Defense Health Agency

PROCEDURES MANUAL

NUMBER 6010.13 Volume 1
September 27, 2018

J-1

SUBJECT: Medical Expense and Performance Reporting System (MEPRS) for Fixed Military Medical and Dental Treatment Facilities (DTFs): Business Rules

References: See Enclosure 1.

1. PURPOSE. This Defense Health Agency-Procedures Manual (DHA-PM), based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (ae), establishes the Defense Health Agency's (DHA) procedures to:

a. Provide a uniform and standardized system of healthcare managerial cost accounting for the Military Health System (MHS) and the MEPRS. MEPRS:

(1) Provides detailed uniform performance indicators, common expense classification by work center/cost center, uniform reporting of personnel utilization data by work centers, and a labor cost assignment methodology.

(2) Methodology provides consistent performance data to managers responsible for healthcare delivery in support of dual Warfighter Support Operations and integrated Tri-Service healthcare missions.

(3) Defines a set of functional work centers/cost centers, applies a uniform performance measurement system, prescribes a cost assignment methodology, and obtains reported information in standard formats for fixed Military Medical Treatment Facilities (MTFs) and fixed Military DTFs. Resource and performance data must reflect the resources used in delivering healthcare services and also comply with MEPRS functional work/cost center requirements. Data must be complete, accurate, and timely, and in sufficient detail to permit review and audit by management at all levels of the Health Affairs (HA) and DHA organizations.

b. Prescribes the standardized procedures, business rules, service units, allocation factors and guidelines for the uniform reporting of expense, labor/personnel, and/or output data for fixed military medical and DTFs.

c. Cancels and along with DHA Procedures Manual "Medical Expense and Performance Reporting System (MEPRS) Procedures Manual for Fixed Military Medical and Dental Treatment Facilities Uniform Chart of Accounts, Volume 2," September 27, 2018 (Reference (e)) reissues DoD 6010.13-M, "Medical Expense and Performance Reporting System for Fixed Military MTFs and DTFs," April 7, 2008 (hereby canceled) (Reference (f)).

2. APPLICABILITY. This DHA-PM:

a. Applies to:

(1) The OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff, the Combatant Commands, the Office of the Inspector General of the DoD, the Defense agencies, the DoD Field Activities, and all other organizational entities in DoD (hereafter referred to collectively as the "DoD Components").

(2) Fixed MTFs and DTFs that are funded by the Defense Health Program and produce direct patient care workload will transmit MEPRS data in accordance with this DHA-PM. Waiver requests from MEPRS reporting should be sent by the Service Medical Chief Financial Officer and approved by the DHA Administration and Management Directorate (J1), Trust Fund and Revenue Cycle Management Division and the Assistant Secretary of Defense for Health Affairs (ASD(HA))/Health Budgets and Financial Policy Office.

b. Does not apply to:

(1) DoD facilities that are not involved in direct patient care performed at fixed MTFs and DTFs; such as, medical research facilities, installation line unit battalion aide stations, DoD facilities for field service (e.g., force combat support and evacuation hospitals), facilities afloat (e.g., hospital ships and sick bays aboard ships), and tactical casualty staging facilities (e.g., medical advance base staging facilities and medical advance base components contained within mobile-type units).

(2) DoD facilities that are not part of the fixed MTF/DTF direct patient care mission and organizations and should not report any data in the unique fixed MTF/DTF identifiers (e.g., Defense Medical Information System Identification (DMIS ID) code, MEPRS codes, financial Fund Centers, etc.).

3. POLICY IMPLEMENTATION. The MHS must have budgetary accounting, and cost management policies and practices that ensure the DHP is compliant with References (a), (b), and (d) through (ae). MEPRS provides a uniform and standard labor, and expense reporting system for all fixed military MTFs and DTFs (see Reference (d)).

a. In accordance with, Reference (k), MEPRS supports fixed MTFs/DTFs within the MHS in approximating and reporting full cost of resources used to produce output by responsibility segments/functional cost centers. The full cost data derived from MEPRS may be used by the

department in developing the actuarial liability estimates for the Military Retirement Health Benefits Liability in the Other Defense Organization General Funds. This information is included in the department's annual agency-wide audited financial statements.

b. MEPRS Management Cost Accounting shall be in accordance with Reference (l). It explains:

"Essential to any discussion regarding cost information collection understands the difference between budgetary accounting and cost accounting. In any given year, the obligations and outlays incurred may be less than, equal to, or greater than the costs recognized for that period. Costs represent resources used or consumed to accomplish a given cost objective. The types of resources consumed may include period outlays for labor and material, while costs may be recognized for the facility at which the work is performed. For example, depreciation costs related to the facility represent a cost to the accounting period and should be allocated to appropriate products/services even though depreciation costs have no impact to the budgetary accounts. Costing is not concerned with the funds used to execute an action, but with the resources (people, supplies, equipment, and so forth) used to complete the action. In budgetary accounting, organizations use allocated funds to acquire inventory and fund employee salaries plus benefits as well as record budgetary obligations to account for the use of the appropriated and allotted funding" (see References (j) through (p)).

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. See Enclosure 3.

6. INFORMATION REQUIREMENTS

a. Information Requirements. MEPRS data transmitted to the Expense Assignment System (EAS), version IV, Repository as described in this DHA-PM, Enclosure 3, paragraphs 1.j. through o., are exempt from licensing in accordance with Reference (g), Enclosure 3, paragraph 1.b.(10).

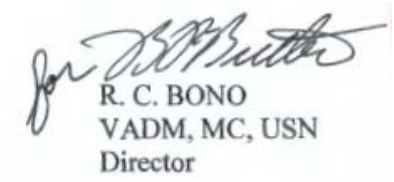
b. Standardization Compliance. In accordance with Reference (h), EAS IV adheres to applicable standards and specifications as cited in the DoD Information Technology (IT) Standards Registry (accessible at: https://gtg.csd.disa.mil), or any future DoD-designated registry for IT and data sharing standards. Authoritative data sources are registered in the DoD Data Services Environment (accessible at: https://metadata.ces.mil/dse). The DHA Solutions Delivery Division, EAS IV Program Office will ensure data, information, and IT services interoperability by making data assets understandable and enabling the reuse of business and mission processes in compliance with established technical, data, and services standards in line with Reference (i).

7. RELEASABILITY. **Cleared for public release**. This DHA-PM is available on the Internet from the Health.mil site at: www.health.mil/DHAPublications.

8. EFFECTIVE DATE. This DHA-PM:

a. Is effective upon signature.

b. Will expire 10 years from the date of signature if it has not been reissued or cancelled before this date in accordance with DHA-Procedural Instruction 5025.01 (Reference (c)).



Enclosures
1. References
2. Responsibilities
3. Procedures

Appendices
1. Medical Expense and Performance Reporting System DoD Skill Type and Suffix Codes
2. Medical Expense and Performance Reporting System Business Rules for Calculation Full-Time Equivalents
3. Reporting Available and Non-Available Time
4. Expense Assignment System IV Assignment Sequence Number
5. Expense Assignment System IV Data Set System Requirements
6. Expense Assignment System IV Business Rules for 'A' – 'Inpatient', 'B' – 'Outpatient', and 'C' – Dental Functional Cost Codes
7. Expense Assignment System IV Business Rules for 'D' – Ancillary Functional Cost Codes
8. Expense Assignment System IV Business Rules for 'E' – Special Support Services' Functional Cost Codes
9. Expense Assignment System IV Business Rules for 'F' – Special Program and 'G' – Readiness Functional Cost Codes
10. Training Programs
11. Medical Expense and Performance Reporting System Issue Resolution

Glossary

TABLE OF CONTENTS

TABLES

ENCLOSURE 1

REFERENCES

(a) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, as amended
(b) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013
(c) DHA-Procedural Instruction 5025.01, "Publication System," August 21, 2015, as amended
(d) DoD Directive 6000.12E, "Health Service Support," January 6, 2011, as amended
(e) DHA-Procedures Manual 6010.13, "Medical Expense and Performance Reporting System for Fixed Military MTFs and DTFs: Uniform Chart of Accounts, Volume 2," September 27, 2018
(f) DoD 6010.13-M, "Medical Expense and Performance Reporting System for Fixed Military MTFs and DTFs," April 7, 2008 (hereby canceled)
(g) DoD 8910.01-M, "Department of Defense Information Collections Manual: Procedures for DoD Internal Information Collections, Volume 1," June 30, 2014, as amended
(h) DoD Instruction 8320.02, "Sharing Data, Information, and Information Technology (IT) Services in the Department of Defense," August 5, 2013
(i) DoD Chief Information Officer Memorandum, "Department of Defense Information Enterprise Architecture," Version 2.0, August 10, 2012
(j) DHA-TM 7220.01, "Defense Health Program (DHP) Common Cost Accounting (CCAS) Guidance," April 29, 2016
(k) Standards and Other Pronouncements, "Statement of Federal Financial Accounting Standards 4: Managerial Cost Accounting Standards and Concepts," June 30, 2015[1], as amended
(l) DoD 7000.14-R, "Department of Defense Financial Management Regulations (FMR)," Volume 4, Accounting Policy, Chapter 19 – Managerial Cost Accounting, current edition
(m) DoD 7000.14-R, "Department of Defense Financial Management Regulations (FMRs)," Glossary, and Volumes 1, 2A, 3, 4, 6A, 10, 11A, and 11B, current edition
(n) DoD 7000.14-R, "Department of Defense Financial Management Regulations (FMR)," Volume 12, Chapter 21, Accounting for Defense Health Program Resources, and Appendix A, DHP Budget Activity 1, Operation and Maintenance, Budget Activity Groups (BAG) and Corresponding Program Element (PE) Structure, current edition
(o) Office of Management and Budget Circular A-123, "Management's Responsibility for Internal Control," December 21, 2004
(p) Office of Management and Budget Circular A-11, Section 83 - Object Classification, "Preparation, Submission, and Execution of the Budget," June 2015
(q) DoD Instruction 6040.40, "Military Health System Data Quality Management Control Procedures," November 26, 2002
(r) DoD Instruction 4000.19, "Support Agreements," current edition
(s) United States Code, Title 10, Chapter 169, Sections 2801-2814

[1]This reference is available at: http://files.fasab.gov/pdffiles/2015_fasab_handbook.pdf
[2]This reference is available at: http://comptroller.defense.gov/Financial-Management/Reports/rates/

(t) Under Secretary of Defense (Comptroller) Web Site, "Military Personnel Composite Standard Pay/Reimbursement Rates[2]
(u) Joint Federal Travel Regulations, Volumes 1 and 2, "Uniformed Service Members," and "Department of Defense Civilian Personnel," current edition
(v) DoD 7000.14-R, "Department of Defense Financial Management Regulations (FMR)," Code of Federal Regulations, Title 48 – Federal Acquisition, Subpart 237.1 – Service Contracts – General, revised December 11, 2014
(w) DoD Instruction 6025.05, "Personal Services Contracts (PSCs) for Health Care Providers (HCPs)," January 6, 1995
(x) United States Code, Title 10, Section 1091
(y) Defense Health Agency, Office of the Chief Financial Officer, Business and Economic Analysis Division, "Military Health System Coding Guidance: Professional Services and Specialty Coding," current edition
(z) Health Care Financing Administration Ruling 87-3, April 27, 1987, CMS Pub. 15-1 §2205.2, Counting Patient Days for Maternity Patients
(aa) Federal Register - 68 Fed. Reg. 45346, 45419-20 (August 1, 2003, (adding 42 C.F.R. §412.106 (a)(1)(ii)(B))
(ab) DoD Instruction 5000.64, "Accountability and Management of DoD Equipment and Other Accountable Property," May 19, 2011
(ac) DoD Instruction 3110.06, "War Reserve Material Policy," current edition
(ad) Joint Publication 1-02, "Department of Defense Dictionary of Military and Associated Terms," current edition
(ae) United States Code, Title 31, Sections 1101, 1341 and 1517

ENCLOSURE 2

RESPONSIBILITIES

1. USD(P&R). The USD(P&R) will provide general policy guidance and instruction on manpower management to DoD Components.

2. ASD(HA). Under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness (USD(P&R)), the ASD(HA) issues MHS-level guidance to the Military Departments and the DHA and provides oversight to ensure that fixed MTF/DTF direct patient care operations comply with existing federal laws and regulations.

3. UNDER SECRETARY OF DEFENSE (COMPTROLLER) (USD(C)). The USD(C) will provide policy guidance and instruction to DoD healthcare and readiness resources within the DoD.

4. DIRECTOR, DHA. Under the authority, direction, and control of the ASD(HA), the Director, DHA, will:

a. Issue supplemental MHS-level guidance to the Military Departments and the DHA and exercises management responsibility to ensure that fixed MTF/DTF direct care operations are cost-effective and comply with existing federal laws and regulations.

b. Facilitate effectiveness and efficiency by providing automated information systems that support successful management and reporting of the MEPRS by fixed MTFs/DTFs.

c. Establish a systematic process by which the Military Departments and DHA can jointly evaluate and implement policy recommendations, program changes, and automated information systems, thereby reducing inconsistency and facilitating standardization.

d. Maintain a database of all Military Department and DHA-specific guidance issued to implement this DHA-PM and ensure that such guidance is consistent with the provisions set forth herein.

e. Ensure MHS business practice standardization guidance and policy issued for Common Cost Accounting Systems, to include procedural compliance for accurate and full managerial cost accounting and cost allocation for standardized MEPRS reporting (References (j) through (n)).

f. Exercise management, direction, and maintenance of the MEPRS program within the DoD.

5. DHA MEPRS PROGRAM MANAGER. Under the Authority, direction, and control of the ASD(HA), the DHA MEPRS Program Manager will be responsible for overall program management, oversight, and administration of the MEPRS Financial and Performance Reporting System (FPRS) Improvement Group and MHS MEPRS reporting for fixed MTFs/DTFs.

6. FPRS GROUP. As the functional proponent for the DoD MEPRS program, FPRS will be responsible for the development, implementation, management, and integration of MEPRS policies, procedures, business practices, and system requirements. The FPRS operates under the auspices of the DHA Medical Business Operations Group (MBOG) and, through the FPRS charter, is empowered to jointly resolve Tri-Service issues in favor of a single, standard, and binding MHS solution.

7. SECTIONS 1–6. All principals mentioned in this section will coordinate their efforts to ensure that MEPRS is consistently implemented and integrated into existing management systems. The DoD Components will implement the provisions of this DHA PM, and collect and report uniform, comparable data.

ENCLOSURE 3

PROCEDURES

1. GENERAL BUSINESS RULES AND GUIDELINES

a. MEPRS provides the DoD with a uniform system for managerial cost accounting and reporting on the fixed military MTF/DTF healthcare funded programs and supporting activities, such as free receipts.

b. The MEPRS Manual provides guidance to ensure consistent identification, recording, and reporting of expense and performance data from fixed MTFs/DTFs. MEPRS information assists in measuring productivity and management effectiveness, developing performance standards, developing program estimating equations, and business planning opportunities.

c. The MEPRS methodology provides consistent performance data to managers responsible for healthcare delivery in support of dual Warfighter Support Operations and integrated Tri-Service healthcare missions.

d. MEPRS defines a set of functional work centers/cost centers, applies uniform performance indicators and a measurement system, provides common expense classification by work center/cost center, provides a uniform reporting of personnel utilization data by work centers/cost centers with a labor cost assignment methodology, prescribes a cost assignment methodology, and obtains reported information in standard formats for fixed MTFs/DTFs. Resource and performance data must reflect the resources used in delivering healthcare services and also comply with MEPRS functional work/cost center requirements. Data must be complete, accurate, and timely, and in sufficient detail to permit review and audit by management.

e. In accordance with Reference (k), MEPRS supports fixed MTFs/DTFs within the MHS in approximating and reporting full cost of resources used to produce output by responsibility segments/functional cost centers. The full cost data derived from MEPRS may be used by the department in developing the actuarial liability estimates for the Military Retirement Health Benefits Liability in the Other Defense Organization General Funds. This information is included in the department's annual agency-wide audited financial statements.

f. MEPRS Management Cost Accounting shall be in accordance with Reference (l). It explains:

> "Essential to any discussion regarding cost information collection understands the difference between budgetary accounting and cost accounting. In any given year, the obligations and outlays incurred may be less than, equal to, or greater than the costs recognized for that period. Costs represent resources used or consumed to accomplish a given cost objective. The types of resources consumed may include period outlays for labor and material, while costs may be recognized for the facility at which the work is performed. For example, depreciation costs related to the facility represent a cost to the

accounting period and should be allocated to appropriate products/services even though depreciation costs have no impact to the budgetary accounts. Costing is not concerned with the funds used to execute an action, but with the resources (people, supplies, equipment, and so forth) used to complete the action. In budgetary accounting, organizations use allocated funds to acquire inventory and fund employee salaries plus benefits as well as record budgetary obligations to account for the use of the appropriated and allotted funding" (References (j) through (p)).

g. The MEPRS Expense Assignment System (EAS) is programmed to report only expenses which supports accurate accrual-based accounting for full costing of fixed MTFs/DTFs. If revenues, public collections, accounts receivable, balance sheet, etc. (non-expense) financial transactions are imported into the EAS system, these transactions are automatically converted to reflect expenses. In compliance with full managerial cost accounting principles, income and revenue should *not* be netted against valid expenses imported into the EAS system since this will result in understated and distorted full costing. For this reason, the Services should exercise care to ensure that only financial expense transactions are interfaced and imported into the EAS system (References (j) through (p)).

h. Reference (o) defines management controls as the organization's, policies, and procedures used to reasonably ensure that programs achieve their intended results, resources are used consistent with the mission of the agency, and reliable and timely information is obtained, maintained, reported, and used for decision-making. The systems that provide data for MEPRS should meet the standards for this regulation through the implementation of detailed guidance, compliance metrics, and reconciliation procedures (Reference (q)).

i. The Service Surgeons General of the Army, Navy, Air Force, and the Director, National Capital Region Medical Directorate will identify their respective MEPRS reporting facilities and ensure compliance with the requirements of this DHA-PM for the preparation and submission of DoD MEPRS data by designated reporting MTFs to ASD(HA).

j. Each medical center, hospital, and dental center is required to transmit EAS data on a monthly basis. Clinics that are subordinate organizational entities to a reporting medical center, hospital, or dental center are not required to submit separate reports since their workload, labor hours, and expense statistics will be included with the parent reporting facility's expense and workload data. Each fixed MTF will report data for their core child subordinate facilities as well as their external partnership agreements. External partnership agreement entities will be identified via a DMIS ID and will report specific data in accordance with ASD (HA) requirements. Each clinic that is not a subordinate entity to a reporting activity shall separately submit their EAS data monthly. All MEPRS reporting will be in compliance with paragraph 2.a. and b. above in the Applicability section.

k. Each MEPRS reporting facility will transmit EAS IV Application monthly MEPRS data files to the EAS IV Repository within 45 days of the end of the reported month. When changes to data in EAS affect the data previously reported, the changes (based on Service Headquarters direction) shall be retransmitted to ASD(HA).

l. Workload, financial, and personnel data shall be reconciled prior to submission of the data in accordance with Service and/or ASD(HA) guidelines. MEPRS reconciliation shall be auditable to source system records for workload, financial, and personnel data. Manually entered data (e.g., depreciation) shall be auditable to source system records and other supporting documents under the guidelines of Reference (q). Information used in the reconciliation of MEPRS data will be maintained for 5 years.

m. The MEPRS reported data will be reviewed under the guidelines of Reference (q), to support monthly completion of the MTF Commander's Data Quality Statement. Minimum support includes validation of financial and workload reconciliation, compliance with the reporting requirement identified in Enclosure 3, and paragraph 1.j. of this DHA-PM and review of specified summary data outliers and expense allocation tests for accuracy.

n. MEPRS end-users are encouraged to review these policies, procedures, and business practices and provide input to support data quality management, continuous process improvements, business process re-engineering, and change management. Issues associated with MEPRS should always be resolved at the lowest level within the organization and changes communicated throughout the Service command and across the MHS.

o. Six months before a base close, before a fixed MTF/DTF closes, and/or before a fixed MTF/DTF DMIS ID will no longer be reported in MEPRS, the facility should submit a memorandum through Military Service Headquarters to ASD(HA) and DHA requesting consideration to terminate MEPRS reporting requirements.

p. Requests for information, clarification or interpretation, or changes to this DHA-PM will be submitted to the ASD(HA) and DHA. Deviations from this DHA-PM must be submitted for approval to ASD(HA) and DHA after coordinating the overall effect of the deviation with the Military Services. Other issues, such as proposed modifications to this DHA-PM, should be submitted in accordance with Enclosure 3, and paragraph 7 of this DHA-PM.

2. UNIFORM CHART OF FUNCTIONAL COST CODE (FCC) ACCOUNT CATEGORIES

a. FCC. FCC is a standard cost accounting element that uniformly labels a work/cost center in the DoD MHS with a four-digit alphanumeric code. FCCs are commonly referred to as MEPRS codes. All workload, expense, and full-time equivalent (FTE) data reported in MEPRS must be aligned to an FCC. An FCC shows aggregated workload, expenses, and/or FTEs at the functional category (first level), summary account (second level), and sub-account (third level). Functional descriptions of authorized reporting in each FCC is available in Reference (e). Refer to Appendix 5 of this DHA-PM for a listing of FCCs at the third-level that require advance DHA and Military Service headquarters approval.

b. Fourth-Level FCC. The purpose of fourth-level FCC is not intended to track a type of workload or program. The fourth-level FCC is provided to enhance the utility and flexibility of the FCC account structure and to support accurate cost allocation and cost accounting for each

fixed MTF/DTF. DHA does not generally prescribe standard fourth-level FCC codes, but may coordinate with the Service headquarters a standardized fourth-level FCC code for MHS Enterprise changes that do not require a unique third-level FCC. Only the Military Service headquarters can determine and approve the use of site-specific fourth-level codes for remote facilities. Although the MTF can add fourth-level FCCs to the EAS IV Application Software at the site level, only the Military Service headquarters can determine and approve the use of site-specific fourth-level FCC codes. FCC codes are arranged in functional categories based on the hierarchy of accounts in which all expenses, FTEs, and/or corresponding performance data are collected to support accurate cost allocation. Performance data reported in MEPRS represents the amount of work/performance produced in a functional activity or work center as measured by a service unit and/or allocation factor. See Table 5 of this enclosure for authorized service unit and allocation factors reported in MEPRS. See Enclosure 3, Appendices 6 through 8, of this DHA-PM for unique service unit and allocation factor criteria, business rules, and calculation methodologies. Fourth-level FCCs are assigned for work centers that meet the criteria of a valid work center as determined and/or standardized by the Service MEPRS Program Office. Fourth-level FCCs assigned for a physical work center must meet specific criteria that are not required for a cost center. The creation of a fourth-level FCC for the purposes of tracking a type of workload or program is not authorized because it distorts all cost accounting and cost allocation reported for the MHS Enterprise.

(1) Cost Center Fourth-Level FCC. A cost center fourth-level FCC is a logical or physical grouping of one or more similar services for the purpose of identifying obligations or developing the cost identification for services. Services are grouped into FCC cost codes to identify expended resources to produce a unit of work and/or segregate costs for management to assess efficiency and usage, examine trends, etc. An example of a cost center is the FCD - Support to Other Military Medical Activities FCC that may accumulate expenses and/or FTEs but does not represent a physical work center and does not have a measurable workload output measured by either a service unit or allocation factor in MEPRS.

(2) Work Center Fourth-Level FCC. A work center fourth-level FCC is a discrete functional or organizational subdivision of an MTF for which provision is made to collect and measure its expenses and determine its workload performance. The total operating cost of the MEPRS final account or average cost per output should be compared with previous processing periods to determine trends and validate anomalies. Identified cost variances should be investigated and documented. The minimum work centers for a facility are established by meeting specific criteria and using the prescribed FCCs as described in Reference (e), Enclosure 3. MTFs are not authorized to create new FCCs for work centers without coordination and approval from the Service MEPRS Program Office.

(a) A work center will be established when the MEPRS reporting facility requires the performance of a function that is assigned or authorized by higher medical authority, manpower (staffing) is assigned, physical space is designated to accomplish the function, and workload is generated. Creating fourth-level MEPRS codes for any purpose other than their intended goal with recommended criteria will create distorted costing of patient care by fourth-level FCC. Generally, the following criteria should be considered for establishing a work center FCC:

1. Normally operates 16 hours or more each month.

2. Has identifiable direct expenses and obligations in the source financial system; e.g., personnel, contracts, supplies, equipment, etc.

3. Has allocated physical space. The same space (square footage) cannot be reported in more than one fourth-level FCC in the same month.

4. Has allocated or assigned manpower. Such staffing may or may not be authorized on the facility manning or staffing documents. In the areas of inpatient, outpatient, and dental care, this means that the medical or dental specialty or subspecialty is assigned.

5. Has a valid work output.

6. Uses a valid workload measure.

7. Service provided, or expenses incurred are unique when compared to other established work centers.

8. Is compatible with the MTF organizational structure.

9. Facilitates the management decision-making process.

(b) A work center shall be established, and expenses identified and reported when the aforementioned criteria are established. Exceptions to the criteria above are FCCs established to accumulate expenses only, such as depreciation accounts, base operations accounts, and indirect cost pools.

c. FCC Categories. The FCC categories for the MEPRS Chart of Accounts used for full cost reporting are shown below. Except for changes made by DHA, these FCC account codes may not be altered or modified at the first, second, or third levels. See Reference (e), Enclosure 3 for all detailed FCC functional descriptions.

