BY ORDER OF THE SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 41-102

25 JUNE 2020

Health Services

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

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

ACCESSIBILITY: Publications and forms are available on the e-publishing website at **www.e-publishing.af.mil** for downloading or ordering.

RELEASABILITY: There are no releasability restrictions on this publication.

OPR: AFMRA/SG1/8YB

Certified by: AF/SG1/8
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Supersedes: AFI 41-102, 5 August 2016

Pages: 55

This publication implements AFPD 44-1, *Medical Operations*, and is in accordance with Defense Health Agency – Procedures Manual (DHA-PM) 6010.13, *Medical Expense and Performance Reporting System (MEPRS) for Fixed Military and Dental Treatment Facilities (DTFs), Volume 1 (Business Rules) and Volume 2 (Uniform Chart of Accounts)* and the *Memorandum of Agreement between the Defense Health Agency (DHA) and the Air Force Surgeon General's Office for Direct Support to the DHA for Military Treatment Facility (MTF) Administration and Management*, DHA-2019-R-1304, paragraph 4.1.1. This AFI mandates use of MEPRS in Air Force Medical Treatment Facilities (MTFs). This publication applies to all Regular Air Force (RegAF), Air Force Reserve, Air National Guard (ANG) personnel, and government civilians working in medical and dental treatment facilities covered by this instruction. It does not apply to medical aid stations, 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. The authorities to waive wing/unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See AFI 33-360, *Publications and Forms Management*, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the requestor's commander for non-tiered compliance items. This publication may be supplemented at any level, but all supplements must be routed to the Office of Primary Responsibility (OPR) of this publication for coordination

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SUMMARY OF CHANGES

This document has been substantially revised and needs to be completely reviewed. Major changes include updates to interim policy guidance to support AF MTFs transition to DHA oversight until guidance can be published to support the day to day management of the MEPRS Program across the DHA facilities. Also the fielding of MHS will drive changes to reporting requirements and would be the definitive policy for future reporting.

Chapter 1

PROGRAM OVERVIEW

1.1. Medical Expense and Performance Reporting System (MEPRS). Is a managerial cost accounting system that accumulates and reports expenses, manpower, and workload performed in Department of Defense (DoD) fixed military medical and dental treatment facilities. An MTF is defined as an established land-based medical center, hospital, clinic, or other facility that provides medical, surgical, or dental care. MEPRS 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.

1.2. MEPRS Identifies the Cost of Care. Provided in MTFs (refer to the terms section for description) by product line and beneficiary category. MEPRS connects the expenses incurred with the Full Time Equivalents (FTEs) (refer to **para 7.5** FTE descriptions) reported and workload generated in each MTF by Functional Cost Code (FCC) (refer to section 5 for detailed info on FCCs), formerly MEPRS codes. It is used as a historical representation of the MTF for comparative analysis performed at higher Headquarters and DHA.

1.3. The Data Derived from MEPRS. Is incorporated into business planning analysis and used by the Air Force Medical Service (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.

Chapter 2

ROLES AND RESPONSIBILITIES

2.1. The Surgeon General, (AF/SG).

2.1.1. Implements Medical Expense and Performance Reporting System (MEPRS) for Fixed Military Medical and Dental Treatment Facilities in accordance with DHA-PM 6010.13 until MTFs are transferred to the DHA, or the publication of detailed DHA MEPRS processing procedures or, whichever occurs earlier.

2.1.2. Develops guidance for uniform reporting requirements and comparable data submission to designated management levels within DoD.

2.2. Air Force Medical Readiness Agency (AFMRA) SG1/8YB.

2.2.1. Arranges for funding of Air Force MEPRS software and hardware requirements.

2.2.2. Participates in and directs release of MEPRS software.

2.2.3. Acts as the Air Force representative to the Financial and Performance Reporting System Improvement Work Group to make joint guidance regarding MEPRS and Expense Assignment Systems Version IV internet (EASIV*i*) systems.

2.2.4. Directs guidance updates/changes for Air Force specific requirements.

2.3. The Command Surgeons. Aids AFMRA MEPRS in advocating timely and accurate MEPRS reporting.

2.4. Air Force Medical Readiness Agency (AFMRA)/SGAR (MEPRS)).

2.4.1. Assists MTFs in providing timely and accurate data transmissions.

2.4.2. Acts as focal point between MTFs and AFMRA/SG1/8YB on MEPRS related issues.

2.5. The Air Force Life Cycle Management Center Program Executive Office for Business and Enterprise Systems.

2.5.1. Provides tier II field assistance to all Air Force MTFs for EASIVi related software problems. As required, analyzes and elevates problems to DHA/ Solution Delivery Division (SDD) for subsequent resolutions by EAS IV T3.

2.5.2. Acts as Air Force authorizing agency for EASIVi and central repository access.

2.5.3. Interfaces with DHA/SDD to resolve all AF unique infrastructure issues to include assisting with the definition of system requirements.

2.6. MTF Commander or Director.

2.6.1. Assumes responsibility for overall operation of MEPRS within the MTF.

2.6.2. Integrates MEPRS data into the MTF's management audit and review processes.

2.7. Squadron Commander.

2.7.1. Integrates MEPRS data into the Squadron’s management audit and review processes.

2.7.2. Ensures that their staff comply with workload and timecard reporting suspenses.

2.8. The Medical Resource Management Function will:

2.8.1. Manage MEPRS program within the MTF. **(T-0)**

2.8.2. Ensure MEPRS program is adequately staffed; with an alternate Point of Contact (POC) appointed in writing. **(T-0)**

2.8.3. Provide accurate and timely data and ensure active participation in the MTF Data Quality Management Control Program (DQMCP). (**T-0**)

2.8.4. Ensure MEPRS Program Manager (MPM) and/or alternate attends a MEPRS Training class within the first year of assignment. **(T-0)**

2.8.5. Perform MEPRS data analysis and ensure ongoing feedback on performance measures to the Executive Committee. **(T-0)**

2.9. The MEPRS Program Manager will:

2.9.1. Be responsible for analysis and overall timely submission of validated MEPRS data, due 45 calendar days after the end of the reporting month. **(T-0)**

2.9.2. Provide mandatory training annually for the MEPRS work centers POCs with recurring training as needed. **(T-0)**

2.9.3. Coordinate with the Resource Advisor, 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 expenses) is accurate. **(T-0)**

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

2.9.5. Ensure 100% of timecard approval and demographic accuracy prior to generating the Defense Medical Human Resource System *internet* (DMHRS*i)* output file. Labor hours and salary are a critical data component depicting the AFMS level of effort, by which the DHP is reimbursed for healthcare activities. **(T-0)**

2.9.6. Complete reconciliation of financial, personnel and workload data in coordination with the appropriate personnel (T-0). Refer to the specific chapter for information on appropriate processes: financial - **Chapter 9**, personnel - **Chapter 7**, and workload - **Chapter 8**. More detailed information on these topics is contained in MEPRS Course Student Guide.

2.9.7. Review all data sets annually or as needed.

2.9.8. Attend Knowledge Sharing Sessions. **(T-1)**

2.9.9. Run the Composite Health Care System (CHCS) Inpatient/Outpatient Workload Reconciliation Report (IWRR/OWRR) and send it to the clinical timekeepers and timecard approvers bi-weekly to facilitate accurate time entry prior to submission and approval. **(T-1)**

2.9.10. Run the IWRR/OWRR for the entire inclusive dates of the data month and reconcile against the DMHRS*i* Summary View Report, as required during the DMHRS*i* End of Month process. **(T-0)** This aids the timekeepers with facilitating accurate reporting.

2.9.11. In conjunction with appropriate personnel ensure all systems' files and tables are updated and synchronized. **(T-0)** Data reconciliation ensures program compliance and accuracy in collecting, coding, and reporting workload, financial, and personnel data.

2.9.12. Ensure initial and ongoing training of all personnel in the mechanics of MEPRS data reporting. **(T-0)**

2.10. Flight Commanders.

2.10.1. Ensure a MEPRS/DMHRS*i* work center primary and alternate POCs are appointed in writing to act as a liaison with the MPM. **(T-0)** All work center POCs receive annual MEPRS/ DMHRS*i* training and refresher training as needed.

2.10.1.1. Ensure the MEPRS work center POCs are at least an E-5 or above for military personnel or GS-06 or above for civilian personnel. **(T-1)** A. waiver request for any exceptions to E-5/GS-06 must be approved by AFMRA MEPRS.

2.10.1.2. Please send the waiver request from the work center Flight Commander through the MPM to AFMRA MEPRS. **(T-1)**

2.10.1.3. In the waiver request explain the reason for the exception, state the proposed person's name and confirm the person is capable of added responsibility.

2.10.1.4. AFMRA MEPRS provides approval/disapproval and returns the request for the MPM's records. **(T-1)**

2.10.1.5. 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 (DMHRS*i*, workload or financial).

Note: It is crucial that the supervisors be involved with DMHRS*i* template development and the time/labor reporting process. In support of that requirement, the individual listed as the "Supervisor" in an individual's Human Resource (HR) record in DMHRS*i* receives a courtesy notification via DMHRS*i* worklist of the timecard their subordinate submitted each pay period.

2.10.2. Validate and approve all work center data collection processes for their Flights/Elements when required, but at least annually. **(T-1)**

2.10.3. Ensure that their staff have submitted their timecard or workload for the duration of the leave or temporary duty (TDY) PRIOR to going on leave or TDY. **(T-1)** Ensure that their staff comply with all sections of this instruction, but especially section **2.13**, as this data drives 70% of the total expenses reported by an MTF in support of their mission. **(T-1)**

2.11. The MEPRS Work Center POC or Alternate will:

2.11.1. Coordinate all work center specific issues concerning MEPRS, which includes workload, expenses and personnel time reporting. **(T-1)** They will forward all required workload reports to the MPM within three workdays after the end of the reporting month. **(T-1)** When an electronic submission is used, a local process is implemented to notify the MPM that the data has been validated and submitted. The work center POC ensures the accuracy of the workload for the productivity of their work center and the timely submission of the workload to the MPM. **(T-1)**

2.11.2. With assistance from the MPM work center POCs should only use accurate FCCs and provide work center specific task training as needed (personnel (DMHRS*i*), financial or workload).

2.12. The DMHRS*i* Work Center Timecard Approver or Alternate will:

2.12.1. Be responsible for ensuring all personnel (assigned, borrowed, contract or volunteer) within their work center completes their biweekly timecard in DMHRS*i*. **(T-1)** They must notify the DMHRS*i* HR Manager and the MPM, of all departures, arrivals, transfers, changes in demographic information and other pertinent data. **(T-1)**

2.12.2. Facilitate accurate labor hour reporting by clinical staff every pay period by utilizing the CHCS IWRR/OWRR, provided by the MPM. **(T-1)** The IWRR/OWRR contains workload by name, MEPRS code, and approximate number of minutes.

