

**ARMY MEDICAL EXPENSE AND PERFORMANCE REPORTING SYSTEM  
(MEPRS)**

The Office of The Surgeon General, MEPRS Project Office, Falls Church, Virginia, and the U.S. Army Medical Command, MEPRS Division, Fort Sam Houston, Texas, publishes and distributes the Army MEPRS News Bulletin quarterly by fiscal year (FY) to MEPRS administrators worldwide. We have designed the Army MEPRS News Bulletin to enhance communication within the Army medical treatment facilities.

/signed/  
MICHAEL I. IRELAND  
GM-14  
Army MEPRS Project Officer

/signed/  
GARNET R. DALE  
MAJ, MS  
Chief, MEPRS Division

**DISTRIBUTION:**

Commanders, MEDCOM MEDCENs/MEDDACs  
ATTN: Resource Management

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## **TABLE OF CONTENTS**

**SECTION I: TRISERVICE HAPPENINGS**

**SECTION II: ITEMS OF INTEREST**

**SECTION III: UNIFORM CHART OF ACCOUNTS PERSONNEL  
UTILIZATION SYSTEM (UCAPERS)**

**SECTION IV: ARMY HEALTH CARE FINANCIAL MANAGEMENT  
SYSTEM (AHCFS)**

1. **EASIII 9.0 Release.** The 9.0 release will allow interfacing of workload from Composite Health Care System (CHCS) to Expense Assignment System Version III (EASIII). Below is a very high level overview of what you can expect with this change:

a. The ASD and SAS file contained in the EASIII SAS Detail File are passed to CHCS. This will tell CHCS what codes are valid for EASIII and where to put the workload. This file will be used if you do not want CHCS to pass certain SASs and/or MEPRS code on a particular SAS.

b. Transactions between EASIII and CHCS are monitored nightly, hence, updates may be made to the SAS Detail File on an as needed basis. EASIII prints a log showing the status of files being transmitted.

c. The CHCS may generate multiple files for any given month and pass to EASIII (i.e., workload corrections).

d. For any given SAS, you will not be able to change data against any MEPRS code passed by CHCS. However, you will be able to add nonexistent codes to the SAS (this works in the same method as System Generated SASs in EASIII).

e. Data from CHCS will be brought into EASIII via the Batch Merge process and provide the same functionality that exists with Personnel and Financial.

2. **Breast Cancer Prevention, Diagnosis, And Education Initiative (BCPDEI).** A congressionally mandated program to improve prevention, diagnosis, and education in breast cancer for DOD's women beneficiaries utilizing funds allocated in the FY 96 Defense Authorization Act. This program makes use of \$25 million provided for this purpose (a one time allocation) in the DHP budget. Under the BCPDEI, half the allocated funds will be distributed based on female population in medical treatment facility (MTF) catchment areas. The other half will be allocated based on the merit (as judged by the DOD Breast Cancer Working Group) of regional proposals for educational projects to increase awareness, early detection, and optimal treatment for women beneficiaries. Due to the high visibility of this funding, specific cost account guidance needs to be established in order to accurately track expenditures and capture workload. This funding will be used to set up various Breast Health Centers which will be work centers as defined in MEPRS. The Mobile Education Units (MEUs) in Region 2 will be "moving" work centers; the location in which they are parked will be the workload collection point. The following new MEPRS codes are proposed:

**BCD** - Breast Cancer Prevention, Diagnosis, and Education at MEUs and Station Hospitals.

**BCE** - Breast Cancer Prevention, Diagnosis, and Education at Referral Centers only.

Further guidance on the implementation of the BCPDEI MEPRS Codes is forthcoming with the FY 97 guidance. For the Army, these functions are performed in either the OB/GYN Clinics or the General Surgery Clinics and as it stands, the Army will not use these codes unless separate work centers are established.

**3. Ambulatory Procedure Visit (APV) DGA.** APV refers to a medical or surgical intervention requiring immediate (day of procedure), preprocedure, and immediate postprocedure care in an ambulatory type setting. The APV is determined by the complexity, intensity, and duration of care provided. A licensed or registered care practitioner will be directly involved in the health care intervention related to the AP IAW local standards of care. The total length of time that care is provided in the health care facility is less than 24 hours.

a. Ambulatory Procedure Unit (APU) may refer to more than one location or area within an MTF (MEDCEN, MEDDAC or freestanding outpatient clinic). An AP may occur in any existing inpatient or outpatient setting, without a distinct work center designated as an APU.

