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TRICARE
MANAGEMENT ACTIVITY

MB&RS

CHANGE 75
6010.55-M
APRIL 10, 2008

CORRECTED TRANSMITTAL

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE REIMBURSEMENT MANUAL (TRM)

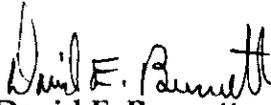
The TRICARE Management Activity has authorized the following addition(s)/revision(s) to the 6010.55-M, issued August 2002.

CHANGE TITLE: TRICARE REIMBURSEMENT MANUAL CHANGE -
CONSOLIDATED

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change extends the Physician Scarcity Area (PSA) bonus payment through June 30, 2008 and makes other clarifying changes.

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


David E. Bennett
Acting Chief, Office of Medical Benefits
and Reimbursement Systems

ATTACHMENT(S): 24 PAGE(S)
DISTRIBUTION: 6010.55-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

CORRECTED TRANSMITTAL

REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 1

Section 11, pages 1 through 5

Section 33, pages 1 and 2

Section 11, pages 1 through 5

Section 33, pages 1 and 2

CHAPTER 2

Section 1, pages 3 and 4

Section 1, pages 3 and 4

CHAPTER 3

Section 1, pages 9 and 10

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CHAPTER 5

Section 2, pages 1 through 3

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DURABLE MEDICAL EQUIPMENT CLAIMS: PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)

ISSUE DATE: December 29, 1982

AUTHORITY: [32 CFR 199.4\(d\)\(3\)\(ii\)](#)

I. APPLICABILITY

This policy is mandatory for reimbursement of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provided by either network or non-network providers. Alternative network reimbursement methodologies are also permitted when approved by the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

II. ISSUE

How are claims for DMEPOS to be reimbursed?

III. POLICY

A. Reimbursement for DMEPOS is established by fee schedules. The maximum allowable amount is limited to the lower of the billed charge, the negotiated rate (network providers) or the DMEPOS fee schedule amount.

B. The DMEPOS fee schedule is categorized by state. The allowed amount shall be that which is in effect in the specific geographic location at the time covered services and supplies are provided to a beneficiary. For DMEPOS delivered to the beneficiary's home, the home address is the controlling factor in pricing and the home address shall be used to determine the DMEPOS allowed amount.

C. Payment for an item of DME may also take into consideration:

1. The lower of the total rental cost for the period of medical necessity or the reasonable purchase cost; and
2. Delivery charge, pick-up charge, shipping and handling charges, and taxes.

D. The fee schedule classifies most DMEPOS into one of six categories.

1. Inexpensive or other routinely purchased DME.
2. Items requiring frequent and substantial servicing.

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CHAPTER 1, SECTION 11

DURABLE MEDICAL EQUIPMENT CLAIMS: PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)

3. Customized items.
4. Other prosthetic and orthotic devices.
5. Capped rental items.
6. Oxygen and oxygen equipment.

E. Inexpensive or routinely purchased DME.

1. Payment for this type of equipment is for rental or lump sum purchase. The total payment may not exceed the actual charge of the fee for a purchase.

2. Inexpensive DME. This category is defined as equipment whose purchase price does not exceed \$150.

3. Other routinely purchased DME. This category consists of equipment that is purchased at least 75% of the time.

4. Modifiers used in this category are as follows (not an all-inclusive list):

- RR Rental
- NU Purchase of new equipment. Only used if new equipment was delivered.
- UE Purchase of used equipment. Used equipment that has been purchased or rented by someone before the current purchase transaction. Used equipment also includes equipment that has been used under circumstances where there has been no commercial transaction (e.g., equipment used for trial periods or as a demonstrator).

F. Items requiring frequent and substantial servicing.

1. Equipment in this category is paid on a rental basis only. Payment is based on the monthly fee schedule amounts until the medical necessity ends. No payment is made for the purchase of equipment, maintenance and servicing, or for replacement of items in this category.

