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

Chapter 15, Charges and Payments for Medical Care (Sections I through VI)
(Paragraphs 15.01 through 15.48); Appendix 15A through Appendix 15J
Rescinds Chapter 15 dated July 14, 1971 through Change 10 dated February 5,1982
This document includes:

Title page and Foreword for M-1, Part I, dated **May 27, 1968** (Change 107)
Contents page for M-1, Part I, dated **July 27, 1993**
Contents and Rescissions pages for Chapter 15, dated **December 9, 1982**
Text for paragraphs 15.01 through 15.30, dated **December 9, 1982**
Text for paragraphs 15.31 through 15.48, dated **December 7, 1983** (Change 2)
Text for Appendix 15A through Appendix 15H, dated **December 9, 1982**
Text for Appendix 15I, dated **October 31, 1983** (Change 1)
Text for Appendix 15J, dated **December 7, 1983** (Change 2)

These are listed at the end of Chapter 15, Appendix J and **were not filed/scanned in chronological/numerical order:**

Text for Interim Issue 10-89-5, dated **December 29, 1989**
Text for Interim Issue 10-86-9, dated **October 23, 1986**
Text for Interim Issue 10-86-3, dated **March 11, 1986**
Text for Interim Issue 10-87-12, dated **November 2, 1987**
Text for Interim Issue 10-88-1, dated **January 25, 1988**
Text for Interim Issue 10-88-16, dated **September 15, 1988**
Text for Interim Issue 10-88-17, dated **November 3, 1988**
Text for Interim Issue 10-88-18, dated **November 18, 1988**
Text for Interim Issue 10-84-34, dated **December 21, 1984**
Text for Interim Issue 10-85-31, dated **December 31, 1985**
Text for Interim Issue 10-85-7, dated **February 7, 1985**

Text for Interim Issue 10-86-12, dated **December 24, 1986**
Change 2, dated **December 7, 1983**
Change 1, dated **October 31, 1983**
Transmittal sheet, dated **December 9, 1982**
Change 10, dated **February 5, 1982**
Change 9, dated **October 29, 1981**
Change 8, dated **August 10, 1978**
Change 7, dated **March 1, 1974**
Change 6, dated **October 18, 1973**
Change 5 dated **June 15, 1973**
Change 4, dated **April 30, 1973**
Change 3, dated **December 15, 1972**
Change 2, dated **February 14, 1972**
Change 1, dated **December 9, 1971**
Transmittal sheet, dated **July 14, 1971**

PART I

M-1

CHANGE 107

VETERANS ADMINISTRATION

DEPARTMENT OF MEDICINE AND SURGERY MANUAL

OPERATIONS

PART ONE

MEDICAL ADMINISTRATION ACTIVITIES

MAY 27, 196

WASHINGTON, D.C. 20420

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

May 27, 1968

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

H. M. Engle

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

Distribution: RPC: 1016
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FOREWORD

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

This manual consists of [seven] parts as follows:

Part I --- Medical [Administration] Activities
Part II --- Prosthetic and Sensory Aids
Part III --- [Domiciliary] ~~Administration~~ Visiting Service
Part IV --- Veterans Canteen Service
[Part V --- Performance Standards
Part VI --- Restoration Programs
Part VII --- Building Management Service]
3/1/85 Part VIII: Management and Staff Programs

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

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

[ ]

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

PART I. MEDICAL ADMINISTRATION ACTIVITIES

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RESCISSIONS

The following material is rescinded. (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 I, dated July 14, 1971, and changes 1 through 10.

b. **DM&S Circulars**

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10-76-22
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change 1

c. **Interim Issues**

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CHAPTER 15. CHARGES AND PAYMENTS FOR MEDICAL CARE

SECTION I. 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 (No-Fault 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. 5011, 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 diem 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 ~~Operation 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 ~~services and medical supplies~~ medical care by Chg. 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. I, 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 II. 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 in 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 which have adopted compensation to victims of crimes acts.

deleted by chg 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 2-4763, 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 119, 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 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 diem 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 diem 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. 15 I) Bey chg1

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 10-1023 and 2-4763 (if obtained) will be forwarded promptly to the District Counsel at the regional office of jurisdiction. Other related information pertinent to the claim, subsequently obtained, will also be submitted to that office. The District Counsel will be responsible for notifying the third party of the assignment of claim or cause of action, when indicated.	Hospital, nursing home, or outpatient care furnished to veterans for examination or treatment of disabilities resulting from negligence or legal wrong of a third party.	Appendix 15A.

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 employer when a veteran attributes the need for medical care to employment. Copies of VA Forms 10-2381 and 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.	Hospital, nursing home or outpatient care furnished to veterans for injury or disease resulting or allegedly resulting from their employment.	Appendix 15A or rates established by a State authority.

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 (021B) 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 par. 15.11a), 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.	Hospital, nursing home or outpatient care for which insurance carriers or group plan are or will become liable.	Appendix 15A.

15.17 d. Effective immediately, each VA medical facility will attach to each reimbursable insurance billing statement (UB-82) going to an insurer whose coverage is known or suspected bo be a supplement to Medicare, a copy of the HCFA letter addressed to the Deputy Assistant General Counsel dated July 20, 1988. Bills previously denied by Medicare supplemental carriers on the basis that Medicare was not billed will be resubmitted with the HCFA lettar as an attachment. (II 10-88-16)

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 119, 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 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 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.

15.18 NO-FAULT INSURANCE

Establishment of Claim	Medical Care Provided	Reimbursement Rates
When power of attorney is obtained on VA Form 10-2381, promptly notify the insurance carrier of the veteran's admission by use of FL 10-310 with an attached signed copy of VA Form 10-2381. When power of attorney is not obtained, forward a copy of VA Form 10-1023 to the District Counsel.	Hospital, nursing home or outpatient care for which insurance carriers are or will become liable.	Appendix 15A.

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 of Claim	Medical Care Provided	Reimbursement Rates
When power of attorney is obtained, forward a copy to the District Counsel with a Reference Slip, VA Form 3230, 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.	Hospital, nursing home or outpatient care furnished a veteran who is a victim of a crime of personal violence.	Appendix 15A.

a. Billings will be prepared on VA Form 10-9014 with item 11 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**

Emergency Treatment Provided	Medical Care Provided	Reimbursement Rates
Emergency humanitarian services to:	Emergency hospitalization and emergency outpatient treatment when furnished under:	Appendix 15A or as noted in subparagraphs below.
Nonveteran	VA Regulations 6046(C)(1) and 6060.2	
Ineligible person (Individual admitted to care on presumed entitlement and later found ineligible for medical care or readjustment counseling as a veteran.)	VA Regulations 6046(C)(2) and 6060.2	
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).	VA Regulations 6046(C)(3) and 6060.2	

(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.

Deleted by II 10-84-16

(5) When the VA provides medical care to an ineligible person who is a Medicare beneficiary and the services were provided in good faith on the mistaken assumption that the person was an eligible veteran, Public Law 95-142 authorizes Medicare reimbursement to the VA. Services provided will be reimbursed by Medicare through the day the VA medical facility was informed the patient was not an eligible veteran or the day it was medically feasible to discharge or transfer the patient to a Medicare participating hospital.

(a) Billings must be submitted within 6 months using the rates in 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 15E 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. All Public Law 95-142 claims will be submitted to:

Delete per II 10-84-16

Bureau of Support Services
Office of Direct Reimbursement
ATTN: Unit 34
P.O. Box 990
Baltimore, MD 21203

Health Care Financing Administration
Division of Accounting
P.O. Box 17255
Baltimore, MD 21203-7255
(This change 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, will 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, II, ch. 13; MP-1, pt. II, 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 Treatment Provided	Medical Care Provided	Reimbursement Rates
Medicare patients	Inpatient and outpatient care when furnished under VA Regulation 6046(C)(1) or 6060.2	Appendix 15E.

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.

(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 diem 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 diem 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 or 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 Care Financing Administration. A copy will be retained in the CHR until the receipt of HCFA Form 1568, Reply to Notice of Admission, which will furnish necessary information for proper billing. Deleted by II 10-84-16

(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)." DO NOT INCLUDE THE STATEMENT "SECTION 1814(C) CLAIM" ON THESE BILLINGS. by II 10-84-16

(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 Health Services, for outpatient services) at the same time. The "hospital copy" of HCFA Forms 1453 and/or 1483, as indicated, and a copy of HCFA Form 1568, Reply to Notice of Admission, received from the Health Care Financing Administration (for inpatient billings), will be filed in the patient's CHR. If the patient could not sign item 15, HCFA 1453, or item 12, HCFA 1483, on admission to care, is unable or unavailable to sign at time of billing and there is no representative to sign for the patient, the 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 Service for submission to: by II 10-84-16

delete & Proceed by II 10-84-16

Bureau of Support Services
Office of Direct Reimbursement
P.O. Box 990
Baltimore, Maryland 21203

HEALTH CARE FINANCING ADMINISTRATION
DIVISION OF ACCOUNTING
P.O. BOX 17255
BALTIMORE, MD. 21203-7255
(EFF. ON 7-2-84)

(6) **Deductible and Coinsurance Charges Billed to Medicare Beneficiaries.** The 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 part A from HCFA Form 1568. Amounts billed to the patient will be entered on lines V, W, and X of HCFA Form 1453 regardless of whether he/she has paid them. Entries in items 17E and 21, HCFA Form 1483, will reflect only amounts paid by the patient prior to submission of billing. When the patient is covered under part B, the HCFA Form 1568 will indicate whether the part B deductible has been met. If the deductible has not been met, or the patient is unable to supply this information, he/she will be billed for the entire current deductible plus 20 percent of the outpatient charges and/or medical services in excess of the deductible. Unless the HCFA Form 1568 indicates that the deductible has been met, the following statement will be placed on VA Form 10-9014 or the transmittal letter when billing for any portion of the part B deductible: "The charge for part B deductible is an estimate, based on available information and is subject to adjustment when official information is received from the Health Care Financing Administration." Sentence deleted by II 10-84-16

DIVISION OF ACCOUNTING by II 10-84-16

(7) **Refunds Due Medicare Patients.** Refunds of any amount erroneously collected from the patient prior to the submission of the billings for part B services (HCFA Form 1483) to HCFA will be made directly to the patient by HCFA and deducted from the hospital's reimbursement. Any other refunds due to a patient will be made by the medical facility.

delete & Proceed by CALLING HCFA, DIVISION OF ACCOUNTING by II 10-84-16

Proceed by II 10-84-16

HCFA, DIVISION OF ACCOUNTING WILL SUPPLY INFORMATION ON WHETHER OR NOT THE PATIENT IS COVERED UNDER PT. B & IF THE PT. B DEDUCTIBLE HAS BEEN MET.

c. **Persons Attending National Conventions of VA Recognized Service Organizations**

Emergency Treatment Provided	Medical Care Provided	Reimbursement Rates
Persons attending national conventions of VA recognized service organizations who are not eligible for such care as VA beneficiaries.	Emergency outpatient examination and treatment.	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. 5011, 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.

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 a 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	Medical Care	Reimbursement Rates
a. **Department of Defense**		
(1) Primary beneficiaries as specified in a negotiated agreement.	Inpatient and outpatient care or other medical services as specified in the agreement.	Use SF 1080 and negotiated agreement.
(2) In the absence of a negotiated agreement, active duty military personnel of the Army, Navy or Air Force.	Inpatient or outpatient care in emergencies, or inpatient care or outpatient examination/treatment when authorized by appropriate officials of the respective military departments.	Use SF 1080 and appendix 15D.

Federal Agency	Medical Care	Reimbursement Rates
(3) Inactive duty personnel of the uniformed services, including National Guard units.	Physical examination authorized by respective service departments.	Use SF 1080 and appendix 15D.
by chg. 1 In the absence of a negotiated VA-DOD sharing agreement send billings to: (4) ~~Send billings to:~~ Army	The Commander U.S. Army Health Services Command ATTN: HSC-CM Fort Sam Houston, TX 78234	
Navy (and Marines)	Chief, Bureau of Medicine and Surgery (Code 142) ~~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 the terms of 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 Agency	Medical Care	Reimbursement Rates
b. **Department of Transportation** Active Military Personnel of the U.S. Coast Guard	Inpatient or outpatient care and emergency dental treatment when authorized by a responsible official of the Coast Guard facility	See SF 1081 and appendix 15D.