2.12.3. Facilitate accurate labor hour reporting on timecards for associated MEPRS codes, prior to staff submitting the timecard. **(T-1)** This maximizes reimbursement for the healthcare provided.

Note: Every attempt should be made to ensure all personnel have their timesheets in by Close of Business (CoB) Friday the last duty day of the pay period.

2.12.4. Ensure all personnel have their timecards in "SUBMITTED" status No Later Than (NLT) CoB the first duty day after timecard period ends (Monday). In conjunction with the MPM, they must approve or reject timecards NLT CoB the third duty day after timecard period ends (Wednesday). **(T-1)**

2.12.5. Personnel not expected to be at work on Monday (TDY/Leave) must submit their timecards prior to leaving the last duty day prior to their absence. **(T-1)**

2.12.6. If any personnel are not available to submit their timecard by the suspense date due to emergency leave, provide details to the MPM NLT the end of any timecard period so their labor hours can be manually submitted prior to the suspense date for the timecard period. **(T-1)**

2.12.7. Ensure all rejected timecards are corrected, re-submitted and approved NLT CoB the fifth duty day after the timecard period ends (Friday). **(T-1)**

2.12.8. Upon rejection of a timecard, they must immediately notify the individual that their timecard was rejected along with the reason for the rejection. **(T-1)**

2.12.9. Ensure all timecards are in 100% "APPROVED" status by CoB seventh duty day after the timecard period ends (second Tuesday). **(T-1)**

2.12.9.1. This is in support of DQMCP Questions 3c-DMHRS*i* Timecards Submitted and 3d-DMHRS*i* Timecards Approved, which has been updated to evaluate each pay period separately.

2.12.9.2. Civilian timecards are reconciled the weekend after the timecard period ends (Saturday) with the Defense Civilian Pay System (DCPS) pay file, unless exempt from reconciliation, the total hours must match the time reported on their DCPS timecard or the DMHRS*i* timecards are rejected. **(T-1)** All civilian rejected timecards must immediately be corrected, re-submitted and approved within two duty days (Tuesday, the tenth calendar day after pay period ends). **(T-1)**

2.12.9.3. AFMRA MEPRS extracts DMHRS*i* submitted compliance metrics on the third calendar day (Tuesday) after each pay period ends, and extract DMHRS*i* approved compliance on the eleventh calendar day (Wednesday) after each pay period ends.

Note: Overall responsibility for reporting MEPRS data (e.g., DMHRS*i*, expenses and workload) lies with the Squadron Commanders or equivalent, as designated by the MTF Commander or Director.

2.13. All Personnel Working at or Assigned to the MTF During the Timecard Period will: Accurately report their hours in DMHRS*i* NLT CoB the first duty day after timecard period ends (Monday). **(T-1)** If there is any reason that the employee is unavailable during the day of required submission, they should ensure their timecard is filled out prior to the absence (TDY, Leave, Detail, etc.). Actual hours are reported for work performed inside and outside the MTF in support of the mission. There is no hour reporting constraint (e.g., 168 a month or 80 hours per pay period). The only exception is Civil Service personnel refer to **para 7.2.2.2** A full explanation of the business rules regarding the reporting of DMHRS*i* time is found in the DMHRS*i* Air Force End of Month Processing Guide and DHA-PM 6010.13.

Note: Every attempt should be made to ensure all personnel have their timesheets in by CoB Friday the last duty day of the pay period.

Note: It is crucial that the supervisors be involved with DMHRS*i* template development and the time/labor reporting process. In support of that requirement, the individual listed as the "Supervisor" in an individual's HR record in DMHRS*i* receives a courtesy notification via DMHRS*i* worklist of the timecard their subordinate submitted each pay period.

2.14. Resource Advisor (RA) will: assist the MPM in resolving any financial data inconsistencies/problems and advise on all errors and required corrections to the financial data. **(T-1)** They also coordinate on the financial reconciliation process.

2.15. The Data Quality Manager (DQM):

2.15.1. Is appointed and is familiar with responsibilities outlined in DoDI 6040.40, *Military Health System (MHS) Data Quality Management Control (DQMC) Program*, and DHA-PM 6010.13. **(T-0)**

2.15.2. Is crucial in aiding the resolution of any data inconsistencies/problems within the MTF.

2.15.3. Will aid in addressing workload discrepancies identified by the MPM that are referred to the work center POC for resolution, with notification made to the DQM. **(T-1)**

2.16. The Group Practice Manager (GPM) will:

2.16.1. Review all clinic and provider profiles annually, and as needed. **(T-1)**

2.16.2. Aid in resolving workload discrepancies identified by the MPM are 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 AFMRA MEPRS.

3.1.1. In accordance with DHA-PM 6010.13, Volume 1, enclosure 3, section 7, all unresolved issues, along with comments and proposed resolution are forwarded to AFMRA ATTN AF MEPRS Program Manager, AFMRA/SG1/8YB.

3.1.2. AFMRA/SG1/8YB logs and reviews all guidance issues for duplication, conformity to MEPRS principles, clarity, and completeness. The AF MEPRS Program Manager coordinates with the appropriate Air Force Consultant(s). Feedback is provided to AFMRA MEPRS Manager for distribution to the MTFs.

Chapter 4

DATA SUBMISSION

4.1. Data Submission Suspense.

4.1.1. Each Air Force Fixed MTF is required to submit MEPRS data monthly, 45 calendar days after the end of the data month. **(T-0)** 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 Defense Medical Information System Identification (DMIS ID) may be used (when authorized) to further granulate data.

4.1.2. The MPM at each reporting facility will forward the monthly MEPRS files to the EASIV*i* Repository after validation, reconciliation and allocation have been completed, no later than 45 calendar days after the close of the reporting month. **(T-0)** If later than 45 calendar days, annotate the reason for delinquency on the Data Quality Statement. **(T-0)**

4.1.3. Refer to the current Fiscal Year's (FY) MEPRS Processing Timeline Matrix for specific completion timelines.

4.2. Reports Required for Monthly Backup.

4.2.1. At a minimum, the following monthly reports are saved electronically using the following naming conventions: **(T-1)**

4.2.1.1. Expense Allocated Report - Exp Allocated MoYr_DMIS ID (Allocation Verification folder). **(T-1)**

4.2.1.2. Personnel Allocated Report - Pers Allocated MoYr_DMIS ID (Allocation Verification folder). **(T-1)**

4.2.1.3. Cost Table Report - Cost Tbl Rpt MoYr_DMIS ID (Standard Reports folder). **(T-1)**

4.2.1.4. Personnel Detailed Report - Pers Det MoYr_DMIS ID (Standard Reports folder). **(T-1)**

4.2.1.5. Financial Pure Data Rpt - Pure Fin MoYr_DMIS ID (System Interfaces folder). **(T-1)**

4.2.1.6. Financial Audit Report by Fiscal Year and Month - Fin Audit MoYr_DMIS ID (Data Audit folder). **(T-1)**

4.2.2. Monthly data should be saved and retained for five years. If corrections are made, ensure the newly corrected dated and signed files are saved.

4.3. Ambulatory Care Units (ACUs).

4.3.1. ACUs perform a medical mission to line personnel, using non-(Defense Health Program) (DHP) dollars, in multiple product lines (physical therapy, mental health and possibly some minimal primary care). This function allows line units to save time from going to the MTF for routine ongoing medical care thus allowing line missions to continue with minimal interruption.

4.3.2. These units are required to have their own Defense Medical Information Systems Identification (DMIS ID), identified as LN-CLN, they are a parent DMIS IDs, they are not a subordinate (child) of the MTF, as they are expending line resources not DHP resources.

4.3.3. ACUs are not expected to perform a monthly DQ statement; however they receive DQ evaluation and provider training from the local MTF.

4.3.4. If the ACU medical staff do come to the MTF to perform medical care they are expected to fill out a DMHRSi Timecard. These personnel should be set up in DMHRSi as hourly employees so they would only have to report time directly in support of the medical care they are providing in the MTF, not the care they are providing in the ACU location.

Chapter 5

MEPRS CODING

5.1. The Basic Coding Approach.

5.1.1. 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.

A-Inpatient Care	B-Ambulatory Care	C-Dental Care	D-Ancillary Services
E-Support Services	F-Special Programs	G-Medical Readiness	

5.1.2. 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.

Functional Category	**Summary Account**
A-Inpatient Care	AA-Medical Care
	AB-Surgical Care
	AC-Obstetrical and Gynecological Care
	AD-Pediatric Care
	AE-Orthopedic Care
	AF-Psychiatric Care
	AG-Family Medicine Care
B-Ambulatory Care	BA-Medical Care
	BB-Surgical Care
	BC-Obstetrical & Gynecological Care
	BD-Pediatric Care
	BE-Orthopedic Care
Functional Category	**Summary Account**
	BF-Psychiatric and/or Mental Health Care
	BG-Family Medicine Care
	BH-Primary Care
	BI-Emergency Medicine
	BJ-Flight Medicine
	BL-Physical Therapy

Note: Not a complete list, refer to DHA-PM 6010.13.

5.1.3. 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 FCCs is provided by the Air Force MEPRS Program Manager annually.

Table 5.3. MEPRS Sub Accounts.

Functional Category	Summary Account	Sub Account
A-Inpatient Care	AD-Pediatric Care	ADAA-Pediatrics
		ADBA-Nursery
B-Ambulatory Care	BG-Family Medicine Clinic	BGAB-AFMH-Non-AD
		BGAH-AFMH-GME

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. The following criteria listed below needs to be met before establishing a work center and assigning an FCC. It should:

5.2.1. The work center is identified as the physical location where care is performed. Any care provided in this location would be reported as care to this FCC. (I.e. visiting sub specialists would report in the location, regardless of the type of care they are providing).

5.2.2. Have compatibility with the Unit Manning Document (UMD) or other allocated manpower (e.g., contractors).

5.2.3. Have identifiable expenses (Supplies/Equipment/Contracts/Salaries).

5.2.4. Have allocated physical space and operate 16 hours or more each month.

5.2.5. Have valid production (count/code) as defined by DHA-PM 6010.13 or an AF special interest program (**Attachment 2**).

5.2.6. Have a uniqueness of service provided or expenses incurred when compared to other established work centers.

5.2.7. Have Executive Leadership coordination.

5.2.8. Coordinate with AFMRA MEPRS for any clarification.

5.2.9. FCCs not listed on the AF Account Subset Definition (ASD) or Program Element Mapping (PEMAP) should not be entered into CHCS/ Armed Forces Health Longitudinal Technology Application (AHLTA) or other systems without approval from AFMRA MEPRS.

5.3. Establishing Functional Cost Codes.

5.3.1. A work center is made in coordination with basic coding guidance. FCCs and related data, as defined in the ASD, form the basis for cost allocation and MEPRS reporting.

