MEDICAL AND DENTAL SERVICES
FISCAL YEAR 1997

The FY 1997 DoD reimbursement rates for inpatient, outpatient, and other services are provided in accordance with Title 10, United States Code, section 1095. Due to the voluminous nature of the High Cost Drug Reimbursement Rates (Section III.D) and the rates for High Cost Services Requested by External Providers (Section III.E), these sections are not included in this package. Complete listings of these rates, however, are available on request from the Office of the Assistant Secretary of Defense (Health Affairs) action officer identified at Tab N. The medical and dental service rates in this package (to include the rates for high cost drug reimbursement and for high cost services requested by external providers) are effective October 1, 1996.

INPATIENT, OUTPATIENT AND OTHER RATES AND CHARGES

I. INPATIENT RATES 1/ 2/

Per Inpatient Day	International Military Education and Training (IMET)	Interagency & Other Federal Agency Sponsored Patients	Other
A. Burn Center	$2,107.00	$3,824.00	$4,086.00
B. Surgical Care Services (Cosmetic Surgery)	$897.00	$1,629.00	$1,741.00

C. All Other Inpatient Services
(Based on Diagnosis Related Groups (DRG) Charges 3/)

1. FY 1997 DIRECT CARE INPATIENT REIMBURSEMENT RATES

ADJUSTED STANDARD AMOUNT	IMET	INTERAGENCY	OTHER (FULL/ 3RD PARTY)
Large Urban	$2,154	$4,141	$4,392
Other Urban/ Rural	$2,275	$4,344	$4,635
Overseas	$2,405	$5,207	$5,533

2. OVERVIEW

The FY 1997 inpatient rates are based on the cost per DRG which is the inpatient full reimbursement rate per hospital discharge, weighted to reflect the intensity of the principal diagnosis, secondary diagnoses, procedures, patient age, etc. involved. The average costs per Relative Weighted Product (RWP) for large urban, other urban/rural and overseas facilities will be published annually as an inpatient adjusted standardized amount (ASA) (See item 1 above). The ASA will be applied to the RWP for each inpatient case, determined from the DRG weights, outlier thresholds and payment rules published annually for hospital reimbursement rates under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) pursuant to 32 CFR 199.14(a)(1) including adjustments for length of stay outliers. The published ASAs will be adjusted for area wage differences and indirect medical education (IME) for the discharging hospital. An example of how to apply DoD costs to a DRG standardized weight to arrive at DoD costs is contained in part 3 of Section I.C., below.

3. EXAMPLE OF ADJUSTED STANDARDIZED AMOUNTS FOR INPATIENT STAYS

Figure 1 shows examples for a nonteaching hospital in a Large Urban Area.

a. The cost to be recovered is DoD's cost for medical services provided in the nonteaching hospital located in a large urban area. Billings will be at the third party rate.

b. DRG 020: Nervous System infection except viral meningitis. The RWP for an inlier case is the CHAMPUS weight of 2.9769. (DRG statistics shown are from FY 1996).

c. The DoD adjusted standardized amount to be charged is $4,392 (i.e., the third party rate as shown in the table).

d. DoD cost to be recovered at a nonteaching hospital with area wage index of 1.0 is the RWP factor (2.9769) in item 3.b., above, times the amount ($4,392) in 3.c., above.

Cost to be recovered is $13,075.

Figure 1. Third Party Billing Examples

DRG Number	DRG Description	DRG Weight	Arithmetic Mean LOS	Geometric Mean LOS	Short Stay Threshold	Long Stay Threshold
020	Nervous System Infection Except Viral Meningitis	2.9769	11.2	7.8	1	30

Hospital	Location	Area Wage Rate Index	IME Adjustment	Group ASA	Applied ASA
Nonteaching Hospital	Large Urban	1.0	1.0	$ 4,392	$ 4,392

Patient	Length of Stay	Days Above Threshold	Relative Weighted Product (RWP)			TPC Amount***
			Inlier*	Outlier**	Total	
#1	7 days	0	2.9769	0.0000	2.9769	$ 13,075
#2	21 days	0	2.9769	0.0000	2.9769	$ 13,075
#3	35 days	5	2.9769	0.8397	3.8166	$ 16,763

