

Fee schedules based on Medicare's Resource-Based Relative Value Scale or the Medicare Physician Fee Schedule

I. Introduction

According to a 2006 survey conducted by the American Medical Association (AMA) (“2006 survey”), more than 75 percent of private, non-Medicare payers (health insurers, HMOs, PPOs, self-insured employers, etc.—collectively, “managed care organizations” [MCOs]) were utilizing the Medicare Resource-Based Relative Value Scale (Medicare RBRVS) in at least one of their product lines. Many commercial managed care contracts offered to physicians contain fee schedules purporting to base payment on the Medicare RBRVS, although recent developments indicate that such use is not always consistent with the current Medicare payment system. Contractual fee schedules may also state that payment will be based on a percentage of the “Medicare Physician Fee Schedule.” These references to the Medicare RBRVS or the Medicare Physician Fee Schedule may encourage physicians to make a number of assumptions concerning contractual payment. These assumptions often include the belief that: (1) payment will be calculated based on the relative values that the current Medicare RBRVS assigns to the physician’s services, multiplied by a conversion factor to which the parties have agreed; or (2) payment rates will be based on what Medicare **actually pays** for the physician’s services. Yet fee schedule language may use the terms “Medicare RBRVS” or the “Medicare Physician Fee Schedule” imprecisely and may not include recent improvements in the Medicare RBRVS valuation.

This resource is designed to help physicians identify, understand and potentially rectify through negotiation problematic issues that frequently arise when managed care agreements purport to base payment on the Medicare RBRVS or the Medicare Physician Fee Schedule. This resource suggests questions that physicians may employ in their efforts to minimize confusion, confirm the payment amounts and judge whether signing the contract makes sound business sense.

MCO employees and representatives—even those who draft managed care agreements—may not fully understand the Medicare RBRVS or the various meanings of “Medicare Physician Fee Schedule.” A physician should not, therefore, assume that the individuals who drafted the contract or other MCO personnel understand: (1) that the term “Medicare Physician Fee Schedule” may not mean what they think it means; (2) the Medicare RBRVS itself; (3) how the MCO will use the Medicare RBRVS to determine payment; or (4) whether the “Medicare RBRVS” referenced in the contractual fee schedule is identical to the Medicare RBRVS as it is currently used by the Medicare program to pay Medicare claims. The questions contained in this resource are designed to help physicians alert MCO personnel of the confusion that often accompanies reference to the Medicare RBRVS or Medicare Physician Fee Schedule. Knowledge is power, and physicians who can educate MCO personnel concerning contractual deficiencies may buttress their ability to seize the initiative in framing contract negotiations.

II. Organized medicine’s position: The Medicare RBRVS can be a valid basis upon which to determine payment in non-Medicare contexts.

AMA policy states that the Medicare RBRVS can function as a legitimate basis for commercial fee schedules, provided that the Medicare RBRVS remains annually updated and rigorously validated. This policy pertains to the Medicare

RBRVS relative values only.¹ The AMA is committed to identifying the extent to which MCOs modify, adopt and implement the Medicare RBRVS. The AMA also strongly encourages MCOs that use the Medicare RBRVS to utilize the most current version.²

III. A possible alternative approach

One method of dealing with concerns and confusion fostered by language purporting to base payment on “a percentage of the Medicare RBRVS” or “a percentage of the Medicare Physician Fee Schedule” is to replace that language. For example, the physician may want to suggest replacing such references with something like the following language:

“MCO will pay the physician:

1. _____% of the **actual physician rates** paid by Medicare, effective 01/01/20__ [nationally][for the physician’s geographic location];
2. _____% of Medicare Average Sales Price (ASP) Drug Pricing, effective 01/01/20__;³
3. _____% of Medicare Clinical Laboratory Fee Schedule (MCLFS), effective 01/01/20__ [nationally][for the physician’s geographic location];
4. _____% of Medicare Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule, effective 01/01/20__ [nationally][for the physician’s geographic location].”⁴

Restructuring the contract’s language in this way clarifies the scope of the MCO’s payment obligations and enables the physician to calculate expected payment because payment is now defined in terms of what Medicare **actually pays**.

In addition to suggesting this language, the physician should consider suggesting that the MCO update each of these schedules contemporaneously with Medicare’s updates. If the MCO’s fee schedule already contemplates using one or more of the schedules listed in (1) through (4) above, the physician should consider verifying when the MCO will perform updates relative to Medicare. For example, some MCO contract fee schedules using ASP update their ASP quarterly just as Medicare does. Nevertheless, these MCO quarterly updates often do not occur contemporaneously with Medicare’s. Instead, MCO ASP quarterly updates often occur at least 30 days after Medicare’s updates.

