Manual M-1, Operations. Part I, Medical Administration Activities

Chapter 22, Unauthorized Medical Services (Sections I through III; Paragraphs 22.01 through 22.16)

Rescinds Chapter 22 dated, August 23, 1984

This document includes:

Title page and Foreword for M-1, Part I, dated **May 27, 1968** (Change 107)
Contents page for M-1, Part I, dated **July 27, 1993**
Contents and Rescissions pages for Chapter 22, dated **February 19, 1993**
Text dated **February 19, 1993**

Transmittal sheet located at the end of the document:

Sheet dated **February 19, 1993**

Changes prior to 1993 also located at the end of the document:

Change 1, dated **October 15, 1985**
Transmittal sheet, dated **August 23, 1984**

Changes prior to 1984 also located at the end of the document:

Change 1, dated **March 26, 1973**
Transmittal sheet, dated **November 17, 1972**

PART I

M-1

CHANGE 107

VETERANS ADMINISTRATION

DEPARTMENT OF MEDICINE AND SURGERY MANUAL

OPERATIONS

PART ONE

MEDICAL ADMINISTRATION ACTIVITIES

MAY 27, 196

WASHINGTON, D.C. 20420

Department of Medicine and Surgery
Veterans Administration
Washington, D.C. 20420

May 27, 1968

Part I, "Medical [Administration] Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is published for the compliance of all concerned.

H. M. Engle

H. M. ENGLE, M. D.
Chief Medical Director

Distribution: RPC: 1016
FD-PRR

May 27, 1968

M-1, Part I
Change 107

FOREWORD

VA Department of Medicine and Surgery Manual M-1, "Operations," promulgates certain policies and mandatory procedures concerning administrative management and medical [administration] operational activities of the Department of Medicine and Surgery. It is for [ ] application at all VA [ ] hospitals, domiciliaries, centers, regional office outpatient clinics, VA outpatient clinics, [ ] the VA prosthetic center, prosthetic distribution centers, and all Veterans Canteen Service installations.

This manual consists of [seven] parts as follows:

Part I --- Medical [Administration] Activities
Part II --- Prosthetic and Sensory Aids
Part III --- [Domiciliary] ~~Administration~~ Voluntary Services
Part IV --- Veterans Canteen Service
[Part V --- Performance Standards
Part VI --- Restoration Programs
Part VII --- Building Management Service]
3/10/75 Part VIII: Management Analyst Program

Parts II [through V] have been issued as complete parts. Part I is comprised of [~~27~~ 30] chapters with titles as indicated in the table of contents. Chapters, as completed, will be issued separately as changes to this manual. Each chapter has its own title page, rescission page and table of contents.

This manual will ultimately rescind the provisions of VA Manuals M10-3, M10-6, and M10-11, [ ] pertinent to medical [administration] activities. All directives not in conflict with the provisions of this manual may be utilized for informational and guidance purposes only.

[ ]

6/1/88 IX - Staffing Guidelines
6/20/89 X - CHAMPVA Program (not added)

PART I. MEDICAL ADMINISTRATION ACTIVITIES

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RESCISSIONS

The following material is rescinded.

1. COMPLETE RESCISSIONS

a. Manuals

M-1, part I, chapter 22, dated November 17, 1972, and change 1
M-1, part I, chapter 22, dated August 23, 1984

b. Interim Issues

10-74-1
10-74-26
10-77-12
10-80-25
10-84-21, and supplement 1
10-85-12

c. Directives/Circulars

10-83-180
10-89-022
10-90-064
10-91-043

CHAPTER 22. UNAUTHORIZED MEDICAL SERVICES

SECTION 1. GENERAL

22.01 BASIC AUTHORITY

a. The basic authorities for reimbursement or payment of expenses for medical services (including outpatient treatment and necessary travel expenses) obtained without prior authorization from VA (Department of Veterans Affairs) are in 38 CFR (Code of Federal Regulations) 17.80 through 17.91, 17.95 and 17.96.

b. Title 38 CFR Section 17.81 is the authority for reimbursement or payment of expenses of repairs to prosthetic appliances and similar devices furnished without prior authorization.

