

# CUSTOMARY, PREVAILING, AND REASONABLE FEES (CPR FEES)

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## CUSTOMARY, PREVAILING, AND REASONABLE FEES (CPR FEES)

The concept of Customary, Prevailing, and Reasonable fees, commonly abbreviated as CPR fees, represents a fundamental and historically significant standard implemented within the structure of healthcare and wellness reimbursement systems, particularly in contexts involving third-party payers such as insurance companies. CPR fees serve as the primary mechanism by which insurers determine the maximum allowable payment for a specific service or procedure rendered by a healthcare professional, including psychologists, psychiatrists, clinical social workers, and other behavioral health providers. This system is designed to provide a baseline for financial predictability and cost control, ensuring that payments made by the insurance entity remain within a defined range that reflects typical market rates rather than arbitrary charges set solely by individual practitioners. Crucially, CPR fees are often synonymous with the older, more frequently cited acronym, Usual, Customary, and Reasonable fees (UCR), though minor contextual differences may exist depending on the specific legal jurisdiction or payer contract. The implementation of CPR fees is a central feature in nearly all medical insurance plans, acting as a critical constraint on the overall cost of healthcare services and directly influencing both provider revenue and patient out-of-pocket expenses.

The core function of the CPR methodology is the creation of a reimbursement ceiling. When a provider submits a claim for a service--for example, a 50-minute psychotherapy session--the insurer evaluates the charge against their established CPR schedule for that specific service code (CPT code) within the relevant geographic area. If the provider's billed charge exceeds the calculated CPR maximum, the insurer will only pay up to the CPR limit, leaving the remaining balance either to be absorbed by the patient (via balance billing, depending on the contract type) or written off by the provider. This system inherently profiles the dominating fees in a specific region, relying on vast datasets compiled from submitted claims by thousands of different providers over defined periods. This rigorous data collection and statistical analysis are necessary to establish a fee profile that is deemed equitable and reflective of the actual market dynamics for specialized services, thus preventing potential overcharging or outlier pricing practices that could inflate overall healthcare expenditures.

Understanding the mechanism of CPR fees is essential for both practitioners navigating insurance contracts and patients managing their financial obligations. For behavioral health providers, the acceptance of CPR rates often dictates participation in preferred provider networks (PPOs) or health maintenance organizations (HMOs). When a provider agrees to accept the insurer's CPR rate, they are typically agreeing to accept that rate as payment in full for the covered service, minus any patient responsibility (co-payments, deductibles, or co-insurance). This contractual agreement prevents the provider from attempting to collect the difference between their actual billed charge and the insurance payment, a practice known as balance billing. Therefore, CPR fees do not simply reflect a suggested price; they often represent a legally binding maximum allowable

charge within the context of managed care contracts, solidifying their role as a powerful financial regulatory tool within the complex interplay of healthcare economics and psychological service delivery.

## Historical Context and Rationale for Implementation

The establishment of formalized fee standards like CPR and UCR arose primarily in the post-World War II era, coinciding with the substantial growth of employer-sponsored health insurance and the rise of third-party payment systems. Prior to this period, healthcare transactions were largely direct exchanges between patient and physician, with negotiated or established charges being the norm. However, as insurance became the primary payer, the inherent incentives shifted; providers had less motivation to control costs, and patients were insulated from the true price of care. This led to significant variation and often rapid inflation in medical charges, prompting insurers and policymakers to seek standardized mechanisms to manage escalating expenditures and ensure fiscal responsibility across the burgeoning healthcare landscape. The initial rationale behind implementing the UCR framework, which later evolved into the CPR model, was fundamentally rooted in consumer protection and fiduciary duty--insurers needed a robust, defensible method to justify the amount they paid for services to their policyholders and regulatory bodies.

The early attempts to define "reasonable" costs lacked uniformity, leading to inconsistent reimbursement practices. The adoption of the UCR/CPR model standardized the reliance on external, quantifiable data rather than subjective judgment. By requiring fees to meet criteria that were statistically grounded in regional practice patterns, the system aimed to introduce a degree of objectivity and transparency into the claims process. This move was critical for the burgeoning fields of mental health and psychology, where services are often intangible and highly specialized, making objective valuation challenging. By benchmarking psychological services against the charges submitted by a large pool of peers within a defined geographic radius, insurers could argue that the resulting CPR fee was truly reflective of the market rate for quality care, preventing outlier providers from charging excessive rates that were not supported by the local economic reality or complexity of the service provided.

