Codify by AAPC

Psychiatry Coding & Reimbursement Alert

Reader Question: Factor in Method to Determine Reimbursement Using RVUs

Question: Using the RVUs provided for a particular code, how do I arrive at the appropriate reimbursement for the particular service?

Texas Subscriber

Answer: The Medicare Physician Fee Schedule establishes different values for codes depending on the setting/site (facility or nonfacility) in which the provider performs the service or procedure. For some services,the total relative value units (RVUs) for a given procedure are the same in a facility or a non-facility setting. In some cases, however, the two totals may differ.

How it works: The facility and non-facility total RVUs are the sum of three component RVUs: physician work RVUs (to cover the cost of the provider's "work"), practice expense RVUs (to cover the cost of supplies,equipment, etc.), and malpractice expense RVUs (to cover the cost of professional liability expenses).

Physician work RVUs and malpractice expense RVUs are the same, regardless of the setting (facility or nonfacility). Practice expense RVUs may vary by site of service, however (which accounts for the difference in facility and non-facility RVU totals for a given code).

Medicare fees also vary geographically. Thus, each component RVU is multiplied by its own geographic practice cost index for the payment locality in which the service is rendered before the components are summed and multipliedby the dollar conversion factor that translates RVUs into fees.

Non-facility calculations: Add together the physician work RVUs, the non-facility practice expense RVUs, and the malpractice RVUs for the total non-facility RVUs for a given code.

To then figure out the national, geographically unadjusted Medicare fee for a code, multiply the transitioned non-facility RVU total by the 2014 conversion factor ($35.8228). Note that private payers and other public payers may use different conversion factors for setting their fees, even if they use the same RVUs as Medicare.

Example: To calculate the geographically unadjusted Medicare fee for E/M visit code 99213 (Office or other outpatient visit for the evaluation and management of an established patient ...) multiply the transitioned non-facility total (2.04) by $35.8228. You can therefore figure out that the 2014 unadjusted fee for 99213 is $73.08.

Alternative: You can simply look up national or local Medicare reimbursement rates for specific procedures on the Medicare Web site at www.cms.hhs.gov/PFSlookup, or on https://www.aapc.com/codes/. Many individual Medicare carriers have similar Web tools.

For example, TrailBlazer's fee schedule search tool (www.trailblazerhealth.com/Tools) shows the participating fee, the non-participating fee, and the limiting fee for both facility and non-facility visits, as well as the breakdown for modifiers 26 (Professional component) and TC (Technical component).

CPT® 2023 American Medical Association. All rights reserved.