MEDICAL AND DENTAL SERVICES
FISCAL YEAR 1998

The FY 1998 Department of Defense (DoD) reimbursement rates for inpatient, outpatient, and other services are provided in accordance with Section 1095 of title 10, United States Code. Due to size, the sections containing the Drug Reimbursement Rates (Section III.D) and the rates for Ancillary Services Requested by Outside Providers (Section III.E) are not included in this package. The Office of the Assistant Secretary of Defense (Health Affairs) will provide these rates upon request (see Tab N for the point of contact). The medical and dental service rates in this package (including the rates for ancillary services, prescription drugs or other procedures requested by outside providers) are effective October 1, 1997.

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	$2,618.00	$4,754.00	$5,079.00
B. Surgical Care Services (Cosmetic Surgery)	955.00	1,733.00	1,852.00

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

1. FY98 Direct Care Inpatient Reimbursement Rates

Adjusted Standard Amount	IMET	Interagency	Other (Full/Third Party)
Large Urban	$2,199.00	$4,131.00	$4,372.00
Other Urban/Rural	2,194.00	4,215.00	4,499.00
Overseas	2,450.00	5,614.00	5,960.00

2. Overview

The FY98 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 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 $4,372 (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 3.b., above, multiplied by the amount ($4,372) in 3.c., above.

e. Cost to be recovered is $13,015.

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	$4,372.00	$4,372.00

Patient	Length of Stay	Days Above Threshold	Relative Weighted Product			TPC Amount***
			Inlier*	Outlier**	Total	
#1	7 days	0	2.9769	0.0000	2.9769	$13,015
#2	21 days	0	2.9769	0.0000	2.9769	13,015
#3	35 days	5	2.9769	0.6297	3.6066	15,768

* 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 (2.9769/7.8) × (35-30)
= .33 (.38165) × 5 (take out to five decimal places)
= .12594 × 5 (take out to five decimal places)
= .6297 (take out 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	$105.00	$195.00	$208.00
BAB	Allergy	39.00	73.00	78.00
BAC	Cardiology	81.00	150.00	160.00
BAE	Diabetic	44.00	82.00	87.00
BAF	Endocrinology (Metabolism)	85.00	158.00	168.00
BAG	Gastroenterology	110.00	203.00	216.00
BAH	Hematology	145.00	269.00	287.00
BAI	Hypertension	81.00	149.00	159.00
BAJ	Nephrology	171.00	317.00	338.00
BAK	Neurology	109.00	202.00	215.00
BAL	Outpatient Nutrition	34.00	63.00	67.00
BAM	Oncology	114.00	211.00	225.00
BAN	Pulmonary Disease	141.00	260.00	278.00
BAO	Rheumatology	84.00	156.00	166.00
BAP	Dermatology	63.00	117.00	124.00
BAQ	Infectious Disease	141.00	260.00	278.00
BAR	Physical Medicine	78.00	145.00	155.00
BAS	Radiation Therapy	72.00	132.00	141.00
BAZ	Medical Care Not Elsewhere Classified (NEC)	84.00	156.00	166.00
	B. Surgical Care			
BBA	General Surgery	$119.00	$220.00	$235.00
BBB	Cardiovascular and Thoracic Surgery	110.00	203.00	216.00
BBC	Neurosurgery	137.00	253.00	270.00
BBD	Ophthalmology	84.00	155.00	166.00
BBE	Organ Transplant	191.00	353.00	376.00
BBF	Otolaryngology	88.00	162.00	173.00
BBG	Plastic Surgery	100.00	184.00	196.00
BBH	Proctology	67.00	124.00	132.00
BBI	Urology	101.00	187.00	199.00
BBJ	Pediatric Surgery	89.00	164.00	175.00
BBZ	Surgical Care NEC	65.00	120.00	127.00

