THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

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DCFO ~~FAA~~
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MAY 30 2008

MEMORANDUM FOR UNDER SECRETARY OF DEFENSE (COMPTROLLER)

SUBJECT: Medical and Dental Reimbursement Rates and Cosmetic Surgery Rates

The attached document contains the updated Calendar Year (CY) 2008 Department of Defense (DoD) Medical and Dental reimbursement rates and Cosmetic Surgery rates. The rates are to be used by military treatment facilities, effective July 7, 2008, until superseded. The CY 2007 rates will be superseded by these CY 2008 rates.

The TRICARE Management Activity (TMA) requests this package be posted to DoD Comptroller's Web site: http://www.defenselink.mil/comptroller/rates/fy2008.html.

My point of contact for this action is Lt Col Jeanne Yoder, TMA Uniform Business Office, who may be reached at 703-681-6757, or email: Jeanne.Yoder@tma.osd.mil.

S. Ward Casscells, MD

Attachment:
As stated

DEPARTMENT OF DEFENSE UNIFORM BUSINESS OFFICE MEDICAL AND DENTAL REIMBURSEMENT RATES AND COSMETIC SURGERY RATES

1. Introduction:

1.1. In accordance with Title 10, United States Code, section 1095, the Department of Defense (DoD) Uniform Business Office (UBO) developed the Calendar Year (CY) 2008 Medical and Dental Reimbursement Rates and Cosmetic Surgery Rates. These are charges for professional and institutional healthcare services provided in military treatment facilities (MTFs) operated as part of the Defense Health Program (DHP). These medical and dental rates shall be used to submit claims for reimbursement of the costs of the healthcare services provided by MTFs in accordance with the various MTF Cost Recovery Programs: Medical Services Accounts (MSA), Third Party Collections Program (TPCP), and Medical Affirmative Claims (MAC). The Cosmetic Surgery Rates shall be used to recover the estimated full payment before cosmetic surgery procedures are scheduled and performed. The CY 2007 rates will be superseded by these CY 2008 rates.

1.1.1. The Fiscal Year (FY) 2008 inpatient rates released October 1, 2007, remain in effect until further notice.

1.2. The CY 2008 outpatient medical and dental rates and CY 2008 Cosmetic Surgery Rates are effective for healthcare services provided on or after July 7, 2008.

1.3. This CY 2008 Outpatient Medical and Dental Services Reimbursement Rate Package contains the following rates:

Section 3.2.1: Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (CMAC) Rate Tables (modified for UBO use)
Section 3.3: Dental Rates
Section 3.4: Immunization/Injectables Rates
Section 3.5: Anesthesia Rate
Section 3.6: Durable Medical Equipment/Durable Medical Supplies (DME/DMS) Rates
Section 3.7: Transportation Rates
Section 3.8: Other Rates
Appendix A: Elective Cosmetic Surgery Procedures.

1.4. Due to size, the sections containing the CHAMPUS Maximum Allowable Charges (CMAC) and dental rates modified for UBO use are not included in this package. These rates are posted on the TRICARE Management Activity (TMA) UBO Web site, http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.

2. Government Billing Calculation Factors:

2.1. Full Reimbursement: The full outpatient reimbursement (FOR) rate shall be 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. The FOR discounts for IMET and IOR are calculated based on an analysis of FY 2007 expense and workload data from all DoD MTFs that offered outpatient services. The data analysis included processing to identify and eliminate poor quality data. It also included adjustments of the FY 2007 data to account for FY 2008 military and civilian pay raises, asset use fees, distribution of expenses between payroll, and non-payroll expense categories, and a DoD inflation adjustment. Discount rates for IMET and IOR are calculated by removing those types of expenses that are specifically to be excluded from consideration in IMET and Interagency billing from the FOR and the full inpatient reimbursement rate (FRR[1]). The rates included in section 3 represent the FOR (unless otherwise specified). IOR rates exclude the "Miscellaneous Receipts" (asset use charge percentage for military pay, civilian pay and other) portion of the FOR price computation. IMET rates exclude both the "Miscellaneous Receipts" portion and the "Military Personnel" portion of the FOR price computation.

