Proper Pricing for your Services: A Building Block to Increase Revenue

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Part 1: What is CPT?

What is CPT?
CPT is a registered trademark of the American Medical Association (AMA). The CPT Category I (CPT I) codes are a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The purpose of the terminology is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby provides an effective means for reliable nationwide communication among physicians, patients, and third parties.

Each CPT Category 1 code corresponds to a single procedure or service. The intent of CPT codes is not to transmit all possible information about a procedure or service; the intent is to identify the procedure or service. The CPT code for a service is unique and permanent.

Part 1: What is CPT?

What determines the base price of a CPT?

The price of a CPT code, also known as the relative value unit (RVU), is determined by the Centers for Medicare & Medicaid Services (CMS) and reflects the cost of providing the service. It's calculated using a formula that includes the "physician work," "practice expense," and "malpractice insurance" components.

Physician Work

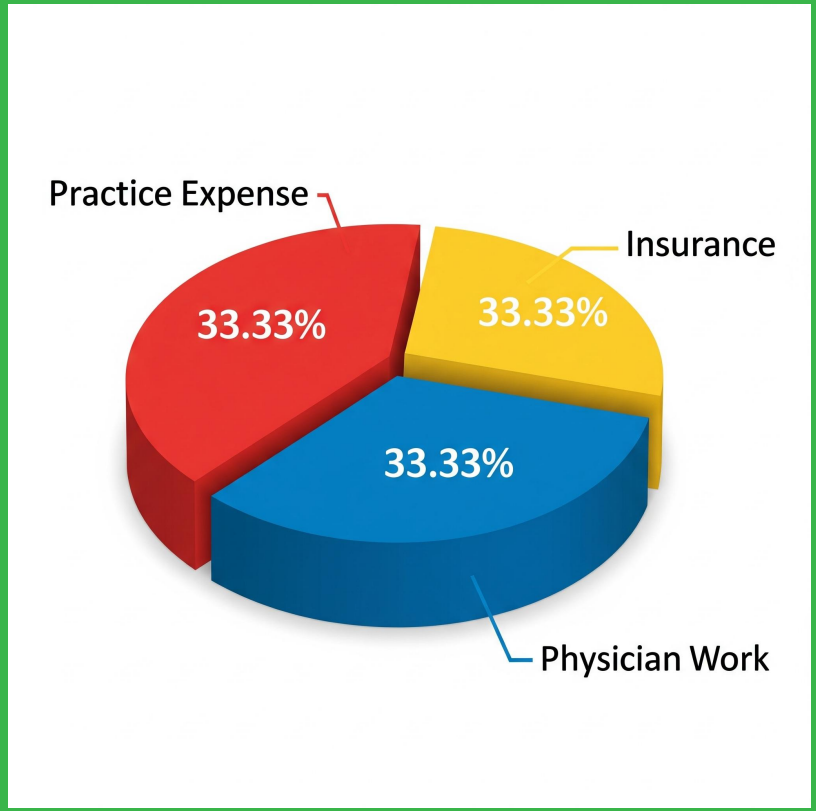
The time, technical skill, physical and mental effort, judgment, and stress associated with the procedure

Practice Expense

The overhead costs of running a practice, including the cost of non-medical staff, rent or mortgage, and equipment and supply expenses

Malpractice Insurance

The cost of the insurance that protects providers from malpractice claims



Part 1: What is CPT?

How does the RVU-based price deviate across the United States?

Fee-for-service Medicare payments to physicians and other licensed clinical practitioners (including NPs, PAs, and Mental Health Specialists) are adjusted for geographic differences in market conditions and business costs. These geographic adjustments are intended to ensure that payment to providers reflects the local costs of providing care, so that the Medicare program does not overpay in certain areas and underpay in others.

Each of the three components of the Medicare Physician Fee Schedule (Physician Work, Practice Expense, and Malpractice Insurance) is adjusted for differences across geographic areas for each component. When they are combined, these three components are known as the geographic adjustment factor.

Part 1: What is CPT?

How does the RVU-based price deviate across the United States?

