OFFICE OF MANAGEMENT AND BUDGET

Cost of Hospital and Medical Care and Treatment Furnished by the United States; Certain Rates Regarding Recovery From Tortiously Liable Third Persons

By virtue of the authority vested in the President by Section 2(a) of P.L. 87–693 (76 Stat. 593; 42 U.S.C. 2652), and delegated to the Director of the Office of Management and Budget by Executive Order No. 11541 of July 1, 1970 (35 Federal Register 10737), the three sets of rates outlined below are hereby established. These rates are for use in connection with the recovery, from tortiously liable third persons, of the cost of hospital and medical care and treatment furnished by the United States (Part 43, Chapter I, Title 28, Code of Federal Regulations) through three separate Federal agencies. The rates have been established in accordance with the requirements of OMB Circular A–25, requiring reimbursement of the full cost of all services provided. The rates are established as follows:

1. *Department of Defense.* The FY 1997 inpatient rates are based on the cost per Diagnostic Related Group (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).

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.

2. *Department of Health and Human Services.* The sum of obligations for each cost center providing medical service is broken down into amounts attributable to inpatient care on the basis of the proportion of staff devoted to each cost center. Total inpatient costs and outpatient costs thus determined are divided by the relevant workload statistic (inpatient day, outpatient visit) to produce the inpatient and outpatient rates. In calculation of the rates, the Department's unfunded retirement liability cost and capital and equipment depreciation cost were incorporated to conform to requirements set forth in OMB Circular A–25. In addition, each cost center's obligations include costs for certain other accounts, such as Medicare and Medicaid collections and Contract Health funds used to support direct program operation. Certain cost centers that primarily support workload outside of the directly operated hospitals or clinics (public health nursing, public health nutrition, health education) were excluded this year as not being a part of the traditional cost of hospital operations and not contributing directly to the inpatient and outpatient visit workload. Overall, these rates reflect a more accurate indication of the cost of care in HHS facilities.

In addition, this year separate rates per inpatient day and outpatient visit were computed for Alaska and the rest of the United States. This gives proper weight to the higher cost of operating medical facilities in Alaska.

3. *Department of Veterans Affairs.* The actual direct and indirect costs are compiled by type of care for the previous year, and facility overhead costs are added. Adjustments are made using the budgeted percentage changes for the current year and the budget year to compute the base rate for the budget year. The budget year base rate is then adjusted by estimated costs for depreciation of buildings and equipment, central office overhead, Government employee retirement benefits, and return on fixed assets (interest on capital for land, buildings, and equipment (net book value)), to compute the budget year tortiously liable reimbursement rates. Also shown for inpatient per diem rates are breakdowns into three cost components: Physician; Ancillary; and Nursing, Room, and Board. As with the total per diem rates, these breakdowns are calculated from actual data by type of care.

These rates represent the reasonable cost of hospital, nursing home, medical, surgical, or dental care and treatment (including prostheses and medical appliances) furnished or to be furnished by the United States in Federal hospitals, nursing homes, and outpatient clinics administered by the Department of Defense, Department of Veterans Affairs, and the Department of Health and Human Services.

For such care and treatment furnished at the expense of the United States in a facility not operated by the United States, the rates shall be the amounts expended for such care and treatment.

1. Department of Defense

For the Department of Defense (DoD), effective October 1, 1996 and thereafter:

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 OASD (Health Affairs). 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 and 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 non-teaching 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. Relative Weighted Product (RWP) for an inlier case is the CHAMPUS weight of 2.9769. (DRG statistics shown are from FY96.)

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 non-teaching 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 No.	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
Non-Teaching Hospital	Large Urban	1.0	1.0	$4.392	$4,392

Patient	Length of stay	Days above threshold	Relative weighted product			TPC amount [3]
			Inlier [1]	Outlier [2]	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

[1] DRG Weight.
[2] Outlier calculation=44% 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)×(35–30).
=.44(.38165)×5 (take out to 5 decimal places).
=.16793×5 (take out to 5 decimal places).
=.8397 (take out to 4 decimal places).
[3] Applied ASA x Total RWP.

II. Outpatient Rates [1 2]

MEPRS code [4]	Per visit clinical services	International military education and training (IMET)	Interagency and other federal agency-sponsored patients	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

MEPRS code [4]	Per visit clinical services	International military education and training (IMET)	Interagency and other federal agency-sponsored patients	Other
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
	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
	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

MEPRS code [4]	Per visit clinical services	International military education and training (IMET)	Interagency and other federal agency-sponsored patients	Other
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 and 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).			
	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).			

