

CHAMPVA POLICY MANUAL

CHAPTER: 3
SECTION: 5.1
TITLE: OUTPATIENT AND INPATIENT PROFESSIONAL PROVIDER
REIMBURSEMENT

AUTHORITY: 38 CFR 17.270(a) and 17.272(b)

RELATED AUTHORITY: 32 CFR 199.14(h) (1)

I. EFFECTIVE DATE

May 1, 1992

II. POLICY

A. Allowable charge. The term “allowable charge” is the maximum amount CHAMPVA will authorize for professional services of physicians and other individual professional providers (including professional services rendered by these providers in hospitals) and for certain other services provided incidental to the professional services. The allowable charge is the lower of (1) the billed charge, (2) the prevailing charge, or (3) the Medicare Economic Index (MEI) adjusted prevailing (known as the maximum allowable prevailing charge). The profiled amount (the prevailing charge or the CHAMPVA maximum allowable charge (CMAC), whichever is lower) to be used is based upon the date of service. If there is no MEI adjusted prevailing rate, the statewide prevailing rate or the billed charge. If there are no CMAC, MEI, or statewide prevailing rates, the billed charge is allowed. The allowable charge may not exceed the billed amount under any circumstances.

B. CMAC. The CHAMPVA maximum allowable charge (CMAC) is equivalent to the payments for similar services under TRICARE. CMAC applies to all fifty states and Puerto Rico. Guam and the Virgin Islands are paid as billed for professional services.

1. CMAC values are used to calculate the allowable charge for outpatient and inpatient professional claims. The CMAC class code is based on the provider's classification and the locality (zip code) where the provider provides the service. There are three classes of CMAC codes.

a. Class I: Physicians and Clinics

(1) Audiologist;

(2) Dentist (DDS);

- (3) Doctor of Dental Medicine (DDM);
- (4) Doctor of Osteopathy (DO);
- (5) Medical Doctor (MD);
- (6) Occupational therapist;
- (7) Optometrist;
- (8) Oral surgeons;
- (9) Physical therapist;
- (10) Podiatrist (DPM);
- (11) Psychologist;
- (12) Speech therapist (LCSP);
- (13) Hospital clinic;
- (14) Any indication of a group practice of physicians;
- (15) Emergency room; and
- (16) VA Medical Center.

b. Class II: (N/A)

c. Class III/IV: This is not an all-inclusive list.

- (1) Certified Addictions Counselor (CAC);
- (2) Certified Nurse Midwife;
- (3) Certified Nurse Practitioner (NP or CNP);
- (4) Certified Physician Assistant (PA);
- (5) Certified Registered Nurse Anesthetist (CRNA);
- (6) Licensed Practical Nurse (LPN);
- (7) Registered Nurse (RN); and
- (8) Social Worker (MSW).

2. The CHAMPVA CMAC rates are the same payment rates utilized by TRICARE. The CHAMPVA CMAC rates are updated on or about November 1 of each year.

3. CHAMPVA CMAC rates are equivalent to payments for similar services under Title XVIII of the Social Security Act (Medicare).

C. Prevailing charge. The prevailing charge (rate) is an amount equal to the maximum reasonable charge allowed physicians for a specific procedure in a specific locality.

1. Unless otherwise excepted, prevailing charges are developed on a non-specialty basis and are set at the 80th percentile of charges made for a given procedure during the base period. The "base period" used to calculate the new prevailing charge is the 12 months beginning July 1 through June 30 of the year prior to the calendar year for which updated prevailing charges will become effective. All billed charges for similar services in the same locality will be included in the database for the base period. Neither the highest nor the lowest charges will be included in the database. The minimum number of billed charges in the base period needed to determine a percentile prevailing charge is eight (8).

2. Prevailing charges are established for each MEI for each state and one for the remaining rural areas for each state. A rural area for this purpose is a zip code that is not designated by the Office of Management and Budget (OMB) as belonging to a MEI. If part of a zip code falls into a MEI, the entire zip code will be considered as being in the same MEI. The zip code of the locality where the services were rendered, not the zip code of the residence of the beneficiary or other third party submitting the claim to CHAMPVA, will be used to determine the area designation for calculation of the prevailing charge. Prevailing charges will be based only on those rates identified within a MEI. State prevailing charges will be based upon those rates within the state and will include rates that fall within the MEI.