Before Medicare pays for a service, the RVUs for that service are adjusted for geographic differences in input prices and for provider type. Policy adjustments are also made, such as for services furnished in a provider shortage area. Then the sum of the three geographically adjusted total RVUs (Work, Expense, and Malpractice Insurance) is multiplied by a conversion factor that determines Medicare payment in dollars.

Part 1: What is CPT?

Where is this information stored?

Since Medicaid and Medicare are run by the government of the United States, the pricing index related to CPT base pricing is determined annually by the Centers for Medicare & Medicaid Services (CMS). CPT itself is owned and trademarked by the American Medical Association (AMA.)

Part 2: RVU-Based Pricing in PCC

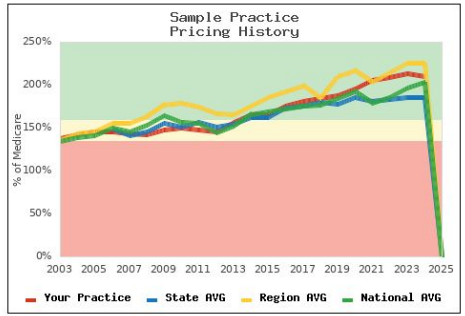
Dashboard Overview

The Practice Vitals Dashboard for your practice reports your current pricing percentage above CMS's base medicare prices.

If you drill down into the Annual State, Regional, and National Benchmarks, you can review how your practice pricing baseline relates to those in your region or state. This uses the GPCI and RVU calculations talked about earlier in this course.

Your practice baseline may be higher than your regional baseline based on well paying Fee-For-Service private insurance contracts, but at minimum you want each CPT your practice uses to have a baseline price consistent with your region so you are not losing money on providing services. There is no such thing as a "loss leader" in medicine and you should not be pricing below cost to "attract customers."

Annual State, Regional & National Benchmarks



Year	Practice AVG	State AVG	Regional AVG	National AVG
2003	138%	N/A%	136%	134%
2004	142%	N/A%	143%	139%
2005	145%	N/A%	146%	141%
2006	145%	149%	155%	150%
2007	143%	141%	156%	146%
2008	142%	146%	163%	153%
2009	148%	155%	177%	164%
2010	150%	151%	179%	157%
2011	148%	157%	174%	156%
2012	146%	151%	167%	144%
2013	157%	154%	165%	152%
2014	166%	162%	175%	166%
2015	166%	162%	185%	169%
2016	175%	173%	192%	172%
2017	181%	175%	199%	176%
2018	184%	180%	184%	177%
2019	188%	178%	210%	184%
2020	196%	186%	217%	192%
2021	205%	181%	203%	179%
2022	209%	183%	214%	186%
2023	213%	186%	226%	197%
2024	210%	185%	225%	203%

Part 2: RVU-Based Pricing in PCC

RVU Reporting in the EHR

Use the RVU reports in the Practice Management tool to calculate annual yearly price increases. I recommend the report Reimbursement Analysis w/ RVUs (by CPT Code) found in SRS.

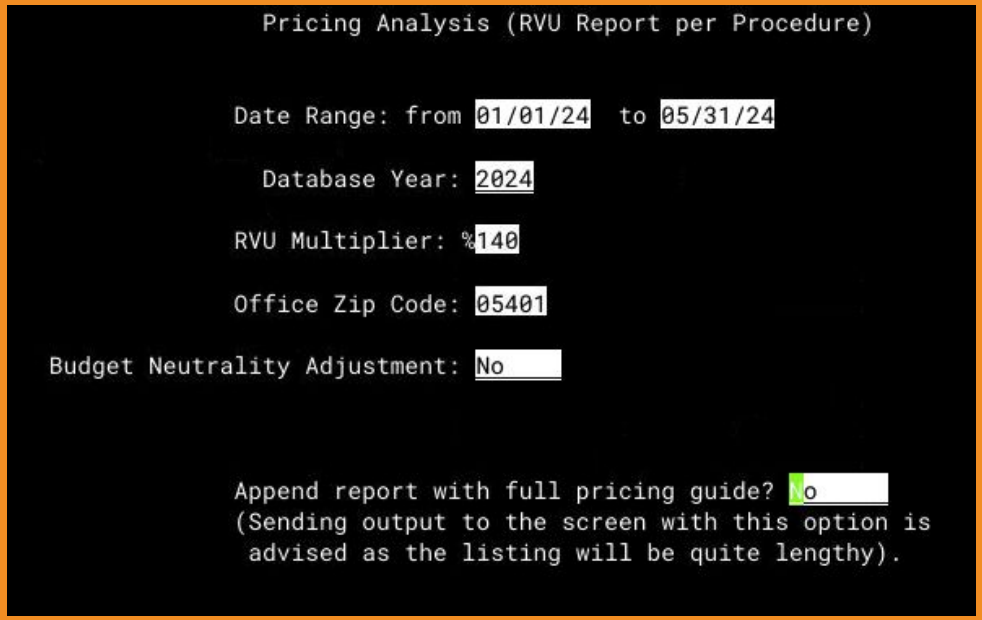
When you enter report criteria, consider the following:

