OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUN 29 2010

MEMORANDUM FOR UNDER SECRETARY OF DEFENSE (COMPTROLLER)

SUBJECT: Calendar Year 2010 Outpatient Medical, Dental, and Cosmetic Procedure Reimbursement Rates and Guidance

The attached document contains the Department of Defense Uniform Business Office Calendar Year (CY) 2010 Outpatient Medical, Dental, and Cosmetic Procedure Reimbursement Rates and Guidance. The rates are to be used by Military Treatment Facilities, effective July 1, 2010, until superseded. The CY 2009 rates will be superseded by these CY 2010 rates. The TRICARE Management Activity (TMA) requests this package be posted on the Comptroller's Web site: http://www.defenselink.mil/comptroller/rates/fy2010.html.

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

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President, Uniformed Services University of the Health Sciences
Performing the Duties of the Assistant Secretary of Defense (Health Affairs)

Attachment:
As stated

Department of Defense Uniform Business Office
Calendar Year 2010 Outpatient Medical, Dental and Cosmetic Procedure Reimbursement Rates and Guidance

1.0 Introduction

The Department of Defense (DoD) Uniform Business Office (UBO) developed the calendar year (CY) 2010 outpatient medical, dental, and cosmetic procedure reimbursement rates in accordance with Title 10, United States Code, Section 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 Program, and Medical Affirmative Claims.

The Fiscal Year (FY) 2010 Adjusted Standardized Amount (ASA) inpatient rates released October 1, 2009, remain in effect until further notice.

The "Calendar Year 2010 Outpatient Medical, Dental, and Cosmetic Procedure Reimbursement Rates and Guidance" describes rates that are effective for health care services provided on or after July 1, 2010.

The "Calendar Year 2010 Outpatient Medical, Dental, and Cosmetic Procedure Reimbursement Rates and Guidance" covers the following rates:

Section 3.2:	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:	Subsistence Rate
Section 4.2:	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) and 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. FOR rates are, in most cases, determined by the amount TRICARE will allow for a given service. When this cannot be determined, an analysis of actual military FY 2009 expense and workload data was used to determine FOR rates. This analysis 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 from the data collection year to the current year.

Discounts for IMET and IOR also are calculated based on an analysis of FY 2009 expense and workload data from all DoD MTFs that offered outpatient and inpatient services. IMET and IOR adjustments are calculated by removing from the FOR and FRR those types of expenses that are specifically excluded from consideration in IMET and Interagency billing. The rates included in Section 3.0 represent the FOR (unless otherwise specified). IOR rates exclude the "Miscellaneous Receipts" (asset use charge, percentage for military pay, civilian pay, and other) portion of the FOR/FRR price computation. IMET rates exclude both the "Miscellaneous Receipts" portion and the "Military Personnel" portion of the FOR/FRR price computation. 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 pursuant to Chapter 5, Part II, Foreign Assistance Act 1961. Funding is appropriated from the International Affairs budget of the Department of State. Not all foreign national patients participate in the IMET program. IMET rates applied to health care services are listed below:

All services except ambulance and dental are 63.72 percent of the FOR
Ambulance: 63.88 percent of the FOR
Dental: 49.43 percent of the FOR

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

All services except ambulance and dental are 94.10 percent of the FOR
Ambulance: 94.27 percent of the FOR
Dental: 94.25 percent of the FOR

3.0 Outpatient Medical and Dental Services Rates

3.1 Terminology

Ambulatory Procedure Visit (APV)—defined in DoD Instruction 6025.8, Ambulatory Procedure Visit (APV), September 23, 1996, 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 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 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.

Ambulatory Procedure Unit (APU)—an 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.

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 provided to patients under observation are billed for institutional charges only.

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

Professional Component

CMAC reimbursement rates, established under Title 32, Section 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. CMAC rates pertain to professional 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 are formatted for military billing systems and include rates for additional services not reimbursed by TRICARE.

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 Medical 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 component services. The CMAC table is further categorized by provider class. 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, 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-based rates are available 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 are used to determine the DoD ED institutional charges. For CPT codes 99281-99285, only the institutional component is billed.

NOTE: Ambulance transport to and from the ED to another location is not part of the ED institutional rate and is billed separately.

OBS—CPT codes used for observation services include: 99218-99220. Rates for these observation services are derived using Medical Expense and Performance Reporting System (MEPRS) data and are used to bill for institutional services. Professional services are not billed for observation.

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 2010 APV flat rate is $1,909.96.

3.3 Dental Rates

MTF dental charges are based on a dental flat rate multiplied by a DoD-established relative weight for each American Dental Association Current Dental Terminology (CDT) code 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 3.1 illustrates the dental rate for IMET, IOR and FOR/Third Party.