b. It is the AMEDDs policy to encourage the efficient use of health care resources consistent with the provision of high quality care. Optimal use of APVs and APUs in all Army MTFs is encouraged in circumstances where it is cost effective, patient outcomes are not compromised, and patient needs are met.

c. The standard of care provided for the AP will be based on guidelines/criteria published by national specialty organizations, e.g., the American College of Surgeons, the Association of Operating Room Nurses, or the American College of Obstetrics and Gynecology. These standards will be implemented IAW local standards of care and practice. The standard of care will be consistent throughout the organization in all practice settings.

d. Freestanding APUs (not attached to an MTF with full inpatient services) will establish emergency and other contingency transfer and transportation arrangements for the AP patient IAW current national, specialty, and local standards of care and practice. Said arrangements with a nearby medical facility capable of treating complications requiring hospitalization or further intervention will be in writing.

#### **4. APV Procedures.**

a. Patient Selection Criteria. The nature of the procedure, the medical status,

2

and/or the assessed nursing needs of the patient generate a requirement for short term (but not inpatient) care. The care of the patient during the AP is more appropriately rendered in a specialized area (such as an APU or extended care area) rather than in the traditional outpatient clinic setting. The AP category is appropriate for all types of

patients for whom the procedure, the anesthesia, and/or the nursing care requirements necessitate preprocedure and/or postprocedure care, observation or assistance.

(1) Each MTF will develop a facility specific list of medical and/or surgical interventions or other care appropriate for management as an AP. This list shall be based on organizational capabilities and existing managed care contractual agreements.

(2) Each MTF will establish AP patient selection and disposition criteria that will be made available to all appropriate health care staff.

(3) All types of anesthesia may be selected for use with an AP, as deemed appropriate by the privileged provider. Anesthetics should be chosen which will allow for patient recovery and release in less than 24 hours.

b. Licensure, Credentialing and Privileging Requirements and Procedures. Requirements and procedures will be IAW AR 40-68, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards and current organizational policy.

c. Quality Management. The MTF Quality Improvement, Risk Management and Utilization Management programs will include the APU(s) and APVs generated within the organization.

d. Pre-AP Testing Requirements. Preprocedural processing, diagnostic testing and consultation or referrals will be IAW established MTF policy.

e. Preoperative and Recover Room Protocols, Staffing and Organization. Policies, procedures and practice will be locally determined and IAW current organizational policy.

f. Disposition and Followup. Each MTF will establish criteria for determining which AP patients require the assistance of a nonmedical attendant and the criteria for patient release postprocedure.

(1) For procedures requiring postprocedure observation or assistance by a responsible nonmedical attendant, the nonmedical attendant will accompany the patient at the conclusion of the AP or upon release from the APU.

3

(2) Patient postprocedural followup processes will be IAW established MTF policy.

g. Medical Records Documentation. Maintenance, coding, and retirement.

(1) Documentation for the AP must meet the standards for a short term stay (abbreviated medical record) and must comply with current JCAHO documentation standards.

(a) Where appropriate, the standard forms (SF), or other forms as noted, are recommended for use in the AP record. At a minimum, the documentation in the medical record will include: a Privacy Act Statement (DD Form 2005); an abbreviated medical record (SF 539); an ongoing, interdisciplinary assessment of patient needs and patient plan of care which includes, but is not limited to: preprocedure and postprocedure patient instructions, to include a brief physician summary of care provided, and Advanced Medical Directives; provider orders (DA Form 4256); other relevant forms, as appropriate: patient procedure or operative consent (SF 522), operative report (SF 516), tissue report (SF 515), anesthesia record (SF517); progress notes (SF 509) and all appropriate therapeutic documentation, to include postprocedure follow-up telephone call; the Medical Record - Emergency Care and Treatment Record (SF 558), if an AP occurs subsequent to treatment in an Emergency Department/ Service; and all diagnostic reports (e.g., laboratory, radiology or electrocardiogram (EKG) reports, etc).

(b) A copy of the patient's postprocedure instructions with a summary of care (e.g., SF 509 or SF 539, etc.) will be forwarded to the health/outpatient treatment record. A mechanism should be in place to ensure that the AP is annotated on the DA Form 5571 (Master Problem List).

(2) The official biostatistical collection of the AP is the Ambulatory Data System (ADS). Providers will select the appropriate ICD-9 (International Classification of Diseases - Ninth Revision - Clinical Modification) diagnoses and the Current Procedural Terminology (CPT) medical procedures and evaluation and management services relevant to the AP. Nursing personnel are responsible for properly annotating any nursing related care and services associated with ADS. The MTF will develop a mechanism for internal tracking of the AP.

