CHAPTER 5
SECTION 3

ALLOWABLE CHARGES - CHAMPUS MAXIMUM ALLOWABLE CHARGES (CMAC)

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AUTHORITY: 32 CFR 199.14

I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

II. ISSUE

How are allowable charge determinations to be made in the determination of reimbursement for 1992 and forward?

III. POLICY

A. On September 6, 1991, the Final Rule was published in the **Federal Register** implementing the provisions of the Defense Appropriations Act for Fiscal Year (FY) 1991, Public Law 101-511, Section 8012, which limits payments to physicians and other individual health care providers.

B. The final rule provided for the setting of TRICARE payments at the Medicare locality levels. This required a zip code to Medicare locality crosswalk to be developed, and locally-adjusted appropriate charge data be maintained by the contractor for each locality.

1. This file shall contain all active zip codes. Nevertheless, contractors shall probably encounter zip codes that do not appear on the zip code/Medicare locality file. As needed, TMA shall inform the contractors of the Medicare locality of new zip codes. In rare instances where the contractors have not been notified of the Medicare locality for a zip code, the contractors shall be responsible for referring identified zip codes to TMA so that TMA can place the zip code in a Medicare locality.

2. The zip code/Medicare locality file will contain a two digit state code [both alphabetic abbreviations and Federal Information Processing System (FIPS) codes], the five digit zip code, and a three digit Medicare locality code for each zip code. The file will contain about 42,000 codes. In addition to the zip code/Medicare locality file, a listing of the corresponding seven digit Medicare codes and how they correspond to each of the three digit codes will be provided to the contractors.

3. The zip code/Medicare locality file has a file layout as follows:

DATA TYPE	COLUMNS	
State abbreviation	1-2	alphabetic
State FIPS code	3-4	numeric
Zip code	5-9	numeric
Locality	10-12	numeric

For example, the first two columns will be the State code, the third and fourth columns will be the State FIPS code, the fifth through ninth columns will be 5-digit zip code, and the 10th-12th columns will be the Medicare locality code. The most current locality for the zip code would always be in columns 10-12. Previous years localities would be in the columns next to columns 10-12 by year in descending order, newest to oldest. Eliminated zip codes shall be zero filled. The file is in ASCII format and will be provided on a 3.5" diskette.

a. When a claim is submitted to the contractor, the contractor shall use the provider's zip code (see below) to determine the provider's Medicare locality and then access the appropriate locality-specific procedure code file. The contractor shall thus need to maintain one file for every Medicare locality in the contractor's geographic area instead of one file for each state. Medicare locality codes consist of a three-digit code.

NOTE: The zip code where the service was rendered determines the locality code to be used in determining the allowable charge under CMAC. In most instances the zip code used to determine locality code will be the zip code of the provider's office. The contractors are to use the provider's zip code on the claim to determine place of service. A zip code of a P.O. Box would not be acceptable except in Puerto Rico. Anesthesiologists, radiologists and pathologists would be allowed to use the zip code of a P.O. Box (TRICARE Systems Manual (TSM), Chapter 2, Section 2.7, Element Name: Provider Zip Code). Contractors must use the zip code of the MTF for services provided under a partnership arrangement/Resource Sharing. For hospital-based providers or providers in a teaching setting, the contractors must use the zip code of the hospital.

b. For payment purposes, the contractor shall determine whether this calculated amount (locally-adjusted CMAC for the appropriate payment locality) is lower than the billed charge. For partnership claims or claims where the provider has agreed to take a discount from the prevailing, this reduction must be taken into consideration. Therefore, for claims involving a discount, the prevailing must be discounted then compared to the billed charge to determine the lower of the two.

C. Categories of care not subject to the National Allowable Charge System. Pricing for certain categories of health care shall remain the responsibility of the contractor. The following categories will continue to be priced under current contractor procedures:

Routine Dental (ADA codes)
Ambulance

D. The CMAC applies to all 50 states, Puerto Rico, and the Philippines. Further information regarding the reimbursement of professional services in the Philippines, see the TRICARE Policy Manual (TPM), Chapter 12, Section 11.1. Guam and the U.S. Virgin Islands are to still be paid as billed for professional services.

E. Updates to the CMACs shall occur annually and quarterly when needed. The annual update usually takes place February 1. However, circumstances may cause the updates to be delayed. Managed Care Support Contractors (MCSCs) shall be notified when the annual update is delayed.

