APPENDIX H

MEDICAL AND DENTAL SERVICES RATE COMPUTATION

SUBMITTED BY THE OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

Note: Budget exhibit includes Sections I, II, and III for IMET, Interagency and Other. This exhibit is to be included only in the President's budget. The format of the budget exhibit for medical and dental rates may vary slightly from year to year due to the addition/deletion of rates, changes in nomenclature, updated notes and other unforeseen reasons.

INPATIENT, OUTPATIENT AND OTHER RATES AND CHARGES

A. INPATIENT RATES 1/ 2/

Per Inpatient Day	Prior FY	Current FY	Budget FY
1. Burn Center	$_____	$_____	$_____
2. Surgical Care Services (Cosmetic Surgery)	$_____	$_____	$_____

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

FY 1996 DIRECT CARE INPATIENT REIMBURSEMENT RATES

ADJUSTED STANDARD AMOUNT	Prior FY	Current FY	Budget FY
Large Urban	$_____	$_____	$_____
Other Urban/ Rural	$_____	$_____	$_____
Overseas	$_____	$_____	$_____

B. OUTPATIENT RATES 1/ 2/

Meprs Code 4/	Per Visit Clinical Services	Prior FY	Current FY	Budget FY
	1. Medical Care			
BAA	Internal Medicine			
BAB	Allergy			
BAC	Cardiology			
BAE	Diabetes			
BAF	Endocrinology			
BAG	Gastroenterology			
BAH	Hematology			
BAI	Hypertension			
BAJ	Nephrology			
BAK	Neurology			
BAL	Nutrition			
BAM	Oncology			
BAN	Pulmonary Disease			
BAO	Rheumatology			
BAP	Dermatology			
BAQ	Infectious Disease			
BAR	Physical Medicine			
	2. Surgical Care			
BBA	General Surgery			
BBB	Cardiovascular/Thoracic Surgery			
BBC	Neurosurgery			
BBD	Ophthalmology			
BBE	Organ Transplant			
BBF	Otolaryngology			
BBG	Plastic Surgery			
BBH	Proctology			
BBI	Urology			
BBJ	Pediatric Surgery			
	3. Obstetrical and Gynecological (OB-GYN)			
BCA	Family Planning			
BCB	Gynecology			
BCC	Obstetrics			

Meprs Code 4/	Per Visit Clinical Services	Prior FY	Current FY	Budget FY
	4. Pediatric Care			
BDA	Pediatric			
BDB	Adolescent			
BDC	Well Baby			
	5. Orthopedic Care			
BEA	Orthopedic			
BEB	Cast Clinic			
BEC	Hand Surgery			
BEE	Orthopedic Appliance			
BEF	Podiatry			
BEZ	Chiropractic Clinic			
	6. Psychiatric and/or Mental Health Care			
BFA	Psychiatry			
BFB	Psychology			
BFC	Child Guidance			
BFD	Mental Health			
BFE	Social Work			
BFF	Substance Abuse Rehabilitation			
	7. Primary Medical Care			
BGA	Family Practice			
BHA	Primary Care			
BHB	Medical Examination			
BHC	Optometry			
BHD	Audiology Clinic			
BHE	Speech Pathology			
BHF	Community Health			
BHG	Occupational Health			
BHI	Immediate Care Clinic			
	8. Emergency Medical Care			
BIA	Emergency Care Clinic			
	9. Flight Medicine Clinic			

Meprs Code 4/	Per Visit Clinical Services	Prior FY	Current FY	Budget FY
BJA	Flight Medicine			
	10. Underseas Medicine Care			
BKA	Underseas Medicine Clinic			
	11. Rehabilitative Services			
BLA	Physical Therapy			
BLB	Occupational Therapy			
BLC	Neuromuscularskeletal screening			
	12. Same Day Surgery			

C. OTHER RATES AND CHARGES

MEPRS Code 4/	PER VISIT Clinical Service	Prior FY	Current FY	Budget FY
	1. Immunizations	$_____	$_____	$_____
	2. Hyperbaric Services			
	1-60 minutes	$_____	$_____	$_____
	61-120 minutes	$_____	$_____	$_____
	121-180 minutes	$_____	$_____	$_____
	181-240 minutes	$_____	$_____	$_____
	Each Additional Hour	$_____	$_____	$_____

(Note: Charges may be prorated based on usage)

3. Family Member Rate $_____

(formerly Military Dependents Rate)

4. Third Party Drug Reimbursement Rates 5/

Include the third party drug reimbursement rates for prescriptions requested by external providers and obtained at the Military Treatment Facility as an attachment to the exhibit. Attachment should be entitled “Third Party Drug Reimbursement Rates.”

