

Coding and Documentation of Domestic Violence

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Part I: Introduction and Rationale

Introduction

Domestic violence (DV) is a major public health problem in the United States, affecting between two and four million women each year.^{1,2} Women turn to the health care system throughout their lives for routine health maintenance; pregnancy and childbirth; illness or injury care; mental health assessment and treatment; and when assisting or accompanying their children or other family members for their own health care. Doctors, nurses and other providers are urged to screen routinely for DV, yet progress is hindered because health systems lack the data, formalized procedures and the reimbursement schemes to fully implement and sustain published screening guidelines. Documentation and coding of DV can improve our ability to conduct useful research and also positively affect reimbursement for DV screening, identification, assessment, care and follow-up. Improved documentation and coding will thus ultimately improve health services for victims.

Although medical record documentation of DV is recommended³ it is still uncommon. Accurate coding of DV is even more unusual. Two statistics underline the pressing need within the industry to address coding and documentation: The US Department of Justice estimate that nearly 4 out of 10 (37%) women seeking medical attention in emergency departments for violence-related injury are victims of domestic violence⁴ but an analysis of Health Care Utilization Project (HCUP) data show that only 7 in 100,000 hospitalized patients overall have a DV code entered in their medical record.⁵

Improved documentation and coding will strengthen our understanding of the impact of domestic violence on a patient's health. Historically, medical chart-based research has focused primarily on injuries directly caused by abuse. However, when DV is documented and coded accurately, the most common diagnoses accompanying a domestic violence code are related either to a chronic or an acute medical problem⁶. Abuse is associated with a range of adverse physical health effects including arthritis, chronic neck or back pain, migraines, stammering, visual impairment, sexually transmitted infections, chronic pelvic pain, peptic ulcers, irritable bowel disease, and other digestive problems.⁷ Because DV is so gravely under documented, this research is in its infancy and an accurate understanding of its health consequences have been only partially realized. Our limited ability to clearly and accurately understand the health impact of abuse ultimately weakens efforts to improve the health and safety of victims of domestic violence.

Documentation and coding are also directly connected to reimbursement. Currently there is no procedure code for domestic violence and (unless they substitute other codes for their identification and intervention) providers will not receive *any* reimbursement for services specifically addressing DV. The diagnostic codes for in-patient care that do exist are reimbursed at a significantly lower level than other clinical issues. The AMA, the AHA, and the American Health Information Management Association (AHIMA) indicate that if DV is identified, a DV diagnostic code *must* be used as a primary diagnosis. This important policy and practice mandate is clearly not being followed in the field. If it were, providers may be financially penalized for identification and intervention of DV because the reimbursement level for this code is so low or even non-existent.

In an environment in which providers are being asked to do more, often in less time, adequate reimbursement for DV screening and intervention could be key to ensuring that clinicians incorporate DV intervention into their practice behaviors. Ultimately, resolving these issues and promoting accurate documentation and coding may prove to be one of the most influential strategies to improving the health care response to DV and can identify and help victims of violence who are currently not being reached through other community systems.

This paper will discuss the documentation and coding process and its relationship to enhanced health services to victims, improved research, and increased reimbursement for providers. In order to develop a more effective approach to DV in the health care arena, we will make recommendations to providers, health information professionals, institutions and policy makers on how to improve the documentation and coding of domestic violence in a way that protects the safety and confidentiality of victims of domestic violence.

The argument for accurate documentation and coding of DV

Victim advocates and health care providers have been working together for many years to strengthen the health care response to DV. However, there are systematic barriers to doing so, most significantly the lack of data and institutional support for such interventions. Many of the principal barriers providers face can be approached and overcome by promoting accurate documentation and coding of DV.

There are a host of critical benefits that can be realized by accurate documentation and coding, several of which are described below:

Continuity of care: Documentation of DV helps the health care provider consider the effects of abuse over time. Accounts in the medical record of earlier episodes can assist the patient in recognizing escalation. As patients return for future or follow-up care, change providers, see specialists, or seek emergency care, an accurately documented medical record can help ensure that the patient receives consistent; appropriate; and continuous care. Further, the medical record can help ensure that each provider who takes part in the patient's care understands the role that abuse plays in the presenting medical condition.

Legal evidence collection: The medical record can provide persuasive evidence in legal proceedings including criminal prosecution, divorce, child custody, and other civil matters should such action be pursued. Careful documentation may actually decrease the likelihood that providers may be asked to appear in court to give testimony, by offering evidence compelling enough to persuade the offender to settle prior to the start of formal court proceedings.

