



Medicare
Learning
Network

**PAYMENT
SYSTEM
FACT SHEET
SERIES**

Medicare Physician Fee Schedule

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Medicare Part B pays for physician services based on the Medicare Physician Fee Schedule (MPFS), which lists the more than 7,000 covered services and their payment rates.

Physician services include the following:

- Office visits;
- Surgical procedures; and
- A range of other diagnostic and therapeutic services.

Physician services are furnished in all settings including:

- Physicians' offices;
- Hospitals;
- Ambulatory Surgical Centers;
- Skilled Nursing Facilities and other post-acute care settings;
- Hospices;
- Outpatient dialysis facilities;
- Clinical laboratories; and
- Beneficiaries' homes.



MEDICARE PHYSICIAN FEE SCHEDULE PAYMENT RATES

Payment rates for an individual service are based on three components:

1) Relative Value Units (RVU)

The three separate RVUs that are associated with the calculation of a payment under the MPFS are:

- Work RVUs reflect the relative levels of time and intensity associated with furnishing a physician fee schedule service and account for more than 50 percent of the total payment associated with a service. By statute, all work RVUs must be examined no less often than every five years. The calendar year (CY) 2008 Physician Fee Schedule Final Rule includes the impact of the most recent Five Year Review of physician work RVUs. To maintain budget neutrality, this review resulted in application of a separate 0.8806 adjustment to all work RVUs.
- Practice expense (PE) RVUs reflect the costs of maintaining a practice such as renting office space, buying supplies and equipment, and staff costs. PE RVUs account for approximately 45 percent of the total payment associated with a given service. The CY 2007 Physician Fee Schedule Final Rule implemented a revised PE methodology that uses a “bottom-up approach” for direct costs and supplementary survey data for indirect costs. This methodology is more transparent than the previous PE methodology, allowing specialties and other stakeholders to predict the effects of proposals to improve accuracy of PE payments. We are in the second year of a four-year transition to the revised methodology. The CY 2008 PE RVUs include refinements to the PE inputs, and we continue to work with the medical

community to ensure that the PE inputs are correct.

- Malpractice RVUs represent the remaining portion of the total payment associated with a service. There were no revisions to the Malpractice RVUs in the CY 2008 Physician Fee Schedule Final Rule.



2) Conversion Factor (CF)

To determine the payment rate for a particular service, each of the three separate RVUs is adjusted by the corresponding geographic cost index (as explained below). The sum of the geographically adjusted RUVs is multiplied by a dollar CF. The CF is updated on an annual basis according to a formula specified by statute. The formula specifies that the update for a year is equal to the Medicare Economic Index (MEI) adjusted up or down depending on how actual expenditures compare to a target rate called the Sustainable Growth Rate (SGR). The MEI is a measure of inflation faced by physicians with respect to their practice costs and general wage levels. The SGR is calculated based on medical inflation, the projected growth in the domestic economy, projected growth in the number of beneficiaries in fee-for-service Medicare, and changes in law or regulation. Based on the criteria

discussed above, the update to the CF for CY 2008, as published in the November 27, 2007 Physician Fee Schedule Final Rule, resulted in a CF of \$34.0682. However, as a result of the Medicare, Medicaid, and SCHIP Extension Act of 2007, for claims with dates of service from January 1, 2008 through June 30, 2008, the CF is \$38.0870. For claims with dates of service from July 1, 2008 and after, the CF for CY 2008 will revert back to the \$34.0682 that was outlined in the Final Rule. There are a number of other factors that may affect payment rates in 2008. These include additional codes



from the most recent Five Year Review of physician work RVUs, limits on payments for ophthalmologic procedures required by the Deficit Reduction Act of 2005, and other annual refinements including coding changes.

3) Geographic Practice Cost Indices (GPCI)

GPCIs are adjustments that are applied to each of the three relative values used in calculating a physician payment. The purpose of these adjustments is to account for geographic variations in the costs of practicing medicine in different areas within the country. We are required to review, and if necessary, adjust GPCIs at least every three years. The CY 2008 Physician Fee Schedule Final Rule includes updated and budget neutralized GPCIs. Beginning in January 2008, updated GPCIs will be phased in over a two-year period. In CY 2008, GPCIs are calculated as one-half the difference between the fully implemented 2007 GPCIs and the fully implemented 2009 (updated) GPCIs.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 extended the application of the 1.0 floor in the work GPCI until June 30, 2008 for any locality for which the GPCI index is less than 1.0.



MEDICARE PHYSICIAN FEE SCHEDULE PAYMENT RATES FORMULA

$$[(\text{Work RVU} \times \text{Budget neutrality adjustor } (0.8806))^* \times \text{Work GPCI}] + (\text{PE RVU} \times \text{PE GPCI}) + (\text{MP RVU} \times \text{MP GPCI}] \times \text{CF}$$

* Round the product of the two factors (i.e., the Work RVU and Budget neutrality adjustor) to two decimal places.

To find additional information about the MPFS, visit http://www.cms.hhs.gov/PhysicianFeeSched/01_overview.asp on the CMS website.

This fact sheet was prepared as a service to the public and is not intended to grant rights or impose obligations. This fact sheet may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at <http://www.cms.hhs.gov/MLNGenInfo> on the CMS website.

Medicare Contracting Reform (MCR) Update

In Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes and to view the list of current MACs for each jurisdiction at <http://www.cms.hhs.gov/MedicareContractingReform/> on the CMS website.

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