

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

### **Chapter 18, Outpatient Care-Fee (Sections I through XXII (Paragraphs 18.01 through 18.79); Appendix 18A**

**Revises Chapter 18 through Change 2, dated December 16, 1993**

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PART I  
**M-1**  
CHANGE 107

VETERANS ADMINISTRATION  
DEPARTMENT OF MEDICINE AND SURGERY MANUAL

# OPERATIONS



PART ONE

MEDICAL  
ADMINISTRATION  
ACTIVITIES

WASHINGTON, D.C. 20420

MAY 27, 196

M-1, Part I  
Change 107

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

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## 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, domiciliarys, 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]

*3/10/85 Part VIII - Management Analyst Program in 30*  
Parts II [through V] have been issued as complete parts. Part I is comprised of [27] 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, revision 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)*

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*This Chapter was Reserved, but  
was never written. It  
never existed.*

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**RESCISSIONS**

The following material is rescinded:

1. COMPLETE RESCISSIONS

a. **Manuals**

M-1, Part I, Chapter 18 dated December 21, 1983, and changes 1, 2, 3, 4, 5, and 6, and Appendix 18A

b. **Interim Issues**

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## CHAPTER 18. OUTPATIENT CARE-FEE

### SECTION I. GENERAL

#### 18.01 AUTHORITY

a. **Outpatient Treatment and Examination.** Basic authorities are Title 38 Code of Federal Regulations (CFR) 17.50b and Title 38 United States Code (U.S.C.) 1703.

b. **Transportation.** The basic authority is 38 CFR 17.100 and Department of Veterans Affairs (VA) Manuals MP-1, Part II, Chapter 3, and M-1, Part I, Chapter 25, or the appropriate VA Directives and Handbooks which replace these chapters.

#### 18.02 DEFINITIONS

a. **Clinic of Jurisdiction (COJ).** This term refers to VA health care facility assigned fee-basis outpatient jurisdiction over the geographical area in which the veteran has established residence.

b. **Clinic Director.** This term refers, when used in this chapter, to the person in charged of an outpatient clinic (OPC), or outpatient service in a VA medical center, an Associate Chief of Staff for Ambulatory Care, or another designated VA physician in a VA medical center or clinic with fee-basis responsibility.

c. **Chief, Medical Administration Service (MAS).** This term includes the Chief, MAS, of a VA medical center with fee-basis outpatient authority and the Chief, Medical Administrative Officer of an independent OPC.

d. **Austin Automation Center (AAC).** This term refers to the VA's data processing center located in Austin, TX. The AAC is responsible for providing automated data processing support for fee-basis activities to all COJs.

e. **ID Card - Identification Card.** This term applies to VA Form 10-1174, VA Fee-Basis Outpatient Medical Care Authorization, an accountable form issued to veterans eligible for fee-basis treatment who require outpatient medical services.

f. **Supportive Medical Services.** Supportive medical services include, but are not limited to treatment, care and services provided by:

- (1) Psychologists,
- (2) Chiropractors,
- (3) Podiatrists,
- (4) Registered nurses,
- (5) Licensed vocational (or practical) nurses,
- (6) Inhalation therapists,
- (7) Physical therapists, and

(8) Other professional or paraprofessional personnel as prescribed by an authorized physician.

g. **Outpatient Diagnostic Services.** Diagnostic services obtained as an outpatient on a fee or contract basis.

h. **VA Facility.** For purposes of this chapter, this term refers to a VA medical center, VA medical and regional office center, VA independent OPC, and VA outpatient satellite clinic. It can mean another Federal medical facility with which VA has contracted to provide medical services to veterans.

i. **Geographically Inaccessible.** This term refers to a location of a veteran's permanent residence which is so remote from a VA facility that it would be uneconomical to transport the veteran to a VA facility, as defined in subparagraph h. **NOTE:** *Arbitrary mileage boundaries are not to be established.* The distance of a veteran's permanent residence from a VA facility does not by itself constitute geographical inaccessibility. The combined costs of travel and care in a VA facility as compared to fee-basis care will be the determining basis. A cost comparison is required to determine whether fee medical care or VA care is more economical.

**j. Vendor and/or Fee Participants**

(1) This term refers to private physicians, clinics, group practices, psychologist, podiatrists, optometrists, nurses, pharmacists, and others who provide medical treatment, services, medications, or supplies to veterans authorized to provide medical treatment, services, medications, or supplies to veterans authorized to receive care at VA expense.

(2) The term "fee vendors" is frequently used by the AAC and Financial Management System (FMS) staff when referring to fee-basis health care providers. **NOTE:** *Generally, fee participants are licensed or registered in the State where they are practicing their professions.*

k. **Register Number.** Denotes the Social Security Number or employer's (taxpayer) identification number, as appropriate, of the fee participants. Payment to the fee participants for services rendered will be in the name and address associated with the Register Number.

l. **Fee-Basis System User Manual.** This term refers to Appendix A of this chapter. It provides detailed instructions for fee-basis operations.

m. **Decentralized Hospital Computer Program (DHCP) Fee-Basis User Manual.** This term refers to the current manual on the use of the DHCP Fee-basis Program.

n. **DHCP-Fee-basis Program.** This term refers to the DHCP used for fee-basis operations.

n. **Central-Fee System.** This term refers to the fee-basis automated data processing system maintained at the AAC.

p. **Primary Service Area (PSA).** The PSA is the geographic boundary established as being the responsibility of a specific VA facility.

q. **Treatment Plan.** For the purpose of this chapter, VA Form 10-10m, Medical Certificate, or Standard Form (SF) 509, Medical Record-Progress Note, or equivalent, which contain a basic evaluation, tentative diagnosis, and statement of planned fee-basis treatment, including estimated length of treatment, will serve as a treatment plan. The 10-10m must be completed within current VA guidelines and indicate the type of care needed, i.e., routine.

r. **Comprehensive Treatment Plan.** For the purposes of this chapter, a comprehensive treatment plan can be considered a progress note, or equivalent, which gives:

(1) An assessment and/or evaluation of the patient,

- (2) Diagnosis(es),
- (3) Goals and objectives of fee-basis treatment, and
- (4) Estimated length of treatment will be considered.

s. **Visits.** For the purposes of this chapter, a visit is defined as:

- (1) Same patient,
- (2) Same medical center,
- (3) Same vendor,
- (4) Same purpose of visit, and
- (5) Same treatment date.

t. **Responsible Facility.** The VA facility responsible for the PSA where the veteran resides is the responsible facility for outpatient fee-basis care. The responsible facility authorizes and pays for outpatient fee-basis care for veterans residing within their PSA.

### 18.03 BASIC POLICY

a. Provisions of the law call for all veterans who seek care at VA expense, including those with special eligibility, to obtain such care in VA facilities.

(1) When appropriate VA officials determine that certain VA services are unavailable, or cannot be economically provided due to geographic inaccessibility, a veteran with special eligibility may be authorized fee-basis care, but only as described in this chapter.

(2) Should a veteran's condition or situation change, or, if a VA facility's capability is extended, constraints of law require that the authorization for fee-basis care be canceled, and that the veteran be requested to return to the VA facility for needed medical services.

(3) Fee-basis authorization will **not** be considered a permanent status for any veteran. There will be active, continuing participation by VA administrative and clinic managers and by other staff working in the fee-basis program to ensure compliance with this basic policy

b. The clinic Director and the Chief, MAS, are the officials who authorize fee-basis care, but only for veterans, as described in subparagraph c, who cannot economically travel to a VA facility because of illness, debility, or geographical inaccessibility, or when a VA facility does not have the capability to furnish the needed medical services. **NOTE:** *The number of authorized fee-basis visits will be at the discretion of the clinic Director; this determination is based upon the medical needs of the patients.*

c. Following the basic policy outlined in subparagraphs, a and b, fee-basis care may be authorized for the following veterans:

(1) A service-connected veteran for any service-connected disability, or for an adjunct condition, including a veteran who was released from the Armed Forces because of disability incurred in line of duty for that disability.

(2) A service-connected veteran whose disability(ies) is rated 50 percent or more, for any condition other than dental.

(3) A veteran who is eligible for to participate in a Rehabilitation Program under 38 U.S.C. Chapter 31 and who is medically determined to be in need of medical services for any of the following reasons, to:

(a) Make possible the veteran's entrance into a Rehabilitation Program; or

(b) Achieve the goals of the veteran's Vocational Rehabilitation Program; or

(c) Prevent interruption of a Rehabilitation Program; or

(d) Hasten the return to a Rehabilitation Program of a veteran placed in discontinued status because of illness, injury or dental condition; or

(e) Hasten the return to a Rehabilitation Program of a veteran in interrupted or leave status; or

(f) Secure and adjust to employment during the period of employment assistance; or

(g) Enable the veteran to achieve maximum independence in daily living.

(4) A veteran who received VA inpatient care, for treatment of nonservice-connected conditions for which treatment was begun during the period of inpatient care. The outpatient treatment, both medical facility and fee-basis combined, may not continue for a period exceeding 12 months following discharge from the VA facility except when the attending VA physician finds that a longer period is required by virtue of the disabilities being treated, and such findings are to be documented in the veteran's medical records.

(5) A veteran of the Mexican border period, for any condition other than dental, when it has been determined based on an examination by a physician employed by VA, or by a fee or contract physician in areas where a VA-employed physician is not available, that the medical condition of this veteran precludes appropriate treatment in a VA facility.

(6) A veteran of World War I, for any condition other than dental, when it has been determined based on an examination by a physician employed by VA, or by a fee or contract physician in area where a VA - employed physician is not available, that the medical condition of this veteran precludes appropriate treatment in a VA facility.

(7) A veteran receiving increased VA pension for Aid and Attendance or Housebound benefits, for any condition other than dental, when it has been determined based on an examination by a physician employed by VA, or by a fee or contract physician in areas where a VA-employed physician is not available, that the medical condition of this veteran precludes appropriate treatment in a VA facility.

d. Medical Administration applies an expiration date to each fee-basis authorization. Monthly, the AAC will mail to MAS a list of the names of veterans whose authorizations expire during the next 3 months. The AAC continues monthly follow-up reports on these veterans until it receives notices of disposition made on all of them by the clinics.

(1) This policy assumes most authorizations will expire on schedule and the veteran's need for care will have been met. If the clinic Director decides the episode of care is incomplete, MAS will either cancel the authorization and schedule the veteran for VA staff care, or extend the fee-basis expiration date. In any case, the clinic Director will decide which action is appropriate.

(2) In making the decision, the clinic Director reviews the veteran's medical record, consults with the fee-basis provider, as needed, and with the advice from MAS considers the relative total cost of each action. The clinic Director documents the decision on SF 509, Medical Record--Doctor's Progress Note, which is then filed in the veteran's medical record.

e. The policy presumes that veterans authorized VA fee-basis care will select fee participants who will furnish to them ethical and sound medical services.

(1) Medical services are personal services which the fee participant either renders personally to the veteran, or orders the necessary medical services and supervises another fee participant who renders the medical services personally to the veteran.

(2) VA responsibility for the care and treatment furnished under the fee program is limited to payment of fees for services provided.

(3) For purposes of this chapter, the term "medical service" includes, but is not limited to:

(a) Medical examination,

(b) Outpatient treatment and rehabilitative services,

(c) Certain minor outpatient surgical procedures,

(d) Optometric examinations,

(e) Podiatric outpatient services, and

(f) Medications, drugs and supplies incidental to the authorized outpatient care.

(4) Homemaker, domestic-type services (such as house cleaning, meal preparing, companion, etc.), are not medical services and shall not be authorized under the fee-basis program but may be authorized under the Pilot HomeMaker/Home Health Aid Program (see par. 18.78c).

(5) The clinic Director is the final authority for deciding if a service performed by a fee participant constitutes medical services. **NOTE:** *The medical center or clinic Director can consult the Regional (VISN) Director for assistance in resolving any questions on what may be defined as a medical service.*

f. Fee participants are not required to be United States citizens. Clinic directors are responsible for determining whether the non-citizen provider may become a fee provider based upon the non-citizen's ability to provide quality medical services.

g. Active duty members of the Armed Forces cannot provide medical services as fee participants because of the prohibition against dual compensation from the Federal government.

h. A family member may receive reimbursement for provisions of bowel and bladder care and/or home health services when the following conditions are met:

(1) The family member has been trained and certified by a Spinal Cord Injury Center as being competent to provide bowel and bladder care.

(2) Reimbursement will not exceed the hourly rate paid to nursing assistants employed by VA at a VA facility.

#### 18.04 BILLING

a. Recovery of the cost of medical care should be initiated in the following instances:

(1) Allied veterans,

(2) Workers compensation,

(3) Motor vehicle accident,

(4) Crime of personal violence,

- (5) Tortfeasor,
- (6) Beneficiaries of other Federal agencies, and
- (7) Third party health insurance.

**NOTE:** Refer to M-1, Part 1, Chapter 15, "Charges and Payments for Medical Care," for specific guidelines regarding medical care cost recovery.

b. Category C veterans, i.e., those veterans eligible for outpatient care under 38 CFR 17.60(m), who agree to make a copayment to VA who have been authorized fee-basis medical care will be billed at 20 percent of the current rate for an OPC visit as listed in M-1, Part 1, Chapter 15, Appendix 15A, for each visit made to a fee-basis provider. If the fee-basis provider's actual charge is less than 20 percent of the current VA outpatient billing rate, the veteran will be billed the actual charge.

c. VA Form 10-9014, Statement of Charges for Medical Care, must be issued to the veteran for copayment.

#### **18.05 CONTROLS**

Clinics of jurisdiction must ensure proper controls are implemented to maintain the integrity of the fee-basis system. The following procedures must be followed to ensure that adequate controls are in place:

- (1) The same employee who opens a batch must make all the payments within that batch and close the batch;
- (2) The same employee who opens a particular batch cannot certify the same batch;
- (3) The same employee who opens a particular batch cannot transmit the same batch; and
- (4) Payments may only be deleted from an open batch by the employee who entered the payment.

(5) Security keys have been established to limit those persons who can complete certain functions within the fee-basis package. The Chief, MAS (Medical Administration Service), should provide guidance to Information Resources Management regarding those individuals to be issued security keys.

(6) The security key FBAASUPERVISOR should be given to the Assistant Chief, Medical Administration Service, and Chief, Fee Services Unit (or Lead Clerk). In some larger clinics of jurisdiction, it may be appropriate to give this key to the Chief, Fee Services Unit and Lead Clerk, in addition to the Assistant Chief, MAS.

(7) Only holders of the security key FBAASUPERVISOR can perform the following:

- (a) View the "Valid ID Cards List";
- (b) Enter obligations;
- (c) Make adjustments to obligations;
- (d) List batches pending release;
- (e) Print rejected payment items;
- (f) Release a batch to Austin for payment;
- (g) Enter changes into the Vendor Master Record;
- (h) Finalize a batch;
- (i) Delete reject flag;
- (j) Queue data for transmission;
- (k) Enter or edit site parameter information;
- (l) Add or change a vendor in the Central Fee file;
- (m) Edit payments from batches that have been released;
- (n) Print VA Form 10-7079 for a specified date range;
- (o) View obsolete ID Card List;
- (p) Re-open a batch other than their own;
- (q) Reinitiate rejected payment item; and
- (r) Compile fee schedule.

(8) The security key FBAA ESTABLISH VENDOR should be given to the Assistant Chief, Medical Administration Service and Chief Fee Services Unit. These individuals should also be given access to view CALM through submission of VA Form 30-9957, Timesharing User Access Request. The FBAA ESTABLISH VENDOR security key will allow the user to enter a new vendor into the system or edit existing vendor data.

(9) The Chief, MAS, should be the individual to use the option "Compile Fee Schedule" to activate a change in the fee schedule.

(10) Fiscal Service should be given option Finalize a Batch, Delete Reject Flag and Adjustment to Obligation Entry. A 994-10 code sheet will be done by Fiscal Service through IFCAP for payment of invoices.

## SECTION II. PROGRAM MANAGEMENT

### 18.06 TERMINATING PARTICIPATION OF VENDORS IN THE FEE PROGRAM - DUE PROCESS

a. The clinic Director may propose that a vendor should be terminated from participation in the fee program for failure to comply with program requirements.

b. In emergency situations such as when a vendor's participation in the program would threaten the physical or mental health of a beneficiary, the clinic Director may summarily terminate participation, and then follow the due process procedures set forth in subsection c. In such cases, the clinic Director shall provide immediate notice of the termination to the vendor and to all beneficiaries known to receive care from the vendor.

c. To terminate participation of a vendor, the clinic Director shall, except as provided in subsection b, mail to the vendor (using return receipt mail) written notices of the VA's intention to terminate participation. The notice shall state specific reasons for the proposed termination. It shall also state that the vendor may, within 14 days of receiving the notice, furnish the clinic Director written reasons why the termination should not be carried out, and may furnish any other evidence pertinent to the decision. The clinic Director, may with discretion, extend the time period provided to the vendor for responding to the notice of termination, and may agree to hear oral testimony from the vendor or the vendor's representative.

d. After considering the response of the vendor, if any, and any other evidence submitted by the vendor, the clinic Director shall make a final determination and notify the vendor in writing of the determination. If participation is terminated, the notice shall state the effective date of the termination. The notice shall also state that the vendor may appeal the decision to the Director of the medical center where the clinic of jurisdiction is located.

e. If the vendor appeals to the director of the medical center, all of the evidence considered by the clinic Director shall be furnished to the Director of the medical center for consideration. A final written decision signed by the medical center Director shall be provided to the vendor.

### 18.07 GENERAL

a. The clinic Director, or medical center Director, may establish an advisory group, under the provisions of M-1, part I, chapter 1, section VII, and assign to this group the responsibility for formal, periodic reviews to determine the effectiveness of control and appropriateness of utilization of their facility's fee-basis authority. If an advisory group is not assigned this responsibility the clinic Director will assure that reviews are completed through another mechanism. These reviews will be similar to reviews for VA staff outpatient and inpatient care programs. The reviews will be conducted on an annual basis (at a minimum). The findings and recommendations presented will be documented in writing. Those documents will be made available to Central Office survey teams upon request. The clinic Director is responsible for the development and updating of the fee-basis program plan, consistent with population and illness factors in their primary service area, for the judicious use of funds allocated to their facility for fee-basis care.

Efficiency reviews will be conducted in accordance with current guidelines.

b. Programs will be established and reviews will be done for areas of the fee-basis program as needed to meet the requirements of the JCAHO (Joint Commission for Accreditation of Healthcare Organizations) and MP-1, part II, Chapter 15, "Internal Control Systems."

c. A Memorandum of Understanding will be established by each clinic of jurisdiction with any other VA facilities where patient treatment may cross over PSA lines. This Memorandum of Understanding will be a signed agreement between facilities on how specific situations will be handled regarding fee-basis programs. The Memorandum of Understanding will be completed prior to July 1, 1991, and will be reviewed and updated as necessary. Unusual problems which occur regarding authorization of care, payment of bills, etc., for fee-basis care which can not be decided between VA facilities will be referred to the Regional Director for a final determination.

#### **18.08 NONCOMPLIANCE WITH PROGRAM REQUIREMENTS/INTERNAL CONTROLS**

a. All personnel who are involved in any aspect of administering the fee-basis program must be continuously alert for any irregularities and practices by individuals or groups participating in the fee-basis program that are not in keeping with program policy and criteria. Invoices, payments and visits information as well as the monthly veterans payment analyses listings and the semi-annual tabulated listings of fee-participants' gross earnings are example of items, that when reviewed separately or in combination may indicate misuse of the program. When potential program abuses or other program irregularities are found, the Chief, Medical Administration Service, will be notified immediately and when appropriate, immediate remedial action will be taken. The Chief, Medical Administration Service, will also report significant findings of program abuses and other program irregularities to the clinic Director. Refer to MP-1, part II, Chapter 15, "Internal Control Systems," for further information regarding internal control directives and risk assessments.

b. Each clinic of jurisdiction should complete an internal control review of the locally identified areas of the fee-basis system on an annual basis. Current VA directives and applicable chapters of MP-1, part II, will serve as guidelines for establishment and completion of internal control reviews.

c. The clinic Director, or medical center Director, will obtain the advice and assistance of the District Counsel having jurisdiction when non compliance by either veterans or fee participants cannot be resolved satisfactorily at the clinic level.

#### **18.09 PROFESSIONAL REVIEW OF MEDICAL INVOICES**

a. Professional review of medical invoices will be limited to those invoices which require a medical evaluation and decision. The reviewing physician will annotate the invoice as to the action to be taken, initial and forward it for administrative processing. When the number of treatments has increased markedly, or other information indicates a change in the veteran's condition, the reviewing physician will schedule the veteran for staff examination and evaluation, consult the fee-basis physician, or take other appropriate action. The results of these evaluations will be documented on an SF 509 for filing in the veteran's CHR (Consolidated Health Record).

b. Results of these evaluations may serve to meet the review requirements prescribed by paragraph 18.22b. When an evaluation for this purpose is conducted, a copy of

pertinent findings will be sent to the veteran's fee physician, nursing agency or other individuals providing treatment or medical supportive services.

#### **18.10 RESOLVING DIFFERENCES OF PROFESSIONAL OPINION**

When there is a difference of opinion between the VA physician reviewing medical invoices and the fee-basis physician with respect to medical needs, every effort will be made to resolve the difference in a manner which will maintain good professional relations. When necessary, advice or assistance of the clinic Director should be obtained.

#### **18.11 PROFESSIONAL REVIEW AND AUDIT OF FEE-BASIS PRESCRIPTIONS**

Professional review and audit of fee-basis prescriptions will be conducted as prescribed in the "Invoice Processing" section of the Fee-Basis System User Manual.

#### **18.12 ANALYSES OF PHYSICIAN/PHARMACY GROSS EARNINGS LISTINGS**

a. Report No. 80002, a tabulated listing in duplicate, reflecting each fee medical and pharmacy vendor's gross earnings under this program will be sent by the DPC to each clinic every April and October. The listing sent in April reflects the earnings by fee vendors from October through March. The listing sent in October reflects the earnings by fee vendors from October through September. The earnings are listed in order of the highest to the lowest amounts earned. These lists are accompanied by another list identifying the veterans treated or provided services by each of the fee vendors. The Chief, Medical Administration Service, with assistance from professional staff as may be required, will analyze the fee vendor's fee-basis income reported on these tabulations to determine if such income appears inconsistent with established policies, the veteran population served by the fee vendor, the usual frequency and treatment furnished, etc. All fee-basis services provided by individual fee participants/vendors with gross earnings of \$40,000 and above during October through March and \$80,000 and above during October through September must be given particular attention in these analyses.

b. Findings of these analyses will be furnished to the clinic Director promptly upon its completion, but not later than 6 weeks after receipt of each fee participant's gross earnings tabulation. When, in the opinion of the clinic Director, the total amount paid to a fee participant/vendor during the period analyzed appears excessive or unrealistic under the prevailing circumstances, the medical center Director (if applicable) will be notified. After review by the medical center Director, the appropriate Regional Director will be provided with a complete report of the matter, including corrective actions taken or appropriate recommendations to be considered to prevent abuse of this program.

#### **18.13 WORKFLOW**

All processing areas concerned with applications for treatment should be studied and evaluated regularly to assure a smooth expeditious workflow. Since applications may be received in several working areas and in different ways, i.e., VA Form 10-10, letters, telegrams, or telephone, it is important that a systematic review be comprehensive. The Chief, Medical Administration Service, must be aware of factors which delay processing and take prompt remedial action. The staff should be particularly alert for cases which appear to indicate an emergency. These cases should be singled out for prompt professional decision and special handling.

**18.14 COMMUNICATIONS AND CORRESPONDENCE**

a. The preparation of correspondence is the joint concern of the clinic Director and the Chief, Medical Administration Service, and will be initiated for the signature of either individual, as appropriate. The person to whom correspondence is directed and the nature of its contents will be the basis for determining which official will be responsible for composition and signature unless responsibility for signature is specified in this chapter.

b. Continual systematic checks of outgoing correspondence addressed to fee-basis vendors, veterans, and others, should be made. Letters should be neatly typed and based on principles of the "4-S Formula For Writing Letters," (MP-1, pt. II, ch. 10, app. B). Replies to incoming correspondence should be made within 10 workdays of receipt of correspondence. If there will be a delay, an acknowledgment will be sent. It is essential that telephone conversations with vendors, their staff, VA beneficiaries, and others, be conducted in a courteous, friendly manner. VA Form 119, Report of Contact, should be made when appropriate to have a complete, informative record. A Report of Contact may be completed through use of the DHCP Fee-Basis package. The instructions for preparation of a Report of Contact are contained in the "Medical Fee - Registration Options" section of the DHCP Fee-Basis User Manual.

c. Requests for information related to any record of the fee-basis program (e.g., medical records, fee participants, etc.) are subject to the restrictions of the Privacy Act of 1974 and the provisions of the Freedom of Information Act. Requests will be processed under the provisions of M-1, part I, Chapter 9, "Release of Medical Information." Information, however, will be provided in response to inquiries from vendors concerning claims they have submitted for payment for fee-basis services they have rendered.

**18.15 BUDGET**

a. The Chief, Medical Administration Service, is responsible for budget management. This includes preparation of budget estimates for the fee-basis program, cost estimates which take into consideration realistic medical care needs, execution of the fiscal operating plan and compliance with the fee-basis program plan. Appropriate measures should be adopted which will assist in reaching these objectives.

b. Development, planning and execution of budget requirements will be accomplished in close coordination with, and through exchange of ideas between, the Chief, Medical Administration Service, the medical center Director and the clinic Director and in compliance with guidelines established within the region.

c. Non-VA hospital workload funding (.27 - Fee Medical, .21 - Contract Hospital and .28 - Fee Dental) are unarmarked and decentralized to all medical centers.

d. Payment for home oxygen is to be made from .01 funds as follows:

(1) If the veteran is on fee-basis for medical care, home oxygen should be paid for by the COJ.

(2) If the veteran is being treated at a VA medical center, home oxygen should be paid for by the treating medical center.

**18.16 REVIEW OF ID CARD STATUS**

a. Veterans will not automatically have their ID card terminated at the end of their authorized period of validity. The clinic Director will review the veteran's medical

record, consulting with the fee-basis provider as necessary, prior to making a determination. If fee-basis care is warranted, it should be continued. When a veteran has been receiving care with the same treating physician for an extended period of time and the termination of fee-basis status could interfere with the patient's progress, this may be a valid reason for continuing fee-basis care. Veterans in receipt of psychiatric services through the fee-basis program require special consideration with regard to termination of services, i.e., consideration of an established relationship between the veteran and care giver.

b. The clinic Director may request to have the veteran report for an examination for a determination regarding continuation/termination of ID card status when such a determination cannot be made from existing records.

### **SECTION III. REQUESTS FOR OUTPATIENT MEDICAL SERVICES**

#### **18.17 EVALUATION FOR FEE-BASIS CARE/TREATMENT PLANS**

a. If a veteran is authorized an evaluation (as a one-time visit) for fee-basis care via VA Form 10-7079, the evaluation will include a physical examination and treatment plan. The VA physician will then review the evaluation, physical examination and treatment plan and either approve or disapprove fee-basis care. The original treatment plan will be filed in the veteran's CHR and a copy returned to the fee-basis physician. If VA physician feels fee-basis care should be authorized but that the treatment plan submitted is not acceptable the VA physician will request a modification of the treatment plan prior to authorization of fee-basis care.

b. If a veteran is evaluated for and placed on fee-basis care by a COJ, the VA physician will do a treatment plan.

c. The VA physician may want to request that a treatment plan, or comprehensive treatment plan (as determined necessary by VA), be submitted by the fee-basis physician under the following circumstances:

- (1) Request to exceed the \$125.00 monthly limit for routine care;
- (2) Fee-basis physician's request for supportive medical services on an ongoing basis;
- (3) A significant change in the patient's condition; or
- (5) A significant change in treatment being provided.

d. All veterans being treated on HBHC (Hospital Based Home Health Care) and SCI (Spinal Cord Injury) Home Care will have a treatment plan which meets the requirements of JCAHO.

#### **18.18 ROUTINE AUTHORIZATIONS**

Initial applications or requests for outpatient treatment, other than emergent or when prompt medical care is required, must be approved prior to the time treatment is obtained.

**18.19 AUTHORIZATION OF EMERGENT TREATMENT**

When outpatient treatment is obtained without advance authorization due to need for emergent or prompt medical services, a fee-basis authority may be approved for the 15-day period preceding the date of receipt of notification by VA. Notice may be made by telephone, telegram, or other appropriate means, by the veteran or someone acting in veteran's behalf. The date of receipt of a telephone notice, dispatch date of a telegram, or postmark of a letter will be accepted as the date of notification. The first date on which approved services were rendered during the 15-day period will be entered as the initial date in the "Period of Validity" block on VA Form 10-7079, Request for Outpatient Medical Services.

**18.20 PREPARATION OF AUTHORIZATIONS FOR FEE-BASIS OUTPATIENT MEDICAL SERVICES**

VA Form 10-7079 is the source document which will be used for authorizing fee-basis outpatient medical and supportive medical services. Instructions for its preparation and distribution as provided in "Requests for Outpatient Medical Services" section of the Fee-Basis System User Manual and in "Medical Fee - Enter Authorization" section of the DHCP Fee-Basis User Manual will be followed.

**SECTION IV. ESTABLISHING FEE-BASIS STATUS****18.21 BASIC CRITERIA**

a. Fee-basis treatment will not be approved unless criteria in paragraph 18.03 are met and outpatient medical or nursing services are currently required for specific conditions. Authorizations will be issued only for those conditions that currently require care that cannot economically be provided in a VA facility. The authorization may be for specific, listed, condition(s) or "outpatient treatment for any medical condition" as determined to be medically necessary.

b. The authority to approve outpatient fee-basis care is the responsibility of the clinic Director at the VA health care facility which has responsibility for the PSA (Primary Service Area) in which the veteran resides. If the responsible VA facility is not a COJ, the COJ must coordinate the processing of the application for fee-basis care with the responsible VA facility. If a veteran is in receipt of outpatient medical services at a VA facility and requires additional services that must be provided on a fee-basis, the authorization (and payment) for these services should be handled by the VA health care facility which has responsibility for the PSA in which the veteran resides. In some cases, this may mean that a veteran is receiving treatment in one VA facility and authorization and payment for fee services may be the responsibility of another VA facility. Prior to authorization of fee-basis care by the second facility alternative methods of treatment should be considered. Procedures are to be established to assure processing of applications for fee-basis care does not exceed 10 days. A veteran may be placed on fee-basis activity at up to three clinics of jurisdiction. If activity is attempted at more than three clinics of jurisdiction the fourth COJ will not be allowed to add the veteran to its files until at least one of the other clinics of jurisdiction removes the veteran's name from its records.

c. When you have added a veteran to your medical center and the veteran is on fee-basis through another COJ, you will receive a warning notice from the

Austin DPC that the veteran is on another medical center's veteran list. You should contact the other medical center to determine the veteran's permanent residence. Action should be taken accordingly. Veterans should normally be on fee-basis status at only one COJ. Exceptions would be veterans who reside in another part of the nation during a substantial part of the year, i.e., veterans living Minnesota who reside in the state of Florida during the winter months. Medical centers must carefully monitor veterans enrolled in the fee-basis program at multiple clinics of jurisdiction.

d. Veterans who have a permanent change of address which places them in the primary service area of a VA health care facility other than the one which authorized fee-basis care will be evaluated by the new facility. The provisions of M-1, part I, chapter 5 will be applied with respect to the transfer of medical records. Continuation of fee-basis care will only be approved if the receiving facility finds the veteran still meets the criteria established in paragraph 18.03.

#### **18.22 ID CARD FEE-BASIS STATUS**

a. Veterans, not temporarily or permanently residing in foreign countries, who are eligible for fee-basis treatment by meeting the basic criteria and who currently require medical services for a specified period of time, as indicated by a VA staff physician's treatment plan, will be issued an ID card, VA Form 10-1174, VA Fee-Basis Outpatient Medical Care Authorization. ID card fee-basis status will not be authorized on a prima facie basis except under the provisions of 38 CFR 17.35. This card may be used by the veteran to obtain outpatient medical services from a licensed physician of choice for the approved disabilities recorded on the card.

b. The expiration date will not be shown on the ID card; however, a specific validity period for each authorization will be estimated by the clinic Director's professional designee. The estimated validity period will be based on each veteran's eligibility status and on the nature of the condition(s) which are to be provided care under the ID card authorization. The validity periods will not exceed a period of 36 months. The estimated validity period, including its expiration date, will be recorded on the individual's initial VA Form 10-7079. Reviews, as prescribed in paragraph 18.03d, to determine the need to continue each veteran on a fee-basis status must be conducted at a minimum of every 36 months from the date of the beginning of the period of validity of the veterans latest fee-basis authorization.

c. Eye examinations performed by an optometrist or ophthalmologist for the determination of refractive error are considered authorized care under the fee program when the ID card authorizes "Outpatient treatment for any condition." Eyeglass prescriptions written by the optometrist or ophthalmologist must be sent to the appropriate COJ for filling as a prosthetic item.

d. An SF 509 will be annotated by the authorizing physician to reflect the service-connected and other disabilities approved for treatment, and the reason for authorizing a fee status in lieu of providing VA staff treatment.

e. In all instances, VA Forms 10-1174 will be prepared locally. VA Forms 10-1174 are numbered, accountable forms and must be safeguarded by storage in a locked drawer. Each form issued, canceled, or destroyed for any reason must be accounted for by an entry containing its accountable number and a description of type and date of disposition on VA Form 10-1174a, Accountability Record of VA Fee-Basis Outpatient Medical

Care Authorization. Each entry will bear the signature of the employee making disposition of the VA Form 10-1174 as verification of its accuracy. An ID card will be reissued when loss or card deterioration is reported, a change in service connection occurs, or the clinic Director determines a service-connected or adjunct disability is to be added or deleted from the card. The accountable number of the VA Form 10-1174 issued to a veteran will be recorded on VA Form 10-7079.

f. FL 10-431, Letter of Approval for Fee-Basis Outpatient Treatment (Selected), and VA Form 10-1174 will be mailed to the veteran at the time of initial issue or reissue of ID card fee-basis authorization. VA Form 10-1174b, Non-VA Hospitalization and Non-VA Outpatient Treatment Benefits, should be enclosed.

g. Whenever VA terminates a veteran's fee-basis authorization, or denies a request for fee-basis care, the veteran will be advised of the decision in a letter signed by the Chief, Medical Administration Service, which explains the reasons for the denial or termination. If the termination or denial is based upon the veteran's failure to meet a legal eligibility requirement; e.g., the veteran is not service-connected, the letter shall advise the veteran that a notice of disagreement and appeal may be filed to the BVA (Board of Veterans Appeals). If the termination or denial is based upon a medical judgment, e.g., care can be provided in a VA facility, the letter shall advise the veteran that they may appeal the determination to the medical center Director at the responsible VA facility.

h. In the latter case, if the medical center Director does not grant the appeal, and the veteran seeks to appeal the case to the BVA, the veteran will be informed that the BVA has advised that it lacks jurisdiction over the matter. If the veteran insists that BVA review the case, the Chief, Medical Administration Service, will prepare a Statement of the Case. The "Issue" section of the Statement of the Case will contain language showing that the BVA has indicated that they do not have jurisdiction over the issue, but that the veteran is challenging this position and wishes to appeal to BVA on the basis of jurisdiction. The "Pertinent Law and Regulations" section will cite 38 CFR 19.1. All appeals to the BVA will be completed by the COJ.

### **18.23 HOME NURSING SERVICES**

The provisions of M-1, part I, chapter 30, section III, will apply for authorizing home nursing services on fee-basis to eligible veterans.

### **18.24 SUPPORTIVE MEDICAL SERVICES RECOMMENDED BY A VA STAFF PHYSICIAN**

Supportive medical services will be prescribed and monitored by a VA staff physician. VA Form 10-7079 will be processed in keeping with instructions in the "Requests for Medical Services" section of the Fee-Basis System User Manual.

### **18.25 AMBULATORY SURGERY**

a. Certain diagnostic and minor surgical procedures performed on an ambulatory basis may be authorized when medically indicated for the specific disabilities listed on a veteran's ID card and for veterans issued ID cards authorizing "Treatment for Any Outpatient Condition." Normally, fee physicians will be required to request authority in advance of rendering such services; however, payment may be approved for these services

when rendered for emergent conditions. Ambulatory surgery which may be authorized is limited to surgical procedures which can be done at no added risk to patients on an outpatient basis. These surgical procedures are the types usually accomplished under local anesthesia and done in properly equipped and staffed sites which meet professionally acceptable standards. Cosmetic surgery, dental surgery, voluntary sterilization procedures or similar elective procedures will not be authorized. The advice of appropriate VA professional staff will be requested for resolving questionable claims for payment relating to ambulatory surgery.

b. The following examples include, but are not limited to, the type of procedures that may be authorized:

- (1) Excision of cutaneous and subcutaneous lesions;
- (2) Suture of simple lacerations and minor plastic procedures, such as simple small skin grafts or movement of small skin flaps;
- (3) Excisional biopsies;
- (4) Simple foreign-body surgery;
- (5) Diagnostic procedures such as laryngoscopies, bronchoscopies, sigmoidoscopies, thoracenteses, and paracentesis;
- (6) Nerve blocks for control of pain;
- (7) Application of casts; and
- (8) Reduction of uncomplicated dislocations and fractures.

c. Payment of claims for authorized ambulatory surgery will be made in accordance with the provisions of paragraph 18.70. Fees should not exceed the usual and customary charges to the general public in the community for similar services.

