

2023 Medicare Physician Fee Schedule Final Rule Summary

On Tuesday, November 1, 2022, the Centers for Medicare & Medicaid Services (CMS) issued the 2023 Medicare Physician Fee Schedule (MPFS) [final rule](#), which estimates a 4% cut to radiation oncology services for 2023. This additional cut adds to year-over-year reductions that 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 major reforms to the physician fee schedule and 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 is actively lobbying Congress to address payment cuts by year's end. **Please contact your Member of Congress in opposition to Medicare cuts by going to: <https://www.astro.org/Advocacy/Become-an-Advocate>.**

The final 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 (Table 148) shows the estimated impact on total allowed charges by specialty of all the RVU changes. CMS will 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 Protecting Medicare and American Farmers from Sequester Cuts Act, as well as the Medicare Access and CHIP Reauthorization Act statutorily-required update of 0%, and a budget neutrality adjustment of -1.60%. The budget neutrality adjustment accounts for increased values for several evaluation and management code families.

Additionally, 2023 marks the second year of the 4-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 is set at \$33.06. This represents a decrease of \$1.55, or 4.48%, from the 2022 MPFS Conversion Factor rate update of \$34.61.

Table 146: Calculation of the CY 2023 PFS Conversion Factor

CY 2022 Conversion Factor		\$34.6062
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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	-1.60% (0.9840)	
CY 2023 Conversion Factor		\$33.0607

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
G6015		Radiation tx Delivery IMRT	\$375.13	\$356.06	-5.08%
77427		Radiation tx Management x5	\$192.76	\$188.12	-2.41%
77014		CT Scan for Therapy Guide	\$123.89	\$119.35	-3.67%
77301		Radiotherapy Dose Plan IMRT	\$1,863.89	\$1,816.35	-2.55%
G6012		Radiation Treatment Delivery	\$246.40	\$232.42	-5.67%
77014	26	CT Scan for Therapy Guide	\$45.33	\$43.97	-3.01%
G6013		Radiation Treatment Delivery	\$247.09	\$233.08	-5.67%
77263		Radiation Therapy Planning	\$170.26	\$165.96	-2.52%
77373		SBRT Delivery	\$1,039.92	\$994.14	-4.40%
77301	26	Radiotherapy Dose Plan IMRT	\$423.23	\$412.93	-2.43%
77334	26	Radiation Treatment Aid(s)	\$60.91	\$59.18	-2.84%
77300		Radiation Therapy Dose Plan	\$66.10	\$65.13	-1.46%
G6002		Stereoscopic X-Ray Guidance	\$75.10	\$73.73	-1.82%
77336		Radiation Physics Consult	\$84.09	\$85.30	1.43%

77338		Design Mlc Device for IMRT	\$466.15	\$458.22	-1.70%
77300	26	Radiation Therapy Dose Plan	\$32.88	\$32.40	-1.45%
77290		Set Radiation Therapy Field	\$469.26	\$447.64	-4.61%

G Codes

In the CY 2020 MPFS final rule, CMS stated it would maintain the current coding for radiation therapy services, including the HCPCS G-codes, with their current work RVUs and direct PE inputs, in the interest of rate stability for the RO Model. On August 29, 2022, CMS finalized an indefinite delay of the Radiation Oncology Model (RO Model) to a date to be determined through future rulemaking.

Given the indefinite delay in the implementation of the RO Model, CMS states it is reviewing current coding and payment policies for radiation therapy services, “including whether we should adopt the revised CPT coding that was established in CY 2015 to allow for coding and payment consistency.” The Agency will address any such changes in future rulemaking. ASTRO will closely monitor and engage in any potential rulemaking in this area, as it would likely have a serious impact on radiation oncology given that the G codes represent roughly half of all spending for radiation therapy under the Fee Schedule

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 provides 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 updates to the clinical labor prices for CY2023 that are of interest to radiation oncology. The 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 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 requested additional feedback on clinical labor pricing from commenters in response to the proposed rule, especially any data that would continue to improve the accuracy of its final pricing.

CMS finalized the clinical labor prices shown in Table 8 below. There are no changes from the proposed rates.

Table 8: Finalized CY 2023 Clinical Labor Pricing

Labor Code	Labor Description	Source	CY 2021 Rate Per Minute	Final Rate Per Minute	Year 2 Phase-In Rate Per Minute	Total % Change
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 th 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 MPFS services and overall payment among the professionals and suppliers paid under the MPFS.

With the goal of improving the information it uses in its PE methodology, CMS requested information on how it could 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 final rule, CMS states it thinks “it is necessary to establish a roadmap toward more routine PE updates, especially because potentially improper or outdated allocation of PE across services may affect access to certain services, which could exacerbate disparities in care and outcomes.

Establishing payments that better reflect current practice costs would mitigate possible unintended consequences, such as labor market distortions due to indirect cost allocations that do not reflect the current evolution of health care practice.”