5.3.2. First determine if the new work center meets the above requirements as stated in **para 5.2**

5.3.3. No FCCs are used in CHCS/AHLTA, DMHRSi, EASIV*i* or any other approved Military Health System (MHS) data system, without AFMRA MEPRS approval. **(T-1)** The CHCS Administrator, in coordination with the MPM, ensures only approved FCCs are used in the CHCS Files/Tables. **(T-1)**

Note: MHS GENESIS is driving some changes in MEPRS reporting, and would override any policy outlined in this document.

5.4. Account Subset Definition (ASD).

5.4.1. The 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 **Table 8.2** in this instruction for more information on Data Set usage). AFMRA MEPRS will validate all facilities' ASD annually. **(T-1)**

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

5.4.3. During budget preparation for new FY, the MTF RA, Manpower Manager, MPM, and Logistics Office coordinates work center RC/CCs and FCCs or Functional Account Codes (FACs). The addition or deletion of work centers or FCCs are coordinated with each affected area to ensure proper allocation of data. This occurs following the close out of the third quarter.

5.4.4. Following in-house coordination, the MTF must submit the coordinated ASD to AFMRA MEPRS for review and approval. **(T-1)**

Note: Brief all changes during DQ, Executive Committee and Cost Center Manager meetings to ensure widest possible dissemination.

5.4.5. Coordinate with systems administrators to ensure the accuracy of tables located in CHCS/AHLTA and Defense Medical Logistics Standard Support (DMLSS) or any other system(s) that interface with or provide data to EASIV*i*.

5.4.6. DHA-PM 6010.13 is the master document used to ensure FCCs reflects the correct workload capture and expense assignment. RC/CCs and FACs are matched to FCCs as outlined in the PEMAP spreadsheet. All FCCs and RC/CCs used by the RA, Manpower Manager, and Logistics Office should reflect the same information. The PEMAP is published annually by AFMRA/SG1/8YB, who validates appropriate FCC, RC/CC, Program Element Code (PEC), and 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.

Note: The PEMAP is frequently updated throughout the year so always ensure to work with the most current version. Refer to Knowledge Exchange-MEPRS Documents page for the most accurate information.

5.5. Cost Pool "X" Codes.

5.5.1. Cost Pools 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 Medicine 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, for example, the code for Family Practice Teams B (BGAB) and E (BGAE) cost pool would be "BGXA". Assign all shared personnel

and expenses (e.g., supply costs, square footage, linen, etc.) to the cost pool code. Those accumulated costs are distributed from the cost pool to the clinics within the cost pool based on workload for each product line 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: Cost pools are not used in MHS GENESIS

5.5.2. Clinicians are never assigned to, or able to charge time against cost pool codes.

5.5.3. 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.

5.6.1. **Attachment 2** contains unique Air Force account codes.

5.6.2. Air Force MTFs are not authorized to use the FCCs in **Table 5.4** these codes may be valid in DHA-PM 6010.13, but not for use in AF Reporting.

Table 5.4. MEPRS Codes Not Used In AF Reporting.

AAN-Physical Medicine	ABJ-Proctology	ABL-Organ Transplant
ABM-Burn Unit	AFB-Substance Abuse Rehab	AGE-Family Practice GYN
AGG-Family Practice Ortho	BAR-Physical Medicine	BBE-Organ Transplant
BBN-Burn Clinic	BCA-Family Planning	BCD-Breast Care
BHA-Primary Care	BHF-Community Health	FAA-Area Reference Labs
BKA-Undersea Medicine	EDH-Fire Protection	EDI-Police Protection
FAA-Area Reference Labs	FAC-Ophthalmic Fabrication	FBC-Industrial Hygiene
FBD-Radiation Health	FDB-Base Operations	FDD-Decedent Affairs
FEC-Transient Patient Care		

5.6.3. These codes are aligned with other product lines. If this work is performed in AF facilities, refer to AFMRA MEPRS for specific guidance.

5.6.4. Third level "Z" Not Elsewhere Classified codes may only be used with approved DHA waiver.

Chapter 6

TABLE MAINTENANCE

6.1. Tables Used Within the EASIV*i* System. Ensure personnel, financial and workload data are properly identified and aligned for correct cost allocation. **(T-1)** All EASIV*i* and associated system tables are reviewed and updated at least annually. **(T-1)**

6.2. AFMRA/SG1/8YB: Will review and update the master tables at least annually but also as needed throughout the year. **(T-1)**

6.3. MTF MPMs will:

6.3.1. Keep the tables in EASIV*i* updated to reflect current year activities. **(T-0)**

6.3.2. Ensure ASD Table changes are made prior to each fiscal year, and when appropriate throughout the year, following AFMRA MEPRS approval. **(T-0)**

6.3.3. Approve all FCCs (with AFMRA MEPRS authorization) in use at the MTF. **(T-0)**

6.3.4. No FCCs are used in CHCS/AHLTA, DMHRS*i*, EASIV*i* or any other approved MHS data system, without AFMRA MEPRS approval. **(T-1)** The CHCS Administrator, in coordination with the MPM, ensures only approved FCCs are used in the CHCS Files/Tables. **(T-1)**

6.3.5. Ensure approved FCCs are used appropriately in the CHCS File/Table structure. Non-approved FCCs are identified and appropriate corrective actions are coordinated by the DQ Assurance Team. **(T-0)**

6.3.6. Reconcile the EASIV*i* ASD Table with DMHRS*i* and the CHCS Site Definable MEPRS Table prior to the annual FY update, and where necessary throughout the year. **(T-0)**

6.3.7. Complete an annual review of users who have access to add, edit or delete FCCs in CHCS, with support from the CHCS Administrator. **(T-0)**

Chapter 7

PERSONNEL UTILIZATION AND SALARY EXPENSE DATA

7.1. Time and Salary Reporting.

7.1.1. 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. DMHRS*i* is the required system to capture this information and provide it to MEPRS. Refer to **para 7.10** for a more detailed background of the DMHRS*i* system.

Note: It is crucial for the supervisors be involved with DMHRS*i* template development and the time/labor reporting process. In support of that requirement, DMHRS*i* provides a notification via DMHRS*i* work list to the "Supervisor" listed in the individual's HR record each pay period.

7.1.2. Personnel data generally include both salary and FTEs. MEPRS defines 168 hours as one FTE. Please refer to **para 2.11** and **2.12** for the responsibilities of the work center MEPRS and DMHRSi POCs.

7.1.3. There are a wide variety of helpful time reporting tools to review for more detailed time reporting requirements, such as the MEPRS Time Reporting Matrix, DMHRS*i* AF End of Month Processing Guide, and DHA-PM 6010.13 Volume 1 Appendix 3.

7.1.4. All personnel working at the MTF during the timecard pay period will accurately report their hours in DMHRS*i* NLT CoB the first duty day after timecard period ends (Monday). **(T-1)** Actual hours should be reported for work performed inside and outside the MTF in support of the mission. There is no hour reporting constraint (e.g., 168 a month or 80 hours per pay period). The only exception is Civil Service personnel. Refer to **para 7.2.2.2** or to the DMHRS*i* AF End of Month Processing Guide for more definitive instruction.

7.1.5. AFMRA MEPRS will extract DMHRS*i* submitted compliance on the third calendar day (Tuesday) after each pay period ends, **(T-1)** and extract DMHRS*i* approved compliance on the eleventh calendar day (second Wednesday) after each pay period ends.

7.2. Timecard Submission Guidelines.

7.2.1. All Personnel must have their timecards in “SUBMITTED” status NLT CoB the first duty day after timecard period ends (Monday), if the employee is unavailable on this day the data must be input prior to their departure (TDY, leave, detail etc.). **(T-1)** Timecard Approvers in conjunction with the MPM must approve or reject timecards NLT CoB the third duty day after timecard period ends (Wednesday). **(T-1)** All rejected timecards are corrected, re-submitted and approved NLT CoB the fifth duty day after the timecard period ends (Friday). **(T-1)** Upon rejection of a timecard, timecard approvers must immediately notify the individual that their timecard was rejected along with the reason for the rejection. **(T-1)** All timecards must be in 100% “APPROVED” status by CoB seventh duty day after the close of the timecard period (second Tuesday). **(T-1)** This is in support of DQMCP Questions 3c-DMHRS*i* Timecards Submitted & 3d-DMHRS*i* Timecards Approved, which has been updated to evaluate each pay period separately.

7.2.2. Actual Hours in support of the mission should be reported in the appropriate 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. The following personnel are required to submit timecards:

7.2.2.1. United States RegAF personnel assigned and borrowed (e.g., manning assistance) to the facility; to include assigned personnel loaned to a non-MEPRS reporting facility (line or civilian medical facility). **(T-1)**

7.2.2.2. Federal civilian employee assigned or borrowed to the facility. Hours reported by civil service personnel are reconciled with the DCPS pay file and must match time reported on their DCPS timecard. **(T-1)**

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.

7.2.2.3. Foreign national employees (direct and indirect hire) paid from appropriated funds. **(T-1)**

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.

7.2.2.4. Military medical program students (e.g., phase II, interns, residents, etc.) working in or assigned to the facility to complete training requirements. **(T-1)**

7.2.2.5. Contractors working in the facility. **(T-1)** Contractors will submit only available hours (FTEs). Salary expenses (financial compensation) is reflected in the financial system. **(T-1)**

7.2.2.5.1. If the contract does not require personnel to report the number of work hours, the work center POC will refer to the Contract Officer's Representative (COR) to determine the hours worked based on the statement of work and submit the available contract hours. **(T-1)**

7.2.2.5.2. *Do not include day workers in the facility that is covered by a service contract (e.g., Copier Repair, or base Civil Engineer personnel).* **(T-1)** *These personnel are considered part of the services paid by the contract.*

7.2.2.6. Reserve, Air National Guard personnel assigned to serve their tour at the facility should report accounting according to this instruction. **(T-1)**

7.2.2.7. Patient squadron personnel who are RegAF members assigned to the patient squadron may help within the facility and their time is captured as borrowed personnel. Members of the patient squadron document their appropriate grade/rank but are assigned occupation codes that define the work that they are supporting.

7.2.2.8. Borrowed personnel from outside the facility (not on the MTF UMD) will report their time and salary to the work centers they are supporting. **(T-0)** 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 FCC FCGC for non-MTF activity. The total time they report should represent the total amount of time they worked during the reporting month.

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

7.2.2.8.2. Borrowed personnel will report time, until they are no longer performing recurring duties in the facility. **(T-0)**

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

7.2.2.9. Volunteers only report available hours as there is no salary compensation; included as volunteers are students (externs) under a Memorandum of Understanding with local colleges or facility programs such as Red Cross, dental assistants or pharmacy students, etc.