Improved understanding of the impact of domestic violence: Accurate documentation and coding of DV can offer new information about health consequences or associated conditions, which in turn will help providers treat patients more effectively, efficiently and compassionately. For example, preliminary research indicates that common health problems associated with DV include: hypokalemia (low potassium) dehydration, tobacco use, and urinary tract infections⁸. These new insights need to be studied further and confirmed, and can best be accomplished by doing medical chart reviews, if the charts can provide accurate and valid documentation. The capacity to generate new knowledge is crucial to broadening our understanding of the impact of abuse.

Justification for specific clinical recommendations: Data collected as a result of proper documentation and coding facilitates the promotion of informed clinical recommendations based on evidence. New data can help us work toward sound evidence-based clinical guidelines that can be endorsed by health care experts at a national level.

Reimbursement for services: As stated above, documentation and coding of DV is related to reimbursement for clinicians. Because victims may need service beyond the treatment of physical injuries, such as risk assessment, counseling, safety planning and referral outside the health care system, proper documentation and coding can facilitate reimbursement to providers for offering these much needed additional services. Providers will be more likely to incorporate domestic violence screening and intervention into their practice if they are adequately reimbursed for their time.

Strong risk management: As DV screening and intervention increasingly becomes the standard of care, providers and health care delivery sites can be held accountable for failure to diagnose and record accounts of abuse, or for not delivering necessary care. Proper documentation can be a powerful tool to protect providers from potential liability.

Justification for funding and policy reform: In addition to measuring and shaping clinical responses to DV, coding is also critical from a policy perspective. Data that demonstrate the adverse impact of DV on victims, on their dependents, and on the health care system could be a vital tool in ongoing efforts to promote funding for identification and intervention programs, as well as for research on a par with the vital funding that the criminal justice system receives. Complete and accurate data will also help advocacy efforts to increase funding for shelters and other services, and could conceivably encourage local, state, and federal agencies to adopt effective, and measurable public policies of a quality worthy of replication.

Justification for services: Insurance companies, the Medicaid system and HMOs are primarily data driven. It is necessary to document need in order to justify enhanced services and the allocation of new or existing resources. For example, studies show that without early identification and preventive care, health systems pay on average \$873.00 more per episode of care than they would pay for the care of patients who are not victims of abuse.⁹ This type of information can be used to encourage HMOs to implement early identification and prevention programs for DV.

In the absence of data that can demonstrate a concrete need to respond to abuse, or payment for providers to do so, significant change in the health care response to DV will be difficult if not impossible to achieve. Adequate documentation and coding of DV lies at the heart of efforts to understand and improve patients' health and safety, produce evidence-based clinical recommendations, provide legal evidence of abuse, and promote reimbursement for services provided to victims.

Caveats and cautions

While there is much to be gained, there are serious risks involved with coding and documentation of DV. A more systematized documentation of DV in the medical record can also make patients more vulnerable to further abuse and inappropriate disclosure of their health information. Ancillary health care staff, employers, insurers, law enforcement personnel, and others who may have legitimate or unauthorized access to medical records in which DV is documented can discriminate against the patient or even alert the perpetrator. Perpetrators who discover that a patient has disclosed her abuse can conceivably retaliate. It is essential that strategies to ensure medical records privacy are implemented coincident with efforts to improve documentation and coding of DV in order to ensure patient (and staff) safety to the fullest extent possible. Policies, protocols, and practices surrounding the documentation, coding and disclosure of health information regarding victims of DV must respect patient autonomy and confidentiality and serve to improve the safety and health status of victims. *(For specific recommendations regarding how to increase the privacy of health information for victims of DV, please see Health Privacy Principles for Protecting Victims of Domestic Violence, written and published by the Family Violence Prevention Fund.)*¹⁰

Part II: Understanding Documentation and Coding in the Medical Record

Overview: Medical Records Documentation and the Coding Process

Each time a patient seeks health care from a provider, the encounter is documented in the medical record and a diagnosis and/or a procedure code records the activity. Two categories of health care workers are most likely to be involved in the documentation and coding of DV: the health care provider, and the health information management (HIM) professional.

The process itself can be divided into three general steps:

1. Identification by the provider of DV “cases”;
2. Written documentation in the medical record by the provider of DV; and
3. Coding in the medical record by the HIM professional based on existing chart documentation.

Providers are reimbursed based on the documentation and the codes that support their level of care. Data about specific health issues is also collected as a result of the codes.

