Department of Veterans Affairs **VHA HANDBOOK 1907.04**
Veterans Health Administration **Transmittal Sheet**
Washington, DC 20420 **February 4, 2008**

PATIENT TREATMENT FILE (PTF) CODING INSTRUCTIONS

1. PURPOSE. This Veterans Health Administration (VHA) Handbook provides procedures for completing Patient Treatment File (PTF) Coding

2. SUMMARY OF MAJOR CHANGES. This is a new Handbook, which is being issued to reflect PTF software changes and updated requirements.

3. RELATED DIRECTIVE. VHA Directive 1907.

4. RESPONSIBLE OFFICE. VHA's Chief Officer, Health Systems Management and Technology Office (19) is responsible for the contents of this Handbook. Questions may be referred to 760-777-1170.

5. RESCISSIONS. MP-6, Part XVI, Supplement 4.1, Chapters 1 through 9, dated March 24, 1992, and all previous supplements, are rescinded.

6. RECERTIFICATION. This VHA Handbook is scheduled to be recertified on or before the last working day of February 2013.

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PATIENT TREATMENT FILE (PTF) CODING INSTRUCTIONS

1. PURPOSE

This Veterans Health Administration (VHA) Handbook establishes procedures for the use of the Patient Treatment File (PTF).

2. DEFINITIONS

a. **Absent Sick in Hospital (ASIH).** When a patient is absent from a bed in a Department of Veterans Affairs (VA) Nursing Home, Domiciliary, Contract Nursing Home (CNH), or Community Nursing Home because of an admission to a VA medical center or other non-VA facility for acute care, the number of days is calculated as ASIH.

b. **Admission**. An admission is a formal acceptance by a hospital of a patient who is to be provided with room, board, and continuous nursing services in an area of the hospital where patients generally stay at least overnight.

c. **Admission Transaction (101).** PTF transaction prepared upon admission to inpatient status for every hospital inpatient, Domiciliary patient, Nursing Home Care Unit (NHCU) patient, Fee Basis inpatient, or CNH patient at VA expense. This screen contains admission and discharge information for the episode of care and the basic patient demographic information.

d. **Admission, Discharge, Transfer (ADT).** The ADT Package encompasses the Veterans Health Information and Technology Architecture (VistA) applications and options that include the admission, discharge and transfer processes. The ADT package is a part of the Patient Information Management System (PIMS). ***NOTE:*** *More information can be found at http://www.va.gov/vdl/application.asp?appid=55*.

e. **Austin Corporate Franchise Data Center (CFD).** CFD is a recognized Federal data center within VA. As a franchise fund, or fee-for-service organization, CFD provides Information Technology (IT) enterprise solutions to support the IT needs of customers within the Federal sector.

f. **Bedsection.** A bedsection is the general treatment type (specialty) being provided to a patient on an officially designated (or "VA-approved") ward or bed location.

g. **Contract Nursing Home (CNH).** Patients who are residing in a CNH or community nursing home under VA auspices.

h. **Diagnosis Related Group (DRG).** DRG is a method of case mix adopted by the Federal government, and some other payers, as a prospective payment mechanism for hospital inpatients. It is a classification system that places patients with similar diseases into clinically-related groups. ***NOTE:*** *Related diseases and treatments tend to consume similar amounts of health care resources and incur similar amounts of cost.* DRGs are used to determine reimbursement

for hospitalized patients with health care coverage under Medicare. DRGs are assigned using: the principal diagnosis and up to eight additional diagnoses, the principal procedure and up to five additional procedure codes, age and gender, and discharge status. A DRG is assigned to each bed section and a final DRG is assigned on the Principal Diagnosis Transaction (701).

i. **Domiciliary.** A Domiciliary is a residential rehabilitation program that provides short-term rehabilitative and long-term health maintenance care for veterans who require minimal medical care. The Domiciliary care program provides health care and related services to eligible veterans, including those who are homeless. Domiciliary patients are normally ambulatory and do not require the level of clinical intervention or observation routinely provided to nursing home patients. It provides a:

(1) Full range of rehabilitation services for patients who do not require bedside nursing care.

(2) Semi-structured, therapeutic environment, while providing optimal opportunities for community interaction both inside and outside the institution.

j. **Error Analysis Listing (EAL).** The EAL Report provides information as to whether data transmitted from VistA was accepted or rejected by the PTF central database; it is transmitted from the CFD daily. This is generated as an e-mail message to the VistA mail group PTF Austin Messages and PTF Transaction Types (PTT). CFD messages are grouped by the facility station identifier and, where applicable, suffix code, i.e., 6959AA. ***NOTE:*** *A list of the error codes can be found at:* *http://vaww.va.gov/nds/apps/errorcode/ErrorResults.asp* .

k. **Fee Basis.** Fee Basis is non-VA health care paid by VA.

l. **Inpatient.** An inpatient is a recipient of medical services who is admitted to a VA facility or non-VA facility under VA auspices and receives health care services, room, board, and continuous nursing service in a unit or area of the hospital or health care facility where patients generally stay overnight.

m. **Inpatient Discharge.** An inpatient discharge is the termination of hospitalization through the formal release of the inpatient by the hospital.

n. **Medical Administration Service (MAS) Screen.** The MAS screen is the screen in PTF that contains patient diagnoses and information about patient movement(s), surgeries(s) and procedures(s).

o. **Monthly Program Cost Report (MPCR).** The MPCR is a computer-generated summary report, prepared at CFD through the linkage of the Decision Support System (DSS), VHA Work Measure (VWM) and National Patient Care Database (NPCD) systems.

p. **Nursing Home Care Unit (NHCU).** A NHCU is a specialized health care unit designed to care for patients who require skilled nursing care, supportive personal care, convalescent care, and respite care and who do not require hospitalization.

q. **Non-Operating Room (OR) Procedure.** A non-OR surgical procedure is not conducted in an OR; it includes those conducted in an ambulatory surgery center, radiology, catheterization laboratory, endoscopy suites, or at bedside.

r. **Patient Movement Transaction (501).** A Patient Movement Transaction is a PTF transaction prepared on every hospital inpatient, NHCU inpatient, Domiciliary inpatient and for non-VA inpatient care under VA auspices (authorized and CNH admissions). A Patient Movement Transaction (501) must be completed to report a change in specialty occurring during an episode of hospitalization and must include the related diagnostic codes. Which one is completed depends on the physical location of the patient and the information to be entered.

s. **Physical Location Transaction (535).** A Physical Location Transaction (535) is a PTF transaction prepared in the background by the application (no user interaction necessary) each time a patient occupies a bed different from the treating specialty.

t. **Principal Diagnosis.** The principal diagnosis is the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care. ***NOTE:*** *Prior to, and during fiscal year 1994, the term Primary Diagnosis was used, then referred to as the Diagnosis Responsible for the Length of Stay (DXLS).*

u. **Principal Diagnosis Transaction (701).** The Principal Diagnosis Transaction is a PTF transaction prepared on every hospital inpatient, NHCU patient, Fee Basis inpatient, and Contract or CNH patient. ***NOTE:*** *A 702 (Disposition Transaction) only appears on the Error Analysis Listing (EAL) when there is more than one diagnosis transmitted.*

v. **Procedure Transaction (601).** A Procedure Transaction is a PTF transaction prepared to report non-OR procedures (see subpar. 2q) performed during an episode of care.

w. **Professional Fee Transaction (801)**. A Professional Fee Transaction is a PTF transaction prepared to report professional services for inpatient bedside procedures and consults performed and not captured in any other package (e.g., radiology).

x. **Patient Treatment File (PTF).** The PTF is an abstract that is kept for all inpatients of VA hospitals or patients receiving care from a non-VA hospital under VA auspices. The PTF provides an abstract of inpatient activity, diagnoses, procedures, and surgeries performed from the time of admission to the time of discharge from inpatient care.

y. **Record Printout (RPO).** The RPO displays the current coded data content of an individual master record in the PTF system for a treatment episode.

z. **Service Connection**. Service connection is a VA decision that an illness or injury was incurred in or aggravated during active military service as adjudicated by the Veteran Benefits Administration (VBA).

aa. **Surgical Transaction (401).** A Surgical Transaction is a PTF transaction prepared to report surgical procedures performed in an OR during an episode of care. PTF transactions must be completed for patients who have had surgery during an episode of care.

bb. **Transactions Processed Listing (TPL).** The TPL, a report of PTF status, i.e., accepted, rejected, pending, wrapped, and deleted, is transmitted as part of the EAL. This is generated as a VistA email message to mail groups PTF Austin Messages and PTT. ***NOTE:*** *Austin CFD messages are based on the facility code.*

cc. **Treating Specialty.** Treating specialty is the subsection of the specialty being provided to the patient by a specialized provider within a general specialty such as Medicine or Surgery (i.e., Peripheral Vascular). Multiple treating specialties can exist on more than one ward.

dd. **Veterans Equitable Resource Allocation System (VERA).** VERA ensures that the allocation of funds is equitably distributed based on veterans who use the VA health care system rather than being based on historic funding patterns.

