

CHAPTER 15. CHARGES AND PAYMENTS FOR MEDICAL CARE

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RESCISSIONS

The following material is rescinded. (Material on billing or reimbursement rates may be retained for historical and other purposes such as development of delinquent billing cases.)

1. COMPLETE RESCISSIONS

a. **Manuals**

Chapter 15, M-1, part 1, dated July 14,1971, and changes I through 10.

b.**DM&S Circulars**

10-71-159
10-76-22
10-78-197
10-72-17
10-76-159
10-82-40 change I
10-73-171
10-77-13710-8360
10-74-177
10-78-199
10-83-147
10-75-166
10-81-181

c.**Interim Issues**

10-73-33
10-81-1
10-76-28
10-81-22
10-77-30
10-81-36
10-77-31
10-81-57
10-77-40
10-82-2
10-77-44
10-82-5
10-77-54
10-82-8
10-79-25
10-82-13
10-79-36
10-82-35
10-79-44
10-82-56
10-80-8
10-83-1 by change 1
10-80-29
10-80-60

CHAPTER 15. CHARGES AND PAYMENTS FOR MEDICAL CARE**SECTION 1. GENERAL****15.01 SCOPE**

- a. The Federal Medical Care (Cost) Recovery Act, Public Law 87-693, 42. U.S.C. 2651-2653, provides statutory authority for recovery of the reasonable cost of medical care provided at Government facilities or at Government expense when the patient was entitled to such care at another person's expense because of that person's negligence or legal wrong.
- b. Public Law 97-72, 38 U.S.C. 629, provides statutory authority for recovery of the cost of care and services furnished for a nonservice-connected disability that was incurred incident to a veteran's employment where the disability is covered under a workers' compensation law or plan that provides for reimbursement or indemnification for the cost of health care and services, or that is the result of a motor vehicle accident which occurs in a State that has an automobile accident reparations statute (NoFault Law) or that is the result of a crime of personal violence in a State or a political subdivision thereof in which a person so injured is entitled to health care and services at the State's or political subdivision's expense. The United States is subrogated to any rights to recover such costs that the veteran has and may intervene in any action brought by the veteran or file suit independently.
- c. Public Law 97-174, 38 U.S.C. 501 1, authorizes the Veterans Administration and Department of Defense to enter into negotiated agreements at the facility level to provide medical care to identified primary beneficiaries in their respective medical facilities at rates to be negotiated locally. During a period of war or national emergency, the VA may also contract with private facilities for hospital care and medical services for certain veterans.
- d. The Economy Act of June 30, 1932, as amended (31 U.S.C. 686) established authority for Federal agencies to enter into interagency agreements for materials, supplies, equipment, work or services. It is the policy of the VA to furnish VA support services to other Federal departments or agencies when it is determined to be in the interest of the Government to do so, and provided the services are within the capabilities of the VA and will not adversely affect the care and treatment of VA beneficiaries. Guidelines for preparing interagency cross-servicing support agreements are in MP-2, part 108-77, subpart 108-77.1.
- e. Under the provisions of Section 607(a) of the Foreign Assistance Act of 1961, as amended, 22 U.S.C. 2357, the Agency for International Development may request medical care at VA facilities for beneficiaries of friendly developing countries. Specific agreements negotiated with the assistance of the Director of the Agency for International Development specify a defined reimbursement methodology using the actual per them rate of the VA facility providing the service.
- f. VA Regulations 6062 (A) through (H) and 6048(D) provide regulatory authority for recovery of the reasonable cost of medical care provided to specified categories of individuals at VA health care facilities.
- g. This chapter contains the billing procedures and the charges for medical care and services provided by the VA when charges are required by statute or by regulation. It also contains vouchering procedures and rates payable for authorized medical care obtained for VA beneficiaries from other Federal facilities.

15.02 POLICY

- a. Charges at current interagency rates established or negotiated by the VA will be made for medical care and/or related services furnished:
- (1) Active duty personnel of the uniformed services.
 - (2) Military retirees not entitled to such care as VA beneficiaries.
 - (3) Beneficiaries of other Federal agencies, including Federal employees for work-incurred injuries or diseases when authorized by the Office of Workers' Compensation Programs, Department of Labor.

b. Charges at rates determined and established by OMB (Office of Management and Budget) for tort cases or by the Administrator for all others, will be made for medical care and/or related services furnished:

- (1) Persons for injuries or diseases resulting from the negligence or tortious actions of third persons for which the VA has the specific right to recover reasonable costs.
- (2) Veterans for non-service-connected disabilities to the extent that insurance carriers or employers are or will become liable.
- (3) Non-service-connected veterans for injuries or diseases incurred or aggravated during the course of and/or resulting from their employment for which the employer is obligated to pay under "workers' compensation," "employer's liability" or other State or Federal statute such as the U.S. Longshoremen's and Harbor Workers' Compensation Act.
- (4) Veterans for non-service-connected disabilities when entitlement exists for medical care or reimbursement for all or part of the cost thereof by reason of medical care insurance coverage or participation in a health plan such as an HMO (Health Maintenance Organization),
- (5) Veterans for service-connected disabilities when it is medically determined that reinjury or aggravation of the service-connected disability is due to a compensable occupational injury or disease or the negligence or other legal wrong of a third person.
- (6) Persons for injuries resulting from a motor vehicle accident when payment is collectible from the medical payment coverage or personal injury protection coverage of an automobile insurance policy, from uninsured motorists' coverage on an automobile insurance policy, or from the Uninsured Motorists' Fund in those States having Uninsured Motorists' Laws, or from "no-fault" automobile insurance policies.
- (7) Persons entitled to receive health care and services at the expense of a State or subdivision for personal injuries suffered as a result of a crime of personal violence.
- (8) Persons provided emergency humanitarian care who have no eligibility as veterans.
- (9) Persons admitted or accepted for care as veterans but subsequently found to be ineligible as veterans.
- (10) Ineligible veterans furnished readjustment counseling at Operations Outreach Vet Centers or readjustment counseling services at Vet Centers or readjustment counseling or mental health services by contract providers. (*delete & insert by change 1.*)
- (11) VA employees and members of their families residing on VA installations when they cannot obtain emergency treatment from private sources and who have no eligibility as veterans.
- (12) Allied beneficiaries (see ch. 24). If the allied Government declines responsibility, the allied veteran will be billed.

c. Charges for -service and medical supplies (*medical care by change 1*) procured from non-VA sources will be billed at the rates charged the VA.

15.03

INTERNAL CONTROLS

a. Each health care facility will establish an ongoing medical care cost recovery program which will include, as a minimum:

- (1) A policy directive explaining the medical care cost recovery program, defining potentially collectible cases and assigning responsibility for identifying recoverable cases.
- (2) Procedural guidelines for employees whose duties include identifying collection cases and/or initiating billing actions.

- (3) Formalized orientation and training for clinical and administrative personnel to assure their awareness of the potential for recovery in certain types of cases and of employees' responsibility for identifying appropriate cases at any point in the application, examination and treatment phases as well as during medical record processing.
 - (4) Control mechanisms to assure that all medical records with "E" code diagnoses are reviewed to identify potential cases requiring cost recovery actions, that all appropriate collection actions are or have been initiated and that required billing actions are prepared promptly and periodically as appropriate.
 - (5) An annual systematic review to evaluate the effectiveness of the program, identify deficiencies for corrective action, and document program accomplishments. Any downward trend in the number of collection cases identified or acted on should be analyzed to determine the reasons for decreased activity.
- b. Public Law 97-72 establishes that the rights of the United States shall be subrogated to any right or claim of the veteran or the veteran's estate in obtaining reimbursement for the costs of health care and services provided for non-service-connected disabilities incurred incident to a veteran's employment, as a result of a motor vehicle accident covered by no-fault automobile insurance coverage, or as the result of a crime of personal violence in those States or political subdivisions thereof which authorize payment or reimbursement for such health care and services. Legal action may be initiated by the United States if acknowledgment of the claim or reimbursement has not been received (partial or total) within 180 days after the 1st day on which care and services were furnished to the veteran. Therefore, key elements in establishing a legal claim for reimbursement are timely identification and prompt billing of recoverable cases.
- c. The Billing activity in MAS will maintain an accounting record of active and pending cases for quarterly reconciliation with Fiscal Service.

15.04 RECONCILIATION

Quarterly, as of December 31, March 31, June 30 and September 30, Medical Administration Service and Fiscal Service will reconcile the outstanding statements of charges. Mutually agreeable procedures will be developed at each facility to provide an accurate record of all collection actions pending and completed. (See MP-4, pt. 1, ch. 5.)

15.05 AMIS REPORT REQUIREMENTS

MP-6, part VI, supplement No. 1.2, chapters 19 and 21 require submission of the following:

- a. **Monthly:** VA Form 10-7400-7 (AMIS), Special Program Data for VA Hospitals, Segment 358.
- b. **Quarterly:** VA Form 10-7457 (AMIS), MAS Code Sheet, Medical Care Cost Recovery Program, Segment 291.

SECTION 11. RECOVERY OF COSTS FOR MEDICAL CARE

15.06 IDENTIFYING POTENTIAL LIABILITY

Medical Administration Service has the primary responsibility for identifying applicants for whom statements of charges must be prepared, including:

- a. Those who have incurred injury or disease as a result of negligence or legal wrong of a third party (tort-feasor).
- b. Those who have incurred injury or disease attributed to their employment (workers' compensation).
- c. Those entitled to payment for the costs of hospital or nursing home care and/or medical services by reason of membership a union, group plan or any form of health plan or those who are eligible under any contractual or statutory insurance plan providing for payment or reimbursement for medical care. Included under this category are those entitled to medical care under the medical payment coverage, personal injury protection coverage or uninsured motorists' coverage clauses of auto insurance policies; the medical payment coverage clause of a homeowner's or tenant's insurance policy; the Uninsured Motorists' Law or No-Fault Law of an individual State; or under a crime of personal violence statute in those States or political subdivisions thereof adopted compensation to victims of crimes acts. (*deleted by change 1*)

15.07 COOPERATION WITH OTHER FEDERAL AGENCIES

a. The agency accepting primary responsibility for the patient as a beneficiary is responsible for taking recovery action. Since the Federal Medical Care Recovery Act, Public Law 87-693, 42 U.S.C. 2651-2653, applies to all Federal agencies, the VA may be asked to assist another agency in effecting recoveries. Conversely, the VA will be responsible for initiating medical care cost recovery action for a veteran admitted as a VA beneficiary to another Federal hospital when third party involvement is indicated including action under Public Law 97-72, 38 U.S.C. 629.

b. Medical Administration Service will notify any other Federal agency of possible claims for reimbursement when the VA is providing medical care to patients at the expense of that Federal agency. The patient will be requested to complete VA Form 10-1023, Information Regarding Possible Claim Against Third Party, when it is possible that the United States may be entitled to reimbursement for the cost of medical care furnished. The completed VA Form 10-1023 (a duplicate copy will be filed in the consolidated health record) will be forwarded promptly to the appropriate agency or service department nearest to the VA facility's location, as indicated below:

Army-Commanding General of the Army area.

Navy-District Legal Officer in the Naval District.

Air Force-Staff Judge Advocate of the nearest Air Force installation.

Public Health Service-Regional Attorney, Office of General Counsel.

DHHS (Department of Health and Human Services) having regional jurisdiction of the State in which the VA facility is located.

Other Federal Agency-The office forwarding the authorization for medical care.

c. There will be instances when referrals will be made to a VA facility by OCHAMPUS (Office of Civilian Health and Medical Program of the Uniformed Services) or the CHAMPUS fiscal intermediary to effect recovery action. The VA facility which approved CHAMPVA (Civilian Health and Medical Program of the VA care for the veteran's spouse, survivor or dependent beneficiary is also responsible for taking medical care cost recovery action when indicated. The fiscal intermediaries, as CHAMPUS contractors, are responsible for identifying medical care cost recovery cases. The VA facility processing a medical care cost recovery claim will take initial action in requesting the provider to prepare and submit relevant supporting information (DA Form 1863-5). The fiscal intermediary will forward to the responsible VA facility the completed DA Form 1863-5 and the "PAID" copy of the hospitalization claim, DA Form 1863-1. A statement of charges together with documentation supporting the VA claim will be forwarded by the VA health care facility to the appropriate District Counsel of the regional office of jurisdiction. When remittances are received by the District Counsel, in settlement of medical care cost recovery claims, they will be forwarded to the agent cashier of the VA facility where charges originated.

15.08 ASSIGNMENT OF CLAIM

a. VA Form 10-1023, Information Regarding Possible Claim Against Third Party, will be prepared when circumstances leading to the need for treatment indicate a possible claim by the VA or another Federal agency relating to employment (workers' compensation), to the negligence or legal wrong of a third party (tort-feasor), to liability under a State Uninsured Motorists' Law, No-Fault Law or State or local Victim of Violent Crime Law, or under a contractual obligation to pay or reimburse the cost of medical care such as under the "medical payment" coverage clause of certain insurance policies.

(1) The VA Form 10-1023 should always be prepared promptly, to the extent that information is available. Even an incomplete VA Form 10-1023 should be sent to the VA District Counsel or to the other Federal agency as soon as possible to alert those offices of the potential claim.

(2) Normally, the original of the VA Form 10-1023 will be filed in the administrative file of the CHR (consolidated health record). When the original is forwarded to another Federal agency responsible for initiating a claim (par. 15.07b), a copy will be retained in the CHR.

b. When the VA has primary responsibility for possible cost recovery action, the following forms will be prepared in triplicate and signed by the applicant prior to admission or at such time thereafter when information relative to a potential claim becomes known.

(1) VA Form 24763, Power of Attorney and Assignment, will be used for tort-feasor claims when there is a possibility of a cause of action against a third party. The employee obtaining the patient's signature on the form is responsible for instructing the patient to read the information on the reverse of the document and for insuring that the address of the appropriate District Counsel is recorded on the reverse of the form.

(2) VA Form 10-2381, Power of Attorney and Agreement, will be used for all workers' compensation or reimbursable insurance and crimes of personal violence claims.

(3) The original of each form will be filed in the CHR, one copy will be forwarded promptly to the District Counsel, and one copy must always be given to the patient or his/her designee.

(4) When, at the time of admission, it is not clear whether the potential claim is against a tort-feasor or an employer or against an insurance plan (whether contractual or statutory), both the VA Form 2-4763, Power of Attorney and Assignment, and VA Form 10-2381, Power of Attorney and Agreement, will be completed.

(5) When the appropriate power of attorney cannot be obtained because of the patient's emergent condition, it will be obtained as soon as his/her condition permits.

15.09 DUAL COVERAGE

A patient may have a claim or cause of action under one or more types of coverage. Appropriate assignment(s), as defined in paragraph 15.08, will be obtained for each type of potential claim. Cases of possible dual coverage will be referred to the District Counsel for advice and guidance in processing billing actions.

15.10 REFUSAL TO ASSIGN CLAIM

a. An applicant as described in paragraph 15.02b who is otherwise eligible for medical care under 38 U.S.C. ch. 17 who refuses to assign a claim or cause of action to the VA will be advised that billings will be prepared for the cost of medical care and that his/her employer or insurance carrier, or other appropriate third party will be billed for the cost of care pursuant to the provisions of the Medical Care Recovery Act and/or 38 U.S.C. 629.

b. Under circumstances defined in paragraph 15.02b, a cause of action and assignment of claim may be established without obtaining the veteran's signature on VA Form 2-4763 or 10-2381. The record will be annotated with the reasons why the veteran refused to sign or could not sign the assignment of claim. A copy of this annotation, with supporting information about the possible claim, will be forwarded promptly to the District Counsel.