2.2. Discount: A government billing calculation factor (percentage discount) shall be applied to the FOR when billing for outpatient services as described below.

2.2.1. International Military Education and Training (IMET) rate:
Ambulance: 59.39% of the FOR
Anesthesia: 57.36% of the FOR
Dental: 46.55% of the FOR
Immunization: 59.42% of the FOR
Air Evacuation–Ambulatory: 58.10% of the FOR
Air Evacuation–Litter: 60.08% of the inpatient FRR
All other IMET where specific rates are not specified (e.g., CMAC, durable medical equipment): 57.42% of the FOR.

2.2.2. Interagency/Other Federal Agency Sponsored Rate (IOR):
Ambulance: 93.89% of the FOR
Anesthesia: 93.94% of the FOR

[1] The inpatient FRR is necessary for the air evacuation litter transportation rate.

Dental: 93.97% of the FOR
Immunization: 94.20% of the FOR
Air Evacuation–Ambulatory: 94.72% of the FOR
Air Evacuation–Litter: 94.44% of the inpatient FRR
All other IOR where specific rates are not specified (e.g., CMAC, durable medical equipment): 94.04% of the FOR.

3. Outpatient Medical and Dental Services Rates/Charges:

3.1. Terminology:

3.1.1. Ambulatory Procedure Visit (APV). An APV is defined in DoD Instruction 6025.8, Ambulatory Procedure Visit (APV), September 23, 1996, as a procedure or surgical intervention that requires pre-procedure care, a 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 do not require post-procedure care by a medical professional shall not be considered APVs. The nature of the procedure and the medical status of the patient combine for a requirement for short-term care but not inpatient care. These procedures are appropriate for all types of patients (obstetrical, surgical and non surgical), who by virtue of the procedure or anesthesia, require post-procedure care and/or monitoring by medical personnel.

3.1.2. 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 providing the intensive level of care associated with APVs.

3.1.3. Emergency Department Services. MTF ambulatory services furnished in the Emergency Department are strictly institutional charges.

3.1.4. Observation Services. MTF ambulatory services furnished in Observation units are strictly institutional charges.

3.1.5. Outpatient Services. Services rendered in a location other than the observation unit, the Emergency Department, or an APU.

3.2. Professional Component:

3.2.1. CMAC Rates:

3.2.1.1. The CMAC rates, established under Title 32, Section 199.14(h) of the Code of Federal Regulations (CFR), are used to determine the appropriate charge for the professional and technical components of services based on the Healthcare Common Procedure Coding System (HCPCS) methodology, which includes

the Current Procedural Terminology (CPT) codes. CMAC rates pertain to outpatient services (e.g., office and clinic visits), and ancillary services (e.g., laboratory and radiology). UBO CMAC rates differ from standard TMA CMAC rates in that UBO CMAC rates include charges for additional services not covered by TRICARE.

3.2.1.2. UBO CMAC rates are calculated for 91 distinct "localities." These localities recognize differences in local costs to provide healthcare services in the many different geographic 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. For MTFs outside the Continental United States (OCONUS)–except for MTFs in Alaska and Hawaii, which have separate locality rates–CMAC locality 391 is used. The complete DMIS ID-to-CMAC Locality table is posted on: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.

3.2.1.3. For each CMAC locality, the UBO creates two sub tables of rates: CMAC and Component. The CMAC rate table specifies the rates to use as payment for professional services and procedures identified by CPT and HCPCS codes, which cannot be separately provided as component services. The CMAC table is further categorized by provider class. The Component rate table specifies the 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, further categorized by provider class.

3.2.1.4. CMAC Provider Class: The UBO CMAC rates are computed based on the 4 provider classes: (1) Physician Class; (2) Psychologist Class; (3) Other Mental Health Providers; and (4) Extra Medical Provider. UBO CMAC-based rates described in section 3.2.1.1. are posted on the TMA UBO Web site at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.

