THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

25 June 12

MEMORANDUM FOR UNDER SECRETARY OF DEFENSE (COMPTROLLER)

SUBJECT: Calendar Year 2012 Outpatient Medical, Dental, and Elective Cosmetic Procedure Reimbursement Rates and Guidance

The attached document contains the Department of Defense Uniform Business Office Calendar Year (CY) 2012 Outpatient Medical, Dental, and Elective Cosmetic Procedure Reimbursement Rates and Guidance. The rates are to be used by military treatment facilities, effective July 1, 2012, until superseded. The CY 2011 rates will be superseded by these CY 2012 rates. TRICARE Management Activity (TMA) requests this package be posted on the Comptroller's Web site: http://www.defenselink.mil/comptroller/rates/fy2012.html.

The point of contact for this action is Ms. DeLisa Prater, TMA, Uniform Business Office, Program Manager. Ms. Prater may be reached at (703) 681-6757, or at Delisa.Prater@tma.osd.mil.

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Attachment:
As stated

Department of Defense Uniform Business Office
Calendar Year 2012 Outpatient Medical, Dental, and Elective Cosmetic Procedure Reimbursement Rates and Guidance

1.0 Introduction

The Department of Defense (DoD) Uniform Business Office (UBO) developed the Calendar Year (CY) 2012 Outpatient Medical, Dental and Elective Cosmetic Procedure Reimbursement Rates in accordance with Title 10, United States Code, Section (Sec.) 1095. These rates are the charges for professional and institutional health care services provided in military treatment facilities (MTFs) financed by the Defense Health Program Appropriation. These rates are used to submit claims for reimbursement of the costs of the health care 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 Fiscal Year (FY) 2012 Adjusted Standardized Amount (ASA) inpatient rates released January 1, 2012, remain in effect until further notice.

The "CY 2012 Outpatient Medical, Dental and Elective Cosmetic Procedure Reimbursement Rates and Guidance" describes rates that are effective for health care services provided on or after July 1, 2012.

This "CY 2012 Outpatient Medical, Dental, and Elective Cosmetic Procedure Reimbursement Rate and Guidance" covers the following rates:

Section 3.2:	Civilian Health and Medical Program of the Uniformed Services 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 Rates
Section 3.6:	Durable Medical Equipment/Durable Medical Supplies (DME/DMS) Rates
Section 3.7:	Transportation Rates
Section 3.8:	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 TRICARE Management Activity (TMA) UBO Web site: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.

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 neither TRICARE allowable charges nor CMS reimbursement can be determined; actual military FY 2011 expense and workload data are used to determine FORs. This process identified and eliminated poor quality data and included adjustments to account for the current military and civilian pay raises; an asset use charge, distribution of expenses between payroll and non-payroll expense categories; and a DoD inflation adjustment to account for cost increases from the data collection year to the current year.

Discounts for IMET and IOR are also calculated based on FY 2011 expense and workload data from all DoD MTFs that offer outpatient and inpatient services. IMET and IOR adjustments are calculated by removing from the FOR or FRR those expenses which are excluded from consideration in IMET and Interagency billing. The rates included in Sec. 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 health care services are listed below:

All services except ambulance and dental are 67.87 percent of the FOR.
- Ambulance: 67.83 percent of the FOR
- Dental: 46.97 percent of the FOR

The IOR is used to bill other federal agencies. IORs applied to health care services are listed below:

All services except ambulance and dental are 93.39 percent of the FOR.
- Ambulance: 93.48 percent of the FOR
- Dental: 93.94 percent of the FOR

3.0 Outpatient Medical and Dental Services Rates

3.1 Terminology

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 health care 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) 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.

Emergency Department (ED) - ambulatory services furnished within a MTF's Emergency Department and are strictly considered institutional and appended institutional charges only.

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 Component

CMAC reimbursement rates, established under Title 32, Sec. 199.14(h) 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. UBO CMAC rates differ from standard TMA CMAC rates in that UBO CMAC rates are formatted for military billing systems and include charges for additional services not reimbursed by TRICARE. UBO CMAC rates pertain to professional services (e.g., office and clinic visits), ancillary services (e.g., laboratory and radiology) and OBS professional services.

UBO CMAC rates are calculated for 91 distinct "localities". These localities recognize differences in local costs to provide health care 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 and Hawaii, CMAC locality (391) is used. The complete DMIS ID-to-CMAC Locality table is available on the TMA UBO Web site: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm

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 professional and technical component services. 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.

Both CMAC and Component rate tables are further categorized by provider class. The four provider classes are 1) Physicians, 2) Psychologists, 3) Other Mental Health Providers, and 4) Other Medical Providers. UBO CMAC rates are available on the TMA UBO Web site: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.

Institutional Component

ED - TRICARE Ambulatory Payment Classification (APC) rates for ED 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.

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 CMS Payment Factor by the FY 2011 DoD average OBS number of hours. 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 2012 APV flat rate is $1,965.96.