#### **18.26 SUPPORTIVE MEDICAL SERVICES RECOMMENDED BY A PRIVATE PHYSICIAN**

Supportive medical services must be prescribed by an authorized fee physician. The treating fee physician is expected to estimate the total cost of services plus the cost of supportive medical services of other physicians or other health care providers the physician recommends.

#### **18.27 BOWEL AND BLADDER CARE FOR QUADRIPLEGIC VETERANS**

a. Bowel and bladder care is considered a supportive medical service when provided to quadriplegic veterans and may be authorized as a home health service on fee-basis. Bowel and bladder care may also be authorized for veterans with spinal cord injuries (other than quadriplegics) when a VA physician determines that compelling medical reasons warrant issuing such authorization.

b. Veterans who meet the eligibility requirements for fee-basis care may be provided bowel and bladder care on a fee basis (see par. 18.03c).

c. Bowel and bladder care should be provided by a licensed or registered health care provider or a trained paraprofessional working under the direction and supervision of a

licensed health care provider. (See subpar. 18.03h concerning authorization of this care by a family member.)

d. Payment of claims for authorized bowel and bladder care will be made in accordance with the provisions of paragraph 18.70.

e. Bowel and bladder care at VA expense may be authorized for a veteran in receipt of Aid and Attendance, including High Level A&A.

#### **18.28 RECORDING MEDICAL TERMINOLOGY ON ID CARD**

a. The nomenclature to be recorded on ID cards for identifying disabilities approved for treatment will be described in accordance with the latest edition of the AMA (American Medical Association's) publication, CMIT (Current Medical Information and Terminology), except for psychoneurotic and psychiatric conditions which will be described as "Nervous Disorders." Clinic Directors may approve terminology other than listed in CMIT. Deviations should be limited to instances when the disability approved for treatment is not listed or when warranted by other special circumstances.

b. The provisions of M-2, part I, Chapter 17, "Emergency Medical Identification Emblems, Cards, Symbols and Labels," apply to veterans on a fee-basis status.

#### **18.29 SHORT-TERM MEDICAL SERVICES**

a. VA Form 10-7079 will be the source document for obtaining examination or a complete episode of treatment within a designated, concise period of time. Authorizations for short-term services will be restricted to treatment or examination that can normally be completed within a 60-day period, and for which generally a one-time payment will be made to the physician or other fee participant. A period of validity for short-term services may be extended over a greater interval, if required to permit completion of examination or treatment. On these rare occasions, justification for authorizing an interval greater than 60 days will be documented on an SF 509.

b. Veterans who are authorized short-term treatment may select a qualified physician of their choice to render the services required. In the absence of this selection, Medical Administration personnel will arrange for treatment by a qualified physician located within a reasonable distance of the veteran's residence. The selection of a physician to conduct an examination for rating purposes will be made by Medical Administration personnel. VA Form 21-2507, Request for Physical Examination, will at times reflect the name of the physician(s) who may not be selected to conduct the required examination. Medical Administration personnel will ensure that such physicians are not selected to conduct examinations for rating purposes.

c. Clinics will establish suitable procedures for monitoring short-term requests for the purpose of ensuring timely completion of authorized medical services.

d. VA Form 60-3542, Authorization to Report - Voucher for Mileage Allowance, will be used to notify veterans of travel authorization to obtain authorized short-term medical services. Fiscal Service will be provided with a copy of each of these forms issued.

**18.30 MEDICAL SERVICES OUTSIDE JURISDICTIONAL AREA**

a. Veterans with ID card authorizations, vacationing outside the geographical area of their COJ, may obtain fee medical services (for which they are eligible) in any State, and the Commonwealth of Puerto Rico or other territory or possession of the United States when suitable VA health care facilities are not feasibly available. Approval of treatment and payment of fees for outpatient medical services will be the responsibility of the clinic having jurisdiction over the veteran's permanent address. That COJ will process out-of-area invoices from onhand information and resources. When necessary, the clinic having jurisdiction over the area in which treatment was rendered will be contacted to obtain data required for processing payment, to ensure maximum allowable fee for service provided. All activities related to the Contract Hospital program (applications, authorizations, timely transfer to the appropriate VA medical center, denials, payments, PTF reporting etc.) are to be completed by VA facility responsible for the PSA where the service is provided. Refer to M-1, part I, Chapter 21, "Non-VA Hospitalization in the United States," for complete information regarding the Contract Hospital Program.

b. An ID card status may be established for veterans receiving outpatient staff treatment when uninterrupted care is needed and the veteran will temporarily reside where suitable VA health care facilities are not available. Fee status will be limited to the period during which VA staff treatment is not feasibly obtainable.

c. Veterans residing in the Panama Canal Zone may be issued restricted ID cards to obtain medical services from other Federal hospitals in the Panama Canal Zone. ID cards issued for this purpose will be the responsibility of the VA Medical Center, Washington, DC.

d. Eligible veterans requiring fee medical care while traveling or residing in foreign countries should follow current directives as well as provisions of M-1, part I, chapter 23. For the purposes of authorizing medical services in foreign countries, a foreign country is defined as any place other than:

- (1) The 50 United States,
- (2) Territories and possessions of the United States,
- (3) The District of Columbia,
- (4) The Commonwealth of Puerto Rico, or
- (5) The Republic of the Philippines.

The Department of State, through its Foreign Service Officer, is responsible for coordinating and arranging for medical care in foreign countries. In Canada, medical care for service-connected disability(s) may be obtained through any office of the Canadian Department of Veterans Affairs. In other foreign countries medical care may be obtained through the U.S. Embassy or Consulate Office. Requirements of prior authorization for outpatient treatment of veteran's service-connected disability(s) is required. The VA Medical Center, Washington, DC, is responsible for management of medical benefits to eligible veterans temporarily or permanently residing in Canada or other foreign countries. Outpatient treatment for veterans temporarily or permanently residing in the Republic of the Philippines will be the responsibility of the Manila VA Regional Office. The VA Outpatient Clinic in Honolulu, HI, is responsible for

management of medical benefits for eligible veterans in the Trust Territory of the Pacific Islands (Micronesia).

## SECTION V. TERMS OF PAYMENT

### 18.31 GENERAL

It is the policy of VA to provide necessary outpatient treatment to a veteran eligible for such treatment at no cost to the veteran. Fees authorized in any fee-basis arrangement will be the only fees allowable, not only from VA but from all sources, for the specified treatment. Upon agreeing to treat veterans for the conditions authorized on their ID cards, a fee participant/vendor is barred, from accepting payment from the veterans, or from another party, over and above the amount allowed by VA. This intent is made clear in information contained on the fee-basis ID card.

### 18.32 ID CARD MONTHLY DOLLAR LIMITATION FOR ROUTINE SERVICES

a. A total of \$125.00 is the maximum dollar value of routine medical and nursing services which may be incurred during any calendar month with an ID card authorization, except as provided in subparagraph b and c. VA payments made for drugs, medications and other medical supplies furnished directly to veterans by non-VA sources will not be included when computing the monthly cost of routine medical services. The same applies to mileage allowances paid to veterans to obtain authorized fee-basis care or to fee participants to travel to veterans residences to provide authorized fee-basis care. A value less than the \$125.00 monthly dollar limitation will not be shown on the ID card. Claims for lesser amounts incurred monthly for routine medical and nursing services with ID cards will be paid, when all requirements are met, since \$125.00 is the maximum monthly dollar limitation for such services.

b. When fees will exceed the \$125.00 monthly dollar limitation, the treating physician will be asked to justify the clinical need to the satisfaction of the clinic Director in advance of rendering services. A treatment plan may be requested to satisfy this requirement. When approved, the monthly dollar limitation will be increased and the physician notified of the action taken. The approved increased monthly dollar limitation, and the estimated period of time the increase will remain in effect, will be noted in the Authorization Remarks area of the "Medical Fee - Enter Authorization" option in the DHCP Fee-Basis software. This is to be done to avoid referral of claims to the clinic Director for the approved increased amount received during the specified period of time. The treating physician and the veteran, if appropriate, will be informed when anticipated treatment is considered excessive or not in keeping with accepted medical practices.

c. Fees exceeding the monthly dollar limitation for medical services rendered without prior approval may be approved when considered appropriate by the clinic Director, if they would have been approved in accordance with subparagraph b. As necessary, the treating physician and the veteran will be contacted by a VA professional designee to ensure their awareness of program requirements or for the purpose of establishing a fee monthly dollar limitation for routine medical services commensurate with clinical needs.

### 18.33 PAYMENT FOR UNPAID PORTIONS OF MEDICAL SERVICES PAID BY OTHER SOURCES

a. When a veteran is authorized, or eligible for, non-VA care at VA expense the care will be paid for by VA. There can be no advance agreement to share the costs with

another provider, nor can VA suggest to the veteran, either before or after VA authorization for care is granted, that the veteran elect to receive benefits from a third party or elect to have the third party share costs, if the veteran is eligible for such care at VA expense. VA is to be considered the primary provider for these authorizations. Payments will be made in accordance with current guidelines regarding payment for non-VA care.

b. Billing for reimbursement to VA will be initiated, when appropriate, in accordance with guidelines published in M-1, part I, chapter 15.

## **SECTION VI. TERMINATING ID CARD FEE-BASIS STATUS**

### **18.34 NOTIFICATION OF TERMINATION TO VETERANS**

a. A review will be done as outlined in paragraph 18.16 prior to termination of ID card status. ID card status is not to be considered a permanent status for any veteran (see par. 18.03). Although this status is not to be considered permanent, sensitivity should be used when terminating ID card status and informing the veteran of such termination.

b. Veterans who have their ID card fee status terminated will be notified of the date that entitlement will be terminated. This notification will be via letter and will be mailed at least 30 days prior to date ID card status is to be terminated. The letter will indicate the reason(s) why ID card status is being terminated and advise the veteran regarding their eligibility to report to the nearest VA facility for needed care. They will be instructed to return the ID card and will also be advised about the provisions in paragraph 18.19 for obtaining authorization for fee-basis treatment which may be required for emergent conditions. A pre-addressed, non-franked, business reply envelope may be provided to the veteran for the purpose of returning the fee-basis ID card. The next-of-kin will be requested to return the ID card of a deceased veteran. A pre-addressed, non-franked, business reply envelope may be provided for this purpose. One follow-up request to return ID card will be made.

c. The Austin DPC will delete a veteran from the fee-basis file after 3 years of inactivity. The COJ will notify the veteran of this action and request return of the ID card.

### **18.35 NOTIFICATION OF TERMINATION TO DPC**

Veterans whose ID card fee status is terminated for any reason will be promptly deleted from the veterans master file. (Veterans in delete status will remain on the Central Fee file until the end of the fiscal year to allow payment processing of any claims for services obtained prior to termination of ID card fee status.) Refer to the "Medical Fee - Delete Master Record Adjustment" section of the DHCP Fee-Basis User Manual for instructions regarding this entry.

## **SECTION VII. POLICIES FOR MISCELLANEOUS FEE AND CONTRACT SERVICES**

### **18.36 OUTPATIENT DIAGNOSTIC AND TREATMENT SERVICES**

Veterans receiving OPT care at a VA facility who need additional diagnostic services that cannot be provided economically at that VA, or other VA health care facility, will

be provided those services on a fee or contract basis using that facility's regular medical care operating funds (.01). Veterans receiving OPT treatment at a VA facility who need supplemental/supportive treatment services that cannot be provided economically at that VA or other VA health care facility, will be provided those services on a fee or contract basis using that facility's fee medical funds (.27). These supplemental treatment services will be authorized and paid by the VA facility responsible for the PSA where the veteran resides. If no outpatient care is going to be provided to the otherwise eligible veteran because the VA facility is incapable of providing economical care due to geographical inaccessibility or the unavailability of the needed services, the veteran may be placed on a fee medical program. Fee medical funds will not be used to pay for services rendered as part of a sharing agreement with a community medical facility for specialized medical resources.

## **SECTION VIII. FEE SERVICES PERFORMED IN A VA HEALTH CARE FACILITY**

### **18.37 GENERAL**

If necessary services at a VA health care facility cannot be secured by use of full- or part-time staff physicians, consultants or attendings, such services may be provided on a fee-basis at the VA health care facility.

### **18.38 APPOINTMENT OF PHYSICIANS AND OTHER HEALTH CARE PROVIDERS**

a. Physicians who perform fee-basis services in a VA health care facility will be appointed in accordance with the provisions of VHS&RA Supplement, MP-5, part II, chapter 2. When such an appointment is not possible, consideration may be given to contracting for the services of scarce medical specialists under 38 U.S.C. 4117.

b. Generally, providers of medical care must meet licensing requirements of their particular professions in the state where the service is given. If licensure is not required in the state, the provider must be certified or be eligible for membership in the appropriate national or professional association that sets standards for the profession.

c. Fee providers must be U.S. citizens unless it is determined that there are no qualified citizens available (see par. 18.03).

d. Personnel Service should provide assistance in all matters regarding appointment of Physicians and other health care providers.

### **18.39 FEES**

Consideration will be given to negotiating fees paid for services rendered under this section. The fact that VA is furnishing office space, supplies and services should normally result in a fee that will be less than if services were performed in the physician's own office. The annual income limitation provisions of VHS&RA Supplement, MP-5, part II, chapter 3, will apply.

### **18.40 VETERANS SCHEDULING AND TRAVEL**

Scheduling and beneficiary travel reimbursements will be handled in the same manner as for other veterans reporting to a VA health care facility for staff outpatient treatment.

**18.41 ROUTING**

Outpatient Routing and Statistical Activity Record or Outpatient Routing Slip may be used to route patients to fee-basis physicians at VA health care facilities. An outpatient visit will be credited, and clinic stops identified, as appropriate, in accordance with the guidelines contained in M-1, part I, Chapter 17, "Outpatient Care--Staff."

**18.42 SERVICES OTHER THAN EXAMINATIONS FOR COMPENSATION AND PENSION PURPOSES**

VA Form 10-7078, Authorization and Invoice for Medical and Hospital Services, is the source document which will be used to authorize fee participants to provide services, other than examinations for compensation and pension purposes, at a VA health care facility. One copy of VA Form 10-7078 will be prepared and processed each month for each fee participant performing these services prescribed in the "Invoice Processing" section of the Fee-Basis System User Manual. Payments for these services will be made from the health care facility's regular medical care operating funds. These certified vouchers will be forwarded to Fiscal Service for payment rather than through the DHCP-FEE system.

**18.43 COSTING OF EXAMINATIONS FOR COMPENSATION AND PENSION PURPOSES**

All examinations for C&P (compensation and pension) purposes performed at any VA health care facility by physicians on a fee basis will be costed to fee medical funds account (.27). VA health care facilities not designated as a COJ will use these funds, through the COJ serving their areas, but only for those C&P examinations performed within their facilities by physicians on a fee basis. VA health care facilities assigned COJ responsibilities will use .27 funds for C&P examinations performed at their facilities by physicians on a fee basis.

**18.44 C&P EXAMINATIONS PERFORMED ON FEE-BASIS IN HEALTH CARE FACILITIES NOT CLINICS OF JURISDICTION**

a. Health care facilities having C&P examinations performed by fee physicians at their facilities will prepare a VA Form 10-7079 for each veteran given such an examination. On a daily basis, VA Form 10-7079 will be forwarded to the Fee Services Section in the appropriate COJ for processing. All veterans receiving a C&P examination must be registered through ADT (Admission/Discharge/Transfer) in DHCP. An outpatient visit will be credited, and clinic stops identified, as appropriate, in accordance with the guidelines in M-1, part I, Chapter 17, "Outpatient Care--Staff."

b. The clinics of jurisdiction will coordinate the estimated amount to be reserved for this procedure for each VA health care facility in their area. These amounts will be taken into consideration in the clinics of jurisdiction's preparation of VA Form 4-1358, Estimated Miscellaneous Obligation or Change in Obligation. All VA Forms 10-7079 for veterans who have been given C&P examinations will be processed by the clinics of jurisdiction. Payment for these C&P examinations will be made through the FEE system using fee medical funds (.27) allocated to the COJ. As necessary during the obligation month, VA health care facilities will notify the clinics by telephone of any increases or decreases in the original estimated .27 funds the facilities provided at the beginning of the month. This will allow the clinics to adjust their VA Form 4-1358 as appropriate.

#### **18.45 C&P EXAMINATIONS PERFORMED ON FEE BASIS IN CLINICS OF JURISDICTION**

Clinics of jurisdictions having C&P examinations performed by fee physicians at their facilities will prepare a VA Form 10-7079 for each veteran given such an examination.

### **SECTION IX. FEE-BASIS OUTPATIENT TREATMENT BY OTHER FEDERAL HOSPITALS**

#### **18.46 GENERAL**

Outpatient medical care or examination may be authorized for veterans in a Federal hospital. Normally, these will be for short-term examination or treatment.

### **SECTION X. FUNDS FOR PAYMENT OF FEE-BASIS AND CONTRACT SERVICES**

#### **18.47 GENERAL**

a. Unless otherwise specified, fee-basis outpatient medical services, excluding medications and other pharmaceutical supplies, authorized under the provisions of this chapter will be paid from medical care funds, Obligation Analysis Account .27 - Outpatient Fee Medical. These funds are allocated through the Regional Director to clinics of jurisdiction. Supplemental outpatient diagnostic services as well as medications, drugs, oxygen and other pharmaceutical supplies will be paid from regular medical care operating funds, Obligation Analysis Account .01 - All Other. Travel expenses, when approved, for veterans authorized fee-basis care may be paid from regular medical care operating funds allocated for beneficiary travel or the appropriate fee-basis cost account.

b. Payments for authorized medical treatment and services (including diagnostic services) made from medical care Obligation Analysis Account .27 funds or Medical Care Operating funds .01, and payments for authorized medications, drugs (including oxygen) and supplies furnished by non-VA pharmacies, will be processed through DHCP-FEE. (See subpar. 18.76f concerning procurement of oxygen and accessories.) Beneficiary travel payments processed through the DHCP-FEE System will be restricted to travel payments made to those veterans authorized travel expenses in connection with care obtained by ID-card authorizations.

#### **18.48 FEE-BASIS AND CONTRACT DIALYSIS CARE**

a. The provisions of M-2, part IV, chapter 4, will apply for the authorization of dialysis care on a fee or contract basis to eligible veterans.

b. VA health care facilities without an approved dialysis program will not independently authorize fee-basis or contract dialysis care despite COJ authority, except in connection with ongoing contract hospitalization or in order to provide emergency care under the provisions of 38 CFR 17.50b to eligible veterans. Individuals inquiring about dialysis care will be referred to the closest VA dialysis center or satellite dialysis unit functioning as an interim dialysis center. The facility nearest the veterans home, or COJ, may carry out the administrative aspects of contract or fee basis dialysis after the treatment is authorized by the Director of a VA medical center with a dialysis center or authorized satellite.

c. VA Form 10-7078 is the source document for use by VA health care facilities with an approved dialysis program to authorize fee-basis or contract dialysis care. VA Form 10-7079 will not be used for this purpose. VA Form 10-1174, ID cards, will not be issued to veterans authorized fee-basis or contract dialysis care.

d. Separate VA Forms 4-1358 will be maintained monthly by VA health care facilities which may authorize fee-basis or contract dialysis for obligating funds and accounting of expenditures in connection with this program.

e. Dialysis care will be paid from the medical center's recurring .01 Medical Care Account.

## **SECTION XI. FEES FOR MEDICAL AND PHARMACEUTICAL SERVICES**

### **18.49 ENTERING INTO AGREEMENTS**

Clinic Directors will not enter into agreements with State medical, osteopathic or pharmaceutical associations for the purpose of establishing negotiated fees for outpatient medical services. Acceptance of the ID card or VA Form 10-7079 by a fee participant to provide services to VA beneficiaries will be considered an act establishing an implied agreement by the vendor to provide services at the VA fees established by the authorizing COJ.

### **18.50 GUIDE FOR DEVELOPMENT OF VA FEES FOR MEDICAL AND SUPPORTIVE MEDICAL SERVICES**

a. Fee schedules will be established at each COJ for payment for non-VA medical services as outlined in paragraph 18.51. The 75th percentile payment method will be used by all clinics of jurisdiction that have utilized the DHCP fee-basis program for 1 year or more or have sufficient data to utilize the revised payment methodology.

b. Clinic Directors may establish local rates for payment for any services which cannot be paid using the 75th percentile method (less than 8 occurrences) as outlined in paragraph 18.51a.

c. Locally established rates will not be greater than the usual and customary charges to the general public in the community for similar services.

### **18.51 VA MEDICAL FEE SCHEDULES**

a. Payment for authorized medical services will be made based upon the 75th percentile for all clinics of jurisdiction that have been on the DHCP fee-basis program for at least 1 year, or have sufficient data to utilize the revised payment methodology. A minimum of 8 occurrences is required to establish the 75th percentile for any one CPT (Current Procedural Terminology) code. Payment for fee-basis dental care will be made in accordance with the Dental Schedule of Fees per M-1, part I, chapter 19.

b. On an annual basis, the Chief, Medical Administration Service, through the DHCP fee-basis option "Compile Fee Schedule," will rank all billed amounts by CPT code for the COJ for the previous fiscal year. This will establish the medical payment rate (75th percentile) for the current fiscal year.

c. The payment rate, 75th percentile, is established by listing all charges for each CPT code for each COJ in ranking order, bottom to top. The total number of occurrences

for each CPT code is multiplied by 75 percent. The number of charges are ranked from the lowest rate billed to the highest rate billed and the charge that falls at the 75th percentile is the maximum rate which will be paid.

d. All bills that fall at or below the 75th percentile are be paid at the rate billed. All bills submitted which are in excess of the 75th percentile will be paid at the 75th percentile.

e. Fees for medical services provided in the Republic of the Philippines fall under the jurisdiction of the VA Regional Office in Manila while fees for services provided in foreign countries fall under the jurisdiction of the VA Medical Center, Washington, DC.

f. Fees for medical services rendered VA beneficiaries through community resources in foreign countries will not exceed the usual and customary charges to the general public for similar services. (Applicable only to the VA Medical Center, Washington, DC, and the VA Regional Office, Manila, Republic of the Philippines.)

g. When a new COJ is established, it will utilize the 75th percentile payment data of the decentralizing COJ until there is sufficient data for the new COJ to establish their own 75th percentile payment rate. The clinic Director and/or Chief, Medical Administration Service, should request and review the 75th percentile payment rate printout from the decentralizing COJ. The clinic Director should make adjustments to the payment rate, when necessary, to assure the payment rate for the newly established COJ is appropriate for the area served.

h. When a new COJ is being established by assuming workload from more then one COJ, the COJ being established will need to review the payment date from each of the COJs transferring workload to determine which facility's payment data will be used by the newly established COJ. The clinic Director and Chief, MAS should request and review the 75th percentile payment rate printout from each COJ and determine which 75th percentile payment rate is most appropriate for the newly established COJ. The clinic Director should make adjustments to the selected payment rate, when necessary, to assure the payment rate for the newly established COJ is appropriate for the area served.

i. The release of the schedule maximum allowable fee for a particular service can be withheld as an exception under the Freedom of Information Act.

#### **18.52 EXCESS FEES**

In unusual circumstances when the interests of the veteran and VA will be best served, clinic Directors may approve requests for payments to be made in excess of the 75th percentile. The basis for requesting and authorizing payments under this provision will be fully documented in the CHR.

#### **18.53 METHOD FOR DEVELOPMENT OF VA FEES FOR DRUGS AND MEDICATIONS**

a. Fees paid for pharmaceutical services will be based on the cost of generic drugs. The average wholesale price of the generic equivalent, according to manufacturer, listed in the current "Red Book, Pharmacists' Guide to Products and Prices" or "Blue Book, Pharmacists' Guide to Products and Prices" plus a fixed dispensing fee per prescription, equal to the fixed dispensing fee currently being paid by Medicaid in the state the medication is dispensed, will be the basis of reimbursement to the pharmacy.  
**EXCEPTION:** *Veterans who have had their prescription filled with brand name drugs will*

*be reimbursed the amount paid to the pharmacy.* Drugs are generically acceptable where there is assurance by the FDA that products are therapeutically equivalent and meet the following criteria:

(1) They are pharmaceutical equivalents in that they contain identical amounts of the same active ingredient in the same dosage form, and meet compensable or other applicable standard of strength, quality and purity.

(2) They are bioequivalent in that they do not present a known or potential bioequivalence problem.

b. Fee-basis prescriptions will only be filled with VA formulary medication, unless a request for deviation from this policy has been approved.

c. Any request from a fee-basis physician to deviate from the use of VA formulary medication must be reviewed and approved by the Pharmacy and Therapeutics Committee.

d. If a brand name was dispensed by a non-VA pharmacy, and payment for it is authorized in accordance with appendix 18A, then payment will be the most current "Red Book" or "Blue Book" cost of the brand name drug plus the Medicaid dispensing fee.

e. Each clinic Director will ensure that the latest information on products and their average wholesale prices are made available to clinic personnel. "Red Book" and "Blue Book" periodically publishes information, usually on microfiche, updating its list of products and average wholesale prices. This updated information is available free of charge, or at a nominal fee, through the larger wholesale drug companies.

f. The Chief, Medical Administration Service, will obtain the state Medicaid dispensing rate from their respective state Medicaid office.

#### **18.54 FEES FOR VA BENEFICIARIES TREATED AT OTHER FEDERAL AGENCIES**

When outpatient medical services are performed for eligible VA beneficiaries at installations under the jurisdiction of other Federal agencies, fees will be authorized at current rates prescribed by VA directives or, if not so prescribed, those stipulated by the agency providing the service.

### **SECTION XII. OBLIGATIONS OF FUNDS**

#### **18.55 OBLIGATION DOCUMENTS**

a. On the first workday of each month, the Chief, Medical Administration Service, will complete a separate VA Form 4-1358, Estimated Miscellaneous Obligation or Change in Obligation, to establish estimated obligations for services to be rendered for each of the various fee-basis categories of services as prescribed in the "Obligations" section of the Fee-Basis System User Manual. Refer to the "Medical Fee - Enter Obligation" section of the DHCP Fee-Basis User Manual for specific DHCP instructions. The amounts to be obligated for each of the fee-basis categories will be based upon the estimated cost of bills or invoices to be received during the month. The amounts obligated for each of the fee-basis categories of services will be the best estimates possible based on experience and any factor that may influence the amounts to be paid for each category.

b. At the end of each month, the estimated amounts for each of these documents will be adjusted by Medical Administration Service to represent the total amount of proper bills or invoices date stamped in VA by the last day of the month for the services covered by each obligation document. For the purposes of fee-basis payments, it has been determined that the obligation to the government is incurred after the billing is received and a decision is made that the services provided were authorized. Refer to the "Medical Fee - Adjustment to Obligation Entry" section of the DHCP Fee-Basis User Manual for instructions regarding this entry. Bills or invoices to be included in the adjusted obligation which are rejected or withheld temporarily and are subsequently approved for payment will be liquidated against the obligation for the month in which they are approved.

### **SECTION XIII. DETAILED PROCEDURES FOR PROGRAM ACTIVITIES**

#### **18.56 THE FEE-BASIS SYSTEM USER MANUAL AND DHCP FEE-BASIS USER MANUAL**

a. Detailed procedures and technical instructions are contained in appendix 18A, Fee-Basis System User Manual. The Fee-Basis System User Manual explains the relationships and interdependence with other activities, such as CALM, which are vital for the efficient administration of the fee-basis program. It also provides procedures and technical instructions including specific instructions for avoiding or correcting "rejected" transactions in the DHCP-FEE System. The DHCP Fee-Basis User Manual was designed to provide such assistance to personnel engaged in fee-basis-related activities. The DHCP Fee-Basis User Manual provides step-by-step guidance through the DHCP Fee-Basis software package. References to pertinent sections of the Fee-Basis System User Manual and DHCP Fee-Basis User Manual are made throughout this chapter when appropriate.

b. The instructions contained in these manuals are directive in nature. However, non-directive, related information has been included in it which will be useful to clinic personnel for gaining a greater understanding of overall fee-basis operations. Careful application of these instructions will ensure an effective operation of this program. The Chief, Medical Administration Service, will make sufficient numbers of these manuals readily available to clinic personnel performing fee-basis-related activities.

### **SECTION XIV. VETERANS MASTER RECORD FILE IN THE FEE SYSTEM**

#### **18.57 MAINTAINING CURRENT VETERANS MASTER FILE**

a. The DPC maintains a master file of all veterans authorized ID card fee-basis care. The Chief, Medical Administration Service, will be responsible for establishing procedures to ensure staff awareness about the importance of maintaining the veterans master file in the most accurate and current condition possible. It is also vital to enter a MRA (Master Record Adjustment) for any changes of address and other changes, such as eligibility status changes, for all veterans on a fee-basis status as soon as the changes become known to clinic personnel. Instructions regarding the completion of an MRA are contained in appendix 18A, "Master Record Files" and in the "Medical Fee - Veteran MRA Main Menu" section of the DHCP Fee-Basis User Manual.

b. It is essential to delete veterans from the master file promptly upon receipt of notice by clinic personnel that a veteran on a fee-basis status has died, or, when action is

taken to terminate a veteran's fee-basis status for any reason, such as when the veteran changes permanent address to an area outside the clinic's jurisdictional area, is transferred to VA staff care, etc. The veterans will be kept in the Central Fee-System's veterans master file through the end of the fiscal year to await any bills that may be outstanding.

## **SECTION XV. REGISTER OF FEE-BASIS PARTICIPANTS/VENDORS**

### **18.58 PURPOSE**

An accurate, up-to-date register of fee-basis participants/vendors will be maintained to:

- a. Provide a complete roster of qualified physicians, and others who will furnish medical services on a fee basis.
- b. Provide basic records to identify fee-basis participants/vendors and process payments for services under the DHCP Fee-Basis Program.

### **18.59 REGISTER NUMBERS AND MAINTENANCE OF THE REGISTER OF FEE-BASIS PARTICIPANTS/VENDORS**

The Chief, Medical Administration Service is responsible for the accurate assignment of register numbers and the maintenance of the Register of Fee-Basis Participants/Vendors as specifically directed in the "Master Record Files" and the "Register of Fee-Basis Participants/Vendors" sections of the Fee-Basis System User Manual and the "Medical Fee - Vendor Options" section of the DHCP Fee-Basis User Manual. The importance of maintaining an accurate, up-to-date Register of Fee-Basis Participants/Vendors at each clinic and the DPC cannot be over-stressed. This is the basic requisite for making timely payments, avoiding payment of interest penalties for late payments as required by the Prompt Payment Act, as amended, avoiding complaints from vendors and for providing management with useful data on the administration of the fee-basis program.

### **18.60 REPORTING OF CALENDAR YEAR EARNINGS**

The Social Security numbers or employer (taxpayer) identification numbers contained in the Register of Fee-Basis Participants will also be used by DPC for the purpose of reporting individual fee participants' calendar year earnings of \$600 or more to the Internal Revenue Service.

### **18.61 PHARMACY REGISTER NUMBERS**

The participating pharmacy's Social Security number, employer (taxpayer) identification number and chain store number, as appropriate, will be used as pharmacy register numbers. The participating pharmacies' register numbers and addresses will be maintained in an accurate and current status as prescribed in paragraph 18.83. Specific instructions for adding participating pharmacies' register numbers to the DHCP-FEE system are prescribed in the "Fee-Basis Prescriptions" subsection of the "Invoice Processing" section of the Fee-Basis System User Manual and the "Medical Fee-Vendor- Display Enter Edit" option section of the DHCP Fee-Basis User Manual.

**SECTION XVI. INVOICES FOR MEDICAL AND PHARMACEUTICAL SERVICES****18.62 PROCESSING INVOICES AND PAYMENT CYCLES**

a. All invoices for fee-basis medical and pharmaceutical services will be processed on a first-received, first-processed basis. All invoices for fee-basis services will be administratively and professionally reviewed and approved and processed for payment as prescribed in the "Invoice Processing" section of the Fee-Basis System User Manual and the "Medical Fee" and "Pharmacy Fee" section of the DHCP Fee-Basis User Manual.

b. Daily payment cycles are established for the clinics and the DPC for processing all invoices for fee-basis services. Cutoff dates for payments of these invoices will not be established at the clinics. The clinics will process fee-basis payment transactions on a daily basis by queuing date for transmission as described in the "Supervisor Options" section of the DHCP Fee-Basis System User Manual.

**18.63 INVOICES FOR MEDICAL SERVICES**

a. The ID card and VA Form 10-7079 instruct fee participants to bill VA in their usual manner. To come within the scope of Public Law 97-177 (Prompt Payment Act, as amended) bills must be "proper invoices" and must pertain to a veteran whose eligibility to receive the care involved has been definitely determined. A bill or written request for payment for medical services which may be approved under the provisions of this chapter must show the following information to be considered a "proper invoice": the name and address of the health care provider; the health care provider's Social Security or employer's (taxpayer) number; the veteran's name and Social Security number; the invoice number and date; date of treatment/service; the medical conditions for which treated; a description of the services rendered; appropriate CPT codes(s); and, the fees being charged for the services rendered. Bills for home nursing services and other supportive medical services prescribed by a non-VA physician must also include the name of the physician who prescribed such services. When inadequate invoices are received (those lacking any of these essential items or pertaining to a veteran whose eligibility for the services involved has not been determined), the fee participant will be notified in writing within 7 calendar days of receipt of such bills that these bills cannot be processed for payment until a proper invoice is submitted or until eligibility of the veteran for the services involved has been determined.

b. Invoices, however, need not be returned for correction or suspension when information is omitted that is not essential for determining approval for payment or when clinic personnel can accurately identify and insert the missing data from information previously provided by the fee participant or which is a matter of record.

c. All invoices received in connection with medical services which may be approved under the provisions of this chapter must be processed in accordance with current VA directives for complying with the requirements of the Prompt Payment Act, as amended.

**18.64 INVOICES FOR PHARMACEUTICAL SERVICES**

a. Participating pharmacies may submit their claims for fee prescriptions on their usual billing form or on VA Form 10-7191, Statement of Account for Prescriptions. Use of VA Form 10-7191 is optional.

b. Generally, payment will only be authorized for a 10-day supply of medication, with no refills.

c. Invoices for fee prescriptions including invoices for drugs and medications obtained by beneficiaries under the circumstances described in paragraph 18.30, will be processed for payment by the COJ responsible for establishing fee-basis status. Fees will be paid as prescribed in paragraph 18.51. Prescriptions filled by more than one pharmacy, under the same ownership, may be submitted by controlling or headquarters pharmacy and processed as one invoice.

d. Current VA directives for complying with the requirements of the Prompt Payment Act, as amended, will be followed in the processing of claims from participating pharmacies.

e. All prescriptions will be referred to Pharmacy Service for completion of 100 percent review. Instructions for approving invoices for payment, adjusting amounts claimed, and processing partial payments are contained in the "Invoice Processing" section of the Fee-Basis System User Manual and the "Pharmacy Fee - Main Menu" section of the DHCP Fee-Basis System User Manual.

#### **18.65 PARTICIPATING PHARMACY PRESCRIPTION RECORDS**

The participating pharmacies' prescriptions will be filed in Pharmacy Service.

#### **18.66 PREHEADED VA FORM 10-7191**

The DPC has established procedures for routinely providing preheaded VA Form 10-7191, to participating pharmacies in numbers consistent with the degree of participation. Normally, action by clinic personnel for providing preheaded VA Form 10-7191 to participating pharmacies will not be required.

#### **18.67 FREQUENCY AND METHOD OF TRANSMITTING PAYMENT INFORMATION AND UPDATING FEE VENDOR MASTER RECORDS TO THE DPC**

The clinic Director will ensure that all transactions relating to the fee-basis program are processed as expeditiously as possible by all operating elements involved in the processing of these transactions. Procedures will be developed at each clinic to ensure that fee-basis-related transactions processed on a timely basis by one operating element are not delayed at a subsequent operating element. The processing of proper invoices from fee vendors for services rendered to veterans on whom eligibility for such services has been established and which contain all information necessary to approve payment will be processed as promptly as possible. Failure to process invoices in a timely manner may result in the payments of interest penalties as required by the provisions of the Prompt Payment Act, as amended. Data related to fee vendor master records and payment information will be transmitted to the DPC on a daily basis by appropriate clinic personnel.

### **SECTION XVII. REIMBURSEMENT TO BENEFICIARIES FOR PERSONAL FUNDS EXPENDED**

#### **18.68 GENERAL**

A veteran in an approved fee-basis status who has paid for outpatient medical services may claim and be reimbursed for treatment obtained for a service-connected or other

approved disability. Amounts to be paid will be governed by the provisions of paragraph 18.51.

#### **18.69 EVIDENCE REQUIRED**

A receipted bill, which will include the data outlined in paragraph 18.63, is required. Payment for services rendered will be approved or disapproved by Medical Administration Service personnel unless professional review is required. The original bill is preferred, although not required.

