THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MEMORANDUM FOR UNDER SECRETARY OF DEFENSE (COMPTROLLER)

SUBJECT: Calendar Year 2025 Outpatient Medical, Dental, and Elective Cosmetic Procedure Reimbursement Rates and Guidance

The attached document contains the Department of War's (DoW) Calendar Year (CY) 2025 Uniform Business Office (UBO) Outpatient Medical, Dental, and Elective Cosmetic Procedure Reimbursement Rates and Guidance. The rates are to be used by military medical treatment facilities, effective October 1, 2025, and supersede all previous rates. We request this package be posted on the DoW Reimbursement Rates website (https://comptroller.defense.gov/Financial-Management/Reports/rates2025/), under the Financial Management Reports section labeled "Medical and Dental Services."

My point of contact for this action is Ms. DeLisa Prater, UBO Program Manager, (703) 275-6380, or e-mail: delisa.e.prater.civ@health.mil.

Stephen L. Ferrara, M.D.
Acting

Attachment:
As stated

Department of War
Calendar Year 2025 Outpatient Medical, Dental, and Elective Cosmetic Procedure Reimbursement Rates and Guidance

1. Introduction

The Defense Health Agency (DHA) Uniform Business Office (UBO) developed the Calendar Year (CY) 2025 Outpatient Medical, Dental and Elective Cosmetic Procedure Reimbursement Rates in accordance with Title 10, United States Code, Section 1095. These rates are the charges for professional and institutional healthcare services provided in military medical treatment facilities (MTFs) funded by the Defense Health Program appropriation. These rates are used to submit claims for reimbursement of the costs of healthcare services provided by MTFs in accordance with the various MTF Cost Recovery Programs: Medical Services Account (MSA), Third Party Collections and Medical Affirmative Claims.

The enclosed rates are effective for healthcare services provided on or after October 1, 2025, and will remain in effect until superseded.

Healthcare service procedure codes or rates released after approval, on a quarterly basis as part of the Healthcare Common Procedure Coding System (HCPCS) code set updates or as ad hoc Current Procedural Terminology (CPT®)/HCPCS additions and deletions, follow the same current/approved methodology described herein and are effective on the date set by the UBO Program Office.

1.1 Military Health System (MHS) Charge Description Master (CDM).

MTFs utilize the charging and billing methodology aligned with the modernized electronic health record and billing system. Healthcare service procedure codes outlined in this guidance are housed in the MHS CDM for itemized billing of patient care provided in MTFs.

For CY 2025, healthcare services traditionally updated using Medical Expense and Performance Reporting System (MEPRS) data were updated by applying the Fiscal Year (FY) 2024 to FY 2025 inflation factor (3.38%) for Operations and Maintenance (O&M) developed using an alternative methodology, adjusting the CY 2024 rate by the Operation and Maintenance (O&M) inflation factor from FY 2024 to FY 2025 (3.38%). This applies to Ambulance Services, Dental Services, certain Immunizations, and Ambulatory Procedure Visits.

The O&M inflation factor used in the CY 2024 rate development cycle (FY 2023 – FY 2024) was 3.17%.

1.2 Rates Addressed in this Guidance.

- Civilian Health and Medical Program of the Uniformed Services Maximum Allowable Charge Rate Tables (modified for UBO use)
- Dental Rates
- Immunization/Injectables Rates

- Anesthesia Rates
- Durable Medical Equipment/Durable Medical Supplies Rates
- Transportation Rates
- Food Service Charges at Appropriated Fund Dining Facilities (Subsistence Rate)
- Elective Cosmetic Procedure Rates

2. Terminology.

2.1 Ambulatory Payment Classification (APC) Rate System - Provides a set of prospectively determined charges applicable to outpatient services provided in hospitals. It is used to group institutional services that are clinically comparable, including the use of resources. CPT®/HCPCS codes and descriptors are used to identify and group the services into appropriate APCs. The Emergency Department institutional billing rates established under this system in Section 3.2 include the institutional costs associated with items or services that are directly related to performing a procedure and are, in most cases, packaged within the APC group.

