BY ORDER OF THE
SECRETARY OF THE AIR FORCE

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Health Services

MEDICAL EXPENSE AND PERFORMANCE REPORTING SYSTEM (MEPRS) FOR FIXED MILITARY MEDICAL AND DENTAL TREATMENT FACILITIES

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This publication implements Air Force Policy Directive (AFPD) 41-1, Health Care Programs and Resources, and Department of Defense (DoD) 6010.13-M, Medical Expense and Performance Reporting System (MEPRS) for Fixed Military Medical and Dental Treatment Facilities Manual. It mandates use of the Medical Expense and Reporting System (MEPRS) in Air Force Medical Treatment Facilities (MTFs). It does not apply to Limited Scope Medical Treatment Facilities (LSMTFs) medical aid stations, Line Acute Care Units (ACUs), squadron medical elements, designated functional flights, deployed mobile MTFs, occupational and environmental health laboratories, medical research and development functions, Air National Guard Medical Units, or Air Reserve Medical Units. There is no waiver authority for this instruction except for the Limited Scope Medical Treatment Facilities (LSMTFs) listed in chapter 4. This publication may be supplemented at any level, but all direct Supplements must be routed to the OPR of this publication for coordination prior to certification and approval, also send any comments or suggested improvements on AF Form 847, Recommendation for Change of Publication. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual (AFMAN) 33-363, Management of Records, and disposed of in accordance with Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS)

SUMMARY OF CHANGES

This is a quadrennial update with the current prescribed tiered format to include updated inspection requirements that tie to the Self-Assessment Checklist (SAC) elements.
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10.1. The MEPRS Program Manager in conjunction with appropriate personnel will ensure all systems’ files and tables are updated and synchronized as required.

10.2. The MPM will ensure initial and ongoing training of all personnel in the mechanics of MEPRS data reporting.

10.3. MTFs will use WAM for CHCS-generated workload data.

10.4. Changes to data in EASIVi can be made ONLY if correction in CHCS/AHLTA, DMHRSi or the source financial system is not possible.

10.5. Refer to the Self-Assessment Checklist (SAC) for specific Inspection requirements.

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Chapter 1

PROGRAM OVERVIEW

1.1. Medical Expense and Performance Reporting System (MEPRS).

1.1.1. (MEPRS) is a cost management system that accumulates and reports expenses, manpower, and workload performed in DoD fixed military medical and dental treatment facilities. It is the basis for establishing a uniformed reporting methodology that provides consistent financial and operating performance data to support senior leaders who are responsible for allocating the programmatic resources used to sustain the health care delivery system. The MEPRS information assists in measuring productivity and management effectiveness, developing performance standards and process improvement initiatives to enhance business planning opportunities and resource allocation.

1.1.2. Since the data derived from MEPRS may be incorporated into business planning analysis and used by the AFMS and DoD in making strategic programmatic decisions-- the data must be accurate, timely and reliable. Data integrity issues can affect the outcome of studies, analyses, and metrics; resulting in erroneous assumptions and leading to faulty decisions made concerning the efficiency and effectiveness of medical facilities and provider productivity.

1.1.3. MEPRS identifies the cost of care provided in Medical Treatment Facilities by product line and beneficiary category. MEPRS connects the expenses incurred with the FTEs reported and workload generated in each MTF by Functional Cost Code (FCC); it will be used as a historical representation of the MTF for comparative analysis performed at higher Headquarters and DHA.
Chapter 2

ROLES AND RESPONSIBILITIES

2.1. The Surgeon General, (AF/SG) will:
   2.1.1. Implement Medical Expense & Performance Reporting System (MEPRS) for Fixed Medical and Dental Treatment Facilities IAW DoD 6010.13-M.
   2.1.2. Develop guidance for uniform reporting requirements and comparable data submission to designated management levels within DoD.

2.2. Air Force Medical Support Agency (AFMSA)/SGYR will:
   2.2.1. Arrange for funding of Air Force MEPRS software and hardware requirements.
   2.2.2. Participate in and direct release of MEPRS software.
   2.2.3. Act as Air Force representative to the Tri-Service MEPRS Management Improvement Group (MMIG) to make Tri-Service guidance regarding MEPRS and Expense Assignment Systems Version IV internet (EASIVi) systems.
   2.2.4. Direct guidance updates/changes for Air Force specific requirements.

2.3. The Command Surgeons will:
   2.3.1. Ensure facilities provide timely and accurate MEPRS reporting.

2.4. Air Force Medical Operations Agency (AFMOA)/SGAR will:
   2.4.1. Aid MAJCOM SGs and Military Treatment Facilities (MTFs) in providing timely and accurate data transmissions.
   2.4.2. Act as focal point between MTFs and AFMSA/SGYR on MEPRS related issues.

2.5. The Air Force Program Executive Office Enterprise Information Systems (AFPEO EIS/HIB) will:
   2.5.1. Test software; provide instructions and guidance for implementing system changes.
   2.5.2. Provide field assistance to all Air Force MTFs for EASIVi related software problems.
   2.5.3. Act as Air Force authorizing agency for EASIVi and central repository access.
   2.5.4. Act as interface with the Defense Health Agency (DHA) and Defense Health Service Systems (DHSS) to resolve all AF unique infrastructure issues, assist with the definition of system requirements, test and support the implementation of all software upgrades.

2.6. Medical Wing/Group Commander will: (T-0)
   2.6.1. Assume responsibility for overall operation of MEPRS within the MTF. (T-0)
   2.6.2. Integrate MEPRS data into the MTF's management audit and review processes. (T-0)

2.7. The Medical Resource Management Function will: (T-0)
   2.7.1. Manage MEPRS program within the MTF. (T-0)
2.7.2. Ensure MEPRS program is adequately staffed to provide accurate and timely data and is an active participant in the MTF Data Quality Management Control Program (DQMCP). Ensure MEPRS Program Manager (MPM) attends a MEPRS Training class within the first year of being assigned. This is Self-Inspection Checklist Items 1 and 33. (T-0)

2.7.3. Perform MEPRS data analysis and ensure ongoing feedback on performance measures to the Cost Center Manager Program and Executive Committee. (T-0)

2.8. **The MEPRS Program Manager (MPM) will:** (T-0)

2.8.1. Be responsible for the analysis and overall timely submission of validated MEPRS data by 45 days after the end of the reporting month. This is Self-Inspection Checklist Item 31. (T-0)

2.8.2. Provide mandatory training annually for the MEPRS work centers Point(s) of Contact with recurring training as needed. This is Self-Inspection Checklist Items 34, and 35. (T-0)

2.8.3. Coordinate with the Budget Analyst (BA), Resource Advisors (RA), Logistics, Manpower, Facility Management, specific work centers, and any other personnel necessary to ensure at least annually, that the methodology for reporting (workload, time and money) is accurate. (T-0)

2.8.4. Be responsible for gathering, validating and manually inputting data in a timely manner, in order to meet the above transmission requirement. (T-0)

2.8.5. Ensure 100% of timecards have been approved and are demographically accurate prior to generating the Defense Medical Human Resource System internet (DMHRSi) output file. Labor hours and salary are a critical data component depicting the AFMS level of effort, by which we are reimbursed for healthcare activities. This is Self-Inspection Checklist Item 13. (T-0)

2.8.6. Complete reconciliation of financial, personnel and workload data in coordination with the appropriate personnel. This is Self-Inspection Checklist Items 20, 22, and 23. (T-0)

2.8.7. Review all data sets annually or as needed. There is more specific guidance on the responsibilities of the MPM throughout this AFI. This is Self-Inspection Checklist Item 21. (T-0)

2.9. **Flight Commanders will:** (T-0)

2.9.1. Ensure a MEPRS work center primary and alternate POC are appointed in writing to act as a liaison with the MPM. All work center POCs will receive annual DMHRSi training and refresher training as needed. (T-0)

**Note:** The MEPRS work center POC(s) must be military (an E-5 or above) or civilian (GS-06 or above). These tasks could potentially be performed by one or more persons, if multiple POCs are used, identify them separately on the appointment letter with responsible task (DMHRSi, workload or financial).

2.9.2. Validate and approve all work center data collection processes for their Flights/Elements when required, but at least annually. This is Self-Inspection Checklist Item 5. (T-0)

2.10. **The MEPRS Work Center POC or Alternate will:** (T-0)
2.10.1. Coordinate all work center specific issues concerning MEPRS, which includes workload, expenses and personnel time reporting. They will forward all required workload reports to the MPM within 3 workdays after the end of the reporting month. When an electronic submission is used, a local process must be implemented to notify the MPM that the data has been validated and submitted. The work center POC will ensure the accuracy of the workload for the productivity of their work center and the timely submission of the workload to the MPM. (T-0)

2.10.1.1. With assistance from the MPM, work center POCs will use only accurate Functional Cost Codes (FCCs) and provide work center specific task training as needed (Personnel (DMHRSi), Financial or Workload). (T-0)

2.10.1.2. Be responsible for ensuring all personnel (assigned, borrowed, contracted or volunteer) within their work center completes their biweekly timesheet in DMHRSi. They must notify the DMHRSi Human Resource (HR) Manager and the MPM of all departures, arrivals, transfers, changes in demographic information and other pertinent data. (T-0)

2.10.1.3. Approve or reject DMHRSi timecards NLT COB the third duty day after timecard period ends (Wednesday). All rejected timecards must be corrected, re-submitted and approved NLT COB the fifth duty day after the timecard period ends (Friday). Upon rejection of a timecard, Timecard Approvers must immediately notify the individual that their timecard was rejected along with the reason for the rejection. This is Self-Inspection Checklist Item 8. (T-0)

Note: Civilian timecard reconciliation will happen 7 to 10 days after submission and approval; any rejected timecards will be corrected within 3 duty days.

Note: Overall responsibility for reporting MEPRS data (i.e DMHRSi, expenses and workload) lies with the Squadron Commanders or equivalent, as designated by the Group/Wing Commander.

2.11. All personnel working at the MTF during the timecard period will accurately report their hours in DMHRSi NLT COB the first duty day after timecard period ends (Monday). Actual hours will be reported, for work performed inside and outside the MTF in support of the mission. There is no hour reporting constraint (168 a month or 80 hours per pay period). The only exception would be Civil Service personnel refer to para 7.2.2. Full explanation of the business rules regarding the reporting of DMHRSi time may be found in the DMHRSi EOM Guidance and DoD 6010.13-M. (T-0)

2.12. Budget Analyst (BA) will be the POC and assist the MPM in resolving any financial data inconsistencies/problems; and will advise on all errors and required corrections to the financial data. They will also coordinate on the financial reconciliation process. This is Self-Inspection Checklist Item 23. (T-0)

2.13. The Data Quality Manager (DQM) is appointed and will be familiar with responsibilities outlined in DoD 6040. 40 and DoD 6010.13-M: and is crucial in aiding the resolution of any data inconsistencies/problems within the MTF.

2.13.1. Workload discrepancies identified by the MPM will be referred back to the work center POC for resolution, with notification made to the DQM. (T-0)
2.14. The Group Practice Manager (GPM) will be familiar with responsibilities outlined in DoD 6010. 13-M; and is crucial in aiding with the resolution of any clinical data inconsistencies within the MTF.

2.14.1. The GPM will review all provider profiles annually, and as needed. This is Self-Inspection Checklist Item 21.

2.14.2. Workload discrepancies identified by the MPM will be referred back to the work center POC for resolution, with notification made to the GPM.
Chapter 3

ISSUE PROCESSING

3.1. Submit any issues to AFMOA/SGAR for resolution, as outlined in DoD 6010. All unresolved issues, along with comments and proposed resolution will be forwarded to AFMSA/SGYR ATTN AF MEPRS Program Manager, AFMSA/SGYR.

3.1.1. AFMSA/SGYR logs and reviews all guidance issues for duplication, conformity to MEPRS principles, clarity, and completeness. The AF MEPRS Program Manager will coordinate with the appropriate Air Force Consultant(s). Feedback will be provided to AFMOA MEPRS Manager for distribution to the MTFs.
Chapter 4

DATA SUBMISSION

4.1. Data submission suspense. Each Air Force Fixed MTF is required to submit MEPRS data monthly, 45 calendar days after the end of the data month. Medical facilities that are subordinate to a reporting medical facility do not submit separate reports since their workload and expense statistics are combined into the parent facility's report; however a child DMIS ID may be used (when authorized) to further granulate data. This is Self-Inspection Checklist Item 18. (T-0)

4.1.1. Each reporting facility forwards the monthly MEPRS files to the EASIVi Repository after validation; reconciliation and allocation have been completed, no later than 45 calendar days after the close of the reporting month. If later than 45 calendar days, annotate the reason for delinquency on the Data Quality Statement. This is Self-Inspection Checklist Item 31. (T-0)

4.1.2. Reports required for monthly backup. As a minimum, the following monthly reports must be saved electronically using the following naming conventions:

Note: Monthly Data should be saved and retained for five years. Ensure if corrections are made the newly corrected, dated and signed files are saved.


4.1.2.3. Cost Table Report – Cost Tbl Rpt MoYr_DMIS ID (Standard Reports folder.)

4.1.2.4. Personnel Accepted Report – Pers Det MoYr_DMIS ID (Standard Reports folder).

4.1.2.5. Pure Financial Report – Pure Fin MoYr_DMIS ID (System Interfaces folder/AF Navy subfolder).

4.1.2.6. Financial Audit Report – Fin Audit MoYr_DMIS ID (Data Audit folder/AF subfolder).

4.1.3. Refer to the current FY’s MEPRS Processing Timeline Matrix for specific completion timelines.

4.2. Limited Scope Medical Treatment Facilities (LSMTFs) or Acute Care Units (ACUs) are not required to process MEPRS data. These facilities perform a predominately Family Medicine mission to a generally AD Population and there is no need for further granulation of these units data. There are also has several Aid Stations that are minimally staffed to perform immediate medical care and are not considered for MEPRS reporting. ACUs are Line funded. Any provider that spends time working in a MEPRS Reporting MTF should report time as borrowed staff.

