

VETERANS ADMINISTRATION

DEPARTMENT OF MEDICINE AND SURGERY MANUAL

OPERATIONS

PART ONE

**MEDICAL
ADMINISTRATION
ACTIVITIES**

WASHINGTON, D.C. 20420 MAY 27, 1968

M-1, Part I
Change 107

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

May 27, 1968

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

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Chief Medical Director

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FOREWORD

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

This manual consists of seven parts as follows:

Part I ---	Medical Administration Activities
Part II ---	Prosthetic and Sensory Aids
Part III ---	Domiciliary Administration
Part IV ---	Veterans Canteen Service
Part V ---	Performance Standards
Part VI ---	Restoration Programs
Part VII---	Building Management Service

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

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

May 27, 1968

PART I. MEDICAL ADMINISTRATION ACTIVITIES

CONTENTS

CHAPTER	SUBJECT
1	MANAGEMENT AND OPERATIONAL ACTIVITIES
2	QUARTERS AND SUBSISTENCE
3	STATE VETERANS' HOMES
4	ADMISSIONS--HOSPITAL AND DOMICILIARY CARE
5	MEDICAL RECORDS
6	REPORTING CHANGES IN STATUS
7	PATIENT DATA AND QUALITY CONTROL
8	PATIENTS' FUNDS
9	RELEASE OF MEDICAL INFORMATION
10	ABSENCES
11	TRANSFERS
12	NURSING HOME CARE
13	RELEASES FROM INPATIENT CARE
14	SERIOUS ILLNESSES AND DEATHS
15	CHARGES AND PAYMENTS FOR MEDICAL CARE
16	OUTPATIENT CARE--GENERAL
17	OUTPATIENT CARE--STAFF
18	OUTPATIENT CARE--FEE
19	OUTPATIENT DENTAL TREATMENT
20	OUTPATIENT EXAMINATIONS
21	NON-VA HOSPITALIZATION IN THE UNITED STATES
22	UNAUTHORIZED MEDICAL SERVICES
23	HOSPITAL AND MEDICAL SERVICES--OUTSIDE THE UNITED STATES
24	ALLIED BENEFICIARIES
25	BENEFICIARY TRAVEL
26	HOSPITAL ACCREDITATION
27	APPEALS
28	ACTIVATION OF NEW HOSPITALS

APPENDIXES

APPENDIX

A	GUIDE FOR DEVELOPING FEE SCHEDULES FOR MEDICAL AND ANCILLARY SERVICES
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M-1, Part I
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May 27, 1968

CHAPTER 1. MANAGEMENT AND OPERATIONAL ACTIVITIES

CONTENTS

PARAGRAPH	PAGE
1.01 - 1.10	SECTION I. SHARING SPECIALIZED MEDICAL RESOURCES, FACILITIES, EQUIPMENT AND PERSONNEL
1.01	General 1-1
1.02	Purpose 1-1
1.03	Definitions 1-1
1.04	Authority and Responsibility 1-2
1.05	Changers 1-2
1.06	Funding 1-2
1.07	Procedures 1-2
1.08-1.10	(Reserved.)
1.11-1.15	SECTION II. CONTRACTING FOR SCARCE MEDICAL SPECIALIST SERVICES
1.11	General 1-3
1.12	Policy 1-3
1.13-1.15	(Reserved.)
1.16-1.23	SECTION III. VA BED CONTROL
1.16	Definitions 1-3
1.17	Bed Capacities 1-4
1.18	Responsibility of the Director, Facility Planning Service 1-4
1.19	Changes in Bed Capacities and/or Bed Distribution 1-4
1.20	Statistical Reporting 1-5
1.21-1.23	(Reserved.)
1.24-1.33	SECTION IV. PATIENT CONDUCT
1.24	Authority 1-7
1.25	Responsibility 1-7
1.26	Types of Offenses and Application of Penalties 1-7
1.27	Procedures 1-8
1.28	Readmission of Patients Following Irregular Discharge 1-8
1.29	Applicability to Non-VA Facilities 1-8
1.30-1.33	(Reserved.)

May 27, 1968

1.34-1.38	SECTION V. LODGING OF PATIENTS	
1.34	General	1-8
1.35	Policy	1-8
1.36	Administrative Procedures and Controls	1-9
1.37-1.38	(Reserved.)	

May 27, 1968

CONTENTS--Continued

PARAGRAPH		PAGE
1.39-1.74	SECTION VI. MISCELLANEOUS OPERATING POLICIES	
1.39	Definition	1-15
1.40	Employee Attitudes	1-15
1.41	Funds for Patient Welfare	1-15
1.42	Alcoholic Beverages	1-16
1.43	National Hospital Week	1-16
1.44	Banking Facilities for Patients	1-16
1.45	Testamentary Capacity of Patients	1-17
1.46	Deportation of Patients	1-18
1.47	Telephone Recording Services	1-18
1.48	Remittances Enclosed in Official Mail	1-18
1.49	Organizational and Functional Charts	1-18
1.50	Membership in Hospital Assoc	

CHAPTER 1. MANAGEMENT AND OPERATIONAL ACTIVITIES

SECTION I. SHARING SPECIALIZED MEDICAL RESOURCES, FACILITIES, EQUIPMENT AND PERSONNEL

1.01 GENERAL

a. Under the provisions of 38 U.S.C. 5053 and VA Regulation 6210 the VA may join with non-VA hospitals, clinics and medical schools in a cooperative effort to share the use of specialized medical resources. This will be accomplished by establishing mutual use and exchange of use agreements when such agreement(s) will obviate the need for a similar resource to be provided in a VA health care facility. Primary emphasis in this program area will be directed to outpatient diagnostic services and care. Inpatient care, however, is not excluded.

b. Directors are expected to be alert to developments in the medical care field and in their respective medical communities, and to use initiative and resourcefulness in negotiating agreements when the sharing concepts can be employed effectively in the management of the VA medical care program.

c. The provisions of this section do not affect the authority to procure medical services on a contract or fee basis as provided in chapter 18, or the authority to transfer VA patients to non-VA hospitals for care in emergencies as provided in chapters 11 and 21.

1.02 PURPOSE

a. The broad purpose of the program for sharing specialized medical resources is to expand the availability of unusual, costly or scarce medical resources in the medical community, including communities away from major medical centers. Cooperative efforts on the part of VA facilities and non-VA facilities are contemplated. Under this concept, any of the following methods may be used--(1) patients of a community hospital facility would use VA resources which otherwise would not be used to a maximum effective capacity (a mutual use agreement) or (2) VA patients would use a resource of a community hospital facility at agreed [upon] rates (a mutual use agreement) or (3) VA patients would use a resource of a community hospital facility and, in exchange, patients of the community facility would use a VA resource (an exchange of use agreement).

b. An exchange of use agreement will be considered when, for example, a VA facility needs two pieces of unusual equipment, neither one of which can be justified on the basis of full-time use by veterans. A facility in the community may also require the same equipment, but is unable to justify use on the basis of the needs of its patients. The VA facility and the community facility could then negotiate an exchange of use agreement to provide that the VA facility would install one of the items of equipment and make its use available to the community facility when not required by the VA for care of veterans. In turn, the community facility would agree to install the other item of equipment and make its use available to the VA.

c. The sharing concept should also be applied to hospitals in a regionalized setting. An exchange of use or mutual use agreement may be instituted under a tri-party arrangement whereby VA facility "A" participating in a regionalization program may share certain specialized medical resources, which it has, in exchange with a community hospital or medical school furnishing VA facility "B" with certain specialized medical resources. Under this concept the VA [facility affiliated with a] medical school [] having a broader base of specialized medical resources may be in a better bargaining position to enter into sharing agreements and thus provide less endowed VA facilities the specialized medical resources of community and medical school facilities.

1.03 DEFINITIONS

a. The term "resources" as used herein means specialized medical resources (equipment, space or personnel) which, because of cost, limited availability, or unusual nature, are either unique in the medical community or are subject to maximum utilization only through mutual use or exchange of use.

b. The term "community facility" means a medical school, clinic or other medical installation having hospital facilities; [organ banks, blood banks, and similar institutions, and] Federal, State, local or other public and private hospital.

c. "Mutual use" refers to a circumstance whereby the VA provides non-VA facilities the use of resources which are not being used to maximum effective capacity for care of VA patients, or a circumstance whereby the VA purchases resources which are needed for VA patients.

d. "Exchange of use" means sharing of resources, on the part of both parties, when: (1) the VA Director determines it desirable to utilize resources of a non-VA facility to obviate the need for providing a similar resource in the VA facility, [and] (2) the VA Director determines that a particular VA resource is not utilized to full capacity in the care and treatment of veterans, the use of which can be exchanged for use of a needed resource a non-VA facility has to offer.

1.04 AUTHORITY AND RESPONSIBILITY

a. The VA Director is responsible for determining whether there is a need to strengthen and improve operations through participating in a sharing agreement. In making this determination the Director will assure himself or herself that:

- (1) No veteran will be denied care because of use of resources for non-veteran-patients, and
- (2) The rights and privileges of career employees will be fully protected.

b. When a determination is made that an agreement of this nature will be beneficial to both the VA and the non-VA facility, the Director will designate a qualified medical representative to assist the facility contracting officer in developing the agreement.

c. All proposed, new or revised agreements will be forwarded to: [REGIONAL DIRECTOR 10BA_/13C] for approval of the Chief Medical Director. Proposed agreements will be returned to the facility to be consummated. Agreements which are disapproved will be returned with appropriate comment(s) and recommendation(s).

1.05 CHARGES

Charges for VA resources will be made according to instructions in chapter 15 and appendix 15E.

1.06 FUNDING

a. The cost of any resources obtained by the VA will be paid from medical care funds available at the facility.

b. Reimbursement for use of VA resources provided non-VA facilities will be deposited to the medical care appropriation. Appropriation reimbursements resulting from exchange of use and mutual use agreements will be funded back to the individual VA facility concerned.

1.07 PROCEDURES

a. The procedures in chapter 11 will apply in transferring VA patients to non-VA facilities for inpatient care except that VA Form 10-7078 will cite VA Regulation 6050.5 as the authority. Veterans normally will not be admitted directly to the non-VA facility as inpatients under such an agreement, but rather by transfer from a VA facility.

b. Procedures for the referral of outpatients (veterans) are in chapter 18. VA Form 10-7079 will be used and will cite VA Regulation 6060.3(A) as authority.

c. The authority for admission of patients transferred from non-VA facilities is VA Regulation 6046(D). The authority for treating outpatients referred from non-VA facilities is VA Regulation 6060.3(B).

d. The provisions cited in chapter 11, restricting the transfer to a non-VA hospital to only those patients who develop a bona fide medical emergency which precludes moving the patient to another VA facility, do not apply when such a transfer to a non-VA hospital is for the purpose of sharing specialized medical resources under a sharing agreement.

1.08-1.10 (Reserved.)

SECTION II. CONTRACTING FOR SCARCE MEDICAL
SPECIALIST SERVICES

1.11 GENERAL

Section 4117, title 38, United States Code, and VA Regulation 6098 authorize the VA to enter into contracts with schools and colleges of medicine, osteopathy, dentistry, podiatry, optometry, nursing, clinics and any other group or individual capable of furnishing such services to provide scarce medical specialist services at VA facilities. These services, when determined necessary, will be acquired in accordance with the provisions of VAPR 8-3.204.

1.12 POLICY

a. A determination by the VA Director that scarce medical specialist services should be acquired by contract will be made only when ALL of the following conditions are met:

- (1) The need for such services is clearly demonstrated,
- (2) Conventional employment practices have been unsuccessful,
- (3) This method is the most practical to obtain the required services,
- (4) Sufficient funds are available within the facility's primary fund allocation, and
- (5) The rights and privileges of career employees are fully protected.

b. Conventional employment methods will be used to provide human resources essential for the care of patients, i.e., appointments as full-time, part-time, attending or consultant staff. Within this framework, lines of responsibility for patient care are clearly established, rates of pay are fixed on an equitable basis, and continuity of services is assured. Use of contract arrangements to circumvent Federal rules and regulations on employment practices and compensation is prohibited.

c. Health care facility Directors will forward new and renewal contract proposals with supporting data to: ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR (10B) for approval of the Chief Medical Director. Health care facility Directors will be notified of the decision reached in each case.

1.13-1.15 (Reserved.)

SECTION III. VA BED CONTROL

1.16 DEFINITIONS

- a. Authorized Beds. The number of beds established by the President or the Administrator for a facility based on its present or planned structural capacity.
- b. Operating Beds. The number of beds approved by the Chief Medical Director which are necessary to support the planned level of activity.
- c. Overcapacity Beds. The number of operating beds in excess of the authorized bed capacity of a bed program required to meet a temporary situation not exceeding 30 days in duration.
- d. Bed Program. The bed capacity designated for the care of persons requiring a service of a particular type. VA bed capacity is currently classified into the following bed programs:
 - (1) Hospitals.
 - (2) Domiciliaries.
 - (3) Nursing Home Care Units.
- e. Bed Section. A subdivision of a bed program. For planning and control purposes, all VA facility bed capacities are currently classified into bed sections as defined in VA Manual MP-6, part VI, supplement No. 1.2, chapter 21.

1.17 BED CAPACITIES

All beds regularly maintained for assignment to inpatients will be included in bed capacities, except beds which exist for temporary occupancy of patients concurrently assigned to other beds in the facility. Isolation, seclusion, intensive care, and dialysis units, are examples of types of beds included. Beds in admitting areas, recovery rooms, EKG, EEG and pulmonary function laboratories, are examples of beds excluded.

1.18 RESPONSIBILITY OF THE DIRECTOR, FACILITY PLANNING SERVICE

The Director, Facility Planning Service, Central Office, is responsible for administration of the DM&S Bed Control program and will:

- a. Prepare for the signature of the Associate Deputy Chief Medical Director, or designee, all directives to field facilities establishing or changing:
 - (1) Authorized bed capacity.

- (2) Operating bed capacity. (See par. 1.19 for delegation of authority to Medical District Directors and facility Directors.)
 - b. Maintain the DM&S master record of the VA bed programs and bed sections and coordinate changes.
 - c. Initiate requests for approval by the Administrator (or designee) of changes in authorized bed capacities when indicated, except those involving new construction projects. The Facilities Service or Facility Management Office will coordinate all changes in authorized bed capacities involving all new projects with the Director, Facility Planning Service.
 - d. Answer inquiries from field facilities and Central Office officials concerning the bed control program.