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

Federal Agency	Medical Care	Reimbursement Rates
c. **Retired Members of the Uniformed Services**	Hospital care or outpatient treatment, on presentation of appropriate ID card, when not otherwise eligible as a VA beneficiary or as referred by terms of a negotiated agreement	Use SF 1080 and Appendix 15D or rates as specified in 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 non-service-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-1866-3 (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 ~~VIII~~ VIc. Schg. 1

(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 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
11th Floor, Room 1150
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 ~~SF 1081~~ SF 1080 to: Delete & Insert per II 10-84-19

~~Director, Federal Health Program Service~~
~~Financial Management Branch~~
~~5600 Fisher Lane~~
~~Rockville, MD 20852~~

Division of Beneficiary Medical Programs
Bureau of Health Care Delivery & Assistance
Parklawn Building, Room 7-36
5600 Fishers Lane
Rockville, MD 20857

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

(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 1173, Uniformed Services Identification and Privilege Card, is the primary means of identification.

(4) The CHAMPUS program requires copayment of certain expenses related to medical care provided. When inpatient care is received, spouses and children of active duty members pay the first $25 of the hospital charges or $6.55 per day, whichever is greater. (The $6.55 rate is effective October 1, 1982; rates 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.

(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) **Billing**

(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 (Office of Workers' Compensation Programs)**	Examination, medical treatment as authorized.	Use VAF 10-9014 and appendix 15D.

(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-exsiting, 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 15D.

(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 10 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 15D. 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 diem 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	Medical Care	Reimbursement Rates
f. **OPM (Office of Personnel Management)**	Physical examinations for Civil Service employment (other than VA) or disability retirement, or for Civil Service retirement annuitants, when authorized by OPM.	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.

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

Federal Agency	Medical Care	Reimbursement Rates
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.	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.	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, or initial treatment for a 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.

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	Medical Care	Reimbursement Rates
h. **PHS (Public Health Service)**		
(1) Commissioned Officers (Active duty)	Inpatient or outpatient care.	Use SF 1080 and appendix 15D.
(2) Other beneficiaries such as eligible seafarers.	Inpatient or outpatient care authorized in advance or provided in a life-threatening emergency.	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.)

15.26 MEDICAL CARE PROVIDED BENEFICIARIES OF OTHER FEDERAL AGENCIES

a. 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.

15.25 h (6) Notification of the PHS and request for authorization to treat a PHS beneficiary can be made by calling 1-800-368-2777. per II 10-84-19
15.25 h (7) Billings will be submitted to the address listed in subpara. c. per II 10-84-19

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

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 facilities 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. When medical 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 HHS (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.

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

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 hemodialysis 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 anesthesias, 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

Total Protein

Serum Albumin

Alkaline Phospatose

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 non-VA 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

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.

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 diem rate current at the time services were provided for domiciliary care. The local per diem 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 (10BA __/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 diem 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 outpatient 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.

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-feasor, 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:	**II 10-80-29**	**II 10-81-2**	**II 10-82-5**
Inpatient, per day: 5 Ch. 1			
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:	($110)	($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

Effective Date:	4/7/80	5/11/81	1/4/82
Reference:	II 10-80-29	II 10-81-2	II-10-82-5
Outpatient, per visit:			
Routine services	$ 51	$ 54	$ 61
[1] Specialized services			
[2] per prescription, refill only	5.75	6.25	6.25
[3] **Hemodialysis:**			
Hospital component	$141	$167	$172
Tort-feasor only	Inpatient Rate	Inpatient Rate	Inpatient Rate
All other	Inpatient Rate plus $141	Inpatient Rate plus $167	Inpatient Rate plus $172

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-feasor, 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	*See II 10-88-17, 11-3-88
Reference:	II 10-83-1	II 10-83-18	
Inpatient, per day:			
GM&S			
All-inclusive rate:	**($315)**	$319	
Itemized billings:			
Room, board and nursing	$203	$206	
Physician	80	$81	
Ancillary	32	$32	

Effective Date:	12-15-82	11-1-83	See II 10-88-17, 11-3-88
Reference:	II 10-83-1	II 10-83-18	
Inpatient, per day: (Con.)			
NP			
All-inclusive rate:	($195)	$185	
Itemized billings:			
Room, board and nursing	$135	$128	
Physician	46	$44	
Ancillary	14	$13	
	*II 10-82-35		
VA NHCU			
All-inclusive rate:	($119)	$126	
Itemized billings:			
Room, board and nursing	$95	$100	
Physician	13	$14	
Ancillary	11	$12	
Outpatient, per visit:			
Routine services	$65	$71	
[1] Specialized services Per prescription, refill [2] only	*$6.75	$7.50	
[3] **Hemodialysis:**			
Hospital component			
Tort-feasor only			
All other			

Community (Contract) Nursing Home:	Cost to the VA
Emergency Outpatient Dental Services:	See footnote 4
Prosthetics:	See footnote 1
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:

[1] *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.

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, Illinois. 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 other item or service furnished will be billed by the facility concerned. The per visit rate will not be charged in these cases.

[2] *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 made for each prescription in lieu of the perfacility-visit rate.*

[3] *Tort-feasor cases receiving hemodialysis care will be billed at the authorized inpatient per diem rate only. In all other third party cases, the hospital component for hemodialysis will be charged in addition to the appropriate inpatient per diem 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.*

[4] *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 of Maximum Allowances for Fee Dental Services for that State as prepared by the fee jurisdictional facility. (See par. 15.48.)*

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

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: i.e. 521

2. A 6-digit identifier consisting of:

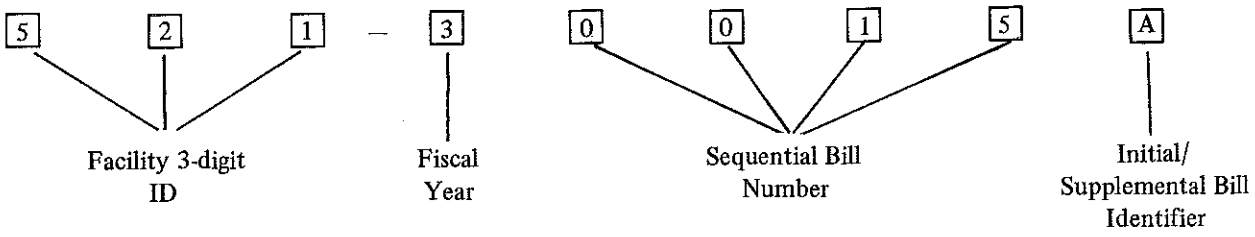
a. 1st position–fiscal year i.e.: Fiscal year "83"–521-3.

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, 521-32110D, 521-40072E, 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).



Item 3B–Date bill as prepared.

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 10 – 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.

Item 11– 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 12, 13, 14, and 15–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 diem 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 "All-inclusive 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 outpatient 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 1 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.

VA (EIN) (EMPLOYER IDENTIFICATION NUMBERS)

M&ROC's	EIN
402 Togus	01-6001944
405 White River Junction	03-0278504
436 Fort Harrison	81-0233746
437 Fargo	45-0226662
438 Sioux Falls	46-0227571
442 Cheyenne	83-0168494
452 Wichita	48-0544203
455 San Juan	66-0386593
460 Wilmington	51-0065004

MC's	
500 Albany	14-1339778
501 Albuquerque	85-0102219
502 Alexandria	72-0411414
503 Altoona	23-1357099
504 Amarillo	75-1616212
505 Tacoma	91-0565150
506 Ann Arbor	38-1358897
508 Decatur	58-0587213
509 Augusta	58-0587214
512 Baltimore	52-0615642
513 Batavia	16-1164194
514 Bath (M&D)	16-0763362
515 Battle Creek	38-1358893
516 Bay Pines (M&D)	59-2102233
517 Beckley	55-0357746
518 Bedford	04-6015879
519 Big Spring	75-6111827
520 Biloxi (M&D)	64-0317136
521 Birmingham	63-0810292
522 Bonham (M&D)	75-0793129
523 Boston	04-2133157
525 Brockton	04-2132902
526 Bronx	13-6009516
527 Brooklyn	11-1823825
528 Buffalo	16-1165465
529 Butler	25-0975161
531 Boise	82-0218828
532 Canandaigua	16-1171228
533 Castle Point	~~14-1339776~~ 14-1630103 by chg. 1
534 Charleston	57-0720016
535 Chicago (L)	36-2165436
537 Chicago (WS)	36-2480618
538 Chillicothe	31-6014208
539 Cincinnati	31-0542398
540 Clarksburg	55-0362865
541 Cleveland	34-0715726

MC's (Cont'd)	EIN
542 Coatesville	23-6014856
543 Columbia, MO	43-6161186
544 Columbia, SC	57-0314569
546 Miami	59-6003624
549 Dallas	75-6108647
550 Danville	37-0662493
552 Dayton (M&D)	31-0540155
553 Allen Park	38-1358896
554 Denver	84-0850519
555 Des Moines	42-0959192
556 N. Chicago	36-2171572
557 Dublin (M&D)	58-0561276
558 Durham	56-0564306
561 East Orange	22-1526640
562 Erie	25-0974473
564 Fayetteville, AR	71-0548518
565 Fayetteville, NC	56-1303855
566 Fort Howard	52-1221991
567 Fort Lyon	84-0853571
568 Fort Meade	46-0362332
569 Fort Wayne	35-1511916
570 Fresno	94-1160821
573 Gainesville	59-1222496
574 Grand Island	47-0376049
575 Grand Junction	84-0832294
578 Hines	36-2171572
579 Hot Springs (M&D)	46-0359485
580 Houston	74-2184934
581 Huntington	55-0357745
583 Indianapolis	35-1511916
584 Iowa city	42-1032435
585 Iron Mountain	38-1358898
586 Jackson	64-6006815
589 Kansas City	43-6173947
590 Hampton (M&D)	54-1172096
591 Kerrville	36-2542172
592 Knoxville	42-0680606
594 Lake City	59-0643002
595 Lebanon	23-1357100
596 Lexington	61-0443527
597 Lincoln	47-0376431
598 Little Rock ~~74-1612229~~	71-0550821
599 Livermore	94-2774270
600 Long Beach	95-1652897
603 Louisville	61-0990338
604 Lyons	22-1487104
605 Loma Linda	95-3625072
607 Madison	39-0817517

74-1612229F

MC's (Cont'd)	EIN
608 Manchester	02-0222932
609 Marion, IL	37-0662492
610 Marion, IN	35-1516418
611 Marlin	74-1115601
612 Martinez	94-2674840
613 Martinsburg (M&D)	55-0357747
614 Memphis	62-0480254
617 Miles City	81-0233747
618 Minneapolis	41-0696270
619 Montgomery	63-0288981
620 Montrose	13-3093365
621 Mountain Home (M&D)	62-0478102
622 Murfreesboro	62-0476141
623 Muskogee	73-0766778
626 Nashville	62-0484828
627 Newington	06-1044499
629 New Orleans	72-0448791
630 New York	13-2972977
631 Northampton	04-2104504
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

MC's (Cont'd)	EIN
670 Syracuse	15-0619303
671 San Antonio	74-2112082
673 Tampa	59-1641493
674 Temple (M&D)	75-1812000
676 Tomah	39-6011913
677 Topeka	48-0545196
678 Tucson	86-0096757
679 Tuscaloosa	63-0297932
680 Tuskegee	63-0803166
685 Waco	74-6026829
686 Leavenwroth (M&D)	48-0543337
687 Walla Walla	91-0579494
688 Washington	53-0197060
689 West Haven	06-0678854
690 West Roxbury	04-6322152
691 Los Angeles (W&B)	95-3626252
692 White City (DO)	93-0788526
693 Wilkes-Barre	24-0796250
695 Wood (M&D)	39-1326366

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:	**II 10-81-1**	**II 10-81-57**	**II 10-82-35**
5 by chg 1			
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 billings except Medicare outpatient	Inpatient rate plus $141	Inpatient rate plus $172	Inpatient rate plus $176
Medicare outpatient (maintenance dialysis)	$188	$223	$230

Community (Contract) Nursing Home:	Cost to the VA
Emergency Outpatient Dental Services:	See footnote 4
Prosthetics:	See footnote 1
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.

Fiscal Year:	1984	1985	1986
Effective Date:			
Reference:			
5 **Inpatient, per day:** Cy Chg. 1			
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: (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.

[1] *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.

Footnotes (Con.)

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 service 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, Illinois. 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 will be billed by the facility concerned. The per visit rate will not be charged in these cases.

