Compassion*Works – MFRS
Medical Food Reimbursement Specialists
Information on HCPCS Codes Reimbursement and Determination

How HCPCS codes Reimbursements are Determined

From this HCPCS lookup, you'll find three things:

1. **A description of each HCPCS code,**
2. **The Relative Value Amount (RVU)**
3. **The Geographic Practice Cost (GPCI).**

When put together, they become the Physician or DME Fee Schedule.

Using RVUs to Determine How Much You're Provider Was Paid

Each HCPCS code is given a value - an amount of money Medicare will pay a hospital or a physician for that service as an average. Then, cities and other geographic areas are assigned an RVU - relative value amount - that is a percentage, higher or lower, of the average HCPCS payment.

Here's how that works: Depending on "where you live in", the RVU will be higher or lower than the average, based on the cost of doing business. So, for example, the cost of doing business is higher than average in New York City. The average = 1. The RVU for New York City might be 1.3. In Birmingham, Alabama, which has a much lower cost of doing business, the RVU might be .75.

What is a Geographic Practice Cost Index?

The GPCI is the amount paid for each HCPCS code once the average has been multiplied by the RVU. It's not a percentage - it's the actual dollar amount. Looking at Code X from above, the average coast (RVU = 1.0) might be $100. In New York City, where the RVU is 1.3, Code X is worth $130. In Birmingham, Alabama where the RVU is .75, Code X would be worth $75.

When combined, the code payment amount, the RVU and the GPCI result in physician's or DME fees for every service they may provide to you, their patient. It's called the Physician or DME Fee Schedule.

Remember, the Physician or DME Fee Schedule only tells you what Medicare pays for these services. If you have private insurance, the amount paid to your provider or hospital may be more or less.

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When you do a HCPCS lookup, you can learn four things:

1. You can use a HCPCS code to find out what service or procedure it represents.
2. You can use a service or procedure to look up the HCPCS codes that might apply.
3. You can find out how much Medicare pays a provider and a facility in your area for that service or procedure (the RVU).
4. You can find out the average amount paid across the US for that code**.

What are Medicare's HCPCS Codes?
Healthcare Common Procedure Coding System - Billing Codes

HCPCS Codes, Healthcare Common Procedure Coding System numbers, are the codes used by Medicare and monitored by CMS, the Centers for Medicare and Medicaid Services. They are based on the CPT Codes (Current Procedural Technology codes) developed by the American Medical Association.

****HCPCS Codes are generally a description of service provided****

HCPCS Codes are numbers assigned to every task and service a medical provider may provide to a Medicare patient. Since everyone uses the same codes to mean the same thing, they ensure uniformity. For example, no matter what provider a Medicare patient receives medical food/Enteral Formula for inborn error of metabolism (code B4157 or S9435) that provider will be paid by Medicare the same amount another provider in that same **geographic region** would be.

There are two sets of codes.

1. The first set, HCPCS Level I, are based on and identical to CPT codes, the codes developed by the American Medical Association.
2. Level II HCPCS codes are used by medical suppliers other than physicians, such as ambulance services or durable medical equipment. These are typically not costs that get passed through a physician's office so they must be dealt with by Medicare or Medicaid differently from the way a health insurance company would deal with them.

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Depending on negotiations with private health insurers.

We need to understand how health insurance works for DME Suppliers:

Each year, providers and healthcare facilities like testing labs, hospitals, pharmacies and others (i.e. DME), negotiate pricing with health insurers and payers. In its simplest form, it goes like this:

Provider: When a patient with PKU needs a particular dietary medical food, we charge $100 for the medical food, and $75 for the shipping.

Payer: That's too much money. We'll pay you $55 for the medical food and $35 for the shipping.

Provider: I can't pay my staff or keep my lights turned on for that paltry amount! How about $65 for the medical food and $45 for the shipping?

Payer: Deal.

That negotiation takes place for every possible product/service your DME supplier provides, with every insurance company, each year.

Some insurance companies refuse to pay some providers the amount those providers believe they are entitled to be paid. When that happens, the provider will stop accepting that form of insurance as reimbursement.

Then, of course, once the provider no longer accepts that insurance company's reimbursement schedule, then the provider no longer accepts patients who use that payer's insurance.

We can't pass judgment on whether a provider should, or should not; accept the amount of money a payer is willing to pay. For one reason, we have a free enterprise system of healthcare payment.

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****Each provider in private practice, or each hospital or other lab or facility (i.e. DME) has a right to charge what it wants to charge, and which payers it wishes to work with.**

Example:

Here's another way to think about it. Suppose you went to work and did your job well. When it came time to get your paycheck, your employer told you he had decided your services weren't really worth what you expected to be paid, so he was going to begin paying you less. Take it or leave it. That's the position providers are put in by payers each year.

We also have to recognize that when payers reimburse at the higher amounts a provider wants to be paid, it costs us patients more in the forms of premiums, co-pays, higher deductibles and sometimes taxes, too.

Be aware, too, that providers may change plans, or insurers and payers may add or drop providers from year to year. Whenever you change insurance plans, it's always good to double check whether you will be able to see the providers you usually have.

Note: Enteral Formula / Medical Foods are typically considered a medical benefit vs. pharmacy benefits. Some patients have coverage for both or one or of the other. If so, you will choose the most affordable route.**

This information is used for Medical benefits and not pharmacy benefits. Pharmacy benefits uses NDC codes to identify a particular "product" not a medical service such as a HCPCS code. This is not a guarantee of benefits and / or payments.