IV. Meaning of “Medicare Physician Fee Schedule”

Many managed care contracts purport to base payment on a percentage of the Medicare Physician Fee Schedule. Use of the term “Medicare Physician Fee Schedule” may, however, be subject to interpretive ambiguities. For example, an MCO may intend “percentage of the Medicare Physician Fee Schedule” to mean that the MCO will pay a percentage of what Medicare actually pays the physician. But a physician may understand “Medicare Physician Fee Schedule” to refer only to the relative values in the Medicare RBRVS. As long as any ambiguity exists, the physician may be unable to predict contractual payment rates, as more fully discussed below. Unless other language in the contract eliminates all ambiguity as to how the physician will be paid, it is advisable that the physician seek additional information from the MCO concerning the precise meaning of its use of the term “Medicare Physician Fee Schedule.”⁵

¹ H-400.960 Harnessing Market Forces in Medical Pricing. The AMA’s policy is limited to RBRVS relative values only because of concerns that the AMA has regarding other aspects of the Medicare Payment System, (e.g., the geographic practice cost indexes and the Medicare conversion factor that are used in the process that Medicare uses to ultimately determine physician payment rates).

² D-400.999 Non-Medicare Use of the RBRVS.

³ If the physician expects to be paid for furnishing drugs, basing drug payment on a percentage of ASP drug pricing will generally provide more clarity than drug payment based on the Average Wholesale Price (AWP). Unlike the ASP rate, there is no single recognized rate establishing the AWP. Additionally, ASP rates are easily accessible on the Centers for Medicare and Medicaid Services (CMS) Web site, are available prior to their effective date, and cover a broad range of HCPCS codes.

⁴ This sample language has been suggested by Mark Rieger, Chief Executive Officer of National Healthcare Exchange Services (NXHS).

⁵ The AMA believes that the term “Medicare Physician Fee Schedule” should be understood to refer to the Medicare RBRVS and its relative values, in part because the Medicare Physician Fee Schedule published every year in the Federal Register by CMS only lists

V. A brief explanation of the Medicare RBRVS

A. The Medicare RBRVS measures the amount of physician resources required to provide a specific service.

The Centers for Medicare and Medicaid Services (CMS) uses the Medicare RBRVS to measure the total amount of physician resources required to provide a specific physician service. The total amount of physician resources is referred to as the service's "relative value." A service's relative value is measured by determining the "relative value units" (RVUs) with respect to the following three factors: (1) physician work; (2) practice expense; and (3) professional liability insurance. The Medicare RBRVS determines each service's work, practice expense and professional liability insurance RVUs.

The physician work RVU accounts, on average, for 52 percent of the total relative value for each physician service. The factors used to determine the physician work RVU include: the time it takes to perform the service; the technical skill, physical effort, mental effort, and judgment required to perform the service; and the stress on the physician resulting from the service's potential risk to the patient. The physician work RVUs are updated each year to account for changes in medical practice. These updates are based on recommendations from a committee involving the AMA and national medical specialty societies: the AMA/Specialty Society RVS Update Committee (RUC).

In 2008, the AMA strongly supported the enactment of section 133 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Section 133 of MIPPA (Section 133) prohibits CMS in 2009 and in subsequent years from arbitrarily reducing the work RVU for all services in the interest of achieving budget neutrality. Section 133 was enacted in response to CMS' implementation in 2007 and 2008 of arbitrary, across-the-board reductions in work RVUs in order to achieve budget neutrality—CMS chose to reduce work RVUs rather than reducing the applicable conversion factors. These reductions unfairly reduced payments for services that were work-intensive vis-à-vis those that were not. Because section 133 now prohibits CMS from performing such reductions, CMS can no longer corrupt the work RVUs to meet budget neutrality goals. The importance of this victory for MCO fee schedules is discussed below.

The practice expense RVU measures physician resources used to provide a particular service. Expenses included in this RVU are those associated with the physician's use of nonclinical personnel to provide the service and expenses for office space, equipment and supplies. The practice expense RVU accounts, on average, for 44 percent of the relative value assigned by the Medicare RBRVS to each physician service.

The professional liability insurance RVU accounts, on average, for 4 percent of the relative value for each physician service, and is designed to reflect the cost of obtaining medical liability insurance.

Once the Medicare RBRVS assigns the appropriate numerical values to the work, practice expense and professional liability insurance RVUs for a specific service, the Medicare RBRVS then adds these numerical values to derive the specific service's relative value. Calculating a particular service's relative value does not, however, determine what Medicare will pay the physician.