3.2.2. Institutional Component:

3.2.2.1. Emergency Department (ED): TRICARE Ambulatory Payment Classification (APC) rates for ED Evaluation and Management services are used to determine the DoD ED institutional charges. For CPT codes 99281-99285, only the institutional component is billed. NOTE: 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. Observation: The CPT codes used for Observation services include: 99218-99220 and 99234-99236. The rates for these Observation services are derived using Medical Expense and Performance Reporting System (MEPRS) cost data to determine the hourly Observation rate. The hourly Observation rate is then multiplied by the average FY 2007 Observation patient stay of 5.89 hours. Only the institutional charge is billed.

3.2.2.3. Ambulatory Procedure Visit Rate: There is an institutional flat rate for all APV procedures/services. The flat rate is based on the institutional cost of all MTF APVs divided by the total number of APVs. The flat rate is **$1,568.00**.

3.3. Dental Rates: MTF dental charges are based on a dental flat rate multiplied by a DoD-established relative weight for each of the American Dental Association (ADA) Current Dental Terminology (CDT) codes representing the dental services/procedures performed. The dental flat rate is based on the average DoD cost of dental services at all dental treatment facilities. Table 3.3.1. illustrates the dental rate for IMET, IOR and Other (Full/Third Party).

Table 3.3.1.

CDT	Clinical Service	IMET	IOR	Other (Full/Third Party)
	Dental Services CDT code weight multiplier	$54.00	$109.00	$116.00

Example: For CDT code D0270, bitewing single film, the DoD relative weight is 0.24. The relative weight of 0.24 is multiplied by the appropriate rate, IMET, IOR, or Full/Third Party rate to obtain the charge. If the Full/Third Party rate is used, then the charge for this CDT code will be $116.00 x 0.24, which is $27.84.

The list of CY 2008 CDT codes and relative weights for dental services is too large to include in this document. This table is posted on the TMA UBO Web site at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.

3.4. Immunization/Injectables Rates.

3.4.1. A separate charge shall be made for each immunization or injection administered. The charge for immunizations, allergen extracts, allergic condition tests, and the administration of certain medications when these services are provided in a separate immunization or "shot" clinic, are described below. The charge is applicable for each administration of an immunization or injection.

3.4.1.1. Immunization rates are based on CMAC rates whenever CMAC rates are available.

3.4.1.2. If there is no CMAC rate, the National Average Payment (NAP) is used. The NAP represents commercial and/or Medicare national average

payment for services, supplies, drugs, and non-physician procedures reported using Healthcare Common Procedure Coding System (HCPCS) Level II codes.

3.4.1.3. Human Papilloma Virus (HPV) Vaccination Rate. The charge for the HPV vaccination is $100.00 for each administration of the vaccine.

3.4.1.4. If there is no CMAC rate and there is no NAP rate, a flat rate of **$69.00** will be billed. The flat rate is based on the average full cost of these services, exclusive of any costs considered for purposes of any outpatient visit.

3.5. Anesthesia Rate. The flat rate for anesthesia professional services is based on an average DoD cost of service in all MTFs. The flat rate for anesthesia is **$1,006.00.**

3.6. Durable Medical Equipment/Durable Medical Supplies Rates: Durable Medical Equipment (DME) and Durable Medical Supplies (DMS) rates are based on the Medicare Fee Schedule floor rate. The HCPCS codes for which rates are provided include: A4206-A9999, E0100-E9999, K0001-K0547, L0100-L9999, and V0001-V9999. This rate table is posted on the TMA UBO Web site at: http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates.cfm.

3.7. Transportation Rates:

3.7.1. Ground Ambulance Rate: Ambulance charges shall be based on hours of service, in 15-minute increments. The rates for IMET, IOR, and Other (Full/Third Party) listed in the Table 3.7.1. are for 60 minutes (1 hour) of service. MTFs 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).

Table 3.7.1.

CDT/CPT	Clinical Service	IMET	IOR	Other (Full/Third Party)
A0999	Ambulance	$136.00	$215.00	$229.00

3.7.2. Air Evacuation Rate:

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. For example, transportation from Base A to Base B, which consists of three legs, is charged as a single trip within a 24-hour period. The appropriate charges are billed only by the

Global Patient Movement Requirement Center (GPMRC). The charges reflected in Table 3.7.2 are only for the cost of providing medical care. The rates for IMET, IOR, and Other (Full/Third Party) are listed in Table 3.7.2.
Table 3.7.2.