2.2 Ambulatory Procedure Visit (APV) - A procedure or surgical intervention that requires pre-procedure care, an actual procedure to be performed, and immediate post-procedure care as directed by a qualified health care provider. Minor procedures that are performed in an outpatient clinic setting that does not require post-procedure care by a medical professional are not considered APVs. The nature of the procedure and the medical status of the patient combine as a short-term care requirement, but not for inpatient care. These procedures are appropriate for all types of patients (e.g., obstetrical, surgical and non-surgical including cosmetic) who by virtue of the procedure or anesthesia require post-procedure care and/or monitoring by medical personnel.

2.3 Ambulatory Procedure Unit (APU) - 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.

2.4 Ambulatory Surgery Center (ASC) Rate System - Provides prospectively determined charges applicable to ambulatory surgery services provided in MTFs that are not hospitals (i.e., they do not provide inpatient services). It is used to group surgical procedures based on ranges of cost.

2.5 Emergency Department (ED) - A location or organization within an MTF that provides emergency care, diagnostic services, treatment, surgical procedures, and proper medical disposition of an emergency nature to patients who present themselves to the service. It refers patients to specialty clinics and admits patients to the hospital, as needed.

2.6 Evaluation & Management (E&M) - Services that involve the evaluation and management of a patient's health, provided by physicians or other qualified healthcare professionals.

2.7 Hospital - An MTF that provides inpatient services.

2.8 Observation (OBS) - Ambulatory services furnished within the hospital's ED or in a nursing unit, including the use of a bed and periodic monitoring by the hospital's nursing or other staff that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission as an inpatient. Both professional and institutional services are billed.

3. Outpatient Medical and Dental Services Rates. Due to size, the sections containing the actual rate tables are not included in this document. These rates are available from the DHA UBO web site at https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Uniform-Business-Office/UBO-Rates-Overview/MHS-UBO-Rates.

3.1 Government Billing Calculation Factors

3.1.1 The terms Full Outpatient Rate (FOR) or Full Inpatient Reimbursement Rate (FRR), when appropriate, are used for claims submission to third-party payers and to all other applicable payers not included within International Military Education and Training (IMET) and Interagency/Other Federal Agency Sponsored Rate (IOR) billing guidance.

3.1.2 FORs are, in most cases, determined by the amount TRICARE will allow for a given service. When this cannot be determined, the Centers for Medicare and Medicaid Services (CMS) reimbursement rates are used. When both TRICARE allowable charges and CMS reimbursement rates cannot be determined, actual military expense and workload data are used to determine FORs. This process identifies and eliminates poor quality data and includes adjustments to account for the current military and civilian pay raises, asset use charges, distribution of expenses between payroll and non-payroll expense categories, and a DoD inflation adjustment to account for cost increases from the data collection period.

3.1.3 Discounts for IMET and IOR are calculated based on FY expense and workload data from all DoW MTFs that offer outpatient and inpatient services. IMET and IOR adjustments are calculated by removing those expenses which are excluded from consideration in IMET and interagency billing from the FOR or FRR. The rates included represent the FOR (unless otherwise specified). IORs exclude the "Miscellaneous Receipts" (e.g., asset use charge, percentage for military pay, civilian pay and other) portion of the FOR/FRR price calculation. IMET rates exclude both the "Miscellaneous Receipts" portion and the "Military Personnel" portion of the FOR/FRR price calculation. A government discount or billing calculation factor (percentage discount) is applied to the FOR when billing for IMET and IOR services.

3.1.4 The IMET Program is a key funding component of U.S. security assistance that provides training on a grant basis to students from allied and friendly nations. Authority for the IMET program is found in Chapter 5, part II, Foreign Assistance Act of 1961. Funding is appropriated from the International Affairs budget of the

Department of State. Not all foreign national patients participate in the IMET program.