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	$45.00	$83.00	$89.00
BCB	Gynecology	74.00	136.00	146.00
BCC	Obstetrics	68.00	126.00	135.00
BCZ	OB-GYN Care NEC	112.00	207.00	221.00
	D. Pediatric Care			
BDA	Pediatric	$54.00	$100.00	$106.00
BDB	Adolescent	55.00	101.00	108.00
BDC	Well Baby	36.00	66.00	70.00
BDZ	Pediatric Care NEC	64.00	119.00	126.00
	E. Orthopaedic Care			
BEA	Orthopaedic	$83.00	$153.00	$164.00
BEB	Cast	45.00	82.00	88.00
BEC	Hand Surgery	38.00	70.00	75.00
BEE	Orthotic Laboratory	59.00	110.00	117.00
BEF	Podiatry	49.00	91.00	97.00
BEZ	Chiropractic	21.00	38.00	40.00
	F. Psychiatric and/or Mental Health Care			
BFA	Psychiatry	$97.00	$179.00	$191.00
BFB	Psychology	71.00	132.00	141.00
BFC	Child Guidance	59.00	109.00	117.00
BFD	Mental Health	80.00	147.00	157.00
BFE	Social Work	80.00	149.00	159.00
BFF	Substance Abuse	62.00	115.00	123.00
	G. Family Practice/Primary Medical Care			
BGA	Family Practice	$67.00	$124.00	$132.00
BHA	Primary Care	64.00	118.00	126.00

MEPRS Code 4/	Clinical Service	International Military Education & Training (IMET)	Interagency & Other Federal Agency Sponsored Patients	Other (Full/ Third Party)
BHB	Medical Examination	$59.00	$109.00	$117.00
BHC	Optometry	42.00	77.00	82.00
BHD	Audiology	30.00	55.00	58.00
BHE	Speech Pathology	81.00	149.00	159.00
BHF	Community Health	41.00	75.00	80.00
BHG	Occupational Health	59.00	108.00	115.00
BHH	TRICARE Outpatient	42.00	78.00	83.00
BHI	Immediate Care	82.00	152.00	162.00
BHZ	Primary Care NEC	43.00	79.00	84.00
	H. Emergency Medical Care			
BIA	Emergency Medical	$107.00	$198.00	$211.00
	I. Flight Medical Care			
BJA	Flight Medicine	$85.00	$157.00	$167.00
	J. Underseas Medical Care			
BKA	Underseas Medicine	$32.00	$58.00	$62.00
	K. Rehabilitative Services			
BLA	Physical Therapy	$29.00	$54.00	$57.00
BLB	Occupational Therapy	53.00	98.00	104.00

III. 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	$10.00	$19.00	$20.00
DGC	B. Hyperbaric Chamber 5/	$180.00	$333.00	$355.00
	C. Ambulatory Procedure Visit (APV) 6/	$376.00	$691.00	$737.00
	D. Family Member Rate (formerly Military Dependents Rate)	$10.20		

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

The FY 1998 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. Final rule of 32 CFR Part 220, estimated to be published October 1, 1997, will eliminate the high cost ancillary services' dollar threshold and the associated term "high cost ancillary service." In anticipation of that change, the phrase "high cost ancillary service" has been replaced with the phrase "ancillary services requested by an outside provider." The list of drug reimbursement rates is too large to include here. These rates are available on request from OASD (Health Affairs) -- see Tab N for the point of contact.

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

Final rule of 32 CFR Part 220, estimated to be published October 1, 1997, will eliminate the high cost ancillary services' dollar threshold and the associated term "high cost ancillary service." In anticipation of that change, the phrase "high cost ancillary service" has been replaced with the phrase "ancillary services requested by an outside provider." The list of FY 1998 rates for ancillary services requested by outside providers and obtained at a Military Treatment Facility is too large to include here. These rates are available on request from OASD(Health Affairs) -- see Tab N for the point of contact.