4.2.1. Pope – DMIS ID 0355 – 43rd Medical Flight

4.2.2. McChord – DMIS ID 0395 – 62nd Medical Flight
4.2.3. Lajes - DMIS ID 0629 – 65th Medical Flight (1 Oct 2014)
4.2.4. Croughton – DMIS ID 0653 – 422nd ABS Medical Flight
4.2.5. Upwood – DMIS ID 0814 – 423rd ABS Medical Flight
4.2.6. Gielenkirchen – DMIS ID 0799 – 470th Medical Flight
4.2.7. Fairford – DMIS ID 0815 – 7040th ABG Medical Flight
4.2.8. Izmir – DMIS ID 0825 – 425th ABS Medical Flight
4.2.9. USAFR – DMIS ID 5591 – Air Force Reserve Medical Units
4.2.10. SOAWC – DMIS ID 5592 – Special Ops Air Warfare Center – ACU
4.2.11. 17th ASOS – DMIS ID 5593 – 17th Air Support Ops Squadron – ACU
4.2.12. 724th STS – DMIS ID 5594 – 724th Special Tactical Squadron – ACU
4.2.12.1 1st SOW – DMIS ID 5595 – 1st Special Operations Wing – ACU
4.2.13. 353rd SOG – DMIS ID 5596 – 353rd Special Operations Group – ACU
4.2.15. 27th SOW – DMIS ID 5598 – 27th Special Operations Wing – ACU
4.2.16. 22nd STS – DMIS ID 5599 – 22nd Special Tactical Squadron – ACU
4.2.17. Arnold – DMIS ID 7079 – Arnold Air Station
4.2.18. Menwith Hill – DMIS ID 7434 – Menwith Hill Medical Center

Note: Air Force does not report data using Dental DMIS IDs.

4.2.19. LSMTFs and ACUs are still to process their data within AHLTA/CHCS, and submit DOWR/CAPER information with the existing reporting timelines. This information will be used for historical information and support business planning.

4.2.20. LSMTFs and ACUs will not be expected to perform a monthly Data Quality Statement; they will receive DQ evaluation and provider training, from the host MTF.
Chapter 5

MEPRS CODING

5.1. The Basic Coding Approach: All MEPRS activities are categorized into one of the following seven functional categories as shown in Table 5.1.

Table 5.1. MEPRS Functional Categories.

<table>
<thead>
<tr>
<th>Functional Category</th>
<th>Summary Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>A - Inpatient Care</td>
<td>AA - Medical Care</td>
</tr>
<tr>
<td></td>
<td>AB - Surgical Care</td>
</tr>
<tr>
<td></td>
<td>AC - Obstetrical and Gynecological Care</td>
</tr>
<tr>
<td></td>
<td>AD - Pediatric Care</td>
</tr>
<tr>
<td></td>
<td>AE - Orthopedic Care</td>
</tr>
<tr>
<td></td>
<td>AF - Psychiatric Care</td>
</tr>
<tr>
<td></td>
<td>AG - Family Practice Care</td>
</tr>
<tr>
<td>B - Ambulatory Care</td>
<td>BA - Medical Care</td>
</tr>
<tr>
<td></td>
<td>BB - Surgical Care</td>
</tr>
<tr>
<td></td>
<td>BC - Obstetrical &amp; Gynecological Care</td>
</tr>
<tr>
<td></td>
<td>BD - Pediatric Care</td>
</tr>
<tr>
<td></td>
<td>BE - Orthopedic Care</td>
</tr>
<tr>
<td></td>
<td>BF - Psychiatric and/or Mental Health Care</td>
</tr>
<tr>
<td></td>
<td>BG - Family Practice Care</td>
</tr>
<tr>
<td></td>
<td>BH – Primary Care</td>
</tr>
<tr>
<td></td>
<td>BI – Emergency Medicine</td>
</tr>
<tr>
<td></td>
<td>BJ – Flight Medicine</td>
</tr>
<tr>
<td></td>
<td>BL – Physical Therapy</td>
</tr>
</tbody>
</table>

Note: Not a complete list, refer to DoD 6010.13-M

5.1.1. Summary Accounts: A summary account is a two-letter designator that groups major functions within functional categories. As shown in Table 5.2.

Table 5.2. MEPRS Summary Accounts.

<table>
<thead>
<tr>
<th>Functional Category</th>
<th>Summary Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>A - Inpatient Care</td>
<td>AD - Pediatric Care</td>
</tr>
<tr>
<td></td>
<td>ADAA – Pediatrics</td>
</tr>
<tr>
<td>B - Ambulatory Care</td>
<td>BA - Medical Care</td>
</tr>
<tr>
<td></td>
<td>BB - Surgical Care</td>
</tr>
<tr>
<td></td>
<td>BC - Obstetrical &amp; Gynecological Care</td>
</tr>
<tr>
<td></td>
<td>BD - Pediatric Care</td>
</tr>
<tr>
<td></td>
<td>BE - Orthopedic Care</td>
</tr>
<tr>
<td></td>
<td>BF - Psychiatric and/or Mental Health Care</td>
</tr>
<tr>
<td></td>
<td>BG - Family Practice Care</td>
</tr>
<tr>
<td></td>
<td>BH – Primary Care</td>
</tr>
<tr>
<td></td>
<td>BI – Emergency Medicine</td>
</tr>
<tr>
<td></td>
<td>BJ – Flight Medicine</td>
</tr>
<tr>
<td></td>
<td>BL – Physical Therapy</td>
</tr>
</tbody>
</table>

5.1.2. Sub-Accounts. A third and fourth letter identify a sub-account that describes the actual activities of an MTF as examples reflect in table 5.3. A complete list of AF Approved Functional Cost Codes (FCCs) is provided by the Air Force MEPRS Program Manager annually.

Table 5.3. MEPRS Sub Accounts.

<table>
<thead>
<tr>
<th>Functional Category</th>
<th>Summary Account</th>
<th>Sub Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>A - Inpatient Care</td>
<td>AD - Pediatric Care</td>
<td>ADAA – Pediatrics</td>
</tr>
</tbody>
</table>
5.2. Work Center Definition. A work center is a discrete functional or organizational subdivision within an MTF authorized to accumulate and measure expense, workload, manpower utilization and performance.

5.2.1. The following criteria listed below must be met before establishing a work center and assigning an FCC; it must:

5.2.1.1. Have compatibility with the Unit Manning Document (UMD) or other allocated manpower (e.g. contractors).
5.2.1.2. Have identifiable expenses (Supplies/Equipment/Contracts/Salaries).
5.2.1.3. Have allocated physical space.
5.2.1.4. Have valid production (count/code) as defined by DoD 6010.13-M or an AF special interest program (Attach 2).
5.2.1.5. Have a uniqueness of service provided or expenses incurred when compared to other established work centers.
5.2.1.6. Have Executive Leadership coordination.

Note: FCCs not listed on the AF Master ASD or Program Element Mapping (PEMAP) will not be entered into CHCS/AHLTA or other systems without approval from AFMOA.

5.3. Establishing Functional Cost Codes (FCC) for a new work center shall be made in coordination with basic coding guidance. FCCs and related data, as defined by the Account Subset Definition (ASD) form the basis for cost allocation.

5.3.1. First determine if the new work center meets the above requirements as stated in par 5.2.

5.3.2. MTF must receive approval from AFMOA/SGAR before new FCCs are implemented. This is Self-Inspection Checklist Item 3.

5.4. Account Subset Definition (ASD) identifies the FCCs used by an MTF, the activation date, deactivation date, if applicable, and the Responsibility Center/Cost Center (RC/CC). It specifies the Assignment Sequence Number (ASN), which is used in the allocation/purification process. It also defines the Data Sets used in the allocation and purification process (refer to Table 8.1. and 8.2. in this instruction for more information on Data Set usage). AFMOA/SGAR will validate all facilities’ ASD annually.

5.4.1. The ASNs are published on the Master MEPRS Table that is released annually from the Air Force MEPRS Program Manager.

5.4.2. During budget preparation for the new Fiscal Year (FY), the MTF Budget Analyst (BA), Resource Advisors (RA) manpower manager, MPM, and logistics office must coordinate work center RC/CCs and FCCs or FACs. The addition or deletion of work centers or FCCs must be coordinated with each affected program to ensure proper allocation of data.
This will occur following the close out of the 3rd quarter. This is Self-Inspection Checklist Item 15. (T-0)

5.4.3. Following in-house coordination, the MTF must submit the coordinated ASD to AFMOA/SGAR for review and approval. (T-0)

**Note:** Brief all changes during Data Quality, Executive Committee and Cost Center Manager (CCM) meetings to ensure widest possible dissemination.

5.4.3.1. Coordinate with systems administrators to ensure the accuracy of tables located in Composite Health Care System (CHCS), Armed Forces Health Longitudinal Technology Application (AHLTA) and Defense Medical Logistics Standard Support (DMLSS) or any other system(s) that interface with or provide data to EASIVi. This is Self-Inspection Checklist Items 18, 19, and 20. (T-0)

5.4.4. DoD 6010.13-M is the master document used to ensure FCCs reflects the correct workload capture and expense assignment. RC/CC codes and Functional Account Codes (FACs) are matched to Functional Cost Codes (FCCs) as outlined in the PEMAP spreadsheet. All FCCs and RC/CCs used by the budget analyst, manpower manager, resource advisors, and logistics office should reflect the same information. The PEMAP is published annually by AFMSA/SGYR, validates appropriate MEPRS Code RC/CC Program Element Code (PEC) FAC usage; there may be multiple RC/CCs assigned to the same FCC, so that a more accurate tracking of financial information may be performed. (T-0)

**Note:** The PEMAP is frequently updated throughout the year so always ensure you are working with the most current version. Refer to Knowledge Exchange - MEPRS Documents page for most current version.

5.5. **Cost Pool "X" Codes** are used in situations where time and expenses are difficult to assign directly and are used by more than one FCC because the work centers share physical space, personnel, and/or supply items. Cost pools can be set up for any clinical function. Care should be taken to ensure that all members of the cost pool benefit from all elements of the cost pool. For example, establish a cost pool when multiple Family Health Clinic teams share supplies/personnel and it is difficult to determine each clinic’s use. Identify cost pools with an "X" in the third position of the FCC. Example - The code for Family Practice Teams B (BGAB) and H (BGAH) cost pool would be "BGXA." Assign all shared personnel and expenses (i.e. supply costs, square footage, linen, etc.) to the cost pool code. Those accumulated costs are then distributed from the cost pool to the specialties within the cost pool based on workload for each specialty during the purification process.

**Note:** Only shared administrative staff should report time to a cost pool; clinical support should charge directly to the different teams as they are performing work in the specific clinical areas.

**Note:** Clinicians are never assigned to, or able to charge time against Cost Pool codes.

5.5.1. Items purchased for a specific work center should be directly expensed to that work center. Any personnel salary, supply expense, contract cost or manning assist expense that can be readily identified to the pure code (example - BGAB or BGAH) should be reported to the specific work center. Cost pools can be used for any clinical area.
5.6. **Unique Air Force Account Codes:** Attachment 2 contains unique Air Force account codes.

5.6.1. Air Force MTFs will not use the following FCCs listed in DoD 6010.13-M: AAD, AAE, AAG, AAI, AAM, AAN, AAO, AAQ, ABH, AEC, BAH, BAR, BAT, BBH, BBJ, BEC, BHA, BHB, BKA, DDB, DDC, FAA, FAC, FDB, FDD, FEC, GEB, and GEC.

5.6.2. Third level "Z" codes may only be used with a DHA approved waiver.
Chapter 6

TABLE MAINTENANCE

6.1. Tables used within the EASIVi system ensure personnel, financial and workload data are properly identified and aligned for correct cost allocation. All EASIVi and associated system tables will be reviewed and updated at least annually.

6.2. AFMSA/SGYR will review and update the master tables at least annually but also as needed throughout the year.

6.3. MTFs will keep the tables in EASIVi updated to reflect current year activities. (T-0)

   6.3.1. Account Subset Definition (ASD) Table changes are made prior to each fiscal year following AFMOA/SGAR approval. This is Self-Inspection Checklist Item 3. (T-0)

   6.3.2. The MPM will approve all FCCs (with AFMOA/SGAR approval) in use at the MTF. (T-0)

   6.3.3. No MEPRS Codes will be used in CHCS/AHLTA or any other approved Military Health System (MHS) data system, without the AFMOA/SGAR approval. The CHCS Administrator, in coordination with the MPM, will ensure only approved MEPRS Codes are used in the CHCS Files/Tables. This is Self-Inspection Checklist Items 3, 5, 16, 18, 19, and 20. (T-0)

   6.3.4. The DQ Assurance Team will provide oversight and ensure approved MEPRS Codes are being appropriately used in the CHCS File/Table structure. Non-approved MEPRS Codes will be identified and appropriate corrective action will be coordinated by the DQ Assurance Team.

   6.3.5. The EASIVi Account Subset Definition (ASD) Table will be reconciled with DMHRSi and the CHCS Site Definable MEPRS Table prior to the annual Fiscal Year update. This is Self-Inspection Checklist Items 4, 6 and 14. (T-0)

   6.3.6. The CHCS Administrator and MPM will complete an annual review of users who have access to add, edit or delete MEPRS Codes in CHCS. (T-0)

Note: The CHCS/AHLTA files are built for ease of use, not for acceptance into EASIVi. The source system for correct FCCs is the EASIVi system. The same FCCs must be reflected in CHCS/AHLTA as EASIVi. The CPT and DRG files must also be synchronized to avoid errors when processing the Comprehensive Ambulatory Professional Encounter Record (CAPER) and Standard Inpatient Data Record (SIDR). Ensure the same software versions are used.
Chapter 7
PERSONNEL UTILIZATION AND SALARY EXPENSE DATA

7.1. Time and Salary Reporting. Timely and accurate control of personnel data is essential for the total success of MEPRS; personnel salary represents 60-75% of the total cost of care.

7.1.1. Personnel data generally includes both salary and Full Time Equivalents (FTEs). MEPRS defines 168 hours as 1 (one) FTE. Please Refer to Para 2.11 for the responsibilities of the work center MEPRS POCs.

7.1.2. There are a wide variety of helpful time reporting tools you can refer to for more detailed time reporting requirements, such as the MEPRS Quick Reference Time Matrix, and DoD 6010.13-M Appendix 3.

