



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 139
6010.55-M
SEPTEMBER 23, 2011**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE REIMBURSEMENT MANUAL (TRM), AUGUST 2002**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: STATE PREVAILING UPDATE

CONREQ: 15086

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change provides language that contractors must update statewide prevailing charges.

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

Ann N. Fazzini

**Ann N. Fazzini
Chief, Medical Benefits and
Reimbursement Branch**

ATTACHMENT(S): 13 PAGE(S)

DISTRIBUTION: 6010.55-M

CHANGE 139
6010.55-M
SEPTEMBER 23, 2011

REMOVE PAGE(S)

CHAPTER 3

Section 1 pages 3 - 10

CHAPTER 5

Section 1, pages 3 and 4

Section 3, pages 5 - 7

INSERT PAGE(S)

Section 1, pages 3 - 10

Section 1, pages 3 and 4

Section 3, pages 5 - 7

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 3, SECTION 1

REIMBURSEMENT OF INDIVIDUAL HEALTH CARE PROFESSIONALS AND OTHER NON-INSTITUTIONAL HEALTH CARE PROVIDERS

b. The summary data used to develop prevailing conversion factors. This is to include every prevailing charge (identified by amount, procedures, weighted frequency, and relative value units) which was used in calculating each conversion factor.

B. Data Base And Profile Updating

NOTE: Annual update of state prevailing amounts, reference Chapter 5, Section 3, paragraph III.G.

1. The 80th percentile of charges shall be determined on a date or dates specified by the Executive Director, TMA. Profile update data used shall be charges for services and supplies provided during the 12 month period ending on June 30 prior to the update. Contractors shall maintain two sets of profiles; the current profiles and the previous year's profiles. The contractor will apply profiles based on the date of service. The fee screen year is the calendar year.

2. Each contractor shall develop procedures to ensure that the data base used to develop the profile for any procedure contains only charges actually made for that procedure. Thus, edits must be developed which will eliminate charges for individual consideration cases, and charges for multiple surgery, as well as aberrant data resulting from coding errors and other data problems. A description of these procedures is to be available for TMA review.

3. All charges, except those identified above, made by individual providers for services rendered to TRICARE beneficiaries during the data base period must be included in the data base. The usual (pre-discount) charges of network providers or the contractor's or a subcontractor's private business may be included if the billing arrangement with the provider or other source of data for the data base is such that accurate data for the state will be obtained.

4. Except when an error has occurred, updated actual prevailings are not to be lower than the previous year's actual prevailings. However, if for two consecutive years the rates are lower than the established profiles, then, in the second year, the rates will be lowered to the higher of the two profiles which are below the established profile. However, if the updated prevailing charge is lower, contractors are to continue using the previous actual prevailing charge. When the updated prevailing charge is 25% or more lower than the previous prevailing charge, the contractor is to review the development of both profiles. If no errors are found, the new profile is to be increased to the level of the previous profile. If the previous profile is higher due to an error in its calculation, the updated profile will be used. The same rules apply to conversion factors when the updated conversion factor is less than the previous one. However, in all cases an actual profile on a procedure takes precedence over an allowance based on a conversion factor.

c. When the current allowance based on a conversion factor is less than the previous allowance based on an actual profile, the previous profile amount is to be used.

b. When the current allowance based on an actual profile is less than the previous allowance based on a conversion factor, the actual profile is to be used.

NOTE: This provision does not apply to those instances where profiles are initially developed for a distinct class of provider which was previously included with providers having higher profiles.

5. Once the contractor has completed the update of its profiles, further revisions in the profiles will not be permitted, except to correct erroneous calculations or to establish profiles for new services. If the contractor finds it necessary to correct profiles or to establish a profile fee for a new procedure, the action will be thoroughly documented and retained in accessible form for not less than the retention period for the claims processed during the active life of that profile.

C. Prevailing Charges

1. Prevailing charges are those charges which fall within the range of charges that are most frequently used in a state for a particular procedure or service. The top of this range establishes an overall limitation on the charges which the contractor shall accept as allowable for a given procedure or service, except when unusual circumstances or medical complications warrant an additional charge (see [Chapter 5, Section 4](#)).

