

Fee schedule analysis: Using your complete practice cost as a guide

The physician fee schedule is an important financial tool within the physician practice. In every industry, including health care, what an entity charges (i.e., fee schedule) for its services should reflect the value of those services, including costs incurred to provide the services. In each physician practice, the fee schedule should be a carefully considered tool that gives patients, payers, regulators and other reviewers a clear picture of how the physician practice defines the value of its services, including the costs it incurs to provide these services. A well-developed and maintained fee schedule sends a signal that the practice is market sensitive, fiscally responsible and organizationally sound.

Picture this: You walk into the grocery store to begin shopping for a special dinner for some friends. You get some meat, fresh vegetables, rice, soup stock and other ingredients. You get to the checkout counter and the clerk takes your first item (the soup stock) and scans it for the price. You look at the screen facing you and next to the price field it reads “Make an offer.” Many physicians treat their services just this way.

This may seem like a ludicrous example, but many physicians depend on some other entity, such as a payer, to establish the value of their services. While a physician practice is not the same as a grocery store, the principle of establishing a fee for a procedure or service is similar in nearly every business. In the above example, the price of each grocery item reflects the combined cost of purchasing the item and operating the business. If the grocery store owner didn’t know what it cost to purchase the product and wasn’t able to factor in the cost of overhead, labor, insurance, theft, etc., the owner wouldn’t be able to appropriately determine whether the store was making or losing money based on the price (or fee) marked on the grocery item.

When a physician depends on a payer, whether it be Medicare or a commercial health insurer, to determine what his or her fee schedule will be, the physician accepts payment amounts that are determined by an entity that, simply stated, doesn’t necessarily make decisions that reflect the value that the individual physician practice would place on its services for patients.

Establishing a physician practice fee schedule

All physician practices need to establish a physician fee schedule or price list for physician services, just as grocers establish their price list for their goods. The physician, like the grocer, should establish a practice-specific fee schedule based on the physician practice’s cost of providing goods and services and the value added by the physician’s services. In other words, the fee schedule should take into account the costs incurred by the practice and the value provided by that practice in delivering quality medical care.

There are many ways to determine the cost of services a physician provides in the practice. This document describes one option that utilizes the Centers for Medicare & Medicaid Services (CMS) Resource-Based Relative Value Scale (RBRVS). To use this method, the physician practice should have the necessary reference sources, including current copies of the AMA Current Procedural Terminology (CPT®) book*, Healthcare Common Procedure Coding Systems

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This educational resource was developed through a cooperative effort between the American Medical Association and MIT Solutions Inc.

(HCPCS), Medicare RBRVS, RBRVS Data Manager and Medicare’s National Correct Coding Initiative (NCCI) or similar resources.†

Why use the Medicare RBRVS to establish a fee schedule?

Policy adopted by the AMA House of Delegates states that a RBRVS that is annually updated and rigorously validated could be a basis for non-Medicare physician fee schedules. This policy and the method described below for developing a physician fee schedule, pertains only to using the relative values reflected in the Medicare RBRVS, and not the Medicare fee schedule (payment amount).

In a RBRVS, services are ranked according to the relative physician effort and the costs involved in providing them. For example, if service A generally takes twice as long to provide, is twice as difficult, and requires twice as much overhead expense (such as non-physician personnel, office space and equipment) as service B, then the RVU of service A may be twice that of service B.

An RBRVS such as Medicare’s is converted into dollars by multiplying the RVU for a particular service by a dollar amount conversion factor. For example, if the RVU for service A (as expressed in a CPT code) is 20 and the RVU for service B (as expressed in a CPT code) is 10, a conversion factor of \$35 yields a payment of \$700 for service A and \$350 for service B. Likewise, a conversion factor of \$50 yields payments of \$1,000 for A, and \$500 for B, and so on for each service the physician provides.

| CPT code | RVU | Conversion factor | Amount |
|-------------------|-----|-------------------|--------|
| XXXXA (service A) | 20 | 35 | \$700 |
| XXXXB (service B) | 10 | 35 | \$350 |

For Medicare (and other health insurers) to ensure that claims are processed in an orderly and consistent manner, use of standardized code sets is essential. The CPT and CMS’ HCPCS code sets are widely used for this purpose.

