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COPAYMENT FOR OUTPATIENT MEDICAL CARE PROVIDED TO VETERANS BY THE DEPARTMENT OF VETERANS AFFAIRS

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy for charging the outpatient copayment. *NOTE: This Directive is being republished to include the change per Public Law 110-387, "Veterans Mental Health and Other Care Improvements Act of 2008," which exempts Veterans from all copayment requirements for hospice care received in any setting. The change to Hospice copayment became effective October 10, 2008. All other outpatient copayment tier designations provided in this Directive became effective October 1, 2008.*

2. BACKGROUND

a. Public Law 106-117, The Veterans Millennium Health Care and Benefits Act, gave the Department of Veterans Affairs (VA) the authority to establish outpatient copayment amounts by regulation. VA's regulations governing copayments for outpatient care are codified at Title 38 Code of Federal Regulations (CFR) §17.108 (c). The exemption for all VA hospice care (in any setting) is established by statute. VA can therefore implement that change immediately (retroactively to the effective date of the law) while it updates the regulation as a parallel initiative.

b. The following explanations are provided to describe the outpatient copayment tiers.

(1) **No Copayment.** Services for which there is no copayment assessed are publicly announced VA public health initiatives (e.g., health fairs), or an outpatient visit consisting solely of preventive screening or immunizations (e.g., influenza immunization, pneumococcal immunization, hypertension screening, hepatitis C screening, tobacco screening, alcohol screening, hyperlipidemia screening, breast cancer screening, cervical cancer screening, screening for colorectal cancer by fecal occult blood testing, and education about the risks and benefits of prostate cancer screening). *NOTE: These initiatives are viewed as cost-effective for health care in that they often provide early detection of irregularities or abnormalities that can be resolved without major intervention.* Also exempt from copayments are laboratories, flat film radiology services, electrocardiograms, smoking cessation counseling (individual and group) and the Weight Management Program for Veterans (MOVE) clinic (individual and group). *NOTE: These services are considered to be a part of the initial provision of care and a separate copayment is not charged.*

(2) **Basic \$15 Copayment.** A basic outpatient visit is an episode of care furnished in a clinic that provides primary care, or in a clinic that is tightly associated with the larger

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interdisciplinary primary care team. A referral is not needed for most basic outpatient visits; however, some ancillary health care services, usually delivered through consultation or referral, are still considered as a basic outpatient visit.

(a) Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care includes, but is not limited to: diagnosis and management of acute and chronic biopsychosocial conditions, health promotion, disease prevention, overall care management, and patient and caregiver education.

(b) Each patient's identified primary care clinician delivers services in the context of a larger interdisciplinary primary care team. A patient has access to the primary care clinician and the primary care team without need of a referral.

(3) **Specialty \$50 Copayment.** A specialty outpatient visit is an episode of care furnished in a clinic that does not provide primary care and that is not part of, or tightly associated with, the larger interdisciplinary primary care team. In general, services delivered in a specialty outpatient visit are provided by highly-specialized, narrowly-focused health care professionals. Specialty outpatient visits are only provided through a referral or consultation. Examples include: surgical consultative services, radiology services requiring the immediate presence of a physician, audiology, optometry, cardiology, magnetic resonance imagery (MRI), computerized axial tomography (CAT) scan, nuclear medicine studies, and ambulatory surgery.

3. POLICY: It is VHA policy that outpatient copayments are assessed based upon the level of service provided; three tiers of outpatient copayments have been implemented.

4. ACTION: The facility Director is responsible for ensuring that:

a. Attachment B Copayment Tier Table is implemented for all copayment assignments for VA care.

b. Attachments B and D are implemented for all Fee Basis Referrals (non-VA) copayment. In order to determine the most appropriate copayment for Fee basis referrals, both Attachments B and D must be utilized.

***NOTE:** Patients who are provided Fee Basis Referrals (non-VA care) are to be charged the applicable copayment (using Attachments B and D), that would have applied had they received the outpatient care in a VA facility.*

c. Staff assigned responsibility for reviewing documentation or claims submitted by the fee-basis provider, determine if the services provided were service connected or non-service connected; and the staff assigned this responsibility refer to the appropriate care (see Att. B and Att. D), to determine the applicable copayment assignment (i.e., no copayment, basic \$15 or specialty \$50 copayment).

d. A three-tier copayment system is in effect for all outpatient care services furnished on and after October 1, 2008. Operationally, copayments are to be determined by the Decision Support System (DSS) Identifiers (ID) (also known as stop codes). The use of these DSS IDs (stop code) designations and the related copayments are consistent for all facilities. Medical centers do not have the authority to charge a different copayment for services. **NOTE:** *The copayment designations are updated on an annual basis to coincide with any changes made to the DSS IDs (see Att. A. for Fiscal Year (FY) 2009 DSS IDs and copayment designations).*

e. If a Veteran has one or more basic care encounters on the same day and no specialty care encounter on that day, the basic copayment for one visit is charged for that day.

f. If a Veteran has one or more basic care encounters and one or more specialty care encounters on the same day, the specialty copayment for one visit is charged for that day.

g. If a Veteran is required to make a copayment for extended care services that were provided either directly by VA, or obtained for VA by contract on the same day as having an outpatient visit, the outpatient copayment is not charged; however, the extended care copayment is charged for those extended care services.

h. The following Veterans are not subject to the copayment requirements for outpatient medical care:

(1) Veterans with a compensable service-connected disability.

