PHYSICIAN AND OTHER HEALTH PROFESSIONAL PAYMENT SYSTEM

*payment***basics**

Revised: October 2020

Physician and other health professional services include office visits, surgical procedures, and a broad range of other diagnostic and therapeutic services. These services are furnished in all settings, including physician offices, hospitals, ambulatory surgical centers, skilled nursing facilities and other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes. Among the 1.2 million clinicians who bill Medicare, 55 percent are physicians. The remainder includes health professionals such as nurse practitioners, physician assistants, and physical therapists.[1] These health professionals may bill Medicare independently or provide services under physician supervision.

Physician services are paid under Part B. Payments for these services (about $70.5 billion in 2018) account for about 17 percent of all Medicare fee-for-service (FFS) spending.

Medicare pays for physician and other health professional services based on a list of services and their payment rates, called the physician fee schedule. The Centers for Medicare & Medicaid Services (CMS) determines the payment rate for each service based on the clinician work required to provide the service, expenses related to maintaining a practice, and professional liability insurance (PLI) costs. Payments are adjusted to account for variations in the input prices in different markets. Medicare's payment rates also may be adjusted based on provider characteristics, additional geographic designations, and other factors. Medicare pays the provider the final calculated amount, less any beneficiary cost sharing.

Defining the services Medicare buys

Under the physician fee schedule, the unit of payment is generally the individual service, such as an office visit or a diagnostic procedure. These range from narrow services (e.g., an injection) to broader bundles of services associated with surgical procedures, which include the surgery and related preoperative and postoperative visits. All services—surgical and non-surgical—are classified according to the Healthcare Common Procedure Coding System (HCPCS), which contains codes for about 8,000 distinct services.

Setting the payment rates

Under the fee schedule, payment rates are based on relative weights, called relative value units (RVUs), which account for the relative costliness of the inputs used to provide clinician services: clinician work, practice expenses, and PLI. The RVUs for clinician work reflect the relative levels of time, effort, skill, and stress associated with providing each service. The RVUs for practice expenses are based on the cost of renting office space, buying supplies and equipment, and hiring nonphysician clinical and administrative staff. The PLI RVUs are based on the premiums clinicians pay for professional liability insurance, also known as medical malpractice insurance.

In calculating payment rates, each of the three RVUs is adjusted to reflect the price of inputs in the local market where the service is furnished. Separate geographic practice cost indexes (GPCIs) are used for this purpose. The fee schedule payment amount is then determined by summing the adjusted weights and multiplying the total by a standard dollar amount (the conversion factor, which is $36.09 in 2020) (Figure 1).[2] For most fee schedule services, Medicare pays the provider 80 percent of the fee schedule amount. The beneficiary is liable for the remaining 20 percent coinsurance.

The policies discussed in this document were current as of September 15, 2020, and reflect any relevant changes implemented in response to the COVID-19 public health emergency as of that date. This document does not reflect proposed legislation or regulatory actions.

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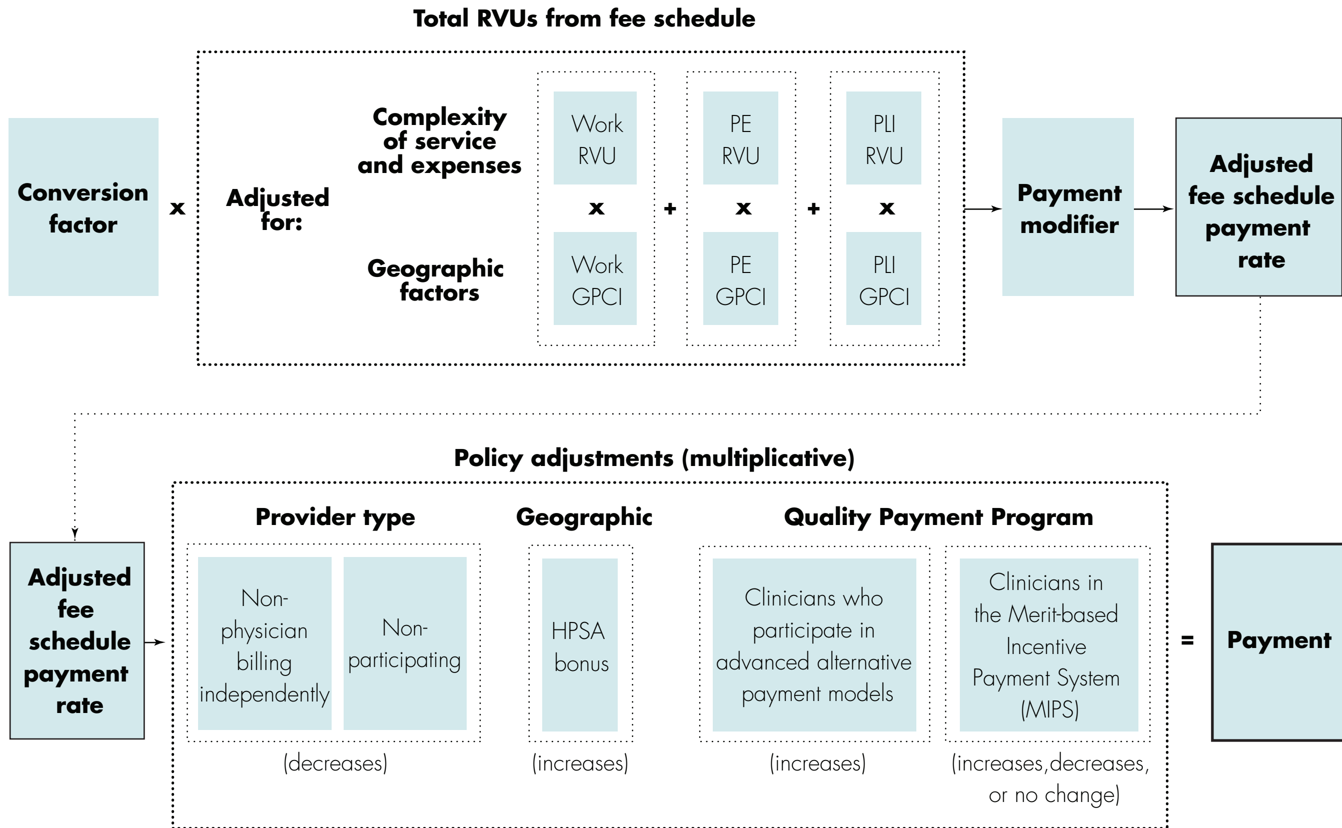
Figure 1 Physician and other health professional payment system