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 3.1 illustrates the IMET, IOR and FOR dental charges for ADA CDT code D0270.

Table 3.1 CY 2012 Dental Rates

ADA CDT Code	Clinical Service	DoD DWV	IMET $31.00	IOR $62.00	FOR $66.00
D0270	Bitewing single film	0.27	$8.37	$16.74	$17.82

Example case: For ADA CDT code D0270, bitewing single film, the DoD DWV is 0.27, which is multiplied by the appropriate rate, IMET, IOR, or FOR rate to obtain the charge. In this example, if the FOR rate is used for D0270, the charge for this ADA CDT code will be $66.00 x 0.27, which is $17.82.

The list of CY 2012 ADA CDT codes and DWVs are too large to include in this document. This table may be found on TMA's UBO Web site:
http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/dental.cfm.

3.4 Immunization/Injectables Rates

A separate charge is made for each immunization, injection or medication that is administered. The charges for immunizations, allergen extracts, and allergic condition tests, which may be provided in a separate immunization or "shot" clinic, are described below.

Immunization rates are based on TMA 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.

If there is no TRICARE rate or Purchased Care Data derived rate available, then 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 HCPCS Level II codes.

If there is no TRICARE rate, Purchased Care Data derived rate, or NAP rate available, then a flat rate of $34.00, calculated using Medical Expense and Performance Reporting System data, is billed. The flat rate is based on the average full cost of these services.

The Immunization/Injectable rate table may be found on the TMA UBO Web site: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/immunization.cfm.

3.5 Anesthesia Rates

Anesthesia charges are determined by adding anesthesia base units plus average time units together then multiplied by the CMS national anesthesia conversion factor ((Base Unit + Average Time Unit) X CMS conversion factor). CMS provides the anesthesia base units, average time units and the conversion factor. The CMS CY 2012 national anesthesia conversion factor is $21.52. The calculated anesthesia rate is for anesthesia professional services performed within the MTFs.

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

DME/DMS rates are based on the Medicare Fee Schedule floor rate. The HCPCS code ranges for which DME/DMS rates are provided include: A4206-A9999, E0100-E8002, K0001-K0899, L0112-L9900, and V2020-V5364. 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 TMA UBO Web site: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/dme_dms.cfm.

3.7 Transportation Rates

Ground Ambulance Rate

The ground ambulance rate reflects ambulance charges based on hours of service, in 15-minute increments. Table 3.2 provides the ambulance rates for IMET, IOR and FOR. These rates are for 60 minutes (1 hour) of service. MTFs are instructed to 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 are rounded to the next 15-minute increment (e.g., 31 minutes is charged as 45 minutes).

Table 3.2 CY 2012 Ground Ambulance Rates

CDT/CPT	Clinical Service	IMET	IOR	FOR
A0999	Ambulance	$156.00	$215.00	$230.00

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 2011 to CY 2012 is 2.65 percent, in line with the CMAC-based UBO rates. Table 3.3 shows the CY2012 in-flight rates for IMET, IOR and FOR/FRR.

Table 3.3 Aeromedical Evacuation Services

Clinical Service	IMET	IOR	FOR/FRR
Aeromedical Evac Services – Ambulatory	$465.55	$695.10	$736.94
Aeromedical Evac Services – Litter	$1,362.32	$2,077.81	$2,205.46

3.8 Subsistence Rate

The subsistence rate is a standard rate that is established by the Office of the Under Secretary of Defense (Comptroller). The Standard Rate is available from the DoD Comptrollers Web site, Tab K: http://www.dod.mil/comptroller/rates. The effective date for this rate is prescribed by the comptroller.

*NOTE: Subsistence charges are billed under the MSA Program only. 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.

The subsistence rate is different from the Family Member Rate, which is addressed in each FY ASA Inpatient policy letter.

4.0 Elective Cosmetic Procedures

Rates covered below are for elective cosmetic procedures only.

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 TMA UBO Web site: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/cs.cfm.

4.2 Elective Cosmetic Procedure Rates

Professional Charges for Elective Cosmetic Procedures

Professional charges for elective cosmetic procedures are based on the CY 2012 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 2012 "facility physician" allowable charges are used for the professional component for services furnished by a provider in a hospital operating room or designated APU. CMAC CY 2012 "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, operating room (outpatient or inpatient service) or APU). 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 fee for an elective cosmetic procedure performed on an outpatient basis using a hospital operating room or APU is based on the APC rate, of the primary procedure, and 50 percent of the APC rate for each additional procedure. The inpatient charge for an elective cosmetic procedure is calculated by multiplying the 2012 TRICARE ASA ($5,215.92) by the relative weighted product associated with the Diagnostic Related Group. 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 pricing methodology. 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, pharmaceuticals, supplies, and professional services. Anesthesia charges are calculated using the national average 2012 anesthesia conversion factor ($21.52), 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.