15.11 EXCLUSIONS

a. A power of attorney will not be obtained in the following instances:

(1) A medical/health insurance policy specifically excludes coverage and reimbursement for medical care and services provided in a Government facility. Copies of such insurance policies will be referred to the District Counsel for a legal opinion on their coverage.

(2) The District Counsel advises against requesting the power of attorney based on other considerations in the case. If the legal opinion is given by telephone, a VA Form 1 19, Report of Contact, will be prepared and placed in the CHR.

(3) A person is receiving authorized hospital care at the request of another agency of the Federal Government. This does not preclude obtaining the patient's signature on that agency's power of attorney form upon request.

(4) The veteran has no other coverage or reimbursement entitlement other than supplementary health coverage which provides: monetary benefits irrespective of the medical and hospital costs incurred; indemnity for time lost from work; payment of mortgage; or payments for other indebtedness such as those covered by credit insurance policies.

b. Non-service-connected veterans under age 65, who are not in receipt of VA pension, not entitled to State Medicaid benefits, not former prisoners of war, not furnished medical care for a condition possibly related to exposure to dioxins or ionizing radiation on active duty and who are furnished emergency medical care without affirming on VA Form 10-10 their inability to defray the expenses of necessary medical care and nonveterans furnished medical care on a humanitarian emergency basis will be billed for such care irrespective of whether or not they have health care insurance coverage. If they have such coverage, it is their responsibility to file a claim for reimbursement with the insurance carrier. The VA health care facility will provide medical information and justification for emergency treatment to the insurance carrier following receipt of a request and signed authorization from the claimant. Payment to the VA shall not be contingent on the claimant's ability to obtain reimbursement.

c. Persons provided medical care on the erroneous presumption that they were eligible veterans will be billed for such care. For those who are entitled to Medicare, Public Law 95-142 permits direct reimbursement to the VA by Medicare for covered inpatient services, excluding custodial care, provided to an ineligible veteran Medicare beneficiary where services were furnished in good faith under the assumption the beneficiary was an eligible veteran. Medicare reimbursement is limited to payment for covered services provided until the date the hospital became aware that the patient was not an eligible veteran, or, if later, the date it was medically feasible to discharge or transfer the patient to a Medicare participating hospital. Medicare will be billed for services rendered. Any costs denied by Medicare will be billed to the ineligible person.

15.12 REVIEW OF ADMISSION ENTITLEMENT

When an employer or insurance carrier has acknowledged responsibility in writing for required treatment, a patient provided medical care under VA Regulation 6047(D) will be requested to review his/her statement of inability to defray the necessary costs of medical care. Medical Administration Service will inform the patient of the requirement to arrange for necessary treatment elsewhere when medically feasible and will assist the patient in making such arrangements. Veterans who refuse to transfer to a community hospital or nursing home will be advised that they will be involuntarily discharged because they can no longer be provided care and that their employer or insurance carrier will be billed for the cost of their care up until they can be removed. Referrals for collections, addressed to the appropriate District Counsel, will include a copy of the application (VA Form 10-10), pertinent counseling notes and copies of any evidence establishing entitlement to treatment elsewhere and the subsequent lack of eligibility for care at VA expense.

15.13 STATEMENTS OF CHARGES

a. Billings to other Federal agencies will be prepared on forms designated in section IV.

b. Billings to third party payers or individuals will be prepared on VA Form 10-9014, Statement of Charges for Medical Care, except:

(1) Billings to Workers' State Compensation Offices which require specific State forms will be prepared on the required State forms.

(2) Medicare billings will be prepared on HCFA-1453, Inpatient Hospital and Skilled Nursing Facility Admission and Billing, for inpatient services and HCFA-1483, Provider Billing for Medical and Other Health Services, for outpatient services including medical supplies. Separate billing forms and (are by chg. 1) required for inpatient and outpatient services because of distinct benefit entitlements under part A and part B of Medicare. Additional forms are required to accompany billings for ESRD (End Stage Renal Disease) services performed under an approved sharing agreement when billings are sent by the VA directly to the Health Care Financing Administration of the Department of Health and Human Services.

c. Billings will be forwarded through Fiscal Service as noted below. In all cases, a complete copy of the billing and forwarding document will be retained and filed in the CHR.

(1) Billings for tort-feasor and workers' compensation cases and those to State or local Government offices under uninsured motorist, "no-fault," or victims of violent crimes statutes, will be forwarded to the District Counsel of jurisdiction by VA Form 3230, Reference Slip.

(2) Other reimbursable insurance billings will be forwarded to the insurance carrier or group plan manager, as appropriate.

(3) Medicare billings will be forwarded to the Bureau of Support Services, Office of Direct Reimbursement, DHHS.

(4) Billings to ineligible persons or those provided emergency humanitarian care will normally be forwarded to the individual except in the case of a minor when the billing will be forwarded to a parent or legal guardian.

d. Patient diagnoses relating to Conditions or disabilities for which third parties are not liable will be excluded from the billing document. Charges will not be made for any additional length of stay attributable to treatment related to such conditions or disabilities.

e. **Charges and Reimbursement Rates Are in Appendixes 15A Through 15H.** Appendix 15B gives instructions for completing VA Form 10-9014, Statement of Charges for Medical Care.

15.14 SPECIALIZED MEDICAL SERVICES

a. The charge for hemodialysis services furnished is the inpatient per them rate in addition to the hemodialysis rate (app. 15A or 15D, as applicable) except for tort-feasor cases. Tort-feasor cases receiving hemodialysis services will be billed at the authorized inpatient per them rate only (app. 15A). Medicare considers maintenance dialysis as an outpatient service. When billing Medicare for maintenance dialysis provided to a nonveteran (except under provisions of subpar. b), the charge is the current interagency rate for an outpatient visit plus the charge for the hospital component of the hemodialysis service (app. 15D).

b. Selected VA medical centers with approved sharing agreements for providing hemodialysis and other ESRD (End Stage Renal Disease) services to nonveteran Medicare beneficiaries receive specific billing instructions and reimbursement rates applicable to such services. (*App. 15I*) by *chg. 1*

c. Charges for specialized diagnostic procedures and medical care purchased by the VA from other Government or private facilities will be billed at the actual amount paid by the VA.

SECTION III. PROCEDURES TO EFFECT RECOVERY

15.15 TORT-FEASOR

Establishment of Claim Medical Care Provided Reimbursement Rates

Copies of VA Forms 10-123 and 2-4763 (if obtained) Hospital, nursing home, or outpatient Appendix 15A will be forwarded promptly to the District Counsel at care furnished to veterans for examination the regional office of jurisdiction. Other related information or treatment of disabilities resulting from negligence or legal wrong of a third party will also be submitted to that office. The District Counsel third party

will be responsible for notifying the third party of the assignment of claim or cause of action, when indicated.

Billings will be prepared on VA Form 10-9014, Statement of Charges for Medical Care, unless the District Counsel advises that a claim or cause of action does not exist. Instructions for completing VA Form 10-9014 are in appendix 15B. Billings will be transmitted to the District Counsel through Fiscal Service for forwarding to the third party immediately following termination

of medical care lasting 30 days or less. When medical care continues beyond 30 days, VA Form 10-9014 will be prepared and submitted to the District Counsel at the end of each month and/or until care is terminated, unless instructed otherwise by the District Counsel.

15.16

WORKERS' COMPENSATION

Establishment of Claim

Medical Care Provided

Reimbursement Rates

FL 10-98 will be used by MAS to promptly notify the Hospital, nursing home or outpatient employer when a veteran attributes the need for medical care furnished to veterans for injury care to employment. Copies of VA Forms 10-2381 and/or disease resulting or allegedly resulting from their employment. 10-1023 and a copy of FL 10-98 will be forwarded to the District Counsel. Notify the District Counsel if veteran refuses to assign claim to the VA.

- a. On receipt of notice that an insurance carrier has either a workers' compensation insurance or employer's liability insurance policy covering the patient's employer, the VA facility will furnish reasonable reports on the patient's condition as may be required by the carrier or to conform with applicable workers' compensation laws.
- b. Billings will be prepared on VA Form 10-9014 and will show charges for care provided for only those conditions for which employers or insurance carriers are presumably liable. Use same billing procedures as for tort-feasors. (See par. 15.15.) When reimbursement rates have been established for medical services related to workers' compensation claims by a State Industrial Accident Commission or comparable State authority, those rates will be used in preparing billings rather than the rates established by the VA.
- c. Instructions for processing Federal employee OWCP (Office of Workers' Compensation Program) claims are in paragraph 15.25e.
- d. Physicians representing workers' compensation or employer's liability insurance carriers or self-insured employers may examine a patient receiving treatment in a VA medical center in the presence of a VA physician at such times as may be mutually agreeable to both physicians.
- e. If testimony of a VA physician is required at a hearing before an official workers' compensation administrative or judicial body in connection with a claim in which the VA has a financial interest, the VA medical center will cooperate with the District Counsel in making such testimony available. The same cooperation will be extended when VA medical records are required for such hearings.

f. The District Counsel, in coordination with the medical center or clinic Director, will try to reconcile disagreements which may arise between workers' compensation insurance carriers or employers and VA facilities as to the amounts charged. If they are not reconcilable locally, the District Counsel will refer the matter to the office of the General Counsel (02JB) for resolution. Within these basic policies, Directors, in coordination with District Counsels, are authorized to deviate from these procedures when necessary to meet requirements of individual State workers' compensation or employer's liability statutes or practices.

15.17

REIMBURSABLE INSURANCE (Including Uninsured Motorists')

Establishment of Claim

Medical Care Provided

Reimbursement Rates

When power of attorney is obtained (see exclusions in Hospital, nursing home or outpatient Appendix 15A. care for which insurance carriers or group plan are or will become liable. par. 15.1 la), Medical Administration Service will promptly notify the insurance carrier or group plan manager of the veteran's admission by use of FL 10-310 or FL 10-98 with an attached signed copy of VA Form 10-2381 or VA Form 10-1023.

15-8

15.li d. EffeLtive immediately, eacli VA medical facility will attach to each reimbursable insurance billing statement (UB-82) going to an insurer whose coverage is known

December 9, 1982 or suspected bo be a supplement to Medicare, a copy of the HCFA **M-1,PartI** letter addressed to the Deputy Assistant General Counsel dated **Chapter 15** July 20, 1988. Bills previously denied by Medicare supplemental

carriers on the basis that Medicare was not billed will be resubmitted with a. If the insurance carrier or group plan manager disclaims liability for payment or reimbursement, all information pertinent

to the claim will be referred to the District Counsel of jurisdiction for a decision on further action. When the District Counsel determines collection action will not be pursued, Fiscal Service will be notified to cancel bills already prepared. A copy of the District Counsel's decision (correspondence or VA Form 1 19, Report of Contact) will be filed in the CHR.

b. Prepare billings on VA Form 10-9014. The completed VA form 10-9014 will be sent to the insurance carrier or group plan

manager through Fiscal Service. Statements will be prepared at the end of the first month when medical care was provided and **rt rt** each subsequent month until medical care is terminated unless advised otherwise by the District Counsel.

c.**Notice of Collection Received.** Payment by the insurance carrier or group plan of an amount which is claimed to be the full amount under the terms of the applicable insurance policy or other agreement normally will be accepted as discharging the obligation, However, if there is a considerable difference between the amount collected and the amount billed, the Chief of Medical Administration Service will request advice and guidance from the District Counsel on whether additional monies are

rt rt

collectible. When the District Counsel advises that further collection action is warranted, a supplemental bill will be processed in the same manner as the original bill. Notice of collections which certify payment in part or payment in full will be filed in the CHR.

rt

15.18

NO-FAULT INSURANCE

**Establishment of Claim
Medical Care Reimbursement Rates**

When Hospital, power of nursing attorney home is or obtained on outpatient Appendix 15A. care for which insurance VA Form 10-2381, promptly notify the carriers are insurance carrier of the veteran's admis- or will become liable. sion by use of FL 10-310 with an attached signed copy of VA Form

10-L381. When power of attorney is not obtained, forward a copy of VA Form

15-10

10-1023 to the District Counsel.

a. Billings will be prepared on VA Form 10-9014. The complete VA Form 10-9014 will be sent through Fiscal Service to the insurance carrier or State or local agency named by State statute or local ordinance to process such claims. Statements will be prepared at the end of the first month and each subsequent month until medical care is terminated unless advised otherwise by the District Counsel.

b. State statutes or insurance policies may limit no-fault benefits to a specific monetary amount. When VA charges for medical care exceed the statutory or contract monetary benefit, advice of the District Counsel will be requested concerning the need for preparation of additional bills.

15.19

CRIMES OF PERSONAL VIOLENCE

**Establishment
Medical**

**of
Care**

**Claim
Provided
Reimbursement Rates**

When Hospital, power nursing of home attorney or is obtained, outpatient Appendix 15A. forward a copy to the District Counsel care furnished a veteran who is a victim with a Reference Slip, VA Form 3230, of a crime of personal violence. giving specific details on veteran's admission. When power of attorney is not obtained, forward a copy of VA Form 10-1023 to the District Counsel.

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a. Billings will be prepared on VA Form 10-9014 with item I I indicating the State or local agency named by State statutes or local ordinances to process such claims (obtain the proper address from District Counsel if not readily available). Statements will be prepared at the end of the first month when medical care was provided and each subsequent month until medical care is terminated unless advised otherwise by the District Counsel.

b. Billings will be forwarded through Fiscal Service to District Counsel with an explanatory VA Form 3230, Reference Slip.

c. Normally, when the State agency considers such a claim, the veteran must appear before a designated State or local board.

The veteran's signed consent to release medical data should be obtained prior to termination of medical care to assist the veteran in pursuing his/her claim. Consent of the veteran is not necessary, however, to release medical data to support the VA's interest in such a claim. (See 38 U.S.C. 3301(b)(6).)

15.20

EMERGENCY MEDICAL CARE

a.

Humanitarian

15-11

Emergency Treatment Provided

Emergency humanitarian services to:

Nonveteran

Ineligible person (Individual admitted to care on presumed entitlement and later found ineligible for medical care or readjustment counseling as a veteran.)

VA employees and members of their families residing on VA installations who cannot feasibly obtain care from private facilities (not receiving care as beneficiaries of the VA, OWCP, or other Federal agency).

Medical Care Provided

Emergency hospitalization and emergency outpatient treatment when furnished under:

VA Regulations 6046(C)(1) and 6060.2

VA Regulations 6046(C)(2) and 6060.2

VA Regulations 6046(C)(3) and 6060.2

Reimbursement Rates

Appendix 15A or as noted in subparagraphs below.

(1)VA Form 10-9014 will be prepared promptly on completion of care and submitted through Fiscal Service to the person who received the care. When a minor is provided emergency medical care, the billing will be forwarded to a parent or legal guardian.

