CY2024 Medicare Physician Fee Schedule

Key Takeaways for Physicians

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Executive Summary

On November 2, the Centers for Medicare & Medicaid Services (CMS) issued the CY2024 Medicare Physician Fee Schedule final rule which includes updates to physician payment policies, the Quality Payment Program (QPP), and the Medicare Shared Savings Program (MSSP). Most significantly, CMS has reduced the CY2024 conversion factor by 3.37 percent from $33.8872 to $32.7442. The anesthesia conversion factor will also decrease from $21.1249 to $20.4349. These reductions, which apply to services across the fee schedule, are the result of statutorily mandated reductions, which the AOA has been fighting to address through legislation.

Despite the statutorily required reductions to the conversion factor, the rule overall reflects a commitment from CMS to support payment for longitudinal, coordinated care. Key takeaways include the following:

- With the moratorium on implementation of the care complexity add-on code (G2211) expiring on December 31, 2023, CMS has finalized policy to move forward with implementation. This new code presents an opportunity for enhanced payment for office/outpatient evaluation and management (E/M) services, particularly for primary care and office-based specialties, and could allow for a net increase in payment for these specialties. It is important to note that most of the reduction to the CY2024 conversion factor is attributable to implementation of this code. AOA submitted comments on the proposed rule that CMS' assumptions and estimates of utilization for this code were flawed, resulting in an unnecessarily large downward adjustment, but CMS chose to move forward using its analysis from the proposed rule.
- The Biden Administration is heavily focused on addressing behavioral health issues and promoting equity. Several provisions in the rule reflect these priorities, including enhanced payment for a range of behavioral health services, and the creation of new payable codes for Community Health Integration, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation services.
- CMS has finalized policies that will support continued payment and access for telehealth services.

The rule also contains a range of changes to the QPP and MSSP. Overall, CMS has made modifications to the measure lists across each MIPS performance category and made substantial changes to the MIPS value pathways. Additionally, following AOA advocacy CMS will maintain the MIPS performance threshold, upon which payment adjustments are determined, at 75 points. AOA expressed concern that raising the performance threshold would disadvantage small and independent practices, especially those that sought extreme and uncontrollable circumstance exemptions from the MIPS program through 2023 and are just resuming full participation.

Physician Fee Schedule Provisions

This section outlines key changes to payment policy under the physician fee schedule, including changes to the conversion factor, service relative values, telehealth service coverage, evaluation and management services, and behavioral health services. This section also addresses newly created codes, focusing on those that are expected to be widely used across specialties, will have high volume, or relate to a pressing public health challenge. In addition, CMS finalized values for

a large number of codes under this rule. A list of new and revised codes can be found in appendix E of this document.

Conversion Factor and Rate Setting

CMS reduced the CY2024 conversion factor by 3.37 percent from $33.8872 to $32.7442. The anesthesia conversion factor will also decrease from $21.1249 to $20.4349. For physician services (excluding anesthesia), total payment is calculated by first determining the total relative value units (RVUs) for a given services (comprised of three components: physician work, practice expense, and liability insurance) and multiplying the total RVUs by the conversion factor. The formulas used to calculate final payment for Medicare services can be found in Appendices A and B of this document.

The conversion factor reductions, which apply to services across the fee schedule, are the result of statutorily mandated reductions, which the AOA has been fighting to address. Statutory requirements prevent CMS from providing positive payment adjustment under the physician fee schedule without a corresponding negative reduction – changes to the fee schedule must be applied in a budget neutral manner. This means that any changes to RVUs may not result in a net increase to Medicare expenditures when accounting for anticipated utilization. The drivers of the 3.37 percent conversion factor reduction include the following:

- A 1.22 percent reduction as required under the Consolidated Appropriations Act (CAA) of 2023; and
- A 2.15 percent reduction due to a budget neutrality adjustment.

Additionally, the finalized CY2024 geographic practice cost indices (GPCIs) do not reflect a 1.0 work GPCI floor as it expires on December 31, 2023. The AOA endorses equity in reimbursement for rural physicians as part of the strategy to increase the availability of quality health care in rural areas, and advocates for the extension of the GPCI floor beyond 2023.

The change will result in reduced payment in localities where the work GPCI floor is currently applied. According to a 2022 Government Accountability Office report, in 2018, 52 of the 112 payment localities had their work GPCI floor values raised.[1]

All of these cuts come amid rising costs of practicing medicine, which are unsustainable. The AOA continues to work with lawmakers to address the urgent need to reform physician payment and avert the cuts that will take effect in 2024.

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[1] Government Accountability Office. “Information on Geographic Adjustments to Physician Payments for Physicians’ Time, Skills, and Effort.” February 2022. Available here.

Telehealth Services Provisions

Telehealth Service List and Payment Rates

With the AOA's support, CMS finalized a range of policies that will preserve payment for telehealth services. The agency finalized its proposal to pay for telehealth services when the patient's home is the originating site, at the non-facility rate. All claims should appropriately indicate when services were provided via telehealth, with the patient's home as the originating site, using a place of service (POS) modifier 10. CMS will continue to define the patient's "home" to include temporary lodging such as hotels or homeless shelters, or settings where the patient has travelled a short distance from their residence for privacy or personal reasons. The agency is implementing this policy with the recognition that physician practices still functionally maintain their practice expenses when providing services via telehealth. Under the new policy, telehealth services rendered when the originating site is not the patient's home should be billed with a POS modifier 2, and these services will be paid at the facility rate. Additionally, a modifier 95 should be used when the billing physician is in a hospital setting and the patient is at home.

CMS will also continue coverage and payment for all telehealth services included on the Medicare Telehealth Services List as of March 15, 2020.

Beginning in 2024, CMS proposes to simplify its methodology for updating its telehealth services list. Rather than having three separate categories of telehealth services, CMS will shift to a binary standard of "permanent" and "provisional" services. All current Category 3 and "temporary Category 2" codes will be mapped to the provisional list, while all Category 1 and permanent Category 2 codes will be mapped to the new "permanent" code list. Beginning CY2024, CMS has also added the new social determinants of health risk assessment (G0136), described later in this document, to the list of permanent telehealth services.