Clinical Service	IMET	IOR	Other (Full/Third Party)
AirEvac Medical Services–Ambulatory	$301.00	$491.00	$518.00
AirEvac Medical Services–Litter	$903.00	$1,419.00	$1,503.00

3.8. Other Rates:

3.8.1. Subsistence Rate: The Standard Rate that is established by the Office of the Under Secretary of Defense (Comptroller) shall be used as the subsistence rate. The Standard Rate is posted on the DoD Comptroller's Web site (Tab G): http://www.dod.mil/comptroller/rates/. The effective date for this rate shall be as prescribed by the Comptroller.

NOTE: Subsistence is billed under the MSA program only. The MSA office shall collect subsistence from all persons, including inpatients and transient patients not entitled to food service at Government expense. Refer to DoD 6010.15-M, Military Treatment Facility UBO Manual, November 2006, and the DoD 7000.14-R, "Department of Defense Financial Management Regulation," Volume 12, Chapter 19 for guidance on the use of this rate.

3.9.2. OCONUS Prepaid Elective Pregnancy Termination Rate:

3.9.2.1. The DoD Appropriations Act for FY 1996 and the DoD Authorization Act for FY 1996 revised the DoD policy concerning provision of prepaid elective pregnancy termination in overseas MTFs such that the authority of those MTFs to provide prepaid elective pregnancy termination is limited to cases in which the pregnancy is the result of an act of rape or incest.

3.9.2.2. When an overseas MTF provides prepaid elective pregnancy termination services under the limited authority identified above, the rate charged shall be the FRR for services performed for an inpatient. If the services are provided as an APV, the prepaid rate shall be calculated using an estimate of the Professional Component rate described in paragraph 3.2, plus the APV Institutional Rate identified in paragraph 3.2.2.3, plus the anesthesia rate (if anesthesia will be used) identified in paragraph 3.5. If the services are provided on an outpatient basis, the

prepaid rate shall be calculated using CMAC locality 391 plus the charge for any associated pharmaceuticals.

4. Elective Cosmetic Surgery Rates:

4.1. List of Procedures: The procedures listed in Appendix A are those procedures identified as elective cosmetic surgery procedures when performed without medical necessity. Only TRICARE-eligible beneficiaries are authorized to receive cosmetic procedures.

4.2. Patient Payment: Elective cosmetic surgery fees are based on the service provided. The patient receiving the cosmetic procedure (e.g., active duty personnel, retirees, and their family members; and survivors) is fully responsible for all the charges and services (including implants, injectables, and billable ancillaries) associated with the elective surgical procedure. The patient shall be charged the applicable FOR or FRR. The patient is still responsible to pay for the entire cosmetic procedure (e.g., institutional, professional, anesthesia, implants) even if the patient has valid other health insurance (OHI). The patient may file a claim with his insurance company.

4.2.1. Laser Vision Correction: Refer to Office of the Assistant Secretary of Defense (Health Affairs) policy on Vision Correction via Laser Surgery for Non-Active Duty Beneficiaries, April 7, 2000, for further guidance on these services. The policy is posted on: http://ha.osd.mil/policies/2000/00_003.pdf.

4.3. Professional Charges for Elective Cosmetic Surgery:

4.3.1. Rates for the professional charges and anesthesia services are derived from the CMAC rate table based on the CY 2008 median location. Rates are not based on the treating MTF's geographical location.

4.3.2. The CMAC CY 2008 "facility physician" category is used for the professional component for services furnished by the provider in an operating room or an APU.

4.3.3. The CMAC CY 2008 "non facility physician" category is used for the professional component for services furnished in the provider's office.

4.4. Institutional Rate for Elective Cosmetic Surgery:

4.4.1. Institutional charges: The institutional fee is based on two different rate categories depending on where the procedure is performed. For elective cosmetic surgery conducted in a provider's office, the institutional fee is included in the "non-facility physician" professional category in paragraph 4.3.3.

