ASTRO
TARGETING CANCER CARE

251 18th St. South, 8th Floor
Arlington, VA 22202

Main: 703.502.1550 · Fax: 703.502.7852
www.astro.org · www.rtanswers.org

2024 Medicare Physician Fee Schedule
Proposed Rule Summary

On Thursday, July 13, 2023, the Centers for Medicare & Medicaid Services (CMS) issued the 2024 Medicare Physician Fee Schedule (MPFS) proposed rule. The proposed rule updates the payment policies, payment rates and quality provisions for services furnished under the MPFS effective January 1, 2024.[1]

Takeaways for Radiation Oncology

- **MPFS Proposed Rule Cuts Radiation Oncology by -2%**
- **2024 Proposed Conversion Factor: $32.7476 (a reduction of more than 3% from 2023)**
- **Although the "G" codes for conventional treatment delivery, IMRT and IGRT were flagged in the 2023 MPFS final rule for possible revaluation, the 2024 proposed rule does not mention the G codes.**

Why it matters: The proposed cut, in combination with year over year reductions, jeopardizes access to care for cancer patients. This underscores the need for ASTRO's proposed Radiation Oncology Case Rate (ROCR) Program, which would secure stable payment rates and protect access to care. ASTRO will continue its advocacy efforts to achieve more appropriate rate updates that recognize the important role that radiation oncology plays in cancer treatment. Radiation oncologists are encouraged to contact Congress to advance legislation to help mitigate these proposed cuts.

Comments in response to the proposed rule are due to CMS by September 11, 2023.

Go deeper on these issues in the summary below:

- ***MPFS Impact***
- ***Conversion Factor/Target***
- ***Evaluation and Management (E/M) Visit Complexity***
- ***Telephone E/M Services***
- ***Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act***
- ***Direct Supervision via Use of Two-way Audio/Video Communications Technology***
- ***Proposals on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Medical Services***
- ***Soliciting Public Comment on Strategies for Updates to Practice Expense Data***

[1] 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.

Collection and Methodology

- ***Services Addressing Health-Related Social Needs***

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 2024 by approximately 2%.

Table 104: CY 2024 PFS Estimated Impact on Total Allowed Charges by Specialty

Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Radiation Oncology and Radiation Therapy Centers	$1,552	0%	-2%	0%	-2%

Additionally, 2023 marks the third 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 2024 MPFS Conversion Factor (CF), based on the proposed 2024 rates, is set at $32.7476. This represents a decrease of $1.14, or more than 3%, from the 2023 MPFS CF rate update of $33.8872. This 3% decline stems from a statutorily mandated budget neutrality adjustment (-2.7%) to account for changes in work RVUs and the increase provided by the Consolidated Appropriations Act of 2023 (1.25%).

Table 102: Calculation of the CY 2024 PFS Conversion Factor

CY 2023 Conversion Factor		$33.8872
Conversion Factor without CAA, 2023 (2.5% increase for CY 2023)		$33.0607
CY 2024 RVU Budget Neutrality Adjustment	-2.7% (0.9783)	
CY 2024 1.25% increase provided by the CAA, 2023	1.25% (1.0125)	
CY 2024 Conversion Factor		**$32.7476**

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	2023 National Rate	2024 National Rate	2024 Impact
G6015		Radiation tx Delivery IMRT	$364.97	$349.74	**-4%**
77427		Radiation tx Management x5	$192.82	$186.66	**-3%**
77014		CT Scan for Therapy Guide	$122.33	$117.56	**-4%**
77301		Radiotherapy Dose Plan IMRT	$1,861.76	$1,813.23	**-3%**
G6012		Radiation Treatment Delivery	$238.23	$225.63	**-5%**
77523		Proton Treatment Delivery	Carrier Priced	Carrier Priced	**N/A**
77014	26	CT Scan for Therapy Guide	$45.07	$43.55	**-3%**
77263		Radiation Therapy Planning	$170.11	$164.07	**-4%**
77301	26	Radiotherapy Dose Plan IMRT	$423.25	$409.02	**-3%**
77373		SBRT Delivery	$1,018.99	$977.84	**-4%**
G6013		Radiation Treatment Delivery	$238.90	$226.61	**-5%**
77334	26	Radiation Treatment Aid(s)	$60.66	$58.95	**-3%**
99205		Office o/p new hi 60-74 minutes	$220.94	$216.79	**-2%**
77336		Radiation Physics Consult	$87.43	$87.44	0%
77338		Design Mlc Device for IMRT	$469.68	$460.10	**-2%**
77338	26	Design Mlc Device for IMRT	$227.04	$219.41	**-3%**
77435		SBRT Management	$646.91	$627.44	**-3%**
77300	26	Radiation Therapy Dose Plan	$33.21	$31.77	**-4%**
77300		Radiation Therapy Dose Plan	$66.76	$65.17	**-2%**

Evaluation and Management (E/M) Visit Complexity

After a three-year delay, CMS is proposing to implement a separate add-on payment for HCPCS code G2211. The full descriptor for this code is:

> *Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)*

The Agency believes this add-on code will better recognize the resource costs associated with E/M visits for primary care and longitudinal care of complex patients. This policy was originally finalized in the 2021 MPFS final rule, but Congress suspended the use of the code by prohibiting CMS from making additional payment under the MPFS for complex E/M visits before January 1, 2024.