Elimination of Frequency Limitations for Certain Services

CMS finalized the policy continuing to suspend frequency limitations for Medicare telehealth subsequent care services in inpatient settings, nursing facility settings, and critical care consultations on a temporary basis for CY2024. This will allow the agency more time to continue collecting data on these services and "evaluate patient safety while preserving access in a way that is not disruptive to practice patterns that were established during the Public Health Emergency (PHE)." Frequency limitations will continue to be suspended for the following codes:

- Subsequent inpatient visit (99231, 99232, 99233)
- Subsequent nursing facility visit (99307, 99308, 99310, G0508, G0509)
- Critical care consultations (G0508, G0509)

CMS will reevaluate this policy based on new data in future rulemaking.

Implementation of Telehealth Flexibilities under the CAA 2023

The *Consolidated Appropriations Act, 2023*, extended temporary Medicare telehealth flexibilities established during the COVID-19 PHE through **December of 2024**. CMS finalized policy implementing these extensions, which include the following.

- Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHC) can serve as a distant site provider for non-behavioral/mental telehealth services.
- Medicare patients can receive telehealth services authorized under the Medicare telehealth service list in their home.
- There are no geographic restrictions for originating sites for non-behavioral/mental telehealth services.
- Some non-behavioral/mental telehealth services can be delivered using audio-only communication platforms.
- An in-person visit within six months of an initial behavioral/mental telehealth service, and annually thereafter, is not required.
- Telehealth services can be provided by a physical therapist, occupational therapist, speech language pathologist, or audiologist.

Definition of "Direct Supervision"

CMS will continue to define direct supervision in a manner that allows the requirement to be satisfied via the "virtual presence" and immediate availability of the supervising practitioner through real-time audio and video interactive telecommunications. CMS extended this policy through 2024 to ensure continuity in light of how many practices have restructured following flexibilities granted during the PHE. CMS will re-evaluate this policy in future rulemaking based on availability of additional data regarding patient safety. The AOA expressed concern and opposed the long-term extension of this flexibility to CMS in our response to the proposed rule due to patient safety concerns for services provided by non-physician clinicians incident to a physician service, as well as for services provided by non-physician clinicians being supervised by non-physician practitioners.

Supervision of Residents in Teaching Settings

CMS finalized policy to allow the teaching physician to have a virtual presence in all teaching settings, only in clinical instances when the service is furnished virtually (i.e., a 3-way telehealth visit, with all parties in separate locations).

Remote Patient Monitoring (RPM) and Remote Therapeutic Monitoring (RTM)

In an effort to expand access to RPM and RTM services, CMS finalized the following changes to its coverage policies for these services:

- Clarifying that RPM and RTM codes may be billed concurrently with care management services, including Chronic Care Management (CCM), Transitional Care Management (TCM), Behavioral Health Integration (BHI), Principal Care Management (PCM), and Chronic Pain Management (CPM) services. However, RPM and RTM services may not be billed together;
- RPM and RTM services may only be furnished to established patients;
- Allowing Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to report RPM and RTM services under the existing general care management code (G0511), and improving reimbursement for the code in a corresponding fashion; and
- Clarifying that beneficiaries getting surgery and related services covered by a global payment can also get RPM/RTM services if the latter is separate from the diagnosis for the procedure/services covered by a global payment.

New Codes to Address Health Related Social Needs

In recent years, CMS has worked to develop ways to better promote comprehensive, coordinated care and "value practitioners' work when they incur additional time and resources helping patients with serious illnesses navigate the healthcare system or removing health-related social barriers interfering with the practitioner's ability to execute a medically necessary plan of care." To this end, CMS finalized a range of new codes to support the work and time spent by physicians and auxiliary personnel. These include Community Health Integration services, Principal Illness Navigation services, and Social Determinants of Health Risk Assessment. CMS also states that payment for these new codes will promote equity and access to care, and support the White House's National Strategy on Hunger, Nutrition and Health, and the Cancer Moonshot Initiative.

As an example of the type of work CMS views as undervalued, CMS describes how "practitioners and their staff of auxiliary personnel 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." It is important to note that these codes are intended for a broad range of patients and conditions. The table below outlines the newly created codes.

Table 1. Newly Created Codes for Health Related Social Needs

Code	Short Descriptor	Work RVUs
Community Health Integration (CHI)		
G0019	Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month; in specified activities (see full descriptor below)	1.00
G0022	Community health integration services, each additional 30 minutes per calendar month	0.70
SDOH Risk Assessment		
G0136	Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment tool, 5-15 minutes	0.18
Principal Illness Navigation (PIN)		
G0023	Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, for specified activities (see full descriptor below)	1.00
G0024	Principal Illness Navigation services, additional 30 minutes per calendar month	0.70
G0140	Principal Illness Navigation – Peer Support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, for specified activities (see full descriptor below)	1.00

G0146	Principal Illness Navigation – Peer Support, additional 30 minutes per calendar month	0.70

Community Health Integration (CHI) Services

CMS finalized 2 new codes to account for community health integration services. CHI services can be furnished monthly, as medically necessary, following a CHI initiating visit in which the practitioner identifies the presence of SDOH need(s) that significantly limit the practitioner's ability to diagnose or treat the problem(s) addressed in the visit. E/M services and annual wellness visits (AWVs) may serve as the initiating visits for CHI services. The codes finalized include G0019, 60 minutes of CHI services performed by auxiliary personnel in a calendar month, and G0022, for each additional 30 minutes of time spent on CHI services for a patient. CMS chose to maintain the 60 minute threshold for G0019 as it felt that it would be difficult for personnel to address patients' social needs in under an hour. CMS is not placing limits on G0022 being billed more than once per month.

