DEPARTMENT OF DEFENSE (DoD) UNIFORM BUSINESS OFFICE
MEDICAL & DENTAL REIMBURSEMENT RATES AND
COSMETIC SURGERY 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) 2006 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) 2006 inpatient rates released October 1, 2005, remain in effect until further notice.

1.2. The CY 2006 outpatient medical and dental rates and CY 2006 cosmetic surgery rates are effective June 12, 2006.

1.3. The CY 2006 Outpatient Medical and Dental Services Reimbursement Rate Package update consists of the following rates:

Section 3.2.1: Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (CMAC) Rate Tables
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) Rates
Section 3.7: Transportation Rates
Section 3.8: Pharmacy Dispensing Fee
Section 3.9: Other 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 outpatient rate (FOR) charges when billing for outpatient services as described below.

2.1.1. International Military Education and Training (IMET) rate:
Ambulance: 56.49% of the FOR
Anesthesia: 59.87% of the FOR
Dental: 40.00% of the FOR
Immunization: 55.32% of the FOR
Pharmacy Dispensing Fee: 25% of the FOR
Air Evacuation – Ambulatory: 53.86% of the FOR
Air Evacuation – Litter: 53.83% of the FOR
All other IMET where specific rates are not specified (e.g. CMAC, durable medical equipment): 56.13% of the FOR.

2.1.2. Interagency/Other Federal Agency Sponsored Rate (IOR):
Ambulance: 94.81% of the FOR
Anesthesia: 94.59% of the FOR
Dental: 95.00% of the FOR
Immunization: 93.62% of the FOR
Pharmacy Dispensing Fee: 100.00% of the FOR
Air Evacuation – Ambulatory: 94.59% of the FOR
Air Evacuation – Litter: 94.54% of the FOR
All other IOR where specific rates are not specified (e.g., CMAC, durable medical equipment): 94.80% of the FOR.

2.2. Full Reimbursement. The full outpatient rate (FOR) shall be used for claims submission to Third Party Payers and to all other applicable payers not included within IMET and IOR billing guidance. The FOR is calculated through analysis of FY2005 expense and workload from all DoD military treatment facilities that offered outpatient services. The data analysis included processing to identify and eliminate poor quality data. It also included adjustments of the FY2005 data to account for FY2006 military and civilian pay raises, asset use fees, distribution of expenses between payroll and non-payroll expense categories, and a DoD inflation adjustment. The Discount Rates for IMET and IOR are calculated by removing from the FOR those types of expenses which are specifically to be excluded from consideration in IMET and Interagency billing. The rates included in section 3 represent the full rate (unless otherwise specified).

3. Outpatient and Inpatient Medical and Dental Services Rates/Charges.

3.1. Terminology.

3.1.1. Ambulatory Patient Visit (APV). An APV is defined in DoD Instruction 6015.1-M, "Ambulatory Patient Visit (APV)," December 9, 1999, as procedures or surgical interventions that require pre-procedure care, a procedure to be performed, and immediate post-procedure care as directed by a qualified health care provider. Minor procedures that are performed in the outpatient clinic setting that do not require post-procedure care by a medical professional shall not be considered APVs. The nature of the procedure and the medical status of the patient combine for a requirement for short-term care, but not inpatient care. These procedures are appropriate for all types of patients (obstetrical, surgical and non surgical) who by virtue of the procedure or anesthesia require post-procedure care and/or monitoring by medical personnel. An ambulatory procedure unit (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 or care associated with APVs.

3.1.2. Ambulatory Services. Military treatment facility (MTF) ambulatory services encompass the healthcare services furnished 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.

3.1.3. Outpatient Services. Services rendered in other than the ED, observation unit, APU or in the operation 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 199.14(h), are used to determine 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., office and clinic visits), ambulatory services (e.g., ambulatory procedure visits, observation and emergency department visits), and ancillary services (e.g., laboratory and radiology).

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. For all military treatment

facilities located Outside the Continental United States (OCONUS), the "National Average" CMAC locality (300) is used. 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 3.2.1.1. above are available on the TMA UBO website at: *http://tricare.osd.mil/rm/index.cfm?pageId=10.*

3.2.2. Institutional Component.

3.2.2.1. Emergency Department (ED). TRICARE ambulatory payment classification (APC) rates for emergency department evaluation & management codes 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 ED institutional rate and is billed separately.

3.2.2.2. Observation (OBS). The institutional charges for observation evaluation & management codes are derived using Medical Expense and Performance Reporting System (MEPRS) cost data to determine the hourly OBS rate. The hourly OBS rate is then multiplied by the average OBS patient stay of 8 hours. Finally, the institutional charge is added to the CMAC professional charge to generate the DoD OBS overall rate.

3.2.2.3. Ambulatory Patient 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 **$1,299.00**.

3.3. Dental Rates. MTF outpatient charges are based on a dental flat rate multiplied by a 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. illustrates the dental rate for IMET, IOR and Other (Full/Third Party).

Table 3.3.1.

CDT	Clinical Service	IMET	IOR	Other (Full/Third Party)
	Dental Services ADA code weight multiplier	$40.00	$95.00	$100.00

Example: For ADA code D0270, bitewing single film, the weight is 0.39. The weight of 0.39 is multiplied by the appropriate rate, IMET, IOR, 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 $39.00 ($100.00 x 0.39 = $39.00).

