

## 2023 Medicare Physician Fee Schedule Proposed Rule Summary

On Thursday, July 7, 2022, the Centers for Medicare & Medicaid Services (CMS) issued the 2022 Medicare Physician Fee Schedule (MPFS) [proposed rule](#), which estimates a 4% cut to radiation oncology services for 2023. The proposed cut in combination with year over year reductions will prevent radiation oncology practices from investing in the latest technologies for treatment delivery and jeopardize access to care for cancer patients. This underscores the need for an alternative payment model for radiation oncology that secures stable payment rates and protects access to care, particularly for our most vulnerable patient populations. ASTRO will continue its advocacy efforts to achieve more appropriate rate updates that recognize the important role that radiation oncology plays in cancer treatment. Comments in response to the proposed rule are due to CMS by September 7, 2022.

The proposed rule updates the payment policies, payment rates, and quality provisions for services furnished under the MPFS effective January 1, 2023. The MPFS pays for services furnished by physicians and other practitioners in all sites of service. These services include visits, surgical procedures, diagnostic tests, therapy services, specified preventative services and more. Payments are based on the relative resources typically used to furnish the service. Relative value units (RVUs) are applied to each service for physician work, practice expense and malpractice. These RVUs become payment rates through the application of a Conversion Factor, which is updated annually.

### **MPFS Impact**

The MPFS Impact Table shows the estimated impact on total allowed charges by specialty of all the RVU changes. CMS is proposing to reduce payments for radiation oncology services for 2023 by approximately 4%. Of that total cut, 3% of the reduction is due to the expiration of the 3% increase associated with the Protecting Medicare and American Farmers from Sequester Cuts Act, as well as the Medicare and CHIP Reauthorization Act statutorily-required update of 0%, and a budget neutrality adjustment of 1.55%. The budget neutrality adjustment accounts for increased values for several evaluation and management code families.

Additionally, 2023 marks the second year of the four-year phase-in of the Clinical Labor Price update, which has the effect of lowering payments to specialties that use expensive equipment, such as radiation oncology, in the budget neutral environment for practice expense (PE).

### **Conversion Factor/Target**

The 2023 MPFS Conversion Factor, based on the proposed 2023 rates, is set at \$33.08. This represents a decrease of \$1.53, or more than 4%, from the 2022 MPFS Conversion Factor rate update of \$34.61. This 4.42% decline stems from a statutorily mandated budget neutrality adjustment (0.00%) to account for changes in work RVUs, the expiration of the 3% increase to the CY 2022 Conversion Factor under the Protecting Medicare and American Farmers from

Sequester Cuts Act, and the CY 2022 RVU Budget Neutrality Adjustment (-1.55%).

**Table 136: Calculation of the CY 2022 PFS Conversion Factor**

CY 2022 Conversion Factor		\$34.6062
Conversion Factor without CY 2022 Protecting Medicare and American Farmers from Sequester Cuts Act		\$33.5983
Statutory Update Factor	0.00% (1.0000)	
CY 2023 RVU Budget Neutrality Adjustment	-1.55% (0.9986)	
<b>CY 2022 Conversion Factor</b>		<b>\$33.0775</b>

The table below reflects the impact of the Conversion Factor reduction and Clinical Labor Price changes on key radiation oncology services.