2. Supplies and accessories are not allowed separately.

3. For oxygen and oxygen supplies see [Chapter 1, Section 12](#) and TRICARE Policy Manual ([TPM](#)), [Chapter 8, Section 10.1](#).

G. Certain customized items.

1. The beneficiary's physician must prescribe the customized equipment and provide information regarding the patient's physical and medical status to warrant the need for the equipment.

2. See [TPM, Chapter 9, Section 15.1](#) for further information regarding customization of DME.

H. Capped rental items.

Items in this category are paid on a monthly rental basis not to exceed a period of continuous use of 15 months or on a purchase option basis not to exceed a period of continuous use of 13 months.

I. Rental fee schedule.

1. For the first three rental months, the rental fee schedule is calculated so as to limit the monthly rental of 10% of the average of allowed purchase prices on claims for new equipment during a base period, updated to account for inflation. For each of the remaining months, the monthly rental is limited to 7.5% of the average allowed purchase price. After paying the rental fee schedule amount for 15 months, no further payment may be made except for payment for maintenance and servicing.

2. Modifiers used in this category are as follows:

RR	Rental
KH	First month rental
KI	Second and third month rental
KJ	Fourth to fifteenth months
BR	Beneficiary elected to rent
BP	Beneficiary elected to purchase
BU	Beneficiary has not informed supplier of decision after 30 days
MS	Maintenance and Servicing
NU	New equipment
UE	Used equipment

3. Claims Adjudication Determinations.

a. Adjudication of DME claims involves a two-step sequential process involving the following determinations by the contractor:

(1) **Step 1:** Whether the equipment meets the definition of DME, is medically necessary, and is otherwise covered; and

(2) **Step 2:** Whether the equipment should be rented or obtained through purchase (including lease/purchase). To arrive at a determination, the following information is required:

(a) A physician's statement of the patient's prognosis and the estimated length of medical necessity for the equipment.

(b) The reasonable monthly rental charge.

(c) The reasonable purchase cost of the equipment.

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(d) The contractor must determine whether, given the estimated period of medical necessity, it would be more economical and appropriate for the equipment to be rented or purchased.

b. If the beneficiary opts to rent/purchase, the contractor must establish a mechanism for making regular monthly payments without requiring the claimant to submit a claim each month. (It is not required or expected that the contractor will automate the automatic payment; the volume of this type claim will be quite low.) In cases of "indefinite needs," medical necessity must be evaluated after the first three months and every six months thereafter. Special care should be taken to avoid payment after termination of TRICARE eligibility or in excess of the total allowable benefit. In making monthly payments, the contractor will report on the TRICARE Encounter Data (TED) only that portion of the billed charge which is applicable to that monthly payment. (See the TRICARE Systems Manual (TSM), Chapter 2.) For example, a wheelchair is being purchased for which the total charge is \$770. The contractor determines that payments will be made over a ten month period. The allowed charge is \$600. The contractor will show the monthly billed charge as \$77 and \$60 as the allowed. For **Extended Care Health Option (ECHO)**, the maximum number of contiguous months during which a prorated amount may be authorized for cost-share shall be the lesser of:

(1) The number of months calculated by dividing the initial allowable cost for the item of equipment by \$2,500 and doubling the resulting quotient, or

(2) The number of months of useful equipment life for the requesting beneficiary, as determined by the contractor.

4. Notice To Beneficiary.

When the contractor makes a determination to rent or purchase, the beneficiary shall be notified of that determination. The beneficiary is not required to follow the contractor's determination. He or she may purchase the equipment even though the contractor has determined that rental is more cost effective. However, payment for the equipment will be based on the contractor's determination. Because of this, the notice should be carefully worded to avoid giving any impression that compliance is mandatory, but should caution the beneficiary concerning the expenses in excess of the allowed amount. Suggested wording is included in [Chapter 1, Addendum B](#).

J. Oxygen and oxygen equipment.

Oxygen and oxygen equipment is to be reimbursed in accordance with [Chapter 1, Section 12](#).