1.19 CHANGES IN BED CAPACITIES AND/OR BED DISTRIBUTION

- a. Authority
 - (1) Directors are authorized to utilize overcapacity beds or make redistribution among bed sections, to meet an emergency or other temporary situation not to exceed 30 days.
 - (2) Medical District Directors are authorized to approve redistribution of operating beds within the approved operating bed capacity of the facility and in accordance with the established mission of the facility. No redistribution of beds will be made which in effect would change the mission; such changes require the approval of the Associate Deputy Chief Medical Director.
 - (3) Medical District Directors are authorized to approve temporary changes in the total number of facility operating beds within the authorized bed capacity for a period of 6 months unless a specifically approved Central Office construction or nonrecurring maintenance project extends beyond this 6-month period.
 - (4) Changes in operating beds that eliminate a bed section require approval of the appropriate Regional Director.
 - (5) Medical District Directors will provide signed copies of all memorandums authorizing changes in accordance with subparagraphs (1) through (3) above to the appropriate Regional Director and to the Director, Facility Planning Service. Memorandums will provide effective dates of all changes and will be in accordance with established AMIS reporting format. Information copies will be provided by the Medical District Director to Associate Deputy Chief Medical Director (136D).
 - (6) Changes in authorized bed capacities require prior approval of the Administrator or designee.
- b. Request for Approval and Reporting Other Changes

(1) Proposed adjustments involving changes including construction, M&R, and facility funded projects or any modifications, other than those defined in subparagraph a(1) through (3) above, will be fully justified and submitted by the facility Director through the Medical District Director and the appropriate Regional Director to the Director, Facility Planning Service, with a copy of the current bed status report (G&L) showing recommended changes. This specific request for bed adjustment will be made in addition to any other considerations (i.e., construction proposals, budget submissions, etc.) which may have been involved in the proposed adjustment.

(2) Directors will be advised of the approval or disapproval of the proposed adjustment. If the proposal is approved, instructions will be provided Directors for reporting the specific dates of all bed adjustments.

(3) Directors will assure themselves that there is accurate and timely reporting of approved adjustments by bed sections in order to maintain accurate bed inventory at all times. Annually the Director will conduct a physical inventory to insure that the operating and authorized beds by ward unit are accurately recorded and reported.

1.20 STATISTICAL REPORTING

a. Directors will forward one copy of the bed status report (G&L) for the last day of each month to the Director, Facility Planning Service, and one copy to the Regional Director of your region, RCS 10-280. The bed status report (G&L) will be in accordance with exhibit A which contains the minimum information required. Additional information may be added at the discretion of the Director. Any redistribution of authorized beds between ward units within the total approved by the Administrator must be explained as follows: The bed status report (G&L) for the last day of each month must include as a footnote, or accompanying letter, any difference from that reported on the last day of the previous month; and explanation of this change; and the assurance that this change is consistent with appropriate standards.

b. Instructions for reporting bed capacities for each bed section are contained in VA Manual MP-6, part VI, supplement No. 1.2, chapter 21 (AMIS), RCS 10-167.

1.21-1.23 (Reserved.)

BED STATUS REPORT
EXHIBIT A
HOSPITAL

Ward	Bed Section	Patients Previ- ously Reported	Pa- Gains Remain- ing	Beds* Losses ating Beds	Autho- Oper- vice Beds	out of Ser- cant Beds	Va- rized ***			
MEDICAL										
2B	Cardiology		27	4	3	28	30	0	2	30
2C	General		40	7	10	37	40	0	3	40
2D	Dermatology		20	3	2	21	25	5	4	30
TOTAL			87	14	15	86	95	5	9	100
SURGERY										
4A	ENT		31	6	5	32	35	0	3	35
4B	Gen. Surg.		36	4	6	34	40	0	6	40
4C	Plastic		26	3	1	28	30	0	2	30
4D	G.U.		35	5	7	33	38	2	5	40
5	SICU		11	5	4	12	15	0	3	15
TOTAL			139	23	23	139	158	2	19	160
PSYCHIATRY										
6B	Acute		37	2	4	35	40	0	5	40
6C	Minimal		34	4	4	34	35	0	1	35
TOTAL			71	6	8	69	75	0	6	75
			297	43	46	294	328	7	34	335

NHCU**

DOMICILIARY**

- * Explain reasons beds out of service and approximate target date beds will be returned to service.
- ** Column headings are the same as Hospital, except domiciliaries will show section in lieu of ward and member in lieu of patients.
- *** On the last day of the month explain any difference from the distribution of authorized beds as shown on the last day of the previous month.

PREPARED BY: Medical Administration Service

SECTION IV. PATIENT CONDUCT

1.24 AUTHORITY

The authority to prescribe rules and regulations to promote good conduct on the part of patients is in VA Regulation 6066. Other references on this subject may be found in chapter 13, and in M-2, part XIX. As used in this section, the word "patient" includes patients in VA medical centers, medical and regional office centers, nursing homes care units, restoration centers and patient-members in domiciliaries.

1.25 RESPONSIBILITY

Directors of field facilities are responsible for establishing local policies and procedures necessary to assure full attainment of benefits from the treatment being offered. To aid in accomplishing this objective, Directors will establish a set of requirements to inform participants of the standard of behavior expected of them. Rules and regulations contained in VA Regulation 218 will be posted in a conspicuous place.

1.26 TYPES OF OFFENSES AND APPLICATION OF PENALTIES

Infractions of standards of conduct by patients will be classified as described herein. In determining penalties to be imposed, consideration will be given to the patients' physical and mental condition. Patients whose health would be endangered will not be discharged.

a. Failure to Cooperate with Medical Staff. Irregular discharges will be given patients who:

(1) Refuse, neglect, or obstruct observation and examination.

(2) Refuse, neglect, or obstruct reasonable treatment. Refusal of offered treatment will be measured by the decision that would have been made under the circumstances by a reasonable person. If a person of ordinary judgment and prudence would have accepted the offered treatment, the treatment is considered reasonable and the refusal thereof by a patient may be considered unreasonable. NOTE: Irrespective of above, patients will not be given irregular discharges if they are unable to comprehend or make an adequate judgment about their best interests and where the guardian or nearest relative refuses permission for sound treatment or action.

b. Unauthorized Absence. A patient who fails to return from authorized absence on the scheduled date or who leaves the facility without approval of the physician, the Chief, Domiciliary Operations, or their designees, will be given an irregular discharge as of midnight on the scheduled date of return or date the patient absented himself/herself. This is not applicable to incompetent patients or to competent patients whom the attending physician believes are unable to comprehend or make adequate judgments about their best interests; or who are committed.

c. Disorderly Conduct. A patient who is not amenable to the rules governing conduct is subject to disciplinary action, including irregular discharge from the facility. When a discharge is not appropriate because of the patient's condition, lesser penalties such as denial of privileges may be imposed. When continued hospitalization, domiciliation or nursing care is required, an irregular discharge may be given after arrangements have been made for continued care at other than VA expense. Disorderly conduct includes such actions as:

- (1) Introduction, possession, or consumption of intoxicating beverages or narcotics at a VA facility, except as prescribed by VA physicians.
- (2) Introduction or possession of firearms or other weapons.
- (3) Theft, damage, destruction, loss, or misuse of VA property or property of other patients, employees, or other persons.
- (4) Interference with the treatment or comfort of other patients.

1.27 PROCEDURES

a. All employees share responsibility for assuring acceptable behavior of patients. Directors may delegate authority to staff physicians and Chiefs, Domiciliary Operations, to impose minor penalties, such as refusal of authorized absences, revocation or restriction of privileges, and denial of attendance at entertainments, for infractions not serious in nature. Reports of incidents, including the corrective action taken, will be recorded on SF 509, Doctor's Progress Notes, for patients in VA medical centers, medical and regional office centers and nursing homes care units. Reports of incidents, including the corrective action taken, will be recorded on VA Form 10-5506, Record of Patient-Member Conduct, for patient-members in domiciliaries. VA Form 10-5506 will be filed in the patient-member's folder.

b. Serious charges (e.g., endangering life or health of others, narcotics and alcohol violations, possession of dangerous weapons, theft, etc.) will be reported and processed in accordance with DM&S Supplement, MP-1, part I, chapter 2. When circumstances warrant, the Director will be notified immediately by telephone. Patients will be informed in writing of the disposition made of the charges.

1.28 READMISSION OF PATIENTS FOLLOWING IRREGULAR DISCHARGE

A patient who has received an irregular discharge as provided in this section will be authorized admission when he or she has satisfied the admitting authority that he or she will conform to expected standards of behavior. Care will be exercised to prevent an incriminatory attitude merely to keep an applicant with a disciplinary record from being admitted. Under no circumstances will an emergency applicant be denied admission based solely on a prior irregular discharge or unacceptable behavior.

1.29 APPLICABILITY TO NON-VA FACILITIES

The provisions of this section are applicable to patients receiving hospitalization or nursing home care in other Government or private facilities as beneficiaries of the VA.

1.30-1.33 (Reserved.)

SECTION V. LODGING OF PATIENTS

1.34 GENERAL

a. VA facilities may furnish lodging to outpatients held over in connection with examination, treatment, or participation in an approved VA research project.

b. Applicants for hospitalization or domiciliary care may be furnished lodging only on an exception basis, as provided in paragraph 1.35c.

c. Outpatients may be lodged at the facility, if accommodations are available; or authorized accommodations at commercial establishments when adequate accommodations are unavailable at the VA facility.

d. Applicants for hospitalization or domiciliary care may be provided overnight lodging only when accommodations at the concerned VA facility are suitable for this purpose.

1.35 POLICY

a. A patient who reports to a VA medical facility for outpatient examination or treatment and is held over for the convenience of the VA may be furnished lodging for either medical or administrative reasons. The term "outpatient," as used in this section, refers to patients and others reporting for the following purposes:

- (1) Compensation, pension or insurance examinations.
- (2) Outpatient treatment-service connected (OPT-SC).
- (3) Outpatient treatment-pre-bed care (OPT-PBC).
- (4) Outpatient treatment-non-service connected (OPT-NSC).
- (5) Outpatient treatment-aid and attendance (OPT-A&A)
- (6) Outpatient treatment-non-bed care (OPT-NBC).

(7) Research. (Includes visits made by veteran-patients, nonveteran-patients who visit under a sharing arrangement, and bona fide volunteers taking part in an approved VA research project.)

(8) Outpatient treatment under the approved terms of a sharing agreement.

(9) Outpatient treatment-ambulatory care (OPT-AC).

b. An applicant for hospital, nursing home or domiciliary care generally will not be furnished lodging. Instead, the applicant will be:

(1) Admitted; or

(2) Scheduled for admission (includes OPT-PBC status); or

(3) Referred for prearranged admission to another VA facility; or

(4) Placed on the waiting list; or

(5) Dismissed, if findings show hospitalization, nursing homes or domiciliary care not medically required.

c. Notwithstanding the provisions of subparagraph b above, if a VA health care facility Director or designee determines that inclement weather, irregular transportation schedules or other compelling reasons prevent an applicant's departure until the following day, or that an applicant's reporting time does not allow for completion of indicated examinations and/or tests until the following day, the Director or designee may authorize lodging of the applicant providing accommodations at the health care facility are utilized.

d. The term "lodging," as it relates to overnight accommodations furnished hospital, nursing home or domiciliary admission applicants at a VA facility, will include the furnishing of a bed and other accessories usually provided by commercial lodging establishments. The furnishing of medical services or medications is not included. If a person who is being lodged develops need for inpatient care that person will be admitted. The usual eligibility criteria are applicable to veterans. A person who requires outpatient care for an urgent condition arising during lodging will be provided care to the extent medically needed. Care provided an ineligible person will be billed for at the prescribed rate.

1.36 ADMINISTRATIVE PROCEDURES AND CONTROLS

a. Identification. Field facilities who maintain lodgers in accordance with this policy will establish local procedures for identifying the lodgers to staff personnel engaged in furnishing the service. In the interest of achieving uniform record-keeping, VA Form 3230-1, Reference Slip (stencil), will be overprinted and used as an identification and ward referral document. A chronological log book also will be maintained to provide a central point for identifying all persons being furnished lodging. The names of the lodgers will be listed in the log book, with the date and hour lodging accommodations started and ended, the reason for lodging, and information as to whether the lodger, on termination of lodging accommodations, left the facility or was admitted.

b. **Bed Usage.** Directors of facilities having more than one bed category of care, hospital, nursing, or domiciliary, are responsible for establishing controls to insure that beds from one category are not used to lodge applicants from another category, pending availability of suitable beds for admission to the proper section.

c. **Management Controls.** Lodging activity at health care facilities will be reviewed semiannually to determine that it is being effectively administered consistent with acceptable management practices and local needs. Review findings will be recorded and corrective action taken when indicated.

d. **Work Count.** Persons provided lodging at VA health care facilities will not be counted as bed occupants or absent bed occupants. Instead, visits made by persons who are lodged at a VA facility, in connection with their visits as outpatients, admission applicants or research participants, will be included in AMIS report data, as applicable, in accordance with the instructions contained in VA Manual MP-6, part VI, supplement No. 1.2, chapter 31. Instructions for preparation of VA Form 10-2875, Outpatient Routing and Statistical Activity Record, are in appendix 17A.

1.37-1.38 (Reserved.)

SECTION VI. MISCELLANEOUS OPERATING POLICIES

1.39 DEFINITION

As used in this section, the word "patient" includes patients in VA medical centers, medical and regional office centers, nursing home care units, and patient-members in domiciliaries.

1.40 EMPLOYEE ATTITUDES

a. It is not enough to simply provide service. It is imperative that it be furnished cheerfully, courteously, and with tact and understanding. Patients, their families and friends, and others must unfailingly be treated with dignity, friendliness and consideration. Administrative convenience or personal opinions about legislation relating to veterans benefits will not be accepted as excuses for behavior which does not meet this standard. Every employee, individually and as a part of the organization, is responsible for conducting himself or herself at all times in a manner which reflects credit on the VA medical program.

b. Directors will emphasize this matter in facility directives. A vigorous ongoing program will be conducted to elevate the quality of personnel attitudes and responses, and to eradicate those which are unacceptable.

1.41 FUNDS FOR PATIENT WELFARE

a. Funds to meet the recreational and religious needs of veteran-patients are provided generally from donations made to the General Post Fund, and as supplemented by advances of such funds to facilities by Central Office. Policy and procedures pertaining to the General Post Fund are stated in MP-4, part V, and DM&S Supplement, MP-4, part VII. General Post Funds are administered by VA management officials at each facility.

b. Funds deposited in Personal Funds of Patients for safekeeping are controlled by VA management officials and are available for use by or for the patient in whose name the account is maintained.

c. Patient groups, committees, councils, etc., may establish a recreational and entertainment fund by contributions or as a result of patient activities with the approval of the facility Director, provided the maintenance and use of such fund has therapeutic value. The amount in the recreational and entertainment fund should not be permitted to become excessive to the objectives to be obtained or prejudice patient care. These funds are not Government funds and will not be deposited with the agent cashier. Management will periodically audit the expenditures from the fund but control and custody will be the responsibility of the patient organization. Such functions will conform to accepted standards of conduct and business. VA employees, in addition to providing guidance for accomplishing therapeutic objectives, may advise on bookkeeping methods, audit and reconciliation procedures, and operating practices and controls. However, VA employees will not handle such funds or engage in financial and related transactions such as bookkeeping, issuing receipts, making deposits, purchasing and selling. Contribution of patients to the recreational and entertainment fund and participation in the activity will be voluntary, and the facility Director will assure there is no coercion of patients, direct or implied.

d. The establishment of any fund, other than described in this paragraph, is not authorized.

