MEDICAL AND DENTAL SERVICES
FISCAL YEAR 2000

The FY 2000 Department of Defense (DoD) reimbursement rates for inpatient, outpatient, and other services are provided in accordance with Title 10, United States Code, section 1095. Due to size, the sections containing the Drug Reimbursement Rates (section III.E) and the rates for Ancillary Services Requested by Outside Providers (section III.F) are not included in this package. The Office of the Assistant Secretary of Defense (Health Affairs) will provide those rates upon request (see Tab O for the point of contact). The medical and dental service rates in this package (including the rates for ancillary services and other procedures requested by outside providers) are effective October 1, 1999. Pharmacy rates are updated on an as needed basis.

INPATIENT, OUTPATIENT AND OTHER RATES AND CHARGES

I. INPATIENT RATES 1/ 2/

Per Inpatient Day	International Military Education & Training (IMET)	Interagency & Other Federal Agency Sponsored Patients	Other (Full/Third Party)
A. Burn Center	$3,080.00	$5,529.00	$5,840.00
B. Surgical Care Services (Cosmetic Surgery)	$1,411.00	$2,533.00	$2,675.00

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

1. FY00 Direct Care Inpatient Reimbursement Rates

Adjusted Standard Amount	IMET	Interagency	Other (Full/Third Party)
Large Urban	$2,921.00	$5,498.00	$5,775.00
Other Urban/Rural	$3,236.00	$6,532.00	$6,883.00
Overseas	$3,606.00	$8,520.00	$8,941.00

2. Overview

The FY00 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 cost 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 paragraph I.C.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 (LOS) 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 paragraph I.C.3., 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 non-teaching 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 2.3446. (DRG statistics shown are from FY 1998.)

c. The DoD adjusted standardized amount to be charged is $5,775 (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 (2.3446) in subparagraph 3.b., above, multiplied by the amount ($5,775) in subparagraph 3.c., above.

e. Cost to be recovered is $13,540.

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	2.3446	8.1	5.7	1	29

Hospital	Location	Area Wage Rate Index	IME Adjustment	Group ASA	Applied ASA
Non-teaching Hospital	Large Urban	1.0	1.0	$5,775	$5,775

Patient	Length of Stay	Days Above Threshold	Relative Weighted Product			TPC Amount***
			Inlier*	Outlier**	Total	
#1	7 days	0	2.3446	000	2.3446	$13,540
#2	21 days	0	2.3446	000	2.3446	$13,540
#3	35 days	6	2.3446	0.8144	3.1590	$18,243

* DRG Weight

** Outlier calculation = 33 percent of per diem weight × number of outlier days
= .33 (DRG Weight/Geometric Mean LOS) × (Patient LOS - Long Stay Threshold)
= .33 (2.3446/5.7) × (35-29)
= .33 (.41133) × 6 (take out to five decimal places)
= .13574 × 6 (carry to five decimal places)
= .8144 (carry to four decimal places)

*** Applied ASA × Total RWP

II. OUTPATIENT RATES 1/ 2/

Per Visit

MEPRS Code 4/	Clinical Service	International Military Education & Training (IMET)	Interagency & Other Federal Agency Sponsored Patients	Other (Full/Third Party)
	A. Medical Care			
BAA	Internal Medicine	$104.00	$194.00	$204.00
BAB	Allergy	53.00	99.00	105.00
BAC	Cardiology	87.00	163.00	172.00
BAE	Diabetic	61.00	114.00	121.00
BAF	Endocrinology (Metabolism)	102.00	190.00	201.00
BAG	Gastroenterology	146.00	272.00	287.00
BAH	Hematology	179.00	334.00	352.00
BAI	Hypertension	106.00	198.00	208.00
BAJ	Nephrology	208.00	387.00	409.00
BAK	Neurology	121.00	225.00	238.00
BAL	Outpatient Nutrition	42.00	79.00	83.00
BAM	Oncology	134.00	250.00	264.00
BAN	Pulmonary Disease	153.00	285.00	301.00
BAO	Rheumatology	101.00	188.00	199.00
BAP	Dermatology	78.00	146.00	154.00
BAQ	Infectious Disease	178.00	332.00	350.00
BAR	Physical Medicine	83.00	155.00	163.00
BAS	Radiation Therapy	128.00	238.00	251.00
BAT	Bone Marrow Transplant	115.00	214.00	226.00
BAU	Genetic	367.00	683.00	721.00
	B. Surgical Care			
BBA	General Surgery	$148.00	$276.00	$291.00
BBB	Cardiovascular and Thoracic Surgery	320.00	595.00	628.00
BBC	Neurosurgery	173.00	323.00	341.00
BBD	Ophthalmology	90.00	168.00	177.00
BBE	Organ Transplant	399.00	742.00	783.00
BBF	Otolaryngology	106.00	197.00	207.00
BBG	Plastic Surgery	131.00	244.00	258.00
BBH	Proctology	84.00	157.00	165.00
BBI	Urology	112.00	209.00	221.00
BBJ	Pediatric Surgery	167.00	311.00	328.00
BBK	Peripheral Vascular Surgery	78.00	146.00	154.00
BBL	Pain Management	97.00	180.00	190.00