K. Parenteral/enteral nutrition therapy - parenteral/enteral pumps can be either rented or purchased.

L. The DMEPOS pricing information is available at <http://www.cms.hhs.gov/suppliers/dmepos> and the claims processors are required to replace the existing pricing with the updated pricing information within 10 calendar days of publication on the internet. See

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the TRICARE Operations Manual (TOM), Chapter 1, Section 4 regarding updating and maintaining TRICARE reimbursement systems.

M. Inclusion or exclusion of a fee schedule amount for an item or service does not imply any TRICARE coverage.

N. Extensive maintenance which, based on manufacturer recommendations, must be performed by authorized technicians is covered as medically necessary. This may include breaking down sealed components and performing tests that require specialized testing equipment not available to the beneficiary. Maintenance may be covered for patient owned-DME when such maintenance must be performed by an authorized technician.

IV. EXCLUSIONS AND LIMITATIONS

A. A cost that is non-advantageous to the government shall not be allowed even when the equipment cannot be rented or purchased within a "reasonable distance" of the beneficiary's current address. The charge for delivery and pick up is an allowable part of the cost of an item; consequently, distance does not limit access to equipment.

B. Line-item interest and carrying charges for equipment purchase shall not be allowed. A lump-sum payment for purchase of an item of equipment is the limit of the government cost-share liability. Interest and carrying charges result from an arrangement between the beneficiary and the equipment vendor for prorated payments of the beneficiary's cost-share liability over time.

C. Routine periodic servicing such as testing, cleaning, regulating, and checking that is generally expected to be done by the owner. Normally, the purchasers are given operating manuals that describe the type of service an owner may perform. Payment is not made for repair, maintenance, and replacement of equipment that requires frequent substantial servicing, oxygen equipment, and capped rental items that the patient has not elected to purchase.

V. EFFECTIVE DATE September 1, 2005.

- END -

BONUS PAYMENTS IN HEALTH PROFESSIONAL SHORTAGE AREAS (HPSA) AND IN PHYSICIAN SCARCITY AREAS (PSA)

ISSUE DATE: April 18, 2003

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 bonus payments in medically underserved areas made?

III. POLICY

A. On April 15, 2002, the **Final Rule** was published in the **Federal Register**. This rule provided for a bonus payment, in addition to the amount normally paid under the allowable charge methodology, to providers in medically underserved areas. Medically underserved areas are the same as those determined by the Secretary of Health and Human Services (**HHS**) for the Medicare program, designated as **Health Professional Shortage Areas (HPSAs)** and **Physician Scarcity Areas (PSAs)** found in all 50 states and Puerto Rico. HPSAs include both primary care and mental health identified HPSAs and PSAs include both primary care and specialty identified PSAs. Only one HPSA bonus can be paid, even if the primary care and mental health HPSAs overlap. This is also true when there is an overlapping of primary care and specialty PSAs.

B. The bonus payments shall be equal to the bonus payments authorized by Medicare, except as necessary to recognize any unique or distinct characteristics or requirements of the CHAMPUS/TRICARE program, and as described in instructions issued by the Executive Director, TMA. The bonus payment, for HPSA, both medical and mental health areas, is 10% of the amount actually paid, not 10% of the amount allowed, e.g., **CHAMPUS Maximum Allowable Charge (CMAC)**. The HPSA bonus payment only applies to physician (as defined in [32 CFR 199.2](#)) services rendered in these medically underserved areas. Effective September 1, 2003, the HPSA bonus payment also applies to podiatrists, oral surgeons, and optometrists. Effective January 1, 2005, the PSA bonus payment is 5% of the amount actually paid to primary care physicians (general practitioners, family physicians, internists, and OB/GYN) and to other specialties. **The PSA bonus only goes through June 30, 2008.** Oral surgeons (dentists), podiatrists, and optometrists are not eligible for the PSA bonus payment.

