DEPARTMENT OF DEFENSE (DoD) UNIFORM BUSINESS OFFICE OUTPATIENT MEDICAL & DENTAL SERVICES REIMBURSEMENT RATES AND COSMETIC SURGERY REIMBURSEMENT RATES

1. Introduction.

1.1. In accordance with Title 10, United States Code, section 1095, the DoD Uniform Business Office (UBO) has released the Calendar Year (CY) 2005 medical and dental reimbursement rates and cosmetic surgery reimbursement rates. These represent the charges for professional and institutional healthcare services provided in Military Treatment Facilities (MTFs) within the Defense Health Program (DHP). The rates shall be used to submit claims for reimbursement of services rendered in accordance with the MTF Cost Recovery Programs: Medical Services Accounts (MSA), Third Party Collections Program (TPCP) and Medical Affirmative Claims (MAC).

1.1.1. The Fiscal Year (FY) 2005 inpatient rates released November 3, 2004, remain in effect until further notice.

1.2. The CY 2005 Outpatient Medical and Dental Rates and CY 2005 Cosmetic Surgery Rates are effective September 14, 2005.

1.3. The CY 2005 Outpatient Medical and Dental Services Reimbursement Rates and Cosmetic Surgery Reimbursement Rates update consists of the following rates:

Section 3.2.1.: Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (CMAC) Rates
Section 3.3: Dental Rates
Section 3.4: Immunization/Injectibles Rates
Section 3.5: Anesthesia Rate
Section 3.6: Durable Medical Equipment/Durable Medical Supplies (DME/DMS)
Section 3.7: Transportation Rates
Section 3.8: Pharmacy Dispensing Fee
Section 3.9: Other Rates
Section 4: Cosmetic Surgery Rates
Appendix A: Elective Cosmetic Surgery Procedures

1.4. Due to size, the sections containing the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charges and dental rates are not included in this package. These rates are available from the TRICARE Management Activity (TMA) Uniform Business Office (UBO) website:
http://tricare.osd.mil/rm/index.cfm?pageId=10

2. Government Billing Calculation Factors.

2.1. Discount. A government billing calculation factor (percentage discount) shall be applied to the full reimbursement rate (FRR) charges when billing for outpatient services as follows:

2.1.1. International Military Education and Training (IMET) rate
Ambulance: 55.19% of the full reimbursement rate
Dental: 37.88% of the FRR
AirEvacuation – Ambulatory: 53.86% of the FRR
AirEvacuation - Litter: 53.83% of the FRR
All other IMET where specific rates are not specified (e.g., anesthesia, immunization, CMAC, durable medical equipment, pharmacy dispensing fee): 53.83%* of the FRR.

2.1.2. Interagency/Other Federal Agency Sponsored Rate (IAR):
Ambulance: 94.54% of the FRR
Dental: 93.94% of the FRR
AirEvacuation – Ambulatory: 94.59% of the FRR
AirEvacuation - Litter: 94.54% of the FRR
All other IAR where specific rates are not specified (e.g., anesthesia, immunization, CMAC, DME, pharmacy dispensing fee). 94.54%** of FRR.

* IMET Fixed Multiplier Methodology: Overall average IMET rate divided by the overall average FRR rate

** IAR Fixed Multiplier Methodology: Overall average IAR rate divided by the overall average FRR rate

2.2. Full Reimbursement. The full reimbursement rate (FRR) shall be used for claims submission to Third Party Payers and to all other applicable payers not included within IMET and IAR billing guidance. The rates included in section 3 represent the full rate (unless otherwise specified).

3. Outpatient Medical and Dental Service Rates.

3.1. Terminology.

3.1.1. Ambulatory Procedure Visit (APV). An APV is defined in DoD Instruction 6025.8, "Ambulatory Procedure Visit (APV)," dated September 23, 1996, as immediate (day of procedure) pre-procedure and immediate post-procedure care requiring an unusual degree of intensity and provided in an ambulatory procedure unit (APU). An APU is a location or organization within an MTF (or freestanding outpatient clinic) that is specially equipped, staffed, and designated for the purpose of providing the intensive level of care associated with APVs. Care is required in the facility for less than 24 hours.

3.1.1. Ambulatory Services. Military Treatment Facility (MTF) ambulatory services encompass the healthcare services rendered in the following locations: Emergency Department (ED), Observation (OBS) Unit, and Ambulatory Procedure Unit (APU)/operating room. Ambulatory services rates include both professional and institutional services and charges.

