Robinson Ventures, LLC

# Author's Note

### A new payment code is only as valuable as the operating system behind it.

When policy creates a reimbursement pathway, the first question is usually, "*What does the code pay?*" The most useful question is "*What does code operationalization and delivery require?*" In this case, CMS is evaluating whether clinical authority, community trust, and a qualified coaching workforce can be assembled into one accountable delivery model.

In the proposed incident-to-billing model, a certified coach does not independently bill under a borrowed license. The proposed pathway depends on a Medicare-enrolled practitioner, a clinically integrated course of treatment, appropriate supervision, qualifying coach training, contemporaneous evidence, and a contracting structure that can withstand audit scrutiny.

#### CONCLUSION

*Treat CY 2027 as a reimbursement design opportunity. Defend the favorable CBO workforce provisions during the comment period, build a narrow implementation blueprint now, and authorize a pilot only after the final rule, claim instructions, locality rates, and CBO and FQHC implications are verified.*

# Executive Summary

### CMS has proposed a credible community-based delivery lane - but the revenue belongs to the organizations that can integrate the full compliance chain.

#### THESIS

*The CY 2027 PFS proposal would establish national payment and conditions for CPT 0591T, 0592T, and 0593T. CMS expressly recognizes CBO-employed health coaches and proposes general supervision for those workers when qualification standards are met. That is the opening. The durable value comes from converting the opening into a controlled clinical operating model. [1]*

Four conclusions should drive executive decisions:

1. **This is a proposed Medicare payment pathway** for existing Category III CPT codes. CMS is considering HCPCS G-codes instead.
2. **Coaches do not bill independently.** The supervising Medicare-enrolled practitioner or billing entity submits the claim; the CBO participates through workforce, infrastructure, and contract design.
3. **The CBO provision is unusually favorable.** CMS proposes that CBO-employed individuals may work under general supervision if the training and certification standards are met.
4. **FQHC participation requires its own billing lane analysis.** Under current CMS guidance, incident-to-only services generally do not create a stand-alone FQHC billable visit and are included in the FQHC PPS payment. [4]

Robinson Ventures, LLC

| Executive Question | Robinson Ventures Answer | Immediate Action |
|---|---|---|
| Is the opportunity real? | Yes - subject to final rule and implementation instructions. | Advance advocacy and readiness in parallel. |
| Can a qualified coach furnish the service? | Yes, as auxiliary personnel under the applicable supervision and incident-to requirements. | Build an auditable credential matrix. |
| Can a CBO bill Medicare directly? | Not on the proposed facts. Payment flows through the enrolled billing practitioner/entity. | Design the practitioner contract and funds flow. |
| Can every Evidence-Based Practice (EBP) workshop be billed? | Not established. Training may qualify the coach; the encounter must still meet the coaching code and clinical requirements. | Map curriculum, encounter, time, and documentation. |

# Executive Recommendation

### Approve a rule-to-readiness program instead of approving production billing before the final-rule gates are cleared.

Robinson Ventures recommends a two-track response: Track 1 - Shape the policy while building the implementation evidence. The policy track closes on September 14, 2026. Track 2 - The readiness track should reach a pilot-ready design before the final rule, without submitting claims or representing the proposal as settled policy. [1]

| Gate | Minimum Condition | Why it Matters |
|---|---|---|
| Final authority | Final rules, code set, supervision standard, telehealth status, and claims instructions verified. | Proposed provisions can change. |
| Billing lane | Medicare-enrolled practitioner/entity, place of service, assignment, and FQHC implications confirmed. | The coach is not an independent biller. |
| Workforce | Each coach has a documented qualifying credential or ACL-program training pathway. | Generic 'health coach' titles are not enough. |
| Clinical integration | Practitioner-led treatment relationship, referral, care plan, escalation, and follow-up workflow. | Incident-to-billing requires more than a community referral. |
| Evidence | Time, consent, goals, progress, supervision, and coach identity captured in the billing record. | The claim must be reproducible from the chart. |
| Economics | Final locality rate, group utilization, coinsurance, denials, FMV payment, and overhead modeled. | Gross allowed amount is not contribution margin. |