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For services with both a professional and technical component, only the professional component would be included in the calculation of the bonus payment. The bonus payment is based on where the service is performed which must be in the medically underserved area, not the billing office, etc. The bonus payment applies to both assigned and non-assigned claims. It also applies to network and non-network physicians. In addition, claims filed under Prime, Extra, and Standard for services provided in medically underserved areas can receive the bonus payment. For TFL claims, only those claims where TRICARE is primary would qualify for the bonus payment. For **other health insurance (OHI)** claims, the bonus payment would apply, but only on the amount paid by the government.

C. Depending on the areas, the bonus shall be calculated based on 10% or 5% of the amount actually paid a physician during a calendar quarter for services rendered in a medically underserved area. In order to receive the HPSA bonus payment, the physician must put a "QU" modifier on the claim for services rendered in an urban HPSA and a "QB" modifier on a claim for services rendered in a rural HPSA. In order to receive the PSA bonus payment, the physician must put an "AR" modifier on the claim for services rendered in a PSA. "QB", "QU" and "AR" are modifiers to the CPT/HCPCS procedure codes. The contractor shall sum all claim payments that qualify for the quarter and pay an additional 10% for the "QB" and "QU" modifier claims and an additional 5% for the "AR" modifier claims. An overlapping of HPSAs and PSAs can occur. When this happens, only one HPSA bonus and one PSA bonus can be paid. This means that a maximum of 15% bonus could be paid. The bonus payment shall only be paid quarterly as a pass-through payment (not-at-risk). There are no retroactive payments, adjustments or appeals, for obtaining a bonus payment. The contractor is not responsible for prescreening or post auditing of claims.

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

IV. EFFECTIVE DATE June 1, 2003.

- END -

duty in support of operations that result from the terrorist attacks on the World Trade Center and the Pentagon on September 11, 2001.

(2) The cost-share is partially waived in certain cases for these beneficiaries. On claims from non-participating professional providers for services rendered to Standard beneficiaries, the allowable amount is the lesser of the billed charge or the balance billing limit (115%) of the CMAC. In these cases, the cost-share is 20% of the lesser of the CMAC or the billed charge, and the cost-share for any amounts over the CMAC that are allowed is waived. Any amounts that are allowed over the CMAC will be paid entirely by TRICARE.

(3) The exception to the deductible and cost-share requirements under Operation Noble Eagle/Operation Enduring Freedom for TRICARE Standard and Extra is effective for services rendered from September 14, 2001, through October 31, 2008.

d. For Certain Reservists. The Director, TRICARE Management Activity, may waive the individual or family deductible for dependents of a reserve component member who is called or ordered to active duty for a period of more than 30 days but less than one year in support of a contingency operation. For this purpose, a reserve component member is either a member of the reserves or National Guard member who is called or ordered to full-time federal National Guard duty. A contingency operation is defined in 10 U.S.C. 101(a)(13). Also, for this purpose a dependent is a lawful husband or wife of the member or an eligible child.

B. TRICARE Prime.

1. Copayments and enrollment fees under TRICARE Prime are subject to review and annual updating. See [Chapter 2, Addendum A](#) for additional information on the benefits and costs. In accordance with Section 752 of the National Defense Authorization Act, P.L. 106-398, for services provided on or after April 1, 2001, a \$0 copayment shall be charged to TRICARE Prime ADFMs of active duty service members (ADSMs) who are enrolled in TRICARE Prime. Pharmacy copayments and Point of Service charges are not waived by the FY01 Authorization Act.

2. In instances where the CMAC or allowable charge is less than the copayment shown on [Addendum A](#), network providers may only collect the lower of the allowable charge or the applicable copayment.

3. The TRICARE Prime copayment requirement for emergency room services is on a PER VISIT basis; this means that only one copayment is applicable to the entire emergency room episode, regardless of the number of providers involved in the patient's care and regardless of their status as network providers.

4. No copayments or authorizations are required for TRICARE Prime clinical preventive services which are described in the TPM, [Chapter 7, Section 2.2](#).