#### **18.70 PAYMENT**

Approved claims will be certified by the Chief, Medical Administration Service, or a designee. The claim, identified with the obligation number of the current month's VA Form 4-1358 for the appropriate category of fee-basis services, and supporting receipted bill will be forwarded to Fiscal Service. Beneficiary travel will be processed for payment, when appropriate.

#### **18.71 REIMBURSEMENT FOR COST OF MEDICATIONS**

Beneficiaries in an approved fee-basis status will be reimbursed by the COJ when they have paid with their own funds for prescriptions needed for prompt treatment of service-connected or other approved disabilities when such medication was not immediately available from a VA pharmacy or participating pharmacy. A receipted statement itemized by the pharmacy as to the kind, quantity and cost of all medicines furnished is required. Amounts to be paid will be governed by the provisions of paragraph 18.53. When approved, reimbursement will be entered through the DHCP Fee-Basis System in accordance with the instructions contained in the "Pharmacy Fee - Main Menu" section of the DHCP Fee-Basis User Manual and the "Master Record Files - Pharmacy" section of the Fee-Basis System User Manual. The veteran will be advised as to how to procure medicines in the future.

### **SECTION XVIII. STATISTICAL REPORTING**

#### **18.72 GENERAL**

Funding allocated for the provision of fee-basis services is principally based on statistics generated on fee-basis payments processed through the Central Fee system. Therefore, when "Out of System" payments are made those expenditures are not included in fee-basis cost reporting.

### **SECTION XIX. BENEFICIARY TRAVEL**

#### **18.73 GENERAL**

Veterans in an authorized ID card status who submit a written claim for reimbursement of expenses of travel incident to obtaining approved medical services may be reimbursed for such expenses, but only within the constraints prescribed in M-1, part I, chapter 25, which govern beneficiary travel payments. (See par. 18.29 for travel involving veterans authorized short-term care. Veterans authorized fee-basis dental care are also entitled to beneficiary travel.)

**18.74 CLAIMS**

A claim for beneficiary travel received, or postmarked, within 30-days from the date the veteran initially obtained approved fee-basis medical services will be approved for payment of travel expenses incurred in keeping with the provisions of M-1, part I, chapter 25. This approved travel claim will serve as authority to pay travel allowances for the continuous period of fee-basis status beginning with the initial visit. Claims received, or postmarked, following the 30-day period will be effective from the date of receipt, or postmark, of the claim unless the beneficiary meets the criteria of 38 CFR 17.101(a) (1), (2) or (3). Claims approved under 38 CFR 17.101 will be paid only for travel which occurs after this approval. Claims for travel expenses will be filed in the CHR.

**18.75 PROCESSING TRAVEL PAYMENTS**

Travel limitations, processing travel payments and frequency of travel payments will be in keeping with instructions prescribed in the "Invoice Processing" section of the Fee-Basis System User Manual and instructions provided in the "Travel Payment Only" section of the DHCP Fee-Basis User Manual.

**SECTION XX. PRESCRIPTIONS FILLED IN VA PHARMACIES****18.76 GENERAL**

a. The provisions in M-1, part I, chapter 16, section X, apply to the filling of prescriptions for veterans on fee-basis status.

b. Eligibility for prescribed drugs, medications and/or medical requisites necessary for a condition for which an eligible beneficiary is entitled to treatment will be established on a one-time basis. Medical Administration Service personnel will input eligibility information into the DHCP system which will then be accessed by Pharmacy Service personnel to determine eligibility for prescribed drugs and medications.

c. Prescriptions received from fee-basis physicians for treatment of patients in fee-basis status will be referred directly to Pharmacy Service.

d. Fee-basis prescriptions will only be filled with VA formulary medication. Any prescriptions presented to the VA Pharmacy for medications which are not on the VA formulary, and for which no request to deviate from the use of the VA formulary was received, will be reviewed by the Chief, Pharmacy Service. The Chief, Pharmacy Service, will contact the fee-basis physician concerning the substitution with a drug on VA formulary. If the substitution of a VA formulary medication is not acceptable the fee-basis physician will be advised that their request will be referred to the Pharmacy and Therapeutics Committee. Each medical center should develop a process in which non-formulary prescriptions are handled in a means which will not interrupt patient therapy.

e. The VA pharmacy will determine whether the prescription is for treatment of a condition for which the veteran is eligible prior to dispensing drugs and medications. Questionable prescriptions will be referred by Pharmacy Service to the reviewing physician for determination. As necessary, the reviewing VA physician will contact the fee-basis physician relative to the medication in question. If the fee-basis physician

decides to change the medication, the reviewing physician will annotate the original prescription and return it to the pharmacy for dispensing.

f. When oxygen is prescribed for any veteran on fee-basis status, the prescription will be reviewed by a designated VA physician to ensure that the prescription of home oxygen is in keeping with established VA medical criteria for home oxygen therapy. Any questions concerning the prescription of home oxygen by a fee physician will be resolved by the designated Department of Veterans Affairs (VA) physician before any authorization is given. If home oxygen is indicated, an authorization will be limited to the furnishing of oxygen. VA Form 10-7078 will be used to authorize the service, and will be issued to an appropriate supplier for direct delivery to the veteran. Reduction valves, tubing, masks, and other equipment needed to administer oxygen will be authorized as prescribed in M-1, Part II, Chapter 11, Section V.

## SECTION XXI. MEDICAL REPORTS

### 18.77 ID CARD AUTHORIZATION

a. Routine medical reports are not required for veterans receiving treatment under identification (ID) card authorization. When unusual circumstances warrant or when the veteran's disability has significantly improved or worsened, medical data may be requested from the participating physician or other fee participant. Special medical reports from participating physicians may be requested, if necessary, to comply with periodic review requirements prescribed in paragraph 18.22b.

b. Brief, routine reports reflected on the fee participant's billing statement will not be filed in the Consolidated Health record (CHR). Only reports indicating significant change in condition; requesting increase of the maximum monthly limitation; indicating need for patient referral for supportive medical services; and containing similar type information appropriate for retention, will be filed in the CHR.

c. Refer to paragraph 18.17 for information regarding evaluation and treatment plans.

d. Reports disclosing a significant change in the service-connected (SC) disability will be referred to the Adjudication Division having jurisdiction of the veteran's claim folder for any rating action indicated.

## SECTION XXII. FEE-BASIS HOME HEALTH SERVICES

### 18.78 POLICY

a. Fee-basis home health services are supportive medical services prescribed by and under the direction of a VA physician or a physician contracted by the VA for providing treatment to veterans. These services are skilled treatment services as performed by professional health care providers and professional health care technicians.

b. Home health services may be authorized on fee-basis, consistent with eligibility, when:

- (1) It is necessary, or appropriate, for effective and economical treatment;
- (2) It has been determined that such services will be required; and
- (3) Compelling medical reasons warrant issuing such an authorization.

c. Home Health Services may be provided on a daily basis as long as the total cost of care (Fee-Basis Outpatient Care and Home Health Services Program) does not exceed the cost that would have been incurred if the veteran was treated in a contract nursing home during any one month.

c. Authorization for non-medical type services, such as domestic, custodial or homemaker services which, although beneficial to the veteran and may obviate the need of VA institutionalization, may not be approved under the Fee-Basis Home Health Services Program, as these services are not considered medical treatment. Homemaker and/or Home Health Aide services may be purchased by participating in the Homemaker and/or Home Health Aide Service Pilot Program. The Office of Geriatrics and Extended Care (114A) in VA Central Office is responsible for approving a medical center's request to participate in the Homemaker and/or Home Health Aide Service Pilot Program.

d. The basic care procedures of catheter irrigation, colostomy bag changes, dressing changes, external catheter changes, medication administration, assistance with prosthetic devices, massage, and turning the patient previously listed as nonmedical services have been redefined as medical services and may be authorized as Fee-basis home health services when the services both demonstratively facilitate the ongoing treatment or rehabilitation of the veteran and due to compelling medical reasons are found to be medically necessary. Positioning and transferring previously listed under the Assistance with Activities of Daily Living Program have been redefined as medical services.

c. Bowel and bladder care to include catheter irrigation, changing colostomy bags, and changing external catheters are considered as supportive medical services and may be authorized as a home health service on fee-basis when a VA physician determines that compelling medical reasons warrant issuing such authorization.

d. Bowel and bladder care should be provided by a licensed or registered health care provider, or a trained paraprofessional working under the direction and supervision of a licensed health care provider. Due to the nature of the physical limitations and special needs of spinal cord injury patients, bathing may be provided as a fee-basis home health service after bowel and bladder care has been rendered.

e. Bowel and bladder care at VA expense may be authorized for a veteran in receipt of Aid and Attendance (A&A), including high level A&A.

#### **18.79 PROCEDURES**

a. Fee-basis home health services requested for veterans must be accomplished by a physician's statement (if a VA physician, documentation will be on SF 509, Medical Record-Doctor's Progress Notes; if a fee-basis physician documentation, will be on physician's office stationery) and submitted to the Chief, Medical Administration Service (MAS), at the clinic of jurisdiction.

b. The physician's statement must contain the following information:

- (1) Specific medical services required;
- (2) Duration of time home health services should be authorized;
- (3) Frequency of visits by provider(s); and
- (4) Estimated total monthly cost of providing home health services.

c. The Chief, MAS, will review all requests for fee-basis home health services and the physicians' statements. A careful review by the Chief, MAS, with consultation, as appropriate, with the concerned professional service(s) will be made as to the requested services and which services constitute medical treatment and may be authorized through the Fee-Basis Home Health Service Program. Consideration must be given to alternative VA programs available to provide effective and economical treatment to the veteran.

d. When the determination is to authorize fee-basis home health services, a referral will be made to the Chief, Nursing Service, or the Public Health Nurse, as appropriate, for assistance in arranging for health care providers to administer the authorized home health services.

e. A 12-month review process will be established for all veterans in receipt of fee-basis home health services. The review will be used to determine if the fee-basis home health services should be continued, or if alternate less costly VA programs are available. The health care facility Director will designate the individual(s) to perform this review.

## FEE-BASIS SYSTEM USER MANUAL

## I. DHCP FEE-BASIS SYSTEM SET-UP

a. To implement the Fee DHCP package the system needs to be customized for your medical center. The Site Parameters, Enter Obligation Numbers, and Create Suspension Letter options allow customizing. All information pertaining to the DHCP Fee-Basis software is written for Version 1, unless otherwise specified.

b. The **Site Parameter Enter/Edit** option is used to enter or edit site specific information (parameters). There can be only one name per site for this option, but you may change any of the information for the site. Remember the name of your site because the system does not default to the last name entered, but you may enter a question mark to see the last name entered. Only users with the security key, FBAASUPERVISOR, may use this option.

c. The **Enter/Edit Suspension Letters** option is used to create or edit the suspense letters. These letters may be printed periodically (daily, weekly, semi-weekly) and mailed to the fee-basis vendors. Only payments with a suspense code will generate a suspension letter. The middle portion of the letter is automatically created by the suspension codes entered by the user making payments. The suspension letters, if sent, reflect actions taken at the medical center level only.

## II. REQUESTS FOR OUTPATIENT MEDICAL SERVICES

a. **Eligibility.** Upon receipt of application for medical benefits, usually by VA Form 10-10, Application for Medical Benefits, from a veteran, eligibility for fee-basis care must be determined in accordance with basic policy prescribed in M-1, part I, paragraph 18.03.

b. **Authorization.** Upon approval of outpatient treatment under fee basis, VA Form Letter 10-431 and VA Form 10-1174, VA Fee Basis Outpatient Medical Care Authorization, are forwarded to the veteran by the COJ for ID card status authorization. For a short-term authorization, a copy of VA Form 10-7079, Request for Outpatient Medical Services, will be forwarded to the veteran or the provider as appropriate. A letter should also be sent to the veteran explaining the short-term authorization.

c. **Preparation of VA Form 10-7079, Request for Outpatient Medical Services**

(1) The Enter Authorization option, located in the "Medical Fee - Main Menu" section of the DHCP fee-basis package is used to enter/edit/delete an authorization for fee services. In order to enter an authorization the veteran must be in the Patient File (entered through ADT (Admission/Discharge/Transfer) Register, Load Edit options and have an eligibility status of "Verified" or "Pending Verification.")

(2) There are three types of authorization (treatment types) in the outpatient DHCP fee-basis package including:

(a) LT - Long-Term Care (ID Card status) for ongoing outpatient care,

(b) ST - Short-Term Care which includes C&P exams,

(c) HHS - Home Health Care for home health visits only. (This includes home health nursing, home health physical therapy and home health speech therapy.)

(3) A veteran can have as many short-term authorizations as necessary, however, a veteran can have only one long-term care and one home health care authorization.

(4) If a new date for ID Card status is issued, the user should edit the 'TO DATE' and leave the original "From Date" the same, even if the card expires and is later re-issued. A default to "To Date" for long-term authorization, can be set through the site parameters on the Supervisor Menu. The Authorization remarks area is a good place to document different periods of authorizations, as well as enter the initials of the person entering the authorization.

(5) Any time an authorization is entered for the first time an MRA will be created the next time the supervisor queues data for transmission to Austin. Any changes or edits require the user to create a veteran MRA. Refer to the "Medical Fee- Veteran MRA" section of the DHCP Fee-Basis User Manual.

(a) **Veteran's Name.** The DHCP fee-basis module interfaces with the ADT DHCP package providing access to registration data entered through ADT options. Refer to the DHCP Fee-Basis User Manual - "Medical Fee - Enter Authorization" section for guidelines regarding completion of Request for Outpatient Medical Services, VAF 10-7079.

(b) **Identification Number.** The veteran's Social Security number is obtained from the ADT DHCP interface.

(c) **Period of Validity.** A specific validity period for each authorization will be estimated by the clinic Director's professional designee, based on each veteran's eligibility status and on the nature of the condition(s) which is to be provided care under the fee authorization. The validity period will be entered on the VA Form 10-7079. For home nursing services (code 2) and ID card fee status (code 3), the end-of-validity date represents the date by which time a review of the veteran's condition to determine whether or not the veteran should remain on ID status should have been completed. Enter the inclusive dates during which the veteran is approved to obtain medical or home nursing services (codes 2 and 3) or short-term status (code 1). The "end-of-validity" date must be at least 1 day later than the "issue" date except for C&P (Compensation and Pension) examinations where the "From Date" and "To Date" will be the date the C&P examination was performed.

(d) **Address of Veteran.** The DHCP fee-basis module interfaces with the ADT DHCP package providing access to this registration data entered through ADT options.

(e) **Date of Issue.** Enter the month, day and year the request for outpatient medical services is authorized. The issue date must be equal to or less than the "From Date".

(f) **Name and Address of Fee Participants/Vendors.** When a specific vendor is selected for the veteran this information should be entered on VA Form 10-7079. The Social Security number or taxpayer identifying number of the fee participant will be recorded following the name and title.

(g) **Description of Disability.** Record up to three diagnosis(es) or condition(s), including adjunct, for which the veteran is approved to receive outpatient treatment. Describe

these in accordance with the current AMA edition of the CMIT. Record "OUTPATIENT TRMT FOR ANY MED COND" for veterans eligible under 38 CFR 17.60 (h) or (i).

(h) **Authorization Remarks.** Enter any special remarks concerning the authorization. Complete this block when requesting (a) medical services for a limited duration of a specific nature when the number of procedures is known, or (b) medical supportive treatment prescribed by a VA staff physician. Enter the frequency and description of each procedure recommended. When home nursing services are authorized, this item will be used to record a summary of pertinent medical information regarding the patient's condition, and if appropriate, enter the name of the private physician responsible for the patient's medical treatment. No entry is required in this block when the usual ID card status is established which authorized the veteran to obtain treatment for approved conditions or diagnoses.

(i) **State Code.** The DHCP fee-basis module interfaces with the ADT DHCP package providing access to this registration data entered through ADT options.

(j) **County Code.** The DHCP fee-basis module interfaces with the ADT DHCP package providing access to this registration data entered through ADT options.

(k) **Type of Patient.** Enter appropriate patient type from the following types:

PATIENT TYPE	CODE
Surgical	00
Medical	10
Home Nursing Services	60
Psychiatric-Contract	85
Psychiatric	86
Neurological-Contract	95
Neurological	96

(l) **Year of Birth.** The DHCP fee-basis module interfaces with the ADT DHCP package providing access to this registration data entered through ADT options.

(m) **War.** The DHCP fee-basis module interfaces with the ADT DHCP package providing access to this registration data entered through ADT options. There must be a consistency between the war code (period of service) and year of birth. The war codes (period of service) follow with the year of birth for consistency verification:

WAR	CODE	YEAR OF BIRTH
Korean	0	1886-1940
World War 1 or Mexican border period	1	1861-1905
World War 11	2	1876-1932
Spanish-American War	3	1859-1889
Pre-Korean	4	1863-1935
Post-Korean	5	1886-1948
Operation Desert Storm - Active Duty	6	1973-or before
Vietnam Era	7	1899-1958
Post-Vietnam Era (on or after May 8, 1975)	8	Over Age 16
Operation Desert Storm - Veteran	X	1973 or before
New Philippine Scouts & Commonwealth Army	Y	
Merchant Marine	Z	1876-1932

(n) **Purpose of Visit.** Enter the appropriate code for the purpose of the visit (explanations are listed alphabetically):

- 06 Aid and Attendance of Housebound (Outpatient medical services for veterans entitled to treatment for any medical condition under 38 CFR 17.60(i).)
- 03 Application for Medical Benefits, VA Form 10-10 (Patients examined to determine their need for hospital, outpatient or domiciliary care).
- 30 Authorized Contract Hospitalization Care for SC Disabilities in Private Facilities
- 13 CHAMPVA Beneficiary Master Record
- 12 CHAMPVA Sponsor Master Record
- 15 Class I Dental Treatment
- 16 Class II Dental Treatment
- 21 Class III Dental Treatment
- 17 Class IIa Dental Treatment
- 18 Class IIb Dental Treatment
- 19 Class IIc Dental Treatment
- 20 Class IIr Dental Treatment
- 22 Class IV Dental Treatment
- 23 Class V Dental Treatment
- 24 Class VI Dental Treatment
- 42 Community Nursing Home for Active Duty Personnel
- 41 Community Nursing Home for NSC Disabilities
- 40 Community Nursing Home for SC Disabilities
- 01 Compensation and Pension
- 50 Contract Readjustment Counseling and Related Mental Health Svcs.
- 82 Fee Oxygen
- 72 HISA - NSC
- 73 HISA - SC
- 71 Home Health Services (Non-Nurse)
- 70 Home Health Services (Nurse)
- 11 Medical Care Provided to Obviate the Need for Hospital Admission
- 07 Miscellaneous (Includes fee-basis medical services for: (1) nonservice-connected disabilities of veterans participating in a Rehabilitation Program under 38 U.S.C. Chapter 31 and who are medically determined to be in need of medical services to accomplish the goals of the Rehabilitation program; (2) authorized beneficiaries of other Federal agencies; and (3) beneficiaries of nations allied with the United States in World Wars I and II as comprehended in chapter 24.
- 35 Non-VA Hospital Care for NSC Disabilities in a Private Hospital - Limited to PR, VI, AL and HI.
- 36 Non-VA Hospital Care for Veterans in a Federal Hospital (authorized, unauthorized, SC & NSC)
- 34 Non-VA Hospital Care for Women not Appropriately Classified Elsewhere
- 33 Non-VA Hospital Care or Medical Services for Emergencies for a veteran receiving inpatient care in a Federal hospital at VA expense.
- 32 Non-VA Hospital Care or Medical Services for Emergencies for a Veteran receiving inpatient care in a VA medical center.
- 80 OPT Diagnostic Services Obtained by Independent VA OPT Clinic in Connection with care to Obviate the Need for Hospital Admission.
- 83 OPT Services for Inpatients
- 85 OPT Services for Outpatients

- 05 Outpatient Treatment NSC (Fee-basis medical services for treatment of nonservice-connected disabilities following an episode of VA hospitalization, for authorized disabilities only. This includes outpatient treatment for nonservice-connected disabilities being provided by another Federal medical facility following an episode of VA-authorized hospitalization at such facility for those disabilities. Also includes fee-basis medical services to supplement outpatient treatment for nonservice-connected disabilities being provided by VA staff and any other fee-basis medical services for treatment of nonservice-connected disabilities not appropriate for reporting by use of other codes.)
- 10 Outpatient Treatment - SC 50 percent or More (Authorized fee-basis medical services for treatment of any medical condition(s) of veterans with disabilities which have been adjudicated as service connected with ratings of 50 percent or more.)
- 09 Outpatient Treatment - SC Less than 50 percent (Authorized fee-basis services for to veterans for treatment of disabilities which have been adjudicated as service-connected with ratings of less than 50 percent. This includes services to treat disabilities which are associated with and held to be aggravating the service-connected disabilities, including disabilities incurred or aggravated in the line of duty for which the veterans received disability retirement from the Armed Forces.)
- 08 Outpatient Treatment - World War I and Mexican Border Period (Authorized fee-basis services for treatment of nonservice-connected medical disabilities of veterans whose only entitlement to these benefits is by virtue of military service during World War I or the Mexican border period).
- 81 Supplemental Diagnostic Services for a Veteran in a Medical Center's Outpatient program.
- 60 Treatment and Rehabilitation for Alcohol and Drug Dependence or Abuse Disabilities.
- 84 Supplement Diagnostic Services - Treatment/Allergy Clinics
- 31 Unauthorized VA Hospital Care
- 04 VA Insurance (Patients examined for insurance purposes such as a waiver of premium, application for insurance or reimbursement of insurance).

o. **Clinic/medical center of Jurisdiction.** The medical center name, address and telephone number will automatically be entered here as established through the site parameter option.

p. **Treatment Type Code.** Enter one of the following codes:

- 1 - Short-term
- 2 - Home Nursing Services
- 3 - ID Card Fee Status

q. **Type of Care.** Enter one of the following codes:

- 1 - C&P Examination
- 2 - OPT/NSC
- 3 - OPT/SC

r. **Sex and POW Status Codes.** The DHCP fee-basis module interfaces with the ADT DHCP package providing access to this registration data entered through ADT options.

s. **Approved By.** The name and title of the clinic Director will automatically be entered in this block. A facsimile signature of this official will be stamped by authorized administrative personnel on the original copy of requests for medical services authorizations or for home nursing services when there is documentation of authorization by professional designee of the clinic Director in the medical record. Medical Administration Service personnel will be designated in writing by the Chief, Medical Administration Service to perform this function. The employees designated this responsibility will not certify invoices for payment for services provided to a veteran whose fee-basis authorization was approved by those employees. The entry of the name and title of the clinic Director is to be done through "Enter/Edit Site Parameter" at the time the DHCP fee-basis software is installed.

### **III. MASTER RECORD FILES**

#### **a. Veteran**

(1) The instructions for preparation of the VA Form 10-7079 (the initial input document) are contained in the "Request for Outpatient Medical Services" section of this appendix as well as the "Medical Fee - Enter Authorization" section of the DHCP Fee-Basis User Manual.

(2) With the implementation of the DHCP fee-basis package COJs will be responsible for maintaining master files on two computer systems. Veteran files will continue to be maintained by the Central Fee system at the Austin DPC. DHCP Fee requires the use of the veteran file at the local level as well. It is most important that both sets of files be identical. In an attempt to ensure file accuracy, the DHCP system automatically creates MRAs (Master Record Adjustments) whenever it can distinguish that a change to the local data files needs to be forwarded to the central files. There are instances where changes to local data files should NOT result in changes to the central file, as when the data captured at the local level is not used by the central fee system.

(3) The purpose of the Veteran MRA DHCP option is to allow users to make adjustments to the veteran master record in Central Fee in Austin.

(4) Automatic creation of a Veteran MRA occurs only when the data related to long-term authorization. Any authorization with a Treatment Type Code of "ID Card Status" or "Home Health" is considered long-term.

(5) An Add Type MRA will automatically be created when:

(a) A new long-term authorization is entered for a veteran.

(b) A short-term authorization is changed to long-term.

(6) A Change Type MRA will automatically be created when the following long-term authorization data is edited:

(a) From Date

(b) To Date

(c) Purpose of Visit

(d) Treatment Type (Changed from "ID Card" to "Home Health" or "Home Health" to "ID Card")

(e) Type of Care

(f) Whenever the address data is edited during a reimbursement payment associated with a long-term authorization.

(7) MRA's are NOT created whenever the Registration or Load/Edit options are used through the DHCP ADT program. After any changes/corrections are made through the DHCP ADT program a Change Type Veteran MRA must be done to update the Central Fee file in Austin.

(8) There are four options in the Veteran MRA menu, consisting of:

(a) Add Type Veteran MRA

(b) Change Type Veteran MRA

(c) Delete Type Veteran MRA

(d) Reinstate Type Veteran MRA

(9) The **Add Type Veteran MRA** option is used to add veteran master records to the Central Fee system when the automatic MRA transmission failed or rejected. If the Veteran MRA rejected on the 10001 Report, Fee-Basis MRA and Batch Header Rejects, the user would need to make the correction to the authorization, using either the Load/Edit option or the Enter Authorization option, and use the Add Type Veteran MRA option to add the veteran to Central Fee.

(10) The **Change Type Veteran MRA** option is used when the automatic Change MRA transmission failed or rejected on the 10001 Report, Fee Basis MRA and Batch Header Rejects, or when the Load/Edit or Registration options are used. The system cannot change the FROM and the TO date of an authorization on the same day. If the user is trying to change the FROM date of the authorization, the user must answer "Y" to the question, "Auth. From Date Change?" If the user has changed the address of a fee-basis veteran, a Change Type Veteran MRA must be transmitted to change the address in the Central Fee system in Austin DPC.

(11) The **Delete Type Veteran MRA** option is used when the veteran's long-term or home health authorization period has expired or is being cancelled. Note: Changing the TO date or leaving the TO date of the long-term or home health authorization the same does not put the veteran in delete status in Central Fee. The user MUST use the Delete Type Veteran MRA option. Short-term authorizations are not entered in the Central Fee system and do not need to be put in delete status. Central Fee will automatically the veteran in delete status after 3 years of no payment activity and validity date has expired.

(12) The **Reinstate Type Veteran MRA** option will reinstate veterans in delete status in Central Fee. If the veteran is not listed on the 03002, Fee Basis Listing - Veterans, the veteran will be re-added as an automatic veteran MRA when the authorization date is changed. Veterans not in delete status may also be re-added to the Central Fee system using the Add Type Veteran MRA.

**b. Veterans' Master Address File**

The DPC will prepare and maintain a veteran's master record file for all veterans on a fee-basis status; home nursing care (code 2), ID card (code 3). The Chief, Medical Administration Service, will be responsible for establishing procedures to ensure maximum awareness and accuracy of veteran's permanent home address and for ensuring changes of address are promptly entered into the ADT DHCP program and that a Change Type Veteran MRA is completed to update the address in the Central Fee system. The Change Type Veteran MRA should be done the same day that the address is changed through the ADT DHCP program.

**NOTE:** *The DPC maintains deleted master records in an inactive status for purging from their files as follows: veterans master files at the end of the fiscal year: fee participants and pharmacies at end of the fiscal year in which the delete transaction was submitted. Clinic personnel may reinstate to an active status these deleted master records during the same fiscal year, as appropriate, by completing a Reinstate Type Veteran MRA.*

**c. Participant/Vendor**

(1) Initial Input and MRA (Master Record Adjustments) are done through DHCP fee-basis options for participants/vendors. Specific instructions regarding DHCP input are in the "Medical Fee - Vendor Options - Display, Enter, Edit Demographics" section of the DHCP Fee-Basis User Manual. Only holders of the security key, FBAA ESTABLISH VENDOR, may enter or edit vendor information.

(2) The purpose of these vendor options is to allow users to enter, edit or display information on individual vendors (doctor, pharmacy, physical therapist etc.). Vendors must be entered correctly into the system for payment to occur.

(3) The **Display, Enter, Edit Demographics** option allows users to display, enter or edit data under the same option. Vendors may be displayed by entering the name, or the entire ID number, or the last four digits of the ID number.

(4) Users may enter a new vendor using the Display, Enter, Edit Demographic option under Vendor Options. Data entry format is quite structured as follows:

(a) Individual vendors, (doctors, physical therapist, etc.) should be entered in accordance with CALM (Centralized Accounting for Local Management) vendorizing guidelines. See section X of this appendix as well as the Vendorizing Guidelines. It is recommended that the user have access to view CALM so the vendor can be input as it appears in CALM.

(b) Do not use commas or periods as part of the punctuation of a vendor name, such as FAMILY PRACTICE GROUP, P.C.; enter the name as FAMILY PRACTICE GROUP PC.

(c) Vendors with identical names may be entered by using quotation marks at the beginning and ending of the name.

(d) Pharmacy chain store numbers must have three digits (e.g. 003, 111, 325, etc.) and cannot have four digits.

(5) New vendors entered into DHCP fee-basis are automatically batched and transmitted to Central Fee and CALM when the Queue Data for Transmission option is used. Remember, because CALM is the paying file, vendors entered into DHCP should be entered EXACTLY the way the vendors are listed in CALM. Users accessing this option should have access to CALM microfiche or direct access to CALM to verify the vendor listing in CALM. For assistance with vendorizing, refer to the Vendorizing Guidelines booklet distributed by Austin. Only the holder of security key, FBAA ESTABLISH VENDOR, may enter or edit vendors.

(6) Editing a vendor allows the user to change the demographic information of a vendor. Users should not use the edit option to change an ID number if a vendor changes numbers. The old number should be deleted using the Vendor MRA Delete option, and a complete new vendor should be entered.

(7) The following are specific instructions regarding the Vendor Display, Enter, Edit Demographics option:

(a) **Vendor Identification/Register Number.** The first entry is usually numeric but it can also be "P", "T," or "X". Entries 2-9 must be numeric. Entry 10 (if used) should be alpha and is referred to as the suffix which is used when a participant requests payment be made to more than one address. If all 26 alpha (A-Z) suffixes for a basic vendor ID number have been exhausted, contact Austin Finance Vendorizing Unit at FTS 770-4151 and ask for a number to be used. NOTE: The CALM system converts a vendor ID number with an alpha suffix by removing the first digit and moving the remaining eight digits over, e.g. a vendor ID number of 123456789A in FEE would become 23456789A in CALM.

(b) **Delete Vendor.** When a Delete Vendor MRA is submitted the vendor will be deleted from the Clinic DHCP files, but it will not be deleted from the master file in Austin until all computer processing has been completed for the current fiscal year. No payments nor changes can be made while record is in delete status.

(c) **Reinstate Vendor.** A vendor can be reinstated if they were previously deleted with the current fiscal year. Refer to report No. 03001. If two asterisks (\*\*) appear at the end of the print line, the vendor was placed in delete status within the present fiscal year and can be reinstated.

(d) **Physician Specialty Code.** The valid specialty codes from MP-6, part V, supp. No. 1.5, chapter 4, section A, item 29, follow:

CODE	PHYSICIAN SPECIALTY
16 .....	Allergy and Immunology
01 .....	Anesthesiology
30 .....	Dermatology
32.....	Internal Medicine
04.....	Neurological Surgery
50.....	Neurology
03.....	Obstetrics and Gynecology
06.....	Ophthalmology
07.....	Orthopedic Surgery
08.....	Otolaryngology (ENT)
15.....	Family Practice

17	Nuclear Medicine
72	Pathology
40	Pediatrics
73	Physical Medicine and Rehab.
09	Plastic Surgery
41	Preventive Med. and Public Health
10	Colon and Rectal Surgery
51	Psychiatry
52	Psychiatry and Neurology
61	Radiology
02	Surgery
11	Thoracic Surgery
12	Urology
99	Physicians-Nondiplomates

(e) **Type of Vendor Code.** Must be coded as follows:

1	Public Hospital
2	Physician
3	Pharmacy
4	Prosthetics
5	Travel
6	Radiology
7	Laboratory
8	Other

(f) **Vendor Participation Code.** Must be coded as follows:

01	Doctor of Medicine
02	Doctor of Osteopathy
03	Home Nursing Care
04	Dentist
05	Community Nursing Home
06	Contract Hospital
07	Contract Readjustment Counseling
08	Contract Halfway House
09	HISA
10	Home Health Services
11	Dialysis
12	All Other Individual Participants
13	All Other Participants (Not Indiv)
14	Pharmacy

(g) **Vendor Chain Store Number.** Enter 3 digit chain store number. Usually applicable to pharmacy vendors only.

(h) **Clinic Affiliation.** The name of clinic the vendor is affiliated with, if any, should be entered here.

**d. Pharmacy**

(1) The Pharmacy Fee-Basis program is a payment process for medication reimbursement of emergent medications provided to eligible veterans by local hometown pharmacies. The program will reimburse the hometown pharmacy (vendor) or the veteran when the veteran has paid the vendor directly.

(2) The pharmacy payment process consists of utilizing the following options:

(a) The **Enter Pharmacy Invoice** option is used to enter pharmacy invoices. The system will automatically assign a new invoice number when the user is entering a new pharmacy invoice. In order to continue with a previously entered invoice, the user must enter that invoice number. Please note, as with medical payments, the user should write the invoice number assigned by the computer on the actual invoice for future reference. The user does NOT have to have an open pharmacy batch when entering invoices.

(b) The **Review Fee Prescriptions** option will be used by Pharmacy Service to determine if a veteran is entitled to a particular medication. If the prescription is disapproved for payment, the denial reason will automatically be placed in the suspension file and will generate a letter to the pharmacist when the Suspension Letters are printed. In order to ensure that payment is at the Red Book/Blue Book cost, the pharmacist must answer the question, "Was a Generic Drug issued to patient?" with a "YES" or "NO" response. Regardless of the answer to that question, the pharmacist must also answer "Enter VA Generic Drug equivalent.". If the pharmacist answers "No" to the initial question, the system will beep when the clerk is completing the invoice payment. This beep notifies the clerk that they payment for the prescription should be based on VA Generic Drug equivalent Red Book/Blue Book cost. The pharmacist also has the opportunity to enter any remarks; for example, if the prescription is for a 6-month supply, the pharmacist may record that only a 10 day supply be approved for payment. These remarks are displayed when the MAS clerk is completing the invoice for payment.

(c) The **Complete Pharmacy Invoice** option is used after the pharmacist reviews the prescription and allows the user to enter the remaining payment data. The user must complete the Red Book/Blue Book cost, verify the amount paid and amount suspended, and complete the suspension code. If the user has an open pharmacy batch, the user may assign the invoice to a batch at this time or the process may be completed during the Close Out Pharmacy Invoice option.

(d) The **Open Pharmacy Batch** option is used to open a pharmacy batch in order to reimburse pharmacies and/or patients. Users may find it beneficial to have "Batch Options" on the menu of the clerks performing the Fee Pharmacy responsibilities.

(e) The **Close Out Pharmacy Invoice** option is used to assign invoices payable to pharmacies to batches. This option is utilized after all of the other steps of the payment process have been completed. Only those invoices that have processed through the Enter Pharmacy Invoice, Review Fee Prescription and Complete Pharmacy Invoice options may be closed out.

(f) The **Patient Reimbursement** option is used to assign invoices payable to patients to batches. The process is similar to the Enter Pharmacy Invoice option and all steps must be completed (Review Fee Prescription, Complete Pharmacy Invoice, and Close Out Pharmacy Invoice) before the reimbursement may be batched for release of payment to the veteran.

1. If the reimbursement is going to someone other than the veteran, such as a conservator or estate executor, the reimbursement has to be processed as a Pay Out of

System, using SF-1034, Public Voucher for Purchases and Services Other Than Personal. Standard Form 1055, Claims Against the United States for Amounts Due in the Case of a Deceased Creditor, should be filled out by conservator etc. and include their personal Social Security number.

2. If the reimbursement is going to a veteran with a short-term authorization, the DHCP system will automatically send an Add Type Veteran MRA to Central Fee. Remember that short-term authorizations are not in Central Fee, thus the short-term authorization will stay in Central Fee for seven days only in order to process the reimbursement. If the reimbursement rejects, it will be necessary to use the Add Type Veteran MRA at the time that the reimbursement is going through the Reinitiated Rejected Payment Items option.

3. Even though payment is going directly to the patient, the user is required to enter the pharmacy vendor name and ID number. If the pharmacy vendor is not already active in the DHCP system and has not provided their ID number, the user may add the pseudo vendor as follows:

Vendor Name:	FEE REIMBURSEMENT
Vendor ID#:666666666	
Address:	810 Vermont Ave. NW
City:	Washington
State:	District of Columbia
Zip Code: 20420	
County:	Washington

**NOTE:** *It is important that when this vendor is added to DHCP the user should follow immediately with a Fee Only Vendor Add MRA. This vendor should be added to Central Fee, but not to CALM.*

4. DHCP Fee allows the user to change the veteran address information at the time the invoice is being entered. If the address is changed, the system will automatically transmit a Change Type Veteran MRA to Austin so the payment will go to the correct address.

(3) **Register Number (Record Number).** (See Sec. IV, "Fee-Basis Register," in this appendix.) Position 10 must be left blank. If there is more than one pharmacy with the same name and same identification number and check should be sent to different addresses, contact the vendor and request a chain store number. Then, prepare an "Add" transaction.

