



DoD INSTRUCTION 6040.42

MANAGEMENT STANDARDS FOR MEDICAL CODING OF DoD HEALTH RECORDS

Originating Component: Office of the Under Secretary of Defense for Personnel and Readiness

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DoD Instruction 6040.43, "Custody and Control of Outpatient Medical Records," June 10, 2004

Approved by: Peter Levine, Acting Under Secretary of Defense for Personnel and Readiness

Purpose: In accordance with the authority in DoD Directives 5124.02 and 5136.13, this issuance establishes policy, assigns responsibilities, and prescribes procedures for centralized oversight, standardized operations, and ensured quality and performance for the coding of DoD Health Records.

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SECTION 1: GENERAL ISSUANCE INFORMATION

1.1. APPLICABILITY. This issuance:

a. Applies to:

(1) OSD, the Military Departments (including the Coast Guard at all times, including when it is a Service in the Department of Homeland Security by agreement with that Department), the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD.

(2) Any fixed medical facility within the Military Health System (MHS).

b. Does **not** apply to:

(1) Non-fixed deployed medical facilities.

(2) MHS medical facilities not involved in direct patient care.

1.2. POLICY. It is DoD policy that:

a. All patient services within the MHS must be documented and coded completely, accurately, and promptly, adhering to industry-established, legal, and MHS-specific guidelines and criteria (as permitted by MHS data collection systems) to ensure accuracy and consistency of code assignment, proper code sequence, valid data reporting, and authorized exchange of data with non-MHS organizations. This supports the continuity of patient care, MHS enterprise resource allocation, the integrity of MHS information, performance measurement, quality management, provider productivity, research, and MHS cost recovery programs.

b. The Defense Health Agency (DHA) and the Military Departments routinely collect, aggregate, and analyze sufficient data to manage coding operations and quality.

c. Coding quality performance is monitored routinely against MHS and DHA enterprise data collection and reporting requirements by DHA and the Military Departments. This supports the MHS's overall mission of providing quality health care and preventing health care billing fraud, waste, abuse, or mismanagement of government resources.

d. All DoD Health Records are maintained through collaboration between the DHA, the Military Departments, and the National Capital Region Medical Directorate (NCR MD). Together they must ensure that the records are accessible for complete and timely coding in order to facilitate appropriate medical care and legal and administrative proceedings and to optimize cost recovery.

e. The DHA will manage all data obtained from coding activity of the DoD Health Records in accordance with its data management plans and make such data available to the Military Departments and the NCR MD, as necessary.

1.3. INFORMATION COLLECTIONS. The collection referred to in Paragraphs 1.2.b. and 3.1.d.(1)(d) does not require licensing with a report control symbol in accordance with Paragraphs 7 and 8 of Volume 1 of DoD Manual 8910.01.

SECTION 2: RESPONSIBILITIES

2.1. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS. Under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness, the Assistant Secretary of Defense for Health Affairs:

- a. Develops policy and guidance to manage, operate, and routinely evaluate medical coding performance.
- b. Ensures MHS synchrony with national standards by routinely updating the code references for International Classification of Disease (ICD), Current Procedural Terminology (CPT), and the Healthcare Common Procedure Coding System (HCPCS).
- c. Monitors the Military Departments' and NCR MD's compliance with this issuance.
- d. Modifies or supplements this issuance, as needed.

2.2. DIRECTOR, DHA. Under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness and through the Assistant Secretary of Defense for Health Affairs, the Director, DHA:

- a. In coordination with the Military Departments and NCR MD, establishes an office to implement and oversee the formal DoD Medical Coding Program to develop procedural guidance and monitor performance and compliance with this issuance and all other applicable guidance.
- b. Ensures availability of training opportunities for health information management workforce development in the areas of clinical documentation improvement (CDI), coding, auditing, and performance management.
- c. Publishes procedural and clarifying enterprise guidance in coordination with the Military Departments, and serves as the proponent for enterprise manuals that specify procedures for clinical documentation, abstraction, coding, auditing and performance management measures, and improvement.
- d. Ensures that the exchange of electronic medical records between various medical facilities is conducted in a secure manner that helps maintain patient privacy.
- e. Ensures that data developed from a medical record coding activity is managed in compliance with applicable statutes and regulations and is made available to support MHS missions, as needed.
- f. Through the Military Departments and NCR MD, ensures the assigned military treatment facility (MTF) commanders comply with, oversee, and execute the procedures outlined in this issuance.

2.3. SECRETARIES OF THE MILITARY DEPARTMENTS. The Secretaries of the Military Departments ensure that the Surgeons General of the Military Departments and the MTF commanders comply with, oversee, and execute the procedures outlined in this issuance.