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CHAPTER 2, SECTION 1 COST-SHARES AND DEDUCTIBLES

5. Effective for care provided on or after March 26, 1998, Prime enrollees shall have no copayments for ancillary services in the categories listed below (normal referral and authorization provisions apply):

a. Diagnostic radiology and ultrasound services included in the CPT¹ procedure code range from 70000 through 76999, **or any other code for associated contrast media**;

b. Diagnostic nuclear medicine services included in the CPT¹ procedure code range from 78000 through 78999;

c. Pathology and laboratory services included in the CPT¹ procedure code range from 80000 through 89399; and

d. Cardiovascular studies included in the CPT¹ procedure code range from 93000 through 93350.

e. Venipuncture included in the CPT¹ procedure code range from 36400 - 36416.

f. Fetal monitoring for CPT¹ procedure codes 59020, 59025, and 59050.

NOTE: Contractors are not required to search their files for claims for ancillary services which were not processed according to these guidelines. The contractor shall, however, if requested by an appropriate individual, adjust specific claims under these guidelines if the date of service is on or after March 26, 1998.

6. Point of Service (POS) option. See [Chapter 2, Section 3](#).

C. Basic Program: TRICARE Standard.

1. Deductible Amount: Outpatient Care.

a. For care rendered all eligible beneficiaries prior to April 1, 1991, or when the active duty sponsor's pay grade is E-4 or below, regardless of the date of care:

(1) Deductible, Individual: Each beneficiary is liable for the first fifty dollars (\$50.00) of the TRICARE-determined allowable amount on claims for care provided in the same fiscal year.

(2) Deductible, Family: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed one hundred dollars (\$100.00).

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CHAPTER 3, SECTION 1

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

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](#)).

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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

HOSPITAL AND OTHER INSTITUTIONAL REIMBURSEMENT

ISSUE DATE:

AUTHORITY:

I. INTRODUCTION

TRICARE reimbursement of a non-network institutional health care provider shall be determined under the TRICARE DRG-based payment system as outlined in [Chapter 6](#) or other TRICARE-approved method. Other methodologies must be proposed in writing and approved by the Contracting Officer. The procedures below are not required for reimbursement of the network providers of care. The contractor and network providers are free to negotiate any mutually agreeable reimbursement mechanism which complies with state and federal laws. Any agreement, however, in which the methodology deviates from the accepted contract proposal methodology and which is detrimental to the TRICARE beneficiary or to the government may be rejected by the Contracting Officer, and any agreement which calls for reimbursement at higher rates than those approved for standard TRICARE must be approved by the Contracting Officer.

II. PAYMENT OF CAPITAL AND DIRECT MEDICAL EDUCATION (CAP/DME) COST

A. General

The contractor will make an annual payment to each hospital subject to the TRICARE/CHAMPUS DRG-Based Payment System (except children's hospitals) which requests reimbursement for capital and direct medical education costs, CAP/DME. The payment will be computed based on [Chapter 6, Section 8](#). These procedures will apply to all types of CAP/DME payments (including active duty). All CAP/DME payments will be non-financially underwritten and will be made from the non-financially underwritten, bank account (see the TRICARE Operations Manual ([TOM](#)), [Chapter 3, Section 2](#)).

B. Payment Procedures

The contractor shall use the following procedures **and the procedures in the TOM, Chapter 3**, in making CAP/DME payments to hospitals:

1. Receive claim or request for payment from the hospital.
2. Compute the amount due for each hospital submitting claims during a month, stopping processing prior to check write.

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3. Submit a voucher in an electronic format to the TRICARE Management Activity (TMA), Contract Resource Management (CRM) (see the TOM, [Chapter 3, Addendum A, Figure 3-A-8](#)). (A fax copy is not necessary.)

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

C. Adjustments For Underpayments

The contractor shall determine the amount of the underpayment and pay any additional payment to the hospital with the next group of checks being cut and report as a payment as described in [paragraph II.B.](#) above.