(3) The AP will not be Carded for Record Only (CRO). All documentation related to the AP will be filed in a DA Form 3444-series folder, on the left side of the inpatient folder. If there is no existing inpatient record, or the MTF does not provide inpatient services, a DA Form 3444-series folder will be initiated. The folder will be annotated with the patient's name, family member prefix (FMP) and sponsor's social security number (SSN). AP records will be stored in a limited access area of the MTF,

4

e.g., the inpatient records section. The original AP record will not be integrated into the health/outpatient treatment record.

(4) Records will be retired to the National Personnel Records Center IAW AR 25-400-2, policy for retirement of inpatient medical records. MEDCENs will retire records five years after the end of the year of the last inpatient discharge or AP;

MEDDACs will retire records one year after the end of the year of the last inpatient discharge or AP.

h. Medical Expense Performance Reporting System (MEPRS).

(1) For MEPRS accounting purposes, APVs will be identified using a four digit alphanumeric code. The first three digits are the patient's outpatient specialty code. The fourth digit, the number 5, will be added to distinguish this new category of work, e.g., a general surgery AP patient will be coded "BBA5".

(2) If pre-AP processing is accomplished in an AMU or preadmission clinic, in addition to a monthly patient numerical tally, the minutes of service related to the care provided and the type of patient by service (B--5) will be recorded.

i. Billing Procedures.

(1) Current procedures will be followed for Third Party Collection Program (TPCP), Interagency, and International Military Education and Training (IMET) billing. Same day surgery rates applicable to these categories, as prescribed in the annual DOD Medical and Dental Services Reimbursement Rates document, will continue to be used until multiple billing rates are established. A mechanism to track these visits and to identify and document other health insurance will be established at the MTF level.

(2) APVs under the TPCP are billed using automated outpatient billing systems. APVs for IMET and Interagency rates are billed as outpatient visits through the CHCS.

(3) APVs are not admissions to the MTF thus, there will be no local subsistence charge for active duty, retirees or family members.

5. The instructions contained in this document become effective **1 October 1996**.

a. **Ambulatory Nursing Services DGE.** Ambulatory Nursing Services MEPRS Code DGE is effective 1 October 1996. The following functional description is provided:

*NOTE: The functions captured in DGAC - Preadmission Unit are now included in the DGE account.*

5

(1) FUNCTION: Ambulatory Nursing Service provides a centrally managed and coordinated program of nursing assessment and care in an outpatient/ambulatory setting. Therapies include teaching, short term observation, medication/fluid administration, treatment intervention, and nursing assessment. Prepares necessary records to document care provided. Coordinates with the various clinics, services, designated wards, Same Day Surgery/Ambulatory Procedure Visit (SDS/APV) Unit, third party reimbursement coordinator and A&D staff for preadmission/ preprocedure processing when not performed in an APU.

(b) COSTS: This account shall be charged with all the operating expenses incurred in operating and maintaining the function. The aggregate of these expenses shall be ultimately assigned through a stepdown process to referring final operating accounts.

(c) PERFORMANCE FACTOR: Minutes of Service

(d) ASSIGNMENT PROCEDURE: Aggregate expenses shall be assigned based on the ratio of patient minutes of service from each referring account to the total number of patient minutes of service provided by this work center.

**6. Workload Assignment Module (WAM).** A new subsystem in the CHCS 4.5 release. It will serve as the workload reporting module for inpatient, outpatient, and ancillary workload performed by DOD MTFs. The information collected in WAM will be electronically forwarded to the EASIII and compiled into the Medical Expense and Performance Report (MEPR).

a. The WAM integrates EASIII and CHCS databases and alleviates dual entry for data which are a by-product of CHCS. The interface requires a close working relationship between MEPRS, PAD, RAD, LAB, Pharmacy and CHCS personnel to ensure data is accurate and timely. Personnel in each area must have an understanding of the reporting requirements. The Resource Manager and the MEPRS personnel must make the MTF Commander aware of the interface and the importance of the data which is passed to MEPRS and therefore, DOD.

b. The WAMs alpha test site is at the Madigan Army Medical Center. The first phase of testing found disconnects in some of the CHCS database file and table builds necessary to capture workload data accurately from CHCS.

c. To ensure data integrity, MEPRS personnel must be familiar with the files and tables in CHCS, and how they relate to the workload which is passed to EASIII via WAM.