(2) Veterans who are former prisoners of war.

(3) Veterans awarded a Purple Heart.

(4) Veterans who were discharged or released from active military service for a disability incurred or aggravated in the line of duty.

(5) Veterans who receive disability compensation under Title 38 United States Code (U.S.C.) 1151.

(6) Veterans whose entitlement to disability compensation is suspended pursuant to 38 U.S.C. 1151, but only to the extent that the Veteran's continuing eligibility for care is provided for in the judgment or settlement described in 38 U.S.C. 1151.

(7) Veterans whose entitlement to disability compensation is suspended because of the receipt of military retirement pay.

(8) Veterans of the Mexican border period or World War I.

(9) Military retirees provided care under an interagency agreement, as defined in Public Law 106-117, Section 113.

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(10) Veterans who VA determines to be unable to defray the expenses of necessary care under 38 U.S.C. 1722(a).

i. The following services are not subject to the copayment requirements for outpatient medical care:

(1) Special registry examinations (including any follow-up examinations or testing ordered as part of the special registry examination) offered by VA to evaluate possible health risks associated with military service.

(2) Counseling and care for sexual trauma, as authorized under 38 U.S.C. 1720D.

(3) Compensation and pension examinations requested by the Veterans Benefits Administration (VBA).

(4) Care provided as part of a VA-approved research project authorized by 38 U.S.C. 7303.

(5) Outpatient dental care provided under 38 U.S.C. 1712.

(6) Readjustment counseling and related mental health services authorized under 38 U.S.C. 1712A.

(7) Emergency treatment paid for under 38 U.S.C. 1725 or 38 U.S.C. 1728.

(8) Extended care services authorized under 38 U.S.C. 1710B.

(9) Care or services authorized under 38 U.S.C. 1720E for certain Veterans regarding cancer of the head or neck.

(10) Care as authorized under 38 U.S.C. 1710(e).

(11) Care provided to a Veteran for a non-compensable 0 percent service-connected disability.

(12) Publicly-announced VA public health initiatives (e.g., health fairs), or an outpatient visit consisting solely of preventive screening and immunizations (e.g., influenza immunizations, pneumococcal immunizations, hypertension screening, hepatitis C screening, tobacco screening, alcohol screening, hyperlipidemia screening, breast cancer screening, cervical cancer screening, screening for colorectal cancer by fecal occult blood testing, and education about the risks and benefits of prostate cancer screening).

(13) Laboratory services, flat film radiology services, and electrocardiograms.

(14) Smoking cessation counseling (individual and group) under 38 U.S.C. 17.108(e)(13).

(15) MOVE Program (individual and group) under 38 U.S.C. 17.108 (e) (12).

(16) Hospice Care

j. Outpatient care is not subject to the outpatient copayment requirements, when provided to a Veteran during a day for which the Veteran is required to make a copayment for extended care services that were provided either directly by VA or obtained for VA by contract.

k. Outpatient copayment collections are deposited into the Medical Care Collections Fund (36_528703).

5. REFERENCES

- a. Pub L 106-117: Pub L. 110-387
- b. Title 38 U.S.C. 1710(a), (f), and (g), 1710B.
- c. Title 38 Code of Federal Regulations 17.108.

6. FOLLOW-UP RESPONSIBILITY: The Chief Business Officer (16) is responsible for the contents of this Directive. Questions may be addressed to (202) 461-1587.

7. RESCISSIONS: VHA Directive 2008-060 is rescinded. This VHA Directive expires March 31, 2014.

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Under Secretary for Health

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ATTACHMENT A

DECISION SUPPORT SYSTEM (DSS) IDENTIFIERS (ALSO KNOWN AS STOP CODES), DEFINITIONS, AND COPAYMENT TIER TABLE FOR DEPARTMENT OF VETERANS AFFAIRS (VA) CARE

1. The Fiscal Year (FY) 2009 Decision Support System (DSS) Identifiers (IDs) (i.e., a three-digit code if primary ID only, and a six-digit code if primary and secondary IDs) and copayment tiers provided in Attachment B must be used for all outpatient copayment activity. Outpatient copayments are based on basic visits, specialty visits, and no copayment designations as determined by DSS IDs. The use of these DSS ID designations and the related copayments must be consistent for all facilities. Medical centers do not have the authority to charge a different copayment for services.

2. Clinics for which no copayments are charged are designated as "NON." Basic copayment clinic designations are indicated with "B," and specialty copayment clinic designations are indicated with "S."

3. Refer to the current Veterans Health Administration (VHA) DSS ID Directive or the DSS at: <http://vaww.dss.med.va.gov> for the definitions associated with all DSS clinic stop codes.

4. **Definitions**

a. **"DSS Identifier" or "DSS ID."** A three-digit or six-digit code used to report the production unit responsible for specific types of outpatient health care:

(1) The first three digits of a DSS ID report the workgroup, the production unit, or the clinic department (Clinic Stop) responsible for the care delivered.

(2) The second three digits, if needed, are used to report added specificity about either the type of service or the type of service provider.