* DRG Weight

** Outlier calculation = 44 percent of per diem weight x number of outlier days
= .44 (DRG Weight/Geometric Mean LOS) x (Patient LOS - Long Stay Threshold)
= .44 (2.9769/7.8) x (35-30)
= .44 (.38165) x 5 (take out to 5 decimal places)
= .16793 x 5 (take out to 5 decimal places)
= .8397 (take out to 4 decimal places)

*** Applied ASA x Total RWP

II. OUTPATIENT RATES 1/ 2/

MEPRS Code 4/	PER VISIT Clinical Services	International Military Education And Training (IMET)	Interagency & Other Federal Agency-Sponsored Patient	Other
	A. Medical Care			
BAA	Internal Medicine	$92	$167	$178
BAB	Allergy	$34	$61	$66
BAC	Cardiology	$61	$111	$119
BAE	Diabetes	$57	$103	$110
BAF	Endocrinology	$71	$130	$139
BAG	Gastroenterology	$89	$162	$173
BAH	Hematology	$89	$162	$173
BAI	Hypertension	$60	$108	$116
BAJ	Nephrology	$114	$207	$221
BAK	Neurology	$86	$156	$167
BAL	Nutrition	$24	$43	$46
BAM	Oncology	$81	$148	$158
BAN	Pulmonary Disease	$97	$175	$187
BAO	Rheumatology	$73	$133	$142
BAP	Dermatology	$54	$98	$105
BAQ	Infectious Disease	$76	$139	$148
BAR	Physical Medicine	$73	$132	$141
	B. Surgical Care			
BBA	General Surgery	$107	$193	$207
BBB	Cardiovascular/Thoracic Surgery	$92	$167	$178
BBC	Neurosurgery	$108	$197	$210
BBD	Ophthalmology	$72	$131	$140
BBE	Organ Transplant	$109	$199	$212
BBF	Otolaryngology	$83	$150	$160
BBG	Plastic Surgery	$87	$158	$169
BBH	Proctology	$63	$114	$122
BBI	Urology	$93	$169	$180
BBJ	Pediatric Surgery	$53	$97	$103

MEPRS Code 4/	PER VISIT Clinical Services	International Military Education And Training (IMET)	Interagency & Other Federal Agency-Sponsored Patients	Other
	C. Obstetrical and Gynecological (OB-GYN)			
BCA	Family Planning	$59	$108	$115
BCB	Gynecology	$67	$121	$129
BCC	Obstetrics	$63	$114	$121
	D. Pediatric Care			
BDA	Pediatric	$51	$93	$100
BDB	Adolescent	$49	$89	$95
BDC	Well Baby	$30	$54	$58
	E. Orthopaedic Care			
BEA	Orthopaedic	$74	$135	$144
BEB	Cast Clinic	$34	$63	$67
BEC	Hand Surgery	$37	$67	$72
BEE	Orthopaedic Appliance	$53	$95	$102
BEF	Podiatry	$44	$80	$86
BEZ	Chiropractic Clinic	$24	$44	$47
	F. Psychiatric and/or Mental Health Care			
BFA	Psychiatry	$79	$144	$154
BFB	Psychology	$75	$137	$146
BFC	Child Guidance	$46	$83	$89
BFD	Mental Health	$71	$129	$138
BFE	Social Work	$60	$109	$117
BFF	Substance Abuse Rehabilitation	$60	$110	$117

MEPRS Code 4/	PER VISIT Clinical Services	International Military Education And Training (IMET)	Interagency & Other Federal Agency-Sponsored Patients	Other
	G. Primary Medical Care			
BGA	Family Practice	$58	$106	$113
BHA	Primary Care	$56	$102	$109
BHB	Medical Examination	$50	$91	$97
BHC	Optometry	$37	$68	$73
BHD	Audiology Clinic	$27	$48	$52
BHE	Speech Pathology	$60	$108	$116
BHF	Community Health	$39	$70	$75
BHG	Occupational Health	$51	$92	$98
BHI	Immediate Care Clinic	$75	$137	$146
	H. Emergency Medical Care			
BIA	Emergency Care Clinic	$91	$164	$176
	I. Flight Medicine Clinic			
BJA	Flight Medicine	$85	$154	$164
	J. Underseas Medicine Care			
BKA	Underseas Medicine Clinic	$26	$46	$50
	K. Rehabilitative Services			
BLA	Physical Therapy	$24	$44	$47
BLB	Occupational Therapy	$32	$58	$62
BLC	Neuromuscularskeletal screening	$20	$37	$39
	L. Ambulatory Procedure Visit	$413	$746	$797