7.2.2.10. All non-DHP employees working in non-DHP programs such as Family Advocacy (FCC FASF) or exceptional family member program (FCC FAZN) or domestic abuse victim advocate (FCC FASF) will report their time utilizing the appropriate Code. **(T-1)**

7.3. Collect Time Until the Member is No Longer Assigned.

7.3.1. Military, civilians, contractors, or volunteers working (assigned or borrowed) in the MTF will report time in DMHRS*i*. **(T-0)**

7.3.2. When personnel out process for a Permanent Change of Station (PCS), retirement, or separation, report their time following their departure from the facility to the day before the day they are expected to sign into the new duty station, retirement date or separation date (to include terminal leave) to FCC FDGA-PCS/Estimated Time of Separation (ETS) Related Functions.

7.3.3. The time spent attending out-processing appointments, to include terminal leave is charged to FCC FDGA-PCS/ETS Related Functions.

7.3.4. For personnel who are absent without leave, to include incarceration, continue to collect time for only the first 30 calendar days. If the individual(s) are gone for longer than 30 calendar days, depart them from the facility.

7.3.5. Personnel attending school are captured in FCC FALA-Continuing Education to include travel.

7.3.6. Personnel attending Professional Military Education are captured in GBAA-Readiness Training to include travel.

7.3.7. 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; the purpose of DMHRS*i* is to appropriately allocate the salary to the work produced.

7.3.8. Time is not captured or reported for civilian employees paid from non-appropriated funds or direct and indirect hire foreign national employees in an unpaid absence status.

7.3.9. Civilians on leave without pay report their time in DMHRS*i* under task code 02.04. The timecard is rejected in DMHRS*i*, during reconciliation, if hours are not entered to match the civilian pay timecard.

7.4. The MPM will be Responsible for Importing the DMHRS*i* DoD EASIV*i* Create File into EASIV*i*. (T-1) Note: Refer to the DMHRS*i* AF End of Month Processing Guide for step by step instructions.

7.5. Full Time Equivalents (FTEs).

7.5.1. The three types of FTE data are assigned, available, and non-available. DHA-PM 6010.13, Volume 1 Appendix 3, defines the use of available and non-available time and standard business rules.

7.5.2. Available FTEs are based on hours worked. Available FTEs are calculated by dividing available hours in a given work center by 168 (one 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 payroll timecard should always match what is reported in DMHRS*i*.

7.5.3. Military personnel report all hours spent in support of mission requirements, including work performed at home. **(T-1)** Civilian personnel report approved overtime/compensatory time. **(T-1)**

7.5.4. Assigned FTEs are based on the actual number of calendar days during each month an individual is assigned to the MTF. Assigned FTEs are not based on hours; rather it is the percentage of time actually assigned to a work center any given month.

7.5.5. Non-available FTEs include leave, sick (quarters/hospital admission/medical appointments), and military other (RegAF only).

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

7.6. Military Salaries. Are standardized rates based on composites of all pay, allowances, and entitlements updated annually (in accordance with AFI 65-503, *U.S. Air Force Cost and Planning Factors*). Grade/salary tables for military are provided to DMHRS*i* annually from the Air Force MEPRS Program Manager.

7.7. Civilian Salaries. Are provided to DMHRS*i* by an interface with DCPS. Local personnel use the Automated Time Attendance and Production System to actually report their work hours for pay purposes.

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 is distributed. For example, if monthly salary is $2,500.00 and the hours reported are 160 available and 32 non-available, the total FTEs would be 1.14. The amount distributed would still be $2,500.00.

7.10. Method of Data Collection.

7.10.1. DMHRS*i* is the directed methodology of personnel time capture.

7.10.2. The MHS, in fulfilling a Deputy Secretary of Defense mandate to simplify and centralize medical personnel asset visibility, has chosen DMHRS*i*, is an integrated human resource management system. DMHRS*i* is intended to provide the MHS with an automated information system integrating HR data from multiple information sources and allows real-time access to essential Manpower, HR, Labor Cost Assignment (LCA), education and training, and Readiness information across the MHS.

7.10.3. The Deputy Surgeon General has mandated the use of the LCA, HR, and Manpower modules. The single most important factor for the Air Force is that DMHRS*i* serves as a source system for manpower, HR and readiness. The primary need for DMHRS*i* within the AFMS is to support functional processes for LCA, the critical labor source feed for 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: RegAF, 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 RegAF, guard, and reserve personnel is fed from the Military Personnel Data System. Likewise, data for government civilian service personnel and local national personnel is fed from the Defense Civilian Personnel Data System. Personnel data for contractors and volunteers are manually entered.

7.10.6. The responsibility of personnel at each site is to effectively manage and update the DMHRS*i* 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 personnel perform record maintenance tasks and maintain the 18 essential data elements, as outlined in the DMHRS*i* CONOPS and the DMHRS*i* Air Force End of Month Processing Guide.

7.10.7. The LCA, HR, and Manpower integrated management of DMHRS*i* is critical and should be part of the Data Quality Assurance Team. Thus ensuring it is used to its fullest potential, fostering communication between functional areas, and recommending process changes to the MTF/CC.

Chapter 8

DATA SETS (WORKLOAD)

8.1. The Data Set (Workload).

8.1.1. The data set 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**.**

8.1.2. Workload is captured in a data set that is used for allocation to quantify the amount of work accomplished by a work center. DHA-PM 6010.13 defines specific allocation factors for the various workload data. Air Force guidance and procedures 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 database administrator(s), and the MPM is crucial in establishing local workload validation procedures. The GPM must be an integral part of all workload-capturing clinical processes. **(T-1)**

8.1.3. All workload factors are covered in this document. Not all work centers documented on the master ASD File are used by all facilities. The UMD is the starting point to determine which codes should be reported in the system. For further guidance contact AFMRA MEPRS.

8.1.4. Coordinate with appropriate work center personnel to determine the most efficient and effective means of acquiring the manually collected workload data. Implement additional procedures required by MEPRS reporting requirements as necessary.

8.1.5. If a work center closes, contact AFMRA MEPRS for appropriate actions.

8.1.6. 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 specific service.

8.1.7. **Table 8.1** is the automated and manually generated data set standard table and reflects how data is input into EASIV*i*. S indicates system-generated data and M indicates data that is manually tracked and input to EASIV*i*. For system-generated data, the Workload Assignment Module (WAM) is used. Automated workload captured in CHCS is transmitted via the WAM for use in the EASIV*i* System. The CHCS data is summarized for entry into EASIV*i* using generated reports in WAM, and is validated prior to transmission to EASIV*i*.

Table 8.1. Data Set Standard Table.

DATA SET ID	DATA SET DESCRIPTION	INPUT METHOD INDICATOR
OBDs	OCCUPIED BED DAYS	S-CHCS
ADMs	ADMISSIONS	S-CHCS
DISPs	DISPOSITIONS	S-CHCS
OUTPT VISITS	OUTPATIENT VISITS	S-CHCS

TOTAL VISITS	TOTAL VISITS	S-CHCS
DENTAL WTD PROC	DENTAL WEIGHTED PROCEDURES	M-Manual
SQ FT	SQUARE FOOTAGE	M-Manual
EIA MEALS	MEALS SERVED	M-Manual
EIB MEALS	MEALS SERVED	M-Manual
WTD NUTR PROCS	WEIGHTED NUTRITIONAL PROCEDURES	M-Manual
F ACCOUNTS-RAW	SPECIAL PROGRAM ACCOUNTS-RAW	M-Manual
F ACCOUNTS-WTD	SPECIAL PROGRAM ACCOUNTS-WTD	M-Manual
G ACCOUNTS	MEDICAL READINESS ACCOUNTS	M-Manual
SQ FT CLEANED	SQUARE FOOTAGE CLEANED	M-Manual
AMB WTD PROC	AMBULATORY WEIGHTED PROCEDURES	S-CHCS
DAA*/####	PHARMACY WEIGHTED PROCEDURES	S-CHCS
DBA*/DBD*/DBE*/###	LABORATORY WEIGHTED PROCEDURES	S-CHCS
DBB*/####	LABORATORY WEIGHTED PROCEDURES	M-Manual
DCA*/DIA*/####	RADIOLOGY/NUCLEAR MEDICINE WTD	S-CHCS
DDE*/####	CARDIAC CATHERIZATION WTD	M-Manual
DEA*/####	CENTERAL STERILE SUPPLY HOURS	M-Manual
DFA*/DFB*/DFC*/####	ANESTHESIOLOGY/ SURGICAL SUITE/ POST ANESTHESIOLOGY MINUTES OF SERVICE	M-Manual
DGA*/####	AMBULATORY PROCEDURE UNIT MOS	S-CHCS
DGB*/DGD*/####	DIALYSIS MINUTES OF SERVICE	M-Manual
DGE*/####	AMBULATORY NURSING SERVICES MOS	M-Manual
DHA*	RESPIRATORY/PULMONARY WTD	M-Manual
DJ**/####	INTENSIVE CARE UNIT HOURS OF SERVICE	M-Manual
EDG*/####	TRANSPORTATION MILES DRIVEN	M-Manual
EEA*/####	LOGISTICS $ VALUE OF SUPPLIES/EQUIP	M-Manual
EGA*./####	BIOMEDICAL EQUIPMENT REPAIR HOURS	M-Manual
EHA*/####	POUNDS OF LAUNDRY	M-Manual

Note: * Identifies valid FCCs, #### Identifies appropriate DMIS ID for reporting facility

8.2. Data Sets are used for Allocation and Purification.

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

8.2.2. Purification is defined as the cost assignment of cost pool (##X#) accounts.

8.2.3. Refer to **Table 8.2:** Data Set Business Rules, and other guidance supplied by AFMRA/ SG1/8YB to ensure accurate reporting. Coordinate with appropriate work center personnel to determine the most efficient and effective means of acquiring the manually collected workload data. Implement additional procedures required by MEPRS reporting requirements as necessary.

8.2.4. **Table 8.2:** Represents all data sets used in EASIV*i*. It also identifies the workload factor indicator and the FCCs allowed/not allowed on the Data Sets as well as identify data elements that can be edited. Not all codes are used by all MTFs.

Table 8.2. Data Set Business Rules.

