THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MEMORANDUM FOR UNDER SECRETARY OF DEFENSE (COMPTROLLER)

SUBJECT: Calendar Year 2024 Outpatient Medical, Dental, and Elective Cosmetic Procedure Reimbursement Rates and Guidance

The attached document contains the Uniform Business Office (UBO) Calendar Year (CY) 2024 Outpatient Medical, Dental, and Elective Cosmetic Procedure Reimbursement Rates and Guidance. The rates are to be used by military medical treatment facilities, effective October 1, 2024. The CY 2024 rates supersede the CY 2023 rates. We request this package be posted on the Comptroller's website under the Financial Management Reports section "Medical and Dental Services" at https://comptroller.defense.gov/Financial-Management/Reports/rates2024.

My point of contact for this action is Ms. DeLisa Prater, Program Manager, Defense Health Agency/UBO. She may be reached at (703) 275-6380 or at delisa.e.prater.civ@health.mil.

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Acting

Attachment:
As stated

Department of Defense, Defense Health Agency Uniform Business Office
Calendar Year 2024 Outpatient Medical, Dental, and Elective Cosmetic Procedure Reimbursement Rates and Guidance

1.0 Introduction

The Department of Defense (DoD) Defense Health Agency (DHA) Uniform Business Office (UBO) developed the Calendar Year (CY) 2024 Outpatient Medical, Dental and Elective Cosmetic Procedure Reimbursement Rates in accordance with Title 10, United States Code, Section 1095. These rates are the charges for professional and institutional healthcare services provided in military medical treatment facilities (MTFs) financed by the Defense Health Program appropriation. These rates are 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 Account (MSA), Third Party Collections and Medical Affirmative Claims.

The "CY 2024 Outpatient Medical, Dental and Elective Cosmetic Procedure Reimbursement Rates and Guidance" describes rates that are effective for healthcare services provided on or after October 1, 2024, and will remain in effect until superseded.

Furthermore, healthcare service procedure codes or rates released after approval, on a quarterly basis as part of the HCPCS code set updates or as ad hoc CPT/HCPCS additions and deletions, would follow the same current/approved methodology described in these rates and guidance and are effective on the date set by the UBO Program Office.

MHS Charge Description Master (CDM):

MTFs utilize the charging and billing methodology aligned with the modernized electronic health record and billing system. Healthcare service procedure codes outlined in the Inpatient and Outpatient Rates policy letters are housed in the MHS CDM for itemized billing of patient care provided in MTFs.

For CY 2024, healthcare services traditionally updated using Medical Expense and Performance Reporting System (MEPRS) data were developed using an alternative methodology, adjusting the CY 2023 rate by the Operation and Maintenance (O&M) inflation factor from Fiscal Year (FY) 2023 to FY 2024 (3.17%). These services include Ambulance, Dental, certain Immunizations, and the Ambulatory Procedure Visit.

The O&M inflation factor used in the CY 2023 rate development cycle (FY 2022-FY 2023) was 4.13%.

This "CY 2024 Outpatient Medical, Dental, and Elective Cosmetic Procedure Reimbursement Rate and Guidance" covers the following rates and discounts for billing other government agencies and programs:

Section 3.2:	Civilian Health and Medical Program of the Uniformed Services Maximum Allowable Charge Rate Tables (modified for UBO use)
Section 3.3:	Dental Rates
Section 3.4:	Immunization/Injectables Rates
Section 3.5:	Anesthesia Rates
Section 3.6:	Durable Medical Equipment/Durable Medical Supplies Rates
Section 3.7:	Transportation Rates
Section 3.8:	Food Service Charges at Appropriated Fund Dining Facilities (Subsistence Rate)
Section 4.2:	Elective Cosmetic Procedure Rates

Due to size, the sections containing the actual rate tables are not included in this document. These rates are available from the DHA UBO Website at MHS UBO Rates | Health.mil.