1.42 ALCOHOLIC BEVERAGES

Exclusive of liquors which are necessary for medicinal purposes in treating patients, alcoholic beverages are prohibited on VA premises except as stated in VA Regulation 218, as follows:

"Provided such possession is consistent with the laws of the State in which a facility is located, liquor may be used and maintained in quarters assigned to employees as their normal abode, and away from the abode with the written consent of the head of the facility which specifies a special occasion for use and limits the area and period for the authorized use."

1.43 NATIONAL HOSPITAL WEEK

National Hospital Week will be observed annually by all field facilities. Directors will arrange an appropriate program to depict the contribution being made by the VA to meet the hospital needs of the Nation. The program will also afford an excellent opportunity to acquaint citizens in the local community with the advancements made in methods of treatment including use of new or improved equipment and facilities. The cooperation of local newspapers, radio and television stations, and community organizations should be solicited to publicize the occasion. There is no authority, however, to expend appropriated funds for publicity or entertainment in connection with the program.

1.44 BANKING FACILITIES FOR PATIENTS

a. Within the Director's overall responsibility for providing for the general welfare of patients, the need for adequate banking services is of primary importance. It is generally expected that competent patients' requirements for cashing checks, depositing funds, and transmitting funds will be met by the services offered by the Fiscal Service, Veterans Canteen Service, branch or contract post offices where available, or other money order services.

b. Where competent patients' requirements cannot be satisfactorily met in this manner, Directors are authorized to negotiate for a local reputable financial institution to render such services within the facility. The arrangements, however, will specifically prohibit the institution from soliciting deposits or the sale of securities. Patients will be informed that the granting of this permission to the local institution is no guaranty of its integrity or soundness and that any transactions are the patient's responsibility. If the arrangements require that the institution be provided space on either a full-time or part-time basis, the information will be submitted to the Chief Medical Director in accordance with and in the form prescribed by MP-3, part II.

1.45 TESTAMENTARY CAPACITY OF PATIENTS

a. Patients expressing a desire to execute wills, change the beneficiaries of insurance policies, or enter into other legal transactions, such as the sale of property, will be advised to consult legal counsel. A list of attorneys in the local community who are available for consultation may be furnished the interested patients. Directors may also establish a procedure for contacting the attorney selected by the patient and arranging for the attorney to visit the facility.

b. Patients without guardians appointed by courts, who in the opinion of the medical staff are considered incapable of comprehending the significance of their act, will be discouraged from entering into such transactions. Relatives or other persons who contact the facility with respect to obtaining such a patient's signature for transactions of this nature will be advised of the medical staff's opinion and will be discouraged from seeking the patient's cooperation. If they remain insistent on completing the transaction, an appropriate entry will be

made in the medical records listing the names of the relatives or friends who were present and describing the patient's physical and mental condition in sufficient detail to indicate the degree of his or her ability to comprehend the significance of the act. The relatives or other persons will be advised of this action; or the significance of the opinion in the event the patient's signature is contested; and of the fact that the records are subject to being subpoenaed by the court and may be used by the person making the record to refresh his or her recollection, if called as a witness in court.

c. When a seriously ill patient enters into such transactions, an appropriate entry in medical records as described above will be made.

d. Employees will not assist patients in these transactions except as stated herein: An employee may, at the request of a patient and with the Director's permission, assist in the actual writing of a will, as a secretary, at the dictation of the patient, when such patient is physically disabled to such a degree as to be unable to write the will without assistance. In addition, employees may, in an individual capacity, witness wills executed by patients. It is also important that employees who personally choose to witness wills executed by patients be apprised of the significance of their act, and of their personal responsibility to respond if subpoenaed to testify as witnesses in litigations.

e. Veterans Benefits Counselors are excluded from the above restriction with respect to assisting patients in changing beneficiaries of Government life insurance policies, subject to the provisions of subparagraphs b and c above.

1.46 DEPORTATION OF PATIENTS

The proposed deportation of a hospital or nursing home care unit patient or domiciliary member by the Department of Justice will be promptly reported to the Medical District Director. The report will furnish the full name, claim number, home address, and diagnosis of the patient or member as well as the proposed date of discharge to the Department of Justice, if known.

1.47 TELEPHONE RECORDING SERVICES

The installation of approved telephone recording devices is authorized only for the purposes of recording conversations involving commitments made, benefits authorized, or consents for operations and autopsies. When it is determined necessary to record conversation for these purposes, the recording devices utilized will be installed in accordance with the guidelines established by MP-6, part VIII, chapter 2. Such recordings will prevent subsequent misunderstandings or controversies by providing a record of the conversations. An exception to the foregoing provision is that SSI (Hot Line) telephone conversations may be recorded when desired since that system is used only for intra-VA communications.

1.48 REMITTANCES ENCLOSED IN OFFICIAL MAIL

a. Remittances received in official mail will be safeguarded and controlled. These procedures are not applicable to remittances received in employee, patient, and member mail.

b. The receipt of cash will be verified with the amount stated in the letter of transmittal. The actual amount received will be entered on the correspondence or envelope and initialed by the employee opening the mail. Any discrepancies will be noted on the correspondence or envelope. The employee will also enter on VA Form 07-4522, Registry Log, the name of the sender, amount received, and any identifying number, if shown. The correspondence and cash will be delivered to the agent cashier who will receipt for the cash by signing the registry log.

c. The mail room clerk will make negotiable instruments such as checks, drafts, etc., with the exception of U.S. Treasury checks, nonnegotiable by placing a stamped endorsement on the reverse. This endorsement will be in the format as described in MP-4, part I. The instruments made nonnegotiable with any other nonnegotiable instruments will be routed in the envelope in which received to the agent cashier.

d. More rigid controls may be installed at facilities where the volume of cash and negotiable instruments received warrant such action.

1.49 ORGANIZATIONAL AND FUNCTIONAL CHARTS

All VA medical facilities will maintain current charts depicting the organizational and functional alignment of activities through the unit level. These charts will be readily available to help each employee, regardless of level, understand his or her position in the organization and the relationship of his or her work to the organization as a whole.

1.50 MEMBERSHIP IN HOSPITAL ASSOCIATIONS, COUNCILS AND OTHER HEALTH CARE ORIENTED ORGANIZATIONS

a. Facilities are authorized, in their institutional names only, to join and pay membership fees in hospital associations, councils and such other organizations as the Director determines have resources which can be used to the substantial benefit of his or her facility as an entity, as distinct from benefiting solely individual members of the staff.

b. Directors will encourage participation in such organizations and will provide for the payment of membership dues from the field facility budget. Central Office will continue to pay the costs of all VA facility inspection/membership fees in the Joint Commission on Accreditation of Hospitals; the American Psychiatric Association; the American Hospital Association and the College of American Pathologists Laboratory Inspection and Accreditation program.

c. If an organization, of which a health care facility is a member, proposes to levy an assessment other than dues for membership, the Director will make no payment without the prior approval of the appropriate Medical District Director. This limitation applies whether or not the health care facility pays membership dues in the organization proposing to levy the special assessment.

d. Staff members will also be encouraged to participate in allied health, professional, and administrative organizations on an individual basis when such organizations do not meet the provisions of subparagraph a above. Employees may be excused without charge to leave to attend meetings of such organizations as provided in MP-5, part I, chapter 630, paragraph 251.

1.51 SPACE FOR REPRESENTATIVES OF NATIONAL SERVICE ORGANIZATIONS

a. The VA is authorized by 38 U.S.C. 3402(a)(2) to furnish office space and suitable office facilities to paid full-time representatives of those organizations specified in 38 U.S.C. 3402(a)(1), and of other national service organizations recognized by the Administrator pursuant to the provisions of that statute. A paid full-time representative of a national service organization is one issued accreditation by the General Counsel, who devotes full-time, as distinguished from voluntary occasional time, to the service of claimants, and whose salary is paid by a recognized organization. The language of the law limits the furnishing of space and office facilities to accredited representatives of recognized national organizations. It does not authorize the furnishing of space and facilities to representatives of State, county or local organizations as such. There is no other statutory authority to furnish space and office facilities.

b. Space for accredited representatives of organizations will be provided in all health care facilities under the jurisdiction of the Department of Medicine and Surgery, if available, as may be reasonably necessary for accredited representatives or their employees engaged in preparation of claims for hospitalized or domiciled veterans. The amount of space available for reasonable needs of the organization will be in accordance with prevailing VA standards regarding space utilization.

c. No space assignment will be made under this authorization to any accredited representative whose services in connection with the preparation, presentation, and prosecution of claims under laws administered by the VA are not available to all persons seeking such services without discrimination as to age, sex, religion, race, color or national origin.

d. To further implement the provisions of the Civil Rights Act of 1964, as set forth in VA Regulations 7001 through 7013, the Director of each facility will obtain from each national service organization to which office space and facilities are furnished a certification on VA Form 27-8206, Statement of Assurance of Compliance (Under Title VI, Civil Rights Act of 1964), that their program is conducted in compliance with

all requirements imposed by or pursuant to this act and the VA regulations promulgated thereunder. These forms will be prepared in duplicate and the original will be forwarded to Central Office at the time the office space or facility is initially furnished. Facility name and number will be entered in item 1 on each form immediately following name of organization. Mail completed forms to ADCMD (10B).

e. Individual facility certificates are required of all national service organizations except the Veterans of Foreign Wars, the Marine Corps League and the Catholic War Veterans. These organizations will certify at the national level for each and every location where space and facilities are being provided to their organization by the VA.

f. Nonexpendable property and nonconsumable expendable property may be provided for these offices in accordance with MP-2, subchapter E, section 108-27.5201(c).

g. Telephone service for accredited service organizations may be provided as outlined in MP-6, part VIII.

1.52 VISITING PROCEDURES

a. Directors are responsible for prescribing visiting hours. Visits to individual patients may be limited or prohibited for therapeutic reasons. As a general policy, children under 15 years of age are normally not permitted to visit patients on the wards unless such visits are considered therapeutically desirable. Patients whose conditions permit them to leave the ward areas may visit with friends and relatives, including children, in other suitable areas.

b. Directors are responsible for establishing the necessary administrative procedures to accomplish the above. However, the procedures will not include the issuance of individual written permissions which are deemed unnecessary. When documentation of visits is needed as a part of patient care, necessary entries will be made in the patients' medical records.

1.53 EDUCATIONAL PROGRAM ON THE HAZARDS OF SMOKING

An educational program will be conducted at each facility that will bring to the attention of patients and employees the hazards of smoking as outlined in the report of the advisory committee of the Public Health Service. The program will insure that VA patients and employees receive a continuing exposure to information on the hazards of smoking.

1.54 DONATIONS--TOBACCO PRODUCTS AND CANTEEN COUPON BOOKS

a. Free cigarettes and other tobacco products will not be accepted for distribution to VA patients nor will the use of these items be approved as prizes in any games or contests. Monetary donations which specify the purchase of cigarettes or other tobacco products will not be

accepted. Donors will be requested to authorize such donations for some other purpose.

b. The Director will be responsible for establishing and maintaining adequate controls over the storage, distribution, and accountability of canteen gift coupon books.

1.55 PATIENT'S MAIL

a. Directors of medical facilities and domiciliaries are responsible for providing written instructions for processing of mail and packages for patients who are physically or mentally unable to comprehend or handle such mail or packages. The identification of such patients, including the degree of restriction on receipt and/or disposition of mail and packages will normally be made by the patient's attending physician.

b. The following subjects will be included in any instructions issued by the facility Director.

(1) Cash and negotiable instruments received will be disposed of as provided in chapter 8.

(2) Clothing and valuables received will be processed in accordance with M-1, part VII, chapter 9.

(3) Contraband items received will be delivered to the Chief of Medical Administration, in exchange for a receipt, for determination as to further disposition.

(4) Business letters, addressed to patients unable to comprehend their meaning, which may require action to protect the patient's interest will be forwarded to the patient's guardian or fiduciary, if any. If there is no guardian or fiduciary, the Chief of Medical Administration will forward them to the patient's nearest relative, or solicit the advice of the District Counsel, when necessary.

1.56 DEFINITION OF TERM "PHYSICIAN"

Wherever used in this manual, the term "physician" includes physician's assistant to the extent specifically authorized by the health care facility Medical Executive Committee and consistent with basic policy and general guidelines established by the Chief Medical Director.

1.57 ADMINISTRATIVE OFFICER OF THE DAY

a. Directors of medical facilities and domiciliaries are authorized to use any appropriate member of the non-medical staff as Administrative Officer of the Day during other than regular duty hours. The Administrative Officer of the Day will be responsible for such administrative management and nonmedical supervision as necessary to relieve the Medical Officer of the Day of all responsibility not requiring medical decisions or the exercise of professional judgment. Specific

delegations of authority to the Administrative Officer of the Day will be determined locally.

b. It is expected that these responsibilities will be assigned to an employee who would normally already be on duty (e.g., Medical Administration Assistant). The responsibility will not be assigned routinely to regular day staff on a compensatory, standby or on call basis.

1.58 VOTING

a. Consistent with long established VA policy, patients will be given every assistance and opportunity to exercise their voting privilege. Subject to professional opinions, patients will be granted authorized absence for such periods of time as are necessary to register or to vote. If they are unable to leave the facility, assistance will be provided for registering and for voting by absentee ballot.

b. The Department of Defense periodically publishes a pamphlet, DoD Gen-6, entitled "Voting Information." This pamphlet provides, by State, information necessary for registration, voting and absentee ballots. Limited copies of this publication may be requested from the VA Forms and Publications Depot, if not on file at the facility.

1.59 ANNUAL PENSION AND INCOME QUESTIONNAIRE

An annual income questionnaire will be completed by or on behalf of every veteran in receipt of a disability pension awarded in accordance with 38 U.S.C. 15, subchapter II. Income questionnaires for incompetent veterans without fiduciaries receiving VA hospital, nursing home treatment or domiciliary care, including patients on NBC status, for whom institutional awards are in effect, will be mailed directly to the VA Director. Directors will arrange to have the questionnaires completed in accordance with instructions accompanying the questionnaire and other instructions that may be provided by the Department of Veterans Benefits and Assistant Administrator for Data Management and Telecommunications. Every effort will be made to accurately report all income from records available in Veterans Assistance Office, Medical Administration, Social Work Service and other sources at the facility.