Table 3.1 CY 2010 Dental Rates

CDT	Clinical Service	Weight	IMET	IOR	FOR (Third Party)
D0270	Bitewing single film	0.26	$43.00	$82.00	$87.00

Example case: For CDT code D0270, bitewing single film, the DoD relative weight is 0.26. The relative weight of 0.26 is multiplied by the appropriate rate, IMET, IOR, or FOR/Third Party rate to obtain the charge. In this example, if the FOR/Third Party rate is used for D0270, the charge for this CDT code will be $87.00 x 0.26, which is $22.62.

The list of CY 2010 CDT codes and relative weights for dental services may be found on TMA's UBO Web site at: 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 charge for immunizations, allergen extracts, allergic condition tests, and the administration of certain medications, 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, Purchased Care Data is used to derive rates. Rates are derived from Purchased Care Data by using the Military Health System (MHS) Management Analysis and Reporting Tool or M2 system. This reporting tool allows for querying and detailed trend analysis including summary and detailed views of population, clinical, and financial data from all MHS regions worldwide and Direct and Purchased Care Data. Data pulled from the previous and current fiscal year (to date) allows the calculation of "Average Amount Allowed" for use.

If there is no TRICARE rate or Purchased Care Data derived rate available, then the National Average Payment (NAP) is used. 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 $48.00, calculated using MEPRS 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 Rate

The anesthesia rate is a flat rate for anesthesia professional services and is based on an average DoD cost of service in all MTFs. The CY 2010 flat rate for anesthesia is $1,257.00.

3.6 Durable Medical Equipment/Durable Medical Supplies Rates

DME and 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. The Dental 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 Other (Full/Third Party). 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 2010 Ground Ambulance Rates

CDT/CPT	Clinical Service	IMET	IOR	FOR (Third Party)
A0999	Ambulance	$145.00	$214.00	$227.00

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 2009 to CY 2010 is 2.9 percent, in line with the CMAC-based UBO rates. Table 3.3 shows the CY 2010 in-flight rates for IMET, IOR and FOR/FRR (Third Party).

Table 3.3 Aeromedical Evacuation Services

Clinical Service	IMET	IOR	FOR/FRR (Third Party)
Aeromedical Evac Services–Ambulatory	$434.00	$648.00	$687.00
Aeromedical Evac Services–Litter	$1,270.00	$1,937.00	$2,056.00

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 Fiscal Year ASA Inpatient policy letter.

4.0 Cosmetic Procedures

Cosmetic procedure rates covered below are for elective cosmetic procedures only.

4.1 Patient Charge Structure

Cosmetic procedures are not a TRICARE covered benefit. Cosmetic procedures provided in MTFs are restricted to TRICARE-eligible beneficiaries, including TRICARE for Life, on a "space-available" basis. Patients receiving cosmetic procedures (e.g., Active Duty personnel, retirees, family members, and survivors) are fully responsible for charges for all services (including implants, cosmetic injectables, anesthesia, and other separately billable items) associated with cosmetic procedures. The list of cosmetic procedures with associated cosmetic rates can be found on the TMA UBO Web site: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/cs.cfm.

4.2 Cosmetic Procedure Rates

Professional Charges for Cosmetic Procedures

Professional charges for cosmetic procedures are based on the CY 2010 CMAC national average when available. Rates are not adjusted for the treating MTF's geographical location. The CMAC CY 2010 "facility physician" rate is used for determining the professional component for services furnished by the provider in a hospital operating room or designated APU. The CMAC CY 2010, "non facility physician" rate is used for the professional component for services furnished in the provider's office. Professional fees for cosmetic procedures are rounded to the nearest dollar.

Institutional Charges for Cosmetic Procedures

Institutional charges for 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 or APU (outpatient service), or operating room (inpatient service)). For cosmetic procedures conducted in a provider's office/minor surgery room the institutional charge is included in the "non facility physician" professional rate. The institutional fee for a 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. Institutional charges for cosmetic procedures performed on an inpatient basis are covered below in the section Inpatient Charges for Cosmetic Procedures. Institutional fees for cosmetic procedures are rounded to the nearest dollar.

Anesthesia Charges for Cosmetic Procedures

Anesthesia rates associated with cosmetic procedures include anesthesia pharmaceuticals, supplies, and professional services. Anesthesia charges are calculated using the median 2010 TRICARE Physician Conversion Factor ($20.95), multiplied by the sum of base units and national average time units (measured in 15 minute increments) of the primary procedure, and rounded to the nearest dollar.

Inpatient Charges for Cosmetic Procedures

The charges for cosmetic procedures performed on an inpatient basis are calculated by multiplying the 2010 TRICARE ASA ($4,835.85) by the relative weighted product associated with the Medical Severity Diagnosis Related Group for the primary cosmetic procedure. If a cosmetic procedure is combined with a medically necessary procedure during the same surgical visit, the cosmetic procedure charge is adjusted to avoid duplicate institutional charging. The institutional charge, for a cosmetic procedure, when combined with a medically necessary procedure, is reduced by 50 percent from the initial charge.