6

d. It is imperative that the DMIS IDs and MEPRS codes are correctly aligned. Incorrect alignment of DMIS IDs and MEPRS codes impacts directly on workload, manpower, and expenses. Please ensure that the DMIS IDs in place at your MTF are currently valid for the work center to which you have them assigned. An example of an invalid DMIS ID might be when two TMCs are combined. The DMIS IDs for the TMCs must be de-activated and a new DMIS ID established for the combined clinic.

e. The following are the steps for ensuring the interface proceeds without major problems:

- (1) Print and review your DMIS ID Table.
  - (2) Print and review your Account Subset Definition (ASD) table.
  - (3) Request a Site Definable MEPRS table from the CHCS Administrator.
  - (4) Request the Division Center DMIS ID code table from the CHCS Administrator.
  - (5) Compare the above tables. The only difference between your ASD and the site definable MEPRS table in CHCS should be the codes YYY, XXX, and the old ICU codes (AAH\_, etc). All other codes not on the ASD but on the site definable MEPRS table should be de-activated by the CHCS administrator. This is also the time to clean up your ASD if it contains MEPRS codes which you are not currently using.
- f. Clean up on the CHCS side can take a bit of work, because some MEPRS codes may be tied to locations which now have to be rearranged.
  - g. Ensure you have the correct DMIS ID to MEPRS code alignment on the ASD.
  - h. Ensure all the DMIS IDs for which you expect to receive workload via WAM are activated on the Division Center DMIS ID table in CHCS. This must include DMIS IDs for DENTAC, as you expect to get workload from pharmacy for the Dental Clinics.

## **SECTION II: ITEMS OF INTEREST**

1. **MEPRS Central.** A multi-user information system that supports the reporting and analysis of financial and operating performance data from DOD MTFs and falls under the umbrella of the Corporate Executive Information System (CEIS). This centralized component supports MTFs, Intermediate Commands, Offices of the Services Surgeons General, and the Office of the Assistant Secretary of Defense for Health Affairs. Vector Research Incorporated was the responsible source for Retrospective Case Mix Analysis

7

System (RCMAS), Resource Analysis Planning System (RAPS), and MEPRS Central. The CEIS Customer Support Division has assumed this responsibility. The management of MEPRS Central and providing customer service is now the responsibility of this office. Customer support includes the issuance of passwords, providing data analysis and interpretations of data elements, performing requested data queries and providing MEPRS information in spreadsheet formats, graphs, and charts. The Customer Support Division's number is 1-800-865-7023.

2. **Medicare Subvention.** The Department of Defense (DOD) has proposed to the Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS), a demonstration where the Medicare program would treat the DOD

and its Military Health Services System (MHSS) as a risk-type health maintenance organization (HMO) for dual eligible Medicare/DOD beneficiaries. Under this agreement, the DOD could continue to maintain its current level of effort in terms of financial commitment to caring for the dual eligible population. Medicare could pay for dual eligible receiving care from the DOD managed care program above DOD's current level of effort.

a. To support/monitor this project, a workgroup has been formed consisting of representatives from MEDCOM Resource Management, PASBA Division, CEIS, MEDCOM Coordinated Care Division, and a representative from OTSG. The workgroup has been created to work the Medicare Demonstration issues basically on a fast track in that the objective is to begin the demonstration on 1 Oct 96, in Regions 6 and 11, and Alaska sometime in the future. This workgroup will relay to the Services and Lead Agents the progress and issues as they are worked into the implementation plan.

b. MEPRS personnel participate as part of the DCSRM. We are mainly responsible for concerns/direction in regards to workload and expense data used to support the initial LOE and the ongoing use of said data at the MTFs.

**3. Borrowed Military Manpower (BMM).** In Newsletter No. 7 we mentioned Health Affairs formed a Borrowed Military Manpower Work Group for the purpose of developing common definitions and methodologies for collecting and reporting BMM data. Health Affairs has not identified the Stepdown Assignment Statistics (SAS) for reporting this data however, the following definitions were developed:

a. Borrowed Labor. All personnel (e.g., Defense Health Program (DHP) and Non-DHP military, civilian, contractor) providing services at an activity other than the activity where they are permanently assigned and/or employed. The service provided is for positions or assignments which would customarily be filled by full-time staff personnel, or which provide temporary services that augment MTF/DTF capabilities on a regularly

8

scheduled basis to satisfy a continuing need (if augmenting services are performed 16 or more hours per month, a separate work center code must be established/utilized). The gaining DHP activity will record this labor as borrowed labor under the applicable work center account.

b. Loaned Labor. All personnel (e.g., DHP and non-DHP military, civilian, contractor) permanently assigned and/or employed at one activity who are temporarily providing services at another activity or supporting DOD or Service contingency operations. The loaning DHP activity will record this labor as loaned under the appropriate Healthcare Service Support "F" account or Readiness "G" account.