1.60 USE OF GUIDE DOGS AT VA HEALTH CARE FACILITIES

a. Blind persons may be permitted to use guide dogs while visiting VA facilities, subject to restrictions for professional reasons and local circumstances.

b. Guide dogs will not normally be maintained at the VA facility for hospitalized or domiciled blind beneficiaries. Guide dogs should, however, be allowed to periodically visit the patient, when feasible.

c. Implementing local instructions will be published at each facility.

1.61 DISREGARD OF "NUISANCE" LETTERS

a. When a person has been repeatedly and adequately furnished information he or she requested, and he or she continues to make the same inquiry, the Director may authorize discontinuance of further responses.

b. Requests for permission to disregard such correspondence will be initiated by the appropriate service chief and forwarded to the Director for approval or disapproval. Approved requests will be filed in the patient's administrative records folder, if the matter concerns a patient. If the matter does not concern a patient, the approval will be filed in the office of the service chief.

1.62 AUTHORITY OF VA OFFICERS AND EMPLOYEES TO DETER INTERROGATION OR ARREST OF PATIENTS AT VA FACILITIES

a. VA officers and employees have no legal authority to deter law enforcement authorities, Federal or State, from questioning or arresting a patient at a VA facility. That position is proper and will be maintained. A basis question of jurisdiction to enforce criminal laws or serve process may be involved in these situations, but this is a question which can and will be resolved by contact with the local VA District Counsel.

b. The issuance of rules and regulations regarding confidentiality of alcohol and drug abuse patient records does not alter our position regarding cooperation with law enforcement authorities. VA personnel will not, however, discuss or divulge information regarding drug or alcohol treatment, except where a court of competent jurisdiction (Federal Court) has so ordered the information to be produced. Whether an individual is a patient in drug treatment or otherwise, if law enforcement officials with authority over criminal matters wish to question or arrest a patient, VA employees have no legal authority to interfere. The VA has a duty and an obligation to care for the interests of the patient and therefore will, if the medical evidence warrants, communicate to the authorities the general condition of the patient (without specific diagnosis) and whether or not it would be medically advisable to move or question him or her.

c. The following guidelines are set forth as policy and procedure:

(1) Step 1. As a general rule, State and Federal officers have authority to enter VA property and buildings and serve criminal process (arrest) or ask questions of VA patients. The VA District Counsel will advise on this matter, since there may be a question of whether a State retained such authority at the time the United States acquired the property.

(2) VA officers and employees will in no way obstruct the officers in the performance of their duties unless the officers have absolutely no right to be there. (See subpar. (1) above.)

(3) Step 3. Alternate ways of handling the situation will be attempted, e.g., arranging for arrest or questioning of patient at another time, if the patient is in need of further treatment.

(4) Step 4. If subparagraph (3) above cannot be agreed on by the authorities, and the patient is on the drug/alcohol ward, we will attempt to reach an agreement with authorities whereby the patient can be delivered to another location at the facility for arrest or questioning. This subparagraph is desirable to maintain the drug/alcohol treatment relationships between doctors and patients. In the attempt to reach a compromise agreement, subparagraph (5) below should be adhered to.

(5) Step 5. At no time will drug/alcohol related information be discussed or provided to anyone unless required by a specific order of a Federal District Court as provided for in the current published rules and regulations.

(6) Step 6. In these situations, the VA District Counsel will be consulted, and all events will be fully documented.

1.63 PROTECTION OF PATIENTS' RIGHTS

All medical and prosthetic research and, to the maximum extent practicable, all patient care will be carried out only with the full and informed consent of the patient subject or, in appropriate cases, a representative thereof.

1.64 REHABILITATIVE SERVICES

a. The term "rehabilitative services" is defined as such professional counseling and guidance services and treatment programs as are necessary to restore, to the maximum extent possible, the physical, mental and psychological functioning of an ill or disabled person. However, the types of vocational rehabilitation services as provided in 38 U.S.C. 31 are not a part of "rehabilitative services" as herein defined.

b. VA facilities may enter into contractual arrangements with industry in providing therapeutic work for pay programs. VA facilities may also enter into contractual relationships with nonprofit entities for providing such therapeutic work and for other services needed in connection with the compensated work therapy programs. All funds received on contracts for work projects performed in VA compensated work therapy programs, whether managed by the VA or a nonprofit entity, will be deposited in or credited to the rehabilitative services revolving fund. A nonprofit entity may retain funds which are proceeds of a contract necessary for actual overhead expenses when approved by the VA, but such funds must be credited to the revolving fund. Wages paid to patients and members participating in compensated work therapy programs must not be less than those prescribed by regulations promulgated pursuant to the Fair Labor Standards Act, as amended by and contained in 29 CFR, part 525, for handicapped workers.

1.65 NATIONAL IMMUNIZATION PROGRAMS

a. VA facilities are authorized to conduct immunization programs for veterans as part of national immunization programs conducted by the Department of [Health and Human Services].

b. VA facilities may administer immunizations to eligible veterans (voluntarily requesting such immunizations) in connection with the provision of care for a disability in any VA facility.

c. Vaccine will be furnished by the Department of [Health and Human Services] at no cost to the VA.

d. The provisions of 38 U.S.C. 4116 will apply to claims alleging negligence or malpractice on the part of VA personnel granted immunity under such section.

1.66 EXPRESS MAIL SERVICE

Express mail is offered through the U.S. Postal Service and is designed to guarantee delivery between designated points within 24 hours. Express mail is available as follows:

a. Programmed service, which may be used when there is a need for a quick, highly reliable delivery on a regularly scheduled basis, such as daily, weekly, or monthly. Programmed service is divided into the following options:

(1) Option I: Door-to-Door. Your mail pouch is picked up at a specified place and time and delivered to the addressee.

(2) Option II: Door to Destination Airport. Your mail pouch is picked up at a specified place and time and delivered to the destination airport, where it can be picked up by the addressee.

(3) Option III: Originating Airport to Addressee. You take your mail pouch to your airport. On arrival at the destination airport it is delivered to the addressee.

(4) Option IV: Airport-to-Airport. You take your mail pouch to your airport; your addressee picks it up at the destination airport.

b. [On-Demand service, which may be used on an as-needed basis for guaranteed 24-hour delivery. To obtain express mail service, contact the local U.S. Postal Service customer service representative for further information. The various types of service, rates and delivery points will be explained. Express mail costs will be borne by the using facility at the time the service is received. The three-digit number assigned by the U.S. Postal Service for centralized billing purposes will not be used. Express mail volumes and costs will not be included on VA Form 60-7492, Semi-annual Report of Mailing Costs, RCS 64-1. (See MP-1, pt. II, ch. 6, app. D, par. 6.)

1.67 POSSIBLE GOVERNMENT ADMINISTRATIVE ERROR AS BASIS FOR
ADMINISTRATOR'S EQUITABLE RELIEF

a. Authority has been vested in the administrator by 38 U.S.C. 210(c)(2) to grant relief when it has been determined that benefits administered by VA were not provided a person by reason of administrative error on the part of the Federal Government or any of its employees. This authority has been implemented by VA Regulation 7 and has not been delegated by the Administrator. Equitable relief may be provided in the amount the Administrator determines, and to any person(s) the Administrator determines is equitably entitled. The term "administrative error" includes determinations by members of the medical staff deemed to have been in error on the basis of the circumstances and evidence present at the time the alleged error occurred, and but for which benefits would have been provided.

(1) "Administrative Error" attributable to members of the medical staff for purposes of equitable relief under VA Regulation 7 is limited to actions or omissions which are essentially administrative in nature rather than those involving professional medical judgment. Administrative error may be medical in nature, e.g., the failure to perform an ordered laboratory test or procedure. If such errors occur, they can appropriately be considered under the provisions of VA Regulation 7. However, the appropriate scope of the administrative relief remedy does not extend to situations which involve an error in professional judgment as to the proper mode of treatment for a patient, e.g., decisions of a treating physician, based upon medical determinations, that a veteran's admission to a VA medical center was not warranted or that a patient was not an appropriate candidate for surgery.

(2) The Chief, Medical Administration Service, will request the District Counsel to review any questionable cases involving the medical staff's actions, to determine whether requests for reimbursement of private medical expenses based upon alleged staff error should be processed as administrative error cases or as tort claims under the provisions of the Federal Tort Claims Act. If the District Counsel determines that relief under the provisions of VA Regulation 7 is inappropriate, the medical center will refer the claimant to the District Counsel for advice and assistance, and advise the claimant that the provisions of VA Regulation 7 are not applicable in his or her case.

b. Each case of possible administrative error submitted to the appropriate VA facility for consideration must, before transmittal to VA Central Office, include the following minimum documentation:

(1) A comprehensive brief of the facts and circumstances signed by or for the aggrieved person, and endorsed or denied by the Chief of Medical Administration Service, in whole or in part;

(2) A complete copy of the VA medical record, if any, pertaining to the specific episode of care involved;

- (3) A complete comprehensive record of the period of non-VA hospitalization or outpatient care pertaining to the claim;
- (4) When it would have been required for this veteran to obtain VA hospitalization, a signed statement of inability to defray the costs of the medical care (e.g., a signed VA Form 10-10 or 10-10r with the appropriate blocks completed);
- (5) A complete billing summarization and submission of:
 - (a) All statements, billings and invoices covering the full period of care on the letterhead of the respective health care providers, certified by an authorized employee that the services listed were in fact rendered;
 - (b) A certification by claimant as to all other possible third party payers, e.g., privately held insurance, Workers' Compensation, CHAMPUS, Medicaid, to include also whether there is such coverage, whether a claim has been made and disposition by third party payer;
 - (c) Total amount of claim, amount paid or which may be paid by third party payers, and balance requested to be paid by the VA;
 - (d) Copies of all correspondence relating to claim, i.e., between VA and veteran, between veteran and non-VA provider, and between veteran and third party payer;
 - (e) Each provider of care will certify that the charges are reasonable, are the usual such charges, and do not exceed those charged comparable non-VA patients (e.g., a signed VA Form 10-583 certification);
- (6) The Chief of Medical Administration Service will either certify that none of the charges claimed by non-VA hospitals and none of the invoices for the physicians and ancillary services providers contain fees that exceed the VA (or other Government) fee schedule for that area, or explain why any do; and
- (7) A copy of the most recent eligibility document showing all service-connected disabilities.

M-1, Part I
Chapter I
Change 16

February 5, 1992

- c. Only claims determined to be nonpayable under chapter 22 will be considered under this paragraph.

1.68-1.74 (Reserved.)

SECTION VII. MANAGEMENT FUNCTIONS

1.75 PURPOSE

a. The complexity and scope of medical and administrative programs associated with the current health care delivery systems demand constant surveillance of these activities to ensure that they remain dynamic and effective in goals and performance. The management functions needed to accomplish the health care facility's goals are the responsibility of the Director. [The Director] will specify the mechanisms, when not described in this section, to fulfill these responsibilities. Such mechanisms may include a committee, subcommittee, board, council, etc. It is the prerogative of the Director to determine whether a single function or combination of functions can be effectively and efficiently performed by the selected mechanism. The review of all functions at prescribed intervals with prompt, complete, and concise reporting will contribute significantly to the day-to-day decisions to be made by the Director.

b. Where the Director elects to utilize a committee to provide advice on medical center management, [the Director will ensure that] a balanced mix of professional and administrative expertise exists in its makeup. This is especially important in considering utilizing a committee whose responsibilities will include making recommendations about resource planning, distribution and control. Members of those committees will have special interests, but they must realize by their appointment that judicious use of their knowledge should point to the most effective utilization of available resources. Knowledgeable advice coming from a balanced professional and administrative committee can result in more equitable and effective decisions. The final decision will rest with the Director, and the decision will be most functional when advice embodies all pertinent aspects of a situation for consideration.

c. The management functions discussed and described in this section are not all inclusive of the Director's responsibilities. They are primarily those considered mandatory by VA and JCAH[O] (Joint Commission on Accreditation of [Healthcare Organizations]) requirements. For certain functions, VA and JCAH[O] may specify the mechanism (committee, board, etc.) by which the function will be accomplished. The list of functions in this section is not all-inclusive and may be amended by VA and JCAH[O] requirements.

d. It is recognized that clinics not in [medical centers] do not have all of the functions shown, and to that extent deviation from this section is authorized. If any policies established by this section are in conflict with other [VHA] publications, this section will apply and its provisions be observed.

1.76 JOINT CONFERENCE COUNCIL

The Director may establish a Joint Conference Council to function as an advisory group. The duties and composition the Council will be prescribed by the Director.

M-1, Part I
Chapter I
Change 16

February 5, 1992

1.77 MANDATORY COMMITTEES/BOARDS

For the performance of a specific function, the type of mechanism, such as a committee or board, may be stated in VA and JCAH[O] requirements. VA manuals and directives may specify committees or boards for the performance of functions. The VA committees/boards listed in this paragraph are mandatory. All other VA committees/boards prescribed for specific functions will exist if the Director determines that such mechanisms are appropriate. Where a JCAH[O] requirement states that a committee shall be established, this committee is mandatory for VA healthcare facilities, unless directed otherwise by VA issue.

a. Deans Committee or Medical Advisory Committee. Functions are prescribed in M-8, part 1, chapter 3. The Deans Committee has the primary responsibility for advising the Director and the Chief Medical Director on the development, conduct and evaluation of all education and research programs at VA health care facilities affiliated with medical and dental schools. A Medical Advisory Committee may be established to serve in a manner similar to the Deans Committee in those facilities not affiliated with medical or dental schools.

b. Executive Committee of the Governing Body. This committee (JCAH[O] requirement) in VA medical centers is the governing body acting as a committee-of-the-whole [Director, assisted by the Chief of Staff (with the Clinical Executive Board) and the Assistant Director (with the Administrative Executive Board)].

c. Executive Committee of the Medical Staff. The functions of this committee (JCAH[O] requirement) in VA medical centers [may] be accomplished by the CEB (Clinical Executive Board) [or some other committee appropriately constituted to meet JCAHO requirements. When the executive committee of the medical staff is other than the CEB, the mandatory reviews and functions outlined in paragraphs 1.78 b. and 1.79 will be realigned to meet JCAHO requirements for the executive committee of the medical staff.]

d. Professional Standards Boards (Physicians, Dentists, Podiatrists, Optometrists, Nurses, Nurse Anesthetists, Physician Assistants, and Expanded-Function Dental Auxiliaries). The appointment and specific duties of individual boards are pre-prescribed in [VHA] Supplement, MP-5, part II, chapter 2. These boards serve as the mechanism to meet JCAH[O] requirements concerning the method of selection of applicants, review delineation of clinical privileges, and evaluation of professional performance.

e. Physical Standards Board. Function prescribed by [VHA] Supplement, MP-5, part II, chapter 10.

f. Occupational Safety and Health Committee. Function prescribed by MP-3, part III, chapter 2, and JCAH[O] standards.

g. Infection Control Committee. Function prescribed by MP-3, part III, chapter 2, and JCAH[O] standards.

h. Medical Radioisotope Committee. Function prescribed by M-2, part XX, and JCAH[O] standards.