Data Set Business Rules					
Data Set Br Id	**Data Set Business Rule Description**	**Data Set Indicator**	**FCC Include**	**FCC Exclude**	**Editable Indicator**
##01	OBDs, DISPs, ADMs	RAW	A%	__X_	Y
##02	INPATIENT COST POOLS	RAW, WTD	A%, B%, C%, FC%	__X_	Y
##05	VISITS	RAW	B%, FBN%	__X_	Y
##06	DENTAL	WTD	C%	__X_	Y
##07	WTD PROC WITH COST POOLS - DAA%	RAW, WTD	A%, B%, C%, D%, F%, __X_	E%	Y
##08	DCA%, DBB%, DBD%, DBE%, DBF%	RAW, WTD	A%, B%, C%, D%, F%	__X_, G%	Y
##11	DDE%	RAW,WTD	A%, B%, FB%,FC%	__X_	Y
##14	DEA%	WTD	A%, B%, C%, D%, F%, __X_	E%, G%	Y
##15	DF%	RAW,WTD	A%, B%, CA%, FC%	__X_	Y
##16	DGA%	RAW,WTD	A%, B%, CA%, FC%	__X_	Y
##17	DGB%	RAW,WTD	A%, B%, FC%	__X_	Y
##18	DGD%	RAW,WTD	A%, B%, FC%	__X_	Y
##19	DGE%	RAW,WTD	A%, B%, CA%, FC%	__X_	Y
##20	DHA%	RAW,WTD	A%, B%, C%, FB%, FC%, FE%	__X_	Y
##21	DIA%	RAW,WTD	A%, B%, C%, FB%, FC%	__X_	Y
##22	DJA%, DJB%, DJD%	RAW	A%, B%,FC%	__X_	Y
##24	EEA%	WTD	A%, B%, C%, D%, E%, F%, G%, __X_		Y
##25	EBD%	WTD	A%, B%, C%, D%, EBF%, F%	__X_	Y
##26	EBE%	WTD	A%, B%, D%, E%, F%	__X_	Y
##27	EBH%	RAW	A%, B%, C%, D%, F%,	__X_	Y
##28	EBI%	WTD	ABF%, C%, F%	__X_	Y
##29	EGA%	WTD	A%, B%, C%, D%, E%, F%, G%, __X_		Y
Data Set Br Id	**Data Set Business Rule Description**	**Data Set Indicator**	**FCC Include**	**FCC Exclude**	**Editable Indicator**
##30	EIA%	WTD	A%, B%, C%, FEF	_X_, ADB, AGH	Y
##31	EIB%	WTD	EIA%, FDC%	__X_	Y
##33	EL%	WTD	A%, B%, C%, D%, F%	E%, G%, __X_	Y
##34	ALL CODES	RAW	A%, B%, C%, D%, E%, F%, G%, __X_		Y
##35	ALL CODES	RAW	A%, B%, C%, D%, E%, F%, G%	__X_	Y

##36	F ACCT RAW PROC	RAW	FAF_, FBI_, FBJ_, FBK_, FEA_, FEF_	FAB, FBE, FBL, FBN,FDH, FDI_, __X_	Y
##38	F ACCT WTD PROC	WTD	FAB_, __X_	A%,B%,C%, D%,E%, FAF, FBE, FBI, FBJ, FBK, FBN,FDC, FDH, FDI, FEA, FEF, G%	Y
##39	DENTAL DEPRECIATION	RAW	C%	__X_	Y
##40	SPECIAL PROGRAMS DEPRECIATION	RAW	F%	__X_	Y
##41	STD FTE & GENERIC AMOUNT COST POOLS - E, F, & G	WTD	A%, B%, C%, D%, E%, F%, G%	__X_	Y
##42	READINESS DEPRECIATION	RAW	G%	__X_	Y
##43	WTD PROC WITH COST POOLS - DBA%	RAW,WTD	A%, B%, C%, D%, F%, __X_	E%	Y

Note: ## identifies FY-FY20 would be Br Id 2001 for OBDs.

8.3. 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. **(T-0)** Significant workload inconsistencies are corrected at the data source by the work center and EASIV*i* is updated accordingly. Contact AFMRA MEPRS for guidance.

8.4. Work Center Specific Workload Validation.

8.4.1. Workload reconciliation is a monthly requirement to be performed by the MPM. To reconcile, compare the Monthly Statistical Report and the WAM reports. Both data sets represent data as of the point in time when the reports are generated and therefore may be different. Anomalies are reported to the DQM and GPMs.

Note: If end of day processing has not been accomplished, the *End-of-Day Delinquency Report* prints instead of the *Monthly Statistical Report.* The Biometric Data Quality Assurance Service Worldwide Workload Report (WWR) suspense for inpatient facilities only is due no later than the fifth duty day after the month has ended, and WAM is usually generated later in the month.

8.4.2. 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 care provider. 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.

Performance Factors: Admissions (ADMs), Occupied Bed Days (OBDs), Dispositions (DISPs), Relative Weighted Products, Diagnosis Related Groups, and Relative Case Mix Index.

8.4.3. 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 falls 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*i*) are reported in the clinic where resources were consumed. Refer to the AFMS workload guidelines. All workload should have corresponding FTEs and expenses**.**

Performance Factors: Total Visits, Outpatient Visits and Relative Value Units.

8.4.4. Dental Workload (C Accounts). The MPM receives the monthly Dental Weighted Values (DWVs) and the Composite Time Values (CTVs) from AFMRA MEPRS. Ensure the workload has corresponding FTEs and expenses.

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

Note: Dental workload is provided to AFMRA MEPRS from the command dental activity, and should be the same data that is provided via the Base Dental Summary Report.

8.4.5. Ancillary Services (D Accounts). Workload data reported within the ancillary data sets are 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 EASIV*i* ancillary data sets.

8.4.5.1. Pharmacy (DA). Ensure requesting work centers are accurately reported by reviewing workload products for invalid codes and coordinate with the CHCS Database Administrator to evaluate these codes in CHCS annually. Ensure the workload has corresponding FTEs and expenses. Use the PHR MEPRS group report to validate pharmacy workload reported. In coordination with Pharmacy personnel resolve any exceptions identified on the PHR workload exception report.

Performance Factors: Raw-Number of Scripts; Weighted-Weighted Value of Scripts.

Note: Prescriptions provided to a discharged patient during hospital release should be charged to the ambulatory FCC, not the Inpatient code (e.g., an internal medicine patient (AAAA), should have their prescriptions charged to BAA* not AAAA, based on the Air Force Medical Home (AFMH) Team code of the attending provider).

8.4.5.2. 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. In coordination with laboratory personnel resolve any exceptions identified on the laboratory workload exception report.

Performance Factor: Raw-Number of Procedures; Weighted- Current Procedural Terminology (CPT) Value of Tests Performed.
Allocation Methodology: Weighted-Value of Tests Performed.

8.4.5.3. 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.

Performance Factor: Raw-Number of Procedures; Weighted-CPT Value of Tests Performed.
Allocation Methodology: Weighted-Value of Tests Performed.

8.4.5.4. 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. In coordination with radiology personnel resolve any exceptions identified on the radiology workload exception report.

Performance Factor: Raw-Number of Procedures; Weighted-CPT Value of Tests Performed.
Allocation Methodology: Weighted-Value of Tests Performed.

8.4.5.5. Cardiac Catheterization (DDE). 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.

Performance Factor: Raw-Number of Tests; Weighted-CPT Value of Tests Performed.
Allocation Methodology: Weighted-Value of Tests Performed.

8.4.5.6. Sleep Lab (DDZ). 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.

Performance Factor: Raw-Number of Tests; Weighted-Minutes of Service.
Allocation Methodology: Weighted-Minutes of Service.

8.4.5.7. Inhalation Respiratory Therapy (DHA). Ensure requesting work centers workload is accurately reported. Ensure the workload has corresponding FTEs and expenses. EASIV*i* requires entry of raw number of cases by CPT Code and automatically calculates

Performance Factor: Raw-Number of Cases; Weighted- CPT Value of Tests Performed.
Allocation Methodology: Weighted-Value of Tests Performed.

8.4.5.8. 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 DHA-PM 6010.13 for guidance. Ensure the workload has corresponding FTEs and expenses.

Performance Factor: Weighted-Hours of Service.
Allocation Methodology: Hours of Service.

Note: Several smaller facilities have incorporated the Central Sterile Supply (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 AFMRA MEPRS for further guidance.

8.4.5.9. Anesthesia (DFA), Surgical Suite (DFB), Post Anesthesia Care Unit (DFC), Ambulatory Procedure Unit (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 DHA-PM 6010.13. Coordinate with surgery department for collection of data. Ensure the workload has corresponding FTEs and expenses.

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 three areas are used for all episodes of care.

8.4.5.10. Hemodialysis (DGB) and Peritoneal Dialysis (DGD). Ensure proper workload reporting is occurring either through CHCS or manually. Validation includes the review of the methodology (tracking process) used to calculate these figures. The methodology includes time, number, and type of personnel to ensure accuracy. Ensure the workload has corresponding FTEs and expenses.

Performance Factor: Raw-Cases; Weighted-Minutes of Service.
Allocation Methodology: Minutes of service.

8.4.5.11. 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 includes time, number, and type of personnel to ensure accuracy. Ensure the workload has corresponding FTEs and expenses.

Performance Factor: Raw-Cases; Weighted-Hours of Service.
Allocation Methodology: Hours of Service.

8.4.6. Support Services (E Accounts). Workload data reported within the support data sets are 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.

8.4.6.1. 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). 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.

Allocation Methodology: Square Footage.

8.4.6.1.1. Square Footage. All square footage of medical buildings are 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 DMLSS.

8.4.6.1.2. Square footage cleaned by FCC cannot exceed square footage by FCC, but is most likely the same for clinical areas. For example, mechanical rooms are not cleaned under the housekeeping contract but are included in the MTFs square footage. Square footage cleaned is obtained from the Facility Management Officer using a report from DMLSS.

Note: Unused and facility common square footage is reported against the Plant Management FCC-EDAA/**5741-Real Property Management.

8.4.6.2. 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 allocated against the benefitting work center. If the fuel cards are shared or the MTF has general service administration leased vehicles, it is necessary to break out each user to make sure that expenses are allocated to the using work centers. Contact the vehicle control personnel for transportation issues. Under other circumstances, see AFMRA MEPRS for clarification. Ensure EDG-transportation has FTEs and expenses as appropriate.

Allocation Methodology: Miles Driven.

8.4.6.3. Medical Materiel (EE). Report the month net dollar value of supplies/equipment issued (6xxxx, excluding 612xx, 615xx, 64xxx, 67xxx, 68xxx, 69xxx, also exclude PEC 87701/87901) by FCC, refer to **Table 8.3** for reporting requirements). 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 is used to allocate the cost of medical logistics. This information is found in EASIV*i* under standard report section, expense accepted by RC/CC Report. Ensure FCC EEA-Medical Logistics has corresponding FTEs and expenses as appropriate.

Allocation Methodology: Dollar Value of Supplies and Equipment issued.

Table 8.3. Table to be used for the Development of the EEAA Data Set – Supplies Issued.

Include EEICs	**Exclude EEICS**	**Exclude PECs**
60xxx	612xx	87701
613xx	615xx	87901
614xx	64xxx	
618xx	65xxx	
619xx	67xxx	
62xxx	68xxx	
Include EEICs	**Exclude EEICS**	**Exclude PECs**
63xxx	69xxx	

66xxx		

8.4.6.4. Housekeeping (EF). Ensure FCC EFA-Housekeeping has corresponding FTEs and expenses as appropriate.

Allocation Methodology: Square Footage Cleaned. Refer to **para 8.4.6.1.2**

8.4.6.5. Biomedical Equipment Repair (EG). Report hours of service by the requesting FCCs for Biomedical Equipment Repair Technician 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, 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. Use DMLSS MEPRS report as the source document.