SECTION 3: PROCEDURES

3.1. DHA MEDICAL CODING PROGRAM OFFICE (MCPO). The MCPO publishes MHS coding procedural instructions and operational guidance and is responsible for the following functions:

a. CDI Programs.

(1) The MCPO establishes CDI programs to ensure that DoD Health Records are timely, relevant, complete, and authenticated in order to be coded accurately.

(a) CDI programs facilitate the overall quality and completeness of clinical documentation to accurately represent the severity, acuity, and risk of mortality profile of the patient being treated.

(b) Appropriate and complete documentation of clinical conditions and treatment within the health record must be available for accurate coding of severity of illness, TRICARE DRG assignment as specified by the TRICARE grouper, and complexity of care of the patient.

(c) In accordance with Paragraph 3.1.a.(2) of this issuance, the MCPO will publish guidance to address and mitigate barriers to achieving CDI.

(2) The MCPO will publish and maintain CDI program guidance. CDI program guidance will include, at a minimum:

(a) Reviewing DoD Health Records for completion on an ongoing basis at the point of care, in accordance with creation and documentation requirements contained in DoD Instruction (DoDI) 6040.45.

(b) Evaluating DoD Health Records for the presence, timeliness, readability (whether handwritten or printed), quality, consistency, clarity, accuracy, completeness, and authentication of clinical documentation.

(3) The MCPO will publish health record completion and delinquency policies consistent with accreditation standards, regulatory requirements, and medical staff guidelines.

(4) Trained and preferably credentialed CDI professionals (e.g., Certified Clinical Documentation Specialists, Certified Documentation Improvement Practitioners) must be available at inpatient facilities and consulted for analysis and interpretation of health record documentation.

(a) Such analysis will identify and rectify situations where documentation is insufficient to accurately support the patient's severity of illness and care, including: specificity of principal diagnosis; present on admission indicators; associated comorbidities or complications; treatments; and procedures.

(b) CDI staff analyzes data, formulates provider queries, tracks CDI program performance, and successfully communicates with providers, administration, health information management staff, and others, as necessary.

(5) In accordance with the accreditation standards, regulatory requirements, and enterprise guidelines contained in DoDI 6040.45, the MCPO will provide ongoing CDI training, development, and tools to educate members of the patient care team and others involved in the documentation process regarding:

- (a) Compliant query practices;
- (b) Health record completion and delinquency policies; and
- (c) The CDI quality assurance process.

(6) The Military Departments and the NCR MD will perform internal clinical documentation audits monthly and will report results of documentation accuracy and delinquency patterns through Military Departments and NCR MD headquarters commands to the MCPO. The MCPO, through the Military Departments and the NCR MD commands, will provide DHA analysis of audit results, including deficiencies to be corrected, to the MTFs. When possible, the original provider will correct any erroneous entries based on DoD and DHA published policy and guidance. These internal clinical documentation audits are separate and distinct from MCPO external audits and audits required by DoDI 6040.40.

b. Medical Record Abstraction.

(1) An efficient and comprehensive health records retrieval process is essential to complete coding accurately and ensure coding is standardized and comparable across the MHS enterprise. The MTF coder will only code documentation that was part of the DoD Health Record during the inpatient visit or outpatient encounter.

(2) The MCPO will publish and maintain abstraction guidance, including: source data across multiple systems; abstraction instructions; decision-making tools; operational definitions; a description of defined data elements, their allowable values, and their location; inclusionary or exclusionary variable information; guidelines for recording the data; and timeliness.

(3) The MCPO will provide ongoing abstraction training to educate members of the patient care team and medical record staff on compliant abstraction practices.

(4) MTF performance will be evaluated on the effectiveness of its document management system, as required by DoDI 6040.45. Coding must be compliant with both MHS coding and ethics guidelines and DoDI 6040.40 performance measures. MTF commanders must ensure that coding within their facilities meets the established standard of 97 percent records availability set by the Medical Business Operations Group for DoD Health Records, with a goal of 100 percent.

c. Coding Research and Assignment.

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

(2) The MCPO will publish MHS enterprise-wide coding and ethics guidelines and criteria, to include coding work force productivity standards, in coordination with the Military Departments. Coders must use published guidance to ensure accuracy and consistency of code assignment, proper code sequence, proper quantities, and valid data reporting. These criteria will be based on MHS enterprise-specific circumstances and current editions of ICD, CPT, HCPCS, and DSM codes. Coding data also will be used to measure productivity and assess performance against published MHS productivity standards.

