

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

Chapter 21, Authorized Non-VA Hospitalization in the United States
(Paragraphs 21.01 through 21.17; Appendix 21A through Appendix 21C)
Rescinds Chapter 21 dated April 13, 1983 through Change 3 (12/14/87)

This document includes:

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PART I

M-1

CHANGE 107

VETERANS ADMINISTRATION

DEPARTMENT OF MEDICINE AND SURGERY MANUAL

OPERATIONS



PART ONE

MEDICAL
ADMINISTRATION
ACTIVITIES

WASHINGTON, D.C. 20420

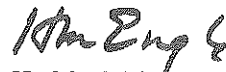
MAY 27, 1968

M-1, Part I
Change 107

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

May 27, 1968

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



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

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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 *Voluntary Services*
- Part IV --- Veterans Canteen Service
- [Part V --- Performance Standards
- Part VI --- Restoration Programs
- Part VII --- Building Management Service]

3/10/88 Part VIII - Management Analyst Program - 10 30
Parts II [through V] have been issued as complete parts. Part I is comprised of [27] chapters with titles as indicated in the table of contents. Chapters, as completed, will be issued separately as changes to this manual. Each chapter has its own title page, 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.

[]

4/188 IX - Stopping Sailing Lines

4/2/89 X - CHAMPVA Programs (not added)

PART I. MEDICAL ADMINISTRATION ACTIVITIES

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This Chapter was Reserved; but was never written. It never existed.

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RESCISSIONS

The following material is rescinded:

1. COMPLETE RESCISSIONS

a. Manuals

M-1, Part I, Chapter 21, dated December 29, 1967, and changes 105, 114, 124, 127, 163, 166, 171, and 172.

M-1, Part I, Chapter 21, dated April 13, 1983, and change 1, 2 and 3.

b. Circulars/Directives

10-75-219

10-79-018

10-80-041

10-85-040

10-85-085

10-88-011

10-88-034

10-89-022

10-90-064

10-90-143, and Supplement No. 1

c. Interim Issues

II 10-67-43

II 10-68-35

II 10-68-49

II 10-80-12

II 10-81-17

II 10-81-25

II 10-82-15

II 10-82-29

II 10-82-30

CHAPTER 21. AUTHORIZED NON-VA HOSPITALIZATION IN THE UNITED STATES**21.01 PURPOSE**

The Secretary of the Department of Veterans Affairs (VA), henceforth known as the Secretary, may contract for hospital care with non-VA facilities when VA is not capable of providing economical hospital care due to geographic inaccessibility, or is not capable of furnishing the care or services. This chapter contains policies and procedures relating to care for VA beneficiaries in VA medical centers at VA expense. **NOTE:** *Instructions for development and utilization of mutual use and exchange of use agreements under the authority of 38 Code of Federal Regulations (CFR) 17.210 are in M-1, Part I, Chapter 1.*

21.02 DEFINITIONS

a. **Hospital.** For the purposes of this chapter:

(1) **Hospitals**, other than those under the direct jurisdiction of VA, are classified either as other Federal or non-Federal.

(2) **Federal hospitals** are further classified as hospitals with agreements and those without agreements for bed allocations to VA.

(3) **Non-Federal hospitals** may be contract or noncontract.

(4) A **contract hospital** is one with which VA has negotiated a formal contract in accordance with paragraph 21.06a.

(5) A **noncontract hospital** is one with which VA does not have a formal contract, but whose services may be utilized on an individually authorized basis.

b. **Clinic Director.** The term Clinic Director includes the Associate Chief of Staff for Ambulatory Care, Chief, Ambulatory Care Section, Chief Medical Officer (CMO), or where neither of these positions exist, the physician who has been delegated responsibility for clinical ambulatory care activities.

c. **Chief, Medical Administration Service (MAS).** The Chief, MAS, refers to the Chief, MAS, in a VA medical center and the Chief, Medical Administrative Officer, in an independent outpatient clinic.

d. **States.** The term "States" means each of the several States, Territories and possessions of the United States, the District of Columbia, the Commonwealth of Puerto Rico, and the Government of the Northern Mariana Islands.

21.03 ELIGIBILITY

a. Title 38, CFR, Section 17.47 and 17.48, define basic veteran eligibility for VA hospital care.

b. Title 38, CFR, Section 17.50b, defines eligibility for contract (fee basis) hospital care.

21.04 SCOPE

a. Title 38, CFR, Section 17.50f, provides payment authority and methodology for non-VA hospital claims.

b. Non-federal hospitals will be used only when VA facilities are not capable of furnishing economical hospital care because of geographical inaccessibility, or are not capable of furnishing the care or services

required. A VA facility may be considered incapable of furnishing needed care because of geographical inaccessibility when it is not feasibly available due to the urgency of the veteran's medical condition.

c. Persons retired for disability from military service may not be hospitalized in other Federal hospitals as beneficiaries of VA except those persons retired for disability who require care for a chronic condition, as defined in 38 CFR 17.46b(b), may be hospitalized in Alaska and Hawaii in other Federal hospital beds that have been allocated to VA.

d. Priorities for utilization of non-VA hospitals, other than under a sharing agreement, when reasonably available, are in order as follows:

- (1) Federal hospitals with beds designated for VA use.
- (2) Other Federal hospitals.
- (3) Contract non-Federal hospitals.
- (4) Noncontract non-Federal hospitals.

e. Utilization guidelines for authorized non-VA hospitalization are as follows:

HOSPITAL TREATMENT OF (Subject to unavailability of facilities and other limitations and provisions of 38 CFR 17.50 through-17.50f)	FEDERAL		NONFEDERAL	
	Without Beds Allocated to VA for Emergent Care	With Beds Allocated To VA	Contract	Noncontract
(1) Service-connected disability or adjunct condition, or a disability incurred in line of duty and for which the applicant received a disability discharge from military service	X	X	X	X
(2) A disability of a veteran who has a total disability permanent in nature from a service-connected disability.	X	X	X	X
(3) Nonservice-connected disabilities(except in the Virgin Islands, Alaska and Hawaii).	X	X		
(4) Nonservice-connected disabilities of veterans in the Virgin, Islands, Alaska and Hawaii	X	X	X	X
(5) Disabilities of women veterans not precluded by 38 CFR 17.48(h)	X	X	X	X

HOSPITAL TREATMENT OF (Subject to unavailability of facilities and other limitations and provisions of 38 CFR 17.50 through-17.50f)	FEDERAL		NONFEDERAL	
	Without Beds Allocated to VA for Emergent Care	With Beds Allocated To VA	Contract	Noncontract
(6) A disability of a veteran who is participating in a Rehabilitation program under 38 United States Code (U.S.C.), Chapter 31, for any of the reasons enumerated in 38 CFR, paragraph 17.48(j).	X	X	X	X
(7) Any condition of a veteran who had been authorized transportation to or from a designated hospital for admission or discharge, who develops a medical emergency that prevents completion of travel to the original destination.	X	X	X	X
(8) Service connected disability of Commonwealth Army veterans and New Philippine Scouts for care in a VA Facility in the United States.	X	X		
(9) Medical emergencies which pose a serious threat to the life or health of a veteran receiving medical services in a facility over which the Secretary has direct jurisdiction, other Government facilities for which the Secretary contracts, or in nursing homes with which the Secretary contracts under 38 U.S.C. 1720.	X	X	X	X

f. The number of beds allocated to VA by other Federal hospitals may be exceeded during any month with the consent of the commanding officer of the hospital concerned, provided the utilization is appropriately reduced in subsequent months, so that the average daily census at the end of the fiscal year does not exceed the total bed allocations.

g. Veterans with emergent conditions may be admitted at the end of the fiscal year even though such admission may result in an average daily census in excess of that allocated to VA.

21.05 OTHER FEDERAL HOSPITALS

a. The Under Secretary for Health has the authority to make agreements and to establish bed allocations with other Federal hospitals.

b. Formal surveys and inspections of other Federal hospitals with beds allocated to the VA are not required; however, VA staff are encouraged to make periodic visits. Any indication that VA beneficiaries may be receiving inadequate care will be explored and resolved locally. If necessary, the assistance of the Regional Director may be required. Maximum rapport and cooperation between the institutions are essential.

21.06 NON-FEDERAL HOSPITALS

a. At the discretion of Directors of VA medical centers and outpatient clinics, contracts with non-Federal hospitals (other than through sharing agreements and scarce medical specialty agreements) may be developed, executed, amended, re-negotiated, or terminated by the facility contracting officer in accordance with VA procurement regulations. Contracts for bed allocations will not be made with non-Federal hospitals which have not been accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO).

b. Formal surveys and inspections of non-Federal hospitals will not be made. The policies outlined in paragraph 21.05b apply.

c. Before an existing contract with a hospital which has lost accreditation is renewed, VA medical center officials will confer with management at the contract hospital to determine if VA requirements are being met. If not, notice will be given to terminate the VA contract.

21.07 WHEN TO MAKE CONTRACTS

Contracts with non-Federal hospitals may be made when the best interests of VA and its beneficiaries will be served. Contracts will not be made when there is an infrequent demand for use of non-Federal hospital beds.

21.08 AUTHORITY TO PROVIDE HOSPITAL AND PROFESSIONAL CARE

a. VA medical center and VA clinic Directors, or their designees, will, except in instances defined in following subparagraph b, authorize necessary hospital and professional care for eligible beneficiaries at non-VA hospitals.

b. Chiefs of Staff, or their designees, will authorize necessary hospital and professional care in non-VA hospitals for veterans, whose eligibility for hospitalization has been determined, and who are found to be in need of non-VA hospitalization for an emergent condition which developed during authorized travel to the originally designated medical center preventing completion of travel, or during authorized travel after hospital discharge preventing completion of travel to the originally designated point of return (see 38 CFR 17.50b(a)(8)).

c. The Chief of Staff or Clinic Director, may authorize necessary hospital and professional care in non-VA hospitals for veterans who either report to a VA facility in need of emergency treatment that cannot be provided by VA, or develop a need for emergent treatment while receiving medical services in a VA medical center, contract nursing home, outpatient clinic or a Government facility with which the Secretary has a contract.

(1) The need for emergent treatment must be determined by a VA physician. Such authorization may be granted only when VA or other Government facility is incapable of furnishing the necessary treatment and transfer to a non-VA hospital is the only means of providing such treatment.

(2) Non-VA hospital care may only be authorized until such time as the patient's condition is stabilized to allow the patient to be safely transferred to a VA or other Government hospital.

d. Return of the veteran to the responsible VA health care facility or transfer to the nearest appropriate VA or other Government facility will be accomplished as soon as the veteran's medical condition has stabilized and will permit safe transfer without hazard. Clinics of Jurisdiction (COJ) may be contacted for assistance or guidance, but the clinic will not be held responsible for the action necessary to accomplish them or for the payment of costs.

(1) Payment for non-VA hospital care as described the preceding subparagraph c, will be the responsibility of the VA health care facility faced with the emergency and which authorized the care, irrespective of whether the veteran is service-connected or not. Costs of the program will be recorded

as "contract hospital"; however, these costs must be absorbed within the facility's recurring medical care funds and not paid from COJs contract hospitalization funds. Costs of the program will be carefully monitored. The appropriate Regional Director will be apprised by the facility when financial problems are encountered with the non-VA hospital program.

(2) When a veteran receiving medical services at an independent outpatient clinic requires referral for emergency medical care at a public or private facility, payment will be made from their contract hospitalization funds.

(3) Payment for emergency non-VA hospital care furnished to veterans receiving care in a VA contract community nursing home will be made by the VA facility which authorized the contract for community nursing home care irrespective of which Primary Service Area (PSA) the contract hospital is located.

f. Directors, or their designees, will authorize necessary diagnostic services at non-VA facilities (on an inpatient or outpatient basis) in order to complete requests from VA Regional Offices for Observation and Examination (O&E) of a person to determine eligibility for VA benefits or services. When the VA medical center staff believes that the examination can be conducted on an outpatient basis, the Adjudication Officer, or designee, will be contacted by telephone. Final action will be based on the agreement reached. Authorization and payment for public or private care under these circumstances will be the responsibility of the appropriate clinic of jurisdiction. Payment for such care will be made from contract hospitalization funds.

g. Basic skills and resources are available among the health care facilities of each region or network, and experience has shown that very few inpatients need to be transferred outside of the VA system for crisis intervention or the treatment of the acutely disturbed or homicidal patient. To cope with this group of patients, a VA medical center may request permission to transfer demonstrably homicidal patients to a suitable facility when it has been determined by the Chief of Staff, or designee, that they are incapable of providing the necessary care.

21.09 AUTHORIZATION

a. Requests for hospitalization in Federal hospitals with a bed allocation to VA will be processed immediately.

(1) Written evidence of medical need and eligibility are not necessarily required in order to authorize hospitalization verbally, if available information confirms eligibility for treatment requested and a VA physician has determined that medical need exists.

(2) For admissions to non-Federal hospitals and those Federal hospitals without a bed allocation to VA, the medical needs of the patient must be on an emergent basis which precludes utilization of VA facilities or other contract Government beds. Normally, if the request is made in person or by telephone, and eligibility and medical need can be determined, a decision will be made at that time and the person informed.

(3) If the required information is not readily available, immediate action will be taken to acquire it by the most expeditious means. Such action could involve, but not be limited to, contacts with the hospital, doctor, patient's family, local veterans service officer, other VA offices, etc. Any reasonable doubt as to need and eligibility will be resolved in favor of the patient. As soon as a decision is reached, the interested party(ies) will be notified.

(4) Verbal authorizations will be confirmed by written authorizations within 2 workdays following verification of eligibility. At the time the written authorization is granted, a letter will be forwarded to the veteran which will direct the veteran not to make any payments to the non-Federal hospital, as VA payment is considered as payment in full.

(5) The effective date of the authorization will be the date the request is made. When a request is dispatched to VA after the date and hour of emergency admission (but within 72 hours), the effective date of authorization will be the admission date. (See 38 CFR 17.50d on calls involving veteran in a noncontiguous State or Territory.)

b. Emergency non-VA care in public or private hospitals may only be authorized until such time as the veteran can be safely transferred to a VA or other Government facility under contract with VA. **NOTE:** *Voluntary elective admissions to a non-VA facility will not be authorized.* Any authorization for emergency hospitalization at VA expense must carry with it the requirement for timely transfer of the veteran to an appropriate VA medical facility at such time as the condition requiring emergency care has improved or stabilized to the point that the veteran can be safely transferred without hazard. For this purpose, an emergency will be deemed to have ended at that point when, in sound medical judgment, an individual could have been safely transferred to a VA medical center to continue treatment. After the termination date, no additional care in the public or private facility would be paid by VA.

c. The requirement of timely transfer will be conveyed at the time of initial contact involving hospitalization at VA expense and no additional payments will be authorized once the patient's condition has been stabilized and the patient can be safely transferred to a VA facility. This will also be noted on VA Form 10-7078, Authorization and Invoice for Medical and Hospital Services, as well as on letters of authorization sent to attending physicians. The veteran and/or the veteran's representative will be notified immediately.

d. In transferring a veteran who requires continued hospital care for a service-connected disability, or a woman veteran, the expense of the patient's care in a non-VA facility will be borne by the VA medical center requesting the transfer.

e. Payment for non-VA hospital care will be limited to amounts based on rates established by Medicare under the Prospective Payment System (PPS) processing system which uses Diagnostic Related Groups (DRGs). Non-VA hospitals in Maryland or the Finger Lakes Hospital Association in New York (Myers Community Hospitals, Soldiers and Sailors Memorial Hospital, F.F. Thompson Hospital, Geneva General Hospital and Newark-Wayne Hospital) are excluded from the Health Care financing administration (HCFA) prospective payment system. Payment for non-VA hospital care in facilities or distinct part hospital units excluded from participation in the PPS system are made based upon their state prospective payment system, or upon the usual and customary charge, unless a lower rate has been negotiated. A statement to this effect will be noted on VA Form 10-7078.

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

g. When partial payment has been made by another Federal agency and the payment of the balance is requested from VA, the claim will be reviewed to determine the eligibility of the veteran. If the veteran meets the eligibility criteria for non-VA hospital care and VA authorizes payment, VA will make reimbursement on the entire charges through the date it is determined the veteran could have been safely transferred to a VA facility. The non-VA facility will be notified that the payment received from the other Federal agency must be returned to that agency as VA is considered the primary provider for the authorized conditions only.

h. When a veteran requires specialized non-emergent medical care for service-connected conditions at a non-VA facility because such care is not available within the VA medical care system or covered under a negotiated sharing agreement, care will be authorized in advance by the COJ of the veteran's residence. Payment for such care will be made from contract hospitalization funds.

i. When information on the direct admission of a veteran to a non-VA hospital is reported to "the nearest VA medical center," (or any VA field facility) that information will be documented and immediately reported to the VA facility responsible for payment of private hospitalization in the area in which the non-VA hospital is located.

j. Instructions on setting up a VA Form 10-7078 authorization through the Decentralized Hospital Computer Program (DHCP) Fee-Basis software can be found in the Fee-Basis User Manual under the Civil Hospital Main Menu. Normally, the authorization will be valid from the effective date of authorization to "Disposition," since the exact discharge or transfer date is often not known at the time the authorization is established in DHCP. When the Disposition date is known in advance it will be entered. If date is unknown, hit the return key and proceed to the next field.

21.10 CONTROLS

a. Controls will be established to provide continuous follow-up with the non-VA hospital authorized to provide emergency treatment, to determine when the veteran's condition will permit transfer. Follow-up contacts will be the responsibility of the Clinic Director or designee and discussed on a physician-to-physician basis. If necessary, and where geographically feasible, a VA physician will visit the patient in the hospital (after having obtained permission from the hospital and treating physician) to determine if the condition of the patient has stabilized or improved to the extent transfer can safely be accomplished without hazard.

b. The decision to transfer a veteran will be based solely on the veteran's medical condition. Any delay in transfer due to administrative procedures, such as commitment action, etc., will not justify payment beyond the date the veteran could be moved. Authorization for hospital and professional care will be terminated if the VA physician determines that the veteran may be transferred, but the veteran refuses to accept transfer or the treating physician refuses to release the veteran. When this occurs, the private or public hospital, treating physician, veteran, and other concerned persons will be notified in writing that VA will not be responsible for payment of the costs of care from that point in time.

c. In those cases where psychiatric patients cannot be medically stabilized for transfer within 72-hours, the request for authorization of continued non-VA care should only be approved after careful review by the VA medical center Chief of Staff, or designee.

d. Where state laws or rules preclude the admission or transfer to a VA facility for psychiatric care pending court action, the authorization for care in a public, state, county, city or private facilities should not be granted.

e. In every case of public or private hospitalization, authorization may continue only for as long as the patient's medical condition precludes transfer to VA. This determination must be made by the responsible VA physician based on the medical information provided by the private physician. Where the medical information provided is insufficient to justify the private physician's contention that the patient cannot be transferred, VA authorization will be discontinued, and claims for further care will be considered unauthorized. When approving claims for payment or reimbursement of public or private hospital care not previously authorized, a determination must be made by the reviewing VA physician as to when, in VA physician's opinion, the patient could have been safely transferred to a VA facility. Payment will be made only for the period of the emergency during which transfer was not possible.

21.11 OBLIGATIONS

a. MAS personnel will generate VA Form 4-1358, Estimated Miscellaneous Obligation or Change in Obligation, through the DHCP Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) package at the beginning of each month. An estimated amount will be entered to cover the estimated monthly cost of hospitalization and all other costs for beneficiaries hospitalized at other than VA medical centers. VA Form 4-1358 will be electronically transmitted to Fiscal Service where an obligation number will be assigned and electronically returned to MAS personnel.

b. Each authorization will be automatically recorded on VA Form 4-1358 through use of the DHCP-fee software, although non-automatic entries may also be made if necessary. Posting will include a reference number, the patient name and the estimated expense to be incurred during the current month. As invoices are received and processed for payment, the amount liquidated for each hospital will be automatically posted on VA Form 4-1358 through the fee software. If at the end of the month it appears that the estimated costs are not realistic, an appropriate adjustment in the monthly obligation will be accomplished.

21.12 INVOICES AND PAYMENTS

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 for non-VA hospital care will be made in amounts based on rates established for Medicare for the appropriate DRG. Payment for non-VA hospital care in facilities or distinct part hospital units excluded from the PPS based payment system will be made based on the national cost-to-charge ratio (see App. 21B).

b. Payment for services and supplies furnished beneficiaries in contract non-Federal hospitals will be made in accordance with the terms of the current contract. The provisions of this chapter must be incorporated prior to the awarding of new contracts.

c. Payment for authorized medical care furnished to VA beneficiaries in other Federal hospitals will be made at the appropriate interagency reimbursement rates approved by Office of Management and Budget (OMB) for the period of time when the medical care was provided (see Ch. 15).

d. Payment for authorized medical care furnished to VA beneficiaries in Department of Defense (DOD) hospitals under negotiated agreements authorized by provisions of Public Law (Pub. L.) 97-174, Veterans Affairs and the Department of Defense Health Resources Sharing and Emergency Operations Act, will be at the negotiated rates.

e. In computing patient days for payment purposes, either the first or last day of the authorized hospitalization will be counted, but not both.

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

g. When a bill for unanticipated expenses is submitted by the non-Federal hospital or a third party for DRG excluded care, or by a physician for services rendered to the veteran as an individual patient, it will not be necessary to prepare an amended or new authorization. If it is professionally determined by the clinic Director, or designee, that such services or supplies were necessary as a part of the authorized hospitalization, the Chief, MAS, or designee, process it for payment.

h. Invoices for payment should be supported with adequate medical documentation, i.e., emergency room reports, hospital summaries, operating room reports, etc., as appropriate, to support the medical need for which the original authorization was granted. Where medical documentation does not support the reasons for which the original authorization was issued, as specified on VA Form 10-7078 (see limitations of 38 CFR 17.50c) or, the veteran was treated for a condition for which eligibility does not exist under 38 CFR 17.50b, costs for treatment or appropriate portions thereof will not be paid.

i. The vendor's tax identification number (TIN) or Social Security Number (SSN) is required when care is provided by a non-Federal health care provider.