2.0 Government Billing Calculation Factors

The Full Outpatient Rate (FOR) or Full Inpatient Reimbursement Rate (FRR), when appropriate, is used for claims submission to third-party payers and to all other applicable payers not included within International Military Education and Training (IMET) and Interagency/Other Federal Agency Sponsored Rate (IOR) billing guidance. FORs are, in most cases, determined by the amount TRICARE will allow for a given service. When this cannot be determined, Centers for Medicare and Medicaid Services (CMS) reimbursement rates are used. When both TRICARE allowable charges and CMS reimbursements cannot be determined, actual military expense and workload data are used to determine FORs. This process identifies and eliminates poor quality data and includes adjustments to account for the current military and civilian pay raises, asset use charges, distribution of expenses between payroll and non-payroll expense categories, and a DoD inflation adjustment to account for cost increases from the data collection period.

Discounts for IMET and IOR are calculated based on FY expense and workload data from all DoD MTFs that offer outpatient and inpatient services. IMET and IOR adjustments are calculated by removing those expenses which are excluded from consideration in IMET and Interagency billing from the FOR or FRR. The rates included in Section 3.0 represent the FOR (unless otherwise specified). IORs exclude the "Miscellaneous Receipts" (e.g., asset use charge, percentage for military pay, civilian pay and other) portion of the FOR/FRR price calculation. IMET rates exclude both the "Miscellaneous Receipts" portion and the "Military Personnel" portion of the FOR/FRR price calculation. A government discount or billing calculation factor (percentage discount) is applied to the FOR when billing for IMET and IOR services.

The IMET Program is a key funding component of U.S. security assistance that provides training on a grant basis to students from allied and friendly nations. Authority for the IMET program is found in Chapter 5, part II, Foreign Assistance Act of 1961. Funding is appropriated from the International Affairs budget of the Department of State. Not all foreign national patients participate in the IMET program.

The IMET rates applied to healthcare services are listed below:

All Services (Except Ambulance and Dental):	63.57 Percent (%) of the FOR.
Ambulance:	63.57 Percent (%) of the FOR
Dental:	45.91 Percent (%) of the FOR

The IORs applied to healthcare services are listed below:

All Services (Except Ambulance and Dental):	92.98 Percent (%) of the FOR.
Ambulance:	92.98 Percent (%) of the FOR
Dental:	94.03 Percent (%) of the FOR

3.0 Outpatient Medical and Dental Services Rates

3.1 Terminology

Ambulatory Payment Classification (APC) Rate System - Provides a set of prospectively determined charges applicable to outpatient services provided in hospitals. It is used to group institutional services that are clinically comparable including the use of resources. CPT®/ HCPCS codes and descriptors are used to identify and group the services into appropriate APCs. The Emergency Department institutional billing rates established under this system in Section 3.2 include the institutional costs associated with items or services that are directly related to performing a procedure and are, in most cases, packaged within the APC group.

Ambulatory Procedure Visit (APV) - A procedure or surgical intervention that requires pre-procedure care, an actual procedure to be performed, and immediate post-procedure care as directed by a qualified healthcare provider. Minor procedures that are performed in an outpatient clinic setting that does not require post-procedure care by a medical professional are not considered APVs. The nature of the procedure and the medical status of the patient combine as a short-term care requirement, but not for inpatient care. These procedures are appropriate for all types of patients (e.g., obstetrical, surgical and non-surgical including cosmetic) who by virtue of the procedure or anesthesia require post-procedure care and/or monitoring by medical personnel.

Ambulatory Procedure Unit (APU) - 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.

Ambulatory Surgery Center (ASC) Rate System - Provides prospectively determined charges applicable to ambulatory surgery services provided in MTFs that are not hospitals (i.e., they do not provide inpatient services). It is used to group surgical procedures based on ranges of cost.

Emergency Department (ED) - A location or organization within an MTF that provides emergency care, diagnostic services, treatment, surgical procedures, and proper medical disposition of an emergency nature to patients who present themselves to the service. It refers patients to specialty clinics and admits patients to the hospital, as needed.

Hospital - An MTF that provides inpatient services.

Observation (OBS) - Ambulatory services furnished within the hospital's ED or in a nursing unit, including the use of a bed and periodic monitoring by the hospital's nursing or other staff that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission as an inpatient. Both professional and institutional services are billed.