(3) The DSS ID is comprised of the Primary Stop Code and, if present, the Credit Pair or Secondary Stop Code, respectively, and is represented on the Veterans Health Information Systems and Technology Architecture (VistA) Medical Administration Service (MAS), Health Administration Service (HAS), Chief Business Officer (CBO) Outpatient packages field as Stop Code Number and Credit Stop Code, respectively.

b. **Primary Stop Code.** The first three characters of the DSS ID. This entity is known in the VistA MAS package, in File #44, as the field "Stop Code Number."

c. **Credit Pair or Secondary Stop Code.** The final three characters of a six-character DSS Identifier. This entity is identified in the VistA MAS package, in File #44, as the field "Credit Stop Code."

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d. **VistA Clinic Set-Up.** To set up a clinic in the VistA MAS Package for an Outpatient Clinic, the field Stop Code Number is required. The field Credit Stop Code can also be entered, as appropriate, to further characterize the responsible clinic.

e. **DSS ID Updates.** DSS annually updates the codes that identify outpatient production units which are known as DSS IDs. This is done to provide standard reference workload accounting for all VHA.

5. FY 2009 Changes. The following changes became effective October 1, 2008 for FY 2009.

NOTE: Public Law 110-387 became effective October 10, 2008, and exempted first party medical care copayments for all Veterans receiving hospice care.

a. DSS Stop Code 156	HBPC – PSYCHOLOGIST	Basic
b. DSS Stop Code 157	HBPC – PSYCHIATRIST	Basic
c. DSS Stop Code 162	MEDICAL FOSTER HOME	NON
d. DSS Stop Code 195	POLYTRAUMA TRANSITIONAL REHABILITATION PROGRAM INDIVIDUAL	NON
e. DSS Stop Code 196	POLYTRAUMA TRANSITIONAL REHABILITATION PROGRAM GROUP	NON
f. DSS Stop Code 230	PM&RS DRIVER TRAINING	NON
g. DSS Stop Code 351	HOSPICE AND PALLATIVE CARE	NON**
h. DSS Stop Code 372	WEIGHT MANAGEMENT COUNSELING (MOVE) Program Individual	NON*
i. DSS Stop Code 373	WEIGHT MANAGEMENT COUNSELING (MOVE) Program Group	NON*
j. DSS Stop Code 438	INTERMEDIATE LOW VISION CARE	NON

* This change became effective June 16, 2008, Patch IB*2*398.

** This change became effective October 10, 2008, Patch IB*2*409

k. DSS Stop Code 593	RESIDENTIAL REHABILITATION TREATMENT PROGRAM (RRTP) OUTREACH SERVICES	NON
l. DSS Stop Code 594	RESIDENTIAL REHABILITATION TREATMENT PROGRAM (RRTP) AFTERCARE – COMMUNITY	NON
m. DSS Stop Code 595	RESIDENTIAL REHABILITATION TREATMENT PROGRAM (RRTP) AFTERCARE – VA	NON
n. DSS Stop Code 596	RESIDENTIAL REHABILITATION TREATMENT PROGRAM (RRTP) ADMISSION SCREENING SVCS	Basic
o. DSS Stop Code 597	TELEPHONE/RESIDENTIAL REHABILITATION TREATMENT PROGRAM (RRTP)	NON
p. DSS Stop Code 719	MHV SECURE MESSAGING	NON

6. The Stop Codes (DSS Identifiers) that are entered into the clinic set-up directly impact the outpatient copayment bills generated from the Integrated Billing (IB) software. New options have been created with the installation of patch SD*5.3*537 that help identify clinics that have been set-up with Stop Codes which may be causing unexpected results for outpatient copayment bills (i.e., Non-conforming Clinics Stop Codes). These options can be found on the Scheduling Supervisor's Menu or on the DSS Extract Manager's Menu. The Revenue or Business Office at each site needs to be made aware of these reports in order to identify, correct, and prevent incorrect copayments being sent to patients.

a. The specific names of the options are:

(1) **DSS Extract Manager's Option.** This option is called: DSS Identifier Non-Conforming Clinics Report [ECX CLN STOP REP]; or

(2) **Scheduling Package Supervisor's Menu.** This option is called: Non-Conforming Clinics Stop Code Report [SD CLN STOP CODE REP].

b. Once a discrepancy is found, the copayment bills can be manually corrected, and the site is required to use the Set up a Clinic [SDBUILD] menu option to make corrections in order to prevent future errors. Here is a sample report from the Scheduling Supervisor's menu option:

NON-CONFORMING CLINICS STOP CODE REPORT
(All Clinics)

Hospital Location File (#44). Use Set-up a Clinic [SDBUILD] menu option to make corrections.

CLINIC NAME	PRIMARY STOP CODE	SECONDARY CREDIT STOP CODE	REASON FOR NON- CONFORMANCE
117 Nursing	117	117	Cannot be primary
257 Mental Hygiene			Missing primary code
271 Surgical Clinic	429	429	429 cannot be secondary

3 PROBLEM CLINICS FOUND

ATTACHMENT B

**DECISION SUPPORT SYSTEM (DSS) IDENTIFIERS (ID) OR STOP CODES AND
COPAYMENT TIER TABLE**

This table provides the copayment tier designations that are effective October 1, 2008.