3.1.5 The IMET rates applied to healthcare services are listed below:

All Services (Except Ambulance and Dental):	60.89 Percent (%) of the FOR.
Ambulance:	60.89 Percent (%) of the FOR
Dental:	43.86 Percent (%) of the FOR

The IORs applied to health care services are listed below:

All Services (Except Ambulance and Dental):	91.58 Percent (%) of the FOR.
Ambulance:	91.58 Percent (%) of the FOR
Dental:	92.89 Percent (%) of the FOR

3.2 Civilian Health and Medical Program of the Uniformed Services Maximum Allowable Charge (CMAC) Rates

3.2.1 Professional Components:

3.2.1.1 TRICARE CMAC reimbursement rates, established under Title 32, Sec. 199.14(j) of the Code of Federal Regulations, are used to determine the appropriate charge for the professional and technical components of services based on the HCPCS methodology, which includes the CPT® codes.

3.2.1.2 DHA UBO CMAC rates differ from standard TRICARE CMAC rates in that DHA UBO CMAC rates are formatted for MHS military billing systems and include charges for additional services not reimbursed by TRICARE. DHA UBO CMAC rates pertain to professional services (e.g., office and clinic visits), ancillary services (e.g., laboratory and radiology) and OBS professional services.

3.2.1.3 DHA UBO CMAC rates are calculated for distinct "localities." These localities recognize differences in local costs to provide healthcare services in the different geographical regions in which MTFs are located. Each MTF Defense Military Information System Identification (DMIS ID) is mapped to its corresponding CMAC locality code to obtain the correct rates.

3.2.1.4 For all MTFs located outside the continental United States, Alaska, and Hawaii, the national average CMAC locality file (300) is used except for Guam and Puerto Rico which have their own CMAC localities.

3.2.1.5 The complete DMIS ID-to-CMAC Locality table is available on the DHA UBO Website at https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/TRICARE-Health-Plan/Rates-and-Reimbursement/CMAC-Rates/Locality-To-ZIP.

3.2.1.6 For each CMAC locality, the DHA UBO creates two sub-tables of rates: (1) CMAC, and (2) Component.

(1) The Component rate table specifies which rates to use for CPT® codes which can be provided as distinct professional and technical components, or as a combined professional and technical service. A separate rate is provided for each component.

(2) UBO CMAC rates for billing of professional services are available on the DHA UBO web site at: https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Uniform-Business-Office/UBO-Rates-Overview/MHS-UBO-Rates.

3.2.1.7 To consolidate into fewer regional price fee schedules and for use in the MHS CDM, CMAC localities are further mapped to DHA Markets.

3.2.1.8 The MHS approved a Parent-Child DMIS ID Market Mapping methodology to serve as a new MTF Regional Grouping Transition Plan. This methodology is known as the Regional Charge Table approach. At a high level, the Market Mapping Assignment will decrease the number of locality charge tables from the 100+ CMAC Charge Tables to 15 Regional Charge Tables for use within the MHS CDM.

3.2.2 INSTITUTIONAL COMPONENTS:

3.2.2.1 ED - TRICARE Ambulatory Payment Classification (APC) rates for ED Evaluation & Management services, CPT® codes 99281-99285, are used to determine the DoW ED institutional charges. Ambulance transport to the ED and from the ED to another location is not part of the ED institutional rate and is billed separately.

3.2.2.2 E&M - CPT® codes 99202-99215 pricing has been updated from utilizing the Non-Facility rate to the CMAC Facility Physician rate. These codes can be billed in combination with HCPCS G0463, which is based on TRICARE Outpatient Prospective Payment System reimbursement methodology, to account for facility fees.

3.2.2.3 OBS - The HCPCS codes used for OBS institutional services are G0378 and G0379. The rate for G0378 is an hourly rate, derived by dividing the APC payment rate by the average number of hours a patient was in observation status. There is no charge for G0379, a direct admission inpatient service.

3.2.2.4 APV Rate – The APV rate is an institutional flat rate for all APV procedures/services. This rate is based on the institutional cost of all MTF APVs divided by the total number of APVs and is associated with the 99199

procedure code. The CY2025 APV flat rate is $3,472.73 and was adjusted by the O&M Inflation Factor for the CY2025 development cycle.

