Your Revenue Cycle and Fee Schedule Development
Introduction

• Fee Schedule (Charge Master)
  • Important financial tool within the Health Center
  • Device for billing & collecting services rendered
  • Can indicate Health Center’s compliance with policies & regulations
Fee Schedule

• Concise tool provides payers, patients & regulators understanding of how the Health Center defines value of its services
• May send signal the Health Center is market sensitive, fiscally responsible & organizationally sound
Fee Schedules

• Why is maintaining the fee schedule important?
  • Establishes charges to be submitted to payers
    • Medicare
    • Medicaid
    • Commercial insurance
    • Self-pay patients
  • Improper fee schedule could result in the Health Center not receiving full reimbursement
  • As new procedure codes are added fees need to be assigned
Importance of Fee Analysis

- Ensure Health Center is utilizing fee schedule to its advantage
- Consider the need of surrounding community
- Evaluate methodology
- Ensure adherence with state & regulatory requirements
Developing & Maintaining

- Statutory & regulatory requirements
- Public Health Service Act, Section 330 principles
- Can be complex & confusing at times
- The more complex the Health Center = the more complex the fee analysis process
Establishing a Fee Schedule

• Fees or payments must be designed to cover the health center’s reasonable costs in providing the service
• Fees or payments must be consistent with locally prevailing rates or charges for the service
• Must be a corresponding schedule of discounts applied to the fees or payments for uninsured & underinsured persons whose incomes are at or below 200% of the current federal poverty income guidelines, which discounts must be adjusted on the basis of each patient’s ability to pay
• Comparison against Medicare Physician Fee Schedule (MPFS) to ensure no fees are below allowable amount
• Considers costs of services
• Establish & use minimum charge threshold to ensure fees are reasonable compared to market
• Establish & use maximum charge threshold to ensure that fees are not priced too high
• Comparison against national & state average charge levels to understand competitiveness, market dynamics & relative value of services
• Understand use & utilization of procedures & modifiers
• Validation of reimbursement through contracts & EOBs
Fee Schedule Philosophy

• Maximum Allowable Payment (MAP)
  • Determine the MAP from payers
  • Set fees above the MAP

• Surveys & published lists
  • Obtain & utilize published data to establish fees
  • Timeliness of data is concerning
  • Where is data obtained?
Fee Schedule Philosophy

• Asking others…
  • Raises legal concerns
  • Does not take into consideration the uniqueness of the Health Center
  • No assurance of appropriate methodology originally utilized
Fee Schedule Philosophy

• Relative value units
  • Fees are tied to the assigned value of a procedure
    • Three parts of the value:
      1. Physician work
      2. Time
      3. Risk
What are Relative Value Units (RVUs)?

• Resource Based Relative Value Scale (RBRVS)
• Unique to the medical industry
• Values are directly associated with medical services
## 2017 National Physician Fee Schedule Relative Value File April Release

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Source: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html)
RVUs are...

- Non-monetary relative units of measure that indicate the value of health care services & differences in resources consumed when providing resources or services
- Objective, standardized method of analyzing resources involved in the provision of services
Fee Schedule Philosophy

• Pricing Philosophies
  • Blending philosophies
    • Market driven with RVUs used to correct discrepancies in market based fees & vice versa
    • Incorporate cost
Considerations in Establishing Methodology

- Expenses
- Conversion factors
- Payers
- Market dynamics
- State & regulatory requirements
Components of Analysis

- Resource Based Relative Value Scale (RBRVS)
- Medicare Physician Fee Schedule (MPFS)
- Local & national charge data
- Cost
- Fee relationships
  - Utilization of modifiers
  - Component billing
    - Technical Component (TC) vs.
    - Professional Component (PC)
Benchmarking Fees

- Benchmark: standard against which something can be measured or judged
  - Appropriate to utilize external standards
    - MPFS
      - Ensure charges are not below the allowable amount
    - RBRVS
      - Establish minimum & maximum charge limits
      - Establish & compare conversion factors for each code
Benchmarking Fees

• Competitive factor
  • Competition drives fees in nearly every industry
  • More competitive area = more sensitivity to fees
    • Particularly true for E&M codes
Conversion Factors

• Conversion Factor (CF) = dollar amount utilized for core fee schedule establishment
  • RVU * CF = Reimbursement or Fee
  • Studies show consumers tend to be more price-sensitive about certain physician encounters
  • May adjust visit codes & surgical codes
Charge Thresholds

- **Minimum charge threshold**
  - Enables Health Center to determine the point in which a procedure is considered below the minimum amount
    - Could be the “floor” for the fee schedule model
    - May trigger review
      - Considering competition does not always indicate fee adjustment
Charge Thresholds

- **Maximum charge threshold**
  - Enables Health Center to determine the point in which a procedure is considered above the maximum amount
    - Ceiling for the fee schedule model
    - May trigger review
      - Considering competition does not always indicate fee adjustment
Modifier Relationships

• Approximately 300 modifiers
  • Those that affect reimbursement
    • *One example*: modifier 80
  • Those that do not affect reimbursement
    • *One example*: modifier 25
Modifier Relationships

- Determine how the fee is affected by the modifier
  - Modifier reduces reimbursement
    - Fee typically remains same as non-modified code
  - Modifier increases reimbursement
    - Fee is increased by the same ratio
PC/TC Modifiers

- Established to distinguish portion of service furnished by physician
  - 26 modifier = Professional Component (PC)
  - TC modifier = Technical Component (TC)
    - Sum of fees charged for a procedure modified with PC & TC should equal the total global nonmodified counterpart
      - Example: Global 12345 = $100 sum of 12345-26 & 12345-TC = $100
Code Changes

