



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUN 20 2007

MEMORANDUM FOR UNDERSECRETARY OF DEFENSE (COMPTROLLER)

SUBJECT: Medical and Dental Reimbursement, Cosmetic Surgery and Pharmacy Rates

The updated Calendar Year 2007 Department of Defense Medical and Dental rates are to be used by Department of Defense Medical and Dental facilities, effective June 30, 2007, until superceded.

The July 2007 Pharmacy rates are to be used by Department of Defense Medical and Dental facilities, effective June 30, 2007, until superceded.

The TRICARE Management Activity (TMA) requests that this package be posted on the Comptroller's website: <http://www.defenselink.mil/comptroller/rates/fy2007.html>.

My point of contact for this action is Lieutenant Colonel Jeanne Yoder, TMA Uniform Business Office at 703-681-3492, ext. 4068, or email: Jeanne.yoder@tma.osd.mil.


S. Ward Casscells, MD

Attachments:
As stated

ATTACHMENT 1:
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) developed the Calendar Year (CY) 2007 medical and dental reimbursement rates and cosmetic surgery reimbursement rates. These are the charges for professional and institutional healthcare services provided in Military Treatment Facilities (MTFs) operated as part of the Defense Health Program (DHP). These rates shall be used to submit claims for reimbursement of the costs of the healthcare services provided by MTFs in accordance with the various 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) 2007 inpatient rates released October 1, 2006, remain in effect until further notice.

1.2. The CY 2007 outpatient medical and dental rates and CY 2007 cosmetic surgery rates are effective for healthcare services provided on or after June 30, 2007.

1.3. This CY 2007 Outpatient Medical and Dental Services Reimbursement Rate Package contains the following rates:

Section 3.2.1: Civilian Health and Medical Program of the Uniformed Services
(CHAMPUS) Maximum Allowable Charge (CMAC) Rate Tables
modified for UBO use

Section 3.3: Dental Rates

Section 3.4: Immunization/Injectables 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: 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 modified for UBO use are not included in this package. These rates are available from

the TRICARE Management Activity (TMA) Uniform Business Office (UBO) website:
http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.

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. The International Military Education and Training (IMET) and the Interagency/Other Federal Agency Sponsored Rate (IOR) rates for Air Evacuation of litter patients shall be based on the inpatient full reimbursement rate (FRR).

2.1.1. International Military Education and Training (IMET) rate:

Ambulance: 58.24% of the FOR

Anesthesia: 60.16% of the FOR

Dental: 44.79% of the FOR

Immunization: 58.33% of the FOR

Air Evacuation – Ambulatory: 58.10% of the FOR

Air Evacuation – Litter: 60.08% of the FRR

All other IMET where specific rates are not specified (e.g., CMAC, durable medical equipment): 58.10% of the FOR.

2.1.2. Interagency/Other Federal Agency Sponsored Rate (IOR):

Ambulance: 94.71% of the FOR

Anesthesia: 94.47% of the FOR

Dental: 94.79% of the FOR

Immunization: 93.75% of the FOR

Air Evacuation – Ambulatory: 94.72% of the FOR

Air Evacuation – Litter: 94.44% of the FRR

All other IOR where specific rates are not specified (e.g., CMAC, durable medical equipment): 94.72% 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 discounts for IMET and IOR are calculated based on an analysis of FY2006 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 FY2006 data to account for FY2007 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 and FRR 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). IOR rates exclude the “Miscellaneous

Receipts” (asset use charge percentage for military pay, civilian pay and other) portion of the FRR price computation. The IMET rates exclude both the “Miscellaneous Receipts” portion and the “Military Personnel” portion of the FRR price computation.

3. Outpatient Medical and Dental Services Rates/Charges.

3.1. Terminology.

3.1.1. Ambulatory Procedure Visit (APV). An APV is defined in DoD Instruction 6015.1-M, “Ambulatory Procedure Visit (APV),” December 9, 1999, as a procedure or surgical intervention that requires 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 of care associated with APVs.

3.1.2. Emergency Department Services. Military treatment facility (MTF) ambulatory services furnished in the Emergency Department are strictly institutional charges.

3.1.3. Observation Services. Military treatment facility (MTF) ambulatory services furnished in Observation (OBS) Units are strictly institutional charges.