DSS ID NUMBER	DSS ID PAIR	DSS ID NAME	Copayment Tier B=Basic S=Specialty Non=No Copayment
102		ADMITTING/SCREENING	B
103		TELEPHONE TRIAGE	NON
	103801	IN Veterans Integrated Service Network (VISN) PHONE TRIAGE – NOT Department of Veterans Affairs (VA) MEDICAL CENTER	NON
	103802	OUT OF VISN, VA PHONE TRIAGE	NON
	103803	COMMERCIAL PHONE TRIAGE	NON
104		PULMONARY FUNCTION	S
105		X-Ray	NON
106		Electroencephalogram (EEG)	S
107		Electrocardiogram (EKG)	NON
108		LABORATORY	NON
109		NUCLEAR MEDICINE	S
115		ULTRASOUND	S
116		RESPIRATORY THERAPY	B
	117	NURSING	B
118		HOME TREATMENT SERVICES	B
119		COMMUNITY NURSING HOME FOLLOW- UP	N
120		HEALTH SCREENING	NON
121		RESIDENTIAL CARE [NON-MENTAL HEALTH (MH)]	B
123		NUTRITION/DIETETICS/INDIVIDUAL	B
124		NUTRITION/DIETETICS/GROUP	B
125		SOCIAL WORK SERVICE	B
126		EVOKED POTENTIAL	S
127		TOPOGRAPHICAL BRAIN MAPPING	S
128		PROLONGED VIDEO-EEG MONITORING	S
130		EMERGENCY DEPARTMENT	S
131		URGENT CARE	B

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DSS ID NUMBER	DSS ID PAIR	DSS ID NAME	Copayment Tier
142		ENTEROSTOMAL TX, WOUND OR SKIN CARE	B
	143	SLEEP STUDY	NON
144		RADIONUCLIDE THERAPY	S
145		PHARMACOLOGY or PHYSIOLOGIC NUCLEAR MYOCARDIAL PERFUSION STUDIES	S
146		POSITRON EMISSION TOMOGRAPHY (PET)	S
147		TELEPHONE/ANCILLARY	NON
148		TELEPHONE/DIAGNOSTIC	NON
149		RADIATION THERAPY TREATMENT	S
150		COMPUTERIZED TOMOGRAPHY (CT)	S
151		MAGNETIC RESONANCE IMAGING (MRI)	S
152		ANGIOGRAM CATHETERIZATION	S
153		INTERVENTIONAL RADIOGRAPHY	S
154		MAGNETOENCEPHALOGRAPHY (MEG)	S
155		INFO ASSISTS TECHNOLOGY	S
156		HBPC-PSYCHOLOGIST	B
157		HBPC-PSYCHIATRIST	B
159		COMPLEMENTARY & ALTERNATIVE THERAPIES	B
160		CLINICAL PHARMACY	B
	162	MEDICAL FOSTER HOME	NON
165		CHAPLAIN SERVICE: BEREAVEMENT COUNSELING	NON
166		CHAPLAIN SERVICE – INDIVIDUAL	NON
167		CHAPLAIN SERVICE – GROUP	NON
168		CHAPLAIN SERVICE – COLLATERAL	NON
169		TELEPHONE/CHAPLAIN	NON
170		HOME BASED PRIMARY CARE (HBPC) – PHYSICIAN	B
171		HBPC – REGISTERED NURSE (RN) LICENSED PRACTICAL NURSE (LPN)	B
172		HBPC – PHYSICIAN EXTENDER (NP, CNS, PA)	B
173		HBPC - SOCIAL WORKER	B
174		HBPC – THERAPIST	B
175		HBPC – DIETITIAN	B
176		HBPC - CLINICAL PHARMACIST	B
177		HBPC – OTHER	B
	177201	HBPC- PHYSICAL MEDICINE & REHABILITATION SERVICE (PM&RS)	B

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DSS ID NUMBER	DSS ID PAIR	DSS ID NAME	Copayment Tier
	177210	HBPC- SPINAL CORD INJURY (SCI)	B
178		HBPC/TELEPHONE	NON
	179	REAL-TIME VIDEO CARE	B
180		DENTAL	NON
181		TELEPHONE/DENTAL	NON
182		TELEPHONE CASE MANAGEMENT	NON
	184	CARE/CASE MANAGER	NON
	185	PHYSICIAN EXTENDER (NP)	Refer to primary stop code
	186	PHYSICIAN EXTENDER (PA)	Refer to primary stop code
	187	PHYSICIAN EXTENDER (CNS)	Refer to primary stop code
	188	PHYSICIAN RESIDENT	Refer to primary stop code
190		ADULT DAY HEALTH CARE	B
191		COMMUNITY ADULT DAY HEALTH CARE FOLLOW-UP	NON
195		POLYTRAUMA TRANSITIONAL REHABILITATION PROGRAM INDIVIDUAL	NON
196		POLYTRAUMA TRANSITIONAL REHABILITATION PROGRAM GROUP	NON
197		POLYTRAUMA – INDIVIDUAL	S
198		POLYTRAUMA – GROUP	S
199		POLYTRAUMA – TELEPHONE	N
201		PM & RS	S
202		RECREATION THERAPY SERVICE	NON
203		AUDIOLOGY	S
204		SPEECH PATHOLOGY	S
205		PHYSICAL THERAPY	B
206		OCCUPATIONAL THERAPY	B
207		PM&RS INCENTIVE THERAPY FACE-TO-FACE	NON
208		PM&RS COMPENSATED WORK THERAPY/TRANSITIONAL WORK EXPERIENCE (PM&RS CWT/TWE) FACE-TO-FACE	NON
209		VIST COORDINATOR	NON