CPT Code	MOD/SOS	CPT Descriptor	2022 National Rate	2023 National Rate	2023 Impact
<b>G6015</b>		Radiation tx Delivery IMRT	\$375.17	\$357.26	<b>-5%</b>
<b>77427</b>		Radiation tx Management x5	\$192.78	\$188.89	<b>-2%</b>
<b>77014</b>		CT Scan for Therapy Guide	\$123.90	\$118.76	<b>-4%</b>
<b>77301</b>		Radiotherapy Dose Plan IMRT	\$1,864.09	\$1,824.36	<b>-2%</b>
<b>G6012</b>		Radiation Treatment Delivery	\$246.42	\$232.88	<b>-5%</b>
<b>77014</b>	26	CT Scan for Therapy Guide	\$45.34	\$43.00	<b>-5%</b>
<b>G6013</b>		Radiation Treatment Delivery	\$247.12	\$233.88	<b>-5%</b>
<b>77263</b>		Radiation Therapy Planning	\$170.28	\$166.39	<b>-2%</b>
<b>77373</b>		SBRT Delivery	\$1,040.03	\$997.03	<b>-4%</b>
<b>77301</b>	26	Radiotherapy Dose Plan IMRT	\$423.28	\$401.92	<b>-5%</b>
<b>77334</b>	26	Radiation Treatment Aid(s)	\$60.91	\$58.22	<b>-4%</b>
<b>77300</b>		Radiation Therapy Dose Plan	\$66.11	\$64.51	<b>-2%</b>

<b>G6002</b>		Stereoscopic X-Ray Guidance	\$75.10	\$74.10	<b>-1%</b>
<b>77336</b>		Radiation Physics Consult	\$84.10	\$85.02	1%
<b>77338</b>		Design Mlc Device for IMRT	\$466.20	\$456.83	<b>-2%</b>
<b>77300</b>	26	Radiation Therapy Dose Plan	\$32.88	\$31.43	<b>-4%</b>
<b>77290</b>		Set Radiation Therapy Field	\$469.31	\$447.57	<b>-5%</b>

### **Clinical Labor Pricing Update**

Clinical labor rates were last updated in 2002 using Bureau of Labor Statistics (BLS) data and other supplemental sources where BLS data were not available. In the 2022 MPFS final rule, CMS implemented an update of the Clinical Labor Prices, phased in over four years. This was in conjunction with the final year of the supply and equipment pricing update and was meant to address concerns that current wage rates are inadequate because they do not reflect current labor rate information, as well as concerns that updating the supply and equipment pricing without updating the clinical labor pricing would create distortions in the allocation of direct PE.

The finalized implementation of this update provided that one quarter of the difference between the current price and the fully phased-in price is implemented for CY 2022, one third of the difference between the CY 2022 price and the final price is implemented for CY 2023, and one half of the difference between the CY 2023 price and the final price is implemented for CY 2024, with the new direct PE prices fully implemented for CY 2025.

The table below lists the proposed updates to the clinical labor prices for CY2023 that are of interest to radiation oncology. The proposed cost per minute for the clinical staff type was derived by dividing the average hourly wage rate by 60. In cases where an hourly wage rate was not available for a clinical staff type, the proposed cost per minute for the clinical staff type was derived by dividing the annual salary (converted to 2021 dollars using the Medicare Economic Index) by 2080 (the number of hours in a typical work year) to arrive at the hourly wage rate and then again by 60 to arrive at the per minute cost. To account for the employers' cost of providing fringe benefits, such as sick leave, CMS used the benefits multiplier of 1.296 as employed in CY 2002. CMS requests additional feedback on clinical labor pricing from commenters in response to the proposed rule, especially any data that will continue to improve the accuracy of its final pricing.

**Table 5: CY 2023 Clinical Labor Pricing**

<b>Labor Code</b>	<b>Labor Description</b>	<b>Source</b>	<b>CY 2021 Rate Per Minute</b>	<b>Final Rate Per Minute</b>	<b>Year 2 Phase-In Rate Per Minute</b>	<b>Total % Change</b>
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L050C	Radiation Therapist	BLS 29-1124	0.50	0.89	0.695	78%
L050D	Second Radiation Therapist for IMRT	BLS 29-1124	0.50	0.89	0.695	78%
L063A	Medical Dosimetrist	BLS 19-1040	0.63	0.91	0.770	44%
L107A	Medical Dosimetrist/Medical Physicist	L063A, L152A	1.08	1.52	1.298	41%
L152A	Medical Physicist	BLS 19-2012(75 <sup>th</sup> percentile)	1.52	2.14	1.832	41%

### **Request for Information on Strategies for Updates to Practice Expense (PE) Data Collection and Methodology**

The PE inputs used in setting MPFS rates, including both the development of PE RVUs and, historically, the relative shares among work, PE, and malpractice RVUs across the MPFS, are central in developing accurate rates and maintaining appropriate relativity among PFS services and overall payment among the professionals and suppliers paid under the MPFS.