MEPRS Code 4/	Clinical Service	International Military Education & Training (IMET)	Interagency & Other Federal Agency Sponsored Patients	Other (Full/Third Party)
	C. Obstetrical and Gynecological (OB-GYN) Care			
BCA	Family Planning	$57.00	$106.00	$112.00
BCB	Gynecology	89.00	165.00	175.00
BCC	Obstetrics	74.00	138.00	146.00
BCD	Breast Cancer Clinic	184.00	342.00	361.00
	D. Pediatric Care			
BDA	Pediatric	$62.00	$115.00	$121.00
BDB	Adolescent	65.00	122.00	129.00
BDC	Well Baby	42.00	79.00	83.00
	E. Orthopaedic Care			
BEA	Orthopaedic	$93.00	$174.00	$183.00
BEB	Cast	59.00	110.00	117.00
BEC	Hand Surgery	69.00	129.00	136.00
BEE	Orthotic Laboratory	67.00	125.00	132.00
BEF	Podiatry	56.00	105.00	111.00
BEZ	Chiropractic	25.00	47.00	50.00
	F. Psychiatric and/or Mental Health Care			
BFA	Psychiatry	$124.00	$230.00	$243.00
BFB	Psychology	93.00	174.00	184.00
BFC	Child Guidance	57.00	105.00	111.00
BFD	Mental Health	104.00	194.00	204.00
BFE	Social Work	102.00	190.00	200.00
BFF	Substance Abuse	99.00	184.00	195.00
	G. Family Practice/Primary Medical Care			
BGA	Family Practice	$74.00	$138.00	$146.00
BHA	Primary Care	77.00	143.00	151.00
BHB	Medical Examination	80.00	148.00	156.00
BHC	Optometry	50.00	93.00	98.00
BHD	Audiology	35.00	65.00	69.00

MEPRS Code 4/	Clinical Service	International Military Education & Training (IMET)	Interagency & Other Federal Agency Sponsored Patients	Other (Full/Third Party)
BHE	Speech Pathology	$101.00	$188.00	$199.00
BHF	Community Health	66.00	123.00	130.00
BHG	Occupational Health	73.00	136.00	143.00
BHH	TRICARE Outpatient	56.00	104.00	109.00
BHI	Immediate Care	107.00	200.00	211.00
	H. Emergency Medical Care			
BIA	Emergency Medical	$126.00	$234.00	$247.00
	I. Flight Medical Care			
BJA	Flight Medicine	$88.00	$164.00	$173.00
	J. Underseas Medical Care			
BKA	Underseas Medicine	$43.00	$79.00	$84.00
	K. Rehabilitative Services			
BLA	Physical Therapy	$41.00	$77.00	$81.00
BLB	Occupational Therapy	61.00	114.00	120.00

III. AMBULATORY PROCEDURE VISIT (APV) 6/

Per Visit

MEPRS Code 4/	Clinical Service	International Military Education & Training (IMET)	Interagency & Other Federal Agency Sponsored Patients	Other (Full/Third Party)
	Medical Care			
BB	Surgical Care	937.00	1,740.00	1,836.00
BD	Pediatric Care	233.00	430.00	454.00
BE	Orthopaedic Care	1,179.00	2,192.00	2,313.00
	All other B clinics not included above (BA, BC, BF, BG, BH, BI, BJ, BK and BL)	430.00	797.00	841.00

