Guidebook

Fee Basis Data: A Guide for Researchers

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Contents

Terms v

1. Overview 1

2. Data 3
2.1. File names 3
2.2. File contents 3
2.3. Missingness 9

3. Access 16
3.1. Austin Information Technology Center (AITC) 16
3.2. Web-based access 16

4. Institutional Aspects of the Fee Basis System 18
4.1. Coverage 18
4.2. Veteran status 19
4.3. Fee Card eligibility 19
4.4. Payment rules 20

5. Recommendations for Analyzing Fee Basis Data 24
5.1. Finding records 24
5.2. Creating discharge records from invoice records 24
5.3. Apparent data anomalies 25
5.4. Facility charges vs. ancillary charges 25

6. Resources 26
6.1. Contacts for the Fee Basis program 26
6.2. Fee Basis program web site 26

References 28

Tables and Appendices

Table 1: AITC File Names and Brief Descriptions 3
Table 2: Names and Formats of Geographic Variables, FY2009 5
Table 3: Number of Diagnosis and Procedure Codes, by File and Year Range 6
Table 4: Variables That Describe Setting and Type of Care, by File 7
Table 5: Important Payment Variables, by File 8
Table 6: Names and File Locations of Fee Basis Variables, FY2009 11
Table 7: Selected Procedure Guides on the Fee Basis Intranet Site (January, 2010) 27
Appendix A. Contents of FY2009 Inpatient (INPT) File 30
Appendix B. Contents of FY2009 Inpatient Ancillary (ANCIL) File 35
Appendix C. Contents of FY2009 Outpatient (MED) File 38
Appendix D. Contents of FY2009 Pharmacy Payments (PHR) File 40
Appendix E. Contents of FY2009 Pharmacy Vendors (PHARVEN) File 42
Appendix F. Contents of FY2009 All Other Vendors (VEN) File 43
Appendix G. Contents of FY2009 Travel Payments (TVL) File 45
Appendix H. Contents of FY2009 Fee Card (VET) File 46
Appendix I. Formatted Values of Selected Variables in FY2009 48
Appendix J. Fee Purpose of Visit (POV) Information and Table 52
Appendix K. SAS Program Example: Average Cost per CPT for One Vendor 63
Appendix L. Adjustment Code (ADJCD1 and ADJCD2) Values 64
Appendix M. Payment Guideline for Preauthorized Inpatient Claims 65
Appendix N. Payment for Physician and Non-physician Professional Services 71
Appendix O. Payment of Non-VA Outpatient Facility Charges 75

Terms

AITC	Austin Information Technology Center
AWP	Average Wholesale Price
CDR	Cost Distribution Report
CFR	Code of Federal Regulations
CMS	Center for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CTC	Cost to Charge
DHCP	Decentralized Hospital Computer Program
DSS	Decision Support System
E&M	Evaluation and management
FCDM	Financial and Clinical Data Mart
FMS	Financial Management System
ICD-9	International Classification of Disease, 9th Revision
IRMS	Information Resource Management Systems
MPCR	Monthly Program Cost Report
MST	Military Sexual Trauma
NDE	National Data Extract
NPCD	National Patient Care Database
NVH	PTF Non-VA Hospitalization File
OPC	Outpatient Care File
PTF	Patient Treatment File
RBRVS	Resource-Based Relative Value System
RVU	Relative Value Unit
USC	United States Code
VA	U.S. Department of Veterans Affairs
VERA	Veterans Equitable Resource Allocation
VHA	Veterans Health Administration
VistA	Veterans Health Information Systems and Technology Architecture

1. Overview

The Department of Veterans Affairs (VA) can make payments to non-VA health care providers under many arrangements. The most common are sharing agreements with affiliate medical schools and contracts with medical specialists. Non-VA care may also be authorized under the Fee Basis program when VA cannot offer needed care, when a non-VA provider would be economical, or on an emergency basis when travel to a VA facility is medically infeasible. In addition, VA may place a Veteran in a private or state-run nursing home when a bed in a VA nursing home is unavailable or if the nursing home is distant from the patient's residence. Payment for these types of care falls under the Fee Basis program.

Most Fee Basis services fall into one of five categories: short-term acute inpatient care, often followed by transfer to a VA facility; community nursing home care; emergency outpatient treatment; home-based care; and ongoing outpatient treatment in cases where the nearest VA facility is distant. Fee Basis payments represented over 10% of total VA health care spending in FY2009 and a much larger fraction of payments for services often provided under contract, such as long-term care.

Each VA station tracks Fee Basis invoices and submits reports to the national office. These reports are merged to form a system-wide database consisting of eight files: four that record health care encounters and four for administrative and travel records. These files are available for research use by VA employees following a standard approval process. They feature information on patients, providers, care provided, charges and payments, and financial processing. The files are accessible to VA employees through timeshare accounts at the VA Austin Automation Center.

The Fee Basis data will be most useful for studying conditions where contract care is common, such as home-based care and nursing care, and for determining typical non-VA charges for health care services (both charges and payments are reported) and comparing those to VA costs.

Relatively few published studies have made use of Fee Basis data. Chapko, Ehreth, and Hedrick (1991) discuss Fee Basis data in their early review of methods for determining the cost of VA health care. A large study of VA adult day health care (ADHC) programs counted contract care paid through Fee Basis and other programs (Chapko et al. 1993). Two studies have investigated the use of Fee Basis care by female Veterans. Frayne et al. (2002) surveyed Women Veterans Coordinators at VA facilities to determine how often Fee Basis care was used to provide low-volume services to female Veterans. They found that most centers use Fee Basis care for procedures specific to females (e.g., mammography and gynecologic oncology), although very few used it for military sexual trauma counseling. Washington et al. (2003) assessed the availability of women's health services at VA facilities serving 400 or more women per year. Fee Basis and other contract care accounted for very small proportions of most services, except for serum pregnancy test (9.0% of 136 sites) and screening mammography (62.2%). Youssef and others (2010) employed Decision Support System (DSS) and Fee Basis data to study VA cost of treating *S. aureus* and *C. difficile* infections. Finally, Palmer et al. (2010) studied the quality of care among Fee Basis providers of colonoscopy.

This guidebook is intended to help researchers understand and use national Fee Basis files. It describes characteristics of Fee Basis data such as contents, missingness, and concordance between files, and makes recommendations about its use for research. Chapter 1 presents an overview of the guidebook. Chapter 2 and its appendices describe all variables in the FY2009 Fee Basis files, including variable name, type, length, and missingness. Chapter 3 describes how to access the data through the Austin Automation Center or the VHA Support Services Center web site on the VA private network. Chapter 4 and its appendices offer detailed information about Fee Basis eligibility and payment rules, information critical to understanding utilization and cost patterns in the data. In Chapter 5 we summarize our notes and recommendations for researchers. Chapter 6 provides references for further information, including contact information for VA administrators knowledgeable about the Fee Basis program and data.

2. Data

2.1. File names

There are eight Fee Basis files for each fiscal year. Table 1 lists their Austin Information Technology Center (AITC) file names and gives a general description of their contents. The files are stored in SAS® data file format.

Table 1: AITC File Names and Brief Descriptions

Type of Data	Name Suffix	Full AITC File Name[1]
Hospital stays	INPT	MDPPRD.MDP.SAS.FEN.FYyy.INPT
Inpatient ancillary services and physician charges	ANCIL	MDPPRD.MDP.SAS.FEN.FYyy.INPT.ANCIL
Outpatient services	MED	MDPPRD.MDP.SAS.FEN.FYyy.MED
Payments to pharmacies	PHR	MDPPRD.MDP.SAS.FEN.FYyy.PHR
Travel expenses	TVL	MDPPRD.MDP.SAS.FEN.FYyy.TVL
Pharmacy vendors	PHARVEN	MDPPRD.MDP.SAS.FEN.FYyy.PHARVEN
All other vendors	VEN	MDPPRD.MDP.SAS.FEN.FYyy.VEN
Fee Basis ID Cards for selected Veterans	VET	MDPPRD.MDP.SAS.FEN.FYyy.VET

[1] Substitute the last two digits of the fiscal year for 'yy' in the file names above.

2.2. File contents

Care provided through the Fee Basis program is entered by VA staff into the VistA Fee Basis package. Data entries are based on invoices submitted to VA, at times supplemented by information gathered during telephone calls to the non-VA providers. Extracts from local VistA systems are merged to form national Fee Basis data files.

The data files in each fiscal year represent all claims paid during the year. They do not represent all claims received or processed during the year. Most importantly, they do not represent all care provided during the fiscal year. This is a critical difference from other VA utilization files such as the DSS national data extracts, the Outpatient Care File (OPC) and the Patient Treatment File

(PTF). To find all care provided in a particular fiscal year requires searching by treatment date over several years of Fee Basis claims, a process described in more detail below.

About 120 variables appear in one or more of the Fee Basis files. Table 6 – placed at the end of this chapter due to its length – lists each variable and indicates with an 'X' which files the variable appears in. In some cases there are two or more variables representing the same concept. For example, fiscal year appears as "FISYR" in three files and "FY" in two others. An official data dictionary has not been created for the Fee Basis files. We therefore used the SAS procedure PROC CONTENTS to generate a list of all variables. Results appear in Appendices A to H, where each appendix pertains to a separate Fee Basis file. For each variable we report the name, type (numeric or character), length, format, and label. We also report its rate of missingness, generated from a different SAS procedure.

In the inpatient stay (INPT) file, a record represents services rendered during one invoice period. Facilities may invoice VA once per calendar month, and so a stay that covers parts of two calendar months will often be represented by two (or more) invoices. In the inpatient ancillary (ANCIL) and outpatient services (MED) files, each record shows a single Current Procedure Terminology (CPT) code per record representing a single procedure or encounter. Some encounters have multiple procedures that are paid as a single encounter; other encounters have multiple procedures and there are separate payments for each procedure.

A single inpatient encounter may generate zero, one, or multiple ANCIL records, depending on the number of ancillary procedures and physician services received. Each record in the pharmacy services (PHR) file represents a single prescription, whether for a medication or a pharmacy supply (e.g., skin cleanser, bathing cloths). Each record in the vendor files (PHARVEN, VEN) pertains to a particular vendor, while Fee ID Card records in the VET file correspond to individual Veterans rather than the particular services those Veterans have received.

Below we summarize the contents for six categories of variables: patient demographics, military service, location, clinical aspects, payment, and financial processing within VA.

2.2.1. Demographic variables

The demographic information in the Fee Basis files is very limited. The VET file has a variable for gender (SEX) and, for decedents, the date of death (DEATHDT). Because the VET file contains relatively few records, researchers must match Fee Basis records to other VA databases, such as the Outpatient Care File (OPC/NPCD), the Patient Treatment File (PTF), of the Decision Support Systems (DSS) National Data Extracts to obtain demographic data. The Fee Basis files have a patient ID variable (scrambled SSN [SCRSSN]) that enables researchers to merge these data.

2.2.2. Military service variables

Variables representing period of service (WARCODE) and prisoner-of-war status (POW) appear in the VET file. No other service-related variables appear in the Fee Basis files. Service variables for all Fee Basis patients can be obtained from other VA databases.

2.2.3. Geographic variables

Every Fee Basis file contains variables for county of residence and state of residence (including Canadian provinces and certain foreign countries). Table 2 lists the variable names and formats.

We checked the concordance of corresponding numeric and character values across records in two years of Fee Basis data. Numeric values were associated with the same character values consistently, except when HOMSTATE took the values of '90' or '99.' Potential errors in HOMSTATE appear in HOMECNTY as well, which is derived by concatenating HOMSTATE and CNTY.

Table 2: Names and Formats of Geographic Variables, FY2009

Variable	Numeric Format	Character Format
VA Station	STA3N (4 digits)	STA6A (6 digits) STANUM (6 digits)
County	CNTY HOMECNTY	*None*
State[1]	HOMSTATE	STATE

[1] Includes Canadian provinces, Puerto Rico, Guam, and the Philippines

STA3N, STA6A, and STANUM refer to the station at which the data are input, which should be the station paying for the service. The primary service area (HOMEPSA) indicates the station to which the Veteran's residence is assigned based on geography. It not necessarily the station at which the Veteran receives most VA care or the station which will pay for a particular Fee Basis service. To locate the facility at which the Veteran usually receives VA care, VIReC recommends consulting the preferred facility indicator in the VHA Enrollment Database (VIReC 2007). For a brief presentation of the rules governing which VA station must pay for a particular Fee Basis service, see the notes of the Fee Program Office national call on 8 November 2007, available on the Fee Basis intranet web site.

2.2.4. Clinical variables

Table 3 shows the number of diagnosis and procedure variables in each of the Fee Basis files. Through FY2008 there were up to five ICD-9 discharge diagnosis codes recorded in the inpatient discharge (INPT) file and no admission diagnoses. Starting in FY2009 there are up to 25 discharge diagnoses and up to 25 admission diagnoses. The outpatient services file reports a single discharge diagnosis (DXLSF) alone. There were no diagnosis codes in the ancillary and physician services (ANCIL) file until FY2009, when a single discharge diagnosis code (DXLSF) was added. Ancillary file records can be linked by patient ID and service dates to discharge records in the INPT file. Diagnosis codes do not appear on the pharmacy (PHR) file.

Table 3: Number of Diagnosis and Procedure Codes, by File and Year Range

Variable	Variable Name	Inpatient Facility (INPT)	Inpatient Ancillary (ANCIL)	Outpatient (MED)	Pharmacy (PHR)
Admission Diagnoses	DXPOA1-DXPOA25	-FY2008: 0 FY2009-: 25	0 0	0 0	0 0
Discharge Diagnoses	DXLSF, DX2-DX25	-FY2008: 5 FY2009-: 25	0 1	1 1	0 0
Inpatient Procedures	SURG9CD1-SURG9CD25	-FY2008: 5 FY2009-: 25	0 0	0 0	0 0
Ancillary, Physician, or Outpatient Procedures	CPT1	0*	1	1	0
CPT modifiers	CPTMD1-CPTMD4	0 0	-FY2007: 0 FY2008-: 4	-FY2004: 0 FY2005-: 4	0 0

* A variable exists but all values are missing.

Procedure codes appear in the inpatient procedures file (INPT) and the outpatient services file (MED). Through FY2008 there were up to five ICD-9 procedure codes; starting in FY2009 this was raised to 25 codes. Each outpatient (MED) record contains a single CPT procedure code. There are also up to four two-character CPT modifier codes in the ancillary (ANCIL) and outpatient (MED) files. They were added to the ancillary file in FY2008 and to the outpatient file in FY2005.

Six additional variables indicate the setting of care and vendor or care type. They appear in Table 4, where an 'X' indicates that the variable appears in the file. Vendor type (TYPE), payment category (PAYCAT), treatment code (TRETYPE), and place of service (PLSER) all provide information on the type or setting of care. They could form part of an overall strategy to locate care provided in specialized settings, such as state homes, or of specialized services like kidney dialysis. PLSER values overlap considerably with those of the Medicare Carrier Line Place of Service codes. The Fee Purpose of Visit (FPOV) and Health Care Financing Agency Payment Type (HCFATYPE) variables feature values pertaining to setting (inpatient, outpatient, home-based), specific items (e.g., supplies and diagnostics), and miscellaneous purposes.[1]

[1] The Health Care Financing Administration (HCFA) has been renamed the Centers for Medicare and Medicaid Services (CMS).

Table 4: Variables That Describe Setting and Type of Care, by File

Variable	Variable Name	Inpatient (INPT)	Inpatient Ancillary (ANCIL)	Outpatient (MED)	Pharmacy (PHR)
Type	TYPE	X	X	X	X
Payment Category	PAYCAT	X	*	X	X
Fee Purpose of Visit	FPOV	X	X	X	
HCFA Payment Type	HCFATYPE		X	X	
Treatment Code	TRETYPE			X	
Place of Service	PLSER		X	X	

* Variable exists but all values are missing.

Formatted FY2009 values for Fee Purpose of Visit (FPOV), HCFA Payment Type (HCFFMT), Treatment Code (TRETYPE), Place of Service (PLSER), and Vendor Type (TYPE) appear in Appendix I, starting on page 48. New values may be added over time. Appendix J, copied from the Fee Basis program web site, describes in detail the types of records for which each Fee Purpose of Visit (FPOV) codes is assigned.

2.2.5. Payment variables

The Fee Basis files' primary purpose is to record VA payments to non-VA providers. Table 5 lists the most important payment variables and in which files they appear. Additional variables, most of them relating to FMS processing, appear in Table 6 at the end of this chapter.

The Amount Claimed (PAMTCL) appears in the inpatient (INPT) file alone. Claimed amounts should be listed on all invoices submitted to VA, but except for inpatient facility claims they are not added to the Fee Basis files. It may be possible to extract claimed amounts for files other than INPT from the VistA system of a particular medical center.

The amount paid to vendors is expressed in two variables, Payment Amount (AMOUNT) and FMS Disbursed Amount (DISAMT). Before FY2007 DISAMT had an implied decimal point whereas AMOUNT did not. Starting in FY2007 the two variables are equal, although the number of nonmissing values still differs slightly between them and so annual totals will not exactly match.