(4) **Chain Store Number.** Enter if applicable, otherwise leave blank. Any three-digit number is acceptable; however, verify name, register number, chain store number and address with CALM Vendor File as other clinics may be using the same number. NOTE: The CALM system converts a FEE pharmacy register number when the pharmacy is a chain store by removing the first four digits of the register number, substituting the three digits of the chain store number in entries 1-3, moving the remaining five digits to entries 4-8 and placing an "X" in entry 9, e.g., the pharmacy register number "123456789 with chain number 001" would become "00156789X" in the CALM Vendor file. CALM allows only 9 digit ID numbers.

(5) See Section III, "Master Record Files - Participant/Vendor," for full instructions regarding initial input of vendor information as well as Master Record Adjustments.

#### IV. FEE-BASIS REGISTER

##### a. Medical Participant/Vendor Register Numbers

(1) The Social Security number, or tax payer identification number, of the individual fee participant accepted to participate in the fee-basis program will be used as the register number. Appropriate resource material such as the American Medical Association Directory of Physicians, the Yearbook and Directory of Osteopathic Physicians, etc., will be used. Clinics, groups, partnerships, etc., will be identified with the "Taxpayer Identifying Numbers" assigned to them by Internal Revenue Service. "DUNS" numbers (DUNN and Bradstreet Uniform Numbering System Numbers) may be used when "Taxpayer Identifying Numbers" cannot be obtained.

(2) The Social Security number, or taxpayer identifying number, will be solicited from the fee participant/vendor when it is not a matter of record at the clinic. Pseudo Social Security numbers will not be used for this purpose.

(3) State or county health agencies, and city or other civic related health activities without a taxpayer identifying number, will be assigned a 9-digit register number by the COJ only if they are unable to obtain the taxpayer's identifying number. The register number assigned for clinic use only will be comprised of a prefix of two consecutive zeroes, the next two digits will consist of consecutively assigned numbers beginning with 01 and the last five digits will be the participation code of the State or county health agency. A serial log register will be maintained by the clinic to record assignment of register numbers for this purpose. Check with CALM to assure that the number is not already in use for CALM.

(4) When a fee participant/vendor requests payments be made to more than one address, an alpha modifier will be assigned as the 10th digit of the Social Security or taxpayer identifying number.

##### b. Register Listings

(1) The fee basis register file (Report No. 03001) is a listing for both active fee medical vendors and those in delete status who will accept VA beneficiaries as patients.

(2) To facilitate maintenance of a current fee-basis master register file, delete transactions will be transmitted to DPC for fee participants and pharmacies who relocate their practice outside the area of the COJ, and who will not accept VA beneficiaries. Clinics will arrange with the DPC concerning the frequency, e.g., monthly, quarterly, etc., that the listings of fee participants and pharmacies are desired in order to ensure that register files are accurate. **NOTE:** *This may be done by submitting VA Form 30-7589, Request for Data Processing Service to:*

**Department of Veterans Affairs (200/397A)  
Data Processing Center  
1615 East Woodward Street  
Austin, TX 78772 (Exhibit 19)**

(3) The listings contained in Report No. 03001 (Fee-Basis Listing-Physicians, Clinics, Agencies, other Organizations and Fee-Basis Listing-Pharmacies) designate those

vendors in delete status by having two asterisks (\*\*) on the listings appearing to the extreme right of the line item after "ZIP code." The participants and pharmacies containing asterisks will be automatically deleted from the Fee Master File and Register Listing at the end of the fiscal year in which they were placed in delete status. Payments cannot be made to a participant or pharmacy in delete status. Fee participants and pharmacies with no payment activity within the last 2 years will be purged annually by the CALM system. The CALM and FEE systems are matched and records purged from the CALM system are deleted from the FEE system. Listings resulting from the CALM purge and the matching of the two files are forwarded to clinics of jurisdiction.

(4) The register listings will contain the following information:

(a) **Name.** Name of medical participant/vendor.

(b) **Register Number.** Social Security number or taxpayer identifying number or pharmacy register and chain store number.

(c) **Office Address.** Business mailing address including city, State and ZIP code, of fee participant/vendor.

(d) **Specialty Code.** The specialty codes from MP-6, part V, supp. No. 1.5, chapter 4, section A, item 29, should be used. Specialty codes are listed in section III of this appendix.

(e) **Participation Code.** Participation codes provided as in section III of this appendix will be used.

## **V. OBLIGATIONS**

### **a. Obligation Estimates**

(1) The obligation options in fee-basis DHCP are used to enter obligations, acquire information regarding the current balance, make adjustments to the obligation, and track the activity of the batches made against an obligation. Specific instructions are contained in section "Medical Fee - Supervisor Options - Enter Obligation, Adjustment to Obligation Entry, Detail Obligation Display, and Obligation Balance Inquiry" of the DHCP Fee-Basis User Manual.

(2) On the 1st workday of each month, a separate VA Form 4-1358, Estimated Miscellaneous Obligation or Change in Obligation, will be entered through the fee-basis DHCP system to establish estimated costs for Medical and Nursing services, Beneficiary Travel, ID Card Status, Beneficiary Travel short-term, and Pharmacy. These obligations are to cover estimated costs of services rendered for an extended or indefinite period to veterans who have been issued ID cards and, to cover all authorizations to specific fee participants on a limited or short-term basis.

(3) The **Enter Obligation** option is used to enter obligations into the Fee-Basis Obligation file. Using this option does not take the place of preparing the 1358's; this option allows batches to be opened and payments to be made. Each obligation should have a description which clearly identifies the obligation number; e.g., July long-term, June Fee Pharmacy, etc. Obligations must be entered before payment batches may be opened. Only users with the security key, FBAASUPERVISOR, may use this option.

(4) **Adjustment to Obligation Entry** is an option used to enter adjustments to different obligation numbers. When a payment batch is released through the Release a Batch option, an adjustment is automatically made to the obligation. Individual adjustments may also be made to the obligation; for example, if more money is needed in an obligation, an increase is made to the obligation. Only holders of the FBAASUPERVISOR security key may enter adjustments.

(5) **Detail Obligation Display** lists all activity (batches released, manual adjustments, rejected payments) made against an obligation. This option can be printed on a device and is helpful when verifying batch amounts, determining open balances, and matching accounts with Fiscal Service.

(6) Rejects as shown on Fee-Basis Medical Control Register Listings (Report No. 10002) will be deleted and VA Forms 4-1358 adjusted accordingly.

(7) At the end of the month, the initial estimated dollar amount and any subsequent changes will be adjusted and the obligation "closed out" through the Adjustment to Obligation Entry option. The obligated amount should represent the total dollar amount of proper bills or invoices received during the month for services covered by each obligation number. The fee-basis beneficiary travel obligation will be adjusted at the end of the month to reflect the total dollar amount actually paid during the month for beneficiary travel.

## VI. INVOICE PROCESSING

### a. Veteran Travel

#### (1) Travel Limitations

(a) Payment at the lowest possible rate prescribed by current beneficiary travel reimbursement policy as stated in M-1, part I, chapter 25, may be made for travel (round trip) between the veteran's permanent or temporary residence and a point considered reasonable to obtain adequate medical services. In unusual circumstances, the clinic Director may approve travel of a greater distance considering such factors as availability of medical personnel or facilities, type of treatment or examination required, etc. Travel will not be approved for a distance greater than the distance to the nearest suitable VA medical facility available to treat the veteran.

(b) Travel expenses will normally be paid at the rate prescribed by current VA directives and subject to the provisions of 38 CFR 17.100 and 17.100(g). Travel expenses, such as hired car, ambulance or other means, will be paid when approved by the clinic Director, or designee, to accommodate the veteran's physical condition. In these instances, payment will be commensurate with the usual fees verified to be prevailing for the type of carrier used in the community where travel is performed.

#### (2) Claims

(a) A claim for beneficiary travel received, or postmarked, within 30 days from the date the veteran initially obtained approved medical services will be approved for payment of travel expenses. This approved travel claim will serve as authority to pay travel allowances for the continuous period of fee-basis status beginning with the initial visit. Claims received, or postmarked, subsequent to the 30-day period will be effective

from the date of receipt, or postmark, of the claim unless the beneficiary meets the criteria of 38 CFR 17.101(a): (1) the circumstances prevented a request for prior travel authorization, (2) due to VA delay or error, prior authorization for travel was not given, or (3) there was a justifiable lack of knowledge on the part of a third party acting for the veteran that a request for prior authorization was necessary. Claims approved under 38 CFR 17.101 will be paid only for travel which occurs after this approval. Claims for travel expenses will be filed in the CHR.

(b) The **Enter Travel Payment** option is used to reimburse the veteran's travel expenses. Veterans authorized fee basis care may, under certain circumstances be authorized reimbursement for their travel expenses from their home to the fee provider. The amount to be paid is then determined and the veteran is reimbursed utilizing the Travel Payment Only option. As in processing fee medical payments, a travel batch must be opened prior to processing any payments.

(c) The **Travel Payment Only** option is used to enter/edit/delete a travel payment for a fee basis patient. Please refer to the Fee Basis User Manual - "Payment Options - Travel Payment Only" for specific instructions regarding travel payment entries.

**(3) Certification of Travel**

(a) Enter notation "\_\_\_\_ miles @ \$\_\_\_\_ for\_\_\_\_visits = \$\_\_\_\_" on medical invoice.

(b) Payment of travel expenses totalling \$5 or more will be processed for payment in the daily processing. Lesser amounts will be accumulated by DPC and processed for payment at the end of the month regardless of the total amount to be paid. The DPC will prepare and forward the Fee-Basis Medical Control Register Listing (Report No. 10002) to the clinic. Rejects are deleted and totals adjusted. VA Form 4-1358 is changed accordingly and Fiscal Service notified of the new total.

(c) Upon receipt of Report No. 12004, "Outpatient Payment Listing," review and certify payment of travel as follows:

"Travel performed incident to medical treatment services obtained under authority of ID card. Approved claim for travel expense reimbursement on file.

\_\_\_\_\_  
Name Title

\_\_\_\_\_  
Date"

(d) Forward certified copy of Report No. 12004 to Fiscal Service for release of 994 transactions.

(e) If batch or line item rejects in Report No. 10002, resubmit medical and travel. If reject is in Report No. 12009, Fee Basis Input-Reject Listing, in which case Fiscal Service can verify if both medical and travel rejected or if only medical or only travel rejected. This verification can be done by Fiscal Service by locating the line number assigned by the computer and the prefix number assigned for CALM (julian processing date + 500 + C,D,K,M,N,P,R or T, as appropriate) or Report No.12009. (See description of Report No. 12009 in Reports section.) From Report No.12009, Fiscal Service can

check Report No. 12007 showing prefix numbers that are new, processed or continued and Report No. 12006 showing line item numbers or prefix numbers that have been deleted by Fiscal Service. Medical Administration Service personnel may assist Fiscal Service personnel with these verification actions.

**b. Fee-Basis Medical Services**

**(1) Administrative Review**

(a) Invoices in letters opened in the mail room, because it was not addressed to a particular unit, will be date stamped in the mail room on date of receipt. Such invoices will be delivered to the concerned unit on date of receipt. Invoices in letters addressed to a particular unit, such as the Fee Services section, will be opened and date stamped on the date of receipt in that unit. Medical Administration Service personnel will determine:

1. If treatment was rendered for a condition approved for treatment;
2. If the number of treatments increased markedly or other factors suggest need for professional review;
3. That fees are in line with those charged the general public and not in excess paragraph 18.51, this manual; and
4. That total charges do not exceed \$125.00, or other approved limitation, for any 1 month.

(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 for VA.

(c) Invoices from physicians and supportive medical personnel providers not qualified to treat veterans as VA beneficiaries will not be approved for payment. The physicians or individual concerned will be notified by the clinic Director of the reason for denial and that payment for services rendered will be a private matter between the provider and the veteran. The veteran will be concurrently informed of the action taken. When unusual circumstances exist, the clinic Director may obtain the assistance and advice from the Regional Director.

(d) Fees for treatment provided for a condition that is not recorded on the ID card but for which the veteran is entitled to care may be approved for payment when considered proper by the clinic Director. Completion of the administrative certification of the invoice is the authority to pay the bill as presented.

(e) When an eligible veteran requests and is authorized non-VA care at VA expense, the authorization must cover the cost of all treatment for which eligibility exists. There can be no advance agreement to share the costs, nor can VA suggest to the veteran, either before or after VA authorization for care is granted, that the veteran may elect to receive benefits from a third party or elect to have the third party share costs if the veteran is eligible for such care at VA expense. VA is to be considered the primary payer for these authorizations.

(f) In addition to provisions in subparagraphs a through d of this subparagraph, a proper invoice will include the following:

1. Name and address of the business concern and SSN or employer ID of the physician or other health care providers,

2. Invoice date,

3. Treatment/service date(s),

4. The veteran's name, the medical condition treated, description of services rendered, appropriate CPT code(s), and fee being charged. If the bill received does not contain the above, it is not a proper invoice and must be returned to the business concern within seven calendar days indicating that payment will not be processed until the above conditions are met. This notification will stop the count of days allowed to process the bill on time. Failure to notify the business concern within seven calendar days that an invoice is improper will result in the payment of an interest penalty. Bills for medical services to veterans for whom eligibility has not yet been established will not be considered valid VA obligations until eligibility for services has been established. In these cases, the business concern will be advised within seven calendar days that the bill is not proper until eligibility can be established.

(2) **Professional Review.** Professional review will be limited to those invoices which require a medical evaluation and decision. The reviewing physician will annotate the invoice as to the action to be taken, initial and forward it for administrative processing. When the number of treatments has increased markedly, or other information indicates a change in the veteran's condition, the reviewing physician will schedule the veteran for staff examination and evaluation, contact the fee-basis physician or take other appropriate action. Results of these evaluations will be documented on SF 509, Medical Record Progress Notes, for filing in the veteran's medical records. (See forms section.)

**(3) Approving Invoices for Payment**

(a) Invoices for payment which have passed administrative or professional review will be included in a batch and the entire batch certified for payment by Medical Administration Service personnel designated in writing by the Chief, Medical Administration Service, to perform this action. A rubber stamp will be used to insert the following certification on approved invoices:

"ADMINISTRATIVE CERTIFICATION: Fees for services and/or supplies furnished are approved in the amounts billed with the following exceptions:\*

---

(Signature, title and date)

\*Amount of \$ suspended"

(b) The "Medical Fee - List Items in a Batch" option of the DHCP Fee-Basis package should be used to print a listing of all approved payments included in a batch. Any suspense codes applicable, by patient name, will be included in this listing. This listing will be printed, certified, and attached to the applicable invoices and forwarded to

Fiscal Service. The certification of this list will negate the previous requirement that each invoice be individually certified.

(c) Normally, exceptions will be limited to citing those necessary to account for any difference between the amount claimed and the amount approved for payment. When one medical service is rendered during a service month and the amount claimed is different than the amount certified, enter one of the suspension code numbers, as appropriate. Refer to the DHCP Fee-Basis User Manual - "Medical Fee - Payment Options - Enter Payment" regarding procedures for suspending portions of billed amounts. Suspension codes 1 through 9 and A through I, as follows, may be used when appropriate:

CODE	EXPLANATION
1	Charge exceeds maximum amount payable in accordance with VA policy.
2	Adjustment was made to correct mathematical error on your invoice.
3	Medical Service/Ú was provided for a condition which is not authorized at VA expense.
4	Amount differs from amount claimed. An explanatory letter is being forwarded under separate cover.
5	Fees for service previously processed. If payment not received, notify Fiscal Service.
6	Fees for this invoice exceed the monthly dollar limitation established for this veteran.
7	Physician's signature missing on Ú.
8	Patient/representative's signature missing on Statement of Receipt.
9	No evidence of record that medication needed immediately.
A	Pharmacist's certification missing on copy.
B	Certification not signed by pharmacist.
C	NDC code, name of manufacturer, brand name, strength or quantity dispensed, is missing.
D	Item not a medical requisite paid for by VA. (Do not return prescription.)
E	Veteran's full name, address, or Social Security number missing.
F	Payment for personal items or private room not permitted.
G	Veteran refused transfer to VA medical center. Payment made to date stabilized or date of refusal.
H	Ú is for recurring/refill medication not paid by VA.
I	Payment for generic equivalent. Prescription did not prohibit substitution.

#### (4) Entries to VA Forms 10-7079a, Payment Information Card

VA Form 10-7079a or copy 3 of VA Form 10-7079 is essentially a worksheet for recording payments made for fee-basis services. Data previously recorded on the Payment Information Card will be readily available through DHCP, thus creation of additional cards is not necessary. The previously established cards should continue to be maintained as long as necessary for history information. This "back-up" file should be discontinued approximately 12 months after conversion to the DHCP Fee-Basis program, or when the facility feels the "back-up" information is no longer needed.

#### (5) Authorization for Fee Services Performed in VA Health Care Facilities

One VA Form 10-7078, Authorization and Invoice for Medical and Hospital Services, will be prepared each month for each fee participant providing fee-basis outpatient

services at a VA health care facility. The original and copy 2 will be sent to the fee participant. VA Form 10-7078 will be prepared as follows:

- (a) **Item 1.** The date will normally be the first calendar day of the authorized month.
- (b) **Items 2 through 4A.** The words "not applicable" will be entered in these spaces.
- (c) **Item 5.** The validity period will be from the first to the last day of the authorized month.
- (d) **Items 6 & 7**
  - 1. Estimated number of examinations at per examination rate.
  - 2. Estimated number of outpatient treatment visits at per visit rate.
- (e) **Item 8.** No entry.
- (f) **Items 9 through 12.** Self-explanatory.

b. Copy 4 of VA Form 10-7078 for each fee participant will be forwarded to Fiscal Service at the beginning of each month. The estimated amount of each authorization will be posted on a separate VA Form 10-1358 established for this purpose and charged against the facility's regular medical care operating funds. At the end of the month, Medical Administration Service personnel will assist the fee participants in the preparation of a consolidated invoice for each authorization, listing veterans treated or examined by each person who performed fee services in the VA health care facility during the month. Fees for these services will be charged to cost subaccount 2561.

**c. Fee-Basis Prescriptions**

**(1) Administrative Review**

(a) The pharmacy bills and accompanying prescriptions will be reviewed by the Chief, Pharmacy Service to determine if FDA generic equivalents were dispensed. If a brand name drug was dispensed, the Chief, Pharmacy Service, will check to see if the pharmacist annotated the prescription to explain why a generic drug was not dispensed. If the prescription is properly annotated, the Chief, MAS, will process the bill in accordance with paragraph 18.53. If the bill was not properly annotated, the Chief, Pharmacy Service, will indicate what the generic equivalent would be if one was available. The Chief, MAS, will then process these bills in accordance with the payment methodology used in paragraph 18.53. The prescription will also be reviewed to determine that the following requirements are met:

- 1. The original prescription must bear:
  - a. Date written and name and address of the patient.
  - b. Signature of the prescribing medical or osteopathic physician with the statement, "This medication order is needed immediately for the patient's disability which the VA has authorized me to treat."

c. Signature of VA patient, or a representative if the patient's signature cannot be obtained without undue hardship, to the statement, "I acknowledge receipt of prescription No. \_\_\_\_ (or medical requisite which must be described by common name) on \_\_\_\_ (date)."

d. The name of the manufacturer or brand name of the product dispensed. (if not specified by the physician, the pharmacist will add such data.)

e. If a generic drug was not dispensed, the pharmacist will indicate why the generic drug was not dispensed and be paid the red book or blue book cost of the brand name drug plus the state Medicaid dispensing fee.

2. The certified copy of the prescription must bear:

a. Date written and name and address of the patient.

b. Name of prescribing medical or osteopathic physician with the statement, "This medication order is needed immediately for the patient's disability which VA has authorized me to treat."

c. If the patient's representative is given medication, the representative will sign the following statement, "I acknowledge receipt of prescription No. \_\_\_\_ on (date) ."

d. Signature of the pharmacist to the statement, "I certify that this is a true copy of prescription No. \_\_\_\_ on file under that number at the \_\_\_\_\_."

e. The name of the manufacturer or brand name of the product dispensed. (If not specified by physician, the pharmacist will add such data.)

f. If a generic drug was not dispensed, the pharmacist will indicate why the generic drug was not dispensed and be paid the red book or blue book cost of the brand name drug plus the Medicaid dispensing fee.

(b) The itemized VA Form 10-7191 or the pharmacy's usual billing form will show the veteran's identification number, the prescription number, date filled, amount claimed for each prescription on the invoice and total amount claimed. The pharmacist will place and sign the following certification on the invoice: "I certify that fees claimed are not in excess of rates charged for identical services to other persons who are not VA beneficiaries." **(NOTE: Payments of bills failing to pass this administrative review will be disallowed in keeping with instructions in par. 3, Audit of Prescriptions Filled by Non-VA Pharmacies.)**

(c) Beneficiaries in an approved fee status will be reimbursed by the COJ when they have used their own funds for prescriptions needed for prompt treatment of service-connected or other approved disabilities and such medication was not immediately available from a VA pharmacy or a participating pharmacy, or when the veteran was unaware that such services were available. A receipted statement, signed by the Pharmacist and itemized by the pharmacy as to the kind, quantity and cost of all medicines furnished is required. When approved, direct payment to the veteran will be made. The veteran will be advised as to how to procure medicines in the future. Refer to the "Pharmacy Fee - Patient Reimbursement" section of the DHCP Fee Basis User Manual as well as the "Master Record Files - Pharmacy" of this appendix for

instructions regarding this procedure. Veterans who have had their prescription filled with brand name drugs will be reimbursed the amount the veteran paid the pharmacy.

(2) **Professional Review.** Reviews by staff physicians of fee-basis prescriptions will be limited to invoices which require a medical evaluation and decision. All prescriptions written by fee-basis physicians and filled in non-VA pharmacies will be referred to Pharmacy Service for 100 percent review. Findings will be reported to the clinic Director for evaluation and appropriate action, when determined necessary by the Chief, Pharmacy Service.

(3) **Audit of Prescriptions Filled by Non-VA Pharmacies**

(a) Prescriptions written by fee-basis physicians and filled by non-VA pharmacies will be reviewed, prior to approval of payment to determine whether medication was prescribed for a disability approved for treatment.

(b) Payment will be suspended for prescriptions which are not for disabilities approved for treatment. Each entry of any prescription not approved for payment will be deleted for payment by drawing a line in red through the entry. Refer to the "Pharmacy Fee - Complete Pharmacy Invoice" section of the DHCP Fee-Basis User Manual for instructions regarding pharmacy invoice payments, as well as the "Invoices for Medical and Pharmaceutical Services" section of this chapter. A letter may be generated by the DHCP Fee-Basis program for all amounts suspended to advise the veteran and the pharmacy the reason(s) payment was not approved. If a prescription has been annotated, by the pharmacist, that the prescribing physician has been contacted, and the physician has verified that the prescription is for treatment of a condition listed on the veteran's ID card, payment will be approved. When the reviewing physician believes the medication prescribed was not appropriate for the condition under care, that official or designee will discuss the matter with the fee-basis physician. If agreement on the appropriateness of medication cannot be reached, payment for additional prescriptions of the medication in question will not be approved. The veteran and pharmacy involved will be notified.

(c) The Pharmacy Service reviewing official, will identify prescriptions for stabilized conditions, and prescriptions for medications required on a recurring basis, which could be provided more economically by VA. The prescribing physician, and/or the patient, will be contacted and instructed to send prescriptions of this kind to VA for filling.

(4) **Adjusting Amounts Claimed.** Adjustment codes and their explanations are listed under "Approving Invoices for Payment" paragraph of this appendix. When use of any of these suspense codes is not appropriate, a letter explaining the reason(s) for suspension will be sent to the pharmacy signed by the clinic Director or designee.

(5) **Approving VA Forms 10-7191, Statement of Account for Prescriptions.** When an invoice is approved for payment, the Chief, Medical Administration Service, or designee, will sign and date the administrative certification. A rubber stamp will be used to insert this certification on invoices.

(6) **Pharmacy Payment Process**

(a) The DHCP Pharmacy Fee-Basis program is a payment process for medication reimbursement of emergent medications provided to eligible veterans by local hometown

pharmacies. The program will reimburse the hometown pharmacy (vendor) or the veteran when the veteran has paid the vendor directly.

(b) The pharmacy payment process consists of utilizing the following options in the DHCP Fee-Basis package:

(1) The **Enter Pharmacy Invoice** option is used to enter pharmacy invoices. The system will automatically assign a new invoice number when the user is entering a new pharmacy invoice. In order to continue with a previously entered invoice, the user must enter that invoice number. NOTE: As with medical payments, the user should write the invoice number assigned by the computer on the actual invoice for future reference. The user does not have to have an open pharmacy batch when entering invoices. Invoices may be entered so the pharmacist either reviews or does not review the prescriptions.

(2) The **Review Fee Prescriptions** option is used by Pharmacy Service to determine if a veteran is entitled to a particular medication. If a prescription is denied by Pharmacy they put in "remarks" that payment is denied. When prescription is "completed" the appropriate suspension code will be entered by MAS. A letter will be generated to the pharmacist when suspension letters are printed. In order to ensure that payment is at the Red Book/Blue Book cost, the pharmacist must answer the question, "Was a Generic Drug issued to patient?" with a "YES" or "NO" response. Regardless of the answer to that question, the pharmacist must also answer "Enter VA Generic Drug equivalent:". If the pharmacist answers "No" to the initial question, the system will beep when the clerk is completing the invoice for payment. This beep notifies the clerk that the payment for the prescription should be based on the VA Generic Drug equivalent Red Book/Blue Book cost. The pharmacist also has the opportunity to enter any remarks; for example, if the prescription is for a 6-month supply, the pharmacist may record that only a 10-day supply was approved for payment. The remarks are displayed when the clerk is completing the invoice for payment.

(3) The **Complete Pharmacy Invoice** option is used after the pharmacist reviews the prescriptions and allows the user to enter the remaining payment data. The user must complete the Red Book/Blue Book cost, verify the amount paid and the amount suspended, and complete the suspension code. If the user has an open pharmacy batch, the user may assign the invoice to a batch at this time or the process may be completed during the Close Out Pharmacy Invoice option.

(4) The **Open Pharmacy Batch** option is used to open a pharmacy batch in order to reimburse pharmacies and/or patients. Users may find it beneficial to have "Batch Options" on the menu of the clerks performing the Fee Pharmacy responsibilities.

(5) The **Close Out Pharmacy Invoice** option is used to assign invoices payable to pharmacies to batches. This option is utilized after all of the other steps of the payment process have been completed. Only those invoices that have processed through the Enter Pharmacy Invoice, Review Fee Prescription (if this was requested), and Complete Pharmacy Invoice options may be closed out.

(6) The **Patient Reimbursement** option is used to assign invoices payable to patients to batches. The process is similar to the Enter Pharmacy Invoice and all steps must be completed (Review Fee Prescription, Complete Pharmacy Invoice, and Close Out Pharmacy Invoice) before the reimbursement may be batched for release of payment to

the veteran. If the reimbursement is going to someone other than the veteran, such as a conservator or estate executor, the reimbursement has to be processed as a Pay Out of System, using SF 1034, Public Voucher for Purchases and Services Other than Personal. Even though payment is going directly to the patient, the user is required to enter the pharmacy vendor name and ID number. If the reimbursement is going to a veteran with a short-term authorization, the DHCP system will automatically send an Add Type Veteran MRA to Central Fee. Remember that short-term authorizations are not in Central Fee, thus the short-term authorization will stay in Central Fee for one day only in order to process the reimbursement. If the reimbursement rejects, it will be necessary to use the Add Type Veteran MRA at the time that the reimbursement is going through the Reinitiated Rejected Payment Items option.

(c) DHCP Fee allows the user to change the veteran address information at the time the invoice is being entered. If the address is changed, the system will automatically transmit a Change Type Veteran MRA to Austin so the payment will go to the correct address.

(d) VA Form Letter 10-434, Notice to Participating Pharmacy Re Prescription Services for Veterans in ID Card Status, will be prepared by Medical Administration Service and mailed to the new pharmacy participant.

(e) Pharmacies comprising a chain of stores under the same name may submit identical taxpayer identifying numbers. When an invoice is received from a new chain store pharmacy requesting payment to the individual store preparing the bill, Medical Administration Service will telephone the vendorizing unit of CALM, DPC, Austin, TX, (telephone: FTS 770-4151) requesting the next successive FEE chain store number (three digit suffix to taxpayer identifying number).

(f) A current pharmacy register (Report No. 03001) listing will be provided by the DPC.

(g) When payment certification of fee prescriptions is completed, immediately forward original or certified copies of prescriptions to Pharmacy Service for filing.

(h) The DPC has established procedures for routinely providing preheaded VA Forms 10-7191 to participating pharmacies in numbers consistent with the degree of participation. Normally, action by clinic personnel for providing VA Forms 10-7191 will not be required.

## **VII. PAYMENT PROCESS**

a. The DHCP payment process is a series of several options used to automate the fee-basis billing process.

b. First a batch is opened to each user and an obligation number is assigned to that batch. Payments are then entered using the **Enter Payment** option for vendor generated bills for either short-term or long-term authorized care. The **Reimbursement Payment Entry** option is for bills paid by veterans. An invoice number is assigned by the computer when payments are entered. This number should be written on the paper invoice for future reference.

c. The **Multiple Payment Entry** option is used to enter identical (except for service date) medical payments for a patient. This option was designed to accommodate such services as home nursing where the patient may be seen frequently by a visiting nurse.

d. When the user has completed entry of payments, the batch is closed, using the **Close Out Batch** option. Once the batch is closed no further payments may be added to that batch. The **Release a Batch** option is then used by the supervisor to verify that a batch is ready to be transmitted to Austin DPC. Each batch is released individually by the supervisor. Only holders to the FBAASUPERVISOR security key may release batches.

e. The supervisor may display a list of all fee basis batches which are pending release, by using the **List Batches Pending Release** option. Only batches which have been "closed" by the clerk will be on the list and only holders of the security key FBAASUPERVISOR may use this option.

f. Actual transmission of data to Austin DPC uses the **Queue Data for Transmission** option. Any MRA's not yet transmitted, will be transmitted PRIOR to the payment data. Therefore, a veteran may be added to the master file and a bill related to that veteran may be paid in the same submission. Both veteran and vendor type MRA's will be transmitted prior to the payment data. Two separate batches are created for vendor MRA's with one batch for pharmacy type vendors and another for all other type vendors. Because of this there will be instances where an MRA batch will not have any transaction included in it. This causes no problems because the batch is ignored. The data is stored in a mailman message with a separate message for each batch. The messages are stored in the "IN" basket of the user who uses this option.

g. Do not use the batch status option to determine whether the batch has been transmitted. The status of the batch is changed to "Transmitted" when the data in the batch is stored in the mailman message and not when the data is really transmitted. So use of the option for this purpose is not valid.

h. A user can check whether the data has been transmitted by doing a 'Q'query of the mailman message. A query will show the user originating the message, date/time created, local message ID number (number referred to in the confirmation message received back from Austin), and the recipients of the message. The two recipients are the user who used the option and "XXX@Q-FEE.VA.GOV", representing the queue at the Austin DPC. Beside the recipient will be a status. The status will be either "Awaiting transmission" or "Sent". If the status is "Sent" the date and time sent and the message number assigned by Austin will be noted.

i. The mailman messages are sent in the sequence they are created. If five messages (batches) were queued for transmission, and a query of the first message shows the status as "awaiting transmission", you need not bother checking the remaining messages, as they could not have been sent. If the first message has been sent, you then can check the status of the last message. If the last has been sent, they all have been sent.

j. The Austin computer system will automatically send a confirmation message for every message it receives. The subject will be "FEE CONFIRMATION" and the date/time sent will be noted. It will be from "POSTMASTER@FOC-AUSTIN.VA.GOV". The body of the message will state "Ref: Your FEE message #nnnnnn with Austin ID nnnnnn, MSC confirmation number is n-nn-nn-nnnnn."

k. Detail analysis of the confirmation messages is not usually necessary. If 10 fee messages were queued for transmission and 10 confirmation messages are received from Austin, there is no need to review the confirmation messages. If you receive less confirmation messages than there were Fee messages, not all Fee messages were

transmitted. This can happen for several reasons and those that are not sent will be transmitted the next time the Queue option is used.

### **VIII. BATCH OPTIONS**

a. Once a batch is opened in the DHCP Fee-Basis package these batch options allow individuals to monitor open batches and make appropriate changes within the batches.

b. The **Display Open Batches** option is useful as a supervisory tool and to see how many batches are yet to be paid against the obligation at the end of the month. Remember, only the supervisor and the user who opened the batch may close it.

c. The **Edit Batch Data** option allows the user to edit the batch obligation number and date opened. The user cannot change the type of batch such as a medical batch to a pharmacy batch. Users may want to edit an empty batch at the beginning of a month when the obligation number changes. Users with the FBAASUPERVISOR security key may edit any batch data.

d. The **List Items in a Batch** option is used to display all payment items in a selected batch. A user may access this option to determine why the batch does not balance. This option may also be used to determine if open batches have payments.

e. The **Re-open a Batch** option may be used when users have closed a batch, but want to re-open it to continue making payments in the same batch. Users may also access this option when they have closed a batch and need to re-open it or delete a payment. Users may only re-open a batch that they originally opened; however, users with the security key FBAASUPERVISOR, may re-open any batch.

f. The **Status of a Batch** option may be used to obtain the current status of a batch. The user may determine if a batch is open, transmitted, or closed. The user may also determine when a batch was finalized and when payment should have been issued by Austin.

### **IX. FINALIZE A BATCH**

a. After a batch has been transmitted to Austin, Fiscal Service will use the **Finalize A Batch** option to handle any rejects and reassignments to a new batch. This finalizes or vouchers the batch. This option allows Fiscal Service to reject an entire batch or any line item within the batch by patient and line number. It is important to understand that until a batch has been finalized action cannot be taken on rejected line items or reassign rejected items to a new batch. When items are rejected, the dollar amount for those items are added back into the obligation balance. When there are a large number of rejects in a batch (90 percent of line items) it may be easier to reject the entire batch, and then delete the reject flags on those line items not rejected.

b. The **Reinitiate Rejected Payment Items** option is used to transfer payment items that have been rejected by the Central Fee System in Austin and to assign them to a new batch. This option would be utilized after the reasons for rejection have been corrected. It is possible to reinitiate all rejected line items in a batch at once which is useful if the entire batch is rejected, or to reinitiate any one line item. Be sure to assign the new batch the same obligation number as used in the batch with the rejected items.

- c. The FBAASUPERVISOR security key is required to complete these options.

## X. REJECT OF PAYMENT ITEM

- a. The **Reinstate Rejected Payment Item** option allows the user to enter rejected payment items into a new batch and edit to make corrections on the rejected items. All payments should be corrected before re-transmitting to Austin DPC. The user correcting the error may want to document on the rejected invoice any corrective action taken. Users may find it beneficial to create a menu with all necessary menu options needed to correct rejected items, including ADT and DHCP FEE options.

- b. Although the rejects are probably the most difficult portion of the DHCP Fee program there are many similarities to each step of the manual process in finding and correcting the error. The payments usually reject because something was wrong with the veteran or vendor master record. The MRA's reject for reasons such as no county code, incorrect purpose of visit, and wrong type of action. The Reject and Warning Codes are listed in section XIV of this appendix.

- c. After you have identified the reject code and made the appropriate MRA transaction, you are now ready to re-initiate your reject. It is important that you create your MRA transaction prior to reinitiating your rejected items.

## XI. DATA PROCESSING SYSTEMS INTERFACE

There are three data processing systems concerned with processing fee-basis payments. Each system has at least one master file. The systems are as follows:

- a. **FEE (Fee-Basis).** The Central FEE system provides administrative assistance for processing payments and generates statistical data for program monitoring. The system is centralized at the Data Processing Center, Austin, Texas. There are three master files in the FEE system. They are the physician master file (includes clinics, corporations, etc.), the pharmacy master file and the veteran master file. Brief descriptions follow:

- (1) The physician master file contains the medical center number of the COJ that reported the participant to the FEE system, the medical participant's identification number, name of participant, street address, city, State abbreviation, ZIP Code, numeric State code, county code, participation code, specialty code, number of dollars paid by month and last activity date (year, month and day).

- (2) The pharmacy master file contains the medical center number of the COJ that reported the pharmacy to the FEE system, pharmacy identification number, chain store number (if any), name of pharmacy, street address, city, State abbreviation, ZIP Code, numeric State code, county code, number of dollars paid by month and last activity date (year, month and day).