A hypothetical physician practice fee schedule

For a typical family practice, the listing may look like the hypothetical model, presented as **Figure 1** at the end of this document. Use this as your guide to estimate your cost per RVU and create your own physician practice fee schedule by following these 12 steps:

1. Compile a complete list of all CPT codes billed in the most recent year and enter in **Column A** of the spreadsheet. Remember, since this model depends on the presence of RVUs, only enter CPT codes that have a corresponding RVU value. Many HCPCS Level II codes, such as those for drugs and supplies, do not have RVU values assigned and therefore should be excluded from the table.
2. Add a corresponding CPT short descriptor to **Column B** of the spreadsheet, and how many times the procedures were billed in **Column C**.
3. To find the total practice cost RVUs per CPT code, enter the sum of the non-facility practice expense RVU and the professional liability insurance (PLI) RVU that you obtained from the *Medicare RBRVS: The Physicians’ Guide*, or other source in **Column D**.
4. Calculate your practice cost (excluding physician salary/other income and anticipated profit) for the most recent full year, totaling your practice’s monthly expense statements. Place this figure in the box titled **“Estimated physician practice expense and PLI cost for year,”** which is located at the bottom of the chart. You should account for each employed physician’s practice expense and professional liability insurance in your calculations.

† Visit www.amabookstore.com to order these and other resources.

5. Take your practice cost and divide by the sum of **Column E** to obtain your average cost per RVU¹. Place this figure in the box titled “**RVU¹**,” which is located at the bottom of the chart.
6. To calculate the physician practice cost (excluding physician salary/income and anticipated profit) to perform a service, multiply the total of the PE and PLI RVUs (**Column D**) by the average cost per RVU¹ and place in **Column F**.
7. Enter the Medicare physician work RVU that you obtained from *Medicare RBRVS: The Physicians’ Guide*, or other source in **Column G**.
8. Calculate your physician resource cost (physician salary/other income) for the most recent year from your practice’s financial statements. Place this figure in the box titled “**Physician resources**,” which is located at the bottom of the chart. If a physician employs other physicians with base salaries, and/or if the physician practice is a medical corporation in which all physicians receive a salary, those salaries should be included in this step.
9. Take your physician resource cost and divide by the sum of **Column H** to obtain your cost per work RVU². Place this figure in the box titled “**RVU²**,” which is located at the bottom of the chart.
10. To calculate the physician resource cost (physician salary/other income) required for a service, multiply the Medicare physician work RVU (**Column G**) by the average cost per RVU² and enter the value in **Column I**.
11. To obtain the total practice costs plus additional physician resources per service, add the practice cost of service (**Column F**) to physician resources required for service (**Column I**) and enter the value in **Column J**.
12. From this point in the spreadsheet you can add any additional markup percentage to the total practice costs plus physician resource per service (**Column J**) to the fee schedule and enter the value in **Column K**. This markup must be adequate to allow for all losses due to non-payment or payment that is less than total practice cost. Non-payment may occur due to the provision of charity care, bad debt or payer payment policies (i.e. bundling rules that recognize payment for only one procedure or service performed, when two procedures or services were performed) or other disallowances. When you practice incurs losses for any reason, the financial viability of the practice may be threatened unless sufficient revenues in excess of cost are collected from other sources. It may also allow for profit as well as contributions to reserves and/or future capital expenditures.

Again, just as the grocery store owner has a right and a rationale for setting his or her prices, the physician practice sets its fees based on the costs incurred in providing physician services—together with values associated with training, qualifications, length of time in practice, reputation, skills, amount of charity care given, geographic area and other relevant factors.

Services not listed in the *Medicare RBRVS: The Physicians’ Guide* may not be covered by Part B of Medicare or may be considered “carrier priced.” A private payer may determine the amount it will pay the physician for a service, or it may adopt another reimbursement methodology entirely. If the physician provides services that are not listed with RVUs in the *Medicare RBRVS: The Physicians’ Guide*, it is important that the reimbursement amount (i.e., from a private payer) and the value of the services provided to patients are not overlooked so that the physician practice can obtain the most complete snapshot of its practice.

