Dear Customer:

The 2017 edition of *The Essential RBRVS* contained an error on page Introduction – 2. Under the section New for 2017, the conversion factor should have been listed as $35.8887. The conversion factor is correct in other sections of the book.

If you are a customer of the updateable version of *The Essential RBRVS*, this change has been made in your April update. For customers of the annual version, replacement pages that can be inserted into your book can be downloaded from: https://www.optumcoding.com/ProductUpdates/

With appreciation,

Optum360
Introduction

Development
The Essential RBRVS incorporates the relative values produced by the Centers for Medicare and Medicaid Services (CMS) for the Medicare Physician Fee Schedule (MPFS) into a comprehensive reference of resource-based relative value scale (RBRVS) relative values.

Even though RBRVS was developed specifically for assigning reimbursement rates to Medicare services, over 75 percent of non-Medicare payers use Medicare RBRVS to establish fees or maximum allowables for physician services. This works well for those services assigned relative values by CMS for Medicare. However, because Medicare does not assign a value to all services, the MPFS has gaps. In order to create a complete RBRVS-based fee schedule, these gap services need to have relative values assigned.

The Essential RBRVS Gap Methodology
The gaps in The Essential RBRVS are created when the Medicare Physician Fee Schedule (MPFS) does not provide values for procedure or supply codes. The gaps are created using various methodologies depending on the code.

For most codes, gap relative values are calculated by using relative value information from the Optum Relative Value Scale and adjusted to a scale similar to the MPFS relative values (RBRVS). The Optum relative values are developed by and are proprietary to Optum. Optum relative values are assigned when Optum has an understanding of how the procedure is typically billed by the industry and how it relates to other procedures. Relative values are based on difficulty, time, work, risk, and resources. Relative values are established by Optum employees, including an Optum Medical Director, clinicians, certified procedural coders, and analysts. Optum also consults with a panel of outside physicians and dentists during the relative value development process for certain codes.

Because Optum relative values are on a different scale than RBRVS relative values, we develop ratios relating the RBRVS and Optum scales for approximately 250 code ranges (within the CPT®, HCPCS, and CDT systems). These ratios are multiplied by the Optum relative value to create the gap value. If Optum does not assign a relative value to a code, a gap value is not calculated. An example of the methodology is as follows (numbers used are for example purposes only): Procedure code 15828 is not valued in the MPFS. Optum has a relative value of 185 for this procedure code. The calculated ratio of Optum to the MPFS relative value units for the range of codes that this procedure code falls in is .366. The gap value would be $185 \times .366 = 67.70$.

Codes that are valued by Medicare’s Clinical Lab Fee Schedule (CLAB); Durable Medical Equipment, Prosthetics/Orthotics, & Supplies Fee Schedule (DMEPOS); or the Medicare ASP (average sale price) drug pricing files are treated differently. For these codes, the dollar values (national limit in CLAB) are used and relative values are created by dividing the dollar amounts by the MPFS national conversion factor. The CLAB, DMEPOS, and ASP files used are the most recent available at the time of printing. These files may update throughout the year.

Note: Gap relative values should not be used to calculate a Medicare reimbursement rate. In addition, the gap work relative value should not be used to calculate the outpatient prospective payment system (OPPS) rate.

Features
The Essential RBRVS is the most comprehensive resource-based relative value scale available. Below are The Essential RBRVS features:

- Physician services, including those not part of the MPFS.
- Clinical laboratory services.
- Level II codes, such as durable medical equipment (DME), medical and surgical supplies, and transportation.
- J codes (injectable drugs).
- Appendix A — This table provides the information necessary to determine if Medicare allows or makes adjustments to payment for the following: PC/TC component, assistant-at-surgery, multiple procedures, bilateral procedures, co-surgery or team surgery. The preop, intraop, and postop splits, the endoscopic base code, as well as the indicator identifying the level of physician supervision of diagnostic tests, if any, are also listed in appendix A. The special payment rules for each are identified at the beginning of the table.
- Appendix B — Payment for the technical component (TC) portion of a radiology service will be limited to the lesser of the Medicare Physician Fee Schedule (MPFS) amount or the Outpatient Prospective Payment System (OPPS) amount in 2017. This is referred to by CMS as
the OPPS cap on the technical component of radiology services. Appendix B provides the OPPS PE and MP RVUs for radiology services affected by the cap. The Y in the OPPS column in the data indicates services that appear in Appendix B. This ruling affects codes primarily in the Radiology section, but also affects codes in the Surgery, Medicine, Category III, and HCPCS sections. Starting in 2017, a Y has been added to the OPPS column to indicate a code for which the OPPS rule applies and the OPPS value is less than the MPFS amount. The Y indicates that the OPPS rule applies and the MPFS amount is less than the OPPS amount.