For purposes of this code, CMS adopts the CPT's definition of SDOH and states that SDOHs "may include but are not limited to food insecurity, transportation insecurity, housing insecurity, and unreliable access to public utilities, when they significantly limit the practitioner's ability to diagnose or treat the problem(s) addressed in the CHI initiating visit." The agency also notes that the new CHI codes are intended to include the following services: a person-centered assessment, practitioner, home- and community-based care coordination, health education, building patient self-advocacy skills, health care access/health system navigation, facilitating and providing social and emotional support, and leveraging lived experience when applicable.

CMS is designating CHI services as care management services that may be furnished under the general supervision of the billing practitioner. General supervision means the service is furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required during the performance of the service. Additionally, CHI services may only be billed by practitioners who have an "incident to" benefit for billing their services (e.g., physicians). Services must be appropriately documented in the medical record, and patient consent must be obtained for these services to be billed. Full descriptors for these services can be found in Appendix C of this document.

Work and practice expense values for G0019 are crosswalked to 99490, and values for G0022 are crosswalked to 99439.

Principal Illness Navigation (PIN) Services

CMS created 4 new codes for Principal Illness Navigation services. Two of the codes are intended for auxiliary personnel providing individualized help to a patient (and caregiver, if applicable) to identify appropriate practitioners and providers for care needs and support, and access necessary care in a timely manner, especially when the landscape is complex and delaying care can be deadly. The other two codes are for PIN service provided specifically by peer support specialists for behavioral health conditions.

Overall, CMS notes that PIN services are primarily intended for supporting socioeconomically disadvantaged patients and those facing barriers to care. They are particularly important for

patients undergoing treatment for severe and/or debilitating conditions. Examples provided by CMS include the following:

- surgery, imaging and radiation therapy, chemotherapy for cancer;
- psychiatry, psychology, vocational rehabilitation for severe mental illness;
- psychiatry, psychology, vocational rehabilitation, rehabilitation and recovery programs for substance use disorder; and
- infectious disease, neurology and immunology for human immunodeficiency virus (HIV)-associated neurocognitive disorders.

The new PIN codes seek to better recognize and pay for "when certified or trained auxiliary personnel under the direction of a billing practitioner, which may include a patient navigator or certified peer specialist, are involved in the patient's health care navigation as part of the treatment plan for a serious, high-risk disease expected to last at least 3 months, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, functional decline, or death."

Services that qualify as PIN initiating visits include:

- Outpatient E/M services;
- Transitional Care Management (TCM) services;
- Psychiatric diagnostic evaluation (90791);
- Health Behavior Assessment and Intervention Services (96156, 96158, 96159, 96164, 96165, 96167, and 96168); and
- AWVs when the billing physician identifies in the medical record high-risk conditions that qualify for PIN services.

CMS is designating PIN services as care management services that may be furnished under the general supervision of the billing practitioner. Services must be appropriately documented in the medical record, and patient consent must be obtained for these services to be billed. PIN services may be billed by the same practitioner more than once per month for any single serious high-risk condition, and they may be billed in addition to other care management services. However, time and effort may not be duplicated. Full descriptors for these services can be found in appendix C of this document.

CMS is establishing crosswalks for G0023 and G0140 to 99490 with a work RVU of 1.00, and crosswalks for G0024 and G0146 to 99439 with a work RVU of 0.70.

Social Determinants of Health (SDOH) Risk Assessment

CMS finalized its new stand-alone G code, HCPCS code G0136, for *Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months*.

SDOH risk assessment refers to a review of the individual's SDOH or identified social risk factors that influence the diagnosis and treatment of medical conditions. CMS created this code in recognition of the impact SDOHs have on a patient's overall health, and to identify and value the work involved in the administering an SDOH risk assessment as part of a comprehensive social history. The SDOH risk assessment must utilize a standardized, evidence-based tool and be furnished in conjunction with one of the following services:

- An outpatient E/M;
- AWV;
- Psychiatric diagnostic evaluation (90791);
- Health Behavior Assessment and Intervention Service (96156, 96158, 96159, 96164, 96165, 96167, and 96168); or
- Hospital discharge visit.

CMS outlines that any standardized, evidence-based SDOH risk assessment tool that has been tested and validated through research may be used. Examples include, but are not limited to, the CMS Accountable Health Communities (AHC) tool, the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) tool, and instruments identified for Medicare Advantage Special Needs Population Health Risk Assessment.

The SDOH risk assessment is intended to be used when a practitioner has reason to believe there are unmet SDOH needs that are interfering with the practitioner's diagnosis and treatment. As a result, the service is not considered a screening. Additionally, CMS clarifies that this service does not include practitioners asking screening questions ahead of a visit. SDOH needs identified through the risk assessment must be documented in the medical record. However, physicians rendering the service are not required to have the capacity to directly address these needs. CMS wants to encourage wider efforts among physicians and other providers to identify SDOH needs, even if many providers currently lack the capacity to directly address these needs through CHI, PIN, and other care management services.

CMS is directly cross-walking the work and practice expense (PE) values for this code to G0444 which has a work RVU of 0.18.

Evaluation and Management (E/M) Services

Visit Complexity Add-on Code

CMS is proposing to move forward with implementation of the office/outpatient (O/O) E/M visit complexity add-on code, G2211. This code was initially going to be implemented in the 2021 rule. However, Congress enacted a moratorium on implementation through the end of 2023. The code would be reported in conjunction with O/O E/M visits to better account for additional resources associated with primary care, or similarly ongoing medical care related to a patient's single, serious condition, or complex condition.

The O/O E/M visit complexity add-on reflects the time, intensity, and PE resources involved when practitioners furnish the kinds of O/O E/M office visit services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single high-risk disease) and to address the majority of a patient's health care needs with consistency and continuity over longer periods of time. The code is intended to be used widely across O/O E/M visits.

CMS explains the need for this code, stating the following:

> The expertise of those who rely predominantly on E/M services to report their services is left relatively underrecognized within the previous and current E/M coding and valuation structure. This is because E/M valuation is broad-based and the same E/M visit codes are routinely reported both alone and with many different procedural codes. We believe that

this specific gap in appropriate valuation and coding is in addition to, and not overlapping with, the gaps in coding and valuation that led to the creation of care management coding, remote patient monitoring, etc.

