

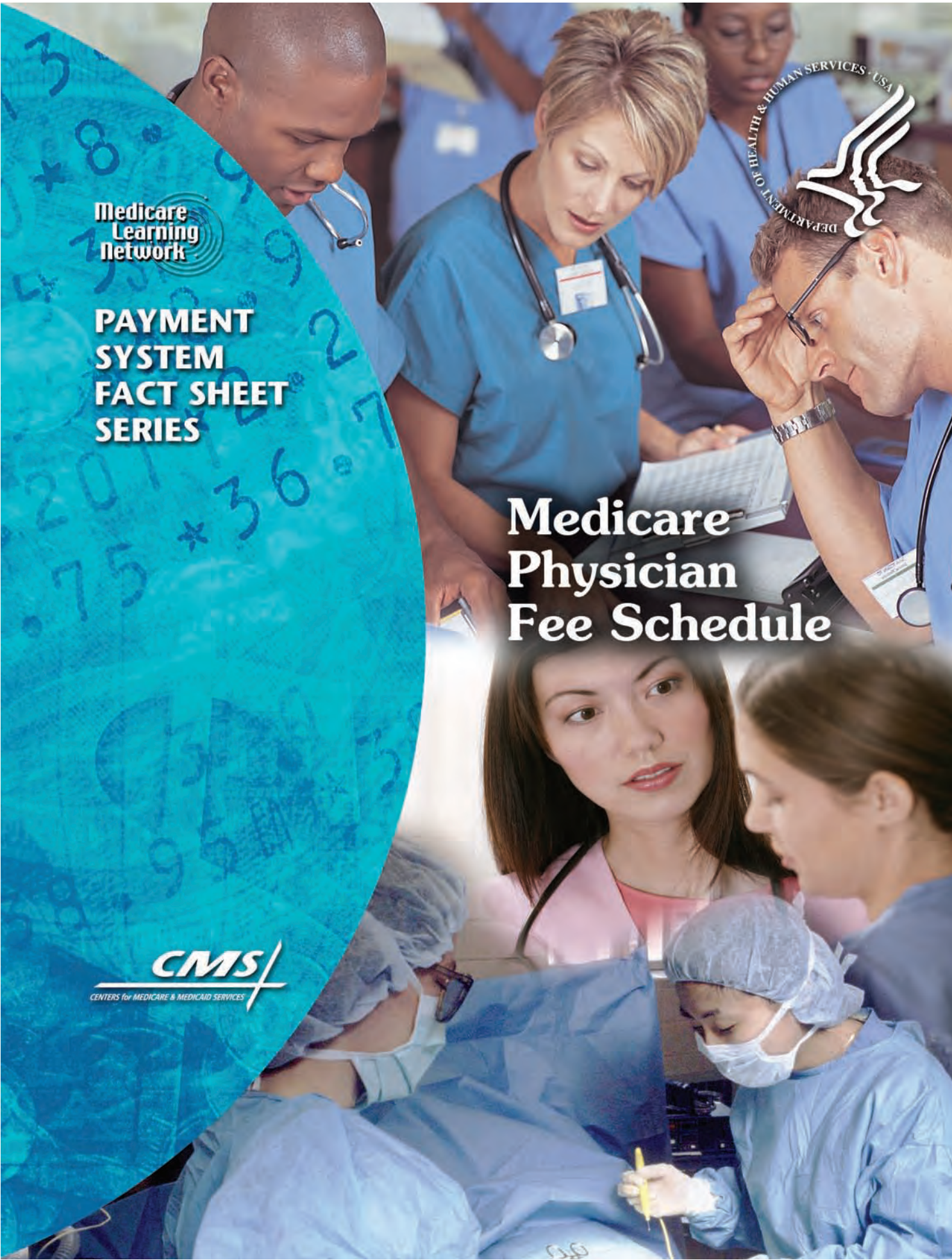


Medicare  
Learning  
Network

**PAYMENT  
SYSTEM  
FACT SHEET  
SERIES**

# Medicare Physician Fee Schedule

**CMS**  
CENTERS for MEDICARE & MEDICAID SERVICES



**M**edicare 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. Beginning in 2007, a budget neutrality (BN) adjustor (0.8806) was made to the physician work portion of the calculation to account for increases in total work RVUs resulting from the most recent Five Year Review of Work RVUs. Effective January 1, 2009, this work adjustor, which was applied to the physician work portion of the calculation in 2007 and 2008, will be eliminated as a separate adjustment to the work RVU and placed on the physician conversion factor (CF) (discussed below).
- 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 calendar year (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 bottom-up approach will be phased in over a four-year period. Services furnished on or after January 1, 2009 will be based

on the third year of this transition. PE RVUs will be based on 75 percent of these bottom-up calculated RVUs and 25 percent on the former



2006 resource-based PE RVUs. This methodology is more intuitive than the previous PE methodology, allowing specialties and other stakeholders to predict the effects of direct cost proposals to improve accuracy of PE payments. We continue to work with the medical community to ensure that the direct cost input data 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 2009 Physician Fee Schedule Final Rule.

## 2) 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 RVUs 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 2009, as published in the November 19, 2008 Physician Fee Schedule Final Rule, would have resulted in a -10.1 percent reduction to the CF for CY 2009. However, as a result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, claims

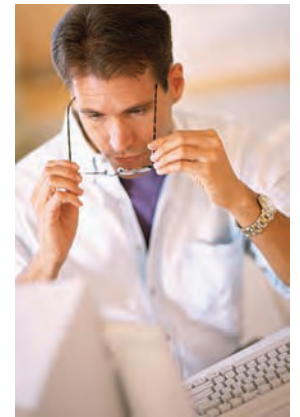


with dates of service from January 1, 2009 through December 31, 2009 are provided a 1.1 percent increase in the CF. Additionally, as discussed above, Section 133(b) of the MIPPA required that the Secretary of the Department of Health and Human Services apply the required BN adjustment to the CF beginning January 1, 2009 instead of continuing to apply the BN adjustment to the work RVUs required as a result of the Five Year Review of Work. This required a BN adjustment to the CF of 6.41 percent. The final 2009 CF is \$36.0666, which is outlined in the November 19, 2008 Physician Fee Schedule Final Rule.

### 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 2009 Physician Fee Schedule Final Rule includes updated and budget neutralized GPCIs.

Beginning in January 2008, updated GPCIs were phased in over a two-year period. In CY 2008, GPCIs were calculated as one-half the difference between the fully implemented 2007 GPCIs and the fully implemented 2009 GPCIs. The transition was fully effective January 1, 2009. Section 134 of the MIPPA extended the 1.00 work GPCI through December 31, 2009. Additionally, Section 134(b) of the MIPPA sets a permanent 1.50 work GPCI floor in Alaska for services furnished beginning on January 1, 2009.



## MEDICARE PHYSICIAN FEE SCHEDULE PAYMENT RATES FORMULA

$$[(\text{Work RVU} \times \text{Work GPCI}) + (\text{PE RVU} \times \text{PE GPCI}) + (\text{MP RVU} \times \text{MP GPCI})] \times \text{CF}$$

To find additional information about the MPFS, visit [http://www.cms.hhs.gov/PhysicianFeeSchd/01\\_overview.asp](http://www.cms.hhs.gov/PhysicianFeeSchd/01_overview.asp) on the Centers for Medicare & Medicaid Services (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.