(2)Persons who received medical care at VA expense at non-VA health care facilities as a result of presumed entitlement and who are subsequently found to have been ineligible will be billed at the rates paid by the VA for such medical care,

(3)Persons who received readjustment counseling services and were later found ineligible for such counseling will be billed at the outpatient rate for each day of counseling services. Billings on VA Form 10-9014 will be prepared by the vet center. A copy of the billing will be sent to the Chief, Medical Administration Service at the vet center's support facility for control and reconciliation of billing actions. The vet center will coordinate all billing actions with the Chiefs of Medical Administration and Fiscal Services at the parent facility.

(4)When billing has been made for a veteran found ineligible for VA medical care benefits because of the character of discharge and subsequent notice is received that the character of discharge has been modified so that it is no longer a bar to entitlement, outstanding billings will be canceled or withdrawn. When payment had been received by the VA, a refund will be made.

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en the VA provides medical care to an ineligible person wi

ry and the services were provii

on the mistaken assumption that the person was an eligible veteran, Public Law 95-142 authorizes Medicare reim
VA. Services provided will be reimbursed by Medicare through the day the VA medical facility was inform(
s not an eligible veteran or the day it was medically feasible to discharge or transfer the patient to a Medicare part

(a)Billings must be submitted within 6 months using the ratesin appendix 15D. The Health Care Financing
Administration will be billed for the total cost of care; the patient will not be billed for deductibles or coinsurance.
Therefore, the breakdown of rates and charges in appendix 1 SE do not apply to such billings.

(b)Billings will be prepared on HCFA Form 1453 and the entry, "Section 1814(i) claim" will be shown in item 30.
Attach a statement indicating the date the medical facility was made aware of the patient's ineligibility as a veteran.
When the patient could not be transferred or discharged for medical reasons on the day the VA was informed the person
was an ineligible veteran, a copy of the pertinent medical records or discharge summary will also be attached to the
billing. AD Public Law 95-142 claims will be submitted to:

/13ureau of Support Service
Office of Direct Health Care Financing Administration Reimbursemen
ATTN: Unit I Division of Accounting 34
P.O. Box 17255

P.O. Box 990 Baltimore, MD 21203-7255

(This chan@e of address will be effective on 7-2-84.) -per II 10-84-16

(6)The Office of Workers' Compensation Programs accepts responsibility for payment of medical care costs up to the
date of disallowance for potential beneficiaries of that office pending adjudication of their claims. On receipt of notice of
disallowance from that office, the patient, if legally eligible, will be provided medical care as a VA beneficiary or, if not
eligible, wiji be discharged on completion of emergency care and will be billed for medical care provided after the date
of disallowance.

(7)If a major disaster or emergency is declared, the VA may be reimbursed for medical care provided as a humanitarian
service in emergency relief assistance when such care is authorized and directed by the Office of Disaster Response and
Recovery, FEMA (Federal Emergency Management Agency). In other instances involving disaster assistance,
reimbursement will be sought from the recipients of such assistance or the requesting authority. (See app. 13A, DM&S
Supplement, MP-1, pt, 11, ch. 13; MP-1, pt. 11, ch. 13.) VA Form 10-9014 will be used when billing individual
recipients for emergency medical care unless other reimbursement arrangements have been made with the agency
authorizing the emergency medical care. A VA Form 10-9014 will normally be prepared for each person provided such
care.

b. Medicare

Emergency Medical Treatment Care Provided Reimbursement Rates

Medicare patients
Inpatient and outpatient care when
Appendix 15E.
furnished under VA Regulation

6046(C)(1) or 6060.2

*NOTE: Instructions for billing Medicare for services furnished an ineligible person on presumption of eligibility as a veteran when that person is a Medicare beneficiary are in **paragraph 15.20a(5)**.*

(1) Health Insurance for the Aged and Disabled, known as "Medicare," is a program of health insurance which assists most persons 65 years of age and older, certain persons under age 65 qualifying as disabled and those having chronic renal disease in defraying hospital, medical and other health expenses. The program includes two related health insurance programs: hospital insurance (pt. A) covers inpatient services and some posthospital care; voluntary supplementary medical insurance (pt. B) supplements the basic hospital insurance and covers outpatient services and some ancillary inpatient services.

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Care Financing Administration will be retained in the Charter
tion for proper

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(2) Deductible and Coinsurance. Under part A, each Medicare patient is responsible for a deductible amount for the first 60 days of inpatient care and coinsurance of one-fourth the per them rate for the 61st through the 90th day. If the patient then exercises the one-time right to use the 60 lifetime reserve days, the coinsurance is one-half of the per them rate for the additional 60 days. If the patient remains hospitalized beyond 90 days and decides not to use the lifetime reserve days, the patient is responsible for the total cost of inpatient days beyond 90 days. Under part B, covered patients are responsible for a yearly deductible and 20 percent of the charges for all other covered services.

(3) When a nonveteran Medicare beneficiary is admitted to a VA facility provided outpatient care, a notice of admission to care (HCFA Form 1453, Inpatient Hospital and Skilled Nursing Facility Admission and Billing, for inpatient services and/or HCFA Form 1483, Provider Billing for Medical and Other Health Services, for outpatient services) will be sent to the Health

HCFA Form 1568, Re to to to

(4) Medicare legislation requires that the patient's medical record contain a statement by a physician that emergency treatment was furnished, and, when inpatient care was provided, the date the emergency ended. The signature of the Chief, Medical Administration Service in item 29, HCFA 1453, or item 22, HCFA Form 1483, will be accepted by the Health Care Financing Administration as certification that such statement is on file. If the emergency ended before the patient was released from the medical facility, enter this fact in item 30 of HCFA Form 1453, e.g., "Emergency ended (date)."

(5) Billing. A single SF 1080 will be used to transmit one or more billings (HCFA Form 1453, Inpatient Hospital and Skilled Nursing Facility Admission and Billing, for inpatient services and/or HCFA Form 1483, Provider Billing for Medical and Other

H time. The "hospital covv" of HCFA Forms 1453 and/or 1483, as indicated,
n (f from the Health Care Financing Administration pr
nt could not sign item 15, HCFA I, Or 1 er 1483,
at time of billing and there is no representative to sign for the patient, the

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Chief, Medical Administration Service may sign the appropriate item as a hospital official and explain the circumstances in the remarks section of the appropriate form. The remaining copies of the billing form, with SF 1080 and supporting documentation,

will be forwarded to Fiscal submission to:

t-V

SupportService@-@@6

FIL)AIVCIIVC fi'OIT)@@@TIP6TIOIL,l

irect Reimbursemen@t 0 F cc- iD u 90

203

(6) Deductible an(to Medicare Beneficiaries. Tlfe patient will be billed on VA Form 10-9014

for any applicable deductible, coinsurance or noncovered charges at the same time that a billing is submitted to the Health Care Financing Administration. The hospital will usually be able to ascertain the proper amount to be charged to the patient under art Amounts billed to the patient will be entered on lines V, W, and X of HCFA Form 1453 regard-

them. Entries -in items 17E and 21, HCFA Form 1483. will refl

unts paid

FA Form 1568 will indicate whet]

et, or the patient is unable to su rmation,

ctible plus 20 percent of the outpatient charges and/or medical services in excess; dicates that the deductible has been met, the following statement will be placed on en billing for any portion of the part B deductible: "The charge for part B deductn and is subject to adjustment when official information is received from the t3 I P,'c) (@ @i F @ C-@d (-) /,-T/ 1?1-6- 6y 7-7

of any amount erroneously collected from the patient prior to the submission of 3) to HCFA will be made directly to the patient by HCFA and deducted from the s due to a patient will be made by the medical facility.

lyess aid

atient prior to submission c

een in

tle (deductible. Unless the HCFA 01 56 VA Form 10-9014 or the transm ible is an estimate, based on av, Health Care Financing Administr,,

(7) Refunds Due Medicare Patient4, the billings for part B services (HCFA 's reimbursement. Any other re

en the patient is coN

pa

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7

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c. Persons Attending National Conventions of VA Recognized Service Organizations

Emergency Treatment Provided

Persons attending national conventions of VA recognized service organizations who are not eligible for such care as VA beneficiaries.

15-15

Medical Care Provided

Emergency outpatient examination and treatment.

Reimbursement Rates

As stipulated in contractual agreement between the VA and such organizations.

(1)The contractual agreement will provide for recovery of the cost of providing emergency outpatient services to such individuals.

(2)On completion of the national convention, charges will be promptly prepared on VA Form 10-9014 and submitted through
Fiscal Service to the National Headquarters Office of the organization.

NOTE: The Assistant Deputy Administrator for Procurement and Supply provides guidance concerning the development and implementation of these agreements. However, all resulting contracts will be negotiated by Supply Service at the local facility.

15.21

MEDICAL SERVICES FURNISHED FOR RESEARCH PURPOSES

a. When medical services are furnished on an inpatient or outpatient basis as part of an approved research project to a person (veteran or nonveteran) purely for the research program and not as a part of approved medical care to an eligible veteran, the research appropriation must reimburse the medical care appropriation according to provisions of VA Regulation 6062(G) at the applicable rates in appendix 15A. Billing for services obtained from non-VA sources exclusively for research purposes (travel, special procedures, etc.) will be for the same amount charged the VA.

b. The Medical Administration Service Billing activity will submit a memorandum to Fiscal Service through the Chief of Staff requesting that the medical care appropriation be reimbursed from the research appropriation for the cost of medical services furnished solely for research purposes. The billing will indicate the name of the person provided services, social security number, dates of care, type of services, total cost, and the research project number to which the charges are to be allocated.

SECTION IV. BILLING FOR MEDICAL CARE FURNISHED BENEFICIARIES OF OTHER FEDERAL AGENCIES AND ALLIED BENEFICIARIES

15.22

USE OF VA MEDICAL FACILITIES

a. Under the provisions of 38 U.S.C. 501 1, as amended by Public Law 97-174, the "Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," VA and DOD facilities are authorized to enter into negotiated agreements which identify: each agency's primary beneficiaries; the types of care to be provided; and the reimbursement rate for those services. The negotiated agreements will be initiated and developed by the VA medical center (Supply Service) and the DOD facility directly involved and will be submitted to VA Central Office for approval,

b. VA medical facilities may also provide, on a reimbursable basis, authorized medical care and services for beneficiaries of other Federal agencies with which the VA medical facility has negotiated an interagency agreement under provisions of 31, U.S.C. 686, The Economy Act of 1932, as amended, and MP-2, part 108-77, subpart 108-77.1.

c. When a Federal agency requests infrequent services, i.e., outpatient examinations for an FBI agent, FAA controller, etc., and there is no approved interagency agreement, such services may be provided on a reimbursable basis with proper authorization from the requesting agency.

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d. Furnishing medical care or services to beneficiaries of other Federal agencies is contingent on the capability of existing staff to provide the care or services with available resources without interfering with the primary mission of providing medical care for eligible veterans.

15.23

CHARGES FOR CARE

a. A negotiated agreement with a DOD facility will specify charges for all services included in the agreement. In the absence of .
negotiated agreement, charges will be made at the appropriate current rates in appendix 15D.

b. Charges for services provided beneficiaries of a Federal agency will be prepared monthly, as appropriate, on plain bond paper in multiple billing format, except for OWCP beneficiaries. Each billing action will have a covering SF 1080, Voucher for Transfers Between Appropriations and/or Funds, or SF 1081, Voucher and Schedule of Withdrawals and Credits, as indicated in paragraph 15.24, reflecting the grand total of the multiple billings. When care was provided under a VA-DOD agreement, the agreement number will be shown on the covering document and billing will be processed as specified in the agreement. In the absence of an agreement, copies of the authorization or request for services will be attached to the SF 1080, as appropriate. Billings will be addressed to the appropriate agency as indicated in paragraph 15.25a and routed through Fiscal Service for dispatch to that agency.

c. Billings for OWCP claims will be prepared monthly, as appropriate, on VA Form 10-9014 and routed through Fiscal Service prior to dispatch to the appropriate regional OWCP Office. See paragraph 15.25e.

d. Billings to the military services must indicate the branch of uniformed service (i.e., a billing to Department of the Navy must indicate if the person is Navy or a Marine), social security number, whether on active duty or retired, rank or rating, outpatient care or inpatient care, dates of care, and the condition for which medical care was given.

e. Charges will be based on the type of care provided. For example, the NP (neuropsychiatric) inpatient rate will be used when psychiatric inpatient care is furnished at a GM&S (general medical and surgical) medical center; the GM&S inpatient rate will be used when medical or surgical inpatient care is furnished at an NP medical center. When inpatient care or outpatient treatment is rendered for drug dependency, the abbreviation DARP (Drug Abuse Rehabilitation Program) will be included following the person's name, and the GM&S rate will be used for such care furnished on an inpatient basis. (Such disclosure is authorized in 38 U.S.C. 3301(b)(3).)

15.24 TRAVEL COSTS

Travel incident to medical care for beneficiaries of other Federal agencies will not be provided at VA expense. Travel costs to and from a VA medical facility on transfer or discharge will be charged to the Federal agency authorizing medical care. Before transferring a military patient or retiree of the uniformed services, the known capabilities of nearby military medical facilities will be considered.

15.25

MEDICAL CARE FURNISHED OTHER FEDERAL AGENCIES

Federal Agency

a.

Department of Defense

(1)
in a negotiated agreement.

Primary beneficiaries as specified

(2) In the absence of a negotiated agreement, active duty military personnel of the Army, Navy or Air Force.

15-14

Medical Care

Inpatient and outpatient care or other medical services as specified in the agreement.

Inpatient or outpatient care in emergencies, or inpatient care or outpatient examination/treatment when authorized by appropriate officials of the respective military departments.

Reimbursement Rates

Use SF 1080 and negotiated agreement.

Use SF 1080 and appendix 15D.

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Federal Agency

(3) Inactive duty personnel of the uniformed services, including National Guard units.

by chg. In the absence of a
@4) **Send**

Medical Care

Reixnbursement Rates

Physical examination authorized by Use SF 1080 and appendix 15D. respective service departments.

The Commander

negotiated VA DOD sharir g U.S. Army Health Services Command agreement send billings to:

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Army
ATTN: HSC-CM

Fort Sam Houston, TX 78234

Navy
Chief, Bureau of Medicine and Surgery
Marines)
(Code 142)

(and

Department of the Navy

Washington, D.C. 20390

Air

Force
Department of the Air Force

Detachment 1, 76 ALD/ACFMCD

Bolling Air Force Base

Washington, D.C. 20332.

Billings for services performed under tfe terms or a negotiated VA-DOD sharing agreement should

be send directly to the military facility involved. by change 1 (5) Vouchers for services requested by an Armed Forces examining and entrance station or an Army treatment facility will be forwarded to the installation requesting/authorizing the service.

(6)Vouchers for physical examinations performed for prospective new members of the National Guard will be sent to the National Guard Headquarters of the appropriate State. Vouchers for authorized medical care to a current member of the National Guard, including vouchers for examinations in connection with medical care, will be forwarded to the Army or Air Force address

above.

**Federal
Medical**

**Agency
Care
Reimbursement Rates**

b. **Department** **of** **Transportation**
Inpatient or outpatient care and emer-
See SF 1081 and appendix 15D.

Active Military Personnel of gency dental treatment when authorized
Coast Guard by a responsible official of the Coast
Guard facility

Submit billings to the address shown on the Coast Guard authorization.

**Federal
Medical**

**Agency
Care
Reimbursement Rates**

c. **Retired** **Members** **of** **the** **Uni-**
Hospital care or outpatient treatment,
formed on presentation of appropriate ID card,
when not otherwise eligible as a VA
beneficiary or as referred by terms of
a negotiated agreement

(1)When a military retiree is a primary beneficiary as defined in a VA-DOD negotiated agreement, the procedures in subparagraph a apply.

(2)Public Law 89-614 provides for the VA's furnishing of hospital or outpatient care to former members of the uniformed services of the Department of Defense, who are entitled to retired or retainer pay, in VA facilities on a space available and reimbursable basis.

(3)"Retiree Beneficiary" is defined as a retired member of the uniformed services who, at the time and place he/she applies for medical care at a VA facility, would not have been otherwise eligible for such care as a beneficiary of the VA, i.e., is a nonservice-connected veteran, under age 65, not receiving VA pension, not a former prisoner of war, not entitled to Medicaid, and does not indicate on VA Form 10-10 that he/she is financially unable to defray cost of medical care.

(4)No specific authorization from the uniformed services will be required. Retirees will be expected to present the appropriate identification card as follows:

(a) Military: DD Form 2 (Gray) or (Blue)

(b) PHS Commissioned Corps: PHS-1 866-3 (Gray) or DD Form 2 (Blue)

(c) Coast Guard: DD Form 2CG (Gray) or DD Form 2 (Blue)

(d)National Oceanic and Atmospheric Administration (formerly Environmental Science Services Administration, and Coast and Geodetic Survey): DD Form 2 (Gray) or (Blue)

(5)Hospital care will be furnished under authority of VA Regulation 6046(B)(2), priority group VIII. Outpatient care will be furnished under authority of VA Regulation 6060.1, priority group VW V I C.

(6) Billing

(a)Charges for services rendered to retired Army, Navy (includes Marine Corps) and Air Force personnel will be prepared monthly on SF 1080 and forwarded to the appropriate military department at the addresses shown in **15-20**

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subparagraph a. When inpatient care or outpatient treatment is provided for drug dependency, the abbreviation DARP will be included following the retiree's name.

(b) Charges for services for retired members of the Coast Guard will be forwarded on SF 1081 monthly to:

Bureau of Medical Services
Federal Center, Bldg. 3
1 1 th Floor, Room II 5 0
6525 Belcrest Road
West Hyattsville, MD 20782

(c)Charges for services for retired members of the National Oceanic and Atmospheric Administration and PHS Commissioned

Corps will be forwarded monthly on an -
Delete
& I ert per II 10-84-19

@ctor,

Federal

Health
C,

Ijivirion of Beneficiary Medical Programs

Fina

Bureau of Health Care Delivery & Assistance

560(

Parklawn Building, Room 7-36

5600 Fishers Lane

Rockville,

MD
20857

**Federal
Medical**

**Agency
Care**

Reiirbursement Rates

d. **Dependents** of **Active** **Duty** and
Hospital Care and outpatient treat-
Use DA Form 1863-1 and appendix
Retired **Members** of **the** **Uniformed**
ment will be limited to bona fide
15D or rates specified in a negotiate
emergency cases as a humanitarian **Services**
agreement.
measure.

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(1)If dependents of active duty military members are included as beneficiaries in a VA-DOD negotiated agreement, billing procedures in subparagraph a apply.

(2)In the absence of a negotiated agreement between VA and DOD, medical treatment and hospital care at VA facilities for dependents of active duty or retired members of the armed forces will be limited to bona fide emergency care provided as a humanitarian measure. At the earliest possible date following such emergency admission or outpatient care, dependents of active duty and retired members of the armed forces will be transferred or referred to the nearest medical facility of the uniformed services or to a public or private hospital at private expense.

(3)Dependents eligible for medical care in community facilities under the CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) are the lawful spouse and dependent children of active duty or retired members of the uniformed services. DD Form 1 173, Unifq@med Services Identification and Privilege Card, is the primary means of identification.

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(4)
received, spouse and children of a
greater. (The V4@.-ra Ce effective

nt of certain expenses covered by CHAMPUS medical coverage provided. When inpatient care is received, the first \$25 of the hospital charges or \$@ per day, whichever is greater, change annually.) Spouses and children of retirees pay all except 75 percent of allowable charges for inpatient care. For services provided on an outpatient basis, a beneficiary is responsible for the first \$50 of covered outpatient services or \$100 per family during a fiscal year (example: October 1, 1982, through September 30, 1983). After the annual deductible for allowable charges is met, CHAMPUS will pay 80 percent of the remaining allowable charges for spouse and children of active duty personnel and 75 percent of the remaining allowable charges for spouse and children of military retirees.

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(5)The beneficiary (or sponsor) will be advised that those charges not reimbursed by CHAMPUS as "not covered" services will be subsequently billed to the recipient (or sponsor) of those medical services.

(6)When medical care is furnished, the dependent (or sponsor) will complete items 1 through 13 of DA Form 1863-1, Services and/or Supplies Provided by Civilian Hospitals. A copy of DA Form 1863-1 will be filed in the patient's administrative or medical records folder, as appropriate. Records established incident to dependent care will be retained at medical facilities and are subject to the same retention and disposition standards as equivalent records of veteran patients.

(7)

B@g

(a)DA Form 1863-1 will reflect the charges for all medical care and services provided using rates in appendix 15D. Medical Administration Service will complete the remaining items on DA Form 1863-1 except for items 27 and 32 which are not applicable. Item 33 will be signed by the Director or his/her designee.

(b)The original and one copy of DA Form 1863-1 will be forwarded through Fiscal Service to the appropriate CHAMPUS claims office. One copy will be filed in the CHR.

(c)After payment has been received from CHAMPUS for allowable charges, VA Form 10-9014 will be prepared for those charges which are not paid by CHAMPUS and are the responsibility of the CHAMPUS beneficiary. The completed VA Form 10-9014 will be routed through Fiscal Service to the recipient of services (or sponsor) and a copy retained for file in the CHR.

(d)A copy of DA Form 1863-1 may be given to the CHAMPUS beneficiary (or sponsor) on written request of the beneficiary (or sponsor).

Federal				Agency
Medical				Care
				Reimbursement Rates
e.	Department	of	Labor,	OWCP
Examination,		medical	treatment	as
(Office		of	Use VAF 10-9014 and appendix 15D.	Workers' Compensation
				authorized.
				Programs)

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(1)The Federal Employees' Compensation Act authorizes payment of medical/rehabilitative treatment for Federal employees for injuries and/or diseases caused by factors of Government service. Benefits are also authorized when Government employment

causes a serious aggravation of a pre-existing, nonjob-related condition. Treatment of concurrent conditions which the employee may have in addition to the accepted job injury is not authorized and payment for such treatment will not be made by OWCP.

(2)CA Form 16, Request for Examination and/or Treatment, is the initial authorization to provide treatment. When additional medical documentation such as CA Form 20, Attending Physician's Report, or a discharge summary are requested by the Regional OWCP, they will be provided to assist in adjudicating the claim.

(3)Individual billings on VA Form 10-9014 will be prepared monthly, as appropriate, at the all-inclusive interagency rates in appendix I SD.

(4) Each VA Form 10-9014 will be assigned a bill number in item 3A from the register established for medical care cost recovery programs. (See app. 15B.) This number may be either the next in sequence or one taken from a separate register block set aside for OWCP cases.

(5)With the initial billing (item 3C), forward the CA Form 16 as the authorization for treatment and, if available, CA Form 20. On supplemental billings, the claim number assigned by the regional OWCP office must be shown in item 16. If the approved CA Form 1, 2 or 2a with the claim number assigned has not been returned to the personnel office, the facility personnel office must obtain the claim number by phone. Supplemental billings lacking the OWCP claim number will be returned as incomplete. When a VA medical facility provides OWCP medical treatment to an employee of another Federal agency, the MAS Billing activity will contact the personnel office of that Federal agency to obtain the OWCP claim number for supplemental billings.

(6)The EIN (Employer Identification Number) must be shown in item IO on VA Form 10-9014. Billings without the facility EIN will be returned for completion. EIN are in appendix 15C.

(7)Bill at the all-inclusive rates for inpatient care in appendix I SD. In the second column of item 17A (VA Form 10-9014), cross out the entries "Room, Board and Nursing; Physician; Ancillary" and type in "All-inclusive rate." Show days of inpatient care at the current interagency per them rate and total cost. When medical care spans a period when interagency rates change, show the number of days at each appropriate rate. Similar adjustments will be made for item 17B when rates change during the period outpatient care has been provided.

Federal Agency

f.

OPM (Office of Personnel Management)

Medical Care

Physical examinations for Civil Service employment (other than VA) or disability retirement, or for Civil Service retirement annuitants, when authorized by OPM.

Reimbursement Rates

Use SF 1081 and appendix 15D.

(1) When retirement examinations for the OPM cannot be completed in 30 days, notify the authorizing official in order to permit alternate arrangements, if desired. Obtain authorization in advance when hospitalization is determined necessary to conduct a proper examination.

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(2) Forward SF 1081 and report of examination in accordance with instructions in the letter of authorization.

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Federal Agency

g.Prospective employees and employees of the VA (Health services as authorized by 5 U.S.C. 7901 and implemented in the VA by ch. 792, MP-5, Pt. I.

Medical Care

Physical examination when authorized by an appropriate VA official or by VA directives.

Emergency treatment and treatment for minor ailments which interfere with the immediate ability to perform duty in accordance with station policy.

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Reimbursement Rates

No charge for authorized examinations.

No charge for emergency diagnostic examination and first treatment.

When a VA employee receives unauthorized medical examination or other than emergency treatment, minor ailment to remain on the job, and is not entitled to such care as an eligible veteran, the employee will be billed on VA Form 10-9014 for services received.

ial treatment for a

Reimbursement rates in appendix 15A apply. The completed VA Form 10-9014 will be submitted through Fiscal Service to the person who received the medical services.

Federal Agency

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h.

PHS (Public Health Service)

(1)
Commissioned Officers (Active
duty)

(2)
Other beneficiaries such as eli-
gible
seafarers.

Medical Care

Inpatient or outpatient care.

Inpatient or outpatient care authorized in advance or provided in a life-threatening emergency.

Reimbursement Rates

Use SF 1080 and appendix 15D.

Use SF 1080 and appendix 15D.

(3) Only those American seafarers who are under treatment at a PHS facility, or those who suffer a life-threatening emergency away from a PHS facility, are eligible for PHS contract medical care.

(4) Normally, medical care provided to PHS beneficiaries is authorized by that agency in advance. However, should emergency care be provided to an eligible PHS beneficiary without authorization, the PHS must be notified within 72 hours of the commencement of such care.

(5) Retired members of the commissioned corps of the PHS are retired members of the uniformed services. (See subpar.

c.) MEDICAL CARE PROVIDED BENEFICIARIES OF OTHER FEDERAL AGENCIES

Other Federal agencies (Bureau of Prisons, FAA, FBI, Peace Corps, Secret Service, etc.) may request infrequent medical examinations or other medical care for beneficiaries of that agency. Such medical care may be provided on a reimbursable basis when facilities are available.

b. The letter of authorization should specify the names of the beneficiaries, the scope of the requested medical care, any special forms on which to document medical findings (e.g., SF 88, Report of Medical Examination) and instructions for submitting medical data and billings.

5.25h (6) Notification of the PHS and request for authorization to treat a PHS beneficiary can be made by calling 1-800-363-2777. per II 10-34-19 15.25 h (7) Billings will be submitted to the address listed in subpara. c. per IT 10-84-19

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c.Charges for medical care will be prepared on SF 1081 in multiple billing format showing the names (and addresses, if pertinent) of persons provided care, date(s) of care, and specific type of care. Reimbursement rates in appendix 15D apply. All billings will be routed through Fiscal Service for dispatch to the responsible Federal agency.

15.27 MEDICAL CARE FURNISHED ALLIED BENEFICIARIES

Allied Beneficiaries

Medical Care

Reimbursement Rates

- a. British and Canadian. Hospital care and outpatient treatment Use VA Form 4-1082 and appendix 15A. when authorized (see ch. 24).
- b. Pensioners of certain other Nations Allied with the United States in YM and WWII

Billing procedures are in chapter 24.

SECTION V. PAYMENT FOR MEDICAL CARE PROVIDED BY NON-VA MEDICAL FACILITIES

15.28 AUTHORITY

a.The provisions of VA Regulations of 6050 through 6050.6., 6052 and 6053@apply to the use of non-VA facilities for providing medical care at VA expense to VA beneficiaries. Applicable procedures are in chapters 21, 22, and 23.

b.Under the provisions of the VA-DOD Health Care Resources Sharing Act, the VA and DOD may enter into negotiated agreements to provide care for VA beneficiaries in DOD health facilities and for DOD beneficiaries in VA facilities. The act also authorizes the VA to contract with private facflities for hospital care and medical services for certain veterans during periods of war or national emergency.

15.29

PAYMENTS TO OTHER FEDERAL MEDICAL FACILITIES

a.'A'hen medi@ services are provided VA beneficiaries by a DOD health facility under the provisions of a negotiated agreement, the rates specified in the agreement will be reimbursed by the VA.

b.In the absence of a negotiated agreement with a DOD health facility, authorized medical care provided VA beneficiaries in DOD health facilities will be reimbursed at the current rates set forth in appendix 15F.

c.Medical care provided VA beneficiaries in IIHS (Department of Health and Human Services) hospitals or clinics will be reimbursed at the current rates in appendix 15F.

15.30 PAYMENTS FOR NON-VA HOSPITAL CARE

All costs incurred in connection with the transfer of patients to non-VA hospitals for further care when authorized under a sharing agreement, when authorized during a period of war, or national emergency or when necessary to secure specialized or emergent services in a medical emergency are the responsibility of the transferring VA facility. Billings to the VA will be billings in full as specified on VA Form 10-7078, Authorization and Invoice for Medical and Hospital Services. The veteran, his/her insurer or any other third party will not be billed by the non-VA hospital. If there is any potential for collection from insurance carriers or other third parties for the cost of care, collection action to obtain reimbursement will be taken by the responsible VA facility in accordance with procedures to effect recovery as defined in section III.

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15.31 PAYMENTS TO CONTRACT NON-FEDERAL HOSPITALS

Payments for services and supplies furnished beneficiaries in contract non-Federal hospitals will be made in accordance with the terms of the contract.

15.32 PAYMENTS TO NONCONTRACT, NON-FEDERAL HOSPITALS

a. The noncontract, non-Federal hospital may prepare bills in the same manner as it does for the general public. Detailed itemization or other supporting evidence of services and supplies provided, will not be required unless charges appear inconsistent with treatment rendered, or unless information on the bill is insufficient to make such a determination. Payment may be made only at rates considered reasonable and not in excess of those customarily charged the general public for similar services in the hospital where rendered. (See ch. 18.)

b. Fees listed in the approved State fee schedule developed by the clinic of jurisdiction are the maximum allowable. Lesser fees will be approved for payment when not in excess of charges made to the general public in the community for the same service.

15.33 CHARGES UNDER SHARING AGREEMENTS

a. Contracts for mutual use and/or exchange of use of specialized medical resources between the VA and non-VA medical facilities are developed and negotiated by Supply Service. Charges for services furnished by the VA for inpatient and outpatient care and specialized medical services under sharing agreements are developed by Fiscal Service in accordance with the provisions of MP-4, part V, chapter 6.

b. A copy of the approved sharing agreement will be provided to Medical Administration Service for billing purposes. Billings prepared by the VA will be made to the parties of the agreement and not to individual patients. (See par. 15.14b for special billing instructions when billing Medicare for ESRD services furnished to nonveterans under an approved sharing agreement.)

15.34 HOSPITAL AND MEDICAL SERVICES-OUTSIDE THE UNITED STATES

The provisions of chapter 23 apply. Claims for services provided veterans in foreign countries, excluding the Philippines, will be submitted to the Chief, Medical Administration Service (136), VA Medical Center, 50 Irving Street, NW., Washington, D.C. 20422.

15.35 COMPUTATION OF PATIENT DAYS OF CARE IN NON-VA HOSPITALS

a. In computing patient days of care in non-VA hospitals for payment purposes, at the option of the VA either the first or last day of the authorized hospitalization will be counted but not both. If the patient is admitted and discharged on the same day, payment will be made for 1 day.

b. Payment will not be made for periods of 24 or more consecutive hours of absence.

15.36 UNANTICIPATED EXPENSES

When a bill for unanticipated expenses is submitted by either the non-Federal hospital or a third party such as a physician, private nurse, etc., it is not necessary to prepare an amended or new authorization. If it is determined by the medical center Director or clinic Director, or designee, that such services or supplies were necessary as part of the authorized hospitalization, the Medical Administration Service Billing activity will post the obligation number and decimal suffix of the original authorization to the bill and process it for payment.

[15.37 PAYMENTS FOR FEE-BASIS AND/OR CONTRACT HEMODIALYSIS SERVICES

a.Fee-Basis Services. Payments for any fee-basis services are made according to established fee schedules reflecting prevailing rates charged to the general public for the same services. Charges in excess of these rates are suspended from payment by the VA. Since 90 percent of all dialysis patients in the country are Medicare beneficiaries, the Medicare approved

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rate must be considered the usual and customary charge to the public in the community for similar services. This policy also is contained in DM&S Manual M-2, part IV, chapter 4, section V, paragraph 4.10b which states:

"When fee-basis or contract dialysis is utilized, the VA should receive assurances from the non-VA dialysis facility that ordinarily the VA will be charged no more than Medicare has approved that facility to receive for providing the same services to Medicare beneficiaries. The VA may pay 100 percent of the approved charge while Medicare may deduct coinsurance and deductible amounts."

b.

Composite Prospective Reimbursement Rate

(1) Beginning August 1, 1983, Medicare has assigned each health care facility providing he--nodialysis services with a composite prospective reimbursement rate. This is the rate that Medicare will reimburse the facility for each hemodialysis treatment. The facility will receive from Medicare the same rate of reimbursement for dialysis performed in the facility and for home dialysis. The intent of this change is to encourage facilities to place more patients on home dialysis programs which are less expensive to operate.

(2)The composite prospective reimbursement rate normally includes coverage of charges for certain routine laboratory tests as well as the purchase and delivery of home dialysis supplies. Supplies include all durable and disposable items and medical supplies necessary for the effective performance of a patient's dialysis. Supplies include, but are not limited to, dialyzers, forceps, sphygmomanometer with cuff and stethoscope, scales, scissors, syringes, alcohol wipes, sterile drapes, needles, topical anesthetics, and rubber gloves. Medicare gives its beneficiaries the choice of obtaining home dialysis supplies from the parent facility (in which case the parent facility charges Medicare the full composite prospective reimbursement rate) or of purchasing their own supplies. If the Medicare beneficiary elects to purchase his/her own supplies, then the facility is reimbursed by Medicare at an adjusted lower composite prospective rate which also is assigned to the facility by Medicare.

(3)Certain routine laboratory services are included in the assigned composite prospective rate. Routine laboratory services include the following tests:

Per Dialysis

Hematocrit

Per Week

Prothrombin time for patients on anti-coagulant therapy

Serum Creatinine

BUN

Per Month

CBC

Serum Calcium

Serum Potassium

Serum Chloride

Serum Bicarbonate

Serum Phosphorous

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Total Protein

Serum Albumin

Alkaline Phosphatase

SGOT

LDH

Separate charges or payments for these,routine tests are not authorized by Medicare.

(4)If the facility is providing the patient with training for home dialysis, an additional charge of \$20 per treatment may be added to the facility's assigned composite prospective rate.

c.Monthly Capitation Rate. In addition to the composite prospective reimbursement rate which is charged for each hemodialysis treatment, each facility also has been assigned by Medicare a monthly capitation rate. The monthly capitation rate is a total monthly charge for the physician services component of the dialysis program. Additional charges for physician services may be made if more than 12 hemodialysis treatments are given within the month or if other than routine dialysis care is given to the patient.

d.Processing Vouchers. VA medical centers processing vouchers for fee and/or contract hemodialysis services should ascertain the Medicare assigned composite prospective reimbursement rates and the monthly capitation rate for the nonVA dialysis facilities requesting payment from the VA. Verification of the rates may be made either by obtaining a copy of the letter assigning those rates from the non-VA facility or by requesting the information from the Medicare Fiscal Intermediary. A listing of the Medicare Fiscal Intermediaries by State is contained in appendix 15J.

15.38-15.39 (Reserved.)]

SECTION VI. COMPUTING CHARGES FOR MEDICAL CARE PROVIDED BY THE VA

15.40

STANDARD RATES

a.Standard medical care cost recovery rates for reimbursement of medical care costs are established periodically and set forth in this chapter. These rates include charges for all services and supplies normally provided VA beneficiaries under the same circumstances. Additional charges for transportation, specialized services, prosthetic items, etc., are noted in appendixes 15A and 15D.

b.Negotiated agreements between the VA and DOD specify rates for identified services and apply only to the parties to that agreement for the period covered by the agreement. Charges or reimbursements will be in accordance with rates in the agreement.

15.41 FIGURING INPATIENT DAYS

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In computing inpatient days of care, count the day of admission but not the day of disposition. Hospitalization for less than 24 hours following admission, when hospital care is terminated by transfer, discharge or death, will be counted as 1 day of care for billing purposes. The day of departure for any absence of more than 24 hours is not counted in computing hospital or nursing care days. Count the day of the patient's return from absence except when disposition is effected on that day.

15.42 DETERMINING CHARGES

Charges for inpatient care will not exceed the appropriate rate current when treatment was provided as calculated pursuant to 38 CFR section 17.62(h). When hemodialysis services are furnished, an additional charge as indicated in appendixes 15A and 15D will be included except for tort-feasor cases (see par. 15.14a) or nonveteran Medicare beneficiaries receiving ESRO services at selected VA medical facilities under approved sharing agreements.

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15.43 CHARGES FOR DOMICILIARY CARE

Persons who have been admitted to VA domiciliaries and later found ineligible will be discharged upon receipt of notification of ineligibility. A charge will be made for each day of care received by such ineligible persons at the local per them rate current at the time services were provided for domiciliary care. The local per them rate will be obtained from Fiscal Service. Charges will be prepared on VA Form 10-9014 and submitted through Fiscal Service to the ineligible person who received domiciliary services.

15.44

CARE IN NON-VA FACILITIES

When care is provided at VA expense in a non-VA hospital or community nursing home, the rate to be charged will be the actual amount paid by the VA.

15.45 BILLING FREQUENCY

Billings for services provided by VA facilities will be prepared and submitted monthly, as a minimum, unless instructed otherwise by the District Counsel. Billings for items and services furnished by the VA Prosthetic Center, New York, New York, or the Prosthetic Distribution Center, Denver, Colorado, will be prepared and submitted quarterly by the providing facility.

15.46

DETERMINATION OF OTHER CHARGES

a. When the VA provides emergency medical care or services to non-VA beneficiaries at the request of a private or public hospital and the VA does not have an agreement or negotiated contract with that medical facility, charges must be determined for such services. Inpatient care will be billed at the appropriate inpatient rates shown in appendix 15A. Charges for outpatient services, i.e., laboratory tests, X-ray procedures, etc., will be developed on a local basis consistent with guidelines in chapter 18. The usual and customary fee for the specific medical service in the community, as determined by the clinic of jurisdiction, will be charged for such outpatient care.

b. When unusual circumstances occur and the billing rate cannot be determined locally, a statement giving specific details of services provided will be submitted to the appropriate Regional Director (1 OBA / 136B) for assistance and advice as to the proper charges for care for non-VA beneficiaries.

15.47

CHARGES FOR DRUG DEPENDENCE TREATMENT

Inpatient charges to other Federal agencies for drug dependence treatment for their beneficiaries will be at the current interagency GM&S per them rate. When drug dependence treatment is provided on an outpatient basis, the charge will be the current interagency outpatient visit rate for routine services. Reimbursement rates are in appendix 15D.

15.48

CHARGES FOR OUTPATIENT DENTAL CARE

- a. The current outpatient visit rate for tort cases will be charged for emergency dental services furnished on an outpa-tient basis when billing is made to a tortiously liable third party.
- b. The rates established in the VA Schedule of Maximum Allowances for Dental Services for that State, as developed by the fee jurisdictional facility, will be charged for emergency dental services furnished to other persons ineligible for such services as veteran beneficiaries.

NOTE: No separate or additional charge is made for emergency dental services furnished at a VA medical facility to an inpatient. The inpatient rate charged is an all-inclusive rate covering all services provided other than those purchased from a non-VA source and costs of transportation provided by the VA.

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VA REIMBURSEMENT RATES-THIRD PARTY CASES

Itemized billings on VA Form 10-9014 for medical services provided to: humanitarian emergency, VA Regulation 6046(C)(1); ineligible persons, VA Regulation 6046(C)(2); VA employees and members of their families, VA Regulation 6046(C)(3); tort. feason, workers' compensation (other than Federal), reimbursable insurance, "no-fault" or uninsured motorists' insurance, crimes of personal violence, VA Regulation 6048(D). Charges on SF 1082 for medical services provided allied beneficiaries, VA Regulation 6046(B)(3), will show the appropriate all-inclusive rate.

Effective

Date:

4/7/80

5/11/81

1/4/82

Reference:

1110-80-29

11

10-81-2

1110-82-5

Inpatient, per day@

GM&S

All-inclusive

rate:

(\$170)

(\$245)

(\$285)

Itemized billings:

Room,	board	and	nursing
			\$110
			\$159
			\$184
			Physician
			43
			62
			72
			Ancillary
			17
			24
			29
			NP
All-inclusive			rate:
(\$1			10)
			(\$154)
			(\$170)

Itemized billings:

Room,	board	and	nursing
\$			76
			\$107
			\$118
			Physician
			26

			36
			40
		Ancillary	
			8
			11
			12
		VA NHCU	
All-inclusive		rate:	
			(\$74)
			(\$98)
			(\$109)
		Itemized billings:	
Room,	board	and	nursing
\$			59
\$			78
			\$ 87
			Physician
			8
			11
			12
			Ancillary
			7
			9
			10

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Effective

Date:

4/7/80

5/11/81

1/4/82

Reference:

1110-80-29

10-81-2

11-10-82-5

H

Outpatient, per visit:

Routine

services

\$

51

\$

54

\$ 61

1 Specialized services

2

per

prescription,

refdl

only

5.75

6.25

6.25

3

Hemodislysis:

Hospital

component

\$141

\$167

\$172

Tort-feasor

only

Inpatient

Rate

Inpatient

Rate

Inpatient Rate

All

other

Inpatient

Rate

Inpatient

Rate

Inpatient Rate

plus

\$141

plus

\$167

plus \$172

VA REIMBURSEMENT RATES-TEfRD PARTY CASES

Itemized billings on VA Form 10-9014 for medical services provided to: humanitarian emergency, VA Regulation 6046(C)(1); ineligible persons, VA Regulation 6046(C)(2); VA employees and members of their families, VA Regulation

6046(C)(3); tortfeasor, workers' compensation (other than Federal), reimbursable insurance, "no-fault" or uninsured motorists' insurance, crimes of personal violence, VA Regulation 6048(D). Charges on SF 1082 for medical services provided allied beneficiaries, VA Regulation 6046(B)(3), will show the appropriate all-inclusive rate.

Effective

Date:

12-15-82

11-1-83

@44@

,Itfgr@ce:

1110-83-1

1110-83-18

Inp@tient, per day:

GM&S

All-inclusive

rate:

(\$315)

\$319

Itemized billings:

Room,

board

and

nursing

\$203

\$206

Physician

80

\$81

Ancillary

32

\$32

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Effective

Date:

12-15-82

11-1-83

Reference:

1110-83-1

1110-83-18

Inpatient, per day: (Con.)

NP

All-inclusive

rate:

(\$195)

\$185

Itemized billings:

Room,

board

and

nursing

\$135

\$128

Physician

46

\$44

Ancillary

14

\$13

*11 10-82-35

VA NHCU

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All-inclusive rate:
(\$ 1 1 9)
\$126

Itemized b@gs:

Room, board and nursing
\$95
\$100

Physician
13
\$14

Ancillary
11
\$12

Outpatient, per visit:

Routine services
\$65
\$71

2 Per prescription, ' Specialized services refiu
\$7.50
only
*\$6.75

3 HeModialySiS:

Hospital component

Tort-feasor only

All other

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Community (Contract) Nursing Home:	Cost to the VA
Emergency Outpatient Dental Services:	See footnote 4
Prosthetics:	See footnote I
Specialized Medical Procedures: (purchased from non-VA sources)	Cost to the VA
Transportation, if furnished:	Cost to the VA

NOTE: Itemized statements for care in a non- VA facility or community nursing home will reflect the same detail as received by the VA.

Footnotes:

I Charges for the following specialized services/supplies will be in addition to the outpatient rate OR in lieu of the outpatient rate if no medicall dental care is given:

- a. Services procured from outside sources.*
- b. The actual cost of prosthetic or orthopedic appliances, sensory aids, medical accessories, or equipment furnished, and/or repairs to such items. The VA facility whose funds are utilized will bill.*
- c. The prime cost of the appliance or repair services furnished will be billed by the VA facility in which the shop or clinic is located. Prime costs will consist of the combined total of materials used plus direct labor costs as posted to the work order on completion of the job.*
- d. The cost of hearing aids furnished from audiology clinic stock, as invoiced by the VA Supply Depot, Hines, 171inois. The controlling facility for the clinic concerned will bill.*
- e. The actual cost of belts, elastic hose, commerce . ally purchased orthopedic shoes and repairs, and/or any other item or service furnished by the VA prosthetics center will be billed. For fabricated items, the prime costs only will be charged. Ae facility paying for the item or service will prepare the bill. The per visit rate will not be charged in these cases.*
- f The actual cost of hearing aid batteries, stump socks, typhlocanes for the blind, hearing aid repairs, and/or other item or service furnished will be billed by the facility concerned. The per visit rate will not be charged in these cases.*
- 'Costs of drugs and medicines prescribed by VA physicians and dentists are included in the outpatient charge for routine services. For refills of prescriptions only, when the patient does not receive any other medical or dental service, the applicable charge will be nwded for each prescription in lieu of the perfacility-visit rate.*
- ' Tort-feasor cases receiving hemodialysis care will be billed at the authorized inpatient per them rate only. In all other third party cases, the hospital component for hemodialysis will be charged in addition to the appropriate inpatient per them rate. For example, patients receiving GM&S inpatient care will be billed at the applicable GM&S rate plus the hemodialysis rate; NP inpatient care will be billed at the applicable NP rate plus the hemodialysis rate. The hemodialysis rate will be charged only for those days when hemodialysis was provided.*
- 'Charges for emergency outpatient dental care for tort-feasor cases (third party liability) will be at the current outpatient visit rate. Charges for all other emergency outpatient dental care will be in accordance with the VA Schedule ofmaximum Allowances for Fee Dental Services for that State as prepared by the fee ju?isdictional facility. I (See par. 15.48.)*

Charges for medical care and for specialized medical Services procured from non-VA sources will be in addition to# the inpatient rate. No cha@s will be made for the actual cost of prosthetic items, medical suppllest drugs or medicines furnished to VA inpatients; these chares are included in the computation of the per di-em rate. by change I

INSTRUCTIONS FOR COMPLETING VA FORM 10-9014, STATEMENT OF CHARGES FOR MEDICAL CARE

Items 1 and 2-Self-explanatory.