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DSS ID NUMBER	DSS ID PAIR	DSS ID NAME	Copayment Tier
210		SPINAL CORD INJURY	B
	210414	SCI-CYSTOURO	B
211		AMPUTATION FOLLOW-UP CLINIC	S
212		EMG – ELECTROMYOGRAM	S
213		PM&RS VOCATIONAL ASSISTANCE	NON
214		KINESIOTHERAPY (KT)	B
215		SCI HOME CARE PROGRAM	B
216		TELEPHONE REHABILITATION (REHAB) AND SUPPORT	NON
217		BLIND REHAB OUTPATIENT SPECIALIST (BROS)	B
218		COMPUTER ASSISTED TRAINING (CAT) BLIND REHAB	B
219		TBI (TRAUMATIC BRAIN INJURY)	S
220		VISOR and ADVANCED BLIND REHAB	NON
221		TELEPHONE/VISUAL IMPAIRMENT SERVICE TEAM (VIST)	NON
222		PM&RS COMPENSATED WORK THERAPY/SUPPORTED EMPLOYMENT (PM&RS CWT/SE) FACE TO FACE	NON
229		TELEPHONE/BLIND REHAB PROGRAM	NON
230		PM&RS DRIVER TRAINING	NON
290		OBSERVATION MEDICINE	S
291		OBSERVATION SURGERY	S
292		OBSERVATION PSYCHIATRY	S
293		OBSERVATION NEUROLOGY	S
294		OBSERVATION BLIND REHAB	S
295		OBSERVATION SPINAL CORD (SCI)	S
296		OBSERVATION REHABILITATION	S
301		GENERAL INTERNAL MEDICINE	B
302		ALLERGY IMMUNOLOGY	S
303		CARDIOLOGY	S
	303115	ECHOCARDIOGRAM	S
304		DERMATOLOGY	S
305		ENDO METAB (EXCEPT DIABETES)	S

DSS ID NUMBER	DSS ID PAIR	DSS ID NAME	Copayment Tier
306		DIABETES	S
307		GASTROENTEROLOGY	S
308		HEMATOLOGY	S
309		HYPERTENSION	S
310		INFECTIOUS DISEASE	S
	310323	CHRONIC INFX DSE PRIMARY CARE	B
311		PACEMAKER	S
312		PULMONARY/CHEST	S
313		RENAL/NEPHROL(EXCEPT DIALYSIS)	S
314		RHEUMATOLOGY/ARTHRITIS	S
315		NEUROLOGY	S
316		ONCOLOGY/TUMOR	S
317		ANTI-COAGULATION CLINIC	B
318		GERIATRIC CLINIC	B
319		GERIATRIC EVALUATION AND MANAGEMENT (GEM)	B
320		ALZHEIMER'S AND DEMENTIA CLINIC	S
321		Gastrointestinal (GI) ENDOSCOPY	S
322		WOMEN'S CLINIC	B
323		PRIMARY CARE/MEDICINE	B
	323160	PHARMACY CONSULTS	B
	323531	MENTAL HEALTH MEDICAL PRIMARY CARE	B
324		TELEPHONE/MEDICINE	NON
325		TELEPHONE/NEUROLOGY	NON
326		TELEPHONE/GERIATRICS	NON
327		MED Physician (MD) PERFORM INVASIVE Operating Room (OR) Procedure (PROC)	S
328		MEDICAL SURGICAL DAY UNIT (MSDU)	B
329		MEDICAL PROCEDURE UNIT	S
330		CHEMOTHERAPY PROCEDURES UNIT MEDICINE	S
331		PRE-BED CARE (MD) (MEDICAL SERVICE)	B
332		PRE-BED CARE RN (MEDICAL SERVICE)	B
333		CARDIAC CATHETERIZATION	S
334		CARDIAC STRESS TEST/EXERCISE TOLERANCE TEST (ETT)	S
335		PADRECC (PARKINSON'S DISEASE RECC)	S
336		MEDICAL PRE-PROCEDURE EVALUATION	NON

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DSS ID NUMBER	DSS ID PAIR	DSS ID NAME	Copayment Tier
337		HEPATOLOGY CLINIC	S
348		PRIMARY CARE GROUP	B
349		SLEEP MEDICINE	S
350		GERIATRIC PRIMARY CARE	B
351		HOSPICE AND PALLITIVE CARE	NON
352		GRECC CLINICAL DEMONSTRATION	B
	370	LONG TERM CARE SCREENING / ASSESSMENT	NON
	371	CCHT SCREENING	NON
372		WEIGHT MANAGEMENT COUNSELING (MOVE PROGRAM) INDIVIDUAL	NON
373		WEIGHT MANAGEMENT COUNSELING (MOVE PROGRAM) GROUP	NON
394		MED SPECIALTY GROUP	S
401		GENERAL SURGERY	S
402		CARDIAC SURGERY	S
403		EAR, NOSE, AND THROAT (ENT)	S
404		GYNECOLOGY	S
405		HAND SURGERY	S
406		NEUROSURGERY	S
407		OPHTHALMOLOGY	S
408		OPTOMETRY	S
409		ORTHOPEDICS	S
410		PLASTIC SURGERY	S
411		PODIATRY	B
412		PROCTOLOGY	S
413		THORACIC SURGERY	S
414		UROLOGY CLINIC	S
415		VASCULAR SURGERY	S
416		AMBULATORY SURGERY EVALUATION BY NON-MD	NON
417		PROSTHETIC, ORTHOTICS	B
418		AMPUTATION CLINIC	S
419		ANESTHESIA PRE-operation (OP) and/or POST-OP CONSULTATION	S
420		PAIN CLINIC	S
421		VASCULAR LABORATORY	S
422		CAST CLINIC	B
423		PROSTHETIC SUPPLY DISPENSED	NON
424		TELEPHONE/SURGERY	NON
425		TELEPHONE/PROSTHETICS/ORTHOTICS	NON

