Chapter 5 Section 3

CHAMPUS Maximum Allowable Charges (CMAC)

Issue Date: March 3, 1992
Authority: 32 CFR 199.14

1.0 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.

2.0 ISSUE

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

3.0 POLICY

3.1 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 (PL) 101-511, Section 8012, which limits payments to physicians and other individual health care providers.

3.2 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.

3.2.1 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.

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

3.2.3 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 five 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 through 12. Previous years localities would be in the columns next to columns 10 through 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.

3.2.3.1 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. 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 Military Treatment Facility (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.

3.2.3.2 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.

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

3.3.1 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 (American Dental Association (ADA codes)
Ambulance

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

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.	

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 OPPS for services rendered on or after May 1, 2009 (implementation of OPPS). 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.

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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