Documentation of DV

Health care providers provide a written narrative of every patient encounter in the medical record. Records can be dictated and then transcribed, hand written, typed and printed, or computer-generated. Most medical records are paper-based, however a growing number are electronic (desktop, network, or web-based). A well-documented patient encounter should do the following:

1. Detail the reason for the visit,
2. Describe the symptoms or problems (if any) that prompted the visit,
3. Describe related health issues the patient is experiencing,
4. Summarize the patient’s overall health history,
5. Record relevant findings from the physical exam,
6. Record results of laboratory and other diagnostic procedures,
7. Record options discussed with patients and referrals offered, and
8. Documents arrangements made for follow-up care.

Benefits of clear and accurate documentation serve to:

1. Enhance communication among providers about an individual patient’s care,
2. Provide evidence in criminal or civil proceedings,
3. Measure the cost and prevalence of specific health problems, and
4. Record the activities and procedures for which reimbursement will be sought.

Unless accurate and complete documentation of an episode of care is recorded in the medical chart, the record of that encounter may be lost forever. Patient care could suffer due to lack of communication among different providers, and the patient would not have an opportunity to review her “history” with the provider and thus elucidate the progressive patterns of coercion that are the hallmarks of DV. In addition, failure to document could impair the ability of the patient to seek legal redress from the batterer.

What is a Code?

Based on the provider’s written narrative of care, the HIM professional attaches procedural and diagnostic codes (called CPT and ICD-9-CM codes, respectively) to codify the nature of the encounter. These codes have the following functions:

1. To describe the injury/illness for which the patient was seen,
2. To describe the procedure(s) done during the visit,
3. To establish a level of insurance reimbursement for specific procedures,
4. To help researchers identify prevalence, severity and costs associated with specific illnesses or injuries, and
5. To assist the health care professional in providing optimal care by better documenting diagnoses and procedures that have previously been performed.

The medical record is a legal document. In order for a condition to be coded, the condition or event must be documented accurately by the health care provider in a timely fashion, and supported by the treatment of the patient. In effect, from the perspective of health information management personnel, if a provider did not document an injury or illness, it did not happen!

There are two primary coding lexicons:

- Current Procedural Terminology codes (procedure codes only for outpatient care)
- ICD-9-CM codes (inpatient and outpatient diagnostic codes and inpatient procedure codes).

1. Current Procedural Terminology (CPT) Codes

Current Procedural Terminology (CPT) is a systematic listing of procedure codes and services performed by a health care provider primarily for outpatient services. CPT codes are used to determine the level of reimbursement for outpatient care and must be accompanied by an ICD-9-CM code. In general, CPT codes are not used for inpatient care. Each procedure within the CPT lexicon is identified by a five-digit code that reflects the service rendered during a visit for care.

CPT Codes are subdivided into four general groups:

1. Evaluation and management services,
2. Surgical care,
3. Diagnostic services, and
4. Therapeutic services.

2. ICD9 – CM Codes Specific to Domestic Violence

International Classification of Diseases (ICD) codes are used to describe the diagnosis of injury or illness, or to describe a treatment procedure. ICD codes are used to track the prevalence and cost of specific health conditions. For inpatient care, ICD codes are also used to establish a level of reimbursement for services provided. The codes in current use are called ICD-9-CM codes. ICD-10 codes are currently under review and are expected to be implemented in 2002-2003. *(Please see Appendix B for a discussion of ICD-10 codes as they relate to intimate partner violence).*

ICD-9 clinical diagnosis codes are generally categorized into three sections:

1. Diagnostic or clinical condition codes.
2. E-codes that describe the circumstances of an injury or illness; and
3. V-codes that describe historical issues or counseling needs.

Specific Codes and Guidelines for Domestic Violence

CPT Codes

CPT codes **do not** currently exist for domestic violence. In the outpatient setting, the only way to identify and code DV specifically is by ICD-9 codes in combination with other CPT codes.

CPT codes that can be used when treating DV victims to receive reimbursement:

- Complex evaluation and management (99303)
- Team conferences (99374-2)
- Care plan oversight (99374-5)
- Preventive medicine services (99381)
- Preventive medicine counseling (99401)

Providers can document services provided to DV victims under one of the categories in the box above (among others). Reimbursement for these services, however, depends upon the individual health setting and the details of each patient's insurance coverage. If DV-specific ICD-9 codes are not used in combination with the above procedure codes, important information about the frequency of DV will not be captured, nor will we ascertain any information about health problems that are associated with DV.

ICD-9 CM Codes

ICD-9 codes related to adult DV do exist and are categorized into four major areas: (Please see Appendix A for a list of the actual family violence-related codes).

