictated within 24 hours of completion of surgery.

3. Narrative summary not dictated within 4 working days of patient discharge.

(6) *Committee actions.* Ongoing peer review; that is, minutes, recommendations, counseling, and sanctioning documents of any case leading to investigation or adverse privileging actions of the practitioner.

(7) *Other.* The PAF will at all times contain a verified current State license expiration date, date of last clinical privileges reappraisal (minimum of every 2 years), date of last training (certification of completed courses, and number of hours or units of continuing education certified by professional societies or associations).

b. The PAF will be filed with the PCF but will not be part of the PCF.

c. The chief of the department or service will use the PAF data in periodic reevaluation and privilege reappraisal (para 4-8e).

d. The PAF data may be removed and destroyed, except as required to be transferred to the PCF (para 4-11), when the credentials committee judges that the data are reflected accurately and completely in the most current performance assessment and privileges reappraisal. (The practitioner should be given the opportunity to keep any productivity and computer-generated data prior to its destruction.)

e. A practitioner may, on request and in the presence of a command representative, be allowed to review the contents of his or her PAF. In addition, the contents of the PAF may be used by an appropriate supervisor for counseling purposes, letters of recommendation, letters of inquiry, evaluation reports (for example, OER), and preparation of graduate professional education documentation and reference.

f. PAF criteria definitions are in the glossary.

4-13. National Practitioner Data Bank reports

a. *Public Law 99-660.* (The Health Care Quality Improvement Act of 1986, Public Law 99-660, title IV provides for reporting of malpractice claims resulting in monetary settlements and professional review actions to the National Practitioner Data Bank. HCPs (para 9-1) will be reported, whether licensed or under grace periods or waivers for licenses. 10 USC 1102 provides protection for those providing information to professional review bodies, unless such information is false and the persons providing it knew that the information was false.)

b. *Malpractice payments.* Upon notification by the local CJA to the risk manager that a monetary award has been granted to a claimant (settled administratively by the Army Judge Advocate General Corps or litigation cases settled or adjudicated by the Department of Justice), the MEDDAC, MEDCEN, or DENTAC will report the following within 7 working days per e below.

(1) Name of claimant.

(2) Name of patient (if not the claimant).

(3) Claim number used by the CJA.

(4) MTF or DTF.

(5) Date of incident.

(6) Primary and secondary diagnoses for which the patient entered care. (See narrative summary in inpatient treatment record (ITR) for inpatients.)

(7) Amount and date of settlement or adjudication.

(8) Name, rank, SSN, and AOC or SI of practitioner with primary care responsibility (excludes house staff).

(9) Nature and attribution of alleged negligence or incompetence that led to the claim. The attribution may include one or more of the following:

(a) A physician.

(b) A nonphysician.

(c) Institutional responsibility; for example, equipment and power failure. (Payment for claims that deviate from standards of care but outside the control of practitioner will not be reported to the data bank.)

(10) Peer review of performance of the practitioner to whom the care was attributed and how, in the opinion of the review body, the situation might have been avoided. This body will then categorize the case as—

(a) Met standards of care.

(b) Minor deviations from standards of care.

(c) Did not meet standards of care (major deviations).

(11) When peer review determines substandard care to one or more licensed practitioners (excludes house staff), a separate report will be submitted for each practitioner.

c. *Professional review actions.*

(1) Professional review actions are privileging actions that adversely affect clinical privileges for privileged practitioners (after appellate review, commander decision if no appeal, or separation—whichever comes first).

(2) For HCPs (para 9-1), whether licensed or under grace periods or waivers, and house staff who are convicted, plead guilty, plead

nolo contendere, receive a discharge in lieu of court-martial, receive a discharge in lieu of criminal investigation, or receive a less than honorable discharge for unprofessional conduct (para 4-9k(5)), a DD Form 2499 will be submitted within 3 working days of the date the practitioner was formally charged with committing the unprofessional conduct or on the date of discharge, whichever comes first.

(3) For HCPs not individually privileged, DD Form 2499 will be completed as follows:

- (a) Blocks 1-9, information as appropriate.
- (b) Block 10, omit.
- (c) Block 11, check or specify the reason for action.
- (d) Block 12, give State of licensure and expiration date.
- (e) Block 13, do not complete. TSG is the notification authority.

d. *PCF*. Copies of the reports sent for inclusion in the data bank will be placed in Part III of those practitioners' PCF identified with the case. If the practitioner(s) is no longer at the MTF or DTF, the report will be sent to HQDA (SGPS-PSQ). (See *e* below.) (For the nonprivileged HCP, a notation will be made in the appropriate departmental or service records.)

e. *National Practitioner Data Bank reporting*. Reports will be sent through the next higher headquarters to HQDA (SGPS-PSQ), 5109 Leesburg Pike, Falls Church, VA 22041-3258. TSG is the reporting authority. Copies of reports sent will be given to the HCPs.

f. *HCP Data Bank inquiries*. Inquiries for data on HCPs will be made to the National Practitioner Data Bank as follows:

- (1) By the appropriate recruiting agency at the time of application for employment.
- (2) By the MEDDAC, MEDCEN, or DENTAC at the time a practitioner applies for clinical privileges.
- (3) By the MEDDAC, MEDCEN, or DENTAC at the time of periodic reevaluation and privilege renewal.
- (4) By the MEDDAC, MEDCEN, or DENTAC at the beginning of any investigation of an HCP for substandard performance or unprofessional behavior.