3.1.4. Outpatient Services. Services rendered in other than the observation unit, the Emergency Department, or an APU.

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 the professional and technical components of 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), and ancillary services (e.g., laboratory and radiology). UBO CMAC rates differ from standard TMA CMAC rates in that UBO CMAC rates include charges for additional services not “covered” by TRICARE.

3.2.1.2. UBO CMAC rates are calculated for 91 distinct “localities,” which recognize differences in local costs to provide healthcare services in the many different geographic regions based in which MTFs are located. 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), CMAC locality (391) is used. The complete DMIS ID-to-CMAC Locality table is available at:

http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.

3.2.1.3. For each CMAC locality, the UBO creates two sub-tables of rates: CMAC and Component. The CMAC rate table specifies the rates to use as payment for professional services and procedures identified by CPT and HCPCS codes, which cannot be separately provided as component services. The CMAC table is further categorized by provider class. The Component rate table specifies the rates to use for CPT codes, which can be provided as distinct professional and technical components, or as a combined professional and technical service. A separate rate is provided for each component, further categorized by provider class.

3.2.1.4. CMAC Provider Class. The UBO CMAC rates are computed based on the four provider classes: 1 – Physician Class, 2 – Psychologist Class, 3 – Other Mental Health Providers, and 4 – Extra Medical Provider. UBO CMAC-based rates described in section 3.2.1.1. are available on the TMA UBO website at:

http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.

3.2.2. Institutional Component.

3.2.2.1. Emergency Department (ED). TRICARE Ambulatory Payment Classification (APC) rates for emergency department Evaluation & Management services are used to determine the DoD ED institutional charges. For CPT codes 99281-99285 only the institutional component is billed. NOTE: Ambulance transport to the ED and from the ED to another location is not part of the ED institutional rate and is billed separately.

3.2.2.2. Observation (OBS). The CPT codes used for Observation services include: 99218-99220 and 99234-99236. The rates for these Observation services 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 FY 2006 OBS patient stay of 6.25 hours. Only the institutional charge is billed.

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 treatment facility APVs divided by the total number of APVs. The flat rate is **\$1,433.00**.

3.3. Dental Rates. MTF dental charges are based on a dental flat rate multiplied by a DoD-established relative weight for each of the American Dental Association (ADA) Current Dental Terminology (CDT) codes representing the dental services/procedures performed. The dental flat rate is based on the average DoD cost of dental services at all dental treatment facilities. Table 3.3.1. illustrates the dental rate for IMET, IOR and Other (Full/Third Party).

CDT	Clinical Service	IMET	IOR	Other (Full/Third Party)
	Dental Services CDT code weight multiplier	\$43.00	\$91.00	\$96.00

Example: For CDT code D0270, bitewing single film, the DoD relative weight is 0.24. The relative weight of 0.24 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 CDT code will be \$96.00 x 0.24, which is \$23.04.

The list of CY 2007 CDT codes and relative weights for dental services is too large to include in this document. This table may be found on the TMA's UBO website at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.

3.4. Immunization/Injectables 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. Immunization rates are based on CMAC rates whenever CMAC 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. Human Papilloma Virus (HPV) Vaccination Rate. The charge for the HPV vaccination is \$100.00 for the vaccine, in addition to an administration fee.

3.4.1.4. If there is no CMAC rate and there is no NAP rate, a flat rate of **\$48.00** 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 **\$886.00**.

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 for which rates are provided include: A4206-A9999, E0100-E9999, K0001-K0547, L0100-L9999, and V0001-V9999. This rate table may be found on the TMA UBO website at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.

3.7. Transportation Rates.

3.7.1. Ground 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).

CDT/CPT	Clinical Service	IMET	IOR	Other (Full/Third Party)
A0999	Ambulance	\$99.00	\$161.00	\$170.00

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 below in Table 3.7.2.

Table 3.7.2.

Clinical Service	IMET	IOR	Other (Full/Third Party)
AirEvac Medical Services – Ambulatory	\$301.00	\$491.00	\$518.00
AirEvac Medical Services – Litter	\$903.00	\$1,419.00	\$1,503.00

3.8. Other Rates.

3.8.1. 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 this rate 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, November 2006, and the DoD 7000.14-R, “Department of Defense Financial Management Regulation,” Volume 12, Chapter 19 for guidance on the use of this rate.