Care provided under contract are eligible for interest payments. Thus the variable INTIND (interest indicator), which equals '1' if the claim is eligible for interest and '0' otherwise, is also an indicator of contract care. The amount of interest paid on the claim, if any, appears as the variable INTAMT. It has two implied decimal places. For example, an interest payment of

Table 5: Important Payment Variables, by File

Variable	Variable Name	Inpatient (INPT)	Inpatient Ancillary (ANCIL)	Outpatient (MED)	Pharmacy (PHR)
Claimed amount	PAMTCL	X			
Payment amount	AMOUNT	X	X	X	X
FMS disbursed amount	DISAMT	X	X	X	X
FMS interest indicator	INTIND	X	X	X	X
FMS interest amount	INTAMT	X	X	X	X
Medicare pricer amount	PAMT	X			

* Includes the physician charge when that is not billed separately.

$14.21 would appear as '1421.' INTAMT is part of AMOUNT and DISAMT; it should not be added to them.

The inpatient (INPT) file includes PAMT, the Medicare prospective payment that would apply to the stay. VA calculates PAMT from CMS pricer software on the basis of DRG and length of stay. There are additional payments for direct medical education, capital-related costs, and other factors as appropriate. The VA payment (DISAMT) is typically less than or equal to the PAMT value, although in some cases VA will pay more than Medicare would pay. For more details, including rules for handling patients transferred during a stay, see federal regulation 38 CFR 17.55.

The important payment variables that appear in the ANCIL file likewise are found in the outpatient MED file. They include the two variables that show the total payment (AMOUNT and DISAMT) and the interest portion of the total payment, if any (INTAMT).

The pharmacy vendors (PHARVEN) and all other vendors (VEN) files contain only summary payments by month. These data records cannot be linked to particular patients or encounters. Likewise, the Fee Card (VET) file contains only summary payment figures by month, although researchers can match the records to other data by SCRSSN and other identifiers. Research by VA staff members indicates that vendor ID (VENDID) in the VEN and PHARVEN files is consistent across sites, reliably links to Fee Basis workload files, and corresponds to a vendor file in VistA.[2] Appendix K presents a SAS program that calculates the average cost per CPT code for a particular station. Through a simple modification it could be limited to a specific vendor as well.

[2] Ellen Zufall, personal communication, 2 October 2006.

The travel payments (TVL) file shows reimbursements for particular travel events, TVLAMT. Through patient ID (SCRSSN) and travel date (TVLDTE) one can link these payments to encounters recorded in the encounter-level inpatient and outpatient files (INPT, ANCIL, MED).

2.2.6. Financial processing variables

Many variables in the Fee Basis files record details of invoice and check processing. Most files contain the invoice date, obligation number, check number and date, several variables pertaining to check cancellation and denials of payment, and the DHCP internal control number. Five additional variables – Financial Management System (FMS) transaction number, line number, date, batch number, and release date – reflect processing of payments through the FMS. With few exceptions these variables will be of little interest to researchers.

The payment amount variables (AMOUNT and DISAMT) are missing (blank) in a small number of cases. These represent cases in which payment is disallowed. The values of Adjustment Codes 1 and 2 (ADJCD1 and ADJCD2) explain the reason for non-payment. Appendix L lists their current values.

2.3. Missingness

The last column of Appendices A to H shows the percentage of variable values missing in the FY2009 files. Rates of missingness are generally low. A few variables of interest to researchers are missing at least 95% percent of the time in certain files:

- MDCAREID: Medicare Provider ID (INPT, ANCIL files) – 100% missing
- CPT1: outpatient procedure code (INPT file) – 100% missing
- PAYCAT: payment category (ANCIL file) – 100% missing
- Several FMS processing variables (all files) – 98-100% missing
- SPECCODE: suspense code (VEN, PHARMVEN) – 100% missing

The Medicare provider ID (MDCAREID) is required by Medicare Pricer software to determine the prospective payment for a stay. The values are missing for all records. In many cases the Medicare provider ID is unnecessary because the prospective payment already appears in the variable PAMT. If a researcher wishes to find the provider ID, one approach is to use the vendor identification variables (VEN13N, VENDID) to locate the vendor's name and location in the VEN file, and then to use this information to find the Medicare provider ID using publicly available files from CMS, the agency that oversees the Medicare program.

Inpatient procedures are captured by ICD-9 codes (SURG9CD1-SURG9CD5), whereas the CPT1 code is typically used for outpatient procedures. The CPT1 variable in the inpatient (INPT) file appears to serve merely as a placeholder. The FMS processing variables and the suspense code (SPECCODE or SUSCODE), whose 18 values refer to invoice processing or claim type, are unlikely to be used for research. The payment category (PAYCAT) is missing for all records in the inpatient services (ANCIL) file. Missing values of PAYCAT could be imputed by finding the matching inpatient stay in the INPT file.

Researchers must consider whether a missing value means "not applicable." For example, more than 75% of inpatient (INPT) records lack a value for any of the surgery codes (SURG9CD1-SURG9CD5). This most likely reflects a low frequency of surgery rather than missing data. The Fee Basis program will not pay for non-emergent surgery, and thus we should expect to see relatively few of them in these data. Conversely, all stays should have at least one discharge diagnosis. A missing value of the primary diagnosis code (DXLSF) should therefore be treated as truly missing. The same cannot be said for DX2-DX5, however, as additional diagnosis codes are optional.

Notes and Recommendations

- The same concept (such as fiscal year, state, or county) may be represented by several variables, sometimes in differing formats.

- Missingness is generally very low except for selected variables. It can vary substantially by year and by file.

Table 6: Names and File Locations of Fee Basis Variables, FY2009[1]

Variable	Fee Basis File							
	INPT	ANCIL	MED	PHR	PHARVEN	VEN	VET	TVL
ACCPTDTE	X	X	X	X				X
ACTCODE	X	X	X	X				X
ADHCP		X						
ADJAMT1	X	X	X	X[2]				
ADJAMT2			X	X[2]				
ADJCD1	X	X	X	X				
ADJCD2			X	X				
ADMDATE	X	X	X					
AGECNTL							X	
AMOUNT	X	X	X	X				
AMTCLMD				X				
APRMOTR					X	X	X	
AUGMOTR					X	X	X	
AUTHFLG	X	X	X					
BATCHNUM	X	X	X	X				X
CANCODE	X	X	X	X				X
CANDAT	X	X	X	X				X
CANRSN	X	X	X	X				X
CCADDR1							X	
CCADDR2							X	
CCCITY							X	
CCCNTY							X	
CCCODE							X	
CCST							X	
CCZIP							X	
CHAINNUM				X				X
CHKDAT	X	X	X	X				X
CLMDATE	X	X	X	X				X
CNTY	X	X	X	X			X	
CPT1	[3]	X	X					
CPTMD1		X[4]	X[5]					

[1] Variable labels appear in Appendices A-H.
[2] In the PHR file ADJATM1 is called ADJAM1 and ADJACMT2 is called ADJAM2.
[3] Variable exists but all values are missing.
[4] Added in FY2008.
[5] Added in FY2005.

Table 6: Names and File Locations of All Fee Basis Variables (cont'd) [1]

Variable	Fee Basis File							
	INPT	ANCIL	MED	PHR	PHARVEN	VEN	VET	TVL
CPTMD2		X[4]	X[5]					
CPTMD3		X[4]	X[5]					
CPTMD4		X[4]	X[5]					
DEATHDT							X	
DECMOTR					X	X	X	
DELCODE							X	
DHCP	X		X	X				X
DISAMT	X	X	X	X				X
DISDATE	X	X						
DISTYP	X	X						
DOB	X	X	X				X	
DX2	X							
DX3	X							
DX4	X							
DX5	X							
DX6-DX25	X[6]							
DXLSF	X		X					
DXPOA1-DXPOA25	X[6]							
EFTNO	X	X	X	X				X
ENDDTE							X	
FEBMOTR					X	X	X	
FILLDTE				X				
FMSDATE	X	X	X	X				X
FMSTNO	X	X	X	X				X
FPOV	X	X	X				X	X
FY	X	X	X	X				X
HCFATYPE		X	X					
HOMECNTY	X	X	X	X	X	X	X	
HOMEPSA	X	X	X	X				
HOMSTATE	X	X	X	X	X	X	X	
INTAMT	X	X	X	X				X

[1] Variable labels appear in Appendices A-H.
[4] Added in FY2008.
[5] Added in FY2005.
[6] Added in FY2009.

Table 6: Names and File Locations of All Fee Basis Variables (cont'd) [1]

Variable	Fee Basis File							
	INPT	ANCIL	MED	PHR	PHARVEN	VEN	VET	TVL
INTIND	X	X	X	X				X
INVDATE	X	X	X	X				
INVLNNUM	X	X	X	X				X
INVNUM	X	X	X	X				X
ISSUEDT							X	
JANMOTR					X	X	X	
JULDAY	X	X	X	X				X
JULMOTR					X	X	X	
JUNMOTR					X	X	X	
LASTPAY							X	
LINENO	X	X	X	X				X
LPAYTYP							X	
MARMOTR					X	X	X	
MAYMOTR					X	X	X	
MDCAREID	X	X						
NOVMOTR					X	X	X	
NPI	X	X	X	X	X	X		
OBNUM	X	X	X	X				X
OCTMOTR					X	X	X	
PAMT	X							
PAMTCL	X							
PARTCODE					X	X		
PATTYPE	X	X	X					
PAYCAT	X	[7]	X	X				X
PAYTYPE	X	X	X	X				X
PDRG	X							
PLSER		X	X					
POW							X	
PRESC				X				
PROCDTE	X	X	X	X				X
RELNO	X	X	X	X				X
SCRSSN	X	X	X	X			X	X
SEPMOTR					X	X	X	
SEX							X	

[1] Variable labels appear in Appendices A-H.
[7] Variable exists but all values are missing.

Table 6: Names and File Locations of All Fee Basis Variables (cont'd) [1]

Variable	Fee Basis File							
	INPT	ANCIL	MED	PHR	PHARVEN	VEN	VET	TVL
SPECCODE					X	X		
SRCEIND	X	X	X	X				X
SSNSUF	X	X	X	X			X	X
STA3N	X	X	X	X	X	X	X	X
STA6A	X	X	X	X	X	X	X	X
STANUM	X	X	X	X				X
STASUF							X	
STATE	X	X	X	X				
STRTDTE							X	
SUFNAM							X	
SURG9CD1	X							
SURG9CD2	X							
SURG9CD3	X							
SURG9CD4	X							
SURG9CD5	X							
SURG9CD6-SURG9CD25	X[8]							
SUSCODE	X	X	X					
TRANSDAT	X	X	X	X				X
TREATDT			X					
TREATDTF	X	X						
TREATDTO	X	X						
TRETYPE			X				X	
TVLAMT								X
TVLDATE								X
TYPE	X	X	X	X	X	X	X	X
VALENDY							X	
VATYPE			X					
VEN13N	X	X	X	X	X	X		X
VENDID	X	X	X	X	X	X		X
VENNAME					X	X		
VENSITEN	X	X	X	X				X
VENSUF	X	X	X		X	X		
VINVDATE	X	X	X	X				X

[1] Variable labels appear in Appendices A-H.
[8] Added in FY2009.

Table 6: Names and File Locations of All Fee Basis Variables (cont'd) [1]

Variable	Fee Basis File							
	INPT	ANCIL	MED	PHR	PHARVEN	VEN	VET	TVL
VOLUMIND	X	X	X					
VTADDR1							X	
VTADDR2							X	
VTADDR3							X	
VTCITY							X	
VTICN							X	
VZIP					X	X		
WARCODE							X	
XSEX							X	
ZIP	X	X	X	X			X	

[1] Variable labels appear in Appendices A-H.

3. Access

There are three ways to access Fee Basis data. The raw files are stored at the Austin Information Technology Center (AITC). Researchers can access the files described earlier through timeshare accounts. Information Resource Management Systems (IRMS) staff have access to the underlying VistA data files as well. Summary data are also available through the VHA Support Services Center (VSSC) web site on the VA intranet (http://klfmenu.med.va.gov).

3.1. Austin Information Technology Center (AITC)

VA users may obtain AITC timeshare accounts through their local IRMS office. The request must specify the functional task code that corresponds to Fee Basis data. The code is confidential and can be obtained through IRMS or the local Information Security Officer. Once access to AITC is obtained, the Fee Basis files can be manipulated and extracted through SAS programs.

VistA data files are organized into related sets known as "modules" or "packages." The Fee Basis package contains more than 40 files. Four will be of most interest to researchers: Fee Basis Patient (161); Fee Basis Payment (162); Fee Basis Vendor (161.2); and Fee Basis CPT RVU (162.97), which lists the relative value units assigned to outpatient procedures in a particular year. VistA files are accessed using the FileMan application. Access requires special permission from IRMS, and thus IRMS programmers often create the extracts themselves. A researcher interested in studying these files directly should request READ access to files 161 – 163.99.

3.2. Web-based access

Summary Fee Basis expenditure data are also available through the KLFMenu intranet site. Although KLFMenu is web-based application, to access it a user must have an AITC timeshare account and approval for a functional task code corresponding to national DSS data.

The following are brief instructions for locating Fee Basis data once the user has reached KLFMenu. The layout of KLFMenu is updated from time to time, and so the actual series of steps may vary from those presented here.

1) On the first screen, click on "Finance." A list of data cubes and briefing books will appear.

2) Select "Non-VA Care" to limit the selections to Fee Basis data cubes and briefing books. To access the Non-VA Care Cube requires ProClarity software to be installed on the user's PC. Briefing books and reports may be viewed without the software.

3) a. Clicking on a briefing book causes a table to appear that shows the reports and other information available. Click on the report folder to see the full list of reports. Click on an individual report to reach a new screen with options for selecting data by time, location, and other characteristics. The selected data will appear on the screen.

b. Clicking on a report will likewise cause a new table to appear. The user can select data by year, month, VISN, and other characteristics. The data selected will appear in a table on the screen.

c. Clicking on a data cube will launch the ProClarity software application. It enables the user to generate reports using the largest set of characteristics. Training on how to use ProClarity software is available online.

All of these options show payments (disbursed amounts) by VISN or station within a particular fiscal year. Some provide additional details, such as counts of unique patients or additional clinical detail. The data cubes contain only summary information. They cannot be used to obtain data on specific individuals or encounters.

The VSSC web site (KLFMenu) is updated and expanded each year. The VSSC help desk can assist users in locating data.

4. Institutional Aspects of the Fee Basis System

Using the Fee Basis data for research requires a basic understanding of laws and regulations that govern it. This section describes two elements of the program: the range of services covered and the payment rules used to determine the amount that VA will pay (DISAMT). Additional information appears in a federal regulation, 38 CFR 17.52.

4.1. Coverage

The Fee Basis program covers the full range of medical and dental care, with these exceptions:

- Elective and non-emergent surgery, except where VA facilities are not feasibly available.
- Care for dependent children, except newborns, in situations where VA pays for the mother's obstetric care during the same stay. The Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111-163) authorizes VA to provide post-delivery and routine care to a newborn child of qualifying women Veterans receiving VA maternity care for up to seven days following the birth. Prior to the passage of this law on May 1, 2010, VA did not cover the cost of health care provided to dependent children, including newborns in situations where VA pays for the mother's obstetric care during the same stay.
- Inpatient care beyond the time when a patient is stabilized and can be transferred to a VA facility, except where a VA facility is not feasibly available.
- Care provided in foreign countries other than the Philippines.
- Inpatient care, regardless of patient's health status, if VA was not notified within 72 hours of admission. This rule applies even when the patient is incapable of making a call. (Veterans may submit unauthorized claims, however, and VA has legal authority to pay them under certain conditions. See 38 USC 1725 and 1728.)
- A claim for which the Veteran had coverage by a "health plan" as defined in statute. Health plans include private health insurance, Medicare, Medicaid, and other forms of insurance that will pay for medical treatment arising from the patient's injury or illness (e.g., automobile insurance following a car accident). The generosity of the coverage is immaterial; if it covers any part of the provider's bill, then VA may not pay anything. If the Veteran has insurance, VA cannot pay even when the entire claim is less than the deductible. If a Veteran has only Medicare Part B or has both Medicare Parts A and B, no VA payment may be made. If a Veteran has only Medicare Part A then VA may consider payment for ancillary and professional services usually covered under Part B.[3]

[3] The Fee Basis program office notes: "This reference is specific to certain claims for Non-Service Connected emergency medical care under Title 38 USC 1725 which stemmed from Public Law 106-117, Section 111, Veterans Millennium Health Care and Benefits Act. The section of the Act expanded authority for VA to consider payment of certain emergency medical care claims for certain Veterans. Among the several limitations to this benefit is that the Veteran can have no other health care coverage, in whole or in part, for the episode of care claimed."

- Outpatient prescriptions beyond a 10-day supply. The prescription must be for a service-connected condition or must otherwise have specific approval.
- Prosthetic items. Federal law puts prosthetics into a special payment category that mandates full financial support from VA. As implemented in VA policy, it requires that VA facilities provide all necessary prosthetics, orthotics, and assistive devices ("prosthetics") needed by patients. VA medical centers may purchase prosthetics and related items, such as clothing specialized for prosthetic limbs, and then dispense them through VA facilities. Nevertheless, the National Fee Program Office has interpreted VHA Directive 2006-029 to preclude Fee Basis providers from receiving payment for prosthetics. The impact on inpatient and emergent care is unclear, however, as the definition of "prosthetic" in VA is so broad as to include items placed inside the body, such as internal fixation devices, coronary stents, and cardioverter defibrillators (Smith, Su and Phibbs 2010). Each year the Fee Basis program funds thousands of coronary angioplasties alone, many of which will include stents. This indicates that VA pays for prosthetics, broadly defined, in some circumstances.