IV. OTHER RATES AND CHARGES 1/ 2/

Per Visit

MEPRS Code 4/	Clinical Service	International Military Education & Training (IMET)	Interagency & Other Federal Agency Sponsored Patients	Other (Full/Third Party)
FBI	A. Immunization	$16.00	$30.00	$32.00
DGC	B. Hyperbaric Chamber 5/	$153.00	$285.00	$301.00

C. Family Member Rate $10.85
(formerly Military Dependents Rate)

D. Reimbursement Rates For Drugs Requested By Outside Providers 7/

The FY 2000 drug reimbursement rates for drugs are for prescriptions requested by outside providers and obtained at a Military Treatment Facility. The rates are established based on the cost of the particular drugs provided based on the DoD-wide average per National Drug Code (NDC) number. Final rule 32 CFR Part 220, which was not published at the time that this package was prepared, eliminates the dollar threshold for high cost ancillary services and the associated term "high cost ancillary service." The phrase "high cost ancillary service" will be replaced with the phrase "ancillary services requested by an outside provider" on publication of final rule 32 CFR Part 220. The list of drug reimbursement rates is too large to include in this document. Those rates are available on request from OASD (Health Affairs). See Tab O for the point of contact.

E. Reimbursement Rates for Ancillary Services Requested By Outside Providers 8/

Final rule 32 CFR Part 220, which was not published at the time that this package was prepared, eliminates the dollar threshold for high cost ancillary services and the associated term "high cost ancillary service." The phrase "high cost ancillary service" will be replaced with the phrase "ancillary services requested by an outside provider" on publication of final rule 32 CFR Part 220. The list of FY 2000 rates for ancillary services requested by outside providers and obtained at a Military Treatment Facility is too large to include in this document. Those rates are available on request from OASD (Health Affairs). See Tab O for the point of contact.

F. Elective Cosmetic Surgery Procedures and Rates

Cosmetic Surgery Procedure	International Classification Diseases (ICD-9)	Current Procedural Terminology (CPT) 9/	FY 2000 Charge 10/	Amount of Charge
Mammaplasty – augmentation	85.50 85.32 85.31	19325 19324 19318	Inpatient Surgical Care Per Diem Or APV	a/ b/
Mastopexy	85.60	19316	Inpatient Surgical Care Per Diem Or APV or applicable Outpatient Clinic Rate	a/ b/ c/
Facial Rhytidectomy	86.82 86.22	15824	Inpatient Surgical Care Per Diem Or APV	a/ b/
Blepharoplasty	08.70 08.44	15820 15821 15822 15823	Inpatient Surgical Care Per Diem Or APV or applicable Outpatient Clinic Rate	a/ b/ c/
Mentoplasty (Augmentation / Reduction)	76.68 76.67	21208 21209	Inpatient Surgical Care Per Diem Or APV or applicable Outpatient Clinic Rate	a/ b/ c/
Abdominoplasty	86.83		Inpatient Surgical Care Per Diem	a/
Lipectomy Suction per region 11/	86.83	15876 15877 15878 15879	Inpatient Surgical Care Per Diem Or APV or applicable Outpatient Clinic Rate	a/ b/ c/

Cosmetic Surgery Procedure	International Classification Diseases (ICD-9)	Current Procedural Terminology (CPT) 9/	FY 2000 Charge 10/	Amount of Charge
Rhinoplasty	21.87 21.86	30400 30410	Inpatient Surgical Care Per Diem Or APV or applicable Outpatient Clinic Rate	a/ b/ c/
Scar Revisions beyond CHAMPUS	86.84	1578_	Inpatient Surgical Care Per Diem Or APV or applicable Outpatient Clinic Rate	a/ b/ c/
Mandibular or Maxillary Repositioning	76.41		Inpatient Surgical Care Per Diem	a/
Dermabrasion		15780	APV or applicable Outpatient Clinic Rate	b/ c/
Hair Restoration		15775	APV or applicable Outpatient Clinic Rate	b/ c/
Removing Tattoos		15780	APV or applicable Outpatient Clinic Rate	b/ c/
Chemical Peel		15790	APV or applicable Outpatient Clinic Rate	b/ c/
Arm/Thigh Dermolipectomy	86.83	15836/ 15832	Inpatient Surgical Care Per Diem Or APV	a/ b/