2. Unless the Executive Director, TMA, has made a specific exception, prevailing profiles must be developed on a statewide basis. Localities within states are not to be used, nor are prevailing profiles to be developed for any area larger than individual states.

3. Prevailing profiles also are to be developed on a nonspecialty basis. Of course, types of service are to be differentiated. For example, for a given surgical procedure the surgeon, assistant surgeon, and the anesthesiologist would all be reimbursed based on different profiles. However, reimbursement for the actual surgery would be based on only one profile, regardless of whether the surgery was performed by a specialist or a general surgeon. An exception to this rule is that when services are performed by different classes of providers; e.g., a physician vis-a-vis a non-physician, separate profiles are to be developed for each class of provider. For example, there are three distinct classes of providers who render similar psychiatric services; psychiatrists, psychologists and others (Masters of Social Workers (MSWs), marriage and family counselors, pastoral counselors, mental health counselors, etc.). Moreover, two distinct classes of providers render obstetrical services; physicians and nurse midwives. Separate profiles are to be developed for each of the classes. Since a physician can render more comprehensive services than non-physicians (and likewise for psychologists as opposed to MSWs) the profile for the lesser-qualified class of provider should never be higher than that for a higher-qualified class of provider. For example, in cases in which psychologists' profiles are higher than psychiatrists', the psychologists' profiles should be lowered to that of the psychiatrists' profiles.

4. When there are two or more procedures which are identical except for the amount of time involved (e.g., CPT¹ procedure codes 90843 and 90844), the contractor is to ensure

¹ CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

that the profile for the shorter procedure does not exceed the profile for the longer procedure. In those cases in which it does, the contractor is to reduce the profile for the shorter procedure to that of the longer procedure (see [Chapter 5, Section 3](#)).

D. Conversion Factors

1. General

Submitted charges must be compared with the applicable prevailing charge to determine the allowable charge for the service. If there is insufficient actual charge data to determine the prevailing charge in the state for a service, the contractor shall calculate a prevailing charge by multiplying the appropriate prevailing charge conversion factor by the appropriate relative value units.

a. Conversion factors are to be developed for broad types of services. As a minimum, the types of service shall include medicine, surgery, anesthesia, radiology, and pathology. In addition, separate conversion factors must be developed for each class of provider which can provide a particular type of service. For example, there should be three medicine conversion factors - one for physicians, one for psychologists, and one for other non-physician providers.

b. Conversion factors are used to derive "approximate" prevailing charges. Since prevailing charges based on conversion factors are estimates of actual (but unknown) "average" charges, their reliability is only as good as the known, but often limited, data. Contractors must exercise extreme care in developing conversion factors. When beneficiaries, physicians, and suppliers inquire regarding reimbursement based on the use of a conversion factor, the contractor shall use its best judgment based on the data available to it (including information the physician or supplier may furnish) to resolve the issue.

c. In those cases in which a profile has been increased to the previous year's level, the contractor shall also use the higher previous amount in calculating a conversion factor. A conversion factor is simply a mathematical representation of what is currently being paid for similar services, and thus it should be based on the profiles actually in use.

2. Relative Value Scales

Relative value scales developed or adopted by the contractor shall be carefully reviewed and validated before they are used. The contractor is responsible for ensuring that a relative value scale which is used to estimate prevailing charges accurately reflects charge patterns in the area serviced by the contractor. When a conversion factor results in an obviously incorrect amount (either high or low), the contractor is to make an adjustment in its relative value scale which will correct the error. Such corrections are to be reviewed in subsequent profile updates to ensure they are accurate.

