Understanding RHC Fee Schedule Maintenance and Methodologies

RHC Financial Health
Winter Learning Series # 1

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Disclaimer

Any dollar amounts attributed to services on these slides are presented solely for illustration and education. These amounts should not be construed to suggest any specific pricing or pricing methodology for medical services.

Why do we have to be careful when we discuss any type of pricing or charge methodologies?

- To prevent the appearance of industry price-fixing
- To prevent any federal anti-trust violation
- To protect the financial and proprietary information of our organizations
- To remain objective and independent

“Generally, the antitrust laws require that each company establish prices and other competitive terms on its own, without agreeing with a competitor.”—Federal Trade Commission

https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/dealings-competitors/price-fixing

Charge data is available from public sources. However, this is compiled from claims data and not from industry collaboration or price-fixing.

Let’s just ask… ?

- When was the last time that you did a global review of your fee schedule?
- Who in your organization is responsible for adding or revising charge items?
- Do you have a standard methodology for calculating fee schedule amounts or is it a wild *&%$ guess?
- Are you leaving money on the table with your commercial payers?
- Patty, what are you even talking about?

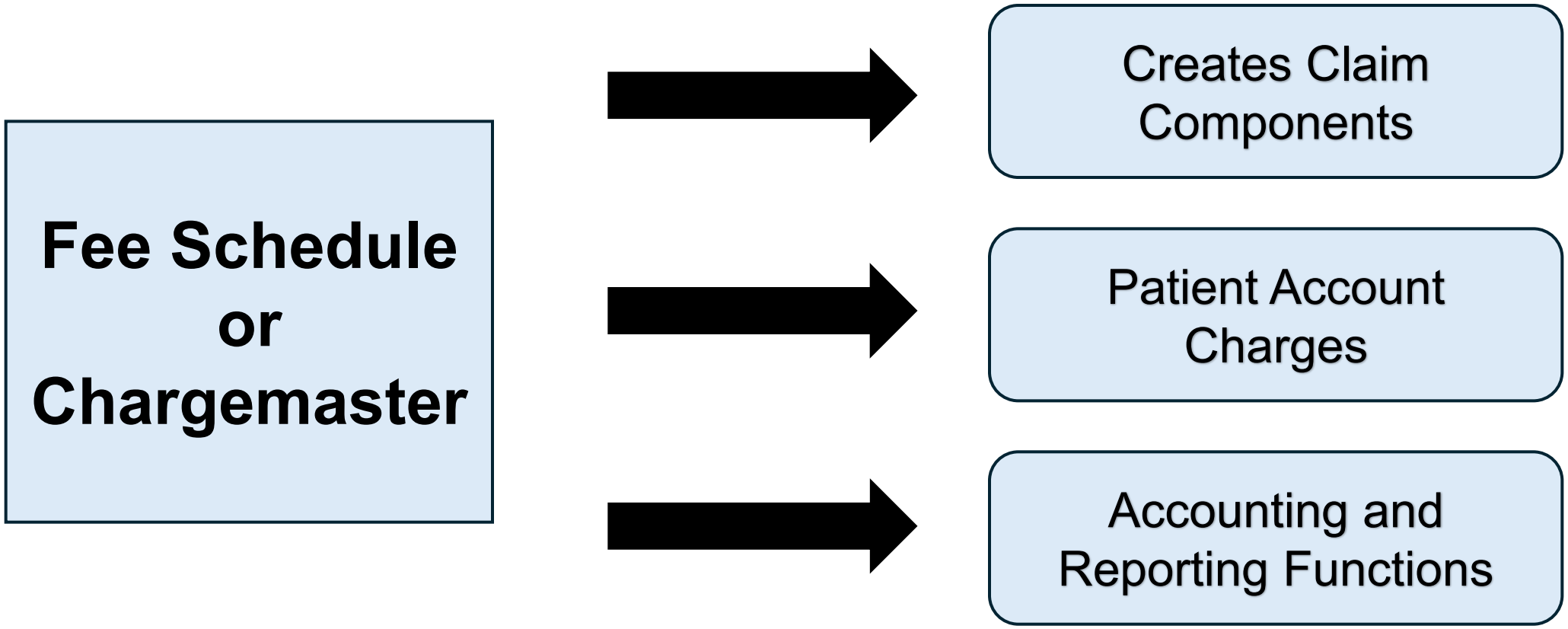
What is the Fee Schedule?

If you are a hospital-based RHC, you may share the hospital’s chargemaster or CDM.

Fee Schedules and Chargemasters

- A **fee schedule** is a table which is part of your PM/EHR system. It correlates a charge amount to a CPT/HCPCS code. The fee schedule may also include revenue codes, POS codes, and hard-coded modifiers. When a CPT code is entered into the electronic medical record, the charge and other information will also populate the claim fields and post to the patient account.

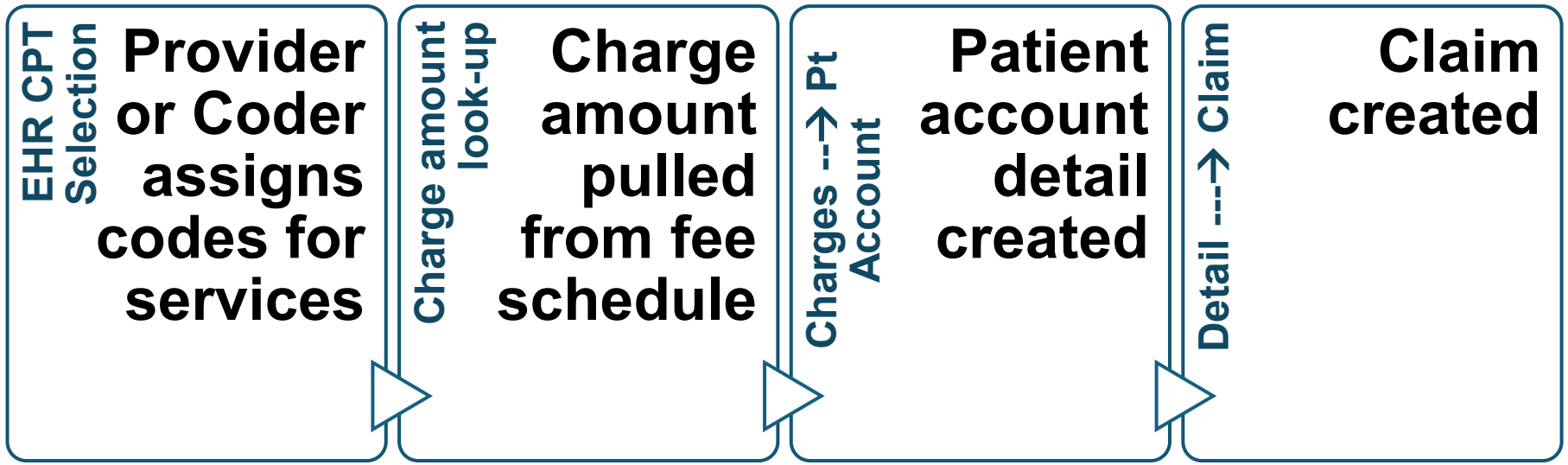
- A **chargemaster or CDM** has a similar but expanded function, but may contain additional information. A CDM will also assign a code or service to the correct general ledger account for the revenue. The CDM may also be integrated with inventory control and other financial reporting.


Fee Schedule
or
Chargemaster
Creates Claim Components
Patient Account Charges
Accounting and Reporting Functions

Common Fee Schedule Data

- Charge or Item Number
- CPT/HCPCS Code
- Code or Item Description
- Charge Amount
- May point to a specific fee schedule (not best practice)
- Revenue Code
- POS Code
- Type of Service
- Modifiers
- May have payer specific data
- May assign General Ledger account for revenue assignment
- Hospital CDMs integrate with other systems and modules

Behind the scene in your System



Charge #	CPT CODE	Revenue code	Clinic Description	POS	Charge Amount
18443	99202	521	LEVEL 2 OFFICE VISIT NEW	72	XXX.XX
1849	99203	521	LEVEL 3 OFFICE VISIT NEW	72	XXX.XX
73990	10060	521	I&D INCIS & DRAIN ABSCESS SINGEL SIMP	72	XXX.XX
48511	12001	521	LACERATION REPAIR <= 2.5 CM	72	XXX.XX
57019	93005	521	EKG Tracing only		XXX.XX
57020	93010	521	EKG Read only		XXX.XX
72285	J0696	636	ROCEPHIN 250MG	72	XXX.XX
275969	G0438	521, 522, 525	MEDICARE FIRST ANNUAL WELL VISIT	72	XXX.XX
275970	G0439	521, 522, 525	MEDICARE ANNAUL WELL VISIT - SUBSQUENT	72	XXX.XX

Why is it important to maintain a fee schedule?