22.02 DEFINITIONS

a. **Clinic of Jurisdiction.** This term refers to a VA health care facility assigned fee basis program management and payment responsibility.

b. **Chief, MAS (Medical Administration Service).** This title refers to the Chief, MAS, in a VA medical center and the Chief Medical Administration Officer, in an independent VA outpatient clinic.

c. **Clinic Director.** This title includes Associate Chief of Staff for Ambulatory Care, Chief Ambulatory Care Section, or where neither of these two positions exists, the physician who has been delegated responsibility for clinical ambulatory care activities.

d. **Emergency.** This term applies to a situation when, in sound medical judgment, delay in immediate treatment would have been hazardous to the claimant's health or life.

(1) In applying this definition, the opinion of the physician who provided the unauthorized service generally will be considered sufficient to resolve the point. The distance involved, degree of disability, availability of transportation, and weather conditions are examples of other circumstances to be considered.

(2) An emergency shall be deemed to have ended at that point when, based on sound medical judgment, a VA physician determines that an individual who received emergency hospital care or emergency medical services could have been transferred to or reported to a VA medical center for continuation of treatment for the disability (38 CFR 17.80a).

e. **VA Facilities Not Feasibly Available.** This statement means that an attempt to use VA or other Federal facilities beforehand would not have been reasonable, sound, wise or practicable, or that treatment had been or would have been denied. If available evidence indicates that the person for whom a claim is made had elected to procure medical services from private sources in preference to available VA facilities, VA facilities cannot be deemed to have been unavailable.

22.03 RESPONSIBILITIES

a. The Chief, MAS, is responsible for developing claims submitted under the provisions of this chapter, including approval or disapproval of the claim. Those portions of the claim involving professional factors will be coordinated with the medical staff.

b. Medical evaluation of all claims will be furnished by a member of the medical staff designated by the Chief of Staff or Clinic Director, to include a certification that all professional prerequisites of 38 CFR 17.80 either have or have not been satisfied.

SECTION II. JURISDICTION FOR DEVELOPMENT OF CLAIMS

22.04 WITHIN THE UNITED STATES

Claims for reimbursement or payment for unauthorized medical services rendered within the United States will be developed and resolved in the clinic of jurisdiction responsible for the area in which the services were furnished (see Consolidated Address and Territorial Bulletin 1 Series).

22.05 OUTSIDE THE UNITED STATES

Claims originating in places outside the United States will be processed as follows:

a. **Republic of the Philippines.** Claims are developed and resolved at the Regional Office, Manila, Philippines.

b. **Commonwealth of Puerto Rico.** Claims are developed and resolved at the VA Medical Center, San Juan, PR.

c. **Canada.** Claims are developed and resolved at the VA Medical Center, Washington, DC.

d. **Other Foreign Countries.** Claims may be filed with the American Embassy or consulate in the country where services were provided. Claims are developed and forwarded to the VA Medical Center, Washington, DC, for final action. Claims may be submitted directly to the VA Medical Center, Washington, DC, if the veteran has returned to the United States before having had a chance to contact the appropriate Foreign Post (see ch. 23).

SECTION III. PROCESSING CLAIMS

22.06 APPLICATION

a. VA Form 10-583, Claim for Payment of Cost of Unauthorized Medical Services, may be filed by:

(1) The veteran who received the services or the veteran's representative.

(2) The hospital or clinic or other community resource which provided the services.

(3) A person other than the veteran who paid for the services from their personal funds. NOTE: *Providers of medical services (except those in foreign countries) must include their tax identification or Social Security Number with their claim.*

b. MAS personnel will enter on each invoice the payment due date which is 30 calendar days after receipt in the unit or mail room. Unit personnel will also annotate on the invoice the date the VA accepted the services as a valid obligation of the VA. Payment will be processed via DHCP (Decentralized Hospital Computer Program). A proper invoice will include the following minimum information:

(1) Patient's name, date of birth if known, and sex.

(2) Date of admission, and discharge, death, or transfer to another hospital.

(3) Type of disposition (discharge, death, or transfer to another facility).

(4) Total charges billed for care provided, and the amount billed for payment.