1.78 CLINICAL EXECUTIVE BOARD

a. Membership. Membership of this board will consist of the Chief of Staff (chairperson), and those members defined in Medical Staff Bylaws. The guidelines for the

M-1, Part I
Chapter I
Change 16

February 5, 1992

bylaws will be [M-1, part I, chapter 26, Appendix A, Bylaws and Rules of the Medical Staff]. One or more board members from the active medical or dental staff designated as "members-at-large" will be assigned on a rotating basis. []

b. Purpose. The purposes of this board are:

- (1) To ensure that all functional reviews described in paragraph 1.79 are accomplished.
- (2) Liaison with management.
- (3) Coordination of medical activities.
- (4) Final evaluations of program reviews, including records of individual clinical service meetings (medical care evaluation). Analyze HSRO-SIR quality of care program reviews, findings, and recommendations for coordination and facilitation of implementation of any approved corrective actions or improvements.
- (5) To receive recommendations and findings which require approval and/or action by the Clinical Executive Board, and to ascertain whether follow-up action is recorded.
- (6) To act independently in recommending professional policies and procedures, including quality control of patient care programs, to the Director.
- (7) To review activities of the professional accreditation function to ensure compliance with appropriate JCAH[O] requirements and recommendations.

c. Meetings. The board will meet monthly or more frequently on the call of the chairperson.

February 5, 1992

M-1, Part I
Chapter 1
Change 16

M-1, Part I
Chapter I
Change 16

February 5, 1992

1-20a

M-1, Part I
Chapter I
Change 16

February 5, 1992

d. Minutes. Minutes of meetings will be maintained and will include names of members and others attending, actions taken and/or recommendations made. Copies of minutes will be distributed to board members, the Director, and concerned personnel.

1.79 MANDATORY REVIEWS FOR CLINICAL EXECUTIVE BOARD

Functions in the following subparagraphs are under the jurisdiction of the Clinical Executive Board. Personnel assigned responsibility for review of these functions will submit reports and/or minutes of meetings as determined necessary by the Director to the Clinical Executive Board.

a.

House Staff. A formal channel of communication between residents, and fellows-in-training and administration is essential. Matters concerning patient care, house staff rules and procedures, and quality and content of the education program will be reviewed. Solutions and recommendations will be documented. Minutes of all meetings of these groups should ultimately be presented to the Deans Committee or Medical Advisory Committee for consideration, then forwarded to the Director (M-8, pt. II, ch. 1).

b.

Professional Accreditation. Responsibilities inherent in this function include writing, reviewing and revising medical staff bylaws,

M-1, Part I
Chapter I
Change 16

February 5, 1992

rules and policies. (See JCAH Survey Questionnaire, pt. 1.) Quarterly reviews will identify areas of noncompliance with JCAH standards.

- c. Employee Attitudes. (See par. 1.40.)
- d. Medical Records. This functional area will be reviewed as required by JCAH standards and chapter 26.
- e. Utilization Review. This functional area will be reviewed as required by JCAH standards and chapter 26.
- f. Therapeutic Agents and Pharmacy Reviews. Reviews will comply with JCAH Standards and M-2, part I, chapter 3.
- g. Medical Radioisotope Committee. Reviews will comply with JCAH Standards and M-2, part XX.
- h. Blood Services. Blood transfusion and blood bank activities comprise this functional area. Compliance with standards of the Joint Blood Council, Inc., and American Association of Blood Banks, as well as the requirements stated in M-2, part I, chapter 12, will be assured.
- i. Tissue Review. This functional area will be reviewed as required by JCAH standards and chapter 26.
- j. Infection Control. This functional area will be reviewed as required by JCAH standards; chapter 26; and MP-3, part III.
- k. Education. It is essential that provisions be made at each health care facility to conduct a quality continuing education and training program in medical, dental, and all allied health fields. Any meaningful program will include identification of needs and specific planning to meet these needs. (See M-8, pt. I, ch. 3.)
- l. House Staff Review. This function is an important mechanism through which the professional staff exercises supervision and quality control of the house staff. The review process will involve the overall qualifications, performance, suitability and discipline of house staff trainees. (See M-8, pt. II, ch. 1.)
- m. Research and Development Committee. (See M-3, pt. I, ch. 1.)
- n. Medical Library. Responsibilities inherent in this function include the proper selection of books and journals consistent with the needs of the medical staff, establishment of procedures governing use of the medical library, selection of periodicals to be bound and determinations as to disposition of excess, obsolete, or unserviceable publications. (See M-8, pt. III, ch. 4, and JCAH standards.)
- o. Emergency Care. This functional area will be reviewed, as appropriate, by JCAH standards.
- p. Nursing Home Inspection. (See ch. 12.)

M-1, Part I
Chapter I
Change 16

February 5, 1992

- q. Special Care Unit. This functional area will be reviewed as required by JCAH standards.
- r. Hospital Based Home Care. This functional area will be reviewed as required by JCAH standards.
- s. Autopsies as a Percentage of Deaths. (See M-2, pt. VI, ch. 8.)
- t. Laboratory Utilization Review. The basic mechanism for review will consist of regularly scheduled audits and appropriate actions by the Clinical Executive Board. The depth and complexity of the audits will be determined locally. In addition, review of laboratory usage will be incorporated into the HSRO program.
- [u. Geriatric Program. This functional area will be reviewed, as appropriate, by JCAH standards, medical facility demographic studies, consumer demand and plans for the facility health delivery system.]

1.80 ADMINISTRATIVE EXECUTIVE BOARD

- a. Membership. The membership of this board will consist of the Assistant Director (chairperson), and additional members, appointed by the Director from the administrative and/or professional staff as determined necessary by the Director.
- b. Purpose. The purposes of this board are to:
 - (1) Insure that all functional reviews described in paragraph 1.81 are accomplished.
 - (2) Receive recommendations and findings which require approval and/or action by the Administrative Executive Board.
 - (3) Act independently in recommending broad administrative policies and procedures to the Director.
 - (4) Assure that all necessary follow-up actions are taken.
 - (5) Review the administrative accreditation function to insure compliance with appropriate JCAH requirements and recommendations. Analyze HSRO-SIR quality of care program reviews, findings and recommendations for coordination and facilitation of implementation of any approved corrective actions or improvements.
- c. Meetings. The board will meet monthly or more frequently at the call of the chairperson.
- d. Minutes. Minutes of meetings will be maintained and will include the names of members and others attending, actions taken and/or recommendations made. Copies of minutes will be distributed to board members, the Director and other concerned personnel.

M-1, Part I
Chapter I
Change 16

February 5, 1992

1.81 MANDATORY REVIEWS FOR ADMINISTRATIVE EXECUTIVE BOARD

Functions in the following subparagraphs are under the jurisdiction of the Administrative Executive Board. Personnel assigned responsibility for review of these functions will submit reports and/or minutes of meetings, as determined necessary by the Director, to the Administrative Executive Board.

a. Administrative Accreditation. Conformance with all administrative aspects of JCAH standards is mandatory. Use JCAH Hospital Survey Questionnaire, part I, as a guide in the quarterly review of this function. Recommendations will be made and follow-up action scheduled to expedite compliance in all areas. Where responsibilities for management of this function overlap with other specific responsibilities described in this section, the scope of this function will be general in nature.

b. Employee Attitudes. (See par. 1.40.)

c. Budget and Financial Management. This function is to advise the Director in all phases of budget, including forecast, planning, and execution on a continuing basis. It will include review of the facility's overall annual operating plan to assure alignment with the facility's program objectives and assigned mission; establishment of a continuing cost ceiling control within the facility's target allowance; assurance of continuing internal balance and consistency; and recommendations of those courses of action which will best conform to continuing professional and operational requirements of the facility, within the dollar limitations of the facility's appropriation. All recommendations and actions taken in other functional areas affecting the budgetary operations of the facility will be coordinated with personnel responsible for the budget and financial management.

d. Career Development. The scope of this function includes the development of general policies and programs to obtain a competent work force and includes the matter of making continuing efforts to improve employee competence and performance. (See MP-5, pt. I, chs. 4 and 419.)

e. Incentive Awards. (See the provision of MP-5, pt. I, ch. 451.)

f. Position Management. This function is concerned with assuring that the work is organized and assigned in the most effective manner and that there is a continuing evaluation of requests for positions, skills and knowledge. (See MP-5, pt. I, ch. 250.)

g. Equal Employment Opportunity. Personnel assigned this function will assure that the facility adheres to established objectives. Items to be evaluated will include those specifically listed in MP-5, part I, chapter 713.

h. Equipment Replacement. The scope of this function includes establishing guidelines which will insure development of a facility-wide

M-1, Part I
Chapter I
Change 16

February 5, 1992

replacement program which will fairly and effectively meet the needs of all facility elements. (See MP-2, subch. E., subpt. 108-25.4.)

i. Commodity Standards. This function will be evaluated for compliance with objectives established by MP-2, subchapter E, subpart 108-31.50.

j. Facilities Master Plan and Space Utilization. Development of a master plan for space utilization at each facility is essential. Scheduled reviews and progress reporting on updating this master plan will be accomplished in accordance with the provisions of VA Handbook H-08-9, "Planning Criteria for VA Facilities."

k. Security and Disaster Planning. Review of this function includes periodic assessment of the adequacy of police staffing in relation to needs, as well as measures to insure training of police on a continuing progressive basis employing the latest techniques available. Formulation, review and update of disaster contingency plans; the periodic verification of personnel and resources preparedness for the execution of such plans and the updating of community disaster planning are also required.

l. Occupational Safety and Health. (See provisions of MP-3, pt. III, ch. 2, and JCAH standards.)

m. Community Affairs. Conscientious participation and leadership in community affairs will help meet the needs and welfare of the community, provide personal satisfaction to employees, and accrue benefits to patients. Personnel assigned this function will assist facility management in aggressively encouraging employees at all levels to participate in community affairs. Review MP-1, part I, chapter 4. Management should be provided advice as to how the facility, and its employees might:

- (1) Participate in youth programs of education, recreation, counseling and health needs.
- (2) Become actively involved in organizations that promote the welfare of the community.
- (3) Make VA facilities available for use by the community that would not inhibit or reduce the quality of our service to veterans: for example, the use of closed circuit TV for seminars and programs of mutual interest to the community.
- (4) Make available VA professional advice and information to those who can use them.
- (5) Establish regular and continuing communication between VA staff and community leaders.
- (6) Provide speakers for local groups.

M-1, Part I
Chapter I
Change 16

February 5, 1992

(7) Take the initiative in providing open houses and other forms of hospitality.

(8) Provide the public, via news media, with timely and helpful information about the facility. (Information Service representative is an excellent resource for assistance in formulating an effective program.)

(9) Assist in meeting the Federal Government's responsibility in consumer affairs.

n. Management Improvement. Personnel responsible for review of this function will assure that an effective management review and improvement program has been implemented and is functioning effectively. Such a program will include a meaningful Systematic Review program; Work Simplification program; Cost Reduction program; Internal Management Reporting Systems and long- and short-range plans. There will be evidence of absolute controls to monitor the updating of these programs to assure attainment of individual program objectives.

o. Energy Management. This function requires establishment of a facility-wide energy management action plan and a constant assessment of compliance with mandated energy conservation measures. Evaluation and continuous monitoring of all forms of energy usage are also required to provide optimum utilization consistent with the facility's mission. All recommendations and actions taken in other functional areas affecting the utilization of energy sources at the facility will be coordinated with personnel responsible for energy management.

p. Data Validation. A system providing data validation review procedures for data collection methods and sources. The objective is to assure accurate, timely, and consistent submission of data to various management information systems, such as AMIS reports, RCS 14-4 Cost Distribution Report, PAID, CALM and other management information systems (excluding operational systems such as the Supply Accounting System Log I).

q. VA Voluntary Service. (See M-2, pt. XVII.)

r. Geriatric Program. The scope of this activity encompasses a review of eligibility for the elderly veteran, removal of physical barriers, furnishing decor and furniture suitable for older patients, as well as adequate, proper signage, voluntary services and other related programs.

1.82-1.90 (Reserved.)

SECTION VIII. HEALTH SERVICES REVIEW ORGANIZATION []

1.91 PROGRAM DESCRIPTION

[a. The Administrator has determined that for the purposes of Public Law 96-385, section 505, 38, U.S.C. 3305, the HSRO-SIR/SERP (Health

M-1, Part I
Chapter I
Change 16

February 5, 1992

Services Review Organization-Systematic Internal Review/Systematic External Review Program) is the VA's Medical Quality Assurance Program. To the extent that quality assurance records and documents generated by the VA's Medical Quality Assurance Program are made strictly confidential by VA Regulations 6500 through 6534, implementing 38 U.S.C. 3305, they can only be accessed or disclosed in accordance with the provisions of that statute and those regulations.

b. The HSRO-SIR Program is an organized, systematic, continuous effort to identify deficiencies, evaluate and maintain internal controls, and implement improvements in order to achieve excellence in the delivery of health care services. The review and monitoring of all aspects of patient care is essential to the effective and efficient improvement of the quality of patient care.

c. The HSRO-SERP Program is an external review program that evaluates facilities and programs using standards, criteria, evaluative algorithms, and measuring instruments. HSRO-SERP is the VA's national program for evaluating the quality of care provided in each medical facility, as well as the effectiveness of the HSRO-SIR Program administered at each facility.

d. HSRO-SIR is the surveillance of all aspects of patient care within a VA medical facility which is necessary for the program's full effectiveness. This quality assurance and evaluation program encompasses all direct patient care and supporting services and all sites of care. HSRO-SIR emphasizes an accountability for all health care personnel.

e. In establishing and implementing the VA's Medical Quality Assurance Program, standards will be set and criteria patterned which assess the desired level of the quality of care. Health care actually provided can then be compared to the standards. The combination of the standards with periodic measurement of performance against these standards forms the information base of HSRO-SIR/SERP. The discrepancies identified when comparing the quality of health care provided and the predetermined standards for excellence are analyzed in the context of resources available, expectations of population served, and other specific circumstances. In a quality of care evaluation, certain value judgments are required based on local and national standards. Recommendations developed on analysis of data acquired by the evaluation should lead to planning and implementation of corrective action.]

1.92 RESPONSIBILITY

The Director of each health care facility is responsible for providing the leadership in quality of care assurance and for establishing and operating the HSRO-SIR program. The Director may designate a key staff official the responsibility to promote, implement, and coordinate the program.