Cosmetic Surgery Procedure	International Classification Diseases (ICD-9)	Current Procedural Terminology (CPT) 9/	FY 2000 Charge 10/	Amount of Charge
Refractive surgery			APV or applicable Outpatient Clinic Rate	b/ c/
Radial Keratotomy		65771		
Other Procedure (if applies to laser or other refractive surgery)		66999		
Otoplasty		69300	APV or applicable Outpatient Clinic Rate	a/ b/ c/
Brow Lift	86.3	15839	Inpatient Surgical Care Per Diem Or APV	a/ b/

G. Dental Rate 12/

Per Procedure

MEPRS Code 4/	Clinical Service	International Military Education & Training (IMET)	Interagency & Other Federal Agency Sponsored Patients	Other (Full/Third Party)
	Dental Services ADA code and DoD established weight	$45.00	$109.00	$115.00

H. Ambulance Rate 13/

Per Visit

MEPRS Code 4/	Clinical Service	International Military Education & Training (IMET)	Interagency & Other Federal Agency Sponsored Patients	Other (Full/Third Party)
FEA	Ambulance	$62.00	$116.00	$122.00

I. Ancillary Services Requested by an Outside Provider 8/

Per Procedure

MEPRS Code 4/	Clinical Service	International Military Education & Training (IMET)	Interagency & Other Federal Agency Sponsored Patients	Other (Full/Third Party)
	Laboratory procedures requested by an outside provider CPT '99 Weight Multiplier	$13.00	$20.00	$21.00
	Radiology procedures requested by an outside provider CPT '99 Weight Multiplier	$57.00	$86.00	$90.00

J. AirEvac Rate 14/

Per Visit

MEPRS Code 4/	Clinical Service	International Military Education & Training (IMET)	Interagency & Other Federal Agency Sponsored Patients	Other (Full/Third Party)
	AirEvac Services - Ambulatory	$195.00	$364.00	$384.00
	AirEvac Services – Litter	$567.00	$1,056.00	$1,114.00

K. Observation Rate 15/

Per hour

MEPRS Code 4/	Clinical Service	International Military Education & Training (IMET)	Interagency & Other Federal Agency Sponsored Patients	Other (Full/Third Party)
	Observation Services – Hour	$17.00	$31.00	$32.00

NOTES ON COSMETIC SURGERY CHARGES:

a/ Per diem charges for inpatient surgical care services are listed in section I.B. (See notes 9 through 11, below, for further details on reimbursable rates.)

b/ Charges for ambulatory procedure visits (formerly same day surgery) are listed in section III.C. (See notes 9 through 11, below, for further details on reimbursable rates.) The ambulatory procedure visit (APV) rate is used if the elective cosmetic surgery is performed in an ambulatory procedure unit (APU).

c/ Charges for outpatient clinic visits are listed in sections II.A-K. The outpatient clinic rate is not used for services provided in an APU. The APV rate should be used in these cases.

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 98 percent hospital and 2 percent professional charges. The outpatient per visit percentages are 89 percent outpatient services and 11 percent professional charges.

2/ DoD civilian employees located in overseas areas shall be rendered a bill when services are performed.

3/ The cost per Diagnosis Related Group (DRG) 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 is comparable to procedures used by the 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. MEPRS codes are used to ensure that consistent expense and operating performance data is reported in the DoD military medical system. An example of the MEPRS hierarchical arrangement follows:

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

5/ Hyperbaric service charges shall be based on hours of service in 15-minute increments. The rates listed in section III.B. are for 60 minutes or 1 hour of service. Providers shall calculate the charges based on the number of hours (and/or fractions of an hour) of service. Fractions of an hour shall be rounded to the next 15-minute increment (e.g., 31 minutes shall be charged as 45 minutes).

6/ Ambulatory procedure visit is defined in DOD Instruction 6025.8, "Ambulatory Procedure Visit (APV)," dated September 23, 1996, as immediate (day of procedure) pre-procedure and immediate post-procedure care requiring an unusual degree of intensity and provided in an 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. Care is required in the facility for less than 24 hours. All expenses and workload are assigned to the MTF-established APU associated with the referring clinic. The BB, BD and BE APV rates are to be used only by clinics that are subaccounts under these summary accounts (see 4/ for an explanation of MEPRS hierarchical arrangement). The All Other APV rate is to be used only by those clinics that are not a subaccount under BB, BD or BE.