Date Range: Use a full year for a period of time that has already been paid, so as to avoid bringing down your average payments. A good rule of thumb is to exclude the past 3 months as you may still be receiving payments on those charges.

Database Year: The current year will make sure you are pulling the correct information that PCC has acquired from CMS.

RVU Multiplier: This is your percentage above Medicare rate that you determine as your baseline from review of your Dashboard statistics.

Office Zip Code: This will set the GPCI values for your office location to make sure you are figuring in region costs.



Part 2: RVU-Based Pricing in PCC

Reading the Report

The report displays every CPT on your practice's Procedures table, broken down into insurance groups based on your practice's Insurance Groups table. Each row indicates your average charged and deposited amounts for that insurance for the date range. Each row also calculates the charge amount based on both the baseline medicare rates for your location and what the baseline rate would be if multiplied by the RVU Multiplier you determined on the dashboard.

Title: Reimbursement Analysis w/ RVUs (by CPT Code)

Procedure Code Set A	Procedure Name	Ins Group at Time of Service	Units	Number of Valid RVU Units	Total Number of RVUs	Avg RVU Per Unit	Avg Charge Amount	Avg Deposited	Avg Deposited as Percent of MCare FACF	RVU Medicare FACF	RVU Medicare FACF at 250%	Charge Amount	Amount Deposited (all pmts)
99391	PE Under 1 Year	Personal/No Insurance	8	8	24	3	$240.00	$132.66	137.90%	$96.20	$240.51	$1,920.00	$1,061.28
99391	PE Under 1 Year	Other	23	23	68	3	$240.00	$119.42	124.14%	$96.20	$240.51	$5,520.00	$2,746.71
99391	PE Under 1 Year	BCBS	240	240	714	3	$239.83	$171.85	178.64%	$96.20	$240.51	$57,560.00	$41,243.76
99391	PE Under 1 Year	Cigna	40	40	119	3	$240.00	$120.13	124.88%	$96.20	$240.51	$9,600.00	$4,805.20
99391	PE Under 1 Year	UHC	20	20	59	3	$240.00	$129.88	135.01%	$96.20	$240.51	$4,800.00	$2,597.53
99391	PE Under 1 Year	Molina	40	40	119	3	$240.00	$111.96	116.39%	$96.20	$240.51	$9,600.00	$4,478.51
99391	PE Under 1 Year	Aetna	7	7	21	3	$240.00	$134.49	139.80%	$96.20	$240.51	$1,680.00	$941.43
99391	PE Under 1 Year	Medicaid	9	9	27	3	$240.00	$71.43	74.25%	$96.20	$240.51	$2,160.00	$642.88
99391			387	387	1151	3	$239.90	$151.21	0.00%	$0.00	$0.00	$92,840.00	$58,517.30