M-1, Part I
Chapter I
Change 16
1.93 SCOPE

February 5, 1992

The scope of HSRO-SIR must incorporate quality assurance features of other ongoing programs and activities for improvement (e.g., systematic review, work simplification, position management, productivity measurement, performance standards, employee suggestions, organization and procedural analysis, and DM&S Management Improvement program), to insure that all such programs and activities contribute to quality assurance in unified ways, avoiding duplication and gaps. HSRO-SIR covers Administrative Services, Allied Health Services, and Patient Care Services as identified in the VA Organization Manual M-00-1. Categories of the program for quality assurance will include:

- a. Preventive Activities. Planning and development of work force, facilities, equipment and organization for programs of health care to meet the needs of VA clients within the constraints of available resources.
- b. Concurrent Activities. Surveillance over facilities and equipment, supervision of personnel and monitoring of health care by appropriateness of level and the logic and timeliness of care of individual patients.
- c. Retrospective Activities. Monitoring of preventive and concurrent activities through statistical analysis of selected date, comparing indicators of performance with standards.

1.94 PROGRAM OPERATIONS

- a. Program operation requires each health care facility to prepare a plan for its HSRO-SIR program. The plan will be submitted through appropriate committees or functional units for approval by the Clinical Executive Board of Administrative Executive Board, and the Joint Conference Committee. Integrated or combined quality of care review on a multiservice or multidisciplinary basis will be encouraged with appropriate participation in criteria selection, standard setting and evaluation. Small services, selected diagnoses, or selected topics may best use consultants, attendings or other regional or district groups.
- b. As the needs arise and the resources become available, district plans for HSRO-SIR will be developed, integrating facility plans.
- c. The methods and frequency of evaluations of the categories listed in paragraph 1.93 shall conform to the requirements of the JCAH, College of American Pathology and other accreditation agencies at a minimum. Additional evaluations may be recommended by the Health Care Review Service depending on local problems.
- d. The guidelines for evaluation include:
 - (1) Development of valid objective criteria.
 - (2) Valid measurement and comparison of recorded or observed performance with predetermined criteria.

M-1, Part I
Chapter I
Change 16

February 5, 1992

(3) Peer review of variations from criteria and peer analysis of unjustified variations to ascertain their type and source.

(4) Establishment of specific appropriate corrective actions or recommendations.

(5) Immediate accountable and documented reporting of audit results.

(6) Reaudit to measure the effectiveness of corrective actions.

e. HSRO-SIR closely relates to other VA programs. POMR (problem oriented medical record) is the VA standard method for the accumulation and recording of clinical information. An organized medical record facilitates the review and abstraction of data. CME (continuing medical education) has a primary goal to improve the skill of professionals in the provision of care. HSRO-SIR recommendations should include an allocation of a portion of educational resources specifically directed to local, goal-oriented, quality of care, educational needs.

1.95 REPORTING

HSRO-SIR reporting will be by written records of minutes of related meetings, management briefings, evaluation actions--plans--recommendations, and a list of evaluations and re-evaluations completed and in progress. Each service will keep written records of related activities. Such records will be readily available for HSRO-SERP and JCAH site surveys. Minutes and records, as appropriate, for each service will be forwarded to a committee or functional unit of the Clinical Executive Board or the Administrative Executive Board for review and action and transmittal to the Joint Conference Council as required.

1.96-1.99 (Reserved.)

SECTION IX. PATIENT DATA CARD

1.100 PATIENT DATA CARD

The appropriate patient data card, either VA Form 10-1124, 10-1124b or 10-1124e, will be prepared for each veteran or nonveteran patient or patient-member receiving hospital, nursing home or domiciliary care, or entitled to receive recurring outpatient medical services on a staff-visit basis, at VA health care facilities.

a. VA Form 10-1124b will be used for any veteran or nonveteran for whom a statement of charges is to be made under the MCCR (Medical Care Cost Recovery) program.

b. VA Form 10-1124 will be used for all other veterans without service-connected disabilities [and for CHAMPVA beneficiaries treated in VA health care facilities.]

M-1, Part I
Chapter I
Change 16

February 5, 1992

c. VA Form 10-1124e will be used for all other veterans with service-connected disabilities (including those rated 0 percent), or military retirees retired for disabilities incurred in line of duty.

1.101 INFORMATION FOR PATIENT DATA CARD

a. VA regional offices will furnish clinics of jurisdiction with a copy of VA Form 21-6796, Rating Decision on all veterans in their area of jurisdiction for whom service connection is initially established. These will include zero percent evaluations and cases disallowed due to receipt of retired pay. They will be batched and forwarded daily.

b. VA Form 21-8764, Original Disability Compensation Award Attachment is included with the notice of award letter sent by the Department of Veterans Benefits to veterans granted service connection. It conveys, along with other information, instructions on obtaining and using a patient data card and refers the veteran to the nearest VA health care facility to apply for the card. Veterans may report directly to VA facilities with the forms or send them by mail.

c. Veterans Benefits Counselors in regional offices who receive calls from veterans requesting information on obtaining patient data cards will be providing to the clinics of jurisdiction a TARGET printout with additional information included that will be adequate for issuing the card.

d. Additional sources of information for preparing patient data cards include Va Form 10-10, Application for Medical Benefits [VA Form 10-10d, VA Application for Medical Benefits for Dependents or Survivors--CHAMPVA, VA Form 3232, General Information Request (CHAMPVA)]. VA Form 10-7131, Exchange of Beneficiary Information and Request for Administrative and Adjudicative Action, or other official VA records such as claims folders that might be available.

e. All available files, records and controls will be reviewed prior to issuing a patient data card to assure that one has not already been provided to the veteran.

f. Relevant information will be recorded on VA Forms 10-1124w, Worksheet for VA Forms 10-1124, 10-1124b, and 10-1124e, Patient Data Card. Instructions for preparing VA Form 10-1124w are in appendix 1B. Following completion of the worksheet, the date and signature of the preparer will be entered in the space headed "PREPARED BY."

[g. Lines 8 and 9 of the patient data card have been reserved for local use. Any data desired by the VA facility preparing the card may be entered on these lines and recorded on the corresponding worksheet.]

1.102 PREPARING THE PATIENT DATA CARD

a. Instructions for embossing the five-line patient data card are in appendix 1C. When embossing is completed, enter an imprint of the

embossed card on the worksheet in the space headed "Patient Data Card Imprint," and review to determine:

- (1) that the card has been accurately and properly embossed according to embossing instructions;
- (2) that information in the imprint corresponds with information on the worksheet;
- (3) that each embossed character is legible and of the quality required for good imprinting and easy readability.

b. When the verification review is completed, document the verification by signing in the space headed "VERIFIED BY."

c. Indicate the type of card prepared, i.e., VA Form 10-1124, 10-1124b, or 10-1124e, by circling the corresponding form number in the title on the VA Form 10-1124w, Worksheet. [For CHAMPVA beneficiaries, circle VA Form 10-1124 and add the word "CHAMPVA".]

d. Enter in the "Remarks" section of VA Form 10-1124w any explanatory information that might be relevant, such as, "Corrected SSN provided by veteran," or "Service connection verified by telephone call to VAH ERIE; CHR being forwarded."

1.103 ISSUING THE PATIENT DATA CARD

a. Patient data cards prepared for inpatients [] are retained on the ward, nursing care unit, or other functional element for imprinting identifying data on medical records or other VA forms. The cards are presented to patients [] when they are released from bed care. NOTE: VA Form 10-1124b (billing) will not be presented to a patient unless that patient is expected to return for outpatient treatment.

b. VA Form 10-1124c, Instructions to Patient Re Use of Patient Data Card will always be given to patients with delivery of the initial patient data card. The patient will be instructed to read the information on the card. In addition, the "NOTE" on the card will be read to the patient. It states, "Your patient data card may not be used to obtain medical services of any kind at VA expense from local doctors, clinics, hospitals, pharmacies or other providers of medical services or supplies."

c. The same instructions apply to delivery of initial patient data cards prepared for [patients] entitled to outpatient treatment.

d. Patient data cards prepared as a result of requests received by mail (par. 1.101 a, b and c) will be embossed using the information made available through all sources. The regional office will not be contacted and request to provide any additional information. The embossed patient data card, accompanied by VA Form 10-1124c, will be mailed to the veteran with a cover letter including the information shown below.

M-1, Part I
Chapter I
Change 16

February 5, 1992

Directors are free to add any other information describing services available at the nearest VA medical facility.

"I am informed that you were recently awarded a service-connected disability rating. When this award is made, the law directs that you as a service-connected veteran will be provided priority health care in VA facilities. I would like to tell you about the program. Enclosed is a priority patient data card for your use and VA Form 10-1124c, which covers instructions on using it. Please read the instructions carefully. This special patient data card records vital information on documents prepared for your medical record and will minimize the processing time required for your enrollment and scheduling. Within the medical center or clinic, your card will help us provide you with priority service. Should you feel that you require medical care, it is recommended that you contact the VA medical center (address and telephone) which is nearest your residence. If you call for an appointment in advance, it will help us serve you better. Please remember two important things: Always bring your patient data card when you apply or visit for medical care, and your patient data card may not be used to obtain medical services of any kind at VA expense from local doctors, clinics, hospitals, pharmacies or other providers of medical services or supplies."

1.104 OUTPATIENT APPOINTMENT NOTICE, VA FORM 10-1124a

The patient data card may be used as an appointment card by attaching the adhesive-backed paper appointment notice, VA Form 10-1124a, to the back of the patient data card. The date, time and clinic (service) of each scheduled appointment is written in ink on the appointment notice. The adhesive-backed form is removed from the patient data card when an episode of outpatient treatment is ended.

1.105 REPLACEMENT OF PATIENT DATA CARD

a. The patient data card will be replaced when loss is verified or when imprinting deterioration is detected. It will also be replaced to reflect change in data such as change in VA facility providing recurrent services or change in residence. []

b. Procedures applicable to preparation and issuance of the initial card apply to issuance of a corrected or replacement card. This includes preparing a new VA Form 10-1124w, Worksheet, and filing the completed worksheet in the consolidated health records after the prior worksheet has been removed from the folder and disposed of according to provisions of DM&S Records Control Schedule 10-1.

1.106 USE OF VA FORM 10-1124b, PATIENT DATA CARD (BILLING)

a. This patient data card with the red embossing panel will be used to identify and categorize each individual receiving medical care for which collection action is required or indicated under the Medical Care Cost Recovery program. This includes:

M-1, Part I
Chapter I
Change 16

February 5, 1992

(1) [Veterans receiving care under any reimbursable program; i.e., tort feason, workers' compensation, other reimbursable insurance, or in States with automobile reparations or crimes of personal violence statutes, victims of uninsured or unknown motorists or of crimes of personal violence.]

(2) [Beneficiaries of other Federal agencies; i.e., Department of Defense; Department of Labor, Office of Workers' Compensation Programs; Department of State; Department of Justice, etc.]

(3) [Allied beneficiaries.]

(4) [Nonveterans admitted for hospital care or provided outpatient care under any program which requires billing, i.e., humanitarian emergency, sharing agreement, research, other nonveterans, etc.]

b. Effective procedures will be developed and implemented to utilize the patient data card (billing) efficiently to coordinate and control billing and collection operations. These procedures may include the following:

(1) Control Card. Imprint a 5 x 8 card immediately after embossing and verifying the VA Form 10-1124b. Forward this card, appropriate Power of Attorney and Assignment form(s) or authorization documents, and the administrative record folder to the Medical Administration Service employee assigned responsibility for billing operations. This card will serve as a control document for recording all billing and collection transactions. All relevant information necessary for preparation of the quarterly AMIS segment 291, Medical Care Cost Recovery program should be included on the control card.

(2) Ward Procedures for Inpatients. The VA Form 10-1124b will be interfiled with other patient data cards for patients currently on the active ward rolls.

(a) A listing will be prepared by data card imprint on the first workday of each month showing every patient on the ward roster identified by a VA Form 10-1124b. These listings will be forwarded to the Billing activity for review and for preparation of required interim billings for reimbursements.

(b) All patients identified by VA Form 10-1124b will be cleared through the Billing activity at the time of release from inpatient status. Clearance may be arranged by telephone or by using VA Form 10-2322, Clearance Sheet.

(c) The VA Form 10-1124b for all patients released from inpatient status who are not scheduled to return for authorized outpatient services will be returned to the Admission activity for subsequent disposition according to provisions of DM&S Records Control Schedule 10-1.

(3) Clinic Procedures for Outpatients.

M-1, Part I
Chapter I
Change 16

February 5, 1992

(a) The adhesive-backed outpatient appointment notice, VA Form 10-1124a, is also used with the patient data card (billing). The scheduled appointment, date, time and clinic to be visited are recorded in ink on the appointment notice.

(b) Notice of each outpatient visit made by anyone with a red-colored patient data card (billing) will be forwarded promptly to the Billing activity. This can be done by a designated receptionist or by a clinic clerk using a data card imprint on an overprinted VA Form 3230, Reference Slip, plainly marked, "Outpatient Visit (billing)."

(c) All applicable information relevant to or required for billing should be recorded on the VA Form 3230, including:

1. Date of visit and clinic visited.
2. Beneficiary travel paid or reimbursed.
3. Prosthetic or orthopedic appliance furnished.
4. Sensory aids, medical accessories or equipment furnished.
5. Services procured from non-VA sources.
6. Prescription refills (including mail-in) when no other services are provided.]

(d) A patient data card (billing) is not required when emergency outpatient care is provided as a humanitarian service to nonveterans. Pertinent information will be recorded in the emergency care record in sufficient detail for necessary billing action, and the record will be forwarded promptly to the Billing activity.

1.107 USE OF VA FORM 10-1124e, PATIENT DATA CARD
(SERVICE-CONNECTED)

This patient data card with the triangular purple design in the embossing panel is used only for veterans with service-connected disabilities and military retirees retired for disabilities incurred in line of duty. Special care must be taken to assure that VA Form 10-1124e is not prepared until such service connection or disability retirement status has been verified and documented in the CHR or outpatient treatment record.

1.109-1.111 (Reserved.)

SECTION X. APPEALS

1.112 PURPOSE

This section provides general instructions for and responsibilities of DM&S field facility staff in the appeals process. Specific appeals

M-1, Part I
Chapter I
Change 16

February 5, 1992

processing procedures may be found in VA Manual M1-1, "Field Appellate Procedures."

1.113 RIGHT TO APPEAL

a. The right to appeal to the Administrator is provided by law (38 U.S.C. 4004). All questions on claims involving benefits under the laws administered by the VA will be subject to one review on appeal to the Administrator. Examples of subject matters that are appealable include denial of medical benefits on the basis of legal eligibility determinations. The most frequently appealed decisions of DM&S involve denial of unauthorized medical expenses claims and denial of dental benefits. (Determinations of the DM&S involving the need for or nature of medical treatment, as distinguished from legal or basic entitlement to treatment, are not appealable.) Final decisions on such appeals will be made by the Board of Veterans Appeals.

b. Occasionally, uncertainty or controversy arises as to whether a determination is appealable to the Board of Veterans Appeals. When this occurs, the claim will be developed for appellate review and certified to the Board of Veterans Appeals for a decision as to whether the issue is appealable. The law and regulations in the Statement of the Case for such an issue will include pertinent portions of 38 U.S.C. 4004(a) and 38 CFR 19.3.

c. VA regulations governing appeals are in the 9800 and 9900 series.