With the goal of improving the information they use in their PE methodology, CMS is requesting information on how they can improve the collection of PE data inputs and refine the PE methodology. CMS thinks that of the various PE inputs, indirect expenses (e.g., rent and IT) present the best opportunity to build “consistency, transparency, and predictability” into the methodology. The primary source for indirect PE information is currently the Physician Practice Information Survey (PPIS), fielded by the AMA and participated in by ASTRO.

In the proposed rule, CMS is signaling its intent to move to a standardized and routine approach to valuation of indirect PE, and they are seeking feedback on what this might entail. Any new approach to valuation of indirect PE would be proposed in future rulemaking.

### **Determination of Malpractice Relative Value Units (RVUs)**

Malpractice (MP) expense RVUs are resource-based and must be reviewed at least every five years. The Agency calculated MP RVUs in the CY 2023 proposed rule similar to how they did in the CY 2020 update, but they are proposing to incorporate some methodological refinements.

CMS considers the following factors when they determine MP RVUs for individual MPFS services:

- (1) Specialty-level risk factors derived from data on specialty-specific MP premiums incurred by practitioners;
- (2) Service-level risk factors derived from Medicare claims data of the weighted average risk factors of the specialties that furnish each service; and
- (3) An intensity/complexity of service adjustment to the service-level risk factor based on either the higher of the work RVU or clinical labor portion of the direct PE RVU.

The MP RVU calculation requires CMS to obtain information on specialty-specific MP premiums that are linked to specific services, and using this information, they derive relative risk factors (RFs) for the various specialties that furnish a particular service.

Because MP premiums vary by state and specialty, the MP premium information must be weighted geographically and by specialty. The MP RVUs that the Agency is proposing were calculated using four data sources:

- MP premium data presumed to be in effect as of December 31, 2020;
- CY 2020 Medicare payment and utilization data;
- Higher of the CY 2022 final work RVUs or the clinical labor portion of the direct PE RVUs; and
- CY 2022 MP GPCIs.

In the CY 2023 proposed rule, the Agency is seeking comment on the following refinements:

- (1) Improving the current imputation strategy to develop a more comprehensive data set when CMS specialty names are not distinctly identified in the insurer filings, which sometimes use unique specialty names or do not include all CMS specialties.
- (2) Creation of a risk index for the calculation of MP RVUs.

Table 27 below shows the proposed risk index values for radiation oncology and service risk group. These risk index values are calculated by dividing the national average premium for each specialty by the volume-weighted national average premium across all specialties

**Table 27: CY 2023 Risk Index by Specialty and Service Risk Group**

<b>Medicare Specialty Code and Name</b>	<b>2023 Service Risk Group</b>	<b>2023 Risk Index</b>
92-Radiation Oncology	ALL	0.905

### **Rebasing and Revising the Medicare Economic Index**

The Medicare Economic Index (MEI) reflects the weighted-average annual price change for various inputs involved in furnishing physicians' services, akin to a physician-specific inflation calculation. It is no longer used to update the MPFS Conversion Factor, but the MEI cost weights have historically been used to update the Geographic Practice Cost Index (GPCI) cost share weights to weigh the four components of GPCI practice expense (employee compensation, office rent, purchased services, and medical supplies and equipment) and to recalibrate the relativity adjustment to ensure that the total pool of aggregate PE RVUs remains relative to the pool of work and malpractice expense RVUs.

The current model of the MEI was described in the November 25, 1992 Federal Register and has been updated five times. Currently, the 2006-based model is in use (last updated in 2014). It relies on data from the 2006 AMA PPIS. Concern has been expressed regarding whether data from self-employed physicians (as in the PPIS) continues to be appropriate given the trend toward practice consolidation and hospital-owned practices. And, it has been recommended that CMS should find a different data source that allows for more frequent updates.

