

CHAPTER 13  
SECTION 1.2

## ALLOWABLE CHARGES - APPLICATION OF CRITERIA

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### I. ISSUE

How are allowable charge determinations to be made in the determination of TRICARE/CHAMPUS reimbursement?

### II. POLICY

A. The allowable charge for a covered service is defined in [Chapter 13, Section 1.1](#). The contractor must exercise judgment in applying the allowable charge criteria so that its allowable charge determinations are realistic. In addition to data on physicians' charges to their patients in general, contractors shall take into account special factors in individual cases that might affect the reasonableness of charges under TRICARE/CHAMPUS. The special factors could involve travel, medical complications, or other unusual circumstances such as prolonged time and attention required by a patient's condition, etc. (as described in [Chapter 13, Section 4.1](#)).

#### B. Separate Allowable Charge Determination for Each Service.

1. Different services and supplies for which charges are made under TRICARE/CHAMPUS, may not (except in the two situations described below) be grouped together for the purpose of making one overall allowable charge determination. Thus, in processing a claim for reimbursement, a separate allowable charge determination must be made with respect to each separate service or item for which a charge is made. For example, one overall allowable charge determination may not be made for 12 inpatient hospital visits for which a total charge of \$500 was made, if that total charge consists of: (1) a \$100 fee for the initial inpatient hospital visit; (2) a \$50 fee for the second inpatient hospital visit; and (3) a \$35 fee for each ten subsequent inpatient hospital visits. Where different prevailing charges are applicable to each of these three types of visits, a separate allowable charge determination must be made for each type of visit. Similarly, if a physician reports an office visit, including an examination, urinalysis, and white blood cell count, three allowable charge determinations would be necessary if additional amounts were charged above the usual office fee for the additional services. It is important to note that this applies to different services which are normally billed separately.

2. There are instances, however, when a provider may split a bill into separate items which are normally billed as a single comprehensive service. When the "fragmentation" or

"unbundling" of CPT-4 procedure codes occurs, the policy on "Rebundling of Procedure Codes" contained in [Chapter 13, Section 1.4](#), should be followed. "Fragmentation" or "unbundling" is separately reporting the component parts of a procedure instead of reporting a single comprehensive code which includes the entire procedure.

C. Exceptions to Separate Allowable Charge Determinations.

1. Exception 1.

a. An exception to this might occur with respect to the components of a uniform series of tests and examinations, or a common combination of procedures which can be treated as a single procedure, and for which the prevailing charge can be established. Such a "single procedure" would, by definition, have to always consist of the same components, and would have to be generally recognized by physicians and other persons furnishing covered services as a common combination of procedures or uniform series of tests and examinations. In other words, the description of the service as well as the name and procedure code used to identify it would have to be known and recognized as pertaining to a particular, unvarying group of tests, examinations, or procedures. An exception to the "unvarying" requirement is found in multi-channel laboratory tests. (See [Chapter 13, Section 3.4](#).)

b. There may be a wide variety of uniform series of tests and examinations, or common combinations of procedures. Each one would have to be properly identified, and a separate allowable charge would have to be determined for each. For example, one service may be described as "an office visit including a comprehensive diagnostic history and physical examination". Another service may be described as "an office visit with EKG". These two services may not be treated as the same common combination of procedures for the purpose of determining allowable charge or for compiling profile information.

c. Physicians or other persons who perform uniform series of tests and examinations or common combinations of procedures may itemize the individual components of these services on their bills if they wish, and make separate charges for them. Where this occurs, a separate allowable charge determination for each item is necessary.