B. Geographical Practice Cost Index⁶

After the Medicare RBRVS determines the numerical value of a service's work, practice expense and professional liability insurance RVUs, CMS adjusts each of those RVUs using the Geographical Practice Cost Index (GPCI) in an effort to reflect broad differences in the costs of operating medical practices in 89 different localities in the United States.

The work GPCI adjusts the work RVU to take into account geographic differences in the cost of living in the 89 localities. The work GPCI is **not** based on **physician** earnings. It is instead based on the earnings of the following seven professional

the relative values assigned to the services for which Medicare pays. Visit <http://edocket.access.gpo.gov/2008/E8-26213.htm> to view the Medicare Physician Fee Schedule for 2009.

⁶ GPCI accuracy is subject to question. AMA policy reflects organized medicine's accuracy concerns. *See e.g.*, H-400.952 Consolidation of Medicare Fee Schedule Areas stating that "The AMA will continue to petition CMS to improve the accuracy of the Geographic Practice Cost Indices (GPCIs) through the use of accurate practice costs and timely data; and will petition CMS and, if necessary, the Congress to retain as distinct Medicare localities, cities where recent inclusion in state-wide localities by CMS is based on criteria that do not allow for appropriate recognition of the higher costs associated with practice in these areas."

occupational groups: architecture and engineering; computer, mathematical and natural sciences; social scientists, social workers and lawyers; education, library and training; registered nurses; pharmacists; writers, artists and editors.

The Medicare Prescription Drug Improvement and Modernization Act of 2003 required all GPCIs in 2004–2006 to be set at least at 1.0—the national average. Subsequent legislation extended this 1.0 floor until June 30, 2008. Fortunately for many physicians, Section 134 of MIPPA (“Section 134”) continued the 1.0 floor through December 31, 2009. By continuing the 1.0 floor, MIPPA resulted in physicians in 55 of the 89 GPCI localities receiving \$400,000,000 in 2009 that they would not have received had the 1.0 floor been allowed to expire.

The practice expense GPCI adjusts the practice expense RVU to reflect geographic differences in the prices of medical practice inputs (e.g., office rent per square foot and staff hourly wages) in the 89 GPCI localities. The practice expense GPCI is not physician-specific. In other words, it does not reflect geographic differences in the amount of space that physicians rent nor in the number of nonphysician personnel they employ. It is important to distinguish between the practice expense component of the practice expense RVU and the practice expense GPCI—the practice expense RVU reflects average direct and indirect practice expenses, but the practice expense GPCI takes into account only the differences in these costs across geographic areas relative to the national average.

The professional liability insurance GPCI reflects geographic differences in premiums for a mature claims policy that provides \$1 million/\$3 million of coverage.

C. CMS determines physician payment for a particular physician service by multiplying the relative value of that service by a *conversion factor*.

Once the Medicare RBRVS determines a service’s relative value, CMS determines what Medicare will pay for that service by multiplying the service’s relative value by a **conversion factor**, a monetary amount set by CMS. The Medicare conversion factor varies from year to year. In 2009 the conversion factor is \$36.0666. Generally speaking, the greater the relative value assigned by the Medicare RBRVS to a physician service, the more Medicare will pay a physician for providing that service. This is because Medicare applies a single conversion factor to calculate the majority of physician fees.

VI. Identifying and rectifying problems that may exist when managed care contracts purport to base payment on a “percentage of the Medicare RBRVS,” or on a “percentage of the Medicare Physician Fee Schedule”

A. Fee schedules paying a “percentage of the Medicare RBRVS” or a “percentage of the Medicare Physician Fee Schedule” may provide little, if any, information concerning actual payment.

Frequently, managed care agreements state that the MCO will pay the physician based on a “percentage of the Medicare RBRVS,” or “a percentage of the Medicare Physician Fee Schedule.” Such references to the Medicare RBRVS or to the Medicare Physician Fee Schedule may lead a physician to believe erroneously that the MCO will pay the physician based on a percentage of what Medicare actually pays. This belief may be mistaken because, as described above, Medicare’s RBRVS does not by itself determine payment rates. Accordingly, use of the phrase “percentage of the Medicare RBRVS” does not provide the physician with meaningful information regarding actual payment. References to the “Medicare Physician Fee Schedule” will be just as problematic if by that phrase the MCO means the Medicare RBRVS. Additional ambiguity arises to the extent the MCO uses the term “based on” to mean something other than “identical to” (i.e., that the MCO has made changes to the official, current Medicare RBRVS or Medicare Physician Fee Schedule).