- (3) The veteran master file contains the medical center number of the COJ that reported the veteran to the FEE system, veteran identification number, name of veteran, street address, city, State abbreviation, ZIP Code, birth year, purpose of visit code (C&P examination, etc.), war code, patient type code (medical, surgical, etc.), treatment type code (1, 2 or 3), sex, POW, and date of death if applicable,

ID card issue date, end-of-validity date, numeric State code, county code, number of dollars paid for travel by month and last activity, type and date (medical-M, pharmacy-P, travel-T, and year, month and day).

b. **CALM (Centralized Accounting for Local Management).** The CALM system is VA accounting and payment system. The system is centralized at Austin Finance located at the Data Processing Center, Austin, Texas. All VA facilities are serviced by CALM. Some of the facilities are enhanced-CALM whereby the payment vouchers are filed in Fiscal at the VA facility. The payment vouchers for full-CALM facilities are sent to and maintained at Austin Finance. CALM has a master file of all vendors with whom VA conducts business. FEE payments must be processed through the FEE master file for fee-basis data verification, statistical collection and control and then through the CALM master file for payment. The identification numbers and "stub" names (the first three spaces of the name field) in the FEE and CALM master files must agree to process payments. Examples of CALM "stub" names follow:

<b>NAME</b>	<b>CALM "STUB" NAME</b>
Jones Associates	JON
J J Jones	J J
J Jones	J

c. **AMIS (Automated Management Information System).** AMIS data is accumulated from:

(1) Medical FEE transactions that are released to CALM for payment. These transactions automatically provide the AMIS system with data.

(2) Disk file of accumulated FEE statistics processed 3 workdays prior to the end of the month. At the end of each month, all facilities are furnished Report No. 16002, "Fee Basis System AMIS Flash Count," showing the number of input records and number of visits for the month. A fee-basis visit is defined as: same medical center, same patient, same vendor, same POV, and same treatment date.

## **XII. LISTING OF REPORTS**

A listing of reports that are generated from the Fee system follows. The listing is in numerical order by report number and includes RCS numbers, COIN numbers, frequencies of reports, how reports are transmitted, transmittal forms and distributions. There are a number of other reports reflecting data on the fee-basis program which are too numerous to include in this listing. Those reports are generated by other than the Fee-ADP system. For example, AMIS generates a considerable number of reports from data provided by FEE for AMIS Segment 228. Report Numbers 1UE1 and 1VC1 are only included in this listing because of their importance to Medical Administration Service.

REPORT NUMBER	NAME	RCS #	COIN #	FREQUENCY	TRANSMISSION		DISTRIBUTION
					MEDIA	FORM	
03001 (1st part)	Fee Basis Listing-Physicians Clinics, Agencies and Other Corporations	10-0004	OPF 14	As Requested	Mail	Hard Copy	MAS
03001 (2d part)	Fee Basis Listing-Pharmacies	10-0004	OPF 14	As Requested	Mail	Hard Copy	MAS
03002	Fee Basis Listing-Veterans	10-0004	OPF 14	As Requested	Mail	Hard Copy	MAS
10001 (A&B)	Fee Basis MRA and Header Reject	10-0004	OPF 1	Daily	E MAIL	Teletype	MAS
10002	Outpatient Payment Listing	10-0004	OPF 2	Daily	E MAIL	Teletype	MAS
10002	Inpatient Payment Listing	10-0004	OPF 2	Daily	E MAIL	Teletype	MAS
10003	Summary Hometown Pharmacy Payment	10-0004	OPF 3	Daily	E MAIL	Teletype	MAS
12001	FEE Basis Control Reject Listing	10-0004	OPF 4	Daily	E MAIL Mail	Teletype Hard Copy	Fiscal Field facilities Austin Finance
12002	Pharmacy - Payment Listing Hold/Pending Payments	10-0004	OPF 5	Daily	E MAIL Mail	Teletype Hard Copy	MAS/Fiscal Field facilities Austin Finance
12003	Medical/Other Services Listing Hold/Pending Payments	10-0004	OPF 6	Daily	E MAIL Mail	Teletype Hard Copy	MAS/Fiscal Field facility Austin Finance
12003	Contract Hospitalization Payment Listing (INP)	10-0004	OPF 6	Daily	E MAIL Mail	Teletype Hard Copy	MAS/Fiscal Field facility Austin Finance
12003	Community Nursing Home Payment Listing (INP)	10-0004	OPF 6	Daily	E MAIL Mail	Teletype Hard Copy	MAS/Fiscal Field facility Austin Finance
12003	Dental Payment Listing (OPT)	10-0004	OPF 6	Daily	E MAIL Mail	Teletype Hard Copy	MAS/Fiscal Field facility Austin Finance
12003	Dialysis Payment Listing (OPT)	10-0004	OPF 6	Daily	E MAIL Mail	Teletype Hard Copy	MAS/Fiscal Field facility Austin Finance

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REPORT NUMBER	NAME	RCS #	COIN #	FREQUENCY	TRANSMISSION MEDIA	TRANSMITTED FORM	DISTRIBUTION
<b>12004</b>	Veteran Reimbursement Payment Listing Hold/Pending payments	10-0004	OPF 7	Daily	E MAIL Mail	Teletype Hard Copy	MAS/Fiscal Field facilities Austin Finance
<b>12004</b>	Beneficiary Travel Payment Listing Hold/Pending payments	10-0004	OPF 7	Daily	E MAIL Mail	Teletype Hard Copy	MAS/Fiscal Field facilities Austin Finance
<b>12005</b>	Register-Vendor File Update Listing	10-0004	OPF 8	Daily	MSG Mail	Hard Copy Hard Copy	Austin Finance Austin Finance
<b>12006</b>	Linkage Input Control File Deletion Records	None	OPF 9	Daily	E MAIL Mail	Teletype Field Facilities Hard Copy	MAS/Fiscal Austin Finance
<b>12007</b>	Stored Linkage Input Processing Status	NONE	OPF 10	Daily	E MAIL Mail	Teletype Hard Copy	MAS/Fiscal Field facilities Austin Finance
<b>12008</b>	Fee Basis Generated Type 942 Input	None	OPF 11	Daily	MDG	Hard Copy	Austin Finance A&C
<b>12009</b>	Fee Basis Input-Reject Listing	None	OPF 12	Daily	E MAIL Mail	Teletype Hard Copy	MAS Fiscal Field facilities Austin Finance
<b>12010</b>	CALM (Fee Basis) System Interest Penalty Payment Report	10-0004		Daily	E MAIL Mail	Teletype Hard Copy	MAS Fiscal Field facilities Austin Finance
<b>16001</b>	Fee System-AMIS/FEE Basis Seg-228 Report	None	OPF 13	Monthly (2 Days Prior to EOM)	Mail	Hard Copy	VACO
<b>16002</b>	Fee Basis System-AMIS Flash	10-0004	OPF 27	Monthly (2 Days Prior to EOM Daily)	E MAIL	Teletype	MAS (Field facilities)

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REPORT NUMBER	NAME	RCS #	COIN #	FREQUENCY	TRANSMISSION MEDIA	TRANSMITTED FORM	DISTRIBUTION
25001	FEE Basis List of Veterans With More Than 36 Months of No Payment Activity	10-0004	OPF 39	Monthly	Mail	Hard Copy	MAS (Field facilities)
26001	Veterans Whose FEE Basis Validity Period Needs Review - (Up coming Expiration Date)	None	OPF 38	Monthly	Mail	Hard Copy	MAS (Field facilities)
26002	Veterans Whose FEE Basis Validity Period Needs Review (End -Validity "Follow-up Requirements)	None	OPF 38	Monthly	Mail	Hard Copy	MAS (Field facilities)
28001	Fee Basis System Veteran Record Updated With Date of Death Resulting From BIRLS Match	10-0004	OPF 47	Monthly	Mail	Hard Copy	MAS (Field facilities)
60001	FEE Basis System Veteran Payment Analysis medical center Status Report		OPF 20	Quarterly	Mail	Hard Copy	MAS Field VACO (141A8) (161B2) (162) (34)
60002	Fee Basis Veteran Payment Analysis	10-0004	OPF 21	Semiannually	Mail Mail	Hard Copy Microfiche	MAS (Field facilities) VACO (161B2) (162) (34)
70001	Cost Analysis of FEE Basis Medical Voucher	10-0004	OPF 26	Annually(FY)	Mail	Microfiche (161B2)	VACO (162) (34)
70002	Participant (Medical) Detailed Summary	10-0004	OPF 29	(FY)	Mail	Microfiche	(162)
70003	Physician/Pharmacy Earnings Report, Participant (Pharmacy) Detailed Summary	10-0004	OPF 29	Semiannually (FY)	Mail Mail	Hard Copy Microfiche VACO	MAS (Field facilities) (161B2) (162) (34)

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REPORT NUMBER	NAME	RCS #	COIN #	FREQUENCY	TRANSMISSION MEDIA	TRANSMITTED FORM	DISTRIBUTION
<b>70004</b>	Consolidated Physician/Pharmacy Earnings Report-Medical Participants Paid by More Than One FEE COJ	10-0004	OPF 29	Semiannually (FY)	Mail	Microfiche  (161B2)	MAS (Field facilities) VACO  (162) (34)
<b>70005</b>	Consolidated Physician/Pharmacy Earnings Report-Medical Participants Paid by More Than One COJ	10-0004	OPF 29	Semiannually (FY)	Mail	Microfiche  (161B2)	MAS (Field facilities) VACO  (162) (34)
<b>70006</b>	Cost Analysis of Fee Basis Medical Voucher by Veterans by Average Monthly Cost for All Data Processed During Fiscal Year	10-0004	OPF 26	Annually (FY)	Mail	Hard Copy	VACO (161B2)
<b>70007</b>	Costs by Facility, State & County & Purpose of Visit Parts I-IX	10-0004	OPF 31	Annually (FY) (FY)	Mail	Hard Copy Microfiche	MAS (Field facilities) VACO (34) (162)
<b>70008</b>	Costs by Facility, State & County & Purpose of Visit Parts I-IX	10-0004	OPF 32	Annually (FY) (FY)	Mail	Hard Copy Microfiche	MAS (Field facilities) VACO (172) (162) (34)
<b>70009</b>	Report to Congress Provision of Care by Contract Programs	10-0004	OPF 34	Annually (FY) (FY)	Mail	Hard Copy Microfiche	MAS (Field facilities) VACO (172) (34)
<b>80001</b>	Physician Inactive Listing and Pharmacy Inactive Listing	10-0004	OPF 19	Semiannually (FY)	Mail Mail	Hard Copy Microfiche	MAS (Field facilities) VACO (161B2) (162) (34)

REPORT NUMBER	NAME	RCS #	COIN #	TRANSMISSION FREQUENCY	TRANSMITTED MEDIA	FORM	DISTRIBUTION
<b>80002</b>	Physician/Pharmacy Earning Report, Participant (Medical) and Participant (Pharmacy)	10-0004	OPF 18	Semiannually (FY)	Mail	Hard Copy Microfiche	MAS (Field facilities) VACO (161B2) (162) (34)
<b>IUEI</b>	Report of Outpatient Visit by Purpose and Type-FEE	10-0004		Monthly	Mail	Hard Copy	MAS (Field facilities) VACO (722) (162) (34)
<b>IVCI</b>	FEE Management Control Report (AMIS)	10-0004		Monthly	Mail	Hard Copy	MAS (Field facilities) VACO (722) (162) (34)
<b>80002</b>	Physician/Pharmacy Earning Report, Participant (Medical) and Participant (Pharmacy)	10-0004	OPF 18	Semiannually (FY)	Mail	Hard Copy Microfiche	MAS (Field facilities) VACO (136F) (162) (34)
<b>S0101</b>	Fee No Match Non Zero Stub Mismatch Listing Physicians & Clinics		OPF 42	annually	Mail	Hard Copy	MAS (Field facilities) VACO (161B2) Austin Fin
<b>S0102</b>	Fee No Match Non Zero Stub Mismatch Listing Pharmacies		OPF 40	annually	Mail	Hard Copy	MAS (Field facilities) VACO (161B2) Austin Fin
<b>S0103</b>	Fee No Match Zero Listing Physicians & Clinics		OPF 41	annually	Mail	Hard Copy	MAS (Field facilities) VACO (161B2) Austin Fin

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REPORT NUMBER	NAME	RCS #	COIN #	FREQUENCY	TRANSMISSION MEDIA	TRANSMITTED FORM	DISTRIBUTION
<b>S0104</b>	Fee No Match Zero Listing Pharmacies		OPF 44	annually	Mail	Hard Copy	MAS (Field facilities) VACO (161B2) Austin Fin
<b>S0105</b>	MD/PR File Summary of Purged and Non-Zero/Mismatched Records		OPF 44	annually	Mail	Hard Copy	MAS (Field facilities) VACO (161B2) Austin Fin
<b>020</b>	Physician/Pharmacy or Veterans Reports			Request	Mail	Hard Copy	MAS (Field

### XIII. DESCRIPTION OF REPORTS

Input data provided by the clinics on all fee-basis related transactions are used by the computer to generate a number of reports. One of the uses of these reports is to assist management in VA Central Office and the clinics in monitoring payments made, providing number of visits with related dollar volume and other statistics concerning the outpatient medical, pharmacy and travel fee-basis program. Several of the reports are vital in day-to-day fee-basis operations as they provide the clinics with reject and warning codes which need review for possible correction and resubmission of transaction in order for payments to be made. The reports are based on data residing in the central fee files at Austin DPC. Descriptions of the reports follow:

#### a. Recurring Reports

(1) Report No. 03001, Fee-Basis Listing - Physicians, Clinics, Agencies, and Other Corporations (part 1) and Fee-Basis Listing - Pharmacies (part 2). These listings represent vendors in active or delete status on central fee file and contain the ID number, specialty code, name, address, city, state, zip code, participation code and two \*\*'s if vendor is in "delete" status and provides a total record count. The list is generated based upon a request for data processing service from a COJ specifying desired frequency and number of copies of report. It may be requested in alphabetical sequence by name, by ID number sequence or by both sequences. If listing is needed by geographical location, i.e., by state code, zip code, etc., refer to the 020 series reports. If a physician, clinic, agency or corporation on part 1 or a pharmacy on part 2 has two \*\*'s (in delete status), they may be reinstated in the current fiscal year.

(2) **Report No. 03002, Fee-Basis Listing - Veterans.** Report No. 03002 is a listing of veterans in the central fee-basis master file. Home Health veterans, POV 70-73, are listed at the beginning. The listing contains the ID number, name, address, city, state, zip code, issue date, expiration date, treatment type, purpose of visit, and delete code. The code N, X, or D at the end of the print line indicates that the veteran was placed in delete status this fiscal year and can be reinstated during the same fiscal year. Veterans in delete status D were deleted by the medical center, veterans in delete status N were deleted by Austin DPC, and veterans in delete status X are deceased and were either deleted by BIRLS or receipt of date of death from the medical center. Each listing provides total record count. This listing is generated based upon a request for data processing service from a COJ specifying desired frequency and number of copies of the report. This may be requested in alphabetic sequence by name, by ID number sequence or by both sequences. If listing is needed by geographical location, e.g., state or zip code, refer to the 020 series reports.

#### (3) **Report No. 10001, Fee-Basis MRA and Header Rejects**

(a) Report No. 10001 is a listing of Master Record Adjustment and batch header transactions for review and necessary action by Medical Administration Service. This report lists only rejections and warnings of one day's processing. Transactions without errors are not shown. Reject codes identify the reason for rejection. 00A, 00B, and 00E are "Warning" codes that indicate the transaction was accepted but requires review and possible action by the clinic. (See "Reject and Warning Codes with Descriptions" section.) If the batch header rejects, prepare a new batch header and retransmit the entire batch.

(b) The total number of MRA's submitted, accepted and rejected is shown at the end of the report.

(c) If indicated action is not taken on rejects, the medical participants' master record file cannot be adjusted, and payments will not be made. On warning codes, review by Medical Administration Service will determine whether or not corrective action is required.

(d) Footnotes corresponding to reject code 039 and warning code 00E are reflected at the bottom of the report when applicable.

(4) **Report No. 10001A, Fee-Basis MRA and Header Rejects.** Report No. 10001A is a listing of veteran(s) added or attempted to add to your medical center and veteran is already active at least one other COJ. This report is generated based on a reject code 039 or a warning code 00E listed in report 10001. Coordinate with other facility to request corrective action.

(5) **Report No. 10001B, Fee-Basis MRA and Header Rejects.** Report No. 10001B is a listing of veteran(s) that another COJ added or attempted to add to their file and veteran is already active at your COJ. Coordinate with other facility to determine corrective action.

(6) **Report No. 10002, Fee-Basis Medical Control Register Listing**

(a) Report No. 10002 is a listing, by batch, of the payment transactions processed that day. It reflects reject codes (if any). The listing includes medical center number, report number, COIN (Computer Output Identification Number) number, CALM prefix, batch number, record type, veteran's ID number, pay type, name of veteran, vendor ID number, amount approved, obligation number, purpose of visit code, patient type, suspension code (if any), month, day, and year of services rendered, treatment type, invoice date, invoice number and reject codes (if any). This listing contains a summary at the end of the printout of batch totals, dollar amounts accepted and dollar amounts rejected.

(b) If the batch is in balance, the rejected line items need review and possible resubmission. Medical Administration Service must correct each line item containing a reject code.

(c) If the batch is out of balance, a message is printed at the end of the report, "This batch will not be included in subsequent processing. Please resubmit after correction." Correct any errors in batch and resubmit the entire batch.

(7) **Report No. 10003, Fee-Basis Control Register Listing**

(a) Report No. 10003 is a listing, by batch, of the pharmacy payment transactions processed that day. It reflects reject codes, if any. The listing includes medical center number, report number, COIN number, CALM prefix, batch number, record type, veteran ID number, pay type, veteran name, pharmacy register number, chain number (if any), amount claimed, obligation number, amount approved, suspense code, date prescription was filled, prescription number, invoice date, invoice number and reject code. Subtotals (dollar amount and card count) are shown for each pharmacy. This listing contains a summary at the end of the printout which includes batch totals for pharmacy of dollar amount in batch, dollar amount accepted and dollar amount rejected. Also included are total payments, total accepted, and total rejected.

(b) If the batch is in balance, the rejected line items need review and possible resubmission by Medical Administration Service. Corrected data should be resubmitted under a new batch number

(c) If the batch is out of balance, a message is printed at the end of the report, "This batch will not be included in subsequent processing. Please resubmit." Correct any errors in batch and resubmit the entire batch.

**(8) Report No. 12001, Fee-Basis Control Reject Listing**

(a) Report No. 12001 is a listing for Fiscal Service of linkage input transactions (code 994) that were rejected in that day's processing. It shows reject codes that identify the reason for the rejection. An example of the print line follows:

"087FEE. 123.994.01.110179.648200.403P007593.403P007594.\$" The "087FEE" indicates FEE reject 087, "123" is medical center number, "994" is the transaction code, "01" is the status code, "110179" is transaction date, "648200" is reference number, "403P007593" and "403P007594" are interface record identification numbers appearing on these rejected 994 transactions and "\$" indicates end of message. The "."s (periods) in the print line represent a break in fields coded.

(b) This report is transmitted to all clinics and a printed report of full-CALM medical centers is sent to Austin Finance. Fiscal Service at the clinics receive their rejects in a teletype formatted similarly to the Report No. 12001; however, it contains no header line title nor identifying numbers.

**(9) Report No. 12002, Outpatient Fee-Payment Listing--Pharmacy**

(a) Report No. 12002 is a listing for Fiscal Service of pharmacy payment transactions processed that day. This listing is generated daily and includes vendor ID number and payee name. It also includes the prefix number (julian processing date plus 500), plus "P" (for pharmacy), the line item number, obligation number, invoice number, invoice date, stub name, prescription number, veteran ID number, veteran name, dollar amount, date filled, MSG (suspension code) and batch number. It also contains a subtotal for each pharmacy and total number of transactions, total dollar amount of payments and approved total dollar amount to be paid by obligation number at the end of the report. The data appearing on this listing are held in the computer system pending preparation of payment release (FEE transaction 994) by Fiscal Service at (enhanced) CALM clinics and by Austin Finance for full-CALM clinics.

(b) This report is transmitted to full-CALM clinics for information only. A printed reported of full-CALM medical centers is sent to Austin Finance.

**(10) Report No. 12003, Outpatient Fee Payment Listing-Medical**

(a) Report No. 12003 is a listing for Fiscal Service of medical payment transactions processed that day. This listing is generated daily and includes vendor ID number and payee name. It also includes the prefix number (julian processing data plus 500 and "M" for medical, "C" for contract hospital, etc.), the line item number, obligation number, invoice number, invoice date, stub name, veteran's ID number, veteran's name, dollar amount, service date, MSG (suspension code) and batch number. It also contains total number of transactions, total dollar amount of payments approved and total dollar amounts to be paid by obligation number. The data appearing on this listing are held in

the computer system pending preparation of payment release (FEE transaction 994) by Fiscal Service at enhanced-CALM clinics and by Austin Finance for full-CALM clinics.

(b) This report is transmitted to full-CALM clinics for information only. A printed report of full-CALM medical centers is sent to Austin Finance.

**(11) Report No. 12004, Outpatient Fee-Payment Listing-Travel**

(a) Report No. 12004 is a listing for Medical Administration Service and Fiscal Service of travel payment transactions and reimbursements to the veteran processed that day. Separate listings are generated daily for reimbursements and for travel payments totaling \$5 or more. Travel payments that are less than \$5 are accumulated in the computer system until the total is \$5 or greater or until the last processing day of the month at which time a payment transaction will be generated regardless of dollar amount. The listings contain the prefix number julian processing date plus 500 and "R" for reimbursement or "T" for travel, the line item number, obligation number, veteran's ID number, service date, dollar amount, name of veteran, street address, city, state, zip code and batch number. Reimbursement listings also include invoice number and invoice date. Also included are total number of transactions, total dollar amount, and dollar amount totals to be paid by obligation number. The data appearing on this listing are held in the computer system pending review and certification or deletion of line item(s) by Medical Administration Service and receipt of payment release transaction 994 or delete transaction 994 by Fiscal Service at enhanced-CALM clinics and by Austin Finance for full-CALM clinics.

(b) This report is transmitted to full-CALM clinics for information only. A printed report of full-CALM medical centers is sent to Austin Finance.

**(12) Report No. 12005, Register-Vendor File Update Listing**

(a) Report No. 12005 is a listing for Austin Finance of FEE transactions that update the CALM vendor file and the FEE participant file. It is a combined listing for pharmacies, physicians and clinics. The listing is printed in vendor register number sequence. The first three digits of the prefix number are the julian date plus 500. The fourth digit represents the transaction type; e.g., add or change. The interface record number is a sequentially computer assigned number. The listing contains the vendor register number, chain number (if any), name of vendor, address (street address, city, State and ZIP Code), stub name in the CALM vendor file for change transactions, participant code and action code.

(b) This report is not transmitted to clinics. It is routed to Austin Finance only.

**(13) Report No. 12006, Linkage Input Control File Deletion Records**

(a) Report No. 12006 is a listing for Fiscal Service showing the status of the control records marked for deletion by a 994 "Delete" transaction. This action places a record in a "Delete" status. It does not delete the record from the file. The listing reflects identification, medical center number, prefix number (julian date plus 500 and "P", "M", "C", "R", or "T", as appropriate), identification record number (line item number), age (number of days records have been stored), and storage status. Also included is disposition (deletion activated) by medical center number, prefix and record number. Deletion may be for a line number or all items included in one prefix number. When all

items are deleted, "X's" will appear for the interface identification number. "Record Disposition Effected" for one or more line items for a particular batch will appear on this report after submission of 994.10 (payment release) transaction by Fiscal to show that "Delete" transaction has been accepted by the computer.

(b) This report is transmitted to all clinics. A printed copy is routed to Austin Finance for full-CALM clinics.

**(14) Report No. 12007, Stored Linkage Input Processing Status**

(a) Report No. 12007 is a daily processing listing for Fiscal Service showing the status of the FEE payment transactions held in the system pending receipt of a 994.10 (payment release) transaction by Fiscal. The listing contains a group number consisting of medical center number and prefix number (julian date plus 500 and "M", "P", "C", "R", or "T", as appropriate), storage status (new or continued) and disposition processed.

(b) Payment transactions pending more than 15 days will be reviewed by VA Central Office Budget and Finance Staff and inquiry by telephone made to Fiscal Service at the COJ.

(c) This report is transmitted to all clinics and to VA Central Office, Budget & Finance Staff. A printed copy is routed to Austin Finance for full-CALM clinics.

**(15) Report No. 12008, Fee-Basis Generated Type 942 Input**

(a) Report No. 12008 is a listing for Fiscal Service computer generated CALM 942 transactions for participants and pharmacies that update the CALM vendor file. Examples of the print lines follow:

1. FEB.002.942.01.110179.541001.345678912. ..SPEAR DRUGS .123 LEE CIRCLE  
..ANYWHERE .US.44811\$ 345678912

2. FEB.002.942.01.022681.541012.12356789X. ..BASIC PHARMACY .1234 Lake ST  
..ANYWHERE .US.44811\$ 444456789 123

3. FEB.002.942.03.110179.541013.34567891A.J D..N.J D DOE MD. 117 EAST I2th  
ST.ANYWHERE.US.44811\$ 234567891A

4. FEB.002.942.01.110179.541014.123456789. ..N.J BROWN MD .195 E MAIN  
..ANYWHERE .US.44811\$ 123456789

(b) The listing is in the format of a CALM transaction (fields are separated by a period). The fields are: FEB (indicates FEE transaction), 002 (CALM routing indicator), 942.01 or 03 (indicates add or change), 6 digit number (medical center number & computer generated record number), CALM ID number, stub name (change transactions only), natural person indicator, vendor name, address, city, state, and FEE vendor ID number. FEE and CALM ID number are different if FEE contains a suffix or chain store number. The ID number is converted to a 9 digit number for CALM. The suffix is converted by dropping the 1st digit, moving the numbers to the left and adding the suffix to the end. The pharmacy chain store number is converted by removing the first four digits of the register number, substituting the three digits of the chain store number for the first three digits, moving the remaining five digits to the left and placing an "X" as the ninth digit; e.g., the FEE number "444456789" with a chain store number of "123" became "12356789X" as the CALM register number.

(c) This report is printed for Austin Finance only.

**(16) Report No. 12009, Fee Basis Input--Reject Listing**

(a) Report No. 12009 is a listing for Fiscal Service of reject and warning messages resulting from processing FEE payment data and master record adjustments against the CALM vendor file. The listing is generated daily and consists of rejects that will not be forwarded to CALM for changing the CALM vendor file and transactions that were previously released by 994 transactions for payment. For full-CALM clinics, Austin Fiscal will reconcile the reject and return the voucher to the clinic for reinput into FEE. For enhanced-CALM medical centers, Fiscal Service at the clinic should reconcile the vendor record and resubmit payment. The first three digits represent the reject and warning code numbers. The rejects must be resolved and resubmitted. The warning code 104 requires establishment of a PAT number in the CALM file. Payment can be released after PAT number has been established. (If the PAT number has not been established in CALM when the prefix is released, all transactions under that obligation number will reject with a "105". Examples of the print lines follow:

1. 105-508554M00070201000A10679 123456789 987654321 10 003800 J D DOE J D INVALID OBLIG NO. A10679

2. 094-508557100000800000 581362388 B B LOVE INVALID VENDOR ID 581362384

(b) In example 1 above, "105" indicates a reject code, "508" is the medical center number, "554M" is the prefix number (julian date plus 500 and "M" for medical transaction), "000702" is the line item number, "01000" is a sequentially computer generated number representing the storage status field, "A10679" is the obligation number, "123456789" is vendor ID number, "987654321" is the veteran's ID number, "10" is the service month, "003800", is amount paid, "J D Doe" is the name of vendor, "J D" is CALM stub name, "INVALID OBLIG NO. A10679" is the printed message.

(c) In example 2, "094" indicates a reject code, "508" is the medical center number, "557" is the prefix number, "1" is "Add" transaction for a medical vendor ("2" is "Add" transaction for a pharmacy vendor, "3" is "Change" transaction for a medical vendor and "4" is "Change" transaction for a pharmacy vendor), "000008" is the interface record number, "00000" is a computer generated number representing the storage status field (always all zeros for MRA's), "581362388" is vendor ID number, "B B LOVE" is the vendor name, "INVALID VENDOR ID 581362384" is the printed message. The format of the report varies for the different reject or warning codes and for the two processing steps involved ("Add" and "Change" transactions).

(d) This report is transmitted to all fee clinics and a printed report is sent to Austin Finance for full-CALM medical centers.

**(17) Report No. 12010, Interest Penalty Payment Report**

(a) This listing is generated whenever a 994 transaction is received for a payment that was released more than 30 days after the invoice date. It includes the vendor ID number, vendor name, invoice number, prefix number, pat number and interest paid. It also summarizes totals by pat number and provides a total of all interest paid.

(b) A payment transaction is automatically generated for CALM.

(c) This report is transmitted to all fee clinics and a printed report is sent to Austin Finance for full-CALM medical centers.

**(18) Report No. 16001, AMIS/Fee-Basis Segment 228 Report**

(a) Report No. 16001 is a listing for the Austin DPC, by clinic number, showing names of the clinics, total number of input records processed and total number of visits. The FEE system provides this information monthly 3 workdays prior to the end of the month via computer file to AMIS (Automated Management Information System). NOTE: This report includes the number of input records and number of visits released for payment and not the numbers processed.

(b) Report No. 16001 is sent to VACO and Austin DPC only.

**(19) Report No. 16002, Fee Basis System AMIS Flash Count.** Report No. 16002 is an AMIS Flash Count teletype printout showing the number of input records and number of visits for a particular COJ. The report is generated for each clinic 3 workdays prior to the end of the month and teletyped to each COJ. NOTE: This report includes the number of input records and number of visits released for payment and not the number processed.

**(20) Report No. 25001, Fee-Basis List of Veterans With More Than 36 Months of no Payment Activity.** Report No. 25001 is a monthly listing for Medical Administration Service of veterans who have been automatically placed on delete status by the DPC because of payment inactivity for more than 36 months and validity date has expired or for short-term status records, 6 months after expiration date. The listing shows each veteran's last name and first and middle initials, identification number, date of last payment recorded, type of last payment and fee-basis ID card issue and expiration dates. The last payment data are posted to the veteran's master file from payment transactions processed through the FEE system and input into the system for statistical purposes of out-of-system medical payments. This report is prepared to assist the clinics in "cleaning up" of their files of veterans on active fee-basis status. Hence, Payment Information Cards and related documents for the veterans listed should be pulled from the clinic's files. If there is any reason why a veteran listed should not have been deleted, the veteran may be reinstated within the same fiscal year according to instructions to reinstate veterans. It is possible for such conditions to be present because there is no mechanism at present to report out-of-system payments for fee pharmacy or fee travel benefits. Hence, such payments will not be reflected in the veteran's master file and veterans receiving such out-of-system payments may appear on this report.

**(21) Report No. 26001, Veterans Whose Fee-Basis Validity Period Needs Review (Upcoming Expiration Dates).** Report No. 26001 is a monthly listing for Medical Administration Service of veterans whose fee-basis ID card validity period is due to expire, usually 90 days from date the report was processed. This listing is prepared to assist Medical Administration Service staff identify those veterans which must undergo mandatory periodic reviews to determine whether or not medical and legal justification is still present to justify continuation of authorized fee-basis care. From the review, the determination must be made whether the veteran's care should be transferred to VA staff or the fee-basis authorization should be terminated or extended. In any event, the central fee file must be updated by either deleting the veteran from the veteran's master file (because the veteran was transferred to VA staff care or the fee

authorization was terminated) or to continue the veteran on active status by submitting a change to the validity period expiration date (to reflect that the fee authorization was extended). It is essential that such updates be submitted to the DPC as soon as the review's outcome is determined. Failure to do so will result in a veteran's continual listing on the following report (Report No. 26002) until the disposition of the review is made known to the DPC. Veterans on short-term status are not listed on this report. This report is for information purposes only. The computer takes no action on these records.

**(22) Report No. 26002, Veterans Whose Validity Period Needs Review (End-of-Validity "Follow-up" Requirements).** Report No. 26002 is a monthly listing of veterans whose fee-basis ID card validity period is due to expire or has expired and who were previously listed on Report No. 26001 for required action by Medical Administration Service. Veterans on this report on which Medical Administration Service has not submitted to DPC a delete or change transaction the result of prescribed reviews will continue to be listed on subsequent reports No. 26002 until appropriate disposition of the veterans' status has been made. Veterans in short-term or delete status are not listed on this report.

**(23) Report No. 28001, Fee-Basis System Veteran Records Updated with Date of Death resulting from BIRLS Match.** Report No. 28001 is a monthly listing for Medical Administration Service of veterans who the BIRLS system has indicated have died. In the case of a death the Fee System will update the veteran master record with the date of death provided by BIRLS and place the master record in delete status. If a veteran has been placed in deceased status in error he may be reinstated and the ending validity date extended by a change MRA transaction.

**(24) Report No. 60001, Fee-Basis Veteran Payment Analysis medical center Status Report.** Report No. 60001 is in two parts. One listing, a combined status report for all medical centers, is routed quarterly on microfiche form to VA Central Office and one hard copy of the listing is routed to Medical Administration Service at each COJ with its data only. The listing includes the FYTD (fiscal year to date) total number of medical visits, average cost per medical visit, average number of medical visits per unique veteran, total amount paid for medical visits, total number of unique veterans with medical visits and the average medical visits costs per unique veteran. It also shows the FYTD total number of prescriptions filled by non-VA pharmacies, total amount of dollars paid for those prescriptions, total number of unique veterans that received prescriptions and the average cost per prescription. Also included is the total dollar amount paid for travel, the number of unique veterans who received travel pay and the average travel amount paid per unique veteran. No action is required on this report by Medical Administration Service. It is provided to assist concerned personnel in monitoring fee-basis program activities.

**(25) Report No. 60002, Fee-Basis Veterans Payment Analysis**

(a) Report No. 60002 is a semiannual listing for Medical Administration of a clinic's veterans for whom payments of \$600 or more for medical services have been paid during the report period. The listing is in descending order by the highest total dollar amount paid for medical services. It includes the total amount paid, by month, for medical, pharmacy and travel and total dollar figure for FYTD plus total visit and prescription count for each veteran.

(b) No specific action is necessary on this report. It is generated for clinic review and analysis of high cost users.

(c) The notation "NOT-IN-FILE" means that the veteran's name is not in the veteran master file under the veteran ID number used for processing payment to the medical participant or pharmacy. Payments were for short-term veterans.

**(26) Report No. 70001, Cost Analysis of Fee-Basis Medical Vouchers and by Average Monthly Cost Range for All Data Processing During Fiscal Year**

(a) Report No. 70001 provides at the end of each fiscal year, by individual COJ, the total number of veterans by service month of the fiscal year for whom fee services were provided. The total number of veterans is broken out to show the numbers and percentages of veterans whose services for the service month were under \$75, \$75-\$100, \$101-\$125, \$126-\$150, \$151-\$175 and \$176 and over, the average cost per veteran and median cost per veteran.

(b) Also included in Report No. 70001 are "average per service month" and "total number of veterans serviced". The "average per service month" depicts the average figure of the number of veterans that received fee services and the number and percentages within the different cost ranges.

(c) The "total number of veterans serviced" contains data for unique veterans.

(d) This annual fiscal year report needs no specific action. It is for information to determine the adequacy of the established monthly limitation of routine outpatient services under ID card authorization. This report goes to (161B2) in VA Central Office only.

**(27) Report No. 70002, Physician/Pharmacy Earnings Report--Participant (Medical) Detailed Summary**

(a) Report No. 70002 is in addition to the existing semiannual Physician/Pharmacy Earnings Report No. 80002 and will be utilized VA Central Office to further evaluate payments to vendors to identify program abuse. Names of physicians in the fee basis vendor file will not be printed on the report if zero dollars were paid to these vendors during the reporting period.

(b) If a vendor (medical participant) is in delete status, an asterisk (\*) appears to the immediate right of the printed data on the report.

(c) The report is printed semiannually (fiscal year) after end-of-month processing in March and September.

(d) Within clinic, the participants (vendors) are printed in descending order by high earner (dollars paid to vendor).

(e) Within participant, the veteran statistics are printed in descending order by highest dollar amount paid for the services for the veteran FYTD (fiscal year to date). The veterans' last names are printed first followed by their first and second initials.

(f) Totals are printed for the total number of veterans, number of visits and dollars paid for veterans' services.

(g) A separate entry, **TOTAL STATISTICAL PAYMENTS (FYTD)**, is printed as the last entry in the COJ report and depicts the accumulative medical "out-of-system" or

statistical payments for the reporting period. In the event the clinic has not reported any statistical payment transactions, the word "NONE" appears in the "amount paid for veteran services (FYTD)" column on the report.

**(28) Report No. 70003, Physician/Pharmacy Earnings Report-Participant (Pharmacy) Detailed Summary**

(a) Report No. 70003 is in addition to the semiannual Physician/ Pharmacy Earnings Report No. 80002 and will be utilized by the clinics of jurisdiction and VA Central Office to further evaluate payments to vendors. Names of pharmacies in the fee-basis file will not be printed on the report if zero dollars were paid to these vendors during the reporting period.

(b) If a pharmacy is in "delete" status, an asterisk (\*) appears to the immediate right of the printed data on the report.

(c) The report is printed semiannually after end-of-month processing in March and September and is produced by COJ. Within COJ, the pharmacies (vendors) are printed in descending order by high earner. Within pharmacies, the veteran statistics are printed in descending order by highest cost for "AMOUNT PAID FOR VETERAN SERVICES (FYTD)." The veteran's last name is printed first followed by the first and second initials. The veteran's name is derived from the Veterans' Master Record File.

