CHAPTER 13
SECTION 1.5

ALLOWABLE CHARGES - CHAMPUS MAXIMUM ALLOWABLE CHARGES (CMAC)

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I. ISSUE

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

II. 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 1991, Public Law 101-511, Section 8012, which limits increases in maximum allowable payments to physicians and other individual health care providers and authorizes reductions in such amounts for overpriced procedures. Specific reimbursement methods were established and were originally to be effective on January 1, 1992, but were delayed until May 1, 1992. The specific reimbursement methods are as follows:

1. Prevailing charge level.

a. Beginning May 1, 1992, the prevailing charge level shall be calculated on a national basis, then adjusted for localities.

b. The national prevailing charge level is the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period (12 months ended June 30, 1991).

c. The base period shall be a period of 12 calendar months and the prevailing charge shall be adjusted once a year unless otherwise changed by the TRICARE Management Activity (TMA).

2. Appropriate charge level. (Referred to as the maximum allowable prevailing charge, MAPC, in Chapter 13, Section 1.3.)

a. Beginning May 1, 1992, the appropriate charge level shall be calculated on a national basis, then adjusted for localities.

b. The appropriate charge level shall be established from a 1991 national appropriate charge file developed from the 7/86-6/87 claims data, by applying appropriate

Medicare Economic Index (MEI) updates through 1990, and prevailing charge cuts, freezes, or MEI updates for 1991 as prescribed in the September 6, 1991, final rule. As outlined in the final rule, any TRICARE/CHAMPUS prevailing charge that was reduced to less than 150 percent of the Medicare Resource-Based Relative Value Scale (RBRVS) value by the 1991 cuts shall be restored to its former level for the 1992 prevailing calculations.

(1) For each CPT-4 code, the 1991 national appropriate charge described above shall be compared to the final Medicare RBRVS fee schedule values, and the ratio of the TRICARE/CHAMPUS 1991 appropriate charge to the Medicare fee schedule value shall be calculated.

(2) If the ratio of the 1991 national TRICARE/CHAMPUS appropriate charge to Medicare RBRVS value calculated in (1) is higher than 1.5, the appropriate charge shall be cut the minimum of 15 percent or the percent necessary to reach the 1.5 ratio level. If the ratio calculated in (1) is less than 1.5 and the procedure is not primary care, the 1991 appropriate charge shall not be adjusted. If the procedure is primary care and the ratio is not greater than 1.5, the 1991 appropriate charge shall be increased by the MEI. This new charge level shall be considered the 1992 national TRICARE/CHAMPUS appropriate charge level for a procedure for services rendered on or after May 1, 1992.

(3) In the case of procedures for which there is no value in the 1991 appropriate charge file (for example, because a new CPT-4 code was added after 6/87), the national prevailing charge level will be used in the calculations in paragraph II.A.2.b.(2) above.

c. The appropriate charge level for each procedure is the product of the following two-step process:

(1) All procedures are classified into one of three categories.

(a) Overpriced procedures

(b) Primary care procedures

(c) Other procedures

(2) For each year, appropriate charge levels shall be calculated by adjusting the prior year's appropriate charge levels.

(a) For overpriced procedures, the prior year's appropriate charge level for each procedure shall be reduced by the lesser of the percentage by which it exceeds 150 percent of the Medicare converted relative value unit of fifteen percent.

(b) For primary care procedures, the prior year's appropriate charge level shall be adjusted by the Medicare Economic Index (MEI), as the MEI is applied to Medicare prevailing charge levels.

(c) For other procedures, the prior year's appropriate charge level for each procedure shall be continued.

3. Locality adjusted charge levels.

a. The national prevailing charge levels and the national appropriate charge levels shall be adjusted for localities using the same (or similar) geographical areas and the same geographic adjustment factors as are used for determining allowable charges under Medicare.

B. The allowable charge for authorized care shall be the lowest of the billed charge, the national prevailing charge level of a procedure adjusted by the appropriate local geographic adjustment factor, or the national appropriate charge level of a procedure adjusted by the appropriate local geographic adjustment factor.

1. TRICARE/CHAMPUS refers to the lower of the national prevailing charge level or the national appropriate charge level as the CHAMPUS Maximum Allowable Charge (CMAC).