III. OTHER RATES AND CHARGES

MEPRS Code 4/	PER VISIT Clinical Service	International Military Education and Training (IMET)	Interagency & Other Federal Agency Sponsored Patients	Other
FBI	A. Immunizations	$8.00	$15.00	$16.00
DGC	B. Hyperbaric Services 5/ (per hour)	$110.00	$201.00	$214.00
	C. Family Member Rate (formerly Military Dependents Rate)	$9.90		

D. Reimbursement Rates For High Cost Drugs Requested By External Providers 6/

The FY 1997 high cost drug reimbursement rates are for prescriptions requested by external providers and obtained at the Military Treatment Facility. The high cost drug reimbursement rates are too voluminous to include in this package. A complete listing of these rates is available on request from the OASD(Health Affairs) action officer identified at Tab N.

E. Reimbursement Rates for High Cost Services Requested By External Providers 7/

The FY 1997 high cost services requested by external providers and obtained at the Military Treatment Facility are too voluminous to include in this package. A complete listing of these rates is available on request from the OASD(Health Affairs) action officer identified at Tab N.

F. Elective Cosmetic Surgery Procedures and Rates

COSMETIC SURGERY PROCEDURE	INTERNATIONAL CLASSIFICATION DISEASES (ICD-9)	CURRENT PROCEDURAL TERMINOLOGY (CPT) 8/	FY 97 CHARGE 9/	AMOUNT OF CHARGE
Mammaplasty	85.50 85.32 85.31	19325 19324 19318	Surgical Care Services or Ambulatory Procedure Visit	a/ b/
Mastopexy	85.60	19316	Surgical Care Services or Ambulatory Procedure Visit	a/ b/
Facial Rhytidectomy	86.82 86.22	15824	Surgical Care Services or Ambulatory Procedure Visit	a/ b/
Blepharoplasty	08.70 08.44	15820 15821 15822 15823	Surgical Care Services or Ambulatory Procedure Visit	a/ b/
Mentoplasty (Augmentation Reduction)	76.68 76.67	21208 21209	Surgical Care Services or Ambulatory Procedure Visit	a/ b/
Abdominoplasty	86.83	15831	Surgical Care Services or Ambulatory Procedure Visit	a/ b/

COSMETIC SURGERY PROCEDURE	INTERNATIONAL CLASSIFICATION DISEASES (ICD-9)	CURRENT PROCEDURAL TERMINOLOGY (CPT) 8/	FY 97 CHARGE 9/	AMOUNT OF CHARGE
Lipectomy, suction per region 10/	86.83	15876 15877 15878 15879	Surgical Care Services or Ambulatory Procedure Visit	a/ b/
Rhinoplasty	21.87 21.86	30400 30410	Surgical Care Services or Ambulatory Procedure Visit	a/ b/
Scar revisions beyond CHAMPUS	86.84	1578_	Surgical Care Services or Ambulatory Procedure Visit	a/ b/
Mandibular or Maxillary Repositioning	76.41	21194	Surgical Care Services or Ambulatory Procedure Visit	a/ b/
Minor Skin Lesions 11/	86.30	1578_	Surgical Care Services or Ambulatory Procedure Visit	a/ b/
Dermabrasion	86.25	15780	Surgical Care Services or Ambulatory Procedure Visit	a/ b/