(d) Totals are computed for number of veterans, number of prescriptions and amount of dollars paid to pharmacies.

**(29) Report No. 70004, Consolidated Physician/Pharmacy Earnings Report-Medical Participants Paid by More Than One Fee COJ**

(a) Report No. 70004 reflects the medical participants (vendors) that are paid by more than one COJ. The report is printed in descending order by high earner participant with corresponding medical center number, facility name, participant name and fee dollar amount paid (FYTD). In many instances, the participant names will be somewhat different but the register number will be the same. The differences in participant names are caused by how the clinics of jurisdiction input the names; however, the stub names must agree.

(b) Totals are printed for

(1) number of clinics that a physician serves, and

(2) the dollar amount paid for all services.

(c) This report is distributed to VA Central Office and Austin DPC.

**(30) Report No. 70005, Consolidated Physician/Pharmacy Earnings Report--Pharmacy Participants Paid by More Than One Fee COJ**

(a) Report No. 70005 reflects the pharmacy participants (vendors) that are paid by more than one COJ. The report is printed in descending order by high earner pharmacy with corresponding medical center number, facility name, pharmacy name and fee dollar amount paid (FYTD). In many instances, the pharmacy names will be somewhat different but the register number will be the same. The differences in pharmacy names are caused by how the clinics of jurisdiction input the names; however, the stub names must agree.

(b) Totals are printed for (1) number of clinics that a pharmacy serves and (2) the dollar amount paid to a pharmacy.

(c) This report is distributed to VA Central Office and Austin DPC.

**(31) Report No. 70006, Cost Analysis of Fee-Basis Medical Vouchers by Veterans and by Average Monthly Cost Range for All Data Processed During Fiscal Year**

(a) Report No. 70006 provides for all clinics the total number of veterans by service month of the fiscal year for whom fee services were provided. The total number of veterans is broken out to show the numbers and percentages of veterans whose services for the service month were under \$75, \$75-\$100, \$101-\$125, \$126-\$150, 151-175, \$176 and over, the average cost per veteran and median cost per veteran.

(b) Also included in Report No. 70006 are "average per service month" and "total number of veterans serviced." The average per service month depicts the average figure of the number of veterans that received fee services and the number and percentages within the different cost ranges.

(c) The "total number of veterans serviced" contains data for unique veterans. This figure will not equal the sum of the data on Report No. 70001 for individual clinics because some of the veterans are included in the data for more than one COJ.

(d) This annual fiscal year report needs no specific action. It is for use by VA Central Office to determine the adequacy of the established monthly limitation of routine outpatient services under ID card authorization.

**(32) Report No. 70007, Fee Veterans and Costs by Clinic, State, County and Purpose of Visit by Fiscal Year.** Report No. 70007 is to provide VA Central Office Medical Statistics and VA Central Office Medical Administration Service with statistics that can be utilized to aid in the initiation of medical policy to alter, modify or change the distribution of the fee-basis Workload. The report is printed monthly and reflects fiscal-year-to-date totals. A copy of each clinic's report is sent to the clinic concerned for informational purposes.

**(33) Report No. 70008, Fee Veterans and Costs by Region, National and Purpose of Visit by Fiscal Year.** Report No. 70008 is to provide VA Central Office Medical Statistics and VA Central Office Medical Administration Service with statistics that can be utilized to aid in the initiation of medical policy to alter, modify or change the distribution of the fee-basis workload.

**(34) Report No. 80001, Physicians Inactive Listing**

(a) Report No. 80001, part 1, is a listing of physicians and other medical vendors who have had no payment activity for 1 or more years. Report No. 80001, part 2, is a listing of pharmacies which have had no payment activity for 1 or more years. It is a numeric listing, by vendor ID number, and should be used by Medical Administration Service to identify "inactive" vendors. A "delete" action may be submitted to delete these inactive vendors from the Fee-Basis Master files.

(b) The total count for physician and pharmacy vendors on this listing appears at the end of the pharmacy inactive listing, part 2 of this report.

**(35) Report No. 80002, Physician/Pharmacy Earnings Report**

(a) Report No. 80002, part 1, is a semiannual listing of gross earnings of medical participants in the order of the highest dollar earner. Report No. 80002, part 2, is a semiannual listing of gross earnings of pharmacies in the order of the highest dollar earner. These dollar amounts are used by Medical Administration Service in conducting analyses of fee participant's gross earnings of \$40,000 and above during the October through March period and \$80,000 and above during the period of October through September for compliance with limit on yearly payments to fee participants' as described in paragraph 18.12, in this manual.

(b) This report will be used by Medical Administration Service in conjunction with Report No. 70002 in reviewing the high earning vendors.

**(36) Report No. IUE1, Report of Outpatient Visits and Invoices by Purpose and Type Fee**

(a) This report is generated monthly by AMIS based on data provided to that system by the FEE-ADP system. This transfer of information furnishes data for AMIS segment 228. (See VA Form 10-708a in "Forms" section.) Only information pertaining to a specific clinic is sent to Medical Administration service at that clinic.

(b) The report shows the total number of invoices, with the total number outpatient visits by purpose of visit and the number involved, which were released for payment during the report period. The average cost per invoice, average cost per visit, the total number of visits for service-connected disabilities and the percentage of the total number of visits made for service-connected disabilities, accumulative for the fiscal year, are also shown in the report. Not all purpose of visit codes are included in this report. This information will be used by clinic management for monitoring workloads and costs of the fee basis program.

(c) Copies of this report containing data for each clinic and nationwide totals are distributed to Medical Administration Service at VA Central Office.

**(37) Report No. IVC1 , Fee Management Report**

(a) This report is generated monthly by AMIS based on data processed to that system by the FEE-ADP system. Only information pertaining to a specific clinic is sent to Medical Administration Service at that clinic.

(b) The report shows the total number of outpatient visits by purpose of visit with their average costs. Accumulative totals by month for the fiscal year through the report period and the projected totals for the end of the fiscal year are also provided. Not all purposes of visit codes are included in this report. This information is provided to assist clinic management in monitoring the program and for budget planning purposes.

(c) Copies of this report containing data for each clinic and nationwide totals are distributed to Medical Administration Service (161B1) at VA Central Office.

(38) Report No. S0101, Fee No Match-Non Zero/Stub name Mismatch Listing-Physicians and Clinics. This report is a result of the Fee/CALM files purge. The vendors listed were not purged from the central fee file but either did not match the

CALM stub name or had been paid in the past year but are no longer in the CALM file. This report is sent to VACO, Austin Finance, Austin DPC, and each medical center.

(39) **Report No. S0102, Fee No Match-Non Zero/Stub name Mismatch Listing-Pharmacies.** This report is a result of the Fee/CALM files purge. The pharmacy vendors listed were not purged from the central fee file but either did not match the CALM stub name or had been paid in the past year but are no longer in the CALM file. This report is sent to VACO, Austin Finance, Austin DPC, and each medical center.

(40) **Report No. S0103, Fee No Match-Zero Listing-Physicians and Clinics.** This report is a result of the Fee/CALM files purge. The vendors listed were purged from the central fee file due to no matching vendor in the CALM file. This report is sent to VACO, Austin Finance, Austin DPC, and each medical center.

(41) **Report No. S0104, Fee No Match-Zero Listing-Pharmacies.** This report is a result of the Fee/CALM files purge. The pharmacy vendors listed were purged from the central fee file due to no matching vendor in the CALM file. This report is sent to VACO, Austin Finance, Austin DPC, and each medical center.

(42) **Report No. S0105, MD/PR File Summary of Purged and Non-Zero/Mismatched Records.** This report is a summary listing of records for each medical center that were either purged or mismatched. This report is sent to VACO, Austin Finance, and Austin DPC.

b. **Incomplete Reports.** If a report is received in Medical Administration Service or in Fiscal Service with missing pages, contact should be made to the Operations Division, Production Services Section, FTS 770-7623, DPC, Austin. If the report date is quite recent, the missing pages will probably be retransmitted by Austin; otherwise, the missing pages will be photocopied and mailed.

c. **On Request Reports.** Individual on request reports may be obtained by using VA Form 30-7589 or telephonic request to Production Services Section at the DPC. Requests via telephone must be confirmed in writing and sent to:

Department of Veterans Affairs (200/397A)  
Data Processing Center  
1615 East Woodward Street  
Austin, TX 78772  
Telephone: FTS 770-7623

Examples of such request are facility participant, pharmacy or veteran file listings, gummed name and address labels produced from the participant, pharmacy, or veteran files, etc. Additionally, several geographically-oriented reports are available upon request. These include (a) veterans, (b) physicians and clinics, (c) pharmacies, (d) physicians, and clinics and pharmacies. Each of the above may be requested (a) alphabetically by name, (b) numerically by ID number, (c) sequential order by numeric State code and by numeric county code within each State and (d) numerically by ZIP Code. Examples of these reports are provided at end of this section. The available options follow.:

020--MSA--Physicians and Clinics  
(Medical participants listed alphabetically by last name within participation code.)

020--MSN--Physicians and Clinics  
(Medical participants listed numerically by ID number within participation code.)

020--MSS--Physicians and Clinics  
(Medical participants listed in sequential order by numeric State code and by numeric county code within each State within participation code.)

020--MSZ--Physicians and Clinics  
(Medical participants listed numerically by ZIP Code within participation code.)

020--PSA--Pharmacies  
(Pharmacies listed alphabetically by name.)

020--PSN--Pharmacies  
(Pharmacies listed numerically by ID number.)

020--PSS--Pharmacies  
(Pharmacies listed in sequential order by numeric State code and by numeric county code within each State.)

020--PSZ--Pharmacies  
(Pharmacies listed numerically by ZIP Code.)

020--BSA--Physicians, Clinics and Pharmacies  
(Medical participants and pharmacies listed alphabetically by name within participation code.)

020--BSN--Physicians, Clinics and Pharmacies  
(Medical participants and pharmacies listed numerically by ID number within participation code.)

020--BSS--Physicians, Clinics and Pharmacies  
(Medical participants and pharmacies listed in sequential order by numeric State code and by numeric county code within each State by participation code.)

020--BSZ--Physicians, Clinics and Pharmacies  
(Medical participants and pharmacies listed numerically by ZIP Code within participation code.)

020--VSA--Veterans  
(Veterans listed alphabetically by last name with initials of first and middle names appearing first.)

020--VSN--Veterans  
(Veterans listed numerically by ID number.)

020--VSS--Veterans  
(Veterans listed in sequential order by numeric State code and by numeric county code within each State.)

020--VSZ--Veterans  
(Veterans listed numerically by ZIP Code.)

**NOTE:** *Reports comparable to the 020 series reports described above are also available upon request to VA Central Office staff providing these data for all clinics.*

**XIV. REJECT AND WARNING CODES WITH DESCRIPTIONS**

Reject and warning codes are reported when data for fee-basis transactions cannot be accepted without review or possible resubmission of input because required information is missing, incorrect or does not match data in the Master Record Files. Descriptions of reject and warning codes follow:

a. **Medical Administration Reject Codes.** The following reject codes will appear on reports 10001, 10002 and 10003 and will require correction and resubmission of input and/or corresponding master records. It is possible that a rejected transaction may contain more than one reject code. Each reject code must be resolved. Corrected transactions may be input with the current daily input batch rather than corrections in a separate batch. If a payment batch (type B3 or B5) rejects because of an out-of-balance condition or incorrect batch header, all payments in that batch must be resubmitted.

- 001 Treatment code not 1, 2 or 3 on veteran MRA, medical payment or payment replenishment.
- 002 First initial of veteran was not alpha or it was blank. On veteran name changes, the entire name field must be coded.
- 003 Middle initial of veteran was not alpha or blank.
- 004 First position in veteran last name was not alpha, or it was blank or special characters were used. Also imbedded blanks are in last name. The 1st 3 characters may not contain hyphen, apostrophe, slash or period.
- 005 Invalid Veteran ID. Not a Social Security number or C-number. Not at least 9 digits. Position number 1 is 8 or 9. Digits 2 through 9 not numeric. If pseudo-Social Security number, position 1 must be "P," positions 2 and 3 must be "40" and last two digits must be the same as birth year on VA Form 10-7079 and on line No. 18 of card 2 on VA Form 10-7079b.
- 006 Invalid Veteran ID Suffix. Veteran Master Record must have acceptable suffix, if used: A, B, C, D, F, H, J, K, M or T. If first position of ID number is C or P, suffix must be blank.
- 007 County Code Missing or Incompatible With Numeric State Code.
- 008 Invalid Purpose of Visit.

**IF RECORD TYPE IS:****POV MUST BE:**

2	Medical	10, 03-11
C	Contract Hospitalization	30-36
D	Dental	15-24
H	Contract Halfway House	60
K	Dialysis	90-91
N	Community Nursing Home	40-42
O	Other Institutional Services	80-84
R	Contract Readjust Counseling	50
S	Home Health Services	70-73
6	CHAMPVA Medical	12-13

- 010 Inconsistent State Abbreviation. Two-letter alpha abbreviation does not correspond to numeric State code in participant, pharmacy or Veteran Master Records. For payment transactions neither state or county code may be blank.
- 011 Invalid Patient Type. Must be 00, 10, 40, 60, 85, 86, 95 or 96.
- 012 Invalid Birth Date. Cannot be blank, if action code A. Cannot be blank if war code is coded on action code C. Must be in date configuration MMDDYY. Must be valid year. Month & day must be valid date or zeros. Must be consistent with war code.

013 Invalid War Code: Must be 0, 1, 2, 3, 4, 5, 7, 8, or Z. Must be consistent with year of birth.

**IF WAR CODE IS:**

**YEAR OF BIRTH MUST BE:**

0	Korean	1886-1940
1	WW I or Mexican border	1861-1905
2	WW II	1876-1932
3	Spanish-American	1859-1889
4	Pre-Korean	1863-1935
5	Post-Korean	1886-1948
7	Vietnam Era	1899-1958
8	Post-Vietnam	1905-Current age of 16
Y	New Philippine Scout/Cwealth Army	
Z	Merchant Marine	1876-1932

014 Incorrect medical center Number (in all transactions). Must be three-digit numeric with no blanks.

015 Incorrect payment type. Code must be:

V - Vendor

R - Reimbursement

T - Travel

S - Statistical

016 Incorrect transaction type (card code) must be:

1 - Participant MRA

2 - Veteran MRA

3 - Medical Payment

4 - Pharmacy MRA

5 - Pharmacy Payment

T - Beneficiary Travel Payment

017 Batch Header with No Transactions.

018 Action Code not A, C, D, or R for vendor or veteran MRA.

020 Action "D" MRA transaction must be blank after ID#.

021 Action "R" MRA transaction must be blank after ID#.

022 Cannot add this record because a record is already on file in active status.

023 Cannot add this record or process payment transaction because vendor is in delete status.

024 Must fill out at least one change field in "Change" transactions.

026 Cannot delete, or add, this record because vendor/veteran is in delete status.

027 Cannot reinstate this record because vendor/veteran is already active.

028 First 3 positions should be the medical center number, the 4th position should be the 1st digit of the processing year, and the 5th position should always be the number 5.

029 ICL number must be numeric.

030 City cannot be blank on action "A" for veterans and vendors. First character must be alpha.

031 State must be valid two-letter abbreviation. Cannot be blank on action "A" for veterans and vendors.

032 ZIP Code not Numeric. Must not be blank on action "A". (ZIP plus 4).

033 POW code must either be 1 or 2. Cannot be blank for action "A" for veterans.

034 Sex code must either be 1 or 2. Cannot be blank for action "A" for veterans.

035 Date of death must be greater, or a later date, than the issue date of the ID Card.

- 037 Veteran ID number on input payment transaction does not match veteran ID number and POV code on veteran master record file.
- 038 Date of service (medical payment) and date prescription filled (pharmacy payment) on payment transactions do not fall within the veteran's validity period on the veteran master record file.
- 039 Veteran is active in 3 clinics of jurisdiction. At least one other medical center must put veteran in a delete status in order to add to your medical center.
- 040 Participation code must be 01-13. Cannot be blank on action "A".
- 041 Participant ID Number not Numeric on Action "A." NOTE: Prefix (pos. 1) may be P, T or X in medical or pharmacy MRA.
- 042 Pharmacy or participant name cannot begin with 'The' or titles, e.g., 'Dr', 'Drs', 'Mr', 'Mrs', 'Ms', etc.
- 043 Participant or pharmacy not in file for payment.
- 044 medical center not on fee pharmacy program.
- 045 "Fee Only" indicator not "1" or blank.
- 046 Veteran ID card issue date invalid, not in six-digit date configuration (MMDDYY), or missing. No ending date of validity period on an Add transaction. Date must be prior to expiration date.
- 047 Veteran ID card end-of-validity date invalid. Date must be later than issue date. Date must be six-digit date configuration (MMDDYY). Date can be blank on a "Change" transaction.
- 048 Batch number must not be blank or different in pharmacy detail card from pharmacy batch header.
- 049 Pharmacy chain number must be numeric or blank.
- 050 Invalid invoice date (MMDDYY).
- 051 Date prescription filled must not be blank and must be consistent with billing and processing dates. Must be six-digit date configuration (MMDDYY).
- 052 Prescription number must not be blank on pharmacy payment.
- 053 Pharmacy amount claimed must be numeric. Cannot be zero.
- 054 Pharmacy amount approved must be numeric or blank. Cannot be zero.
- 056 Inconsistency between amount approved and amount claimed for pharmacy payment, or missing adjustment code: amount approved must be less than amount claimed; if amount approved is not blank, adjustment code cannot be blank.
- 057 PSA must be numeric or blank.
- 058 First ICD-9 code must not be blank for POV 30 through 36.
- 059 Duplicate batch number and batch type on travel payment.
- 060 "Change," "Delete" or "Reinstate" MRA's invalid because vendor not in FEE file.
- 061 Obligation number invalid. Must be alphanumeric or blank if batch is statistical.
- 062 Suspense code must be 1-6 or A-I.
- 063 Treatment date or travel date invalid. Must be 6 digit numeric, MMDDYY. Cannot be over 5 years.
- 065 Medical amount must be numeric. Amount approved cannot be blank.
- 066 Travel amount approved must be numeric. Cannot be zeros. Travel amount approved cannot be blank.
- 067 Invalid travel obligation number. Must be alphanumeric.
- 068 Cannot change MRA because record is in delete status.
- 069 Invoice # must be alphanumeric for payment type 'V'.
- 070 Obligation number must be blank for statistical travel.
- 071 CPT code cannot be blank for outpatient payments.
- 072 Obligation number must be blank for statistical batch.
- 073 If payment type is 'S' (statistical), statistical indicator in batch header must also be 'S'.
- 074 Participant or pharmacy change MRA with Fee Only indicator blank and vendor not in CALM file.

- 075 Does not have "FEE" in header system identifier field in batch header.
- 077 Invalid batch transaction type in header. If batch header type is "B," then transaction type must be:
  - T - travel payment.
  - 3 - Outpatient medical payment
  - 5 - Pharmacy payment
  - 7 - Outpatient CHAMPVA payment
  - 8 - CHAMPVA pharmacy payment
  - 9 - Inpatient medical payment
- 078 Invalid batch transaction type in header. If batch header type is "C," then transaction type must be:
  - 1 - Medical vendor MRA
  - 2 - Veteran MRA
  - 4 - Pharmacy vendor MRA
  - 6 - CHAMPVA MRA
- 079 Invalid batch date in batch header card, MMDDYY.
- 080 Invalid medical center number or ARS routing indicator in ARS header.
- 081 Batch type must be B or C."
- 082 Payment amount must be numeric in header. Cannot be zero.
- 083 Both travel amount and medical amount cannot be zero in header (VA Form 10-7088b) except for statistical batch, when travel amount must be zero.
- 084 CALM obligation prefix missing or is not alphanumeric in header.
- 085 Statistical indicator not blank or not "S" in header code.
- 095 Vendor ID is not in calm vendor file.
- 099 Stub name in file disagrees with payment transaction. Fee stub name and CALM stub name differ.

b. **Fee Warning Codes.** These warning codes will appear on reports 10001 and 10002. They indicate the transaction was accepted but additional action may be necessary.

- 00A Physician specialty code invalid or blank, was changed to 99 in MRA transaction.
- 00B Physician or pharmacy record already in CALM file and fee only indicator blank in MRA add transaction - record added regardless. Check CALM vendor file to ensure that complete name and address are identical.
- 00E Veteran is active at another COJ. Record added to your medical center.
- 104 PAT reference (obligation) number not in file for batch (first day only). Establish a PAT reference record before payment input. For travel with amount less than \$5 this error may not be detected until the end of the month.

c. **Fiscal Reject Codes.** These reject codes will appear on reports #12001 which are routed to Fiscal and # 12009 which are routed to Fiscal Service. Fiscal Service corrects all errors pertaining to 994 transactions. For MRA errors, Fiscal Service will review the current CALM records, PAT records, and vendor records. Corrective action will then be taken by Fiscal Service if error is in CALM. If error is in FEE, records will be noted on the error listing and the listing will be forwarded to Medical Administration for corrective action.

- 086 Input transaction 994 will reject with this code for one of the following reasons:
  - A---Input status code is not 00, 01, 02, 10 or 90.
  - B---The status code is 90; the input medical center number is 002 (Austin); however, the transaction was actually input by other than Austin.

- C---The status code is either 02 or 10 and the input clinic is full-CALM, but the transaction was input by other than Austin.
- 087 Input transaction 994 will reject with this code for one of the following reasons:  
A---The input status code is 90 but the input medical center number is not 002 (Austin).  
B---The input status code is 00, 01, 02 or 10, but the routing indicator is not compatible with the input clinic number.  
C---The input status code is 00 or 01, and the input clinic is not full-CALM; either the routing indicator is not compatible with the input clinic number or the transaction did not originate from medical center 002 (Austin).
- 088 Invalid transaction format or "FEE" not in first three positions.
- 089 Invalid transaction date. Must be six digits (MMDDYY).
- 090 Invalid reference number. Must be alphanumeric and contain no blanks.
- 091 Duplicate fields not allowed on 994 transaction, status codes 01, 02, 10 and 90.
- 092 On a 994 transaction, the group identification number must contain a valid medical center number. The first three positions of the prefix must be numeric and the last position must be alpha to match prefix.
- 093 Vendor ID contains blanks.
- 094 Vendor record is already in file.
- 095 Vendor ID is not in CALM vendor file.
- 096 Invalid vendor ID.
- 097 Invalid Stub name.
- 099 Stub name in file disagrees with payment transaction. Fee stub name and CALM stub name differ.
- 100 Duplicate address transactions (add or changes).
- 102 Invalid amount.
- 103 Vendor record flagged---no payments allowed except offsets by CALM. This means a judgment has been levied against the earnings of the payee. CALM has been flagged to reject the payments. MP-4, part 4, change 162, Page 12G-32 (10) has levy procedures. Medical center needs to send invoices to Finance to pay the judgment.
- 105 PAT reference (obligation) number not in file for transaction. This reject results from not correcting code 104 warning message.

**d. Fiscal Warning Code**

- 104 PAT reference (obligation) number not in file for batch (first day only). Establish a PAT reference record before payment input. For travel with amount less than \$5 this error may not be detected until the end of the month.

**XV. STATE AND COUNTY CODES**

"Alpha and Numeric State Codes" and "Numeric State and County Codes" are provided in this section for ready reference in preparing input documents for the FEE-ADP system.

**a. Alpha and Numeric State Codes**

<b>STATE</b>	<b>ALPHA STATE</b>	<b>NUMERIC STATE CODE</b>	<b>STATE</b>	<b>ALPHA STATE</b>	<b>NUMERIC STATE CODE</b>
Alabama	AL	01	Maine	ME	23
Alaska	AR	02	Maryland	MD	24
Arizona	AZ	04	Massachusetts	MA	25
Arkansas	AR	05	Michigan	MI	26
California	CA	06	Minnesota	MN	27
Canal Zone	CZ	61	Mississippi	MS	28
Colorado	CO	08	Missouri	MO	29
Connecticut	CT	09	Montana	MT	30
Delaware	DE	10	Nebraska	NE	31
District of Columbia	DC	11	Nevada	NV	32
Florida	FL	12	New Hampshire	NH	33
Georgia	GA	13	New Jersey	NJ	34
Guam	GU	66	New Mexico	NM	35
Hawaii	HI	15	New York	NY	36
Idaho	ID	16	North Carolina	NC	37
Illinois	IL	17	North Dakota	ND	38
Indiana	IN	18	Ohio	OH	39
Iowa	IA	19	Oklahoma	OK	40
Kansas	KS	20	Oregon	OR	41
Kentucky	KY	21	Pennsylvania	PA	42
Louisiana	LA	22	Puerto Rico	PR	72
Rhode Island	RI	44	Virginia	VA	51
South Carolina	SC	45	Virgin Islands	VI	78
South Dakota	SD	46	Washington	WA	53
Tennessee	TN	47	West Virginia	WV	54
Texas	TX	48	Wisconsin	WI	55
Utah	UT	49	Wyoming	WY	56
Vermont	VT	50			

b. Numeric State and County Codes

**ALABAMA STATE CODE 01**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Autauga	001	Dallas	047	Marengo	091
Baldwin	003	De Kalb	049	Marion	093
Barbour	005	Elmore	051	Marshall	095
Bibb	007	Escambia	053	Mobile	097
Blount	009	Etowah	055	Monroe	099
Bullock	011	Fayette	057	Montgomery	101
Butler	013	Franklin	059	Morgan	103
Calhoun	015	Geneva	061	Perry	105
Chambers	017	Greene	063	Pickens	107
Cherokee	019	Hale	065	Pike	109
Chilton	021	Henry	067	Randolph	111
Choctaw	023	Houston	069	Russell	113
Clarke	025	Jackson	071	St. Clair	115
Clay	027	Jefferson	073	Shelby	117
Cleburne	029	Lamar	075	Sumter	119
Coffee	031	Lauderdale	077	Talladega	121
Colbert	033	Lawrence	079	Tallapoosa	123
Conecuh	035	Lee	081	Tuscaloosa	125
Coosa	037	Limestone	083	Walker	127
Covingto	039	Lowndes	085	Washington	129
Crenshaw	041	Macon	087	Wilcox	131
Cullman	043	Madison	089	Winston	133
Dale	045				

**ALASKA STATE CODE 02**

(Census Divisions)

Aleutians West	010	Kenai Peninsula	122	Sitka	220
Aleutians East	013	Ketchikan Gateway	130	Skagway-Yakutat- Angeon	231
Anchorage	020	Kodiak Island	150	Southeast Fairbanks	240
Bethel	050	Lake & Peninsula Matanuska- Susitna	164 170	Valdez-Cordova	261
Bristol Bay	060	Nome	180	Wade Hampton	270
Dillingham	070	North Slope	185	Wrangell- Petersburg	280
Fairbanks North Star	090	Northwest Arctic	188	Yukon-Koyukuk	290
Haines	100	Prince of Wales		Not Specified	999
Juneau	110	Outer Ketchikan	201		

**ARIZONA STATE CODE 04**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Apache	001	Greenlee	011	Pima	019
Cochise	003	La Paz	012	Pinal	021
Coconio	005	Maricopa	013	Santa Cruz	023
Gila	007	Mohave	015	Yavapai	025
Graham	009	Navajo	017	Yuma	027

**ARKANSAS STATE CODE 05**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Arkansas	001	Garland	051	Newton	101
Ashley	003	Grant	053	Ouachita	103
Baxter	005	Greene	055	Perry	105
Benton	007	Hempstead	057	Phillips	107
Boone	009	Hot Spring	059	Pike	109
Bradley	011	Howard	061	Poinsett	111
Calhoun	013	Independence	063	Polk	113
Carroll	015	Izard	065	Pope	115
Chicot	017	Jackson	067	Prairie	117
Clark	019	Jefferson	069	Pulaski	119
Clay	021	Johnson	071	Randolph	121
Cleburne	023	Lafayette	073	St. Francis	123
Cleveland	025	Lawrence	075	Saline	125
Columbia	027	Lee	077	Scott	127
Conway	029	Lincoln	079	Searcy	129
Craighead	031	Little River	081	Sebastian	131
Crawford	033	Logan	083	Sevier	133
Crittenden	035	Lonoke	085	Sharp	135
Cross	037	Madison	087	Stone	137
Dallas	039	Marion	089	Union	139
Desha	041	Miller	091	Van Buren	141
Drew	043	Mississippi	093	Washington	143
Faulkner	045	Monroe	095	White	145
Franklin	047	Montgomery	097	Woodruff	147
Fulton	049	Nevada	099	Yell	149

**CALIFORNIA STATE CODE 06**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Alameda	001	Mendocino	045	Sierra	091
Alpine	003	Merced	047	Siskiyou	093
Amador	005	Modoc	049	Solano	095
Butte	007	Mono	051	Sonoma	097
Calaveras	009	Monterey	053	Stanislaus	099
Colusa	011	Napa	055	Sutter	101
Contra Costa	013	Nevada	057	Tehama	103
Del Norte	015	Orange	059	Trinity	105
El Dorado	017	Placer	061	Tulare	107
Fresno	019	Plumas	063	Tuolumne	109
Glenn	021	Riverside	065	Ventura	111
Humboldt	023	Sacramento	067	Yolo	113
Imperial	025	San Benito	069	Yuba	115
Inyo	027	San Bernardino	071		
Kern	029	San Diego	073		
Kings	031	San Francisco	075		
Lake	033	San Joaquin	077		
Lassen	035	San Luis Obispo	079		
Los Angeles	037	San Mateo	081		
Madera	039	Santa Barbara	083		
Marin	041	Santa Cruz	085		
Mariposa	043	Santa Clara	087		
		Shasta	089		

February 20, 1991

M-1, Part I  
Chapter 18  
APPENDIX 18A

**COLORADO STATE CODE 08**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Adams	001	Fremont	043	Montrose	085
Alamosa	003	Garfield	045	Morgan	087
Arapahoe	005	Gilpin	047	Otero	089
Archulet	007	Grand	049	Ouray	091
Baca	009	Gunnison	051	Park	093
Bent	011	Hinsdale	053	Phillips	095
Boulder	013	Huerfano	055	Pitkin	097
Chaffee	015	Jackson	057	Prowers	099
Cheyenne	017	Jefferson	059	Pueblo	101
Clear Creek	019	Kiowa	061	Rio Blanco	103
Conejos	021	Kit Carson	063	Rio Grande	105
Costilla	023	Lake	065	Routt	107
Crowley	025	La Plata	067	Saguache	109
Custer	027	Larimer	069	San Juan	111
Delta	029	Las Animas	071	San Miguel	113
Denver	031	Lincoln	073	Sedgwick	115
Dolores	033	Logan	075	Summit	117
Douglas	035	Mesa	077	Teller	119
Eagle	037	Mineral	079	Washington	121
Elbert	039	Moffat	081	Weld	123
El Paso	041	Montezuma	083	Yuma	125

**CONNECTICUT STATE CODE 09**

Fairfield	001	Middlesex	007	Tolland	013
Hartford	003	New Haven	009	Windham	015
Litchfield	005	New London	011		

**DELAWARE STATE CODE 10**

Kent	001	New Castle	003	Sussex	005
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**DISTRICT OF COLUMBIA CODE 11**

Washington	001
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**FLORIDA STATE CODE 12**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Alachua	001	Broward	011	Collier	021
Baker	003	Calhoun	013	Columbia	023
Bay	005	Charlotte	015	Dade	025
Bradford	007	Citrus	017	De Soto	027
Brevard	009	Clay	019	Dixie	029
Duval	031	Lafayette	067	Pasco	101
Escambia	033	Lake	069	Pinellas	103
Flagler	035	Lee	071	Polk	105
Franklin	037	Leon	073	Putnam	107
Gadsden	039	Levy	075	St. Johns	109
Gilchris	041	Liberty	077	St. Lucie	111
Glades	043	Madison	079	Santa Rosa	113

## FLORIDA STATE CODE 12--Continued

County	Code	County	Code	County	Code
Gulf	045	Manatee	081	Sarasota	115
Hamilton	047	Marion	083	Seminole	117
Hardee	049	Martin	085	Sumter	119
Hendry	051	Monroe	087	Suwannee	121
Hernando	053	Nassau	089	Taylor	123
Highlands	055	Okaloosa	091	Union	125
Hillsborough	057	Okeechobee	093	Volusia	127
Holmes	059	Orange	095	Wakulla	129
Indian River	061	Osceola	097	Walton	131
Jackson	063	Palm Beach	099	Washington	133
Jefferson	065				

## GEORGIA STATE CODE 13

County	Code	County	Code	County	Code
Appling	001	Clayton	063	Gilmer	123
Atkinson	003	Clinch	065	Glascocock	125
Bacon	005	Cobb	067	Glynn	127
Baker	007	Coffee	069	Gordon	129
Baldwin	009	Colquitt	071	Grady	131
Banks	011	Columbia	073	Greene	133
Barrow	013	Cook	075	Gwinnett	135
Bartow	015	Coweta	077	Habersham	137
Ben Hill	017	Crawford	079	Hall	139
Berrien	019	Crisp	081	Hancock	141
Bibb	021	Dade	083	Haralson	143
Bleckley	023	Dawson	085	Harris	145
Brantley	025	Decatur	087	Hart	147
Brooks	027	De Kalb	089	Heard	149
Bryan	029	Dodge	091	Henry	151
Bulloch	031	Dooly	093	Houston	153
Burke	033	Dougherty	095	Irwin	155
Butts	035	Douglas	097	Jackson	157
Calhoun	037	Early	099	Jasper	159
Camden	039	Echols	101	Jeff Davis	161
Candler	043	Effingham	103	Jefferson	163
Carroll	045	Elbert	105	Jenkins	165
Catoosa	047	Emanuel	107	Johnson	167
Charlton	049	Evans	109	Jones	169
Chatham	051	Fannin	111	Lamar	171
Chattahoochee	053	Fayette	113	Lanier	173
Chattooga	055	Floyd	115	Laurens	175
Cherokee	057	Forsyth	117	Lee	177
Clarke	059	Franklin	119	Liberty	179
Clay	061	Fulton	121	Lincoln	181
Long	183	Pike	231	Tift	277
Lowndes	185	Polk	233	Toombs	279
Lumpkin	187	Pulaski	235	Towns	281
McDuffie	189	Putnam	237	Treutlen	283
McIntosh	191	Quitman	239	Troup	285

**GEORGIA STATE CODE 13--Continued**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Macon	193	Rabun	241	Turner	287
Madison	195	Randolph	243	Twiggs	289
Marion	197	Richmond	245	Union	291
Meriwether	199	Rockdale	247	Upson	293
Miller	201	Schley	249	Walker	295
Mitchell	205	Screven	251	Walton	297
Monroe	207	Seminole	253	Ware	299
Montgomery	209	Spalding	255	Warren	301
Morgan	211	Stephens	257	Washington	303
Murray	213	Stewart	259	Wayne	305
Muscogee	215	Sumter	261	Webster	307
Newton	217	Talbot	263	Wheeler	309
Oconee	219	Taliaferro	265	White	311
Oglethorpe	221	Tattnall	267	Whitfield	313
Paulding	223	Taylor	269	Wilcox	315
Peach	225	Telfair	271	Wilkes	317
Pickens	227	Terrell	273	Wilkinson	319
Pierce	229	Thomas	275	Worth	321

**HAWAII STATE CODE 15**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Hawaii	001	Kalawao	005	Maui	009
Honolulu	003	Kauai	007		

**IDAHO STATE CODE 16**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Ada	001	Benewah	009	Bonner	017
Adams	003	Bingham	011	Bonneville	019
Bannock	005	Blaine	013	Boundary	021
Bear Lake	007	Boise	015	Butte	023
Camas	025	Gooding	047	Nez Perce	069
Canyon	027	Idaho	049	Oneida	071
Caribou	029	Jefferson	051	Owyhee	073
Cassia	031	Jerome	053	Payette	075
Clark	033	Kootenai	055	Power	077
Clearwater	035	Latah	057	Shoshone	079
Custer	037	Lemhi	059	Teton	081
Elmore	039	Lewis	061	Twin Falls	083
Franklin	041	Lincoln	063	Valley	085
Fremont	043	Madison	065	Washington	087
Gem	045	Minidoka	067		

**ILLINOIS STATE CODE 17**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Adams	001	Hardin	069	Morgan	137
Alexander	003	Henderson	071	Moultrie	139
Bond	005	Henry	073	Ogle	141
Boone	007	Iroquois	075	Peoria	143

## ILLINOIS STATE CODE 17--Continued

County	Code	County	Code	County	Code
Brown	009	Jackson	077	Perry	145
Bureau	011	Jasper	079	Piatt	147
Calhoun	013	Jefferson	081	Pike	149
Carroll	015	Jersey	083	Pope	151
Cass	017	Jo Daviess	085	Pulaski	153
Champaign	019	Johnson	087	Putnam	155
Christian	021	Kane	089	Randolph	157
Clark	027	Knox	095	St. Clair	163
Coles	029	Lake	097	Saline	165
Cook	031	La Salle	099	Sangamon	167
Crawford	033	Lawrence	101	Schuyler	169
Cumberland	035	Lee	103	Scott	171
De Kalb	037	Livingston	105	Shelby	173
De Witt	039	Logan	107	Stark	175
Douglas	041	McDonough	109	Stephenson	177
Du Page	043	McHenry	111	Tazewell	179
Edgar	045	McLean	113	Union	181
Edwards	047	Macon	115	Vermilion	183
Effingham	049	Macoupin	117	Wabash	185
Fayette	051	Madison	119	Warren	187
Ford	053	Marion	121	Washington	189
Franklin	055	Marshall	123	Wayne	191
Fulton	057	Mason	125	White	193
Gallatin	059	Massac	127	Whiteside	195
Greene	061	Menard	129	Will	197
Grundy	063	Mercer	131	Williamson	199
Hamilton	065	Monroe	133	Winnebago	201
Hancock	067	Montgomery	135	Woodford	203