3. SCOPE

This Handbook covers the responsibilities and requirements for appropriate use of the PTF file. PTF is a computer database containing a generated record for each patient admitted to inpatient care in a VA medical center, as well as for those receiving inpatient care in a non-VA facility at VA expense (i.e., Millennium Bill, Fee Basis, Contract and CNH, etc.).

a. PTF is housed at and administered by the Austin CFD. The information found in the PTF ultimately plays a major role in accurate data retrieval for research purposes, resource allocation, third party billing, and various reporting requirements.

b. The PTF provides a record of inpatient activity, diagnoses, procedures, and surgeries performed from the time of admission to the time of discharge from inpatient care.

c. A PTF abstract is created upon admission for every patient admitted to any VA facility, including a medical center, Domiciliary, and NHCU or for every patient admitted to a non-VA facility under VA auspices. Much of the data is automatically transferred from the VistA PIMS to the PTF package.

4. PROCEDURES FOR PTF TRANSACTIONS ***NOTE:*** *In this Handbook, an* ******* *denotes a field that cannot be edited, unless the individual staff member holds the eligibility key as these fields cross over automatically from the ADT package and need to be maintained in the source package.*

a. The PTF abstract for each episode of care contains complete data for admission, disposition, transfer, diagnosis and operations or procedures for treatment rendered in the following facilities:

(1) VA medical centers (VA medical centers),

(2) Non-VA hospitals, at VA expense (Fee or Sharing), for example Public Health Service Hospitals (DA), Public Hospitals (DM), Private Hospitals (DS) (refer to the NPCD website for

the various programs active for the respective facility at: http://vaww.aac.va.gov/npcd/Stations.php),

(3) VA NHCUs,

(4) VA Domiciliary (DOM), and

(5) CNH and community nursing home.

b. Separate PTF transactions must be prepared on all patients treated in non-VA facilities (at VA expense) whose length of stay exceeds 1 calendar day. These include: the admission transaction, the diagnostic transaction, and the disposition transaction. If applicable, the procedural and surgical transactions must also be completed. These are Fee Basis cases that generate a stub record within PTF when an authorization (VA Form 10-7078, Authorization and Invoice for Medical and Hospital Services) is completed for a patient in the Fee Package.

c. All PTF transactions must be completed according to current VHA policy. Workload that is not submitted by the closeout date will not be included in VERA calculations. The only exceptions are CNH and Fee Basis patients which can be submitted for the 2 prior fiscal years for authorized claims and 5 years for unauthorized claims.

d. The following are considered source documents:

(1) VA Form 10-10EZ, Application for Health Benefits.

(2) VA Form 10-10EZR, Health Benefits Renewal Form.

(3) VA Form 10-10M, Medical Certificate, or a similar local facility document containing the same information.

(4) VA Form 10-7078, Authorization and Invoice for Medical and Hospital Services, used for CNH and Fee Basis.

(5) Patient's health record.

(6) Other miscellaneous administrative records.

5. ABSENT SICK IN HOSPITAL (ASIH)

a. When a VA NHCU inpatient, CNH inpatient, or Domiciliary inpatient is transferred to hospital inpatient status for care, the patient is placed in ASIH status for the NHCU, CNH, or Domiciliary. Upon hospital admission, a PTF transaction is created (without user input) to report the episode of medical center care.

b. The number of days the patient is on ASIH status must be monitored; however, no nursing home discharge PTF transaction will be prepared unless 30 days of inpatient care for the NHCU and Domiciliary patient or for the CNH patient have transpired, or the patient dies, or goes AMA

(against medical advice) while in the hospital. The NHCU and Domiciliary PTF abstract automatically posts a discharge date that is equal to 30 days in hospital. If the ASIH episode is less than 30 days, a PTF transaction is prepared to report the episode of hospital care and the discharge date is removed from the Domiciliary and NHCU PTF abstract. If the patient is then readmitted to the nursing home or Domiciliary after 30 days ASIH in a hospital, a new admission PTF transaction is created to reflect the nursing home episode of care.

c. If the ASIH episode is less than 30 days for the NHCU, CNH, or Domiciliary inpatient, a PTF transaction is prepared to report the episode of hospital care. If the patient dies in a hospital while on ASIH, the patient is reported as a discharge from the nursing home, CNH or Domiciliary as "While ASIH" and the death is reported on the hospital PTF transactions.

d. When a patient on authorized absence from a Domiciliary is admitted to a hospital (VA, DM, or DS) for treatment, the absence is cancelled, the status changed to ASIH, and the patient needs to be discharged from Domiciliary, effective the date of admission to the hospital.

e. If the NHCU, CNH, or Domiciliary patient is admitted to a hospital (VA or on a Fee Basis) for care and the hospital episode is more than 30 days, then the patient is discharged from the NHCU, CNH, or Domiciliary, a PTF transaction must be completed to reflect the episode of care provided in the NHCU, CNH, or Domiciliary.

6. CENSUS

a. A census PTF abstract is required for all bed occupants as of 11:59 p.m. on March 31, June 30, September 30, and December 31. A census abstract is automatically created at 11:59 p.m. on the census date. All diagnoses and procedures must be included in the census PTF abstract as of the census day (see the VistA documentation manual at http://www.va.gov/vdl/application.asp?appid=55 for additional information on the parameters and on how this occurs).

b. It is not necessary for providers to complete VA Form 10-7976D, Medical Staff Census Worksheet. It is appropriate for the coder to extract the information from Computerized Patient Record System (CPRS) to complete the census PTF.

c. A Census Status Report provides the names of the patients for which a census record must be completed. The Census Status Report allows facility staff to print a report of all active admissions as of a specified census date. The first time the Census Status Report is run for a particular census date, a Census Work File is created for that date.

d. When completing the Census Transaction Screens, the screens looks the same as when completing a routine PTF Admission screen. For the 701 census screen, a discharge date is not required. The 701 census screen is also where the census number can be located after the census record is closed. This number changes if the record is reopened for any reason. On the 501, 601, and 401 screens, only enter information from the quarter currently due for close out. Example: If a patient had surgery on April 1, and the census closeout was March 30, the April 1 surgery codes on the census transaction would not be included.

e. If the patient was discharged before the census abstract was completed, the census PTF abstract must be closed before the routine PTF abstract can be closed. The message, "PTF# MUST be closed for CENSUS first," appears when attempting to close the PTF abstract that has a corresponding census abstract that has not been closed for census purposes. PTF abstracts on census patients discharged before census closeout are not to be released for transmission until census closeout is completed to prevent the generation of duplicate record errors at the Austin CDF.

f. When releasing a PTF abstract and the corresponding census abstract has not yet been released, the following message appears, "Census Record # also needs to be released," and a prompt to release the census record appears. Once an abstract has been released, it can only be reopened through either the Open Released or Transmitted Census Records option under the Census Menu or Open Released or Transmitted PTF Records option under the PTF menu.

g. One or all statuses may be selected, and some or all of the following information must be provided for each census abstract:

(1) Patient name and last four digits of the social security number (SSN),

(2) Admission date,

(3) Ward location on the census date,

(4) PTF number, and

(5) Census status (and census number if it was transmitted).

h. At the conclusion of the report, the total number of census records for each status and the overall statistics are given.

