National Fee Analyzer

Charge data for evaluating fees nationally

Contents

Charge Data

The data used in the *National Fee Analyzer* is actual provider charge data collected from health insurance payers by FAIR Health, Inc. This national charge data is aggregated and combined with a relative value and conversion factor methodology. The relative value clinically compares and ranks medical procedures by difficulty, work, risk, and the material costs of these procedures. The conversion factor is the dollar amount developed for each charge by dividing the charge by the code's relative value.

Please note that while insurance payers contribute billed charges to the data used in this product, no individual physician or clinic is identifed in the data. Additionally, no allowed amounts or insurance company paid amounts are used in the product.

FAIR Health licenses the data to many of its insurance payer customers under the name FAIR Health RV Medical Module. The FAIR Health RV Medical Module product has four releases per year—February, May, August, and November. The *National Fee Analyzer* and the FAIR Health RV Medical Module use data that falls within a 12-month period. For example, the November 2011 release of the FAIR Health RV Medical Module product contains data with a date of service range from September 2010 through August 2011.

National 50th and 75th Percentile Amounts

These amounts were developed using the blended methodology described in the Charge Data section.

National 50th Percentile—This column is the 50th percentile of the database nationally. Percentiles are frequently misunderstood. A fee at the 50th percentile does not mean 50 percent of providers charge that amount. If your fee for a given service is at the 50th percentile, then, based on FAIR Health methodology and data, 50 percent of the submitted charges for that service are equal to or higher than your fee.

National 75th Percentile—This column is the 75th percentile of the database nationally. If your fee is at the 75th percentile, then, based on FAIR Health methodology and data, 25 percent of the submitted charges are equal to or higher than yours.

Medicare Amounts

The majority of values for CPT codes are from the Medicare Physician Fee Schedule (MPFS). The codes contained in the MPFS are primarily professional services, but some technical (facility) services are also listed. While the amounts from the MPFS reflect the nonfacility reimbursement amounts, it should be noted that for procedures that must be performed on an inpatient basis, CMS does not provide a separate nonfacility rate. For procedures that must be performed on an inpatient basis, the facility reimbursement rate is provided.

For 2012, the MPFS fees are based on a conversion factor of 24.6712.

For codes that are not valued on the MPFS, the RVU column will display 0.00. For these codes, the fee in the Medicare Average column comes from one of the following fee schedules.

Average Sales Price (ASP) Drug Pricing Files — The ASP Drug Pricing Files provide a national fee schedule. Medicare does not adjust reimbursement rates based on geographic area; however, different rates exist for some drugs based on supplier. The majority of codes on the ASP pricing files are for HCPCS J codes. The *National Fee Analyzer* contains the subset of fees from the ASP drug pricing files that are assigned to CPT codes.

Clinical Lab Fee Schedule (CLAB) — The clinical laboratory fee schedule contains fees for outpatient laboratory services from the 80000 section of CPT codes. The fee displayed is the CLAB National Limitation Amount.

Actual reimbursement rates vary by locality, but the national average reimbursement provides a good benchmark to compare to provider charges and private payer allowables. Medicare amounts are subject to change throughout the year. The Medicare averages published in *National Fee Analyzer* are the most current available at the time of printing. Please check with CMS or your local carrier to obtain rates for a specific locality and date.

Geographic Adjustment Factors

Table A lists commercial (non-Medicare) Geographic Adjustment Factors (GAF) so you can align the national average percentile amounts found in *National Fee Analyzer* with local fees. For example, the GAF for the Birmingham, Alabama area is 0.781. To arrive at a Birmingham area-adjusted 75th percentile amount for code 10040, multiply the national amount by the GAF ($163.86 x 0.781 = $127.97).

Table B lists Medicare Geographic Adjustment Factors (GAF) so you can adjust the Medicare national fee schedule amount to your locality, by multiplying the listed Medicare fee by your locality's adjustment factor. Note that this table will not yield the exact Medicare reimbursement but should closely approximate the expected amount. Calculating the exact reimbursement amount requires the individual components of each total RVU as well as the associated GPCIs for those components.