3. Calculation Of Prevailing Charge Conversion Factors

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 3, SECTION 1

REIMBURSEMENT OF INDIVIDUAL HEALTH CARE PROFESSIONALS AND OTHER NON-INSTITUTIONAL HEALTH CARE PROVIDERS

a. Prevailing charge conversion factors used with relative value scales to fill gaps in contractor prevailing charge screens shall be calculated from the following formula:

C/F = Prevailing charge conversion factor.
 CHG = The fully adjusted prevailing charge for a procedure.
 SVC = The number of times the procedure was performed by all physicians in the state.
 RVU = The relative value unit assigned to the procedure.
 SUM OF SVC = The total number of times all procedures for which actual prevailing charges have been established and were performed in the state.

$$C/F = \frac{\text{CHG} \times \text{SVC} + \frac{\text{CHG}}{\text{RVU}} \times \text{SVC} + \dots + \frac{\text{CHG}}{\text{RVU}} \times \text{SVC}}{\text{Sum of SVC}}$$

EXAMPLE: Compute a prevailing charge conversion factor on the basis of known prevailing charges within the same type of service.

PROCEDURE	FREQUENCY	ACTUAL CHARGE	RELATIVE VALUE
1	30	\$5.00	1
2	70	12.00	2
3	50	35.00	5
4	40	20.00	3
5	<u>60</u>	8.00	1.5
	250		

b. Method

(1) For each procedure, divide the prevailing charge by the relative value and multiply the result by the frequency of that procedure in the charge history.

(2) Add all the results of these computations.

(3) Divide the result by the sum of all the frequencies.

c. Solution

$$\frac{(5 \times 30)}{1} + \frac{(12 \times 70)}{2} + \frac{(35 \times 50)}{5} + \frac{(20 \times 40)}{3} = \frac{(8 \times 60)}{1.5} =$$

250

$$(5 \times 30) + (6 \times 70) + (7 \times 50) + (6.67 \times 40) = (5.33 \times 60) =$$

250

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 3, SECTION 1

REIMBURSEMENT OF INDIVIDUAL HEALTH CARE PROFESSIONALS AND OTHER NON-INSTITUTIONAL HEALTH CARE PROVIDERS

$$\begin{array}{rcccccc} 150 & + & 420 & + & 350 & + & 266.8 & + & 319.8 & = \\ \hline & & & & & & 250 & & & \end{array}$$

$$\frac{1506.6}{250} = \$6.03$$

d. The conversion factors calculated for any profile year shall reflect prevailing charges calculated on the basis of charge data for the applicable profile year. Also, prevailing charges established through the use of a relative value scale and conversion factors, in effect, consist of two components. Consequently, the conversion factors used must be recalculated when there is an extensive change in the relative value units assigned to procedures (as may occur if the contractor begins to use a different or updated relative value scale but not if the unit value of a single procedure is changed) in order to ensure that the change(s) in unit values do not change resultant conversion factors.

e. Since conversion factors are a calculated amount and will only be used when multiplied by a relative value, conversion factors are to be rounded only to the nearest whole cent. It will not be acceptable to round to the nearest dollar or tenth dollar (dime).

E. Procedure Codes. The CPT² Coding System includes Level I: CPT Codes and Level II: Alpha Character and TMA approved codes for retail and mail order pharmacy. (Reference the TRICARE Systems Manual (TSM), [Chapter 2, Addendum E](#) and [F](#).)

F. Professional surgical procedures will be subject to the same multiple procedure discounting guidelines and modifier requirements as prescribed under the Outpatient Prospective Payment System (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.

G. Professional procedures which are terminated or are bilateral will be subject to discounting based on modifier guideline requirements 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.

H. Prevention Of Gross Dollar Errors. Parameters Consistent With Private Business. The contractor shall establish procedures for the review and authorization of payment for all claims exceeding a predetermined dollar amount. These authorization schedules shall be consistent with the contractor's private business standards.

I. Industry standard modifiers and condition codes may be billed on 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 are essential for ensuring accurate processing and payment of these claims.

² CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 3, SECTION 1

REIMBURSEMENT OF INDIVIDUAL HEALTH CARE PROFESSIONALS AND OTHER NON-INSTITUTIONAL HEALTH CARE PROVIDERS

III. ALLOWABLE CHARGE METHOD: APPLICATION

A. Durable Medical Equipment (DME), Durable Equipment (DE), And Supplies. Also, see [Chapter 1, Section 11](#) and the TRICARE Policy Manual (TPM), [Chapter 8, Section 2.1](#).