The full descriptor for the code is as follows.

G2211 *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, or complex condition.*

CMS provides guidance in the rule for application of code. First, it defines the following key terms in the descriptor:

- **continuing focal point for all needed health care services:** describes a relationship between the patient and the practitioner, when the practitioner is the continuing focal point for all health care services that the patient needs. For example, a patient has a primary care practitioner that is the continuing focal point for all health care services, and the patient sees this practitioner to be evaluated for sinus congestion. The inherent complexity that this code (G2211) captures is not in the clinical condition itself— sinus congestion —but rather the cognitive load of the continued responsibility of being the focal point for all needed services for this patient. There is previously unrecognized but important cognitive effort of utilizing the longitudinal relationship itself in the diagnosis and treatment plan and weighing the factors that affect a longitudinal doctor patient relationship.
- **ongoing care:** describes a longitudinal relationship between the practitioner and the patient which is not limited to primary care. (e.g., an infectious disease physician caring for a patient with HIV).

Second, CMS elaborates that application of the code "is not based on the characteristics of particular patients (even though the rationale for valuing the code is based on recognizing the typical complexity of patient needs) but rather the relationship between the patient and the practitioner" and the need to recognize the complexity inherent to O/O E/M visits that is generally unrecognized. Therefore, the code is intended to be used widely by physicians, regardless of specialty, for O/O E/M visits that serve as the continuing focal point for all needed health care services. However, the code should not be used for visits where the relationship with the physician is of a "discrete routine, or time-limited nature" such as visits with a new provider for the removal of a mole or treatment of a simple virus. Additionally, G2211 may not be billed with an E/M appended with a modifier -25 where a minor procedure is performed on the same day.

Definition of Split (Or Shared) Visit

Split (or shared) E/M visits refer to visits provided in part by physicians and other practitioners in hospitals and other institutional settings where clinicians do not have the ability to bill "incident to" a physician service. For 2024, CMS will not be implementing its original proposal and will instead, for purposes of Medicare billing for split (or shared) services, define the "substantive portion" as more than half of the total time spent by the physician and NPP performing the split (or shared) visit, or a substantive part of the medical decision making as defined by CPT. However, critical care services which do not use medical decision making and only use time, "substantive portion" continues to mean more than half of the total time spent by the physician and NPP performing the split (or shared) visit.

In its CY2022 proposed rule, CMS proposed a policy for split (or shared) E/M visits for physicians and other qualified health care professionals in the facility setting and established a definition for what constituted the "substantive portion" of a visit to determine who billed the service. AOA expressed concern with CMS' proposal to base the definition of "substantive portion" of a split or shared E/M visit on the practitioner who provides "more than half of the total time" performing the visit as CMS' proposal was inconsistent with CPT guidelines.

Advancing Access to Behavioral Health Provisions

In recognition of the ongoing behavioral health crisis and behavioral health workforce shortage, CMS has finalized a series of payment changes to support payment and access for a broad range of behavioral health services. Exact changes to work RVUs can be found in appendix D of this document.

General Behavioral Health Integration Care Management

Out of concern for undervaluation of care management services as practices seek to implement behavioral health integration, CMS has finalized updated values for the corresponding codes (99484 and G0323). Many practices identify financial barriers and poor payment rates as barriers to integrating behavioral health into their practice. Enhanced payment will support delivery of integrated care.

Psychotherapy Codes

Similar to its approach to other cognitive services, CMS believes that physician work for psychotherapy services is undervalued, which may contribute to workforce and access challenges. To address this, CMS is finalizing a 19.1 percent increase to the work RVUs for psychotherapy services, including standalone psychotherapy codes, E/M psychotherapy add-on codes (90833, 90836, and 90838), and Health Behavior Assessment and Intervention codes (96156, 96158, 96159, 96164, 96165, 96167, and 96168). This increase will be phased in over 4 years.

While CMS did not initially propose to include E/M psychotherapy add-on codes for increases in work RVUs, CMS has ultimately decided to include them as this is how psychiatrists often bill their services, and CMS hopes that inclusion of these codes will promote psychiatrist participation in Medicare and more appropriately support code relativity.

Physician Fee Schedule Substance Use Disorder (SUD) Bundle

CMS is increasing the valuation of codes for office-based treatment of SUD to be priced consistent with the crosswalk codes used to value the bundled payments made for OUD treatment services furnished at Opioid Treatment Programs (OTPs). As CMS notes in the rule, beneficiaries receiving buprenorphine in settings outside of OTPs have similarly complex health care needs as compared to beneficiaries receiving OUD treatment services at OTPs. Additionally, this change is intended to increase the value consistent with the newly finalized value of psychotherapy services, which are included in this payment bundle. Many addiction medicine specialists provide services outside of an OTP setting, and this change will support appropriate payment for office-based treatment of OUD billed with HCPCS codes G2086 and G2087.

Marriage and Family Therapists (MFT) and Mental Health Counselors (MHCs)

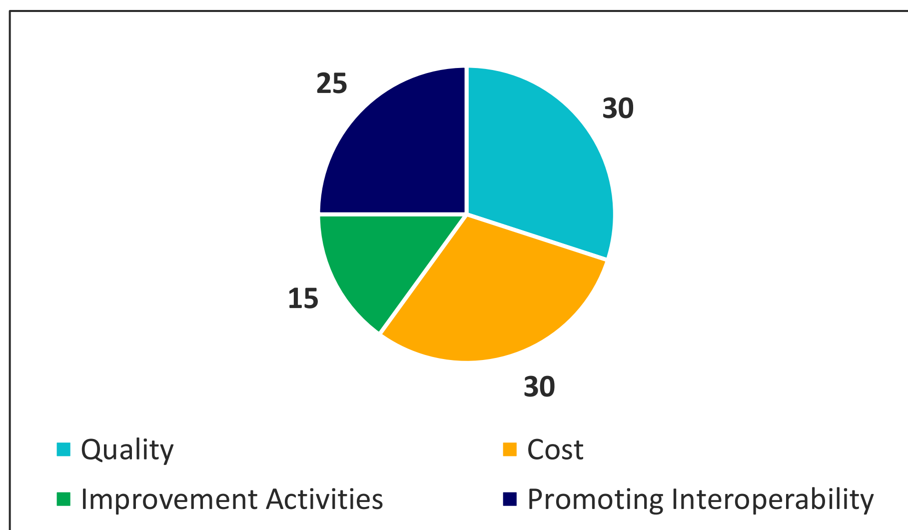
CMS is implementing provisions of the Consolidated Appropriations Act of 2023 providing for Medicare coverage and payment of services provided by marriage and family therapists and Mental Health Counselors. These clinicians, who are trained in providing mental health care services, will now be able to bill Medicare directly. CMS defines both provider types and the services they provide in its regulation. This change will support broader access to behavioral health services.

Quality Payment Program Provisions

Physicians who participate in the Medicare program and do not meet the low-volume threshold for Medicare allowed charges and beneficiaries treated in a year must participate in the Quality Payment Program. Physicians must report under either the Merit Based Incentive Payment System (MIPS) or the Alternative Payment Model (APM) Performance Pathway. This section outlines key changes related to performance under MIPS and APMs.

Physicians participating in MIPS are measured under 4 performance categories: cost, quality, promoting interoperability, and improvement activities. The weights for each of these categories determine a physician's final MIPS score, which is displayed in the chart below.

Table 1. Proposed MIPS Performance Category Weights



This section outlines key changes to each of the MIPS performance categories, the performance threshold upon which payment adjustments are determined, and changes to the APM performance pathway. The final rule implements changes across each performance category. Details regarding new and revised measures under each category, as well as new and revised MIPS Value Pathways, can be found on the QPP webpage.

MIPS Performance Threshold

CMS withdrew its proposal to increase the Merit-Based Incentive Payment System (MIPS) performance threshold and will instead maintain the current threshold of 75 points for the 2024 performance year. In AOA's letter to CMS, we expressed concern to their proposal to raise the performance threshold citing how it would disadvantage small and independent practices, especially those that sought extreme and uncontrollable circumstance exemptions from the MIPS program through 2023 and are just resuming full participation.

MIPS Performance Category Changes

Cost Performance Category

The cost performance category accounts for 30 percent of a physician's total MIPS score. CMS is finalizing 5 new episode-based cost measures, which will each have a 20-episode case minimum. These measures include:

- Heart failure;
- Psychoses and related conditions;
- Depression;
- Low back pain; and
- Emergency medicine.

CMS is also removing its Simple Pneumonia with Hospitalization episode-based cost measure.

CMS established in previous rulemaking that the MIPS cost category would include improvement scoring to reward participants that showed progress. Physicians will be eligible for a 1 percent improvement score which is calculated at the performance category level without statistical significance.

Quality Performance Category

The quality performance category accounts for 30 percent of a physician's total MIPS score. CMS has finalized a measure set inventory of 198 quality measures, which includes the addition of 11 new measures, removal of 11 measures, and partial removal of 3 measures whereby these measures will only be available for physicians participating in applicable MVPs. CMS has also made modifications to 59 existing measures. It is important to note that this list excludes Qualified Clinical Data Registry (QCDR) measures.

CMS finalized its proposal to maintain the data completeness criteria threshold to at least 75 percent for the CY 2026 performance period/2028 MIPS payment year, and not finalizing the proposal to increase the data completeness criteria threshold to at least 80 percent for the CY 2027 performance period/2029 MIPS payment year.

Improvement Activities Performance Category

The improvement activities performance category accounts for 15 percent of a physician's total MIPS score. CMS finalized an inventory of 106 IA measures, which includes the addition of 5 new, modification of 1 existing, and removal of 3 existing improvement activities. New activities include:

- Human Immunodeficiency Virus (HIV) Prevention Services;
- Practice-Wide Quality Improvement in MIPS Value Pathways;
- Use of Computable Guidelines and Clinical Decision Support to Improve Adherence for Cervical Cancer Screening and Management Guidelines;
- Behavioral/mental Health and Substance Use Screening and Referrals for Pregnant and Post-partum Women; and
- Behavioral/Mental Health and Substance Use Screening & Referral for Older Adults.

CMS is also removing three current IA measures and modifying 1 existing measure.

Promoting Interoperability Performance Category

The promoting interoperability category accounts for 25 percent of a physician's total MIPS score. CMS finalized a range of changes to this category, which include:

- lengthening the performance period for this category from 90 days to 180 days;
- modifying one of the exclusions for the Query of Prescription Drug Monitoring Program (PDMP) measure; and
- modifying the Safety Assurance Factors for Electronic Health Record Resilience (SAFER) Guide measure to require MIPS eligible clinicians to affirmatively attest to completion of the self-assessment of their implementation of safety practices.

Additionally, CMS will continue to automatically reweight this performance category for MIPS eligible clinicians, groups, and virtual groups that are:

- ambulatory surgical center (ASC)-based;
- Hospital-based;
- Non-patient facing; and
- Small practices.

MIPS Value Pathways (MVPs)

Modifications to Existing MVPs

CMS continues to refine the MIPS program to better promote value. The MVP performance pathway streamlines activities and measures in each of the performance categories to focus on those that are relevant to a particular specialty, condition, or episode of care. In turn, this also supports improved performance measurement by allowing clinicians to report on a smaller, more relevant set of measures. This pathway may also help alleviate burden associated with reporting under traditional MIPS by allowing physicians to report a reduced number of measures or activities. For CY2024, CMS made changes to the 12 existing MVPs and proposed 5 new MVPs.

CMS has also modified its subgroup scoring policies for MVP participants. CMS will not calculate a facility-based score at the subgroup level and will continue to calculate a facility-based score in traditional MIPS and assign the higher of the two final scores. Subgroups will receive their affiliated group's complex patient bonus, if applicable. Subgroups will only receive reweighting based on any reweighting applied to its affiliated group. Additionally, subgroups will be allowed to submit a targeted review beginning with the 2023 performance period.

Table 3. Existing MVPs

Existing MVPs	
Advancing Cancer Care	Advancing Rheumatology Patient Care
Optimal Care for Kidney Health	Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
Optimal Care for Patients with Episodic Neurological Conditions	Advancing Care for Heart Disease
Supportive Care for Neurodegenerative Conditions	Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
Promoting Wellness*	Improving Care for Lower Extremity Joint Repair
Optimizing Chronic Disease Management*	Patient Safety and Support of Positive Experiences with Anesthesia

*The Promoting Wellness and Optimizing Chronic Disease Management MVPs were consolidated into a new, single Value in Primary Care MVP.

Newly Created MVPs

CMS finalized 5 new MVPs, which include:

1. Focusing on Women's Health;
2. Prevention and Treatment of Infectious Disease, Including Hepatitis C and HIV;
3. Quality Care in Mental Health and Substance Use Disorders;
4. Quality Care for Ear, Nose, and Throat (ENT) Disorders; and
5. Rehabilitative Support for Musculoskeletal Care.

CMS has consolidated the Promoting Wellness and Optimizing Chronic Disease Management MVPs into a single MVP, referred to as the Value in Primary Care MVP. Accordingly, CMS made changes to measures and activities under each of the performance categories.

Currently, participation in MVPs is optional. However, CMS has stated that its goal is to fully shift participation into MVPs or Alternative Payment Models (APMs) and ultimately sunset traditional MIPS. The agency has not established a timeline for this effort and must still establish a comprehensive range of participation options across specialties.

Advanced Alternative Payment Model (APM) Track

The Advanced APM pathway is the second track for participation in the Quality Payment Program and was intended to incentivize high-quality, high-value care and help shift physicians away from fee-for-service. CMS finalized 2 key changes for CY2024, consistent with requirements under statute related to the QP threshold and the APM incentive payment.

To participate in this track and qualify for an APM incentive bonus, physicians must meet minimum thresholds of either payment or patient volume through the APM to be determined a Qualifying Participant (QP). For CY2024, CMS finalized policy, consistent with statutory requirements, to raise the QP thresholds to the following:

- 75 percent of Medicare Part B payments must be through an APM
- 50 percent of Medicare patients must be through an APM

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provided for a 5 percent incentive payment for clinicians participating in Advanced APMs through the 2022 performance year, which was then extended for an additional year at 3.5 percent under the CAA 2023. This incentive is no longer available in 2024. Statute also provides for payments for Advanced APM participants to be determined using a slightly higher conversion factor. MACRA provides for two separate conversion factors to be implemented beginning in 2024, where APM participants will receive an annual 0.75 percent update to payment each year, while the general Medicare conversion factor will receive a 0.25 percent update.

While CMS initially proposed to end the use of APM entity-level QP determinations and make all QP determinations at the individual eligible clinician level, it has withdrawn this proposal for 2024.

Medicare Shared Savings Program Provisions (MSSP)

CMS is seeking to increase participation by accountable care organizations (ACOs) in the MSSP to promote a transition to value-based care. In this rule, CMS finalized several policies it believes will support this transition and encourage participation.

Medicare Clinical Quality Measures (CQM) for Shared Savings Program ACOs

CMS is establishing the Medicare CQMs for ACOs participating in the Medicare Shared Savings Program as a new collection type for MSSP ACOs under the APM Performance Pathway (APP). To facilitate population-based activities that promote health, CMS will:

- Provide all ACOs with a list of beneficiaries eligible for Medicare CQMs each quarter throughout the performance year;
- Align standards for data completeness, benchmarking, and scoring ACOs for the Medicare CQM collection type with MIPS benchmarking and scoring policies; and
- Continue to permit practices to report quality data using the CMS web interface measures, eCQMs and/or MIPS CQMs collection types in performance year 2024.

Aligning Certified Electronic Health Record Technology (CEHRT) Requirements for Shared Savings Program ACOs with MIPS

Beginning in 2025, an ACO participant, ACO provider/supplier, and ACO professional that is a MIPS eligible clinician, Qualifying APM Participant (QP), or Partial QP, regardless of track, would be required to report the MIPS Promoting Interoperability performance category measures and requirements to MIPS and earn a performance category score for the MIPS Promoting Interoperability performance category at the individual, group, virtual group, or APM Entity level.

Benchmarking Methodology Modifications

CMS finalized several significant benchmarking refinements designed to encourage sustained participation in the program and protect ACOs that serve complex populations. These include:

- Capping the risk score growth in an ACO's regional service area when calculating regional trends used to update the historical benchmark, while also accounting for an ACOs market share;
- Eliminating overall negative regional adjustments to support participation by ACOs serving medically complex and high-cost populations; and
- Applying the same CMS-Hierarchical Condition Categories (HCC) risk adjustment model used in the performance year for all benchmark years, when calculating prospective HCC risk scores to risk adjust expenditures used to establish, adjust, and update an ACO's benchmark.

Beneficiary Assignment Methodology

CMS finalized its proposal to modify the beneficiary assignment methodology to better account for beneficiaries who receive primary care from nurse practitioners, physician assistants, and clinical nurse specialists during the 12-month assignment window and who received at least one primary care service from a physician used in assignment in the preceding 12-months. Beginning in 2025, CMS will apply a revised beneficiary assignment methodology that will include a new third step, which will use an expanded window for assignment (a 24-month period that includes the applicable 12-month assignment window and the preceding 12-months) to identify additional beneficiaries for assignment.