Item 3A-The bill number will be developed as follows:

1. Facility's 3-digit identification number: ie. 521
2. A 6-digit identifier consisting of:
 - a. 1 st position -fiscal year i.e.: Fiscal year "8 3 "-5 21 -3.
 - b . 2d through 5th position-sequential bill number issued to each VA Form 10-9014 during fiscal year. i.e.: Fifteenth Statement of Charges for Medical Care issued during fiscal year 1983 would be 521-30015.
 - c.6th position-Initial or supplemental bill identifier for treatment of patient for the same episode of care regardless of fiscal year (Codes A through Z). i.e.: If initial billing for patient for this episode of care, complete bill would be numbered 521-30015 A- Subsequent bills for same patient for same episode of care might be numbered as follows: 521-30216B, 521-31742C, 521321 1 OD, 52140072E, 521-40519F, etc.

Subsequent bill identifiers will continue through Z-indicating the 26th bill.

If the same patient has a second unrelated incident of billable medical care, initial and subsequent billings would begin a new alphabetical sequence-A (initial), B, C, D, etc. (Supplemental).

5F
2F
F3]
o@

Facility	3-digit
F	cal
Sequential	Bill
	@ial/
	ID
	Year
	Number
	Supplemental Bill

Identifier

Item 3B-Date bill as prepared.

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Item 3C-Check appropriate entry for this bill.

Item 3D-Show the period covered by this bill.

Items 4, 5, and 6-Self-explanatory.

Item 7-Check appropriate entry. If "other" is checked, clarify type of case.

Item 8-Self-explanatory.

Item 9-Show appropriate VA Regulation for billing, i.e., VAR 6048(D) or 6062(A), (B)(1), (B)(2) or (H).

Item IO - Show the mailing address, three digit station number and mail routing symbol of the VA health care facility preparing the billing. If the (EIN) (employer identification number) is required, it may be included in this space as the last line entry. OWCP billings *must* have the EIN.

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Item I I - Space is sufficient for two addresses, when appropriate, i.e., employer and insurer, third party and policy holder, etc.

In any case, the relationship/responsibility of the addressee must be shown.

Item 1 2, 1 3, 1 4, and 1 5 -Self-explanatory.

Item 16-Supplemental OWCP billings must show the workers' compensation claim number.

Item 17A- Complete items appropriate for this billing. There is space for two episodes of hospitalization or for a rate change within a billing period. The three component parts of the appropriate all-inclusive per them rate will be indicated on all bills (Room, Board, and Nursing; Physician; Ancillary). For rates, use appendix 15A except for OWCP billings. For Federal OWCP billings, cross out the entries "Room, Board, and Nursing; Physician; Ancillary" and insert "Allinclusive rate." Bill at interagency rates in appendix 15D.

Item 17B- List dates of visits which are being billed on this statement. Show date of next scheduled outpatient visit. If out-patient care is terminated, show "none". Space permits a rate change within the billing period. For rates, use appendix 15A except for OWCP billings when rates in appendix 15D apply.

Item 17C- Use appendix 15A or 15D footnotes I through 4, as applicable. Also include transportation costs and the actual cost

of services purchased from non-VA sources, if any.

Item 18-If case is referred to a District Counsel, complete this block.

Item 19 and 20-Self-explanatory.

NOTES:

1.Additional information about any item may be continued on bond paper clearly identified as continuation of a specific item. Indicate in the appropriate item of VA Form 10-9014, "continued on attached sheet".

2. *Fiscal audit entries may be placed on the reverse of VA Form 10-9014 on internal copies only.*
3. *The transmittal letter forwarding the billing should include specific information applicable to the case and/or individual facility. For example:*
- a. *A statement of the office and address to which payment is to be made if different than Item 10, VA Form 10-9014.*
 - b. *A request for the return of the copy of the statement of charges with payment or a referral to the bill number with payment.*
 - c. *When required on detailed itemized billings, it should contain the statement, "The maximum amount to be collected by the VA does not exceed the VA's per diem rate multiplied by the number of inpatient days of care furnished to the patient." A modification of this statement, as recommended by the District Counsel, may be used.*

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VA (EIN)@ (EMPLOYER IDENTIFICATION NUMBERS)

MC,s			M&ROC's EIN (Contd) EIN
402			Togus 01-6001944
542			Coatesville 23-6014856
405	White	River	Junction 03-0278504
543		Columbia,	MO 43-6161186
436		Fort	Harrison 81-0233746
544		Columbia,	SC 57-0314569
437			Fargo 45-0226662
546			Miami 59-6003624
438		Sioux	Falls 46-0227571
549			Dallas 75-6108647

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442					Cheyenne 83-0168494
550					Danville 37-0662493
452					Wichita 48-0544203
552			Dayton		(M&D) 31-0540155
455			San		Juan 66-0386593
553			Allen		Park 38-1358896
460					Wilmington 51-0065004
5S4					Denver 84-0850519
555			Des		Moines 42-0959192 MC's
5	5	6		N.	Chicago 36-2171572
557			Dublin		(M&D) 58-0561276
500					Albany 14-1339778
5	5	8			Durham 56-0564306
501					Albuquerque 85-0102219
561			East		Orange 22-1526640
502					Alexandria 72-0411414
562					Erie 25-0974473
503					Altoona 23-1357099
564			Fayetteville,		AR 71-0548518
504					Amarillo 75-1616212
565			Fayetteville,		NC 56-1303855
505					Tacoma 91-0565150
566			Fort		Howard 52-1221991
506			Ann		Arbor 38-1358897
567			Fort		Lyon 84-0853571
508					Decatur 58-0587213

568		Fort	Meade
			46-0362332
509			Augusta
			58-0587214
569		Fort	Wayne
			35-1511916
512			Baltimore
			52-0615642
570			Fresno
			94-1160821
513			Batavia
			16-1164194
573			Gainesville
			59-1222496
5	14	Bath	(M&D)
			16-0763362
574		Grand	Island
			47-0376049
515		Battle	Creek
			38-1358893
575		Grand	Junction
			84-0832294
516	Bay	Pines	(M&D)
			59-2102233
578			Hines
			36-2171572
517			Beckley
			55-0357746
579	Hot	Springs	(M&D)
			46-0359485
518			Bedford
			04-6015879
580			Houston
			74-2184934
519		Big	Spring
			75-6111827
581			Huntington
			55-0357745
520		Biloxi	(M&D)
			64-0317136
583			Indianapolis
			35-1511916
5		21	Birmingham
			63-0810292
584		Iowa	city
			42-1032435
522		Bonham	(M&D)
			75-0793129
585		Iron	Mountain
			38-1358898
523			Boston
			04-2133157
586			Jackson
			64-6006815
525			Brockton
			04-2132902

589	Kansas	City 43-6173947
526		Bronx 13-6009516
590	Hampton	(M&D) 54-1172096
527		Brooklyn 11-1823825
591		Kerrville 36-2542172
528		Buffalo 16-1165465
592		Knoxville 42-0680606
529		Butler 2S-0975161
594	Lake	City 59-0643002
531		Boise 82-0218828
595		Lebanon 23-1357100
532		Canandaigua 16-1171228
596		Lexington 61-0443527
533	Castle	Point Lincoln
597		47-0376431
534		Charleston 57-0720016
598	Little	Rock 71-0550821
535	Chicago	(L) 36-2165436
599		Livermore 94-2774270
537	Chicago	(WS) 36-2480618
600	Long	Beach 95-1652897
538		Chillicothe 31-6014208
603		Louisville 61-0990338
539		Cincinnati 31-0542398
604		Lyons 22-1487104
540		Clarksburg 55-0362865
605	Loma	Linda 95-3625072
541		Cleveland 34-0715726
607		Madison 39-0817517

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MC's

(Contd)

MC's

EIN
(Cont'd)
EIN

608

Manchester
02-0222932

670

Syracuse
15-0619303

609

Marion,

IL
37-0662492

671

San

Antonio
74-2112082

610

Marion,

IN
35-1516418

673

Tampa
S9-1641493

611

Marlin
74-1115601

674

Temple

(M&D)
75-1812000

612

Martinez
94-2674840

676

Tomah
39-6011913

613

Martinsburg

(M&D)
55-0357747

677

Topeka
48-0545196

614

Memphis
62-0480254

678

Tucson
86-0096757

617

Miles

City
81-0233747

679

Tuscaloosa
63-0297932

618

Minneapolis
41-0696270

680

Tuskegee
63-0803166

619

Montgomery
63-0288981

685

Waco
74-6026829

620				Montrose 13-3093365
686		Leavenworth		(M&D) 48-0543337
621	Mountain		Home	(M&D) 62-0478102
687		Walla		Walla 91-0579494
622				Murfreesboro 62-0476141
688				Washington 53-0197060
623				Muskogee 73-0766778
689		West		Haven 06-0678854
626				Nashville 62-0484828
690		West		Roxbury 04-6322152
627				Newington 06-1044499
691	Los		Angeles	(W&B) 95-3626252
629		New		Orleans 72-0448791
692	White		City	(DO) 93-0788526
630		New		York 13-2972977
693				Wilkes-Barre 24-0796250
631				Northampton 04-2104504
695		Wood		(M&D) 39-1326366
632				Northport 11-2589323
635		Oklahoma		City 73-1097102
636				Omaha 47-0376487
637				Asheville 56-0524682
640		Palo		Alto 94-1179505
641		Perry		Point 52-0592209
642				Philadelphia 23-1403775
644				Phoenix 86-0101019
645		Pittsburgh		(HD) 25-0996490
646		Pittsburgh		(UD) 25-1011842
647		Poplar		Bluff 43-0655862

648			Portland
			93-0386962
649		Prescott	(M&D)
			86-0096758
650			Providence
			05-0259410
652			Richmond
			54-0515611
653			Roseburg
			93-0386959
654			Reno
			88-0059762
655			Saginaw
			38-2391420
656		St.	Cloud
			41-0697932
657		St.	Louis
			43-0687806
658			Salem
			54-0515648
659			Salisbury
			53-0564309
660		Salt	Lake
			City
			87-0372919
662		San	Francisco
			94-1160824
663			Seattle
			91-0565166
664		San	Diego
			23-7262137
665			Sepulveda
			95-6521504
666			Sheridan
			83-0168495
667			Shreveport
			72-0423660
668			Spokane
			91-1109753

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VA REIMBURSEMENT RATES-OTHER FEDERAL AGENCIES

Charges to DOD in the absence of a negotiated agreement and other Federal agencies for medical services provided to: active duty personnel, VA Regulation 6046(B)(1); retirees of the uniformed services, VA Regulation 6046(A); beneficiaries of other Federal agencies, VA Regulation 6046(B)(2).

NOTE: When a VA medical facility has a negotiated agreement with a specific DOD facility, the rates for services identified in the negotiated agreement will be used. For services not covered in a negotiated agreement, and for services provided to beneficiaries of other Federal agencies, the following rates will be used.

Fiscal

Year:
1981

1982
1983

Effective

Date:
10/1/80
10/1/81
10/1/82

Reference:
1110-81-1
1110-81-57
11 10-82-35

Inpatient, per day:

GM&S
\$200
\$236
\$260

NP
123
140
159

VA

NHCU
79
90
98

Outpatient, per visit:

Routine
\$
\$

services
47
51
\$ 54

Specialized services

Per

prescription,

refill

only
5.75
6.25
6.75

Hemodialysis:

Hospital

component
\$141
\$172
\$176

All
Inpatient

billings

except
rate

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Inpatient			rate
			Inpatient rate
Medicare			outpatient
plus			\$141
plus			\$172
			plus \$176
Medicare			outpatient
			\$188
			\$223
			\$230
			(maintenance dialysis)
Community	(Contract)	Nursing	Home:
			Cost to the VA
Emergency	Outpatient	Dental	Services:
			See footnote 4
			Prosthetics:
			See footnote I
Specialized	Medical		Procedures:
			Cost to the VA
			(purchased from non-VA sources)
Transportation,	if		furnished:
			Cost to the VA

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NOTE: Itemized statements for care in a non-VA facility or community nursing home will reflect the same detail as received by the VA.

Fiscal

**Year:
1984
1985
1986**

**Effective Date:
Reference:**

Inpatient, per day:

GM&S

NP

VA NHCU

Outpatient, per visit:

Routine services

Specialized services

Per prescription,
refill only

Hemodialysis:

Hospital component

All billings except

Medicare outpatient
(maintenance dialysis)

Community	(Contract)	Nursing	Home:
			Cost to the VA
Emergency	Outpatient	Dental	Services:
			See footnote 4
			Prosthetics:
			See footnote 1
Specialized		Medical	Procedures:
			Cost to the VA (purchased from non-VA sources)
Transportation,		if	furnished:
			Cost to the VA

NOTE: Itemized statements for care in a non-VA facility or community nursing home will reflect the same detail as received by the VA.

'Charges for the following specialized services/supplies will be in addition to the outpatient rate OR in lieu of the outpatient rate if no medical/dental care is given:

- a. Services procured from outside sources.*

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Footnote8 (Con.)

b.

The actual cost of prosthetic or orthopedic appliances, sensory aids, medical accessories, or equipment furnished, and/or repair of such items. The VA facility whose funds are utilized will bill.

c. The prime cost of the appliance or repair service furnished will be billed by the VA facility in which the shop or clinic is located. Prime costs %III consist of the combined total of materials used plus direct labor costs as posted to the work order on completion of the job.

d. The cost of hearing aids furnished from audiology clinic stock, as invoiced by the VA Supply Depot, Hines, Rtiniois. The controlling facility for the clinic concerned will bill.

e. The actual cost of belts, elastic hose, commercially purchased orthopedic shoes and repairs, and/or any other item or service furnished by the VA prosthetics center will be billed. For fabricated items, the prime costs only will be charged. The facility paying for the item or service will prepare the bill. The per visit rate will not be charged in these cases.

f. The actual cost of hearing aid batteries, stump socks, typhlocanes for the blind, hearing aid repairs, and/or any other item or service furnished %III be billed by the facility concerned. The per visit rate will not be charged in these cases.

'Drugs and medicines prescribed by VA physicians and dentists are Included in the outpatient charge for routine services. For refills of prescriptions only, when the patient does not receive any other medical or dental service, the applicable charge will be made for each prescription in lieu of the per-facility-visit rate. Drugs and medications prescribed by other than VA physicians will not be furnished.