2. The national CMACs (including the 1992) shall be converted to local geographic levels (Medicare locality) using the Medicare Geographic Practice Cost Indices (GPCIs). This conversion process requires two steps.

a. The contractor shall determine which Medicare locality pertains to a provider's claim by examining the provider's zip code on the provider file at the time the claim is processed and using a zip code/Medicare locality crosswalk. See below the additional discussion of the zip code fill.

b. For each Medicare locality, there are three different GPCIs which pertain to the three separate components of the Medicare RBRVS value (work, overhead, and malpractice insurance). In order to calculate a locally-adjusted Medicare RBRVS value, each component of the RBRVS value is multiplied by its particular GPCI. This must be done separately for each procedure code because the proportion of the total RBRVS value that is allocated to the three separate components varies for each procedure. For example, work may constitute 50 percent of the total value for one procedure, but only 33 percent of another. (On average, work represents 54.2 percent of the total value, overhead accounts for 41.0 percent, and malpractice insurance is 4.8 percent.) This variance in the tree RBRVS components requires that TRICARE/CHAMPUS calculate a unique overall Geographic Adjustment Factor (GAF) for each CPT-4 code for each locality. The GAF is the weighted overage of the tree GPCIs, where the weights are the percentages of the total RBRVS value allocated to each component.

(1) TRICARE/CHAMPUS shall calculate the procedure-specific GAF using the following formula:

GAF = (Work % * Work GPCI) + (Overhead % * Overhead GPCI) + Malpractice % * Malpractice GPCI)

EXAMPLE: for CPT-4 code 33512 in Colorado:

RBRVS Components:	WORK	OVERHEAD	MALPRACTICE
Portion of Total	.3593	.5453	.0954
Colorado GPCIs	.999	.988	.683
National CMAC =	$3,000		

GAF CALCULATION:
GAF = (.3593 * .999) + (.5453 * .988) + (.0954 * .683) = .9629
Locally-Adj. CMAC = .9629 * $3,000 = $ 2,889

(2) TRICARE/CHAMPUS shall then calculate the locally-adjusted appropriate charge by multiplying the national CMAC (including the 1992) by the GAF. This calculated amount shall be called the Locally-adjusted CMAC for each CPT-4 procedure. The contractors shall be provided files by TMA which contain the locally-adjusted CMAC for each CPT-4 code (for each Medicare locality, a file listing each CPT-4 code and the calculated locality-adjusted CMAC) and for each payment locality (identified by zip codes within the locality -- the zip code/Medicare locality crosswalk).

(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 provider's zip code will be the zip of his/her office practice. The contractors are to use the provider's zip code on the provider file at the time the claim is processed and not the zip code on the claim. 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 (ADP Manual, Chapter 2, Section 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. The final rule provided for the setting of TRICARE/CHAMPUS 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. Each calendar quarter, a new zip code/Medicare locality file shall be provided to the contractors. 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. 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 2-digit state code [both alphabetic abbreviations and Federal Information Processing System (FIPS) codes], the 5-digit zip code, and a 3-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 7-digit Medicare codes and how they correspond to each of the 3-digit codes will e provided to the contractors.

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

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

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

4. TMA CMAC support contractor shall also provide quarterly updates (replacement file/cartridge) to the contractors on new zip codes and their Medicare locality. The contractors are to have the updates on the zip code file implemented and available for claims received on and after the first day of the second month in the quarter, e.g., August 1.

5. TMA CMAC support contractor shall also provide a quarterly updated pricing file (replacement file/tape) to the contractors. Both zip code replacement file and the pricing replacement file will be provided on the tenth day of the start of each quarter, e.g., July 10. Both of these files will be accumulative. The updated pricing file will contain the Medicare locality and the CMAC for each procedure code within each given Medicare locality. The main purpose of the update tapes is to provide the contractors with any changes that have been made to the CMACs and the zip codes. The contractors are to inform TMA (PAA) of any missing CMAC price, locality, or zip code so that it can be included in the next update. The contractors are to have the updates on the CMAC tape implemented and available for claims received on and after the first day of the second month in the quarter, e.g., August 1. Each quarterly update tape will have an effective date given with the specific procedure code and CMAC correction. The effective date is defined as the date the CMAC was originally effective. The correction date is defined as the date on which the correct CMAC will be used for claims and adjustments processed on and after that correction date. For audit trail purposes, both the originally calculated CMAC and the corrected CMAC will be on the quarterly CMAC update tape. Interim updates, not annual or quarterly, are to be entered on the contractor's system no later than ten (10) work days after receipt by the contractor. The most recent update (change record) is to be added above the old one(s). When new records are added above the old ones, the first record that would be found in the file for a given CPT-4 code would be the most current information. All variables shall be zero-filled and right-adjusted. CMAC variables will have two implied decimal places.

6. TMA will provide the contractors with national conversion factors (CF) for most professional services (medical and surgical), adjusted to each Medicare locality. Separate CFs will be provided for medical, surgical, radiology, and pathology services for each of the Medicare localities and for each of the four classes of providers. The national CFs will be used by the contractors in pricing "by report" and "unlisted" procedures. The contractors' medical consultants are to use the Medicare RVUs as published in the Federal Register, in estimating an RVU when they apply the national conversion factors. See Chapter 13, Section 1.5, Addendum 1.

NOTE: The national conversion factors are not to be applied to anesthesiology, lab, DME, routine dental, Program for Persons with Disabilities, and other non-professional services such as drugs, supplies, facility charges, or ambulance services.

National conversion factors will be provided in a separate pricing file. The layout for this file is as follows:

VARIABLE	COLUMNS	DATA TYPE COMMENTS
TRICARE/CHAMPUS Locality No.	1-3	range 001-225*
Class 01 CF - Medical	4-8	
Class 01 CF - Surgical	9-13	
Class 01 CF - Radiology	14-18	
Class 01 CF - Pathology	19-23	
Class 04 CF - Medical	24-28	
Class 04 CF - Surgical	29-33	
Class 04 CF - Radiology	34-38	
Class 04 CF - Pathology	39-43	
Class 02 CF - Medical	44-48	
Class 03 CF - Medical	49-53	
*NOTE: * For services provided on or after February 1, 1998, the range is 301 - 389.*		

The file shall be on a 3.5" diskette in ASCII character data. All variables shall be zero-filled and right-adjusted. All conversion factor variables will have two implied decimal places.

D. Categories of care not subject to the National Allowable Charge System.

1. Pricing for certain categories of health care shall remain the responsibility of the contractor (see Chapter 13, Section 1.5, Addendum 1). The following categories will continue to be priced under current contractor procedures:

Durable Medical Equipment (DME)

Routine Dental (ADA codes)

Anesthesiology

Lab (as designated in Chapter 13, Section 1.5, Addendum 1)

Ambulance

Special purpose procedural codes included in the ADP Manual, Chapter 2, Addendum F. (See Chapter 13, Section 1.5, Addendum 1 for specific designation of pricing responsibility.)

2. The contractors shall continue paying claims for new procedures following current policy as described in the OPM Part Two, Chapter 4. However, a new set of locally-adjusted prevailing charges shall be provided to each contractor annually, and these update files shall include new codes for which sufficient claims data exist to calculate locally-adjusted prevailing charges.

3. Low volume procedures are now defined as those procedures with less than eight claims nationally per year. In the past, low-volume was designate on the state level. Under the new system, there shall be fewer low-volume codes because there shall typically be enough claims on a national level to create locally-adjusted prevailing charges. For cases where there are fewer than eight claims nationally and the contractor has not been provided with a locally-adjusted prevailing, the contractors shall follow current policies as described in the Operations Manual.

NOTE: The definition of a low volume procedure as less than fifty (50) claims began with the first CMAC file update occurring after April 1, 1994. For CMAC file changes on or before April 1, 1994, a low volume procedure was less than eight claims.

E. The following procedures which may have been separately reimbursed in the past are no longer eligible for separate TRICARE/CHAMPUS cost-sharing. Payment for these services is included in the payment for other services.

15850	Remove sutures under anes., same surgeon
20930	Allograft, morselized
20936	Autograft, same incision
22841	Internal spinal fixation
78890	Generation of automated data <= 30 min.
78891	Generation of automated data > 30 min.
90885	Psych. eval. of records, reports, tests
92340-92342	Fitting of spectacles
92352-92358	Special services for aphakia
92370-92371	Repair and refit spectacles
92531-92534	Vestibular function tests
94150	Vital Capacity, Total (Separate Procedure)

97010	Hot or cold packs
99024	Post-op follow-up visit incl. in global service
99025	Initial patient visit when minor surg. done
99050	Visit after normal office hours
99052	Visit 10pm-8am
99054	Visit on Sunday/holiday
99056	Visit outside office due to patient request
99058	Office services on emergency basis
99288	Physician direction of EMS/ALS
99358, 99359	Prolonged E&M services before/after visit
99376	Care plan oversight > 60 min

F. The CHAMPUS Maximum Allowable Charge (CMAC) applies to all fifty states and Puerto Rico. Guam and the Virgin Islands are to still be paid as other foreign countries as billed for professional services.

G. The Appropriations Act of Fiscal Year 1993, Public Law 102-396, Section 9011 had several provisions which affects the TRICARE/CHAMPUS allowable charge payment methodology.

1. Reductions in maximum allowable payments.

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

b. The appropriate reductions are reflected in the CMACs for services rendered and paid on or after November 1, 1993.

2. Balance billing limitation.

a. Nonparticipating providers may not balance bill a beneficiary an amount which exceeds the applicable balance billing limit. This limit is 115 percent of the TRICARE/CHAMPUS allowable charge. (Also see Chapter 11, Section 14.1 and Chapter 13, Section 1.4 and Chapter 13, Section 3.7.)

b. Failure by a provider to comply with this requirement is a basis for exclusion from the TRICARE/CHAMPUS program.

c. Effective November 1, 1993. See OPM Part Two, Chapter 4 for specific application of this date.

H. National Defense Authorization Act for Fiscal Year 1992, 10 USC Section 1106 had several provisions which affect the TRICARE/CHAMPUS allowable charge payment methodology.

1. Change in the claims filing deadline.

a. All (including beneficiary) claims must be filed with the appropriate contractor no later than one year after the services are provided. For inpatient admissions, facility charges (not professional charges) must be filed with the appropriate contractor no later than one year after the date of discharge.

b. Effective January 1, 1993. See OPM Part Two, Chapter 1 for specific application of this date.

2. Filing of claims by providers.

a. With the signing (November 18, 1997) of the Department of Defense Authorization Act of 1998 (Public Law 105-85) the claims filing process returns to the status that existed before October 1, 1996, when the requirement to file claims was imposed on non-participating providers by the National Defense Authorization Act for Fiscal Year 1992.

b. See OPM Part Two, Chapter 1.

I. The Appropriations Act for Fiscal Year 1994, Public Law 103-139, Section 8010, enacted November 11, 1993, had several provisions which affect the TRICARE/CHAMPUS allowable charge payment methodology.

1. Reduction in maximum allowable payments.

a. This Act authorizes reductions in maximum allowable payments to physicians and other individual professional providers (including clinical laboratories) for overpriced procedures. These are the procedures for which the prior year's national CHAMPUS Maximum Allowable Charge (CMAC) exceeds the Medicare fee. In such comparisons, reduction will be the lesser of the percentage by which the CMAC exceeds the Medicare fee, ratio level of 1.0, or fifteen (15) percent (except that the reduction may be waived if determined to impair adequate access to health care services for beneficiaries).

b. The appropriate reductions are reflected in the CMACs for services rendered and paid on or after April 1, 1994.

2. This Act authorizes an increase when justified by economic circumstances. The CHAMPUS maximum allowable charge may be increased in accordance with Medicare's economic index. Such increases are reflected in the CMACs for services rendered and paid on or after April 1, 1994.

J. The first CMAC file update for 1999, raises all CMACs that are priced using the Medicare RVUs to the Medicare Fee Schedule levels.

III. POLICY CONSIDERATIONS

A. A charge that exceeds the allowable charge may be determined to be allowable only when unusual circumstances or medical complications justify the higher charge (see the Chapter 13, Section 4.1 and Section 4.3). The allowable charge may not exceed the billed charge under any circumstances.

B. The allowable charge for physician assistant services other than assistant-at-surgery may not exceed 85 percent of the allowable charge for a comparable service rendered by a physician performing the service in a similar location. For cases in which the physician assistant and the physician perform component services of a procedure other than assistant-at-surgery (e.g., home, office, or hospital visit), the combined allowable charge for the procedure may not exceed the allowable charge for the procedure rendered by a physician alone. The allowable charge for physician assistant services performed as an assistant-at-surgery may not exceed 65 percent of the allowable charge for a physician serving as an assistant surgeon when authorized as TRICARE/CHAMPUS benefits. Physician assistant services must be billed through the employing physician who must be an authorized TRICARE/CHAMPUS provider. (See Chapter 13, Section 2.5.)

IV. EFFECTIVE DATE

May 1, 1992, except as stated above.

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