1. *Adult Maltreatment and Abuse codes:*

The Adult Physical Abuse code (995.81) is the primary code that identifies each recorded incidence of DV. Other codes in the 995.8 range add specificity about the abuse such as physical, sexual etc. (See appendix A for actual codes).

2. *E – codes:*

E-codes are used as modifier codes that provide information as to when and where the abuse happened, to whom or by whom, and how. E-codes are important in helping to codify the specific details of an abuse incident and the identity of the perpetrator, and therefore specify the problem being documented as DV as opposed to some other form of “adult maltreatment.” However, E-codes are *not* required codes. As a result, E codes appear in fewer than 20% of documented DV cases.¹¹ We therefore have very little in the way of accurate data about the true impact of DV on the health care system.

3. *History Codes and Counseling (V - codes)*

Another important place where information about DV can be captured is through History codes, also known as V-codes (see Appendix A for actual codes). These codes give us information about the history of abuse or the need for counseling as a result of DV. However, a history code cannot be used if the condition being described is still present. For example, if a patient sees a provider for an injury caused by her husband; the provider identifies and documents a history of DV; but the abuse is still ongoing, the history V-code cannot be entered into the medical record. If a provider is treating a current injury, the only way to document an ongoing history of DV is through a written narrative in the chart. V-codes that denote suspicion of DV also exist. These (V-71 category) codes cannot be used in conjunctions with other DV-related IDC-9 codes because they denote suspicion only. From a legal standpoint, if a V-71 code is used, the abuse is suspected by not confirmed.

4. *Injury or Abuse codes*

Each medical record must also contain an additional injury or abuse code that records the underlying condition for which hospitalization is necessary (for example: fracture, stab wound, etc.). In general, these codes have been used as primary diagnosis codes and represent the abuse or violent act suffered by the victim in each individual case. Injury or abuse codes could identify any type of injury or abuse (fracture, contusion, gunshot, and malnutrition).

Coding Guidelines

General Coding Clinic Guidelines:

A collaborative group including the American Medical Association, the American Hospital Association and the American Health Information Management Association has developed clear rules for health care providers and HIM personnel on how codes should be used and the documentation that is necessary to establish a particular level of care for purposes or reimbursement. The rules are referred to as “Coding Clinic Guidelines.” The following is a summary of those guidelines and definitions:

1. **Primary diagnosis (PDX)** – This defines the condition established after study to be chiefly responsible for admitting the patient to the hospital. The primary code is not always the cause as determined at the time of admission– but is defined as the primary condition for the treatment. The PDX determines the amount a provider will be reimbursed for the treatment given.
2. **Secondary diagnoses** - refers to all conditions that coexist at the time of admission that affect treatment of the patient care during the hospitalization.
3. **Coding specificity** - Codes must be assigned to the highest level of specificity possible. This means that HIM professionals should use the most specific codes available to them according to the information provided in the medical record. The first three digits describe the general problem and the last two describe the situation in more detail. *(For example: The DV codes range from 995.80 to 995.85 and the 4th and 5th digit codes describe the type of abuse – sexual, physical, etc. Therefore, because it provides the least specificity, the 995.80 adult maltreatment, NOS (not otherwise specified) code should really never be used.)*

Specific Coding Clinic Recommendations for DV:

In 1998, the Coding Clinic specified that DV must be coded as the primary diagnosis *regardless* of other presenting conditions.¹² Thus, if abuse is discovered at any time during the encounter, it must be coded as the primary diagnosis. *(see Appendix C for a copy of the Coding Clinic Guidelines).* This is a very important decision about which very few providers, institutions or HIM professionals know. For example, if a patient is admitted with an open fracture of the radius and ulna as a result of DV, although surgical repair of the fractured bones may be the clinical condition requiring admission, according to the Coding Clinic guidelines, the DV code must be used as the primary diagnosis and the fractured radius and ulna in this case must be coded as the secondary diagnosis. Therefore, if DV is disclosed or discovered at any time during the encounter, it must be coded as the primary diagnosis. This is not common practice. More common is that the fracture is recorded as the primary diagnosis and DV is either not noted (preventing researchers from capturing critical information about DV in the health system) *or* is coded as a secondary diagnosis.

