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# relative value units:

## THE BASIS OF MEDICARE PAYMENTS

### THERE'S MORE THAN ONE WAY TO DETERMINE YOUR PHYSICIAN'S PAYMENT

BY JOHN VERHOVSHEK, MA, CPC

Medicare fee-for-service payments are calculated based on relative value units (RVUs) assigned to each covered CPT®/HCPCS Level II code. As defined in Medicare's National Physician Fee Schedule Relative Value File, there are three RVU categories that, when totaled, determine payment.

1. **Work RVUs** account for the provider's work when performing a procedure or service. Work RVUs typically account for 50% or more of the RVU total for a given code.
2. **Practice expense (PE) RVUs** reflect the cost of non-physician labor and expenses for building space, equipment and office supplies.
3. **Malpractice (MP) RVUs** reflect the cost of malpractice insurance for each procedure or service.

Work and MP RVUs for a given code remain the same whether the service is provided in the physician office, an inpatient hospital or any other healthcare setting. But because the expense of providing a service may differ depending on where the service is provided (facility vs. non-facility), the Physician Fee Schedule (PFS) lists separate columns to describe "facility" versus "non-facility" PE RVUs. You can find the place of service (POS) information you need to determine when to use the facility versus non-facility amounts in the Centers for Medicare & Medicaid Services (CMS) Claims Processing Manual 100-04, chapter 26, section 10.5.

#### ADD IT UP

To find the RVU total for a specific code, simply calculate the sum of work RVUs, MP RVUs, and either the facility or non-facility PE RVUs (as applicable to your POS). For example, per the 2015 National Physician Fee Schedule Relative Value File, CPT® 17260 *Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.5 cm or less* is assigned 0.96 work RVUs, 0.12 MP RVUs, 0.91 facility PE RVUs and 1.59 non-facility PE RVUs, for a total of 1.99 facility RVUs and 2.67 non-facility RVUs. Note that facility and non-facility totals for each active CPT® code may be found in the Physician Fee Schedule Relative Value File (columns M and L, respectively).

#### ADJUST FOR REGIONAL COST DIFFERENCES

Because the cost of practicing medicine varies by geographic location, CMS applies separate Geographic Practice Cost Indices (GPCI) to each of the three relative values (work, MP and PE) used to calculate payment. CMS is required to update the GPCIs every three years.

The easiest way to find GPCIs for your location is by using the **Physician Fee Schedule Look-Up Tool**, found on the CMS website. The tool allows you to search by code, locality and type of information (e.g., RVUs, pricing information of GPCIs.)

For example, if you're in Seattle and want to find the GPCIs for your area, select "Geographic Practice Cost Index" from the "Type of Information" pull-down menu, and then select "Specific Locality" from the "Select Carrier/Medicare Administrative Contractor (MAC) Option."

A "Carrier/MAC Locality" option displays where you can select "Seattle (King Cnty) WA" from the pull-down menu. Click "Submit" and the results will show you that the "GPCI WORK" for Seattle is 1.025, the "GPCI PE" is 1.155, and the "GPCI MP" is 0.495. The average GPCI value is 1. We know that work RVUs and PE RVUs are paid slightly higher than average in Seattle, while MP RVUs are paid at approximately half the average rate.

#### APPLY THE FORMULA TO DETERMINE FINAL RVUs

To determine the true, total RVUs for a procedure or service in your area, you would apply the following formula:

**(work RVUs × work GPCI) + (PE RVUs × PE GPCI) + (MP RVUs × MP GPCI)**

For example, to determine the final RVUs for 17260 when provided in a physician office in Seattle, apply the formula as follows:

**(0.96 work RVUs × 1.025 work GPCI) + (2.67 non-facility PE RVUs × 1.155 PE GPCI) + (0.12 MP RVUs × 0.495 MP GPCI) = 4.12725 RVUs**

In the facility setting, the total is found by applying the same formula, but using the facility PE RVUs:

**(0.96 work RVUs × 1.025 work GPCI) + (1.59 facility PE RVUs × 1.155 PE GPCI) + (0.12 MP RVUs × 0.495 MP GPCI) = 2.87985 RVUs**

#### FACTOR IN CONVERSION FACTOR

To calculate payment, you must multiply the POS- and locality-specific RVU total by a dollar conversion factor (CF). The CF for 2015 was $33.9764. The CF is updated annually, but it is consistent for all POS and localities.

From our examples above, we already know the specific RVU totals for 17260 in the facility and non-facility setting in Seattle. To arrive at a current payment amount, we multiply these totals by the CF:

- **Seattle, facility:**
  2.87985 RVUs x 33.9764 CF = $97.85
- **Seattle, non-facility:**
  4.12725 RVUs x 33.9764 CF = $140.23

Here's the complete formula used to arrive at these figures:

**[(work RVU × work GPCI) + (PE RVU × PE GPCI) + (MP RVU × MP GPCI)] × CF = final payment**

You can skip the math (and save time) by using the Physician Fee Schedule Search tool. If you select "Pricing Information" from the "Type of Information" pull-down menu, select "Seattle (King Cnty) WA" as your locality, and specify code 17260, the lookup tool will tell you the non-facility and facility prices for the code.