## INDIANA STATE CODE 18

County	Code	County	Code	County	Code
Adams	001	Dearborn	029	Hamilton	057
Allen	003	Decatur	031	Hancock	059
Bartholomew	005	De Kalb	033	Harrison	061
Benton	007	Delaware	035	Hendricks	063
Blackford	009	Dubois	037	Henry	065
Boone	011	Elkhart	039	Howard	067
Brown	013	Fayette	041	Huntington	069
Carroll	015	Floyd	043	Jackson	071
Cass	017	Fountain	045	Jasper	073
Clark	019	Franklin	047	Jay	075
Clay	021	Fulton	049	Jefferson	077
Clinton	023	Gibson	051	Jennings	079
Crawford	025	Grant	053	Johnson	081
Daviess	027	Greene	055	Knox	083
Kosciusko	085	Owen	119	Sullivan	153
Lagrange	087	Parke	121	Switzerland	155
Lake	089	Perry	123	Tippecanoe	157

**INDIANA STATE CODE 18--Continued**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
La Porte	091	Pike	125	Tipton	159
Lawrence	093	Porter	127	Union	161
Madison	095	Posey	129	Vanderburgh	163
Marion	097	Pulaski	131	Vermillion	165
Marshall	099	Putnam	133	Vigo	167
Martin	101	Randolph	135	Wabash	169
Miami	103	Ripley	137	Warren	171
Monroe	105	Rush	139	Warrick	173
Montgomery	107	St. Joseph	141	Washington	175
Morgan	109	Scott	143	Wayne	177
Newton	111	Shelby	145	Wells	179
Noble	113	Spencer	147	Whitley	183
Orange	117	Steuben	151		

**IOWA STATE CODE 19**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Adair	001	Emmet	063	Marion	125
Adams	003	Fayette	065	Marshall	127
Allamakee	05	Floyd	067	Mills	129
Appanoose	007	Franklin	069	Mitchell	131
Audubon	009	Fremont	071	Monona	133
Benton	011	Greene	073	Monroe	135
Black Hawk	013	Grundy	075	Montgomery	137
Boone	015	Guthrie	077	Muscatine	139
Bremer	017	Hamilton	079	O'Brien	141
Buchanan	019	Hancock	081	Osceola	143
Buena Vista	021	Hardin	083	Page	145
Butler	023	Harrison	085	Palo Alto	147
Calhoun	025	Henry	087	Plymouth	149
Carroll	027	Howard	089	Pocahontas	151
Cass	029	Humboldt	091	Polk	153
Cedar	031	Ida	093	Pottawattamie	155
Cerro Gordo	033	Iowa	095	Poweshiek	157
Cherokee	035	Jackson	097	Ringgold	159
Chickasaw	037	Jasper	099	Sac	161
Clarke	039	Jefferson	101	Scott	163
Clay	041	Johnson	103	Shelby	165
Clayton	043	Jones	105	Sioux	167
Clinton	045	Keokuk	107	Story	169
Crawford	047	Kossuth	109	Tama	171
Dallas	149	Lee	111	Taylor	173
Davis	051	Linn	113	Union	175
Decatur	053	Louisa	115	Van Buren	177
Delaware	055	Lucas	117	Wapello	179
Des Moines	057	Lyon	119	Warren	181
Dickinson	059	Madison	121	Washington	183
Dubuque	061	Mahaska	123	Wayne	185
Webster	187	Winneshiek	191	Worth	195
Winnebago	189	Woodbury	193	Wright	197

## KANSAS STATE CODE 20

County	Code	County	Code	County	Code
Allen	001	Elk	049	Kiowa	097
Anderson	003	Ellis	051	Labette	099
Atchison	005	Ellsworth	053	Lane	101
Barber	007	Finney	055	Leavenworth	103
Barton	009	Ford	057	Lincoln	105
Bourbon	011	Franklin	059	Linn	107
Brown	013	Geary	061	Logan	109
Butler	015	Gove	063	Lyon	111
Chase	017	Graham	065	McPherson	113
Chautauqua	019	Grant	067	Marion	115
Cherokee	021	Gray	069	Marshall	117
Cheyenne	023	Greeley	071	Meade	119
Clark	025	Greenwood	073	Miami	121
Clay	027	Hamilton	075	Mitchell	123
Cloud	029	Harper	077	Montgomery	125
Coffey	031	Harvey	079	Morris	127
Comanche	033	Haskell	081	Morton	129
Cowley	035	Hodgeman	083	Nemaha	131
Crawford	037	Jackson	085	Neosho	133
Decatur	039	Jefferson	087	Ness	135
Dickinson	041	Jewell	089	Norton	137
Doniphan	043	Johnson	091	Osage	139
Douglas	045	Kearny	093	Osborne	141
Edwards	047	Kingman	095	Ottawa	143
Pawnee	145	Russell	167	Stevens	189
Phillips	147	Saline	169	Sumner	191
Pottawatomie	149	Scott	171	Thomas	193
Pratt	151	Sedgwick	173	Trego	195
Rawlins	153	Seward	175	Wabaunsee	197
Reno	155	Shawnee	177	Wallace	199
Republic	157	Sheridan	179	Washington	201
Rice	159	Sherman	181	Wichita	203
Riley	161	Smith	183	Wilson	205
Rooks	163	Stafford	185	Woodson	207
Rush	165	Stanton	187	Wyandotte	209

## KENTUCKY STATE CODE 21

County	Code	County	Code	County	Code
Adair	001	Bourbon	017	Caldwell	033
Allen	003	Boyd	019	Calloway	035
Anderson	005	Boyle	021	Campbell	037
Ballard	007	Bracken	023	Carlisle	039
Barren	009	Breathitt	025	Carroll	041
Bath	011	Breckinridge	027	Carter	043
Bell	013	Bullitt	029	Casey	045
Boone	015	Butler	031	Christian	047
Clark	049	Jessamine	113	Muhlenberg	177
Clay	051	Johnson	115	Nelson	179
Clinton	053	Kenton	117	Nicholas	181
Crittenden	055	Knott	119	Ohio	183
Cumberland	057	Knox	121	Oldham	185

**KENTUCKY STATE CODE 21--Continued**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Daviess	059	Larue	123	Owen	187
Edmonson	061	Laurel	125	Owsley	189
Elliott	063	Lawrence	127	Pendleton	191
Estill	065	Lee	129	Perry	193
Fayette	067	Leslie	131	Pike	195
Fleming	069	Letcher	133	Powell	197
Floyd	071	Lewis	135	Pulaski	199
Franklin	073	Lincoln	137	Robertson	201
Fulton	075	Livingston	139	Rockcastle	203
Gallatin	077	Logan	141	Rowan	205
Garrard	079	Lyon	143	Russell	207
Grant	081	McCracken	145	Scott	209
Graves	083	McCreary	147	Shelby	211
Grayson	085	McLean	149	Simpson	213
Green	087	Madison	151	Spencer	215
Greenup	089	Magoffin	153	Taylor	217
Hancock	091	Marion	155	Todd	219
Hardin	093	Marshall	157	Trigg	221
Harlan	095	Martin	159	Trimble	223
Harrison	097	Mason	161	Union	225
Hart	099	Meade	163	Warren	227
Henderson	101	Menifee	165	Washington	229
Henry	103	Mercer	167	Wayne	231
Hickman	105	Metcalfe	169	Webster	233
Hopkins	107	Monroe	171	Whitley	235
Jackson	109	Montgomery	173	Wolfe	237
Jefferson	111	Morgan	175	Woodford	239

**LOUISIANA STATE CODE 22**

**(Louisiana is subdivided into parishes instead of counties.)**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Acadia	001	De Soto	031	Lincoln	061
Allen	003	East Baton Rouge	033	Livingston	063
Ascension	005	East Carroll	035	Madison	065
Assumption	007	East Feliciana	037	Morehouse	067
Avoyelles	009	Evangeline	039	Natchitoches	069
Beauregard	011	Franklin	041	Orleans	071
Bienville	013	Grant	043	Ouachita	073
Bossier	015	Iberia	045	Plaquemines	075
Caddo	017	Iberville	047	Pointe Coupee	077
Calcasieu	019	Jackson	049	Rapides	079
Caldwell	021	Jefferson	051	Red River	081
Cameron	023	Jefferson Davis	053	Richland	083
Catahoula	025	Lafayette	055	Sabine	085
Claiborne	027	Lafourche	057	St. Bernard	087
Concordia	029	La Salle	059	St. Charles	089
St. Helena	091	Tangipahoa	105	Washington	117
St. James	093	Tensas	107	Webster	119
St. John		Terrebonne	109	West Baton Rouge	121
the Baptist	095				
St. Landry	097	Union	111	West Carroll	123

February 20, 1991

M-1, Part I  
Chapter 18  
APPENDIX 18A

**LOUISIANA STATE CODE 22  
(Louisiana is subdivided into parishes instead of counties.)**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
St. Martin	099	Vermilion	113	West Feliciana	125
St. Mary	101	Vernon	115	Winn	127
St. Tammany	103				

**MAINE STATE CODE 23**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Androscoggin	001	Knox	013	Sagadahoc	023
Aroostook	003	Lincoln	015	Somerset	025
Cumberland	005	Oxford	017	Waldo	027
Franklin	007	Penobscot	019	Washington	029
Hancock	009	Piscataquis	021	York	031
Kennebec	011				

**MARYLAND STATE CODE 24**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Allegany	001	Dorchester	019	Queen Annes	035
Anne Arundel	003	Frederick	021	St. Marys	037
Baltimore	005	Garrett	023	Somerset	039
Calvert	009	Harford	025	Talbot	041
Caroline	011	Howard	027	Washington	043
Carroll	013	Kent	029	Wicomico	045
Cecil	015	Montgomery	031	Worcester	047
Charles	017	Prince Georges	033		

<b>Independent City</b>	<b>Code</b>
Baltimore City	510

**MASSACHUSETTS STATE CODE 25**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Barnstable	001	Franklin	011	Norfolk	021
Berkshire	003	Hampden	013	Plymouth	023
Bristol	005	Hampshire	015	Suffolk	025
Dukes	007	Middlesex	017	Worcester	027
Essex	009	Nantucket	019		

**MICHIGAN STATE CODE 26**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Alcona	001	Berrien	021	Delta	041
Alger	003	Branch	023	Dickinson	043
Allegan	005	Calhoun	025	Eaton	045
Alpena	007	Cass	027	Emmet	047
Antrim	009	Charlevoix	029	Genesee	049
Arenac	011	Cheboygan	031	Gladwin	051
Baraga	013	Chippewa	033	Gogebic	053
Barry	015	Clare	035	Grand Traverse	055
Bay	017	Clinton	037	Gratiot	057

## MICHIGAN STATE CODE 26

County	Code	County	Code	County	Code
Benzie	019	Crawford	039	Hillsdale	059
Houghton	061	Mackinac	097	Osceola	133
Huron	063	Macomb	099	Oscoda	135
Ingham	065	Manistee	101	Otsego	137
Ionia	067	Marquette	103	Ottawa	139
Iosco	069	Mason	105	Presque Isle	141
Iron	071	Mecosta	107	Roscommon	143
Isabella	073	Menominee	109	Saginaw	145
Jackson	075	Midland	111	St. Clair	147
Kalamazoo	077	Missaukee	113	St. Joseph	149
Kalkaska	079	Monroe	115	Sanilac	151
Kent	081	Montcalm	117	Schoolcraft	153
Keweenaw	083	Montmorency	119	Shiawassee	155
Lake	085	Muskegon	121	Tuscola	157
Lapeer	087	Newaygo	123	Van Buren	159
Leelanau	089	Oakland	125	Washtenaw	161
Lenawee	091	Oceana	127	Wayne	163
Livinston	093	Ogemaw	129	Wexford	165
Luce	095	Ontonagon	131		

## MINNESOTA STATE CODE 27

County	Code	County	Code	County	Code
Aitkin	001	Isanti	059	Pipestone	117
Anoka	003	Itasca	061	Polk	119
Becker	005	Jackson	063	Pope	121
Beltrami	007	Kanabec	065	Ramsey	123
Benton	009	Kandiyohi	067	Red Lake	125
Big Stone	011	Kittson	069	Redwood	127
Blue Earth	013	Koochiching	071	Renville	129
Brown	015	Lac qui Parle	073	Rice	131
Carlton	017	Lake	075	Rock	133
Carver	019	Lake of the Woods	077	Roseau	135
Cass	021	Le Sueur	079	St. Louis	137
Chippewa	023	Lincoln	081	Scott	139
Chisago	025	Lyon	083	Sherburne	141
Clay	027	McLeod	085	Sibley	143
Clearwater	029	Mahnome	087	Stearns	145
Cook	031	Marshall	089	Steele	147
Cottonwood	033	Martin	091	Stevens	149
Crow Wing	035	Meeker	093	Swift	151
Dakota	037	Mille Lacs	095	Todd	153
Dodge	039	Morrison	097	Traverse	155
Douglas	041	Mower	099	Wabasha	157
Faribault	043	Murray	101	Wadena	159
Fillmore	045	Nicollet	103	Waseca	161
Freeborn	047	Nobles	105	Washington	163
Goodhue	049	Norman	107	Watonwan	165
Grant	051	Olmsted	109	Wilkin	167
Hennepin	053	Otter Tail	111	Winona	169
Houston	055	Pennington	113	Wright	171
Hubbard	057	Pine	115	Yellow Medicine	173

**MISSISSIPPI STATE CODE 28**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Adams	001	Itawamba	057	Perry	111
Alcorn	003	Jackson	059	Pike	113
Amite	005	Jasper	061	Pontotoc	115
Attala	007	Jefferson	063	Prentiss	117
Benton	009	Jefferson Davis	065	Quitman	119
Bolivar	011	Jones	067	Rankin	121
Calhoun	013	Kemper	069	Scott	123
Carroll	015	Lafayette	071	Sharkey	125
Chickasaw	017	Lamar	073	Simpson	127
Choctaw	019	Lauderdale	075	Smith	129
Claiborne	021	Lawrence	077	Stone	131
Clarke	023	Leake	079	Sunflower	133
Clay	025	Lee	081	Tallahatchie	135
Coahoma	027	Le Flore	083	Tate	137
Copiah	029	Lincoln	085	Tippah	139
Covington	031	Lowndes	087	Tishomingo	141
De Soto	033	Madison	089	Tunica	143
Forrest	035	Marion	091	Union	145
Franklin	037	Marshall	093	Walthall	147
George	039	Monroe	095	Warren	149
Greene	041	Montgomery	097	Washington	151
Grenada	043	Neshoba	099	Wayne	153
Hancock	045	Newton	101	Webster	155
Harrison	047	Noxubee	103	Wilkinson	157
Hinds	049	Oktibbeha	105	Winston	159
Holmes	051	Panola	107	Yalobusha	161
Humphreys	053	Pearl River	109	Yazoo	163
Issaquena	055				

**MISSOURI STATE CODE 29**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Adair	001	Chariton	041	Harrison	081
Andrew	003	Christian	043	Henry	083
Atchison	005	Clark	045	Hickory	085
Audrain	007	Clay	047	Holt	087
Barry	009	Clinton	049	Howard	089
Barton	011	Cole	051	Howell	091
Bates	013	Cooper	053	Iron	093
Benton	015	Crawford	055	Jackson	095
Bollinger	017	Dade	057	Jasper	097
Boone	019	Dallas	059	Jefferson	099
Buchanan	021	Daviess	061	Johnson	101
Butler	023	De Kalb	063	Knox	103
Caldwell	025	Dent	065	Laclede	105
Callaway	027	Douglas	067	Lafayette	107
Camden	029	Dunklin	069	Lawrence	109
Cape Girardeau	031	Franklin	071	Lewis	111
Carroll	033	Gasconade	073	Lincoln	113
Carter	035	Gentry	075	Linn	115
Cass	037	Greene	077	Livingston	117

## MISSOURI STATE CODE 29--Continued

County	Code	County	Code	County	Code
Cedar	039	Grundy	079	McDonald	119
Macon	121	Perry	157	Saline	195
Madison	123	Pettis	159	Schuyler	197
Maries	125	Phelps	161	Scotland	199
Marion	127	Pike	163	Scott	201
Mercer	129	Platte	165	Shannon	203
Miller	131	Polk	167	Shelby	205
Mississippi	133	Pulaski	169	Stoddard	207
Moniteau	135	Putman	171	Stone	209
Monroe	137	Ralls	173	Sullivan	211
Montgomery	139	Randolph	175	Taney	213
Morgan	141	Ray	177	Texas	215
New Madrid	143	Reynolds	179	Vernon	217
Newton	145	Ripley	181	Warren	219
Nodaway	147	St. Charles	183	Washington	221
Oregon	149	St. Clair	185	Wayne	223
Osage	151	Ste. Genevieve	186	Webster	225
Ozark	153	St. Francois	187	Worth	227
Pemiscot	155	St. Louis	189	Wright	229

## MONTANA STATE CODE 30

County	Code	County	Code	County	Code
Beaverhead	001	Granite	039	Powell	077
Big Horn	003	Hill	041	Prairie	079
Blaine	005	Jefferson	043	Ravalli	081
Broadwater	007	Judith Basin	045	Richland	083
Carbon	009	Lake	047	Roosevelt	085
Carter	011	Lewis and Clark	049	Rosebud	087
Cascade	013	Liberty	051	Sanders	089
Chouteau	015	Lincoln	053	Sheridan	091
Custer	017	McCone	055	Silver Bow	093
Daniels	019	Madison	057	Stillwater	095
Dawson	021	Meagher	059	Sweet Grass	097
Deer Lodge	023	Mineral	061	Teton	099
Fallon	025	Missoula	063	Toole	101
Fergus	027	Musselshell	065	Treasure	103
Flathead	029	Park	067	Valley	105
Gallatin	031	Petroleum	069	Wheatland	107
Garfield	033	Phillips	071	Wibaux	109
Glacier	035	Pondera	073	Yellowstone	111
Golden Valley	037	Powder River	075	Yellowstone Nat'l Park	113

## NEBRASKA STATE CODE 31

County	Code	County	Code	County	Code
Adams	001	Brown	017	Cheyenne	033
Antelope	003	Buffalo	019	Clay	035
Arthur	005	Burt	021	Colfax	037
Banner	007	Butler	023	Cuming	039

**NEBRASKA STATE CODE 31--Continued**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Blaine	009	Cass	025	Custer	041
Boone	011	Cedar	027	Dakota	043
Box Butte	013	Chase	029	Dawes	045
Boyd	015	Cherry	031	Dawson	047
Deuel	049	Jefferson	095	Platte	141
Dixon	051	Johnson	097	Polk	143
Dodge	053	Kearney	099	Red Willow	145
Douglas	055	Keith	101	Richardson	147
Dundy	057	Keya Paha	103	Rock	149
Fillmore	059	Kimball	105	Saline	151
Franklin	061	Knox	107	Sarpy	153
Frontier	063	Lancaster	109	Saunders	155
Furnas	065	Lincoln	111	Scotts Bluff	157
Gage	067	Logan	113	Seward	159
Garden	069	Loup	115	Sheridan	161
Garfield	071	McPherson	117	Sherman	163
Gosper	073	Madison	119	Sioux	165
Grant	075	Merrick	121	Stanton	167
Greeley	077	Morrill	123	Thayer	169
Hall	079	Nance	125	Thomas	171
Hamilton	081	Nemaha	127	Thurston	173
Harlan	083	Nuckolls	129	Valley	175
Hayes	085	Otoe	131	Washington	177
Hitchcock	087	Pawnee	133	Wayne	179
Holt	089	Perkins	135	Webster	181
Hooker	091	Phelps	137	Wheeler	183
Howard	093	Pierce	139	York	185

**NEVADA STATE CODE 32**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Churchill	001	Humboldt	013	Nye	023
Clark	003	Lander	015	Pershing	027
Douglas	005	Lincoln	017	Storey	029
Elko	007	Lyon	019	Washoe	031
Esmeralda	009	Mineral	021	White Pine	033
Eureka	011				

<b>Independent City</b>	<b>Code</b>
Carson City	510

**NEW HAMPSHIRE STATE CODE 33**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Belknap	001	Grafton	009	Rockingham	015
Carroll	003	Hillsborough	011	Strafford	017
Cheshire	005	Merrimack	013	Sullivan	019
Coos	007				

## NEW JERSEY STATE CODE 34

County	Code	County	Code	County	Code
Atlantic	001	Gloucester	015	Ocean	029
Bergen	003	Hudson	017	Passaic	031
Burlington	005	Hunterdon	019	Salem	033
Camden	007	Mercer	021	Somerset	035
Cape May	009	Middlesex	023	Sussex	037
Cumberland	011	Monmouth	025	Union	039
Essex	013	Morris	027	Warren	041

## NEW MEXICO STATE CODE 35

County	Code	County	Code	County	Code
Bernalillo	001	Hidalgo	023	Sandoval	043
Catron	003	Lea	025	San Juan	045
Chaves	005	Lincoln	027	San Miguel	047
Cibola	006				
Colfax	007	Los Alamos	028	Santa Fe	049
Curry	009	Luna	029	Sierra	051
De Baca	011	McKinley	031	Socorro	053
Dona Ana	013	Mora	033	Taos	055
Eddy	015	Otero	035	Torrance	057
Grant	017	Quay	037	Union	059
Guadalupe	019	Rio Arriba	039	Valencia	061
Harding	021	Roosevelt	041		

## NEW YORK STATE CODE 36

County	Code	County	Code	County	Code
Albany	001	Herkimer	043	Richmond	085
Allegany	003	Jefferson	045	Rockland	087
Bronx	005	Kings	047	St. Lawrence	089
Broome	007	Lewis	049	Saratoga	091
Cattaraugus	009	Livingston	051	Schenectady	093
Cayuga	011	Madison	053	Schoharie	095
Chautauqua	013	Monroe	055	Schuyler	097
Chemung	015	Montgomery	057	Seneca	099
Chenango	017	Nassau	059	Steuben	101
Clinton	019	New York	061	Suffolk	103
Columbia	021	Niagara	063	Sullivan	105
Cortland	023	Oneida	065	Tioga	107
Delaware	025	Onondaga	067	Tompkins	109
Dutchess	027	Ontario	069	Ulster	111
Erie	029	Orange	071	Warren	113
Essex	031	Orleans	073	Washington	115
Franklin	033	Oswego	075	Wayne	117
Fulton	035	Otsego	077	Westchester	119
Genesee	037	Putnam	079	Wyoming	121
Greene	039	Queens	081	Yates	123
Hamilton	041	Rensselaer	083		

**NORTH CAROLINA STATE CODE 37**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Almance	001	Franklin	069	Orange	135
Alexander	003	Gaston	071	Pamlico	137
Alleghany	005	Gates	073	Pasquotank	139
Anson	007	Graham	075	Pender	141
Ashe	009	Granville	077	Perquimans	143
Avery	011	Greene	079	Person	145
Beaufort	013	Guilford	081	Pitt	147
Bertie	015	Halifax	083	Polk	149
Bladen	017	Harnett	085	Randolph	151
Brunswick	019	Haywood	087	Richmond	153
Buncombe	021	Henderson	089	Robeson	155
Burke	023	Hertford	091	Rockingham	157
Cabarrus	025	Hoke	093	Rowan	159
Caldwell	027	Hyde	095	Rutherford	161
Camden	029	Iredell	097	Sampson	163
Carteret	031	Jackson	099	Scotland	165
Caswell	033	Johnston	101	Stanly	167
Catawba	035	Jones	103	Stokes	169
Chatham	037	Lee	105	Surry	171
Cherokee	039	Lenoir	107	Swain	173
Chowan	041	Lincoln	109	Transylvania	175
Clay	043	McDowell	111	Tyrrell	177
Cleveland	045	Macon	113	Union	179
Columbus	047	Madison	115	Vance	181
Craven	049	Martin	117	Wake	183
Cumberland	051	Mecklenburg	119	Warren	185
Currituck	053	Mitchell	121	Washington	187
Dare	055	Montgomery	123	Watauga	189
Davidson	057	Moore	125	Wayne	191
Davie	059	Nash	127	Wilkes	193
Duplin	061	New Hanover	129	Wilson	195
Durham	063	Northampton	131	Yadkin	197
Edgecombe	065	Onslow	133	Yancey	199
Forsyth	067				

**NORTH DAKOTA STATE CODE 38**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Adams	001	Emmons	029	Mercer	057
Barnes	003	Foster	031	Morton	059
Benson	005	Golden Valley	033	Mountrail	061
Billings	007	Grand Forks	035	Nelson	063
Bottineau	009	Grant	037	Oliver	065
Bowman	011	Griggs	039	Pembina	067
Burke	013	Hettinger	041	Pierce	069
Burleigh	015	Kidder	043	Ramsey	071
Cass	017	LaMoure	045	Ransom	073
Cavalier	019	Logan	047	Renville	075
Dickey	021	McHenry	049	Richland	077
Divide	023	McIntosh	051	Rolette	079
Dunn	025	McKenzie	053	Sargent	081

## NORTH DAKOTA STATE CODE 38--Continued

County	Code	County	Code	County	Code
Eddy	027	McLean	055	Sheridan	083
Sioux	085	Stutsman	093	Ward	101
Slope	087	Towner	095	Wells	103
Stark	089	Traill	097	Williams	105
Stelle	091	Walsh	099		

## OHIO STATE CODE 39

County	Code	County	Code	County	Code
Adams	001	Hamilton	061	Muskingum	119
Allen	003	Hancock	063	Noble	121
Ashland	005	Hardin	065	Ottawa	123
Ashtabula	007	Harrison	067	Paulding	125
Athens	009	Henry	069	Perry	127
Auglaize	011	Highland	071	Pickaway	129
Belmont	013	Hocking	073	Pike	131
Brown	015	Holmes	075	Portage	133
Butler	017	Huron	077	Preble	135
Carroll	019	Jackson	079	Putnam	137
Champaign	021	Jefferson	081	Richland	139
Clark	023	Knox	083	Ross	141
Clermont	025	Lake	085	Sandusky	143
Clinton	027	Lawrence	087	Scioto	145
Columbiana	029	Licking	089	Seneca	147
Coshocton	031	Logan	091	Shelby	149
Crawford	033	Lorain	093	Stark	151
Cuyahoga	035	Lucas	095	Summit	153
Darke	037	Madison	097	Trumbull	155
Defiance	039	Mahoning	099	Tuscarawas	157
Delaware	041	Marion	101	Union	159
Erie	043	Medina	103	Van Wert	161
Fairfield	045	Meigs	105	Vinton	163
Fayette	047	Mercer	107	Warren	165
Franklin	049	Miami	109	Washington	167
Fulton	051	Monroe	111	Wayne	169
Gallia	053	Montgomery	113	Williams	171
Geauga	055	Morgan	115	Wood	173
Greene	057	Morrow	117	Wyandot	175
Guernsey	059				

## OKLAHOMA STATE CODE 40

County	Code	County	Code	County	Code
Adair	001	Choctaw	023	Ellis	045
Alfalfa	003	Cimarron	025	Garfield	047
Atoka	005	Cleveland	027	Garvin	049
Beaver	007	Coal	029	Grady	051
Beckham	009	Comanche	031	Grant	053
Blaine	011	Cotton	033	Greer	055
Bryan	013	Craig	035	Harmon	057
Caddo	015	Creek	037	Harper	059

**OKLAHOMA STATE CODE 40--Continued**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Canadian	017	Custer	039	Haskell	061
Carter	019	Delaware	041	Hughes	063
Cherokee	021	Dewey	043	Jackson	065
Jefferson	067	Mayes	097	Pushmataha	127
Johnston	069	Murray	099	Roger Mills	129
Kay	071	Muskogee	101	Rogers	131
Kingfisher	073	Noble	103	Seminole	133
Kiowa	075	Nowata	105	Sequoyah	135
Latimer	077	Okfuskee	107	Stephens	137
Le Flore	079	Oklahoma	109	Texas	139
Lincoln	081	Okmulgee	111	Tillman	141
Logan	083	Osage	113	Tulsa	143
Love	085	Ottawa	115	Wagoner	145
McClain	087	Pawnee	117	Washington	147
McCurtain	089	Payne	119	Washita	149
McIntosh	091	Pittsburg	121	Woods	151
Major	093	Pontotoc	123	Woodward	153
Marshall	095	Pottawatomie	125		

**OREGON STATE CODE 41**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Baker	001	Harney	025	Morrow	049
Benton	003	Hood River	027	Multnomah	051
Clackamas	005	Jackson	029	Polk	053
Clatsop	007	Jefferson	031	Sherman	055
Columbia	009	Josephine	033	Tillamook	057
Coos	011	Klamath	035	Umatilla	059
Crook	013	Lake	037	Union	061
Curry	015	Lane	039	Wallowa	063
Deschutes	017	Lincoln	041	Wasco	065
Douglas	019	Linn	043	Washington	067
Gilliam	021	Malheur	045	Wheeler	069
Grant	023	Marion	047	Yamhill	071

**PENNSYLVANIA STATE CODE 42**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Adams	001	Columbia	037	Lawrence	073
Allegheny	003	Crawford	039	Lebanon	075
Armstrong	005	Cumberland	041	Lehigh	077
Beaver	007	Dauphin	043	Luzerne	079
Bedford	009	Delaware	045	Lycoming	081
Berks	011	Elk	047	McKean	083
Blair	013	Erie	049	Mercer	085
Bradford	015	Fayette	051	Mifflin	087
Bucks	017	Forest	053	Monroe	089
Butler	019	Franklin	055	Montgomery	091
Cambria	021	Fulton	057	Montour	093
Cameron	023	Greene	059	Northampton	095
Carbon	025	Huntingdon	061	Northumberland	097
Centre	027	Indiana	063	Perry	099

## PENNSYLVANIA STATE CODE 42--Continued

County	Code	County	Code	County	Code
Chester	029	Jefferson	065	Philadelphia	101
Clarion	031	Juniata	067	Pike	103
Clearfield	033	Lackawanna	069	Potter	105
Clinton	035	Lancaster	071	Schuylkill	107
Snyder	109	Union	119	Wayne	127
Somerset	111	Venango	121	Westmoreland	129
Sullivan	113	Warren	123	Wyoming	131
Susquehanna	115	Washington	125	York	133
Tioga	117				

## RHODE ISLAND STATE CODE 44

County	Code	County	Code	County	Code
Bristol	001	Newport	005	Washington	009
Kent	003	Providence	007		

## SOUTH CAROLINA STATE CODE 45

County	Code	County	Code	County	Code
Abbeville	001	Dillon	033	Lexington	063
Aiken	003	Dorchester	035	McCormick	065
Allendale	005	Edgefield	037	Marion	067
Anderson	007	Fairfield	039	Marlboro	069
Bamberg	009	Florence	041	Newberry	071
Barnwell	011	Georgetown	043	Oconee	073
Beaufort	013	Greenville	045	Orangeburg	075
Berkeley	015	Greenwood	047	Pickens	077
Calhoun	017	Hampton	049	Richland	079
Charleston	019	Horry	051	Saluda	081
Cherokee	021	Jasper	053	Spartanburg	083
Chester	023	Kershaw	055	Sumter	085
Chesterfield	025	Lancaster	057	Union	087
Clarendon	027	Laurens	059	Williamsburg	089
Colleton	029	Lee	061	York	091
Darlington	031				

## SOUTH DAKOTA STATE CODE 46

County	Code	County	Code	County	Code
Aurora	003	Dewey	041	Lake	079
Beadle	005	Douglas	043	Lawrence	081
Bennett	007	Edmunds	045	Lincoln	083
Bon Homme	009	Fall River	047	Lyman	085
Brookings	011	Faulk	049	McCook	087
Brown	013	Grant	051	McPherson	089
Brule	015	Gregory	053	Marshall	091
Buffalo	017	Haakon	055	Meade	093
Butte	019	Hamlin	057	Mellette	095
Campbell	021	Hand	059	Miner	097
Charles Mix	023	Hanson	061	Minnehaha	099
Clark	025	Harding	063	Moody	101

**SOUTH DAKOTA STATE CODE 46--Continued**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Clay	027	Hughes	065	Pennington	103
Codington	029	Hutchinson	067	Perkins	105
Corson	031	Hyde	069	Potter	107
Custer	033	Jackson	071	Roberts	109
Davison	035	Jerauld	073	Sanborn	111
Day	037	Jones	075	Shannon	113
Deuel	039	Kingsbury	077	Spink	115
Stanley	117	Turner	125	Washabaugh	131
Sully	119	Union	127	Yankton	135
Todd	121	Walworth	129	Ziebach	137
Tripp	123				

**TENNESSEE STATE CODE 47**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Anderson	001	Hamilton	065	Morgan	129
Bedford	003	Hancock	067	Obion	131
Benton	005	Hardeman	069	Overton	133
Bledsoe	007	Hardin	071	Perry	135
Blount	009	Hawkins	073	Pickett	137
Bradley	011	Haywood	075	Polk	139
Campbell	013	Henderson	077	Putnam	141
Cannon	015	Henry	079	Rhea	143
Carroll	017	Hickman	081	Roane	145
Carter	019	Houston	083	Robertson	147
Cheatham	021	Humphreys	085	Rutherford	149
Chester	023	Jackson	087	Scott	151
Claiborne	025	Jefferson	089	Sequatchie	153
Clay	027	Johnson	091	Sevier	155
Cocke	029	Knox	093	Shelby	157
Coffee	031	Lake	095	Smith	159
Crockett	033	Lauderdale	097	Stewart	161
Cumberland	035	Lawrence	099	Sullivan	163
Davidson	037	Lewis	101	Sumner	165
Decatur	039	Lincoln	103	Tipton	167
DeKalb	041	Loudon	105	Trousdale	169
Dickson	043	McMinn	107	Unicoi	171
Dyer	045	McNairy	109	Union	173
Fayette	047	Macon	111	VanBuren	175
Fentress	049	Madison	113	Warren	177
Franklin	051	Marion	115	Washington	179
Gibson	053	Marshall	117	Wayne	181
Giles	055	Maurry	119	Weakley	183
Grainger	057	Meigs	121	White	185
Greene	059	Monroe	123	Williamson	187
Grundy	061	Montgomery	125	Wilson	189
Hamblen	063	Moore	127		

## TEXAS STATE CODE 48

County	Code	County	Code	County	Code
Anderson	001	Bandera	019	Bowie	037
Andrews	003	Bastrop	021	Brazoria	039
Angelina	005	Baylor	023	Brazos	041
Aransas	007	Bee	025	Brewster	043
Archer	009	Bell	027	Briscoe	045
Armstrong	011	Bexar	029	Brooks	047
Atascosa	013	Blanco	031	Brown	049
Austin	015	Borden	033	Burleson	051
Bailey	017	Bosque	035	Burnet	053
Caldwell	055	Fort Bend	157	Kendall	259
Calhoun	057	Franklin	159	Kenedy	261
Callahan	059	Freestone	161	Kent	263
Cameron	061	Frio	163	Kerr	265
Camp	063	Gaines	165	Kimble	267
Carson	065	Galveston	167	King	269
Cass	067	Garza	169	Kinney	271
Castro	069	Gillespie	171	Kleberg	273
Chambers	071	Glasscock	173	Knox	275
Cherokee	073	Goliad	175	Lamar	277
Childress	075	Gonzales	177	Lamb	279
Clay	077	Gray	179	Lampasas	281
Cochran	079	Grayson	181	LaSalle	283
Coke	081	Gregg	183	Lavaca	285
Coleman	083	Grimes	185	Lee	287
Collin	085	Guadalupe	187	Leon	289
Collingsworth	087	Hale	189	Liberty	291
Colorado	089	Hall	191	Limestone	293
Comal	091	Hamilton	193	Lipscomb	295
Comanche	093	Hansford	195	Live Oak	297
Concho	095	Hardeman	197	Llano	299
Cooke	097	Hardin	199	Loving	301
Coryell	099	Harris	201	Lubbock	303
Cottle	101	Harrison	203	Lynn	305
Crane	103	Hartley	205	McCulloch	307
Crockett	105	Haskell	207	McLennan	309
Crosby	107	Hays	209	McMullen	311
Culberson	109	Hemphill	211	Madison	313
Dallam	111	Henderson	213	Marion	315
Dallas	113	Hidalgo	215	Martin	317
Dawson	115	Hill	217	Mason	319
Deaf Smith	117	Hockley	219	Matagorda	321
Delta	119	Hood	221	Maverick	323
Denton	121	Hopkins	223	Medina	325
De Witt	123	Houston	225	Menard	327
Dickens	125	Howard	227	Midland	329
Dimmit	127	Hudspeth	229	Milam	331
Donley	129	Hunt	231	Mills	333
Duval	131	Hutchinson	233	Mitchell	335
Eastland	133	Irion	235	Montague	337
Ector	135	Jack	237	Montgomery	339
Edwards	137	Jackson	239	Moore	341