4.4.1.1. The institutional fee for cosmetic surgery for outpatients using a hospital operating room or APU is based on the lower of 100 percent of the TRICARE Ambulatory Payment Classification (APC) rate associated with the principal procedure, and 50 percent of the APC rate for each additional procedure, or 100 percent of the TRICARE ambulatory surgical center (ASC) rate associated with the principal procedure, and 50% of the ASC rate for each additional procedure, whichever fee is lower.

4.4.1.2. In those instances when there is no APC or ASC associated with the cosmetic procedure, such as calf augmentation, the price of a similar procedure (e.g., involving similar time, skills, and equipment) is used.

4.4.1.3. Institutional prices are rounded to the nearest $10.00.

4.4.1.4. Ancillary services (e.g., laboratory, radiology) are billed at FOR from the National Average CMAC locality (300).

4.5. Anesthesia Rate for Elective Cosmetic Surgery. The anesthesia professional rate is the Physician Conversion Factor ($19.96) of a typical CMAC locality, multiplied by the number of units for each service, rounded to the nearest $10.00.

4.6. Inpatient Rate for Elective Cosmetic Surgery:

4.6.1. Inpatient charges: Institutional and professional charges for inpatient surgical services are based on the diagnosis related group (DRG) 453, Complications of Treatment without Complications and Comorbidities. The institutional and professional fee is the Average MTF FY 2008 Adjusted Standardized Amount (which is $10,265.93) multiplied by the relative weighted product for the DRG.

APPENDIX A: ELECTIVE COSMETIC SURGERY PROCEDURES

Cosmetic Surgery Procedure	CPT/CDT
Dental	
Porcelain Veneers	D2962
Laser Teeth Whitening	D9999
Teeth Whitening	D9972 D9973 D9974
Repair and/or Reconstruction	
Breast	
Breast enlargement w/o implants (Mammoplasty Augmentation w/o implants)	19324
Breast enlargement w/implants (Mammoplasty Augmentation w/implants)	19325
Breast lift (Mastopexy)	19316
Breast nipple; reduction or enlargement (Nipple/Areola Reconstruction)	19350
Breast reduction for women (Mammoplasty)	19318
Breast reduction for men (Mammoplasty - Gynecomastia)	19300
Enlargement of the male chest w/implants (Pectoral Augmentation)	21899
Mastopexy with insertion of breast implant immediately following surgery	19340
Removal of breast prosthetic implant (Removal of intact mammary implant)	19328
Removal implant material contained inside the breast (Removal of implant material)	19330
Cheek	
Enlargement of the cheek (Malar Augmentation)	21270
Chin	
Chin Augmentation/Reduction (Genioplasty)	21120 21121 21125 21127
Ear	
Reshaping of the ear (Otoplasty)	69300
Eye	
Reshaping of the eyelids (Blepharoplasty)	15820 15821 15822 15823
Tightening of lower eyelid (Lateral Canthopexy)	21282
Reshaping corners of the eye (Blepharoptosis; Canthoplasty)	67903 67904 67950

Cosmetic Surgery Procedure	CPT/CDT
Facial Bones	
Surgical repair or alteration of facial bones (Osteoplasty)	21208 21209
Reconstruction of the midface (Midface LeFort)	21141
Transplant/Implant bone for nasal, jaw or cheek (Bone Graft: nasal, maxillary or malar)	21210
Jaw (Upper/Lower)	
Reconstruction of lower jaw (Reconstruction of Mandibular body w/or w/o bone graft, w/or w/o fixation)	21193 21194 21195 21196
Surgical division or sectioning of upper/lower jaw (Osteotomy Mandible/Maxilla)	21198 21206
Neck	
Neck lift (Cervicoplasty)	15819
Nose	
Reshaping of the nose (Rhinoplasty)	30400 30410 30430 30435 30450
Other	
Enhancement of the Buttock w/implants or injection of fat (Buttock Augmentation)	17999
Enlargement of the Calf w/Implants (Calf augmentation)	17999
Enhancement of the Lip; upper/lower (Lip Augmentation)	17999
Reshaping of the belly button (Umbilicoplasty)	17999
Removal	
Excessive Fat Deposits	
Liposuction of trunk, upper/lower extremity (Total Body Liposuction – suction assisted)	15877 15878 15879
Liposuction of trunk, upper/lower extremity w/use of ultrasound guidance (Total Body Liposuction – ultrasound assisted)	17999
Liposuction – Suction assisted (per region other than trunk)	15876 15877 15878 15879
Liposuction w/use of ultrasound guidance (Ultrasound) assisted (per region other than trunk)	17999