B. Physicians should clarify fee schedules basing payment on a percentage of the Medicare Physician Fee Schedule.

As already noted, fee schedules that claim they will pay the physician a percentage of the Medicare Physician Fee Schedule may be ambiguous because “Medicare Physician Fee Schedule” could mean (1) what Medicare actually pays the physician or (2) the Medicare RBRVS. When offered a contract purporting to pay the physician a percentage of the Medicare Physician Fee Schedule, the physician should consider seeking clarification regarding whether (1) or (2) applies.

C. Will payment be based on the current version of the Medicare RBRVS or the Medicare Physician Fee Schedule?

The AMA has learned that some commercial managed care contracts being offered to physicians by MCOs calculate payment by applying a conversion factor to relative values determined by the **2008** Medicare RBRVS, or by a Medicare RBRVS from even earlier years. This development is disturbing because commercial MCOs are in no way bound or restricted by Medicare's budget neutrality requirements. A payment methodology based on an out-dated Medicare RBRVS or Medicare Physician Fee Schedule is not consistent with AMA policy because it ignores the most current relative values.⁷ A method that fails to utilize current relative values will in 2009 and subsequent years deprive some physicians of payment to which they would be entitled under the Medicare RBRVS current relative values.

1. Section 133 and arbitrary work RVU reductions

As mentioned above, Section 133 of MIPPA represents a significant victory for physicians because it will result in many physicians receiving greater Medicare payments than they would have otherwise received in 2009 and following years. Section 133 prohibits CMS from arbitrarily reducing the work RVUs for physician services in 2009 and subsequent years. CMS imposed arbitrary, across-the-board reductions to all work RVUs in 2007 (10.06 percent) and 2008 (11.94 percent) in an effort to achieve budget neutrality. These reductions were arbitrary because they had nothing to do with any change in the actual content of the work RVUs for any physician services. By prohibiting CMS from making such reductions in 2009 and subsequent years, Section 133 significantly increases the relative values that the 2009 Medicare RBRVS assigns to many physician services vis-à-vis the 2008 Medicare RBRVS. And by increasing relative values, Section 133 results in a substantial increase in Medicare payment for physicians who perform services that involve more physician work compared with payments made under the 2008 Medicare RBRVS.

2. Example

The following charts illustrate how a commercial fee schedule using 2008 Medicare RBRVS relative values, with the arbitrary reduction in the work RVU, may significantly reduce payment for certain physician services provided to Medicare beneficiaries. The example below focuses on payment for services designated by CPT Code 99213 Routine Office Visit.

Payment for CPT code 99213: Routine office visit, example 1			
	2007	2008	2009
Work RVU prior to adjustment	0.92	0.92	0.92
Budget neutrality adjuster	0.8994	0.8806	N/A
Adjusted work RVU	0.83	0.81	N/A
Practice Expense RVU	0.71	0.73	0.75
Professional Liability Insurance RVU	0.03	0.03	0.03
Total relative value before the RVU was adjusted for budget neutrality	1.66	1.68	1.70
Total relative value after the work RVU is adjusted for budget neutrality	1.57	1.57	Not applicable after MIPAA section 133
Medicare conversion factor	\$37.8975	\$38.0870	\$36.0666
Medicare payment	\$59.50	\$59.80	\$61.31

⁷ D-400.999 Non-Medicare Use of the RBRVS

The preceding chart shows that the **unadjusted** work RVU for CPT 99213 was 0.92 in 2007–2009. However, CMS in 2007 and 2008 arbitrarily adjusted the work RVU for 99213 to 0.8994 and 0.8806 respectively, rather than applying a budget neutrality adjustment to the Medicare conversion factor. This work RVU adjustment resulted in the work RVU for 99213 being reduced to 0.83 in 2007 and 0.81 in 2008, resulting in the total relative value of 1.57 for 99213 in both 2007 and 2008. When the applicable 2007 and 2008 conversion factors are applied to this 1.57, the resulting payment for a 99213 was \$59.50 in 2007 ($1.57 \times \37.8975) and \$59.80 in 2008 ($1.57 \times \38.0870). Due to Section 133 of MIPPA, CMS can no longer arbitrarily reduce work RVUs in the interest of budget neutrality. Consequently, the 2009 work RVU for 99213 is 0.92, and 99213’s total relative value is 1.70 (which also includes a 0.02 increase in 99213’s practice expense RVU from 2008 to 2009 [i.e., 0.073 to 0.075]). The resulting Medicare payment for a 99213 in 2009 is \$61.31 (1.70×36.0666 [the 2009 Medicare conversion factor]). If a commercial fee schedule calculates payments for 99213 using the 2008 Medicare RBRVS total relative value for 99213 and the 2008 Medicare conversion factor, rather than using the 2009 Medicare RBRVS and conversion factor, the resulting payment reduction can be significant. For example, if a physician practice provided 2,000 99213s annually, a commercial fee schedule using 2009 Medicare relative values and the 2009 conversion factor would pay the practice a total payment of \$122,620 for those 2,000 99213s ($\$61.31 \times 2,000$). If, however, the commercial fee schedule calculated payment for the 2,000 99213s using the 2008 99213 Medicare relative value (1.57) and the 2008 Medicare conversion factor, the resulting payment for 2,000 99213s would be \$119,600 ($\$59.80 \times 2,000$)—a reduction of approximately \$3,000 to which the physician practice would otherwise be entitled had the commercial fee schedule used the 2009 unadjusted relative value for 99213 and the 2009 Medicare conversion factors.