**4. Clinical Pharmacists.** Several sites have called regarding pharmacists working in specific specialty clinics. A clinical pharmacist (CP) privileged in the pharmaceutical

care practice field (PCPF) must have specific educational and experiential requirements as specified in Army Regulation 40-48, Chapter 6. When the CP's duties dictate working in a specific clinic specialty, services such as prescription renewals only count as a clinic visit when they include evaluation or treatment of the patient's condition along with proper documentation of the medical record as specified by the Department of Defense definition of a clinic visit. When the pharmaceutical provider initiates new medication orders/prescriptions for those medications deemed appropriate, a clinic visit can count to the CP's assigned clinic specialty, providing his/her clinical privileges and scope of practice include the use of independent judgment to assess the patient's condition and the authority to change the regimen or prescription of care. When the local credentials committee grants the CP privileges for pharmacokinetics consultation services in a specialty clinic, clinic visits are counted based on the same visit requirements of care provided in all clinics. The same rule applies allowing counting of only one visit in the same clinic on the same day for the same episode of care, even if the patient sees more than one provider.

**5. Pind File Transmissions.** Through FY 95 and FY 96, you have continued to transmit your Quarterly PIND File however, the transition from MEQSII to MEQSIII has eliminated this requirement. With your next reporting month, you do not need to transmit your PIND File. Remember, as with MEQS II, MEQS III is very dependent upon each MTF providing timely MEPRS data. The ongoing Medicare Subvention initiative is quite heavily dependent on accurate and timely MEPRS data and our overall reporting statistics are abysmal still. Do whatever it takes to get your report in on time. There are no more excuses!!

**6. Base Operations (BASOPS).** Beginning in FY 97 most of our MEDCOM facilities' base operations will be on a funded or reimbursable fee-for-service basis. This means the negotiated agreements on funding between MEDCOM tenants and host installations will come across on the financial tape. Each Budget Office will send separate Military Interdepartmental. Purchase Request (MIPR) to Department of Public

9

Works (DPW), DOIM, etc., and all obligations and expenses will hit the financial system on a quarterly basis. For MEPRS reporting we will need to divide that number by three to derive a monthly figure. If the expenses are not reported on the October financial tape, you will need to use the previous month. If necessary, make adjustments to the next month; however, do not report "0" for BASOPS. The funding responsibility for BASOPS services remain unchanged for the following facilities, BAMC, Panama, WRAMC, West Point, Japan, Landstuhl, Heidelberg, and Wuerzburg.

### **SECTION III: UNIFORM CHART OF ACCOUNTS PERSONNEL UTILIZATION SYSTEM**

**Civilian Payroll Tape.** Ensure you are reviewing the EAS Accumulator File Listing. Several sites have noticed a substantial increase in their civilian payroll dollars. Credit

amounts appearing on the civilian payroll tape are recognized as debits in UCAPERS; therefore UCAPERS adds this amount overstating the actual pay. We have submitted an ECP to resolve this situation and is included in the October release however, its imperative you review the EAS Accumulator File Listing and make the appropriate adjustments.

#### **SECTION IV: ARMY HEALTH CARE FINANCIAL MANAGEMENT SYSTEM (AHCFMS)**

**Centralized Operating Locations (OPLOCs).** Beginning in FY 97, the finance center operating locations servicing Army MTFs are being centralized at Rome, New York. This will likely be a process spread over the next two or three years and will mean that each MTF will require two different financial data files each month. One will contain current year financial transactions against prior year obligations. The second will contain only current year transactions against current year obligations. As each MTF begins to be serviced by the Rome Financial Center, its former operating location will need to continue issuing the MTFs a file to account for current year transactions against the MTFs prior year obligations. Rome will provide the current year obligations file and Rome will receive the monthly prior year obligations data from the MTF's previous DOIM and integrate the two files into a consolidated monthly STANFINS input for MEPRS. Rome will then provide this merged file, not a tape, to the MTF by the fifth day of the month following the finance month reported. DFAS at Rome, New York will transmit this file directly to your EASIII box. This latest initiative of consolidating Operating Locations (OPLOC) has a direct impact on AHCFMS and you will need to manually input all newly established Account Processing Codes (APCs) into the AHCFMS APC Table.

10

***REMEMBER: ANYTIME FINANCIAL ADJUSTMENTS ARE MADE, YOU MUST RECERTIFY, REEMERGE, AND RETRANSMIT THE DATA, NO MATTER HOW MINOR THE CHANGE. OUR MEPRS DATA IS BEING COMPARED AT ALL LEVELS AND THEREFORE ALL THE DATABASES MUST BE IDENTICAL.***