(3) Coding reference books, MHS enterprise-wide coding guidelines, and encoder software will be updated annually, or as necessary, as the classification systems are revised. The MTF will publish coding books, while the DHA will publish updated coding guidelines and provide software updates. Coding personnel must use these reference and coding tools, to include the full spectrum of encoder reports, to expedite the coding process and ensure all billable and non-billable events are coded in a timely manner.

(4) Processes, including coding department oversight, must be in place to validate the accuracy of coded encounters, monitor diagnosis and procedure coding, and ensure the complete and accurate description of services. MTFs will establish policies and procedures for obtaining provider clarification, such as allowing the coder to directly contact the provider about a record being coded. Coding supervisors and MTF coding staff will review both provider and coder assigned codes by manual or automated methods.

(5) Coding supervisors must produce and review reports daily, to ensure all billable cases are coded in a timely manner.

(6) In accordance with legal and medical coding practices, the MTFs will use the following guidelines to code minimum standard targets for DQMC reporting, as specified in DoDI 6040.40:

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

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

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

(7) In accordance with legal and medical coding practices, the minimum expected coding accuracy standard for all types of work for experienced professional coders at the target-grade level is 97 percent. Appropriate modified standards may be set for coders in developmental positions. The MCPO also will publish MHS-suggested quality indicators for measuring accuracy.

(8) The MCPO will publish, in accordance with legal and medical coding practices, minimum expected coding productivity standards for experienced professional coders at the target-grade level performing the coder scope of work requirements.

d. Coding Compliance and Auditing.

(1) All levels of the MHS use compliance to adhere to policy and guidance, identify high-risk areas, and ensure that the MCPO takes appropriate corrective actions. The MCPO will develop a mandatory DHA minimum standard compliance policy and template that will include these requirements:

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

(b) The coding compliance plan must contain, at a minimum:

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

(c) Use of auditors external to the MTF, including, but not limited to, DHA, contract personnel, inspectors general, and Military Department audit agencies for official use, to perform review, evaluation, and audit functions.

(d) Coding metrics that are gathered, reported, and monitored monthly to ensure optimal medical record coding program performance. At a minimum, metrics will cover timeliness of record completion, availability of records, quality of documentation, and accuracy of coding. A coding compliance dashboard will be used to measure processes.

(e) The coding process must ensure that the policies and procedures in this issuance are implemented to protect the privacy of individuals in the collection, use, maintenance, and dissemination of personally identifiable information, as required by Section 552a of Title 5, United States Code (otherwise known as the "Privacy Act of 1974," as amended), and implemented by DoD Directive 5400.11 and DoD 5400.11-R.

(2) Coding audits, including continuous internal and external review and evaluation of coding practices to validate the accuracy of coded encounters, and corrective action plans to

correct identified deficiencies are essential to ensure compliance with coding rules and guidelines, identify and avoid potential risk, fraud, and abuse, and identify improvement opportunities.

(a) Internal reviews must be conducted monthly in collaboration with other program areas (e.g., providers, CDI) and results communicated to the patient care team and medical coding staff to determine patterns of claims, denials, and other factors that may suggest inappropriate coding. Results will also be provided to MCPO upon request.

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

(c) The MCPO compiles the results of requested internal coding reviews, independent external coding audit work, and corrective action plans annually. This includes:

1. Timely feedback to both clinical and administrative MTF staff on coding documentation and compliance (e.g., timeliness, accuracy).

2. Incorporating metrics from the DHA Data Quality Management Control Program, as directed in DoDI 6040.40.

3. Identifying opportunities for improvement to the Military Departments' Surgeon General Offices through the monthly monitoring of metrics.

4. Evaluating coding accuracy and timeliness of both provider and medical coding staff.

5. Assessing the timely provision of coded encounters to third-party payers for reimbursement determination.

(d) The MCPO will review results and corrective action plans to determine if the Military Service and NCD MD coders require further education or training, root cause analysis, or additional corrective action.

(e) The MCPO must institute process controls to establish responsibility and accountability among departments. It will develop quality controls and feedback mechanisms to help identify and correct any problems on a timely basis.

e. Workforce Design.

(1) It is essential to build and maintain an adequate and proficient clinical documentation and coding workforce that meets workload requirements across the MHS enterprise. Workforce design and resource allocation depends on workforce management and oversight activities. Locating qualified staff in a setting with access to providers allows for easy communication with

providers to facilitate clinical documentation and coding education. Coding staff may be located on site in a centralized area, or they may be decentralized throughout the medical facility or clinic, in a remote centralized coding unit, or any combination of locations.