Advance Investment Payments (AIPs)

In its CY2023 rule, CMS finalized a policy providing new MSSP participants the option to receive advance shared savings payments to help with the significant costs associated with starting an ACO. CMS is finalizing a series of refinements to this policy, including:

- Permitting ACOs receiving an AIP to progress to performance-based risk by allowing them to advance to two-sided model levels within the BASIC track's glide path beginning in performance year three of the agreement period in which they receive advance investment payments;
- Permitting AIP participants to early renew a participation agreement after their second performance year without triggering full recoupment of advance investment payments at that time;
- Requiring ACOs to report spend plan updates and actual spend information to CMS in addition to publicly reporting such information; and
- Specifying that CMS will immediately terminate advance investment payments to an ACO for future quarters if the ACO voluntarily terminates from the Shared Savings Program.

Helpful Links:

- The text of the final rule can be accessed here.
- The CMS fact sheet for the fee schedule is available here.
- The CMS fact sheet and FAQs on the 2024 Quality Payment Program are available here.
- The CMS fact sheet on Medicare Shared Savings Program is available here.

Questions?

If you have any questions about this document or the contents of the MPFS rule, please contact Gabriel Miller, Senior Director of Regulatory Affairs, at gmiller@osteopathic.org or 202-349-8749.

Appendix

Appendix A: Medicare Payment Calculation Formula

Step 1: Calculate Total RVUs

[Physician Work RVU × Physician Work GPCI] + [Practice Expense RVU × Practice Expense GPCI] + [Malpractice RVU × Malpractice GPCI] = Total RVU

Step 2: Calculate Final Medicare Payment

Total RVU × Medicare Conversion Factor = Medicare Payment

Appendix B: Medicare Anesthesia Payment Calculation

Step 1: Calculate Total Anesthesia Units

[Anesthesia Units for Billed CPT Code] + [Total Service Time ÷ 15] = Total Anesthesia Units

Step 2: Calculate Final Medicare Payment

Total Anesthesia Units × Medicare Anesthesia Conversion Factor = Medicare Payment

Appendix C: Full Code Descriptors for New HCPCS Codes for Services Addressing Health Related Social Needs

Community Health Integration Services
G0019

Community health integration services performed by certified or trained auxiliary personnel, including 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 the ability to diagnose or treat problem(s) addressed in an initiating visit:

- *Person-centered assessment, performed to better understand the individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating visit.*
    - *Conducting a person-centered assessment to understand patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that are not separately billed).*
    - *Facilitating patient-driven goal-setting and establishing an action plan.*
    - *Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan.*
- *Practitioner, Home-, and Community-Based Care Coordination*
    - *Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregiver (if applicable).*
    - *Communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.*
    - *Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.*
    - *Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the SDOH need(s).*
- *Health education- Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of the SDOH need(s), and educating the patient on how to best participate in medical decision-making.*
- *Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the SDOH need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment.*
- *Health care access / health system navigation.*
    - *Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them.*

- *Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.*
- *Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals.*
- *Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.*

G0022

Community health integration services, each additional 30 minutes per calendar month (List separately in addition to G0019).

Principal Illness Navigation (PIN)

G0023

Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month, in the following activities:

- Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition.
  - Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that are not separately billed).
  - Facilitating patient-driven goal setting and establishing an action plan.
  - Providing tailored support as needed to accomplish the practitioner's treatment plan.
- Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services.
- Practitioner, Home, and Community-Based Care Coordination
  - Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; home- and community-based service providers; and caregivers (if applicable).
  - Communication with practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.
  - Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.
  - Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s).
- Health education- Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making.

- Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition.
- Health care access / health system navigation.
    - Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them.
    - Providing the patient with information/resources to consider participation in clinical trials or clinical research as applicable.
- Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.
- Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals.
- Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.

G0024

Principal Illness Navigation services, additional 30 minutes per calendar month (List separately in addition to G0023).

G0140

Principal Illness Navigation – Peer Support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities:

- *Person-centered interview, performed to better understand the individual context of the serious, high-risk condition.*
    - *Conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors, and including unmet SDOH needs (that are not billed separately).*
    - *Facilitating patient-driven goal setting and establishing an action plan.*
    - *Providing tailored support as needed to accomplish the person-centered goals in the practitioner's treatment plan.*
- *Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services.*
- *Practitioner, Home, and Community-Based Care Communication*
    - *Assist the patient in communicating with their practitioners, home-, and community based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, goals, preferences, and desired outcomes, including cultural and linguistic factors. Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s).*
- *Health education—Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making.*

• *Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition.* • *Developing and proposing strategies to help meet person-centered treatment goals and supporting the patient in using chosen strategies to reach person-centered treatment goals.* • *Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet person-centered diagnosis and treatment goals.* • *Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.*
G0146
Principal Illness Navigation – Peer Support, additional 30 minutes per calendar month (List separately in addition to G0140).
Social Determinants of Health Risk Assessment
G0136
Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months.

Appendix D: New and Revised Code Values for Behavioral Health Services

Code	Short Descriptor	Current Work RVUs	New Work RVUs
Behavioral Health Integration			
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team.	0.61	0.93
G0323	Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist, clinical social worker, mental health counselor, clinical professional counselor, professional counselor, or marriage and family therapist time, per calendar month.	0.61	0.93

Psychotherapy Standalone			
90832	Psychotherapy, 30 minutes with patient	1.70	1.78
90834	Psychotherapy, 45 minutes with patient	2.24	2.35
90837	Psychotherapy, 60 minutes with patient	3.31	3.47
90839	Psychotherapy for crisis; first 60 minutes	3.13	3.28
90840	Psychotherapy for crisis; each additional 30 minutes	1.50	1.57
90845	Psychoanalysis	2.10	2.20
90846	Family psychotherapy (without the patient present), 50 minutes	2.40	2.51
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	2.50	2.62
90849	Multiple-family group psychotherapy	0.59	0.62
90853	Group psychotherapy (other than of a multiple-family group)	0.59	0.62
Psychotherapy E/M Add-on			
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service	1.50	1.57
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service	1.90	1.99
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service	2.50	2.62
Health Behavior Assessment and Intervention			
96156	Health behavior assessment, or re-assessment (i.e., health focused clinical interview, behavioral observations, clinical decision making)	2.10	2.20
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	1.45	1.52
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes	0.50	0.52
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	0.21	0.22
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes	0.10	0.10
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	1.55	1.62
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes	0.55	0.58
Substance Use Disorder Bundle			
G2086	Office-based treatment for a substance use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month	7.06	8.36

G2087	Office-based treatment for a substance use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month	6.89	8.19

Appendix E: Work RVUs for New and Revised Codes

This table, which can be found on pages 404-412 of the final rule lists all new and revised codes for which CMS has adopted changes (excluding behavioral health services and services to address health related social needs, which are listed above). For specific details regarding any coding or value changes, please refer to the rule or contact AOA.