**DECISION NOW**

*Authorize a 60- to 90-day readiness build and a coordinated comment strategy. Hold any go-live decision until CMS finalizes the pathway and the billing entity's MAC, compliance, and legal teams confirm the operating model.*

Robinson Ventures, LLC

# Contents and Reading Guide

**The paper moves from policy evidence to operating model, underwriting, and implementation.**


| Section | Topic | Purpose |
|---|---|---|
| 1 | What CMS is proposing | Codes, valuation, qualification, supervision |
| 2 | Incident-to architecture | What the practitioner, coach, and CBO must each do |
| 3 | Operating model | Referral, documentation, claims, and flow of funds. |
| 4 | CBO/CCH implications | How a hub becomes the enabling infrastructure layer |
| 5 | FQHC implications | Why PPS rules require a separate reimbursement lane |
| 6 | Economics | Revenue tracking, margin drivers, and underwriting discipline |
| 7 | Readiness roadmap | What to build before and after the final rule |
| 8 | Governance and risk | Controls that make the model audit-ready |
| 9 | Advocacy priorities | What CMS should clarify before finalization |
| 10 | Robinson Ventures support | A practical path from policy to pilot |


*CBO boards and executives should begin with the Executive Recommendation and the FQHC page. Operating teams should use the incident-to, workflow, and risk sections as a readiness checklist. Advocacy teams should use the closing section to frame a coordinated comment before September 14, 2026.*

# 1. What CMS Is Proposing

**The proposal creates a national Physician Fee Schedule payment and conditions for a three-code health and well-being coaching family.**

CMS proposes a national payment for *CPT 0591T*, *0592T*, and *0593T*, adopts the CPT coaching framework, identifies qualification routes for auxiliary personnel, recognizes CBO employment, and asks whether HCPCS G-codes should replace current pricing of the Category III codes. [1]

| Code | Service | Proposed Valuation | Operational Read |
|---|---|---|---|
| 0591T | Individual initial assessment, 60-90 minutes | Crosswalk to 99490; work RVU 1.00 | Long-form entry encounter; verify final frequency and coding instructions. |
| 0592T | Individual follow-up, at least 30 minutes | Crosswalk to 99439; work RVU 0.70 | Repeatable when reasonable and necessary; no proposed monthly frequency limit. |
| 0593T | Group of 2 or more individuals, at least 30 minutes | Crosswalk to G0109; work RVU 0.23 | Billed once per beneficiary in the group; each participant must satisfy coverage and documentation. |

CMS states that the services were added to the Medicare Telehealth Services List in the CY 2024 final rule. The CY 2027 proposal does not impose a frequency limit when sessions are reasonable and necessary. [1] It proposes CY 2027 conversion factors of 33.1693 for qualifying Alternative Payment Model (APM) participants and 32.8409 for non-qualifying APM participants, but the allowed amount also depends on practice-expense and malpractice RVUs, geographic adjustment, site of service, and final addenda. The provided briefing's approximately $65 initial and $50 follow-up figures are useful directional input. [1][6]

Qualification is specific. CMS identifies national health-coaching, health-education, and nurse-coach standards, and proposes that appropriate certification may be satisfied through training received from evidence-based health-promotion and disease-prevention programs funded under the Older Americans Act and overseen by Administration for Community Living (ACL). That language does not yet enumerate every qualifying program, training role, or proof document. [1][5]