3.2 Civilian Health and Medical Program of the Uniformed Services Maximum Allowable Charge (CMAC) Rates

Professional Components:

TRICARE CMAC Reimbursement rates, established under Title 32, Sec. 199.14(j) of the Code of Federal Regulations, 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. DHA UBO CMAC rates differ from standard TRICARE CMAC rates in that DHA UBO CMAC rates are formatted for MHS military billing systems and include charges for additional services not reimbursed by TRICARE. DHA UBO CMAC rates pertain to professional services (e.g., office and clinic visits), ancillary services (e.g., laboratory and radiology) and OBS professional services.

DHA UBO CMAC rates are calculated for distinct "localities." These localities recognize differences in local costs to provide healthcare services in the different geographic regions 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 MTFs located outside the continental United States, Alaska, and Hawaii, the national average CMAC locality file (300) is used except for Guam and Puerto Rico which have their own CMAC localities. The complete DMIS ID-to-CMAC Locality table is available on the DHA UBO Website at Locality To ZIP | Health.mil.

For each CMAC locality, the DHA UBO creates two sub-tables of rates: CMAC and Component. The Component rate table specifies which 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. UBO CMAC rates for billing of professional services are available on the DHA UBO Website at https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Uniform-Business-Office/UBO-Rates-Overview/MHS-UBO-Rates.

For use in the MHS CDM, CMAC localities are further mapped to DHA Markets in an effort to consolidate into fewer regional price fee schedules. The MHS approved a Parent-Child Defense Medical Information System (DMIS) Identifier (ID) Market Mapping methodology to serve as a new MTF Regional Grouping Transition Plan. This methodology is known as the Regional Charge Table approach. At a high level, the Market Mapping Assignment will decrease the number of locality charge tables from the 100+ CMAC Charge Tables to 15 Regional Charge Tables for use within the MHS CDM.

Institutional Components:

ED - TRICARE Ambulatory Payment Classification (APC) rates for ED Evaluation & Management services, CPT® codes 99281-99285, are used to determine the DoD ED institutional charges. Ambulance transport to the ED and from the ED to another location is not part of the ED institutional rate and is billed separately.

OBS - The HCPCS codes used for OBS institutional services are G0378 and G0379. The rate for G0378 is an hourly rate, derived by dividing the APC payment rate by the average number of hours a patient was in observation status. There is no charge for G0379, a direct admission inpatient service.

APV Rate – The APV rate is an institutional flat rate for all APV procedures/services. This rate is based on the institutional cost of all MTF APVs divided by the total number of APVs and is associated with the 99199 procedure code. The CY 2024 APV flat rate is $3,359.19 and was adjusted by the O&M Inflation Factor for the CY 2024 development cycle.

Operating Room (OR) and Post-Anesthesia Case Unit (PACU) Rates – OR levels (1-5) and PACU levels (1-2) are determined by complexity of service and replace the use of the APV Rate referenced above for institutional costs associated with inpatient and outpatient surgery in MTFs. The price is determined by level (1-5), and calculated by the following logic:

- All surgical CPT codes within each OR Level (1-5) with an approved CMAC rate are averaged to determine the price for each OR Level (initial 60 minutes)
    - OR Level 1 (initial 60 min) rate = average of approved rates for all active surgical CPT codes with a time based charge level of 1
        - The same logic applies for OR Levels 2-5
- All surgical CPT codes within each OR Level (1-5) with an approved CMAC rate are averaged and divided by 4 to determine the price for each OR Level (each additional 15 minutes)
    - OR Level 1 (each additional 15 min) rate = (average of approved rates for all active surgical CPT codes with a time based charge level of 1) / 4
        - The same logic applies for OR Levels 2-5
- PACU Acuity Levels are reflective of the CMAC rate for G0378, hospital observation (60 min)
    - PACU Acuity Level 1 (0-60 min) - CMAC rate for G0378 (hourly observation)
    - PACU Acuity Level 1 (15 min) - CMAC rate for G0378 (hourly observation) divided by 4
    - PACU Acuity Level 2 (0-60 min) - CMAC rate for G0378 (hourly observation) multiplied by 1.5
    - PACU Acuity Level 2 (15 min) - CMAC rate for G0378 (hourly observation) multiplied by 1.5 divided by 4

Dialysis – CPT® code 90999 and HCPCS G0491 pricing is produced at a regional level for each regional charge table. This rate is produced by applying the CY 2024 TRICARE Wage Index for the respective region, to the national TRICARE End Stage Renal Disease (ESRD) facility reimbursement rate plus the national non-labor share rate. CPT 90999 is for use in facility billing of ESRD claims and G0491 for facility billing of Acute Kidney Injury (AKI) claims.