G. Elective Cosmetic Surgery Procedures and Rates

Cosmetic Surgery Procedure	International Classification Diseases (ICD-9)	Current Procedural Terminology (CPT) 9/	FY 1998 Charge 10/	Amount of Charge
Mammaplasty	85.50 85.32 85.31	19325 19324 19318	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate	a/ b/ c/
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 or applicable Outpatient Clinic Rate	a/ b/ c/
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/

Cosmetic Surgery Procedure	International Classification Diseases (ICD-9)	Current Procedural Terminology (CPT) 9/	FY 1998 Charge 10/	Amount of Charge
Abdominoplasty	86.83	15831	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate	a/ b/ c/
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/
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	21194	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate	a/ b/ c/
Minor Skin Lesions 12/	86.30	1578_	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 1998 Charge 10/	Amount of Charge
Dermabrasion	86.25	15780	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate	a/ b/ c/
Hair Restoration	86.64	15775	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate	a/ b/ c/
Removing Tattoos	86.25	15780	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate	a/ b/ c/
Chemical Peel	86.24	15790	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate	a/ b/ c/
Arm/Thigh Dermolipectomy	86.83	1583_	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate	a/ b/ c/
Brow Lift	86.3	15839	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate	a/ b/ c/

H. Dental Rate 13/

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	$35.00	$101.00	$106.00

I. Ambulance Rate 14/

Per Visit

MEPRS Code 4/	Clinical Service	International Military Education & Training (IMET)	Interagency & Other Federal Agency Sponsored Patients	Other (Full/ Third Party)
FEA	Ambulance	$32.00	$60.00	$64.00

J. Laboratory and Radiology 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-4 Weight Multiplier	$9.00	$13.00	$14.00
	Radiology procedures requested by an outside provider CPT-4 Weight Multiplier	23.00	35.00	37.00

K. AirEvac Rate 15/

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	$113.00	$209.00	$223.00
	AirEvac Services - Litter	323.00	598.00	638.00

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 96 percent hospital and 4 percent professional charges. The outpatient per visit percentages are 88 percent outpatient services and 12 percent professional charges.

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 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 services 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). Care is required in the facility for less than 24 hours. This rate is also used for elective cosmetic surgery performed in an APU.

7/ Prescription services requested by outside providers (e.g., physicians or dentists) 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 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 only come to the MTF for prescription services. The standard cost of medications ordered by an outside provider 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 $5.00 dispensing fee per prescription. The final rule at 32 CFR Part 220, estimated to be published October 1, 1997, will eliminate the dollar threshold for high cost ancillary services (by changing the threshold from $25 to $0) and the associated term "high cost ancillary service." In anticipation of that change, the phrase "high cost ancillary service" has been replaced with the phrase "ancillary services requested by an outside provider." The elimination of the threshold also eliminates the bundling of costs whereby a patient is billed if the total cost of ancillary services in a day (defined as 0001 hours to 2400 hours) exceeded $25.00.

8/ Charges for ancillary services requested by an outside provider (physicians, dentists, etc.) 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 that are prescribed by providers external to the MTF. Laboratory and Radiology procedure costs are calculated using the Physicians' Current Procedural Terminology (CPT)-4 Report weight multiplied 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 services. The final rule at 32 CFR Part 220, estimated to be published October 1, 1997, will eliminate the dollar threshold for high cost ancillary services (by changing the threshold from $25 to $0) and the associated term "high cost ancillary service." In anticipation of that change, the phrase "high cost ancillary service" has been replaced with the phrase "ancillary services requested by an outside provider." The elimination of the threshold also eliminates the bundling of costs whereby a patient is billed if the total cost of ancillary services in a day (defined as 0001 hours to 2400 hours) exceeded $25.00.

9/ The attending physician is to complete the CPT-4 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 1998 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/ These procedures are inclusive in the minor skin lesions. However, CHAMPUS separates them as noted here. All charges shall be for the entire treatment, regardless of the number of visits required.

13/ 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.

14/ 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).

15/ Air in-flight medical care reimbursement charges are determined by the status of the patient (ambulatory or litter) and are per patient. The charges are billed only by the Air Force Global Patient Movement Requirement Center (GPMRC).