Understanding & Utilizing Medicare Fee Schedules
November 17, 2015
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Finding Your Carrier/Locality


- Specific geographical area designated by CMS to receive same fee schedule amount
- Determines amount a provider will be paid on a particular service or procedure

Medicare Physician Fee Schedule (MPFS)

http://www.cms.gov >> Medicare >> Physician Fee Schedule Look-Up Tool >> Medicare Physician Fee Schedule Look-up Tool >> Start Search >> Accept

- Provides Medicare payment information on more than 10,000 services, including pricing, the associated Relative Value Units (RVUs), and various payment policies
  - Professional services of physicians
  - Some services covered incident to physicians' services
  - Some diagnostic tests
  - Radiology services
  - Outpatient rehabilitation services
- Payment based on lesser of billed amount or MPFS amount
  - Medicare pays 80%
  - Beneficiary owes 20%
  - Other adjustments to payment may be made under certain circumstances
- Examples of adjustments to the fees shown in the MPFS
  - Some physicians and other health care professionals might qualify for additional payment
    - Health Professional Shortage Area (HPSA) bonus payment, HPSA Surgical Incentive Payment (HSIP), and Primary Care Incentive Payment (PCIP)
    - Electronic Health Records Incentive Program
    - Physician Quality Reporting System
    - Electronic Prescribing
  - Examples of reductions from the published MPFS amount
    - Assistants at surgery receive 16% of the MPFS rate
    - Nurse practitioners, physician assistants, and clinical nurse specialists are paid 85%
    - Registered dietitians or nutrition professionals, for medical nutrition therapy services, are paid 85%
    - Clinical social workers receive 75%
Type of Information
- Pricing Information - Provides the maximum fee schedule amount by HCPCS code
- Payment Policy Indicators - Provides only payment policy indicators information such as global surgery days, multiple surgery indicators, and applicability of professional and technical components
- Relative Value Units (RVUs) - Provides RVU information for work, practice expense, and malpractice costs
- Geographical Practice Cost Index (GPCI) - Established for every Medicare payment locality for each of the three components of a procedure’s RVU
- All - Provides data for each of the above types of information

Facility vs Non-Facility pricing
- Facility
  - Physician’s professional services when provided in a facility (such as a hospital or Ambulatory Surgical Center)
  - Does not apply to services billed on a UB-04
- Non-Facility
  - Includes payment for clinical staff, supplies, and equipment
  - Procedures performed in office
  - Applicable to therapy procedures regardless of whether they are furnished in a facility or non-facility setting
  - Institutions, such as hospitals and Skilled Nursing Facilities (SNFs), are paid at the non-facility rate!

Limiting Charge
- 115% of MPFS amount
- Maximum a nonparticipant may charge a beneficiary
- Nonparticipating health care professionals and suppliers
  - Enroll in Medicare but have not signed Form CMS-460
  - Accept assignment on a case-by-case basis
  - 5% reduction in the Medicare-approved amounts
  - Limit on what the health care professional/supplier may charge the beneficiary

List of codes and more information can be found in MLN product, “How to Use the Searchable Medicare Physician Fee Schedule (MPFS)”
Determines payment amount for outpatient clinical laboratory services

- If furnished in a Medicare-participating laboratory and ordered by a physician or qualified non-physician practitioner who is treating the patient
- **Not all laboratory services are paid based on the fee schedule!**
  - Payment based on the payment methodology for each provider type
    - See CMS Internet-Only Manual (IOM); Publication 100-04, *Medicare Claims Processing Manual*; Chapter 16; Section 30.3 for more information

For laboratory services paid based on fee schedule, payment is the least of:

- Amount billed
- Local fee for geographic area
- National limitation amount (NLA) for HCPCS

Medicare pays 100% of above

- Beneficiary does not owe coinsurance

Kansas and Missouri providers have different localities under the Laboratory Fee Schedule