5. High Cost Services Requested By External Providers 6/

Include the high cost services requested by external providers as an attachment to the exhibit. Attachment should be entitled “High Cost Services Requested By External Providers.”

6. Elective Cosmetic Surgery Procedures and Rates Identify the charge (i.e., Surgical Care Services rate, Same Day Surgery rate, etc.) for the Cosmetic Surgery Procedures outlined below.

COSMETIC SURGERY PROCEDURE	INTERNATIONAL CLASSIFICATION DISEASES (ICD-9)	CURRENT PROCEDURAL TERMINOLOGY (CPT) 7/	CHARGE 8/
Mammaplasty	85.50	19325	_____
	85.32	19324	_____
	85.31	19318	_____
Mastopexy	85.60	19316	_____
Facial	86.82	15824	_____
Rhytidectomy	86.22		_____
Blepharoplasty	08.70	15820	_____
	08.44	15821	_____
		15822	_____
		15823	_____
Mentoplasty	76.68	21208	_____
(Augmentation	76.67	21209	_____
Reduction)			
Abdominoplasty	86.83	15831	_____
Lipectomy,	86.83	15876	_____
suction per		15877	_____
region 9/		15878	_____
		15879	_____
Rhinoplasty	21.87	30400	_____
	21.86	30410	_____
Scar revisions	86.84	1578_	_____
beyond CHAMPUS			_____
Mandibular or	76.41	21194	_____
Maxillary			_____
Repositioning			_____

COSMETIC SURGERY PROCEDURE	INTERNATIONAL CLASSIFICATION DISEASES (ICD-9)	CURRENT PROCEDURAL TERMINOLOGY (CPT) 7/	CHARGE 8/
Minor Skin Lesions 10/	86.30	1578_	_____
Dermabrasion	86.25	15780	_____
Hair Restoration	86.64	15775	_____
Removing Tattoos	86.25	15780	_____
Chemical Peel	86.24	15790	_____
Arm/Thigh Dermolipectomy	86.83	1583_	_____
Brow Lift	86.3	15839	_____

G. Dental Rate

MEPRS Code 4/	PER VISIT Clinical Service	Prior FY	Current FY	Budget FY
N/A	Dental Services	$_____	$_____	$_____

Dental service charges are based on a Composite Time Value. Provider should calculate the charges based on the time value of the procedure times the CTV rate.

H. Ambulance Rate

MEPRS Code 4/	PER VISIT Clinical Service	Prior FY	Current FY	Budget FY
N/A	Ambulance Service	$_____	$_____	$_____

Ambulance charges are based on hours of service. Provider should calculate the charges based on the number of hours (or fraction thereof) that the ambulance is logged out on a patient run.

NOTES ON REIMBURSABLE RATES:

1/ Percentages are applied to both inpatient and outpatient services provided when billing third party payers (e.g., insurance companies). Pursuant to the provisions of 10 U.S.C. 1095, the inpatient Diagnosis Related Groups are __ percent hospital and __ percent professional fee. The outpatient per visit percentages are __ percent hospital, __ percent ancillary and __ 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 of DRG (Diagnosis Related Groups) is based on the inpatient full reimbursement rate per hospital discharge, weighted to reflect the intensity of the principal diagnosis involved. The adjusted standardized amounts (ASA) per Relative Weighted Product (RWP) for use in the Direct Care System is comparable to procedures utilized by Health Care Financing Administration (HFCA) 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 relative weight product for large urban, other urban/rural, and overseas are published as an inpatient standardized amount and include the cost of inpatient professional services. The DRG rates apply to reimbursement from all sources (including 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/ High cost prescription services requested by external providers (Physicians, Dentists, etc.) are only relevant to the Third Party Collection Program. Third party payers (such as insurance companies) are billed for high cost prescriptions in those instances in which dependents 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, subsequently, are not billed by the MTF. A third party payer may be billed if the total prescription costs in a day exceed $____ when bundled together. 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 $____ dispensing fee per prescription.

6/ Charges for high cost services requested by external providers (physicians, dentists, etc.) are only 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 dependents who have medical insurance, seen by providers external to a Military Medical Treatment Facility (MTF), obtain the prescribed service 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. A third party payer may be billed if the total ancillary services costs in a day exceed $____ when bundled together.

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

8/ Family members of active duty personnel, retirees and their family members, and survivors are charged cosmetic surgery rates. The patient is charged the rate as specified in the reimbursable rates for an episode of care. The patient is 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.

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

10/ 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.

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