Cosmetic Surgery Procedure	CPT/CDT
Excessive Fat Deposits (cont'd.)	
Removal and transfer of body fat via liposuction and injection, per area [Autologous Fat Transfer (AFT), Microlipoinjection]	17999
Excessive Skin and Subcutaneous Tissue	
Arm Lift (Brachioplasty)	15836
Buttock Lift	15835
Chin (Submental fat pad)	15838
Hip Lift	15834
Thigh Lift	15832
Combination of Thigh and Buttock Lift (Total Lower Body Lift)	15832 15835
Removal of excess skin and fat only, from abdomen (Panniculectomy)	15830
Removal of excess skin and fat from abdomen with a Tummy Tuck (Panniculectomy w/ Abdominoplasty)	15830 +15847
Combination of Thigh and Buttock Lift w/removal of excess abdominal skin/fat and tummy tuck (Total Lower Body Lift w/Panniculectomy and Abdominoplasty)	15830 +15847 15832 15835
Tightening of abdominal muscle walls with removal of excess skin/fat – Tummy Tuck (Abdominoplasty)	17999
Facial Wrinkles (Rhytidectomy)	
Cheek, Chin, and Neck	15828
Forehead (Brow) Lift	15824
Frown lines	15826
Neck	15825
Superficial muscle of the face and neck (SMAS)	15829
Facial Wrinkles (soft tissue fillers)	
Radience/Radiesse	J3490
Restylane	J3490
Zyderm/Zyplast	J3490
Skin Procedures	
Resurfacing	
Administration of Collagen Injections – subcutaneous	11950 11951 11952 11954
Injection of solution to close off varicose veins (Sclerotherapy)	36469 36468 36470 36471

Cosmetic Surgery Procedure	CPT/CDT
Resurfacing (cont'd.)	
Removal of tattoo by using "sanding" technique (Dermabrasion – Tattoo Removal)	15783
Destruction of tattooed pigments using a laser beam (Laser Tattoo Removal); < 30 sq cm or >30 sq cm	 17999 17999
Removal of skin (thin layer) using a mild form of abrasion Microdermabrasion – facial, per treatment	17999
Removal of the damaged upper layers of the skin using a laser beam (Laser Skin Resurfacing–ablative) full-face or segment of face	17999
Treatment of skin layers by stimulating collagen using a laser beam (Laser Skin Resurfacing –non ablative) per region, full-face or segment of face and/or non-facial	17999
Removal of hair follicles by electric cauterization – Electrolysis per ½ hour	17380
Removal of hair follicles using a laser beam (Laser Hair Removal)	17999
Removal and transplant grafts of skin containing hair (Hair Transplant – Graft) 1-15 grafts More than 15 grafts	 15775 15776
Harvesting of hair 1-5 follicles at a time (Hair Transplant – Micro/Mini Follicular unit Transplantation) 1-500 follicles More than 500 follicles	 17999 17999
Chemodenervation	
Chemodenervation, facial	64612
Chemodenervation, neck muscle	64613
Chemodenervation, extremity	64614
Revisions	
Minimize appearance of scar (Scar Revisions)	13100 13101 13102 13120 13121 13122 13131 13132 13133 13150 13151 13152 13153

Cosmetic Surgery Procedure	CPT/CDT
Revisions (cont'd.)	
Surgical removal of varicose veins (Vein Stripping)	37718 37722 37735 37765 37766 37700
Piercing	
Ear Piercing	69090
Piercing – Other body parts	17999