There are both pros and cons to listing DV as the primary diagnosis. Indeed, whether or not a code is listed as primary or secondary has three major implications:

1. The primary code records the condition that the health care system finds to be chiefly responsible admission. That the coding clinic ranks DV as the primary reason for admission makes an important scientific and policy statement.
2. Primary codes often receive the highest level of reimbursement for the services provided. Domestic violence codes however, yield very low reimbursement. Therefore, if HIM professionals use them as the coding clinic recommends, hospitals, clinics and providers will be penalized for accurately documenting and treating DV.
3. Coding DV as a secondary code while coding and other injuries or health issues as primary diagnoses, while better than no code at all, can limit possibilities for data collection because researchers often assess only primary diagnosis codes.

Current Coding Practices

Despite the existence of Coding Clinic rules, DV is rarely documented or coded at all, either as a primary or secondary diagnosis. An example from the Coding Clinic Guidelines published by the AMA may be helpful in better understanding how DV is currently coded.

“A woman is seen in the Emergency Department after her boyfriend threw a plate at her across the dining room table and hit her in the forehead when he became angry over his dinner. She reports that he is often violent and becomes physically abusive after he drinks excessively. The diagnoses listed in the medical record are battered woman and laceration of the right eyebrow.”

In common practice this episode of DV would be coded as:

- Primary diagnosis - open wound to the forehead (873.42)
- Secondary diagnosis (if included at all) - adult maltreatment (995.81)
- No E-codes or V-codes would be included

Health care providers often fail to document the incidence of DV, or fail to include information about the history of the abuse or who perpetrated it. When this is the case, it is impossible for HIM personnel to apply the adult abuse code. Because the HIM professional has not been trained to code DV as a primary diagnosis per the Coding Clinic guidelines, and because another primary code will ensure a higher level of reimbursement (in one setting, approximately \$1,500.00 for the open wound to the forehead vs. \$945.42 for DV), the abuse, if coded at all, would be the secondary diagnosis. Lastly, because E-codes are not required, in most cases, E codes would not be included at all.

Coding Clinic Guidelines Recommended Practice:

Using the above example, the health care provider should clearly document DV, and the HIM personnel should assign the adult abuse code as the primary or PDX code. The primary and secondary codes and E-codes should thus be recorded as follows:

- primary diagnosis - adult maltreatment (995-81)
- secondary diagnosis - open wound of forehead (873.42)
- E-code - assault by means of striking by blunt or thrown object (E-968.2)
- E-code - by spouse or partner (E-967.3)

Although there is mention of a history of violence (which would normally require a V-code), since the 995.81 code is used, V-codes cannot be listed according to Coding Clinic rules. In this case illustration, the only way to document a history of DV is through the written narrative in the medical record.

Barriers to Accurate Coding of Domestic Violence in the Medical Record

The large discrepancy between the number of reported cases of DV and the number of cases documented in medical records warrants further examination. In order to assess why differences exist between the number of DV cases reported in survey literature and those actually documented and coded in the medical record, it is important to understand barriers to coding and documentation for health care providers and health information management professionals.

Infrequent Documentation: As reviewed above, health care providers must document DV accurately and completely in order for it to be coded correctly. Research shows that only 10% of primary care providers routinely screen for DV, a finding that significantly limits opportunities for identification and therefore documentation.¹³ Barriers to screening and documentation include lack of time and training on part of health care providers and lack of institutionalized support for such interventions. If domestic violence is not identified or documented it will not be coded.

Lack of Administrative Support: The low frequency of screening and documentation is partially a result of the fact that providers are not held accountable for comprehensive and accurate documentation of DV. Health care systems are not taking adequate steps to ensure that DV coding and documentation takes place. A 1999 survey of 650 managed care organizations found that only 18% had formal policies on documenting DV.¹⁴ Domestic violence training for HIM professionals is extremely limited, despite the recommendation by the Coding Clinic guidelines to utilize DV as a primary PDX code. HIM professionals rarely enter E-codes for DV either. This systematic omission is not due to lack of competence on the part of HIM professional; rather it is more a reflection of the time constraints and productivity standards imposed by health systems, insufficient chart documentation by providers, and the lack of mandates or reimbursement specific to E-codes.

Reimbursement Structures: Probably the most important barrier to the codification of DV in the medical record relates to reimbursement for health care services rendered. The obvious barrier in outpatient care is that there is no CPT code for DV, so health care providers (unless they can substitute other CPT codes for DV identification and intervention) will not receive *any* reimbursement for services specifically addressing DV. For inpatient care, DV is generally reimbursed at significantly lower rates than most common types of injury. While rates vary by provider type, location, and insurance carrier, in general, DV reimbursement is less than what is provided for most other clinical conditions. For example, a provider would be reimbursed at approximately \$2793.00 for a PDX of DV with a complication or co-morbidity (CM) (for example, a fractured femur), and \$945.42 without a CM. A fractured femur, on the other hand, without any coding notation for DV, would be reimbursement at \$3053.58 (*see Appendix D for a diagram of reimbursement levels*).