The list of CY 2006 ADA codes and weights for dental services is too large to include in this document. This rate table may be found on the TMA's UBO website at: *http://tricare.osd.mil/rm/index.cfm?pageId=10.*

3.4. Immunization Rates.

3.4.1. A separate charge shall be made for each immunization, injection or medication administered. The charge for immunizations, allergen extracts, allergic condition tests, and the administration of certain medications, when these services are provided in a separate immunization or "shot" clinic, are described below.

3.4.1.1. Based on CMAC rates in cases in which such rates are available.

3.4.1.2. If there is no CMAC rate the National Average Payment (NAP) is used. The NAP represents commercial and/or Medicare national average payment for services, supplies, drugs, and non-physician procedures reported using Healthcare Common Procedure Coding System (HCPCS) Level II codes.

3.4.1.3. If there is no CMAC rate and there is no NAP rate, a flat rate of **$47.00** 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.

3.5. Anesthesia Rate. The flat rate for anesthesia professional services is based on an average DoD cost of service in all MTFs. The flat rate for anesthesia is **$795.00.**

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 A4206-A9999, E0100-E9999, K0001-K0547, L0100-L9999, and V0001-V9999. This rate table may be found on the TMA UBO website at:

http://tricare.osd.mil/rm/index.cfm?pageId=10.

3.7. Transportation Rates.

3.7.1. Ambulance Rate. Ambulance charges shall be based on hours of service, in 15-minute increments. The rates for IMET, IOR 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	IOR	Other (Full/Third Party)
A0999	Ambulance	$87.00	$146.00	$154.00

3.7.2. Air Evacuation 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, IOR and Other (Full/Third Party) are listed in Table 3.7.2. below.

Table 3.7.2.

Clinical Service	IMET	IOR	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 Fee/Rates. 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) codes.

3.8.1.1. The pharmaceutical rate table may be found on the TMA UBO website at: *http://tricare.osd.mil/rm/index.cfm?pageId=10.*

3.8.1.2. Pharmacy Dispensing Fee. 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 2006 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 available from 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 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. Active duty personnel, retirees and their family members, and survivors are fully responsible for all the charges and services (including implants, injectables, and billable ancillaries) associated with the elective surgical procedure. Active duty personnel, retirees and their family members, and survivors shall be charged the rate as specified in the CY 2006 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.

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://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) rate table based on the FY06 median location (300, National Average rates). Rates are not based on the MTF's geographical location.

4.3.2. The CMAC CY 2006 "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 2006 "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 an 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 100% of the TRICARE ambulatory payment classification (APC) rate associated with the principal procedure, and 50% of the APC rate for each additional procedure.

4.4.1.2. The institutional fee for cosmetic surgery for outpatients using a clinic operating room is based on 100% of the TRICARE ambulatory surgical center (ASC) rate associated with the principal procedure, and 50% of the ASC rate for each additional procedure.

4.4.1.3. Ancillary services (e.g., laboratory, radiology) are billed at the full outpatient rate (FOR) from the "National Average" CMAC locality (300).

4.5. Anesthesia Rate for Cosmetic Surgery. The anesthesia professional rate is the CHAMPUS Maximum Allowable Charge (CMAC) for the median location (303, Arizona), which is $17.85 for each base unit.

4.6. Inpatient Rate for Cosmetic Surgery.

4.6.1. Inpatient charges: Institutional and professional charges for inpatient surgical services are based on the diagnosis related group (DRG) of the hospitalization. The institutional and professional fee is the Average (FY) 2006 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.

(c) Added this year

APPENDIX A: ELECTIVE COSMETIC SURGERY PROCEDURES

Cosmetic Surgery Procedure	Current Procedural Terminology (CPT)
Abdominoplasty	15831
Abrasion	15786 (c) 15787 (c)
Blepharoplasty	15820 15821 15822 15823 67903 (c) 67904 (c)
Botox Injection for rhytids	J0585
Brachioplasty	15836
Brow Lift	15824
Buttock Lift	15835
Canthopexy	21282
Canthoplasty	67950 (c)
Capsulectomy	19328 19330
Cervicoplasty	15819
Chemical Peel	15788 15789

Cosmetic Surgery Procedure	Current Procedural Terminology (CPT)
Collagen Injection, subcutaneous	11950 11951 11952 11954
Dermabrasion	15780 15781 15782 15783
Electrolysis	17380
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

Cosmetic Surgery Procedure	Current Procedural Terminology (CPT)
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)
Malar/Maxilla/Nasal Augmentation	21210 21270
Mammoplasty Augmentation	19318 19324 19325
Mandibular or Maxillary Reconstruction	21193 (a)(c) 21194 (a)(c) 21195 21196 (a)
Mastopexy	19316
Osteoplasty (Augmentation/Reduction)	21208 21209
Osteotomy (Mandible/Maxilla)	21198 21206
Otoplasty	69300
Reconstruction midface, LeFort 1	21141
Rhinoplasty	30400 30410 30430 30435 30450 30460 30462

Cosmetic Surgery Procedure	Current Procedural Terminology (CPT)
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
Vein Stripping	37718 (c) 37722 (c) 37735 (c)