F. Provisions which affect the TRICARE allowable charge payment methodology.

NOTE: The first CMAC file update for 1999, raises all CMACs for physicians and psychologists that are priced using the Medicare Relative Value Units (RVUs) to the Medicare Fee Schedule levels. CMACs for mental health providers (clinical social workers, certified marriage and family therapists, and pastoral and mental health counselors under a physician's supervision) shall be reduced by 15% in 1999 and a further 10% in 2000 so that they will be equal to 75% of the CMAC for psychiatrists and psychologists by the year 2000. Medicare reimburses these providers at the same differential.

Effective for services provided on or after September 1, 2003, the payment for certain provider changes to the physician payment level. These providers include: podiatrists, oral surgeons, optometrists, occupational therapists, speech therapists, physical therapists, audiologists, and psychologists. Previously, psychologists were paid under the physician payment level, and the above remaining providers were paid under the non-physician payment level. Podiatrists, oral surgeons, and optometrists shall also come under the HPSA bonus payment. See Chapter 1, Section 33.

1. Reductions in maximum allowable payments to Medicare levels.

2. Balance billing limitation.

a. Nonparticipating providers may not balance bill a beneficiary an amount which exceeds the applicable balance billing limit. This limit is 115% of the TRICARE allowable charge, not to exceed the billed charge.

NOTE: When the billed amount is less than 115% of the allowed amount, the provider is limited to billing the billed charge to the beneficiary. The balance billing limit is to be applied to each line item on a claim.

EXAMPLE 1: No Other Health Insurance (OHI)

Billed charge	$500
Allowable charge	$200
Amount billed to beneficiary (115% of $200)	$230

EXAMPLE 2: OHI

Billed charge	$500
Allowable charge	$200
Amount paid by OHI to the beneficiary	$200
Amount billable to beneficiary (115% of $200)	$230

NOTE: When payment is made by OHI, this payment does not affect the amount billable to the beneficiary by the nonparticipating provider except, when it can be determined that the OHI limits the amount that can be billed to the beneficiary by the provider.

b. Failure to Comply. If a nonparticipating provider fails to comply with this balance billing limitation requirement, the provider shall be subject to exclusion from the TRICARE Program as an authorized provider and may be excluded as a Medicare provider.

c. Granting of Waiver of Limitation. When requested by a TRICARE beneficiary, the contractor, on a case-by-case basis, may waive the balance billing limitation. If the beneficiary is willing to pay the nonparticipating provider for his/her billed charges, then the waiver shall be granted. The contractor shall obtain a signed statement from the beneficiary stating that he/she is aware that the provider is billing above the 115% limit, however, they feel strongly about using that provider and they are willing to pay the additional money. The beneficiary shall be advised that the provider still may be excluded from the TRICARE program, if he/she is over billing other TRICARE beneficiaries and they object. The waiver is controlled by the contractor, not by the provider. The contractor is responsible for communicating the potential costs to the beneficiary if the waiver statement is signed. A decision by the contractor to waive or not to waive the limit is not subject to the appeals process. For the TRICARE Outpatient Prospective Payment System (OPPS), the granting of waivers for balance billing limitations applies only to EXEMPT OPPS providers.

3. Site of Service. CMAC payments based on site of service becomes effective for services rendered on or after April 1, 2005. Payment based on site of service is a concept used by Medicare to distinguish between services rendered in a facility setting as opposed to a non-facility setting. Prior to April 1, 2005, CMACs were established at the higher rate of the facility or non-facility payment level. For some services such as radiology and laboratory tests, the facility and non-facility payment levels are the same. In addition, prior to April 1, 2005, CMAC pricing was established by class of provider (1, 2, 3, and 4). These four classes of providers will be superseded by four categories.

a. Categories.

Category 1: Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, and audiologists provided in a facility including hospitals (both inpatient and outpatient and billed with the appropriate revenue code for the outpatient department where the services were rendered), residential treatment centers (RTCs), ambulances, hospices, military treatment facilities (MTFs), psychiatric facilities, community mental health centers (CMHCs), skilled nursing facilities (SNFs), ambulatory surgical centers (ASCs), etc.

Category 2: Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, and audiologists provided in a non-facility including provider offices, home settings, and all other non-facility settings. The non-facility CMAC rate applies to occupational therapy (OT), physical therapy (PT), or speech therapy (ST) regardless of the setting.