Reimbursements are based on how a code is “weighted.” It is important to note that while reimbursement levels change (depending on location, insurance carrier etc.), the “weight” on which the various reimbursement schedules are based does not vary. HIM professionals are trained to prioritize codes with the highest weights, while codes with lower weights are listed as secondary or not included at all. Therefore, although the Coding Clinic Guidelines recommend that DV always be coded as a primary diagnosis, because of its low weight (and corresponding lower reimbursement level) it is often not coded at all. Because HIM personnel can often choose a primary diagnosis from among a number of other diagnoses with higher weights for a particular patient, the current reimbursement structure deters the HIM professional from coding DV at all. Accordingly, because providers are not reimbursed for time spent working with patients who are victims of DV, the incentives to screen and document abuse are also limited.

In 1998, the Health Care Financing Administration proposed a new severity-adjusted weight that would increase the reimbursement for DV up to 1.741, or approximately \$5323.97 - which is higher than most other trauma or abuse injuries. Clearly the implications would be significant should this be approved. As of this time, however, the new proposal has not been implemented.

Part III: Recommendations to Improve Documentation and Coding of Domestic Violence

In order to improve the health and safety of victims of DV and facilitate improved research regarding the consequences of abuse, DV advocates, health policy makers, providers and health systems need to work together to ensure that the health care system supports accurate documentation and coding of DV. Each group has a unique and vital role in this effort.

Recommendations for Health Care Providers

It is critical that health care providers document DV accurately and completely in the medical record. Documentation provides a record of the effects of a pattern abuse over time; increases communication among multiple providers; documents earlier episodes that can assist the patient in recognizing escalation, and helps the provider understand how DV affects the patient's health. By not accurately or completely documenting the abuse, prospects for early intervention and timely care and treatment are therefore hindered. As mentioned earlier, strong documentation is also useful as evidence in criminal or civil court, and is good practice for purposes of risk management.

Documentation should be comprehensive and should include:

1. A description of the history of abuse: including the details of the present injury or illness, past medical history, sexual history including documenting any sexual assault, history of sexually transmitted diseases, medication history, and relevant social history.
2. Specifics about the abusive incident (if the patient reports a discrete incident): who inflicted the abuse, the perpetrator's conduct, the health impact on victim (injuries and other medical issues), if the perpetrator uses alcohol and drugs, and if there are weapons, particularly firearms, present.
3. Physical examination findings related to abuse, using a body map and photographs if available to supplement written descriptions.
4. Use of the patient's own words, in quotes, along with factually descriptive language.
5. Results of any laboratory and other diagnostic procedures.
6. Assessment and documentation of information pertaining to suicide or homicide risk, and potential for serious harm or injury.
7. Documentation of any police reports or orders of protection, if available.
8. Options discussed and referrals offered.
9. Plans for follow-up and other discharge information.

Recommendations for HIM Professionals and Health Care Systems

To date, much of the focus on strengthening the health care response to DV has been directed to training providers who administer direct care. However, there is also a critical need to educate HIM professionals regarding DV and create tangible administrative supports for appropriate documentation and coding.

Recommendations for HIM Professionals:

1. Use current ICD9 – CM codes for DV as the primary diagnosis, as is recommended by the Coding Clinic guidelines, or *at a minimum*, code DV as a secondary diagnosis.
2. Always include E-codes and V-codes as modifier codes when appropriate.

Recommendations for Health Care Systems:

1. Support training for HIM professionals to utilize current ICD-9 codes for DV, and to use E-codes and V-codes as modifier codes.
2. Build in administrative supports that encourage appropriate coding and documentation of DV by addressing time constraints and by incorporating documentation and coding issues into quality assurance protocols.
3. Review the Coding Clinic guidelines and make clear recommendations to HIM professionals about how to code DV.
4. Establish institutional mechanisms to ensure that medical records are kept private and that staff receive training about confidentiality procedures.

Building these institutionalized responses to DV will strengthen data collection and improve our understanding of the impact of DV on health systems and patients' health outcomes. Doing so could also reduce the risk of liability to the institution. Finally, data made available through proper documentation and coding may justify enhanced services and allocation of new resources through insurance companies, Medicaid and HMOs.

