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ACROinsights – Development of the Medicare Physician Fee Schedule

The goal of this series of articles is to ensure that radiation oncologists are aware of and provided with the knowledge to ensure day-to-day processes are being addressed in a compliant manner. This installment will discuss the development of the Medicare Physician Fee Schedule. The information contained within this ACROinsights article is meant as general guidance and is not intended to replace appropriate legal or authoritative guidance. The discussion below will refer to "physician" payment, but for many services, non-physicians may be paid under the same methodology but at different rates.

How MPFS Started

The Centers for Medicare and Medicaid Services (CMS) utilizes the Medicare Physician Fee Schedule (MPFS) to reimburse physicians for services provided to Medicare Part B beneficiaries. The MPFS was first implemented on January 1, 1992, to replace the old "customary, prevailing and reasonable" (CPR) charge and payment system. MPFS payment rates are based on three key factors: relative value units (RVU), geographic practice cost indexes (GPCI) and the annual budget-determined conversion factor (CF). The first MPFS final rule was published on November 25, 1991, and established the first fee schedules for physicians' services that went into effect in 1992. Relative Value Units (RVUs) are assigned to all Current Procedural Terminology (CPT®) codes; RVUs are based on factors including physician time, complexity, and resource costs associated with physician work, practice expense (PE) and malpractice (MP) (i.e., professional liability insurance). The assigned RVUs are adjusted by geographic practice cost indices (GPCIs), which reflect the variances in practice costs for locations throughout the country. The conversion factor (CF) is a scaling factor used to convert the geographically adjusted RVUs into dollar amounts.

Conversion Factor (CF)

The conversion factor (CF) is the value set each year by Medicare, based on funds allocated by Congress. The CF converts the RVUs, and geographic location of the services provided into a dollar amount assigned by Medicare. Medicare will pay 80% of the assigned rate with the remaining 20% is the responsibility of the patient or their secondary insurance. Services performed on or after April 1, 2013, have been reduced by Medicare by 2% due to sequestration. Rather than 80%, Medicare actually pays 78% of a service's assigned rate. The patient still pays 20% and the 2% is simply unpaid. Sequestration was a strategy employed by the Congress to pass a budget in 2013, and although not meant to be permanent, has survived unchanged. It was suspended during the public health emergency (PHE) due to COVID-19, and is expected to end, but the final date has shifted to account for the deferral during the PHE.

On April 16, 2015, H.R.2 became law, and finalized progressive increases in the CF. As outlined in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) through calendar year (CY) 2019, the CF was to increase by 0.5% each year by 0.5% through end of CY 2019; however, the Bipartisan Budget Act of 2018 reduced the increase to 0.25% for CY 2019. Beginning in CY 2020, the CF no longer played the key role it has played in

determining the swing from year-to-year in reimbursement changes under MPFS. This is due to changes outlined under the Medicare Access and CHIP Reauthorization Act (MACRA). Beginning in CY 2020, the CF was set to remain at the CY 2019 rate and reimbursements and based on performance measures under the Merit-based Incentive Payment System (MIPS). This has continued subsequently; however, Congress has intervened on behalf of physicians to offset decreases to the CF set by Medicare, as Medicare has limited authority to make adjustments outside of previous legislation which limits and sets the factors used to determine the CF value each year.

Additionally, within MACRA, beginning in 2026, CF rates will be based on participation in Advanced Alternative Payment Models (APMs). Qualifying APM participants will see a 0.75% increase to the CF and non-qualifying APM participants will only receive 0.25% increase to the CF. Additional changes to the RVUs and/or inclusion of a budget neutrality factor will continue to influence overall reimbursement each year. This could change in the event Congress changes how payments for physicians are calculated beginning in 2026.

Budget Neutrality

Budget neutrality is a factor used by Medicare to ensure expenditures do not differ more than $20 million above or below those projected for the calendar year. This is described within the CY 2025 MPFS final rule.[i]

> "Section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs may not cause the amount of Medicare Part B expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we make adjustments to preserve budget neutrality."[ii]

The preservation of budget neutrality applies in several ways. One is if the estimated expenditures are outside the $20 million buffer, then Medicare will either decrease the CF to offset the over-budget estimation or increase the CF to offset an under-budget calculation.

Additionally, when services are projected to see payment increases either through revaluation, new codes with an estimated high volume or estimated significant financial impact, Medicare must operate within the set budget. To achieve increased payments for services, those increases must be subtracted from something else, this results in decreases in value for typically high-value services. For example, over the last 4 years, several specialties, including radiation oncology, have seen decreases to RVUs for direct practice expense (PE). Direct PE accounts for the cost and time of clinical staff, supplies, equipment in the office-based setting to perform services like simulations.