(5) Provider name, address and medicare provider number.

(6) Admitting diagnosis with appropriate ICD-CM (International Classification of Diseases, Clinic Modification) Code.

(7) Principal diagnosis with appropriate ICD-CM Code.

(8) Other diagnosis with appropriate ICD-CM Code.

(9) Surgical procedures with dates of procedures and ICD-CM Codes.

c. A claim for unauthorized outpatient medical care must contain the following:

(1) Veteran's name and Social Security Number.

(2) Name and address of health care provider.

(3) Health care provider's Tax ID or Social Security Number.

(4) Invoice number and date.

(5) Date of service and fees being charged.

(6) Condition treated or description of services.

(7) CPT (Current Procedural Terminology) Code (s).

(8) Supporting medical documentation, including emergency room reports.

d. If a bill which is subject to the Prompt Payment Act does not contain the complete information listed in subparagraphs 22.06b and 22.06c, it is not a proper invoice and must be returned to the claimant within 7 calendar days indicating that payment will not be processed until the complete information is provided. This notification will stop the count of days allowed to process the bill on time. Bills for medical services to veterans for whom eligibility has not yet been established will not be considered valid obligations until eligibility for services has been established. In these cases, the claimant will also be advised within 7 calendar days that the bill is not proper until eligibility can be established. The claimant will also be advised that payment processing and the count of days allowed for payment will begin on the day eligibility is established.

e. A copy of the bill or statement of account will be attached to VA Form 10-583. Bills for medical services will be accepted if the charges do not exceed those allowed under paragraph 22.08.

f. Supporting evidence of services and supplies provided will not be required unless charges appear inconsistent with treatment rendered, or unless information on the bill is insufficient to make such a determination. Invoices for payment should be supported with adequate medical documentation, i.e., emergency room reports, hospital summaries, operating room reports, etc., as appropriate to support the medical need.

g. When a claim involves both authorized and unauthorized items, the entire claim may be processed under the provisions of this chapter. The denial of a request for VA authorization made within the 72 hour period (inpatient), and 15 day period (outpatient), does not preclude the processing of a claim for the cost of unauthorized medical care or services for the same period.

22.07 TIME LIMITATIONS

Time limitations with respect to filing and developing claims are in 38 CFR 17.85 and 17.86.

22.08 ALLOWABLE FEES

a. The methodology for determining the maximum allowable fees for medical services provided on an outpatient basis is prescribed in chapter 18. In no event will a fee greater than that charged the general public be paid.

b. The Health Care Financing Administration DRG (Diagnostic Related Group) based PPS (Prospective Payment System) is used for reimbursing/paying for non-VA inpatient care (admissions on or after November 23, 1990). The PPS covers inpatient services furnished by hospitals participating in the Medicare PPS Program, unless care was provided in a distinct unit or excluded facility.

c. Payment or reimbursement for care provided in a distinct unit or excluded facility under Medicare regulations or nonparticipating PPS hospital is made based upon 72 percent of the usual and customary charge.

d. Payment or reimbursement for care provided in the state of Maryland and the Finger Lakes Hospital Association of New York is based upon their Medicare approved unique PPS. Payments are made based upon the amount billed.

e. Payment or reimbursement for admissions in the State of Alaska between November 23, 1990, and November 22, 1991, is based upon an adjusted DRG payment methodology. Payment or reimbursement for admissions in the state of Alaska on or after November 22, 1991, is made based upon the DRG based PPS (with no adjustment made).

f. Payment or reimbursement for blood and for physician's services to the individual veteran are made on a reasonable and customary charge basis (pay amount billed unless determined to be in excess of charge for the same service in the community).

22.09 BRIEFS

Written briefs explaining the reasons for the decision will be prepared only in unusual cases when the Chief, MAS, believes they are essential to support the decision reached.

22.10 DOCUMENTING ELIGIBILITY

Documented evidence of eligibility, pursuant to 38 CFR 17.80 through 17.91, if unavailable at the clinic of jurisdiction processing the claim, will be requested from the appropriate adjudication office, and retained with records of the claim.