Cosmetic surgery procedure	International classification diseases (ICD–9)	Current procedural terminology (CPT) [8]	FY 97 charge 9	Amount of charge
	F. Elective Cosmetic Surgery Procedures and Rates			
Mammaplasty	85.50	19325	Surgical Care Services or	([a])
	85.32	19324	Ambulatory Procedure Visit	([b])
	85.31	19318		
Mastopexy	85.60	19316	Surgical Care Services or	([a])
			Ambulatory Procedure Visit	([b])
Facial Rhytidectomy	86.82	15824	Surgical Care Services or	([a])
	86.22		Ambulatory Procedure Visit	([b])
Blepharoplasty	08.70	15820	Surgical Care Services or	([a])
	08.44	15821	Ambulatory Procedure Visit	([b])
		15822		
		15823		
Mentoplasty (Augmentation Reduction)	76.68	21208	Surgical Care Services or	([a])
	76.67	21209	Ambulatory Procedure Visit	([b])

Cosmetic surgery procedure	International classification diseases (ICD–9)	Current procedural terminology (CPT) [8]	FY 97 charge 9	Amount of charge
Abdominoplasty	86.83	15831	Surgical Care Services or	([a])
			Ambulatory Procedure Visit	([b])
Lipectomy, suction per region [10]	86.83	15876	Surgical Care Services or	([a])
		15877	Ambulatory Procedure Visit	([b])
		15878		
		15879		
Rhinoplasty	21.87	30400	Surgical Care Services or	([a])
	21.86	30410	Ambulatory Procedure Visit	([b])
Scar revisions beyond CHAMPUS	86.84	1578__	Surgical Care Services or	([a])
			Ambulatory Procedure Visit	([b])
Mandibular or Maxillary Repositioning	76.41	21194	Surgical Care Services or	([a])
			Ambulatory Procedure Visit	([b])
Minor Skin Lesions [11]	86.30	1578__	Surgical Care Services or	([a])
			Ambulatory Procedure Visit	([b])
Dermabrasion	86.25	15780	Surgical Care Services or	([a])
			Ambulatory Procedure Visit	([b])
Hair Restoration	86.64	15775	Surgical Care Services or	([a])
			Ambulatory Procedure Visit	([b])
Removing Tattoos	86.25	15780	Surgical Care Services or	([a])
			Ambulatory Procedure Visit	([b])
Chemical Peel	86.24	15790	Surgical Care Services or	([a])
			Ambulatory Procedure Visit	([b])
Arm/Thigh Dermolipectomy	86.83	1583__	Surgical Care Services or	([a])
			Ambulatory Procedure Visit	([b])
Brow Lift	86.3	15839	Surgical Care Services or	([a])
			Ambulatory Procedure Visit	([b])

MEPRS code [4]	Per visit clinical service [12]	International military education and training (IMET)	Interagency and other federal agency sponsored patients	Other
	G. Dental Rate			
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]			
FEA	Ambulance Service	57.00	103.00	110.00
	I. High Cost Laboratory and Radiology Services [7]			
	High Cost Laboratory	6.00	10.00	11.00
CPT–4 Multiplier	High Cost Radiology	20.00	36.00	38.00
CPT–4 Multiplier				
	J. AirEvac Rate [14]			
	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 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. An example of this hierarchical arrangement is as follows:

OUTPATIENT CARE (FUNCTIONAL CATEGORY)

Code	MEPRS
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 a Military Medical Treatment Facility (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 Food and 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.

2. Department of Health and Human Services

For the Department of Health and Human Services, Indian Health Service, effective October 1, 1996 and thereafter:

		HHS
Hospital Care Inpatient Day:		
General Medical Care	Alaska	$1,696
	Rest of the United States	1,037
Outpatient Medical Treatment:		
Outpatient Visit	Alaska	339
	Rest of the United States	207

3. Department of Veterans Affairs

Actual direct and indirect costs are compiled by type of care for the previous year, and facility overhead costs are added. Adjustments are made using the budgeted percentage changes for the current year and the budget year to compute the base rate for the budget year. The budget year base rate is then adjusted by estimated costs for the depreciation of buildings and equipment, central office overhead, Government employee retirement benefits, and return on fixed assets (interest on capital for land, buildings, and equipment (net book value)), to compute the budget year tortiously liable reimbursement rates. Also shown for inpatient per diem rates are breakdowns into three cost components: Physician; Ancillary; and Nursing, Room, and Board. As with the total per diem rates, these breakdowns are calculated from actual data by type of care.

Effective October 1, 1996, and thereafter:

HOSPITAL CARE, RATES PER INPATIENT DAY	
General Medicine	$1046
Physician	125
Ancillary	273
Nursing, Room, and Board	648
Neurology	1014
Physician	148
Ancillary	268
Nursing, Room, and Board	598
Rehabilitation Medicine	822
Physician	93
Ancillary	251
Nursing, Room, and Board	478
Blind Rehabilitation	973
Physician	78
Ancillary	483
Nursing, Room, and Board	412
Spinal Cord Injury	977
Physician	121
Ancillary	246
Nursing, Room, and Board	610
Surgery	1923
Physician	212
Ancillary	583
Nursing, Room, and Board	1128
General Psychiatry	501
Physician	47
Ancillary	79
Nursing, Room, and Board	375
Substance Abuse (Alcohol and Drug Treatment)	330
Physician	31
Ancillary	76
Nursing, Room, and Board	223
Intermediate Medicine	428
Physician	21
Ancillary	63
Nursing, Room, and Board	344
NURSING HOME CARE, RATES PER DAY	
Nursing Home Care	288
Physician	9
Ancillary	39
Nursing, Room, and Board	240
OUTPATIENT MEDICAL AND DENTAL TREATMENT	
Outpatient Visit	194
Emergency Dental Outpatient Visit	121
Prescription Filled	20

For the period beginning October 1, 1996, the rates prescribed herein superseded those established by the Director of the Office of Management and Budget November 29, 1995 (60 FR 61450).

Franklin D. Raines,

Director, Office of Management and Budget.

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