2. Exception 2. Another exception to the requirement that separate allowable charge determinations must be made for each service may occur when a physician bills on the basis of a "global fee" "package charge" covering a period of treatment, instead of on the basis of his charges for individual services rendered. The contractor may determine that such a charge is allowable if it can establish that the common "package charge" or "global fee" does not exceed the total of the amounts which it would have deemed allowable if the physician had made charges on the basis of an itemized list of services. Such a determination must be based on information the contractor has about the prevailing charges in the state, and about the nature of and frequency of the services rendered for which a package charge is made. However, a contact with the physician to obtain such information need not be made by the contractor where it can obtain the information from its own files, the patient's prior claims history, etc. Also, the contractor may exercise its discretion and judgment based on a general knowledge of the fee charging practices of the physician, its knowledge of the normal manner of treatment applicable to particular diagnoses, etc., to determine what services were rendered, and how frequently they were rendered, etc. In all cases, however, the contractor must be able to document what information or judgment was used as the basis for its determination. Where an allowable charge determination is made with respect to a "flat fee" or "package fee",

the prevailing charge profile methodology shall be annotated to reflect the determination process. However, the charge must not be included in the calculation of the prevailing charge for a particular procedure unless the global fee has a recognized code and description as noted in Exception 1 above.

3. Exception 3. A surgery charge normally includes the pre- and post-operative care, and most physicians bill a single surgery charge. Some physicians, though, may bill a surgery charge and separate charges for the pre- and post-operative care. The contractor is to use the sum of the charges as the billed charge and make the allowable charge determination from it. This is similar to a global fee as discussed in Exception 2, above, except the global fee generally involves a series of separate services or period of treatment (such as a global maternity fee which covers the entire maternity episode).

D. Low Charge May Not be Used to Offset High Charge.

1. The contractor shall not make a "package charge" or a "flat fee" out of separately itemized charges on a bill for the purpose of offsetting high charges with low charges. Where the same claim contains (a) a charge for one service which is lower than the highest amount the contractor might otherwise have deemed allowable for the service; and (b) a charge for another service which is higher than the allowable charge, it should not be determined that the combined charges for the two services grouped together are allowable. Although the contractor may give the physician or other person who rendered the service an opportunity to correct any billing error, the contractor must not suggest to the physician or other person that the charge be increased for a given service.

2. There is an exception to this rule, involving multiple surgery. (See [Chapter 13, Section 3.7.](#))

E. Inclusive Dates Shown For Period Covered by Services.

1. The contractor may make an allowable charge determination without further development of the claim where one combined charge is indicated either on the claim forms or on the bill for the services rendered during an inclusive period such as from July 1 to July 15. This can be done only if the nature of each service rendered and the number of times each service or procedure was performed is clearly specified and the contractor is quite certain, from its knowledge of physicians charges, that the combined charge reported is no higher than the total of the charges for each individual item. For instance, a \$100 charge for five office visits is consistent with a prevailing charge of \$20 for an office visit. (Of course, the contractor must also ensure that the total number of visits conforms to TRICARE/CHAMPUS limits.)

2. Where the claim does not clearly specify the nature and frequency of the service rendered, or where there is any question about whether the same service was rendered each time, the contractor shall either obtain this information or use its judgment and general knowledge of the fee charging practices of physicians in the state to resolve the question. In either case, the contractor must document in the claim file what information was obtained and/or what its judgment was.

3. For example, a claim may be submitted showing inclusive dates of July 10 - July 20 and a charge of \$115 for visits made by a physician to an inpatient in a hospital. Assuming

the physician visited the patient only once a day for 11 days, the average charge per visit would be \$10.45. This unlikely per visit charge is an indication that the physician did not visit the patient 11 times during the 11-day period, or that the charges and services rendered during the inclusive period were not identical, or that the physician has made a package charge covering a particular period of treatment rather than specific services. In order to comply with [paragraph II.E.2.](#), above, and to make sure its allowable charge determination is correct, the contractor (a) must either resolve this question through a contact with the patient or physician, or (b) it may exercise its judgment, and on the basis of its knowledge and experience with local fee charging practices, etc., determine that the physician has made a package charge and that the \$115 charge consists of a \$15 charge for the initial inpatient hospital visit and of a \$10 charge made for each of ten subsequent inpatient hospital visits. If these charges satisfy the prevailing charge criteria, the contractor may determine that they are allowable.

4. Complete claim file documentation of the information obtained or judgment made by the contractor is necessary to (a) develop its prevailing charge profiles, and (b) reflect that the contractor has based its reimbursement of the claim on correct determinations of coverage and allowable charges.

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