7. ADMISSIONS TO A NON-VA FACILITY UNDER VA AUSPICES

a. The patient who is hospitalized in a non-VA hospital under contractual or Fee arrangement including authorized hospitalization represents a direct admission to the non-VA facility. The patient who is hospitalized in a non-VA hospital under a sharing agreement is usually admitted to a VA medical center prior to being transferred to the sharing facility. When surgery is performed at the sharing facility, the patient may spend more than 24 hours in the non-VA hospital prior to being transferred back to the VA medical center.

b. When a patient is being treated in a non-VA hospital under VA auspices and refuses to return to the VA medical center (after the patient is stabilized for the remainder of the hospitalization), the patient is discharged from the VA Fee Basis rolls. The number of days (total days of care in the non-VA setting) that the patient was in the non-VA hospital under VA auspices is recorded in the Fee Basis PTF for payment purposes and the patient is given a regular discharge. ***NOTE:*** *The discharge date in the Fee Basis PTF may be different than the date Fee Basis stops payment of the Fee based hospitalization.*

8. PATIENT TREATMENT FILE CONTROL DATA

Each transaction submitted must contain basic information referred to as control data that is entered at registration and intake. Control data identifies and introduces the patient's episode of care in PTF. The control data items are the: patient's SSN, date and time of admission, and facility number, including applicable suffix.

a. **SSN**

(1) The SSN is the primary identification method for matching transactions in an established file. Therefore, it is imperative that all subsequent submissions carry the same SSN currently in the file.

(2) Pseudo-SSNs are automatically generated using the registration package if a patient presents without a SSN or is unable to communicate the SSN. When a pseudo-SSN is used, it will be seen in the PTF package in the transaction record (101 screen) with a "P" designation. If invalid SSNs are entered into VistA using the registration or enrollment process and are not corrected at the time of coding, the Health Information Management (HIM) staff must refer the specific case for correction to the responsible person (i.e., Program Application Specialist (PAS). Invalid SSNs are not to be entered into VistA.

b. **Facility Number.** The facility number is the three-digit VA identification number for the facility at which the patient is treated. Facility numbers can be found at: http://www.appc1.va.gov/directory/guide/home.asp or http://vaww.aac.va.gov/npcd/Stations.php.

c. **Facility Number Suffix.** These are numbers and letters following the facility number, which further define the facility or denotes an integrated facility. For instance, station number 695 denotes the Milwaukee VA Medical Center, but by adding 9AA as the suffix, this now identifies the Milwaukee VA Medical Center Nursing Home as 6959AA. The suffix modifiers can be found at: http://vaww.aac.va.gov/npcd/Stations.php.

d. Facility numbers and suffixes are also used in the transferring facility and receiving facility fields on the PTF 101 Screen. The policy for facility station numbers, including suffixes, can be found at: http://www.warms.vba.va.gov/admin20/mp_1/part2/ch34.doc.

9. FACILITY NUMBERS

a. The PTF System uses the three-digit facility number contained in the latest edition of the Consolidated Address and Territorial Bulletin I-J. PTF requires the use of the full station number including suffix when applicable. Station numbers and suffixes identify both programs and facilities.

(1) To identify the VA facility having responsibility for providing or authorizing care and treatment, the correct station number and suffix for specific programs must be reported. ***NOTE:*** *It is recommended to use http://vaww.aac.va.gov/npcd/Stations.php to familiarize staff with the different programs and suffixes that the facility currently has active.* In some instances, a facility

number and suffix is necessary to indicate specific types of care at a facility, like Nursing Home Care, or specific programs, such as Psychiatric Residential Rehabilitation Treatment Program (PRRTP), as well as locations of care or other authority.

(2) The suffix is appended to the facility number. Facility numbers and suffix modifiers can be found at: http://vaww.aac.va.gov/npcd/Stations.php ***NOTE:*** *These facility numbers and suffixes are also used in the transferring facility and receiving facility fields on the PTF 101 Screen.*

(3) Examples of suffixes are:

NHC at VA facility	9AA, 9AB, 9AC
Domiciliary care at VA facility	BU, BY, BZ
CNH and community nursing home under VA auspices	CNH

b. Consolidated Sites are sites where the VistA database was integrated within another facility. These sites have the same facility number, but separate identifying suffixes. For example, Eastern Kansas Healthcare System consolidated site numbers are: 589A5, Topeka; 589A6, Leavenworth; 589-9AC, Topeka - NHCU; 589-9AD, Leavenworth – NHCU; 5899AC, Topeka – NHCU; 589BU, Leavenworth – Domiciliary.

c. Several medical centers provide more than one type of care. For example, at the Milwaukee, WI, VA Medical Center, "695" would indicate hospitalization in the general acute hospital, "695BU" Domiciliary, and "6959AA" VA NHC. At the Minneapolis, MN, VA Medical Center, where acute and nursing home care are provided, cases are coded as "618" for acute care (no suffix) and 6189AA for NHCU. The Domiciliary at White City, OR, is a stand alone facility and is not attached to a medical center. In this case, the BU is not required in the station number.

d. The facility listing includes State Homes (Domiciliary and Nursing Homes) and State Home Hospitals. The State Home suffix modifiers are:

State Home, Domiciliary	DT, DU, DV, DW
State Home, NHC	9AF, 9AG, 9AH
State Home, Hospital	EL, EM

e. Where specific bed allocations do not exist, the suffix modifiers (immediately after the authorizing facility number) must be used in identifying types of care for identifying patient location for transfers in, transfers out, and for care rendered in non-VA facilities under VA auspices. These suffix modifiers are not to be used for those hospitals, State Homes, etc., included in the VA station number facilities Index Listing that already have a number for the bed allocation.

(1) These suffix modifiers are only to be used only for beds that are not sharing space in VA facilities:

Army hospitals	CS

Navy hospitals	CY
Air Force hospitals	C4
Public Health Service hospitals	DA
Other Federal hospitals	DG
Public hospitals (State, County, etc.)	DM
Private hospitals	DS
CHN (at VA expense)	CNH

(2) Examples are: At the Colorado University Hospital (State owned)--"554DM;" at a private hospital in Colorado Springs--"554DS." A patient admitted to the Omaha VA Medical Center from Offutt Air Force Hospital would be coded "636C4."

f. Agreements have been made with both Federal and non-Federal health care facilities to share a physical location within the same hospital. These multiple agency hospitals must receive an authorization for dual or multi-division facilities from VA Central Office.

(1) Specific suffix modifiers must be authorized by VA Central Office (see http://www.warms.vba.va.gov/admin20/mp_1/part2/ch34.doc). The two letter suffix modifiers are as follows:

Army beds in VA facilities	SA through SF
Air Force beds in VA facilities	SG through SK
Navy beds in VA facilities	SL through SP
Coast Guard beds in VA facilities	SQ through SU
Civilian Health and Medical Program of the Uniformed Services in the United States (CHAMPUS) beds in VA facilities	SV through SZ
Federal Public Health beds in VA facilities	TA through TF
Indian Health beds in VA facilities	TG through TK
Non-Federal Public Hospital beds in VA facilities	TL through TP (includes State, county, or city hospitals)
Civilian hospital beds in VA facilities	TQ through TU

(2) The specialty service of patients who are residing on these non-VA beds in VA facilities must be identified as 98 for non-Department of Defense (DOD) beds in a VA facility and 99 for DOD beds in a VA facility.

10. CODING INSTRUCTION FOR PATIENTS IN VA MEDICAL CENTERS, CONTRACT AND CHN, DOMICILIARY AND NON-VA HOSPITALS UNDER VA AUSPICES

a. **Admission Transaction (101).** An Admission Transaction (101) is created for each admission to a VA medical center, Domiciliary, NHCU, CNH, or a non-VA facility under VA auspices. When the PTF is created, the following information crosses over from the ADT Package:

(1) ***Control Data** (Facility station number (including suffix), date of admission, SSN).