Maintaining the Fee Schedule

- CPT/HCPCS Codes change at least annually. There are also quarterly updates made by CMS.
  - Codes added
  - Codes revised
  - Codes deleted
- The MPFS for Medicare Part B changes annually.
- Commercial payers usually adjust their allowable amounts or reimbursement terms based on the MPFS.
- Payers can change their billing guidance or contract terms.
- Cleaning up duplicate charge items and standardizing pricing.

Maximizing Reimbursement and Shortening A/R Days

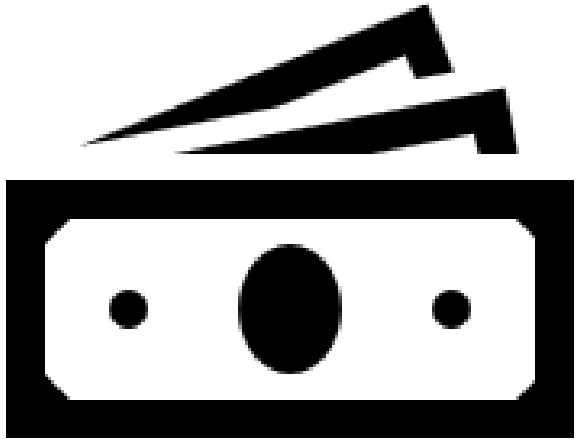
When we conduct routine maintenance on our fee schedule or update fee schedules, we are ensuring that we maximize reimbursement by having charge amounts which are not below a payer's allowable.

We also ensure that we are not submitting obsolete codes or other outdated data that would delay claims processing by creating rejections or denials or preventing payment.

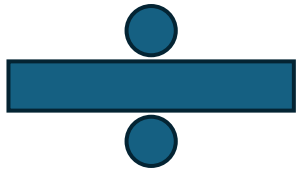
Why is a standard pricing methodology important?

- Charge amounts do not need to be arbitrarily created.
- There needs to be a method to the madness to make sure that charge amounts are set using some standard reference.
- The Medicare Physician Fee Schedule (MPFS) uses WRUs to create allowable amounts based on the resources used to perform a service. This is the most common starting point even though RHCs are not paid Medicare fee-for-service.
- If pricing is not created with a methodology, financial data will not be accurate when analyzing utilization, net revenue and contractual adjustments. Contract negotiation can also be impacted.

Understanding RHC Medicare Reimbursement



Total Allowable Expenses



Total Qualified RHC Encounters

Medicare Encounter Rate (AIR)

Upper Payment Limits (AIR) for clinics after 2020 and for independent clinics prior to 2020

- **2021**: $100 per visit
- **2022**: $113 per visit
- **2023**: $126 per visit
- **2024**: $139 per visit
- **2025**: $152 per visit
- **2026**: $165 per visit
- **2027**: $178 per visit
- **2028**: $190 per visit

The lesser of the actual cost per visit from the cost report OR the UPL for the calendar year.

Established provider=based RHCs (before 2020) receive a grandfathered AIR that increased each year by a MEI. Their AIR is the lesser of actual cost per visit or their grandfathered AIR.

Medicare Payment and Coinsurance Calculation

Total Charges on Claim (CG Line)	225.00
2025 Upper Payment Limit (For Independent and New Clinics after 2020)	159.00
Medicare Payment is 80% of the AIR	127.20
Coinsurance is 20% of the Total Charges on the CG Line	45.00

$172.20

Why does this matter to fee setting?

- Patients will have a higher cost share (deductible and coinsurance) for services in an RHC.
- If gross charges are too high, the RHC will price itself out of the market by charging the patient more than a fee-for-service Medicare provider would collect for the same services.
- For commercial payers, there will be an allowable fee schedule amount and any difference becomes a contractual adjustment.
- For RHCs, the gross charge is directly correlated to the coinsurance or patient responsibility.

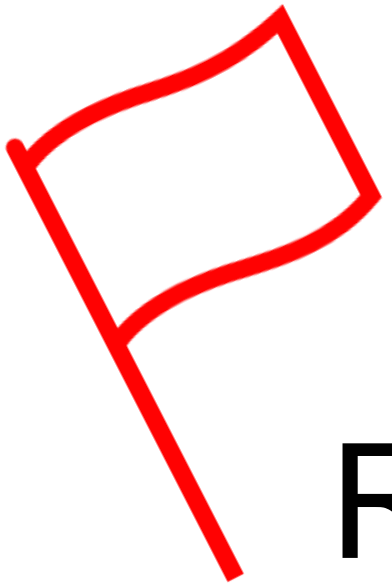
	Charge 1	Charge 2	Charge 3	
Total E & M Charge	**125.00**	**175.00**	**200.00**	
80% of Rate (.80 * 152)	**121.60**	**121.60**	**121.60**	**MAC pays**
20 % Coinsurance (20 % of charges)	**25.00**	**35.00**	**40.00**	**Pt Resp**
Total Reimbursement	**146.60**	**156.60**	**161.60**	

The coinsurance is the wildcard in RHC Medicare reimbursement. The coinsurance is 20% of the total charges. Pricing drives potential net reimbursement. However, if charges are excessively high, then the RHC may outprice itself from the market.

Should an RHC price all E & Ms at the AIR?

NO!

Setting your E & M charges at the AIR can limit the amount of net revenue you can collect from both Medicare services and other payers.



Red Flags that your Fee Schedule is in trouble

Red Flags

- Claims paying below the payer's allowable amount for commercial claims or fee-for-service contracts
- All remits look alike. All claims pay the same amount.
- Decrease in contractual adjustments
- Denials or rejections based on invalid codes
- Duplicate CPT codes with different charge amounts
- Unclear naming convention for code descriptions

Where should the fee schedule or CDM live?

Too Many Cooks in the Kitchen

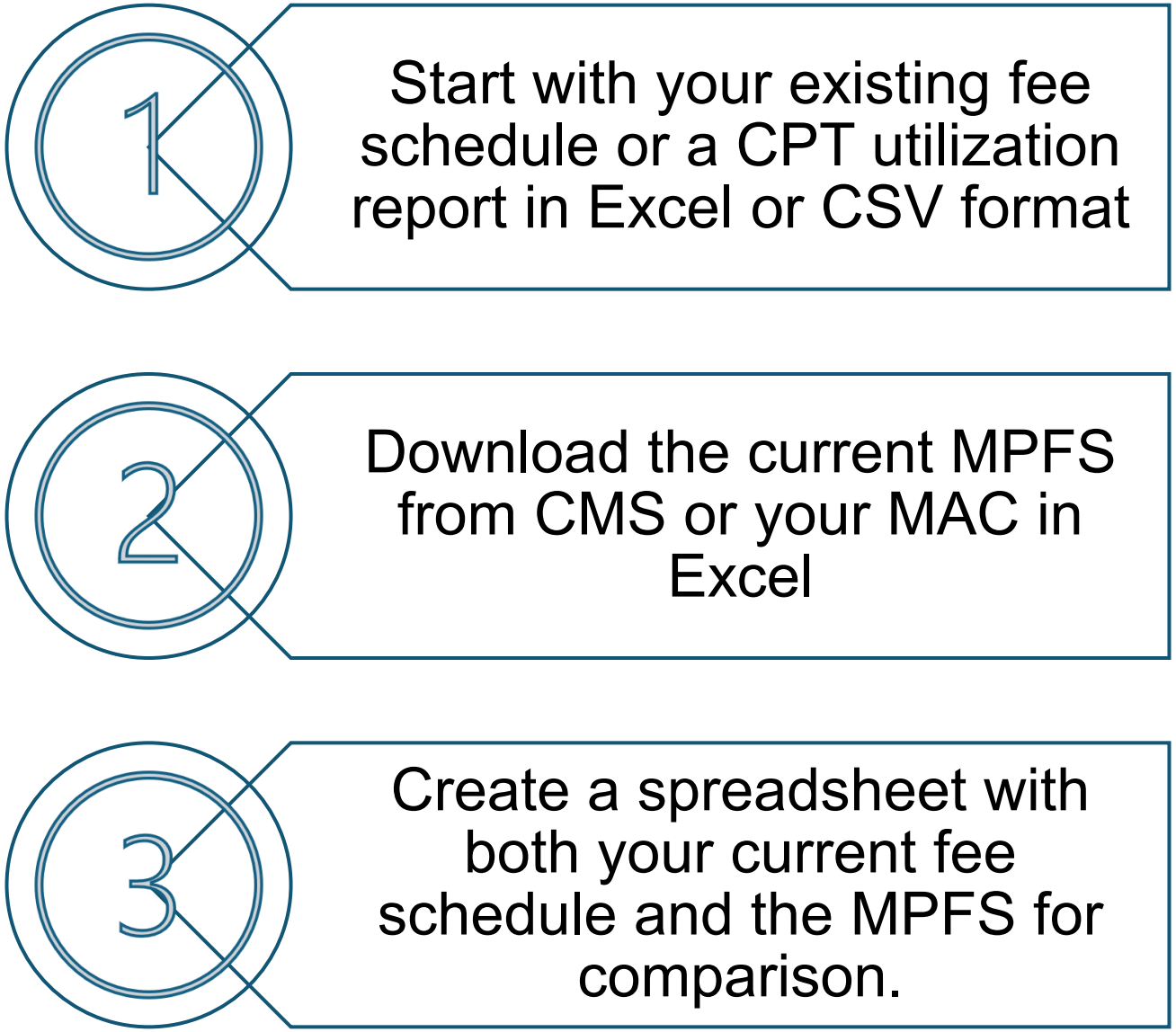
- Some organizations allow multiple people or departments to add or revise codes and charge amounts.
- Anyone who has this permission should completely understand the current established pricing methodology and understand how fee-setting impacts operations and financial reporting.
- When adding new services, you should use your revenue cycle committee structure or have a second layer of review.
- An RCM partner should not be able to add or change the fee schedule without organizational approval.