Many MCO fee schedules employ conversion factors greater than Medicare’s, and when this is the case, a commercial fee schedule’s use of 2008 relative values can often result in greater payment reductions than the reduction illustrated in the preceding paragraph. The following chart illustrates how a commercial fee schedule that calculates payments by multiplying the **2008** Medicare RBRVS relative value for 99213 by the MCO’s conversion factor may result in payments significantly less than would occur if the fee schedule multiplied the **current** Medicare RBRVS relative value assigned to 99213 by that conversion factor. A commercial fee schedule locking in the **2008** Medicare RBRVS relative value for 99213 would retain the **2008** 0.8806 work RVU reduction and also fail to incorporate the 0.02 increase in the practice expense RVU for 99213 that occurred between 2008 (0.73) and 2009 (0.75). Consequently, the commercial fee schedule would still assign 99213 a total relative value of 1.57, rather than the 1.70 total relative value assigned by the 2009 Medicare RBRVS. If a commercial fee schedule applies a \$45.00 conversion to 99213’s 2008 total relative value of 1.57, the resulting payment is \$70.65. But if the fee schedule applies the \$45.00 conversion factor to the 1.70 that reflects the 2009 Medicare RBRVS total relative value for 99213 (uncorrupted by the 2008 arbitrary reduction of 99213’s Work RVU), the resulting payment is \$76.50.

Payment for CPT code 99213: Routine office visit, example 2			
	2007	2008	2009
Work RVU prior to adjustment	0.92	0.92	0.92
Budget neutrality adjuster	0.8994	0.8806	N/A
Adjusted work RVU	0.83	0.81	N/A
PE RVU	0.71	0.73	0.75
PLI RVU	0.03	0.03	0.03
Total relative value before the RVU was adjusted for budget neutrality	1.66	1.68	1.70
Total relative value after the work RVU is adjusted for budget neutrality	1.57	1.57	N/A
Hypothetical MCO conversion factor	\$45.00	\$45.00	\$45.00
MCO payment	\$70.65	\$70.65	76.50

Supposing again that the physician practice provides 2,000 99213 procedures, a commercial fee schedule calculating payment based on the 1.57 relative value would produce a total payment for the 99213s of \$141,300 ($\$70.65 \times 2,000$). But if payment were based on the 2009 relative value for 99213, the total payment would amount to \$151,200 ($\$75.60 \times 2,000$), a difference of approximately \$10,000. Consequently, the fee schedule's use of the 2008 Medicare total relative value for 99213 would result in a payment reduction in 2009 of approximately \$10,000.

These two charts show how Medicare budget neutrality requirements having no legitimate application in commercial markets can nevertheless be used to reduce physician payment. These charts also illustrate the importance of ensuring that any fee schedules basing payment on the Medicare RBRVS incorporate updated relative values contemporaneously with Medicare's updates.

If the contract purports to base payment on a percentage of the Medicare Physician Fee Schedule in the sense that the MCO will pay a percentage of what Medicare pays, the physician should also consider clarifying whether the percentage will be based on what Medicare is **currently** paying.

D. How often will the MCO update relative values?

CMS updates the Medicare RBRVS relative values annually. CMS also reviews the entire Medicare RBRVS every five years and makes appropriate changes pursuant to that review. Even if the MCO uses the current Medicare RBRVS relative values, the physician should consider seeking clarification concerning whether, and how, the MCO's "Medicare RBRVS" incorporates all of the latest CMS updates. Medicare publishes its revised fee schedule in November of each year, with implementation on Jan. 1 of the following year. Some MCOs using the Medicare RBRVS update their relative values on Jan. 1, just as Medicare does. But other MCOs do not perform updates until April or July of the following year. Given this variation, the physician should not assume that updating will take place concurrently with Medicare's. Accordingly, the physician should consider asking the MCO whether it will automatically update its relative values and, if so, when those updates will take place.

Prompt updating is likely to be a key concern for the physician, since the physician community, through the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC), is able to provide significant input to describe new technology to ensure that the Medicare RBRVS relative values are based on the current resources required to perform the service.