The hospital component for hemodialysis will be charged in addition to the appropriate inpatient per them rate except for Medicare maintenance dialysis. For example, patients receiving GM&S inpatient care will be billed at the GM&S rate, plus the hemodialysis rate; NP inpatient care will be billed at the NP rate plus the hemodialysis rate. For Medicare billings where maintenance dialysis is considered an outpatient service, the charge will be the outpatient-visit rate plus the hemodialysis rate. The hemodwysis rate will be charged only for those days when hemodialysis was provided.

'Charges for emergency outpatient dental care will be in accordance with the VA Schedule of maximum Allowances for Fee Dental Services for that State as prepared by the fee jurisdictional facility (See par. 15.48.)

.Charges for medical care and for specialized medical services procured from non-VA sources will be in addition to the inpatient rate. No separate charges will be made for the actual cost of prosthetic items, medical supplies, drugs or medicines furnished to VA inpatients; these charges are included in the computation of the per them rate. by change 1

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VA REIMBUP6EMEENT RATES-MEDICARE PATIENTS IN VA FACILITIES

1. The Health Insurance Program for the Aged, Health Care Financing Administration, will be charged the following rates for emergency services (inpatient and outpatient) provided Medicare patients in VA facilities:

Effective		Date:
		10/1/80
		10/1/81
		10/i/82
		Reference:
		1110-81-1
		1110-81-57
		Inpatient
GM&S,	per	day:
		(\$200)
		(\$236)
Part	A-Medical	Services
		\$183
		\$216
Part	B-Physician	Services
		17
		20
NP,	per	day:
		(\$123)
		(\$140)
Part	A-Medical	Services
		\$113
		\$128
Part	B-Physician	Services
		10
		12
		Outpatient, per visit

Part	B-Physician	Services
\$		47
		\$ 51

2. A Medicare patient's liability for deductible and coinsurance is:

Effective	Date:
	1/1/81
	1/1/82
	1/1/83

Part A-Medical Services

		Inpatient (Hospital)
First	60	days
		\$204
		\$260
		\$304
61	st	thru
		90th
		day
		51
		65
		76
Days		60 Lifetime Reserve (nonrenewable)
		102
		130
		152

Part B-Physician Services

(Applies to all pt. B Benefits-
inpatient and outpatient)

\$	Deductible
	60
	\$ 75

Coinsurance 20 percent of the professional services in excess of the deductible.

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CHARGES TO THE VA-OTHER FEDERAL HOSPITALS

The following rates for medical care will be charged the VA **foi** authorized medical care provided to VA beneficiaries in Federal hospitals.

DOD Hospitals/Medical Centers

(Exception: Rates in a negotiated agreement take precedence.)

1	0	-	I	-	8	4	Effective	Date: 10/1/80 10/1/81 10/1/82 10/1/83
II								10-85-Reference: 10-81-1 10-82-2 10-82-52 II 10- t5
								83-19
Inpatient			care,			per		\$423 day \$285 \$348 \$369 \$327
								(and Panama as of 4/1/82)
Panama				(thru				3/31/82) 344 320 -
Burn			Center,					\$1,256 Brooke 853 1,421 1,188 \$1,342
								Army Hospital, per day
Outpatient,								\$53 routine, 28 35 35 \$41

per visit (and Panama
as of 4/1/82)

Panama (thru 3/31/82)
38
32
-

Specialized services:
Cost to DOD

HHS and PHS Hospitals

Effective **Date:**
10/i/80
10/1/81
10/1/82
10-1-84

11 **Reference:**
11 10-81-1
10-82-2
1110-85-

Inpatient care, per 15
day
\$224
\$254
\$282
\$510

Outpatient, (GMS)
routine,

per \$221
visit
44
50
55
(Np)

per treatment \$62
 To be negotiated 263
 To be negotiated negotiated
 by individual
 by individual individual
 facilities
 facilities facilities
 Specialized services:
 Cost to HHS or PHS

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DOD HOSPITALS/MEDICAL CENTERS

(Exception: Rates in a negotiated agreement take precedence.)
 Effective Date:
 10-1-85
 10-1-86
 Reference
 1110-85-32
 1110-1-86
 Inpatient care, per day
 \$410
 \$410
 (& Panama as of 4/1/82)
 Panama (thru 3/31/82)
 Burn Center, Brooke
 \$1,344
 \$1,506
 Army Hospital, per day
 Outpatient, routine,
 \$55
 \$55
 per visit (&.-Panama
 as of 4/1/82)

Panama (thru 3/31/82)

Specialized services:

HHS AND PHS HOSPITALS

Effective

Date:
10-1-85

Reference:
II 10-85-32

Inpatient

care,

per

\$505 (GM&S)/
day
\$195 (NP)

Outpatient,

routine
\$64
per visit

Renal dialysis,
per treatment

Specialized services

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VA PAYMENTS TO STATE VETERANS' HOMES

Maximum per them rates which may be paid to a State for care of veterans receiving hospital, nursing or domiciliary care in an approved State veterans' home are listed below. In no case may payment exceed one-half of the actual cost of maintenance of the veterans in the home.

Effective

Date:

8/9/77

10/1/80

4-1-84

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Reference:

H

10-77-31

11

10-80-60

TT 10-84-3

Type of Service:

Hospital

care

\$11.50

\$13.25

\$15.25

Nursing

care

10.50

12.10

\$17.05

Domiciliary

care

5.50

6.35,

\$7.30

NOTE: Per them rates for State veterans' homes are established by legislation and do not change annually or on a regular basis.

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CHARGES FOR AEROMEDICAL TRANSPORTATION

1. MOVEMENT OF VA BENEFICIARIES

Charges by the Department of the Air Force will be based on the costs of both transportation and en route medical care.

2. CHARGES ON REGULARLY SCHEDULED AEROMED FLIGHTS

a. The VA will be charged the standard first-class fare at the common user tariff rate plus \$ 1.

b. An additional charge will be made at the inpatient rates in appendix 15F. Charges for medical care will be based on units of 1 day (each 24 hours or fraction thereof) that the patient is actually in the aeromed evacuation system. All time spent in transit, including stops in aeromed staging facilities, will be considered when computing charges.

3. CHARGES ON OTHER THAN SCHEDULED AEROMED FLIGHTS

a. When transportation is provided on other than scheduled aeromed evacuation flights, charges will be based on the operating cost of the aircraft based on the flying hour rate under the U.S. Government rate tariff.

b. When transportation is provided aboard an aircraft carrying other cargo or passengers, charges will reflect that portion of the aircraft's total capability which is devoted to patient care as distinguished from that available for other passengers or cargo use.

c. Charges for medical care will be applied on the same basis as for regularly scheduled flights.

4. DEPARTMENT OF DEFENSE BENEFICIARIES

The VA will not be charged for aeromed evacuation movement of active duty and retired military personnel. These patients are authorized aeromed transportation and en route medical care at Department of Defense expense.

5. BILLING

The Airlift Service Industrial Fund is responsible for billing and collecting charges for patients transported on aeromed evacuation aircraft.

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VA REIMBURSEMENT RATES-ESRD (End Stage Renal Disease)

1. Final settlement rates for the most recent FYE (fiscal year ending) will be used as approved interim billing rates to Medicare-Health Care Financing Administration (HCFA) for ESRD services furnished to nonveteran Medicare beneficiaries under the terms of sharing agreements in the current fiscal year. Delinquent bills for services furnished in prior fiscal years will be prepared using the appropriate final settlement rates. Those billings rejected by Medicare because the patient was not eligible for Medicare coverage should be canceled and billed to the sharing facility in accordance with the sharing agreement.

2. Final settlement rates for kidney transplants for nonveteran Medicare beneficiaries at VA medical centers other than VA Medical Center, Indianapolis, under this program are as follows:

			Per Days Total
			Diem (Limit) Amount
Kidney Transplant From Cadaveric Donor			
FYE 9-30-78			
Part	A	Hospital	\$740.00
		20	\$14,800.00
Part	B	Physician	163.00
		20	3,260.00
			\$18,060.00
FYE 9-30-79			
Part	A	Hospital	\$840.00
		20	\$16,800.00
Part	B	Physician	175.00
		20	3,500.00
			\$20,300.00
FYE 9-30-80			

Part	A	Hospital \$952.00 20 \$19,040.00
------	---	---

Part	B	Physician 189.00 20 3,780.00
------	---	---------------------------------------

\$22,820.00

FYE 9-30-81

Part	A	Hospital \$1,061.48 20 \$21,229.60
------	---	---

Part	B	Physician 210.74 20 4,214.80
------	---	---------------------------------------

\$25,444.40

FYE 9-30-82

Part	A	Hospital \$1,182.49 20 \$23,649.80
------	---	---

Part	B	Physician 234.76 20 4,695.20
------	---	---------------------------------------

\$28,345.00

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Per
Days
Total

Diem
(Limit)
Amount

FYE 9-30-83

Part	A	Hospital
		\$1,281.82
		20
		\$25,636.40
Part	B	Physician
		254.48
		20
		5,089.60

\$30,726.00

FYE

Part A Hospital

Part B Physician

Kidney Transplant From Living Related Donor

FYE 9-30-78

Part	A	Hospital
		\$637.00
		20
		\$12,740.00
Part	B	Physician
		163.00
		20
		3,260.00

\$16,000.00

FYE 9-30-79

Part	A	Hospital
		\$722.00
		20
		\$14,440.00
Part	B	Physician
		175.00

				20
				3,500.00
				\$175940.00
				FYE 9-30-80
Part		A	Hospital	
			\$834.00	
			20	
			\$16,680.00	
Part		B	Physician	
			189.00	
			20	
			3,780.00	
				\$20,460.00
				FYE 9-30-81
Part		A	Hospital	
			\$929.91	
			20	
			\$18,598.20	
Part		B	Physician	
			210.74	
			20	
			4,214.80	
				\$22,813.00
				FYE 9-30-82
Part		A	Hospital	
			\$15035.92	
			20	
			\$20,718.40	
Part		B	Physician	
			234.76	
			20	
			4,695.20	
				\$25,413.60

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Per
Days
Total

Diem
(Limit)
Amount

FYE 9-30-83

Part

A

Hospital
\$1,122.94
20
\$22,458.80

Part

B

Physician
254.48
20
5,089.60

\$27,548.40
FYE

Part A Hospital

Part B Physician

3.Final settlement rates for inpatient ESRD services during the 20-day convalescent stay at the VA Medical Center Indianapolis, following the kidney transplant at the sharing hospital are as follows:

Inpatient

	Per Diem
	Inpatient
Total	20- After 20-
Per	Diem
Day	Days
FYE	Stay Day Stay
	9-30-78
	\$329.00
	20
	6,580.00
	\$122.00
FYE	9-30-79
	373.00
	20
	7,460.00
	135.00
FYE	9-30-80
	423.00
	20
	8,460.00
	146.00
FYE	9-30-81
	471.65
	20
	9,433.00
	180.00
FYE	9-30-82
	525.42
	1

NOTE: There is no rate for physician at this facility because the sharing hospital provides all physician servi .ce.

4. Final inpatient per them settlement rates after a 20-day stay for a kidney transplant or an elective admission for any ESRD patient at a VA Medical Center (other than VA Medical Center Indianapolis, prior to September 30, 1982) under this program are as follows:

Part	Per Per	Total Hospital Physician	
		Inpatient A	Part B Period Diem Diem Per Diem
FYE		9-30-78 \$138.00 \$122.00 \$16.00	
FYE		9-30-79 151.00 135.00 16.00	
FYE		9-30-80 160-00 140.00 20.00	
FYE		9-30-81 200.00 180.00 20.00	
FYE		9-30-82 236.00 216.00 20.00	
FYE		9-30-83 260.00 240.00 20.00	
			FYE
			FYE

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S. Final outpatient visit settlement rates for ESRD patients at VA Medical Center under this program are as follows:

	Period Per Visit Rate (Part B)
FYE	9-30-78 \$41.00
FYE	9-30-79 45.00
FYE	9-30-80 51.00
FYE	9-30-81 47.00
FYE	9-30-82 51.00
FYE	9-30-83 54.00
	FYE
	FYE

6. Final settlement rates for maintenance dialysis are the same for all periods, prior to August 1, 1983, as follows:

Inpatient Basis	Outpatient Basis
Hospital--Part A \$126.00	Part B--\$147.00
Physician--Part B 21.00	
Total \$147.00	

NOTE: This is the maximum allowed under the National Medicare screen unless an exception has been granted by HCFA.

7. Outpatient Maintenance Dialysis--Composite Prospective Rates and Monthly Capitation Rates for Selected VA Medical Centers.

Effective	Date
	8-1-83
	8-1-83
	10-1-86 by II 10-86-6

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MONTHLY

CAPITATION

RATE
COMPOSITE PROSPECTIVE
VAMC
RATE
(COMPONENT)
REIMBURSEMENT RATE

REIMBURSEMENT
(PHYSICIAN

ALBUQUERQUE
\$128.53
\$194.56
\$124.10

ANN

ARBOR
138.00
220.00
\$134.54

DENVER
135.86
161.77
\$131.41

INDIANAPOLIS
129.33
214.23
\$124.18

IOWA

CITY
135.21
220.00
\$131.09

IRON

MOUNTAIN
128.96
211.10

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COMPOSITE PROSPECTIVE MONTHLY CAPITATION RATE COMPOSITE PROSPECTIVE

REIMBURSEMENT
(PHYSICIAN

REIMBURSEMENT RATE
VAMC
RATE
COMPONENT
by IT 10-86-6

LITTLE

ROCK
128.95
144.00
\$124.47

		NORTHPORT	
		138.00	
		220.00	
		\$135.27	
OKLAHOMA		CITY	
		127.51	
		144.00	
		\$123.18	
		PITTSBURGH	
		133.73	
		219.03	
		\$128.08	
		RICHMOND	
		123.86	
		204.98	
		\$119.12	
		SALEM	
		122.10-----	
		--220.00	
		@-\$125.66	
SALT	LAKE	CITY	
		123.82	
		144.00	
		\$119.80	
		SANJUAN	
		121.20	
		195.49	
		\$117.23	
ST.		LOUIS	
		128.47	
		192.42	
		\$123.83	
		TUCSON	
		129.07	
		178.70	
		\$123.63	

NOTE: Home training for hemodialysis is reimbursed at the composite prospective rate plus \$20.00. Also, if services are rendered to the Medicare beneficiary above those normally included as Part of hemodialysis treatments, Medicare can be billed an additional charge for an outpatient visit at the established interagency billing rate.

8.

Other considerations:

a. Renal Transplants. An end stage renal disease patient becomes a transplant patient for billing purposes on the day the patient is prepared for transplant surgery and ceases to be a transplant patient upon recovery from surgery. Medicare uses a 20-day length of stay for audit purposes and will question all bills for renal transplant with a length of stay in excess of 20 days. Reimbursement for a 25-day length of stay transplant bill is not precluded provided the primary reason for the entire 25-day stay was the transplant and justification acceptable to HCFA is furnished. However, a 25-

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day stay due to a transplant (21 days) and the onset of pneumonia in the 19th day should be billed at the transplant rate for 21 days and the other inpatient-medical rate for 4 days.

b. Dialysis-Inpatient Basis. This rate applies to only those dialysis treatments provided to hospital patients other than 1 day dialysis admissions. Dialysis treatment provided after transplant, but prior to full functioning of the new kidney would be billed at the dialysis inpatient rate in addition to the transplant daily rate.

c. Other Inpatient Medical Surgical and Other OP Treatment. End Stage Renal Disease Medicare coverage has been expanded to cover all medical services provided the ESRD patient due to the ESRD ailment or for humanitarian reasons.

d. Dialysis-Outpatient Basis. One day dialysis admissions are billed at this rate because Medicare considers maintenance dialysis as an outpatient function. Although the rates for inpatient and outpatient dialysis may be the same, the reimbursement techniques are different. Therefore, it is necessary to identify the dialysis treatment as inpatient or outpatient.