(1) A - Inpatient Care

(2) B - Outpatient Care

(3) C - Dental Care

(4) D - Ancillary Services

(5) E - Support Services

(6) F - Special Programs

(7) G – Readiness

d. FCC Summary and Sub-Accounts. Each of the functional categories is further divided into summary accounts and sub-accounts. The sub-accounts are collected into their corresponding summary account. An example of this hierarchical arrangement is provided below:

A	Inpatient Care	(functional category)	1st level FCC
AA	Inpatient Medical Care	(summary account)	2nd level FCC
AAA	Inpatient Internal Medicine	(sub-account)	3rd level FCC
AAB	Inpatient Cardiology	(sub-account)	3rd level FCC

e. Final and Intermediate FCC Accounts. Inpatient Care (A), Outpatient Care (B), Dental Care (C), Special Programs (F), and Readiness (G) are final operating expense accounts. Ancillary Services (D) and Support Services (E) are intermediate operating accounts.

f. "Z" Coding Conventions. Occasionally an MTF will have a clinic or activity that does not fall into a standard FCC account. In such cases, interim, or "Z," codes may be used at the third level. These codes are designed to allow the system to accommodate new specialties while new permanent codes are being established. By convention, codes that are "not elsewhere classified" are identified with a "Z" at the third level. The Military Service headquarters, in coordination with the DHA MEPRS Program Office, must approve the use of "Z" codes. Coordination with DHA shall include a brief description of the specialty or service, and the expected or projected time frame for "Z" code usage. Refer to Appendix 5 of this DHA-PM for a listing of FCCs with a 'Z' at the third-level that require advance approval.

3. EXPENSE ALLOCATION METHODOLOGY AND DIRECT EXPENSES

a. Expense Allocation. Expense allocation is also referred to as "stepdown" which is the reassignment of expenses of intermediate operating expense accounts to the final operating expense accounts on the basis of assignment procedures that measure the amount of services rendered by intermediate work centers to the other work centers. The expense allocation methodology distributes expenses by using a rigid hierarchy of intermediate accounts to allocate operating costs to the final accounts.

b. Operating expenses. Operating expenses are the value, measured in dollars, of the transactions and events of work centers. Each work center accumulates operating expenses with a specific definition provided for the function(s) included in each operating expense account. Operating expenses may be "final" or "intermediate," depending on whether or not the account is the final expense accumulation point (inpatient, outpatient, dental, or special programs) in the system, or is further assigned (ancillary or support) to a final operating expense account. Operating expenses may also be classified as "direct" or "indirect."

(1) Direct operating expenses. Direct operating expenses are the expenses identified specifically with a particular work center. This is all expenses incurred in operating and maintaining the clinic, such as expenses for personnel, supplies, and any other expenses identified directly in support of each work center and/or cost center by FCC (Reference (j)).

(2) Indirect operating expenses. Indirect operating expenses are the expenses identified with two or more work centers, but not identified specifically with any particular work center. Indirect expenses should not be reported as a direct operating expense for a work center by FCC; for example, maintenance of specific room/space in a building room should not be expensed directly to a clinical work center by FCC. As an example, the base support (BASOPS) obligations and expenses described in the ED* BASOPS FCCs should never be directly charged to any other FCCs since these are indirect overhead FCCs with specific allocation business rules (References (e), (j), (r), and (s)). When indirect overhead expenses are reported directly to a work center by FCC, the expenses for that work center are distorted, and the cost of patient care for that specialty is inflated during expense allocation.

c. Free receipt expenses. Free receipt expenses are included in the expense allocation process. Free receipt expenses are for goods, services, or equipment provided to a fixed MTF/DTF and not financed from that activity's operating budget. Free Receipts do not result in an issuance of a Standard Form 1080, "Voucher for Transfer Between Appropriations or Funds," or other similar fund transfer document by the providing activity or in a decrease in available obligation authority of the receiver.

(1) Obligations. Obligations are created by any act that legally binds the Government to make a payment. An obligation is a legal reservation of funds and is properly recordable only when supported by documentary evidence. All obligations related to the operational expenses interfaced and imported into EAS IV should also be interfaced and imported into EAS IV. EAS IV uses the operational expenses for cost allocation, and EAS IV does not use obligations during the cost allocation process.

(2) Free receipt entries. Free receipt entries for obligations shall not be manually recorded in EAS IV. Only manual free receipt entries for expenses shall be reported in EAS IV.

d. Stepdown expense assignment. Stepdown expense assignment is the cost allocation methodology used to determine total operating costs for each final account. The stepdown ensures that the full cost of providing a service is appropriately captured and reported. This method of cost assignment uses direct expenses, direct labor hours, and allocation factor data to allocate indirect costs from intermediary accounts in determining the final operating cost for a specific work center/cost center. Allocation factors are used to allocate expenses from indirect intermediate FCC accounts and cost pool FCCs to final FCC accounts. Data sets are used to collect outputs and/or allocation factors used in MEPRS EAS allocation processing to the final MEPRS accounts (see Appendix 5, Table 5 of this enclosure).

e. Purification. Purification is the redistribution of direct expenses and FTEs associated with a cost pool. Cost pools in MEPRS are purified in alphabetical order as the first step during allocation. Each cost pool must have an assigned data set referenced on the Account Subset

Definition (ASD). The cost pool expenses and FTEs are distributed based on the common allocation factor ratios for each account described on the cost pool data set.

(1) Cost pools are necessary for an inpatient ward location. Ward locations provide clinical specialty services to inpatient, ambulatory procedure visit (APV), and observation patients. The expenses and FTEs are apportioned to final accounts based on approved allocation factors reported in the EAS IV inpatient ward FCC data set. In addition, cost pools may be used when multiple work/cost centers use shared resources that are not easily directly attributed to a particular work/cost center. In these cases, allocation factors are defined to apportion resources to the benefiting work/cost centers.

(2) In some situations, expenses cannot be assigned to specific FCC accounts, but are known to be incurred by a limited number of work centers or specialties. In those cases, a cost pool shall be established. For example, the specialties in the inpatient Ward 3E (shown below) share equipment, a supply closet, and nursing staff. The actual use of supplies from the closet, use of the equipment, and the actual support from the inpatient ward nursing staff cannot be practically determined. A cost pool is set up for the inpatient ward 3E. Those costs that are incurred on behalf of individual patient specialties should be charged directly to the inpatient ward cost pool FCC, so those costs will be reported in the flow to the inpatient Ward 3E cost pool FCC.

(3) After all costs have been assigned to an inpatient ward cost pool FCC, the cost pool expenses and/or FTEs are distributed among the inpatient and outpatient specialties based on the ratio of each specialty's Minutes of Service to the Total Minutes of Service for that FCC cost pool. As an example, below is a view of the Inpatient Surgical Ward 3E (ABXA) FCC Data Set with the list of Pure FCCs entered in the EAS VI dataset 'Includes' list. The amount of expense and FTEs purified/allocated to each of the Pure FCCs listed in the 'Includes' list is determined by the number of minutes of service entered for each Pure FCC specialty in the ABX FCC dataset. (see Appendix 6, Table 6 of this enclosure for the Business Rule Matrix on reporting inpatient ward minutes of service.)

Specialty	**Pure FCCs**
General Surgery	ABAA
Plastic Surgery	ABIA
Urology	ABKA
General Surgery Same Day Surgery	BBA5

(a) By convention, cost pool FCCs are identified by an “X” at the third level followed by a 4th character. In the example above, the cost pool FCC for Inpatient Surgical Ward 3E is identified with the ABXA FCC. Another inpatient ward, 4W, which is primarily a medical inpatient ward, may use AAXA Inpatient Medical Ward 4W as an FCC. Inpatient Ward 4E (also a medical inpatient ward) may use the AAXB Inpatient Medical Specialty Ward AAXB FCC, and so on. Cost pools are the only FCCs that have an “X” used at the third level of the FCC. An FCC that does not have an ‘X’ at the third-level is commonly referred to as a pure clinical specialty FCC.

(b) Support to cost pools cannot be reported by ancillary services except for ward and clinic issues by Central Sterile Supply and Pharmacy.

(c) Physicians and Dentists (skill type 1 personnel) shall not charge their time or salary expenses to any cost pool or Intensive Care Units (ICUs) FCCs. The attending physician's and dentist's time and expenses shall always be charged directly to the pure clinical specialty FCC.

(4) Assignment procedure for cost pools involves expenses and FTEs of shared performing specialties shall be redistributed during the purification step of the expense allocation process based on designated allocation factors. Reference Appendix 5, Table 5 of this enclosure for cost pool allocation factors). Cost pools are purified in alphabetical order before the redistribution of the intermediate FCC accounts during the expense allocation process. After all of the cost pool expenses are purified/allocated to the final operating FCC accounts (listed in the cost pool dataset), the cost pool FCC should not have any remaining expenses since this represents unallocated expenses which is considered an error (See Appendix 4, Table 4 of this enclosure for the Assignment Sequence Number (ASN) for the expense allocation process by FCC).

f. Redistribution of intermediate FCC accounts. Redistribution of intermediate FCC accounts (ancillary and support services) expenses to final FCC accounts (benefiting work center/cost center) as indirect expenses is part of the expense allocation process. After the costs are fully assigned, the intermediate operating expense accounts contain zero-dollar balances. Three essential components for the correct allocation of these expenses are the designated allocation factors, ASD, and expenses.

(1) Allocation factors. Allocation factors are used to allocate expenses from indirect intermediate accounts and cost pools (e.g., FTEs, minutes of service, visits, etc.) to final accounts. Allocation factors are different than Service units which are common measures of the outputs being produced by the MTFs, e.g., visits, OBDs and admissions (see Appendix 5, Table 5, and Appendix 6 of this enclosure for a listing of the Allocation Factor and Service Unit for each FCC).

(2) The ASD. The ASD is another important component of the expense allocation process. It is the roadmap for expense allocation and contains a list of FCC accounts, associated data sets, and ASNs. Each FCC account represents a work center/cost center (see Appendix 4, Table 4, for the ASN of each intermediate FCC account used during the allocation process and Appendix 5, Table 5 of this enclosure for a listing of the EAS IV Data Sets.)

(3) ASN. ASN for Stepdown Allocation (locally assigned at the MTF) is the order in which expenses are allocated (see Appendix 4, Table 4 of this enclosure). Expense allocation starts with the lowest ASN first. The lowest ASN supports the most areas in the hospital and the highest supports the fewest. As each account's expenses are allocated, the account is closed. In other words, the stepdown expense allocation process will no longer charge expenses to a closed account.

(a) After the costs are fully assigned, the intermediate operating expense accounts contain zero-dollar balances.

(b) The stepdown methodology does not allow for the reciprocal nature of services. For instance, although housekeeping and commander support staff provide services for each other, allocation is only charged from the lower ASN to the higher ASN section in numerical order.

g. Direct expenses. Direct expenses for each work center/cost center are either captured via a financial or personnel source system or entered manually into the EAS IV system (free receipts and depreciation). Common work center expenses could be supplies, equipment, or a salary expense, including free receipts. Expenses that are merged into EAS from other financial systems should be validated with official reference documentation or with resource or budget personnel (see paragraph 1 of this enclosure). For military pay personnel expenses, refer to Reference (t), and for classification of the individual expense elements, refer to Reference (j).

(1) To prevent distortions of the direct expenses and cost allocation of expenses in MEPRS, coordination shall be completed to ensure that the obligations, expenses, service units/allocation factors, FTEs, square footage, etc. are aligned and reported in the same FCC.

(2) Travel expenses include the costs of transportation of people and authorized excess baggage, per diem, incidental fees such as taxi fare, automobile rentals, locker fees, tolls, and registration fees, etc., (Reference (u)). Travel expenses shall be aligned and reported in the same FCC where the related temporary duty (TDY) man-hours and salary expense are reported (see Table 3 of this enclosure for reporting man-hours, personnel salaries, and related travel expenses).

(3) Attendance for all formal continuing education (CE) training programs for non-student personnel shall be reported in the FAL - CE FCC, regardless of location (local or TDY) or source of instruction (see Table 3, Appendix 10, Table 18, and paragraph 6 of this enclosure for specific business rules on the FAL FCC).

(4) Equipment repaired by the MTF Biomedical Equipment Repair work center will not be directly charged to the MTF Biomedical Equipment Repair work center FCC when purchased. All supplies and equipment ordered by a work center will be directly charged to that work center by FCC and reflected as a direct expense. Only supplies ordered by the Biomedical Equipment Repair and used to repair equipment (bench stock) will be directly charged to the Biomedical Equipment Repair work center FCC.

(5) The expenses incurred to operate a Nutrition Care Clinic shall be reported directly to the BAL (Nutrition Care Clinic). Expenses related to the dining facility for non-patient meal service will be reported directly to FDC (Dining Facility – Non-Patient Food Operations). Expenses incurred in the Nutrition Care Food Operations that cannot be directly attributed to the Dining Facility will be charged to EIB (Combined Food Operations) (see Appendix 8, Table 15, paragraph 11 of this enclosure for specific business rules).

h. EAS IV/MEPRS. EAS IV/MEPRS reports all direct obligations and direct expenses with specific financial data elements used to map Service unique financial data elements to standardized Tri-Service financial data elements. Three standardized Tri-Service financial data elements used in EAS IV/MEPRS reporting are listed below.

(1) Basic Symbol/Limitation Code (BS/L). BS/L includes the basic symbol and limitation code. The basic symbol is a four-digit Treasury account number code that indicates the type of funds or major purpose of the appropriation (Reference (j)). The limitation code is a four-digit suffix to the U.S. Treasury account number (basic symbol). The limitation is used to identify a subdivision of funds that restricts the amount or use of funds for a certain purpose or identifies sub-elements within the account for management purposes. On accounting documents, the limitation is preceded by a decimal point. The Service unique BS/L codes are mapped to standardized DoD BS/L codes in EAS IV for direct and cost allocation.

(2) Program Element Code (PEC). PEC is a code that represents a program that reflects a force mission or a support function of the DoD and contains the resources allocated to achieve an objective or plan (Reference (j)). There are specific authorized PECs allowed within each BS/L code. Each Service unique PEC is mapped to a standardized DoD PEC code in EAS IV for direct and cost allocation.

(3) Standard Element Expense Code (SEEC). SEEC is synonymous with object classes. These are the MEPRS standard financial categories that represent the expenses reported from obligations for items or services purchased by the Government such as labor, supplies, equipment, contracted services, and others. Each Military Service has a unique expense element referred to as Service Unique Element Expense that maps to a related standardized SEEC to facilitate comparison among the Services. Some SEECs are unique to MEPRS for granularity needed for more visibility of certain direct expenses and for more accurate cost allocation. EAS IV SEECs are often equitable to Object Class Codes (OCCs) and sub-object codes (Reference (j)). An SEEC Category code organizes similar DoD SEECs into logical groupings that represent personnel salaries, supplies, contractual services, etc.

4. LABOR HOUR REPORTING METHODOLOGY FOR FTES AND PERSONNEL SALARIES

a. Accurate and timely collection and processing of labor hour data is essential to developing and evaluating manpower staffing, analyzing productivity, and making labor resource decisions at all management levels. In addition, many overhead accounts allocate expenses based upon available labor hours. Therefore, work center/cost center personnel, supervisors, and managers must understand and comply with the rules and principles of collecting and reporting labor-hour data contained in this DHA-PM.

b. Personnel categories (officer, enlisted, civilian, contractor, and volunteer), skill types, and suffix codes shall be used to report labor hours (see Appendix 1, Table 1 of this enclosure for a listing of personnel categories by skill type and suffix code).

c. Labor hours shall be reported as FTEs in MEPRS. FTEs are a work force equivalent of one individual working full-time for a specific period, which may be made up of several part-time individuals or one full-time individual (see Appendix 2, Table 2 of this enclosure for the formulas used to calculate FTEs).

d. MTF personnel, including military, reservist, civilian, contractor, and volunteer, must ensure their labor hours are distributed to the appropriate work center/cost center. Based on the personnel category of the individual, reportable labor hours can include both available and non-available time. Refer to Appendix 3 in this DHA-PM for specific business rules for reporting man-hours by FCC for each personnel category.

e. Non-available hours are reported for assigned military and civilian staff only.

f. Possible sources of available time are assigned, attached (including students), detailed, borrowed, contracted, and volunteer personnel.

g. Borrowed and loaned labor hours within one reporting facility in support of the healthcare mission shall be charged to the benefiting work center/cost center. The benefiting work center is determined based on where the person's time contributes to accomplishing the overall operation and function of the work center regardless of the assigned work center. Only actual labor hours will be reported for borrowed personnel.

h. Loaned labor outside the MTF includes staff personnel whose services are temporarily made unavailable to the MTF/DTF because of emergency and contingency needs or because of the necessity to provide temporary medical support to other facilities or worksites.

i. Contract personnel labor hours shall be credited to the work center/cost center for which they provide service. Only actual available labor hours will be reported (References (v) through (x)).

j. Reservist labor hours shall be credited to the work center/cost center for which they provide service. Only actual available labor hours will be reported.

k. Monthly personnel expenses for military members shall be the amount prescribed for Service specific rates based on each member's grade and Military Service on the 'Military Personnel Composite Standard Pay/Reimbursement Rates' USD(C) web Site at: http://comptroller.defense.gov/Financial-Management/Reports/rates/ (Reference (t)).

l. Monthly personnel expenses for civilians shall be the actual salary provided civilian payroll files from the Defense Finance Accounting Service - Indianapolis Accounting Operations, Accounting Systems Directorate.

m. Contractor personnel salary expenses are derived from the financial accounting system and should be reported in the FCC where the contractor actually worked. The contractor FTEs and salary expenses should be reported in the same FCC. The contractor salary expense is

imported from the source financial system (e.g., General Fund Enterprise Business System, etc.) into EAS IV, and the contractor available FTEs are imported from the source personnel system that is imported into EAS IV; (i.e., Defense Medical Human Resource System internet (DMHRSi)).

n. EAS IV and the source personnel system (i.e., DMHRSi) will report accurate DHA salary expenses and FTEs as defined in this DHA-PM.

o. The following rules apply for determining the number of assigned, available, non-available, and non-reportable hours and/or FTEs to be charged to each work center sub-account FCC for the accurate distribution of personnel (salary) expenses. Reportable time includes both available and non-available hours.

(1) Assigned FTEs. Assigned FTEs are reported for personnel on the facility's manning or staffing document. The state of belonging to a unit and being counted as part of that unit's assigned strength. The assigned work center is determined based on the facility's manpower documents or the assignment made by the commanding officer.

(2) Available hours/FTEs. Available hours/FTEs represent those hours worked or expensed in support of the healthcare and readiness missions regardless of the type of personnel.

(a) Available hours are reported for all personnel types, assigned and borrowed, to include military, reservists, civilians, contractors, and volunteers. Available hours are charged to the assigned work center or benefiting work center(s). Available hours may not be charged to FCCs that accumulate expenses/cost only (e.g., EA* Depreciation FCCs, BASOPS ED* FCCs used for reimbursement to the host installation, etc.).

(b) Available clinical hours include time/hours the provider devotes to patient care and supporting activities, such as medical records update, preparation for clinical and surgical procedures, and patient phone contact.

(c) Individuals should not report their time in overhead/administrative FCCs for the purpose of looking more productive. These salary expenses are spread across multiple FCCs. Overhead administrative accounts should be used appropriately based on their function descriptions.

(d) An individual's available hours can be reported in as many benefiting FCCs as applicable for the monthly reporting period.

(e) Available hours are reported if an individual is authorized to work from home and provides support of the MTF mission that is normally performed in the individual's assigned work center.

(3) Non-available hours. Non-available hours are reported and expensed when they are not performed in direct support of the healthcare or readiness mission. Non-available hours

include authorized leave (annual, sick, other) and UA (e.g., absent without leave (AWOL)). Non-available hours are reported for assigned military and civilian staff only.

(4) An individual's hours. An individual's hours may be recorded as either "Available" or "Non-Available" but not both for the same period of time at one facility. Likewise, the same hours cannot be recorded as available to different work centers; e.g., if a provider works on a Monday from 0800–1000 in the Cardiology Clinic, but is assigned to the Internal Medicine Clinic, the two productive hours cannot be reported as both non-available to the Internal Medicine Clinic and available to the Cardiology Clinic. If an individual works in the clinic from 0730–1630 and is also listed on the provider call roster for the ER for the same time period, the individual records only the time spent in the clinic or time spent in the ER as available time—not available time to both.

(5) Non-reportable time/hours. Non-reportable time/hours are those hours not accounted for by the MTF/DTF where the individual is assigned and are not included in the calculation of the available and non-available hours and FTEs; e.g., regularly scheduled days off (e.g., Saturday and Sunday), meal breaks, and other breaks.

p. The business rules matrix in Table 3 of this enclosure includes the common scenarios or activities that occur at the MTF, the personnel types to which the rule applies, how the time should be classified and where the time should be captured. Table 3 provides detailed guidelines for collecting and reporting available and non-available time/hours for personnel working in support of the Defense Health Program fixed MTFs/DTFs.

q. Business rules for reporting CE, student programs, MTF training, Graduate Medical Education (GME) Programs, Graduate Dental Education (GDE) Programs, etc., is provided in Appendix 10, Table 18 of this enclosure.

5. EAS IV SERVICE UNITS AND ALLOCATION FACTORS

a. Service units and allocation factors. Service units are common measures of the outputs being produced by the MTFs, (e.g., visits, occupied bed days (OBDs), admissions, etc.). Temporary FCCs reported with a 'Z' at the 3rd level FCC and Support Services (E FCCs) do not have a service unit. Allocation factors are used to allocate expenses from intermediate FCC accounts and cost pool FCCs to final operating FCC accounts. The expense allocation process for cost pool FCCs is referred to as purification. During the allocation process, the expenses of all cost pool FCCs purify to a zero balance before expenses of the intermediate (ancillary 'D' and support services 'E') FCCs are allocated to a zero balance to the final operating FCC accounts.

b. Some FCCs have the same service unit and allocation factor. Some EAS IV/MEPRS service units and/or allocation factors are referred to as 'workload' in EAS IV but may not represent all workload output measurements within the MHS.

c. The unique service unit and allocation factor for all FCCs is provided in Appendix 5, Table 5 of this DHA-PM.

d. Unique and specific business rules for reporting the service units and/or allocation factors for 'A - Inpatient Care', 'B - Outpatient Care', and 'C - Dental Care' FCCs are provided in Appendix 6, Tables 6, 7, and 8, respectively, in this DHA-PM. With the exception of cost pools, the 'A', 'B', and 'C' FCCs are considered final operating FCCs that receive stepdown expenses.

e. Ancillary Services in 'D' FCCs represent physical work centers, and are categorized as intermediate FCCs in MEPRS. EAS IV data sets for Ancillary Services document actual ancillary work center support to requesting specialties/work centers. The Ancillary Service expenses are allocated in EAS IV according to the assignment procedures governing the Ancillary Services intermediate accounts.

(1) The alphabetic order of the 'D' FCC accounts is different from the order of expense allocation of the 'D' FCCs. See Appendix 4, Table 4 of this enclosure for the EAS IV ASN for Allocation of the Ancillary Intermediate FCCs.

(2) Each ancillary sub-account FCC has a discrete unit of service and/or allocation factor that is not common among all FCC accounts. Unique and specific business rules for reporting the service units and/or allocation factors for Ancillary Services in EAS IV/MEPRS is provided in Appendix 7, Tables 9 through 14 of this enclosure.

(3) Total expenses of Ancillary Services in 'D' FCCs shall be allocated based on the ratio of weighted procedures performed for each receiving/requesting specialty/work center by FCC account to the total weighted procedures (allocation factor) performed by the individual 'D' FCC ancillary service.

f. Support Services in 'E' FCCs are categorized as intermediate FCCs in MEPRS. The Support Services FCCs do not have a service unit, but they do have allocation factors (see Table 4 of this enclosure for the EAS IV ASN for Allocation of the Support Services 'E' Intermediate FCCs and Table 5 for the EAS IV dataset requirements for all FCCs). The Support Services 'E' FCCs have several different allocation factors and methodologies that produce a more equitable distribution of support expenses to final operating FCCs when actual support cannot be quantified (see Appendix 8, Tables 15 through 17 in this enclosure for unique allocation factor criteria for 'E' Support Services FCCs and Appendix 10, Table 18 for GME/GDE and Training business rules).

g. Special Programs in 'F' FCCs and Readiness in 'G' FCCs are final operating FCCs that report direct expenses and receive stepdown expenses during the expense allocated process in EAS IV (see Appendix 9, Table 17 of this enclosure for unique service unit and allocation factor criteria for 'F' Special Program FCCs). Several 'F' Special Program FCCs have required data set entries. (see Appendix 5, Table 5 of this enclosure for the data set requirements. The Readiness 'G' FCCs do not have any service units or allocation factors.

6. EAS AND REPORTS

a. EAS is a standard automated data processing capability used by the military services for the calculations required to produce the MEPRS data. The EAS application system data types with associated data elements, entity names, and attributes with associated descriptions are provided in the EAS Application and Repository Functional User Guides and in the Application Database Design Description documents. All EAS Application and Repository User and reference documents are available on the public DHA Health IT Directorate SharePoint at: https://info.health.mil/dhss/home/ResDiv/EASIV/PUBLIC/Forms/AllItems.aspx. Persons who access this website will be required to register and obtain approval. Requests for access should be submitted to their respective Service so that the request can be forwarded to DHA Solution Delivery Division.

b. EAS is configured to generate both standard and ad hoc reports. These reports are valuable tools that can assist in both data quality efforts as well as management decision support. Numerous reports in EAS facilitate quality control assessments of processed MEPRS data. These tools can be used to ensure data is processed correctly, reference tables are configured properly, and that the system is operating appropriately. For further information on these reports, refer to the current EAS user's manuals.

7. ISSUE RESOLUTION PROCESS

a. An issue is an important MEPRS question that is in dispute, may have Tri-Service implications and must be resolved in order to facilitate the submission of timely, accurate, and complete MEPRS/EAS data. An issue is any processing problem or improvement that impacts data quality or performance reporting whether functional, interpretational, or system-related. Functional issues include policy changes like the establishment of new FCCs. Interpretation issues necessitate clarification and application of business rules and requirements set forth in this DHA-PM or supplemental Service guidance. System-related issues are issues that involve hardware or software changes to accommodate policy revisions or to correct errors.

b. System Change Requests (SCRs) and System Incident Reports (SIRs). These types of issues include, but are not limited to, new requirements, changes to existing requirements, corrections during beta testing, and table maintenance. The requirements for new functionality or changes/enhancements to existing functionality are SCRs. An SIR is related to the requirements to fix corrections occurring when a system output fails to satisfy a previously established system requirement.

c. The issue resolution process provides a mechanism for organizing, maintaining, and tracking the outcome of MEPRS, EAS, and associated application issues that cannot be settled at the individual MTF/DTF levels and/or Service levels. The process includes both an established issue initiation, control, and monitoring mechanism as well as a defined process to identify, address, and prioritize SIRs and/or SCRs related to MEPRS policy, business rules, or procedures.

d. The FPRS is the functional proponent for the Tri-Service issue resolution process and

responsible for the development, implementation, management, and integration of MEPRS policies, procedures, business practices, and system requirements.

e. MEPRS end-users are encouraged to review these policies, procedures, and business practices and provide input to support data quality management, continuous process improvements, business process re-engineering, and change management. Issues associated with MEPRS should always be resolved at the lowest level within the organization and changes communicated throughout the Service command and across the MHS.

f. Anyone who encounters problems or issues that arise from MEPRS/EAS review, implementation or program requirements that cannot be resolved at the MTF/DTF level can submit an issue through the Service or DHA MEPRS Program Managers using the suggested Issue Paper Resolution Format located in Appendix 11, in this enclosure.

g. The roles for processing issue papers by individual organization are provided below.

(1) MTF MEPRS Coordinator. The MTF MEPRS Coordinator generally serves as the initial point of contact for resolving MEPRS issues at the MTF level and in accordance with Service-level guidelines. If the question has only local implications and can be resolved within Service-level guidelines, the coordinator must ensure the question and its resolution are documented in accordance with Service guidance.

(2) Service Headquarters MEPRS Program Manager. The Service Headquarters MEPRS Program Manager provides Service-specific guidance on MEPRS policy implementation, business rules, and Service-level MEPRS issues. This individual receives, reviews, and submits to DHA all issues requiring resolution above the Service-level. This individual also provides information related to the final resolution of the issue to the MEPRS Coordinators and/or the issue paper originator.

(3) MEPRS Program Office/DHA. The MEPRS Program Office/DHA generally serves as the initial point of contact for MEPRS users not affiliated with an MTF or Service. In conjunction with the FPRS, the office develops, administers, and maintains the Tri-Service issue resolution process. The MEPRS Program Office coordinates appropriate subject matter expert's input as needed to resolve issues, obtains Tri-Service consensus on the issue(s) in favor of a single standard and binding MHS resolution, and refers all issues on which Tri-Service agreement cannot be established to the DHA MBOG for final resolution.

(4) FPRS. The FPRS is responsible for the review and resolution of any differences in favor of a single standard and binding MHS solution. The FPRS serves as the senior staff-level body responsible for the functional oversight of the MEPRS program. The FPRS is responsible for the development, implementation, and management of MEPRS policies, procedures and business practices, and for integrating the collection, processing, and reporting of standard workload, financial, and labor data in EAS.

h. MEPRS users not affiliated with an MTF/DTF or Service.

(1) All users should first attempt to resolve the issue through the MHS Help Desk (800-600-9332).

(2) If the issue cannot be resolved to the satisfaction of the parties involved, the issue should be documented using the Issue Paper Resolution Format and elevated to the DHA MEPRS Program Office.

(3) Depending on the complexity of the issue, a more detailed issue paper may be needed to provide sufficient information for review and analysis.

i. MEPRS users affiliated with an MTF/DTF. Their issue resolution process is divided into4 phases. Only issues that cannot be resolved at the Service level and that have a Tri-Service impact should be forwarded to DHA. The phases for these users are provided below.

(1) Phase 1 - Initiation Process

(a) The issue should be submitted in writing using the Issue Paper Resolution Format.

(b) Requested information includes information related to the originator of the issue, the issue title, systems affected, supporting documentation, and recommended solution.

(c) Service-level guidelines shall be followed for the origination and elevation of MEPRS questions.

(d) Technical system-related issues impacting the processing and transmission of data should always be submitted to the MHS Help Desk (800-600-9332).

(e) If the question(s) cannot be resolved at the local level or the issue(s) have Service-level implications, the Service MEPRS Program Manager shall forward a written statement to DHA detailing the issue, to include examples of the problem and a proposed solution where applicable (see Appendix 11 of this enclosure). This issue paper must be coordinated with the other Service MEPRS Program Managers and should provide supporting objective documentation to include input for appropriate Service-level subject matter experts.

(f) Only the Service MEPRS Program Managers shall elevate an issue to the DHA MEPRS Program Office.

(g) The issue and subsequent analysis should be documented using the Issue Paper Resolution Format and elevated to the DHA MEPRS Program Office.

(2) Phase 2 - Initial Review and Tracking Procedures. Phase 2 activities take place at the DHA MEPRS Program Office and include logging the issue paper into the issue paper database as well as initial review and analysis of the paper. Review and analysis of the issue at the DHA/MEPRS Program Office will be accomplished as follows.

(a) Upon receipt of an issue paper, the MEPRS Program Office will assign an issue number and enter the information into a tracking database.

(b) The MEPRS Program Office will conduct an initial review of the issue, validate the issue as one germane to all Services, request additional clarification and information as may be needed, and disseminate a complete issue paper packet to all Service MEPRS Program Managers for review, comment, and appropriate staffing.

(c) The issue paper packet will include the Issue Paper Resolution Format document and any other available pertinent information including a more detailed issue paper and additional impact summaries.

(d) The issue paper database will be updated on a bi-weekly basis with the latest actions and decisions related to the specific issue paper.

(3) Phase 3 - Issue Coordination and Resolution

(a) During Phase 3 of the issue resolution process, the issue paper package is distributed to the Service MEPRS Program Managers for their review and comment. If resolution cannot be obtained, a meeting is scheduled to discuss the issue and related recommendations. If necessary, the issue will be referred to higher levels as described below in paragraph 7.i.(3)(c) of this enclosure.

(b) Issue paper/SCR meetings will be held to discuss outstanding issues and obtain consensus.

(c) The FPRS, which operates under the auspices of the DHA MBOG and through the FPRS charter, has been empowered to jointly resolve all such differences in favor of a single standard and binding MHS solution. The MBOG will be briefed on the status and impact of outstanding issue papers with the goal of achieving resolution of the issues. Outstanding issue papers are prioritized as: A – Critical Task, B – Important Essential Task, C – Value Added Task, D – Enhancement Task, and E – Non-Essential Task.

(d) If the FPRS is unable to reach a resolution on the issue, the issue will be forwarded to the ASD(HA) Tri-Service MBOG for review and, if possible, resolution.

(e) Issues not resolved in favor of a single standard and binding Tri-Service solution by the MBOG will be forwarded to the Director of DHA and the Medical Deputies Actions Group for their assessment.

(f) Issues which still cannot be resolved in favor of a single, standard, and binding solution will then be forwarded to the ASD(HA) and the Surgeons General for resolution.

(g) Upon final resolution, the issue will be returned to the FPRS for MHS-wide implementation and oversight.

(4) Phase 4 - Final Disposition of Issue and Prioritization of SCRs

(a) Phase 4 includes the activities related to the final disposition of this issue. The Service MEPRS Program Manager and the issue paper originator are notified of the outcome. When required, the MEPRS Program Office will coordinate with the EAS Program Office and other automated information system representatives for preparation of the necessary SCR.

(b) Upon final resolution, the MEPRS Program Office will inform the Service-Level Program Manager.

(c) Necessary changes will be made to this PM and changes and updates will be announced on the MEPRS Web-Portal.

(d) SCRs are prioritized by the FPRS using the same criteria as used in prioritizing issues: A – Critical Task, B – Important Essential Task, C – Value Add-ed Task, D – Enhancement Task, and E – Non-Essential Task. Implementation is coordinated with the EAS Program Office.

(e) Issues are considered resolved when any of the following conditions are met: the ASD(HA) DHA and the Military Services reach consensus and agree to move forward with a recommended solution, the originator of the issue withdraws the issue, the originating Service concedes to FPRS consensus to withdraw the issue, or the MBOG directs final resolution.

j. Issue Processing Procedures and Timelines

(1) If an issue cannot be resolved at the Service level, and the MEPRS representative of the sponsoring Military Service submits an issue paper to the DHA MEPRS program office, the following procedures shall be followed:

(a) Upon receipt of the issue paper, the MEPRS program office shall review, analyze, and distribute the Issue Paper to the Services for review and comment. (Recommended review period: 15 work days from receipt of issue to distribution to Services.)

(b) The Services shall provide comments to the MEPRS Program Office. (Recommended comment period: 15 work days from receipt of issue.)

(2) After receipt of comments and concurrence/non-concurrence from the services, the MEPRS Program Office shall, if necessary, coordinate a meeting within 15 working days to resolve any outstanding issues. (Recommended coordination period: 15 working days from receipt of comments/decision from all three Services.)

(a) The MEPRS Program Office shall process the coordination and disposition of the issue. This includes, if necessary, forwarding the issue for resolution as set forth in paragraph 7 and Appendix 11 of this enclosure (recommended disposition period: 30 work days after receipt of Service comments/decision or meeting with the Services.)

(b) Changes shall be documented for update to this DHA-PM and coordination with the EAS Program Office shall be initiated (recommended resolution period: 10 work days after decision.)

(c) The MEPRS Program Office shall provide written notification of issue resolution and appropriate actions to the Service MEPRS Program Manager (recommended notification period: 15 work days after final resolution.)

k. MEPRS Issue Resolution Format. Below are instructions for using the sample issuance resolution paper format in Enclosure 3, Appendix 11, to assist in submitting an issue for resolution. The format is recommended but not required:

(1) DoD Issue #. Please leave this field blank. The MEPRS Program Office will assign a DoD issue number upon receipt of the issue resolution paper.

(2) Date of Issue. Please insert the date on which the completed issue paper will be sent to the MEPRS Program Office.

(3) Originator of Issue. Please insert your name, title, and phone number.

(4) Issue/Problem Title. Please provide a short (one or two sentence) description of the issue. State the problem simply and what it affects in a quantifiable way; e.g.: "Currently, (this is happening), resulting in (these quantifiable symptoms)." Please identify the systems that are affected by this issue.

(5) Supporting Documentation/Attachments. Please be sure to provide any supporting documentation that may assist in analysis of the issue.

APPENDIX 1

MEDICAL EXPENSE PERFORMANCE REPORTING SYSTEM DoD SKILL TYPE AND SUFFIX CODES

Table 1. MEPRS DoD Skill Type and Suffix Codes and Descriptions

Skill Type (ST)	Description	ST/ SUFFIX	Suffix Description
1	**Clinician** Includes a physician or dentist practitioner normally having admitting privileges and primary responsibility for care of inpatients. Intern and resident physicians and dentists are considered to be clinicians as far as the reporting categories only for the purposes of meeting the requirements for MEPRS. For labor hour collection purposes, these individuals are coded as Skill Type 1.	1D	Dentist
		1F	Fellow – Medical
		1N	Intern – Medical
		1P	Physician
		1R	Resident – Medical
		1S	Intern – Dental
		1T	Fellow – Dental
		1U	Resident – Dental
		1V	Veterinarians
2	**Direct Care Professional** Individuals, other than clinicians, licensed or certified to deliver healthcare. This personnel category includes physical and occupational therapists, podiatrists, psychologists, social workers, physician assistants, independent duty corpsmen, and advanced practice nurses who are privileged. Direct care professionals consult with other healthcare professionals to assess, plan, and implement an effective treatment program.	2A	Nurse Anesthetist
		2C	Community Health Nurse (Credentialed)
		2H	Occupational Health Nurse (Credentialed)
		2M	Nurse Midwife
		2N	Nurse Practitioner
		2P	Physician Assistant
		2S	Clinical Nurse Specialist
		2W	Student-Non GME/GDE

Skill Type (ST)	Description	ST/ SUFFIX	Suffix Description
	For labor hour collection purposes, these individuals are coded as Skill Type 2.	2Z	All Others in ST 2
3	**Registered Nurse** All registered nurses (Skill Type 3), except those who are being used as advanced nurses, such as nurse practitioners, nurse anesthetists, and nurse midwives who are accounted for in the direct-care professional's category (Skill Type 2). Licensed Practical Nurses (LPNs) and Licensed Vocational Nurses (LVNs) are classified as direct-care paraprofessionals (Skill Type 4) and are not registered nurses.	3C	Community Health Nurse (Non-Credentialed)
		3E	Nurse Case Manager
		3H	Occupational Health Nurse (Non-Credentialed)
		3R	Registered Nurse
		3W	Student-Non GME/GDE
		3Z	All Others in ST 3
4	**Direct Care Paraprofessional** Individuals who are skilled to provide technical assistance or follow-up to direct patient care (e.g., LPNs, LVNs, medical specialists, electromagnetic radiation also known as X-ray specialists, dental lab specialists, dental hygienists, and medical technicians). For labor hour collection purposes, these individuals are coded as Skill Type 4.	4A	Nursing Assistant
		4L	LPN or LVN
		4W	Student-Non GME/GDE
		4Z	All Others in ST 4
5	**Administrative, Logistics, or Clerical** All other personnel utilized at the facility who are not involved in direct patient care.	5A	Administrators
		5C	Clerical
		5L	Logisticians
		5M	Medical Record Auditor/Coder
		5W	Student-Non GME/GDE

Skill Type (ST)	Description	ST/ SUFFIX	Suffix Description
		5Z	All Others in ST 5

APPENDIX 2

MEDICAL EXPENSE PERFORMANCE REPORTING SYSTEM BUSINESS RULES FOR CALCULATING FULL-TIME EQUIVALENTS

Table 2. MEPRS Business Rules for Calculating FTEs

PERSON TYPE	FTE TYPE	CALCULATION OF FTE
MILITARY and CIVILIAN	ASSIGNED FTEs	Calculated by dividing the number of assigned days by the number of days in the month for those individuals counted as part of the MTF assigned strength.
	AVAILABLE FTEs	Calculated by dividing the total number of available hours by 168.
	NON-AVAILABLE FTEs	Calculated by dividing the total number of non-available hours by 168. Each category (sick, leave, and military other) should be computed separately.
Appendix 3, Table 3 of this enclosure provides guidelines for differentiating between available and non-available time.		

APPENDIX 3

REPORTING AVAILABLE AND NON-AVAILABLE TIME

Table 3. Specific Rules for Reporting Available and Non-Available Time in Fixed Medical and Dental Facilities

Rule	If an Individual is:	And is:	Then that period of time is considered:	And should be reported to:
1	At work in the facility (including when on call at the facility (rule 3b below), approved telecommuting, pre-approved overtime, or earned comp time for civilians).	Assigned military, assigned civilian, contractor, volunteer, reservist, foreign national, or borrowed military labor	Available time	Benefiting work center/FCC
2a	Performing research during the normal duty day and by authorized and assigned MTF personnel who are hired by the MTF for this specific mission. This type of research is not specific to a single patient as part of patient care delivery; e.g., this type of research is conducted during normal working hours or approved telecommuting hours. Research performed by GME/GDE or other formal student programs should be recorded in the respective student MEPRS code; e.g., FAK, FAM, FAN, FAO, FAP, and FAQ, and should not be recorded in FAH.	Assigned military, assigned civilian, contractor, volunteer, reservist, foreign national, or borrowed military labor	Available time	FAH*

Rule	If an Individual is:	And is:	Then that period of time is considered:	And should be reported to:
2b	Performing research at an MTF that has agreements with external organizations/agencies (e.g., Vaccine Healthcare Center, Jackson Foundation, ISR). This type of external research, which is performed "outside" the MTF mission, should not be reported in MEPRS. Specifically, the work hours, workload, and expenses for external research and external clinical trials should not be reported in MEPRS. Although the external work hours, workload, and expenses of the external research agencies should not be reported in MEPRS, support from the MTF to the external research agencies should be reported. If the MTF loans personnel, office space, or provides ancillary support to an external research agency, this support should be reported in the approved FBZ MEPRS code to record "support" to external research agencies.	Assigned military, assigned civilian, contractor, volunteer, reservist, foreign national, or borrowed military labor	Available time	FBZ

Rule	If an Individual is:	And is:	Then that period of time is considered:	And should be reported to:
2c	From an external research agency working in the MTF to maintain his or her professional credentials/ license. The person should be reported as a volunteer and his or her work hours and workload should be reported in the benefiting work center.	Volunteer	Available time	Benefiting work center/FCC
2d	At an MTF with a formal agreement to borrow personnel from external research agencies to support the MTF mission. The person should be reported as borrowed personnel and his or her work hours and workload should be reported in the benefiting work center.	Contractor, volunteer, reservist, borrowed foreign national, or borrowed military labor	Available time	Benefiting work center/FCC
3a	A privileged provider (skill types 1 and 2) performing clinical (direct patient care) tasks.	Assigned military, assigned civilian, contractor, reservist, foreign national, or borrowed military labor	Available time – clinical	Benefiting work center/FCC Hours/time is entered in the personnel system as clinical (direct patient care) time

Rule	If an Individual is:	And is:	Then that period of time is considered:	And should be reported to:
3b	A privileged provider (skill types 1 and 2), on call within the facility when: 1. Performing clinical work. 2. Performing non-clinical work. Do not report the same time period twice to different work centers.	Assigned military, assigned civilian, contractor, reservist, foreign national, or borrowed military labor	Available time: 1. Clinical time/ hours spent providing patient care or associated patient care tasks shall be entered in the personnel system as clinical time. 2. Non-clinical time/ hours spent in the clinic performing management tasks shall be entered in the personnel system as non-clinical time.	Benefiting work center/FCC
3c	On call at home (not at the facility) and not working.	Assigned military, assigned civilian, contractor, reservist, foreign national, or borrowed military labor	Non-reportable	Any salary costs incurred will be charged to the benefiting work center/FCC without charging the hours
4a	Performing command administrative duties in the facility (e.g., Command Duty Officer, Officer of the Deck, Non-Commissioned Officer of the Day, Field Officer of the Day, Administrative Officer of the Day). Collateral duty for military staff.	Assigned military, reservist, or borrowed military labor	Available time	Appropriate EBC* FCC

4b	Performing detailed internal management control functions (linen inventories, cash count, controlled substances inventories, destruction of classified material, etc.) in support of the MTF/DTF when conducted by an individual who is not assigned to the work center and who has been appointed to perform disinterested/independent inventory by MTF Commander Personnel who perform routine inventories in their work center should report their time to the benefiting work center FCC.	Assigned military, assigned civilian, contractor, volunteer, reservist, foreign national, or borrowed military labor	Available time	Appropriate EBC* FCC

4c	Administrating the medical board process, to include attendance at medical boards at the parent facility. Direct patient care performed in a clinic to document a patient's condition should be recorded in the benefiting clinical work center FCC. Additionally, patient care administration associated with this rule should be charged to the assigned patient administration work center FCC. Personnel assigned to "E" overhead FCCs should report their work hours to their assigned "E" FCC work center. This rule applies to personnel assigned to clinical FCCs for all skill types.	Assigned military, assigned civilian, contractor, volunteer, reservist, foreign national, or borrowed military labor	Available time	FED*
4d	Privileged providers (skill types 1 and 2) who are assigned to "A," "B," or "EBD" FCCs and who attend Clinical Department meetings such as Department Risk Management Committee, Department Utilization Management Committee, and department management meetings within the same department they are assigned.	Assigned military, assigned civilian, contractor, volunteer, reservist, foreign national, or borrowed military labor	Available time	Appropriate EBD* FCC

4e	Privileged providers (skill types 1 and 2) who are assigned to "A", "B", or "C" FCCs and who attend meetings outside their respective department (e.g., MTF Risk Management, MTF UM, MTF Morning Report).	Assigned military, assigned civilian, contractor, volunteer, reservist, foreign national, or borrowed military labor	Available time	Appropriate EBC* FCC
4f	Assigned to an overhead administrative work center (e.g., RM, IMD, PAD) attending committee meetings.	Assigned military, assigned civilian, contractor, volunteer, reservist, foreign national, or borrowed military labor	Available time	Benefiting work center/FCC (typically the assigned work center)
4g	Conducting or attending Joint Commission activities. This rule applies to personnel assigned to clinical FCCs for all skill types. Attendance to formal CE training for this function should be reported in the FAL FCC. Personnel assigned to "E" overhead FCCs should report their work hours to their assigned work center.	Assigned military, assigned civilian, contractor, volunteer, reservist, foreign national, borrowed military labor	Available time	Appropriate EBB*
5	Attending wartime, peacetime, or disaster preparedness readiness training.	Assigned military, assigned civilian, contractor, volunteer, reservist, foreign national, or borrowed military labor	Available time	GBA* (readiness-peacetime/ wartime/ disaster preparedness training)

6a	TAD and/or TDY enroute to permanent change of station for civilians or military. Terminal leave for civilians or military. UA, AWOL 1 to 30 days or sentenced to confinement or suspension (regardless of the length of time). This account is to be used for assigned personnel who have permanently departed the MTF but have not yet been removed from the local manning documents. AWOL or absent without pay or leave without pay for civilians will not be charged to this account since this does not result in a disciplinary action or termination.	Assigned military, assigned civilian (In accordance with Joint Travel Regulations (Reference (u))	Available time	FDG* Note: DMHRSi WILL NOT ALLOW hours to be charged against FCC FDG* without calculating an associated expense
6b	TAD and/or TDY enroute to work at another MTF/DTF.	Assigned military or assigned civilian	Available time	Appropriate support FCC (e.g., FCD*) at the losing/ loaning facility

7	Attending non-readiness related CE, educational/training board certification exams, mission-related conferences (e.g., resource management or patient administration conferences), or professional development courses related to primary duties outside the MTF/DTF and excluding readiness training. Attending in-house or local in-service and other proficiency training (e.g., Cardiopulmonary Resuscitation, Advance Trauma Life Support, Advanced Cardiac Life Support outside the assigned work center. Attending locally conducted non-healthcare related training (e.g., equal employment opportunity, sexual harassment, risk management, safety).	Assigned military, assigned civilian, contractor, volunteer, reservist, foreign national, or borrowed military labor	Available time	FAL* (CE)
8	Deployed from the fixed MTF in support of military operations or operations other than war.	Assigned military, assigned civilian, or foreign national	Available time	GDA* Account to be charged at rate of 8 hours/day (40 hours/week) regardless of number of hours worked/day while deployed

9	Conducting or attending in-service training or day-to-day proficiency training or performing on-the-job- training where they are working and in attendance for this training. This rule excludes student or GME/GDE training program.	Assigned military, assigned civilian, contractor, volunteer, reservist, foreign national, or borrowed military labor	Available time	Benefiting work center where the individual is assigned or the work/cost center where the training is conducted
10	Providing administrative/ overhead support for authorized in-house training/educational programs including in-service, proficiency training or clinical GME/GDE programs outside of the assigned work center.	Assigned military, assigned civilian, contractor, volunteer, reservist, foreign national, or borrowed military labor	Available time	EBF* (Education and Training Support Program); EBE* (GME support expenses - physicians only); or EBI* (GDE support expenses - dentists only)
11	Conducting or supporting education and/or training in support of another organization outside of the assigned MTF/DTF.	Assigned military, assigned civilian, contractor, volunteer, reservist, or foreign national	Available time	FCD* FCE* FCG*
12	Planning, administering, conducting, or attending National Disaster Medical System (NDMS) exercises including SMART Teams; conducting or attending disaster preparedness exercises. This rule does not include training.	Assigned military, assigned civilian, contractor, volunteer, reservist, foreign national, or borrowed military labor	Available time	GGA*