22.11 APPROVED CLAIMS

a. The Chief, MAS, will sign the original VA Form 10-583 on claims that meet the requirements for approval under the provisions of appropriate VA regulations and forward it to Fiscal Service with related invoices attached. A copy of VA Form 10-583 will be filed with the supporting legal eligibility documentation and related correspondence in the applicant's consolidated health record. If a record does not exist, a medical records folder will be established into which the material will be filed. (See ch. 5.)

b. The claimant (s) will be notified and furnished an explanation if the amount approved is less than the amount claimed.

22.12 REFERRAL TO VA CENTRAL OFFICE

When extenuating circumstances prevent a final decision locally, the case will be referred to the Regional Director (13_/161B for review and recommendations. A brief of the pertinent facts and a concise statement of the question(s) at issue will accompany the claim.

22.13 DISALLOWED CLAIMS

a. The Chief, MAS, will personally review all unauthorized claims for inpatient and outpatient medical care that have recommendations for an adverse decision.

(1) When a decision is made to disapprove the claim, the Chief, MAS, will complete the appropriate box in item 6 of VA Form 10-583, sign in item 7, and personally sign the letter of notification of adverse action to the claimant. **NOTE:** *These actions will not be delegated.*

(2) The original VA Form 10-583, a copy of the notification letter and all related correspondence and eligibility documentation will be filed in the applicant's consolidated health record. If a record does not exist, a medical records folder will be established into which the material will be filed. (See ch. 5.)

b. When an adverse decision is made, the letter of notification will advise the claimant of the decision and the reason for it, and of the claimant's appeal rights. A copy of VA Form 1-4107, Notice of Procedural and Appellate Rights, will be included with the letter.

22.14 RECOVERY OF MEDICAL CARE COSTS

If it is learned, upon receipt of a claim, or any time thereafter, that recovery of the cost of the care from tortiously liable, or other third parties including medical insurance companies is appropriate, cost recovery action will be initiated as outlined in chapter 15.

22.15 ADMINISTRATIVE ERROR

a. When there is evidence that any veteran, widow, child of a veteran, or other person, has suffered loss as a consequence of reliance upon a determination by VA of eligibility or entitlement to benefits, without knowledge that it was erroneously made, the facts will be developed and the case referred to the Regional Director (13_/161B) for consideration under 38 CFR 2.7(b). (See ch. 1, for information to be submitted, in addition to that required in subpars. 22.15b and 22.15c, when referral is made.)

b. Prior to referring the case, the following determinations will be made:

(1) That an erroneous determination as to eligibility for benefits was made by an employee of the VA.

(2) That a veteran has acted to the veteran's own detriment based on the erroneous determination.

(3) That the veteran who has acted to the veteran's own detriment was not aware that the determination of eligibility was made in error.

(4) The extent of the loss suffered by the individual and the remedy to be afforded.

c. Adequate evidence will be obtained from the claimant and submitted with the case, which will establish with reasonable certainty that a loss has occurred or will occur if relief is not granted, and to show the extent of the loss. The report should also contain a specific recommendation as to the kind and amount of relief to be granted.

d. In those cases where benefits were not provided to a person by reason of administrative error (38 CFR 2.7(a)), refer to chapter 1, for processing.

NOTE: *Only claims determined to be non-payable under the provisions of this chapter will be considered for processing under 38 CFR 2.7.*

22.16 REPORTS

All non-VA hospitalization authorized at VA expense will be reported in the Patient Treatment File system consistent with the provisions of VA Manual MP-6, part XVI, supplement No. 1.1, chapter 3, and in the Automated Management Information System consistent with the provisions of VA Manual MP-6, part VI, supplement 1.2, and M-1, part I, chapter 21.

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

M-1, Part I
Chapter 22

February 19, 1993

1. Transmitted is a revision to Department of Veterans Affairs, Veterans Health Administration Manual M-1, "Operations," Part I, "Medical Administration Activities," Chapter 22, "Unauthorized Medical Services."