Additionally, it is CMS's position that separately identifiable E/M visits occurring on the same day as minor procedures must include resources that are distinct from the costs associated with furnishing stand-alone E/M visits to warrant different payment. So, the Agency is proposing that G2211 would not be payable when the E/M visit is reported with a modifier -25.

Telephone E/M Services

In the March 31, 2020, COVID-19 interim final rule, CMS finalized separate payment for CPT codes 99441-99443 and 98966-98968, which describe E/M and assessment and management services furnished via telephone. CPT codes 99441-99443 are telehealth services and will remain actively priced through 2024; CPT codes 98966-98968, however, describe telephone assessment and management services provided by a qualified non-physician health care professional, and are not considered telehealth services.

CMS proposes to continue to assign an active payment status to CPT codes 98966-98968 for CY 2024 to align with telehealth-related flexibilities that were extended via the Consolidated Appropriations Act of 2023, specifically section 4113€, which permits the provision of telehealth services through audio-only telecommunications through the end of 2024.

Payment for Medicare Telehealth Services

The Consolidated Appropriations Act (CAA) of 2022 included several provisions that extended certain Medicare telehealth flexibilities adopted during the COVID-19 PHE for 151 days after the end of the PHE. In part, it temporarily removed restrictions on telehealth originating sites for those services to allow telehealth services to patients located in any site in the United States at the time of the telehealth service, including an individual's home. The CAA of 2023 extended the flexibilities of the CAA of 2022 through the end of 2024. The 2024 MPFS proposed rule seeks to replicate the CAA by also extending the policy through the end of CY 2024.

Direct Supervision via Use of Two-way Audio/Video Communications Technology

Direct supervision requires the immediate availability of the supervising physician or other practitioner, but the professional need not be present in the same room during the service. The Agency has established this "immediate availability" requirement to mean in-person, physical, not virtual, availability. During the COVID-19 public health emergency (PHE), CMS changed the definition of "direct supervision" as it pertains to supervision of diagnostic tests, physicians' services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of requiring their physical presence. Via various rules, this policy was extended through the end of 2023, after which the pre-PHE supervision rules would apply.

CMS is concerned about an abrupt transition to its pre-PHE policy (requiring the physical presence of the supervising practitioner) because practitioners have established new patterns of practice during the PHE. In the absence of evidence that patient safety is compromised by virtual direct supervision, CMS believes that an immediate reversion to the pre-PHE definition of direct supervision would prohibit virtual direct supervision, which may present a barrier to access to many services, such as those furnished incident-to a physician's service. The Agency believes practitioners will need time to reorganize their practice patterns established during the PHE to reimplement the pre-PHE approach to direct supervision. Therefore, CMS proposes to extend PHE flexibility of virtual direct supervision through the end of 2024.

Additionally, CMS is seeking comment on whether it should consider extending this flexibility beyond 2024. Specifically, it is interested in input from interested parties on potential patient safety or quality concerns when direct supervision occurs virtually; for instance, if virtual direct supervision of certain types of services is more or less likely to present patient safety concerns, or if this flexibility would be more appropriate for certain types of services, or when certain types of auxiliary personnel are performing the supervised service. It is also interested in potential program integrity concerns, such as overutilization or fraud and abuse, that interested parties may have about this policy.

Payment for Dental Services Linked to Specific Covered Medical Services

In the 2023 MPFS final rule, CMS identified certain clinical scenarios where payment is permitted under both Medicare Parts A and B for certain dental services in circumstances where the services are not considered to be in connection with dental services within the meaning of section 1862(a)(12) of the Act. Dental services for which payment can be made under Parts A and B must be "inextricably linked to" and substantially related to the clinical success of a covered service.

For 2024, CMS is proposing to codify the previously finalized payment policy for dental services prior to, or during, head and neck cancer treatments. Additionally, CMS identified several clinical scenarios where dental services are inextricably linked to a primary medical service that is covered by Medicare. After further review of current medical practice, and through internal and external consultations and consideration of the submissions received through the public process, it believes that there are additional circumstances under which Medicare payment may be made for dental services because they are inextricably linked to other covered medical

services. The Agency proposes to amend its regulations to permit payment for:

1. Dental or oral examination performed as part of a comprehensive workup in either the inpatient or outpatient setting prior to Medicare-covered: chemotherapy when used in the treatment of cancer, chimeric antigen receptor (CAR) T-cell therapy when used in the treatment of cancer, and the administration of high-dose bone-modifying agents (antiresorptive therapy) when used in the treatment of; and
2. Medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with: chemotherapy when used in the treatment of cancer, CAR T-cell therapy when used in the treatment of cancer, and the administration of high-dose bone-modifying agents (antiresorptive therapy) when used in the treatment of cancer. Furthermore, CMS proposes that payment under the applicable payment system could also be made for services that are ancillary to these dental services, such as x-rays, administration of anesthesia, and use of the operating room as currently described in its regulation at § 411.15(i)(3)(ii).