13	Participating in organized or approved readiness physical training or testing when conducted during scheduled duty hours.	Assigned military, reservist, or borrowed military labor	Available time	GFA*
14	In official student status at assigned MTF/DTF for education and training or in-house GME/GDE (fellows, residents, and interns) and other students trained in the MTF as a result of agreements with local colleges, other MTFs, other Services, etc.	Assigned military or borrowed labor (GME/ GDE officer), volunteer, or foreign national	Available time	FAM*, FAN*, FAO*, FAP* or FAQ* (GME/GDE officer only) and to the benefiting work center in accordance with fiscal guidelines for skill type 1 students only. All others (skill types 2 through 5) are appropriately charged to MEPRS code FAK.****
15	In official student status at assigned MTF/DTF (outside of the individual's assigned department) for education and training. Rule excludes skill type 1 personnel.	Assigned military, assigned civilian, volunteer, borrowed labor, or foreign national	Available time	FAK* (trainee expenses other than GME/GDE program)
16	Providing support for internal promotion boards, military-related organizational activities, (e.g., parades and formations); loaned in support of external promotion boards, military courts, base/post details.	All MTF/DTF personnel	Available time	FCG*
17a	Earning compensatory time	Assigned civilian or foreign national direct hire	Available time	Benefiting work center/FCC

17b	Taking approved compensatory time	Assigned civilian or foreign national direct hire	Non-available time	Benefiting work center/FCC
18	Emergency leave, annual leave, sick leave, and furlough.	Assigned military, assigned civilian, or foreign national direct hire	Non-available time	Assigned work center
19	On pass, furlough, special liberty, administrative leave, time off for awards, civilians on annual Reserve Component training, civilians that are in an AWOL or absent without pay status.	Assigned military, assigned civilian, or foreign national direct hire	Non-available time	Assigned work center
20	Participating in administrative activities associated with in/out processing, e.g., obtaining an ID badge or in orientation.	Assigned military, assigned civilian, contractor, or foreign national direct hire	Available time	FCG*
21	Absent for medical and/or dental visits, treatment, sick in quarters, cure leave, on-the-job injury, family/maternity/sick leave	Assigned military, assigned civilian, or foreign national direct hire	Non-available time (sick)	Assigned work center
22	On meal or other breaks	Assigned military, assigned civilian, or foreign national direct hire	Non-reportable	

APPENDIX 4

EXPENSE ASSIGNMENT SYSTEM IV SEQUENCE NUMBER

Table 4: EAS IV ASN for Allocation ACCOUNT DESCRIPTION	FCC
Depreciation of Equipment	
Inpatient Depreciation	EAA
Output Depreciation	EAB
Dental Depreciation	EAC
Special Programs Depreciation	EAD
Readiness Depreciation	EAE
Command, Management, and Administration Command	
Medical IM/IT	EBJ
Command	EBA
Special Staff	EBB
Administration	EBC
Clinical Management	EBD
GME Support Expenses – Physicians Only	EBI
GDE Support Expenses – Dentists Only	EBE
Education and Training Program Support	EBF
Third Party Collection Administration	EBH
Support Services	
Facilities Operations – Healthcare	EDA
Operations of Utilities	EDB
Facility Sustainment	EDC
Facility Restoration and Modernization	EDD
Other Facility Operations Support	EDE
Leases of Real Property	EDF
Transportation	EDG
Fire Protection	EDH
Police Protection	EDI
Communications	EDJ
Other Base Support Services	EDK
Logistics Materiel Management Services [1]	EEA
Housekeeping[1]	

Table 4: EAS IV ASN for Allocation ACCOUNT DESCRIPTION	FCC
MTF In-House Housekeeping Only	EFA
Biomedical Equipment Repair[1]	
MTF In-House Biomedical Equipment Repair (Personnel, Bench Stock, and Shop)	EGA
Laundry Service[1]	
MTF In-House Laundry Service	EHA
Nutrition Management[1]	
MTF In-House Combined Food Operations	EIB
MTF In-House Patient Food Operations	EIA
Inpatient Care Administration	EJA
Ambulatory Care Patient Administration	EKA
Managed Care Administration	ELA
Ancillary Services	
Central Sterile Supply	DEA
Pharmacy	DAA
Clinical Pathology	DBA
Anatomical Pathology	DBB
Cytogenetic Laboratory	DBD
Molecular Genetic Laboratory	DBE
Diagnostic Radiology	DCA
Cardiac Catheterization	DDE
Anesthesiology	DFA
Operating Room - Surgical Suite	DFB
Post-Anesthesia Care Unit	DFC
Ambulatory Procedure Unit	DGA
Hemodialysis	DGB
Peritoneal Dialysis	DGD
Ambulatory Nursing Services	DGE
Medical ICU	DJA
Surgical ICU	DJB
Coronary Care Unit	DJC
Neonatal ICU	DJD
Pediatric ICU	DJE
Inhalation and Respiratory Therapy	DHA
Nuclear Medicine	DIA

[1]If the fixed MTF has an agreement with the host installation/base for Housekeeping, Logistics Material Management, Biomedical Equipment Repair, Laundry, and/or Nutrition Care support as part of a BASOPS support agreement, then the fixed MTF should not use these FCCs (EEA, EFA, EGA, EHA, EIA, EIB and FB*) to report BASOPS expenditures. The fixed MTF should request coordination and guidance for a different FCC to report this unique BASOPS support.

Cost pool direct expenses purify before the stepdown allocation of expenses reported in 'D' and 'E' FCCs.

APPENDIX 5

EXPENSE ASSIGNMENT SYSTEM IV DATA SET SYSTEM REQUIREMENTS

Table 5. EAS IV Standard FCCs with Data Set System Requirements

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
A	INPATIENT CARE				SEE A FCCs - APPENDIX 6 IN THIS DHA-PM	SEE A FCCs - APPENDIX 6 IN THIS DHA-PM
AA	INPATIENT MEDICAL CARE					
AAA	INPATIENT INTERNAL MEDICINE	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADM; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
AAB	INPATIENT CARDIOLOGY	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
AAF	INPATIENT GASTROENTEROLOGY	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
AAJ	INPATIENT NEUROLOGY	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
AAK	INPATIENT HEMATOLOGY AND ONCOLOGY	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
AAL	INPATIENT PULMONARY AND UPPER RESPIRATORY DISEASE	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM;

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
						DISP
AAN	INPATIENT PHYSICAL MEDICINE	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
AAX	INPATIENT MEDICAL WARD	AAX_/ DMIS ID	NUMBER OF OBDs	MINUTES OF SERVICE	MINUTES OF SERVICE	
AAZ	INPATIENT MEDICAL CARE NOT ELSEWHERE CLASSIFIED (Requires advance approval)	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
AB	INPATIENT SURGICAL CARE					
ABA	INPATIENT GENERAL SURGERY	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
ABB	INPATIENT CARDIOVASCULAR AND THORACIC SURGERY	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
ABD	INPATIENT NEUROSURGERY	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
ABE	INPATIENT OPHTHALMOLOGY	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
ABF	INPATIENT ORAL SURGERY	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF;

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
						OBD W/O ANC & W/O PROF; ADM; DISP
ABG	INPATIENT OTOLARYNGOLOGY	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
ABI	INPATIENT PLASTIC SURGERY	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
ABK	INPATIENT UROLOGY	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
ABL	INPATIENT ORGAN TRANSPLANT	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
ABM	INPATIENT BURN UNIT CARE (BROOKE ARMY MEDICAL CENTER ONLY)	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
ABN	INPATIENT PERIPHERAL VASCULAR SURGERY	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
ABQ	INPATIENT VASCULAR AND INTERVENTIONAL RADIOLOGY	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
ABX	INPATIENT SURGICAL WARD	ABX_/ DMIS ID	NUMBER OF OBDs	MINUTES OF SERVICE	MINUTES OF SERVICE	N/A
ABZ	INPATIENT SURGICAL CARE NOT ELSEWHERE CLASSIFIED (Requires advance approval)	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
AC	INPATIENT OBSTETRICAL AND GYNECOLOGICAL CARE					
ACB	INPATIENT OBSTETRICS AND GYNECOLOGY	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
ACX	INPATIENT OB/GYN/NEWBORN WARD	ACX_/ DMIS ID	NUMBER OF OBDs; NUMBER OF BASSINETT DAYS	MINUTES OF SERVICE	MINUTES OF SERVICE	N/A
ACZ	INPATIENT OBSTETRIC AND GYNECOLOGICAL CARE NOT ELSEWHERE CLASSIFIED (Requires advance approval)	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
AD	INPATIENT PEDIATRIC CARE					
ADA	INPATIENT PEDIATRICS	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
ADB	INPATIENT NEWBORN NURSERY CARE	OBD; ADM; DISP	NUMBER OF BASSINET DAYs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
ADX	INPATIENT PEDIATRIC WARD	ADX_/ DMIS ID	NUMBER OF OBDs AND/OR BASSINET DAYs	MINUTES OF SERVICE	MINUTES OF SERVICE	N/A

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
ADZ	INPATIENT PEDIATRIC CARE NOT ELSEWHERE CLASSIFIED (Requires advance approval)	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
AE	INPATIENT ORTHOPEDIC CARE					
AEA	INPATIENT ORTHOPEDICS	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
AEB	INPATIENT PODIATRY	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
AEX	INPATIENT ORTHOPEDIC WARD	AEX_/ DMIS ID	NUMBER OF OBDs	MINUTES OF SERVICE	MINUTES OF SERVICE	N/A
AEZ	INPATIENT ORTHOPEDIC CARE NOT ELSEWHERE CLASSIFIED (Requires advance approval)	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
AF	INPATIENT PSYCHIATRIC CARE					
AFA	INPATIENT PSYCHIATRY	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
AFB	INPATIENT SUBSTANCE ABUSE REHABILITATION CARE	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
AFX	INPATIENT PSYCHIATRIC WARD	AFX_/ DMIS ID	NUMBER OF OBDs	MINUTES OF SERVICE	MINUTES OF SERVICE	N/A
AFZ	INPATIENT PSYCHIATRIC CARE NOT ELSEWHERE CLASSIFIED (Requires advance approval)	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
AG	INPATIENT FAMILY MEDICINE CARE					
AGA	INPATIENT FAMILY MEDICINE	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
AGH	INPATIENT FAMILY MEDICINE NEWBORN NURSERY	OBD; ADM; DISP	NUMBER OF BASSINET DAYs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
AGX	INPATIENT FAMILY MEDICINE WARD - (MUST HAVE APPROVAL TO USE)	AGX_/ DMIS ID	NUMBER OF OBDs AND/OR BASSINET DAYs	MINUTES OF SERVICE	MINUTES OF SERVICE	N/A
AGZ	INPATIENT FAM MED NOT ELSEWHERE CLSFD - (Requires advance approval)	OBD; ADM; DISP	NUMBER OF OBDs; NUMBER OF ADMs; NUMBER OF DISPs	N/A	N/A	OBD W/ANC & W/PROF; OBD W/ANC & W/O PROF; OBD W/O ANC & W/O PROF; ADM; DISP
B	OUTPATIENT CARE				SEE B FCCs - APPENDIX 6 IN THIS DHA-PM	SEE B FCCs - APPENDIX 6 IN THIS DHA-PM
BA	OUTPATIENT MEDICAL CARE					
BAA	OUTPATIENT INTERNAL MEDICINE CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY);

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
						OBS (B 0 ONLY)
BAB	OUTPATIENT ALLERGY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BAC	OUTPATIENT CARDIOLOGY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BAE	OUTPATIENT DIABETIC CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BAF	OUTPATIENT ENDOCRINOLOGY (METABOLISM) CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BAG	OUTPATIENT GASTROENTEROLOGY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY);

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
						OBS (B 0 ONLY)
BAJ	OUTPATIENT NEPHROLOGY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BAK	OUTPATIENT NEUROLOGY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BAL	OUTPATIENT NUTRITION CLINIC – INCLUDES OUTPATIENT AND INPATIENT VISITS	OUTPT VISITS; INPATIENT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BAM	OUTPATIENT HEMATOLOGY AND ONCOLOGY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BAN	OUTPATIENT PULMONARY DISEASE CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY);

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
						OBS (B 0 ONLY)
BAO	OUTPATIENT RHEUMATOLOGY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BAP	OUTPATIENT DERMATOLOGY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BAQ	OUTPATIENT INFECTIOUS DISEASE CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BAR	OUTPATIENT PHYSICAL MEDICINE CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BAS	OUTPATIENT RADIATION THERAPY CLINIC (See Appendix 6)	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY);

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
						OBS (B 0 ONLY)
BAU	OUTPATIENT GENETICS CLINIC (AUTHORIZED FOR KEESLER AFB ONLY)	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BAV	OUTPATIENT HYPERBARIC MEDICINE	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BAX	OUTPATIENT MEDICAL CARE COST POOLS	BAX_/ DMIS ID VISITS	NUMBER OF VISITS	N/A	VISITS IN THE BAX COST POOL	N/A
BAZ	OUTPATIENT MEDICAL CARE NOT ELSEWHERE CLASSIFIED (Requires advance approval)	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BB	OUTPATIENT SURGICAL CARE					
BBA	OUTPATIENT GENERAL SURGERY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BBB	OUTPATIENT CARDIOVASCULAR & THORACIC SURGERY CLINIC	OUTPT VISITS; TOTAL VISITS;	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
		AMB WTD PROC (ADM ONLY)				VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BBC	OUTPATIENT NEUROSURGERY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BBD	OUTPATIENT OPHTHALMOLOGY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BBE	OUTPATIENT ORGAN TRANSPLANT CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BBF	OUTPATIENT OTOLARYNGOLOGY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BBG	OUTPATIENT PLASTIC SURGERY CLINIC	OUTPT VISITS; TOTAL VISITS;	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
		AMB WTD PROC (ADM ONLY)				VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BBI	OUTPATIENT UROLOGY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BBK	OUTPATIENT PERIPHERAL VASCULAR SURGERY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BBL	OUTPATIENT PAIN MANAGEMENT CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BBM	OUTPATIENT VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BBN	OUTPATIENT BURN CLINIC (BROOKE ARMY MEDICAL	OUTPT VISITS; TOTAL VISITS;	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
	CENTER ONLY)	AMB WTD PROC (ADM ONLY)				VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BBX_	OUTPATIENT SURGICAL CARE COST POOLS	BBX_/ DMIS ID VISITS	NUMBER OF VISITS	N/A	VISITS IN THE BBX_ COST POOL	N/A
BBZ_	OUTPATIENT SURGICAL CARE NOT ELSEWHERE CLASSIFIED (Requires advance approval)	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BC	OUTPATIENT OBSTETRICS AND GYNECOLOGY (OB-GYN) CARE					
BCA_	OUTPATIENT FAMILY PLANNING CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BCB_	OUTPATIENT OBSTETRICS AND GYNECOLOGY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BCD_	OUTPATIENT BREAST CARE CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
		(ADM ONLY)				PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BCX_	OUTPATIENT OB-GYN CARE COST POOLS	BCX_/ DMIS ID VISITS	NUMBER OF VISITS	N/A	VISITS IN THE BCX_ COST POOL	N/A
BCZ_	OUTPATIENT OB-GYN CARE NOT ELSEWHERE CLASSIFIED (Requires advance approval)	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BD	OUTPATIENT PEDIATRIC CARE					
BDA_	OUTPATIENT PEDIATRIC CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BDB_	OUTPATIENT PEDIATRIC SUBSPECIALTY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BDX_	OUTPATIENT PEDIATRIC CARE COST POOLS	BDX_/ DMIS ID VISITS	NUMBER OF VISITS	N/A	VISITS IN THE BDX_ COST POOL	N/A
BDZ_	OUTPATIENT PEDIATRIC CARE NOT ELSEWHERE CLASSIFIED (Requires advance approval)	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); = APV (B 5

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
						ONLY); OBS (B 0 ONLY)
BE	OUTPATIENT ORTHOPEDIC CARE					
BEA_	OUTPATIENT ORTHOPEDIC CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BED_	OUTPATIENT CHIROPRACTIC CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BEF_	OUTPATIENT PODIATRY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BEX_	OUTPATIENT ORTHOPEDIC CARE COST POOLS	BEX_/ DMIS ID VISITS	NUMBER OF VISITS	N/A	VISITS IN THE BEX_ COST POOL	N/A
BEZ_	OUTPATIENT ORTHOPEDIC CARE NOT ELSEWHERE CLASSIFIED (Requires advance approval)	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BF	OUTPATIENT					

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
	PSYCHIATRIC/ MENTAL HEALTHCARE					
BFA_	OUTPATIENT PSYCHIATRY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BFB_	OUTPATIENT PSYCHOLOGY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BFC_	OUTPATIENT CHILD GUIDANCE CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BFD_	OUTPATIENT MENTAL HEALTH CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BFE_	OUTPATIENT SOCIAL WORK CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY);

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
						APV (B 5 ONLY); OBS (B 0 ONLY)
BFF_	OUTPATIENT SUBSTANCE ABUSE CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BFX_	OUTPATIENT PSYCHIATRIC/ MENTAL HEALTHCARE COST POOLS	BFX_/ DMIS ID VISITS	NUMBER OF VISITS	N/A	VISITS IN THE BFX_ COST POOL	N/A
BFZ_	OUTPATIENT PSYCHIATRIC AND MENTAL HEALTHCARE NOT ELSEWHERE CLASSIFIED (Requires advance approval)	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BG	OUTPATIENT FAMILY MEDICINE CARE					
BGA_	OUTPATIENT FAMILY MEDICINE CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BGX_	OUTPATIENT FAMILY MEDICINE COST POOLS	BGX_/ DMIS ID VISITS	NUMBER OF VISITS	N/A	VISITS IN THE BGX_ COST POOL	N/A
BGZ_	OUTPATIENT FAMILY MEDICINE CARE NOT ELSEWHERE CLASSIFIED (Requires advance approval)	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
		(ADM ONLY)				PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BH	OUTPATIENT PRIMARY MEDICAL CARE					
BHA_	OUTPATIENT PRIMARY CARE CLINICS	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BHB_	OUTPATIENT MEDICAL EXAMINATION CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BHC_	OUTPATIENT OPTOMETRY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BHD_	OUTPATIENT AUDIOLOGY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BHE_	OUTPATIENT SPEECH PATHOLOGY CLINIC	OUTPT VISITS;	NUMBER OF VISITS	AMBULATORY WEIGHTED	N/A	TOTAL VISITS

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
		TOTAL VISITS; AMB WTD PROC (ADM ONLY)		PROCS (ADM DATA ONLY)		W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BHF_	OUTPATIENT COMMUNITY HEALTH CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BHG_	OUTPATIENT OCCUPATIONAL HEALTH CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BHI_	OUTPATIENT IMMEDIATE CARE CLINIC (FOR SITES NOT AUTHORIZED AN EMERGENCY ROOM (ER)) (See Appendix 6 in this DHA-PM)	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BHX_	OUTPATIENT PRIMARY MEDICAL CARE COST POOLS	BHX_/ DMIS ID VISITS	NUMBER OF VISITS	N/A	VISITS IN THE BHX_ COST POOL	N/A
BHZ_	OUTPATIENT PRIMARY MEDICAL CARE NOT ELSEWHERE CLASSIFIED (Requires advance approval)	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
						ONLY)
BI	OUTPATIENT EMERGENCY MEDICAL CARE					
BIA_	OUTPATIENT EMERGENCY MEDICAL CLINIC (See Appendix 6 in this DHA-PM)	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BIX_	OUTPATIENT EMERGENCY MEDICAL CARE COST POOLS	BIX_/ DMIS ID VISITS	NUMBER OF VISITS	N/A	VISITS IN THE BIX_ COST POOL	N/A
BIZ_	OUTPATIENT EMERGENCY MEDICAL CLINIC NOT ELSEWHERE CLASSIFIED (Requires advance approval)	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BJ	OUTPATIENT FLIGHT MEDICINE CARE					
BJA_	OUTPATIENT FLIGHT MEDICINE CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BJX_	OUTPATIENT FLIGHT MEDICINE CARE COST POOLS	BJX_/ DMIS ID VISITS	NUMBER OF VISITS	N/A	VISITS IN THE BJX_ COST POOL	N/A
BJZ_	OUTPATIENT FLIGHT MED CARE NOT ELSEWHERE CLASSIFIED (Requires advance approval)	OUTPT VISITS; TOTAL VISITS; AMB WTD	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC;

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
		PROC (ADM ONLY)				AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BK	OUTPATIENT UNDERSEAS MEDICINE CARE					
BKA_	OUTPATIENT UNDERSEAS MEDICINE CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BKZ_	OUTPATIENT UNDERSEAS MEDICINE CARE NOT CLASSIFIED ELSEWHERE (Requires advance approval)	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BL	OUTPATIENT REHABILITATIVE SERVICES					
BLA_	OUTPATIENT PHYSICAL THERAPY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BLB_	OUTPATIENT OCCUPATIONAL THERAPY CLINIC	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
		(ADM ONLY)				PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
BLX_	OUTPATIENT REHABILITATIVE SERVICES COST POOLS	BLX_/ DMIS ID VISITS	NUMBER OF VISITS	N/A	VISITS IN THE BLX_ COST POOL	N/A
BLZ_	OUTPATIENT REHABILITATIVE SERVICES NOT ELSEWHERE CLASSIFIED (Requires advance approval)	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	AMBULATORY WEIGHTED PROCS (ADM DATA ONLY)	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC; AMB WTD PROC (ADM ONLY); APV (B 5 ONLY); OBS (B 0 ONLY)
C	DENTAL CARE				See C FCCs in Appendix 6, in this DHA--PM	See C FCCs in Appendix 6, P in this DHA-PM
CA	DENTAL SERVICES					
CAA_	DENTAL CARE	DENTAL WTD PROC	N/A	WEIGHTED PROCEDURES	N/A	CA FCC DENTAL WTD (ADA weighted procedures)
CAA5	DENTAL AMBULATORY PROCEDURES (See Appendix 6 in this DHA-PM)	Raw Dental patient count		ENTER RAW PATIENT COUNT IN THE WEIGHTED PROCEDURES FIELD IN THE DATASET		DENTAL AP (CAA5 ONLY)
CAZ_	DENTAL SVC CARE NOT ELSEWHERE CLASSIFIED (Requires advance approval)	DENTAL WTD PROC	N/A	WEIGHTED PROCEDURES	N/A	DENTAL WTD PROC; DENTAL AP (C AZ5 ONLY)
CB	DENTAL PROSTHETICS					
CBA_	DENTAL LABORATORY	DENTAL LAB WTD PROC	N/A	WEIGHTED PROCEDURES	N/A	DENTAL LAB WTD PROC;
CBX_	DENTAL LABORATORY COST POOLS	CBX_/ DMIS ID DENTAL LAB WTD PROC	N/A	WEIGHTED PROCEDURES	DENTAL LAB WTD PROC	N/A

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
CBZ_	DENTAL PROSTHETICS CARE NOT ELSEWHERE CLASSIFIED (Requires advance approval)	DENTAL WTD PROC	N/A	WEIGHTED PROCEDURES	N/A	DENTAL WTD PROC; DENTAL AP (C 5 ONLY)
D	ANCILLARY SERVICES				See D FCCs Appendix 7 in this DHA-PM	See D FCCs Appendix 7 in this DHA-PM
DA	PHARMACY SERVICE					
DAA_	PHARMACY	DAA_/ DMIS ID	NUMBER OF PROCEDURES	WEIGHTED PROCEDURES	PHARM WTD PROC	PHARM WTD PROC
DAZ_	PHARMACY NOT ELSEWHERE CLASSIFIED (Requires advance approval)	DAZ_/ DMIS ID	NUMBER OF PROCEDURES	WEIGHTED PROCEDURES	PHARM WTD PROC	PHARM WTD PROC
DB	PATHOLOGY					
DBA_	CLINICAL PATHOLOGY	DBA_/ DMIS ID	NUMBER OF PROCEDURES	WEIGHTED PROCEDURES	WTD PROC	LAB WTD PROC
DBB_	ANATOMICAL PATHOLOGY	DBB_/ DMIS ID	NUMBER OF PROCEDURES	WEIGHTED PROCEDURES	WTD PROC	LAB WTD PROC
DBD_	CYTOGENETIC LABORATORY	DBD_/ DMIS ID	NUMBER OF PROCEDURES	WEIGHTED PROCEDURES	WTD PROC	LAB WTD PROC
DBE_	MOLECULAR GENETIC LABORATORY	DBE_/ DMIS ID	NUMBER OF PROCEDURES	WEIGHTED PROCEDURES	WTD PROC	LAB WTD PROC
DBZ_	PATHOLOGY NOT ELSEWHERE CLASSIFIED (Requires advance approval)	DBZ_/ DMIS ID	NUMBER OF PROCEDURES	WEIGHTED PROCEDURES	WTD PROC	LAB WTD PROC
DC	RADIOLOGY					
DCA_	DIAGNOSTIC RADIOLOGY	DCA_/ DMIS ID	NUMBER OF PROCEDURES	WEIGHTED PROCEDURES	WTD PROC	RAD WTD PROC
DCZ_	RADIOLOGY NOT ELSEWHERE CLASSIFIED (Requires advance approval)	DCZ_/ DMIS ID	NUMBER OF PROCEDURES	WEIGHTED PROCEDURES	WTD PROC	RAD WTD PROC
DD	SPECIAL PROCEDURES SERVICES					
DDE_	CARDIAC CATHETERIZATION	DDE_/ DMIS ID	NUMBER OF PROCEDURES	WEIGHTED PROCEDURES	WTD PROC	CARD CATH WTD PROC
DDZ_	SPECIAL PROCEDURES SERVICES NOT ELSEWHERE CLASSIFIED (Requires advance approval)	DDZ_/ DMIS ID	GENERIC AMOUNT	GENERIC AMOUNT	GENERIC AMOUNT IN WTD FIELD	SPEC WTD PROC