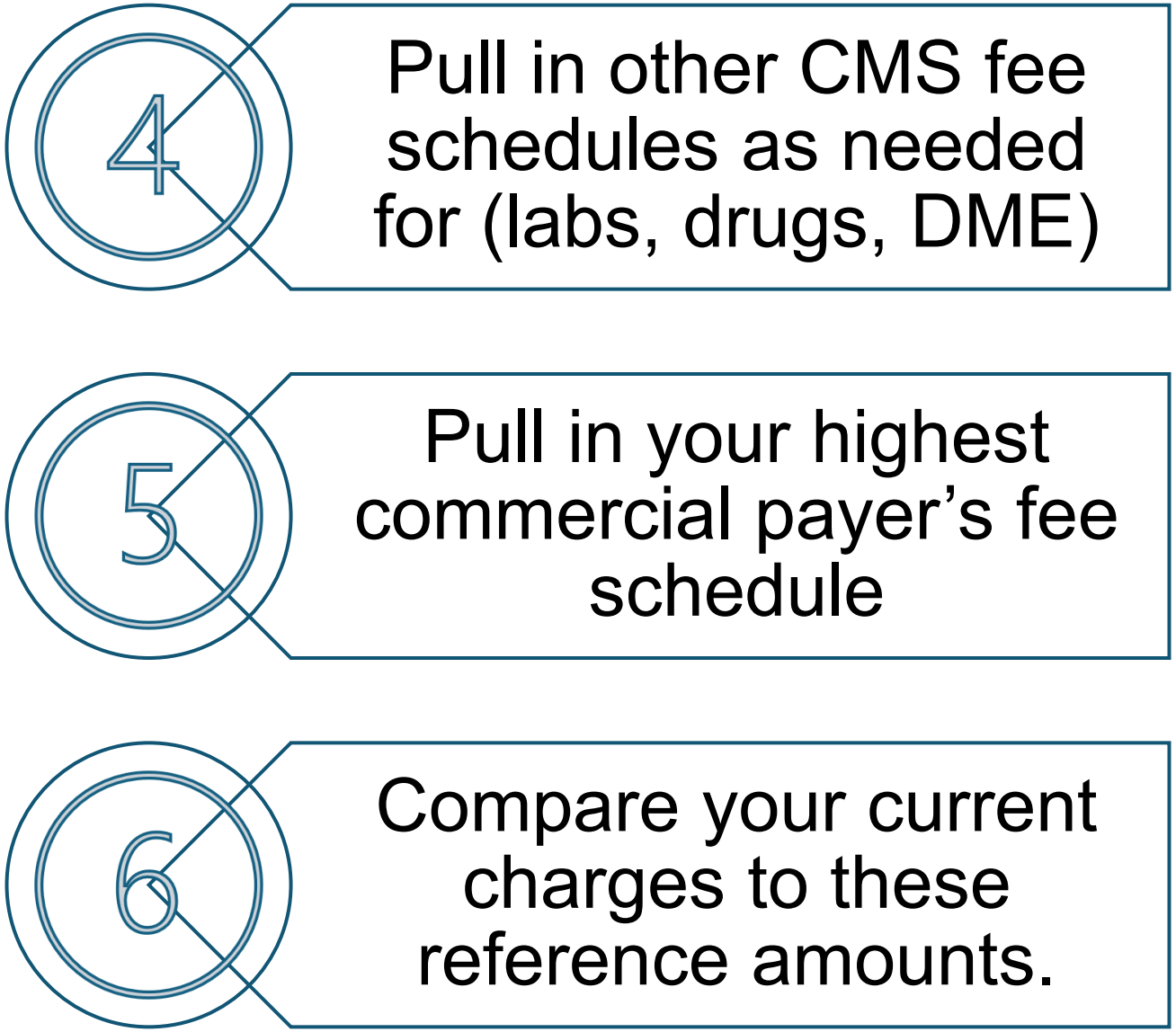
Provider-based RHCs and the hospital CDM

- Make sure that your parent organization understands the relationship between the total charge amount and co-insurance.
- CAHs have the same 20% calculation of coinsurance for outpatient services.
- PPS hospitals have another reimbursement methodology.
- It is important when a CDM review is performed that everyone understands the differences between Critical Access Hospitals, RHCs, and rural PPS hospitals. Fee-setting will not be done the same exact way for all facilities.

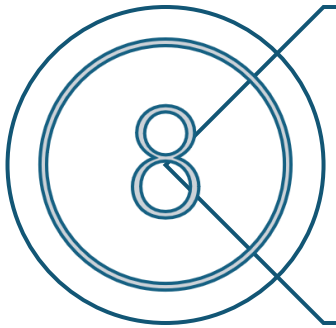
How is a fee schedule built or created?

It is going to require some Excel skills.


1
Start with your existing fee schedule or a CPT utilization report in Excel or CSV format
2
Download the current MPFS from CMS or your MAC in Excel
3
Create a spreadsheet with both your current fee schedule and the MPFS for comparison.

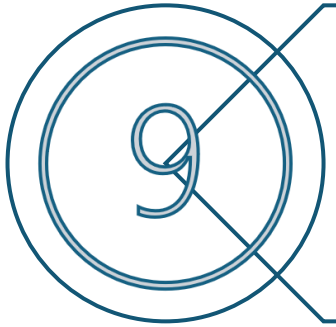

4
Pull in other CMS fee schedules as needed for (labs, drugs, DME)
5
Pull in your highest commercial payer's fee schedule
6
Compare your current charges to these reference amounts.

Validate that your codes and code descriptions are current.



Determine what % of a standard fee schedule you will use for your methodology

1.5% to 3.0% of the MFPS is commonly seen.