4.2. Veteran status

Although VA utilization files contain many non-Veterans, Fee Basis files do not. There are nine situations in which Fee Basis care is authorized. Seven refer explicitly to Veterans alone, while the remaining two are for diagnostic services or eligibility exams, neither of which constitutes treatment. In general persons on active duty in the U.S. military are excluded even if they are transitioning to VA care. One may therefore assume that all patients receiving treatment through the Fee Basis program are Veterans.

4.3. Fee Card eligibility

The Fee ID card enables Veterans to obtain regular outpatient care outside VA. The card relieves the Veteran of the need to obtain separate permission for each visit. Eligibility is based on service connection and other factors, as follows:

(1) Veterans with less than 50% service connection, for treatment of the service-connected disability;
(2) Veterans with 50% or greater service connection, for treatment of any condition;
(3) Veterans receiving aid and attendance (A&A) or housebound status (HB) payments, for treatment of any condition;
(4) Veterans enrolled in a Vocational Rehabilitation Program, for any treatment that is considered necessary to enable the Veteran to enter, continue, or reenter training;
(5) Veterans of World War I, for treatment of any condition;
(6) When VA facilities are not feasibly accessible or medically available.

Exceptions may be made when VA will save money by doing so, or when it is medically contraindicated for the Veteran to travel to the nearest VA facility.

4.4. Payment rules

4.4.1. Elements of a Claim

A Fee Basis claim is defined by four elements:

- one Veteran
- one episode of care, which can have multiple dates within the prescribed treatment
- one provider, as identified by the Tax Identification Number (TIN), and
- one setting of care (inpatient or outpatient).

A claim may be paid directly to a provider, as reimbursement to a Veteran for out-of-pocket expenses, or as reimbursement to a third-party provider of care to the Veteran.[4]

The remainder of section 4.4 details payment rules as of early 2010. These rules are subject to change by statute or regulation. Users interested in learning the rules in force at a particular point in time should contact the Fee Basis program office. Contact information appears in Chapter 6.

4.4.2. Timeliness of claims submission

VA has established rules for timely filing of unauthorized and Millennium Bill ("Mill Bill") claims; see 29 CFR 17.120 and 38 CFR 17.1004. Four FPOV (Fee Purpose of Visit) codes can be used to identify payment for unauthorized claims. As of early 2010 there is no statutory or regulatory time limit for authorized claims.

4.4.3. Timeliness of claims payment

After a claim is submitted electronically it must be entered manually into a Fee Basis approval system. A "claims scrubber" software program is run to ensure completeness and to locate possible errors. A claim without errors or omissions is said to be "clean." If VA has authority to pay the claim and the submitted documentation is sufficient then the claim is approved for payment. VA has set a goal of processing all clean claims within 30 days. Actual processing time has varied considerably over the years. According to the Health Administration Center internet web site, the proportion of claims processed within 30 days rose from under 40% in 2007 to over 97% by the end of 2008.

4.4.4. General payment rules

For inpatient facility charges (those recorded in the INPT file), VA will pay the lesser of (a) any contract payment negotiated with the provider, (b) the Medicare payment (from the CMS PRICER software) for hospitals that participate in Medicare, or (c) a national cost-to-charge (C-T-C) ratio multiplied by the billed amount for charges that are "reasonable, usual, customary," and not in excess of what the general public is charged, for hospitals that do not participate in Medicare. Payments in Alaska are greater.

[4] Source: Fee Basis program newsletter, 7 June 2007.

For outpatient services (MED file) and for anesthesia, other physician charges, and ancillary services relating to inpatient stays (ANCIL file), VA will pay the lesser of (a) the amount billed, (b) the amount calculated using the 75th percentile methodology,[5,6] (c) the usual and customary rate (if there were fewer than eight occurrences of the code in the previous fiscal year), or (d) the contract payment negotiated with the provider. Dental services are paid according to state-specific schedules or according to contracted rates with provider networks.

Three appendices concern payments. Appendices M to O present guidelines prepared for Fee Basis staff members. Appendix M gives payment instructions for 33 different situations involving preauthorized care, including payments to "DRG Facilities" (those that participate in Medicare), payments to "DRG-Exempt" facilities, and to "facilities that have been granted a Federal waiver." The tables do not cover payments for unauthorized claims or for 38 USC 1725 ("Mill Bill") claims. Appendix N presents rules for paying physician fees and professional services, including the professional and technical aspects of certain diagnostic tests. Appendix O is a guide for paying outpatient facility charges, including dialysis services. The three appendices are current as of early 2010 but may be updated at any time.

For outpatient pharmacy charges (PHR file), VA will pay the Average Wholesale Price (AWP) listed in the annual *Drug Topics Red Book*, plus the Medicaid dispensing fee of the provider's state.[7] If medication was obtained on an emergency basis, then VA will reimburse the actual amount paid to the Veteran.

4.4.5. Travel

Many classes of Veterans are eligible for travel payments. VA will arrange for transportation for them or will reimburse expenses on the basis of vouchers submitted. Reimbursements appear in the Travel Expenses (TVL) file. There is a deductible of $3 per trip up to a limit of $18 per month. VA can waive the deductible in hardship cases. The charge for an ambulance trip to a non-VA hospital may be paid through the Fee Basis program if the medical center determines that the hospital services meet the criteria for an unauthorized claim or a 38 USC 1725 ("Mill Bill") claim, or if the patient died while in route to the facility.

4.4.6. Ambulance conveyance

Concerning payments for ambulance conveyance, this statement appeared in the minutes of the national Fee Basis call on November 12, 2009: "In accordance with Federal regulation payment for ambulance services may be made under Mill Bill for transporting a Veteran to a facility only if VA payment is authorized for the emergency treatment provided at the facility, or payment

[5] "Payment under the 75th percentile methodology is determined for each VA medical center by ranking all occurrences (with a minimum of eight) under the corresponding code during the previous fiscal year with charges ranked from the highest rate billed to the lowest rate billed and the charge falling at the 75th percentile as the maximum amount to be paid" (38 CFR §17.56(c)).

[6] In Alaska, the 75th percentile methodology has been supplanted by special rules as of October, 2004. See *Federal Register* vol. 70 no. 23, pp. 5926-5927 (Feb. 4, 2005). These rules may be changed over time.

[7] If a branded medication is prescribed in a non-emergent situation, VA will reimburse only the cost of a generic equivalent, when one exists.

could have been authorized if death had not occurred before emergency treatment could be provided, and the Veteran is financially liable to the provider of emergency transportation, and he or she has no other health insurance or third party liability for payment, in whole or in part, for the emergency transportation."

4.4.7. Coordination with other payers

If a claim is filed for an eligible episode of care, VA must pay the whole amount according to the payment rules noted above. VA will not pay merely a deductible, copayment, or COB (coordination of benefits) amount. If eligible care was already partly paid by the patient or his/her representative then VA will reimburse for charges it was willing to pay.[8]

VA payment constitutes payment in full. Providers cannot bill both VA and the patient or another insurer for the same encounter. If, however, VA is authorized to pay for only certain days in an inpatient stay, then the provider may bill the patient for the remaining days. Providers are not required to accept VA payment in all cases. If the provider declines VA payment then it may be able to charge the patient a greater total amount.

When possible VA will seek reimbursement for Fee Basis payments from sources such as workers compensation payments; payments resulting from motor vehicle accidents, crimes of personal violence, or torts; other agencies when the patient is a beneficiary; and third-party insurance plans.

The Veterans' Emergency Care Fairness Act (Public Law 111-137), signed February 1, 2010, authorizes VA as a secondary payer to third party liability insurance not related to health insurance. The Act amends 38 U.S.C. 1725 (the "Mill Bill") by enabling VA to pay for or reimburse Veterans enrolled in VA health care for the remaining cost of emergency care if the liability insurance only covered part of the cost. Previously, VA could reimburse Veterans or pay non-VA hospitals directly only if a Veteran has no other health insurance. VA may reconsider and provide retroactive reimbursements for emergency treatment that was provided prior to the date of enactment (July 19, 2001), if documentation sufficiently demonstrates the original denial was because the Veteran received partial third party payment. The payment will equal the VA allowable amount for emergency care (had insurance not been a factor) less the amount paid by the motor vehicle insurance for personal injury.[9]

[8] See Fee Handbook 1999, page 4-3.
[9] Source: VHA CBO Database Answers, 18 August 2010.

Notes and Recommendations

- Some Fee Basis claims are rejected for untimeliness or lack of statutory authority. For these reasons, the program does not pay for 100% of care that was otherwise eligible.

- Invoices for most encounters are paid within six months of the encounter date, but VA has authority to pay invoices that are submitted much later. In a few cases invoices are paid even two years or more after the encounter. We therefore recommend searching across three years of Fee Basis records to find nearly all costs for a particular fiscal year.[10]

- Check for missing and outlier values. One method for replacing a missing or anomalous value is to use the average value of payments for the same CPT in the same year, if possible to the same vendor.

[10] HERC is developing a dataset that will roll all inpatient claims for a stay into a single record similar to a discharge record.

5. Recommendations for Analyzing Fee Basis Data

5.1. Finding records

Individual patients can be located through the scrambled social security number (SCRSSN). Vendors each have a unique vendor ID (VENDID) that appears in the four Fee Basis utilization files. In the two vendor files (PHARVEN for pharmacy vendors, VEN for all others) there is additional information on the vendor.

Care provided to persons associated with a particular VA station can be found by selecting records by STA3N. It would seem logical to use the vendor's location, found in the vendor files PHARVEN and VEN, to associate care with a particular station, but this should be approached with caution. Some vendors use centralized billing services located in other cities, in a few cases in other states. Thus the mailing address of the vendor is not always the vendor's actual location.

Several variables are available for locating care in particular settings. These include place of Fee purpose of visit (FPOV), place of service (PLSER), type of treatment (TRETYPE), HCFA payment type (HCFAFMT), and record type (TYPE). Not all of these variables appear in every utilization file. Because coding varies by station, users are encouraged to employ multiple variables in an effort to find all care associated with a particular setting or service type.

If the patient was transported to a VA hospital after stabilization, the record of the VA stay should appear in VA utilization databases. If it cannot be located in the PTF Main file or DSS NDE for inpatient care, search other inpatient files. If it still cannot be found, then the stay may have ended on the day the person stabilized.

5.2. Creating discharge records from invoice records

As noted earlier, Fee Basis records represent individual outpatient procedures (MED and ANCIL files) or monthly inpatient or residential segments (INPT). Thus to determine all care associated with a single encounter may require the user to roll up multiple claims.

To create a single record for an inpatient stay, concatenate adjacent INPT records using patient ID (SCRSSN or SSN), vendor ID (VENDID), and treatment dates (TREATDTF, TREATDTO). VENDID is required because patients may be transferred directly from one facility to another. The total cost of inpatient stays includes the costs from INPT and ANCIL records.

Define length of stay (LOS) as *[max(1, max(stopdt)-min(startdt))]*. This yields very high concordance with LOS figures in the PTF Non-VA Hospitalization (NVH) file.

To find all records associated with an outpatient encounter, search by patient ID (SCRSSN or SSN), vendor ID (VENDID), and treatment date (TREATDT).

Inpatient pharmacy will be included in the inpatient records of the INPT file. The limited outpatient pharmacy provided through the Fee Basis program cannot be sorted by fill date or tied to individual patients. An exception will be injectible medications dispensed in a health care facility such as a doctor's office, dialysis clinic, or hospital outpatient clinic. These injections are recorded as outpatient procedures using HCPCS codes known as "J codes" because the first character of the code is the letter "J". HERC staff have found that coding of injectible medications is uneven in VA utilization databases such as OPC or the DSS NDE for outpatient care. The J code is sometimes specific to the medication, while at other times a non-specific J code is used. An analyst searching for use of injectible medications may need to rely on multiple J codes to find them.

5.3. Apparent data anomalies

When figuring inpatient length of stay (LOS), look for a spike in values of 364 or 365 days. These values may reflect cases in which someone was an inpatient for the entire year as part of a stay that began earlier or lasted longer.

There may be multiple vendor IDs (VENDIDs) for a single stay. This could indicate a transfer between facilities or a physician bill for an inpatient stay. Note that some physicians use the same ID number as the hospital.

There may be multiple STA3Ns for a single stay. This rare event most likely indicates a transfer.

In a review of data from the early 2000s HERC staff found that under 1.0% of records has a TREATDTO date more than two years prior to start of the fiscal year in which the claim appeared. These unusual invoices may reflect claims that were submitted very late, claims that were initially denied and then appealed, or possibly errors in data entry.

5.4. Facility charges vs. ancillary charges

There are instances when there may be claims for facility charges with no corresponding provider charge in the ancillary (ANIP) file. Here we present an example provided by the VHA CBO Database.[11]

- Services provided at a hospital anticoagulation clinic are billable for facility charges only unless the anticoagulation is considered 'incident to' physician services and certain other conditions are met (ASHP 2010).

[11] Source: VHA CBO Database, 13 August 2010.

6. Resources

6.1. Contacts for the Fee Basis program

The Fee Basis program has been managed by the VA Health Administration Center (HAC) in Denver, Colorado, since FY2003. Funding and authorization decisions remain at the local (station) level. Key informants include the following:

- The Chief Business Office (CBO) Question and Answer database, for questions about program rules. The URL of this intranet site is available from HERC on request.
- Judy Sine (judy.sine@va.gov) at the Austin Automation Center for questions about Fee Basis files

6.2. Fee Basis program web site

HAC maintains two web sites on the Fee Basis program. For an internet web site with general information and Frequently Asked Questions for Veterans and providers, visit http://www4.va.gov/hac/hacmain.asp and click on the "Non-VA Care" tab. A website on the VHA intranet offers detailed information for VA researchers, VistA users, and managers. Among its current features are the following:

- Minutes of the national Fee monthly conference calls
- Maximum payment rates by station for rural hospice treatment and home health care
- National repricing agreements, contracts available to all stations
- A fact sheet and Frequently Asked Questions (FAQs) on beneficiary travel
- The PPS Exempt Percentage file, which lists the cost-to-charge ratios and VA surcharge rate used for calculating certain inpatient payments

The intranet web site also provides a series of downloadable Procedure Guides. They explain approval, processing, and coding methods for a variety of financial and clinical situations. Table 7 below shows the list of Procedure Guide titles pertaining to clinical care topics as of late January, 2010. The list of Guides may change over time.

Table 7: Selected Procedure Guides on the Fee Basis Intranet Site (January, 2010)

Adult Day Health Care
Adverse Credit Reporting Resolution
Ambulance Procedure Guide
Bowel and Bladder procedure Guide
Emergency non-VA Care for Service-connected Veterans (38 U.S.C. § 1728)
Emergency non-VA Care for Non-Service Connected Conditions (38 U.S.C. § 1725)
Fee Record Maintenance and Disposition PG
Home Health Care
Negotiated Agreements for Non-VA Preauthorized Health Care Services
Payment for Outpatient Laboratory Services
Payment of Non-VA Outpatient Facility Charges
Payment of Physician and Non-Physician Professional Fees
Per Diem Reimbursement Rates for Partial Hospitalization Under Prospective Payment System
PPS Exempt Procedure Guide
Procedure Guide Acute IPPS Reimbursement

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Appendices

Appendix A. Contents of FY2009 Inpatient (INPT) File

Physical Name: MDPPRD.MDP.SAS.FEN.FY09.INPT

Variables in Creation Order

#	Variable	Type	Len	Format	Label	Percent Missing
1	SCRSSN	Num	7		SCRAMBLED SSN	0%
2	ZIP	Num	7		ZIP CODE	0%
3	STA6A	Char	6		STATION NUMBER	0%
4	STA3N	Num	4	STA3NL.	PARENT STATION	0%
5	HOMECNTY	Num	5	COUNTYL.	PATIENT COUNTY CODE	0%
6	HOMSTATE	Num	3		STATE CODE (NUMERIC)	0%
7	DXLSF	Char	6		ADMITTING OR PRIMARY DIAG CD	100%
8	DX1	Char	6		1ST DIAG CODE (NO DECIMAL)	46.98%
9	DX2	Char	6		2ND DIAG CODE (NO DECIMAL)	48.24%
10	DX3	Char	6		3RD DIAG CODE (NO DECIMAL)	49.63%
11	DX4	Char	6		4TH DIAG CODE (NO DECIMAL)	51.78%
12	DX5	Char	6		5TH DIAG CODE (NO DECIMAL)	54.70%
13	DX6	Char	6		6TH DIAG CODE (NO DECIMAL)	100%
14	DX7	Char	6		7TH DIAG CODE (NO DECIMAL)	100%
15	DX8	Char	6		8TH DIAG CODE (NO DECIMAL)	100%
16	DX9	Char	6		9TH DIAG CODE (NO DECIMAL)	100%
17	DX10	Char	6		10TH DIAG CODE (NO DECIMAL)	100%
18	DX11	Char	6		11TH DIAG CODE (NO DECIMAL)	100%
19	DX12	Char	6		12TH DIAG CODE (NO DECIMAL)	100%
20	DX13	Char	6		13TH DIAG CODE (NO DECIMAL)	100%
21	DX14	Char	6		14TH DIAG CODE (NO DECIMAL)	100%
22	DX15	Char	6		15TH DIAG CODE (NO DECIMAL)	100%
23	DX16	Char	6		16TH DIAG CODE (NO DECIMAL)	100%
24	DX17	Char	6		17TH DIAG CODE (NO DECIMAL)	100%
25	DX18	Char	6		18TH DIAG CODE (NO DECIMAL)	100%
26	DX19	Char	6		19TH DIAG CODE (NO DECIMAL)	100%
27	DX20	Char	6		20TH DIAG CODE (NO DECIMAL)	100%
28	DX21	Char	6		21ST DIAG CODE (NO DECIMAL)	100%
29	DX22	Char	6		22ND DIAG CODE (NO DECIMAL)	100%
30	DX23	Char	6		23RD DIAG CODE (NO DECIMAL)	100%