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
DE	CENTRAL STERILE SUPPLY/ MATERIEL SERVICES					
DEA_	CENTRAL STERILE SUPPLY	DEA_/ DMIS ID	N/A	HOURS OF SERVICE	HRS OF SVC	CSS HOURS OF SERVICE
DEZ_	CEN SPL/MAT SVC NOT ELSEWHERE CLASSIFIED (Requires advance approval)	DEZ_/ DMIS ID	N/A	GENERIC AMOUNT	GENERIC AMOUNT	N/A
DF	SURGICAL SERVICES					
DFA_	ANESTHESIOLOGY	DFA_/ DMIS ID	NUMBER OF PATIENTS	MINUTES OF SERVICE	MINUTES OF SERVICE	DFA MINUTES OF SERVICE
DFB_	SURGICAL SUITE	DFB_/ DMIS ID	NUMBER OF PATIENTS	MINUTES OF SERVICE	MINUTES OF SERVICE	DFB MINUTES OF SERVICE
DFC_	POST ANESTHESIA CARE UNIT	DFC_/ DMIS ID	NUMBER OF PATIENTS	MINUTES OF SERVICE	MINUTES OF SERVICE	DFC MINUTES OF SERVICE
DFZ_	SURGICAL SERVICES NOT ELSEWHERE CLASSIFIED (Requires advance approval)	DFZ_/ DMIS ID	NUMBER OF PATIENTS	MINUTES OF SERVICE	MINUTES OF SERVICE	N/A
DG	SAME DAY SERVICES					
DGA_	AMBULATORY PROCEDURE UNIT (APU)	DGA_/ DMIS ID	NUMBER OF PATIENTS	MINUTES OF SERVICE	MINUTES OF SERVICE	APU MINUTES OF SERVICE
DGB_	HEMODIALYSIS	DGB_/ DMIS ID	NUMBER OF PATIENTS	MINUTES OF SERVICE	MINUTES OF SERVICE	DIALYSIS MINUTES OF SERVICE
DGD_	PERITONEAL DIALYSIS	DGD_/ DMIS ID	NUMBER OF PATIENTS	MINUTES OF SERVICE	MINUTES OF SERVICE	DIALYSIS MINUTES OF SERVICE
DGE	AMBULATORY NURSING SERVICES	DGE_/ DMIS ID	NUMBER OF PATIENTS	MINUTES OF SERVICE	MINUTES OF SERVICE	ANS MINUTES OF SERVICE
DGZ_	SAME DAY SERVICES NOT ELSEWHERE CLASSIFIED (Requires advance approval)	DGZ_/ DMIS ID	NUMBER OF PATIENTS	MINUTES OF SERVICE	MINUTES OF SERVICE	N/A
DH	RESPIRATORY THERAPY SERVICES					
DHA_	RESPIRATORY THERAPY	DHA_/ DMIS ID	NUMBER OF PROCEDURES	WEIGHTED PROCEDURES	WTD PROC	RT/PF WTD PROC BASED ON AMERICAN ASSOCIATION FOR RESPIRATORY CARE PROCEDURES
DHZ_	RESPIRATORY THERAPY SERVICES	DHZ_/ DMIS ID	NUMBER OF PROCEDURES	WEIGHTED PROCEDURES	WTD PROC	N/A

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
	NOT ELSEWHERE CLASSIFIED (Requires advance approval)					
DI	NUCLEAR MEDICINE					
DIA_	NUCLEAR MEDICINE	DIA_/ DMIS ID	NUMBER OF PROCEDURES	WEIGHTED PROCEDURES	WTD PROC	NUC MED WTD PROC
DIZ_	NUCLEAR MEDICINE NOT ELSEWHERE CLASSIFIED (Requires advance approval)	DIZ_/ DMIS ID	NUMBER OF PROCEDURES	WEIGHTED PROCEDURES	WTD PROC	N/A
DJ	INTENSIVE CARE					
DJA_	MEDICAL ICU	DJA_/ DMIS ID	NUMBER OF ICU HOURS OF SERVICE	N/A	ICU HRS OF SVC	ICU HRS OF SVC
DJB_	SURGICAL ICU	DJB_/ DMIS ID	NUMBER OF ICU HOURS OF SERVICE	N/A	ICU HRS OF SVC	ICU HRS OF SVC
DJC_	CORONARY CARE UNIT	DJC_/ DMIS ID	NUMBER OF ICU HOURS OF SERVICE	N/A	ICU HRS OF SVC	ICU HRS OF SVC
DJD_	NICU	DJD_/ DMIS ID	NUMBER OF ICU HOURS OF SERVICE	N/A	ICU HRS OF SVC	ICU HRS OF SVC
DJE_	PEDIATRIC ICU	DJE_/ DMIS ID	NUMBER OF ICU HOURS OF SERVICE	N/A	ICU HRS OF SVC	ICU HRS OF SVC
DJZ_	ICU NOT ELSEWHERE CLASSIFIED (Requires advance approval)	DJZ_/ DMIS ID	NUMBER OF ICU HOURS OF SERVICE	N/A	ICU HRS OF SVC	ICU HRS OF SVC
E	SUPPORT SERVICES				See Appendix 8 in this DHA-PM	
EA	DEPRECIATION					
EAA_	INPATIENT DEPRECIATION	OBD	NUMBER OF OBDs	N/A	OBD	N/A
EAB_	OUTPATIENT DEPRECIATION	TOTAL VISITS	NUMBER OF TOTAL VISITS	N/A	TOTAL VISITS	N/A
EAC_	DENTAL DEPRECIATION	EAC_/ DMIS ID	DENTAL EQUIP COST	N/A	DENTAL EQUIP COST	N/A
EAD_	SPECIAL PROGRAMS DEPRECIATION	EAD_/ DMIS ID	SPEC PROG EQUIP COST	N/A	SPEC PROG EQUIP COST	N/A
EAE_	MEDICAL READINESS DEPRECIATION	EAE_/ DMIS ID	READINESS EQUIP COST	N/A	READINESS EQUIP COST	N/A
EB	COMMAND, MANAGEMENT, AND ADMINISTRATION					
EBA_	COMMAND STAFF	FTES	N/A	AVAILABLE FTES	AVAILABLE FTES	N/A

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
EBB_	SPECIAL STAFF	FTES	N/A	AVAILABLE FTES	AVAILABLE FTES	N/A
EBC_	ADMINISTRATION	FTES	N/A	AVAILABLE FTES	AVAILABLE FTES	N/A
EBD_	CLINICAL MANAGEMENT	FTES	N/A	AVAILABLE FTES	AVAILABLE FTES	N/A
EBE_	GME SUPPORT EXPENSES	FTES	N/A	AVAILABLE FTES	GME STUDENT (BY ST/SUFFIX) AVAILABLE FTES	N/A
EBF_	EDUCATION & TRAINING PROGRAM SUPPORT	FTES	N/A	AVAILABLE FTES	AVAILABLE FTES	N/A
EBH_	THIRD PARTY COLLECTION ADMINISTRATION	FTEs	N/A	AVAILABLE FTES	AVAILABLE FTES	N/A
EBI_	GDE SUPPORT EXPENSES	FTES	N/A	AVAILABLE FTES	GDE STUDENT (BY ST/SUFFIX) AVAILABLE FTES	N/A
EBJ_	SERVICE MEDICAL IM/IT	FTES	N/A	AVAILABLE FTES	AVAILABLE FTES	N/A
EBZ_	COMMAND, MANAGEMENT, AND ADMINISTRATION NOT ELSEWHERE CLASSIFIED (Requires advance approval)	EBZ_/ DMIS ID	N/A	GENERIC AMOUNT	GENERIC AMOUNT	N/A
ED	BASE OPERATIONS SUPPORT SERVICES					
EDA_	FACILITIES OPERATIONS - HEALTH CARE	SQ FT	NUMBER OF SQ FT	N/A	SQ FT	N/A
EDB_	OPERATION OF UTILITIES	SQ FT	NUMBER OF SQ FT	N/A	SQ FT	N/A
EDC_	FACILITY SUSTAINMENT	SQ FT	NUMBER OF SQ FT	N/A	SQ FT	N/A
EDD_	FACILITY RESTORATION AND MODERNIZATION	SQ FT	NUMBER OF SQ FT	N/A	SQ FT	N/A
EDE_	OTHER FACILITY OPERATIONS SUPPORT	SQ FT	NUMBER OF SQ FT	N/A	SQ FT	N/A
EDF_	LEASES OF REAL PROPERTY	SQ FT	NUMBER OF LEASED SQ FT BY DMIS ID/FCC	N/A	SQ FT	N/A
EDG_	TRANSPORTATION	EDG_/ DMIS ID	NUMBER OF MILES DRIVEN	N/A	MILES DRIVEN	N/A

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
EDH_	FIRE PROTECTION	SQ FT	NUMBER OF SQ FT	N/A	SQ FT	N/A
EDI_	POLICE PROTECTION	SQ FT	NUMBER OF SQ FT	N/A	SQ FT	N/A
EDJ_	COMMUNICATIONS	FTES	N/A	AVAILABLE FTES	AVAILABLE FTES	N/A
EDK_	OTHER BASE SUPPORT SERVICES	FTES	N/A	AVAILABLE FTES	AVAILABLE FTES	N/A
EDZ_	BASE OPERATIONS SUPPORT SVC-NOT ELSEWHERE CLASSIFIED (Requires advance approval)	EDZ_/ DMIS ID	N/A	GENERIC AMOUNT	GENERIC AMOUNT	N/A
EE	MATERIEL SERVICES		N/A			N/A
EEA_	MATERIEL MANAGEMENT SERVICES	EEA_/ DMIS ID	N/A	COST OF SUPPLIES AND MINOR PLANT EQUIP	COST OF SUPPLIES AND MINOR PLANT EQUIP	N/A
EEZ_	MATERIEL SVCS NOT ELSEWHERE CLASSIFIED (Requires advance approval)	EEZ_/ DMIS ID	N/A	COST OF SUPPLIES AND MINOR PLANT EQUIP	COST OF SUPPLIES AND MINOR PLANT EQUIP	N/A
EF	HOUSEKEEPING					
EFA_	HOUSEKEEPING	SQ FT CLEANED	NUMBER OF SQ FT CLEANED	N/A	SQ FT CLEANED	N/A
EFZ_	HOUSEKEEPING NOT ELSEWHERE CLASSIFIED (Requires advance approval)	SQ FT CLEANED	NUMBER OF SQ FT CLEANED	N/A	SQ FT CLEANED	N/A
EG	BIOMEDICAL EQUIPMENT REPAIR					
EGA_	BIOMEDICAL EQUIP REPAIR	EGA_/ DMIS ID	N/A	BIOMED EQUIP HRS	BIOMED EQUIP HRS	N/A
EGZ_	BIOMED RPR SVC NOT ELSEWHERE CLASSIFIED (Requires advance approval)	EGZ_/ DMIS ID	N/A	BIOMED EQUIP HRS	BIOMED EQUIP HRS	N/A
EH	LAUNDRY SERVICE					
EHA_	LAUNDRY SERVICE	EHA_/ DMIS ID	NUMBER OF DRY LBS LAUNDRY	N/A	NUMBER OF DRY LBS LAUNDRY	N/A
EHZ_	LAUNDRY SVC NOT ELSEWHERE CLASSIFIED (Requires advance approval)	EHZ_/ DMIS ID	NUMBER OF DRY LBS LAUNDRY	N/A	NUMBER OF DRY LBS LAUNDRY	N/A
EI	NUTRITION MANAGEMENT					

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
EIA_	PATIENT FOOD OPERATIONS	EIA MEALS SERVED	NUMBER 0F MEALS SERVED	N/A	NUMBER 0F MEALS SERVED	N/A
EIB_	COMBINED FOOD OPERATIONS	EIB MEALS SERVED	NUMBER OF MEALS SERVED	N/A	NUMBER 0F MEALS SERVED	N/A
EIZ_	NUTRITION MANAGEMENT NOT ELSEWHERE CLASSIFIED (Requires advance approval)	EIZ_/ DMIS ID	N/A	GENERIC AMOUNT	GENERIC AMOUNT	N/A
EJ	INPATIENT CARE ADMINISTRATION					
EJA_	INPATIENT ADMINISTRATION	DISP	NUMBER OF DISPOSITIONS	N/A	DISP	N/A
EJZ_	INPATIENT ADMINISTRATION NOT ELSEWHERE (Requires advance approval) CLASSIFIED	DISP	NUMBER OF DISPOSITIONS	N/A	DISP	N/A
EK	AMBULATORY CARE PATIENT ADMINISTRATION					
EKA_	AMBULATORY CARE PATIENT ADMINISTRATION	TOTAL VISITS	NUMBER OF TOTAL VISITS	N/A	TOTAL VISITS	N/A
EKZ_	AMBULATORY CARE PATIENT ADINISTRATION NOT ELSEWHERE CLASSIFIED (Requires advance approval)	TOTAL VISITS	NUMBER OF TOTAL VISITS	N/A	TOTAL VISITS	N/A
EL	MANAGED CARE					
ELA_	MANAGED CARE ADMINISTRATION	FTES	N/A	AVAILABLE FTES	AVAILABLE FTES	N/A
ELZ_	MANAGED CARE ADMINISTRATION NOT ELSEWHERE CLASSIFIED (Requires advance approval)	FTES	N/A	AVAILABLE FTES	AVAILABLE FTES	N/A
F	SPECIAL PROGRAMS	See Appendix 9 in this DHA-PM				
FA	SPECIFIED HEALTH-RELATED PROGRAMS					
FAA_	AREA REFERENCE LABORATORIES	F ACCT WTD PROC	N/A	WEIGHTED PROCEDURES	N/A	N/A

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
FAB_	AREA DENTAL PROSTHETIC LAB TYPE 1	F ACCT WTD PROC	N/A	WEIGHTED PROCEDURES	N/A	N/A
FAC_	OPHTHALMIC FABRICATION AND REPAIR	F ACCT RAW PROC	NUMBER OF SPECTACLES FABRICATED OR REPAIRED	N/A	N/A	N/A
FAD_	DOD MILITARY BLOOD PROGRAM	N/A	N/A	N/A	N/A	N/A
FAF_	DOD SCREENING AND TESTING PROGRAM	F ACCT RAW PROC	NUMBER OF TESTS	N/A	N/A	N/A
FAH_	CLINICAL INVESTIGATION PROGRAM	N/A	N/A	N/A	N/A	N/A
FAI_	PHYSIOLOGICAL TRAINING/SUPPORT PROGRAM	N/A	N/A	N/A	N/A	N/A
FAK_	MEDICAL TRAINEE EXPENSES OTHER THAN GME	N/A	N/A	N/A	N/A	N/A
FAL_	CONTINUING HEALTH EDUCATION	N/A	N/A	N/A	N/A	N/A
FAM_	GME INTERN/RESIDENT EXPENSES	N/A	N/A	N/A	N/A	N/A
FAN_	GDE INTERN/RESIDENCY EXPENSES	N/A	N/A	N/A	N/A	N/A
FAO_	GME FELLOWSHIP/ RESIDENT EXPENSE – FULL TIME RESEARCH	N/A	N/A	N/A	N/A	N/A
FAP_	GME FELLOWSHIP EXPENSES	N/A	N/A	N/A	N/A	N/A
FAQ_	GDE FELLOWSHIP EXPENSES	N/A	N/A	N/A	N/A	N/A
FAS_	BEHAVIORAL HEALTH PROMOTION AND PREVENTION	N/A	N/A	N/A	N/A	N/A
FAZ_	SPECIAL HEALTH-RELATED PROGRAMS NOT ELSEWHERE CLASSIFIED (Requires advance approval)	N/A	N/A	N/A	N/A	N/A
FB	PUBLIC HEALTH SERVICES					
FBB_	PREVENTIVE MEDICINE	N/A	N/A	N/A	N/A	N/A
FBC_	INDUSTRIAL HYGIENE PROGRAM	N/A	N/A	N/A	N/A	N/A
FBD_	RADIATION HEALTH PROGRAM	N/A	N/A	N/A	N/A	N/A

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
FBE_	ENVIRONMENTAL HEALTH PROGRAM	N/A	N/A	N/A	N/A	N/A
FBF_	EPIDEMIOLOGY PROGRAM	N/A	N/A	N/A	N/A	N/A
FBI_	IMMUNIZATIONS	F ACCT RAW PROC	NUMBER OF IMMUNIZATIONS AND SCREENING TESTS	N/A	N/A	N/A
FBJ_	EARLY INTERVENTION SERVICES	F ACCT RAW PROC	NUMBER OF INDIVIDUAL FAMILY SERVICE PLANS	N/A	N/A	N/A
FBK_	MEDICALLY RELATED SERVICES (MRS)	F ACCT RAW PROC	NUMBER OF INDIVIDUAL EDUCATIONAL PLANS	N/A	N/A	N/A
FBL_	MULTI-DISCIPLINARY TEAM SERVICES (MTS)	N/A	N/A	N/A	N/A	N/A
FBN_	HEARING CONSERVATION	OUTPT VISITS; TOTAL VISITS; AMB WTD PROC (ADM ONLY)	NUMBER OF VISITS	N/A	N/A	TOTAL VISITS W/ANC; TOTAL VISITS W/O ANC
FBX_	PUBLIC HEALTH SERVICES COST POOL	FBX_/ DMIS ID	N/A	GENERIC AMOUNT	GENERIC AMOUNT	N/A
FBZ_	PUBLIC HEALTH SERVICES NOT ELSEWHERE CLASSIFIED (Requires advance approval)	N/A	N/A	N/A	N/A	N/A
FC	HEALTHCARE SERVICES SUPPORT					
FCA_	PURCHASED/ REFERRED CARE	N/A	N/A	N/A	N/A	N/A
FCB_	CONSULTANT AND GUEST LECTURER PROGRAM	N/A	N/A	N/A	N/A	N/A
FCC_	SUPPORT TO NON-FEDERAL EXTERNAL PROVIDERS	N/A	N/A	N/A	N/A	N/A
FCD_	SUPPORT TO OTHER MILITARY ACTIVITIES	N/A	N/A	N/A	N/A	N/A
FCE_	SUPPORT TO OTHER FEDERAL AGENCIES	N/A	N/A	N/A	N/A	N/A
FCG_	SUPPORT TO NON-MEPRS REPORTING ACTIVITIES	N/A	N/A	N/A	N/A	N/A
FCZ	HEALTHCARE SERVICES SUPPORT	N/A	N/A	N/A	N/A	N/A

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
	NOT ELSEWHERE CLASSIFIED (Requires advance approval)					
FD	MILITARY-UNIQUE MEDICAL ACTIVITIES					
FDB	BASE OPERATIONS-MEDICAL INSTALLATIONS	N/A	N/A	N/A	N/A	N/A
FDC_	DINING FACILITY - NONPATIENT FOOD OPERATIONS	EIB MEALS SERVED	NUMBER OF NON-PATIENT MEALS SERVED	N/A	N/A	N/A
FDD_	DECEDENT AFFAIRS	N/A	N/A	N/A	N/A	N/A
FDE_	INITIAL OUTFITTING	N/A	N/A	N/A	N/A	N/A
FDF_	URGENT MINOR CONSTRUCTION	N/A	N/A	N/A	N/A	N/A
FDG_	TDY/TAD EN ROUTE TO PCS	N/A	N/A	N/A	N/A	N/A
FDH_	MILITARY FUNDED EMERGENCY LEAVE	N/A	N/A	N/A	N/A	N/A
FDI_	IN PLACE CONSECUTIVE OVERSEAS TOUR LEAVE	N/A	N/A	N/A	N/A	N/A
FDX_	MILITARY-UNIQUE MEDICAL ACTIVITIES COST POOLS	FDX_/ DMIS ID	N/A	GENERIC AMOUNT	GENERIC AMOUNT	N/A
FDZ_	MILITARY UNIQUE MEDICAL ACTIVITIES NOT ELSEWHERE CLASSIFIED (Requires advance approval)	N/A	N/A	N/A	N/A	N/A
FE	PATIENT MOVEMENT AND MILITARY PATIENT ADMINISTRATION					
FEA_	AMBULANCE SERVICES	F ACCT RAW PROC	NUMBER OF HOURS OF SERVICE	N/A	N/A	N/A
FEB_	PATIENT MOVEMENT EXPENSES	N/A	N/A	N/A	N/A	N/A
FED_	MILITARY PATIENT PERSONNEL ADMINISTRATION	N/A	N/A	N/A	N/A	N/A
FEF_	AEROMEDICAL STAGING FACILITIES	F ACCT RAW PROC	NUMBER OF PATIENT MOVEMENTS	N/A	N/A	N/A
FEX	COST POOL	FEX_/ DMIS ID	N/A	GENERIC AMOUNT	GENERIC AMOUNT	N/A

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
G	READINESS					
GA	READINESS PLANNING & ADMINISTRATION					
GAA_	DEPLOYMENT PLANNING & ADMINISTRATION	N/A	N/A	N/A	N/A	N/A
GAB_	OTHER READINESS PLANNING & ADMINISTRATION	N/A	N/A	N/A	N/A	N/A
GB	READINESS PEACETIME / WARTIME / DISASTER PREPAREDNESS TRAINING / EXERCISES					
GBA_	READINESS PEACETIME/ WARTIME/DISASTER PREPAREDNESS TRAINING	N/A	N/A	N/A	N/A	N/A
GD	UNIT OR PERSONNEL DEPLOYMENTS					
GDA_	UNIT OR PERSONNEL DEPLOYMENTS	N/A	N/A	N/A	N/A	N/A
GF	READINESS PHYSICAL TRAINING					
GFA_	READINESS PHYSICAL TRAINING	N/A	N/A	N/A	N/A	N/A
GG	PEACETIME DISASTER PREPAREDNESS RESPONSE AND NDMS					
GGA_	PEACETIME DISASTER PREPAREDNESS RESPONSE AND NDMS	N/A	N/A	N/A	N/A	N/A
FCCs USED IN COMPOSITE HEALTHCARE SYSTEM (CHCS)/ARMED FORCES HEALTH LONGITUDINAL TECHNOLOGY APPLICATION (AHLTA) ONLY – (See Appendix 7, Table 14 in this DHA-PM)						
AAC	CORONARY CARE UNIT					

FCC	TITLE	DATA SET ID(S)	RAW STATISTICAL AMOUNT	WEIGHTED STATISTICAL AMOUNT	ALLOCATION FACTOR	SERVICE UNIT
AAH	MEDICAL ICU					
ABC	SURGICAL INTENSIVE CARE					
ADC	NICU					
ADE	PEDIATRIC ICU					
XXX	CARDED FOR RECORD ONLY					
YYY	ABSENT SICK					
FAR	FOR USE BY REFERRAL MANAGEMENT ONLY					

Note: The FAR FCC is approved for use in CHCS only, and it is not authorized for use in EAS IV. The FAR FCC is not authorized to be established in the CHCS Patient Appointment System module, and is not authorized for reporting clinical workload, clinical coding, and/or Relative Value Units (RVUs).

APPENDIX 6

EXPENSE ASSIGNMENT SYSTEM IV BUSINESS RULES FOR 'A' - INPATIENT', 'B' - OUTPATIENT', AND 'C' - DENTAL FUNCTIONAL COST CODES

Table 6. Inpatient Care Business Rules (A FCCs)

INPATIENT CARE BUSINESS RULES (A FCCs). The Inpatient FCCs have two categories of FCCs which include Inpatient Ward (A_X) Cost Pool FCCs and Inpatient (non-cost pool) FCCs that are commonly referred to as 'Pure' FCCs. Pure 'A' (non-cost pool FCCs have unique service units, but do not have allocation factors. Inpatient ward cost pool (A_X) FCCs do not have service units but have allocation factors. Total expenses and FTEs reported in the Inpatient Ward cost pool (A_X) FCCs are purified to 4th level final operating FCC accounts during the expense allocation process. After purification during the expense allocation process, the total expenses in the Inpatient Ward Cost Pools (A_X FCCs) should have a zero balance. See enclosure 3 and paragraph 3 for more discussion on the purification of cost pools that occurs before the stepdown process of the 'D' and 'E' FCCs. See enclosure 3, Appendix 4, and Table 4 in this DHA-PM for a discussion of the EAS IV ASN for the allocation stepdown process of the 'D' and 'E' FCCs. See Volume 1, Enclosure 3, and paragraph 5 in this DHA-PM and enclosure 3, Appendix 5 and Table 5 in this DHA-PM for the EAS IV dataset reporting requirements for Service Units and Allocation Factors. See below for the detailed criteria and business rules for reporting the service units and purification/allocation factors for Inpatient care.
1. Inpatient Ward (A_X) Cost Pool FCCs. Represent the physical location/work center of the inpatient ward where patients occupy a bed. All supplies, equipment, nursing personnel FTEs and salary expenses required to operate an inpatient ward should be reported as direct operational expenses only in the Inpatient A_X FCCs. Square footage and square footage cleaned should be reported in the Inpatient Ward (A_X) FCCs since the Inpatient Wards represent the physical location and work center for inpatient care. Physicians and Dentists are not authorized to report their time or salary expenses in the Inpatient Ward (A_X) FCCs. If reporting of expenses or FTEs vary from these business rules, then it can result in a distortion of patient care cost per service unit during the expense allocation process to the final operating 'A' FCCs. 2. Inpatient Ward (A_X) Minutes of Service as a Purification/Allocation Factor. The Inpatient Ward Cost Pool FCCs do not have a service unit, but they capture and report minutes of service for all patient types who occupy an inpatient bed on an inpatient ward as a purification/allocation factor used during expense allocation. Some outpatients and dental APV patients may temporarily occupy an inpatient bed on an inpatient ward, but these outpatients are not reported as inpatient admissions, inpatient occupied OBDs or bassinet days, or inpatient dispositions. Purification of all inpatient ward expenses in A_X FCCs to

all inpatients, outpatients, and dental patients who occupy an inpatient bed is performed in MEPRS using minutes of service for the equitable distribution of the inpatient ward direct operational expenses. Guidelines for reporting minutes of service as a purification/allocation factor for inpatient wards are provided below.

a. Inpatients reported with a Pure 'A' FCC on an Inpatient Ward dataset FCC. Calculate 1,440 minutes of service (as a weighted allocation factor) per one inpatient OBD and Bassinet Day. Each valid inpatient OBD and/or Bassinet Day is entered in the Inpatient Ward (A_X_) FCC Dataset as a raw count.

b. Outpatients/APVs/Dental APVs. Outpatients/APVs/Dental APVs reported with a Pure 'B' or 'C' FCC on an Inpatient Ward FCC: Calculate actual time (minutes of service) as a weighted allocation factor per outpatient/dental patient that occupies a bed on an inpatient ward. The outpatients/dental patients are not reported with an inpatient OBD as a raw count (see Reference (y) for discussion of APVs).

