Charge Setting and Maintenance

MT Primary Care Association

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Meet Your Presenter

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Agenda

- Charge Setting
- Maintenance
- Medicare G codes

Chargemaster – What and Why

- Fee Schedule (Chargemaster)
  - Important financial tool
  - Device for billing & collecting services rendered
  - Internal Reporting
- 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
  - Compliance

Developing & Maintaining

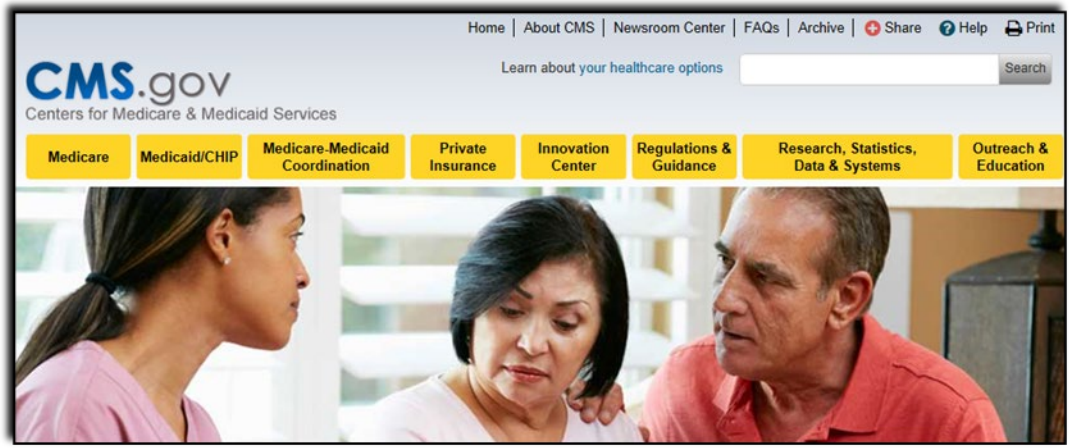
- Public Health Service Act, Section 330
  - Development governed by Requirements of the Health Center Program (Chapter 16 HRSA Compliance Manual)
    - Fees or payments must be designed to cover the health center's reasonable costs in providing the service
    - Fees or payments must be consistent with 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
- The more complex the Health Center = the more complex the fee analysis process?
- Medicare Benefit Policy Manual Ch. 13 Sections 90.1 – 90.2
  - Single fee schedule for all payors

Benchmarks & Analytical Components

- Local Prevailing Rate
  - Percentile
- Maximum Allowable Payment (MAP)
  - Determine the MAP from payers (commercial and government)
  - Set fees above the MAP
- Cost
- Surveys & published lists
- Asking others…
  - Raises legal concerns
  - Does not take into consideration the uniqueness of the Health Center
  - No assurance of appropriate methodology originally utilized

Data Elements

- Local, regional & national information
- Medicare Physician Fee Schedule Database
  - CMS website
    - www.cms.gov
    - Fee Schedules - JF Part B - Noridian
- Appropriate to utilize external standards
  - MPFS & Commercial Payor Allowed Amounts
    - Ensure charges are not below the allowable amount
  - Resource Based Relative Value Scale (RBRVS)
  - Establish minimum & maximum charge limits
  - Establish & compare conversion factors for each code



Relative Value Unit (RVU)

- Resource Based Relative Value Scale (RBRVS)
  - Unique to the medical industry
  - Values are directly associated with medical services
    - 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
- 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