3. The level at which the 80th percentile prevailing charge is set shall be rounded down to the nearest whole dollar. The prevailing charge at the 80th percentile in effect at the time the service was rendered by the provider shall be the amount used when determining the allowable charge regardless of when the claim is received by the Center. If the 80th percentile prevailing charge is less than the billed charge for the service, the prevailing charge at the 80th percentile will be the CHAMPVA allowable charge. For prevailing charges after January 1, 1994, charges included in the MEI calculations will also be included in the respective state prevailing rate calculations.

III. POLICY CONSIDERATIONS

A. Application. This policy applies to all class categories of individual professional health-care providers in all locations where services are provided. Outpatient facility charges include services that aid the individual healthcare professional provider in the treatment of the patient. These charges may include such

services as the use of hospital facilities factoring in overhead costs of utilities, billing, equipment, maintenance costs, insurance, nursing staff, etc., including emergency room services (nonprofessional services), the service of nurses, technicians, and other aides, medical supplies (gauze, oxygen, ointments, dressings, splints, casts, prosthetic devices), and drugs and biologicals which cannot be self-administered.

B. Services provided by individual professional providers. Services provided by individual professional providers of care and other non-institutional healthcare providers include the individual and direct (hands-on) treatment or examination of a patient. Such services may include diagnostic services, surgical services, physical therapy, occupational therapy, speech pathology services, and rehabilitation services. A service may be regarded as diagnostic if it is an examination or a procedure to which the patient is subjected, or which is performed on materials derived from the patient to obtain information to aid in the assessment of a medical condition or the identification of a disease. When professional services or diagnostic tests (e.g., laboratory, radiology, EKG, EEG, pulmonary function studies) that have CMAC pricing are billed, the claim must have the appropriate CPT coding and modifiers, if necessary. Otherwise, the service will be denied. If only the technical component is provided by the hospital, the technical component of the appropriate CMAC will be used.

C. Separate allowable charge determination for each service.

1. Different services and supplies for which charges are made under CHAMPVA may not be grouped together for the purpose of making one overall allowable charge determination. A separate allowable charge determination must be made with respect to each separate service or item for which a charge is made and allowed as a covered service. For example, one overall allowable charge determination may not be made for multiple inpatient hospital visits for which a total charge was made. A separate allowable charge determination must be made for each visit. Similarly, if a physician reports an office visit, including an examination, urinalysis, and white blood cell count, three (3) allowable charge determinations would be necessary if additional amounts were charged above the usual office fee for the additional services that are allowed as covered services. It is important to note that this applies to different services that are normally billed separately.

2. There are instances, however, when a provider may split a bill into separate items that are normally billed as a single comprehensive service. When the "fragmentation" or "unbundling" of CPT procedure codes occurs, refer to [Chapter 3, Section 5.3, *Rebundling of Procedure Codes*](#). "Fragmentation" or "unbundling" is separately reporting the component parts of a procedure instead of reporting a single comprehensive code that includes the entire procedure.

D. Low charge may not be used to offset high charge. CHAMPVA will not make a "package charge" or a "flat fee" out of separately itemized charges on a bill for the purpose of offsetting high charges with low charges. Where the same claim contains a charge for one service which is lower than the highest amount CHAMPVA might

otherwise have deemed allowable for the service and a charge for another service which is higher than the allowable charge, it should not be determined that the combined charges for the two services grouped together are allowable. Although the Health Administration Center (HAC) may give the physician or other person who rendered the service an opportunity to correct any billing error, the HAC must not suggest to the physician or other person that the charge be increased for a given service.

E. Discounted fees/write-offs. If the existence of a participating agreement or other similar agreement which limits the liability of a beneficiary is evident on the EOB from the OHI, the provider's discounted fee or write-off will be used in lieu of actual billed charge. (See [Chapter 3 Section 4.1](#), Other Health Insurance (OHI)).

F. CHAMPVA foreign claims. CHAMPVA foreign claims are claims received from CHAMPVA beneficiaries who received services in a foreign country. CHAMPVA payments will be limited to the area's usual and customary fees. All payments for foreign claims will be made in U.S. currency based on the exchange rate applicable to the date service were rendered. For episodes of hospitalization, the exchange rate will be based on the date of discharge (see [Chapter 3, Section 1.2](#), *Claims Processing - Foreign*).

G. Reimbursements to beneficiaries. Reimbursements to beneficiaries will be made using the same payment methodologies that are used for vendors and providers.

H. Non-covered office visits (see [Chapter 2, Section 15.1](#), *Evaluation and Management Services (Office Visits) General*).

I. Beneficiary cost share and deductible (see [Chapter 3, Section 2.1](#), *Cost Share* and [Chapter 3, Section 2.2](#), *Deductible*).

END OF POLICY