3.8.2. OCONUS Prepaid Elective Pregnancy Termination Rate.

3.8.2.1. The Department of Defense Appropriations Act for FY 1996 and the Department of Defense Authorization Act for FY 1996 revised the DoD policy concerning provision of prepaid elective pregnancy termination in overseas MTFs such that the authority of those MTFs to provide prepaid elective pregnancy termination is limited to cases in which the pregnancy is the result of an act of rape or incest.

3.8.2.2. When an overseas MTF provides prepaid elective pregnancy termination services under the limited authority identified above, the rate charged shall be the Full Reimbursement Rate (FRR) for services performed for an inpatient. If the services are provided as an Ambulatory Procedure Visit (APV), the prepaid rate shall be calculated using an estimate of the Professional Component rate described in paragraph 3.2, plus the APV Institutional Rate identified in paragraph 3.2.2.3, plus the anesthesia rate (if anesthesia will be used) identified in paragraph 3.5 above.

4. Elective Cosmetic Surgery Rates.

4.1. List of Procedures. The procedures listed in Appendix A are those procedures identified as elective cosmetic surgery procedures, when performed without medical necessity. Only TRICARE eligible beneficiaries are authorized to receive cosmetic procedures.

4.2. Patient Payment. Elective cosmetic surgery fees are based on the service provided. The patient receiving the cosmetic procedure (e.g., active duty personnel, retirees and their family members, and survivors) is fully responsible for all the charges and services (including implants, injectables, and billable ancillaries) associated with the elective surgical procedure. The patient shall be charged the rate as specified in the CY 2007 full reimbursement rates. The patient is still responsible to pay for the entire cosmetic procedure (e.g., institutional, professional, anesthesia, implants) even if the patient has valid other health insurance (OHI). 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 these services. The policy can be downloaded from: http://www.ha.osd.mil/policies/2000/00_003.pdf.

4.3. Professional Charges for Elective 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 FY07 median location (303, Arizona). Rates are not based on the treating MTF's geographical location.

4.3.2. The CMAC CY 2007 "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 2007 "non facility physician" category is used for the professional component for services furnished in the provider's office.

4.4. Institutional Rate for Elective 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 elective cosmetic surgery conducted in a provider's office the institutional fee is included in the "non facility physician" professional category as described in paragraph 4.3.3. above.

4.4.1.1. The institutional fee for cosmetic surgery for outpatients using a hospital operating room or Ambulatory Procedure Unit (APU) is based on the lower of 100% of the TRICARE ambulatory payment classification (APC) rate associated with the

principal procedure, and 50% of the APC rate for each additional procedure, or 100% of the TRICARE ambulatory surgical center (ASC) rate associated with the principal procedure, and 50% of the ASC rate for each additional procedure, whichever fee is lower.

4.4.1.2. In those instances when there is no APC or ASC associated with the cosmetic procedure, such as calf augmentation, the price of a similar procedure (e.g., involving similar time, skills and equipment) is used.

4.4.1.3. Institutional prices are rounded to the nearest \$ 10.00.

4.4.1.4. Ancillary services (e.g., laboratory, radiology) are billed at the full outpatient rate (FOR) from the median CMAC locality (303, Arizona).

4.5. Anesthesia Rate for Elective Cosmetic Surgery. The anesthesia professional rate is the CHAMPUS Maximum Allowable Charge (CMAC) for the median location (303, Arizona), which is \$15.46 for each base unit.

4.6. Inpatient Rate for Elective Cosmetic Surgery.

4.6.1. Inpatient charges: Institutional and professional charges for inpatient surgical services are based on the diagnosis related group (DRG) assigned to the hospitalization. The institutional and professional fee is the Average MTF (FY) 2007 Adjusted Standardized Amount (which is \$ 9,265.67) multiplied by the relative weighted product for the DRG.