[2] *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.*

[3] *The hospital component for hemodialysis will be charged in addition to the appropriate inpatient per diem 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 hemodialysis rate will be charged only for those days when hemodialysis was provided.*

[4] *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.)*

[5] 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 diem rate. by change 1

VA REIMBURSEMENT 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**	**10/1/82**
Reference:	**II 10-81-1**	**II 10-81-57**	
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**	by chg 1 1/1/84
Part A–Medical Services				
Inpatient (Hospital)				
First 60 days	$204	$260	$304	$356
61st thru 90th day	51	65	76	$89
60 Lifetime Reserve Days (nonrenewable)	102	130	152	$178
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.			

CHARGES TO THE VA—OTHER FEDERAL HOSPITALS

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

DOD Hospitals/Medical Centers

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

10-1-84	**Effective Date:**	**10/1/80**	**10/1/81**	**10/1/82**	10/1/83
II 10-85-15	**Reference:**	**II 10-81-1**	**II 10-82-2**	**II 10-82-52**	II 10-83-19
$423	**Inpatient** care, per day (and Panama as of 4/1/82)	$285	$348	$369	$327
	Panama (thru 3/31/82)	344	320	—	
$1,256	Burn Center, Brooke Army Hospital, per day	853	1,421	1,188	$1,342
$53	**Outpatient,** routine, per visit (and Panama as of 4/1/82)	28	35	35	$41
	Panama (thru 3/31/82)	38	32	—	
	Specialized services:	Cost to DOD			

HHS and PHS Hospitals

Effective Date:	**10/1/80**	**10/1/81**	**10/1/82**	10-1-84
Reference:	**II 10-81-1**	**II 10-82-2**	II	10-85-15
Inpatient care, per day	$224	$254	$282	$510 (GMS)/ $221 (NP)
Outpatient, routine, per visit	44	50	55	$62
Renal dialysis, per treatment	263	To be negotiated by individual facilities	To be negotiated by individual facilities	
Specialized services:	Cost to HHS or PHS			

(OVER)

DOD HOSPITALS/MEDICAL CENTERS

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

Effective Date:	10-1-85	10-1-86			
Reference :	II 10-85-32	II 10-1-86			
Inpatient care, per day (& Panama as of 4/1/82)	$410	$410			
Panama (thru 3/31/82)					
Burn Center, Brooke Army Hospital, per day	$1,344	$1,506			
Outpatient, routine, per visit (& Panama as of 4/1/82)	$55	$55			
Panama (thru 3/31/82)					
Specialized services:					

HHS AND PHS HOSPITALS

Effective Date:	10-1-85				
Reference:	II 10-85-32				
Inpatient care, per day	$505 (GM&S)/ $195 (NP)				
Outpatient, routine per visit	$64				
Renal dialysis, per treatment					
Specialized services					

VA PAYMENTS TO STATE VETERANS' HOMES

Maximum per diem 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
Reference:	**II 10-77-31**	**II 10-80-60**	II 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 diem rates for State veterans' homes are established by legislation and do not change annually or on a regular basis.

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.

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 Diem	Days (Limit)	Total 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

	Per Diem	Days (Limit)	Total 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
			$17,940.00
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	$1,035.92	20	$20,718.40
Part B Physician	234.76	20	4,695.20
			$25,413.60

	Per Diem	Days (Limit)	Total 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	Days	Total 20-Day Stay	Inpatient Per Diem After 20-Day Stay
FYE 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	20	10,508.40	200.50

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

4. Final inpatient per diem 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:

Period	Total Inpatient Per Diem	Hospital Part A Per Diem	Physician Part B 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			

5. 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
VAMC	COMPOSITE PROSPECTIVE REIMBURSEMENT RATE	MONTHLY CAPITATION RATE (PHYSICIAN COMPONENT)	COMPOSITE PROSPECTIVE REIMBURSEMENT RATE
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	

VAMC	COMPOSITE PROSPECTIVE REIMBURSEMENT RATE	MONTHLY CAPITATION RATE (PHYSICIAN COMPONENT)	COMPOSITE PROSPECTIVE REIMBURSEMENT RATE by II 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
SAN JUAN	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-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

provided the sharing facility should be annotated to indicate the amount of co-insurance and deductibles due from the sharing facility.) If the sharing facility cannot collect the co-insurance 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.

[MEDICARE FISCAL INTERMEDIARIES
STATE ALPHABETICAL LISTING

Service State	Intermediary 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 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

Service State	Intermediary 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
	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
	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

Service State	Intermediary 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 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
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

Service State	Intermediary 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
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

Service State	Intermediary 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
	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 10017
	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. 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

Service State	Intermediary 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 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

Service State	Intermediary Number	Intermediary Office Address
PENNSYLVANIA—Con.	00364	Blue Cross of Northeastern Pennsylvania 70 North Main Street Wilkes-Barre, Pennsylvania 18711
PUERTO 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
TENNESSEE	00390	Blue Cross of Tennessee 801 Pine Street Chattanooga, Tennessee 37402
	00392	Memphis Hospital Service and Surgical Association 85 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 1 Pillsbury Street Concord, New Hampshire 03301
VIRGINIA	51490	Aetna Life and Casualty 3708 Washington Avenue Newport News, Virginia 23607

Service State	Intermediary 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 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

☆U.S. Government Printing Office : 1984 – 421-432/3893

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II 10-89-5

December 29, 1989

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
VACO WASHINGTON, DC	ACTION: INFO: P	
ACCOUNTING CLASSIFICATION	DATE PREPARED 09-20-89	FILE
FOR INFORMATION CALL		
NAME STUART E. MOUNT	PHONE NUMBER 373-2143	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO: DIRECTORS, ALVAMCS, ALVAMDD, AND REGIONAL OFFICES WITH OUTPATIENT CLINICS (REGIONAL DIRECTORS)

THIS IS INTERIM ISSUE 10-89-5 (DTD: DECEMBER 29, 1989)

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: VHSR&A MANUAL M-1, PART I, CHAPTER 15

B. OTHER ISSUE AFFECTED: NONE.

C. REASON FOR ISSUE:

THE OMB (OFFICE OF MANAGEMENT AND BUDGET) HAS ESTABLISHED TORTIOUSLY LIABLE RATES EFFECTIVE OCTOBER 1, 1989. THIS INTERIM ISSUE PROVIDES INSTRUCTIONS FOR IMPLEMENTING NECESSARY CHANGES IN OUR BILLING PROGRAM.

D. TEXT OF ISSUE:

1. EFFECTIVE IMMEDIATELY, EACH VA HEALTH CARE FACILITY WILL PREPARE BILLINGS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1989. FOR ANY TORT FEASOR, WORKERS' COMPENSATION (OTHER THAN FEDERAL), HUMANITARIAN EMERGENCY, INELIGIBLE PERSON, VA EMPLOYEE OR FAMILY MEMBER, ALLIED BENEFICIARY, NO-FAULT OR UNINSURED

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14-103

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

MOTORIST'S INSURANCE, REPARATIONS FOR CRIMES OF PERSONAL VIOLENCE OR REIMBURSABLE INSURANCE. CORRECTED BILLINGS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1989, MUST BE PREPARED, IF PAYMENT HAS NOT YET BEEN RECEIVED, TO REFLECT THE REVISED RATES PUBLISHED IN THIS INTERIM ISSUE.

2. REVISED TORTIOUSLY LIABLE RATES EFFECTIVE OCTOBER 1, 1989, ARE AS FOLLOWS:

INPATIENT MEDICINE: ALL INCLUSIVE RATE	$554
ROOM, BOARD AND NURSING	311
PHYSICIAN	107
ANCILLARY	136
INPATIENT SURGERY: ALL INCLUSIVE RATE	$789
ROOM, BOARD AND NURSING	435
PHYSICIAN	148
ANCILLARY	206

SECURITY CLASSIFICATION

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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

INPATIENT PSYCHIATRY: ALL INCLUSIVE RATE	$273
ROOM, BOARD AND NURSING	193
PHYSICIAN	37
ANCILLARY	43
INPATIENT INTERMEDIATE CARE: ALL INCLUSIVE RATE	$234
ROOM BOARD AND NURSING	168
PHYSICIAN	34
ANCILLARY	32
INPATIENT NEUROLOGY: ALL INCLUSIVE RATE	$505
ROOM, BOARD AND NURSING	281
PHYSICIAN	63
ANCILLARY	161

PAGE NO.	NO. OF PGS.	SECURITY CLASSIFICATION
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14-103

STANDARD FORM 14
REVISED 11-80
GSA FPMR (41 CFR) 101-35.306

Previous editions usable NSN 7540-00-634-3968

II 10-89-5
December 29, 1989

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

INPATIENT REHABILITATION MEDICINE: ALL INCLUSIVE RATE	$412
ROOM, BOARD AND NURSING	238
PHYSICIAN	48
ANCILLARY	126
INPATIENT ALCOHOL AND DRUG TREATMENT: ALL INCLUSIVE RATE	$238
ROOM, BOARD AND NURSING	144
PHYSICIAN	44
ANCILLARY	50
INPATIENT BLIND REHABILITATION: ALL INCLUSIVE RATE	$568
ROOM, BOARD AND NURSING	212
PHYSICIAN	76
ANCILLARY	280

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II 10-89-5
December 29, 1989

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

VA NHCU: ALL INCLUSIVE RATE	$168
ROOM, BOARD AND NURSING	136
PHYSICIAN	8
ANCILLARY	24
INPATIENT SPINAL CORD INJURY: ALL INCLUSIVE RATE	$613
RPP,. BPARD AND NURSING	360
PHYSICIAN	73
ANCILLARY	180
OUTPATIENT, PER VISIT: ROUTINE SERVICES*	$116
* (INCLUDES OUTPATIENT DIALYSIS)	
DENTAL OUTPATIENT VISIT	$ 81
PRESCRIPTION REFILL ONLY	$ 17

THE NEW MEANS TEST OUTPATIENT RATE FOR CATEGORY C VETERANS IS $23.00

SECURITY CLASSIFICATION

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14-103

STANDARD FORM 14
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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

3. IF WE HAVE RECEIVED PAYMENT FROM A HIGHER RATE ALREADY BILLED FOR CARE RENDERED ON OR AFTER OCTOBER 1, 1989, PROCEDURES SHOULD BE IMPLEMENTED TO CORRECT THE OVERPAYMENT BY REFUND.

4. THESE REVISED RATES WILL BE INCORPORATED INTO A FORTHCOMING CHANGE TO M-1, PART I, CHAPTER 15.

E. RESCISSION: THIS INTERIM ISSUE RESCINDS INTERIM ISSUE 10-88-17 DATED NOVEMBER 3, 1988. THIS INTERIM ISSUE IS RESCINDED ON DECEMBER 31, 1990, AND WILL NOT BE CONFIRMED WITH A PRINTED ISSUE.

John A. Gronvall, M.D.

DISTRIBUTION; RPC: 1112 (VACO AND NONVA ONLY)

FD

SECURITY CLASSIFICATION	PAGE NO.	NO. OF PGS.
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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
VACO WASHINGTON, DC	ACTION: INFO: R	
ACCOUNTING CLASSIFICATION	DATE PREPARED 10/10/86	FILE
FOR INFORMATION CALL		
NAME JIM NORTON	PHONE NUMBER 233-2143	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPL ADDRE

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO: DIRECTORS, ALVAMC AND REGIONAL OFFICES WITH OUTPATIENT CLINICS; DISTRICT COUNSEL OFFICES; (REGIONAL DIRECTORS)

THIS IS INTERIM ISSUE 10-86-9 (DTD: 10-23-86)

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: DM&S MANUAL M-1, PART I, CHAPTER 15

B. OTHER ISSUES AFFECTED: NONE

C. REASON FOR ISSUE:

THE OMB (OFFICE OF MANAGEMENT AND BUDGET) HAS ESTABLISHED TORTIOUSLY LIABLE RATES EFFECTIVE OCTOBER 1, 1986. THIS INTERIM ISSUE PROVIDES INSTRUCTIONS FOR IMPLEMENTING NECESSARY CHANGES IN OUR BILLING PROGRAM.

D. TEXT OF ISSUE:

1. EFFECTIVE IMMEDIATELY, EACH VA HEALTH CARE FACILITY WILL PREPARE BILLINGS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1986. FOR ANY TORT FEASOR, WORKERS' COMPENSATION (OTHER THAN FEDERAL), HUMANITARIAN EMERGENCY, INELIGIBLE PERSON, VA EMPLOYEE OR FAMILY MEMBER, ALLIED BENEFICIARY, NO-FAULT OR

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NSN 7540-00-634-3948 ☆ U.S. Government Printing Office: 1984—421-408/11944

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

UNINSURED MOTORIST'S INSURANCE, REPARATIONS FOR CRIMES OF PERSONAL VIOLENCE OR REIMBURSABLE INSURANCE. CORRECTED BILLINGS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1986, MUST BE PREPARED, IF PAYMENT HAS NOT YET BEEN RECEIVED, TO REFLECT THE REVISED RATES PUBLISHED IN THIS INTERIM ISSUE.