3.1.2. Outpatient Services. Services rendered in other than the ED, observation unit, APU or the operating room.

3.2. Professional Component.

3.2.1. CMAC Rates.

3.2.1.1. The CHAMPUS Maximum Allowable Charge (CMAC) rates, established under 32 Code of Federal Regulation (CFR) 199.14(h), are used for determining the appropriate charge for MTF professional and technical services based on the Healthcare Common Procedure Coding System (HCPCS) methodology which includes the Current Procedural Terminology (CPT) codes. CMAC rates pertain to outpatient services (e.g., clinic, laboratory, radiology) and ambulatory services (e.g., ambulatory procedure visits, observation and emergency department visits).

3.2.1.2. CMAC is organized by 90 distinct "localities," which account for differences in geographic regions based on demographics, cost of living, and population. Each MTF Defense Military Information System Identification (DMIS ID) is mapped to its corresponding CMAC locality code to obtain the correct rates. The complete DMIS ID locality table is available at http://www.dmisid.com/cgi-dmis/default.

3.2.1.3. For each CMAC locality, there are two sub-tables of rates: CMAC and Component. The CMAC rate table determines the payment for professional services and procedures identified by CPT and HCPCS codes. The CMAC table is further categorized by provider class. The Component rate table is based on CPT codes with distinct professional and technical components. A separate rate is provided for each component, further categorized by provider class.

3.2.1.4. CMAC Provider Class. The CMAC rates are adjusted based on the provider class, such as physician, psychologist and nurse. CMAC-based rates described in section 3.1.1.1 above are available on the TMA UBO website at: http://tricare.osd.mil/rm/ubo_home.cfm.

3.2.2. Institutional Component.

3.2.2.1. Emergency Department. Department of Veterans Affairs (DVA) ED institutional rates are used to determine the DoD ED institutional charges. The institutional charge is added to the CMAC professional charge to generate the DoD ED overall rate. Ambulance transport prior to admission and post discharge is not part of the ER institutional rate and is billed separately.

3.2.2.2. Observation. Department of Veterans Affairs (DVA) observation institutional rate is used to determine the DoD OBS institutional rates. The institutional charge is added to the CMAC professional charge to generate the DoD OBS overall rate.

3.2.2.3. Ambulatory Procedure Visit (APV) Rate. There is an institutional flat rate for all APV procedures/services. The flat rate is based on the institutional cost of all Military Health System APVs divided by the total number of APVs. The flat rate is: **$819.18**.

3.2.3. Ambulatory Service Which Becomes Inpatient Hospitalization. If the patient's level of care changes to an inpatient status and becomes part of the diagnosis related group, the institutional charges for ER, OBS and/or APV services will not be billed.

3.3. Dental Rates.

MTF outpatient dental charges are based on a dental rate multiplied by the DoD-established weight for the American Dental Association (ADA) code representing the dental service/procedure performed. The dental flat rate is based on the average DoD cost of dental services at all MTFs. Table 3.3.1 includes the dental rate for IMET, IAR and Other (Full/Third Party).

Table 3.3.1.

CDT	Clinical Service	IMET	IAR	Other (Full/Third Party)
	Dental Services ADA code weight multiplier	$25.00	$62.00	$66.00

Example: For ADA code D0270, bitewing single film, the weight is 0.22. The weight of 0.22 is multiplied by the appropriate rate, IMET, IAR, or Full/Third Party rate to obtain the charge. If the Full/Third Party rate is used, then the charge for this ADA code will be $14.52 ($66 x 0.22 = $14.52).

The list of CY 2005 ADA codes and weights for dental services is too large to include in this document. The rate table is on the TMA UBO website at http://tricare.osd.mil/rm/ubo_home.cfm

3.4. Immunization Rates.

The charge for immunizations, allergen extracts, allergic condition tests, and the administration of certain medications, when these services are provided in a separate immunizations or shot clinic, are based on CMAC rates in cases in which such rates are available. In cases in which such rates are not available a flat rate of **$40.00** will be billed. The flat rate is based on the average full cost of these services, exclusive of any costs considered for purposes of any outpatient visit. A separate charge shall be made for each immunization, injection or medication administered.

3.5. Anesthesia Rates.

The flat rate for anesthesia professional services is based on an average DoD cost of anesthesia service in all MTFs. The flat rate for anesthesia is **$749.00**.