1.114 DUE PROCESS

a. "Due process" generally refers to the due process clause of the United States Constitution which provides, in part, that no person will be deprived of his or her property without due process of law.

b. The VA regulation governing due process is 1103. This regulation refers to the claimant's right to adequate notice, representation, and the right to a hearing when requested.

c. The Board of Veterans Appeals requires correction of any deficiency in appeals development procedures which substantially prejudices a claimant's right to due process. If such a deficiency is not corrected prior to certification of an appeal, the board will remand the case to the originating officer for correction.

1.115 DEVELOPMENT OF APPEALS

a. The appellate review process begins when a claimant files a Notice of Disagreement as to a determination that involves an appealable issue.

b. When a Notice of Disagreement is received, it is the responsibility of the Chief, Medical Administration Service, to insure adherence to all necessary procedures of the appeals process. These

M-1, Part I
Chapter I
Change 16

February 5, 1992

procedures include proper recording of the Notice of Disagreement; all necessary actions to assist the claimant in the development of his or her appeal; timely preparation and dispatch of the Statement of the Case; collection and incorporation into the appeals file of all evidence submitted by the claimant; conducting, recording and transcribing the hearing if requested; and receipt and certification of the substantive appeal.

1.116 HEARINGS

a. A claimant or representative may request a hearing at any stage in the adjudication of a claim.

b. If a request for a hearing is not made, it will be assumed that a hearing is not desired. However, careful attention must be given to any express or implied requests for a hearing made by the claimant or representative. Failure to accord the appellant a requested hearing is a substantive deficiency in due process. If a hearing has been requested by a claimant, a waiver of such hearing by the representative without the consent of the claimant does not dispose of the request. It must be ascertained from the claimant whether he or she still desires a hearing.

c. Specific procedures for scheduling and conducting a hearing may be found in VA Manual M1-1, chapter 8.

1.117 CONTROL AND REPORTING OF APPEALS

a. The Chief, Medical Administration Service, is responsible for insuring that proper appeals control procedures are maintained within the health care facility, and for establishing an effective liaison with the appeals reporting office at the appropriate VA regional office.

b. Areas which require close coordination with the VA regional office include:

- (1) Recording of each Notice of Disagreement.
- (2) Recording of each Statement of the Case when dispatched.
- (3) Recording receipt of each Substantive Appeal.
- (4) Certification of the Appeal.

1.118-.119 (Reserved.)

SECTION XI. VA/DOD HEALTH CARE RESOURCES SHARING

1.120 GENERAL

a. Title 38 U.S.C. 5011, provides incentives for sharing of health care resources between the VA (Department of Veterans Affairs) and the DOD (Department of Defense). It supplements, but does not supersede, other legislative sharing authorities.

b. Medical facility directors are to pursue sharing arrangements with DOD medical facilities that would result in increased quality of care, improved services to patients, and enhanced cost effectiveness. Sharing arrangements under 38 U.S.C. 5011 shall not reduce services or diminish the quality of care for veteran beneficiaries. All agreements will be in accord with the VA/DOD Health Care Resources Sharing Guidelines which were agreed to by both agencies on July 29, 1983.

1.121 RESOURCES TO BE SHARED

a. A multitude of services may be covered in a single sharing agreement.

b. Resources not available at either VA or DOD field facilities may be acquired with written approval of the Regional Director. After written permission has been obtained from the appropriate Regional Director to increase existing resources or to acquire new resources, agreements will be submitted to the Regional Director for approval.

1.122 DEVELOPMENT OF AGREEMENTS

a. After potential areas for sharing have been identified, medical center staff should discuss projected costs, workload, and resources with their counterparts at DOD facilities. Rates will be locally determined. Use of VA Form 10-1245c, VA/Department of Defense Sharing Agreement, is recommended for writing VA/DOD sharing agreements.

b. No single reimbursement methodology is mandated. The VA Facility or organization should first carefully estimate the costs of providing the service to DOD. This cost must include the incremental cost of personnel, supplies, services, communications and utilities that would not have been incurred if the service had not been provided. Building depreciation, interest on net capital investment and VA Central Office overhead are excluded from the costs and will not be included in the reimbursement rate. While equipment depreciation is not specifically excluded from the cost, facilities are encouraged not to include equipment depreciation in the reimbursement rate due to the nature of funding associated with equipment. Rates should be negotiated with the sharing partners and should take into consideration local needs and conditions. In no case should an estimated rate be below the incremental cost resulting in a subsidy to the sharing partner. Rates should be established for all shared services and bills rendered for services provided. It is improper to exchange services without the preparation of bills. Payments may be at billed rate or offset against payments due. Estimates of cost and worksheets used to develop reimbursement rates need not be forwarded to the Regional Director when submitting a proposal for approval.

c. Facility heads may request permission to acquire or increase health care resources that exceed the needs of the facility's primary beneficiaries but will serve the combined needs of both agencies. Multi-year commitments should ordinarily be obtained from DOD facilities if new medical resources are to be obtained by the VA. No sharing

July 14, 1992

M-1, Part I
Chapter 1
Change 17

M-1, Part I
Chapter 1
Change 17

July 14, 1992

agreement requiring additional capacity will be submitted until written permission to increase existing resources are obtained from the Regional Director. The justification must cite the combined workload of the participating facilities.

d. The medical center Director and, generally, the Base Commanding Officer, will sign proposed local agreements. Agreements will detail the resources to be provided, the cost per unit of those resources, the anticipated number of units, and performance and delivery requirements. Agreements will also include any special arrangements such as transportation, meals, and required escorts.

e. Agreements may be written for a period as long as 5 years.

1.123 APPROVAL OF AGREEMENTS

a. Each locally developed proposed agreement shall be submitted with four copies to the Regional Director, (181 through 13_), in VA Central Office. Each proposal for an agreement shall be effective as an agreement in accordance with its terms on the 46th day after the receipt of such proposal unless earlier disapproved by either agency; or, if earlier approved by the Regional Director and DOD, on the date of approval.

b. Renewal proposals containing cost increases in excess of 10 percent over the previous year, or additional services will be processed as initial agreements. Renewals where the increase in the reimbursement rate is 10 percent or less over the previous year do not require approval, in such cases, the medical center Director may renew the agreement. However, copies of renewals, for which approval is not required, will be sent to the Office of Medical Sharing (181) for inclusion in the Annual Report to Congress.

c. Amendments to existing agreement will be forwarded to the Office of Medical Sharing (181). The same procedures described for initial agreements will be followed for amending agreements.

d. The local Chief, A&MMS (Acquisition and Materiel Management Service), will review all proposed VA/DOD Sharing Agreements. The local Chief, A&MMS, shall review contractual language in the agreement, as well as any impact that the proposed agreement would have on A&MM operations.

1.124 BILLING AND REIMBURSEMENT

a. The billing procedure is described in M-1, part I, chapter 15, section IV. Billing will be accomplished on VA Standard Form 1080, Vouchers for Transfers between Appropriations and/or Funds, generally, on a monthly basis. Agreements involving low number of beneficiaries or costs may provide for quarterly billing. In agreements where each agency will provide some service to the other, each facility must render the other a bill for the gross amount; the facility billing the lesser amount would pay the difference. The medical center must ensure that both reimbursements earned and costs incurred are recorded in the gross amounts prior to calculating the difference and the net payment due.

b. Charges or payments made under the authority of 38 U.S.C. 5001 should be directed to the DOD medical facility entering into the agreement. (See M-1, pt. I, ch. 15, par. 15.25(a)(4).)

July 14, 1992

M-1, Part I
Chapter 1
Change 17

M-1, Part I
Chapter 1
Change 17

July 14, 1992

c. Payments received from DOD will be recorded by Fiscal Service as appropriation reimbursements in accordance with MP-4, part V, paragraph 6D.03. Medical facilities may request a like amount of funding from VA Central Office on the Quarterly Report of Needs/Excesses (RCS 10-0027) in accordance with VHA (Veterans Health Administration) Supplement to MP-4, part VII, paragraph 3D.02a. For earning records as "Research Appropriation" reimbursement, facilities should follow the procedures in accordance with VHA Supplement to MP-4, part VII, paragraph 3D.02a.

1.125 EDUCATION AND TRAINING

a. Military units (including reserve units and National Guard units) may receive training and education at VA facilities as part of reserve assignment. No educational institution is involved and no academic credit is awarded. If students from a military-sponsored academic institution are involved, such as from state approved and accredited schools of practical nursing, medical technologist programs, and schools of nurse anesthesia, a Memorandum of Affiliation, in accordance with policies and guidelines from the Office of Academic Affairs, will be negotiated instead of a VA/DOD sharing Agreement. (M-8, pt. II, ch. 2.) No stipend, fee, or salary will be provided to the trainees. Sharing agreements for education and training with military units are only for training that fully integrated into the VA health care delivery system. Training includes providing care and services to veteran patients by military personnel. The roles of the military personnel are limited to those specified in the sharing agreement. Activities of personnel in VA medical facilities are under the direct supervision of staff designated by the medical center Director.

b. The medical center Director will:

(1) Retain full responsibility for patient care and will maintain the administrative and professional supervision of all military personnel insofar as their presence affects the operation of the VA facility;

(2) Review and approve the education and training schedule provided by the military unit commander. Review will include verifying the licensure and certification of each active duty and reserve trainee for professional and/or technical qualifications and formal privileging of trainees by the usual VA health care facility mechanisms;

CLASSIFYING AND CODING RELIGIOUS PREFERENCES
 FOR ADMISSION PURPOSES

Religious Preferences	Numeric	Codes	Other Names Used or Characteristics
Roman Catholic	00		
Jewish		01	
Eastern Orthodox	02		Russian, Greek, etc.
Baptist		03	Any name containing "Baptist"
Methodist	04		Any name containing "Methodist" or "United Brethren"
Lutheran		05	Any name containing "Lutheran"
Presbyterian	06		Any name containing "Presbyterian"
United Church of Christ	07		Congregational; Evangelical and Reformed
Episcopal	08		Anglican
Adventist	09		Any name containing "Adventist"
Assemblies of God	10		
Brethren		11	Dunkers
Christian Science	12		
Christian of Christ	13		
Church of God		14	
Disciples of Christ	15		Christian
Evangelical Covenant	16		Mission Covenant
Friends		17	Quakers
Jehovah's Witnesses	18		
Latter-Day Saints		19	Mormon
Muslim		20	Mohammedan
Nazarene		21	
Other Religions	22		
Pentecostal	23		
Protestant, other		24	Any protestant group not listed
Protestant, no denomination	25		
Reformed		26	Protestant Reformed; Christian Reformed
Salvation Army	27		

July 14, 1992

M-1, Part I
Chapter 1
Change 17

M-1, Part I
Chapter 1
Change 17

July 14, 1992

Unitarian; Universalist	28
Unknown/No Preference	29

Instructional Notes

1. The larger groups are listed under numeric codes 00 through 08. The remainder of the table (i.e., codes 9 through 29) has been arranged alphabetically to facilitate ready reference .

2. There are many separate church organizations that include terms such as "baptist," "methodist," and so forth, in their names. When encountering a church organization name that is different from those included in this table, code under most applicable listing.

July 14, 1992

M-1, Part I
Chapter 1
Change 17

M-1, Part I
Chapter 1
Change 17

July 14, 1992

3. Any protestant group not enumerated in this table should be coded "24".
4. To aid coding, ask applicant to identify specific denominational preference, e.g., "Anglican," "Lutheran," "Episcopal," "Baptist," "United Brethren." If none, ask for preference of major faith group, e.g., "Catholic," "Jewish." "Protestant."

1A-60

1A-60

INSTRUCTIONS FOR THE PREPARATION OF VA FORM 10-1124w, WORKSHEET FOR
VA FORMS 10-1124, 10-1124b, AND 10-1124e, PATIENT DATA CARD

LINE
NO.

- 1 NAME--Last name, space; first name, space; middle initial.
- 1 RELIGION--Enter religious preference by faith group in spaces 25 and 26. Use two-digit religious codes listed in appendix 1A
- 2 STREET--When the residence address exceeds 22 characters, maximum use of abbreviations will be used. If necessary to abbreviate, use abbreviations similar to those listed in local telephone directory. Use no punctuation.
- 2 COUNTY CODE--Enter in spaces 24 through 26 the three digit numeric county code for the residence address according to codes listed in appendix B. For residents of Puerto Rico or the Virgin Islands, use the last three digits of the ZIP Code for those making staff visit to VA health care facilities in Puerto Rico; use 999 for those island residents making staff visits to other VA health care facilities.
- 3 CITY--STATE--ZIP CODE--Use abbreviations for city name, if necessary. Use State abbreviations listed in MP-I, part II, chapter 6, appendix G. Obtain appropriate ZIP Code relating to the residence address from National ZIP Code Directory.
- 4 Leave blank.
- 5 SOCIAL SECURITY NUMBER--Enter the SSN in spaces 1 through 11 (always leave spaces 4 and 7 blank). When the actual SSN is not available, construct and assign a pseudo SSN using the numerical equivalent of the person's initials and birth date (month, day and year, each expressed in two digits). Numeric equivalents to be used for the initials are as follows:

A,B,C,	=1	P,Q,R	=6
D,E,F	=2	S,T,U	=7
G,H,I	=3	V,W,X	=8
J,K,L	=4	Y,Z	=9
M,N,O	=5	No middle initial	=0

Example: John (NMI) South
born July 1, 1919
Pseudo SSN-407070119

- 5 MARITAL STATUS--In space 14 enter the appropriate marital status code listed below:
N--Never Married
M--Married
S--Separated

March 10, 1986

M-1, Part I
APPENDIX 1B

M-1, Part I
APPENDIX 1B

March 10, 1986

W--Widowed

D--Divorced

U--Unknown.

5 SEX--In space 15 enter the appropriate sex as stated below:

M--Male

F--Female

1B-62

1B-62

LINE
NO.

5 DATE OF BIRTH--Enter in space 17 through 22 the full date of birth (month, day, year), i.e. January 9, 1944 would be 010944.

5 DM&S STATION NUMBER--Enter in spaces 24 through 26 the three-digit facility number of the VA health care facility. Outpatient clinics designated OCH or OCS, use the facility number of the parent facility

6 Leave blank.

7 CLAIM NUMBER--When the veteran has a claim number in addition to the SSN, the first 9 spaces of the line will be used for the eight-digit claim number, preceded by a "C." For CHAMPVA beneficiaries enter the veteran (sponsor) claim number. If the claim number is the social Security number enter "C-SSN" in spaces 1 through 5.