Recommendations for Health Policy Experts and DV Advocates:

In addition to clinical and institutional responses, key health policy reforms need to be implemented if we are to expect documentation and coding for DV to improve. Domestic violence advocates and health policy makers can work together to pursue policy changes that help doctors and nurses identify and help victims, in ways that do not threaten the safety or confidentiality of the patient.

Increase Reimbursement for Domestic Violence ICD-9 Codes

As mentioned above, the Health Care Financing Administration (HCFA) did propose a new reimbursement level for DV, which has not yet been implemented. Advocates and health policy makers interested in promoting stronger and more consistent documentation of DV should encourage HCFA to act on the 1998 proposal, particularly given the Coding Clinic recommendations that DV be listed as a primary diagnosis. Interested individuals and organizations are urged to contact HCFA, AMA, AHA and AHIMA and ask to speak with their Coding Clinic representatives. If the "weight" or reimbursement level of the DV code can't be increased, the Coding Clinic should in the interim recommend that DV be coded as the first secondary code (not the primary diagnosis), so that providers are not financially penalized for documenting DV.

Create a CPT Code for Domestic Violence

Because of the scope of health consequences of DV, it is critical to promote routine screening and intervention in outpatient as well as inpatient settings. The creation of a CPT code for DV would provide an economic incentive for routine screening, intervention and documentation in the medical record. Domestic violence intervention is not a commercial venture, however, because of the severe consequences of abuse, victims often require additional physical and mental health care and documentation and coding can facilitate reimbursement for critical and sometimes life-saving services that patients deserve. In combination with training and collaboration with DV advocacy organizations, the creation of a CPT code for DV could address a real barrier to essential interventions and dramatically improve the health care response to DV in the outpatient setting.

Increase Documentation and Coding at Individual and Institutional Levels

The creation of a new CPT code depends upon many factors, most importantly data that support that a health problem is significant enough to warrant a separate procedure code. Although no CPT code currently exists for DV, abuse must be identified with an ICD-9-CM code. Accurate use of ICD-9 codes in conjunction with CPT codes not specific to DV, as proposed earlier, could help document the prevalence and complexity of this problem, and ultimately justify the development a new CPT code. The end result will be an improvement in our understanding of the consequences of and effective responses to DV.

Enhance Medical Records Privacy

Policies that promote coding and documentation of DV must go hand-in-hand with efforts to ensure maximal confidentiality of medical records. For example, insurance companies have been reported to discriminate against victims of DV if a history of abuse is discovered. ICD-9 codes are included in employer records, and an employer could discriminate against an employee if a DV ICD-9 code is seen. Perhaps most compelling, health records are sometimes sent home as payment information and patients can be endangered if the perpetrator sees that she has disclosed abuse. Health policy makers, health care providers and DV advocates must join together at the federal and state level to press for changes in health policy that promote medical records privacy. In the interim, individual providers and systems can implement internal policies (such as restricting information that goes to employers, insurance companies and private homes) to ensure that records of DV victims are kept private. In this way, identification and documentation of DV would not threaten the patients' privacy and safety. *(For more information on how to do this please refer to Health Privacy Principles for Protecting Victims of Domestic Violence produced by the FVPF, available on the FUND's website www.fvpf.org/health or by calling toll free 1-888-RX Abuse).*

Conclusion

Because most people visit health care settings at some point in their lives, health care providers are in a prime position to identify domestic violence early and participate in intervention and prevention efforts. Providers cite a lack of quantifiable data about DV as well as administrative barriers related to reimbursement as major impediments to identification and intervention. The first step in addressing these challenges is accurate documentation of DV to ensure that HIM professionals can use DV ICD-9-CM codes. This step will provide us with information that demonstrates that DV can be a complex and time-consuming health problem, worthy of financial and administrative support to ensure an appropriate response.

There is also a critical need to educate HIM professionals and create tangible administrative reinforcements for using existing DV codes appropriately. Proper codification would promote the collection of more accurate data regarding the impact of DV on patients' health status, and the impact of DV on health systems.

If partnered with policies that ensure medical records privacy, these important administrative and policy changes have the potential to increase screening and intervention in health settings. These innovations will create opportunities for prevention and new prospects for identifying victims of not currently receiving help through DV agencies or law enforcement. In order to do so, health care providers and HIM professionals must be included in educational and policy reform efforts and invited to collaborate with DV advocates and other community members in the struggle against domestic violence.