Furthermore, the implementation of CPR fees served as a critical tool in managing risk for insurance underwriters. Without a predictable ceiling on how much they might be obligated to pay for specific procedures, insurers would struggle to accurately calculate premiums and maintain solvency. The CPR system, by definition, provides this ceiling, allowing actuaries to model potential liabilities based on known average costs rather than unbounded maximums. While the system has faced significant criticism over time--particularly concerning data aggregation methods and the potential for suppressing fees--its historical importance lies in establishing the foundational principle that reimbursement for healthcare services should not be arbitrary but should instead be tied to verifiable, regional economic data. This regulatory function established the insurer not

merely as a payer, but as a crucial gatekeeper of cost control within the medical economy.

## The Three Components: Customary, Prevailing, and Reasonable

The nomenclature of Customary, Prevailing, and Reasonable fees is derived from the three distinct criteria that must be satisfied for a charge to be fully reimbursed by an insurer under this standard. Each component addresses a different facet of the charge, working synergistically to create the final, allowable payment amount. The first component, the **Customary Fee**, is the charge that the individual provider routinely charges for a specific service under normal circumstances. This criterion focuses internally on the provider's own billing history. Insurance carriers require providers to submit their full schedule of fees, and the customary charge is typically determined by calculating the median or average of the charges the provider has historically submitted for a given CPT code. If a provider charges one patient ninety dollars for a session but routinely charges all other patients one hundred dollars for the same service, the customary fee will be established at the higher, more common rate. The key takeaway is that a charge cannot exceed the provider's own customary fee if it is to be considered for full reimbursement.

The second component is the **Prevailing Fee**, which introduces the external, regional market context. The prevailing fee is defined as the fee most frequently charged for a specific service by all providers within a particular geographic area or community. This is where the profiling of dominating fees occurs. Insurers collect and analyze massive amounts of claims data, typically aggregating charges for a service (like CPT code 90834 for individual psychotherapy) across all participating providers within a defined zip code radius or metropolitan statistical area (MSA). The prevailing fee is often set at a specific percentile of this aggregated data, commonly the 80th or 90th percentile. By setting the prevailing fee at the 80th percentile, for example, the insurer signals that 80 percent of all providers in that region charge that amount or less for the service. A provider's charge must not only be customary to them but must also be at or below this prevailing regional benchmark to be fully recognized by the payer. This component is the primary mechanism used by insurers to control regional price inflation and establish market averages.

The final and most subjective component is the **Reasonable Fee**. In practice, the reasonable fee is the lowest of three potential figures: the provider's actual billed charge, the provider's customary fee, or the regional prevailing fee. However, the concept of reasonableness also incorporates a qualitative judgment regarding the complexity, severity, and unusual nature of the patient's condition and the expertise required for treatment. While often statistically derived as the lowest numerical value, the 'reasonable' element theoretically allows for exceptions. If a case involves extraordinary complexity--for instance, a rare psychological disorder requiring specialized, time-intensive intervention--a fee might be deemed reasonable even if it slightly exceeds the usual prevailing rate, provided that meticulous documentation supports the necessity of the higher charge. In the absence of such compelling documentation, the reasonable fee is strictly the lowest

calculated financial figure, reinforcing the system's bias towards statistical averages and cost minimization over specialized variance.

## Methodologies of Fee Determination and Data Profiling

The integrity and functionality of the CPR system hinge entirely upon the methodologies used by insurance carriers to collect, analyze, and profile fee data. The process begins with continuous aggregation of claims data. Every time a provider submits a claim for reimbursement, that financial data point--the billed charge, the CPT code, the date, and the geographic location--is fed into proprietary databases maintained by the insurance companies or third-party data clearinghouses they contract with. These databases accumulate millions of transactions, which are then segmented by service type and geography. Geographic segmentation is critical because the cost of living and, consequently, the cost of practice (rent, utilities, salaries) varies significantly between urban centers like New York City and rural areas in the Midwest; thus, the prevailing fee in one area must not influence the prevailing fee in another.

The primary statistical technique employed for determining the prevailing fee is the percentile ranking method. After sorting all aggregated fees for a particular service code (e.g., individual psychotherapy, family therapy, or psychological testing) within a specified geographic area, the insurer selects a specific percentile cutoff--most commonly the 80th or 90th percentile. If the 80th percentile is selected, the corresponding dollar amount becomes the prevailing fee ceiling. The rationale for choosing a percentile below 100% is crucial: it effectively removes the highest outliers, preventing extremely expensive, atypical charges from artificially inflating the overall reimbursement rate. This methodology ensures that the prevailing fee reflects the dominant majority of charges in the region, thereby discouraging excessive billing practices while still adequately compensating the majority of providers.