Note: RVU (relative value unit), GPCI (geographic practice cost index), PE (practice expense), PLI (professional liability insurance), HPSA (health professional shortage area). This figure depicts Medicare program payments only. The fee schedule lists separate PE RVUs for facility and nonfacility settings. Fee schedule payments are often reduced when specified nonphysician practitioners bill Medicare independently, but not when services are provided "incident to" a physician's service and billed under a physician's billing number. Clinicians who participate in advanced alternative payment models receive an incentive payment of 5 percent of their professional services payments. Clinicians in MIPS receive a positive or negative payment adjustment (or no change) based on their performance in four areas: quality, resource use, advancing care information, and clinical practice improvement.

Through payment modifiers, Medicare may adjust its payment for a service because of special circumstances. For example, physicians use a modifier to bill for a service when they assist in a surgery; payment for an assistant surgeon is 16 percent of the fee schedule amount for the primary surgeon. Other modifiers apply to multiple procedures performed for the same patient on the same day, preoperative or postoperative management without surgical care, and bilateral surgery.

There is a downward adjustment if services are furnished by certain nonphysician practitioners. For example, services billed independently by advanced-practice registered nurses and physician assistants are paid at 85 percent of the full fee schedule amount. When nonphysician practitioners perform a service "incident to" a physician's service and the service is billed under the physician's billing number, Medicare pays the full fee schedule amount for the service as if the physician had personally furnished it.

Medicare also adjusts fee schedule payments downward when services are furnished by clinicians who are not in Medicare's participating provider program. Payment rates for services

provided by nonparticipating providers are 95 percent of the full fee schedule amount.

Physicians may receive higher payments for services they provide in underserved areas. Physicians who provide services in health professional shortage areas (HPSAs) receive a 10 percent bonus payment. These payments are intended to attract more physicians to HPSAs.

Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established the Quality Payment Program for clinicians. Under this program, beginning in 2019, clinicians who participate in qualified advanced alternative payment models (A–APMs) receive an incentive payment of 5 percent of their professional services payments. Most other clinicians participate in the Merit-based Incentive Payment System (MIPS) and receive a positive or negative payment adjustment (or no change) based on their performance in four areas: quality, resource use, advancing care information (formerly meaningful use of electronic health records), and clinical practice improvement.[3]

Updating payments

CMS reviews the RVUs of new, revised, and some potentially misvalued services annually. HCPCS codes and the conversion factor are also updated annually. The update of RVUs includes a review of changes in medical practice, coding changes, new data, and the addition of new services. In updating the RVUs, CMS receives advice from a group of physicians and other health professionals sponsored by the American Medical Association and specialty societies.

The conversion factor is updated according to a schedule set by MACRA. There was no update in 2020. ■

1 The other types of nonphysician practitioners are: audiologist, chiropractor, clinical psychologist, clinical social worker, certified registered nurse anesthetist, optometry, occupational therapy, speech language pathology, certified clinical nurse specialist, certified nurse midwife, and registered dietician/nutrition professional.

2 Anesthesia services are reimbursed differently than other clinician services. The payment for anesthesia is based on base units, which CMS assigns to anesthesia HCPCS codes, and time units, which are based on the length of time the patient was under anesthesia. The sum of the base units and time units are then multiplied by an anesthesia conversion factor, which is different than the fee schedule conversion factor.

3 CMS estimates that about 540,000 clinicians are exempt from MIPS in 2020 because they fell under CMS's low-volume threshold.