Procedure	Procedure Name	Ins Group at Time of Service	Units	Number	Total Number	Avg RVU	Avg Charge	Avg Deposited	Avg Deposited	RVU Medicare	RVU Medicare	Charge Amount	Amount Deposited
99391.25	Modified PE under 1 year	Personal/No Insurance	12	12	36	3	$210.83	$145.87	151.64%	$96.20	$240.51	$2,530.00	$1,750.49
99391.25	Modified PE under 1 year	Other	66	66	196	3	$214.47	$119.98	124.72%	$96.20	$240.51	$14,155.00	$7,918.42
99391.25	Modified PE under 1 year	BCBS	3	3	9	3	$218.33	$0.00	0.00%	$96.20	$240.51	$655.00	$0.00
99391.25	Modified PE under 1 year	Cigna	312	312	928	3	$220.19	$171.42	178.19%	$96.20	$240.51	$68,700.00	$53,482.78
99391.25	Modified PE under 1 year	UHC	72	72	214	3	$216.39	$120.34	125.10%	$96.20	$240.51	$15,580.00	$8,664.72
99391.25	Modified PE under 1 year	Molina	30	30	89	3	$217.50	$139.53	145.04%	$96.20	$240.51	$6,525.00	$4,185.87
99391.25	Modified PE under 1 year	Aetna	41	41	122	3	$220.49	$116.28	120.87%	$96.20	$240.51	$9,040.00	$4,767.42
99391.25	Modified PE under 1 year	Medicaid	15	15	45	3	$210.33	$134.49	139.80%	$96.20	$240.51	$3,155.00	$2,017.35
99391.25	Modified PE under 1 year	Personal/No Insurance	12	12	36	3	$217.08	$72.94	75.82%	$96.20	$240.51	$2,605.00	$875.26
99391.25			563	563	1674	3	$218.37	$148.60	0.00%	$0.00	$0.00	$122,945.00	$83,662.31

Procedure	Procedure Name	Ins Group at Time of Service	Units	Number	Total Number	Avg RVU	Avg Charge	Avg Deposited	Avg Deposited	RVU Medicare	RVU Medicare	Charge Amount	Amount Deposited
99392	PE 1-4 Year	Personal/No Insurance	5	5	16	3	$245.00	$177.59	173.53%	$102.34	$255.86	$1,225.00	$887.96
99392	PE 1-4 Year	Other	21	21	66	3	$245.00	$129.03	126.08%	$102.34	$255.86	$5,145.00	$2,709.59
99392	PE 1-4 Year	BCBS	166	166	525	3	$245.00	$186.18	181.92%	$102.34	$255.86	$40,670.00	$30,905.37
99392	PE 1-4 Year	Cigna	28	28	89	3	$245.00	$127.81	124.89%	$102.34	$255.86	$6,860.00	$3,578.68
99392	PE 1-4 Year	UHC	21	21	66	3	$245.00	$150.45	147.01%	$102.34	$255.86	$5,145.00	$3,159.48
99392	PE 1-4 Year	Molina	29	29	92	3	$245.00	$119.74	117.01%	$102.34	$255.86	$7,105.00	$3,472.60
99392	PE 1-4 Year	Aetna	9	9	28	3	$245.00	$149.30	145.89%	$102.34	$255.86	$2,205.00	$1,343.70
99392	PE 1-4 Year	Medicaid	16	16	51	3	$245.00	$67.95	66.40%	$102.34	$255.86	$3,920.00	$1,087.20
99392			295	295	933	3	$245.00	$159.81	0.00%	$0.00	$0.00	$72,275.00	$47,144.58

Part 2: RVU-Based Pricing in PCC

Working with Report Output

Two columns on the report can help you determine if you raise a price or leave a price alone: Average Charge Amount and RVU Medicare FAFC at X%.

When you export the report to a spreadsheet, you can run a simple formula to quickly see if a price needs to be raised. Click on an empty column and enter an "=" to begin typing a function, and then subtract the RVU Medicare column from the Average Charge Amount column. (In the example below, that's "=H4-L4"). This will result in either a positive or negative value. You can click and drag on the lower-right corner to extend the formula to the rest of the cells. If the result is negative, then the corresponding CPT needs a price increase of that amount. If the value is positive, your price is probably based on reimbursement unrelated to the calculated Medicare baseline cost and you can ignore that CPT.