3. Criteria for Reporting an Inpatient Ward in an A_X FCC. Inpatient operating beds authorized to be reported for an inpatient ward are sometimes referred to as a normal, routine, or constructed bed. An operating/constructed bed is an inpatient bed originally designed and constructed for the delivery of peacetime inpatient care in a MTF; usually spaced on 8-foot centers (approximately 140 - 200 square feet) and furnished with suction, medical gas and nurse call capacity; meets standards applied by common hospital accreditation bodies. Only inpatient wards with qualified inpatient operating beds are authorized to report inpatient admissions, OBDs, and dispositions. Criteria for classification of an inpatient ward authorized to report inpatient bed days is provided below (see References (z) and (aa)).

a. Qualified Inpatient Ward Occupied Operating/Constructed Beds INCLUDE:

(1) LDRP (combined labor, delivery, recovery and postpartum);

(2) Special and/or intensive care; and

(3) Pediatric cribs set up in patient rooms.

b. Qualified Inpatient Ward Occupied Operating/Constructed Beds EXCLUDE:

(1) Transient patient beds

(2) Bassinets (See Bassinet Days below)

(3) Incubators

(4) LDR (combined labor, delivery, recovery not used for postpartum

(5) External partnership or external VA bed

(6) Internal non-DoD bed

4. Criteria for Reporting Inpatient Occupied Bed Service Unit. Criteria for Reporting Inpatient Occupied Bed Service Unit on inpatient wards as described in Appendix 6, Table 6, paragraph 3, above is a day in which a patient occupied an operating bed at the census taking hour (normally midnight). The following are also counted as bed days:

a. Same day transfer out if a patient is transferred to a non-MTF.

b. When the patient occupies a bed day in more than one inpatient care area in one day, the bed day shall be counted only in the inpatient care area where the patient is located at the census-taking hour. This definition excludes days during which the inpatient is subsisting out, on convalescent leave, on authorized or unauthorized leave, or in a transient status.

c. Active duty military patients not requiring inpatient care, and assigned for administrative or other non-medical reasons, shall not be counted as a bed day.

5. Criteria for Counting OBDs for Maternity Patients as a Service Unit. Until 2003, there were no Medicare rules that explicitly addressed the treatment of labor and delivery days for purposes of the Disproportional Share Hospital (DSH) calculation. In 2003, Center for Medicare and Medicaid (CMS) amended the DSH regulation to "clarify" that a patient day should not be counted for a patient who is in a labor and delivery room at census-taking hour unless the patient previously occupied a routine bed at some point since admission (see References (z) and (aa)).

6. Criteria for Reporting an Inpatient Bassinet Day Service Unit. This criteria in the inpatient ward is a day in which a live birth at the reporting facility occupied a bassinet in the newborn nursery at the census taking hour (normally midnight). The stay must be continuous since birth. The stay is also not dependent on the status of the mother. This excludes days spent by infants in a bassinet on a pediatric nursing unit, pediatric or neonatal intensive care unit, or other nursing unit. Bassinet Day is a Service Unit. If the mother and baby are placed in a consolidated Mother-Baby Ward or consolidated Labor Delivery, Recovery, and Postpartum (LDRP) unit, an OBD will be reported for the mother, and a Bassinet Day will be reported for the newborn.

7. Pure Inpatient 'A' FCCs (non-cost pool FCCs). Pure Inpatient 'A' FCCs (non-cost pools FCCs) should only report man-hours and salary expenses of the admitting/attending credentialed provider as a 'direct' operating expense. The pure 'A' FCC should not be used to report consultations provided by other specialty providers. Outpatient consultations from other specialty providers should be reported in the appropriate outpatient 'B' FCC of the provider providing a consultation. In EAS IV/MEPRS, these consultations are reported as an Inpatient Count Visit in the 'B' outpatient FCC of the consulting provider (see enclosure 3, Appendix 6, Table 7 for Outpatient Business Rules for more detail of reporting inpatient visits in a 'B' FCC). Pure (non-cost pool) 'A' FCCs are considered final operating FCCs that receive all stepdown costs from the physical inpatient ward (inpatient ward A_X FCC cost pool) and the intermediate ('D' and 'E' FCCs). The total direct and allocated expenses reported in the Pure Inpatient 'A' FCCs (non-cost pool) are measured against inpatient service units of admission, OBD/bassinet day, and disposition. Examples of pure inpatient 'A' FCCs are AAA - Inpatient Internal Medicine, ABA - Inpatient General Surgery, etc.

8. Reporting Inpatient Admission Service Units. Reporting Inpatient Admission Service Units for pure 'A' FCCs in MEPRS is linked to the reporting of the inpatient OBD and bassinet day service units. An inpatient admission is the act of placing an individual under treatment or observation in a medical center or hospital. The day of admission is the day on which the medical center or hospital makes a formal acceptance (assignment of a register number) of the patient who is to be provided with room, board, and continuous nursing service in an area of the hospital where patients normally stay at least overnight (to qualify for a bed day at census hour). When reporting inpatient admission data, always exclude: total absent-sick patients, carded-for-record only (CRO) cases, and transient patients.

9. Reporting Inpatient Disposition Service Units. The removal of a patient from the census of a medical center or hospital because of discharge to duty, to home, transfer to another medical facility, death, or other termination of inpatient care. The day of discharge is the day on which the medical center or hospital formally terminates the period of inpatient hospitalization.

10. Clinics with observation beds. An outpatient clinic may be equipped with beds for observation of patients awaiting transfer to a hospital, and for the care of cases that cannot be cared for on an outpatient status, but that do not require hospitalization. Such beds shall *not* be considered in calculating occupied-bed days by MTFs.

Table 7. Outpatient Care Business Rules (B FCCs)

OUTPATIENT CARE BUSINESS RULES (B FCCs). Pure (non-cost pool) clinic Outpatient care 'B' FCCs are reported with a service unit of a 'count visit'. Visits are also used as an allocation factor for outpatient cost pool FCCs (B_X) when these expenses are purified. Total expenses for 'B' cost pool FCCs are purified to a zero balance during the expense allocation process. The FBN - Hearing Conservation FCC is the only exception for reporting count visits in 'B' FCCs. See Enclosure 3, Appendix 5, Table 5 in this DHA-PM for data set service unit and allocation factor requirements for all FCCs. See below for detailed criteria and business rules for reporting the service units and purification and allocation factors for Outpatient care.

1. Reporting a Clinic in a 'B' FCC. A clinic is a health treatment facility primarily intended and appropriately staffed and equipped to provide emergency treatment and/or outpatient services. A clinic is also intended to perform certain non-therapeutic activities related to the health of the personnel served, such as physical examinations, immunizations, medical administration, preventive medicine services, and health promotion activities to support a primary military mission. A clinic may be equipped with beds for observation of patients awaiting transfer to a hospital, and for the care of cases that cannot be cared for on an outpatient status, but that do not require hospitalization. Such beds shall not be considered in calculating occupied-bed days by MTFs. A clinic reported in a fourth level 'B' FCC shall meet the criteria of work center as described in Enclosure 3, and paragraph 2.b. in this DHA-PM.

2. Count Visits. Currently in MEPRS reporting, 'count' visits are interfaced from CHCS to EAS IV, and the visits are used as both a service unit for outpatient clinics and a purification and allocation factor for 'B' outpatient cost pools. Weighted values are captured in the EAS IV Ambulatory Data Module (ADM), and weighted values from the ADM module are under development for future use as a possible service unit, purification factor, and/or allocation factor.

a. Count Visit Service Unit vs. Purification/Allocation Factor. Outpatient and Inpatient Visits are reported in a 'B' FCC. Visits are classified as either outpatient or inpatient visits in MEPRS reporting, but both types of visits are considered outpatient/ambulatory care that should be reported in a 'B' FCC. All pure 'B' FCCs are measured with a service unit of expense per (count) visit, and all 'B' cost pool FCCs are purified during expense allocation with (count) visits. The FBN - Hearing Conservation FCC is the only exception for reporting count visits in a 'B' FCC.

b. Criteria of Count Visit. The following criteria must be met before a visit can be reported as a 'count' visit. The criteria for a count visit should not be confused with reporting all encounters/RVUs which are considered 'count' workload. For example, a non-count visit can produce count RVUs. There must be interaction between an authorized patient and a healthcare provider. Independent judgment about the patient’s care must be used, assessment

of the patient's condition must be made, and any one or more of the following must be accomplished.

(1) Examination

(2) Diagnosis

(3) Counseling

(4) Treatment

(5) Documentation must be made in the patient's authorized record of medical treatment. Documentation must include at least the date, name of clinic, reason for visit, assessment of the patient, description of the interaction between the patient and the healthcare provider, disposition, and signature of the provider of care. There must be final documentation upon completion of prescribed treatment. In all instances, a clear and acceptable audit trail must be maintained.

3. Inpatient vs. Outpatient Visit Criteria. The following types of visits are reportable as a count visit when the criteria are met. See criteria of a count visit in Enclosure 3, Appendix 6, Table 7, and paragraph 2, above in this DHA-PM.

a. Inpatient Visit. An inpatient visit shall be counted for the following situations.

(1) Each time an inpatient is seen within the admitting MTF on a consultative basis in an outpatient clinic, or in the physical examination and standards section for evaluation of profile changes.

(2) Each time contact is made by clinic or specialty service members (other than the healthcare provider from the treating clinic or specialty service) with patients on hospital units or wards, when such services are scheduled through the respective clinic or specialty service

(3) Conversely, a routine ward round made by a physical therapist or dietitian shall not be counted as a visit (see Enclosure 3, Appendix 6, Table 7, and paragraph 8 below.

b. Outpatient Visit. An outpatient visit can be counted for the following situations.

(1) All visits to a separately organized clinic or specialty service made by patients who are not currently admitted to the reporting MTF as an inpatient.

(2) Each time medical advice or consultation is provided to the patient by telephone if the criteria of a count visit are met. See criteria of a count visit provided in Enclosure 3, Appendix 6, Table 7, paragraph 2, above in this DHA-PM.

(3) Each time a patient's treatment or evaluation results in an admission and is not part of the preadmission or admission process.

(4) Each time all or part of a complete or flight physical examination, regardless of the type, is performed in a separately organized clinic or specialty service. Under this rule, a complete physical examination requiring the patient to be examined or evaluated in four different clinics is reported as a visit in each of the four clinics.

4. Multiple Visits Reporting Criteria

a. Multiple visits may be counted if a patient is provided care in different clinics or is referred from one care provider to another care specialty provider for consultation in the same clinic, and the patient care is documented; e.g., a patient seen at a primary care clinic and two other specialty clinics on the same day can be counted as three visits; a Pediatric patient referred to a pediatric specialty provider in the same clinic; a patient seen in a primary community medical home clinic and referred to behavioral health specialty provider in the same clinic.

b. A patient is seen in clinic in the morning and again in the afternoon can be reported as two visits if the first visit was complete; e.g., the patient was evaluated, treated, dispositioned, and the visit was documented properly in the medical record.

(1) If the afternoon visit is merely a continuation of the morning visit, then only one visit can be counted; e.g., a patient seen in the orthopedic clinic in the morning is sent to radiology for electromagnetic radiation also known as X-rays, and then returns to the orthopedic clinic in the afternoon for continued evaluation or treatment. These rules apply even if the patient is admitted to an inpatient status immediately following a clinic visit.

(2) If the patient is seen by more than one healthcare provider in the same clinic in the same episode of care, only one visit is counted per patient.

5. Second Opinion Visits. If the patient requests a second opinion, a visit can be counted provided the criteria is met. See criteria of a count visit in Enclosure 3, Appendix 6, Table 7, paragraph 2. above in this DHA-PM.

6. Telemedicine Visits. If a patient is present in a provider's office and another provider is contacted through telemedicine, both providers may count the visit in their clinic specialty. This is considered a valid medical consultation, and as such, it requires proper medical documentation by the consulted physician ensuring that the criteria of a visit are met. See criteria of a count visit in enclosure 3, Appendix 6, Table 7, paragraph 2, above in this DHA-PM. A visit should not be counted if the patient is not present during the consult.

7. Unique Clinics. There are a few outpatient 'B' clinic FCCs that have unique criteria that shall be met before the 'B' FCC is reported in MEPRS. See below.

a. Radiation Therapy Clinic (BAS FCC) Count Visits. This Radiology clinical service has a service unit of a visit. Radiation is usually given once a day in a dose that is based on the type and location of the tumor. When the daily dose is divided into smaller doses that are given more than once a day (usually separated by 4 to 6 hours), the therapy must be reported as one visit.

b. Immediate Care Clinic (BHI FCC) Count Visits. The Immediate Care Clinic FCC was created for MTFs that render lifesaving first aid and that make referrals to the nearest facility that has the capability of providing the needed services because the MTF is not authorized an Emergency Room. Criteria for reporting an Immediate Care Clinic requires an ambulance service provided at least during normal clinic duty hours and generally 24 hours per day; at least one physician available within 30 minutes or less; and are not authorized an Emergency Room. If the MTF has an Emergency Room with Ambulance Service and has created a secondary valid outpatient clinic work center created to provide first aid and provide healthcare for acute illnesses that do not require Emergency Room and trauma care, then an Acute Care Clinic can be established in the BHA - Outpatient Primary Care FCC. Use of the BHI FCC requires prior Service and DHA MEPRS approval.

c. Outpatient Emergency Medical Clinic: (BIA FCC) Count Visits. The function of the Emergency Medical Clinic provides 24-hours a day emergency care, diagnostic services, treatment, surgical procedures, and proper medical disposition of an emergency nature to patients who present themselves to the service. It refers patients to specialty clinics and coordinates with other Physician/Dentist specialties and sub-specialties for the admission of patients to the MTF, as needed. It also provides clinical consultation services and professional on-the-job (OJT) training of assigned personnel, supports mass casualty and fire drills, and prepares reports.

8. Services Not Reportable as Count Visits

a. Occasion of Service. Without an assessment of the patient's condition or the exercise of independent judgment, as to the patient's care, screening examinations, procedures, or tests are classified as an "occasion of service" because they do not meet the criteria of a count visit in Enclosure 3, Appendix 6, Table 7, and paragraph 2, above in this DHA-PM.

b. Ward Rounds and Grand Rounds. Ward rounds and grand rounds are considered part of the inpatient care regimen and are not counted as inpatient visits. Visits by an inpatient to an outpatient clinic for the convenience of the attending provider, and instead of ward or grand rounds, shall not be counted.

c. Group Education and Information Sessions. These sessions shall not be counted when they do not meet the criteria of a count visit provided in Enclosure 3, Appendix 6, Table 7, paragraph 2, above in this DHA-PM.

Table 8. Dental Care Business Rules (C FCCs)

DENTAL CARE BUSINESS RULES (C FCCs). Dental care can be performed in a Dental Clinic work center, in a Dental Lab work center, or in a fixed MTF Surgical Suite, APU, etc. The reporting for these Dental Care functions in EAS IV/MEPRS is unique due to distinct functions and different service units. See Enclosure 3, Appendix 5, and Table 5 in this DHA-PM for EAS IV dataset, service unit, and allocation factor requirements for all FCCs. See below for unique Dental Care service units and/or allocation factor reported in EAS IV/MEPRS.
1. Dental Care Clinics (CAA FCC). Dental Care Clinics (CAA FCC) report weighted values that have been developed for dental clinical procedures based on the American Dental Association (ADA) weighted procedure codes. These values are furnished by the MHS dental community on a periodic basis. All expenses, man-hours and FTEs, dental clinic weighted workload, square footage, etc. will be reported in the Dental Clinic FCC of the work center where the procedure is performed. Dental procedures performed in a Dental Clinic should not be reported as an Ambulatory Dental Procedure in CAA5, or the direct operating expenses and allocated expenses of the Dental Clinic will be distorted. Dental ADA weighted procedures are the unique service unit of procedures performed in the Dental Clinic work centers.
2. Dental Care Ambulatory Procedures. EAS IV is designed to identify Dental procedures performed in a dental clinic vs. Dental ambulatory procedures performed in fixed MTF work centers; such as the Surgical Suite, APU. EAS IV has two different service units for each type of dental procedure. The methodology is dependent on use of specific 4th level FCCs. The service unit of a Dental Ambulatory Procedure performed in a fixed MTF work center (Surgical Suite, APU, etc.) is established in EAS IV with the unique 4th level FCC of CAA5 so they can be separated and identified from procedures performed in a Dental Clinic work center. Dental personnel are not authorized to report their man-hours, salary expenses, etc., in the MTF work centers FCCs (Surgical Suite, Ambulatory Procedure Unit, etc.). Dental personnel should report their man-hours to the designated Dental Ambulatory Procedure CAA5 FCC only when the procedure is *not* performed in a Dental Clinic (Reference (y)).

a. Service Unit for Dental Ambulatory Procedures Performed in a fixed MTF Medical Work Center in the CAA5 FCC. Dental Ambulatory Procedures should be reported with a unique service unit of a raw, unweighted patient count, but users must enter the raw, unweighted patient count in the EAS IV Dental weighted procedure field in the Dental weighted procedure dataset. Dental ambulatory surgical procedures are performed in MTF work centers (not Dental clinics) and are supported by MTF personnel. It is important to identify dental procedures performed in a fixed MTF work center vs. dental procedures performed in a fixed DTF Dental Clinic for accurate MEPRS direct operational expense and total allocated expenses per each type of Dental service unit (Reference (y)).

b. Service Unit for Dental Procedures Performed in a Dental Clinic. Identification of and reporting dental procedures performed in a Dental Clinic work center by unique 4th level FCC vs. Dental procedures performed in a fixed MTF work center by unique 4th level FCC supports more accurate direct expense and expense allocation reporting in MEPRS. When Dental Ambulatory Procedures are reported with a raw, unweighted count and as a requesting specialty service in the fixed MTF EAS IV datasets for Surgical Suite, Ambulatory Procedure Unit, etc., these fixed MTF work centers calculate their weighted minutes of service for each Dental patient raw patient using their unique FCC and dataset business rules. This allows the expense allocation of the fixed MTF work centers to the Dental Ambulatory Procedure FCC to be equitable with the expense allocation to the MTF APVs that are performed in the same MTF work centers.

c. Dental Ambulatory Procedure (CAA5 FCC). Raw, unweighted patient counts are not considered 'visits'. CAA5 is not authorized to be used when the Dental patient care and procedure are performed in a Dental Clinic. CAA5 is only authorized to be used when a Dentist utilizes Medical personnel and support; e.g., Nursing Same Day Surgery Unit, Nursing Surgical Suite, Nursing Recovery Room, etc., (Reference (y)).

3. Dental Prosthetics. Dental Prosthetics are reported in a CB* FCC, and Composite Lab Values are used as a dental weighted procedure service unit. Dental Prosthetics are not authorized to report a surgical ambulatory procedure in CBA5.

4. Dental Prosthetic Cost Pool CBX FCC. Dental Prosthetic Cost Pool uses the Composite Lab Values as a purification factor during the allocation process in EAS IV.

APPENDIX 7

EXPENSE ASSIGNMENT SYSTEM IV BUSINESS RULES FOR 'D' - ANCILLARY FUNCTIONAL COST CODES

Table 9. Pharmacy Weighted Procedures

Pharmacy Procedures	**Weighting Factor**
Prescription	1.00
Clinic Issue	0.60
Sterile Product	2.00
Unit Dose	0.15
Bulk Issue	2.00
Prescription Types	**Weighting Factor**
Prescription (New, Modified, Renewed) (Rx)	1.00
Edit Prescription (EAP)	0.00
Partial Action (PQD)	1.00
Remove a Refill (RRE)	1.00
Forward a Prescription (FAP)	1.00
Decrement at forwarding	1.00
Incremented at accepting	1.00

1. Prescription. Count written order for a medication or device prescribed for an individual Patient A's refill is counted the same as a prescription.

2. Clinic Issue. Count each handout or prepared issue to a clinic for subsequent issue to individual patients by non-pharmacy personnel. A weighted value of 0.6 for each unit of issue is counted.

3. Sterile Product. Count each parenteral bottle, bag, or syringe that is prepared by the pharmacy, i.e., has any number of additive parenterals and is ready for administration. A weighted value of 2.0 for each unit of sterile product.

4. Unit Dose. Count each dose. A weighted value of 0.15 for each dose.

5. Bulk Issue. Count each line item issued to clinics or wards to be used within the clinic or ward. Each line item will have a weighted value of 2.0.

6. Clinical Pharmacist working in an outpatient clinic. A Clinical Pharmacist working in an outpatient clinic and performing direct patient care and consultation should report their available man-hours and workload in the appropriate 'B' FCC of the clinic where the patient care is performed. This specific patient care will be reported with a clinic count visit in CHCS/AHLTA.

Table 10. Laboratory Weighted Values

Pathology Procedures Weighted Values (DB FCCs). All clinical pathology and anatomical pathology workload performance shall be weighted and reported in accordance with the EAS IV Current Procedural Terminology (CPT) Table as defined by Optum CPT coding guidelines and MHS unique weighted values. Users can print the table from EAS.
Clinical Pathology (DBA FCC). Count, as defined in the EAS IV CPT Table. Each test, specimen, patient, smear, tube, bottle, plate, slide, or antigen (pool) performed on or for an inpatient, outpatient, clinic, ward, treatment area, or other requesting authority. Raw count includes all procedures or tests performed for standardization purposes and distribute expenses based on the ratio of weighted procedures provided to each receiving FCC account to the total weighted procedures performed by the clinical pathology function.
Anatomical Pathology (DBB_FCC). Count, as defined in the EAS IV CPT Table. Raw count includes the number of autopsies, frozen sections, cytology smears, special stains, and paraffin blocks performed on or for an inpatient, outpatient, or deceased. The Anatomical Pathology module in CHCS is not being used by the MTFs. Anatomical Pathology information is maintained in another system, and the local MEPRS personnel manually key the service units and allocation factors into the DBB FCC dataset each month.
Cytogenetic Laboratory (DBD_ FCC). Count, as defined in the EAS IV CPT Table. Raw Count includes each test, specimen, patient, smear, tube, bottle, plate, slide, or antigen (pool) performed for cell culture of body fluids (peripheral blood, amniotic fluid, bone marrow, solid tumors, tissues); cell harvest procedures; microscopic chromosome analysis; C-banding; silver staining; and fluorescent in situ hybridization.
Molecular Genetic Laboratory (DBE_ FCC). Count, as defined in the EAS IV CPT Table. Raw Count includes extractions of Deoxyribonucleic Acid (DNA) from body fluids, and analysis of the DNA by a variety of specialized procedures including polymerase chain reaction, southern blotting, single strand conformational polymorphism, and DNA sequencing to diagnose hereditary genetic disease.

Table 11. Radiology and Nuclear Medicine Weighted Procedures

Radiology and Nuclear Medicine Procedures Weighted Values. All diagnostic radiology and nuclear medicine workload performance will be weighted and reported in accordance with the EAS IV CPT Table as defined by Optum CPT coding guidelines and MHS unique weighted values. Raw count for radiology and nuclear medicine procedures shall be the number of procedures. Users can print the table from EAS.
Diagnostic Radiology (DCA FCC). Count, as defined in the EAS IV CPT Table, site licensing, each procedure or test performed for an inpatient or outpatient, and including procedures performed on portables.
Nuclear Medicine (DIA FCC). Count, as defined in the EAS IV CPT Table, site licensing, each procedure or test performed for an inpatient or outpatient, and including procedures performed on portables.
NOTE: Radiation Therapy Clinic (BAS FCC) is not an ancillary service. This Radiology clinical service has a service unit of a visit. The EAS IV CPT Table for Radiology procedures is not used to report Radiation Therapy outpatient clinic service units or workload. BAS FCC Service Unit Additional Information. Radiation is usually given once a day in a dose that is based on the type and location of the tumor. When the daily dose is divided into smaller doses that are given more than once a day (usually separated by 4 to 6 hours), the therapy must be reported as one visit.

Table 12. Ancillary Minutes of Service (MOS) Business Rules

Several Ancillary work centers capture and report MOS as a service unit and/or allocation factor in MEPRS. The business rules for the calculation of the ancillary MOS by FCC and work center is provided in the table below.