Additionally, the Agency also seeks comment on whether it should consider radiation therapy in the treatment of cancer more broadly (not in conjunction with chemotherapy, and not in relation to head and neck cancer treatment) as medical services that may be inextricably linked to dental services. CMS does not believe that radiation therapy alone necessarily leads to the same level of treatment-induced immunosuppression as for cancer patients receiving chemotherapy since radiation specifically targets malignant cells and has more targeted and localized effects on the body as compared to system-wide immunosuppression effects of chemotherapy for cancer treatment. However, it seeks comment on whether dental services prior to radiation therapy in the treatment of cancer, when furnished without chemotherapy, such as second line therapy for metastasized cancer in the head and neck, would be inextricably linked to the radiation therapy services, and therefore payable under Medicare Parts A and B.

Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection and Methodology

In the CY 2023 MPFS final rule, CMS issued a request for information (RFI) on strategies to update practice expense (PE) data collection and methodology. The Agency currently relies on the AMA's Physician Practice Information Survey (PPIS), which it notes "may represent the best aggregated available source of information at this time." Many RFI responses asked CMS to wait for the AMA to complete a refresh of its survey data, but the Agency is concerned that "waiting for refreshed survey data would result in CMS using data nearly 20 years old to form indirect PE inputs to set rates for services on the PFS."

CMS is again asking interested parties to provide feedback on how to achieve optimal PE data collection and methodological adjustments over time. Specifically, CMS requests feedback on the following:

1. If CMS should consider aggregating data for certain physician specialties to generate indirect allocators so that PE/HR calculations based on PPIS data would be less likely to over-allocate (or under-allocate) indirect PE to a given set of services, specialties, or practice types. Further, what thresholds or methodological approaches could be employed to establish such aggregations?

2. Whether aggregations of services, for purposes of assigning PE inputs, represent a fair, stable and accurate means to account for indirect PEs across various specialties or practice types?
3. If and how CMS should balance factors that influence indirect PE inputs when these factors are likely driven by a difference in geographic location or setting of care, specific to individual practitioners (or practitioner types) versus other specialty/practice-specific characteristics (for example, practice size, patient population served)?
4. What possible unintended consequences may result if CMS were to act upon the respondents' recommendations for any of highlighted considerations above?
5. Whether specific types of outliers or non-response bias may require different analytical approaches and methodological adjustments to integrate refreshed data?

Services Addressing Health-Related Social Needs

In recent years, CMS has worked to identify gaps in appropriate coding and payment for care management/coordination and primary care services under the MPFS. To improve payment accuracy, the Agency is exploring ways to better identify and value practitioners' work when they incur additional time and resources helping patients with serious illnesses navigate the health care system or removing health-related social barriers that are interfering with the practitioner's ability to execute a medically necessary plan of care. Practitioners and their staff sometimes obtain information about and help address, social determinants of health (SDOH) that significantly impact the practitioner's ability to diagnose or treat a patient.

Additionally, practitioners and their staff sometimes help newly diagnosed cancer patients and other patients with similarly serious, high-risk illnesses navigate their care, such as helping them understand and implement the plan of care and locate and reach the right practitioners and providers to access recommended treatments and diagnostic services, taking into account the personal circumstances of each patient. Payment for these activities, to the extent they are reasonable and necessary for the diagnosis and treatment of the patient's illness or injury, is currently included in payment for other services such as E/M visits and some care management services.

CMS believes that medical practice has evolved to increasingly recognize the importance of these activities; however, this work is not explicitly identified in current coding. The Agency is proposing to create new coding to identify and value these services for MPFS payment and distinguish them from current care management services. CMS expects that its proposed new codes would also support the CMS pillars for equity, inclusion and access to care for the Medicare population and improve patient outcomes, including for underserved and low-income populations where there is a disparity in access to quality care. They would also support the White House's National Strategy on Hunger, Nutrition and Health, and the White House's Cancer Moonshot Initiative.

CMS is proposing five new codes recognizing services that may be provided by auxiliary personnel incident to the billing physician or practitioner's professional services, and under the billing practitioner's supervision, when reasonable and necessary to diagnose and treat the patient:

HCPCS Code	Descriptor	Current Work RVU	RUC Work RVU	CMS Work RVU	CMS Time Refinement
GXXX1	Community health integration services performed by certified or trained auxiliary personnel, which may include a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit	NEW	-	1.00	No
GXXX2	Community health integration services, each additional 30 minutes per calendar month	NEW	-	0.70	No
GXXX3	Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, which may include a patient navigator or certified peer specialist; 60 minutes per calendar month, in the following activities	NEW	-	1.00	No
GXXX4	Principal Illness Navigation services, additional 30 minutes per calendar month	NEW	-	0.70	No
GXXX5	Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes	NEW	-	0.18	No

Quality Payment Program

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

For a copy of the proposed rule: https://public-inspection.federalregister.gov/2023-14624.pdf

For a fact sheet on the proposed rule: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-proposed-rule