	D	E	F	G	H	I	J	K	L	M	N	O
1												
2												
3	Units	Number of Valid RVU Units	Total Number of RVUs	Avg RVU Per Unit	Avg Charge Amount	Avg Deposited	Avg Deposited as Percent of MCare FACF	RVU Medicare FACF	RVU Medicare FACF at 250%	Charge Amount	Amount Deposited (all pmts)	
4	8	8	24	3	$240.00	$132.66	137.90%	$96.20	$240.51	$1,920.00	$1,061.28	=H4-L4
5	23	23	68	3	$240.00	$119.42	124.14%	$96.20	$240.51	$5,520.00	$2,746.71	-$0.51
6	240	240	714	3	$239.83	$171.85	178.64%	$96.20	$240.51	$57,560.00	$41,243.76	-$0.68
7	40	40	119	3	$240.00	$120.13	124.88%	$96.20	$240.51	$9,600.00	$4,805.20	-$0.51
8	20	20	59	3	$240.00	$129.88	135.01%	$96.20	$240.51	$4,800.00	$2,597.53	-$0.51
9	40	40	119	3	$240.00	$111.96	116.39%	$96.20	$240.51	$9,600.00	$4,478.51	-$0.51
10	7	7	21	3	$240.00	$134.49	139.80%	$96.20	$240.51	$1,680.00	$941.43	-$0.51
11	9	9	27	3	$240.00	$71.43	74.25%	$96.20	$240.51	$2,160.00	$642.88	-$0.51
12	387	387	1151	3	$239.90	$151.21	0.00%	$0.00	$0.00	$92,840.00	$58,517.30	

Part 2: RVU-Based Pricing in PCC

Prices Outside of CMS Guidance

You will notice that for some CPTs the Medicaid X% will be 0. This is due to some things being supplied by the state and thus not in the CMS documentation. VFC vaccines are an excellent example of this as the vaccine is supplied for free to Medicaid patients by the state. To figure out the cost of these procedures you need to perform a different sort of calculation, such as your cost + storage + time for administering the procedure.

Another factor is self-pay patients who pay at time of service and receive a discount. PCC can help you set this discount automatically by either a flat rate that does not change when you increase your prices or by a percentage discount off the price.

Part 3: Adjust for True Reimbursement

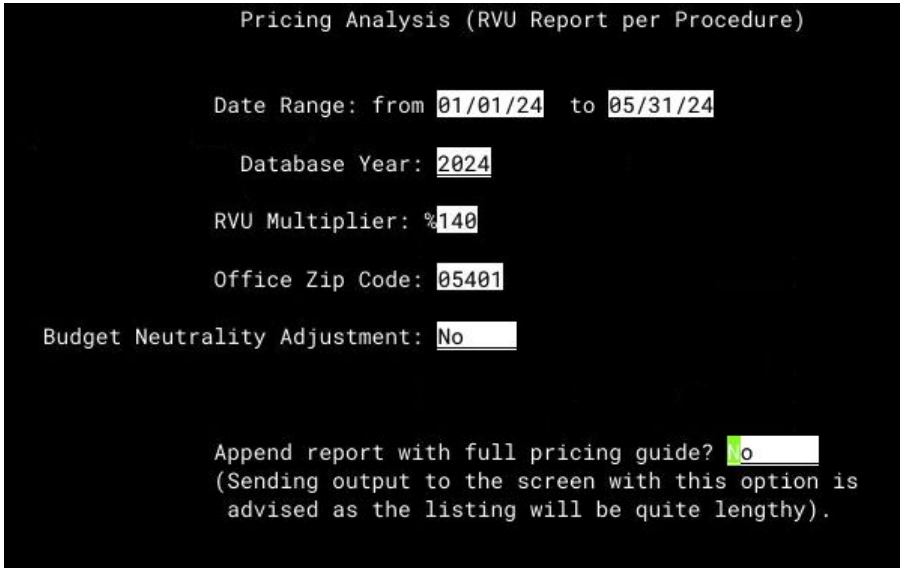
Leaving Space to Breath

Once you have a baseline set, you will want to let new charge and payment data come in to set a new baseline against total reimbursement.

Use the same report (Reimbursement Analysis w/ RVUs by CPT Code) to examine 3 months of data as you did for setting annual baseline pricing.