(2) ***Full Name of Patient.**

(3) ***Prisoner of War Status (POW)**

1	POW in World War I
2	POW in WWII, Europe only
3	POW in WWII, South Pacific
4	POW in Korean Conflict only
5	POW in Vietnam only
6	Other
7	POW in Persian Gulf War
8	POW in Yugoslavia Conflict

(4) **Marital Status**

Never Married	N
Married	M
Separated	S
Widow/Widower	W
Divorced	D
Unknown	U

(5) **Sex.** One of the following codes is entered:

M	Male
F	Female

(6) **Date of Birth.**

(7) ***Period of Service.** The codes following are directly related to the Code of Federal Regulations (CFR) (admission authority) under which a patient is eligible for care and treatment:

1	World War I (April 6, 1917-November 11, 1918); date can be extended to April 1, 1920, if veteran served in Russia
2	World War II (December 7, 1941-December 31, 1946)
3	Spanish-American War (April 21, 1898-July 4, 1902)
4	Pre-Korean (Peacetime before June 27, 1950)
0	Korean Conflict (June 27, 1950-January 31, 1955)
5	Post-Korean and Peacetime Service (February 1, 1955-February 27, 1961)
7	Vietnam Era (February 28, 1961-May 7, 1975)
8	Post-Vietnam and Peacetime Service (May 8, 1975-August 1, 1990)
X	Persian Gulf War (Beginning August 2, 1990)
9	Other or None
W	Service in Czechoslovakian or Polish Armed Forces (Public Law 94-491)

Z	Merchant Marine (December 7, 1941-August 5, 1945)
A	Active Duty – Army
B	Active Duty – Navy and Marine Corps
C	Active Duty – Air Force
D	Active Duty – Coast Guard (Department of Transportation)
E	Retired members of uniformed services
F	Medically Remedial Enlistment Program
G	Merchant Seamen (during WWII period only) (United States Public Health Service (USPHS)
H	Other USPHS beneficiaries
I	Observation and examination
K	Job Corps and Peace Corps
L	Railroad retirement
M	Beneficiaries of Foreign Governments
N	Humanitarian (non-veteran Emergency)
O	CHAMPUS Restore, Albuquerque, NM only
P	Other contract reimbursable (non-veteran)
Q	Other Federal agency – dependent (DOD Dependents at VA Facility)
R	Donors (non-veteran)
S	Special Studies (non-veteran)
T	Other non-veteran (not classified elsewhere)
U	Civilian Health and Medical Program of VA (CHAMPVA) surviving spouse, surviving child (Public Law 93-82) rated VA 100 percent and/or permanent and total (P&T)
V	CHAMPUS – CHAMPUS patients at VA
Y	New Philippine Scouts and Commonwealth Army Veterans
6	Persian Gulf War – Active Duty from Operation Desert Shield

(a) Active Military. Active military duty status takes precedence over any other status. In other words, a patient admitted while on active duty must be coded as A, B, C, or D, even though the patient may have eligibility for health care as a veteran by virtue of a previous period of service.

(b) Veteran. Use the code for the period of service that is auto-populated within VistA when a veteran has served in two or more wars except when it is known that the patient is service connected (SC) for a condition incurred in a prior war.

(c) Other Non-veterans. This group includes all patients other than veterans and active duty military, such as humanitarian emergencies, reimbursement cases, allied beneficiaries, donors, etc. If an Office of Workers Compensation Program (OWCP) case is admitted, code as "J," even though the patient is eligible as a veteran (not to be used for extended care).

(8) ***Exposure to Agent Orange (AO).** When answered “yes” and an applicable period of service is entered upon registration, one of the following is entered. For Korean de-militaized zone (DMZ), the period of service is January 1, 1968-December 31, 1969.

1	No claim of Service in Vietnam or Korean DMZ
2	Claims--Vietnam Service or Korean DMZ--no exposure to AO
3	Claims--Vietnam Service or Korean DMZ --exposed to AO
4	Claims--Vietnam Service or Korean DMZ--unknown exposure

(9) ***Exposure to Ionizing Radiation.** When answered "yes," the period of service is coded 0, 2, 4, 5.

1	No claim of Exposure to Ionizing Radiation
2	Claims--Exposure - Hiroshima or Nagasaki, Japan
3	Claims--Exposure - Nuclear Testing
4	Claims--Exposure - both Nuclear Testing and Japan

(10) ***Military Sexual Trauma (MST) Exposure.** This information is automatically completed using the MST software package for any period of service. The selection must be "yes" or "no."

(11) ***Nuclear Testing (NT) Radium.** This information is automatically completed when the period of service is 0, 2, 4, 5, or 7. The selection must be "yes" or "no."

(12) ***Combat Veteran (CV).** This information is completed at the time of registration. The selection must be "yes" or "no."

(13) **Residence, the State and County Codes.** The permanent residence of a patient must be entered using codes according to current VHA policy. If patient's residence is a Domiciliary, the state and county in which it is located is entered. These codes are entered upon registration, but may be edited.

(14) **Zip Code.** The following is entered:

(a) ZIP code of permanent residence can be found in the National Zip Code Directory; this is automatically populated from the Geographic Means Test (GMT).

(b) If residence is a foreign country, code 75999.

(15) ***Means Test (MT) Indicator.** A MT indicator must be entered for all VA patients who were admitted on and after July 1, 1986. The source document for this information is VA Form 10-10EZ or VA Form 10-10EZR. One of the following codes is entered:

AS	MT Co-payment Exempt. SC veteran receiving VA compensation or at least 10 percent SC or special category veteran. Special categories include: Mexican Border War, Spanish American War, World War I veteran, former POW, and Purple Heart.

AN	Non-service connected (NSC) and 0 percent SC veterans who are means test co-payment exempt. AN is used for NSC veterans who are required to complete the MT, and for veterans in receipt of VA pension, aid and attendance or housebound allowance, or State Medicaid.
CMT Co-payment Required	MT Co-payment Required Veterans. This includes those pending adjudication.
N	Non-veteran.
X	Not applicable. (The veteran was admitted prior to July 1, 1986, with no change in the level of care being received, i.e., if the patient was in the NHCU on July 1, 1986, and has remained in the NHCU since that date with no transfer to the hospital for treatment, the "X" MT indicator must be accepted).
U	MT was not done or was not completed.
G	GMT.

(16) ***Income.** The total gross household income must be transmitted with each discharge from a medical facility. This information is obtained from either VA Form 10-10EZ or VA Form 10-10EZR.

(17) **Race and Ethnicity.** There are two fields; one is for Race and the other for Ethnicity. Race can have more than one value reported. The ethnicity and race is entered at registration and can be edited at coding if necessary. The selections for Race can be found in file #10. The selections for Ethnicity can be found in file #10.2.

(18) **Spinal Cord Injury Indicator.** If the patient's spinal cord indicator changes during the patient's admission, the spinal cord indicator may be edited to indicate the appropriate information.

1	Paraplegia - Traumatic
2	Quadriplegia - Traumatic
3	Paraplegia - Non-traumatic
4	Quadriplegia - Non-traumatic
X	Not Applicable

(19) ***Percent of Service Connection.** The veteran's percentage of SC disability is to be entered. If the veteran is not service connected, no entry is to be made.

