C-Suite Cheat Sheet Series

Medicare Physician Fee Schedule (MPFS) 101

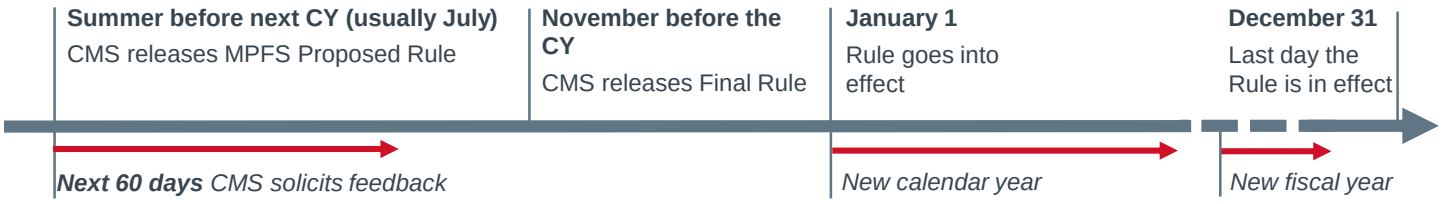
Educational Briefing

What is the MPFS and how does it compare to other Medicare fee schedules?

- The Medicare Physician Fee Schedule (MPFS) is the payment system through which CMS reimburses physicians, other health care professionals, or providers/suppliers for services billed on a Fee-For-Service (FFS) basis.
- MPFS covers mostly physician services, while CMS publishes other fee schedules for ambulance services, clinical laboratory services, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).
- It is the main payment system for CMS to reimburse physicians (and other health care professionals) for routine services such as office visits, surgical procedures, anesthesia services, diagnostic tests, and radiology services.

How often is the MPFS updated, and which elements are subject to change?

- CMS updates the fee schedule annually to ensure reimbursement reflects changing costs due to new policies, input from industry groups or new research.

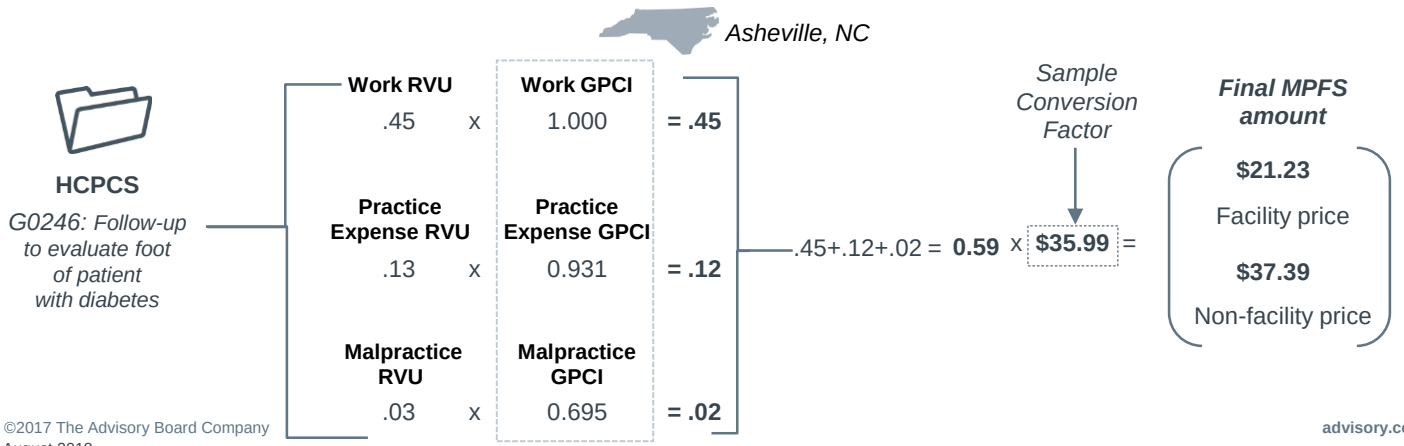


How do MPFS rates impact payments to providers and beneficiaries?

- CMS bases fee-for-service payments for Medicare providers on whatever payment is less, the actual charge or the MPFS amount.
- For most services, CMS pays for 80% of the service and the Medicare beneficiary pays for 20%, although this varies.

How are MPFS rates determined?

- Rates for each service (based on the service's HCPCS code) are determined by a combination of measures which attempt to reflect the time, intensity, and cost of delivering any service, and then adjust these factors based on geographic variations.
- To calculate the payment, a conversion factor amount (which, according to the Bipartisan Budget Act of 2018 increases by .25%, and is adjusted due to other CMS initiatives), is multiplied by a combination of:
  - The service's **Work RVU** (relative value unit), which reflects the relative time and intensity associated with delivering that service, multiplied by a **Work GPCI** (Geographic Practice Cost Index) which reflects the cost of practicing in that given location
  - The service's **Practice Expense (PE) RVU**, which reflects the costs of maintaining a practice (such as renting space, buying supplies and paying staff) associated with that service, multiplied by the **PE GPCI** (which is dependent on the type of facility)
  - The service's **Malpractice (MP) RVU** which reflects the cost of malpractice insurance for that given service, multiplied by the **MP GPCI** for that location (or the relative cost of malpractice insurance in that given location).
- The final payment amount is then adjusted based on the site of service: a facility (such as a hospital or ambulatory surgical center) or a non-facility (such as physician's office). Generally, CMS pays more for non-facility services as physicians are responsible for providing clinical staff, supplies and equipment in these settings.



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Source: CMS; Advisory Board interview and analysis.