21.13 RECOVERY OF MEDICAL CARE COSTS

If at any time it is learned that recovery of the cost of such care from tortuously liable or other third parties is appropriate, cost recovery action will be initiated as outlined in M-1, Part I, Chapter 15.

21.14 REPORTING CHANGES IN STATUS OF PATIENTS

The provisions of M-1, Part I, Chapter 6, apply.

21.15 DISPOSITION OF FUNDS, EFFECTS AND/OR REMAINS OF VA BENEFICIARIES

The provisions of M-1, Part I, Chapter 14, apply.

21.16 TRANSFERS TO VA MEDICAL CENTERS

a. VA beneficiaries admitted to non-Federal hospitals or to other Federal hospitals without a bed allocation to VA will be transferred to a VA medical center at the earliest possible date in accordance with the policies in paragraph 21.09.

b. A request for a bed reservation in a VA hospital will be made as soon as possible and by the most expeditious means after receipt of notice that a patient is being or has been placed in a non-VA hospital at VA expense. An exception may be made when it is known that the patient cannot be moved for an indefinite period of time.

c. The only exceptions to transfer of a veteran to a VA medical facility will be those instances where:

(1) It is known that the patient is scheduled for discharge from the hospital within the immediate future (i.e., within the next 24 to 48 hours) and a VA physician determines that transfer would not be considered practical or in the best interest of the veteran or VA; or,

(2) At the time the veteran's condition will permit transfer, the distance to the nearest appropriate VA facility makes the transfer economically impractical, and/or not in the best interest of the veteran or VA.

d. Transfer of patients from non-VA hospitals where they are being treated at VA expense, to VA medical centers will be arranged expeditiously. Admission will be scheduled in accordance with priorities established.

e. Because most veterans in public or private hospitals at VA expense are in Priority Group I for admission to VA, the unavailability of a VA bed should not continue beyond 72 hours. When an appropriate bed in a VA medical center cannot be made available in the region or network within 72 hours, the Regional Director should be contacted for assistance. Facility Directors should take action to ensure that this program receives necessary emphasis to control the use of public and private hospitals.

21.17 REPORTS

a. All non-VA hospitalizations paid at VA expense will be reported in the Patient Treatment File (PTF) system consistent with the provisions of VA Manual MP-6, Part XVI, Chapter 3, and in the Automated Management Information System (AMIS) consistent with the provisions of VA Manual MP-6, Part IV, Supplement 1.2, Chapter 21.

b. Each medical center which reports costs in subaccounts 2575, 2580, and 2598 for non-VA hospitalization will record the workload on AMIS segment 344, 347, and/or 348 as appropriate. All non-VA hospitalizations must be recorded on these AMIS segments. Sharing agreement workload should not be recorded on these segments.

OTHER FEDERAL HOSPITALS WITH AGREEMENTS FOR BED ALLOCATION TO VA

Following is a listing of Federal hospitals which have allocated beds for use of Department of Veterans Affairs (VA) beneficiaries:

VA FACILITY HAVING JURISDICTION

OTHER FEDERAL HOSPITAL

ALASKA

VA Regional Office
Anchorage, AK

U.S. Air Force Hospital
Elmendorf Air Force Base, AK

HAWAII

VA Regional Office
Honolulu, HI

Tripler Army Medical Center
Honolulu, HI

NORTH DAKOTA

VA Medical Center
Fargo, ND

U.S. Air Force Hospital
Minot, ND

TEXAS

VA Outpatient Clinic
El Paso, TX

William Beaumont Army Medical
El Paso, TX Center

VA Outpatient Clinic
San Antonio, TX

Brooke General Hospital
Ft. Sam Houston, TX

WASHINGTON

VA Medical Center(American Lake)
Tacoma, WA

Madigan Army Medical Center
Tacoma, WA

PAYMENTS FOR NON-VA HOSPITAL CARE

1. Prospective Payment System

To ensure compatibility with other Federal hospital care reimbursement programs, the Department of Veterans Affairs (VA) will reimburse non-Federal hospitals using payment rates established by the Health Care Financing Administration (HCFA), Department of Health and Human Services, under its Diagnostic Related Groups (DRG)-based prospective payment system. Title 6 of Public Law 98-21 (Social Security Amendments of 1983) provides for Medicare payment for inpatient services under a prospective payment system (PPS), rather than on a reasonable cost basis. Medicare payment will be made at a predetermined specific rate for each hospital discharge. All discharges are classified according to a list of DRGs. The prospective payment rate will include capital-related costs (e.g., depreciation, taxes, rent, etc.). Medicare payment for hospital inpatient services will be determined fully under a national DRG payment methodology. The PPS system will apply to all inpatient services furnished by all hospitals participating in the Medicare Program except for psychiatric, specifically designated referral and cancer centers, rehabilitation units, alcohol units and other hospitals excluded in the Medicare Rules and Regulations.

2. VA Payment Rates

In reimbursing non-Federal acute medical-surgical hospitals, VA will adopt the Medicare Federal DRG rates. These rates vary by region of the country and according to whether the hospital is classified "urban," "rural," or "other urban." There are nine Medicare regions. VA will utilize 27 different payment schedules, three for each region.

3. Payment of Non-Federal Hospital Claims

a. The non-Federal hospital will submit a bill to VA for each discharge, using classifications and terminology consistent with International Classification of Diseases, Clinical Modification, 9th Edition (ICD-9-CM). The bill must contain the following information:

(1) The Provider's Medicare number (for approved PPS facilities only).

(2) The principal diagnosis, (that is, the condition established after study to be chiefly responsible for the admission), secondary diagnosis, procedures performed and discharge status.

(3) Disposition (whether transferred to another hospital - VA or non-VA, discharge or death).

b. Medicare pays hospitals the "net" DRG rate, i.e., the DRG rate minus required deductible and coinsurance amounts. However, veterans will not be required to pay deductible or coinsurance amounts. Therefore, VA will pay the full DRG rate, and advise the hospital that this constitutes payment in full for inpatient services provided the veteran.

c. The DRG rate includes the cost of all non-physician hospital inpatient services, (CT scans, hemodialysis, prosthetic items, pacemakers, laboratory and X-ray services, etc.), including those which the hospital must purchase from another facility. No separate billing or payment should be made for these services. Not included in the DRG rate are costs relating to blood supplies, and physicians' services to individual patients furnished by an entity other than the hospital providing the inpatient care. Payment or reimbursement for blood and for physicians' services to the individual veteran are ancillary services and will be made on a reasonable and customary charge basis. Payment for the physicians' services to the hospital rather than to the individual patient is included in the DRG prospective payment; these services to the hospital may not be billed separately.

d. Payments not to exceed the DRG rate will also be paid in the following circumstances:

(1) When the VA hospital transfers the patient to a non-VA hospital for special procedures (see examples).

(2) When the eligible veteran or proxy pays the hospital bill and then claims reimbursement from VA (see examples).