Every physician practice should understand its costs in providing services and should keep those costs, as well as the desired financial return, in mind when determining whether to accept payment amounts by health insurers. Of course, any calculation of the fee schedule of a particular physician group should be done independently—not in consultation with any other group—and should be based on the costs and desired return of that practice. Likewise, any negotiation by a physician group with a payer should be done independently—and not together with competing physician practices. This said, physicians who choose to understand and utilize practice costs to establish their fee schedule are not only applying good sense, but are also establishing a fee schedule that will help to ensure that the practice will thrive in today’s challenging market.

Figure 1. Hypothetical model—Procedure codes billed in the past year (Family practice example)

| A | B | C | D | E | F | G | H | I | J | K |
|--|------------------------------|---------------------------------------|---|---|---|------------------------------------|--|---|---|---|
| CPT® code | Short descriptor | Hypothetical times billed during year | Medicare RBRVS practice expense (PE) and practice liability (PLI) relative value units (2008) | Total PE and PLI relative value units per code per year (C x D) | Practice cost of service (D x cost per RVU ¹) | Medicare physician work RVU (2008) | Total physician work relative value units per year (C x G) | Physician resources required for service (G x physician resource per RVU ²) | Total practice costs plus physician resource per service (F+ I) | Physician practice fee schedule (J x %) |
| 99213 | Office/Outpatient Visit, Est | 1,484 | 0.76 | 1,128 | \$49.81 | 0.92 | 1,365 | \$30.98 | \$80.78 | |
| 99214 | Office/Outpatient Visit, Est | 850 | 1.11 | 943 | \$72.74 | 1.42 | 1,207 | \$47.81 | \$120.56 | |
| 99232 | Subsequent Hospital Care | 290 | 0.44 | 128 | \$28.84 | 1.39 | 403 | \$46.80 | \$75.64 | |
| 99212 | Office/Outpatient Visit, Est | 170 | 0.58 | 99 | \$38.01 | 0.45 | 77 | \$15.15 | \$53.16 | |
| 99308 | Nursing Fac. Care, Subseq. | 116 | 0.50 | 58 | \$32.77 | 1.16 | 135 | \$39.06 | \$71.83 | |
| 99211 | Office/Outpatient Visit, Est | 106 | 0.37 | 39 | \$24.25 | 0.17 | 18 | \$5.72 | \$29.97 | |
| 99231 | Subsequent Hospital Care | 105 | 0.26 | 27 | \$17.04 | 0.76 | 80 | \$25.59 | \$42.63 | |
| 90772 | Theat/Proph/Diag Inj., SC/IM | 104 | 0.39 | 40 | \$25.56 | 0.17 | 18 | \$5.72 | \$31.28 | |
| 99233 | Subsequent Hospital Care | 84 | 0.62 | 52 | \$40.63 | 2.00 | 168 | \$67.34 | \$107.97 | |
| 93000 | Electrocardiogram, Complete | 81 | 0.45 | 37 | \$29.49 | 0.17 | 14 | \$5.72 | \$35.22 | |
| 99215 | Office/Outpatient Visit, Est | 77 | 1.43 | 110 | \$93.72 | 2.00 | 154 | \$67.34 | \$161.06 | |
| 99238 | Hospital Discharge Day | 75 | 0.57 | 43 | \$37.36 | 1.28 | 96 | \$43.10 | \$80.45 | |
| 99307 | Nursing Fac. Care, Subseq. | 74 | 0.32 | 24 | \$20.97 | 0.76 | 56 | \$25.59 | \$46.56 | |
| 99309 | Nursing Fac. Care, Subseq. | 60 | 0.67 | 40 | \$43.91 | 1.55 | 92 | \$52.19 | \$96.10 | |
| 99223 | Initial Hospital Care | 50 | 1.18 | 59 | \$77.33 | 3.78 | 188 | \$127.28 | \$204.61 | |
| 99222 | Initial Hospital Care | 49 | 0.82 | 41 | \$53.74 | 2.56 | 127 | \$86.20 | \$139.94 | |