Allocation Methodology: Hours of Service.

8.4.6.6. 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.

Allocation Methodology: Pounds of Laundry.

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

8.4.6.7. Food Operations (EI). Report meals served by FCC. Food service personnel will provide the MPM a copy of the Nutrition Management Information System Report. **(T-0)**

Ensure the workload has corresponding FTEs and expenses.
Allocation Methodology: Meals Served.

8.5. System Generated Information.

8.5.1. Inpatient Administration (EJ) is allocated using the OBDs data set from WAM. Ensure EJ-Inpatient Care Administration has corresponding FTEs and expenses as appropriate.

Allocation Methodology: Occupied Bed Days (OBDs).

8.5.2. Ambulatory Administration (EK). Ambulatory Administration is allocated using the Total Visit data set from WAM. Ensure EK-Ambulatory Administration has corresponding FTEs and expenses as appropriate.

Allocation Methodology: Total Visits.

8.5.3. TRICARE/Managed Care Administration (EL) is allocated using the Total FTEs in clinical Areas (A, B, C, and D). Ensure EL-TRICARE/Managed Care Administration has corresponding FTEs and expenses as appropriate.

Allocation Methodology: Full Time Equivalents. (A, B, C, and D)

8.6. Other Data Required for Reporting Purposes (F Accounts).

8.6.1. F Account Raw Procedures

8.6.1.1. Immunizations (FBI) reports the number of immunizations performed in the reporting month. Ensure FBI-Immunization has corresponding FTEs and expenses as appropriate.

Performance Factor: Immunizations

8.6.1.2. Early Intervention Services (FBJ) reports the number of active cases in the reporting month. Ensure FBJ-Early Intervention Services (Ages 0-2) has corresponding FTEs and expenses as appropriate.

Performance Factor: Active Cases

8.6.1.3. Medically Related Services (FBK) reports the number of active cases in the reporting month. Ensure FBK-Medically Related Services (Ages 3-21) has corresponding FTEs and expenses as appropriate.

Performance Factor: Active Cases

8.6.1.4. Ambulance Services (FEA) reports 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.

Performance Factor: Hours of Service

8.6.1.5. Aeromedical Staging Facility (ASF) (FEF) reports 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 2nd ASF Travis AFB, 4th ASF Joint Base San Antonio, 10th ASF Joint Base Andrews, 18th ASF Ramstein AB, 15th ASF Joint Base Pearl Harbor – Hickam, 18th ASF Kadena AB.

Performance Factor: Number of Patient Movements

8.6.2. F Account Weighted Procedures, Area Dental Laboratory reports the Composite Lab Values (CLVs) produced during the reporting month. Ensure FAB-Area Dental Laboratory has corresponding FTEs and expenses as appropriate. The Air Force has only one Area Dental Laboratory at Peterson AFB in Colorado Springs, Colorado.

Performance Factor: Composite Time Values (CTVs).

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.

9.2.1. 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 Finance and Accounting System (DFAS) using the Commander's Resources Integration System (CRIS) financial program with the Defense Enterprise Accounting and Management System as the source file for input into EASIV*i*. Personnel expenses are generated from DMHRS*i*.

9.2.2. Financial Data reported in MEPRS are accrued Expenses-paid and accrued expenses-unpaid. Expenses include all current months' transactions that affect any current or prior year financial obligation. For information only, Total Obligations is reported for only the current year, Total Obligations consist of accrued Expenses-paid, accrued expenses-unpaid and obligations.

9.2.3. 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. AFMRA MEPRS provides a depreciation spreadsheet to assist in the determination of the monthly depreciation calculations. The following procedures apply:

9.2.3.1. The depreciation expense is 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).

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

9.2.3.3. 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.

9.2.3.4. 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.

9.2.3.5. Apply investment equipment purchases shared by inpatient and outpatient accounts using the applicable ratio in **Table 9.1**

Table 9.1. Distribution Ratios for Investment Equipment (Depreciation).

Average Daily Patient Load	Inpatient	Outpatient
Greater than 100	40%	60%
Less than 100	20%	80%
Clinics		100%

Note: If an MTF changes from inpatient to an outpatient facility, the depreciable equipment is moved in MEPRS to the current outpatient service using the equipment. Any inpatient depreciable equipment transferred to another facility is deleted from the listing.

9.2.3.6. 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.

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

9.3. Combined Food Operations. EIBA-Combined Food Operations expenses are manually entered in financial adjustments. Obtain these expenses from the AF Form 544, *Ration Earnings Record,* year-to-date column or the cumulative year-to-date purchases from end of month food services report.

9.4. EASIV*i* Financial Processing.

9.4.1. The RA will validate total expenses for all years (at RC/CC level) and obligations for current year monthly. **(T-0)** During this process the RA should validate accuracy of PECs, RC/CCs and EEICs; in conjunction with the Base Financial Management Analysis (FMA) Coding Package.

9.4.2. A financial file is created monthly by the RA or the MPM using CRIS and imported into EASIV*i* by the MPM. The RA coordinates with the MPM on all EASIV*i* financial adjustments. All errors, warnings and negative numbers for expenses and obligations are researched, explained and documented by the RA. If corrective actions cannot be determined locally, contact AFMRA MEPRS for further guidance. Corrections are required in the month the error occurred and all subsequent months. Re-allocation and re-transmission of each month is required. Corrections are made in the source financial system as appropriate.

9.4.3. The MPM works closely with the RA to conduct the reconciliation. The RA coordinates requirements with the base financial services office, DFAS, civilian personnel office, or other critical base support agencies to ensure accurate data is received and minimal edits are needed. The RA and Resource Management Office flight commander will sign the finalized reconciliation documentation. **(T-1)**

9.4.4. Ensure financial data reported in EASIV*i* is the same as that reported through the financial management and DFAS systems. Source data received via the monthly financial file is not to be altered.

9.4.5. AFMRA MEPRS provides oversight of financial reconciliation by conducting a quarterly comparison of EASIV*i* financial data to financial system reported data. Discrepancies are communicated back to the MTF for explanation and/or correction, and to ensure the audit trail is complete.

9.4.6. AFMRA/SG1/8YB will perform a financial reconciliation annually by comparing DFAS data to EASIV*i*. **(T-1)** Discrepancies are communicated back to the MTF through AFMRA MEPRS for explanation and/or correction, and to ensure the audit trail is complete.

Note: Any changes to financial data, to include personnel salary should be evaluated for reallocation and retransmission.

Chapter 10

DATA QUALITY MANGMENT CONTROL PROGRAM (DQMCP)

10.1. MTFs will use WAM for CHCS-Generated Workload Data.(T-0) Issues identified in WAM or the workload migration process that drives update to data is made in the source file of CHCS by the responsible work center. After corrections, reinitialize WAM and resubmit file to EASIV*i*. 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.

10.2. Changes to Data in EASIV*i*. Can only be made if correction in CHCS/AHLTA, DMHRS*i* or the source financial system is not possible. Corrections made outside of the source systems are coordinated with the affected work center, the DQM, GPM, RA or Logistics as appropriate.

10.3. MEPRS/DMHRS*i* Personnel. Support the MTF data quality program and data quality assurance team by either answering specific DQ review list/statement questions, providing data summary documentation and taking other necessary actions described in the Data Quality Team User's Guide (DQ TUG).

DOROTHY A. HOGG
Lieutenant General, USAF, NC
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

DHA-PM 6010.13, *Medical Expense and Performance Reporting System for Fixed Military Medical and Dental Treatment Facilities, Volume1 (Business Rules) and Volume 2 (Chart of Accounts*), 27 September 2018

Memorandum of Agreement between the Defense Health Agency and the Air Force Surgeon General's Office for Direct Support to the DHA for Military Treatment Facility Administration and Management, DHA-2019-R-1304, 3 July 2019

DoDI 6040.40, *Military Health System (MHS) Data Quality Management Control (DQMC) Program*, 27 December 2019

AFPD 44-1**,** *Medical Operations*, 9 June 2016

AFMAN 41-120, *Medical Resource Management Operations*, 28 August 2019

AFI 65-503, *US Air Force Cost and Planning Factors*, 13 July 2018

AFI 33-322, *Records Management and Information Governance Program*, 23 Mar 2020

Note: The following References are available on the Knowledge Exchange (KX) MEPRS Website at the following link:
https://kx.health.mil/kj/kx7/AFMOAMEPRS/Pages/home.aspx

Note: The following References are available to review the DHA-PM 6010.13 Volumes 1 & 2

https://health.mil/Reference-Center/Policies/2018/09/27/DHA-PM-6010-13-MEPRS-Volume-1

https://health.mil/Reference-Center/Policies/2018/09/27/DHA-PM-6010-13-MEPRS-Volume-2

Expense Assignment System Version IV *internet* (EASIV*i*) Functional Users Guide, 12 November 2014

MEPRS *Course Student Guide*, 1 October 2019

MEPRS *Time Reporting Matrix*, 24 September 2019

PEMAP-*Program Element Mapping spreadsheet* 1 October 2019

DMHRS*i Air Force End of Month Processing Guide*, April 2019

DMHRS*i Joint Concept of Operations (CONOPS)*, March 2018

Data Quality *Team User's Guide (DQ TUG),* 17 December 2018

AFMS *Workload Guidelines*, 1 October 2009

Adopted Forms

None

Adopted Forms

AF Form 847**,** *Recommendation for Change of Publication*

AF Form 544*, Ration Earnings Record*

Abbreviations and Acronyms

ACUs—Ambulatory Care Units (line clinics)

ADMs—Admissions

AFMS—Air Force Medical Service

AFMH—Air Force Medical Home

AFMRA—Air Force Medical Readiness Agency

AHLTA—Armed Forces Health Longitudinal Technology Application

ASD—Account Subset Definition

ASF—Aero-medical Staging Facility

ASN—Assignment Sequence Number

BHCF—Behavioral Health Care Facilitator

CAIB—Community Action Information Board

CE—Continuing Education (interchangeable with Continuing Health Education-CHE)

CHCS—Composite Health Care System

CONOPS—Concept of Operations

COR—Contract Officer's Representative

CPT—Physicians' Current Procedural Terminology

CRIS—Commander's Resource Integration System

CSS—Central Sterile Supply

CTV—Composite Time Values

DCPS—Defense Civilian Pay System

DES—Disability Evaluation System

DFAS—Defense Finance and Accounting Service

DHA—Defense Health Agency

DHP—Defense Health Program

DISPs—Dispositions

DMIS ID—Defense Medical Information Systems Identification

DMHRSi—Defense Medical Human Resource System-*internet*

DMLSS—Defense Medical Logistics Standard Support

DoD—Department of Defense

DQ—Data Quality

DQM—Data Quality Manager

DQMCP—Data Quality Management Control Program

DWV—Dental Weighted Values

EASIVi—Expense Assignment System, Version 4*internet*

EEIC—Element of Expense Investment Code

ETS—Estimated Time of Separation

FAC—Functional Account Code

FCC—Functional Cost Code

FTE—Full Time Equivalent

FY—Fiscal Year

GPM—Group Practice Manager

HIPAA—Heath Insurance Portability & Accountability Act

HR—Human Resource

IBHC—Internal Behavioral Health Consultant

IWRR—Inpatient Workload Reconciliation Report

LCA—Labor Cost Assignment

MEB—Medical Evaluation Board

MEPRS—Medical Expense and Performance Reporting System

MHS—Military Health System

MPM—MEPRS Program Manager

MTF—Medical Treatment Facility

OBDs—Occupied Bed Days

OPR—Office of Primary Responsibility

OWRR—Outpatient Workload Reconciliation Report

PCM—Primary Care Manager

PCS—Permanent Change of Station

PEBLO—Physical Evaluation Board Liaison Office

PEC—Program Element Code

PEMAP—Program Element Mapping

PHA—Physical Health Assessment

PRAP—Personnel Reliability Assurance Program

PSD—Presidential Support Duty

RA—Resource Advisor

RC—Responsibility Center

RegAF—Regular Air Force

SDD—Solution Delivery Division

SME—Squadron Medical Element

TBI—Traumatic Brain Injury

TDY—Temporary Duty

UMD—Unit Manning Document

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 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 Version IV*i* (EASIV*i*)—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 source files (personnel, financial and workload) to EASIV*i*.

Medical Treatment Facility—An established land-based medical center, hospital, clinic, or other facility that provides medical, surgical, or dental care.

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

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

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

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, *Glossary of Healthcare Terminology* for a more detailed description.

Attachment 2

AIR FORCE UNIQUE ACCOUNT CODES

A2.1. General. The following codes are the descriptions for Air Force unique account codes.

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. MTF Commander or Director, Deputy Commander (when authorized), MTF Superintendent, First Sergeant; and their immediate secretarial and administrative staff are included in this expense account. Time reported includes attendance at any official function.

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-Assessment (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. EBCA-Medical Resource Management Administration. This account includes the functions of Medical Resource Management Flight. Refer to AFMAN 41-120, *Medical Resource Management Operations*.

Allocation Methodology: Total Available FTEs of the facility

A2.5. EBCB–Personnel and Administration. This account includes the functions of the Commander's Support Staff (Orderly Room).

Allocation Methodology: Total Available FTEs of the facility.

A2.6. EBCC–Committees. This account includes those committees authorized by Air Force Instructions and MTF committee regulations. Staff meetings are not included in this account. Refer to **Attachment 3** for a general list of committees that should be included in this FCC.

Allocation Methodology: Available FTEs of the facility.

A2.7. 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 includes attendance at any official functions.

Allocation Methodology: Total Available FTEs of the FCCs under the purview of the squadron. Update the ASD dataset definition annually or as needed.

A2.8. 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 includes attendance at any official functions.

Allocation Methodology: Total Available FTEs of the FCCs under the purview of the squadron. Update the ASD dataset definition annually or as needed.

A2.9. EBCF-Aerospace Medicine Squadron/ Operational Medical Readiness 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.

Allocation Methodology: Total Available FTEs of the FCCs under the purview of the squadron. Update the ASD dataset definition annually or as needed.

A2.10. EBCH-Medical Operations Squadron/Healthcare 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 includes attendance at any official functions.

Allocation Methodology: Total Available FTEs of the FCCs under the purview of the squadron. Update the ASD dataset definition annually or as needed.

A2.11. 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 includes attendance at any official functions.

Allocation Methodology: Total Available FTEs of the FCCs under the purview of the squadron. Update the ASD dataset definition annually or as needed.

A2.12. 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 includes attendance at any official functions.

Allocation Methodology: Total Available FTEs of the FCCs under the purview of the squadron. Update the ASD dataset definition annually or as needed.

A2.13. 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 includes attendance at any official functions.

Allocation Methodology: Total Available FTEs of the FCCs under the purview of the squadron. Update the ASD dataset definition annually or as needed.

A2.14. EBCL–Supervision Oversight. This account is 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 is 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.

A2.15. EBDA–Clinical Management. This code accounts for costs of MTF Clinical Management services to include department heads (SGH, SGA, SGN), Health Care Integrators, GPMs and their immediate staff. Time spent performing Clinical Peer Reviews are captured under this code. This does not include day-to-day clinic operations. If a GPM supports all clinical areas they are assigned and they report a majority of their time to EBDA. If the MTF has multiple GPMs, they are assigned to the clinical work center they support. This code would also be the assigned code for Non-Empaneled Medical Officers. Contact AFMRA MEPRS for further guidance.

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

A2.16. 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.

A2.17. 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.

A2.18. EDAF-Facility Management. This code is used to document costs of manpower, supplies and equipment used by the staff supporting the MTF Facility Management Branch. All MTF authorized and assigned personnel who perform this function are captured in this FCC.

A2.19. ELAB-Clinical in and Out-processing. This code is to be used by Medical Management personnel to document 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 FCCs.

A2.20. ELAD–Disease Management. This code is used to accumulate all the operating expenses incurred in implementing, administering and performing required documentation on Disease Management Activities. This is not to be used by AFMH clinic personnel managing enrolled patient population.

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

A2.21. ELAF-Exceptional Family Member Program (EFMP). 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 Special Needs Identification and Assignment Coordination (SNIAC)/EFMP requirements, data collection and reporting following DoD and AF requirements, and assignment coordination database/records maintenance.

Allocation Methodology: FTEs reported in B Accounts.

A2.22. ELAH– Heath Insurance Portability & Accountability Act (HIPAA) Privacy Program. This account is used to accumulate all the operating expenses incurred in implementing and administering the 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 Available FTEs of the facility.

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

A2.23. ELAN-Case Management/Case Management Wounded Warriors. This account is used to accumulate all the operating expenses incurred in documenting 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.

A2.24. ELAU-Utilization Management. This account is used to accumulate all the operating expenses incurred in implementing administering and performing the required documentation of Utilization Management Activities. This is not to be used by AFMH clinic personnel managing enrolled patient population.

Allocation Methodology: FTEs reported in A and B FCCs.

A2.25. FABB-Dental Evaluation and Consultation Service. The Area Dental Prosthetic Laboratory (Type 1) facility is an entity designated specifically to support other dental facilities. The capabilities of the Area Dental Prosthetic Laboratory (Type 1) facility include the assignment of a full time, board-certified, board-eligible, or trained prosthodontist; consultation for Uniformed Services dental officers; conducting CE programs for dental personnel; preparing and processing education bulletins; conducting user tests of new prosthetic materials and refinement of techniques; providing fixed prosthodontic capability; providing removable prosthodontic capability; providing all metal casting capability; and providing unique services, as required, such as orthodontic support and appliances, surgical implant appliances, maxillofacial appliances, teaching models, and aids. This account is only performed at Joint Base San Antonio.

A2.26. FAFD-Transgender Medical Evaluation Unit. This account is used to accumulate all the operating expenses incurred in implementing, administering, and performing documenting the clinical and administrative oversight of patients seen by the Medical Multidisciplinary Team within the required documentation of the Transgender Medical Evaluation Unit.

A2.27. FAHC-Graduate Health Science Education. This account is used for capturing costs incurred by the Air Force Clinical Investigations Program in direct support of Graduate Health Science Education requirements. This code may be used for any scholarly activity by the Clinical Investigations Program regardless of location.

A2.28. FAHR-Research and Development. This account is used for capturing costs incurred supporting research and development requirements outside of the Clinical Investigations Program. This includes direct support to HQ AF, AFMRA, or other external grants for the medical research requirements.

A2.29. FALA-Continuing Education. This account is used for capturing costs incurred by an MTF in support of Continuing Education requirements. This includes all CE regardless of location or source of instruction, to include in-services.

A2.30. 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.

A2.31. FASY -Mental Health Promotions. 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., Community Action Information Board (CAIB) and Integrated Delivery System (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.

A2.32. FBBP Health Promotions. This code is used to account for the administration of health promotion programs and health promotion education activities that are part of building healthier communities. Administration of health promotion programs include committee attendance for installation health promotion working groups, and others (e.g., medical council, health consumer advisory councils, unit/installation briefings/meetings, etc.) where health promotion representation is necessary or requested. Health Promotion should count the hours for planning, programming, executing and evaluating all health promotion activities. Health promotion staff have oversight of installation health and wellness education and track their time in appropriate FCCs to the work that they are performing. Health promotion activities include administering health assessments, 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.

Note: Count Visits are not captured in FBBP for the above activities. The MTF may establish a non-count clinic with non-count appointment types in the electronic health record (CHCS/AHLTA, MHS GENESIS) using the "FBBP" FCC and code the encounter appropriately.

Nutritional medicine care and treatment is not part of this function and should continue to be captured in FCC BALA. Nutritional medicine FCC BALA should not be captured in this location, to be able to capture FCC BALA accurately is should be performed in its own distinct location, if it meets the criteria for a separately organized function, if the criteria for a separately organized location is not met, this care should be captured in family practice FCC BGAZ. Criteria for work center development is in **para 5.2**

A2.33. 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 RegAF 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 is 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 Physical Health Assessments (PHA) Program. The PHA Cell manages the administrative requirements for all non-flyer PHAs (Flight Medicine captures empaneled PHAs under their code). The PHA cell earns 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 is coded under the physician's FCC.

A2.34. FCGJ- Personnel Reliability Assurance Program (PRAP)/Presidential Support Duty (PSD) Administration. PRAP encompasses the reliability programs known as PRAP and Arming and Use of Force. All PRAP/PSD administrative functions should be coded under this code.

A2.35. FCGM-Military Training Consult Service. This account is 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 does not perform clinical operations.

A2.36. FCZC - Clinical Proficiency Readiness. The function of the Clinical Proficiency Readiness account summarizes the man-hours and related salary expenses of the MTF/DTF that are incurred as the result of a formal and approved affiliate agreement with an external healthcare organization for the purpose of gaining and/or maintaining clinical experience that enhances the clinical readiness of personnel who are assigned to a fixed MTF/DTF. This account is authorized for civilian and military personnel. This account is not authorized for students, contractors, Reservists/National Guard, or borrowed personnel. This account is not authorized for personnel who are loaned to an external healthcare organization for the purpose of providing backfill support to the mission of the external organization. This account is not authorized for personnel who work at an external organization for the purpose of compensation or for after-duty work that is commonly referred to as 'moonlighting'. This account is not authorized for MTF External Resource Sharing Agreements. This account is not authorized for Military Readiness Training exercises or classes, MTF In-house training, or Continued Healthcare Education Training. Formal and approved affiliate agreements do not require reimbursement so only personnel available man-hours and related salary expenses are authorized to be reported in this account.

A2.37. FDZC-Closing/Opening Clinical Work Centers. This code is used to track time for personnel that are setting up or breaking down clinical services, when there is no workload generated. 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 (e.g., Landstuhl or San Antonio Military Medical Center).

A2.38. FEBB-Travel for Air Force Personnel/Non-Medical Attendants. This code accounts for the costs of travel for RegAF personnel (in their capacity as either a patient or a non-medical attendant) and their non-medical attendants assigned to locations without fixed MTF to obtain medical or dental care. This code would also be used by the MTF employee to track the time

away from the work center, but it would be appropriate to report any actual work time (telework) to the appropriate FCC.

A2.39. FEBC-Travel for Family Members and Medical Attendants Overseas. This code accounts for the costs of travel for the family members of RegAF personnel (in their capacity as either a patient or a non-medical attendant) and attendants assigned to locations without fixed MTF, to obtain medical care when stationed overseas. This code would also be used by the MTF employee to track the time away from the work center, but it would be appropriate to report any actual work time (telework) to the appropriate FCC.

A2.40. FEDB-Physical Evaluation Board Liaison Office (PEBLO). This code accounts for the PEBLO for the MTF and its geographic areas of responsibility. They perform counseling, case file management, data collection and analysis, medical and administrative coordination, and other procedural work related to MEB processing, Temporary Disability Retired List (TDRL) re-evaluations and all other Disability Evaluation System requirements in accordance with applicable instructions, regulations, or directives.

A2.41. FEDC-Medical Evaluation Board (MEB). This code supports the requirements of the Disability Evaluation System and the MEB process. This account can include the labor-hours expended to complete the MEB Narrative Summary and all related documentation and coordination required to complete an assessment of the Service member's condition, fitness for duty, and ancillary services ordered specifically for the completion of the MEB Narrative Summary. This is not used to capture clinical time/work in performance of the MEB evaluation that would be captured in the appropriate "B" account to receive full workload generation and billing capability.

A2.42. 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.

A2.43. 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 TBI Clinic is a distinct work center 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.

A2.44. Air Force Medical Home (AFMH) Team Codes. Used to report labor hours, workload and expenses for facilities using the AFMH Team concept to provide Internal Medicine (BAA*), Primary Care (BGA*), Pediatrics (BDA*) and Flight Medicine (BJA*). A complete list is provided in **Attachment 4**.

Note: This applies only to legacy CHCS/AHLTA and not MHS GENESIS configured sites which implement PCMH code reductions during the Patient Care Location File location build process. FOR MHSG configured sites only, The action to reduce/consolidate the individual PCMH team MEPRS codes to report only one Medical Home MEPRS code per standalone outpatient clinic will also eliminate the use of B**Z MEPRS for the Air Force MTFs.

A2.44.1. Ensure RC/CCs for these codes are mapped to the appropriate team, so that the expenses are readily identifiable. Ensure that DMLSS also reflects the appropriate RC/CCs to issue supplies and equipment to the correct team.

A2.44.2. Ensure the team codes are appropriately set up in DMHRS*i* with local organizations so the non-available time and expenses are charged to the correct team.

A2.44.3. Using a cost pool to help account for shared space, supplies, expenses or personnel would be advisable.

A2.44.4. **Example-B Team:** BGAB/540B-AFMH Team B, shares a supply closet with BGAC/540C-AFMHT C, purchase those shared supplies in BGXA so that the cost of those supplies is distributed to the teams based on the workload production of each of the teams.

A2.45. BAAR, BDAR, and BGAR-GME Resident Procedure Clinic. This code is 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).

A2.46. BAAZ, BDAZ, and BGAZ-Non-AFMH Related Functions.

A2.46.1. These codes are used to report labor hours, workload and expenses for functions not appropriately captured under the AFMH concept. These functions include, but are not limited to:

A2.46.2. Clinical Pharmacy. Used to report labor hours, workload and expenses for facilities with a separately organized clinic providing Clinical Pharmacy Services. This is a clinical function performed in an ambulatory clinic, not to be tracked as DA-Pharmacy workload.

A2.46.3. BGAZ-Behavioral Health Optimization Program (BHOP). The BHOP is a term used to describe a specific behavioral health service operating within a patient centered medical home, using a consultative model of behavioral healthcare that is delivered by psychologists, social workers, nurse practitioners, and nurses who have all received specific training in primary care behavioral health. In general, the goal of the BHOP is to position the Internal Behavioral Health Consultant (IBHC) and Behavioral Health Care Facilitator (BHCF) on the healthcare team to augment and improve the delivery of overall healthcare. The IBHC is not used to provide comprehensive mental health evaluations or treatment of behavioral health conditions, as occurs in the specialty mental health clinic but functions as a member of the primary care team. The IBHC and BHCF 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 Primary Care Team regarding recommendations and the patient’s status is key to the BHOP staff's role. In contrast to specialty mental health settings, consultation by the BHOP staff does not require a separate signed informed consent document since behavioral assessment and intervention are a part of the primary care team’s service. The PCM remains in charge of the patient’s care.

A2.47. BHBA-BOMC (Base Operational Medicine) Clinic. This code is used to capture all operating expenses for conducting separately organized clinical functions in support of the BOMC Program. Refer to above **para A2.44.1** thru A2.44.4 for detailed information as to how to set this code up for accurate reporting.

Attachment 3

OFFICIAL COMMITTEE MEETINGS

Table A3.1. Official Committee Meetings.

Committees Meetings to be Included in FCC-EBCC
Aerospace Medicine Council
Cancer Function
Cost Center Manager Meeting
Credentials Committee
Data Quality/Information Management Working Group (DQ/IM)
Committees Meetings to be Included in FCC-EBCC (cont)
Dental Executive Function
Education & Training Function
Environment of Care/Patient Safety Committee
Equipment Review Authorization Activity (ERAA)
Ethics Function
Executive Committee of the Medical Staff
Executive Council
Family Advocacy Committee
Family Maltreatment Case Management Team
Health Care Council
Infection Control Committee
Medical Library Function
Medical Readiness Staff Function
Medical Records Function
Medical Records Review Function
Nursing Executive Function
Odyssey Board of Experts
Operative and other Invasive Procedures Function
Performance Improvement/Risk Management Function
Pharmacy & Therapeutics/Medications Management
Population Health Function
Professional Staff Function
Resuscitative Care and Special Care Function
Space Utilization Function
Tissue, Blood and Blood Components Function
Note: This list is not all inclusive, and several of these Committees/Functions could potentially be combined to lessen the actual number of meetings. The purpose of this code is to reflect time out of the work center as an advisor/ representative to the MTF and specific product line or expertise.

Attachment 4

PATIENT CENTERED MEDICAL HOME CODE LISTING

A4.1. Patient Centered Medical Home Code Listing.

A4.1.1. This applies only to legacy CHCS/AHLTA and not MHS GENESIS configured sites which implement PCMH code reductions during the Patient Care Location File location build process. FOR MHSG configured sites only, The action to reduce/consolidate the individual PCMH team MEPRS codes to report only one Medical Home MEPRS code per standalone outpatient clinic will also eliminate the use of B**Z MEPRS for the Air Force MTFs.

INTERNAL MEDICINE TEAMS

BAAA	INTERNAL MEDICINE TEAM A Non-GME
BAAB	INTERNAL MEDICINE TEAM B Non-GME
BAAC	INTERNAL MEDICINE TEAM C Non-GME
BAAD	INTERNAL MEDICINE TEAM D Non-GME
BAAE	INTERNAL MEDICINE TEAM E Non-GME
BAAF	INTERNAL MEDICINE TEAM F Non-GME
BAAG	INTERNAL MEDICINE TEAM G Non-GME
BAAH	INTERNAL MEDICINE TEAM H Non-GME
BAAJ	INTERNAL MEDICINE TEAM J Non-GME
BAAL	INTERNAL MEDICINE TEAM L GME
BAAM	INTERNAL MEDICINE TEAM M GME
BAAN	INTERNAL MEDICINE TEAM N GME
BAAP	INTERNAL MEDICINE TEAM P GME
BAAQ	INTERNAL MEDICINE TEAM Q GME
BAAR	INTERNAL MEDICINE-GME RESIDENT PROCEDURE CLINIC
BAAS	INTERNAL MEDICINE TEAM S GME
BAAT	INTERNAL MEDICINE TEAM T GME
BAAW	INTERNAL MEDICINE TEAM W GME
BAAZ	INTERNAL MEDICINE -Non-AFMH RELATED FUNCTIONS

PEDIATRIC MEDICAL HOME TEAMS

BDAA	PEDIATRIC TEAM A Non-GME
BDAB	PEDIATRIC TEAM B Non-GME
BDAC	PEDIATRIC TEAM C Non-GME
BDAD	PEDIATRIC TEAM D Non-GME
BDAE	PEDIATRIC TEAM E Non-GME
BDAF	PEDIATRIC TEAM F Non-GME
BDAG	PEDIATRIC TEAM G-GME
BDAH	PEDIATRIC TEAM H-GME
BDAI	PEDIATRIC TEAM I-GME
BDAJ	PEDIATRIC TEAM J-GME
BDAK	PEDIATRIC ADOLESCENT TEAM-K
BDAL	PEDIATRIC TEAM L-GME
BDAR	PEDIATRIC-GME RESIDENT PROCEDURE CLINIC
BDAZ	PEDIATRIC TEAM Non-AFMH Related Functions

FAMILY MEDICINE TEAMS

BGAA	WARRIOR OPERATIONAL MEDICINE CLINIC TEAM A-AD
BGAB	FAMILY MEDICINE CLINIC TEAM B Non-AD
BGAC	COMBINED FAMILY MEDICINE CLINIC TEAM C AD/NON-AD
BGAD	WARRIOR OPERATIONAL MEDICINE CLINIC TEAM D-AD
BGAE	FAMILY MEDICINE CLINIC TEAM E Non-AD
BGAF	FAMILY MEDICINE CLINIC TEAM F Non-AD
BGAG	FAMILY MEDICINE CLINIC TEAM G Non-AD
BGAH	FAMILY MEDICINE CLINIC -TEAM H - GME
BGAI	FAMILY MEDICINE CLINIC TEAM I - GME
BGAJ	FAMILY MEDICINE CLINIC -TEAM J-GME
BGAK	FAMILY MEDICINE CLINIC TEAM K-GME

FLIGHT MEDICINE TEAMS

BJAA	FLIGHT AND OPERATIONAL MEDICINE CLINIC
BJAC	FLIGHT MEDICINE–PRAP/PSD CLINIC
BJAT	FLIGHT MEDICINE–TRAINEE CLINIC

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