7.1.3. All personnel working at the MTF during the timecard pay period will accurately report their hours in DMHRSi NLT COB the first duty day after timecard period ends (Monday). Actual hours should be reported, for work performed inside and outside the MTF in support of the mission. There is no hour reporting constraint (168 a month or 80 hours per pay period). The only exception would be Civil Service personnel refer to para 7.2.2. Refer to the DMHRSi EOM Processing Guidelines for more definitive instruction. (T-0)

7.2. All Personnel must submit their timecards NLT COB the first duty day after timecard period ends (Monday). Timecard Approvers must approve or reject timecards NLT COB the third duty day after timecard period ends (Wednesday). All rejected timecards must be corrected, re-submitted and approved NLT COB the fifth duty day after the timecard period ends (Friday). Upon rejection of a timecard, Timecard Approvers must immediately notify the individual that their timecard was rejected along with the reason for the rejection. Actual Hours in support of the mission should be reported in the appropriate Functional Cost Codes (FCCs), and should total to at least the appropriate number of duty hours for that pay period. Hours are used to distribute salary across the functional areas of the MTF, and are crucial in accurately reporting the cost of services provided within the MTF. (T-0)

7.2.1. United States active duty military personnel assigned and borrowed (e.g. manning assistance) to the facility. (T-0)

7.2.2. Federal civilian employee assigned or borrowed to the facility. Hours reported by civil service personnel are reconciled with the Defense Civilian Pay System (DCPS) pay file and will match time reported on their DCPS time card. (T-0)

Note: The one exception would be Providers under the Provider/Dental Pay Plan, only their Non-Available time is reconciled, as they may have requirements to work more than the normal 80 hours per pay period.

7.2.3. Foreign national employees (direct and indirect hire) paid from appropriated funds. (T-0)

Note: Indirect hires are foreign national personnel working within our facilities who are in-place as a result of an agreement between the U.S. and a foreign government.
7.2.4. Military medical program students (e.g. phase II, interns, residents, etc.) working in or assigned to the facility to complete training requirements. (T-0)

7.2.5. Contract personnel working in the facility. Contractors will submit only available hours (FTEs). Salary expenses (Financial Compensation) is reflected in the financial system. (T-0)

   7.2.5.1. If the contract doesn’t require personnel to report the number of work hours, the work center POC will refer to the Quality Assurance Personnel (QAP) to determine the hours worked based on the statement of work and submit the available contract hours.

   7.2.5.2. Do not include day workers in the facility who are covered by a service contract (e.g. Copier Repair, or base CE personnel). These personnel are considered part of the services paid by the contract.

7.2.6. Reserve, Air National Guard and Individual Mobilization Augmentee (IMA) personnel assigned to serve their tour at the facility. Personnel will report in accordance to current DMHRSi business rules. (T-0)

7.2.7. Patient Squadron Personnel: Active duty members assigned to the patient squadron may help within the facility and their time is captured as borrowed personnel. Members of the Patient Squadron will use their appropriate Grade/Rank but will be assigned occupation codes that define the work that they are supporting. (T-0)

7.2.8. Borrowed Personnel: Personnel borrowed from outside the facility (not on the MTF Unit Manning Document (UMD) will report their time and salary to the work centers they are supporting. An example of borrowed personnel would be the Squadron Medical Elements (SMEs) who are assigned to a flying squadron but provide services within the MTF. Track available time to the benefiting work centers for borrowed personnel, and report the remainder of their time to FCGC – Squadron Medical Element (SME) Non-MTF Activity, the total time they report should represent the total amount of time they worked during the reporting month. (T-0)

   7.2.8.1. Time for the entire pay period needs to be accounted for so that salary distribution to clinical services is accurate.

   7.2.8.2. Borrowed personnel will report time, until they are no longer performing recurring duties in the facility.

   7.2.8.3. If borrowed personnel (SMEs) are deployed from their unit, do not report any deployment time for them.

7.2.9. Volunteers only report working hours as there is no salary compensation; included as volunteers are students utilized under an MOU with local colleges or facility programs such as Red Cross, Dental Assistant Program or pharmacy students. (T-0)

7.2.10. All Non-DHP Employees working in Non-DHP programs such as, Family Advocacy (FASF) or Exceptional Family Member Program (FAZN), Domestic Abuse Victim Advocate (DAVA) (FASF) will report their time to the appropriate Code. (T-0)

7.3. Collect time until the member is no longer assigned (military and civilian), or working (borrowed, contract and volunteers, etc.) in the MTF.
Note: Report active duty departing personnel until their Report No Later than Date (RNLTD) or
day before they sign in at their next unit.

7.3.1. For personnel, who are AWOL, continue to collect time for only the first 30 days. If
the individual(s) are gone for longer than 30 days, depart them from the facility.

7.3.2. When personnel process out for a PCS, retirement, or separation, report their time
following their departure from the facility to the RNLT date, final duty day or separation date
to FDGA – PCS/ETS Related Functions.

7.3.2.1. The time they spend attending out-processing appointments will also be charged
to FDGA – PCS/ETS Related Functions.

7.3.3. Personnel attending school, report only the class time under FALA - Continuing
Education (CE). Travel time will be charged to FDGA - PCS/ETS Related Functions.

7.3.4. Personnel attending Professional Military Education (PME) will be captured in GBAA
– Readiness Training. Travel time will be charged to FDGA - PCS/ETS Related Functions.

7.3.5. When personnel are working outside of the MTF the entire month (deployed or TDY)
or on leave it is not appropriate to report more than the total number of regularly scheduled
duty hours in the reporting month. Keep in mind; we are trying to appropriately allocate the
salary to the work produced.

7.3.6. Time will not be captured or reported for civilian employees paid from non-
appropriated funds or direct and indirect hire foreign national employees in an unpaid
absence status time would not be captured for reporting.

7.3.7. Civilians on leave without pay will report their time in DMHRSi under task code
02.04. The timecard will reject in DMHRSi, during reconciliation, if hours are not input to
match the civilian pay timecard.

7.4. The MPM will be responsible for importing the DMHRSi DoD EASIVi Create File
into EASIVi. Refer to the DMHRSi End of Month Manual (EOM) for step by step instructions.
(T-0)

7.5. The three types of FTE data are assigned, available, and non-available. DoD 6010.13-
M, Chapter 3, defines the use of available and non-available time. Refer to Appendix 3 for a list
of standard reporting scenarios.

7.5.1. Available FTEs are based on hours worked. Available FTEs are calculated by
dividing available hours in a given work center by 168 (1 FTE equals 168 hours). Actual
hours should be reported to support all mission operations. Civilians are the only personnel
category that has a capped hour requirement, the time reported on their civilian timecard.

7.5.1.1. Military personnel report all hours spent in support of mission requirements,
including work performed at home. Civilian personnel will report approved
overtime/compensatory time.

7.5.2. Assigned FTEs are based on the actual number of days during each month an
individual is assigned to the MTF. Assigned FTEs are not based on hours, but the percent of
time actually assigned to a work center any given month.
7.5.3. Non-available FTEs include leave, sick (quarters/hospital admission/medical appointments), and military other (AD only).

7.5.3.1. Leave is charged in accordance with normal duty hours (schedule). If personnel work a 12 hour schedule you would charge leave in 12 hour increments, but not charge leave on their normal off days.

7.6. Military salaries are standardized rates based on composites of all pay, allowances, and entitlements updated annually (IAW AFI 65-503, U. S. Air Force Cost and Planning Factors). Grade/Salary tables for Military will be provided to DMHRSi annually from the Air Force MEPRS Program Manager as soon as they are available.

7.7. Civilian salaries are provided to DMHRSi by an interface with DCPS, local personnel use the Automated Time Attendance and Production System (ATAAPS) to actually report their payable work hours.

7.8. Available FTEs are applied against the Grade/Salary Table to calculate personnel costs. Salary expense for non-available time is charged to the assigned work center.

7.9. The Grade/Salary Table reflects the monthly cost per FTE and is the maximum amount that will be distributed. For example, if monthly salary is $2,500.00 and the hours reported are 160 available and 32 non-available, then the total FTEs would be 1.14. The amount distributed would still be $2,500.00.

7.10. Methods of Data Collection

7.10.1. Defense Medical Human Resource System internet (DMHRSi) is the directed methodology of personnel time capture.

7.10.2. The Military Health System (MHS), in fulfilling a Deputy Secretary of Defense mandate to simplify and centralize medical personnel asset visibility, has chosen DMHRSi, a Commercial-Off-The-Shelf (COTS) integrated Human Resource Management System. DMHRSi is intended to provide the MHS with an Automated Information System (AIS) that integrates HR data from multiple information sources and allows real-time access to essential manpower, HR, Labor Cost Assignment (LCA), Education and Training (E&T), and readiness information across the MHS.

7.10.3. The Deputy Surgeon General (DSG) has mandated the use of the LCA, HR, and Manpower modules. The single most important factor for the Air Force is that DMHRSi will serve as a source system for manpower, human resources and readiness. The primary need for DMHRSi within the AFMS is to support functional processes for LCA, the critical labor source feed for the Medical Expense and Performance Reporting System (MEPRS), and the need for visibility of management data on all personnel working for the AFMS and subsequently the entire DoD.

7.10.4. The HR asset for the MTFs consists of the following personnel types: active duty, guard, reserve, civilian or government service, contractor, local national and volunteer. HR assets can either be assigned to an MTF or borrowed from another military facility in order to fulfill specific functions within the MTF.

7.10.5. Personnel data for active duty, guard, and reserve personnel is fed from the Military Personnel Data System (MILPDS) and data for government civilian service personnel is fed from the Defense Civilian Personnel Data System (DCPDS). Personnel data for contractors,
local nationals and volunteers must be manually entered. HR personnel at each MTF will be responsible for the management of DMHRSi HR records for all person types throughout the employment life cycle, as outline in the DMHRSi Concept of Operations (CONOPS). A list of the HR roles and responsibilities are listed in DMHRSi CONOPS Usage Policies.

7.10.6. The responsibility of HR personnel at each site is to effectively manage and update the DMHRSi HR records so that Senior Leadership has full visibility of all person-types working in a particular site and also visibility of all person-types enterprise wide. It is critical the site HR personnel perform record maintenance tasks and maintain the 18 essential data elements, as outlined in the DMHRSi CONOPS.

7.10.7. The LCA, HR, and Manpower integrated management of DMHRSi is critical. Each MTF will form a Functional Integrated Working Group (FIWG) consisting of primary points of contact for each module to provide oversight to the DMHRSi processes, ensure it is used to its fullest potential, foster communication between functional areas, and recommend process changes to the MTF/CC.
Chapter 8
DATA SETS (WORKLOAD)

8.1. The Data Sets (Workload) section describes the workload data requirements of MEPRS and includes an explanation of the applicability of existing Air Force data collection procedures to the MEPRS data requirements.

8.2. Workload is captured in a data set that is used for allocation to quantify the amount of work accomplished by a work center. DoD 6010.13-M defines specific allocation factors for the various workload data. Air Force guidance and procedures will further define specific workload reporting requirements. Workload is associated with both patient care and non-patient care activities. Coordination with work center personnel, Data Quality Assurance Team, the CHCS/AHLTA Data Base Administrator(s), and the MPM is crucial in establishing local workload validation procedures. The Group Practice Manager must be an integral part of all workload-capturing clinical processes. This is Self-Inspection Checklist Item 17.

8.2.1. All workload factors will be covered in this document. Not all work centers documented on the master Accounts Subset Definition (ASD) File will be used by all facilities. The Unit Manpower Documents (UMD) will be the starting point to determine which codes should be reported in the system. For further guidance contact AFMOA/SGAR.

8.2.2. Coordinate with appropriate work center personnel to determine the most efficient and effective means of acquiring the manually collected data. Implement additional procedures required by MEPRS reporting requirements as necessary. (T-0)

8.2.3. If a work center closes, contact AFMOA/SGAR for appropriate actions.

8.3. Data Sets identify and collect different types of workload factors, expenses, FTEs, weighted factors, and other information such as square footage, in a prescribed format. Data Sets summarize workload data by FCC and show which work centers benefit from a particular service.

8.3.1. Table 8.1. is the automated and manually generated Data Set Standard Table and reflects how data is input into EASIVi. S indicates system-generated data and M indicates data that is manually tracked and input to EASIVi. For system-generated data, the Workload Assignment Module (WAM) must be used. Automated workload captured in CHCS will be transmitted via the WAM for use in the EASIVi System. The CHCS data is summarized for entry into EASIVi using generated reports in WAM, and must be validated prior to being transmitted to EASIVi.