D. Recoupment Of Erroneous CAP/DME Payments

If the contractor overpays a provider for CAP/DME claims, the contractor shall follow recoupment procedures as specified in the TOM, [Chapter 11, Section 4](#) to include offsetting overpayments against future payments.

1. Offset funds shall be included as credits on the monthly CAP/DME voucher for the month the credits were processed.

2. Collections shall be included as separate lines indicating the month the collection was deposited (normally the prior month).

3. Debts established under this paragraph and related transactions shall be reported on the monthly Accounts Receivable Report (see the TOM, [Chapter 3, Section 10, paragraph 2.0.](#)).

III. TRICARE INPATIENT MENTAL HEALTH PER DIEM PAYMENT SYSTEM

See [Chapter 7, Section 1](#), for additional instructions. See [paragraph II.](#), for voucher preparation instructions. Effective for all admissions occurring on or after January 1, 1989, non-network inpatient mental health care shall be paid based on a per diem rate determined by TMA and provided to the contractor. Network inpatient mental health care may be paid at a rate negotiated by the contractor which is different from the inpatient mental health per diem; however, a higher rate must be approved by the Contracting Officer and the beneficiary's cost-share must be computed to be the lesser of the amount which would apply under the per diem rate or the contractor-negotiated rate. The TRICARE-determined rate shall apply to any out-of-region beneficiaries who are admitted to the facility.

IV. INPATIENT MENTAL HEALTH HOSPITAL, PARTIAL HOSPITALIZATION, AND RESIDENTIAL TREATMENT CENTER (RTC) FACILITY RATES

Effective with Fiscal Year 1998, contractors shall submit three iterations of inpatient mental health, partial hospitalization (half day-three to five hours and full day-six or more hours) and RTC rates by facility to the TMA, Office of Medical Benefits and Reimbursement Systems-Aurora (MB&RS). This data shall be reported in [an Excel spreadsheet](#). The information shall include the Name of the Facility, Provider Number and the Location of the

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Facility. For inpatient mental health facilities indicate whether the facility is high volume or low volume and if high volume, the date when the facility became high volume. In addition, if a high volume inpatient mental health facility or RTC has been limited to a cap amount, so indicate. (See [32 CFR 199.14](#) and [Chapter 7, Section 1 and 4.](#)) For those psychiatric hospitals affected by the deflator computation, the contractor shall submit the high volume rate no later than 30 days from the date the deflator factor is received. The data shall be submitted using the following format:

NOTE: After year 2000 change number of iterations to submit only current year.

A	B	C
1	Field Name	Picture Comments
2	Provider/Facility Number	X(9) Employer Identification Number
3	Fiscal Year	9(2) Current Fiscal Year plus the two previous Fiscal Year Iterations
4	Facility Type	9(1) 1=Inpatient 2=Half Day Partial 3=Full Day Partial 4=RTC
5	Facility Name	X(40) Name of the Facility Providing the Treatment
6	Facility Street Address	X(30) Street Address of the Facility
7	Facility City	X(18) City Where the Facility is Located
8	Facility State or Country Code	X(2) State or Country Where Facility is Located (Alpha Code) (TRICARE Systems Manual (TSM), Chapter 2)
9	Facility Zip Code	X(9) Zip Code Where Facility is Located
10	Per Diem Rate (Separate Record for each Per Diem Rate)	9(7)v99 1=Inpatient High Volume Per Diem Rate 2=Inpatient Low Volume Per Diem Rate - Adjusted by Wage Index and IDME Factors 3=Half Day Partial Hospitalization Per Diem Rate 4=Full Day Partial Hospitalization Per Diem Rate 5=RTC Per Diem Rate
11	High Volume Indicator	X(1) Indicates if Facility is High Volume (1=True, 0=False)
12	High Volume Date	9(8) If High Volume Indicator is True - Date Facility Became High Volume YYYYMMDD
13	High Volume Per Diem or RTC at Cap Amount	9(7)v99 If Per Diem has been Limited by Cap Amount, Provide Capped Amount

V. BILLED CHARGES/SET RATES

When a beneficiary is not enrolled in TRICARE Prime, the contractor shall reimburse for institutional care received from non-network providers on the basis of billed charges, if reasonable for the area and type of institution, or on the basis of rates set by statute or some other arrangement. The basic guidance shall be that the beneficiary's share shall not be increased above that which would have been required by payment of a reasonable billed charge.