RVUs File - Example

2025 National Physician Fee Schedule Relative Value File January Release

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RELEASED 10/31/2024

HCPCS	MOD	DESCRIPTION	STATUS CODE	NOT USED FOR MEDICARE PAYMENT	WORK RVU	NON-FAC PE RVU	NON-FAC NA INDICATOR	FACILITY PE RVU	FACILITY NA INDICATOR	MP RVU	NON-FACILITY TOTAL	FACILITY TOTAL
99202		Office o/p new sf 15 min	A		0.93	1.16		0.40		0.07	2.16	1.40
99203		Office o/p new low 30 min	A		1.60	1.61		0.69		0.16	3.37	2.45
99204		Office o/p new mod 45 min	A		2.60	2.21		1.15		0.24	5.05	3.99
99205		Office o/p new hi 60 min	A		3.50	2.83		1.59		0.34	6.67	5.43
99211		Off/op est may x req phy/qhp	A		0.18	0.51		0.07		0.01	0.70	0.26
99212		Office o/p est sf 10 min	A		0.70	0.95		0.30		0.05	1.70	1.05
99213		Office o/p est low 20 min	A		1.30	1.35		0.57		0.10	2.75	1.97
99214		Office o/p est mod 30 min	A		1.92	1.80		0.83		0.15	3.87	2.90
99215		Office o/p est hi 40 min	A		2.80	2.42		1.28		0.21	5.43	4.29

Analytical Spreadsheet

- Build the spreadsheet

- ✓ Procedure code
- ✓ Modifier
- ✓ Description
- ✓ Fee
- ✓ Frequency (12 months)
- ✓ Gross Charges
- ✓ Total Non-Facility RVU
- ✓ Local Prevailing Rate
- ✓ Medicare Non-Facility Reimbursement (CLFS, ASP, DMEPOS, Other)
- ✓ Calculated Conversion Factor
- ✓ Payor Allowed Amount
- ✓ Charge Data Comparisons

Fee Schedule Analysis Example

Health Center Costs (audit report):	$ 2,500
Total RVU's (Effort)	17
Cost per RVU	$ 147

	Utilization (A)	RVU Value (B)	Total RVU's (A x B) = C
99212	5	1	5
99213	3	2	6
99214	2	3	6
	10		17

	RVU Value (B)	Cost Per RVU (D)	Fee Scheduled Based on Cost (B x D)	Market: 50th Percentile per Fee Schedule Analyzer	Market: 65th Percentile per Fee Schedule Analyzer	Market: 75th Percentile per Fee Schedule Analyzer	Medicare Fee Schedule	BCBS	Current Fee
99212	1	$ 147	$ 147	$ 125	$ 130	$ 135	$ 80	95	95
99213	2	$ 147	$ 294	$ 205	$ 210	$ 215	$ 130	145	145
99214	3	$ 147	$ 441	$ 350	$ 355	$ 360	$ 210	235	235

Maintaining Fees

- Policy
- Identify codes with $0 fee
- Identity duplicate codes, different prices
- Identify fees less than MAP
- Compare cost to charges
  - Determine cost per RVU vs charge per RVU
- Identify those codes below the 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
- Option to identify those codes above the 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

Net Financial Impact and Other Considerations

- Financial 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
- Considerations for supplies
  - Prescription drugs
  - Eyeglasses / Dentures
  - Labs (dental) and other supplies
- To facilitate access, charges can be:
    - Priced at less than locally prevailing rates
    - Prices can be set to cover expenses
    - Prices can be set below cost
- Patients > 200% Federal Poverty Level

Code Changes

- Code changes should be 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
- Perform a thorough analysis/engage third-party every 2-3 years
- Developing & maintaining correct fee schedule is crucial
  - Team approach is recommended
    - Clinical team should review fee schedule to ensure codes exist for services rendered (missed revenue)??
  - Ongoing reviews should be conducted

Medicare G code charges

- Can charges be set at or above eligible PPS rates without taking other factors into consideration?

Medicare G Code Charges

- NO
- Factors to consider
  - Bundle of services in each G code charges
  - Relationship to individual CPT/HCPC charges
- Paid the lesser of charge or eligible rate

Summary

- Health Center should assign an employee to monitor fee schedule updates
- Employee should have a thorough understanding of fee schedules
  - Validation of reimbursement through contracts & EOBs
- Consider having a secondary approval
  - Addition or deletion of codes
  - Changes in reimbursement
  - Check for updates at least quarterly
- Consider impact of fees on Medicare G code charge amounts
- Policy
- HRSA Operational Site Visit (OSV)

Questions?

Thank you!