Please note that the Medicare values included in this book are those available at the time of printing. CMS may issue corrections throughout the year.

**RBRVS Highlights**

**New for 2017**

Each year CMS must apply a number of adjustments to the conversion factor (CF) and relative value units (RVU) to meet statutory requirements. The conversion factor beginning January 1, 2017 will be $35.8887 for the Physician Fee Schedule and $22.0454 for anesthesia, adjusted to reflect budget neutrality, the Medicare Access and CHIP Reauthorization Act (MACRA) 0.5 percent adjustment, and the -0.18 percent target recapture amount.

**Medicare Sustainable Growth Rate (SGR)** — The Medicare Access and CHIP Reauthorization Act, signed into law April 16, 2015, permanently repealed the sustainable growth rate (SGR) formula. The sustainable growth rate set targets intended to control the actual growth in aggregate Medicare expenditures for physicians’ services. If expenditures exceeded the target, the update was reduced. If expenditures were less than the target, the update was increased. From 2002–2015, the SGR would have caused reductions in reimbursement as high as 25 percent if annual cuts were not averted by Congress.

**Quality Payment Program** — The Centers for Medicare and Medicaid Services has developed the Quality Payment Program to replace the previous SGR system. The Quality Payment Program has two tracks that providers may choose from—the Merit-based Incentive Payment Systems (MIPS) or the Advanced Alternative Payment Models (APMs).

The MIPS program will incorporate the PQRS reporting for 2017 and 2018 with anticipated changes beginning in 2019. The other components of MIPS include reporting Improvement Activities, Advancing Care Information (replaces EHR requirements), and Cost (replacing the value based modifier). The MIPS program will be in transition for 2017; however, providers must report a minimum of these components or face a penalty up to 4 percent in 2019. Providers who complete all the required reporting in 2017 may be eligible for a bonus up to 4 percent in 2019.

The APMs are care models as defined by CMS. This listing may change from year to year as determined by CMS. Participants are eligible for an incentive payment up to 5 percent.

A provider is included in the Quality Payment Program in 2017 if you are:

- An Advanced APM
- Bill over $30,000 per year to Medicare AND care for more than 100 Medicare patients per year.
- Medicare participant two or more years

To participate in the MIPS program the provider must be a:

- Physician
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist

The performance period opens January 1, 2017 and closes December 31, 2017. Providers have until October 2017 to begin participation or are subject to a 4 percent reduction in 2019.

**Sequestration Reduction in Reimbursement** — The Budget Control Act of 2011, known as the “sequestration,” implements reductions in federal spending. The sequestration order signed on March 1, 2013 resulted in a 2 percent reduction in Medicare reimbursement and is presently scheduled to be in effect through to 2021. It should be noted that the reduction is not a 2 percent reduction to the fee schedule amount, but instead a 2 percent reduction on the amount Medicare will pay the provider. For example, the Medicare approved amount is $100. The patient is responsible for 20 percent or $20 and Medicare is responsible for $80. The Medicare amount of $80 is reduced by the 2 percent sequestration reduction and the provider is paid $78.40.

**Potentially Misvalued Services** — As part of the Affordable Care Act, periodically CMS must identify potentially misvalued services, review these services, and make appropriate adjustments to the relative values of said services. Congress has set a target for adjustments to misvalued services between years 2016–2018 through the Achieving a Better Life Experience Act of 2014. In 2017 and 2018 a target of 0.5 percent was set. This means that if the reductions in misvalued codes in 2017 are less than 0.5 percent, the total revenue under the fee schedule is a reduction equal to the percentage difference between 0.5 percent and the percent of those expenditures represented by the misvalued code. Reductions must be made to all physician fee schedule services.

For 2017 CMS has proposed misvalued code changes would result in 0.51 percent in net expenditure reductions. Because these changes would meet the misvalued code target, a broad overall reduction to the physician fee schedule will not be required.

**Telehealth (Telemedicine) Services** — The following services have been included as services that are eligible to be furnished as a telehealth service: