



DEFENSE  
HEALTH AGENCY

**MB&RO**

**OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS  
16401 EAST CENTRETECH PARKWAY  
AURORA, CO 80011-9066**

**CHANGE 90  
6010.58-M  
NOVEMBER 21, 2013**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE REIMBURSEMENT MANUAL (TRM), FEBRUARY 2008**

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

**CHANGE TITLE: TRICARE BUNDLED HEALTHCARE COMMON PROCEDURE CODING SYSTEM  
CODES NOT PAID SEPARATELY**

**CONREQ: 16079**

**PAGE CHANGE(S): See page 2.**

**SUMMARY OF CHANGE(S):** This change establishes policy to adopt a bundling provision as under Medicare's Physicians Fee Schedule. The bundled codes will be found on a TRICARE Management Activity (TMA) website and updated with the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (CMAC) updates.

**EFFECTIVE DATE: October 1, 2013.**

**IMPLEMENTATION DATE: Upon direction of the Contracting Officer.**

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Date: 2013.11.18 07:59:41 -07'00'

**Ann N. Fazzini  
Team Chief, Medical Benefits &  
Reimbursement Office (MB&RO)  
Defense Health Agency (DHA)**

**ATTACHMENT(S): 4 PAGE(S)  
DISTRIBUTION: 6010.58-M**

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

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6010.58-M  
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**REMOVE PAGE(S)**

**CHAPTER 5**

Section 3, pages 3 - 5

**INSERT PAGE(S)**

Section 3, pages 3 - 6

# TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

## Chapter 5, Section 3

### CHAMPUS Maximum Allowable Charges (CMAC)

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**Note:** Effective for services provided on or after October 1, 2013, TRICARE adopts Medicare's Ambulance Fee Schedule (AFS) as the TRICARE CMAC for ambulance services, in accordance with 32 CFR 199.14(j)(1)(i)(A). See Chapter 1, Section 14. The AFS reimbursement methodology does not apply to the TRICARE Overseas Program (TOP), except for Puerto Rico.

#### **3.4 Bundled Codes**

**3.4.1** Bundled codes are codes for which payment is included in the payment for another service under the Physician Fee Schedule or CMAC, for professional services.

**3.4.2** There are a number of services/supplies that are covered under TRICARE and that have Healthcare Common Procedure Coding System (HCPCS) codes, but they are services for which TRICARE bundles payment into the payment for other related services. If contractors receive a claim that is solely for a service or supply that must be bundled, the claim for payment shall be denied by the contractor. Separate payment is never made for routinely bundled services and supplies. A listing of these "bundled" codes will be maintained on TMA's Rates and Reimbursement web site (<http://www.tricare.mil/tma/Rates.aspx>) and updated each year in conjunction with the annual CMAC update.

**3.5** 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 Operations Manual (TOM), Chapter 24, Section 9. Guam and the U.S. Virgin Islands are to still be paid as billed for professional services.

**3.6** 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. MCSCs shall be notified when the annual update is delayed.

**3.7** Provisions which affect the TRICARE allowable charge payment methodology.

**3.7.1** Reductions in maximum allowable payments to Medicare levels.

#### **3.7.2 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.

#### **3.7.2.1 Categories**

- Category 1: Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, audiologists, and Certified Nurse Midwives (CNMs) 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, MTFs, psychiatric

## TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

### Chapter 5, Section 3

#### CHAMPUS Maximum Allowable Charges (CMAC)

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, audiologists, and CNMs 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.

#### 3.7.2.2 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.

#### 3.7.2.3 Payment Of 0510 And 0760 Series Revenue Codes

Effective for services on or after May 1, 2009 (implementation of Outpatient Prospective Payment System (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.

#### 3.7.2.4 Reimbursement Hierarchy For Procedures Paid Outside The OPPS

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

**3.7.2.4.1.1** 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 6010.58-M, February 1, 2008**

Chapter 5, Section 3

CHAMPUS Maximum Allowable Charges (CMAC)

COLUMN	DESCRIPTION
5	Physician class Professional Component (PC) rate
6	Physician class Technical Component (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.

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

**3.7.2.4.2** DMEPOS. If there is no DMEPOS available, the contractor shall reimburse the procedure using state prevailings.

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

**3.7.2.5** 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.

**3.7.3** 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 OPSS for services rendered on or after May 1, 2009 (implementation of OPSS). Refer to [Chapter 1, Section 16, paragraphs 3.1.1.1 through 3.1.1.3](#) and [Chapter 13, Section 3, paragraphs 3.1.5.2 and 3.1.5.3](#) for further detail.

**3.7.4** 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.

**3.7.5** 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.

**3.7.5.1** 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.

**TRICARE Reimbursement Manual 6010.58-M, February 1, 2008**

Chapter 5, Section 3

CHAMPUS Maximum Allowable Charges (CMAC)

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**3.7.5.2** Contractors shall create a state prevailing annual report as described in the Contract Data Requirements List (CDRL) DD Form 1423.

**3.7.6** Effective for services provided on or after October 1, 2011, the payment for CNMs is to be made at 100 percent of the physician provider class. For services provided prior to October 1, 2011, CNMs are paid at the non-physician provider class.

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