- The following example demonstrates the calculation for a wage-adjusted per-session rate for the non-US region with an assigned wage index of 1:
    - Per session rate: $384.82
    - Labor share of per-session rate: $384.82 multiplied by 55.2% (or 0.552) = $212.42
    - Wage index adjusted labor share: $212.42 multiplied by 1 = $212.42
    - Non-labor share of per-session rate: $384.8 multiplied by 44.8% (or 0.448) = $172.40
    - Final waged adjusted per-session rate: $212.42 + $172.40 = $384.82

3.3 Dental Rates

MTF dental charges are based on a flat rate multiplied by the DoD established dental weighted value (DWV) for each American Dental Association (ADA) Current Dental Terminology (CDT) procedure code. The dental flat rate represents the average DoD cost of dental services at all dental treatment facilities. Table 1 illustrates the FOR dental charge for ADA CDT code D0270.

Table 1: CY 2024 Dental Rates

CDT Code	Clinical Service	DoD DWV	FOR	Rate
D0270	Bitewing – Single radiographic image	0.37	$115.71	$42.81

Example: For ADA CDT code D0270, bitewing single radiographic image film, the DoD DWV is 0.37, which is multiplied by the appropriate FOR rate to obtain the charge. In this example, the FOR rate is used for D0270, the charge for this ADA CDT code will be $42.81. To determine the IOR or the IMET charges per dental code, multiply the FOR for the clinical service by the dental IMET/IOR percentages.

The list of CY 2024 ADA CDT codes and DWVs are too large to include in this document. This table may be found on DHA UBO's Website at https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Uniform-Business-Office/UBO-Rates-Overview/MHS-UBO-Rates.

3.4 Immunization/Injectables Rates

A separate charge is made for each immunization, injection or medication that is administered. Immunization rates are based on DHA TRICARE injectable rates whenever TRICARE rates are available.

If there is no TRICARE rate available, Purchased Care Data is used to derive rates. Rates are derived from Purchased Care Data by using the Military Health System Management Analysis and Reporting Tool or M2 system. This reporting tool allows for querying and detailed trend analysis including summaries and detailed views of population, clinical, and financial data from

all MHS regions worldwide. Data pulled from previous and current FY (to date) allows calculation of average amount allowed for rate use. Outlier rates are adjusted using historical Purchased Care Data of up to five (5) years.

If there is no TRICARE rate, or Purchased Care Data derived rate available, then a flat rate of $76.48**,** calculated using the FY 2023 to FY 2024 O&M inflation factor, is billed. Traditionally, the flat rate is calculated using MEPRS data and is based on the average full cost of these services.

The Immunization/Injectable rate table may be found on the DHA UBO Website at https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Uniform-Business-Office/UBO-Rates-Overview/MHS-UBO-Rates.

3.5 Anesthesia Rates

Anesthesia charges are split into base rates and interval rates. The anesthesia base rates are determined by multiplying the anesthesia relative value base unit by the locality-specific TRICARE anesthesia conversion factor (RVU base unit * locality-specific TRICARE anesthesia conversion factor). The anesthesia interval rates are determined per interval of time; the rate calculation for one anesthesia time-based interval is the RVU interval unit of 1 multiplied by the locality-specific TRICARE anesthesia conversion factor (Interval of 1 * locality-specific TRICARE anesthesia conversion factor). An RVU interval unit of 1 is equal to 15 minutes. The total charge for professional anesthesia-based rates is calculated by adding the base rate to the interval rate multiplied by the number of time units in 15-minute intervals.

Total professional anesthesia-based rate = [(base rate) + (interval rate * number of 15-minute time intervals)]

TRICARE provides the anesthesia RVU base units for each anesthesia procedure. The locality-specific TRICARE anesthesia conversion factors are mapped based on TRICARE locality. The calculated anesthesia rates are for professional anesthesia-based services performed within the MTFs.