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426		WOMEN'S SURGERY	S
428		TELEPHONE/OPTOMETRY	NON
429		OUTPATIENT CARE IN THE OPERATING ROOM	S
	429430	CYSTO ROOM IN OPERATING ROOM	S
430		CYSTO ROOM IN UROLOGY CLINIC	S
431		CHEMOTHERAPY PROCEDURES UNIT-SURGERY	S
432		PRE-BED CARE MD (SURGICAL SERVICE)	B
433		PRE-BED CARE RN (SURGERY)	B
434		NON-OR ANESTHESIA PROCEDURES	S
435		SURGICAL PROCEDURE UNIT	S
436		CHIROPRACTIC CARE	B
437		VICTORS & ADVANCED LOW VISION	NON
438		INTERMEDIATE LOW VISION CARE	NON
439		LOW VISION CARE	NON
	449	FITTINGS & ADJUSTMENTS	NON
	450	COMPENSATION AND PENSION (C&P) EXAM	NON
	451	LOCALLY DEFINED CREDIT PAIR	NON
	452	LOCALLY DEFINED CREDIT PAIR	NON
	453	LOCALLY DEFINED CREDIT PAIR	NON
	454	LOCALLY DEFINED CREDIT PAIR	NON
	455	LOCALLY DEFINED CREDIT PAIR	NON
	456	LOCALLY DEFINED CREDIT PAIR	NON
	457	TRANSPLANT	S
	458	LOCALLY DEFINED CREDIT PAIR	NON
	459	LOCALLY DEFINED CREDIT PAIR	NON
	460	LOCALLY DEFINED CREDIT PAIR	NON
	461	LOCALLY DEFINED CREDIT PAIR	NON
	462	LOCALLY DEFINED CREDIT PAIR	NON
	463	LOCALLY DEFINED CREDIT PAIR	NON
	464	LOCALLY DEFINED CREDIT PAIR	NON
	465	LOCALLY DEFINED CREDIT PAIR	NON
	466	LOCALLY DEFINED CREDIT PAIR	NON
	467	LOCALLY DEFINED CREDIT PAIR	NON
	468	LOCALLY DEFINED CREDIT PAIR	NON
	469	LOCALLY DEFINED CREDIT PAIR	NON
	470	LOCALLY DEFINED CREDIT PAIR	NON
	471	LOCALLY DEFINED CREDIT PAIR	NON
	472	LOCALLY DEFINED CREDIT PAIR	NON

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DSS ID NUMBER	DSS ID PAIR	DSS ID NAME	Copayment Tier
	473	LOCALLY DEFINED CREDIT PAIR	NON
	474	RESEARCH	NON
	475	LOCALLY DEFINED CREDIT PAIR	NON
	476	LOCALLY DEFINED CREDIT PAIR	NON
	477	LOCALLY DEFINED CREDIT PAIR	NON
	478	LOCALLY DEFINED CREDIT PAIR	NON
	479	LOCALLY DEFINED CREDIT PAIR	NON
	480	COMPREHENSIVE FUNDOSCOPY EXAM	S
	481	BRONCHOSCOPY	S
	482	LOCALLY DEFINED CREDIT PAIR	NON
	429481	If Outpatient Bronchoscopy is done by Surgery in the OR	S
	312481	If Outpatient Bronchoscopy is done in the Pulmonary Area	S
	327481	If Outpatient Bronchoscopy is done by Medicine in the OR	S
	329481	If Outpatient Bronchoscopy is done in the Medical Procedure Unit	S
	435481	If Outpatient Bronchoscopy is done in "Lumps and Bumps" Surgery Procedure Unit	S
	483	LOCALLY DEFINED CREDIT PAIR	NON
	484	LOCALLY DEFINED CREDIT PAIR	NON
	485	LOCALLY DEFINED CREDIT PAIR	NON
502		MENTAL HEALTH CLINIC INDIVIDUAL	B
503		MENTAL HEALTH RESIDENTIAL CARE INDIVIDUAL	B
505		DAY TREATMENT – INDIVIDUAL	B
506		DAY HOSPITAL – INDIVIDUAL	B
509		PSYCHIATRY - INDIVIDUAL	B
510		PSYCHOLOGY (PSO) – INDIVIDUAL	B
512		MENTAL HEALTH CONSULTATION	B
513		SUBSTANCE USE DISORDER – INDIVIDUAL	B
514		SUBSTANCE USE DISORDER - HOME VISIT	B
516		POST TRAUMATIC STRESS DISORDER (PTSD) – GROUP	B
519		SUBSTANCE USE DISORDER/PTSD TEAMS	B
522		Department of Housing and Urban Development (HUD)- VA Shared Housing (VASH)	NON
523		OPIOID SUBSTITUTION	NON
524		ACTIVE DUTY SEXUAL TRAUMA	NON