APPENDIX A: ELECTIVE COSMETIC SURGERY PROCEDURES

Cosmetic Surgery Procedure	CPT /CDT
<i>Dental</i>	
Porcelain Veneers	D2962
Laser Teeth Whitening	D9999
Teeth Whitening	D9972 D9973 D9974
<i>Injections</i>	
Administration of Collagen Injections – subcutaneous	11950 11951 11952 11954
Injection of solution to close off varicose veins (Sclerotherapy)	36469 36468 36470 36471
<i>Laser Skin Procedures</i>	
Destruction of tattooed pigments using a laser beam (Laser Tattoo Removal); < 30 sq cm or >30 sq cm	17999 17999
Destruction of varicose veins using laser beam (Laser treatment of Leg Veins)	17999
Removal of the damaged upper layers of the skin using a laser beam (Laser Skin Resurfacing– ablative) full-face or segment of face	17999
Removal of hair follicles using a laser beam (Laser Hair Removal)	17999
Treatment of skin layers by stimulating collagen using a laser beam (Laser Skin Resurfacing –non ablative) per region, full-face or segment of face and/or non-facial	17999
<i>Repair and/or Reconstruction</i>	
<i>Breast</i>	
Breast enlargement w/o implants (Mammaplasty Augmentation w/o implants)	19324
Breast enlargement w/implants (Mammaplasty Augmentation w/implants)	19325
Breast lift (Mastopexy)	19316
Breast nipple; reduction or enlargement (Nipple/Areola Reconstruction)	19350
Breast reduction for Women (Mammoplasty; reduction)	19318
Breast reduction for Men (Mastectomy- Gynecomastia)	19300
Enlargement of the Male Chest w/implants (Pectoral Augmentation)	21899
Mastopexy with insertion of breast implant immediately following surgery	19340
Removal of breast prosthetic implant (Removal of intact Mammary implant)	19328
Removal implant material contained inside the breast (Removal of Implant material)	19330
<i>Cheek</i>	
Enlargement of the cheek (Malar Augmentation)	21270
<i>Chin</i>	
Chin Augmentation/Reduction(Genioplasty)	21120 21121 21125 21127

Cosmetic Surgery Procedure	CPT /CDT
<i>Repair and/or Reconstruction</i>	
<i>Ear</i>	
Reshaping of the ear (Otoplasty)	69300
<i>Eye</i>	
Reshaping of the eyelids (Blepharoplasty)	15820 15821 15822 15823
Tightening of lower eyelid (Lateral Canthopexy)	21282
Reshaping corners of the eye (Canthoplasty)	67903 67904 67950
<i>Facial bones</i>	
Surgical repair or alteration of facial bones (Osteoplasty)	21208 21209
Midface (Midface LeFort)	21141
Transplant/Implant bone for nasal, jaw or cheek (Bone graft; nasal, maxillary or malar)	21210
<i>Jaw (Upper/Lower)</i>	
Reconstruction of lower jaw (Reconstruction of Mandibular body w/ or w/o bone graft, w/ or w/o fixation)	21193 21194 21195 21196
Surgical division or sectioning of upper/lower jaw (Osteotomy Mandible/Maxilla)	21198 21206
<i>Neck</i>	
Neck lift (Cervicoplasty)	15819
<i>Nose</i>	
Reshaping of the nose (Rhinoplasty)	30400 30410 30430 30435 30450
<i>Other</i>	
Enhancement of the Buttock w/ Implants or injection of fat (Buttock Augmentation)	17999
Enhancement of the Lip; upper/lower (Lip Augmentation)	17999
Enlargement of the Calf w/Implants (Calf augmentation)	17999
Reshaping of the Belly button (Umbilicoplasty)	17999
<i>Removal</i>	
<i>Excessive Fat Deposits</i>	
Liposuction – Suction assisted per region	15876 15877 15878 15879
Liposuction w/ use of ultrasound guidance (Ultrasound) assisted per region	17999
Removal and transfer of body fat via liposuction and injection, per area [Autologous Fat Transfer (AFT), Microlipoinjection]	17999