Finalize your fee schedule and upload it to your PM/EHR

Finding the “sweet spot” in fee setting methodology

Comparing Current Fee Schedule to MFPS

Chg #	CPTCODE	REV Code	Current CMS Description	POS	Fee	2025 MPFS	Difference	% of MPFS	Comment
74605	10060	521	I&d abscess simple/single	72	250.00	119.50	130.50	2.09	
75111	10061	521	I&d abscess comp/multiple	72	225.00	201.11	23.89	1.12	
1125	11057	521	Parng/cutg b9 hyprkr les >4	72	75.00	82.45	(7.45)	0.91	Fee below current MPFS
1145	11200	521	Rmvl skin tags up to&inc 15	72	115.00	86.71	28.29	1.33	
75320	11201	521	Rmvl skin tags ea addl 10	72	120.00	17.32	102.68	6.93	
1500	99202	521	Office o/p new sf 15 min	72	60.00	67.66	(7.66)	0.89	Fee below current MPFS
1501	99203	521	Office o/p new low 30 min	72	125.00	105.80	19.20	1.18	
1502	99204	521	Office o/p new mod 45 min	72	300.00	158.91	141.09	1.89	
63987	99205	521	Office o/p new hi 60 min	72	285.00	209.99	75.01	1.36	
448	99212	521	Office o/p est sf 10 min	72	55.00	53.19	1.81	1.03	
1887	99213	521	E & M, est, Level 3	72	95.00	86.34	8.66	1.10	
449	99213	521	Office o/p est low 20 min	72	75.00	86.34	(11.34)	0.87	Fee below current MPFS
450	99214	521	Office o/p est mod 30 min	72	140.00	121.66	18.34	1.15	
451	99215	521	Office o/p est hi 40 min	72	200.00	170.89	29.11	1.17	
222897	G0402	521, 522,525	Initial preventive exam	72	150.00	156.49	(6.49)	0.96	Fee below current MPFS
222898	G0403	521	Ekg for initial prevent exam	72	50.00	13.44	36.56	3.72	
275969	G0438	521, 522, 525	Ppps, initial visit	72	225.00	156.18	68.82	1.44	
1560	G0439	521, 522, 525	Ppps, subseq visit	72	275.00	122.89	152.11	2.24	

Comparing Highest Payer Allowable to MPFS

Chg #	CPTCODE	REV Code	Current CMS Description	POS	Fee	2025 MPFS	Highest Payer	% Highest
74605	10060	521	I&d abscess simple/single	72	250.00	119.50	180.00	1.51
75111	10061	521	I&d abscess comp/multiple	72	225.00	201.11	285.00	1.42
1125	11057	521	Parng/cutg b9 hyprkr les >4	72	75.00	82.45	100.00	1.21
1145	11200	521	Rmvl skin tags up to&inc 15	72	115.00	86.71	105.00	1.21
75320	11201	521	Rmvl skin tags ea addl 10	72	120.00	17.32	40.00	2.31
1500	99202	521	Office o/p new sf 15 min	72	60.00	67.66	92.00	1.36
1501	99203	521	Office o/p new low 30 min	72	125.00	105.80	128.00	1.21
1502	99204	521	Office o/p new mod 45 min	72	300.00	158.91	300.00	1.89
63987	99205	521	Office o/p new hi 60 min	72	285.00	209.99	299.00	1.42
448	99212	521	Office o/p est sf 10 min	72	55.00	53.19	90.00	1.69
1887	99213	521	E & M, est, Level 3	72	95.00	86.34	112.00	1.30
449	99213	521	Office o/p est low 20 min	72	75.00	86.34	112.00	1.30
450	99214	521	Office o/p est mod 30 min	72	140.00	121.66	158.00	1.30
451	99215	521	Office o/p est hi 40 min	72	200.00	170.89	260.00	1.52
222897	G0402	521, 522,525	Initial preventive exam	72	150.00	156.49	280.00	1.79
222898	G0403	521	Ekg for initial prevent exam	72	50.00	13.44	32.00	2.38
275969	G0438	521, 522, 525	Ppps, initial visit	72	225.00	156.18	315.00	2.02
1560	G0439	521, 522, 525	Ppps, subseq visit	72	275.00	122.89	280.00	2.28

	RHC Fee Schedule Amount	Highest Commercial Payer Allowable*$140	Contract at 70% of Charges
Example 1	125.00	~~140.00~~	87.50
		Will pay lesser of charge or allowable	
Example 2	155.00	140.00	108.50
Example 3	225.00	140.00	157.50

Medicare Payment and Coinsurance Calculation

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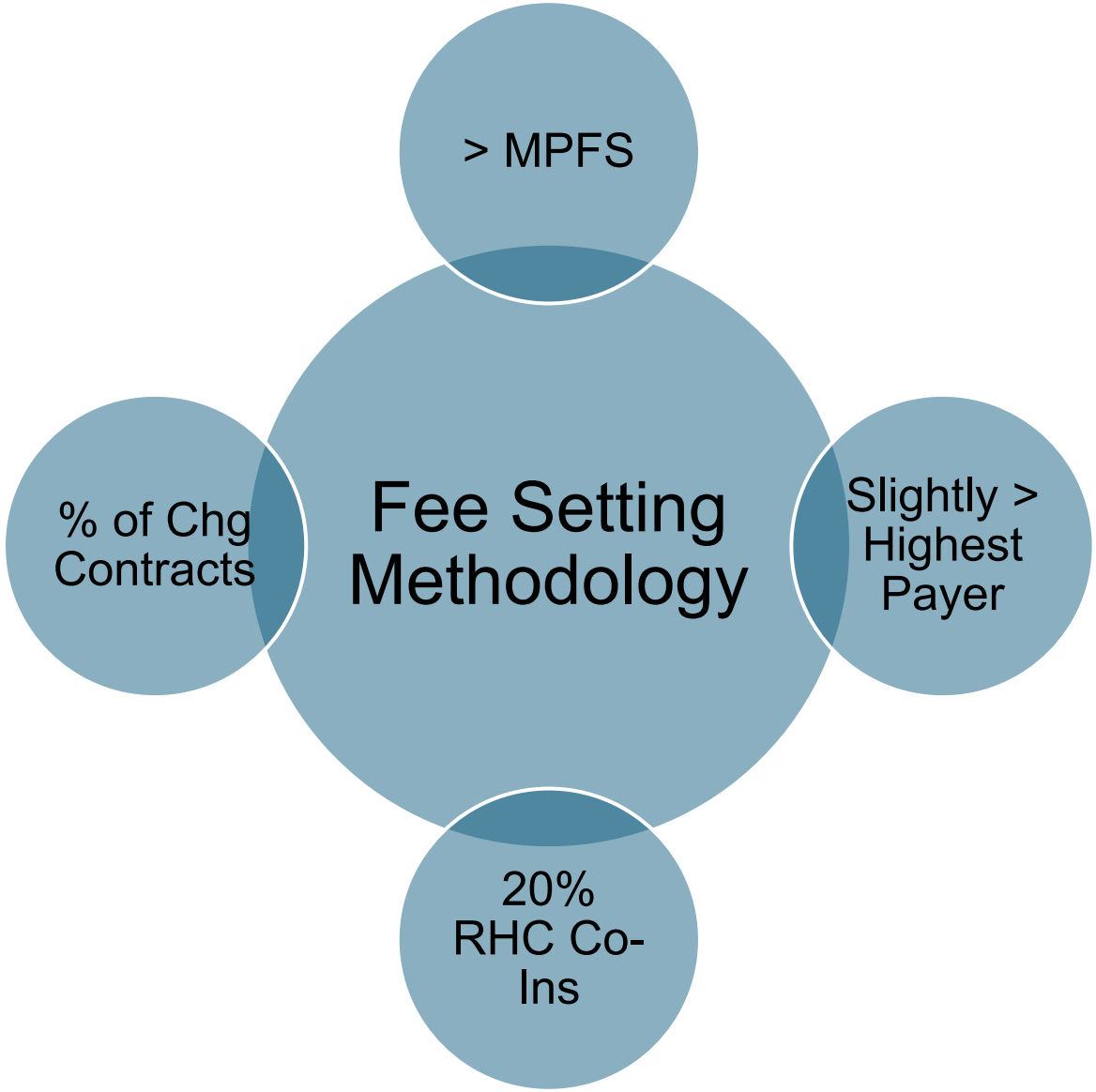
$172.20