<table>
<thead>
<tr>
<th>DATA SET ID</th>
<th>DATA SET DESCRIPTION</th>
<th>INPUT METHOD INDICATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>OBD</td>
<td>OCCUPIED BED DAYS (TO INCLUDE BASSINET DAYS)</td>
<td>S - CHCS</td>
</tr>
<tr>
<td>ADM</td>
<td>ADMISSIONS</td>
<td>S - CHCS</td>
</tr>
<tr>
<td>DISP</td>
<td>DISPOSITIONS</td>
<td>S - CHCS</td>
</tr>
<tr>
<td>OUTPT VISITS</td>
<td>OUTPATIENT VISITS</td>
<td>S - CHCS</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------</td>
<td>----------</td>
</tr>
<tr>
<td>TOTAL VISITS</td>
<td>TOTAL VISITS (IN&amp;OUT TO INCLUDE APVS &amp; OBSERVATIONS)</td>
<td>S - CHCS</td>
</tr>
<tr>
<td>DENTAL WTD PROC</td>
<td>DENTAL WEIGHTED PROCEDURES</td>
<td>M - Manual</td>
</tr>
<tr>
<td>SQ FT</td>
<td>SQUARE FOOTAGE</td>
<td>M - Manual</td>
</tr>
<tr>
<td>EIA MEALS</td>
<td>MEALS SERVED</td>
<td>M - Manual</td>
</tr>
<tr>
<td>EIB MEALS</td>
<td>MEALS SERVED</td>
<td>M - Manual</td>
</tr>
<tr>
<td>WTD NUTR PROCS</td>
<td>WEIGHTED NUTRITIONAL PROCEDURES</td>
<td>M - Manual</td>
</tr>
<tr>
<td>CLAIMS BILLED</td>
<td>TOTAL CLAIMS BILLED BY WORK CENTER</td>
<td>S – CHCS - Inpt M – Manual - all else</td>
</tr>
<tr>
<td>F ACCOUNTS - RAW PROC</td>
<td>SPECIAL PROGRAM ACCOUNTS - RAW PROCEDURES</td>
<td>M - Manual</td>
</tr>
<tr>
<td>F ACCOUNTS - WTD PROC</td>
<td>SPECIAL PROGRAM ACCOUNTS - WTD PROCEDURES</td>
<td>M - Manual</td>
</tr>
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<td>G ACCOUNTS</td>
<td>MEDICAL READINESS ACCOUNTS</td>
<td>M - Manual</td>
</tr>
<tr>
<td>SQ FT CLEANED</td>
<td>SQUARE FOOTAGE CLEANED</td>
<td>M - Manual</td>
</tr>
<tr>
<td>AMB WTD PROC</td>
<td>AMBULATORY WEIGHTED PROCEDURES</td>
<td>M - Manual</td>
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<td>DAA*/####</td>
<td>PHARMACY WEIGHTED PROCEDURES</td>
<td>S - CHCS</td>
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<td>DBA*/DBD*/DBE*/####</td>
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<td>S - CHCS</td>
</tr>
<tr>
<td>DBB*/####</td>
<td>LABORATORY WEIGHTED PROCEDURES</td>
<td>M - Manual</td>
</tr>
<tr>
<td>DCA*/DIA*/####</td>
<td>RADIOLOGY/NUCLEAR MEDICINE WEIGHTED PROCEDURES</td>
<td>S - CHCS</td>
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<td>DDA*/####</td>
<td>EKG WEIGHTED PROCEDURES</td>
<td>M - Manual</td>
</tr>
<tr>
<td>DDE*/####</td>
<td>CARDIAC CATHERIZATION WEIGHTED PROCEDURES</td>
<td>M - Manual</td>
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<td>DEA*/####</td>
<td>CENTERAL STERILE SUPPLY HOURS OF SERVICE</td>
<td>M - Manual</td>
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<tr>
<td>DFA*/DFB*/DFC*/####</td>
<td>ANESTHESIOLOGY/ SURGICAL SUITE/ POST ANESTHESIOLOGY MINUTES OF SERVICE</td>
<td>M - Manual</td>
</tr>
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<td>AMBULATORY PROCEDURE UNIT MINUTES OF SERVICE</td>
<td>S – CHCS</td>
</tr>
<tr>
<td>DGB*/DGD*/####</td>
<td>DIALYSIS MINUTES OF SERVICE</td>
<td>M - Manual</td>
</tr>
<tr>
<td>DGE*/####</td>
<td>AMBULATORY NURSING SERVICES MINUTES OF SERVICE</td>
<td>M - Manual</td>
</tr>
<tr>
<td>DHA*/DDD*/####</td>
<td>RESPIRATORY/PULMONARY WEIGHTED PROCEDURES</td>
<td>M - Manual</td>
</tr>
<tr>
<td>DJ**/####</td>
<td>INTENSIVE CARE UNIT HOURS OF SERVICE</td>
<td>M - Manual</td>
</tr>
<tr>
<td>EDG*/####</td>
<td>TRANSPORTATION MILES DRIVEN</td>
<td>M-Manual</td>
</tr>
<tr>
<td>EEA*/####</td>
<td>MEDICAL LOGISTICS $ VALUE OF SUPPLIES/EQUIP ISSUED</td>
<td>M-Manual</td>
</tr>
<tr>
<td>EGA*.####</td>
<td>BIOMEDICAL EQUIPMENT REPAIR HOURS OF SERVICE</td>
<td>M-Manual</td>
</tr>
<tr>
<td>EHA*/####</td>
<td>POUNDS OF LAUNDRY</td>
<td>M-Manual</td>
</tr>
</tbody>
</table>
Note:* Identifies valid MEPRS Code, #### Identifies appropriate DMIS ID for reporting facility

8.4. Data Sets are used for:

8.4.1. Allocation is defined as cost assignment of intermediate operating expense accounts (D - Ancillary & E - Support Accounts).

8.4.2. Purification is defined as cost assignment of cost pool accounts.

8.4.3. Refer to Table 8.2. Data Set Business Rules and other guidance supplied by AFMSA/SGYR to ensure accurate reporting. Coordinate with appropriate work center personnel to determine the most efficient and effective means of acquiring the manually collected data. Implement additional procedures required by MEPRS reporting requirements as necessary.

8.4.4. Table 8.2. Represents all Data Sets used in EASIVi. It also identifies the workload factor indicator and the FCCs allowed/not allowed on the Data Sets and identify data elements that can be edited. Not all codes are used by all MTFs.

Table 8.2. Data Set Business Rules.

<table>
<thead>
<tr>
<th>Data Set Business Rule Description</th>
<th>Data Set Indicator</th>
<th>FCC Include</th>
<th>FCC Exclude</th>
<th>Editable Indicator</th>
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<td>#01 OBD, DISP, ADM</td>
<td>RAW</td>
<td>A%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#02 INPATIENT COST POOLS</td>
<td>RAW, WTD</td>
<td>A%, B%, C%, FC%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#05 VISITS</td>
<td>RAW</td>
<td>B%, FBN%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#06 DENTAL</td>
<td>WTD</td>
<td>C%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#07 WTD PROC WITH COST POOLS</td>
<td>RAW, WTD</td>
<td>A%, B%, C%, D%, F%, G%, <em>X</em></td>
<td>E%</td>
<td>Y</td>
</tr>
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<td>G ACCT</td>
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<td>GE%</td>
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Note: ## identifies FY – FY15 would be Br Id 1501 for OBD.

8.5. **Workload accuracy and reconciliation:** Workload accuracy and reconciliation is the responsibility of the performing work center. The MPM in cooperation with appropriate MEPRS work center POCs and work center managers will establish a process to conduct workload validation, including assigning responsibility for validating data accuracy, data correction, and accurate reporting. Significant workload inconsistencies will be corrected at the data source by the work center and EASIVi will be updated accordingly. Consult AFMOA/SGAR for additional guidance. This is Self-Inspection Checklist Items 7 and 22.

8.6. **Work Center Specific Workload Validation:** Workload reconciliation is a monthly requirement to be performed by the MPM. To reconcile, compare the Monthly Statistical Report (MSR) and the Workload Assignment Module (WAM) reports. EASIVi workload should be the same as the data reflected in the WWR. Both data sets represent data as of the point in time when the reports are generated and therefore may be different. Identified anomalies will be reported to the Data Quality Manager and Group Practice Managers. (T-0)

**Note:** If End of Day Processing has not been accomplished, the *End-of-Day Delinquency Report* will print instead of the *Monthly Statistical Report*. The Biometric Data Quality Assurance Service (BDQAS) WWR suspense for **inpatient facilities only** is no later than the 5th duty day after the month has ended, and WAM is usually generated later in the month.

8.6.1. **Inpatient Workload (A Accounts).** Ensure proper FCCs are identified in CHCS Reports to identify the type of care the patient is receiving based on the specialty of the primary provider of care. Ensure inpatient ancillary requests contain the appropriate
requesting inpatient FCC that is used during the inpatient stay while prescriptions issued at the time of discharge is properly assigned to the appropriate outpatient work center. Ensure workload has corresponding FTEs and expenses. (T-0)

**Performance Factors:** Admissions (ADM), Occupied Bed Days (OBD), Dispositions (Disp) and Relative Weighted Products (RWPs)

8.6.2. Outpatient Workload (B Accounts). Capture the workload where the care is provided (example: Provider assigned to Internal Medicine and sees a patient in Family Practice, the visit will fall under the Family Practice FCC). If the provider sees a patient in other than their normally assigned clinic, both workload (encounter), ancillary services (Lab, Rad, Pharmacy etc.) and time (DMHRS) will be reported in the clinic where resources were consumed. Refer to the AFMS Workload Guidelines for specific workload reporting guidance. All workload must have corresponding FTEs and expenses. (T-0)

**Performance Factors:** Total Visits, Outpatient Visits and Relative Value Units (RVUs).

8.6.3. Dental Workload (C Accounts). The MPM will receive the Monthly Dental Weighted Values (DWVs) and the Composite Time Values (CTVs) from the Base Dental Service Report (BDSR). The source data will be MEPRS DWV and MEPRS CTV Values for MEPRS Reporting. Ensure the workload has corresponding FTEs and expenses. (T-0)

**Performance Factors:** Dental Weighted Values (DWVs) and Composite Time Values (CTVs).

**Note:** Dental workload is provided to AFMOA/SGAR from the Command Dental Activity, and should be the same data that is provided via the Base Dental Summary Report.

8.6.4. Ancillary Services (D Accounts). Workload data reported within the Ancillary datasets will be used to allocate ancillary costs back to the requesting work centers. Use the MEPRS Group Report or other applicable ancillary report from CHCS or appropriate system to reconcile data reported in EASIVi ancillary datasets. (T-0)

8.6.4.1. Pharmacy (DA). Ensure requesting work centers are accurately reported by reviewing workload products for invalid codes and coordinate with the CHCS Database Administrator to eliminate these codes in CHCS annually. Ensure the workload has corresponding FTEs and expenses. Use the PHR MEPRS Group Report to validate pharmacy workload reported. (T-0)

**Performance Factors:** Raw-Number of Scripts, Weighted-Weighted Value of Scripts.

**Allocation methodology:** Weighted Value of Scripts.

**Note:** Prescriptions provided to an Inpatient during discharge should be charged to the Ambulatory MEPRS Code, not the Inpatient code (i.e and Internal Medicine patient (AAAA), should have their prescriptions charged to BAA* not AAAA, based on the PCMH Team code of the overseeing provider).

8.6.4.2. Clinical Pathology (DBA), Cytogenetic Laboratory (DBD), and Molecular Genetics Laboratory (DBE). Ensure requesting work centers are accurately reported by reviewing workload products for invalid FCCs and coordinate with the CHCS Database Administrator to eliminate these codes in CHCS. Ensure the workload has corresponding FTEs and expenses. Use the LAB MEPRS Group Report to validate laboratory workload reported in WAM.
Performance Factor: Raw-Number of Procs, Weighted- CPT Value of Test Performed. (T-0)
Allocation methodology: Weighted Value of Tests Performed.

8.6.4.2.1. Anatomical Pathology (DBB): Ensure requesting work centers are accurately reported by reviewing workload products for invalid FCCs and coordinate with the Co-Path Database Administrator to eliminate these codes in the system. Ensure the workload has corresponding FTEs and expenses. (T-0)

Performance Factor: Raw-Number of Procedures, Weighted- CPT Value of Test Performed.
Allocation methodology: Weighted Value of Tests Performed.

8.6.4.3. Diagnostic Radiology (DC) and Nuclear Medicine (DI): Ensure requesting work centers are accurately reported by reviewing workload products for invalid FCCs and coordinate with the CHCS Database Administrator to eliminate these codes in CHCS. Ensure the workload has corresponding FTEs and expenses. Use the RAD MEPRS Group Report to validate radiology workload reported in WAM. (T-0)

Performance Factor: Raw-Number of Procedures, Weighted- CPT Value of Test Performed.
Allocation methodology: Weighted value of Tests Performed.

8.6.4.4. Special Procedure Services (DD) (i.e. electrocardiograms, pulmonary function tests, sleep studies, etc.). MTFs with a separately defined cardio or pulmonary function, or those which have work centers that conduct studies in one place on behalf of other clinics in the MTF or civilian network providers, will establish a non-count clinic with non-count appointment types in CHCS in the appropriate “D” FCC, to capture the workload and generate CAPER encounters for all workload done. The provider responsible for reading these tests will also capture their workload in a non-count clinic with non-count appointment type in the same “D” FCC, and will also generate CAPER records. The provider will capture their time spent reading these tests in the appropriate “D” FCC. All workload is manually entered into EASIVi. The recommendation is to generate as much of the data as possible through CHCS. CHCS data will be the source data system. Any remaining data not included in the CHCS generated data will be provided to the MPM within the prescribed timeframe. (T-0)

Performance Factor: Raw-Number of Tests, Weighted – CPT Value of Test Performed.
Allocation methodology: Weighted Value of Tests Performed.

8.6.4.4.1. Electrocardiography (DDA), Pulmonary Function (DDD), and Inhalation Respiratory Therapy (DHA). Ensure requesting work centers workload is accurately reported. Refer to preceding paragraph for instructions on how to capture this workload. Ensure the workload has corresponding FTEs and expenses. EASIVi requires entry of raw number of cases by CPT Code and will automatically calculate weighted values. (T-0)

Performance Factor: Raw-Number of Cases, Weighted- CPT Value of Test Performed.
Allocation methodology: Weighted Value of Tests Performed.

Note: If a clinic owns an EEG machine, the workload would be captured and coded as part of the episode of care, it would not need to be broken out by the separate DDA Code.

8.6.4.5. Central Sterile Supply (DE). A local method should be developed to determine accurate workload reporting by FCC hours of service. These hours should be inclusive of
preparation, cleansing, sterilization and distribution etc., see DoD 6010.13-M for guidance. Ensure the workload has corresponding FTEs and expenses. Coordination with work center personnel will provide appropriate time for reporting purposes.

**Performance Factor:** Weighted-Hours of Service.

**Allocation methodology:** Hours of Service.

**Note:** Several smaller facilities have incorporated the CSS service with the Dental CSS operation, in this instance, all of this workload should be tracked as CSS work, unless dental is the only benefiting work center. Contact AFMOA/SGAR for further guidance.

8.6.4.6. Anesthesia (DFA), Surgical Suite (DFB), Post Anesthesia Care Unit (DFC), Ambulatory Procedure Unit (APU) (DGA), and Ambulatory Nursing Services (DGE). Ensure proper workload reporting is occurring in the MTF either electronically or manually. Use the methodology as described in DoD 6010.13-M. Coordinate with surgery department for collection of data. Ensure the workload has corresponding FTEs and expenses. (T-0)

**Performance Factor:** Raw-Cases, Weighted-Minutes of Service.

**Allocation methodology:** Minutes of Service.

**Note:** There is a relationship between Anesthesiology, Surgical Suite, and Recovery room, but there is no expectation that all 3 areas will be used for all episodes of care.

8.6.4.7. Hemodialysis (DGB) and Peritoneal Dialysis (DGD). Ensure proper workload reporting is occurring either through CHCS or manually. Validation will include the review of the methodology (tracking process) used to calculate these figures. The methodology will include times, numbers, and types of personnel to ensure accuracy. Ensure the workload has corresponding FTEs and expenses. (T-0)

**Performance Factor:** Raw-Cases, Weighted - Minutes of Service.

**Allocation methodology:** Minutes of Service.

8.6.4.8. Intensive Care Units (DJ). Ensure proper workload reporting is occurring either through CHCS or manually. Validation should include the review of the methodology used to calculate these figures. The methodology will include times, numbers, and types of personnel to ensure accuracy. Ensure the workload has corresponding FTEs and expenses. (T-0)

**Performance Factor:** Raw-Cases, Weighted - Hours of Service.

**Allocation methodology:** Hours of Service.

8.6.5. Support Services (E Accounts). Workload data reported within the support datasets will be used to allocate support costs back to the requesting work centers.