In 2022, the labor values used by Medicare for calculating PE for clinical staff increased for the first time since 2002. The increases were carried out over 4 years due to significant changes, with CY 2025 the final and full implementation year. This would result in higher PE RVUs for freestanding cancer centers and other office based settings, but Medicare had to pay for increases to other services such as E/M services. In order to pay for the new coding changes for E/M visits (CPT® codes 99202-99215) and recognizing these codes are used by most physicians, but predominantly for primary care such as internal medicine and family practice, Medicare enacted budget neutrality. Increases to services due to higher values, like the increase for clinical labor values, were instead passed on to pay for the change in E/M visit valuations. Additionally, specialized services like those for radiation oncology have high PE values due to costly equipment whereas family practice does not have the same overhead, so the increases for payments to large scale services are taken from services which have more overhead.

Calculating Payments

ACROinsights – The Status of Bundled Payment Models

Determining the dollar amount for a given service will depend on the setting in which the services are provided. Freestanding or office-based settings use the values for non-facilities (non-hospitals) to calculate payment rates. The amount paid to the radiation oncologist is the same amount for the professional services/component regardless of whether the physician provided those services in the facility or non-facility setting. Services such as E/M visits and codes outside of the 77xxx series, such as placement codes for brachytherapy applicators are paid different amounts based on the setting.

The following are the formulas used to calculate Medicare payments based on the type of service and the setting in which it was provided.

Non-Facility Payment Rate Formula

[(Work RVU * Work GPCI) + (Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor = Payment Rate

Physicians working in the facility setting (i.e., inpatient and outpatient hospitals and ambulatory surgical centers (ASCs) will use the same physician work values, but different values for PE and MP.

Facility Payment Rate Formula

[(Work RVU * Work GPCI) + (Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor = Payment Rate

Using an example for a complex simulation (CPT® code 77290), the following shows how the reimbursement rate was calculated to show the national payment rate from Medicare for CY 2025, with the values in the MPFS final rule.

Service Description			RVU		RVU Totals	
HCPCS	MOD	DESCRIPTION	WORK RVU	NON-FAC PE RVU	MP	NON-FACILITY TOTAL
77290		Ther rad simulaj field cplx	1.56	11.57	0.09	13.22
77290	TC	Ther rad simulaj field cplx	0.00	10.71	0.03	10.74
77290	26	Ther rad simulaj field cplx	1.56	0.86	0.06	2.48

2025 Medicare Non-Facility National Payment Rates (Example for CPT® 77290, complex simulation)

Global = [(1.56 * 1.000) + (11.57 * 1.000) + (0.09 * 1.000)] * 32.3465 = $427.62
Technical (TC) = [(0.00 * 1.000) + (10.71 * 1.000) + (0.03 * 1.000)] * 32.3465 = $347.40
Professional (26) = [(1.56 * 1.000) + (0.86 * 1.000) + (0.06 * 1.000)] * 32.3465 = $80.22

2025 Medicare Facility Payment Rate (Physician in a Facility) (Example for CPT® 77290, complex simulation)

Professional (26) = [(1.56 * 1.000) + (0.86 * 1.000) + (0.06 * 1.000)] * 32.3465 = $80.22

Geographic location also impacts what a physician or office-based setting is paid for each service by Medicare. For example, all physicians and all office-based settings are paid the same amount for services in the state of Iowa, because there are no geographic changes based on where in the state the practice is located. Alternatively, in Illinois, practices located in Cook County are paid differently than those in DuPage, Kane, Lake and Will counties in which these four are classified as Suburban Chicago locale and all paid the same, but less than Chicago.

When determining payment for services it is important to know the setting, i.e., facility or non-facility, and geographic location, specifically the county in which the services are provided in the state.

The Take Home Message

All radiation oncologists should have a basic understanding of how they are paid and how those values can and do change each year. It's not so much about being in the weeds and understanding all of the nuances, but an appreciation of the terminology and how the changes can impact payment. Healthcare is a business, to be able to treat patients and keeping the doors open is key, but keeping the doors open means getting paid for services is vital. There are many opportunities for ACRO members to learn about and participate in conversations related to physician reimbursement, but first radiation oncologists must understand how payments are calculated.

[i] Calendar Year 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; Medicare Overpayments, https://www.federalregister.gov/public-inspection/2024-25382/medicare-and-medicaid-programs-calendar-year-2025-payment-policies-under-the-physician-fee schedule

[ii] Social Security Act Compilation of the Social Security Laws, Payment for Physician Services, Sec. 1848. [42 U.S.C. 1395w–4], https://www.ssa.gov/OP_Home/ssact/title18/1848.htm