Appendix A

Domestic Violence Related ICD-9-CM Codes

The International Classification of Diseases (ICD-9) clinical diagnosis codes related to domestic violence define DV in terms of adult maltreatment syndrome. The ICD-9-CM codes related to domestic violence are categorized into four major areas:

Domestic Violence Related ICD-9-CM Codes

- 995.80 adult maltreatment
- 995.81 physically abused person, battered person
- 995.82 adult emotional/psychological abuse
- 995.83 adult sexual abuse
- 995.84 adult neglect (nutritional)
- 995.85 other adult abuse and neglect (multiple forms of abuse and neglect)

- Health care providers *must* use the most specific codes; therefore the less specific 995.80 domestic violence code should not be used.
- **Coding Clinic Guidelines developed by the AMA, AHA, and the AHIMA state that domestic violence should be documented as the primary diagnosis regardless of other presenting health problems**

E-Codes:

- E-codes are used as modifier codes that describe the circumstance of an injury or illness and in the case of domestic violence the nature of the abuse and the perpetrator. E-codes help identify domestic violence as opposed to other forms of “adult maltreatment.”

Domestic Violence Related E-Codes

- | | |
|--------------------------|---|
| • E967.1, E967.3, E967.9 | Identifies who committed the act of violence |
| • E960 - E968 | Identifies the nature of the abuse |
| • E904.0 & E968.4 | Identifies the intent of neglect |
| • E980 - E989 | Notes whether the injury was accidentally or purposefully inflicted |

In addition to DV-related E-codes, other E-codes identify where an act of violence occurred, for example in a house, apartment, outside, etc. (*Please refer to the ICD-9-CM code book 2000 for a copy of those codes*).

V-Codes: History and Counseling Code

V-codes give information about the history of abuse or the need for counseling as a result of domestic violence. The history code specific to domestic violence are:

-
-

Domestic Violence V-Codes (history Codes)

- V15.41 physical abuse and rape
- V15.42 emotional abuse
- V15.49 other abuse
- V61.11 counseling for the victim
- V61.12 counseling for the perpetrator

ICD-10-CM Codes

ICD-10 – CM: New Diagnostic Codes

ICD-10-CM is the new coding scheme and lexicon to be implemented by the year 2002. Generally, ICD-10-CM presents a radical departure in coding from ICD-9-CM. In the case of domestic violence, however, most of the changes are not substantive. All of the 1996 and 1998 changes made to the ICD-9-CM domestic violence codes are carried over to the ICD-10-CM codes, they are simply classified in different categories. First, the series of 995.8 codes are now classified under T74 or injury codes. Second, the E codes (perpetrator codes) are now external cause codes and prefaced with a Y.

Although most of the ICD-9-CM and ICD-10-CM coding rules are the same for domestic violence, there is one significant change. ICD-10-CM includes a series of unconfirmed or suspected domestic violence and abuse codes, similar to the V-71 series of the ICD-9-CM. These codes are implemented in response to the uncertainty of identifying domestic violence during a specific encounter or the possible unwillingness of the healthcare worker to document suspicions and/or screen more carefully if domestic violence is a possibility. The suspected but unconfirmed domestic violence codes can not be used in combination with any perpetrator codes since there is only suspicion, limiting the information we can learn from the data.

Also, in recognition for the need to screen in pediatric settings, there is discussion within various governmental agencies (e.g., Health Care Finance Administration, Center for Healthcare Statistics) and among Coding Clinic board members to develop a new series of domestic violence codes that indicate a suspicion of domestic violence among *any* member of the family, not necessarily the member being treated. These codes would be used when a patient is being treated for abuse and there is suspicion on the part of the healthcare worker that abuse may have also occurred with another family member (such as the patient's mother, father or sibling in the pediatric setting or the patient's child in other settings). If developed, this new code is intended to help identify violence in the family to alert healthcare workers to the possibility of future abuse.

Appendix D:

**Fiscal Year 1999 DRG Weights
and REI standardized for Large Urban Cities**

DRG	Case Mix Weight	Urban Adjusted REI
Domestic Violence w/cc	.8651	\$2793.00
Domestic Violence wo/cc	.2958	945.42
Concussion w/cc	1.0237	3305.44
Concussion wo/cc	.5651	1824.66
Chest Trauma w/cc	1.3207	4264.42
Chest Trauma wo/cc	.5625	1816.26
Pneumonia w/cc	1.0622	3429.75
Pneumonia wo/cc		2218.91
Fracture of the Femur	.6872	3053.58
Fractured, sprained, strained, dislocated upper arm or lower leg		
w/cc	1.0114	3265.72
wo/cc	.3868	1248.94

The above \$ figures do not take into account type of hospital or region of the country. For more information please go to www.tricare.osk.mil/DRGrates

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