FCC/MEPRS Code	Title	Business Rules
DFA	Anesthesiology	1. Anesthesia weighted minutes of service includes the elapsed time during any direct interaction with patients involving an anesthesiologist and/or anesthetist. 2. The total elapsed time captured in step 1 above should then be multiplied by the number of anesthesiologists and/or anesthetists, including residents and student nurse anesthetists (when replacing a person trained in anesthesia) participating in the procedure that is performed in the surgical suite operating room. 3. Examples of direct interaction with patients can include patient interviews in the Preadmission Unit, acute pain management rounds for patients on a ward, emergency intubations (wards/ICU/ER), ER procedures (spinal taps), and I.V. access procedures (wards/ICU).

FCC/MEPRS Code	Title	Business Rules
DFB	Surgical Suite (also referred to as Operating Room)	1. The surgical suite weighted minutes of service includes the elapsed time of an operation performed in the operating room multiplied by the number of hospital personnel participating in each operation. 2. Starting time begins with the start of surgical suite personnel participating in each operation. Elapsed time is the difference between the starting preparation and ending time is when clean-up of the surgical suite following an episode of surgery is complete. 3. The surgical suite MOS are meant to include only those personnel who are directly assigned to the surgical suite. (Surgeons, anesthesiologists, nurse anesthetists, etc. are excluded from this work center.) It also includes student nurses and trainees when replacing individuals in the surgical suite team.
DFC	Post Anesthesia Care Unit (PACU) (also referred to as Recovery Room)	1. Post Anesthesia Care Unit weighted minutes of service includes the period of time beginning when the patient enters the post-anesthesia care unit and ending when the patient leaves the post-anesthesia care unit. 2. The PACU MOS are meant to include only those personnel who are directly assigned to the PACU (Surgeons, anesthesiologists, nurse anesthetists, etc. are excluded from this work center.) It also includes student nurses and trainees when replacing individuals in the PACU team.

All DG* FCCs	All Ambulatory Nursing Services Reported in DG* FCCs - See below 1) DGA - Ambulatory Procedure Unit (APU) normally used to support Same Day Surgery patients. (Reference (y)) for discussion of APUs and APVs. 2) DGB - Hemodialysis FCC 3) DGD - Peritoneal Dialysis FCC 4) DGE - Ambulatory Nursing Services FCC - Normally used for Ambulatory Nursing Units that support a combination of different types of patients and/or multiple functions; e.g., Preadmission, LDP, etc.	1. Ambulatory Nursing Service MOS for all DG* FCCs are counted from the time the patient arrives in the ambulatory nursing services unit until the patient leaves the unit. The patient receives care, assessment, pre-operative interview, and processing while in the unit. 2. The ambulatory nursing services MOS are meant to include only those personnel who are directly assigned to the ambulatory nursing service DG* FCC and work center. (Physicians, GME residents/interns, anesthesiologists, nurse anesthetists, etc. are excluded from reporting man-hours or minutes of service for this work center.) 3. Ambulatory Nursing Services minutes of service shall not include time that the patient is out of the unit, such as for radiology or laboratory services. 4. Minutes of Service for Ambulatory Nursing Services reported in DG* FCCs are NOT multiplied by the number of staff and should represent the actual time elapsed that the patient was on the DG* Nursing Unit. 5. Standalone and independent Labor & Delivery Unit work centers that are not part of a consolidated Labor, Delivery, Recovery, and Postpartum (LDRP) are referred to as a Labor, Delivery, and Recovery (LDP) unit. LDP units should be reported as an ancillary service with minutes of service. Minutes of service should represent the actual time elapsed that the patient was on the DGE* Nursing Labor & Delivery Unit. NOTE: See Enclosure 3, Appendix 6, and paragraph 1. for Inpatient business rules for reporting LDRP consolidated units in A_X FCCs. LDRPs have consolidated Labor, Delivery, Recovery, and Postpartum

FCC/MEPRS Code	Title	Business Rules
		performed in one location/inpatient ward, and the MOS are tracked per patient ambulatory and inpatient specialty FCC on the Inpatient ward FCC. (Reference (z) and (aa)). 6. Standalone and independent Nursing Preadmission Units are an ancillary service that should be reported with minutes of service. The requesting FCC specialty reported on a Preadmission Dataset shall be reported with an outpatient care (B FCC) because the patient has not been admitted as an inpatient yet, and a procedure and admission may be cancelled during the preadmission processing.

Table 13. Miscellaneous Ancillary Accounts (DD, DE, and DHA FCCs) Business Rules

Miscellaneous Ancillary Services with unique service units and allocation factors that are not included in Enclosure 3, Appendix 7, and Tables 6 through 12 above are provided below.
1. Cardiac Catheterization (DDE) FCCs. CPT codes for Cardiac Catheterization cannot be entered through the Radiology module in CHCS. CPT codes are included on the Optum CPT coding guidelines with MHS unique weighted values that are maintained in EAS IV. MTF MEPRS personnel manually enter the Cardiac Catheterization service units and allocation factors in the DDE dataset in EAS IV. Service unit and Allocation factor are Cardiac Catheterization weighted procedures (see Enclosure 3, Appendix 5, and Table 5 of this DHA-PM.
2. Central Sterile Supply (DE*) FCCs. Service unit and allocation factor for the Central Sterile Supply work center is Central Sterile Hours of Service. See service units and allocation factors in Enclosure 3, Appendix 5, and Table 5 of this DHA-PM.
3. Respiratory Therapy Services (DH* FCCs). Respiratory Therapy reports with unique procedure codes and not with CPT codes. The procedure codes and weighted values are based on the most current version of the 'Uniform Reporting Manual for Respiratory Care' that is developed by the American Association for Respiratory Care. The majority of the respiratory therapy procedures are performed for inpatients, but some support is provided to outpatients. The Respiratory Therapy table is maintained in EAS IV and can be printed.

Table 14. MEPRS/CHCS ICU Code Relationship and Business Rules

DJ* ICU MEPRS Code	A Level ICU Code
DJAA	AAHA
DJBA	ABCA
DJCA	AACA
DJDA	ADCA
DJEA	ADEA

1. ICUs are classified as an ancillary service in a DJ* ICU MEPRS code in EAS IV/MEPRS, but the Nursing ICUs are reported with an 'A' Level ICU code in CHCS. The 'A' Level ICU Codes are not considered MEPRS codes.

2. There is a relationship and mapping between the DJ* ICU MEPRS Codes and the 'A' Level ICU Codes in CHCS. See mapping of the DJ* ICU MEPRS Codes to the CHCS 'A' Level ICU codes in Table 9 above.

3. The Standard Inpatient Data Record (SIDR) reports admissions, dispositions, bed days, and live births by the “A” level ICU Codes listed above. In comparison, EAS IV/MEPRS reports the ICUs in an ancillary DJ* FCC/MEPRS code with ICU Hours of Service. Requesting ‘A’ Inpatient MEPRS codes are reported by requesting specialty on the EAS IV DJ* ICU datasets. These 'A' MEPRS codes are different than the A Level ICU Codes (see Enclosure 3, Appendix 5, and Table 5 in this DHA-PM for all Inpatient 'A' MEPRS codes (non-cost pool FCC) dataset requirements.

4. The service unit and allocation factor for the DJ* ICU FCCs in EAS IV/MEPRS reporting is ICU Nursing Hours of Service. The ICU Hours of Service reported in the DJ* FCCs in EAS IV/MEPRS are counted from the time the patient arrives in the ICU unit until the patient leaves the unit.

5. The ICU Hours of Service are meant to include only those personnel who are directly assigned to the ICU work center. Physicians, Anesthesiologists, Nurse Anesthetists, and GME/GDE skill Type 1 personnel are not authorized to report man-hours in the DJ* ICU FCC/MEPRS codes.

APPENDIX 8

EXPENSE ASSIGNMENT SYSTEM IV BUSINESS RULES FOR 'E' - SUPPORT SERVICES FUNCTIONAL COST CODES

Table 15. Miscellaneous Support Services In 'E' FCCs Business Rules

SUPPORT SERVICES BUSINESS RULES (E FCCs). The intermediate 'E' support FCCs report administrative, logistical, BASOPS, overhead, etc. direct expenses that are allocated to final operating FCCs based on specific allocation factors. The 'E' Support Services FCCs do not have a service unit in EAS IV, but they have designated allocation factors. The Support Services 'E' FCCs have several different allocation factors and methodologies that produce a more equitable distribution of support expenses to final operating FCCs when actual support cannot be quantified. The Support Service FCC expenses are allocated according to the assignment procedures governing the Support Services intermediate FCC accounts. The alphabetic order of the 'E' FCC accounts is different from the order of expense allocation by FCC. See the EAS IV ASN in Enclosure 3, Appendix 4 and Table 4 in this DHA-PM. See Enclosure 3, Appendix 3, and Table 3 for business rules for man-hour reporting. There are no Support Services 'E' FCC cost pools in EAS IV (see Enclosure 3, Appendix 5, Table 5 of this DHA-PM for the EAS IV dataset and allocation factors for 'E' Support Services FCCs). See below for description of unique business rules and methodologies for calculation of the allocation factors and expense allocation for Support Services 'E' FCCs (see Enclosure 3, Appendix 8, and Table 16 below for the business rules for the depreciation methodology for the 'EA' Depreciation FCCs). See Reference (e), enclosure 3, and paragraph 5 for all 'E' FCC functional descriptions.
1. Available FTEs as Allocation Factor for 'E' Support Services FCCs. EAS IV automatically calculates the allocation factor of available FTE work-month for some 'E' FCCs so these FCCs do not require data set entry of allocation factors. Total expenses for each of these Support Services 'E' FCCs shall be allocated in EAS IV based on a ratio of each receiving FCC account's available FTE work-months (excluding patients) to the total available FTE work-months in the all FCC performing/allocated 'E' FCC accounts. Excluding 'Z' level FCCs at the third level, the Support Services 'E' FCCs that allocate their expenses based on Available FTEs are listed below: a. EBA_ COMMAND STAFF b. EBB_ SPECIAL STAFF c. EBC_ ADMINISTRATION d. EBD_ CLINICAL MANAGEMENT e. EBF_ EDUCATION & TRAINING PROGRAM SUPPORT - This FCC is intended only for personnel who teach formal CE, mandatory MTF formal training classes, and non-GME/GDE student programs (see Enclosure 3, Appendix 10, Table 18 for the man-hour reporting guidelines for the EBF FCC).

f. EBH_ THIRD PARTY COLLECTION ADMINISTRATION

g. EBJ_ SERVICE MEDICAL IM/IT

h. EDJ_ COMMUNICATIONS

i. EDK_ OTHER BASE SUPPORT SERVICES

j. ELA_ MANAGED CARE ADMINISTRATION - ELA FCC expenses should only allocate to Inpatient 'A' and Outpatient 'B' FCC accounts.

2. GME Support to Physicians (EBE FCC). This FCC is not authorized for GME/GDE or any other student man-hours or related expenses (see Enclosure 3, Appendix 10, Table 18 in this DHA-PM for the EBE GME FCC business rules for reporting).

3. GDE Support to Dentists (EBI FCC). This FCC is not authorized for GME/GDE or any other student man-hour or related expenses (see Enclosure 3, Appendix 10, Table 18 in this DHA-PM for the EBI GDE FCC business rules for reporting).

4. BASOPS Support Services (ED* FCCs). BASOPS Support Services (ED* FCCs) expenses include services provided by the host installation to the fixed MTF/DTF which in turn reimburses the host installation for the support. A few of the ED* FCCs use available FTEs as an allocation factor for expense allocation, but several of the ED* FCCs have unique methodologies required for an equitable distribution of the base operation support expenses (see Enclosure 3, Appendix 5, Table 5 in this DHA-PM which reflects all of the allocation factors required for expense allocation of the base operation support services expenses reported in the ED* FCCs (see Enclosure 3, Appendix 8, Table 15, and paragraph 1 (EDJ and EDK FCC) in this DHA-PM for BASOPS ED FCCs that allocate based on available FTEs). Specific business rules for remaining BASOPS ED FCCs are listed below (see Reference (r) for more BASOPS guidance).

5. Square footage. To determine the square footage statistic for expense allocation, the number of square feet in each department, service, and division of the healthcare facility must be determined either by a physical measurement of the facility or by a measurement from blueprints. Floor area measurements should be taken from the center of walls to the center of adjoining corridors if a hallway services more than one department. Exclude stairwells, elevators, other shafts, and idle area. Idle areas are those areas closed off or unused for a period of time. Hallways, waiting rooms, and storage areas serving only one department should be included in that department.

a. Commonly used areas. Commonly used areas, such as lobbies, shall be divided equitably among the users of those areas. The effect of measuring only usable space will allocate the space (commonly used and idle area) among the departments in the ratio of space used. When changes in assigned areas have been made during the year as the result of new construction, departmental relocation, expansion, or curtailment of service, sufficient data should be maintained and updated in the EAS IV Square Footage data set by fiscal month.

b. Square Footage of Physical Work Centers vs. Cost Centers. Square Footage of physical work centers vs. cost centers is used for accurate expense allocation of the BASOPS overhead accounts related to the building maintenance, utilities, restoration, etc. The Square Footage dataset should include square footage of physical work centers located within the physical fixed MTF/DTF buildings that corresponds to the appropriate FCC of that work center. If a fixed MTF/DTF function is performed in a building or location that is not a physical work center in the fixed MTF/DTF, and the fixed MTF/DTF does not fund the maintenance, overhead, utilities, etc. of that location/building, then no square footage should be reported for that external building/location.

c. Loaned Square Footage. If square footage in the fixed MTF/DTF is loaned to an external organization for their use, then the appropriate FC* FCC should be reported for that square footage so that the cost of that square footage overhead is not charged to any fixed MTF/DTF programs.

d. Leased Buildings. The square footage of leased buildings should not be reported in the EAS IV Square Footage Dataset but should be reported in the EDF FCC - Leases of Real Property dataset. In the ASD for the EDF FCC, the specific DMIS ID code and direct patient care, ancillary services, etc., should be listed as the requesting FCC in the EDF FCC dataset. All of the fixed MTF/DTF functions performed in the leased space/building that is funded by the lease agreement should be listed in the 'Includes' by DMIS ID and FCC. The expense for the specific lease agreement should be reported as a direct obligation and expense in the EDF FCC. The expense allocation process will then allocate the lease expenses only to those DMIS ID(s) and FCC codes listed in the 'Includes' in the ASD of the EDF FCC.

6. The EDG Transportation FCC. The EDG Transportation FCC include the BASOPS installation charges to the fixed MTF/DTF for the use of the host installation vehicles. These MTF/DTF expenses should only be allocated to the work centers by FCC that receive a benefit when they use a host installation vehicle in each month. Normally, the host installation and fixed MTF maintain a monthly log of the host installation vehicles that are loaned to the fixed MTF/DTF personnel, and the log includes the mileage per vehicle and per work center by FCC. These monthly 'miles driven' should be recorded in the EDG dataset by individual FCC to align and allocate expenses to only the MTF/DTF work centers that received a benefit.

a. MTF/DTF personnel who drive the installation vehicles are not funded on a reimbursement basis so they should not report their available man-hours in this FCC and should report their available man-hours in the FCC of the benefiting work center.

b. If the MTF/DTF purchases a vehicle, then the cost of the vehicle will be charged directly to the FCC of the benefiting work center and will not be reported in the BASOPS Transportation EDG FCC.

7. Material Management Services (Logistics) (EEA FCC). This FCC represents the local fixed MTF Logistics Division. This FCC is intended to capture only the operational expenses for Logistics. The expense allocation of EEA FCC is intended to stepdown the expenses for operating Logistics to the work centers that made purchases and received support from the fixed MTF Logistics personnel. The EAS IV EEA FCC dataset requires manual data entry of the expenses represented by the dollar value of the supplies and equipment purchased by FCC. EAS IV performs cost allocation based on the ratio of the supply/equipment expense amounts by individual FCC to the total supply/equipment expense amount reported in the EEA FCC dataset.

a. All supplies and equipment ordered/requested by each work center/FCC through Logistics shall be charged directly to the FCC of the requesting work center for accurate reporting of direct operational expenses for each work center by FCC. MTF Budget and Logistics should never consolidate direct supply and equipment obligations and expenses for multiple work centers in the EEA FCC, or all patient care costing is distorted.

b. EEA FCC EAS IV Dataset: Pharmaceutical supply direct expenses reported by the DA Pharmacy Services FCC are normally excluded from the EEA FCC dataset since the Pharmacy Services purchase these supplies directly from a Prime Vendor, and do not receive direct support from Logistics for these purchases. Combined Food Operations subsistence supplies should also be excluded from the EEA FCC dataset. Any purchase of supplies and equipment that are not purchased by the Logistics staff should not be entered into the EEA FCC EAS IV Dataset by FCC.

c. A common problem occurs when supplies/equipment are directly charged to the EEA Logistics FCC instead of to the work center by FCC that ordered and received the

supplies/equipment. When this occurs, the direct Logistics operational expenses are overstated, and only the work centers reporting direct supplies/equipment by FCC receive allocation of the EEA Logistics total expenses (personnel, etc.). The work centers that ordered and received the supplies/equipment that was directly charged to the EEA Logistics FCC do not receive a fair and equitable distribution of the total EEA Logistics operational expenses, and their direct expenses are understated. This practice distorts direct costing and cost allocation in EAS IV.

8. Housekeeping (EFA FCC). Housekeeping (EFA FCC) operational expenses are allocated based on housekeeping square footage 'cleaned' that is recorded in the Housekeeping EFA dataset. To determine this statistic, the number of square feet in each department, service, and division of the healthcare facility that are cleaned under housekeeping services must be determined. Floor area measurements should be taken from the center of walls to the center of adjoining corridors if a hallway services more than one department. Stairwells, elevators, and commonly used areas (lobbies) should be charged to the appropriate housekeeping account. Hallways, waiting rooms, and other areas serving only one department should be included in that department. The effect of measuring only cleaned space will allocate the space (commonly used areas) among the departments in the ratio of space cleaned. When changes in assigned areas have been made during the year as the result of new construction, departmental relocation, expansion, or curtailment of service or changes in housekeeping requirements, sufficient data should be maintained and updated in the EAS IV Square Footage data set by fiscal month.

a. Please note that the housekeeping dataset should only include square footage that is cleaned by the housekeeping staff and will not always match the square footage recorded in the square footage dataset by FCC.

b. The Square Footage Cleaned dataset is linked only to the operational expenses reported in the EFA FCC. If Housekeeping expenses are reported in other FCC, the expenses will not be allocated in EAS IV with the Square Footage Cleaned dataset.

9. Biomedical Equipment Repair (EGA FCC). The Biomedical Equipment Repair work center by FCC performs repair and maintenance on fixed MTF/DTF equipment, as well as equipment for external organizations. Repairs for external organizations should be reported in the appropriate 'F' Special Programs FCC. When Biomedical personnel perform a repair for a work center, they should not report their available man-hours to that work center. The allocation factor for the Biomedical Equipment Repair work center is 'hours of service' by FCC of the work center supported. Hours of Service includes the time elapsed to perform the repair. The basis of allocation is the ratio of hours of service by requesting FCC to total hours of service performed.

10. Laundry EHA FCC. Laundry EHA FCC operational expenses includes picking up, sorting, issuing, distributing, mending, washing, and processing in-service linens including uniforms and special linens. Dry cleaning services are also included. This FCC and dataset also includes contract laundry services. Laundry operational expenses should be allocated based on the number of pounds entered into the laundry dataset each month. The number of pounds that should be recorded in the laundry dataset should equal the number of pounds after the linen has been processed and dried by individual work center/FCC. Pieces of laundry may be used as an alternative allocation factor 'only' if the ability to convert to dry pounds of laundry processed is not feasible. Pounds of laundry processed and dried is the preferred measure and should be used whenever possible. Allocation is based on a ratio of pounds of dry laundry processed for each receiving FCC account to the total pounds of dry laundry processed for the MTF.

11. Nutrition Care (EI* FCCs). Nutrition Care has multiple business rules and FCCs. Patient and Combined Food Operations are reported in EIA and EIB FCC accounts, respectively, with an allocation factor of total (raw) number of meals served. Expenses, personnel, square footage, etc. of the Nutrition Care Food Operations that cannot be directly attributed to the Dining Facility (FDC - Dining Facility - Non-Patient Food Operations) will be charged to EIB (Combined Food Operations).

a. Patient Food Operations reports the number of meals served to patients. This includes providing meal service to inpatients, outpatients, transient patients, etc. Since EIA is an output measurement using an allocation factor and is not a physical work center within the Nutrition Care Food Operations, no personnel should be assigned to this account. No square footage, no work hours, and no expenses of any type should be charged directly to the EIA - Patient Food Operations FCC since it is not a physical location.

b. The EIA Patient Food Operations dataset should report the number of meals served by the different requesting patient specialty FCCs. The grand total number of meals served that is reported in the EIA dataset should equal the single entry for the grand total number of meals served for the EIA FCC that was entered in the EIB FCC dataset. The expenses allocated from the EIB FCC to the EIA FCC are then allocated again to the individual requesting patient care specialty FCCs for the meals served when the EIA FCC total expenses are allocated. This process prevents the allocation of non-patient food operations in the dining facility from being charged to patient care FCCs.

c. Total expenses for the EIB - Combined Food Operations shall be assigned based on the ratio of patient number of meals served (EIA) and non-patient number of meals served (FDC) in each receiving account to the total Number of Meals Served (EIB) in the MTF. The square footage reported for EIB will generate an allocation from the ED** FCC overhead accounts to EIB, based on the pro rata share of the MTF square footage. Square footage and direct costs reported in EIB, Combined Food Operations will then be distributed to either EIA or FDC based on pro rata share of the number of meals served. Square footage and direct costs reported in FDC, Dining Facility – Non-Patient Food Operations will not generate an allocation to either EIA or EIB. The EIB - Combined Food Operations FCC dataset in EAS IV requires only two entries so that EAS IV can allocate a ratio of total EIB expenses to the EIA

and FDC FCCs. The only two entries required for the EIB FCC dataset are below.

(1) Grand total of number of meals served for patients should be reported in the EIA - Patient Food Operations FCC as a requesting FCC.

(2) Grand total number of meals served to non-patients should be reported in the FDC - Dining Facility - Non-Patient Food Operations FCC.

d. Meal Service. There are two types of meal service: Traditional Meal Service where diners pay a flat rate without regard to the menu items taken and A la carte Meal Service, where diners pay for only selected food items. Workload comparisons should not be done between the two types of meal service. The allocation factor for the meal service is 'Number of Meals Served' which includes the total count for EIA - Patient Number of Meals Served and FDC - Dining Facility – Non-Patient Number of Meals Served. Number of Meals Served includes all meals served to outpatients, APVs, inpatients, observation patients, transient patients, Cooked Therapeutic In-flight Meals, etc. Transient Number of Meals Served are those served to transient patients, either on inpatient units or in the dining room, plus Cooked Therapeutic In-flight Meals as reported in the FEF FCC account.

12. Patient Administration. Patient Administration has two FCCs with different allocation factors.

a. Inpatient Care Administration (EJA FCC) performs Inpatient Care reviews and codes inpatient clinical records. The total expenses in the EJA FCC is allocated to all inpatient specialty FCCs based on ratios of Inpatient Dispositions by FCC specialty to total Number of Inpatient Dispositions reported in the month.

b. Outpatient Care Administration (EKA FCC) performs a variety of clerical duties pertaining to outpatients and outpatient records. EKA FCC should only be used by personnel who are dedicated to the ambulatory care/outpatient care mission in the Patient Care Administration Division/Department. Since this account allocates to all Ambulatory "B" work centers based on total visits, all Ambulatory Care coders should be reported in this account, regardless of location. This includes Ambulatory Care coders who may be dedicated to specific clinics. The total expenses in the EKA FCC is allocated to all outpatient specialty FCCs based on ratios of Total Visits by FCC specialty to Total Visits in the month.

13. Managed Care Administration. Managed Care Administration reports all FTEs, expenses, etc. in EL FCCs. Total expenses reported in the EL FCCs are allocated to receiving FCCs based on a ratio of available FTEs. EL FCC expenses should only allocate to 'A' Inpatient and 'B' Outpatient FCCs (see Enclosure 3, Appendix 8, Table 15, paragraph 1, in this DHA-PM for additional information.