Category 3: Services, of all other providers not found in Category 1, provided in a facility including hospitals (both inpatient and outpatient and billed with the appropriate revenue code for the outpatient department where the services were rendered), RTCs, ambulances, hospices, MTFs, psychiatric facilities, CMHCs, SNFs, ASCs, etc.

Category 4: Services, of all other providers not found in Category 2, provided in a non-facility including provider offices, home settings, and all other non-facility settings.

b. Linking the site of service with the payment category. The contractor is responsible for linking the site of service with the proper payment category. The rates of payment are found on the CMAC file that are supplied to the contractor by TMA through its contractor that calculates the CMAC rates.

c. Payment of 0510 and 0760 series revenue codes.

(1) Effective for services on or after April 1, 2005, payment of 0510 and 0760 series revenue codes shall begin. Payment would be made as billed unless a discounted negotiated rate can be obtained for OPPS exempt providers.

(2) Effective for services on or after May 1, 2009 (implementation of OPPS), payment of 0510 and 0760 series revenue codes will be based on the HCPCS codes submitted on the claim and reimbursed under the OPPS for providers reimbursed under the OPPS methodology.

d. Reimbursement Hierarchy For Procedures Paid Outside The OPPS.

(1) CMAC Facility Pricing Hierarchy (No Technical Component (TC) Modifier).

(a) The following table includes the list of rate columns on the CMAC file. The columns are number 1 through 6 by description. The pricing hierarchy for facility CMAC is 8, 6, 4, then 2.

COLUMN	DESCRIPTION	CATEGORY CROSSWALK
1	Non-facility CMAC for physician/LLP class	Category 2
2	Facility CMAC for physician/LLP class	Category 1
Description: If non-physician TC > 0, then pay the non-physician TC. Otherwise, if the Physician class TC rate > 0, then pay the Physician class TC rate. Otherwise, if the Facility CMAC for non-physician class > 0, then pay the Facility CMAC for non-physician class. Otherwise, pay Facility CMAC for physician/LLP class.		

COLUMN	DESCRIPTION	CATEGORY CROSSWALK
3	Non-facility CMAC for non-physician class	Category 4
4	Facility CMAC for non-physician class	Category 3
5	Physician class Professional Component (PC) rate	
6	Physician class TC rate	
7	Non-physician class PC rate	
8	Non-physician class TC rate	
Description: If non-physician TC > 0, then pay the non-physician TC. Otherwise, if the Physician class TC rate > 0, then pay the Physician class TC rate. Otherwise, if the Facility CMAC for non-physician class > 0, then pay the Facility CMAC for non-physician class. Otherwise, pay Facility CMAC for physician/LLP class.		

NOTE: Hospital-based therapy services, i.e., OT, PT, and ST, shall be reimbursed at the non-facility CMAC for physician/LLP class.

(b) If there is no CMAC available, the contractor shall reimburse the procedure under Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

(2) DMEPOS. If there is no DMEPOS available, the contractor shall reimburse the procedure using state prevailings.

(3) State Prevailing Rate. If there is no state prevailing rate available, the contractor shall reimburse the procedure based on billed charges.

e. Informing the provider community of the pricing changes for 2005. The contractors are to inform the provider community of the pricing changes based on site of service beginning April 1, 2005, for services rendered on or after this date. Medicare has been using site of service for some time. TMA would simply be adopting this pricing from Medicare. Contractors may need to renegotiate agreements with providers reflecting this change.

f. Services and procedure codes not affected by site of service. Anesthesia services, laboratory services, component pricing services such as radiology, and "J" codes are some of the more common services and codes that will not be affected by site of service.

g. CMAC history files. The contractor is to retain and maintain previous years CMAC files for historical purposes. Since the 2005 CMAC file format is different, it will be more difficult to link to the previous years CMAC files.

4. Multiple Surgery Discounting. Professional surgical procedures which are reimbursed under the CMAC payment methodology will be subject to the same multiple surgery guidelines and modifier requirement as prescribed under the OPPS for services rendered on or after May 1, 2009 (implementation of OPPS). Refer to Chapter 1, Section 16,

paragraph III.A.1.a. through c. and Chapter 13, Section 3, paragraph III.A.5.b. and c. for further detail.

5. Industry standard modifiers and condition codes may be billed on outpatient hospital or individual professional claims to further define the procedure code or indicate that certain reimbursement situations may apply to the billing. Recognition and utilization of modifiers and condition codes are essential for ensuring accurate processing and payment of these claims.

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