7 ELIGIBILITY CODE--Enter in space 11 the lowest numbered appropriate eligibility.

a. For Veterans--

- (1) Service connected 50 Percent or more.
- (2) Aid and attendance or housebound, Mexican border, or World War I veterans, and POW's.
- (3) Service connected less than 50 Percent.
- (4) Nonservice connected, receiving VA Pension.
- (5) Other nonservice connected.
- (6) Domiciliary patient.

b. For Nonveterans--enter appropriate code and on line 9, enter the term "nonveteran." This will distinguish a veteran's card from a non-veteran's card.

- (1) CHAMPVA beneficiary.
- (2) Collaterals of veterans.
- (3) VA employees.
- (4) Other Federal agencies.
- (5) Allied veterans.
- (6) Humanitarian emergencies.
- (7) Sharing agreement.
- (8) Reimbursable insurance.

7 PERCENTAGE SERVICE CONNECTION--In spaces 13,14,and 15 indicate the amount of service connection, i.e., 070 = 70% or, indicate in space 14 and 15 PP for presumptive psychosis (38 CFR 17.33), DD for disability discharge (LOD) not rated by VA for service

March 10, 1986

M-1, Part I
APPENDIX 1B

M-1, Part I
APPENDIX 1B

March 10, 1986

connection, or NA (not applicable for veterans with other than honorable discharges and treatment is limited to ILOD disabilities, in spaces 13,14, and 15 indicate CAV for Commonwealth Army Veterans or NPS for New Philippine Scouts-Note: This does not apply in the Philippines Treatment for CAV or NPS is limited to service-connected disabilities or those adjunct to a service-connected disability, and may only be provided in a VA health care facility or other contracted Government facility within the 50 States, the Territories and possessions. Treatment in non-VA facilities at VA expense is prohibited. (Make no entry for CHAMPVA beneficiaries.)

1B-64

1B-64

LINE
NO.

7 PERIOD OF SERVICE--Enter in space 17 the following numerical codes to denote period of active military service for veterans or the alphabetical codes for persons not being treated as veterans:

- 0-Koren Conflict (6/27/50-1/31/55)
- 1-World War I (4/6/17-11/11/18-Extend to 4/1/20 if served in Russia)
- 2-World War II (12/7/41-12/31/46)
- 3-Spanish-American War (4/21/98-7/4/02--Extend to 7/15/03 If service in Moro Province)
- 4-Pre Korean (All PK Peacetime) (Before 6/27/50)
- 5-Post Korean Conflict--Peacetime service (2/1/55-8/4/64)
- 7-Vietnam Era (5/5/64-5/7/75)
- 8-Post Vietnam-Peacetime sece (on/after 5/8/75)
- 9-Other or None

- A--Active Duty--Army
- B--Active Duty--Navy, Marine Corps
- C--Active Duty--Air Force
- D--Active Duty--Coast Guard
- E--Retired Members Uniformed Forces
- F--Medical Remedial Enlistment Program
- G--Merchant Seaman--USPHS
- H--Other USPHS Beneficiaries
- J--Office of Workers Compensation Program
- K--Job Corps and Peace Corps
- L--Railroad Retirement
- H--Beneficiaries-Foreign Governments
- N--Humanitarian, Nonveteran, Emergency
- P--Other Contract Reimbursement, Nonveteran
- R--Donors (Nonveteran)
- S--Special Studies (Nonveteran)
- T--Other Nonveteran
- U--Spouse, Surviving Spouce, Child-CHAMPVA
- W--Service in Czechoslovakia/Polish Armed Forces
- Y-CAV (Commonwealth Army Veterans) or NPS (New Philippine Scout)-Service in the Republic of Philippines Armed Forces.

March 10, 1986

M-1, Part I
APPENDIX 1B

M-1, Part I
APPENDIX 1B

March 10, 1986

7 MODIFIER--In space 18 indicate with a "V" only if veteran served in Vietnam during the vietnam era (period of service Code 7) (make no entry for CHAMPVA beneficiaries).

7 SPECIAL CATEGORIES--In space 24,25 and 26 list the special categories, POW (Prisoner of War), A&A (Aid and Attendance), HBS (Hosebound Status), MBP (Mexican Border Period), WWI (World War I) and SAW (Spanish-American War). If two categories apply, i.e., veteran is A&A and POW, indicate both as "AAPOW" in space 22-26. In space 20 through 26 enter CHAMPVA for CHAMPVA beneficiaries, SC ONLY for Commonwealth Army Veterans an New Philippine Scouts (leave space 22 blank), or LIMITED for veterans with other than honorable discharges and treatment is limited to ILOD disabilities.

1B-66

1B-66

March 10, 1986

M-1, Part I
APPENDIX 1B

M-1, Part I
APPENDIX 1B

March 10, 1986

8 For use by local VA facility, if desired.

9 Enter the term "nonvet" if appropriate.

1B-67

1B-67

June 29, 1980

M-1, Part I
APPENDIX 1C

M-1, Part I
APPENDIX 1C

June 29, 1980

(2) All embossers will be adjusted to emboss standard alpha/numeric characters at a profile height of 0.017".

e. Each imprinter must have provision for a ward or clinic identification card. This card provides for the identification of the health care facility and the nursing unit, clinic, or other functional element where medical care or services are provided. It is used in conjunction with the patient data card. The ward or clinic identification card is embossed as follows:

1C-69

1C-69

June 29, 1980

M-1, Part I
APPENDIX 1C

M-1, Part I
APPENDIX 1C

June 29, 1980

Line 1--VAMC, followed by the three-digit station number as provided in the current issue of the Consolidated Address and Territorial Bulletin. Outpatient clinics should indicate--VAOPC and the parent station three-digit number. Independent outpatient clinics use their own three-digit number.

Line 2--The location of the health care facility. Use abbreviations to condense the location name to seven or eight characters so that the printing layout of the combined PDC and ward or clinic designation will imprint within the allotted imprinting area of VA forms.

Line 3--Identification of the ward, clinic, or other functional element providing the medical care.

f. A standard size credit card (2 1/8" x 3 3/8" x 0.030") may be used for embossing the ward or clinic identification card. Also, the "first character" position will be located in the same position as the "first character" of the patient identification card, i.e., 1/2" down from the top edge and 3/8" in from the left edge of the card. These cards may be cut to size.

2. Printing Layout--The printing layout encompasses the patient data card, ward or clinic identification card and data. The configuration has been arranged to provide an imprinting area measuring 4-1/2" x 1-1/2". The imprinting area is shown in the sketch below delineated by the broken line:

1C-70

1C-70

APPEAL PROCEDURES

I. DEFINITIONS

- A. Notice of Disagreement--A written statement by a claimant or representative expressing disagreement with a decision made by the VA health care facility.
- B. Statement of the Case--It is an explanation of the adverse decision. It will be limited to matters relevant to the issue or issues with which disagreement has been expressed. Its purpose is to provide the claimant with sufficient information concerning the decision so the claimant can prepare an effective substantive appeal.
- C. Substantive Appeal--This is the claimant's response to the statement of the case. VA Form 1-9, Appeal to Board of Veterans Appeals, is used for this purpose.

II. PROCEDURES

- A. A notice of disagreement must be filed with the facility which made the adverse determination within 1 year of the date of the letter of notification of that determination. Upon receipt of a notice of disagreement which is not timely filed, the claimant will be informed that the decision became final at the expiration of the 1-year period. If the claimant protests an adverse determination with respect to timely filing of the notice of disagreement or substantive appeal, the claimant will be furnished FL 1-25a, Statement of the Case. Furthermore, if a clear and unmistakable error is alleged, an appeal may be made from a determination that there was no error.
- B. Following timely receipt of the notice of disagreement, the Chief, Medical Administration Service or designee will review the case. If the claimant has submitted additional information that permits granting the benefit, this will be done. If no evidence is submitted, or the disagreement has not been resolved by the granting of the benefits sought or withdrawal of the notice of disagreement, then a statement of the case will be prepared. The Adjudication Officer or designee of the regional office having jurisdiction of the claim will be informed of each notice of disagreement received.
- C. The statement of the case will be prepared in an original and three copies and mailed to the claimant within 30 days of receipt of the notice of disagreement. FL 1-25a will be used as the first page. Nonletterhead stationery will be used for succeeding pages. The statement of the case is divided into the following parts:
1. Notice to the Appellant: This notice is preprinted on the FL 1-25a. If the claimant has a representative, an appropriate entry will be made, otherwise "None" will be entered.
 2. Issue: State the issue(s) covered in the statement of the case. In order to further identify the areas of disagreement, a brief statement of the claimant's contentions shall be set forth immediately below.
 3. Summary of Evidence: All evidence relative to the issues will be summarized.

Short quotations are permissible when appropriate for clarity and accuracy. Subheadings may also be used.

4. Pertinent Law and Regulations Provisions: Va Regulations and sections of Title 38, United States Code which are pertinent to the issues will be cited and discussed. CFR numbers will be used for citations to VA Regulations. Department of Medicine and Surgery manuals may not be cited or used.

5. Decision: The decision made on the issue(s) raised will be stated.

6. Reasons for Decision: An analysis and explanation of the criteria on which the decision is based will be furnished. This Portion of the statement of the case will clarify and reduce to simple terms the technical language of the laws and regulations in their application to the evidence and issues. Department of Medicine and Surgery manual provisions may be used in this section.

7. Signature and Review: Only the original will be signed and dated by the person who prepared it. The entire case will be forwarded to the Chief, Medical Administration Service for signature as the reviewing official.

D. A copy of the statement of the case without signatures will be transmitted by FL I-25 to the claimant with VA Form 1-9. A copy of the statement of the case will also be sent to the claimant's representative. The Adjudication Officer of the regional office having jurisdiction of the claim will be notified at point that the statement of the case has been dispatched.

E. Matters not to be disclosed in the statement of the case are those considered by the clinic Director to be injurious to the physical or mental health of the claimant.

F. An FL 1-28a, Supplemental Statement of the Case, will be prepared in the same format as the initial statement except that FL 1-28a will be used. It will be mailed to the claimant and any representative within 30 days of any of the following occurrences:] (1) new and material evidence has been introduced, (2) an amended decision has been made, or (3) a material error in the statement of the case has been discovered. The supplement statement of the case will be so designated and will be limited to essential changes or additions to sections of the original statement adequate to give complete information to the claimant. The prior statement will not be repeated. The claimant will be informed that the supplemental statement of the case amplifies the statement of the case of prior date. FL 1-28 will be used in transmitting a supplemental statement of the case.

G. When VA Form I-9 has been returned by the claimant, the Adjudication Officer of the regional office having jurisdiction of the claim will be informed that a substantive appeal has been received.

H. After review of the substantive appeal, the case will be certified to the Board of Veterans Appeals utilizing a VA Form 1-8, Certification of Appeal. The form shall not be signed until:

1. The questions(s) involved in the appeal are accurately determined.

2. An opportunity to make a personal appearance has been accorded, if requested, and a complete transcript of the record, when a hearing has been held, is in the file.

3. A completed FL 1-646, Statement of Accredited Representative in Appealed Case, is of record when there is a valid appointment of an accredited service organization, or, if the form has not been executed, the fact that the representative has been given an opportunity to make a presentation in support of the appeal is shown by correspondence in file or notation on VA Form 1-8.

4. A statement of the case has been furnished.

I. FL 1-26 will be used to advise the claimant that the appeal has been certified to BVA (Board of Veterans Appeals). A copy of the FL 1-26 will be given to the accredited service representative. The Adjudication Officer of the regional office having jurisdiction of the claim will be informed that the appeal has been certified.

j. The Adjudication Officer will advise the health care facility when the appeal complete with medical records should be sent to the regional office for attachment of the C-folder and forwarding to BVA.

K. If the claimant requests a hearing at the health care facility, one shall be afforded to the claimant at anytime during the appeal process prior to certification of the appeal to the BVA. If a hearing is requested, it will be scheduled and accomplished within 30 days of receipt of such request. The claimant and witnesses will be allowed to present their testimony under oath. The proceedings will be recorded. The copies of the transcript will be given to claimants and accredited service representatives within 15 days of the hearing. The original transcript will be appended to the appeal.

L. The service organization representative will be given an opportunity to execute a VA Form 1-646 immediately prior to certification of appeal in the following instances:

1. A hearing was not conducted.

2. A hearing was conducted in which a representative of the service organization did not participate.

3. Additional evidence is submitted subsequent to execution of VA Form 1-646.

4. Development in remanded cases is completed.

5. Unusual circumstances indicate that the representative should have an opportunity to make a presentation to protect the interests of the claimant.

6. Additional evidence is submitted during or subsequent to the hearing.

M. Remand cases will be processed in the same manner and within the same time constraints as an original appeal.

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

Change 16

M-1, Part I
Chapter 1

February 5, 1992

1. Transmitted is a change to Department of Veterans Affairs, Veterans Health Administration Manual M-1, "Operations," Part I, "Medical Administration Activities," Chapter 1, "Management and Operational Activities." Brackets have been used to indicate the changes.

2. Principal changes are:

a. Paragraph 1.77 c: Amended to read "Executive Committee of the Medical Staff. The functions of this committee (JCAHO requirement) in VA medical centers may be accomplished by the CEB (Clinical Executive Board) or some other committee appropriately constituted to meet JCAHO requirements. When the executive committee of the medical staff is other than the CEB, the mandatory reviews and functions outlined in paragraphs 1.78 b. and 1.79 will be realigned to meet JCAHO requirements for the executive committee of the medical staff."

b. Paragraph 1.78 a: Second sentence amended to read "The guidelines for the bylaws will be M-1, pt.I, ch.26, Appendix A, Bylaws and Rules of the Medical Staff."

c. All references to JCAH are updated to JCAHO (Joint Commission on Accreditation of Healthcare Organizations). All references to DM&S are updated to VHA (Veterans Health Administration).

3. Filing Instructions

Remove pages

Insert pages

1-19 through 1-20

1-19 through 1-20a

James W. Holsinger, Jr., M.D.
Chief Medical Director

Distribution: RPC: 1103
FD

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Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

M-1, Part I
Change 17

Chapter 1

July 14, 1992

1. Transmitted is a change to Department of Veterans Affairs, Veterans Health Administration Manual M-1, "Operations," Part I, "Medical Administration Activities," Chapter 1, "Management and Operation Activities. Brackets have not been used to indicate changes.

2. Principal changes are editorial and the adding of subparagraph d to paragraph 1.123:

"d. The local Chief, A&MMS (Acquisition and Materiel Management Service), will review all proposed VA/DOD Sharing Agreements. The local Chief, A&MMS, shall review contractual language in the agreement, as well as any impact that the proposed agreement would have on A&MM operations."

3. Filing Instructions

Remove Pages

Insert Pages

1-31 through 1-32

1-31 through 1-32a

(Signed 7/14/92
by John T. Farrar, M.D.
for

James W. Holsinger, Jr., M.D.
Chief Medical Director

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