2. REVISED TORTIOUSLY LIABLE RATES EFFECTIVE OCTOBER 1, 1986, ARE AS FOLLOWS:

INPATIENT MEDICINE: ALL INCLUSIVE RATE	$436
ROOM, BOARD AND NURSING	286
PHYSICIAN	48
ANCILLARY	102
INPATIENT SURGERY: ALL INCLUSIVE RATE	$508
ROOM, BOARD AND NURSING	330
PHYSICIAN	64
ANCILLARY	114

SECURITY CLASSIFICATION

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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

INPATIENT PSYCHIATRY: ALL INCLUSIVE RATE	$323
ROOM, BOARD AND NURSING	249
PHYSICIAN	23
ANCILLARY	51
INPATIENT INTERMEDIATE CARE: ALL INCLUSIVE RATE	$197
ROOM, BOARD AND NURSING	161
PHYSICIAN	11
ANCILLARY	25
INPATIENT NEUROLOGY: ALL INCLUSIVE RATE	$378
ROOM, BOARD AND NURSING	250
PHYSICIAN	12
ANCILLARY	116

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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

INPATIENT REHABILITATION MEDICINE: ALL INCLUSIVE RATE	$344
ROOM, BOARD AND NURSING	234
PHYSICIAN	7
ANCILLARY	103
INPATIENT ALCOHOL AND DRUG TREATMENT: ALL INCLUSIVE RATE	$121
ROOM BOARD AND NURSING	82
PHYSICIAN	14
ANCILLARY	25
INPATIENT BLIND REHABILITATION: ALL INCLUSIVE RATE	$485
ROOM, BOARD AND NURSING	227
PHYSICIAN	13
ANCILLARY	245

SECURITY CLASSIFICATION

PAGE NO.	NO. OF PGS.
4	6

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

VA NHCU: ALL INCLUSIVE	$167
ROOM, BOARD AND NURSING	141
PHYSICIAN	4
ANCILLARY	22
INPATIENT SPINAL CORD INJURY: ALL INCLUSIVE RATE	$501
ROOM, BOARD AND NURSING	348
PHYSICIAN	11
ANCILLARY	142
OUTPATIENT, PER VISIT: ROUTINE SERVICES	$ 69
PRESCRIPTION REFILL ONLY	$ 13

SECURITY CLASSIFICATION

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STANDARD FORM 14
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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

3. THESE REVISED RATES WILL BE INCORPORATED INTO A FORTHCOMING CHANGE TO M-1, PART I, CHAPTER 15.

E. RESCISSION: THIS INTERIM ISSUE IS RESCINDED ON OCTOBER 22, 1987, AND WILL NOT BE CONFIRMED WITH A PRINTED COPY.

136F/10

John A. Gronvall

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

DISTRIBUTION: RPC: 1112 (VACO & NONVA ONLY)
FD

SECURITY CLASSIFICATION

PAGE NO.	NO. OF PGS.
6	6

3-27-86

II 10-86-3
March 11, 1986

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
VACO WASHINGTON, D.C. 20420	ACTION: INFO:	
ACCOUNTING CLASSIFICATION	DATE PREPARED 11/8/85	FILE
FOR INFORMATION CALL		
NAME STUART MOUNT (136F)	PHONE NUMBER 389-2143	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

PLEASE RESTRICT TRANSMISSION TO 69 CHARACTERS PER LINE

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO: DIRECTORS, ALVAMC AND REGIONAL OFFICES WITH OUTPATIENT CLINICS;

DISTRICT COUNSEL OFFICES; (REGIONAL DIRECTORS)

THIS IS INTERIM ISSUE 10-86-3 (DTD: 3-11-86)

A. BASIC ADMINISTRATIVE ISSUES AFFECTED: DM&S MANUAL M-1, PART I, CHAPTER 15

B. OTHER ISSUES AFFECTED: NONE

C. REASON FOR ISSUE:

THE VA HAS ESTABLISHED REVISED INTERAGENCY BILLING RATES EFFECTIVE DECEMBER 1, 1985. THIS INTERIM ISSUE PROVIDES INSTRUCTIONS FOR IMPLEMENTING NECESSARY CHANGES IN OUR BILLING PROGRAM.

D. TEXT OF ISSUE:

1. EFFECTIVE IMMEDIATELY, EACH VA HEALTH CARE FACILITY WILL PREPARE BILLINGS FOR SERVICES RENDERED TO BENEFICIARIES OF OTHER FEDERAL AGENCIES ON OR AFTER DECEMBER 1, 1985, AT THE REVISED RATES PUBLISHED IN THIS INTERIM ISSUE. CORRECTED BILLINGS FOR SERVICES SHOULD BE PREPARED TO REFLECT THE REVISED RATES PUBLISHED IN THIS INTERIM ISSUE.

SECURITY CLASSIFICATION		
PAGE NO.	NO. OF PGS.	
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TELEGRAPHIC MESSAGE

II 10-86-3
March 11, 1986

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

2. REVISED INTERAGENCY RATES EFFECTIVE DECEMBER 1, 1985, ARE AS FOLLOWS:

MEDICINE	$340
SPINAL CORD INJURY	$345
SURGERY	$360
PSYCHIATRY	$281
DRUG AND ALCOHOL	$162
NURSING HOME	$119
OUTPATIENT	$ 64
PHARMACY-PRESCRIPTION REFILL	$ 11.00
HEMODIALYSIS:	
HOSPITAL COMPONENT	$118
PHYSICIAN COMPONENT	$ 12

THE HOSPITAL COMPONENT FOR HEMODIALYSIS WILL BE CHARGED IN ADDITION TO THE INPATIENT PER DIEM RATE EXCEPT WHEN BILLING MEDICARE FOR MAINTENANCE DIALYSIS, IN WHICH CASE THE PHYSICIAN COMPONENT WILL BE CHARGED IN ADDITION TO THE HOSPITAL COMPONENT. IF OTHER THAN

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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

MAINTENANCE DIALYSIS CARE IS PROVIDED TO A MEDICARE BENEFICIARY TREATED AS A HUMANITARIAN EMERGENCY, AN ADDITIONAL CHARGE FOR AN OUTPATIENT VISIT MAY BE MADE BY THE VA.

INPATIENT CHARGES TO OTHER FEDERAL AGENCIES WILL BE AT THE CURRENT INTERAGENCY PER DIEM RATE FOR THE TYPE OF BED SECTION OR DISCRETE TREATMENT UNIT PROVIDING THE CARE.

3. THESE REVISED INTERAGENCY RATES WILL BE INCORPORATED INTO A FORTHCOMING CHANGE TO M-1, PART I, CHAPTER 15.

E. RESCISSION: THIS INTERIM ISSUE IS RESCINDED ON MARCH 10, 1987, AND WILL NOT BE CONFIRMED WITH A PRINTED ISSUE. 136F/10A

John W. Ditzler

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

DISTRIBUTION: RPC: 1112 (VACO AND NONVA ONLY)
FD

SECURITY CLASSIFICATION		
PAGE NO.	NO. OF PGS.	
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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
VACO WASHINGTON, DC	ACTION: INFO: p	
ACCOUNTING CLASSIFICATION	DATE PREPARED 10/14/87	FILE
FOR INFORMATION CALL		
NAME NANCY HOWARD	PHONE NUMBER 373-2143	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO: DIRECTORS, ALVAMC AND REGIONAL OFFICES WITH OUTPATIENT CLINICS;

DISTRICT COUNSEL OFFICES; (REGIONAL DIRECTORS)

THIS IS INTERIM ISSUE 10-87-12 (DTD: 11/2/87)

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: DM&S MANUAL M-1

PART I, CHAPTER 15

B. OTHER ISSUES AFFECTED: NONE.

C. REASON FOR ISSUE:

THE OMB (OFFICE OF MANAGEMENT AND BUDGET) HAS ESTABLISHED TORTIOUSLY LIABLE RATES EFFECTIVE OCTOBER 1, 1987. THIS INTERIM ISSUE PROVIDES INSTRUCTIONS FOR IMPLEMENTING NECESSARY CHANGES IN OUR BILLING PROGRAM.

D. TEXT OF ISSUE:

1. EFFECTIVE IMMEDIATELY, EACH VA HEALTH CARE FACILITY WILL PREPARE BILLINGS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1987. FOR ANY TORT FEASOR, WORKERS' COMPENSATION (OTHER THAN FEDERAL), HUMANITARIAN EMERGENCY, INELIGIBLE PERSON, VA EMPLOYEE OR FAMILY MEMBER, ALLIED BENEFICIARY, NO-FAULT OR

SECURITY CLASSIFICATION

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II 10-87-12
November 2, 1987

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

UNINSURED MOTORIST'S INSURANCE, REPARATIONS FOR CRIMES OF PERSONAL VIOLENCE OR REIMBURSABLE INSURANCE. CORRECTED BILLINGS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1987, MUST BE PREPARED, IF PAYMENT HAS NOT YET BEEN RECEIVED, TO REFLECT THE REVISED RATES PUBLISHED IN THIS INTERIM ISSUE.

2. REVISED TORTIOUSLY LIABLE RATES EFFECTIVE OCTOBER 1, 1987, ARE AS FOLLOWS:

INPATIENT MEDICINE: ALL INCLUSIVE RATE	$473
ROOM, BOARD AND NURSING	266
PHYSICIAN	91
ANCILLARY	116
INPATIENT SURGERY: ALL INCLUSIVE RATE	$611
ROOM, BOARD AND NURSING	337
PHYSICIAN	114
ANCILLARY	160

SECURITY CLASSIFICATION

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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

INPATIENT PSYCHIATRY: ALL INCLUSIVE RATE	$236
ROOM, BOARD AND NURSING	168
PHYSICIAN	32
ANCILLARY	36
INPATIENT INTERMEDIATE CARE: ALL INCLUSIVE RATE	$190
ROOM, BOARD AND NURSING	137
PHYSICIAN	27
ANCILLARY	26
INPATIENT NEUROLOGY: ALL INCLUSIVE RATE	$393
ROOM, BOARD AND NURSING	219
PHYSICIAN	49
ANCILLARY	125

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II 10-87-12
November 2, 1987

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

INPATIENT REHABILITATION MEDICINE: ALL INCLUSIVE RATE	$372
ROOM, BOARD AND NURSING	215
PHYSICIAN	44
ANCILLARY	113
INPATIENT ALCOHOL AND DRUG TREATMENT: ALL INCLUSIVE RATE	$197
ROOM BOARD AND NURSING	119
PHYSICIAN	37
ANCILLARY	41
INPATIENT BLIND REHABILITATION: ALL INCLUSIVE RATE	$465
ROOM, BOARD AND NURSING	174
PHYSICIAN	62
ANCILLARY	229

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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

VA NHCU: ALL INCLUSIVE	$168
ROOM, BOARD AND NURSING	136
PHYSICIAN	8
ANCILLARY	24
INPATIENT SPINAL CORD INJURY: ALL INCLUSIVE	$524
ROOM, BOARD AND NURSING	308
PHYSICIAN	62
ANCILLARY	154
OUTPATIENT, PER VISIT: ROUTINE SERVICES*	$127
*(INCLUDES OUTPATIENT DIALYSIS)	
PRESCRIPTION REFILL ONLY	$14

THE NEW MEANS TEST OUTPATIENT RATE FOR CATEGORY C VETERANS IS $25.00.

SECURITY CLASSIFICATION

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II 10-87-12
November 2, 1987

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

3. THESE REVISED RATES WILL BE INCORPORATED INTO A FORTHCOMING CHANGE TO M-1, PART I, CHAPTER 15.

E. RESCISSION: THIS INTERIM ISSUE IS RESCINDED ON NOVEMBER 1, 1988, AND WILL NOT BE CONFIRMED WITH A PRINTED ISSUE.

136F/10

John A Gronvall, M.D.

DISTRIBUTION: RPC: 1112 (VACO AND NONVA ONLY)
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TELEGRAPHIC MESSAGE

January 25, 1988

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
VACO WASHINGTON, DC	ACTION: INFO: P	
ACCOUNTING CLASSIFICATION	DATE PREPARED 12/23/87	FILE
FOR INFORMATION CALL		
NAME NANCY HOWARD	PHONE NUMBER 373-2504	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO: DIRECTORS, ALVAMC AND REGIONAL OFFICES WITH OUTPATIENT CLINICS; ~~DISTRICT COUNSEL OFFICES; (REGIONAL DIRECTORS) (MEDICAL DISTRICT DIRECTORS)~~

00/ THIS IS INTERIM ISSUE 10-88-1

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: DM&S MANUAL M-1, PART I, CHAPTER 15.

B. OTHER ISSUES AFFECTED: NONE.

C. REASON FOR ISSUE:

THE VA HAS ESTABLISHED REVISED INTERAGENCY BILLING RATES EFFECTIVE DECEMBER 1, 1987. THIS INTERIM ISSUE PROVIDES INSTRUCTIONS FOR IMPLEMENTING NECESSARY CHANGES IN OUR BILLING PROGRAM.

D. TEXT OF ISSUE:

1. EFFECTIVE IMMEDIATELY, EACH VA HEALTH CARE FACILITY WILL PREPARE BILLINGS FOR SERVICES RENDERED TO BENEFICIARIES OF OTHER FEDERAL AGENCIES ON OR AFTER DECEMBER 1, 1987, AT THE REVISED RATES PUBLISHED IN THIS INTERIM ISSUE. CORRECTED

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II 10-88-1
January 25, 1988

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

BILLINGS FOR SERVICES SHOULD BE PREPARED TO REFLECT THE REVISED RATES PUBLISHED IN THIS INTERIM ISSUE.

2. REVISED INTERAGENCY RATES EFFECTIVE DECEMBER 1, 1987, ARE AS FOLLOWS:

MEDICINE	$396
SURGERY	$516
SPINAL CORD INJURY	$436
BLIND REHABILITATION	$387
NEUROLOGY	$327
REHABILITATION MEDICINE	$310
GENERAL PSYCHIATRY	$194
INTERMEDIATE MEDICINE	$155
NURSING HOME CARE	$140
ALCOHOL - DRUG	$162
PRESCRIPTION - REFILL	$ 13
OUTPATIENT*	$107

RATE INCLUDES DIALYSIS TREATMENT

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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO: INPATIENT CHARGES TO OTHER FEDERAL AGENCIES WILL BE AT THE CURRENT INTERAGENCY PER DIEM RATE FOR THE TYPE OF BED SECTION OR DISCRETE TREATMENT UNIT PROVIDING THE CARE.

3. THESE REVISED INTERAGENCY RATES WILL BE INCORPORATED INTO THE REVISION OF M-1, PART I, CHAPTER 15.

4. THESE RATES SHOULD NOT BE USED FOR LOCALLY DEVELOPED VA/DOD SHARING AGREEMENTS. RATES FOR VA/DOD SHARING AGREEMENTS SHOULD BE DEVELOPED BASED ON LOCAL COSTS.

E. RESCISSION: THIS INTERIM ISSUE RESCINDS INTERIM ISSUE 10-86-12 DATED DECEMBER 24, 1986 AND WILL NOT BE CONFIRMED BY A PRINTED ISSUE.

F. FOLLOW-UP RESPONSIBILITY: DIRECTOR, MEDICAL ADMINISTRATION SERVICE (136F).

John A Gronvall, M.D.

DISTRIBUTION: RPC: 1112 (VACO AND NONVA ONLY)
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September 15, 1988

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
VACO WASHINGTON, DC	ACTION: P INFO:	
ACCOUNTING CLASSIFICATION	DATE PREPARED 8/26/88	FILE
FOR INFORMATION CALL		
NAME PATRICK KIELY	PHONE NUMBER 233-2933	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO: DIRECTORS, ALVAMC, ALVAMDD, AND REGIONAL OFFICES WITH OUTPATIENT CLINICS, (REGIONAL DIRECTORS)

00/136 THIS IS INTERIM ISSUE 10-88-16 (DTD: 9-15-88)

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: DM&S MANUAL M-1, PART I, CHAPTER 15.

B. OTHER ISSUES AFFECTED: NONE.

C. REASON FOR ISSUE:

1. MANY HEALTH INSURANCE POLICIES ARE WRITTEN AS A SUPPLEMENT TO COVERAGE PROVIDED BY MEDICARE AND WILL ACCEPT BILLS FOR PAYMENT CONSIDERATION ONLY AFTER THE BILLS HAVE BEEN REVIEWED BY MEDICARE. SINCE THE VA IS PROHIBITED BY LAW TO BILL MEDICARE, MOST OF THESE "MEDICARE SUPPLEMENTAL" CARRIERS ARE DENYING PAYMENT ON THE BASIS THAT MEDICARE, THE PRIMARY PAYER, HAS NOT BEEN BILLED.

2. DUE TO THE PROHIBITION AGAINST THE VA BILLING MEDICARE, WHICH CLEARLY RULES-OUT ANY POSSIBILITY OF OBTAINING A BILL-SPECIFIC DENIAL FROM THE HEALTH CARE FINANCING ADMINISTRATION (HCFA), HCFA HAS PROVIDED A GENERAL STATEMENT WHICH EXPLAINS THEIR STATUTORY RESTRICTION AGAINST FINANCING VA CARE EXCEPT UNDER LIMITED CIRCUMSTANCES. THIS STATEMENT,

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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
THIS SPACE FOR USE OF COMMUNICATION UNIT		

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

WHICH IS INCLUDED IN A HCFA LETTER DATED JULY 20, 1988, ADDRESSED TO THE VA'S DEPUTY ASSISTANT GENERAL COUNSEL, SHOULD SERVE TO SATISFY THE BILL PROCESSING REQUIREMENTS OF THE MEDICARE SUPPLEMENTAL CARRIERS.

3. SINCE THE MEDICARE SUPPLEMENTAL CARRIERS WILL REQUIRE AN "OFFICIAL" RESPONSE FROM HCFA, THE ABOVE-REFERENCED LETTER WILL, EFFECTIVE IMMEDIATELY, ACCOMPANY EACH REIMBURSABLE INSURANCE BILLING STATEMENT REFERRED TO INSURERS WHOSE COVERAGE IS KNOWN OR SUSPECTED TO BE WRITTEN AS A MEDICARE SUPPLEMENTAL POLICY. COPIES OF THE HCFA LETTER HAVE BEEN DISTRIBUTED TO EACH FACILITY AS AN ATTACHMENT TO THE TRANSCRIPT OF MEDICAL ADMINISTRATION SERVICE'S AUGUST 17, 1988, REGULARLY SCHEDULED MONTHLY CONFERENCE CALL. FACILITIES WHICH HAVE NOT RECEIVED A COPY OF THAT LETTER, ARE DIRECTED TO CONTACT MR. PATRICK KIELY (136B) AT FTS 373-2933 ASAP.

D. <u>TEXT OF ISSUE:</u>

1. INSERT NEW PARAGRAPH 15.17 d, "d. EFFECTIVE IMMEDIATELY, EACH VA MEDICAL FACILITY WILL ATTACH TO EACH REIMBURSABLE INSURANCE BILLING STATEMENT (UB-82) GOING TO AN INSURER WHOSE COVERAGE IS KNOWN OR SUSPECTED TO BE A SUPPLEMENT TO MEDICARE, A COPY OF THE HCFA LETTER ADDRESSED TO THE DEPUTY ASSISTANT

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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
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FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

GENERAL COUNSEL DATED JULY 20, 1988. BILLS PREVIOUSLY DENIED BY MEDICARE SUPPLEMENTAL CARRIERS ON THE BASIS THAT MEDICARE WAS NOT BILLED WILL BE RESUBMITTED WITH THE HCFA LETTER AS AN ATTACHMENT."

E. RESCISSIONS: THIS INTERIM ISSUE IS RESCINDED ON SEPTEMBER 15, 1989 AND WILL NOT BE CONFIRMED WITH A PRINTED ISSUE.

John A Gronvall, M.D.

DISTRIBUTION: RPC: 1112 (VACO AND NONVA ONLY)
FD

SECURITY CLASSIFICATION

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II 10-88-17

November 3, 1988

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
VACO WASHINGTON, D.C.	ACTION: INFO: P	
ACCOUNTING CLASSIFICATION	DATE PREPARED 10-12-88	FILE
FOR INFORMATION CALL		
NAME NANCY L. HOWARD	PHONE NUMBER 373-3187	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

DIRECTORS, ALVAMCS, ALVAMDD, AND REGIONAL OFFICES WITH OUTPATIENT CLINICS; (REGIONAL DIRECTORS)

THIS IS INTERIM ISSUE 10-88-17 (DTD: 11-3-88)

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: DM&S MANUAL M-1, PART I, CHAPTER 15

B. OTHER ISSUES AFFECTED: NONE.

C. REASON FOR ISSUE:

THE OMB (OFFICE OF MANAGEMENT AND BUDGET) HAS ESTABLISHED TORTIOUSLY LIABLE RATES EFFECTIVE OCTOBER 1, 1988. THIS INTERIM ISSUE PROVIDES INSTRUCTIONS FOR IMPLEMENTING NECESSARY CHANGES IN OUR BILLING PROGRAM.

D. TEXT OF ISSUE:

1. EFFECTIVE IMMEDIATELY, EACH VA HEALTH CARE FACILITY WILL PREPARE BILLINGS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1988. FOR ANY TORT FEASOR, WORKERS' COMPENSATION (OTHER THAN FEDERAL), HUMANITARIAN EMERGENCY, INELIGIBLE PERSON, VA EMPLOYEE OR FAMILY MEMBER, ALLIED BENEFICIARY, NO-FAULT OR UNINSURED

SECURITY CLASSIFICATION	PAGE NO.	NO. OF PGS.
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II 10-88-17
November 3, 1988

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ M PLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

MOTORIST'S INSURANCE, REPARATIONS FOR CRIMES OF PERSONAL VIOLENCE OR REIMBURSABLE INSURANCE. CORRECTED BILLINGS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1988, MUST BE PREPARED, IF PAYMENT HAS NOT YET BEEN RECEIVED, TO REFLECT THE REVISED RATES PUBLISHED IN THIS INTERIM ISSUE.

2. REVISED TORTIOUSLY LIABLE RATES EFFECTIVE OCTOBER 1, 1988, ARE AS FOLLOWS:

INPATIENT MEDICINE: ALL INCLUSIVE RATE	$483
ROOM, BOARD AND NURSING	271
PHYSICIAN	93
ANCILLARY	119
INPATIENT SURGERY: ALL INCLUSIVE RATE	$681
ROOM, BOARD AND NURSING	375
PHYSICIAN	128
ANCILLARY	178

SECURITY CLASSIFICATION

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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

INPATIENT PSYCHIATRY: ALL INCLUSIVE RATE	$232
ROOM, BOARD AND NURSING	164
PHYSICIAN	32
ANCILLARY	36
INPATIENT INTERMEDIATE CARE: ALL INCLUSIVE RATE	$209
ROOM, BOARD AND NURSING	150
PHYSICIAN	30
ANCILLARY	29
INPATIENT NEUROLOGY: ALL INCLUSIVE RATE	$426
ROOM, BOARD AND NURSING	237
PHYSICIAN	53
ANCILLARY	136

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November 3, 1988

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BO' ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

INPATIENT REHABILITATION MEDICINE: ALL INCLUSIVE RATE	$374
ROOM, BOARD AND NURSING	216
PHYSICIAN	44
ANCILLARY	114
INPATIENT ALCOHOL AND DRUG TREATMENT: ALL INCLUSIVE RATE	$213
ROOM, BOARD AND NURSING	129
PHYSICIAN	40
ANCILLARY	44
INPATIENT BLIND REHABILITATION: ALL INCLUSIVE RATE	$545
ROOM, BOARD AND NURSING	203
PHYSICIAN	73
ANCILLARY	269

SECURITY CLASSIFICATION

PAGE NO.	NO. OF PGS.
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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

VA NHCU: ALL INCLUSIVE RATE	$160
ROOM, BOARD AND NURSING	130
PHYSICIAN	7
ANCILLARY	23
INPATIENT SPINAL CORD INJURY: ALL INCLUSIVE RATE	$539
ROOM, BOARD AND NURSING	317
PHYSICIAN	64
ANCILLARY	158
OUTPATIENT, PER VISIT: ROUTINE SERVICES*	$110
* (INCLUDES OUTPATIENT DIALYSIS)	
DENTAL OUTPATIENT VISIT	$ 70
PRESCRIPTION REFILL ONLY	$ 16

THE NEW MEANS TEST OUTPATIENT RATE FOR CATEGORY C VETERANS IS $22.00.