(2) Specialized training, education, skills, and resources are necessary to ensure proper documentation and code assignment, sequencing, and reporting of the DoD Health Record. To ensure that coded data accurately reflects the documented diagnoses and services provided to patients, it is essential to recruit, hire, and retain experienced and preferably-credentialed staff (e.g., Registered Health Information Technicians, Registered Health Information Administrators, Certified Coding Specialists, Certified Coding Specialists – Physician-based, Certified Outpatient Coders, Certified Inpatient Coders).

(3) Contract coding services may provide time-limited documentation and coding support to assist with backlogs or cover regular coding duties. The contractor must ensure that contract staff are sufficiently trained, credentialed, and eligible to obtain access to all relevant DoD Health Record data and MHS systems necessary to perform their duties. The MTF must monitor all coding contract services work for quality, timeliness, and appropriate coding.

(4) The MCPO will monitor and assess at least quarterly workload, accuracy, and productivity of all coding staff, so that recommendations can be made for MHS coding workforce management and allocation around predicted workload.

f. Education and Training.

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

(2) Provider education will support quality of documentation and accuracy of code assignment and must include feedback using audit results of each provider's own work. The MCPO training guidance will address provider assessment and feedback.

(3) The MHS will develop and provide enterprise curricula, training, and online tools to support ongoing provider and coder education. The MCPO should use MHS encoder reports to assist with training initiatives.

(4) The MHS compliance software provides every coder with current web-based copies of the MHS grouper—the TRICARE Grouper Software, all required coding books, including ICD, CPT, and HCPCS, and a number of references and support tools. Staff must use all of the software's available tools and resources for complete and accurate coding.

3.2 THE MILITARY DEPARTMENT SURGEONS GENERAL AND THE DIRECTOR, NCR MD. The Military Department Surgeons General, within and for their respective Military Departments, and the Director, NCR MD, for his or her assigned MTFs:

- a. Promptly forward deficiencies and findings (through the Service Headquarters Commands and NCR MD) to the Director, DHA, as directed in additional organization guidance.
- b. Monitor medical records documentation and coding operations.
- c. Include effectiveness in meeting coding accuracy standards in military and civilian performance reports.
- d. Arrange for random and targeted external audits of their MTFs to:
 - (1) Verify compliance with clinical documentation and coding standards, policy, and procedural and clarifying enterprise guidance, including enterprise manuals.
 - (2) Identify improvement opportunities for clinical documentation and coding.
- e. Ensure optimal DoD Health Record coding program performance through the monitoring of metrics. At a minimum, metrics must cover timeliness of record completion, availability of records, quality of documentation, and completeness and accuracy of coding.
- f. Monitor and evaluate the availability of complete DoD Health Records per DHA, in accordance with DoDI 6040.40.
- g. Monitor and manage workflow.
 - (1) Workflow management depends on discrete business functions and standard operating procedures. Both of these ensure non-biased, accurate, and consistent clinical coding, data capture, and education, and promote efficiency, improved communication, and support. Workflow management must be structured, monitored for workload, and consistently evaluated for staff availability by the Military Departments and the NCR MD. This includes identification of process and quality controls and feedback mechanisms to push coding assignments to coders based on their availability and expertise, as well as MTF need. Contract and remote coding services may be used and must be monitored by the Military Departments and the NCR MD for quality and timeliness to ensure compliance.
 - (2) Established and effective lines of communication among coding, CDI, and compliance staff must exist to ensure all applicable coding workload is identified, reviewed, and coded in a timely and appropriate manner.
 - (3) Coding processes, including collateral registry duties, must be streamlined to ensure maximum productivity (e.g., assigning similar work types on a given day). Non-coding duties, such as release of information, filing, assembly and analysis, and other administrative duties should be assigned by the Military Departments and the NCR MD to non-coder staff.

3.3. MTF COMMANDERS. MTF commanders:

- a. Implement a DoD Health Records control process, which must include procedures to achieve a 97 percent availability of complete medical records for coding while striving for 100 percent, in accordance with DoDI 6040.40.
- b. Ensure a coding compliance plan is current, available, and used at their MTFs.
- c. Incorporate external auditors as part of their compliance plans.
- d. Provide internal auditors, trainers, and coders with appropriate, available resources, including coding references materials in either hard copy or electronic form.
- e. Ensure availability of coders as advisors or mentors, auditors, and instructors to coding and clinical staff.
- f. Ensure coding instructors and auditors are current in MHS coding guidance and coding industry standards.
- g. Ensure that all individuals who assign codes to encounters are trained to a level sufficient to meet accuracy standards.
- h. Ensure that individuals who document in the record are available and responsive to coders when the coders have questions or when they need to clarify the documentation to assign the most correct code.
- i. Incorporate coding accuracy standards in coder performance reviews.