Table 3: CY 2024 TRICARE Anesthesia Rate
(Base Rate, Interval Rate, and Professional Anesthesia Rate Pricing Example)

					390 Alaska	**314 Colorado**
				Locality CF →	$40.80	$21.11
CDM Description	**CPT Code**	**Type of Pricing**	**# of 15-minute intervals**	**TRICARE Base Unit**	**Rate** (Alaska)	**Rate** (Colorado)
Anes Salivary Gland w Biopsy	00100	Base	N/A	5.0	$204.00	$105.55
		Interval	1	N/A	$40.80	$21.11
		Base + Interval	4	5.0	$367.20	$189.99

Table 3 illustrates the calculation of the TRICARE Anesthesia Base Rate, Interval Rate, and One hour procedure total rate calculation example for CPT Code 00100 for the regional localities of Alaska and Colorado. For the Alaska locality, the total professional charge for an hour of service (Base rate + Interval rate) is calculated by adding the base rate of $204.00 for CPT code 00100 to the interval rate of $40.80 multiplied by 4-time interval units (4 units of 15-minute intervals to equal 1 hour), so $204.00 + $163.20 = $367.20

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

DME/DMS rates are based on the Medicare Fee Schedule floor rate. When there is no Medicare Fee Schedule floor rate for a given item, Purchased Care data from the M2 system is used to establish a rate based on the average amount allowed. The DME/DMS rate table may be found on the DHA UBO Website at https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Uniform-Business-Office/UBO-Rates-Overview/MHS-UBO-Rates.

Additionally, the Defense Medical Logistics Standard Support (DMLSS) Master Catalog captures the average price paid for over 100,000 medical supplies commonly used by DHA. Only DMLSS line items with an associated HCPCS code listed in the DMLSS Master Catalog will be utilized. All weighted average unit cost prices utilize the following equation:

$$\frac{\text{Sum of Total Current Unit of Purchase Price Amount}}{\text{Sum of Total Unit of Purchase Quantity}} = \text{Weighted Average Unit Cost Per Item}$$

C1752: Catheter, hemodialysis/peritoneal, short-term:

$$\frac{\$26{,}086.52}{145} = \$179.91$$

3.7 Transportation Rates

Ground Ambulance Rate
The ambulance rate is calculated based on the number of minutes. MTFs are instructed to calculate the charges based on the number of minutes that the ambulance is logged out on a patient run. To determine the IOR or the IMET charges per ambulance code, multiply the FOR for the clinical service by the ambulance IMET/IOR percentages.

Table 3: CY 2024 Ground Ambulance Rates

CDT/CPT	Clinical Service	FOR	Per Minute Rate
A0999	Ambulance	$306.3	$5.11

Aeromedical Evacuation Rate:

The aeromedical evacuation rate reflects transportation charges of a patient per trip via air in-flight or ambulatory medical care. 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. A trip encompasses the time from patient pickup to drop off at the appropriate facility.

For example, transportation from Base A to Base B, which consists of three legs, is charged as a single trip within a 24-hour period. The appropriate charges are billed only by the Global Patient Movement Requirements Center (GPMRC). These charges are only for the cost of providing medical care, a separate charge for transportation may be generated by GPMRC.

The in-flight medical care reimbursement rates are calculated based on the FOR (ambulatory patients) and FRR (litter patients). The ambulatory and litter rates are adjusted to compensate for inflation. The increase from CY 2023 to CY 2024 is 3.17% percent, in line with the direct care FY 2023-FY 2024 O&M inflation rate. Table 4 shows the CY 2024 in-flight rates for FOR/FRR. To determine the IOR or the IMET charges for aeromedical evacuation services, multiply the FOR/FRR for the clinical service by the IMET/IOR percentages.

Table 4 Aeromedical Evacuation Services

Clinical Service	FOR
Aeromedical Evac Services – Ambulatory	$1,000.54
Aeromedical Evac Services – Litter	$2,994.34

3.8 Food Service Charges at Appropriated Fund Dining Facilities (Subsistence Rate)

The food service charge at appropriated fund dining facilities, formerly the subsistence rate, is a standard rate that is established by the Office of the Under Secretary of Defense (Comptroller). The Standard Rate for is available from the DoD Comptroller's Website at: https://comptroller.defense.gov/Financial-Management/Reports/rates2024/ (Tab G, "Food Service Charges at Appropriated Fund Dining Facilities"). The effective date for this rate is prescribed by the Comptroller.