As a rule, you want to exclude the last 3 months of data just as you did when running your annual report, and I recommend having 3 months of data to set averages. This would mean setting your true reimbursement pricing six months after setting your baseline prices, when you have data from 6 months ago through 3 months ago.

Once you have the output of your three month sample, you can find prices that are below a certain threshold. I recommend a minimum 20% buffer between charges and payments.



Part 3: Adjust for True Reimbursement

Leaving Space to Breath

When viewing these reports it is important to remember that the Units column represents the number of times a CPT was charged to an insurance company and that the **Avg Deposited** column indicates the average deposited when all payments are added together and divided by the number of units. Your average deposit amount might differ from the reported value if you've had zero dollar payments or payments made at 100% of the charge. This is why a 20% buffer is recommended.

If you want to do a deeper dive into the exact reimbursements of each unit by insurance payor, you can run the Insurance Reimbursement Analysis tool in Practice Management. The F3 "Charge Details" report can display the exact payments for each unit. This is not recommended for yearly pricing as it would be much more time consuming than leaving yourself a buffer, but can help you spot if any individual payments come in at 100% of the charge amount.

Part 3: Adjusting for true Reimbursements

Leaving Space to Breath

As when setting prices annually, you can use a function on a spreadsheet to find your overall value and determine your buffer.

For this valuation you want to divide your Average Charge Amount by your Average Deposited. To run this as an equation, enter a calculation in a new column. (In the example below, "=I4/H4".) This will show how much of your charge you are getting paid. The result should be less than 0.80. A quotient of 0.79 and below is 79%, or at minimum a 21% buffer to account for any variance. A quotient of 0.81 or higher would be a 19% buffer or lower, giving you less of a buffer for any variance from the average.

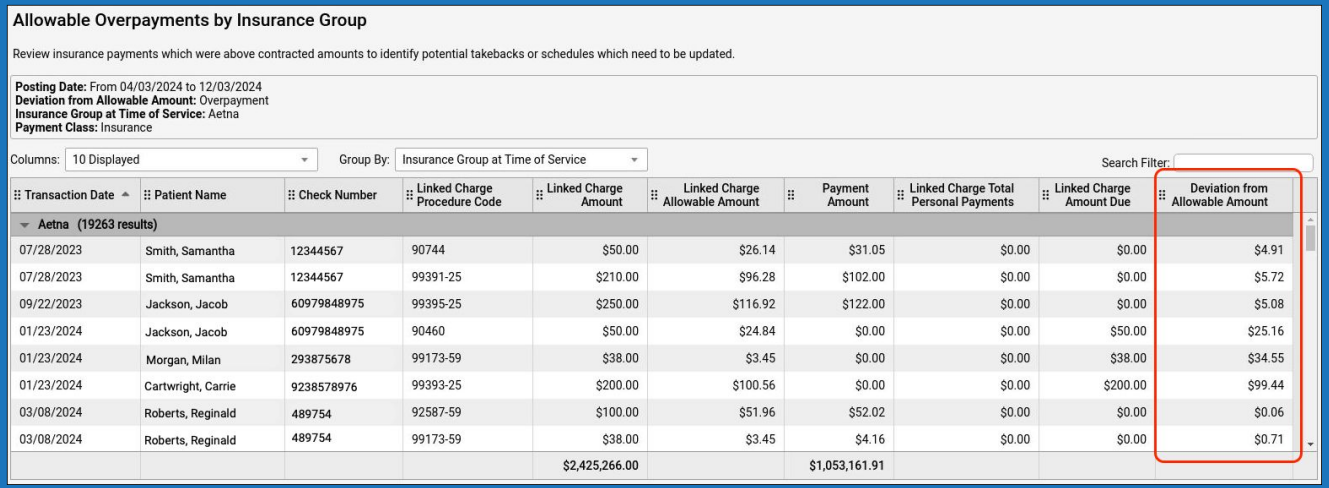
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
83	Procedure Code Set A	Procedure Name	Ins Group at Time of Service	Units	Number of Valid RVU Units	Total Number of RVUs	Avg RVU Per Unit	Avg Charge Amount	Avg Deposited	Avg Deposited as Percent of MCare FACF	RVU Medicare FACF	RVU Medicare FACF at 250%	Charge Amount	Amount Deposited (all pmts)	=I83/H83
84	99394.25	Modified PE 12 to 17 yrs	Personal/No Insurance	10	10	35	3	$249.50	$206.92	185.27%	$111.69	$279.22	$2,495.00	$2,069.24	$0.83
85	99394.25	Modified PE 12 to 17 yrs	Other	50	50	173	3	$248.10	$128.81	115.33%	$111.69	$279.22	$12,405.00	$6,440.65	$0.52
86	99394.25	Modified PE 12 to 17 yrs	BCBS	401	401	1384	3	$249.79	$204.13	182.77%	$111.69	$279.22	$100,165.00	$81,858.03	$0.82
87	99394.25	Modified PE 12 to 17 yrs	Cigna	88	88	304	3	$248.86	$139.15	124.59%	$111.69	$279.22	$21,900.00	$12,245.30	$0.56
88	99394.25	Modified PE 12 to 17 yrs	UHC	21	21	72	3	$243.33	$157.45	140.97%	$111.69	$279.22	$5,110.00	$3,306.41	$0.65
89	99394.25	Modified PE 12 to 17 yrs	Molina	36	36	124	3	$251.25	$119.34	106.85%	$111.69	$279.22	$9,045.00	$4,296.10	$0.47
90	99394.25	Modified PE 12 to 17 yrs	Aetna	19	19	66	3	$248.95	$157.41	140.93%	$111.69	$279.22	$4,730.00	$2,990.74	$0.63
91	99394.25	Modified PE 12 to 17 yrs	Medicaid	2	2	7	3	$260.00	$150.88	135.09%	$111.69	$279.22	$520.00	$301.76	$0.58
92	99394.25	Modified PE 12 to 17 yrs	Kaiser	54	54	186	3	$251.57	$69.08	61.85%	$111.69	$279.22	$13,585.00	$3,730.49	$0.27
93	99394.25			681	681	2351	3	$249.57	$172.16	0.00%	$0.00	$0.00	$169,955.00	$117,238.72	$0.69