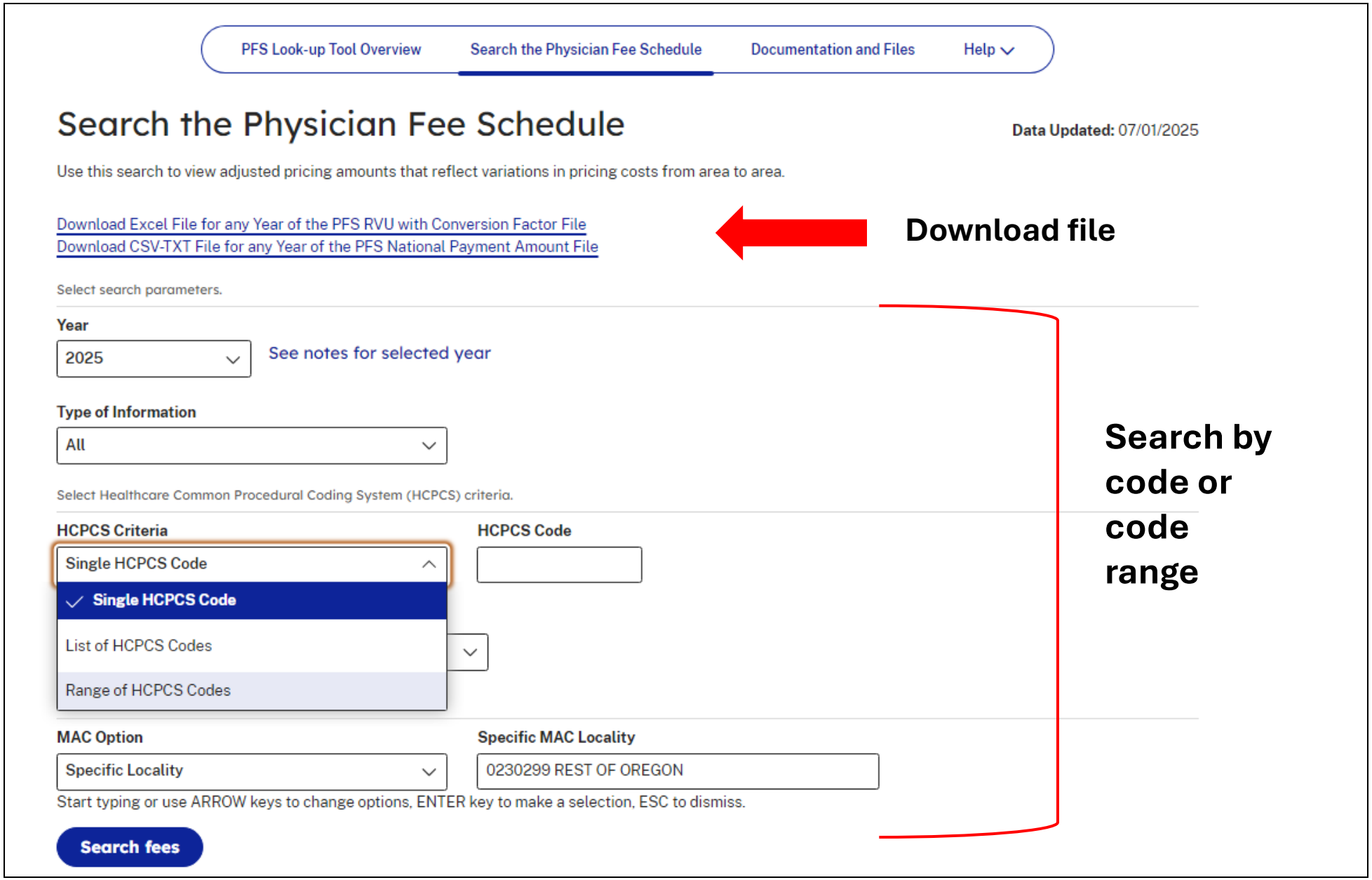
Gone are the days of excessive charges

- Most organizations will find their “sweet spot” as a % of the MFPS and other CMS fee schedules to develop a standard fee-setting methodology.
- Pricing transparency
- Self-pay pricing
- Some RHCs will have % of charges contracts in place especially hospital-based clinics or clinics with longstanding evergreen contracts.
- Charge amounts that are too high will increase the patient’s cost share in RHCs and in outpatient CAHs.
- Consult your cost report consultant for adjustments to a CAH fee schedule for analysis of the cost to charge ratio effect.


> MPFS
% of Chg Contracts
Fee Setting Methodology
Slightly > Highest Payer
20% RHC Co-Ins

CMS Fee Schedules

Where to find the CMS Fee Schedules



https://www.cms.gov/medicare/physician-fee-schedule/search

Fee Schedules

A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. Providers may access the most current fee schedules from the CMS link(s) below.

Medicare Physician Fee Schedule (MPFS) - Access MPFS amounts and related information concerning the development of such payment amounts.

- PC/TC Indicators
- Sequestration - Mandatory 2% Payment Reduction Continues for Medicare FFS Program

Physician Fee Schedule Lookup - Access a tool that allows providers to search by HCPCS code; providing detailed payment information for specific services covered under the MPFS.

Ambulance Fee Schedule - Access a fee schedule which applies to all ambulance services, including volunteer, municipal, private, independent, and institutional providers, i.e., hospitals, critical access hospitals (except when it is the only ambulance service within 35 miles), and skilled nursing facilities.

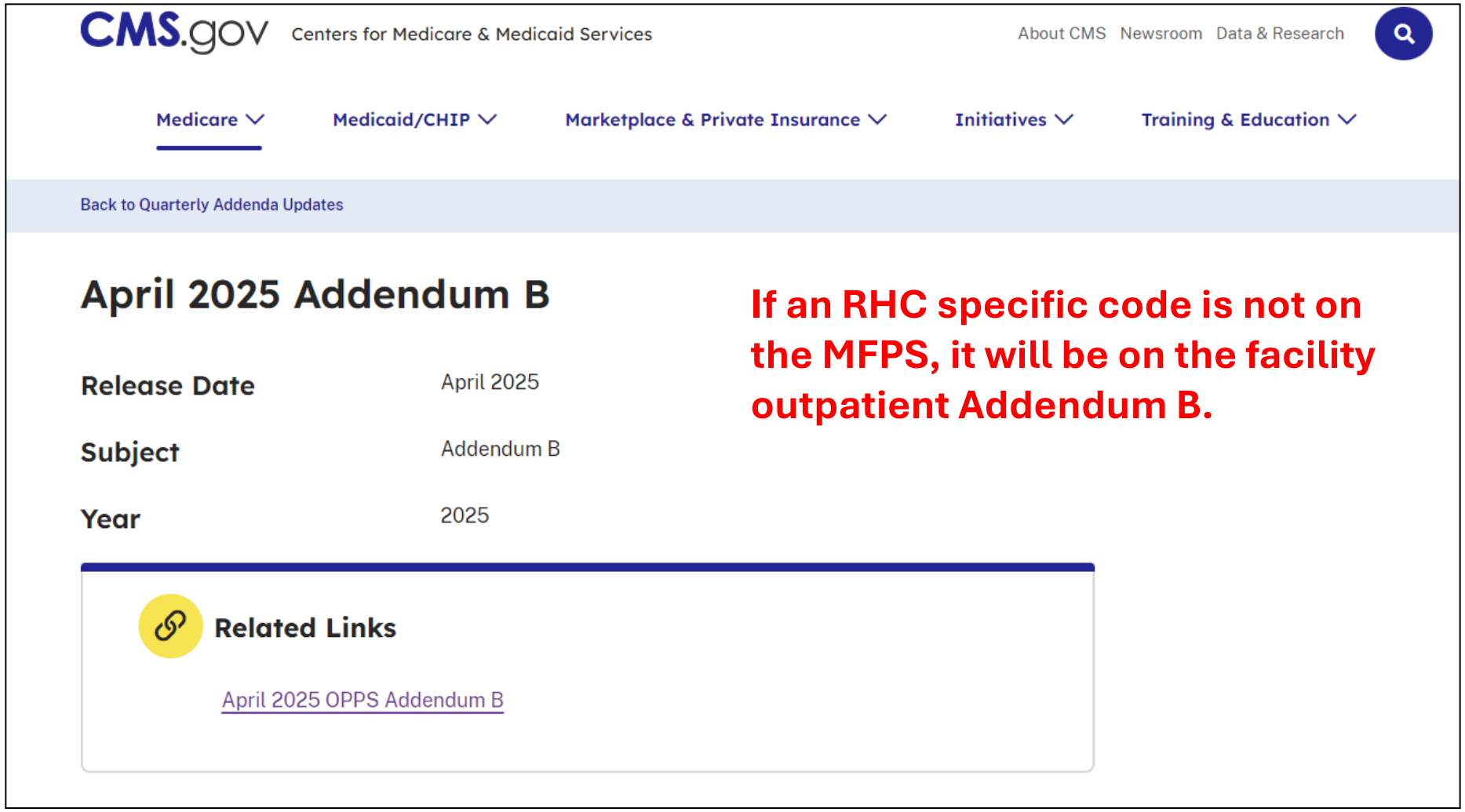
Lab 

Clinical Laboratory Fee Schedule - Access the Outpatient clinical laboratory services fee schedule.