B. Physician Assistant Services. The allowable charge for physician assistant services is determined in accordance with the provisions of [Chapter 1, Section 6](#), and is based on a percentage of the allowed charge for the service when performed by the employing physician. Only the employing physician may bill for physician assistant services. Physician assistants' billed and allowed charges must be excluded from calculation of physician profiles. Payment is made to the employing physician who is an authorized TRICARE provider.

C. Teaching Physicians. Payment for services of teaching physicians may be made on an allowable charge basis only if an attending physician relationship has been established between the teaching physician and the patient. Refer to [Chapter 1, Section 4](#) for a full explanation of applicable prerequisites.

IV. ALTERNATIVE REIMBURSEMENT METHODS FOR NON-NETWORK PROVIDERS

The contractor, with the concurrence of the Executive Director, TMA (or a designee), may, subject to the approval of the ASD(HA), establish an alternative method of reimbursement designed to produce reasonable control over health care costs and to assure a high level of acceptance of the TRICARE-determined charge by the individual health care professionals or other non-institutional health care providers furnishing services and supplies to TRICARE beneficiaries. Alternative methods shall not result in reimbursement greater than under the allowable charge method above, nor result in a higher cost for the affected beneficiary population.

V. CHAMPUS MAXIMUM ALLOWABLE CHARGE SYSTEM

A. General. The CHAMPUS Maximum Allowable Charge (CMAC) System is effective for services rendered on and after May 1, 1992. Contractors shall process claims using the requirements specified in the TPM (specific TPM references follow). Adjustments shall be processed using the reimbursement system in place at the time the services were rendered. 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. For processing an adjustment on a claim which was reimbursed using CMAC, the zip code which was used to process the initial claim must be used to determine the locality for the allowable charge calculation for the adjustment. Adjustments shall be processed using the appropriate fee screen year, which shall be based on the date of service. Post Office Box zip codes are acceptable only for Puerto Rico and for providers whose major specialty is anesthesiology, radiology or pathology (see [Chapter 5, Section 3](#)).

B. Locality Code. For TED reporting, the locality code used in the reimbursement of the procedure code is to be reported for each payment record line item, i.e., on each line item

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 3, SECTION 1

REIMBURSEMENT OF INDIVIDUAL HEALTH CARE PROFESSIONALS AND OTHER NON-INSTITUTIONAL HEALTH CARE PROVIDERS

where payment is based on a CMAC, the locality shall be reported. Any adjustment to a claim originally paid under CMAC without a locality code, shall include the locality code that it was priced on at the time of the initial payment. The locality code reported on the initial claim shall be used to process any future adjustments of that claim unless one of the conditions listed below occurs:

1. The adjustment is changing the type of pricing from CMAC to state prevailing in which case the locality code should be blank filled, or;
2. The initial claim was priced incorrectly because of using a wrong locality code, in which case the correct locality code should be used.

VI. BONUS PAYMENTS IN MEDICALLY UNDERSERVED AREAS

A. An additional payment shall be made quarterly to physicians who qualify and provide services in medically underserved areas [Health Professional Shortage Areas (HPSA) and Physician Scarcity Areas (PSA)]. To initiate action for the additional payment, providers shall use modifiers that will signify the provider is requesting the additional payment. The modifiers are "QU" (urban HPSA), "QB" [rural HPSA], and "AR" [PSA bonus payment]. "QU", "QB" and "AR" are modifiers to the CPT/HCPCS procedure codes. The provider shall be paid an additional 10% HPSA bonus of the total amount paid, excluding interest payments, for claims that were processed during the calendar quarter for services rendered on or after June 1, 2003. The provider shall be paid an additional five percent PSA bonus of the total amount paid, excluding interest payment, for claims that were processed during the calendar quarter for services rendered on or after January 1, 2005. The contractor shall have 30 calendar days from the end of the calendar quarter to make the payments to the providers who qualify. The bonus payments could be paid to network, non-network, participating, or non-participating physicians. Special programs such as TPR, SHCP, and TSP shall be included in the bonus payment process. Contractors shall send bonus payments directly to the non-participating physician. Contractors shall report these claims on TEDs as required by the TSM, [Chapter 2, Section 2.7](#) (Procedure Code Modifiers). See [Chapter 1, Section 33](#) for additional information.