(20) The following are fields that are entered upon discharge of the patient from the VA medical center:

(a) Source of Admission. These codes indicate where VA medical center, Domiciliary, NHCU, Fee Basis, and CNH patients come from and their status at the time of admission. Select and enter the appropriate code from the following list:

1. **Hospital**

a. Direct admission of a veteran from:

1D	VA NHCU
1E	VA Domiciliary
1G	CNH and community nursing home under VA auspices
1H	CNH, not under VA auspices
1J	Government (non-Federal) mental hospital not under VA auspices
1K	All other non-VA hospitals (not under VA auspices) including community hospitals
1L	State Home (Domiciliary or nursing home)
1M	Direct (not currently on active outpatient status)
1P	Outpatient Treatment (includes Emergency Room (ER) if in outpatient status)
1R	Research – Veteran
1T	Observation and examination

b. Direct admissions of a non-veteran from:

2A	Non-veteran, other than military
2B	Military personnel not directly from military hospital
2C	Military personnel by transfer from a military hospital

c. Transfer in of a veteran or non-veteran from:

3A	VA medical center
3B	Transfer in from another Federal hospital under VA auspices
3C	Other non-VA hospital under VA auspices (includes State Home Hospital)
3D	Transfer from VA medical center to Military facility under VA auspices
3E	Transfer from a VA medical center to a VA medical center and patient has been continuously hospitalized since before July 1, 1986 (MT indicator of X)

2. **NHCU**

a. Direct Admission from:

5A	VA Medical Center
5B	Non-VA Hospital (under VA auspices)
5C	VA Domiciliary
5G	All other sources (community, etc.)

b. Transfer-in of a Veteran from:

5D	A VA NHCU to a VA NHCU when the veteran has been in a nursing home continuously since before July 1, 1986 (MT indicator of X)

5E	Another VA NHCU
5F	CNH (under VA auspices)

3. **CNH Under VA Auspices**

a. Direct admission of a veteran to a CNH:

6A	VA Medical Center
6D	All other sources (community, etc.)

b. Transfer-in of a veteran to a CNH:

6B	VA NHCU
6C	Another CNH (under VA Auspices)

4. **Domiciliary.** Admission or transfer to a Domiciliary from:

4A	VA medical center
4B	VA medical center on non-bed care
4C	VA NHCU
4D	Another VA Domiciliary
4F	Community hospital, under VA auspices
4G	Community hospital, not under VA auspices
4H	CNH, under VA auspices
4J	CNH, not under VA auspices
4K	State Home Domiciliary
4L	State Home Nursing Care
4M	Military hospital
4N	Other Federal hospital, under VA auspices
4P	Other Federal hospital, not under VA auspices
4Q	Other government hospital (State, county, city) not under VA auspices (includes State Home Hospital)
4R	Other government hospital (State, county, city) under VA auspices (includes State Home Hospital)
4S	Referred by Outpatient Clinic
4T	Referred by a welfare agency (local or Regional Office)
4U	Referred by a national service organization
4W	Self-Walk-In
4Y	All other sources (unknown or no information)

5. **Non-VA Hospitals Under VA Auspices**

a. Direct admission of a veteran from:

1D	VA NHCU
1E	VA Domiciliary

1G	CNH and community nursing home under VA auspices
1H	CNH not under VA auspices
1J	Government (non-Federal) mental hospital not under VA auspices
1K	All other non-VA hospitals (not under VA auspices)
1L	State Home (Domiciliary or nursing home)
1M	Direct (excludes admission from outpatient status)
1P	Outpatient Treatment
2A	Non-veteran (other than military)

b. Transfer-in of a veteran from:

3A	VA medical center
3C	Other non-VA hospital under VA auspices (includes State Home Hospital)

(b) Transferring VA Facility. This entry identifies the VA facility or the non-VA facility from which the patient was admitted or transferred. Identification of the facility from which the patient was admitted or transferred is linked to the patient's source of admission. For example: A patient is admitted to the University Hospital in Augusta, GA, from Augusta, GA, VA Medical Center; the transferring from facility would be 509 for VA Augusta. ***NOTE:*** *Facility numbers for transferring facilities are found at web address* *http://vaww.aac.va.gov/npcd/Stations.php* . The following suffixes apply:

1. **Hospital**

a. If the source of admission is a code 1D, 1E, 1G, or 3A through 3C, the transferring facility will be identified along with the transferring suffix listed beside it.

1D	9AA or 9AB if integrated
1E	BU
1G	CNH
3A, 3C	The number of the VA facility from which the veteran was transferred.

b. If the source of admission is a code 1H through 1T, or 2A, no entry is to be made. If the source of admission is a non-VA facility, enter the three-digit facility number for the medical center. ***NOTE:*** *Suffix modifiers which identify non-VA facilities can be found on web site* *http://vaww.aac.va.gov/npcd/Stations.php* .

2. **Nursing Home**

a. If the source of admission is 5A, 5C, 5E or 5F, identify the transferring facility.

5A	The number of the VA facility from which the veteran was transferred.
5C	BU
5E	9AA or 9AB if integrated

5F	CNH

b. If the source of admission is 5G, no entry is to be made.

3. **Domiciliary**

a. If the source of admission is 4A, 4C-4E, 4H, 4K-4N, or 4R, identify the transferring facility:

4A	The number of the VA facility from which the veteran was transferred
4C	9AA or 9AB if integrated
4D	The number of the Domiciliary from which the veteran was transferred
4H	CNH
4K	State Home or Domiciliary
4L	State Nursing Home
4M	Military Hospital
4N	Other Federal hospital under VA Auspices
4R	Other government hospital (non-Federal)

b. If the source of admission is 4B, 4G, 4J, 4P or 4Q, no entry will be made.

4. **Non-VA Hospitals**

a. If the source of admission code is 1D, 1E, 1G, 2C or 3A through 3C, identify the transferring facility number along with one of the following:

1D	9AA or 9AB if integrated
1E	BU
1G	CNH
3A, 3C	The number of the VA facility from which the veteran was transferred

b. If the source of admission code is 1H-1P, 2A, or 2B, no entry is to be made.

(22) When a patient is discharged from a VA medical center, the following information is required for the automated PTF 101 screen:

(a) *Date and Time of Discharge. This is manually entered for CNH and Fee Basis Patients.

(b) *Discharge Status. One of the following codes, which represents the patient's bed occupancy status at the time of discharge, must be entered through the Bed Control Package (for CNH and Fee Basis patients, this must be manually entered):

1	Bed Occupant
2	Patient on Pass (or authorized absence)
3	Patient on Leave (includes unauthorized absence)

NOTE: *2 and 3 are not used for non-VA PTF.*

(c) *Discharge or Treating Specialty. This is manually entered for CNH and Fee Basis patients. The current treating specialties can be found at: http://vaww.va.gov/NDS/PatientTreatmentFile.asp

(d) *The Specialty Code and the MPCR Account Code

1. The Specialty Code and the MPCR Account Code are to reflect the treating service of the physician, not the physical location of the bed.

2. The VA inpatient specialties and accounts are used to assign a patient to a particular specialty while the patient is in a VA facility. Having a specialty or service of treatment does not indicate or mean that a facility has an approved bed section. For example, although most VA medical centers have a Rehabilitative Medicine Service, they may not necessarily have a VA Central Office approved or designated rehabilitation bed section. This distinction is important since only bed sections that have been approved by VA Central Office may be submitted to the NPCD at Austin CFD. Any PTF abstract submitted by a facility for specialties that have not been approved by VA Central Office are rejected.

(e) Source of Payment. One of the following must be entered for Fee Basis patients at a non-VA facility under VA auspices:

1	Contract or Community – public and private hospitals
2	Sharing
3	Contract or Community – military and Federal agencies
4	Paid unauthorized services

(f) *POW Status. When a patient is admitted to the NHCU or CNH, one of the following is entered manually:

1	POW in WWI
2	POW in WWII, Europe only
3	POW in WWII, South Pacific
4	POW in Korean Conflict only
5	POW in Vietnam Era only
6	Other
7	Persian Gulf War
8	Yugoslavia Conflict

(g) *Discharge or Treating Specialty. For non-VA PTF and CNH patients, manually enter the bed section code from the following:

15	Medicine
50	Surgery
92	Psychiatry, General Intermediate
93	Psychiatry, Acute

44	NHCU (used for CNH patients)

(h) *Type of Disposition. One of the following disposition codes will cross over from the ADT Package. This must be entered for CNH and Fee Basis patients.

1	Regular
2	Non-bed care
3	Expiration of 6-month limitation (used for CNH patient only)
4	Irregular
5	Transfer to like facility (examples: VA medical center to VA medical center, VA NHCU to VA NHCU, CNH to CNH or another hospital under VA auspices)
6	Death, with autopsy
7	Death, without autopsy

1. **Outpatient Treatment.** Select and enter one of the following codes (no entry will be made if the Type of Disposition is 4, 6, or 7):

1	Yes
3	No

2. **VA Auspices.** Select and enter one of the following codes to indicate whether further care is to be provided under VA auspices at VA expense (no entry will be made if the Type of Disposition is 4, 6, or 7):

1	Yes
2	No

(i) Place of Disposition. Select and enter one of the following codes to show where the patient is going:

X	Return to community-independent
0	VA medical center – needs suffix
1	Military hospital
2	Other Federal hospital
3	Other Government hospital (state, county, city, and State Home Hospital) at VA expense
4	Community hospital – requires facility number
5	VA NHCU
7	CNH at VA Expense
B	State Home – nursing care
C	VA Domiciliary
D	State Home - Domiciliary care
F	Foster home
G	Halfway house
H	Boarding house
J	Penal institution

K	Residential hotel or care facilities (i.e., Young Mens Christian Association (YMCA)
L	Other placement, not specified elsewhere or unknown
M	Refer VA-paid (pd) Home or Community Health
P	Home-based Primary Care (HBPC)
R	Spinal Cord Injury (SCI) VA Central Office-approved program only
T	Respite
U	Hospice Care
Y	Refer to Medicare Home Health Care
Z	Refer to other agency-Paid Home Health Care

(j) Receiving Facility. Make entries only if the beneficiary is to receive further care (hospital, nursing home, Domiciliary, or non-VA facility) under VA auspices. Use facility numbers from the website at: http://vaww.aac.va.gov/npcd/Stations.php , or use the three-digit facility code that identifies the discharging VA facility. For CNH, add the suffix code, CNH. If the facility is transferring a patient to a community hospital at VA expense or on the basis of a contract, community, or sharing agreement, enter the facility's own three-digit code and use the suffix to indicate the type of community hospital (DM), which is providing further care.

1. In the case of a VA medical center NHCU placement, use the three-digit facility code, which identifies the discharging VA facility, and add the nursing home suffix code, 9AA.

2. If the facility is transferring the patient to the VA Nursing Home, enter the VA facility three-digit code and use the suffix to indicate the type of community hospital which is providing further care.

(k) ASIH. For NHCU and Domiciliary patients that are ASIH, leave this field blank as it will auto-populate. For CNH the ASIH days must be entered.

(l) Compensation and Pension (C&P) Status

1	Treated for compensable SC condition (rated 10 percent or more). (Use even if the veteran is receiving a VA pension.)
2	Treated for a non-compensable SC condition (rated less than 10 percent). (Use even if the veteran is receiving a VA pension.)
3	Treated for a NSC condition and has a compensable SC disability, which did not require medical care.
4	Treated for a NSC condition and has a non-compensable SC disability which (rated less than 10 percent) did not require medical care. (Use even if the veteran is receiving a VA pension.)
5	Treated for NSC condition and is in receipt of a VA pension.
6	Treated for NSC condition has non-compensable disability, which did not require medical care and is not in receipt of a VA pension.
7	Treated for NSC condition, has no SC disability, and is not in receipt of a VA pension.
8	Non-veteran

b. **Patient Movement Transaction (501).** A Patient Movement Transaction is defined as any transfer between bed sections and the patient remains on the new bed section as of midnight of that date or a transfer to a specialized unit where the patient remains as of midnight of that date.

(1) A Patient Movement Transaction (501) is completed for each transfer between bed sections in a VA health care facility. A patient movement will not be reported for patients placed in a specialty bed due to a lack of available beds on an appropriate bed section or transferred for reasons other than a change in patient care requirements. For non-VA admissions, the 501 must be manually completed, as it does not auto-populate.

(2) The 501 screen(s) contains information about patient movement(s) listed on the "MAS" screen including patient discharge movement. Because a 501 screen is generated for every patient movement, there may be more than one 501 screen. Unlike the "MAS" screen which shows all bed movements (535 screen), the 501 screen is only generated for bed section changes.

(3) The following information is required for the 501 screen and is auto-populated except for Fee Basis and CNH patient. Fee Basis and CNH 501 data may be edited.

(a) *Date and Time of Movement.

(b) *Losing Bed Section.

(c) Leave Days on Bed Section. Enter the number of days on this bed section that the patient was on authorized or unauthorized leave during the present episode of care. Any period of unauthorized absence must be included in the leave days reported. This field is auto-populated except for Fee Basis and CNH. Leave days are not included in the length of stay in PTF.

(d) Pass Days on Bed Section. Enter the number of days on this bed section that the patient was on pass during the present episode of care. This field is auto-populated except for Fee Basis. Pass days under 96 hours are included in the length of stay in PTF.

(e) Principal Diagnosis for Losing Bed Section. Enter the International Classification of Diseases , 9th edition, Clinical Modification (ICD-9-CM) diagnostic code for the condition established after study to be chiefly responsible for occasioning the treatment for the bed section.

(f) Other Diagnostic Codes. Only four other diagnostic codes are permitted for each patient movement.

(g) Psychiatry AXIS Classifications

1. The appropriate AXIS IV (Severity of Psychosocial Stressors) and AXIS V (Global Assessment of Functioning Scale) must be entered.

2. The determination of the AXIS Classifications is made by the clinical staff based on the patient's overall condition and is not based on the ICD-9-CM Psychiatric Diagnostic code(s) entered.

3. AXIS IV – Severity of Psychosocial Stressors. Codes and terms are:

0	Inadequate information or no change in condition
1	None
2	Mild
3	Moderate
4	Severe
5	Extreme
6	Catastrophic

4. AXIS V – Global Assessment of Functioning Scale. This scale requires the entry of two ratings. One rating will be made for the current time period and the second for the highest level of functioning in the past year. If there is no rating for the past year, no entry is to be made in the second two digits. Rating scores range from 1 (grossly impaired) to 90 (absent or minimal symptoms). The entry of 0 indicates inadequate information. The range of scores listed is to be used for entry into both ratings. Score ranges and associated level of functioning are as follows:

90 to 81	Absent or minimal symptoms.
80 to 71	If symptoms are present, they are transient and expectable reactions to psychosocial stressors.
70 to 61	Some mild symptoms or some difficulty in social, occupational or school functioning.
60 to 51	Moderate symptoms or moderate difficulty in social, occupational or school functioning.
50 to 41	Serious symptoms or serious impairment in social, occupational or school functioning.
40 to 31	Some impairment in reality testing or communication or major impairment in several areas, such as school, family relations, judgment, thinking or mood.
30 to 21	Some danger of hurting self or others, occasionally fails to maintain personal hygiene, or gross impairment in communication or judgment or ability to function in almost all areas.
20 to 11	Some danger of hurting self or others, or occasionally fails to maintain minimal personal hygiene, or gross impairment in communication.
10 to 1	Persistent danger of severely hurting self or others, or persistent inability to maintain minimal personal hygiene, or serious suicidal act.
0	Inadequate information.

(h) Treated for SC Condition. Each 501 segment must contain information as to whether or not the patient was treated for a SC condition during that portion of the inpatient stay. This information is to be based on the principal diagnosis for the movement.

(i) Transactions per Discharge. The NPCD will not process more than twenty-five 501 transactions per discharge. All 501 transactions over the twenty-five limit will be rejected by the NPCD. The PTF option must be used to select no more than 25 movements to send to NPCD (refer to the VistA documentation for PTF found on the VistA Documentation Library website at http://www.va.gov/vdl/).

(j) DRG Calculations. DRG calculations for PTF data occur locally and at NPCD. Currently the local VistA calculations are not transmitted to NPCD, but are recalculated within the NPCD as the official DRGs for the hospital stay. The discharge date is used for the final DRG calculation.

c. **Physical Location Transaction (535)**

(1) The Physical Location Transaction must be used to monitor the times a patient is housed in a physical location (bedsection) that is different from the treating specialty. For example, when insufficient beds are available for use by Medical Service, the patient may be physically transferred to a bed on the Surgical Service. The physical location of the patient and the appropriate MPCR codes must be entered for all patients on the discharge transaction. A 535 transaction is to be created at this time.