• Code changes are made routinely to incorporate new, edited & deleted codes
• Important to update your Health Center fee schedule annually
  • Exclude codes that are not to be considered from your fee schedule analysis
Data Elements

• Fee schedule
  • Procedure code with modifier, if any
  • Fee amount
  • Annual (or other period) frequency

• EOB forms
  • Prior three months of commercial EOBs only
  • EOBs should represent codes performed most often
Data Elements

• Local, regional & national information
• Physician Fee Schedule Database
  • Found at CMS website
    • [www.cms.gov](http://www.cms.gov)
Analytical Spreadsheet

• Building the spreadsheet
  • Procedure code
  • Description
  • Modifier
  • Fee
  • Frequency
  • Gross Charges
  • Total Non-Facility RVU

• Medicare Non-Facility Reimbursement
  • Calculated Conversion Factor
  • EOB data
  • Charge Data Comparisons
Charge Structure Development & Other Related Topics

Sample Analysis
Adjusting the Fees

• Identify those fees under the MPFS
• Identify codes where cost of service exceeds collection amount
  • Utilizing cost account analysis
  • Determine cost per RVU
• Identify those codes below the minimum charge threshold
• Option to identify those codes above the maximum charge threshold
Determine Adjustment Amount

- Complex
- Economy
- Market
- Location
Medicare FQHC Prospective Payment System (PPS)

Charge Structure Considerations
PPS Background Basics

- Specific five G codes, each with their own qualifying visit CPT codes
  1) G0466 – FQHC visit, new patient
  2) G0467 – FQHC visit, established patient
  3) G0468 – FQHC visit, IPPE or Annual Wellness Visit
  4) G0469 – FQHC visit, mental health, new patient
  5) G0470 – FQHC visit, mental health, established patient
• FQHC PPS base payment rate will be increased by the percentage increase in a market basket of FQHC goods & services
  • Base rate from January 1, 2019 through December 31, 2019 = $169.77
  • Base Rate x Geographic Adjustment Factor (GAF)
    • Established = $169.77 x GAF
    • Higher Intensity = + 34.16%
• Medicare payment = 80% of the lesser of the actual G code charge or the PPS rate
• Beneficiary coinsurance = 20% of the lesser of the actual G code charge or the PPS rate
• Total payment would not exceed the lesser of the “Medicare visit” charge or PPS rate
PPS: Charge Structure Implications

- Limited CMS regulations for PPS rate establishment methodology, but must be documented
- Accuracy of data captured within your Health Center fee structure will be even more important due to the direct correlation to the PPS payment calculations/rates
- Other essential considerations:
  - Further emphasis on capturing & maximizing data representative of the “typical bundle of charges” & services
  - Reference the most current CMS date (i.e., base rate, GAFs, qualifying visit codes for each G-code)
Charge Structure Development & Other Related Topics

Charge Structure Summary
Calculating the Net Financial Impact

• Final impact is normally less than the difference between the new fee & the current fee times the frequency
• Increases in fees do not always result in an increase in reimbursement
Summary of Analysis Steps

1) Download RBRVS file
2) Generate internal electronic fee schedule
3) Merge two spreadsheets
4) Generate utilization report by procedure code
5) Incorporate utilization data into spreadsheet
6) Calculate gross charge
7) Calculate current CF by procedure code
8) Add Medicare non-facility reimbursement
Summary of Analysis Steps

9) Identify fees under MPFS
10) Add cost of procedure to spreadsheet
11) Identify codes where cost of service exceeds collection
12) Identify codes below minimum charge threshold
13) Identify codes above maximum charge threshold
14) Compare to national/local information
Summary of Analysis Steps

15) Conduct EOB analysis
16) Decide on fee adjustment
17) Assess & calculate PPS G-code impact
18) Recommend new fee
19) Compare to national/local information
20) Conduct EOB analysis
21) Conduct financial impact analysis
22) Set fee
Summary

• Developing & maintaining correct fee schedule is crucial
• Team approach is recommended
• Ongoing reviews should be conducted
Summary

• Health Center should assign an employee to monitor fee schedule updates
• Employee should have a thorough understanding of fee schedules
• Consider having a secondary approval
  • Addition or deletion of codes
  • Changes in reimbursement
  • Check for updates at least quarterly
Billing Best Practice Goals

• Operationally track front desk collections
  • Identify best practices and best personnel for trainers

• Providers complete coding/charts same day as the date of service (DOS)

• Charges are entered < 2 days of DOS

• Claims transmission within 2 days of charge

• Payment posting < 3 days of receipt of EOB/check

• Denial rate < 10%
Medicare opportunities

- Set correct fee schedule and G codes to capture full eligible PPS rate
- File Medicare Advantage wrap-around OR contract for your full Medicare PPS rate
- Evaluate Medicare Chronic Care management program viability
PA Medical Assistance - Thoughts

• What are you seeing on Medicaid wrap-around?
  • Settlement timing?
  • Alterations/edits to report filed during the process?
  • Settlement payment timing expectations?
  • How far have you calculated? 2017? Beyond?
  • Getting paid correctly by MCO’s?
• Who is electing to be paid PPS by MCO’s?
• Who is electing fee for service with wrap?
PA Medical Assistance - Thoughts

- Change in scope (CIS) updates
  - Michele Minter newer person at the state
  - CIS process is not fast, but faster and helpful interactions
  - CIS events are not subject to materiality, only the necessity for an interim CIS is optional
  - Discuss billing and rate philosophies

- PA state MCO contacted me
  - Wanted to understand CIS process
  - Surprised by 7 figure settlement want early notice
Revenue Cycle Opportunities

- Do you analyze your net patient service revenue by payer?
- Can you explain your net patient service revenue by payer?
- How do you investigate the differences between cash expected and collected?
- Any success stories from the group?
Questions?
Thank You!
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