NOTE: Effective January 1, 2006, for services rendered on or after this date, the "QU" and "QB" modifiers shall be replaced with modifier "AQ".

1. The contractor is to inform providers of the PSA and HPSA bonus payments through stuffers and their quarterly news bulletin. The stuffers and bulletin should provide direction on what is required in order to obtain the bonus payment.
2. Basis of bonus payments to TRICARE-authorized providers is solely when a "AQ", "QU", "QB", or "AR" modifier is found on the claim.

B. Bonus payments are passthrough payments, non-financially underwritten payments. The contractor shall follow the process below. This process is similar to the payment of capital and direct medical education found under the DRG reimbursement system (see [Chapter 3, Section 2, paragraph II](#)).

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 3, SECTION 1

REIMBURSEMENT OF INDIVIDUAL HEALTH CARE PROFESSIONALS AND OTHER NON-INSTITUTIONAL HEALTH CARE PROVIDERS

1. All bonus payments are non-financially underwritten and shall be made from the non-financially underwritten, bank account (see the TRICARE Operations Manual (TOM), [Chapter 3, Section 2](#)).

2. Bonus Payment Procedures. The contractor shall use the following procedures in making bonus payments to physicians:

a. Accumulate and tally claims paid with "QU", "QB", or "AR" modifiers.

b. Compute the amount due each physician for submitted claims during the calendar quarter for HPSA services rendered on or after June 1, 2003 and PSA services rendered on or after January 1, 2005. The PSA bonus only goes through June 30, 2008. Stop processing prior to check writing. Compute the total amount due all physicians. For services with both a professional and technical component, only the professional component would be included in the calculation of the bonus payment. The amount due is computed from claims with the "QU", "QB" and "AR" modifiers, then based on the amount paid (see [paragraph VI.B.3.d.](#)).

c. Any interest payments shall not be included in the computation of the payable bonus amount.

d. On the first work day of the last week of the month following the quarter, submit a voucher (see [paragraph VI.B.3.](#)) by express mail to TMA, CRM (a fax copy is not necessary).

e. After receiving clearance from TMA, CRM, continue processing through check write and mail out checks within two work days.

3. Vouchers

a. Format

- Physician Name
- Physician Address
- Physician Provider Number
- Period Covered (Quarter)
- Amount Paid/Collected for Bonus (see [paragraph VI.B.3.d.](#))
- Total Bonus Paid [5 and/or 10% of the above bullet]

b. Sort Bonus Payment

- By Type (e.g., standard or active duty)
- By Coverage (Prime, Extra, Standard)
- By Fiscal Year of Bank Account
- By Contract
- By City & State
- By Region
- By Physician
- By Physician Number

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 5, SECTION 1

ALLOWABLE CHARGES - NON-NETWORK PROVIDERS

PROVIDER	CHARGE	NUMBER OF SERVICES
C	11.00	3
	13.00	54
	15.00	11
D	12.00	32
E	12.50	18
	13.50	22

CHARGE	# OF SERVICES	CUMULATIVE SERVICES
\$11.00	3	3
12.00	70	73
12.50	18	91
13.00	70	161
13.50	87	248
15.00	46	294

b. In the above example, 80 percent of the total of 294 services equals 235.2 services. The prevailing charge is, therefore, the 236th charge or \$13.50. Calculations of the 80th percentile are to be rounded to the next higher number of accumulative services.

c. To more accurately reflect prevailing charges in a state, a minimum of eight (8) charges must be used to establish a prevailing charge.