(2) Leave and pass days for the time the patient is in a physical location different from the specialty location will be transmitted in the 535 transaction.

d. **Procedure Transaction (601)**

(1) Procedures must be reported on the 601 transaction. “Procedure" for the purpose of PTF includes dental procedures, and is defined as a non-OR intervention operation or non-surgical action (diagnostic, therapeutic, etc.). Procedures may be documented in progress notes, on consultation reports, radiology and nuclear medicine reports, etc.

(a) When a patient is transferred to a private hospital for a procedure, and returns within the same calendar day, the procedure is coded as part of the current VA medical center hospitalization.

(b) When an inpatient at a Domiciliary has an ambulatory procedure, the procedure is not coded into the current admission in the PTF file as it is coded and transmitted as an ambulatory procedure.

(c) When an inpatient of the facilities’ NHCU has an ambulatory procedure, the procedure is coded in the current NHCU PTF file.

(2) The procedures transaction can accommodate five ICD-9-CM code entries performed at any date and time during a period of hospitalization. If more than five procedures were performed, only the most significant is to be entered. The PTF system accepts a maximum of thirty-two transactions per hospitalization.

(3) The number of dialysis episodes must be reported on the procedure transaction. Multiple dialysis types of treatment received during a hospitalization may be reported on the 601 transaction for the date of occurrence.

(4) Enter the following information:

(a) Date and time of procedure of first dialysis treatment for the movement.

(b) Number of Dialysis Treatments. If the procedure code is dialysis related, the coder will be prompted to enter the number of dialysis treatments given to the patient. Dialysis treatments must be tallied and documented on each patient movement within a period of hospitalization to ensure inclusion with specific treating specialties (i.e., Medical Intensive Care Unit). If unknown, leave blank to prevent entering erroneous data.

e. **Surgical Transaction (401)**

(1) A Surgical Transaction (401) must be prepared for each surgical episode except for CNH, NHCU or Domiciliary patients. The term "operative room procedure" includes surgery performed in an OR. A surgical transaction must be prepared for VA inpatients undergoing surgery in VA facilities and for veterans undergoing surgery in non-VA facilities at VA expense when the patient leaves and returns to the VA facility within a calendar day.

(2) The PTF system accepts a maximum of ten transactions per hospitalization.

(3) Five surgical codes may be reported for each date and time of surgery per episode. If more than five exist, the codes need to be consolidated when possible on another date and time within the same movement, or deleted, based on clinical importance. The following must be entered:

(a) Date and Time of Surgery (Operation).

(b) Surgical Specialty. Identify the specialty of the Chief Surgeon who performed the operation. If the surgeon is a resident, use the code that reflects the current residency assignment.

48	Cardiac Surgery
49	Transplantation
50	General or for Non-VA PTF or when specialty is not identified in the following
51	Gynecology
52	Neurosurgery
53	Ophthalmology
54	Orthopedics
55	Otorhinolaryngology (ENT)
56	Plastic Surgery including head and neck
57	Proctology
58	Thoracic Surgery including Cardiac Surgery

59	Urology
60	Oral surgery (Dental)
61	Podiatry
62	Peripheral Vascular
78	Anesthesiology

(c) Category of Chief Surgeon

1. For patients operated upon in a VA facility, select the code that will identify the team of surgeons operating:

1	Staff, full-time
2	Staff, part-time
3	Consultant
4	Attending
5	Fee Basis
6	Resident
7	Other (includes Intern)

2. For patients operated upon in a non-VA facility, select and enter the code that identifies the team of surgeons operating. N is the most commonly used code.

V	VA team of surgeons
M	Mixed VA and non-VA team of surgeons
N	Non-VA team of surgeons

(d) Category of First Assistant. For patients operated upon in a VA facility, select and enter the code that identifies the employment status or category of the first assistant. For patients operated upon in a non-VA facility, an entry is not required.

1	Staff, full-time
2	Staff, part-time
3	Consultant
4	Attending
5	Fee Basis
6	Resident
7	Other (includes intern)
8	No assistant

(e) Principal Anesthetic Technique. For patients operated upon in a VA facility, select and enter one of the following codes. For patients operated upon in a non-VA facility, make no entry.

0	None
1	Inhalation (open drop)
2	Inhalation (circle absorber)

3	Intravenous
4	Infiltration
5	Field block
6	Nerve block
7	Spinal
8	Epidural
9	Topical
R	Rectal
X	Other

(f) Source of Payment. Leave Blank for patients operated upon in a VA facility. For patients operated on in a non-VA facility, enter one of the following:

1	Contract – public and private Hospitals
2	Sharing
3	Contract – military and Federal
4	Unauthorized

(g) Operative Codes. ICD-9-CM Procedural Codes must be used. Five procedural codes may be reported for each surgical episode per segment.

f. **Principal Diagnosis Transaction (701).** A Principal Diagnosis Transaction (701) must be completed for all releases from a VA medical center, Domiciliary, NHCU, or CNH under VA auspices. The 701 is "created" when the patient has more than one diagnostic code to be entered. A maximum of thirteen codes can be entered on the 701 for the episode of care. The Principal Diagnosis is where the assigned DRG and PTF number can be located.

(2) The following information is required for the 701 screen:

(a) *Date and Time of Discharge. This does not auto-populate for CNH and Fee Basis patients and must be entered.

(b) *Discharge Specialty.

(c) *Physical Location and MPCR Codes.

(d) Principal Diagnosis.

(e) Other Diagnostic Codes. Only twelve additional diagnostic codes may be entered for each patient.

(3) A DRG for each episode of care is calculated upon entry of all final diagnoses, and displayed on this screen. Following completion and verification of data on all PTF screens, the 701 transaction is utilized to "close" and "release" the patient's database record in preparation for transmittal to the NPCD. Current DRG options within VistA default to the average from the Centers for Medicare and Medicaid (CMS) information, using the Medicare Grouper logic published in the Federal Register.

(4) The abstract information from closed and released patient records is "transmitted" using VistA PTF options to CFD, which uses the data for several purposes nationally. CFD re-computes the DRGs for resource allocation to the hospital. ***NOTE:*** *PTF EAL and 419 reports are generated to validate PTF data transmission and indicate errors.*

g. **Professional Fee Transaction (801)**

(1) A Professional Fee Transaction (801) is created when professional services for inpatient visits, procedures and consults are performed and are not captured in any other package (e.g., radiology). This is an optional transaction.

(2) Each episode of care has CPT codes assigned and each CPT code may have up to eight diagnosis codes assigned. Service connection, combat veteran (CV), and the various eligibilities are tied to the individual diagnostic code. If at least one diagnostic code assigned to a CPT code is related to a veteran's service connection or other eligibility (e.g., MST), then the entire procedure (CPT code) is billing exempt. Note that the system will prompt the coder to associate the ICD-9 codes to any of the eligibilities claimed by the veteran, whether they are SC or the other various eligibilities (e.g., CV, AO, MST) to which the veteran may be entitled.

(3) The 801 data does not transmit to the CFD and does not affect any PTF reports. This data transmits only to the Integrated Billing package.

(4) The end user can assign up to two modifiers. Each CPT code must have at least one ICD-9 assigned.

(5) Once the diagnostic code is added, the end user can associate the diagnosis with the patient's service connection or other eligibility, if appropriate for the care provided. If a patient is SC, VistA displays the patient's SC disabilities.

11. RESUBMISSION OF INPUT AND EDITING OUTPUTS

a. **General Information**

(1) The PTF System has been developed with the concept of accepting and retaining data that meets edit specifications. A PTF master record is created only when the record is error free. It is important to determine whether or not the transaction has been accepted. A transaction will be accepted providing:

(a) It contains valid and consistent Control Data (SSN, date and time of admission, and facility number);

(b) It has the appropriate transaction type code; and,

(c) There are no edit or error conditions in the remaining portion of the transaction.