**Note:** Refer to Attachment 2 for Support Services FCCs using FTEs as an allocation methodology.

8.6.5.1. Third Party Collection Program (EBH). Ensure claims billed reflect the correct FCC for the specialty being billed. Also, ensure only appropriate FTEs are assigned to and reporting time to this work center. Personnel asking patients for other health insurance information in the clinics and ancillary services should not be reporting time in
EBHA. The only exception would be if someone were assigned to the area for TPC support. Ensure workload has corresponding FTEs and expenses. Validation will include verification of the provider’s FCC. (T-0)

**Allocation methodology:** Claims billed (submitted).

8.6.5.2. Plant Management (EDA), Operation of Utilities (EDB), Maintenance of Real Property (EDC), Minor Construction (Modernization)(EDD), Other Engineering Support (EDE), Lease of Real Property (EDF), Fire Protection (EDH), and Police Protection (EDI). These accounts support the infrastructure of the facility. Ensure the listed work centers have corresponding FTEs and expenses as appropriate. Only Plant Management would capture Time and FTEs, the remaining codes in this section would be for financial transactions only. (T-0)

**Allocation methodology:** Square Footage.

8.6.5.2.1. Square Footage. All square footage of medical buildings must be reported by FCC at the start of each fiscal year and updated monthly as changes occur. Square footage and square footage cleaned is obtained from the Facility Management Officer using a report from Defense Medical Logistics Standard Support (DMLSS).

**Note:** Unused and facility common square footage would be reported against the plant management FCC – EDAA/**5741 – Real Property Management.

8.6.5.3. Transportation (EDG). The reporting of vehicle mileage is dependent on MTF-unique circumstances. Report all MTF vehicle mileage by FCC. When a work center has its own fuel card, the requirement for reporting mileage is unnecessary, as the cost is already being allocated against the using work center. If the fuel cards are shared or the MTF has GSA leased vehicles, then it is necessary to break out each user to make sure that expenses are allocated to the using work centers. Contact the Vehicle Control Officer/NCO for transportation issues. Under other circumstances, refer to AFMOA/SGAR for clarification. Ensure EDG - Transportation has corresponding FTEs and expenses as appropriate.

**Allocation methodology:** Miles driven.

8.6.5.4. Medical Materiel (EE). Report the Month Net Dollar Value of Supplies/Equipment issued (6XXXX, excluding 612, 615, 64x, 67x, 68x, 69x, also exclude Program Element Code (PEC) 87701/87901) by FCC. The cost of operating Medical Materiel is based on the Element of Expense Investment Codes (EEICs) used by the various work centers. A ratio of 6XXXX supplies used will be used to allocate the cost of Medical Logistics. This information is found in EASIVi under Standard Report section, Expense Accepted by RC/CC Report. Ensure EEA - Medical Logistics has corresponding FTEs and expenses as appropriate. This is Self-Inspection Checklist Items 25 and 26. (T-0)

**Allocation methodology:** Dollar value of supplies and equipment issued.

8.6.5.5. Housekeeping (EF). Ensure EFA - Housekeeping has corresponding FTEs and expenses as appropriate. (T-0)

**Allocation methodology:** Square footage cleaned.
8.6.5.5.1. Square Footage cleaned by FCC cannot exceed square footage by FCC, but will be most likely the same for clinical areas. For example, mechanical rooms are not cleaned under the housekeeping contract but are included in your square footage. Square footage cleaned is obtained from the Facility Management Officer using a report from Defense Medical Logistics Standard Support (DMLSS).

8.6.5.6. Biomedical Equipment Repair (EG). Report Hours of Service by the requesting FCCs for Biomedical Equipment Repair Technician (BMET) repairs performed. Ensure the workload reported by FCC and RC/CC matches the current PEMAP. If this work center is a regional Medical Equipment Repair Center (MERC), ensure hours spent in support of outside activities are reported under the appropriate “FC” FCC. Ensure EGA - Biomedical Equipment Repair has corresponding FTEs and expenses as appropriate. The Defense Medical Logistics Standard Support (DMLSS) MEPRS is the source document. (T-0)

Allocation methodology: Hours of service.

8.6.5.7. Linen and Laundry (EH). Report clean, dry pounds of laundry issued to each requesting FCC. Beginning each fiscal year, validate the weight of each clean item on the master list by the Medical Materiel Flight. Ensure EHA - Linen/Laundry has corresponding FTEs and expenses as appropriate. Actual weight by work center can be used. (T-0)

Allocation methodology: Pounds of laundry.

Note: If laundry services are part of the housekeeping contact laundry workload would not be reported separately.

8.6.5.8. Food Operations (EI). Report Meals Served by FCC. Food Service personnel will provide the MPM a copy of the Nutrition Management Information System (NMIS) Report. Ensure the workload has corresponding FTEs and expenses. (T-0)

Allocation methodology: Meals served.

8.7. System Generated Information

8.7.1. Inpatient Administration (EJ) will be allocated using the Occupied Bed Day Data Set from WAM. Ensure EJ - Inpatient Care Administration has corresponding FTEs and expenses as appropriate. (T-0)

Allocation methodology: Occupied Bed Days.

8.7.2. Ambulatory Administration (EK). Ambulatory Administration will be allocated using the Total Visit Data Set from WAM. Ensure EK - Ambulatory Administration has corresponding FTEs and expenses as appropriate. (T-0)

Allocation methodology: Total Visits.

8.7.3. TRICARE/Managed Care Administration (EL) will be allocated using the Total Full Time Equivalents (FTEs) in clinical Areas (A, B, C, and D). Ensure EL - TRICARE/Managed Care Administration has corresponding FTEs and expenses as appropriate. (T-0)

Allocation methodology: Full Time Equivalents.
8.8. Other Data required for reporting purposes (F and G Accounts)

8.8.1. F Account Raw Procedures

8.8.1.1. Immunizations (FBI) workload will be the number of immunizations performed in the reporting month. Ensure FBI - Immunization has corresponding FTEs and expenses as appropriate. (T-0)

8.8.1.2. Early Intervention Services (FBJ) workload will be the number of active cases in the reporting month. Ensure FBJ - Early Intervention Services (Ages 0-2) has corresponding FTEs and expenses as appropriate. (T-0)

8.8.1.3. Medically Related Services (FBK) workload will be the number of active cases in the reporting month. Ensure FBK - Medically Related Services (Ages 3-21) has corresponding FTEs and expenses as appropriate. (T-0)

8.8.1.4. Ambulance Services (FEA) workload will be the hours of service that the ambulance is on runs in the reporting month. Ensure FEA - Ambulance Services has corresponding FTEs and expenses as appropriate. (T-0)

8.8.1.5. Aero Medical Staging Facility (FEF) workload will be the number of Patient Movements performed in the ASF during the reporting month. Ensure FEF - Aero Medical Staging Facility has corresponding FTEs and expenses as appropriate. The Air Force has ASF missions at Andrews, Hickam, Kadena, Lackland, Ramstein, and Travis. (T-0)

8.8.2. F Account Weighted Procedures

8.8.2.1. Area Dental Laboratory (FAB) workload will be the Composite Lab Values (CLVs) produced in the Area Dental Laboratory during the reporting month. Ensure FAB - Area Dental Laboratory has corresponding FTEs and expenses as appropriate. The Air Force has 3 Area Dental Labs 86th Medical Group, Ramstein AB Germany; 18th Medical Group, Kadena AB Okinawa Japan; and 21st Medical Group, Peterson AFB Colorado. (T-0)
Chapter 9

FINANCIAL DATA

9.1. Financial Data includes all expenses and obligations associated with operating the MTF and meeting the organization’s mission.

9.2. Expense data is a combination of supply, equipment, contract, depreciation, additional support and special program costs. These expenses make up the direct expenses for MEPRS reporting. Expenses are collected monthly from Defense Financial Accounting System (DFAS) or Defense Enterprise Accounting and Management System (DEAMS) using the Commander’s Resources Integration System (CRIS) financial program as the source file for input into EASIVi. Personnel expenses are generated from Defense Medical Human Resources System – internet (DMHRS i)

9.2.1. Financial Data reported in MEPRS are expenses-paid (AEP) and expenses-unpaid (AEU). Expenses will include all current months’ transactions that affect any current or prior year financial obligation. For information only, Total Obligations (AEP+AEU+UOO) is reported for only the current year.

9.2.2. The MPM is responsible for calculating investment equipment depreciation at the beginning of each fiscal year. Only investment equipment currently in use at the MTF is depreciated. AFMOA/SGAR provides a Depreciation/Free Receipt Spreadsheet to assist in the determination of the monthly depreciation and free receipt calculations. This is Self-Inspection Checklist Item 29. The following procedures apply: (T-0)

9.2.2.1. The depreciation expense will be charged to one or more of the following FCCs based on location of the investment equipment: Inpatient (EAAA), Outpatient (EABA), Dental (EACA), Special Program (EADA), or Medical Readiness (EAEA). (T-0)

9.2.2.2. Request Medical Logistics provide a list of investment equipment currently in use from the Equipment Management Module of the Defense Medical Logistics Standard Support (DMLSS) system: Annual Capital Equipment Depreciation Report, and the DMLSS Active Historical Maintenance Report. These reports will provide necessary information (name, nomenclature, fiscal year in which received, purchase price, and cost center) to enter into the depreciation spreadsheet. (T-0)

9.2.2.3. Do not depreciate equipment in the year of installation, start depreciating equipment the beginning of the next fiscal year. If equipment becomes no longer serviceable or is removed from the facility in the course of the year, make the appropriate updates to the depreciation spreadsheet. (T-0)

9.2.2.4. Investment equipment purchases are identified and separately totaled by Inpatient, Outpatient, Dental, Special Programs, and Medical Readiness purchases. The investment equipment threshold is $100,000 unless changed by AF guidance. (T-0)

9.2.2.5. Apply investment equipment purchases shared by inpatient and outpatient accounts using the applicable ratio in table 9.1. (T-0)
Table 9.1. Distribution Ratios for Investment Equipment (Depreciation).

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<th>Average Daily Patient Load</th>
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<th>Outpatient</th>
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<tr>
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<td>60%</td>
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<tr>
<td>Less than 100</td>
<td>20%</td>
<td>80%</td>
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<tr>
<td>Clinics</td>
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**Note:** If an MTF changes from inpatient to an outpatient facility, the depreciable equipment must be moved in MEPRS to the current outpatient service using the equipment. Any inpatient depreciable equipment transferred to another facility will be deleted from the listing.

9.2.2.6. After the total dollar amount is established for inpatient and outpatient investment equipment purchases, enter it in the depreciation spreadsheet to yield the monthly depreciation expenses. (T-0)

**Note:** Dividing the total investment purchases by 60 months resulting in a five-year depreciation cycle derives the monthly Depreciation Expense

9.3. Other Non-OBL Expenses are also calculated using the Depreciation/Free Receipt Spreadsheet. Base support services, fire protection, and police protection expenses are assigned in accordance with DoD 6010.13-M, Chapter 2, which designates assignment procedures governing the work center account. These expenses are calculated monthly based on personnel salaries and direct expenses from EASIVi using the Expense Accepted for Allocation Report. More detailed instructions are provided in the Depreciation/Free Receipt Spreadsheet. This is Self-Inspection Checklist Items 27, 28 and 29. The calculations are outlined below: (T-0)

9.3.1. FCC EDHA, Fire Protection, is the total expenses by multiplying ".00008 x total expenses". Enter the calculated amount in financial adjustments (net month expenses only).

9.3.2. FCC EDIA, Police Protection, is the total expenses by multiplying ".0007 x total expenses". Enter the calculated amount in financial adjustments (net month expenses only).

9.3.3. FCC EDKA, Other Base Support Services is the total expenses by multiplying ".0015 x total expenses". Enter the calculated amount in financial adjustments (net month expenses only).

**Note:** MEPRS Codes EDHA, EDIA or EDKA will not be used to report time.

9.4. Combined Food Operations

9.4.1. FCC EIBA Combined Food Operations expenses must be manually entered in financial adjustments. Obtain these expenses from the AF Form 544; year-to-date column or the cumulative YTD purchases from End of Month Food Services Report will be input.

9.5. EASIVi Financial Processing

9.5.1. The Budget Analyst (BA)/Resource Advisor (RA): will validate total expenses for all years (at RC/CC level) and obligations for current year monthly. During this process the Budget Analyst should validate accuracy of PECs, RC/CCs and EEICs. The Current PEMA in conjunction with the Base AFO Funds Management (FM) Coding Package. (T-0)

9.5.1.1. A financial file will be created monthly by the Budget Analyst using the Commander’s Resource Integration System (CRIS) and imported into EASIVi by the MPM. The Budget Analyst will coordinate with the MPM on all EASIVi financial
adjustments. All errors, warnings and negative numbers for expenses and obligations will be researched, explained and documented by the Budget Analyst. If corrective actions cannot be determined locally, contact AFMOA/SGAR for further guidance. Corrections will be required in the month the error occurred and all subsequent months. Reallocation and re-transmission of each month is required. Correction will be made in the source financial system as appropriate. (T-0)

9.5.1.2. The MPM will work closely with the Budget Analyst to conduct the reconciliation. The BA will coordinate requirements with the Base Financial Services Office (BFSO), Defense Financial Accounting Service (DFAS), Civilian Personnel Office (CPO), or other critical base support agencies to ensure accurate data is received and minimal edits are required. The Budget Analyst and RMO Flight Commander will sign the finalized reconciliation documentation. This is Self-Inspection Checklist Items 23 and 24. (T-0)

9.5.1.3. Ensure financial data reported in EASIVi is the same as that reported through the financial management and DFAS systems. Source data received via the monthly financial file and must not be altered. (T-0)

9.5.1.4. AFMOA/SGAR will provide oversight of financial reconciliation by conducting a quarterly comparison of EASIVi financial data to financial system reported data. Discrepancies will be communicated back to the MTF for explanation and/or correction, and to ensure the audit trail is complete.

9.5.1.5. AFMSA/SGYR will conduct a financial reconciliation annually by comparing DFAS data to EASIVi. Again, any discrepancies will be communicated back to the MTF through AFMOA/SGAR for explanation and/or correction, and to ensure the audit trail is complete.