*NOTE: Food service charges are billed under the MSA Program only. Please refer to DHA-PM 6015.01: Military Medical Treatment Facility (MTF) Uniform Business Office (UBO) Operations Procedure Manual, October 2017, as amended, and the DoD 7000.14-R, "Department of Defense Financial Management Regulation," Volume 12, Chapter 19, for guidance on the use of this rate.

The food service charge is different from the Family Member Rate, which is addressed in each FY ASA Inpatient policy letter.

4.0 Elective Cosmetic Procedures

4.1 Patient Charge Structure

Elective cosmetic procedures *are not* TRICARE covered benefits. Elective cosmetic procedures provided in MTFs are restricted to TRICARE-eligible beneficiaries, including TRICARE for Life, on a "space-available" basis. Patients receiving elective cosmetic procedures (e.g., Active Duty personnel, retirees, family members, and survivors) are responsible for charges for all services (including implants, injectables, anesthesia, and other separately billable items) associated with elective cosmetic procedures. A list of elective cosmetic procedures and their associated rates can be found on the DHA UBO Website at https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Uniform-Business-Office/UBO-Rates-Overview/MHS-UBO-Rates

4.2 Elective Cosmetic Procedure Rates

Professional Charges for Elective Cosmetic Procedures:

Professional charges for elective cosmetic procedures are based on the CY22 CMAC national average when available. When CMAC allowable charges are not available, charges are determined based on estimates of the medical resources required relative to procedures that have CMAC pricing. Professional charges for elective cosmetic procedures are applied in both inpatient and ambulatory settings. Elective cosmetic charges are not adjusted for the treating MTF's geographical location.

CMAC CY 2024 "facility physician" allowable charges are used for the professional component for services furnished by a provider in a hospital operating room or designated Ambulatory Procedure Unit (APU). CMAC CY 2024 "non-facility physician" allowable charges are used for the professional component for services furnished in a provider's office.

Institutional Charges for Elective Cosmetic Procedures:

Institutional charges for elective cosmetic procedures are based on the procedure performed and the location of the service provided (i.e., provider's office/minor surgery room, hospital operating room (either on an outpatient or inpatient basis), operating room of a MTF that is not a hospital (i.e., does not provide inpatient services).

For elective cosmetic procedures conducted in a provider's office/minor surgery room, the institutional fee is included in the "non-facility physician" professional charge.

> The institutional charge for elective cosmetic procedures performed in a *hospital operating room* on an outpatient basis is based on the APV flat rate for the primary procedure with no additional institutional charge for bilateral or additional procedures.
>
> The institutional charge for elective cosmetic procedures performed in *an operating room of a facility that is not a hospital* is also based on the APV flat rate for the primary procedure with no additional institutional charge for bilateral or additional procedures.
>
> The institutional charge for an elective cosmetic procedure performed in a hospital on an inpatient basis is calculated by multiplying the CY 2024 TRICARE Adjusted Standardized Amount (ASA), $8,552.20, by the relative weighted product (RWP) associated with the Diagnostic Related Group (DRG).

If an elective cosmetic procedure is combined with a medically necessary procedure during the same surgical visit, the elective cosmetic procedure charge is adjusted to avoid duplicate institutional charges. The institutional charge, for an elective cosmetic procedure, when combined with a medically necessary procedure is reduced by 50 percent (%) from the initial charge.

Most ancillary services (e.g., laboratory, radiology, and routine pre-operative testing) are included in the institutional pricing methodology described above. Ancillary services and supplies not included are billed at the FOR.

Anesthesia Charges for Elective Cosmetic Procedures:

Anesthesia rates associated with elective cosmetic procedures include anesthesia professional services. Anesthesia charges are calculated using the CY 2024 national anesthesia conversion factor, multiplied by the sum of base units and national average time units (measured in 15-minute increments) of the primary procedure. An additional anesthesia charge, based on additional minutes of service, is added for secondary procedures performed during the same surgical encounter. Anesthesia charges are applied in both inpatient and ambulatory settings.