DSS ID NUMBER	DSS ID PAIR	DSS ID NAME	Copayment Tier
525		WOMEN'S STRESS DISORDER TREATMENT TEAMS	B
527		MENTAL HEALTH TELEPHONE	NON
	527564	TELEPHONE MH TEAM CASE MANAGEMENT	NON
528		TELEPHONE/HOMELESS CHRONICALLY MENTALLY ILL (HCMI)	NON
529		HCHV/HCMI	NON
530		TELEPHONE/HUD-VASH	NON
532		PSYCHOSOCIAL REHABILITATION-INDIVIDUAL	B
533		MH INTERVENTION BIOMEDICAL CARE INDIVIDUAL	B
534		MENTAL HEALTH INTEGRATED CARE	B
535		MH VOCATIONAL ASSISTANCE – INDIVIDUAL	NON
536		TELEPHONE/MH VOCATIONAL ASSISTANCE	NON
537		TELEPHONE/PSYCHOSOCIAL REHABILITATION	NON
538		PSYCHOLOGICAL TESTING	S
540		PTSD CLINICAL TEAM (PCT) POST-TRAUMATIC STRESS-INDIVIDUAL	B
542		TELEPHONE/PTSD	NON
545		TELEPHONE/SUBSTANCE USE DISORDER	NON
546		TELEPHONE/MHICM	NON
547		INTENSIVE SUBSTANCE USE DISORDER – GROUP	B
550		MENTAL HEALTH CLINIC (GROUP)	B
552		MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM)	B
553		DAY TREATMENT – GROUP	B
554		DAY HOSPITAL – GROUP	B
557		PSYCHIATRY – GROUP	B
558		PSYCHOLOGY – GROUP	B
559		PSYCHOSOCIAL REHABILITATION – GROUP	B

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DSS ID NUMBER	DSS ID PAIR	DSS ID NAME	Copayment Tier
560		SUBSTANCE USE DISORDER – GROUP	B
561		PCT-POST TRAUMATIC STRESS GROUP	B
562		PTSD – INDIVIDUAL	B
564		MH TEAM CASE MANAGEMENT	B
565		MH INTERVENTION BIOMED CARE GROUP	B
566		MH RISK-FACTOR-REDUCTION ED GROUP	B
567		MH INTENSIVE CASE MANAGEMENT (MHICM) GROUP	B
568		MENTAL HEALTH COMPENSATED WORK THERAPY/SUPPORTED EMPLOYMENT (CWT/SE) FACE TO FACE	NON
571		SeRV-MH (Services for Returning Veterans – Mental Health IND	NON
572		SeRV-MH (Services for Returning Veterans – Mental Health) GROUP	NON
573		MH INCENTIVE THERAPY FACE-TO-FACE	NON
574		MENTAL HEALTH COMPENSATED WORK THERAPY/TRANSITIONAL WORK EXPERIENCE (CWT/TWE) FACE-TO-FACE	NON
575		MH VOCATIONAL ASSISTANCE Group	NON
576		PSYCHOGERIATRIC CLINIC, INDIVIDUAL	B
577		PSYCHOGERIATRIC CLINIC, GROUP	B
579		TELEPHONE/ PSYCHOGERIATRICS	NON
580		PTSD DAY HOSPITAL	B
582		PSYCHOSOCIAL REHABILITATION AND RECOVERY CENTER (PRRC), IND	B
583		PHYCHOSOCIAL REHABILITATION AND RECOVERY (PRRC), GROUP	B

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DSS ID NUMBER	DSS ID PAIR	DSS ID NAME	Copayment Tier
584		TELEPHONE PSYCHOSOCIAL REHABILITATION AND RECOVERY CENTER (PRRC)	NON
590		COMMUNITY OUTREACH HOMELESS VETS BY STAFF OTHER THAN HCHV AND RRTP PROGRAMS	NON
591		INCARCERATED VETERANS RE-ENTRY	NON
593		RESIDENTIAL REHABILITATION TREATMENT PROGRAM (RRTP) OUTREACH SERVICES	NON
594		RESIDENTIAL REHABILITATION TREATMENT PROGRAM (RRTP) AFTERCARE-COMMUNITY	NON
595		RESIDENTIAL REHABILITATION TREATMENT PROGRAM (RRTP) AFTERCARE-VA	NON
596		RESIDENTIAL REHABILITATION TREATMENT PROGRAM (RRTP) ADMISSION SCREENING SERVICES	B
597		TELEPHONE/RESIDENTIAL REHABILITATION TREATMENT PROGRAM (RRTP)	NON
602		ASSISTED HEMODIALYSIS	B
603		LIMITED SELF CARE HEMODIALYSIS	B
604		HOME/SELF HEMODIALYSIS TRAINING	B
606		CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD)	B
607		LIMITED SELF CARE CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD)	B
608		HOME/SELF CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD) TRAINING	B
610		CONTRACT DIALYSIS	B
611		TELEPHONE/DIALYSIS	NON
640		SEND-OUT PROCEDURES – NOT FEE	NON
641		SEND-OUT PROCEDURES – DoD –NOT PAID BY FEE	NON
642		SEND-OUT PROCEDURES FEE	NON
	643	SEND-OUT PROCEDURES – RADIOLOGY	NON
656		Department of Defense (DOD) NON-VA CARE	NON
674		Administrative Patient Activities (Non-Count CBO)	NON