3.2.2.5 Operating Room (OR) and Post-Anesthesia Case Unit (PACU) Rates – OR levels (1-5) and PACU levels (1-2) are determined by complexity of service and replace the use of the APV Rate referenced above for institutional costs associated with inpatient and outpatient surgery in MTFs. The price is determined by level (1-5), and calculated by the following logic:

- All surgical CPT® codes within each OR Level (1-5) with an approved CMAC rate are averaged to determine the price for each OR Level (initial 60 minutes).

- OR Level 1 (initial 60 min) rate = average of approved rates for all active surgical CPT® codes with a time-based charge level of 1. The same logic applies for OR Levels 2-5.

- All surgical CPT® codes within each OR Level (1-5) with an approved CMAC rate are averaged and divided by 4 to determine the price for each OR Level (each additional 15 minutes).

    - OR Level 1 (each additional 15 min) rate = (average of approved rates for all active surgical CPT® codes with a time-based charge level of 1) divided by 4. The same logic applies for OR Levels 2-5.

- PACU Acuity Levels are reflective of the CMAC rate for G0378, hospital observation (60 min).

    - PACU Acuity Level 1 (0-60 min) - CMAC rate for G0378 (hourly observation)
    - PACU Acuity Level 1 (15 min) - CMAC rate for G0378 (hourly observation) divided by 4
    - PACU Acuity Level 2 (0-60 min) - CMAC rate for G0378 (hourly observation) multiplied by 1.5
    - PACU Acuity Level 2 (15 min) - CMAC rate for G0378 (hourly observation) multiplied by 1.5 divided by 4

3.2.2.6 Dialysis – CPT® code 90999 pricing is produced at a regional level for each regional charge table. This rate is produced by applying the CY2025 TRICARE Wage Index for the respective region, to the national TRICARE End Stage Renal Disease (ESRD) facility reimbursement rate plus the national non-labor share rate. The CMS Labor Share value is 55.2% and the Non Labor Share value is 44.8%. Per CMS guidelines, only the labor-related share has the TRICARE Wage Index applied.

- The following example demonstrates the calculation for a wage-adjusted per-session rate for the non-US region with an assigned wage index of 1:

    - Per session rate: $388.79
    - Labor share of per-session rate: $388.79 multiplied by 55.2% (CMS Labor Share value (or 0.552) = $214.61
    - Wage index adjusted labor share: $214.61 multiplied by 1 = $214.61
    - Non-labor share of per-session rate: $388.79 multiplied by 44.8% (CMS Non-Labor Share value) (or 0.448) = $174.17
    - Final waged adjusted per-session rate: $214.61 + $174.17 = $388.78

3.3 Dental Rates

MTF dental charges are based on a flat rate multiplied by the DoW established dental weighted value (DWV) for each American Dental Association (ADA) Current Dental Terminology (CDT) procedure code. The dental flat rate represents the average DoW cost of dental services at all dental treatment facilities. Table 1 illustrates the FOR dental charge for ADA CDT code D0270.

Table 1: CY2025 Dental Rates

CDT Code	Clinical Service	DoD DWV	FOR	Rate
D0270	Bitewing – Single radiographic image	0.37	$119.62	$44.26

Example: For ADA CDT code D0270, bitewing single radiographic image film, the DoW DWV is 0.37, which is multiplied by the appropriate FOR rate to obtain the charge. In this example, the FOR rate is used for D0270, the charge for this ADA CDT code will be $44.26. To determine the IOR or the IMET charges per dental code, multiply the clinical service FOR by the dental IMET/IOR percentages.

The list of CY 2025 ADA CDT codes and DWVs are too large to include in this document. This table may be found on DHA UBO's web site at https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Uniform-Business-Office/UBO-Rates-Overview/MHS-UBO-Rates.

3.4 Immunization/Injectables Rates

3.4.1 A separate charge is made for each immunization, injection or medication that is administered.

3.4.2 Immunization rates are based on DHA TRICARE injectable rates whenever TRICARE rates are available.

3.4.3 If there is no TRICARE rate available, Purchased Care Data is used to derive rates. Rates are derived from Purchased Care Data by using the Military Health System Management Analysis and Reporting Tool or M2 system. This reporting tool allows for querying and detailed trend analysis including summaries and detailed views of population, clinical, and financial data from all MHS regions worldwide. Data pulled from previous and current FY (to date) allows calculation of average amount allowed for rate use. Outlier rates are adjusted using historical Purchased Care Data of up to five (5) years.