3.6. Durable Medical Equipment/Durable Medical Supplies (DME/DMS) Rates.

Durable Medical Equipment (DME) and Durable Medical Supplies (DMS) rates are based on the Medicare Fee Schedule floor rate. The HCPCS codes contained in this table are for A4216-A7527, E0100-E2621, K0001-K0649, L0100-L8670, and V2020-V2784. This rate table is on the TMA UBO website at:
http://tricare.osd.mil/rm/ubo_home.cfm

3.7. Transportation Rates.

3.7.1. Ambulance Rate.

Ambulance charges are based on hours of service, calculated in 15-minute increments. The rates for IMET, IAR and Other (Full/Third Party) listed in the Table 3.7.1 are for 60 minutes (1 hour) of service. MTFs shall calculate the charges based on the number of hours (and/or fractions of an hour) that the ambulance is logged out on a patient run. Fractions of an hour shall be rounded to the next 15-minute increment (e.g., 31 minutes shall be charged as 45 minutes).

Table 3.7.1.

CDT/CPT	Clinical Service	IMET	IAR	Other (Full/Third Party)
A0999	Ambulance	$101.00	$173.00	$183.00

3.7.2. AirEvac Rate.

Air in-flight medical care reimbursement charges are determined by the status of the patient (ambulatory or litter) and are per patient per trip during a 24-hour period. The appropriate charges are billed only by the Global Patient Movement Requirement Center (GPMRC). These charges are only for the cost of providing medical care. The rates for IMET, IAR and Other (Full/Third Party) are listed in Table 3.7.2 below.

Table 3.7.2.

Clinical Service	IMET	IAR	Other (Full/Third Party)
AirEvac Medical Services – Ambulatory	$279.00	$490.00	$518.00
AirEvac Medical Services – Litter	$809.00	$1,421.00	$1,503.00

3.8. Pharmacy Dispensing Fee.

All pharmaceutical prescriptions filled and dispensed by the MTF are billable. This includes pharmaceutics ordered both internally by MTF providers and externally by civilian providers.

3.8.1. Pharmaceutical rates. Pharmaceutical rates are scheduled to be updated semiannually in CY2006 and will be published in a separate rate package. The rates are based on the Managed Care Pricing File and are identified by National Drug Code (NDC) code.

3.8.1.1. The pharmaceutical rate table is available on the TMA UBO website at http://tricare.osd.mil/rm/ubo_home.cfm

3.8.1.2. The prescription charge is calculated by multiplying the number of units (e.g., tablets or capsules) by the unit cost and adding a Pharmacy Dispensing Fee ($8.00) for the cost of dispensing the prescription. Dispensing costs include overhead, supplies, and labor, etc. to fill the prescription.

3.8.1.3. The CY 2005 outpatient rate update for the Pharmacy Dispensing Fee is **$8.00**.

3.9. Other Rates.

3.9.1. Subsistence Rate. The Standard Rate that is established by the Office of the Under Secretary of Defense (Comptroller) shall be used as the subsistence rate. The Standard Rate is on the DoD Comptrollers website, Tab G: http://www.dod.mil/comptroller/rates/. The effective date for these rates shall be as prescribed by the comptroller.

NOTE:
Subsistence charge is billed under the Medical Services Account (MSA) Program only. The MSA office shall collect subsistence charges from all persons, including inpatients and transient patients not entitled to food service at Government expense. Please refer to DoD 6010.15–M, Military Treatment Facility UBO Manual, April 1997, and the DoD 7000.14–R, "Department of Defense Financial Management Regulation," Volume 12, Chapter 19 for guidance on the use of these rates.

4. Cosmetic Surgery Rates.

4.1. List of Procedures. The procedures listed in Appendix A are those procedures identified as cosmetic surgery procedures.

4.2. Patient Payment. Elective cosmetic surgery fees are based on the service provided. Family members of active duty personnel, retirees and their family members, and survivors are fully responsible for all the charges and services (including implants, injectibles, and billable ancillaries) associated with the elective surgical procedure. The

family members of active duty personnel, retirees and their family members, and survivors shall be charged the rate as specified in the CY 2005 full reimbursable rates. Even if the patient has valid other health insurance (OHI), the patient is still responsible for the bill. The patient may file a claim with his insurance company. (Note: Follow DoD billing policy for Active Duty.)