Hospital Outpatient Prospective Payment System (OPPS) - Access details about all services paid under the PPS which are classified into groups called Ambulatory Payment Classifications (APCs). Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC.

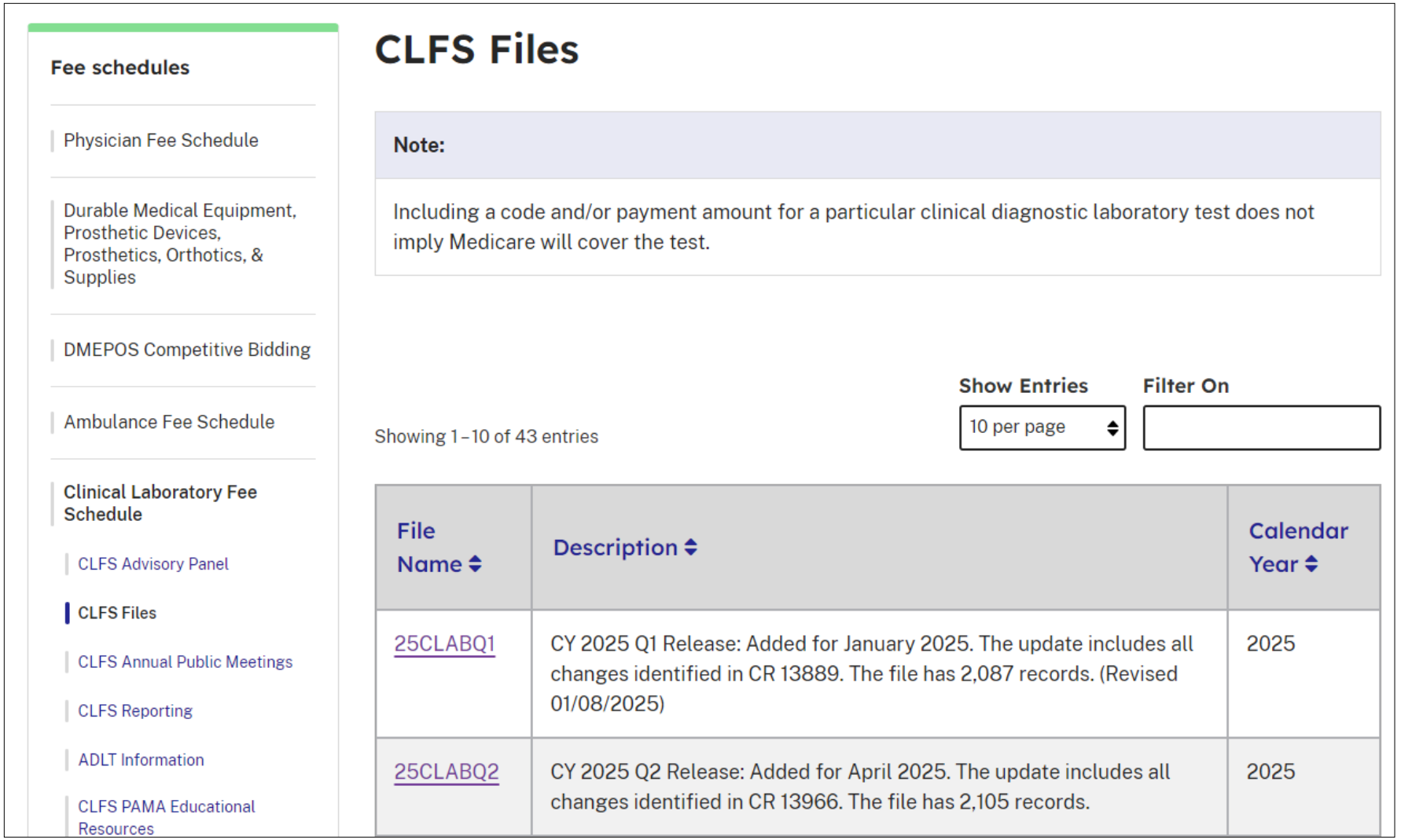
Opioid Treatment Program (OTP) - Access information about the Opioid Treatment Program, enrollment, and payment schedules.

Prospective Payment Systems (PPS) - Access details about each PPS (method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount). The payment amount for a particular service is derived based on the classification system of that service. CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities.



https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient-pps/quarterly-addenda-updates/april-2025-addendum-b

CMS Clinical Lab Fee Schedule



Fee schedules

- Physician Fee Schedule
- Durable Medical Equipment, Prosthetic Devices, Prosthetics, Orthotics, & Supplies
- DMEPOS Competitive Bidding
- Ambulance Fee Schedule
- Clinical Laboratory Fee Schedule
  - CLFS Advisory Panel
  - CLFS Files
  - CLFS Annual Public Meetings
  - CLFS Reporting
  - ADLT Information
  - CLFS PAMA Educational Resources

CLFS Files

Note:

Including a code and/or payment amount for a particular clinical diagnostic laboratory test does not imply Medicare will cover the test.

Showing 1–10 of 43 entries

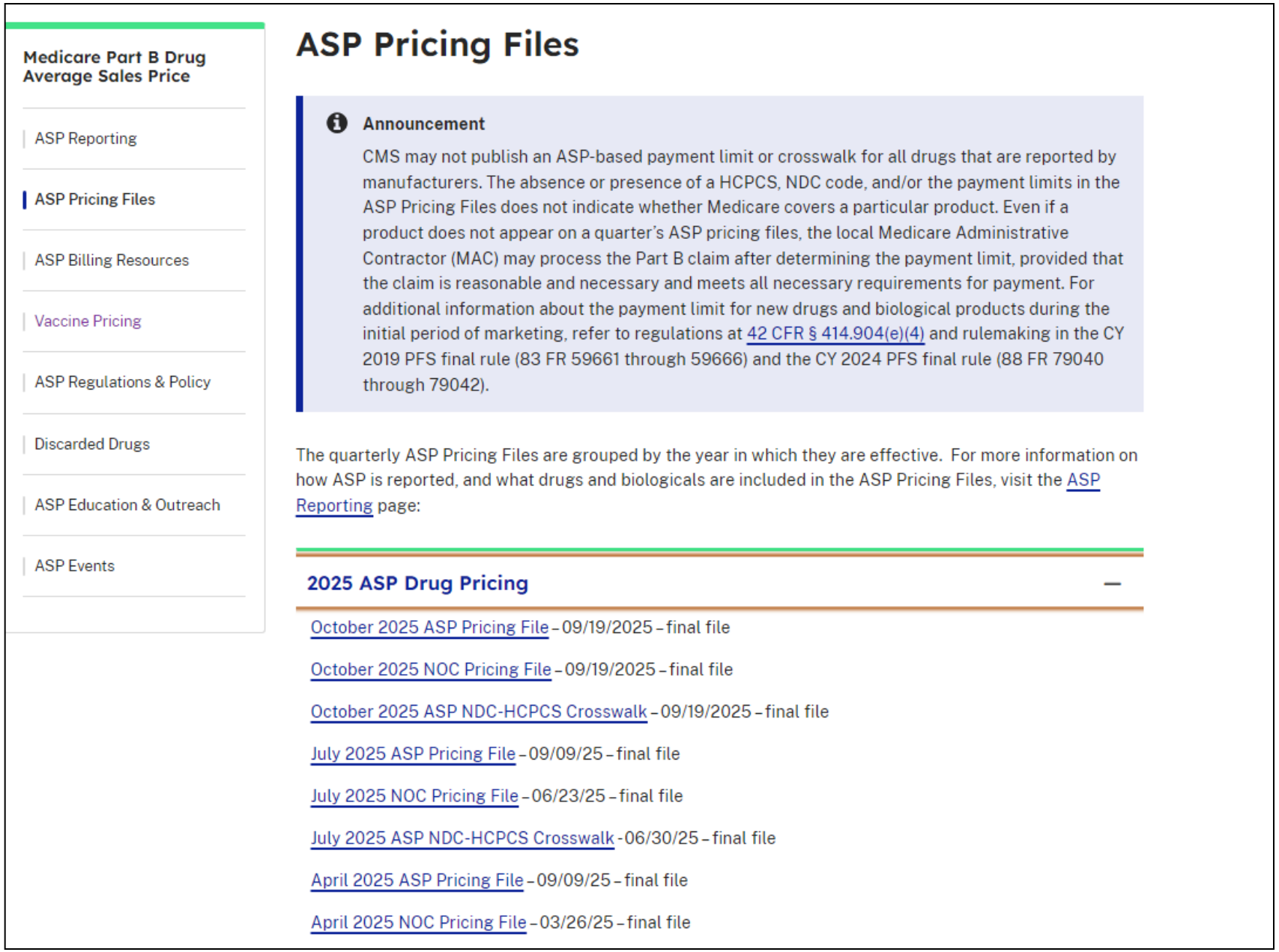
Show Entries: 10 per page

Filter On:

File Name	Description	Calendar Year
25CLABQ1	CY 2025 Q1 Release: Added for January 2025. The update includes all changes identified in CR 13889. The file has 2,087 records. (Revised 01/08/2025)	2025
25CLABQ2	CY 2025 Q2 Release: Added for April 2025. The update includes all changes identified in CR 13966. The file has 2,105 records.	2025

https://www.cms.gov/medicare/payment/fee-schedules/clinical-laboratory-fee-schedule-clfs/files

Drug Pricing and NDC Crosswalk



Medicare Part B Drug Average Sales Price

- ASP Reporting
- ASP Pricing Files
- ASP Billing Resources
- Vaccine Pricing
- ASP Regulations & Policy
- Discarded Drugs
- ASP Education & Outreach
- ASP Events

ASP Pricing Files

Announcement

CMS may not publish an ASP-based payment limit or crosswalk for all drugs that are reported by manufacturers. The absence or presence of a HCPCS, NDC code, and/or the payment limits in the ASP Pricing Files does not indicate whether Medicare covers a particular product. Even if a product does not appear on a quarter's ASP pricing files, the local Medicare Administrative Contractor (MAC) may process the Part B claim after determining the payment limit, provided that the claim is reasonable and necessary and meets all necessary requirements for payment. For additional information about the payment limit for new drugs and biological products during the initial period of marketing, refer to regulations at 42 CFR § 414.904(e)(4) and rulemaking in the CY 2019 PFS final rule (83 FR 59661 through 59666) and the CY 2024 PFS final rule (88 FR 79040 through 79042).

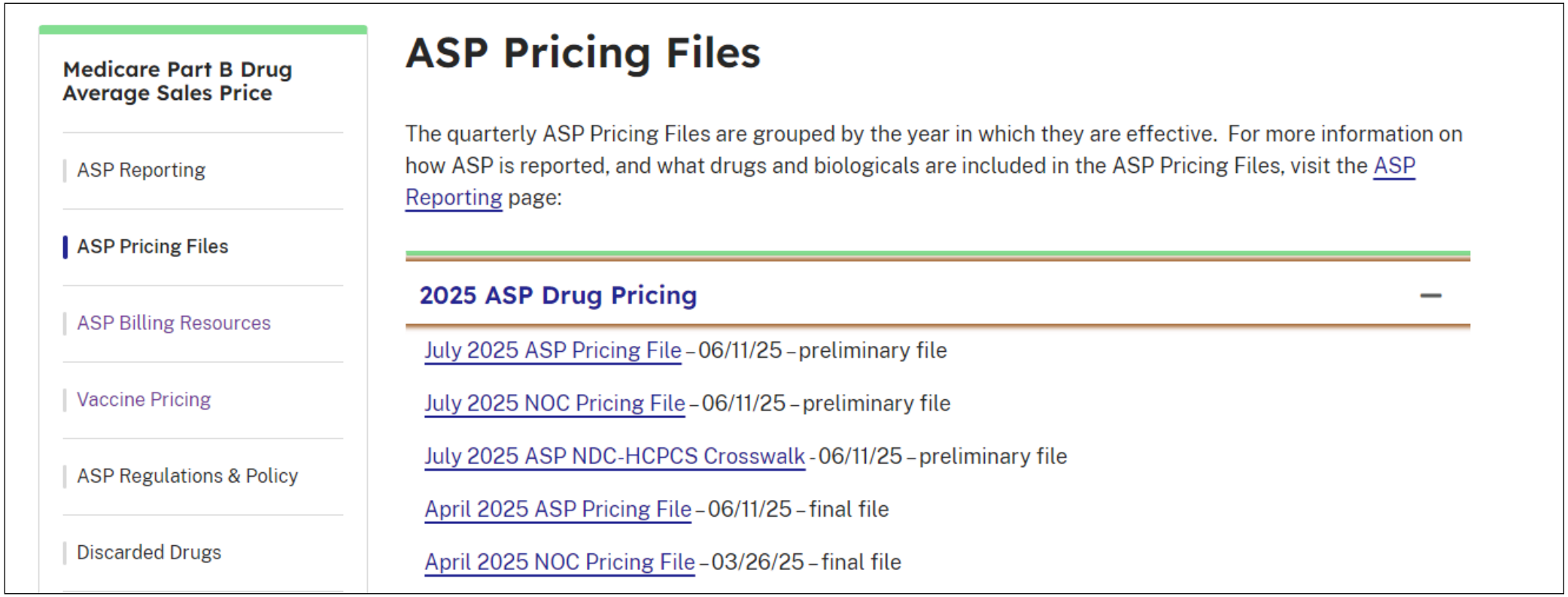
The quarterly ASP Pricing Files are grouped by the year in which they are effective. For more information on how ASP is reported, and what drugs and biologicals are included in the ASP Pricing Files, visit the ASP Reporting page:

2025 ASP Drug Pricing —

- October 2025 ASP Pricing File – 09/19/2025 – final file
- October 2025 NOC Pricing File – 09/19/2025 – final file
- October 2025 ASP NDC-HCPCS Crosswalk – 09/19/2025 – final file
- July 2025 ASP Pricing File – 09/09/25 – final file
- July 2025 NOC Pricing File – 06/23/25 – final file
- July 2025 ASP NDC-HCPCS Crosswalk - 06/30/25 – final file
- April 2025 ASP Pricing File – 09/09/25 – final file
- April 2025 NOC Pricing File – 03/26/25 – final file

https://www.cms.gov/medicare/payment/part-b-drugs/asp-pricing-files

CMS Average Sales Price for Drugs (Quarterly)



Medicare Part B Drug Average Sales Price

- ASP Reporting
- ASP Pricing Files
- ASP Billing Resources
- Vaccine Pricing
- ASP Regulations & Policy
- Discarded Drugs