(3) When a third party insurer (except other Federal Agencies) pays the veteran's bill and the veteran asks VA to pay deductible and coinsurance amounts (see examples).

e. If a question arises as to the appropriateness of the information provided by the hospital, the bill will be returned with instructions as to the correct form and content and/or a request for clarification of the information required. After the bill has been reviewed for completeness, the data will be entered into the local Decentralized Hospital Computer Program (DHCP) pricer system which is transmitted to the Central System located at the Austin Automation Center (AAC) for assignment of the DRG and appropriate DRG rate. Outlier and pass-through costs in addition to payments for the DRG will be computed and a report will be returned to the VA facility submitting the data.

4. Transfers

a. If a non-VA hospital transfers a veteran to another VA or Non-VA hospital, VA will pay the transferring hospital a "per diem" rate for each day the veteran was hospitalized (the total not exceeding the full DRG rate). The per diem rate is determined by dividing the rate for the appropriate DRG assigned to the patient by the average length of stay (ALOS) for the DRG. This figure becomes your daily rate and must be multiplied by the number of days to be paid.

Example: Patient is admitted directly to a private hospital for an acute emergency. After 3 days his condition stabilizes, and the veteran is transferred to VA for continued treatment of the same conditions. The hospital will be reimbursed for 3 days of care, not to exceed the full DRG rate.

DRG Rate = \$3,000
ALOS: 4 days
Per diem rate = \$3,000 divided by 4 = \$750
Number of Authorized Days: 3 days
Total Payment to hospital = 3 x \$750 = \$2,250

b. Transfers from medical or surgical units to other excluded distinct units providing psychiatric or rehabilitation service within the same facility are considered to be discharges from medical or surgical care. Payment based on the full DRG rate will be made in these cases.

Example: Using information from the example above, the veteran was hospitalized in a non-VA hospital for cardiac arrest. The veteran spent 3 days on an acute medical unit and then was transferred to an excluded rehabilitation unit within the same facility. In this case, the full DRG rate for cardiac arrest would be paid for the 3 days of care. Payment to the hospital would be the full DRG rate of \$3,000. The remaining days of care on the excluded rehabilitation unit would be paid on the basis of the national cost-to-charge ratio (see par. 6(a)).

5. Pass-Through Costs

The DRG rate paid to hospitals serves as total payment for inpatient operating costs for all items and services furnished, other than physicians' services, and blood costs, associated with each discharge. These include operating costs for routine services, ancillary services, and intensive care type unit services. However, the DRG rate reimbursed by VA will cover capital-related costs and the costs of direct medical education. These reimbursements will be in addition to the full DRG rate. The capital-related expenses will be figured at a 9 percent add on to the DRG rate. The Direct Medical Education Reimbursement will be based on the I/R (Intern/Resident) ratio contained in the HCFA Pricer. If the I/R

ratio is above 0.25, the reimbursement will be 12 percent of the DRG rate (including outlier payments) for each discharge. If the I/R ratio is greater than 0 and less than or equal to .25, the amount will be 4 percent of the DRG rate (including outlier payments) for each discharge.

Example: Hospital bill for a veteran whose principal diagnosis was cardiac arrest and who was assigned DRG 129. Assume the total DRG reimbursement rate for the region and location is \$3,000. The hospital will be paid \$3,000, plus 9 percent for capital-related costs, plus the appropriate I/R ratio based on the HCFA Pricer.

6. Psychiatric Hospitals; Referral and Cancer Centers; Excluded Hospitals and Units

a. Since the Medicare Program has not established DRG-based payment rates for psychiatric hospitals and distinct units, VA will continue to pay these hospitals and distinct units on the basis of reasonable cost, which is calculated to be a percentage of the billed charge. HCFA has determined that the national ratio of Medicare inpatient operating costs to Medicare operating costs is 72 percent. Hence, VA will reimburse hospitals at rates that are 72 percent of usual and customary charges in the community (unless VA has negotiated to pay a hospital at lower rates).

Example: A psychiatric hospital treats a veteran with a diagnosis of depressive neurosis. The length of stay is 20 days. The hospital's charge to VA is \$2,500 (which is determined to be usual and customary in the community). Therefore, VA will pay the hospital 72 percent of \$2500 = \$1,800.

b. Payments for non-VA care in excluded facilities or units will not be calculated through the DHCP-fee pricer. The amount to be suspended from the above invoices must be computed by the facility processing the payment to the excluded facility or unit.

7. Excluded Hospitals - Exceptions to Medicare Exclusions

a. Payment for treatment provided in hospitals not participating with Medicare are exempt from PPS and are paid based upon the usual and customary charge, unless a lower rate has been negotiated.

b. Payments for treatment provided in the State of Maryland or the Finger Lakes Hospital Association in New York are exempt from PPS as payments are based upon their unique payment system whereby facilities will be reimbursed at the billing rate charged.

c. Payments for treatment in psychiatric hospitals, rehabilitation hospitals, cancer hospitals, and distinct units are exempt from PPS when those hospitals/units meet the Medicare exclusion requirements. Payment for treatment in excluded hospitals or units will be paid at 72 percent of the usual and customary charges, unless a lower rate has been negotiated.

8. Interim Payments

a. Interim payments to facilities providing medical and surgical care under DRG-based prospective payment system **will not be made** by VA while the veteran continues authorized non-VA hospital care. Full payment based on the DRG assignment will be made after the veteran is discharged from authorized non-VA care.

b. Interim payments will be made based on the national cost-to-charge ratio only to facilities excluded from the DRG payment system (see preceding par. 7).

9. Computation of Payment/Reimbursement Amounts Based on DRG's

a. Based on the data submitted to the AAC, the AAC will:

(1) Assign the appropriate DRG,

(2) Compute a dollar amount based on the DRG rate for the provider location and discharge or transfer status of the patients,

(3) Compute any outliers,

(4) Compute pass-through costs, and

(5) Determine a DRG total amount (computed DRG amount + outliers + pass-through). The AAC will then compute a total amount for payment based on other data submitted by the VA facility. This information will be returned to the VA facilities authorizing the non-VA hospital care.

b. The following are examples of the total computed for payment, if payment is to be made to the provider (non-Federal hospital):

(1) Total Amount Billed to VA by Provider. The amount claimed equals the billed charges. No payment has been made from any source. The DRG total is less than or equal to the amount claimed. Pay the DRG total.

Example: The hospital billed charges and amount claimed is \$5,000. The DRG computed plus outliers and pass-through (= DRG total) comes to \$3,000. - Then pay \$3,000

(2) Total Amount Billed to VA By Provider. The amount claimed equals the billed charges. No payment has been made from any source. The DRG total is more than the amount claimed. Pay the DRG total.

Example: The hospital billed charges and amount claimed is \$5,000. The DRG computed plus outliers and pass-throughs comes to \$7,000. Pay the hospital \$7,000

(3) Balance Due Billed to VA By Provider - Partial Payment Made by Private Insurance. The amount claimed is less than the billed charges. Some payment has been made by an insurer other than Medicare or other Federal source. Payment is under any regulatory authority. The DRG total is less than or equal to the amount claimed. Pay the DRG total minus the difference between billed charges and the amount claimed.

Example: The hospital billed \$10,000. Blue Cross paid \$3,000. The amount claimed is \$7,000. ($\$10,000 - \$3,000 = \$7,000$). The DRG computed plus outliers and pass-through comes to \$4,000. ($\$4,000 - \$3,000 = \$1,000$). Pay the hospital \$1,000.

(4) Balance Due Billed To VA By Provider. Partial Payment Made By Private Insurance. The amount claimed is less than the billed charges. Some payment has been made by an insurer, other than Medicare or other Federal source. The DRG total is more than the amount claimed. If the DRG total minus the difference between the billed charges and the amount claimed is greater than zero "0", pay that difference.

Example: The hospital billed \$10,000. Blue Cross paid \$6,000. The amount claimed is \$4,000. ($\$10,000 - \$6,000 = \$4,000$). The DRG computed plus outliers and pass-through comes to \$7,000. ($\$7,000 - \$6,000 = \$1,000$). Pay the hospital \$1,000.

Example: The hospital billed \$10,000. Blue Cross paid \$9,000. The amount claimed is \$1,000. ($\$10,000 - \$9,000 = \$1,000$). The DRG computed plus outliers and pass-throughs comes to \$4,000. ($\$4,000 - \$9,000 = -\$5,000$) No payment will be made to the hospital.

c. The following are examples of the total computed for payment if the payment to be made is a reimbursement to the veteran or some other third party:

(1) Total Amount Billed is Claimed. The total amount claimed equals the billed charges. The DRG total is less than or equal to the amount claimed. Reimburse the DRG total.

Example: The hospital bills the veteran for \$5,000. No payment has been made from any insurance or Federal source and the amount claimed for payment is \$5,000. The DRG computed plus outliers and pass-through (= DRG total) comes to \$3,000. Reimburse the hospital \$3,000.

(2) Total Amount Billed is Claimed. The amount claimed equals the billed charges. The DRG total is greater than the amount claimed. Reimburse the DRG amount.

Example: The patient died on the second day of care. The hospital bill for 2 days is \$2,000. No payment has been made from any insurance or Federal source and the amount claimed is \$2,000. The DRG computed plus outliers and pass-through comes to \$3,000. Reimburse the hospital \$3,000.

(3) Balance Due After Partial Payment from Private Insurance - Care Not Previously Authorized (Unauthorized Claim). The amount claimed is less than the billed charges. Some payment has been made by an insurer other than Medicare or other Federal agency. The care was unauthorized by VA and is paid under 38 CFR 17.80. The DRG total is less than or equal to the amount claimed. Reimburse the DRG total.

Example: The hospital billed \$10,000. The patient's Blue Cross paid \$5,000. The veteran paid the balance and the amount claimed for reimbursement comes to \$5,000. ($\$10,000 - \$5,000$). The DRG computed plus outliers and pass-through comes to \$4,000. Reimburse the veteran \$4,000.

(4) Balance Due After Partial Payment From Private Insurance - Care Not Previously Authorized (Unauthorized Claim). The amount claimed is less than the billed charges. Some payment has been made by an insurer other than Medicare or other Federal agency. The care was unauthorized by VA and is paid under 38 CFR 17.80. The DRG total is more than the amount claimed. Reimburse the amount claimed.

Example: The hospital billed \$10,000. The patient's insurance paid \$7,000. The veteran paid the balance and the amount claimed for reimbursement is \$3,000. The DRG plus outliers and pass-through comes to \$5,000. Reimburse the veteran \$3,000.

(5) Balance Due After Partial Payment From Private Insurance - Care Authorized by VA. The amount claimed is less than the billed charges. Some payment has been made by an insurer other than Medicare or other Federal agency. The care was authorized by VA (any regulatory authority code except 38 CFR 17.80). The DRG total is less than or equal to the amount claimed. Reimburse the DRG total minus the difference between billed charges and the amount claimed.

Example: The hospital billed \$10,000. Blue Cross paid \$3,000. The veteran paid the balance and the amount claimed for reimbursement is \$7,000. ($\$10,000 - \$3,000$). The DRG computed plus outlier and pass-through comes to \$4,000. Reimburse the DRG total \$4,000 minus the difference between billed charges and the amount claimed ($\$10,000 - \$7,000$) = \$3,000. Reimburse the veteran \$1,000 ($\$4,000 - \$3,000$).

(6) Balance Due After Partial Payment From Private Insurance - Care Authorized by VA. The amount claimed is less than the billed charges. Some payment has been made by an insurer other than Medicare or other Federal agency. The care was authorized by VA - any regulatory authority other than 38 CFR 17.80. The DRG total is more than the amount claimed. If the DRG total minus the difference between the billed charges and the amount claimed is greater than zero "0", reimburse this difference.

Example: The hospital billed \$10,000. Blue Cross paid \$6,000. The veteran paid the balance and the amount claimed for reimbursement is \$4,000 ($\$10,000 - \$6,000 = \$4,000$). The DRG computed plus outlier and pass-through comes to \$7,000. Reimburse the DRG total of \$7,000 minus the difference

between the billed charges and the amount claimed ($\$10,000 - \$4,000 = \$6,000$) = \$1,000. Reimburse the veteran \$1,000 ($\$7,000 - \$6,000$).

Example: The hospital billed \$10,000. Blue Cross paid \$9,000. The veteran paid the balance and the amount claimed for reimbursement is \$1,000. The DRG computed plus outlier and pass-through comes to \$4,000. Reimburse the DRG total of \$4,000 minus the difference between the billed charges and the amount claimed ($\$10,000 - \$1,000 = \$9,000$) = -\$5,000. Since the result of this calculation is a negative amount or less than 0, no reimbursement will be made. Reimburse the veteran nothing.

**PROCESSING INVOICES FOR PAYMENT OF MEDICAL AND
SURGICAL NON-VA HOSPITAL CARE**

1. Content and Review of Invoices

a. The non-Federal hospital will submit a bill to the Department of Veterans Affairs (VA) at the time of discharge. Billings may be accepted in any format, including submission of the Health Care Financing Administration (HCFA)Form 1453 or UB-82, but must include the following minimum information clearly identified:

- (1) Patient's date of birth;
- (2) Patient's sex;
- (3) Patient's name;
- (4) Date of Admission;
- (5) Date of discharge (death, or transfer to another hospital);
- (6) Type of disposition (discharge, death, or transfer to another facility);
- (7) Total charges billed for care provided;
- (8) Amount claimed for payment;
- (9) Provider name, address and Medicare provider number;
- (10) Admitting diagnosis with appropriate International Classification of Diseases, Clinical Modification, 9th Edition (ICD-9-CM) code;
- (11) Principal diagnosis with appropriate ICD-9-CM code;
- (12) Other diagnoses with appropriate ICD-9-CM code; and
- (13) Surgical Procedures with dates of procedures and ICD-9-CM codes.