3.4.4 If there is no TRICARE rate, or Purchased Care Data derived rate available, then a flat rate of $79.06**,** calculated using the FY 2024 to FY 2025 O&M inflation factor, is billed. Traditionally, the flat rate is calculated using MEPRS data and is based on the average full cost of these services.

3.4.5 The Immunization/Injectable rate table may be found on the DHA UBO Website at https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Uniform-Business-Office/UBO-Rates-Overview/MHS-UBO-Rates.

3.5 Anesthesia Rates

3.5.1 Anesthesia charges are split into base rates and interval rates.

3.5.1.1 The anesthesia base rates are determined by multiplying the anesthesia relative value unit (RVU) base unit by the locality-specific TRICARE anesthesia conversion factor (RVU base unit multiplied by locality-specific TRICARE anesthesia conversion factor).

3.5.1.2 The anesthesia interval rates are determined per interval of time; the rate calculation for one anesthesia time-based interval is the RVU interval unit of 1 multiplied by the locality-specific TRICARE anesthesia conversion factor (Interval of 1 multiplied by locality-specific TRICARE anesthesia conversion factor).

3.5.2 An RVU interval unit of 1 is equal to 15 minutes.

3.5.3 The total charge for professional anesthesia-based rates is calculated by adding the base rate to the interval rate multiplied by the number of time units in 15-minute intervals.

Total professional anesthesia-based rate = [(base rate) + (interval rate x number of 15-minute time intervals)]

3.5.4 TRICARE provides the anesthesia RVU base units for each anesthesia procedure. The locality-specific TRICARE anesthesia conversion factors are mapped based on TRICARE locality.

3.5.5 The calculated anesthesia rates are for professional anesthesia-based services performed within the MTFs.

3.5.6 Refer to section 4.2 for anesthesia charges related to elective cosmetic procedures.

Table 2: CY 2025 TRICARE Anesthesia Rate
(Base Rate, Interval Rate, and Professional Anesthesia Rate Pricing Example)

					390 Alaska	**314 Colorado**
				Locality CF →	$27.86	$20.39
CDM Description	**CPT® Code**	**Type of Pricing**	**# of 15-minute intervals**	**TRICARE Base Unit**	**Rate** (Alaska)	**Rate** (Colorado)
Anes Salivary Gland w Biopsy	00100	Base	N/A	5.0	$139.30	$101.95
		Interval	1	N/A	$27.86	$20.39
		Base + Interval	4	5.0	$250.74	$183.51

Table 3 illustrates the calculation of the TRICARE Anesthesia Base Rate, Interval Rate, and one hour procedure total rate calculation for CPT® Code 00100 for the regional localities of Alaska and Colorado. For the Alaska locality, the total professional charge for an hour of service (Base rate + Interval rate) is calculated by adding the base rate of $139.30 for CPT® code 00100 to the interval rate of $27.86 multiplied by 4-time interval units (4 units of 15-minute intervals to equal 1 hour), so $139.30 + $111.44 = $250.74

3.6 Durable Medical Equipment/Durable Medical Supplies (DME/DMS) Rates

3.6.1 DME/DMS rates are based on the Medicare Fee Schedule floor rate. When there is no Medicare Fee Schedule floor rate for a given item, Purchased Care data from the M2 system is used to establish a rate based on the average amount allowed. The DME/DMS rate table may be found on the DHA UBO Website at https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Uniform-Business-Office/UBO-Rates-Overview/MHS-UBO-Rates.