# 2. The Incident-to Pathway

**The coach can furnish the health coaching service; the practitioner remains the clinical and billing anchor.**

### THE PRECISE FRAMING

*The proposed model uses auxiliary personnel operating under a Medicare-enrolled physician's or practitioner's supervision, within the practitioner's course of diagnosis or treatment, and in accordance with State law. Under the current legislation, only the supervising practitioner may bill the incident to service. [2]*

| Element | What the Rule Supports | Still to be Designed |
|---|---|---|
| Clinical relationship | Service is integral to practitioner diagnosis or treatment. | Initial clinical service, care plan, active involvement, referral, and escalation. |
| Auxiliary personnel | Employee, leased employee, or contractor may qualify under 42 CFR 410.26, subject to requirements. | Entity relationship, exclusions screening, State law, and coach credential file. |
| Supervision | CMS proposes direct supervision, then states CBO-employed individuals may operate under general supervision. | Final-rule clarification, named supervisor, availability, review cadence, and coverage. |
| Setting | Incident-to-regulation applies in a non-institutional setting; proposed CBO language supports community delivery. | Place of service, home/community/telehealth workflow, and billing instructions. |
| Claim ownership | Only the supervising practitioner bills under current incident-to-regulation. | Contract, reassignment, flow of funds, FMV methodology, and revenue-cycle accountability. |

CMS guidance has long described incident-to-services as part of the patient's normal course of treatment after a practitioner personally performs an initial service and remains actively involved. The proposed coaching section does not restate every legacy requirement. Implementation teams should reconcile the final rule with 42 CFR 410.26, CMS manuals, and Medicare Administrative Contractors (MAC) instructions rather than relying on the coaching paragraph alone. [2][3]

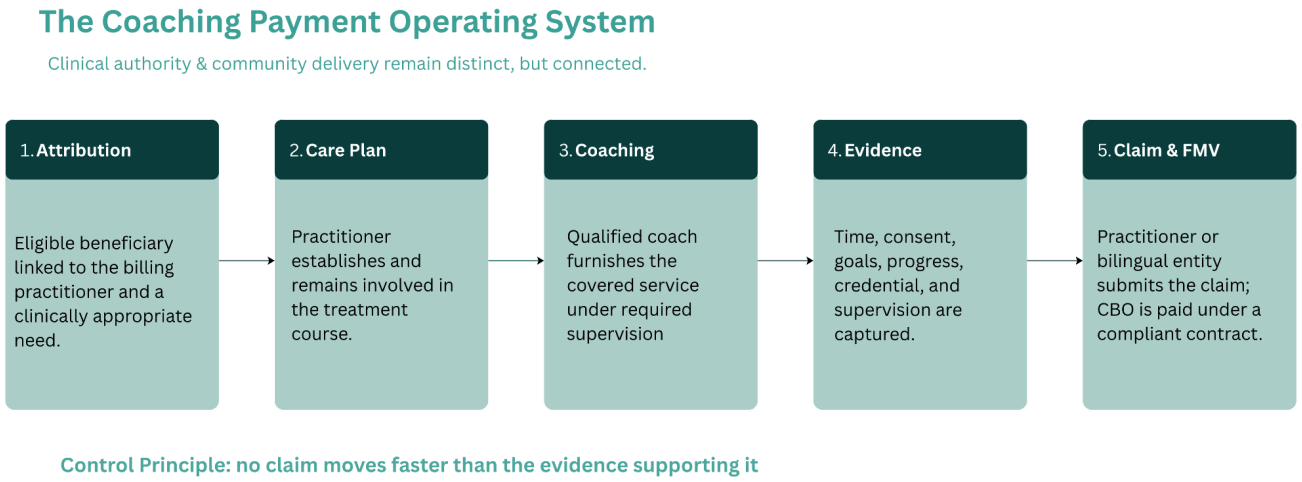
Robinson Ventures, LLC

### THE SUPERVISION AMBIGUITY

*Read the CBO general-supervision sentence as a favorable proposed exception or clarification that must be preserved - it is not a permission to apply general supervision to every coach, employer, site, or billing arrangement.*

# 3. The Community-to-Clinic Operating System

**A viable model connects five evidence-producing steps without losing responsibility at the handoffs.**




| Owner | Primary Responsibility | Required Evidence |
|---|---|---|
| Billing practitioner/entity | Clinical appropriateness, treatment relationship, plan, supervision, claim, and compliance accountability. | Practitioner service, care plan, orders/referral, supervisor record, claim file. |
| CBO or community care hub | Coach workforce, qualification, scheduling, community access, documentation operations, and contract performance. | Roster, credentials, exclusion checks, training, assignment, QA, encounter ledger. |
| Coach | Patient-centered coaching service within code, time, scope, escalation, and documentation rules. | Start/stop or total time, goals, interventions, progress, follow-up, identity. |
| Shared infrastructure | EHR/RCM integration, consent, eligibility, charge capture, reconciliation, denial management, and reporting. | Interface logs, billing edits, claim status, remittance, corrections, audit trail. |

**FUNDS-FLOW DISCIPLINE**

*The practitioner or enrolled billing entity receives Medicare payment. The CBO/Community Care Hub (CCH) should be compensated for bona fide services under a documented, counsel-reviewed arrangement using an appropriate fair-market-value methodology. [6]*

# 4. What This Means for CBOs and Community Care Hubs

### The hub's advantage is the ability to make distributed community delivery consistent, billable, and auditable.

For CBOs who operate in a networked model, the proposed rule strengthens the case for a hub function that individual community organizations cannot economically reproduce on their own. CMS explicitly identifies community care hubs, area agencies on aging, centers for independent living, aging and disability resource centers, and similar nonprofits as CBOs that may employ health coaches. [1]

| Hub Capability | Commercial Value | Readiness Evidence |
|---|---|---|
| Network workforce | Aggregates qualified coaches and protects coverage, language, geography, and capacity. | Master roster, credential crosswalk, capacity map, substitute coverage. |
| Clinical contracting | Creates one accountable interface for one or more billing partners. | Contract template, responsibility matrix, service levels, FMV support. |
| Shared documentation | Prevents each CBO from buying a separate EHR/RCM stack. | Minimum data set, note template, interface, retention, role-based access. |
| Revenue-cycle quality | Converts services into clean claims and measurable denial causes. | Eligibility, edits, reconciliation, denial log, corrective action. |
| Braided funding control | Protects grant funds for gaps while avoiding duplicate charging. | Encounter-level funding source, cost allocation, audit trail, grant-term review. |
| Performance management | Builds a payer-ready proof story beyond fee-for-service volume. | Access, engagement, goal attainment, utilization, outcomes, equity measures. |

**THE BUSINESS-DEVELOPMENT OPPORTUNITY**

*A CCH can sell more than coach time. It can provide a clinically connected community access platform: workforce supply, credential assurance, documentation, quality control, reporting, and referral closure. That broader value proposition is more defensible than a simple per-session staffing contract.*

The most important constraint is one that is defined: An ACL-program training may qualify a coach, but not automatically establish that a full evidence-based workshop is itself the billed coaching service. The encounter still must satisfy the final code description, medical necessity, clinical integration, time, and documentation. [1][6]

Robinson Ventures, LLC

# 5. The FQHC Opportunity - and the PPS Constraint

### FQHCs can be strong clinical anchors, but the PFS code does not automatically create a separate FQHC payment.

FQHCs bring the patient panel, trusted practitioners, primary-care workflow, quality infrastructure, and community mission needed to make coaching clinically meaningful. They are natural partners for referral, care-plan integration, escalation, and longitudinal measurement.