Questions concerning method and frequency of updates are equally important when contract language purports to pay a percentage of the Medicare Physician Fee Schedule, where "Medicare Physician Fee Schedule" means the amount that Medicare actually pays the physician. Here again, the physician should consider asking the MCO whether it will automatically update payment rates concurrently with Medicare's updates, or whether contractual amendments are prerequisites to updates.

E. What are the MCO's conversion factors, in dollars and cents?

The conversion factor that an MCO uses in conjunction with its RBRVS system plays an instrumental role in payment determination. Although Medicare has used a single conversion factor (except for anesthesia), some MCOs use two or more conversion factors. Prior to signing a contract, the physician should feel confident that he or she understands what conversion factor(s) the MCO intends to use when calculating physician payments and the value of those conversion factors in dollars and cents. The physician may also be well advised to determine the scope of the conversion factors used by the MCO, as different conversion factors can be used to calculate payment for surgical, specialty and primary care services. Different conversion factors may also be used to determine payment that is contingent on the type of health plan product in which the physician has agreed to participate. The physician should also consider asking whether, when and how the MCO will update its conversion factor, including whether the conversion factor can decrease.

F. What are the components/relative values of the MCO's RBRVS?

Although a contract may purport to use a Medicare RBRVS, the physician should consider clarifying whether the components of the MCO's RBRVS are identical to those used by Medicare (i.e., physician work, practice expense and professional liability insurance RVUs). Because MCOs in commercial markets are not constrained by Medicare requirements, nothing prohibits MCOs from utilizing (intentionally or unintentionally) non-Medicare components in their RBRVS.

Even if the MCO RBRVS uses the same components as Medicare's, the physician may consider clarifying whether the MCO's RBRVS assigns the same numerical values to the work, practice expense and professional liability insurance RVUs that the Medicare RBRVS assigns to the CPT codes that correspond to the services that the physician will be providing under the contract. An MCO's assignment of differing numerical values to those CPT codes is likely to produce payments that deviate from Medicare's.

G. Physicians should determine how the MCO defines the components of its RBRVS system.

If the MCO's RBRVS uses only physician work, practice expense and professional liability insurance RVUs, the physician may wish to clarify whether the MCO's **definition** of these RVU components is identical to Medicare's. A fee schedule's reference to the Medicare RBRVS does not ensure that the MCO defines the work, practice expense or physician liability insurance RVUs identically with Medicare. For example, although the MCO's RBRVS may contain a "practice expense" RVU component, such inclusion does not guarantee that the practice expense RVU accounts for all of the expenses included within Medicare's definition.

H. Will the MCO use Medicare's GPCI and associated 89 localities?

A fee schedule basing payment on the Medicare RBRVS without further description does not communicate vital information regarding whether or not the MCO will geographically adjust payments. Even if the fee schedule alludes to geographical adjustments, the physician should not assume that those adjustments will be identical to those made by Medicare's GPCI. Nor should the physician assume that localities the MCO might employ in connection with its geographical adjustments are coextensive with Medicare's 89 localities. Accordingly, prior to signing an agreement, the physician may wish to clarify whether: (1) the MCO will geographically adjust some or all of the components of its RBRVS system; (2) those adjustments will correspond to GPCI adjustments; and (3) the extent to which any adjustments are performed in association with Medicare's 89 GPCI localities. **The physician may wish to focus particularly on whether the MCO's geographical adjustments will comport with Section 134's continuation of Medicare's 1.0 GPCI floor—a continuation that prevented what otherwise would have been a significant reduction in Medicare payment for many physicians.**

The aforementioned GPCI-related issues also exist if there is language that claims to base payment on "a percentage of the Medicare Physician Fee Schedule."

I. How often will the MCO update geographic adjustments?

CMS is required to update the GPICIs every three years. Accordingly, CMS revised the GPICIs for 1995 to 1997, 1998 to 2000, 2001 to 2003 and 2004 to 2006. CMS is currently performing its 2007–2009 review. In 2008, CMS completed its GPCI review and proposed new GPICIs. Federal legislation requires that GPCI updates be phased in over a two-year period, which in the current three-year period took place in 2008 and 2009. To accomplish this 2008 and 2009 phase-in, the GPICIs contained in the 2008 Medicare Physician Fee Schedule Final Rule were calculated as one-half the difference between the fully implemented 2007 GPICIs and the fully updated 2009 GPICIs that were published in the 2009 Medicare Physician Fee Schedule Final Rule.

Even if the MCO uses the current Medicare GPICIs, the physician should consider seeking clarification concerning whether and how the MCO's "Medicare RBRVS" incorporates the latest Medicare GPCI updates.

