

CHAPTER 13  
SECTION 1.3

## ALLOWABLE CHARGES - APPLICATION OF THE MAXIMUM ALLOWABLE PREVAILING CHARGE

Issue Date: November 1, 1988

Authority: [32 CFR 199.14\(h\)](#)

---

### I. ISSUE

How are "maximum allowable prevailing charges" to be used in limiting the TRICARE/CHAMPUS maximum allowable prevailing charge for physician and other individual professional services?

### II. BACKGROUND

A. DoD Appropriation Act, 1989. Section 8019 of the Department of Defense Appropriation Act for Fiscal Year 1989, Public Law 100-463, required that "None of the funds contained in this Act available for the Civilian Health and Medical Program of the Uniformed Services under the provisions for section 1079(a) of Title 10, United States Code, shall be available for reimbursement of any physician or other authorized individual provider of medical care in excess of the lower of: (a) the eightieth percentile of the customary charges made for similar services in the same locality where the medical care was furnished, as determined for physicians in accordance with Section 1079(h) of Title 10, United States Code; or (b) the allowable amounts in effect during fiscal year 1988 increased to the extent justified by economic changes as reflected in appropriate economic index data similar to that used pursuant to Title XVIII of the Social Security Act". The DoD Appropriation Act for Fiscal Year 1990 contained the same requirement.

B. MEDICARE ECONOMIC INDEX (MEI). In 1972, in response to concerns about rising physician fees reimbursed under Part B of the Medicare program, Congress mandated that an additional fee limit be included in the calculation of "reasonable" charges. Under Section 224 of the Social Security Act Amendments of 1972 (Pub. L. 92-603), the prevailing charge--an amount equal to the maximum reasonable charge allowed physicians for a specific procedure in a specific locality--could exceed the July 1972-June 1973 prevailing charge only by an amount reflected by an index of changes in physicians' operating expenses and earnings levels. This index is known as the Medicare Economic Index (MEI). Under Medicare, in the case of physicians' services only, annual increases in prevailing charges are provided to account for inflation, but only to the extent that there are updates in the MEI. The MEI updates have progressively increased the initial prevailing charge level that was established for the (then) fiscal year ending June 30, 1973.

1. In recent years, the MEI has been established by legislation. The Omnibus Budget Reconciliation Act of 1987 set the MEI for 1989 at 3.0 percent for primary care services and 1.0

percent for other physician services. The same legislation defined "primary care services" as "...physicians' services which constitute office medical services, emergency department services, home medical services, skilled nursing, intermediate care, and long-term care medical services, or nursing home, boarding home, domiciliary, or custodial care medical services".

For services furnished in 1990, after March 31, 1990, the Omnibus Budget Reconciliation Act of 1989 set the percentage increase in the MEI at: (a) 0 percent for radiology services, for anesthesia services, and for certain other specified overpriced services; and (b) 2 percent for other services (other than primary care services). The MEI for primary care services furnished during the above period was calculated by the Health Care Financing Administration to be 4.2 percent. Also, the above legislation added two eye examination procedures as primary care services.

2. Under TRICARE/CHAMPUS, the Medicare Economic Index (MEI) limitation applied to physicians' and other individual professional providers' services. In applying the MEI, TRICARE/CHAMPUS follows the Medicare procedures subject to changes based on differences in the TRICARE/CHAMPUS and Medicare programs.

C. DoD Appropriation Act, 1991. Section 8012 of the Fiscal Year 1991 Department of Defense Appropriations Act, PL 101-511, required that "None of the funds contained in this Act available for the Civilian Health and Medical Program of the Uniformed Services shall be available for payments to physicians and other authorized individual health care providers in excess of the amounts allowed in fiscal year 1990 for similar services, except that: (a) for services for which the Secretary of Defense determines an increase is justified by economic circumstances, the allowable amounts may be increased in accordance with appropriate economic index data similar to that used pursuant to Title XVIII of the Social Security Act; and (b) for services the Secretary determines are overpriced based on an analysis similar to that used pursuant to Title XVIII of the Social Security Act, the allowable amounts shall be reduced by not more than 15 percent".

D. DoD Appropriation Act, 1993. Section 9011 of the Fiscal Year 1993 Department of Defense Appropriations Act, PL 102-396, authorized:

1. Reductions in maximum allowable payments to physicians and other individual professional providers (including clinical laboratories) for overpriced procedures. These are the procedures for which the prior year's national CHAMPUS Maximum Allowable Charge (CMAC) exceeds the Medicare fee. For such comparisons, reduction will be the lesser of the percentage by which it exceeds the Medicare fee or fifteen (15) percent.

2. Balance billing limits for nonparticipating providers. Such providers may not balance bill a beneficiary an amount which exceeds the applicable balance billing limit (115 percent of the TRICARE/CHAMPUS allowable charge). Failure by a provider to comply with this requirement is a basis for exclusion from the TRICARE/CHAMPUS program.

E. National Defense Authorization Act, 1992. 10 USC Section 1.106 of the Fiscal Year 1992 National Defense Authorization Act, authorized:

1. Change in claims filing deadline to no later than one year after the services are provided. For inpatient admission, facility charges (excluding professional services) have a claims filing deadline of one year from date of discharge.

2. Filing of claims by providers requires providers to file claims on behalf of TRICARE/CHAMPUS beneficiaries. The provider is prohibited from imposing any administrative charge related to the claim filing requirement. Providers who fail to comply with the requirement or who fail to obtain a waiver will have the TRICARE/CHAMPUS allowable charge reduced by ten (10) percent. The reduction shall not be balanced billed to the beneficiary. (See [Chapter 13, Section 1.5, paragraph II.H.2.](#))

F. DoD Appropriation Act, 1994. Section 8010 of the Fiscal Year 1994 Department of Defense Appropriations Act, PL 103-139, enacted November 11, 1993, authorized reductions in maximum allowable payments to physicians and other individual professional providers (including clinical laboratories) for overpriced procedures. These are the procedures for which the prior year's national CHAMPUS Maximum Allowable Charge (CMAC) exceeds the Medicare fee. For such comparisons, reduction will be the lesser of the percentage by which it exceeds the Medicare fee or fifteen (15) percent.

### III. POLICY

A. The following policies and procedures are applicable to the pricing of all covered services provided through April 30, 1992, and for those procedures and services that remain the responsibility of the contractor under the provisions of [Chapter 13, Section 1.5.](#)

B. Allowable charge. For covered service of physicians and other authorized individual professional providers, the TRICARE/CHAMPUS allowable charge will be the lowest of the amounts identified in [paragraph III.B.1.](#), [paragraph III.B.2.](#), and [paragraph III.B.3.](#) below:

1. The billed charge for the service.
2. The applicable prevailing charge (see [Chapter 13, Section 1.1.](#)).
3. The fiscal year 1988 prevailing charge adjusted and limited by the MEI and additional statutory provisions (referred to as the maximum allowable prevailing charge (MAPC). The MAPC has been renamed in [Chapter 13, Section 1.5](#) as the appropriate charge level. (See the [OPM Part Two, Chapter 4, Section I.B.](#))

*NOTE: Under a program approved by the Director, TMA, and when a provider has agreed to discount his or her normal billed charges for the purpose of calculating the allowable charge, the discounted fee shall be considered the provider's actual billed charge when the discounted amount is below the billed charge.*

C. The MAPC Limitation. The MAPC limitation applies to prevailing charges (including prevailing charges determined through the use of conversion factors and relative value scales) for physicians' and other individual professional providers' services. It is also applicable in connection with those medical or professional groups that are subject to the prevailing charge limitation on payments for services reimbursed on an allowable charge basis.

1. Prevailing Charges for which the MAPC is Applicable. The MAPC will be applied to the professional services of physicians and other individual professional providers (including professional services rendered by these providers in hospitals) and to certain other services provided incident to these professional services (with certain exceptions as noted in [paragraph III.C.2.](#) below). The prevailing charges for the following services would be limited by the MAPC (see the [OPM Part Two, Chapter 4, Section I.B.](#)):

- a. Direct professional patient care services/procedures (including adjunctive dental care) which may be performed only by physicians or other authorized individual professional providers (see [32 CFR 199.6\(c\)](#)).
- b. Office visits combined with clinical laboratory services for which a single prevailing charge screen is maintained.
- c. Office visits combined with EEG or EKG services for which a single prevailing charge screen is maintained.
- d. Radiological services performed in a radiologist's (or other physician's or individual professional provider's) office. ([Chapter 13, Section 4.4](#))
- e. Injection services that can be performed only by physicians or individual professional providers, e.g., because they are in reality surgical procedures or otherwise require the special skills of a physician or individual professional provider.
- f. Interpretation of X-rays, EKGs, and EEGs for which separate charges can be identified.
- g. Portable X-ray service with interpretation only where the charge for the interpretation cannot be separately identified.

2. Prevailing Charges for which the MAPC is Not Applicable. The prevailing charges for the following services or supplies would not be limited by the MAPC (see the [OPM Part Two, Chapter 4](#)):

1. All clinical laboratory services (except as indicated in [paragraph III.C.1.b.](#) above).
2. Portable X-ray services (except as indicated in [paragraph III.C.1.g.](#) above).
3. The "technical" components of EKG or EEG services where separate prevailing charge screens are used for such components and for the "professional" components.
4. Durable medical equipment.
5. Prosthetic devices (including cataract lenses).
6. Orthotic appliances.
7. Ambulance services.

8. Legend drugs including routine injections and immunizations (see [Chapter 13, Section 3.6](#)).

D. Application of the Medicare Economic Index (MEI) to Primary Care Services. In any year in which the Medicare program applies a different MEI to primary care services (see BACKGROUND information), TRICARE/CHAMPUS will include maternity care and delivery services and well-baby care services as primary care for the purposes of applying the MEI. Under TRICARE/CHAMPUS, for the services of physicians and other authorized individual professional providers, the primary care MEI will be applied to the following CPT-4 codes:

54150  
54160  
59000-59899  
90000-90080  
90100-90170  
90300-90370  
90400-90470  
90500-90580  
90753-90757  
90763-90764  
92002  
92004  
92012  
92014

E. The MEI Rates. The MEI rates are furnished by Medicare each year. The MEI rates are as follows:

FEE SCREEN YEAR	MEI
1991 (October 7, 1991-April 1992) Primary care services Other professional services (see <a href="#">paragraph III.D.</a> above)	2.0%
1990 (Apr-Dec) Primary care services	4.2%
1990 (Apr-Dec) Other professional services (see NOTE)	2.0%
1989 (Feb-Dec) Primary care services	3.0%
1989 (Feb-Dec) Other professional services	1.0%

*NOTE: For prevailing charges for which the MEI is applicable, the 1989 pricing profile was used for services rendered during the period January 1, 1990, through March 31, 1990. For those services or supplies for which the MEI is not applicable, the profile update for January 1, 1990, was required.*

*NOTE: For FSY 1990, all radiology, anesthesia, and the following specific procedure codes will receive a 0 percent increase: 19162, 19200, 19220, 19240, 27125, 27126, 27127, 27130, 27132, 27134, 27137, 27138, 28290, 28292, 28293, 28294, 28296, 28297, 28298, 28299, 29870, 29871, 29872, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29884, 29886, 29887, 29889,*

31000, 31001, 31002, 31020, 31021, 31030, 31031, 31032, 31033, 31360, 31365, 31367, 31368, 32440, 32480, 32500, 32520, 32522, 32525, 33206, 33207, 33208, 33210, 33212, 33216, 33218, 33219, 33232, 33405, 33510, 33511, 33512, 33513, 33514, 33516, 35001, 35011, 35013, 35021, 35045, 35081, 35082, 35091, 35092, 35102, 35103, 35112, 35121, 35122, 35131, 35132, 35141, 35142, 35151, 35152, 35161, 35301, 35311, 35321, 35331, 35341, 35351, 35355, 35361, 35363, 35371, 35372, 35381, 39400, 44120, 44130, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44152, 44153, 44155, 44156, 44160, 44950, 44960, 45378, 45379, 45380, 45382, 45383, 45385, 47600, 47605, 47610, 47620, 49500, 49505, 49510, 49515, 49520, 49525, 49530, 49535, 49540, 49550, 49552, 49555, 49560, 49565, 49570, 49575, 49580, 49581, 49590, 50590, 52500, 52601, 52612, 52614, 52630, 52640, 52650, 58102, 58120, 58150, 58152, 58180, 58200, 58210, 58260, 58265, 58267, 58270, 58275, 58280, 58285, 63001, 63003, 63005, 63010, 63015, 63016, 63017, 63030, 63031, 63035, 64716, 64718, 64719, 64721, 65850, 65855, 66840, 66850, 66920, 66930, 66940, 66983, 66984, 66985, 67107, 67108, 67208, 67210, 67218, 67227, 67228, 69631, 69632, 69633, 69635, 69636, 69637, 69641, 69642, 69644, 69646, 76700, 76705, 76770, 76775, 92226, 92230, 92235, 92265, 92270, 92275, 92280, 92283, 92284, 92285, 92286, 92287, 93000, 93005, 93010, 93012, 93014, 93015, 93017, 93018, 93024, 93040, 93041, 93042, 93045, 93501, 93503, 93505.