Table 16. Depreciation Distribution and Methodology Table

Inpatient Distribution Percentages Based on Inpatient Average Daily Patient Load (ADPL)	Inpatient	Outpatient
Greater than 99 ADPL	40%	60%
Less than 100 ADPL	20%	80%
Outpatient Distribution Percentages	Inpatient	Outpatient
Clinics	0%	100%
DEPRECIATION METHODOLOGY		
1. Depreciation Methodology. This account will not collect costs during the fiscal year in which the equipment is purchased and does not collect expenses for equipment below the DoD Capitalization Threshold level. Acquisitions below the capitalization dollar threshold shall be charged to the receiving accounts as operating expenses. The equipment capitalization threshold is established by the USD(C). The Military Service Headquarters MEPRS representative can establish a lower current threshold amount. The capitalization equipment threshold that applies as of fiscal 2014 is $250,000. The methodology reflects the depreciation expense of capitalized equipment acquisitions to MTF accounts. Each Military Service shall ensure that a set of records is established for each fixed MTF (medical or dental) under its control. Each MTF's records must show the original dollar value of acquisitions of modernization and replacement equipment for each of the last 5 fiscal years (References (m) and (ab)).		
2. After verifying that none of the equipment expenses were interfaced from the source financial system and already expensed in EAS IV, and using the Inpatient and Outpatient Distribution Percentages provided above, each fiscal year's acquisitions of capitalized equipment shall be classified into one of the four categories as follows: a. Inpatient Depreciation - EAA FCC: Record depreciation expense in the EAA FCC after applying percentage to the total expense of capitalized equipment purchased for Inpatient, Outpatient, Ancillary, and Administrative work centers. b. Outpatient Depreciation - EAB FCC: Record depreciation expense in the EAB FCC after applying percentage to the total expense of capitalized equipment purchased for Inpatient, Outpatient, Ancillary, and Administrative work centers. c. Dental Depreciation - EAC FCC: Record all depreciation expense in the EAC FCC for all Dental capitalized equipment purchased for Dental work centers.		

d. Special Programs Depreciation - EAD FCC: Record all depreciation expense in the EAD FCC for all Special Programs capitalized equipment purchased for 'F' FCC Special Program work centers.

e. Readiness Depreciation - EAE FCC: Record all depreciation expense in the EAE FCC for all Readiness capitalized equipment purchased for 'G' FCC Readiness Programs and work centers.

3. At the end of each fiscal year, the cost of the capitalized item acquisitions by the four categories for that year shall be added to the present category totals and the totals prior to the last 5 fiscal years, as well as the dollar value of any equipment transferred out (no longer owned by the MTF) or surveyed due to theft, disappearance, or destruction shall be subtracted. This subtraction may also pertain to equipment affected by operations that are no longer performed by the MTF.

a. The new total for each category shall be divided by five for inclusion in the respective cost assignment methodology as the current fiscal year's depreciation expense. To obtain a monthly figure, divide the fiscal year expense by 12.

b. The cost assignment of inpatient and outpatient depreciation expenses is based on workload generated each month by the "A" and "B" final MEPRS accounts (see Enclosure 3, Table 16 percentages above).

c. Assignment of the depreciation expense to Inpatient FCCs during the reporting period shall be based on the ratio of OBDs for each Inpatient Care FCC account to the total OBDs in the MTF. Assignment of the depreciation expense to Outpatient FCCs during the reporting period shall be based on the ratio of Total Visits for each Outpatient Care FCC account to the total number of visits (inpatient and outpatient) in the MTF.

d. The assignment for dental, special programs, and medical readiness is based on the dollar value of equipment to the "C," "F," and "G" FCC accounts.

4. The following guidelines also apply when calculating depreciation. Equipment salvage value is zero. Post-acquisition cost adjustments shall not be considered. Reciprocal acquisition cost adjustments will be made for transfer of equipment among MTFs or inpatient closures.

a. Depreciation FCC accounts include only capitalized equipment depreciation expenses of the MTF that are in-use replacement and modernization capitalized equipment. Specifically excluded are expenses associated with plant equipment necessary for new and expanded facilities, and real property installed equipment (such as environmental control units and elevators).

b. Capitalized equipment includes tangible assets (excluding real property and the plant) that exceed the established capitalization threshold and is depreciated in MEPRS. This includes investment and expense equipment that exceed the capitalization threshold.

APPENDIX 9

EXPENSE ASSIGNMENT SYSTEM IV BUSINESS RULES FOR 'F' - SPECIAL PROGRAM' AND 'G' - READINESS' FUNCTIONAL COST CODES

Table 17. Special Program (F) and Readiness (G) FCCs Business Rules

1. Special Programs in 'F' FCCs. Special Programs in 'F' FCC are final operating FCCs that report direct expenses and receive stepdown expenses during the expense allocation process in EAS IV. Functional descriptions of all 'F' FCCs are available in DHA MEPRS Manual, Volume 2, Enclosure 3, paragraph 6.

a. FBN - Hearing Conservation FCC. The only Special Program 'F' FCCs that has a service unit is FBN - Hearing Conservation FCC. The criteria to define a Hearing Conservation Visit is different than the criteria to define an Outpatient visit in a 'B' FCC (see Appendix 6, Table 7, paragraph 2 in this DHA-PM). Criteria for FBN visits include all active duty and those civilians who are enrolled in the Hearing Conservation Program who present for their annual monitoring testing, significant threshold shift follow-up, and audiology diagnostic referrals excluding remediation and rehabilitation.

b. Allocation Factor for all 'F' Special Program Cost Pools. There are only three 'F' Special Program Cost Pool FCCs: FBX - Public Health Services Cost Pool, FDX - Military-Unique Medical Activities Cost Pools, and FEX Cost Pool with allocation factors. These cost pools have a Generic Amount allowed for the allocation factor. The allocation factor is to be determined by the nature of the functions assigned to the FCC, and the expenses incurred (likely to be available FTE work-months).

c. Several 'F' Special Program FCCs. Several 'F' Special Program FCCs do not have a service unit or allocation factor, but they have data set entry requirements (see Enclosure 3, Appendix 5, Table 5 in this DHA-PM for the data set requirements).

2. The 'G' Readiness FCCs do not have any service units or allocation factors. They do not have any data set entry requirements either. Obligations and expenses for the purchase of 'war zone' and 'war reserve material' supplies, equipment, and personnel that are intended for use outside of the fixed MTF/DTF should not be reported in MEPRS (References (ac) and (ad)).

APPENDIX 10

TRAINING PROGRAMS

Table 18. Training Programs

1. EBE FCC - GME Support for Physicians. A GME program provides long-term physician training in a specialty for organized clinical GME physician programs authorized at the MTF. MTFs designated as GME training sites for active duty trainees primarily sponsor this program. This sub-account specifically excludes salaries of trainees receiving GME physician training (see the MEPRS FAM, FAO, and FAP FCC sub-account FCCs below in this table for additional business rules and guidelines). This function is normally supported by military and civilian personnel staff authorizations including program director, faculty staff, preceptors, secretary, and other members of administrative support organized into an office of the chief or director of training and education. GME/GDE students or any other student are not authorized to report man-hours in the EBE FCC.

a. EBE FCC GME expenses. EBE FCC GME expenses are allocated only to final operating FCCs with available FTEs reported with the specific skill type and suffix code combinations of 1F (Fellow - Medical), 1N (Intern - Medical), and 1R (Resident - Medical). Total GME EBE FCC expenses shall be allocated to the benefiting work center FCCs based on a ratio of each benefiting work center's FCC available trainee FTEs (by skill type/suffix) to the total available trainee FTEs (by skill type/suffix). The EBE FCC should include only the available man-hours of the physicians/other authorized personnel when they are not performing direct patient care because they are teaching/mentoring a GME student.

b. GME Branch/Division. The GME Branch/Division work center should report all direct expenses and personnel assigned and available to the GME work center in the EBE FCC.

c. Specific GME Information. GME Support shall be a sub-account that includes all expenses incurred in operating and maintaining the organized training and educational functions defined by the controlling Military Service to be conducted at the MTF. These functions may include, but are not limited to, attending rounds, precepting residents in clinic (when the patients being attended are not patients of the preceptor), educational committee meetings, preparation and presentation of educational lectures, and counseling of residents. These expenses also include the military and civilian personnel costs of staff authorizations for conducting and directing clinical GME programs for physicians. However, training time and expenses associated with readiness or emergency operations must be charged to the applicable sub-account. In-service training conducted by work center personnel (within their primary work center) to maintain or expand individual professional standards shall be charged to the individual’s primary work center. Costs not associated with GME functional activities shall be reported under the corresponding work center.

2. EBF - Education & Training Program Support. This sub-account FCC is intended only for personnel who teach formal CE, mandatory MTF formal training classes, and non-GME/GDE student programs. The EBF sub-account FCC specifically includes only the FTEs and salaries of personnel who are teaching and providing the in-house training and excludes FTEs and salaries of trainees, students, and all personnel who receive the training.

a. Teaching programs that are included in the EBF FCC are in-house continuing education training for physicians, dentists, veterinarians, nurses, medical specialists, allied health scientists, administrators, other enlisted direct-care paraprofessionals, and assigned non-medical personnel. Post-graduate training programs for nurses, allied health scientists, and administrators are also included (for the Navy, post-graduate training programs for nurses, allied health scientists, and administrators are centrally funded and are not utilized at the MTF level).

b. Examples of instruction included in this FCC account that are not all inclusive are Enlisted Personnel Training and Education Programs, which include the Navy's Class C schools; the Army and Air Force Phase II training of practitioners and technicians; Phase II training; Cardiopulmonary Resuscitation training (instructors only); Advanced Cardiac Life Support training; and Advance Trauma Life Support training.

c. Additional EBF FCC Information. Education and Training Program Support shall be a sub-account that includes all expenses incurred in operating and maintaining the function of conducting the organized training and education programs (other than GME and GDE) at the MTF. These expenses include the military and civilian personnel costs of staff supporting the officer and enlisted training and educational programs, and expenses for any equipment, supplies, or services purchased in support of approved training and education programs. Military and civilian personnel who are organized into an office of the chief or director of GME or GDE may assign a portion of their time to this sub-account if they conduct or support the training programs under this sub-account. MTF personnel who are assigned to other work centers and conduct or support the training programs under this account may assign a portion of their time to this sub-account. Personnel attending in-service OJT training conducted by their work centers shall report that time to their respective work centers. However, individuals tasked to conduct in-service training for other than their assigned work center shall be charged to this sub-account.

(1) If established as separate work centers in the MTF and authorized on the MTF manning document, this FCC sub-account should also be used to establish unique fourth level FCC sub-accounts to report the MTF Medical Library and the MTF Education and Training Office. All personnel, salaries, equipment supplies, space, etc. for these work centers should be aligned to the same FCC sub-account of each work center.

(2) Personnel who receive the training/instruction should report their man-hours in the appropriate FCC. Reference subaccounts of FAI - Physiological Training and Support Program FCC, FAL CE FCC, and FAK - Student Trainee Programs – Other Than GME or GDE Programs FCC. See additional business rules for these training FCCs below in this table.

(3) Training time and expenses associated with readiness or peacetime operations must be charged to the applicable 'G' Readiness FCC sub-account.

(4) MTF IM/IT Department audio-visual and other MTF IM/IT equipment and services that are borrowed to support functions in the EBF FCC sub-account should be expensed to the appropriate EBJ FCC sub-account.

3. EBI FCC – GDE Support for Dentists. A GDE program provides long-term dentist training in a specialty for organized clinical GDE dentist programs authorized at the MTF/DTF. MTFs/DTFs designated as GDE training sites for active duty trainees primarily sponsor this program. Total expenses in the EBI FCC are allocated only to final operating FCCs with available FTEs reported with the specific skill type and suffix code combinations of 1S (Intern - Dental), 1T (Fellow - Dental), and 1U (Resident - Dental). The EBI FCC should include only the available man-hours of the physicians/dentists/other authorized personnel when they are not performing direct patient care because they are teaching/mentoring a GDE student. This FCC is not authorized for GME/GDE students or any other student man-hours or related expenses.

a. The GDE Branch/Division work center should report all direct expenses and personnel assigned and available to the GDE work center in the EBI FCC.

b. This FCC account specifically excludes salaries of trainees receiving GDE training (see Special Programs FAN and FAQ FCC sub-accounts below in this table for additional business rules). Military and civilian personnel staff authorizations organized into an office of the chief or director of training and education normally supports this function.

c. Specific GDE Information. GDE Support shall be a sub-account that includes all expenses incurred in operating and maintaining the organized training and educational functions defined by the controlling Military Service to be conducted at the MTF. These functions may include, but are not limited to, attending rounds, precepting residents in clinic (when the patients being attended are not patients of the preceptor), educational committee meetings, preparation and presentation of educational lectures, and counseling of residents. These expenses also include the military and civilian personnel costs of staff authorizations for conducting and directing clinical GDE programs for dentists. However, training time and expenses associated with readiness or emergency operations must be charged to the applicable sub-account. In-service OJT training conducted by work center personnel (within their primary work center) to maintain or expand individual professional standards shall be charged to the individual’s primary work center. Costs not associated with GDE functional activities shall be reported under the corresponding work center.

d. Total GDE EBI FCC expenses shall be allocated to the benefiting work center FCCs based on a ratio of each benefiting work center's FCC available trainee FTEs (by skill type/suffix) to the total available trainee FTEs (by skill type/suffix).

4. FAI - Physiological Training and Support Program. The Physiological Training and Support Program teach flying personnel the stress of modern military aviation and space flight and prepare them to meet these stresses. The program includes operation of low-pressure chambers, operation of ejection seat trainers, and the management of all pressure suit activities. The program is also responsible for the operation of compression chambers used in Hyperbaric Oxygen therapy (see EBF FCC above in paragraph 2 in this table for additional business rules).

5. FAK - Student Trainee Program - Other Than GME or GDE Program FAK FCC. FAK - Student Trainee Program - Other Than GME or GDE Program FAK FCC shall be a sub-account that includes all trainee salaries computed for the time the trainee is in a pure learner role in a training program other than GME or GDE. Labor distribution of trainee salaries are determined as follows (see the EBF FCC above in paragraph 2 in this table for additional business rules).

a. If the trainee's curricula require mainly classroom training and patient care or support is incidental, the labor shall be 50 percent chargeable to this sub-account and 50 percent chargeable to the work center(s) the trainee supports.

b. If the trainee mainly performs clinical tasks that would normally be performed by permanently assigned personnel, the labor shall be 30 percent chargeable to this sub-account and 70 percent chargeable to the work center(s) the trainee supports.

c. If the trainee's curricula are entirely classroom training, 100 percent of the trainee's time is chargeable to this sub-account. The local administrative office should assist in creating site-specific, man-hour templates or schedules to ensure accurate and timely reporting in MEPRS EAS.

6. FAL - CE FCC. FAL – CE FCC includes the time and expenses incurred by the MTF in support of continuing health education requirements and MTF required/mandatory formal training. It includes all continuing health education programs, regardless of location or source of instruction. The CE Program shall be a sub-account that includes all expenses incurred in support of continuing health education requirements. Costs may include tuition, Temporary Additional Duty (TAD) or TDY expenses, salaries, fees, and contractual expenses. Time related for personnel who provide the training/instruction should be reported in the appropriate EBF FCC (see EBF FCC above in paragraph 2, in this table for additional business rules).

7. FAM - GME Intern and Resident– Physicians Program FCC. The GME Intern and Resident – Physicians Program includes the portion of trainee salary expenses and man-hours represented by the time the physician participating in a GME program is in a pure learner role (classroom, work center training, etc.), (see EBE FCC above in paragraph 1 in this table for additional GME business rules). Specific FAM FCC business rules are provided below:

a. GME trainee salary expenses related to time spent directly contributing to work center output must be charged to the receiving work center.

b. The GME Intern and Resident Expenses Program shall be a sub-account that includes GME trainee salary expenses computed for the time the trainee is in a pure learner role in a GME program.

c. During the first year of GME, labor distribution of the trainee's monthly salary shall be 50 percent chargeable to this sub-account and 50 percent chargeable to the work center(s) the trainee supports.

d. For the trainee who has completed the first year, labor distribution during the second and later years of GME (in which the curricula require mainly performance of clinical tasks), shall be 30 percent chargeable to this sub-account and 70 percent chargeable to the work center(s) the trainee supports.

e. The recommended procedure to capture this workload is using work-hour templates or schedules. The local GME administrative office should assist in creating site-specific templates or schedules to ensure accurate and timely reporting in MEPRS EAS.

8. FAN - GDE Intern and Resident – Dentists Program FCC. The GDE Intern and Resident – Dentists Program includes the portion of trainee salary expenses and work-hours represented by the time the trainee participating in a GDE program is in a pure learner role (classroom, work center training, etc.). GDE trainee salary expenses related to time directly contributing to work center output must be charged to the receiving work center (see EBI FCC above in paragraph 3 of this table for additional GDE business rules). Specific business rules for FAN FCC are below:

a. The GDE Intern and Resident – Dentists Program shall include GDE trainee salary expenses computed for the time the trainee is in a pure learner role in a GDE program.

b. During the first year of GDE, labor distribution of the trainee's monthly salary shall be 50 percent chargeable to this sub-account and 50 percent chargeable to the work center(s) the trainee supports.

c. For the trainee who has completed the first year, labor distribution during the second and later years of GDE (in which the curricula require mainly performance of clinical tasks), shall be 30 percent chargeable to this sub-account and 70 percent chargeable to the work center(s) the trainee supports.

d. The recommended procedure to capture this workload is using work-hour templates or schedules. The local GDE administrative office should assist in creating site-specific templates or schedules to ensure accurate timely reporting in MEPRS EAS.

9. FAO - GME Fellowship and Resident – Full-Time Research Program FCC. GME Fellowship and Resident – Full-Time Research Program includes the portion of trainee salary expenses and work-hours for fellows and residents performing full-time research and no patient care. GME programs are defined in the EBE sub-account FCC above in paragraph 1 of this Table. The period of time for which the fellow or resident is performing full-time research shall be charged to this sub-account. Specific FAO FCC business rules are below.

a. The FAO sub-account FCC includes fellow and resident trainee salary expenses when they are performing full-time research under the GME program.

b. Fellow and resident trainees' monthly labor expenses shall be charged to this sub-account for the period they are performing full-time research, as specified by the GME program.

c. The recommended procedure to capture this workload is work-hour templates or schedules. The local GME administrative office should assist in creating site-specific templates or schedules to ensure accurate and timely reporting in MEPRS.

10. FAP - GME Fellowship Program FCC. The function of GME Fellowship Program includes the portion of fellowship trainee salary expenses and work-hours represented by the time the physician is in a GME fellowship program. GME programs are defined in the EBE FCC account above in paragraph 1 of this Table. Specific FAP FCC business rules are below.

a. Fellow trainee salary expenses related to time directly contributing to work center output must be charged to the receiving work center.

b. The GME Fellowship Program shall be a sub-account that includes fellow trainee salary expenses for the time the physician is in a pure learner role in a GME fellowship program.

c. Labor distribution of the fellow trainee shall be 10 percent chargeable to this account and 90 percent chargeable to the work center(s) the trainee supports.

d. The recommended procedure to capture this workload is work-hour templates or schedules. The local GME administrative office should assist in creating site-specific templates or schedules to ensure accurate and timely reporting in MEPRS.

11. FAQ - GDE Fellowship Expenses Program FCC. The function of the GDE Fellowship Program includes the portion of fellowship trainee salary expenses and work-hours represented by the time the dentist is in a GDE fellowship program. GDE programs are defined in the MEPRS EBI FCC account above in paragraph 3 of this table. Fellow trainee salary expenses related to time directly contributing to work center output must be charged to the receiving work center. Specific FAQ FCC business rules are below.

a. The GDE Fellowship Program shall be a sub-account that includes fellow trainee salary expenses for the time the physician is in a pure learner role in a GDE fellowship program.

b. Labor distribution of the fellow trainee shall be 10 percent chargeable to this account and 90 percent chargeable to the work center(s) the trainee supports.

c. The recommended procedure to capture this workload is work-hour templates or schedules. The local GDE administrative office should assist in creating site specific templates or schedules to ensure accurate and timely reporting in MEPRS.

APPENDIX 11

MEDICAL EXPENSE AND PERFORMANCE REPORTING SYSTEM ISSUE RESOLUTION

Below are instructions for using the sample issuance resolution paper format on the following pages to assist in submitting an issue for resolution. The format is required.

a. DoD Issue #. Please leave this field blank. The MEPRS Program Office will assign a DoD issue number upon receipt of the issue resolution paper.

b. Date of Issue. Please insert the date on which the completed issue paper will be sent to the MEPRS Program Office.

c. Originator of Issue. Please insert your name, title, and phone number.

d. Issue/Problem Title. Please provide a short (one or two sentence) description of the issue. State the problem simply and what it affects in a quantifiable way; e.g.: "Currently, (this is happening), resulting in (these quantifiable symptoms)." Please identify the systems that are affected by this issue.

e. Supporting Documentation/Attachments. Please be sure to provide any supporting documentation that may assist in analysis of the issue.

f. Issue Type. Identify the appropriate type(s) of issue(s).

g. Description of Issue/Problem. Provide a detailed description of the problem that will allow an in-depth analysis and understanding of the issue.

h. Recommended Solution. Please provide your recommended solutions for the issue. If possible, also provide the pros and cons for the issue and, if multiple recommendations are provided, identify the solution that you feel is best. Provide workable improvements or recommendations and identify the expected outcomes and measurements.

i. Impact. Please provide any potential impacts of not resolving the issue.

j. Date Resolution Required. Please provide your best estimate of the date by which the issue must be resolved.

ISSUE PAPER RESOLUTION FORMAT

DoD Issue #:_____ Date of Issue: _____

Originator of Issue: _____

Organization and Phone Number: _____

Recommended Priority (Low, Medium, High):
_____

Issue/Problem Title: _____
_____
_____
_____
_____

Systems Affected (EAS IV, DMHRSi, CHCS, AHLTA), etc. _____

Supporting Documentation / Attachments: _____
_____
_____
_____

Issue Type (check one): Functional ____ Interpretational ____ Systems ____

Description of Issue/Problem: _____
_____
_____
_____
_____
_____
_____
_____

Recommended Solution: _____
_____
_____
_____
_____

ISSUE PAPER RESOLUTION FORMAT

Impact If Not Resolved:

Recommended Solution Is Standardized For DHA: Yes ____ No ____

Work-around Exists for This Issue: Yes ____ No ____

If Yes, describe Work-around:

Date Resolution Required: _____

For DHA/MEPRS Program Office Use Only:

Reviewer:_____ Review Date: _____

Recommendation (check one):

Accept ____ Defer ____ Need Additional Information ____ Reject ____

Reviewer Comments:

Approvals:

Air Force Representative: _____ Date: _____

Army Representative:_____Date: _____

Navy Representative: _____ Date: _____

DHA Representative: _____ Date: _____

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

ADPL	Average Daily Patient Load
AHLTA	Armed Forces Health Longitudinal Technology Application
APU	Ambulatory Procedure Unit
APV	Ambulatory Procedure Visit
ASD	Account Subset Definition
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASN	Assignment Sequence Number
AWOL	Absent Without Leave
BASOPS	Base Operations
CE	Continuing Education
CHCS	Composite Healthcare System
CPT	Current Procedural Terminology
DHA	Defense Health Agency
DHA-PM	Defense Health Agency-Procedures Manual
DMHRSi	Defense Medical Human Resources System Internet
DMIS ID	Defense Medical Information System Identifier
DNA	Deoxyribonucleic Acid
DTF	Dental Treatment Facility
EAS	Expense Assignment System
ER	Emergency Room
FCC	Functional Cost Code
FTE	Full-Time Equivalent
FPRS	Financial and Performance Reporting System
GDE	Graduate Dental Education
GME	Graduate Medical Education
ICU	Intensive Care Unit
IT	Information Technology
LPN	Licensed Practical Nurse
LVN	Licensed Vocational Nurse
MBOG	Medical Business Operations Group
MEPRS	Medical Expense and Performance Reporting System
MHS	Military Health System

MTF	Medical Treatment Facility
NDMS	National Disaster Medical System
OBD	occupied bed day
OB-GYN	Obstetrics and Gynecology
PEC	Program Element Code
RVU	Relative Value Unit
SCR	System Change Request
SEEC	Standard Element Expense Code
SIR	System Incident Report
TAD	Temporary Additional Duty
TDY	Temporary Duty
USD(C)	Under Secretary of Defense (Comptroller)
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
VA	Department of Veterans Affairs

PART II. DEFINITIONS

Unless otherwise noted, these terms and their definitions are for the purposes of this DHA-PM.

appropriation. (1) appropriated amounts; (2) funds; and (3) authority to make obligations by contract before appropriations and (4) other authority making amounts available for obligation or expenditure (Reference Section 1101 of (ae)).

APV. Ambulatory Procedure Visit. A type of outpatient visit in which immediate pre-procedure and post-procedure care requires an unusual degree of intensity and is provided in an ambulatory procedure unit. Care is required in the facility for less than 24 hours (Reference (y)).

capitalize. To record and carry forward into one or more future periods any expenditure the benefits from which will then be realized (Reference (ab)).

capitalization threshold. The capitalization threshold is the dollar amount that determines the proper financial reporting of the asset. Asset acquisition costs that are below the threshold are to be expensed. Asset acquisition costs that are greater than the threshold is to be capitalized on the Balance Sheet and depreciated over the asset's useful life (Reference (ab)).

depreciation. Depreciation is the systematic and rational allocation of the acquisition cost of an asset, less its estimated salvage or residual value, over its estimated useful life. Estimates of

useful life of military equipment must consider factors such as usage, physical wear and tear and technological change (Reference m)).

method of depreciation. DoD policy permits the use only of the straight-line method of depreciation, except for military equipment. For military equipment, an activity-based method of depreciation, which recognizes the change in an asset's value as a result of use rather than time, may also be used (Reference m)).

mobilization. The process by which the Military Services or part of them are brought to a heightened state of readiness for war or other national emergency. This includes activating all or part of the RC as well as assembling and organizing personnel, supplies, and materiel (Reference ad))

readiness. The ability of military forces to fight and meet the demands of assigned missions (Reference ad)).

tangible assets. Have an estimated useful life of two years or more; are not intended for sale in the ordinary course of operations; are acquired or constructed with the intention of being used or being available for use by the entity; and have an initial acquisition cost, book value, or when applicable, an estimated fair market value that equals, or exceeds, DoD capitalization threshold (Reference m)).