Note: Any changes to financial data, to include personnel salary, will necessitate updating the monthly Depreciation/Free Receipt spreadsheet (personnel expense net or financial expense net). Reallocate and retransmit as appropriate.
Chapter 10

MEPRS DATA QUALITY

10.1. The MEPRS Program Manager in conjunction with appropriate personnel will ensure all systems’ files and tables are updated and synchronized as required. Data reconciliation ensures program compliance and accuracy in collecting, coding, and reporting workload, financial, and personnel data. (T-0)

10.2. The MPM will ensure initial and ongoing training of all personnel in the mechanics of MEPRS data reporting. This is Self-Inspection Checklist Items 5 and 34. (T-0)

10.3. MTFs will use WAM for CHCS-generated workload data. Issues identified in WAM or the workload migration process that drives update to data must be made in the source file of CHCS by the responsible work center. After corrections, reinitialize WAM and resubmit file to EASIVi. It would also be appropriate to regenerate and retransmit the WWR file during this process if data affected impacted data reported in WWR, for inpatient facilities only. (T-0)

10.4. Changes to data in EASIVi can be made ONLY if correction in CHCS/AHLTA, DMHRSi or the source financial system is not possible. Corrections made outside of the source systems will be coordinated with the affected work center, the DQM, the GPM, the Budget Advisor or Logistics as appropriate. (T-0)

10.5. Refer to the Self-Assessment Checklist (SAC) for specific Inspection requirements. (T-0)

THOMAS W. TRAVIS
Lieutenant General, USAF, MC, CFS
Surgeon General
Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References
DoD 6010.13-M, Medical Expense and Performance Reporting System for fixed Military Medical and Dental Treatment Facilities, 7 April 2008
DoDI 6040.40, Military Health System Data Quality Management Control Procedures, 26 November 2002
AFI 41-120, Medical Resource Operations, 18 October 2001
AFI 41-210, Patient Administration Functions, 22 March 2006
AFI 65-601, Volume 1, Budget Guidance and Procedures, 16 August 2012
AFMAN 33-363, Management of Records, 1 March 2008
AFPD 41-1, Health Care Programs and Resources, 15 April 1994
Joint Federal Travel Regulation (JFTR) U5243, 1 October 2012
Air Force Records Information Management System (AFRIMS), 4 June 2012
MEPRS Course Student Guide, 7 June 2013
Air Force Master Account Subset Definition file, 1 October 2013
MEPRS Time Reporting Matrix, 1 October 2013
PEMAP – Program Element Mapping spreadsheet 1 October 2013
DMHRSi End of Month (EoM) Guide, 1 March 2014
DMHRSi Concept of Operations (CONOPS), 23 March 2010
AFMS Workload Guidelines, 1 October 2009

Adopted Forms
AF Form 847, Recommendation for Change of Publication

Abbreviations and Acronyms
AFPD—Air Force Policy Directive
AFRIMS—Air Force Records Information Management System
ACU—Acute Care Units (Line Clinics)
ADPL—Average Daily Patient Load
AHLTA—Armed Forces Health Longitudinal Technology Application
ALOS—Average Length of Stay
APPROP—Appropriation Codes - Classification of appropriated funds
APV—Ambulatory Procedure Visit
APU—Ambulatory Procedure Unit
ASD—Account Subset Definition
ASF—Aero medical Staging Facility
ASN—Assignment Sequence Number
ASWC—Assigned Work Center
ATAAPS—Automated Time Attendance and Production System (DCPS Feeder System)
BDQAS—Biometric Data Quality Assurance Service
BFSO—Base Financial Support Office
BMET—Biomedical Equipment Repair Technician
CAPER—Comprehensive Ambulatory Patient Encounter Record (formerly SIDR- Standard Inpatient Data Record
CC—Cost Center
CDA—Central Design Activity
CE—Continuing Education (Formally Continuing Health Education – CHE)
CHAMPUS—Civilian Health and Medical Program for the Uniformed Services
CHCS—Composite Health Care System
CLV—Composite Lab Values
CONOPS—Concept of Operations
COTS—Commercial Off-the-Shelf
CPO—Civilian Personnel Office
CPT—Physicians’ Current Procedural Terminology
CRIS—Commander’s Resource Integration System
DES—Direct Expense Schedule
DFAS—Defense Financial Accounting Service
DHA—Defense Health Agency (Formerly TMA- TRICARE Management Activity)
DMIS—Defense Medical Information Systems
DMHRSi—Defense Medical Human Resources System - internet
DMLSS—Defense Medical Logistics Standard Support
DMSSC—Defense Medical Systems Support Center
DoD—Department of Defense
DRG—Diagnostic Related Groups
DQ—Data Quality
DQM—Data Quality Manager
DQMCP—Data Quality Management Control Program
DSS—Database Sustainment Manager
DTF—Dental Treatment Facility
EASIVi—Expense Assignment System, Version 4 internet
EEIC—Element of Expense & Investment Code
EOM—End of Month
FAC—Functional Account Code
FCC—Functional Cost Code
FOA—Field Operating Agency
FTE—Full Time Equivalent
FY—Fiscal Year
GPM—Group Practice Manager
HCI—Health Care Integrator
HIPAA—Health Insurance Portability & Accountability Act
Hosp/SL—Hospital/Sick Leave
HR—Human Resources
IMA—Individual Mobilization Augmentee
JFTR—Joint Federal Travel Regulation
M2—Business Object program for retrieving data from Master Data Repository (MDR)
MAJCOM—Major Command
MEPRS—Medical Expense and Performance Reporting System
MFI—Medical Facility Identification
MHS—Military Health System
MMIG—MEPRS Management Improvement Group
MPM—MEPRS Program Manager
MTF—Medical Treatment Facility
OASD/HA—Office of the Assistant Secretary of Defense (Health Affairs)
OBD—Occupied Bed Day
OI—Operating Instruction
PBAS—Program Budget Accounting System
PCMH—Patient Centered Medical Home
PEC—Program Element Code
PEMAP—Program Element Mapping
POTFF—Protection of Force and Family
QAP—Quality Assurance Personnel
QC—Quality Control
RC—Responsibility Center
RDS—Records Disposition Schedule
RMO—Resource Management Office
RVU—Relative Weighted Unit
RWP—Relative Weighted Product
SCR—System Change Request
SEEC—Standard Expense Element Code
SIR—System Incident Report
SME—Subject Matter Expert/Squadron Medical Element
TAA—Training Affiliation Agreement
UIC—Unit Identification Code
WAM—Workload Assignment Module
WWR—Worldwide Workload Report

Terms

Adjustment—The process of adding, subtracting, or otherwise modifying incurred expenses or data into an array or format that reflects MEPRS recognized expenses and statistics.

Admission—The act of placing an individual under treatment or observation in a hospital.

Aero Medical Staging Facilities—Medical facilities having aero medical staging beds, located on or in the vicinity of an enplaning or deplaning air base or air strip that provides reception, administration, processing, ground transportation, feeding, and limited care for patients entering or leaving the aero medical evacuation system.

Allocation—Reassignment of expenses from intermediate (Ancillary (D) and Support (E)) accounts to final operating expense accounts.

Ancillary Services—Services that participate in the care of patients principally by assisting and augmenting attending physicians and dentists in diagnosing and treating human ills.

Cost Assignment—The distribution or transfer of an item of cost or a group of items of cost to one or more work centers.
Cost Pool— Operating expense accounts, which collect direct or indirect operating expenses for purposes of reassignment to work center accounts and ultimately to final operating expense accounts.

Depreciation— The decrease in the service potential of equipment as a result of wear, deterioration, or obsolescence, and the subsequent allowance made for the process in the accounting records of the activity.

Disposition— The removal of a patient from the census of an inpatient facility by reason of discharge to duty, to home, transfer to another medical facility, death, or other termination of inpatient care.

Expense Assignment System (EAS)— A standard automated data processing capability utilized by the military departments for the calculations required to produce the Medical Expense and Performance Reports.

Expenses— The total of accrued expenses paid and unpaid

Migration— The process of bringing in the files (personnel, financial and workload) to EASIVi.

Obligations— The total of accrued expenses paid and unpaid plus undelivered orders outstanding.

Service Unit— A measure of work produced by a function within an MTF such as occupied bed days, visits, procedures, square footage, etc.

Purification— Reassignment of expenses from one operating expense account to one or more other operating expense accounts

Validation— The process of checking the files (personnel, financial and workload) against existing tables in EASIVi.

Visit— Healthcare characterized by the professional examination and/or evaluation of a patient and the delivery of or prescription of a care regimen. Refer to DoD 6015.1-M for a more detailed description.
Attachment 2

AIR FORCE UNIQUE ACCOUNT CODES

A2.1. General. The following codes are to be used whenever a separately defined work center is established.

A2.2. EBAA – Command. This code accounts for the cost of providing command jurisdiction over all personnel assigned or attached to the medical facility. Includes cost in determining the facility’s medical capability in relation to available medical service officers, supporting staff and facilities; implementing directed programs; caring for and safeguarding all property under command control; and supervising the care, treatment and welfare of the patients. Medical Wing/Group Commander, Deputy Commander (when authorized), Group Superintendent, First Sergeant; and their immediate secretarial and administrative staff will be included in this expense account. Time reported includes attendance at any official function. All personnel attending Group Commander’s Call will be reported using this code.

Allocation methodology: Total Available FTEs of the facility.

Note: For Squadron Command functions see specific paragraphs below.

A2.3. EBBA - Special Staff. This code includes the Administrator, Chief of the Medical Staff (formerly Chief of Hospital Services), Nurse Executive, Medical Law Consultant (when authorized), Chaplain Services (when authorized), Credentials, Infection Control, Self-Inspection (when appointed by letter to perform a self-inspection), Quality Assurance and Risk Management programs, and their immediate secretarial and administrative staff. This account also includes the Dental and Biomedical Advisors when functioning as Group Staff.

Allocation methodology: Available FTEs of the facility.

A2.4. EBBH - Health Promotion Program. This code is used to account for the administration of health promotion activities to build healthier communities. The coordinator and their direct staff will have oversight of the Health and Wellness Center (HAWC) and will have to track their time in appropriate MEPRS Codes to the work that they are performing. FCGH would be used to report patient care time. The Health Promotion Coordinator will annotate committee attendance for the Installation Health Promotion Working Group, and others (i.e. Aerospace Medicine Council, Health Consumer Advisory Council, wing briefings/meetings, etc.) where health promotion representation is required or requested. The health promotion manager should count the hours for all planning, programming, executing and evaluating all health promotion activities.

Allocation methodology: Total Available FTEs of the facility.

A2.5. EBCA - Medical Resource Management Administration. This account includes the functions of Medical Resource Management Flight (RMO). Refer to AFI 41-120 for guidance.

Allocation methodology: Total Available FTEs of the facility

A2.6. EBCB – Commander’s Support Staff (CSS). This account includes the functions of the Commander’s Support Staff (Orderly Room).

Allocation methodology: Total Available FTEs of the facility.
A2.7. EBCC – Committees. This account includes those committees authorized by Air Force Instructions and MTF committee regulations. Staff meetings are not included in this account. Allocation methodology: Available FTEs of the facility. Refer to attachment 3 for a general list of committees that should be included in this FCC.

Allocation Methodology: Total Available FTEs of the facility

A2.8. EBCD - Dental Squadron. This code accounts for the cost of providing effective management of all assigned dental functions and resources by the Squadron Commander, senior enlisted manager, and their immediate administrative staff. Functions include planning, organizing, operating, evaluating, and improving all aspects of system performance for the dental squadron; developing effective relationships with other group entities; defining roles and responsibilities that optimize effectiveness of the Dental Squadron; and providing oversight for education, training, and career management of squadron personnel. Time reported will include attendance at any official functions. Squadron Commander’s Call will be reported in this code.

Allocation methodology: Total Available FTEs of the MEPRS codes under the purview of the squadron. Update the ASD dataset definition annually or as needed.

A2.9. EBCE - Medical Support Squadron. This code accounts for the cost of providing effective management of all assigned medical support functions and resources by the Squadron Commander, senior enlisted manager, and their immediate administrative staff. Functions include planning, organizing, operating, evaluating, and improving all aspects of system performance for the Medical Support Squadron; developing effective relationships with other group entities; defining roles and responsibilities that optimize effectiveness of the Medical Support Squadron; and providing oversight for education, training, and career management of squadron personnel. Time reported will include attendance at any official functions. Squadron Commander’s Call will also be reported in this code.

Allocation methodology: Total Available FTEs of the MEPRS codes under the purview of the squadron. Update the ASD dataset definition annually or as needed.

A2.10. EBCF - Aerospace Medicine Squadron. This code accounts for the cost of providing effective management of all assigned aerospace medicine functions and resources by the Squadron Commander, senior enlisted manager, and their immediate administrative staff. Functions include planning, organizing, operating, evaluating, and improving all aspects of system performance for the Aerospace Medicine Squadron; developing effective relationships with other group entities; defining roles and responsibilities that optimize effectiveness of the Aerospace Medicine Squadron; and providing oversight for education, training, and career management of squadron personnel. Time reported should include attendance at any official functions. Squadron Commander’s Call will also be reported in this code.

Allocation methodology: Total Available FTEs of the MEPRS codes under the purview of the squadron. Update the ASD dataset definition annually or as needed.

A2.11. EBCH - Medical Operations Squadron. This code accounts for the cost of providing effective management of all assigned medical operations functions and resources by the Squadron Commander, senior enlisted manager, and their immediate administrative staff. Functions include planning, organizing, operating, evaluating, and improving all aspects of system performance for the Medical Operations Squadron; developing effective relationships with other group entities; defining roles and responsibilities that optimize effectiveness of the
Medical Operations Squadron; and providing oversight for education, training, and career management of squadron personnel. Time reported will include attendance at any official functions. Squadron Commander’s Call will also be reported in this code.

**Allocation methodology:** Total Available FTEs of the MEPRS codes under the purview of the squadron. Update the ASD dataset definition annually or as needed.

**A2.12. EBCI – Inpatient Operations Squadron.** This code accounts for the cost of providing effective management of all assigned inpatient operations functions and resources by the Squadron Commander, senior enlisted manager, and their immediate administrative staff. Functions include planning, organizing, operating, evaluating, and improving all aspects of system performance for the Inpatient Operations Squadron; developing effective relationships with other group entities; defining roles and responsibilities that optimize effectiveness of the inpatient operations squadron; and providing oversight for education, training, and career management of squadron personnel. Time reported will include attendance at any official functions. Squadron Commander’s Call will also be reported in this code.

**Allocation methodology:** Total Available FTEs of the MEPRS codes under the purview of the squadron. Update the ASD dataset definition annually or as needed.