GLOSSARY

G.1. ACRONYMS.

CDI	clinical documentation improvement
CPT	current procedural terminology
DHA	Defense Health Agency
DoDD	DoD directive
DoDI	DoD instruction
DSM	Diagnostic and Statistical Manual of Mental Disorders
HCPCS	Healthcare Common Procedure Coding System
ICD	International Classification of Disease
MCPO	Medical Coding Program Office
MHS	Military Health System
MTF	military treatment facility
NCR MD	National Capital Region Medical Directorate

G.2. DEFINITIONS. Unless otherwise noted, these terms and their definitions are for the purpose of this issuance.

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

case mix index. A relative value assigned to a diagnosis-related group of patients in a medical care environment. The case mix index value is used in determining the allocation of resources to care for or treat the patients in the group.

CDI. A program that improves the quality of clinical documentation, regardless of its impact on revenue. CDI programs facilitate accurate representation of health care services through complete and accurate reporting of diagnoses and procedures. This can have an impact on Centers for Medicare and Medicaid Services quality measures, present on admission, pay-for-performance, value-based purchasing, data used for decision making in health care reform, and other national reporting initiatives that require the specificity of clinical documentation. Improving the accuracy of clinical documentation can reduce compliance risks, minimize a

health care facility's vulnerability during external audits, and provide insight into quality of care issues.

compliance. An oversight process, supported by appropriate organizational conditions (e.g., culture, regulations, policies, procedures, controls) which, over time, are most likely to ensure that employee actions and character are consistent with MHS policy, ethics, and core values.

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

DSM. A comprehensive classification of officially recognized psychiatric disorders, published by the American Psychiatric Association for use by mental health professionals to ensure uniformity of diagnosis. DSM describes symptoms and does not discuss the causes of the disorders.

DoD Health Records. Defined in DoDI 6040.45.

encounter. An interaction between a patient and an authorized health care professional that includes assessment, treatment, or advice provided to the patient over a specific period of time. Documentation describing the interaction is made in the patient's record of medical treatment.

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

health information management. The practice of acquiring, analyzing, and protecting digital and traditional medical information vital to providing quality patient care. Health information management professionals often serve in bridge roles, connecting clinical, operational, and administrative functions.

ICD. Code set maintained by the World Health Organization and used by providers, other qualified health care professionals, health information managers, coders, and insurers to classify diseases and other health problems recorded on many types of health and vital records, including death certificates and health records. ICDs enable the storage and retrieval of diagnostic information for clinical, epidemiological, and quality purposes and for reimbursement and resource allocation. ICD-Clinical Modification codes are used in all U.S. health care settings. ICD-Procedure Coding System codes are used in inpatient hospital settings only.

medical services. Treatment and preventive services provided to a patient in a hospital, clinic, or ambulatory service center that include professional, institutional, ancillary, and prescription drug services.

Military Departments. Defined in Joint Publication 1-02. Responsibilities assigned to the Military Departments in this issuance are expected to be met by their respective subordinate medical units.

MTF. Defined in Joint Publication 1-02.

personally identifiable information. Defined in DoDD 5400.11.

provider. A health care professional who may be classified as “privileged” or “non-privileged.” “Privileged providers” include licensed physicians, advanced practice nurses, physician assistants, independent duty corpsman, oral surgeons, optometrists, residents (other than post-graduate year ones), physical and occupational therapists, and other qualified health care providers. “Non-privileged providers” includes those providers who provide services incident to written orders of privileged providers (e.g., nurses, technicians, independent duty medical technicians).

REFERENCES

- DoD 5400.11-R, “Department of Defense Privacy Program,” May 14, 2007
- DoD Directive 5136.01, “Assistant Secretary of Defense for Health Affairs (ASD(HA)),” September 30, 2013
- DoD Directive 5136.13, “Defense Health Agency (DHA),” September 30, 2013
- DoD Directive 5400.11, “DoD Privacy Program,” October 29, 2014
- DoD Instruction 6040.40, “Military Health System Data Quality Management Control Procedures,” November 26, 2002
- DoD Instruction 6040.45, “DoD Health Record Life Cycle Management,” November 16, 2015
- DoD Manual 8910.01, Volume 1, “DoD Information Collections Manual: Procedures for DoD Internal Information Collections,” June 30, 2014, as amended
- Joint Publication 1-02, “Department of Defense Dictionary of Military and Associated Terms,” current edition
- United States Code, Title 5, Section 552a (otherwise known as “the Privacy Act of 1974, as amended”)