COSMETIC SURGERY PROCEDURE	INTERNATIONAL CLASSIFICATION DISEASES (ICD-9) CHARGE	CURRENT PROCEDURAL TERMINOLOGY (CPT) 8/	FY 97 CHARGE 9/	AMOUNT OF CHARGE
Hair Restoration	86.64	15775	Surgical Care Services or Ambulatory Procedure Visit	a/ b/
Removing Tattoos	86.25	15780	Surgical Care Services or Ambulatory Procedure Visit	a/ b/
Chemical Peel	86.24	15790	Surgical Care Services or Ambulatory Procedure Visit	a/ b/
Arm/Thigh Dermolipectomy	86.83	1583_	Surgical Care Services or Ambulatory Procedure Visit	a/ b/
Brow Lift	86.3	15839	Surgical Care Services or Ambulatory Procedure Visit	a/ b/

G. Dental Rate

MEPRS Code 4/	PER VISIT Clinical Service 12/	International Military Education and Training (IMET)	Interagency & Other Federal Agency Sponsored Patients	Other
CA	Dental Services (CTV 1)	$9.00	$25.00	$26.00
CA	Dental Services (CTV 2)	$7.00	$20.00	$21.00
CB	Dental Prosthetics Laboratory (CLV)	$2.00	$ 6.00	$ 6.00

H. Ambulance Rate 13/

MEPRS Code 4/	PER VISIT Clinical Service	International Military Education and Training (IMET)	Interagency & Other Federal Agency Sponsored Patients	Other
FEA	Ambulance Service	$57.00	$103.00	$110.00

I. High Cost Laboratory and Radiology Services 7/

MEPRS Code 4/	PER VISIT Clinical Service	International Military Education and Training (IMET)	Interagency & Other Federal Agency Sponsored Patients	Other
	High Cost Laboratory CPT-4 Multiplier	$6.00	$10.00	$11.00
	High Cost Radiology CPT-4 Multiplier	$20.00	$36.00	$38.00

J. AirEvac Rate 14/

MEPRS Code 4/	PER VISIT Clinical Service	International Military Education and Training (IMET)	Interagency & Other Federal Agency Sponsored Patients	Other
	AirEvac Services (Ambulatory)	$89.00	$162.00	$173.00
	AirEvac Services (Litter)	$265.00	$481.00	$513.00

NOTES ON COSMETIC SURGERY CHARGES:

a/ Charges for inpatient Surgical Care Services are contained in Section I.B. (See Notes 9 through 11 on reimbursable rates for further details.)

b/ Charges for Ambulatory Procedure Visits (formerly Same Day Surgery) are contained in Section II.L. (See Notes 9 through 11 on reimbursable rates for further details.)

NOTES ON REIMBURSABLE RATES:

1/ Percentages can be applied when preparing bills for both inpatient and outpatient services. Pursuant to the provisions of 10 U.S.C. 1095, the inpatient Diagnosis Related Groups and inpatient per diem percentages are 96 percent hospital and 4 percent professional fee. The outpatient per visit percentages are 58 percent hospital, 30 percent ancillary and 12 percent professional.

2/ DoD civilian employees located in overseas areas shall be rendered a bill when services are performed. Payment is due 60 days from the date of the bill.

3/ The cost per DRG (Diagnosis Related Groups) is based on the inpatient full reimbursement rate per hospital discharge, weighted to reflect the intensity of the principal and secondary diagnoses, surgical procedures, and patient demographics involved. The adjusted standardized amounts (ASA) per Relative Weighted Product (RWP) for use in the Direct Care System will be comparable to procedures utilized by Health Care Financing Administration (HCFA) and the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS). These expenses include all direct care expenses associated with direct patient care. The average cost per RWP for large urban, other urban/rural, and overseas will be published annually as an adjusted standardized amount (ASA) and

will include the cost of inpatient professional services. The DRG rates will apply to reimbursement from all sources, not just third party payers.

4/ The Medical Expense and Performance Reporting System (MEPRS) code is a three digit code which defines the summary account and the subaccount within a functional category in the DoD medical system. An example of this hierarchical arrangement is as follows:

Outpatient Care (Functional Category)	MEPRS CODE
Medical Care (Summary Account)	BA
Internal Medicine (Subaccount)	BAA

MEPRS codes are used to ensure that consistent expense and operating performance data is reported in the DoD military medical system.