**CRITICAL REIMBURSEMENT DISTINCTION**

*Current CMS FQHC guidance says services furnished incident to an FQHC visit are included in the FQHC Prospective Payment System (PPS) payment, and an encounter consisting only of incident-to-services is not a stand-alone billable FQHC visit. The CY 2027 coaching proposal does not expressly establish a separate FQHC PPS payment pathway for 0591T -0593T. [4]*

| Potential Lane | Strategic Use | Decision Before Launch |
|---|---|---|
| FQHC as care integrator | The practitioner identifies the need, establishes a plan, receives documentation, and incorporates coaching into longitudinal care. | Determine whether and how cost is reflected in PPS, contracts, grants, or value-based arrangements. |
| FQHC as direct billing entity | Potential use only if final CMS instructions authorize a separately payable code or other qualifying mechanism. | Obtain MAC, billing, compliance, and counsel confirmation; do not infer PFS payment. |
| Separate PFS billing entity | A non-FQHC enrolled practitioner/entity may serve as the billing anchor for qualifying community coaching. | Resolve enrollment, employment/contracting, reassignment, place-of-service, records, and anti-commingling controls. |
| Value-based funding | ACO, MA, grant, or payer contracts may fund coaching when FFS mechanics are weak. | Define attribution, outcomes, unit price, data rights, and non-duplication. |

**ROBINSON VENTURES POSITION:** *Use the comment period to request explicit FQHC and RHC instructions. Until CMS provides them, model the FQHC as a clinical and data partner first - not as a guaranteed separate-fee billing vehicle.*

# 6. Reimbursement Economics

### The group code can improve delivery leverage; the business case must be built from final allowed amounts and real operating costs.

The implementation briefing provided estimates of approximately $65 for *0591T* and $50 for *0592T* using the proposed crosswalks and conversion factors. These figures are directional and should not be used as final contracting or budgeting rates. The group code's value comes from per-beneficiary billing, but each beneficiary remains a separate coverage, documentation, and cost-sharing event. [1][6]

**REVENUE EQUATION**

*Gross allowed revenue = (initial sessions x final locality rate for 0591T) + (follow-up sessions x final locality rate for 0592T) + (qualified group participants x qualified group sessions x final locality rate for 0593T).*

*Contribution margin subtracts coach labor, supervision, technology, RCM, QA, denials, no-shows, credentialing, compliance, and contract costs.*

| Driver | Upside Case | Downside Case | Management Response |
|---|---|---|---|
| Referral conversion | Practitioner workflow identifies eligible patients consistently. | Community participants lack clinical linkage. | Build closed-loop referral and attribution. |
| Group utilization | Stable cohorts with eligible beneficiaries and full documentation. | Dropout, mixed eligibility, or workshop-code mismatch. | Pilot curriculum-to-code crosswalk and attendance QA. |
| Coach capacity | Standard notes, routing, and coverage produce high direct service time. | Administrative burden consumes coach hours. | Centralize scheduling, credentialing, and RCM. |
| Collections | Eligibility and secondary coverage reduce patient balances. | Coinsurance creates friction or bad debt. | Use compliant financial counseling and coverage checks. |
| Denials | Clear evidence and consistent supervision support first-pass payment. | Ambiguous code, site, or credential rules drive rework. | Pre-bill edits, denial taxonomy, and stop-loss thresholds. |

Traditional Medicare PFS services generally carry beneficiary coinsurance, subject to secondary coverage and other applicable rules. Affordability is therefore a service-design issue and not a billing footnote. FQHC cost-sharing mechanics differ and must be modeled separately. [4]

**INVESTMENT RULE**

*Do not underwrite the service on billed sessions. Underwrite it on eligible, documented, cleanly paid sessions after contractual and operating costs.*