Code	Short Descriptor	Current Work RVUs	New Work RVUs
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments	New	32.00
22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments	New	35.50
22838	Revision (e.g., augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed	New	36.00
22860	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)	27.13	27.13
27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (e.g., bone allograft[s], synthetic device[s]), without placement of trans fixation device	New	7.86
30117	Excision or destruction (e.g., laser), intranasal lesion; internal approach	3.26	3.91
30118	Excision or destruction (e.g., laser), intranasal lesion; external approach (lateral rhinotomy)	9.92	7.75
31242	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve	New	2.70
31243	Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve	New	2.70
33276	Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]) including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation when performed	New	9.50
33277	Insertion of phrenic nerve stimulator transvenous sensing lead	New	5.43

33278	Removal of phrenic nerve stimulator including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; system, including pulse generator and lead(s)	New	9.55
33279	Removal of phrenic nerve stimulator including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only	New	5.42
33280	Removal of phrenic nerve stimulator including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator only	New	3.04
33281	Repositioning of phrenic nerve stimulator transvenous lead(s)	New	6.00
33287	Removal and replacement of phrenic nerve stimulator including vessel catheterization, all imaging guidance, and interrogation and programming when performed; pulse generator	New	6.05
33288	Removal and replacement of phrenic nerve stimulator including vessel catheterization, all imaging guidance, and interrogation and programming when performed; transvenous stimulation or sensing lead	New	8.51
52284	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed	New	3.10
58580	Transcervical ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency	New	7.21
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	36.58	37.00
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	18.34	18.76
59425	Antepartum care only; 4-6 visits	7.80	7.80
59426	Antepartum care only; 7 or more visits	14.30	14.30
59430	Postpartum care only (separate procedure)	3.22	3.22
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	40.39	41.05
59515	Cesarean delivery only; including postpartum care	22.13	22.79
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	38.29	38.71
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	20.06	20.48
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following	40.91	41.57

	attempted vaginal delivery after previous cesarean delivery		
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care	22.66	23.32
61889	Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)	New	25.75
61891	Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)	New	11.25
61892	Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, when performed	New	15.00
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver requiring pocket creation and connection between electrode array and pulse generator or receiver	5.19	5.19
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array, with detachable connection to	5.30	4.35
64590	Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver direct or inductive coupling, requiring pocket creation and connection between electrode array and pulse generator or receiver	2.45	5.10
64595	Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array	1.78	3.79
64596	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator including imaging guidance, when performed; initial electrode array	New	C
64597	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator including imaging guidance, when performed; each additional electrode array	New	C
64598	Revision or removal of neurostimulator electrode array, peripheral nerve, with integrated neurostimulator	New	C
65778	Placement of amniotic membrane on the ocular surface; without sutures	1.00	0.84
65779	Placement of amniotic membrane on the ocular surface; single layer, sutured	2,50	1.75
65780	Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	7.81	7.03

67516	Suprachoroidal space injection of pharmacologic agent (separate procedure)	New	1.53
75580	Noninvasive estimate of coronary fractional flow reserve derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional	New	0.75
76881	Ultrasound, complete joint (i.e., joint space and periarticular soft-tissue structures), real-time with image documentation	0.90	0.90
76882	Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (e.g., joint space, periarticular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft tissue mass[es]), real-time with image documentation	0.69	0.69
76883	Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity	1.21	1.21
76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real time ultrasound visualization of vascular needle entry, with permanent recording and reporting	0.30	0.30
76984	Ultrasound, intraoperative thoracic aorta (e.g., epiaortic), diagnostic	New	0.60
76987	Intraoperative epicardial cardiac (e.g., echocardiography) ultrasound for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report	New	1.90
76988	Intraoperative epicardial cardiac (e.g., echocardiography) ultrasound for congenital heart disease, diagnostic; placement, manipulation of transducer, and image acquisition only	New	1.20
76989	Intraoperative epicardial cardiac (e.g., echocardiography) ultrasound for congenital heart disease, diagnostic; interpretation and report only	New	0.70
76998	Ultrasonic guidance, intraoperative	1.20	0.91
92622	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes		1.25
92623	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes	New	0.33
92972	Percutaneous transluminal coronary lithotripsy	New	2.97
93150	Therapy activation of implanted phrenic nerve stimulator system including all interrogation and programming	New	0.85

93151	Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system	New	0.80
93152	Interrogation and programming of implanted phrenic nerve stimulator system during a polysomnography	New	1.82
93153	Interrogation, without programming of implanted phrenic nerve stimulator system	New	0.43
93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional	0.52	0.52
93298	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional	0.52	0.52
93584	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; anomalous or persistent superior vena cava when it exists as a second contralateral superior vena cava, with native drainage to heart	New	1.20
93585	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; azygos/hemi-azygos venous system	New	1.13
93586	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; coronary sinus	New	1.43
93587	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; venovenous collaterals originating at or above the heart (e.g., from innominate vein)	New	2.11
93588	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; venovenous collaterals originating below the heart (e.g., from the inferior vena cava)	New	2.13
96547	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes	New	C
96548	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes	New	C
97037	Application of a modality to 1 or more areas; low-level laser therapy (i.e., non-thermal and non-ablative), for post operative pain reduction	New	N
97550	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home	New	1.00

	or community (e.g., activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; initial 30 minutes		
97551	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; each additional 15 minutes	New	0.54
97552	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face with multiple sets of caregivers	New	0.23
99459	Pelvic examination	New	0.00
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	1.50	1.50
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes	1.40	1.40