ASP Pricing Files

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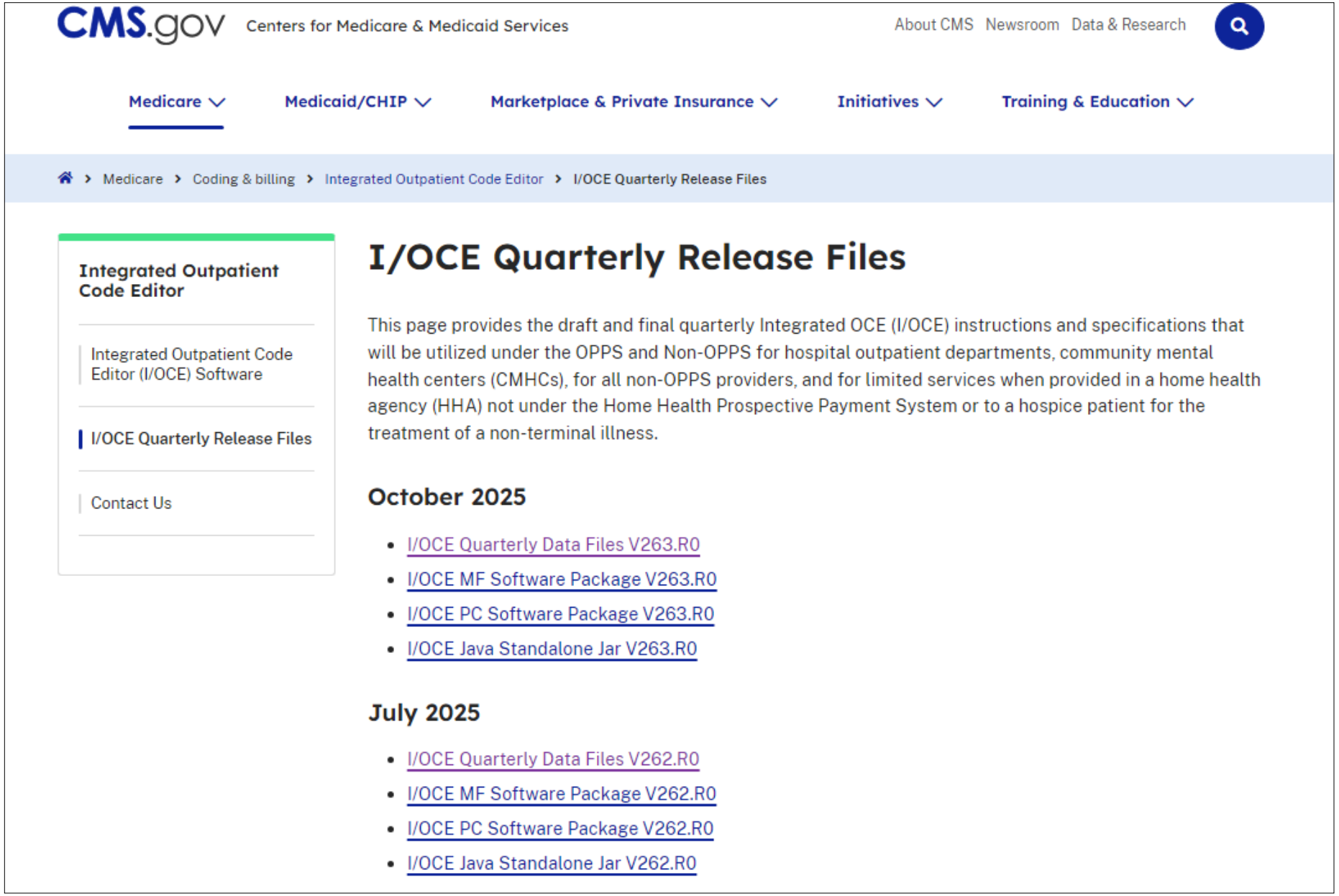
2025 ASP Drug Pricing

- July 2025 ASP Pricing File – 06/11/25 – preliminary file
- July 2025 NOC Pricing File – 06/11/25 – preliminary file
- July 2025 ASP NDC-HCPCS Crosswalk - 06/11/25 – preliminary file
- April 2025 ASP Pricing File – 06/11/25 – final file
- April 2025 NOC Pricing File – 03/26/25 – final file

https://www.cms.gov/medicare/payment/part-b-drugs/asp-pricing-files

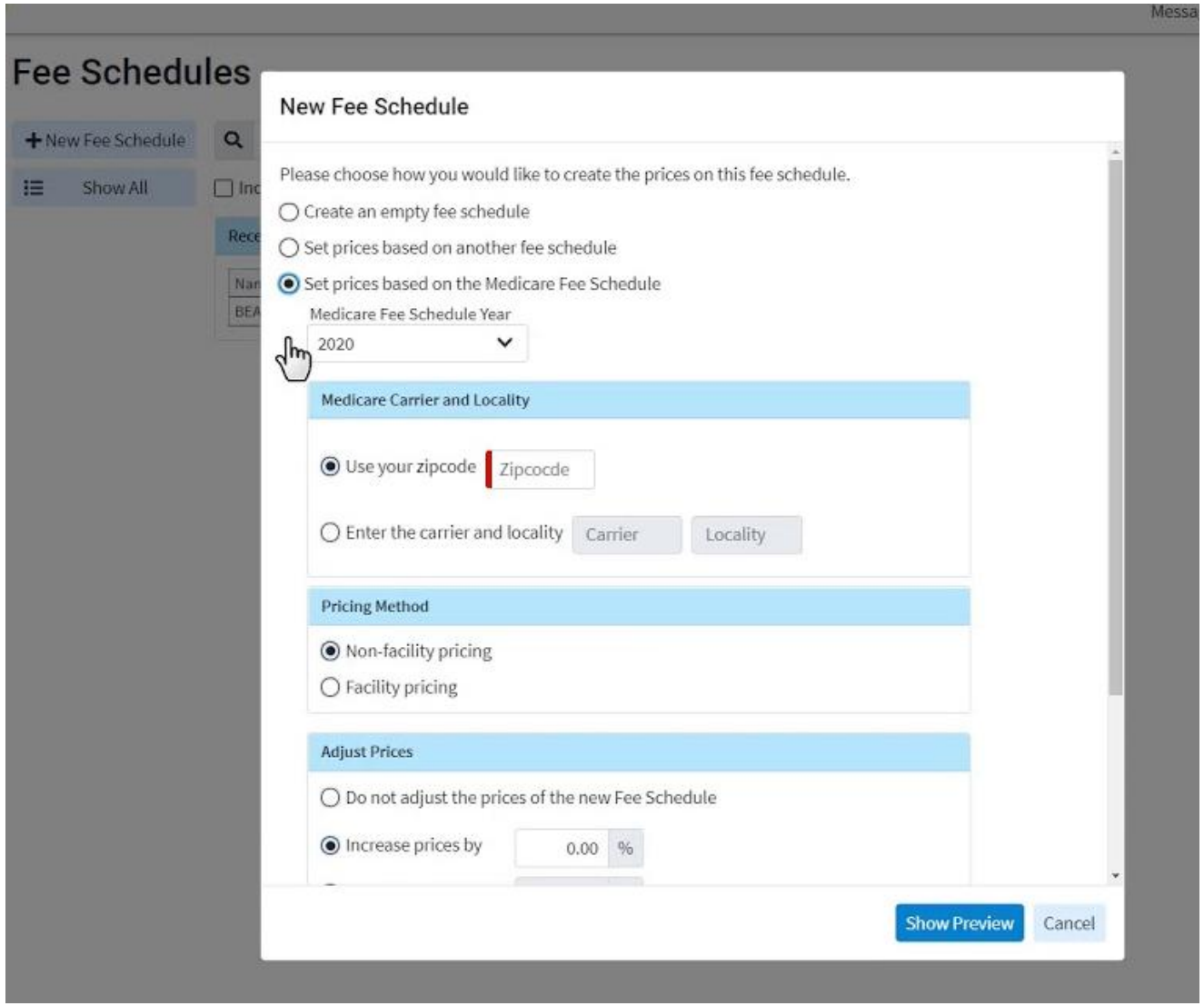
Quarterly OCE Edits



https://www.cms.gov/medicare/coding-billing/outpatient-code-editor-oce/quarterly-release-files

Fee Schedule Wizards

Example of an EHR Fee Schedule Wizard



Source: CollaborateMD (you tube)

Caution with Wizard Tools

- The wizard may not pull in all the schedules you need or may not include RHC-specific codes found on Addendum B.
- You must have a standard fee-setting methodology established to know which mark-up to apply to the wizard.
- Descriptions may be truncated when imported
- You may lose custom codes you created for utilization tracking
- Some products will automatically update fee schedules so check your default settings and preferences if you do not want to use the wizard function.
- Watch for product updates to tables.

Hospital CDM Maintenance

Hospitals may have software modules which interface with the Chargemaster to make quarterly updates or to suggest edits.

Not all hospitals have this utility.

Some updates will come from the vendor in files which need to be updated and reviewed.

Questions or Comments

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Patty Harper is CEO of InQuiseek Consulting, a healthcare consulting company based in Louisiana. She has over 28 years of healthcare experience in the areas of healthcare finance & reimbursement, health information management, compliance, and practice management. She began her healthcare career as a hospital controller and reimbursement analyst. Patty holds a B.S. in Health Information Administration (cum laude) from Louisiana Tech University. She is credentialed through AHIMA as an RHIA, CHTS-IM, and CHTS-PW. Patty successfully completed AHIMA's ICD-10 Academy and has previously been recognized as an ICD-10 Trainer. She is also Certified in Healthcare Compliance (CHC®) thorough the Compliance Certification Board. Patty is a frequent speaker and contributor for national, state and regional and rural healthcare associations on these and other reimbursement-related topics.