Part 4: Upkeep

PCC Recommendation

PCC recommends updating your prices once a year, to keep your prices up to date with minimal repeated effort. If you only increase prices, then each year you will have fewer code adjustments from the year before, reducing work each subsequent year.

PCC tools can also help you know when to increase prices based on reimbursement. If your office uses ERA autoposting in the EHR, and you load your fee schedules into your PCC system's allowables tool, you can see right on the ERA if an insurance pays less than or more than your allowed amount. Or you can run the Allowable Overpayments/Under Payment by Insurance Group reports in the PCC EHR report library.



Allowable Overpayments by Insurance Group

Review insurance payments which were above contracted amounts to identify potential takebacks or schedules which need to be updated.

Posting Date: From 04/03/2024 to 12/03/2024
Deviation from Allowable Amount: Overpayment
Insurance Group at Time of Service: Aetna
Payment Class: Insurance

Columns: 10 Displayed | Group By: Insurance Group at Time of Service | Search Filter:

Transaction Date	Patient Name	Check Number	Linked Charge Procedure Code	Linked Charge Amount	Linked Charge Allowable Amount	Payment Amount	Linked Charge Total Personal Payments	Linked Charge Amount Due	Deviation from Allowable Amount
Aetna (19263 results)									
07/28/2023	Smith, Samantha	12344567	90744	$50.00	$26.14	$31.05	$0.00	$0.00	$4.91
07/28/2023	Smith, Samantha	12344567	99391-25	$210.00	$96.28	$102.00	$0.00	$0.00	$5.72
09/22/2023	Jackson, Jacob	60979848975	99395-25	$250.00	$116.92	$122.00	$0.00	$0.00	$5.08
01/23/2024	Jackson, Jacob	60979848975	90460	$50.00	$24.84	$0.00	$0.00	$50.00	$25.16
01/23/2024	Morgan, Milan	293875678	99173-59	$38.00	$3.45	$0.00	$0.00	$38.00	$34.55
01/23/2024	Cartwright, Carrie	9238578976	99393-25	$200.00	$100.56	$0.00	$0.00	$200.00	$99.44
03/08/2024	Roberts, Reginald	489754	92587-59	$100.00	$51.96	$52.02	$0.00	$0.00	$0.06
03/08/2024	Roberts, Reginald	489754	99173-59	$38.00	$3.45	$4.16	$0.00	$0.00	$0.71
				$2,425,266.00		$1,053,161.91			