Appendix A. Contents of FY2009 Inpatient (INPT) File (cont'd)

#	Variable	Type	Len	Format	Label	Percent Missing
31	DX24	Char	6		24TH DIAG CODE (NO DECIMAL)	100%
32	DX25	Char	6		25TH DIAG CODE (NO DECIMAL)	100%
33	SURG9CD1	Char	6		1ST SURG CODE (NO DECIMAL)	69.54%
34	SURG9CD2	Char	6		2ND SURG CODE (NO DECIMAL)	79.55%
35	SURG9CD3	Char	6		3RD SURG CODE (NO DECIMAL)	85.62%
36	SURG9CD4	Char	6		4TH SURG CODE (NO DECIMAL)	90.37%
37	SURG9CD5	Char	6		5TH SURG CODE (NO DECIMAL)	92.96%
38	SURG9CD6	Char	6		6TH SURG CODE (NO DECIMAL)	100%
39	SURG9CD7	Char	6		7TH SURG CODE (NO DECIMAL)	100%
40	SURG9CD8	Char	6		8TH SURG CODE (NO DECIMAL)	100%
41	SURG9CD9	Char	6		9TH SURG CODE (NO DECIMAL)	100%
42	SURG9CD10	Char	6		10TH SURG CODE (NO DECIMAL)	100%
43	SURG9CD11	Char	6		11TH SURG CODE (NO DECIMAL)	100%
44	SURG9CD12	Char	6		12TH SURG CODE (NO DECIMAL)	100%
45	SURG9CD13	Char	6		13TH SURG CODE (NO DECIMAL)	100%
46	SURG9CD14	Char	6		14TH SURG CODE (NO DECIMAL)	100%
47	SURG9CD15	Char	6		15TH SURG CODE (NO DECIMAL)	100%
48	SURG9CD16	Char	6		16TH SURG CODE (NO DECIMAL)	100%
49	SURG9CD17	Char	6		17TH SURG CODE (NO DECIMAL)	100%
50	SURG9CD18	Char	6		18TH SURG CODE (NO DECIMAL)	100%
51	SURG9CD19	Char	6		19TH SURG CODE (NO DECIMAL)	100%
52	SURG9CD20	Char	6		20TH SURG CODE (NO DECIMAL)	100%
53	SURG9CD21	Char	6		21ST SURG CODE (NO DECIMAL)	100%
54	SURG9CD22	Char	6		22ND SURG CODE (NO DECIMAL)	100%
55	SURG9CD23	Char	6		23RD SURG CODE (NO DECIMAL)	100%
56	SURG9CD24	Char	6		24TH SURG CODE (NO DECIMAL)	100%
57	SURG9CD25	Char	6		25TH SURG CODE (NO DECIMAL)	100%
58	TYPE	Char	1	$TYPEFMT.	RECORD TYPE CODE	0%
59	STANUM	Char	6		STATION NUMBER	0%
60	INVNUM	Char	9		INVOICE NUMBER	0%
61	SSNSUF	Char	1		SSN SUFFIX (LAST POSITION)	100%
62	PAYTYPE	Char	1	$PAYTFMT.	PAYMENT TYPE	0%
63	VEN13N	Char	13		VENDOR ID WITH SUFFIX	0.04%
64	VENDID	Char	9		VENDOR ID BASE	0.04%

Appendix A. Contents of FY2009 Inpatient (INPT) File (cont'd)

#	Variable	Type	Len	Format	Label	Percent Missing
65	VENSUF	Char	4		VENDOR ID SUFFIX (CHAIN STORE #)	67.83%
66	AMOUNT	Num	8		PAYMENT AMOUNT	0%
67	FPOV	Char	2	$POVFMT.	FEE PURPOSE OF VISIT CODE	0%
68	PATTYPE	Char	2	$PATTFMT.	PATIENT TYPE CODE	0%
69	TREATDTF	Char	8	TREATMENT	DATE FROM	0%
70	TREATDTO	Char	8		TREATMENT DATE TO	0%
71	PROCDTE	Char	8		PROCESSING DATE	0%
72	INVDATE	Char	8		DATE INVOICE RECEIVED	0%
73	MDCAREID	Char	6		MEDICARE PROVIDER ID	36.73%
74	STATE	Char	2		STATE CODE (ALPHA)	0.06%
75	CNTY	Num	8		COUNTY CODE (NUMERIC)	0.06%
76	HOMEPSA	Num	8		PRIMARY SERVICE AREA	0%
77	SUSCODE	Char	1	$SUSFMT.	SUSPENSE CODE	48.06%
78	CPT1	Char	5		CPT CODE	100%
79	DXPOA1	Char	1		PRESENT ON ADMISSION DG 1	100%
80	DXPOA2	Char	1		PRESENT ON ADMISSION DG 2	100%
81	DXPOA3	Char	1		PRESENT ON ADMISSION DG 3	100%
82	DXPOA4	Char	1		PRESENT ON ADMISSION DG 4	100%
83	DXPOA5	Char	1		PRESENT ON ADMISSION DG 5	100%
84	DXPOA6	Char	1		PRESENT ON ADMISSION DG 6	100%
85	DXPOA7	Char	1		PRESENT ON ADMISSION DG 7	100%
86	DXPOA8	Char	1		PRESENT ON ADMISSION DG 8	100%
87	DXPOA9	Char	1		PRESENT ON ADMISSION DG 9	100%
88	DXPOA10	Char	1		PRESENT ON ADMISSION DG 10	100%
89	DXPOA11	Char	1		PRESENT ON ADMISSION DG 11	100%
90	DXPOA12	Char	1		PRESENT ON ADMISSION DG 12	100%
91	DXPOA13	Char	1		PRESENT ON ADMISSION DG 13	100%
92	DXPOA14	Char	1		PRESENT ON ADMISSION DG 14	100%
93	DXPOA15	Char	1		PRESENT ON ADMISSION DG 15	100%
94	DXPOA16	Char	1		PRESENT ON ADMISSION DG 16	100%
95	DXPOA17	Char	1		PRESENT ON ADMISSION DG 17	100%
96	DXPOA18	Char	1		PRESENT ON ADMISSION DG 18	100%
97	DXPOA19	Char	1		PRESENT ON ADMISSION DG 19	100%
98	DXPOA20	Char	1		PRESENT ON ADMISSION DG 20	100%

Appendix A. Contents of FY2009 Inpatient (INPT) File (cont'd)

#	Variable	Type	Len	Format	Label	Percent Missing
99	DXPOA21	Char	1		PRESENT ON ADMISSION DG 21	100%
100	DXPOA22	Char	1		PRESENT ON ADMISSION DG 22	100%
101	DXPOA23	Char	1		PRESENT ON ADMISSION DG 23	100%
102	DXPOA24	Char	1		PRESENT ON ADMISSION DG 24	100%
103	DXPOA25	Char	1		PRESENT ON ADMISSION DG 25	100%
104	CLMDATE	Char	8		DATE RELEASED TO CALM	0%
105	INTIND	Char	1	$INTFMT.	INTEREST INDICATOR	0%
106	PAMTCL	Num	8		AMOUNT CLAIMED	0%
107	PAMT	Num	8		PRICER AMOUNT	0%
108	PDRG	Char	4		PRICER DRG	51.06%
109	VINVDATE	Char	8		VENDOR INVOICE DATE	0%
110	ADMDATE	Char	8		DATE OF ADMISSION	0%
111	DISDATE	Char	8		DATE OF DISCHARGE	36.87%
112	DOB	Char	8		DATE OF BIRTH	0%
113	DISTYP	Char	3	$DISPTYP.	DISPOSITION TYPE	0%
114	VOLUMIND	Char	5		VOLUME INDICATOR	0%
115	AUTHFLG	Char	1	$AUTHFLG.	AUTHORIZATION FLAG	0%
116	ADJCD1	Char	5	$ADJRSN.	ADJUSTMENT REASON CODE 1	48.06%
117	ADJAMT1	Num	8		ADJUSTMENT AMOUNT 1	0%
118	NPI	Char	10		NATIONAL PROVIDER ID	73.35%
119	PTACTNUM	Char	20		PATIENT ACCOUNT NNUMBER	100%
120	EDICLMID	Char	1		EDI CLAIM IDENTIFIER	100%
121	CNTRCTNM	Char	20		CONTRACT NUMBER	100%
122	ACCPTDTE	Char	5		DATE ACCEPTED AT CENTRAL FEE	0.14%
123	SRCEIND	Char	1		SOURCE (F)MS OR (P)URCH CARD	0.46%
124	FMSDATE	Char	5		DATE SENT TO FMS (JULDATE	0.46%
125	RELNO	Char	4		RELEASE PREFIX NUMBER	0%
126	JULDAY	Char	3		JULIAN DAY NUMBER	0%
127	PAYCAT	Char	1	$PAYCAT.	PAYMENT CATEGORY	0%
128	ACTCODE	Char	1	$ACTCODE.	FMS ACTIVITY CODE	0.14%
129	DISAMT	Num	8		FMS DISBURSED AMOUNT	0.14%
130	INTAMT	Num	8		FMS INTEREST AMOUNT	0.14%
131	EFTNO	Char	8		FMS CHECK/EFT NUMBER	0.14%
132	CHKDAT	Char	8		FMS CHECK DATE	0.14%
133	CANDAT	Char	8		FMS CHECK CANCEL DATE	99.84%

Appendix A. Contents of FY2009 Inpatient (INPT) File (cont'd)

#	Variable	Type	Len	Format	Label	Percent Missing
134	CANCODE	Char	1	$CANCODE.	FMS CHECK CANCEL CODE	99.84%
135	CANRSN	Char	1	$CANRSN.	FMS CHK CANCEL REASON	99.84%
136	OBNUM	Char	6		OBLIGATION NUMBER	0%
137	DHCP	Char	23		DHCP INTERNAL CTL NO.	0.44%
138	FMSTNO	Char	11		FMS TRANSACTION NO.	0%
139	LINENO	Char	3		FMS TRANS LINE NUMBER	0%
140	TRANSDAT	Char	8		FMS TRANSACTION DATE	0.14%
141	FY	Char	4		FISCAL YEAR (CCYY)	0%
142	BATCHNUM	Char	5		BATCH NUMBER	0%

Appendix B. Contents of FY2009 Inpatient Ancillary (ANCIL) File

Physical Name: MDPPRD.MDP.SAS.FEN.FY09.INPT.ANCIL

Variables in Creation Order

#	Variable	Type	Len	Format	Label	Percent Missing
1	SCRSSN	Num	7		SCRAMBLED SSN	0%
2	ZIP	Num	7		ZIP CODE	0%
3	STA6A	Char	6		STATION NUMBER	0%
4	STA3N	Num	4	STA3NL.	PARENT STATION	0%
5	HOMECNTY	Num	5	COUNTYL.	PATIENT COUNTY CODE	0%
6	HOMSTATE	Num	3		STATE CODE (NUMERIC)	0%
7	DXLSF	Char	6		ADMITTING OR PRIMARY DIAG CD	100%
8	TYPE	Char	1	$TYPEFMT.	RECORD TYPE CODE	0%
9	STANUM	Char	6		STATION NUMBER	0%
10	INVNUM	Char	9		INVOICE NUMBER	0%
11	SSNSUF	Char	1		SSN SUFFIX (LAST POSITION)	100%
12	PAYTYPE	Char	1	$PAYTFMT.	PAYMENT TYPE	0%
13	VEN13N	Char	13		VENDOR ID WITH SUFFIX	0.02%
14	VENDID	Char	9		VENDOR ID BASE	0.02%
15	VENSUF	Char	4		VENDOR ID SUFFIX (CHAIN STORE #)	66.54%
16	AMOUNT	Num	8		PAYMENT AMOUNT	0%
17	FPOV	Char	2	$POVFMT.	FEE PURPOSE OF VISIT CODE	0%
18	PATTYPE	Char	2	$PATTFMT.	PATIENT TYPE CODE	0%
19	TREATDTF	Char	8		TREATMENT DATE FROM	0%
20	TREATDTO	Char	8		TREATMENT DATE TO	0%
21	PROCDTE	Char	8		PROCESSING DATE	0%
22	INVDATE	Char	8		DATE INVOICE RECEIVED	0%
23	MDCAREID	Char	6		MEDICARE PROVIDER ID	100%
24	STATE	Char	2		STATE CODE (ALPHA)	0%
25	CNTY	Num	8		COUNTY CODE (NUMERIC)	0%
26	HOMEPSA	Num	8		PRIMARY SERVICE AREA	0%
27	SUSCODE	Char	1	$SUSFMT.	SUSPENSE CODE	10.23%
28	CPT1	Char	5		CPT CODE	0%
29	CLMDATE	Char	8		DATE RELEASED TO CALM	0%
30	INTIND	Char	1	$INTFMT.	INTEREST INDICATOR	0%
31	VINVDATE	Char	8		VENDOR INVOICE DATE	0%

Appendix B. Contents of FY2009 Inpatient Ancillary (ANCIL) File (cont'd)

#	Variable	Type	Len	Format	Label	Percent Missing
32	ADMDATE	Char	8		DATE OF ADMISSION	42.83%
33	DISDATE	Char	8		DATE OF DISCHARGE	100%
34	DOB	Char	8		DATE OF BIRTH	0%
35	DISTYP	Char	3	$DISPTYP.	DISPOSITION TYPE	100%
36	VOLUMIND	Char	5		VOLUME INDICATOR	0%
37	AUTHFLG	Char	1	$AUTHFLG.	AUTHORIZATION FLAG	0%
38	ADJCD1	Char	5	$ADJRSN.	ADJUSTMENT REASON CODE 1	10.24%
39	ADJAMT1	Num	8		ADJUSTMENT AMOUNT 1	0%
40	NPI	Char	10		NATIONAL PROVIDER ID	70.64%
41	PTACTNUM	Char	20		PATIENT ACCOUNT NNUMBER	100%
42	EDICLMID	Char	1		EDI CLAIM IDENTIFIER	100%
43	CNTRCTNM	Char	20		CONTRACT NUMBER	100%
44	ACCPTDTE	Char	5		DATE ACCEPTED AT CENTRAL FEE	0%
45	SRCEIND	Char	1		SOURCE (F)MS OR (P)URCH CARD	0.39%
46	FMSDATE	Char	5		DATE SENT TO FMS (JULDATE)	0.39%
47	RELNO	Char	4		RELEASE PREFIX NUMBER	0%
48	JULDAY	Char	3		JULIAN DAY NUMBER	0%
49	PAYCAT	Char	1	$PAYCAT.	PAYMENT CATEGORY	0%
50	ACTCODE	Char	1	$ACTCODE.	FMS ACTIVITY CODE	0%
51	DISAMT	Num	8		FMS DISBURSED AMOUNT	0%
52	INTAMT	Num	8		FMS INTEREST AMOUNT	0%
53	EFTNO	Char	8		FMS CHECK/EFT NUMBER	0%
54	CHKDAT	Char	8		FMS CHECK DATE	0%
55	CANDAT	Char	8		FMS CHECK CANCEL DATE	99.66%
56	CANCODE	Char	1	$CANCODE.	FMS CHECK CANCEL CODE	99.66%
57	CANRSN	Char	1	$CANRSN.	FMS CHK CANCEL REASON	99.66%
58	OBNUM	Char	6		OBLIGATION NUMBER	0%
59	FMSTNO	Char	11		FMS TRANSACTION NO.	0%
60	LINENO	Char	3		FMS TRANS LINE NUMBER	0%
61	TRANSDAT	Char	8		FMS TRANSACTION DATE	0%
62	FY	Char	4		FISCAL YEAR (CCYY)	0%
63	BATCHNUM	Char	5		BATCH NUMBER	0%
64	PLSER	Char	2	$PLSFMT.	PLACE OF SERVICE	0%
65	HCFATYPE	Char	2	$HCFFMT.	HCFA TYPE OF SERVICE	16.77%

Appendix B. Contents of FY2009 Inpatient Ancillary (ANCIL) File (cont'd)

#	Variable	Type	Len	Format	Label	Percent Missing
66	ADJCD2	Char	5	$ADJRSN.	ADJUSTMENT REASON CODE 2	100%
67	ADJAMT2	Num	8		ADJUSTMENT AMOUNT 2	0%
68	CPTMD1	Char	5		CPT MODIFIER 1	100%
69	CPTMD2	Char	5		CPT MODIFIER 2	100%
70	CPTMD3	Char	5		CPT MODIFIER 3	100%
71	CPTMD4	Char	5		CPT MODIFIER 4	100%
72	ADHCP	Char	30		DHCP INTERNAL CTL NO.	0.73%

Appendix C. Contents of FY2009 Outpatient (MED) File

Physical Name: MDPPRD.MDP.SAS.FEN.FY09.MED

Variables in Creation Order

#	Variable	Type	Len	Format	Label	Percent Missing
1	SCRSSN	Num	7	SSN.	SCRAMBLED SSN	0%
2	STA6A	Char	6		STATION NUMBER	0%
3	STA3N	Num	4	STA3NL.	PARENT STATION	0%
4	ZIP	Num	7		ZIP CODE	0%
5	HOMECNTY	Num	6	COUNTYL.	PATIENT COUNTY CODE	0%
6	HOMSTATE	Num	3		STATE CODE (NUMERIC)	0%
7	DXLSF	Char	6		1ST DIAG CODE (NO DECIMAL)	7.03%
8	TYPE	Char	1	$TYPEFMT.	RECORD TYPE CODE	0%
9	STANUM	Char	6		STATION NUMBER	0%
10	INVNUM	Char	9		INVOICE NUMBER	0%
11	INVLNNUM	Char	2		INVOICE LINE NO.	0%
12	SSNSUF	Char	1		SSN SUFFIX (LAST POSITION)	100%
13	PAYTYPE	Char	1	$PAYTFMT.	PAYMENT TYPE	0%
14	VEN13N	Char	30		VENDOR ID WITH SUFFIX	0.04%
15	VENDID	Char	9		VENDOR ID BASE	0.04%
16	VENSUF	Char	4		VENDOR ID SUFFIX (CHAIN STORE #)	70.34%
17	VENSITEN	Char	15		VENDOR SITE NAME	100%
18	AMOUNT	Num	8	8.2	PAYMENT AMOUNT	0%
19	FPOV	Char	2	$POVFMT.	FEE PURPOSE OF VISIT CODE	0%
20	PATTYPE	Char	2	$PATTFMT.	PATIENT TYPE CODE	0%
21	TREATDT	Char	8		TREATMENT DATE(SASDATE)	0%
22	PROCDTE	Char	8		PROCESSING DATE(SASDATE)	0%
23	TRETYPE	Char	1	$TTYPFMT.	TYPE OF TREATMENT CODE	0%
24	INVDATE	Char	8		DATE INVOICE RECEIVED(SASDATE)	0%
25	STATE	Char	2		STATE CODE (ALPHA)	0%
26	CNTY	Num	8		COUNTY CODE (NUMERIC)	0%
27	HOMEPSA	Num	8		PRIMARY SERVICE AREA	0%
28	CPT1	Char	5		CPT CODE	0%
29	SUSCODE	Char	2	$SUSFMT.	SUSPENSE CODE	50.62%
30	PLSER	Char	2	$PLSFMT.	PLACE OF SERVICE	0.01%
31	HCFATYPE	Char	2	$HCFFMT.	HCFA TYPE OF SERVICE	15.66%
32	VATYPE	Char	2		VA TYPE OF SERVICE	100%
33	CLMDATE	Char	8		DATE RELEASED TO CALM(SASDATE)	0.03%

Appendix C. Contents of FY2009 Outpatient (MED) File (cont'd)

#	Variable	Type	Len	Format	Label	Percent Missing
34	INTIND	Char	1	$INTFMT.	INTEREST INDICATOR	0%
35	VINVDATE	Char	8		VENDOR INVOICE DATE	0%
36	ADMDATE	Char	8		DATE OF ADMISSION	100%
37	DOB	Char	8		DATE OF BIRTH	0%
38	VOLUMIND	Char	5		VOLUME INDICATOR	0%
39	AUTHFLG	Char	1	$AUTHFLG.	AUTHORIZATION FLAG	0%
40	CPTMD1	Char	5	$CPTMOD.	CPT MOD1	87.39%
41	CPTMD2	Char	5	$CPTMOD.	CPT MOD2	98.97%
42	CPTMD3	Char	5	$CPTMOD.	CPT MOD3	99.94%
43	CPTMD4	Char	5	$CPTMOD.	CPT MOD4	100%
44	ADJCD1	Char	5	$ADJRSN.	ADJUSTMENT REASON CODE 1	50.62%
45	ADJCD2	Char	5	$ADJRSN.	ADJUSTMENT REASON CODE 2	99.90%
46	ADJAMT1	Num	8		ADJUSTMENT AMOUNT 1	0%
47	ADJAMT2	Num	8		ADJUSTMENT AMOUNT 2	0%
48	NPI	Char	10		NATIONAL PROVIDER ID	72.71%
49	ACCPTDTE	Char	5		DATE ACCEPTED AT CENTRAL FEE (JULDATE)	0.05%
50	SRCEIND	Char	1		SOURCE (F)MS OR (P)URCH CARD	0.48%
51	FMSDATE	Char	5		DATE SENT TO FMS (JULDATE)	0.48%
52	RELNO	Char	4		RELEASE PREFIX NUMBER	0.03%
53	JULDAY	Char	3		JULIAN DAY NUMBER	0.03%
54	PAYCAT	Char	1	$PAYCAT.	PAYMENT CATEGORY	0.03%
55	ACTCODE	Char	1	$ACTCODE.	FMS ACTIVITY CODE	0.05%
56	DISAMT	Num	8		FMS DISBURSED AMOUNT	0%
57	INTAMT	Num	8		FMS INTEREST AMOUNT	0%
58	EFTNO	Char	15		FMS CHECK/EFT NUMBER	0.05%
59	CHKDAT	Char	8		FMS CHECK DATE	0.05%
60	CANDAT	Char	8		FMS CHECK CANCEL DATE	99.81%
61	CANCODE	Char	1	$CANCODE.	FMS CHECK CANCEL CODE	99.81%
62	CANRSN	Char	2	$CANRSN.	FMS CHK CANCEL REASON	99.81%
63	OBNUM	Char	100		OBLIGATION NUMBER	0%
64	DHCP	Char	30		DHCP INTERNAL CTL NO.	0.22%
65	FMSTNO	Char	11		FMS TRANSACTION NO.	0.03%
66	LINENO	Char	3		FMS TRANS LINE NUMBER	0.03%
67	TRANSDAT	Char	8		FMS TRANSACTION DATE	0.05%
68	FY	Char	4		FISCAL YEAR (CCYY)	0%

Appendix D. Contents of FY2009 Pharmacy Payments (PHR) File

Physical Name: MDPPRD.MDP.SAS.FEN.FY09.PHR

Variables in Creation Order

#	Variable	Type	Len	Format	Label	Percent Missing
1	STA6A	Char	6		ADMITTING STATION	0%
2	STA3N	Num	4	STA3NL.	PARENT STATION	0%
3	HOMECNTY	Num	5	COUNTYL.		0%
4	HOMSTATE	Num	3			0%
5	SCRSSN	Num	7		SCRAMBLED SSN	0%
6	ZIP	Num	7		ZIP CODE	0%
7	TYPE	Char	1	$TYPEFMT.	RECORD TYPE CODE	0%
8	STANUM	Char	6			0%
9	INVNUM	Char	9		INVOICE NUMBER	0%
10	INVLNNUM	Char	2			0%
11	SSNSUF	Char	1			100%
12	PAYTYPE	Char	1	$PAYTFMT.		0%
13	VEN13N	Char	30		VENDOR ID WITH SUFFIX	49.81%
14	VENDID	Char	9			49.81%
15	CHAINNUM	Char	4			49.81%
16	VENSITEN	Char	15			100%
17	AMOUNT	Num	8		PAYMENT AMOUNT	0%
18	FILLDTE	Char	8		DATE PRESCRIPTION FILLED (SASDATE)	0%
19	PROCDTE	Char	8		PROCESSING DATE(SASDATE)	0%
20	PRESC	Char	8		PRESCRIPTION NUMBER	0%
21	INVDATE	Char	8		DATE INVOICE RECEIVED(SASDATE)	0%
22	STATE	Char	2			0%
23	CNTY	Num	8			0%
24	HOMEPSA	Num	8		PRIMARY SERVICE AREA	0%
25	AMTCLMD	Num	8		PAYMENT AMOUNT CLAIMED	0%
26	CLMDATE	Char	8		DATE RELEASED TO CALM(SASDATE)	0%
27	INTIND	Char	1	$INTFMT.	INTEREST INDICATOR	0%
28	VINVDATE	Char	8		VENDOR INVOICE DATE	0%
29	ADJCD1	Char	5	$ADJRSN.		92.96%
30	ADJCD2	Char	5	$ADJRSN.		100%
31	ADJAM1	Num	8			0%
32	ADJAM2	Num	8			0%

Appendix D. Contents of FY2009 Pharmacy Payments (PHR) File (cont'd)

#	Variable	Type	Len	Format	Label	Percent Missing
33	NPI	Char	10		NATIONAL PROVIDER ID	92.36%
34	ACCPTDTE	Char	5			0%
35	SRCEIND	Char	1			0.37%
36	FMSDATE	Char	5			0.37%
37	RELNO	Char	4		RELEASE PREFIX NUMBER	0%
38	JULDAY	Char	3		JULIAN DAY NUMBER	0%
39	PAYCAT	Char	1	$PAYCAT.	PAYMENT CATEGORY	0%
40	ACTCODE	Char	1	$ACTCODE.	FMS ACTIVITY CODE	0%
41	DISAMT	Num	8		FMS DISBURSED AMOUNT	0%
42	INTAMT	Num	8		FMS INTEREST AMOUNT	0%
43	EFTNO	Char	15		FMS CHECK/EFT NUMBER	0%
44	CHKDAT	Char	8		FMS CHECK DATE	0%
45	CANDAT	Char	8		FMS CHECK CANCEL DATE	99.40%
46	CANCODE	Char	1	$CANCODE.	FMS CHECK CANCEL CODE	99.40%
47	CANRSN	Char	2	$CANRSN.	FMS CHK CANCEL REASON	99.40%
48	OBNUM	Char	100		OBLIGATION NUMBER	0%
49	DHCP	Char	30		DHCP INTERNAL CTL NO.	0%
50	FMSTNO	Char	11		FMS TRANSACTION NO.	0%
51	LINENO	Char	3		FMS TRANS LINE NUMBER	0%
52	TRANSDAT	Char	8		FMS TRANSACTION DATE	0%
53	FY	Char	4			0%
54	BATCHNUM	Char	5			0%

Appendix E. Contents of FY2009 Pharmacy Vendors (PHARVEN) File

Physical Name: MDPPRD.MDP.SAS.FEN.FY09.PHARVEN

Variables in Creation Order

#	Variable	Type	Len	Format	Label	Percent Missing
1	STA3N	Num	5	STA3NL.	PARENT STATION	0%
2	HOMECNTY	Num	5	COUNTYL.	PATIENT COUNTY CODE	0%
3	HOMSTATE	Num	3		STATE CODE (NUMERIC)	0%
4	STA6A	Char	6		STATION NUMBER	0%
5	VZIP	Num	7		VENDOR ZIP CODE	0.05%
6	TYPE	Char	1	$TYPEFMT.	RECORD TYPE CODE	0%
7	VEN13N	Char	13		VENDOR ID WITH SUFFIX	0%
8	VENDID	Char	9		VENDOR ID BASE	0%
9	VENSUF	Char	4		VENDOR ID SUFFIX (CHAIN STORE #)	0%
10	VENNAME	Char	30		VENDOR NAME	0%
11	PARTCODE	Char	2	$PARTFMT.	PARTICIPATION CODE	100%
12	SPECCODE	Char	2	$SPECFMT.	SPECIALTY CODE	100%
13	JANMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR JAN	0%
14	FEBMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR FEB	0%
15	MARMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR MAR	0%
16	APRMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR APR	0%
17	MAYMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR MAY	0%
18	JUNMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR JUN	0%
19	JULMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR JUL	0%
20	AUGMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR AUG	0%
21	SEPMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR SEP	0%
22	OCTMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR OCT	0%
23	NOVMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR NOV	0%
24	DECMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR DEC	0%
25	NPI	Char	10		NATIONAL PROVIDER ID	84.54%

Appendix F. Contents of FY2009 All Other Vendors (VEN) File

Physical Name: MDPPRD.MDP.SAS.FEN.FY09.VEN

Variables in Creation Order

#	Variable	Type	Len	Format	Label	Percent Missing
1	SCRSSN	Num	7		SCRAMBLED SSN	0%
2	STA6A	Char	6			0%
3	STA3N	Num	4	STA3NL.	PARENT STATION	0%
4	TYPE	Char	1	$TYPEFMT.	RECORD TYPE CODE	0%
5	STANUM	Char	6			0%
6	INVNUM	Char	9			0%
7	INVLNNUM	Char	2			0%
8	SSNSUF	Char	1			100%
9	PAYTYPE	Char	1	$PAYTFMT.		0%
10	VEN13N	Char	30			100%
11	VENDID	Char	9			100%
12	CHAINNUM	Char	4			100%
13	VENSITEN	Char	15			100%
14	TVLAMT	Num	8	8.2		0%
15	TVLDATE	Char	8			0%
16	PROCDTE	Char	8		PROCESSING DATE(SASDATE)	0%
17	CLMDATE	Char	8		DATE RELEASED TO CALM(SASDATE)	0%
18	INTIND	Char	1	$INTFMT.	INTEREST INDICATOR	0%
19	VINVDATE	Char	8		VENDOR INVOICE DATE	0%
20	RELNO	Char	4		RELEASE PREFIX NUMBER	0%
21	JULDAY	Char	3		JULIAN DAY NUMBER	0%
22	PAYCAT	Char	1	$PAYCAT.	PAYMENT CATEGORY	0%
23	ACTCODE	Char	1	$ACTCODE.	FMS ACTIVITY CODE	0%
24	DISAMT	Num	8		FMS DISBURSED AMOUNT	0%
25	INTAMT	Num	8		FMS INTEREST AMOUNT	0%
26	EFTNO	Char	15		FMS CHECK/EFT NUMBER	0%
27	CHKDAT	Char	8		FMS CHECK DATE	0%
28	CANDAT	Char	8		FMS CHECK CANCEL DATE	99.55%
29	CANCODE	Char	1	$CANCODE.	FMS CHECK CANCEL CODE	99.55%
30	CANRSN	Char	2	$CANRSN.	FMS CHK CANCEL REASON	99.55%
31	OBNUM	Char	100		OBLIGATION NUMBER	0%
32	DHCP	Char	30		DHCP INTERNAL CTL NO.	0%
33	FMSTNO	Char	11		FMS TRANSACTION NO.	0%

Appendix F. Contents of FY2009 All Other Vendors (VEN) File (cont'd)

#	Variable	Type	Len	Format	Label	Percent Missing
34	LINENO	Char	3		FMS TRANS LINE NUMBER	0%
35	TRANSDAT	Char	8		FMS TRANSACTION DATE	0%
36	ACCPTDTE	Char	5			0%
37	SRCEIND	Char	1			0.39%
38	FMSDATE	Char	5			0.39%
39	FY	Char	4			0%
40	BATCHNUM	Char	5			0%

Appendix G. Contents of FY2009 Travel Payments (TVL) File

Physical Name: MDPPRD.MDP.SAS.FEN.FY09.TVL

Variables in Creation Order

#	Variable	Type	Len	Format	Label	Percent Missing
1	STA3N	Num	5	STA3NL.	PARENT STATION	0%
2	HOMECNTY	Num	5	COUNTYL.	PATIENT COUNTY CODE	0%
3	HOMSTATE	Num	3		STATE CODE (NUMERIC)	0%
4	STA6A	Char	6		STATION NUMBER	0%
5	VZIP	Num	7		VENDOR ZIP CODE	0.01%
6	TYPE	Char	1	$TYPEFMT.	RECORD TYPE CODE	0%
7	VEN13N	Char	13		VENDOR ID WITH SUFFIX	0%
8	VENDID	Char	9		VENDOR ID BASE	0%
9	VENSUF	Char	4		VENDOR ID SUFFIX (CHAIN STORE #)	76.04%
10	VENNAME	Char	30		VENDOR NAME	0%
11	PARTCODE	Char	2	$PARTFMT.	PARTICIPATION CODE	20.22%
12	SPECCODE	Char	2	$SPECFMT.	SPECIALTY CODE	67.58%
13	JANMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR JAN	0%
14	FEBMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR FEB	0%
15	MARMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR MAR	0%
16	APRMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR APR	0%
17	MAYMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR MAY	0%
18	JUNMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR JUN	0%
19	JULMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR JUL	0%
20	AUGMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR AUG	0%
21	SEPMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR SEP	0%
22	OCTMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR OCT	0%
23	NOVMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR NOV	0%
24	DECMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR DEC	0%
25	NPI	Char	10		NATIONAL PROVIDER ID	78.02%

Appendix H. Contents of FY2009 Fee Card (VET) File

Physical Name: MDPPRD.MDP.SAS.FEN.FY09.VET

Variables in Creation Order

#	Variable	Type	Len	Format	Label	Percent Missing
1	SCRSSN	Num	7	SSN.	SCRAMBLED SSN	0%
2	STA6A	Char	6		STATION NUMBER	0%
3	STA3N	Num	4	STA3NL.	PARENT STATION	0%
4	ZIP	Num	5		ZIP CODE	0%
5	HOMECNTY	Num	6	COUNTYL.	PATIENT COUNTY CODE	0%
6	HOMSTATE	Num	3		VETERANS STATE CODE (NUMERIC)	0%
7	STASUF	Char	3		SATELLITE ID	100%
8	TYPE	Char	1	$TYPEFMT.	RECORD TYPE CODE	0%
9	SSNSUF	Char	1		SSN SUFFIX (POSITION 10)	100%
10	SUFNAM	Char	10		VETERANS NAME SUFFIX	93.59%
11	VTADDR1	Char	35		VETERANS ADDRESS LINE 1	0%
12	VTADDR2	Char	35		VETERANS ADDRESS LINE 2	76.53%
13	VTADDR3	Char	35		VETERANS ADDRESS LINE 3	97.98%
14	VTCITY	Char	30		VETERANS ADDRESS CITY	0%
15	ISSUEDT	Char	8		ISSUE DATE	0%
16	VALENDY	Char	8		END VALIDITY DATE	0%
17	CNTY	Num	8		VETERANS COUNTY CODE	0%
18	DOB	Char	8		DATE OF BIRTH	0%
19	FPOV	Char	2	$POVFMT.	FEE PURPOSE OF VISIT CODE	0%
20	TRETYPE	Char	1	$TTYPFMT.	TREATMENT CODE	0%
21	XSEX	Char	1		SEX CODE (1=MALE; 2=FEMALE)	0%
22	POW	Char	1		PRISONER OF WAR CODE	0%
23	DEATHDT	Char	8		DEATH DATE	0%
24	WARCODE	Char	2	$WARFMT.	WAR CODE	0%
25	VTICN	Char	17		INTEGRATION CONTROL NUMBER	100%
26	CCCODE	Char	1		CONFIDENTIAL ADDR INDICATOR(=2)	0%
27	CCADDR1	Char	35		CONFIDENTIAL ADDR LINE 1	99.82%
28	CCADDR2	Char	35		CONFIDENTIAL ADDR LINE 2	100%
29	CCCITY	Char	30		CONFIDENTIAL ADDR CITY	99.82%
30	CCST	Char	2		CONFIDENTIAL ADDR STATE	99.82%
31	CCZIP	Char	9		CONFIDENTIAL ADDR ZIP CODE	99.82%
32	STRTDTE	Char	8		CONFIDENTIAL ADDR START DATE	0%

Appendix H. Contents of FY2009 Fee Card (VET) File (cont'd)

33	ENDDTE	Char	8		CONFIDENTIAL ADDR END DATE	0%
34	CCCNTY	Char	3		CONFIDENTIAL ADDR COUNTY	0%
35	AGECNTL	Char	2		AGE CONTROL	100%
36	LPAYTYP	Char	1	$LPAYFMT.	TYPE LAST PAYMENT	35.50%
37	LASTPAY	Char	8		DATE LAST PAYMENT	0%
38	DELCODE	Char	1		DELETE CODE	100%
39	JANMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR JAN	0%
40	FEBMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR FEB	0%
41	MARMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR MAR	0%
42	APRMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR APR	0%
43	MAYMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR MAY	0%
44	JUNMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR JUN	0%
45	JULMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR JUL	0%
46	AUGMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR AUG	0%
47	SEPMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR SEP	0%
48	OCTMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR OCT	0%
49	NOVMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR NOV	0%
50	DECMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR DEC	0%
51	SEX	Char	1		SEX CODE (M=MALE; F=FEMALE)	0%

Appendix I. Formatted Values of Selected Variables in FY2009

FPOV: Fee Purpose of Visit (See Appendix J for more information on FPOV.)

Value	Label
1	COMP AND PEN
2	OPT UNAUTH CLAIM
3	APP-MED BENEFIT
4	VA INSURANCE
5	OPT FOR NSC
6	AA/HB BENEFITS
7	MISCELLANEOUS
8	OPT WWI MEX BOR
9	OPT < 50% SC
10	OPT > OR =50% SC
11	OBVIATE NEED
15	CLASS I DENTAL
16	CLASS II DENTAL
17	CLASS IIA DENTAL
18	CLASS IIB DENTAL
19*	CLASS IIC DENTAL
20*	CLASS IIR DENTAL
21	CLASS III DENTAL
22	CLASS IV DENTAL
23	CLASS V DENTAL
24	CLASS VI DENTAL
30	CON HOSP FOR SC
31	UNAUTH CON HOSP
32	CON HOSP EMER VA
33	CON HOSP EMER FED
34	CON HOSP WOMEN
35	CON HOSP NSC
36	CON HOSP FED HOS
37	IPT HOSPICE FEE
38	IPT HOSPICE CONT
39	IPT 38 U.S.C. 1725
40	CNH SC DIS 38 USC 1710
41	CNH NSC DISABIL
42	CNH ACTIVE DUTY
43	CNH HOSPICE & PALLIATIVE
44	CNH RESPITE CARE
50*	CONT READJUST
52	OPT 38 U.S.C. 1725
55	MST
56†	DIALYSIS
60*	CONTRACT HALFWAY HOUSE
67†	MATERNITY CARE SERVICES
68†	BOWEL AND BLADDER CARE: AGENCY
69†	BOWEL AND BLADDER CARE: FAMILY CAREGIVER
70	HOME HEALTH NURS
71	HOME HEALTH
72	RESPITE CARE IN HOME/HOME HAS
73	RESPITE CARE IN ADHC
74	HHS (NON-NURSE PROF)
75	CHIROPRACTIC CARE
76	ADULT DAY HEALTH CARE(ADHC)
77	OPT HOSPICE FEE
78	OPT HOSPICE CONT
79	RESPITE CARE OTHER
80	OPT DIAGNOSTIC
81	SUPP OPT SERVICE
82	FEE OXYGEN
83*	OPT INPATIENTS
84*	SUPP ALLERGY
85*	OPT FOR OPTS
86	STATE ADHC (ADULT DAY HEALTH CARE)
87	STATE DOM
88	STATE HOSPITAL
89	STATE NH (NURSING HOME)

* Currently inactive.
† Values added after March, 2009. The implementation date varied across sites.

Appendix I. Formatted Values of Selected Variables in FY2009 (cont'd)

HCFFMT: HCFA Payment Type

Value	Fee Basis Label	CMS Label*
[blank]	UNKNOWN	**
0	BLD/PACKED CELLS	Whole Blood
1	MEDICAL CARE	Medical Care
2	SURGERY	Surgery
3	CONSULTATION	Consultation
4	DIAG XRAY	Diagnostic Radiology
43	DIAG XRAY PROF C	**
5	DIAG LAB	Diagnostic Laboratory
53	DIAG LAB PROF CO	**
6	RADIATION THERAP	Therapeutic Radiology
7	ANESTHESIA	Anesthesia
8	ASSIST SURG	Assistant at Surgery
9	OTHER MED SER	Other Medical Items or Services
A	USED DME	Used DME
B †	AMB SURG CENTER	High Risk Screening Mammography
C ††	No label assigned	Low Risk Screening Mammography
D ††	No label assigned	Ambulance
E ††	No label assigned	Enteral/Parenteral Nutrients/ Supplies
F ††	No label assigned	Ambulatory Surgical Center (Facility Usage for Surgical Services)
G ††	No label assigned	Immunosuppressive Drugs
H	HOSPICE	Hospice
I	No label assigned	**
L	RENAL SUPP HOME	ESRD Supplies
M	ALT PAY MN DIAL	Monthly Capitation Payment for Dialysis
N	KIDNEY DONOR	Kidney Donor
P ††	No label assigned	Lump sum purchase of DME, Prosthetics, Orthotics
V	PNEUMOCOCCAL VACC	Pneumococcal/Flu Vaccine
Y	2ND OP ELEC SURG	**
Z	3RD OP ELEC SURG	**

* Source: CMS Pub 100-04 Medicare Claims Processing, Transmittal 1830, Change Request 6693 (October 16, 2009). http://www.cms.gov/transmittals/downloads/R1830CP.pdf (accessed Nov. 17, 2010).

** CMS does not use this code.

† Note that the Fee Basis label differs substantially in meaning from the CMS label.

†† Without a label one cannot be certain that VA uses this code in the same manner as CMS.

Appendix I. Formatted Values of Selected Variables in FY2009 (cont'd)

TYPE: Record Type

```
1     MEDICAL VENDOR
3     FEE MEDICAL
4     PHARM VENDOR
5     PHARMACY
7     STATE HOME
9     INPATIENT
T     TRAVEL
```

TRETYPE: Type of Treatment

```
0     [not assigned, although it appears in some years]
1     SHORT-TERMT
2     HOME NURSING SER
3     ID CARD FEE
4     STATE HOME
```

PAYCAT: Payment Category

```
Value       Label

C     CONTRACT HOSPITAL
D     DENTAL
H     CONTRACT HALFWAY HOUSE
K     DIALYSIS
M     MEDICAL
N     COMMUNITY NURSING HOME
P     PHARMACY
R     REIMBURSEMENT
T     TRAVEL
```

PAYTYPE: Payment Type

```
Value       Label

R     VET REIMBURSE
S     STAT PAYMENT
T     TRAVEL PAYMENT
V     VENDOR PAYMENT
```

Appendix I. Formatted Values of Selected Variables in FY2009 (cont'd)

PLSER: Place of Service

Value	Label	Value	Label
00	UNASSIGNED	33	CUSTOD CARE FAC
01	UNASSIGNED	34	HOSPICE
02	UNASSIGNED	35	UNASSIGNED
03	UNASSIGNED	36	UNASSIGNED
04	UNASSIGNED	37	UNASSIGNED
05	UNASSIGNED	38	UNASSIGNED
06	UNASSIGNED	39	UNASSIGNED
07	UNASSIGNED	40	UNASSIGNED
08	UNASSIGNED	41	AMBULANCE LAND
09	UNASSIGNED	42	AMBUL AIR/WATER
10	UNASSIGNED	43	UNASSIGNED
11	OFFICE	44	UNASSIGNED
12	HOME	45	UNASSIGNED
13	UNASSIGNED	46	UNASSIGNED
14	UNASSIGNED	47	UNASSIGNED
15	UNASSIGNED	48	UNASSIGNED
16	UNASSIGNED	49	UNASSIGNED
17	UNASSIGNED	50	FED QL HTH CTR
18	UNASSIGNED	51	INP PSYCH FACIL
19	UNASSIGNED	52	PSY PART HOSPIT
21	INP HOSPITAL	53	COMM MHC
22	OPT HOSPITAL	54	INT CARE/MENT/R
23	EMERG RM HOSP	55	RESID SUB ABUSE
24	AMB SURG CENTER	56	PSYCHIATRIC RTC
25	BIRTHING CENTER	60	MASS IMMUN CTR
26	MILITARY TRMT FAC	61	COMP IPT REH FAC
27	UNASSIGNED	62	COMP OPT REH FAC
28	UNASSIGNED	65	RENAL TREATMENT FAC
29	UNASSIGNED	71	ST/LOC PUB HTH CLC
30	UNASSIGNED	72	RURAL HTH CLINIC
31	SKILL NUR FACIL	81	INDEPENDENT LAB
32	NURSING FACIL	99	OTHER UNLIST FAC

Note: new values are added over time. Unassigned values are not currently used by VA.

Appendix J. Fee Purpose of Visit (POV) Information and Table

The following document, entitled "Fee Purpose of Visit (POV) Document," may be found on the Fee Program Office intranet web site under Policies & Programs and then Program Information.

Overview

When establishing authorizations for the use of non-VA medical services in the VistA Fee software modules, we use "Purpose of Visit" (POV) codes to identify the appropriate authority to expend VA funds for payment of the claims. It is very important in today's data world to accurately use these codes to correctly identify not only the authority used to expend the funds, but to also capture workload and expenditures in the various health care programs that Fee Offices typically process for payment. It is essential that Fee Office staff, as well as other VA employees who use the VistA Fee authorization menu options to process payments for non-VA care, enter data accurately to ensure the workload reports are associated with the appropriate Fee program and POV.

Background:

As briefly discussed in the overview, the POV code may be assigned to authorizations entered into the VistA Fee system in various ways. There are times when you create a POV when you disposition an authorization, and there are times when you choose the actual POV code to be entered. There are even times when a POV code is automatically created in the authorization module by just choosing the appropriate program for which you are going to make a VistA Fee system payment. The current system gives the user the ability to enter many different choices. There is no editing logic built into the VistA Fee system to inform the user whether or not they have selected the appropriate POV. In short, the accuracy of Fee workload / expenditure data depends upon your decision as to which POV code is appropriate for each authorization.

Table of examples of the variations when and how POV codes are identified in VistA Fee

Program Type	Method of Identification	POV Identified
Unauthorized Claims	Unauthorized claims menu used for processing in VistA Fee.	VistA Fee automatically populates POV when you identify the unauthorized claim Program Type as an inpatient (Civil Hospital) or outpatient (Medical) claim.

Mill Bill – NSC Emergency Care	Unauthorized claims menu used for processing in VistA Fee.	VistA automatically populates POV when you identify the unauthorized claim as a Mill Bill Program Type as an inpatient (Civil Hospital) or outpatient (Medical) claim.
Civil Hospital	Civil Hospital menu used for processing in VistA Fee.	Select the appropriate authorization related to all the possible authorities for inpatient care.
Outpatient	Fee Medical menu used for processing in VistA Fee.	Dropdown in the authorization entry process related to all the possible authorities for outpatient care.
CNHC	Community Nursing Home menu used for processing in VistA Fee.	Dropdown in the authorization entry process related to the CNHC authorities.
Dental	Fee Medical menu used for processing in VistA Fee.	Dropdown in the authorization entry process related to all the possible authorities for outpatient dental care.
State Home	State Home menu used for processing in VistA Fee.	Dropdown in the authorization entry process related to the State Home authorities.
Pharmacy	Pharmacy menu used for processing in VistA Fee.	Associated with the POV related to the primary authorization for care in the VistA Fee system.

Recommended Processes:

These general recommendations will help the user choose the correct POV code for the authorization. A detailed table of all the POV codes follows the below recommendations, along with a description of when they should be applied to the authorization.

- Civil Hospital (Pre-authorized): The POV is established according to the authority the user chooses when completing the entry of the civil hospital authorization. The POV the user selects must match the authority used to determine the Veteran's eligibility for VA payment. The numbers assigned in the listing of authorities for approval of non-VA inpatient care are not the same as the POV code numbers in the VistA Fee system. Most of the authorities are self-explanatory and matched with the POV assigned in the VistA system on the detailed POV table provided.

- Community Nursing Home Care: The POV is established according to the authority the user chooses when completing the entry of the CNHC authorization. The authority the user picks should match with the authority they used to determine the Veteran's eligibility for VA payment. When entering the CNHC authorization the user will be prompted to choose the appropriate POV listed in the dropdown listing. Only the POV codes listed can be used, limiting the user to only POV codes related to the CNHC authorities.

- Outpatient Medical (Pre-authorized): The POV is established according to the authority the user chooses when completing the entry of the outpatient authorization. Pre-authorized outpatient non-VA care can have more than one type of eligibility applied under certain authorities and the user is responsible to assign the most appropriate POV using the table provided.

NOTE: The Outpatient Medical is used to process other program payments such as Dental, Dialysis, Fee Bene Travel, Chiropractic care, Women's Health, some Geriatrics, and Extended care services, Bowel and Bladder Care, Compensation and Pension exams and certain contracted non-VA care.

- State Home: The POV is established according to the authority the user chooses when completing the entry of the State Home authorization. The authority should match the authority used to determine the veteran's eligibility for VA payment. When entering the State Home authorization, the user must choose the appropriate POV listed in the dropdown listing. Only the POV codes listed may be used, limiting the user to only POV codes related to the State Home authorities.

- Unauthorized Claims (Inpatient and Outpatient): The POV is auto-selected when the user identifies the authorization as being for unauthorized inpatient or outpatient care in VistA Fee. The VistA Fee system auto populates the appropriate code for the user; there is no option to choose a POV code from a dropdown list

- Mill Bill: The POV is established when the user identifies the authorization as being for an unauthorized Mill Bill inpatient or outpatient care claim in VistA Fee. The VistA Fee system auto populates the appropriate code for the user; there is no option to choose a POV code from a dropdown list

---

Outpatient Medical Authorization Entry Need to Know:

In order to ensure the information passes through to Central Fee without rejection, the Outpatient Medical authorization entry has different combinations of POV codes and other data entry fields. The POV table below explains when to use the additional data fields appropriately with the user's choice of POV code. It is important to follow this information carefully to reduce the number of rejections related to the Veteran Master Record Listing.

Purpose of Visit Codes

Services	Inpatient or Outpatient	POV Code	Treatment Type Code	Notes / Comments
Compensation and Pension Exam	Outpatient	01	1	*Use when paying for C&P exams only. C&P exams are evaluation only and should not be used to process any services for treatment.*
Outpatient Unauthorize Claim	Outpatient	02	1	*VistA system automatically assigns the POV code when the Fee clerk identifies the "Medical" Fee Program type for the services related to a claim for unauthorized outpatient care under U.S.C. 1728.*
Application for Medical Benefits (VAF 10-10)	Outpatient	03	1	*Only for use by designated facilities.*
VA Insurance Exam	Outpatient	04	1	*Use when the outpatient treatment authorized is to conduct a VA Insurance exam, upon request by VA Insurance Center or VARO.*
OPT Services eatment for NSC Disabilities	Outpatient	05	1	*Use when the outpatient treatment authorized is for non-emergent NSC treatment of a Veteran with service-connected disabilities with VA Clinician referral and no other POV would apply.*
				Use when the outpatient treatment authorized is for non-emergent treatment of a Veteran with no service-connected disabilities with VA Clinician referral and no other POV would apply.
				Use when the outpatient treatment authorized is for emergent treatment of a Veteran with no service-connected disabilities with VA Clinician referral and no other POV would apply.
				Use when the outpatient treatment authorized is for emergent NSC treatment of a Veteran with service-connected disabilities with VA Clinician referral and no other POV would apply.
OPT for Veterans In receipt of Aid & Attendance or Housebound	Outpatient	06	1	*Use when the non-emergent outpatient treatment is authorized under the Aid & Attendance/ Housebound entitlement.*

				Use when the preauthorized emergent outpatient treatment is authorized under the Aid & Attendance/ Housebound entitlement.
			3	*Use when a Fee ID Card is issued for treatment authorized under the Aid & Attendance/Housebound entitlement.*
MISC. (Eligibility under Vocational Rehabilitation, other Federal Agency or Allied Benefit)	Outpatient	07	1	*Use when the non-emergent outpatient treatment is authorized under the entitlements listed in the description.*
				Use when the emergent outpatient treatment is authorized under the entitlements listed in the description.
OPT World War I & Mexican Border	Outpatient	08	1	*Use when the non-emergent outpatient treatment is authorized for a Veteran with a period of service listed as World War I, Spanish American War, or Mexican Border Period.*
				Use when the preauthorized emergent outpatient treatment is authorized for a Veteran with a period of service listed as World War I, Spanish American War, or Mexican Border Period.
			3	*Use when a Fee ID Card is issued for non-emergent outpatient treatment authorized for a Veteran with a period of service listed as World War I, Spanish American War, or Mexican Border Period.*
Outpatient Service-connected less than 50%	Outpatient	09	1	*Use when the non-emergent outpatient treatment is authorized for a Veteran's Service-connected condition, if the combined rating is less than 50%.*
				Use when the preauthorized emergency outpatient treatment is for treatment of the Veteran's Service-connected condition.
			3	*Use when a Fee ID Card is issued for treatment of the Veteran's Service-connected condition, if the combined rating is less than 50%.*
Outpatient Service-connected 50% or more	Outpatient	10	1	*Use when the non-emergent outpatient treatment is authorized for a Veteran's Service-connected condition, if the combined rating is 50% or more.*

				Use when the preauthorized emergency outpatient treatment is for treatment of the Veteran's Service-connected condition.
			3	*Use when a Fee ID Card is issued for treatment of the Veteran's Service-connected condition, if the combined rating is 50% or more.*
OPT to Obviate the need for Hospital	Outpatient	11	1	*Used only by certain facilities. This POV code should only be used when approving medical care that will avoid the admission of a Veteran to inpatient care in Alaska, Hawaii, Guam and the U.S. Virgin Islands.*
CHAMPVA Sponsor		12	N/A	*Not for Fee Program use.*
CHAMPVA Beneficiary		13	N/A	*Not for Fee Program use.*
Not in Use		14		*Not for Fee Program use.*
Class I Dental Treatment	Outpatient	15	1	*Use when the dental treatment is for Service-connected compensable dental disability.*
Class II Dental Treatment	Outpatient	16	1	*Use when the dental treatment is for a Veteran who applied and was authorized VA dental benefits within 90 days of discharge from Active Duty and has not been provided dental care upon discharge from Active Duty as cited on the Veteran's DD214.*
Class IIa Dental Treatment	Outpatient	17	1	*Use when the dental treatment is for a Service-connected non compensable dental condition resulting from combat wounds of dental trauma.*
Class IIb Dental Treatment	Outpatient	18	1	*Use when the dental treatment is for non compensable dental conditions for POWs.*
Class IIc Dental Treatment	Outpatient	19	1	*No longer used.*
Class IIr Dental Treatment	Outpatient	20	1	*No longer used.*
Class III Dental Treatment	Outpatient	21	1	*Use when the dental treatment is for a Service-connected adjunct medical condition.*
Class IV Dental Treatment	Outpatient	22	1	*Use when the dental treatment is for a Veteran wit a total rating of 100% SC.*
Class V Dental Treatment	Outpatient	23	1	*Use when the dental treatment is for a Veteran under Vocational Rehabilitation/Chapter 31.*

Class VI Dental Treatment	Outpatient	24	1	*Use when any veteran scheduled for admission or receiving outpatient care under 38 U.S.C. may receive dental care if the dental condition is clinically determined to be complicating a medical condition currently under treatment. Each episode of dental care will be predicated on referral and consultation, followed by a clinical judgmental decision.*
Not in Use		25		*Not for Fee Program use.*
Not in Use		26		*Not for Fee Program use.*
Not in Use		27		*Not for Fee Program use.*
Not in Use		28		*Not for Fee Program use.*
Not in Use		29		*Not for Fee Program use.*
Authorized Contract Hospital care for Service-connected condition	Inpatient	30		*Use when the inpatient emergency is preauthorized and for the Veteran's service-connected condition.*
Unauthorized Contract Hospital care	Inpatient	31		*VistA system automatically assigns when the authorization for services is entered for payment and Fee Program type "Civil Hospital" is selected for unauthorized inpatient care under U.S.C. 1728.*
Contract Hospital Emergency - VA	Inpatient	32		*Use when the Contract Hospital emergency is for a Veteran receiving care (Inpt or Otpt) in VAMC.*
Contract Hospital Emergency - Federal	Inpatient	33		*Use when the Contract Hospital emergency care is for a Veteran receiving care (Inpt or Otpt) in a Federal hospital at VA expense.*
Contract Hospital Women Veterans	Inpatient	34		*Use when the Contract Hospital emergency is for care of a woman Veteran (without any other eligibility).*
Contract Hospital NSC	Inpatient	35		*Use when the Contract Hospital emergency is an NSC condition in AK, VI & HI only)* .
Contract Hospital Federal Hospital	Inpatient	36		*Use when the Contract Hospital care is for a Veteran receiving inpatient care in a Federal Hospital at VA expense.*
Inpatient Hospice Contract/Sharing Agreement	Inpatient	37		*Use when the inpatient Hospice care is referred under a contract or sharing agreement.*

Inpatient Hospice Fee Basis Authority	Inpatient	38		*Use when the inpatient care is referred under the Fee Basis authority.*
Inpatient 38 U.S.C. 1725 (Millennium Bill)	Inpatient	39		*VistA system **automatically** assigns when the authorization for services is entered for payment **and Fee Program type "Civil Hospital" is selected** for unauthorized inpatient care under U.S.C. 1725.*
CNH for Services-connected Disability(ies)	Inpatient	40		*Use when the CNH referral is for the Veteran's SC disability(ies).*
CNH for NSC Disability(ies)	Inpatient	41		*Use when the CNH referral is for the Veteran's NSC disability(ies).*
CNH for Active Duty Personnel	Inpatient	42		*Use when the CNH referral is for Active Duty personnel only.*
CNH for Hospice & Palliative Care	Inpatient	43		*Use when the CNH referral is for Hospice and Palliative purposes.*
CNH for Respite Care	Inpatient	44		*Use when the CNH referral is for Respite purposes.*
Not in Use		45		*Not for Fee Program use.*
Not in Use		46		*Not for Fee Program use.*
Not in Use		47		*Not for Fee Program use.*
Not in Use		48		*Not for Fee Program use.*
Not in Use		49		*Not for Fee Program use.*
Contract Readjustment counseling & related Mental Health services		50		*Inactive POV code. Not for Fee Program use.*
Not in Use		51		*Not for Fee Program use.*
Outpatient 38 U.S.C. 1725 (Millennium Bill)	Outpatient	52	1	*VistA system automatically assigns the POV code when the Fee clerk identifies the "Medical" Fee Program type for the services related to a claim for unauthorized outpatient care under U.S.C. 1725.*
Not in Use		53		*Not for Fee Program use.*
Not in Use		54		*Not for Fee Program use.*
Military Sexual Trauma Services	Outpatient	55	1	*Use when the services referred are directly related to the MST authority. No other POV should be used to override this authority.*
Dialysis	Outpatient	56	1	*Use for preauthorized non-VA Dialysis ESRD treatment.*
Not in Use		57		*Not for Fee Program use.*
Not in Use		58		*Not for Fee Program use.*

Not in Use		59		*Not for Fee Program use.*
Contract Halfway House/Substance Abuse rehabilitation or treatment	Inpatient	60		*Inactive POV code. Not for Fee Program use.*
Not in Use		61		*Not for Fee Program use.*
Not in Use		62		*Not for Fee Program use.*
Not in Use		63		*Not for Fee Program use.*
Not in Use		64		*Not for Fee Program use.*
Not in Use		65		*Not for Fee Program use.*
Not in Use		66		*Not for Fee Program use.*
Outpatient Maternity Care services	Outpatient	67	1	*Use for preauthorized outpatient maternity care.*
Bowel & Bladder Care: Agency	Outpatient	68	1	*Use when care is given by an Agency*
Bowel & Bladder Care: Family Caregiver	Outpatient	69	1	*Use when care is given by a Family member*
Home Health Nursing Services	Outpatient	70	2	*Use if a nurse makes skilled visit. Each visit needs to be paid individually (Not lumped together).*
Homemaker/Home Health Aid Services (H/HHA)	Outpatient	71	1 or 2	*Use for Homemaker or Home Health Aid visits. Each visit needs to be paid individually (Not lumped together). Use this code for Bowel and Bladder if the provider is a non-professional.*
Respite Care in Homemaker/ Home Health Aid Services	Outpatient	72	1	*Use for Respite care provided in the home by H/HHA services. This will require communication between the Fee and Clinical staff to know if the main purpose of H/HHA was for Respite. Each visit needs to be paid individually (Not lumped together).*
Respite Care in ADHC	Outpatient	73	1	*Use for Respite care provided in an ADHC service. This will require communication between the Fee and Clinical staff to know if the main purpose of ADHC was for Respite. Each visit needs to be paid individually (Not lumped together).*
Home Health Services (Non-Nursing Professional)	Outpatient	74	1 or 2	*Use if a skilled visit is made by a non-nursing professional such i.e. Physical Therapist, Social Worker, etc. Each visit needs to be paid individually (Not lumped together).*

Chiropractic Care	Outpatient	75	1	*Use whenever chiropractic care is referred regardless if SC or NSC for the condition being treated.*
Contract Adult Day Health Care (CADHC)	Outpatient	76	1	*Use for Adult Day Health Care that is purchased.*
Hospice & Palliative Care (OPT)	Outpatient	77	1	*Use for Hospice Care provided in the home by a Hospice/Palliative care agency. Care should be provided and paid for on a per diem bases. NOTE: Eventually this will be the Fee POV code to use for Home Hospice because POV 78 is being phased out. Make sure to enter each date of care separately.*
Hospice & Palliative Care (OPT)	Outpatient	78	1	*Use for Hospice Care in the home. Paid for on per diem basis. Each day of care that we pay for needs to be entered separately.* *NOTE: This code is being phased out.*
Respite Care (Other)	Outpatient	79	1	*Use for Respite Care provided in the home. Each visit needs to be paid individually. (Not lumped together).*
Outpatient diagnostic services obtained by an independent VA clinic to obviate hospital care	Outpatient	80	1	*Used by specific VA facilities only.*
Diagnostic services – VAMC Outpatient	Outpatient	81	1	*Use when the diagnostic services are needed for a Veteran receiving outpatient VA care.*
Fee Oxygen	Outpatient	82		*Inactive POV code. Not for Fee Program use.*
Outpatient services for VA Inpatient	Outpatient	83	1	*Inactive POV code. Not for Fee Program use.*
Supplemental Diagnostic Services	Outpatient	84	1	*Inactive POV code. Not for Fee Program use.*
Outpatient Services for VA Outpatients		85	1	*Inactive POV code. Not for Fee Program use.*
State Home ADHC	Inpatient	86	1	*Use for State Home care that is for Adult Day care in a State Home facility.*
State Home Dom	Inpatient	87	1	*Use for State Home care that is in a State Home Domiciliary.*
State Home Hospital	Inpatient	88	1	*Use for State Home care that is in a State Home Hospital.*

State Home NH	Inpatient	89	1	*Use for State Home care that is in a State Nursing Home Facility.*
Not in Use		90		*Not for Fee Program use.*
Not in Use		91		*Not for Fee Program use.*
Not in Use		92		*Not for Fee Program use.*
Not in Use		93		*Not for Fee Program use.*
Not in Use		94		*Not for Fee Program use.*
Not in Use		95		*Not for Fee Program use.*
Not in Use		96		*Not for Fee Program use.*
Not in Use		97		*Not for Fee Program use.*
Not in Use		98		*Not for Fee Program use.*

Appendix K. SAS Program Example: Average Cost per CPT for One Vendor

This program calculates and prints out the average cost for selected procedures (CPT codes). In place of 'S640EGZ' the analyst should use his/her own AITC username. 'FY09' refers to the fiscal year of the data.

The program assumes that a separate program has already been run to extract relevant Fee Basis variables from the MED file and the VEN file with results saved as SAS datasets FEEMED and FEEVEN, respectively. This step is not required but will save processing time if changes are later made to the SAS code below. If the initial step is omitted then both the JCL code and the SAS code in the program below should reference the original MED and VEN files rather than the new datasets FEEMED and FEEVEN.

```
 […standard initial JCL code omitted here…]
//IN1 DD DSN=S640EGZ.FY09.FEEMED,DISP=SHR
//IN2 DD DSN=S640EGZ.FY09.FEEVEN,DISP=SHR

data cases; set in1.feemed (rename=(cpt1=cptcode));
   where cptcode in ('76090' '76091' '76092');
   proc sort; by ven13n;

data vendors; set in2.feeven;
   proc sort nodupkey; by ven13n;

data both; merge vendors (in=a) cases (in=b);
  by ven13n; if a and b;
retain tally 1;

proc report nowindows headskip;
   col sta3n venname amount tally rate;
   define sta3n / group width=23;
   define venname / group width=28 order=freq descending;
   define amount / sum format=dollar8.;
   define tally / sum '' width=3;
   define rate / computed format=dollar6.1 'RATE PER';
    compute rate; rate=amount.sum/tally.sum; endcomp;
   break after sta3n / skip ol summarize suppress;
```

Appendix L. Adjustment Code (ADJCD1 and ADJCD2) Values

Alt Services Should Have Been Utilized
App Proc Not Followed/Time Limit Not Met
Benefit Max Reached For This Time Period
Benefit Maximum Has Been Reached
Blood Deductible
Charges Exceed Contracted/Legislated Fee
Charges Exceed Fee Schedule/Max Amount
Claim Denied - No Coverage For Newborns
Claim Denied Charges
Claim Specific Negotiated Discount
Collection Against Prior Overpayment
Contractual Adjustment
Covered By Liability Carrier
Date Of Death Precedes Date Of Service
Denied-Interim Bills Cannot Be Processed
Diagnosis Is Not Covered/Missing/Invalid
Duplicate Claim/Service
Eligibility/Residency/Other Reqs Not Met
Expenses Incurred Prior To Coverage
Incorrect Payer-Send To Correct Payer
Information Lacking For Adjudication
Insufficient Info From Another Provider
Interest Amount
Missing
Monthly Medicaid Patient Liability Amt
Multiple Physicians/Assists Not Covered
Multiple Surgery/Concurrent Anesth Rules
Non-Covered Charge(s)
Non-Covered Visits
Not Deemed A Medical Necessity By Payer
Not Qualified For Emergent/Urgent Care
Patient Cannot Be Identified As Insured
Patient Health Id Nbr/Name Do Not Match
Place Of Service Invalid/Inappropriate
Pmt For Claim Provided In A Previous Pmt
Pmt Included In Allowance For Other Serv
Pmt Made To Patient/Ins/Resp Party
Portion Of Payment Deferred
Prearranged Demonstration Project Adj
Pre-Cert/Auth Exceeded Or Absent
Proc Cd Inconsistent With Modifier
Proc Cd Inconsistent With Provider Type
Proc/Rev Cd Inconsistent W/ Patient Age
Proc/Rev Cd Inconsistent With Gender
Insufficient Info From Another Provider
Interest Amount
Professional Fees Removed From Charges
Provider Ineligible To Prscr/Perf Serv
Provider Not Eligible On Date Of Service
Psychiatric Reduction
Routine Exam/Screening Is Not Covered
Services Not Documented In Pat Med Rcds
Spans Eligible & Ineligible Periods
Supporting Information Insufficient
Time Limit For Filing Has Expired
UNKNOWN
Work-Related - Liability Of Workers Comp

Appendix M. Payment Guideline for Preauthorized Inpatient Claims

The following guideline for paying preauthorized inpatient claims appeared in the May, 2007, Fee Basis newsletter. Two common abbreviations used are DRG (diagnosis-related group) and CTC (cost-to-charge). These tables pertain *only* to preauthorized inpatient claims; they do not pertain to 38 USC 1725 ("Mill Bill") or unauthorized claims.

When VA has a contract with the provider, the VA allowable amount is determined by the terms of the contract.

If there is no contract, then VA's allowable amount is based on the type of facility.

Facilities that participate in the Medicare Inpatient Prospective Payment System (IPPS) the VA allowable amount is calculated by the current CMS Pricer plus an annual VA surcharge. This surcharge is already built into the VistA Fee allowable amount. The Pricer is located at the Austin Automation Center and you access it automatically through the VistA Fee package. You don't need to know the surcharge amount to process a claim, but you may get a call from a vendor asking what the amount is. Here are the amounts:

1999 - 2.71%	2002 - 2.56%	2005 - 2.59%
2000 - 2.68%	2003 - 2.69%	2006 - 2.60%
2001 - 2.60%	2004 - 2.69%	2007 - 2.51% [12]

Facilities that do not participate in the Medicare IPPS (e.g. critical care assess hospitals, psychiatric hospitals, certain cancer specialty centers) are DRG exempt. The VA allowable amount is determined by using the VA cost-to-charge payment methodology. The billed charge is multiplied by the VA cost-to-charge ratio and the result is the total VA allowable amount. Here are the cost-to-charge (C-T-C) ratios:

1999 - 68%	2002 - 65%	2005 - 61%
2000 - 66%	2003 - 62%	2006 - 57%
2001 - 65%	2004 - 62%	2007 - 54% [13]

Facilities that have been granted a Federal waiver, the VA allowable amount is the full billed charge.