SECURITY CLASSIFICATION

PAGE NO.	NO. OF PGS.
5	6

II 10-88-17
November 3, 1988

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

3. IF WE HAVE RECEIVED PAYMENT FROM A HIGHER RATE ALREADY BILLED FOR CARE RENDERED ON OR AFTER OCTOBER 1, 1988, PROCEDURES SHOULD BE IMPLEMENTED TO CORRECT THE OVERPAYMENT BY REFUND.

4. THESE REVISED RATES WILL BE INCORPORATED INTO A FORTHCOMING CHANGE TO M-1, PART I, CHAPTER 15.

E. RESCISSION: THIS INTERIM ISSUE RESCINDS INTERIM ISSUE 10-87-12 DATED NOVEMBER 2, 1987. THIS INTERIM ISSUE IS RESCINDED ON NOVEMBER 3, 1989 AND WILL NOT BE CONFIRMED WITH A PRINTED ISSUE.

John A Gronvall, MD.

DISTRIBUTION: RPC: 1112 (VACO AND NONVA ONLY)
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SECURITY CLASSIFICATION		
PAGE NO.	NO. OF PGS.	
6	6	

II 10-88-18

November 18, 1988

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
VACO WASH DC	ACTION: P INFO:	
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME NANCY L. HOWARD	PHONE NUMBER 373-3187	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

DIRECTORS, ALVAMC, ALVAMDD AND REGIONAL OFFICES WITH OUTPATIENT CLINICS; DISTRICT COUNSEL OFFICES.

THIS IS INTERIM ISSUE 10-88-18 (DTD: 11-18-88)

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: DM&S MANUAL M-1, PART I, CHAPTER 15.

B. OTHER ADMINISTRATIVE ISSUE AFFECTED: NONE.

C. REASON FOR ISSUE:

THE VA HAS ESTABLISHED REVISED INTERAGENCY BILLING RATES EFFECTIVE DECEMBER 1, 1988. THIS INTERIM ISSUE PROVIDES INSTRUCTIONS FOR IMPLEMENTING NECESSARY CHANGES IN OUR BILLING PROGRAM.

D. TEXT OF ISSUE:

1. EFFECTIVE IMMEDIATELY, EACH VA HEALTH CARE FACILITY WILL PREPARE BILLINGS FOR SERVICES RENDERED TO BENEFICIARIES OF OTHER FEDERAL AGENCIES ON OR AFTER DECEMBER 1, 1988, AT THE REVISED RATES PUBLISHED IN THIS INTERIM ISSUE. CORRECTED BILLINGS

SECURITY CLASSIFICATION

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STANDARD FORM 14
REVISED 11-80
GSA FPMR (41 CFR) 101-35.306

Previous editions usable NSN 7540-00-634-3968

II 10-88-18
November 18, 1988

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

FOR SERVICES SHOULD BE PREPARED TO REFLECT THE REVISED RATES PUBLISHED IN THIS INTERIM ISSUE.

2. REVISED INTERAGENCY RATES EFFECTIVE DECEMBER 1, 1988 ARE AS FOLLOWS:

MEDICINE	$424
SURGERY	$602
SPINAL CORD INJURY	$470
BLIND REHABILITATION	$480
NEUROLOGY	$372
REHABILITATION MEDICINE	$327
GENERAL PSYCHIATRY	$201
INTERMEDIATE MEDICINE	$183
NURSING HOME CARE	$139
ALCOHOL - DRUG	$185
PRESCRIPTION - REFILL	$ 14
OUTPATIENT *	$ 96
DENTAL OUTPATIENT	$ 61

*RATE INCLUDES DIALYSIS TREATMENT

SECURITY CLASSIFICATION

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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

INPATIENT CHARGES TO OTHER FEDERAL AGENCIES WILL BE AT THE CURRENT INTERAGENCY PER DIEM RATE FOR THE TYPE OF BED SECTION OR DISCRETE TREATMENT UNIT PROVIDING THE CARE.

3. THESE REVISED INTERAGENCY RATES WILL BE INCORPORATED INTO THE REVISION OF M-1, PART I, CHAPTER 15.

4. THESE RATES SHOULD NOT BE USED FOR LOCALLY DEVELOPED VA/DOD SHARING AGREEMENTS. RATES FOR VA/DOD SHARING AGREEMENTS SHOULD BE DEVELOPED BASED ON LOCAL COSTS.

E. RESCISSION: THIS INTERIM ISSUE RESCINDS INTERIM ISSUE 10-88-1 DATED JANUARY 25, 1988 AND WILL NOT BE CONFIRMED BY A PRINTED ISSUE. THIS INTERIM ISSUE WILL BE RESCINDED ON NOVEMBER 17, 1989.

F. FOLLOW-UP RESPONSIBILITY: DIRECTOR, MEDICAL ADMINISTRATION SERVICE (136F).

John A. Gronvall, M.D.

DISTRIBUTION: RPC: 1112 (VACO AND NONVA ONLY)
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SECURITY CLASSIFICATION	PAGE NO.	NO. OF PGS.
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1-22-85

II 10-84-34
December 21, 1984

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE / ACTION: / INFO:	SECURITY CLASSIFICATION
VACO WASH., DC 20420		
ACCOUNTING CLASSIFICATION	DATE PREPARED 12/4/84	FILE
FOR INFORMATION CALL		
NAME KAREN WALTERS (136F)	PHONE NUMBER 389-2337	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

PLEASE RESTRICT TRANSMISSION TO 69 CHARACTERS PER LINE

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:
DIRECTORS, ALVAMC AND REGIONAL OFFICES WITH OUTPATIENT CLINICS;

DISTRICT COUNSEL OFFICES; (REGIONAL DIRECTORS)

THIS IS INTERIM ISSUE 10-84-34 (DTD 12-21-84)

A. BASIC ADMINISTRATIVE ISSUES AFFECTED: DM&S MANUAL M-1, PART I CHAPTER 15

B. OTHER ISSUES AFFECTED: NONE

C. REASON FOR ISSUE:

THE OMB (OFFICE OF MANAGEMENT AND BUDGET) HAS ESTABLISHED TORTIOUSLY LIABLE RATES EFFECTIVE OCTOBER 1, 1984. THIS INTERIM ISSUE PROVIDES INSTRUCTIONS FOR IMPLEMENTING NECESSARY CHANGES IN OUR BILLING PROGRAM.

D. TEXT OF ISSUE:

1. EFFECTIVE IMMEDIATELY, EACH VA HEALTH CARE FACILITY WILL PREPARE BILLINGS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1984, FOR ANY TORT FEASOR, WORKERS' COMPENSATION (OTHER THAN FEDERAL), HUMANITARIAN EMERGENCY, INELIGIBLE PERSON, VA EMPLOYEE OR FAMILY MEMBER, OR ALLIED BENEFICIARY, OR FOR REIMBURSABLE INSURANCE,

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II 10-84-34
December 21, 1984

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

NO-FAULT OR UNINSURED MOTORIST'S INSURANCE OR REPARATIONS FOR CRIMES OF PERSONAL VIOLENCE, AT THE REVISED RATES PUBLISHED IN THIS INTERIM ISSUE. CORRECTED BILLINGS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1984, MUST BE PREPARED, IF PAYMENT HAS NOT YET BEEN RECEIVED, TO REFLECT THE REVISED RATES PUBLISHED IN THIS INTERIM ISSUE.

2. REVISED TORTIOUSLY LIABLE RATES EFFECTIVE OCTOBER 1, 1984, ARE AS FOLLOWS:

INPATIENT MEDICINE: ALL INCLUSIVE RATE	$375
ROOM, BOARD AND NURSING	$243
PHYSICIAN	$ 94
ANCILLARY	$ 38
INPATIENT SURGERY: ALL INCLUSIVE RATE	$405
ROOM, BOARD AND NURSING	$262
PHYSICIAN	$102
ANCILLARY	$ 41

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II 10-84-34
December 21, 1984

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

INPATIENT SPINAL CORD INJURY: ALL INCLUSIVE RATE	$307
ROOM, BOARD AND NURSING	$198
PHYSICIAN	$ 78
ANCILLARY	$ 31
INPATIENT PSYCHIATRY: ALL INCLUSIVE RATE	$310
ROOM, BOARD AND NURSING	$215
PHYSICIAN	$ 74
ANCILLARY	$ 21
VA NHCU: ALL INCLUSIVE RATE	$139
ROOM, BOARD AND NURSING	$111
PHYSICIAN	$ 15
ANCILLARY	$ 13
OUTPATIENT, PER VISIT: ROUTINE SERVICES	$ 75
PER PRESCRIPTION REFILL ONLY	$ 8.75

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II 10-84-34
December 21, 1984

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

3. THESE REVISED RATES WILL BE INCORPORATED INTO A FORTHCOMING CHANGE TO M-1, PART I, CHAPTER 15.

E. RESCISSION: THIS INTERIM ISSUE IS RESCINDED ON DECEMBER 20, 1985 AND WILL NOT BE CONFIRMED WITH A PRINTED COPY. 136F/10

John W. Dutzler MD.

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FD
DCO-2 each

SECURITY CLASSIFICATION	PAGE NO.	NO. OF PGS.
	4	4

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
VACO WASHINGTON, DC 20420	ACTION: INFO:	
ACCOUNTING CLASSIFICATION	DATE PREPARED 11/8/85	FILE
FOR INFORMATION CALL		
NAME STUART MOUNT (136F)	PHONE NUMBER 389-2143	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

PLEASE RESTRICT TRANSMISSION TO 69 CHARACTERS PER LINE

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO: DIRECTORS, ALVAMC AND REGIONAL OFFICES WITH OUTPATIENT CLINICS; DISTRICT COUNSEL OFFICES; (REGIONAL DIRECTORS)

THIS IS INTERIM ISSUE 10-85-31 (DTD: 12-31-85)

A. BASIC ADMINISTRATIVE ISSUES AFFECTED: DM&S MANUAL M-1, PART I CHAPTER 15

B. OTHER ISSUES AFFECTED: NONE

C. REASON FOR ISSUE:

THE OMB (OFFICE OF MANAGEMENT AND BUDGET) HAS ESTABLISHED TORTIOUSLY LIABLE RATES EFFECTIVE OCTOBER 1, 1985. THIS INTERIM ISSUE PROVIDES INSTRUCTIONS FOR IMPLEMENTING NECESSARY CHANGES IN OUR BILLING PROGRAM.

D. TEXT OF ISSUE:

1. EFFECTIVE IMMEDIATELY, EACH VA HEALTH CARE FACILITY WILL PREPARE BILLINGS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1985, FOR ANY TORT FEASOR, WORKERS' COMPENSATION (OTHER THAN FEDERAL), HUMANITARIAN EMERGENCY, INELIGIBLE PERSON, VA EMPLOYEE OR FAMILY MEMBER, OR ALLIED BENEFICIARY, OR FOR REIMBURSABLE INSURANCE,

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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO: NO-FAULT OR UNINSURED MOTORIST'S INSURANCE OR REPARATIONS FOR CRIMES OF PERSONAL VIOLENCE, AT THE REVISED RATES PUBLISHED IN THIS INTERIM ISSUE. CORRECTED BILLINGS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1985, MUST BE PREPARED, IF PAYMENT HAS NOT YET BEEN RECEIVED, TO REFLECT THE REVISED RATES PUBLISHED IN THIS INTERIM ISSUE.

2. REVISED TORTIOUSLY LIABLE RATES EFFECTIVE OCTOBER 1, 1985, ARE AS FOLLOWS:

INPATIENT MEDICINE: ALL INCLUSIVE RATE	$418
ROOM, BOARD AND NURSING	$272
PHYSICIAN	$104
ANCILLARY	$ 42
INPATIENT SURGERY: ALL INCLUSIVE RATE	$453
ROOM, BOARD AND NURSING	$294
PHYSICIAN	$113
ANCILLARY	$ 46

SECURITY CLASSIFICATION

PAGE NO.	NO. OF PGS.
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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

INPATIENT SPINAL CORD INJURY: ALL INCLUSIVE RATE	$441
ROOM, BOARD AND NURSING	$287
PHYSICIAN	$110
ANCILLARY	$ 44
INPATIENT PSYCHIATRY: ALL INCLUSIVE RATE	$345
ROOM, BOARD AND NURSING	$238
PHYSICIAN	$ 83
ANCILLARY	$ 24
VA NHCU: ALL INCLUSIVE RATE	$154
ROOM, BOARD AND NURSING	$123
PHYSICIAN	$ 17
ANCILLARY	$ 14
OUTPATIENT, PER VISIT: ROUTINE SERVICES	$ 80
PER PRESCRIPTION REFILL ONLY	$ 11.00

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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO: 3. THESE REVISED RATES WILL BE INCORPORATED INTO A FORTHCOMING CHANGE TO M-1, PART I, CHAPTER 15.