5/ Hyperbaric services are to be charged based on full hours and 15 minute increments of service. Providers should calculate the charges based on the number of hours (or fraction thereof) of service. Fractions of hours should be rounded to the next 15 minute increment (e.g. 31 minutes becomes 45 minutes).

6/ High cost prescription services requested by external providers (Physicians, Dentists, etc.) are relevant to the Third Party Collection Program. Third party payers (such as insurance companies) shall be billed for high cost prescriptions in those instances in which beneficiaries who have medical insurance, seen by providers external to a Military Medical Treatment Facility (MTF), obtain the prescribed medication from an MTF. Eligible beneficiaries (family members or retirees with medical insurance) are not personally liable for this cost and shall not be billed by the MTF. Medical Services Account (MSA) patients, who are not beneficiaries as defined in 10 U.S.C. 1074 and 1076, are charged at the "Other" rate if they are seen by an outside provider and come to the MTF for prescription services. A bill will be produced if the total prescription costs in a day (defined as 0001 hours to 2400 hours) exceeds $25.00 when bundled together. Bundling refers to the accumulation of a patient's bills during the previously defined 24 hour period. The standard cost of high cost medications includes the cost of the drugs plus a dispensing fee, per prescription. The prescription cost is calculated by multiplying the number of units (tablets, capsules, etc.) times the unit cost and adding a $5.00 dispensing fee per prescription.

7/ Charges for high cost ancillary services requested by external providers (Physicians, Dentists, etc.) are relevant to the Third Party Collection Program. Third party payers (such as insurance companies) shall be billed for high cost services in those instances in which beneficiaries who have medical insurance, are seen by providers external to an MTF, and obtain the prescribed service from an MTF. Laboratory and Radiology procedure costs are calculated using the CPT-4 weight multiplied by either the high cost laboratory or radiology multiplier (Section III.I). Eligible beneficiaries (family members or retirees with medical insurance) are not personally liable for this cost and shall not be billed by the MTF. MSA patients, who are not beneficiaries as defined by 10 U.S.C. 1074 and 1076, are charged at the "Other" rate if they are seen by an outside provider and

come to the MTF for high cost services. A bill will be produced if the total ancillary services costs in a day (defined as 0001 hours to 2400 hours) exceed $25.00 when bundled together. Bundling refers to the accumulation of a patient's bills during the previously defined 24 hour period.

8/ The attending physician is to complete the Physicians' Current Procedural Terminology code to indicate the appropriate procedure followed during cosmetic surgery. The appropriate rate will be applied depending on the admission type of the patient, e.g., ambulatory procedure visit or inpatient surgical care services.

9/ Family members of active duty personnel, retirees and their family members, and survivors will be charged cosmetic surgery rates. The patient shall be charged the rate as specified in the FY 1997 reimbursable rates for an episode of care. The charges for elective cosmetic surgery are at the full reimbursement rate (designated as the "Other" rate) for Surgical Care Services in Section I.B., or Ambulatory Procedure Visits as contained in Section II.L of this attachment. The patient will be responsible for both the cost of the implant(s) in addition to the prescribed cosmetic surgery rates.

> NOTE: The implants and procedures used for the augmentation mammaplasty are in compliance with Federal Drug Administration guidelines.

10/ Each regional lipectomy will carry a separate charge. Regions include head and neck, abdomen, flanks, and hips.

11/ These procedures are inclusive in the minor skin lesions. However, CHAMPUS separates them as noted here. All charges are for the entire treatment regardless of the number of visits required.

12/ Dental services are based on a Composite Time Value (CTV). Charges should be calculated based on the time value of the procedure times the CTV rate. The first CTV (1.0 value) shall be calculated using the CTV 1 rate. Any subsequent CTVs and portions thereof shall be calculated using the CTV 2 rate. The Composite Lab Value (CLV) should be used to calculate charges for dental appliances and prostheses.

13/ Ambulance charges are based on full hours and 15 minute increments of service. Providers should calculate the charges based on the number of hours (or fraction thereof) that the ambulance is logged out on a patient run. Fractions of hours should be rounded to the next 15 minute increment (e.g. 31 minutes becomes 45 minutes).

14/ Air in-flight medical care reimbursement charges are determined by the status of the patient (Litter or Ambulatory) and are per patient.