1. How Often Do DRG Payment Rates Change?

DRG payment rates are revised annually at the beginning of the Federal fiscal year. Notification of proposed changes is published by the Centers for Medicare and Medicaid

[12] The surcharge was 2.36% in FY2008, 2.21% in FY2009, and 2.14% in FY2010.
[13] The C-T-C ratio was 51.0% in FY2008, 49.3% in FY2009, and 48.3% in FY2010.

Services (CMS) in the Federal Register usually by June first, and final regulations regarding DRG payment rate changes are published around September first. The DRG payment rate is determined based on date of discharge. If a Veteran was admitted to the hospital in September 2006 (FY 2006) and discharged on or after October 1, 2006 (FY 2007) then the FY 2007 DRG payment rates will apply.

2. Payments to DRG Facilities

Sometimes there can be confusion about when to pay the full DRG and when to pay per diem rates for non-VA facility care subject to the PPS/DRG payment methodology. The following should help guide you. Please keep in mind that the following examples are based on hospital stays that have been pre-authorized under 38 CFR 17.52 or 17.54.

FOR INPATIENT PREAUTHORIZED CLAIMS ONLY

	If a Veteran is:	**Then the VA allowable amount for the non-VA facility care is:**
1)	Directly admitted to or transferred to a non-VA facility and expired or discharged within 24 hours	The Full DRG amount
2)	Transferred from VA to a non-VA facility, treatment is completed and discharged	The Full DRG amount
3)	Directly admitted to non-VA facility, treatment is completed and discharged	The Full DRG amount
4)	Transferred by VA to a non-VA facility, then transferred to a second non-VA facility, treatment is completed and discharged	• For the first non-VA facility, per diem not to exceed full DRG amount • For the second non-VA (discharging) facility, the full DRG amount
5)	Admitted to a non-VA facility, stabilized and then transferred to another non-VA facility (VA facilities not available) for continued treatment of the same condition(s), treatment is completed and discharged	• For the admitting non-VA facility, per diem not to exceed full DRG amount • For the second non-VA (discharging) facility, the full DRG amount

6)	Admitted directly to a non-VA facility and stabilized but no VA bed available, treatment is completed and discharged	The full DRG amount
7)	Admitted directly to a non-VA facility and refuses transfer to VA upon stabilization	Per diem (not to exceed full DRG) up to the point of stabilization
8)	Transferred from VA to a non-VA facility and then transferred back to the VA	Per diem, not to exceed full DRG amount
9)	Admitted directly to a non-VA facility, stabilized and then transferred to VA	Per diem not to exceed full DRG amount
10)	Receiving VA Contract Nursing Home care, is admitted to non-VA facility from a VA Contract Nursing Home, emergency treatment completed, and transferred to VA (NOT an NHCU or Intermediate Care Unit)	Per diem, not to exceed full DRG amount
11)	Receiving VA Contract Nursing Home, is admitted to non-VA facility from a VA Contract Nursing Home, emergency treatment completed, and discharged back to VA Contract Nursing Home	The full DRG amount
12)	Admitted from a Community Nursing home (not paid for by VA) to a non-VA facility, discharged back to a Community Nursing Home	The full DRG amount
13)	Admitted from a Community Nursing home (not paid for by VA) to a non- VA facility, and transferred to VA	Per diem not to exceed full DRG amount
14)	Transferred from a medical or surgical unit in a non-VA facility to a DRG exempt unit providing psychiatric or rehabilitation service within the same facility, treatment is completed and discharged. Transfer to VA was not possible.	• The full DRG amount for medical/surgical care • For the second DRG exempt unit, the full VA C-T-C amount NOTE, The movement to an excluded unit is considered to be a discharge from medical/surgical care.

3. Payments to DRG Exempt Facilities

The following examples explain when to pay the full VA allowable amount and when to pay per diem rates. DRG exempt facilities are paid using the VA cost-to-charge ratio payment methodology. Please keep in mind that the following examples are based on hospital stays that have been pre-authorized under 38 CFR 17.52 or 17.54.

FOR INPATIENT PREAUTHORIZED CLAIMS ONLY

	If a Veteran is:	**Then the VA allowable amount for the non-VA facility care is:**
1)	Directly admitted to or transferred to a non-VA DRG exempt facility and expired or discharged within 24 hours	The Full VA C-T-C amount
2)	Transferred from VA to a non-VA DRG exempt facility, treatment is completed and Veteran discharged	The Full VA C-T-C amount
3)	Directly admitted to non-VA DRG exempt facility, treatment is completed and discharged	The Full VA C-T-C amount
4)	Transferred by VA to a non-VA DRG exempt facility, then transferred to a second non-VA DRG facility, treatment is completed and discharged	• The VA C-T-C per diem not to exceed the full VA C-T-C amount • For the second non-VA DRG exempt (discharging) facility, the full DRG amount
5)	Admitted to a non-VA DRG exempt facility, stabilized and then transferred to another non-VA facility (VA facilities not available) for continued treatment of the same condition(s), treatment is completed and discharged	• For the admitting non-VA DRG exempt facility, the VA C-T-C per diem not to exceed the full VA C-T-C amount • For the second non-VA (discharging) facility, the full DRG amount
6)	Admitted to a non-VA DRG exempt facility, stabilized and then transferred to another non-VA DRG exempt facility (VA facilities not available) for continued treatment of the same condition(s), treatment is completed	• For the admitting non-VA DRG exempt facility, per diem not to exceed the full VA C-T-C amount • For the second non-VA DRG

	and discharged	exempt (discharging) facility, the full VA C
7)	Admitted directly to a non-VA DRG exempt facility and stabilized but no VA bed available, treatment is completed and discharged	The full VA C-T-C amount
8)	Admitted directly to a non-VA DRG exempt facility and refuses transfer to VA upon stabilization	The VA C-T-C per diem up to the point of stabilization not to exceed the full VA C-T-C amount
9)	Transferred from VA to a non-VA DRG exempt facility and then transferred back to the VA	The VA C-T-C per diem not to exceed the full VA C-T-C amount
10)	Admitted directly to a non-VA DRG exempt facility, stabilized and then transferred to VA	The VA C-T-C per diem not to exceed the full VA C-T-C amount
11)	Receiving VA Contract Nursing Home care, is admitted to non-VA DRG exempt facility from a VA Contract Nursing Home, emergency treatment completed, and transferred to VA (NOT an NHCU or Intermediate Care Unit)	The VA C-T-C per diem not to exceed the full C-T-C amount
12)	Receiving VA Contract Nursing Home, is admitted to non-VA DRG exempt facility from a VA Contract Nursing Home, emergency treatment completed, and discharged back to VA Contract Nursing Home	The full VA C-T-C amount
13)	Admitted from a Community Nursing home (not paid for by VA) to a non-VA DRG exempt facility, discharged back to a Community Nursing Home	The full VA C-T-C amount
14)	Admitted from a Community Nursing home (not paid for by VA) to a non-VA DRG exempt facility, and transferred to VA	The VA C-T-C per diem not to exceed the full C-T-C amount
15)	Transferred from a medical or surgical unit in a non-VA DRG exempt facility to a DRG exempt unit providing psychiatric or	• For the first DRG exempt facility, the VA C-T-C per diem (not to exceed the full C-T-C

	rehabilitation service within the same facility, treatment is completed and discharged. Transfer to VA was not possible.	amount) • For the second DRG exempt unit, the full VA C-T-C amount NOTE: The movement to an excluded unit is considered to be a discharge from medical/surgical care.

4. Payments to Facilities with Federal Waivers

The following examples explain when to pay the full billed charge and when to pay per diem rates for care in non-VA facilities that have been granted a Federal waiver. Please keep in mind that the following examples are based on hospital stays that have been pre-authorized under 38 CFR 17.52 or 17.54.

FOR INPATIENT PREAUTHORIZED CLAIMS ONLY

	If a Veteran is:	**Then the VA allowable amount for the non-VA facility care is:**
1)	Directly admitted or transferred from VA to a non-VA facility granted a federal waiver, treatment is completed and discharged	The full billed charge
2)	Directly admitted or transferred from VA and then transferred to another non-VA facility granted a federal waiver where treatment is completed and discharged or transferred back to VA	The full billed charge
3)	Directly admitted or transferred from VA to a non-VA facility granted a federal waiver and stabilized but no VA bed available, treatment is completed and discharged	The full billed charge
4)	Admitted directly to non-VA facility granted a federal waiver or transferred from VA and refuses transfer to VA upon stabilization	Pay full billed charges for each day through the date of stabilization (but not beyond stabilization date)

Appendix N. Payment for Physician and Non-physician Professional Services

The following guide appears on the Fee Basis intranet web site.

Payment for Physician and Non-physician Professional Services

Introduction

This guide establishes procedures for the payment of claims for non-VA physician and non-physician professional services, including reimbursement of professional and technical components for certain diagnostic tests.

Note: This guide does not provide guidance for the payment of Facility charges (see Payment of Non-VA Outpatient Facility Charges Procedure Guide).

Issue Date

11/20/09
Version 1

Policy for Payment of non-VA Professional Services, Excluding Anesthesia Services

Payment for non-VA physician and non-physician professional services, excluding anesthesia services, associated with outpatient and inpatient care provided at non-VA facilities are paid in the following order:

Pay the contract or negotiated agreement rate.

In the absence of a contract or negotiated agreement, Professional Fees approved under Fee Authority 38 U.S.C. 1703 and 1728 are paid as follows:

Pay the lesser of:
RBRVS rate Billed charges Re-priced claim rate (from re-pricing agent)
When there is no RBRVS rate, pay the lesser of:
Local VA Fee Schedule rate Billed charges Re-priced claim rate
When there is no Local VA Fee Schedule rate, pay the lesser of:
Usual & customary charges[1] Re-priced claim rate

In the absence of a contract or negotiated agreement, Professional Fees approved under Fee Authority 38 USC 1725 are paid as follows:

Pay the lesser of:
70% of the applicable Medicare rate, or
Amount the Veteran is personally liable to the provider

[1] Usual and customary charges are the charges the provider bills the general public for the same services.

Policy for Payment of Non-VA Professional Anesthesia Services

Professional Anesthesia Fees approved under Fee Authority 38 U.S.C. 1703 and 1728 are paid as follows:

Pay the contract or negotiated agreement rate.

In the absence of a contract or negotiated agreement pay the lesser of:

- Local VA Fee Schedule
- Billed charges, or
- Re-priced claim rate

When there is no Local VA Fee Schedule rate, pay the lesser of:

- Usual and customary charges
- Re-priced claim rate

In the absence of a contract or negotiated agreement, Professional Fees approved under Fee Authority 38 USC 1725 are paid as follows:
Pay the lesser of:
70% of the applicable Medicare rate, or
Amount the Veteran is personally liable to the provider

Policy Exclusions

This policy does not apply to the payment of physician and non-physician professional services performed in the state of Alaska.

Who May File a Claim for Professional Services

The following individuals/entities may file a claim:
The provider of care, or his /her agent
The Veteran
A person or organization acting on behalf of the Veteran

Guidelines for Processing Professional Claims

Physician and non-physician services are billed using an applicable CPT/HCPCS code. When a CPT/HCPCS code is input into VistA Fee, the system defaults to an established RBRVS rate, if available; otherwise, it defaults to the VA Fee Schedule amount. In the absence of both a RBRVS and VA Fee Schedule rate VistA Fee prompts, "unable to determine a fee schedule amount," in which case the amount determined to be paid is manually entered.

Prior to entering the payment amount, review the billing form and type of service, and revenue code[2] to distinguish between professional and facility charges. Caution must be exercised not to use the CPT/HCPCS codes for this review, as these codes are appropriately used to bill for both facility and professional services.

After verifying whether the billed service is for a professional or an institutional service, follow the established procedures for processing claims.

[2] Revenue codes are used only on CMS Form 1450.

Continued on next page

Professional and Technical Components

Some professional charges for diagnostic services are comprised of both a professional and technical component. When both the professional and technical components are billed together it is termed the global charge. Caution must be exercised not to pay the global charge when the CPT code without modifier is billed. When reviewing the Veteran Payment History in VistA Fee for possible duplicate payment, the reviewer must look for the base five-digit CPT code with and without modifier to determine if prior payment was made.

The professional component of a procedure is provided by the physician and includes the supervision and/or performance of the test (if any), the interpretation, and the written report.

Modifier “26” indicates that the billed charge is only for the professional component.

The technical component of the procedure includes costs associated with technician salary, equipment, and supplies.

Modifier “TC” indicates that the billed charge is only for the technical component of the service.

[The remainder of the guide pertains to financial processing variables and is omitted. The full guide is available on the Fee Basis web site.]

Appendix O. Payment of Non-VA Outpatient Facility Charges

The following guide appears on the Fee Basis intranet web site.

Payment of Non-VA Outpatient Facility Charges

Introduction to Payment of Outpatient Facility Charges

This topic contains information on the processing of Non-VA outpatient facility charges, including dialysis services, billed on the CMS Form 1450.

Additional information regarding the payment of dialysis claims may be found in VHA Directive 2007-025, Non-VA Dialysis Care.

Change Date 11/20/09 Version 3

Definition of Outpatient Facility Charges

Facility Charges include services that aid the individual health care professional in the treatment of the patient. These charges are usually billed on CMS Form 1450 and include the use of hospital facilities factoring in overhead costs of utilities, billing, equipment, maintenance costs, insurance, nursing staff, etc.

Facility charges include Operating Room, Recovery Room, Emergency Department, Dialysis, Miscellaneous Supplies and Services, and other institutional charges.

Note: *Facility charges are not to be confused with physician and non-physician professional services. Refer to program guide "**Payment for Physician and Non-Physician Professional Services."***

Policy for Payment of Outpatient Facility Charges for Claims Processed under 1703 and 1728

Services purchased by contract or negotiated agreement are paid in accordance with the terms of the agreement.

In the absence of a contract or negotiated agreement payment for outpatient facility charges approved under Fee Authority 38 U.S.C. 1703 and 1728 is the lesser of:

Facility Charges (Including Supplies and Miscellaneous Items)
Local VA Fee Schedule amount
Billed amount not to exceed Usual and Customary charge[1]

Repricer amount
[1] The usual and customary charge is the amount charged by the provider to the general public for the same services

Policy for Payment of Outpatient Facility Charges for Claims Processed under 1725

Payment for Outpatient facility charges approved under Fee Authority 38 U.S.C. 1725 is:

Facility Charges (Including Supplies and Miscellaneous Items)
The lesser of the amount the Veteran is personally liable, or 70% of the Medicare allowable amount under the applicable OPPS or ASC schedule.

Guidelines for Processing Outpatient Facility Charges

VA has not yet adopted Medicare reimbursement methodology that prices outpatient institutional charges for claims processed under 38 U.S.C. 1703 and 1728; however, the majority of health care providers bill in accordance with Medicare guidelines. Consequently, when a health care provider submits a properly coded claim for facility charges VA must make a manual adjustment to the VistA automated payment rate.

For example, when the code used results in payment for the service as a professional fee under the RBRVS rate, or there is no associated CPT/HCPCS code, the services must be entered using a non-specific code when paying facility charges and other related billing services for outpatient procedures performed in a facility. For example, code 99070 that is billed with revenue code 0622, indicating facility charges inappropriately defaults to pay the RBRVS rate.

In accordance with Medicare guidelines, vendors are not required to code certain supplies and services, as some supplies and services do not have an assigned CPT/HCPCS code and other items may be identified by revenue code. When processing facility charges the Fee office will either request that the provider code all line items on the billing invoice where an applicable code is available, or when the provider will not code the claim to VA requirements request HIMS code all un-coded line items on the claim that have an applicable code. Ensure the correct code is used for each line item to prevent improper payment.

For those services and supplies that do not have an available CPT/HCPCS code, CPT code 99070 will be used with the proper revenue code and place of service. To assure correct

reimbursement, all efforts should be made to ensure that the most appropriate and valid CPT code is assigned to the specific line item prior to assigning CPT code 99070, as code 99070 will pay the usual and customary charge.

Note: When compiling the Fee Schedule the supervisor should add/edit the value for 99070 to zero and this will allow VistA Fee to process and correctly pay the line item at the usual and customary charge. The Fee Schedule is compiled annually on the first business day in the month of October. For example, when an institutional claim is processed for a line item without a CPT/HCPCS code, but the item is indeed payable, the data entry in the Fee Medical Program module would be:

Select Service Provided//99070
Revenue Code//270

Caution: The programming logic in the VistA Fee defaults to the RBRVS rate. Because CPT/HCPCS codes are also used to identify professional services, caution must be exercised not to accept the default rate when paying facility charges. When processing facility charges using a CPT/HCPCS code, it is necessary to override the RBRVS rate and enter the lesser of the usual and customary charge, the repricing amount, or the amount calculated using the 75th percentile methodology (local VA Fee Schedule).