THE ASSISTANT SECRETARY OF DEFENSE

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HEALTH AFFAIRS

JUL - 9 2014

MEMORANDUM FOR UNDER SECRETARY OF DEFENSE (COMPTROLLER)

SUBJECT: Calendar Year 2014 Outpatient Medical, Dental, and Elective Cosmetic Procedure Reimbursement Rates and Guidance

The Department of Defense (DoD) outpatient billing systems/solutions are being enhanced for a new generation of healthcare services billing technology. As a result of the transition to Central Billing Events Repository (CBER) and the Armed Forces Billing and Collections Utilization Solution (ABACUS), the outpatient rates are being reconfigured to cover charges for two billing methodologies:

- Rates applicable to the legacy systems, including Composite Healthcare System and Third Party Outpatient Collection system (TPOCS)
- Rates applicable only to CBER/ABACUS.

The legacy systems rates are to be used by military treatment facilities, effective July 1, 2014, and continued until billing operations are transitioned to the CBER/ABACUS methodologies or until superseded.

The attached document contains the DoD Uniform Business Office Calendar Year (CY) 2014 Outpatient Medical, Dental and Elective Cosmetic Procedure Reimbursement Rates and Guidance. The CY 2013 rates will be superseded by these CY 2014 rates. The Defense Health Agency (DHA) requests this package be posted on the Comptroller's web site: http://comptroller.defense.gov/Portals/45/documents/rates/fy2014/2014_i.pdf

The point of contact for this action is Ms. DeLisa Prater, Program Manager, DHA/Business Support Directorate, Uniform Business Office. She may be reached at (703) 681-6757 or at DeLisa.Prater@dha.mil.

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Attachment:
As stated

Department of Defense Uniform Business Office
Calendar Year 2014 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) 2014 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 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) 2014 Adjusted Standardized Amount (ASA) inpatient rates, released October 1, 2013, remain in effect until further notice.

The "CY 2014 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, 2014.

Within CY 2014 the Defense Health Agency (DHA) will begin implementation of a new generation of enhanced healthcare services billing technology, the Central Billing Events Repository (CBER) and the Armed Forces Billing and Collections Utilization Solution (ABACUS). As a result of the transition, outpatient rates will cover charges for two billing methodologies:

- Rates applicable with the legacy systems including the Composite Healthcare System (CHCS) and Third Party Outpatient Collection system (TPOCS). These rates are listed in A and B below. They become effective July 1, 2014 and continue until billing operations are transitioned to the CBER/ABACUS methodologies, and/or until superseded.

- Rates applicable with transition to CBER/ABACUS. These rates are listed in A and C below. They become effective upon implementation of CBER/ABACUS capabilities.

  A. Billing rates applicable with legacy systems and CBER/ABACUS

Section 2.1:	Adjustment Factors for Billing Other Government Agencies
Section 2.2:	Dental Rates
Section 2.3	Immunization/Injectables Rates
Section 2.4	Durable Medical Equipment/Durable Medical Supplies (DME/DMS) Rates
Section 2.5:	Transportation Rates
Section 2.6:	Subsistence Rate

Section 2.7: Elective Cosmetic Procedure Rates

B. Billing rates applicable only with legacy systems

Section 3.2: Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (CMAC) Rate Tables Modified for UBO Legacy System Use
Section 3.3: Anesthesia Rates for Legacy System Use

C. Billing rates applicable only with CBER/ABACUS

Section 4.2: Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (CMAC) Rate Tables modified for UBO CBER/ABACUS Use
Section 4.3: Anesthesia Rates for CBER/ABACUS Use
Section 4.4: Ambulatory Payment Classification Rates
Section 4.4: Ambulatory Surgery Center Rates

2.0 Billing Rates Applicable including Legacy Systems and CBER/ABACUS

2.1 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 do 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 to determine the need for a possible admission as an inpatient. Both professional and institutional services are billed.

2.2 Adjustment Factors for Billing Other Government Agencies

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 2013 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, 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 2013 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 below 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 62.20 percent of the FOR.
- Ambulance: 62.10 percent of the FOR
- Dental: 45.65 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 93.63 percent of the FOR.
- Ambulance: 93.48 percent of the FOR
- Dental: 93.40 percent of the FOR

2.3 Dental Rates

MTF dental charges are based on a flat rate multiplied by the DHA 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 2.1 illustrates the IMET, IOR and FOR dental charges for ADA CDT code D0270.

Table 2.1 CY 2014 Dental Rates

ADA CDT Code	Clinical Service	DoD DWV	IMET $37.00	IOR $77.00	FOR $82.00
D0270	Bitewing single film	0.27	$9.99	$20.79	$22.14

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 $82.00 x 0.27, which is $22.14.

The list of CY 2014 ADA CDT codes and DWVs are too large to include in this document. This table may be found on DHA's UBO Web site at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/dental.cfm.

2.4 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 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.

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 $51.00, 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 DHA UBO Web site at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/immunization.cfm.

2.5 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 DHA UBO Web site at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/dme_dms.cfm.

2.6 Transportation Rates

Ground Ambulance Rate

The ground ambulance rate reflects ambulance charges based on hours of service in 15-minute increments. Table 2.2 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). Ambulance rates used for billing are located on the DHA UBO Web site at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/ambulance.cfm.

Table 2.2 CY 2014 Ground Ambulance Rates

CDT/CPT®[1]	Clinical Service	IMET	IOR	FOR
A0999	Ambulance	$184.00	$278.00	$297.00

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.

[1] CPT is registered trademark of the American Medical Association.

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 CY2013 to CY2014 is 1.59 percent, in line with the CMAC-based UBO rates. Table 2.3 shows the CY 2014 in-flight rates for IMET, IOR and FOR/FRR.

Table 2.3 CY2014 Aeromedical Evacuation Services

Clinical Service	IMET	IOR	FOR/FRR
Aeromedical Evac Services – Ambulatory	$477.21	$712.51	$755.39
Aeromedical Evac Services – Litter	$1,396.44	$2,129.84	$2,260.69

2.7 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 at: http://comptroller.defense.gov/financialmanagement/reports/rates2014.aspx (Tab K). 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.

2.8 Elective Cosmetic Procedures

Rates covered below are for elective cosmetic procedures only.

2.8.1 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 Web site at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/cs.cfm.

2.8.2 Elective Cosmetic Procedure Rates

Professional Charges for Elective Cosmetic Procedures

Professional charges for elective cosmetic procedures are based on the CY 2014 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 2014 "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 2014 "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 Ambulatory Payment Classification (APC) rate for each additional procedure. The inpatient charge for an elective cosmetic procedure is calculated by multiplying the 2014 TRICARE Adjusted Standardized Amount (ASA), $5,573.80, 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 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 professional services. Anesthesia charges are calculated using the CY 2014 anesthesia conversion factor ($22.68), 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.

3.0 Billing Rates Applicable only with Legacy Systems

3.1 Civilian Health and Medical Program of the Uniformed Services CMAC Rate Tables Modified for UBO Legacy System Use

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 TRICARE CMAC rates in that UBO CMAC rates are formatted for legacy 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 DHA 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 CHCS provider class. The four provider classes are: 1) Physicians, 2) Psychologists, 3) Other Mental Health Providers, and 4) Other Medical Providers. UBO CMAC rates for legacy billing are available on the DHA UBO Web site at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.

Institutional Component

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 using the APC payment rate based off of the average hospital stay of greater than or equal to 8 hours in an OBS unit. 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 2014 APV flat rate is $2,454.75.

3.2 Anesthesia Rates for Legacy System Use

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 CY 2014 anesthesia conversion factor used was $22.68. The calculated anesthesia rate is for anesthesia professional services performed within the MTFs. Anesthesia rates used for legacy billing are located on the DHA UBO Web site at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/anesthesia.cfm.

4.0 Billing Rates Applicable only to CBER/ABACUS

4.1 Terminology.

Ambulatory Payment Classification (APC) – The APC 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 billing rates established under this system 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 Surgery Center (ASC) - The ASC system provides prospectively determined charges applicable to ambulatory surgery services provided in MTFs that do not provide inpatient services. It is used to group surgical procedures based on ranges of cost. The billing rates established under this system apply only to the institutional charges for the ambulatory surgery procedures included in an ASC group.

4.2 Civilian Health and Medical Program of the Uniformed Services CMAC Rate Tables modified for CBER/ABACUS Use

UBO CMAC rates modified for CBER/ABACUS use follow the TRICARE CMAC rate structure used for TRICARE reimbursement. CBER/ABACUS UBO CMAC rates may include up to eight distinct billing rates for a given procedure depending on whether the procedure has separately priced professional and technical components and the types of providers that can perform the procedure:

- Nonfacility CMAC for physician/LLP class
- Facility CMAC for physician/LLP class
- Nonfacility CMAC for non-physician class
- Facility CMAC for non-physician class
- Physician Class Professional Component (PC) CMAC
- Physician Class Technical Component (TC) CMAC
- Non-physician Class PC CMAC
- Non-physician Class TC CMAC

UBO CMAC rates modified for CBER/ABACUS include rates for selected procedures that TRICARE does not reimburse.

The assignment of providers to physician vs non-physician class billing rates is based on the HIPAA taxonomy of the provider. For example, when the treatment MTF creates a separate institutional charge for a service, the professional charge will be at the facility rate. If there is no separate institutional charge, the professional charge will be at the non-facility rate. Separate professional and technical component rates are used for those procedures where TRICARE establishes separate professional and technical reimbursement. UBO CMAC rates modified for CBER/ABACUS use are available on the DHA UBO Web site at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/cmac.cfm.

4.3 Anesthesia Rates for CBER/ABACUS

Anesthesia charges are determined by adding anesthesia base units plus actual encounter time units (rounded up to the next 15 minute increment) multiplied by the locality adjusted conversion factor for the MTF's zip code. Files containing the base units for each anesthesia procedure as well as the locality adjusted conversion factors are located on the DHA UBO Web site at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/anesthesia.cfm.

4.4 Ambulatory Payment Classification Rates

APC charges are billed to recover the institutional cost for services provided on an ambulatory basis by MTFs offering inpatient services. APC charges are determined from coded medical records and national TRICARE APC reimbursement files with the wage portion of the APC rate adjusted for the wage index of the treatment MTF. The TRICARE APC Grouper application is used to assign APCs based on reported CPT®/HCPCS codes. MTFs code medical services only

once, and those codes are used for both professional and institutional billing; they do not maintain distinct systems for professional and institutional coding. APC rates used for UBO billing are available on the DHA UBO Web site at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.

4.5 Ambulatory Surgery Center Rates

ASC charges are billed to recover the institutional cost for ambulatory surgical services provided by MTFs offering ASC procedures. ASC charges are determined from TRICARE reimbursement files which classify ambulatory surgery procedures into groups and provide a reimbursement level for each group assignment and metropolitan statistical area of the treatment MTF. ASC rates used for UBO billing are available on the DHA UBO Web site at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.