3.6.2 Additionally, the Defense Medical Logistics Standard Support (DMLSS) Master Catalog captures the average price paid for over 100,000 medical supplies commonly used by MTFs. Only DMLSS line items with an associated HCPCS code listed in the DMLSS Master Catalog will be utilized. All weighted average unit cost prices utilize the following equation:

$$\frac{\text{Sum of Total Current Unit of Purchase Price Amount}}{\text{Sum of Total Unit of Purchase Quantity}} = \text{Weighted Average Unit Cost Per Item}$$

C1752: Catheter, hemodialysis/peritoneal, short-term:

$$\frac{\$26{,}086.52}{145} = \$179.91$$

3.7 Transportation Rates

3.7.1 Ground Ambulance Rate: Ground ambulance transportation charges are calculated using a mileage rate plus a base rate in alignment with TRICARE reimbursement based off the CMS Ambulance Fee Schedule methodology. This approach ensures reimbursement reflects the level of service provided and accounts for geographic cost variations across regional CDM Localities.

3.7.1.1 Mileage Rate: A per-mile charge applies for each loaded patient mile (the distance traveled with a patient onboard).

- Mileage Base Rate (A0425)

3.7.1.2 Base Rate: In addition to the mileage rate, a flat fee applies per patient transport based on the level of service and whether the transport was emergency or non-emergency:

- Basic Life Support (BLS), Non-Emergency (A0428)
- Basic Life Support (BLS), Emergency (A0429)
- Advanced Life Support, Level 1, Non-Emergency (A0426)
- Advanced Life Support, Level 2, Emergency (A0427)

3.7.1.3 To account for regional cost differences, DHA applies a geographic practice cost index aligned to regional CDM Localities. Mileage and base rates are derived from CMS Ambulance Fee Schedules Public Use Files within the current year.

Table 3: CY 2025 Ground Ambulance Rates

Service	HCPCS Code	Urban Rate	Units	Total
Base Rate (BLS, Non-Emergency)	A0428	$273.60	1	$273.60
Mileage (per loaded patient mile)	A0425	$9.15/mile	10 miles	$91.50
Total Charge				$365.10

3.7.1.4 When determining IOR or IMET charges, the applicable discount percentages are applied to the combined mileage and base charges.

3.7.1.5 UBO Ambulance rates for billing of ambulance services are available on the DHA UBO Website at https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Uniform-Business-Office/UBO-Rates-Overview/MHS-UBO-Rates.

3.7.2 Aeromedical Evacuation Rate:

3.7.2.1 The aeromedical evacuation rate reflects transportation charges of a patient per trip via air in-flight or ambulatory medical care. Air in-flight medical care reimbursement charges are determined by the status of the patient (ambulatory or litter) and are per patient per trip during a 24-hour period. A trip encompasses the time from patient pickup to drop off at the appropriate facility.

EXAMPLE: Transportation from Base A to Base C (with a stop at Base B), consists of three legs, and is charged as a single trip within a 24-hour period. The appropriate charges are billed by U.S. Transportation Command's Global Patient Movement Requirements Center (GPMRC). These charges are only for the cost of providing medical care; a separate charge for the air transport (pilots, fuel, use of aircraft) is generated by GPMRC.

3.7.2.2 The in-flight medical care reimbursement rates are calculated based on the FOR (ambulatory patients) and FRR (litter patients). The ambulatory and litter rates are adjusted to compensate for inflation. The increase from CY 2024 to CY 2025 is 3.38% percent, in line with the direct care FY 2024-FY 2025 O&M inflation rate.

3.7.2.3 Table 4 shows the CY 2025 in-flight rates for FOR/FRR.

3.7.2.4 To determine the IOR or the IMET charges for aeromedical evacuation services, multiply the FOR/FRR for the clinical service by the IMET/IOR percentages.

Table 4 Aeromedical Evacuation Services

Clinical Service	FOR
Aeromedical Evac Services – Ambulatory	$1,034.35
Aeromedical Evac Services – Litter	$3,095.55

3.8 Food Service Charges at Appropriated Fund Dining Facilities (Subsistence Rate)

3.8.1 The food service charge at appropriated fund dining facilities, formerly the subsistence rate, is a standard rate that is established by the Office of the Under Secretary of Defense (Comptroller).

3.8.2 The Standard Rate for is available from the DoD Comptroller's Website at: https://comptroller.defense.gov/Financial-Management/Reports/rates2025/ (Tab G, "Food Service Charges at Appropriated Fund Dining Facilities"). The effective date for this rate is prescribed by the Comptroller.