However, the methods of data profiling are not without controversy. Historically, the data used to calculate CPR fees was often opaque, leading to accusations that insurers manipulated the data or used non-representative samples to systematically suppress reimbursement rates. A notable legal challenge involved the use of data from Ingenix (a subsidiary of UnitedHealth Group), which was accused of maintaining a flawed database that artificially lowered UCR rates, resulting in billions of dollars of underpayments to patients and providers. Although regulatory changes and lawsuits have forced greater transparency in recent decades, the proprietary nature of the insurance industry's internal data processing means that providers often lack full visibility into how their specific regional prevailing fee is calculated, creating continuous tension regarding the fairness and accuracy of the reimbursement ceilings imposed upon them.

## Impact on Healthcare Providers, Especially in Psychology

For healthcare providers, particularly those in the mental and behavioral health sectors, CPR fees fundamentally dictate financial feasibility and business models. Due to the high demand for mental health services, many psychologists and counselors choose to participate in insurance networks to ensure a steady patient flow. When a provider signs a contract with an insurer, they implicitly or explicitly agree to accept the established CPR fee schedule for covered services. This means that the provider cedes control over their pricing structure to the insurer's statistical modeling. For many psychologists, especially those with high overhead costs or specialized training, the CPR rate may be significantly lower than their ideal market rate, forcing them to balance the volume of patients gained through network participation against the lower per-session reimbursement rate.

The constraints imposed by CPR fees directly lead to the common practice of differential pricing. A provider who is "in-network" must accept the CPR rate for insured patients, but for "out-of-network" or cash-pay clients, they are free to charge their actual, higher customary fee. This discrepancy can create administrative complexity and ethical dilemmas regarding equitable access to care. Furthermore, if a provider's customary fee consistently exceeds the prevailing fee for their region, they face a financial penalty every time they treat an insured patient, as the insurer will only pay up to the prevailing fee, forcing the provider to write off the difference (contractual adjustment). This dynamic strongly incentivizes providers to keep their customary fees aligned with, or below, the prevailing regional rates to maximize their reimbursement potential under network contracts.

A critical consequence for behavioral health providers is the issue of parity. While mental health parity laws aim to ensure that coverage for mental health services is comparable to medical and surgical benefits, the application of CPR fees can sometimes undermine this goal. If the prevailing fee for a psychological service (e.g., cognitive behavioral therapy) is set extremely low due to the inclusion of data from lower-cost providers, such as interns or master's-level counselors, it can depress the reimbursement rate for doctoral-level psychologists, making participation financially unsustainable for highly trained specialists. Therefore, providers must constantly advocate for fair geographic clustering and accurate professional classification within the insurer's data profiling to ensure that the determined CPR rate truly reflects the prevailing fee for their specific level of education, licensure, and expertise within the practice community.

## Implications for Patients and Beneficiaries

For patients, the CPR fee structure holds significant implications for their financial liability and access to affordable care. When a patient sees an in-network provider, the CPR fee acts as a protective measure, as the patient generally only owes their defined co-payment or co-insurance based on that maximum allowable charge. Since the provider has agreed to the CPR rate, the patient is protected from balance billing. This predictability is a cornerstone of managed care benefits, allowing beneficiaries to budget for their medical and psychological expenses with a degree of certainty regarding the final costs. The CPR standard thus fulfills its original intent of

providing a reasonable cost structure for the consumer.

However, the situation changes drastically when a patient seeks care from an out-of-network provider. In this scenario, the insurer still calculates the CPR fee for the service provided, and the patient's insurance plan will reimburse them (or the provider) based on that calculated CPR rate, minus the patient's deductible and co-insurance. Since the out-of-network provider has no contractual obligation to the insurer, they are free to bill their full customary fee, which is often substantially higher than the CPR rate. The resulting gap between the provider's billed charge and the insurer's CPR-based payment creates a significant financial liability for the patient, a phenomenon known as the "surprise bill." This situation is particularly common in specialized psychological testing or emergency mental health services where choice of provider is limited.