- **KS Lab Locality 15 (Eastern Kansas)**
  - Johnson and Wyandotte Counties
- **KS Lab locality 12 (Western Kansas)**
  - Rest of State
- **MO2 Lab Locality 07 (Eastern Missouri)**
- **MO1 Lab Locality 15 (Western Missouri)**

QW modifier

- Clinical Laboratory Improvement Amendments (CLIA) of 1988 waived test
Payment for ambulance transports under the Ambulance Fee Schedule

- Includes base rate payment (level of service provided) plus a separate payment for mileage
  - **To the nearest appropriate facility**
  - Covers transport of beneficiary to nearest appropriate facility and all medically necessary covered items and services associated with transport
  - Precludes separate payment for items and services furnished under ambulance benefit

Payment based on lesser of billed amount or fee schedule amount

- Medicare pays 80%
- Beneficiary owes 20%
- Payment based on the zip code for the location the beneficiary was loaded into the ambulance

Zip Code to Carrier Locality File

- Find zip code for pick up location
- Make note of Urban/Rural/Super Rural designation (5th column)
  - Urban = blank
  - Rural = R
  - Super Rural = B

Ambulance Fee Schedule Public Use Files

- Find Carrier/Locality
- Urban pick up
  - Use column 7a for base rate and mileage

<table>
<thead>
<tr>
<th>Miles</th>
<th>Rate</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Rate (A0426-A0434)</td>
<td>N/A</td>
<td>Column 7a</td>
</tr>
<tr>
<td>Miles (A0425, A0435, A0436)</td>
<td>Total # of Miles</td>
<td>Column 7a</td>
</tr>
<tr>
<td>Total Allowed Amount (Base Rate + Mileage)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- **Rural pick up**
  - Use column 7b for base rate and for mileage beyond 17 miles
  - Use column 8 for mileage for first 17 miles

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<tr>
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</thead>
<tbody>
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<td><strong>Base Rate</strong> (A0426-A0434)</td>
<td>N/A</td>
<td>Column 7b</td>
</tr>
<tr>
<td><strong>First 17 Miles</strong> (A0425, A0435, A0436)</td>
<td># of Miles (no more than 17)</td>
<td>Column 8</td>
</tr>
<tr>
<td><strong>Miles 18+</strong> (A0425, A0435, A0436)</td>
<td>Total Miles – 17 (if applicable)</td>
<td>Column 7b</td>
</tr>
</tbody>
</table>

**Total Allowed Amount** (Base Rate + Mileage) | Add all rows

- **Super Rural pick up – Ground only (does not apply to air ambulance)**
  - Use column 7c for base rate
  - Use column 8 for mileage for first 17 miles
  - Use column 7b for mileage beyond 17 miles

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Ambulatory Surgical Center (ASC) Fee Schedule

http://www.wpsmedicare.com >> (appropriate Part B MAC jurisdiction) >> Fees >>
Current Year Fee Schedules >> 20xx Specialty Pricing >> 20xx Ambulatory Surgical Center (ASC) Fees

- Medicare makes a single payment to ASCs for covered surgical procedures
  - Separate payment may be made for covered ancillary services integral to a covered surgical procedure
    - If billed immediately before, during, or immediately after the covered surgical procedure
- Paid the lesser of the actual charge or the ASC payment rate for each procedure or service
  - Medicare pays 80%
  - Beneficiary owes 20%
  - Other adjustments to payment may be made under certain circumstances
  - Most preventive services paid 100% by Medicare
- Determine the County/Core Based Statistical Area (CBSA) is for your provider

Additional Resources

- CMS Internet-Only Manual (IOM); Publication 100-04, Medicare Claims Processing Manual
- CMS Medicare Learning Network® (MLN) Educational Publications
  (http://www.cms.gov/MLNProducts/downloads/MLNCatalog.pdf)
  - Ambulance Fee Schedule (ICN 006835)
  - Clinical Laboratory Fee Schedule (ICN 006818)
  - Medicare Physician Fee Schedule (ICN 006814)
  - How to Use the Searchable Medicare Physician Fee Schedule (ICN 901344)

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