# 7. A 90-Day Readiness Roadmap

**Build the evidence before the claim and preserve the ability to stop if the final rule weakens the model.**

| Phase | Primary Work | Decision Output |
|---|---|---|
| Days 0-30 \| Define | Policy crosswalk; comment letter; billing-lane options; workforce inventory; client and partner interviews; FQHC issue analysis. | Executive issue brief, comment package, preliminary model, and go-forward hypotheses. |
| Days 31-60 \| Design | Credential standard; practitioner-CBO responsibility matrix; service definition; care-plan and escalation workflow; note, time, consent, and supervision evidence. | Pilot operating manual, documentation pack, contract term sheet, and control map. |
| Days 61-90 \| Test | Tabletop cases; mock claims; pro forma; group-program crosswalk; technology workflow; denial scenarios; training and QA calibration. | Pilot-readiness scorecard, final-rule dependency list, and conditional launch recommendation. |
| Post-final \| Validate | Compare final rules; verify MAC and payer instructions; load final rates; obtain legal/compliance approvals; contract; configure; train. | Formal go/no-go and controlled pilot authorization. |
| Pilot \| Prove | Limited sites/cohorts; daily reconciliation; weekly clinical/RCM review; defined stop criteria; outcomes and margin tracking. | Evidence-based scale, redesign, or exit decision. |

The readiness build should produce one integrated proof pack without disconnected policies. At minimum it should contain:

1. **Authority matrix.** Final rules, CFR, manuals, MAC guidance, payer policies, and State-law dependencies.
2. **Workforce file.** Coach credential, training provenance, scope, exclusions check, supervision assignment, and renewal cadence.
3. **Encounter file.** Eligibility, initiating clinical work, consent, care plan, time, coaching content, progress, escalation, and practitioner review.
4. **Financial file.** Locality rate, utilization, cost sharing, FMV, cost allocation, denials, and contribution margin.
5. **Governance file.** Named owners, audits, corrective action, refund/disclosure protocol, and board reporting.

# 8. The Controls That Make the Model Defensible

**The implementation risk is concentrated on the handoffs: clinical to community, coach to chart, chart to claim, and payment to contract.**

| Risk | Failure Mode | Minimum Control |
|---|---|---|
| Rule status | Proposed language is treated as effective coverage | Policy version control; final-rule and MAC activation gate. |
| Qualification | Job title accepted without auditable certification or training. | Credential crosswalk, source document, issue/expiry, role, and approval. |
| Supervision | Unnamed practitioner, unclear availability, or inconsistent review. | Assignment, coverage calendar, communication standard, documented review. |
| Clinical linkage | Community recruitment substituted for practitioner-led treatment. | Eligibility, initial clinical service, care plan, referral, follow-up. |
| Service fidelity | EBP class assumed to be code-compliant coaching. | Curriculum-to-code analysis, encounter notes, goals, time, participant-level evidence. |
| Time | Rounded or reconstructed time, overlapping services, missing group attendance. | Contemporaneous time method, overlap edits, attendance reconciliation. |
| Funds flow | CBO paid from an unsupported percentage of claims or duplicate funding. | Counsel-reviewed contract, FMV support, encounter funding source, allocation. |
| FQHC billing | PFS code is billed as a separate FQHC encounter without authority. | Final CMS/MAC confirmation and PPS-specific billing memo. |
| Privacy/security | Community access exceeds minimum necessity or data crosses systems without control. | BAA/data-use analysis, access roles, secure exchange, incident response. |
| Overpayment | Denials, miscoding, or unsupported paid claims are not corrected. | Monitoring, sampling, corrective action, repayment, and disclosure decision process. |

Robinson Ventures, LLC

**MANAGEMENT DOCTRINE**

*Scale the coach network only after the pilot proves clinical fit, clean documentation, first-pass payment, acceptable beneficiary experience, and positive contribution margin.*

# 9. The Comment Period

### The provisions that make community delivery viable are still open to change through September 14, 2026.

CMS is soliciting comments on the valuation, conditions of payment, certification standards, and whether HCPCS G-codes should be created for CY 2027. Comments must identify file code *CMS-1848-P*; the electronic docket is *CMS-2026-2377*. [1]

1. **Preserve general supervision for CBO-employed coaches.** Resolve the direct-versus-general text and make the CBO lane operational across community and telehealth settings.
2. **Make the credential pathway auditable.** Define qualifying ACL programs, eligible training roles, minimum documentation, and how future programs are added.
3. **Clarify training versus billable service.** State when ACL evidence-based program delivery meets *0593T* and when training qualifies the coach to deliver a separate encounter.
4. **Create durable, recognizable coding.** Explain whether permanent HCPCS G-codes would improve MAC, Medicare Advantage, and operational consistency.
5. **Resolve FQHC and RHC payment mechanics.** State whether coaching is separately payable, bundled, or eligible through a care-management pathway, and identify claim requirements.
6. **Publish implementation guardrails.** Specify clinical initiation, consent, time, supervision, documentation, telehealth, group attendance, cost-sharing, and monitoring expectations.