4.2.1. Laser Vision Correction. Refer to Office of the Assistant Secretary of Defense (Health Affairs) policy on Vision Correction Via Laser Surgery For Non-Active Duty Beneficiaries, April 7, 2000, for further guidance on billing for these services. The policy can be downloaded from: http://www.ha.osd.mil/policies/2000/00_003.pdf

4.3. Professional Charges for Cosmetic Surgery.

4.3.1. Rates for the professional charges and anesthesia services are derived from the CHAMPUS Maximum Allowable Charge (CMAC) CY05 rate table based on the FY05 median location (375, Brazoria, Texas.). Rates are not based on the MTF's geographical location.

4.3.2. The CMAC CY 2005 "facility physician" category is used for the professional component for services furnished by the provider in an operating room or an ambulatory procedure unit.

4.3.3. The CMAC CY 2005 "non facility physician" category is used for the professional component for services furnished in the provider's office.

4.4. Institutional Rate for Cosmetic Surgery.

4.4.1. Institutional charges: The institutional fee is based on two different rate categories depending on the location of the procedure. For cosmetic surgery conducted in a provider's office, a separate institutional fee will not apply.

4.4.1.1. The institutional fee for cosmetic surgery for outpatients using a hospital operating room is based on the CMS Ambulatory Payment Classification (APC) rate associated with the principal procedure.

4.4.1.2. The institutional fee for cosmetic surgery for outpatients using a clinic operating room is based on the CMS Ambulatory Surgical Center (ASC) rate associated with the principal procedure.

4.5. Anesthesia Rate for Cosmetic Surgery. The anesthesia professional rate is the CHAMPUS Maximum Allowable Charge (CMAC) for the median location (375, Brazoria, Texas), which is $18.23 for each base unit.

4.6. Inpatient Rate for Cosmetic Surgery.

4.6.1. Inpatient charges: Institutional charges for inpatient surgical services are based on the diagnosis related group (DRG) of the hospitalization. The institutional fee is the facility's Adjusted Standardized Amount (which is based on the actual cost to the facility to produce a relative weighted product) multiplied by the relative weighted product for the DRG.

APPENDIX A:

The following are notations found in Appendix A:

(a) Charges for inpatient surgical care services are based on the cost per DRG.

(b) Each regional lipectomy shall carry a separate charge. Regions include head and neck, abdomen, trunk and hips.

APPENDIX A: ELECTIVE COSMETIC SURGERY PROCEDURES

Cosmetic Surgery Procedure	Current Procedural Terminology (CPT)
Abdominoplasty	15831
Blepharoplasty	15820 15821 15822 15823
Botox Injection for rhytids	J0585
Brachioplasty	15836
Brow Lift	15824
Buttock Lift	15835
Canthopexy	21282
Capsulectomy	19328 19330
Cervicoplasty	15819
Chemical Peel	15788 15789
Collagen Injection, subcutaneous	11950 11951 11952 11954
Dermabrasion	15780 15781 15782 15783
Electrolysis	17380

Cosmetic Surgery Procedure	Current Procedural Terminology (CPT)
Excision/destruction of minor benign skin lesions	11400 11401 11402 11403 11404 11406 11420 11421 11422 11423 11424 11426 11440 11441 11442 11443 11444 11446 17000 17003 17004 17106 17107 17108 17110 17111 17250
Facial Rhytidectomy	15824 15825 15826 15828 15829
Genioplasty	21120 21121 21125 21127
Hair Restoration	15775 15776
Hip Lift	15834
Lipectomy Suction per region	15876(b) 15877(b) 15878(b) 15879(b)

Cosmetic Surgery Procedure	Current Procedural Terminology (CPT)
Malar/Maxilla/Nasal Augmentation	21210 21270
Mammoplasty – augmentation	19318 19324 19325
Mandibular or Maxillary Reconstruction	21195(a) 21196(a)
Mastopexy	19316
Osteoplasty (Augmentation/Reduction)	21208 21209
Osteotomy (Mandible/Maxilla)	21198 21206
Otoplasty	69300
Reconstruction midface, LeFort 1	21141(a)
Rhinoplasty	30400 30410 30430 30435 30450 30460 30462
Scar Revisions beyond CHAMPUS	13100 13101 13102 13120 13121 13122 13131 13132 13133 13150 13151 13152 13153
Sclerotherapy	36468 36469 36470 36471
Tattoo Removal	15783
Thigh Lift	15832