CMS made clear in the final rule it intends to move to a standardized and routine approach to valuation of indirect PE, but it will propose any new approach in future rulemaking. It did note that while it believes the AMA Physician Practice Information Survey (PPIS) is still the best available source of data, it remains interested in possible alternatives to use of a sole source of data. It stated,

“We have clear agreement among interested parties that the economic and medical landscapes have changed, and rapidly. Our intent remains to seek data that capture such changes on a more frequent basis, and allow for others to explore and study how best to assess and account for changes with more rapid feedback loops.... For these reasons, it is possible that CMS would look to using verifiable, more objective data sets in the future to supplement or augment survey data alone.”

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 it did in the CY 2020 update, but it proposed to incorporate some methodological refinements.

CMS considers the following factors when it determines 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 proposed 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 sought 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.

In the final rule, the Agency said the feedback it received was, overall, supportive. It believes that the negative impacts of this MP update are relatively modest and agrees with the majority of commenters that believe that the impacts do not outweigh the benefit of updated and expanded premium data that yield more accurate professional liability insurance costs across all specialties. Therefore, CMS is finalizing its methodological improvements as proposed.

Table 33 below shows the 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 33: CY 2023 Risk Index by Specialty and Service Risk Group

Medicare Specialty Code and Name	2023 Service Risk Group	2023 Risk Index
92-Radiation Oncology	ALL	0.907

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. It stated 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 158 below demonstrates the potential impact of rebasing and revising MEI cost share weights on radiation oncology services.

In the proposed rule, CMS proposed not to use this update in CY 2023, but rather sought 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. ASTRO provided comments highlighting how the significant decreases in professional liability insurance (PLI) payments under the rebasing and revising proposal may negatively impact geographical areas with relatively high PLI premiums. While the Agency did not address ASTRO’s comments directly, it did state that it would consider feedback from ASTRO and others in future rulemaking.

The final CY 2023 MEI update is 3.8% based on the most recent historical data available (not the rebased and revised MEI weights).

Table 158: CY 2023 PFS Estimated Impact on Total Allowed Charges by Specialty using Proposed Rebased and Revised MEI Cost Share Weights 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			\$33.0607	\$33.642	\$31.834
Radiation Oncology and Radiation Therapy Centers	Total	\$1,608	-2%	1%	6%
	Non-Facility	\$1,539	-2%	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.

Effective for CY 2023, CMS (1) finalized the proposal to clarify and codify certain aspects of the current Medicare FFS payment policies for dental services when that service is an integral part of specific treatment of a beneficiary's primary medical condition; and (2) other clinical scenarios under which Medicare Part A and Part B payment can be made for dental services, such as dental exams and necessary treatments prior to, or contemporaneously with, organ transplants, cardiac

valve replacements, and valvuloplasty procedures.

The Agency is also finalizing payment for dental exams and necessary treatments prior to the treatment for head and neck cancers starting in CY 2024, and it is finalizing a process in CY 2023 to review and consider public recommendations for Medicare payment for dental service in other potentially analogous clinical scenarios. CMS states that it will “work to address commenters’ thoughtful feedback and questions regarding the operational aspects of billing and claims processing for these services.” The finalization of these dental service coverage proposals is in-line with ASTRO’s comments on the proposed rule, which were appreciative of the attention to coverage for dental services, particularly involving radiation therapy, as well as the clarification of when a dental service will be covered by Medicare Parts A and B.

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 would *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 finalized the proposal 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 includes CPT Code 77427 (Radiation tx management x5).

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 sought to engage with interested parties and solicit comment regarding ways to identify and improve access to high value, potentially underutilized services by Medicare beneficiaries.

The Agency received several comments in response to this request for information and plans to consider the suggestions for possible future rulemaking and program refinement.

Soliciting Public Comment on Strategies for Improving Global Surgical Package Valuation

CMS sought 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’s ongoing assessment of its data collection process, it welcomed 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 its data collection methodology and the RAND report findings.

Although CMS said it did not receive a great deal of feedback on its specific request for information as to whether global packages are still relevant, it believes the information it received demonstrates that there may be variations in patients’ individual postoperative care needs. While it agrees with commenters that in-person visits with the proceduralist is the standard of care on which global packages were based, it will continue to examine whether this specific model of postoperative care is still necessary or relevant for all procedures.

The Agency received a “spectrum of comments” that demonstrates there is not, at this time, clear public consensus on this issue or the preferred strategy for valuing global surgical packages. It will consider the specific strategies proposed by commenters and the concerns regarding impact on the relative value scale and the resources that would be required to revalue these codes.

In the final rule, CMS went on to say,

“The matter of global valuation is complex. Global packages comprise a large number of codes, and their valuation has a significant impact on the PFS relative value scale. Accurately valuing the work and other inputs of the globals is critically important to ensure not only that the practitioners providing those services are paid accurately for the work performed, but that there is no inequitable impact on practitioners paid outside of 10- and 90-day global packages. The diversity of procedures paid under global packages may mean that blanket approaches to valuation or revaluation may not achieve the desired degree of accuracy. And, finally, while universally agreed-upon data strategies may

prove elusive, good data analysis is a critical foundation on which to base any method for valuing these packages. We appreciate the public’s engagement on this issue, and continue to welcome additional insights from interested parties as we consider appropriate next steps.”

Quality Payment Program

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

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

<https://www.cms.gov/files/document/cy2023-physician-fee-schedule-final-rule-cms-1770f.pdf>

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

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

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

<https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notice/cms-1770-f>