| 93010 | Electrocardiogram Report | 46 | 0.07 | 3 | \$4.59 | 0.17 | 8 | \$5.72 | \$10.31 | |
| 99203 | Office/Outpatient Visit, New | 44 | 1.21 | 53 | \$79.30 | 1.34 | 59 | \$45.12 | \$124.42 | |
| 17003 | Destruct Premalg LES, 2-14 | 36 | 0.12 | 4 | \$7.86 | 0.07 | 3 | \$2.36 | \$10.22 | |
| 71020 | Chest X-Ray | 34 | 0.68 | 23 | \$44.56 | 0.22 | 7 | \$7.41 | \$51.97 | |
| 71020 | Chest X-Ray | 34 | 0.08 | 3 | \$5.24 | 0.22 | 7 | \$7.41 | \$12.65 | |
| 20610 | Drain/Inject, Joint/Bursa | 30 | 1.12 | 34 | \$73.40 | 0.79 | 24 | \$26.60 | \$100.00 | |
| 97110 | Therapeutic Exercises | 29 | 0.31 | 9 | \$20.32 | 0.45 | 13 | \$15.15 | \$35.47 | |
| 99204 | Office/Outpatient Visit, New | 29 | 1.61 | 46 | \$105.51 | 2.30 | 66 | \$77.44 | \$182.96 | |
| 99283 | Emergency Dept. Visit | 28 | 0.37 | 10 | \$24.25 | 1.34 | 37 | \$45.12 | \$69.37 | |
| 99284 | Emergency Dept. Visit | 26 | 0.61 | 16 | \$39.98 | 2.56 | 66 | \$86.20 | \$126.17 | |
| 99239 | Hospital Discharge Day | 24 | 0.77 | 19 | \$50.46 | 1.90 | 46 | \$63.98 | \$114.44 | |
| 99285 | Emergency Dept. Visit | 23 | 0.92 | 21 | \$60.29 | 3.80 | 87 | \$127.95 | \$188.24 | |
| 90471 | Immunization Admin | 22 | 0.39 | 9 | \$25.56 | 0.17 | 4 | \$5.72 | \$31.28 | |
| 17000 | Destruct Premalg Lesion | 22 | 1.22 | 27 | \$79.95 | 0.62 | 14 | \$20.88 | \$100.83 | |
| RVUs for physicians' practice per year ^a | | | | 3,143 | | | 4,636 | | | |
| | | | | | Cost per relative value unit | | | | | |
| ¹ Estimated physician practice expense and PLI cost for year (hypothetical) ^b : | | | | \$206,000 | RVU ¹ : | \$65.54 | | | | |
| ² Physician resources (hypothetical) ^c : | | | | \$156,110 | RVU ² : | \$33.67 | | | | |
| ^a MGMA data from 2005 based on 2004 data. | | | | | | | | | | |
| ^b SMS survey data extrapolated to 2007. Includes: Non-MD payroll, office expenses, annual cost for medical equipment and supplies, rent, utilities, administrative, janitorial and professional liability expenses. Enter your total cost of running your practice. | | | | | | | | | | |
| ^c Source: May 2006 Bureau of Labor Statistics wage estimate. | | | | | | | | | | |

* Note: Numbers in Figure 1 have been rounded to the nearest cent.

Visit www.ama-assn.org/go/psa and select “PSA Toolkits” then “Defensible Fee Schedule Toolkit” to access a fee schedule analysis worksheet calculator to perform a fee schedule analysis for your practice and view a hypothetical model for the current year.

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Questions or concerns about practice management issues?

AMA members and their practice staff can e-mail the AMA Practice Management Center at practicemanagementcenter@ama-assn.org for assistance.

For additional information and resources, there are three easy ways to contact the AMA Practice Management Center:

- Call **(800) 621-8335** and ask for the AMA Practice Management Center.
- Fax information to **(312) 464-5541**.
- Visit www.ama-assn.org/go/pmc to access the AMA Practice Management Center Web site.

Physicians and their practice staff can also visit www.ama-assn.org/go/pmalerts to sign up for free Practice Management Alerts, which help you stay up to date on unfair payer practices, ways to counter these practices, and practice management resources and tools.

The AMA Practice Management Center is a resource of the AMA Private Sector Advocacy unit.