Commercial Geographic Adjustment Factors

In order to adjust the national averages to specific geographic areas, geographic adjustment factors have been calculated by taking the difference from the national average for each service area across all service areas for each geographic area. Averages were then taken across the service 5

	CPT Code	Description	Medicare RVU	50th Percentile	75th Percentile	90th Percentile	Medicare Average
	17250	Chemical cauterization of granulation tissue (proud flesh, sinus or fistula)	2.24	106.06	143.74	191.31	80.19
	17260	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.5 cm or less	2.65	195.54	251.93	319.34	94.87
	17261	lesion diameter 0.6 to 1.0 cm	4.04	211.11	270.01	342.81	144.64
	17262	lesion diameter 1.1 to 2.0 cm	4.93	255.80	330.23	421.21	176.50
	17263	lesion diameter 2.1 to 3.0 cm	5.37	288.92	372.38	470.15	192.25
	17264	lesion diameter 3.1 to 4.0 cm	5.77	318.05	412.53	521.08	206.57
	17266	lesion diameter over 4.0 cm	6.54	395.87	512.90	648.42	234.14
	17270	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	4.24	224.67	292.08	368.28	151.80
	17271	lesion diameter 0.6 to 1.0 cm	4.60	232.45	302.12	381.01	164.69
	17272	lesion diameter 1.1 to 2.0 cm	5.24	281.14	362.34	457.42	187.60
	17273	lesion diameter 2.1 to 3.0 cm	5.86	333.62	432.60	546.55	209.80
	17274	lesion diameter 3.1 to 4.0 cm	6.90	364.74	472.75	597.49	247.03
	17276	lesion diameter over 4.0 cm	7.99	413.43	532.97	675.89	286.05
	17280	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	3.97	263.58	340.27	431.95	142.13
	17281	lesion diameter 0.6 to 1.0 cm	5.01	271.36	352.30	444.68	179.36
	17282	lesion diameter 1.1 to 2.0 cm	5.76	318.05	410.53	521.08	206.22
	17283	lesion diameter 2.1 to 3.0 cm	6.89	364.74	472.75	599.49	246.67
	17284	lesion diameter 3.1 to 4.0 cm	7.88	411.43	530.97	673.89	282.11
	17286	lesion diameter over 4.0 cm	10.14	458.12	593.20	752.29	363.03
	17311	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks	18.62	1145.96	1472.56	1872.13	666.62
+	**17312**	each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)	10.95	696.48	895.09	1138.06	392.02

CPT Code	Description	Medicare RVU	50th Percentile	75th Percentile	90th Percentile	Medicare Average
90945	Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional	2.41	254.81	371.52	484.55	86.28
90947	Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated evaluations by a physician or other qualified health care professional, with or without substantial revision of dialysis prescription	3.50	368.30	526.45	716.50	125.30
90951	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month	26.50	1892.50	2583.25	3531.50	948.73
90952	with 2-3 face-to-face visits by a physician or other qualified health care professional per month	0.00	1515.20	2070.80	2825.00	0.00
90953	with 1 face-to-face visit by a physician or other qualified health care professional per month	0.00	1009.80	1378.20	1885.00	0.00
90954	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month	23.09	1602.47	2185.31	2991.85	826.65
90955	with 2-3 face-to-face visits by a physician or other qualified health care professional per month	12.93	894.31	1223.27	1671.05	462.91
90956	with 1 face-to-face visit by a physician or other qualified health care professional per month	9.02	631.50	861.75	1176.50	322.93
90957	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month	18.19	1262.00	1722.50	2356.00	651.23
90958	with 2-3 face-to-face visits by a physician or other qualified health care professional per month	12.28	843.87	1152.41	1576.85	439.64
90959	with 1 face-to-face visit by a physician or other qualified health care professional per month	8.33	553.84	756.46	1035.20	298.22
90960	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month	8.00	631.50	861.75	1178.50	286.41
90961	with 2-3 face-to-face visits by a physician or other qualified health care professional per month	6.72	503.40	687.60	941.00	240.58
90962	with 1 face-to-face visit by a physician or other qualified health care professional per month	5.19	364.69	498.24	681.95	185.81