(2) Analysis and review of all edit code messages in the right margin of EAL for the transaction provides information as to the data accepted or rejected.

(3) A maximum of five edit conditions is permitted in any given transaction before processing is terminated. When the computer encounters a total of six unacceptable edit conditions for one transaction, a code 999 is issued and the transaction is rejected.

b. **Transactions Processed Listing (TPL)**

(1) The TPL listing shows the disposition of the transactions submitted. There are five possible dispositions: Accepted, Rejected, Pending, Wrapped, and Deleted.

(a) Accepted transactions appear on the TPL without any notation.

(b) Rejected transactions carry the notation "Rejected" and also appear on the EAL.

(c) Transactions that carry the notation "Pending" means there was not enough information to establish a master record and the valid data is being retained for processing in the next cycle. The system is expecting more data.

1. If some transactions for a period of care are error free while other transactions for the veteran's episode of care are found to have errors, the transactions that are error free are retained in a "Pending File" until the transaction in error is correctly resubmitted.

2. Records held in the pending file appear on the TPL with the notation that the record is pending and the date the transaction was put on the pending file. Records remain on the pending file for 120 days; if no corrective action has been taken in this period of time, the record is dropped from the pending file. The TPL shows those records that have been deleted; they carry the notation "Deleted."

(d) A transaction with the notation "Wrapped" means that the transaction has had the control data changed (probably SSN) and it will be processed in the next weekly cycle. The facility does not have to do anything. This just tells the facility that a change has been received and it will be processed.

(e) A transaction with the notation "Deleted" means that the record has been dropped from the file either as a result of an "099 Deletion Transaction" initiated by the facility or the record has been dropped because 120 days have passed without submission (resubmission) of data necessary to create a master record.

(2) The TPL is a composite listing, of all transactions (accepted and rejected), for a reporting facility for the processing cycle.

(a) Transactions for a given master record in the processing cycle are listed in transaction type code sequence.

(b) Three print lines are devoted to each transaction.

1. The first line contains abbreviated headings for data fields in the particular transaction.

2. The second line displays the content of the transaction exactly as submitted by the reporting facility. Applicable edit codes appear in the right margin parallel to the transaction.

3. The third line contains a symbol beneath the data field that did not pass edit specification, plus information indicating the reason for producing an RPO. The following symbols correlate to the codes:

a. An asterisk (*) indicates the entry contained an invalid code, and

b. A pound sign (#) indicates the entry is inconsistent with other data in the transaction(s) and/or master record.

c. **RPO**

(1) A RPO displays the current coded data content of an individual master record in the system for a treatment episode. As an output of processing, it is a tool to resolve data that failed a consistency edit. It permits the user to compare stored data with current input. If a record printout has been produced, "RPO" appears on EAL under the error codes of the applicable transaction in the right margin on the third line. As a result of edit processing for a cycle, only one RPO is produced for a master record even though "RPO" may be referenced for more than one transaction.

(2) A reporting facility can initiate a request for a RPO, but facilities are encouraged to obtain access to the Austin PTF database for additional or detailed information and retrieve the RPO themselves. Should such a request be processed in the same cycle in which one was generated, the facility receives two record printouts for the record. Such requests may arise when there is a need to obtain or verify data in a master record for a treatment period. Two types of RPO requests are provided, and each type is described in the following:

(a) RPO Request for a Specific Treatment Period. Transaction type "150" will produce an RPO for a specific treatment period existing in the PTF files of the current fiscal year and 1 prior fiscal year. In order to locate the master record, the following information must be provided in the request:

1. Transaction Type (TT) “150.”

2. SSN of beneficiary.

3. Date and time of admission referencing the date and time of admission of the requested treatment period. If the time of the admission is not known enter four zeroes.

4. Enter the facility number of the medical center where the requested treatment period took place.

5. Enter the facility number of the facility requesting the RPO.

(b) RPO Request for Master Records for a Beneficiary (TT 150, TT 151). Transaction type "150" produces RPOs for a specific treatment period existing in the files of the current fiscal year or I prior fiscal year. The following information will be provided in the request:

1. TT 150,

2. SSN,

3. Date and time of admission, and

4. RPO Transaction Code Type.

a. **150 Master Record Produce RPO.** This includes the entire content of a specific treatment period existing in the files of current fiscal year or 1 prior fiscal year. The period identified by date of admission.

b. **151 Master Record Produces RPOs.** This includes all records of the beneficiary's treatment periods existing in files of the current fiscal year and 1 prior fiscal year. Limited information is provided in the request, as: Transaction type “151” and SSN.

(3) "Reason codes" that appear in the upper portion of the RPO provide a reference to determine why the document was provided.

Reason Code	Definition
ERROR	RPO produced because of edit condition
REQST	RPO produced by means of transaction request
INFO	To verify all segments of PTF are present

d. **Edit Tables**

(1) An edit is a computer check to determine that input is correct. This is done by programming in the computer. The acceptable codes for each category of care have been written into edit tables. The facility number in each transaction is checked with a facility number edit table.

(2) This edit table contains and identifies the code of each reporting facility that supplies input and the category of care that is reportable from that activity. Based on category of care identified by the complete facility number in the transaction, edit tables for the category are used to check or edit input. If the code in the facility number item does not match any code in the facility number edit table, the transaction is rejected, as the computer cannot select the appropriate edit table.

e. **Types of Edits**

(1) **Validity Edit.** This edit checks to determine that the code entered for the item, is an acceptable code for the transaction and category of care. The symbol indicator (*) asterisk will appear on outputs to indicate an invalid code.

(2) **Consistency Edit.** This edit compares data in related items, to determine that they are consistent and acceptable for the category of care. The symbol indicator, a (#) pound sign, appears on outputs to denote an inconsistent code. A consistency edit cannot be completed if any entry that is part of the edit contains an invalid code. The EAL shows the asterisk (*) below the invalid code(s).

f. **Sequence of Edits**

(1) For processing, all transactions are sorted by SSN, date and time of admission, station number, and transaction type code. Transactions are edited separately and in numerical sequence. First, the data content within the transaction itself is edited and next, it is edited against data that has been stored on other transactions for the treatment episode. If all the data in the transactions meets edit conditions, a master record is created.

(2) The sequence is as follows:

(a) A validity edit of the data content within the transaction.

(b) A consistency edit of the data content within the transaction itself.

(c) If errors occur in subparagraphs 11f(2)(a) or 11f(2)(b) the transaction is rejected.

g. **Entire Transaction Rejected**

(1) If the transaction has been rejected, the data content that caused its rejection needs to be corrected, and the transaction type code indicating the purpose of the original intended action used.

(2) None of the original input for this transaction has been stored.

h. **Replacement of Accepted Stored Data in a Master Record**

(1) Submission of a 101 (Admission Transaction) deletes all existing records (master and pending) for a record with the same control data.

(2) All data submitted for replacement purpose in a transaction must meet edit conditions or none of the data will be accepted, and the content of the master record remains unaltered.

i. **Deletion of Master Record**

(1) Due to errors in reporting there may be a need to delete an established master record or component segments of a record. A deletion action is used only when the record cannot be adjusted by using a replacement action.

(a) This option is only available to holders of the DG PTFTRANS security key.

(b) Transaction type "099" removes the complete existing content of a master record that has been established in the PTF system. In addition to the transaction type, this transaction requires control data, SSN, date and time of admission, and facility number that are identical to the data that established the master record. If the time and date of admission are not known, zeroes need to be entered.

(2) The following are examples for reasons to delete an existing master record:

(a) The facility number has been incorrectly identified; or

(b) An admission was reported, but actually did not take place (admission canceled).

12. FACILITY REPORTS

a. A list of facility reports and their frequency can be located on the Intranet at http://austin.aac.va.gov/Frntpage.EOS.html

b. For access to run PTF facility reports, complete VA Form 9957, Access Request Form, to request access; it can be found at: http://vaww.va.gov/vaforms/va/pdf/va9957.pdf.