#### ADDITIONAL RESOURCES

+ **CMS, PFS Relative Value Files**
+ **Physician Fee Schedule Look-Up Tool**
+ **Physician Fee Schedule Search Page**

## experts: pending health insurance mergers will hit patients right in the wallet

BY SAM P.K. COLLINS

**Impending multi-billion health insurance mergers involving four major providers have drawn the ire of patient advocacy groups that say such deals violate antitrust laws and threaten to fatten insurance companies' coffers at patients' expense.**

**Earlier this year, Anthem, Inc. made a $47.5 billion bid for Cigna Corp and Aetna, Inc. proposed a takeover of Humana Inc. Meanwhile, UnitedHealth Group, currently the nation's largest insurer, also approached Aetna. These deals, if they come to fruition, would create a trinity of mega-insurance companies, each one generating more than $100 billion revenue annually. Justice Department officials have geared up to examine the mergers to see if they would benefit consumers.**

**A study by the American Medical Association (AMA), however, suggests that may not be the case, pointing out that a small group of companies already dominate a significant number of insurance markets in the United States. The consolidation of Anthem and Cigna and Aetna and Humana, AMA representatives say, will reduce options in the market for Medicare recipients, particularly those enrolled in the private Medicare Advantage plan.**

**"A lack of competition in health insurer markets is not in the best interests of patients or physicians," AMA President Steven J. Stack, M.D. said in a press statement. "If a health insurer merger is likely to erode competition, employers and patients may be charged higher than competitive premiums, and physicians may be pressured to accept unfair terms that undermine their role as patient advocates and their ability to provide high-quality care. Given these factors, AMA is urging federal and state regulators to carefully review the proposed mergers and use enforcement tools to preserve competition."**

**The analysis, required by the Affordable Care Act (ACA), found that the three largest insurers in more than 30 states commanded at least 80 percent of enrollment. In more than half of the states, a single provider had more than half of the total enrollees. Though hospitals acquired physicians groups, AMA said 60 percent of doctors worked with practices with fewer than 10 patients. Citing federal antitrust laws, the medical group said that further consolidation would allow insurance companies to raise prices and reduce quality the detriment of insurance holders.**

**This study follows the American Hospital Association's letter to the Justice Department that scrutinizes the Aetna-Humana merger, which it described as a threat to competition in up to 154 metropolitan areas in 23 states. The Commonwealth Fund also released a study that found that the Aetna-Humana merger would drive up prices for seniors, especially since there was high concentration among nearly 97 percent of Medicare Advantage markets. A study published in a Harvard-affiliated peer review journal in August predicted that insurers would "bulk up" so that they can dominate their marketplace and raise rates without consequence.**

**Since the ACA's passage, the Justice Department has challenged health insurance mergers focusing on its effect on local and regional markets. In 2010, Michigan's Blue Cross Blue Shield reneged on its consolidation with an in-state competitor after the Justice Department threatened to block the deal with an antitrust lawsuit. In 2012, officials scrutinized Humana's acquisition of Arcadian Management Services, Inc., a health care services company. The health companies responded by divesting its Medicare Advantage plans in 51 counties and parishes.**

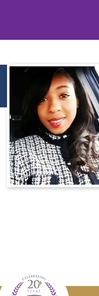
**The future of the deals currently under question have yet to be determined. While insurers waved off criticism about the merger, saying doctors and hospitals are fearful that bigger companies would cut their payments, concerned parties say the ACA protects against premium hikes that the merger would bring.**

**A key tenet of the ACA centers on lower premiums via increased competition between insurers in marketplaces. Obama administration officials told the New York Times earlier this year that consumers, sensitive to price changes, reacted by a wider variety of choices by switching over to lower premium plans during the 2014 open enrollment window. That led insurance companies to keep premiums as low as possible to attract customers, as found in a county-level analysis conducted by the federal government last year that showed more moderate increases in health care premiums, compared to years past. That year, nearly 60 percent of counties had an increase in the number of the insurers offering health plans, while fewer than 10 percent experienced a decline.**

**Obamacare opponents say the health care law includes provisions that may have spurred the consolidation, including a requirement that insurers spend a percentage of premiums of health care, a rule that critics say forces companies to cut administrative costs by merging. GOP lawmakers wasted little time in July blaming Obamacare for proposed mergers, rehashing arguments that the insurance law would place smaller providers at a disadvantage and drive up premiums.**

**But an investigation conducted by the Center for Public Integrity (CPI) challenged those allegations, outlining other factors that influenced the mergers. Those causes, CPI's Wendell Potter says, include the increasing number of Baby Boomers rushing to the Medicare rolls. In his piece, Potter also pointed to previous consolidations in the 1990s that created the current trifecta of major insurance companies and a shrinking employer-based health insurance market that has been on the decline since the turn of the century.**

## in the SPOTLIGHT | GET TO KNOW A PMB TEAM MEMBER!



**NAME:** Helen Morris

**POSITION:** Data Entry

**YEARS WITH PMB:** 2

**FAVORITE MUSIC GROUP:** Hillsong

**HOW DO YOU SPEND YOUR SPARE TIME?** Playing the drums.

**WHAT IS A MEANINGFUL QUOTE TO YOU?**
"The greatest tragedy in life is not death, but a life without a purpose." ~Myles Munroe

**WHAT MOTIVATES YOU EVERY DAY?**
My family. Knowing that I am making them proud with my achievements makes me want to work harder at my life goals.