E. RESCISSION: THIS INTERIM ISSUE IS RESCINDED ON 12-30-86, AND WILL NOT BE CONFIRMED WITH A PRINTED COPY. 136F/10

John W. Ziegler

DISTRIBUTION: RPC: 1112 (VACO & NONVA ONLY)
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SECURITY CLASSIFICATION	PAGE NO.	NO. OF PGS.
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II 10-85-7
February 7, 1985

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
VACO WASH., DC 20420	ACTION: INFO:	
ACCOUNTING CLASSIFICATION	DATE PREPARED 12/13/84	FILE
FOR INFORMATION CALL		
NAME KAREN WALTERS (136F)	PHONE NUMBER 389-2337	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT PLEASE RESTRICT THE TEXT OF THIS MESSAGE TO A MAXIMUM OF 69 CHARACTERS PER LINE

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

DIRECTORS, ALVAMC AND REGIONAL OFFICES WITH OUTPATIENT CLINICS;

~~DISTRICT COUNSEL OFFICES; (REGIONAL DIRECTORS)~~

THIS IS INTERIM ISSUE 10-85-7 (DTD: 2-7-85)

A. BASIC ADMINISTRATIVE ISSUES AFFECTED: DM&S MANUAL M-1, PART I, CHAPTER 15

B. OTHER ISSUES AFFECTED: NONE

C. REASON FOR ISSUE:

THE VA HAS ESTABLISHED REVISED INTERAGENCY BILLING RATES EFFECTIVE NOVEMBER 1, 1984. THIS INTERIM ISSUE PROVIDES INSTRUCTIONS FOR IMPLEMENTING NECESSARY CHANGES IN OUR BILLING PROGRAM.

D. TEST OF ISSUE:

1. EFFECTIVE IMMEDIATELY, EACH VA HEALTH CARE FACILITY WILL PREPARE BILLINGS FOR SERVICES RENDERED TO BENEFICIARIES OF OTHER FEDERAL AGENCIES ON OR AFTER NOVEMBER 1, 1984, AT THE REVISED RATES PUBLISHED IN THIS INTERIM ISSUE. CORRECTED BILLINGS FOR SERVICES RENDERED ON OR AFTER NOVEMBER 1, 1984, SHOULD BE PREPARED TO REFLECT THE REVISED RATES PUBLISHED IN THIS INTERIM ISSUE.

SECURITY CLASSIFICATION	PAGE NO.	NO. OF PGS.
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II 10-85-7
February 7, 1985

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

2. REVISED INTERAGENCY RATES EFFECTIVE NOVEMBER 1, 1984, ARE AS FOLLOWS:

MEDICINE	$308
SPINAL CORD INJURY	$251
SURGERY	$332
PSYCHIATRY	$252
DRUG AND ALCOHOL	$129
NURSING HOME	$114
OUTPATIENT	$ 61
PHARMACY-PRESCIPTION REFILL	$ 8.75
HEMODIALYSIS:	
HOSPITAL COMPONENT	$118
PHYSICIAN COMPONENT	$ 12

THE HOSPITAL COMPONENT FOR HEMODIALYSIS WILL BE CHARGED IN ADDITION TO THE INPATIENT PER DIEM RATE EXCEPT WHEN BILLING MEDICARE FOR MAINTENANCE DIALYSIS, IN WHICH CASE THE PHYSICIAN COMPONENT WILL BE CHARGED IN ADDITION TO THE HOSPITAL COMPONENT. IF OTHER THAN MAINTENANCE DIALYSIS

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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

CARE IS PROVIDED TO A MEDICARE BENEFICIARY TREATED AS A HUMANITARIAN EMERGENCY, AN ADDITIONAL CHARGE FOR AN OUTPATIENT VISIT MAY BE MADE BY THE VA.

INPATIENT CHARGES TO OTHER FEDERAL AGENCIES WILL BE AT THE CURRENT INTERAGENCY PER DIEM RATE FOR THE TYPE OF BED SECTION OR DISCRETE TREATMENT UNIT PROVIDING THE CARE.

3. THESE REVISED INTERAGENCY RATES WILL BE INCORPORATED INTO A FORTHCOMING CHANGE TO M-1, PART I, CHAPTER 15.

E. RESCISSION: THIS INTERIM ISSUE IS RESCINDED ON FEBRUARY 6, 1986, AND WILL NOT BE CONFIRMED WITH A PRINTED ISSUE. 136F/10A

John W. Ditzler

DISTRIBUTION: RPC: 1112 (VACO & NONVA ONLY)
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SECURITY CLASSIFICATION		
PAGE NO.	NO. OF PGS.	
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TELEGRAPHIC MESSAGE

JAN 5 1987

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
VACO WASHINGTON, DC	ACTION: INFO: R	
ACCOUNTING CLASSIFICATION	DATE PREPARED 12/8/86	FILE
FOR INFORMATION CALL		
NAME JIM NORTON	PHONE NUMBER 233-2504	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MU. ADD

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

DIRECTORS, ALVAMC AND REGIONAL OFFICES WITH OUTPATIENT CLINICS; DISTRICT COUNSEL OFFICES; (REGIONAL DIRECTORS)

THIS IS INTERIM ISSUE 10-86-12 (DTD: 12/24/86)

A. BASIC ADMINISTRATIVE ISSUES AFFECTED: DM&S MANUAL M-1, PART I, CHAPTER 15

B. OTHER ISSUES AFFECTED: NONE.

C. REASON FOR ISSUE:

THE VA HAS ESTABLISHED REVISED INTERAGENCY BILLING RATES EFFECTIVE DECEMBER 1, 1986. THIS INTERIM ISSUE PROVIDES INSTRUCTIONS FOR IMPLEMENTING NECESSARY CHANGES IN OUR BILLING PROGRAM.

D. TEXT OF ISSUE:

1. EFFECTIVE IMMEDIATELY, EACH VA HEALTH CARE FACILITY WILL PREPARE BILLINGS FOR SERVICES RENDERED TO BENEFICIARIES OF OTHER FEDERAL AGENCIES ON OR AFTER DECEMBER 1, 1986, AT THE REVISED RATES PUBLISHED IN THIS INTERIM ISSUE. CORRECTED BILLINGS FOR SERVICES SHOULD BE PREPARED TO REFLECT THE REVISED RATES PUBLISHED IN THIS INTERIM ISSUE.

SECURITY CLASSIFICATION	PAGE NO.	NO. OF PGS.
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STANDARD FORM 14
REVISED 11-80
GSA FPMR (41 CFR) 101-35.306

Previous editions unusable NSN 7540-00-834-3968

Rescinded by II 10-88-1, dtd 1-25-88

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

2. REVISED INTERAGENCY RATES EFFECTIVE DECEMBER 1, 1986, ARE AS FOLLOWS:

MEDICINE.....$344

SURGERY.....$402

REHABILITATION MEDICINE.....$267

SPINAL CORD INJURY.....$391

BLIND REHABILITATION.....$379

NEUROLOGY.....$294

PSYCHIATRY.....$250

DRUG AND ALCOHOL.....$94

INTERMEDIATE MEDICINE.....$151

NURSING HOME CARE.....$130

OUTPATIENT.....$56

PHARMACY - PRESCRIPTION REFILL....$11

HEMODIALYSIS:

HOSPITAL COMPONENT.....$118

PHYSICIAN COMPONENT.....$12

SECURITY CLASSIFICATION

PAGE NO.	NO. OF PGS.
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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO: THE HOSPITAL COMPONENT FOR HEMODIALYSIS WILL BE CHARGED IN ADDITION TO THE INPATIENT PER DIEM RATE EXCEPT WHEN BILLING MEDICARE FOR MAINTENANCE DIALYSIS, IN WHICH CASE THE PHYSICIAN COMPONENT WILL BE CHARGED IN ADDITION TO THE HOSPITAL COMPONENT. IF OTHER THAN MAINTENANCE DIALYSIS CARE IF PROVIDED TO A MEDICARE BENEFICIARY TREATED AS A HUMANITARIAN EMERGENCY, AN ADDITIONAL CHARGE FOR AN OUTPATIENT VISIT MAY BE MADE BY THE VA.

INPATIENT CHARGES TO OTHER FEDERAL AGENCIES WILL BE AT THE CURRENT INTERAGENCY PER DIEM RATE FOR THE TYPE OF BED SECTION OR DISCRETE TREATMENT UNIT PROVIDING THE CARE.

3. THESE REVISED INTERAGENCY RATES WILL BE INCORPORATED INTO A FORTHCOMING CHANGE TO M-1, PART I, CHAPTER 15.

E. RESCISSION: THIS INTERIM ISSUE IS RESCINDED ON DECEMBER 5, 1987, AND WILL NOT BE CONFIRMED WITH A PRINTED ISSUE. 136F/10A

John A. Gronvall

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

DISTRIBUTION: RPC: 1112 (VACO AND NONVA ONLY)
FD

SECURITY CLASSIFICATION	PAGE NO	NO. OF PGS.
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STANDARD FORM 14
REVISED 11-80
GSA FPMR (41 CFR) 101-35.306

Previous editions usable NSN 7540-00-134-3968

3/26/84

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

M-1, Part I
Chapter 15
Change 2

December 7, 1983

Chapter 15, "Charges and Payments for Medical Care," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

NOTE: The purpose of this change, other than editorial, is to outline procedures to ensure that payments made by the VA for fee basis and/or contract hemodialysis services will be no more than the rates approved by Medicare for the same service.

Page 15-ii:

Under paragraph 15.36, delete "15.37-15.39 (Reserved.)" and insert the following:

"15.37 Payments for Fee-Basis and/or Contract Hemodialysis Services 15-21

15.38-15.39 (Reserved.)"

Under Appendix 15I, add "15J Medicare Fiscal Intermediaries—State Alphabetical Listing ..... 15J-1".

Pages 15-21 through 15-23: Remove these pages and substitute pages 15-21 through 15-24 attached.

Pages 15J-1 through 15J-8: Insert these pages attached.

DONALD L. CUSTIS, M.D.
Chief Medical Director

Distribution: RPC: 1112
FD

2-9-84

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

M-1, Part I
Chapter 15
Change 1

October 31, 1983

Chapter 15, "Charges and Payments for Medical Care," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

NOTE: The purpose of this change, other than editorial, is to provide current interim rates and a chronological recording of reimbursement rates for end stage renal disease services provided to nonveteran Medicare beneficiaries under the terms of approved sharing agreements with certain VA medical centers.

Page 15-ii, appendixes: Under appendix 15H add "15I VA Reimbursement Rates—ESRD (End Stage Renal Disease) . . . . .15I-1".

Page 15-iii, paragraph 1b: Add

"10-78-197

10-82-40

10-83-60

10-83-147"

Page 15-iii, paragraph 1c: Add "10-83-1".

Page 15-2, paragraph 15.02b(10): Delete "at Operation Outreach Vet Centers." and insert "or readjustment counseling services at Vet Centers or readjustment counseling or mental health services by contract providers.".

Page 15-2, paragraph 15.02c: Delete "services and medical supplies" and insert "medical care".

Page 15-3, paragraph 15.06: Delete subparagraph c and insert the following:

"c. Those entitled to medical care under the medical payment coverage, personal injury protection coverage or uninsured motorists' coverage clauses of automobile 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 which have enacted statutes for providing for payment or reimbursement of medical expenses or payment of compensation to or for victims of criminal acts.

"d. Those receiving hospital or nursing home care and/or medical services for the treatment of a nonservice-connected disability and who are entitled to payment or reimbursement of the costs of such care by reason of membership in union, group, or prepaid medical insurance plan."

Page 15-6, paragraph 15.13b(2), line 3: After "forms" delete "and" and insert "are".

Page 15-7, paragraph 15.14b, line 3: After "services." add "(App. 15I.)".

Page 15-15, paragraph 15.25a(4):

Delete "Send billings to:" and insert "In the absence of a negotiated VA-DOD sharing agreement send billings to:".

At the end of the paragraph, add "Billings for services performed under the terms of a negotiated VA-DOD sharing agreement should be sent directly to the military medical facility involved.".

Page 15-16, paragraph 15.25c(5), line 2: Delete "priority group V1b." and insert "priority group V1c.".

Page 15-19, paragraph 15.25g, penultimate paragraph, line 1: After "examination" insert a comma.

After "emergency treatment" delete the comma.

Page 15-22, paragraph 15.42, line 3: Delete "ESRO" and insert "ESRD".