Invoices which do not contain this information should be returned to the non-Federal hospital which submitted the bill for completion of these items.

b. The principal diagnosis must be identified as such and must be in full ICD-9-CM code through the fifth digit, if available. The principal diagnosis is the condition established after study to be chiefly responsible for the patient's admission.

c. Other diagnoses are conditions which coexist at the time of admission, or which develop subsequently. Excluded are conditions which relate to earlier episodes and which have no bearing on the current admission for hospital care. Other diagnoses must be in full ICD-9-CM code through the fifth digit, if available. Up to four other diagnoses may be accepted.

d. Surgical procedures must be in full ICD-9-CM codes through the fourth digit, if possible. One principal and up to two other surgical procedures may be submitted. The principal surgical procedure is that which is therapeutic rather than diagnostic, most related to the principal diagnosis or is necessary to take care of a complication. Surgical procedures include incision, excision, amputation, introduction, endoscopy, repair, destruction, suture, and manipulation. Only if no therapeutic procedure has been performed, can a diagnostic procedure be the primary surgical procedure.

e. Invoices and necessary medical records will be reviewed to verify eligibility for payment by VA. Review will include the determination of the number of days of hospital care which will be authorized by VA (38 Code of Federal Regulations (CFR)17.50c or 17.80a). If on review a procedure or diagnosis is found not to be part of authorized care or not medically necessary, denial of the procedure or diagnosis will be made and the Diagnostically Related Group (DRG) will be calculated excluding the ICD-9-CM code for that procedure or diagnosis.

f. The claim for payment will be processed through the Decentralized Hospital Computer Program (DHCP) Fee-Basis Civil hospital pricer software.

2. Edit Procedure

a. The HCFA Grouper at the Austin Automation Center will perform edits on the data submitted similar to those performed on entries into the Fee and Patient Treatment File (PTF) system. Data submitted are subject to edit for accuracy and consistency.

(1) Accuracy is verified by testing each data entry to see if it is a legitimate code. *Example:* A ten digit number is entered into the veteran's social security number section. This would constitute an error in accuracy.

(2) Consistency is verified by correlating two data entries, each of which individually may be correct but viewed together are logically inconsistent.

b. All errors in accuracy and consistency will be denoted with an asterisk (*) under the error. All errors identified by an asterisk indicate rejection of all data related to that submission and nonacceptance of that record.

c. A pound (#) sign will be used to flag relevant data fields anytime the episode of care under consideration results in payment of either a day or cost outlier. Special attention should be paid to verify the data elements in these fields before certifying the voucher for payment. The # sign does not indicate an error.

d. If the report is returned indicating that the provider is a facility excluded from the DRG prospective pay system, then payment will be computed based on the national cost-to-charge ratio times the billed charges that are reasonable, usual, customary, and not in excess of rates or fees the hospital charges the general public for similar services in the community.

January 12, 1995

1. Transmitted is a revision to Department of Veterans Affairs (VA), Veterans Health Administration (VHA) Manual M-1, "Operations," Part I, "Medical Administration," Chapter 21, "Authorized Non-VA Hospitalization in the United States."

2. Principal changes are:

a. This chapter has been completely revised to more clearly define the methodology for VA payment of non-VA hospital care. Revisions are required as a result of Inspector General and General Accounting Office audit recommendations.

b. **Paragraph 21.04, e.(2):** Has been added to include eligibility for contract non-VA hospital care for the treatment of any disability of a veteran who has a total disability permanent in nature from a service-connected disability, changes required as a result of Public Law 102-585.

c. **Appendix 21B:** Has been added to explain the prospective payment system which is the process used to determine the amount to be paid for non-VA hospital care.

d. **Appendix 21C:** Has been added to provide instructions for processing invoices for payment of medical and surgical non-VA medical facility care.

3. **Filing Instructions**

Remove pages

21-i through 21-iii
21-1 through 21-8
21A-1 through 21A-2
21B-1

Insert pages

21-i through 21-ii
21-1 through 21-9
21A-1
21B-1 through 21B-6
21C-1 through 21C-2

4. **RESCISSIONS:** M-1, Part I, Chapter 21, dated April 13, 1983; VHA Circulars/Directives: 10-88-011 10-88-034, 10-89-022, 10-90-064, 10-90-143, and Supplement No. 1.

S/by Dennis Smith for
Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

Distribution: **RPC: 1129**
FD

Printing Date: 1/95

July 26, 1988

TELEGRAPHIC MESSAGE

NAME OF AGENCY VACO WASHINGTON, DC		PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED 7/22/88		FILE
FOR INFORMATION CALL			
NAME DALE WOODSON	PHONE NUMBER 373-2504	TYPE OF MESSAGE <input type="checkbox"/> SINGLE <input type="checkbox"/> BOOK <input type="checkbox"/> MULTIPLE-ADDRESS	
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MESSAGE TO BE TRANSMITTED (Use double spacing and all-capital letters)

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

00/136 THIS IS INTERIM ISSUE 10-88-11 (DTD: 7/26/88)

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: DM&S MANUAL M-1, PART I, CHAPTER 21.

B. OTHER ISSUES AFFECTED: DM&S MANUAL M-1, PART I, CHAPTER 20

C. REASON FOR ISSUE: TO PERMIT THE AUTHORIZATION OF NON-VA HOSPITAL CARE TO OBTAIN DIAGNOSTIC SERVICES IN CONNECTION WITH O&E EXAMINATIONS, TO DEFINE FINANCIAL RESPONSIBILITY AND REDEFINE PARAGRAPH 21.22j. EFFECTIVE DATE JULY 1, 1988.

D. TEXT OF THE ISSUE:

1. GENERAL:

A. PUBLIC LAW 100-322 HAS EXPANDED THE AUTHORITY FOR PROVIDING NON-VA HOSPITAL CARE TO CERTAIN PERSONS.

B. CURRENT STATUTES NOW PROVIDE AUTHORITY FOR THE VA TO OBTAIN NECESSARY DIAGNOSTIC SERVICES FROM NON-VA SOURCES TO COMPLETE OBSERVATION AND EXAMINATION REQUESTS.

C. REDEFINE M-1, PART I, CHAPTER 21, PARAGRAPH 21.22j.

SECURITY CLASSIFICATION	
PAGE NO. 1	NO. OF PGS. 4

TELEGRAPHIC MESSAGE

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ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
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MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO:

2. SPECIFIC:

A. INSERT THE FOLLOWING NEW SUBPARAGRAPH TO 21.21 "d" "CLINIC DIRECTORS OR THEIR DESIGNEES WILL AUTHORIZE NECESSARY DIAGNOSTIC SERVICES AT NON-VA FACILITIES (ON AN INPATIENT OR OUTPATIENT BASIS) IN ORDER TO COMPLETE REQUESTS FROM REGIONAL OFFICES FOR OBSERVATION AND EXAMINATION (O&E) OF A PERSON TO DETERMINE ELIGIBILITY FOR VA BENEFITS OR SERVICES."

(1) "AUTHORIZATION AND PAYMENT FOR PUBLIC OR PRIVATE CARE UNDER THESE CIRCUMSTANCES WILL BE THE RESPONSIBILITY OF THE APPROPRIATE CLINIC OF JURISDICTION. PAYMENT FOR SUCH CARE WILL BE MADE FROM CONTRACT HOSPITALIZATION FUNDS."

B. THIS INTERIM ISSUE CHANGES M-1, PART I, CHAPTER 20 AS FOLLOWS: CHANGE PARAGRAPH 20.19 TO READ: "VA FORM 21-2507, REQUEST FOR PHYSICAL EXAMINATION, REQUESTING HOSPITALIZATION FOR O&E (OBSERVATION AND EXAMINATION) WILL BE REFERRED TO THE NEAREST SUITABLE VA MEDICAL CENTER. WHEN THE CLINIC RECEIVES A VA FORM 21-2507 WHICH DOES NOT SPECIFY O&E, AND THE CLINIC

SECURITY CLASSIFICATION

PAGE NO.	NO. OF PGS.
2	4

II 10-88-11
July 26, 1988

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
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FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE <input type="checkbox"/> SINGLE <input type="checkbox"/> BOOK <input type="checkbox"/> MULTIPLE-ADDRESS
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MESSAGE TO BE TRANSMITTED (Use double spacing and all-capital letters)

TO: DIRECTOR BELIEVES THAT O&E IS REQUIRED IN ORDER TO EVALUATE FULLY THE VETERAN'S DISABILITIES, THE CLINIC WILL FORWARD THE VA FORM 21-2507 WITH ANY ADDITIONAL INFORMATION NECESSARY TO AN APPROPRIATE VA MEDICAL CENTER. WHEN INDICATED, CLINIC DIRECTORS OR THEIR DESIGNEES WILL AUTHORIZE NECESSARY DIAGNOSTIC SERVICES AT NON-VA FACILITIES (ON AN INPATIENT OR OUTPATIENT BASIS) IN ORDER TO COMPLETE REQUESTS FROM REGIONAL OFFICES FOR OBSERVATION AND EXAMINATION. AUTHORIZATION AND PAYMENT PROCEDURES ARE CONTAINED IN M-1, PART I, CHAPTER 21, PARAGRAPH 21.21(d). WHEN THE VA MEDICAL CENTER STAFF BELIEVES THAT THE EXAMINATION CAN BE CONDUCTED ON AN OUTPATIENT BASIS, THE ADJUDICATION OFFICER OR HIS/HER DESIGNEE WILL BE CONTACTED BY TELEPHONE. FINAL ACTION WILL BE BASED ON THE AGREEMENT REACHED."

C. CHANGE PARAGRAPH 21.22j TO READ "WHEN A VETERAN REQUIRES SPECIALIZED MEDICAL CARE FOR SERVICE-CONNECTED CONDITIONS, AT A DISTANT NON-VA FACILITY BECAUSE SUCH CARE IS NOT AVAILABLE WITHIN THE VA MEDICAL CARE SYSTEM OR COVERED UNDER A NEGOTIATED SHARING AGREEMENT, CARE WILL BE AUTHORIZED BY THE CLINIC OF

SECURITY CLASSIFICATION

PAGE NO.	NO. OF PGS.
3	4

II 10-88-11
July 26, 1988

TELEGRAPHIC MESSAGE

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ACCOUNTING CLASSIFICATION	DATE PREPARED	FILE
FOR INFORMATION CALL		
NAME	PHONE NUMBER	TYPE OF MESSAGE <input type="checkbox"/> SINGLE <input type="checkbox"/> BOOK <input type="checkbox"/> MULTIPLE-ADDRESS

THIS SPACE FOR USE OF COMMUNICATION UNIT

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

TO:

JURISDICTION OF THE VETERAN'S RESIDENCE. PAYMENT FOR SUCH CARE
WILL BE MADE FROM CONTRACT HOSPITALIZATION FUNDS."

E. RESCISSION: THIS INTERIM ISSUE IS RESCINDED ON JULY 26, 1989
AND WILL NOT BE CONFIRMED WITH A PRINTED COPY.

John A. Growall, M.D.

DISTRIBUTION: RPC: 1129 (VACO & NONVA ONLY)
FD

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PAGE NO.	NO. OF PGS.
4	4

Department of Medicine and Surgery
Veterans Administration
Washington, DC 20420

MAR 31 1988

M-1, Part I
Chapter 21
Change 3

December 14, 1987

Chapter 21, "Non-VA Hospitalization in the United States," 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 indicate that Clinics of Jurisdiction will use .21 funds to pay for non-VA hospital care for emergent conditions arising during authorized travel.

Pages 21-3 and 21-4: Remove these pages and substitute pages 21-3 and 21-4 attached.

John A. Gronvall, M.D.

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Department of Medicine and Surgery
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APR 4 1988

M-1, Part I
Chapter 21
Change 2

December 14, 1987

Chapter 21, "Non-VA Hospitalization in the United States," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is changed as indicated below:

NOTE: This change will establish procedures by which COJ's can pay for non-emergency care for service-connected veterans.

Pages 21-5 and 21-6: Remove these pages and substitute pages 21-5 and 21-6 attached.



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M-1, Part I
Chapter 21
Change 1


February 4, 1986

Chapter 21, "Non-VA Hospitalization in the United States," 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 incorporate the provisions of VA Circular 10-85-85 concerning non-VA hospital care to veterans undergoing a chapter 15 vocational rehabilitation program.*

Pages 21-i and 21-ii and 21-1 through 21-4: Remove these pages and substitute pages 21-i and 21-ii and 21-1 through 21-4 attached.

RESCISSIONS: DM&S Circulars 10-85-40 and 10-85-85.


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Errata to M-1, Part I
Chapter 21

September 12, 1983

The revision, dated April 13, 1983, to Chapter 21, "Non-VA Hospitalization in the United States," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is corrected as follows:

Page 21-2, paragraph 21.04, chart

FEDERAL column: Delete column title "Without Allo-Beds Beds to VA" and insert "Without Allocated Beds to VA".

NON-FEDERAL column: Delete column title "cated Contract" and insert "Contract".

Page 21-3, paragraph 21.04, chart

FEDERAL column: Delete column title "Without Allo-Beds Beds to VA" and insert "Without Allocated Beds to VA".

NON-FEDERAL column: Delete column title "cated Contract" and insert "Contract".

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M-1, Part I
Chapter 21

April 13, 1983

Chapter 21, "Non-VA Hospitalization in the United States," Part I, "Medical Administration Activities," VA Department of Medicine and Surgery Manual M-1, "Operations," is revised as indicated below.

NOTE 1: Chapter 21 will be published with its own series of changes and will carry an RPC number separate and distinct from other chapters of M-1, part I.

NOTE 2: The purpose of this revision, other than editorial, is to:

a. Delete authority for providing non-VA hospital care for emergent conditions arising during contract nursing home care (par. 21.04d (chart)).

b. Provide that contracts for bed allocation or inpatient care will be made with non-Federal hospitals only if they are accredited by the JCAH (Joint Commission on Accreditation of Hospitals) and that official inspections of hospitals will not be made (par. 21.12—app. 21A deleted).

c. Add authority for providing non-VA hospital care or medical services at VA expense for veterans who develop a need for emergent medical care while receiving medical services at a VA or other Federal health care facility (PL 96-151), (par. 21.21c). Chart in paragraph 21.04d also updated.

d. Limit authorizations for payment for emergency hospital care and provide for transfer to VA medical centers (par. 21.22e).

e. Provide controls for emergency non-VA hospital care when it is authorized (par. 21.23).

f. Provide for termination of VA payment when emergency care is no longer required (par. 21.25h).

g. Provide for recovery of medical care costs from tortiously liable third parties (par. 21.26).

h. Modify preparation of VA Form 10-7078 to provide limitations for authorizations for emergency treatment (App. 21A).

Pages 21-i through 21-iii, 21-1 through 21C-2: Remove these pages and substitute pages 21-i through 21-iii, 21-1 through 21B-1 attached.

RESCISSIONS:

Manual: Chapter 21, dated December 29, 1967, and changes 105, 114, 124, 127, 163, 166, 171, 172, M-1, part I.

Interim Issues: 10-67-43, 10-68-35, 10-68-49, 10-80-12, 10-81-17, 10-81-25, 10-82-15, 10-82-29, 10-82-30.

DM&S Circulars: 10-75-219, 10-79-18, 10-80-41.



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