**A2.13. EBCJ - Diagnostic and Therapeutic Squadron.** This code accounts for the cost of providing effective management of all assigned diagnostic and therapeutic functions and resources by the Squadron Commander, senior enlisted manager, and their immediate administrative staff. Functions include planning, organizing, operating evaluating, and improving all aspects of system performance for the Diagnostic and Therapeutic Squadron. Functions also includes developing effective relationships with other group entities; defining roles and responsibilities that optimize the effectiveness of the diagnostic and therapeutic squadron; and providing oversight for education, training, and career management of squadron personnel. Time reported will include attendance at any official functions. Squadron Commander’s Call will also be reported in this code.

**Allocation methodology:** Total Available FTEs of the MEPRS codes under the purview of the squadron. Update the ASD dataset definition annually or as needed.

**A2.14. EBCK - Surgical Operations Squadron.** This code accounts for the cost of providing effective management of all assigned surgical operations functions and resources by the Squadron Commander, senior enlisted manager, and their immediate administrative staff. Functions include planning, organizing, operating, evaluating, and improving all aspects of system performance for the Surgical Operations Squadron; developing effective relationships with other group entities; defining roles and responsibilities that optimize effectiveness of the surgical operations squadron; and providing oversight for education, training, and career management of squadron personnel. Time reported will include attendance at any official functions. Squadron Commander’s Call will also be reported in this code.

**Allocation methodology:** Total Available FTEs of the MEPRS codes under the purview of the squadron. Update the ASD dataset definition annually or as needed.

**A2.15. EBCL – Supervision Oversight.** This account will be used to track the FTEs and salary for supervisory oversight to include writing decorations, EPRs, OPRs, civilian appraisals and any personnel counseling required. This account will also be used to track all MTF directed details (Cash count, Drug Inventory, MOD, NCOD, AOD, and Casualty Assistance. This account is
NOT to be used for any time in normally considered patient care, support to the clinic or normal day-to-day running of the clinic.

Allocation methodology: Total Available FTEs of the facility.

A2.16. EBDA – Clinical Management. This code accounts for costs of MTF Clinical Management services to include department heads, Health Care Integrators (HCIs), Group Practice Managers (GPMs) and their immediate Staff. Time spent performing Clinical Peer Reviews will also be captured under this code. This does not include day-to-day clinic operations. If a GPM supports all clinical areas they are assigned and will report a majority of their time to EBDA. If the MTF has multiple GPMs, they will be assigned to the clinical work center they support. Contact AFMOA/SGAR for further guidance.

Allocation methodology: Total Available FTEs of the clinical areas of the MTF (A, B, C, D).

A2.17. EBFN - Audiovisual Services. This code accounts for costs of audiovisual services to include medical illustration and medical photography. Costs include manpower, travel, contractual services, procurement of supplies and materials, expense equipment, necessary facilities and the associated costs specifically identified, and measurable to medical functions, productions and services and support this function.

Allocation methodology: Total Available FTEs of the facility.

A2.18. EBFW - Medical Library. This code accounts for costs of manpower, travel, contractual services, procurement of supplies and materials, expense equipment, necessary space and associated costs to support operation of the medical library.

Allocation methodology: Total Available FTEs of the facility.

A2.19. EBHA – Third Party Collections. See Para 8.6.5.1.

Allocation methodology: Total Claims Billed (submitted)

A2.20. ELAB – Clinical In and Out-processing. This code is to be used by Managed Care personnel to validate the appropriate In and Out-processing of new/departing enrollees. This is not to be used by clinic personnel managing enrolled patient population.

Allocation methodology: FTEs reported in A and B MEPRS Codes.

A2.21. ELAD – Disease Management. This Account is used to accumulate all the operating expenses incurred in implementing and administering Disease Management Activities. This is not to be used by (PCMH) clinic personnel managing enrolled patient population.

Allocation methodology: FTEs reported in A, B, FBI, FBN, and FEA.

A2.22. ELAE - Enhanced Multi-Service Market (E-MSM) Support. This code is to capture all the operating expenses incurred in implementing and administering E-MSM Activities at the MTF Level. This code is not to be used to capture time responding to E-MSM taskings.

Allocation methodology: FTEs reported in A and B Accounts.

A2.23. ELAH – HIPAA Privacy Program. This account is used to accumulate all the operating expenses incurred in implementing and administering the Health Insurance Portability & Accountability Act (HIPAA) program within the facility. This includes administrative tasks,
training (instructor), facility briefings, and ensuring all MTF personnel, including volunteers, and contractors, abide by the rules and regulations of HIPAA.

**Allocation methodology:** Total Visits.

**Note:** Personnel attending HIPAA training will charge time to FALA-Continuing Education.

**A2.24. ELAN – Case Management/Case Management Wounded Warriors.** This Account is used to accumulate all the operating expenses incurred in implementing and administering separately organized Case Management Activities. This is not to be used by clinic personnel managing enrolled patient population.

**Allocation methodology:** FTEs reported in A, B, FBI, FBN, and FEA.

**A2.25. ELAU – Utilization Management** This Account is used to accumulate all the operating expenses incurred in implementing and administering Utilization Management Activities. This is not to be used by (PCMH) clinic personnel managing enrolled patient population.

**Allocation methodology:** FTEs reported in A and B MEPRS Codes.

**A2.26. FALA – Continuing Education (CE).** This account is used for capturing costs incurred by an MTF in support of Continuing Education (CE) requirements. This includes all CE regardless of location or source of instruction, to include in-services.

**A2.27. FASF – Family Advocacy Program.** Use this account to capture the cost and FTEs of operating, maintaining, administering, and supervising the installation Family Advocacy Program, to include Family Maltreatment Services, Family Advocacy Strength-based Services, the New Parent Support Program, Domestic Abuse Victims Advocate, and the Family Advocacy Outreach Program.

**A2.28. FASY - Preventive Mental Health Services.** Use this account to capture the cost and FTEs of briefings, workshops, and seminars provided and attended by groups for prevention education or raising awareness about mental health issues, meetings whose primary purpose is to promote the emotional health and welfare of the base community or population (e.g., CAIB and IDS), command consultation regarding specific programs, community issues, or population health, community crisis response (e.g., trauma stress response, hostage negotiation) and any other mental health promotion initiative (e.g., stress management, suicide prevention) conducted within the base community.

**A2.29. FAZN – Exceptional Family Member Program.** Use this account to capture the cost of reviewing medical records, electronic encounter and treatment histories, interviewing family members, reviewing facility determination inquiries, and making recommendations for family member travel OCONUS and for special needs family member travel within CONUS. This account also includes time spent advising family members/unit representatives on procedures for the family member relocation clearance process, educating base personnel on SNIAC/EFMP requirements, data collection and reporting IAW DoD and AF requirements, and assignment coordination database/records maintenance.

**A2.30. FBBB - Environmental Compliance.** This account will be used to capture the costs to support installation environmental compliance. Activities are limited to compliance with environmental laws as implemented by the federal, state, and local environmental regulatory agencies. This includes, but is not limited to, the Safe Drinking Water Act, Clean Water Act, Clean Air Act, Residential Lead Based Paint Hazard Reduction Act of 1992, and Resource
Conservation and Recovery Act. It includes sampling analysis and monitoring to the extent required to comply with the applicable regulatory authority and the assessment of environmental (not human health) impact of accidents and disasters such as chemical or fuel spills. For overseas bases, includes activities required to comply with the Host Nation Final Governing Standards or the Overseas Environmental Baseline Guidance Document.

A2.31. FBBC - Pollution Prevention. This code accounts for the costs to support installation pollution prevention programs. This includes support of the ozone depleting substance waiver process and retrieval of hazardous material usage and storage data to support reporting requirements. It does not include the inventory and control of hazardous material required to the extent it is required by the Industrial Hygiene Program.

A2.32. FBBD - Environmental Restoration is used to account for the costs to support installation environmental restoration programs. Includes health impact support of environmental restoration (cleanup) activities, human health assessments, and Agency for Toxic Substances and Disease Registry Agency (ATSDR) activities.

A2.33. FBBE - Environmental Conservation Support is used to account for costs to support installation environmental conservation programs including health impact review of Environmental Assessments (EA), Environmental Impact Statements (EIS), installation operations on endangered species, and any installation activities impacting cultural or natural resources.

A2.34. FBEA - Public Health. This account is used to capture all operating expenses for developing and conducting medical services surveillance programs to ensure hazards to individuals and community health are identified, evaluated and eliminated or controlled. Occupational Health Program encompasses providing medical surveillance over civilian and military personnel working in hazardous or potentially hazardous environments. This includes identifying and investigating occupational illnesses; conducting epidemiological investigations in support of occupational health problems; conducting occupational health education and prevention programs; providing for and screening of occupational physical examinations for active duty personnel in hazardous occupations; and monitoring public health and occupation-related physical examinations of federal civilian workers, including pre-employment, fitness for duty, termination, and disability evaluations. The Communicable Disease Program encompasses the control of communicable diseases; the evaluation of foods, food sources, food service facilities, and other public facilities and services used by military, DoD civilian personnel, and beneficiaries. This includes monitoring and investigating communicable diseases (suspected or confirmed illnesses); collating and reporting communicable disease statistics, and other health data; counseling concerning health maintenance and preventive medicine; monitoring disease vector populations; providing medical inspections on incoming aircraft emanating from foreign soil; and maintaining liaison and cooperation with local, state, and federal health authorities. Public Health also evaluates schools, nurseries, day care centers, and other public places for environmental factors which may affect the health of military personnel or their dependents; conducts epidemiological investigations for food borne disease outbreaks; provides inspection of substances for wholesomeness, contract compliance, storage conditions, and keeping qualities; and conducts laboratory examinations of food and food contact surfaces. Public Health is responsible for the PHA Program. The PHA Cell will manage the administrative requirements for all non-flyer PHAs (Flight Medicine will capture empanelled PHAs under their code). The PHA Cell will earn 4E manpower under FAC 5313. If the PHA patient requires seeing a
clinician, an appointment needs to be made with the PCM and the visit count will be coded under the physician’s MEPRS code.

A2.35. FEBB – Medical Standards Management Element (MSME FAC 5318) is used to capture all operating expenses for ensuring and conducting initial flying/Special Operational Duty (SOD) physical exams, Duty Limiting Conditions to include profiles, DAWG, Incoming Base Personnel, Retraining, PCS Clearance and Assignment Limitation Codes profiles to include the PULHES system. Ensures training is completed for all PEPP and AIMWTS users for documentation of physical examination and waiver actions. Ensures mechanism for scheduling or schedules initial flying class/SOD examinations for all enrolled and non-enrolled personnel who require initial flying class/SOD examinations and administrative quality review of AF Form 422/469s. Flight and Operational Medicine Clinic (FOMC) will capture all empanelled PHAs under their code.

A2.36. FCGH - Health and Wellness Center. This code is used to account for health promotion patient activities that are part of building healthier communities and may include a referral from a provider for a diagnosed illness or condition. Health promotion activities include administering the HEAR (Health Evaluation Assessment Review), awareness, education and interventions (including screenings) for tobacco prevention/cessation, fitness health assessment and enhancement exercise prescription, stress management, substance abuse, cardiovascular disease prevention, cancer prevention, injury prevention, and medical self-care. These activities can be conducted at work sites, through outreach programs, in the health and wellness center.

Note: Count Visits will not be captured in Health and Wellness Centers for the above activities. The MTF may establish a non-count clinic with non-count appointment types in CHCS/AHLTA using the “FCGH” FCC and code the encounter in ADM appropriately. Nutritional medicine is not part of this function and should continue to be captured in “BALA”.

A2.37. FCGJ – PRP Administrative Qualifications. At bases with no active PRP mission, all PRP qualifications will occur within the Flight Medicine Clinic and coded under this code.

A2.38. FCGM – Military Training Consult Service. This account will be used to capture the costs to support Military Training Consult Service. This is a behavioral consultation service in support of Basic Military Training instructors to support safe and effective training operations. This function will not perform clinical operations.

A2.39. FCGR - Reserve/Guard Clinic Support. This code is AF Specific. To provide reservist/guard personnel access to CHCS/AHLTA during drill weekend to order the necessary ancillary services to accomplish physicals on their own personnel. This is not to be used when reserve/guard personnel are augmenting the MTF mission.

A2.40. FDZC – Closing/Opening Clinical Work Centers. This code will be used to track time for personnel that are setting up or breaking down clinical services, when there is no RVU generation performed. Any support services provided to closed services (such as Biomedical Equipment Repair on overage equipment). This is where personnel working (full-time) at another service MTF would be assigned (i.e. Landstuhl, SAMMC).

A2.41. FEBB - Travel for Air Force Personnel/Non-Medical Attendants. This code accounts for the costs of travel for active duty Air Force personnel and their non-medical attendants assigned to locations without fixed MTF to obtain medical or dental care.
A2.42. **FEBC - Travel for Family Members and Medical Attendants Overseas.** This code accounts for the costs of travel for the family members of active duty Air Force personnel and attendants assigned to locations without fixed MTF, to obtain medical care when stationed overseas.

A2.43. **FEFA – Aero Medical Evacuation System.** This code accounts for all the operating expenses incurred by aero medical evacuation squadrons and detachments in support of the aero medical evacuation system. Functions may include reception and processing of air evacuation patients en-route to the MTF, as well as reception and processing of returning patients. This work center is not a bedded activity and cannot be used where there is an operational ASF.

A2.44. **BAKT – Traumatic Brain Injury (TBI) Clinic** examines, diagnoses, and treats TBI patients and provides a comprehensive plan of care for patients, including monitoring and maintaining their state of health, counseling and guidance, health education, rehabilitation, and prevention of disease. The Traumatic Brain Injury (TBI) Clinic is a distinct work center shall be a subaccount that includes all expenses incurred in operating and maintaining the clinic, such as expenses for personnel, supplies, travel, and any other expenses identified directly in support of TBI activities.

A2.45. **Patient Centered Medical Home Team Codes.** Used to report labor hours, workload and expenses for facilities using the PCMH Team concept to provide Internal Medicine (BAA*), Primary Care (BGA*), Pediatrics (BDA*, BDB*) and Flight Medicine (BJA*). A complete list is provided in attachment 4.

A2.45.1. Ensure RC/CCs for these codes are mapped to the appropriate team, so that the expenses will be readily identifiable. Ensure that DMLSS also reflects the appropriate RC/CCs to issue supplies and equipment to the correct team.

A2.45.2. Ensure the team codes are appropriately set up in DMHRSi with local organizations so the non-available time and expenses are charged to the correct team.

A2.45.3. Using a cost pool to help account for shared space, supplies, expenses or personnel would be advisable.