The Agency believes that MEI cost weights need to be updated to reflect more current market conditions, and they propose a new methodology for estimating base year expenses that relies on data from the U.S. Census Bureau NAICS 6211 Offices of Physicians. They state that this would provide data that are more indicative of current market conditions of physician ownership practices, rather than only those of self-employed physicians, as in the PPIS. Table 148 below provides demonstrates the potential impact of rebasing and revising MEI cost share weights on radiation oncology services.

CMS is proposing not to use this update in CY 2023, but rather is seeking comment on the potential use of the proposed updated MEI cost share weights to calibrate payment rates and update the GPCI under the PFS in the future.

**Table 148: CY 2023 PFS Estimated Impact on Total Allowed Charges by Specialty using Rebased and Revised MEI Cost Share Weights as Proposed for CY 2023**

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)	(D) Combined Impact	(E) Combined Impact Year 1 MEI Transition	(F) Combined Impact Full MEI Changes
Estimated Conversion Factor			\$34.027	\$33.642	\$31.834
Radiation Oncology and Radiation Therapy Centers	Total	\$1,608	0%	1%	6%
	Non-Facility	\$1,539	0%	1%	6%
	Facility	\$69	-1%	-2%	-8%

**Proposals and Request for Information on Medicare Parts A and B Payment for Dental Services**

Dental services are covered by Medicare in only a limited number of circumstances, including when the dental service requires hospitalization because of an individual’s underlying medical condition and clinical status, or because of the severity of the dental procedure. There are other exceptions when Medicare will cover certain dental services, such as when a dentist provides dental services that are an integral part of the covered primary procedure or service furnished by another physician treating the primary medical illness. Medicare Administrative Contractors determine whether an exception for dental coverage applies on a claim-by-claim basis, and CMS has received feedback that interpretation of these exceptions have been too restrictive.

To provide greater clarity on the issue of dental coverage, CMS is proposing to clarify its interpretation and codify certain payment policies for medically necessary dental services. First, if a dental service is “inextricably linked to, and substantially related and integral to the clinical success of, other covered medical services,” it will be covered by Medicare Parts A and B, whether or not the dental service is provided in an inpatient or outpatient setting.

They clarify that this includes the extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease, in addition to reconstruction of a ridge when performed because of and at the same time as the surgical removal of a tumor, the wiring of teeth when done in connection with the reduction of a jaw fracture, and a dental splint only when used in connection with a covered medical service. They do, however, seek comments on whether it is clinically appropriate for these dental services to be provided in inpatient or outpatient settings.

Additionally, they are seeking comment on the following:

- Other types of clinical scenarios where the dental services may be “inextricably linked to, and substantially related and integral to the clinical success of, other covered medical services”;
  - CMS lists dental exams and medically necessary diagnostic and treatment services prior to treatments for head and neck cancers, such as radiation therapy with or without chemotherapy as possibilities
- The potential establishment of a process to identify for their consideration and review submissions of additional dental services that are inextricably linked and substantially related and integral to the clinical success of other covered medical services;
- Other potentially impacted policies; and
- Potential future payment models for dental and oral health care services.

### **Payment for Medicare Telehealth Services Under Section 1834(M) of the Act**

Several conditions must be met for Medicare to make payment for telehealth services under the MPFS, and in the CY 2021 MPFS final rule, CMS created a new category of criteria for adding services to the Medicare Telehealth Services List in addition to the permanent categories 1 and 2: Category 3. Category 3 services are those that were added to the list during the PHE for which there is likely a clinical benefit when provided via telehealth, but for which there is not yet sufficient evidence available to add it to the list permanently.