Questions concerning method and frequency of GPCI updates are equally important when contract language purports to pay a percentage of the Medicare Physician Fee Schedule when "Medicare Physician Fee Schedule" means the amount that Medicare actually pays the physician.

J. Coding and payment policies and rules

1. Will the MCO use Medicare's coding edits and payment rules and policies or other, proprietary coding and payment methodologies?

Fee schedule language basing payment on the Medicare RBRVS or on a percentage of the Medicare Physician Fee Schedule carries with it **no guarantee** that the MCO will only utilize Medicare's coding edits or payment rules and policies, or even that the MCO will use **any** of those rules and policies. Because the MCO in its commercial business is not

constrained by Medicare requirements, nothing prevents the MCO from utilizing a set of proprietary coding edits and payment rules and policies that are wholly distinct from Medicare's.

Accordingly, prior to signing the contract, the physician would be well-advised to seek answers to the following questions:

1. Will the MCO conform to Medicare policies and rules concerning coding, edits, recoding and modifier use?
2. Will the MCO delete Current Procedural Terminology (CPT®) codes that Medicare recognizes?⁸
3. What documents or attachments will the physician be required to submit when claiming payment for specific services (e.g., those services billed under evaluation and management CPT codes)?
4. Will the MCO bind itself to Medicare's coding edits and bundling policies (e.g., policies concerning multiple surgery reduction), or will it utilize other, proprietary bundling software?
5. If the MCO utilizes proprietary coding edits or payment rules in place of, or in addition to, Medicare's, will the MCO make those coding edits and payment rules available to the physician prior to signing the contract?
6. If the MCO will disclose its coding edits and payment rules, will the disclosure be in a format that can be readily uploaded into, and subsequently utilized by, the physician's practice management system?

Even if a fee schedule purports to base payment on the Medicare RBRVS and current relative values, use of the Medicare RBRVS and current relative value will be of little use to the physician in determining expected payment if the MCO does not also adopt and limit itself to Medicare's coding edits and payment policies.

2. Will the MCO use Medicare's global surgery periods?

Medicare pays surgical procedures according to a **global** period (i.e., one payment reimburses the physician not only for the surgery itself but also for preoperative and postoperative services provided by the physician within specific time frames). For example, the preoperative period included in the global payment period for major surgery is one day and the postoperative period is 90 days. The global period applies regardless of whether the surgery is performed in a hospital, ambulatory surgery center or physician office. Medicare's global period does not include services such as: the surgeon's initial patient evaluation to determine the need for surgery; visits unrelated to the diagnosis for which the surgical procedure was performed; or treatment which was not part of the normal recovery from surgery.⁹

Even if a MCO utilizes the current Medicare RBRVS relative values, the MCO may not adopt Medicare's global payment periods. The AMA has learned that some MCOs have attempted to lower payments for surgical procedures by redefining Medicare global surgery periods. The AMA strongly opposes such redefinition and encourages MCOs using the Medicare RBRVS to employ Medicare's global periods.¹⁰ Notwithstanding the AMA's position, a physician should not assume that a MCO's global periods comport with Medicare's. Accordingly, before signing a contract, a physician may wish to determine which global periods the MCO will apply.

3. To what extent will the MCO utilize Medicare's site-of-service differential?

Sometimes the amount that Medicare pays for a service depends on where the service is provided. Payment that is contingent upon where the service is provided is referred to as the "Medicare site-of-service differential." The Medicare site-of-service differential is intended to take into account the difference in practice expenses between services provided in a facility (e.g., a hospital) and a nonfacility (e.g., the physician's office). The Medicare RBRVS practice expense RVU methodology recognizes that physicians incur more costs when services are performed in the office (e.g., staff wages and supplies) vis-à-vis the hospital, where the hospital incurs the costs of supplies and staff wages. Some MCOs use fee

⁸ CPT is a registered trademark of the American Medical Association.

⁹ Further information can be found in Medicare Claims Processing Manual, Chapter 12: Physicians/Nonphysician Practitioners, § 40, which can be accessed at <http://www.cms.hhs.gov/manuals/iom/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS018912&intNumPerPage=10>.

¹⁰ H-70.948 Exclusion of Preoperative Services from Surgical Global Fee; H-400.956 RBRVS Development

schedules that employ non-Medicare site-of-service payment differentials. Prior to signing a contract, a physician may wish to clarify (1) whether any fee schedules will utilize site-of-service payment differentials, and, if so, (2) the extent to which those differentials diverge from Medicare's.