A2.45.3.1. **Example – B Team:** BGAB/540B – Patient Centered Medical Home Team B, shares a supply closet with BGAC/540C-Patient Centered Medical Home Team C, purchase those shared supplies in BGXA so that the cost of those supplies will be distributed to the teams based on the workload production of each of the teams.

A2.46. **BAAR, BDAR, and BGAR – GME Resident Procedure Clinic.** This code will be used to report labor hours, workload and expenses for GME Procedure training, this code would be affected by the GME Time splits of the Resident Training Program 50% of time to GME Training (FAM*) and 50% of time to patient Care (B*AR).

A2.47. **BAAZ, BDAZ, and BGAZ – Non-PCMH related functions.** This code will be used to report labor hours, workload and expenses for functions not appropriately captured under the PCMH concept. These functions are, but are not limited to:

A2.47.1. **Clinical Pharmacy.** Used to report labor hours, workload and expenses for facilities with a separately organized clinic providing Clinical Pharmacy Services. This will be a clinical function performed in an ambulatory clinic, not to be tracked as DA – Pharmacy workload.
A2.47.2. **Primary Behavioral Healthcare Consultation Service.** Behavioral Health Consultation Service (BHC Service) is a term used to describe any behavioral health service operating within a primary care clinic, using a consultative model of behavioral healthcare that is being delivered by a clinically trained Behavioral Health Consultant (BHC). In general, the goal of the BHC Service is to position the Behavioral Health Consultant on the healthcare team to augment and improve the delivery of overall healthcare, including behavioral healthcare. The BHC will not be used to provide comprehensive assessment or treatment of behavioral health conditions, as occurs in the specialty mental health clinic. The BHC may see the patient or perform limited interventions, but these activities are always designed to support the PCM’s impact on the patients’ health. On-going communication with the PCM regarding recommendations and the patient’s status is key to the BHC’s role. In contrast to specialty mental health settings, consultation by the BHC does not require a separate informed consent document since behavioral assessment and intervention are a part of the primary healthcare team’s service. Moreover, documentation is recorded only in the medical record rather than in a separate mental health chart. The PCM remains in charge of the patient’s care.

A2.48. **BJAB – Personnel Reliability Program/Presidential Support Program (PRP/PSP).** Active PRP should be booked and seen under the BJAB MEPRS code. This code is specific to PRP across the AFMS and will allow us to quantify the workload. AF/SG wants to be able to quantify the PRP workload across the AFMS in order to build a business case to take to AF/A10 requesting they fund the actual authorizations required to do PRP. It is in your best interest to keep all PRP workload within the BJAB MEPRS code.

A2.48.1. AF/SG directed that we rebuild PRP as a core competency within the AFMS. The only way we can do this is to group the PRP patients together so that they are seen by the same group of people. To this end, AF/SG directed that PRP would be managed and supervised by Flight Medicine across the AFMS.

A2.48.2. The PRP Manpower Model and the new Flight Medicine Manpower Model are linked. As we looked at the PRP population at a base, if we rounded up to get a provider under the PRP model, then we would not round up in the Flight Medicine model to earn a flight surgeon. The intent being that these PRP patients with their earned staff (FAC 5320) would be embedded / combined with Flight Medicine. Additionally, the mix of PA’s and physicians in the PRP Manpower Model was determined based on available flight surgeons as preceptors.

A2.48.3. At bases that earn a stand-alone PRP clinic, the clinic (location and staff) should be integrated fully with the Flight Medicine Clinic under MEPRS code BJAB. Enroll all fly PRP patients to BJAA; workload coded as BJAB. Enroll all non-fly PRP patients to BJAA; workload coded as BJAB. The PRP-related administrative work, certifications, qualifications, etc., should be documented under MEPRS code FCGJ. The administrative work includes multi-disciplinary (Dental, Mental Health, Immunizations, Public Health, etc.) administrative evaluations.

A2.48.4. At bases that have active PRP missions, but do not earn additional PRP staff, all PRP patients (both flyer and non-flyer) are to be seen within the Flight Medicine Clinic under MEPRS Code BJAA. Enroll all fly and non-fly PRP patients to BJAA; workload coded as BJAA. The PRP-related administrative work, certifications, qualifications, etc.,
should be documented under MEPRS code FCGJ. The administrative work includes multi-disciplinary (Dental, Mental Health, Immunizations, Public Health, etc.) administrative evaluations.

A2.49. BJAC – Personnel Reliability Program/Presidential Support Program (PRP/PSP) – Non-Flyers. This code would be used at locations where the Non-Flyer PRP/PSP personnel would meet the requirement for a separately organized team.

A2.50. BJAT – Flight Medicine Trainee Clinic. This would be set up at MTFs where they have a separately organized clinic to support Trainee Health, run by flight medicine. Refer to above para A2.45.1 thru A2.45.3 for detailed info as to how to set this code up properly for accurate reporting.
Table A3.1. Official Committee Meetings.

<table>
<thead>
<tr>
<th>Committee/Function requiring formal minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aerospace Medicine Council</td>
</tr>
<tr>
<td>Cancer Function</td>
</tr>
<tr>
<td>Cost Center Manager (CCM) Meeting</td>
</tr>
<tr>
<td>Credentials Committee</td>
</tr>
<tr>
<td>Data Quality/ Information Management Working Group (DQ/IM)</td>
</tr>
<tr>
<td>Dental Executive Function</td>
</tr>
<tr>
<td>Education &amp; Training Function</td>
</tr>
<tr>
<td>Environment of Care/Patient Safety Committee</td>
</tr>
<tr>
<td>Equipment Review Authorization Activity (ERAA)</td>
</tr>
<tr>
<td>Ethics Function</td>
</tr>
<tr>
<td>Executive Committee of the Medical Staff (ECOMS)</td>
</tr>
<tr>
<td>Executive Council</td>
</tr>
<tr>
<td>Family Advocacy Committee</td>
</tr>
<tr>
<td>Family Maltreatment Case Management Team</td>
</tr>
<tr>
<td>Health Care Council</td>
</tr>
<tr>
<td>Infection Control Committee</td>
</tr>
<tr>
<td>Medical Library Function</td>
</tr>
<tr>
<td>Medical Readiness Staff Function (MRSF)</td>
</tr>
<tr>
<td>Medical Records Function</td>
</tr>
<tr>
<td>Medical Records Review Function</td>
</tr>
<tr>
<td>Nursing Executive Function</td>
</tr>
<tr>
<td>Odyssey Board of Experts</td>
</tr>
<tr>
<td>Operative and other Invasive Procedures Function</td>
</tr>
<tr>
<td>Performance Improvement/Risk Management Function</td>
</tr>
<tr>
<td>Pharmacy &amp; Therapeutics /Medications Management</td>
</tr>
<tr>
<td>Population Health Function</td>
</tr>
<tr>
<td>Professional Staff Function</td>
</tr>
<tr>
<td>Resuscitative Care and Special Care Function</td>
</tr>
<tr>
<td>Space Utilization Function</td>
</tr>
<tr>
<td>Tissue, Blood and Blood Components Function</td>
</tr>
</tbody>
</table>

**Note:** This list is not all inclusive, and several of these Committees/Functions could potentially be combined to lessen the actual Number of meetings.
Attachment 4

PATIENT CENTERED MEDICAL HOME CODE LISTING

Table A4.1. Patient Centered Medical Home Code Listing.

**INTERNAL MEDICINE TEAMS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAAA</td>
<td>INTERNAL MEDICINE MEDICAL HOME TEAM A Non-GME</td>
</tr>
<tr>
<td>BAAB</td>
<td>INTERNAL MEDICINE MEDICAL HOME TEAM B Non-GME</td>
</tr>
<tr>
<td>BAAC</td>
<td>INTERNAL MEDICINE MEDICAL HOME TEAM C Non-GME</td>
</tr>
<tr>
<td>BAAD</td>
<td>INTERNAL MEDICINE MEDICAL HOME TEAM D Non-GME</td>
</tr>
<tr>
<td>BAAE</td>
<td>INTERNAL MEDICINE MEDICAL HOME TEAM E Non-GME</td>
</tr>
<tr>
<td>BAAF</td>
<td>INTERNAL MEDICINE MEDICAL HOME TEAM F Non-GME</td>
</tr>
<tr>
<td>BAAG</td>
<td>INTERNAL MEDICINE MEDICAL HOME TEAM G Non-GME</td>
</tr>
<tr>
<td>BAAH</td>
<td>INTERNAL MEDICINE MEDICAL HOME TEAM H Non-GME</td>
</tr>
<tr>
<td>BAAJ</td>
<td>INTERNAL MEDICINE MEDICAL HOME TEAM J Non-GME</td>
</tr>
<tr>
<td>BAAK</td>
<td>INTERNAL MEDICINE MEDICAL HOME TEAM K Non-GME</td>
</tr>
<tr>
<td>BAAL</td>
<td>INTERNAL MEDICINE MEDICAL HOME TEAM L GME</td>
</tr>
<tr>
<td>BAAM</td>
<td>INTERNAL MEDICINE MEDICAL HOME TEAM M GME</td>
</tr>
<tr>
<td>BAAN</td>
<td>INTERNAL MEDICINE MEDICAL HOME TEAM N GME</td>
</tr>
<tr>
<td>BAAP</td>
<td>INTERNAL MEDICINE MEDICAL HOME TEAM P GME</td>
</tr>
<tr>
<td>BAAQ</td>
<td>INTERNAL MEDICINE MEDICAL HOME TEAM Q GME</td>
</tr>
<tr>
<td>BAAR</td>
<td>INTERNAL MEDICINE GME RESIDENT PROCEDURE CLINIC</td>
</tr>
<tr>
<td>BAAS</td>
<td>INTERNAL MEDICINE MEDICAL HOME TEAM S GME</td>
</tr>
<tr>
<td>BAAT</td>
<td>INTERNAL MEDICINE MEDICAL HOME TEAM T GME</td>
</tr>
<tr>
<td>BAAW</td>
<td>INTERNAL MEDICINE MEDICAL HOME TEAM W GME</td>
</tr>
<tr>
<td>BAAZ</td>
<td>INTERNAL MEDICINE MEDICAL HOME Non-PCMH RELATED FUNCTIONS</td>
</tr>
</tbody>
</table>

**PEDIATRIC MEDICAL HOME TEAMS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDAA</td>
<td>PEDIATRIC MEDICAL HOME A Team Non-GME</td>
</tr>
<tr>
<td>BDAB</td>
<td>PEDIATRIC MEDICAL HOME B Team Non-GME</td>
</tr>
<tr>
<td>BDAC</td>
<td>PEDIATRIC MEDICAL HOME C Team Non-GME</td>
</tr>
<tr>
<td>BDAD</td>
<td>PEDIATRIC MEDICAL HOME D Team Non-GME</td>
</tr>
<tr>
<td>BDAE</td>
<td>PEDIATRIC MEDICAL HOME E Team Non-GME</td>
</tr>
<tr>
<td>BDAF</td>
<td>PEDIATRIC MEDICAL HOME F Team Non-GME</td>
</tr>
<tr>
<td>BDAG</td>
<td>PEDIATRIC MEDICAL HOME G Team GME</td>
</tr>
<tr>
<td>BDAH</td>
<td>PEDIATRIC MEDICAL HOME H Team GME</td>
</tr>
<tr>
<td>BDAL</td>
<td>PEDIATRIC MEDICAL HOME I Team GME</td>
</tr>
<tr>
<td>BDAR</td>
<td>PEDIATRIC - GME RESIDENT PROCEDURE CLINIC</td>
</tr>
<tr>
<td>BDAS</td>
<td>PEDIATRIC SUB-SPECIALITY</td>
</tr>
<tr>
<td>BDAZ</td>
<td>PEDIATRIC MEDICAL HOME Non PCMH Related Functions</td>
</tr>
</tbody>
</table>

**ADOLESCENT PED MED HOME TEAMS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDBA</td>
<td>ADOLESCENT PED MED HOME A Team Non-GME</td>
</tr>
<tr>
<td>BDBB</td>
<td>ADOLESCENT PED MED HOME B Team Non-GME</td>
</tr>
<tr>
<td>BDBC</td>
<td>ADOLESCENT PED MED HOME C Team GME</td>
</tr>
</tbody>
</table>
BDBD  ADOLESCENT PED MED HOME D Team GME

**FAMILY HEALTH TEAMS**

BGA1  DEPLOYMENT HEALTH ASSESSMENTS
BGAA  FAMILY HEALTH CLINIC - A Team Non-GME
BGAB  FAMILY HEALTH CLINIC - B Team Non-GME
BGAC  FAMILY HEALTH CLINIC - C Team Non-GME
BGAD  FAMILY HEALTH CLINIC - D Team Non-GME
BGAE  FAMILY HEALTH CLINIC - E Team Non-GME
BGAF  FAMILY HEALTH CLINIC - F Team Non-GME
BGAG  FAMILY HEALTH CLINIC - G Team Non-GME
BGAI  FAMILY HEALTH CLINIC - H Team - GME
BGAJ  FAMILY HEALTH CLINIC - I Team - GME
BGAK  FAMILY HEALTH CLINIC - J Team - GME
BGAL  FAMILY HEALTH CLINIC - L Team - GME
BGAM  FAMILY HEALTH CLINIC - M Team Non-GME
BGAN  FAMILY HEALTH CLINIC - N Team Non-GME
BGAP  FAMILY HEALTH CLINIC - P Team Non-GME
BGAQ  FAMILY HEALTH CLINIC - Q Team Non-GME
BGAR  FAMILY HEALTH - GME RESIDENT PROCEDURE CLINIC
BGAS  FAMILY HEALTH CLINIC - S Team Non-GME
BGAU  FAMILY HEALTH CLINIC - U Team Non-GME
BGAY  FAMILY HEALTH CLINIC - Y Team Non-GME
BGAZ  NON PCMH RELATED FUNCTIONS (Pharmacy, BHOP, DM, etc)

**FLIGHT MEDICINE TEAMS**

BJA1  FLIGHT MEDICINE BASE OPERATIONAL MEDICINE CELL (BOMC)
BJAA  FLIGHT MEDICINE
BJAB  FLIGHT MEDICINE – FLYERS
BJAC  FLIGHT MEDICINE – NON-FLYERS
BJAD  FLIGHT MEDICINE – D TEAM
BJAE  FLIGHT MEDICINE – E TEAM
BJAT  FLIGHT MEDICINE – TRAINEE CLINIC

**Note:** Refer to the Program Element Mapping table to ensure that supplies, equipment and or contracts are charged to the appropriate team code.