4-14. Retired mobilization volunteers

a. Preassigned retired volunteers meeting requirements for clinical privileging (para 4-1) will forward a copy of their PCF at the last MEDDAC, MEDCEN, or DENTAC of assignment to the credentials committee of the preassigned MEDDAC, MEDCEN, or DENTAC.

b. The MEDDAC, MEDCEN or DENTAC staff operations officer or equivalent will semiannually give the credentials committee a current list of preassigned retired volunteers. If a needed PCF is not available, the facility will send a letter to the volunteer requesting a copy of the PCF. This PCF should be filed in the retired volunteer's Military Personnel Records Jacket (MPRJ) on file at U.S. Army Reserve Components Personnel and Administration, ATTN: DARC-PPC, 9700 Page Boulevard, St. Louis, MO 63132-5200. In the event that the volunteer is unable to obtain a copy of the PCF, DA Form 4691-R (front side only) will be submitted.

c. If the volunteer has not responded by the next semiannual update, the operations officer will be informed that the individual's credentials must be made available and verified in order to continue participation in the program.

(MEDDAC, MEDCEN, or DENTAC Letterhead)

S: (Suspense date)

OFFICE SYMBOL (640-10c)

(Date)

MEMORANDUM FOR (Name, Grade, and Address of Practitioner)

SUBJECT: Notice of Summary of (Limitation) (Suspension) of Clinical Privileges

1. You are hereby notified that your clinical privileges at (MEDDAC, MEDCEN, or DENTAC) are (limited) (suspended) as follows: Effective immediately your clinical privileges have been (limited) (suspended) for improper (state specifically the deficiencies involved and the scope of the action). The period of (limitation) (suspension) is (indefinite) (temporary) pending action by the credentials committee at its meeting scheduled for (date).

2. You are advised that you have the right, upon your request, to have the credentials hearing committee conduct a hearing to review this action concerning your privileges. The hearing procedures and your hearing rights are detailed in AR 40-68, chapter 4.

3. In order to have this hearing, you must make a written request for the hearing to the chairperson of the credentials committee within 10 days from the date you receive this notice. If you fail to make the request within that time or if you fail to appear at the hearing so requested, you waive your rights to the hearing and also waive rights to appeal to higher medical or dental authority.

FOR THE COMMANDER (if authorized):

(Signature)

(Typed name)

(Grade and corps)

Chairperson, Credentials
Committee

Figure 4-1. Sample format for a memorandum of notification for a summary action

S: (Suspense date)

PRACTITIONER'S OFFICE SYMBOL (Basic Memo Office Symbol/(Date)) (640-10c)

1st End Practitioner/typist initials/telephone no.

SUBJECT: Notice of Summary of (Limitation) (Suspension) of Clinical Privileges

(Name, Grade, and Address of Practitioner) (date)

FOR: (COMMANDER, MEDDAC, MEDCEN, OR DENTAC AND ADDRESS,

ATTN: Chairperson, Credentials Committee)

Receipt acknowledged. I understand that I have 10 days to request a hearing, if I elect to do so, in accordance with AR 40-68. Further I understand that should I elect not to request a hearing or if I fail to appear at a hearing, I waive my right to appeal to higher medical or dental authority.

(Signature of practitioner)

(Typed name)

(Grade, and corps)

Figure 4-2. Sample format for a separate page endorsement to a memorandum of notification for a summary action

(MEDDAC, MEDCEN, or DENTAC Letterhead)

3. (Suspense date)

OFFICE SYMBOL (640-10c)

(Date)

MEMORANDUM FOR: (Name, Grade, and Address of Practitioner)

SUBJECT: Notification of credentials hearing

1. (The credentials committee) (a credentials hearing committee) will conduct a hearing concerning allegations that may adversely affect your clinical privileges.
2. The allegations to be reviewed are (state the nature of the allegations constituting the grounds for the hearing in sufficient detail. Include the date, identity, and location of the records of activities or cases that are involved in the allegations, so that the practitioner will be appraised of the matters under investigation.)
3. The committee will hold the hearing at (hour) on (date) at (location). You have the right to be present, to present evidence and call witnesses in your behalf, to cross-examine witnesses called by the committee, to consult legal counsel, and to be advised by legal counsel at the hearing. It will be your responsibility to arrange for the presence of any witnesses you desire. Military counsel will not be made available to advise you at the hearing. You may retain a civilian attorney at your own expense.
 - a. Failure to appear at the hearing will constitute a waiver of the rights listed here and the right to appeal.
 - b. The time and place of the hearing may be changed by the chairperson of the hearing committee upon your written request before the indicated suspense date if based on good cause.
 - c. The committee will call the following witnesses: (list of witnesses, if any.)

FOR THE COMMANDER (if authorized):

(Signature)

(Typed name)

(Grade, and corps)

Chairperson, Credentials
Committee

Figure 4-3. Sample format for a memorandum of notification for a credentials hearing

(MEDDAC, MEDCEN, or DENTAC Letterhead)

OFFICE SYMBOL (640-10c)

(Date)

MEMORANDUM FOR: (MEDDAC, MEDCEN, or DENTAC and Address,

ATTN: Chairperson, Credentials Committee)

SUBJECT: Receipt of a Memorandum of Notification of a Credentials Hearing

I hereby acknowledge receipt of the subject Memorandum of Notification of a Credentials Hearing. The memorandum is dated (date) and I received it on (date).

(Signature of practitioner)

(Typed name)

(Grade, and corps)

Figure 4-4. Sample format for a memorandum for acknowledgement of receipt of a memorandum of notification for a credentials hearing