A. Verification Of Billed Services

Reimbursement of billed charges should be subjected to tests of reasonableness performed by the contractor. These tests should be used to protect against both inadvertent and intentional practices of overbilling and/or supplying of excessive services. The contractor should verify that no mathematical errors have been made in the bill.

B. Use Of Local Or State Regulatory Authority Allowed Charges

There are instances in which a local or state regulatory authority, in an attempt to control costs, has established allowable charges for the citizens of a community or state. If such allowable charges have been extended to TRICARE beneficiaries by consent, agreement, or law, and if they are generally (not on a case by case basis) less than TRICARE would otherwise reimburse, the contractor should use such rates in determining TRICARE reimbursement. However, if a state creates a reimbursement system which would result in payments greater than the hospital's normal billed charges, the contractor should not use the state-determined amounts.

C. Discounts Or Reductions

Contractors should attempt to take advantage of all available discounts or rate reductions when they do not conflict with other requirements of the Program. When such a discount or charge reduction is available but the contractor is uncertain whether it would conform to its TRICARE contract, TMA should be contacted for direction.

D. All-Inclusive Rate Providers

All-inclusive rates may be reimbursed if the contractor verifies that the provider cannot adequately itemize its bills to provide the normally required TRICARE Encounter Data (TED). Further, the contractor must ensure that appropriate revenue codes are included on the claim (as well as all other required UB-92 information), even though itemized charges are not required to be associated with the revenue codes. When a contractor reimburses a provider based on an all-inclusive rate, the contractor shall maintain documentation of its actions in approving the all-inclusive rate. The documentation must be available to TMA upon request. (Also, see [Chapter 1, Section 22.](#))

VI. SPECIAL REIMBURSEMENT PROCEDURES FOR CERTAIN RESIDENTIAL TREATMENT CENTERS (RTCs)

The contractor shall pay the network RTCs based on agreements as negotiated by the

LOCALITY-BASED REIMBURSEMENT RATE WAIVER

ISSUE DATE: September 27, 2001

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

What is the process of the locality-based reimbursement rate waivers?

III. POLICY

A. On August 28, 2001, the **Final Rule** was published in the **Federal Register** implementing the FY 2000 and FY 2001 National Defense Authorization Acts (**NDAAs**) pertaining to waivers to the CHAMPUS Maximum Allowable Charge (**CMAC**) to ensure access to health care services in the state or locality, assuming that the services are available.

B. Under the locality-based reimbursement rate waiver, two access locations may be considered for provider reimbursement rates above the CMAC. These are:

1. **Network Waivers:** If it is determined that access to health care services is severely impaired, higher rates may be necessary to ensure the availability of an adequate number and mix of qualified network providers. The amount of reimbursement would be limited to the lesser of (a) an amount equal to the local fee for service charge; or (b) up to 115% of the CMAC. Our first attempt should be to get the provider to join the network at the prevailing CMAC rate.

2. **Locality Waivers:** If it is determined that access to specific health care services is severely impaired, higher payment rates could be applied to all similar services performed in a locality, or a new locality could be defined for application of the higher payment rates. Payment rates could be established through addition of a percentage factor to an otherwise applicable payment amount, or by calculating a prevailing charge, or by using another government payment rate. Higher payments will be paid on a claim by claim basis.