2. Principal changes are:

a. Editorial changes have been made throughout the chapter.

b. **Paragraph 22.07:** Portion outlining time limitations has been removed.

c. **Subparagraph 22.06b:** Clarified the information required to constitute a proper bill.

d. **Subparagraph 22.06e:** Modified to indicate that denial of a request for non-VA hospital admission or outpatient medical service does not preclude the processing of an unauthorized claim for the same period.

3. **Filing Instructions**

Remove pages	Insert Pages
22-i through 22-4	22-i through 22-~~7~~6

4. **RESCISSION:** M-1, part I, chapter 22, dated August 23, 1984; VHA Circulars, 10-83-180, 10-89-022, 10-90-064, 10-91-043; and Interim Issue 10-85-12, dated April 29, 1985.

James W. Holsinger, Jr.
James W. Holsinger, Jr., M.D.
Under Secretary for Health

Distribution: **RPC: 1116**
FD

Printing Date: 2/93

Department of Medicine and Surgery
Veterans Administration
Washington, DC 20420

October 15, 1985

Chapter 22, "Unauthorized Medical Services," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

NOTE: The purpose of this change, other than editorial, is to incorporate the provisions of Interim Issue 10-85-12.

Page 22-ii, paragraph 1b: Add "10-84-21 and supp. No. 1" and "10-85-12".

Pages 22-1 and 22-2: Remove these pages and substitute pages 22-1 through 22-2a attached.

RESCISSIONS: II 10-84-21 and supp. No. 1, and II 10-85-12.

JOHN W. DITZLER, M.D.
Chief Medical Director

Distribution: RPC: 1116
FD

Printing Date: 12/85

10-238F

M-1, Part I
Chapter 22

Department of Medicine and Surgery
Veterans Administration
Washington, D.C. 20420

August 23, 1984

Chapter 22, "Unauthorized Medical Services," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is revised as indicated below:

NOTE: The purpose of this revision, other than editorial, is to:

a. Provide for a termination point for an "emergency" for the purposes of payment of expenses of medical care (pars. 22.02d and 22.07d).

b. Include the requirement that providers of medical care include their tax identification or social security number on vouchers for payment (par. 22.06a).

c. Provide for recovery of medical care costs from responsible third parties (par. 22.14).

d. Provide clarification in processing administrative error cases (par. 22.15).

Pages 22-i and 22-ii and 22-1 through 22-4: Remove these pages and substitute pages 22-i and 22-ii and 22-1 through 22-4 attached.

John A. Gronvall, M.D.

JOHN A. GRONVALL, M.D.
Acting Chief Medical Director

Distribution: RPC: 1116
FD

Department of Medicine and Surgery
Veterans Administration
Washington, D.C. 20420

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M-1, Part I
Chapter 22
Change 1

March 26, 1973

Chapter 22, "Unauthorized Medical Service," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

NOTE: The purpose of this change is to expand and revise the existing appeals paragraph to a "Notice of Procedural and Appellate Rights."

Page 22-3: Remove this page and substitute pages 22-3 and 22-4 attached. (Par. 22.13b changed.)

M.J. Musser

M.J. MUSSER, M.D.
Chief Medical Director

Distribution: RPC: 1116
FD

Department of Medicine and Surgery
Veterans Administration
Washington, D.C. 20420

M-1, Part I
Chapter 22

November 17, 1972

Chapter 22, "Unauthorized Medical Services," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is revised as indicated below:

NOTE 1: Beginning with this revision, chapter 22 will be published with its own series of changes and will carry an RPC number separate and distinct from other chapters of M-1, part I.

NOTE 2: The purpose of this change is to:

a. Provide that the Chief of Medical Administration will approve or disapprove claims for costs of unauthorized medical services (pars. 22.03 and 22.11).

b. Provide that claims initiated in Mexico will be developed and final action taken by the staff at the VA Hospital, Washington, D.C. (par. 22.05c deleted).

c. Provide that the term "administrative error" includes errors with respect to professional matters (par. 22.12b).

Pages 22-i thru 22-3: Remove these pages and substitute pages 22-i through 22-3 attached.

M.J. Musser

M.J. MUSSER, M.D.
Chief Medical Director

Distribution: RPC: 1116 assigned.
FD *(NOTE: This ID same as RPC 1016.)*