Chapter 5 Section 1

Providers

Issue Date: November 1, 1988
Authority: 32 CFR 199.14(j)(1)

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

What is the TRICARE-determined allowable charge?

3.0 POLICY

3.1 The term "allowable charge" is the maximum amount TRICARE will authorize for medical and other health services furnished by physicians, medical groups, professional providers, independent laboratories, suppliers of ambulance services, and suppliers of Durable Medical Equipment, Prostheses, Orthotics, and Supplies (DMEPOS), etc.

3.2 The allowable charge is the lowest of:

- The actual billed charge,
- The prevailing charge (or amount derived from a conversion factor) made for a given procedure, adjusted to reflect local economic conditions, or
- The maximum allowable charge.

Maximum allowable charges are developed on a nationwide, non-specialty basis and are set at the 80th percentile of charges made for a given procedure during the base period. Non-specialty means that there is to be no distinction between types of physicians, although separate profiles are to be developed for different classes of providers, e.g., physicians and non-physicians. Maximum allowable charges will be adjusted to reflect local economic conditions through the application of Medicare Geographic Adjustment Factors.

When no maximum allowable charge is available, a prevailing charge is to be developed for the state where a service or procedure is provided. Prevailing charges are those charges which fall within the range of charges that are most frequently used in a state for a particular procedure or

service. The top of this range establishes an overall limitation on the charges which the contractor shall accept as allowable for a given procedure or service, except when unusual circumstances or medical complications warrant an additional charge.

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

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

3.2.3 When there are two or more procedures which are identical except for the amount of time involved (e.g., CPT[1] procedures codes 90843 and 90844), the contractor is to ensure that the profile for the shorter procedure does not exceed the profile for the longer procedure. In those cases in which it does, the contractor is to reduce the profile for the shorter procedure to that of the longer procedure.

3.2.4 Calculating the Prevailing Charge. For any profile period, the prevailing profile in a state for a particular service or procedure must be calculated as the 80th percentile of all the actual charges made for that service or procedure. In this calculation, all actual charges for the service or procedure shall be arrayed in ascending order and the lowest charge which is high enough to include 80% of the cumulative charges is determined to be the prevailing charge.

3.2.4.1 The proper procedure for establishing prevailing charges based on the 80th percentile is illustrated by the following example:

PROVIDER	CHARGE	NUMBER OF SERVICES
A	$12.00	21
	13.00	16
	15.00	35
B	12.00	17
	13.50	65

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

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

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

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

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

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

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

Note: When a provider has agreed to discount his or her normal billed charges, for the purpose of calculating the allowable charge the discounted fee shall be considered the provider's actual billed charge when the discounted amount is below the billed charge.

3.2.5 Annual update of state prevailing amounts, reference Chapter 5, Section 3, paragraph 3.7.5.

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

Note: Prevailing charges were frozen at 1990 level during the period of January through October 6, 1991, consistent with Public Law 101-511, Section 8012. With the implementation of CMACs on May 1, 1992 (see Section 2), allowable professional charges other than CMACs were frozen for services on or after May 1, 1992. Frozen allowable charges include all TRICARE established prevailings and conversion factors for: ambulance services, anesthesia services[2], DME, and supplies, oxygen and related supplies, etc. This means that contractors shall limit payment for these services to May 1, 1992, levels. For new services or procedure codes since May 1, 1992, the contractors shall establish an allowable charge or conversion factor using the TRICARE allowable methodology, freezing the new allowable charge or conversion factor from the date it is established. Effective October 1, 1997, Level II (HCPCS) shall have allowable charges established by cross-walking from existing allowable charges of TMA assigned codes. Effective with the 2012 CMAC update and subsequent CMAC updates, the provisions in Chapter 5, Section 3, paragraph 3.7.5 regarding the annual update of state prevailing rates shall apply. For ambulance services provided on or after October 1, 2013, TRICARE adopts Medicare's Ambulance Fee Schedule (AFS) as the TRICARE CMAC for ambulance services (see Chapter 1, Section 14.

- END -

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