**TEXAS STATE CODE 48--Continued**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Ellis	139	Jasper	241	Morris	343
El Paso	141	Jeff Davis	243	Motley	345
Erath	143	Jefferson	245	Nacogdoches	347
Falls	145	Jim Hogg	247	Navarro	349
Fannin	147	Jim Wells	249	Newton	351
Fayette	149	Johnson	251	Nolan	353
Fisher	151	Jones	251	Nueces	355
Floyd	153	Karnes	255	Ochiltree	357
Foard	155	Kaufman	257	Oldham	359
Orange	361	San Saba	411	Upton	461
Palo Pinto	363	Schleicher	413	Uvalde	463
Panola	365	Scurry	415	Val Verde	465
Parker	367	Shackelford	417	Van Zandt	467
Parmer	369	Shelby	419	Victoria	469
Pecos	371	Sherman	421	Walker	471
Polk	373	Smith	423	Waller	473
Potter	375	Somervell	425	Ward	475
Presidio	377	Starr	427	Washington	477
Rains	379	Stephens	429	Webb	479
Randall	381	Sterling	431	Wharton	481
Reagan	383	Stonewall	433	Wheeler	483
Real	385	Sutton	435	Wichita	485
Red River	387	Swisher	437	Wilbarger	487
Reeves	389	Tarrant	439	Willacy	489
Refugio	391	Taylor	441	Williamson	491
Roberts	393	Terrell	443	Wilson	493
Robertson	395	Terry	445	Winkler	495
Rockwall	397	Throckmorton	447	Wise	497
Runnels	399	Titus	449	Wood	499
Rusk	401	Tom Green	451	Yoakum	501
Sabine	403	Travis	453	Young	503
San Augustine	405	Trinity	455	Zapata	505
San Jacinto	407	Tyler	457	Zavala	507
San Patricio	409	Upshur	459		

**UTAH STATE CODE 49**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Beaver	001	Iron	021	Sevier	041
Box Elder	003	Juab	023	Summit	043
Cache	005	Kane	025	Tooele	045
Carbon	007	Millard	027	Uintah	047
Daggett	009	Morgan	029	Utah	049
Davis	011	Piute	031	Wasatch	051
Duchesne	013	Rich	033	Washington	053
Emery	015	Salt Lake	035	Wayne	055
Garfield	017	San Juan	037	Weber	057
Grand	019	Sanpete	039		

## WISCONSIN STATE CODE 55

County	Code	County	Code	County	Code
Adams	001	Dodge	027	Jackson	053
Ashland	003	Door	029	Jefferson	055
Barron	005	Douglas	031	Juneau	057
Bayfield	007	Dunn	033	Kenosha	059
Brown	009	Eau Claire	035	Kewaunee	061
Buffalo	011	Florence	037	La Crosse	063
Burnett	013	Fond Du Lac	039	Lafayette	065
Calumet	015	Forest	041	Langlade	067
Chippewa	017	Grant	043	Lincoln	069
Clark	019	Green	045	Manitowoc	071
Columbia	021	Green Lake	047	Marathon	073
Crawford	023	Iowa	049	Marinette	075
Dane	025	Iron	051	Marquette	077
Menominee	078	Price	099	Trempealeau	121
Milwaukee	079	Racine	101	Vernon	123
Monroe	081	Richland	103	Vilas	125
Oconto	083	Rock	105	Walworth	127
Oneida	085	Rusk	107	Washburn	129
Outagamie	087	St. Croix	109	Washington	131
Ozaukee	089	Sauk	111	Waukesha	133
Pepin	091	Sawyer	113	Waupaca	135
Pierce	093	Shawano	115	Waushara	137
Polk	095	Sheboygan	117	Winnebago	139
Portage	097	Taylor	119	Wood	141

## WYOMING STATE CODE 56

County	Code	County	Code	County	Code
Albany	001	Hot Springs	017	Sheridan	033
Big Horn	003	Johnson	019	Sublette	035
Campbell	005	Laramie	021	Sweetwater	037
Carbon	007	Lincoln	023	Teton	039
Converse	009	Natrona	025	Uinta	041
Crook	011	Niobrara	027	Washakie	043
Fremont	013	Park	029	Weston	045
Goshen	015	Platte	031		

## OUTLYING AREAS OF THE UNITED STATES

## AMERICAN SAMOA STATE CODE 60

County	Code	County	Code	County	Code
Eastern	010	Rose	030	Western	030
Manu'a	020	Swains Is.	040	*Am. Samoa	999

Before FY92

**FEDERATED STATES OF MICRONESIA STATE CODE 64**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Chuuk	002	Pohnepi	040	Yap	060
Kosrae	005				

**GUAM STATE CODE 66**

Guam	010	*Guam	999	Before FY92
------	-----	-------	-----	-------------

**MARSHALL ISLANDS STATE CODE 68**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Ailinginae	007	Jabat	110	Mili	320
Ailinglaplap	010	Jaluit	120	Namorik	330
Ailuk	030	Jemo	130	Namu	340
Arno	040	Kili	140	Rongelap	350
Aur	050	Kwajalein	150	Rongrik	360
Bikar	060	Lae	160	Toke	385
Bikini	070	Lib	170	Ujae	390
Bokak	073	Likiep	180	Ujelang	400
Ebon	080	Majuro	190	Utrik	410
Enewetak	090	Maloelap	300	Wotho	420
Erikub	100	Mejit	310	Wotje	430

**NORTHERN MARIANA ISLANDS STATE CODE 69**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Northern Islands	085	Saipan	110	Tinian	120
Rota	100				

**PALAU (TRUST TERRITORY) STATE CODE 70**

<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>	<b>County</b>	<b>Code</b>
Aimeliik	002	Ngaraard	214	Ngiwal	228
Airai	004	Ngarchelong	218	Peleliu	350
Angaur	010	Ngardmau	222	Sonsorol	370
Kayangel	100	Ngaremlengui	223	Hatobohei	050
Koror	150	Ngatpang	224	Ngeremlenquit	227
Melekeok	212	Ngchesar	226		

## PUERTO RICO STATE CODE 72

Name	State Code	County Code
Adjuntas	72	001
Aguada	72	003
Aguadilla	72	005
Aguas Buenas	72	007
Aibonito	72	009
Anasco	72	011
Arecibo	72	013
Arroyo	72	015
Barceloneta	72	017
Barranquitas	72	019
Bayamon	72	021
Cobo Rojo	72	023
Caguas	72	025
Camuy	72	027
Canovanas	72	029
Carolina	72	031
Catano	72	033
Cayey	72	035
Ceiba	72	037
Ciales	72	039
Cidra	72	041
Coamo	72	043
Comerio	72	045
Corozal	72	047
Culebra	72	049
Dorado	72	051
Fajardo	72	053
Florida	72	054
Guanica	72	055
Guayama	72	057
Guayanilla	72	059
Guaynabo	72	061
Gurabo	72	063
Hatillo	72	065
Hormigueros	72	067
Humacao	72	069
Isabela	72	071
Jayuya	72	073
Juana Diaz	72	075

**PUERTO RICO STATE CODE 72--Continued**

<b>Name</b>	<b>State Code</b>	<b>County Code</b>	
Juncos	72	077	
Lajas	72	079	
Lares	72	081	
Las Marias	72	083	
Las Piedras	72	085	
Loiza	72	087	
Luquillo	72	089	
Manati	72	091	
Maricao	72	093	
Maunabo	72	095	
Mayaguez	72	097	
Moca	72	099	
Morovis	72	101	
Naguabo	72	103	
Naranjito	72	105	
Orocovis	72	107	
Patillas	72	109	
Penuelas	72	111	
Ponce	72	113	
Quebradillas	72	115	
Rincon	72	117	
Rio Grande	72	119	
Sabana Grande	72	121	
Salinas	72	123	
San German	72	125	
San Juan	72	127	
San Lorenzo	72	129	
San Sebastian	72	131	
Toa Alta	72	135	
Toa Baja	72	137	
Trujillo Alto	72	139	
Utua	72	141	
Vega Alta	72	143	
Vega Baja	72	145	
Vileques	72	147	
Villalba	72	149	
Yabucoa	72	151	
Yauco	72	153	
*Puerto Rico	72	999	Before FY92

**U.S. MINOR OUTLYING ISLANDS STATE CODE 74**

<b>Territory</b>	<b>Code</b>	<b>Territory</b>	<b>Code</b>	<b>Territory</b>	<b>Code</b>
Baker Island	050	Johnston	200	Navassa Is.	350
Howland Is.	100	Kingman Reef	250	Palmyra Atoll	400
Jarvis Is.	150	Midway Is.	300	Wake Island	450
*Swan Islands	999	Before FY92			

**VIRGIN ISLANDS OF THE UNITED STATES STATE CODE 78**

<b>Island</b>	<b>Code</b>	<b>Island</b>	<b>Code</b>
St. Croix	010	St. John	020
St. Thomas	030		
*Virgin Islands	999 Before FY92		

**FOREIGN COUNTRIES**

<b>Name</b>	<b>County Code</b>	<b>State Code</b>
*Canada	260	91
*Europe	999	93
*Philippines	725	96
*Mexico	595	91
*All Other	999	90

\* Used by VA but not officially listed in FIPS (Federal Information Processing Standards Publication).

**XVI. EXAMPLES OF NON-MEDICAL TYPE SERVICES NOT AUTHORIZED UNDER  
FEE-BASIS HOME HEALTH CARE**

1. This attachment is not intended to be an all inclusive listing on non-medical type services which may not be approved under the Fee-Basis Home Services Program. It should be used as a guideline in distinguishing between those supportive medical services, or medical treatment, that can be authorized and those non-medical services that cannot be authorized.

2. The following are redefined:

**Assistance With  
Activities of  
Daily Living**

**Homemaker Services**

**Other**

Feeding  
Toileting  
Ambulation  
Grooming (including oral  
hygiene)  
Dressing  
\*Bathing

Housekeeping  
Food preparation  
Marketing  
Laundry  
Home Chores

Companionship  
Sitter Services  
Recreation

*\*Bathing may be provided to spinal cord injury patients as a medical service in conjunction with bowel and bladder care.*

July 20, 1995

1. Transmitted is change to Department of Veterans Affairs, Veterans Health Administration Manual, M-1, "Operations," Part I, Medical Administration Activities," Chapter 18, "Outpatient Care -Fee."

2. Principal changes are:

a. **Paragraph 18.02k:** Is revised to delete requirement that fee participants must be a citizen of the United States.

b. **Paragraph 18.03f:** Is revised to delete the requirement that fee participants be United States citizens.

c. **Paragraph 18.03h:** Is revised to allow for reimbursement of family member for bowel and bladder care and/or home health services when the provisions of 18.03h (1) through (2) are met.

3. **Filing Instructions**

**Remove pages**

18-i through 18-ii  
18-1 through 18-6

**Insert Pages**

18-i through 18-ii  
18-1 through 18-6

4. **RESCISSIONS:** None.

S/ 7/20/95 by  
Kenneth W. Kizer, M.D., M.P.H.  
Under Secretary for Health

Distribution: **RPC: 1111**  
FD

Printing Date: 7/95

Printing Dated: 12/91

Department of Veterans Affairs  
Veterans Health Administration  
Washington, DC 20420

M-1, Part I  
Chapter 18  
Change 2

December 16, 1993

1. Transmitted is change to Department of Veterans Affairs, Veterans Health Administration Manual M-1, "Operations," Part I, "Medical Administration Activities," Chapter 18, "Outpatient Care-Fee."

2. Principal changes are:

a. Information contained in M-1, Part I, Chapter 30, "Home Health Services," Section III, "Fee-Basis Home Health Services," and Appendix 30A has been incorporated into Chapter 18. Brackets have not been used to indicate the changes.

b. Section III, "Fee-Basis Home Health Services," is revised to address policy changes for authorizing fee-basis home health services.

c. Non-medical basic care procedures and some assistance with activities of daily living procedures have been changed to medical services.

3. Filing Instructions

Remove pages

18-iii through 18-v  
18-33  
18A-83

Insert pages

18-iii through 18-v  
18-33 through 18-35  
18A-83 through 18-84

4. RESCISSION: Chapter 30, change 3, Section III, and appendix 30A, dated March 17, 1986.

John T. Farrar, M.D.  
Acting Under Secretary for Health

Distribution: RPC 1111  
FD

Printing Date: 12/93

November 25, 1991

1. Transmitted is a change to Department of Veterans Affairs, Veterans Health Administration Manual M-1, "Operations," Part I, "Medical Administration Activities," Chapter 18, "Outpatient Care-Fee." Brackets have not been used to indicate the changes.

2. Principal changes are:

a. Paragraphs 18.50, 18.51 and 18.52: Are changed to reflect the use of the 75th percentile payment method.

b. Paragraph 18.51: Is reworded to clarify guidelines.

c. Section XV of Appendix A: Revises county codes for outlying areas of the United States. Revised county codes are effective October 1, 1991.

3. Filing Instructions

Remove pages Insert pages

18-23 through 18-26

18-23 through 18-26

18A-79 through 18A-82

18A-79 through 18A-82

JAMES W. HOLSINGER, Jr., M.D.  
Chief Medical Director

Distribution: RPC 1021  
FD

February 20, 1991

1. Transmitted is a revision to Veterans Health Services and Research Administration Manual M-1, "Operations," Part I, "Medical Administration," Chapter 18, "Outpatient Care-Fee." The entire chapter contains changes as required to provide guidance and instruction regarding the Decentralized Hospital Computer Program for fee-basis activities. All references to earmarked medical care funds have been removed. Brackets have not been used to indicate the changes.

2. Principal changes are:

- a. Paragraph 18.02: Includes additional definitions.
- b. Paragraph 18.05: New paragraph to outline necessary integrity controls.
- c. Paragraph 18.06: New paragraph added to outline policy and procedure for terminating vendors, including due process.
- d. Paragraph 18.07: Eliminates the requirement for establishment of an advisory group. Requires establishment of reviews to meet requirements of JCAHO and VA internal controls. Requires the establishment of a Memorandum of Understanding.
- e. Paragraph 18.08: Requires an annual internal control review of the fee program.
- f. Paragraph 18.12: Increases vendor income guidelines.
- g. Paragraph 18.15: Outlines the cost accounts to be used for payment for fee services.
- h. Paragraph 18.16: New paragraph regarding review of ID card status.
- i. Paragraph 18.17: New paragraph added regarding treatment plans.
- j. Paragraph 18.21: Allows activity at up to three clinics of jurisdiction.
- k. Paragraph 18.22: Changes the terminology used on the ID card.
- l. Paragraph 18.25: Includes examples of ambulatory surgical procedures.
- m. Paragraph 18.27: Includes guidelines regarding veterans in receipt of high level A&A.
- n. Paragraph 18.30: Incorporates in authorization of fee medical care for veterans traveling or residing in foreign countries.
- o. Paragraph 18.32: Increases the monthly ID card limitation to \$125.
- p. Paragraph 18.33: Emphasizes the responsibility of VA to pay for non-VA care authorized by VA or for which the veteran is eligible.

- q. Paragraph 18.38: Expands information provided regarding appointment of health care providers.
- r. Paragraph 18.48: Reflects the change of cost account for dialysis care.
- s. Paragraph 18.50: Includes the use of the 80th percentile method of payment.
- t. Paragraph 18.51: Explains the use of the 80th percentile method of payment.
- u. Paragraph 18.53: Permits full reimbursement to veterans for prescriptions they have personally paid for.
- v. Paragraph 18.56: Incorporates information relating to the DHCP Fee-Basis User Manual.
- w. Paragraph 18.60: Removes all references to the term "natural persons".
- x. Paragraph 18.63: Incorporates provisions of the Prompt Payment Act, as amended.
- y. Paragraph 18.76: Incorporates guidelines pertaining to filling of prescriptions with VA formulary medications.
- z. Old Paragraph 18.41: Deleted
- aa. Old Paragraphs 18.88 and 18.89 and 18.90: Eliminated as these procedures do not apply with DHCP.
- bb. Appendix A, Fee-Basis System User Manual, has been updated to reflect the implementation of Version 1 of the Decentralized Hospital Computer Program for fee-basis, and revised reports listing in accordance with DHCP fee-basis programs. All changes are administrative in nature and in keeping with program guidelines established in M-1, part I, chapter 18.

### 3. Filing Instructions

Remove pages

18-i through 18-23  
A-i through A-78

Insert pages

18-i through 18-33  
18A-1 through 18A-82

JAMES W. HOLSINGER JR., M.D.  
Chief Medical Director

Distribution: RPC: 1111  
FD

Printing Date: 3/91

December 4, 1986

Chapter 18, "Outpatient Care-Fee," 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 incorporate provisions of the Means Test (Pub. L. 99-272) which require billing of Category C veterans and to remove the four visit limitation on the initial fee-basis authorization.*

**Pages 18-i through 18-iv:** Remove these pages and substitute 18-i through 18-v attached.

**Pages 18-1 through 18-8a:** Remove these pages and substitute 18-1 through 18-8b attached.



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

Distribution: RPC: 1111  
FD

Printing Date: 1/87

Department of Medicine and Surgery  
Veterans Administration  
Washington, DC 20420

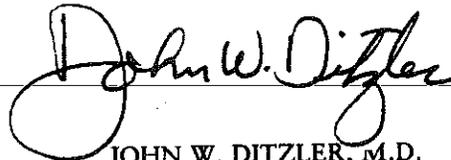
10-16-86  
M-1, Part I  
Chapter 18  
Change 5

June 24, 1986

Chapter 18, "Outpatient Care-Fee," 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 provide a mechanism for the veteran to request an administrative review of denial of fee-basis care. The BVA has indicated that the Board would no longer review the denial of fee-basis care since this issue was felt to be under the jurisdiction of DM&S. Consequently, the Board has indicated that DM&S set up an administrative review procedure to handle such denials. The veteran may still request the BVA to consider an appeal based on jurisdiction (38 CFR 19.1).*

Pages 18-7 and 18-8: Remove these pages and substitute pages 18-7 through 18-8a attached.



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

Distribution: RPC: 1111  
FD

Printing Date: 7/86

Note: reprinted at contractor's expense to improve quality of product.

Department of Medicine and Surgery  
Veterans Administration  
Washington, DC 20420

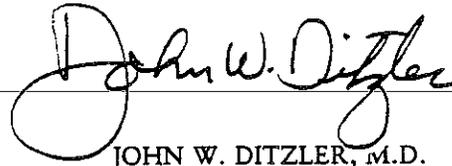
AUG 22 1986 M-1, Part I  
Chapter 18  
Change 5

June 24, 1986

Chapter 18, "Outpatient Care-Fee," 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 provide a mechanism for the veteran to request an administrative review of denial of fee-basis care. The BVA has indicated that the Board would no longer review the denial of fee-basis care since this issue was felt to be under the jurisdiction of DM&S. Consequently, the Board has indicated that DM&S set up an administrative review procedure to handle such denials. The veteran may still request the BVA to consider an appeal based on jurisdiction (38 CFR 19.1).*

Pages 18-7 and 18-8: Remove these pages and substitute pages 18-7 through 18-8a attached.



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

Distribution: RPC: 1111  
FD

Printing Date: 7/86

AUG 15 1986

March 26, 1986

Chapter 18, "Outpatient Care-Fee," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

The purpose of this chapter change is to incorporate provisions of DM&S Circulars 10-84-156 and 10-85-74 and Interim Issues 10-84-26, 10-84-28, 10-84-33, 10-85-8, 10-85-10, and 10-85-29.

**Pages 18-i and 18-ii:** Remove these pages and substitute pages 18-i and 18-ii attached.

**Page 18-iv, paragraph 1b:** Add the following:

"II 10-84-26  
II 10-84-28  
II 10-84-33

II 10-85-8  
II 10-85-10  
II 10-85-29"

**Pages 18-9 through 18-12:** Remove these pages and substitute pages 18-9 through 18-12a attached.

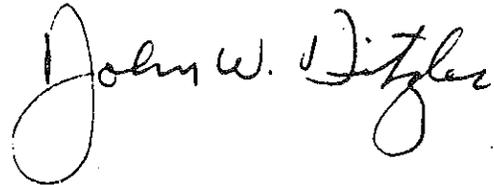
**Pages 18-15 and 18-16:** Remove these pages and substitute pages 18-15 through 18-16a attached.

**Pages 18-19 and 18-20:** Remove these pages and substitute pages 18-19 and 18-20 attached.

**Pages A-3 through A-10:** Remove these pages and substitute pages A-3 through A-10a attached.

**Pages A-19 through A-50:** Remove these pages and substitute pages A-19 through A-50a attached.

**RESCISSIONS:** Interim Issues 10-84-26, 10-84-28, 10-84-33, 10-85-8, 10-85-10, and 10-85-29.



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

Distribution: RPC: 1111  
FD

Printing Date: 7/1

Department of Medicine and Surgery  
Veterans Administration  
Washington, DC 20420

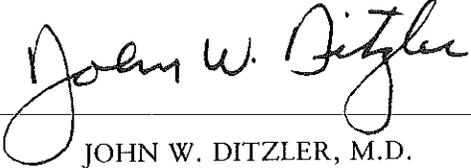
5-27-86  
M-1, Part I  
Chapter 18  
Change 3

February 4, 1986

Chapter 18, "Outpatient Care-Fee," 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 clarify policy surrounding the payment to family members who provide bowel and bladder care.*

Pages 18-3 and 18-4. Remove these pages and substitute pages 18-3 through 18-4a attached.



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

Distribution: RPC: 1111  
FD

Printing Date: 4/86

Department of Medicine and Surgery  
Veterans Administration  
Washington, DC 20420

3-12-86  
M-1, Part I  
Chapter 18  
Change 2

January 3, 1986

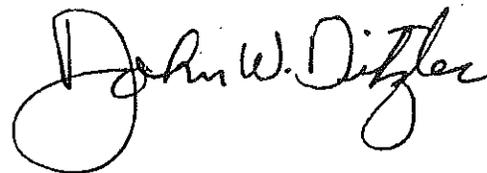
Chapter 18, "Outpatient Care-Fee," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

*NOTE: The purpose of this change is to rescind the interim issues which require the collection of data for the Reports Control Symbol 10-0131 (formerly RCS 13-50).*

Page 18-iv, paragraph 1b: Add the following:

"II 10-79-43 ✓  
II 10-79-56 ✓  
II 10-80-54 ✓  
II 10-80-72". ✓

RESCISSIONS: Interim Issues 10-79-43, 10-79-56, 10-80-54, 10-80-72.



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

Distribution: RPC: 1111  
FD

Printing Date: 2/86

2-11-85

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

M-1, Part I  
Chapter 18  
Change 1

November 2, 1984

Chapter 18, "Outpatient Care-Fee," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

The purpose of this chapter change other than editorial is to (1) incorporate provisions of II 10-84-13; (2) add an edit code to allow veterans to be active at only one Clinic of Jurisdiction at a time; and (3) further clarify appropriate application of earmarked medical care analysis account .27 fund.

Page 18-ii: Delete:

18.45 Services to Supplement or Complete Staff Treatment ..... 18-11

18.46 Services to Supplement OPT-NSC Care ..... 18-11"

and insert "18.45-18.46 (Reserved)."

Pages 18-1 and 18-2, 18-9 through 18-14, A-3 through A-8, A-19 and A-20, and A-51 and A-52: Remove these pages and substitute pages 18-1 and 18-2, 18-9 through 18-14, A-3 through A-8, A-19 and A-20, A-51 through A-52a attached.

*John W. Ditzler M.D.*

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

Distribution: RPC: 1111  
FD

Publication Date: January 11, 1985

4/24/84

December 21, 1983

Chapter 18, "Outpatient Care-Fee," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is revised as indicated below. The use of brackets to denote new or revised material is precluded due to the extensive nature of the revision.

NOTE: The purpose of this chapter revision, other than editorial changes, is to consolidate all previous instructions on fee-basis outpatient medical care and to:

1. Reorganize its contents to agree with sequence of program events.
2. Delete procedural instructions from this policy issue and relocate those instructions to a more appropriate new technical issue, the "Fee-Basis System User Manual," M-1, part I, chapter 18, appendix A.
3. Define terms used in previous instructions which were not defined; e.g., "physically separated VA outpatient clinics" and "geographically inaccessible."
4. Clarify and expand basic policies governing the authorization of fee-basis outpatient medical services to comply with the provisions of Public Law 94-581, Public Law 96-22 and Public Law 96-151.
5. Implement various new methods for improving the control and administration of this program. This includes the requirement that an advisory group be established at each clinic of jurisdiction to assist Clinic Directors with the effective administration of this program.
6. Exclude VA payments made for drugs and medications from calculation of the established monthly dollar limitation for routine medical services obtained by veterans on ID-card fee status.
7. Clarify the appropriate application of earmarked medical care analysis account .27 funds.
8. Implement new method for developing VA fees for drugs and medications.

Pages 18-i through 18-v, 18-1 through 18-36 and 18A1 through 18A3: Remove these pages and substitute pages 18-i through 18-iv and 18-1 through 18-23 attached.



DONALD L. CUSTIS, M.D.  
Chief Medical Director

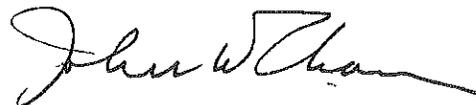
Distribution: RPC: 1111  
FD

May 10, 1977

Chapter 18, "Outpatient Care-Fee," 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 abolish the statistical reports required by section XVI.*

✓ Page 18-25: Delete Section XVI, "Statistical Reports" and paragraphs 18.101 through 18.103.



JOHN D. CHASE, M.D.  
Chief Medical Director

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September 7, 1973

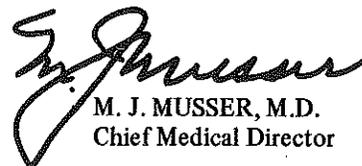
Chapter 18, "Outpatient Care-Fee," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

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

1. Incorporate the provisions of Interim Issue 10-73-6.
2. Provide for mailing of VA Form Letter 10-431, Letter of Approval for Fee Basis Outpatient Treatment, at time of initial issue or reissue of ID card.
3. Provide that VA Hospital, Washington, D.C., will issue VA Form 10-1174f, VA Foreign Medical Services Information Card, to eligible veterans in Canada and other foreign countries.
4. Provide that the Outpatient Clinic in Honolulu will be responsible for management of medical benefits for eligible veterans in the Trust Territory of the Pacific Islands (Micronesia).
5. Provide that veterans in ID card status may obtain outpatient care for approved disabilities from military installations, when the military facility is willing to furnish such care.
6. Provide instructions for use of new VA Form 10-7191b, Data Code Sheet for Participating Pharmacies.
7. Provide pharmacy with disability(s) for which veteran is entitled to receive drugs and medicines while in fee-basis status.
8. Provide monthly payment for beneficiary travel expenses totaling \$5 or more (effective July 1973).

Page 18-v, paragraph 1

- ✓ Subparagraph a: Under subparagraph (2), Add
- ✓ "(3) Change 3, chapter 18, M-1, part I".
- ✓ Subparagraph b: Add "II 10-73-6".
- ✓ Pages 18-7 through 18-10: Remove these pages and substitute pages 18-7 through 18-10a attached.
- ✓ Pages 18-13 through 18-14a: Remove these pages and substitute pages 18-13 through 18-14a attached.
- ✓ Pages 18-17 through 18-22: Remove these pages and substitute pages 18-17 through 18-22a attached.
- ✓ Pages 18-33 and 18-34: Remove these pages and substitute pages 18-33 and 18-34 attached.
- ✓ Pages 18A-1 and 18A-2: Remove these pages and substitute pages 18A-1 and 18A-2 attached.
- ✓ RESCISSIONS: II 10-73-6 and change 3, chapter 18, M-1, part I.

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

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March 26, 1973

Chapter 18, "Outpatient Care-Fee," 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:*

1. Provide for semimonthly payment cycles for processing invoices for fee-basis medical services and fee-basis pharmacy services.
2. Provide that following invoice processing and professional review prescriptions from participating pharmacies will be maintained in Pharmacy Service.
3. Provide that determination of patients' entitlement will be made prior to forwarding fee-basis physicians' prescriptions to Pharmacy Service.
4. Provide for payment by the VA for fee-basis prescriptions refilled by participating pharmacies.

✓ Pages 18-11 and 18-12: Remove these pages and substitute pages 18-11 and 18-12 attached.

✓ Pages 18-19 and 18-20: Remove these pages and substitute pages 18-19 through 18-20a attached.

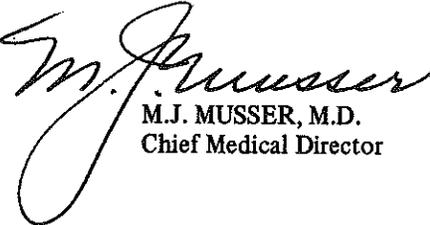
✓ Page 18-34, figure 18.5, paragraph 2

Line 1: Delete "An original," and insert "A".

Line 8

After "may" delete "not".

After "refilled." delete "Payment will not . . . as described above.".

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

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November 14, 1972

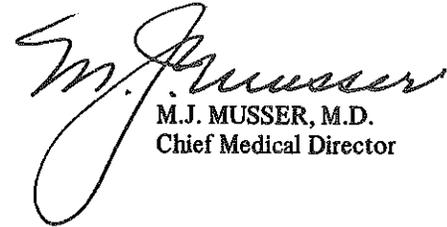
Chapter 18, "Outpatient Care-Fee," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

*NOTE: The purpose of this change is to:*

1. Provide that requested changes to exceed the maximum fees listed in the fee schedule will be made by adjustment to the conversion factor only.
2. Provide for inclusion of purpose code 5 (OPT-NSC) as a valid code to identify drug treatment cases and other OPT-NSC cases for which fee-basis treatment is authorized.

Page 18-4, paragraph 18.10, line 4: After "current" delete "value and requested new value." and insert "conversion factor and requested new conversion factor."

*dy 6*  
Page 18A-2, "Purpose" paragraph, line 9: Insert "Code 5. Outpatient Treatment-NSC. Authorized fee-basis services for treatment of non-service-connected disabilities."



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

M-1, Part I  
Chapter 18  
Change 3

August 29, 1972

Chapter 18, "Outpatient Care-Fee," 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 provide for payment of the unpaid portion of the fee participant's invoice when partial payment is made by other sources.*

*chp. 6* Pages 18-13 and 18-14: Remove these pages and substitute pages 18-13 through 18-14a attached.

*M.J. Musser*  
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Chief Medical Director

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*Rec'd by M-1, Pt I, 6  
Chapter 18, change  
(9-7-73)*

May 22, 1972

Chapter 18, "Outpatient Care-Fee," 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:*

1. Increase from \$30 to \$40 the maximum value of routine medical and nursing services which may be incurred during any calendar month with an ID card authorization.
2. Rescind Appendix 18B, "Diagnostic Codes for the Outpatient Fee-Basis Medical Program."
3. Provide that when ID card authorizes "treatment for any condition," needed determination of refractive error may be obtained from an optometrist.

Page 18-iv, under "APPENDIXES": Delete "18B Diagnostic Codes . . . 18B-1".

chq 6 — Page 18-8, paragraph 18.32a, line 7: After "required." insert "When the ID card authorizes 'treatment for any condition,' needed determination of refractive error may be obtained from an optometrist. Eyeglass prescriptions must be sent to the station of jurisdiction."

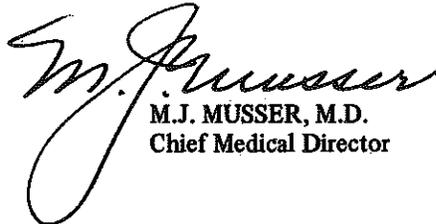
chq 5 — Pages 18-11 and 18-12: Remove these pages and substitute pages 18-11 and 18-12 attached. (Pars. 18.40a and 18.42a changed.)

chq 3 — Page 18-14, paragraph 18.53a, line 5: Delete "\$30" and insert "\$40".

Page 18-15, paragraph 18.57b, line 3: Delete "\$30" and insert "\$40".

chq 6 — Page 18A-1, "Description of Disability" paragraph, lines 3 and 4: After "terminology)" delete "if the original . . . codes in the appendix."

Pages 18B-1 through 18B-8: Remove these pages. (App. B deleted.)

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

Distribution: RPC: 1111  
FD

December 10, 1971

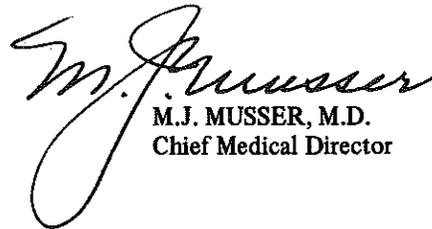
Chapter 18, "Outpatient Care—Fee," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

*NOTE: The purpose of this change is to:*

1. Revise the procedure for authorization and payment to fee participants providing outpatient examination and/or treatment services at a VA station.
2. Revise the listing of medical accessories which community pharmacies may furnish eligible veterans to include disposable syringes.

Pages 18-21 through 18-24: Remove these pages and substitute pages 18-21 through 18-24a attached. (Par. 18.84 changed.)

*Chylo* Page 18-34, figure 18.5, paragraph 3a(1): After "needles" insert "or up to 30 disposable hypodermic syringes."

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

Distribution: RPC: 1111  
FD

June 15, 1971

Chapter 18, "Outpatient Care—Fee," 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 18 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 revision, other than editorial, is to update Chapter 18, "Outpatient Care—Fee," and to convert veteran's identification number, fee participants register number, pharmacy record number to social security number or taxpayer identifying number as appropriate.*

*NOTE 3: Specific changes include:*

- a. **Paragraph 18.01a:** Revised to include VA Regulations 6060(H) and 6060(I).
- b. **Paragraph 18.04:** Revised to change title of VA Form 10-1174 to "VA Outpatient Medical Treatment Information Card."
- c. **Paragraph 18.09c:** Revised to provide for payment of fees charged for auxiliary services and/or supplies when no agreement has been negotiated.
- d. **Paragraph 18.12:** Revised to provide for purchase of needed outpatient treatment services from other Federal agencies on the basis of a formal or informal agreement.
- e. **Paragraph 18.20:** Revised to provide for use of fee participant's social security number in lieu of locally assigned register number and to establish a serial log register for State, county or other related health activities.
- f. **Paragraph 18.32**
  - (1) Subparagraph a: Revised to provide for permanent issue of ID card authorization without annual renewal.
  - (2) Subparagraph f: Revised to provide for reinstating terminated ID card status.
- g. **Paragraph 18.33b:** Revised to provide for issuance of restricted ID cards to entitled veterans residing in the Panama Canal Zone.
- h. **Paragraph 18.49:** Revised to discontinue use of VA Pamphlet 10-97.
- i. **Paragraph 18.51**
  - (1) Subparagraph b: Revised to include reference to keypunching instructions for DM&S keypunching activities as contained in MP-6, part VII, supplement No. 2.2.
  - (2) Subparagraph e: Deleted to discontinue annual renewal of ID cards by DPC.
- j. **Paragraph 18.64:** Revised to provide for use of pharmacy participant's social security number in lieu of locally assigned record number, to establish method for serial assignment of chain store numbers by medical administration, and to provide instructions to DPC to create pharmacy record card for new participants.
- k. **Paragraph 18.98:** Revised to provide for fiscal year tabulation and listing of veterans for whom payment was made for fee-basis medical and/or nursing services to be furnished by DPC following payment processing of June 1972 invoices.

l. **Paragraph 18.99:** Revised to change submission date of VA Forms 10-7088 to 10th workday of July for veterans whose ID card status was terminated.

m. **Paragraph 18.101:** Revised to change semiannual statistical data tabulation to annual tabulation of number, type and total cost for each different type of procedure rendered.

n. **Appendix 18A**

(1) "Identification Number" paragraph: Revised to provide for use of veteran's social security number in lieu of claim number.

(2) "Diagnostic Code No." paragraph: Deleted to discontinue the recording of the two-digit diagnostic code in item (4) of VA Form 10-7079, Request for Outpatient Medical Services.

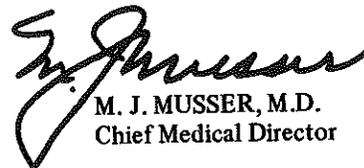
(3) "Name and Address of Fee Participant" paragraph: Revised to provide for inclusion of fee participant's social security number on VA Form 10-7079 when fee status is authorized for limited duration.

(4) "Purpose" paragraph: Revised to amend code numbers for purpose of visit.

o. **Appendix 18B:** Deleted.

p. **Appendix 18C:** Changed to Appendix B, "Diagnostic Codes for the Outpatient Fee-Basis Medical Program."

Pages 18-i through 18-v, 18-1 through 18-35, 18A-1 through 18A-3, 18B-1 through 18B-4, and 18C-1 through 18C-8: Remove these pages and substitute pages 18-i through 18-v, 18-1 through 18-36, 18A-1 through 18A-3, and 18B-1 through 18B-8.



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Chief Medical Director

Distribution: RPC: 1111 assigned  
FD (This ID same as RPC 1016.)