d. When it is necessary to establish charges through the use of price lists, these charges shall also be used to establish the required prevailing charge limits. In this regard, if a contractor cannot derive precise data on the frequency of services from its records, it may use any information it has about the volume of business done by various suppliers in its area in order to weight the charges used to calculate the prevailing charges. This information must be documented and retained for review.

e. A sales tax on any service or item covered is part of a beneficiary's medical expense for which he or she is responsible and for which he or she may receive reimbursement of the allowable charge after the cost-share and deductible is met. Therefore, the total charge for a service or item, including the sales tax, is the correct amount to use in the determination of the prevailing charge. For example, if a supplier charges \$7 for a covered medical supply and 28 cents sales tax, the total charge of \$7.28 is the amount to use in the determination of the prevailing charge for that supply.

NOTE: 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.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 5, SECTION 1

ALLOWABLE CHARGES - NON-NETWORK PROVIDERS

f. Annual update of state prevailing amounts, reference Chapter 5, Section 3, paragraph III.G.

C. The allowable profiles (CHAMPUS Maximum Allowable Charge (CMAC) files) will be updated at least once per year, and this will usually occur on February 1.

NOTE: Prevailing charges were frozen at 1990 level during the period of January-October 6, 1991, consistent with P.L. 101-511, Section 8012. With the implementation of CMACs on May 1, 1992 (see Chapter 5, Section 2), 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. **Effective with the 2012 CMAC update and subsequent CMAC updates, the provisions in Chapter 5, Section 3, paragraph III.G. regarding the annual update of state prevailing rates shall apply.**

* Effective November 1, 1998, the pricing of anesthesia services were put under a reimbursement methodology found in Chapter 1, Section 9.

- END -

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 5, SECTION 3

ALLOWABLE CHARGES - CHAMPUS MAXIMUM ALLOWABLE CHARGES (CMAC)

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 Healthcare Common Procedure Coding System (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 8 by description. The pricing hierarchy for facility CMAC is 8, 6, then 2 (global, clinical and laboratory pricing is loaded in Column 2).

COLUMN	DESCRIPTION
1	Non-facility CMAC for physician/LLP class
2	Facility CMAC for physician/LLP class
3	Non-facility CMAC for non-physician class
4	Facility CMAC for non-physician class

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, pay Facility CMAC for physician/LLP class.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 5, SECTION 3

ALLOWABLE CHARGES - CHAMPUS MAXIMUM ALLOWABLE CHARGES (CMAC)

COLUMN	DESCRIPTION
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, 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, i.e., [Column 1](#).

(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 16, paragraph III.A.1.a. through c.](#) and [Chapter 13, Section 3, paragraph III.A.5.b. and c.](#) for further detail.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 5, SECTION 3

ALLOWABLE CHARGES - CHAMPUS MAXIMUM ALLOWABLE CHARGES (CMAC)

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.

G. Annual Update of State Prevailing Amounts. Effective with the 2012 CMAC update, for professional services and items of DMEPOS for which there is no CMAC fee schedule amount or DMEPOS fee schedule amount (i.e., reimbursement is made by creating state prevailing rates), the contractor shall perform annual updates of the state prevailing amounts.

1. The contractor shall use the charges for claims for services that were provided on July 1 and ending on June 30. The updated amounts shall be implemented with the CMAC file, which normally occurs in February. For example, the annual update to state prevailings for 2012, shall be established using claims data from July 1, 2010, through June 30, 2011, and shall be implemented with the 2012 CMAC update, and continue with subsequent CMAC updates.

2. Contractors shall create a state prevailing annual report. The report shall include, at a minimum, the HCPCS/Current Procedural Terminology (CPT) code, the applicable state, provider class, modifier, current pricing, the effective date for the current pricing, and previous pricing (if applicable) for the most recent two years, as well as the effective dates for the previous two years pricing. The first report shall be provided to TMA March 1, 2012, with each subsequent report provided the 20th of the month in which the CMAC file is implemented. The report is to be an Excel file and submitted via the E-Commerce Extranet.

- END -