Services that have been added to the Medicare Telehealth Services List on a Category 3 basis will remain on the list through the end of CY 2023. Under the Agency’s current policy, all other services, including CPT Code 77427 Radiation treatment management, that were temporarily added to the Medicare Telehealth Services List on an interim basis during the PHE and have not been added to the Medicare Telehealth Services List on a Category 1, 2, or 3 basis will *not* remain on the list after the end of the PHE.

However, the Consolidated Appropriations Act of 2022 extended some of the flexibilities implemented during the PHE for COVID-19 for an additional 151 days after the end of the PHE. This included the originating site for the telehealth service being any site in the United States at which the beneficiary is located when the service is furnished, including the beneficiary’s home. To give full effect to this provision, the Agency proposes to continue to include the services that were temporarily added to the list during the PHE but have not since been added on a Category 3 or other basis, and which are currently set to be removed from the list at the end of the PHE on the list through the 151-day period after the end of the PHE. This would include CPT Code

77427.

### **Request for Information: Medicare Potentially Underutilized Services**

CMS has concerns regarding the potential underutilization of high value health services, particularly among potentially underserved communities. In concert with the CMS strategy to advance health equity in addressing health disparities that underlie the health system, CMS seeks to engage with interested parties and solicit comment regarding ways to identify and improve access to high value, potentially underutilized services by Medicare beneficiaries.

CMS is seeking comment on how to best define and identify high value, potentially underutilized health services. They also are looking to understand what existing services within current Medicare benefits may represent high value, potentially underutilized services.

CMS is also seeking comments on ways to recognize possible barriers to improved access to high value services and how they might best mitigate some of the obstacles to care. CMS is inviting the public to submit information about specific obstacles to accessing these services and how specific potential policy, payment, or procedural changes could reduce potential obstacles and facilitate better access to high value health services. Specifically, they are soliciting new and innovative ideas that may help broaden perspectives about potential solutions. Ideas may include, but are not limited to:

- Educational or marketing strategies (informed by beneficiary input) to promote awareness of available programs and resources that advance the utilization of “high value” services;
- Aligning of Medicare and other payer coding, payment and documentation requirements, and processes related to “high value” services;
- Recommendations from States and other interested parties regarding how to best raise awareness of underutilized services, with special consideration for the dual-eligible population;
- Enabling of operational flexibility, feedback mechanisms, and data sharing that would enhance the utilization of “high value” services; and
- New recommendations regarding when and how CMS issues regulations and policies related to “high value” services and how CMS can advance rules and policies for beneficiaries, clinicians, and providers.

### **Soliciting Public Comment on Strategies for Improving Global Surgical Package Valuation**

CMS is seeking public comment on strategies to improve the accuracy of payment for the global surgical packages (“global packages”) under the MPFS. Currently, there are over 4,000 physicians’ services paid as global packages under the MPFS. Global packages generally include the surgical procedure and any services typically provided during the pre- and postoperative periods (including E/M services and hospital discharge services).

While some interested parties have challenged the methodology or conclusions of the RAND reports, CMS argues that they have not yet received data suggesting that postoperative E/M visits are being performed more frequently than indicated by the data collected and analyzed in the RAND reports. CMS also believes that RAND has adequately responded to critiques of its



methodologies and findings. However, as part of CMS' ongoing assessment of their data collection process, they welcome comments from the public on ideas for other sources of data that would help assess global package valuation (including the typical number and level of E/M services), as well as our data collection methodology and the RAND report findings.

### **Quality Payment Program**

Additional information regarding proposed changes to the Quality Payment Program will be included in a subsequent summary document.

To view the 2023 Physician Fee Schedule proposed rule, please visit:

<https://www.federalregister.gov/public-inspection/2022-14562/medicare-and-medicaid-programs-calendar-year-2023-payment-policies-under-the-physician-fee-schedule>

For a fact sheet on the 2023 Physician Fee Schedule proposed rule, please visit:

<https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-proposed-rule>

For 2023 Physician Fee Schedule proposed rule data files, appendices, and other materials, please visit:

<https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeeschedpfs-federal-regulation-notices/cms-1770-p>