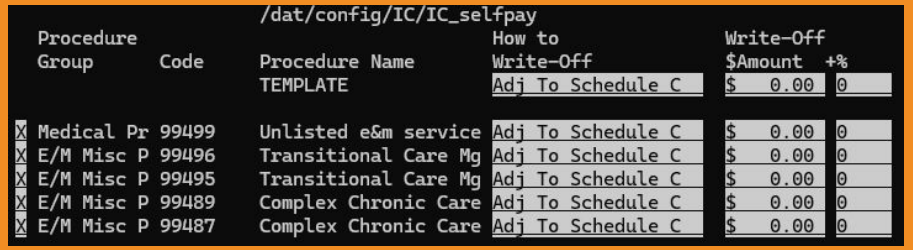
Part 4: Upkeep

Overcoming Fears

Many practices worry how raising prices will affect self-pay patients.

Remember that you can set your practice up with a self-pay discount for time-of-service payments, allowing you to raise prices without raising costs for patients without insurance. The base price will be discounted by the percentage amount increase of the new price.

If you would like to raise self-pay prices by the same percentage amount as your overall pricing (remember there are no loss leaders in medicine), you can also set your discounts by a percentage of the charge instead of by a base rate, raising the amount charged to self-pay patients incrementally with your other price increases.



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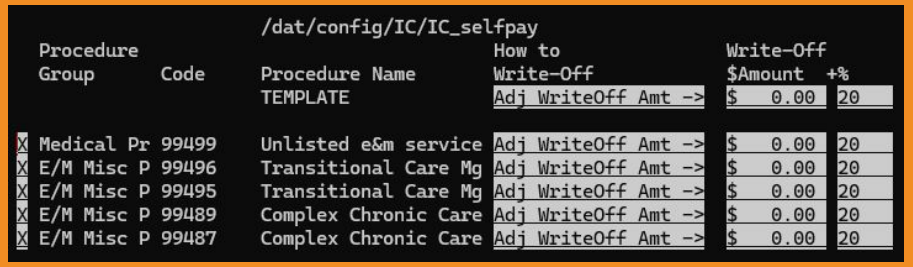
	Procedure Group	Code	Procedure Name	How to Write-Off	Write-Off $Amount	+%
			TEMPLATE	Adj To Schedule C	$ 0.00	0
X	Medical Pr	99499	Unlisted e&m service	Adj To Schedule C	$ 0.00	0
X	E/M Misc P	99496	Transitional Care Mg	Adj To Schedule C	$ 0.00	0
X	E/M Misc P	99495	Transitional Care Mg	Adj To Schedule C	$ 0.00	0
X	E/M Misc P	99489	Complex Chronic Care	Adj To Schedule C	$ 0.00	0
X	E/M Misc P	99487	Complex Chronic Care	Adj To Schedule C	$ 0.00	0



/dat/config/IC/IC_selfpay

	Procedure Group	Code	Procedure Name	How to Write-Off	Write-Off $Amount	+%
			TEMPLATE	Adj WriteOff Amt ->	$ 0.00	20
X	Medical Pr	99499	Unlisted e&m service	Adj WriteOff Amt ->	$ 0.00	20
X	E/M Misc P	99496	Transitional Care Mg	Adj WriteOff Amt ->	$ 0.00	20
X	E/M Misc P	99495	Transitional Care Mg	Adj WriteOff Amt ->	$ 0.00	20
X	E/M Misc P	99489	Complex Chronic Care	Adj WriteOff Amt ->	$ 0.00	20
X	E/M Misc P	99487	Complex Chronic Care	Adj WriteOff Amt ->	$ 0.00	20

Please fill out the course survey in the app

What Questions Do You Have?