Consider an example: an out-of-network psychologist bills \$250 for a session. The insurer determines the regional CPR rate is \$150. If the patient has a 20% co-insurance, the insurer pays 80% of the CPR (\$120), and the patient is responsible for the remaining \$130 (the \$30 co-insurance plus the \$100 difference between the billed charge and the CPR rate). This out-of-pocket exposure highlights that the CPR fee, when used for out-of-network benefits, functions as a limit on the insurer's payment obligation, not a limit on the provider's billing practices, thereby shifting the burden of the cost difference directly onto the patient. Understanding this mechanism is vital for patients seeking to manage their financial obligations and make informed choices regarding in-network versus out-of-network mental health services.

## Legal and Ethical Challenges

The reliance on the Customary, Prevailing, and Reasonable fee system has historically been fraught with legal and ethical challenges, primarily centering on the subjective nature of the "reasonable" component and the anti-competitive implications of fee suppression. Litigation has frequently challenged the transparency and methodology used by insurance companies to determine the prevailing fee. A major point of contention is whether the aggregation of data truly reflects a fair market price or if it constitutes a form of price-fixing. If major insurers utilize similar, proprietary, or manipulated databases that consistently set prevailing fees at an artificially low percentile, this can be interpreted as an anti-competitive practice that unfairly limits provider income and potentially restricts patient access to high-quality care, especially if specialists opt out of insurance networks due to low reimbursement.

Another significant ethical concern arises from the application of the 'Reasonable' criterion to complex cases. While insurers argue that the system is flexible enough to accommodate medically necessary exceptions, providers often claim that the bureaucratic hurdles required to justify a fee above the prevailing rate are prohibitive and frequently denied. This rigid adherence to statistical averages can pressure providers to limit time or resources spent on complex patients whose needs

might genuinely warrant a higher charge, potentially compromising the quality of psychological care delivered. For example, extensive psychological evaluations or crisis intervention services may inherently cost more due to required documentation or extended hours, yet the rigid CPR ceiling may fail to account for this necessary complexity.

Furthermore, the lack of uniformity in defining the geographic area for "prevailing" fees poses a continuous legal vulnerability. An insurer might define a vast geographic region for a prevailing fee calculation, thereby including data from low-cost suburban or rural practices, which unfairly depresses the reimbursement rate for providers operating in high-cost urban centers within that same region. Conversely, a too-narrow definition might be accused of failing to capture a representative sample. These definitional battles often end up in arbitration or court, highlighting that despite the quantitative basis of the CPR system, its implementation relies heavily on subjective administrative decisions regarding data segmentation, which are constantly scrutinized for bias and fairness.

## Transition to Modern Reimbursement Models

While the CPR/UCR framework remains foundational to many traditional insurance plans and indemnity products, the healthcare industry is increasingly transitioning toward alternative and more sophisticated reimbursement models. The inherent limitations of CPR--its reactive nature (based on historical billing rather than outcomes) and its tendency to incentivize volume over value--have spurred the development of prospective payment systems designed to align provider incentives with quality outcomes and global cost management. These newer models, such as capitation, bundled payments, and Diagnosis-Related Groups (DRGs, primarily for inpatient medical care), aim to move away from the fee-for-service structure that CPR governs.

In behavioral health specifically, there is a growing trend toward value-based care (VBC). VBC models attempt to reward providers not for the number of sessions billed (as measured against the CPR rate), but for achieving measurable improvements in patient mental health outcomes, adherence to evidence-based practice guidelines, and successful integration of physical and behavioral health care. Under VBC contracts, providers might receive bonuses or shared savings payments if they manage a patient population efficiently and effectively, regardless of the precise customary fee they bill. This shift recognizes that simply controlling the price per unit of service (the CPR function) does not necessarily control the total cost of care or improve patient wellness.

Despite the move toward VBC and other capitated systems, CPR fees continue to play an essential, albeit evolving, role. Even in modern contracts, the established CPR rate often serves as the baseline reference point or the foundation upon which more complex payment calculations are built. For instance, in hybrid models, payment might involve a per-member per-month fee (capitation) supplemented by a fee-for-service component that is still adjudicated against the

existing CPR schedule. Therefore, while pure CPR reimbursement is declining in prevalence, its underlying principle--the statistical benchmarking of regional fees to establish a reasonable maximum payment--remains a critical, enduring concept in the financial administration of psychological and medical services, necessitating continued vigilance from providers and policymakers regarding the transparency and fairness of data profiling methodologies.

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