Pages 15A-1, 15A-2, 15D-1, and 15D-2: Add the superscript "5" to the phrase "Inpatient, per day:"

Pages 15A-4 and 15D-3: Add the following footnote:

"5 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 diem rate."

Page 15C-1, under EIN for 533 Castle Point: Delete "14-1339776" and insert "14-1630103".

Page 15E-1, paragraph 2: Add a fifth column to the chart with the following:

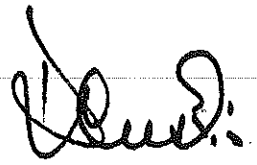
Opposite "Effective date" add "1/1/84"

Opposite "First 60 days" add "$356"

Opposite "61st thru 90th day" add "89"

Opposite "60 Lifetime Reserve Days" add "178"

Pages 15I-1 through 15I-6. Insert these pages attached.



DONALD L. CUSTIS, M.D.
Chief Medical Director

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

December 9, 1982

Chapter 15, "Charges and Payments for Medical Care," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is revised as indicated below. The use of brackets to denote new or revised material is precluded due to the extensive nature of the revision.

NOTE: The purpose of this chapter revision, other than to make editorial changes, is to consolidate all previous instructions on charges and payments for medical care and to:

1. Incorporate provisions of Public Law 97-72 which gives the VA statutory authority to recover the reasonable cost of medical care provided in workers' compensation, uninsured motorists' and crimes of personal violence cases.

2. Incorporate provisions of Public Law 97-174 which authorizes the VA and DOD (Department of Defense) to enter into facility-negotiated agreements for providing medical care to designated beneficiaries at locally negotiated rates.

3. Revise and update appendixes to provide a chronological listing of medical care rates charged or reimbursed by the VA.

4. Delete the listing of other Federal agencies with whom the Administrator of Veterans Affairs has approved agreements for outpatient services. Interagency agreements for medical care/services provided other Federal agencies may be originated at field facilities and will be submitted to VA Central Office for approval.

Pages 15-i through 15-iii and 15-1 through 15I-1: Remove these pages and substitute pages 15-i through 15-iii and 15-1 through 15H-1 attached.

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Chief Medical Director

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Rec'd 3/24/82

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

M-1, Part I
Chapter 15
Change 10

February 5, 1982

Chapter 15, "Charges and Payments for Medical Care," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

NOTE: The purpose of this change, other than editorial, is to clarify charges for dental care furnished on an outpatient basis to persons not eligible for such services as veterans.

Page 15-ii

Under "PARAGRAPH," line 6, delete "15-40-15-46" and insert "15.40-15-48".

Under section VI add:

"15.47 Charges for Drug Dependence Treatment 15-18
15.48 Charges for Outpatient Care ..... 15-18".

Pages 15-17 and 15-18: Remove these pages and substitute pages 15-17 and 15-18 attached.

Pages 15A-1 and 15A-2: Remove these pages and substitute pages 15A-1 and 15A-2 attached.

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Chief Medical Director

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by cho. rev. 7/12/9/82

Rec'd 3-26-82

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

M-1, Part I
Chapter 15
Change 9

October 29, 1981

Chapter 15, "Charges and Payments for Medical Care," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

NOTE: The purpose of this change is to provide current per diem rates for State Veterans Homes activities as originally published in Interim Issue 10-80-60.

Page 15G-1

Under "Hospital Care": Delete "$11.50" and insert "$13.25".

Under "Nursing Care": Delete "$10.50" and insert "$12.10".

Under "Domiciliary Care": Delete "$5.50" and insert "$6.35".

RESCISSION: Interim Issue 10-80-60.

DONALD L. CUSTIS, M.D.
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by chp rec. 3/19/82

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

August 10, 1978

Chapter 15, "Changes and Payments for Medical Care," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

NOTE: The purpose of this change is to update policy on reimbursement for care in State home facilities pursuant to Public Law 94-581, previously announced in Interim Issue 10-77-31.

Page 15G-1: Remove this page and substitute page 15G-1 attached.

RESCISSION: II 10-77-31.

Thomas J. FitzGerald

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Acting Chief Medical Director

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Ky chg. rec.
8/29/82

Department of Medicine and Surgery
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M-1, Part I
Chapter 15
Change 7

March 1, 1974

Chapter 15, "Charges and Payments for Medical Care," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

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

1. Provide that the rate charged tort feasors for persons furnished care and treatment at Government expense in a non-VA facility will be the amount paid by the VA.

2. Provide that the charge for drug dependence treatment rendered on an inpatient basis in NP facilities will be at the current VA reimbursement rate for GM&S hospitals.

Page 15-iii, paragraph 1a: Add "(3) Change 1, chapter 15, M-1, part I"

Pages 15-5 and 15-6: Remove these pages and substitute pages 15-5 and 15-6 attached.

Pages 15-17 and 15-18: Remove these pages and substitute pages 15-17 and 15-18 attached.

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By chp. rev. 9/12/82

Department of Medicine and Surgery
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M-1, Part I
Chapter 15
Change 6

October 18, 1973

Chapter 15, "Charges and Payments for Medical Care," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

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

1. Revise appendix 15A to depict VA reimbursement rates.
2. Provide charges and reimbursement rates for fiscal year 1974.
3. Provide Medicare deductibles and coinsurance for part A and part B services effective January 1, 1973.
4. Provide for increase in maximum per diem rates which may be paid to State Veterans' Homes.
5. Add Appendix 15I, "Medical Care Rates–Other Federal Hospitals."

Pages 15-i and 15-ii: Remove these pages and substitute pages 15-i and 15-ii attached.

Page 15-iii, paragraph 1c: Add "Cir. 10-73-171".

Pages 15-9 through 15-12: Remove these pages and substitute pages 15-9 through 15-12 attached.

Pages 15-15 and 15-16: Remove these pages and substitute pages 15-15 and 15-16 attached.

Pages 15A-1 and 15A-2: Remove these pages and substitute pages 15A-1 and 15A-2 attached.

Page 15B-1: Remove this page and substitute page 15B-1 attached.

Page 15C-1: Remove this page and substitute page 15C-1 attached.

Page 15D-1: Remove this page and substitute page 15D-1 attached.

Page 15G-1: Remove this page and substitute page 15G-1 attached.

Page 15H-1: Remove this page and substitute page 15H-1 attached.

Page 15I-1: Insert this page attached.

M.J. Musser

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Distribution: RPC: 1112
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Department of Medicine and Surgery
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M-1, Part I
Chapter 15
Change 5

June 15, 1973

Chapter 15, "Charges and Payments for Medical Care," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

NOTE: The purpose of this change is to clarify those instances when third party billings may be prepared for veterans who are admitted for treatment of service-connected or adjunct disabilities resulting from accidental injury or industrial disease. Normally, such cases would not be categorized under VA Regulation 6047 (A) or (B).

Pages 15-1 and 15-2: Remove these pages and substitute pages 15-1 and 15-2 attached.

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9/12/82

Department of Medicine and Surgery
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April 30, 1973

Chapter 15, "Charges and Payments for Medical Care," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

NOTE: The purpose of this change is to add Appendix 15H, "Charges for Aeromedical Transportation."

Page 15-ii, under **APPENDIXES**: Add: "15H Charges for Aeromedical Transportation . . . . 15H-1".

Page 15-iii, paragraph 1b: Add "II 10-73-3".

Page 15-14, paragraph 15.24h

Title

Line 1: Delete **"Bureau"** and insert **"Office"**.

Line 2: Delete **"(BEC)"** and insert **"(OFEC)"**.

Subparagraph (2), line 2: Delete "BEC" and insert "OFEC".

Page 15F-2, under "FEDERAL AGENCY" column, line 18: Delete **"BUREAU"** and insert **"OFFICE"**.

Page 15H-1: Insert this page attached.

RESCISSION: II 10-73-3.

M.J. Musser

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

M-1, Part I
Chapter 15
Change 3

December 15, 1972

Chapter 15, "Changes and Payments for Medical Care," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

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

1. Provide for cancellation or withdrawal of an outstanding bill of collection when character of discharge has been modified.

2. Provide for reimbursement to the VA for:

a. Emergency relief assistance authorized and directed by the Office of Emergency Planning.

b. Emergency care of victims of disasters when the VA assists the American National Red Cross in providing medical treatment and other services when prior approval is obtained.

3. Provide charges and reimbursement rates for fiscal year 1973.

4. Provide that authorized medical services requested by agencies listed in appendix 15F may be furnished even though the specific category of beneficiary is not identified therein.

5. Provide maximum per diem rates which may be paid to State veterans' homes.

Pages 15-i and 15-ii: Remove these pages and substitute pages 15-i and 15-ii attached.

Page 15-iii paragraph 1c: Add "Cir. 10-72-178".

Pages 15-7 and 15-8: Remove these pages and substitute pages 15-7 through 15-8a attached, (Par. 15.18a (3), (5) and (6) added.)

Pages 15A-1 and 15A-2: Remove these pages and substitute pages 15A-1 and 15A-2 attached.

Page 15B-1: Remove this page and substitute page 15B-1 attached.

Page 15C-1: Remove this page and substitute page 15C-1 attached.

Page 15D-1

Title: Delete ", FISCAL YEAR 1972".

Paragraph 1, line 1: Delete "1971," and insert "1972".

Pages 15F-1 and 15F-2: Remove these pages and substitute pages 15F-1 and 15F-2 attached.

Page 15G-1: Insert this page attached.

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M-1, Part I
Chapter 15
Change 2

February 14, 1972

Chapter 15, "Charges and Payments for Medical Care," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

NOTE: The purpose of this change is to:

1. Revise appendix 15A to amend the charge for dental services to exclude the code E visit rate when such services are solely for impressions, insertions, and adjustments incident to dental prosthetic appliances effective January 1, 1972.

2. Revise appendix 15D to increase medicare patient's liability for deductible and coinsurance (part A) effective for admissions on or after January 1, 1972.

Page 15-14, paragraph 15.24h(2), line 2: After "part I," delete "chapter 9, section B, paragraph 7." and insert "chapter 810.".

Page 15A-2, footnote 3(g), line 3: After "partial." insert "The per-facility visit charge (code E) will not apply for dental services rendered solely for prosthetic appliances."

Page 15D-1, paragraph 2

Line 2: Delete "1971" and insert "1972".

"Amount" column

Line 1: Delete "60.00" and insert "68.00".

Line 2: Delete "15.00" and insert "17.00".

Line 3: Delete "30.00" and insert "34.00".

By chp rev. 01
12-4-87

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Department of Medicine and Surgery
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M-1, Part I
Chapter 15
Change 1

December 9, 1971

Chapter 15, "Charges and Payments for Medical Care," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

NOTE: The purpose of this change is to provide for the identification of beneficiaries of the Department of Defense who are treated in VA facilities for drug dependence.

Page 15-2, paragraph 15.07b, line 6: Delete "signed" and insert "completed".

Page 15-10, paragraph 15.24a(3), line 2: After "format." insert "When inpatient care or outpatient treatment is rendered for drug dependence, the abbreviation DARP (Drug Abuse Rehabilitation Program) will be included following the serviceman's name."

Page 15-11, paragraph 15.24b(5)(a), line 2: After "department." insert "When inpatient care or outpatient treatment is rendered for drug dependence, the abbreviation DARP will be included following the retiree's name."

Page 15-16, paragraph 15.29

Under "Other Federal Hospitals" column, line 3: Delete "Corozal Hospital," and insert "Mental Health Center,".

Under "Reimbursement Rates" column

Line 1: After "Appendix" delete "15A" and insert "15C".

Lines 2 through 4: Delete "Outpatient . . . Code D".

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by chg. rev. 6/12/87

498455

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

M-1, Part I
Chapter 15

July 14, 1971

Chapter 15, "Charges and Payments for Medical Care," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is published for the compliance of all concerned.

NOTE 1: Chapter 15 will have its own series of changes and will carry an RPC number separate and distinct from other chapters of M-1, Part I.

NOTE 2: The purpose of this chapter is to consolidate all instructions and directives pertaining to medical care cost recovery. Included are charges to be made by the VA for medical and dental services furnished non-VA beneficiaries and reimbursement rates payable for services provided VA beneficiaries in non-VA facilities. Appendixes relative to charges and reimbursement rates will be revised and reissued when such changes are effected.

Pages 15-i through 15-iii, and 15-1 through 15F-2: Insert these pages attached. (Ch. 15 added.)

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

Distribution: RPC: 1112 assigned
FD (This ID same as RPC: 1016)

by chp. rev.
10/12/82