9. Recovery of co-insurance and deductibles: Medicare reimburses the provider for bad debts arising from uncollectable co-insurance and deductibles. When the VA is the provider of services under ESRD sharing agreements, our contractual relationship is with the sharing facility rather than the patient and the sharing facility is expected to reimburse the VA for co-insurance and deductibles within a reasonable length of time after receipt of billing. (A copy of the Medicare billing

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ided the sharing facility should be annotated to indicate the amount of co-

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prov insurance and deductibles due from the sharing facility.) If the sharing facility cannot collect the coinsurance and/or deductible amounts from the patient and will not reimburse the VA, the VA will submit a bad debt claim to Medicare supported by evidence furnished by the sharing facility that reasonable collection efforts had been made. If the sharing facility determined the Medicare patient to be indigent or medically indigent according to guidelines in the Medicare provider reimbursement Manual HIM 15, paragraph 312, the co-insurance and/or deductible amounts may be deemed uncollectable without applying reasonable collection efforts. In such cases, the VA will submit the bad debt claim to Medicare supported by evidence of such determination furnished by the sharing facility.

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APPENDIX I SJ

[MEDICARE FISCAL INTERMEDIARIES

STATE ALPHABETICAL LISTING

Service

**Intermediary
State
Number
Intermediary Office Address**

ALABAMA
00010
Blue Cross-Blue Shield of Alabama

930 South 20th Street

Birmingham, Alabama 35298

ALASKA
00430
Blue Cross, Washington-Alabama, Inc.

15700 Dayton Avenue, North

P.O. Box 327

Seattle, Washington 98111

ARIZONA
0030
Blue Cross of Arizona, Inc.

321 West Indian School Road

P.O. Box 13466

Phoenix, Arizona 85002

ARKANSAS
00020
Arkansas Blue Cross and Blue Shield, Inc.

P.O. Box 1418, 601 Gaines Street

Little Rock, Arkansas 72203

CALIFORNIA
00040
Blue Cross of Southern California

P.O. Box 70000

Van Nuys, California 91470

51050
Aetna Life and Casualty

Medicare Claim Administration

2600 Wilshire Boulevard, Suite 201

Los Angeles, California 90057

51051
Aetna Life and Casualty

Medicare Claim Administration

California Pacific Professional Center

97 Marin Drive

Novato, California 94947

00041
Blue Cross of Northern California

December 9, 1982

1950 Franklin Street

Oakland, California 94659

19050
Kaiser Foundation Health Plan, Inc.

1956 Webster Street, Room 310-A

Oakland, California 94612

COLORADO
00050
Colorado Hospital Service

700 Broadway

Denver, Colorado 80203

CONNECTICUT
51070
Aetna Life and Casualty

270 Farmington Avenue

P.O. Box 329

Farmington, Connecticut 06032

M-1,

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Service

Intermediary
State
Number
Intermediary Office Address

CONNECTICUT-Con.
00060
Blue Cross of Connecticut, Inc.

370 Bassett Road

North Haven, Connecticut 06473

50072
The Travelers Insurance Company

2200 Whitney Avenue

Hamden, Connecticut 06518

DELAWARE
00070
Blue Cross of Delaware, Inc.

201 West 14th Street

Wilmington, Delaware 19801

DISTRICT OF
COLUMBIA
00080
Group Hospitalization, Inc.

550 12th Street, SW.

Washington, D.C. 20024

52280
Mutual of Omaha

P.O. Box 456, Downtown Station

Omaha, Nebraska 68101

FLORIDA
00470
Blue Cross of Florida, Inc.

P.O. Box 2711

Jacksonville, Florida 32203

December 9, 1982

51100
Aetna Life and Casualty

Taylor Building

121 North Osceola Avenue

Clearwater, Florida 33515

00090
Blue Cross of Florida, Inc.

P.O. Box 2711

Jacksonville, Florida 32203

GEORGIA
00100
Blue Cross and Blue Shield of

Georgia/Atlanta, Inc.

3348 Peachtree Street, NE.

Atlanta, Georgia 30302

00101
Blue Cross of Georgia/Columbus

P.O. Box 7368

Columbus, Georgia 31908

HAWAII
19050
Kaiser Foundation Health Plan, Inc.

1956 Webster Street, Room 310-A

Oakland, California 94612

December 9, 1982

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17120
Hawaii/Guam Medical Services Association

1504 Kapiolani Boulevard

Honolulu, Hawaii 96808
IDAHO
00110
Blue Cross of Idaho, Inc.

1501 Federal Way

P.O. Box 7368

Boise, Idaho 83701

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December 7, 1983

Service

**Intermediary
State
Number
Intermediary Office Address**

ILLINOIS
00121
Health Care Service Corporation

233 North Michigan Avenue

Chicago, Illinois 60601

51140
Aetna Life and Casualty

Medicare Claim Administration

1913 North Knoxville Avenue

P.O. Box 1702

December 9, 1982

Peoria, Illinois 61656

00122
Illinois Hospital and Health Services, Inc.

227 North Wyman Street

Rockford, Illinois 61101

INDIANA
00130
Mutual Hospital Insurance, Inc.

120 West Market Street

Indianapolis, Indiana 46204

IOWA
00140
Blue Cross of Iowa

Ruan Building

Des Moines, Iowa 50307

00141
Blue Cross of Western Iowa and South Dakota

Third and Pierce Streets

Sioux City, Iowa 51102

KANSAS
00150
Blue Cross of Kansas

1133 Topeka Boulevard

P.O. Box 239

Topeka, Kansas 66601

December 9, 1982

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KENTUCKY

00160

Blue Cross of Kentucky

9901 Linn Station Road

Louisville, Kentucky 40223

LOUISIANA

00170

Blue Cross of Louisiana

P.O. Box 15699

Baton Rouge, Louisiana 70815

MAINE

00180

Associated Hospital Service of Maine

110 Free Street

Portland, Maine 04101

MARYLAND

00190

Blue Cross of Maryland, Inc.

700 East joppa Road

Baltimore, Maryland 21204

52280

Mutual of Omaha

P.O. Box 456, Downtown Station

Omaha, Nebraska 68101

MASSACHUSETTS

00200

Blue Cross of Massachusetts, Inc.

100 Summer Street

Boston, Massachusetts 02106

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Service

**Intermediary
State
Number
Intermediary Office Address**

MASSACHUSETTS-Con.
51220
Aetna Life and Casualty

Medicare Claims Administration

400 Mechanics National Tower

Worcester Center

Worcester, Massachusetts 01608

MICHIGAN
00210
Blue Cross of Michigan

600 LaFayette East

Detroit, Michigan 48226

50230
The Travelers Insurance Company

26555 Evergreen

Detroit, Michigan 48076

MINNESOTA
00220
Blue Cross of Minnesota

3535 Blue Cross Road

St. Paul, Minnesota 55165

MISSISSIPPI
00230
Blue Cross of Mississippi

P.O. Box 1043

Jackson, Mississippi 39205

MISSOURI
00240
Blue Cross of Kansas City

3637 Broadway, P.O. Box 169

Kansas City, Missouri 64141

00241
Blue Cross Hospital Service of Missouri

4444 Forest Park Boulevard

St. Louis, Missouri 63108

MONTANA
00250
Blue Cross of Montana

P.O. Box 5004

Great Falls, Montana 59403

December 9, 1982

NEBRASKA
00260
Blue Cross of Nebraska

P.O. Box 3248

Main Post Office Station

Omaha, Nebraska 68101

52280
Mutual of Omaha Insurance Company

P.O. Box 456, Downtown Station

Omaha, Nebraska 68101

NEVADA
51290
Aetna Life and Casualty

4600 Kietzke Lane, Suite 155

P.O. Box 7290

Reno, Nevada 89510

NEW

HAMPSHIRE
00270
New Hampshire-Vermont Hospital Service

2 Pillsbury Street

Concord, New Hampshire 03301

NEW

JERSEY
53310
Prudential Insurance Company of America

P.O. Box 5000

Millville, New Jersey 08332

December 9, 1982

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December 7,

1983

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Service

**Intermediary
State
Number
Intermediary Office Address**

NEW

JERSEY-Con.
00280
Hospital Service Plan of New Jersey

33 Washington Street

Newark, New Jersey 07102

NEW

MEXICO
00290
New Mexico Blue Cross, Inc.

12800 Indian School Road, NE.

Albuquerque, New Mexico 87112

NEW

YORK
00300
Blue Cross of Northeastern New York, Inc.

P.O. Box 8650

Albany, New York 12208

December 9, 1982

00301
Blue Cross of Western New York, Inc.

Blue Cross Building

298 Main Street

Buffalo, New York 14202

50333
The Travelers Insurance Company

229 Seventh Street

Garden City, New York 11530

00303
Blue Cross of Greater New York

622 Third Avenue

New York, New York 100 1 7

00304
Rochester Hospital Service Corporation

41 Chestnut Street

Rochester, New York 14604

00305
Blue Cross of Central New York

344 South Warren Street

Syracuse, New York 13202

00306
Hospital Plan, Inc.

December 9, 1982

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5 Hopper Street

Utica, New York 13501

00307

Hospital Service Corporation of Jefferson County

158 Stone Street

Watertown, New York 13601

NORTH

CAROLINA

00310

North Carolina Blue Cross

P.O. Box 3824

Durham, North Carolina 27702

NORTH

DAKOTA

00320

Blue Cross of North Dakota

301 Eighth Street, South

Fargo, North Dakota 58102

OHIO

00332

Hospital Care Corporation

1351 Taft Road

Cincinnati, Ohio 45206

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December 7, 1983

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Intermediary

December 9, 1982

Service

**State
Number
Intermediary Office Address**

OHIO-Con.
00333
Blue Cross of Northeast Ohio

2066 East Ninth Street

Cleveland, Ohio 44115

00334
Blue Cross of Central Ohio

P.O. Box 16526

Columbus, Ohio 43216

56360
Nationwide Mutual Insurance Company

P.O. Box 1625

Columbus, Ohio 43216

00337
Blue Cross of Northwest Ohio

P.O. Box 943

Toledo, Ohio 43601

00338
Blue Cross of Eastern Ohio

2400 Market Street

Youngstown, Ohio 44507

OKLAHOMA
00340
Blue Cross of Oklahoma

December 9, 1982

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1215 South Boulder Avenue

Tulsa, Oklahoma 74119

OREGON
19050
Kaiser Foundation of Health Plan, Inc.

Medicare Liaison Division

1956 Webster Street, Room 310-A

Oakland, California 94612

00350
Northwest Hospital Service

P.O. Box 1271

Portland, Oregon 97207

PENNSYLVANIA
00360
Hospital Service Plan

1221 Hamilton Street

Allentown, Pennsylvania 18102

51390
Aetna Life and Casualty-Medicare

500 Office Center Building

Ft. Washington, Pennsylvania 19034

00361
Capital Blue Cross

100 Pine Street

Harrisburg, Pennsylvania 17101

00362
Blue Cross of Greater Philadelphia

1333 Chestnut **Street**

Philadelphia, Pennsylvania 19107

00363
Blue Cross of Western Pennsylvania

1 Smithfield Street

Pittsburgh, Pennsylvania 15222

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December

7,

1983

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Service

**Intermediary
State
Number
Intermediary Office Address**

PENNSYLVANIA-Con.
00364
Blue Cross of Northeastern Pennsylvania

70 North Main Street

PUERTO

Wilkes-Barre, Pennsylvania 18711

RICO

00470

Blue Cross of Florida/Puerto Rico, Inc.

P.O. Box 2711

Jacksonville, Florida 32203

57400

Cooperative de Sequros de Vida

de Puerto Rico

P.O. Box 3428-GPO

San Juan, Puerto Rico 00936

RHODE

ISLAND

00370

Blue Cross of Rhode Island

444 Westminister Mall

Providence, Rhode Island 02901

SOUTH

CAROLINA

00380

Blue Cross of South Carolina

Drawer F, Forest Acres Branch

Columbia, South Carolina 29219

SOUTH

DAKOTA

00141

Blue Cross of Western Iowa/South Dakota

Third and Pierce Streets

Sioux City, Iowa 51105

December 9, 1982

TENNESSEE
00390
Blue Cross of Tennessee

801 Pine Street

Chattanooga, Tennessee 37402

00392
Memphis Hospital Service and Surgical Association

8S Danny Thomas Boulevard

Memphis, Tennessee 38101

51441
Aetna Life and Casualty

2670 Union Avenue-Suite 606

Memphis, Tennessee 38112

TEXAS
00400
Group Hospital Service, Inc.

P.O. Box 22146

Dallas, Texas 75222

UTAH
00410
Blue Cross of Utah

P.O. Box 30269

Salt Lake City, Utah 84125

VERMONT
00270
New Hampshire-Vermont Hospitalization Service

I Pillsbury Street

December 9, 1982

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Concord, New Hampshire 03301

VIRGINIA
51490

Aetna Life and Casualty

3708 Washington Avenue

Newport News, Virginia 23607

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Part

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December 7, 1983

Chapter 15

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Service

Intermediary

State

Number

Intermediary Office Address

VIRGINIA-Con.

52280

Mutual of Omaha Insurance Company

P.O. Box 456, Downtown Station

Omaha, Nebraska 68101

00423

Blue Cross of Virginia

P.O. Box 27401

Richmond, Virginia 23261

00424

Blue Cross of Southwestern Virginia

3959 Electric Road, SW.

P.O. Box 13047

December 9, 1982

Roanoke, Virginia 24045

WASHINGTON
00430
Blue Cross, Washington-Alaska, Inc.

15700 Dayton Avenue, North

P.O. Box 327

Seattle, Washington 98113

51500
Aetna Life and Casualty

200 West Thomas Building

Seattle, Washington 98119

WEST

VIRGINIA
00441
Blue Cross Hospital Service, Inc.

P.O. Box 1353, Commerce Square

Charleston, West Virginia 25325

00443
Parkersburg Hospital Service, Inc.

203 Union Trust Building

P.O. Box 1948

Parkersburg, West Virginia 26101

00444
West Virginia Hospital Service, Inc.

20th and Chapline Street

Wheeling, West Virginia 26003

WISCONSIN
00450
Associated Hospital Service, Inc.

401 West Michigan Street

Milwaukee, Wisconsin 53201

WYOMING
00460
Wyoming Hospital Service

4020 House Avenue

P.O. Box 2266

Cheyenne, Wyoming 82001

VIRGIN

ISLANDS
52280
Mutual of Omaha Insurance Company

P.O. Box 456, Downtown Station

Omaha, Nebraska 68101

GUAM
17120
Hawaii Medical Service Association

1504 Kapiolana Boulevard

Honolulu, Hawaii 96808

USA
Administration
99990
Health Care Financing Administration

Office of Direct Reimbursement

1705 Equitable Building-B-4

Baltimore, Maryland 21235

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