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DSS ID NUMBER	DSS ID PAIR	DSS ID NAME	Copayment Tier
	674685	CCHT PATIENT ORIENTATION TECHNOLOGY	NON
680		HCBC ASSESSMENT	NON
683		CCHT NON-VIDEO MONITORING	NON
	684	CCHT NON-VIDEO INTERVENTION	NON
685		CARE OF CCHT PROGRAM PATIENTS	NON
686		TELEPHONE CONTACT BY CARE COORDINATION STAFF	NON
	690	GENERAL TELEHEALTH REAL TIME	NON
	691	PRE-EMPLOYMENT PHYSICAL MILITARY PERSONNEL	NON
	692	GENERAL TELEHEALTH REAL TIME SAME STATION	Refer to Primary
	693	GENERAL TELEHEALTH REAL TIME NOT SAME STATION	Refer to Primary
	694	STORE-AND-FORWARD TELEHEALTH	NON
	695	STORE-AND-FORWARD TELEHEALTH SAME STATION	Refer to Primary
	696	STORE-AND-FORWARD TELEHEALTH – NOT SAME STATION	Refer to Primary
	697	CHART CONSULT	NON
	701	BLOOD PRESSURE CHECK	NON
703		MAMMOGRAM	NON
704		FEMALE GENDER SPECIFIC CANCER SCREENING	NON
	706	ALCOHOL SCREENING	NON
	707	SMOKING CESSATION	NON
	710	FLU/PNEUMOCOCCAL VACCINATION	NON
	712	HEPATITIS C REGISTRY	NON
	713	GAMBLING ADDICTION	B
	714	OTHER EDUCATION	B
	715	ONGOING TREATMENT (Non-MH)	B
	716	POST SURG ROUTINE AFTERCARE	B
	717	PPD	NON
718		DIABETIC RETINAL SCREENING	NON
	719	MHV SECURE MESSAGING	NON
999		EMPLOYEE HEALTH	NON
	999510	PSO-Employee Assistance Program (EAP) – NOTE: Optional.	NON

ATTACHMENT C

BUSINESS RULES FOR NON-VA MEDICAL CARE AND SERVICES

1. Staff assigned responsibility for entering authorizations into the Veterans Health Information and Technology Architecture (VistA) Fee Basis package will indicate whether care is for accident related and potentially cost recoverable services.
2. Staff, as appropriate, assigned responsibility for reviewing the non-Department of Veterans Affairs (VA) care claim for payment will indicate if the care provided on each line item is related to the Veteran's service-connected disabilities (the primary diagnosis will be used for this purpose).
3. The Potential Cost Recovery Report or a comparable tool will be used to identify claims that have been paid through the Fee Basis software and have first or third-party billing potential.
4. Claims with first and third party billing potential are referred to Medical Care Cost Recovery (MCCR)-Chief Business Office (CBO) to ensure claims are generated to third-party insurers and for establishing first-party debts.

ATTACHMENT D

**COPAYMENTS FOR NON-VA MEDICAL CARE SERVICES PROVIDED TO
 VETERANS AT THE VA'S EXPENSE**

This table provides the copayment tiers for certain non-Department of Veterans Affairs (VA) medical care and services. All other care and/or services must be assigned, as appropriate, copayments that are consistent with Attachment B (e.g., as if the care and services were provided in a VA facility).

NON-VA MEDICAL CARE AND/OR SERVICE	COPAYMENT
BOWEL AND BLADDER CARE – FAMILY MEMBER OR OTHER TRAINED AND PAID BY VA	NON
BOWEL AND BLADDER CARE – PAID BY VA PURCHASED CARE – <u>NOT</u> FAMILY MEMBER OR OTHER TRAINED INDIVIDUAL AND PAID BY VA	B
CHIROPRACTIC CARE	B
COMMUNITY NURSING HOME	Long-term Care (LTC) RATE
PURCHASED SKILLED HOME CARE (COUNTY HEALTH NURSE)	B
COMMUNITY HEALTH NURSE – FEE PAID FOR NON VA CARE	B
CONTRACT DIALYSIS	B
PURCHASED SKILLED HOME CARE (HBHC)	B
HOSPICE AND PALLIATIVE CARE	NON
HOME MAKER/HOME HEALTH – IF MEDICAL SERVICES PROVIDED	B
HOME MAKER/HOME HEALTH – BASIC CARE, COOKING, CLEANING, NO MEDICAL SERVICES PROVIDED – NON MEDICAL SERVICES	N
Obstetrics (OB)/ Gynecology (GYN) OB/GYN OUTPATIENT CARE	B
PRESCRIPTION MEDICATIONS – IF VA REIMBURSED PATIENT OR VA PAID FOR PRESCRIPTION	MEDICATION COPAYMENT RATE FOR EACH 30 DAY OR LESS SUPPLY (as appropriate)
PUBLIC HEALTH NURSE – VA PURCHASED CARE	B

NOTE: No copayment will be charged for emergency treatment paid for under Title 38 United States Code (U.S.C.) 1725 or 38 U.S.C. 1728. This attachment must be used in conjunction with Attachment B to determine appropriate fee basis copayment.