**COMMENT SUBMISSION STRATEGY**

*CBOs, community care hubs, FQHCs, aging networks, and aligned practitioners should submit coordinated but organization-specific comments. The strongest record will combine patient access, workforce feasibility, compliance controls, and quantifiable implementation evidence - not advocacy language alone.*

# 10. How Robinson Ventures Can Help

### Robinson Ventures converts the proposed reimbursement pathway into a board-ready decision, a compliant operating design, and a measurable pilot.

Our role is to integrate strategy, operations, revenue, governance, and investment discipline. For CBO/CCH networks and FQHC partners, this means building the complete system instead of leaving the client with a policy summary and a list of unresolved questions.

| Workstream | Representative Deliverables | Executive Value |
|---|---|---|
| Policy and advocacy | Rule crosswalk, issue matrix, coalition strategy, comment letter, final-rule comparison. | Protects the provisions that make the model viable. |
| Operating model | Partner architecture, RACI, clinical workflow, service definition, supervision, escalation, and SOPs. | Turns distributed delivery into one accountable system. |

| | | |
|---|---|---|
| Commercial structure | Billing-lane options, FMV framework, term sheet, funds-flow map, FQHC analysis. | Aligns incentives without confusing gross payment and value. |
| Technology and RCM | Minimum data set, EHR/RCM workflow, note template, edits, reconciliation, denial taxonomy. | Makes the claim traceable to the evidence. |
| Financial underwriting | Locality-rate model, capacity, group economics, cost sharing, denials, margin, sensitivities. | Defines the threshold for go, redesign, or hold. |
| Pilot and governance | Readiness scorecard, training, mock audit, launch plan, dashboard, QA, scale gates. | Creates evidence that supports payer, board, and partner decisions. |

*A Robinson Ventures Health Coaching Readiness Sprint can move an organization from policy interest to a conditional pilot decision in 60 to 90 days, while preserving explicit stop gates for final-rule, FQHC, legal, compliance, and economic risk.*

For existing clients, the sprint can connect to broader community care hubs, social-care compliance, payer contracting, and innovation work. For prospective clients, it provides a focused entry point with tangible executive, operational, and financial outputs.

**Submit comments to the Centers for Medicare & Medicaid Services:** Regulations.gov docket CMS-2026-2377

# Sources

**[1]** Medicare and medicaid programs; CY 2027 payment policies under the physician fee schedule and other changes to part B payment and coverage policies; Medicare shared savings program requirements; and medicare prescription drug inflation rebate program. (2026, July 16). Federal Register. https://www.federalregister.gov/documents/2026/07/16/2026-14327/medicare-and-medicaid-programs-cy-2027-payment-policies-under-the-physician-fee-schedule-and-other

**[2]** 410.26 Services and supplies incident to a physician's professional services: Conditions. (2026, August 19). Ecfr.Gov. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-B/section-410.26

**[3]** MLN Matters "Incident to" Services. (2016, August 24). In CMS. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se0441.pdf

**[4]** Medicare Benefit Policy Manual, Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services. (2026 February 20). In CMS. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

**[5]** Health promotion | ACL administration for community living. (2026, March 6). Acl.Gov. https://acl.gov/programs/health-wellness/disease-prevention

**[6]** Reimbursement pathways for whole-person health: Updates in the CY 2027 physician fee schedule. (2026, August 6). Partnership2acc.Org. https://www.partnership2acc.org/news-events/reimbursement-pathways-for-whole-person-health-updates-in-the-cy-2027-physician-fee-schedule