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 5, SECTION 2

LOCALITY-BASED REIMBURSEMENT RATE WAIVER

C. Coordination of the request for a locality-based reimbursement rate waiver shall be submitted to the TMA **Chief, Medical Benefits and Reimbursement Systems (MB&RS)** by the Director, TRICARE Regional Office (DTRO). The Director shall work with the Managed Care Support Contractor (MCSC) to ensure that both are in agreement with the waiver request.

D. The procedures that are to be followed when submitting a waiver are as follows:

1. Identify the waiver that is being requested.

a. Network waivers - needed to ensure availability of an adequate number and mix of qualified network providers.

b. Locality waivers - needed to ensure access to services in a locality defined by a current TRICARE locality or a new one established by zip code.

2. Who can apply:

a. **DTRO**

b. Providers through the DTRO

c. Beneficiaries through the DTRO

d. **MCSC** through the DTRO

e. **Military Treatment Facility (MTF) through the DTRO**

3. How to apply:

a. Applicant must submit a written waiver request to the DTRO. The request must justify that access to health care services is severely impaired due to low reimbursement levels (CMAC payment rates).

b. Justification for the waiver must include at the minimum:

- Number of providers in a locality

- Mix of primary/specialty providers needed to meet patient access standards

- Number of providers who are TRICARE participating

- Number of eligible beneficiaries in the locality

- Availability of MTF providers

- Geographic characteristics

- Efforts that have attempted to create an adequate network, including any additional non-health care payments above the CMAC rates made by the MCSC.

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CHAPTER 5, SECTION 2

LOCALITY-BASED REIMBURSEMENT RATE WAIVER

- Letters of intent
- Cost effectiveness
- Other relevant factors that warrant the higher payment to resolve the access to care issue

E. The DTRO shall conduct a thorough analysis and forward recommendations with a cost estimate for approval to the TMA Director **or designee** through the TMA Contracting Officer (CO) for coordination. Disapprovals by the DTRO will not be forwarded to the TMA Director **or designee**. The TMA Director **or designee** is the final approval authority. A decision by the TMA Director **or designee** to authorize, not authorize, terminate, or modify the authorization of higher payment amounts is not subject to appeal.

1. Network waivers: If the TMA Director **or designee** approves an increase of up to 15% above the CMAC, the contractor will have the authority to offer designated providers up to 15% above CMAC for joining the network.

2. Locality waivers: If the TMA Director **or designee** approves a higher payment rate for certain services in a locality, reimbursement rates for those procedure codes in that locality would be adjusted by the managed care support contractor in order to improve the access to services.

- END -

ALLOWABLE CHARGES - CHAMPUS MAXIMUM ALLOWABLE CHARGES (CMAC)

ISSUE DATE: March 3, 1992

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.

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ALLOWABLE CHARGES - CHAMPUS MAXIMUM ALLOWABLE CHARGES (CMAC)

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

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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.

α. 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

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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, occupational therapists, speech therapists, physical therapists, and audiologists provided in a facility including hospitals (both inpatient and outpatient where the hospital is generating a revenue bill, i.e., revenue code 0510), residential treatment centers, ambulances, hospices, military treatment facilities, psychiatric facilities, community mental health centers, skilled nursing facilities, ambulatory surgical centers, etc.

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Category 2: Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, and audiologists provided in a non-facility including provider offices, home settings, and all other non-facility settings.

Category 3: Services, of all other providers not found in Category 1, provided in a facility including hospitals (both inpatient and outpatient where the hospital is generating a revenue bill, i.e., revenue code 0510), residential treatment centers, ambulances, hospices, military treatment facilities, psychiatric facilities, community mental health centers, skilled nursing facilities, ambulatory surgical centers, 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 OPSS exempt providers.

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

d. Reimbursement Hierarchy For Procedures Paid Outside The OPSS.

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

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
1	Non-facility CMAC for physician/LLP class
2	Facility CMAC for physician/LLP class
3	Non-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, 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.

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COLUMN	DESCRIPTION
4	Facility CMAC for non-physician class
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.

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 OPPTS for services rendered on or after implementation of OPPTS. 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.

- END -