7/ Prescription services requested by outside providers (e.g., physicians and dentists) that are relevant to the Third Party Collection Program. Third party payers (such as insurance companies) shall be billed for prescription services when beneficiaries who have medical insurance obtain medications from a Military Treatment Facility (MTF) that are prescribed by providers external to the MTF. Eligible beneficiaries (family members or retirees with medical insurance) are not liable personally 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 only come to the MTF for prescription services. The standard cost of medications ordered by an outside provider that includes the cost of the drugs plus a dispensing fee per prescription. The prescription cost is calculated by multiplying the number of units (e.g., tablets or capsules) by the unit cost and adding a $6.00 dispensing fee per prescription. Final rule 32 CFR Part 220, which was not published at the time that this package was prepared, eliminates the dollar threshold for high cost ancillary services and the associated term "high cost ancillary service." The phrase "high cost ancillary service" will be replaced with the phrase "ancillary services requested by an outside provider" on publication of final rule 32 CFR Part 220. The elimination of the threshold also eliminates the need to bundle costs whereby a patient is billed if the total cost of ancillary services in a day (defined as 0001 hours to 2400 hours) exceeds $25.00. The elimination of the threshold is effective as per date stated in final rule 32 CFR Part 220.

8/ Charges for ancillary services requested by an outside provider (e.g., physicians and dentists) are relevant to the Third Party Collection Program. Third party payers (such as insurance companies) shall be billed for ancillary services when beneficiaries who have medical insurance obtain services from the MTF which are prescribed by providers external to the MTF. Laboratory and Radiology procedure costs are calculated by multiplying the DoD established weight for the Physicians' Current Procedural Terminology (CPT 99) code by either the laboratory or radiology multiplier (section III.J). 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 only come to the MTF for ancillary services. Final rule 32 CFR Part 220, which was not published at the time that this package was prepared, eliminates the dollar threshold for high cost ancillary services and the associated term "high cost ancillary service." The phrase "high cost ancillary service" will be replaced with the phrase "ancillary services requested by an outside provider" on publication of final rule 32 CFR Part 220. The elimination of the threshold also eliminates the need to bundle costs whereby a patient is billed if the total cost of ancillary services in a day (defined as 0001 hours to 2400 hours) exceeds $25.00. The elimination of the threshold is effective as per date stated in final rule 32 CFR Part 220.

9/ The attending physician is to complete the CPT 99 code to indicate the appropriate procedure followed during cosmetic surgery. The appropriate rate will be applied depending on the treatment modality of the patient: ambulatory procedure visit, outpatient clinic visit or inpatient surgical care services.

10/ Family members of active duty personnel, retirees and their family members, and survivors shall be charged elective cosmetic surgery rates. Elective cosmetic surgery procedure information is contained in section III.G. The patient shall be charged the rate as specified in the FY 2000 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 inpatient per diem surgical care services in section I.B., ambulatory procedure visits as contained in section III.C, or the appropriate outpatient clinic rate in sections II.A-K. The patient is responsible for the cost of the implant(s) and the prescribed cosmetic surgery rate. (Note: The implants and procedures used for the augmentation mammaplasty are in compliance with Federal Drug Administration guidelines.)

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

12/ Dental service rates are based on a dental rate multiplier times the American Dental Association (ADA) code and the DoD established weight for that code.

13/ Ambulance charges shall be based on hours of service in 15 minute increments. The rates listed in section III.I are for 60 minutes or 1 hour of service. Providers shall 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 shall be rounded to the next 15 minute increment (e.g., 31 minutes shall be charged as 45 minutes).

14/ Air in-flight medical care reimbursement charges are determined by the status of the patient (ambulatory or litter) and are per patient. The appropriate charges are billed only by the Air Force Global Patient Movement Requirement Center (GPMRC). These charges are only for the cost of providing medical care. Flight charges are billed by GPMRC separately using the commercial rate effective the date of travel plus $1.00.

15/ Observation Services are billed at the hourly charge. Begin counting when the patient is placed in the observation bed and round up to the nearest hour. If the status of a patient changes to inpatient, the charges for observation services are added to the DRG assigned to the case and not separately billed. If a patient is released from observation status and is sent to an APV, the charges for observation services are not billed separately but are added to the APV rate to recover all expenses.