F. Change in TRICARE/CHAMPUS Fee Screen Year (FSY). With the adoption of the MEI in 1989, the TRICARE/CHAMPUS FSY changed from a fiscal year to a calendar year. However, due to the legislation discussed in background above, the following are the TRICARE/CHAMPUS fee screen years since after the adoption of the MEI:

- FSY 1989: February-December 1989
- FSY 1990: April 1990-December 1990
- FSY 1991: October 7, 1991-April 1992
- FSY 1992: May 1992-February 1993 (for both nationally and contractor priced claims for dates of service on or after May 1, 1992)
- FSY 1993: March-October 1993 (for both nationally and contractor priced claims for dates of service on or after March 1, 1993). November 1993-March 1994 (for both nationally and contractor priced claims for dates of service on or after November 1, 1993)
- FSY 1994: April 1994- and on (for both nationally and contractor priced claims for dates of service on or after April 1, 1994)
- FSY 1995: January 1995, reporting code "15" (for both nationally and contractor priced claims for dates of service on or after January 1, 1995) and February-December 1995, reporting code "95" (for both nationally and contractor priced claims for dates of service on or after February 1, 1995. **NOTE:** CA/HI was to implement "95" March 1, 1995, instead of February 1, 1995, with dates of service on or after March 1, 1995. For CA/HI, "15" goes through February 1995.
- FSY 1996: January 1996, reporting code "16" (for both nationally and contractor priced claims for dates of service on or after January 1, 1996) and February-December 1996, reporting code "96" (for both nationally and contractor priced claims for dates of service on or after February 1, 1996).

- FSY 1997: January and February 1997, reporting code "17" (for both nationally and contractor priced claims for dates of service on or after January 1, 1997) and March-December 1997, reporting code "97" (for both nationally and contractor priced claims for dates of service on or after March 1, 1997).
- FSY 1998: January 1998, reporting code "18" (for both nationally and contractor priced claims for dates of service on or after January 1, 1998) and February-December 1998, reporting code "98" (for both nationally and contractor priced claims for dates of service on or after February 1, 1998). Effective August 1, 1998, reporting code "18" shall not be used. Reporting code "98" effective date will be adjusted back to January 1, 1998 (for both nationally and contractor priced claims for dates of service on or after January 1, 1998, and ending for dates of service on or before July 31, 1998). Reporting code "28" shall be used for both nationally and contractor priced claims for dates of service on or after August 1, 1998, ending for dates of service on or before December 31, 1998.
- FSY 1999: January 1999, reporting code "19" (for both nationally and contractor priced claims for dates of service on or after January 1, 1999) and February - December 1999, reporting code "99" (for both nationally and contractor priced claims for dates of service on or after February 1, 1999).

*NOTE: Prevailing charges were frozen at 1990 levels during the period of January-October 6, 1991, consistent with P.L. 101-511, Section 8012. With the implementation of CHAMPUS Maximum Allowable Charges (CMACs) on May 1, 1992 (see Section 1.5 of this chapter), allowable professional charges other than CMACs were frozen for services on or after May 1, 1992. Frozen allowable charges include all TRICARE/CHAMPUS established prevailings and conversion factors for: ambulance services, anesthesia services, durable medical equipment (DME) and supplies, oxygen and related supplies, etc. This means that contractors shall limit payment for these services to May 1, 1992, levels. For new services or procedure codes since May 1, 1992, the contractors shall establish an allowable charge or conversion factor using the CHAMPUS allowable methodology, freezing the new allowable charge or conversion factor from the date it is established. Effective October 1, 1997, Level II (HCPCS) shall have allowable charges established by cross-walking from existing allowable charges of TMA assigned codes.*

*NOTE: Prevailing charges for Primary Care procedures (listed in paragraph III.D. above) were increased by 2 percent effective October 7, 1991. Prevailing charges for the procedures listed below were frozen. Prevailing charges for all other procedures were reduced by 15 percent.*

00100-01999\*\*

19160

19162

20550

20600

20605

20610

27230

27232

27234

27238

27240  
27242  
27246  
27248  
31500  
32000  
32020  
32035  
32036  
35111  
52340  
52606  
52620  
69645  
90200-90292  
90600-90654  
90699  
90750-90752  
90760-90762  
90801-90862  
92250  
92260  
99062-99065  
99100-99140  
99160-99174  
06000-06999  
98000-98899  
80002-80099  
81000-87999  
89000-89398

\*\* These are not recognized TRICARE/CHAMPUS codes, however, all anesthesia reimbursement were frozen. ([Chapter 13, Section 3.1](#))

In addition to the above specific listing, all "not elsewhere classified" procedures, defined as CPT-4 codes with the last two digits equal to 99, also had their 1990 prevalings frozen in FSY 1991. All conversion factors were also frozen in FSY 1991.

G. Introduction and acceptance of 99000 series CPT codes. For claims received on or after January 1, 1992 and coded with the new 99000 series evaluation and management codes, contractors have been advised to use a crosswalk (see [Chapter 13, Section 1.3, Addendum 1, Exhibit 1](#)) provided by TMA that crosswalks from the old 90000 series codes to price such claims. For the interim period from January 1, 1992, up to May 1, 1992, the date that the new TRICARE/CHAMPUS national allowable charge system (see [Chapter 13, Section 1.5](#)) is implemented, TRICARE/CHAMPUS has decided to accept either the current 90000 series codes or the new 99000 series codes.

1. Claims coded with 99000 series codes for care provided prior to May 1, 1992, received on or after January 1, 1992, are to be priced using the crosswalk procedures which are discussed below.

2. For procedures where there is a one to one crosswalk (see [Chapter 13, Section 1.3, Addendum 1, Exhibit 1](#) the allowable charge for the new 99000 series code is the allowable charge for the existing 90000 series code based on the actual date of service. This means, if the care was rendered prior to October 7, 1991, the crosswalk table must contain pricing which was a result of the crosswalk using the profiles in effect for April 1, 1990. If the care was rendered on or after October 7, 1991, the crosswalk table must contain pricing which was a result of the crosswalk using the profiles in effect October 7, 1991. Although not designated in the Medicare crosswalk, the preventive medicine and newborn care codes are to be crosswalked and priced as shown in [Chapter 13, Section 1.3, Addendum 1, Exhibit 3](#).

3. For new 99000 series procedures where there is a crosswalk of blended 90000 series procedures (see [Chapter 13, Section 1.3, Addendum 1, Exhibit 2](#)), the allowable charge for the new 99000 series code is the highest allowable charge for the 90000 codes used to blend the new 99000 series code per the crosswalk.

EXAMPLE: 99283 is billed.

Per the crosswalk, blended 90000 series procedures:

90510

90515

90550

90560\*

\*Highest allowable

99283 would be priced using the allowable value for 90560.

The allowable charge for the new 99000 series code is the allowable charge for the existing 90000 series code based on the actual date of service. This means, if the care was rendered prior to October 7, 1991, the crosswalk table must contain pricing which was a result of the crosswalk using the profiles in effect for April 1, 1990. If the care was rendered on or after October 7, 1991, the crosswalk table must contain pricing which was a result of the crosswalk using the profiles in effect October 7, 1991.

4. Some 99000 series codes, including 99361-99373, 99401-99404, and 99411-99412, are non-covered codes. In addition, coverage and pricing of 99000 series codes 99420 and 99429 are to be determined through medical review only.

5. Claims with the new codes are to be paid at the lower of the allowed billed charge or the crosswalked allowable charge for the new the new 99000 series code. If there is not a current allowable charge established for a 90000 series code, the contractor shall use the conversion factor process for establishing the current allowable charge for the 90000 series code.

6. TRICARE/CHAMPUS will continue to accept the old 90000 series codes if coded on claims received on or after January 1, 1992. The contractors are to accept claims for care provided prior to May 1, 1992, with the 90000 series codes which are received on or before September 30, 1992. Such claims must be processed to completion with the payment records reporting a processed to completion date less than or equal to December 31, 1992. Payment records with a 90000 code shall be rejected beginning with vouchers processed at TMA on or after January 1, 1993. Effective October 1, 1992, contractors are instructed to deny line items submitted with 90000 series codes. An Explanation of Benefits (EOB) message shall be identified in the COM-FI and Operations Manual for denial of such claims. The payment

records for FIDCERS shall report a reason for denial code "8 - Other". The contractor shall not crosswalk the 90000 series codes to the new 99000 series codes, but are to continue to price the claims using the actual date of service and the corresponding allowable charge file.

7. Contractors are to crosswalk the 90000 series codes for care provided on or after May 1, 1992, to the 99000 series codes. This process applies to claims received on or before September 30, 1992. The crosswalk is provided in [Chapter 13, Section 1.3, Addendum 2](#). The allowable charge for the 90000 series code is the lowest CHAMPUS maximum allowable charge (CMAC) effective May 1, 1992, when the 90000 series code crosswalks to multiple 99000 series codes.

EXAMPLE: 90360 is billed.  
Per the crosswalk, blended 99000 series procedures:  
99301\*  
99312  
99313  
\*Lowest CMAC  
90360 would be priced using the CMAC for 99301.

An EOB message is established in the COM-FI and Operations Manual that states that an obsolete code was submitted, and future claims submitted with obsolete codes are to be denied. If the allowed amount is disputed by the provider or beneficiary, the contractor is to change the code and make an adjustment only if documentation submitted clearly indicates a different 99000 series code or the narrative description indicates a different 99000 series code. For allowable charge reviews which do not provide the necessary information for change of the procedure code, the contractor shall review the accuracy of the code on the claim being crosswalked and ensure that the reimbursement is correct based on the crosswalk table and the date of service.

Claims which are received on or after October 1, 1992, coded with 90000 series codes, shall be denied. An Explanation of Benefits (EOB) message shall be identified in the Operations Manual for denial of such claims. The payment records for FIDCERS will report a reason for denial code "8 - Other".

8. The attached schedule in [Chapter 13, Section 1.3, Addendum 3](#) summarizes the payment of 90000 and 99000 series codes. The schedule is being provided to assist the contractor understand this policy.

9. For claims requiring adjustments, the contractors will retain the originally coded procedures in making the adjustments. This means that if a claim was originally coded with a 90000 series code, the adjusted claim would retain a 90000 series code.

10. The contractors will continue to use existing dump codes as specified under the old 90000 series codes until the TRICARE/CHAMPUS national allowable charge system is implemented.

H. Accumulation of Annual MAPC changes. TRICARE/CHAMPUS will accumulate MAPC changes, based on FY 1988 prevailing charges updated using the MEI and additional statutory provisions such as the reductions in prevailing charges under Section 8012 of PL 101-511.

I. Methods. Both prevailing charges and maximum allowable prevailing charges are calculated on a national basis beginning in May 1992. Adjustments to reflect local economic conditions will be made using geographic adjustment factors published by the Health Care Financing Administration. See [Chapter 13, Section 1.5](#) and [OPM Part Two, Chapter 4](#) for details on methods.

#### IV. POLICY CONSIDERATIONS

A. Conversion Factors Adjustment. Beginning with the application of the MEI (February 1, 1989), conversion factors (C/F) for 1989 and future years established by the contractors must be adjusted for the MEI (adjusted by applying the MEI to the prevailing charges used to develop C/F).

B. No Prior Year Area-Prevailing Charge. When there is no prior year area-prevailing charge for a procedure, the TRICARE/CHAMPUS allowable charge will be the lower of the billed charge or the current year area-prevailing charge. In such a circumstance, this year will be the base year for the MAPC purposes.

C. No Area-Prevailing Charge for Any Year. When there is no area-prevailing charge for a procedure for any year, the conversion factor (C/F) price for the prior year may be compared with the current year's C/F price and the higher amount to be compared against the billed charge to determine the TRICARE/CHAMPUS allowable charge.

D. New, Rare, or Unusual Procedures. The TRICARE/CHAMPUS allowable charge for new, rare, or unusual procedures will be the amount as determined in accordance with [Chapter 13, Section 4.3](#).

E. Anesthesia Services. The MEI should be applied to prevailing charge conversion factors for anesthesiologists' services (see [Chapter 13, Section 3.1](#)) exactly as if the conversion factors were the prevailing charges.

F. HCPCS. Refer to [Chapter 13, Section 23.1](#), concerning the policy for handling HCPCS.

V. EFFECTIVE DATE            February 1, 1989 (unless otherwise indicated above).

- END -