K. What will the MCO pay for procedure codes to which Medicare has yet to assign a payment rate?

The physician may anticipate that he or she will seek payment for providing services to which Medicare has yet to assign a payment rate. If Medicare has yet to adopt codes, a fee schedule basing payment on the Medicare RBRVS or on a percentage of the Medicare Physician Fee Schedule may also lack applicable rates. If the physician expects to provide such services under the contract, the physician may wish to ask the MCO whether and how much the MCO will pay for those services.

L. If payment will be based on a pre-2009 version of the Medicare RBRVS or Medicare Physician Fee Schedule, how will new codes added since the pre-2009 version be priced?

As already discussed, some MCOs are offering physicians contracts that would determine payment by applying a conversion factor to pre-2009 Medicare RBRVS relative values. Payment methodologies based on pre-2009 Medicare RBRVS relative values may not include codes that Medicare has subsequently developed. The physician may want to seek clarification concerning whether and how the MCO will recognize these subsequent codes.

M. Will the MCO provide specific payment examples?

Anytime the physician does not feel confident that fee schedule language or the MCO's explanation provides information sufficient to accurately predict payment, the physician may want to consider requesting examples showing how the physician will be paid for providing a specific service. In some cases, state law may even require the MCO to provide such examples.¹¹

N. Will the MCO pay the physician for items and services not compensated by its conversion factor/Medicare RBRVS or Medicare Physician Fee Schedule methodologies?

Medicare sometimes pays physicians for providing items and services using payment mechanisms other than the conversion factor/Medicare RBRVS methodology. Contracts purporting to pay the physician based on the Medicare RBRVS or on a percentage of the "Medicare Physician Fee Schedule" may lead physicians to erroneously assume that the MCO will pay the physician for **all** of the items and services for which Medicare pays. For example, in addition to paying physicians pursuant to its conversion factor/RBRVS methodology, Medicare also pays physicians utilizing:

1. ASP Drug Pricing;
2. the Clinical Diagnostic Laboratory Fee Schedule; and
3. the Durable Medical Equipment (DME), Prosthetics, Orthotics and Supplies Fee Schedule.

References to a "Medicare RBRVS" or "a percentage of the Medicare Physician Fee Schedule" convey no specific information concerning: (a) whether the MCO will pay the physician in a manner analogous to 1, 2 or 3; and (b) the amount of that payment. Accordingly, the physician may wish to seek clarification concerning the extent to which the MCO will pay for drugs, clinical lab services, DME, prosthetics, orthotics or supplies.

P. Does the MCO utilize the Hospital Outpatient Prospective Payment System cap for imaging services?

Section 5102(b) of the Deficit Reduction Act of 2005 placed a payment limit on the technical component (TC) of many diagnostic imaging tests. This cap is based on the Hospital Outpatient Prospective Payment System (HOPPS). Under this cap, the amount Medicare Part B pays for the TC of a diagnostic imaging test performed in a freestanding setting (e.g., a

¹¹ See e.g., Tenn. Code Ann. § 56-7-1013(b)

physician office), must be the lower of what Medicare Part B pays for the TC or what the HOPPS pays for the TC. The HOPPS cap has sometimes lowered physician payment for the TC of diagnostic tests. If the physician anticipates billing the MCO for providing diagnostic imaging tests, the physician may consider asking the MCO to clarify whether and to what extent the MCO's conversion factor/RBRVS payment methodology incorporates the HOPPS cap.

Q. Does the contract contain one fee schedule or different fee schedules for different plans or products in which the physician will be required to participate?

A contract may obligate a physician to participate in more than one health plan or product offered by the MCO. Such plans or products may include, but not be limited to, a health maintenance organization, preferred provider organization, and governmental or self-funded employer plans or products. Each plan or product is likely to have a different fee schedule associated with it to reflect the fact that physician practices often have a different cost structure for participating in different health products and/or the fact payers are charging different premiums for those products. If a contract presents a physician with various fee schedules purporting to base payment on the Medicare RBRVS or Medicare Physician Fee Schedule, the physician should consider using this document to clarify the meaning and use of each such fee schedule.

VII. Conclusion

Many managed care contracts that purport to base payment on the Medicare RBRVS or on a percentage of the Medicare Physician Fee Schedule may not provide information sufficient to enable a physician to determine what actual compensation rates will be, and may not be based on current relative values. Physicians should, therefore, be reticent to make assumptions concerning payment under the contract until they obtain satisfactory, clarifying information from the MCO offering the contract. This resource should facilitate such efforts. For further assistance or information, please contact the AMA's Private Sector Advocacy unit at (312) 464-4503. Visit www.ama-assn.org/go/rbrvs for information on the Medicare RBRVS and the AMA/Specialty Society RVS Update Committee (RUC).