Medicare Clinical Labor Update/Office Based Practice Expense Fix

The current pandemic and subsequent public health emergency have shined a much-needed light on the disparities and inequity in access to healthcare. This is a complex problem without a simple solution. The Medicare program was designed to provide the elderly with financial protection from the cost of medical care and, in the process, to increase access to services of high quality. The recent changes to reimbursement rates in the Medicare program do not provide for orderly change, access to care or financial protections for Medicare beneficiaries, nor do they provide for equity among physicians, all guiding principles of the program.[1]

President Biden signed into law the Protecting Medicare and American Farmers from Sequester Cuts Act, which was enacted on December 9, 2021. The law included provisions that patched 3% of the 3.75% conversion factor cut that was scheduled to go into effect January 1, 2022. The law also implemented a delay in resuming the 2% Medicare sequester for three months (January 1 – March 31, 2022), followed by a reduction to 1% for three months (April 1 – June 30, 2022). The legislation erased the 4% Medicare PAY-GO cut and prevented any additional PAY-GO cuts through 2022.

However, other Medicare cuts went into effect January 1, 2022.

CMS finalized a policy to update clinical labor rates starting January 1, 2022. Due to budget neutrality constraints, increasing the 20+ year-old Medicare Physician Fee Schedule (MPFS) clinical labor rates resulted in steep Medicare cuts to numerous non facility/office based procedures. In the table below, we highlight a small sample of specific procedures which are impacting a large range of Americans enrolled in Medicare by implementing this new CMS clinical labor policy. Thus, the physician practices that have increased wages for their clinical labor staff over the past 20 years, to keep up with the market, with no corresponding rate increases in the MPFS, are now suffering paralyzing cuts from a policy intended to align the wages with current market.

Conflating the impact of the clinical labor cuts are the effects of the supply/equipment updates. CMS finalized a policy to update supply and equipment rates starting January 1, 2019. The supply/equipment updates also dramatically shifted relative value units in the MPFS, resulting in steep Medicare cuts to many of the same non facility/office based procedures impacted by the new CMS clinical labor policy. The supplies/equipment policy was phased in over a four year period, with the final year starting January 1, 2022.

The most egregious negative impacts to non facility/office based procedures (i.e. greater than 10%), as a result of the Medicare policy to increase clinical labor rates, which resulted in payment reductions to cover those clinical labor rates, should be mitigated immediately.

Reducing access to services in the non facility/office based setting will create an even greater disparity in healthcare and inequity to healthcare access for vulnerable populations, result in beneficiaries losing timely access to essential health care services and will negatively impact small business and the workforce.

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[1] https://babel.hathitrust.org/cgi/pt?id=mdp.39015030280716&view=1up&seq=12&skin=2021

Table: Impact of Clinical Labor Changes on CY2022 Payment for Selected Procedures[2]

HCPCS Code	Descriptor	2022 Estimated Isolated CL Impact	2023 Anticipated Isolated CL Impact	2024 Anticipated Isolated CL Impact	2025 Anticipated Isolated CL Impact	Total Anticipated Isolated CL Impact
19081	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance	-3%	-3%	-3%	-3%	-12%
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)	-4%	-4%	-4%	-4%	-16%
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	-3%	-3%	-3%	-3%	-12%

[2] Numbers in table vary due to rounding

HCPCS Code	Descriptor	2022 Estimated Isolated CL Impact	2023 Anticipated Isolated CL Impact	2024 Anticipated Isolated CL Impact	2025 Anticipated Isolated CL Impact	Total Anticipated Isolated CL Impact
36902	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	-3.5%	-3.5%	-3.5%	-3.5%	-14%
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	-4%	-4%	-4%	-4%	-16%
93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)	-2%	-2%	-2%	-2%	-8%
G6015	Intensity modulated treatment delivery, single or multiple fields/arcs,via narrow spatially and temporally modulated beams, binary, dynamic mlc, per treatment session	-2%	-2%	-2%	-2%	-9%