Cosmetic Surgery Procedure	CPT /CDT
<i>Removal</i>	
<i>Excessive Fat Deposits</i>	
Liposuction of trunk, upper/lower extremity (Total Body Liposuction – Suction assisted)	15877 15878 15879
Liposuction of trunk, upper/lower extremity w/ use of ultrasound guidance (Total Body Liposuction – Ultrasound assisted)	17999
<i>Excessive Skin and Subcutaneous Tissue</i>	
Arm lift (Brachioplasty)	15836
Buttock Lift	15835
Chin (Submental fat pad)	15838
Hip Lift	15834
Thigh Lift	15832
Combination of thigh and buttock lift (Total Lower Body Lift)	15832 15835
Combination of thigh, buttock lift w/ removal of excess abdominal skin/ fat and tummy tuck (Total Lower Body Lift w/ Panniculectomy & Abdominoplasty)	15830 +15847 15832 15835
Tightening of abdominal muscle walls with removal of excess skin/fat – Tummy Tuck (Abdominoplasty)	17999
Removal of excess skin and fat only, from abdomen (Panniculectomy)	15830
Removal of excess skin and fat from abdomen with a Tummy Tuck (Panniculectomy w/ Abdominoplasty)	15830 +15847
<i>Facial Wrinkles (Rhytidectomy)</i>	
Cheek, Chin, and Neck	15828
Forehead (Brow) Lift	15824
Frown lines	15826
Neck	15825
Superficial muscle of the face and neck (SMAS)	15829
<i>Facial Wrinkles (Soft tissue fillers)</i>	
Botox	J5085
Radiance/Radiesse	J3490
Restylane	J3490
Zyderm/Zyplast	J3490
<i>Resurfacing</i>	
Chemical Peel – facial/non-facial	15788 15789 15792 15793
Removal of the top layers of the skin by “sanding” the surface (Dermabrasion - facial/non-facial)	15780 15781 15782
Removal of tattoo by using “sanding” technique (Dermabrasion – Tattoo Removal)	15783

Cosmetic Surgery Procedure		CPT /CDT
Resurfacing		
Removal of skin (thin layer) using a mild form of abrasion Microdermabrasion – facial, per treatment		17999
Removal of hair follicles by electric cauterization – Electrolysis per ½ hour		17380
Removal and transplant grafts of skin containing hair (Hair Transplant – Graft)		
1-15 grafts		15775
More than 15 grafts		15776
Harvesting of hair 1-5 follicles at a time (Hair Transplant - Micro/Mini Follicular unit Transplantation)		
1-500 follicles		17999
More than 500 follicles		17999
Revisions		
Skin Procedures		
Minimize appearance of scar (Scar Revisions)		13100 13101 13102 13120 13121 13122 13131 13132 13133 13150 13151 13152 13153
Surgical removal of varicose veins (Vein Stripping)		37718 37722 37735 37765 37766 37700

Cosmetic Surgery Procedure	CPT /CDT
<i>Skin Procedures</i>	
Excision/Destruction of minor benign skin lesions	11400
	11401
	11402
	11403
	11404
	11406
	11420
	11421
	11422
	11423
	11424
	11426
	11440
	11441
	11442
	11443
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	11446
	17000
	17003
	17004
	17106
	17107
	17108
	17110
	17111
	17250

**ATTACHMENT 2:
DEPARTMENT OF DEFENSE (DoD) UNIFORM BUSINESS OFFICE
JULY 2007 PHARMACY RATES**

1. Introduction.

1.1. In accordance with Title 10, United States Code, section 1095, the DoD Uniform Business Office (UBO) developed the July 2007 pharmacy rates. These are the rates for pharmaceuticals dispensed in Military Treatment Facilities (MTFs) operated as part of the Defense Health Program (DHP). These rates shall be used to submit claims for reimbursement of the costs of the pharmaceuticals provided by MTFs in accordance with the various MTF Cost Recovery Programs: Medical Services Accounts (MSA), Third Party Collections Program (TPCP) and Medical Affirmative Claims (MAC).

1.2. The July 2007 pharmacy rates are effective for pharmaceuticals provided on or after June 30, 2007 until superceded.

2. Pharmacy Rates/Charges

2.1. Pharmacy Billing

2.1.1 Pharmacy Billing. All pharmaceutical prescriptions filled and dispensed by the MTF are billable. This includes pharmaceuticals prescribed both internally by MTF providers and externally by civilian providers.

2.1.2. Pharmaceutical Rates. The rates are based on the Average Wholesale Price (AWP) from the Defense Supply Center- Philadelphia's Managed Care Pricing File and identified by National Drug Code (NDC). Only NDCs for prescription pharmaceuticals are billed.

2.1.2.1. There is no separate Pharmacy dispensing fee.

2.1.2.2. Once published, the pharmaceutical rate table may be found on the TMA UBO website at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.