3.8.3 The food service charge is different from the Family Member Rate, which is addressed in each FY Room and Board Inpatient policy letter.

NOTE: Food service charges are billed under the MSA Program only. Please refer to DHA-PM 6015.01: MTF UBO Operations Procedure Manual, October 2017, as amended, and the DoD 7000.14-R, "Department of Defense Financial Management Regulation," Volume 12, Chapter 19, for guidance on the use of this rate.

4. Elective Cosmetic Procedures

4.1 Patient Charge Structure

Elective cosmetic procedures *are not* TRICARE covered benefits. Elective cosmetic procedures provided in MTFs are restricted to TRICARE-eligible beneficiaries, including TRICARE for Life, on a "space-available" basis. Patients receiving elective cosmetic procedures (e.g., Active Duty personnel, retirees, family members, and survivors) are responsible for charges for all services (including implants, injectables, anesthesia, and other separately billable items) associated with elective cosmetic procedures. A list of elective cosmetic procedures and their associated rates can be found on the DHA UBO Website at https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Uniform-Business-Office/UBO-Rates-Overview/MHS-UBO-Rates.

4.2 Elective Cosmetic Procedure Rates

4.2.1 Professional Charges for Elective Cosmetic Procedures:

4.2.1.1 Professional charges for elective cosmetic procedures are based on the CY 2025 CMAC national average when available. When CMAC allowable charges are not available, charges are determined based on estimates of the medical resources required relative to procedures that have CMAC pricing. Professional charges for elective cosmetic procedures are applied in both inpatient and ambulatory settings. Elective cosmetic charges are not adjusted for the treating MTF's geographical location.

4.2.1.2 CMAC CY 2025 "facility physician" allowable charges are used for the professional component for services furnished by a provider in a hospital operating room (OR) or designated Ambulatory Procedure Unit (APU).

4.2.1.3 CMAC CY25 "non-facility physician" allowable charges are used for the professional component for services furnished in a provider's office.

4.2.2 Institutional Charges for Elective Cosmetic Procedures:

4.2.2.1 Institutional charges for elective cosmetic procedures are based on the procedure performed and the location of the service provided (i.e., provider's

office/minor surgery room, hospital OR (either on an outpatient or inpatient basis), OR of an MTF that is not a hospital (i.e., does not provide inpatient services).

4.2.2.2 For elective cosmetic procedures conducted in a provider's office/minor surgery room, the institutional fee is included in the "non-facility physician" professional charge.

- The institutional charge for elective cosmetic procedures performed in a *hospital OR* on an outpatient basis is based on the APV flat rate for the primary procedure with no additional institutional charge for bilateral or additional procedures.
- The institutional charge for elective cosmetic procedures performed in *an OR of a facility that is not a hospital* is also based on the APV flat rate for the primary procedure with no additional institutional charge for bilateral or additional procedures.
- The institutional charge for an elective cosmetic procedure performed in a hospital on an inpatient basis is calculated by multiplying the CY 2025 TRICARE Adjusted Standardized Amount, $9,142.76, by the relative weighted product associated with the Diagnostic Related Group (DRG)

4.2.2.3 If an elective cosmetic procedure is combined with a medically necessary procedure during the same surgical visit, the elective cosmetic procedure charge is adjusted to avoid duplicate institutional charges. The institutional charge, for an elective cosmetic procedure, when combined with a medically necessary procedure is reduced by 50 percent (%) from the initial charge.

4.2.2.4 Most ancillary services (e.g., laboratory, radiology, and routine pre-operative testing) are included in the institutional pricing methodology described above. Ancillary services and supplies not included are billed at the FOR.

4.2.3 Anesthesia Charges for Elective Cosmetic Procedures

Anesthesia rates associated with elective cosmetic procedures include professional anesthesia services. Anesthesia charges are calculated using the CY 2025 national anesthesia conversion factor, multiplied by the sum of base units and national average time units (measured in 15-minute increments) of the primary procedure. An additional anesthesia charge, based on additional minutes of service, is added for secondary procedures performed during the same surgical encounter. Anesthesia charges are applied in both inpatient and ambulatory settings.